Berkshire Healthcare
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

TRUST BOARD MEETING

(conducted electronically via Microsoft Teams)

10:00am on Tuesday 10 May 2022

AGENDA

No	Item	Presenter	Enc.
OPENING BUSINESS			
1.	Chairman's Welcome and Public Questions	Martin Earwicker, Chair	Verbal
2.	Apologies	Martin Earwicker, Chair	Verbal
3.	Declaration of Any Other Business	Martin Earwicker, Chair	Verbal
4.	Declarations of Interest i. Amendments to the Register ii. Agenda Items	Martin Earwicker, Chair	Verbal
5.1	Minutes of Meeting held on 12 April 2022	Martin Earwicker, Chair	Enc.
5.2	Action Log and Matters Arising	Martin Earwicker, Chair	Enc.
QUALITY			
6.0	Patient Story – WestCall	Debbie Fulton, Director of Nursing and Therapies/Dr Sandeep Sandhu, WestCall, Bernadine Blease, Head of Community Networks, Helen Pailthorpe, Berkshire Community Dental Service	Verbal
6.1	Patient Experience Report – Quarter 4	Debbie Fulton, Director of Nursing and Therapies	Enc.
6.2	Safe Staffing Six Monthly Report	Debbie Fulton, Director of Nursing and Therapies	Enc.
6.3	Quality Accounts 2021-22	Dr Minoo Irani, Medical Director	Enc.
6.4	Review of Current Processes Against the Recommendations from the Final Ockenden Report	Debbie Fulton, Director of Nursing and Therapies	Enc.
EXECUTIVE UPDATE			
7.0	Executive Report	Julian Emms, Chief Executive	Enc.
PERFORMANCE			
8.0	Month 12 2021/22 Finance Report	Paul Gray, Chief Financial Officer	Enc.
8.1	Month 12 2021/22 Performance Report	Paul Gray, Chief Financial Officer	Enc.

No	Item	Presenter	Enc.
8.2	Finance, Investment and Performance Committee meeting on 28 April 2022	Naomi Coxwell, Chair of the Finance, Investment and Performance Committee	Enc.
STRATEGY			
9.0	Combined Projects and Strategy Implementation Plan Update Report	Alex Gild, Deputy Chief Executive	Enc.
CORPORATE GOVERNANCE			
10.0	Audit Committee Meeting held on 28 April 2022	Rajiv Gatha, Chair, Audit Committee	Enc.
10.1	Annual Report 2021-22*	Julian Emms, Chief Executive	Enc.
10.2	Council of Governors Update	Martin Earwicker, Trust Chair	Verbal
Closing Business			
11.	Any Other Business	Martin Earwicker, Chair	Verbal
12.	Date of the Next Public Trust Board Meeting –12 July 2022	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

* ***It is a legal requirement that an NHS Foundation Trust's Annual Report is not published until the Report has been laid before Parliament. The draft Annual Report is therefore excluded from the Public Trust Board papers on the Trust's website.*

Berkshire Healthcare
NHS Foundation Trust

Unconfirmed minutes

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Minutes of a Board Meeting held in Public on Tuesday, 12 April 2022

(Conducted via Microsoft Teams)

Present:	Martin Earwicker	Chair
	David Buckle	Non-Executive Director
	Naomi Coxwell	Non-Executive Director
	Rajiv Gatha	Non-Executive Director
	Mark Day	Non-Executive Director
	Aileen Feeney	Non-Executive Director
	Mehmuda Mian	Non-Executive Director
	Julian Emms	Chief Executive
	Alex Gild	Chief Financial Officer
	Dr Minoo Irani	Medical Director
	Debbie Fulton	Director of Nursing and Therapies
	David Townsend	Chief Operating Officer
	Paul Gray	Chief Financial Officer
In attendance:	Julie Hill	Company Secretary
	Tammy Ives	Lead Ketogenic Dietitian

22/045	**Welcome and Public Questions** (agenda item 1)
	The Chair welcomed everyone to the meeting. There were no public questions.
22/046	**Apologies** (agenda item 2)
	There were no apologies.
22/047	**Declaration of Any Other Business** (agenda item 3)
	There was no other business.

22/048	**Declarations of Interest** (agenda item 4)
	i. **Amendments to Register** – none
	ii. **Agenda Items** – none
22/049	**Minutes of the previous meeting – 08 February 2022** (agenda item 5.1)
	The Minutes of the Trust Board meeting held in public on Tuesday 08 February 2022 were approved as a correct record.
22/050	**Action Log and Matters Arising** (agenda item 5.2)
	The schedule of actions had been circulated. **The Trust Board:** noted the action log.
22/051	**Board Story – A Dietetics Story (**agenda item 6.0)
	The Chair welcomed Tammy Ives, Lead Ketogenic Dietitian to the meeting. Tammy Ives reported that her dissertation for her MSc in Advanced Professional Practice in Paediatric Dietetics was around the use of the ketogenic diet as a treatment for children with drug resistant epilepsy. Ms Ives said that she undertook a service evaluation to review the efficacy and tolerability of the ketogenic diet in a Paediatric ketogenic diet service based in a District General Hospital (Royal Berkshire NHS Foundation Trust) in order to compare the findings in the literature typically based in tertiary hospital centres. Tammy Ives gave a presentation (the presentation slides are attached to the minutes of the meeting) and highlighted the following points: • The ketogenic diet was first used in America in the 1920s and was a very high fat, low carbohydrate with low/moderate protein intake and was used to treat drug resistant epilepsy • The objectives of the Royal Berkshire ketogenic diet service review were to: calculate the percentage seizure reduction from the baseline at 3 and 6 months on the ketogenic diet; to compare hospital admissions related to epilepsy 6 months prior to starting the ketogenic diet and 6 months after being on the ketogenic diet; and to identify issues with tolerance and reported side effects. • 10 children were selected for the study. The results of the study showed that after 3 months on the ketogenic diet, 50% of the children achieved at least a 50% reduction in the number of seizures they experienced; 70% of the children achieved at least a 50% seizure reduction after 6 months on the ketogenic diet; 1 child was seizure free; 2 children did not respond to the ketogenic diet; 3 children had 4 hospital admissions in the 6 months prior to starting the ketogenic diet; there were no children admitted to hospital 6 months after starting the ketogenic diet. • The main side effect of the ketogenic diet was constipation. 2 of the children opted to come off the ketogenic diet in spite of the fact that they had an 80% seizure reduction. • Feedback from the families was very positive

	The Chair asked whether there were any downsides with being on the ketogenic diet in longer term. Ms Ives said that the main concern was around if the ketogenic increased cholesterol levels. Ms Ives said that patients' cholesterol levels were monitored and being on the ketogenic diet did not appear to result in higher cholesterol levels. It was noted that 1 in 10 patients developed renal stones but this tended to be an issue for those patients who had insufficient fluid intake. Mark Day, Non-Executive Director asked how the service motivated patients, particularly teenagers to maintain the ketogenic diet. Ms Ives agreed that it was challenging but said that an important motivator was getting the young people to reflect on how their quality of life had improved because they were not experiencing the same frequency of seizures. The Medical Director said that ketogenic diets were very helpful in treating drug resistant patients and sometimes this enabled clinicians and patients to buy time until new anti-epileptic drugs were developed and/or there were advances in surgery. David Buckle, Non-Executive Director asked whether the ketogenic diet was consistent with NICE guidance Ms Ives confirmed that the ketogenic diet was part of the NICE guidance for children who failed to respond to two to three anti-epileptic drugs. The Chair thanked Tammy Ives for her presentation.
22/052	**Quality Assurance Committee Meeting – 1 March 2022** (agenda item 6.1)
	a) Minutes of the Quality Assurance Committee held on 01 March 2022 David Buckle, Chair of the Quality Assurance Committee reported that in addition to the standing items, the Committee had received a presentation on the Trust's all ages Eating Disorder Service. Dr Buckle said that the Committee had noted that demand for Eating Disorder Services had increased during the pandemic and that this was reflected nationally. The Committee had also noted that due to recruitment challenges, the Eating Disorder Service was breaching the NHS Long-Term Plan target in relation to access and waiting times standards for children and young people with eating disorders. Dr Buckle reported that the Committee had also received a presentation on the Trust's Tissue Viability Service and an update from the Chief Operating Officer on the impact of the COVID-19 lock down in terms of increased demand for services, particularly mental health services. Dr Buckle said that the Committee were satisfied with the mitigations the Trust had put in place to manage the increased demand. Dr Buckle reported that the Committee had reviewed the quarter 3 draft Quality Accounts Report 2021-22 which would be presented to the Trust Board for approval in May 2022.

	b) Learning from Deaths Quarterly Report The quarterly Learning from Deaths report was submitted to the Trust Board for information. **c) Guardian of Safe Working Practices Report** The quarterly Guardian of Safe Working Practices report was submitted to the Trust Board for information. The Chair thanked Dr Buckle for his update. **The Trust Board noted**: a) The minutes of the Quality Assurance Committee held on 01 March 2022 b) The Learning from Deaths Quarterly Report and c) The Guardian of Safe Working Practices Quarterly Report.
22/053	**Executive Report** (agenda item 7.0)
	The Executive Report had been circulated. **The Trust Board**: noted the paper.
22/054	**2021 National NHS Staff Survey Results Report** (agenda item 7.1)
	The Deputy Chief Executive presented the paper and reported that the format of the national NHS Staff Survey had gone through its biggest change in recent years, aligning questions (some changed or added) to the seven NHS "People Promise" elements. It was noted that the staff engagement and morale themes remain unchanged. The Deputy Chief Executive said that the Trust's Staff Survey results needed to be viewed within the challenging context of year two of the COVID-19 pandemic which had tested and continued to test the resilience of staff. The Deputy Chief Executive reported that the Trust's response rate had remained consistently high over the last three years (60% in 2021, 8% above the national average). The Deputy Chief Executive highlighted the following points: • The Trust's results were positive overall with above average scores in all elements and themes. • The Trust's Staff Engagement result remained at the top of our national peer group (7.4 score). The Trust was also strongest in its peer group for the "We are always learning" element • In another difficult year of the Covid-19 pandemic, undoubtedly impacting the resilience of staff, the Trust's results in some areas had dropped, but these were largely in line with falls in the best/average/worse scores for our peer group. • Whilst we could no longer compare the theme trends from previous years, our overall performance remained strong, with certain questions showing significant

	improvement since last year including *acting on concerns of patients and addressing staff concerns of unsafe clinical practice.* • Top scoring questions included: *recommending Berkshire Healthcare as a place to work and shared team objectives.* • The staff survey results help the Trust to triangulate where we need to improve the experience of our staff, to truly be "Outstanding for Everyone". • However, the results showed that the Trust was making minimal progress in areas such as *work pressures* and the *unwarranted differential experiences of our staff with protected characteristics.* These areas remained a focus for action. The Chair congratulated the Trust on an impressive set of Staff Survey results. The Chair said that the Trust also recognised that there were areas for further improvement, for example, addressing the differential experience of Black, Asian and Minority Ethnic staff compared to their white counterparts. David Buckle, Non-Executive Director added his congratulations and commented that the results were especially impressive at a time when the NHS was under considerable pressure. Dr Buckle said that an above average response rate of 60% also added additional assurance around validity of the results. Dr Buckle asked what the Trust had done to improve the response rate from 46% in 2016 to 60% in 2021. The Deputy Chief Executive explained that the Trust had targeted those areas of the workforce which had poorer response rates. This included providing printed versions for staff who did not have access to computers, for example, Estates and Facilities Staff and providing time out for staff to complete the Staff Survey. The Deputy Chief Executive said that the Trust's focus on acting on staff feedback, for example, "You Said, We Did" sessions at the All Staff Briefings meant that staff were more willing to complete the Staff Survey if they thought that their feedback would be acted upon and would make a difference. The Chair asked whether the 60% response rate reflected the diversity of the workforce. The Deputy Chief Executive said that the Trust had tested this last year and would do the same this year and confirmed that last year's respondents were reflective of the diversity of the workforce. The Chief Executive said that a key advantage for the Trust was that given that the overall results were positive, the Trust was able to concentrate on a small number of areas where further work was required. The Chief Executive said that improving Equalities, Diversity and Inclusion was challenging but pointed out that initiatives such as the introduction of a zero tolerance policy for patients racially abusing staff at Prospect Park Hospital was having a positive impact on the work experience of Black, Asian and Minority Ethnic Staff. The Chief Executive said that moving forward, it would be important for the Trust and the Trust Board not to become complacent. **The Trust Board:** noted the report.
22/055	**Gender Pay Gap Report** (agenda item 7.2)
	The Deputy Chief Executive presented the paper and highlighted the following points:

	• Like other NHS providers, the female workforce made up most of our staffing (83.01%) • There had been a slight increase in the number of women in quartiles 1-3 (Q1-Q3) of pay and a significant decrease in the highest quartile of pay (Q4). • The number of females in the lowest quartile of pay (Q1) had remained higher than the proportion of females employed in the Trust. • The gender pay gap was slightly worse than it was three years ago, the number of female employees in the highest quartile of pay (Q4) had reduced. • For different reasons, most staff employed on a part time basis were female – a factor that contributed to the gender pay gap. • The majority number of staff who used the childcare salary scheme were female – this had a disproportionate impact on the hourly rate of female staff. • The average "bonus" pay gap relating to Clinical Excellence Awards had decreased by 11.03%. The Chair commented that it was difficult to know what more the Trust could do to reduce the gender pay gap. The Chief Executive pointed out that one of the reasons why there was a gender pay gap in the Trust was due to female staff opting to work part-time, often because of caring responsibilities. The Chief Executive said that the Trust would not want to reduce the gender pay gap if that meant that staff were discouraged from working part-time. The Chief Executive said that the Medical Director had identified that female consultants were significantly less likely than their male counterparts to submit applications for clinical excellence awards. The Chief Executive said some female consultants working part time had not realised that they were eligible for consideration of a clinical excellence award. The Medical Director reported that every female consultant was invited to attend a focus group which was externally facilitated. The Trust took account of the feedback from the focus group and now there was a 50/50 gender split of applications for clinical excellence awards. Naomi Coxwell, Non-Executive Director said that the gender pay gap data highlighted the importance of developing a talent management pipeline to ensure that internal candidates were able to apply for promotion opportunities at all levels of the Trust. Ms Coxwell welcomed the Trust's work around ensuring that staff had a career conversation as part of the annual appraisal process. The Chief Executive said that the Trust's talent management process was well developed for Board, Sub-Board and the Senior Leadership Team and said that the Director of People was extending the talent management process to cover staff at agenda for change 8a-8b levels in the Trust. Aileen Feeney, Non-Executive Director asked whether the Trust had considered setting up a women's staff network in order to provide a sounding board for ideas. The Chief Executive suggested that setting up targeted focus group sessions may be more effective than establishing another staff network. **The Trust Board:** **a)** Approved the publication of the Gender Pay Gap Report; and **b)** Noted the report.

22/056	**Month 11 2121-22 Finance Report** (agenda item 8.0)
	The Chief Financial Officer presented the paper and highlighted the following points: • The Trust was reporting a deficit of £0.2m against a £0.2m deficit plan for February 2022, with the year to date position being a £0.5m surplus. • The Trust continued to forecast a £1m surplus against a target to breakeven for the year. • The Trust continued to defer investment income due to workforce availability. Following discussions with Commissioners, the Trust was hoping to be able to carry forward more of the upsent investment funding into next year. • Non-pay spend was £0.3m above plan. The main non-pay pressure continued to be the expenditure of Out of Area Placements. There was also an additional change of £260k in respect of a rates assessment on Erlegh House. • Capital expenditure year to date was £5m, £2.3m under plan of which £1.6m related to the Capital Departmental Expenditure Limit (CDEL) control total. It was expected that the CDEL control total would be used in full by the end of March 2022. • Cash balances remained strong at £54.2m Naomi Coxwell, Non-Executive Director referred to the non-permanent staffing (excluding COVID-19 costs) from April 2020 to February 2022 trend chart on page 87 of the agenda pack which showed an increasing trend over the last two quarters and asked whether the expectation was that this trend would revert back to the position during 2020-21 or would remain high. The Chief Financial Officer reminded the meeting that in 2020-21 due to the COVID-19 pandemic, a number of services were paused and staff were redeployed and therefore it was difficult to make comparisons. The Chief Financial Officer said that demand for services was above pre-pandemic levels with higher levels of patient acuity and this presented significant pressures on the workforce. The Chief Financial Officer said that the Trust would need to closely monitor the situation during 2022-23 and take a view as to whether the current level of agency spend was sustainable. The Director of Nursing and Therapies pointed out that some of the agency spend over the last two quarters was because NHS Professionals were unable to fill rotas due to high levels of staff off sick because of COVID-19. The Chair asked why some staff opted to work for agencies rather than join the Staff Bank. The Chief Executive reported that the reasons why some staff preferred agency working included higher rates of pay, more flexibility around working patterns and concerns around discrimination in the workplace. The Chief Executive said that the Trust was undertaking a piece of work to see if there was more that could be done to attract more staff to join the Staff Bank. **The Trust Board:** noted the report.

22/057	**Month 11 2121-22 "True North" Performance Scorecard Report** (agenda item 8.2)
	The Month 11 "True North" Performance Scorecard had been circulated. The Chief Financial Officer presented the paper highlighted that self-harm incidents were above target but pointed out that 19 incidents on Bluebell ward were from one patient and that 3 patients accounted for 35 of the incidents. The Chief Financial Officer reported that the Patient Friends and Family Test response rate was at 0% against a 15% target and pointed out that this was not zero but a rounding of a low response rate. There was a project underway to implement the new system so it would take some time to see improvements. The Chair commented that he was pleased to see that areas of under-performance were backed by clear action plans. Aileen Feeney, Non-Executive Director said that she was pleased to see that the True North Performance Scorecard Report now included standard deviation lines. **The Trust Board:** noted the report.
22/058	**Board Vision Metrics Report** (agenda item 8.3
	The Chief Financial Officer presented the paper and highlighted the key changes since the Vision Metrics had last been presented to the Trust Board in December 2021: • The Trust had achieved the top score in its peer group for Staff Engagement in the 2021 National Staff Survey. • There had been no inpatient deaths from self-harm since October 2018. • The Friends and Family Test (FFT) collection was proving challenging to recover since it was restarted. A project had introduced a new system for collecting patient experience information across Mental Health and Community services and work was underway to increase uptake as the system matured • Benchmark positions had been refreshed for 2020/21 data recently published. • The Trust's performance had deteriorated in respect of falls, use of restraint (now retired as a driver metric due to sustained performance improvement) and pressure ulcers. There had been an improvement relation to a reduction in the number of patient on patient assaults, patient on staff assaults and mental health bed occupancy. • NHS England/Improvement System segmentation had been added to the Vision Metrics in addition to the Trust's segmentation. The Chair said that it would be helpful if the Trust Board had an opportunity to review the Board Vision Metrics. The Chair said that he was keen not to duplicate information already presented to the Trust Board, for example, as part of the True North Performance Scorecard Report but said that it was helpful to the Trust Board to have an overarching "big picture" view of the Trust's performance. Naomi Coxwell, Non-Executive Director pointed out that the mental health use of restraint had continued to be included as a Board Vision Metric but this was no longer a driver metric on the True North Performance Scorecard Report because of the Trust's sustained performance and therefore queried its value as a Board Vision Metric.

	The Chief Executive agreed with the Chair that it would be helpful for the Trust Board to review the Board Vision Metrics. **Action: Chief Financial Officer** **The Trust Board**: noted the report.
22/059	**Finance, Investment and Performance Committee Meeting – 24 March 2022** (agenda item 8.4)
	Naomi Coxwell, Non-Executive Director reported that in addition to the standard reports, the Finance, Investment and Performance Committee meeting held on 24 March 2022 had received a presentation by the Director of People on the Trust's staff retention work. Ms Coxwell said that turnover of staff in clinical roles was much higher than for non-clinical roles and this was partly due to an increase in the number of newly created clinical posts as a result of increased national funding. Ms Coxwell reported that the key reasons why staff left the Trust were: promotion, relocation, to undertake education and training and work life balance. Ms Coxwell said that the Trust was undertaking a range of activities to try and reduce staff turnover, including a focus on career conversations with staff as part of the annual appraisal process, the expansion of the apprenticeship scheme, development of an internal recruitment policy, upskilling managers and developing remote and hybrid working roles providing that this did not impact on patient safety. Ms Coxwell reported that the Committee had acknowledged that there was no shortage of ideas to reduce staff turnover and had stressed that the next stage would be to focus on the implementation of these ideas. The Chair thanked Ms Coxwell for her update.
22/060	**Council of Governors Update** (agenda item 9.0)
	The Chair reported that nominations had opened for governor elections in: Wokingham, Windsor, Ascot and Maidenhead, Slough and West Berkshire. There was also a vacancy for a Clinical Staff Governor.
22/061	**Trust Seal Report** (agenda item 9.1)
	The Chief Financial Officer reported that the Trust's Seal had been affixed onto a proposal to vary the electricity supply at Prospect Park Hospital by installing on site electrical vehicle charging points equipment. **The Trust Board**: noted the report.
22/062	**Any Other Business** (agenda item 10)
	There was no other business.

22/063	**Date of Next Public Meeting** (agenda item 11)
	The next Public Trust Board meeting would take place on 10 May 2022
22/064	**CONFIDENTIAL ISSUES:** (agenda item 12)
	The Board resolved to meet In Committee for the remainder of the business on the basis that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.

I certify that this is a true, accurate and complete set of the Minutes of the business conducted at the Trust Board meeting held on 12 April 2022.

Signed……. Date 10 May 2022

(Martin Earwicker, Chair)

Service evaluation of a paediatric KD at RBH

BY

TAMMY IVES

What is the ketogenic diet?

- First used in 1920's in U.S.A
- A very high fat diet, low carbohydrate and low/moderate protein intake
- Drug resistant epilepsy
- KD services are typically based in tertiary centres.

MSc Advanced Professional Practice in Paediatric Dietetics.

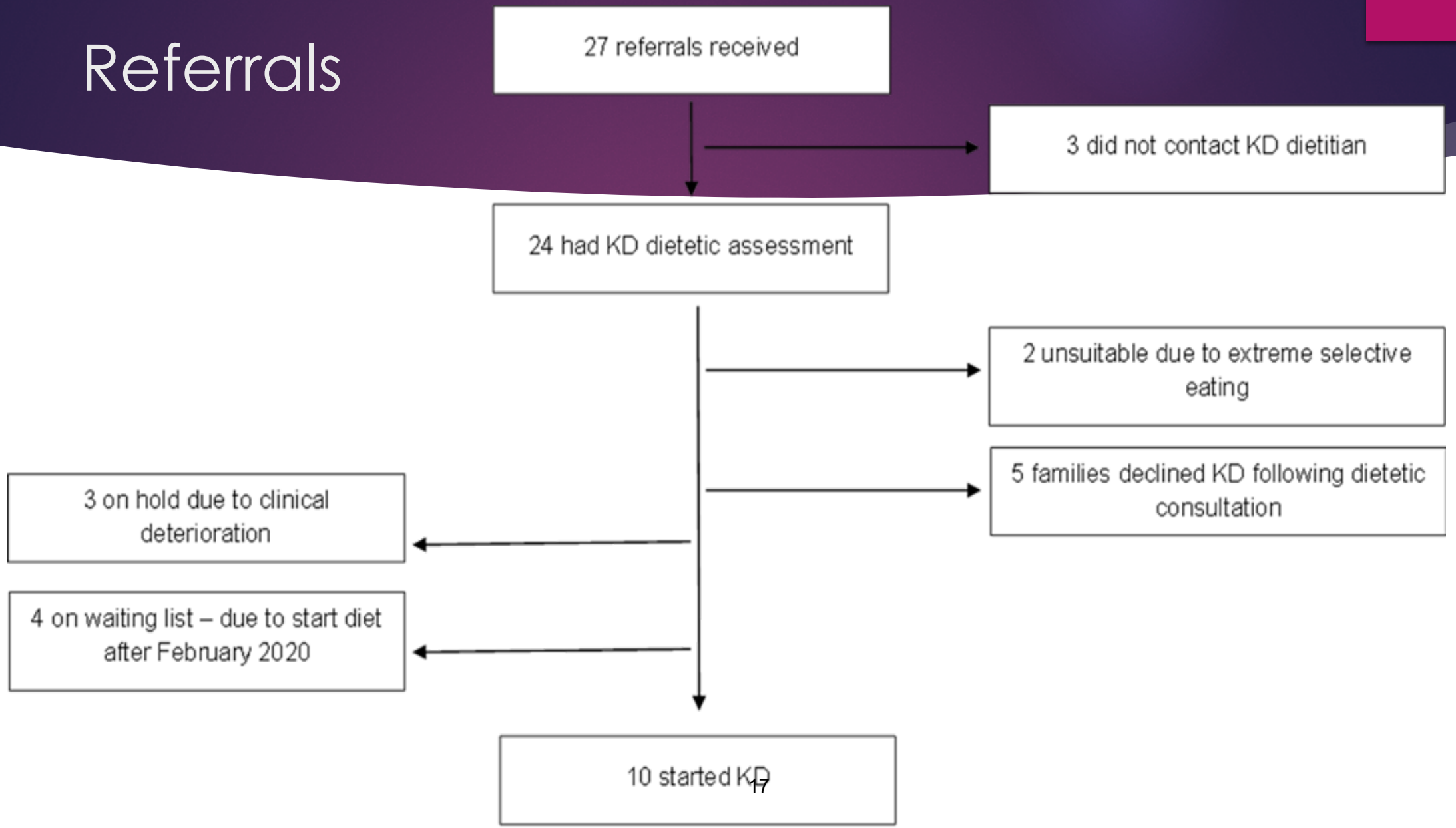
- Graduated in 2020

- Aim of service evaluation: to review the efficacy and tolerability of the KD in a paediatric KD service based in a DGH and compare to findings in the literature typically based in tertiary centres.

Objectives

1) To calculate percentage seizure reduction from baseline at 3 and 6 months on KD.
2) To compare hospital admissions related to epilepsy 6 months prior to starting KD and 6 months after KD commenced.
3) To identify issues with tolerance and reported side effects.

Referrals


27 referrals received
3 did not contact KD dietitian
24 had KD dietetic assessment
2 unsuitable due to extreme selective eating
5 families declined KD following dietetic consultation
3 on hold due to clinical deterioration
4 on waiting list – due to start diet after February 2020
10 started KD

Results – efficacy of KD

- 50% achieved at least 50% SR at 3/12
- 70% achieved at least 50% SR at 6/12
- N=1 Seizure free!!
- N=2 = non responders (<50% SR)
- N=3 had 4 admissions 6/12 pre KD
- 0 admissions 6/12 on KD

Tolerance

- Side effects and reasons for weaning off diet.
- 3 constipation & 1 carnitine deficiency.
- 4 weaned off diet early – 2 non responders
- 2 wanted to come off diet despite >80% seizure reduction.

KDT provision in a district general hospital: a mixed-methods study of outcomes and recommendations arising from an MDT focus group

- Write it up!!

- Mixed methods approach – FOCUS GROUP

- 3 main themes identified

- Identity of the service
- Patient safety and quality
- Supportive team working

Quotes from Focus Group

- 'it's a completely different service, and for the patient, it is a better service …in terms of proximity and the fact they know that the keto team is part of their epilepsy team and in very close communication, it makes a massive difference for us locally' (P4)
- 'I think the first thing that strikes me is the teamwork. The team as a whole really is a massive positive and I think we work really well together' (P3).
- 'For me personally it would be the immense support I've been given in settling into the team…. And helping me upskill with the KD' (P6).

Feedback from families.

- “This diet has been a steep learning curve and I remember how overwhelmed I felt in the beginning, trying to cram in every bit of information as quickly as I could so I could master this diet. Thankfully those days are behind and I truly am thankful for the help and support you have given us over the past year especially with the new recipes.”
- “Since being on the diet he has been much more alert and interactive. I have always believed that all the seizures he was having was wearing him out and he was reclusive. I felt he felt for every happy moment he had he was "punished" by having a seizure so he wouldn't interact so he wouldn't have a seizure. This is no longer the case. School too have seen an improvement.”

Patient feedback

“I first started the diet in December 2018, and have been seizure free since then.”

“I wouldn't be where I am now if it wasn't for your fantastic support.”

Berkshire Healthcare NHS Foundation Trust

BOARD OF DIRECTORS MEETING 10/05/2022

Board Meeting Matters Arising Log – 2022 – Public Meetings

Key:

Purple - completed
Green – In progress
Unshaded – not due yet
Red – overdue

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
14.12.21	21/234	Freedom to Speak Up Guardian Report	Future reports to provide more targeted examples of where the learning from concerns raised had not been fully implemented.	July 2022	**MC**	To be included as part of the next Freedom to Speak Up Report.	
12.04.22	22/058	Board Vision Metrics Report	The Trust Board to review the Board Vision Metrics	June 2022	**PG**	To be discussed at the June 2022 Trust Board Discursive meeting.	

Berkshire Healthcare
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Board	10th May 2022
Title	Patient Experience Report Quarter 4 (January -March 2022)
	Item is for noting
Purpose	The purpose of this report is to provide the Board with an overview of the patient experience information and activity for Quarter 4
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
Equalities and Diversity Implications	Section 5 of the report includes characteristic data in respect of complaints.
SUMMARY	This report is for information and provides detail of patient experience data and feedback including complaints and compliments collected across the Trust during quarter 4 (January – March 2022). It is the view of the Director of Nursing that there are no new themes or trends identified from the patient experience data within the report. The total number of complaints are comparable with the previous quarter and there is also a similar percentage of closed complaints that are either partially or fully upheld with these generally being spread across services. The highest numbers of upheld/ partially upheld complaints relate to care and treatment (20) with these being very specific to the individual with no obvious themes emerging. We are seeing that wait times especially for CAMHS services are featuring across both formal and informal complaints, local resolution and MP enquires. This is not a new theme and there are a number of initiatives in place to support reduced waiting times particularly for neurodiversity pathways. The demographic data shows that for ethnicity and gender there is correlation between percentage of attendances and percentage of complaints received.

	The positive compliments and feedback received continues to far outweigh the concerns and complaints raised; that said every concern / complaint is reviewed with feedback provided and consideration given to learning from the persons experience. The new patient experience tool which has been developed in partnership with 'I WantGreatCare' launched toward the end of quarter 3, it is recognised that the new tool and optimum use of the information received through it will take time to embed. During quarter 4 over 1000 responses were received through the questionnaire with an overall satisfaction rate of 4.66 out of 5 stars and a 92.9% positive experience score. A sample of the free text feedback has been provided in the report alongside the overall percentage satisfaction of those who have responded using the new tool during December. The PHSO continues to catch up with complaints raised to them and as a result we have a large number that we have provided information to assist their decision making and are awaiting a decision around whether the PHSO will progress to an investigation. Some 15- steps visits have recommenced, and Appendix 3 of the report provides a short summary of these.
ACTION REQUIRED	The Board is asked to: Note the report.

Berkshire Healthcare
NHS Foundation Trust

Quarter Four – Patient Experience Report (1 January 2022 – 31 March 2022)

1. Introduction

This report is written for the board and contains the quarterly patient experience information for Berkshire Healthcare (The Trust) incorporating; complaints, compliments, PALS, and our new patient survey programme (which is collected using paper, online, text, kiosks, and tablets) through the platform *iWGC (I want great Care)*.

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 four 2021-22 there were 56 complaints received (including re-opened complaints), which mirrors the numbers for the same period for 2020-21.

There were 114,715 reported patient contacts and discharges from our inpatient wards, giving a sustained complaint rate of 0.05%.

Table 1: Formal complaints received

	2020-2021						2021-22						
Service	**Q1**	**Q2**	**Q3**	**Q4**	**Total for year**	**% Of Total**	**Q1**	**Q2**	**Q3**	**Higher or lower than previous quarter**	**Q4**	**Total for year**	**% Of Total**
CMHT/Care Pathways	4	11	7	12	34	**15.96**	5	8	10	↓	9	32	**13.85**
CAMHS - Child and Adolescent Mental Health Services	2	3	3	6	14	**6.57**	5	10	6	↑	10	31	**13.42**
Crisis Resolution & Home Treatment Team (CRHTT)	4	2	3	4	13	**6.1**	5	4	2	↑	4	15	**6.49**
Acute Inpatient Admissions – Prospect Park Hospital	7	4	1	9	21	**9.86**	11	8	7	↓	6	30	**12.99**
Older Adults inpatients – Prospect Park Hospital	0	0	1	0	1	**0.46**	2	0	2	↑	3	7	**3.03**
Community Nursing	2	1	5	2	10	**4.69**	4	5	2	↓	1	12	**5.19**
Community Hospital Inpatient	5	6	3	4	18	**8.45**	6	8	6	↓	5	25	**10.82**
Common Point of Entry	1	1	3	1	6	**2.82**	0	1	1	↓	0	2	**0.87**
Out of Hours GP Services	4	0	3	1	8	**3.76**	1	1	5	↓	2	9	**3.90**

	2020-2021						2021-22						
Service	**Q1**	**Q2**	**Q3**	**Q4**	**Total for year**	**% Of Total**	**Q1**	**Q2**	**Q3**	**Higher or lower than previous quarter**	**Q4**	**Total for year**	**% Of Total**
PICU - Psychiatric Intensive Care Unit	2	0	0	2	4	**1.88**	3	1	2	↓	1	7	**3.03**
Urgent Treatment Centre	1	0	1	0	2	**0.94**	1	1	0	↓	0	2	**0.87**
Older Adults Community Mental Health Team	1	1	1	2	5	**2.35**	0	0	0	↑	2	2	**0.87**
Other services in Q4	11	33	20	13	78	**36.62**	16	14	12	↑	13	64	**27.71**
Grand Total	44	62	51	56	213		59	61	55		56	231	100

The 'other services' complaints were split over 13 different services, and there is nothing of note to report as these services only saw numbers of 1 or 2 complaints.

There were two reportable complaints for the Criminal Justice Liaison and Diversion service, but one complaint was a re-opened complaint.

3 of the 56 formal complaints received were about, or mentioned, Covid, these were:

- One regarding the vaccine given to school aged children
- Two were regarding care on inpatient wards and reduced activities available during the outbreaks with restrictions in place during Covid

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 three 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 four

29 of the 56 (52%) complaints received during Quarter four were related to adult mental health service provision.

Table 2: Adult mental health service complaints

	Geographical Locality						
Service	**Bracknell**	**Portsmouth**	**Reading**	**Slough**	**West Berks**	**Wokingham**	**Grand Total**
Adult Acute Admissions - Bluebell Ward			3				**3**
Adult Acute Admissions - Snowdrop Ward			1				**1**
CMHT/Care Pathways	2		1	1	2	3	**9**
CMHTOA/COAMHS - Older Adults Community Mental Health Team			1		1		**2**
Criminal Justice Liaison and Diversion Service - (CJLD)		2					**2**
Crisis Resolution and Home Treatment Team (CRHTT)			4				**4**
Learning Disability Service Inpatients - Campion Unit - Ward			1				**1**
Older Adults Inpatient Service - Rowan Ward			2				**2**

	Geographical Locality						
Service	**Bracknell**	**Portsmouth**	**Reading**	**Slough**	**West Berks**	**Wokingham**	**Grand Total**
PICU - Psychiatric Intensive Care - Sorrel Ward			1				**1**
Psychological Medicine Service			1				**1**
Talking Therapies - PWP Team	1		1				**2**
Veterans TILS Service			1				**1**
Grand Total	**3**	**2**	**17**	**1**	**3**	**3**	**29**

2.2.1 Number and type of complaints made about a CMHT

9 of the 56 complaints (16%) received during Quarter four related to the CMHT service provision, detail below. There were 10,437 reported attendances for CMHT and the ASSiST service during Quarter four, giving a complaint rate of 0.09%, compared 0.10% in Quarter three, 0.07% in Quarter two and 0.04% in Quarter one.

There were two formal complaints for the Talking Therapies service in Quarter four.

Table 3: CMHT complaints

	Geographical Locality					
Main subject of complaint	**Bracknell**	**Reading**	**Slough**	**West Berks**	**Wokingham**	**Grand Total**
Attitude of Staff	2				1	**3**
Care and Treatment		1		2	2	**5**
Waiting Times for Treatment			1			**1**
Grand Total	2	1	1	2	3	**9**

5 of the complaints about the CMHT related to care and treatment, these included.

- Concerns about the level of care being offered
- A lack of support from the CMHT (predominantly for services based in West Berkshire and Wokingham.

2.2.2 Number and type of complaints made about CPE

There were no complaints received about CPE in Quarter four out of 1,368 contacts.

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

During Quarter four, 7 of the 56 complaints (12%) related to Adult and Older Adult Acute Mental Health inpatient services (including APOS) and Sorrel Ward. This is a decrease from the 9 received in Quarter three (18%), Quarter two (20%) and Quarter one (24%).

There were 235 reported discharges from mental health inpatient wards (including Sorrel Ward) during Quarter four giving a complaint rate of 3%, a reduction from 4.5% in Quarter three.

Table 4: Mental Health Inpatient Complaints

	Ward				
Main subject of complaint	**Bluebell Ward**	**Snowdrop Ward**	**Rowan Ward**	**Sorrel Ward**	**Grand Total**
Abuse, Bullying, Physical, Sexual, Verbal	1				**1**
Attitude of Staff	1			1	**2**
Care and Treatment	1	1	1		**3**
Discharge Arrangements			1		**1**
Grand Total	**3**	**1**	**2**	**1**	**7**

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

In Quarter four, 4 of the 56 complaints (9%) were attributed to CRHTT, an increase from 2 in Quarter three but comparable with other quarters during the year where there were 4 in quarter two , and in Quarter one we received 5.

There were 14,363 reported contacts for CRHTT during Quarter four giving a complaint rate of 0.03%, compared to 0.01% in Quarter three, 0.02% in Quarter two and 0.03% in Quarter one.

Table 5: CRHTT complaints

	Geographical Locality	
Main subject of complaint	**Reading**	**Grand Total**
Attitude of Staff	1	**1**
Care and Treatment	1	**1**
Confidentiality	1	**1**
Medical Records	1	**1**
Grand Total	**4**	**4**

2.3 Community Health Service Complaints received in Quarter four

During Quarter four, 14 of the 56 complaints (25%) related to community health service provision. The table below shows further details.

Table 6: Community Health service complaints

	Geographical Locality						
Service	**Bracknell**	**Reading**	**Slough**	**West Berks**	**Windsor, Ascot, and Maidenhead**	**Wokingham**	**Grand Total**
Community Hospital Inpatient Service - Ascot Ward						1	**1**
Community Hospital Inpatient Service - Donnington Ward					1		**1**
Community Hospital Inpatient Service - Highclere Ward				1			**1**
Community Hospital Inpatient Service - Oakwood Ward		2					**2**

	Geographical Locality						
Service	**Bracknell**	**Reading**	**Slough**	**West Berks**	**Windsor, Ascot, and Maidenhead**	**Wokingham**	**Grand Total**
Community Physiotherapy			1				**1**
District Nursing					1		**1**
Integrated Pain and Spinal Service - IPASS						1	**1**
Out of Hours GP Services		2					**2**
Podiatry						1	**1**
Rapid Response						2	**2**
Sexual Health	1						**1**
Grand Total	**1**	**4**	**1**	**1**	**2**	**5**	**14**

2.3.1 Community Health Inpatient Ward Complaints

During Quarter four, 5 of the 56 complaints (9%) received related to inpatient wards. This is compared to 6 in Quarter three, 8 in Quarter two and 6 in Quarter one.

There were 462 reported discharges from community health inpatient wards during Quarter four giving a complaint rate of 1.1%, compared to 1.2% in Quarter three, 1.3% in Quarter two and 1% Quarter one.

Table 7: Community Health Inpatient complaints

	Ward				
Main subject of complaint	**Ascot Ward**	**Henry Tudor Ward**	**Highclere Ward**	**Oakwood Ward**	**Grand Total**
Care and Treatment		1	1	2	**4**
Discharge Arrangements	1				**1**
Grand Total	**1**	**1**	**1**	**2**	**5**

The five complaints received were in relation to four of the seven community inpatient wards. The top theme was care and treatment.

There has been a further reduction in complaints received about the Oakwood Unit who received two of the five complaints for Community Health Inpatients in Quarter four.

2.3.2 Community Nursing Service Complaints

District Nursing received one complaint in Quarter four, compared to 2 in Quarter three, 5 in Quarter two and 6 in Quarter one.

There were 71,052 reported attendances for the Community Nursing Service during Quarter four giving a complaint rate of 0.002%. 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

	Geographical Locality
Main subject of complaint	**Windsor, Ascot, and Maidenhead**
Care and Treatment	1
Grand Total	**1**

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

There were 2 complaints in Quarter four for WestCall, out of 16,725 reported attendances, giving a complaint rate of 0.011%, which is a decrease compared to 0.027% in Quarter three, 0.006% in Quarter two, 0.005% for Quarter one and 0.01% for Quarter four.

There were no complaints for the Urgent Care Centre, which had 3,979 attendances.

2.4 Children, Young People and Family service Complaints

2.4.1 Physical Health services for children

There were three complaints for Children's physical health services in Quarter four, details are below.

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

	Geographical Locality			
Service	**Reading**	**West Berks**	**Windsor, Ascot, and Maidenhead**	**Grand Total**
Children's Speech and Language Therapy - CYPIT	1			**1**
Children's Occupational Therapy - CYPIT			1	**1**
Immunisation		1		**1**
Grand Total	**1**	**1**	**1**	**3**

2.4.2 CAMHS complaints

During Quarter four, 10 of the 56 complaints (18%) were about CAMHS services (compared to 6 in Quarter three). There were 8,928 reported attendances for CAMHS during Quarter four giving a complaint rate of 0.11%, compared to 0.07% in Quarter three, 0.14% in Quarter two and 0.06% for Quarter one.

Table 10: CAMHS Complaints

	Main subject of complaint			
Service	**Attitude of Staff**	**Care and Treatment**	**Waiting times for Treatment**	**Grand Total**
CAMHS - AAT		2		2
CAMHS - ADHD		1	1	2
CAMHS - Anxiety and Depression Pathway	1			1
CAMHS - Rapid Response	1	1		2
CAMHS - Specialist Community Teams		1	2	3
Grand Total	2	5	3	10

There was an increase from 6 to 10 complaints for CAMHS. Five of these related to Care and Treatment, three related to waiting times and two related to staff attitude. We have seen a slight increase in formal complaints around waiting times from one in Quarter two, two in Quarter three to three in Quarter four.

2.5 Learning Disabilities

There were no complaints about the community-based team for people with a Learning Disability and there was 1 complaint for our Learning Disability Inpatient Ward (Campion Unit) during Quarter four.

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 usually published a quarter behind, but it can be three quarters behind. The table below shows the information for Mental Health Trusts, up to and including Quarter four 2021-22.

Table 11: KO41A Return

	2018-19				2019-20				2020-21				2021-22	
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
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**	**3,312**	**3,227**
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	74	68
Berkshire Healthcare NHS Foundation Trust	**49**	**45**	**38**	**51**	**47**	**52**	**56**	**51**	**40**	**47**	**37**	**51**	**48**	**46**
Cornwall Partnership NHS Foundation Trust	31	28	20	30	24	22	23	19	12	27	15	8	94	27
Devon Partnership NHS Trust	44	56	33	45	52	46	56	49	15	31	49	40	46	50
Dorset Healthcare University NHS Foundation Trust	91	90	92	54	61	60	64	88	60	109	98	95	97	119
Kent and Medway NHS and Social Care Partnership Trust	87	115	121	118	121	128	124	90	70	111	78	80	115	95
Oxford Health NHS Foundation Trust	50	56	58	56	52	61	72	68	44	54	54	55	51	56
Somerset Partnership NHS Foundation Trust	17	14	24	18	24	24	17	19	45	90	..	..	..	..
Southern Health NHS Foundation Trust	91	95	82	68	73	51	52	51	29	51	40	31	28	32
Surrey and Borders Partnership NHS Foundation Trust	26	36	16	26	22	28	32	27	9	27	24	17	20	20
Sussex Partnership NHS Foundation Trust	209	192	181	173	178	217	219	194	99	164	154	198	267	286

When looking at this data, it is important to do so with the following in mind:

- The numbers do not reflect the complexity of the complaints
- It does not give an indication of the quality of the responses e.g. how many of these are re-opened complaints
- Some Trusts with low levels of reported formal complaints and combined PALS and Complaints offices have a rigorous process of informal resolution before accepting a complaint as formal (this approach needs to be managed carefully as the regulations do not give the instruction to do this)
- Some Trusts with high levels of reported formal complaints treat every complaint contact as formal
- One Trust with low levels of reported formal complaints has an average response time of over 120 days

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 four there were 49 complaints closed.

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

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**	**Q1**	**Q2**	**Q3**	**Comparison to previous quarter**	**Q4**	**% Of 21/22**
Not Upheld	9	25	19	18	71	36%	27	36	34	↓	21	51.00%
Partially Upheld	13	34	20	28	95	48%	19	18	22	-	22	35.00%
Upheld	12	6	0	7	25	12.50%	9	11	6	-	6	14.00%
Disciplinary Action required	0	0	0	0	0	0	0	0	0	-	0	0
Grand Total	**34**	**65**	**39**	**53**	**191**		**55**	**65**	**62**		**49**	

49% of complaints closed were either partly or fully upheld in the quarter (compared to 43% last quarter), these were spread across several differing services. Of these, 2 were about staff attitude (down from 3 in Quarter three), 3 were in relation to medical records, and 20 related to care and treatment received (up from 19). There was a CAMHS complaint about waiting time and one care and treatment complaint for Children's Speech and Language Therapy had an element around waiting times for an appointment. Complaints upheld or partially upheld for care and treatment equated to 68% of all closed complaints for Quarter four.

Table 13: Complaints upheld and partially upheld

	Main subject of complaint						
Service	**Access to Services**	**Attitude of Staff**	**Care and Treatment**	**Communication**	**Medical records**	**Waiting Times for Treatment**	**Grand Total**
Adult Acute Admissions - Daisy Ward			1				1
CAMHS - Rapid Response			1				1
CAMHS - Specialist Community Teams						1	1
Children's Speech and Language Therapy - CYPIT			1				1
CMHT/Care Pathways			4				4
Common Point of Entry	1						1
Community Hospital Inpatient Service - Henry Tudor Ward			1				1
Community Hospital Inpatient Service - Highclere Ward			2				2
Criminal Justice Liaison and Diversion Service - (CJLD)					3		3
Crisis Resolution and Home Treatment Team (CRHTT)			1				1

	Main subject of complaint						
Service	**Access to Services**	**Attitude of Staff**	**Care and Treatment**	**Communication**	**Medical records**	**Waiting Times for Treatment**	**Grand Total**
District Nursing			2				2
Immunisation				1			1
Learning Disability Service Inpatients - Campion Unit - Ward		1					1
Out of Hours GP Services		1	4				5
Podiatry			1				1
Talking Therapies - PWP Team			1				1
Veterans TILS Service			1				1
Grand Total	**1**	**2**	**20**	**1**	**3**	**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			
Q4	**Q3**	**Q2**	**Q1**	**Q4**	**Q3**	**Q2**	**Q1**
100	100	100	100	100	100	99	100

All complaints closed in Quarter four 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 1st January and 1st March 2022. 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 2020-21 Q4 attendances
Black/Black British	3	5.36	2.67
Mixed	1	1.79	3.49
Not stated	11	19.64	15.89
White	41	73.21	66.66
Grand Total	56		

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 four.

Table 16: Gender

Gender	Number of patients	% Complaints received	% Breakdown of 2020-21 Q4 attendances
Female	31	55.36	53
Male	25	44.64	46.98
Not stated	0	0	0.009
Grand Total	56		

5.3 Age

Table 17: Age

	Number of patients	% Complaints received	% Breakdown of 2020-21 Q4 attendances
0 to 4	1	1.79	18.41
5 to 9	2	3.57	4.14
10 to 14	5	8.93	4.34
15 to 19	7	12.50	4.52
25 to 29	1	1.79	2.87
30 to 34	5	8.93	3.14
35 to 39	1	1.79	3.56
40 to 44	1	1.79	3.58
45 to 49	2	3.57	3.52
50 to 54	2	3.57	3.73
55 to 59	7	12.50	4.46
65 to 69	1	1.79	4.63
70 to 74	3	5.36	4.53
75 to 79	4	7.14	5.56
80 to 84	6	10.71	6.16
85 +	2	3.57	6.55
Not known	6	10.71	11.98
Grand Total	56		

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 has been one new enquiry where the PHSO has asked for further information, but they are not currently progressing the case. We have been asked by the Local Government Ombudsman to provide information on a case that they are investigating, which does not relate to care we have provided.

We have closed one case, relating to Talking Therapies, which the PHSO did not uphold. The table below shows each case against the service.

There are currently two cases open for investigation, one for Oakwood and one for Podiatry.

Table 18: PHSO

Month open	Service	Month closed	Current Stage
Jan-21	Community Inpatient Services	n/a	PHSO have been sent information to aid their decision on whether they will investigate
Feb-21	Community Inpatient Services	n/a	PHSO have been sent information to aid their decision on whether they will investigate
Apr-21	Veterans TILS	n/a	PHSO have been sent information to aid their decision on whether they will investigate
May-21	Talking Therapies	Apr-22	PHSO have been sent information to aid their decision on whether they will investigate
Jun-21	Community Nursing	n/a	PHSO have been sent information to aid their decision on whether they will investigate
Jul-21	District Nursing	n/a	PHSO have been sent information to aid their decision on whether they will investigate
Jul-21	Talking Therapies - Admin/Ops Team	n/a	PHSO have been sent information to aid their decision on whether they will investigate
Aug-21	Health Visiting	n/a	PHSO have been sent information to aid their decision on whether they will investigate
Aug-21	Podiatry	n/a	Investigation underway
Sep-21	Children's Speech and Language Therapy - CYPIT	n/a	PHSO have been sent information to aid their decision on whether they will investigate
Sep-21	CMHT/Care Pathways	n/a	PHSO have been sent information to aid their decision on whether they will investigate
Sep-21	Veterans TILS Service	n/a	PHSO have been sent information to aid their decision on whether they will investigate
Nov-21	Oakwood Ward	n/a	Investigation Underway
Dec-21	Corporate	n/a	PHSO have been sent information to aid their decision on whether they will investigate
Jan-22	Criminal Justice Liaison and Diversion Service	n/a	PHSO have been sent information to aid their decision on whether they will investigate
Jan-22	Children's Speech and Language Therapy - CYPIT	n/a	Local Government Ombudsman (LGO) have been sent information to assist with their investigation

7. Multi-agency working

In addition to the complaints detailed in this 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 10 complaints received that were led by another organisation during Quarter four; three led by NHSE, two by Frimley Health, two by SCAS, one by EBPCC, one by West Berks CCG and one by a GP.

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 19: MP Enquiries

Service	Care and Treatment	Commun-ication	Discharge Arrange-ments	Medication	Other	Support Needs (Including Equipment, Benefits, Social Care)	Waiting Times for Treatment	Grand Total
Adult Acute Admissions - Rose Ward	1							1
CAMHS - ADHD	2			1		1	2	6
CAMHS - Anxiety and Depression Pathway							2	2
CAMHS - Common Point of Entry (Children)	1							1
CAMHS - Specialist Community Teams	2						2	4
Children's Speech and Language Therapy - CYPIT	1							1
CMHT/Care Pathways		1	1					2
CMHTOA/COAMHS - Older Adults Community Mental Health Team		1						1
IT					1			1
Neuropsychology	1							1
Grand Total	**8**	**2**	**1**	**1**	**1**	**1**	**6**	**20**

There were 20 enquiries raised by constituents to their MPs in Quarter four. This compares to 10 in Quarter three, 15 in Quarter two and 17 in Quarter one.

Eight of the MP enquiries related to care and treatment (one with an element about waiting times) and six were regarding waiting times. The enquiries for waiting times were all related to CAMHS services. Overall, 13 of the enquiries were for CAMHS (up from four).

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 20: Concerns managed by services – Local Resolution complaints

Service	Count of Service
Adult Acute Admissions - Rose Ward	1
Children's Speech and Language Therapy - CYPIT	2
CMHT/Care Pathways	1
Community Based Neuro Rehab - CBNRT	1
Continence	1
Criminal Justice Liaison and Diversion Service - (CJLD)	1
District Nursing	4
Health Visiting	2
IMPACTT	1
Other	1
Physiotherapy Musculoskeletal	3
Talking Therapies - High Team	1
Talking Therapies - PWP Team	1
Grand Total	**20**

There were 20 local resolution complaints logged in Quarter four, up from 17 in Quarter three, 16 in Quarter two and down from 35 in Quarter one. This focus and importance of recording local resolution complaints continues to be discussed in the regular Complaint Handling Training course delivered by the Complaints Office.

Communication was the most common theme for the local resolutions that were logged with 5 relating to this subject. There were four local resolution complaints relating to discharge planning.

There were no common themes coming out of the four concerns logged by District Nursing.

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 18 informal complaints received in Quarter four compared to 13 in Quarter three, 25 in Quarter two and 32 in Quarter one.

Table 21: Informal complaints

	Main subject of complaint					
Service	Access to Services	Care and Treatment	Communication	Confidentiality	waiting Times for Treatment	Grand Total
CAMHS - AAT			1		1	2
Children's Occupational Therapy - CYPIT		1				1
Children's Speech and Language Therapy - CYPIT					1	1
CMHT/Care Pathways		2	3			5
Community Hospital Inpatient Service - Windsor Ward		1				1
District Nursing	1	1				2
Eating Disorders Service		1		1		2
Neuropsychology					1	1
Patient Experience			1			1
Phlebotomy					1	1
School Nursing			1			1
Grand Total	1	6	6	1	4	18

8.4 NHS Choices

There were 5 postings on NHS Choices during Quarter four; 4 were negative and 1 was 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 22: NHS Choices

Service	No of postings	Positive	Negative
WestCall	3	Dr was insightful, kind, calming and went above and beyond to ensure I got the care I needed. Was comforting when I explained that I didn't realise my symptoms were more severe than I'd previously thought. Honestly want to write a thank you card as was one of the most supportive doctors I've spoken to in a long time. Very grateful for the experience I've had.	Been on the phone with 111 with bad back pain over few days with coming back problem for years. 111 service advice to explain to WestCall doctor what's been going on and how long, to explain that GP didn't care at all about my problem. Unfortunately not even WestCall doctor cared much. All it sounds as she just wanted to tick a box call me back. Every timeline was bad and I said I didn't hear her properly she would raise her voice with anger. Not mentioning that she didn't sound interested in what I have been saying to her or trying to explain about my symptoms and pains. 111 consultant was the best person I have spoken so far, interested, caring, giving the right advice. Lady over the phone didn't help much. NHS service it's getting worse and worse over the years looks like they don't even care for patients. I wouldn't write a review but I just had enough. Every time I call GP, they don't care it doesn't matter if it's about me or my children. When I call 111, they try to help but WestCall or emergency ward doesn't really look like they to their job.
			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

Service	No of postings	Positive	Negative
			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.
West Berkshire CMHT	1		I thought Hillcroft house was supposed to be there for me, but nothing but staff sickness all the time, left in the isolation in trying support myself major changes. I know the staff trying to help, but no focus to my care, no care planning central to my welfare as just complaints about me having go else we're unmet needs thankfully got help for. Nothing ends argument who right or wrong. I lost trust in the psychiatry as a patient as seem to be from an old world of authority only over my welfare no more than a submissive which put me further way from mental help as not considered unmet needs impact on my mental health. The mental health service makes me feel worse about myself ever before. that can't even understand the basic about me, that focus always elsewhere for need something else has no connection with me. I have no choice to move forward with or without them and can honestly say the mental health service makes me feel even worse that I am an outcast, simple things understanding how my psychical health impacts on my mental health, every label thrown at me putting me down can be human for sake. My feeling is the mental health service is more interested in itself than me and only there as patient to meet there need exclusively and the run around can't do in finding the mental health support, and rather be discharged in this situation as mental health service only makes my mental health worse.

Service	No of postings	Positive	Negative
Neuropsychology	1		My Assessment was conducted face-to-face by Assessor X on 26th Nov 21. I was accompanied by Supporter Y. For the follow-up phone-call on 16th Dec 21 I was alone. At the Assessment, X started talking to Y over my head about offering Y a job interview. I found this unprofessional and rude. I have problems with loud noise, and X made a joke of it later on the phone. Both Y and I thought the questions put to me at interview weren't far-reaching enough or age-related. (Assessor X also seemed unpleasantly surprised to learn that I'd been educated to university level.) On 1st Dec I was told my case had been referred to a Multi-Discipline Panel - this turned out to be X and one other. When I received the Assessor's Synopsis there were a lot of inaccuracies in it - the invention of a maternal half-brother, misquoting myself and Y, and more. Acting on Y's advice, in the phone-chat on 16th Dec I asked Assessor X for a further accompanied interview to discuss the inaccuracies in person. I also asked to be given the Assessment Results to date but was told I couldn't have one until X judged whether the inaccuracies were relevant to the conclusions reached. It didn't seem to occur to Assessor X that, relevant or not, any inaccuracies would undermine my faith in the Assessor's judgment. Assessor X then asked me for Supporter Y's phone number, on the grounds that Y too had raised queries. X didn't ask whether Y or I would mind this exchange of personal information. I found this unprofessional and disrespectful. By this time I no longer trusted the Assessor's 'take' on anything, nor did I think they had listened to me properly. Assessor X did admit to having little experience with older people - so if I was given to X as a Test Case I think in all fairness I should have been told, and my case handled appropriately. Finally on 16th Dec we left it that I would contact my Supporter Y and get back to X to arrange an interview - but before I could do this, X's Office rang me on 20th Dec with an interview date. I felt pushed and rushed into a decision. At this point I felt I had no choice but to withdraw from any further dealings with the Assessor, and therefore sadly Autism Erleigh. I was too afraid of Assessor X; I couldn't cope with any more misjudgements. I am very upset and disappointed - I waited 3 years for this chance, my trust was broken, my case-notes scrapped, I was left with no answers, and worse, unable to cope with the fallout. At the very least, I hope Autism Erleigh will use my experience to improve their service for future clients. Thank you for taking the time to read this - it has been one of the most painful things I've ever had to write.

8.5 PALS Activity

PALS has continued to provide a signposting, information, and support 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. The PALS Manager continues in the roles of Freedom to Speak Up champion and Armed Forces Service Network champion.

There were 518 queries recorded during Quarter 4. 444 were responded to within 5 working days and 5 were taken up as a formal complaint. In addition, there were 284 non-BHFT queries recorded. The longest wait for an acknowledgement was 12 working days. This is due to capacity within the service and the complexity of some of the queries that are coming through. Due to these service pressures and as described in the Quarter 3 report, we extended the acknowledgement target to 5 working days to manage expectation and this is monitored as part of the Quality Improvement processes within the wider Patient Experience Team. This will be escalated to a driver metric whereby there would be a structured process to monitor and test/implement improvement ideas.

There were a broad range of services involved in these queries but the highest number of queries received were in relation to:

- CMHT. Care Pathways
- Operational HR
- Admin Teams and Office based staff.
- CAMHS – AAT

CMHT. Care Pathways

- Sharing of information, consent, and capacity.
- Communication with relatives and clinicians.
- Family concerns about support provided. Management of physical health condition. Signposted to external agencies.
- Advocacy support and referrals.
- Appointment cancellations.
- Requesting a change of clinician and concerns about prescribed medication. Requesting a review of diagnosis and discharge concerns.
- Access to medical records.

CAMHS

- Parents seeking updates/ confirmation of referrals.
- Patient seeking a supporting letter.
- Parent seeking additional support prior to discharge.
- Requesting diagnosis report and rubber stamping of private diagnosis.
- Concerns about waiting times.
- Process for onward referral to ADHD pathway.
- Delay in sending questionnaires.

There were 15 Covid related queries which were predominantly how to visit loved ones on the ward and vaccination queries.

9. The Friends and Family Test

9.1 Overall responses and iWGC

There has been significant engagement with services in the build of this new measurement and reporting tool, with plans to further develop the surveys with more service/care group specific questions as part of the third phase of the project.

The Patient Experience Team, along with staff from across the Trust are learning how to use the management interface system for iWGC and attached as Appendix two is a Trust summary report taken from this system which shows the data collected during Quarter four.

We receive responses through a variety of methodologies. These range from the following: Online surveys, paper surveys, QR Codes on posters, survey pins on business cards and SMS (SMS due to be active from May 2022).

During Quarter four, we received 1,021 reviews in total , 816 online (including an electronic link, tablet and kiosk) reviews and 205 paper surveys.

The collated responses demonstrated:

- 4.66/5 Trust wide experience score
- 92.9% positive experience

- 3.7% negative experience

Services have access to real time reporting through the Management Interface (MI) system and can pull both the scores and comments, either as list or a word cloud. Reporting can also be shown in a dashboard and split by service, location, care group etc. Services are able to monitor reviews against care as well as seeing suggestions for improvement with real time access to the results.

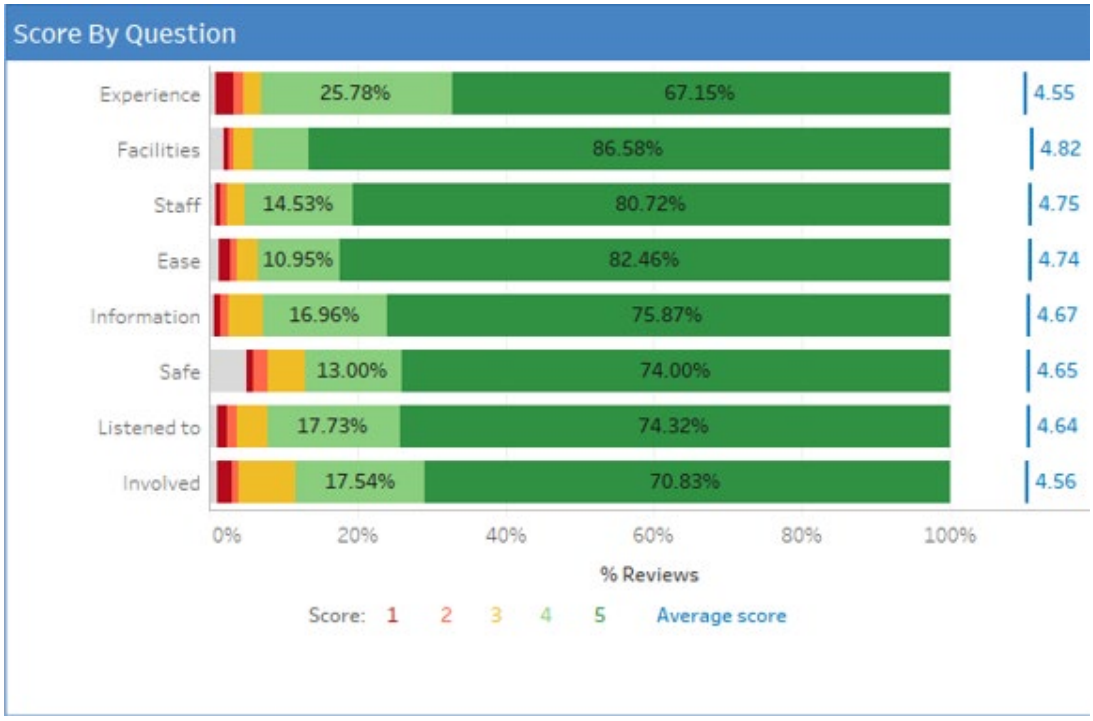
Below are examples of some of the feedback that has been shared with us during Quarter four, that will enable services to understand the patient experience within their services and will support improvement work where appropriate:

Service	Feedback	Improvement suggestion
Community Nursing	Staff member was polite and patient, he explained the procedure and asked my consent. Very empathetic care	Telephone before arriving, so I am ready. Supply same size of dressing as I had in hospital.
Intermediate care	Staff were all very friendly and made me feel at ease Very supportive in all aspects.	Time of visits changed every day.
Sexual health clinic	Happy to come to this clinic, .if staff were not professional and friendly I would not be here	
School Nursing	Bedwetting clinic is amazing, its been so hard but the clinic has helped so much.	Would have been better if the GP would have told me about this service years ago it would have saved me and my son so much time, expense and would not have affected his emotional wellbeing and sense of self so much. GPs really need a better understanding of what the school nurses do as they seem to have no idea.
CRHTT	as soon i got there they sorted things out straight away. staff were very patient. follow up very good and i was seen at home rather than a hospital. Difficult time for me and put me back on track	
Community Ward (east)	the staff who have a massive workload helped me as much as they could. I felt the ward was under manned and they did so well considering	Catering company leaves a lot to be desired. Lottery on choices. Not the ward staff fault
Audiology	When people attend a hospital they don’t want fuss , they want a calm environment with things explained clearly by staff that know what they are talking about in an easy to understand manner . This was my experience today .	
MSK Physio	Physios asked relaxed questions to assess extent for my problems and waved my questions well and monitored progress. Tailored care progress my needs. Fantastic service and care given.	There was a delay following referral from my doctors to the first session Emails to be sent in a timely manner. I would receive

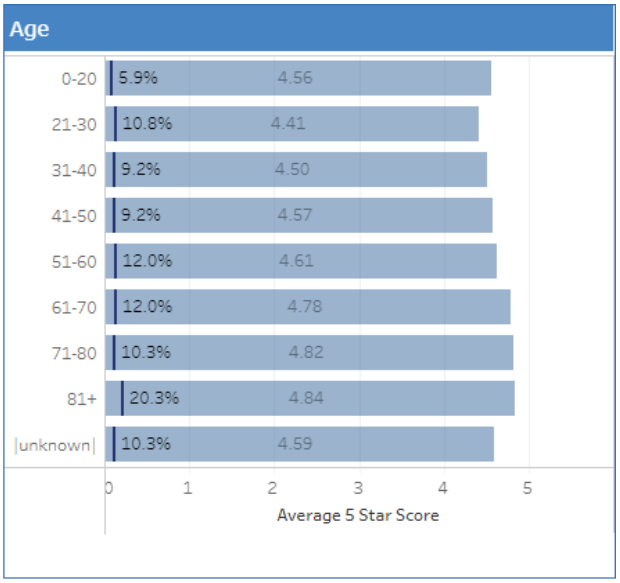
Service	Feedback	Improvement suggestion
	Exercises were clear and information/emails sent with pictures to better explain.	emails with exercises a week after my appointment.
Court Justice Liaison and Diversion	The way [name removed] dealt with situation never made me feel uncomfortable and instilled lots of confidence in me to make sure I did the things I needed to do. Very supportive, got to meet on face to face basis. Very nice. I am so much happier since engaging with the service, [name removed] was a great help and I enjoyed our check in phone calls. Very helpful.	In the way you give information to people, other people might not be getting as much support as I did. Daunting question is 'how can we help you' this is a hard question to answer when you yourself don't even know the answer.

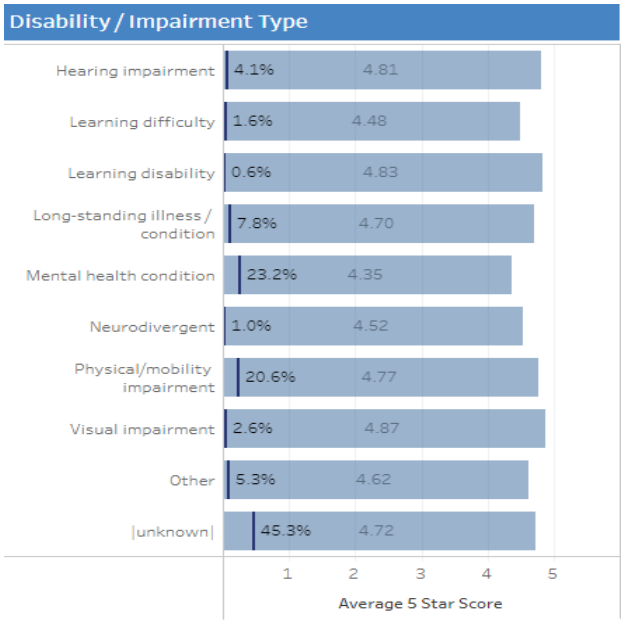
The pictures below show some examples of the information on the service level reports.

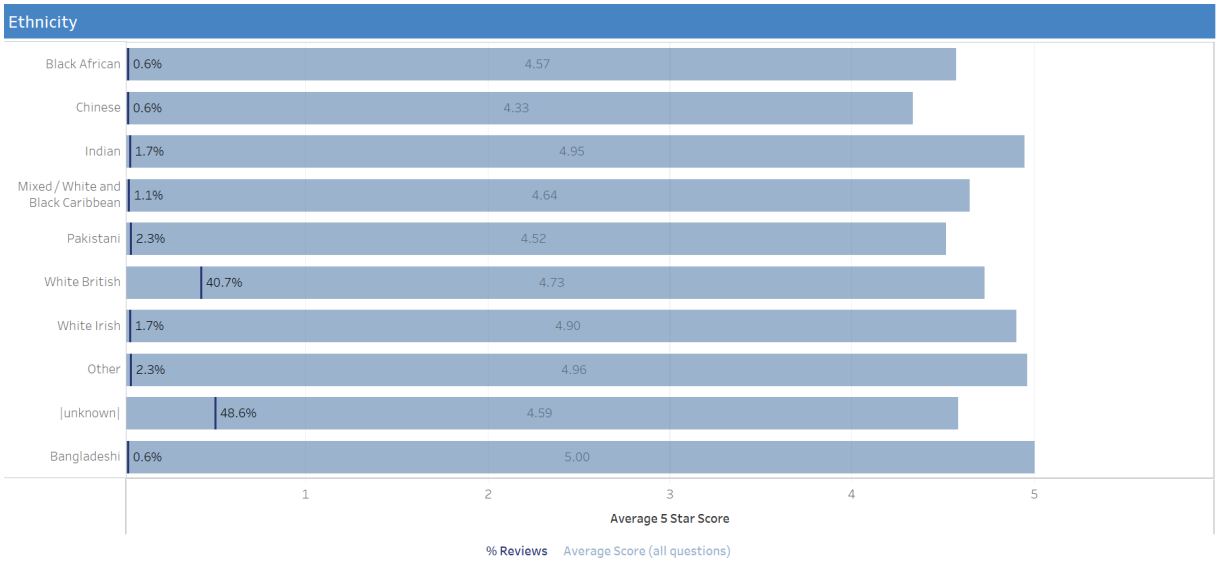
Picture 1: Review summaries



Picture 2: Examples of characteristic information







The tables below contain the FFT results; this will be presently differently moving forward from the quarterly reports for 2022-23.

Table 23: Response rate for the FFT

		Number of responses	Response Rate
2021-22	Q4	1021	0.54%
	Q3	5271	4.53%
	Q2	6124	6%
	Q1	5788	5.66%
2020-21	Q4	4259	4.66%

		Number of responses	Response Rate
	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%

During this reporting period we have been transitioning to the new patient experience tool and for a variety of reasons, as a result, we have experienced a drop in FFT response. As the new tool is currently being embedded, we are seeing that not all services are actively capturing feedback from patients as yet, some services have experienced technical issues such as not using the correct survey links, some services have also requested new question sets which has meant their original surveys were disabled and not in use. Although the online version of the form has been available for all adult service questionnaires since the outset, kiosks and ipads have been delivered during the quarter to support a wider range of options for patients to complete the questionnaire and the SMS system will be functional from May 2022; this will all assist in improved uptake.

Table 24: FFT percentage positive rating split by community health and mental health services

	2020/21				2021/22			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	**Q4**
Community Health Services	70%	90%	85%	89%	93%	90%	94%	**87%**
Mental Health Services	60%	85%	81%	83%	75%	84%	86%	**92%**
Trust Total	59%	90%	85%	89%	87%	88.3%	90%	**93%**

*Rating of good or better than good has replaced recommendation to a friend

Table 25: FFT results for Inpatient Wards, shown as a percentage

		2020/2021				**2021/2022**			
Ward	**Ward type**	**Q1%**	**Q2%**	**Q3%**	**Q4%**	**Q1%**	**Q2%**	**Q3%**	**Q4%**
Oakwood Ward	Community Inpatient Ward	0.00%	0%	0%	100%	52%	100%	100%	**100%**
Highclere Ward		0%	50%	67%	0%	81%	100%	75%	**85%**
Donnington Ward									
Henry Tudor Ward		98.30%	100.00%	93%	100	70.66	88.88%	97%	**90.50%**
Windsor Ward		100%	0%	93%	100%	100%	85%	100%	**0%**
Ascot Ward		100%	90%	100%	100%	95%	100%	100%	**0%**
Jubilee Ward		0%	100%	50%	98%	100%	92.22%	96%	**0%**
Bluebell Ward	Mental Health Inpatient Ward	0%	0%	100%	0%	75%	100%	50%	**86%**
Daisy Ward		50%	100%	100%	100%	67%	0%	0%	**0%**
Snowdrop Ward		100%	0%	67%	85%	100%	0%	83%	**100%**

		2020/2021				2021/2022			
Ward	**Ward type**	**Q1%**	**Q2%**	**Q3%**	**Q4%**	**Q1%**	**Q2%**	**Q3%**	**Q4%**
Orchid Ward		0%	100%	75%	0%	92%	94.73%	0%	**0%**
Rose Ward		100%	0%	100%	0%	100%	100%	0%	**100%**
Rowan Ward		0%	0%	0%	0%	100%	0%	100%	**100%**
Sorrel Ward		100%	0%	100%	0%	100%	0%	0%	**0%**

Table 26: Carer FFT results

	2018/19	2019/20	2020/21	**2021/22**
Q1	111	67	335	**18**
Q2	32	201	408	**94**
Q3	39	314	242	**58**
Q4	86	258	411	**20**

The Trust Carer Lead has taken on the responsibility of promoting and collecting the carer FFT, and the Patient Experience Team are continuing to report on the results.

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

There is no activity to report for Always Events, Patient Participation, and Involvement Champions as these were not carried out as part of the pandemic response.

The 15 Steps Programme restarted during Quarter two, the report is attached as Appendix three.

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 our communities.

The Trust asked Healthwatch Wokingham, Healthwatch Reading and Healthwatch West Berkshire to conduct service user research about its Ageing Well services; 2hr Urgent Community Response and 2 Day Community Rehabilitation.

The aim was to get an overview of care whilst accessing the Ageing Well services and how our patients felt about their experience. The report is attached as Appendix four.

The service created an action plan based on this report which is in the table below:

Table 27: Actions following Ageing Well report.

You Said	We did (or are doing)
Communication and awareness of the service can be reviewed to ensure patients understand the service and their care	A communication strategy is being developed. The service information for intermediate care 2-day element is being developed at the moment by the teams, the 2 hrs element have an information handout. We will need to work on having versions in different languages and easy read and for the information to signpost to a central line (in and out of hours) rather than individual staff mobiles.
How do we communicate what happens after the Urgent Community Response service	Review exit strategy and discharge methods for patients. Engage with Community Voluntary sector, Health Watch and Age UK to co-design follow up care support.
Joined up care - patients telling a story once - how do services work closer together?	We have identified that there are different templates for community services including UCR teams across. Our solution is to streamline paperwork to reduce duplication.

You Said	We did (or are doing)
Equipment - understanding the issues and reporting issues	Meeting with NRS and their therapists regarding equipment issues; there is a process for considering other equipment and calling NRS for advice on alternatives.
Consistency: ensure that the Urgent Community Response service is referred to by the correct name by teams	Owned by the teams who have been reminded of using consistent language.
Development of fridge magnets to indicate the most recent visit	Fridge magnets have been ordered and delivered. Need a process for completion; concern that the magnets will not work due to volume of visits and ownership of filling it in. Agreed to trial a sign in sheet for staff to complete with the name and role.

11. Compliments

There were 772 compliments reported during Quarter four. The services with the highest number of recorded compliments are in the table below.

It is worth noting that in addition to these compliments logged there are many compliments coming through via the patient experience tool.

Table 28: Compliments

Service	Number of compliments
Talking Therapies - Admin/Ops Team	272
District Nursing	143
Physiotherapy Musculoskeletal	44
Community Respiratory Service	32
Community Dietetics	22
Heart Function Service	21
Children's Speech and Language Therapy - CYPIT	17
Criminal Justice Liaison and Diversion Service - (CJLD)	17
Community Hospital Inpatient Service - Highclere Ward	14
Podiatry	12
CMHTOA/COAMHS - Older Adults Community Mental Health Team	12

Table 29: Examples of compliments received during Quarter four

Windsor Ward - Wokingham Community Hospital *Thank you so much for the extra special care you took in looking after me, during my stay in Windsor Ward. Your kindness and helpfulness were really appreciated at this difficult time for me. I found being in hospital such an ordeal, particularly with the covid situation, so your friendliness was special.*	Criminal Justice Liaison and Diversion Service - (CJLD) Email from patient's grandad: *Thank you and your team for all there help and understanding. To say that ****** is a different boy is an understatement, he is now totally changed into a talkative, well behaved, loving young Man and working well with his education.*
CRHTT – East *Hi Manager, I truly am so relieved to be feeling more like my old self…just wanted to reiterate my thanks to you all. You and your team were very supportive. WAM Dr, Support Worker and Psychologist have been very good. I am so relieved to feel the light at the end of the tunnel…I've got my smile back. Hallelujah 😊. PS I'm cooking and baking again! Wonderful!*	Community Dental Service *I would like to say how incredibly impressed I have been with Community Dentist xx* *My son, who is 6, has been terrified of dentists since he was 3 years old, after being treated badly during a routine check-up with a previous dentist.*

	xx put my son at ease immediately. We have seen so many dentists in the past year, and she is by far the most outstanding - not just in her approach and attitude, but her kindness and empathy made all the difference. *I would like dentist HM* to be acknowledged and rewarded for her efforts - she has been truly amazing, and I am so grateful.* *Kind regards,* *Mother of patient**
Health Visiting *It was so useful having xxx to talk to about all the elements on your mind as a first-time mum. Explaining each part of the red book each time, which we hadn't previously been told about was really informative - gives you more of an understanding of your baby and their checks. It would have been useful to have had this explained in hospital/initial visit, but we are grateful to xxx for doing this for us. For my husband it was also good as she checked on how he was doing to - sometimes the partners are overlooked – thanks :-) really pleased with the knowledge and expertise so far.*	Health Hub - Wokingham *I would like to take this opportunity to say a huge thank you to who took my call yesterday as the delivery of night bags was out of stock.* *The call handler went the extra mile to assist in procuring the bags desperately required.* *The whole team has always spoken to me, making me feel valued as a user of the service.* *It makes life for me as a carer so much easier taking one worry out of my hands.* *So a huge thank you to the customer facing team and all others involved ensuring we are well looked after and valued.*

The Rainbow Room, West Berkshire Community Hospital

Many thanks for your letter to my Dad, xx and myself after the passing of my Mum. I have wanted to email since we received your letter but have only just got round to it!

I just wanted to thank you all for looking after my Mum during her last few days in the Rainbow Room and also for making us all feel at home and well cared for too at what was such a distressing time for us all. I think once Mum had arrived with you, we found it strange not being as 'medical' as the RBH and this took us a while to adapt to but soon became a comfort - everything was explained by your team and we were soon at ease with letting nature take its course and keeping Mum as comfortable as we could without interfering and causing unnecessary distress to her. All of Mum's needs were met and every time the team came in to reposition her/change her etc, she always looked far better and more comfortable than when we were with her (clearly none of us would have made very good nurses!!)

On the night Mum passed away, I knew that it was going to happen and am still battling with myself for not listening to my instinct and not staying with her until the end but I'm sure in time this will pass. xx had spoken with my brother and had put his mind at rest about leaving on the Sunday and so I kept going over what xx had said and told myself it was ok to go. At times I have felt that if we had been contacted to return a bit earlier, we could have been there for her in her final moments but I do understand that things can change very quickly and it was out of everyone's control really - when it's time for someone to go, it's time for them to go! Again, I wanted to thank you for being so kind to us on that night and after Mum had passed away, giving us the time we needed - not that any of us really knew what we needed or how long we should have stayed with her after but we were certainly made to feel at ease and that was much appreciated and made that time easier.

Having spent a month visiting Mum in hospital, I am really feeling a void now that we are not doing that and this has been on my mind quite a lot. When I had my babies, I really felt that I wanted to speak with the midwives again and I have found this much the same! So thank you for giving me the opportunity to do that - even though I am just waffling on and actually giving feedback on the care we received, rather than my Mum!

Anyway, once again, thank you so much for looking after us all and especially the care you gave my poor old Mum during her final days. Please can you also thank xx and xx for reassuring us all when we needed it - we will be forever thankful for such a positive experience at the most devastating time of our lives!

Thank you again for all that you do. for everyone - you really are all heroes!
Urgent Community Response Team Wokingham *Thank you for your amazing care and immense support you gave my husband. You and your team gave him another chance to live again. We are both immensely grateful. Thank you for bringing generosity and magic to the work you do. It makes me happy to see my husband improving. Every day he sits in his chair and eats his lunch. He has regular physio and is so well looked after that he has already gained one kilogram. I would love to meet you and am sorry to have missed you when you visited him.* *Just to say a huge thank you to everyone involved at looking after my dad before he passed away. The care he received was exceptional from the Rapid Response Team and carers. I wish I could remember everyone's name but please pass on a special thank you. Such compassion and care from everyone who looked after Dad. Before Dad passed, we discussed how to say, 'thank you' and we decided on some vouchers to have a drink on us at the Brown Bag. You all do such an amazing job and hope you realise what comfort you bring to people at a difficult time.*

Table 30: Compliments, comparison by quarter

	2020/21					2021/22				
	Q1	Q2	Q3	Q4	2021/22	Q1	Q2	Q3	Q4	2020/21
Compliments	873	975	1,010	1,319	4,177	1076	986	960	772	3794

Liz Chapman

Head of Service Engagement and Experience

21 April 2022

Formal Complaints closed during Quarter four 2021/22

ID	Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome	Subjects
8326	Reading	Crisis Resolution and Home Treatment Team (CRHTT)	Minor	Pt feels the Crisis service is 'atrocious and potentially fatal'	Not Upheld		Care and Treatment
8322	Portsmouth	Criminal Justice Liaison and Diversion Service - (CJLD)	Low	Patient is unhappy the reason for his arrest and nature of the offence is recorded on his medical records. He feels it has adversely affected him as people he has asked for treatment have declined. He has spoken to the ICO.	Not Upheld		Medical Records
8330	Bracknell	District Nursing	Low	Family unhappy the pt has been discharged as they were not in when DN's called and a note was left to say pt does not fit criteria fo DN service	Partially Upheld	Share learning with team-importance of good communication with patient and family members. Importance of ensuring optimum dressing regime followed and if family taking on some or all of role that have been supported and confident, competent to do so.	Care and Treatment
8352	West Berks	Out of Hours GP Services	Minor	No call recieved from Dr following 111 call, 15 hours later	Partially Upheld	Apology to patient for missing the 2-hour call back target Servicel to send additional courtesy messages to the service user if there are protracted delays.	Care and Treatment
8349	Reading	Learning Disability Service Inpatients - Campion Unit - Ward	Low	Pt does not feel wanted on the ward as they are informal. Feels the staff ignore him and walk off and are constantly on their phones	Partially Upheld	Arrange for the ward manager to reiterate the message that phones must not be taken on to our ward. Arrange for the ward manager to order more fob watches	Attitude of Staff
8350	Reading	Out of Hours GP Services	Moderate	Pt unhappy with diagnosis following a call on 17.12.21	Upheld	Presentation of Ectopic Case at WestCall Clinical Meeting to raise awareness	Care and Treatment
8324	Wokingham	CMHT/Care Pathways	Low	Pt unhappy with Dr meeting, does not want communication with them again. States they do not hear from their CC and has been on the wait list for 2.5 yrs	Not Upheld		Attitude of Staff
8353	Wokingham	Immunisation	Low	Complainant on behalf of all school age children regarding the the content of the Flu spray	Not Upheld	Not processed as formal complaint as issues are outside scope of formal complaint and related to national policy	Medication
8346	Reading	Crisis Resolution and Home Treatment Team (CRHTT)		pt states the people who answer the calls for Crisis are always so depressing, they do not say their names but insist the pt says theirs. Pt feels their attitude lacks any form of help	Not Upheld	Local resolution	Attitude of Staff
8306	West Berks	Community Hospital Inpatient Service - Highclere Ward	Low	Complainant thanked IO for the work involved but would like clarification on several points from the response ORIGINAL COMPLAINT Complainant believes there are several areas for improvement on the ward, including mobilising pts, help with food, lack of advice regarding medication given and information regarding Ulcers on discharge. Ulcer care seems lacking throughout admission, during and discharge.	Partially Upheld	A medication list is sent with the patient as per protocol but for staff to ensure that any details surrounding the prescription of insulin is detailed on the discharge letter. Contact number of the Care Manager and name of Care agency is added to the discharge letter, detailing package of care Visitor guidance clearly displayed and conversation had with relatives prior to visiting the Inpatient unit about the new guidance Patients' dietary needs clearly displayed by the patients bed, red tray system in operation detailing if patients require assistance	Care and Treatment
8321	Reading	Common Point of Entry	Low	Patient unhappy that she has been denied access to our MH services. She said she has been overlooked by services despite multiple referrals and has been discharged prematurely and without her knowledge	Partially Upheld		Access to Services
8361	Reading	Adult Acute Admissions - Bluebell Ward	Low	3 further point to be answered before finally directing to the PHSO RO COMPLAINT Unhappy with response raising many questions on various points of our response letter ORIGINAL COMPLAINT: 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	Original complaint - not upheld Re-opened complaint (altered issues) - partially upheld. Physical health to be discussed on admission. S132 rights to be read and documented.	Care and Treatment
8304	Portsmouth	Criminal Justice Liaison and Diversion Service - (CJLD)	Low	Pt extremely unhappy with the response and BHFT holding information about them, also feels there is conflicting statements between all services ORIGINAL COMPLAINT pt wishes their medical records rectified and in some cases erased, general operational questions also to be answered	Partially Upheld	apology offered for where there were errors in report and that staff member did not wear a mask	Medical Records
8282	Reading	Out of Hours GP Services	Minor	Pt disputing call back was made by Dr ORIGINAL COMPLAINT: Pt promised called back from SCAS within 2 hours - no call made. Family called 999, pt taken to hospital with double pneumonia, hypertensive with low oxygen levels	Partially Upheld	Apology to complainant via response letter WestCall to develop pre-emptive text alert system warning patients of delays. This will be sent on receipt of a referral from 111	Care and Treatment
8266	West Berks	Immunisation	Low	Informal concerns raised regarding the 2nd C19 vac and the HPV vac ORIGINAL COMPLAINT Family unhappy with informal responses into the handling of the incident for which the Child was not Covid vaccinated due to their medical history	Upheld	Initial concerns - Local resolution	Communication
8324	Wokingham	CMHT/Care Pathways	Low	Pt unhappy with Dr meeting, does not want communication with them again. States they do not hear from their CC and has been on the wait list for 2.5 yrs	Not Upheld		Attitude of Staff
8297	Reading	PICU - Psychiatric Intensive Care - Sorrel Ward	Low	Not happy with the response, want another meet with Dr on the ward and still waiting for a 2nd opinion ORIGINAL COMPLAINT Family unhappy that new Dr has said pt does not have schizophrenia, family want to know why the pt has been taking meds for that for 10 yrs if doesn't have it believes PPH are refusing to help the pt and are not talking to the family	Not Upheld		Care and Treatment
8291	Wokingham	Out of Hours GP Services	Minor	Family not satisfied with the response, feels offended at some of the content ORIGINAL COMPLAINT Pt seen at WestCall, family feel the Dr was very patronising and said the pt to needed drink 'Chicken Broth and full sugar orange Squash' Dr called Paediatric Dr under complainants request. PRESS INTEREST	Partially Upheld	Apology to family for misunderstanding behind clinicians' words and actions which resulted in hurt feeling. Clinician has reflected on this case and given a full and frank explanation of the reasoning behind the actions he took.	Attitude of Staff
8382	Bracknell	Sexual Health	Low	family member unhappy at the procedure performed on the pt and not being allowed to be involved, pt feeling unwell and family feel this is due to the treatment	Not Upheld		Care and Treatment

8364	Windsor, Ascot and Maidenhead	CAMHS - Anxiety and Depression Pathway		pt's counsellor unhappy with the outcome of the pts CAMHS assessment and the phrasing of the assessor when they said 'we can't always gets what we want in life'	Not Upheld		Attitude of Staff
8367	Bracknell	CAMHS - AAT	Minor	Pt journey over the last 6 years stating the pts lengthy struggle through to the eventual diagnosis of Autism	Not Upheld		Care and Treatment
8390	Wokingham	Rapid Response	Low	3. Family have one final question, wanting to know time when pt was checked as 10 mins after DN departure the pt had stopped breathing. Re-opened complaint - 2. family have raise 4 further questions following the response Original complaint - DECEASED Pt: 1. Family wish to know what happened when the nurse from RRT went to visit the pt	Not Upheld		Care and Treatment
8345	Slough	CMHT/Care Pathways	Low	Patient unhappy with care and treatment from mental health services. Unhappy with diagnosis and medication. Also lost property when admitted. Patient unhappy with attitude of staff and seeking compensation	Partially Upheld	Ward staff to return property that has been located on the ward since patient's discharge Email from complainant requesting specific support moving forward to be shared with care coordinator to explore further	Care and Treatment
8374	Wokingham	CMHT/Care Pathways	Minor	Patient is unhappy with CMHT. He says they do not assess need for care and do not offer help when contacted. He also says the manager offered to make a referral for him if he withdrew his complaint.	Partially Upheld	Service Manager to clarify role of duty and response to callers as learning for the wider team Patientto be offered medical review as part of the joint meeting with Consultant Psychiatrist and team lead Patient to commence psychological therapy as soon as possible as medication has had limited impact to date	Care and Treatment
8370	Reading	Adult Acute Admissions - Bluebell Ward	Low	Pt unhappy with the way duty psychiatrist spoke with the patient when admitted to PPH and angry that they listened to their mother believing this will hinder care	Not Upheld		Attitude of Staff
8358	Wokingham	Podiatry	Minor	Pt seen by a different podiatrist who allegedly caused an issue which had been resolved, family sate new podiatrist did not have any knowledge of diabetes	Partially Upheld	Communication was not satisfactory to patient on 1st Dec when the patient presented with a new wound to right third toe. The Podiatrist (1st Dec appt)should have fully explained what was present before and after their treatment of the new wound and ensured before at the end of the treatment that the patient had fully understood this and the treatment plan agreed. This will be feedback to the podiatrist involved to ensure that they are made aware of the improvement required.	Care and Treatment
8316	Bracknell	CMHTOA/COAMHS - Older Adults Community Mental Health Team		Complainant feels the clinicians involved entered the premises without permission and they consider them an intruder. The Police were called	Not Upheld		Abuse, Bullying, Physical, Sexual, Verbal
8354	Windsor, Ascot and Maidenhead	Community Hospital Inpatient Service - Henry Tudor Ward	High	Daughter unhappy with the lack of rehabilitation provided to her father. Concern around PU care	Upheld	See IO report for detailed action plan	Care and Treatment
8319	West Berks	CMHTOA/COAMHS - Older Adults Community Mental Health Team		Family still unhappy with outcome and asking for completed action plan detailing the learning Family have questions around the Doctor ORIGINAL COMPLAINT - 2020 Family unhappy that police came into their home following an alleged call from services and safeguarding regarding the EOL pt	Not Upheld	Outcome was recorded in first complaint	Communication
8295	Reading	CMHT/Care Pathways	Low	Family concerns for staff member (relative) and delays in CMHT dealing with pt. Family feel safeguarding issues and email exchange needs to be reviewed they also feel the Trust has taken inappropriate steps with pt/staff member over the Covid period	Upheld	There was confusion with the referral and communication between CMHT, the Gateway and GP.	Care and Treatment
8407	Bracknell	CMHT/Care Pathways	Low	Unhappy with the attitude of staff members in the meeting plus the Dr when they arrived at pt house 15 points to address. Audio recording of meeting included	Not Upheld		Attitude of Staff
8409	Bracknell	CMHT/Care Pathways	Low	Patient unhappy with how the Dr spoke to him when regarding a meeting patient had arranged with sols in Church Hill House. Patient was meeting sols to appeal CTO and felt Dr was trying to influence them	Not Upheld		
8411	Portsmouth	Criminal Justice Liaison and Diversion Service - (CJLD)	Low	Patient had a meeting with IO on his previous complaint and 'accidentally' recorded the meeting on his bodycam. He says the notes from that meeting are inaccurate and his accidental recording is evidence of that	Partially Upheld		Medical Records
8359	Reading	Crisis Resolution and Home Treatment Team (CRHTT)	Minor	Care and treatment of the patient from CRHTT - feel the staff are unprofessional / CMHT - no follow up has been provided / GP - medication issues	Partially Upheld		Care and Treatment
8383	Windsor, Ascot and Maidenhead	CAMHS - Specialist Community Teams	Minor	Family feel the pt needs to be seen urgently and feels it is outrageous they have to wait 3 years	Not Upheld		Waiting Times for Treatment
8399	West Berks	CMHT/Care Pathways	Minor	Agreed in october that pt should have support , it took 7 weeks for a call from services. care coordinator set up agreement for specific dates to call but did not call. CC arranged home visits on 4 occasions and cancelled each one. promised a call by a team lead, did not happen. pt feels let down	Upheld	Staff members cancelling appointments will make their supervisors aware so this can be monitored. Once a staff member is allocated to a new patient, there will be an expectation that they will be contacted within 2 weeks. This may not necessarily mean treatment will start but introduction should take place	Care and Treatment
8420	Reading	Veterans TILS Service	Minor	Pt expressing dissatisfaction in the service to date. Does not understand why they are under Berkshire when they live in West Sussex with a GP in hampshire. Pt carrying a ligature around with them for the next opportunity. Issues with face 2 face meeting and unhappy with phone and zoom	Partially Upheld	Ensure admin check with client that online is acceptable for them for fist appointment in both TILS and C TS and discuss that F2F appointments are available if preferred When referring to CTS, explore with clients the mode of appointments the would prefer and note any needs and that support calls would usually be via telephone for example when on wait list for treatment with CTS. The current referral form from TILS to CTS currently states preference for F2F as option, we will amend the form to add an option as only F2F appointment required. When offering support calls on the phone the clinician to acknowledge to the client if they have requested Face to face appointments and explain rationale for the telephone appointments. Feedback to staff re learning If seeing clients at venues, explore if comfortable with venue and if there are any issues, work with them to find solutions or escalate to supervisor and record in notes Feedback to staff re learning When conducting risk assessments on the phone with clients, take into account previous engagement with clinician and how open the client might be – if any concerns then move to face to face as soon as possible	Care and Treatment

8403	Reading	CAMHS - Specialist Community Teams	Minor	parent feels pt needs urgent assessments, believes they were on a wait list in 2016 and were discharged. Pt's behaviour is concerning and now at home as parent believes school is currently not the best place. ASD traits	Partially Upheld	SCT mental health assessment will determine whether an ASD referral needs to be pursued. Letter of advocacy sent to parent to present to school Patient and Parent to be invited to 'emotional coping skills' psychoed group with SCT	Waiting Times for Treatment
8398	Wokingham	CAMHS - ADHD	Low	overall provision and a lack of therapeutic support, family feel this contravenes NICE Guidance for children with autism. CAMHS have offered medication as the only solution and the pt is now been unable to attend full-time education or access any therapeutic support from such a setting since June 2019.	Not Upheld	It has been agreed to discuss patient's situation at the CAMHS Complex Cases Panel on 3/03/2022 to consider whether specialist services, either National or local could contribute to the current care plan by offering either further assessment or intervention. Dr will continue to offer the health perspective in any planning regarding Thomas' education	Care and Treatment
8362	Reading	Children's Speech and Language Therapy - CYPIT	Low	Promised activity sheets whilst on wait list, never received. Told by reception staff pt not on the list, complainant wishes to know if on, how long to wait, still waiting for sheet 2 months later. Why when she calls does no one pick up.	Partially Upheld	When there has been no response to telephone messages x 2, practitioners to send brief letter (email or post) explaining we have been unable to contact them and provide details of how to contact service Practitioners to be reminded of 'tone' when providing advice to parents and how for some parents who are anxious about their child's development this can be misinterpreted as patronising. Preferred method of contact to be recorded on RiO under "communication needs" and practitioners to be reminded to refer to this when following up referrals or telephone messages. Activity sheets to be forwarded	Care and Treatment
8397	Reading	CAMHS - Rapid Response		Pt presented at RBH A&E from school due to disclosure of suicidal ideations. School are very concerned at the lack of support from the CAMHS service	Partially Upheld	No response required. f2f meeting had, referrals made, pt safe	Care and Treatment
8378	Windsor, Ascot and Maidenhead	District Nursing	Minor	DECEASED PATIENT. EOL Care. Poor management of patient's pain and husband's last catheter changes. Paramedics were called due to patient's severe chest pains and they felt the tension caused through pain and last catheter change was the root cause of the chest pain	Partially Upheld	The delays around gaining authorisation paperwork and communication between the district nursing service and the palliative service need to be addressed. Clear guidelines need to be put in place for the process of what happens when JIC Meds are prescribed for palliative patient and how this is communicate to the district nursing teams.	Care and Treatment
8436	Slough	Community Physiotherapy		family unhappy at the lack of physio following discharge from hospital and the fact the physiotherapist did not follow consultant instructions	Not Upheld	Closed as Local resolution	Care and Treatment
8341	Reading	Adult Acute Admissions - Daisy Ward	Minor	Historic concerns relating to medication and then stay in PPH from April 2021, plus incorrect entries on medical records. Pt wishes to transfer from Slough CMHT to WAM CMHT too	Partially Upheld	Advocacy will continue to support patient with the plan to address her concerns regarding medical information being incorrect in her medical notes. Cco to prioritise discussion around this with patient and advocacy, and consultant to look at this and make a decision around the information that patient does not believe should be in her nursing notes, in particular around Somatisation Disorder.	Care and Treatment
8425	Reading	Talking Therapies - PWP Team	Minor	Pt feels they are not getting support due to the process/system of the organisation	Partially Upheld	Admin will now send a text message to the client asking them to contact Talking Therapies not just leave a voice message. This will be followed with an email. Email will be sent to Admin staff to remind them of this procedure. When Daily Supervisor Team open a referral on IAPTUS for Talking Therapies they will email the referral to Talking Therapies Admin so that they are aware of the referral and then send out the opt in by email, telephone call and text message. Email will be sent to all DS staff to remind them of this process.	Care and Treatment
8401	Wokingham	CMHT/Care Pathways	Low	Pt has 16 points they wish to raise centred around the CMHT worker	Not Upheld		Care and Treatment
8411	Portsmouth	Criminal Justice Liaison and Diversion Service - (CJLD)	Low	Patient had a meeting with IO on his previous complaint and 'accidentally' recorded the meeting on his bodycam. He says the notes from that meeting are inaccurate and his accidental recording is evidence of that	Partially Upheld		Medical Records
8350	Reading	Out of Hours GP Services	Moderate	2 points to answer from original response ORIGINAL COMPLAINT Pt unhappy with diagnosis following a call on 17.12.21	Upheld	Presentation of Ectopic Case at WestCall Clinical Meeting to raise awareness	Care and Treatment
8306	West Berks	Community Hospital Inpatient Service - Highclere Ward	Low	Complainant thanked IO for the work involved but would like clarification on several points from the response ORIGINAL COMPLAINT Complainant believes there are several areas for improvement on the ward, including mobilising pts, help with food, lack of advice regarding medication given and information regarding Ulcers on discharge. Ulcer care seems lacking throughout admission, during and discharge.	Partially Upheld	A medication list is sent with the patient as per protocol but for staff to ensure that any details surrounding the prescription of insulin is detailed on the discharge letter. Contact number of the Care Manager and name of Care agency is added to the discharge letter, detailing package of care Visitor guidance clearly displayed and conversation had with relatives prior to visiting the Inpatient unit about the new guidance Patients' dietary needs clearly displayed by the patients bed, red tray system in operation detailing if patients require assistance	Care and Treatment

Berkshire Healthcare NHS Foundation Trust

iWantGreatCare

Site Name	Service Name	Hierarchy Level	Hierarchy Name	FFT Data Submission
All	All	All	All	All

Experience Score	Question	Has Reply?	Publishable?	Review Source	Review Date
All	All	All	All	All	1/1/2022 to 3/31/2022 and Null values

FILTERS(S) IN USE

Performance Over Filtered Date Range

% Positive	92.93%
% Negative	3.78%
Average 5 Star Score (all questions)	4.66
Review Count	1,032

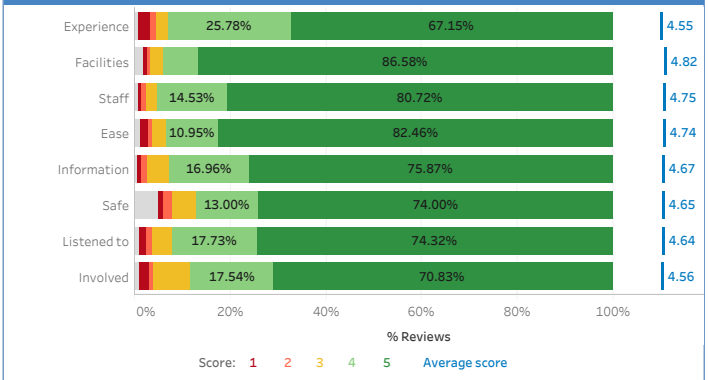
Performance Previous Month

% Positive	93.22%
% Negative	3.88%
Average 5 Star Score (all questions)	4.65
Review Count	516

Performance Current Month

% Positive	96.45%
% Negative	1.52%
Average 5 Star Score (all questions)	4.74
Review Count	197

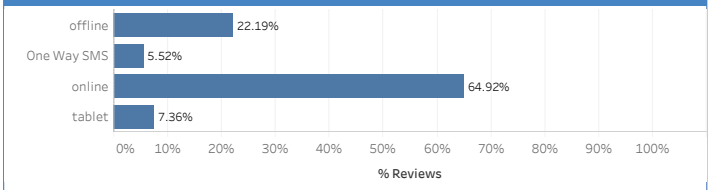
Score By Question



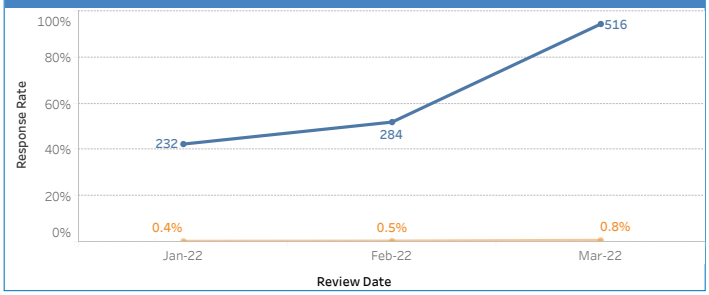
Reviews & Replies

Reviews with Review free text	1,014	98.26%
Reviews with Improvements free text	982	95.16%
Reviews with no free text	18	0.00%
Reviews replied to	0	0.00%

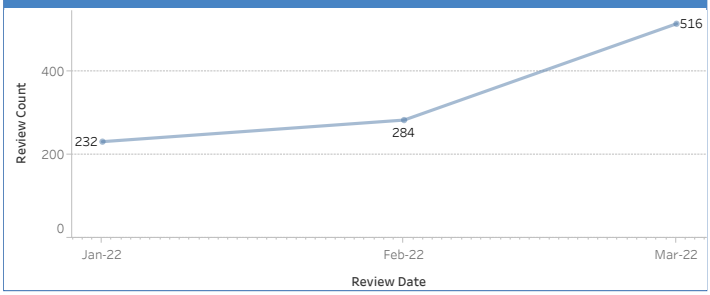
Review Source



Response Rate



Review Count



Berkshire Healthcare
NHS Foundation Trust

15 Steps Challenge

Quarter 4 2021/22

Considerations

- Covid restrictions were still in place for some services and it was thought inappropriate to do 15 steps visits at this time.
- One of the Lead Nurses for Professional Practice was unavailable for whole of January.
- 15 Steps schedule restarted for March, due to work commitments and annual leave only two visits were carried out.

Henry Tudor Ward, St Marks

This was a good visit and the team saw many positives

- The ward appeared calm with evidence of effective leadership.
- The ward was clean and organised.
- Safety of the patients was a high priority.
- Staff were warm and welcoming and were appropriately dressed with ID badges clearly visible.
- It was clear who was in charge.
- There were many facilities for the patients to enjoy, like the garden area, a spacious day room and the support of an Activity Co-ordinator to help with activities and rehabilitation.
- Staff had access to a WhatsApp group for support with work issues.

There were some observations made which were discussed at the time of the visit with the manager.

- The staff board needed updated – Manager confirmed that this was in progress.
- Patient information only appeared to be in English – Recommendation was made to make information in other languages available.
- Water dispenser and squash is usually only available in the summer months – Suggested that its made available all year round.
- The day room appeared cluttered with an excess of chairs – The newly appointed Activity Co-ordinator will be looking into how these can be more effectively used or stored.

Podiatry, St Marks

Positives observed during the visit

- Podiatrist in charge was very helpful and accommodating.

- Staff were cheerful and helpful.
- Staff had a social WhatsApp group.
- Clear evidence of changes and improvements that had recently been implemented through QMIS.
- Clinic rooms were clean and spacious.
- Appointments for urgent cases were on target.
- Good interaction between staff and patients.

There were some observations made which were discussed at the time of the visit with the podiatrist in charge on the day.

- Waiting room area is very compact and did not allow for a receptionist.
- Patient information only appeared to be in English – Recommendation was made to make information in other languages available.
- Patient information for wheelchair users was not at a convenient height – Suggestion made to move the information so everyone could reach it.
- Patient feedback box and forms not clearly identifiable – Suggested that the box and forms are placed in a more visible situation and labelled more clearly.
- Non urgent case waiting times were around 28 weeks which is outside of the target – Recruitment had been an issue but this has recently improved with new appointments to the team.

Friends & family team discussion:
Members of all the teams said that, should a family member or friend be admitted to any of the services visited they would feel confident in the care that they would receive.

Linda Nelson and Pauline Engola
Lead Nurses for Professional Practice
April 2022

Berkshire Healthcare
NHS Foundation Trust

Board Meeting Date	10th May 2022
Title	Six Monthly Safe Staffing Review – October 2021-Marhc 2022
	Item is for NOTING including the declaration by Nursing and Medical Directors
Purpose	The purpose of this report is to provide board assurance of the trust's compliance with safe staffing national guidelines
Business Area	Nursing and Governance
Author	Linda Nelson - Professional Development Nurse Debbie Fulton - Director Nursing and Therapies
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 supports maintaining good patient experience
Resource Impacts	N/A
Legal Implications	N/A
Equalities and Diversity Implications	N/A
Summary	This report supports the 2016 National Quality Board and October 2018 NHSI Developing Workforce safeguard expectations in relation to board oversight of staffing on the wards. The current assessment of staffing across the wards demonstrates that establishment alongside temporary staffing, which provides flexibility to meet additional observation requirements is appropriate, however some of our wards continue to have significant vacancy and, alongside this during this reporting period Covid continued to have a significant impact on the wards in terms of covid positive cases, the need for cohorting and on the community wards some bed closures due to enable social distancing. Covid also continued to impact the staffing of the wards due to sickness absence amongst permanent and temporary staffing. Across all wards senior staff and managers have continued to deploy the available staff resource to maintain safety, with all

	areas having mitigation and processes in place for when there are staff shortages. There has been an increase in shifts with less than 2 registered staff during this reporting period compared to previous one, and ward managers, clinical leads, matrons and therapists not included in safe staffing numbers have provided support and clinical care to maintain safety. Adequate medical cover is available during routine working hours for inpatient mental health and community health wards. Several programmes of work are in place as part of our workforce strategic initiative to support recruitment and retention including international recruitment, apprenticeships, support for newly qualified staff and healthcare workers, wellbeing offers and restorative supervision (professional Nurse Advocacy). A deep dive is being undertaken around staffing at PPH to look at whether we have the right staff at the right times for example whether staff on a twilight shift would be beneficial and whether the skill mix is right to support a therapeutic environment. The safer care tool module is being rolled out across the wards, this enables day to day assessment that staffing is right to meet patient acuity and will assist with deployment of staff where there is most needs in a more objective way.
ACTION REQUIRED	The Board is asked to: Consider this report and note the declaration provided by the Director of Nursing and Medical Director

Six Monthly Safe Staffing Review.
October 2021 – March 2022

1.0 Executive Summary.

The purpose of this report is to provide assurance to the board of the Trust's compliance with safe staffing in line with expectations of the National Quality Board (2016) and the National Health Service Improvement (NHSI) Developing Workforce Safeguards Guidance (2018), along with the declaration from the Director of Nursing and Therapies and the Medical Director that safe staffing is in place across the organisation.

The Covid pandemic has continued to impact on the wards during this reporting period for a variety of reasons, including sickness absence of our permanent staff and also amongst the temporary workforce which at times has resulted in significant staffing challenges. Patient complexity, infection control requirements aimed at minimising patient to patient Covid transmission, including cohorting, flexing of bed numbers on our community wards to enable social distancing where possible whilst supporting the system to meet pressure of demand and some closure to admissions due to Covid outbreaks over the reporting period have also impacted.

To improve staff resilience and support in all areas of the trust the Professional Nurse Advocate (PNA) programme commenced roll out in June 2021 and is gathering momentum. This is alongside the other health and well-being initiatives which are already established within the trust and signposted on Nexus. The PNA programme is a Health Education England supervision initiative supported by Ruth May and has been a requirement in midwifery for a number of years and is now being rolled out widely across healthcare. Within the trust we were already providing similar supervision across our Mental Health teams in the form of space groups and are now looking to use the PNA trained staff to support staff working in physical health services. The trust currently has 18 nurses who have completed the programme and 33 at various stages of completing the course. The trust is actively supporting further applicants to undertake the programme and currently has the highest take up in the region. It involves providing restorative supervision which in turn will assist with improving recruitment and retention challenges and wellbeing as staff feel supported and listened to.

The SafeCare module; which provides information on actual staff levels together with the acuity of patients, has been implemented on the East and West Community Health Services (CHS) wards. Starting in May 2022 the Mental Health wards will be implementing the safe care module in a phased way. It is envisaged that Campion ward will complete the module after the Mental Health wards.

In January 2020; the NHS Long Term Plan was published and set out the direction for the future health services. Part of this is ensuring that NHS providers have the appropriate number and skill mix of staff to keep patients safe and deliver high quality of care, with a focus on mental health, learning disabilities and community services. The Government's revised 2021-22 mandate to NHS England and NHS Improvement (published March 2022) continues to support this ideology.

Non-registered Nursing Associate trainees (NA) are included in the staffing figures reported because their training is work based and NHSE plan to monitor this training pathway within all Trusts and require it to be included in safe staffing reporting. The trust currently has 22 NAs employed in a variety of areas and 13 staff at various stages of NA training.

Registered nurse vacancies on the Mental Health inpatient wards remain challenging which is reflective of the national picture for recruitment. Prospect Park Hospital (PPH) through their dedicated recruitment and retention programme have worked hard using various initiatives such as overseas recruitment, open days and social media platforms to attempt to obtain both permanent qualified and non-qualified staff. Despite this work, vacancy levels still remain high. Community Health ward recruitment continues with variable amounts of success and vacancy levels remain largely unchanged.

Much of the registered nursing recruitment onto our wards is through the recruitment of newly qualified registered nurses, whilst this supports staffing numbers and continuity of care on the wards it does come with additional pressure on more senior staff who are required to provide mentorship for all newly registered nurses through their preceptorship; this is challenging when combined with continuous high occupancy, high use of temporary staff and high patient acuity. Enhanced systems are in place at PPH to ensure that junior nurses feel supported to build resilience and confidence such as a robust preceptee programme, the development of space groups, the PNA and preceptee survival kits.

In line with national reporting, shifts with less than two registered nurses are monitored each month. During the reporting period 16.3% of all shifts had less than 2 registered nurses, this is compared to 7.4% in the previous 6 month reporting period and is reflective of the impact of sickness absence amongst both our permanent and temporary workforce.

At PPH the number of shifts reported with less than two registered nurses has increased since the last six-month report.1078 shifts overall were reported during this current period, compared to 631 in the previous six months, this equates to 27% shifts having less than 2 registered nurses (Daisy ward had the highest with 208 shifts followed by Rose ward with 206). All wards across the hospital provide mutual support when able and a Duty Senior Nurse (DSN) is available to reduce the risk, alongside clinical development leads, matrons and the ward managers.

West Community Health Services had 10.29% of their available shifts with less than two registered nurses (an increase on 4.6% in the previous 6 months): Highclere ward; 120 and Ascot ward; 112 were the highest reporters. In the East the Community wards reported 1.73% shifts with less than two registered nurses(0.81% in the previous 6 months): Jubilee; 19 and Henry Tudor; 0.

30,472 temporary staffing requests were made across the Trust to support the wards in meeting their requirements for minimal staffing as well as providing additional cover for increased observational levels each month; 26.27% of these requests were not able to be filled. 26.65% of requested shifts were for registered nurses, 29.84% of which remained unfilled. Many registered nursing shifts filled through NHSP are Berkshire Healthcare staff doing additional hours over and above their contract.

The international recruitment campaign has only just started to positively impact due to recruitment checks and processes required, we currently have three international nurses in post, 1 due to start in April, 8 to start in June, and a further 6-8 international nurses to start in September. A

recruitment strategy for HCA's has been developed this includes approval to over recruit alongside a quarterly campaign where hospital wide recruitment is conducted. This has evolved into work that looks at the way the trust communicates the role better to interested candidates and an onboarding programme with the ultimate aim being to improve staff retention of new starters.

Reporting of incidents where staffing is below the expected/required number remains limited in some areas with some continued suspected under reporting in certain areas which experience the most challenges with staffing. Incidents reported have been assessed as having low or no impact due to the mitigation put in place by staff.

1.1 Prospect Park Hospital (PPH).

The overall staffing vacancies at PPH across the wards throughout the past six months has increased from 11.94% in October 2021 to 17.27% in March 2022 (March 2022 destination on leaving data shows 39.62% leavers going to no employment and 18.87% going to other NHS organisations). Recruitment of newly registered staff from students on placement at PPH continues and most preceptees from the previous year continue to work within the hospital. However, work on retention of all grades of staff is still required and an onboarding programme has been introduced to try and mitigate this. Daily staffing huddles are standard practice within the hospital and allow the Designated Senior Nurse (DSN), Matrons and Ward Managers to identify staffing shortages and provide an oversight of activity within the hospital and together plan appropriate actions to ensure safe staffing cover within the hospital across the 24-hour period. This enables the DSN on duty to deploy or move staff to support areas where there is greatest need and staffing challenges which can change rapidly. It is recognised that due to staffing difficulties newly qualified nurses are sometimes in charge on a shift which is not ideal. To acknowledge this; part of the daily status exchange meetings identify when a junior nurse is in charge and may need assistance. The Duty Senior Nurse (DSN) can then arrange extra support for staff. In addition, there are 4 matrons who each cover 2 wards/ areas and who provide support where the staff member in charge is newly qualified The Nurse Consultant runs monthly structured supportive supervision sessions (space groups) for preceptees which are well attended and received. These are well established across the mental health wards alongside one-to-one sessions. The increase in the PNA numbers across mental health services has also assisted in facilitating these supportive sessions. In addition, there is a programme to improve resilience and confidence in band 5 nurses called 'Reaching my Potential'. This support is crucial when there is continually a high occupancy rate alongside high patient acuity and high use of temporary staff in the acute mental health wards to meet patient need.

PPH continue to work with the finance team (PPH beyond budget) looking at ward hours required versus actual ward hours worked (section 3). This looks at both qualified and unqualified staff required at any one time on the ward to meet safe staffing plus additional hours required for observation. It is envisaged that the introduction of the SafeCare tool across the Mental Health wards will complement this initiative. A deep dive exercise involving workforce planning and the Mental Health Inpatient wards will commence in May 2022 to identify short, medium and long-term workforce transformation opportunities to help address the current staffing challenges.

Patient acuity has remained high. Wards were dealing with increased patient physical health needs and some associated higher levels of anxiety due to Covid 19; the hospital has a physical health lead to support staff around this alongside senior staff on the ward, the Nurse Consultant, matrons and the senior management team.

20,511 shifts were requested to support the wards in meeting their agreed staffing requirements as well as providing additional cover for increased observational levels each month; 25.64% of these requests were not able to be filled. 20.62% of requested shifts were for registered nurses, 29.55% of which remained unfilled. Within PPH, the wards have been able to support each other, and support is also available from senior staff. There is on-going work across wards on recruitment and with mobility of staff around the hospital to ensure safety of all wards when this occurs.

The wards have additional resource not captured in safe staffing which includes psychology and Occupational Therapy/ therapy assistants, Clinical Development Leads and Ward Managers as well as the medical workforce. In addition, the mental health wards now have Activity Coordinators who assist in engaging patients in activities across the afternoon and evening period. Staff who work across wards on a sessional basis are not calculated as part of the safe staffing measure.

Considerable work is being undertaken to manage the bed flow and reduce the bed occupancy at PPH, as detailed in table 5. All the acute mental health wards have experienced challenges with high bed occupancy throughout this reporting period with occupancy figures of three of the four acute wards averaging at over 90%. Rose ward and Snowdrop ward averages are 92% and Bluebell is 96%. Daisy ward figures are slightly lower than the other three wards at 82% to enable isolation of acute patients as required. In addition, there are still challenges with managing length of stay compared to similar trusts.

The number of reported shifts with less than two registered nurses has more than doubled at 1078 for this 6-month period (478 during April 2021 - October 2021) across Prospect Park Hospital some of which is linked to the impact of the Covid. Daisy ward had the highest number of shifts with less than two registered nurses overall at 208 and Rose ward had 206. Sorrel ward had the lowest number with 66.

Sickness rates (graph 4) have been varied across this reporting period with all wards bar one (Bluebell ward 3.35% November 2021) above the Trust's target of 3.5 % for the duration of the report.

1.3 Campion Unit.

Campion Unit has continued to have strong leadership. Throughout the six months there has been high levels of observations for a number of patients on the unit due to patient and staff vulnerability. This reflects the very complex and challenging patients on the unit. 1447 temporary shifts were requested to meet the requirements of levels of observations; 38.07% were requests for registered nurses. The low unfilled rate (total unfilled 17.06% RN unfilled 12.55%) is due to the unit predominantly using their own staff to cover additional staffing requirements which provides continuity of care to the patients.

The average bed occupancy during the reporting period has been 44%. The sickness rate was around 7% during October and November but has been above 13% for the other months.

1.4 Community Wards.

West Community Health Wards (CHS).

Vacancies have varied across the wards throughout the reporting period. Wokingham wards has had a higher number of vacancies than the other West CHS wards throughout the reporting period which has meant higher temporary staffing requests, particularly for registered nurses (vacancies

between 4-8 WTE). Oakwood unit and WBCH vacancy levels have remained consistently lower than Wokingham wards over the last 6 months(vacancies between 0-4 WTE). Despite this, there have been a significant number of unfilled shifts which have impacted staffing levels due to sickness absence.

Bed occupancy has decreased marginally across all wards for this six-month period at 84.4% (April 2021-September 2021; average 86.6%) which was due to Covid outbreaks and closures plus the need to match patients needing community beds to availability. The total number of temporary requests was 6683; 39.98% were for registered nurses with 29.94 % of requests being unfilled. West CHS wards have regular meetings with the acute Trusts locally to increase communication and support patient flow for the community beds and identify suitable patients earlier which assists with a more consistent bed occupancy across the West wards. In addition, the SafeCare tool has been implemented on all the West wards which is starting to give a clearer picture of patient acuity and enable the effective deployment of staff to ensure care is maintained.

Sickness rates have been consistently above the Trust's agreed target of 3.5% in all wards due to high numbers of long-term sickness which the wards have been managing with the support of human resources procedures and some short-term sickness, especially in relation to Covid. The sickness figures do not include those individuals who are able to work from home with Covid.

There were 281 shifts with less than two registered nurses in the West CHS wards (10.29%), 112 were on Ascot ward Wokingham Hospital and 120 on Highclere at WBCH. At both Wokingham Hospital and West Berkshire hospitals, the wards work closely together to ensure safety on these occasions and clinical managers/ANPs are also available during working hours to provide support and assistance as are Physiotherapy and Occupational Therapy staff.

East Community Health Wards.

Staffing levels on both Henry Tudor and Jubilee have remained stable. Henry Tudor ward bed capacity for the 6-month period was their usual 24 beds (apart from January when it was 23 for a time). Jubilee ward bed capacity was 16 to allow for social distancing in the nightingale ward structure. Their capacity has increased to 20 from 9th April. The average bed occupancy across both wards was 78% which has increased from the previous six months of 73%. The total number of temporary requests was 1831; 36.48% were for registered nurses with 5.68% of requests being unfilled. The sickness rate for Henry Tudor ward has been above 3.5% for the period October 2021to March 2022 with the months of November 2021, December 2021 and January 2022 being particularly challenging at over 11.5%. Jubilee sickness levels have been below the trust sickness threshold for four months although an increase in February and March has been seen. There were 19 shifts in the reporting period where there were less than two registered nurses (Henry Tudor ward 0; Jubilee ward 19). Patient safety was not compromised on either of the wards during the time frame. An activity coordinator has recently been appointed across both wards to assist in providing a therapeutic environment for both patients and visitors. The East CHS wards have completed the implementation of the SafeCare tool and it is envisaged it will give a more accurate picture of staffing levels and patient acuity.

2.0 Main Report.

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

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

As part of the safe staffing review, both the Director of Nursing and Therapies and the Medical Director must confirm in a statement to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable. This can be found on page 21.

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

The directive states that establishment setting must be done annually, with a mid-year review, and should take account of:

- Patient acuity and dependency using an evidence-based tool (as designed and where available).
- Activity levels.
- Seasonal variation in demand.
- Service developments.
- Contract commissioning.
- Service changes.
- Staff supply and experience issues.
- Where temporary staff have been required above the set planned establishment.
- Patient and staff outcome measures.

Different roles.
The national minimum staffing expectation of at least two registered staff on each ward for every shift remains a requirement. However, vacancies across all wards means that at times this has been challenging to maintain. The number of shifts where there are less than two registered staff on duty is monitored on a monthly basis at executive and board meetings. The exception to this minimum is on Campion Unit where it was agreed that a skill-mix of one registered with three support workers was best able to meet with patient need at night.

2.1 Current Situation.
Berkshire Healthcare NHS Foundation Trust has the following wards:
1 Learning disability unit.
7 Community hospital wards (5 units).

7 Mental health wards.

All the wards have a staffing establishment that includes an allowance of 24% for planned and unplanned leave (training, annual leave, sickness absence). Table 1 demonstrates the actual and agreed staffing level on each shift.

Table 1: Current Staffing establishment, bed numbers and shift patterns October 2021 to March 2022 :

	Beds	FTE Establishment in budget 2021/22	Professional judgement FTE	Planned shift pattern (Early-late-night)
Bluebell	**22**	39.26	36.76 + 1 ward manager + 0.5 DSN + 1 CDL = 39.26	6-7-5 activity coordinator inc on the late shift
Daisy	**20**	39.95	37.45 + 1 ward manager + 0.5 DSN + 1 CDL =39.95	6-7-5 activity coordinator inc on the late shift
Rose	**22**	44.15	41.65 + 1 ward manager + 0.5 DSN + 1 CDL = 44.15	6-7-5 activity coordinator inc on the late shift
Snowdrop	**22**	38.31	35.81 + 1 ward manager + 0.5 DSN + 1 CDL = 38.31	6-7-5 activity coordinator inc on the late shift
Orchid	**20**	41.8	39.3 + 1 ward manager + 0.5 DSN + 1 CDL = 41.8	6-6-5
Rowan	**20**	42.60	40.1 + 1 ward manager + 0.5 DSN + 1 CDL = 42.60	7-7-5
Sorrel	**11**	37.00	34.5 + 1 ward manager + 0.5 DSN + 1 CDL = 37.0	6-6-5
Campion	**9**	37.11	36.11 + 1 ward manager = 37.11	7-7--5
WBCH	44	63.46	**DONNINGTON** 39.9 + 1 ward matron + 0.3 staff development lead = 41.2	9-6-6
			HIGHCLERE 35.9 + 1 ward matron + 0.3 staff development lead = 37.2	6-5-4
Oakwood	**24**	46.67	45.1 + 1 ward manager and 1 dep. ward manager matron = 47.1	9-7-4
Wokingham	**46**	61.31	59+ 1 ward manager + 0.8 matron = 60.8	13-10-7
Henry Tudor	**24**	32.80	30.8+ 1 ward manager = 31.8	7-6-4
Jubilee	**22**	30.23	30.8 + 1 ward manager = 31.8	7-5-5

Bed numbers available varied during this period due to social distancing. At times across a month, wards may require additional staff above what is planned within the establishment. This is to both meet patient need and the increased dependency needs of the patients. The staffing levels are reviewed daily and monthly alongside a range of quality and workforce indicators to monitor the impact and experience for patients.

3.0 Review of staffing establishment.

When workforce modelling is undertaken for the wards, the Keith Hurst dependency modelling tools are used to assist in the triangulation of data, alongside benchmarking and clinical judgement. For Mental Health wards this is the Mental Health Optimal Staffing Tool (MHOST) and the SafeCare tool (which uses the SNCT for the dependency calculations) for other wards. It is recognised that these modelling tools use a snapshot of dependency of patients on a given day and that dependency can fluctuate. Therefore, review using the tools utilises the collation of daily data over a period of time (20 days) to understand the average dependency for each ward. This is an increased snapshot reporting period from previous reports. Moving forward, with improved accuracy of data in the SafeCare tool, we will be able to review staffing establishment on an ongoing daily basis not just as a snapshot time.

3.1 Review using workforce modelling tool.

Tables 2 and 3 below show the current establishments compared to the recommended establishment from the 20-day review undertaken in March 2022 using the current available Keith Hurst tools**.**

Table 2: Prospect Park Hospital Wards:

Ward	Bed Number	Current establishment (WTEs)	Average additional staff requested above establishment (WTE per day)	Recommended establishment from March 2022 review (WTEs)	Total actual establishment (including unfilled shifts requested)
Sorrel	11	38	3.75	48.89	41.75
Rose	22	34.15	5.35	53.92	39.45
Snowdrop	22	35.95	4.73	53.19	40.68
Bluebell	22	35	4.76	38.06	39.76
Daisy	20	35.95	4.61	37.99	40.56
Rowan	20	42	6.50	53.96	48.5
Orchid	20	36	5.89	46.94	41.89
Total	137	283.07	35.29	309.39	292.59

The review was undertaken over a 20-day period in line with the Developing Workforce Safeguards recommendations and offers a guide. From this review it is clear that the recommended establishment compared to actual establishment was sub-optimal across most of the wards to meet the patient need over the 20-day period (a further 16.8wte would have been required to meet recommended staffing); however the wards all have a clinical development lead

and ward manager who are able to step and provide patient care (14 wte) and alongside this psychology and AHP staff are not reflected in the establishment but also support the wards and provide patient care including some weekends and therefore whilst the staffing was sub-optimal the wards were not assessed as being unsafe.

Staff employed to cover additional patient observations are regularly used and based on Rowan ward to provide the necessary additional staff to meet patient acuity needs and ensure continuity of care. All acute wards have now successfully recruited Activity Co-ordinators who work on the wards during the 4pm-10pm period, 7 days per week. This supports both safe staffing and the therapeutic environment.

In April/May 2022 workforce deep dives will be commencing involving the mental health in patient services at PPH. This will look at workforce transformation and more specifically at whether the right staff are available at the right time and whether the correct skill mix is available. Alongside this commencement of the safeCare tool will also provide increased analysis of staffing requirements. An update will be provided in the next 6 monthly report.

Table 3: Community Wards, Oakwood and Campion:

Ward	Bed Numbers	Current establishment	Recommended establishment from March 2022 review	Average additional staff requested above establishment (WTE per day	Total actual establishment (including unfilled shifts requested)
Oakwood Ward	24	46.67	46.1	3.29	49.96
Wokingham Wards (Ascot and Windsor)	46	61.31	65.5	4.40	65.71
WBCH (Highclere and Donnington)	49	63.46	58.2	4.54	68.0
Henry Tudor Ward	24	32.8	30.2	2.27	35.07
Jubilee Ward	22	30.23	22.5	1.26	31.49
Campion	9	37.11	26.6	2.64	39.75

Bed numbers available varied during this period due to social distancing and covid outbreaks. Ward Manager/Matron posts are not included in these figures. The wards all have ANPs and allocated therapy staff who work on the ward. These roles are key members of the multi-disciplinary team but not included in these figures.

The review of staffing in March 2022 occurred while the bed occupancy was lower than expected on some of the Community Wards due to the need to maintain social distancing measures (Jubilee ward had 16 beds available during the 6-month period). This is reflected in the outcome of this review (lower suggested recommended establishment than actual establishment). In addition, Campion unit had only 44.4% occupancy rate throughout the data collection period. Taking this

into consideration it indicates that baseline agreed staffing levels with the ability to increase this with the use of temporary staff as required continues to be appropriate for achieving safe staffing if shifts created by absence and/or vacancy can be covered.
However, the SafeCare data collated each day has indicated that on most occasions since collecting commenced in October 2021 that staffing on the West CHS wards has been sub-optimal, due to being unable to fill gaps in rota created by vacancy, absence and need for additional staffing to support 1:1 nursing. Data entry has been erratic especially in January/February 2022 leading to spikes in data so it may not demonstrate a true reflection (see Appendix 1). Work is ongoing to improve data entry across all the Community Health Service wards so that data is fully reflective of the wards in relation to staffing and patient acuity and then, going forward, use this data to accurately reflect our staffing requirements.

To work out hours required for observations; data was collected from the wards around the number of observations each day. This data was used to both predict how many ward hours each ward would need and then retrospectively how many ward hours they needed. This is compared to how many ward hours were worked.

In addition to required ward hours, e-roster data has been analysed to understand available and unavailable hours of substantive staff. Available hours are hours that staff are available to be on the ward. Unavailable hours are hours where staff are paid but are on leave, study, sick, off the ward etc. If the number of 'available hours' on average a substantive staff member works is identified, we can forecast how many temporary hours are required to cover the number of 'ward hours' required each day.

3.2 Care Hour per Patient Day (CHPPD) Data Collection.
Lord Carter's review: 'Operational Productivity and Performance in English Acute Hospitals: Unwarranted Variations' (2016); highlighted the importance of the non-acute sectors in ensuring efficiency and quality across the whole NHS health economy. One obstacle identified to eliminate unwarranted variation in clinical staff distribution across and within the NHS provider sector has been the absence of a single means of consistently recording, reporting and monitoring staff deployment. CHPPD provides this measure. The CHPPD is calculated by taking the actual hours worked (split into registered nurses and healthcare support workers) divided by the number of patients occupying beds on the ward at midnight and is fed into the national data collections team each month .

CHPPD does not consider patient acuity, ward environmental issues, patient turnover or movement of staff for short periods only staffing levels in relation to patient numbers on individual in patient wards. The Model Hospital no longer provides data to benchmark us against comparable trusts. The table below shows the CHPPD for each of the wards over this six-month period which shows how many care hours each. Moving forward the SafeCare tool will be used to demonstrate actual and required staffing levels for the Inpatient wards.

3.3 SafeCare Tool.
Managing staff deployment is of great importance to the Trust and ensuring that staffing levels match demand so that both over and understaffing is avoided is crucial to maintain and deliver services. How patient activity considering occupancy, patient acuity and dependency is understood requires processes to be able to respond to changing demand yet address cost pressures. The SafeCare tool is a software module which can be added onto the already implemented Allocate E-

Roster system and assists in providing a consistent way of interpreting productivity and efficiency alongside quality and safety outcome measures. The tool was developed across a number of hospitals and specialities nationally to evidence optimal staffing levels. In addition, it enables data to be collected in real time rather than retrospectively, therefore demonstrating more accurate acuity and dependency data. It supports the CHPPD measurement and provides operational staffing control which ensures governance and transparency. West CHS wards and East CHS wards are now live. Roll out to the Mental Health wards has been delayed slightly until May 2022 due to shortages in the e roster team.

Further analysis of the accurate data will be performed going forward, however, what we have seen to date is that the staffing levels on the CHS West wards are predominantly suboptimal, further work is being undertaken as part of a review for what staffing is required against the dependency of the patients acknowledging that there were many temporary staffing shifts required due to sickness, and vacancy but that many of these were not able to be filled by temporary staffing; and that the staffing requirement on the wards in CHS East are showing as accurate.

Table 4: BHFT CHPPD:

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Bluebell	7.90	9.50	9.40	9.00	11.00	10.40
Daisy	10.60	12.50	11.50	11.80	12.60	11.80
Rose	8.60	9.30	9.90	10.30	8.40	8.40
Snowdrop	9.40	8.90	11.30	8.60	9.10	8.00
Orchid	9.50	13.90	13.10	10.90	11.20	15.10
Rowan	13.00	14.60	18.00	15.00	13.30	19.30
Sorrel	17.80	19.80	19.50	20.10	19.20	19.60
Campion	51.70	40.50	43.40	43.40	43.40	38.60
Donnington	6.30	6.50	6.30	6.00	6.40	6.20
Highclere	6.20	6.90	7.00	7.30	7.30	6.70
Oakwood	8.70	8.60	7.30	6.90	7.40	6.80
Ascot	7.10	9.60	6.90	6.30	7.60	6.90
Windsor	6.00	7.70	6.30	6.50	5.20	6.20
Henry Tudor	8.80	8.00	9.20	9.30	8.60	7.20
Jubilee	9.40	9.90	10.00	9.00	9.10	9.30

Campion Unit CHPPD data figures are remained high but have reduced during this 6-month period. The high levels are due to the high amount of level 2 observation, patients who required 2 on 1 supervision for safety/safeguarding reasons and another patient needing 2 to 1 supervision due to challenging behaviour. For this group of patients' levels of risk carries higher priority than the number of patients in the unit.

3.4 Bed occupancy.

Table 5 below details monthly bed occupancy over the reporting period, the data highlighted in red is where bed occupancy has exceeded 90%. The areas that have frequently experienced bed occupancy in excess of 90% are the Acute Adult Mental Health Wards In addition, some of the West CHS wards (West Berkshire wards and Wokingham wards) also demonstrated periods of high occupancy although the average was under 90%.During this reporting period all wards were impacted by Covid with some periods of time requiring beds to be closed to ensure appropriate cohorting and management of patients to minimise the risk of transmission in line with national guidance.

Table 5: Bed Occupancy:

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Average
Bluebell	99.00%	94.40%	96.50%	97.10%	92.50%	97.10%	96%
Daisy	80.30%	79.70%	88.40%	86.80%	73.90%	85.60%	82%
Rose	96.50%	96.70%	84.30%	86.20%	94.60%	93.50%	92%
Snowdrop	88.40%	96.80%	79.90%	94.30%	95.50%	96.30%	92%
Orchid	91.00%	87.30%	77.10%	91.50%	91.10%	81.00%	87%
Rowan	93.70%	85.50%	62.10%	66.10%	82.30%	72.10%	77%
Sorrel	93.00%	95.50%	88.00%	88.00%	92.50%	97.40%	92%
Campion	34.40%	42.60%	44.40%	44.40%	44.40%	55.90%	44%
Donnington	86.70%	85.60%	80.10%	91.10%	88.30%	90.70%	87%
Highclere	94.70%	84.20%	86.50%	85.20%	88.10%	89.00%	88%
Oakwood	77.20%	66.80%	85.50%	83.60%	85.10%	88.10%	81%
Ascot	92.40%	65.40%	99.00%	93.10%	68.30%	80.80%	83%
Windsor	92.70%	81.00%	83.00%	78.20%	87.20%	78.00%	83%
Henry Tudor	71.40%	84.30%	64.50%	69.60%	68.80%	83.10%	74%
Jubilee	84.90%	81.50%	76.00%	83.70%	82.40%	84.70%	82%

Occupancy on Daisy ward was consistently below 90% due to the need to ensure a cohort area for covid positive patients however, there were occasions when some or all of these beds were not required during this reporting period. Bluebell ward occupancy was consistently above 90%,other wards had variable occupancy due to covid outbreaks and need to close wards for periods of time during the reporting period. Other areas have seen an increase in bed occupancy namely the East CHS wards; Campion Unit's lower occupancy rate for the six months reflects the complex and challenging patients that have remained on the ward and their rate remains unchanged at 44%.

4.0 Workforce data

Several factors have the potential to impact on the wards ability to achieve the agreed staffing levels on every shift; these include vacancies, maternity leave and sickness absence.

4.1. Vacancies.

Table 6 below shows the combined whole-time equivalent vacancy rate of registered nursing and healthcare support staff for each ward according to finance data over the last six months. PPH registered nurse vacancies has increased during the last six months (26.60 in November to 35.60 in March) and there has also been an increase in unregistered vacancies. Graph 2 below, demonstrates a variable picture across the mental health wards. Campion unit has consistently had low vacancy rates but has challenges filling specialist RN positions long term.

Registered nursing recruitment on the mental health wards continues to be challenging in line with the national picture despite proactive recruitment activity especially from international recruitment campaigns and newly qualified staff. Further work will be undertaken in the next few months to offer an 18 month rotational Mental Health band 5 role between inpatient and community facilities with a band 6 position possibly available on completion.

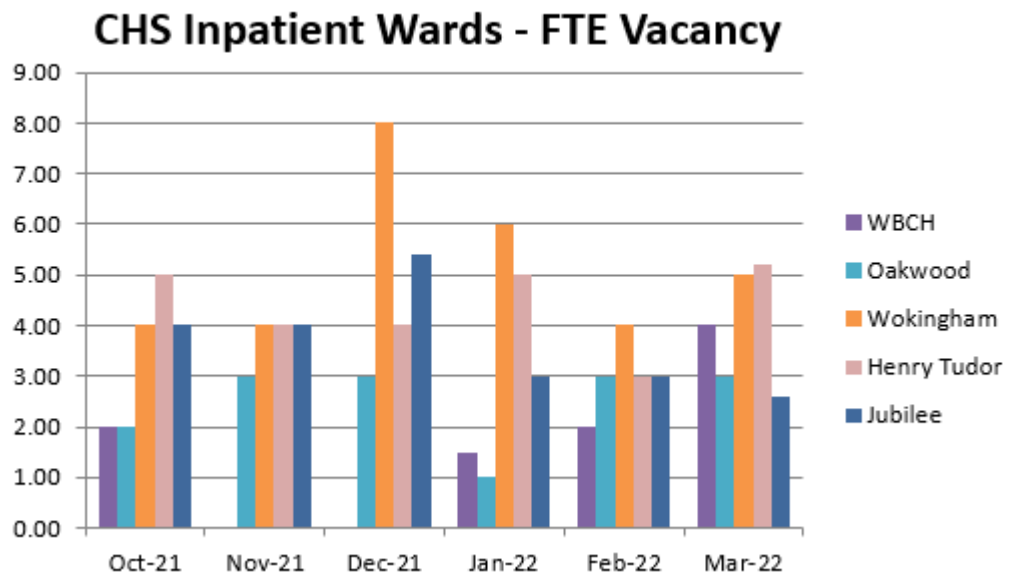
The CHS wards have had some staffing challenges especially on Wokingham wards with reference to qualified staff. Oakwood Unit and West Berkshire had consistently low vacancy levels in the 6-month period. Jubilee saw an increase in vacancies in October/November 2021 but levels have since stabilised. Henry Tudor had a higher level of non-qualified vacancies but this has now reduced. Their qualified vacancies remained low but have now started increasing (1WTE apart from March 3WTE).

Table 6: Whole Time Equivalent (WTE) vacancy of registered nursing and healthcare worker combined:

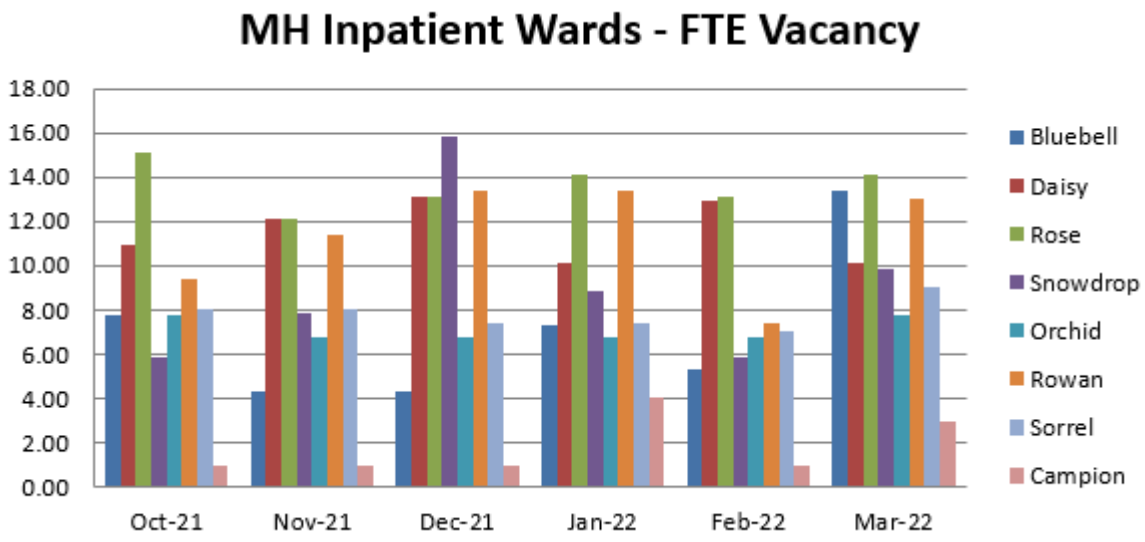
		Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
MH Wards	Registered	29.60	26.60	31.60	28.60	27.60	35.60
	Unregistered	35.52	33.12	35.48	37.48	31.92	41.72
CHS Wards	Registered	9.00	8.00	8.40	7.50	9.00	13.20
	Unregistered	8.00	7.00	9.00	9.00	6.00	6.60
Campion	Registered	1.00	1.00	1.00	2.00	1.00	1.00
	Unregistered	0.0	0.00	0.00	2.00	0.00	2.00

Graphs 1 and 2 below detail the split of vacancy across the wards and demonstrate variation in level of vacancy that each ward is experiencing.

Graph 1: WTE on the Community Wards by Month:



Graph 2: WTE on the Mental Health Wards by Month:



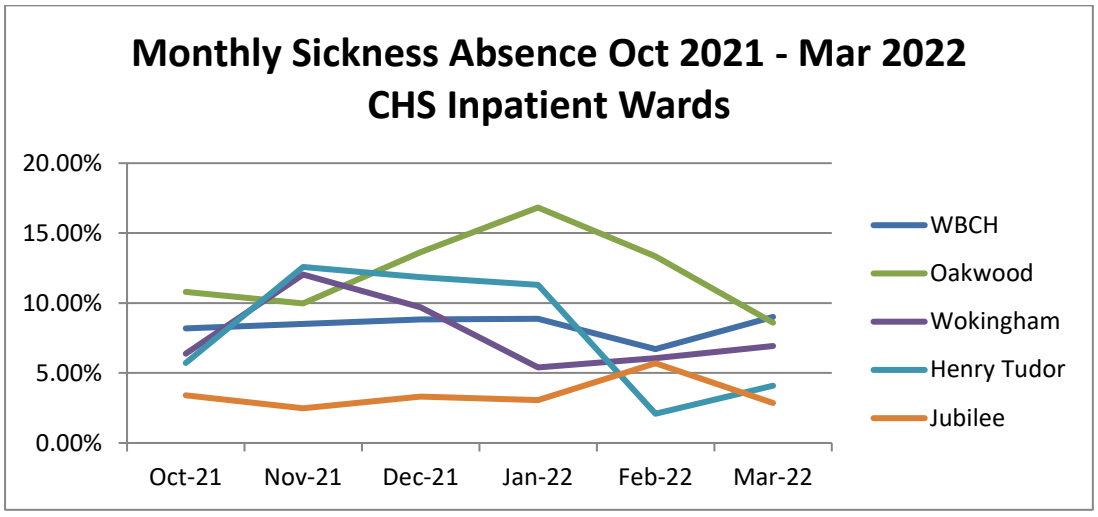
4.2 Sickness absence**.**

Graphs 3 and 4 detail the sickness absence as a percentage of the total registered nursing and care staff workforce for each ward. The sickness absence includes long and short-term sickness.

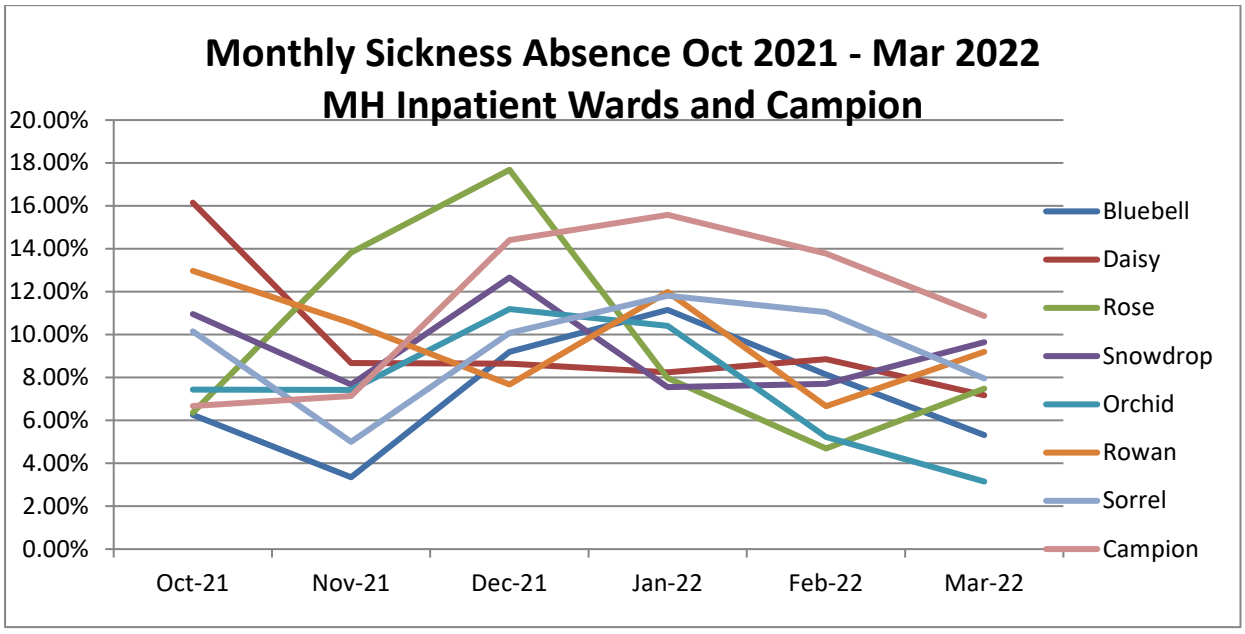
The Trust sickness absence target is 3.5% and most wards exceed this at the time of this report (apart from Bluebell ward in November 2021 and Jubilee ward October 2021-January 2022, Orchid ward March 2022), this has coincided with a Covid outbreaks across the country plus an increase in long term sickness absence. The Trust has a sickness absence policy which with support from the Human Resources department, ensures that appropriate action is taken to support staff and managers with sickness related absenteeism. There are several wards with a high sickness absence due to a combination of both long and short-term sickness factors. These wards are working closely with Human Resources and Occupational Health providers to ensure that

appropriate support is offered, and action being taken. A Health, Wellbeing and Engagement Manager is now in post to support actions aimed at reducing sickness absence. In addition, there are several initiatives which are widely advertised to address both physical and mental health care needs of staff including a health and wellbeing hub for staff and the PNA programme. These can be accessed by all staff via Nexus the Trust internet site or via Occupational Health referral if appropriate. Covid levels have been high and increasing throughout the last 6 months, which has impacted on sickness absence. Infection Prevention and Control measures including Mask wearing and regular self-testing has continued throughout. Information on how to access the support systems especially in relation to mental well-being are available on NEXUS as it is seen to be beneficial especially for those individuals working in isolation.

Graph 3: Sickness absence for wards as a percentage of total ward staffing (Community Wards):



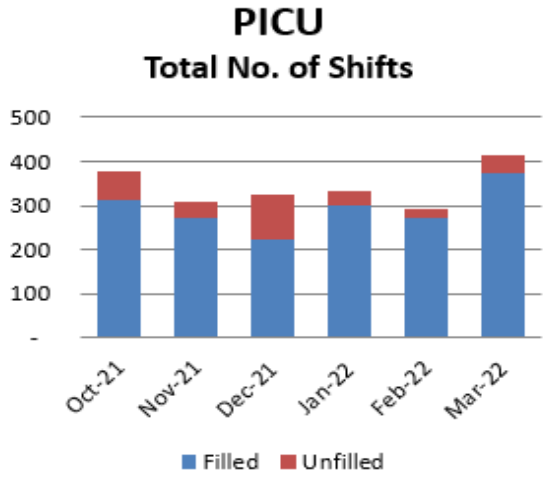
Graph 4: Sickness absence for wards as a percentage of total ward staffing (Mental Health, Wards and Learning Disability):

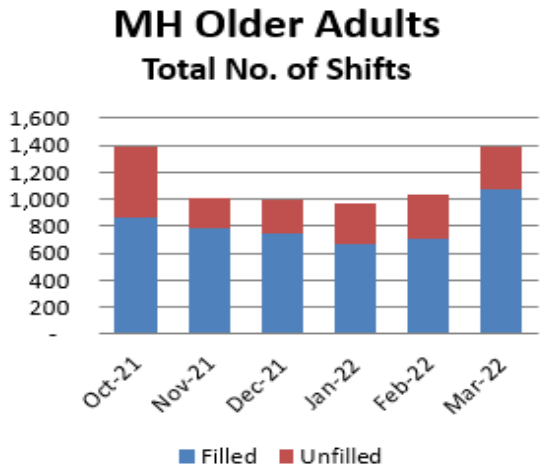


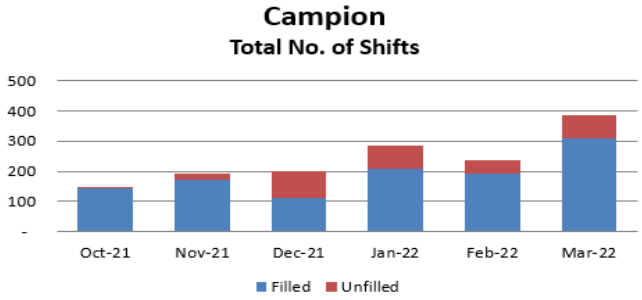
4.3 Temporary staffing.

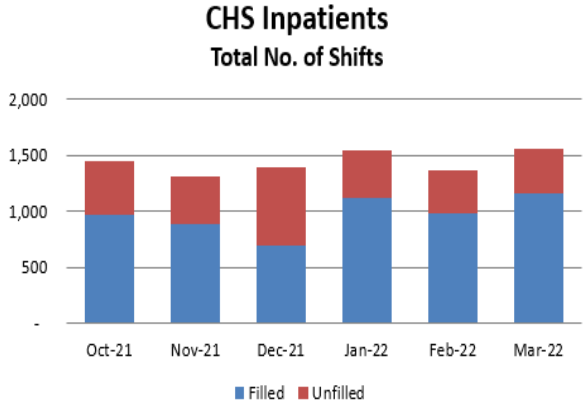
When the wards have vacancies and sickness within their nursing staff establishment, they use temporary staffing (agency / bank, or additional shifts by their own staff) to ensure that safe staffing levels are maintained. Temporary staffing is also used where patient need means that additional staff are required. It is recognised that increased numbers of agency and bank staff have the potential to impact on quality of care. Therefore, the wards continue to work hard with the support of the recruitment team to fill vacancies with the aim to reduce the reliance on temporary staffing.

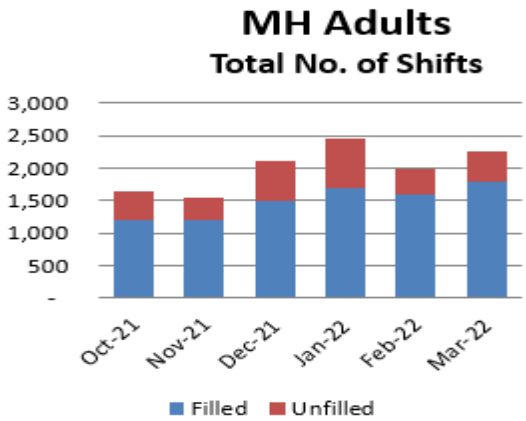
The graphs below show the total number of shifts required to be filled for each area as well as number of these that were filled/ unfilled. All CHS and MH wards have had difficulty in filling required shifts. There has been an increase in temporary staffing need over the last six months which has coincided with Covid outbreaks and staffing vacancies.











5.0 Displaying planned and actual registered and care staff on the wards.

All the wards within the trust have a display board which shows the number of staff that the ward had planned to have on shift and the number of staff on shift. This is clear to visitors to the ward as to the number of registered nurses and care staff on the ward at the time. The nurse in charge of the shift portrayed so that visitors can identify who to contact if they have a concern or want to speak to them. These boards are monitored during quality visits to individual wards throughout the year by senior managers and 15 steps visits to ensure they are current.

6.0 Safety on our wards.

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

6.1 Quality indicators.

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

These indicators are:

Community Wards:

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

Mental Health Wards:

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

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

Table 5: Quality metric for mental health inpatient wards (October 2021 – March 2022):

Ward	AWOL	Falls	Patient on Patient Assault	Patient on Staff Assaults	Prone Restraint	Seclusion	Self-harm
Bluebell	21	7	20	26	2	3	310
Daisy	17	4	4	33	0	2	60
Rose	12	5	21	57	1	4	136
Snowdrop	20	5	11	33	5	6	119
Orchid	2	10	1	12	0	0	1
Rowan	0	19	6	14	0	2	1
Sorrel	5	1	19	58	6	75	40
Campion	0	0	6	52	0	2	31
Total	**77**	**51**	**88**	**285**	**14**	**94**	**698**

* Correct at time of report

There has been an overall increase in incidents reported during this period compared to the previous six months (1160 to 1307). The figures for self-harm have increased (from 467 to 698) but notably the figure for prone restraints has fallen by half (from 27 to 14). Reducing assaults, falls, prone restraint and self-harm are all key priorities for the trust and are included within the Trusts harm free care/ supporting our staff plan on a page initiative, quality improvement approaches are being used to support identification of countermeasures to achieve reduction.

Table 6: Quality metric for community physical health inpatient wards (October 2021 to March 2022):

Ward	Drugs	Falls	Pressure Ulcers	Patient on Staff Assaults
Donnington	17	21	19	7
Highclere	5	17	9	0
Oakwood	18	23	10	1
Wokingham	17	27	9	2
Henry Tudor	15	8	5	0
Jubilee	14	3	1	0
Total	**86**	**99**	**53**	**10**

* Correct at time of report

Incidents reported during this six-month period are similar to the previous 6 months (250 to 248) There was a decrease in drug errors (104 to 86) but an increase in patient on staff assaults (18 to 10). Pressure ulcer desk top reviews and learning events are undertaken and ensure learning is shared within teams across the Trust and ensures information is disseminated to relevant staff. There is also further work going on in the trust to improve staff training and awareness of pressure damage to improve incident numbers.

Reducing falls is a key focus for the Trust and is part of the harm free care driver metrics using a quality improvement approach to support reduction
All medication incidents have been reported as being low or causing no harm.

6.2 Red flags.

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

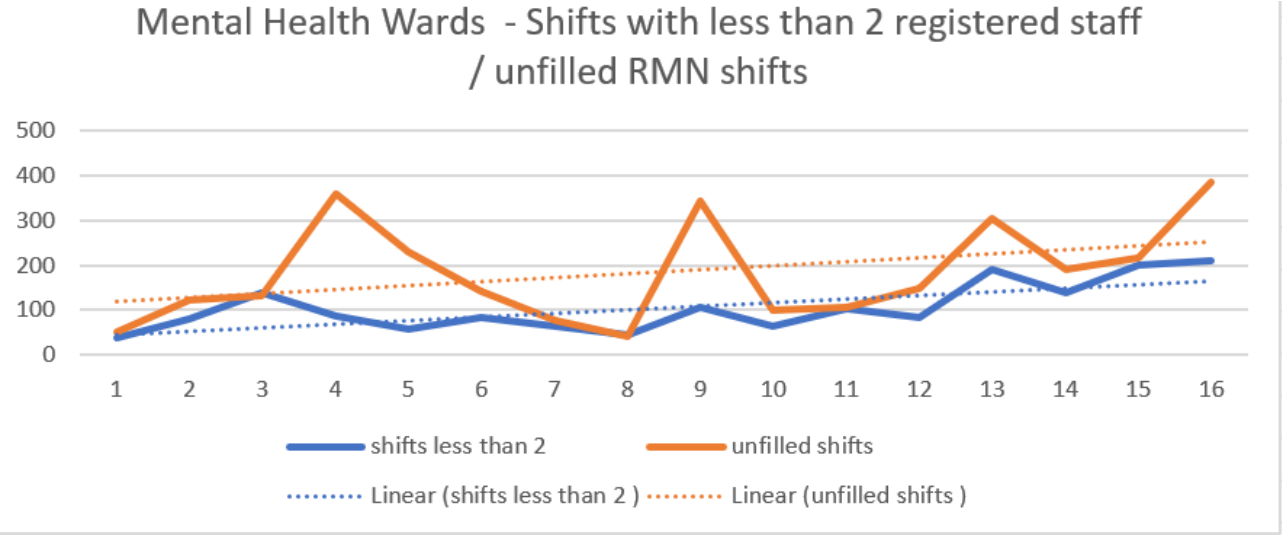
Table 7 demonstrates the number of occasions by ward and month where there were less than two registered nursing staff on a shift.

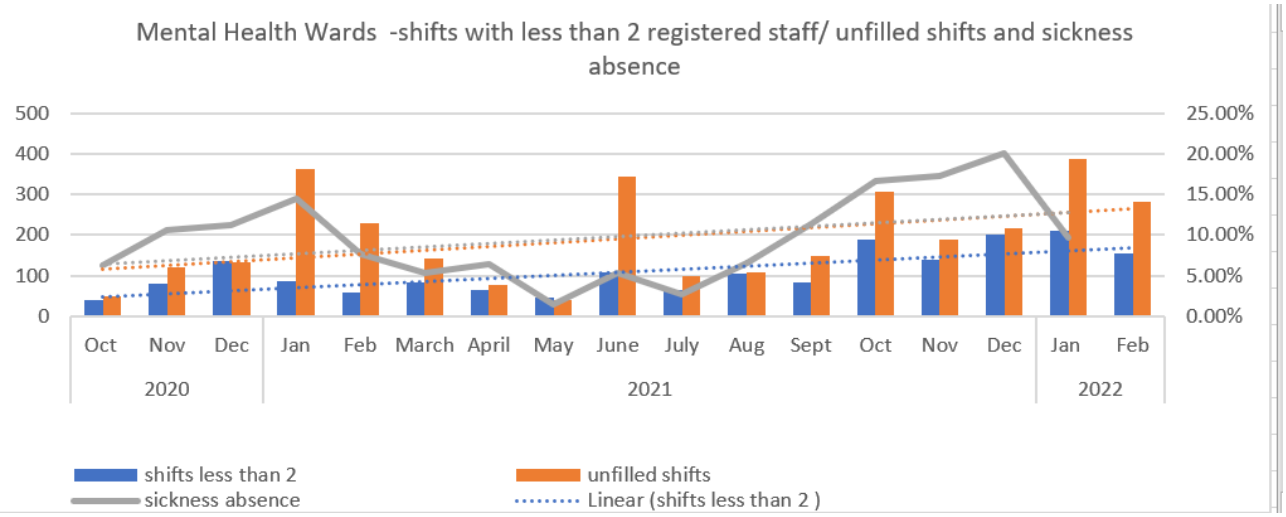
For all the wards where there are less than two registered nurses, senior staff and ward managers (who are supernumerary to the safe staffing numbers) as well as other clinical staff such as Physiotherapy and Occupational Therapy provide support when available. For the wards at Prospect Park Hospital, the Duty Senior Nurse is also available and able to take an overview of the wards and redeploy staff to areas of most need as necessary.

Table 7: wards and number of occasions where there were less than two registered nursing staff on duty (excluding supernumerary roles of Ward Manager/ Matron/ Clinical Development Lead and ANP):

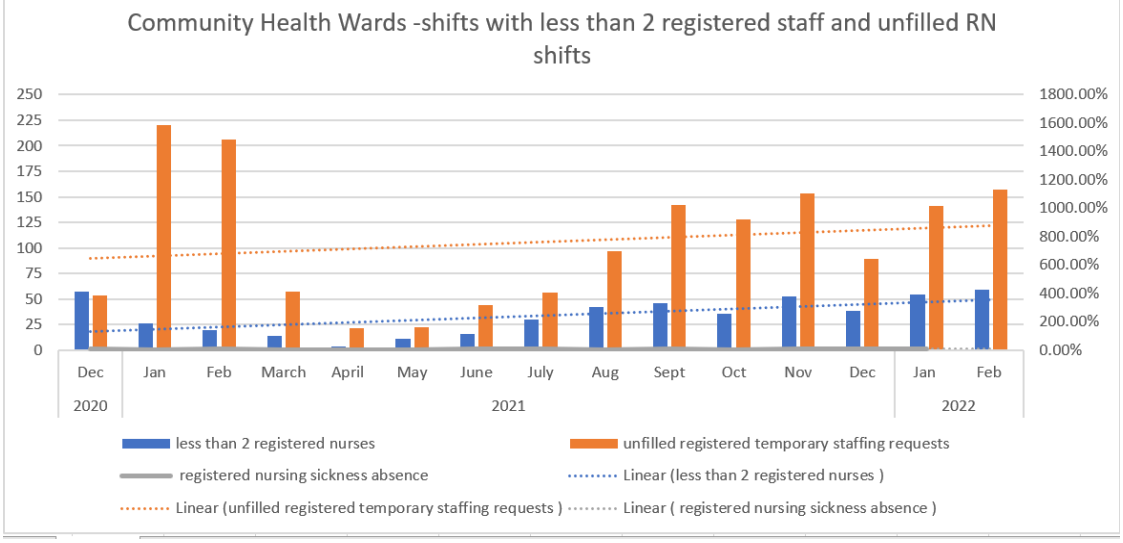
	October		November		December		January		February		March		Total for ward	%
	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night		
Bluebell	17	14	6	9	18	8	29	2	17	8	12	7	**147**	**26.9**
Daisy	47	13	28	10	40	19	19	7	16	1	4	4	**208**	**38.1**
Rose	12	4	25	6	28	10	37	13	30	2	36	3	**206**	**37.7**
Snowdrop	4	10	2	6	10	12	21	12	14	0	26	3	**120**	**21.9**
Orchid	11	5	13	6	12	11	27	15	17	8	12	8	**145**	**26.5**
Rowan	19	9	12	7	2	9	9	15	26	11	9	8	**136**	**24.9**
Sorrel	16	5	6	3	10	12	3	2	1	4	0	4	**66**	**12.1**
Campion	2	0	0	0	0	0	0	0	0	0	0	0	**2**	**0.36**
Donnington	0	0	19	6	1	0	0	2	0	0	3	3	**34**	**6.22**
Highclere	10	10	0	1	11	5	18	6	28	4	19	8	**120**	**21.9**
Oakwood	0	1	0	0	0	1	6	0	0	0	0	0	**8**	**1.46**
Ascot	12	2	17	6	9	10	14	4	13	9	12	4	**112**	**20.5**
Windsor	0	0	1	0	0	2	3	0	4	1	1	0	**12**	**2.19**
Henry Tudor	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**
Jubilee	0	1	0	3	2	5	2	6	0	0	0	0	**19**	**3.47**
Total for month	**224**		**192**		**242**		**272**		**214**		**186**		**1335**	**16.3**

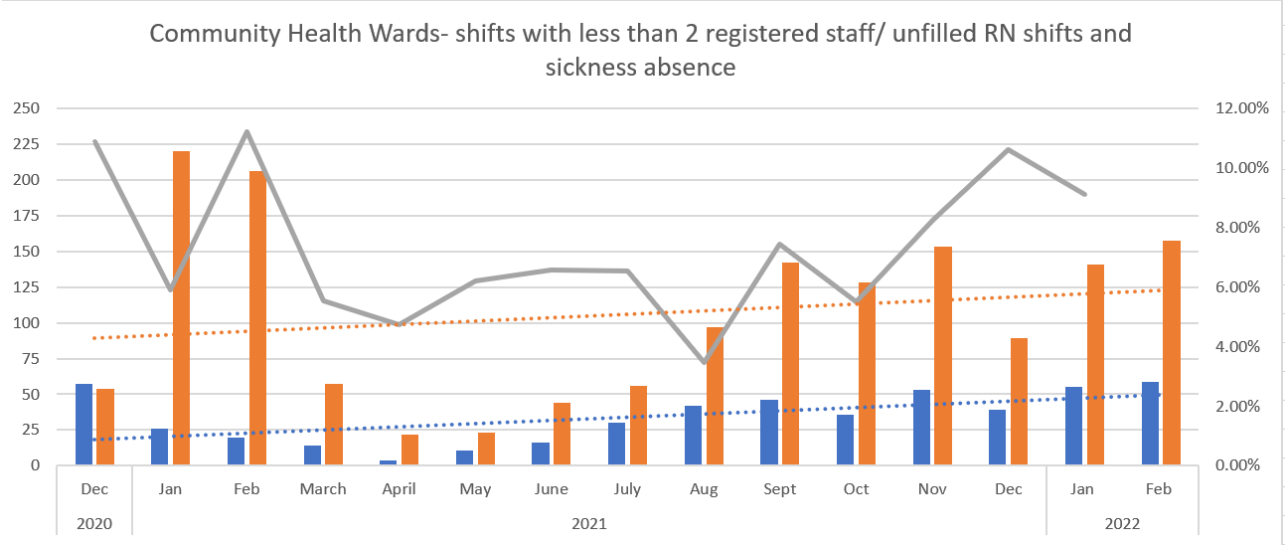
Registered Nursing temporary fill rate and shifts with less than 2 registered staff for Prospect Park Hospital





Registered Nursing temporary fill rate and shifts with less than 2 registered staff for the Community Health Wards.





7.0 Safe Staffing Declaration.

Each month the Director of Nursing and Therapies is required to make a declaration regarding safe staffing based on the available information.

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

7.1 Declaration by Director of Nursing and Therapies and Medical Director.

The current assessment of staffing across the wards demonstrates that establishment alongside temporary staffing, which provides flexibility to meet additional observation requirements would be appropriate. However, during this reporting period, the Covid pandemic has continued to impact on staffing across the organisation with staff sickness and reduced availability of bank and agency staffing causing challenges in addition to the vacancy across our wards. The mental health and community West wards have as a result experienced sub-optimal levels of staffing across this reporting period and staff not calculated within safe staffing numbers including ward managers, clinical leads, matrons, and therapists have all supported wards to ensure that safety has been maintained. The high use of temporary staffing to cover vacancy and absence also means that there is limited assurance that care was always of a high quality, and it is possible that patient experience was compromised.

Adequate medical cover is available during routine working hours for inpatient mental health and community health wards.

Out of hours medical cover is provided by junior doctors for the mental health wards with Consultant Psychiatrists providing on-call cover from home.

8.0 Nursing Associates.

The Nursing Associate (NA) role is a nursing role which has been created due to the inability to recruit enough registered nurses. In addition, it will bridge the skills gap between healthcare support workers and registered nursing professionals. It is seen as offering a range of benefits: working alongside more senior regulated professionals, helping to improve patient care and a career pathway development opportunity. This role is an important part of workforce development within the Trust. Qualified NAs are registered with the Nursing and Midwifery Council (NMC).

There are 22 qualified NAs working in a range of services (community nursing, community mental health teams, community health wards) across the trust. 13 trainee NAs are at different stages of their training across all services from Cohorts 5, 6, 7 and 8. The most recent cohort has 3 students which is an increase from the 1 participant in cohort 7. Work is being undertaken within the trust to continue to encourage suitable applicants for future cohorts.

9.0 Conclusion and next steps.

Staffing on our wards remains a challenge due to continued vacancy, high sickness absence and challenges in securing temporary staffing.

When looking at the care hours per patient day, the SafeCare tool and professional judgement, it is believed that establishments are right to meet optimal levels of care in the Community Health East wards, whilst the Safe Care module indicates staffing to be sub-optimal for the West CHS wards, this is impacted by vacancy and challenges in temporary staffing provision to cover these, the dependency tool used over the 20 day snapshot indicated adequate staffing had all temporary shifts been filled. Staffing will be monitored over the next 6-month period to ensure that the establishment remains appropriate for west community wards.

For our mental health wards the introduction of the safercare tool alongside the deep dive work and the beyond budgeting project will enable further assessment of ward establishments to ensure that establishment alongside flexibility through temporary staffing remains appropriate.

Next Steps

- Work with the PPH Beyond Budgeting project to establish safe staffing requirements on the wards at PPH which incorporates staffing needed for observational levels.

- Participate in the deep dive work with the mental health wards as required.

- Complete staffing review in October 2022 across all inpatient areas using agreed national toolkits.

- Continue with focused recruitment plans which have achieved some positive results in securing new staff. Support the international recruitment and apprenticeship programmes. Support the preceptorship programme to ensure preceptee feel confident to fulfil their role on the wards.

- Use the SafeCare tool to give a more accurate picture of staffing needs across the wards. Continue the implementation of the SafeCare tool to the mental health wards across the Trust.

- Support the Nurse Associate pathway and recruitment post qualifying. Support with any work streams associated with increasing the Nurse Associate programme take up.

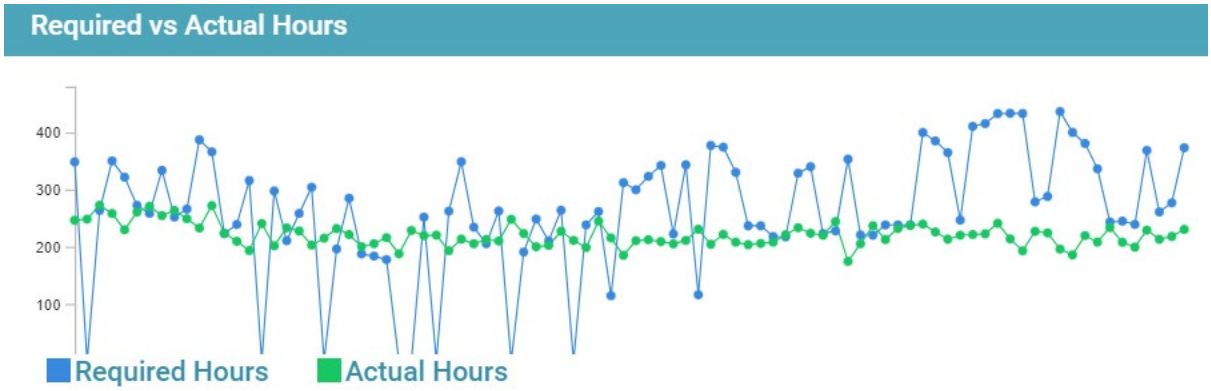
- Implement the newly developed community nursing dependency tool.

Appendix 1.

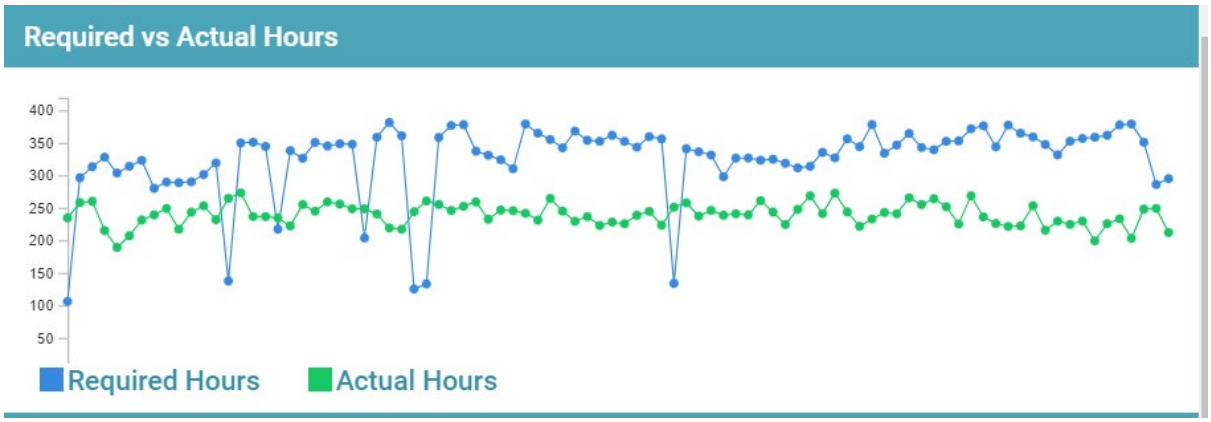
SafeCare data East and West Community Healthcare wards 1st January-31st March 2022.

The SafeCare data for the West and East CHS wards indicates that staffing levels are sub optimal at times. However due to the spikes which are caused by missing data it is difficult to establish the validity of the results. Most of the missing data relates to when the wards were still embedding the SafeCare process. Data entry has improved over the last month and moving forward the data will be more accurate and should give a more accurate picture of whether staffing matches patient dependency and acuity.

Wokingham wards.



West Berkshire Community Hospital wards.



Oakwood ward.

Henry Tudor ward.

Jubilee ward.

NHS
Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10th May 2022
Title	Quality Account 2021/22
Purpose	NHS Foundation Trusts must publish a quality account each year, as required by the NHS Act 2009, and in the terms set out in the NHS (Quality Accounts) Regulations 2010.
	ITEM FOR APPROVAL
Business Area	Trust Wide
Executive Lead	Medical Director
Authors	Head of Clinical Effectiveness and Quality Account & NICE Lead
Relevant Strategic Objectives	All: The priorities reported within the Quality Account align to the Trust Annual Plan on a Page.
CQC Registration/ Patient Care Impacts	Data and evidence to support CQC inspections and improvements in patient care.
Legal Implications	The Board of Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year
Equalities and Diversity Implications	N/A
SUMMARY	This is the 2021/22 report of the Trust's Quality Account for final approval by the Board. The Trust Quality Assurance Committee (QAC) have reviewed the draft report in committee during Q1, Q2 and Q3. The Q4 version has been shared virtually with the QAC at the end of April 2022 for comment, and all required actions identified have been incorporated within this final version. National guidance has been published by NHS Improvement (NHSI), and again this year we are not required to submit the Quality Account as part of the annual report to NHSI or to commission an external audit on the Quality Account. We are still required under legislation to complete a Quality Account in line with Department of Health guidance, and this must be signed in line with the statement of Directors responsibilities, and then published on the Trust website by 30th June 2022. We are required to share the Quality Account with specified stakeholders. The Q3 version of the account was shared at the beginning of March 2022 with Frimley and Berkshire West Clinical Commissioning Groups, Bracknell Forest Council Health and Care Overview and Scrutiny Panel, our Council of Governors and local Healthwatch organisations. The responses received from our stakeholders provide external assurance that support the consistency and accuracy of the information presented in the Quality Account (Appendix F). In line with Department of Health and NHSI requirements the Quality Account consists of three main sections: • Part 1 is the Chief Executive's Statement. • Part 2 is a report on the priorities for improvement and statements of assurance from the Board. This part details:

	○ Our achievement against the objectives of the 2021/22 Annual Plan on a Page ○ Our 2022/23 priorities linked to the Annual Plan on a Page. ○ Mandated Statements of Assurance from the Board, which must cover Clinical Audit, Research, CQUINs, CQC, Data Quality, Information Governance and Learning from Deaths. • Part 3 is a review of quality performance in 2021/22 and must include at least three measures in each of the areas of quality - patient safety, clinical effectiveness, and patient experience. Pages 4 and 5 of the report give a high-level overview of our achievement against our trust priorities for 2021/22, and these are summarised below: Many of the priorities have been met, these are: Patient Experience (Section 2.1.1) • A new patient experience measurement tool called 'I Want Great Care' (iWGC) was launched in December 2021 to advance the way we measure and improve patient experience. • All nationally mandated access waiting time targets that are relevant to the Trust are being met. • Bed occupancy and average length of stay targets are being met on community health wards. The delayed transfers of care target was met on adult mental health wards in 11 of the 12 months of 2021/22. Patient Safety (Section 2.1.2) • We continue to adhere to recommended infection control measures to protect both patients and staff from COVID-19. • The number of category 2, 3 or 4 pressure ulcers due to a lapse in care by trust staff were below the target threshold. • The target for physical health monitoring of patients with severe mental illness (SMI) was met. Clinical Effectiveness (Section 2.1.3) • NICE Guidance compliance remains above 80% • We are participating in all mandated national clinical audits and confidential enquiries. • We continue to progress several initiatives to support local Trust and/or University of Reading led research. • We continue to report on and learn from deaths of patients. Supporting our staff (Section 2.1.4) • Our 2021 National Staff Survey score for staff engagement was 7.4/10 and was one of the highest scores in the country. • Our People Strategy 2021-24 continues to be implemented, with the aim of making the Trust outstanding for everyone. Areas where trust targets are not currently being met are as follows: Patient Experience (Section 2.1.1) • The percentage of patients that rated our services as good or very good in the Friends and Family Test (FFT) is below the 95% target threshold. The response rate for this survey is also low at 3.5% for the year. • The 30-day average length of stay target was not met by Mental Health Inpatients and this service also breached the occupancy target during the

	quarter. Acuity on these wards has been high. Additional beds have been commissioned in the independent sector, and several other pieces of work are ongoing to address this. Patient Safety (Section 2.1.2) • The number of falls on older adult inpatient wards breached the target threshold of 22 per month in all months of 2021/22. Wards experiencing the highest numbers are being supported with coaching by the Quality Improvement team and wider work has involved writing new guidelines on supportive observations and a timelier review of falls by implementing the format recommended by the Royal College of Physicians (RCP). • The number of self-harm incidents on mental health inpatient wards breached the target threshold of 42 in 11 of the 12 months in 2021/22. It is recognised that looking at the numbers of self-harm alone is not a helpful measure as many of our patients use self-harm as a way of coping with difficult feelings and to keep themselves safe. Whilst continuing to review the self-harm data, the division are focusing on reducing the use of restraint to also impact the incidents of self-harm and are involved in workshops with other Trusts looking at how to address this area. Supporting our staff (Section 2.1.4) • The staff sickness rate was above the target threshold of 3.5% during the year. The staff support service is in place to help address this, and a fast-track referral service to physiotherapy has been established for those staff experiencing musculoskeletal (MSK) issues. Board members are asked to note that this version of the Quality Account does not contain full-year incident data from the national reporting and learning system (NRLS) as we are awaiting its national publication. These will be added as soon as they are released and prior to publication on the website in June 2022.
ACTION REQUIRED	The Board is asked to seek any clarification required and approve the 2021/22 Quality Account. Directors are asked to consider the Statement of Directors' Responsibilities in Respect of the Quality Account (page 70), and ensure they are satisfied with the quality account in relation to the requirements detailed in this statement. Directors must confirm to the best of their knowledge and belief they have complied with the requirements detailed on page 70 in preparing the Quality Account, and the statement must then be signed by the Chair and Chief Executive by order of the Board to confirm this. Once approved, the final Quality Account will be published on our Trust Website by the deadline 30th June 2022, thus fulfilling our Statutory duties in this area.

Berkshire Healthcare
NHS Foundation Trust

Quality Account 2021/22

"Our vision is to be recognised as the leading community and mental health service provider by our staff, patients and partners"

What is a Quality Account?

A Quality Account is an annual report about the quality of services provided by an NHS healthcare organisation. Quality Accounts aim to increase public accountability and drive quality improvements in the NHS. Our Quality Account looks back on how well we have done in the past year at achieving our goals. It also looks forward to the year ahead and defines what our priorities for quality improvements will be and how we expect to achieve and monitor them.

About the Trust

We are a community and mental health trust, providing a wide range of services to people of all ages living in Berkshire. To do this we employ approximately 4,500 staff who operate from our many sites as well as out in people's homes and in various community settings.

We deliver joined up physical and mental health services, helping people to remain independent at home for as long as possible and providing the care and support that best meets the needs of our patients, in the most suitable location. From early years to end of life, we offer a wide range of services to keep you and your family well. We also run several specialist clinics and services aimed at young people, adults, and older people to support and treat mental health, physical health, and sexual health conditions.

We have a major focus on the contribution we can make to the local population by working in collaboration with our commissioners and partner providers to identify new ways of working to benefit patients. We work in partnership with Berkshire's two acute hospital trusts, Royal Berkshire Hospital NHS Foundation Trust and Frimley Health NHS Foundation Trust. We also work closely with Berkshire's six local authorities and a diverse range of community and charitable organisations.

The Care Quality Commission (CQC) oversee patient quality and safety and we are rated overall as 'Outstanding' by them. This award supports our wider aim to be a leading provider of mental and physical health service

As a Foundation Trust we are accountable to the community we support. NHS Improvement regulate our financial stability and have given us a financial sustainability risk rating of 4, which is the best rating we could have (they rate from 1 to 4, with 1 being at most risk and 4 being the least risk).

We are also a digital pioneer, having been named by NHS England as a 'Global Digital Exemplar'. This allows us to transform patient care through use of technology.

Contents

Quality Account Summary and Highlights 2021/22

Figure 1- Trust Summary for the 2021/22

Indicator (Click on links to access the related main sections of the report)		2021/22 Target	Results 20/21	Results 21/22	Comment
Patient Experience					
Patient Friends and Family Test- response rate		≥15%	Data collection suspended nationally due to COVID-19	**3.5%******	**Target not met**
Patient Friends and Family Test (FFT) - % of patients stating they rate the service as good or very good	Community services (Mental health and physical health combined)	≥95%		**89%******	**Target not met**
	Mental health inpatients	≥95%		**85%******	**Target not met**
	Community hospital inpatients	≥95%		**92%******	**Target not met**
	Minor Injuries Unit	≥95%		**No Data #**	**No Data #**
Carer Friends and Family Test (FFT) - % of carers rating the service as good or very good		No target set		**96%******	**Target Met**
Managing patient flow- Bed occupancy rate on adult inpatient wards	Adult mental health acute inpatient wards	≤85%	91.9%*	**93.3%****	**Target not met**
	East adult community inpatient wards	≤85%	46.4%*	**75.5%****	**Target Met**
	West adult community inpatient wards	≤85%	83.5%*	**86.9%****	**Target not met, but was met in 10 of 12 mths**
Managing patient flow- Average length of stay on adult inpatient wards	Adult mental health acute inpatient wards	≤30 days	46 days*	**59 days****	**Target not met**
	East adult community inpatient wards	≤24 days	10 days*	**16 days****	**Target met**
	West adult community inpatient wards	≤24 days	21 days*	**22 days****	**Target met**
Patient flow- adult mental health delayed transfers of care		≤7.5%	3.5%*	**8.9%****	**Target not met, but was met in 11 of 12 mths**
Patient Safety					
Number of falls on Older People's Inpatient Wards (Community Inpatient Wards and OPMH Wards		<20 per month	N/A	**33****	**Target not met**
Pressure ulcers (PUs) due to lapse in care by Trust staff	Number of category 2 PUs due to lapse in care by Trust staff	≤19 per year	22***	**18******	**Target Met**
	Number of category 3, 4 unstageable or deep tissue injury PUs due to lapse in care by Trust staff	≤18 per year	10***	**2******	**Target Met**
Self-harm incidents by mental health inpatients		≤42 per month	177*	**95****	**Target not met**
Patients with Severe Mental Illness (SMI) referred to Community Mental Health Teams (CMHT) will have all parameters of the annual physical health check completed within one year of referral to the CMHT		60%	N/A	**79%****	**Target Met**
Patients with Severe Mental Illness (SMI) referred to Community Mental Health Teams (CMHT) will have smoking status recorded within one year of referral to the CMHT		60%	N/A	**81%****	**Target Met**
Clinical Effectiveness					
Compliance with recommendations relating to VTE in NICE Clinical Guideline on COVID-19		≥80%	N/A	**100%**	**Target Met**
Supporting our Staff					
Staff engagement score (National NHS Staff Survey)		≥8 out of 10	7.5***	**7.4******	**Target not met**
Staff sickness level		<3.5%	3.05%*	**4.21****	**Target not met**

*** Figure for Mar 2021 ** Figure for Mar 2022 *** Annual Figure 20/21 **** Annual Figure- 21/22**
 # The Minor Injuries Unit (MIU) have been involved in setting up a new national Patient Reported Experience Measure in their area and have not been collecting FFT data whilst this is being set up.

The figure below gives an overview of highlights for this year. We strive to provide a positive experience for all our patients and staff and, where this is not the case, will continue to learn from these to make improvements.

Patient Experience Priorities

- A new patient experience measurement tool called 'I Want Great Care' (iWGC) was launched to advance the way we measure and improve patient experience.
- Our community health inpatient wards have successfully managed the flow of patients though the service and have kept bed occupancy rates and average lengths of stay for patients to below target thresholds. Adult mental health wards have kept delayed transfers of care to below target thresholds in 11 of the 12 months during the year.

Patient Safety Priorities

- We have met our target of ensuring that at least 60% of patients with severe mental illness that are referred to our Community Mental Health Teams have had all parameters of their annual physical health check completed within one year or referral- 2021/22 result 79%.
- We have met our target of having fewer than 19 category 2 and fewer than 18 category 3 or 4 pressure ulcers (PUs) due to a lapse in care by trust staff during the year- 2021/22 result: 18 cat. 2 PUs, 2 cat. 3, 4 or unstageable PU at the end of Q3.

Clinical Effectiveness Priorities

- We have participated in all applicable national clinical audits, taking actions that lead to improvements.
- We continue to operate a robust system for reviewing NICE guidance to ensure that care is delivered in line with national best practice standards.
- We continue reviewing, reporting, and learning from deaths in line with national guidance.

Supporting our Staff Priorities

- We have published a new People Strategy that has the aim of making the Trust outstanding for everyone
- We continue to embed the principles of a just and learning culture and are already seeing a reduction in the number of full investigations under our disciplinary and early resolution policies.

Care Quality Commission (CQC) Rating

We are rated as "Outstanding" overall by the CQC and all our services are individually rated as either "Outstanding" or "Good".

2022/23 Trust Priorities

Patient Experience Priorities. We will improve outcomes by: Reducing the number of patients waiting for services. Identifying and addressing inequality of access to service. Collecting patient and carer feedback to deliver improvement in services.

Patient Safety Priorities. We will provide safe services by: Protecting patients and staff from COVID-19. Identifying and prioritising patients at risk of harm resulting from waiting times and always ensuring face-to-face care where clinically indicated. Reducing falls, pressure ulcers, inpatient self-harm, and suicides. Recognising and responding to physical health deterioration on our inpatient wards. Improving the physical health of patients with serious mental illness. Strengthening our safety culture.

Clinical Effectiveness Priorities. We will demonstrate our delivery of evidence-based services by: Reporting on the implementation of NICE guidance related to Trust priorities. Continuing to review, report, and learn from deaths in line with new national guidance.

Supporting our People Priorities. We will make the Trust a great place to work by: Ensuring our teams have access to effective health and wellbeing support. Promoting a culture of respect, compassion, and kindness. Not tolerating bullying, harassment, or abuse of any kind. Supporting staff to work flexibly and connect with their teams. Acting on feedback from staff to improve satisfaction and identify inequalities. Providing opportunities for staff to show initiative and make improvements. Supporting staff to achieve their career aspirations.

Part 1. Statement on Quality by the Chief Executive of Berkshire Healthcare NHS Foundation Trust

Berkshire Healthcare continues to deliver effective, safe, and efficient care for our patients. We continue to do this in a way that minimises the risk posed by COVID-19 and can offer this care in a variety of settings. We have also risen to the challenge of delivering the Flu and COVID-19 vaccination programmes this year.

Our priority is that patients have a positive experience of the care we provide. The impact of the pandemic has led to longer patient waits for some of our services and we are committed to managing these service waits. We are also making the best use of technology in the provision of patient care so that our patients can choose to have their assessments in a variety of ways including face-to-face, online, via telephone or through a combination of these methods. We have also introduced a new patient feedback system to make it easier to gather and respond to feedback.

Patient safety continues to be of paramount importance to us and our Trust Board monitors all areas of patient safety through scrutiny of a variety of metrics. Research has shown that people with serious mental illness (SMI) are at a greater risk of poor physical health and have a higher premature mortality than the general population. To address this, we want to ensure that these patients receive a full physical health check within one year of referral to our Community Mental Health Teams. Achievement against this objective is promising so far, and we will continue building on this progress.

Our clinical effectiveness systems ensure that we are providing the right care to the right patient at the right time and in the right place. Our NICE and clinical audit programme allow us to measure our care against current best practice leading to improvement. We continue supporting research studies in a variety of areas to help inform future healthcare.

Our programme of learning from deaths allows us to systematically review the care we have provided to patients who have died and share the learning where it is determined that the patient's care should have been better. This work continues to be scrutinised by our Board and reported publicly.

We have also launched our new People Strategy which has the overall aim of making our Trust a great place to work for everyone. We continue to be rated as Outstanding by the Care Quality Commission, and all our services are individually rated as either outstanding or good. This rating has been maintained thanks to the hard work and effort of all our staff and stakeholders.

The information provided in this report is, to the best of my knowledge, accurate and gives a fair representation of the current services provided.

Julian Emms CEO

(Date after Board sign-off)

Part 2. Priorities for Improvement and Statements of Assurance from the Board

2.1. Achievement of Priorities for Improvement for 2021/22

ⓘ This section details the Trust's achievements against its quality account priorities for 2021/22. These priorities were identified, agreed, and published as part of the Trust's 2020/21 quality account.

These quality account priorities support the goals detailed in the Trust's 2021/22 True North Annual Plan (see Appendix A). The Trust's Quality Strategy also supports this through the following six elements:

- **Patient experience and involvement – for patients to have a positive experience of our services and receive respectful, responsive personal care**
- **Harm-Free Care – to avoid harm from care that is intended to help**
- **Clinical Effectiveness – providing services based on best practice**
- **Organisation culture – patients to be satisfied and staff to be motivated**
- **Efficiency – to provide care at the right time, way, and place**
- **Equity – to provide equal care regardless of personal characteristics, gender, ethnicity, location, and socio-economic status.**

Although the areas of efficiency and equity do not have their own sub sections in this report, please note that they are covered in other sections of the report where it is relevant to do so.

2.1.1. Patient Experience and Involvement

ⓘ One of the Trust's priorities is ensuring that patients have a positive experience of our services and receive respectful, responsive personal care. This sub-section details our performance against our patient experience priorities for 2021/22.

Our 2021/22 Patient Experience Priorities:

Improving outcomes

1. We will reduce the number of patients waiting for our services
2. We will use patient and carer feedback to drive improvements in our services
3. We will manage patient flow effectively and ensure that patients stay within our services no longer than is clinically appropriate
4. We will engage and communicate with patients and the public to make sure that they understand how to access the right help at the right time

Trust performance in relation to complaints, compliments and the National Community Mental Health Survey is also detailed in this section.

Reducing the number of patients waiting for our services and minimising risk of harm to patients resulting from waiting times

ⓘ It is important that patients are seen as quickly as possible following referral to one of our services. This helps to provide the best outcome and experience for the patient. The NHS has set several ambitious waiting time targets to manage this, including those relating to mental health and planned hospital care.

The outbreak of COVID-19 necessitated a rapid response from NHS organisations to reduce the risk that the pandemic posed to us all. This response included only undertaking face-to-face care where it was absolutely necessary to do so and using appropriate personal protective equipment (PPE).

Some clinical teams were able to maintain their service provision by using different methods of care delivery, i.e. through virtual appointments. However, the impact of the pandemic has resulted in the lengthening of waiting times for some of our services, and it is therefore important that these are reduced. It is also important that mitigating actions are implemented to maintain the safety of patients where they are having lengthy waits.

Overview of Trust performance against current mandated access targets for patients during 2021/22
Trust performance against nationally mandated access targets is as follows.

	Target wait time	Met by trust?
Community Paediatrics	< 18 weeks	Yes
Diabetes Outpatient Service	< 18 weeks	Yes
Audiology diagnostics	< 6 weeks	Yes
A&E (MIU)	< 4 hours	Yes
IAPT- Assessment	< 6 weeks	Yes
IAPT Treatment	< 18 weeks	Yes

Details of further initiatives carried out by services to manage their waiting times can be found in the 'Other Service Improvements' section of this document.
We acknowledge families in Berkshire have to wait a long time for assessment for Autism and ADHD for children and young persons referred to our Child and Adolescent Mental Health Service. The service is actively working to resolve this through significant new investment; demand, capacity, and transformation modelling; and an ongoing recruitment campaign. More detail on these steps is given in the Service Improvements section later in this report.

Using patient and carer feedback to drive improvements

One of the Trust's priorities is to use patient and carer feedback to drive improvements in our services. We use several methods to achieve this, including the Friends and Family Test, learning from complaints and the national community mental health survey. The sections below detail how we have performed during the year in this area.

I want Great Care
A new Patient Experience Measurement Tool called 'I Want Great Care' (iWGC) was launched in December 2021 and is being introduced across the whole organisation. The aim of the tool is to measure patient experience in a standardised way across all teams and services within the organisation, and for this data to be available to teams and services in real time, supporting understanding of patient experience and improvement activity. The experience data collated can be viewed not only at organisational and service level but also by differing demographics meaning that we can see if there is inequality of experience by protected characteristics.

The tool uses a 5-star scoring system as an overview, as well as free text to capture the patients overall experience alongside their experience around facilities, staff, information, feeling listened to, ease, involvement, and safety. Free text invites the patient to comment on both their experience and suggested improvements. The tool also includes the friends and Family test questions to enable continued reporting of this.

Patient Friends and Family Test (FFT)

ⓘ The Friends and Family Test (FFT) is used by most NHS funded services in England. It supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. The FFT asks people if they would recommend the services they have used, and can be completed by text messaging after discharge, by card or on the internal Trust patient survey.

Data submission and publication for the Friends and Family Test was paused during the response to COVID-19 and therefore results are not available for the 2020/21 financial year.

In 2021, the question asked in the Friends and Family test was changed to "Overall, how was your experience of our service." Respondents are asked to rate the service on a scale from "Very Good" to "Very Poor."

Response Rate

Figure 2 below demonstrates the response rate for 2021/22 and shows that a rate of 3.5% was achieved overall for 2021/22.

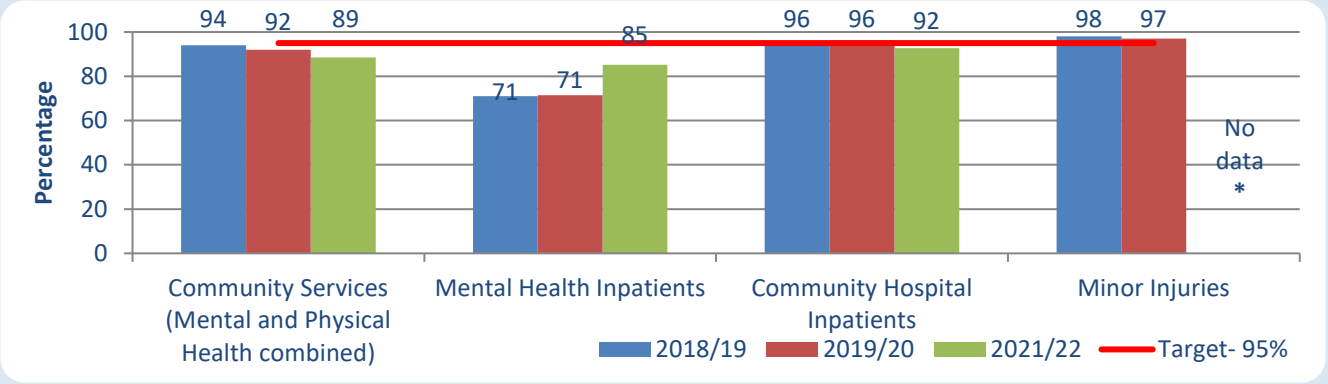
Satisfaction Rate

Figures 3 and 4 below demonstrate the Trust's achievement in relation to this target by showing the percentage of respondents stating that they were extremely likely or likely to recommend services (prior to 2021) or rate the service as good or very good (2021 onwards). The figures show that the target 95% rate has not been met during the year.

Figure 2- Response Rate for Patient FFT

2021/22 Quarter	Q1	Q2	Q3	Q4	2020/21 Full Year
% Response Rate	5.7%	6.0%	4.5%	0.5%	3.5%

Figure 3- Patient Friends and Family Test (FFT): Percentage of patients extremely likely or likely to recommend the service to a friend or family member (prior to 2021) or rate the service as good or very good (2021 onwards)- Target 95%



** The Minor Injuries Unit (MIU) have been involved in setting up a new national Patient Reported Experience Measure in their area and have not been collecting FFT data whilst this is being set up.*

Figure 4- Patient Friends and Family Test- total number of responses

Survey and Service	2019/20			2021/22		
	Total no. of respondents	Respondents likely or extremely likely to recommend service		Total no. of respondents	Respondents likely or extremely likely to recommend service	
		No.	%		No.	%
Community Services- Mental Health & Physical Health Combined	44515	40828	92	18625	16553	89
Mental Health Inpatients	920	654	71	110	94	85
Community Hospital Inpatients	621	594	96	591	545	92
Minor Injuries Unit	715	694	97	0	0	No data

Source for figures: Trust Patient Experience Reports. No data for 20/21 as FFT paused during the response to COVID-19

Carer Friends and Family Test (FFT)

ⓘ The Friends and Family Test for carers asks if carers would recommend Trust services. Whilst this is not mandated nationally, the Trust recognises the crucial role that carers have and the value of their feedback.

Figures 5 and 6 below demonstrate the Trust's achievement in relation to the Carer Friends and Family Test.

Figure 5- Carer Friends and Family Test: Percentage of carers extremely likely or likely to recommend the service to a friend or family member (pre-2021) or rating the service as good or very good (2021 onwards)

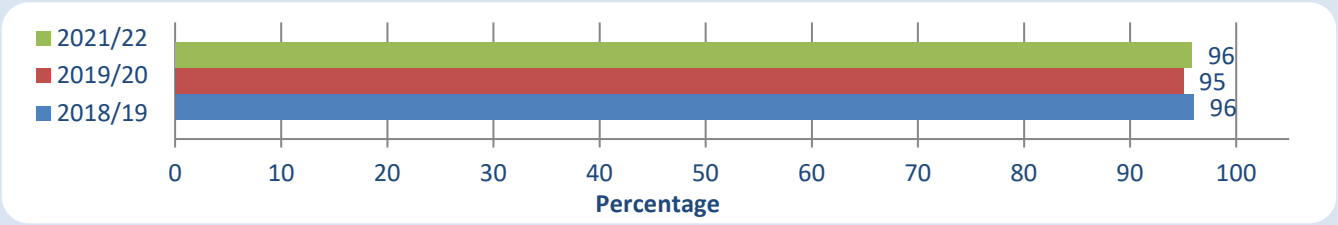


Figure 6- Carer Friends and Family Test- total number of responses

Survey and Service	2019/20			2021/22		
	Total no. of respondents	Respondents likely or extremely likely to recommend service		Total no. of respondents	Respondents likely or extremely likely to recommend service	
		No.	%		No.	%
All carers	1473	1404	95	192	184	96

Source for figures: Trust Patient Experience Reports. No data for 20/21 as FFT paused during the response to COVID-19.

Learning from Complaints and Compliments

The Trust has continued to respond to and learn from complaints and compliments. Figures 7 and 8 below show the monthly number of complaints and compliments received by the Trust.

During Quarter four 2021-22 there were 56 complaints received (including re-opened complaints), the same number as in Q4 of 2021-22. 231 complaints were received during the whole of 2021/22.

29 (52%) of the 56 complaints received in Q4 2021/22 related to adult mental health service provision. Of these complaints:

- 9 related to Community Mental Health Teams (CMHT)
- 7 related to mental health inpatient wards
- 4 related to Crisis Resolution and Home Treatment Teams (CRHTT)

The remaining mental health complaints were spread across other services.

14 (25%) of the 56 complaints related to adult community health services. Of these complaints:

- 5 related to community hospital inpatients
- 2 related to the Westcall GP Out of Hours Service
- 2 related to rapid response

The remaining community health complaints were spread across other services.

13 (23%) of the 56 complaints related to Children's, Young Peoples and Families Services (CYPF). Of these complaints:

- 10 related to Child and Adolescent Mental Health Services (CAMHS)
- 3 related to children's physical health services

Each service takes complaints seriously, with staff directly involved being asked to reflect on the issues raised and consider how they will change practice. Examples of improvements have included ensuring both parents are documented in a child's clinical record; ensuring that staff attend new syringe driver training; revising a welcome pack; and ensuring that staff receive training on frailty scores. In addition, as part of the safety culture work, the Head of Service User Engagement and Experience is leading a project looking to understand the experience, challenges, and

pressures of being an Investigating officer for complaints.

99% of complaints were acknowledged within three working days during 2021/22, with 100% resolved within the timescale agreed with the complainant. Please also note that the number of complaints, together with response and resolution times is included within section 3 of this report as they are indicators of quality.

***Figure 7- Complaints received* (excluding re-opened complaints)**

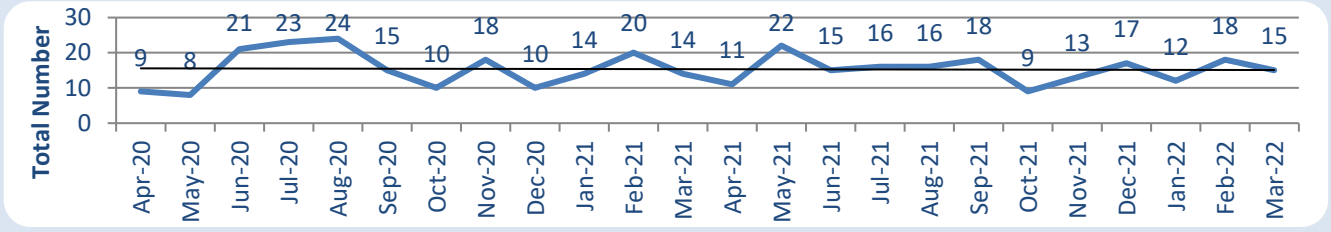
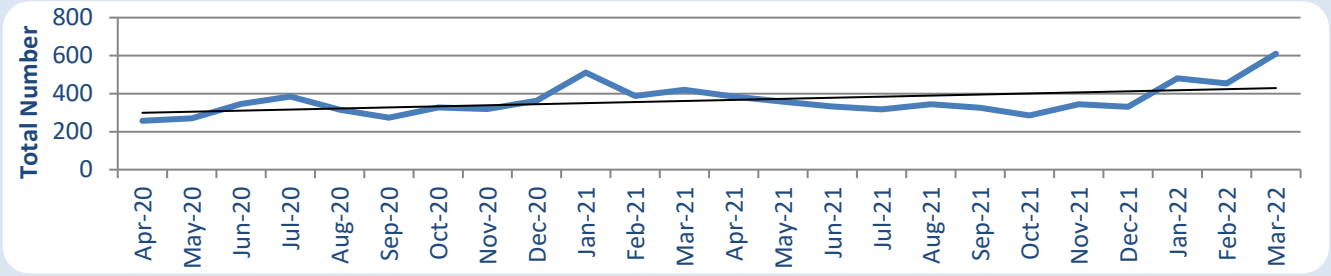


Figure 8- Compliments received



Sources: Trust Complaints and Compliments Reports- this is based on compliments being submitted voluntarily by service

National NHS Community Mental Health Survey

ⓘ The National Community Mental Health Survey is undertaken annually to ascertain the experiences of people that receive specialist care or treatment for a mental health condition. Feedback from people about their experiences of these services is crucial in highlighting good care and in identifying risks to service quality

The survey sample. People aged 18 and over were eligible for the survey if they were receiving care or treatment for a mental health condition and were seen face to face at the trust, via video conference or telephone between 1 September 2020 and 30 November 2020. Responses were received from 327 (27%) respondents, compared to a national response rate of 26%. The Trust response rate was the same as in the previous year.

About the survey and how it is scored. The survey contained several questions organised across 12 sections. Responses to each question and section were converted into scores from 0 to 10 (10 representing the best response). Each score was then benchmarked against 53 other English providers of NHS mental health services, resulting in the Trust being given a rating for each question and section on a five-point scale ranging from "much better" to "much worse" than expected.

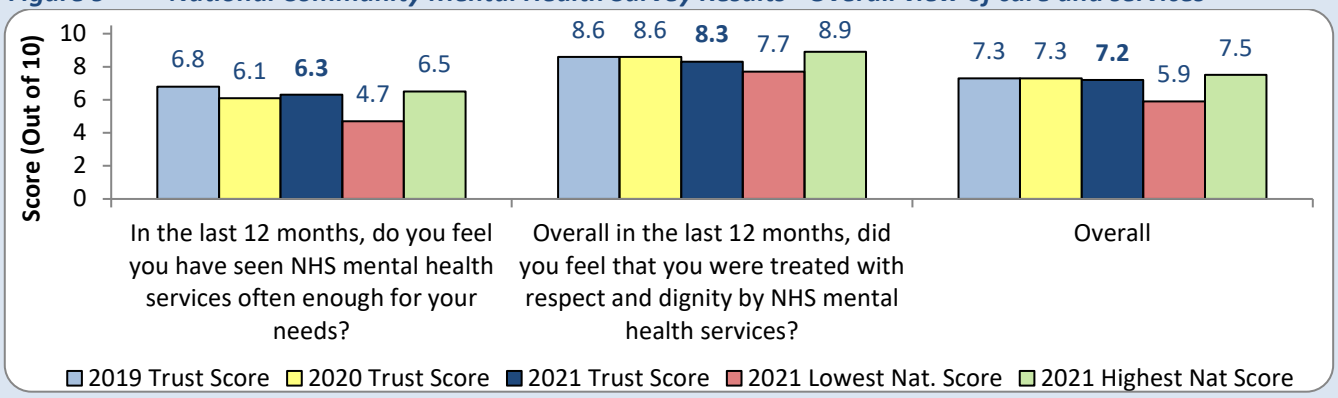
Summary of Trust results. In the 2021 survey, the Trust was rated "about the same" as the 53 other Trusts for 11 of the 12 sections, with no section scores being worse than or much worse than expected. The Trust scored "Better than Expected" for the "Feedback" section, although scores for this section were generally low for all Trusts.

Respondents' overall view of care and experience

Figure 9 gives an overview of Trust scores for overall experience. The 2021 Trust scores (shown by the dark blue bar in the middle of each question) are compared with the highest and lowest scores achieved by all Trusts (the red and green bars to the right of the dark blue bar), and with the Trust scores in 2019 and 2020 (the light blue and yellow bars to the left).

These survey results have been shared with clinical leads to share with their teams and to identify any further actions that would have a positive impact.

Figure 9- National Community Mental Health Survey Results - Overall view of care and services



Managing Patient Flow in Adult Inpatient Services

ⓘ It is important to manage patient flow through our inpatient wards effectively to ensure that patients stay on our wards no longer than clinically appropriate with minimal delays.

Work undertaken to improve flow in adult inpatient services include the following:

In West Community Health Services:

- A system-wide Urgent and Emergency Care Board has been set up to improve the flow of patients and to speed up transfers to our wards.
- As part of the Hospital Discharge Service (HDS) requirements for COVID-19, a team has been placed in the acute hospital to facilitate the timely discharge of patients to the range of options in the community. These options include discharging a patient home with an intermediate care package in place, discharging to a community bed, or discharging to a care home placement. The Discharge Service Team operate with a live list of patients ready to leave the acute setting and facilitate twice daily calls with all services involved to ensure plans are in place to transfer patients on the day they become fit for discharge. A collaborative review of the processes put in place during the initial COVID-19 period is now underway with systems partners to ensure opportunities for continuous service improvements are identified, but recognising that the National funding for this scheme has now ceased
- Admission and Discharge Coordinators on trust in–patient units manage the flow of patients into and out of our beds with support from the medical and nursing team. Our wards operate daily board rounds to ensure that we do not miss an opportunity to plan for and progress a discharge. As part of an enhanced service to manage COVID-19 we have been able to offer 7-day coordinators on our in-patient units to support the HDS team in transferring patients to the wards. The community wards are now working to mirror the discharge pathway approach implemented in the acute hospital. Additional dedicated transport arrangements were put in place for the winter period to support the timely discharge of patients from community wards to their onward destination, but this has now ceased.
- Clear escalation points to senior leads are in place to support with any potential delays.
- System- wide scorecard measures have been developed to assess the effectiveness of our rapid community discharge arrangements.
- The development of a live list of patients waiting to leave the acute and community hospitals is currently being developed.
- Community hospital utilisation is being reviewed with a view to amending the admission criteria to maximise the effective flow.
- Social distancing beds have been reduced across the community wards with just 3 beds retained to support admissions from home.

In East Community Health Services:

- In-reach teams offer a 7 day a week service to support discharge from our acute partners. This team works the discharge teams and frailty teams. Patients are also signposted to the right services both within and outside the trust.
- Twice-daily Consultant-led board rounds are undertaken using a Multidisciplinary Team (MDT) approach with representation from pharmacy,

therapists, nursing, management, and social workers. Virtual access to these is available
- Clear escalation points to senior leads are in place to support with any potential delays, including an on-call manager at the weekends.
- Length of stay and delays remains below 11 days for both wards during the pandemic
- Medical input and Advance Nurse Practitioners are available from 8am- 8pm 7 days per week with senior reviews of each admission- all clerked and assessed by the ward team. Expected discharge dates are agreed and medical treatment plans are in place and discussed at all board rounds. There is now less reliance on Out of Hours GP services and reduced referrals back to Wexham Park Hospital due to deterioration.
- Consultants review every patient daily including at weekends.
- Therapy cover is in place 7 days per week with rehab goals and discharge planning starting immediately on admission. Home assessments can be completed and home visits/checks on discharge if required.
- Community referral pathways to our inpatient units are now in place to help acute admission avoidance.
- A GP hotline is now available for GPs and South-Central Ambulance Service partners to have direct access to community Geriatricians.

Achievement against this priority is measured with reference to three indicators:
- Adult inpatient bed occupancy. Target- no more than 85% bed occupancy
- Average patient length of stay on adult inpatient wards. Targets: No more than 30 days on Adult Mental Health inpatient wards. No more than 24 days on adult community health inpatient wards. Please also note that West Berkshire Community Hospital has eight neuro-rehabilitation beds with a target length of stay of 42 days, and so this will impact on this figure.
- Delayed transfers of care for mental health inpatient wards- this occurs when a patient is ready for discharge and is still occupying a bed. Target- no more than 7.5%.

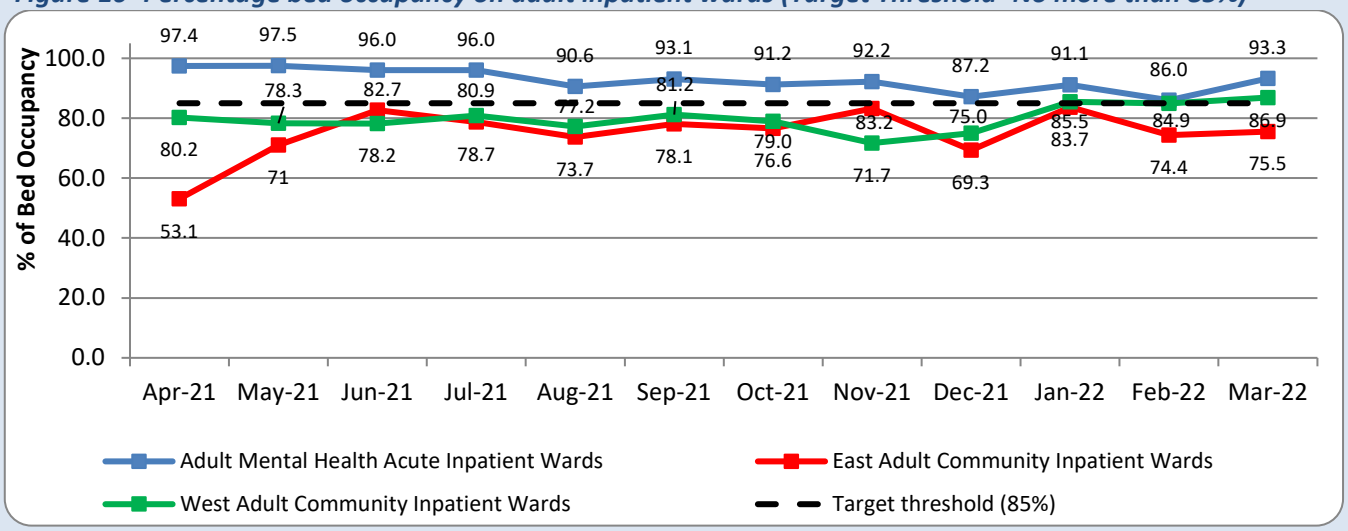
Figures 10 to 12 below detail achievement against these targets.

Adult Mental Health Inpatient wards continue to meet the delayed transfers of care targets (except in March 2022) during the year but have not met the bed occupancy or length of stay targets. Additional beds have been commissioned in the independent sector to support timely admission to an appropriate inpatient bed and ensure we are able to deliver on the continuity of care principles. Acuity on the mental health in-patients' wards has been high, impacting on length of stay and occupancy. Most Trusts across the country are now pre- commissioning beds in the independent sector and as a result, both locally and nationally, access to beds can be challenging. An increase in the incidents of COVID on the ward have also impacted on bed availability. Bed state, admission and discharges are managed by the bed management team at Prospect Park Hospital. Daily meetings are held with ward managers to look at priorities and where the blocks are. There is a fortnightly meeting held for those patients who have stayed over 60 days to review their care and any actions that need to be taken. A project plan has also been developed across mental health services in Berkshire to improve flow throughout the system. This project has several different workstreams for example, delayed discharges of people with Psychosis, Psychiatric Intensive Care Unit (PICU) referral and stepdown, Emotional Unstable Personality Disorder (EUPD) inpatient offer, anticipatory care plans and proactive discharge planning meetings. Post admission liaison meetings continue to be held to identify those patients that may be at risk of longer stays and to address this at the start of the admission. These work streams continue and a regular bed optimisation meeting for oversight of the progress.

Community Inpatient services in the east of the county met all their monthly bed occupancy and length of stay targets during the year. West community inpatient services breached their bed occupancy targets in January 2022 and March 2022 and breached their average length of stay target in six of the twelve months during the year. The Length of stay in Berkshire West is likely to be impacted by both the increasing complexity of patients being referred to the wards and a reduction in the availability of therapy staff available to work at weekends. 7-day working was introduced using existing in-patient and musculoskeletal (MSK) therapists during the pandemic period, but this can only be continued with permanent additional staff to service a weekend roster. Confirmation of funding is awaited prior to substantive recruitment.

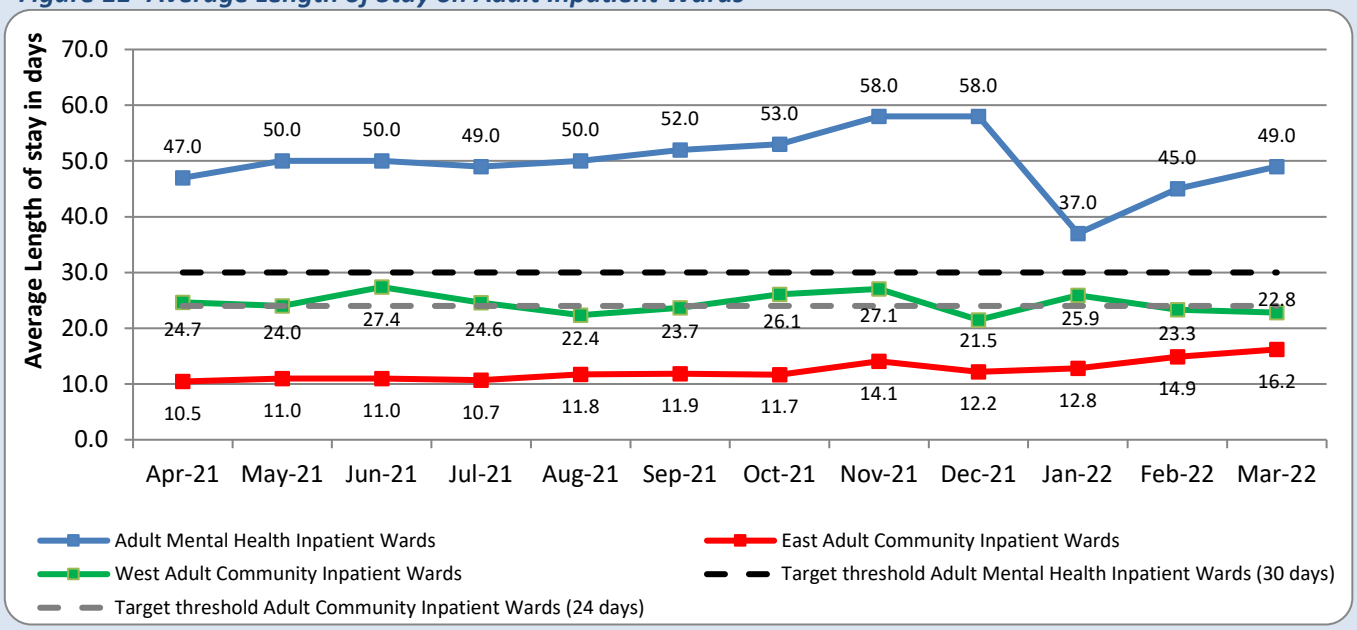
East Community Inpatient services also monitor the number of discharged patients with a length of stay over 28 days. During 2021/22 26 patients were discharged following a length of stay greater than 28 days.

Figure 10- Percentage bed occupancy on adult inpatient wards (Target Threshold- No more than 85%)



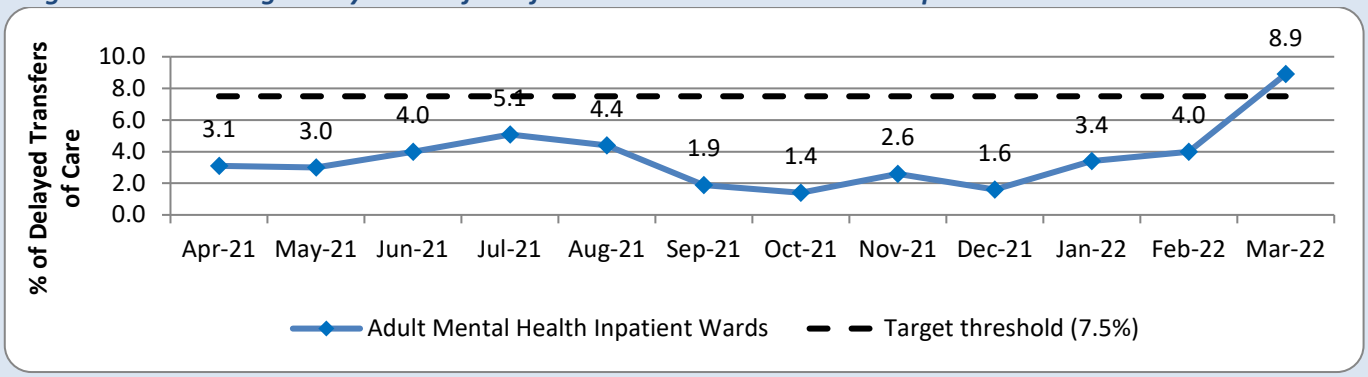
** Non-acute mental health inpatient wards include Older Adult Mental Health Wards*

Figure 11- Average Length of Stay on Adult Inpatient Wards



*Please note that West Berkshire Community Hospital has eight beds for Neuro-rehabilitation patients with a target length of stay of 42 days which will have an impact on the West Adult community Inpatient ward figure above

Figure 12- Percentage delayed transfers of care on Adult Mental Health Inpatient Wards



Sources for Data- Trust performance reports on Tableau

Engaging and communicating with patients and the public to make sure that they understand how to access the right help at the right time

ⓘ It is important that our patients can access the right help from our services at the right time. Services such as our Patient Advice and Liaison Service (PALS) as well as our engagement with local Healthwatch organisations help to facilitate this

PALS has continued to provide a signposting, information, and support service throughout the pandemic response.

PALS has continued to facilitate the 'Message to a loved one' service, collating messages for patients, which are then delivered on the ward. This was available across all inpatient areas. The PALS Manager continues in the roles of Freedom to Speak Up champion and Armed Forces Service Network champion.

There were 518 queries recorded during Quarter 4 of 2021/22. 444 were responded to within 5 working days and 5 were taken up as a formal complaint. In addition, there were 284 non-Berkshire Healthcare queries.

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 our communities. We asked Healthwatch Wokingham, Healthwatch Reading and Healthwatch West Berkshire to conduct service user research about its Ageing Well services; 2hr Urgent Community Response and 2 Day Community Rehabilitation. The aim was to get an overview of care whilst accessing the Ageing Well services and how our patients felt about their experience. A report on this has been produced.

2.1.2. Harm-Free Care

ⓘ We aim to prevent errors in healthcare that can cause harm to patients. These errors are rarely the fault of individuals, but are usually the result of problems with the systems staff work in. Regardless, NHS patients should be treated in a safe environment and be protected from avoidable harm.

Our 2021/22 Harm-Free Care Priorities:

Providing safe services

1. We will protect our patients and our people from getting COVID-19 by using appropriate infection control measures
2. We will minimise risk of harm to patients resulting from waiting times.
   Please note that this area is covered within the section on reducing waiting times in the Patient Experience section above
3. We will continue to reduce falls, pressure ulcers, self-harm in in-patient services and suicide across all our services
4. We will recognise and respond promptly to physical health deterioration on our in-patient wards
5. We will improve the physical health of people with severe mental illness
6. We will strengthen our safety culture to empower staff and patients to raise safety concerns

The Trust's aim throughout the year has been to foster an environment where staff members can be confident to raise concerns about patient safety. In support of this, a 'Freedom to Speak Up' policy has been implemented, and this is described further in Section 2.1.4- Supporting our staff. The Trust is also signed up to the 'Sign up to Safety' pledges and through this has committed to put safety first, continually learn, be honest and transparent, collaborate in learning, and support staff to help them understand and improve on when things go wrong. Learning occurs across the organisation with respect to errors, incidents, near misses and complaints. The Trust has continued to engage with and contribute to cross organisational initiatives such as the regional patient safety collaborative.

Protecting our patients and our people from COVID-19

ⓘ It is vitally important that our patients and staff are protected from COVID-19. The trust has stringent infection control practices in place, and these have been enhanced to manage the coronavirus risk

Examples of additional resources and guidelines that have been put in place to protect patients and staff from COVID-19 include the following:

- A Standard Operating Procedure is in place for placement of COVID-19 Inpatients. This includes advice on management of isolation, cohorting and stepdown of isolation. Guidance on screening, in line with national guidance, is in place. National guidelines and updates are reviewed and implemented.
- Guidance for community and outpatient settings.
- Resources for staff are available on the trust COVID intranet page and are disseminated to clinical teams and via newsletters. Resources are regularly reviewed and updated. Links to information include:
  - Self-isolation (Test and Trace)
  - Staff testing including lateral flow testing requirements
  - Staying safe at work
  - Staff risk assessments in place for all staff
  - Staff wellbeing programme and support
  - PPE videos for donning and doffing
  - Social distancing in the workplace
  - Staff vaccination
- Review and overview of stock levels and supply of Personal Protective Equipment (PPE) is undertaken by the Deputy Director of Nursing and by the Estates and Facilities Management team.
- Infection Prevention and Control (IPC) Team training videos and resources have been produced for induction and mandatory training. Development of an IPC resource pack has been disseminated to staff and is available on the Trust intranet.
- All-staff briefings. This is a live broadcast which is also published on Teams and includes a live question and answer aspect to support practical application of guidance.
- Service visits are carried out by the IPC team, Director of Nursing, clinical directors, and divisional managers to support implementation of guidance
- Visiting guidelines have been updated
- Supporting guidelines are available for managers
- Guidance on the use of face masks is available for all staff in non-clinical areas as well as face coverings for visitors / outpatients
- Messaging around social distancing is reinforced in teams live events, newsletters, and other communication channels.
- Alternative space is provided to non-clinical staff who need to be in work to support social distancing
- Risk assessment tools for outpatients and non-clinical areas have been produced to assess returning to 1-metre social distancing

The Trust is monitoring these measures in several ways:

Trust Wide assessment. At an organisational level, the Trust has completed and updated a Trust-wide Infection Prevention and Control Board Assurance Framework (BAF). This framework has been produced nationally by NHS England to support all healthcare providers to effectively self-assess their compliance with Public Health England (PHE) and other COVID-19-related infection prevention and control guidance and to identify risks leading to improvement in this area. It is a live document and is reviewed by the trust Board and several forums within the Trust. Risk assessments support review and application of Hierarchy of Controls. A COVID-19 clinical reference group continues to meet bi-weekly.

Service-level assessment. To help individual services meet the required guidelines, the Trust have developed service specific risk assessments and Infection Prevention and Control COVID-19 compliance tools. These tools are completed monthly on every ward and service, with the frequency of completion increased during outbreaks and in areas of high incidence. The tools cover the areas of:

- Hand Hygiene
- Environmental Decontamination
- Decontamination of patient equipment
- Personal Protective Equipment (PPE)
- Care of patients with confirmed or suspected COVID-19

Action plans are completed and implemented because of these assessments which are reviewed by service leads and clinical directors. Learning is shared from incidents and services use handovers and team

meetings to update on changes. An action plan is in place for implementation of 'Every Action Counts' supportive resources.

Individual Staff PPE Competence Tools are completed for every member of staff that is required to wear PPE. The results of these are held at service level and ensure that all staff can wear PPE correctly to reduce the risk of infection. Staff are undertaking individual sign-off within services.

Hand Hygiene audits are completed by all inpatient services monthly and all community services on a quarterly basis. This audit is designed to ascertain whether, over a designated period, healthcare workers have adequately decontaminated their hands. The audit is undertaken opportunistically without the staff members knowing that the observation is being undertaken. Specific observations are made; before patient contact, before aseptic task/ clean task, after body fluid exposure risk, after patient contact, after contact with the patient's surroundings and ensuring staff are bare below the elbow. Where scores are below 80% staff are required to ensure action is taken within their areas to improve compliance prior to the next report. Figure 13 below details the findings from this audit during the year.

Figure 13- Hand Hygiene Audit Results

Area	April	May	June	July	August	September	October	November	December	January	February	March
Jubilee	100%	100%	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%
Henry Tudor	100%	100%	100%	100%	100%	100%	96%	94%	98%	78%		98%
Pheonix House	94%	100%	98%	96%	100%		100%	92%	100%	80%	83%	93%
Woodlands Childrens Respite	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Ascot	100%	100%	90%	90%	100%	92%	98%	100%	96%	100%	91%	96%
Windsor	100%	99%	100%	98%		100%	100%	100%	100%	100%	100%	100%
Donnington	100%	100%	100%	90%	91%	100%	100%	100%	100%	100%	100%	100%
Highclere	100%	100%	100%	100%		100%	100%	100%	100%	100%	100%	100%
Oakwood	100%	100%	100%	84%	91%	97%	100%	81%	100%	100%	100%	100%
Campion	100%	100%	100%	100%	100%	100%		100%	100%	100%		100%
ECT	100%		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Bluebell	100%	96%	94%	90%	100%	95%	100%	100%		100%	100%	100%
Daisy		100%	100%	100%		100%	100%	100%	100%	100%	100%	
Orchid	100%	100%	100%	100%	100%	100%	95%	100%	100%	100%	100%	
Rose	100%		100%			83%	75%	86%	90%	100%	90%	91%
Rowan	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Sorrel	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Snowdrop	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Place of saftey				100%		100%	100%	100%	100%	100%	100%	100%

Source- Infection Prevention and Control Monthly Reports

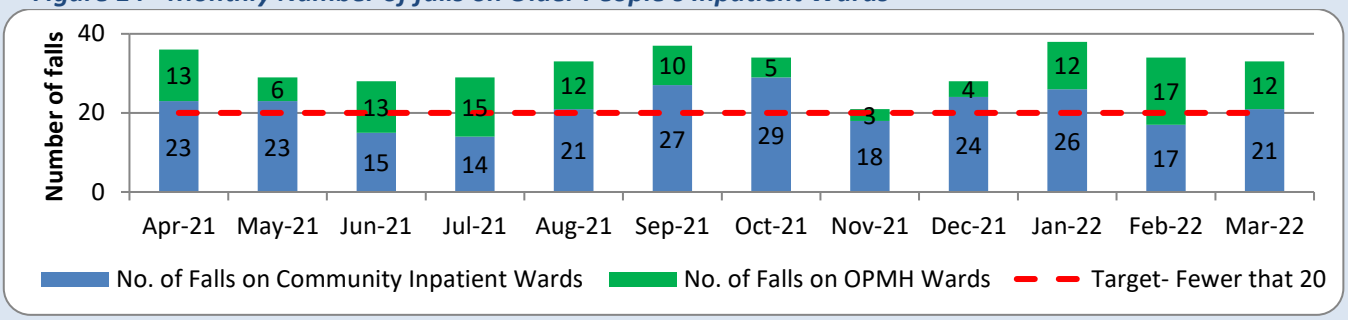
Reducing Falls on Older People's Inpatient Wards

ⓘ The Trust considers prevention of falls a high priority. The Royal College of Physicians reports that falls are the most reported type of patient safety incident in healthcare. Although most people falling in hospital experience no or low physical harm (such as minor cuts and bruises), others suffer severe consequences, such as hip fracture, head injury or, on rarer occasions, a fall will be fatal (falls are the commonest cause of death from injury in the over 65s). The personal consequences of a fall for the individual can be significant and even 'minor' falls can be very debilitating.

The Trust has set a priority to reduce falls on its community inpatient wards and older people's mental health inpatient wards to no more than 20 falls per month. Figure 14 below details achievement against this target and shows that it has not been met this year. Consideration is also now also being given to the level of harm experienced because of each fall to inform future improvement work.

To support the ongoing focus on reducing the number of inpatient falls, the wards experiencing the highest numbers are being supported with coaching by the Quality Improvement team to utilise all the QI tools available. Wider work has involved writing new guidelines on supportive observations and a timelier review of falls by implementing the format recommended by the Royal College of Physicians (RCP).

Figure 14- Monthly Number of falls on Older People's Inpatient Wards



Source for figure: Trust QPEG Falls Reports. Please note that patients may fall more than once, and this figure represents the total number of falls and not the total number of individual patients that have fallen.

Preventing Pressure Ulcers

ⓘ Pressure ulcers, sometimes known as 'bed sores' or 'pressure sores', are damage to the skin and underlying tissues caused by pressure or pressure and friction. They can range in severity from a red patch or blister to a complex open wound. Pressure ulcers are graded from 1 (superficial) to 4 (most severe).

The Trust has set two targets to prevent pressure ulcers in 2021/22:

1. To have no more than 19 grade 2 pressure ulcers due to a lapse in care by Trust staff
2. To have no more than 18 grade 3 or 4, unstageable or deep tissue injury pressure ulcers due to a lapse in care by Trust staff

In pursuance of this target, the Trust has continued to ensure that all clinical staff have had relevant training in pressure ulcer prevention and management. All developed pressure ulcers of category 3 and 4 that are potentially due to a lapse in care are discussed at a learning event following a desktop review. This is to investigate whether there is anything that could have been done differently to help prevent the skin damage, or to identify where improvements in the care we provide can be made. All category 2 pressure damage are reviewed by the handler and finalised by the patient safety team. Thematic reviews are held on a quarterly basis to enable learning opportunities.

Figures 15 and 16 below detail progress against these targets and show that there have been 18 category 2 and 2 category 3, 4 unstageable or deep tissue injury pressure ulcers due to a lapse in care by trust staff declared during the year.

It should also be noted that during 2020/21, following review, the number of category 3 or 4 pressure ulcers with a lapse in care has increased to 10 across all localities, both inpatients and the community. This is an increase on the number that were originally reported in the 2020/21 Quality Account (3 cases) but still below the threshold of 18 for the year.

Figure 15- Developed Category 2 Pressure Ulcers due to a Lapse in Care

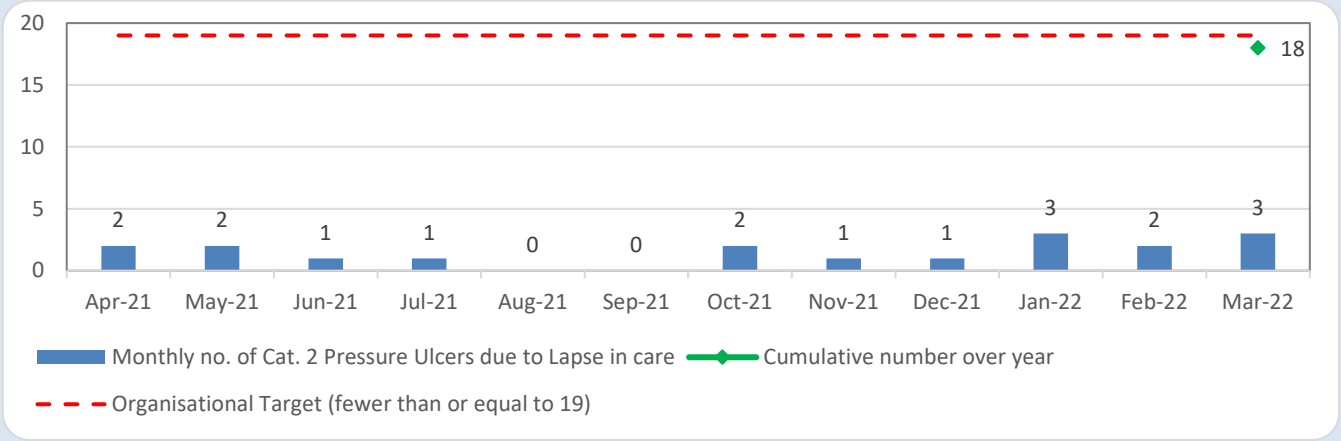
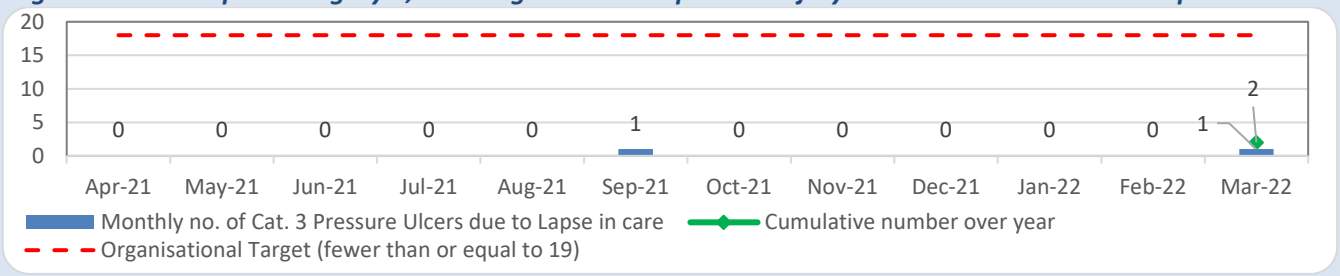


Figure 16- Developed Category 3, 4 unstageable or deep tissue injury Pressure Ulcers due to a Lapse in Care



Source for both figures: Trust Quarterly Pressure Ulcer Report

Reducing Self-Harm Incidents on Trust Mental Health Inpatient Wards

ⓘ Self-harm is when an individual intentionally injures themselves as a way of dealing with or expressing overwhelming emotional distress. It is sometimes carried out when individuals feel they have no other option.

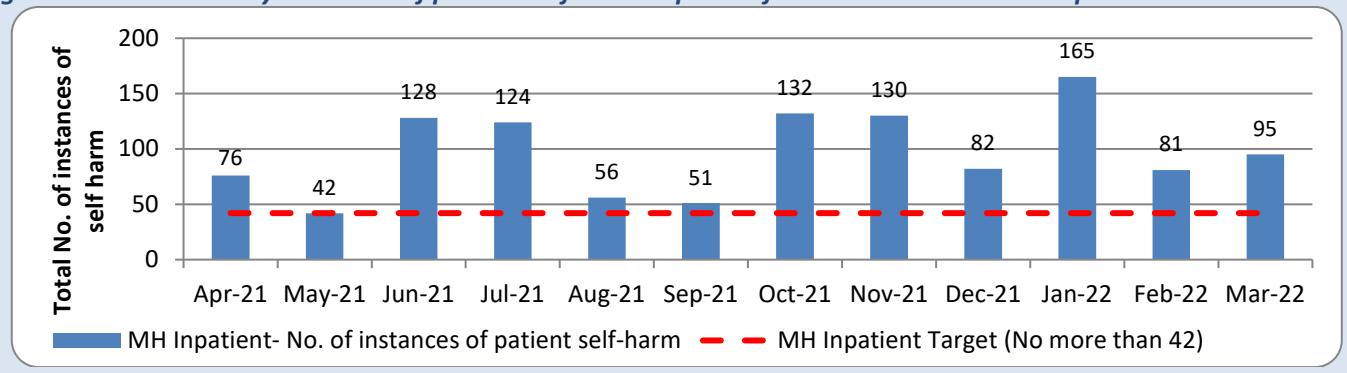
Two of the adult mental health wards are using Quality Improvement methodology to reduce self-harm incidents on their wards. One of these wards has been testing the use of activity co-ordinators during the early evening, which is when the data showed a higher incidence, as well as having more self-directed activities available at these times. The other ward is focusing on the level of harm and are reducing the number of ligatures which contribute towards this. The numbers of self-harm incidents can fluctuate significantly based on the acuity and needs of the patient group at any one time.

Figure 17 below shows monthly performance during 2021/22 and shows that the target of having no more than 42 self-harm incidents per month has only been met in May 2021 this year.

It is recognised that looking at the numbers of self-harm alone is not a helpful measure as many of our patients use self-harm as a way of coping with difficult feelings and to keep themselves safe. It is also well recognised that the more restrictive we are in stopping self-harm, the higher the level of harm can become as more extreme methods are used when usual means are not available. We have noted a correlation in the data in relation to self-harm and restraint, with two wards showing as highest contributors to these areas. Whilst continuing to review the self-harm data, as a division we are discussing wards focusing on reducing the use of restraint to also impact the incidents of self-harm. We are involved in workshops with other Trusts looking at how to measure and address this area.

Whilst the data has remained high for self-harm there have been quite significant fluctuations in these from 50 to over 130 at other times. The wards that have this as a driver metric review self-harm incidents in their daily huddle by completing a safety cross of any self-harm incidents in the past 24hrs. This data is reflected in the Datix reports which are reviewed monthly at patient safety and quality meetings. Often these extreme fluctuations are related to 1 or 2 patients. For example, 77 of the 130 self-harm incidents in November 2021 involved 4 patients.

Figure 17- Monthly instances of patient self-harm reported for Trust mental health inpatients



Source- Trust Tableau Dashboard

Suicide Prevention

ⓘ The trust is focusing on suicide prevention by developing staff skill and knowledge, creating a no blame culture, and supporting service users and their families through safety planning.

In Quarter 4 2021/22 the suicide prevention strategy group has updated the Trust suicide prevention plan in response to the National Confidential Enquiry into Suicide and Homicide (NCISH) Annual report 2022: UK patient and general population data 2009-2019, and real-time surveillance data. Themes from the report and how we have responded include:

Clinical Risk. Risk factors for suicide– such as previous self-harm, alcohol or drug misuse, multiple mental health diagnoses, living alone – are common among patients who die by suicide. 1 in 10 patients were known to have died on or near an anniversary or significant date. We have updated training and risk assessment prompts to remind staff to enquire about significant dates and anniversaries which may then form part of the safety planning interventions.

Acute Care. From 2009-2019, over a quarter (29%) of patients died by suicide in acute care settings, including in-patients, post-discharge care and crisis resolution/home treatment. Of the estimated 67 suicides by mental health in-patients in 2019, half were on agreed leave. The highest number of post-discharge deaths occurred 3 days after discharge from psychiatric in-patient care. We have already implemented 48-hour follow up on discharge and work is underway to enhance vigilance and the safety of leave arrangements before discharge and leave. The "10 ways to improve safety" toolkit will be promoted again.

People under 18. During 2009-2019 there were 213 suicides by patients aged under 18, an average of 19 deaths per year. This represents 19% of general population suicides in this age group, a lower proportion than in older groups (27%). Recent numbers appear to be higher, reflecting the increase in general population suicides by people aged under 18. We are working with CYP colleagues to update our strategy plan to reflect the recommendations in the report about service access

Economic Adversity - There were 281 deaths per year in patients who had experienced recent economic adversity, i.e. financial problems, workplace problems or homelessness. These patients were more likely to be middle-aged men, unemployed, divorced or separated, and were more likely to have recent illness onset, especially depression, and alcohol and drug misuse than other patients. We have updated training to ensure clinical staff are aware of the features of those at suicide risk in the context of economic adversity and highlighted organisations that support people facing debt or other financial problems. We have arranged bespoke sessions for staff from Samaritans to raise awareness of supports for debt management when safety planning.

Patients with physical illness. NCISH findings show an increase in the number of patients with a comorbid physical illness since 2014, accounting for 25% of all patient suicides in 2009-2019 overall. The risk profile of these patients was not the same as for patients generally – they are older, common risk factors such as self-harm or alcohol/drug misuse are less often present, and a higher proportion are women. We have updated our training so that clinical services are aware of the risk from opioids prescribed for pain and the need to enquire about access to opioids available at home, particularly among older patients.

Patients with a history of domestic violence. The majority of patients with a history of domestic violence were female. They were more often younger, single, or divorced, living alone and unemployed than other women. Self-harm, previous alcohol or drug misuse and personality disorder diagnosis were more common in this group, potentially reflecting previous trauma or abuse. We have devised bespoke workshops for services to raise awareness of the risk associated with domestic violence, especially in female patients, but also in men. The workshops focus on assessing suicide risk in relation to the experience or threat of domestic violence.

Suicide prevention during COVID-19. Findings from NCISH real-time data collection of suspected suicide deaths in England during the pandemic show experiences such as anxiety, isolation, or disruption to care may have contributed to some suspected suicide deaths by mental health patients. We had already provided bespoke workshops and updated our training so that staff are aware of the need to maintain support for patients under the care of mental health services,

particularly for patients who are anxious or isolated, or have experienced disruption to care. We will continue to strengthen our key messages and our support to staff so they can focus on key areas for suicide prevention.

We are in the process of setting up a space for staff to talk about their experiences of suicide with colleagues.

Our system work to improve the care and safety planning for those who misuse alcohol/ substances continues and this is being led by the Professional Lead for Clinical Quality and Governance.

We are also working on increasing the use of our tableau monitoring dashboards so that we can easily see if key learning is being embedded and is making a difference to patient experience, complaints, benchmarking data, and the offer of specific interventions.

Figure 18- Number of suicides per 10,000 people under Berkshire Healthcare Trust Mental Healthcare

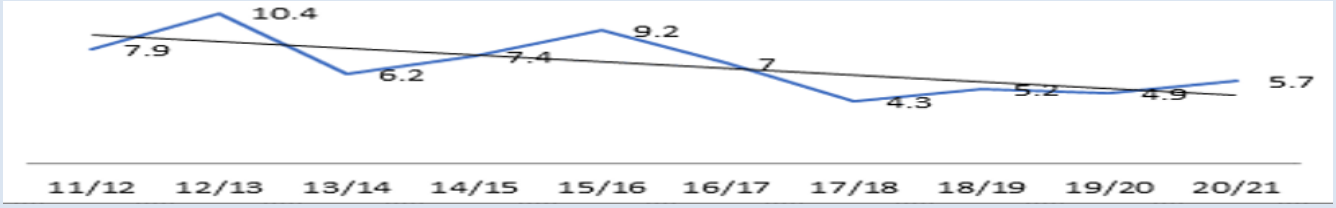
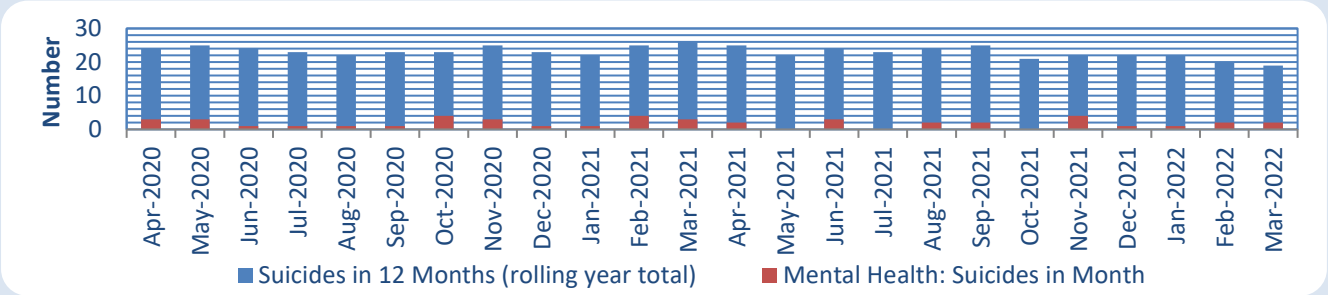


Figure 19- Suicides of patients under Berkshire Healthcare Trust mental healthcare



Source- Trust Tableau Dashboard

Recognising and responding promptly to physical health deterioration on in-patient wards

ⓘ Wards are required to recognise and respond promptly to physical health deterioration by following the National Early Warning Score (NEWS) Trust policy. All inpatient deaths, and deaths within seven days of transfer from our wards to an acute hospital are reviewed in line with the Trust Learning from Deaths policy to ensure that there are no deaths because of failure to spot a deteriorating patient and act in a timely manner.

Figure 20 below shows the number of unexpected inpatient deaths and deaths within 7 days of transfer from one of our inpatient wards to an acute hospital. The figure shows that there was one lapse in care confirmed during quarter 1 of 2021/22 for a death that occurred in 2020/21. Learning points identified from a review of this death include recognising Melaena (the passing of black stools) and its associated signs and symptoms.

Figure 20- Unexpected inpatient deaths and deaths within 7 days of transfer to an acute hospital

Quarter	Q1	Q2	Q3	Q4	Annual Total
Total unexpected inpatient deaths and deaths within 7 days of transfer to an acute hospital reported during quarter	8	5	8	8	29
Total lapses in care agreed (will relate to deaths in previous quarters)	1	0	0	0	1

Source- Trust Learning from Deaths Report

Improving the physical health of people with severe mental illness (SMI)

ⓘ National statistics show that people with serious mental illness (SMI) are at a greater risk of poor physical health and have a higher premature mortality than the general population, often dying 20 years sooner from conditions like cardiovascular disease or cancers. To address this health inequality, we have committed to increase the number of patients with SMI having a full annual physical health check within a year of referral to our community mental health services.

A Physical Health Team has been embedded in community mental health services with the remit of improving the physical health of people with SMI. All these patients are now offered a physical health check once they have been accepted onto the community mental health team (CMHT) caseload. This team are also developing a toolkit for use by all mental health practitioners to help them support patients to improve their physical health and access health checks. This will be accompanied by a bite-sized training programme.

The physical health check for patients with SMI consists of checking and recording seven parameters: Body Mass Index (BMI). Systolic blood pressure. Diastolic blood pressure. Lipids. HbA1C or glucose. Alcohol status. Smoking status

To measure performance against this objective, an initial driver target for the trust was set that by September 2021, 30% of all patients with SMI that are referred to CMHT, will have all parameters of the annual physical health check completed in less than 365 days of referral to the CMHT. This target was achieved in July 2021, and so was reset to 50% by September 2021 and 60% by March 2022. Figure 21 below details performance against this target.

The Physical Health Team working with the CMHTs have continued to make improvements in offering and completing physical health checks throughout the year. The target of 60% compliance with the above target was achieved in September 2021. Progress to date has been good and the current state is 80% for patients who have been on the caseloads less than one year.

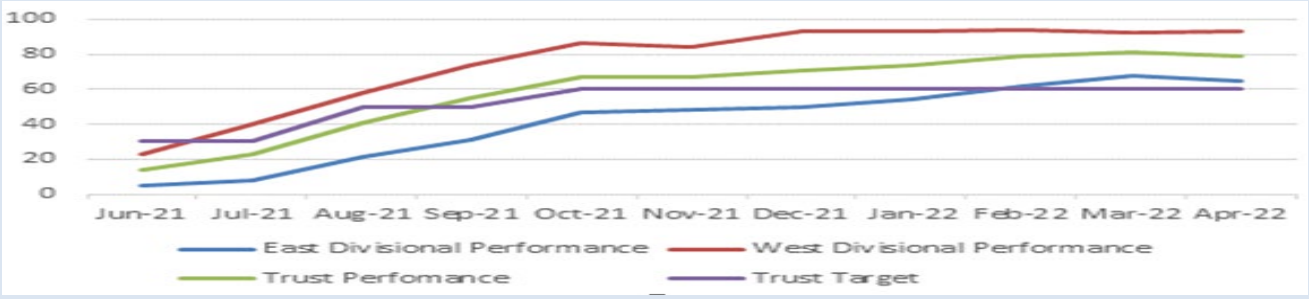
This still means 20% of these patients had not had a health check which can result in poor health outcomes impacting the "Patient Experience" and "Harm Free Care" elements of the True North objectives. The vision therefore remains to ensure physical health checks are completed for all new patients with SMI to bring their life expectancy in line with the general population. The aim is that 100% of eligible patients will be offered a physical health check. To continually improve and reach this goal, the targets for 2022/23 have been revised as follows:

- Minimum 95% compliance with all 7 parameters of the health check by March 2023 across all localities
- Stretch target of 90% of above cohort by September 2022

Further to this, data is now being monitored for physical health checks completed for patients with SMI on CMHT caseloads for more than one year. These checks are undertaken in primary care however, secondary care has a responsibility to ensure our patients are aware of these checks and are encouraged and supported to attend. Data will be monitored for the next 3 months, and then new driver metrics and countermeasures will be set for:

- Facilitating access to a physical health check in primary care – recorded as completed by GP
- Smoking status and intervention recorded

Figure 21- Percentage of patients with Severe Mental Illness (SMI) that are referred to CMHT and have had all parameters of the annual physical health check completed within a year of referral to CMHT



Strengthening our safety culture to empower staff and patients to raise safety concerns without fear, and to facilitate learning from incidents

Strengthening our Safety Culture

The Safety Culture Steering Group continues to oversee developments to further enhance the trust safety culture.

The group have reviewed the NHS England/ Improvement 'Supporting our staff- A toolkit to promote cultures of civility and respect' and are confident that the workstreams in place are aligned to that of the toolkit. There are however a number of resources available that the trust is exploring utilising including; 'Professionalism pyramid', Resources to support 'Essential Manager' and 'Excellent manager' programmes and some Organisational Development resources. The group are exploring how these can be fed into training and other areas of work as part of the people promise.

A revised 'Zero Tolerance for Abuse' statement has been developed for inclusion as standard in all appointment letters. The wording is currently being finalised but seeks to send a clear message that abuse to our staff will not be tolerated while making clear how we will always aim to work in a positive and respectful way with our patients.

The trust Safety Culture heatmap continues to be refined with recent patient safety metrics being added to be viewed alongside patient experience and HR metrics to enable the trust to identify areas that may need additional support.

More than 49 staff have now completed the Professional Nurse Advocate (PNA) Programme. The PNA model is underpinned by Restorative Clinical Supervision (RCS) which has strong evidence base with research highlighting that supporting staff with emotional resilience, connecting the lived experience of the nurses with quality improvement and education and feedback into the local clinical governance agenda has positive impacts on recruitment and retention. This mode of supervision is expected to be mandated by NHS England later this year.

The Safety Culture Charter continues to be promoted with services using this as a focal point for more focused work on developing safety culture within teams. For example the team on Campion Unit have set up a Safety Culture Group in which the Safety Culture Charter was reviewed as a starting point for the team to determine their priorities for improvement.

Never Events

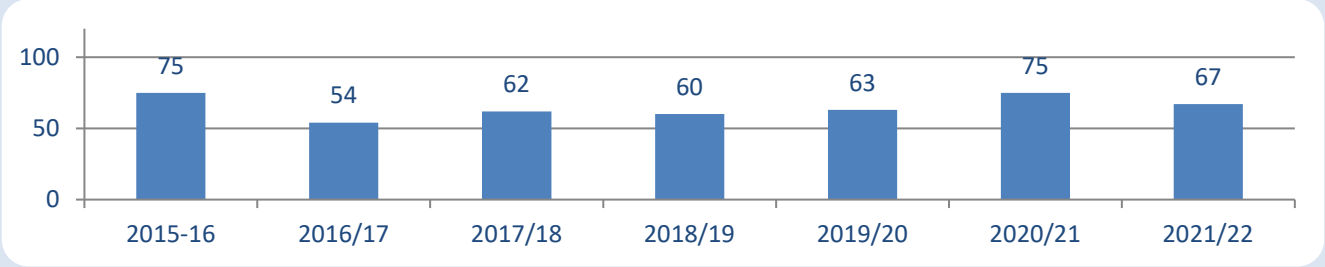
ⓘ Never events are a sub-set of Serious Incidents and are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.

The Trust has reported 0 never events in 2021/22

Serious Incidents (SIs)

Figure 22 below shows the annual number of serious incidents reported by the Trust in comparison with the previous financial years.

Figure 22- Number of SIs reported by the Trust- Year on Year Comparison (excluding pressure ulcers)



Source: Trust Serious Incident Report

During Quarter 4 2021/22 there were a total of 20 serious incidents originally reported; this is 5 more than were originally reported in the previous quarter and 9 fewer than originally reported in Q4 last year. At the time of writing this report, 1 of these 20 incidents has been downgraded, and one has been closed as it is reported under Berkshire West CCG. Therefore, for the purposes of this report, 18 serious incidents have been included as serious incidents for Quarter 4 2021/22.

13 (72%) of the 18 serious incidents were reported by Mental Health Services:

- 3 by Community Mental Health West
- 5 by Community Mental Health East
- 5 by Mental Health Inpatients

5 (28%) of the 18 serious incidents were reported by Community Physical Health Services, all from the west division.

The categories of serious incidents reported in Q4 2021/22 are as follows:

- **Suspected suicide cases**. 5 cases reported, the same as in Q3, and 3 fewer than in Q4 last year.
- **Unexpected deaths**. 3 cases reported, 2 fewer than in Q3 and in Q4 last year.
- **COVID-19 related**. All deaths of patients with COVID-19 cited on part 1 of the death certificate and that meet the NHS England definition of a probable or definite hospital acquired infection have been investigated as serious incidents by Berkshire Healthcare. There have been 2 incidents this quarter that meets this threshold.
- **Falls:** 4 cases reported as serious incidents in Q4, 2 more than in Q3.
- **Information Governance (IG) Breach:** 1 breach reported that met the threshold for a serious incident
- **Other:** 1 incident

There were 31 inquests concluded in Q4 2021/22, 18 of which had been declared by the Trust as serious incidents. This is an increase in inquest activity from the previous quarter. 3 additional inquests were adjourned with all 3 being SIs. No Preventing Future Deaths reports were issued.

Ethnicity and serious incident reporting: According to the ethnicity recorded on RiO for serious incidents reported in Q4, 10 patients were White British, 4 patients were White-English/Welsh/Scottish/Northern Irish/British, 3 patients were unknown ethnicity, and 1 patient was Asian/Asian British Pakistani.

In response to thematic analysis, learning and requirements for improvement that have been identified from serious incident investigations, there continues to be significant patient safety activity across the Trust during this quarter.

Across mental health services, the suicide prevention strategy has been updated in response to the National Confidential Enquiry into Suicide and Homicide (NCISH) report which also has clear links to learning from our own serious incidents. A domestic abuse workshop has been developed which is initially to be delivered to Crisis Resolution and Home Treatment Teams (CRHTT)/ Psychological Medicine Service (PMS) (East and West) and the Intensive Management of Personality -disorder and Clinical Therapies Team (IMPACTT) based on learning from a serious incident that involved these services. The workshop includes a series of four short film clips to highlight a crisis assessment of somebody who is a perpetrator of domestic violence and in mental health distress. Work has also begun on a drug and alcohol improvement project following recognition of themes in relation to consideration of, and support to, patients with a dual diagnosis. Talking Therapies have updated their Standard Operating Procedures to guide staff response when there is disclosure of overdose and our mental health services are using the learning from our serious incident reviews around people who do not meet thresholds for secondary care being supported to access (via bridging) primary care through new transformation roles.

For physical health services in the community there continues to be a focus on raising awareness of when the risk of sepsis should be considered and what steps should be taken to assess and document these decisions. Work on developing guidance to support staff decisions concerned with observation/ supervision of patients at risk of falls has now been drafted and is being shared with key stakeholders prior to approval. Embedding processes around missed visits also remains a priority and learning around managing head injuries for patients on an anticoagulant has been widely shared.

Quality Concerns

ⓘ The Trust Quality and Performance and Executive Group review and identify the top quality concerns at each meeting and these are also reviewed at the Trust Quality Assurance Committee (QAC) to ensure that appropriate actions are in place to mitigate them. Quality concerns are identified through some of the information sources provided in this account, together with intelligence received from performance reports, our staff, and stakeholders.

Acute adult mental health inpatient bed occupancy continues to be consistently above 90% at Prospect Park Hospital. This means that patients might not receive a good experience all the time. Delayed discharges have stabilised, and the new bed management system is working well. There are programmes of work in place to support reduction in occupancy and out-of-area placements, but the pressure remains on local beds.

Shortage of permanent nursing and therapy staff. Mental and physical health inpatient services as well as several our community-based adult and young people's services for mental and physical health are now affected by shortages of permanent nursing and therapy staff and increased demand. This has a potential impact on the quality of patient care and experience and increases our costs. Our new workforce strategy will focus on how to retain and grow staff to meet our demand. A new workforce forecasting model has been developed to support understanding of gaps so that appropriate, cost-effective interventions can be agreed.

Wait times. Wait lists in some services are rising due to a combination of service capacity and increased demand. This increases risk to patients and means that we are not meeting national or local targets in all services. A long wait for an outpatient appointment does not provide a good experience for patients, families, and carers. Some services have had long waits for several years, and these are due to several reasons, including limited funding from commissioners and staff vacancies. Wait lists are monitored monthly at the Quality Performance and Experience meeting. Action plans and programmes of work are being taken forward with system partners to reduce some of these wait times.

Duty of Candour (DOC)

ⓘ The Duty of Candour is a legal duty on hospital, community, and mental health Trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. Duty of Candour aims to help patients receive accurate, truthful information from health providers.

The Trust has an 'Open Communication (Being Open) a Duty to be Candid' policy that supports our culture of openness when things go wrong. Face to face training has been provided alongside a trust intranet page where staff can access information and advice. The Patient Safety Team monitors incidents to ensure that formal Duty of Candour is undertaken.

The Trust process for formal Duty of Candour includes meeting with patients and families, apologising for their experience, explaining the investigation process, inviting them to be involved in the investigation and then sharing the report and findings when the investigation is complete. We also ensure that support is offered to patients, family, and carers as appropriate. The Duty of Candour supports the Trust learning from deaths programme detailed later in this report.

Figure 23 below details the total number of incidents requiring formal duty of candour during the year. The Trust considers that the Duty of Candour was met in all cases.

Figure 23- Incidents requiring formal Duty of Candour (DOC)

Month (2021/22)	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Incidents with formal DOC	24	52	35	35	21	29	19	39	39	34	31	38

2.1.3. Clinical Effectiveness

ⓘ Clinical effectiveness aims to ensure that each patient receives the right treatment in the right place at the right time. Achieving this requires the application of the best knowledge (derived from research, clinical experience, and patient preferences) to achieve optimum processes and outcomes of care for patients.

Our 2021/22 Clinical Effectiveness Priorities are as follows:

1. We will demonstrate our delivery of evidence-based services by reporting on the implementation of NICE guidance related to Trust priorities identified in this Quality Account
2. We will continue to review, report, and learn from deaths in line with national guidance. Please note that this priority is detailed in section 2.3 of this report as it is also a required statement of assurance from the Board

This section also includes a statement on rota gaps for NHS Doctors in Training, and the plan for improvement to reduce such gaps. Trust performance against the Learning Disability Improvement Standards is also included I this section

Implementing National Institute for Health and Care Excellence (NICE) Guidance

ⓘ NICE provides the NHS, and those who rely on it for their care, with an increasing range of advice on effective healthcare. NICE guidelines, technology appraisals and quality standards provide valuable evidenced-based information on clinically effective and cost-effective services.

The Trust has reviewed its compliance with two high-priority NICE Guidelines.

Managing COVID-19- Recommendations relating to Venous thromboembolism (VTE) prophylaxis (Guideline NG191). An assessment of compliance against this guideline has been completed with input from Community Inpatient Wards (East and West Berkshire), Mental Health Inpatient Wards and Pharmacy. The assessment included a review of 11 NICE recommendations that were deemed to be applicable to the Trust in this area. These covered the areas of; management in hospital; management of people with COVID-19 and additional risk factors and information and support.

The assessment found that the Trust was meeting all 11 (100%) of the recommendations. Community inpatient services have systems in place to prevent, assess and manage VTE and, as recommendations relating to COVID are updated, these would be implemented as required. Mental Health Inpatients also follow the recommendations where they are relevant, noting that patients would be transferred to an acute trust if they required any major physical health intervention in these circumstances. In addition, pharmacy have produced a guideline for managing VTE which includes information on COVID-19.

Supporting Adult Carers (NG150). This Guideline is relevant to all services that manage patients with adult carers. The Guideline contains a total of 92 recommendations that are relevant to many our trust services. These recommendations cover the areas of; information and support for carers; identifying carers; assessing carers needs; helping carers stay in, enter, or return to work, education and training; social and community support for carers; training in providing care and support; psychological and emotional support for carers; support during changes to the caring role; and support for carers during the end of life and after the person dies.

The Trust has approved a Carers Strategy that contains six standards and a self-assessment process to audit compliance. This Carers Strategy is being driven forward by the Carers Lead for the Trust. The standards within the strategy have also been mapped to the NICE Guideline. Work is progressing well in this area, but the Trust are not yet able to mark the guideline as compliant as there are several recommendations to be met across several services. Work undertaken to date

includes a baseline evaluation to ascertain the status of carer activities; developing standard templates and information; reviewing recording of carers on RiO and launching a working carers network for staff.

Further work that is progressing in this area includes launching the roll-out of the self-assessment audit process; identifying gaps and developing workstreams to support services to achieve the standards; progressing working carer initiatives and sharing learning and best practice from bespoke carer projects such as Mind the Gap (carers supporting veterans).

NHS Doctors in Training- Rota Gaps and Plans for Improvement

ⓘ The Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 requires NHS Trusts to make a statement in their Quality Report on rota gaps for NHS Doctors in Training, and the plan for improvement to reduce such gaps

The Trust's original 'Guardians of Safe Working' (GOSW) have now stepped down after five years in the role and have been replaced by a single GOSW, also a consultant psychiatrist. The new GOSW continues the duty to advocate for safe working hours for junior doctors and to hold the Board to account for ensuring this. As part of this duty, the Guardian GOSW reports quarterly to the Board on activity relating to Junior Doctor working hours and rota gaps.

Figure 24 below details the Psychiatry rota gaps for NHS Doctors in training in the Trust during 2021/22. Gaps because of the pandemic have now reduced to such a low level that they are now recorded as part of normal sickness. The reduction in trainee numbers continues and has continued to create gaps in the Out of Hours rota. Our system of cover continues to work as normal, and gaps are generally covered quickly.

Figure 24- Rota Gaps for NHS Doctors in Training – Psychiatry – 1st April 2021- 31st March 2022

Rota Gaps	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
	385	377	184	193	0	4077.5	4015.5	1909	2107.5	0

Source- Trust Medical Staffing Team

The Learning Disability Improvement Standards

ⓘ The Learning Disability Improvement Standards have been developed to help NHS trusts measure the quality of care they provide to people with learning disabilities, autism, or both. They contain several measurable outcomes which clearly state what is expected from the NHS in this area.

The outcomes have been developed by people with learning disabilities and/or autism and their families. By taking this approach to quality improvement patient and carer experience is embedded as the primary objective; and the importance of how the NHS listens, learns, and responds to improve care is highlighted.

The four improvement standards concern:

- Respecting and protecting rights
- Inclusion and engagement
- Workforce
- Learning disability services standard (aimed solely at specialist mental health trusts providing care to people with learning disabilities, autism, or both)

Berkshire Healthcare make an annual submission of our performance against these standards, which also include surveys of staff and people using our services.

The results from the 2021 Learning Disability Improvement Standards are currently being collated by NHS Benchmarking. Once all the data (submitted in Nov-Dec 2021) has been checked and verified the Trust will be able to review and compare the outcomes from the latest review against the standards (including results from the survey of people using our services and staff)

In relation to the areas of focus from the 2020 review of standards, the following is being undertaken:

Increasing awareness of health inequalities experienced by people with learning disabilities and autistic people across the Trust; and improving our ability to segment outcome data and patient experience feedback to help target future areas for prioritisation and actions (respecting and protecting rights)

The Health Inequalities Board, chaired by our Deputy Chief Executive, includes learning disability as one of the core areas of focus. As a result this has helped to ensure that the Connected Care team continue to work on the creation of dashboards that will help GPs to identify people in their practice as the first step. There is also further work planned to help flag important information for other NHS and social care providers to help to achieve this improvement goal

Increasing awareness and use of reasonable adjustments (inclusion and engagement)

We will be promoting the e-learning provided by Health Education England, now available via the Trust's Nexus E-learning platform. Some staff have participated in the piloting of the new national learning disability and autism awareness training (Oliver McGowan Mandatory Training in Learning Disability and Autism), and we await the completion of the trial, when the Department for Health and Social Care will use the learning and evaluation to inform a wider rollout of the training.

Supporting a cohort of staff to undertake the Advanced Practice Credential in Learning Disability and Autism (ACP LD/A) with support from Health Education England to further develop specialist skills (workforce)

Three team members have been accepted onto the Advanced Practice Credential in Learning Disability and Autism (ACP LD/A) and have continued with their learning programme. They are completing their Service Improvement Project prior to completion of this module at the end of the academic year. The projects include, supporting the development of a pathway for people who have increased anxiety around vaccine immunisations; exploring the benefits of using the Assessment of Motor Processing Skills (AMPS) tool as part of the dementia pathway; and increasing the awareness and safe use of mobile apps, and creating codesigned information to share with others.

Work with Commissioners to support the development of local Dynamic Support Registers which seek to identify those people at risk of admission to inpatient services and provide intervention in the community to avoid all but essential admission (learning disability services standard)

The Commissioners in East Berkshire have undertaken a soft launch of the Dynamic Support Register (and associated tools), while Berkshire West have prioritised the implementation for children and young people. The Learning Disability Service continues to meet with Commissioners on a fortnightly basis to report back on admissions and discharges as part of the NHSE "Care Room" process and participate in other development opportunities with Commissioners at Place and Integrated Care System (ICS) meetings. This has seen a sustained reduction in the use of inpatient beds (with admissions only taking place where they are seen to be essential).

2.1.4. Supporting our Staff

ⓘ The Trust is committed to acting in line with our values, with a strong focus on delivering services which provide good outcomes for patients and their families. We will listen and respond to our staff and provide opportunities for training and development.

Our 2021/22 Supporting our Staff Priorities are as follows:

1. We will improve the mental and physical health and wellbeing of our people, reducing musculoskeletal disorders and other sickness absences
2. We will have a zero tolerance to bullying and harassment, and racism, taking action wherever we see or hear poor experience for our people
3. We will support the growth and development of our people through high quality appraisal, supervision, and training
4. We will actively support our people to work flexibly, including remote working where appropriate, as part of our new offer
5. We will act on feedback from the staff survey in order to further improve satisfaction and address any identified inequalities
6. We will provide opportunities for our people to show initiative and make improvements for their colleagues and patients through great team working, Quality Improvement and Bright Ideas

Details on Freedom to Speak Up are also included in this section.

The priorities detailed above have been translated into our People Strategy 2021-24. This strategy has the aim of making the Trust Outstanding for Everyone. The key priorities of this strategy are detailed in the graphic below.

People Strategy Key Priorities

Retaining our People

Growing and Retaining for the Future

ⓘ The Trust is committed to ensure that we improve recruitment, retention, and satisfaction of our staff. We want to have high levels of engagement across all our services and increase the numbers of staff who feel they have an influence on how we work and make decisions.

Recruitment will always be a vital element for the NHS, and we will continue to focus on recruiting the best people to our roles. However, our greatest challenge is reducing our high turnover of staff. While some turnover is healthy in an organisation, our turnover is still too high, averaging around 15%, in line with neighbouring trusts and has increased in line with turnover post Covid across the NHS and private sector. This remains a challenge and our primary area of focus in the People Directorate

We need to focus on making Berkshire Healthcare a place where people want to stay and work. Attracting, training, and retaining a diverse workforce has many benefits. It means we will be able to keep skilled staff, reduce wasted time and money by not having to continually recruit and train new people, and reduce pressure on existing people whose workload often must increase to fill the gaps.

Our People Strategy is designed to address the issues of attraction and retention of workforce. However, we are operating in a context of increasing competition for staff across the NHS and specific workforce shortages in key clinical areas within the Thames Valley. We have a three-year strategy in both Integrated Care Systems (ICS) to support our workforce issues with targeted interventions to help us attract, develop, and retain staff. Nevertheless, in the short term, these can, at best, only mitigate our risks as the underlying gap in the workforce supply cannot be solved quickly.

Student numbers are declining in physical health nursing and whilst we have seen an increase in registrations for mental health nursing degrees, nationally, the student numbers still do not match the number of leavers from these roles. This will create gaps in our own workforce and within the wider marketplace which providers will need to fill. Inevitably this will mean more turnover as staff seek promotion opportunities elsewhere. As NHS vacancies have been increasing recently due to funding for transformation and to clear backlogs, trusts within the region have already seen turnover increase. Analysis shows that the local NHS workforce is being recycled between neighbouring providers (between 12-15% of our workforce) with our leavers largely joining the Royal Berkshire and Frimley NHS Foundation Trusts and our new joiners coming from the same sources.

There are four pipelines we can use to address workforce gaps, all of which the trust is exploring: international recruitment; continuing ad hoc recruitment; increasing student placement numbers and growing our own staff through apprenticeships.

We are currently recruiting for a dedicated international recruitment team to support a great welcome to Berkshire Healthcare. The trust, however, needs to consider an investment in apprenticeships and the resources required. In addition to this, we continue to look at ways to free up clinical time to care via business process transformation and continue to work on our engagement activities.

We have undertaken an exercise to collate and analyse data from our leavers. The three main reasons for leaving are relocating work closer to home, work/life balance and career progression. We are currently working with services to identify countermeasures to address the main reasons for leaving including putting together plans to support flexible working requests.

We had an average of 1.5% agency staff during the year, and the percentage of temporary staff (both bank and agency staff was 12%

In total we welcomed 967 new joiners to BHFT during the year and had 804 leavers. Figure 25 shows the number of vacancy advertisements posted per month.

Figure 25- Vacancy advertisements posted per month

Month	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2020/21	121	143	181	193	185	212	204	201	149	199	197	238
2021/22	187	223	274	303	287	331	328	343	265	342	228	342

Supporting the growth and development of our people through high quality appraisal, supervision and training

ⓘ It is important that all staff are supported to grow and develop in their roles with the Trust. This can be achieved by ensuring they have high quality appraisal, supervision, and training to help support patient and staff satisfaction, safety, and effectiveness.

The Trust ensures that all its staff have the appropriate skills, training, and support for their roles through its recruitment and training programmes and have launched a new online learning platform to support this.

Clinical Education
We are undertaking a complete review of our clinical education programme, with a view of developing a service transformation plan to make sure there is sufficient training and clinical education provision to meet the needs of our workforce now and in the future, and to make sure these programmes are equally and easily accessible to all staff.

Phase one of the clinical education project was completed in December 2021. This focused on clinical skills training as well as Mental Health training and included feedback from Children's, Young Peoples and Families Services (CYPF)/ Child and Adolescent Mental Health Services (CAMHS), Community Adult Mental Health, Older Adult Mental Health, Older adult services, and adult inpatients services. In summary, psychosocial Interventions, supporting people with neurodiversity, suicide prevention, alcohol/substance misuse, domestic violence and non-medical prescribing were the key areas that emerged from the Mental Health gap analysis. Medicines Management, Echocardiogram (ECG) and cannulation are areas of focus as part of the Physical Health training needs gap analysis.

Phase 2 of the Clinical Education Training needs gap analysis will involve reviewing existing provision of in-house and external training to ensure that we are able to meet the identified training needs for staff across the organisation. As part of phase 2 several clinical skills training courses have been reviewed and revised with an emphasis of releasing time from the face-to-face learning by using a blended learning approach. The review plan for Mental Health training will be a key objective of the newly appointed Clinical Education Senior Project lead.

Nexus e-learning platform
The migration from Slate to the Nexus e-learning platform is on track and will be completed in March 2022. The Nexus e-learning audiences project to extend the training compliance dashboard to clinical education courses is progressing well and is also on track to launch in April 2022

Healthcare Support work onboarding (HCSWOB) – Pilot at Prospect Park Hospital (PPH)
Cohort 3 of the HCSWOB programme started in November 2021 and the feedback from the pilot has been positive in terms of staff experience. Phase 2 of this project will evaluate the retention rates of the support worker staff as part of the pilot. The plan is to roll out the HCSWOB programme to the wider Trust and launch in June 2022.

Placement Expansion
Phase 2 of the placement expansion project is progressing well and despite increased demands on the workforce, placement expansion in Mental Health and Physical Health services has continued. Placement expansion in CYPF and CAMHS services remains challenging and maintaining current capacity is the focus of the Learning Environment Leads. The Placement and Student support offer remains focused on support for services, wards and teams and increased support is targeted as needed. There is also a student education programme 1 day per week. The objective of this programme is to release time back to services and to support student competency sign off

New Training Space
The training team are working with the Estates team to establish further suitable accommodation for our training needs when we move out of Fitzwilliam House. Following a workshop in November, high level requirements have been defined and a project team has been set up. The Estates team are now using this to source suitable accommodation that will meet our training needs.

International Nurses Recruitment
Our fourth international nurse joined the trust at the end of the year, and we plan to recruit another twenty in the coming year. Nine are currently going through

recruitment checks to join us at the end of June 2022. Our second cohort will join in October 2022. International nursing applicants must have a recognised English Language qualification, e.g. the International English Language Testing System (IELTS), when applying for our roles. We do support some internationally qualified nurses who are already in the country and working for our trust as Health Care Support Workers to take their English Language qualifications. We have staff members dedicated to the recruitment and pastoral care of our new international nurses ensuring that they are fully supported as they join the trust and settle into their new lives here in the UK.

Appraisal Process

Streamlined appraisal documents will be introduced for 2022. This is an interim measure, whilst a thorough review of the appraisal process takes place this year with a view to finding a digital solution for 2023.

Training

The Trust always strives to comply with statutory and mandatory training requests and is promoting a positive training culture. An e-learning system has been embedded to make it much easier to locate the relevant training required for each member of staff. As a global digital exemplar, the Trust has rapidly moved to delivering training virtually, which has meant that it has continued to be delivered throughout the COVID-19 pandemic. We have adopted a blended approach to deliver our training requirements.

Looking After our People

Improving the mental and physical health and wellbeing of our people, reducing musculoskeletal disorders and sickness absence

ⓘ The Trust needs staff that are healthy, well and at work to deliver high quality patient care. Looking after the health and wellbeing of staff directly contributes to the delivery of quality patient care.

Improving the mental and physical health and wellbeing of our people

The past two years have been incredibly challenging for everyone. Rewarding and recognising people for their contributions is important as it helps people feel valued and improves morale and wellbeing. As a way of saying thank you, a £25 voucher was sent to all staff in December 2021 to recognise their hard work over the year. There was a lot of positive feedback with many staff reaching out to the Executives or on social media to express their gratitude.

The trust has been trialling the use of the Peppy app to support our staff whose experience of the menopause may be impacting on their life, both in and out of the workplace. The initiative was launched on world menopause day with 117 users registered on the app with an additional 29 interested. Peppy provides instant messaging support from expert practitioners, one to one video appointments and access to vetted resources and events. The costs have been funded for a year, with the review planned for March 2022.

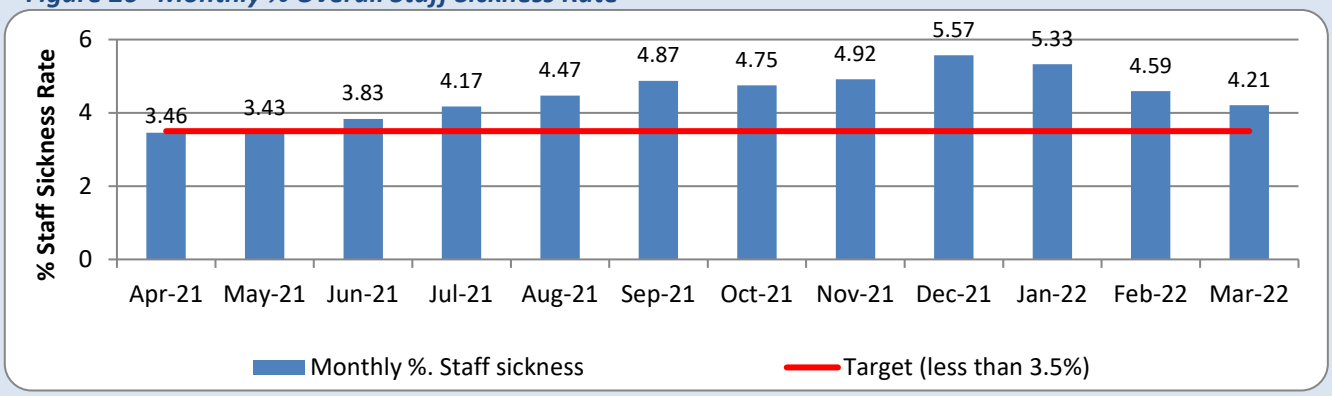
The Integrated Care System (ICS) Wellbeing Matters service, which is hosted by Berkshire Healthcare, continues to support staff across the ICS. As well as training and engagement, the Wellbeing Matters team offer wellbeing hubs for teams, staff support post incident (BHFT only) and in the moment support via the Wellbeing Line with rapid assessments for Improving Access to Psychological Therapies (IAPT) services where appropriate. In December 2021 alone, 103 staff contacted the hub for individual support with 14 receiving clinical assessment and there were another 28 contacts for team/group support (across all ICS partners in Berkshire).

The Enhanced Occupational Health and Wellbeing Project in the Berkshire Oxfordshire and Buckinghamshire (BOB) ICS has moved into phase two. Training spaces for Mental Health First Aid (MHFA) are being offered to staff (additional to the trust MHFA training which will recommence in early 2022), as well as 'REACTMH' which is designed to support individuals to have an effective Wellbeing Conversation. The BOB ICS Wellbeing Champion network (launching in January 2022), launched by our NED Wellbeing Champion, will be an additional level of support and networking for our trust Wellbeing Champions, whose network is also launching in January. Health kiosks and an ICS health and wellbeing website are currently being explored.

Reducing staff sickness

Figure 26 below details the monthly percentage of staff sickness absence and shows that the target rate was not achieved during 2021/22. During the year there were 1202 different occurrences/episodes of covid sickness affecting 1070 employees. During COVID the NHS saw a dip overall in turnover levels and has seen an increase since pandemic restrictions have been eased. There seem to be two main reasons for increased turnover. Firstly, the external recruitment market has picked up and secondly there are more roles being advertised in the NHS as funding for new roles to clear backlogs of work has created new roles.

Figure 26- Monthly % Overall Staff Sickness Rate



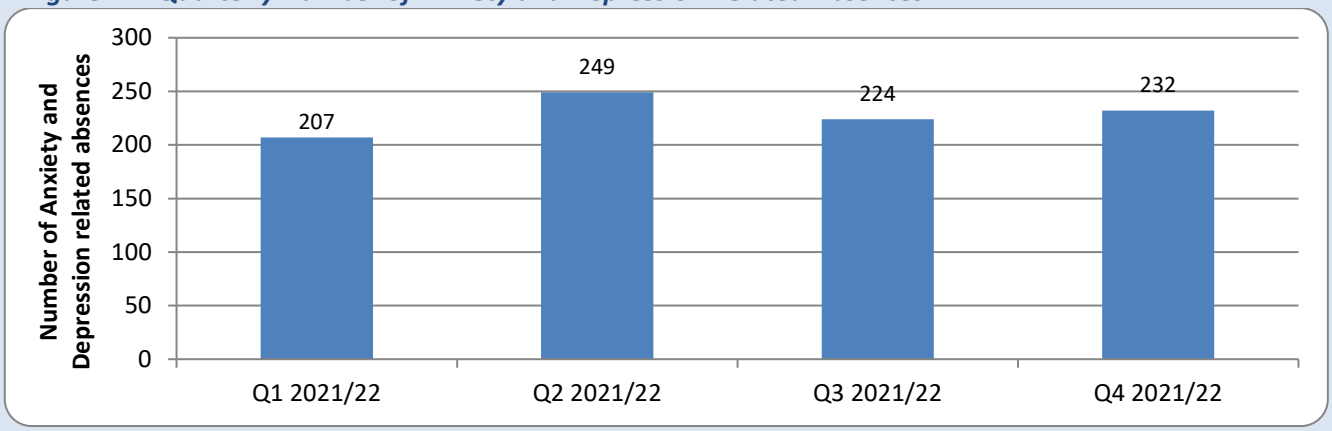
Source- Trust Tableau Dashboard

Reducing stress, anxiety, and depression

The Health and Safety Executive (HSE) define work-related stress as "The adverse reaction people have to excessive pressures or other types of demand placed on them at work". Stress itself is not an illness, but if it becomes excessive and prolonged then mental or physical illness may develop.

Figure 27 below details the quarterly number of anxiety and depression related absences. As anticipated by the Wellbeing Lead and the Psychological Therapies Lead, the number of anxiety and depression related absences have been greater after the COVID-19 second wave as staff took stock and reflected on their experiences during that time.

Figure 27- Quarterly Number of Anxiety and Depression Related Absences



Source- Trust HR Department

Reducing musculoskeletal (MSK) disorders

Musculoskeletal disorders can affect muscles, joints, and tendons. It is important that our staff do not sustain work related musculoskeletal disorders, and we aim to reduce the occurrence of these injuries during the year. We have put in place the following actions to try and prevent these injuries from occurring:

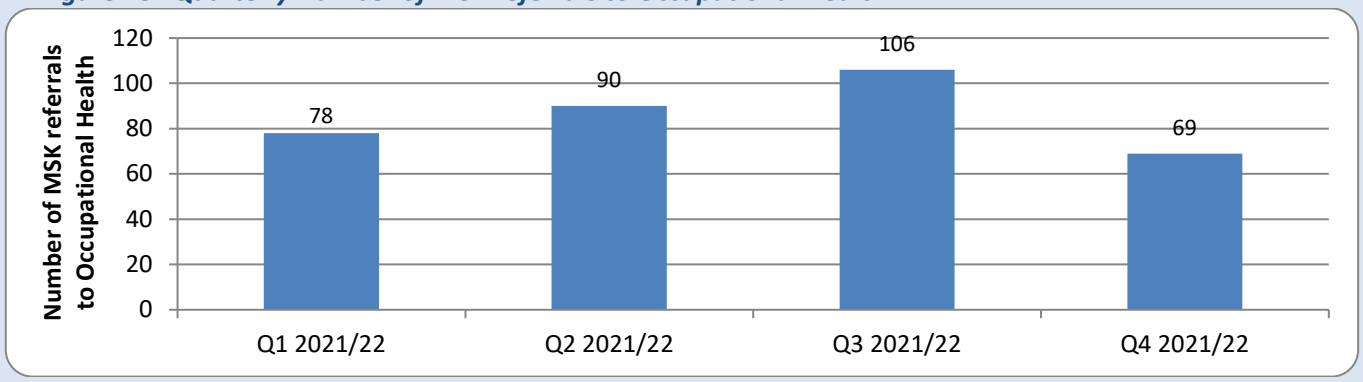
We have an established a fast-track referral process to a physiotherapy service that sits alongside the Occupational Health (OH) team. Managers can make a referral for someone in their team if they think this will support them, or often our staff self-refer to this service. The service is available for all staff and often it is used by those who remain at work but with a MSK problem. Additionally, if someone is off sick with a MSK

reason given as the reason for their absence, a referral to the physio service is often made alongside this or prior to an OH referral.

In addition, where people are home-working, managers continue to check that they have the necessary equipment to enable this, always remembering the importance of MSK health. Where required, an ergonomics assessment is undertaken and, if needed, additional or different equipment is provided. We have also been monitoring the impact of home working on MSK issues and have not seen any significant reported differences.

Figure 28 below details the monthly number of musculoskeletal referrals made to occupational health for our Trust staff. MSK referrals have been more prominent from ward areas, rather than from those working from home, as staff are managing patients with greater physical health needs and are required to do more lifting.

Figure 28- Quarterly Number of MSK referrals to Occupational Health



Source- Trust HR Department

Acting on feedback from the staff survey to further improve satisfaction and address any identified inequalities

ⓘ The results from the National NHS Staff Survey are used by the Trust to inform local improvements in staff experience and wellbeing. This is important as a positive staff experience plays an important part not only in staff welfare, but also in helping to maintain and improve on patient safety and experience.

Both the Trust People Strategy and Equality Diversity and Inclusion Strategy have been informed and designed based on learning from; the staff survey; Workforce Race Equality Standard (WRES) data; Workforce Disability Equality Standard (WDES) data; and engagement workshops with our staff and networks.

We were the best performing community and mental health trust in the country for our staff engagement scores in the 2020 national survey, having been second in 2019. National teams are working with us to learn how we have achieved this level of staff satisfaction.

The Trust participated in the 2021 NHS National Staff Survey between October and November 2021. For the 2021 survey onwards the questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience.

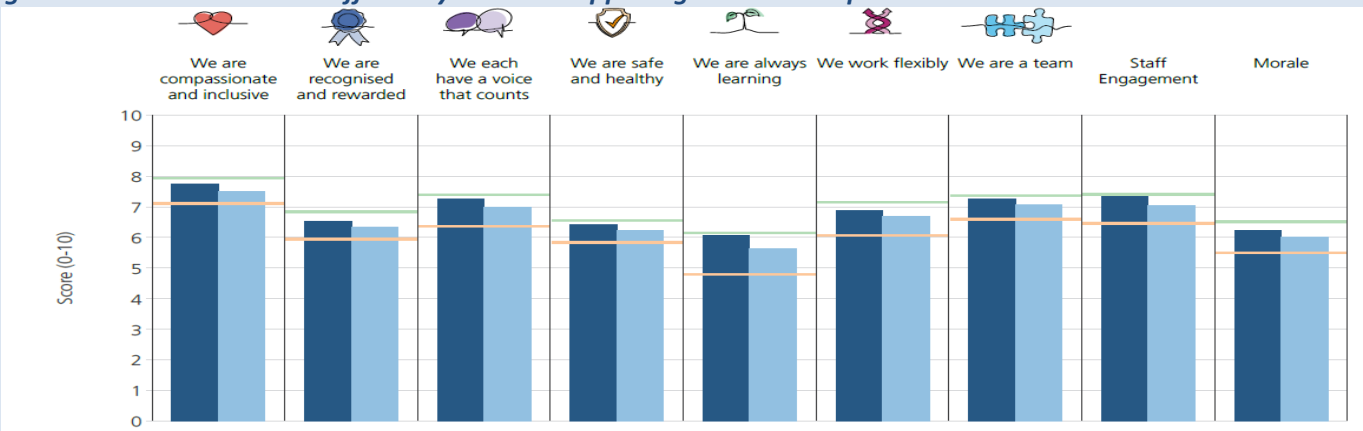
The Survey Sample.

The survey was conducted online, resulting in it being open to over 4000 of the Trust's employees. 2682 staff responded to the 2021 survey and our response rate was 60% this year, the same as in 2020. This is a greater rate than the average response rate for similar Trusts to ours (52%)

Summary of Trust Results.

This year, when mapped against the themes within the People Promise, our scores are above the average for similar Trusts in all themes and the best in our group of trusts for two of these themes. 73.5% of trust respondents recommended the Trust as a place to work, and 77.0% stated they would be happy with the standard of care provided by the trust. The figure below details the Trust results mapped against the themes in the People Promise.

Figure 29- 2021 Trust NHS Staff Survey Results mapped against the People Promise



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.9	6.8	7.4	6.6	6.1	7.1	7.4	7.4	6.5
Your org	7.7	6.5	7.3	6.4	6.1	6.9	7.3	7.4	6.2
Average	7.5	6.3	7.0	6.2	5.6	6.7	7.1	7.0	6.0
Worst	7.1	5.9	6.4	5.8	4.8	6.1	6.6	6.5	5.5
Responses	2,607	2,653	2,581	2,602	2,537	2,639	2,609	2,654	2,654

Source- 2021 NHS Staff Survey- Trust Benchmark Report

The Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES)

The WRES is a requirement for all NHS Trusts and part of the NHS standard contract. WRES results are an important driver of our equality and inclusion activity in relation to our Black, Asian, and Minority Ethnic (BAME) staff. It is a mirror that allows NHS Trusts to visualise workplace inequalities between BAME and White staff through nine key indicators and then devise countermeasures for ameliorating the gaps. Four of the nine WRES indicators focus on workforce composition and people management, four are based on data from the National NHS Staff Survey questions, and one indicator focuses on BAME representation at Board level.

The table below details the 2021 National Staff Survey scores that relate to the WRES

Figure 30- Staff survey results relating to the Workforce Race Equality Standard

Indicator and Description	Ethnicity	Trust Scores (%) 2018 (%)	2019 (%)	2020 (%)	2021 (%)	2021 Average (median) for combined MH/LD and community Trusts (51 Trusts)
Percentage of staff experiencing harassment bullying or abuse from patients, relatives, or the public in the last 12 months	White	22.5	22.2	19.6	19.9	26.2
	BAME	31.2	30.3	30.6	29.4	31.8
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	White	20.1	19.5	17.8	14.1	18.1
	BAME	26.2	24.5	23.4	22.9	22.9
Percentage of staff believing the Trust provides equal opportunities for career progression or promotion	White	62.9	68.2	70.4	67.5	61.0
	BAME	41.4	49.6	49.7	45.7	46.8
In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues?	White	6.8	5.9	4.7	5.3	6.0
	BAME	16.9	12.6	11.6	14.4	14.4

Source- 2021 National Staff Survey

The Workforce Disability Equality Standard (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 part of the NHS standard contract and facilitates a better understanding of the experiences of disabled staff, thus supporting positive change and the creation of a more inclusive working environment for disabled people. It has a similar ethos to the WRES and is underpinned by 10 metrics that cover the workforce profile, recruitment and capability processes, experiences of disabled staff, board make up, and the opportunity that disabled staff have to voice and air their concerns and to be heard. The Table below details the 2021 National Staff Survey results that relate to the WDES.

Figure 31- Staff survey results relating to the Workforce Disability Equality Standard

Indicator and Description	Whether staff have a Long-term condition (LTC) or illness	Trust Scores (%) 2019 (%)	2020 (%)	2021 (%)	2021 Average (median) for combined MH/LD and community Trusts (51 Trusts)
Percentage of staff experiencing harassment bullying or abuse from patients, relatives, or the public in the last 12 months	No LTC/ Illness	23.1	20.3	20.0	24.7
	LTC/ Illness	30.2	30.0	30.0	32.2
Percentage of staff experiencing harassment, bullying or abuse from manager in the last 12 months	No LTC/ Illness	8.5	7.1	5.4	7.1
	LTC/ Illness	15.6	14.7	12.0	13.4
Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	No LTC/ Illness	14.4	13.3	11.1	12.3
	LTC/ Illness	23.2	21.2	19.3	20.2
Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	No LTC/ Illness	60.4	59.5	63.4	61.0
	LTC/ Illness	57.3	53.8	55.5	59.4
Percentage of staff believing the Trust provides equal opportunities for career progression or promotion	No LTC/ Illness	64.1	66.7	64.3	60.2
	LTC/ Illness	60.3	58.5	52.9	54.4
Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	No LTC/ Illness	16.9	14.6	16.3	14.7
	LTC/ Illness	22.7	24.3	19.8	20.8
Percentage of staff satisfied with the extent to which their organisation values their work	No LTC/ Illness	61.1	66.5	61.1	51.5
	LTC/ Illness	53.8	55.2	51.5	43.6
Percentage of Disabled staff saying their employer has made adequate adjustment(s) to enable them to carry out their work	LTC/ Illness	74.6	77.0	81.3	78.8
Staff Engagement Score	No LTC/ Illness	7.5	7.6	7.5	7.2
	LTC/ Illness	7.0	7.2	7.1	6.7

Source- 2021 National Staff Survey

The Trust has made progress on the WRES and WDES and wants to be an outstanding place to work for everyone.

From a WRES perspective, we continue to work on the three-year plan to:

- Reduce the percentage of BAME staff experiencing harassment, bullying or abuse from patients.
- Reduce the percentage of BAME staff experiencing harassment, bullying or abuse from colleagues and managers
- Eliminate the gap in experience between our BAME and white staff.
- Achieve consistency in the data for the above WRES indicators for at least three years.

From a WDES perspective, we continue to work on the three-year plan to:

- Reduce the number of disabled staff who experience harassment bullying or abuse from patients
- Reduce the number of disabled staff harassed, bullied, or abused by colleagues
- Eliminate the differential between disabled and non-disabled staff
- Reduce the number of disabled staff experiencing harassment, bullying or abuse from managers

Just and learning culture

ⓘ The Trust is committed to strengthening our Safety Culture to empower staff and patients to raise safety concerns without fear and to facilitate learning from incidents.

As part of the Trust Safety Culture programme, we continue to empower staff and patients to raise safety concerns without fear and to facilitate learning from incidents. This will include reducing any unwarranted disciplinary action and disproportionate sanctions for all staff, whatever their characteristics.

The casework report for 2021/22 indicates that most of our disciplinary cases are ending after the initial fact find stage i.e., they do not proceed to a full disciplinary investigation. The introduction of dedicated investigating officers, funded by and piloted on behalf of Frimley Integrated Care System (ICS), has continued to be successful.

Since June 2021, the investigating officers (IOs) have supported a total of 23 closed cases and are currently assigned 8 live cases. Of the 23 cases which have closed, they have supported a combination of full investigations and fact finds, and have worked on 17 disciplinary issues, five early resolution cases and one whistleblowing case. Of the disciplinary cases that proceeded to full investigation, the average resolution time of the cases managed by the dedicated investigating officers was 52 days (compared to the overall Trust average noted above of 62 days). To the end of March 2022, they have spent a total of c650 hours, an average of approximately 21 hours working on each case. This involves interviewing people, producing and agreeing notes with witnesses and writing the fact find summary and full management reports. This is time that our service managers would otherwise have needed to release from their day jobs to support this work. For comparison purposes, the expenditure on the dedicated IOs this year has been £26K. They are paid at the top of band 7 (NHSP), whereas a number of the internal service managers who undertake investigations are 8a, and on occasions 8b. In addition, service managers are supported by a HR Business Partner at their meetings and with report writing, meaning that this cost would have been roughly doubled if we had not introduced the dedicated team of IOs. Furthermore, feedback from commissioning managers continues to be positive about the timeliness and quality of the work of the dedicated investigating officers.

The data for 2021/22 continues to highlight a disproportionate number of BAME staff who experience involvement in the casework process, and we plan to explore this further with the support of and funding from Equality Diversity and Inclusion colleagues and Frimley ICS.

Belonging to the Trust

Zero Tolerance of Bullying and Harassment and racism, taking action wherever we see or hear poor experience for our people

ⓘ The Trust is committed to promoting and sustaining a working environment in which all members of staff feel valued and respected. Any kind of bullying, discrimination, harassment, racism or acts of indignity at work are deemed as unacceptable and will be fully investigated in accordance with the Trust's Performance Management and Disciplinary Policy.

The Trust has a zero-tolerance policy for aggression, bullying, exclusion and racism. Members of staff have the right to be treated with dignity and respect and any member of staff that raises a concern because they are subjected to behaviour or treatment that does not promote dignity and respect will be fully supported.

All staff are encouraged to report incidents of bullying and harassment through our incident management system DATIX. In addition staff can raise via our Freedom To Speak Up guardian, their line manager or human resources (HR). We also have a dedicated Violence Reduction Lead who monitors reports of bullying and harassment via our incident reporting systems and proactively reaches out to offer staff support. When incidents are reported we conduct an initial fact-find and decide if the incident requires a full investigation. We have an independent team of investigators who will investigate incidents if required.

As well as encouraging people to speak up, we are also building our ability to 'listen up'. Further information on 'Freedom to Speak Up' is detailed later in this report. In the 2021 National NHS Staff Survey, 23.1% of our staff respondents stated that they had personally experienced harassment, bullying or abuse at work from patients / service users, their relatives, or other members of the public. This compares with 27.2% on average nationally. However, the level of bullying and harassment that our staff experience is still unacceptable, and we continue to focus on this area. We have also created a role dedicated to preventing violence towards our staff from patients.

Tackling Racism

The Trust recognises that the vast majority of race related crime/ racial abuse is not reported by staff and

a targeted race crime project is in progress at Prospect Park Hospital, where staff experience significant numbers of race-related incidents. They are following a Quality Improvement approach and the current priority countermeasures include:

- Standard work/flow chart detailing all the steps that will be taken to respond to incidents
- Use of Quality Improvement methodology to reverse de-sensitisation of staff - all wards have a tracker metric about racial abuse
- Running a campaign that gives visual information about how we are doing in relation to any forms of racial abuse, raising awareness and sense of openness, communications, posters, and celebrating each day of success.
- PPARET service (Prospect Park Advocacy for Racial Equality Team) – a safe space for people to be able to speak up, facilitate, mediate, reconciliate, recommend, and communicate. The Equality Diversity and Inclusion (EDI) team is supporting staff at Prospect Park Hospital in the development of a role descriptor for and recruitment to these posts where staff will have protected time in their contracted roles.
- Staff racial crisis team/line – provides an immediate platform to offload
- Standard work/formal escalation process to give different options when informal/local resolution hasn't worked. This would include follow up conversations, feedback on outcomes, support from senior leadership
- Making our Datix incident reporting system form more user friendly for reporting these kinds of incidents, with coaching sessions with staff to build confidence in reporting
- Customised follow up message following the submission of the Datix incident form when reporting these types of incidents, with the option to indicate whether you are satisfied, with follow up actions to take if not satisfied

A dedicated staff safety lead is now in post to provide support to staff and look at ways to reduce physical and verbal violence against them. A post- incident support team is also in place to support staff and managers after an incident.

The 'Ready for Change' Programme looks at raising awareness of allyship and cultural intelligence to build understanding of different perspectives in the workplace. Roll out of this programme is going well with a full and light version available to participants.

The Equality Diversity and Inclusion (EDI) team and Freedom to Speak Up (FTSU) Guardian, as part of the Black, Asian, and Minority Ethnic (BAME) transformation programme, completed a survey of all BAME staff in the trust regarding their experience of micro-aggressions. They repeated the same survey with all staff in the learning disability service and used that data to run training sessions for staff on the impact of micro-aggressions on those they worked with.

In 2020/21, 128 hate-crime related incidents were reported in the Trust. 116 (91%) of these 128 incidents involved race, 13 (10%) involved religion, 7 (5%) involved disability and 3 (2%) involved sexual orientation. As detailed above, there is a dedicated piece of work taking place looking at countermeasures to reduce the incidence of race hate.

Violence and Aggression

We have introduced a new Staff Experience, Support and Improvement Lead to provide additional assistance to staff who have experienced workplace violence and to help with projects relating to violence reduction. Staff who have been assaulted are contacted via email, offered reassurance and practical support, signposted to the appropriate specialist help, and made aware of the range of psychological assistance that the Trust provides for individuals and teams. Staff feedback and concerns are escalated.

To help further reduce assaults to staff, the Personal Safety Team have offered Promoting Safer and Therapeutic Services (PSTS)/Breakaway training to community teams outside of mental health. A new 3-day training package on the prevention and management of violence and aggression has also been developed for staff working on mental-health inpatient wards who are exempt from the full 6-day course.

The Freedom to Speak Up (FTSU) Guardian and Equality Diversity and Inclusion Workforce Manager have led on a programme of work to highlight the extent of racial abuse, Microaggressions and other incidents against staff who may have protected characteristics. Various Services have been surveyed to determine employee's experiences and who the perpetrators are. Survey results are then presented to the service to initiate a conversation between staff and managers and to consider measures to reduce such negative experiences.

New Ways of Working

Supporting our people to work flexibly, including remote working where appropriate, as part of our new offer

ⓘ The COVID-19 pandemic has required staff to work in different ways to maintain safety whilst minimising the spread of the virus. A large proportion of staff have been working from home as a result, and it is important to the Trust that these staff are able to operate safely and effectively.

The purpose of this project is to reduce duplication and waste in our recruitment system and look at ways to make it inclusive and accessible to all candidates. High level mapping for recruitment processes has now taken place, and detailed process mapping is underway. Key issues have been identified and improvements have started to be delivered, for example, the scheduling of interviews has now been automated and this will now be communicated with training provided. The completion of the appointment form is a process that currently causes delays when information is not fully provided, and this form is now being prioritised for digitalisation. We are also exploring how we can provide candidates with status updates on their applications. Lastly, all communications that are sent to candidates are currently being improved to make them more accessible to candidates, and we are looking to pilot sending out questions ahead of interviews to ensure we are fair and inclusive to neurodivergent candidates.

Providing opportunities for our people to show initiative and make improvement for their colleagues and patients through great team working, Quality Improvement and Bright Ideas

ⓘ The Trust has a Quality Improvement (QI) Programme that provides opportunities for staff to make improvements using QI methodology. Alongside this, the Trust encourages Bright Ideas to be submitted by Trust staff to improve services.

The Quality Improvement programme is making a big difference, with 80% of respondent staff in the 2021 national staff survey stating that they were able to make suggestions to improve the work of their team,

Quality Improvement Projects.
Examples of Quality Improvement Projects undertaken by Trust staff include the following:
Rapid Improvement Event (RIE) - 3-day face to face event for over 50 staff on racial abuse of staff at Prospect Park Hospital (PPH). Further Information on this area is included in the 'Belonging to the Trust' section in the Supporting our Staff part of this report.

Bluebell ward self-harm project. Further Information on this area is included in the 'Self Harm' section in the Patient safety part of this report.

Physical health checks for patients with a Severe Mental Illness (SMI) diagnosis- community mental health teams. Further Information on this area is included in the 'Physical Health Check' section in the Patient safety part of this report.

Falls. Further Information on this area is included in the 'Falls' section in the Patient safety part of this report.

Neurodiversity strategy. The Quality Improvement team are supporting the neurodiversity strategy. This addresses the health inequalities, both physical and mental, that exist in service users with diagnosed or suspected neurodivergence. The project is split into three key workstreams, access to services, workforce *and* training and awareness.

Improving the Attention Deficit Hyperactivity Disorder (ADHD) pathway in the Children's, Young Peoples and Families division (CYPF). With support from the Quality Improvement team, the CYPF division are improving the ADHD pathway to deliver assessment and treatment in a way that is timely and clinically effective, minimising waste and maximising efficiency. One part of this has involved reducing time to initiate medication following a diagnosis of ADHD.

Emotionally Unstable Personality Disorder (EUPD) pathway. In 2017 a green belt Quality Improvement practitioner, alongside many Trust staff and patients, developed a new end-to-end EUPD pathway for

community mental health teams and in-patient services. This work continues and has now been rolled out across all services. All elements of the pathway are now operational and there are some good initial indicators with a reduction in occupied beds days at Prospect Park Hospital for people with an EUPD diagnosis. The psychology team within the hospital are also using Quality Improvement methodology and metrics to monitor this.

Bright Ideas

Bright Ideas supports the Trust's commitment to being a learning organisation and delivering innovative and high-quality patient care. The team works at all levels across the organisation to shape, lead, and implement an organisation-wide approach for innovation that is supported by the Executive Team and Trust Board. The team complements existing improvement activity and structures, such as those for Research and Development and Quality Improvement.

Current Bright Ideas innovations include:

- The Health Bus- This project is working to a proposed launch of early 2022. The bus is currently being fitted out.
- Vital Signs Monitoring for children and young people on ADHD pathway- This project will be reviewed and evaluated
- Menopause Support – the trail of the PEPPY app has started, with 112 members of staff having been issued a licence. Anecdotal feedback is positive so far
- Dementia aids- This project is in design stage and aims to create "bus stops" in community wards to distract dementia patients who may try to leave the wards.
- Digital tool for covid and appointments.
- Testing the efficacy of iPads for delivering Cognitive Behavioural Therapy (CBT) in Older Peoples Mental Health. Early results are promising but this needs to be scaled up to test further.

Building on the Bright Ideas platform, we have been developing the use of networks and networking to create connections internally and externally. The purpose of these is to create the ability to respond and support the Trust, with tricky issues that may require an innovative approach. A series of four webinars have been arranged with the first being in April 2022 and is themed around menopause. The following three are related to digital, sustainability and how to make changes in Berkshire Healthcare. We are also in the process of planning a hackathon hosted at Microsoft Thames Valley Park Offices and will work on how we manage soft plastics in Berkshire Healthcare. We are also designing a 'Brighter Together' event planned for October 2022.

Freedom to Speak Up

ⓘ Following a review by Sir Robert Francis in 2015, a national standard 'Freedom to Speak Up' policy was published by NHS Improvement and NHS England. This policy has the aim of developing a more open and supportive culture for staff to raise any issues of patient care, quality, or safety. The Trust has subsequently adopted this standard policy in its own policy.

The Trust's policy and procedure in relation to this area is contained within ORG013- Freedom to Speak Up: Raising Concerns (Whistleblowing). This policy emphasises the importance of staff being able to speak up about any concern to ensure the safety and effectiveness of our services. Under the policy, Trust staff members are encouraged to raise concerns (confidentially, unless required to disclose by law) about risk, malpractice, or wrongdoing that they may think is harming the services the Trust delivers. Such examples may include, amongst others, unsafe patient care, unsafe working conditions, inadequate training, or a culture of bullying.

How does the Trust ensure that staff do not suffer detriment from speaking up?

If a member of staff raises a genuine concern, then they will not be at risk of losing their job or suffering from any form of reprisal as a result. The Trust will not tolerate any harassment or victimisation of anyone raising a concern. In addition, providing that the staff member is acting honestly, it will not matter if the staff member is mistaken or if there is an innocent explanation for the concern.

How can staff speak up?

Staff are encouraged to raise concerns in several ways:

1. By raising the concern with their line manager, lead clinician or tutor (for students). This may be raised orally or in writing and advice can be sought from a trade union if the employee is a member.

2. If the member of staff does not feel they can raise the issue with their line manager, or they feel the line manager has not addressed their concerns, then it can be raised with any of the following; their Locality Divisional, Clinical or Corporate Services Director, The Trust Freedom to Speak up Guardian, The Trust Executive Director with Responsibility for Whistleblowing (Currently the Director of Nursing and Therapies); through a dedicated confidential external telephone line or e-mail service, or through the local Counter Fraud Specialist.
3. If the above channels have been followed, and the member of staff still has concerns, then the Trust Chief Executive or nominated Non-Executive Director can be contacted via e-mail or by letter about the concern.
4. Alternatively, concerns can be raised formally with external bodies such as National Guardian's Office, relevant Registration bodies or Trade Unions, Health & Safety Executive, NHS Improvement, the Care Quality Commission and NHS England.

How is feedback given to staff raising a concern?
Feedback is given as appropriate to each case and would depend on the concern raised and if the information is confidential or not. The aim is to share learning from concerns raised.

The role of the Freedom to Speak Up Guardian
The Trust Freedom to Speak Up Guardian helps to protect patient safety and the quality of care, improve the experience of workers, and promote learning and improvement. This is achieved by ensuring that: workers are supported in speaking up, barriers to speaking up are addressed, a positive culture of speaking up is fostered and issues raised are used as opportunities for learning and improvement. This role is now fully embedded in the Trust and awareness of this facility is very well publicised Trust-wide. Between 1st April 2021 and 31st March 2022, 56 cases were brought to the Trust's Freedom to Speak up Guardian.

2.1.5. Other Service Improvement Highlights in 2021/22

ⓘ In addition to improvements resulting from the priorities detailed above, services have undertaken additional initiatives to improve the quality, safety and experience of care provided to patients. Details of some of these improvements are detailed in the sections below.

2.1.6. Improvements in Community Physical Health Services for Adults

The Nutrition and Dietetics Service have introduced a Ketogenic Dietitian role at the Royal Berkshire Hospital to help treat children with epilepsy. This role has helped achieve improvements in the seizure frequency of children following the ketogenic diet.
The 'Low Carb East' virtual pilot programme for patients with type 2 diabetes finished its second cohort in 2021. All invited patients completed the programme and they all achieved at least a 5% weight loss, with 25% of them achieving a >10% weight loss. The average HBA1c reduction for the group was 16.3mmol/mol, and one patient achieved complete diabetes remission.

Berkshire Community Dental Service (CDS). Many children are referred to the CDS due to a high level of dental decay. Traditionally all decayed baby teeth have been filled or extracted so the child is dentally fit on discharge. However, the national FICTION trial has found that there was little difference in the outcome after 3 years between treating all the decayed baby teeth and only treating those which are symptomatic. This does not apply to decay in permanent teeth which is treated. Therefore, since April 2021, if the child is cooperative for simple treatment, the service has been treating symptomatic baby teeth only. All local dentists were informed of this change in treatment planning, and it was well accepted by the children and families as it reduced the number of appointments. Only those children who cannot accept any treatment in the surgery are referred for extractions under general anaesthetic and the waiting list is reducing as a result. On discharge the dentist is advised to re-refer if the child has symptoms and the service will be monitoring the number of re-referrals to assess the success of this approach.

The Diabetes Service has made considerable changes to its delivery over the past year. A new Diabetes Specialist Nurse referral triage clinic is now in place which allows for earlier intervention and improved consultant consultation. Changes have been made to the duration of all outpatient clinic appointment slots, and specialist technology clinics have also been introduced.

Type 1 and Type 2 Structured Group Education sessions are now being delivered virtually. In addition, the service has developed virtual sessions for people with Type 1 diabetes who are commencing Flash Glucose Monitoring, and Insulin Pump Structured Group Education sessions. They have received one winning and two runners-up awards at the national X-PERT award ceremony for their provision of Type 2 structured education, and a poster has been accepted by the Primary Care Diabetes Society highlighting excellent outcomes following adaptation of Type 1 structured education to virtual delivery.
An Integrated Diabetes Specialist Nursing Service has also started in East Berkshire to support Primary Care teams in managing their patients with Diabetes. Audit has demonstrated the effectiveness of this service in improving diabetes outcomes, as well as an improvement in Health Care Professional skills and confidence. Health Care Professional education has also been adapted and delivered virtually to Primary Care across the Frimley Integrated Care System.
Service improvement methodology is being used by the service to drive improvement in outcomes for people with Type 1 diabetes. From January 2022, the Service has also employed its own dedicated Diabetes Consultant.

The Podiatry Service has continued using data intelligence from the RiO patient record system to help with service recovery post-COVID and the extensive backlog. They can view the specific treatment caseloads for patients with enough detail to support decisions about how best to tackle the backlog.
The service has also secured diabetes transformational funding to improve the acute multidisciplinary foot team pathway at the Royal Berkshire Hospital.

Hearing and Balance Services have developed innovative ways to overcome the capacity challenges faced by their service. They have been able to adapt their limited capacity to address the referral demands on their service and this has resulting in the continued successful delivery of all their Key Performance Indicators. The team also upskilled their workforce to help meet demand, e.g. junior clinicians were trained to carry out assessments of older paediatrics. The team also maximised use of innovative technologies, such as remote fitting apps and software for hearing aids that allow clinicians to remotely reprogramme a patient's hearing aids. A concerted effort was made by the team to reduce the 9-12month backlog for Paediatric Hearing reviews to within 3-months, and this continues to be maintained. The adult backlog was quickly removed within 2-months. As a result, the service continues to receive positive patient feedback and engagement. The service is also working with manufacturers to reduce or improve recycling of plastics and so reduce the carbon footprint. They have updated their diagnostic vestibular equipment to ensure safe and effective provision of balance services. In addition, they have maximised opportunities to celebrate and appreciate diversity and inclusion by hosting a team event for South Asian and Black history months.

The Tissue Viability Service are working collaboratively with mental health services to develop training and support on preventing and managing pressure ulcers. Work to address this has included upskilling mental health staff in this area, weekly support visits by the Tissue Viability Nurses (TVNs) to the mental health units to help review wounds, and support in reviewing patients whose wounds are challenging in nature.

The East Berkshire Lower Limb Service have been pro-active in supporting patients to self-manage their wounds from home, to help them manage independently without complications. They have maintained consistently high healing rates for non-complex venous leg ulcers, with 89% of these ulcers healed within 12 weeks in January 2022.

The East Berkshire Musculoskeletal (MSK) Physiotherapy Team now carry out a blended mixture of face-to-face and virtual appointments, working with patients and staff to determine what the correct hybrid model should be. They have also launched self-help webinars to help members of the public manage their condition and continue to expand their First Contact Practitioner clinics in GP surgeries.

The East Berkshire Sexual Health Service has improved their premises at the Garden Clinic. This has included installation of air conditioning units to ensure compliance with the medicines management safety policy, and to provide a safe, comfortable working environment for both patients and staff. Funding was also received for additional refurbishment and decorating work to help improve infection control and modernise the feel of the service. Refurbishment work is due to be completed by end of March 2022.

Cardiac and Respiratory Specialist Services (CARRS) in the West of Berkshire have implemented a robust triage process for patients in the Heart Function Service. The cardiac rehabilitation team have produced exercise videos that can be used by patients at home.

The Respiratory team have reintroduced staff teaching sessions and have recruited a Home Oxygen Service Assessment and Review Administrator. They have also acquired a stock of Aerochambers to save both patients and clinicians time in having to request a prescription from the GP. The Pulmonary Rehabilitation team introduced a walking diary to support patients to walk as an exercise at home during COVID-19 restrictions. An exercise sheet for patients with an Abdominal Aortic Aneurysm (AAA) has been produced, and they have also recruited a Pulmonary Rehabilitation administrator to free up clinical time for clinicians.

The AIRs Respiratory Service in East Berkshire have implemented a new supportive discharge process for patients in Wexham Park hospital with COVID-19. This service includes an holistic assessment with support and onward referral as appropriate. Overall patients have benefitted from this process and potential adverse events were identified early.

The East Berkshire Heart Function Service are opening more clinic days in Slough, Windsor, and Maidenhead. They are working alongside the Heart Failure Society to produce a national framework of competencies for Heart Function Nurses. In March 2022, they plan to pilot the delivery of IV diuretics in the community and are also planning a pilot of telehealth in Slough and Bracknell in this month to reduce unplanned Heart Failure admissions.

The Berkshire West Community-Based Neuro-Rehabilitation Team (CBNRT) have developed a risk-based system that allowed their patients to return safely to face-to-face rehabilitation during the COVID-19 pandemic. This system includes a face-to-face decision-making tool which has been shared at the National Community Stroke call.
A project has also been undertaken to help the team improve their conversations with patients with severe communication impairments. Training was delivered which has successfully upskilled clinicians' knowledge of communication strategies and increased their confidence in communicating with and providing rehabilitation to these patients.

Wokingham Intermediate Care Team have undertaken a quality improvement project to reduce routine waiting times for community physiotherapy and falls assessments. A root cause analysis identified that Therapy Assistants in the team could help further support this aim, and that these Therapy Assistants had also expressed an interest in further developing and utilising their skills. The team therefore changed the way they traditionally complete rehabilitation follow up visits and this has allowed them to utilise spare capacity more effectively as well as developing the skills of the Therapy Assistants. Alongside other projects, this change has led to a reduction in waiting lists from 18 to under 6 weeks.

The Berkshire West Hospital Discharge Service have implemented a new discharge facilitation service for patients leaving the Royal Berkshire Hospital. This allows patients to leave the acute hospital as soon as they became medically optimised for discharge. The service is based in the Royal Berkshire Hospital and operates 7 days a week.

The Berkshire West Urgent Community Response team for care home residents (UCR-CH) is a unique service that provides an alternative to hospital admission. They support 53 care homes (residential, nursing, general and dementia care) equating to approximately 2500 residents within Berkshire West. These residents are often the frailest in the local population, and many choose to avoid admission to hospital. The team have initiated a two-hour physical health crisis response service for Care Home residents that helps them avoid the need for admission to an acute hospital setting. The service has tripled the number of patients they have supported and have adapted throughout the COVID-19 pandemic in response to the evidence base, leading to higher success rates and reduced COVID-19 related deaths. The service provided essential clinical support, as well as reassuring families that the care their loved ones were being given was equal to that of hospital with the added luxury of being at home. The team supported residents and their families in those final hours and days, and supported families to say goodbye to their loved ones as safely as possible. The team has received a great deal of positive feedback from residents, families, care homes and local authorities for the excellent service that was delivered. At a national level, it was noted that the availability of this service had a positive impact on both hospital admissions and mortality.

Community Nursing Teams in East Berkshire have worked in an integrated way with other services to improve patient outcomes. This has included reviewing their caseloads with GP services and the wider Multidisciplinary Team, covering in-reach services when they are under-resourced and supporting

community wards by providing continence assessments for patients prior to discharge. Electronic authorisation has also been introduced to support best practice in prescribing, and a Diabetic Lead Nurse is in place to support patients on the District Nursing caseload.

Community Nursing Teams in Berkshire West have developed some patient self-management support resources to help them safely and accurately manage some of their own healthcare requirements. These resources cover the administration of insulin and non-insulin injections as well as catheter flushes and simple wound care. Support for patients was maintained by the team through regular telephone contact. In addition, the nursing caseload became more manageable, and teams were able to maintain a higher quality of care delivery to more complex patients.

Reading Community Nursing Team have implemented several improvements during the year. There are seven Community Nursing teams across Reading and these teams worked together to share resources and workload to meet the increasing demand on their service. An allocation project was introduced to look at the current situation and develop a standard work to support with the daily allocation. This project resulted in improved workload, less wasted visits, closer working across the service and more time for completion of records.
The team have also implemented a project to better organise and enhance their triage process to ensure that all referrals are actioned in the same way by all. Roles have also been developed to meet the increasingly complex needs of patients. The practice population has been assessed to look at areas of high care need, and roles such as Wound Care Nurse Specialist, Diabetes Nurse Specialist, Clinical Development and Quality Lead and IV Nurse therapist have been introduced as a result. The team have also invested a lot of time and effort in a recruitment drive and have people actively wanting to join our team.

2.1.7. Improvements in GP Out-of-hours Services and Urgent Care Services

The Urgent Care Team provides GP out-of-hours services via their virtual triage centre, Primary Care Centres, and mobile GP services. They have undertaken a project to optimise their out-of-hours primary care capacity and provide agile support for the Berkshire West system at a time when daytime primary care practices had reduced access and 111 referrals are high. In addition, Point of Care (POC) testing would be delivered in patients' places of residence to avoid admission to acute settings. To achieve this, the team maximised their clinical staffing with Advanced Nurse Practitioners (ANP) and pharmacists to support the GP team. They also piloted new software developments in their Adastra clinical patient management system. As a result, the WestCall GP out-of-hours service has increased the number of patients triaged and treated virtually by 13% on 2020 and by 31% on 2019: averaging over 550 extra patients per month since March 2020. This means that the team is triaging and treating 27% more patients per month since the pandemic started. The Adastra software pilot has meant GPs can safely identify and prioritise urgent cases, and the ANPs, paramedic and pharmacy staff can work through the lower acuity cases. In addition, the provision of point of care testing helps patients to remain in their place of residence and avoid entry to acute settings for diagnostics.

WestCall GP Out of Hours Service has embraced IT changes and now utilises electronic prescribing using smart cards. It allows clinicians who are prescribers to send electronic prescriptions directly to the chemist of patients' choosing. This reduces the risk of forgery, tampering, misplaced paper scripts and is more safe, secure, and robust than other older prescribing methods. It also increases the ability to audit prescribed drugs, eliminates unnecessary face-to-face interactions and removes unnecessary travel. The Service is also using "BIG WORD" to help triage patients whose first language is not English and require interpretation advice.

2.1.8. Improvements in Services for Children, Young People and Families (CYPF), including Child and Adolescent Mental Health Services (CAMHS)

Work carried out across the CYPF Division. The CYPF division continue their proactive response to COVID-19. 2021 started in lockdown with schools and children's centres being shut, and services quickly moved to telephone and then online delivery of appointments. They have built on the advances made with technology and digital solutions to deliver safe and effective care to their patients, and service recovery plans are also being implemented to increase the number of face-to-face appointments. The division also continue supporting the health and wellbeing of their staff, with wellbeing champions identified in teams, wellbeing conversations embedded in management and supervision discussions, and protected lunch times introduced.

Teams have been proactive in embedding Quality Management Improvement System (QMIS) principles. For example, the School Nursing team have used this methodology to reduce the number of patients that do not attend their service, and the Berkshire Eating Disorders Service (BEDS) administrative team have innovated and modernised many of their admin processes during 2021. The division also continues to develop robust working relationships with both Frimley and Berkshire Oxfordshire and Buckinghamshire Integrated Care Systems to develop services.

All CYPF services are involved in the provision of services to children with Special Educational Needs and Disability (SEND). National SEND inspections recommenced in 2021 and the CYPF division were involved in the Reading, Slough and Bracknell inspection, the Wokingham re-inspection and the ongoing reviews within the Royal Borough of Windsor and Maidenhead. The reinspection in Wokingham noted progress made against 5 of the 6 actions. The Reading inspection went well, with the report highlighting strengths in several key areas including joint working, enabling quick responses, and Education, Health and Care Plans (EHCPs) being consistent, clear, and well informed by professional advice. The Slough inspection resulted in a written statement of action but recognised strengths in the use of the Support Hope & Recovery Online Network (SHaRON) digital platform. The formal outcome of the Bracknell inspection is due later in 2022. A standardised central point of access for referrals for an Educational Healthcare Assessment (EHCA) has also been embedded across the service and is working well.

The Children in Care Team have continued ensuring that Initial Health Assessments (IHAs) for children in care are undertaken within 28 days of the child entering care; that children under 5 have a Review Health Assessment (RHA) 6-monthly; and older children have an RHA annually. This multiagency process requires in-depth knowledge of the process itself and an ability to work with partners across six local authorities. The team has also seen an increase in the number of unaccompanied asylum-seeking children referred to them this year and have adapted the service to meet this need. Virtual assessments now also form part of the service offer for review health assessments. The team are also proud of the service offered to children placed in Berkshire by non-Berkshire local authorities (known as "hosted children"). They ensure that these hosted children receive the same service as children looked after by Berkshire's six Local Authorities.

The Children and Young People's Integrated Therapy Service (CYPIT) have embedded an impact-based clinical decision-making model across the service. This ensures that patients receive care that is led by their needs. They have also implemented a new referral prioritisation system that has helped the service to manage their demand. Partnership working has continued with colleagues and key partners in the local authorities to find solutions to address the escalating volume of requests for an Educational Health Assessment. The team in the east of the county have developed online training packages for people in schools to watch at a time of their choosing. In the east of the county a defined Occupational Therapy (OT) action plan is in place to address waiting times.

The Health Visiting (HV) and School Nursing (SN) 0-19 years services continue exceeding national targets in delivering the Healthy Child Programme. The Bracknell HV team have completed all outstanding child development reviews that were suspended during the COVID-19 pandemic and are now able to offer all 2.5yr reviews as face-to-face appointments. The teams have also achieved UNICEF Baby Friendly initiative re-accreditation. Following a competitive tendering process, Berkshire Healthcare have also been awarded the 0-19yr Public Health Nursing contract for the next

3 years with an option to extend for a further 2 years. Reading Public Health team have separately commissioned the school nursing service to deliver a bespoke service to address obesity in children. The Bracknell school nursing team have also secured additional investment to support the development and implementation of school nurse drop-ins, and this has received very positive feedback.

The School Aged Immunisation Service have delivered an expanded flu vaccine programme to all children from reception year to year 11, and quickly adapted their service to deliver the COVID-19 vaccination to pupils aged 12-15yrs. More than 84,000 flu vaccine doses and 23,000 COVID-19 vaccine doses were given between September and December 2021. A specialist nurse has also been allocated to each locality, linking directly Local Authorities to promote uptake of all immunisation programmes. They will also promote uptake in hard-to-reach groups such as traveling families, home educated children, and children in care. Funding for a Health Bus has been secured to support this.

The Community Children's Nursing (CCN) team have made improvements to ensure that a child's bloods are received in a timely manner prior to the child's attendance at an oncology clinic for Intravenous chemotherapy and review by a doctor. A nurse will now visit the child prior to this clinic appointment so that a decision as to how the child should be treated can be made prior to the clinic appointment. This allows the medication to be provided during the clinic appointment without the need for the family to wait and return to the hospital. The CCNs in the west of the county have introduced a rapid response service that provides support and advice to the police when there has been an unexpected child death. They have also introduced an "8-8" service, extending service hours to prevent children being admitted to hospital. The teams have also contributed to a joint workshop with the Alexander Devine Children's Hospice to increase knowledge and understanding of end-of-life care.

The Special Schools Nursing (SSN) Team in Berkshire West have made several improvements to their service. These include clarifying roles with heads of special schools, leading to the development of standard operating procedures; ensuring appropriate SSN cover across these schools; re-assessing clinical competencies and producing a training plan; and reviewing care plans, consent forms and information sharing.

The Woodlands Children's Respite Service have worked with Infection Control Team and NHS Professionals to ensure that the unit has remained open throughout the most recent COVID-19 wave.

The Community Paediatrician Service are bringing services back to pre-COVID levels within COVID compliance restrictions. Face-to-face clinic appointments are now in place with the option to keep online/telephone consultations where appropriate. They have recruited two consultant community paediatrics posts and continue to meet their required targets. The administration team have benefitted from the system envoy post which allows staff to send correspondence electronically and remotely to parents, carers, external hospitals, and other agencies. A joint business case between Berkshire Healthcare and Frimley Health has also been successfully presented to the CCG to support the appropriate medical examinations of children and young people following safeguarding concerns.

The CYPF Dietetic Service is a small and dedicated team that predominantly work with children who have complex health needs and require enteral feeding support. They have reduced the plastic use and costs associated with enteral feeding and have developed consistent and good quality enteral feeding resources across clinical teams. They are also streamlining training for staff in a variety of non- special school settings. A pathway has been developed to help manage constipation in children who are fed enterally. The team are also working with their Speech and Language Therapy and Occupational Therapy colleagues to develop a parental resource to support selective/fussy eaters. Finally, the service is involved with the Berkshire Oxfordshire and Buckinghamshire Integrated Care Service pathway work on Avoidant/restrictive food intake disorder (ARFID).

The CYPF Neurodiversity- Autism Assessment Team and Attention Deficit Hyperactivity Disorder (ADHD) Team. There are national challenges regarding waits for autism and ADHD assessment and the average weeks waiting is 53.85 weeks for an autism assessment and 69.88 weeks for an ADHD assessment. Steps are being taken to address this. Following comprehensive demand, capacity, workforce and transformation modelling completed by the service, significant new investment has been received from the Clinical Commissioning Groups to expand this service and an ongoing recruitment campaign is in place. The service has been successful in appointing 29 Whole Time

Equivalent people to date (around 61% of the target workforce). The investment is also being used to work in partnership with external providers to provide additional autism and ADHD assessments on our behalf (as well as ADHD medication when required). This is significantly increasing the number of appointments the service can offer.

New investment has also been used to establish new posts including Family Support Worker and Children's Wellbeing Practitioners (CWP). CWPs provide brief evidence-based interventions for children and young people with anxiety, low mood, and emotional regulation difficulties. As part of the Support Hope and Resources Online Network (SHaRON) online platform, our digital support platform has now been offered to parents/carers of children with ADHD who are waiting for assessment has also been launched (this was already in place for autism).

The service has also embedded its own digital offer allowing fully digital assessments to be offered alongside face-to-face appointments when needed. An East Berkshire Neurodiversity Network has also been established to connect everyone with an interest in this area, including professionals across health, education, and social care and those with lived experience. The service has also undertaken several Quality Improvement projects which have achieved significant reductions in DNAs, in the wait for medication initiation and the wait for diagnostic decision.

The service has also piloted a transition group with the Adult ADHD team that is designed to support young people who are transitioning from CYPF to adult ADHD services. An innovative research project, called the Growth at Home Project, has also been undertaken by the ADHD team. This trains parents/carers of children prescribed ADHD medication to undertake routine physical monitoring of their child's weight and blood pressure at home.

Child and Adolescent Mental Health Services (CAMHS)

Phoenix Unit (previously Willow House) commenced its new service on 1st May 2021. The Unit provides an intensive day programme and home treatment service for young people aged 12-18 years of age with moderate to severe and complex mental health disorders whose needs cannot be adequately met within community and outpatient settings ("tier 4 CAMHS"). The service has been designed collaboratively with young people and meets the needs of the local population of young people who would otherwise have been admitted to an adolescent inpatient unit. It welcomes up to 16 young people at any one time, with the average length of stay of around 12 weeks. During this time young people access a multidisciplinary assessment and formulation of their difficulties leading to an individualised care plan comprised of evidence-based interventions. The service works collaboratively with other professionals and has recently developed joint working with colleagues in the local acute hospitals. This work has helped facilitate a smoother and quicker discharge from the acute hospital, thus improving patients' and carers' experiences of care received.

Getting Help/ Mental Health Support Teams (MHST) have produced a series of 60 webinars on a variety of topics including supporting young people with eating disorders, ADHD, and managing anxiety. The webinars are targeted at education and other professionals and have been attended by over 1000 people. Four resilience and wellbeing workshops have also been delivered to education settings across East Berkshire. MHSTs have also co-produced an animated video for children and young people that describes their work and how to access their service.

The Anxiety and Depression Pathway (A&D) have carried out team training in the areas of overcoming sensory sensitivities, identifying autism in girls, using imagery in trauma work, autism, and suicide prevention, and managing endings. They also continued to develop their SHaRON online network for parent support and information dissemination. An initiative called 'Find Out Fridays' has also been implemented to provide information on topics such as self-harm, return to school anxiety, Obsessive Compulsive Disorder (OCD), and parent self-care. Parent workshops about OCD and overcoming return to school anxiety were also completed, with recordings accessible anytime via SHaRON. Therapy, review, and discharge checklists have also been developed to help therapy remain goal-focussed

Mental Health and Children in Care. In East Berkshire there has been continued work with the children in care specialist practitioner. Data and cases have been identified across the localities to inform the scope for development of a mental health Children in Care service. A draft service specification has been produced with the aim of increasing the service for this group of young people.

The CAMHS Health and Justice Team delivers health input to the six Berkshire Youth Offending Teams (YOTs). One of its long-term goals is to establish collaborative clinical formulation and trauma informed interventions within the six YOTs for young people who are identified as having complex needs. Each YOT has received training from the team and, where this is fully embedded, the team are finding that caseworkers are becoming more confident and competent at engaging and working directly with young people due to the support and supervision they are receiving from health staff. Multi-agency work is also more effective and streamlined because it is based on a shared formulation.

The Common Point of Entry (CPE) team have implemented several actions to improve efficiency and manage the increase in demand. A clinical skill mix review has been undertaken and the capacity of the admin team has been increased to allow clinicians to focus on clinical tasks. The team have also developed and implemented the "CAMHS Trusted Assessment" to support consistent clinical decision making and reduce waste. A new process and dedicated team have also been created to manage referrals for neurodiversity.

The Berkshire Eating Disorder Service (BEDS) is now one all age service providing seamless treatment across all ages. They offer tailored interventions based on individual need that are appropriate to developmental, rather than chronological, age. In May 2021, the service set up a 12 month "First Episode Rapid Early Intervention in Eating Disorders" (FREED) pilot pathway for 16–25-year-olds. This has resulted in significantly earlier interventions for referrals in this group that meet the inclusion criteria. Additional investment in the service has also seen the creation of business support and new senior clinical roles to help manage the increasing demands on the service. The administrative team have innovated and modernised many of the admin processes. BEDS have also collaborated with 'Beat', an Eating Disorders Charity, to commission training for primary care and acute hospitals staff as well as parent support groups. In collaboration with Oxfordshire and Buckinghamshire, BEDS has also embarked on a 3-year project to develop a "Pathway for Eating Disorders and Autism developed from Clinical Experience" (PEACE) pathway. This is in recognition of the frequent overlap between these two diagnoses and the often-poorer outcomes for people with both. BEDS imagined and subsequently developed the first ever SHaRON (Support Hope and Recovery Online Network) 13 years ago. During this year they have upgraded begun expansion of this digital platform to give access to more resources to more people. BEDS has also continued to provide support in the promotion and marketing of SHaRON beyond the trust.

A Clinical Consultation Group and Forum has been developed to address any unmet need of patients with disordered eating and Avoidant/ Restrictive Food Intake Disorder (ARFID). This Group will help advise and make recommendations to aid clinical decision making for these patients. They will also review cases where the proposed care plan requires additional resource and clinical support from other trust services or requires funding to deliver a care package over and above that within usual service provision.

2.1.9. Improvements in Services for Adults with Learning Disabilities (LD)

Move to the new Campion Ward. As a result of significant trust investment, Jasmine Ward (located opposite the library at Prospect Park Hospital) has been redeveloped, and in May 2021 became the new specialist inpatient learning disability service. This new ward has a modified layout and improved environment for patients and staff alike. It has nine bedrooms which can be allocated flexibly to accommodate different numbers of males and females to separate areas whilst maintaining privacy. Patients can also lock and unlock their bedroom using a fob or wristband. There are two baths with specialist seats, several toilets/ wet-rooms, and a patient laundry area to help people maintain their independence and daily living skills. An outdoor area that is immediately accessible from the ward, with a garden area nearby. A sensory room has been included with an interactive projector system that allows patients to relax, listen to music and play games to promote movement and participation. A dedicated de-escalation area is also included- something the team did not have in their previous location. A much larger clinic room, a multidisciplinary team room with Teams technology and a new rest area is also in place.

Improving health outcomes for people. The Learning Disability Service has been participating in the Trust's "Reducing Health Inequalities Steering Group" to help improve knowledge of and support for patients with Learning Disabilities. This work has included developing the Connected Care and RiO patient record systems to improve the identification and flagging of important information about people with learning

disabilities (to make reasonable adjustment more effective) Awareness training for staff has also been introduced via the trust's Nexus e-learning platform.

Participation in national staff development programmes. Three members of staff from the learning disability service, (a nurse, an occupational therapist, and a speech and language therapist) where independently selected by Health Education England to participate in an inaugural training programme linked to the Advanced Clinical Practice Credential, provided by Edgehill University. The three students are seeking to advance their practice in caring for patients with learning disabilities and/or autism and will be identifying an area for service improvement as part of this. They are currently planning their improvement projects. A member of staff from the inpatient service has also joined the inaugural Professional Nurse Advocate programme. This programme seeks to develop their skills to facilitate restorative supervision for their colleagues and teams, in nursing and beyond.

2.1.10. Improvements in Mental Health Services for Adults, Including Talking Therapies (TT) and Older Peoples Mental Health Team (OPMH)

Talking Therapies

Online Appointment Bookings allow clients to book an appointment into a clinician's diary. This saves administration time and improves the patient journey. The administrative team are also able to use this booking link to book other assessments and can fill multiple appointments more efficiently.

A Direct to Digital Pathway is now available through the service's existing digital offering, SilverCloud. It is important that patients gain access to treatment as quickly as possible to improve the likelihood of engagement, and they can now click on a link at the referral stage to gain immediate access to treatment and support via SilverCloud.

The HealthMakers service delivers peer support and self-management to patients using a volunteer model. The nature of the service and the type of support delivered has not been easily transferred to online delivery, but the staff and volunteers in the team have developed a programme of virtual pop-in cafes and regular online group self- management courses to be delivered in the East of Berkshire. The service is also working with SilverCloud to offer the content of the self -management groups as an online intervention supplemented with peer support.

Talking Therapies Perinatal Pathways have been developed for many years and offer priority assessment and treatment appointments to our perinatal clients (men and women). A named perinatal lead collaborates with perinatal champions across the service to develop and improve the service for clients. Clinical links have also been established with key perinatal services and collaborative working has supported the smooth transition of care across services. A SilverCloud programme on perinatal wellbeing for new parents/ carers has also been implemented and is very well received. Operational procedures have also been updated to extend the perinatal priority period to the child's 2nd birthday.

Clinically Led workforcE and Activity Redesign (CLEAR). This year Talking Therapies have been the Berkshire Healthcare host site for CLEAR. Funded by Health Education England, this programme is designed to help understand rising demands, and uses a unique methodology to recognise how the redesign of services and workforce can improve care. Two clinicians and one clinical sponsor have been trained to deliver this methodology in Improving Access in Psychological Therapies (IAPT). Two projects are also being undertaken, including one focusing on of the Enhanced Trauma Pathway in IAPT.

Psychological interventions for people living with Long COVID. The Talking Therapies service has a key role in providing psychological interventions that focus on depression and anxiety to people living with Long COVID. They have worked quickly and effectively to develop care pathways and interventions in this area**.** They have also worked with Oxford and Buckinghamshire IAPT services to developed Guided Self-Help workbooks specifically for Long COVID and have suggested adaptations to high intensity interventions to support therapists. Teaching on Long COVID has also been provided to therapists and regular group supervision sessions are given. The Talking Therapies team in West Berkshire has strong working relationships with the Berkshire Long COVID Integrated Service (BLIS) at the Royal Berkshire Hospital NHS Foundation Trust and have developed pathways for individuals referred from BLIS to Talking Therapies.

Between February and November 2021, 139 individuals were referred, with a recovery rate of 56% (above IAPT national targets for recovery). In East Berkshire, the Talking Therapies team is working with Frimley Integrated Care Service, offering joint assessments and co-facilitated groups. Four group courses have been completed to December 2021, with a total of 42 individuals completing treatment. The service has also developed a group course, 'Living with Long COVID', focusing on distress, anxiety, and depression.

Community-Based Mental Health Services for Adults

The Gateway to mental health treatment has continued the integration of access to primary and specialist mental healthcare services. Recent developments have streamlined access for clients to an initial mental health assessment. This new process has successfully reduced wait times and ensures that only clients with the greatest need for specialist treatment are assessed by the specialist Common Point of Entry Team. Others can quickly access primary care and wellbeing interventions. To ensure that escalating risk and complex needs continue to be identified and met, the Gateway also host a Teams-based Integrated Referrals Meeting. This is a frequently arranged and well-attended online referrals and pathway meeting. The meeting consistently helps to identify and facilitate the best treatment pathways for clients and avoids duplication and delays. It is an excellent example of multi-disciplinary team working for the benefit of client access and experience.

Op COURAGE: Veterans Mental Health and Wellbeing Service. In April 2020, the Veterans Transition, Intervention and Liaison Service and Complex Treatment Service were rebranded nationally to fall under the umbrella branding of Op COURAGE. The service works collegiately with the Fire Service in Berkshire, Buckinghamshire, and Oxfordshire to help support veterans and have also co-developed a monthly 'Walk-In' in Buckinghamshire for veterans and their families. Veteran peer support workers have been recruited into the service and their contribution to client engagement, recovery and service development has been invaluable. These peer support workers have spent many years in the military and have been pivotal in helping to shape the service to meet the needs of veterans. They work with clients to help with engagement and social support alongside the clinicians, as well as supporting the service by tailoring what they offer to be more veteran-aware.

The Complex Treatment Service has developed several new interventions to support the veterans' recovery. "True Strength" is a compassion-focused therapy informed group approach that addresses issues with anger. The service is also working collaboratively with the London Op COURAGE service to deliver this jointly to clients across both services, and they plan to work with other Op COURAGE services in the coming year to support the wider veteran community.

The service has also introduced the "Be Your Best Ally" group in collaboration with Combat Stress. This is a veteran-specific compassionate resilience group that is based on the work by Dr Deborah Lee for the Berkshire Traumatic Stress Service. The aim is for veterans to develop more compassion towards themselves, and participants have found the group extremely helpful as part of their journey to recovery. The strength of peer support and shared experiences has been fundamental to the success of the group.

A new Group called 'Moving Forward' has also been developed with the aim of helping veterans address transitional difficulties between military and civilian life. It draws upon the lived experience of the veterans working within the team, as well as that of clinicians. It helps veterans to define, comprehend and make sense of the difficulties they have been experiencing, and to use value-based therapeutic exercises that encourage renewed self-discovery with greater flexibility and proactivity in making the most of their civilian life.

Berkshire Traumatic Stress Service has set up a thriving service user group which is helping to shape the service. Service users' views give a unique insight based on lived experience of Post-Traumatic Stress Disorder (PTSD), Complex PTSD and of using the trauma service. Their involvement has helped the service to utilise the ideas, skills, experience, expertise, and opinions of the people who use the service. Some of the areas covered to date include reviewing and co-producing letters and other service materials and developing therapy and group materials.

The Birth Trauma Service has developed a new group to support clients to understand perinatal PTSD / birth trauma, help them to start using techniques to manage symptoms and prepare for memory processing, and to introduce compassion as an antidote to their symptoms and wellbeing to help reclaim their lives after trauma. Group members report that they are finding it helpful to meet other women going through similar situations. Early analysis of group outcome measures suggests some improvement in PTSD symptoms for this group.

Thames Valley Liaison and Diversion Services have implemented a Lived Experience and Peer Support element to their service. They have worked with NHS England and the Revolving Door organisation to recruit volunteers and peer support workers with lived experience of the criminal justice system and vulnerabilities. This will expand across the wider service into the Buckinghamshire, Oxford, and Hampshire areas next year. They are working with Aspire, a third sector provider, who have been commissioned to support the recruitment of staff with lived experience across Buckinghamshire and Oxford. A Service User Engagement Pathway has also been developed that enables service users, once discharged, to engage in service user feedback, forums, focus groups and co-production opportunities.

The service has also been funded by Thames Valley Police to run a small project screening the health needs of a small cohort of offenders before referral into mainstream services. Whilst this was a small project, it identified that individuals who are arrested for a violent offence have a complex array of unmet mental health needs, and there was a higher-than-average level of neurodiversity in the group. The project further identified that 72% of participants had scores suggesting clinically significant Post Traumatic Stress Disorder and Anxiety, whilst 36% indicated severe depression.

NHS England have chosen the service as a pilot site to fund and mobilise a Reconnect Service. This service works with individuals released from prison in the Thames Valley to assess and identify health vulnerabilities and social issues to support them with health and social care needs. This Service has been operational since August 2021 and is due to complete mobilisation into the remaining prisons in March 2022. The early success of the pilot has led to the trust being asked to establish a further pilot site in Hampshire starting from April 2022.

Recognising that female offenders have specific needs that are not currently well served within criminal justice, the service has also worked with partners across Criminal Justice to develop a female pathway within and out of the criminal justice system.

Mental Health services for the Homeless – a service improvement project is being undertaken in Windsor and Maidenhead to identify barriers and facilitators to integrating mental health provision for the homeless, and to make recommendations to improve mental health care for this group.

The Berkshire Specialist Perinatal Service continue to expand their care pathways to meet mental health needs of women during and post pregnancy. They have so far embedded pathways on tokophobia and birth Trauma to support women who fear childbirth and those experiencing PTSD due to traumatic birth experiences. The service aim to launch new care pathways for evidence-based psychological therapies focussed on early pregnancy loss and / or unsuccessful IVF/assisted conception for the East Berkshire community. They also offer assessment and sign-posting services for carers and partners to help alleviate the mental health suffering of people who care for mothers with mental health problems.

The Psychological Medicine Service provide services at Wexham Park Hospital and the Royal Berkshire Hospital. At Wexham Park, the service continues to have an excellent relationship with the hospital team and performance targets are being consistently met. The team continue offering teaching to their acute colleagues which has been well received. Work has started on accreditation by the Royal College to Psychiatrists, which will take place in the new year.

At the Royal Berkshire Hospital service, a practice development nurse has been appointed and is providing a regular space group and reflective practice for the team. They also provide teaching for their acute colleagues as well as delivering restorative supervision sessions.

The Berkshire Early Intervention in Psychosis Service (EIP) now offer a county wide multidisciplinary team meeting via Teams which has resulted in increased consistency of care, team cohesion and the sense of the wider team approach. The team offer clients their preferred method of consultation. They continue to see clients face-to-face, but also offer virtual appointments once clients have returned to work to promote the least disruption to their normal routine. The psychology team also offer additional online support in the form of acceptance and commitment therapy which has received positive feedback. The children and young people's component of the team have also completed an online parent's group.

The Adult Autism Spectrum Disorder (ASD), Adult Attention Deficit Hyperactivity Disorder (ADHD) and Neuropsychology Team are making improvements to their RiO patient record system. An ASD pathway is complete, is being tested and the team are hopeful the ADHD team will follow soon. This improvement will allow the team to have a much better understanding of

their waitlists. There has also been a focus on recruitment and skill mix this year, and the ASD team are piloting a new scheme whereby two Clinical Psychologists from Newbury Community Mental Health Team (CMHT) are on a 6-month placement with the ASD team to learn how to assess and diagnose. The ADHD team have also recruited non-medical prescribers to support the service. The Neuropsychology team have recruited a new assistant psychologist and 3 new administrators.

The Family Safeguarding Model (FSM) is an intervention that focuses on supporting the needs of children and adults in order that children can safely remain within their families. The mental health team have been responsive to the changing restrictions resulting from the pandemic and their clients have expressed a need for an intervention about managing the psychological impact of pandemic restrictions, relaxing and managing the anxieties of increased integration. The service has adapted their clinical offering to accommodate this and be responsive to the changing needs. FSM mental health consultation sessions have been embedded in the Duty and Assessment teams at Children's Social Care sites where FSM is operational. This has allowed for a smoother transition of cases that are escalated to the FSM. Monthly bitesize training sessions have also been embedded, and this part of the service has extended its offering to foster carers, as well as staff. During the year, the FSM team have demonstrated a sustained reduction in crisis contacts amongst their client group. Patient experience data has also shown a reduction in mental health symptoms and an increase in reported family functioning for their group. In January 2022 the service began offering reflective wellbeing sessions to 'therapeutic carers' (as per the Mockingbird model approach to supporting foster carers and preventing placement breakdown).

The Intensive Management of Personality -disorder and Clinical Therapies Team (IMPACTT) have implemented new initiatives in the Mental Health Pathway for people with Emotionally Unstable Personality Disorder.

The Psychologically Informed Consultation and Training (PICT) team is a collection of senior psychologists and psychotherapists with specialist knowledge of working with personality disorders. The journey to recovery for this group can be very difficult if they do not feel that staff know how to best help them, they are 'bounced' between different services, or they feel judged for their difficulties. The PICT work has focused on developing and delivering training packages for professionals working across secondary care and primary care sectors, helping to dispel some of the stigma of this diagnosis, and working with staff to improve their confidence and skills in working with these difficulties. PICT staff are also offering supervision for the Structured Clinical Management programme which forms part of the Emotionally Unstable Personality Disorder (EUPD) pathway. In addition, two of the senior psychologists in the team are now trained in delivering the NHS approved Knowledge and Understanding Framework (KUF), a 3-day programme to address stigma and improve staff confidence in supporting this client group. The PICT team have also appointed an Advanced Lived Experience KUF Development lead who is bringing and using their experience of living with an EUPD diagnosis to co-facilitate training programmes and support the wider Trust strategy.

The Service User Network (SUN) is a new initiative that provides community-based, open access peer support groups across multiple geographic locations across Berkshire. It helps those with personality disorder difficulties who may find it difficult to engage with other therapy services or are waiting to access these. Participants have given positive feedback about their experiences accessing this service.

The Assertive Intervention Stabilisation Team (ASSIST) service, which was initially developed in Slough, has been adapted and extended across Berkshire to provide support to people diagnosed with EUPD who may be experiencing such increased levels of distress that they may be considered for inpatient admission. Inpatient admissions for people with these difficulties hold a risk of becoming lengthy and unhelpful and is often counterproductive to recovery. ASSIST has worked with the Crisis Resolution and Home Treatment Team (CRHTT) and Prospect Park Hospital to support the prevention of admission, or enable safe speedy discharge if admission was unavoidable, by offering a programme lasting up to 12 weeks for up to 14 patients at any one time. The focus of this intervention is to help recover stability by supporting people with their wider needs e.g. housing, financial difficulties etc, as well as therapeutic support and the development of coping skills to manage their risk behaviours.

Dialectical Behaviour Therapy (DBT) and Mentalization Based Treatment (MBT) teams have worked hard during the initial COVID-19 lockdown to enable their intensive therapy offer of weekly groups and individual sessions to move onto remote delivery. This has continued throughout the year, and although some of

the patients found this transition difficult, as did the staff, patient attendance has in fact improved. As a result, the IMPACTT team have recognised the benefit of an ongoing remote therapy offer alongside in-person working.

The Crisis Resolution and Home Treatment Team (CRHTT) in Berkshire West. Professional Nurse Advocate Training has been completed by the manager and nurse consultant, with other key team members due to complete this during the next year. The service also has six non-medical prescribers and five staff members on the Advance Clinical Practitioner Pathway. These clinicians can draw upon, and role-model the four pillars of advance practice that include research, leadership, education, and clinical interventions. Team members have contributed to the development of interactive learning events that address serious incidents and complaints. Transformational work has also been undertaken to allow for tighter integration of the service with NHS111. The service has also worked with "Together" and "Berkshire West Breathing Space" to provide a welcoming and safe space for anybody aged 18yrs and over who is experiencing mental distress or a mental health crisis, as an alternative to using A&E or other urgent care services.

The Crisis Resolution and Home Treatment Team (CRHTT) in East Berkshire has received accreditation from the Royal College of Psychiatrists and is now one of twenty-eight accredited teams in the country. Several service improvements have underpinned this achievement including an increase in the frequency and quality of clinical supervision; tighter integration of the service with NHS111; an increased focus on staff wellbeing and development of medication workshops which provide an opportunity for learning and team supervision from a clinical pharmacist.

Berkshire West Locality Community Mental Health Services. Reading locality are involved in a pilot study relating to the provision of the mental health transformation work. The Pilot has been recruited to and the project is due to start on 1st of April 2022. The Trust are also looking to roll out Mental Health Integrated Care Services (MHICs) in the west of the county. The purpose of MHICS is to offer a service to patients in primary care with significant mental health difficulties, who previously would have fallen in the gap between primary and secondary care. Flow into the MHICS service will mainly be from primary care, with a limited referral rate from secondary care. The Wokingham service will start roll-out towards the end of this year, with Newbury starting in the following year. This project is following on from the MHICs East project which has been up and running for the past 2 years.

Wokingham Community Mental Health Team (CMHT) have recently been re- Accredited by the Royal College of Psychiatrists. This resulted in positive feedback relating to support for student placements, staff wellbeing, the referral process, the team's Structured Clinical Management Programme, the Induction process and collaboration with patients.

Bracknell Community Mental Health Team (CMHT) have introduced a dedicated physical health pathway for patients referred to the CMHT with Severe Mental Illness (SMI). Quality Improvement methodology has also been reintroduced to the team, and this has resulted in several improvements including staff feeling better supported and more confident about managing abusive or threatening calls to the service.

Slough Community Mental Health Team (CMHT) have introduced protected learning for serious incident reviews. They have also appointed a Transitions Lead to support patients discharged from hospital, and to help alleviate any concerns around this.

Older Peoples Mental Health Services (OPMH)

Improving OPMH staff skills in understanding behaviours that challenge in dementia. Over the past year, OPMH have set up a multidisciplinary, Trust-wide steering group to improve the support offered to people with Behaviours that Challenge (BtC) in dementia. As a result of these meetings, a half-day training package was developed to refresh staff skills about therapeutic interventions in dementia care (including formulation models and principles from Positive Behaviour Support) and this workshop has now been delivered to each of the six Community Older Adult Mental Health Services across the Trust. Each community team has BtC champions to attend monthly supervision groups, peer network meetings and CPD opportunities about psychosocial interventions in dementia care. There are now 31 BtC champions across the community services and they plan to deliver two specialist CPD workshops with these clinicians in 2022 (with this learning being cascaded within their local teams). Alongside these positive developments, they are piloting a bespoke specialist assessment form for people referred with BtC, making closer links with existing care home in-reach services, and preparing a

business case to develop mental health intensive support teams in both East and West Berkshire.

Psychology Interventions in Nursing and Community Services (PINC) have been established in East Berkshire for several years, and this service has now been rolled out to West Berkshire Community Services. Two members of staff have been employed to offer integrated care to housebound patients with long term conditions in Reading, Wokingham, and Newbury. The offer available is for up to 12 sessions of Cognitive Behavioural Therapy (CBT) aimed at helping patients to manage the psychological consequences (e.g. depression/anxiety) of living with long term conditions such as Heart Failure and Chronic Obstructive Pulmonary Disease (COPD). Results in east Berkshire have demonstrated a reduction in symptoms, improved quality of life and a reduced use of NHS resources.

Reducing digital exclusion of older people. The pandemic and the move to online and remote ways of working has the potential to exclude some populations, such as older people who do not have access to information technology (IT). To address this, a successful application to the Trust Bright Ideas programme has resulted in two sim enabled iPads being available to loan to older people to participate in online therapy in Windsor and Maidenhead (WAM). Further work is being undertaken to scale this work up and make it available to more older people.

A Post-Diagnosis for Dementia role has been funded in the Windsor and Maidenhead (WAM) memory clinic. This may also act as a template for the development of similar posts in other localities across Berkshire.

Wokingham OPMH Team have made some changes to their memory services over the last year. They have streamlined the assessment process to reduce the number of assessment visits required by the patient from two to one. This has reduced the patient wait for feedback and diagnosis as the team gather any collateral information by telephone, and a scan is also offered at that point. A feedback appointment is then offered when the scan results are available, and this appointment includes cognitive testing and a diagnosis where appropriate. This new process has received positive feedback from both patients and carers. The team have also changed the way they provide information to patients and carers following their diagnosis, as giving too much information at the diagnostic appointment can be overwhelming and hard to retain. To address this, a post diagnostic support practitioner offers an appointment 4-6 weeks after diagnosis to offer support and advice. The team have received much positive feedback on this improvement and patients and carers seem to really appreciate the time to go over their questions.

2.1.11. Improvements in Medicines Management

COVID-19 Vaccination Service. The Trust rose to the challenge of supporting the national COVID-19 vaccination drive in December 2020 and set up a hospital vaccination Hub at Wokingham Hospital. The Pharmacy Team has supported this priority work throughout 2021/22 and actively contributed to process design, vaccines management, staff training and system governance. They have continued to help create safe and effective working solutions as the vaccination drive has gone beyond the Trust in 2022 and into the county's schools.

Enhanced Discharge. A national directive was issued to all Trusts early in the COVID-19 pandemic to facilitate the safe early discharge of patients from acute trusts into community hospitals and then into community settings (known as Enhanced Discharge). The pharmacy team worked with the trust's community hospitals to develop extended working to cover weekend discharges. This relied upon Pharmacy staff working flexibly and beyond their regular contracted hours to deliver medication and advice as-and-when required, and this is now leading to further development of the pharmacy service under the umbrella of the Ageing Well project.

Mental Health Integrated Community Services (MHICS). The MHICS project has rolled out across the Frimley Integrated Care System (ICS) to break down barriers between service providers from all sectors and to support the delivery of holistic care to mental health patients in their own localities. Specialist mental health pharmacists from Berkshire Healthcare are providing advice to patients within their own GP-led Primary Care Networks (PCNs).

2.2. Setting Priorities for Improvement for 2022/2023

ⓘ This section details the Trust's priorities which reflect the Trust Annual Plan on a Page for 2022/23 (see Appendix A). Specific priorities have been set in the areas of patient experience, harm free care, clinical effectiveness, and supporting our people. They have been shared for comment with Trust governors, local Clinical Commissioning Groups (CCGs), Healthwatch Organisations and Health Overview and Scrutiny Committees. Responses to this consultation are included in Appendix H, together with the Trust response to each comment made by the stakeholders.

2.2.1. Harm-Free Care Priorities

Providing Safe Services

- We will protect our patients and staff from getting COVID-19 by using appropriate infection control measures
- We will identify and prioritise patients at risk of harm resulting from waiting times, and always ensure face-to-face care where clinically indicated.
- We will continue to reduce falls, pressure ulcers, self-harm in in-patient services and suicide across all our services.
- We will recognise and respond promptly to physical health deterioration on our in-patient wards.
- We will improve the physical health of people with serious mental illnesses.
- We will strengthen our safety culture to empower staff and patients to raise safety concerns without fear, and to facilitate learning from incidents.

2.2.2. Clinical Effectiveness Priorities

- We will demonstrate our delivery of evidence-based services by reporting on the implementation of NICE guidance related to Trust priorities.
- We will continue to review, report, and learn from deaths in line with new national guidance.

2.2.3. Patient Experience Priorities

Improving Outcomes

- We will reduce the number of patients waiting for our services.
- We will identify and address inequality of access to services and improve outcomes.
- We will collect more patient and carer feedback and use this to deliver improvements in our services.

2.2.4. Supporting our People Priorities

A great place to work

- We will ensure our teams have access to effective health and wellbeing support.
- We will promote a culture of respect, compassion, and kindness.
- We will not tolerate bullying, harassment, or abuse of any kind.
- We will support staff to work flexibly and connect with their teams.
- We will act on feedback from staff to further improve satisfaction and address any identified inequalities.
- We will provide opportunities for staff to show initiative and make improvements through great team working, Quality Improvement and Bright Ideas.
- We will support staff to achieve their career aspirations.

With our health and care partners: We will work in partnership with our health and social care partners to address health inequalities and to collaborate on the redesign of services to provide better and more efficient care.

2.2.5. Monitoring of Priorities for Improvement

All priorities detailed above will be monitored on a quarterly basis by the Trust Quality Assurance Committee as part of the Quality Report and the Trust Board will be informed of performance against agreed targets. The Trust will report on our progress against these priorities in our Quality Account for 2022/23.

2.3. Statements of Assurance from the Board

During 2021/22 Berkshire Healthcare NHS Foundation Trust provided and/or sub-contracted 49 relevant health services.

Berkshire Healthcare NHS Foundation Trust has reviewed all the data available to them on the quality of care in all these relevant health services.
The income generated by the relevant health services reviewed in 2021/22 represents 100% of the total income generated from the provision of relevant health services by Berkshire Healthcare NHS Foundation Trust for 2021/22.

The data reviewed aims to cover the three dimensions of quality – patient safety, clinical effectiveness, and patient experience. Details of a selection of the measures monitored monthly by the Board which are considered to be most important for quality accounting purposes are included in Part 3. These incorporate more than three indicators in each to the key areas of quality.

2.3.1. Clinical Audit

ⓘ Clinical audit is undertaken to systematically review the care that the Trust provides to patients against best practice standards. Based upon audit findings, the Trust makes improvements to practice improving patient care. Such audits are undertaken at both national and local level.

National Clinical Audits and Confidential Enquiries
During 2021/22, 14 national clinical audits and 5 national confidential enquiries covered relevant healthcare services which Berkshire Healthcare NHS Foundation Trust provides.

During that period Berkshire Healthcare NHS Foundation Trust participated in 100% (n=14/14) of national clinical audits and 100% (n=5/5) of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Berkshire Healthcare NHS Foundation Trust was eligible to participate in during 2021/22 are shown in the first column of Figure 32 below. This column also details the national clinical audits and national confidential enquiries that Berkshire Healthcare NHS Foundation Trust participated in during 2021/22.

The national clinical audits and national confidential enquiries that Berkshire Healthcare NHS Foundation Trust participated in and for which data collection was completed during 2021/22 are also listed below in Figure 32 alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry (detailed in the second column of Figure 32).

Figure 32- National Clinical Audits and Confidential Enquiries

National Clinical Audits and Confidential Enquiries that the Trust was eligible to participate in and did participate in during 2021/22	Data collection status, number of cases submitted as a percentage of the number of cases required by the terms of each audit and other comments
1. National Clinical Audits (N=14)	
National Clinical Audit and Patient Outcomes Programme (NCAPOP)	
National Sentinel Stroke Audit	Data Collection: Apr 21 to Mar 22. 417 patients submitted, across 3 services, 80 six-month follow-ups (final figure not yet available). Report due: Annually December 2022
National Diabetes Footcare (Community Podiatry care)	Data Collection: Apr 21 to Mar 22. 279 patients submitted, across 1 service (final figure not yet available). Report due: May 2023
National clinical audit of Psychosis – Physical Health and employment	Data Collection: Apr 21 to May 21. 100 (100%) patients submitted across 6 services. Report due: December 2021
National Clinical Audit of Psychosis – Early Intervention in Psychosis (EIP) Re-Audit	Data collection Oct 21 to Nov 21. 92 patients submitted, across 1 service. Report due: July 2022

National Clinical Audits and Confidential Enquiries that the Trust was eligible to participate in and did participate in during 2021/22	Data collection status, number of cases submitted as a percentage of the number of cases required by the terms of each audit and other comments
National Asthma and COPD Audit Programme (NACAP): pulmonary rehabilitation	Data Collection: Apr 2021 to Mar 2022. 80 patients submitted, across 1 service (final figure not yet available). Report due: Annually 2022/23 (tbc)
National Audit of Inpatient Falls	Data Collection: Apr 21-Mar 22. 3 (100%) patients submitted, across 2 services (final figure not yet available). Report due: November 2022
National Diabetes Audit - Secondary care	Data Collection: Apr 21 to Mar 22. 1652 patients HbAc1, 227 Structured Education and 103 Insulin pump patients submitted, across 1 service (final figure not yet available). Report due: June 2023
National audit of care at end of life	Data collection Jul 21 to Oct 21. 17 (100%) patients submitted, across 1 service. Report due: July 2022
National audit of Dementia – Memory services	Data collection September 2021 to January 2022. 256 patients (100%) submitted, across 6 services. Report due: August 2022
Non- NCAPOP Audits	
National Audit of Cardiac Rehabilitation	Data Collection: Apr 21 to Mar 22. 322 patient assessment 1's & 184 assessment 2's submitted, across 1 service). Report due: Dec 2022
Prescribing Observatory for Mental Health (POMH) – 18b Prescribing Clozapine	Data Collection: Feb 21 – Apr 21. 130 (100%) patients submitted, across 10 services. Report due: August 2021
POMH – 14c Prescribing for substance misuse: alcohol detoxification	Data Collection: May 21 to June 21. 36 patients submitted, across 2 services. Report due: Nov 2021
POMH – 19b Prescribing for Depression in adult mental health services	Data Collection: Oct 21 to Nov 22. 142 (100%) patients submitted, across 6 services. Report due: Apr 22
POMH – 1h&3e: Prescribing high dose and combined Antipsychotics	Data Collection: Mar 22 to Apr 22. 77 patients submitted, across 1 service (final figure not yet available). Report due: August 2022
2. National Confidential Enquiries (N=5)	
A. NCEPOD - Medical and Surgical Clinical Outcome Review Programme- Physical Health in mental Health services	A. Data Collection: Jan 2021 to Jul 2021. 4 (100%) patients submitted, across 1 service. Report due: May 2022
B. NCEPOD – Child Health Clinical Outcome Review Programme- Transition from Child Health to adult services	B. Data Collection: July 2021 to April 2022. 3 patients submitted, across 1 service (final figure not yet available). Report due: 2022/23 (tbc)
C. NCISH - Mental Health Clinical Outcome Review Programme- Suicide and Homicide 2021/22	C. Data Collection: April 2021 to March 2022. 41 (100%) patients submitted, across 1 service. Report due: 2022/23 (tbc)
D. NCISH - Mental Health Clinical Outcome Review Programme- Real-time surveillance of suicide by patients under mental health care	D. Data Collection: April 2021 to March 2022. 82 patients (100%) submitted, across 1 service. Report due: 2022/23 (tbc)
Learning Disability Mortality Review Programme (LeDeR)	Data Collection: Apr 21 to Mar 22. 51 (100%) patients submitted, across 1 service. Report due: May 2023 (tbc)

The reports of 6 (100%) national clinical audit were reviewed by the Trust in 2021-22. This included national audits for which data was collected in earlier years with the resultant report being published in 2021/22. Berkshire Healthcare NHS Foundation Trust intends to take actions to improve the quality of healthcare provided as detailed in Appendix B.

Local Clinical Audits

The reports of 19 local clinical audits and 6 service evaluations were reviewed by the Trust in 2021/22 and Berkshire Healthcare NHS Foundation Trust intends to take actions to improve the quality of healthcare which are detailed in Appendix C.

2.3.2. Research and Development (R&D)

ⓘ The Trust participates in research activity to help provide new knowledge that has the potential to be valuable in managing and treating patients. It is important that such research is open to critical examination and open to all that would benefit from it.

The Trust is committed to research as a driver for improving the quality of care we provide to our patients across Berkshire. It enables our staff and the wider NHS to improve the current and future health outcomes of the patients we serve. In 2021/22 we ranked joint 7th out of 48 Mental Health and Community Trusts for the number of National Institute for Health Research (NIHR) portfolio studies which people participated in.

The Thames Valley and South Midlands region recruited 78,581 participants to research hosted by the National Institute for Health Research (NIHR). At Berkshire Healthcare the overall number of research participants that were recruited in 2021/22 to participate in research approved by a Research Ethics Committee was 1,712 from 37 studies (NIHR reported only).

Divisional Activity and collaborations

The Trust continues to grow its Research portfolio and increase research opportunities for Berkshire Healthcare patients.

The Children, Young Persons and Families Division hosted CO CAT, a study developing an online, parent-led, Cognitive Behavioural Therapy (CBT) programme for children with anxiety because of COVID. Collaborations with the University of Reading and the Children's Speech and language therapy will see an increase in research opportunities offered.

The Community Mental Health East and West Divisions hosted PPiP2. This is a study that aims to establish the prevalence of pathogenic antibodies in patients with first episode psychosis

The Community Physical Health East and West Divisions have hosted projects. ADDRESS II is a project aiming to establish a support system to facilitate future research into type 1 diabetes. PALLUP is a study aiming to identify and understand the palliative care needs of severely frail elders; develop the evidence-base for provision of community palliative care; and co-design resources better to access and deliver palliative care.

The Mental Health Inpatient Division continued to host research studies targeting the development and validity of new tools to measure lived experiences for patients who are under the care of an NHS mental health service. One study is developing new ways to measure negative and threatening voices. This study is sponsored by University of Oxford and funded by a NIHR clinical Doctoral Research fellowship.

Berkshire Healthcare are working with colleagues across the region to increase capacity for Research within the Integrated Care System (ICS). Early engagement has created opportunities for research collaborations. In 2021/22 Berkshire Healthcare continued to successfully collaborate with several partner organisations to act as a Patient Identification Centre (PIC). In addition to this Berkshire Healthcare have collaborated on several grant applications with the University of Lancaster, University of Reading, Queens University Belfast, Oxford Health and University of Oxford. The results of these applications will be confirmed in the 2022/23 financial year.

2.3.3. CQUIN Framework

ⓘ The Commissioning for Quality and Innovation (CQUIN) payments framework was set up from 2009/2010 to encourage NHS providers to continually improve the quality of care provided to patients and to achieve transparency. CQUINs enable commissioners (such as the Clinical Commissioning Groups) to reward excellence, by linking a proportion of service providers' income to the achievement of national and local quality improvement goals.

The Trust have no CQUIN to deliver for 2021/22. The CQUIN programme will be reinstated for the 2022/23 financial year.

The following statements, shown in brackets, have been kept in this report to meet the requirements of the Quality Account regulations.
[A proportion of Berkshire Healthcare NHS Foundation Trust's income in 2021/22 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement, or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2021/22 and for the following 12-month period can be found in the appendices.]

[The income in 2021/11 conditional upon achieving quality improvement and innovation goals is N/A. The associated payment received for 2020/21 was N/A]

2.3.4. Care Quality Commission (CQC)

ⓘ The Care Quality Commission (CQC) is the independent regulator for health and social care in England. It ensures that services such as hospitals, care homes, dentists and GP surgeries provide people with safe, effective, compassionate, and high-quality care, and encourages these services to improve. The CQC monitors and inspects these services, and then publishes its findings and ratings to help people make choices about their care.

Berkshire Healthcare NHS Foundation Trust is required to register with the Care Quality Commission (CQC), and its current registration status is registered with no conditions attached to registration.

The Care Quality Commission has not taken enforcement action against Berkshire Healthcare NHS Foundation Trust during 2021/22.
Berkshire Healthcare NHS Foundation Trust is subject to periodic reviews by the Care Quality Commission. Following our CQC inspection of our core services in November 2019, and a "Well Led" inspection in December 2019 the Trust is now rated as Outstanding overall. Both our Community Physical Health services for adults and our End-of-Life service have been recognised as Outstanding. They join our Learning Disability In-Patients and our Older Peoples Community Mental Health services who also hold an outstanding rating. All our services are now either outstanding or good.

The CQC detailed the following actions that the Trust must take to improve:
Acute wards for adults of working age and psychiatric intensive care wards. The Trust must:

- Ensure that ligature risks are managed appropriately, ensure that patients are kept safe- for example promoting the sexual safety of people using the service, and ensure an alarm system is easily accessible to patients and visitors and that they are made aware of how to use them (Regulation 12)
- Ensure that the ward environment is always adequately furnished and maintained. (Regulation 15)
- Ensure restrictions are necessary and proportionate responses to risks identified for particular individuals (Regulation 13)

Specialist community mental health services for children and young people. The Trust must:

- Continue to work with commissioners to ensure waiting times are not excessive, thereby putting

young people waiting to receive treatment at increased risk. Particular attention needs to be paid to ensuring timely access to services for those referred to the attention deficit hyperactivity disorder pathway and autism assessment pathway.

An action plan is submitted to the CQC outlined how we planned to respond to these highlighted areas and the majority of these are now completed.

Berkshire Healthcare NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2021/22:

1. Wokingham Special Educational Needs and Disabilities (SEND) re-inspection 11th -13th May 2021
2. Reading Special Educational Needs and Disabilities (SEND) inspection 21st – 25th June 2021
3. Slough Special Educational Needs and Disabilities (SEND) inspection 27th Sept – 1st October 2021
4. Bracknell Special Educational Needs and Disabilities (SEND) inspection- December 2021
5. UNICEF Baby Friendly Initiative (BFI) reassessment 7th – 8th July 2021
6. Child and Adolescent Mental Health Services (CAMHS) CQC Integrated Care Service (ICS) review 5th – 15th July 2021

Berkshire Healthcare NHS Foundation Trust intends to take the following action to address the conclusions or requirements reported by the CQC:

- SEND Inspections (items 1-4 above). The action plans are held and monitored by the Local Authorities and CCGs, and the Trust will feed into these, and action as required
- BFI (item 5 above). An action plan has been produced by the Trust and is being progressed
- CAMHS CQC ICS Review- This was an ICS collaborative review with system partners and is being used to help inform the CAMHS project work being undertaken in the Berkshire Oxfordshire and Berkshire ICS area.

Berkshire Healthcare NHS Foundation Trust has made the following progress by 31 March 2022 in taking such action:

- Actions are being progressed as per the action plans noted above.

The CQC has carried out the following unannounced Mental Health Act (MHA) visits during the 2021/22 financial year:

- 27th September 2021- Daisy Ward and Snowdrop Ward- Prospect Park Hospital
- 7th December 2021- Campion Unit- Prospect Park Hospital

2.3.5. Data Quality and Information Governance

ⓘ It is important that data used by NHS services is of a high quality so that it can be best used to inform decisions on the management of patients. In addition, data must be of a high quality to help inform organisational decision-making and planning.

The Secondary Uses Service (SUS)

Berkshire Healthcare NHS Foundation Trust submitted records during 2021/22 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

— Which included the patient's valid NHS number was:
100% for admitted patient care
100% for outpatient care, and
* for accident and emergency care

— Which included the patient's valid General Medical Practice Code was:
99.8% for admitted patient care
99.9% for outpatient care, and
* for accident and emergency care

* This data is now being collected through the ECDS and we do not have any concerns in this area as we have consistently performed over 99%.

Information Governance

ⓘ Information Governance requires the Trust to set a high standard for the handling of information. The aim is to demonstrate that it can be trusted to maintain the confidentiality and security of personal information, by helping individuals to practice good information governance.

Berkshire Healthcare NHS Foundation Trust Data Security and Protection Toolkit (DSPT) overall score for 2020/21 was 'Standards Exceeded'. The Information Governance Group is responsible for maintaining and improving standards in this area.

The 2021/22 result will be updated in June 2022 as per national NHS Digital deadlines.

Data Quality

Berkshire Healthcare NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2021/22 by the Audit Commission.

Berkshire Healthcare NHS Foundation Trust are taking the following actions to improve data quality:

The Trust is using the latest Commissioning Data Set version to send data. Data is continuously monitored, and improvements made where required.

The Trust continues to track the improvement of data quality. An overarching Information Assurance Framework (IAF) provides a consolidated summary of every performance information indicator and action plans. The key messages are shared at monthly IM&T meetings and quarterly super user presentations. A six-weekly data quality forum is held to share the priorities and audit results with services.

Data Quality and Data Assurance audits are carried out throughout the year as part of the IAF, where data issues are identified, and internal action plans are put in place. The data is monitored until assurance is gained so that the Trust can have a high confidence level in the data being reported. The assurance reports and the Performance Scorecard are reviewed in monthly and quarterly locality meetings. External Data Quality reports published on the NHS Digital website are analysed to ensure consistency in reporting both internally and externally.

The clinical coding team continue to review and improve the Trust's diagnostic data. As part of our continuous improvement programme, a full detailed audit took place in November 2021, which showed that 98% of primary and 93.6% of secondary diagnoses were coded correctly. The audit recommendations were to promote collaborative working between clinicians and coders at the earliest opportunity. The second recommendation was to ensure Part II discharge summaries are all completed within the Trust policy timescales; and should be available at the point of coding; as of immediate effect.

2.3.6. Learning from Deaths

ⓘ Many people experience excellent care from the NHS in the months or years leading up to their death. However, some patients experience poor quality care resulting from multiple contributory factors. The purpose of mortality review is to identify whether problems in care might have contributed to the death and to learn in order to prevent recurrence.

The Trust learning from deaths process includes all patients identified on our electronic patient records who have accessed one of our services in the year before death. In most cases these are expected deaths but where a specific trigger is noted (as identified in our policy) we then review these deaths further.

The level of review required will depend on whether certain criteria are met, and we review the care provided for all patients who had a learning disability and died.

Figure 33 below details the number of deaths of Trust patients in 2021/22. This is presented alongside the number of case record reviews and investigations of these deaths that were undertaken over the same period, as well as an assessment of the number of deaths that were more likely than not to have been due to problems in care provided. Please note that the table contains statements that are mandated by NHS Improvement for inclusion.

Figure 33- Deaths of Trust patients in 2021/22- case reviews and investigations carried out in 2021/22

	1. Total number of Deaths	2. Total number of reviews and investigations carried out			3.Deaths more likely than not due to problems in care
Mandated Statement	During 2021/22 the following number of Berkshire Healthcare NHS Foundation Trust patients died	By 31st March 2022, the following number of case record reviews and investigations have been carried out in relation to the deaths.			The number and percentage of the patient deaths during the reporting period that are judged to be more likely than not to have been due to problems in the care provided to the patient are detailed below. (These numbers have been estimated using either Initial Findings Report or Root Cause Analysis methodology)
		1st Stage Case Record Reviews (Datix)	2nd Stage Review (IFR/ SJR)	Case Record Review & Investigation (SI)	
Total 21/22	**3971** ↓	**461**	**209** ↓	**36**	**2 representing 0.05%** ↓
Mandated Statement	This comprised of the following number of deaths which occurred in each quarter of that reporting period:	The number of deaths in each quarter for which a case record review or an investigation was carried out was:			In relation to each quarter, this consisted of:
Q1 21/22	**858**	**110**	**50**	**10**	**1 representing 0.12%**
Q2 21/22	**953**	**128**	**58**	**6**	**0**
Q3 21/22	**1175**	**111**	**47**	**9**	**0**
Q4 21/22	**985**	**112**	**54**	**11**	**1 representing 0.10%**

Source- Trust Learning from Deaths Reports

Several learning points were identified from the review and actions arising from the learning points have been completed and monitored through the Trust mortality review group. The impact of actions is monitored through the Serious Incident process.

Figure 34 below details the number of deaths of Trust patients in 2020/21 that had case note reviews and investigations carried out in 2021/22. This is presented alongside an assessment of the number of these deaths that were more likely than not to have been due to problems in care provided and, as a result, a revised estimate of the number of deaths that were more likely than not due to problems in care in 2020/21. Please note that the table contains statements that are mandated by NHS Improvement for inclusion in the Quality Account.

Figure 34- Deaths of Trust patients in 2020/21 with case reviews and investigations carried out in 2021/22

	1. Reviews and investigations carried out		2.Deaths more likely than not due to problems in care	3. Revised estimate of deaths in 2020/21 that were more likely than not due to problems in care
Mandated Statement	The number of case record reviews and investigations completed after 31st March 2021 which related to deaths which took place before the start of the reporting period (deaths before 1st April 2021)		The number and percentage of patient deaths before the reporting period that are judged to be more likely than not to have been due to problems in the care provided to the patient. (These numbers have been ascertained using either Initial Findings Report or Root Cause Analysis methodology)	The number and % of the patient deaths during 2019/20 that are judged to be more likely than not to have been due to problems in the care provided to the patient.
	Case Record Reviews	Investigations (SIs)		
Total	**75**	**23**	**2**	**3, representing 0.06%**

2.4. Reporting against core indicators

ⓘ Since 2012/13, all NHS Foundation Trusts have been required to report performance against a core set of indicators. This section details the Trust's performance against these core indicators.

Where available, the national averages for each indicator, together with the highest and lowest scores nationally have also been included.

It is important to note, as in previous years, that there are several inherent limitations in the preparation of quality reports which may impact the reliability or accuracy of the data reported.

- Data is derived from many different systems and processes. Only some of these are subject to external assurance or included in internal audit's programme of work each year.
- Data is collected by many teams across the Trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted.
- In many cases, data reported reflects clinical judgement about individual cases, where another clinician might have reasonably classified a case differently.
- National data definitions do not necessarily cover all circumstances, and local interpretations may differ.
- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years.

Figure 35	2019/20	2020/21	2021/22	National Average 2021/22	Highest and Lowest
The percentage of adult mental health inpatients receiving a follow-up within 72 Hours of Discharge *	N/A	N/A	**88.3%**	**73% (Dec-21)**	**No data**
* Please note that we have replaced the older indicator, relating to 7-day follow up of mental health patients discharged with a CPA, as it is no longer being reported as part of the NHS Oversight Framework. Measurement against this new indicator, which requires mental health inpatients to be followed up within 72 hours (3 days) of discharge, is a key part of the work to support the suicide prevention agenda within the NHS Long Term Plan. The National Confidential Inquiry into Suicide and Safety in Mental Health (2018) found that the highest number of deaths occurred on day 3 post discharge, and this new indicator helps to address this.					
Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons: In line with national policy to reduce risk and social exclusion and improve care pathways we aim to ensure that all patients discharged from mental health inpatient care are followed up (either face to face or by telephone) within 72 hours of discharge.					
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of services: The Trust has a good level of compliance with this indicator through the implementation of its Transfer and Discharge from Mental Health and Learning Disability Inpatient Care Policy.					

Source- Trust Tableau Dashboard

The indicator "The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period" is no longer included as it is no longer required to be reported on as part of the NHS Oversight Framework.

Figure 36	2019/20	2020/21	2021/22	National Average 2021/22	Highest and Lowest
The percentage of Mental Health patients aged— (i) 0 to 15; and (ii) 16 or over, readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period	6.1%	6.3%	**6.2%**	**Data Not Yet Available**	
Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons: The Trust focusses on managing patients at home wherever possible and has fewer mental health beds for the population than in most areas. Sometimes the judgement to send a patient home may be made prematurely or there may be deterioration in the patient's presentation at home due to unexpected events.					
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of services, by: Work being undertaken around gatekeeping for admission to the hospital should start to ensure all admissions are appropriate and/or have greater consideration of their benefits and risks. A Post Admission Review (PAR) is now in place and embedded which takes place within 72 hours (wherever possible) and produces an intended discharge date (IDD). This is monitored at the daily bed management team so that plans are checked, and any concerns escalated.					

Source- Trust Tableau Dashboard

Figure 37	2019/20	2020/21	2021/22	National Average 2021/22 For combined MH/LD and community Trusts	Highest and Lowest
The indicator score of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends *This finding has been taken from the percentage of staff respondents answering 'yes' to Question 18d of the National NHS Staff Survey: "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation."*	74.4%	80.1%	**77.0%**	**64.9%**	**45.0%-82.4%**
Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons: The Trust's score is better than average, and this is maintained.					
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of services, by: Implementing a People Strategy that has the overall aim of making the trust outstanding for everyone.					

Source: National Staff Survey

Figure 38	2019/20	2020/21	2021/22	National Figures 2021/22	Highest and Lowest
Patient experience of community mental health services indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period	7.3	7.3	**7.2**	**6.8** (national average)	**5.9-7.5**
Berkshire Healthcare NHS Foundation Trust considers that this score is as described for the following reasons: The Trusts score is in line with other similar Trusts.					
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this score, and so the quality of services, by: Being committed to improving the experience of all users of their services. Data is collected from several sources to show how our users feel about the service they have received. Actions are put in place through several initiatives to improve both an individual's experience and if required to change the service provision.					

Source: National Community Mental Health Survey

Figure 39	2019/20	2020/21	2021/22	National Figures 2021/22	Highest and Lowest
The number of patient safety incidents reported	6294 *	5510 *	Data not yet available through NRLS *	Not yet available **	Not yet available **
Rate of patient safety incidents reported within the Trust during the reporting period per 1000 bed days	62.9 *	62.7 *	Data not yet available through NRLS *	Not yet available ** (Median)	Not yet available **
The number and percentage of such patient safety incidents that resulted in severe harm or death	58 (0.9%) *	37 (0.7%) *	Data not yet available through NRLS*	Not yet available **	Not yet available **
Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons: The above data shows the reported incidents per 1,000 bed days based on Trust data reported to the NRLS. High levels of incident reporting are encouraged as learning from low level incidents is thought to reduce the likelihood of more serious incidents.					
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of services, by: Bolstering the internal governance and scrutiny of serious incident reports, their recommendations and action plans. Implementation of strategies to address common findings in serious incident reports.					

Sources: ** Trust Figures reported to the NRLS. Please note that these figures are representative of the number of incidents reported at the time the report is sent and are subject to change over time.*
*** NRLS/ NHSI Organisation Patient Safety Incident Report covering 6 months between X- X relating to 50 Mental Health Organisations Only*

Part 3. Review of Quality Performance in 2021/22

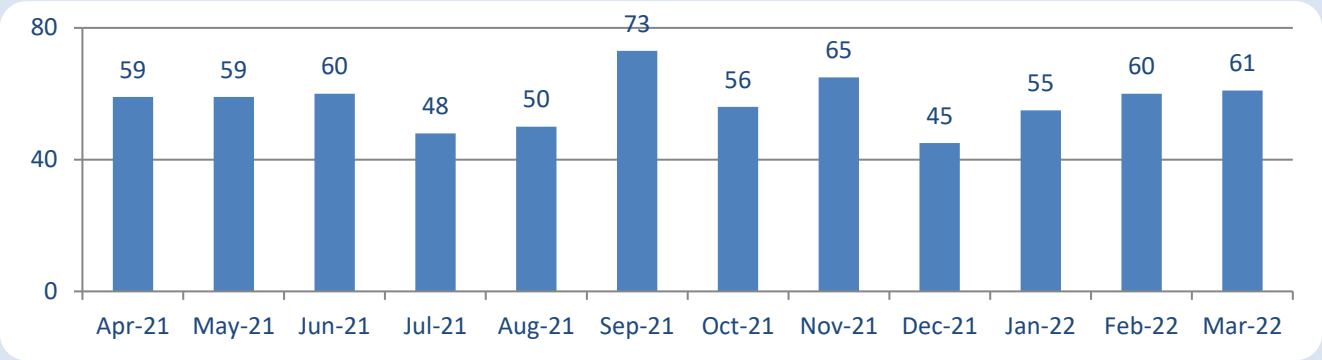
ⓘ In addition to the key priorities detailed in Part 2 of this report, the Trust Board receives monthly Performance Assurance Framework reports related to key areas of quality. The metrics in these reports are closely monitored through the Trust Quality Governance systems including the Quality Executive Group, the Quality Assurance Committee, and the Board Audit Committee. They provide assurance against the key national priorities from the Department of Health's Operating Framework and include performance against relevant indicators and performance thresholds set out in the Compliance Framework. Information relating to specific areas of Trust quality and safety performance in 2019/20 is detailed below.

Medication errors

ⓘ A medication error is any patient safety incident where there has been an error in the process of prescribing, preparing, dispensing, administering, monitoring, or providing advice on medicines. Such patient safety incidents can be divided into two categories: errors of commission (e.g. wrong medicine or wrong dose of medicine) or errors of omission (e.g. omitting a dose or failing to monitor).

Figure 40 below details the total number of medication errors reported per month When interpreting this figure, it should be noted that a high and increasing rate of medication error reporting is a sign of a healthy learning culture in the organisation and that reporting of such errors is being encouraged as the first step in ensuring that a robust safety culture exists. The data reported also includes all the near misses and documentation errors, so they are not all actual incidents. There is also evidence to suggest that not all incidents and near misses that staff acted upon were reported, so any increase may be due to better reporting culture rather than a less safe organisation.
There were no medication errors during 2021/22 that led to moderate patient harm or above.

Figure 40: Number of Medication Errors Reported Each Month



Source: Medicines Safety Quarterly Report

Absent without leave (AWOL) and absconsions

The definition of absconding used in the Trust is different than AWOL. Absconsion refers to patients who are usually within a ward environment and can leave the ward without permission.

Figures 41 and 42 below detail the number of absconsions on a Mental Health Act Section and the number of patients absent without leave on a Mental Health section.

Figure 41- Absent without leave (AWOL) on a Mental Health Section- (Rolling quarters)

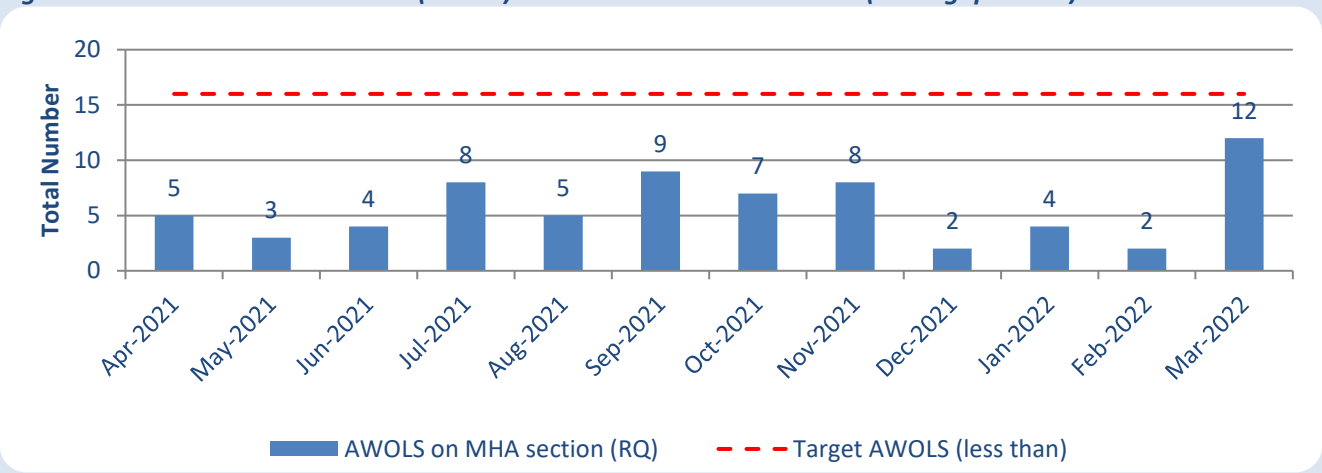
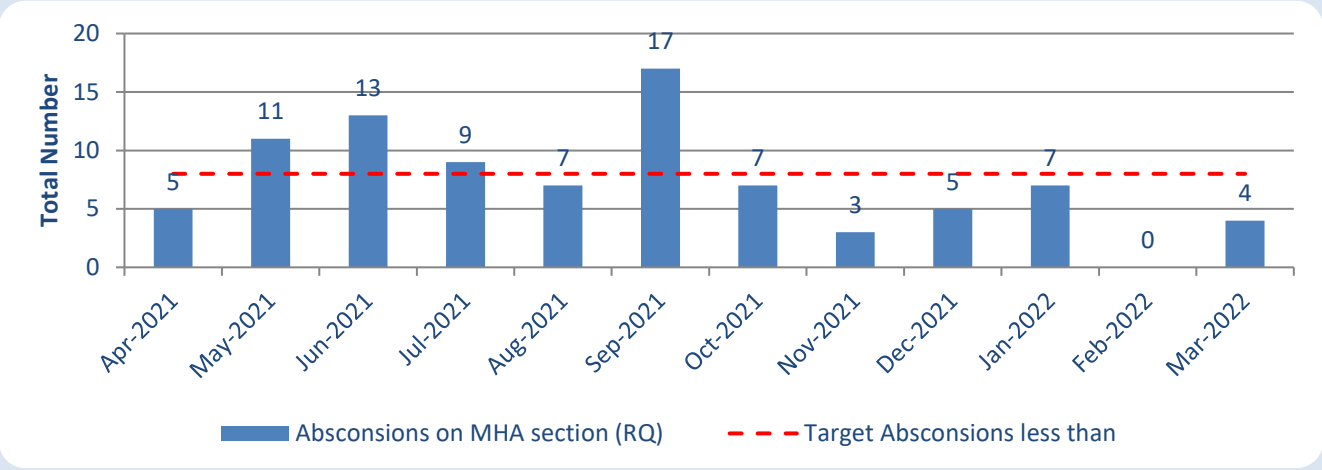


Figure 42- Absconsions on a Mental Health Act (MHA) Section- (Rolling Quarters)



Source- Trust Tableau Dashboard

Other Quality Indicators

Figure 43- Other Quality Indicators	Annual Target	2019/20	2020/21	2021/22	Commentary
Patient Safety					
Never Events	0	0	0	**0**	Total number of never events
Infection Control- MRSA bacteraemia	0	0	0	**1 (No lapse in care identified)**	Total number of MRSA Cases *Source- Trust Inf. Control. Rept.*
Infection Control- C. difficile due to lapses in care	<6	1	1	**3 (Rate 0.03 per 1000 bed days)**	Total number & rate per 1000 occupied bed days of C. Diff due to lapse in care by Trust. *Source- Trust Infection Control Reports*
Medication errors	N/A	910	761	**691**	Total number of medication errors reported. *Source- Trust Medicines Management Report*
Inappropriate out-of-area placements (OAP) for adult mental health services (Occ. Bed days as OAP)	Reduce as per NHSI Target	86 (Target Met)	211 (Target not met)	**194 (Target not met)**	Average monthly total bed days spent out of area
Mental Health minimising delayed transfers of care (Relates to Mental Health delays only- Health & Social Care).	<7.5%	6.8%	4.5%	**3.6%**	Average monthly %. Calculation = number of days delayed in month divided by Occupied Bed Days in month.
Clinical Effectiveness					
Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	53%	91.7%	93.9%	**81.6%**	Average monthly %
Improving access to psychological therapies (IAPT): proportion of people completing treatment who move to recovery	50%	56.7%	55.5%	**53.6%**	Average Monthly %
IAPT: People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral	75%	95.7%	96.9%	**97.7%**	Average monthly %
IAPT: People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral	95%	100%	100%	**100%**	Average monthly %

Figure 43- Other Quality Indicators	Annual Target	2019/20	2020/21	2021/22	Commentary
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge	95%	99.1%	97.7%	**99.1%**	Average monthly %
Patient Experience					
Community Paediatric Service- Referral to Treatment waiting times (RTT)- Incomplete pathways- How many within 18 weeks (%)	95% <18 weeks	99.8%	99.5%	**98.4%**	Average monthly %
Diabetes Service- Referral to Treatment waiting times (RTT)- Incomplete pathways- How many within 18 weeks (%)	95% <18 weeks	100%	99.7%	**100%**	Average monthly %
Complaints received		231	213	**231**	Total number of complaints
1. Complaint acknowledged within 3 working days	100%	100%	99.6%	**99.0%**	% meeting requirement
2. Complaint resolved within timescale of complainant	90%	99.5%	99.7%	**100%**	% meeting requirement

Source- Trust Tableau Dashboard except where indicated in commentary

**Please note that metrics relating to admissions to adult facilities for patients under 16 years old and the Data Quality Maturity Index are not detailed as they are no longer part of the NHSI system oversight framework*

Statement of Directors' responsibilities in respect of the Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, Directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust annual reporting manual 2021/22 and supporting guidance detailed requirements for quality reports 2021/22
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2021 to May 2022
  - papers relating to quality reported to the Board over the period April 2021 to May 2022
  - feedback from commissioners dated April 2022
  - feedback from governors dated April 2022
  - feedback from local Healthwatch organisations dated April 2022
  - feedback from Overview and Scrutiny Committees dated April 2022
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2022
  - the 2021 national patient survey, November 2021
  - the 2021 national staff survey, February 2022
  - the Head of Internal Audit's annual opinion of the Trust's control environment dated May 2022
  - CQC inspection report dated March 2020
- the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review, and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

Date and signature following Board in Q4 **Martin Earwicker, Chairman**

Date and signature following Board in Q4 **Julian Emms, Chief Executive**

Appendix A- Annual Plan on a Page

Annual Plan on a Page- 2021-22

Annual plan on a page 2021/22

NHS
Berkshire Healthcare
NHS Foundation Trust

Our vision: To be **recognised** as the **leading community** and **mental health** service provider by **our staff, patients** and **partners.**

Harm-free care

Providing safe services

- We will protect our patients and our people from getting COVID-19 by using appropriate infection control measures
- We will minimise risk of harm to patients resulting from waiting times
- We will continue to reduce falls, pressure ulcers, self-harm in in-patient services and suicide across all of our services
- We will recognise and respond promptly to physical health deterioration on our in-patient wards
- We will improve the physical health of people with serious mental illnesses
- We will strengthen our safety culture to empower our people and patients to raise safety concerns without fear, and to facilitate learning from incidents

Supporting our people

A great place to work

- We will improve the mental and physical health and wellbeing of our people, reducing Musculoskeletal disorders and other sickness absences
- We will have a zero tolerance to bullying and harassment, and racism, taking action wherever we see or hear poor experience for our people
- We will support the growth and development of our people through high quality appraisal, supervision and training
- We will actively support our people to work flexibly, including remote working where appropriate, as part of our new offer
- We will act on feedback from the staff survey in order to further improve satisfaction and address any identified inequalities
- We will provide opportunities for our people to show initiative and make improvements for their colleagues and patients through great team working, Quality Improvement and Bright Ideas

Good patient experience

Improving outcomes

- We will reduce the number of patients waiting for our services
- We will use patient and carer feedback to drive improvements in our services
- We will manage patient flow effectively and ensure that patients stay within our services for no longer than is clinically appropriate
- We will engage and communicate with patients and the public to make sure that they understand how to access the right help at the right time

Money matters

A financially sustainable organisation

- We will work as a team to manage spend within the financial plan for each service
- We will work as a team to identify opportunities for efficiencies
- We will transform our clinical and non-clinical services using a digital first / patient safe approach, to improve patient experience, streamline our estate, reduce our carbon footprint and support work-life balance for our people

With our health and care partners: **We will work in collaboration with our health and social care partners to address health inequalities and create sustainable health and care that builds on our new ways of working.**

Annual Plan on a Page 2022/23

Our **vision:** To be **recognised** as **the leading community and mental health service provider** by **our staff, patients and partners.**

NHS
Berkshire Healthcare
NHS Foundation Trust

Harm-free care

Providing safe services

- We will protect our patients and staff from getting COVID-19 by using appropriate infection control measures
- We will identify and prioritise patients at risk of harm resulting from waiting times, and always ensure face to face care where clinically indicated
- We will continue to reduce falls, pressure ulcers, self-harm in in-patient services and suicide across all of our services
- We will recognise and respond promptly to physical health deterioration on our in-patient wards
- We will improve the physical health of people with serious mental illnesses
- We will strengthen our safety culture to empower staff and patients to raise safety concerns without fear, and to facilitate learning from incidents

Supporting our people

A great place to work

- We will ensure our teams have access to effective health and wellbeing support
- We will promote a culture of respect, compassion and kindness
- We will not tolerate bullying, harassment or abuse of any kind
- We will support staff to work flexibly and connect with their teams
- We will act on feedback from staff in order to further improve satisfaction and address any identified inequalities
- We will provide opportunities for staff to show initiative and make improvements through great team working, Quality Improvement and Bright Ideas
- We will support staff to achieve their career aspirations

Good patient experience

Improving outcomes

- We will reduce the number of patients waiting for our services
- We will identify and address inequality of access to services and improve outcomes
- We will collect more patient and carer feedback and use this to deliver improvements in our services

Money matters

A financially sustainable organisation

- We will work as a team to manage within the financial plan for our service
- We will work as a team to identify and deliver improved productivity

With our health and care partners: We will work in partnership with **our health and social care partners to address Health Inequalities and to collaborate on the redesign of services to provide better and more efficient care.**

Appendix B- National Clinical Audits- Actions to Improve Quality

National Clinical Audits Reported in 2021/22 and results received that were applicable to Berkshire Healthcare NHS Foundation Trust

National Audits Reported in 2021/22		National Audit Aim/ Objectives	Actions to be Taken
NCAPOP Audits			
1	**National Clinical Audit of Psychosis (NCAP) – Early Intervention in Psychosis (EIP) audit 2020**	In 2019, NHS England published the NHS Long Term Plan and the NHS Mental Health Implementation Plan 2019/20 - 2023/24. These plans set new targets for access to a NICE-approved care package within 2 weeks of referral for people experiencing first episode psychosis and achievement of NICE concordant treatment by EIP services. It also built on the requirements of the original Early Intervention in Psychosis Access and Waiting Time Standard (NHS England, NICE & NCCMH, 2016). The audit standards are based on the NICE quality standards in relation to treating and managing psychosis (NICE QS80, 2015; NICE QS102, 2015)	- Developing a Standard Operating Procedure (SOP) for physical health screening for clients on all stages of their pathway in the team. - Point of care machines are now being trialled in all teams improving monitoring of glucose and lipid levels by clinicians. - Creation of an information pack around clozapine improving knowledge and gaining informed consent from clients and improved documentation around this. - Monitoring of trials of antipsychotic and pharmacist starting early conversations around clozapine with clients in collaboration with the consultant. - Increase provision of Family Intervention training to all staff - Ensure each staff member has an ongoing Family Intervention case throughout year - SOP implemented identifying process to evidence the Access Waiting Time standard via Mental Health Service Data Set and Referral to Treatment Time processes - Process in place to identify and oversee removal of clients once they have been assessed and allocated to a care coordinator to ensure all staff are trained to do this via the SOP.
2	**National Clinical Audit Psychosis (NCAP) - Physical Health and Employment spotlight audit**	The NCAP physical health and employment spotlight audit 2020/21 was commissioned by the Royal College following discussions with NHS England and Improvement and the Healthcare Quality Improvement Partnership (HQIP). The audit looked at the care provided to all patients with psychosis in England and Wales, by adult mental health services in the community (excluding CAMHS and EIP services).	- Training at regular bi-annual intervals. - Case by Case supported on the wards at admission. - Presentation of results from this audit to the consultant group to identify best practice in documentation of assessment of Wernickes encephalopathy and relevant blood tests. - Develop standard work for the documentation of signs and symptoms of Wernickes. - Breath alcohol to be measured as part of initial assessment - Update admission checklist. - Competency Framework for support staff includes this skill- will form part of inductions. - Integrate into essential training – Physical Health Day. - Discussion with Commissioners, Partner Agencies and Pharmacy about relapse prevention medication being prescribed at discharge as currently only prescribed by specialist services. Make a formulary application and take to next DTC meeting for discussion.

National Audits Reported in 2021/22		National Audit Aim/ Objectives	Actions to be Taken
			- To discuss the results for the standard around patients co-prescribed benzodiazepine medication with the medical team and pharmacy colleagues - Local Audit for deep dive into prescribing to understand the rationale for co-prescribing. - To discuss the results for the standard around prescribing parenteral thiamine with the medical team and pharmacy colleagues - Drug and alcohol lead to continue to discuss with prescribers on a case-by-case basis and reinforce efficacy of an IM route for this medication.
3	**National Diabetes Audit (NDA) into Care Processes and Treatment Targets including Structured Education**	The National Diabetes Audit (NDA) measures the effectiveness of diabetes healthcare against NICE Clinical Guidelines and NICE Quality Standards, in England and Wales. The NDA collects and analyses data for use by a range of stakeholders to drive changes and improvements in the quality of services and health outcomes for people with diabetes.	- Internal Funding agreed for a Diabetes Consultant to be employed by Trust - Weekly meetings commenced with Diabetes Consultant (releasing 1PA clinical time to support service development until recruited to internal Consultant post) - New Diabetes Specialist Nurse referral triage clinic in place since Dec 20 leading to earlier intervention and improved consultation when seen in the Diabetes Consultant Clinics - Virtual delivery of Insulin Pump and Type 1 Structured Education - Virtual Group sessions for people with Type 1 commencing Flash Glucose Monitoring - Improved data set due to creation of Diabetes Assessment form on the RiO patient record plus capturing of patients offered insulin pump therapy - Improvement in outcomes for people with Type 1 Diabetes is service driver Metric - Skill mix review – Band 4 Assistant Practitioner Post to be advertised and Diabetes Specialist Dietitian - Attendance at monthly National Diabetes Audit Quality Improvement Collaborative resulting in shared learning. - As part of audit, met with Brighton and Hove NHS Trust who achieve better outcomes. They use a Consultation Tool developed by Kings Collage at Consultant appointments- are more structured. Discussing with Consultants re introducing this tool into practice - Type 1 and Technology specific clinics commenced in July 2021 - Duration of clinic slots increased - Discussed with Frimley ICS Diabetes Board that we need to reduce variation in people with Type 1 Diabetes and improve outcomes. Will work with the ICS so we can obtain data for people with Type 1 who are not managed under Specialist Care. - Member of Trust Reducing Inequalities Steering Group

National Audits Reported in 2021/22		National Audit Aim/ Objectives	Actions to be Taken
Non-NCAPOP Audits			
4	**Prescribing Observatory for Mental Health (POMH) 20a: Prescribing of Valproate in mental health services**	POMH national audit to determine the quality of valproate prescribing in mental health services including physical health checks and off-label prescribing. Aim: To improve the quality of prescribing valproate in mental health services Objectives: 1. To determine whether clear rationales for prescribing valproate are documented including off-label prescribing. 2. To establish the extent to which physical health checks and regular monitoring are taking place while receiving valproate. 3. To ensure women of child-bearing age are on the pregnancy prevention programme 4. To ensure plasma level monitoring is not offered routinely	1. The consultants of all patients that have been highlighted as not having appropriate Annual Risk Acknowledgement Form documentation will be written too to complete asap 2. The Medical Director will remind all prescribers of valproate their responsibilities around the Prevent programme for women of childbearing age 3. A Trust database of all women of childbearing age on valproate will be created and monitored monthly for compliance with the Prevent programme 4. Review off-label cases identified to establish any risks or learning. 5. Presentation of audit and discussion at Medical Educational Meeting 6. To ensure a 3-month review occurs following initiation 7. Promotion of Physical Health Form on RiO patient record and sharing of guidance with the Medical Staffing Committee
5	**POMH 18b: The use of Clozapine**	POMH re-audit addressing the use of Clozapine. Standards are derived from NICE Guideline CG178- Psychosis and schizophrenia in adults 2014, and the British Association for Psychopharmacology - Evidence-based guidelines for the pharmacological treatment of schizophrenia: Updated recommendations from the British Association for Psychopharmacology 2019. A comparison is made against outcomes of the Trust's initial audit (ID 3996) that was carried out in June 2018 (POMH-UK Topic 18a).	- To implement the clozapine care pathway on the RIO patient record. - Clozapine clinic lead to be a regular member of the physical health programme board. - Trust clozapine lead to review physical health monitoring dashboard. - Each CMHT and the early intervention in psychosis team to review processes to ensure that yearly reviews are effectively and safely booked. - Clozapine prescribers to ask GPs in their letters to add clozapine to the summary care record as per the information in the leaflet 'Clozapine – Information for Primary care'
6	**POMH Topic 14c: Prescribing for substance misuse: alcohol detoxification**	This is the third audit on Topic 14: Prescribing for substance misuse: alcohol detoxification. Aim: To improve the quality and safety in the prescribing of patients experiencing substance misuse whereby requiring alcohol detoxification Objectives: 1a. To determine the quality and completeness of the documented assessment of drinking history, current daily alcohol intake and physical examination on admission. 2. To identify which blood tests relevant to the identification of alcohol-related physical health problems have been carried out during at admission 3. Pharmacotherapy to treat the symptoms of acute	- 'How to 'guide to be shared with clinicians through Patient Quality and Safety meetings and the academic meeting attendees. - Liaise with RiO Digital Transformation to simplify process. - Physical Health and Lifestyle form to be promoted via physical health training sessions. - Letter template for use with EPO to have physical health screening added. - CPA process to have physical health checks as a priority. - New Community Mental Health Framework documentation (nationally led) to include physical health checks. - Physical health education and training programme.

National Audits Reported in 2021/22		National Audit Aim/ Objectives	Actions to be Taken
		alcohol withdrawal should be limited to a benzodiazepine, carbamazepine and clomethiazole 4. Thiamine should be prescribed parenterally for inpatients in acute alcohol withdrawal	- Physical Health and Lifestyle form to be promoted via physical health training sessions to include what will work for clinicians. - IPS to liaise with service managers to ensure new starters meet with the team to understand the service offer and how to refer. - Provide update to include in PPSQ agenda (east and west mental health) audit section with the employment actions re CPA and other client discussions.

Appendix C- Local Clinical Audits- Actions to Improve Quality

	Audit Title	Aim/Actions
1	(7420/CA) Consent to admission in inpatient services. Mental capacity audit (Nov 2020)	An audit was undertaken by the Trust Safeguarding Adult Team to establish whether the actions from a Mental Capacity Act (MCA) Audit undertaken in 2019 led to improvement in compliance with the MCA in relation to consent to admission. The aim of the audit was to: • Review the admission process with reference to consent to admission • Establish levels of compliance with MCA 2005 and MCA Deprivation of Liberty Standards (DoLS) and Trust policy 'Admission and Transfer Policy CCR045'. Findings will enable the Trust to identify good practice, gaps in service processes and any barriers to embedding the MCA into everyday clinical practice which will support services to undertake the Quality Improvement project to develop MCA processes. Actions: - MCA flow chart to be implemented in East in-patient wards.- A Quality Improvement project to consider these areas has been raised. - Standard work relating to expected documentation relating to MCA to be developed in conjunction with Safeguarding team.- Clerking on admission by Advanced Nurse Practitioners and medics to include consent statement to examination and treatment. - Electronic Admission booklet incorporating joint initial assessment to be introduced- explore drop down re MCA.- Highlight to service leads and ward managers, with decision to be made as to appropriate action to address in team meetings. Care plan standard work to be developed.- Care plan audit to incorporate review of MCA and personalisation where applicable.- Highlight to service leads and ward managers, with decisions to be made as to appropriate action to address – consider supervision, team meetings.- Include appropriate terminology in MCA training.- Mental health practitioner to deliver training re dementia care and terminology.- Further training will be offered to registered in-patient staff, and will include completion of DoLS application and scenarios of application- DoLS flowchart to be re-shared.- Rio project to ensure dedicated area on system for recording legal representative.

	Audit Title	Aim/Actions
2	(5052/CA) Review of Psychotropic Medications in patients with Learning Disability (STOMPwLD) in Campion Unit PPH	To reduce the rate of mental health related long-term medication prescribed to People with Learning Disabilities (PwLD) and/ or Autistic Spectrum Disorder (ASD) who are in the absence of any documented mental health diagnoses (including adults with a learning disability and/ or autism being prescribed antipsychotics and/ or antidepressants without an appropriate clinical reason). To ensure the prescribing of psychotropic medication in PwLD follow Royal College of Psychiatrists and NICE guidelines. To review medication antipsychotics, antidepressants, anxiolytics, hypnotics, and mood stabilisers prescribed in PwLD. Actions: - Share learning at academic meeting, Learning Disability Governance meeting, Learning Disability doctors meeting, Campion unit meeting - The POMH audit of Learning Disability may function as suitable re-audit - More routine side effect scale for inpatients - Weekly standard Glasgow scale by nursing staff and/ or doctors
3	(6611/CA) Antimicrobial Audit for the Integrated Care Home Service	The Rapid Response & Treatment (RRAT) service provides enhanced medical care to West Berkshire care home residents who have deteriorated and may require hospitalisation. This audit assesses the care pathway when antibiotics are prescribed. Antibiotic prescribing is based on the Berkshire Healthcare and the Royal Berks microguide. Where guidance is lacking, advice is sought from the duty microbiologist at the Royal Berkshire Hospital. The objectives are: - To determine Integrated Care Home Service compliance against nationally recognised standards of good antimicrobial stewardship and practice. - To establish the extent to which local Trust prescribing guidelines for antimicrobial prescribing are followed by prescribers. - To identify areas of potential risk. Actions: - Share learning with all members within the integrated care home service to ensure all prescribers are aware of the need to document antibiotic prescribed, dose, frequency, course length, antimicrobial prescribing from all prescribers (GP, Hospital Discharge, and other Health professionals) while the patient is on the RRAT caseload, the reason if unable to take cultures, allergy status on both clinical record and Rio alert. - To work with audit department to create a data collecting spreadsheet which will simplify analysis of data. - To update data collection form to include data on whether renal function was reviewed, and renal impairment acted upon.

	Audit Title	Aim/Actions
4	(6702/SE) Service Evaluation of Drop-out Rates in DBT and MBT between April 2017 and April 2020 in the Intensive Management of Personality-Disorder and Clinical Therapies Team (IMPACTT)	There is an understanding that in Dialectical Behavioural Therapy (DBT) and Mentalization-Based Treatment (MBT) there is a high drop-out rate in the early stages of treatment (DBT pre-commitment and MBT-I) due to the complex nature of their diagnosis and difficulties in engagement. This is a service evaluation set up to assess the dropout rates within the Intensive Management of Personality-Disorder and Clinical Therapies Team (IMPACTT). This was carried out because of noted high rates of dropouts within the service. The objectives of the project are to look at the drop-out rates in both MBT and DBT streams, the reasons for drop out and the point at which clients dropped out. Actions: - Future research to investigate whether attendance in MBT-I and DBT pre-commitment predicts future attendance and drop out in full treatment. - To investigate the rates of re-referral back into the service and whether treatment was later completed with IMPACTT or another service. - Recognising and assessing client's commitment to see through the treatment at assessment stage, particularly their motivation for change. At this point exploring potential barriers to treatment engagement, and putting together a plan to help overcome barriers, or suggest re-referral for when the individual feels more able to commit to treatment fully. - To additionally look at the role COVID-19 has had on dropout rates, particularly with therapy moving to online format. - To look at drop-out rates in full treatment alone, to be able to compare drop-out rates more directly to the existing literature.
5	(5736/SE) Urinary Tract Infection (UTI) in mental health, to treat or not to treat? …empirically	Urinary Tract Infections (UTI's) are considered a common differential in the aetiology of primary psychiatric disorders, relapse of existing psychiatric disorders and in the elderly. However, despite this knowledge, guidelines for treatment of UTI's remain stringent. The presence of genitourinary symptoms may be considered 'essential' for a confirmed diagnosis of a UTI, but such information may be difficult to ascertain in an acutely unwell psychiatric patient. Patients with mental health problems often refuse to give a urine sample when presented with UTI symptoms, so treating empirically (based on observation / experience) helps with stabilization of mental state and improvement in urinary infection symptoms. There is very little guidance on empirical treatment of UTI's that is based solely on clinical presentation that does not rely on patient reports. There appears to be no guidance that focuses on treatment of suspected UTI's in acutely unwell non-communicative or disruptive and agitated psychiatric patients. This service evaluation was conducted to provide guidance on the treatment of UTI's in acutely unwell patients who are not able to coherently communicate their distress or may be asymptomatic but may have a strong clinical indication of an underlying UTI. Actions: - All patients to have urine dip stick on admission and urine dipstick to be repeated if any change in mental state during hospital stay - To consider empirical treatment based on clinical presentation regardless of urine dipstick - Due attention to be given to patients presenting with change in mental state and clinical suspicion of UTI - Current guidelines for diagnosis and treatment of UTI's to be reviewed - Suggest adding a new category in the current guidelines and devise guideline for 'patients with mental health issues' or 'patients not able to communicate' in the existing protocol.

	Audit Title	Aim/Actions
6	(5916/CA) Daisy Ward Standards and Effectiveness of MDT Documentation Audit Oct-Dec 2019 (Junior Dr Audit)	The quality of Multi-Disciplinary Team (MDT) documentation can have medicolegal implications, result in poor communication between healthcare team members and cause inefficiency in composing discharge summaries due to lack of clarity on the rationale for various treatments and intervention during an inpatient stay. Furthermore, if leave arrangements are also not documented clearly on the MDT-ward round proforma, it can result in conflict between patients and nursing staff. The objective of this audit was to review MDT-ward round documentation compared to standards set out in the GMC's Good Medical Practice and the Royal College of Psychiatry's Good Psychiatric Practice. Actions: - Capture input of non-medical/nursing MDT members on MDT-ward round pro-forma to appreciate the outcomes of their assessments/interventions in the patient's therapeutic journey on the ward. - Document the patient's view on treatment and admission to improve the documentation of shared decision making and patient-centric care. - Improve mental state examination documentation to contribute to the documentation of the rationale for treatment decisions, risk assessments and leave arrangements.
7	(6704/CA) Medication documentation and reconciliation within Crisis Team West (Junior Dr Audit)	Medication prescription and administration has the potential for causing unintentional harm to the patient. In this Crisis Team West led audit, a medication error is defined as an incident in which there has been an error in the process of prescribing, dispensing, preparing, administering, monitoring, or providing medicine advice, regardless of whether any harm occurred. The process of prescribing and giving medication advice is reliant on accurate and up to date. This topic was chosen for audit in order to; review practice and improve (where required) patient safety and reduce medication errors; to measure against Royal College of Psychiatry Home Treatment Team Accreditation Standards; to review whether over the counter medication, alternative therapies or discontinued/non-compliance with medication is documented as prescribed. Actions: - Introduce proforma as part of initial assessment to standardise assessment. - Provide training session to staff introducing electronic medication proforma for initial assessment.
8	(6835/CA) Audit of Prolactin Levels in Patients on Risperidone and Paliperidone (Junior Dr Audit)	Hyperprolactinemia is one of the side effects of antipsychotics. Risperidone is known to have the highest prevalence of hyperprolactinemia. Prolactin elevation results in hypogonadism as it inhibits the release of luteinizing hormone and follicle-stimulating hormone from the pituitary gland. For both sexes, this can cause sexual dysfunction, infertility, galactorrhoea as well as increased risk of osteoporosis. Men may develop gynecomastia, and women may experience hirsutism, acne, and menstrual abnormalities, including amenorrhea and oligomenorrhea. This audit aimed to review practice against Trust Guidelines on Monitoring Hyperprolactinaemia (published in 2019) to identify where practice could be improved, thereby helping to minimise risks. Actions: - Document the reasons behind patients' refusal for a blood test. - Liaise with the GP when patients are not having their prolactin tested for despite being encouraged to do so by their CMHT psychiatrist.

	Audit Title	Aim/Actions
9	(7326/CA) JD - Re-Audit of Assessment of Alcohol use in Royal Berkshire Hospital Psychological Medicine Service (PMS)	Alcohol consumption is common in the UK. According to statistics, there was an estimated 1.3 million hospital admissions (7.4% of all hospital admissions) with either alcohol use being the primary reason for admission or forming a secondary diagnosis. NICE guidelines (for the assessment of alcohol in liaison psychiatric services) recommend the use of formal assessment tools to assess the nature and severity of alcohol misuse, though a previous audit identified non-compliance with this recommendation. As a result of the previous audit, the PMS decided that it should start using an Audit tool during a patient full assessment. Also, since the previous audit an Alcohol Nurse has been in role (commenced October 2020) at the Royal Berkshire Hospital. The aim of this re-audit was to review whether the Psychological Medicine Service based at the Royal Berkshire Hospital is following local Standard Operating Procedures and NICE guidance when assessing alcohol use in in patients. The objectives were to determine current compliance and compare against the previous audit, to identify the cause of any non-compliance, and to implement changes to practice to improve practice, if required. Actions: - Integrate Alcohol assessment into PMS assessment template. - Use Audit-C in assessments to triage patients who need a more comprehensive review by Alcohol and Drug specialist
10	(5322/CA) Berkshire Community Inpatient Ward Audit: Are the nutritional needs of community inpatients being met?	The aim of this audit is to assess if patients on the community inpatient wards are able to choose their own meals and meals are suitable for any dietary restrictions taking into account; whether every patient is screened using the Malnutrition Universal Screening Tool (MUST); whether details of factors relating to nutritional risk are recorded for every patient on initial assessment; if the nutritional screening stages are completed correctly and outline any possible areas of difficulties; the correct plan is documented and whether the appropriate plan put in place was a result of the initial score; whether a patient at medium risk or high risk of malnutrition has been commenced on a food record chart and whether the appropriate action plan has been commenced and followed correctly as well as whether a patients special dietary requirements are noted on admission and visible to the healthcare professional completing menus and serving food. Actions - Training on MUST and support given on a regular basis to nursing staff. Develop training videos to support ward and community staff. If MUST score greater than 2, refer to dietitian. - Provide International Dysphagia Diet Standardisation Initiative framework training to staff. - The menu is re-evaluated to contain codes with options for cultural preferences and special diets. More options given as currently only one option for vegetarian, one non-vegetarian and one fish-based meal. - Timely collection of meal orders. E.g. to take meal orders one day in advance to ensure all patients receive their requested meals from the catering department. - Arrange regular staff training on dietary requirement including special and religious diets. - Recommend proper menu planning, include alternative single meal option such as salad meal to break monotony of daily meals, use of À la carte menu along with cyclical menus to offer additional meal choices to meet religious & therapeutic requirements of patients as all meals cannot be incorporated into standard set menus.

	Audit Title	Aim/Actions
11	(7601/CA) Re-audit on Management of Non-Gonococcal Urethritis (NGU)	This is a re-audit assessing performance against the 2015 British Association for Sexual Health and HIV (BASHH) UK National Guidelines on the management of non-gonococcal urethritis (NGU). This project links to a previous audit carried out in 2018/2019, ID 4661. Aim to identify potential areas for improving our investigations and management of NGU to overall enhance patient care. Actions: - Ensure clinicians are aware of where to locate the leaflets available in clinic or SMS link to Patient Information Leaflet on BASHH website - Document offer of written information on the patient proforma by free text or selecting the 'advice/leaflets' box - Clinicians informed re. the window period for NGU contacts and ensure this is re-iterated to the patients - Change 'contact slip' check box on proforma to 'partner notification' as a prompt for clinicians to discuss with patients and document - Encourage all patients to complete a full sexual health screen including HIV testing - PIC or PIB code if a test is declined or not required (recently negative and no risk or still in window period), this should be documented in the notes - If a patient is needle phobic and declining, Point of Care Testing should be used - Mycoplasma genitalium testing available locally - Testing all men presenting with urethritis at the first attendance
12	(8148/CA) Compliance to Guidelines for Paediatric Hearing Aid Verification – a Clinical Audit.	This audit reviews paediatric Hearing Aid appointments for compliance to guidelines with respect to hearing aid verification (BSA, 2018; Hearing and Balance Services Department, 2021). Aim to increase compliance of departmental staff with hearing aid verification guidelines for paediatric appointments. Actions: - Amend proforma for appointments to allow for recording clinical reasoning for verification processes. - Provide training to all appropriate departmental staff on how to conduct Real Ear to Coupler Difference measurements and the importance of these.
13	(7221/CA) Antipsychotic prescription for management of delirium in older adult in acute setting (Junior Dr Audit)	This audit is based on NICE Clinical Guideline CG103 and NICE Quality Standard QS63 regarding the assessment of antipsychotic use in management of older people presenting with delirium in acute inpatient wards. Aim to improve the management and treatment of patients with delirium. Actions: - Qualitative research (a survey or retrospective audit or cohort study using the same sample) to look at the patient characteristics who are being prescribed antipsychotics for delirium. - Long term follow-up of the patient discharged on antipsychotics and whether they are reviewed and/or stopped by other services. - Consider training needs and education for staff in care homes on delirium presentation and management.

	Audit Title	Aim/Actions
14	(7781/CA) Assessment of alcohol use disorder and its cognitive sequalae in older adult PMS referral in year 2020 (Junior Dr Audit)	Psychological Medicine Services (PMS) is participating in the Trust's 'Alcohol and Cognitive Impairment (working) Group', with a view to developing a pathway within Older Persons Mental Health (OPMH) Services for individuals presenting with cognitive impairment and alcohol use. This audit was designed to review the process of assessment and management of all referrals to PMS Older Adults with alcohol related problems and cognitive impairment. Through this audit, it is hoped that the PMS service can ensure that when an older adult is referred for any alcohol related problems, a holistic assessment of alcohol misuse and it's cognitive sequalae and consequently their management is in accordance with national standards. Actions: - Add the 3 questions of the Audit C to the proforma used by mental health nurses. - Ordering, distribution and training of Emergency Department and ward staff to use Audit C scratch card. - Education session about alcohol assessment and availability of secondary services for signposting and referral. - Creation of a pathway for alcohol assessment and referral for older adult PMS
15	(8234/CA) Re-audit on communication between health professional and next-of-kin during the course of inpatient admission (Junior Dr Audit)	This re-audit was conducted to establish whether there had been a change in current practice pertaining to communicating with the next- of-kin during inpatient admission at Prospect Park Hospital, following the baseline audit (ID 5493). The baseline audit took place in 2019, for which the Royal College of Psychiatrists' Standards for Inpatient Mental Health Services (2nd edition, 2017) were used to demonstrate national guidelines for best practice. The standards have since been updated to a 3rd edition published in 2019. When a patient is admitted to a Psychiatric hospital, it can be an unnerving experience not only for patients, but also for their next- of-kin, who are often also their caregivers. Educating the next- of- kin about patient diagnosis and treatment may equip them with skills to support patients, enhance treatment adherence, decrease relapse rate, and ultimately lead to a decreased financial burden on mental health services. Thus, it is important for doctors, with patient consent, to communicate effectively with the next-of-kin during inpatient admission. Actions: - Weekly Multidisciplinary Team (MDT) prompts to communicate with next-of-kin to share clinical information. - A RiO patient record template for documentation of contact made with next- of-kin. - The Carers' Strategy Team will review and update local policy on the Intranet.
16	(6554/SE) - Understanding Barriers & Facilitators to Accessing & Engaging in Mental Health Support in Adult Survivors of Domestic Abuse	There are many mental health sequelae of domestic abuse, such as depression and anxiety disorders. The BRAVE service in Berkshire has recently been set up to provide psychological support for survivors of domestic abuse. BRAVE is based in Slough Community Mental Health Team (CMHT) and covers East Berkshire, with funding for a 3-year pilot provided in partnership with the Domestic Abuse Partnership Boards across East Berkshire and the Thames Valley Police & Crime Commissioner. The service is not receiving an even number of referrals from all areas within Berkshire, and it is not clear whether this is because the service users themselves do not want to seek support, or because third sector organisations are not making referrals. This service evaluation aimed to understand the reasons and to identify the barriers and facilitators to accessing domestic abuse mental health support, as well as what may help to keep victims engaged in this support. Action: 1. Educating wider professional networks on domestic abuse and its mental health sequelae. 2. Highlighting the importance of wider marketing. 3. Tailoring victim-facing materials to address their concerns and fears.

	Audit Title	Aim/Actions
17	(7381/SE) Evaluation of the Trust Positive Risk Management Panel's Recommendations & Implementation (Junior Dr Project)	This service evaluation will allow an assessment of the effectiveness and success of the Positive Risk Management Panel (PRMP) in aiding decision-making by reviewing the types of questions brought to the panel, the recommendations made by the panel and whether these recommendations are ultimately implemented. The aim is to understand the themes within questions posed to the PRMP, explore the types of recommendations subsequently made by the panel and determine the extent to which these recommendations are followed and applied by the clinical team. Actions:- Educating clinical teams as to the role of the service.- Triaging referrals.- Introducing a mandatory feedback tool for clinical teams to return to the panel, documenting adherence and justifications for deviation.- Audit of justifications given.
18	(7885/SE) - Staff engagement with the Support Hope and Recovery Online Network (SHaRON)	This service evaluation aimed to review staff engagement with the Support Hope and Recovery Online Network (SHaRON) within Berkshire Healthcare services, as SHaRON has varying levels of uptake and success across services. SHaRON is an online, peer support network, moderated by staff, accessible 24/7 to service users and/or relatives and carers. It was important to consider reasons for the varying levels of uptake, as less success means that service users do not have access to a potentially beneficial support network and when utilised, SHaRON is a system that can help Berkshire Healthcare reach its True North Goals. Actions: - Provide initial and refresher training to staff. - Each service to define their SHaRON referral pathway and eligibility criteria. - Provide anonymised anecdotal accounts from SHaRON users to clearly outline the benefits of joining - Communicate examples of potential risks and safety concerns and mitigations in place and perceived risks and safety issues by staff and actual experience of SHaRON users. - Create more 'pull' or demand from service users to become SHaRON members by advertising it. - Provide update at Trust briefing event on SHaRON to show there is a high level of support and endorsement and to generate further interest. - Communicate a 'you said', 'we will do' approach followed by a 'you said' 'we did'.
19	(7427/CA) Audit of Child Protection Record Keeping Documentation 20-21	The aim of this audit was to establish if the key actions from the previous audit (August 2018) have been adhered to in Berkshire Healthcare NHS Foundation Trust, for children subject to a Child Protection Plan, and that there is good compliance of the use of the Safeguarding Form. Actions: - All Trust and Royal Borough of Windsor and Maidenhead practitioners will be reminded to request core group minutes & record the request in the child's records. - To increase the number of cases to ensure that the report is shared with the child's parents. - To ensure that the social workers details are recorded on the safeguarding form. - As per the record keeping policy to ensure that all RiO patient record entries are validated once complete. - All practitioners should ensure they attend the Core Group meetings.

	Audit Title	Aim/Actions
20	(7600/CA) Mental Capacity Act (MCA)-Standards audit for adults who lack capacity to consent to dental investigations & treatment under IV sedation	This retrospective audit is part of the work of the Regional Managed Clinical Network (MCN) for Special Care Dentistry. It is a starting point to assess current practice with a view to standardising the way capacity is assessed and consent gained for our patient group who require serious medical treatment. The same audit is taking place in Bucks Community Dental Service (CDS) and Oxford Community Dental Service; this information will be shared. The aim was to carry out a retrospective baseline audit to assess current compliance against the MCN standards. Actions: - As part of the work of the MCN, new consent forms were developed to be considered for use across the region. These address all aspects of the standards that the audit assessed. - This new consent form could be considered by the management of the Berkshire Community Dental Service for implementation when finalised. - Follow up the results from the other services. - Inform Berkshire Community Dental Service senior management team of the audit findings and the potential new consent form which will better ensure compliance. - Introduce staff to the new consent process. - Consider re audit if agreed after a suitable time period.
21	(8413/CA) Re-Audit of The Quality of Review Health Assessments for Children and Young People in Care	This audit is required as part of the reporting schedule (Children and Young People in care) to Frimley and Berkshire West Clinical Commissioning Groups. This is a re- audit based on the national standard for the quality of health assessments. (National Tariff Payment System). The audit is of Review Health Assessments (RHAs) completed by Berkshire Healthcare staff. RHAs completed by non-Berkshire Healthcare staff are quality assured individually at the time of receipt. Actions: - The findings of the audit will be shared at the Children, Young People and Families Directorate, Patient, Safety and Quality meeting. - The following will be incorporated into the level 3 children in care training provided for all staff undertaking review health assessments. The following should be recorded on the RHA: - the date of all past appointments with health professionals.- the date of all future appointments with health professionals.- the date of the last dental check should be recorded and can be obtained from the child / young person or carer. If a child is aged 3 years and is not registered with a dentist, then a recommendation should be made to register with a dentist.- Information gathered from other health professionals providing care e.g. (CAMHS, therapies, hospital services, GP)- the date of the most recent eye test - the date of the most recent hearing test should be recorded on the RHA if available. If it is not available, the date can be obtained from the newborn hearing screen service or care plus. If the child has not had a school entry hearing screen at the appropriate age it will need requesting from school nursing or audiology.- Information from other health professionals should be gathered and recorded on the RHA. If the child is in receipt of one of these services and it is provided by Berkshire Healthcare, then the information will be available on RiO. If not, then the practitioner will be required to obtain this information from the relevant health professional. - The Drug Use Screening Tool should be completed for all children were there is evidence of substance misuse. - The Strengths and Difficulties Questionnaire should be available and if not, the reason recorded. - The family composition of the home where the child is placed should be documented. If the child has an Education, Health and Care Plan which is not available on the RiO patient record then a copy should be requested from Social Worker.

	Audit Title	Aim/Actions
22	(7935/CA) Discharge communication between general adult acute psychiatric ward, GP, and community mental health team	Given a probable positive association between increased numbers of re-admittance to hospital and delay in dissemination of discharge summaries to appropriate care givers, as well as increase in risk of adverse events to patients in post- discharge period; it is vital that discharge communication is efficient amongst secondary and primary care providers for a safe continuity of care. This audit aimed to improve the content of initial discharge letters which are sent to the GP when a patient is discharged from the ward. Specifically, it reviewed whether the initial discharge letter is sent within 24 hours of discharge to the GP, and whether the initial letter includes elements of care planning as outlined in NICE guideline (NG53) Transition between inpatient mental health settings and community or care home settings. Actions: - Doctors to ensure that discharge plan/care plan section in discharge letter is completed. - Having clear subtitles such as physical health and housing/benefit in discharge letter may act as reminders or prompts to including this information. - Similarly, questions with specific wording are likely to improve documentation on social aspects of care. - Whenever a safety plan is completed partially or could not be completed at the time of discharge, then reason to be documented within safety plan.
23	(4875/CA) Discharge paperwork audit (2019) managing discharges within the Slough Home Treatment Team	Within the Crisis Resolution and Home Treatment Team (CRHTT) East, it had been apparent that discharges were not being completed in a timely manner, potentially leading to several implications: - Patients may request their discharge summaries, and if the paperwork is not completed, they are not able to access this. - Without a discharge summary, the GP may not be aware of any changes to medication, therefore individuals are not able to receive up-to-date repeat prescriptions. - Sometimes, if the paperwork has not been completed and the individual has not been fully discharged from the team, this may delay access to another service. The objectives for this audit were to check and understand the team's current performance against the agreed clinical standard which is: discharge paperwork should be completed within 7 working days of the individual being informed of their discharge. Actions: - A discharge summary must be completed for all patients within 7 days of their discharge from CRHTT. - Even if patient's care is transferred to community mental health team, GP must be notified following their discharge. - A discharge letter/summary must be sent to GP's informing them of all admissions to PPH during CRHTT input. - We agreed that a discharge is not required each time for a frequent attender unless there is a change to their care plan. - A discharge letter/summary must be sent for patients with out of area GP's withing 7 days as a standard. - Where a discharge summary is not done, reasons should be documented in patient's progress notes. There appears to be various ways of sending these discharge summaries out to the GP – via post, electronic transfer via docman and envoy post. Not all staff members appear to be either familiar with or not having access to docman or envoy post. - Staff should have access and adequate training for electronic transfer methods. - Staff should have protected time in rotations dedicated for completing discharge summaries. - Discharge summaries completed by Band 3 staff require countersigning by their supervisors which sometimes cause delay. There should be a dedicated 1:1 weekly supervision for Band 3 staff.

	Audit Title	Aim/Actions
24	(5525/SE) Evaluation of group psychoeducation for perinatal Post Traumatic Stress Disorder (PTSD)	Approximately 4% of women develop PTSD following a traumatic childbirth. However, as childbirth is generally viewed as a positive life event, there is currently a lack of understanding and awareness of postnatal PTSD, and many women go untreated. The Berkshire traumatic stress service set up a birth trauma pathway to treat women with postnatal PTSD. As postnatal PTSD is often misunderstood and women report feeling alone in their struggles, a psychoeducation group was trialled to help individuals to understand their diagnosis and treatment and allow them to speak to other women experiencing similar difficulties. To our knowledge, there are currently no studies or audits exploring the use of psychoeducation groups for perinatal PTSD. Actions:- To continue delivering the group in its current format with the content, length, and size of the group to remain the same, with a few additional elements to be added in. - To continue to ensure there is time and space for reflection, and discussion of barriers and challenges that may arise. - Group to cover nightmares in more detail.- Time spent on coping with anger and difficult feelings towards healthcare staff following their birth experience.- Additional resources, such as, books and websites where they can find out a bit more information about birth trauma to be given out during the groups.- Wanting to hear stories from people who have completed treatment to know there is hope. - Content to pass onto family and friends, or a session involving family and friends to help increase their understanding. - For the group to discuss how much information would be shared early on when setting the group boundaries and rules and to discuss how best to handle triggering situations that can arise within sessions.
25	(8501/CA) Identification of hypertension in inpatient acute and old age psychiatry wards at Prospect Park Hospital (PPH) through regular observations. (Junior Dr Audit)	This audit aimed to identify whether repetitive high blood pressure measurements that do not reach the threshold of National Early Warning Score (NEWS) warning are escalated for medical review, and to discuss the estimated effect of implementing routine blood pressure review on diagnosing new hypertension and identifying poorly controlled known hypertension. Hypertension is a risk factor for various health conditions that could be significantly life-limiting. Because it is usually asymptomatic, hypertension is often picked up opportunistically when the blood pressure is measured. Whilst hypotension can be easily picked up through NEWS, hypertension is not flagged until the systolic blood pressure exceeds 220 mmHg, a value that suggests hypertensive crisis, requiring emergency treatment. Actions:- Initial cardiometabolic risk screening form to be completed before the first few MDTs so as not to miss any risks on admission. - To set reminder in MDT forms which will be revisited every week, to review physical observations (to include a reminder at the bedside, such as a laminated poster on the observation machine outlining the diagnostic values of hypertension, with a reminder to document in RiO and mention in hand-over if BP raised.- There is no alert system available to assist nurses and support workers to identify raised blood pressure. A reminder/system at the bedside, such as a laminated poster on the obs machine (e.g. as attached below) outlining the diagnostic values of hypertension, with a reminder to document in RiO entry and mention in hand-over if BP raised.

Appendix D- CQUIN 2021/22

No CQUIN for 2021/22.

Appendix E- CQUIN 2022/23

The national 2022/23 CQUIN can be found at the following Link:
https://www.england.nhs.uk/publication/combined-ccg-icb-and-pss-commissioning-for-quality-and-innovation-cquin-guidance/

Appendix F- Statements from Stakeholders

Berkshire Healthcare NHS Foundation Trust – Quality Account 2021/22 Response from Council of Governors to the Trust

This report provides an excellent account of Berkshire Healthcare Foundation Trust. The information is clearly expressed and with much of interest for all readers. The Governors feel that these figures reflect the actual performance of the Trust.

We know staff and management are proud of the CQC rating of 'outstanding' and, indeed, as Governors we are happy to be associated with such a high performing Trust.

It is true however, that not every one of the Trusts' 160 services meets a high standard of excellence every day. This is one reason for welcoming the new patient satisfaction measure introduced at Berkshire Healthcare 2022 and which should impact reporting in 2022/23.

The CQC has limited capacity to scrutinise large and complex NHS organisations. So governors welcome the opportunity to visit any service and see for themselves how it operates and talk to staff and patients about their activities and concerns.

Governors appoint non-executive directors to the board of the Trust. 'Non-execs' provide further scrutiny and they also visit services to understand the operation at the patient interface.

Members of the public can get involved through '15-step' visits and by engaging with the Trust through their local Healthwatch organisation.

Anyone can become a member of the Trust – see the website for joining details – and as a member you can get involved and put yourself forward as a governor helping fulfil the aim to provide public scrutiny of the local NHS services.

For the last two years I have mentioned governors wanted further recognition of the important role carers play in a patients' recovery through trust policies and processes. We are pleased that implementation of this initiative has started, albeit rather slowly. We regard this as a way of multiplying the effectiveness of our clinicians. It has been neglected by the NHS for too long.

We are interested in the well-being of staff without which Trust services could not operate. The NHS has a mixed reputation in relation to looking after employees, and we are pleased that BHFT scores relatively highly when compared to its peers in the nationally mandated staff survey. We know more can be done especially in supporting minorities.

We are happy that management keeps governors up to date on the rare occasions when service quality concerns are raised. Governors are free to question the executive in Governor Council meetings some of which are also open to the public.

These comments are based on the Quality Account for the third quarter of 2021-2022. The draft report was circulated to the 30 members of the Council of Governors for the Trust in March 2022. All governors were given the opportunity to comment. Feedback is passed on to the team responsible for the report.

Paul Myerscough, Lead Governor

Berkshire Healthcare NHS Foundation Trust Response:

The Trust welcomes this response from the Council of Governors to its 2021/22 Quality Account.

We would like to thank the Governors for their ongoing commitment to helping improve our trust services.

We are grateful for the comments received which has helped inform the quality account and make it a more accessible document.

We note the comments made in relation to the new 'iWantGreatCare' patient experience measure and we will be further reporting on this in the 2022/23 Quality Account.

In relation to supporting carers, we will again be including a section on this in our 2022/23 Quality Account to help promote and progress this area further. We have a full-time carer lead role in place to continue the implementation of our carer strategy.

We agree that the positive wellbeing of our staff is vital to the successful operation of our services. We thank the Governors for their support in this, and staff access to effective health and wellbeing support has again been set as an objective for the 2022/23 financial year.

We look forward to keeping the Council of Governors appraised of our progress and thank you for your ongoing support.

Responses to individual queries have been included in a separate document and sent to the Chair of the Council of Governors.

Commissioners Response – BHFT Quality Account 2021/22

This statement has been prepared on behalf of Frimley CCG.

The Clinical Commissioning Group is providing a response to the Quality Account 2021/22 submitted by Berkshire Healthcare Foundation Trust (BHFT).

The Quality Account provides information on the achievements of the priorities for improvement that were set for 2021/22 and gives an overview of the quality of care provided by the Trust during this period. The priorities for 2022/23 are also detailed in the report. The CCG is committed to working with the Trust to achieve further improvements and successes in the areas identified within this Quality Account.

The Trust's Quality Priorities highlighted in the previous Quality Account were covered within the overall categories of Patient Experience, Harm-Free Care, Clinical Effectiveness, and Supporting Staff. These have been retained for 2022/3, with a framework in place to monitor priorities for improvement.

The CCG would like to take this opportunity to commend BHFT for adapting their practices and pathways in order deliver effective services whilst maintaining the safety to staff, patients and partners, particularly during the challenging circumstances of the COVID-19 pandemic.

Patient Experience and Involvement

We note the Trust's continued commitment to using patient and carer feedback to improve services. The adoption of the "I Want Great Care" measurement tool supports this. As part of this work, we note the focus on inpatient flow and minimising delayed transfers of care, with most targets on track for achievement. Areas for further gains in adult mental health acute wards have been identified in respect of bed occupancy and length of stay. We acknowledge that conditions have been challenging for all mental health providers with an increase in demand and acuity seen during the pandemic. The Trust continues to build on the measures and mechanisms for this discussed in last year's report, with developments such as live listings of patients awaiting discharge, and a scorecard for assessing rapid community discharge arrangements.

The resumption of the Friends and Family Test has been actioned, following a temporary national suspension due to the COVID-19 pandemic. We note that response rates are lower than anticipated to date, but the Trust continues to promote this feedback mechanism and focus on improving its positive response ratings.

Harm-Free Care

The Trust has been assiduous in applying and monitoring infection prevention and control measures to mitigate COVID infection risks for patients and staff.

Inpatient falls continue to be a key priority and a challenge in terms of reducing numbers; we note that the target of fewer than 20 inpatient falls per month has been difficult to achieve consistently. We acknowledge that Trust's close monitoring of this work and steps taken to address the risks, including the rapid quality improvement event held in late 2021 and the ongoing quality improvement initiatives adopted at ward-level.

We applaud the Trust's achievement of its pressure ulcer targets, namely:

- To have no more than 19 grade 2 pressure ulcers due to a lapse in care by Trust staff (9 recorded to date)
- To have no more than 18 grade 3 or 4, unstageable or deep tissue injury pressure ulcers due to a lapse in care by Trust staff (1 recorded to date)

Although the achievement of reducing self-harm incident on mental health inpatient wards has not been achieved consistently throughout the year, we appreciate the complexities particularly in respect of patients who use self-harm to cope with difficult feelings, and the risks of escalation if overly restrictive practices are

adopted. We acknowledge the work being done around use of activity co-ordinators at times of higher incidence, and work on reduction of risks around ligature-related incidents.

Suicide rates remain on a downward trajectory year-on-year since 2011/12, but the pandemic has presented particular challenges with a recent rise evident. It is encouraging to see the time and energy the Trust devotes to minimising risks, including work on risk and safety plans, and the forthcoming workshop for staff on reducing risks for autistic adults and young people.

We acknowledge that the Trust has a rigorous process for reviewing and learning from deaths and applaud the Trust's consistent and informative engagement with the Frimley ICS Mortality Review Group. Lapses in care identified in relation to deaths remain low but are nevertheless closely examined to draw out learning and drive improvement.

We also note the significant improvement across the year in the percentage of CMHT service users with a Serious Mental Illness who have all their annual physical health check parameters completed within a year of referral. The Trust is now exceeding its target percentage.

The Quality Account is clear about key quality risks and mitigating actions, including the aforementioned adult mental health inpatient bed occupancy rates, shortages of permanent nursing and therapy staff, and waiting times (a challenge exacerbated by the pandemic).

All of the above is supported by the Trust's commitment to strengthening its safety culture, including staff training, and an open and honest culture that promotes and learns from incident reporting. The Trust has been consistently open and engaged with the CCG on Serious Incident reporting and maintains an organised and expert approach to investigations, learning and action planning.

Clinical Effectiveness

It is reassuring to see that the Trust maintains a strong clinical audit function and, notably, has undertaken detailed reviews of compliance with two high priority NICE guidelines:

1. Managing COVID-19- Recommendations relating to Venous thromboembolism (VTE) prophylaxis (Guideline NG191) – for which the Trust meets 100% of the recommendations.
2. Supporting Adult Carers (NG150) – for which, alongside other steps, the Trust has developed a Carers Strategy including key standards and a compliance audit process.

We note and applaud the Trust's work on Learning Disabilities Improvement standards. We would particularly like to mention the strong engagement and support the CCG has received from the Trust's Learning Disabilities Team on the LeDeR programme, and in supporting vaccination services with uptake of COVID vaccinations among people with Learning Disabilities.
On the subject of COVID vaccinations, we must also mention the excellent work carried out by the Trust's Hospital Hub and the dedication shown by the School Aged Immunisation Service (SAIS) in rolling out COVID vaccinations to 12–15-year-olds with relatively short notice and during their busiest period.

Supporting Staff

With the challenges in availability of permanent nursing and therapies staff particularly in mind, we note the Trust's work on staff retention (turnover being a challenge), appraisals, training support, health, and wellbeing. Also notable is the way in which the Trust has supported staff in different ways of working (including home-working) during the pandemic, and its encouragement of staff initiative and ideas to promote quality improvement.

Staff sickness has been a challenge for all organisations during the pandemic, not only due to COVID-related absences but also the pressures on NHS staff. It is unsurprising that the data show a rise in sickness rates

during this period. We note the Trust's dedication to addressing these challenges, including initiatives and support to promote staff mental health.

It is notable that the Trust enjoys high levels of staff satisfaction (recorded via the NHS National Staff Survey) and that their advice has been sought from the national team on how this has been achieved.

Our commentary above summarises some of the key aspects reported in this year's Quality Account, but we also acknowledge the depth and detail included on many other aspects of quality work undertaken across the Trust's diverse range of services over the past year.

Priorities for 2022/23

As discussed above, we note the Trust's decision to continue with its existing key priorities into 2022/23, and that these broad areas of focus contain a huge amount of subsidiary detail and ambition. This indicates an organisation that continues to push itself to achieve more and has a strong governance framework in place which enables the identification of priorities on which to focus.

We would like to thank the Trust for sharing this report for comment and look forward to working together in the new context of the Integrated Care Board during 2022/23. We are keen to maintain a strong interface with the Trust on quality issues and to act as a bridge and facilitator across all parts of the system in support of quality improvement, pathway redesign and achieving the best possible outcomes for patients.

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust Response:

The Trust wishes to thank Frimley CCG for this response to its 2021/22 Quality Account, and appreciate the time taken to review our report and formulate this response.

We would like to thank the CCG for the ongoing support they have given throughout the year. We reciprocate the sentiments made in relation to our strong partnership working, for example in relation to our shared work on learning from deaths and LeDeR and would like to thank the CCG for their valuable input in these areas.

We are committed to maintaining a strong future interface with our commissioners and with the Integrated Care Board and look forward to continuing this partnership working to address the needs of our shared patient population.

Berkshire Healthcare NHS Foundation Trust Quality Accounts 2021-22:
Comments by Bracknell Forest Council's Health and Care Overview & Scrutiny Panel

General comments

1. The report outlines high performance from Berkshire Healthcare NHS Foundation Trust (BHFT) and demonstrates a commitment to learning and improvement. We particularly congratulate you on the overall Outstanding rating from the Care Quality Commission, with all of your services individually rated as outstanding or good. The Panel noted that NHS Improvement judged the Trust to have the highest level of performance for finance and use of resources. We also note your progressive use of technology to transform patient care, recognised by NHS England as a 'Global Digital Exemplar'.

2. Including an acronym list with the report was very useful and made it easily accessible to the Panel. A map showing the division between East and West Berkshire would also be a helpful appendix.

Specific queries and comments

1. Page 9: 51% of complaints related to adult mental health provision. What improvements have you implemented as a result? What plans do you have in place to reduce the overall level of complaints in this area?

2. Page 15: Harm-Free Care. The panel is aware of mandatory training designed to prevent harm to those with learning disabilities or autism due to poor communication or lack of understanding of their needs. What is your plan for implementing this training?

3. Page 25: What are the reasons for focussing on the two NICE guidelines highlighted on this page? How do you ensure the implementation of new NICE guidelines?

4. Page 28: Staff turnover this year is 15% compared with 13.1% in 2020-21. Has COVID-19 led to increased staffing pressures?

5. Page 28: The statistics on vacancies show an increase in the last 10 months with approximately a 70% between January 2021 and January 2022. What percentage of your current staff are agency staff?

6. Page 29: The report states 8 nursing international recruits secured. How do you support international recruits, for example, how do you assess English language skills, particularly in a medical setting? Are language classes provided if necessary? Is recruiting from the European Union more challenging since we left the EU?

7. Page 32: Congratulations on being the best performing community and mental health trust in the country for your staff engagement scores in the 2020 national survey. This is a significant achievement and the Panel notes that other national teams are working with you to learn more.

8. Page 33: Bullying and racism. What mechanisms do you have for staff reporting? How do you undertake independent investigations?

9. Page 33: Is there evidence of increased aggression towards staff at weekends, particularly in accident and emergency? Are additional security staff bought in to manage aggressive patients?

10. Page 37: Changes to the Diabetes service are noted and welcomed given the cost and health implications for the NHS and residents. What is the target for reducing Type 1 diabetes in 2022/23?

11. Page 40: Is the SHaRON Support Hope and Recovery Online Network well advertised and easily accessible to users and carers?
12. Page 40: East Berkshire has focussed on increasing support and waiting times for Occupational Therapy. Why only in this geographic area?
13. Page 41: We are pleased to hear about increased investment in the Bracknell school nursing team. Could you provide data on the new drops ins and what they are delivering?
14. Page 42: We are pleased that ADHD has received new investment and recruited 27 people. Where will the Family Support Workers and Children's Wellbeing Practitioners be located? How many of each are provided for each area?
15. Page 42: We are pleased to see that clinical staff have received training on recognising autism in girls. What measures are you using to monitor that this is resulting in higher identification of needs and referral of girls to support services?
16. It is recognised that ADOS (Autism Diagnostic Observation Schedule) has a male bias. What is your position on using DISCO (Diagnostic Interview for Social and Communication Disorder) where appropriate as a tool to better recognise internalised autism presentation in girls?
17. Page 42: Where are 'Find out Fridays' being advertised?

In conclusion, the Panel considers that, on all important measures, the Trust is performing exceptionally well. On behalf of the residents of Bracknell Forest who we represent, we are very appreciative of the high-quality patient care and health services provided by the Trust.

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust Response:

The Trust welcomes this response from Bracknell Forest Council's Health and Care Overview and Scrutiny Panel to its 2021/22 Quality Account.

We thank you for the general comments made in relation to our progress during the year. We agree with the suggestion of including a map of our East and West Berkshire localities and have done so in the appendices of our final report.

In relation to the specific questions raised, we have addressed each of them individually below:

1. Learning from complaints about mental health service provision. Learning from complaints is an ongoing and standing item agenda at all Divisional Performance and Patient Safety and Quality Meetings. Key themes and lessons are shared widely with the services and discussions are held on complex cases and sensitive issues. We share lessons learnt from investigations (serious incidents and complaints), reviews and audits to help create a culture of continuous learning and to prevent re occurrences of the same themes. Areas of improvement specifically for mental health have included:

- Completion Risk summary and safety plans
- Physical health monitoring
- Improving safeguarding reporting
- Improving record keeping and documentation
- Knowledge on the referral pathways for geriatric services

- Teams to ensure all potential triggers for deterioration which are recorded in the person's previous history are included in the risk formulation/assessment
- Improving ownership of actions emerging from the multidisciplinary team (MDT)

2. The Oliver McGowan Mandatory Training in Learning Disability and Autism (Health Education England (hee.nhs.uk)) has been in development for a number of years, and some of our trust staff were involved in one of the pilot training events. These pilots are still being evaluated and once The Oliver McGowan Mandatory Training trial is complete the Department for Health and Social Care will use the evaluation to inform a wider rollout of the training. We will therefore need to wait for the wider rollout, but it is anticipated that this will be mandatory training for staff as indicated as part of the national rollout.

3.NICE Guidance. We have a Trust policy and procedure for implementing NICE Guidance which involves identifying, assessing, and implementing NICE Guidance that is relevant to our services. The trust target is to be compliant with at least 80% or more of the guidelines that are relevant to us, and currently this is at 86%. Progress is monitored at the Trust Clinical Effectiveness Group, chaired by the Trust Medical Director. The two NICE Guidelines detailed within this year's Quality Account report were selected for inclusion by our Trust Clinical Effectiveness Group. They were selected for sharing in the Quality Account following the feedback on the 2020/21 Quality Account by stakeholders and their topical relevance and interest to the wider public.

4. Staff Turnover. During COVID the NHS saw a dip overall in turnover levels and has seen an increase since pandemic restrictions have been eased. There seem to be two main reasons for increased turnover. Firstly, the external recruitment market has picked up and secondly there are more roles being advertised in the NHS as funding for new roles to clear backlogs of work has created new roles.

5.Agency Staffing. For 2021, we had an average of 1.5% agency staff. However, please note that the percentage of temporary staff (both bank staff and agency staff) was at around 12%.

6.International Nurses. International nursing applicants must have a recognised English Language qualification such as the International English Language Testing System (IELTS), when applying for our roles. We do support some internationally qualified nurses who are already in the country and working for our trust as Health Care Support Workers to take their English Language qualifications. We have staff members dedicated to the recruitment and pastoral care of our new international nurses ensuring that they are fully supported as they join the trust and settle into their new lives here in the UK.

7.Staff Engagement Scores. Thank you for your comment about this. The trust is hugely proud of this achievement. Nevertheless, there is always more that we can do to improve our employee experience and we continue to work on those areas that we think we can do better in.

8.Reporting Bullying and Harassment. All staff are encouraged to report incidents of bullying and harassment through our incident management system DATIX. Staff are encouraged to raise concerns via our Freedom To Speak Up guardian, their line manager or Human Resources (HR). We also have a dedicated Violence Reduction Lead who monitors reports of bullying and harassment via our incident reporting systems and proactively reaches out to offer staff support. When incidents are reported we conduct an initial fact-find and decide if the incident requires a full investigation. We have an independent team of investigators who will investigate incidents if required.

9.Violence and aggression at weekends. The Trust does not operate an Emergency Department. There is evidence that staff can feel more vulnerable at weekends due to lower staffing levels and this can include managing violence and aggression, all contributing factors are reviewed as part of the incident investigation process.

10.Diabetes Service. Type 1 Diabetes is an autoimmune disease and so it is not possible to reduce the numbers of people with Type 1 as it is not related to lifestyle factors. People with Type 1 diabetes account for around 10% of all

people with diabetes. The Diabetes Centre therefore focus on managing the outcomes for these patients, we participate in the National Audit of Diabetes and are involved in a Quality Improvement programme to improve the outcomes for patients with Type 1 diabetes

11.The SHaRON Support Hope and Recovery Online Network. For Services which host a ShaRON platform there is marketing and leaflets available. Access to SHaRON is via a referral process from a Trust service, patients can only be invited to join if they are eligible. All eligible patients receive relevant information leaflets about the service which is discussed at an appointment with them.

12. Occupational Therapy (OT) for Children and Young People This is within the service improvement section and the East Service has highlighted this as an area which has received additional investment from the CCG this year. The service in the east of the county is commissioned jointly by Frimley CCG and the 3 local authority areas in the east of the county (Bracknell, Slough and RBWM). Berkshire West CCG commission OT for the west of the county from Berkshire Healthcare and Royal Berkshire Foundation Trust.

13.School Nurse (SN) drop-ins in Bracknell. This is within the service improvement section and the Bracknell school nursing team secured additional investment to support the development and implementation of school nurse drop-ins.
The aim of the drop-ins is to:

- Improve general health and wellbeing of primary school children by supporting them, their parents, and carers to feel empowered to make informed healthy life choices.
- To provide the opportunity for parents/carers of primary school aged children as well as children themselves to meet with the SN directly to discuss any health needs/concerns they may have.
- Improve the general health and wellbeing of young people at secondary school enabling them to make informed and safe choices to take responsibility for their own behaviour, healthcare, and lifestyle.

Data is provided on a quarterly basis to Bracknell Forest Public Health on the uptake of the service.

14.Family Support Workers and Children's Wellbeing Practitioners. All the new posts are recruited into the Berkshire wide team and will operate from sites across the whole county.

15.Recognising autism in girls. Various studies have previously suggested that the ratio of autistic males to females ranges from 2:1 to 16:1. The estimate is currently 3:1 and there are ongoing national challenges around missed diagnosis or misdiagnosis for autistic girls and women. In terms of referrals to our autism assessment team, previous analysis of data shows that mean age of referral for girls was decreasing, but that boys were still referred and diagnosed younger. The data also suggested that schools were less likely to refer girls for an assessment of autism.

We provide free training to schools and other settings (e.g., Primary Perspectives in Education and Primary Care) which includes information on identification and how autism can present differently in girls or those who mask and camouflage. The concept of masking and camouflaging is often associated with girls and women but can also occur in boys and men. We also explain that, when young people mask and camouflage, this may mean there are few concerns in the school setting but there can be a high cost to the young person (in terms of the cognitive and emotional effort required) and that the family are much more likely to be aware of the challenges the young person faces than the school.

We also have an open referral system whereby anyone can refer for an autism assessment including parents/carers and the young person themself if they are 16 years or older. This is intended to remove potential barriers to referral and is easily completed via on online referral form. All assessments consider what the needs of the young person are to make the most helpful recommendations, signposting and any onward referrals that might be needed. Assessment reports will also include specific resources and information on how autism might present in girls and/or where masking

and camouflaging is part of the profile. We also provide training on autism to clinicians across the CAMHS services through the clinical effectiveness seminary programme.

16.The ADOS (Autism Diagnostic Observation Schedule) and DISCO (Diagnostic Interview for Social and Communication Disorder). Autism assessments consider information from a range of sources. There are core components to the assessment, but assessments are also modified when needed. Assessments include:

- Detailed autism specific developmental history with parent/carer**.**
- Assessment (through interaction with and observation of the child or young person) of social and communication skills and behaviours, focusing on features consistent with ICD-11 or DSM-5 criteria. This is often completed using the ADOS-2, but not always.
- Information obtained from the school setting– by detailed questionnaire or where helpful observation in school and/or interview with school staff
- Discussion with the child/ young person wherever possible to gather additional information about their lived experiences
- Additional self-report measures such as the Camouflaging of Autistic Traits Questionnaire and the Autism Quotient (AQ50)

All clinicians are aware of the limitations of the ADOS-2 and all assessments will carefully consider information from a range of sources. No one aspect of the assessment is unduly weighted in terms of reaching a diagnostic decision i.e. all the information obtained from a range of sources will be reviewed and carefully considered by at least 2 clinicians before a diagnostic decision is reached.
The DISCO is an interview schedule completed with a parent/carer and therefore assessment through interaction and observation is still required (which is the function of the ADOS-2). Throughout all aspects of the assessment, the team is very aware of the need to carefully consider the diagnostic assessment process for girls or where masking and camouflaging may be present. We consider this from the point of recruitment of staff onwards and we ask all interview candidates about their understanding of autism in girls and explore their understanding of masking and camouflaging. This is also included as ongoing Continued Professional Development training for the team

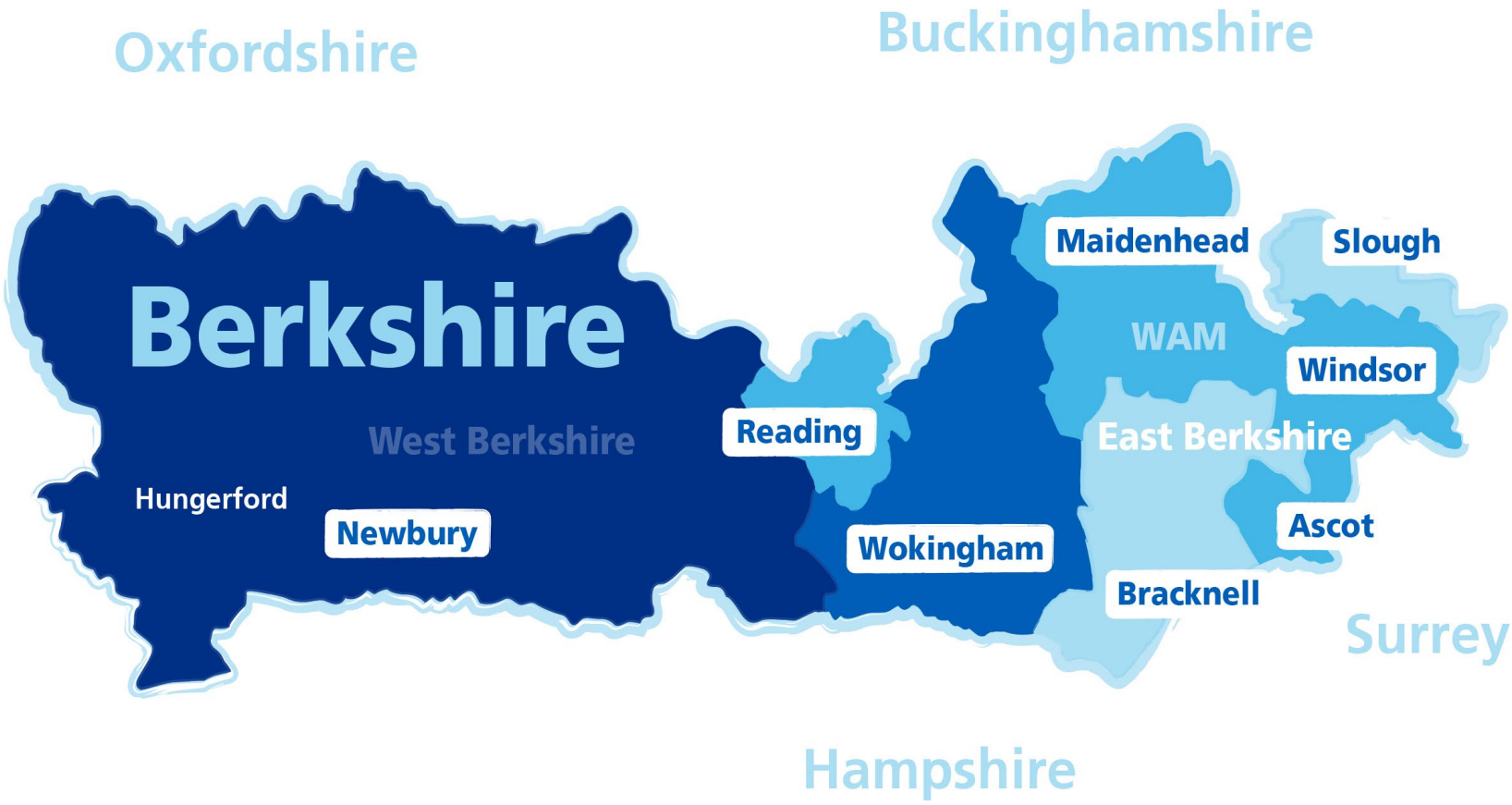
Our clinicians understand the nature of autism spectrum disorders and the wide variation in the ways they can be seen. This includes the need to look deeper for signs of autism, to modify assessment processes when needed and to consider lived experiences throughout the assessment process. We understand the importance of considering experienced/internalised autism in our assessments and the risks when the focus is only on observed autism. We also understand the importance of self-reporting to help us gain a greater understanding of the young person, their profile of strengths and challenges, their lived experience and what they feel would most help them.

17.Find out Fridays are advertised on SHaRON to all members of the A&D subnet. All parents coming to our service are offered SHaRON. Currently we have over 700 members.

Appendix G- Independent auditor's report to the Council of Governors of Berkshire Healthcare NHS Foundation Trust on the quality report

Not required for 2021/22

Appendix H- Map of Berkshire Localities



Glossary of acronyms used in this report

Acronym	Full Name
A&D	Anxiety and Depression
A&E	Accident and Emergency
ADHD	Attention Deficit/ Hyperactivity Disorder
AIRS	Adult Integrated Respiratory Team
ACP LD/A	Advanced Practice Credential in Learning Disability and Autism
AMPS	Assessment of Motor Processing Skills
ARFID	Avoidant/restrictive food intake disorder
ASD	Autistic Spectrum Disorder
ASSIST	Assertive Intervention Stabilisation Team
AWOL	Absent Without Leave
BAF	Board Assurance Framework
BAME	Black Asian and Minority Ethnic
BASHH	British Association for Sexual Health and HIV
BEDS	Berkshire Eating Disorder Service
BLIS	Berkshire Long COVID Integrated Service
BMI	Body Mass Index
BtC	Behaviours that Challenge
CAMHS	Child and Adolescent Mental Health Service
CARRS	Cardiac and Respiratory Rehabilitation Service
CBNRT	Community-Based Neuro-Rehabilitation Team
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CCN	Community Children's Nursing
CDS	Commissioning Data Set or Community Dental Service
CDiff	Clostridium Difficile
CLEAR	Clinically Led workforcE and Activity Redesign
CMHT	Community Mental Health Team
COPD	Chronic Obstructive Pulmonary Disease
COVID-19	Coronavirus disease 2019
CPA	Care Programme Approach
CPE	Common Point of Entry
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRHTT	Crisis Resolution and Home Treatment Team
CWP	Children's Wellbeing Practitioner
CYPF	Children, Young People and Families
CYPIT	Children and Young People's Integrated Therapy Service
DBT	Dialectical Behavioural Therapy
DOC	Duty of Candour
DoLS	Deprivation of Liberty Standards

Acronym	Full Name
DSPT	Data Security and Protection Toolkit
ECG	Electrocardiogram
EDI	Equality Diversity and Inclusion
EHCA	Educational Healthcare Assessment
EHCP	Education Health and Care Plan
EIP	Early Intervention in Psychosis
EUPD	Emotionally Unstable Personality Disorder
FFT	Friends and Family Test
FREED	First Episode Rapid Early Intervention in Eating Disorders
FSM	Family Safeguarding Model
FTSU	Freedom to Speak Up
GMC	General Medical Council
GOSW	Guardian of Safe Working
HDS	Hospital Discharge Service
HV	Health Visitor, Health Visiting
IAF	Information Assurance Framework
IAPT	Improving Access to Psychological Therapies
ICS	Integrated Care System
IFR	Initial Findings Report
IHA	Initial Health Assessment
IHV	Institute of Health Visiting
IMPACTT	Intensive Management of Personality Disorders and Clinical Therapies Team
IPC	Infection Prevention and Control
IPS	Individual Placement and support (Employment Service)
IV	Intravenous
iWGC	I Want Great Care (patient experience monitoring)
KUF	Knowledge and Understanding Framework
LAC	Looked After Children
LD	Learning Disability
LeDeR	Learning Disability Mortality Review Programme
LIC	Lapse in Care
LoS	Length of Stay
MAPPA	Multi-agency Public Protection Arrangements
MBT	Mentalization-Based Treatment
MCA	Mental Capacity Act
MCN	Managed Clinical Network
MDT	Multi-Disciplinary Team
MH	Mental Health
MHA	Mental Health Act
MHFA	Mental Health First Aid
MHICS	Mental Health Integrated Community Health Service
MHST	Mental Health Support Team

Acronym	Full Name
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSK	Musculoskeletal
MSG	Medicines Safety Group
MUST	Malnutrition Universal Screening Tool
NACAP	National Asthma and COPD Audit Programme
NAIF	National Audit of Inpatient Falls
NCAP	National Clinical Audit of Psychosis
NCAPOP	National Clinical Audit and Patient Outcomes Programme
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NCISH	National Confidential Enquiry into Suicide and Homicide
NDA	National Diabetes Audit
NEWS	National Early Warning System
NGU	Non-Gonococcal Urethritis
NHS	National Health Service
NHSE	NHS England
NHSI	NHS Improvement
NICE	The National Institute of Health and Care Excellence
NIHR	National Institute of Health Research
NRLS	National Reporting and Learning System
OAP	Out of Area Placement
OCD	Obsessive Compulsive Disorder
OH	Occupational Health
OPMH	Older Peoples Mental Health
OT	Occupational Health
PALS	Patient Advice and Liaison Service
PCN	Primary Care Network
PEACE	Pathway for Eating Disorders and Autism developed from Clinical Experience
PHE	Public Health England
PICT	Psychologically Informed Consultation and Training
PICU	Psychiatric Intensive Care Unit
PINC	Psychology Interventions in Nursing and Community
PMS	Psychological Medicine Service
PNA	Professional Nursing Advocate
POCT	Point of Care Testing
POMH	Prescribing Observatory for Mental Health
PPE	Personal Protective Equipment
PPH	Prospect Park Hospital
PPARET	Prospect Park advocacy for racial equality team
PRMP	Positive Risk Management Panel
PRN	Pro re nata (as required)
PTSD	Post-Traumatic Stress Disorder
PU	Pressure Ulcer

Acronym	Full Name
QAC	Quality Assurance Committee
QI	Quality Improvement
QMIS	Quality Management and Improvement System
R&D	Research and Development
RHA	Review Health Assessment
RIE	Rapid Improvement Event
RiO	Not an acronym- the name of the Trust patient record system
RRAT	Rapid Response and Treatment
RTT	Referral to Treatment Time
SE	Service Evaluation
SEND	Special Educational Needs and Disability
SHaRON	Support Hope & Recovery Online Network
SI	Serious Incident
SJR	Structured Judgement Review
SMI	Severe Mental Illness
SN	School Nurse/ School Nursing
SOP	Standard Operating Procedure
SSN	Special Schools Nursing
STOMPwLD	Stopping Over-Medication of People with a Learning Disability
SUN	Service User Network
SUS	Secondary Users Service
TT	Talking Therapies
UCR-CH	Urgent Community Response team for care home residents
UTI	Urinary Tract Infection
VTE	Venous Thromboembolism
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
YOT	Youth Offending Team

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Meeting Date	10th May 2022
Title	Review of current processes against recommendations from Final Ockenden Report
	Item for Noting
Purpose	The purpose of this paper is to share with the Board a review undertaken by the Director of Nursing &Therapies and the Medical Director of current BHFT practices against the recommendations within the final Ockenden Report published 30th March 2022. The review provides assurance in relation to our current practices, highlighting much good practice; it also highlights ongoing improvement work and a few actions agreed as part of the review.
Business Area	Nursing & Governance
Author	Debbie Fulton, Director Nursing and Therapies
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
Equalities and Diversity Implications	N/A
SUMMARY	The Ockenden Report - Final , Findings, Conclusions and Essential Actions from the independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust was published on 30th March 2022. Whilst the Independent review was of maternity services and the report is therefore highlighting tragic failings in and recommendations for maternity services, it is important to recognise that the failings in overarching governance arrangements alongside many of the quality and safety thematic findings are equally applicable to any provider of healthcare. The report details 4 key pillars for particular attention: 1. Safe staffing levels 2. A well-trained workforce 3. Learning from incidents 4. Listening to families Looking at the management and how investigations were handled within the maternity services at the Trust, the key themes requiring improvement were: • The poor quality of incident investigations; • Poor complaints handling; • Local concerns with statutory supervision of midwifery investigations; • Concerns with clinical guidelines and clinical audit; • Poor clinical leadership The above issues led to a lack of learning, missed opportunities to improve safety and did not provide families with honest and open responses.

	The Trust provides assurance about the quality and safety of patient care through its governance structures and processes at service, divisional and corporate level. To ensure that there is clarity about responsibility for governance at every level of the organisation, we are currently mapping the existing process and confirming the trust governance structure. A good level of assurance around our serious incident investigation process and listening to families as part of that process can be gained from our achievement of the Royal College of Psychiatry serious incident accreditation in January 2021.The accreditation process involved self-assessment and external peer review against a set of 60 standards covering: organisational process around serious incidents, the incident review process, the serious incident report, involvement of staff in the process and involvement of patients and families in the serious incident process. The report also illustrates the importance of creating a culture where all staff feel safe and supported to speak up. Our national staff survey results are also a good indication of staff confidence in raising concerns and those concerns being acted on as well as the culture within the organisation. However, these assurances do not mean that there is not room for further improvement and we will continue to focus on our approaches to the review of incidents and the embedding of learning as a result of these as well as further developing of our safety culture within the organisation to ensure that every member of staff feels safe to speak up and for people to listen when they do. Safe staffing across our wards is monitored monthly and a 6-monhtly review is undertaken to provide confidence in our staffing establishments and recommendations are made as a result of the 6-monhtly reviews. We can evidence changes to skill-mix and staffing numbers as a result. Workforce is however one of biggest challenges with recruitment and retention initiatives in place as part of the People Strategy and strategic workforce initiatives. The report should not be seen in isolation, there are a number of recommendations within it that are relevant to strategic areas of work , for example • National Patient safety Strategy • People strategy • Safety culture improvement work • Freedom to Speak up strategy • Patient Experience tool implementation The recommendations detailed within the attached review should be considered when progressing these strategies and programmes of work.
ACTION REQUIRED	Board is asked to: • Note the review and provide and feedback

Berkshire Healthcare
NHS Foundation Trust

Review of current processes against relevant/ translatable 'local' and 'all Trust' actions for learning from Final Ockenden Report (published March 2022)

Action	Current Position in Berkshire Healthcare	Gaps / actions required to address these
Clinical Governance		
Incidents must be graded appropriately, with the level of harm recorded as the level of harm the patient actually suffered and in line with the relevant incident framework.	Good governance processes in place for checking level of harm - All Datix are reviewed by patient safety team (facilitators) with proactive follow up and query raised back to team if narrative within the incident does not appear to reflect incident rating recorded which enables correct harm level to be recorded and also allows for learning for reporter. A patient safety , experience and learning group is chaired by Deputy Director Nursing weekly which brings together Patient safety , Safeguarding , Complaints, Infection control and Head of clinical effectiveness & Audit to discuss any incidents / experience - this ensures that silo working is mitigated, and right people are aware of incidents with departments working together in a multi-professional manner with right level of grading and therefore investigation is achieved. Training is delivered to staff which includes understanding of levels of harm Royal College of Psychiatry Serious Incident Accreditation achieved January 2021.	

Action	Current Position in Berkshire Healthcare	Gaps / actions required to address these
The Trust executive team must ensure an appropriate level of dedicated time and resources are allocated within job plans for medics and clinical specialists to undertake incident investigations.	The patient safety team lead incident investigations and learning events using a team approach , with multi-professionals included relevant to incident being investigated. This is not included in specific job plans; Medics have SPA time in their job plan that allows them to be involved in activities such as looking at complaints or serious incidents. The trust has a patient safety team who lead on the review of investigations with relevant multi-professional team colleagues identified to contribute to the investigation. There are medical leads with a small amount of dedicated time that are able to provide input into medical aspects of complaints and incidents when they arise. Clinical governance leads and Clinical Directors also have as part of their job roles. The patient safety team have a mix of Mental / physical / adults and children experience.	
All investigations must be undertaken by a multi-professional team of investigators and never by one individual or a single profession	The Patient Safety Team support all incident investigation , serious incidents are investigated with a lead reviewer from patient safety team and the team drawn from professional with relevant experience for incident being investigated. The Patient Safety Team has a mix of physical and mental health , adults and children experience. Learning reviews / debriefs are also used for incident investigation and are formed of a multi-professional teams reviewing incident. Royal College of Psychiatry Serious Incident Accreditation achieved January 2021.	
The use of HRCRs to investigate incidents must be abolished and correct processes, procedures and	Serious incident framework is used to investigate incidents Work in in progress to be ready for shift to PSIRF when that is introduced	

Action	Current Position in Berkshire Healthcare	Gaps / actions required to address these
terminology must be used in line with the relevant Serious Incident Framework. All trusts must ensure that complaints which meet SI threshold must be investigated as such.	A patient safety , experience and learning group is chaired by Deputy Director Nursing weekly which brings together Patient safety , Safeguarding, Complaints, Infection control and Head of clinical effectiveness & Audit to discuss any incidents / experience - this ensures that silo working is mitigated, and right people are aware of incidents with departments working together in a multi-professional manner with right level of grading and therefore investigation is achieved.	
Individuals clinically involved in an incident should input into the evidence gathering stage, but never form part of the team that investigates the incident.	Clinicians directly involved in provision of clinical care contribute to the evidence gathering but are never part of the review team for serious incidents.	Review of roles such as ward manager in SJR/ Serious incident processes – whilst they are not directly clinically involved in patients care they do have ward responsibility and therefore it is preferable that they are not SJR author or part of the review team to ensure maximum objectivity. All SJR are reviewed by Clinical Director/ governance lead and Ward Managers would never be the main / lead investigator in a serious incident review team
All SIs must be completed within the timeframe set out in the SI framework. Any SIs not meeting this timeline should be escalated to the Trust Board.	Process in place for DoN and MD to be alerted at PSR and TMRG of any delay in ensuring correct info to coroner (SI not completed within timeframe) for serious incidents related to deaths and at PSR any action plans that are outstanding beyond date that completion was due. All SI have date agreed with commissioners for review to be completed in line with current Serious incident framework Process in place for oversight of SI completion by Deputy Director Nursing	Currently no process in place for escalating any delays to trust Board.
All members of the governance team who lead on incident investigations should attend regular appropriate training courses not	All IO are required to undertake incident investigation training prior to being a lead investigator; this is detailed in ORG007 Incidents/Near Misses, Serious Incidents Requiring Investigation and Coroner Requirements. Training records are kept	Governance policy does not specify specific training that the governance team must undertake over and above incident investigation training - this will be reviewed as

Action	Current Position in Berkshire Healthcare	Gaps / actions required to address these
less than three yearly. This should be included in local governance policy.	Incident investigation training is provided by an external company called InPractice- All of the Patient Safety Team have completed this from Band 7 upwards. Between November 20 and April 2022 76 staff in the organisation completed this. IO training has also been provided by Beechcroft in December 2021 for around 25 staff. Governance team have all attended incident investigation training and one of the patients safety specialists has also attended - HSIB Level 3 International Award (Silver) in Safety Investigation Jan - Mar 2022 Deputy Director Nursing is actively participating in national project - Working in coproduction with Making Families Count to continually improve the way we support and involve families following serious incidents Patient safety Specialists have accessed training relevant to the implementation of National Patient Safety Strategy Members of governance team have PABBS evidence-based Suicide Bereavement Training – how to support family's when a family member completes suicide Members of governance team have undertaken human factors training	part of the policy refresh that will be required when PSIRF and national patient safety strategy training syllabus is implemented.
The governance team must ensure their incident investigation reports are easy for families to understand, for example ensuring any medical terms are explained in lay terms as in HSIB investigation reports.	Incident template developed with family feedback and includes a list of abbreviations and their meaning in lay terms.	Medical terms explained in lay terms can be strengthened with support of patent safety partner role Review of HSIB reports to mirror how medical terms are explained
Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan	Some good examples of learning from incidents used to support training for example risk training , suicide training, deteriorating patient training and dysphagia training.	Further development of triangulation /collation of themes across incidents / complaints / litigation and audit outcomes with process to

Action	Current Position in Berkshire Healthcare	Gaps / actions required to address these
	For example: Where the clinical incident is a suicide a tableau dashboard is used to capture detail this enables themes (local and national) to be identified and this is used to inform 3 day suicide prevention training and bespoke staff workshops – examples include prevalence of SMU, Autism, Harm from others, CPA, Family involvement, Information sharing, risk documentation. 2021 National staff survey results demonstrate us to have best score amongst peer group for theme we are always learning (6.1 with average score 5.6)	agree what comes on and off training plans - it is agreed that SECEG to fulfil this role quarterly
Patient and Family Involvement		
The needs of those affected must be the primary concern during incident investigations. Patients and their families must be actively involved throughout the investigation process.	Process in place to ensure family have opportunity to be involved through incident process and for any questions they have to be answered as part of the report . Family Liaison Officer in post to support families through investigation process Royal College of Psychiatry Serious Incident Accreditation achieved January 2021. -this included review of family / patient involvement in serious incidents as well as feedback following incidents Deputy Director Nursing actively participating in national project - Working in coproduction with Making Families Count to continually improve the way we support and involve families following serious incidents	
All feedback to families after an incident investigation has been conducted must be done in an open and transparent manner and conducted by senior members of	Family Liaison Officer in post to support family meetings where helpful Agreement with patient safety teams and Clinical Directors as to which senior staff are most appropriate to support with meetings and investigation feedback.	

Action	Current Position in Berkshire Healthcare	Gaps / actions required to address these
the clinical leadership team, for example Director of Midwifery and consultant obstetrician meeting families together to ensure consistency and that information is in-line with the investigation report findings.	Royal College of Psychiatry Serious Incident Accreditation achieved January 2021. -this included review of family / patient involvement in serious incidents as well as feedback following incidents	
Support for Staff		
There must be a robust process in place to ensure that all safety concerns raised by staff are investigated, with feedback given to the person raising the concern.	Raising Concerns Policy Number of ways for concerns to be raised including FTSUG and Champions , Patient safety Datix which goes direct to DoN . Executive and Non-Executive FTSU leads . Quarterly review of all FTSU cases raised to ensure appropriate investigation and feedback. National Staff Survey responses: Raising concerns theme 7.2 (average 6.8) Individual questions: • I feel secure raising concerns about unsafe clinical practice – 81.8% (up from 78.8% last year) • I am confident that my organisation would address my concerns 72.8 % (up from 71.5% last year) • My organisation acts on concerns raised by patients / service users 85.6% (up from 84.1% last year) • I feel safe to speak up about anything that concerns me in this organisation Trust score 72.6% (against 74.7% last year an average of 66.8%) • If I spoke up about something that concerned me I am confident my organisation would address my concern 65.8% (against average score of 55.1%) FTSU Self-assessment review completed 2021	Safety Culture Steering Group to continue to progress psychological safety amongst staff Freedom to speak up 3- strategy is being refreshed during 2022 Review of National Freedom to Speak up gap analysis being undertaken

Action	Current Position in Berkshire Healthcare	Gaps / actions required to address these
	FTSU index last published in 2021 -overall index score for combined Mental Health / Learning Disability and Community Trusts for 2020 was 83.2% - BHFT score was 84.3% placing us 13th of all NHS Trusts	
The Trust must ensure that all staff are supported during incident investigations and consideration should be given to employing a clinical psychologist to support services	Staff support post incident in place with a range of support including psychology. Prompts are in place through our process to support this. We also support staff when attending Coroners court and they are offered preparation meetings with solicitors or opportunity to observe a hearing if they have not been in one. Junior doctors receive support as well from their supervisor and trust educators. DME meets with DDoN on a monthly basis to discuss incidents relating to trainees. Inquest training is provided by our solicitors to support staff required to attend inquest	
Improving Complaint Handling		
Complaint responses should be empathetic and kind in their nature.	Complaint training available for all staff investigating and responding to complaints. All complaints reviewed by Clinical Director before CEO sign-off.	
Complaints themes and trends should be monitored at the governance meeting, with actions to follow and shared.	Complaint themes and trends are monitored at divisional patient safety and quality meetings . Quarterly Patient Experience Report identifies any themes and trends	
All staff involved in preparing complaint responses must receive training in complaints handling	Training available for all staff involved in investigating and preparing complaint responses , all complaint responses are reviewed by complaints manager and Clinical Director	
Improving Audit Processes		
There must be relevant clinical co-leads for audits.	All national audits have a project initiation document completed (our in house document we developed) (Attached at appendix 1)	

Action	Current Position in Berkshire Healthcare	Gaps / actions required to address these
	it is decided at planning stage and led by CDs on which key staff to include: Audit Facilitator (non-clinical) Clinical Director Operational lead Clinical advisor if applicable Example: POMH for melatonin has Mairi, Colin, a Paediatric consultant and a spec doctor supporting the project in the PID	
Audit meetings must be multidisciplinary in their attendance and all staff groups must be actively encouraged to attend, with attendance monitored.	Clinical Effectiveness group is multi-professional -ToR include Medical Director (Chair), Head of Clinical Effectiveness & Audit, Clinical Audit Manager, Clinical Directors, Research & Development Manager Pharmacy Representative, Clinical Governance Lead Governance Leads Doctor representation from both mental and physical health, Psychology Representation, Patient Safety Representation Where a national audit report or action plan is being discussed the leads attend and present/update to Attendance at Clinical Effectiveness Group through year reviewed at year end for 2021/22 to provide assurance around continued and consistent broad representation/ attendance	
Any action that arises from a SI that involves a change in practice must be audited to ensure a change in practice has occurred.	Action plans are monitored by relevant clinical Director s Some divisions have a local action plan tracker to assist in identifying patterns and themes.	potential gap –There has been no audit registered with the clinical Audit Team over the last year which has been instigated because of an SI - therefore any local audits undertaken are not going through CEG. The new strategic head of QI will be attending CEG when they start in May this will provide a better link between audit projects and QI projects to enable awareness of any projects which impact on each other

Action	Current Position in Berkshire Healthcare	Gaps / actions required to address these
Audits must demonstrate a systematic review against national/local standards ensuring recommendations address the identified deficiencies. Monitoring of actions must be conducted by the governance team.	All national audits are reviewed and a summary is written to support identifying key areas of improvement and good practice – report written by leads and clinical audit team – reported to CEG and then QAC. All have a SMART action plan in place which goes to CEG and QAC for initial approval, the action plan is then reviewed at each CEG in full until all actions are closed. All registered local audits are shared at CEG, CDs are made aware and requested to update on any actions required which are then taken through there PSQ meetings, where a significant trust wide risk has been raised CEG may ask for additional assurance on any actions and would flag to SECEG if required. Local actions monitored at divisional PSQ	
Matters arising from clinical incidents must contribute to the annual audit plan.	Head of Clinical Audit attends the weekly patient safety learning from incident meeting alongside patient safety, patient experience , safeguarding and infection control link into annual audit plan requires development	Further development of triangulation /collation of themes across incidents / complaints / litigation and audit outcomes with process to agree what comes on and off training plans, learning for sharing across the organisation and should be added to audit plans- SECEG to fulfil this role quarterly starting June 22
Staff Voices		
The Trust must address as a matter of urgency the culture concerns highlighted through the staff voices initiative regarding poor staff behaviour and bullying,	National Staff Survey responses to people promise - we each have a voice that counts scored 7.3 (highest benchmark score 7.4 and average 7.0) Safety culture steering group includes civility and kindness Top scoring questions in national staff survey peer group include recommending Berkshire Healthcare as a place to work and shared team objectives.	Ongoing work around equality and inclusion, bullying and harassment with safety culture civility and kindness as a focus alongside embedding safety culture charter which is part of the Trust Plan on a Page

Action	Current Position in Berkshire Healthcare	Gaps / actions required to address these
	The score for 'the people I work with are understanding and kind to one another'- 79.7% against average of 76.9% The score for 'The people I work with are polite and treat each other with respect' – 80.1% against average of 78.8% In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers? 7.0% against average of 8.9% In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues? 13.4% against average 14.6%	
Improving Guidelines Process		
There must be relevant clinical co-leads for developing guidelines	Guidelines are developed by relevant clinical groups	
A process must be put in place to ensure guidelines are regularly kept up-to-date and amended as new national guidelines come into use.	Guidelines currently updated by relevant services / teams , held on staff intranet.	GN/ DB reviewing implementation of more centralised process for guideline sign-off and storage
Leadership and Oversight		
The relevant Clinical Director must have direct oversight of all complaints and the final sign off of responsibility before submission to the Patient Experience team and the Chief Executive.	Relevant Clinical Director have oversight of all complaints, process in place for complaints team review and Clinical Director sign-off before submission to Chief Executive for final signature	
Multidisciplinary working		

Action	Current Position in Berkshire Healthcare	Gaps / actions required to address these
The ward coordinator/ Manager at the Trust must be supernumerary from care provision	All ward managers are supernumerary to ward safe staffing establishment. Mental Health Wards each have a clinical development lead who is also supernumerary. Duty Senior Nurse at PPH	
There must be a clear line of communication between ward and Consultant. Consultant support and on call availability are essential 24 hours per day, 7 days a week for secondary Care MH wards	Consultants have rota for on-call out of hours cover 7 days a week on Mental Health wards and east physical health wards. Consultant included in governance meetings, invited to learning events, review SJRs undertaken by specialist doctors and regularly meet with ward management team	
Senior clinicians such as consultant and ward coordinators must receive training in civility, human factors and leadership.	This is part of current Serious incident training and will be part of National Patient Safety syllabus Safety culture work across the organisation has human factors element to it. All staff learning sessions provided by Chris Turner and Megan Reitz Consultants have had leadership training opportunity through compassionate leadership Training. Ward Mangers have access to leadership courses, many managers have undertaken Excellent Manager Programme.	Refresher and ongoing training to be arranged Implementation of national Patient safety strategy syllabus as it is released Excellent Manger Programme is currently being refreshed
All clinicians at the Trust must work towards establishing a compassionate culture where staff learn together rather than apportioning blame. Staff must be encouraged to speak out when they have concerns about safe care.	Trust safety Culture Steering Group in place with work plan, safety culture charter developed. Just culture principles applied into HR policies and case work. 2021 National Staff Survey indicated: • I feel secure raising concerns about unsafe clinical practice – 81.8% (up from 78.8% last year) • I am confident that my organisation would address my concerns 72.8 % (up from 71.5% last year) • My organisation acts on concerns raised by patients / service users 85.6% (up from 84.1% last year) for the theme ‘we are compassionate and inclusive’ we scored 7.7 against average score of 7.5 and nest score 7.9 in peer group	

Action	Current Position in Berkshire Healthcare	Gaps / actions required to address these
	Use of NHSE Civility and Respect toolkit Compassionate leadership training Excellent Manager Training Trust compassionate Charter Safety Culture all staff learning sessions – Chris Turner and Megan Reitz	
Escalation of Concerns		
The Trust's escalation policy must be adhered to and highlighted on training days to ward staff.	Matrons and Senior leadership team at PPH including lead consultant for escalation of concerns . Senior managers and Head of hospital roles cover community wards Local escalation procedures are in place for escalating concerns FTSU/ quality concerns escalation processes where staff do not wish to speak to managers. Raising concerns policy details escalation routes available to all staff.	
Consultant Ward Rounds and Clinical Review		
All patients with unplanned acute admissions to the ward to a consultant review within 14 hours of admission (Seven Day Clinical Services	MH wards - All patients are reviewed by a consultant next working day with 24/7 access to consultants by junior Doctors Community wards- unplanned acute admissions are not admitted direct to wards. Patients admitted during the weekends are discussed with the consultant on call either immediately after the assessment from the Junior Doctor or if this happens after midnight, they are discussed at 08;00	
They should use a standardised system of communication such as an SBAR to enable all staff to escalate and communicate their concerns.	SBAR used widely across wards	Ongoing training for teams and reminders of importance required to ensure that it is used in all areas
Workforce	Minimum staffing levels for wards include uplift for absence and training - 6 monthly safe staffing report to board used triangulated data that includes sickness absence	Ensure calculation remains accurate using previous 3 years

Action	Current Position in Berkshire Healthcare	Gaps / actions required to address these
Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.		
Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan. • Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred. • Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.	Some good examples of learning from incidents used to support training for example risk training , suicide training, deteriorating patient training and dysphagia training Each Division has a patient safety and quality meeting chaired by Clinical Director these meetings receive shared learning from across the organisation alongside complaints and incidents from their locality. At PPH the Clinical Director has recently started a monthly meeting with matrons, wards managers to look at the themes of Complaints and Si's and actions from these that progress is then monitored to ensure that learning and actions are shared and also don't get lost. Where the clinical incident is a suicide a tableau dashboard is used to capture detail this enables themes (local and national) to be identified and this is used to inform 3 day suicide prevention training and bespoke staff workshops – examples include prevalence of SMU, Autism, Harm from others, CPA, Family involvement, Information sharing, risk documentation. The dashboard data also triggers deep dives and audits if any repeat themes or anomalies are observed -recent examples include 17-25, female suicides, Talking therapy, PMS, court liaison and diversion, risk documentation. This enables us to share further learning with the teams and also make changes to systems – recent examples include PMS	Further development of triangulation /collation of themes across incidents / complaints / litigation and audit outcomes with process to agree what comes on and off training plans, learning for sharing across the organisation and should be added to audit plans- SECEG to fulfil this role quarterly starting June 22 Confirm that there is a clear process in all divisions for follow up of actions from the recommendation's accountability of completion and review and ensure that actions are now embedded -for example through audit

Action	Current Position in Berkshire Healthcare	Gaps / actions required to address these
	escalating to senior staff, use of an MDT template, updating SOPs, bespoke team level training.	
All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding care in case of disagreement between healthcare professionals.	MDT , positive risk panel and complex case forums available to escalate concerns and any disagreement between professionals. Lead consultant/ Director of psychology and other leads available to support if required	Explore if further processes are required across community and Mental health services
Every trust must ensure they have a patient safety specialist with relevant experience	Patient safety team have a mix of experience and specialist backgrounds. 2 safety specialists in place	
There must be regular multidisciplinary skills drills and on-site training for the management of common emergencies including cardiac arrest and the deteriorating patient.	Scenario training provided for ward staff including deteriorating patient, emergency interventions such as choking , cardiac arrest and anaphylaxis, fire training.	
There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.	Staff support / psychological wellbeing support available to both individuals and teams, Professional Nurse Advocacy being rolled out across the Trust. MH have space groups in place.	

National Audits Project Initiation Documentation

Berkshire Healthcare NHS
NHS Foundation Trust

Title of Audit:	
ID No:	

Audit Facilitator	

Clinical Director	

Operational Lead (identified & agreed)	

Clinical Advisor if applicable	

Planning for a Re-audit
If the project is a re-audit, ensure the relevant QAC report and the previous PID have been reviewed to identify any highlighted issues to build into your audit planning. Highlight below.

Teams/Services/Stakeholders involved or required in the audit		
	Named Person or Contact	**Role in Project**

Audit Key Dates	
Timeline Activity	**Date**

Methodology	
Sampling Requirements	
Eligibility Criteria:	
Defined Data Period:	
Defined Population:	
Total Population:	
Sample Size:	
Final Sample Size for Auditing:	
Deadline for Sample Submission:	

Data Collection	
Data Collection Period:	
Data Collection Deadline:	
Extension Requested for Data Collection:	

National Data Opt. Out Process (Clinical Audit Manger to advise)
Is this applicable to the national audit: Yes/No If Yes or No, document the reasons why **and** if Yes, this is to be built into the planning stage with sampling timeline.

Scoping Meeting	
Date:	
Venue:	
People required at scoping meeting:	**Attended Yes/No:**

Project Activities			
Activity	**Person Assigned**	**Start Date**	**Due Date**
Examples:			
Collation of Data lists			
Validation of Data			
Dissemination of Sample			
Data Collection			
Data Input			
Data Queries			

Assumptions of RISK
Provide details of any high-risk areas that if are not happening, need to be flagged in the data collection phase and agreed in the planning process. (*e.g. the risk acknowledgement form in PREVENT not being undertaken or cases where no physical health intervention has been given to a patient i.e. NCAP EIP & Psychosis Spotlight Audits*)

Constraints / issues associated with project
Outline the factors needed to be taken into consideration during the delivery of project. (*e.g. timelines, other projects happening at the same time, deadlines, CQC Inspections*)

Sources of Data to be relied upon (outline below)

Pilot of Audit Tool			
(*e.g. order of questions hampers data collection/inconsistent responses obtained due to ambiguous questions/data does not allow you to measure identified standards*)			
Date	**Work Performed**	**Findings**	**Conclusion**

Validation of Data Collection Forms			
Date	**Number of Forms**	**Findings**	**Compliance Met**

Escalation Details – Facilitators should ensure that there is a plan for escalation built into the planning process.			
This section should document the review of the data collection process at certain points to identify triggers for escalation (*e.g. the percentage of forms received*). This should then impact on who to discuss with and escalate to.			
Data Collection Process Review (date)	**Triggers for Escalation**	**Escalation Contact**	**Action Taken**

National Reports	
Release date of National Report:	

PROJECT DETAILS
This table is to be used to document the issues or problems that arise during the project with the outcome of that issue clearly stated. The status key should be used to regularly review the status of the issue against the countermeasures put in place.

Concern	Cause	Countermeasure	Owner	Due Date	Status
Example 1	*Audit Tool was lacking certain options that would impact on data collection and outcomes would not be accurately presented*	*Lacking specific options against measurement of the standard*			
Example 2	*The uncertainty if whether a Safety Care Plan is given to the patient and where this is recorded.*	*It is recorded on the system but in a different part of RiO. Review all forms with a 'No'*			

Status Key (please select and insert above)

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 May 2022
Title	**Executive Report**
	For Noting
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.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Meeting 10 May 2022

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. Update on the Management of Respiratory Illness including COVID-19

During April 2022, there have been several changes to guidance in relation to the Infection Prevention and Control management of Covid-19 that will enable our outpatient services to return to pre-pandemic levels of activity and improve flow within the wards. The main changes are:

- Removal of social distancing (providing patients do not have respiratory or infectious symptoms) in clinics and waiting rooms as well as on our wards.
- Removal of the need to self-isolate patients who are close contacts of a positive case on our wards (providing the close contacts are asymptomatic)
- Ceasing of routine weekly asymptomatic testing for patients (admission / day 3 and day 5-7 continues but with lateral flow testing in most cases which enables a more instant result than sending specimens to the lab for testing which takes around 24hours to gain a result)

In addition, the case definition has been updated and in addition to:

- continuous cough
- high temperature, fever or chills
- loss of, or change in, your normal sense of taste or smell

the following have been added:

- shortness of breath
- unexplained tiredness, lack of energy
- muscle aches or pains that are not due to exercise
- not wanting to eat or not feeling hungry
- headache that is unusual or longer lasting than usual
- sore throat, stuffy or runny nose
- diarrhoea, feeling sick or being sick

What has not changed:

- Staff, visitors and inpatients (by risk assessment) are to continue wearing masks on all healthcare sites
- Staff working clinically/coming onto healthcare sites continue to undertake asymptomatic Lateral flow (LFD) testing twice weekly and also test with LFD if they develop symptoms
- Staff with positive LFD to remain away from work until they have negative test (they can test from day 5 and require 2 consecutive negative LFD before day 10 and 1 after up to day 14)
- Staff who have been in close contact with a positive case must test for 10 days before coming to work clinically or in a healthcare premises following the contact
- Patients with respiratory symptoms must be isolated/cohorted and tested for covid-19/ flu
- Triage/screening of patients prior to outpatient appointments to ascertain risk and management
- Other mitigations included in hierarchy of controls to continue such as hand hygiene, ventilation, staff not attending work if unwell/ have infectious symptoms

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

3. Latest NHS Staffing Trends

According to the latest NHS workforce statistics published at the end of March 2022, the number of staff resigning voluntarily hit almost 70,000 in the nine months to January 2022.

This was up from around 49,000 in the same period in 2020, and 57,000 in the same period during 2019. Part of the increase appears to be driven by thousands of staff who would normally have resigned in 2020 choosing to leave in 2021 instead, boosting the numbers for that year. However, the rise in 2021 is still around 5,000 higher than the long-term trend once this is accounted for. The number of staff pointing to work-life balance as a reason for leaving their role in the 2021 period was 40 per cent higher than in the same period two years before.

Despite the rise in voluntary resignations, the number of full-time equivalent staff increased by 7 per cent between February 2020 and December 2021, with the greatest annual increase seen in “support to clinical staff”, which could include nursing associates and physician assistants.

Executive Lead: Julian Emms, Chief Executive

4. COVID-19 Discharges to Care Homes

On the 27 April 2022, the High Court ruled that discharging untested hospital patients into care homes in spring 2020 was “necessary to preserve the capacity of the NHS”, but the government acted illegally by failing to recommend that they were isolated on admission.

The judges found in favour of the claims against the Health and Social Care Secretary (on behalf of the Department for Health and Social Care), and Public Health England, because their policies in March and April 2020 on discharges and admissions to care homes were “irrational in failing to advise that where an asymptomatic patient (other than one who had tested negative) was admitted to a care home, he or she should, so far as practicable, be kept apart from other residents for 14 days”.

Lord Justice Bean and Mr Justice Garnham found government had sufficient knowledge about potential asymptomatic transmission to have recommended care homes put some measures in place where possible. However, they found the decisions to discharge patients, including into care homes, and to do so without testing, were not irrational nor illegal.

The judgement said: “The defendants were extremely and understandably concerned by the prospect of the numbers of seriously ill patients requiring intensive care rising so rapidly that the NHS’s intensive care capacity would simply be overwhelmed. In Italy, where the disease had spread some two weeks earlier than in England, hospitals had run out of beds and patients were being left to die at home.”

But the judgment went on: “However, there is a separate question as to how those discharged from hospital to care homes should have been treated and cared for. The fact that discharge was necessary to preserve the capacity of the NHS to provide inpatient care to those seriously affected by COVID did not eliminate the need to consider the best way to manage those discharged.”

Executive Director: Julian Emms, Chief Executive

5. Provider Collaboratives: Explaining their role in system working

The Kings Fund “explainer” of Provider Collaboratives in context of statutory Integrated Care Systems (ICS) is attached as a web copy appendix.

The paper discusses the expectation and purpose of provider collaboratives, being mandated for acute and mental health trusts from July 2022. Working at scale, standardisation and sharing to improve efficiency, sustainability and quality of care are the key drivers for Provider Collaboratives. Examples of collaborative leadership and governance models are offered, noting consideration of form is permissive and likely to be very different by collaborative initiative across the 42 ICSs.

The paper notes there are other collaborative structures within an ICS that seek to achieve similar aims for the population (Place Based Partnerships is one), and so system space to enable Provider Collaboration to flourish is potentially complex.

Executive Director: Alex Gild, Deputy Chief Executive

6. New Chief Operating Officer

As the Trust Board is aware, David Townsend retires from his role on 13 May 2022. This will therefore be his last Trust Board meeting.

Following a national recruitment exercise, Tehmeena Ajmal was appointed to the role. Tehmeena was previously working in Oxford Health NHS Foundation Trust and joined the Trust in mid-April 2022 so that she could have a good period of induction prior to taking over from David on Monday 16 May 2022.

Executive Director: Julian Emms, Chief Executive

7. Health and Care Act 2022

The Health and Care Bill received Royal Assent on 28 April 2022, becoming the Health and Care Act 2022

Central to the Act is the requirement for every part of England to be covered by an Integrated Care System (ICS) and putting these organisations on a statutory footing from 1 July 2022.

ICSs have been established with the aim of coordinating services and to plan in a way that improves population health and reduces inequalities between different groups. They will replace Clinical Commissioning Groups. Part of the legislation includes addressing "the barriers to joined up working, by supporting data sharing between health and social care.

The Act introduces new duties on the Care Quality Commission (CQC) to review ICS service provision, as well as local authorities' adult social care responsibilities. The CQC will consider how well ICSs, local authorities, and CQC registered providers deliver care, as well as how the system functions as a whole. The Secretary of State will set the priorities and objectives of ICS reviews, with a requirement that priorities are set relating to leadership, integration, and quality and safety. The CQC will determine the indicators of quality, methods, period and frequency of these reviews with Secretary of State approval.

Provisions are included to increase transparency on mental health spending. The Secretary of State will publish government expectations as to increases in mental health spending by NHS England and Integrated Care Boards (ICB). ICBs will be required to report on mental health spending.

The act also sets out the new rules and circumstances in which NHS England (NHSE) would seek to curtail capital spending by foundation trusts. The new controls represent an erosion of the autonomy of Foundation Trusts (FT) amid the shift to system-level cooperation within integrated care systems. FTs currently have the freedom to spend their own cash reserves on capital investments, which often causes concerns that the national capital spending limit could be breached.

In Capital Guidance recently published , NHSE set out the approach to using the new powers and argued this would lead to a fairer distribution of funding.

The document states that: “The power would be used as a last resort where a foundation trust is actively pursuing capital expenditure that is not affordable within integrated care system capital envelopes, thereby creating a risk of DHSC breaching its [capital spending] limit...It is expected that system, regional and national mechanisms should mitigate the risk, however, this discretionary power is intended to complement how the capital regime operates to support system working and will only be exercised where this risk has not been mitigated.”

NHSE would consider an intervention where;

- an FT submits a capital plan that is not aligned with and/or exceeds the level of capital notionally allocated to the organisation by the ICS;
- year-to-date or forecast outturn spending by an FT is above the affordable plan;
- or; where capital spending on unplanned projects in-year is without prior notification and discussion with NHSE.

NHSE would first consult with systems and the FT in question before imposing a limit, which would normally stay in place for a single financial year.

The guidance also confirms that systems will be given three-year operational capital envelopes, which it says should give certainty over more than 90 per cent of total capital spending. It adds NHSE is expecting a “flatter spend profile” over each year with less spending focused on the final months of the year.

Executive Lead: Julian Emms, Chief Executive

Presented by Julian Emms
Chief Executive
10 May 2022

Provider collaboratives: explaining their role in system working

21 April 2022
17-minute read
2 comments

Authors

Charlotte Wickens

This explainer looks at provider collaboratives in England, the opportunities they provide and the unresolved questions to consider when thinking about their role in the changing health and care landscape.

What are provider collaboratives?

Provider collaboratives (https://www.england.nhs.uk/wp-content/uploads/2021/06/B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf) are partnerships that bring together two or more NHS trusts (public providers of NHS services including hospitals and mental health services) to work together at scale to benefit their populations. While providers have worked together for many years, the move to formalise this way of working is part of a fundamental shift in the way the health and care system is organised, moving from an emphasis on organisational autonomy and competition to collaboration and partnership working.

What is the rationale for provider collaboratives?

NHS providers face significant challenges including rising demand for services, severe workforce challenges and the legacy of a prolonged funding squeeze. NHS England has argued (https://www.england.nhs.uk/wp-content/uploads/2021/06/B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf) that the challenges facing providers after the Covid-19 pandemic are too much for a single organisation to tackle (https://www.england.nhs.uk/wp-content/uploads/2018/01/acute-care-collaboration-learning.pdf). Formalising provider collaboratives is a culmination of a national

policy focus on addressing these challenges through system working and exploring the potential of working at scale.

> **The rationale for providers working together in this way comes down to improving efficiency, sustainability and quality of care.**

The rationale for providers working together in this way comes down to improving efficiency, sustainability and quality of care. Collaborative arrangements could see providers coming together to consolidate corporate services for greater efficiency, increase sustainability by making better use of a limited workforce and improve quality of care by standardising clinical practice to tackle variations in care across different sites.

NHS England believes that formalising provider collaboratives now will give providers the opportunity to combine resources to address the challenges they are facing. However, there is a limited evidence base (although anecdotal reports of the benefits of co-operation during Covid-19 added to this) and few evaluations of previous initiatives (https://www.kingsfund.org.uk/publications/mental-health-new-care-models), to verify the success of provider collaboration in tackling these longstanding challenges.

The history of provider collaboration: policy and practice

Provider organisations have historically worked together to address mutual challenges, encouraged by a number of policy documents that have both made the case for collaboration and also identified ways to do this.

In 2014, the NHS Five Year Forward View (https://www.kingsfund.org.uk/projects/nhs-five-year-forward-view) set out a number of new models of care with the aim of breaking down barriers between services and delivering integrated care. This was closely followed by the Dalton review (https://www.gov.uk/government/publications/dalton-review-options-for-providers-of-nhs-care), which explored organisational models to underpin this. In practice, these policy documents led to the creation of new models of care that, for example, brought together primary care, community, mental health and hospital services into primary and acute care systems (https://www.kingsfund.org.uk/projects/nhs-five-year-forward-view/primary-acute-care-systems) and hospital providers into acute care collaborations (https://www.kingsfund.org.uk/projects/nhs-five-year-forward-view/viable-smaller-hospitals). Acute care collaborations demonstrated that organisations could take diverse approaches to collaboration, including providers working

together on a range of clinical and non-clinical service areas (multi-specialty chains), hospital group models and trusts working on a specific service area (specialty-based franchises).

> The Royal Free London was an acute care collaboration vanguard site (https://www.england.nhs.uk/publication/no-hospital-is-an-island-learning-from-the-acute-care-collaboratives/) that worked as a hospital group, bringing Barnet Hospital, Chase Farm Hospital, and the Royal Free Hospital together into a single group structure with the aim of reducing variation in clinical services, such as pathology, and reducing costs through collaboration, including spend on agency staff. This group structure was underpinned by a single board and executive team for the group, management teams for each hospital in the group and clinical practice groups working across the different sites.

The 2015 Carter review (https://www.gov.uk/government/publications/productivity-in-nhs-hospitals) identified that efficiencies and quality improvements could be gained by acute hospitals either changing the way clinical services were delivered or sharing some supporting services. This review brought about changes in mental health services, with the Five Year Forward View for Mental Health (https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf) bringing together commissioning and provision of services and delegating budgets for some child and adolescent mental health services (CAMHS) and specialist adult mental health inpatient services to providers, who came together to refocus these pathways and improve the quality of care. This direction was then built on and expanded in the NHS Long Term Plan (https://www.longtermplan.nhs.uk/), with the emergence in April 2020 of NHS-led provider collaboratives (https://www.england.nhs.uk/mental-health/nhs-led-provider-collaboratives/) – groups of providers of specialised mental health, learning disability and autism services that agreed to work together to improve care pathways for their local population.

The NHS Long Term Plan (https://www.longtermplan.nhs.uk/) built on what had come before, describing collaborative arrangements as drivers of integration. This translated into a significant step forward in *Integrating care: next steps to building strong and effective integrated care systems across England* (https://www.england.nhs.uk/publication/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems-across-england/), which introduced formal provider collaboratives and outlined them as one of the four interlocking elements, alongside place, integrated care systems (ICSs) and the national and regional bodies that would make up the future landscape of the NHS. The formalisation of provider collaboration in this form was then confirmed in the Integration and

innovation (https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version) White Paper and NHS England guidance (https://www.england.nhs.uk/wp-content/uploads/2021/06/B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf) , which cited the Covid-19 pandemic as bringing fresh impetus to this type of collaboration as existing collaborative arrangements often played a role in co-ordinating parts of the pandemic response.

The new approach to provider collaboratives

> **From July 2022, all NHS trusts providing acute and mental health services will need to join a provider collaborative.**

From July 2022, all NHS trusts providing acute and mental health services will need to join a provider collaborative. NHS community and ambulance trusts and non-NHS providers, such as voluntary, community and social enterprise (VCSE) sector organisations or independent providers, will be offered the opportunity to take part where this will benefit patients and makes sense for the providers. Individual providers may be involved in more than one collaborative. This is different from previous initiatives because collaboration is now mandated, rather than encouraged, and provider collaboratives will become a universal part of the health and care landscape across England.

However, how these arrangements develop will vary significantly across the country. They may take different forms and will vary in their scale and scope: some will be 'vertical' collaboratives involving organisations that provide different services (eg, collaboratives bringing together primary care, community, local acute, mental health and social care providers); others will be 'horizontal' collaboratives that bring together providers that offer similar services (eg, a chain of acute hospitals or mental health services).

There is little evidence that one model of provider collaboration is more effective than another. Different possible models and routes to bring providers together (https://www.kingsfund.org.uk/publications/new-care-models) have been explored, with evidence showing flexibility is important to allow arrangements to fit with the specific local context. This flexibility is also evident in the NHS England guidance (https://www.england.nhs.uk/wp-content/uploads/2021/06/B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf) which focuses on 'the desired outcomes, rather than on the underpinning governance structure'.

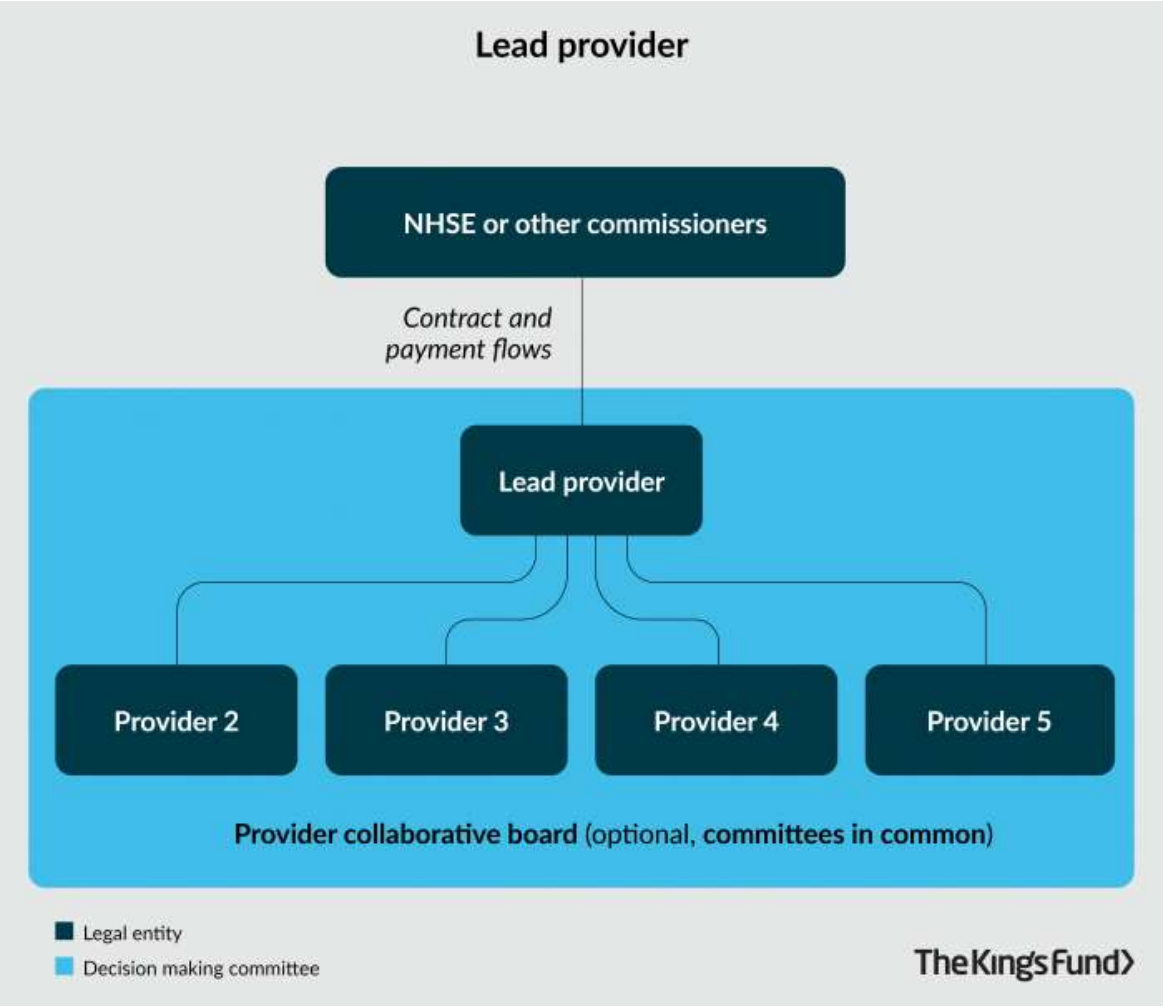
NHS England has set out a number of guiding principles that should underpin the chosen arrangement. These include:

- a shared vision and commitment to collaborate
- strong accountability mechanisms for members
- building on existing successful governance arrangements
- efficient decision-making
- embedding clinical and community voices
- streamlining ways of working.

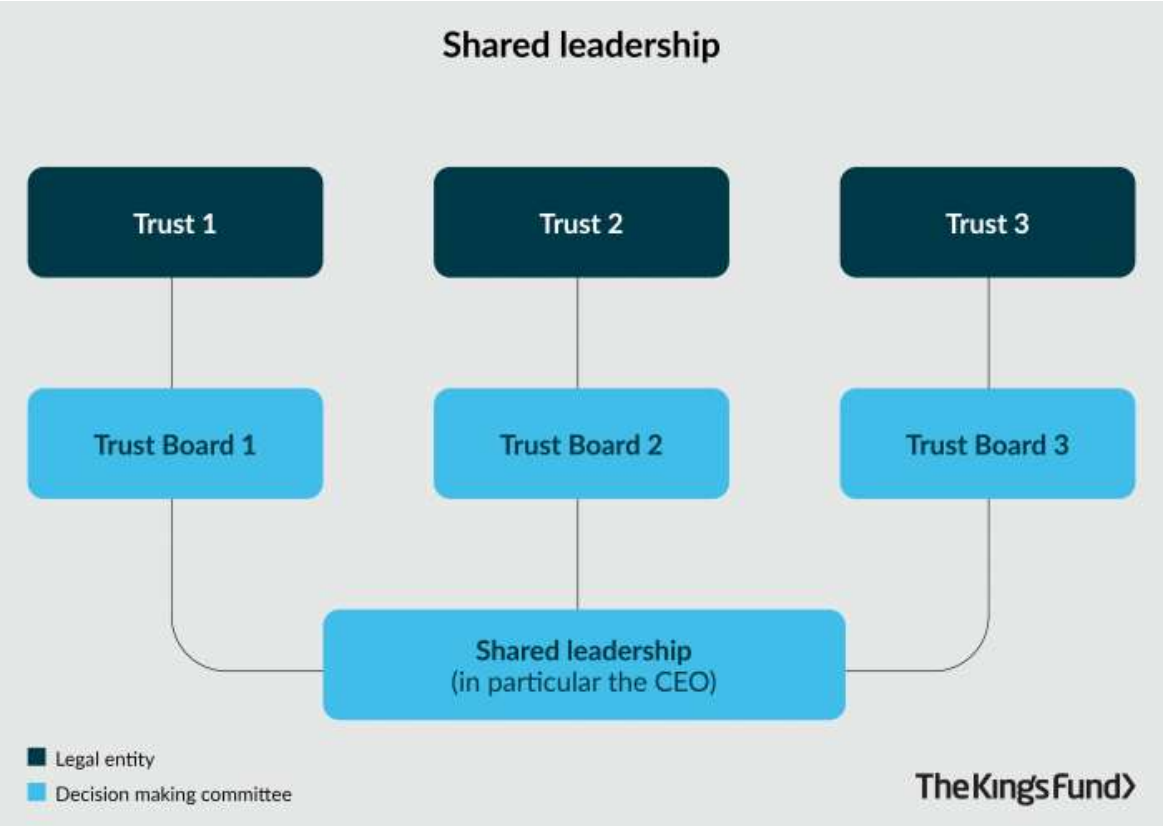
However, the guidance is also clear that it is up to members of the proposed collaborative to decide which arrangement will work best for them in the context of their 'shared purpose and objectives'. This permissive approach recognises that the form and function of the newly mandated provider collaboratives will in many ways be determined locally; influenced by the history of collaboration, the local provider context and the relationships in that area.

While there is no blueprint for developing a provider collaborative, the guidance suggests functions and forms that providers can consider. It highlights several potential models that are being used in different parts of the NHS.

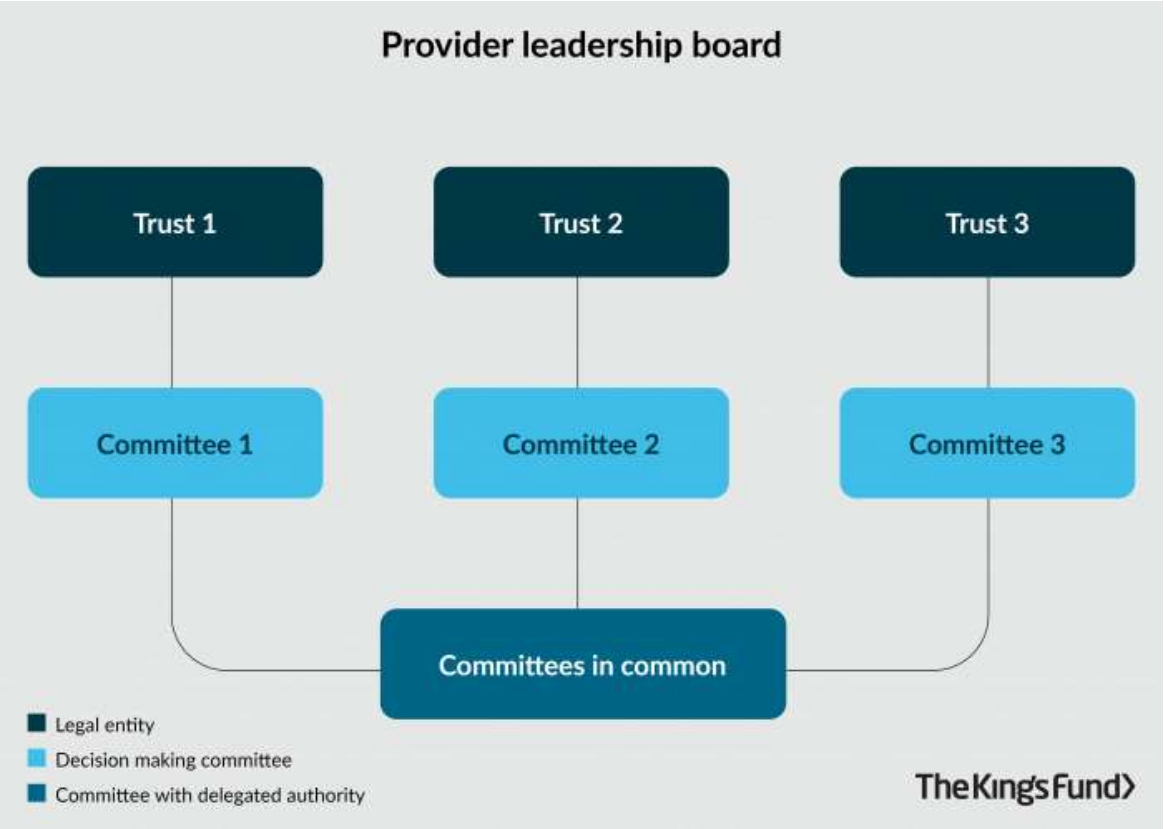
Lead provider – a single trust takes the responsibility, and contract, to deliver a set of services on behalf of the provider collaborative. This is underpinned by a partnership agreement between the collaborative members. This model means there is a single point of contact for the commissioner, but all members of the collaborative are contributing to the shared delivery of the service.



Shared leadership – the same person fills the chief executive posts at all the trusts involved in the collaborative, and sometimes this may also extend to the chairs and other executive posts. Alternatively, the boards of the individual providers can delegate responsibilities within the remit of the provider collaborative to a committee made up of members of another trust's leadership team.



Provider leadership board – with approval from their respective boards, the chief executives or other directors of participating trusts come together to tackle areas of common concern and deliver a shared agenda on behalf of the collaborative members and their system partners.



What are provider collaboratives expected to achieve?

Providers, as with other organisations in the health and care system, are expected to look beyond their organisational priorities to focus on system-wide aims and improving outcomes for the communities they serve. Working at scale, standardisation and sharing are three themes that encapsulate a number of the opportunities identified by NHS England for what provider collaboratives can offer as part of systems.

Working at scale

While the evidence on economies of scale is contested (https://www.england.nhs.uk/publication/no-hospital-is-an-island-learning-from-the-acute-care-collaboratives/), NHS England believe the formalisation and roll-out of collaborative working offers the opportunity for NHS organisations to do things at scale. NHS England argues that scale can be deployed in several different ways, one example being through trusts working together to reduce the cost of back-office functions, for example, by employing a central procurement team, which then leverages the purchasing power of several hospitals and increases volume to drive costs down. This could potentially lead to financial savings across the collaborative but would also standardise the products used across an area, reducing variation and potential adverse events. The potential for efficiency savings could be particularly pertinent in the context of the increased cost improvement targets for 2022/23 (https://www.england.nhs.uk/publication/2022-23-priorities-and-operational-planning-guidance/) with trusts being asked to make savings as high as 5 per cent of their total costs.

Similarly on learning and development for staff, a collaborative has both a much larger pool of staff and greater resources to invest, which means that creating shared programmes could generate a better training and development offer. Scale also enables the specialisation and consolidation of services where appropriate. An example of which is dermatology services, a specialty where workforce shortages (https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2021/11/Dermatology-overview.pdf) are having an impact, where working as a collaborative offers an opportunity to change the model of delivery so that there is one service staffed by clinicians from across the providers, rather than each provider offering their own service.

> The Northern Care Alliance (https://www.northerncarealliance.nhs.uk/) brings together two NHS trusts, Salford Royal NHS Foundation Trust and The Pennine Acute Hospitals NHS Trust. The alliance has operated as a group

since 2016, with decision-making devolved to committees in common. The Northern Care Alliance 10-year vision (https://www.northerncarealliance.nhs.uk/about-us/corporate-priorities-values/vision-10) describes financial sustainability as priority for the group. To date, this has involved centralising procurement into one team across the group, which looks to deliver savings for the trust with a focus on strategic sourcing, supply chain and purchase to pay.

Standardisation

A key driver of NHS England's support for provider collaboratives centres around their role in working at scale to reduce unwarranted variation in outcomes and access to services, including a focus on reducing health inequalities. This is where standardisation of pathways, protocols and policies can be leveraged to improve outcomes and patient experience. Standardisation through collaboratives can be clinician led, as seen in mental health (https://www.england.nhs.uk/mental-health/nhs-led-provider-collaboratives/), and focused on addressing ongoing challenges with new models of care across an area and standardising protocols to reduce variation.

Sharing

Sharing between providers underpins NHS England's concept of collaboratives and the benefits of working at scale. This means that capacity is viewed in a combined sense rather than on an organisational footprint. The opportunities this presents can be illustrated by the example of 'passporting' staff between NHS trusts, an initiative pursued by more mature collaboratives (https://www.wyaat.wyhpartnership.co.uk/our-priorities/workforce), which allows more flexible working for staff and can address gaps in staffing. Working in this way is also becoming increasingly important as providers tackle the backlog of care (https://www.england.nhs.uk/coronavirus/publication/delivery-plan-for-tackling-the-covid-19-backlog-of-elective-care/), with Humber Coast and Vale acute provider collaborative (https://humbercoastandvale.org.uk/) agreeing an elective recovery plan based on joint capacity and managing patient lists (https://humbercoastandvale.org.uk/2021/03/15/elective-care-programme-pandemic/) across the area, rather than on an organisational basis.

What does this mean for patients?

Collaborative partnerships can organise around the needs of people living in the area, rather than planning at individual organisational level, enabling them to deliver more joined-up, high-quality care for patients. This type of collaboration

could deliver the ability to change models of care for patients, which could mean more effective use of resources for providers and better outcomes for patients through improved staffing and concentrated expertise.

West Yorkshire Association of Acute Trusts (https://wyaat.wyhpartnership.co.uk/our-priorities/west-yorkshire-vascular-services) provides an example of what collaborating in this way can mean for patients. This is a partnership arrangement with a committee in common that was established between the NHS trusts that deliver acute hospital services across West Yorkshire and Harrogate. The partnership has created a single, shared vascular service (https://wyaat.wyhpartnership.co.uk/our-priorities/west-yorkshire-vascular-services) in order to improve outcomes for patients, following the recommendations of the Getting it Right First Time (GIRFT) vascular surgery report (https://www.gettingitrightfirsttime.co.uk/surgical-specialty/vascular-surgery/). This entailed consolidating all specialised vascular surgery that requires an overnight stay in two centres, Leeds General Infirmary and Bradford Teaching Hospitals NHS Foundation Trust, while vascular day-case surgery, diagnostics, outpatient appointments and rehabilitation services still take place in local hospitals throughout West Yorkshire.

How do provider collaboratives fit in with the rest of the health and care landscape?

Provider collaboratives are one of many vehicles for collaboration that sit within the context of legislative changes to the delivery and organisation of health services in England through the Health and Care Bill. The Bill looks to establish a legislative framework (https://www.kingsfund.org.uk/publications/health-social-care-white-paper-explained) that promotes better joined-up services. This includes a duty for all health and care organisations, including providers, to collaborate to rebalance the system away from competition and towards integration.

The Bill also formalises ICSs (https://www.kingsfund.org.uk/publications/integrated-care-systems-explained#icss-operating), partnerships that bring providers and commissioners of NHS services across a wide geographical area together with local authorities and other local partners to collectively plan health and care services to meet the needs of their local population.

...provider collaboratives, along with place-based partnerships (https://www.kingsfund.org.uk/publications/place-based-partnerships-integrated-care-systems), are badged as 'a

key component of ICSs' enabling them to deliver their core purpose...

Provider collaboratives lie largely outside these legislative changes, with the formal duties and accountabilities of trusts unaffected by them. However, provider collaboratives, along with place-based partnerships (https://www.kingsfund.org.uk/publications/place-based-partnerships-integrated-care-systems), are badged as 'a key component of ICSs' enabling them to deliver their core purpose and meet the triple aim (https://www.kingsfund.org.uk/publications/health-social-care-white-paper-explained) of improving health and wellbeing of the population, improving quality of care and efficient use of resources – which is now also underpinned by a need to take action on health inequalities (https://www.hsj.co.uk/policy-and-regulation/the-health-and-care-bill-must-require-action-on-health-inequalities/7031282.article).

Providers will play a key role in ICSs, being asked to contribute not just as individual organisations but also to participate in their collaborative form, as the traditional commissioner/provider split is intentionally blurred. This participation could take the form of a provider collaborative taking on some of the functions that were formerly those of the commissioner, such as changing a model of care. This is intended to support the desired shift from a transactional approach to planning services towards organisations working together to do this. Provider collaboratives are intended to work with the ICS to determine how best the collaborative can contribute to the delivery of shared priorities.

Provider collaboratives will also interact with more than one ICS in many cases. Collaboratives are being encouraged to think about how they can be part of partnerships at a multi-ICS level where this scale is necessary to work effectively. They will also interact and interface with other bodies, including those focused on single specialties or clinical support services (such as cancer alliances and clinical support networks (https://www.england.nhs.uk/wp-content/uploads/2021/06/B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf)) which can work with one or more ICS, although how this will work in practice is currently unclear.

Providers will need to identify how they will work at place, a smaller geography within an ICS and the level at which ICS policy (https://www.kingsfund.org.uk/publications/integrated-care-systems-explained#systems) states that much of the activity to integrate care and improve population health will happen. The integration White Paper (https://www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations) strengthened the role of place, with ICSs

expected to delegate significant responsibilities and budgets to this level, and provider collaboratives will need to engage at this level. This will take place through individual members of the provider collaborative working as part of place-based partnerships, but also with the provider collaborative, in its collective form, working together with these partnerships at place.

The exact form of collaboratives' engagement with the new structures in the health and care system is still uncertain but is likely to vary considerably to reflect local priorities. The role provider collaboratives, and place-based partnerships, play going forward should be determined by the improvement or outcome needed, which will determine which collaborative function would be best place to achieve this and shape how these different groupings interact with each other.

What could provider collaboratives look like?

What unresolved questions do provider collaboratives face?

There are a number of unresolved questions remaining that may have an impact on how provider collaboratives develop.

Purpose

Previous collaboration between providers was often spurred by the need to address a clearly defined challenge or issue, such as out-of-area placements in mental health (https://www.kingsfund.org.uk/publications/mental-health-new-care-models) , or by trusts coming together voluntarily because they saw the benefits of collaboration. However, provider collaboratives have already been mandated and are *then* being asked to define what they will achieve. As such, it is unclear what specific problem or challenge they have been designed to address.

There is also a question about what these provider collaboratives will add, given the number of collaborative bodies, including ICSs and place-based partnerships, that may have similar or potentially overlapping purposes.

Balancing permissiveness and pace

There is a tension between the opportunities presented by the flexibility and permissiveness on form and function of provider collaboratives and the need for them to be in place by July 2022. While the emphasis on local flexibility is welcome, it should be acknowledged that it takes time to arrive at a meaningful shared purpose, and that time is already limited.

Similarly, the wide variation in proposed approaches for scope and governance also require time to think through to reach the right choice for a collaborative. The absence of community, ambulance and non-NHS providers, such as VCSE sector organisations, as part of mandatory arrangements also raises a question about what impact this exclusion will have on the membership of provider collaboratives. The unintended consequences of this could lead to more providers adopting tried-and-tested models that bring the same type of providers together, rather than encouraging diversity.

As collaboratives develop, the current flexibility and latitude given to providers to design their own arrangements must carry through into implementation so trusts can take forward what works best in their local context and for the populations they serve. NHS England will need to support this through its approach and behaviour, providing sufficient guidance and highlighting best practice without being too directive.

Footprints

There is potential for footprints to be an issue given that the boundaries of a provider collaborative that spans multiple ICSs will fit poorly with a single ICS's objectives and commissioning arrangements. Provider collaboratives will also be working across multiple places within an ICSs, as well as across several pathways and interacting with different bodies such as cancer alliances or clinical support networks. Navigating this complexity to work efficiently together is likely to take some time.

Capacity and capability

Provider collaboratives need resource – both in terms of funding and people – to deliver their objectives. The guidance is clear that this is something providers must source themselves which may present an issue with strained capacity. Support, time and investment will be needed to ensure that leaders have the capability to step into complex leadership roles and capacity to participate in collaborations and continue leading their individual organisation. These issues are magnified by the number of different collaborative initiatives leaders will be expected to engage with. Clinical and professional leadership capacity (https://www.kingsfund.org.uk/blog/2021/09/provider-collaboratives-clinical-and-professional-leadership) in particular will need attention and a national, regional and local support and training offer would help those in these roles. It is unclear if the capability and capacity exists for providers to generate, engage with and participate in the numerous different collaborative entities.

Culture

There is a cultural component to consider too, with a legacy of competition and autonomy meaning that building relationships will be fundamental to a successful collaborative and developing these will take time. It will require collaborative and compassionate leadership styles (https://www.kingsfund.org.uk/publications/what-is-compassionate-leadership) that enable leaders to commit to a shared vision, working together and buy-in from staff across the providers.

This is crucial as these relationships will be tested, with potential for tension between shared accountability and organisational responsibilities especially when it comes to risk pooling, money, and service models. There will also need to be a cultural shift to ensure that the collaboratives empower clinical and professional leadership (https://www.kingsfund.org.uk/blog/2021/09/provider-collaboratives-clinical-and-professional-leadership), as harnessing this is key to improving services and identifying ways to alter the delivery of care to benefit patients.

Clearly, provider collaboratives will play an important role in the new health and care system, so it is essential that they embrace population health and a system-first approach. The importance of the cultural shift away from organisational autonomy and self-interest to prioritising collaboration and common purpose cannot be underestimated.

What next?

Collaboration is the foundation of the new health and care system and provider collaboratives represent one of a number of ways for working together to use all the clinical and managerial power available to a system to address its priorities. While there are opportunities to be found with providers collaborating in this way, there are still some unresolved questions that could limit the impact, or at least the pace, of implementation.

The next year will be a critical period for the development of provider collaboratives, and for the structures around them, including ICSs and place-based partnerships. However, these arrangements will be implemented at a time of great change for the system and with the prospect of further change to follow as a result of the integration White Paper (https://www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations) and other potential reforms. The Secretary of State has referred to existing provider collaboratives, such as South West London Elective Orthopaedic Centre (https://www.eoc.nhs.uk/), as key 'partnerships for reform' (https://www.gov.uk/government/speeches/health-and-social-care-secretary-speech-on-health-reform) and signalled that he wants to see what trusts working in these partnerships could do with 'greater freedoms'. This suggests that providers

will continue to be a focus of national policy, which is still evolving, and we can expect further developments in this area.

The work for this project was funded by HealthTrust Europe (https://www.healthtrusteurope.com/) . This output was developed and written by The King's Fund and is editorially independent.

Now read this

Provider collaboratives: moving clinical and professional leadership from rhetoric to reality

Provider collaboratives need to invest in developing clinical and professional leadership if they are to be truly collaborative and make a difference for patients, says Paula Head.
By Paula Head - 14 September 2021 3-minute read
(/blog/2021/09/provider-collaboratives-clinical-and-professional-leadership)

Integrated care systems explained: making sense of systems, places and neighbourhoods

Integrated care services represent a fundamental shift in the way the health and care system is organised. This explainer looks at how these bodies are structured, how they are developing and what the future holds.
By Anna Charles - 11 May 2021
(/publications/integrated-care-systems-explained)

Integrated care systems need to be different - but how exactly?

Integrated care systems are intended to be part of a new way of working in health and care based on principles of partnership and collective responsibility. Chris Naylor asks whether this original vision is already at risk and what making a reality of it would involve.
By Chris Naylor - 28 March 2022 4-minute read
(/blog/2022/03/integrated-care-systems-need-to-be-different)

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Meeting Date	10 May 2022
Title	**March 2022 Finance Report**
Purpose	To provide an update to the Committee on the Trust's Financial Performance to 31 March 2022.
Business Area	Finance
Author	Rebecca Clegg, Director of Finance
Relevant Strategic Objectives	Strategic Objective 2: Work with partners to deliver integrated and sustainable services to improve health outcomes for our populations. True North Goal 4: Money Matters – to deliver services that are efficient and financially sustainable.
CQC Registration/Patient Care Impacts	Achievement of CQC Well Led standard.
Resource Impacts	n/a
Legal Implications	Compliance with statutory Financial Duties.
Equality and Diversity Implications	n/a
SUMMARY	The Trust is reporting a £0.7m surplus against the requirement to breakeven in 2021/22. The Trust's cash balance as at 31 March 2022 is £53.9m. The Trust achieved a £0.1m underspend against the capital limit (CDEL).
ACTION	The Trust Board is asked to note the Trust's financial performance.

Berkshire Healthcare NHS
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Finance Report

Financial Year Ending 2021/22

March 2022

Purpose

To provide the Board and Executive with a summary of the Trust's financial performance for the period ending 31 March 2022.

Document Control

Version	*Date*	*Author*	*Comments*
1.0	19/04/2022	Rebecca Clegg	Draft
2.0	19/04/2022	Paul Gray	Final

Distribution

All Directors.

All staff as appropriate.

Contents

1.0 Income & Expenditure

Mar-22	In Month			YTD			21/22
	Act £'m	Plan £'m	Var £'m	Act £'m	Plan £'m	Var £'m	Plan £'m
Operating Income	36.1	25.3	10.8	301.6	291.2	10.3	291.2
Elective Recovery Fund	0.0	0.0	0.0	1.7	1.7	(0.0)	1.7
Top Up Funding	0.4	0.4	0.0	5.7	5.7	0.0	5.7
COVID Funding	0.8	0.8	0.0	9.3	9.3	0.0	9.3
Donated Income	0.4	0.0	0.4	0.4	0.0	0.4	0.0
Total Income	***37.7***	***26.5***	***11.2***	***318.6***	***307.9***	***10.7***	***307.9***
Staff In Post	24.0	17.0	7.0	202.3	200.0	2.2	200.0
Bank Spend	2.1	1.4	0.7	20.4	17.1	3.3	17.1
Agency Spend	0.8	0.3	0.4	6.0	3.9	2.1	3.9
Total Pay	***26.9***	***18.7***	***8.2***	***228.6***	***221.0***	***7.6***	***221.0***
Purchase of Healthcare	2.8	1.7	1.1	22.0	21.2	0.8	21.2
Drugs	0.5	0.5	0.0	5.5	5.6	(0.1)	5.6
Premises	2.6	1.3	1.3	19.1	18.4	0.7	18.4
Other Non Pay	2.9	1.7	1.3	22.5	21.8	0.8	21.8
PFI Lease	0.5	0.5	(0.0)	6.4	6.4	(0.0)	6.4
Total Non Pay	***9.4***	***5.7***	***3.7***	***75.5***	***73.4***	***2.1***	***73.4***
Total Operating Costs	***36.3***	***24.4***	***11.9***	***304.1***	***294.4***	***9.7***	***294.4***
EBITDA	***1.4***	***2.1***	***(0.7)***	***14.5***	***13.5***	***1.0***	***13.5***
Interest (Net)	0.4	0.3	0.1	4.0	3.9	0.1	3.9
Depreciation	0.7	0.7	0.0	8.4	8.2	0.1	8.2
Impairments	0.6	0.0	0.6	0.8	0.0	0.8	0.0
Disposals	(0.0)	0.0	(0.0)	(1.4)	0.0	(1.4)	0.0
PDC	(0.4)	0.1	(0.5)	0.9	1.4	(0.5)	1.4
Total Financing	***1.4***	***1.1***	***0.2***	***12.6***	***13.5***	***(0.9)***	***13.5***
Reported Surplus/ (Deficit)	***(0.0)***	***0.9***	***(0.9)***	***1.9***	***(0.0)***	***1.9***	***(0.0)***
Adjusted Surplus/ (Deficit)	***(0.1)***	***0.9***	***(1.0)***	***0.7***	***(0.0)***	***0.5***	***(0.0)***

Key Messages

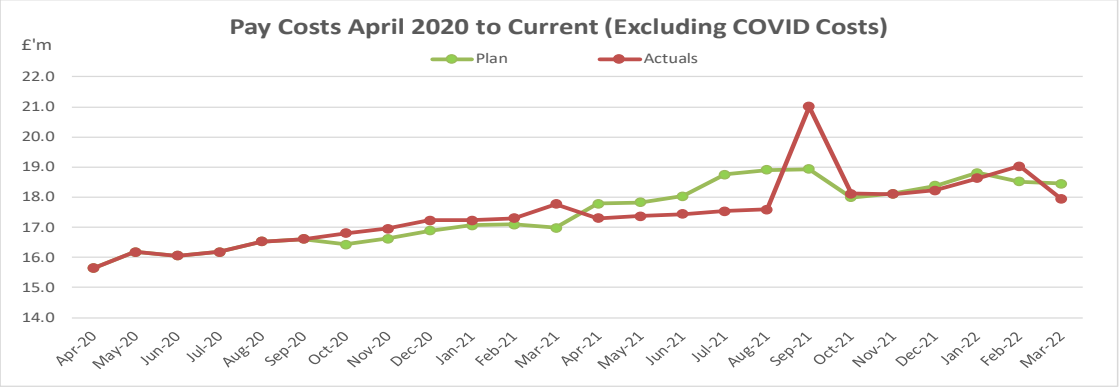
The table above gives the financial performance against the Trust's plan as at 31 March 2022. In month we are reporting £0.1m deficit, which was £1m behind the in-month plan. Overall the Trust is reporting a £0.7m surplus against a plan to breakeven.

The significant variances on income and pay this month primarily relate to the accounting treatment for the central employer pension contribution of 6.3% (£9m).

At month 11 it was agreed with the CCGs that £2m of the unused SDF and SR funding would be returned in anticipation of claw back by NHSE&I, but NHSE&I did not take the funding back. Berkshire West CCG chose to retain the funding. Frimley CCG decided to return the funding to the Trust and this was added to the deferred income for March 2022.

Financial performance has been adjusted for some impairments, the disposal of 3/5 Craven Road and the costs of some donated assets to provide the final position that will count towards the ICS control total.

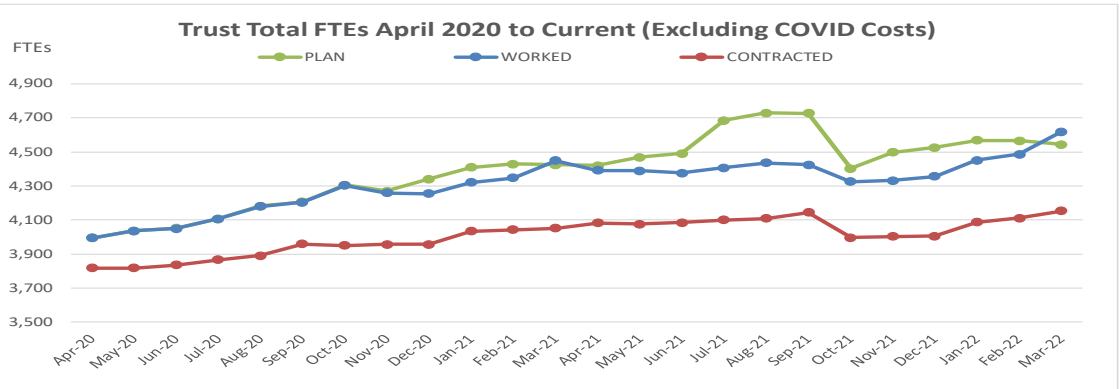
Workforce



Staff Costs

YTD	£'m
2021/22	218.3
2020/21	200.5
▲	9%

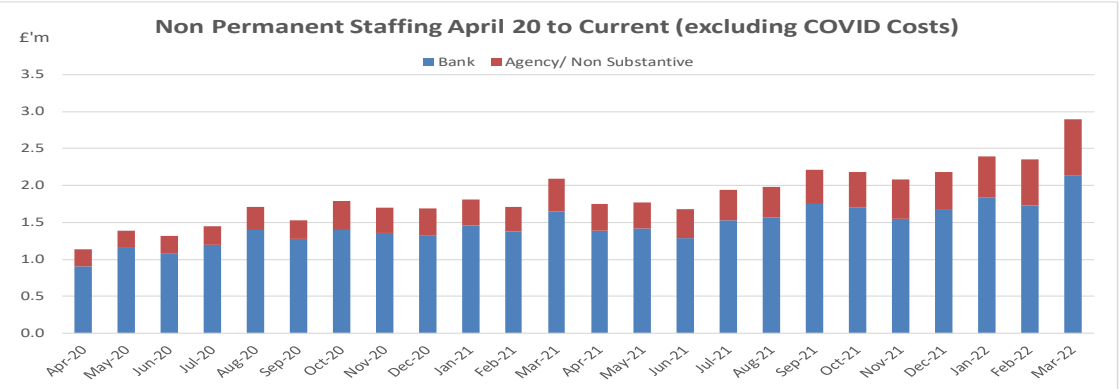
Prior Yr	£'m
Mar-22	17.9
Mar-21	17.8
▲	1%



FTEs

Prior Mth	CFTE	WFTE
Mar-22	4,153	4,618
Feb-22	4,111	4,486
	1% ▲	3% ▲

Prior Yr	CFTE	WFTE
Mar-22	4,153	4,618
Mar-21	4,052	4,447
	2% ▲	4% ▲



Staff Costs

YTD	Bank £'m	Agency £'m
2021/22	19.6	5.9
2020/21	15.6	3.7
	25% ▲	58% ▲

Prior Yr	Bank £'m	Agency £'m
Mar-22	2.1	0.8
Mar-21	1.6	0.4
	30% ▲	73% ▲

Key Messages

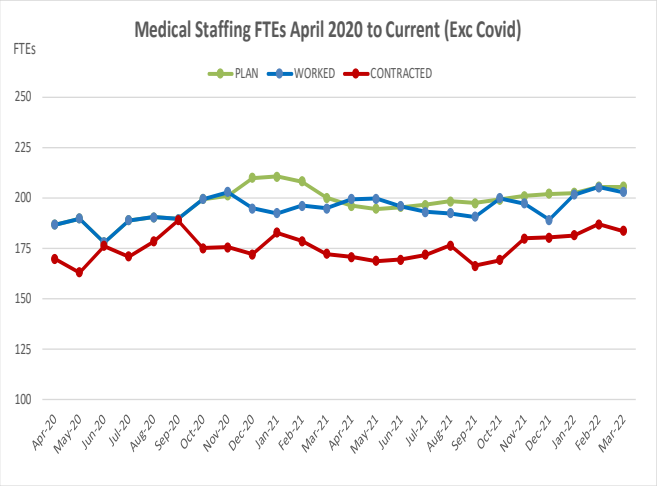
Pay costs in February were £17.9m (excluding COVID costs). Underlying pay excluding COVID costs has risen since the start of the year with costs in March showing an increase against both core funding allocations and new investment funding. Expenditure of £9m to cover the centrally funded element of the employers pension contribution has been excluded to aid comparisons with prior months.

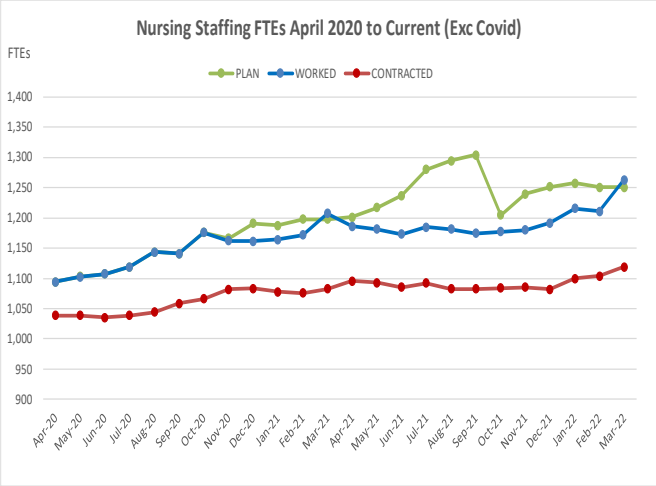
Expenditure on non-permanent staff has increased again continuing the trend seen in recent months. In March, this was linked to cover for annual leave and sickness and is therefore not expected to continue at such a high level into April. The increase was offset by a reduction in the annual leave accrual.

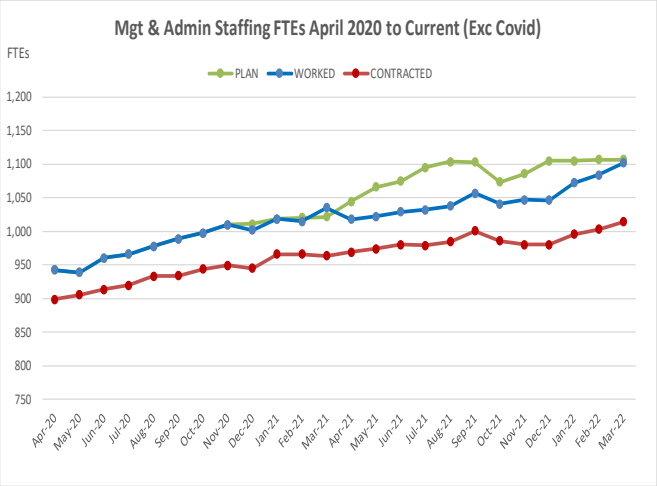
Contracted WTEs increased by 42 and worked WTEs increased by 132 in March. There was an increase in substantive staff of 28 worked WTEs, an increase in bank of 92 worked WTEs and an increase in agency of 12 worked WTEs compared with the previous month. The substantive worked WTE increase was seen across all divisions except MHI. Of the increase in substantive staff, 9 WTEs related to posts funded from specific investment income e.g. MHICS and ICS.

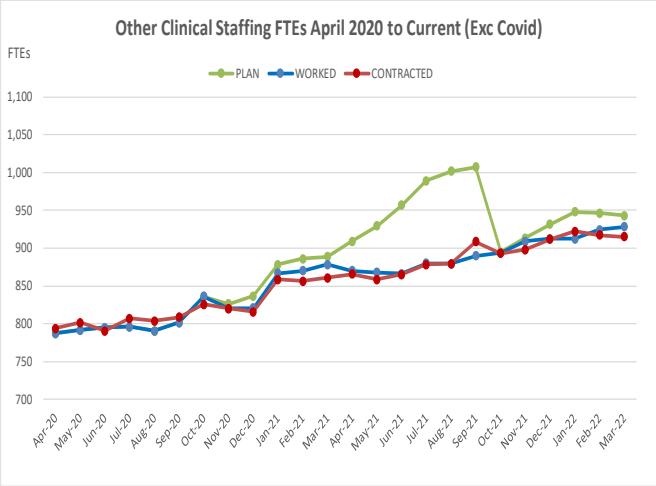
The level of staffing costs attributable to COVID was below £0.1m and lower than in the previous month.

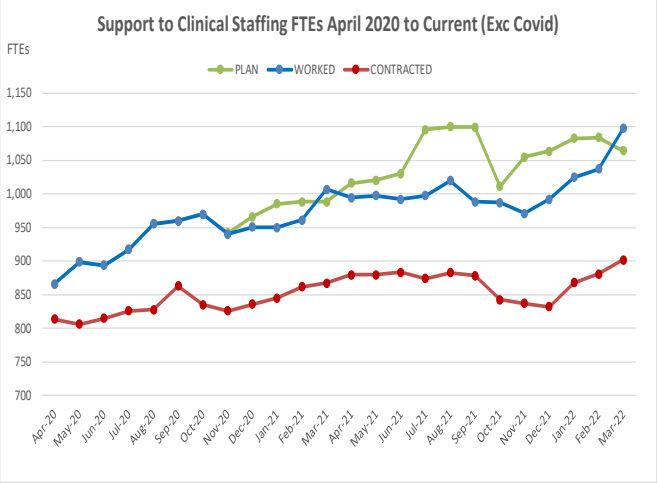
Staffing Detail

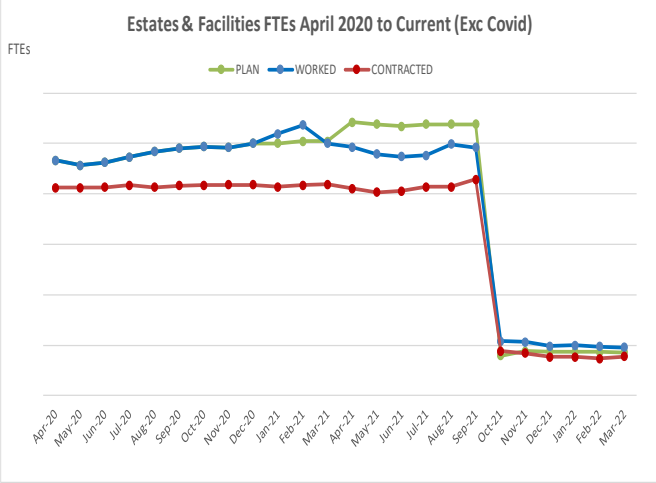










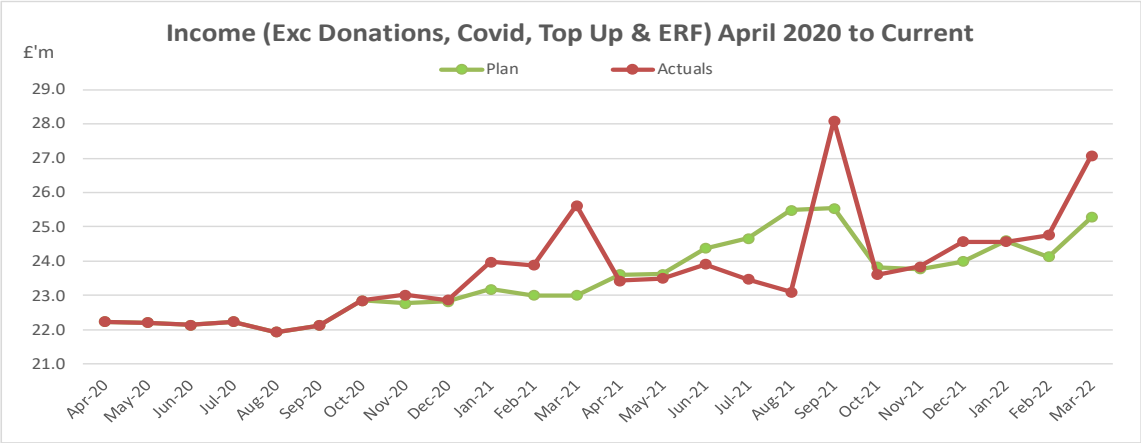


Key Messages

The tables above provide current staffing numbers broken down into core staffing groups. As the plan was developed in 2 stages actuals were closer to plan in the first few months of H2. The gap between plan and actual narrowed following an increase in WTEs in January and February, which has continued into March, with high bank usage to meet current pressures and to enable annual leave to be taken. Contract WTEs increased by 42 and worked WTEs increasing by 132 compared to February. Most of the increase was seen across 3 staff groups— Nursing (52 Worked WTEs); Management and Admin (18 Worked WTEs); and Support to Clinical Staffing (60 worked WTEs).

Of the increased in Worked WTEs, 28 were substantive, 92 were bank and 12 were agency.

Income & Non Pay



Income

YTD	£'m
2021/22	293.9
2020/21	275.1
▲	7%
Prior Yr	**£'m**
Mar-22	27.1
Mar-21	25.6
▲	6%

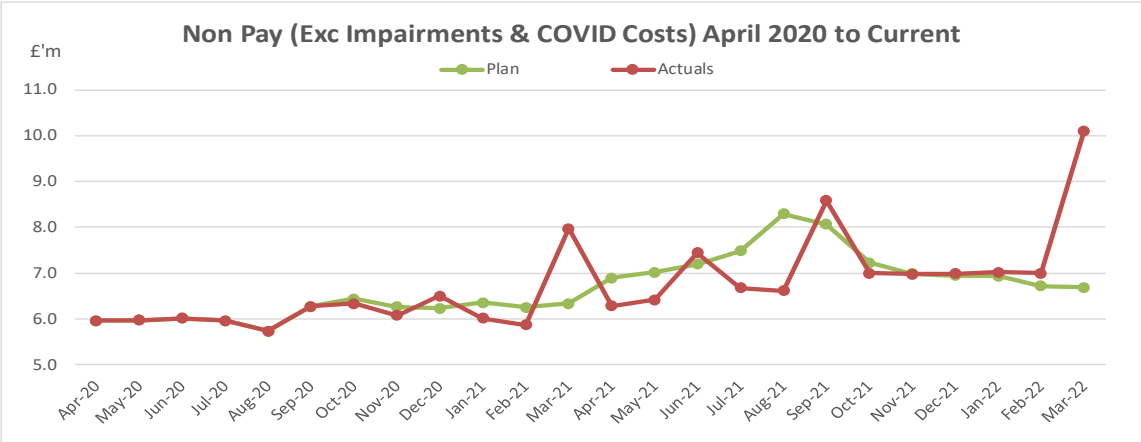
Key Messages

The graph above reflects the Trust's planned and actual income excluding COVID, top up and Elective Recovery Funding for the year to date.

£0.7m of SR and SDF funding, which had been returned to Frimley CCG has now been transferred back to the Trust and deferred.

Deferred income has been released to match increased expenditure in month as appropriate.

Income of £9m to cover the centrally funded element of the employers pension contribution has been excluded to aid comparisons with prior months.



Non Pay

YTD	£'m
2021/22	87.1
2020/21	74.7
▲	17%
Prior Yr	**£'m**
Mar-22	10.1
Mar-21	8.0
▲	27%

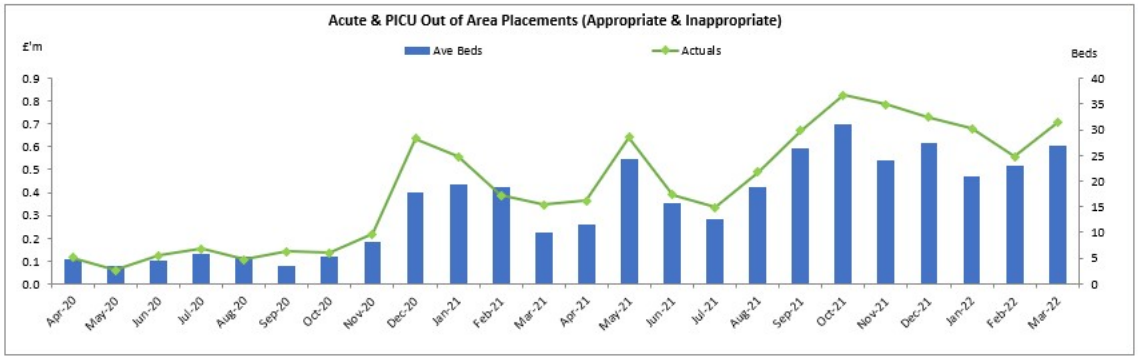
Key Messages

Non Pay spend was £10.1m in month, which was above plan. The main non-pay pressure continues to be the expenditure on Out of Area Placements. The average number of placements has increased from 23 in February to 27 in March and the monthly cost has increased from £0.56m in February to £0.71m in March. Further analysis and narrative can be found on the next page.

In month there was non-recurrent expenditure on a number of areas including IT hardware, medical equipment, the temporary staffing project (recharge from Frimley ICS) and on some of the independent/third sector providers supporting us. We also incurred costs as a result of a temporary increase to the business mileage rate, which was back-dated.

COVID related costs were under £0.1m in month, and slightly lower than in the previous month.

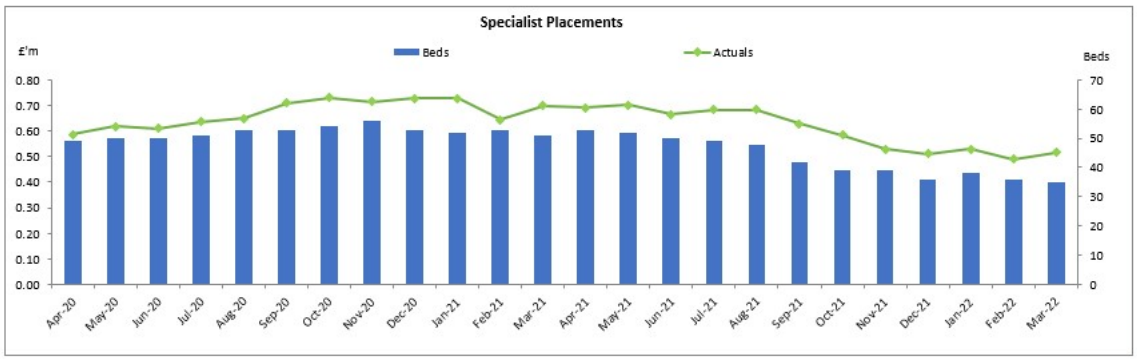
Non Pay Expenditure: Placement Costs



OAPs

YTD	£'m
2021/22	7.2
2020/21	3.0
▲	*141%*

Prior Yr	£'m
Mar-22	0.7
Mar-21	0.3
▲	*105%*



Specialist Placements

YTD	£'m
2021/22	7.2
2020/21	8.1
▼	*-10%*

Prior Yr	£'m
Mar-22	0.5
Mar-21	0.7
▼	*-26%*

Key Messages

Specialist Placements. The number of placements has decreased from 36 in February to 35 in March with costs increasing from £0.49m in January to £0.52m in March. This is generally in line with improved review processes and step down of patients to less restrictive options.

Out of Area Placements. The average number of placements has increased from 23 in February to 27 in March and the monthly cost has increased from £0.56m in February to £0.71m in March.

The Bed Optimisation Programme has now been reset and the project group meets monthly with a status exchange every month, this therefore equates to a fortnightly discussion on the prevailing issues. Each of the workstreams has project support and clinical leadership and a QI approach is being applied to the work. The number of extra-contractual beds has been amended based on what has worked over the prior 6 months. We now contract for 11 Acute beds only and have a plan to taper the usage of these as the financial year progresses, to effectively achieve the zero OAPs trajectory. The position remains tight as we continue to see Covid outbreaks and resulting bed closures.

The Community Enhance Rehabilitation Service business case has now been approved and this will support the work on the psychosis pathway, providing an alternative to bed based provision and both a step up/step down offer.

PICU work is concentrating on flow through the service to ensure that we can effectively step people down in a more timely manner. We have ceased the purchase of ECA PICU beds because they were not a cost effective use of resource as they could not always be accessed when required. We will continue to SPOT purchase PICU beds where they are clinically required.

2.0 Balance Sheet and Cash

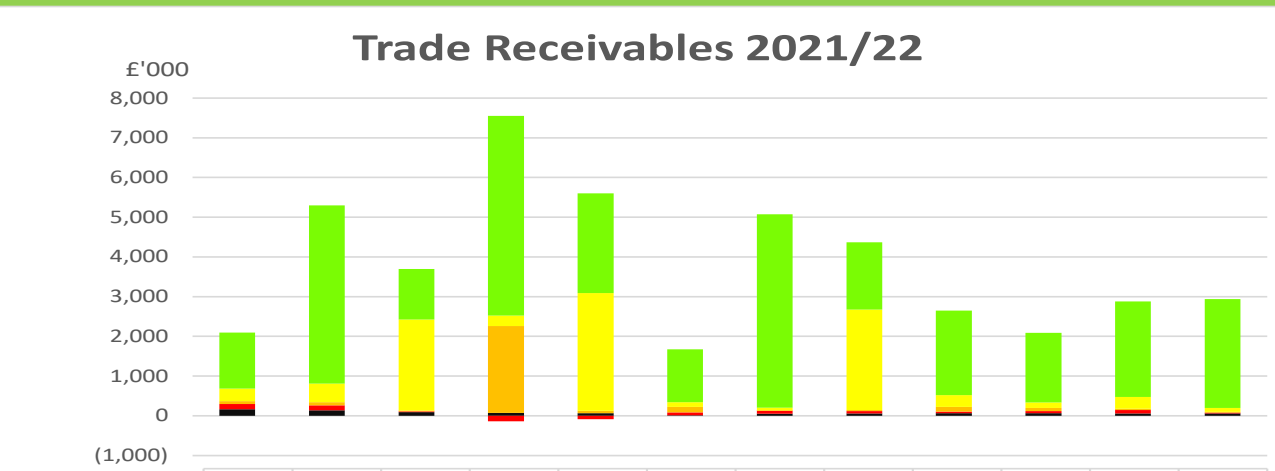
Balance Sheet	20/21 Actual £'m	Current Month Act £'m	Current Month Plan £'m	Current Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m
Intangibles	5.4	4.2	3.4	0.8	4.2	3.4	0.8
Property, Plant & Equipment (non PFI)	38.4	35.2	38.0	(2.8)	35.2	38.0	(2.8)
Property, Plant & Equipment (PFI)	55.5	58.0	55.2	2.8	58.0	55.2	2.8
Receivables	0.0	0.2	0.0	0.2	0.2	0.0	0.2
Total Non Current Assets	**99.3**	**97.6**	**96.6**	**1.0**	**97.6**	**96.6**	**1.0**
Trade Receivables & Accruals	9.4	8.8	14.8	(6.1)	8.8	14.8	(6.1)
Other Receivables	0.2	0.2	0.2	0.0	0.2	0.2	0.0
Cash	39.1	53.9	45.4	8.5	53.9	45.4	8.5
Trade Payables & Accruals	(30.1)	(35.2)	(33.5)	(1.7)	(35.2)	(33.5)	(1.7)
Current PFI Finance Lease	(1.6)	(1.7)	(1.7)	(0.0)	(1.7)	(1.7)	(0.0)
Other Current Payables	(6.2)	(12.8)	(11.8)	(0.9)	(12.8)	(11.8)	(0.9)
Total Net Current Assets / (Liabilities)	**10.9**	**13.2**	**13.4**	**(0.2)**	**13.2**	**13.4**	**(0.2)**
Non Current PFI Finance Lease	(25.5)	(23.8)	(23.8)	(0.0)	(23.8)	(23.8)	(0.0)
Other Non Current Payables	(2.5)	(1.6)	(3.5)	1.9	(1.6)	(3.5)	1.9
Total Net Assets	***82.0***	***85.4***	***82.7***	***2.7***	***85.4***	***82.7***	***2.7***
Income & Expenditure Reserve	30.0	32.5	30.6	1.9	32.5	30.6	1.9
Public Dividend Capital Reserve	20.0	20.7	20.1	0.6	20.7	20.1	0.6
Revaluation Reserve	32.0	32.2	32.0	0.2	32.2	32.0	0.2
Total Taxpayers Equity	***82.0***	***85.4***	***82.7***	***2.7***	***85.4***	***82.7***	***2.7***

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)	5.8	0.0	0.4	(0.4)	5.4	5.6	(0.2)
Depreciation and Impairments	9.4	1.4	0.7	0.7	9.1	8.2	0.9
Operating Cashflow	***15.2***	***1.4***	***1.1***	***0.3***	***14.5***	***13.8***	***0.7***
Net Working Capital Movements	***11.0***	***0.9***	***(1.4)***	***2.3***	***11.6***	***5.2***	***6.5***
Proceeds from Disposals	0.0	0.0	0.0	0.0	2.2	0.0	2.2
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)	(1.9)	(0.6)	(1.3)	(8.1)	(6.4)	(1.7)
Investments	***(7.9)***	***(1.9)***	***(0.6)***	***(1.3)***	***(5.9)***	***(6.4)***	***0.5***
PFI Finance Lease Repayment	(1.5)	(0.1)	(0.1)	0.0	(1.6)	(1.6)	(0.0)
Net Interest	(4.0)	(0.3)	(0.3)	(0.0)	(3.9)	(3.9)	(0.0)
PDC Received	0.8	0.2	0.0	0.2	0.7	0.1	0.6
PDC Dividends Paid	(1.0)	(0.5)	(0.7)	0.2	(0.8)	(0.9)	0.2
Financing Costs	***(5.7)***	***(0.8)***	***(1.2)***	***0.4***	***(5.5)***	***(6.3)***	***0.8***
Other Movements	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Net Cash In/(Out)Flow	***12.7***	***(0.4)***	***(2.0)***	***1.6***	***14.7***	***6.3***	***8.4***
Opening Cash	26.4	54.2	47.2	7.0	39.1	39.1	0.0
Closing Cash	***39.1***	***53.9***	***45.4***	***8.5***	***53.9***	***45.4***	***8.5***

Key Messages

The Trust's closing cash balance for March 2022 is £53.9m, which is £8.5m above revised plan and £0.3m lower than at the end of the previous month. Contributing to the cash position is a net inflow of cash related to income received in advance of anticipated activity, a net increase in working capital balances and the capital receipt from the disposal of 3/5 Craven Road in Reading. The first half surplus of £1m and slippage against capital expenditure of £1.3m are both adding to the current cash surplus.

Cash Management

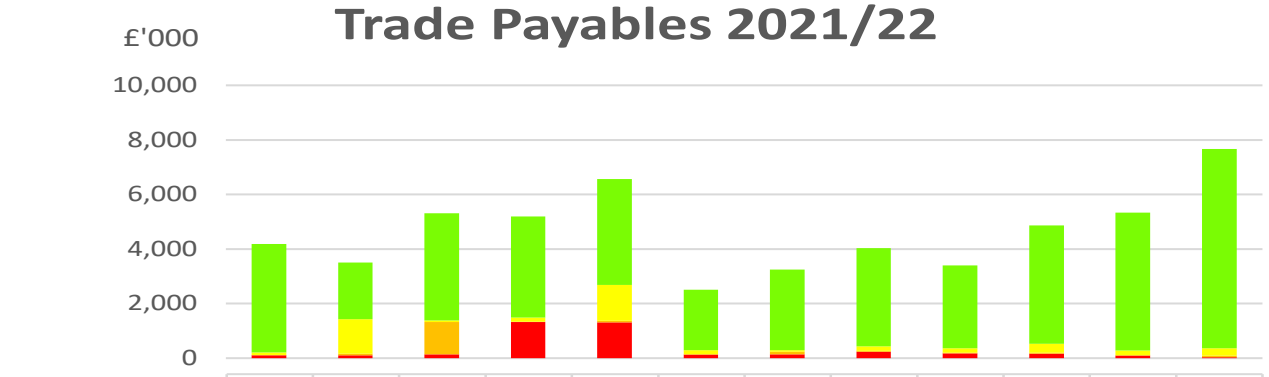


	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
<30 Days	1,413	4,488	1,270	5,029	2,507	1,329	4,868	1,690	2,127	1,750	2,402	2,741
>30 <60 Days	316	472	2,289	262	2,966	121	72	2,530	297	143	301	95
>60 <90 Days	73	77	22	2,193	62	139	6	28	118	79	30	22
>90 < 180 Days	131	124	22	(139)	(84)	70	73	60	38	49	83	18
>180 Days	163	139	90	69	64	13	55	59	66	66	62	61

Key Messages

Overall debtor balances increase by £0.1m mainly due to a increase in current balances. Some balances over 60 days have been cleared since last month and the overall balance has reduced by £0.1m with the largest remaining balances for over 60 days with Slough Borough Council being cleared (£0.08m).

The Trust has made a provision for the risk of impaired receivables of £0.07m in the year end accounts primarily in respect of balances held with individuals for salary overpayment and lease car liabilities.



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
<30 Days	3,976	2,070	3,920	3,697	3,890	2,223	2,948	3,592	3,044	4,346	5,049	7,299
>30 <60 Days	88	1,266	63	152	1,311	143	59	173	156	323	165	271
>60 <90 Days	12	54	1,187	21	60	23	96	31	29	39	23	62
>90 days	109	111	136	1,322	1,309	126	140	235	175	161	99	36

Key Messages

Overall Creditors increased by £2.3m, mainly due to an increase in current (0-30 day) balances. The increase in current balances is primarily down to capital expenditure invoices being received on completed projects in March 2022 and receipt of other invoices in anticipation of year end.

3.0 Capital Expenditure

Schemes	Current Month			Year to Date			FY
	Actual £'000	Plan £'000	Variance £'000	Actual £'000	Plan £'000	Variance £'000	Plan £'000
Estates Maintenance & Replacement Expenditure							
Erlegh Road (LD etc works)	156	17	139	160	135	25	135
Other Trust Owned Properties	65	0	65	121	0	121	0
Leased Non Commercial (NHSPS)	(2)	53	(55)	223	370	(147)	370
Head Office Relocation	0	120	(120)	0	800	(800)	800
Leased Commercial - Erlegh House Atrium	291	20	271	466	135	331	135
Wokingham Willow House Projects	(10)	0	(10)	763	950	(187)	950
Environment & Sustainability	59	5	54	80	49	31	49
Various All Sites	114	17	97	240	130	110	130
Statutory Compliance	112	27	85	206	240	(34)	240
Subtotal Estates Maintenance & Replacement	**784**	**259**	**525**	**2,259**	**2,809**	**(550)**	**2,809**
IM&T Expenditure							
IM&T Business Intelligence and Reporting	0	0	0	(0)	0	(0)	0
IM&T Refresh & Replacement	949	51	898	2,736	2,102	634	2,102
IM&T System & Network Developments	30	60	(30)	310	466	(156)	466
IM&T GDE & Community Projects	(86)	47	(133)	273	465	(192)	465
IM&T Intelligent Automation Software Services	29	0	29	29	0	29	0
IM&T Video Consultations/Teams Rooms	5	0	5	5	0	5	0
IM&T Share Care Records	128	0	128	128	0	128	0
Subtotal IM&T Expenditure	**1,055**	**158**	**898**	**3,482**	**3,033**	**449**	**3,033**
Subtotal CapEx Within Control Total	**1,839**	**417**	**1,422**	**5,741**	**5,842**	**(101)**	**5,842**
CapEx Expenditure Outside of Control Total							
PPH - LD to Jasmine	(54)	0	(54)	89	131	(42)	131
PPH Fire Doors	(0)	0	(0)	117	116	1	116
PPH Place of Safety	0	25	(25)	0	200	(200)	200
PPH Zonal Heating Controls	0	61	(61)	0	350	(350)	350
PPH Ward Bedroom Door Mechanisms (Swipe Access)	185	37	148	352	320	32	320
Service change/redesign (not included in ICH)	0	45	(45)	0	200	(200)	200
Other PFI projects	11	97	(86)	155	631	(476)	631
PPH Elimination of Dormitories - PDC Funded	44	21	23	62	120	(58)	120
Donated Assets	0	0	0	14	0	14	0
IM&T Projects - PDC	203	0	203	656	0	656	0
Subtotal Capex Outside of Control Totals	**388**	**286**	**102**	**1,446**	**2,068**	**(622)**	**2,068**
Total Capital Expenditure	**2,227**	**703**	**1,524**	**7,187**	**7,910**	**(723)**	**7,910**

Key Messages

The Trust has a capital control total of £5.8m, in addition to the £2.1m of spend outside of system control total, with the overall plan being £7.9m. Year end outturn is £0.7m behind plan, of which £0.1m relates to the control total. The majority of the underspend is against PFI schemes which are treated outside of CDEL with the underspend being offset by PDC funded IM&T projects which were not in the plan.

Estates, Maintenance and Replacement is £0.6m behind plan relating to the profiling of expenditure on the Willow House and Head Office Relocation schemes. There is a delay in the Head Office Relocation project, which means that the planned £0.8m spend will slip into next year and some of the in-year underspend is being utilised by other projects approved in year including Erlegh House Atrium works (£0.5m), and Gosbrook Road and Kings Road upgrades (£0.1m).

IM&T is overspent by £0.5m as a result of bringing forward projects from 2022/23 in order to utilise the underspend in Estates projects and maximise the expenditure against CDEL for 2021/22. Key schemes brought forward are Desktop, and Mobile Refresh (£0.5m).

Prospect Park Hospital schemes are underspent by £1.2m year to date. The underspend against PFI schemes is in part due to Zonal Heating Controls (£0.3m) with a number of other projects being in the feasibility phase.

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper - Public

Board Meeting Date	10th May 2022
Title	**True North Performance Scorecard** **Month 12 (March 2022) 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 12 2021/22 (March 2022) 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 12** **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 33 against a revised target of 26 from February 2022. Red for 10 months against a stretch target. Orchid (7), Rowan (5), and Windsor ward (5) were the highest contributors. Existing countermeasures are in place, but additional activities are being implemented: ○ Celebrate success – Donnington ward have sustained lower numbers. Oakwood and Rowan have reached their target and are below their median. ○ 70% of falls were unwitnessed. ○ 67% of falls happened on wards with occupancy over 80%. ○ Severity of harm – 0 falls resulted in moderate or severe harm in the month. ○ All new staff are QMIS trained with a view to improve huddle attendance. 2 QI projects underway in wards. ○ Multi-disciplinary approach to incident investigation.

	○ The teams are reviewing the falls technology with a potential change of contract for one of the less effective products later in the year. • Self-harm incidents on mental health wards (excluding LD) **(Harm Free Care)** – 95 incidents against a target of 42. Bluebell (56) and Snowdrop wards (18) were the highest contributors this month. There was a continued reduction in ligatures. Countermeasures remain in place; including daily safety huddles to identify risks of self-harm and identify specific patient countermeasures, training for staff in dialectical behavior therapy (DBT) and crisis intervention skills, treating personality disorder patients, and a weekly review of individual patient safety plans. • Patient Friends and Family Test (FFT) recommend rate: **(Patient Experience)** - at 79% against a 95% target. The new system is being embedded, so will take some time to see improvements on this measure, which will be revised in 2022/23. • Patient Friends and Family Test (FFT) response rate: **(Patient Experience)** - at 4% against a 15% target. The new system is being embedded, so will take some time to see improvements on this measure, which will be revised in 2022/23. • Mental Health Clustering **(Patient Experience)** - at 78% against an 80% target. Services are operating in a challenging environment which is impacting their ability to achieve the target. Action plans are in place to improve this metric. This driver is due to become a tracker in 2022/23. • Physical Assaults on Staff **(Supporting our Staff)** – at 60 incidents against a target of 44. Campion (10), Snowdrop (10), Sorrel (9) and Rose wards (8) were the highest contributors this month. 40 of these incidents were on mental health wards and A Place of Safety (APOS). Snowdrop was the highest mental health contributor. Countermeasures include use of safety huddles (morning and afternoons) to review risks (also to highlight racial abuse and assaults) and establish plans, and staff presence at times when assaults are highest. • Fire Evacuation training for Inpatient staff **(Supporting our Staff)** – a recent review of the fire metric has split inpatient staff training from other staff. Currently at 93.2% against a 95% target. • 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. An improvement project is underway.

	• Staff turnover (including fixed-term posts **(Money Matters)** – 16.8% against a 16% target. A challenging area which remains a focus for the organisation. • Inappropriate Out of Area Placements **(Money Matters)** – at 434 days against a quarter 4 target of 90 days. Pressures continue but there is an improvement project underway. Pre-commissioned beds are mitigating some of the pressures. A revised trajectory has been submitted for 2022/23. **Tracker 1 Metrics (where red for 1 month or more)** • C.Diff due to lapse in care (Cumulative year to date) **(Regulatory Compliance)** – at 3 for the year to date; no reported incidents since January 2022. The way this is reported has changed, so showing as red due to a target of 0 for the year. • Meticillin-resistant Staphylococcus Aureus (MSSA) bacteraemias (Cumulative year to date) **(Regulatory Compliance)** - at 1 incident year to date; no reported incidents since July 2021. The way this is reported has changed, so showing as red due to a target of 0 for the year. • Sickness rate **(Regulatory Compliance)** – red at 4.59% against a target of 3.5%. This is not a "hard" compliance focus with NHSI but is tracked. Six months red, but we are in the seasonally higher period. • Children and Young People (CYP) referred for an assessment or treatment of an Eating Disorder (ED) will access NICE treatment <1 week (Urgent) **(Regulatory Compliance)** – red at 75% against a 95% target. This is a newly introduced national target that is challenging to achieve for trusts as evidenced by regional and national benchmarking. • Children and Young People (CYP) referred for an assessment or treatment of an Eating Disorder (ED) will access NICE treatment <4 weeks (Routine) **(Regulatory Compliance)** – red at 87.5% against a 95% target. This is a newly introduced national target that is challenging to achieve for trusts as evidenced by regional and national benchmarking. **Tracker Metrics (where red for 4 months or more)** • None to note
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	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Falls incidents in Community & Older Adult Mental Health Inpatient Wards	26 per month increased from 20 in Feb 22	37	17	23	27	33	36	33	21	27	37	34	33
Self-Harm Incidents on Mental Health Inpatient Wards (excluding LD)	42 per month	76	42	128	124	56	51	132	130	82	165	81	95
Pressure ulcers acquired at BHFT due to lapse in care - Grade 3 & 4 (Cumulative YTD)	<18 per year	0	0	0	0	0	1	0	0	0	0	0	0
Number of suicides (per month)	Equal to or less than 3 per month	2	0	3	0	2	2	0	4	1	1	2	2
Physical Health Checks 7 Parameters for people with severe mental illness (SMI)	50% by 30th September 2021, then 60%		19%	31%	43%	52%	68%	67%	71%	74%	78%	81%	80%
Gram Negative Bacteraemia	1 per ward per year	0	0	0	0	0	0	0	0	0	0	0	0

Patient Experience

Patient FFT Recommend Rate: %	95% compliance	90%	92%	79%	89%	85%	89%	92%	90%	92%	92%	79%	
Patient FTT response rate: %	15% compliance	5%	5%	6%	6%	6%	6%	5%	7%	1%	0%	4%	
Mental Health Clustering within target: %	80% compliance	73.9%	73.5%	71.5%	77.2%	80.4%	78.7%	79.4%	79.5%	78.7%	77.2%	77%	78%

Performance Scorecard - True North Drivers (Mar 2022)

Supporting our Staff

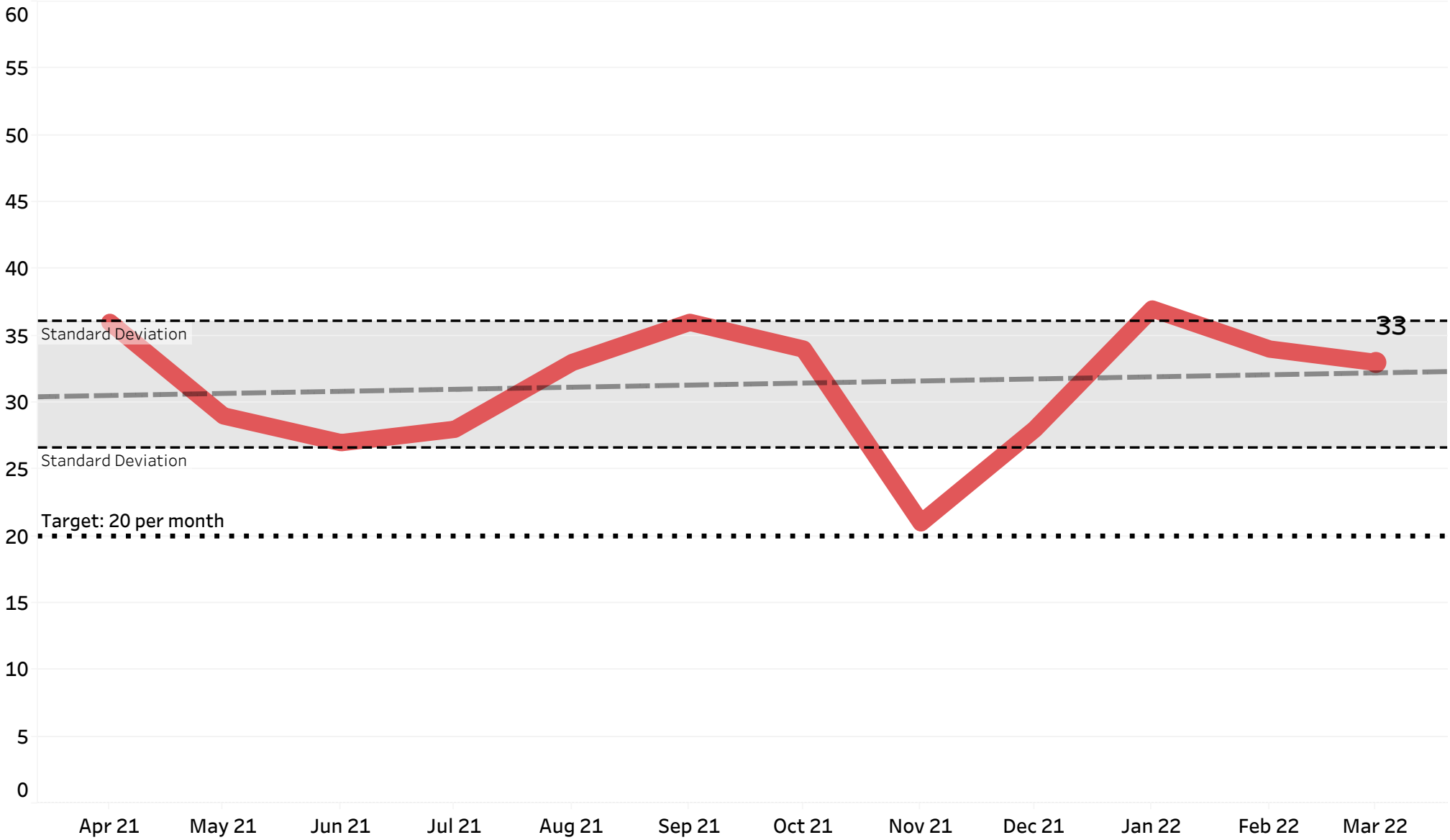
Metric	Target	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Physical Assaults on Staff	44 per month	54	42	50	66	75	80	85	60	33	51	67	60
Staff Engagement Score (Annual Staff Survey) [Suspended centrally in April due t..	Score of 10	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.40
WRES and WDES outcome improvement	TBC												
Fire Evacuation training for inpatient staff	95% compliance						87.9%	89.9%	92%	92.5%	91.9%	91.1%	93.2%

Money Matters

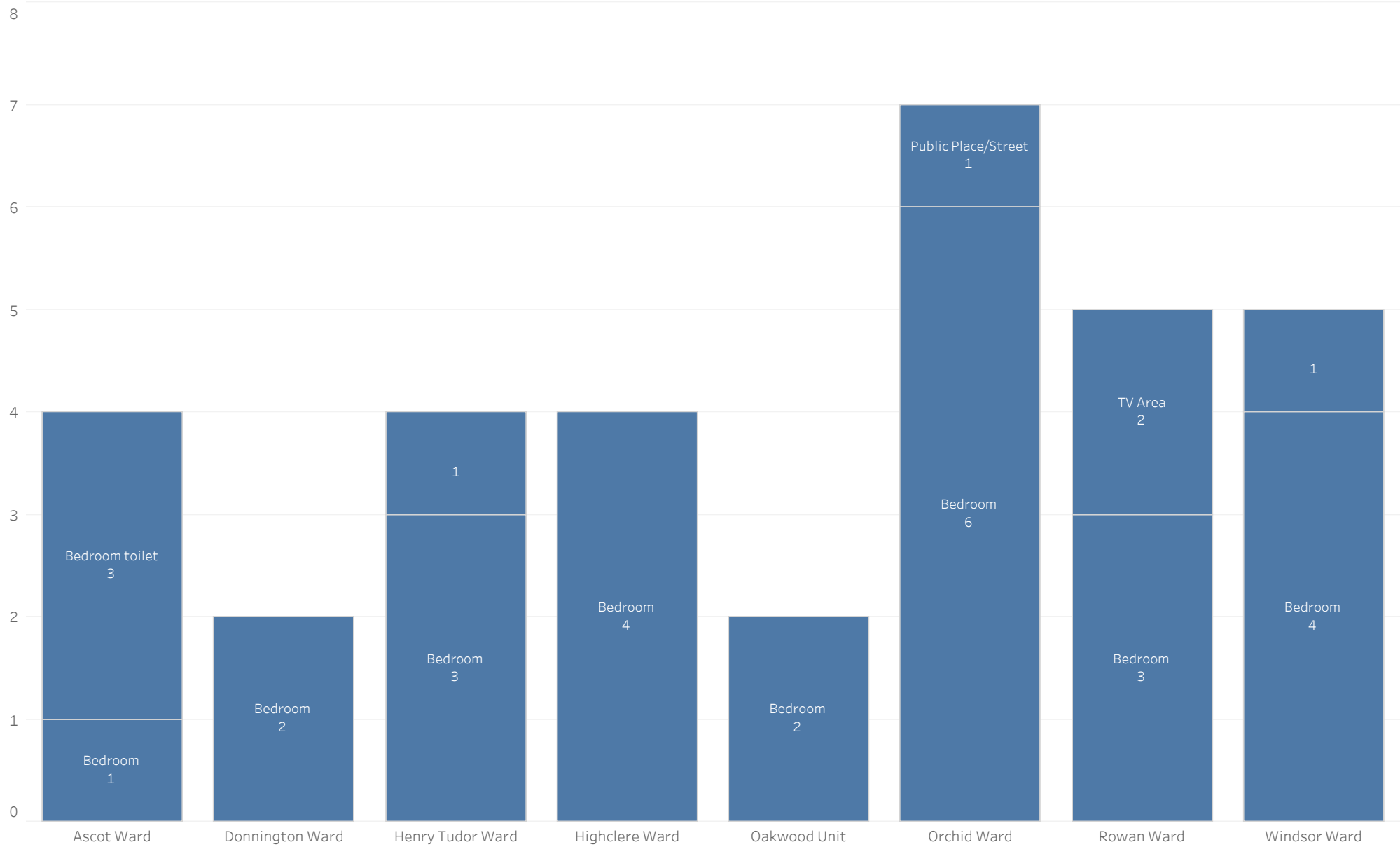
CIP target (£k): (Cumulative YTD)													
Financial surplus £k (excl. STF): (Cumulative YTD to plan) [Suspended centrally due to COVID]													
Mental Health: Acute Occupancy rate (exc. Home Leave HL)	85% Occupancy	97.4%	97.5%	96.0%	96.0%	90.6%	93.1%	91.2%	92.2%	87.2%	91.1%	86%	93.3%
Control total target (£k): (Cumulative YTD)	TBC												
Mental Health: Acute Average Length of Stay (bed days)	30 days	47	50	50	49	50	52	53	58	58	37	45	49
Staff turnover (excluding fixed term posts)	<16% per month	12.5%	12.5%	13.1%	13.8%	14.2%	14.6%	15.4%	15.4%	15.3%	15.3%	15.3%	15.9%
Staff turnover (including fixed-term posts)	<16% per month	14.7%	14.6%	15.3%	15.8%	15.1%	15.6%	16.4%	16.5%	16.3%	16.3%	16.4%	16.8%
Inappropriate Out of Area Placements	90 Cumulative Total Q4	160	587	856	168	418	636	195	266	405	92	191	434

Harm Free Care Driver: Fall incidents in Community & Older Adult Mental Health Inpatient Wards (Apr 21 to Mar 22)

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

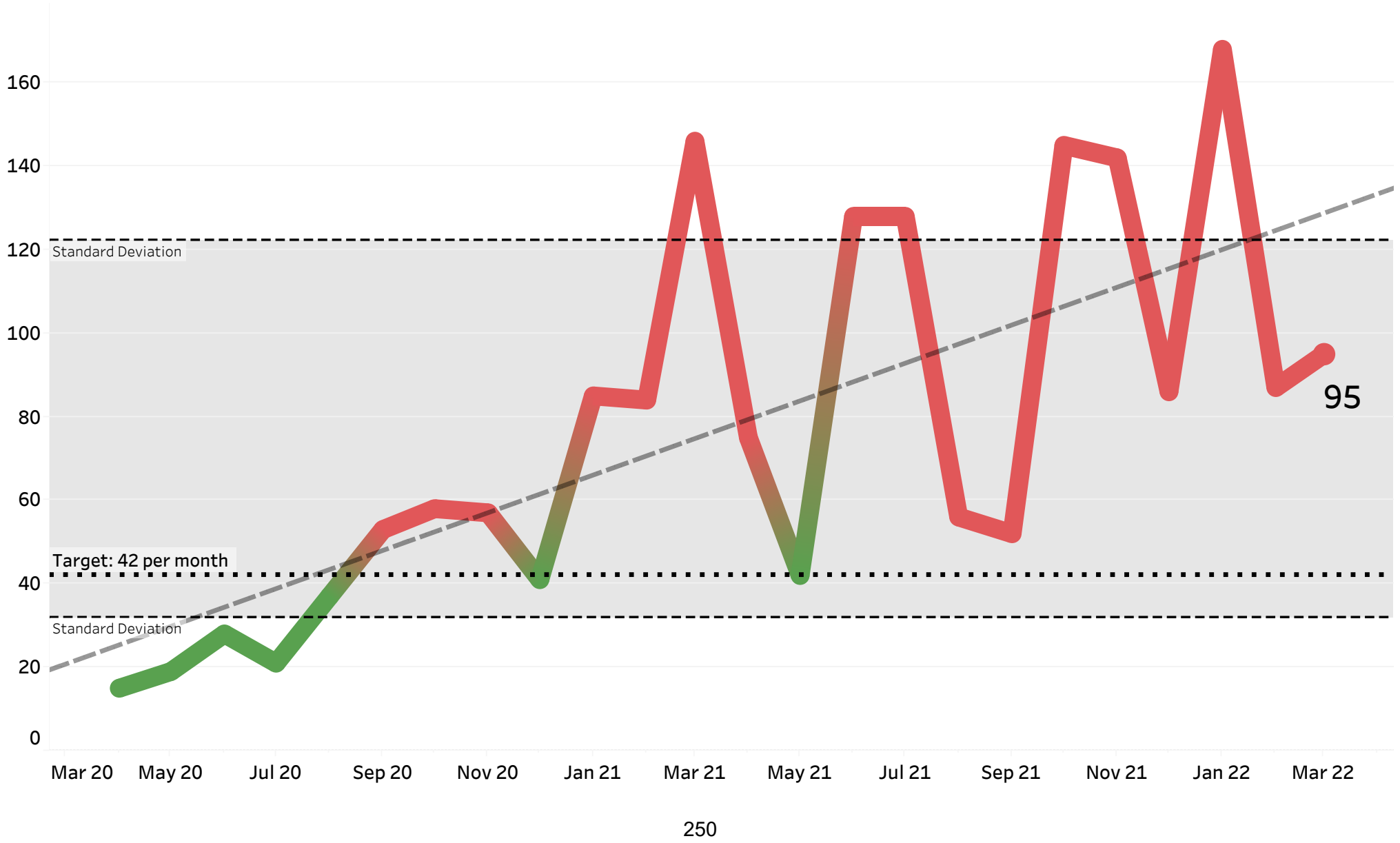


Harm Free Care Driver: Fall incidents in Community and Older Adult Mental Health Inpatient Wards (Mar 2022)

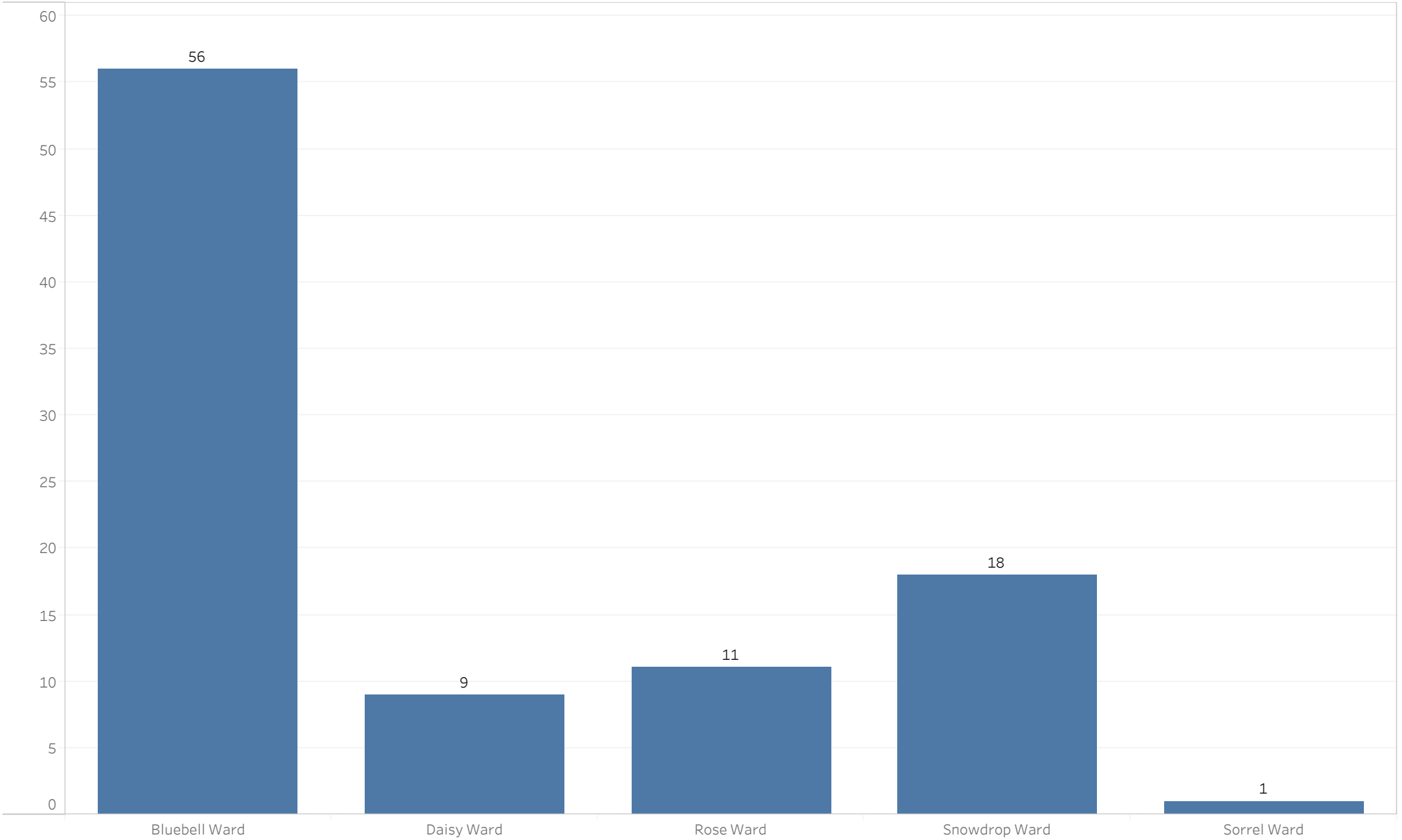


Harm Free Care Driver: Self-Harm incidents on Mental Health Inpatient Wards (excluding LD) (Apr 20 to Mar 22)

Any incident (all approval statuses) where category = self harm

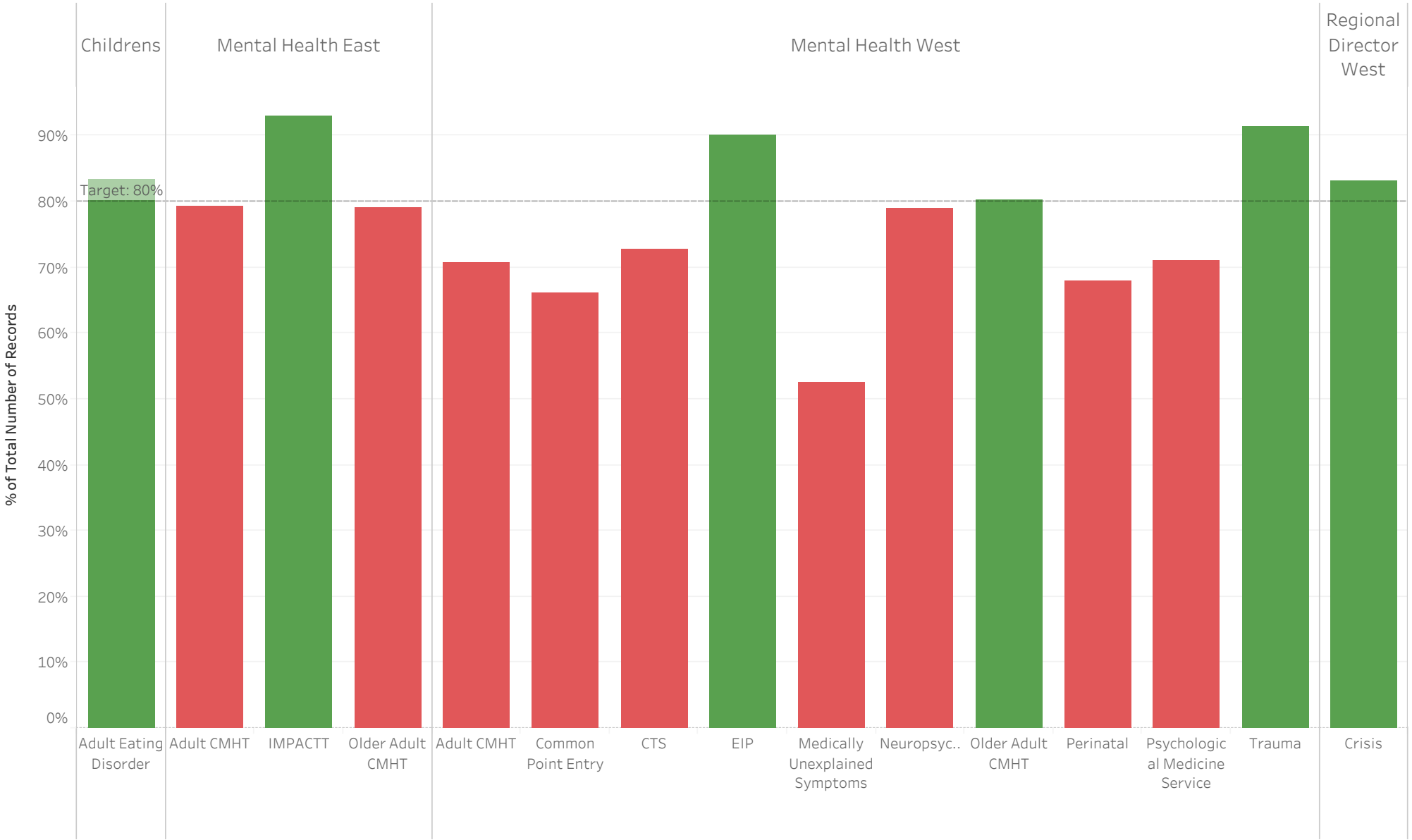


Harm Free Care Driver: Self-Harm incidents on Mental Health Inpatient Wards (excluding LD) by location (Mar 2022)



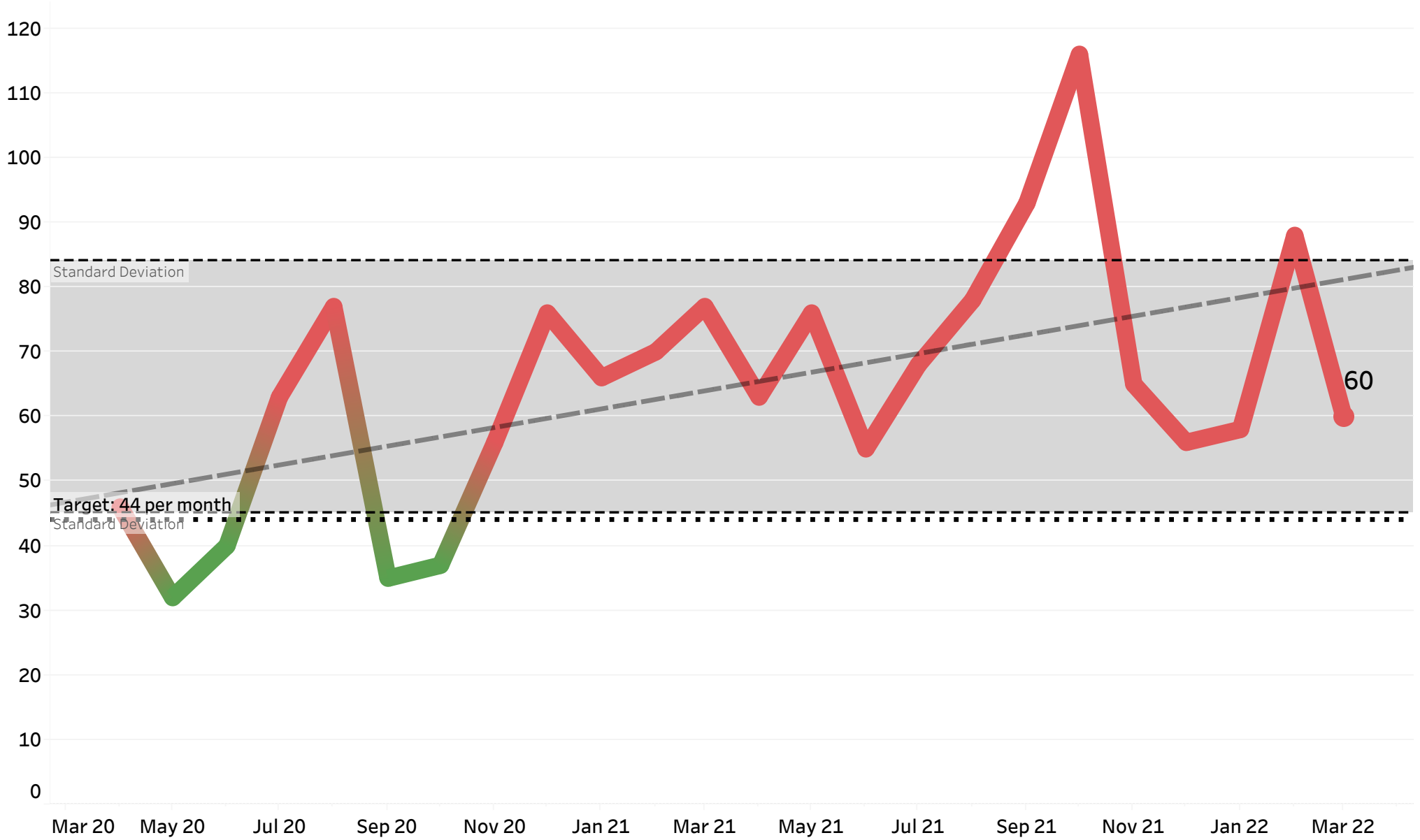
Patient Experience: Clustering breakdown (Mar 2022)

Outpatient Cluster Status (by Service)

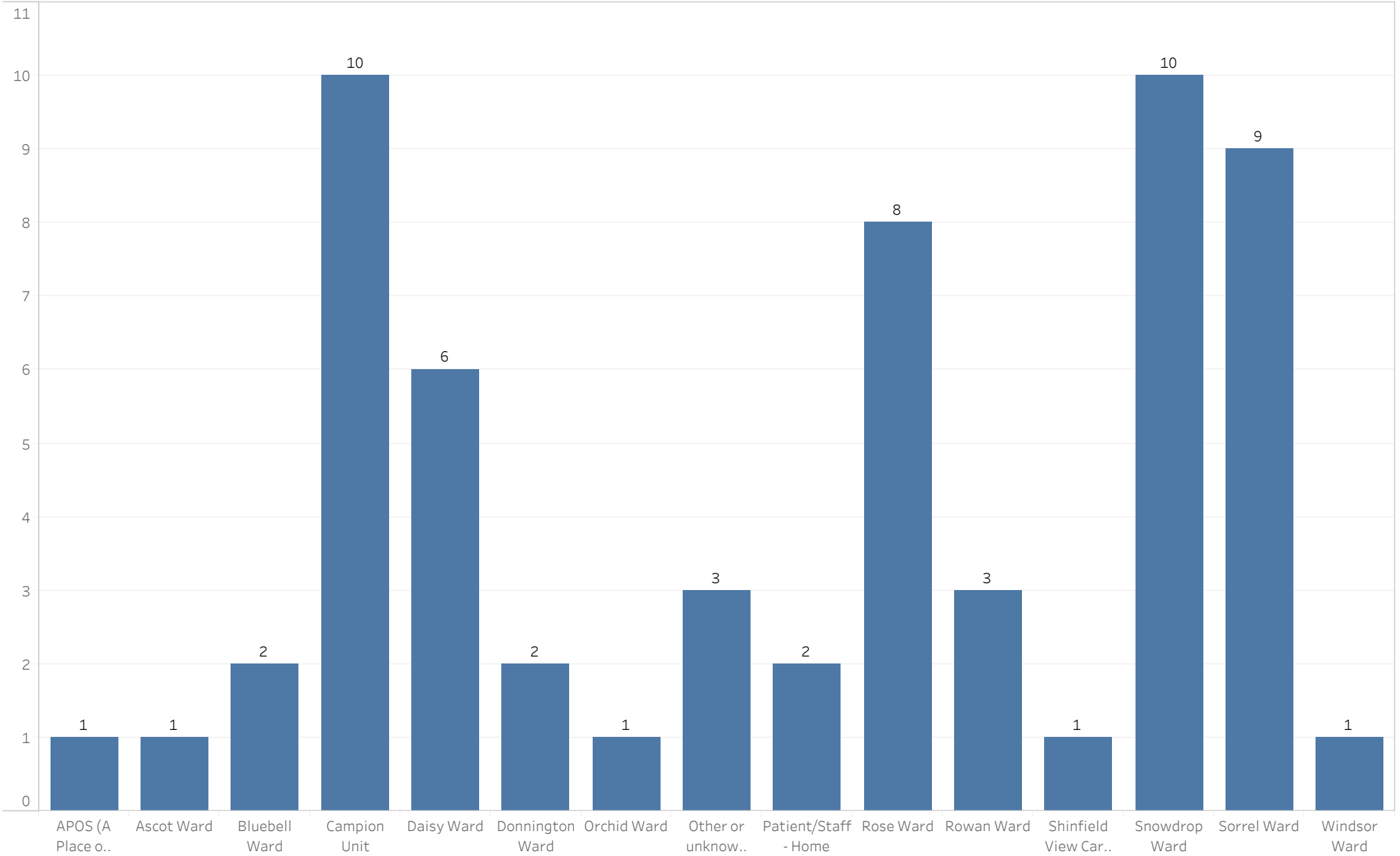


Supporting Our Staff Driver: Physical Assaults on Staff (Apr 20 to Mar 22)

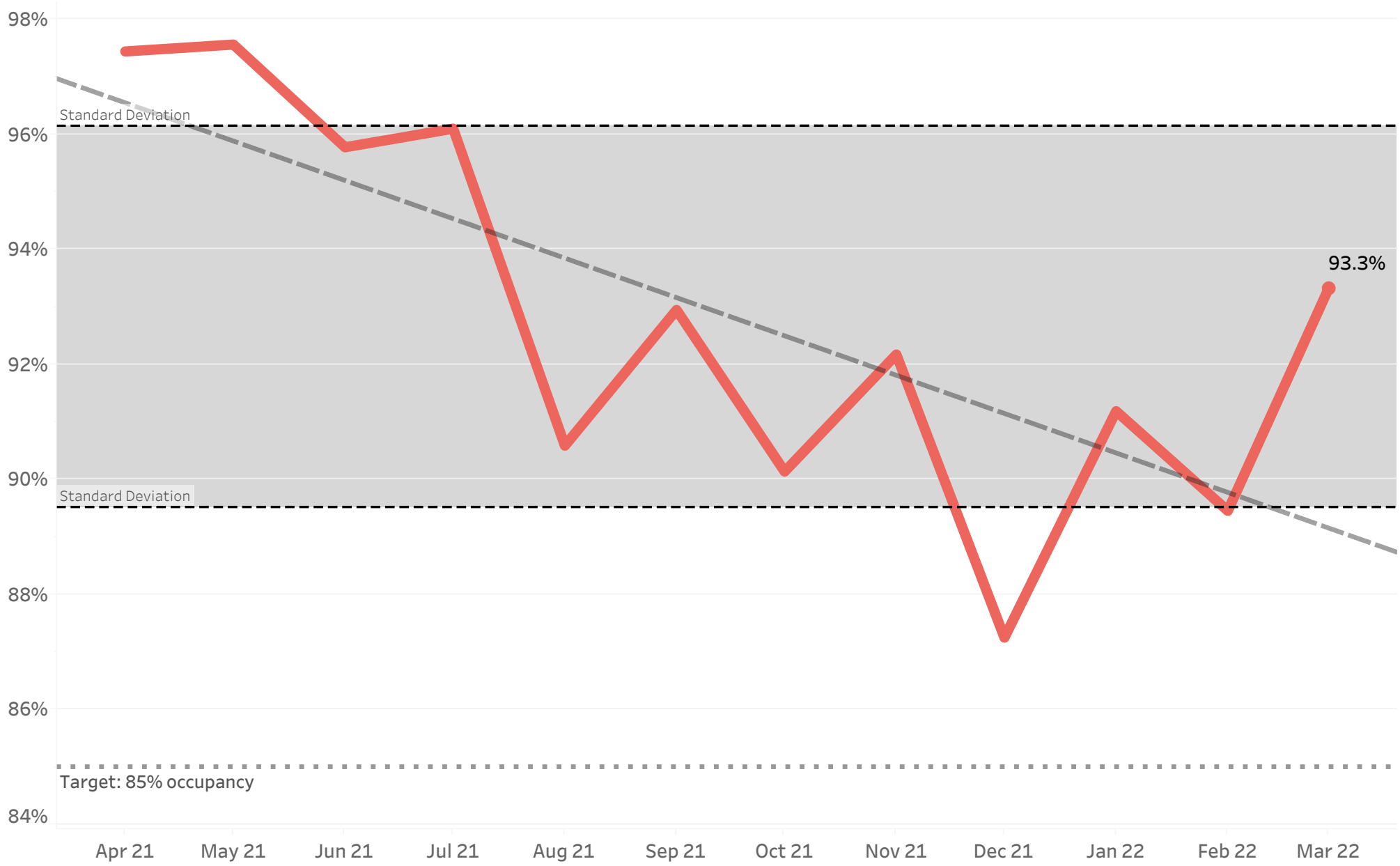
Any incident where sub-category = assault by patient and incident type = staff



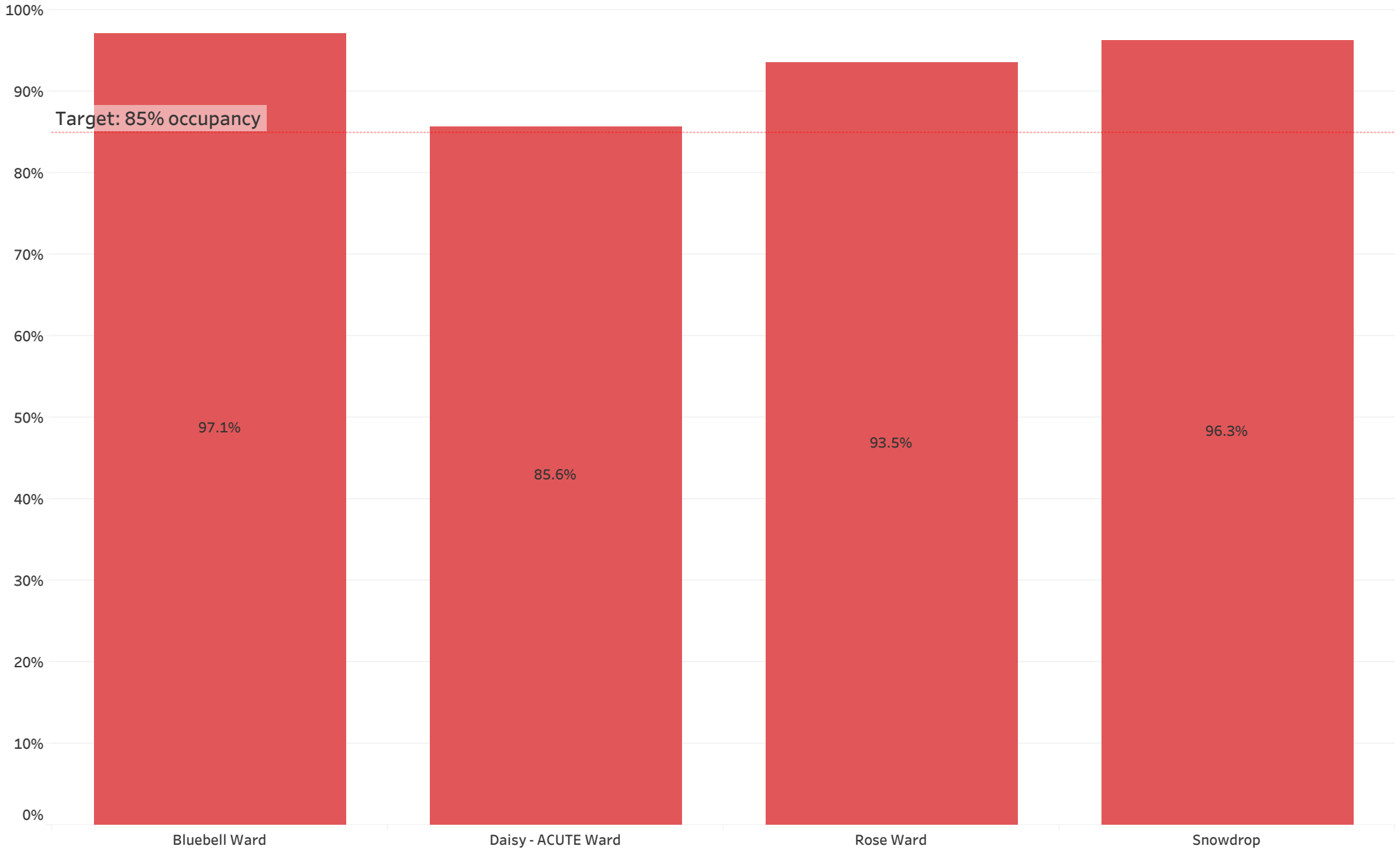
Supporting Our Staff Driver: Physical Assaults on Staff by Location (Mar 2022)



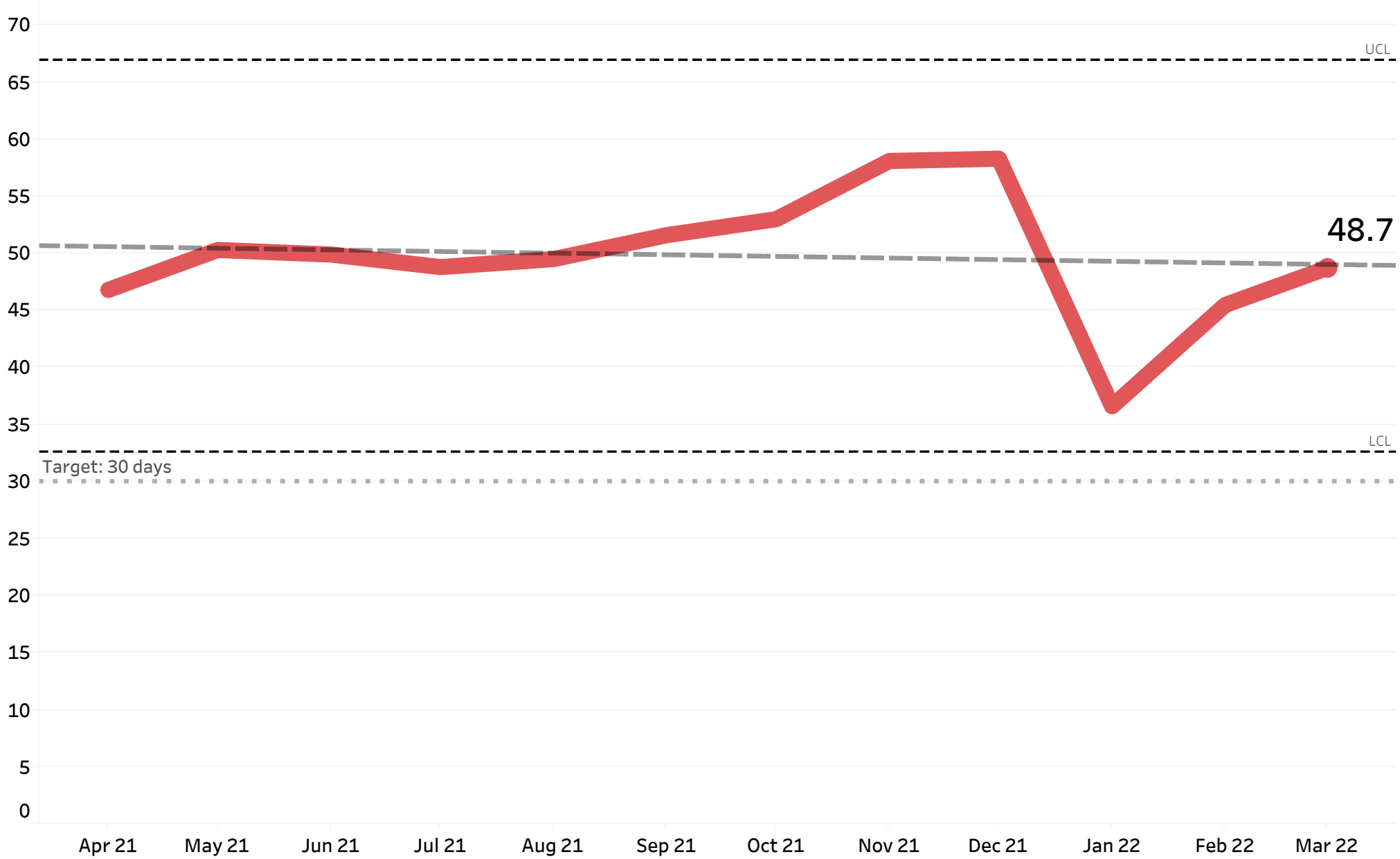
Money Matters: Mental Health Acute Bed Occupancy Rate (Apr 21 to Mar 22)



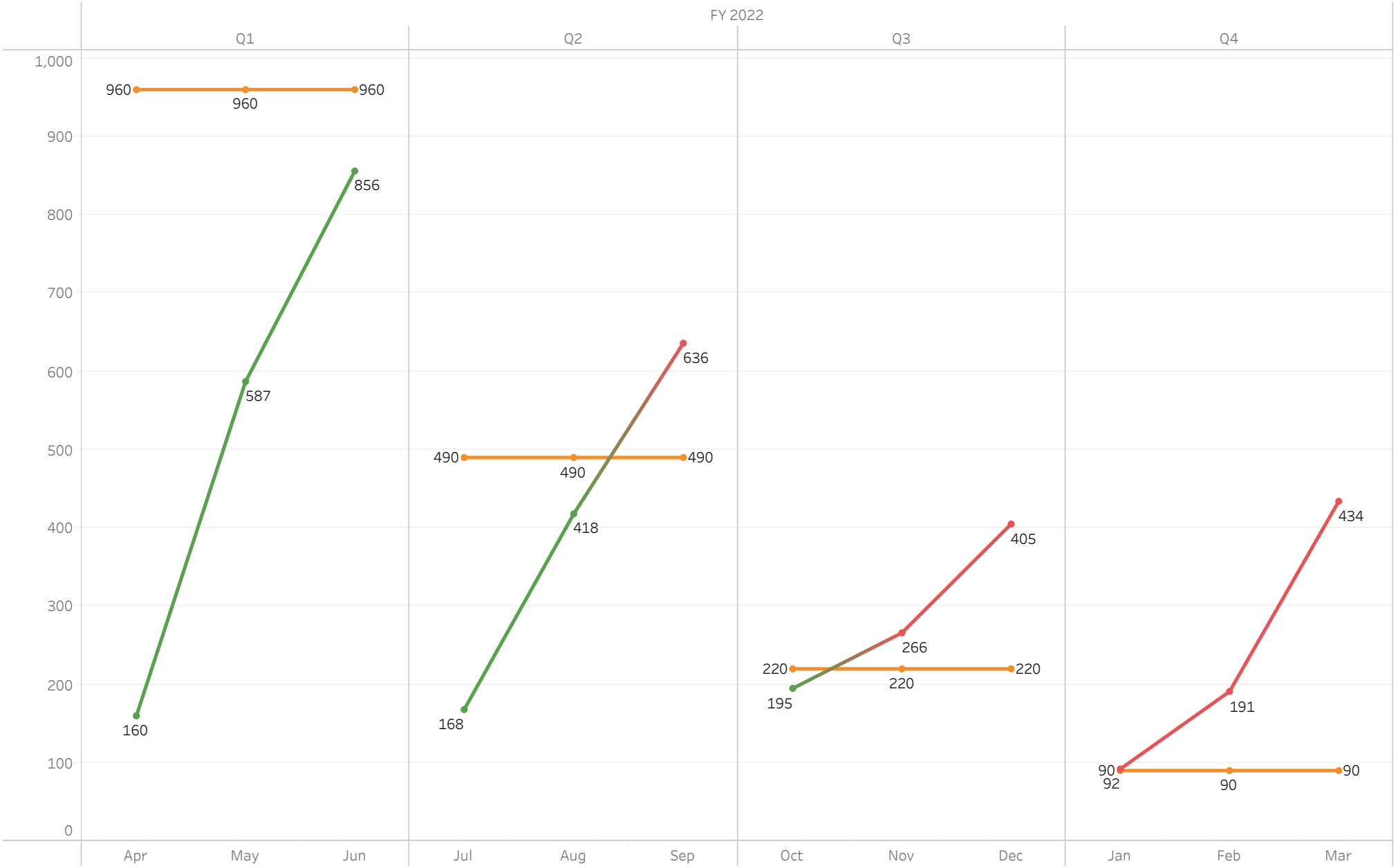
Money Matters Driver: MH Acute Bed Occupancy by Unit (Mar 2022)



Money Matters: Mental Health: Acute Average Length of Stay (bed days) (Mar 2022)



Money Matters Driver: Inappropriate Out of Area Placements



True North Harm Free Care Summary

Tracker Metrics

Metric	Threshold / Target	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Pressure ulcers acquired due to lapse in (Inpatient Wards)	<10 incidents	0	0	0	0	0	0	1	0	0	0	0	0	0
Pressure ulcers acquired due to lapse in (Community East)	< 6 incidents	0	0	0	0	0	0	0	0	0	0	0	0	0
Pressure ulcers acquired due to lapse in (Community West)	< 6 incidents	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health: AWOLs on MHA Section	16 per month	10	5	3	4	8	5	9	7	8	2	4	2	12
Mental Health: Absconsions on MHA section(Excl: Failure to return)	8 per month	4	5	11	13	9	7	17	7	3	5	7	0	4
Mental Health: Readmission Rate within 28 days: %	<8% per month	8	6.60	7.29	8.40	8.30	6.70	5.09	4.29	5.20	5.5	5.55	4.90	6.32
Patient on Patient Assaults (LD)	4 per month	1	0	0	1	1	0	2	0	1	2	1	18	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	13.9%	14.4%	14.2%	13.1%	13.8%	13.6%	14.0%	13.7%	14.0%	13.5%	14.0%	14.3%	15.1%
Suicides per 10,000 population in Mental Health Care (annual)	8.3 per 10,000	4.9	4.9	4.9	4.9	4.9	4.9	4.9	4.9	5.7	5.7	5.7	5.7	5.7
Self-Harm Incidents within the Community [Suspended centrally due to COVID]	31 per month	1	2	2	0	0	0	13	12	0	0	15	19	2
Smoking Status Recorded	55% until Sept 2021			48%	60.1%	65.4%	73.0%	74.5%	69.9%	71.1%	65.2%	81.2%	81.4%	81.4%

True North Patient Experience Summary

Tracker Metrics

		Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Mental Health: Prone (Face Down) Restraint	4 per month	9	4	3	9	5	3	2	4	3	2	3	2	0
Patient on Patient Assaults (MH)	38 per month	8	18	17	15	16	23	21	15	17	14	10	25	7
Health Visiting: New Birth Visits Within 14 days: %	90% compliance	91.2%	88.2%	94.3%	94.1%	96.7%	93.7%	90.6%	91.3%	96.7%	89.1%	77.4%	87.4%	93.0%
Mental Health: Uses of Seclusion	13 in month	4	11	15	13	15	11	15	10	2	0	19	10	11

True North Supporting Our Staff Summary

Tracker Metrics

True North Money Matters Summary

Tracker 1

		Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Mental Health: Delayed Transfers of Care (NHSI target) Monthly and Quarterly [Suspended centrally due to COVID]	7.50%	3.10	3	4	5.09	4.39	1.89	1.40	2.60	1.60	3.40	4.01	8.95

Tracker Metrics

CHS Inpatient Occupancy	80-85% Occupancy	70%	82.0%	83.5%	86%	85%	83%	88.2%	85.5%	81.5%	83.5%	83.4%	74.7%
Mental Health: Non-Acute Occupancy rate (excluding Home Leave): % [Suspended centrally due to COVID]	80% Occupancy	69.89%	74.37%	77.48%	78.36%	86.46%	86.46%	88.89%	92.09%	86.72%	73.56%	80.90%	73.04%
DNA Rate: % [Suspended centrally due to COVID]	5% DNAs	4.29%	4.5%	4.29%	7.5%	4.90%	4.70%	4.79%	4.59%	2.90%	4.79%	4.73%	4.56%
Community: Delayed transfers of care Monthly and Quarterly [Suspended centrally due to COVID]	7.5% Delays	10.6%	7.79%	7.19%	5.60%	9.70%	7.79%	3.59%	5%	4.39%	6.20%	8.64%	11.7%

Regulatory Compliance - Tracker Level 1 Summary

Metric	Threshold / Target	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
C.Diff due to lapse in care (Cumulative YTD)	0	0	0	0	0	0	0	0	2	2	3	3	3
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) infection rate	tbc	1	1	2	0	0	0	0	1	0	0	0	0
Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate per 100,000 bed days	2 in East; 4 in West	0	0	0	1	0	0	0	0	0	0	0	0
Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias (YTD)	0	0	0	0	1	1	1	1	1	1	1	1	1
Count of Never Events in rolling six- month period (Safe Domain)	0	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: %	60% treated	90.9	75	80	50	100	100	60	100	71.3	85.7	66.7	100
A&E: maximum wait of four hours from arrival to admission/transfer /discharge: %	95% seen	98.4	99.3	99.3	98.9	98.8	99.2	99.8	99.5	99.1	99.5	98.8	99.1
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
People with common mental health conditions referred to IAPT will be treated within 6 weeks from referral: %	75% treated	98	98	98	98	98	98	98	97	97	97	98	97
People with common mental health conditions referred to IAPT completing a course of treatment moving to recovery: %	50% treated	54	55.0	54	54	55.9	52	55.0	54	53	52	52	52.5
Proportion of patients referred for diagnostic tests who have been waiting for less than 6 weeks (DM01 - Audiology): % [Suspended centrally due to C..	99% seen	99.3	99.2	99.7	100	99.7	99.1	98.2	99.7	99.7	99.7	100	98.8
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	98.6	100	98.0	100	94.6	96.7	98.9	98	100	100	98.3	98
Sickness Rate: %	<3.5%	3.46	3.43	3.83	4.17	4.47	4.87	4.75	4.92	5.46	5.33	4.59	
CYP referred for an assessment or treatment of an ED will access NICE treatment <1 week (Urgents): %	95% (by 2021)	0%	0%	33.3%	50%	60%	50%	50%	46.4%	75%	50%	50%	75%
CYP referred for an assessment or treatment of an ED will access NICE treatment <4 weeks (Routines): %	95% (by 2021)	8.33%	50%	50%	54.5%	34.7%	38.7%	53.3%	68%	87.5%	46%	50%	87.5%
Patient Safety Alerts not completed by deadline	0	0	0	0	0	0	0	0	0	0	0	0	0

Regulatory Compliance - System Oversight Framework

Metric	Target	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Community Health Services: 2 Hour Urgent Community Response %.	TBC	76.5%	80.5%	84.5%	85.2%	86.0%	84.5%	89.4%	88.5%	84%	80.4%	83.2%	81.3%
Community Health Services: Inpatient Number of Discharges by 5pm	TBC	397	499	474	566	514	199	124	332	283	477	425	915
E-Coli Number of Cases identified	TBC	1	1	2	0	0	2	0	1	1	1	1	0
CHS: VTE Risk Assessment	TBC												
A&E - % Face to Face Assessment within 1 hour	TBC	90.2%	90.4%	88.5%	92%	96%	98.5%	98%	94%	93.5%	94.2%	98.2%	95.4%
Crisis Response Times % 1 hour	TBC					18%	35.5%	17.8%	23.6%	14.4%	56.0%	25%	37.5%
Crisis Response Times % 4 hours	TBC					44%	26.9%	23%	43%	22.2%	49%	53%	55.1%
Crisis Response Times % 24 hours	TBC										1	1	1
4 Week Access Target for Children's Mental Health Services	TBC												
4 Week Access Target for Adults' mental health services	TBC												
4 Week Access Target for Older Person's mental health services	TBC												
Personality Disorder Services	TBC												
Adult Eating Disorder Services	TBC												
Community Rehabilitation Pathways	TBC												
Expand Early Intervention in Psychosis	TBC												
Individual Placement Support - Access Target	TBC												
Number of people with SMI having an annual physical health check	TBC					22%	31%	67%	72%	74%	40%	40%	39%
Potential under reporting of NRLS Safety Incidents	TBC												
Ethnicity and most deprived quintile proportions across service restoration and NHS Long Term Plan metrics	TBC												
From Data Sets - Proportions of patient activities with an ethnicity code	TBC												
Proportion of staff who say they have a positive experience of engagement	TBC					7.5%	7.5%	7.5%	7.5%	7.5%	7.5%	7.5%	7.40%

Regulatory Compliance - System Oversight Framework

Metric	Target	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Number of people working in the NHS who have had a flu vaccination	TBC										1	1	1
Proportion of staff in senior leadership roles who are from a BME background	TBC												
Proportion of staff in senior leadership roles who are women	TBC												
CQC - Quality of Leadership	TBC												
Aggregate score for NHS Staff Survey questions that measure perception of leadership culture	TBC												
People promise index	TBC												
Health and wellbeing index	TBC												
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from (a) managers	TBC					6.70%	6.70%	6.70%	6.70%	6.70%	6.70%	6.70%	7.00%
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues,	TBC					6.70%	6.70%	6.70%	6.70%	6.70%	6.70%	6.70%	13.4%
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from (c) patients/ service users, their relatives or other members of the public in the last 12 months	TBC					7.90%	7.90%	7.90%	7.90%	7.90%	7.90%	7.90%	23.1%
Proportion of people who report that in the last three months they have come to work despite not feeling well enough to perform their duties	TBC					43%	43%	43%	43%	43%	43%	43%	48.5%
Percentage of staff who say they are satisfied or very satisfied with the opportunities for flexible working patterns	TBC					70.1%	70.1%	70.1%	70.1%	70.1%	70.1%	70.1%	67.8%
% of jobs advertised as flexible	TBC												
Staff retention rate (all staff)	TBC	87.4%	86.5%										
Performance against Financial Plan	TBC												
Underlying Financial Position	TBC												
Run Rate Expenditure	TBC												
Overall trend in reported financial position	TBC												
Mental Health 72 Hour Follow Up	TBC	84%	84%	87%	85%	86.2%	88.5%	98.1%	90.5%	92%	90.1%	87.5%	86.4%

Executive Committee Paper

Committee –	Trust Board
Meeting Date	10th May 2022
Paper Title	Quarterly Status Report on Key Trust 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.
Budget/Resource Impacts	As per individual projects
Commissioner Implications	n/a
Brief Executive Summary	Paper to provide assurance and oversight of the Trusts Strategic initiatives and the projects that will deliver True North and strategic priorities. The report provides a status update on the Trust's combined programme, projects, and strategy implementation.
Recommendation/ Action Required	The Board is asked to note the status of the Trust's key initiatives.

Quarterly Status Report on Key Trust Initiatives

Author: Karen Watkins & Neil Murton, Director of Projects

Director: Alex Gild, Deputy Chief Executive

Date: 3rd May 2022

Purpose

This document has been prepared to update the Trust Board at its May 2022 meeting regarding the current status of the organisation's portfolio of key programmes and projects prioritised as Mission Critical and Important, together with other priorities and initiatives to deliver the Trust's vision and Trust North Goals.

Members of the Trust Board are asked to review and note the report.

Document Control

Version	Date	Author	Comments
1	25.04.2022	Karen Watkins & Neil Murton	The document includes an updated version of the Combined Projects/SIP Report submitted to the Business & Finance Executive on 25th April 2022
2	03.05.2022	Karen Watkins & Neil Murton	Revised in response to feedback on first draft.

Distribution:

All Trust Board Members

Document References

Document Title	Date	Published By
Quarterly Status Report on Key Trust Initiatives	Jan 2022	Karen Watkins Director of Projects
Status Report on Trust Strategic Initiatives	Sept 2021	Karen Watkins Director of Projects
Status Report of Trust Strategic Initiatives as impact by the COVID-19 Pandemic	May 2021	Karen Watkins, Director of Projects
Status Report of Trust Strategic Initiatives as impact by the COVID-19 Pandemic	Feb 2021	Neil Murton Director of Projects

CONTENTS

Purpose of Paper

To provide an update, assurance and oversight of the Trust's Strategic initiatives and the projects that will deliver True North and strategic priorities.

Introduction

The Trust identifies its significant strategic projects and programmes through a strategic prioritisation process which references a Strategic Filter. This process was established as part of the Trust's Quality Improvement (QI) Programme and provides the Trust with control over its programme and project portfolio, including assurance that it is focusing on the right priorities ("True North") and that there is best use of resource in the organisation.

Prioritised projects are included on the Trust's Strategic Prioritisation Board and progress of those projects is monitored at Executive level through a monthly Report to the Executive Business & Finance Group.

That report was provided to Board Members in May, September and December 2021 to provide an update on the Trust's key schemes. It was then requested that an overview be provided for members, rather than the full report and the first of these was provided for the February 2022 Trust Board.

An overview is provided here of the projects and programmes on the Strategic Prioritisation Board, including the highlighting of newly established initiatives; those moving to business as usual; those recently closed, together with any initiatives currently reporting an Amber or Red RAG status along with associated implications and risks.

Trust prioritised projects

The current portfolio of prioritised programmes and projects included on the Strategic Prioritisation Board is listed below, against the True North goals they support. Larger scale projects will inevitably support more than one True North Goal and therefore the groupings below reflect the main True North goal the project supports.

Supporting True North Goal 1 – Harm Free Care (Providing safe services) • Quality Improvement Programme • CPA Framework Alternative Model [previously CMH Framework Programme (trusted assessment, formulation and safety plan)] • CHS ePMA • Safety Strategy • CYPF Referral Management System	**Supporting True North Goal 3 – Good Patient Experience (improving outcomes)** • Berkshire West Ageing Well Accelerator Site • Berkshire East Ageing Well • EDI Strategy • East Children's Therapies • CAMHS Tier 4 Service Transformation • Frimley CMH Transformation (Phase2) • BOB Community Mental Health Transformation • Connected Care (BOB and Frimley STP areas) • Patient Experience Measure • Neurodiversity Strategy
Supporting True North Goal 2 – Supporting Our People (A great place to work) • People Strategy • Transfer of EFM Services to NHS Property Services	**Supporting True North Goal 4 – Money matters (A financially sustainable organisation)** • PPH Bed Optimisation • Green Plan • Redevelopment of east community Hospitals (Frimley Integrated Care Hub Programme) • Replacement of Fitzwilliam House

Summary of Project progress end of April 2022

The current status of the Trust's key Programmes and Projects is summarised below:

Project	RAG Status	Comment
Children's Therapies East		Previous issues of leadership and ownership along with lack of clarity re. project aims and scope across the system, impacting staff retention. Business case agreed by Frimley ICS to address wait times. New project management resources in place. Improvement expected.
Frimley Community Mental Health Transformation (Phase 2)		
Berkshire East Ageing Well		
EDI Strategy		Impacted by changes in the EDI team.
CPA Framework Alternative Model		
People Strategy		Overall reporting Amber, but Attraction & Retention workstream reporting RED (see narrative below)
BOB Community Mental Health Transformation		
Prospect Park Bed Optimisation		
Community Enhanced Rehabilitation Team (CERT)		New initiative for which reporting is to be developed
ePMA (electronic prescribing)		Now working to a later timescale
Safety Strategy		
Green Plan		Progress impacted by staffing changes
Neurodiversity Strategy		
CYPF Referral Management System		Initial resourcing issues - now resolved
Redevelopment of East Community Hospitals		This is a system initiative which has challenges in terms of complexity, scope and timescales (capital needing to be spent by March 2024).
Fitzwilliam House replacement		Now working to a later timescale. Currently no indication that the current landlord will serve notice prior to the new accommodation being ready.

Two projects are rated Red:

East Children's Therapies initiative is rated Red due to a few risks including:

- project resource and leadership issues.
- commitment across the system is not fully embedded.
- lack of clarity regarding project aims and scope across the system.

These factors have in turn impacted on staff retention.

New project resources are in place and non-recurrent investment has been agreed by Frimley CCG to support waiting list reduction. Performance of this project is expected to improve.

Redevelopment of the East Berkshire Community Hospitals – a Frimley system initiative to establish Integrated Care Hubs across the ICS and include new build and refurbishments of NHS community estate. It is rated **Red** as no finances nor business cases have yet been presented within the ICS and there is a requirement for capital to be spent by March 2024, which will be challenging on basis of timescale, project scope, complexity and capital / revenue affordability.

Six projects are rated Amber:

People Strategy which includes several workstreams – whilst overall status is Amber the workstream for Attracting & Retaining staff is now Red due to turnover continuing to increase in line with NHS and wider sector trends c.16% in April 2022. Competition for staff across the NHS and staff shortages in Thames Valley continue – these factors are adding risk to the delivery of the strategy.

- Further analysis of the root causes of turnover is being undertaken, and a rapid improvement event is being considered with the highest contributing services.
- A balanced workforce model is being developed to counter over reliance on ad hoc advertisement activity, with repeat adverts failing to secure candidates.
- Investment is being made in apprenticeships, international recruitment, student placement expansion and candidate attraction activities via social media recruitment resourcing.

EDI Strategy is currently rated amber due to staffing changes within the EDI Team, although good progress has been made with Disability Leader status achieved, Stonewell Top 100 placement and a stepped improvement in embedding workplace adjustment process for disabled staff. Forward focus remains on bullying and harassment and career progression for BAME staff.

Community Hospital ePMA (electronic prescribing system) rated amber due to the project start being 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 project board agreed that the go-Live date to be moved by 6 months, from March to September 2022.

CYPF Referral Management System commencement was delayed due to resourcing issues which have since been addressed and the initiative is progressing.

Green Plan – the project is rated at **Amber** due need to recruit
new Trust sustainability lead and therefore risk of delay to initiatives. Green strategy agreed by the Board and incorporated into ICS plans.

Fitzwilliam House replacement – reported as **Amber** as the timescale has slipped, with occupation of the new accommodation now due in December 2022. Whilst a risk, there is currently no indication that the current landlord will serve notice for the Trust to vacate in advance of this date.

Recent changes to the portfolio of Programmes and Projects

Detailed below, are programmes and projects that have recently been established and added to our Strategic Prioritisation Board; established schemes now moving to business usual, together with initiatives that are now closed.

New Key Initiative

The following new initiative was considered in April 2022 and prioritised:

Community Enhanced Rehabilitation Team (CERT) – overall objective of this Berkshire-wide initiative is to reduce the number of specialist "locked Rehabilitation" placements required in the county for those with severe and enduring mental health illness but enabling a clear and timely step-down pathway for patients completing a period of specialist rehabilitation. The initiative will also support avoidance of hospital admissions/re-admissions and facilitate discharges from acute hospital for those requiring rehabilitation.

The following initiatives moving to business as usual:

Quality Improvement Programme (including QMIS) – Moving to business as usual, although transition to a business partnering model has been delayed until Summer 2022, due to senior staffing changes.

Transfer of Estates & Facilities Management Services to NHS Property Services – relevant services transferred to NHS Property Services in October 2021, but a few issues and risks remain and for that reason, the closure of the initiative has been delayed until they have been satisfactorily addressed. The Closure Report is now due for presentation in May 2022.

CAMHS Tier 4 Service Transformation - An out of hospital service has been established, which enabled the closure of the Willow House Tier 4 inpatient service on 30th April 2021. The Tier 4 team is now based in upgraded accommodation in Wokingham and offering day care and some home treatment. The Closure Report for the project is due to be presented in May 2022.

Connected Care – The IT shared record initiative within both BOB and Frimley was moved to business as usual from Quarter 4 of 2021/22.

Berkshire West Ageing Well – The initiative is due to submit its Closure Report in April. The programme for Berkshire East Ageing Well is underway and is due to continue until March 2023.

Conclusion

The Trust continues to achieve good progress in pursuit of its project goals - it has successfully concluded a further two projects since the last report in February 2022 and five initiatives are currently transitioning to business as usual. However, whilst most issues reported relate to later delivery, progress on the Attraction & Retention workstream of the Trust's People Strategy is a continuing concern and staff turnover remains a major risk to the Trust's ability to continue to deliver quality health services.

Action

The Board is asked to note the progress of the strategic projects and initiatives.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 May 2022
Title	**Audit Committee – 28 April 2022**
	Item For Noting
Purpose	To receive the unconfirmed minutes of the meeting of the Audit Committee of 28 April 2022
Business Area	Corporate
Author	Company Secretary for Rajiv Gatha, 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

Berkshire Healthcare
NHS Foundation Trust

Unconfirmed Draft Minutes

Minutes of the Audit Committee Meeting held on

Thursday, 28 April 2022

(Conducted via Microsoft Teams)

Present:	Rajiv Gatha, Non-Executive Director, Committee Chair Mehmuda Mian, Non-Executive Director Naomi Coxwell, Non-Executive Director
In attendance:	Paul Gray, Chief Financial Officer Rebecca Clegg, Director of Finance Debbie Fulton, Director of Nursing and Therapies Minoo Irani, Medical Director Sharonjeet Kaur, RSM, Internal Auditors *(substituting for Clive Makombera)* Amanda Mollett, Head of Clinical Effectiveness and Audit Melanie Alflatt, TIAA Maria Grindley, Ernst and Young, External Auditors Alison Kennett, Ernst and Young, External Auditors Julie Hill, Company Secretary Mark Davison, Chief Information Officer *(present for agenda items 5 and 6)* Graham Harrison, Head of Financial Services Maria Norville, Senior Financial Manager

Item		Action
1.A	**Chair's Welcome and Opening Remarks**	
	Rajiv Gatha, Chair welcomed everyone the meeting.	
1.B	**Apologies for Absence**	
	Apologies for absence were received from: Clive Makombera, RSM, Internal Auditors.	
2.	**Declaration of Interests,**	
	There were no declarations of interest.	
3.	**Minutes of the Previous Meeting held on 19 January 2022**	

	The Minutes of the meeting held on 19 January 2022 were confirmed as a true record of the proceedings.	
4.	**Action Log and Matters Arising**	
	The Action Log had been circulated. The Committee noted the action log.	
5.	**Cyber Security Annual Report**	
	The Chair welcomed Mark Davison, Chief Information Officer to the meeting. The Chief Information Officer presented the report and highlighted the following points: • The Trust's digital environment was protected by layers of technologies, policies and processes in order to protect confidential information and ensure operational continuity of our frontline services. • Scheduled external audits were carried out throughout the year and the Trust had retained its independent accreditations for Information Security Management Systems (ISO27001), Cyber Defences (Cyber Essentials +) and NHS Data Security & Protection (DSPT). • The Trust had 23 Information Security incidents logged in 2021. 1 incident was categorised as a "critical" incident which was an external probe to exploit a vulnerability in our email system. The vulnerability was patched, no actual cyber-attacks occurred and none of our information was compromised. • The Trust had continued to monitor and update systems to remedy the global Log4j vulnerability discovered in December 2021 which had consumed significant resources. To date, the Trust has not suffered any exploitation of this vulnerability. The Chair asked for more information about the Trust's use of multi-factorial authentication (MFA). The Chief Information Officer reported that the Trust's clinical systems already had multi-factorial authentication using the NHS Smart Card & PIN combination. All High privilege accounts also had MFA applied and the Trust's VPN utilised digital certificates on Trust devices along with an individual's network password to deliver MFA access from outside our network. The Trust was reviewing options for non-intrusive multi-factorial authentication for all staff accessing Office 365 etc. The Chair referred to page 27 of the agenda pack and noted that the Trust had piloted the use of software red flags but this was not rolled out because of cost and asked for further information. The Chief Information Officer said that the decision not to continue with the red flag software should have been stated as its value (cost v usefulness) rather than simply cost. The main issue was the high number of alerts and notifications it produced, leading to "alert fatigue" for busy staff.	

	Naomi Coxwell, Non-Executive Director asked about the Cyber Security risks around system working and sharing data with other organisations. The Chief Information Officer said that this together with human factors remained our primary areas of concern especially as the Trust was the only NHS organisation in our Integrated Care System (and one of only 3 in the South East Region) certified to cyber security plus standards and that partner organisations were therefore likely to be operating to lower standards than the Trust. The Committee a) Noted the report and the assurance that robust arrangements were in place to effectively manage the cyber security risks within the Trust.	
6.	**Information Governance Annual Report**	
	The Chief Information Officer presented the report and highlighted the following points: • The Data Security and Protection Toolkit (DSPT) return of Standards was exceeded. • Of the 965 Subject Access Requests (SARs) the Trust received, only 1 exceeded the 30-day timeframe for response. • Of the 297 reported Information Governance incidents, 1 met the threshold of a reportable breach to the Information Commissioner's Office (ICO). • 9 complaints relating to Information Governance were received, the key outcomes were summarised in the report. • There were 3 direct complaints to the Information Commissioner's Office . • 96.87% of staff were compliant with Information Governance Training (95% was the statutory requirement). Key areas of development for 2022 included: • Supporting the delivery of the Trust's Digital Strategy • Developing additional guidance and information for staff on data protection via frequently asked questions. • Delivering data protection contractual considerations and requirements training in partnership with DAC Beachcroft to the Trust Contract and Procurement Teams. • Working with system partners to ensure that data protection considerations and obligations have been met for Integrated Care System driven initiatives. Mehmuda Mian, Non-Executive Director asked whether the number of subject access requests had increased. The Chief Information Officer confirmed that there had been no significant increase over the last year and that numbers of subject access requests were largely unchanged.	

	The Committee: noted the report and the assurance that robust arrangements were in place to effectively manage information governance risks within the organisation.	
7.A	**Board Assurance Framework**	
	The latest Board Assurance Framework had been circulated. The Chief Financial Officer referred to the Workforce risk (Risk 1) and confirmed that the Trust had agreed to expand the Apprenticeship scheme as part of its work around "growing its own" workforce in order to mitigate the national shortage of registered staff. The Chief Financial Officer referred to the Finance risk (Risk 2) and confirmed that the Trust had submitted its Financial Plan 2022-23 to NHS England/Improvement on Tuesday, 26 April 2022. The Chief Financial Officer referred to the Service Demand risk (Risk 6) and reported that an external consultancy had been appointed to produce a report setting out the Mental Health Bed demands for Berkshire, Oxford Health and Surrey and Borders Partnership Trust. The first draft of the report was due in June 2022. The Chief Financial Officer presented the report and proposed that Risk 8B (COVID-19 Recovery) be closed and that any residual risks were covered either as part of the COVID-19 Risk 8A and/or by the Workforce Risk (Risk 1). **The Committee:** a) Noted the report; and b) Approved the closure of the COVID-19 Recovery Risk 8B (any residual risks are covered by the workforce risk (risk 1) and by the Covid-19 risk (risk 8a)	**JH**
7.B	**Corporate Risk Register**	
	The Corporate Risk Register had been circulated. The Chief Financial Officer referred to the Agency Spend risk and reported that the temporary staffing programme to standardise rates had commenced across both Integrated Care Systems and would be implemented from July 2022. The Chief Financial Officer referred to the Prospect Park Hospital Physical Environment risk and reported that the development a new Place of Safety at Prospect Park Hospital was a significant piece of work. The Chief Financial Officer presented the report and proposed that the Mental Health Act Compliance Trust wide risk be closed to reflect the sustained improvement in performance following the mitigations that had been put in place. The Chief Financial Officer also proposed reducing the risk score in respect of the "Near Miss" risk from a risk score of 10 (severe x unlikely) to a risk score of 5 (severe x rare) to reflect the efficacy of the mitigations that had been put in place.	

	The Committee: a) Noted the report b) Approved the closure of the Mental Health Act Compliance Trust wide risk on the Corporate Risk Register c) Approved a reduction in the risk score of the "Near Miss" risk on the Corporate Risk Register from risk score 10 (severe x unlikely) to risk score 5 (severe x rare).	**JH**
8.	**Single Waiver Tenders Report**	
	A paper setting out the single waivers approved from January 2022 to the end of March 2022 had been circulated. The Chief Financial Officer presented the paper and reported that the number of single waiver tenders had increased during quarter 4. It was noted that single waiver tenders had been used to purchase additional capacity in order to reduce waiting lists. This included providing psychology assessment and support for pre-bariatric surgery in order to support a waiting list of around 100 patients. The Trust's lack of psychology input meant that surgeries were being cancelled, adding further to COVID-19 postponed surgeries. The Trust had also entered into a number of agreements with local charities in order to reduce waiting lists. The Chair reminded the Committee that single waivers up to a value of £100,000 were approved by the Chief Financial Officer and that any single waiver above a threshold of £300,000 would be approved in consultation with the Chair of the Audit Committee. It was noted that none of the single waivers met the threshold for the Chair of the Audit Committee's involvement. The Chair confirmed that he had discussed the larger than usual volume of single waiver tenders with the Chief Financial Officer prior to the meeting. Mehmuda Mian, Non-Executive Director referred to Estates and Facility Management software single waiver tender and asked for more information. The Chief Financial Officer explained that approval had been given to this single waiver on the basis of cost because it was cheaper to purchase the software from the particular company, than going via the usual procurement framework route. Naomi Coxwell, Non-Executive Director reported that the Finance, Investment and Performance Committee which had met earlier that day had discussed the challenges for the Finance Team around dealing with the uncertainties at year end. This had been particularly difficult this year because it had not been clear until very late in March whether or not the Commissioners would require the Trust to return any of the unspent additional funding because of the inability to recruit additional staff. It was noted that a number of contracts had been approved with Charities at year end in order to maximise the Trust's spend and to reduce waiting lists. Ns Coxwell said that it was important to bear this in mind when reviewing the single waiver tender report as March 2022 was not a usual month. The Chair confirmed that he fully supported the Trust's approach to maximise its spend especially given the increased demand for services. The Committee noted the report.	

9.	**Information Assurance Framework Update Report**	
	The Chief Financial Officer presented the paper and highlighted the following points: • A total of 5 indicators were audited during Quarter 4. • Three were rated Green (High Confidence) for both Data Assurance and Data Quality. One was rated as Amber (Medium Confidence) for Data Assurance, and one was rated Red (Low Confidence) for Data Quality. Action plans were put into place to address these issues. • The following indicators were audited: o Inappropriate Out of Area Placements (Green) o Mental Health Readmissions within 28 days (audited quarterly) (Green) o Number of Suicides per month (Green) o Physical Assaults on Staff (Green for Data Quality, Amber for Data Assurance) o Mental Health 72 Hour Follow-Up (audited monthly) (Red) The Committee noted the report.	
10.	**Losses and Special Payments Report**	
	The Losses and Special Payments Report quarter 4 report had been circulated. The Committee noted the report.	
11.	**Clinical Claims and Litigation End of Year Report**	
	The Director of Nursing and Therapies presented the paper and reported that during quarter 4 there were two new claims opened (1 relating to Employer Liability and 1 relating to Clinical Negligence). It was noted that during quarter 4, 7 claims were closed (4 clinical negligence claims and 3 employer liability). The Director of Nursing and Therapies reported that during 2021-22 there were a total of 12 claims with an even split across both Clinical Negligence and Employer Liability. The Director of Nursing and Therapies confirmed that compared to other NHS organisations, particularly in the acute sector, the Trust had relatively few claims. The Director of Nursing and Therapies said that it whilst it was difficult to identify any particular themes from the claims data as the numbers were small and the incidents were spread across services, it was important to identify any highlight significant learning that had been implemented as a result of serious incidents that had also resulted in clinical claims. The key learning had been in the areas of suicide prevention, patient assaults on staff and pressures sores. The Committee noted that report.	

12.	**Clinical Audit Report**	

	The Medical Director presented the paper and highlighted the following points:
	
	• There were both statutory and contractual obligations that the Trust must meet with regards to clinical audit and these requirements were being met. All registration and data submission requirements had been met or were on track.
	• In total there were 26 national quality account reportable projects.
	• National Reports published between January 2022 to March 2022 will be presented at the June Quality Assurance Committee). Individual Trust level results had been released for the following national audits; the full national reports are due to be published imminently:
	  • National audit of End-of-Life care local report
	  • (NCAP) National Clinical Audit of Psychosis – Early Intervention in Psychosis local report
	
	The Medical Director reported that the Trust had received an Outlier Letter in respect of the National Audit of Psychosis. It was noted that Outlier analysis was conducted for all national audits. Following this analysis, the Trust was identified as a potential outlier for the following standards:
	
	• **Standard 3** – service users with their first episode of psychosis - the proportion of patients and families who had taken up a family intervention delivered by a person with relevant skills and competencies
	• **Standard 6** – service users with their first episode of psychosis who received a physical health review annually
	
	The Medical Director reported that the Quality Assurance Committee would discuss the national audit in more detail at their next meeting on 7 June 2022.
	
	The Committee noted that report.	

13.	**Anti-Crime Service Progress Report**	

	a) Anti-Crime Annual Report and End of Year Return
	
	Melanie Alflatt, TIAA presented the paper and highlighted the following points:
	
	• In line with NHS Counter Fraud Authority requirements, the Anti-Crime Specialist undertook a fraud risk assessment and developed a risk-based counter fraud work plan that was discussed with the Trust and approved by the Audit Committee.
	• The risk assessment and work plan had identified several areas where the Anti-Crime Specialist would work with the Trust to mitigate the fraud risk.
	• From the work conducted during the course of the year, the Anti-Crime Specialist confirmed the following:
	  ○ There were no frauds subject to investigation that met the materiality threshold for referral to the Trust's external auditors
	  ○ There were no significant system failures or control weaknesses identified that would impact on the Trust's Annual Governance Statement	

	• The annual self-assessment against the incoming Counter Fraud Functional Standard was due for submission by 31 May 2022. The Chief Financial Officer and the Chair of the Audit Committee were both required to authorise the submission. • The Trust had self-assessed that it was compliant with 11 out of 13 components of the functional standards and had partially met 2 components. The partially compliant components related to fraud bribery and corruption risk assessments and polices and register for gifts and hospitality. • The Counter Fraud function was well embedded within the Trust and the work undertaken addressed the generic areas of the Trust's Counter Fraud Strategy. Mehmuda Mian, Non-Executive Director drew attention to page 188 of the agenda pack and asked whether any learning from the joint investigation with another NHS organisation which had resulted in a dismissal but due to case weaknesses, the matter was not deemed suitable to proceed with any criminal action. Ms Alflatt said that she did not have the detail of the case to hand but explained that any learning from the Anti-Crime Specialist's investigation would have been fed back to the Trust. **b) Work Plan 2022-23** Melanie Alflatt presented the paper and reported that the Work Plan 2022-23 provided coverage for the full range of deliverables in line with the requirements set out within the Government's Functional Standard (GovS 013: Counter Fraud), which replaced the NHS Standards for Providers in April 2021. The Chair asked whether the Anti-Crime Specialist was receiving right level of support from the Trust. Ms Alflatt confirmed that the Trust was very supportive and responsive to the work of the Anti-Crime Specialist. The Committee noted the reports.	
14.	**Internal Audit Progress Report**	
	a) Annual Report 2021-22 Sharonjeet Kaur, RSM Internal Auditors presented the report and said that for the 12 months ended 31 March 2022, the draft Head of Internal Audit Opinion for the Trust was that "the organisation had an adequate and effective framework for risk management, governance an internal control. However, the Internal Auditors work had identified further enhancements to the framework of risk management, governance and internal control to ensure that it remained adequate and effective." The Chair asked how many of RSM clients received the highest level in terms of the Internal Auditors Opinion. Ms Kaur said that she did not have the number to hand but confirmed that it was rare to award the highest level and pointed out that the last year had been very challenging for the whole NHS. Ms Kaur said that in terms of the internal audit function, the Trust was performing better than many other trusts.	

Naomi Coxwell, Non-Executive Director asked with the benefit of hindsight whether the Internal Audit Plan 2021-22 was right for the Trust.

The Chief Financial Officer confirmed that the reviews into COVID-19 and apprenticeship had been particularly useful as the Trust had moved into a COVID-19 Recovery phase and services had been re-started. The review of the Trust's Apprenticeship work had informed the business case for further investment into Apprenticeships as part of the mitigations to address workforce shortages.

The Chief Financial Officer reported during the course of the year, if an area arose and the Trust required the Internal Auditors to conduct a review, there was flexibility in the Internal Audit Plan to re-schedule reviews in order to accommodate a new review.

The Chair asked whether the Internal Auditors conducted work outside of the Internal Audit Plan.

Ms Kaur reported that the Internal Auditors also conducted advisory work and pointed out that the Apprenticeship review was advisory. Ms Kaur also said that the Internal Auditors had developed the Assurance Map.

b) Internal Audit Plan 2022-23

Sharonjeet Kaur presented the Internal Audit Plan 2022-23 which was based on analysing the Trust's corporate objectives, risk profile, assurance framework, rolling internal audit strategy as well as other factors affecting the Trust in the year ahead, including changes within the sector.

It was noted that the Internal Auditors had developed the Internal Audit Plan 2022-23 in consultation with the Chief Financial Officer and other Executive Directors. It was also noted that the Internal Audit Plan 2022-23 included a rolling three year Internal Audit Plan

The Chair asked about the process for developing the Internal Audit Plan.

The Chief Financial Officer explained that the Internal Auditors developed a list of potential areas for review based on the Trust's Strategy, Board Assurance Framework and Corporate Risk Register risks and then he met with the Internal Auditors and discussed options. A draft Internal Audit Plan was then discussed at an Executive Committee meeting to ensure that the draft Internal Audit Plan was focussed on the areas where the Trust would receive the most benefit. The draft Internal Audit Plan was then presented to the Audit Committee for approval.

The Chair asked whether the draft Audit Plan should be approved by the Trust Board rather than by the Audit Committee.

The Chief Financial Officer said that given that the Audit Committee had responsibility for overseeing the Trust's internal audit work, he felt that the Audit Committee was the appropriate forum to approve the Internal Audit Plan.

Naomi Coxwell, Non-Executive Director reported that she liked the risk based approach taken in the Internal Audit Plan and the fact that it was aligned to the Trust's Strategy and Board Assurance Framework. Ms Coxwell asked as part

of the individual reviews, whether the internal auditors considered the actions already taken to mitigate the key risks on the Board Assurance Framework.

Ms Kaur explained that the Internal Auditors developed audit scopes for each individual reviews in consultation with the relevant Executive Director lead. It was noted that the Internal Auditors conducted an annual review of the Trust's Board Assurance Framework and may review actions to mitigate a particular risk as part of a deep dive exercise into a particular risk.

c) Assurance Map

Sharonjeet Kaur presented the Assurance Map and explained that Assurance Mapping was a means to align what assurance was received in respect to the key risks in an organisation and was a useful tool in developing and maintaining board and organisational assurance arrangements. It provided an organisation with an improved ability to understand and confirm that they had assurance over key risks and controls or where gaps existed and whether actions were in place to address those gaps or that the level of risk was acceptable.

It was noted that the Internal Auditors undertook an assurance map exercise during April 2022. The aim of the exercise was to build upon the Board Assurance Framework and map out the different sources of assurance for key process areas within the Trust. Ms Kaur reported that the Internal Auditors identified the following areas with limited independent assurance:

- Integrated Care Systems
- Estates
- Population Health
- Patient Level Costing

Ms Kaur reported that she would continue to work with the Company Secretary refine the Assurance Map.

The Chair thanked the Internal Auditors for the Assurance Map and commented that it was helpful to see the key sources of assurance on one page.

d) Internal Audit Progress Report

Sharonjeet Kaur presented the paper and highlighted the following points:

- The following reports had been finalised since the last meeting:
    - COVID-19 Recovery – Waiting List Management (Reasonable Assurance)
    - Board Assurance Framework (Reasonable Assurance)
    - Learning from COVID-19 (Substantial Assurance)
- The draft report on Apprenticeships had been issued. The Data Security and Protection Toolkit Review quality assurance stage was in progress and this would conclude the Internal Audit Plan for 2021-22

The Chair asked whether the Internal Auditors received all the support they needed in order to undertake their work.

Ms Kaur confirmed that the Internal Auditors received excellent support from the Trust.

	The Committee noted the reports.	
15.	**External Audit Report**	
	Maria Grindley, E&Y, External Auditors presented the Outline Audit Planning Report which provided the Committee with a basis to review the proposed audit approach and score and scope for the 2021-22 external audit of the Trust's Annual Report and Accounts. Ms Grindley referred to the summary of the significant accounting and audit matters outlined in the report. It was noted that the areas identified as risks were in line with other NHS trusts and did not indicate that the External Auditors had any concerns about the Trust. The potential risks identified included: • **Fraud risk in relation to the potential manipulation of reported financial performance** – in addition to the standard review of the override of any management controls, the External Auditors would seek assurance around the reported financial performance to defer the recognition of income and/or create inappropriate accruals or provisions in 2021-22 that could be released in 2022-23. • **Valuation of property, plant and equipment, land and building assets –** the national accounting standards required the External Auditors to be assured that the Trust had robust valuations of its assets. • **Going Concern** – the national accounting standards required that the External Auditors seek assurance around the basis of the Trust's disclosure that it continued to be a going concern. • **Accounting for PFIs** – the PFI liability represented a significant balance in the Trust's balance sheet. The PFI liability was based on a model and was subject to a number of complex assumptions. A small movement in these assumptions could have a material impact on the financial statements. • **Remuneration Report and Pension Benefit Disclosures** – the External Auditors would test whether the Trust's disclosures in the Annual Report had been correctly included. • **Value for Money** - there was an expectation that the NHS would use additional funding from the 2021 Government Spending Review to fully restore core services and NHS Long Term Plan commitments. This would require bodies, including the Trust, to take out costs and deliver significant additional efficiencies. Arrangements would need to be re-introduced in the current year, for example the development of cost improvement programmes and an effective programme management office, to prepare to deliver this. The External Auditors expected to consider this as a risk of significant weaknesses in the Trust's arrangements for financial sustainability. Ms Grindley reported that the External Auditors' planning materiality had been set at £5.9m which represented 2% of the Trust's 2020-21 audited gross revenue expenditure. Performance materiality for the Trust's financial statements had been set at £2.9m which represented 50% of planning materiality. The Chair reminded the meeting that the Committee had agreed that it would be helpful if the External Auditors would run a session for the Governors to explain more about the role of the External Auditors.	

	The Company Secretary confirmed that the Governors had been invited to attend the July 2022 Audit Seminar at which the External Auditors would be speaking about how they conduct the external audit. Naomi Coxwell, Non-Executive Director asked about the timescale for completing the external audit of the Trust's Annual Report and Accounts 2021-22. Ms Grindley reported that NHS England/Improvement's submission deadline was 21 June 2022 but confirmed that she was keen to ensure that the external audit would be completed well in advance of the deadline. It was noted that the Trust Board would be asked to delegate approval of the annual accounts to the Audit Committee at the extraordinary meeting on 8 June 2022. Alison Kennett, External Auditors reported that E&Y had received the Trust's financial statements on Tuesday this week and confirmed that the External Auditors were happy with the support they were receiving from the Trust. Ms Grindley thanked the Finance team for their assistance with the external audit. The Committee noted the report.	
16.	**Minutes of the Finance, Investment and Performance Committee meeting held on 27 January 2022 and 24 March 2022**	
	The minutes of the Finance, Investment and Performance Committee meeting held on 27 January 2022 and 24 March 2022 were received and noted.	
17.	**Minutes of the Quality Assurance Committee held on 01 March 2022**	
	The minutes of the Quality Assurance Committee meetings held on 01 March 2022 were received and noted.	
18.	**Minutes of the Quality Executive Committee Minutes – 17 January 2022, 21 February 2022 and 21 March 2022**	
	The minutes of the Quality Executive Committee meetings held on 17 January 2022, 21 February 2022 and 21 March 2022 were received and noted.	
19.	**Annual Work Plan**	
	The Audit Committee's work programme had been circulated. The Committee's Annual Work Plan was noted.	
20.	**Any Other Business**	
	There was no other business.	
21.	**Date of Next Meeting**	
	8 June 2022 (Extraordinary meeting to approve the Annual Report and Accounts 2021-22) 20 July 2022 – formal meeting	

The minutes are an accurate record of the Audit Committee meeting held on 28 April 2022.

Signed: - _____

Date: - **20 July 2022** _____

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 May 2022
Title	Draft Annual Report 2021/22
	ITEM FOR APPROVAL (subject to any final necessary additions and amendments) and Approval sought to delegate to the Audit Committee, the approval of the annual accounts 2021-22
Purpose	This paper provides the Trust Board with the Draft Annual Report 2021/22 for approval
Business Area	Corporate
Author	Chief Executive Officer/Company Secretary
Relevant Strategic Objectives	N/A
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	N/A
Legal Implications	Maintaining compliance with terms of authorisation and meeting regulatory requirements
Equalities and Diversity Implications	The Annual Report includes sections on equality, diversity and inclusion
SUMMARY	Attached is a draft of the Trust's Annual Report 2021/212 for comment and approval. Please note that the Annual Report cannot be published until the final version has been laid before Parliament. The draft Annual Report has therefore not included as part of the Public Trust Board papers. Published on the Trust's website. A copy of the draft Annual Report has been submitted to the External Auditors who are responsible for ensuring that it meets the requirements as set out in NHS Foundation Trust Annual Reporting Manual 2021/22. The financial figures contained within the draft

	Annual Report are also subject to verification by the External Auditors. If any changes of significance arise these will be discussed with and approval sought from the Trust Chair and Chief Executive and notified to other Trust Board members as appropriate. An Extraordinary meeting of the Audit Committee has been arranged on 8 June 2022 to approve the Annual Accounts 2021-22 on behalf of the Trust Board. When approved, the Annual Accounts will be added to the Annual Report.
ACTION REQUIRED	The Board is invited to: 1. Consider and offer any comments on the draft Annual Report 2021/22. 2. Approve the draft for submission to NHS England/Improvement subject to any final necessary additions and amendments and to delegate authority to the Chair and Chief Executive to give Board approval to the final document in light of the timetable for submission to NHS Improvement. 3. Delegate authority to approve the Annual Accounts 2021-22 on behalf of the Trust Board to the Audit Committee