Berkshire Healthcare
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

TRUST BOARD MEETING

(conducted electronically via Microsoft Teams)

10:00am on Tuesday 12 September 2023

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 11 July 2023	Martin Earwicker, Chair	Enc.
5.2	Action Log and Matters Arising	Martin Earwicker, Chair	Enc.
QUALITY			
6.0	Patient Story – Older Adult Mental Health	Debbie Fulton, Director of Nursing and Therapies/Jules Mason, Consultant Psychiatrist for Older Adults, Adult Mental Health Inpatients	Verbal
6.1	Patient Experience Quarterly Report	Debbie Fulton, Director of Nursing and Therapies	Enc.
6.2	Quality Assurance Committee a) Minutes of the meeting held on 29 August 2023 b) Changes to the Committee's Terms of Reference c) Learning from Deaths Quarterly Report d) Guardians of Safe Working Report	Sally Glen, Chair, Quality Assurance Committee	Enc.
EXECUTIVE UPDATE			
7.0	Executive Report	Julian Emms, Chief Executive	Enc.
PERFORMANCE			
8.0	Month 04 2023/24 Finance Report	Paul Gray, Chief Financial Officer	Enc.
8.1	Month 04 2023/24 Performance Report	Paul Gray, Chief Financial Officer	Enc.

No	Item	Presenter	Enc.
8.2	Finance, Investment and Performance Committee Meeting held on 26 July 2023	Naomi Coxwell, Chair of the Finance, Investment and Performance Committee	Verbal
STRATEGY			
9.0	Workforce Race Equality Standard Report	Alex Gild, Deputy Chief Executive/Jane Nicholson, Director of People	Enc.
9.1	Workforce Disability Equality Standard Report	Alex Gild, Deputy Chief Executive/Jane Nicholson, Director of People	Enc.
9.2	Leadership Strategy Report	Alex Gild/Deputy Chief Executive	Enc.
CORPORATE GOVERNANCE			
10.0	Audit Committee Meeting on 26 July 2023	Rajiv Gatha, Chair, Audit Committee	Enc.
10.1	Council of Governors Update	Martin Earwicker, Trust Chair	Verbal
10.2	Schedule of Meetings for 2024	Martin Earwicker, Trust Chair	Enc.
Closing Business			
11.	Any Other Business	Martin Earwicker, Chair	Verbal
12.	Date of the Next Public Trust Board Meeting – 14 November 2023	Martin Earwicker, Chair	Verbal
13.	**CONFIDENTIAL ISSUES:** To consider a resolution to exclude press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.	Martin Earwicker, Chair	Verbal

Berkshire Healthcare
NHS Foundation Trust

Unconfirmed minutes

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Minutes of a Board Meeting held in Public on Tuesday, 11 July 2023

(Conducted via Microsoft Teams)

Present:	Martin Earwicker	Trust Chair
	Naomi Coxwell	Non-Executive Director
	Rebecca Burford	Non-Executive Director
	Mark Day	Non-Executive Director
	Aileen Feeney	Non-Executive Director
	Sally Glen	Non-Executive Director
	Julian Emms	Chief Executive
	Alex Gild	Chief Financial Officer
	Debbie Fulton	Director of Nursing and Therapies
	Paul Gray	Chief Financial Officer
	Dr Minoo Irani	Medical Director
	Tehmeena Ajmal	Chief Operating Officer
In attendance:	Julie Hill	Company Secretary
	Mike Craissati	Freedom to Speak Up Guardian *(present for agenda items 6.1 and 6.2)*
	Jane Nicholson	Director of People
	Karla Inniss	Head of Inclusion (*present for agenda item 9.1)*
	Mark Davison	Chief Information Officer
Patient Story:	Maggie Gibbons	Team Lead - Individual Placement and Support Employment Service
	Gurpreet Athwal	Individual Placement and Support Employment Service Specialist
	Aaron	Individual Placement and Support Employment Service Client
Observers:	Tom Lake	Public Governor
	Olu Odeniyi	Member of Public

23/109	**Welcome and Public Questions** (agenda item 1)
	The Chair welcomed everyone to the meeting. The Chair particularly welcomed Rebecca Burford, Non-Executive Director, who was attending her first Trust Board meeting.

23/110	**Appointment of a New Vice Chair**
	The Chair reported that following Mehmuda Mian's retirement from the Trust, the Council of Governors had appointed Mark Day as the Trust's new Vice Chair with effect from 1 July 2023.
23/111	**Apologies** (agenda item 2)
	Apologies were received from: Rajiv Gatha, Non-Executive Director.
23/112	**Declaration of Any Other Business** (agenda item 3)
	There was no other business.
23/113	**Declarations of Interest** (agenda item 4)
	i. **Amendments to Register** – none
	ii. **Agenda Items** – none
23/114	**Minutes of the previous meeting – 09 May 2023** (agenda item 5.1)
	The Minutes of the Trust Board meeting held in public on Tuesday, 09 May 2023 were approved as a correct record.
23/115	**Action Log and Matters Arising** (agenda item 5.2)
	The schedule of actions had been circulated. **The Trust Board:** noted the action log.
23/116	**Board Story – Individual Placement and Support Employment Service (**agenda item 6.0)
	The Chair welcomed Maggie Gibbons, Team Lead, Individual Placement and Support Employment Service, Gurpreet Athwal, Individual Placement and Support Employment Service Specialist and Aaron, a client of the service. Maggie Gibbons, Team Lead, Individual Placement and Support Employment Service and Gurpreet Athwal, Individual Placement and Support Employment Service Specialist gave a presentation and highlighted the following points: • Employment rates for people with severe mental health issues were unacceptably low. 70-90% of people with mental health issues would like to work but only 37% were in paid employment. For people with severe mental health issues, only 8% were in paid employment. • The Trust's Individual Placement and Support Employment Service comprised a team of 12 employment specialists, two coordinators (east and west Berkshire) and

	three leads working alongside any clients of the Trust who had severe mental health issues and wished to gain, sustain or retain rewarding paid employment. • The Individual Placement and Support Employment service had a key role to play in the Trust's mission to "maximise independence and quality of life" • The Individual Placement and Support Employment Specialists held a caseload of twenty people at any one time and were expected to work. The Employment Specialists got to know their clients and their employment requirements and provided advice, so they did not lose their entitlement to benefits. • The Employment Specialists liaised with employers on behalf of their clients, so employers were aware of any special adjustments they needed to put in place to support clients during the interview process and if successful, any ongoing support they required to fulfil their job role. Aaron, a client of the Individual Placement and Support Employment Service shared his experience of using the service (Aaron's full story is available as part of the Trust Board meeting video published on the Trust's website). Aaron said that he had been out of work for five years following a serious mental health episode and had been referred to the Individual Placement and Support Employment Service via the Trust's Community Health Mental Health Team. Aaron said that he worked with his Employment Specialist, Gurpreet Athwal to identify suitable job roles. It was noted Aaron's ideal job was to be able to his lived experience to help others experiencing mental health issues. Aaron said that he was successful in gaining a Support Worker role and now worked with around eight clients. Aaron said that the Individual Placement and Employment Support Service helped him to rebuild his life and had enabled him to get a job that he loved. Aaron said that he would be starting a course in Counselling in September 2023. The Chair thanked Aaron for sharing his story and wished him well in his future studies and career. Aileen Feeney, Non-Executive Director said that one of the principles underpinning the Individual Placement and Support Employment Service was around helping clients to gain paid employment and asked whether the service also helped clients to gain voluntary work as a means of improving their employment prospects. Maggie Gibbons said that the service model was focussed on helping clients to gain paid employment and commented that the evidence suggested that voluntary work as a means of gaining paid employment could be a long pathway into work for people with severe mental health illness. Sally Glen, Non-Executive Director asked about the service's outcomes in terms of the typical length of employment. Maggie Gibbons reported that the service was measured on a number of targets, for example, the percentage of clients sustaining paid employment for 13 weeks and 26 weeks and over. It was noted that the service worked with around one hundred clients per year with around 50% of clients gaining paid employment. The Chief Executive commented that it was an inspiring presentation and said that the service was evidence based which differentiated it from other less successful employment schemes which had been tried in the past.

	Rebecca Burford, Non-Executive Director asked whether the service supported people to gain qualifications whilst at work. Maggie Gibbons said that the service could support people around further training once in work. The service was also developing opportunities for clients to gain paid employment with the Trust as the Trust expanded the number of roles for people with lived experience to help the Trust to better meet the needs of its patients. The Chief Operating Officer asked what the Trust could do to ensure that there was a supportive environment in place for the Trust's Lived Experience Workers. Maggie Gibbons reported that she was working closely with the Head of Patient Experience to ensure that Lived Experience Workers were mentored and supported when they joined the Trust. The Chair thanked Maggie Gibbons and Gurpreet Athwal their presentation and especially thanked Aaron for sharing his story. **The Trust Board:** noted the presentation.
23/117	**Freedom to Speak Up Guardian Report** (agenda item 6.1)
	The Chair welcomed the Freedom to Speak Up Guardian to the meeting. The Freedom to Speak Up Guardian presented the report and highlighted the following points: • The number and type of cases raised since the last report (December 2022) fitted into the general pattern of cases from the previous periods. During the period, four cases were raised with the Freedom to Speak Up Guardian which included an element of patient safety. The Trust Board could be assured that other patient safety issues were raised via other routes. • A significantly high proportion of cases were around the "staff experience" and specifically from staff who stated the cause was bullying and harassment from fellow staff members. • As requested by the Trust Board, the Freedom to Speak Up Guardian's Report contained some anonymised case study examples of where Race Equality Network members had used the Speak Up process with positive outcomes and learning for the Trust. The Freedom to Speak Up Guardian said that he was seeking Trust Board support in the following areas of focus: • Support and encourage initiatives to address subjective "Staff Experience" concerns, specifically those that included an element of bullying and harassment and/or micro aggressions. • Support and encourage initiatives to minimise the risk of detriment. • Support and encourage initiatives to improve a Listening Up culture, so that all staff feel more able to challenge in a positive way, to encourage positive suggestions that may improve ways of working, the patient experience or efficiencies. In turn this would make raising more traditional Freedom to Speak Up concerns easier and more a part of the culture.

	• Assist in minimising those barriers to communication that may prevent those wishing to speak up (in any way) from doing so. Aileen Feeney, Non-Executive Director asked whether there was anything more that Non-Executive Directors could do to support the Freedom to Speak Up function. The Freedom to Speak Up Guardian suggested that as part of Non-Executive Directors' visits to services, they could ask staff about whether or not they felt confident about raising issues and concerns. Mark Day, Freedom to Speak Up Non-Executive Director Lead requested that future reports also included anonymised case study examples as these brought to life the value of the Freedom to Speak Up process. **Action: Freedom to Speak Up Guardian** Mr Day noted that around 20% of the international nurse cohort had raised issues with the Freedom to Speak Up Guardian and said that international nurses were a key element in the Trust's recruitment strategy and requested that the Trust Board be informed about the actions that were being put in place to support international nurses. The Director of People said that she would discuss the issue with the Freedom to Speak Up Guardian to gain a better understanding about the issues being raised by the international nurses and would inform the Trust Board about the actions being taken to address the concerns of international nurses. **Action: Director of People** Mr Day said that he was encouraged that the Freedom to Speak Up Champion Network had been refreshed and that 35% of the Champions were declared staff network members and 35% had also raised concerns with the Guardian prior to becoming a Champion. The Chief Operating Officer commented that the Freedom to Speak Up Guardian was very visible and was well regarded by staff across the Trust. Sally Glen, Non-Executive Director noted that there were four patient safety concerns raised with the Guardian and asked whether there were any particular theme(s) raised. The Director of Nursing and Therapies confirmed that the concerns related to different areas and that there were no themes. It was noted that all patient safety concerns were investigated and followed up. Naomi Coxwell, Non-Executive Director commented that three out of four individuals who had raised a concern had moved jobs and suggested that individuals moving jobs may not be addressing the underlying issues. The Freedom to Speak Up Guardian said that moving jobs was not a desired outcome but pointed out that there were occasions when an individual was seconded out of a service whilst an investigation was undertaken. It was noted that there were also instances when someone had moved jobs within the Trust due to career progression etc. The Freedom to Speak Up Guardian said that he was discussing with the Director of People how best to support both the person raising a concern and the manager whilst an investigation was being undertaken. The Director of People added that moving an individual to another area was sometimes the right thing to do because this was requested by the individual but agreed that the person raising the concern should not always be the person who was moved.

	Rebecca Burford, Non-Executive Director said that it took courage for an individual to speak up and asked whether these individuals were contacted twelve months later, particularly those who had changed jobs to find out whether they had experienced any longer-term effects from speaking up. The Freedom to Speak Up Guardian said that the Trust encouraged individuals to give feedback on their experience of using the Speaking Up process and the outcome but confirmed that once the case was closed, there was no further follow up. Ms Burford asked whether there was scope to build in a process to identify any longer lasting effects of individuals speaking up and suggested that asking individuals whether or not they would use the speak up process again would be a helpful measure to assess the effectiveness of the speak up process. The Freedom to Speak Up Guardian thanked Ms Burford for her suggestion and agreed to consider introducing a longer-term feedback process. **Action: Freedom to Speak Up Guardian** The Chair thanked the Freedom to Speak Up Guardian for the work he did and thanked the Trust Board for their suggestions about how to make the speak up process even better. **The Trust Board**: a) Noted the report. b) Supported the Freedom to Speak Up Guardian's areas of focus. c) Requested that the Director of People report back to the Trust Board about any actions being taken to support the Trust's International Nurses d) Requested that the Freedom to Speak Up Guardian consider introducing a 12-month feedback process to assess any longer-term impacts of speaking up. e) Requested that the Freedom to Speak Up Guardian include anonymised case study examples in future reports.
23/118	**a) Freedom to Speak Up Review Tool for NHS Trusts and Foundation Trusts** (agenda item 6.2)
	The Director of Nursing and Therapies reported that the Freedom to Speak Up Review Tool was designed to assist Boards in undertaking a self-assessment of the Trust's Freedom to Speak Up systems and processes and to ensure that these were in line with NHS England and the National Guardian's Office requirements as detailed in: ''Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts''. It was noted that the review tool was completed in draft by the Director of Nursing and Therapies and Mark Day, Non-Executive Director Lead for Freedom to Speak Up and was discussed at the May 2023 Trust Board In Committee meeting. **The Trust Board**: approved the Freedom to Speak Up Review Tool Self-Assessment in relation to the Trust's Freedom to Speak Up systems and processes.
23/119	**b) Freedom to Speak Up Strategy 2023-2026** (agenda item 6.2)

	The Director of Nursing and Therapies reported that the Freedom to Speak Up Strategy 2023-26 was a refresh of the 20219-23 Strategy and had been developed in collaboration with the staff networks and with staff from across the Trust. It was noted that the aim of the Strategy was to support the Trust's ongoing improvement journey in achieving an environment where staff felt safe and were encouraged to speak up and which also embedded a culture of managers and leaders listening up and following up of any concerns raised. The Director of Nursing and Therapies said that the refreshed Freedom to Speak Up Strategy was aligned with the Trust's Three-Year Strategic Plan as well as with the People and Equality, Diversity and Inclusion Strategies. Sally Glen, Non-Executive Director referred to the earlier discussion on the Freedom to Speak Up Guardian's Report which had highlighted that five International Nurses had approached the Guardian to discuss issues that they were facing and/or to raise a concern. Ms Glen asked whether the Freedom to Speak Up Strategy should include a specific section on supporting International Nurses. The Director of Nursing and Therapies pointed out that the model of community and mental health services did not exist in many other countries and said that the international nurses sometimes found working outside of the more familiar acute hospital setting more challenging and that these tended to be the issues raised with the Freedom to Speak Up Guardian. **The Trust Board**: approved the Freedom to Speak Up Strategy 2023-26.
23/120	**Annual Complaints Report** (agenda item 6.3)
	The Director of Nursing and Therapies reported that the information contained in the Annual Complaints Report had been presented to the Trust Board throughout the last year as part of the quarterly Patient Experience Reports where more detailed analysis of patient experience data was provided. It was noted that it was a statutory requirement for NHS provider organisations to present an Annual Complaints Report to the Trust Board. The Director of Nursing and Therapies reported that there were slightly more formal complaints received during 2022-23 (240 compared with 231 formal complaints received in 2021-22) but there had also been more patient contacts during the last year. Sally Glen, Non-Executive Director asked whether the complaint themes set out in table 2 of the report were nationally mandate and drew attention to the fact that sexual safety was included within the "alleged abuse, bullying, physical sexual and verbal" category. The Director of Nursing and Therapies confirmed that the complaint categories were nationally prescribed but pointed out that the Quality Assurance Committee received a six-monthly Sexual Safety report which provided more detail about all sexual safety incidents, not just those which were the subject of a formal complaint. The Chair said that it would be helpful if table 2, which sets out the themes of complaints received could be expanded to include the number of upheld, partially upheld and not upheld complaints. **Action: Director of Nursing and Therapies**

	The Trust Board: noted the report.
23/121	**Medical Appraisal and Revalidation: Annual Report** (agenda item 6.4)
	The Medical Director reported that the Medical Appraisal and Revalidation Annual Report 2022-23 was presented in the standard format prescribed by NHS England. The Medical Director confirmed that there were no outstanding actions from 2021-22 and no risks or issues had been identified. It was noted that the e-appraisal platform introduced since April 2022 had been successful and was working well. **The Trust Board:** a) Noted the assurance provided by the Medical Director (Responsible Officer for Revalidation) that the Trust's medical appraisal and revalidation processes were compliant with the regulations and were operating effectively within the Trust. b) Approved the Trust Chair signing the Statement of Compliance
23/122	**Quality Assurance Committee** (agenda item 6.5)
	The minutes of the Quality Assurance Committee meeting held on 30 May 2023 together with the Learning from Deaths and Guardian of Safe Working Hours Quarterly Reports had been circulated. **The Trust Board:** a) Noted the minutes of the Quality Assurance Committee held on 30 May 2023 b) Noted the Learning from Deaths Quarterly Report c) Noted the Guardian of Safe Working Hours Quarterly Report.
23/123	**Executive Report** (agenda item 7.0)
	The Executive Report had been circulated. The following items were discussed further: **a) NHS Workforce Plan** The Chair commented that whilst he was pleased about the government's commitment to invest in more nurse training, he was concerned that the government's figures for the expected increase in the number of new nurses may be over-ambitious based on the number of nurses currently choosing nursing as a degree. The Chief Executive said that there was also a concern about the number of student nurses the Trust could absorb. It was noted that many of the local university places for nursing degrees were filled via the clearing system. The Chief Executive said that the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board were developing a workforce model based on the NHS Workforce

	Plan in order to gain a better understanding about what it meant in terms of any areas of unfunded additional costs. The Chair also pointed out that the national messaging on the government's ambition around reducing the number of overseas nurses was not helpful as trusts would need to rely on overseas recruitment for the short to medium term. The Chief Executive pointed out that non-clinical staff were not included as part of the NHS Workforce Plan. The Chief Executive added that if the NHS Workforce Plan was to be realised, NHS provider organisations would need to invest in digital, change their estate and shift the focus of care away from the acute sector to the community as well as increasing productivity. **b) NHS Staff Sickness** Aileen Feeney, Non-Executive Director asked for more information about the reasons for the record level of NHS staff sickness. The Chief Executive pointed out that the Trust's sickness absence level was much lower than the national level, especially for a mental health provider which tended to have a higher level of staff sickness and reminded the meeting that the Trust had invested in a number of wellbeing schemes to support staff. It was noted that national funding for staff wellbeing hubs had been withdrawn, but the Trust had made a commitment to continue with its own staff health and wellbeing support. The Director of People reported that the Frimley Integrated Care Board was looking at staff sickness at a system level in terms of the degree to which health inequalities were impacting on staff. **The Trust Board**: noted the report.
23/124	**Disability Pay Gap Report** (agenda item 7.2)
	The Director of People reported that in contrast to Gender Pay Gap reporting, the Trust was not required to report on the Disability Pay Gap. The Disability Pay Gap was the difference between the average pay of disabled and non-disabled staff in an organisation. It was noted that the Trust had also taken a decision to report on the Ethnicity Pay Gap. The Director of People reported that the Trust's Median Disability Pay Gap in 2022-2023 was 4.95%**.** This meant that on average that disabled colleagues earned £0.72p more than our non-disabled colleagues. In comparison, the latest 2021 Office of National Statistics stated that the disability pay gap was 13.8% for the United Kingdom. The Chair commented that he was pleased that the Trust had taken the decision to report on the Ethnicity Pay Gap and Disability Pay Gap alongside the mandated reporting of the Gender Pay Gap. **The Trust Board**: noted the report.
23/125	**Month 02 2122-23 Finance Report** (agenda item 8.0)

	The Chief Financial Officer presented the report and highlighted the following points: • The Trust had a financial plan for a £1.3m surplus as part of the agreed plan for the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System • The Trust was reporting a £0.1m deficit against a year-to-date deficit plan of £0.5m. • The Trust's cash balance was below plan at £47.6m but this was expected to recover once the Integrated Care Board's contract payment values were updated for 2023/24 • There was an emerging financial pressure related to the 2023/24 pay award and risk around the clawback of Elective Recovery Funding later in the year. The Trust had flagged the funding formula risk with both the Integrated Care System and with NHS England • NHS England had introduced a new agency expenditure ceiling which applied at a system level and was set at 3.7% of total pay bill for 2023/24. The Trust was currently achieving this target on an individual Trust basis with Agency spend around 2.8% of overall pay costs year to date. • Delivery against the Cost Improvement Programme was on track linked to control total compliance. Detailed Cost Improvement Programme reporting would be included from next month. • The Trust was reporting £0.4m capital spend year to date. Sally Glen, Non-Executive Director reported that she had recently visited Prospect Park Hospital and noted that the new Place of Safety had been delayed until next year and asked whether there were any patient safety issues because of the delay. The Chief Financial Officer explained that the delay in building the new Place of Safety was due to the additional work being undertaken in order to finalise the application for the Deed of Variation which had now been issued to the PFI funding provider and which was expected to be approved towards the end of the calendar year. The Medical Director confirmed that there were no immediate patient safety issues because of the delay but said that there were continuing issues around capacity and patient dignity with regards to the current Place of Safety. **The Trust Board**: noted the report.
23/126	**Month 02 2122-23 "True North" Performance Scorecard Report** (agenda item 8.1)
	The Chief Financial Officer presented the paper and highlighted the following points: • There was a new driver metric for 2023-24, Clinically Ready of Discharge • The incidence of self-harm incidents on Mental Health Inpatient wards (excluding the Learning Disability Unit) was RAG rated Green for the last three months. Further work was being undertaken to understand the trend before making any adjustment to the target. • Staff turnover had been RAG rated Green for the last four months. • The Trust had agreed stretched targets in relation to the Efficient Use of Resources metrics and most of these indicators were RAG rated Red. The Chair referred to the Executive Report (earlier on the agenda) which included a section the record level of NHS Staff Sickness during 2022 and commented that he was

	pleased that although the Trust's staff sickness absence performance was higher than the Trust's target, performance was significantly better than the national position. The Chair requested that the Trust Board receive a definition of what was meant by "Clinically Ready for Discharge." **Action: Chief Financial Officer** **The Trust Board**: noted the report.
23/127	**People Strategy and Equality, Diversity and Inclusion Strategy Update Report** (agenda item 9.0)
	The Chair welcomed The Director of People to the meeting. The Director of People said that the report gave an overview of the progress against objectives for the People Strategy including the people elements of the Trust's Equality, Diversity and Inclusion Strategy. The Director of People said that the report gave an overview of the Trust's People and Equality, Diversity and Inclusion (people elements) Strategies' programmes of work and the progress that had been made. The Director of People reminded the Trust Board that the People and Equality, Diversity and Inclusion Strategies would be refreshed next year and would take account of the NHS Workforce Plan. The Director of People reported that the Trust's anti-racism work was progressing well with the Anti-Racism Strategy and Action Plan in final consultation with key stakeholders. It was noted that Frimley Integrated Care Board was using the Trust as an exemplar for its anti-racism work. Sally Glen, Non-Executive Director commented that her impression from talking to front line staff was that Band 5 nurses were leaving the Trust in order to progress to Band 6 roles and asked about the Trust's work to make it easier for Band 5 Nurses to progress to Band 6. The Director of People explained that the Turnover Rapid Improvement Event had identified that one of the reasons why Band 5 Nurses left the Trust was to take up Band 6 roles elsewhere. The Director of People reported that the Trust's Clinical Education Team was working on a competency-based progression model whereby the Trust would identify pools of staff who were ready for a move to their next pay band. This work had started with defining the competencies and behaviour which would indicate that Band 5 physical health nurses would be ready to progress to Band 6 roles rather than advertising these roles externally. **The Trust Board**: noted the report.
23/128	**Anti-Racism Strategy Report** (agenda item 9.1)
	The Chair welcomed the Head of Inclusion to the meeting. The Deputy Chief Executive introduced the item and explained that being anti-racist meant actively opposing racism by advocating changes that would promote racial equity. The

	Deputy Chief Executive added that whilst most people would not consider themselves to be racist or hold racist views, anti-racism required positive action to oppose racism in all its forms. The Deputy Chief Executive said that the Workforce Race Equality Standard (WRES) results had identified that there was a differential of experience between staff from Black and Asian Minority Ethnic backgrounds compared with white staff and the Trust Board acknowledged that not enough progress was being made around reducing the differentials in experience and that persistent and unacceptable disparities remained. It was noted that in the journey of becoming an anti-racist organisation, the Trust Board had held an anti-racist workshop with the Race Equality Network Chair and members of the Equality, Diversity and Inclusion team. A key output from the workshop was that the Trust Board committed to becoming an anti-racist organisation and outlined its desire to communicate its anti-racism intent by developing a Trust Action Statement. The Trust held a number of anti-racism engagement workshops with staff and community leaders during the spring which developed a number of actions to support the Trust's Anti-Racism Strategy. The Chair referred to the proposed Action Statement (page 256 of the agenda pack) and asked for any comments. Rebecca Burford, Non-Executive Director commended the Trust for developing an Anti-Racist Strategy and commented that not everyone was clear about the difference between not being racist and anti-racism and suggested that the Action Statement be amended to make the difference more explicit. The Chief Executive said that it was important that the communication around the Trust's Anti-Racism work used simple and clear language and was backed up with demonstrable actions that were meaningful to both staff and the public. The Chief Executive agreed with Rebecca Burford that the Action Statement should be more explicit around what was meant by anti-racism. **Action: Deputy Chief Executive** Rebecca Burford referred to the section in green on the action statement and pointed out that changing organisational culture required a strong top-down commitment from the top of the organisation. Sally Glen, Non-Executive Director added her support for the Trust's Anti-Racism Strategy and asked whether the intention was to bring together the Trust's anti-racism work with the work around reducing health inequalities. The Deputy Chief Executive confirmed that the Trust was currently developing the scope of its Health Inequalities Strategy and had agreed to take a corporate approach to the work. The Chair said that there needed to be a process developed around how the Trust Board gained assurance that the population served by the Trust had equity of access to treatment and equity in terms of outcomes. **Action: Deputy Chief Executive** The Chair strongly supported the Chief Executive's views around the importance of keeping the language simple and making sure that the Anti-Racism Strategy was converted into meaningful actions.

	On behalf of the Trust Board, the Chair thanked the Deputy Director for Inclusion, Leadership and Organisational Experience and the Head of Inclusion for their work around developing the Trust's Anti-Racism Strategy. **The Trust Board**: a) Noted the Report b) Approved the Trust's Anti-Racism Strategy and proposed action statement subject to the comments made by the Trust Board in relation to keeping the language simple and making what was meant by anti-racism more explicit in the action statement.
23/129	a) **Digital Strategy Update Report** (agenda item 9.2)
	The Chair welcomed the Chief Information Officer to the meeting. The Chief Information Officer reported that the implementation of the Digital strategy was broadly in line with the plan agreed in December 2021. The Chair commented that a key reason for the Trust investing in digital was to make nurses and other clinicians as efficient as possible so as to free up more time for patient care. The Chief Information Officer agreed and commented that the Trust's investment in the shared care records system (Connected Care) back in 2019 had significantly increased productivity. Sally Glen, Non-Executive Director asked how the Trust managed the interface between the IT specialists and the clinical leads. The Chief Information Officer explained that a significant proportion of the IT specialists had a clinical background before they trained in digital technologies. It was noted that for major projects a senior clinical leader would chair the project board, such as for the implementation of the Electronic Prescribing and Medicines Management (EPMA) system, the Chief Pharmacist is the chair of the project board. The Chief Operating Officer commented that initiatives such as Virtual Wards had the potential to significantly change the traditional model of care and said that the Trust would need to reconcile its strategic ambitions around using more digital technologies with its risk appetite. The Chair referred to page 281 of the agenda pack and asked whether being part of two integrated care systems was hindering the Trust's digital ambitions. The Chief Information Officer said that there was significant variation in terms of digital maturity across individual integrated care system partners and said that there was a danger that this created silo working. However, it also gave the Trust the opportunity to spread best practice between the two integrated care systems. The Chief Information Officer said that the Trust's software development requirements tended to be small scale and therefore the Trust would usually procure software from a UK company. Many of these then sub-contracted development work to other countries, for instance EMIS had a development team based in India.

	The Trust Board: noted the report.
23/130	b) **Digital Maturity Assessment Report** (agenda item 9.2)
	The Chief Information Officer presented the report and highlighted the following points: • In August 2021, NHS England published the NHS Digital What-Good-Looks-Like framework. The seven success measures ranged from leadership and strategy to underlining infrastructure. The themes included well-led, ensuring smart foundations, safe practice, supporting people, empowering citizens, improving care, and healthy populations. • All Trusts were mandated to take part in a national digital maturity assessment process from January-June 2023. Each Trust had a score on the maturity scale between 1 and 5 (most mature). • The Trust's overall score was 3.5. The Trust was the seventh most mature NHS Trust in the country and the second most mature in the Mental Health Trust cohort. • There would be opportunities to increase the Trust's maturity index over the coming years. Some areas of focus coincided with the Trust's Digital Strategy, others would require significant organisational change to achieve. Key domains for improvement opportunities were around Empowering our Patients, Improving Care and Healthy Populations. Aileen Feeney, Non-Executive Director asked for more information about the opportunities to increase the Trust's digital maturity index over the coming years. The Chief Information Officer explained that outside of the Trust's Digital Strategy, some additional elements of enhanced digital maturity would require a significant organisational shift, for example, patient self-triage, self-referral and growth around public health/prevention etc. The Chief Information Officer said that it was important that the Trust focused its efforts on improving services for its patients rather than making changes just to increase its digital maturity score. The Chair said that it would be helpful if the Executive Team could review the NHS Digital What Good Looks Like Framework and put it into the context of the Trust's wider Strategy so that the Board could have a further discussion around the opportunities for using digital to enhance patient care. **Action: Deputy Chief Executive/Chief Financial Officer** **The Trust Board**: a) Noted the report. b) Agreed to have a further discussion around the opportunities as set out in the NHS Digital What Good Looks Life Framework for using digital to enhance patient care.
23/131	**Audit Committee Meeting Held on 23 June 2023** (agenda item 10.0)
	The Audit Committee minutes of the meeting held on 23 June 2023 had been circulated.

	The Trust Board: noted the minutes of the Audit Committee meeting held on 23 June 2023.
23/132	**Council of Governors Update** (agenda item 10.1)
	The Chair reported that following there were a number of new governors following elections for public and staff governors and changes to the local authority appointed governors following the local elections. The Chair reported that the Joint Non-Executive Directors and Council of Governors meeting on 19 July 2023 would be a face to face/hybrid meeting which would be followed by a face-to-face training session facilitated by NHS Providers.
23/133	**External Well-Led Report and Action Plan** (agenda item 10.2)
	A copy of the Trust's External Well-Led Governance Review Report together with an action plan in response to the conclusions/recommendations had been circulated. **The Trust Board:** a) Agreed the action plan in relation to the External Well-Led Review Report; and b) Requested that the Company Secretary report on the progress made to implement the actions in six months' time. **Action: Company Secretary**
23/134	**Trust Seal Report (**agenda item 10.3)
	The Chief Financial Officer reported that the Trust's Seal had been affixed to an agreement for the Trust to enter into two 10-year leases with Wokingham Brough Council for a retail unit at 20 Denmark Street and the part ground floor and first floor offices at Resource House, Wokingham. The Leases will be entered into following completion of the Landlord's refurbishment works. The lease acquisitions are to provide alternative accommodation in central Wokingham for the CMHT and other services that need to be relocated from The Old Forge, before our leases expire in October 2023. It will include the integrated health and social care team that will occupy circa 50% of the space. **The Trust Board**: noted the report.
23/135	**Any Other Business** (agenda item 11)
	There was no other business.
23/136	**Date of Next Public Meeting** (agenda item 12)
	The next Public Trust Board meeting would take place on 12 September 2023.

23/137	**CONFIDENTIAL ISSUES:** (agenda item 13)
	The Board resolved to meet In Committee for the remainder of the business on the basis that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.

I certify that this is a true, accurate and complete set of the Minutes of the business conducted at the Trust Board meeting held on 11 July 2023.

Signed…….. Date 12 September 2023

(Martin Earwicker, Chair)

NHS
Berkshire Healthcare
NHS Foundation Trust

Individual Placement & Support employment service

Board meeting 11 July 2023: About how we work together

Gurpreet Athwal, IPS employment specialist (Bracknell CMHT)
Aaron Slingerland, IPS client
Maggie Gibbons, IPS team lead

Care Quality Commission Inspected and rated Outstanding

ARMED FORCES COVENANT

Diversity and Inclusion Bringing us together

The problem

Employment rates for people with severe mental health issues are **unacceptably low**

70-90% of people with mental health issues would like to work, but only **37%** are in paid employment

And, for people with severe mental health issues, that's just **8%**

How does IPS address this problem?

Overwhelming research evidence that, comparing **individual placement and support** to traditional employment support:

- Time to first job is 50% **faster**
- Average weeks worked per year are more than **double**
- Pay is **higher**
- **Twice** the rate of job outcomes
- Clients **sustain jobs for longer**
- Clients have **reduced symptoms**, **reduced relapses** and spend **fewer days in hospital**

Eight key principles of IPS

1. Competitive paid employment is the primary goal
2. Everyone who wants to work is eligible (zero exclusion)
3. Job search is based on client preferences
4. Rapid job search
5. Employment specialists are integrated into clinical teams:
    - Access and update clinical notes
    - Attend weekly/fortnightly clinical team meetings
    - Have clinical supervision in their localities… but are not clinicians
6. Support is time-unlimited
7. Benefits advice is included
8. Employer engagement – before and after clients gain a job

A little about IPS at BHFT

We are team of 12 employment specialists, two coordinators (east/west) and three team leads, working alongside **any** clients of Berkshire Healthcare who have severe mental health issues and **wish to gain, sustain or retain rewarding, paid employment**. We have been running since 2015.

Each employment specialist holds a caseload of 20 at any one time and is expected to work with 45 clients over a year. Employment specialists are embedded in locality/service clinical teams.

We strongly see ourselves as fulfilling the organisation's mission to **maximise independence and quality of life.**

Over to Gurpreet and Aaron…

Berkshire Healthcare NHS Foundation Trust

BOARD OF DIRECTORS MEETING 12.09.23

Board Meeting Matters Arising Log – 2023 – 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
13.09.22	22/150	Performance Report	The Performance Report to re-introduce the information about the number of individuals who made up the self-harm incidents.	September 2023	**PG**	Action completed	
13.09.22	22/150	Performance Report	The Finance, Investment and Performance Committee to receive an update on the project on reducing the average length of stay for mental health patients	October 2023	**TA**	An update to be presented to the Finance, Investment and Performance Committee in October 2023.	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
13.12.22	22/224	People and EDI Strategies Update Report	A paper on which options were most success in terms of addressing the Trust's workforce challenges to be presented to a future FIP Committee meeting.	July 2023	**JN**	The Workforce Plan was presented to the July 2023 Finance, Investment and Performance Committee meeting.	
13.12.22	22/228	Trust's Constitutional Changes	The changes to the Trust's Constitution to be ratified at the next Annual Members' Meeting in September.	September 2023	**JH**	The changes relating to members/governors will be presented to the AGM for ratification.	
11/04/23	23/052	Trust's Green Plan	The new Sustainability Manager to be invited to attend a future Trust Board meeting to share their perspectives and to help the Board to understand which actions were likely to deliver the most benefit in terms of the Green Agenda.	TBC	**PG**	The meeting date to be confirmed.	
11.07.23	23/117	Freedom to Speak Up Guardian Report	future Freedom to Speak Up Guardian Reports to include anonymised case study reports.	December 2023	**MC**		
11.07.23	23/117	Freedom to Speak Up Guardian Report	The Director of People to discuss the nature of concerns raised by the	September 2023	**JN**	Completed. The Director of People and the Freedom to Speak	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
			Trust's International Nurses			Up Guardian discussed the issue and the Freedom to Speak Up Guardian will attend the International Nursing Recruitment Group meeting to agree how we support international nurses better.	
11.07.23	23/117	Freedom to Speak Up Guardian Report	The Freedom to Speak Up Guardian to consider whether or not to introduce a longer term feedback mechanism for people who have used the Speak Up process.	September 2023	**MC**	In addition to the current process of obtaining feedback on the Speak Up process once a case is closed (from a FTSU point of view), further feedback will be sought 9 months thereafter and timed so as to provide any addition learning to the bi-annual FTSU Board Report.. In addition to this the Guardian will provide	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
						figures on staff turnover for those who have used the process	
11.07.23	23/120	Annual Complaints Report	The Director of Nursing and Therapies to consider adding an additional column in Table 2 in the report which set out the complaint themes to indicate the number of complaints which were upheld, partially upheld and not upheld.	July 2024	**DF**		
11.07.23	23/126	Performance Report	The Trust Board to be provided with a definition of what was meant by "Clinically Ready for Discharge".	September 2023	**PG**	Once a patient is deemed to require no further assessment, intervention or treatment, they are deemed 'clinically ready' or 'medically optimised' for discharge to another location, usually, but not always their home. There are a number of reasons why a patient may not be able to leave the	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
						hospital setting. The responsibilities are varied within the health system from NHS, Local authority, commissioner etc from equipment, funding or bed placement. The delays occur when the criteria for a safe discharge are not met and these become an 'official' delay. This causes flow issues within the hospital/system, which has a knock ion effect potentially on Out of Area Placements.	
11.07.23	23/128	Anti-Racism Strategy	Simple and clear language to be used in communications around the Trust's Anti-Racism Strategy and the action statement to be more explicit around what was meant by being	September 2023	**AG**	Action statement was updated after feedback from the July Trust Board meeting. External facing communication	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
			anti-racist.			has been prepared for The Trust's website and internal engagement materials including, the Trust Leaders Forum presentation on 8th September 2023.	
11.07.23	23/128	Anti-Racism Strategy	A process to be developed to provide assurance to the Trust Board that the population served by the Trust had equity of access to treatment and equity in terms of outcomes.	September 2023	**AG**	The October 2023 Trust Board Strategic Planning meeting will include an update on proposed Trust wide Health Inequalities programme, including key elements required to provide the building blocks of Board assurance i.e. that inequalities are identified and acted upon as matter of usual Trust business routinely utilising inequalities information. As Trust wide, meaningful use	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
						of Equality Impact Assessments develops covering strategic initiatives, projects and service developments, further assurance will be provided.	
11.07.23	23/130	Digital Maturity Assessment Report	The Executive Team to review the NHS Digital What Good Looks Like Framework and put it into the context of the Trust's wider Strategy so that the Board could have a further discussion about the opportunities for using digital to enhance patient care.	September 2023	**AG**	Assessment of NHS Digital's What Good Looks Like (WGLL) framework has been undertaken and is the context for the Trust and Digital strategies. Strategic choices on where to prioritise investment to close "on paper" WGLL and digital maturity gaps will be kept under review. There is an opportunity to discuss digital at the October 2023 Trust Board Strategic Planning	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
						session.	
11.07.23	23/133	External Well Led Report and Action Plan	The Company Secretary to update the progress in implementing the Well-Led Review Action Plan in six months' time.	December 2023	**JH**		

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Meeting Date	12 September 2023
Title	Patient Experience Highlight Report Quarter 1 (April – June 2023)
	Item 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 1
Business Area	Nursing & Governance
Author	Elizabeth Chapman, Head of Patient Experience
Relevant Strategic Objectives	True North goals of harm free care, supporting our people and good patient Experience
CQC Registration	Supports maintenance of CQC registration
Resource Impacts	N/A
Legal Implications	N/A
Equality, Diversity and Inclusion Implications	N/A
SUMMARY	The attached report highlights the key facts from the quarterly patient experience report. The Trust Board agenda for Board Members includes links to the full patient experience report and appendices detailing complaints and Patient Advice and Liaison Service information, 15-steps Visits undertaken during the quarter and the detail of formal complaints closed during the quarter (the Board pack on the Trust's website includes the reports in full with no links).
ACTION REQUIRED	The Board is asked to: Note the report.

Highlight Patient Experience Report
Quarter one 2023/24

1. Why is this coming to the Board?

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

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

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

2. What are the key points?

The iWGC tool enables patients to provide a review of their experience using a 5-star rating for several areas(facilities, staff, ease, safety, information, involvement and whether the person felt listened to) as well as making suggested improvements. The trust has an ambition as part of the Trust strategy to increase the volume of feedback received over the next 3 years to 10% and also to increase the use of the information received to support improvement. All divisions have a performance metric that they are monitoring to improve levels of feedback. For our Mental health wards there is also work in progress to identify alternative ways of capturing patient experience.

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

Patient Experience – overall Trust Summary		Target	Qtr. 1		Qtr. 2	Qtr. 3	Qtr. 4
Total patient contacts recorded (inc discharges from wards)	Number		216,579				
Number of iWGC responses received	Number	**16,000** (based on Q1 contact)	6,450	↑			
iWGC Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	**7.5%** by Mar '24	3%	↔			
iWGC 5-star score	Number	**4.75**	4.71	↑			
iWGC Experience score – FFT (good or very good experience)	%	**95%**	93.8%	↑			
Compliments received directly by services	Number	Total 22.23 **4522**	1091	↑			

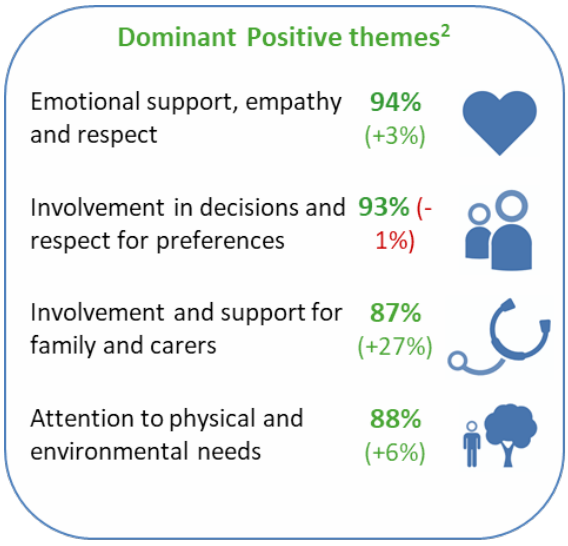
Patient Experience – overall Trust Summary		Target	Qtr. 1		Qtr. 2	Qtr. 3	Qtr. 4
Formal Complaints received	Number	Total 22/23 **240**	68	↑ 1*			
Formal Complaints Closed	Number	Total 22/23 **247**	53	2*			
Formal complaints responded to within agreed timescale	%	**100%**	100%	↔			
Formal Complaints Upheld/Partially Upheld	%	Total 2022/23 **56%** total complaint	62%	↑			
Local resolution concerns/ informal complaints Rec	Number	Total 2022/23 **134**	36	↑ 3*			
MP Enquiries Rec	Number	2022/23 total **88**	24	↔			
Complaints upheld/ partially by PHSO	Number	Total 2022/23 **0**	0	↔			

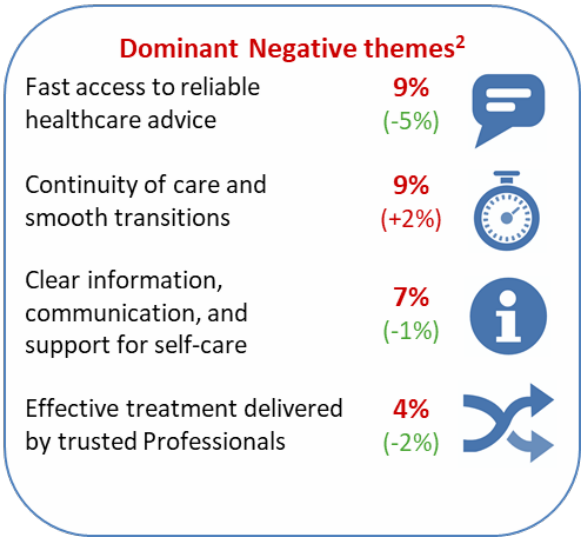
1*Increased from Q4 but within quarterly control limits based on previous quarters over last year
2* Lower than Q4 but less complaints opened in Q4 will result in less to close in Q1
3* increased from Q4 but within quarterly control limits based on previous quarters over last year

There are no significant changes identified in analysis of data that differs from previous reports, the highest number of complaints related to specific care and treatment concerns and the largest volume of MP enquires (15) relates to wait times within CAMHS services (Neurodiversity pathway) for which there is internal work to maximise efficiency and also external conversations in terms of resourcing.

There is work being undertaken across all divisions in relation to highlighted learning and improvements; examples of feedback alongside 'you said, we did' improvements can be found in the full report accessed through the hyperlink.

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





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

We aim to receive feedback that is representative of the diversity across the population. The below table shows the split of both complaint and survey responses by ethnicity. In terms of gender, we see a comparable gender split in terms of complaints in relation to attendances and a lower percentage of men but higher percentage of those identifying as non-binary/ other completing the survey.

Ethnicity	% Complaints received	% Patient Survey Responses	% Breakdown of attendances
Asian/Asian British	5.88	7.95	9.67%
Black/Black British	2.94	3.21	2.67%
Mixed	1.47	2.39	3.49%
Not stated	2.94	10.11	15.89%
Other Ethnic Group	2.94	7.21	1.62%
White British	83.82	69.14	66.66%

4. Conclusions and Recommendations for consideration by the Board

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

There has been a continual increase not only in the number of responses received through the patient experience tool but also in the use of this information for improvement across services. Board members should continue, as part of their contact with services to explore how patient feedback is being used for improvement.

Patient Experience Report Quarter 1 2023/24

Introduction

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

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

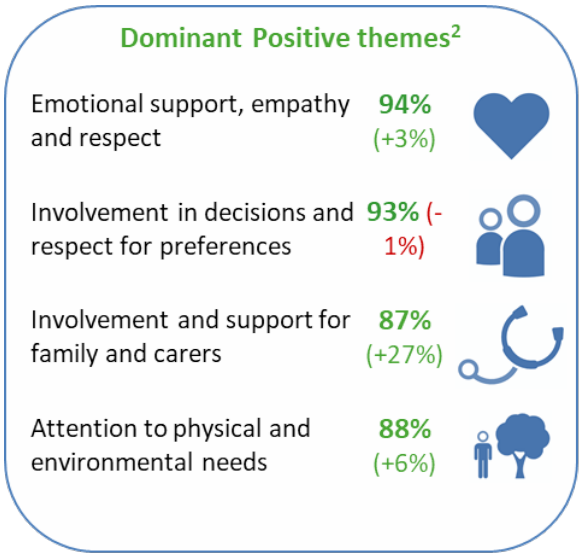
The iWCG tool is used as our primary patient survey programme and is offered to patients following a clinical outpatient contact or, for inpatient wards, on discharge via a variety of platforms. The tool uses a 5-star rating which is comparable across all services within the organisation and is based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

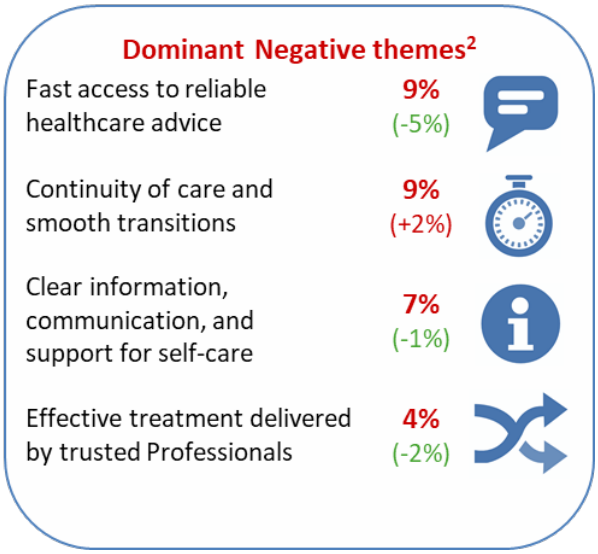
Table 1

Patient Experience – overall Trust Summary		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Total patient contacts recorded (inc discharges from wards)		216,579			
Number of iWGC responses received	Number	6,450			
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	3%			
iWGC 5-star score	Number	4.71			
iWGC Experience score – FFT	%	93.8%			
Compliments received directly by services	Number	1091			
Formal Complaints Rec	Number	68			
Number of the total formal complaints above that were secondary (not resolved with first response)		11			
Formal Complaints Closed	Number	53			
Formal complaints responded to within agreed timescale	%	100%			
Formal Complaints Upheld/Partially Upheld	%	62%			
Local resolution concerns/ informal complaints Rec	Number	36			
MP Enquiries Rec	Number	24			
Complaints open to PHSO	Number	3			

There are no significant changes identified in analysis of data that differs from previous reports, the highest number of complaints related to specific care and treatment concerns and the largest volume of MP enquires (15) relates to wait times within CAMHS services (Neurodiversity pathway) for which there is internal work to maximise efficiency and also external conversations in terms of resourcing.

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





Appendices 2 and 3 contain our PALS and Complaints information for Quarter one.

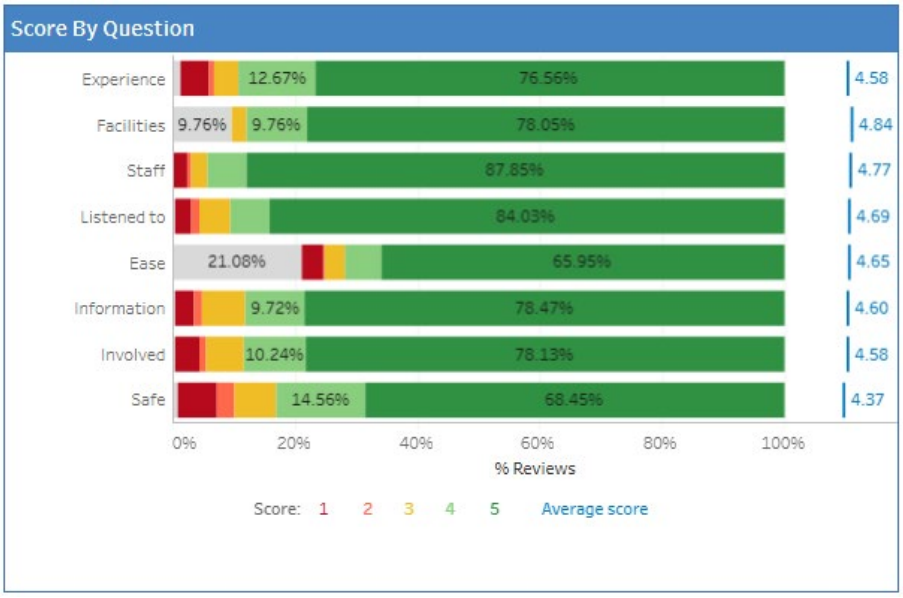
What the data is telling us

Below is a summary and triangulation of the patient feedback we have received for each of our 6 divisions.

Children and Young Peoples division including learning disability services.

Table 2: Summary of patient experience data

Patient Experience - Division CYPF and LD		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	Number	556			
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	2.1%			
iWGC 5-star score	Number	4.59			
iWGC Experience score – FFT	%	89.3%			
Compliments received directly by services	Number	72			
Formal Complaints Rec	Number	14			
Formal Complaints Closed	Number	14			
Formal Complaints Upheld/Partially Upheld	%	93%			
Local resolution concerns/ informal complaints Rec	Number	6			
MP Enquiries Rec	Number	15			



For children's services the iWGC feedback has seen the responses double from last quarter, however, further work needs to continue, young people and parents/carers have been assisting in the ways to promote the new patient experience tool to other service users, including the design and layout of the new posters that will now be used across CYPF services.

Of the 578 responses, 518 responses related to the children's services within the division; these received 90.7% positivity score, with positive comments about staff and services and a few suggestions for further improvement, this included 8 reviews for Phoenix House where comments about staff being caring and compassionate was very positive and there were some suggestions for further improvement regarding support being delayed and lack of communication. 47 of the responses related to learning disability services as detailed below and 11 to eating disorder services.

From the feedback that was received, ease and feeling safe were most frequent reasons for individual questions being scored below 4.

Children's Physical Health Services

There were 4 formal complaints for children's physical health services received this quarter. There were 2 formal complaints about the Speech and Language service. There was also a formal complaint about a young person being vaccinated against the parent's wishes.

486 of the 518 patient survey responses were in relation to children's physical health services. The 2 services with most responses were the Health visiting Bracknell and Immunisation team East; the Health Visiting Bracknell team received 129 of these responses which scored positively receiving a five-star rating of 4.65 and feedback included *We were greeted warmly and the whole experience made us feel comfortable and at ease." "[name removed] helps with all our concern's happy to have this opportunity to seek support and advice" and "Really friendly, understanding of my concerns and gave really sound advice - thank you."*

Children's services have continued to undertake their feedback surveys this quarter for school nursing 50 young people completed the survey , responses included that they were helpful, felt listened to and understanding. There are also some responses that are associated with Health Visiting incorrectly which affects the overall rating for CYPF negatively. We are, along with iWGC looking into this to ensure it is rectified.

Children's services have continued to gain feedback via other methods during this quarter including an online focus group to learn from the experiences of parents/carers and nursery

staff who have attended early years Speech and Language Therapy [SLT] drop-in surgeries in the past. This provided valuable learning detailed in the you said , we did section of this report. The CYPIT East team also attended the “Special Voices” parent group in Slough in February to hold a focus group. Areas of discussion generated included parental involvement, the voice of the child, and a lack of knowledge/understanding about how the CYPIT team operates.

Child and Adolescent Mental Health Services (CAMHS)

For child and adolescent mental health services there were 8 complaints received (these were in relation to care and treatment received, waiting times and medical records; themes around these included failure to medicate, inaccurate records and long wait for treatment). In addition to this, the service received 15 enquiries via MPs, and most of these again related to waiting times.

There have only been 23 responses for CAMHS services received through our patient survey for this quarter. Currently the survey is accessed through paper surveys, online or configured tablets in the departments.

The admin team for CAMHS Getting Help collated feedback from young people who received a service. Experience of Being Referred to a Getting Help Service in the East of Berkshire. They have received 46 responses for this quarter with 38 of the responses describing being satisfied or very satisfied with the referral process (4 of the 46 were dissatisfied / very dissatisfied). As a result of the survey a focus group is planned to gain more detailed understanding of people’s experience.

In addition to the current feedback tools, the anxiety and depression pathway have set up a question on the whiteboard in waiting rooms, asking for feedback and suggestions for young people and their families, there will be a differing question each month.

Compliments for our CAMHS services included “*This is mum, we were one of your crisis counselling families last year. I wanted to let you know how much D is thriving this year and that she is a completely different girl than she was a year ago. She’s back to her old self, her energy and zest for life is back and she’s really happy at school. She breezed through her exams with no stress or anxiety and is absolutely loving athletics which I think does wonders for her mental health, well-being and self-esteem. We valued the support from you last year and I just thought you’d like to hear a positive news story. I wanted to thank you for all you did for D and also for us as parents to help her navigate what was going on for her last year.”*

Learning disability

There was one complaint received this quarter for the Campion Ward regarding care and treatment on the ward.

Overall there were 47 responses for all Learning Disability services from the patient survey received, all responses were for the Community Teams for People with a Learning Disability. These received a 76.6% positive score, this was skewed by 4 responses not having a score; 2 people scored the services as a 1 however there are no comments to understand the reason for this; other feedback included that staff were nice, “Dr. [name removed] communicated on a human level, with humour, and explaining what he was doing..”, “very professional service from all concerned, I manage a service for people with learning disabilities, the service received from the team is excellent, caring and communicative. the client has complex needs and the support managing this has been absolutely fantastic. I am completing this survey on behalf of the client.” and “Good listening, good communication, spending time to examine the client and fast response.”, there were comments for improvements including be polite, listen, explain clearly, waiting time and communication.

Eating disorders

There were no complaints for eating disorders.

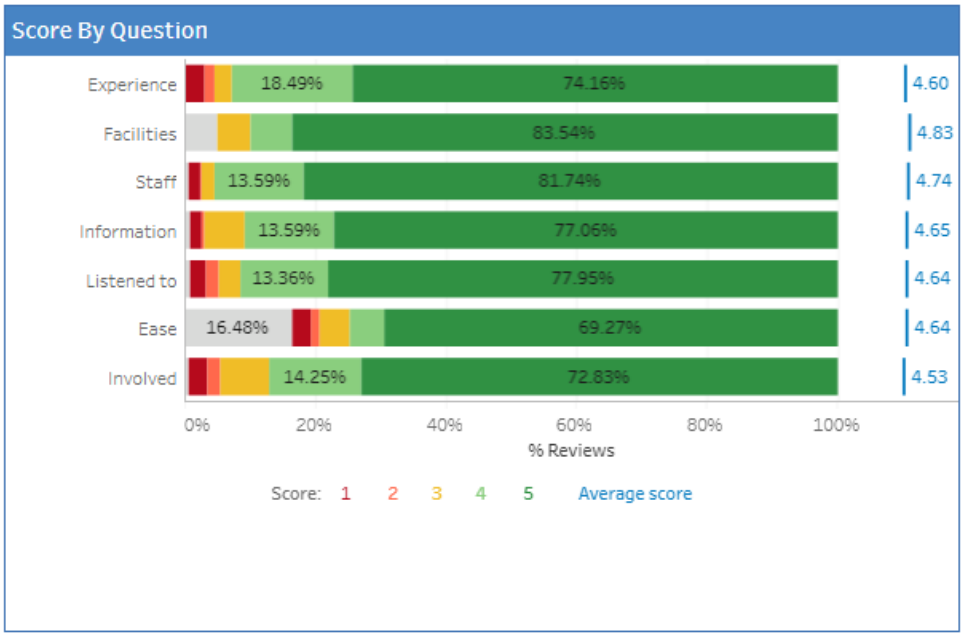
Of the 11 feedback responses received, 9 scored a 5 with comments such as “[name removed] has been absolutely amazing, kind, considerate but firm in order to support me to not only understand more about disordered eating but also how to get well. I will miss her being a part of my life and challenging me to get well. She is incredibly good at her job and I would like to thank her for supporting me to improve my life as significantly as she has. I feel like a different person and I am so so grateful. Thank you”, “[name removed] was AMAZING. Couldn't have been happier to be paired up with her. She went above and beyond to help in any way possible with my journey.”, ”I attended the day programme and without their dedicated help and support. I would not be on my path to recovery. The staff always put us first.”.

The services also have other methods of collating feedback to support service improvement including that The Berkshire PEACE team (Pathway for Eating Disorders and Autism Developed from Clinical Experience) have been running the parent participation groups, with parents invited from Berkshire, Buckinghamshire, and Oxfordshire. The February group took place online via MS Teams and 8 parents attended. Within Adult BEDs [Berkshire Eating Disorder service] have a good system in place of feeding back from the individual groups from day programme, individual first steps group, as well as continuing to regularly review day programme every 3 months. The service users have identified areas for improvement; including more information/ transparency of services and treatments at the point of assessment/ first steps group.

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

Table 3: Summary of patient experience data

Patient Experience - Division MHE		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	**Number**	449			
Response rate (calculated on number contacts)	**%**	2.7%			
iWGC 5-star score	**Number**	4.64			
iWGC Experience score - FFT	**%**	92.7%			
Compliments received directly by services	**Number**	37			
Formal Complaints Rec	**Number**	16			
Formal Complaints Closed	**Number**	16			
Formal Complaints Upheld/Partially Upheld	**%**	37%			
Local resolution concerns/ informal complaints Rec	**Number**	4			
MP Enquiries Rec	**Number**	1			



16 formal complaints were received into the division during this quarter; in addition, there were 4 informal/ locally resolved complaints. 16 complaints were closed during the quarter. 6 of these were either fully or partially upheld and 10 were not upheld Most of the complaints related to communication or care and treatment. One was about discrimination when accessing services.

The services receiving the majority of iWGC responses were CRHTT East 186 responses, Psychological Medicine Service – East 66, CMHT Bracknell 42 responses and Memory Clinic Slough 20 responses. CRHTT East received two formal complaints this quarter, one relating to communication, the other to care and treatment. They received one informal concern relating to attitude of staff. They closed two formal complaints, and both were upheld.

Across the CRHTT East survey responses the average 5-star score was 4.38 with 91.2% positive feedback, an increase from last quarter. 186 of the (overall number of responses received) scored a 4 or 5-star rating with many comments about staff understanding, being helpful, listening and being supportive; "*Very attentive and unrushed. I felt listened to. Staff are very motivated and committed to patients care.*" This quarter, questions relating to feeling involved and ease were least likely to be positive with areas for improvement and dissatisfaction with the service about communication, medication given, early discharge, always a different person to speak to and lack of support.

Feedback from compliments for the service included, '*I had a very good call with A and he explained everything clearly and listened to me and i really felt like i mattered. I had a bad experience with therapy before and was not looking forward to his call but I'm glad I took it. I feel hopeful. Thank you so much, thank A for me.*

The Psychological Medicine Service - East received 97% positive score (4.85-star rating) and received positive feedback about staff being helpful, listening, supportive and understanding. "*Very supportive staff. I was well listened and every staff member was so willing to help*."

CMHT Bracknell received 97.6% positive feedback (4.88-star rating), many of the comments were positive about staff being helpful, listening and Friendly. "*[name removed] is always good at listening to my views and wants and she tries her best to do what she can."* One patient gave a score of 1 and said *'"Hoover carpet."*

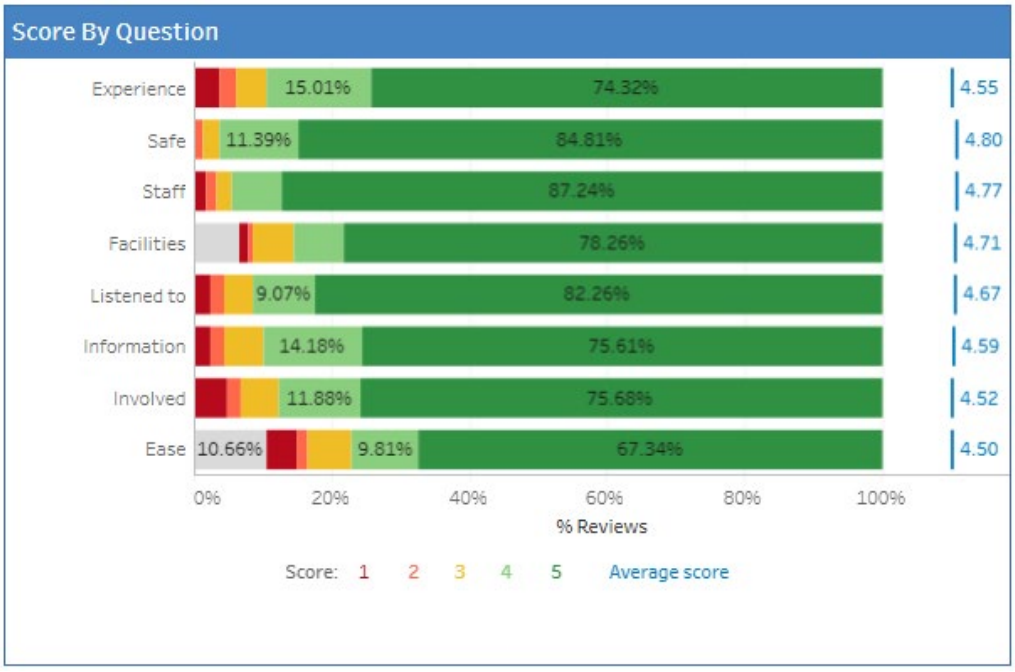
Other areas for being worked on for improvement include reviewing contact telephone numbers to make sure they up to date, provide context and training around the importance of tools to manage and regulate emotions and to have patients involved in more daily activities.

CMHT received 69 responses (Bracknell 42, WAM 15 and Slough 12) with 93.3% positive score and 4.473 star with of the total responses scoring less than a rating of 4; comments included *"Please clean the toilet, looks like the sinks are never clean and it's like that week after week", "The Dr I spoke to did not want to listen to me" and "Listen!!! Someone would not call between outs of 1am and 6am if ur isn't a crisis!!"* There were a number of positive comments about being listened to, staff being professional, helpful and making them feel comfortable.

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

Table 4: Summary of patient experience data

Patient Experience - Division MHW		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	**Number**	1246			
Response rate (calculated on number contacts)	**%**	2.5%			
iWGC 5-star score	**Number**	4.61			
iWGC Experience score - FFT	**%**	89.3%			
Compliments received directly by services	**Number**	557			
Formal Complaints Rec	**Number**	12			
Formal Complaints Closed	**Number**	7			
Formal Complaints Upheld/Partially Upheld	**%**	43%			
Local resolution concerns/ informal complaints Rec	**Number**	7			
MP Enquiries Rec	**Number**	4			



The Mental Health West division has a wide variety of services reporting into it, including Talking Therapy services and Court Liaison as well as secondary mental health services.

The division saw an increase in number of responses received this quarter, this was largely due to increase in responses from Talking Therapies. The 3 services with the most feedback through the patient survey were Talking therapies 790 responses, PMS West 77 responses and Liaison and Diversion 64 responses.

Within Mental Health West the questions relating to ease and facilities had the least number of positive responses.

This division received 12 formal complaints during the quarter with CMHT receiving 7. There were 7 formal complaints closed with 3 being found to be upheld or partially upheld and 4 not upheld.

West Psychological medicines service received two complaints regarding interaction of staff with the patient.

Mental Health West also received 7 informal complaint/locally resolved complaints and 4 MP enquiries.

For CRHTT there were 59 feedback questionnaires completed with a 83.1% positivity score and 4.27-star rating; with lots of positive comments about staff being helpful and listening, *“They were great, very understanding and always clear in what the plans were. They always asked if I'm comfortable and what I needed and planned around me. They always visited me at home as I wasn't comfortable to go into your office, it was never a problem for them.”;* a number of the less positive reviews talked about lack of communication, staff not listening and wanting the staff members who they are being seen by to be consistent.

There were 61 responses received for West CMHT teams with 80.3% positivity score and 4.35-star rating, 49 of these were positive with comments received that staff were supportive and listened, there were 11 negative responses with reviews stating that patients felt like staff didn’t listen, would like appointment times and dates and also would like face to face appointments.

Older adult and memory clinic combined have received 86 patient survey responses during the quarter with a 98.8% positivity rating (4.89-star rating) some of the feedback included *“Both members of the medical staff (on this and previous occasions) were welcoming, made me feel relaxed, gave me as much time as I needed, were quite open and honest in discussions about my condition and portrayed a totally positive perspective throughout.”*

The West Psychological medicine service received 77 responses with an 92.2% positive score and 4.68-star rating (6 responses scored less than 4) many of the comments were positive about staff listening, helpful and being supportive.

For Talking Therapies, their patient survey responses gave a positivity score of 88.6% (4.60-star rating), 97 of the reviews scored less than 4. The vast majority of comments were still very positive about the staff, including that they listened, were understanding and helpful. A number of the comments/areas for improvement were requesting the support to be provided sooner and less questionnaires and wanting to be seen face to face. For example, *“I would prefer face to face support for therapy, I find it hard to connect with others online. Especially in relation to building trust”.*

Examples of positive feedback about Talking Therapies included, *”I am listened to, my views considered, my experiences accepted and I’m not judged or made to feel strange, odd or broken. I am grateful for an honest chat even if I don’t get to make much progress on the app. Thanks for the time.”*, “*[name removed] was so kind & considerate in addition to providing constant reassurance throughout the call. I felt at ease during the call & felt I was not being judged”* .and *“Seen quickly for first appointment. Treated with patience, respect and care. Easy to talk to. Looking forward to next appointment”* Patients reported that they felt *“I felt listened too and the information given was very clear.”, ”I have felt listened to, and understood. I haven’t felt judged at all, so I see this as a safe place.”’ and were “Listened to, asked my opinion and involved me.”*

The service identified that the referral numbers for ethnic groups was decreasing so they did some targeted work reaching out to a Community Wellbeing Hub. The service received the following feedback as a result of this engagement, *'I want to thank you for the mental health counselling that I received at ACRE (Alliance for Cohesion and Racial Equality), offered by XX (Talking Therapies CBT Therapist). I was at the cliff end, but after the first and other counselling sessions, I feel confident and sure of myself'.*

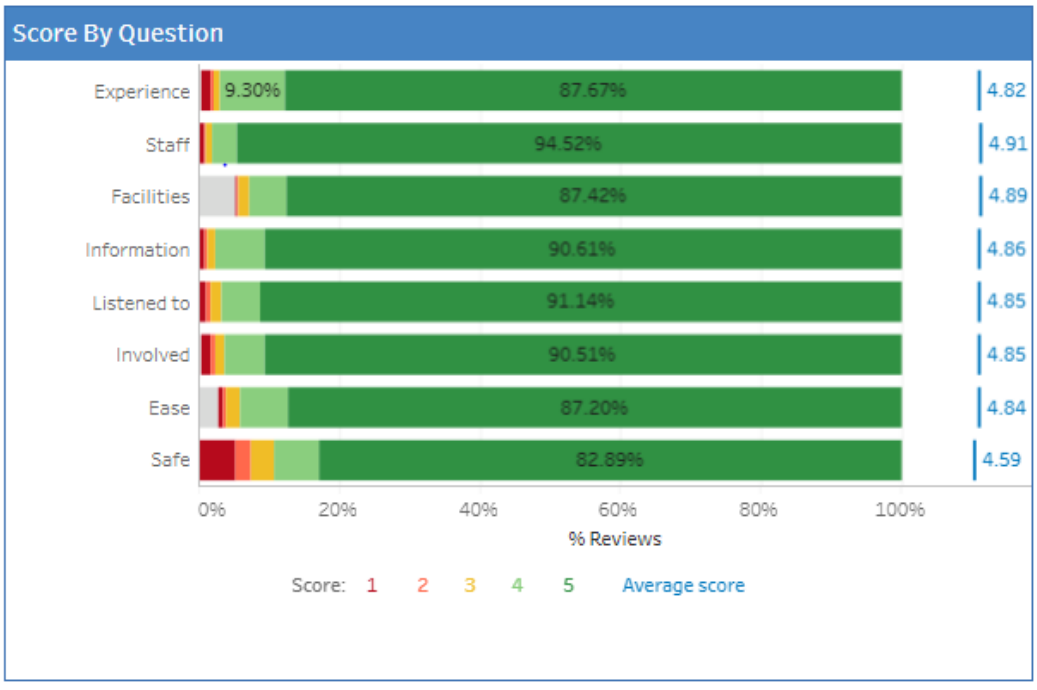
Op Courage

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

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

Table 5: Summary of patient experience data

Patient Experience - Division CHE		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	Number	2044			
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	5.5%			
iWGC 5-star score	Number	4.86			
iWGC Experience score - FFT	%	97%			
Compliments received directly into the service	Number	217			
Formal Complaints Rec	Number	2			
Formal Complaints Closed	Number	2			
Formal Complaints Upheld/Partially Upheld	%	50%			
Local resolution concerns/ informal complaints Rec	Number	1			
MP Enquiries Rec	Number	1			



Two complaints were received this quarter. One for IPASS and one for MSK Physio, both relating to communication.

There were two complaints closed, one for Podiatry, which was not upheld, and one for MSK Physio, which was upheld.

Hearing and balance received 145 responses to the patient experience survey with a 96.6% positive score and 4.84-star rating.

East Community Nursing/Community Matrons received 257 patient survey responses during the quarter with a 98.8% positive scoring, many comments were about staff being caring and kind, for example "*Although I haven't been seen very much I can only say what an amazing service, I was very impressed with how caring and professional everyone was.", "all the nurses are wonderful and kind they will always have a chat with me",* "*Great nurses always kind and caring"* and *"Everyone is wonderful, always came promptly when needed and very caring."* There were also some comments around not being notified of a scheduled visit for example *"Staff are kind and polite, bad experience with one staff who just turned up on the doorstep."*

The wards received 157 feedback responses (91 responses for Jubilee ward 97.8% positive score and 66 Henry Tudor ward 92.4% positive score). Most of the comments for improvement were to have more physio, more staff and more food choices.

As with MSK physio in the West, there was a high number of responses to the patient survey and a high positivity score of 97.7 % (4.82-stars), comments were very complimentary about staff being professional and friendly, *"I was extremely happy with the young lady that assessed me. She was friendly while remaining totally professional".* The reoccurring improvement suggestion for this quarter was for a sooner appointment.

Outpatient services within the locality received a positivity score of 96.7% with 4.92 stars from the 650 responses received. With some very positive feedback including for the UCR & Virtual Community Ward, *"Very efficient and professional. Involved in wider issues that presented with carer team and tried to resolve the problem. I think the service is really valuable after hospital discharge and very reassuring for me. Excellent staff, knowledgeable and kind, and well organised. Thank you."*

The diabetes service received 37 feedback responses with 97.3% positivity and some lovely comments including "The lady that I spoke to was very kind and helpful. And explained everything to me in a way that I could understand." Alongside some helpful suggestions for the service to consider such as "Printed hardcopy of instructions and changes would be useful, as it's easy to forget something if a lot of information is forthcoming."

The Assessment and Rehabilitation Centre (ARC) also received positive feedback including "I was seen on time, The personnel at the ARC centre were polite helpful and friendly. I felt comfortable and well cared for throughout. Even when I was put through my paces and a rehearsal of the daily exercises it was pleasant and encouraging.".

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

Table 6: Summary of patient experience data

Patient Experience - Division CHW		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	Number	2056			
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	2.5%			
iWGC 5-star score	Number	4.81			
iWGC Experience score - FFT	%	95.1%			
Compliments (received directly into service)	Number	196			
Formal Complaints Rec	Number	12			

Formal Complaints Closed	Number	7			
Formal Complaints Upheld/Partially Upheld	%	86%			
Local resolution concerns/ informal complaints Rec	Number	18			
MP Enquiries Rec	Number	3			

Community Health West saw a significant increase in responses this quarter. There are a significant number of services within the division and a generally high level of satisfaction received as detailed in the overall divisional scoring of 95.1% positive satisfaction and 4.81-star rating and the question on staff receiving a 97.4% positive scoring from the 2056 responses received.

There were 12 formal complaints received during the quarter, these were split across several different services. Of these District Nursing received three complaints and Phlebotomy received 2

There were 7 complaints closed for the division during the quarter with 4 being upheld, 1 not upheld, 2 partially upheld.

During this quarter the community hospital wards have received 151 responses through the patient survey receiving a 88.74% positive score and 4.55-star rating, (17 responses scored 3 and below) questions around information and feeling involved received the most results of 3 and below; comments include staff were caring and kind, “Everyone was so considerate and caring and so helpful.”, “I have had an exceptional experience delivered by wonderful staff.”, “I couldn't have had better care and attention anywhere! Thank you to all staff for their kindness, patience and care! Top class!!!” And “Absolutely brilliant. I can’t knock this sort of place at all. Lovely staff, pleasant, you can have a good old laugh with the staff”, there were some individual comments where patients were less satisfied, with comments including better communication, need for more physiotherapy, more staff and to answer the call bell quicker.

WestCall received 21 responses through the iWGC questionnaire this quarter (95.2% positive score, 4.78-star rating, 1 score received below 4. Positive comments included *(“The receptionist was friendly and apologised for the wait. The GP was exceptionally attentive and kind. She took the time for a thorough examination and listened to the concerns we had. The*

clinical sample, despite initially being negative, was sent to the lab, and I have now received a phone call informing me of the positive result and hence the correct medication was prescribed. I'm very grateful that we were not dismissed after the initially negative result." "We saw [name removed] with our young daughter. I thought he was thorough, understanding, kind and very knowledgeable. I came away feeling we were listened to cared for.." WestCall received around 19906 contacts during the quarter.

Podiatry services received 189 patient survey responses. Most responses were very positive receiving 5 stars (overall 96.3% positivity 4.85-star rating) with examples including "Seen on time, and treated very well, professional and friendly, new appointments sorted straight away, really wonderful staff" and "I had the best experience, the lady treated me with the best service. She went above and beyond. She was very friendly and made me feel welcome. I would recommend her for this service".

There were three complaints for Community Nursing, all relating to care and treatment. They have received some of the highest numbers of feedback (515 across the 3 localities in the quarter, with a 99.4% overall satisfaction score and 4.92-star rating).

To provide some context across our East and West District Nursing teams combined there were 44,071 contacts this quarter. Lots of comments included nurses were kind, helpful and caring, "*Nurses are always very pleasant helpful and professional. [name removed] did explain very well regarding the wound and did dress my mum' s leg very well. she is very polite and professional during the visit.", "Fantastic quality of care given to me [name removed] was so gentle and had a calming nature to him absolutely brilliant I really appreciate him coming and I would like him to come again next time" and "Fantastic care given to me I really appreciate it [name removed] was a superstar with showing compassion towards me and made me feel not so vulnerable".* There were several positive comments about nurses being professional and there were very few suggestions for improvement, mainly around visits being moved and occasionally lack of communication about visit being moved.

MSK Physio has received one complaint in the quarter relating to the clinical care the patient received. The service has received 416 patient survey responses with a 96.1% positive score (4.85 star rating), very few areas for improvement were included in the feedback there were a few suggestions including more seating in the waiting room, waiting time for appointment and for the phone to be answered when they call and the overall feedback was extremely positive with lots of comments about staff were friendly, professional, listened and helpful.

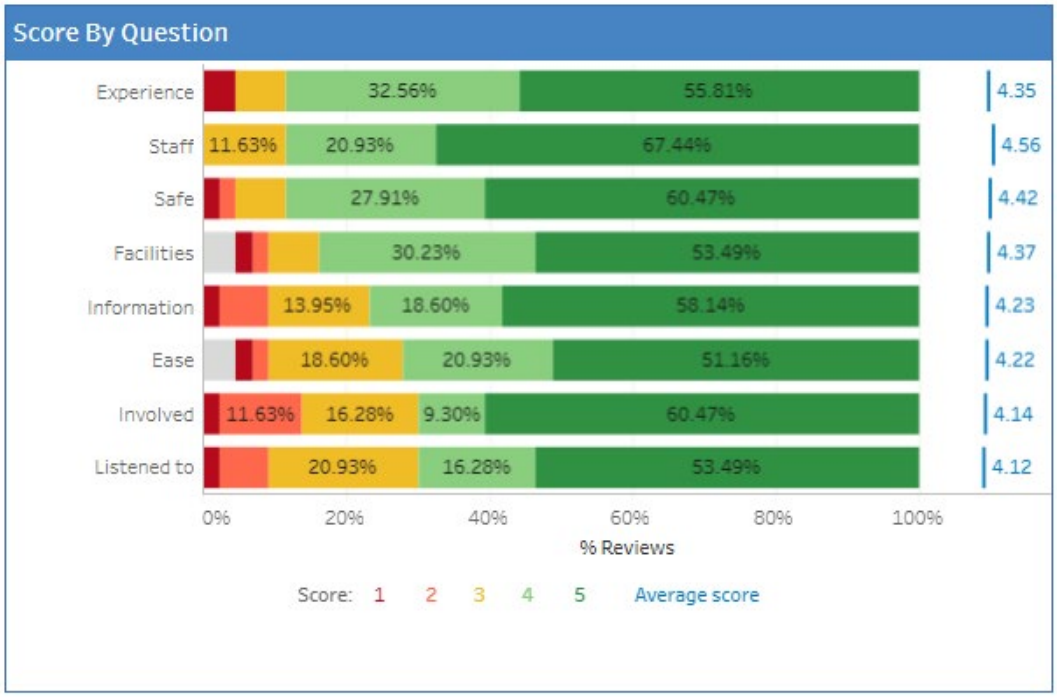
The services across the division received many compliments including ‘*' Hello, I just wanted to say a big thank you to all your staff for looking after me on the evening of 3rd April 2023. Only a minor injury at football, dislocated and broken finger, but it was a wonderful opportunity to meet you all and be once again reminded what a wonderful bunch you all are. Angels all of you. Thank you so so much.*

Mental Health Inpatient Division

Table 7: Summary of patient experience data

Patient Experience - Division MH Inpatients		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	**Number**	43			
Response rate	**%**	28.3%			
iWGC 5-star score	**Number**	4.30			
iWGC Experience score – FFT	**%**	88.4%			
Compliments	**Number**	12			
Formal Complaints Rec	**Number**	10			
Formal Complaints Closed	**Number**	5			

Patient Experience - Division MH Inpatients		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Formal Complaints Upheld/Partially upheld	**%**	80%			
Local resolution concerns/ informal complaints Rec	**Number**	0			
MP Enquiries Rec	**Number**	0			



The satisfaction rate at 88.4% is skewed by 5 of the 43 completed questionnaires giving scores of 1-3. The individual question themes would indicate that the question relating to feeling listened to receives the least positive scores with overall 5-star rating being 4.12; with 13 of the 43 giving a score of 3 or less to this question.

There were 10 formal complaints received for mental health inpatient wards during the quarter, mainly regarding care and treatment. One complaint alleged bullying/harassment and two related to discharge planning. There were no complaints for Sorrel Ward this quarter. There were 5 complaints closed for this Division during the quarter and of these 4 were partially or fully upheld and one was not upheld.

There were many positive comments received in the feedback including comments such as staff were helpful, supportive, kind and caring. 5 of the 43 responses to the survey were from Sorrel Ward and all gave a positive score of 4 or 5. There were some comments for improvement about food needing improvement, one person felt there was bias and stereotyping, wanting hallway lights off at night, knocking and waiting for an answer before opening the door . Examples of the feedback left are "*I felt safe. Staff are lovely. The place was very clean. I was offered food and drink.*," "*[name removed] provided great support and she was very kind. She presented all options available to help me with nicotine dependence. [name removed] does great job!", "Very grateful to be here, am improving in my mental health", "The drug and alcohol nurse [name removed] was mega fantastic and supportive . She was really helpful with what I need like sorting out my benefits / housing / by alcohol problems*." The 12 responses related to Place of Safety provided positive scores and comments, only one scored below 4 and gave no reason for their answer.

Demographic profile of people providing feedback (Breakdown up to date as of Quarter 4 data from our Business Intelligence Team)

Table 8: Ethnicity

Ethnicity	% Complaints received	% Patient Survey Responses	% Breakdown of Q4 attendances
Asian/Asian British	5.88	7.95	9.67%
Black/Black British	2.94	3.21	2.67%
Mixed	1.47	2.39	3.49%
Not stated	2.94	10.11	15.89%
Other Ethnic Group	2.94	7.21	1.62%
White	83.82	69.14	66.66%

The above would indicate that potentially we have a higher number of complaints received compared to attendance percentage from those with Black/Black British heritage and that there is still more feedback being received from White British as a percentage of contacts than from others. It will be important to ensure as we continue to gain an increase in our patient survey responses that everyone is able to access and use the survey; the survey is provided in easy read and a number of differing languages, but it will be important to ensure that the prompts to complete this are not inhibiting feedback representative of the community and our patient attendance.

Table 9: Gender

Gender	% Complaints received	% Patient survey responses	% Breakdown of Q4 attendance
Female	54.41	47.29	53%
Male	45.59	30.80	46.98%
Non-binary/ other	0.00	5.00	0%
Not stated	0.00	16.89	0%

This would indicate that whilst the breakdown by attendance is fairly equally split as are complaints it would appear that we are still more likely to hear the voice of the patient through the patient survey if they are female.

Table 10: Age

Age Group	% Complaints received	% Patient Survey Responses	% Breakdown of Q4 attendance
0 to 4	4.41%	7.03	18.41
5 to 9	4.41%		4.14
10 to 14	5.88%		4.34
15 to 19	4.41%		4.52
20 to 24	4.41%	5.13	2.87
25 to 29	10.29%		3.14
30 to 34	4.41%	7.70	3.56
35 to 39	11.76%		
40 to 44	10.29%	9.29	3.58
45 to 49	5.88%		3.52

Age Group	% Complaints received	% Patient Survey Responses	% Breakdown of Q4 attendance
50 to 54	5.88%	13.18	3.73
55 to 59	1.47%		4.32
60 to 64	5.88%	15.28	4.46
65 to 69	5.88%		4.63
70 to 74	1.47%	16.11	4.53
75 to 79	1.47%		5.56
80 to 84	2.94%	14.89	6.16
85 +	5.88%		6.55
Not known	2.94%	11.34	11.98

Ongoing improvement

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

All services have access to a tableau dashboard detailing response to our patient survey including free text comments and this is refreshed daily to enable live data to be used by services alongside improvement work being undertaken.

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

Some examples of services changes and improvements are detailed below

Service	You said	We did
Reading CAMHS	A young female patient came on their period whilst waiting for an appointment at Erlegh House and didn't have any sanitary supplies with her.	Fed back to clinician as she was saying that at school they have supplies in toilets, huddle ticket was raised about this and team have now implemented this.
Phoenix Unit	Request for music on at mealtimes and decoration for the therapy room	These have both been actioned. In addition, a 'link clinician' has been implemented following feedback around improving communication between Phoenix staff and family members
CYP BEDS	Feedback through the participation group to have motivational quotes and recovery stories in the waiting area.	These have been put up in the waiting area.
Improving access to CAMHS	Families and complaints received told us that the service is good that they received but the route to	A Countermeasure is currently being implemented to have CAMHS Getting Help Team clinicians triaging patients received to CPE and to move them to

Service	You said	We did
Getting Help QI project:	be referred to the team was lengthy.	treatment list for their service (reducing time taken to be referred to the service).
Jubilee Ward	Recent IWGC feedback highlighted that some patients were having communication problems as English is not their first language.	The admin lead has had some information sheets designed in the four most spoken languages, Hindi, Urdu, Punjabi and Polish – the sheets answer some of the most asked questions around pain, comfort, thirst & hunger.
MSK Physio (West)	“It is possible at times to hear other patient's consultations behind curtains separating cubicles”.	We have identified a private room on each site for those patients who request it.
	“I would like there to be less repetition in assessments when referred via the Integrated Pain and Spinal Service (IPASS) or MSK Community Specialist Service (MSK CSS)”.	Collaborative working with IPASS and MSK CSS to set up new pathways to streamline your care and reduce repetition.
MSK Community Specialist Service	“I don’t want to go to reading for an injection”.	The procurement of new estates space has given the opportunity to run injection clinics in Newbury – patients will now be able to access the right treatment closer to home.
	“There is a long wait for appointment in the Thatcham area”.	Due to lack of available estates in the Newbury area – we have invested in a new site (Adlam Villas) to provide clinics in the community close to where people live with greater availability and equitable waits.
	Give more information about opening times, making the welcome message more patient friendly on our phone line messages	we have changed the phone line message to include our opening times and added the email to greeting message. We have also updated the welcome message.
IPASS	“There is a long wait for appointment in the Thatcham area”.	We have now greatly expanded the number of clinics we hold in the Newbury area due to the opening of our new building at Adlam Villas. Patient feedback regarding the lack of choice in this area played a key role in being able to secure funding for this investment.
	“Chairs in the waiting area are too close together – like being in a cupboard”.	A number of comments were received in relation to the waiting area. Service managers visited the area to review this and chairs were moved to facilitate a more private and less enclosed waiting area alongside clearer signage with regards to where to check in and wait.
	“I didn’t know who I was seeing”.	We received a range of comments from patient’s explaining that they weren’t aware of who their assessing clinician was. We took the step of feeding this back to the team to ensure that on patient arrival they clearly introduced themselves with their name and

Service	You said	We did
		role within IPASS. In addition, we reviewed our patient appointment confirmation letters to ensure that the assessing clinician was identified on this.
Psychological Medicine Service	The leaflets provided has information not relevant to patients. Patients need to speak to next of kin and involve them in the care plan.	Through QMIS we are working on changing the Safety Plan and PMS leaflet so that it is tailored to your needs Ensured that it is common practice for all clinicians to speak to and involve carers. We are working on gathering feedback from our carers which will be reported on from IWGC
Eating Disorder Service	Bring back carers support Update resources Expand access to treatment	Relaunched the carers support group Updated outpatient and day programme booklets Online treatment groups are now being delivered
Crisis Resolution and Home Treatment Team (CRHTT)	We used deadnames, incorrect pronouns and misgendered our transgender service users.	Reviewed this through QMIS and shared resources from the Pride Network with all staff. We continue to remind staff of the importance of getting these details correct. We encouraged staff to attend the “Belonging at Berkshire” learning event.

15 Steps

Appendix 1 contains the 15 Steps visits that took place during Quarter 1, with the programme fully recommencing in April 2022.

There were 4 visits this quarter; the Garden Clinic and Podiatry clinic at Upton Hospital in Slough and Ascot Ward and the Physiotherapy service at Wokingham Community Hospital.

Summary

It is very positive to see further increased volumes of patient feedback through our patient survey month on month and all managers and divisional leaders have access to the live tableau dashboard to view this. It is also positive to see a number of services proactively using the feedback to make changes and displaying this for patients and their loved ones to see.

Responses about staff have remained overwhelmingly positive although we recognise that this is not the experience for everyone and do see some feedback and complaints relating to staff attitude for the vast majority of patient contacts their experience of our staff is a good one; we continue to foster our culture of kindness and civility across the organisation.

It has been noted that in some cases we continued to receive scores of 1 (the lowest rating) but with very positive comments alongside this rating which doesn’t quite equate; this has been fed back to iWGC who have advised that this is a recognised issue with feedback across the Trusts that they work with and that as they consider this as a minimal impact, there are no plans to amend the supporting information that is given about the rating scale.

Appendix 2: complaint, compliment and PALS activity

All formal complaints received

	2022-23							2023-24				
Service	**Q1**	**Q2**	**Q3**	**Q4**	**Total for year**	**% of Total**	**Higher or lower than previous quarter**	**Q1**	**Q1 no. of contacts**	**% contacts Q1**	**Total for year**	**% of Total**
CMHT/Care Pathways	11	10	18	14	53	**22.00%**	↑	16	8253	0.19	16	**24.00%**
CAMHS - Child and Adolescent Mental Health Services	4	6	13	10	33	**14.00%**	↓	8	2353	0.34	8	**12.00%**
Crisis Resolution & Home Treatment Team (CRHTT)	3	9	6	4	22	**9.00%**	↑	5	10016	0.05	5	**7.00%**
Acute Inpatient Admissions – Prospect Park Hospital	13	7	9	6	35	**15.00%**	↑	10	152	6.58	10	**14.50%**
Community Nursing	3	0	4	5	12	**5.00%**	↓	3	44071	0.01	3	**4.00%**
Community Hospital Inpatient	4	3	2	1	10	**4.00%**	-	1	367	0.27	1	**1.50%**
Common Point of Entry	0	1	3	1	5	**2.00%**	-	1	470	0.21	1	**1.50%**
Out of Hours GP Services	1	0	1	2	4	**1.50%**	↓	1	19906	0.01	1	**1.50%**
PICU - Psychiatric Intensive Care Unit	1	2	0	4	7	**3.00%**	↓	0	4	0.00	0	**0.00%**
Urgent Treatment Centre	1	0	0	0	1	**0.50%**	↑	1	4197	0.02	1	**1.50%**
Older Adults Community Mental Health Team	1	1	0	0	2	**1.00%**	↑	1	3498	0.03	1	**1.50%**

Other services during quarter	19	11	15	11	56	**23.00%**	↓	21	123292	0.02	21	**31.00%**
Grand Total	61	50	71	58	240	100.00%		68	216579	0.03	68	100.00%

Locally resolved concerns received

Division	April	May	June	Qtr 1
CYPF		2	2	4
Community Mental Health East	1			1
Physical Health	6	9	2	17
Total	**7**	**11**	**4**	**22**

Informal Complaints received

Division	April	May	June	Qtr 1
CYPF		2		2
Community Mental Health East		1	1	2
Community Mental Health West	3	2	2	7
Corporate			1	1
Physical Health	1	1		2
Total	**4**	**6**	**4**	**14**

KO41a Return

We have been informed by NHS Digital that they are no longer collecting and publishing information for the KO41a return on a quarterly basis, but will now be doing so on a yearly basis. We will expect to be asked to submit our information in May 2023, so this will next be reported in the Q2 2023 report.

Formal complaints closed

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

Outcome of formal complaints closed

	2022/23					2023/24		
Outcome	**Q1**	**Q2**	**Q3**	**Q4**	**Higher or lower than previous quarter**	**Q1**	**Total for year**	**% of 22/23**
Not Upheld	23	22	23	38	↓	20	20	38.00%
Partially Upheld	21	30	26	25	↓	22	22	42.00%
Upheld	12	9	7	8	↑	11	11	20.00%
Grand Total	**57**	**61**	**57**	**72**		**53**	**53**	**100.00%**

62% of complaints closed last quarter were either partly or fully upheld in the quarter (compared to 46% in Quarter 4, these were spread across several differing services.

Complaints upheld and partially upheld

	Main subject of complaint										
Service	Abuse, Bullying, Physical, Sexual, Verbal	Access to Services	Attitude of Staff	Care and Treatment	Communication	Confidentiality	Discrimination, Cultural Issues	Medical Records	Medication	Waiting Times for Treatment	Grand Total
Adult Acute Admissions - Bluebell Ward	1		1								2
Adult Acute Admissions - Snowdrop Ward				1							1
CAMHS - ADHD				2				1		1	4
CAMHS - Anxiety and Depression Pathway										1	1
CAMHS - Common Point of Entry (Children)					1						1
CAMHS - Specialist Community Teams					1					1	2
Children's Speech and Language Therapy - CYPIT										1	1
CMHT/Care Pathways		1		2			1				4
Community Hospital						1					1

Inpatient Service - Windsor Ward											
Crisis Resolution and Home Treatment Team (CRHTT)			1				2	1			4
District Nursing				2							2
Immunisation									1		1
Learning Disability Service Inpatients - Campion Unit - Ward				3							3
Older Adults Inpatient Service - Rowan Ward	1										1
Out of Hours GP Services			1							1	2
Phlebotomy					1						1
Physiotherapy Musculoskeletal					1						1
Psychological Medicine Service				1							1
Grand Total	2	1	3	11	4	1	3	2	1	5	33

Care and Treatment complaint outcomes

Care and Treatment complaint outcomes	Partially Upheld	Upheld	Grand Total
Adult Acute Admissions - Snowdrop Ward		1	1
CAMHS - ADHD	2		2
CMHT/Care Pathways	2		2
District Nursing	1	1	2
Learning Disability Service Inpatients - Campion Unit - Ward	3		3
Psychological Medicine Service		1	1
Grand Total	**8**	**3**	**11**

As part of the Trust strategy to continue to improve care, we aim to reduce the number of formal complaints about care and treatment which are found to be upheld or partially upheld. 11 complaints related to care and treatment; of these 8 were partially upheld and 3 were fully upheld. This compares to 33% of all complaints closed that were either fully or partially upheld.

PHSO

The table below shows the PHSO activity since April 2022:

Month opened	Service	Month closed	Current stage
May 2022	Crisis Resolution and Home Treatment Team (CRHTT)	Awaiting update	File sent to PHSO on 11 May 2022 to aid their decision on whether or not to investigate
June 2022	CMHT/Care Pathways	Awaiting update	File sent to PHSO on 14 June 2022 to aid their decision on whether or not to investigate
September 2022	CMHT/Care Pathways	September 2022	PHSO confirmed not investigating
September 2022	Community Hospital Inpatient Service - Donnington Ward	September 2022	PHSO confirmed not investigating
November 2022	Children's Occupational Therapy - CYPIT	November 2022	LGO confirmed not investigating
November 2022	CAMHS - AAT	March 2023	PHSO confirmed not investigating
January 2023	CMHTOA/COAMHS - Older Adults Community Mental Health Team	February 2023	PHSO confirmed not investigating
April 2023	CMHT/Care Pathways	Awaiting update	File sent to PHSO on 20 April 2023 to aid their decision on whether or not to investigate

CQC

It has been announced that from July 2023, at the point of triage, the Mental Health Act (MHA) complaints team within the CQC will consider whether any of the concerns raised could be dealt with as an early resolution by Trusts.

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

PALS activity

PALS provides a signposting, information, and support service. The service deals with a range of queries with an emphasis on informal resolution. PALS collaborates with the complaints team in order to triage queries which be escalated to a formal complaint.

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

With the closure of the PALS office at Prospect Park Hospital, a programme of outreach will be developed, whereby the PALS manager will be visiting sites across Berkshire on a regular basis.

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

There were 383 queries recorded during Quarter one. An increase of 73 since Quarter 4. 354 queries were acknowledged within the 5 working day target, but the recording of queries has fallen behind due to the volume of queries coming into the service. The Patient Experience Team has undertaken work to standardize and streamline the PALS process, in order to make it more user friendly for the wider team and enable the service to be covered consistently during the absence of the PALS Manager.

PALS has engaged a volunteer on a part time basis, and this has improved direct access to the service. The volunteer is also recording queries which has improved the rate of data collection.

In addition, there were 150 non-BHFT queries recorded. Another member of the Patient Experience Team is consistently helping with the recording process in order to improve the rate of data collection.

The services with the highest number of contacts are in the table below:

Service	**Number of contacts**
CMHT/ Care Pathways.	36
CAMHS AAT	26
Other	22
Operational HR	16
Admin teams/ office-based staff	15
CAMHS ADHD	15
Phlebotomy	11

Formal Complaints closed during Quarter one 2023.24							
ID	Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome	Subjects
8921	Reading	Mental Health Services	Minor	Patient has raised various issues regarding care and treatment as a patient on Campion ward	Partially Upheld	Ward manager will continue to discuss the communication approach of staff on the ward to emphasise the importance of caring and compassionate communication Campion Ward Manager to remind staff to ensure they knock before entering sign is on his door and that staff need to knock before entering	Care and Treatment
8902	Reading	Mental Health Services	Low	Lack of support from CMHT, no care worker, requires medication. concerned as no professionals are going to see the pt. Believes revised assessment is required	Not Upheld		Care and Treatment
8939	Reading	Mental Health Services	Low	Questioning at what point an internal SCT referral for this should have been made. Complainant believes this was discussed with clinician and not documented on RiO	Partially Upheld		Waiting Times for Treatment

8911	Windsor, Ascot and Maidenhead	Mental Health Services	Low	Incorrect address noted on records on several occasions. Sympathies sent for deceased mother who is NOT deceased	Partially Upheld	Advanced Mental Health1 Practitioner to attend appropriate training to improve on telephone skills. Feedback to Advanced Mental Health Practitioner 2 regarding mistake in taking notes from the assessment and discussion regarding possible solutions for improvement	Medical Records
8924	Reading	Mental Health Services	Minor	Parents are unhappy with a letter they received from service. They say nobody is providing them with updates, so they have to call repeatedly	Partially Upheld	CAMHS CPE staff to be reminded to record all communication with patients/families/carers on patient notes, including information given. CAMHS CPE to review processes further with regards to information given to patients/families/carers and to remind staff to have a consistent approach which is documented clearly in patient notes. CAMHS CPE to review processes with regards to referral receipt letter and continue process of summary letter which has recently been implemented. CAMHS CPE to review processes with regards to sending letters to patients/families/carers and ensure all letters contain relevant and standardised information.	Communication

8918	Slough	Mental Health Services	Low	Pt unhappy they are being discharged after 20 years, they think is wrong as they need CMHT support	Not Upheld	Patient has been offered a referral to Mental Health Integrated Community Service (MHICS) for ongoing support. Patient to contact Slough CMHT if he is interested after reading the information provided. It has been communicated to Patient that he still has access to Slough CMHT Duty and Crisis Team if he experiences severe distress or feels at risk to himself. Patient is also in receipt of ongoing outpatient psychiatry appointments with Dr. Patient has been provided with a signposting document with guidance on how to access external support, if required.	Care and Treatment
8916	Reading	Mental Health Services	Minor	Unhappy with move from Bluebell to Daisy ward. Staff member derogatory to pt	Partially Upheld	Communication Work around handover and inc the patient as appropriate Understanding care plans, where they are etc?	Attitude of Staff

8880	West Berks	Mental Health Services	Low	Pt wishes a review of treatment over the last 14 years as does not agree with the diagnosis	Partially Upheld	Second opinion outpatient appointment booked Referral sent to CMHT Triage for integrated psychological service to review and offer assessment.	Care and Treatment
8894	Bracknell	Mental Health Services	Low	pt feels they have a disability discrimination complaint against BCMHT as they will not give the staff members email to the pt. Feel previous clinician ignored them. Wishes to be referred to the Clinic for Dissociative Studies and feels this request is being ignored	Partially Upheld	Increased awareness of individual client communication needs. To contact RiO to ask if the system could support this more effectively. Information to be clearly incorporated when plans are made about care for clients. Any discussion about responses to client's complaints or concerns should be recorded at the time on RiO to inform the care provided thereafter. Staff to be refreshed on how to handle complaints when they are reported. Reminder to practice assessors that students working with patients via duty need regular support and oversight.	Discrimination, Cultural Issues

8915	Reading	Mental Health Services	Minor	Pt had an altercation with another pt and sustained facial injuries, family have serious concerns for pt safety	Partially Upheld	Ward Manager has reminded staff that exceptions to mask wearing can be made for health reasons, and that they should take time to listen to reasons given for not wearing a mask. Request made to reposition CCTV camera – would not have prevented incident but would have been helpful to corroborate witness accounts	Abuse, Bullying, Physical, Sexual, Verbal
8914	West Berks	Clinical Services (East and West CHS only)	Moderate	DECEASED PT: 1. why did DN not return call regarding photos 2. why was complainant reported to ASC for neglect 3. why no consistency in care 4. Why did DN's not dress or care for pt's feet	Partially Upheld	Learning for us is when we receive a text from Triage, to update our actions on the health record Learning for us… already undertaken, safeguarding decision guide and flow chart for all staff Learning for us… already undertaken, when a visit is moved it is risk assessed beforehand.	Care and Treatment
8956	Bracknell	Mental Health Services	Low	Specific incident of CPN cancelling at the last moment leaving the pt isolated	Not Upheld		Care and Treatment
8970	Windsor, Ascot and Maidenhead	Clinical Services (East and West CHS only)	Low	Complainant unhappy pt was not picked up as an urgent referral as a high risk pt, also unhappy they were sent to a private clinic who only deal	Not Upheld		Care and Treatment

				with low risk/routine patients			
8975	Reading	Mental Health Services		pt feels un safe on the ward due to a staff member being attacked and allegedly 4 pt being attacked in a week	Not Upheld	complaint withdrawn	Other
8945	Slough	Mental Health Services		In appropriate communication from call handler	Not Upheld	no consent received	Communication
8953	Reading	Mental Health Services	Minor	Lack of pain relief provided when requested	Upheld	1. The team are striving to improve the process of the environmental check to ensure that lack of sanitary bin is noticed and acted upon promptly in the future 2. Improving handovers, communication and documentation	Care and Treatment
8927	Reading	Mental Health Services	Minor	Lack of communication regarding the DSR which the pt seems to have been removed from	Upheld	Change in process/ownership of DSR has mitigated this problem going forward.	Communication
8950	Wokingham	Mental Health Services	Low	Medication ordering / delivery issues. No longer receives regular MH visits	Not Upheld	Patient to access alternative services in the community to seek support for his needs	Medication

8940	Wokingham	Clinical Services (East and West CHS only)	Low	April 2022 Physio reviewed scans of 2018 - advise pt did not have osteophytes, advised differently in Oct 2022 as radiology report from 2018 Showed the pt has Osteophytes	Not Upheld	We will work with the IPASS team to ensure clinicians are clearly explaining all elements of an umbrella term such as Spondylosis or wear and tear going forwards.	Communication
8930	Reading	Mental Health Services	Moderate	appt with psychiatrist that YP has waited 6 months for was cancelled due to sickness with no back up for support	Partially Upheld	Medication review CBT Therapy resuming as agreed with Hedy and family. The CAMHS medical director has agreed a budget for an external locum medical Psychiatrist. A Psychiatry review will be scheduled for Hedy once a locum psychiatrist has been established in post. CAMHS A&D team to review current processes for managing staff sickness/absence to minimise disruption to clinical care during periods of staff sickness within the team. • Establishing a contact person who will link with families clinically to follow up when staff members are ill, • How quickly this should take place. • Consider clinically whether a young person would benefit from reallocation to another to another therapist or staff member and how quickly the team will	Waiting Times for Treatment

						consider reallocation, particularly if a staff member is absent for long periods.	
8976	Slough	Mental Health Services	Low	complainant extremely unhappy that provision is not in place for pt's unable to speak on the telephone when in a crisis	Partially Upheld	Service to investigate opportunities that may be available to assist this client group	Discrimination, Cultural Issues
8963	West Berks	Estates and Facilities Services	Low	Pt wishes to know why we charge an 'entrance fee' at WBCH	Not Upheld		Other

8937	West Berks	Clinical Services (East and West CHS only)	Moderate	YP struggling to breathe, advised they would be seen in 1 hour, no call for 8 hours	Upheld	Monitoring of the productivity of the Locum GP	Waiting Times for Treatment
8923	Bracknell	Mental Health Services	Minor	Unhappy with the response request we listen to the calls ORIGINAL BELOW Patient complains she has had little or no support from CMHT and has had 'disturbing' conversations with CPN	Not Upheld		Care and Treatment
8980	Bracknell	Mental Health Services	Low	call handler was very unhelpful asked why they did not call in hours and then stated they could not help as the pt was 75 yrs old, complainant concerned what they should do if the service is needed in the future.	Upheld	Clinical Supervision for staff member.	Attitude of Staff
8960	Reading	Mental Health Services	Minor	Pt taken to A&E RBH by SCAS. Pt has questions around their interaction with the psychiatrist seen from PMS	Upheld	RBH colleagues to be advised to inform patient of the purpose of referral to PMS	Care and Treatment
8935	Bracknell	Mental Health Services	Minor	Unhappy with respond, requires more details, vast number of points to answer ORIGINAL COMPLAINT BELOW	Not Upheld	Electronic signatures should not be used by staff for patients in the team unless there are exceptional circumstances which should be recorded on RiO	Communication

				Alleged forgery of the pt's signature to obtain information from outside agencies			
8851	Wokingham	Mental Health Services	Moderate	Additional concerns raised that the Trust seem more interested in the consent from the pt for the complaint than pt care. Family concerned for the YP who they say was refused treatment Dec 2020, since then has been in A&E twice. IN GCSE Year but not attended school, family very concerned	Partially Upheld	We are currently developing programmes aimed at reducing waiting lists and waiting times and are recruiting staff to deliver these services. Apology offered partent.	Waiting Times for Treatment
8931	Bracknell	Mental Health Services	Minor	Complainant/relative unhappy the pt has to be seen in their local area as when the complainant is an ex-employee of BHFT and feels this compromises the family	Partially Upheld	All future emails to be monitored and responded to by admin team to ensure emails like letters are acknowledged.	Access to Services
8948	Reading	Clinical Services (East and West CHS only)	Low	Feels the Dr humiliated them at their appt	Partially Upheld	Discuss/ Share case (anonymised) at WestCall Clinical Meeting to promote better communication	Attitude of Staff

8929	Bracknell	Mental Health Services	Low	complaint regarding the lack of contact, triage, assessment and treatment	Partially Upheld	Family members would need to be informed of triage outcome.	Care and Treatment
8993	Bracknell	Mental Health Services		Following a suicide attempt family unhappy with the inconsistencies of the pt care including lack of care coordinator.	Not Upheld	No consent received	Care and Treatment
8964	Slough	Mental Health Services		No communication from service that cc is off sick despite family and pt requesting help, why has no replacement been put in place	Not Upheld	No consent	Care and Treatment
9016	Bracknell	Corporate Office	Low	Pt unhappy that their email was not acknowledged	Not Upheld		Communication
8974	West Berks	Clinical Services (East and West CHS only)	Low	Pt extremely unhappy as trying to book a blood test, on hold for 45 mins then told line is not staffed after 3.30.	Upheld	Main reception at WBCH have been provided with correct opening hours for Phlebotomy.	Communication

8978	Bracknell	Mental Health Services	Low	inaccuracies within an ADHD diagnosis report with some confidentiality breaches	Upheld	Issue revised report – draft to be sent to parent PRIOR to sending out Once report agreed as final, send to original cc list with covering letter explaining there were inaccuracies in the previous report which have been corrected and request any previous version of the report is deleted and replaced with the updated report Provide brief copy of report for school Reminder to all clinicians about the importance of not copying and pasting recommendations from report to report and a recommendations template to be provided to all clinicians which does not have any name included. This can be used in the report or as an appendix to the report Additional ad hoc admin support/digital dictation for clinicians to be explored (including as part of reasonable adjustments) IO to update the clinician that ECG has now taken place (although no GP letter sent yet) and establish next steps for reviewing medication. Reminders to the team about following process for sending out correspondence and ensuring that records clearly show when letters have been sent out.	Medical Records

8992	Wokingham	Clinical Services (East and West CHS only)	Low	Vaccination given to YP without consent. Complainant wishes to know why she was told the YP had been confused with another with the same name and why the service lead refused to put their conversation in writing	Upheld	When entering any response on Cinnamon from a parent/carer, child's ID must be checked against: Name, DOB, NHS number (if on Cinnamon) address and parent/carer's name. Only once these are correct should a response be added to Cinnamon. The name of the parent/carer should be named on the triage notes. If a parent/carer changes their mind from consent to non consent or vice versa, before a triage note is added on Cinnamon and before the response is amended, child's ID is checked against: name, DOB, NHS number (if on Cinnamon) address and parent/carer's name. Parent/carer name to be added to triage note so that the vaccinating nurse can clearly identify a change in response. It should also be clearly documented on the triage notes that the response has been changed/amended from one decision to the other and the parent/carer changing the decision should be named on the triage notes. Service to explore whether vaccinating nurse's identity can be removed from the automated e-mail sent to parents/carers and replaced with a code- to protect and support staff.	Medication

						Parents/carers can request the name of the nurse as required	
9017	Reading	Mental Health Services	Low	pt broke the rule of SUN confidentiality but send a message to a whatsapp group about an unfortunate incident with a male member of the group. Pt feels facilitators could have done more regarding the incident and feels blamed for everything, states they failed in their duty of care	Not Upheld		Attitude of Staff
8988	Wokingham	Clinical Services (East and West CHS only)	Moderate	Unhappy with the response from the PALS enquiry, wishes to know why initial enquiry dated July 21 took till Jan 22 to respond. Also wish to know when they will be assessed by CAMHS	Partially Upheld	waiting time acknowledge, signposted	Waiting Times for Treatment
8996	Wokingham	Clinical Services (East and West CHS only)	Low	Pt unhappy at the lack of confidentiality on the ward and being accused of discussing pt's with relatives. letter dating back to 26 April addressed to CEO was opened by staff on the ward	Upheld	Discuss in team meeting how the team can reduce the visible information around bed spaces.	Confidentiality

				and not passed on to complaints. pt unhappy that notes of therapies are placed above the bed for all to read			
9013	Wokingham	Clinical Services (East and West CHS only)	Minor	DN not wearing a mask despite being asked due to renal pt condition, did not have any in their car either. Pt feels all nurses should at least have them at their disposal	Upheld	All Community nursing staff to carry and wear face mask when dealing with immunocompromise and vulnerable high risk patient.	Care and Treatment
8969	Reading	Mental Health Services	Low	Mum unhappy with response and says it is full of lies. She wants clinician to be changed. ORIGINAL COMPLAINT Medication review required, appt booked but cancelled by service. New prescription needs to be forwarded to GP. Also advised art therapy would be 14 months, they have been waiting between 17/18 months, when will this happen	Not Upheld	Ensure all future appts are booked as face to face appts and there are 2 members of staff present	Medication

9006	Slough	Clinical Services (East and West CHS only)	Minor	Physio appt being changed from NHS facility to private, cancelled without notification	Upheld	When referring patients manually to an alternative provider we will: 1. Check that a Berkshire Healthcare invite letter has not been sent – rather than assuming based on waiting list 2. Discharge patients from Berkshire Healthcare immediately on transferring the referral to private provider The administrative team have been reminded to send a text message in addition to leaving a voicemail when cancelling appointments, and the importance emphasised.	Communication

Appendix 1

15 Steps; Quarter One 2023/24

During quarter one, there were four visits:

Ascot Ward – Wokingham Community Hospital

Positives observed during the visit:

- One staff member approached us and introduced herself took interest in the purpose and nature of our visit
- The ward smelt fresh, and it felt calm
- We spoke to two patients, and they felt the staff were welcoming and listened to their needs.
- There was contact information presented on the ward door
- The were hand sanitizer dispensers on entry to the ward and in the bays

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

- Visiting times was presented at the main door however there was a large notice board that had be placed in the view. The service lead said that she would make sure that the visiting times are more visible
- There was not a key to differentiate the different types of uniforms staff worn and what their jobs tiles were. The service lead said they will look into putting the different uniforms on display

Physiotherapy – Wokingham Community Hospital

Positives observed during the visit:

- Feedback board from I want great care was on display
- Access to a room behind main reception for new appointments and regular patients are offered use of this room for privacy
- They have leaflets on display which are well organised
- Equipment was stored away

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

- The clinic doesn't have a visible mobile phone policy. This was discussed and the team lead indicated that, if the patient is in clinic and the phone is disturbing the session, patients will be asked to turn it off
- A lot of the patient information is only available in English. The Team Lead explained that they can be printed out or emailed in another language upon request. When language needs are identified on referral, these are met at the appointment

The Garden Clinic – Upton Community Hospital

Positives observed during the visit:

- Staff and the reception area were welcoming

- They observed a doctor sanitizing the clinic room in between patients. In clinic rooms all equipment was stored away and no clutter was present

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

- Some of the data and information on show was out of date, this was removed and will be replaced with up to date information
- The clinic was hard to find after leaving main reception mainly due to confusing signage. The team lead indicated that patients had mentioned the same and the manager would be informed.

Podiatry – Upton Community Hospital

Positives observed during the visit:

- Information was available on how to make a complaint and give feedback
- The was a display in the clinic about the different types of shoes Recommended for patients
- There was no photo board to identify staff and their names. However, there were labels on the door for the clinicians available on day of visit

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

- Some of the posters were repetitive. Old posters are being removed.
- There wasn’t a ‘you said, we did’ board. The lead said that they will be replacing the ‘you said, we did’ board which had previously been removed

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	12 September 2023
Title	**Quality Assurance Committee – 29 August 2023**
	ITEM FOR NOTING AND RATIFICATION OF CHANGES TO QAC'S TERMS OF REFERENCE
Purpose	To receive the unconfirmed minutes of the meeting of the Quality Assurance Committee of 29 August 2023.
Business Area	Corporate
Author	Julie Hill, Company Secretary for Sally Glen, Committee Chair
Relevant Strategic Objectives	To provide good outcomes from treatment and care.
CQC Registration/Patient Care Impacts	Supports ongoing registration
Resource Impacts	None
Legal Implications	Meeting requirements of terms of reference.
Equalities and Diversity Implications	N/A
SUMMARY	The unconfirmed minutes of the Quality Assurance Committee meeting held on 29 August 2023 are provided for information. The Committee made minor changes to its terms of reference (shown in tracked changes). The Trust Board is requested to ratify the changes. Attached to the minutes are the following reports which were discussed at the Quality Assurance Committee meeting and are presented to the Trust Board for information: • Learning from Deaths Quarterly Report • Guardians of Safe Working Hours Quarterly Report
ACTION REQUIRED	The Trust Board is requested to:

	a) Receive the minutes and the quarterly Guardians of Safe Working Hours and Learning from Deaths Reports and to seek any clarification on issues covered. b) Ratify the changes to the Committee's Terms of Reference

Berkshire Healthcare
NHS Foundation Trust

Minutes of the Quality Assurance Committee Meeting held on Tuesday, 29 August 2023

(the meeting was conducted via MS Teams)

Present:	Sally Glen, Non-Executive Director (Chair) Rebecca Burford, Non-Executive Director Aileen Feeney, Non-Executive Director Julian Emms, Chief Executive Minoo Irani, Medical Director Tehmeena Ajmal, Chief Operating Officer Guy Northover, Lead Clinical Director Daniel Badman, Deputy Director of Nursing *(deputising for Debbie Fulton, Director of Nursing and Therapies)* Amanda Mollett, Head of Clinical Effectiveness and Audit
In attendance:	Julie Hill, Company Secretary Katie Humphrey, Carers' Lead Sue McLaughlin, Clinical Director Raja Natarajan, Clinical Director Rose Warne, Clinical Director Daniel Payne, Senior Community Services Manager
Observer:	Debbie Riley, Family Liaison Officer

Opening Business

1 Apologies for absence and welcome

Apologies were received from: Debbie Fulton, Director of Nursing and Therapies

The Chair welcomed everyone to the meeting and in particular welcomed Rebecca Burford, Non-Executive Director who was attending her first Quality Assurance Committee meeting since starting her role as a Non-Executive Director on 1 July 2023.

2. Declaration of Any Other Business

There was no other business declared.

3. Declarations of Interest

There were no declarations of interest.

4.1 Minutes of the Meeting held on 30 May 2023

The minutes of the meeting held on 30 May 2023 were confirmed as an accurate record of the proceedings.

4.2 Matters Arising

The Matters Arising Log had been circulated.

The Chair reported that the Director of Estates and Facilities would be attending the next meeting to update the Committee on the Trust's work around managing the Prospect Park Hospital PFI (Private Finance Initiative) interface.

Action: Director of Estates and Facilities

Rebecca Burford, Non-Executive Director referred to the COPD (Chronic Obstructive Pulmonary Disease) Clinical Audit action and asked whether it was still the Trust's practice to write to patients who had been on the waiting list for six months and over asking them to confirm that they still wanted an appointment and if no response was received after the three-week deadline removing them from the waiting list.

The Medical Director said that he shared the Committee's concerns and reported that he had raised the issue the COPD Service Lead and with the Clinical Director and said that he was waiting for confirmation that the practice had stopped.

Ms Burford suggested reviewing those patients who had been removed from the waiting list.

The Medical Director said that the service was currently conducting a harm review and said that this should identify any patients who could potentially have been harmed based upon the vulnerability criteria.

Raja Natarajan, Clinical Director for Community Health Services explained that the harm review would also include looking at the primary reason for the referral and would take account of what else had been offered to the patient in terms of help whilst they were on the waiting list, for example, providing links to the Lung Society resources etc.

Dr Natarajan explained that nationally COPD waiting lists had increased following the COVID-19 pandemic and reported that the service had done some innovative work around increasing group sizes and arranging additional classes for patients etc. Dr Natarajan said that he would ask the service lead to provide an update at the next meeting on how the service was managing the waiting list and on the service's harm review work in relation to patients discharged from the waiting list.

Action: Chief Operating Officer/Raja Natarajan

Ms Burford commented that the Committee met quarterly and therefore it was a long time to wait for an update.

Raja Natarajan explained that each service reported to the relevant monthly Patient Safety and Quality meeting which in turn reported to the monthly Quality and Performance Executive Group. It was noted that the minutes of the Quality and Performance Executive Group were also reported to the Quality Assurance Committee.

The Chief Executive said that he chaired the Quality and Performance Executive Group and provided assurance that the issue would be picked up at the Quality and Performance Executive Group meeting.

Action: Chief Executive

The action log was noted.

Patient Safety and Experience

5.1 Carers Strategy Update

The Chair welcomed Katie Humphrey, Carers' Lead to the meeting.

Katie Humphrey gave a presentation and highlighted the following points:

- A carer was anyone, including children and adults, who looked after a family member; partner or friend who needed help because of their illness, frailty, disability, a mental health problem or an addiction and could not cope without their support. The care they gave was unpaid
- The Trust's Carers Strategy was based on the Carers Trust's Triangle of Care model, NICE principles, national guidance and best practice. It consisted of six Standards for services to work towards. All services should achieve Standards 1-3 which covered being carer aware, services identifying carers and involving carers in the planning of care and staff signposting and referring carers to relevant support
- Standards 4-6 included services having allocated staff responsible for carers, providing an introduction to the service and relevant information across the care pathway to carers and services providing a range of carers support and obtaining carers feedback
- Over the last year, the Carers Strategy work included: carer engagement, developing training including online Friends, Family and Carer Awareness training, updating the information published on the Trust's website and staff intranet, Triangle of Care accreditation, launching the Carers Charter, developing a Carer Toolkit and Self-Assessment Review, participating in NHS England's Mind the Gap Project and developing resources such as confidentiality and information sharing briefings for staff
- Over the next year, the Trust's Carers Strategy work would involve analysing the self-assessment review responses from services, reviewing action plans with teams to target areas for improvement, promoting and recruiting Friends, Family and Carers Champions, Continuing Professional Development, holding workshops for staff who were carers, developing a specific Carer Programme as part of the SilverCloud Health system and refreshing the Carers Strategy

The Chair commented that the role of carers was more important for some services, for example, mental health care of the older adult and children and young people and asked whether the Trust prioritised which services to focus on.

Ms Humphrey said that the expectation was that within mental health services teams should be working towards all six standards. For example, Prospect Park Hospital Wards should be achieving all six Carer Standards and if they were not, additional targeted support would be offered. Ms Humphrey confirmed that the analysis of the self-assessment data would evidence how services were achieving the Standards. Based on this data, the Carers Lead will prioritise which teams/services to work with.

The Chief Operating Officer asked whether there was anything more services could do to support the Trust's work with carers.

Ms Humphrey said that one of her biggest challenges was making sure that she went out and about and met with teams and said that she had been waiting until the new Operational Structure had bedded down and then she would be visiting services again to re-introduce herself and to promote the Carer Strategy work.

The Chief Operating Officer said that she would discuss with her Senior Operational Leadership Team how best to ensure that Ms Humphrey was part of any discussions relevant to the Carers Strategy work.

Action: Chief Operating Officer

The Chair asked whether the Carer Strategy Steering Group was co-chaired with a carer. Ms Humphrey confirmed that she chaired the Steering Group but agreed that it would be a good idea to consider a co-chair for next time.

Action: Carers Lead

The Chair thanked Katie Humphrey for her presentation.

5.2 Suicide Prevention Work Update

The Chair welcomed Sue McLaughlin, Clinical Director to the meeting.

Sue McLaughlin gave a presentation and highlighted the following points:

- The Trust's suicide rate (per 10,000 contacts) and number of suicides had dipped during the COVID-19 pandemic but had now increased to the pre-pandemic level
- The Trust had been successful in recruiting to Accident and Emergency Outreach posts to work on safety planning with people who attended the Royal Berkshire Hospital and Wexham Park Hospital
- These roles were recommendation by the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) to identify individuals who may be at risk of suicide after self-harming
- The Trust was working with the University of West London on running bespoke ligature harm prevention workshops using simulation
- The Trust was continuing its anti-ligature work making the Prospect Park Hospital environment safer by reducing access to ligature points
- There was a focus on holistic assessment and relational security through safety planning
- In-patient admission and recent discharge from hospital continued to be periods of high risk. There was a focus on improving patient safety at these times by ensuring pre-discharge leave and discharge planning to address any adverse circumstances the patient may be returning to
- The Trust had developed a Nurse Consultant Network to support staff with complex cases
- "Turbo Training" had been introduced to respond quickly to themes (observations, novel methods, for example, ordering poisons online and online internet research and pro suicide groups etc)
- A real time suicide dashboard had been developed
- There was a higher prevalence of self-harm on the inpatient wards amongst patients with neurodiversity. In collaboration with a carer bereaved by suicide, the Trust had developed a workshop for staff to help them to make adjustments and create safety plans for neurodiverse patients
- The Trust's surveillance data had prompted deep dives in the following areas:

    - Female deaths (menopause, blanket exclusions, adverse childhood experiences
    - Taking Therapy Deaths (risk assessment, PHQ-9 (depression score)
    - Deaths in the Royal Borough of Windsor and Maidenhead (underway)
    - Alcohol Deaths
- The Trust had developed a robust package of staff support
- Prospect Park Hospital was a test site for the Care Quality Commission's new Ligature Guidance
- The Trust was jointly working with the East and West Berkshire Suicide Prevention Group, led by Public Health to provide a forum for wider learning and an opportunity to inform system priorities
- The Trust was a member of the Thames Valley Suicide Prevention and Intervention Network. The Trust had also been invited to author a chapter on suicide risk in a new NHS England publication
- During 2023-24, the Trust would continue with its Zero Suicide Work in Mental Health inpatient environments, develop and test Suicide and Self-Harm Pathways, review the three-day Suicide Prevention training, implement the NCISH 10 Ways to Improve Safety guidance, review the risk categorisation and the model/documentation for risk assessment and safety/care plans and participate in the Pilot of the Real-Time Surveillance data collection
- The Trust would be holding a "Every Little Thing" Festival on 10 September 2023 to coincide with the World Suicide Prevention Day. The festival was the brainchild of a mother whose daughter sadly lost her life to suicide in May 2020. The festival is so named because there was no singular event that caused her daughter to end her life but rather a complex mix of "every little thing."

The Chair thanked Ms McLaughlin for her excellent presentation and commented that she had not appreciated the extent to which the Trust's Suicide Prevention work had achieved national recognition.

The Chief Operating Officer asked Ms McLaughlin to explain a bit more about the Nurse Consultants Network.

Ms McLaughlin explained that the Nurse Consultants Group Network was a group of very experienced nurses who worked across services and also worked together to support less experienced staff with complex cases etc.

Aileen Feeney, Non-Executive Director asked why there had been a dip in the number of suicides during the COVID-19 pandemic.

Ms McLaughlin explained that the reduction in the number of suicides was reflected internationally and may be due to big events such as a pandemic giving people a sense of purpose and the positive impact of communities coming together to support each other.

The Chair thanked Ms McLaughlin for her presentation.

5.3 Quality Concerns Register Status Report

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

- There were two new concerns since the Register was last presented to the Committee:

    - **Environment at Prospect Park specifically in relation to ligature management** both in terms of ensuring fixtures and fittings conformed to latest standards and contract oversight. This was added following completion of the investigation into the Never Event.
    - **Heath visiting**, reflecting the high caseloads (2.5 times caseload sizes recommended by the National Institute of Health Visiting) and demands on the service resulting in potential for harm/safeguarding concerns for vulnerable children to be missed. Known high risk families and children on Child in Need and Child Protection Plans were prioritised.
- No concerns had been removed since the Register was last presented to this Committee, however it was agreed at the August 2023 Quality and Performance Executive Group meeting that Podiatry and Heart Function concerns would both be removed following sustained improvements.
- For Podiatry, these improvements were following agreed actions to discharge those with lower level need to ensure focus of the service was on those with urgent need and need that could only be met though accessing a podiatry service alongside some recruitment. For Heart function this was as a result of recruitment into the service.

The Chief Executive said that the Health Visiting issue was of concern and pointed out that Health Visiting Services were commissioned by local authorities whose finances had been squeezed in recent years and therefore when the contracts were re-tendered, the contract value may not be sufficient to run the service.

The Chair commented that she found the Quality Concerns Register Report particularly helpful in identifying current areas of concerns. The Chair said that the minutes of the Quality and Performance Executive Group meetings also provided useful context to the Quality Concerns.

The Committee noted the report.

5.4 Never Event Action Update

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

- The never event concerned shower rail gliders at Prospect Park Hospital which were found not to release as expected from the shower rail. This was considered as a never event even when it was a “near miss”
- An investigation was undertaken with the subsequent report summary and recommendations presented to the Committee
- An action plan was developed which was monitored monthly at the Incident Review Group with oversight from the Quality and Performance Executive Group. A quarterly report would be provided to the Quality Assurance Committee

The Deputy Director of Nursing confirmed that the Director of Estates and Facilities would be attending the November 2023 meeting to update the Committee on the Estates Led Action Plan in response to the never event. The Chief Executive suggested an extended time slot of 30 minutes for the item.

Action: Company Secretary

The Deputy Director of Nursing reported that the Trust had recently completed a successful pilot using replacement tracks. The Trust would now proceed with ordering the new tracks.

The Committee noted the report.

5.5 Regulation 28 Action Plan Report

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

- The regulation 28: Preventing Future Deaths Report was issued jointly to the Trust and to the Local Authority following the inquest into the death of Lucy Anne Walles which concluded on 16th June 2023 with a recorded conclusion of Suicide
- The Trust had developed an action plan in response to the issues raised by the Coroner. The Trust was also actively participating in the Local Authority Safeguarding Adult Review that was currently in progress.

The Committee noted the report.

5.6 Sexual Safety Report

The Deputy Director of Nursing presented the paper and reported that a significant amount of work was being done to improve sexual safety of both staff and patients.

The Deputy Director of Nursing said that the Trust's Sexual Safety data indicated that the measures taken to date were insufficient to lead to a significant reduction in the number of physical sexual assaults (incidents coded as physical sexual assaults include all allegations of unwanted in appropriate contact including touching of hair through to rape).

The Deputy Director of Nursing reported that the Trust was therefore reviewing the current service model with a focus on evidence surrounding provision of single sex accommodation. Further countermeasures needed to be considered as an integral part of the refresh on the Sexual Safety Project work.

The Chair commented that she looked forward to hearing about the Trust's further work around reducing sexual safety incidents in due course.

The Committee noted the report.

5.7 Serious Incidents Report

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

- During quarter one, there were a total of 14 serious incidents reported.
- The Trust had been involved in 14 inquests during the quarter. There was one Preventing Future Death reports issued to the Trust following an inquest
- Supporting staff and families post incident remained a key focus for the Trust
- In response to thematic analysis, learning and requirements for improvement that had been identified from serious incident investigations and internal learning reviews, there continued to be significant patient safety activity across the Trust during this quarter.
- For our mental health services, the training programme that was based on identified learning continued to be further developed and provided. Specific, targeted learning events had also recommenced following the organisational restructuring.
- Across physical health, work had begun on addressing some of the issues with digital care plans that had been identified from our investigations.

The Chair referred to the Mental Health section of the report and in particular to the practice of sending patients “opt-in” letters for new treatment pathways, for example, Psychological Therapies patients who did not respond to these letters were then discharged. The Chair suggested that opt-in letters may not be the most appropriate approach for more vulnerable patients.

The Deputy Director of Nursing reported that the Head of Psychological Therapies was reviewing this approach and agreed to ask the Head of Psychological Therapies to provide an update to the Committee.

Action: Deputy Director of Nursing

The Committee noted the report.

5.8 Learning from Deaths Quarterly Report

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

- During quarter 1, 109 deaths had met the criteria to be reviewed by the Executive Mortality Review Group and the outcomes were as follows:
    - 57 were closed with no further action
    - 50 required “second stage” reviews (using an initial finding review/structured judgement review methodology)
- Of the 50 deaths requiring further review, 5 were classified as Serious Incidents requiring investigation. Two deaths were awaiting further information at the time of the report
- The 109 first stage reviews were categorised as follows based on the DATIX information and/or cause of death:
    - Expected deaths: 46
    - Unexpected deaths 63
- During Quarter 1, the Trust Mortality Review Group had received the findings of 44 second stage review reports of which 15 related to patients with a learning disability

The Chair commented that the Learning from Deaths Report was very comprehensive and included a lot of detail. It was noted that the report was also presented to the Trust Board for assurance.

The Chief Executive said a lot of the focus of the Lucy Letby case was around the importance of having a Speaking Up Culture. The Chief Executive added that developing a Safety Culture which focussed on issues relating to systems and processes rather than on blaming individuals when things went wrong was also important. The Chief Executive said that the mortality review systems and processes together with the role of the Medical Examiner were part of the safety process and helped to identity any areas for concern and/or an unusual pattern of deaths.

The Medical Director agreed and advised the Committee that the Learning from Deaths process was established to understand quality of care and learn from deaths where care was poor. The Medical Director added that it would be more difficult to pick up the exceptionally rare cases where clinicians were deliberately harming patients and pointed out that the medical examiner system was designed for that.. The Medical Director said that in the case of every death, he and the Head of Clinical Effectiveness and Audit reviewed all aspects of a patient’s care prior to their death to identify any learning and/or any areas of concern.

The Committee noted the report.

5.9 **National Patient Safety Strategy Implementation Report**

The Deputy Director of Nursing presented the report and highlighted the following points:

- The Patient Safety Specialist roles were well established locally and regionally with regular contact with the Integrated Care Boards and NHS England as well as all local organisations and a number of national organisations and early adopters.
- The implementation of the new national reporting framework - Learning from Patient Safety Events (LFPSE) was planned by 01 September 2023. The risk had been mitigated where possible and Datix queues were being actively managed to reduce risks at the point of transition. There were some risk areas that could not be quantified and addressed until the new system was in use
- Compliance with the Patient Safety Syllabus Level 1 was now around 92%
- The Patient Safety Team and wider Governance Team now had a 100% compliance with Level 1 and Level 2 Syllabus training as required under Patient Safety Response Framework (PSIRF (Patient Safety Incident Response Framework)) competency requirements.
- There was substantial work in progress to ensure compliance with the PSIRF "whole System Approach" training; currently around 70% (from previous 50%).
- There was also substantial work in progress to address further training requirements with all governance teams/individuals in governance posts and future work plans for those involved in completing terms of references for full investigations (to ensure a cultural shift toward psychological safety and whole system approach to learning)
- To support our transition to PSIRF, the Trust was developing an operational implementation plan which would identify which existing processes would need to be amended to meet the new way of working to review incidents. This included the need to update policies to reflect PSIRF (e.g., Duty of Candour, Falls, Pressure Ulcers); to develop terms of references for new meetings/committees; to review templates for initial findings and for writing up learning responses.
- The new policy and implementation plan that supported adoption of the new national framework had been to the Quality and Performance Executive Group meeting in 2023 July and would be presented to Trust Board In Committee meeting in September 2023 ahead of finalisation of these documents and formal Board sign-off in November 2023. Formal sign-off would also be required from the Integrated Care Boards

The Chair acknowledged the significant amount of work that staff had done in order to prepare for the implementation of the National Patient Safety Strategy.

The Committee noted the report.

5.10 Quarterly Infection Prevention and Control Report

The Quarterly Infection Prevention and Control Report had been circulated.

The Deputy Director of Nursing reported that there had been an increase in the incidence of COVID-19 on the wards.

Aileen Feeney, Non-Executive Director asked whether the Trust was planning to immunise staff against COVID-19 this autumn.

The Medical Director reported that the Trust would be following NHS England guidance in relation to the Flu and COIVD-19 staff vaccination programme.

The Chief Operating Officer reported that the Trust's Health Bus had been booked on 10 October 2023 to provide Board Members with the opportunity of having their vaccinations when attending the face to face Trust Board Discursive meeting.

The Committee noted the report.

Clinical Effectiveness and Outcomes

6.0 Clinical Audit Report

The Medical Director reported that five national clinical audit reports had been received and presented to the Clinical Effectiveness Group since the last meeting:

- National Audit of Cardiac Rehabilitation (NACR) Quality and Outcomes Report 2022
- POMH (Prescribing Observatory for Mental Health) Topic 21a: The Use of Melatonin
- National Audit of Care at the End of Life (NACEL) Round 4 (2022-23)
- National Clinical Audit of Psychosis (NCAP): Early Intervention in Psychosis (EIP) Re-audit (2022/23)
- POMH Topic 20b: Improving the quality of valproate prescribing in adult mental health services reaudit.

a) National Audit on Cardiac Rehabilitation

The Medical Director said that the audit had made five key national recommendations and confirmed that all five were relevant to the Cardiac Rehabilitation service and were being achieved.

b) Use of Melatonin

The Medical Director reported that this new audit measured compliance with standards on the management of insomnia in children. It was noted that the Trust had scored above the national sample on three out of the six standards audited.

Three standards were identified as areas for improvement. In order to improve future practice, it was recommended that services created a document listing standard operating procedures for the initiation and review of melatonin. An action plan was in place.

c) Care at the End of Life

The Medical Director reported that this was the fourth year of the audit. All summary scores were above or in line with the national average. Two areas were identified for improvement and were specifically in regard to recording the communication the service had with patients and families. Challenges were noted with regards to the use of the electronic End of Life Care Plan. The recommendation was that in the interim, paper-record care plans would be reinstated whilst solutions were found to improve the electronic issues. An action plan was in place.

d) Early Intervention in Psychosis

The Medical Director reported that the service had seen its overall standard remain as 'Needs Improvement,' with the Effective Treatment domain continuing to significantly contribute to this grading. The service had made great strides in improving the Physical Health metric from an outlier status and 'Greatest need for Improvement' to 'Top Performing.'

The other previous outlier, 'Family Intervention,' continued to be 'Needs Improvement' and 'Carer Education and Support' had dropped to 'Greatest need for Improvement' from 'Top Performing' in 2021/22. Actions from the previous round were only just completed at the time of the re-audit. An action plan was in place with several new initiatives to improve practice.

e) Improving the quality of valproate prescribing in adult mental health services re-audit

The Medical Director reported that Standard 6 was the main area of risk and focus which was around if valproate was prescribed for a woman of childbearing age (WCBA), there should be documented evidence that the conditions of 'prevent', the pregnancy prevention programme, were fulfilled. The total number of women being prescribed valproate had reduced, which showed that the Trust had improved performance since the 2020 audit. However, 64% was still very low especially given the high risk associated with use of valproate in this client group.

The Trust aimed for 100% of these patients to have documented evidence that the conditions of 'PREVENT' were fulfilled. An action plan was in place.

The Medical Director said that the audit included all patients who had been prescribed valporate rather than a sample of patients.

Daniel Payne, Senior Community Service Manager said that the actions taken by the service included changes to the clinical dictation system which would automatically raise a flag when valproate was prescribed. It was noted that there was also emerging evidence that valproate could have an adverse effect on fertility in men.

The Committee noted the report.

6.1 Quality Accounts 2023-24 Quarter 1 Report

The Quality Accounts 2023-24 Quarter 1 Report had been circulated.

The Medical Director said that any comments on the Quality Accounts Report could be sent to either the Head of Clinical Effectiveness and Audit or to himself.

The Committee noted the report.

7.0 Annual Review of Effectiveness and Terms of Reference Review Report

The results of the Committee's Annual Review of Effectiveness Questionnaire had been circulated.

The Chair referred to the question on virtual meetings and proposed that meetings would alternate between face to face and virtual. The Chair noted that although hybrid meetings were not ideal, there were times when the option of being able to join a meeting virtually was useful.

The Committee's Terms of Reference with proposed minor changes shown in tracked changes had been circulated.

The Committee:

a) Noted the results of the Committee's annual review of effectiveness
b) Agreed that future meetings would alternate between being held face to face and held virtually

c) Agreed to recommend to the Trust Board that the changes to the Committee's Terms of Reference (shown in tracked changes) be ratified.

8.0 Guardian of Safe Working Hours Quarterly Report

The Medical Director presented the paper and reported that during the reporting period (1 May 2023 to 31 July 2023), there had been no exception reports.

It was noted that the Guardian of Safe Working Hours had provided assurance to the Trust Board that no unsafe working hours had been identified and there were no other patient safety issues requiring escalation.

The Committee noted the report.

8.1 Minutes of the Mental Health Act Governance Board

The minutes of the Mental Health Act Governance Board meeting held on 17 May 2023 had been circulated.

The Medical Director reported that the Reducing Health Inequalities Project on Mental Health Act Detention Rates of Black Patients was progressing well.

The Medical Director said that there was adequate assurance provided by the various services about the use of the Mental Health Act. There were some areas of improvement identified in relation to consent to treatment and reading the rights to patients.

The Committee noted the minutes.

8.2 Annual Place of Safety Report 2022-23

The Annual Place of Safety Report 2022-23 had been circulated.

The Medical Director commented that there was huge pressure on the Place of Safety with Police Officers often waiting with individuals in their car because the Place of Safety was full. The Medical Director reported that the replacement Place of Safety was scheduled to be completed by summer 2024.

The Committee noted the report.

8.3 Annual Mental Health Act Report 2022-23

The Annual Mental Health Act Report 2022-23 had been circulated.

The Chair commented that the Annual Mental Health Act Report did not include information about cases where the detention paperwork was not renewed on time and was therefore technically, the detention was illegal.

The Medical Director said that in most cases, detention paperwork not completed on time was due to administrative error. The Medical Director said that he would request for this information to be included in future annual reports.

Action: Medical Director

The Committee noted the report.

8.4 Annual Safeguarding Report 2022-23

The Annual Safeguarding Report 2022-23 had been circulated.

The Committee noted the report.

8.5 Quality and Performance Executive Group Minutes – May 2023, June 2023 and July 2023

The minutes of the Quality and Performance Executive Group minutes for May 2022, June 2023 and July 2023 had been circulated.

The Committee noted the minutes.

8.6 Council of Governors Quality Assurance Group – Visits to Services

Copies of Governor Visit Reports to West Berkshire Community Hospital and Wokingham Community Hospital Community Geriatrics, Ascot Ward had been circulated.

The Chair thanked the Governors for their comprehensive reports. The Chair noted that the report to West Berkshire Community Hospital had highlighted issues around accessing Reading and Wokingham Social Services. The Deputy Director of Nursing said that he would be happy to investigate the issue if the Governors provided more information about the issues.

Action: Deputy Director of Nursing

The Committee noted the Governors' service visit reports.

Closing Business

9.0 Quality Assurance Committee Horizon Scanning

There were no additional items identified for future agendas.

The Chair said that the Director of Nursing and Therapies would be providing assurance to next Trust Board on the Trust's systems and processes in relation to the issues raised by the Lucy Letby case.

The Chief Executive said that it would be helpful for the Committee to receive an update in due course on the Trust's work with the Royal Berkshire NHS Foundation Trust to improve the digital interface between the two trusts.

Action: Chief Information Officer

9.1. Any Other Business

There was no other business.

9.2. Date of the Next Meeting

The next meeting was scheduled to take place on 28 November 2023 at 10am. The meeting would be held face to face at London House, Bracknell with the option of attending the meeting via MS Teams.

These minutes are an accurate record of the Quality Assurance Committee meeting held on 29 August 2023.

Signed:- _____

Date: - 28 November 2023

Berkshire Healthcare
NHS Foundation Trust

TRUST BOARD

Quality Assurance Committee

Terms of Reference

Purpose

This document describes the terms of reference for the Trust's Quality Committee, a standing Committee of the Board.

Document Control

Version	Date	Author	Comments
1.0	25.7.12	John Tonkin	Initial draft
2.0	31.7.12	John Tonkin	Amendments following Exec Discussion on 30 July 2012
3.0	20.8.12	John Tonkin	Amendments following Exec Discussion on 16 August 2012
4.0	11.9.12	John Tonkin	Post Board approval – 11 September 2012
5.0	5.4.14	John Tonkin	Post review with Director of Nursing & Governance
6.0	3.6.14	John Tonkin	For Board approval post QAC discussion 22 May 2014 APPROVED AT JUNE 2014 Board meeting
7.0	21.2.17	Julie Hill	Updated to include the Committee's new responsibilities in relation to receiving the Guardians of Safe Working reports and providing oversight of the Trust's mortality review process. Approved at July 2017 Trust Board meeting
8.0	July 2018	Julie Hill	Minor changes - approved by the September 2018 Trust Board meeting
9.0	June 2019	Julie Hill	Minor changes – approved by the September 2019 Trust Board meeting

This document is unrestricted.

Quality Assurance Committee - Terms of Reference

1. Constitution

Berkshire Healthcare NHS Foundation Trust (BHFT) Board has established a Quality Assurance Committee which will act as a formal sub-committee of the Board with terms of reference as set out in this document and approved by the Trust Board.

2. Membership

The Committee's membership will comprise:

- 3 Non-Executive Directors
- Chief Executive
- Chief Operating Officer
- Medical Director
- Director of Nursing and Therapies
- The Lead Clinical Director will routinely attend Committee meetings
- Other directors and managers will attend meetings when requested by the Committee
- The Clinical Lead(s) for the Clinical Audit(s) under discussion will be invited to attend the meeting.

The Board will nominate the Committee Chair from amongst the Non-Executive Director members of the Committee. In the Chair's absence, another Non-Executive Director will chair the Committee.

The Chair of the Quality Assurance Committee will be the designated Non-Executive Director with responsibility for providing oversight of the Trust's mortality review systems and processes.

The Lead Clinical Director will routinely attend Committee meetings and other directors and managers will attend meetings when requested by the Committee.

In order for the meeting to be quorate, 3 members must be present, including at least one Non-Executive Director and one Executive Director. The Board will approve any changes in membership and will approve any changes to these terms of reference.

3. Frequency of Meetings

The Committee will meet on not less than four occasions a year. The Chair may agree requests for additional meetings according to business requirements and urgency.

4. Purpose

The Quality Assurance Committee fulfils a scrutiny role on behalf of the Board on service quality. This will include, but not be restricted to, review of infection control performance, organisational learning from serious incidents, performance against quality priorities, CQC inspection reports,

Trust safeguarding assurance, quality concerns relating to staffing and mortality review systems and processes assurance.

- The Committee will also review any quality indicators as requested by the Trust Board
- Progress in implementing action plans to address shortcomings in the quality of services, should they be identified

The Quality Assurance Committee will provide assurance to the Trust Board as to the quality of service delivery with particular focus on the areas of patient safety, clinical effectiveness and patient experience. The Trust Board may request that the Quality Assurance Committee reviews specific issues where it requires additional assurance about the effectiveness of the governance, risk management and internal control systems in place relating to quality.

On behalf of the Trust Board, the Quality Assurance Committee will receive the update report from the Guardians of Safe Working and will report any issues of concern to the Trust Board.

The Quality Assurance Committee will also be responsible for reviewing, on behalf of the Trust Board, the quality improvement targets set in the annual plan and Quality Account. It will provide assurance to the Trust Board that improvement targets are based on achievable action plans to deliver them and that quality performance issues are followed up and acted on appropriately.

The Trust's Audit Committee will have overall responsibility for independently monitoring, reviewing and reporting to the Trust Board on all aspects of governance, risk management and internal control. On behalf of the Trust Board, the Audit Committee has overall responsibility for overseeing the Board Assurance Framework. The Quality Assurance Committee will be responsible for reviewing the quality related risks on the Board Assurance Committee. Any comments made by the Committee will be reported to the Audit Committee as part of the Board Assurance update report.

Section 5 of these terms of reference sets out the reporting arrangements which will support the Audit Committee in discharging this responsibility.

5. Reporting

The Quality Assurance Committee will receive exception reports covering issues escalated from the Executive quality governance process.

The minutes of the Quality Assurance Committee's meetings will be received by the Trust Board along with the quarterly Learning from Deaths and Guardians of Safe Working Hours for Doctors and Dentists in training reports. The Committee will also refer the Quality Concerns report to the In Committee Trust Board meeting. The Chair of the Committee will provide an oral report to the next convenient Trust Board after each Committee meeting. The Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure to the full Board.

The minutes of Quality Assurance Committee meetings will be included on the Audit Committee agenda for information and comment.

6. Duties

a. Governance, internal control and risk management

To provide in-depth scrutiny on behalf of the Trust Board of the delivery of high quality care through an effective system of governance in relation to clinical services.

b. Audit

To receive and review the findings of Internal and External National Clinical Audit reports ~~covering patient safety, quality and experience~~. If there is any perceived ambiguity regarding the relative roles of the Audit Committee and the Quality Assurance Committee in this respect, the committee chairs will liaise to agree a satisfactory approach. Through its reporting to the Audit Committee, the Quality Assurance Committee will ensure that the Audit Committee is informed of its work in this area

~~To receive summary reports of national clinical audits.~~

c. Quality and safety

To receive reports on compliance with the Care Quality Commission's Fundamental Standards. To receive all reports on the Trust produced by the Care Quality Commission and to seek assurance on the actions being taken to address recommendations and other issues identified.

To ensure that the Trust learns from national and local reviews and inspections and implements all necessary recommendations to improve the safety and quality of care.

To receive reports on significant concerns or adverse findings highlighted by external bodies in relation to clinical quality and safety and the actions being taken by management to address these.

To receive and consider reports from the Health Service Ombudsman

To monitor and review the systems and processes in place in the Trust in relation to Infection Control and to review progress against identified risks to reducing hospital acquired infections.

To review aggregated analyses of adverse events (including serious incidents), complaints, claims and litigation to identify common themes and trends and gain assurance that appropriate actions are being taken to address these.

To receive reports on national mandated clinical audits conducted within the Trust.

To review available benchmarking information on quality, safety and patient experience in support of the realisation of continuous improvement.

To review and contribute to the Trust's annual Quality Account and make recommendations as appropriate for Trust Board approval.

To be responsible for endorsing the Trust's criteria for the scope of the mortality review process.

To review the quarterly reports from the Trust's Mortality Review Group.

To receive the minutes of the Mental Health Act Governance Board.

To review the quarterly Guardians of Safe Working for Doctors and Dentist in Training reports

7. Reporting to the Board

The minutes of the meetings of the Committee will be presented to the Trust Board.

Version ~~9~~ 10 to be approved by the ~~Approved by the~~ Trust Board in September 2023~~19~~

For review: August 2023

QPEG / QAC/ Trust Board	August 2023
Title	**Learning from Deaths Quarter 1 Report 2023/24**
Purpose	To provide assurance to the Trust Board that the Trust is appropriately reviewing and learning from deaths
Business Area	Clinical Trust Wide
Authors	Head of Clinical Effectiveness and Audit
Relevant Strategic Objectives	Aligns with the Trust's True North Goals of Harm Free Care and Good Patient Experience
Equality Diversity Implications	A national requirement is that deaths of patients with a learning disability & Autism are reviewed to promote accessibility to equitable care. This report provides positive assurance of learning from these deaths.
Summary	109 deaths met criteria for a first stage review, were reviewed by the Executive Mortality Review Group (EMRG) and the outcomes were as follows: • 57 were closed at first stage review with no further action required. • 50 required 'second stage' review (using an initial finding review (IFR)/ Structured Judgement Review (SJR) methodology) • Of the 50 deaths requiring further review, 5 were classed as Serious Incident Requiring Investigation (SI) • 2 awaiting further information at time of report. The 109 first stage reviews were categorised as follows, based on the Datix information and/ or cause of death: • Expected deaths: 46 • Unexpected deaths: 63 During Q1, the trust mortality review group (TMRG) received the findings of 44 2nd stage review reports, of which 15 related to patients with a learning disability. Learning themes arising from discussion of second stage review reports were noted at every opportunity. All 30 inpatient deaths in the trust have been independently scrutinised by a Medical Examiner (ME), the ME process allows for the Medical Examiner to also recommend cases for structured judgement review and notify us of any family concerns, none were notified in Q1. In Q1, 5 new complaints or concerns were received from families following the death of a relative, 2nd stage reviews were conducted for all and learning was noted. **Avoidability Scale/ Score** All deaths in physical health services subject to a 2nd stage review were scored using an avoidability scale, of the reviews concluded none were a governance 'cause for concern' (avoidability score of 1, 2 or 3). .
ACTION REQUIRED	The committee is asked to receive and note the Q1 learning from deaths.

Figure 1. Summary of Deaths and Reviews completed in 2023/24.

Figure 1	20/21 total	21/22 total	Total 22/23	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24	Total to date 23/24
Total deaths screened (Datix) 1st stage review	510	467	456	**109**				**109**
Total number of 2nd stage reviews requested (SJR/IFR/RCA)	269	209	192	**50**				**50**
Total number of deaths reported as serious incidents	48	35	31	**5**				**5**
Total Expected Deaths	-	-		**46**				**46**
Total Unexpected Deaths	-	-		**63**				**63**
Total number of deaths judged > 50% likely to be due to problems with care (Avoidability score of 1, 2 or 3)	1	4	0	**0**				**0**
Number of Hospital Inpatient deaths reported (Including patients at the end of life and unexpected deaths following transfer)	185	156	157	**37**				**37**
Total number of deaths of patients with a Learning Disability (1st stage reviews)	53	51	36	**10**				**10**
Total number of deaths of patients with Learning Disability where care was rated as poor	0	0	0	**0**				**0**

Note: The date is recorded by the month we receive the form which is not always the month the patient died
Total number of expected and unexpected deaths is a new additional metric for 2023/24

1.1Total Deaths Screened (1st stage review)
109 deaths were submitted by services through the trust Datix reporting system for a first stage review by the EMRG. Of these 109 deaths reviewed, EMRG advised closing 57 cases, 50 were referred for a second stage review of which 5 were referred for SI investigation. 2cases were awaiting further information at the time of writing this report.

Figure 1 details the first stage reviews by division and whether the death was expected or unexpected based on the first stage review and cause of death.

Figure 1:

Division	Expected Deaths	Unexpected Deaths	Total Deaths 2023/24
Children Young Persons and Families	3	4	7
Learning Disabilities	5	5	10
Community Mental Health	4	39	43
Mental Health Inpatients	1	1	2
Physical Health	33	14	47
Total	**46**	**63**	**109**

Both MH inpatients were transferred to an acute hospital or hospice prior to death.

1.2. 2nd Stage Reviews Completed
The Trust-wide mortality review group (TMRG) meets monthly and is chaired by the Medical Director; 44 second stage reviews have been received and considered by the group in Q1. Figure 3 details the service where the review was conducted.

Figure 3: 2nd Stage Reviews Completed in Q1

Month	Total Number	Divisions
April 2023	11 SJR 5 IFR 1 S42 **17 Total**	Learning Disabilities: 5 SJR West Mental Health: 3 SJR, 3 IFR East Mental Health: 2 IFR Mental health inpatients: 1 SJR

		West Physical Health: 1 SJR, 1 S42 East Physical Health: 1 SJR
May 2023	13 SJR 5 IFR **18 Total**	Learning Disabilities: 7 SJR West Mental Health: 1 IFR East Mental Health: 3 IFR Mental Health Inpatients: 1 IFR West Physical Health: 6 SJR
June 2023	7 SJR 2 IFR **9 Total**	Learning Disabilities: 3 SJR Community Mental Health: 1 IFR Mental health specialist services: 1 IFR Urgent Community Services:1 SJR Scheduled Community Services: 3 SJR

2. Concerns or Complaints

In Q1, 5 new complaints or concerns were received from families following the death of a relative.

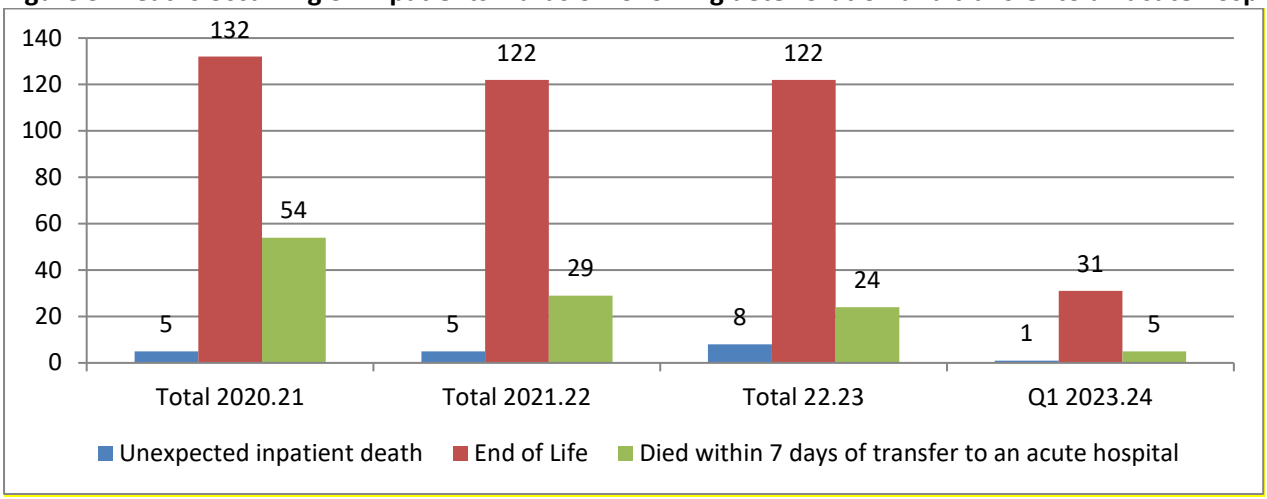
- Communication and Clinical Care (District Nursing) x4
- Clinical Care (Community Mental Health)

None of the complaint related SJR reviews at TMRG raised concern that the quality of care provided had contributed to the patient's death. Learning was noted and has been shared with relevant teams.

3.1 Deaths of patients (including palliative care) on Inpatient Wards

For inpatients we require all deaths to be reported on the Datix system including patients who are expected to die and receiving palliative care. Figure 3 details these.

Figure 3: Deaths occurring on inpatients wards or following deterioration and transfer to an acute hospital.



In Q1 there were 35 deaths reported by community inpatient wards, and 2 deaths reported by mental health inpatients, of which:

- 29 were expected deaths and related to patients who were receiving end of life care (EOL) on our wards. 28 were closed at 1st stage review.
- One older adult patient with a planned EOL transfer to hospice, closed at 1st stage review.
- One Oakwood patient with a planned EOL transfer to hospice, closed at 1st stage review.
- 5 unexpected deaths due to ill health deterioration where they were transferred to an acute hospital and died within 7 days (Including 1 mental health patient). 2nd stage reviews requested for all.
- 1 unexpected death on the ward, 2nd stage review requested.

3.2 Covid-19 Inpatient deaths.

From the deaths noted above, 1 patient who died had tested positive for Covid 19 within the 28 days prior to their death, they were admitted for EOL care, a 2nd stage review was requested as Covid 19 was listed as 1a on the medical certificate of cause of death.

At the start of the Covid 19 pandemic there was a national requirement to submit data on all deaths of inpatients who had died within 28 days of testing positive for Covid 19 or who had Covid 19 stated on their medical certificate of cause of death (MCCD). As of 30th June 2023 we are no longer required to notify deaths of patients who tested positive or who may have Covid 19 stated on their MCCD.

3.3 Medical Examiner (ME)

All 30 inpatient deaths have been independently scrutinised by a Medical Examiner. In 27 cases, the medical certificate of cause of death (MCCD) was agreed and processed. 3 cases were referred by the ME to the coroner, of these:

- 1 required a post-mortem due to a sudden unexpected death, a natural cause was confirmed, and a 2nd stage review is being undertaken.
- 2 have gone to inquest, both due to the patient sustaining a fall prior to admission, which contributed to their death.

The ME process allows for the Medical Examiner to also recommend cases for structured judgement review and notify us of any family concerns, none were notified in Q1.

4. Deaths of Children and Young People

In Q1, 7 deaths were submitted as a Datix for 1st stage review. – 1 case of death by suspected suicide will be reviewed as a serious incident (SI). All other cases were closed at EMRG following 1st stage review. Cause of death was either extreme prematurity or complex disability in most cases. All deaths of children and young people are reviewed by the Berkshire Child Death Overview Panel (CDOP).

5. Deaths of adults with a learning disability

In Q1 the Trust Mortality Review Group (TMRG) reviewed a total of 15 deaths of adults with learning disabilities who had received services from Berkshire Healthcare in the 12 months prior to their death. Of these, 14 reviews were undertaken by the LD service and 1 by Scheduled Community Services. The Structured Judgement Review methodology was used for all reported deaths, the reviews were also appraised by the LD Clinical Review Group (CRG) prior to review and sign off by the TMRG.

The deaths were attributed to the following causes:

Immediate cause of death	Number of deaths
Diseases of the respiratory system	7
Diseases of the heart and circulatory system	3
Cancer	2
Diseases of the nervous system	1
Other	2

No deaths were related to COVID 19.

Demographics:

Gender:

Female	7
Male	8

Age:

The age at time of death ranged from 24 to 88 years of age (median age: 58 yrs.)

Severity of Learning Disability:

Mild	1
Moderate	4
Severe	4
Profound	2
Not Known	4

Ethnicity:

White British	12
Asian or Asian British - Pakistani	3

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

6. Deaths categorised as Serious Incidents

In Q1, 5 deaths were reported as serious incidents (See SI Q1 report for details).

7. Avoidability of deaths scale/ score
Judging the level of the avoidability of a death is a complex assessment, for all deaths in physical health services where a second stage review is conducted, the second-stage reviewer supports the score choice with an explicit judgement comment justifying why the score decision was made, this score is confirmed at TMRG.

Score 1 Definitely avoidable
Score 2 Strong evidence of avoidability
Score 3 Probably avoidable (more than 50:50)
Score 4 Possibly avoidable, but not very likely (less than 50:50)
Score 5 Slight evidence of avoidability
Score 6 Definitely not avoidable

A score of 3,2, or 1 would indicate a governance cause for concern. All deaths reviewed in Q1 were assessed as scoring a 4,5, or 6 and did not raise a governance concern, although this does not prevent learning from being identified when care could have been better.

8.Learning from Deaths

Immediate learning from all deaths is shared by Clinical Directors and Governance Leads through locality governance and quality meetings. Where the need for more focussed learning is identified following 2nd stage review, an Internal Learning Review is facilitated by the Patient Safety Team.

Learning themes are identified at each TMRG from second stage reviews, which are shared via the divisional governance meetings and in the trust clinical Circulation brief to all staff and also where relevant, with the ICS mortality review group for system learning.

Thematic learning on deaths from both the Trust Serious Incident process and mortality review will be summarised in this report in Q4 2023/24.

9.Conclusion

During Q1 the executive mortality review group (EMRG) reviewed 109 first stage reviews of which 46 related to expected deaths and 63 were classed as unexpected. 48 2nd stage reviews were requested.

During Q1 the trust mortality review group (TMRG) received the findings of 44 2nd stage review reports. All hospital inpatient deaths were reviewed by a medical examiner.

All deaths of a physical health cause subject to a 2nd stage review were reviewed using an avoidability scale, and these reviews did not raise a governance cause for concern.

Berkshire Healthcare NHS Foundation Trust

Quality Assurance Committee Paper

Meeting Date	August 2023
Title	Guardian of Safe Working Hours Quarterly Report (May to July 2023)
Purpose	To assure the Trust Board of safe working hours for junior doctors in BHFT
Business Area	Medical Director
Authors	Ian Stephenson & Malar Sandilyan
Relevant Strategic Objectives	1 – To provide accessible, safe, and clinically effective services that improve patient experience and outcomes of care
CQC Registration/Patient Care Impacts	Supports maintenance of CQC registration and safe patient care
Resource Impacts	Currently 1 PA medical time
Legal Implications	Statutory role
Equalities and Diversity Implications	N/A
SUMMARY	This is the latest quarterly Guardian of Safe Working report for consideration by Trust Board. This report focusses on the period 1st May to 1st August 2023. Since the last report to the Trust Board, we have received no exception reports. We do not foresee any problems with the exception reporting policy or process; neither do we see a significant likelihood of BHFT being in frequent breach of safe working hours in the next quarter.
ACTION REQUIRED	The QAC/Trust Board is requested to: Note the assurance provided by the Head of Medical Workforce & Medical Education and the GOSW.

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

This report covers the period 1st May to 1st August 2023

Executive summary

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

This report focusses on the period the period 1st May to 1st August 2023. Since the last report to the Trust Board, we have received no '*hours & rest'* exception reports and no '*education*' reports.

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

Introduction

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

High level data

Number of doctors in training (total): 44 (FY1 – ST6)

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

Number of doctors in training on 2016 TCS (total): 44

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

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

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

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

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

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

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

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

In this period, we have received no exception reports.

Exception reporting is a neutral action and is encouraged by the Guardians and DME. We continue to promote the use of exception reporting by trainees, and make sure that they are aware that we will support them in putting in these reports.

It is the opinion of Medical Staffing and the Guardian of Safe Working that “time off in lieu” (TOIL) is the most appropriate action following an exception report to minimize the effects of excessive work.

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

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

b) Work schedule reviews

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

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

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

c) **Gaps**

(All data provided below for bookings (bank/agency/trainees) covers the period 1st May to 1st August 2023)

Psychiatry	Number of shifts requested	Number of shifts worked	Number of shifts worked by:			Number of hours requested	Number of hours worked	Number of hours worked by:		
			Bank	Trainee	Agency			Bank	Trainee	Agency
	101	100	53	47	0	1027.5	1022	587.5	434.5	0

Reason	Number of shifts requested	Number of shifts worked	Number of shifts worked by:			Number of hours requested	Number of hours worked	Number of hours worked by:		
			Bank	Trainee	Agency			Bank	Trainee	Agency
Gap	38	38	18	20	0	396	396	213	183	0
Sickness	63	62	35	27	0	631.5	626	374.5	251.5	0
Maternity	0	0	0	0	0	0	0	0	0	0
Total	101	100	53	47	0	1027.5	1022	587.5	434.5	0

d) **Fines**

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

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

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

Qualitative information

The OOH rota is currently operating at 1:13 and our system for cover continues to work as normal, with gaps generally being quickly filled. Our bank doctors continue to be an asset, and we continue to increase this pool. We have had one unfilled gap in this period. For this unfilled gap patient safety was not an issue and we always had one junior doctor on duty out of hours.

Issues arising

Exception reporting remains at a level consistent with previous GOSW Board reports. The current level of exception reporting suggests that Junior Doctors are not working unsafe hours, and this is confirmed by the qualitative information from the Junior Doctors Forum. However, it is possible that there may be under-reporting of small excess hours worked.

Actions taken to resolve issues

Next report to be submitted November 2023.

Summary

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

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

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

Questions for consideration

The Head of Medical Workforce & Medical Education and the GOSW asks the Board to note the report and the assurances given above.

The Head of Medical Workforce & Medical Education and the GOSW makes no recommendations to the Board for escalation/further actions.

Report compiled by Ian Stephenson, Head of Medical Workforce & Medical Education and Dr Malar Babu Sandilyan, GOSW.

Appendix A: Glossary of frequently used terms and abbreviations

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

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

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

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

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

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

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

Appendix B

Factsheet: Safety limits and rest

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

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

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

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	12 September 2023
Title	**Executive Report**
	Item for Approval/noting – • **delegation of approval of the National Cost Collection Submission to the Finance, Investment and Performance Committee** • **Board approval of the Staff Vaccination Programme requirements**
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	The Trust Board is requested to: a) To note the report and seek any clarification.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Meeting – 12 September 2023

EXECUTIVE REPORT – Public

1. Never Events

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

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

2. NHS England's Letter Following the Lucy Letby Trial Verdict

Following the trial verdict of Lucy Letby on 18 August 2023 in relation to the appalling murder of seven babies at the Countess of Chester Hospital between June 2015 and June 2016, NHS England wrote to all Provider Trusts, Primary Care Networks, and Integrated Care Boards (letter attached).

The letter details some steps already being taken to strengthen patient safety including:

National Initiatives	Berkshire Healthcare's Work
The introduction of the medical examiner which has created additional safeguards by ensuring independent scrutiny of all deaths not investigated by a coroner and improving data quality, making it easier to spot potential problems	Whilst this is not yet a statutory requirement for non-acute provider organisations across Berkshire this process was commenced for community and mental health wards in December 2021. In addition, any concerns raised by families from the Medical Examiner or requests to complete a Structured Judgement Review (SJR) by the medical examiner have been completed and tracked through our Trust Mortality Review process.
The new patient safety incident response framework, due to be implemented across the NHS from this autumn which represents a significant shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging	Within Berkshire Healthcare we have detailed plans for the implementation of the new national patient safety strategy with formal sign-off of both the revised policy and Patient Safety Implementation Plan due at the November 2023 Trust Board. The has been wide consultation across the Trust to develop this including appointing Patient Safety Partners. In addition, we have been proactively involved in a programme of work

National Initiatives	Berkshire Healthcare's Work
with families, and taking effective steps to improve and deliver safer care for patients.	with Making Families Count (a unique training organisation made up of harmed and bereaved family members working in partnership with senior, experienced NHS professionals who aim to improve outcomes for families and staff affected by serious harm and traumatic bereavements in health services) to produce a handbook for staff working with NHS organisations for compassionate engagement with patients and families.
Strengthened National Freedom to Speak Policy template. There is an expectation that this will be adopted by all NHS providers by January 2024	Within Berkshire Healthcare our Freedom to Speak Up Policy is aligned to the national policy with an updated version in final stages of sign-off and expected to receive final approval during September.
Fit and Proper Person Test	All very senior leaders (Executive and Non-Executive Board members and those on Very Senior Manager contracts) are currently subject to a Fit and Proper Person process. Individuals must be of good character, have the necessary qualifications, competence, skills and experience for their role, have the appropriate level of physical and mental fitness, have not been party to any serious misconduct or mismanagement in the course of carrying out a regulated activity, and not be deemed unfit under the FPPT Regulation provisions. Providers must also ensure that certain information regarding the individuals is available to the CQC. NHS England has now developed a new Fit and Proper Person Test (FPPT) Framework in response to recommendations made by Tom Kark KC in his 2019 review of the FPPT. The new FPPT framework was published on 2 August 2023. The framework is designed to assess the appropriateness of an individual to discharge their duties effectively in their capacity as a board member.

The letter acknowledges that the actions above are not sufficient, and that good governance is also necessary and asks that Boards specifically urgently ensure that:

NHS England's Good Governance Requirements	Berkshire Healthcare's Assurance
All staff have easy access to information on how to speak up.	Within the Trust, speaking up is part of our corporate induction and it is included within training such as our Prevention and Management of Violence and Aggression. There are dedicated pages on our intranet, posters across our sites and we have an active Champions network which supports promotion of

<table>
<tr><th>NHS England's Good Governance Requirements</th><th>Berkshire Healthcare's Assurance</th></tr>
<tr><td></td><td>Freedom to Speak Up. Our Freedom to Speak Up Guardian attends staff network events, away days and undertakes regular service and site visits.

Our national staff survey results (below) are monitored to understand the staff view of speaking up, with actions put in place to continually progress and improve.

<table>
<tr><th></th><th>2018 score</th><th>2022 score</th><th>Movement</th><th>Distance from average scoring 2022</th></tr>
<tr><td colspan="5">We each have a voice that counts</td></tr>
<tr><td>I would feel secure raising concerns about unsafe clinical practice</td><td>76.1%</td><td>80.2%</td><td>+4.1%</td><td>+3.5%</td></tr>
<tr><td>I am confident that my organisation would address my concern</td><td>67.9%</td><td>73%</td><td>+5.1%</td><td>+11.5%</td></tr>
<tr><td>I feel safe to speak up about anything that concerns me in this organisation</td><td>74.8% (2020 first time asked)</td><td>74.9%</td><td>+0.1%</td><td>+7.9%</td></tr>
<tr><td>If I spoke up about something that concerned me I am confident my organisation would address my concern</td><td>65.8% (2020 first time asked)</td><td>65.7%</td><td>-0.1%</td><td>+10.7%</td></tr>
</table>

We recognise that whilst our scores in relation to confidence in acting on clinical concerns has continued to improve, as have scores in terms of confidence to raise any concerns including clinical concerns, the scores for confidence in addressing of any concerns raised has reduced by 0.1; we have a focus on demonstrating positive and decisive action in terms of bullying, harassment and racism experienced by our staff to support further improvement.</td></tr>
<tr><td>Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians (FTSUG) are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.</td><td>Our Freedom to Speak Up Guardian and Deputy Director of People have confirmed that they are aware of the scheme</td></tr>
<tr><td>Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of</td><td>The Freedom to Speak Up Guardian attends staff network and other events as well as visiting sites and services to promote all staff feeling safe to speak up; we have developed a Champion network which includes staff from a diversity of backgrounds, roles and bands across the organisation to support those who may be less confident to speak up. Initatives such as</td></tr>
</table>

NHS England's Good Governance Requirements	Berkshire Healthcare's Assurance
or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.	work undertaken in relation to bullying and harrassment and anti-racism support our continual improvement journey Freedom to Speak Up is part of the Trust Safety Culture improvements and initatives Service visits including out of hours/ weekend visits are undertaken by board and senior leaders Our Freedom to Speak Up Guardian is the chair of the South East Freedom to Speka Up network which enables sharing of good practice and learning.
Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.	Our Freedom to Speak Up Guardian attends Board 6 monthly and provides a report which includes staff experiences around speaking up. A self-assessment using the NHS England's review tool is undertaken 2 yearly by the Board, this was last received at public Board in July 2023. The Trust Freedom to Speak Up Strategy has been refreshed and received at the Public Board in July 2023 Service visits are undertaken by Executive and Non-Executive Directors and this includes out of hours visits. There is a Non-Executive Director responsible for Freedom to Speak Up who meets regularly with the Freedom to Speak Up Guardian
Boards are regularly reporting, reviewing, and acting upon available data.	The Board reviews learning from deaths report quarterly and Freedom to Speak Up report 6 monthly. The Board sees data on whistleblowing and case management.

In addition to the expectations and actions detailed within the letter from NHS England, we recognise the importance of proactively supporting quality improvement, developing leadership with a focus on safety, compassion and kindness as well as tackling the challenges our staff from diverse backgrounds face. Alongside this, supporting the wellbeing and feeling of belonging for our staff and good governance at every level are vital to both the fostering and sustaining of a safety culture and therefore this continues to be our focus and drive for ongoing improvement.

Our 2022 national staff survey results are strong in comparison to many other NHS providers demonstrating a positive speak up culture (as detailed above). As well as this we have above average scores across all themes within the staff survey, including that we are compassionate and inclusive (7.7 sector average 7.5), and we are safe and healthy (6.4 sector average 6.2). We are also best in sector for both staff engagement (7.4 sector average 7) and the 'we are always learning' themes (6.1 sector average 5.7). All of these factors are vital for supporting our vision for a culture where staff feel able to suggest improvements, share learning and raise concerns as part of their day to day working practice, confident that they will be heard and importantly that the concerns will be followed up.

Although lots of work has been undertaken to continue to improve the culture across the organisation there is no room for complacency, there is always more that can be done to ensure that our improvement journey continues. We continue to find ways of promoting how staff can speak up as well as ways of supporting managers and leaders to listen and follow up in an appropriate manner.

We know that the positive experience of working in the trust experienced by the majority of our staff is not the experience of everyone, that is especially true of our staff who are from diverse backgrounds, staff whose first language is not English and also those who work in more junior roles and/or work out of hours and we continue to seek ways to address this.

The drive to promote an anti-racist culture across the organisation that we have commenced alongside the ongoing work to further promote a culture of safety for all will also support our ongoing improvement journey.

Alongside this, as a next step in terms of Freedom to Speak Up, we will revisit the self-assessment document using the new version of the Reflection and Planning Tool and develop a revised improvement plan from this which will be shared with the Board. The Trust will also be implementing the new FPPT framework.

Executive Lead: Debbie Fulton Director of Nursing and Therapies

3. New Fit and Proper Persons Test Requirements

As mentioned above, on 2 August 2023, NHS England published a Fit and Proper Person Test (FPPT) framework in response to the recommendations made by Tom Kark KC in his 2019 review of the FPPT.

The FPPT was originally introduced in 2014 via Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The legislation has not changed but this new framework aims to support NHS organisations' compliance with the regulations and makes some changes to the checks and balances that are intended to ensure directors satisfy the regulatory requirements.

The new framework effectively sets out how NHS England will implement the four Kark proposals broadly accepted by the government. They were the creation of: "specified standards of competence" for board directors; a "database of directors"; a "mandatory reference requirement for each director; and the extension of the FPPT to arms-length bodies including NHS England and the Care Quality Commission.

The NHS national Electronic Staff Record (ESR) system is being updated and will include employment history, references from previous employers or other board members, upheld disciplinary findings that include misconduct or mismanagement, and any ongoing or discontinued investigations relating to disciplinary, grievance, whistleblowing or employee behaviour. The ESR records will be used to populate a standard reference which would be produced whenever a board director leaves their role.

The guidance says that the standard reference will "help foster a culture of meritocracy, ensuring that only board members who are fit and proper are appointed to their role, and that there is no recycling of unfit individuals within the NHS."

The new FPPT requirements will come into effect from March 2024. The Trust will be updating its FPPT Policies and Procedures to comply with the new FPPT Framework.

NHS Providers' On the Day Briefing on the FPPT Framework is attached as an appendix to this report.

Executive Lead: Julie Hill, Company Secretary

4. Right Care, Right Person

The Government has recently published the National Partnership Agreement limiting the police response to mental health crises which will see the Right Care, Right Person (RCRP) approach being implemented.

The intention is help ensure that people with health and/or social care needs are responded to by the right person to best meet their needs. It particularly focuses on the interface between policing and mental health services.

The way this has been described in the media has caused some concern particularly when it was reported in May 2023 that the Metropolitan Police will no longer attend 999 calls linked to mental health incidents from September 2023. Due to stakeholder concern, the date of implementation across London has now been delayed by two months to allow for greater engagement with partners and patient groups.

Against this backdrop, I thought it would be helpful to set out the current position with Thames Valley Police as well as the context in which this initiative has developed.

In terms of background history, the following chronology summarises the origins of Right Care Right Person:

- In November 2018, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) produced the report 'Policing and Mental Health: Picking Up the Pieces' (justiceinspectorates.gov.uk).
- The report highlighted the need for greater joined up working and for the police to be a last resort rather than a first option when responding to people with mental health difficulties.

- This was to achieve a better patient experience and to ensure effective use of all resources to make sure that people experiencing mental health crisis would receive the right help, at the right time, and by the most appropriate service.
- The Right Care Right Person initiative was commenced by Humberside Police in 2019 and is a phased programme of partnership working and withdrawal of the police from certain types of demand, aiming to achieve that vulnerable people are given the right care and support when they are in crisis.
- Meaning that where there is immediate risk to life or a risk of serious harm, police will still attend. However, when agencies call the police about issues which do not meet the threshold for police intervention, they will signpost them to the most appropriate service.

Thames Valley Police are now in the process of rolling out Right Care Right Person . So far Right Care Right Person principles on directing care to the most appropriate agency are now applied to the below categories in the Thames Valley:

- Concern for safety (welfare checks)
- Absent without Leave from psychiatric hospitals
- Walk-outs from other healthcare settings (predominately acute care)

Thames Valley Police call handlers have been trained and provided with a toolkit to support their decision making in relation to whether a call for service is appropriate for a police response. The toolkit is very much in line with the national toolkit that is being developed and will be adopted and rolled out in due course across England and Wales.

Thames Valley Police are refining the toolkit based on partnership feedback and will continue to do so. Thames Valley Police are very clear they will continue to provide a response where there is a clear policing purpose, an immediate threat to life and or an immediate threat of serious injury. Encouragingly Thames Valley Police have just invested in ten full time mental health Police Constables. They will be based in their local policing areas and are committed full time to working directly with mental health partners. At this stage they have not adopted the following categories of Right Care Right Person:

- Mental Health Act Section 136 (S136 provides a power for police to remove a person believed to be suffering from a mental disorder and to be in need of immediate care and control to a Place of Safety)
- Voluntary mental health patients
- Transportation/conveyance

Their intention is to work with partners on these categories before implementation (there is no date set for this yet).

Thames Valley Police have produced the following helpful summary on their approach to implementation:

Concern for Safety Unless there is a real and immediate risk to life or of serious harm, it is unlikely that police will attend	**Expectations** Partner agency should • Exhaust all of their own reasonable enquiries • Be clear about the level or risk / harm • Be available to attend with police support
AWOL from psychiatric hospital Police will not routinely look for AWOL patients. There is an expectation that the hospital will plan S17 leave according to risk and be able to manage their own patient. Hospital staff will be expected to use their powers under S18 where possible.	**Expectations** Hospitals should • Report AWOL patients that fall into the special category • Exhaust all of their own reasonable enquiries • Be clear about the level of risk / harm • Provide information about medication and impact of not taking it / time scales for impact • Be available to attend with police support (e.g., S135(2) warrant
Walk out from Health care facility If a patient has capacity to make a decision, it is unlikely to meet the threshold for a police response. If a patient lacks capacity, there is an expectation that the facility will put measures in place to keep the patient safe.	**Expectations** If a person has left, but there is real and immediate risk to life or of serious harm the facility should • Exhaust all of their own reasonable enquiries • Be clear about what measures were put in place, and how the patient managed to walk out despite these • Be clear about the level of risk / harm • Provide information about any medication and the impact of not taking it / timescales for impact • Be able to explain the plan in place for when the patient is returned.

We enjoy a good relationship with the Thames Valley Police and engage with them at many levels. This will be key to successfully implementing Right Care Right Person N in the way it is intended. However, some stakeholders have raised concern about the quality of engagement they have had with Thames Valley Police, and they are currently attending to this as a matter of priority.

We share the view with Thames Valley Police that because of their complexity and ambiguity many situations that arise are not so easy for those working on the ground to assess quickly and accurately. This was certainly found to be the case in Humberside where initial issues/challenges included:

- specific incidents where a police response had been deemed necessary due to the patient risk in line with Articles 2/3 (saving life or preventing serious

harm), but where the police had refused to attend, or Force Control Room have stated it is not a police matter.
- Additional training and relationship building was required to ensure that a joint response was given where indicated – police as first response vs not responding at all.
- As police response to mental health calls decreased, there was an increase in ambulance mental health calls.

It is encouraging to note that Humberside have made progress on all the above issues. There have also been some significant cost implications in Humberside attributed in the main to the impact of additional staffing required for achieving the police being able to leave those detained under Section 136 of the Mental Health Act and voluntary attenders, at a Health Based Place of Safety (HBPoS) within one hour or arrival.

The total annual additional funding required is currently c£850k from Mental Health budgets across Humberside. The population covered by the Humberside Police Force is 920,000 – similar to the population of Berkshire. An issue we will now need to commence discussions with our two Integrated Care Boards.

Executive Lead: Julian Emms, Chief Executive

5. Staff Flu and COVID-19 Booster Vaccination Campaign 2023

Introduction

Seasonal Flu and Covid-19 vaccination remain a critically important public health intervention and a key priority for 2023-24 as part of protecting the public and staff over the winter months. This winter season, the approach being taken is to ensure timing and co-administration maximises clinical protection and therefore the resilience of health and care services, over the later winter months when Flu and COVID-19 are most likely to be prevalent.

In the Core NHS standard contract for 2023/24, Covid-19 vaccinations and Flu vaccinations for frontline healthcare workers is retained as an employer responsibility to offer and deliver the Flu and Covid-19 vaccine. Where possible, the advice is to deliver the vaccines together, though this may be a challenge with the delivery dates of the vaccines. It is believed by supporting greater levels of co-administration of vaccines, there is collectively an opportunity to achieve greater efficiency in delivery for providers at what we know is already a busy time of year.

The Joint Committee on Vaccination and Immunisation (JCVI) advise that the primary reason to vaccinate frontline healthcare workers is to avoid sickness absences, rather than to protect against transmission or because they are at greater risk of severe Covid-19. The aim is to offer the vaccinations to 100% of frontline healthcare workers, with a minimum uptake of 75%.

The original plan was to maximise and extend protection during the winter and through the period of greatest risk in December 2023 and early January 2024. To do this systems were to commence vaccination for care home residents and care home staff from 2nd October 2023, and other eligible flu and COVID cohorts from 7th October, however as of 30th August, and due to the new variant of Covid, the advice has been to bring forward the Covid vaccination campaign to mid-September 2023.

Communication plan

A communication strategy has been developed. Our communication campaign we are promoting this year follows last year's strapline, in line with national communications, *To immunity and beyond.* Nexus (staff internet) will be updated with the promotional material from early September 2023 and other promotional merchandise has been ordered.

The aim of the communication plan is to help Berkshire Healthcare reach the ambition of vaccinating 75% of staff for Flu. The aim is that the Communication plan will c**reate awareness and knowledge** about the vaccination programme by emphasising the benefits of the vaccine and potential risks of not being vaccinated.

The communication strategy aims to:

- **Make it easy** for those who are keen to have the vaccines to get them by offering various onsite and walk-in clinics.
- **Provide reassurance, information and motivation** for staff who are uncertain about having the vaccines (hesitant / resistant).
- **Peer engagement** by using trusted voices to build trust, provide validation and proof of safety. Can also do this by working with the Networks to be more inclusive with the programme and share messaging wider.
- **Provide low cost incentives** like stickers, pens, bugs, tote bags, stress balls.
- **Celebrate success** frequently via internal channels to encourage uptake, foster friendly competition between divisions and teams.

Our delivery model

This year's campaign is being managed by the Lead Nurse for Immunisations and is being delivered via a number of methods:

- Clinics at Trust locations.
- Peer vaccination on Trust sites and inpatient wards
- The Health Bus which will travel to various sites offering vaccines and health promotion.
- Flu vouchers.
- GP's/Local Pharmacists – where this occurs independently, staff will be asked to report back to the trust.

Vaccine

The Covid-19 vaccine will now be available from the second week of September 2023, the Flu vaccine will be available from the second week of October 2023. Our staff vaccination campaign will launch from mid-September 2023, timings to be confirmed due to the recent government changes.

Flu vaccine

- This year's vaccine will be Sequiris QIVc (cell-based), and can be given to all adults 18+, a different vaccine for the over 65's is not required in this year's campaign, though over 65's can access the preferred adjuvanted vaccine from their GP if preferred.
- Vouchers are being used for those that prefer to receive their vaccination at a local pharmacy.

Covid vaccine

- The Covid vaccine being given is yet to be confirmed at the time of writing this paper.

Requirements for Trust Boards

1. Record their commitment to achieving the ambition of 100% of frontline healthcare workers being vaccinated.
2. All Trust Board members and senior managers receive their vaccinations and publicise it.

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

6. Junior Doctor and Consultant Industrial Action

The British Medical Association has announced the next round of strike dates for September and October 2023, with considerable overlap for the first time (Junior Doctors and Consultant strike days). Not all doctors may choose to strike on these dates, below is potentially minimum staffing levels:

- **Tuesday 19 September:** 'Christmas Day' level of Consultant staffing (which means only 1 Adult/Older Adult Consultant Psychiatrist and 1 CAMHS Consultant providing daytime emergency cover), while junior doctors will work as usual.
- **Wednesday 20 September: "**Christmas Day" level of staffing only from Consultants and Junior Doctors
- **Thursday 21 and Friday 22 September:** Consultants will return to work as usual, full walkout by Junior Doctors
- **2 to 4 October: "**Christmas Day" level of staffing only from Consultants and Junior Doctors

The Trust Medical Staffing Department and Medical Director have implemented measures for previous rounds of Junior Doctors' and Consultants' strikes, so that safe level of medical cover has always been in place and routine clinical work has also been largely protected, with cancellation of routine work on strike days being exceptionally rare.

The overlap of Junior Doctors and Consultant strike days during September and October will be an additional challenge, planning for emergency and routine work cover on these days is on-going.

Executive Lead: Dr Minoo Irani, Medical Director

7. National Cost Collection Submission

The Trust is required on an annual basis to complete a National Cost Collection (NCC) submission. The submission is a mandatory requirement of all NHS providers and is compiled per NHS England's National Cost Collection guidance.

On review of the latest guidance there is a requirement for the submission to have Board level sign off. The actual extract from the guidance is detailed below.

1. The finance director is responsible for the accurate completion of the mandatory costing returns. The submission should be subjected to the same scrutiny and diligence as any other financial returns submitted by the provider, which should include formal review and sign off by the Board (or delegated committee).[1]

[1] This could be completed via electronic correspondence with delegated formal sign off by the Director of Finance

The national deadline for this year's submission has yet to be agreed.

Action

The Trust Board is requested to delegate responsibility for the National Cost Collection submission to the Finance, Investment and Performance Committee.

Executive Lead: Paul Gray, Chief Financial Officer

8. Institute for Fiscal Studies (IFS) Analysis of the NHS Long Term Workforce Plan

At the July 2023 Trust Board meeting, we reviewed the contents of the NHS Long Term Workforce plan – the publication of which has been welcomed by many. At the end of August 2023, the IFS published its analysis of the plan. Its key finding included the following:

- The NHS workforce plan will cost £50 billion and result in the health service employing half the public sector by the 2030s.

- The IFS calculates that under the plan, NHS staff will make up 49% of the public sector workforce in 2036, up from 38% now and 29% in 2010.

- One in 11 workers in England will be employed by the NHS in the mid-2030s, up from one in 17 now.

If social care grows at the same rate, one in 7 workers will be employed in health and care.

- Using estimates of wage growth from the Office of Budget Responsibility, the IFS calculates that expanding the workforce will require the NHS budget to increase by about 3.6% a year, similar to the long-term average but higher than the 2.4% a year since 2010.

- This will take the £156 billion NHS England budget to £265 billion by 2036-37, the report estimates. The IFS estimates that the workforce plan will increase health spending by 2% of GDP, equivalent to about £50 billion in today's prices.

- If honoured, it will drive budgets for the next decade - the estimated cost would be equivalent to 6p on income tax

Executive Lead: Julian Emms, Chief Executive

9. Essex Mental Health Independent Inquiry

The Essex mental health independent inquiry was announced in January 2021 to investigate matters surrounding the deaths of around 2,000 mental health inpatients across NHS trusts in Essex between 2000 and 2020. Dr Geraldine Strathdee was appointed chair of the non-statutory inquiry and, following her advice, the government has confirmed that it will be converted to a statutory inquiry under the Inquiries Act 2005. A statutory inquiry will have legal powers to compel witnesses, including those former and current staff of EPUT to give evidence. The government also commissioned Dr Strathdee to carry out a rapid review of the patient safety data collected for mental health services.

Executive Lead: Tehmeena Ajmal, Chief Operating Officer

Presented by: Julian Emms
Chief Executive
12 September 2023

To:
- All integrated care boards and NHS trusts:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses
  - heads of primary care
  - directors of medical education
- Primary care networks:
  - clinical directors

cc.
- NHS England regions:
  - directors
  - chief nurses
  - medical directors
  - directors of primary care and community services
  - directors of commissioning
  - workforce leads
  - postgraduate deans
  - heads of school
  - regional workforce, training and education directors / regional heads of nursing

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

18 August 2023

Dear Colleagues,

Verdict in the trial of Lucy Letby

We are writing to you today following the outcome of the trial of Lucy Letby.

Lucy Letby committed appalling crimes that were a terrible betrayal of the trust placed in her, and our thoughts are with all the families affected, who have suffered pain and anguish that few of us can imagine.

Colleagues across the health service have been shocked and sickened by her actions, which are beyond belief for staff working so hard across the NHS to save lives and care for patients and their families.

On behalf of the whole NHS, we welcome the independent inquiry announced by the Department of Health and Social Care into the events at the Countess of Chester and will co-operate fully and transparently to help ensure we learn every possible lesson from this awful case.

NHS England is committed to doing everything possible to prevent anything like this happening again, and we are already taking decisive steps towards strengthening patient safety monitoring.

The national roll-out of medical examiners since 2021 has created additional safeguards by ensuring independent scrutiny of all deaths not investigated by a coroner and improving data quality, making it easier to spot potential problems.

This autumn, the new Patient Safety Incident Response Framework will be implemented across the NHS – representing a significant shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients.

We also wanted to take this opportunity to remind you of the importance of NHS leaders listening to the concerns of patients, families and staff, and following whistleblowing procedures, alongside good governance, particularly at trust level.

We want everyone working in the health service to feel safe to speak up – and confident that it will be followed by a prompt response.

Last year we rolled out a strengthened Freedom to Speak Up (FTSU) policy. All organisations providing NHS services are expected to adopt the updated national policy by January 2024 at the latest.

That alone is not enough. Good governance is essential. NHS leaders and Boards must ensure proper implementation and oversight. Specifically, they must urgently ensure:

1. All staff have easy access to information on how to speak up.
2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for

communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.

4. Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.
5. Boards are regularly reporting, reviewing and acting upon available data.

While the CQC is primarily responsible for assuring speaking up arrangements, we have also asked integrated care boards to consider how all NHS organisations have accessible and effective speaking up arrangements.

All NHS organisations are reminded of their obligations under the Fit and Proper Person requirements not to appoint any individual as a Board director unless they fully satisfy all FPP requirements – including that they have not been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether lawful or not). The CQC can take action against any organisation that fails to meet these obligations.

NHS England has recently strengthened the Fit and Proper Person Framework by bringing in additional background checks, including a board member reference template, which also applies to board members taking on a non-board role.

This assessment will be refreshed annually and, for the first time, recorded on Electronic Staff Record so that it is transferable to other NHS organisations as part of their recruitment processes.

Lucy Letby's appalling crimes have shocked not just the NHS, but the nation. We know that you will share our commitment to doing everything we can to prevent anything like this happening again. The actions set out in this letter, along with our full co-operation with the independent inquiry to ensure every possible lesson is learned, will help us all make the NHS a safer place.

Yours sincerely,

Amanda Pritchard
NHS Chief Executive

Sir David Sloman
Chief Operating Officer
NHS England

Dame Ruth May
Chief Nursing Officer, England

Professor Sir Stephen Powis
National Medical Director
NHS England

next day BRIEFING NHS Providers

New Fit and Proper Persons Test Framework published

Introduction

NHS England (NHSE) published a new Fit and Proper Persons Test (FPPT) Framework on 2 August 2023 alongside guidance for chairs and for staff on implementation. A directory of board level learning and development opportunities was published at the same time. NHSE expect elements of the framework to be used from 30 September 2023 with full implementation by 31 March 2024.

In 2019, Tom Kark KC made recommendations to revise the existing FPPT process in his review into its scope, operation and purpose. The FPPT was originally introduced in 2014 via Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The legislation has not changed but this new framework aims to support NHS organisations' compliance with the regulations, and makes some changes to the checks and balances that are intended to ensure directors satisfy the regulatory requirements.

This briefing sets out the key elements of the framework, gives an overview of its contents, and includes our view on the framework and accompanying guidance. **NHS provider trust chairs** are responsible for ensuring this framework is implemented effectively, and **company secretaries** for taking actions set out in the framework and so would particularly benefit from familiarising themselves with it.

NHS Providers was on the national Kark Implementation Steering Group, which included representatives from the Care Quality Commission (CQC), provider board members, and NHSE's Freedom to Speak Up National Guardian among others. We were consulted on a draft of the framework in advance of publication. However we did not receive early sight of the appendices or associated guidance.

We are extremely grateful to the Kark Implementation Team at NHSE for their ongoing engagement with us and our members, and for acting on a number of significant issues we and our members raised during this process.

Key points

- The framework is positioned in the wider context of good governance, leadership and board development and applies to all board members of specified NHS organisations, including interim appointments and non-voting members. Integrated care board (ICB), CQC and NHSE board members are now within its scope, in addition to NHS provider trust and foundation trust (FT) board members.
- The majority of the requirements echo those that already existed in previous FPPT guidance. Core elements that continue to be assessed are: good character; possessing the qualifications, competence, skills and experience required; and financial soundness. These are in addition to standard employment checks such as CV checks, proof of identity and right to work.
- The statutory requirements of the FPPT are set out in Regulation 5 of the Health and Social Care Act 2008 (Regulations 2014). This is a non-statutory framework, based on the recommendations of the Kark Review.
- The framework introduces a new standardised board member reference. These should be created whenever a board member leaves an NHS organisation, regardless of whether they are moving immediately to another NHS role, and should be sought by employing NHS organisations when making a job offer. The reference is based on the NHS standard reference template but includes additional questions relevant to the FPPT.
- The Electronic Staff Record (ESR) will be used to store information related to FPPT checks and references. This will provide a standard way to record and report compliance internally. Retrospective population of data is not proposed.
- From 30 September, the board member reference template should be used for all new board appointments, and new references completed and retained locally for any board member leaving after this date.
- The full framework should be fully implemented by 31 March 2024.
- A full FPPT against the core elements of the framework should be undertaken whenever new appointments are made, if a board member moves to a new board role in their current organisation, and annually thereafter.
- Annual self-attestations by board members to confirm adherence to the regulations will continue.

- For joint appointments, checks will be undertaken by the host/employing organisation and confirmed to the other contracting organisations. For board roles filled by two individuals (job shares) both individuals will need to be assessed.
- **The chair of the board is accountable for taking all reasonable steps to ensure the FPPT is effectively implemented** in their organisation. NHSE regional directors are responsible for ensuring chairs of provider trusts/FTs and ICBs meet the requirements.
- Dispute resolution arrangements differ depending on whether the individual was appointed by NHSE. Processes to resolve disputes about data and information and about the outcome of FPPT assessments are detailed.
- The framework is published alongside eight appendices which include templates, checklists and a privacy notice.
- The additional guidance for chairs provides a summary of the requirements, focused on the actions chairs will need to take.
- Further guidance summarises processes for conducting the testing, entering the information into the Electronic Staff Record (ESR) and signing off the FPPT.
- Appendix 8 accompanying the framework announces an **evaluation of its effectiveness** 18 months following this launch, and advises that future consideration will be given to implementing a public facing register and including other 'significant roles' within scope.

FPPT framework

Good character

Schedule 4 of the Regulations continues to apply and so a search of Companies House's register of disqualified directors, the Charity Commission's register of removed trustees, and a Disclosure and Barring Service (DBS) check remain a requirement, as do checks with the relevant professional bodies where registration is required for a role.

The framework states that there is no statutory definition of 'good character' but sets out a series of considerations that are relevant. It remains the case, as in the prior guidance, that the good character consideration should include whether the individual has been responsible for, contributed to, or facilitated any serious misconduct or mismanagement when carrying out CQC-regulated activity.

It is made clear that context is paramount to judgements here unless there has been a decision by a court or professional regulators, or finding upheld after a disciplinary process. Context and the need for judgement is further emphasised as the framework sets out possible aggravating or mitigating

factors that should be considered when making a judgement. This section goes on to list possible matters that could constitute serious misconduct or mismanagement.

Qualifications, competence, skills required and experience

Again, Schedule 4 of the Regulations applies. For new appointments, NHS organisations must have appropriate processes in place to do initial checks in these areas. Qualifications (and any necessary professional registrations or accreditations) should be checked with the relevant body before appointment. Job descriptions should clearly set out the requirements in this respect. Recruitment, interview and assessment processes should enable the organisation to satisfy itself of the person's appropriateness in relation to the other three areas.

For board members already in post, annual appraisals should be used to feed into the FPPT assessment and appraisals should make use of the forthcoming NHS Leadership Competency Framework. Training may be identified to fill any gaps or development requirements identified. Failure to undergo identified training might mean the board member is not fit and proper. The need for reasonable adjustments should be considered (in line with the Equality Act 2010) when assessing the competence and skill of any individual, and so occupational health (OH) assessments should be undertaken for potential new appointees. The OH assessment itself does not form part of the FPPT.

Financial soundness

This short section reminds chairs that their organisation must continue to seek appropriate information to assure themselves that board members do not meet any of the elements of the unfit person test in Schedule 4 Part 1 of the regulations. These include bankruptcy, sequestration, insolvency and arrangements with creditors.

Breaches

Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 sets out the legal requirements for NHS directors. It will be breached if a board member is unfit on the grounds of character, fails to meet the relevant qualifications or have the relevant competence, skills and experience required, or is financially unsound. The framework expects the NHS organisation itself to identify such breaches. Regulation 5 is also breached if the organisation does not have proper processes in place to make the 'robust assessments' required by the regulations, or if, on receipt of information about a board member's fitness, the organisation reaches a decision about the board member that 'is not in the range of decisions a reasonable person would be expected to reach'.

'Regulatory inspections, such as a CQC inspection' would determine whether a breach has occurred in these latter cases.

Organisations should document the reasons for decisions to appoint someone with, for example, the competence but without the required qualifications, and this should be recorded in the annual return. Documentation should record reasons why an appointment has been made regardless and mitigations and/or reasons for any gaps in assurance.

Board member references

Board member references should be prepared by NHS organisations when a board member leaves, regardless of whether they are moving immediately to another NHS board role. NHS organisations should create and maintain these references so they can make them available if another NHS organisation requests them.

A standardised board member reference is being introduced. This is based on the standard NHS reference template but contains additional questions to support the new FPPT framework. The additional guidance for chairs includes a table in Appendix 2 which sets out the questions the new references will include, such as information regarding any discontinued, outstanding or upheld complaints tantamount to gross misconduct or serious misconduct or mismanagement; disciplinary actions (whether discontinued, outstanding or upheld) under the trust's disciplinary proceedings; and dismissal tantamount to gross or serious misconduct. The forthcoming Leadership Competency Framework (to be published by the end of September) should also be taken into account when writing the reference.

The framework considers the possibility of historical non-disclosure or settlement agreements being in place, and suggests that all parties be asked for permission to include such information in references. It further suggests that organisations consider adding an exclusion to future settlement agreements stating that information may be held on ESR without breaching confidentiality.

The framework also sets out the number and type of references required prior to appointment depending on what type of organisation the individual is moving from. However when the previous employer is not an NHS organisation there remains the expectation that something equivalent to the standardised NHS board member reference will be sought. Any 'negative' information obtained should be discussed with the individual, unless it is incompatible with Regulation 5 and means the individual cannot legally be appointed.

NHS organisations are expected to provide references for former employees within 14 days of request and include the historic information they sought upon that individual's original appointment. The framework also contains provisions for revising references when required.

Electronic Staff Record

The Electronic Staff Record system (ESR) will be used as a central database to hold individual FPPT information for all NHS board members. New data fields will be added to enable this. There is no public-facing register proposed at this time.

While the framework states that the information within ESR is only accessible within the board member's own organisation, individuals within the CQC will also be able to access it to assess compliance during inspection. Access to these records internally should be limited in accordance with local policy and in compliance with data protection law.

Each NHS organisation is responsible for keeping information in ESR up to date, with the chair accountable for this. NHS organisations will need to establish processes for updating ESR and also for individuals to access and exercise their rights in connection with the information held there.

The framework details the information that will be held about board members, and indicates which fields require validation annually as part of FPPT. Trusts and FTs are already expected to have data retention policies to comply with GDPR and the NHS Records Management Code of Practice.

It is worth noting that the additional guidance for chairs emphasises the need for "NHS organisations, as data controllers" to communicate to all those whose details will be held on ESR about the data to be held (and so with board members about the new data fields for the FPPT) and to give them the opportunity to object.

Dispute resolution

Where the dispute is about data or information held in relation to FPPT, local review processes should first be applied. If required, disputes should then be escalated to the NHSE Appointments Team in the case of NHSE appointed individuals otherwise disputes should be subject to further internal review, or in any case the individual may make a referral to the Information Commissioners Office, or instigate an employment tribunal (for executive directors) or civil proceedings. Disputed FPPT outcomes may

again be escalated to NHSE for roles they have appointed to, but otherwise organisations are advised to use internal processes and if required seek their own legal advice or advice from NHSE.

Quality assurance

The framework states that embedding of the FPPT within NHS organisations will be quality assured by the CQC, NHSE and external/independent review. The CQC will consider the processes in place as part of their well-led reviews, and will check evidence as to whether the board members meet the FPPT. In cases where the CQC has concerns it will notify the organisation and the individual concerned. The organisation will be expected to detail the steps taken to assure itself of the individual's fitness within ten days. If the CQC remains unsatisfied they can take further action up to and including regulatory action if there has been a clear breach of regulation.

The framework states that NHSE will 'have oversight' through receipt and review of the annual submissions to the regional director and every three years, NHS organisations will be expected to internally audit the controls in place around FPPT, including sample testing.

Appendices

The framework is published alongside eight appendices. These include a board member reference template, self-attestation template, privacy notice for sending to board members, a FPPT checklist and a statement about 'future considerations' for the FPPT framework.

Additional guidance

The additional guidance for chairs provides a summary of the requirements, focused on the actions chairs will need to take.

It highlights the importance of advising directors that their data will be held on ESR and affording them the opportunity to object, situates the FPPT checks firmly as part of the annual appraisal process, and considers the difference between making balanced judgements and cases where an individual would be automatically barred from being a board member.

It also contains further information about the potential inclusion of discontinued investigations as part of the FPPT. Internal dispute mechanisms will be required not only in case of disputed FPPT outcomes as is the case now, but also in relation to disputes about information held about board members on

ESR. Finally, an FPPT checklist is set out detailing what to consider as part of each check, as well as guidance on completing board member references.

Further guidance is aimed at those who will be for conducting the testing, entering the information into the Electronic Staff Record (ESR) and signing off the FPPT. It summarises the process-related steps and focuses on the data fields in ESR, how they should be completed, and by whom. It includes information on drawing Business Intelligence (BI reports) from ESR to support extraction of a FPPT dashboard.

NHS Providers view

We welcome the intent to encourage transparency and regular conversations between board members about probity, integrity, and upholding the highest standards and values among NHS board members. We also support the aims of the board member references, intended to help reduce the likelihood of directors whose probity or performance has not met agreed standards from moving between NHS institutions. It makes sense to extend the FPPT requirements to ICB, NHSE and CQC board members if they are intended to support good governance and leadership, and to help close the 'revolving door' between NHS organisations.

We strongly welcome the locating of the FPPT within the broader context of board development, and effective appraisals and appointments. A fundamental challenge for the framework (and Kark's recommendations) is that retrospective checks and assurances are unlikely in and of themselves lead to better boards or protect patients from poor decision-making: someone's historic performance in a board role may not be the best indicator of their fitness as a board member now, for example. Ongoing emphasis on integrity and the other Nolan Principles within NHS organisations is more likely to lead to better outcomes for patients than retrospective checks.

We had expressed concerns that perceptions of the existing FPPT requirements as a tick-box exercise rather than meaningful activity may persist in relation to this new framework if it is read as prescriptive as opposed to being a core part of effective performance management and board development, and we are pleased to see the explicit statement that NHSE will recognise that balanced judgements will be required, unless Schedule 4 is clearly breached.

We remain concerned about the implications of the proposed inclusion of ongoing and discontinued disciplinary or grievance proceedings within board member references. The chair's guidance makes it clear that "organisations may wish to take their own legal advice in relation to the potential risk of a

claim from the board member leaving or a prospective employer for matters relating to outstanding or discontinued complaints." We agree that there is potential here for legal challenge and, while appreciating the intent behind full disclosure referencing, worry about NHS provider organisations' capacity to manage this aspect of the framework, and the potential cost of any claims.

Data protection law, data subject access rights and the ability to object to personal data being held mean that the inclusion of one's personal details on the ESR database can only be voluntary. The framework or supporting guidance could have been explicit about the fact there is no mandatory requirement for people to share their personal data (it comes close in the chairs guidance by stating that directors must be advised in order that they have the opportunity to object). It is not explained what the NHS organisation should do in the case of such an objection: we do not believe individuals can be compelled to comply. Based on the thrust of the framework we would expect that the organisation should simply record that a person has elected not to have their data held on ESR.

The framework is not clear about precisely who will have access to the data, stating that it is accessible internally only by very senior colleagues, but also noting that HR colleagues will likely have some access, the CQC may have access, and NHSE will be a data processor. For these reasons, it makes sense that information governance leads be included in the circulation of the framework and very much engaged in its implementation. It is helpful that the framework sets out how organisations should manage Freedom of Information requests in respect of board members' personal data.

We anticipate that those responsible for collating and recording FPPT data will welcome the use of a standardised database for this. While views differ about the efficacy of ESR as a system, it has the benefit of being in use and already established in NHS organisations. Linking ESR to Business Intelligence should also enable reports to be drawn easily from the data to provide the chair with assurance.

FTs will appreciate the explanation about how the FPPT relates to the Council of Governors' role in NED appointments (section 4.5). To summarise: Council has no new responsibilities related to FPPT (they are not involved in judgements about fitness), however the framework suggests they should receive summary outcomes of the FPPT for non-executive board members as part of their involvement in chair and NED appraisals, and be informed of satisfactory initial FPPT assessments for new chair and NED appointments which they would consider in the round during the appointment process.

We welcome the statement in Appendix 8 that there will be an independent evaluation into the effectiveness of the framework 18 months following this launch, with the opportunity to make any required improvements. We encourage our members to feed back their queries, comments and any concerns to us in the interim so that we can share them with NHSE.

Finally, we would like to again thank the Kark Implementation Team at NHSE for their sustained communication and engagement with us and our members as they developed the framework.

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Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Meeting Date	12 September 2023
Title	**July 2023 Finance Report**
	Item for Noting
Purpose	To provide an update to the Board on the Trust's Financial Performance to 31 July 2023.
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: Efficient Use of Resources – A financially and environmentally sustainable organisation.
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 has a plan for a £1.3m surplus as part of the agreed plan for Buckinghamshire, Oxfordshire and Berkshire West ICS. The Trust is reporting a £0.1m surplus against a year-to-date deficit plan of £1.0m. The Trust's cash balance is below plan at £50.1m but this is expected to recover once ICB contract payment values are updated for 2023/24. The Trust is reporting £0.7m capital spend year to date.
ACTION	The 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 2023/24

July 2023

Purpose

To provide the Board and Executive with a summary of the Trust's financial performance for the period ending 31 July 2023.

Document Control

Version	*Date*	*Author*	*Comments*
1.0	09/08/2023	Rebecca Clegg	Draft
2.0	10/08/2023	Paul Gray	Final

Distribution

All Directors.

All staff as appropriate.

Dashboard & Summary Narrative

Target		Actual £m	Plan £m	Achieved	Forecast £m	Plan £m	Achieved
1a	Income and Expenditure Plan	0.1	-1.0	Yes	1.3	1.3	Yes
2a	CIP - Identification of Schemes	12.3	14.1	No	14.1	14.1	Yes
2b	CIP - Delivery of Identified Schemes	3.6	3.6	Yes	14.1	14.1	Yes
3a	Cash Balance	50.1	54.0	No	48.1	48.1	Yes
3b	Better Payment Practice Code Volume Non-NHS	94%	95%	No	95%	95%	Yes
3c	Better Payment Practice Code Value Non-NHS	90%	95%	No	95%	95%	Yes
3d	Better Payment Practice Code Volume NHS	97%	95%	Yes	95%	95%	Yes
3e	Better Payment Practice Code Value NHS	98%	95%	Yes	95%	95%	Yes
4f	Capital Expenditure not exceeding CDEL	0.7	1.0	No	9.5	9.2	No

Key Messages

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

- We are reporting a £0.1m surplus year to date (YTD), which is £1.1m better than planned.
- We are continuing to forecast that we will deliver our planned £1.3m surplus.
- Delivery against the cost improvement plan is on track linked to control total compliance.
- The 23/24 pay award, including back pay to April, and the 22/23 bonus elements were paid in June. After accounting for additional funding we estimate a c£1m full year pressure due to the way the NHS tariff uplift is calculated. However, this is currently being offset by delays to recruitment against core allocations.
- We have had further guidance regarding the elective recovery fund with confirmation that the clawback of allocations at system level will be capped at 16% along with a 2% reduction in targets for providers.
- Cash is still being impacted by delays by Frimley ICB increasing payments to the Trust in line with 2023/24 contract values, but we have agreed a revised schedule of payments addressing this issue.
- Capital is over plan year to date mainly due to the timing and volume of IT kit expenditure. Our forecast remains in excess of our CDEL capital allocation and we are continuing to review spend and opportunities for additional CDEL.

1. Income & Expenditure

Jul-23	In Month Act £'m	In Month Plan £'m	In Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m	2023/24 Plan £'m
Operating Income	29.1	30.2	(1.1)	115.0	115.0	(0.0)	349.2
Elective Recovery Fund	0.3	0.3	0.0	1.3	1.3	0.0	4.0
Donated Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Income	**29.5**	**30.6**	(1.1)	**116.3**	**116.4**	(0.0)	**353.3**
Staff In Post	18.9	21.2	2.2	76.1	78.7	2.5	239.4
Bank Spend	2.0	1.8	(0.2)	8.0	7.3	(0.6)	20.3
Agency Spend	0.6	0.5	(0.2)	2.5	1.9	(0.6)	5.1
Total Pay	**21.5**	**23.4**	**1.8**	**86.6**	**87.9**	**1.3**	**264.7**
Purchase of Healthcare	2.2	1.9	(0.3)	7.0	7.2	0.1	20.6
Drugs	0.6	0.5	(0.1)	1.9	1.8	(0.1)	5.4
Premises	1.5	1.5	0.1	5.9	6.2	0.3	18.5
Other Non Pay	1.6	1.5	(0.1)	6.6	5.9	(0.7)	17.9
PFI Lease	0.8	0.8	(0.1)	3.3	3.0	(0.3)	9.0
Total Non Pay	**6.7**	**6.1**	**(0.6)**	**24.9**	**24.2**	**(0.7)**	**71.4**
Total Operating Costs	**28.2**	**29.5**	**1.3**	**111.5**	**112.1**	**0.6**	**336.1**
EBITDA	**1.2**	**1.1**	**0.2**	**4.9**	**4.3**	**0.6**	**17.1**
Interest (Net)	0.1	0.2	0.2	0.4	1.0	0.6	3.0
Depreciation	0.9	0.9	(0.0)	3.7	3.6	(0.2)	10.7
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Disposals	(0.0)	0.0	0.0	(0.0)	0.0	0.0	0.0
PDC	0.2	0.2	0.0	0.7	0.7	0.1	2.2
Total Financing	**1.2**	**1.3**	**0.2**	**4.8**	**5.3**	**0.5**	**15.9**
Reported Surplus/ (Deficit)	**0.0**	**(0.3)**	**0.3**	**0.1**	**(1.0)**	**1.1**	**1.2**
Adjustments	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**(0.0)**	**0.1**
Adjusted Surplus/ (Deficit)	**0.1**	**(0.3)**	**0.3**	**0.1**	**(1.0)**	**1.1**	**1.3**

Key Messages

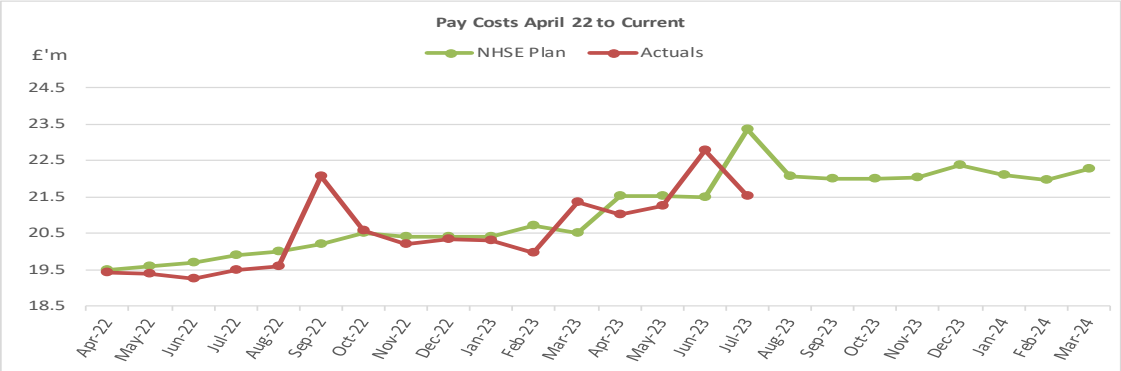
The table above gives the financial performance against the Trust's income and expenditure plan as at 31 July 2023.

The Trust has submitted a plan for a £1.3m surplus as part of the BOB ICB plan, incorporating a £14m cost improvement programme.

At Month 4, the Trust is reporting a £0.1m surplus year to date which is, £1.1m better than plan.

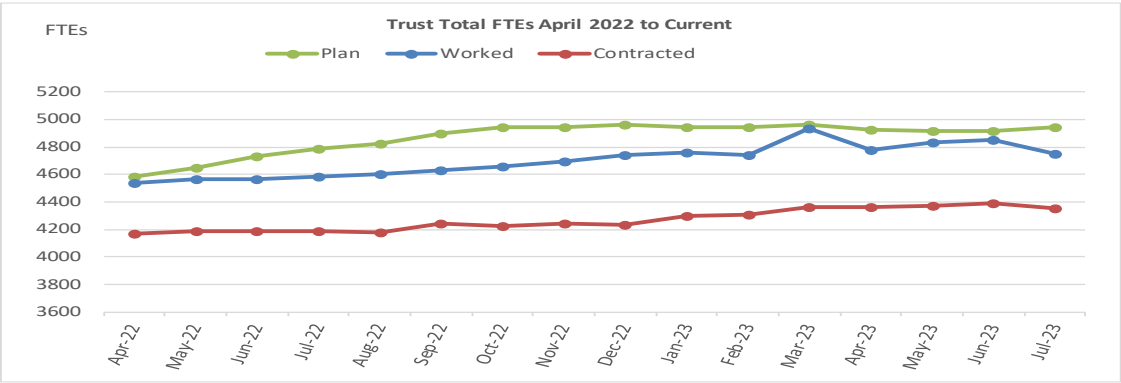
The higher than planned pay award for 2023/24 resulted variances on pay and income in June. We have adjust our NHSE plan in July, to reflect the additional funding to reflect a correct year to date figures.

Workforce



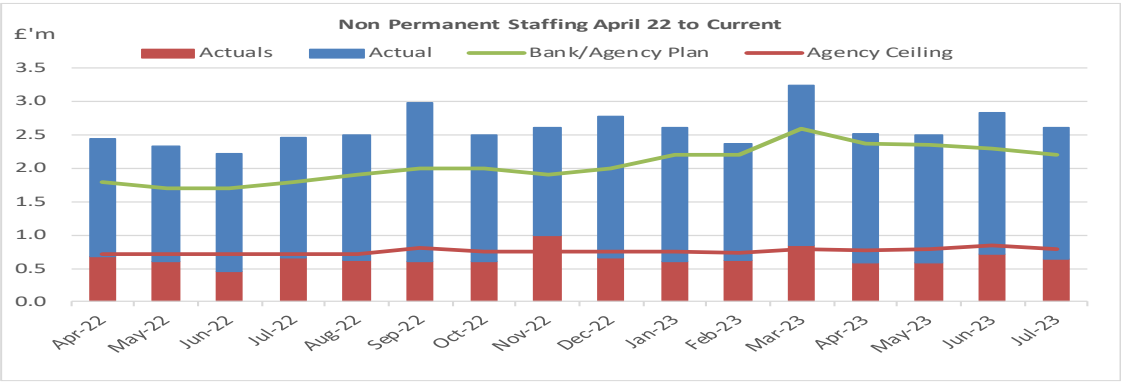
Staff Costs

YTD	£'m
2023/24	86.6
2022/23	77.6
▲	12%
Prior Yr	**£'m**
Jul-23	21.5
Jul-22	19.5
▲	11%



FTE's

Prioir Mth	CFTE	WFTE
Jul-23	4,354	4,750
Jun-23	4,388	4,852
	-1% ▼	-2% ▼
Prior Yr		
Jul-23	4,354	4,750
Jul-22	4,186	4,586
	4% ▲	4% ▲



Staff Costs

YTD	Bank £'m	Agency £'m
2023/24	8.0	2.5
2022/23	7.1	2.4
	13% ▲	5% ▲
Prior Yr	**£'m**	**£'m**
Jul-23	2.0	0.6
Jul-22	1.8	0.7
	10% ▲	-5% ▼

Key Messages

Pay costs in month were £21.5m, which looks lower than plan partly due to the adjustments made to the NHSE plan in month. However, expenditure was low with a drop in WTEs in month. Year to date, pay costs are £1.3m below plan.

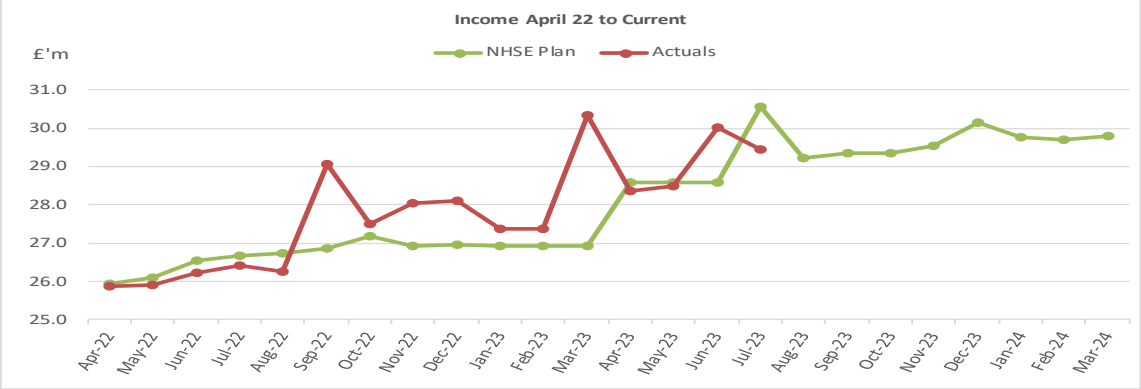
We are continuing to offset some vacancies with higher levels of temporary staffing although actuals are much closer to plan year to date than in the previous year, in part to the work undertaken to align financial and workforce planning.

The underspend on substantive staffing is also offsetting the cost pressure caused by the higher than plan pay award. The cost pressure is expected to be £1m for the year assuming that all planned posts are filled.

We are operating below NHSE System Agency Ceiling of 3.7%, currently running at 2.9% of overall pay costs YTD.

In month, we have seen a reduction in contracted WTEs (34) and worked WTEs (102).

Income & Non Pay



Income

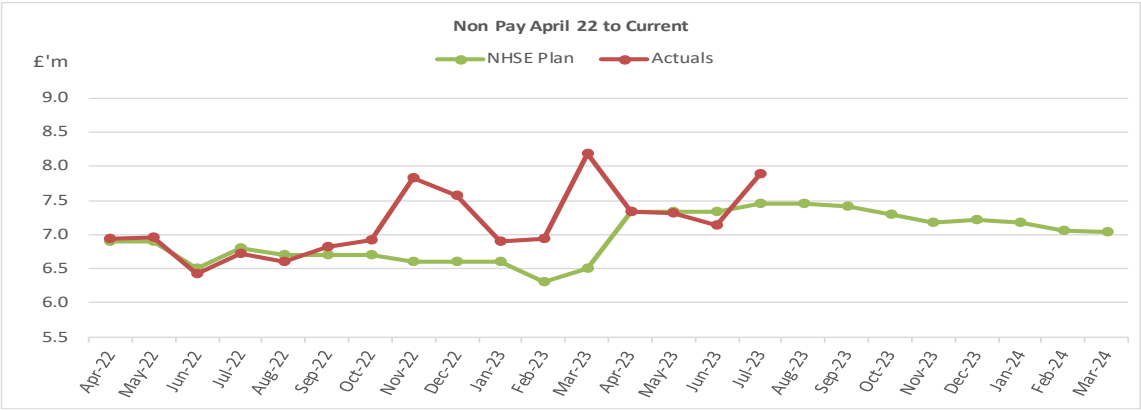
YTD	£'m
2023/24	116.3
2022/23	104.4
▲	11%
Prior Yr	**£'m**
Jul-23	29.5
Jul-22	26.4
▲	11%

Key Messages

In response to the strikes in April, NHSE have reduced the average level of activity increase required to maintain ERF payments by 2%. With further strikes in July, this may be further reviewed. In a further change, NHSE have capped the level of ERF clawback to 16%, which they are holding centrally from ICBS and will release if and when system activity targets have been met. It is expected that this caps our income risk at £0.64m but we are working through the guidance on ERF with the ICBs.

We continue to defer investment income as a result of slippage on new recruitment.

The Trust is continuing to benefit from an increase in bank interest rates and has generated an additional £0.6m year to date in interest.



Non Pay

YTD	£'m
2023/24	29.7
2022/23	27.1
▲	10%
Prior Yr	**£'m**
Jul-23	7.9
Jul-22	6.7
▲	17%

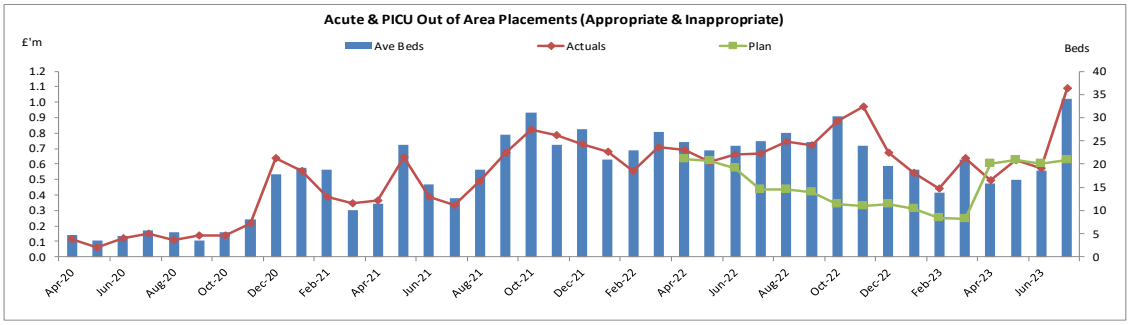
Key Messages

Non Pay spend was £7.9m in month and is now slightly above plan year to date.

Expenditure on Out of Area Placements increased notably this month driven by demand, with costs now above plan.

We continue to see some inflationary cost pressures coming through, including final adjustment to PFI contract values, but these are being managed within our inflation reserve.

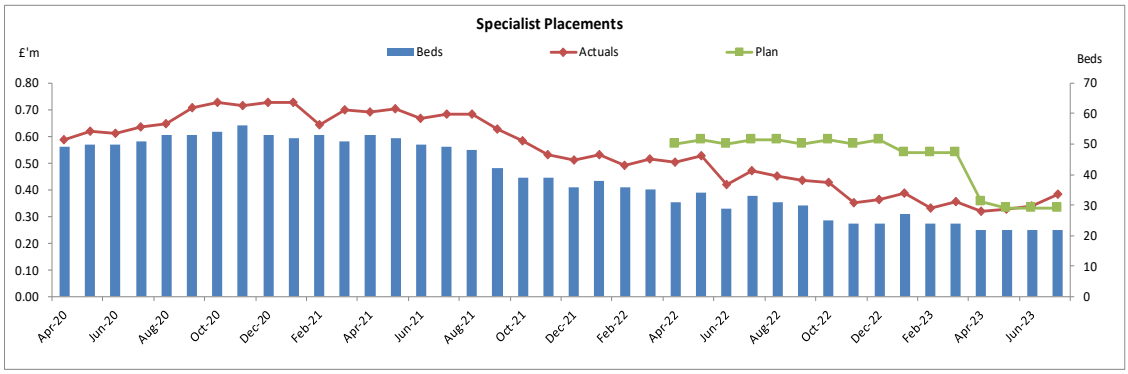
Placement Costs



OAPs

YTD	£'m
2023/24	2.8
2022/23	2.6
▲	*6%*

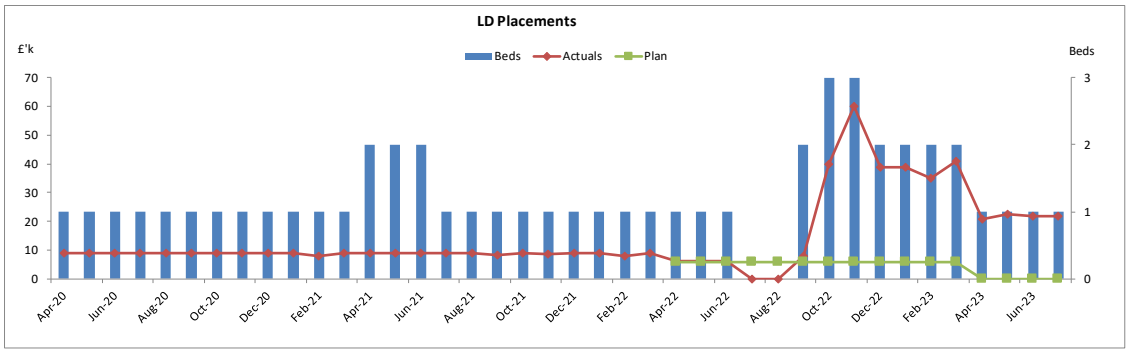
Prior Yr	£'m
Jul-23	1.1
Jul-22	0.7
▲	*63%*



Specialist Placements

YTD	£'m
2023/24	1.4
2022/23	1.9
▼	*-29%*

Prior Yr	£'m
Jul-23	0.4
Jul-22	0.5
▼	*-19%*



LD OAPs

YTD	£'k
2023/24	86.5
2022/23	18.0
▲	*381%*

Prior Yr	£'k
Jul-23	21.7
Jul-22	0.0
▲	

Key Messages

Out of Area Placements. The average number of placements increased from 19 in June to 34 in July. Analysis highlighted that the increase in placements was driven by demand, and that flow through the hospital continued to improve, with more discharges and fewer lost bed days per patient. The monthly costs increased from £0.57m to £1.1m.

We now have a dedicated clinical lead for the delivery of the bed optimisation programme, and this post has supported improving flow, including through daily bed flow meetings, development of a new bed flow dashboard which has provided improved visibility and locality oversight of admission numbers and LOS and also improved identification and escalation of MOFD/CRFD patients. We have agreed that reducing lost bed days linked to patients who are CRFD as a breakthrough objective and set a very ambitious target of 250 bed days per month. Progress against this target is monitored in QPEG.

We will continue to spot purchase PICU beds where they are clinically required. We continue to have significant demand for PICU beds especially for patients with forensic backgrounds, which do not count as an inappropriate out of area bed against the OAPs trajectory but which do have a financial impact. From the 1st January we have reduced our OAP acute overspill beds to 8 and will have an escalation to Director on Call if there is a request to admit to an additional bed.

A paper has been shared with the Board recommending a reduction in acute ward bed base from 86 to 80, to improve patient and staff experience of care with the 6 beds being reprovisioned through the independent sector. The planned acute ward bed reduction is due to be implemented in Q3. An additional 6 block beds will be purchased from September.

Specialist Placements. The average number of placements was 22 which is the same as in the previous months. The cost increased to £0.4m in month linked to increased s17 leave costs.

LD Placements: LD placements remain at 1.

2. Cost Improvement Programme

Cost Improvement Scheme	In Month Act £'k	In Month Plan £'k	In Month Var £'k	YTD Act £'k	YTD Plan £'k	YTD Var £'k	Full Year Plan £'k
OAPs & Specialist Placements	15	187	-172	576	748	-172	2,503
Contract Contribution	134	134	-	536	536	0	1,608
Additional ICB Stretch	0	0	-	0	0	0	3,055
Estates Schemes	23	23	-	92	92	0	276
Telephony Project	29	29	-	116	116	0	350
Divisional Control Total Alignment - CH	261	194	67	844	777	67	2,330
Divisional Control Total Alignment - MH	263	195	68	849	782	67	2,344
Divisional Control Total Alignment - CFAA	89	66	23	288	265	23	796
Divisional Control Total Alignment - Central Services	59	44	15	191	176	15	528
Operational Management Team Restructure	28	28	-	112	112	-	336
Total Cost Improvement	**901**	**901**	**0**	**3,604**	**3,604**	**(0)**	**14,126**

Key Messages

The Trust's initial financial plan included £12m of CIPs to get to a £2m deficit, but following further work within BOB ICB, it was agreed that the Trust would move to a breakeven position which required additional CIPs of £2m to be added to the programme. The Trust has subsequently agreed to deliver a £1.3m surplus on receipt of additional funding.

For month 4, we are reporting that we are on track with the cost improvement programme. There are some small variances in divisional control totals which we are reflecting as over-achievement of CIPs offsetting the underachievement related to OAPs and Specialist Placements.

The schemes listed as divisional control total alignment related primarily to pay costs and centred around new ways of working, upskilling, leadership, skill-mix, service design and recruitment and retention throughout all services.

Contract Contribution includes schemes were additional income contribution is being earned in year but is not being offset by additional costs. It also includes any smaller, generally Non-NHS contracts where action is underway to bring expenditure back in line with contract values.

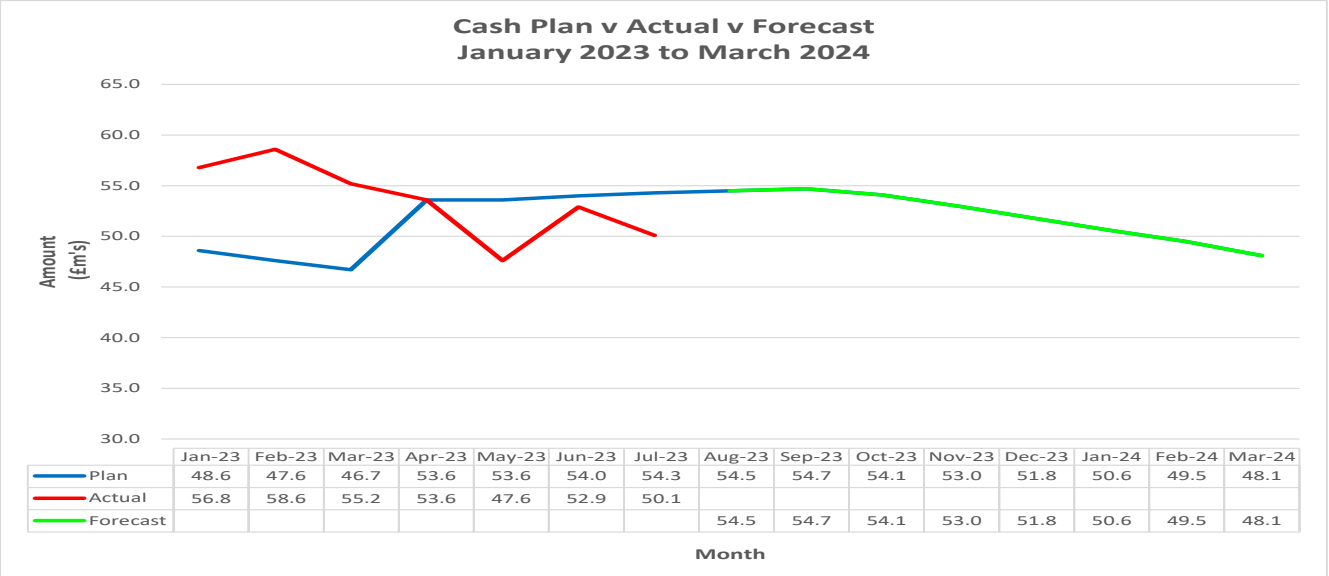
3. Balance Sheet & Cash

Balance Sheet	22/23 Actual (Audited) £'m	Current Month Act £'m	Current Month Plan £'m	Current Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m
Intangibles	4.0	2.2	3.7	(1.5)	2.2	3.7	(1.5)
Property, Plant & Equipment (non PFI)	45.6	45.5	44.4	1.1	45.5	44.4	1.1
Property, Plant & Equipment (PFI)	72.1	71.9	71.5	0.4	71.9	71.5	0.4
Property, Plant & Equipment (RoU Asset)	15.5	14.6	15.1	(0.5)	14.6	15.1	(0.5)
Receivables	0.2	0.2	0.2	0.0	0.2	0.2	0.0
Total Non Current Assets	**137.4**	**134.4**	**134.9**	**(0.5)**	**134.4**	**134.9**	**(0.5)**
Trade Receivables & Accruals	18.9	15.7	18.7	(3.0)	15.7	18.7	(3.0)
Other Receivables	0.3	0.0	0.3	(0.3)	0.0	0.3	(0.3)
Cash	55.2	50.1	54.3	(4.2)	50.1	54.3	(4.2)
Trade Payables & Accruals	(48.2)	(37.7)	(45.9)	8.2	(37.7)	(45.9)	8.2
Borrowings (PFI and RoU Lease Liability)	(4.2)	(3.1)	(4.1)	1.0	(3.1)	(4.1)	1.0
Other Current Payables	(11.8)	(13.1)	(12.4)	(0.7)	(13.1)	(12.4)	(0.7)
Total Net Current Assets / (Liabilities)	**10.2**	**11.9**	**11.0**	**0.9**	**11.9**	**11.0**	**0.9**
Non Current Borrowings (PFI and RoU Lease Liability)	(34.8)	(34.2)	(34.4)	0.2	(34.2)	(34.4)	0.2
Other Non Current Payables	(2.0)	(1.4)	(2.0)	0.6	(1.4)	(2.0)	0.6
Total Net Assets	**110.8**	**110.7**	**109.5**	**1.2**	**110.7**	**109.5**	**1.2**
Income & Expenditure Reserve	32.4	31.7	31.2	0.5	31.7	31.2	0.5
Public Dividend Capital Reserve	21.1	21.1	21.1	0.0	21.1	21.1	0.0
Revaluation Reserve	57.2	57.9	57.2	0.7	57.9	57.2	0.7
Total Taxpayers Equity	**110.8**	**110.7**	**109.5**	**1.2**	**110.7**	**109.5**	**1.2**

Key Messages

The balance sheet is largely as expected year to date. The 22/23 external audit is now complete so the prior year comparatives are final.

Cash is below plan by £4.2m at the end of July. This is primarily due to lower than anticipated income receipts from Frimley ICB which represents c£3.2m of the shortfall. We have agreed an additional £1.8m backlog payment in August, with the remainder in September when the contract is finalised. There is also a smaller under recovery from the local authorities making up the remainder of the shortfall of £1m. The under recovery is not reflected in the debtors position as the income is currently being accrued, and has not yet been invoiced.



	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Plan	48.6	47.6	46.7	53.6	53.6	54.0	54.3	54.5	54.7	54.1	53.0	51.8	50.6	49.5	48.1
Actual	56.8	58.6	55.2	53.6	47.6	52.9	50.1								
Forecast								54.5	54.7	54.1	53.0	51.8	50.6	49.5	48.1

4. Capital Expenditure

Schemes	Current Month			Year to Date			FY	Forecast
	Actual £'000	Plan £'000	Variance £'000	Actual £'000	Plan £'000	Variance £'000	Plan £'000	Outturn £'000
Estates Maintenance & Replacement Expenditure								
Erleigh Road Upgrades - Internal & External	0	0	0	0	0	0	250	250
General Upgrades & Damp Issues CHH	0	0	0	0	0	0	250	200
Wokingham Reprovision - Move from Old Forge	9	25	(16)	9	25	(16)	200	335
Bariatric Facilities Wokingham	54	70	(16)	54	110	(56)	230	230
Leased Non Commercial (NHSPS) Other projects	3	60	(57)	2	100	(98)	235	235
HQ Relocation/MSK Relocation - AV	1	98	(97)	72	121	(49)	121	133
Resource House, Denmark Street	40	100	(60)	69	100	(31)	800	865
Environment & Sustainability	(9)	33	(42)	18	83	(65)	450	390
Service change/redesign	0	25	(25)	0	25	(25)	244	192
Various All Sites	(37)	20	(57)	2	65	(63)	515	465
Statutory Compliance	0	10	(10)	2	10	(8)	390	390
Subtotal Estates Maintenance & Replacement	**61**	**441**	**(380)**	**228**	**639**	**(411)**	**3,685**	**3,685**
IM&T Expenditure								
IM&T Business Intelligence and Reporting	0	10	(10)	0	40	(40)	120	120
IM&T Hardware	61	46	15	439	220	219	4,677	4,677
IM&T GDE & Community Projects	0	0	0	0	0	0	0	0
IM&T Digital Strategy & RiO	(13)	25	(38)	45	100	(55)	1,033	1,033
Subtotal IM&T Expenditure	**48**	**81**	**(33)**	**484**	**360**	**124**	**5,830**	**5,830**
Subtotal CapEx Within Control Total	**109**	**522**	**(413)**	**712**	**999**	**(287)**	**9,515**	**9,515**
CapEx Expenditure Outside of Control Total								
Low Carbon Heating System WBCH	0	0	0	0	0	0	610	610
PPH 'Place of Safety'	0	0	0	0	0	0	1,850	450
Statuory Compliance	0	0	0	3	0	3	110	100
Environment & Sustainability / Zero Carbon	0	16	(16)	0	16	(16)	150	134
Other PFI projects	1	0	1	4	0	4	185	211
Garden Renovation – Wokingham Hospital (Donated)	0	0	0	0	0	0	0	22
Subtotal Capex Outside of Control Totals	**1**	**16**	**(15)**	**7**	**16**	**(9)**	**2,905**	**1,527**
Central Funding								
Total Capital Expenditure	**110**	**538**	**(428)**	**719**	**1,015**	**(296)**	**12,420**	**11,042**

Key Messages

Spend YTD is £0.3m below plan. IM&T hardware spend driven by user demand continues to be the only notable overspend to date. Spend in this area has been increasing driven by higher staffing numbers and an increase in part-time staff. Further work is planned around approval for these requests.

The capital plan currently includes £0.3m of over programming which will need to be addressed in year either through slippage or securing additional CDEL allocation from ICS partners.

The Place of Safety scheme which was due to commence and complete in year will now not complete until early 24/25. This is due the additional work being undertaken in order to finalise the application for the Deed of Variation which has now been issued to the PFI funding provider and which we expect to have approval of towards the end of the calendar year. The forecast outturn for this project has now been adjusted to reflect the delay.

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper - Public

Board Meeting Date	12th September 2023
Title	**True North Performance Scorecard** **Month 4 (July 2023) 2023/24**
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 2023/24.
Business Area	Trust-wide Performance
Author	Chief Financial Officer
Relevant Strategic Objectives	2 - To provide safe, clinically effective services that meet the assessed needs of patients, improve their experience and outcome of care, and consistently meet or exceed the standards of Care Quality Commission (CQC) and other stakeholders.
CQC Registration/Patient Care Impacts	All relevant essential standards of care.
Resource Impacts	None.
Legal Implications	None.
Equality and Diversity Implications	None.
Summary	The True North Performance Scorecard for Month 4 2023/24 (July 2023) 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 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.
	
	Month 4
	
	Performance business rule exceptions, red rated with the True North domain in brackets:
	
	Breakthrough and Driver Metrics
	
	Context and update to driver performance to be provided in discussion of counter measure action and development:
	
	• **Breakthrough** – Self-harm incidents on Mental Health Inpatient Wards (excluding LD) **(Harm Free Care)** – at 47 against a target of 42.
	  ○ Bluebell ward was the top contributor with 26 incidents.
	  ○ CCTV footage has been used to review incidents for learning and a number of actions have been highlighted including; staffing needing to be more proactive, incidents related to leave and also vaping.
	  ○ Counter measures include involving patients in decision making and that staff are listening to them.
	  ○ A new line of enquiry is underway looking at patients with Autism or ADHD and their higher prevalence for self-harm and use of restraint. Countermeasures being reviewed with the neuro diversity team, but includes sensory bags, noise cancelling headphones and focused work to make the environment more sensitive. A revised A3 is under development.
	• I Want Great Care Compliance Rate **(Patient Experience)** – latest month not available at this time, but last month was 3.7% against a 10% target.
	• **Breakthrough** - Clinically Ready for Discharge by Wards including Out of AREA Placements (OAPs) (Mental Health) – **(Patient Experience)** – a new

	indicator for 2023/24, is at 712 against a 250 bed day target. Progress for this new indicator is discharges of longer stay patients driving up the figure, which will remain high whilst these are discharged safely, so expecting red for a few months.
	• **Breakthrough** – Physical Assaults on Staff (Supporting Our Staff) – at 70 against a target of 44.
	  ○ Rose ward was the top contributor with 23 incidents.
	  ○ A Rose ward patient is proving challenging with a number of assaults. Joint team working resulted in a safe discharge for them.
	  ○ An Inpatient nurse is providing community outreach to support the community team.
	  ○ Existing countermeasures remain in place, but under review.
	• Inappropriate Out of Area Placements (OAPs) (Mental Health) – **(Patient Experience)** – at 327 against a 270 bed day target.
	
	Tracker 1 Metrics (where red for 1 month or more)
	• Meticillin-resistant Staphylococcus Aureus (MSSA) Bacteraemias (Cumulative year to date) **(Regulatory Compliance)** – there was 1 incident in May against a target for the year of 0.
	• People with Common Mental Health Conditions Referred to IAPT Completing a Course of Treatment Moving to Recovery - **(Regulatory Compliance)** – at 49.95%, slightly below the 50% target.
	• Sickness rate **(Regulatory Compliance)** – red at 3.8% against a target of 3.5%. This is not a "hard" compliance focus with NHSE but is tracked. Twelve months red.
	• 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 36.3% 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) • PDP (% of staff compliant) Appraisal **(Supporting Our Staff)** – at 92.5% against a 95% target by 31st May 2023. • Health Visiting: New Birth Visits within 14 days **(Patient Experience)** – at 86.8% against a 90% target. Challenges remain in the Reading team, but performance improving. • Uptake of at least one patient outcome measure (ReQoL) in adult Mental Health for new referrals from April 2019 **(Patient Experience)** – at 15.2% against a 20% target – 12 months red. Was suspended over the pandemic. Agreed this will be moved to Divisional scorecard for next month, as a local target and focus will remain within the mental health division. • Self-harm Incidents within the Community **(Harm Free Care)** – at 32 incidents against a target of 31. Further work looking into this metric is being conducted. Is a driver metric for Crisis services and there has been an uptake in recording. • Mental Health: Medically Optimised for Discharge **(Efficient Use of Resources)** - at 21.06% against a target of 7.5%. A positive reporting shift is placing a focus on mental health delays in the systems. • Mental Health Non-Acute Occupancy rate (excluding home leave) **(Efficient Use of Resources)** – at 87.59% against an 80% target. Red for 4 months. • Community Health: Medically Optimised for Discharge **(Efficient Use of Resources)** - at 28.05% against a target of 7.5%. A positive reporting shift is placing a focus on mental health delays in the systems. • Mental Health Acute Occupancy rate (excluding home leave) **(Efficient Use of Resources)** – at 96.8% against an 85% target. Red for 12 months. • Mental Health: Acute Average Length of Stay (bed days) **(Efficient Use of Resources)** – at 70 days against a target of 30 days. Pressures continue, and length of stay remains a focus for teams. An improvement project is underway. Linked to the breakthrough objective Clinically Ready for Discharge, where longer stay patients are being prioritized where appropriate and impacting length of stay which is calculated on discharge.
Action	The Board is asked to note the True North Scorecard.

Harm Free Care

Metric	Target	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23
Breakthrough Self-Harm Incidents on Mental Health Inpatient Wards (ex LD)	42 per month	104	76	72	78	37	27	161	31	22	22	13	47
Breakthrough Restrictive Interventions	TBC												

Patient Experience

IWGC Positive Score %	95% compliance from April 22	94.1%	95.5%	93.3%	94.8%	91.5%	94.5%	92.4%	93.7%	94.0%	94.2%	94.1%	95.2%
IWGC Compliance %	10% compliance	2.2%	3.4%	3.6%	5.4%	2.7%	2.8%	2.3%	3.1%	2.6%	3.3%	3.7%	

		Jul-22	Aug-22	Sept-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Breakthrough Clinically Ready for Discharge by Wards MH(including OAPS)	250 bed days	337	315	336	317	510	414	269	300	415	487	499	565	712

Performance Scorecard - True North Drivers

Supporting our Staff

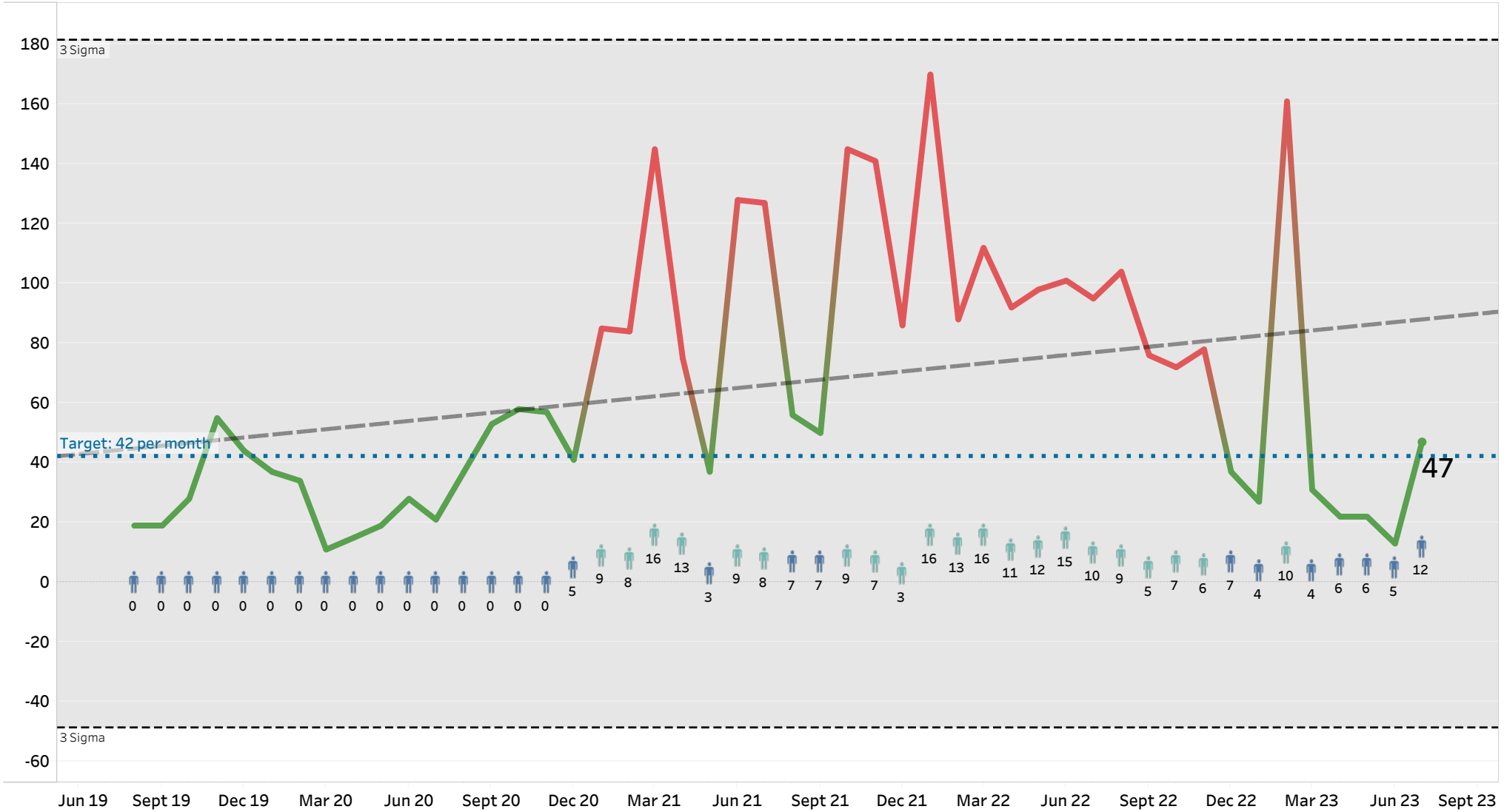
Metric	Target1	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23
Breakthrough Physical Assaults on Staff	44 per month	67	72	71	72	64	35	84	109	79	44	53	70
Staff turnover (excluding fixed term posts)	<=16% per month	17.02%	16.98%	16.5%	16.32%	16.52%	16.21%	15.69%	15.85%	15.85%	14.87%	14.54%	14.35%

Efficient Use of Resources

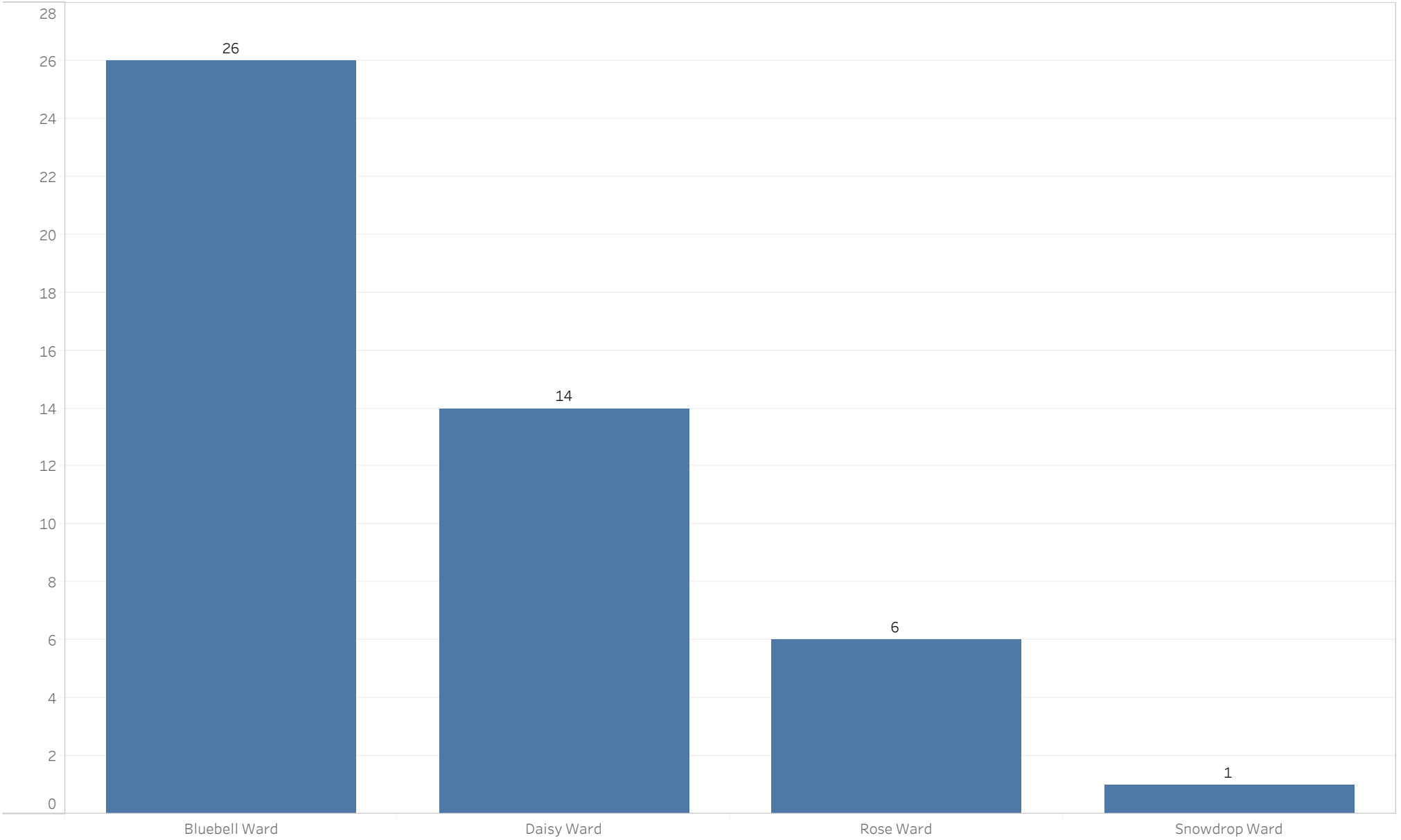
		Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23
YTD variance from control total (£'k)	1.3m	-506	-714	-774	-822	-1092	-1277	-1818	-989	-261	-441	-806	
Inappropriate Out of Area Placements	270 Cumulative Total Q2 2023/24	185	380	266	484	591	50	112	219	110	144	180	327

Harm Free Care Driver: Self-Harm incidents on Mental Health Inpatient Wards (excluding LD) (Aug 19 to Jul 23)

Any incident (all approval statuses) where category = self harm

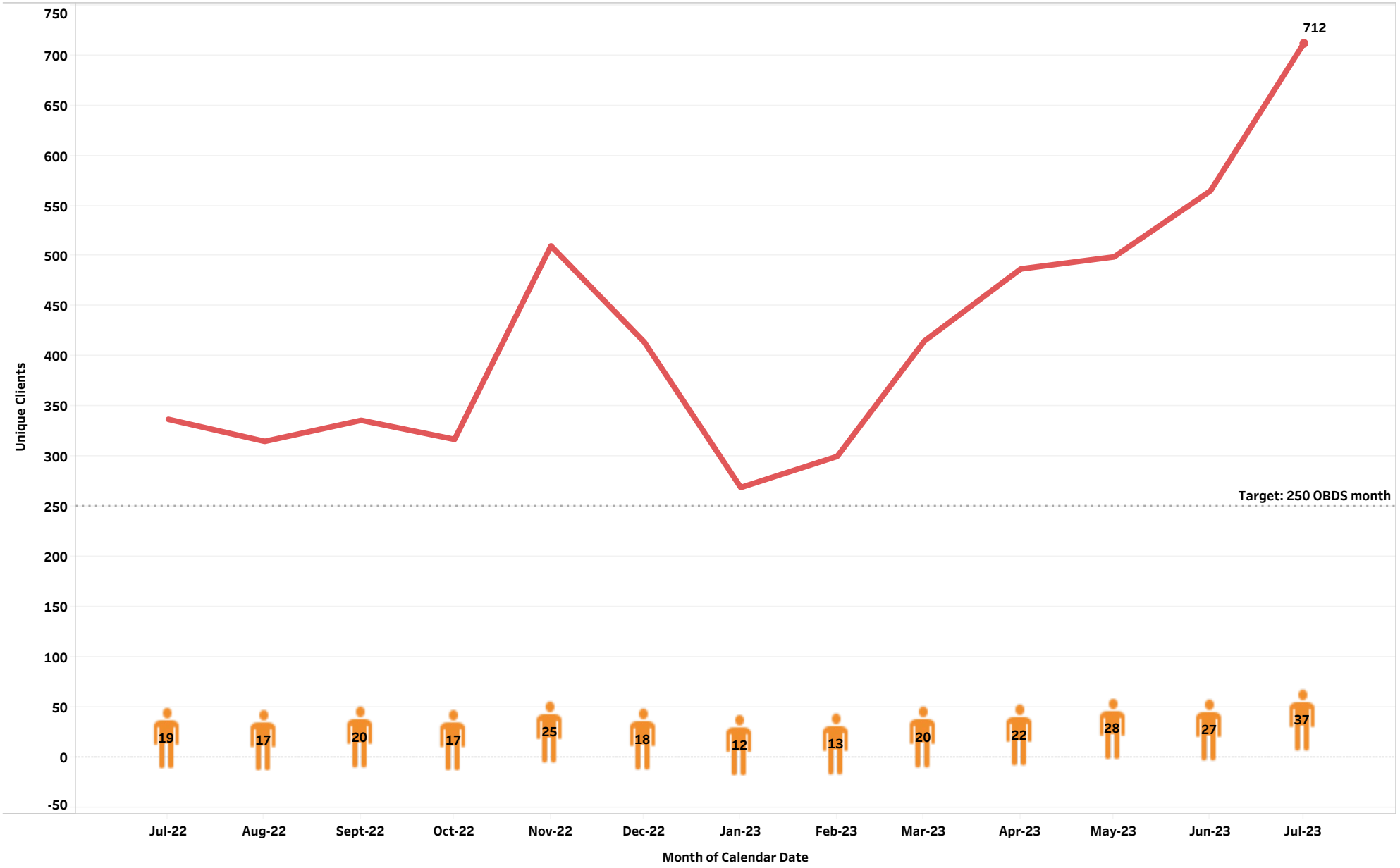


Harm Free Care Driver: Self-Harm incidents on Mental Health Inpatient Wards (excluding LD) by location (July 2023)



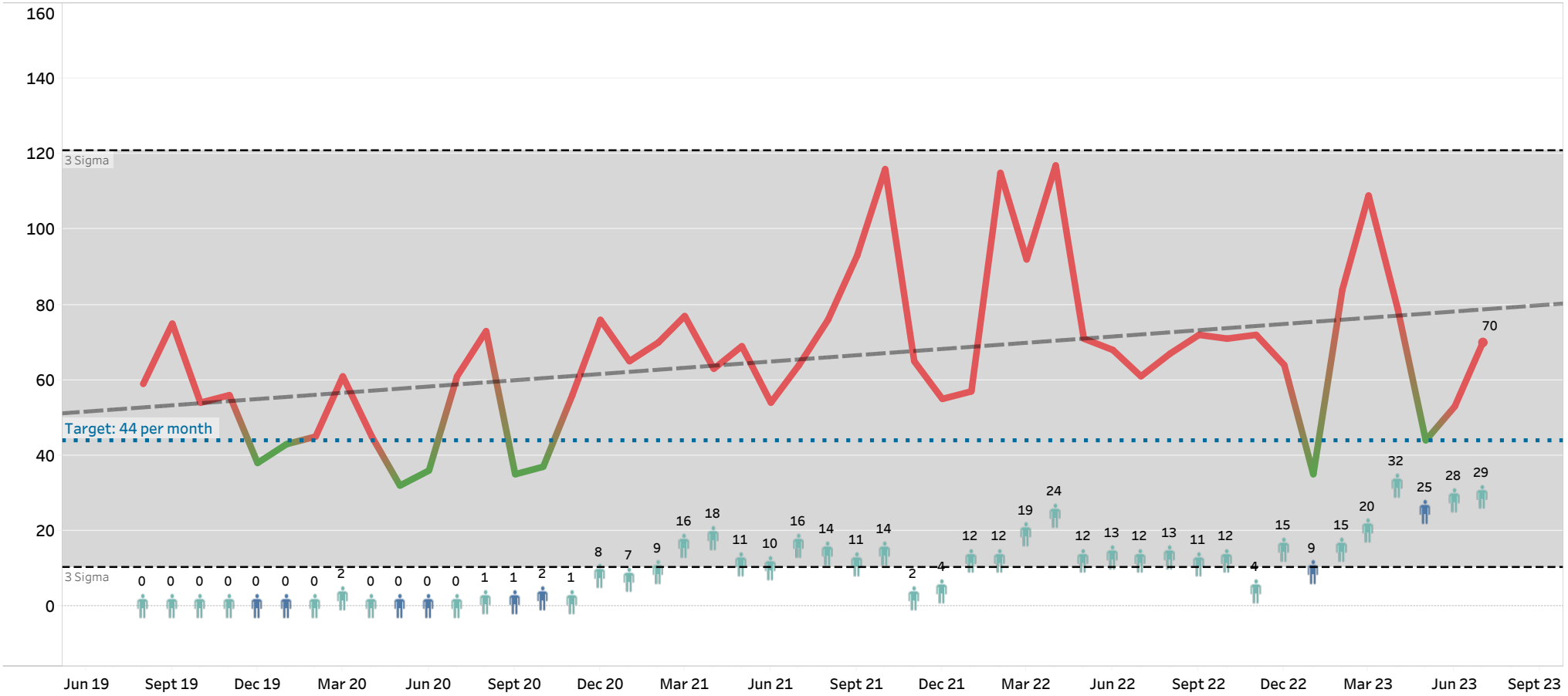
Patient Experience: Breakthrough Clinically Ready for Discharge by Wards MH (Including OAPS) (July 2022-July 2023)

All Mental Health wards excludes Campion ward (Learning Disability)

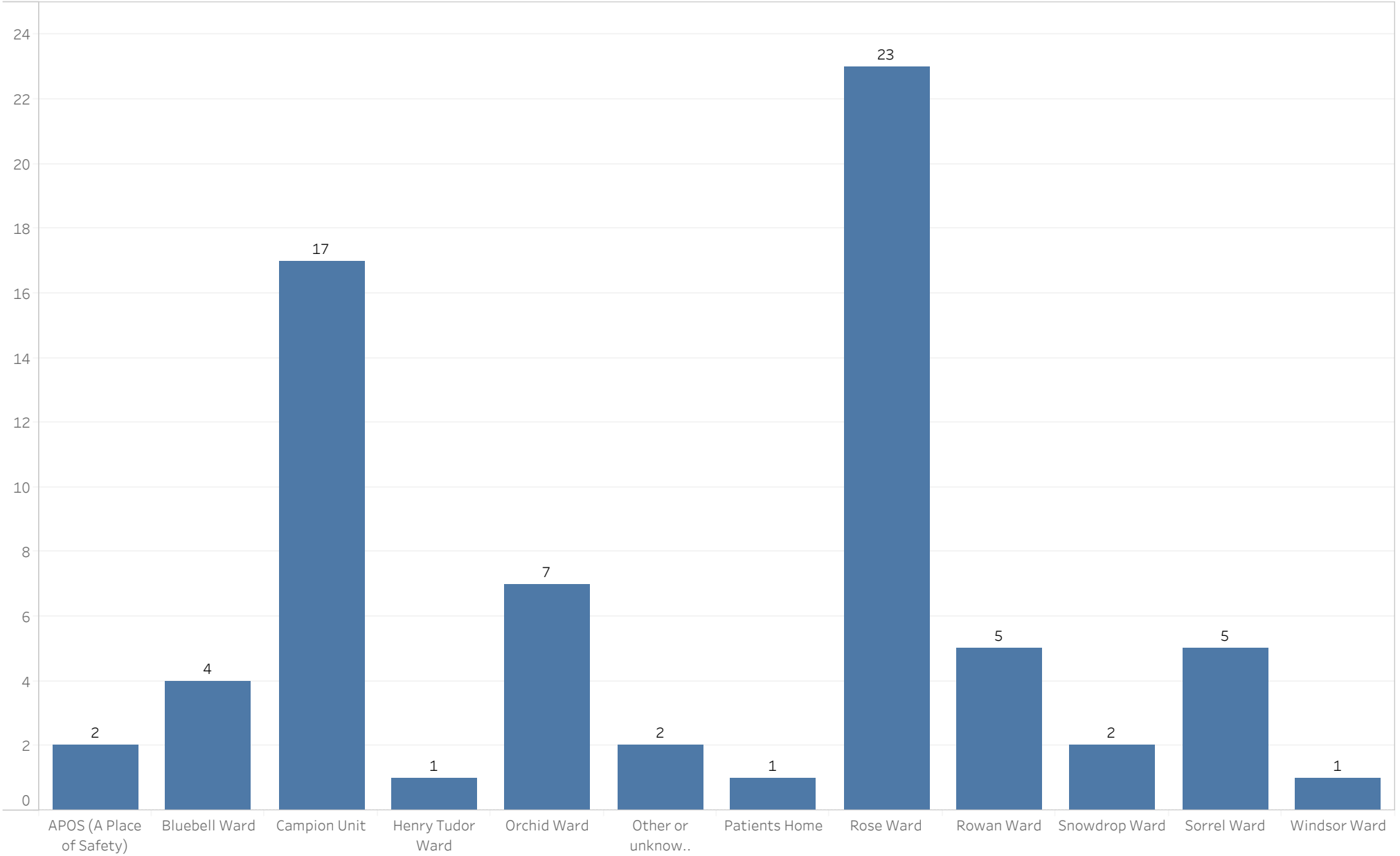


Supporting Our Staff Driver: Physical Assaults on Staff (Aug 19 to Jul 23)

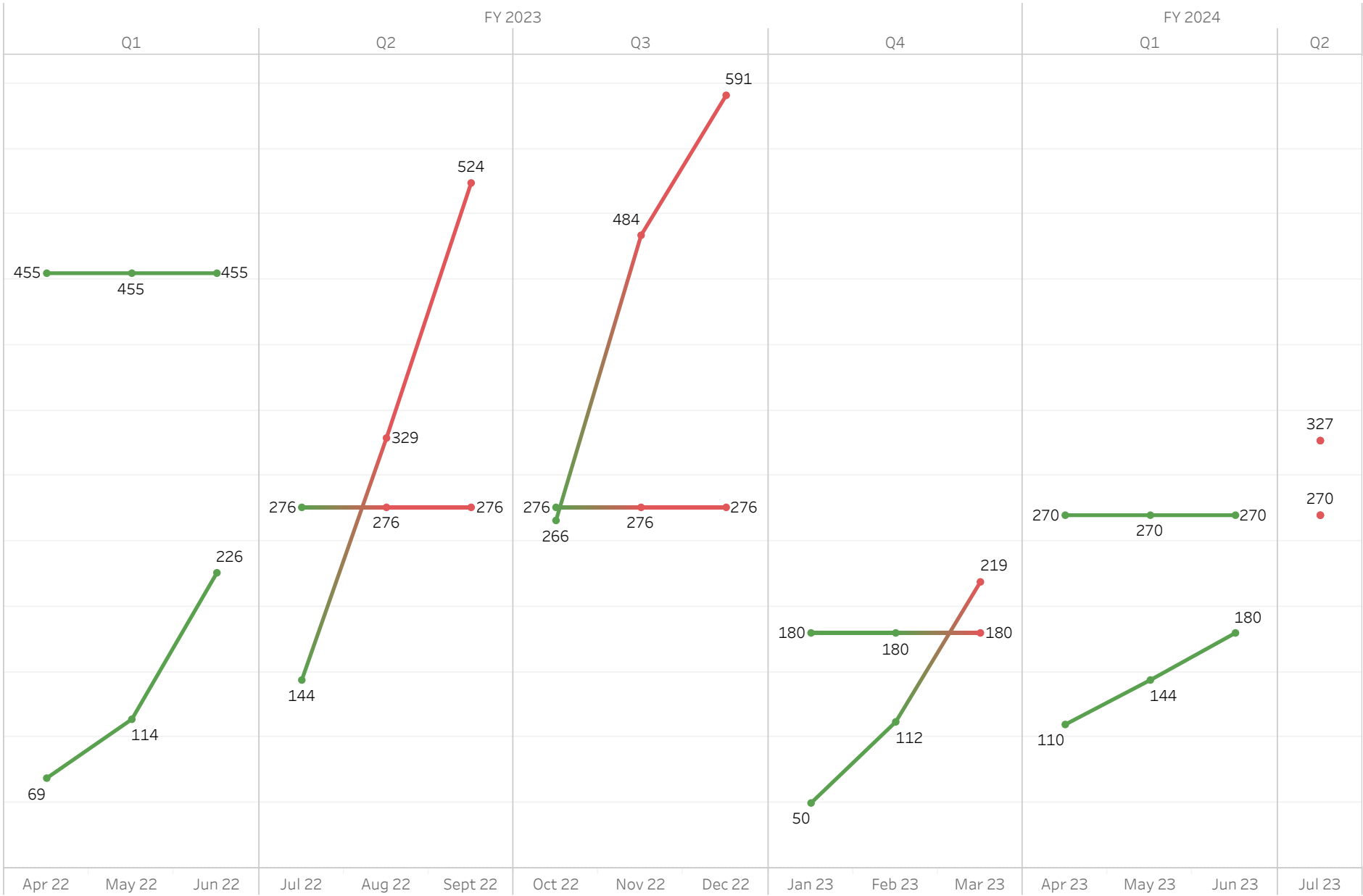
Any incident where sub-category = assault by patient and incident type = staff



Supporting Our Staff Driver: Physical Assaults on Staff by Location (July 2023)



Efficient Use of Resources Driver: Inappropriate Out of Area Placements



True North Supporting Our Staff Summary

Tracker Metrics

		Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23
Statutory Training: Fire: %	90% compliance	91.1%	90.7%	89.6%	92.0%	96.2%	92.2%	92.8%	93.2%	93.0%	94.1%	94.3%	94.2%
Statutory Training: Health & Safety: %	90% compliance	95.9%	96.0%	96.1%	96.1%	96.1%	96.1%	96.2%	95.9%	95.9%	95.9%	96.4%	96.4%
Statutory Training: Manual Handling: %	90% compliance	90.8%	90.0%	91.4%	93.1%	93.2%	92.3%	92.6%	94.3%	94.5%	93.2%	94.0%	94.3%
Mandatory Training: Information Governance: %	95% compliance from April 22	95.9%	96.9%	96.5%	98.1%	93.2%	96.0%	96.8%	97.0%	97.4%	97.7%	98.0%	98.2%
PDP (% of staff compliant) Appraisal: %	95% compliance by 31 May 2023	91.4%	89.9%	88.1%	85.0%	85.0%	85.0%	81.9%	80.4%	14.6%	85.5%	92.1%	92.5%

True North Patient Experience Summary

		Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23
Mental Health: Prone (Face Down) Restraint	4 per month	1	3	1	1	6	2	13	9	3	1	1	2
Patient on Patient Assaults (MH)	25 per month	14	21	21	20	25	15	13	28	22	15	21	10
Health Visiting: New Birth Visits Within 14 days: %	90% compliance	87.2%	82.5%	69.8%	65%	79.1%	79.2%	86.8%	85.9%	77.6%	76.7%	88.4%	86.8%
Mental Health: Uses of Seclusion	13 in month	6	7	6	6	13	6	6	6	5	12	4	10

		Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23
Falls incidents in Community & Older Adult Mental Health Inpatient Wards	26 per month	4	7	5	9	5	5	6	12	27	23	25	11
Physical Health Checks 7 Parameters for people with severe mental illness (SMI)	85%	78%	80%	79%	80%	80%	81%	84%	83%	87%	84%	85%	85%

True North Harm Free Care Summary

Tracker Metrics

Metric	Threshold / Target	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23
Pressure ulcers acquired due to lapse in (Inpatient Wards)	<10 incidents	0	0	0	0	0	0	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
Pressure ulcers acquired due to lapse in (Community West)	< 6 incidents	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health: AWOLs on MHA Section	10 per month from April 2022	8	7	10	12	5	10	3	11	6	11	4	7
Mental Health: Absconsions on MHA section (Excl: Failure to return)	8 per month	8	0	1	0	2	0	1	1	2	0	2	4
Mental Health: Readmission Rate within 28 days: %	<8% per month	2.85	5.87	6.45	1.45	1.53	1.40	1.68	2.62	2.90	5.70	4.04	3.89
Patient on Patient Assaults (LD)	4 per month	2	2	2	2	0	1	1	5	0	1	2	2
Uptake of at least one patient outcome measure (ReQoL) in adult Mental Health for new referrals from April 2019	20% from June 2021	13%	13.5%	13.3%	13.7%	13%	13.6%	13.9%	14.4%	14.4%	15.2%	15.1%	15.5%
Suicides per 10,000 population in Mental Health Care (annual)	7.4 per 10,000	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7
Self-Harm Incidents within the Community	31 per month	36	8	21	51	37	57	51	52	44	44	32	32
Pressure Ulcer with Learning	Tbc									2	2	1	1
Gram Negative Bacteraemia	1 per ward per year	0	0	0	0	0	0	0	0	0	0	0	0

Efficient Use of Resources

Tracker Metrics

		Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23
Mental Health: Medically Optimised for Discharge (NHSI target) Monthly and Quarterly)	7.50%	10.10%	8.780%	9.640%	12.46%	12.28%	6.160%	5.059%	8.110%	12.55%	16.32%	19.25%	21.06%
Community Inpatient Occupancy	80-85% Occupancy	83.6%	87.4%	88.1%	87.7%	86.8%	90.8%	89.3%	89.4%	87.8%	83.5%	86.6%	78.7%
Mental Health: Non-Acute Occupancy rate (excluding Home Leave): %	80% Occupancy	87.72%	87.90%	87.59%	85.75%	80.20%	89.56%	86.82%	78.12%	91.18%	92.60%	92.87%	87.59%
DNA Rate: %	5% DNAs	5.19%	5.24%	4.97%	5.22%	5.20%	4.85%	4.76%	4.92%	5.02%	4.79%	5.29%	5.22%
Community: Medically Optimised for Discharge Monthly and Quarterly: %	7.5% Delays	10.32%	18.55%	17.10%	21.55%	21.71%	16.60%	19.07%	24.37%	23.21%	23.73%	26.02%	28.05%
Mental Health: Acute Occupancy rate (excluding Home Leave):%	85% Occupancy	97.2%	97.1%	96.3%	96.3%	89.7%	97.1%	95.3%	94.8%	94.4%	94.4%	96.4%	96.8%
Mental Health: Acute Average Length of Stay (bed days)	30 days	35	50	38	62	37	43	50	55	41	43	45	70

Regulatory Compliance - Tracker Level 1 Summary

Metric	Threshold / Target	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23
C.Diff due to lapse in care (Cumulative YTD)	6	2	2	2	2	2	2	2	2	0	0	0	0
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) infection rate	tbc	0	0	0	1	0	0	0	0	0	0	0	0
Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate per 100,000 bed days	0	0	0	0	0	0	0	0	0	0	0	0	0
Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias (YTD)	0	1	2	2	3	3	3	3	3	0	1	1	1
Count of Never Events (Safe Domain)	0	0	0	0	0	0	1	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	100	100	83.32	92.82	85.70	91.65	87.5	90	88	75	80	87.5
A&E: maximum wait of four hours from arrival to admission/transfer /discharge: %	95% seen		99.56	99.26	99.53	99.64	99.26	99.37	99.39	99.26	99.35	99.42	99.40
People with common mental health conditions referred to Talking Therapies 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 Talking Therapies will be treated within 6 weeks from referral: %	75% treated	96	94	95	93	94	95	95	95	94	94	93	91
People with common mental health conditions referred to Talking Therapies completing a course of treatment moving to recovery: %	50% treated	49	49	47	52	48	45.5	46	46.5	46.5	48	45	49.95
Proportion of patients referred for diagnostic tests who have been waiting for less than 6 weeks (DM01 - Audiology): %	95% seen	55.66	40.96	35	66.49	82.84	72.48	72.42	69.06	61.26	83.45	92.09	97.79
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	99.28	97.89	98.70	100	100	100	100	100	100	100	100	100
Sickness Rate: %	<3.5%	4.3%	4.5%	4.9%	4.5%	5.1%	4.3%	4.3%	4.1%	3.7%	4.0%	3.8%	
CYP referred for an assessment or treatment of an ED will access NICE treatment <1 week (Urgents): %	95%	50%	66.7%	66.7%	100%	57.1%	100%	66.6%	66.6%	50%	83.3%	66.6%	75%
CYP referred for an assessment or treatment of an ED will access NICE treatment <4 weeks (Routines): %	95%	100%	100%	100%	75%	83.3%	100%	88.8%	66.6%	100%	50%	46.1%	36.3%
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	Threshold / T..	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23
Community Health Services: 2 Hour Urgent Community Response %.	80%	90.4%	88.2%	92.2%	88.9%	85.8%	88.5%	88.5%	89.3%	83.1%	84.2%	87.8%	87.6%
E-Coli Number of Cases identified	Tbc	1	0	1	1	0	0	0	0	0	1	1	0
Mental Health 72 Hour Follow Up	80%	98.5%	98.5%	96.5%	93.6%	87.2%	94.0%	88.6%	93.0%	96.4%	91.6%	90.7%	98.0%
Adult Acute LOS over 60 days % of total discharges	TBC					21.8%	26.5%	50%	27.3%	24.1%	25.8%	22.8%	24%
Older Adult Acute LOS over 90 days % of total discharges	TBC					55.5%	57.0%	40.8%	60%	66.7%	66.7%	50%	36%

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	September 2023
Title	**Workforce Race Equality Standard (WRES)**
	Item for Noting **Item for Discussion**
Purpose	**This report sets out our 2023 data and approach to action against the Workforce Race Equality Standard (WRES) metrics**
Business Area	**People Directorate**
Author	**Ash Ellis, Deputy Director for Leadership, Inclusion, OD**
Relevant Strategic Objectives	Make Berkshire Healthcare a great place to work for our people. Anti-racism commitment in addressing staff experience differential.
CQC Registration/Patient Care Impacts	The relevance of this paper supports all CQC KLOEs and patient experience.
Resource Impacts	The paper references work that needs to be undertaken across the Trust.
Legal Implications	This supports our public sector equality duty and is part of our contractual obligation required by Trusts. We are required to publish this report on our website for 3 years.
Equality and Diversity Implications	This paper helps us to recognise, explore and take action against any inequalities for our workforce.
SUMMARY	This paper provides the Board with an overview of the inequalities experienced by our workforce. It provides data, benchmarking and highlights where we need to do better.
ACTION	To note the report, next steps and seek any clarification.

Workforce Race Equality Standard 2023

Author	Ash Ellis, Deputy Director for Leadership, Inclusion and OD
Purpose of Report	This report sets out our 2023 data and approach to action against the Workforce Race Equality Standard (WRES) metrics

Executive Summary

- The WRES is the national framework through which Trusts are required to measure their performance against nine key indicators for staff representation and experience with regard to race. This comprises Trust workforce data indicators (1 – 4) Nationally set, Trust Staff Survey data indicators (5 – 8) and an indicator focused on BME Board representation.

- The number of BME colleagues has increased by 99 to 1,411 from 1,312 last year. 28.40% of our colleagues are represented in the BME category, compared to 27.4% last year. We have a workforce that is fairly representative of the Berkshire population.

- Overall, we have seen positive change and improvement across 7 of the 9 indicators, with one staying the same and one moving in the wrong direction.

- Indicator 5 has improved for white colleagues over the past 3 years but stayed the same for BME colleagues the last 2 years, which is the one indicator this year that has stayed the same. This is 'Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months'. For the last two years this has remained at 29.4% for BME colleagues. The data indicates that BME colleagues are 10.9% more likely to experience harassment, bullying or abuse from patients, relatives and the public than white colleagues.

- Indicator 4 is where we have moved in the wrong direction. This is the 'Relative likelihood of White staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff'. Moving from 1.28 to 1.44, meaning white colleagues are 1.44 times more likely to access CPD than BME colleagues.

- Our race disparity ratio shows us that white colleagues are 1.93 (clinical) and 1.13 (non-clinical) times more likely to progress through the organisation than BME colleagues with regards to their career progression.

- It is the first time we have explored our Medial, and Bank WRES.

- Although improvement can be seen, we must not pause in our work to reduce inequality of experience for our colleagues. We must acknowledge that we are moving in the right direction but a lot more progress needs to be made, and targeted work has already begun with the two indicators where we haven't made improvement.

- We are developing our anti-racism strategy to dismantle racism and become an anti-racist organisation. The subsequent action plan from this strategy will form our WRES action plan. This is currently being developed and co-created by engagement with our Race Equality Network (REN) and Trust-wide colleagues.

Recommendation	The Board is asked to acknowledge the WRES report and subsequent approach to develop actions.

1. Background

This paper provides an overview of our annual performance against the Workforce Race Equality Standard (WRES) metrics for 2021-22. The data will be published on our public website, along with our action plan, in line with regulatory requirements.

The NHS Equality and Diversity Council (EDC) introduced WRES as a framework for NHS Trusts to focus specifically on race. This was in response to the 2014 study by Roger Kline titled 'The snowy white peaks of the NHS', which highlighted the link between good patient care and an NHS workforce that is representative of the local population it serves.

The WRES came into effect on 1st April 2015. The standard is designed to improve the representation and experience of Black and Minority Ethnic (BME) staff at all levels of the organisation – particularly senior management.

In the context and requirement of the WRES, we will be using language set out in the WRES technical guidance. White staff comprises White British, White Irish and White Other (Ethnic codes A, B, C) whereas BME staff comprise all other categories excluding 'not stated'. We have tried to consider further breakdown of BME, and other ethnic groups refers to; Chinese and any other ethnic group.

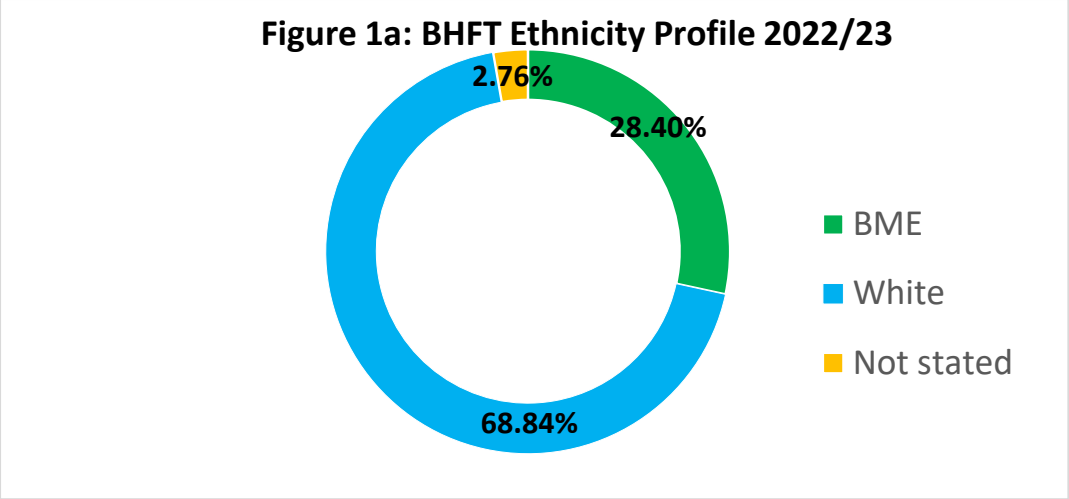
Overall, there are nine indicators that make up the NHS WRES. These comprise:

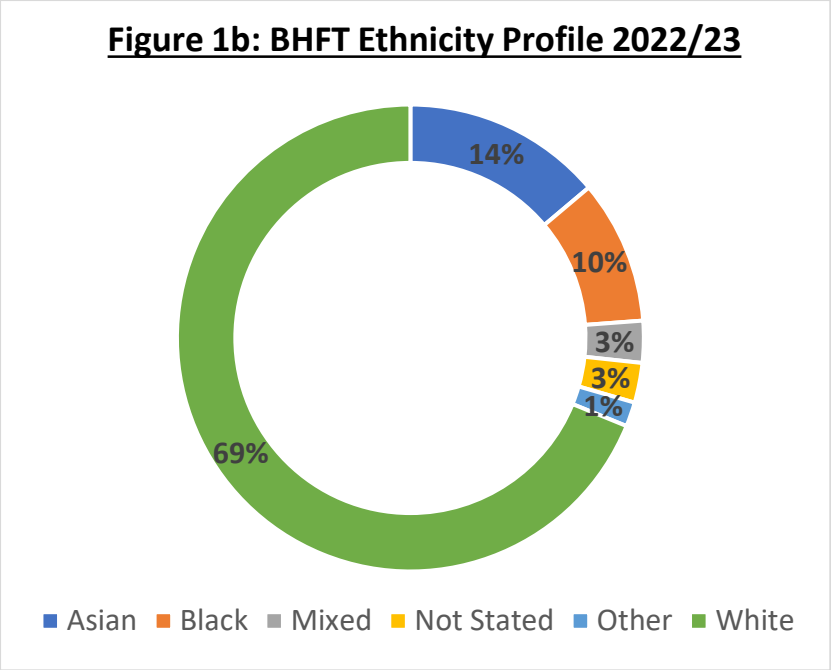
- Workforce indicators (1 – 4),
- Staff Survey indicators (5 – 8)
- and an indicator focused on board representation (9).

The WRES is now mandated as part of the standard NHS Contract, and this supports closer scrutiny of the progress we make and outcomes we achieve.

2. What is our Workforce data telling us?

Data in 2023 shows our total staff is at 4,968.
The number of BME colleagues has increased by 99 to 1,411 from 1,312.
28.40% of our colleagues are represented in the BME category, compared to 27.4% last year.
1,411 are BME and 3,420 are White and 137 have not stated. Figure 1a and 1b below shows our ethnicity profile.





Overall Percentage of BME Staff		2020/21	2021/22	2022/23
Percentage of BME staff in overall Berkshire Healthcare workforce compared with other NHS Trusts in England	**Berkshire Healthcare**	**26%**	**27.4%**	**28.4%**
	NHS Trusts	**21.1%**	**22.4%**	**24.2%**

BHFT Workforce compared to Berkshire Population

	BME	White	Not stated	Total
BHFT Workforce	1,411 (28.40%)	3,420 (68.84%)	137 (2.76%)	4,968
Berkshire Population	279,170 (27.7%)	632,934 (62.9%)	94,280 (9.4%)	1,006,384

	Asian or Asian British *(Indian, Pakistani, Bangladeshi, any other Asian background)*	**Black or Black British** *(Caribbean, African, any other black background)*	**Mixed** *(White & Black Caribbean, White & Black African, White & Asian, any other mixed background)*	**Other Ethnic Groups** *(Chinese, any other ethnic group)*	**White** *(British, Irish, any other white background)*	**Not stated**	**Total**
BHFT Workforce	688 (13.85%)	495 (9.96%)	144 (2.89%)	84 (1.69%)	3,420 (68.84%)	137 (2.76%)	4,968
Berkshire Population	172,453 (17.13%)	33,546 (3.33%)	28,062 (2.78%)	45,109 (4.48%)	632,934 (62.89%)	94,280 (9.36%)	1,006,384

It's also useful to look at our workforce compared to the communities we support to see how representative our workforce is of our local population. The data shows that BHFT BME workforce is overrepresented by 0.7% compared to overall Berkshire population. The data also shows that BHFT white workforce is overrepresented by 5.94% compared to overall Berkshire population. Like within BHFT there is a large population of the overall Berkshire population where we do not know their ethnicity (9.4%). The further breakdown of BME shows that we are underrepresented in our workforce population for Asian and Other Ethnic Groups, and overrepresented for Black and Mixed Groups compared to the overall Berkshire population.

3. WRES Indicators

Indicator 1: Percentage of White staff in Bands 1 to 9 and VSM compared with the percentage of BME staff in the overall workforce.

Figure 2: Workforce Profile – Non-Clinical Staff 2021-23 (across 3 years)

Pay Band	2021 Non-Clinical Workforce Data				2022 Non-Clinical Workforce Data				2023 Non-Clinical Workforce Data			
	Total Non-Clinical Staff	White	BME	Ethnicity Unknown	Total Non-Clinical Staff	White	BME	Ethnicity Unknown	Total Non-Clinical Staff	White	BME	Ethnicity Unknown
Under Band 1	3	2 (67%)	1 (33%)	0 (0%)	5	2 (40%)	3 (60%)	0 (0%)	2	1 (50%)	1 (50%)	0 (0%)
Band 1	13	9 (69%)	3 (23%)	1 (8%)	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)
Band 2	144	113 (78%)	28 (19%)	3 (2%)	70	56 (80%)	14 (20%)	0 (0%)	60	48 (80%)	12 (20%)	0 (0%)
Band 3	276	217 (79%)	56 (20%)	3 (1%)	274	216 (79%)	55 (20%)	3 (1%)	275	215 (78%)	58 (21%)	2 (1%)
Band 4	266	193 (73%)	63 (24%)	10 (4%)	272	199 (73%)	64 (24%)	9 (3%)	298	208 (70%)	77 (26%)	13 (4%)
Band 5	129	97 (75%)	28 (22%)	4 (3%)	130	99 (76%)	30 (23%)	1 (1%)	143	107 (75%)	34 (24%)	2 (1%
Band 6	135	95 (70%)	34 (25%)	6 (4%)	134	95 (71%)	36 (27%)	3 (2%)	153	107 (70%)	42 (27%)	4 (3%)
Band 7	87	56 (64%)	28 (32%)	3 (3%)	103	65 (63%)	34 (33%)	4 (4%)	123	80 (65%)	40 (33%)	3 (2%)
Band 8a	88	68 (77%)	19 (22%)	1 (1%)	84	58 (69%)	24 (29%)	2 (2%)	95	65 (68%)	27 (29%)	3 (3%)
Band 8b	39	35 (90%)	3 (8%)	1 (3%)	58	51 (88%)	6 (10%)	1 (2%)	66	54 (82%)	11 (17%)	1 (1%)
Band 8c	32	27 (84%)	4 (13%)	1 (4%)	36	28 (78%)	7 (19%)	1 (3%)	33	28 (85%)	4 (12%)	1 (3%)
Band 8d	14	9 (64%)	2 (14%)	3 (21%)	15	11 (73%)	1 (7%)	3 (20%)	16	13 (81%)	1 (6%)	2 (13%)
Band 9	4	1 (25%)	1 (25%)	2 (50%)	7	3 (43%)	1 (14%)	3 (43%)	8	5 (62%)	3 (38%)	0 (0%)
VSM	4	1 (25%)	0 (0%)	3 (75%)	4	1 (25%)	0 (0%)	3 (75%)	9	6 (67%)	2 (22%)	1 (11%)
Total	1234	923	270	41	1192	**884**	**275**	**33**	**1272**	**937**	**312**	**32**

- NB. Exec Bord Members excluded prior to 2023 as part of WRES submission.
- 32 people haven't declared their ethnicity, although this has decreased year on year. It is worth noting for those in pay Bands 8d, 9 and VSM, due to the small numbers, where colleagues haven't declared their ethnicity, this can potentially skew the figures.
- Our BME representation has grown in bands 2,3,4, 5, 8b, 9 and VSM. Stayed the same in bands 6, 7 and 8a. It has decreased in bands 8c, 8d.

- In comparison with our overall BME workforce (28.40%) we have over-representation of BME colleagues in bands 7, 8a and 9, under-representation of BME colleagues within 7% of overall BME workforce in bands 2, 3, 4, 5, 6, and VSM. We have under-representation of BME colleagues by more than 10% of overall BME workforce in bands 8b, 8c, and 8d.
- In comparison with our overall white workforce (68.84%) we have over-representation in bands 2, 3, 4, 5, 6, 8b, 8c, 8d. We have over-representation of white colleagues by more than 10% compared to our overall white workforce in bands 2, 8b, 8c and 8d. We have under-representation of white colleagues within 7% of overall white workforce in bands 7, 8a, 9 and VSM.

Figure 3: Workforce Profile - Clinical Staff 2021-23 (across 3 years)

Pay Band	2021 Clinical Workforce Data				2022 Clinical Workforce Data				2023 Clinical Workforce Data			
	Total Clinical Staff	White	BME	Ethnicity Unknown	Total Clinical Staff	White	BME	Ethnicity Unknown	Total Clinical Staff	White	BME	Ethnicity Unknown
Under Band 1	7	5 (71%)	1 (14%)	1 (14%)	7	2 (29%)	4 (57%)	1 (14%)	13	9 (69%)	4 (31%)	0 (0%)
Band 1	1	1 (100%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)
Band 2	171	80 (48%)	83 (49%)	8 (5%)	180	83 (46%)	88 (49%)	9 (5%)	167	79 (47%)	83 (50%)	5 (3%)
Band 3	406	279 (69%)	118 (29%)	9 (2%)	368	242 (66%)	119 (32%)	7 (2%)	358	235 (66%)	114 (32%)	9 (2%)
Band 4	387	295 (76%)	82 (21%)	10 (3%)	**439**	340 (77%)	91 (21%)	8 (2%)	484	363 (75%)	110 (23%)	11 (2%)
Band 5	438	261 (60%)	162 (37%)	15 (3%)	462	260 (56%)	183 (40%)	19 (4%)	468	254 (54%)	200 (43%)	14 (3%)
Band 6	876	653 (75%)	193 (22%)	30 (3%)	862	628 (73%)	205 (24%)	29 (3%)	811	580 (71%)	207 (26%)	24 (3%)
Band 7	652	472 (72%)	160 (25%)	20 (3%)	**682**	504 (74%)	158 (23%)	20 (3%)	760	557 (73%)	181 (24%)	22 (3%)
Band 8a	215	166 (77%)	47 (22%)	2 (1%)	243	182 (75%)	59 (24%)	2 (1%)	271	203 (75%)	60 (22%)	8 (3%)
Band 8b	70	59 (84%)	11 (16%)	0 (0%)	**81**	68 (84%)	12 (15%)	1 (1%)	98	79 (81%)	17 (17%)	2 (2%)
Band 8c	21	16 (76%)	5 (24%)	0 (0%)	23	17 (74%)	6 (26%)	0 (0%)	26	20 (77%)	6 (23%)	0 (0%)
Band 8d	20	19 (95%)	1 (5%)	0 (0%)	18	17 (94%)	1 (6%)	0 (0%)	18	18 (100%)	0 (0%)	0 (0%)
Band 9	4	4 (100%)	0 (0%)	0 (0%)	**3**	3 (100%)	0 (0%)	0 (0%)	3	3 (100%)	0 (0%)	0 (0%)
VSM	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)	1	0 (0%)	1 (100%)	0 (0%)
Total	**3268**	**2310**	**863**	**95**	**3368**	**2346**	**926**	**96**	**3478**	**2400**	**983**	**95**

- NB. Exec Bord Members excluded prior to 2023.
- Our BME representation has grown in bands 2, 4, 5, 6, 7, 8b and VSM. Stayed the same in bands 3 and 9. It has decreased in bands 8a, 8c, and 8d.
- In comparison with our overall BME workforce (28.40%) we have over-representation of BME colleagues in bands 2, 3, 5 and VSM, under-representation of BME colleagues within 7% of overall BME workforce in bands 4, 6, 7, 8a and 8c. We have under-representation of BME colleagues by more than 10% of overall BME workforce in bands 8b, 8d and 9.

- In comparison, with our overall white workforce (68.84%) we have over-representation in bands 4, 6, 7, 8b, 8c, 8d. We have over-representation of white colleagues by more than 10% of overall white workforce in bands 2, 8a, 8b, 8c, 8d and 9. We have under-representation of white colleagues in bands 2, 3, 5 and VSM.
- 95 people haven't declared their ethnicity, although this has decreased by 1 since last year.

Figure 4: Workforce Profile – Medical & Dental staff 2021-2023

Pay Band	2021 Clinical (Medical & Dental) Workforce				2022 Clinical (Medical & Dental) Workforce				2023 Clinical (Medical & Dental) Workforce			
	Total Medical & Dental Staff	White	BME	Ethnicity Unknown	Total Medical & Dental Staff	White	BME	Ethnicity Unknown	Total Medical & Dental Staff	White	BME	Ethnicity Unknown
Consultants	98	31 (32%)	43 (44%)	24 (24%)	**100**	37 (37%)	51 (51%)	12 (12%)	**93**	39 (42%)	52 (56%)	2 (2%)
Snr Medical Manager	0	0	0	0	0	0	0	0	**0**	0	0	0
Non-consultant Career Grade	87	33 (38%)	38 (44%)	16 (18%)	**82**	33 (40%)	43 (53%)	6 (7%)	**82**	30 (37%)	48 (58%)	4 (5%)
Trainee Grade	21	2 (10%)	2 (10%)	17 (81%)	25	9 (36%)	15 (60%)	1 (4%)	**27**	11 (41%)	14 (52%)	2 (7%)
Other	0	0	0	0	0	0	0	0	**0**	0	0	0
Total	206	66	83	57	207	**79**	**109**	**19**	**202**	**80 (40%)**	**114 (56%)**	**8 (4%)**

- In 2 years we have reduced the ethnicity declaration being 'unknown' from 57 down to 8 for this year.
- We have more BME medical colleagues overall than white medical colleagues.
- We have increased the number of BME Consultants in 2 years from 43 to 52, and white Consultants from 31 to 39.

Indicator 2: Relative likelihood of staff being appointed from shortlisting

WRES Indicator	Metric Descriptor		2020/21	2021/22	2022/23
2	Relative likelihood of White applicants being appointed from shortlisting across all posts compared to BME applicants	Berkshire Healthcare	1.46	1.53	1.51
		NHS Trusts	1.61	1.61	1.54

This year we have made improvement but not enough. A value above 1 indicates that white candidates are more likely to be appointed than BME candidates, and a value below 1 indicates that white candidates are less likely to be appointed than BME candidates.

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

WRES Indicator	Metric Descriptor		2020/21	2021/22	2022/23
3	Relative likelihood of BME staff entering the formal disciplinary process compared to White staff	Berkshire Healthcare	1.81	4.59	1.21
		NHS Trusts	1.16	1.14	1.14

We have made great progress over the last year and the most progress we have made in this area for 3 years. However, we still have work to do. A value of “1.0” for the likelihood ratio means that BME and white staff are equally likely to enter formal disciplinary proceedings, whilst a value above 1 indicates that BME staff are more likely to enter formal disciplinary proceedings than white staff, and a value below 1 indicates that BME staff are less likely to enter formal disciplinary proceedings than white staff.

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

WRES Indicator	Metric Descriptor		2020/21	2021/22	2022/23
4	Relative likelihood of White staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff	Berkshire Healthcare	1.51	1.28	1.44
		NHS Trusts	1.14	1.14	1.12

This is the one indicator where we have declined this year, so we will need to particularly focus on this indicator. A value of “1.0” for the likelihood ratio means that white and BME staff are equally likely to access non-mandatory training or CPD, whilst a value above 1 indicates that white staff are more likely to access non-mandatory training or CPD than BME staff, and a value below 1 indicates that white staff are less likely to access non-mandatory training or CPD than BME staff.

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

WRES Indicator	Metric Descriptor		BME 2020/21	White 2020/21	BME 2021/22	White 2021/22	BME 2022/23	White 2022/23
5 Staff Survey Q14a	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	Berkshire Healthcare	31%	20%	29.4%	19.9%	**29.4%**	**18.5%**
		NHS Trusts	32%	25%	32%	26%	**29.2%**	**27%**

This indicator has improved for white colleagues over the past 3 years but has stayed the same for BME colleagues the last 2 years. The data indicates that BME colleagues are 10.9% more likely to experience harassment, bullying or abuse from patients, relatives and the public than white colleagues. We have made no consistent progress since 2020/21.

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

WRES Indicator	Metric Descriptor		BME 2020/21	White 2020/21	BME 2021/22	White 2021/22	BME 2022/23	White 2022/23
6. Staff Survey Q14b/c	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	Berkshire Healthcare	23%	18%	23%	14%	**20.8%**	**15.4%**
		NHS Trusts	25%	20%	23%	18%	**27.6%**	**22.5%**

An improvement of 2.2% from 21/22 for BME colleagues but a 1.4% decline for our white colleagues. However, based on the above our BME colleagues are still 5.4% more likely to experience harassment, bullying or abuse from colleagues than their white counterparts.

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

WRES Indicator	Metric Descriptor		BME 2020/21	White 2020/21	BME 2021/22	White 2021/22	BME 2022/23	White 2022/23
7. Staff Survey Q15	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	Berkshire Healthcare	50%	70%	45.7%	67.5%	**51.7%**	**68.1%**
		NHS Trusts	46%	61%	47%	61%	**44.4%**	**58.7%**

We have seen an improvement for both our white colleagues (0.6%) and our BME colleagues (6%) in their beliefs that the Trust provides equal opportunities for career progression or promotion. There is still a difference of 16.4% in favour of our white colleagues.

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

WRES Indicator	Metric Descriptor		BME 2020/21	White 2020/21	BME 2021/22	White 2021/22	BME 2022/23	White 2022/23
8. Staff Survey Q16b	Percentage of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months	Berkshire Healthcare	12%	5%	14%	5.3%	**13.2%**	**5.2%**
		NHS Trusts	15%	6%	14%	6%	**17%**	**6.8%**

We have seen an improvement for both our white colleagues (0.1% reduction) and our BME colleagues (0.8% reduction). However, the stark reality is that far too many of our colleagues experience discrimination from their colleagues whilst at work. Also our BME colleagues experience discrimination 8% more than our white colleagues.

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

WRES Indicator	Metric Descriptor		2020/21	2021/22	2022/23
9 Board Representation	Percentage difference between Board voting membership and its overall workforce	Berkshire Healthcare	**(-) 15%**	**(-) 4.4%**	**+2.4%**
		NHS Trusts	**10%**	12.6%	**13.2%**

The indicator above shows that we have made great progress over 3 years going from -15% to +2.4% with a marked improvement this year. The difference between percentage BME representation on the board and in the workforce overall is 2.4%%
Our BME workforce is 28.40% and our BME Board Membership is 30.8%. Executive Board Member is 33.3% BME, and Non Executive Board Member is 28.6% BME. Both are above our overall BME workforce population, conveying that we have over-representation of BME colleagues in our Board compared to our workforce.

Figure 5: Talent Pipeline to Board – Executive Director reports

Staff Group	Gender		Ethnicity				Disability			Total in staff group
	Male	Female	White British	White – any other white background	Asian or Asian British	Not Stated	Disabled	Non-Disabled	Not Stated	
Medical	2	2	2	1	1	0	0	3	1	**4**
Clinical	1	5	6	0	0	0	0	6	0	**6**
Corporate	3	11	11	1	0	2	1	9	4	**14**
Total	6 (25%)	18 (75%)	19 (79.2%)	2 (8.3%)	1 (4.2%)	2 (8.3%)	1 (4.2%)	18 (75%)	5 (20.8%)	**24**

The above shows the colleagues who report into Executive Board members, clinical directors, and their declared characteristics.

4. Berkshire Healthcare Race Disparity Ratio

Figure 5: Race Disparity Ratio (RDR) – Comparison of BME Staff Progression with white staff progression in the ICS

Trust Name	% BME Staff	Disparity Ratio					
		Lower to Middle *(from B2,B3, B4, B5 to B6&B7)*		Middle to Upper *(from B6, B7 to B8a and up incl VSM)*		Lower to Upper *(from B2, B3, B4, B5 to B8a and up incl VSM)*	
		Clinical	Non-clinical	Clinical	Non-clinical	Clinical	Non-clinical
Berkshire Healthcare NHS Foundation Trust	28.4%	1.63	0.66	1.18	1.71	1.93	1.13
Buckinghamshire Healthcare NHS Trust	30.7%	2.51	1.26	1.13	0.66	2.84	0.82
Oxford Health NHS Foundation Trust	19.7%	2.17	1.38	1.50	1.20	3.24	1.67
Oxford University Hospitals NHS Foundation Trust	28.3%	2.59	1.38	2.77	1.10	7.16	1.53
Royal Berkshire NHS Foundation Trust	31.5%	1.79	2.63	1.65	1.74	2.95	4.59
South Central Ambulance Service NHS Foun Trust	4.8%	0.68	1.07	-	1.25	-	1.34
Frimley Health NHS Foundation Trust	40.4%	1.89	1.66	1.92	2.04	3.64	3.37
Surrey and Borders Partnership NHS Foun Trust	30.3%	1.99	0.46	1.62	1.35	3.22	0.62

Building on the challenges highlighted by the 9 WRES indicators presented in this report, Figure 5 above presents Berkshire Healthcare's Race Disparity Ratio (RDR) and compares it with the Trust's partners in the BOB and Frimley ICS. It is worth noting that the above RDR is based on the previous year's data.

The RDR is underpinned by the principle that once recruited into an organisation progression/promotion chances should be equally accessible to everyone – an issue that is highlighted as problematic by our WRES data.

Figure 5 suggests that across the ICS, there is a disparity in proportion of BME staff progressing to AfC Band 8 and above compared to the proportion of White staff.

With the understanding that the RDR looks at the probability of White staff being promoted from lower Bands to Bands 8 and 9 and VSM these are the implications of the Berkshire Healthcare's RDR presented in Figure 5:

- Lower to Middle: White staff are 1.63 (clinical) and 0.66 (non-clinical) times more likely to progress through the organisation than BME staff.
- Middle to Upper: White staff are 1.18 (clinical) and 1.71 (non-clinical) times more likely to progress through the organisation than BME staff.
- Lower to Upper: White staff are 1.93 (clinical) and 1.13 (non-clinical) times more likely to progress through the organisation than BME staff.

A value of "1.0" indicates equity in representation at higher and lower levels, a value greater than "1.0" indicates that BME staff are underrepresented at the higher pay bands, and a value below "1.0" indicates BME staff are overrepresented at the higher pay bands.

5. Medical WRES

Medical WRES Indicator Number	Indicator description		Data collection categories and sub-categories	Reporting year 2021/22 Black	White	Asian	Other	Not known	2022/23 Black	White	Asian	Other	Not known
1a	**The composition of the medical and dental workforce**	Number of staff in each medical and dental sub group, disaggregated by ethnicity (based on the workforce as at 31st March in the reporting year)	Medical directors								1		
			Clinical directors (directors of clinical teams)						0	0	0	0	0
			Consultants						2	39	45	5	2
			SAS						6	24	23	10	2
			Locally Employed Doctor (LED)						0	2	3	0	0
			Doctors in postgraduate training						0	0	0	0	0
			All other medical and dental staff						1	15	17	2	4
1b	**Clinical Excellence Awards**	Number of staff eligible for, who applied for, and who were awarded a Clinical Excellence Award, disaggregated by ethnicity and origin of primary medical qualification (based on the financial year)	Was distributed equally across all eligible consultants										
2	**Consultant recruitment**	Consultant recruitment following completion of postgraduate training, disaggregated by ethnicity (based on the financial year)	Number of applicants	0	2	0	0	0	0	1	0	0	0
			Number shortlisted	0	2	0	0	0	0	1	0	0	0
			Number appointed	0	2	0	0	0	0	1	0	0	0
3a	**Complaints, referrals and investigations**	Complaints, referrals to the GMC, and GMC Investigations, disaggregated by ethnicity and origin of primary medical qualification (based on the financial year)	UK Medical Graduate: Total number of medical and dental staff in Trust						3	74	10	6.	3
			UK Medical Graduate: Number of complaints (Trust data)	0	1	0	0	0	0	1	0	0	0
			UK Medical Graduate: Number of referrals to the GMC	0	0	0	0	0	0	0	0	0	0
			UK Medical Graduate: Number of GMC investigations	0	0	0	0	0	0.0%	0.0%	0.0%	0.0%	0.0%
			EEA Medical Graduate: Total number of medical and dental staff in Trust						1	10	3	0	1
			EEA Medical Graduate: Number of complaints (Trust data)	0	0	0	0	0	0	0	0	0	0

			Number of referrals to the GMC	0	0	0	0	0	0	0	0	0	0
			Number of GMC investigations	0	0	0	0	0	0	0	0	0	0
		International Medical Graduate (IMG)	Total number of medical and dental staff in Trust						5	10	64	11	4
			Number of complaints (Trust data)	1	0	5	0	0	0	0	1	0	0
			Number of referrals to the GMC	0	0	0	0	0	0	0	0	0	0
			Number of GMC investigations	0	0	0	0	0	0	0	0	0	0
3b	**Revalidation**	Deferral of revalidation, disaggregated by ethnicity and origin of primary medical qualification (based on the financial year)	UK Medical Graduate	Total number considered for revalidation	0	7	3	1	1	1	5	0	0	1
				Number whose revalidation was deferred	0	0	0	0	0	0	0	0	0	0
			EEA Medical Graduate	Total number considered for revalidation	0	1	0	0	0	0	1	0	0	0
				Number whose revalidation was deferred	0	0	0	0	0	0	1	0	0	0
			International Medical Graduate (IMG)	Total number considered for revalidation	2	5	8	2	2	1	1	7	0	0
				Number whose revalidation was deferred	0	0	0	0	0	0	0	0	0	0

Number	Indicator description	BME	White
Indicator 5	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from…Patients / service users, their relatives or other members of the public	36.10%	38%
Indicator 6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	16.70%	26%
Indicator 7	Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?	60%	68%
Indicator 8	In the last 12 months have you personally experienced discrimination at work from any of the following? Manager / team leader or other colleagues	11.90%	8%

- This is the first year we have completed the medical WRES.
- Medical education i.e. UK/EEA/IMG hasn't been recorded in the Trust prior to May 2023, we have now inserted a process to capture this on ESR going forwards.
- There has been 1 complaint during this period, this came from our largest population group of Asian colleagues.
- There has been 1 deferral during this period from our white colleague population group.
- For indicators 5 and 6 our white colleagues have a poorer experience.
- For indicator 7 our white colleagues are 8% more of the belief that the organisation acts fairly with regard to career progression and promotion than our BAME colleagues.
- For indicator 8, our BAME colleagues have experienced discrimination at work from a manager/colleague 3.90% more than white colleagues.
- 96 colleagues were trained in the UK, 15 colleagues are EEA and 94 colleagues are IMG.

6. Bank WRES

Figure 6: Bank WRES – Female bank workers clinical and non-clinical, ethnicity and pay band comparison

Gender		Female																
Ethnic Origin		Black or Black British African	Any other Asian background	Any other Black background	Any other ethnic group	Any other mixed background	Any other White background	Bangladeshi	White British	Black or Black British Caribbean	Chinese	Indian	White Irish	Not Stated	Pakistani	White & Asian Mixed	White &Black African Mixed	White & Black Caribbean Mixed
	Band																	
Clinical Staff	Band 2	101	18	0	0	0	24	0	97	0	0	23	0	74	0	0	0	0
	Band 3	57	12	0	0	0	21	0	125	0	0	0	0	49	0	0	0	0
	Band 4	0	0	0	0	0	0	0	60	0	0	0	0	12	0	0	0	0
	Band 5	63	17	0	0	0	17	0	132	0	0	0	0	44	0	0	0	0
	Band 6	29	12	0	0	0	19	0	232	0	0	15	0	56	0	0	0	0
	Band 7	0	0	0	0	0	13	0	133	0	0	11	0	29	0	0	0	0
	Band 8a	0	0	0	0	0	0	0	33	0	0	0	0	0	0	0	0	0
	Band 8b	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Band 8c	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Total	**200**	**54**	**11**	**14**	**11**	**93**	**0**	**711**	**13**	**0**	**71**	**14**	**215**	**23**	**0**	**12**	**0**
Non-Clinical Staff	Band 2	0	0	0	0	0	0	0	22	0	0	0	0	0	0	0	0	0
	Band 3	0	0	0	0	0	0	0	66	0	0	0	0	14	0	0	0	0
	Band 4	0	0	0	0	0	0	0	67	0	0	0	0	0	0	0	0	0
	Band 5	0	0	0	0	0	0	0	21	0	0	0	0	0	0	0	0	0
	Band 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Band 7	0	0	0	0	0	0	0	15	0	0	0	0	0	0	0	0	0
	Band 8a	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Band 8b	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Band 8c	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Band 8d	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Band 9	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Total	**0**	**0**	**0**	**0**	**0**	**11**	**0**	**196**	**0**	**0**	**25**	**0**	**32**	**14**	**0**	**0**	**0**
Total		**206**	**60**	**12**	**16**	**13**	**104**	**0**	**902**	**18**	**0**	**94**	**15**	**244**	**34**	**14**	**12**	**14**

Figure 7: Bank WRES – Male bank workers clinical and non-clinical, ethnicity and pay band comparison

Gender		Male																
Ethnic Origin		Black or Black British African	Any other Asian background	Any other Black background	Any other ethnic group	Any other mixed background	Any other White background	Bangladeshi	White British	Black or Black British Caribbean	Chinese	Indian	White Irish	Not Stated	Pakistani	White & Asian Mixed	White &Black African Mixed	White & Black Caribbean Mixed
	Band																	
Clinical Staff	Band 2	88	0	0	0	0	0	0	14	0	0	0	0	28	0	0	0	0
	Band 3	60	0	0	0	0	0	0	14	0	0	0	0	28	0	0	0	0
	Band 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Band 5	19	0	0	0	0	0	0	13	0	0	0	0	0	0	0	0	0
	Band 6	18	0	0	0	0	0	0	16	0	0	0	0	14	0	0	0	0
	Band 7	0	0	0	0	0	0	0	16	0	0	0	0	12	0	0	0	0
	Band 8a	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Band 8b	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Band 8c	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Total	**138**	**15**	**0**	**0**	**0**	**13**	**0**	**78**	**0**	**0**	**19**	**0**	**66**	**0**	**0**	**14**	**0**
Non-Clinical Staff	Band 2	0	0	0	0	0	0	0	14	0	0	0	0	0	0	0	0	0
	Band 3	0	0	0	0	0	0	0	13	0	0	0	0	0	0	0	0	0
	Band 4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Band 5	0	0	0	0	0	0	0	11	0	0	0	0	0	0	0	0	0
	Band 6	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Band 7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Band 8a	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Band 8b	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Band 8c	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Band 8d	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Band 9	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**56**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total		**139**	**17**	**0**	**0**	**0**	**20**	**0**	**134**	**0**	**0**	**25**	**0**	**73**	**0**	**0**	**14**	**0**

- This is the first time we have completed the Bank WRES.

- Our Bank staffing is outsourced and delivered by NHS Professionals (NHSP).
- The above are active NHS Bank Workers (refers to individuals who solely hold a NHS zero hours contract who have undertaken work/paid training within a 6 month period prior to an agreed date)
- NHSP have said, please note that, in order to protect sensitive data, only categories with more than 10 individuals are represented in the table. The total value represents the sum of all individuals.
- It is therefore more challenging to analyse and provide narrative when the make up of banding groups and ethnicity is not provided.
- In some cases, historic WRES submissions and data against WRES survey-based indicators may have contained bank worker data. From 2023 all submissions that relate to bank workers should be summited via this new method to form the Bank WRES, which is a separate submission.
- We have had 278 non-clinical female bank workers (13%). These have been in bands 2,3,4,5 and 7 only.
- We have had 1,442 clinical female bank workers (68%). These have been in bands 2 through to and including 8a.
- Total female bank workers was 1,720 (81%). Our substantive female workforce is 83.25%.
- We have had 56 non-clinical male bank workers (3%). These have been in bands 2,3 and 5 only. They are all white British.
- We have had 343 clinical male bank workers (16%). These have been in bands 2,3,5,6 and 7.
- Total male bank workers was 399 (19%). Our substantive male workforce is 16.75%.
- A total of 2,119 bank workers.
- The majority of our clinical bank workers are Black, or Black British African.
- The majority of our non-clinical bank workers are White British.
- The highest paid clinical bank workers for males is band 7, and for non clinical male bank workers is band 5.
- The highest paid clinical bank workers for females is band 8a, and for non clinical female bank workers is band 7.
- We have 66 who have not stated their ethnicity (3%), this is similar to Trust substantive workforce where 2.76% have not stated ethnicity.

7. Conclusion and next steps

Conclusion

Based on the data outlined in this report we have clear areas where we need to improve and do better for our colleagues, this is across most indicators. However, 7 of the 9 indicators have seen improvement from last year. One Indicator declined over the last year:

- Indicator 4 is the 'Relative likelihood of White staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff'. It has moved from 1.28 to 1.44, meaning white colleagues are 1.44 times more likely to access CPD than BME colleagues.

One Indicator stayed the same over the last year:

- Indicator 5 is the 'Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months'. For two years this has remained at 29.4% for BME colleagues. The data indicates that BME colleagues are 10.9% more likely to experience harassment, bullying or abuse from patients, relatives and the public than white colleagues.

Our race disparity ratio shows us that white colleagues are 1.93 (clinical roles) and 1.13 (non-clinical roles) times more likely to progress through the organisation than BME colleagues with regards to their career progression.

Next Steps

Actions to further improve the Trust's WRES performance align with the Trust's strategic ambitions and priorities, in particular making Berkshire Healthcare a great place to work for our people. To meet this goal the Trust has refreshed its strategy and has committed to becoming anti-racist to address unwarranted differences in staff experience.

In committing to become an anti-racist organisation we will develop our actions in collaboration with our Anti-racism Task Group, Diversity Steering Group, Race Equality Network, Trade Unions and other stakeholders.

In developing our anti-racism strategy, we have begun by exploring our vision and action scope. This is being co-created through anti-racism workshops being led by our EDI team and our Race Equality Network for all of our colleagues to attend. From these workshops we will develop a Trust anti-racism action statement which will be underpinned by a deliberate, intentional and impactful action plan.

The action plan, although currently being co-created is likely to include 3 focus areas being informed by our problem statements above:

- **Develop anti-racist/discriminatory systems**
- **Demonstrate visible commitment to anti-racism**
- **Engagement and Education**

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Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	September 2023
Title	**Workforce Disability Equality Standard (WDES)**
	Item for Noting **Item for Discussion**
Purpose	**This report sets out our 2023 data and approach to action against the Workforce Disability Equality Standard (WDES) metrics**
Business Area	**People Directorate**
Author	**Ash Ellis, Deputy Director for Leadership, Inclusion, OD**
Relevant Strategic Objectives	Make Berkshire Healthcare a great place to work for our people.
CQC Registration/Patient Care Impacts	The relevance of this paper supports all CQC KLOEs and patient experience.
Resource Impacts	The paper references work that needs to be undertaken across the Trust.
Legal Implications	This supports our public sector equality duty, and is part of our contractual obligation required by Trusts. We are required to publish this report on our website for 3 years.
Equality and Diversity Implications	This paper helps us to recognise, explore and take action against any inequalities for our workforce.
SUMMARY	This paper provides the Board with an overview of the inequalities experienced by our workforce. It provides data, benchmarking and highlights where we need to do better.
ACTION	To note the report, next steps and seek any clarification.

Workforce Disability Equality Standard 2023

Author	Ash Ellis, Deputy Director for Leadership, Inclusion and OD
Purpose of Report	This report sets out our 2023 data and approach to action against the Workforce Disability Equality Standard (WDES) metrics

Executive Summary

- The WDES is the national framework through which Trusts are required to measure their performance against 13 key metrics for staff representation and experience with regard to disability. This comprises Trust workforce data indicators (1 – 3) Nationally set, Trust Staff Survey data indicators (4 – 9a), Indicator 9b focuses on disabled staff engagement, and indicator 10 focuses on disabled Board representation.

- The number of Disabled colleagues has increased by 63 to 318 from 255 last year. 6.41% of our colleagues are represented in the Disabled category, compared to 5% last year. The data shows that BHFT Disabled workforce is underrepresented by 6.99% compared to overall Berkshire population (13.4%).

- We still have a large number (413) of the overall workforce (8.18%) who have not declared their disability status. Although on the whole, the number not declaring is reducing year on year, and the number declaring is increasing year on year.

- Our medical colleagues declaration status has stayed the same over 3 years, with almost half or more (44%+) in each groupi44%+ ng not declaring their disability status.

- For clinical colleagues Cluster 4 (8c -9, VSM) is the most underrepresented group compared to overall disability declaration with 4.2%. however, it also has the largest group of colleagues who haven't declared (8.3%).

- For non-clinical colleagues Cluster 4 (8c -9, VSM) is the most underrepresented group compared to overall disability declaration with 4.5%. However, it also has the largest group of colleagues who haven't declared (18.2%).

- Overall, we have seen positive change and improvement across the majority of the indicators. Improvements seen in 8 of the 13 metrics, 4 have stayed the same, and one has declined.

- Indicator 6, is the only indicator to have declined this year. It reveals that disabled colleagues are more likely to have felt pressure from their manager to come to work despite not feeling well enough. This is 6.5% more than non-disabled colleagues. An increase of 2.5% from last year, and above the national average for NHS Trusts.

- Although improvement can be seen, we must not pause in our work to reduce inequality of experience for our colleagues. We must acknowledge that we are moving in the right direction overall but a lot more progress needs to be made, and in co-production with our Purple Network.

Recommendation	The Board is asked to acknowledge the WDES report and subsequent approach to develop actions.

1. Background

This paper provides an overview of our annual performance against the Workforce Disability Equality Standard (WDES) metrics for 2022-23. The data will be published on our public website, along with our action plan, in line with regulatory requirements.

The Workforce Disability Equality Standard (WDES) was introduced in April 2019 as a mandated data collection. The WDES is a collection of 13 metrics across 10 indicators that aim to compare the workplace and career experiences of Disabled and non-disabled staff.

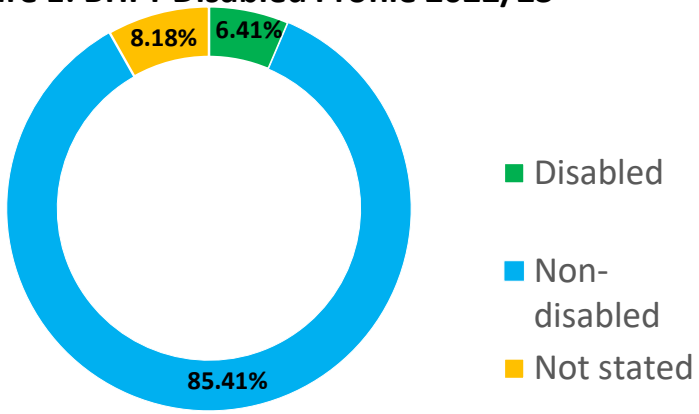
The standard is designed to improve the representation and experience of disabled staff at all levels of the organisation. We can use the data to better understand where the inequalities for our Disabled colleagues exist. This helps us to progress specific actions, to work towards year-on-year improvements.

The WDES is now mandated as part of the standard NHS Contract, and this supports closer scrutiny of the progress we make and outcomes we achieve.

2. What is our Workforce data telling us?

Data in 2023 shows our total staff is at 4,968.
The number of Disabled colleagues has increased by 63 to 318 from 255.
6.41% of our colleagues are declared Disabled, compared to 5% last year.
318 are Disabled and 4,237 are non-disabled and 413 have not stated.
Figure 1 below shows our Disabled profile.

Figure 1: BHFT Disabled Profile 2022/23



Overall Percentage of Disabled Staff		2020/21	2021/22	2022/23
Percentage of Disabled staff in overall Berkshire Healthcare workforce compared with other NHS Trusts in England	**Berkshire Healthcare**	**5%**	**5%**	**6.41%**
	NHS Trusts	**3.4%**	**3.7%**	

Out of 226 NHS Trust's we have the 48th highest population of declared disability. With 14.6% being the highest and 0.5% the lowest.

Out of 226 NHS Trust's we have the 68th least number of people who haven't declared/unknown status. The best being 0.6% and the worst being 64.8%.

We have more colleagues in our Trust who have declared a disability compared to most NHS Trusts' in England by almost 3%.

BHFT Workforce compared to Berkshire Population

	Disabled	Non-disabled	Not stated	Total
BHFT Workforce	318 (6.41%)	4,237 (85.41%)	413 (8.18%)	4,968
Berkshire Population	135,102 (13.40%)	811,294 (80.60%)	59,988 (6%)	1,006,384

(Source, Census 2021 data)

It's also useful to look at our workforce compared to the communities we support to see how representative our workforce is of our local population.

The data shows that BHFT Disabled workforce is underrepresented by 6.99% compared to overall Berkshire population. The data also shows that BHFT non-disabled workforce is overrepresented by 4.81% compared to overall Berkshire population. Like within BHFT there is a large population of the overall Berkshire population where we do not know their disability status (6%), although we have 2.18% more that don't declare compared to the Berkshire population.

3. WDES Indicators

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

Figure 2: Workforce Profile – Non-clinical Staff 2021-23 (across 3 years)

	Overall Workforce Profile 2021			Overall Workforce Profile 2022			Overall Workforce Profile 2023		
	Disabled	Non-disabled	Unknown	Disabled	Non-disabled	Unknown	Disabled	Non-disabled	Unknown
Workforce Total	236 (5%)	3698 (84%)	504 (11%)	255 (5%)	4082 (86%)	430 (9%)	318 (6.41%)	4,237 (85.41%)	413 (8.18%)
Non-clinical staff - 2021				Non-clinical staff - 2022			Non-clinical staff - 2023		
Cluster 1: Bands 1-4	42 (6%)	574 (82%)	86 (12%)	31 (5%)	538 (87%)	52 (8%)	33 (5.2%)	554 (87.2%)	48 (7.6%)
Cluster 2: Bands 5-7	15 (4%)	306 (87%)	30 (9%)	22 (6%)	324 (88%)	21 (6%)	27 (6.4%)	370 (88.3%)	22 (5.3%)
Cluster 3: Bands 8a-8b	7 (6%)	108 (85%)	12 (9%)	6 (4%)	125 (88%)	11 (8%)	13 (8.1%)	136 (84.5%)	12 (7.5%)
Cluster 4: Bands 8c-9&VSM	0 (0%)	41 (76%)	13 (24%)	1 (1%)	45 (73%)	16 (26%)	3 (4.5%)	51 (77.3%)	12 (18.2%)
Total Non-clinical	**64 (5.2%)**	**1,029 (83.4%)**	**141 (11.4%)**	**60 (5.2%)**	**987 (86%)**	**100 (8.7%)**	**76 (5.9%)**	**1,111 (86.7%)**	**94 (7.3%)**

- For non-clinical colleagues all disability declarations have increased across all pay band clusters this year.
- Our highest representation is within cluster 3 (8a—8b) with 8.1% of colleagues in this group declaring a disability.
- Cluster 4 (8c -9, VSM) is the most underrepresented group compared to overall disability declaration with 4.5%. However, it also has the largest group of colleagues who haven't declared (18.2%).
- We have 94 non-clinical colleagues who haven't declared their disability status.
- Although overall the number 'not declaring' is reducing year on year, 3 years ago from 11% to this year 8.18%
- The number of non-clinical staff declaring a disability has increased this year by 0.7%.

- **We still have a large number (413) of the overall workforce (8.18%) who have not declared their disability status.**

Figure 3: Workforce Profile – Clinical Staff 2021-23 (across 3 years)

	Overall Workforce Profile 2021			Overall Workforce Profile 2022			Overall Workforce Profile 2023		
	Disabled	**Non-disabled**	**Unknown**	**Disabled**	**Non-disabled**	**Unknown**	**Disabled**	**Non-disabled**	**Unknown**
Workforce Total	236 (5%)	3698 (84%)	504 (11%)	255 (5%)	4082 (86%)	430 (9%)	318 (6.41%)	4,237 (85.41%)	413 (8.18%)
	Clinical staff - 2021			**Clinical staff - 2022**			**Clinical staff - 2023**		
Cluster 1: Bands 1-4	51 (5%)	845 (87%)	76 (8%)	56 (5%)	872 (88%)	66 (7%)	68 (6.7%)	893 (87.4%)	61 (6%)
Cluster 2: Bands 5-7	99 (5%)	1703 (87%)	164 (8%)	115 (6%)	1747 (87%)	144 (7%)	145 (7.1%)	1766 (86.6%)	128 (6.3%)
Cluster 3: Bands 8a-8b	11 (4%)	260 (91%)	14 (5%)	14 (4%)	300 (93%)	10 (3%)	20 (5.4%)	334 (90.5%)	15 (4.1%)
Cluster 4: Bands 8c-9&VSM	4 (9%)	37 (82%)	4 (9%)	3 (7%)	37 (84%)	4 (9%)	2 (4.2%)	42 (87.5%)	4 (8.3%)
Total Clinical	**165 (5.1%)**	**2845 (87%)**	**258 (7.9%)**	**188 (5.6%)**	**2956 (87.8)**	**224 (6.6%)**	**235 (6.8%)**	**3035 (87.3%)**	**208 (6%)**
Medical and Dental Consultants	3 (3%)	47 (48%)	48 (49%)	3 (3%)	48 (48%)	49 (49%)	3 (3.23%)	48 (51.61%)	42 (45.16%)
Medical and Dental staff, Non-Consultant Career Grade	4 (5%)	47 (54%)	36 (41%)	4 (5%)	46 (56%)	32 (39%)	4 (4.48%)	42 (51.22%)	36 (43.90%)
Medical and Dental Staff, Medical and Dental Trainee Grades	0 (0%)	0 (0%)	21 (100%)	0 (0%)	0 (0%)	25 (100%)	0 (0%)	1 (3.70)	26 (96.30%)
Total medical	**7 (3.4%)**	**94 (45.6%)**	**105 (51%)**	**7 (3.4%)**	**94 (45.4%)**	**106 (51.2%)**	**7 (3.47%)**	**91 (45.05%)**	**104 (51.49%)**

- For clinical colleagues all disability declarations have increased or stayed the same across all pay band clusters this year, with the exception of cluster 4 (8c-9, VSM) where the number of colleagues declaring disability has decreased from 4 to 2.
- Our highest representation is within cluster 2 (5—7) with 7.1% of colleagues in this group declaring a disability.
- Cluster 4 (8c -9, VSM) is the most underrepresented group compared to overall disability declaration with 4.2%. however, it also has the largest group of colleagues who haven't declared (8.3%).
- We have 208 (6%) clinical colleagues who haven't declared their disability status.
- Medical colleagues declaration status has stayed the same over 3 years, with almost half or more in each group not declaring their disability status.
- We have more clinical colleagues with a declared disability than non-clinical colleagues.

Indicator 2: Relative likelihood of staff being appointed from shortlisting

WDES Indicator	Metric Descriptor		2020/21	2021/22	2022/23
2	Relative likelihood of Non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts. **A figure below 1:00 indicates that Disabled staff are more likely than Non-Disabled staff to be appointed from shortlisting.*	Berkshire Healthcare	**1.13**	**1.08**	**0.93**
		NHS Trusts	**1.20**	**1.11**	

We have made good progress in this indicator over the last 3 years, with the above showing that Disabled colleagues are more likely to be appointed from shortlisting than non-disabled colleagues, this is also better than the National average for NHS Trusts.

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

WDES Indicator	Metric Descriptor		2020/21	2021/22	2022/23
3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure. **This metric will be based on data from a two-year rolling average of the current year and the previous year.* ** A figure above 1:00 indicates that Disabled staff are more likely than Non-Disabled staff to enter the formal capability process.*	Berkshire Healthcare	**4.30**	**5.34**	**1.90**
		NHS Trusts	**1.53**	**1.94**	

We have made really good progress on this indicator over the last year, which demonstrates our Just Culture work is having an impact but we must keep momentum as the above still shows our disabled colleagues are 1.90 times more likely to enter the formal capability process than our non-disabled colleagues.

Indicator 4a: Harassment, bullying or abuse in the last 12 months – From patients, their relatives or public

WDES Indicator	Metric Descriptor		Disabled 2020/21	Non-disabled 2020/21	Disabled 2021/22	Non-disabled 2021/22	Disabled 2022/23	Non-disabled 2022/23
4a Staff Survey Q14a	Percentage of disabled staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	Berkshire Healthcare	30%	20%	30%	20%	**27%**	**20%**
		NHS Trusts	32%	25%	32%	25%	32%	24%

Progress has been made with 3% less Disabled staff experiencing harassment, bullying or abuse from patients, their relatives or the public. However, 7% more of Disabled staff experienced this compared to non-disabled staff, which we need to understand and try to address.

Indicator 4b: Harassment, bullying or abuse in the last 12 months – from Managers

WDES Indicator	Metric Descriptor		Disabled 2020/21	Non-disabled 2020/21	Disabled 2021/22	Non-disabled 2021/22	Disabled 2022/23	Non-disabled 2022/23
4b Staff Survey Q14b	Percentage of disabled staff experiencing harassment, bullying or abuse from managers in last 12 months	Berkshire Healthcare	15%	7%	12%	5%	**12%**	**5%**
		NHS Trusts	15%	8.5%	13%	7%	12%	7%

This indicator has stayed the same for the last 2 years at 12% but is still 7% more than non-disabled staff experiencing harassment, bullying or abuse from managers. We need to address this differential in experience, but equally for both groups our managers need to be role modelling the behaviours we expect and need in BHFT.

Indicator 4c: Harassment, bullying or abuse in the last 12 months – from colleagues

WDES Indicator	Metric Descriptor		Disabled 2020/21	Non-disabled 2020/21	Disabled 2021/22	Non-disabled 2021/22	Disabled 2022/23	Non-disabled 2022/23
4c Staff Survey Q14c	Percentage of disabled staff experiencing harassment, bullying or abuse from colleagues in last 12 months	Berkshire Healthcare	21%	13%	19%	11%	**18%**	**12%**
		NHS Trusts	21%	13%	20%	12%	19%	12%

This indicator has seen year on year progress over the last 3 years, with a 1% improvement on last year. However, 6% more of Disabled staff have experienced harassment, bullying or abuse from colleagues. We need to address this differential in experience, but equally for both groups our colleagues need to be demonstrating our Trust behaviours that we expect and need in BHFT.

Indicator 4d: Harassment, bullying or abuse – reporting it

WDES Indicator	Metric Descriptor		Disabled 2020/21	Non-disabled 2020/21	Disabled 2021/22	Non-disabled 2021/22	Disabled 2022/23	Non-disabled 2022/23
4d Staff Survey Q14d	Percentage of Disabled staff compared to Non-Disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	Berkshire Healthcare	54%	59%	56%	63%	**59.8%**	**57.3%**
		NHS Trusts	59%	61%	59%	61%	60.3%	59.8%

This indicator has seen year on year progress over the last 3 years, with a 3.8% improvement on last year, which may demonstrate people are feeling more confident and safe to report, and/or getting familiar with the process. Disabled staff report more than non-disabled staff by 2.5%, which was 5% in the opposite direction 3 years ago. We still have some work to do here though as we are below the national NHS Trust average and we want our colleagues to be able to report in safety and confidence.

Indicator 5: Percentage of staff believing the Trust provides equal opportunities for career progression or promotion

WDES Indicator	Metric Descriptor		Disabled 2020/21	Non-disabled 2020/21	Disabled 2021/22	Non-disabled 2021/22	Disabled 2022/23	Non-disabled 2022/23
5 Staff Survey Q15	Percentage of Disabled staff compared to Non-Disabled staff believing that the Trust provides equal opportunities for career progression or promotion.	Berkshire Healthcare	59%	67%	53%	64%	**61%**	**65%**
		NHS Trusts	54%	60%	54%	60%	56%	62%

The above shows we have made good progress with an 8% improvement on last year for disabled colleagues and 1% for non-disabled colleagues. Although 4% more of non-disabled colleagues believe the Trust provides equal opportunities for career progression or promotion.

Indicator 6: Percentage of staff feeling pressured to come to work when unwell

WDES Indicator	Metric Descriptor		Disabled 2020/21	Non-disabled 2020/21	Disabled 2021/22	Non-disabled 2021/22	Disabled 2022/23	Non-disabled 2022/23
6 Staff Survey Q11e	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	Berkshire Healthcare	24%	15%	20%	16%	**22.5%**	**16%**
		NHS Trusts	24%	17%	21%	15%	19%	13%

This is the only indicator this year that has declined for us. It is therefore an area of concern for which we want to try and understand more, it is also above the average for NHS Trusts. This has increased by 2.5%, and is still 6.5% more than our non-disabled colleagues. Although our non-disabled score has remained the same for the past two years, it is now 3% higher than the average for NHS Trusts.

Indicator 7: Percentage of staff saying that they are satisfied with the extent to which the organisation values their work

WDES Indicator	Metric Descriptor		Disabled 2020/21	Non-disabled 2020/21	Disabled 2021/22	Non-disabled 2021/22	Disabled 2022/23	Non-disabled 2022/23
7 Staff Survey Q4b	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	Berkshire Healthcare	55%	67%	52%	61%	**52%**	**61%**
		NHS Trusts	45%	55%	44%	52%	44%	53%

This indicator has stayed the same for 2 years for both disabled and non-disabled colleagues. However, both are above the average for NHS Trusts by 8%. This indicator needs more exploration amongst our workforce, particularly with how our colleagues feel or think the organisation can show or do more, to demonstrate that their work is valued.

Indicator 8: Percentage of staff saying the organisation has made adequate adjustments for them in their role

WDES Indicator	Metric Descriptor		Disabled staff 2020/21	Disabled staff 2021/22	Disabled staff 2022/23
8 Staff Survey Q30b	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	Berkshire Healthcare	77%	81%	**81%**
		NHS Trusts	76.6%		79%

This indicator has stayed the same for the past 2 years, but is above the national NHS Trusts average by 2%. However, there are still 19% of disabled colleagues who feel we haven't made adequate adjustments to enable them to carry out their work.

Indicator 9: NHS Staff Survey and the engagement of Disabled staff

WDES Indicator	Metric Descriptor		Disabled 2020/21	Non-disabled 2020/21	Disabled 2021/22	Non-disabled 2021/22	Disabled 2022/23	Non-disabled 2022/23
9 National Survey Staff Engagement Score	a. The staff engagement scores for Disabled and Non-Disabled staff	Berkshire Healthcare	7.2	7.6	7.1	7.5	**7.2**	**7.5**
		NHS Trusts	6.8	7.3	6.7	7.2	6.7	7.2
	b. Has Berkshire Healthcare taken action to facilitate the voices of Disabled staff in your organisation to be heard? Please provide an example		**Yes**					

	The voices of disabled colleagues are heard via an active, up and running Purple Staff Network, whose Chair has protected time of half a day each week, admin support and a budget for network activities, and a dedicated teams channel for members. The Purple Staff Network has Executive level sponsorship (Chief Financial Officer). The voice of disabled staff is also sought in the co-production of new strategies, policies, and our Staff Network leads have regular meetings with our EDI Leads to help support the implementation of our strategies, as well as being pivotal members on forums such as Diversity Steering Group (DSG).

Our engagement score has improved by 0.1 for our disabled colleagues over the past 12 months. It has remained the same for our non-disabled colleagues. Both scores are above the NHS Trust average. However, the engagement score of our disabled colleagues is still 0.3 less than our non-disabled colleagues.

Indicator 10: Board membership 2022/23

WDES Indicator	Metric Descriptor			Total	Voting	Non-voting	Exec	Non-exec	Overall Workforce
10 Board representation	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: • By voting membership of the Board. • By Executive membership of the Board.	**Berkshire Healthcare**	**Disabled**	**1 (7.69%)**	**1 (7.69%)**	**0**	**1 (16.67%)**	**0 (0%)**	**318 (6.41%)**
		NHS Trusts		*3.7%*	*3.6%*	*3.9%*	*3.8%*	*3.6%*	*3.7%*
		Berkshire Healthcare	**Non-disabled**	**6 (46.15%)**	**6 (46.15%)**	**0**	**4 (66.67%)**	**2 (28.57%)**	**4,237 (85.49%)**
		NHS Trusts		*72.5%*	*72.3%*	*73.3%*	*75.6%*	*69.6%*	*74.9%*
		Berkshire Healthcare	**Unknown**	**6 (46.15%)**	**6 (46.15%)**	**0**	**1 (16.67%)**	**5 (71.43%)**	**413 (8.18%)**
		NHS Trusts		*23.8%*	*24%*	*22.8%*	*20.6%*	*26.9%*	*21.3%*
			Total Trust Members	**13**	**13**	**0**	**6**	**7**	**4,968**

Figure 4: Board membership compared with overall workforce over 3 years.

	% Difference compared with overall workforce 2020/21			% Difference compared with overall workforce 2021/22			% Difference compared with overall workforce 2022/23		
	Disabled	**Non-disabled**	**Unknown**	**Disabled**	**Non-disabled**	**Unknown**	**Disabled**	**Non-disabled**	**Unknown**
Difference Total Board – Overall Workforce	-5%	-38%	43%	2%	-47%	45%	1%	-39%	38%
Difference Voting Membership – Overall workforce	-5%	-38%	43%	2%	-47%	45%	1%	-39%	38%
Difference Executive Membership – Overall Workforce	-5%	-18%	-23%	11%	-19%	8%	10%	-19%	8%

- The total Board membership of colleagues declaring a disability is 1% higher than the overall workforce, meaning that disabled people are overrepresented at Board compared to our overall workforce.
- Our Executive membership is 10% higher than the overall workforce, meaning that disabled people are overrepresented at Executive membership compared to our overall workforce.
- There is a high number of undeclared/unknown amongst the Board which is not representative of the workforce, this is particularly evident with our Non-executive Directors.
- Compared to NHS Trust's Nationally, we are above the average for representation but below average for the number of our Board who have not declared their disability status.
- Overall it is an improvement on last year as 1 more of the Board have declared their status. But disability declared remains the same.

Figure 5: Talent Pipeline to Board – Executive Director reports

Staff Group	**Gender**		**Ethnicity**				**Disability**			**Total in staff group**
	Male	**Female**	**White British**	**White – any other white background**	**Asian or Asian British**	**Not Stated**	**Disabled**	**Non-Disabled**	**Not Stated**	
Medical	2	2	2	1	1	0	0	3	1	**4**
Clinical	1	5	6	0	0	0	0	6	0	**6**
Corporate	3	11	11	1	0	2	1	9	4	**14**
Total	6 (25%)	18 (75%)	19 (79.2%)	2 (8.3%)	1 (4.2%)	2 (8.3%)	1 (4.2%)	18 (75%)	5 (20.8%)	**24**

The above shows the colleagues who report into Executive Board members and their declared characteristics.

4. Conclusion and next steps

Conclusion

Based on the data outlined in this report we have clear areas where we need to improve and do better for our colleagues, this is across most indicators. However, 8 of the 13 metrics have seen improvement from last year. One Indicator declined, and 4 stayed the same over the last year:

- Indicator 6, is the only indicator to have declined this year. It shows us that disabled colleagues are more likely to have felt pressure from their manager to come to work despite not feeling well enough. This is 6.5% more than non-disabled colleagues. An increase of 2.5% from last year, and above the national average for NHS Trusts.

Four indicators stayed the same over the last year:

- Indicator 4, metric 4b is the 'Percentage of staff experiencing harassment, bullying or abuse from manager in last 12 months'. For two years this has remained at 12% for disabled colleagues. Disabled colleagues are 7% more likely to experience harassment, bullying or abuse from managers than non-disabled colleagues.
- Indicator 7 is the 'percentage of staff satisfied with the extent to which the organisation values their work'. This indicator has stayed the same for 2 years for both disabled and non-disabled colleagues. However, both are above the average for NHS Trusts by 8%. This indicator needs more exploration amongst our workforce, particularly with how our colleagues feel or think the organisation can show or do more, to demonstrate that their work is valued.
- Indicator 8, is 'the percentage of disabled staff who feel their employer has made adequate adjustments to enable them to do their job'. This indicator has stayed the same for the past 2 years, but is above the national NHS Trusts average by 2%, at 81%. However, there are still 19% of disabled colleagues who feel we haven't made adequate adjustments to enable them to carry out their work.
- Indicator 10, is Board representation. There is 1 voting Board member declared disabled which has stayed the same for 2 years. However, this is 1% higher than the overall workforce, meaning that disabled people are overrepresented at Board compared to our overall workforce.

We still have a large number (413) of the overall workforce (8.18%) who have not declared their disability status. Although on the whole, the number not declaring is reducing year on year, and the number declaring is increasing year on year.

Next Steps

Actions to further improve the Trust's WDES performance align with the Trust's strategic ambitions and priorities, in particular making Berkshire Healthcare a great place to work for our people.

The action plan, will be co-created with our PURPLE network and Diversity Steering Group (DSG). It is likely we will focus on areas being informed by our problem statements above:

- To increase disability disclosure rates on ESR.
- To investigate why disabled colleagues feel more pressure from their manager to come to work, despite not feeling well enough to perform their duties.
- To create a culture where disabled staff feel safe, supported, valued and reduce the incidents of harassment, bullying or abuse that our disabled colleagues are subject to.

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Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	September 2023
Title	**Management, Leadership, and Talent Development Strategy**
	Item for Noting
Purpose	This document provides an update to our revised approach to leadership development, pulling key workstreams together in an overall Management, Leadership and Talent Development strategy.
Business Area	People Directorate
Author	Ash Ellis, Deputy Director for Leadership, Inclusion, and Organisational Experience
Relevant Strategic Objectives	Make Berkshire Healthcare a great place to work for our people, and a great place to get care for our patients
CQC Registration/Patient Care Impacts	The relevance of this paper supports all CQC KLOEs and patient experience, but specifically supports the Well Led domain.
Resource Impacts	The paper references work that needs to be undertaken across the Trust.
Legal Implications	No direct legal implications but the outputs will support our mangers in ensuring they fully consider and implement robust people practices.
Equality and Diversity Implications	This paper helps us to recognise, explore and take action against any inequalities for our workforce.
SUMMARY	This document describes our refreshed approach to management, talent and leadership development. This provides a framework through which we will maximise the impact and potential of colleagues. It sets out how we will develop the capacity and capability of our managers to support delivery of our Trust vision and strategy and operational excellence. Proposes that development becomes an essential requirement for all leaders and managers.

ACTION	To note the report, next steps and seek any clarification.

Management, Leadership, and Talent Development Strategy

Lead Director	Jane Nicholson, Director for People
Author	Ash Ellis, Deputy Director for Leadership, Inclusion and OD
Purpose of Report	This document provides an update to our revised Management, Leadership and Talent Development strategy

Executive Summary

The purpose of this strategy is to:

- Describe our approach to management, talent and leadership development.
- Set out how we will continue to develop the capacity and capability to support delivery of our Trust vision and strategy and operational excellence.
- Provide a framework through which we will maximise the impact and potential of colleagues
- Make sure development is an essential requirement for all leaders and managers.
- Be systemic, long-term and whilst developing our leaders and managers to deliver operational excellence, makes a significant contribution to BHFT as an organisation.

Since the pandemic our focus had somewhat shifted, and we have lost some momentum in developing our managers and leaders. We need a renewed focus and investment in leadership and management development utilising digital and virtual solutions in a progressive, 'blended way' to enable our people and culture to grow positively.

This led to the evaluation and stocktake of our current offering, to build on the success of our previous programmes. Our proposed new inclusive and compassionate approach to deliver operational excellence includes:

- Pre-Leadership and management support (Reaching my Potential).
- Management development (Essential knowledge for new Managers).
- Leadership development – 3 factor approach (self,others,organisation), and system.
- More collaborative and holistic approach to developing high performing teams.
- Build and embed our inclusive talent and succession management approach.
- A refresh of our wrap around support to leaders and managers including coaching, mentoring, action learning sets/reflective practice, easy access to evidence based tools and resources, and managers handbook.
- All underpinned by our commitment to anti-racism, diversity and accountable inclusivity, aligning to and built around our core behavioural framework.

The renewed approach has also taken account of a number of factors including: our refreshed vision, mission, values and behaviours; Trust Strategy, publication of the NHS Long-Term plan and national ambitions and priorities; development of the Integrated Care System, its People Plan, and publication of the national NHS People Plan 2020/21.

The refreshed approach builds on our existing development programme, offering flexible and blended, personalised and progressive options that are inclusive across all staff groups.

Measurement and evaluation of the revised approach will include indicators of impact and outcome, seeking to measure progress rather than identify absolute targets.

Recommendation	The Board is asked to note and approve the Leadership Development and Talent Management Strategy

MANAGEMENT, LEADERSHIP AND TALENT DEVELOPMENT STRATEGY

Section 1: Background and purpose

1. We already offer leadership and management development opportunities to people in clinical and non-clinical services, from those starting their leadership and/or management development journey to those wishing to go further at Organisational, System and National level.

2. The products and opportunities available include in-house leadership programmes, management courses, external offers and regional/national offers sponsored by organisations such as the NHS Leadership Academy and Health Education England.

3. We need both Managers and Leaders to meet our mission, aims and strategic objectives. Management and Leadership can be seen as two distinct functions. For the purposes of this strategy, the first function is defined as being concerned with the achievement of today's requirements; the second with the creation of the dynamic that realises tomorrow's

4. The practices of management and leadership intermingle in both posts and individuals. Some post holders are predominately managers, and some are predominately leaders dependent on the responsibility of their post. Both are underpinned by a range of knowledge and skills. Consequently, the focus of our Strategy is primarily on the balancing and development of management and inter-related leadership skills.

5. The purpose of this strategy is to:
    - Describe our approach to management, talent and leadership development.
    - Set out how we will continue to develop the capacity and capability to support delivery of our Trust vision and strategy and operational excellence.
    - Provide a framework through which we will maximise the impact and potential of colleagues.
    - Make sure development is an essential requirement for all leaders and managers and focus on their needs.
    - Be systemic, long-term and whilst addressing the leaders and the managers makes a significant contribution to BHFT as an organisation.

Section 2: Development of this Strategy

1. The strategy has been developed through engagement with Staff Networks, Managers and Leaders across the organisation and acts on feedback from staff through the NHS staff survey and other engagement routes, as well as reviewing previous programmes and a pilot programme. It also brings through learning and insights from our work with the ICS's and the NHS Leadership Academy.

2. We are a partner in the Frimley and BOB Integrated Care System and a member of the Integrated Care Board. We will ensure our management and leadership development strategy and plans are aligned to system-level working and maximise the opportunities to work more collaboratively as a System for the benefit of our patients.

3. This strategy forms a key component in the delivery of the overarching Trust, People and EDI Strategies.

Section 3: Vision and Objectives

1. Our vision is for our leaders and managers is to be highly competent, confident, accountable, compassionate and inclusive – in line with our Trust vision we want BHFT to be 'a great place to get care, and a great place to give care – making the Trust a great place to work for everyone, this won't happen unless we have great leaders who can deliver this vision.

2. Our leaders promote listening, learning, innovation and continuous quality improvement with the vision and inspiration to lead transformational service change and operational excellence. They will model our behaviours and lead our teams positively and by example.

3. Our vision for leadership and management development is for a blended programme entwined with our talent and succession management approach, and workforce planning needs. With clear, easy to navigate development pathway that also considers offers from external partners locally and nationally.

Our renewed approach has taken account of a number of factors including: our vision, mission, values and behaviours; Trust Strategy, the NHS Long-Term plan and national ambitions and priorities; development of Integrated Care Systems, Messenger Review, and publication of the national NHS People Plan and People Promise and the "Leadership way" a framework for leaders in the NHS.

4. Our leaders translate our vision into action and they shape the culture. Therefore, our five overarching strategic management and leadership development priorities are:

    - To ensure we have inclusive and compassionate leadership and management capacity and capability throughout the organisation.
    - To build and embed our inclusive talent management and succession planning approach.
    - A more collaborative and holistic approach to developing high performing teams.
    - To develop and increase leadership and management diversity, that supports inclusion, belonging and our commitment to being an anti-racist organisation.
    - A refresh of our wrap around support to leaders and managers including coaching, mentoring, action learning sets/reflective practice and easy access to evidence-based tools, resources, and managers handbook.

Section 4: Strategic Priorities

Strategic priority one: Ensuring inclusive and compassionate leadership and management capacity and capability

1. We have realigned and refreshed our existing leadership and management development offer to reflect a more inclusive, compassionate and flexible approach to developing the workforce.

2. Although there has been some refinement and rebranding of programme names, the offering remains largely unchanged however necessary steps have been taken to optimise the learning experience, with underpinning principles (Appendix 2).

3. Although there has been some refinement and rebranding of programme, the offering remains largely unchanged however necessary steps have been taken to optimise

the learning experience and feedback, and data and performance has helped to inform the revised offering.

4. If you are a first time manager then it will be a requirement to undertake the core leadership and management pathway (appendix 1) otherwise we will take recognition of prior learning. This screening will be developed through recruitment/on-boarding process.

5. We have a devised a “development pathway” which is accessible to all regardless of banding, and place ownership on the individual to consider which option would represent the most value to enabling them to flourish in their roles.

6. The pathway can also act as a refresher for those experience leaders and managers who want to continue their development.

7. Each part of the pathway consists of a series of modules, learning and resources, offering varying levels of flexibility regarding how these are accessed and how long they take to complete. The pathways are as follows;
   - Pre-Leadership and management support (Reaching my Potential)
   - Management development (Essential knowledge for new Managers)
   - Leadership development – 3 factor approach (self, others, organisation) and system.

Pre-Leadership and finding direction (Reaching my Potential)

Open to any staff wanting to consider their career journey or find direction, whether this is within current role, a sideways move or keen to start building leadership skills. The course covers building confidence, self-assessment, self-awareness and signposting. A safe environment to chat with others, explore and decide on your development pathway.

Personal effectiveness means getting the best out of yourself and performing to the best of your abilities. It involves confidently managing yourself and understanding that it is your responsibility to take the necessary steps towards growth and change. It is also linked to wellbeing, and helps you to be more aware, motivated, confident and focused.

(see Appendix 1 for a programme outline)

Management Development (Essential knowledge for new Managers)

The management part of the pathway is known as ‘Essential Knowledge for New Managers’, designed to support and develop our new manager capability. However existing managers can refresh and update themselves as needed through the blended approach.

- Our managers play a critical role in shaping and communicating organisational priorities across the trust whilst continually influencing how colleagues, patients and other stakeholders experience working in the organisation and accessing our services.
- The impact of strong management has significant implications on the ability of the organisation to achieve its objectives and perform well in areas such as staff satisfaction ratings, staff retention, team performance, staff wellbeing and deliver operational excellence.

- Ensuring our managers feel supported and have continuous opportunities to develop their knowledge and skills is a priority for the Trust. We recognise good managers develop meaningful and compassionate relationships with their teams whilst possessing a strong understanding of the important people processes which reinforces HR best practice and Just & Learning Culture principles are embedded.
- Our core training offer for managers consists of a range of training sessions, tools and resources designed to enhance management capability by developing both interpersonal and functional skills.

This offer, which also serves the function of a specific management induction, aims to provide managers with all the information and resources they require to effectively manage all the necessary operational, and people processes. This will become essential that all managers complete this pathway, with an initial focus on those new into manager roles and those joining BHFT as managers. This may link into mentoring, probation process, development programmes, action learning, mandatory training and personal development planning.

(see Appendix 1 for a programme outline)

Leadership Development (Impact on self, others, organisation, and system)

Leadership is a combination of role modelling positive behaviours and enabling our staff to work in an environment where they are respected and supported to flourish in their roles. It is also about getting results and striving for operational excellence in delivering outstanding healthcare.

Our programme is designed to give our current and future leaders, the skills, knowledge and confidence to be a compassionate, inclusive and non-discriminatory role models who can lead our teams positively in achieving operational excellence.

- This is a programme centred around positive understanding and positive action. This is not a deficit model.
- It is a strengths-based programme where leaders understand and build on their strengths. Each person's leadership journey will be different based on their skills, experience and personal traits.
- The strengths-based programme will seek to develop everyone into the best leaders they can be by helping them recognise their own areas of strength and growth.
- Whilst there will be some core modules and components to the programme, you will explore some areas in greater depth according to your own growth plan.
- The programme contains both core modules and optional modules. The modules will be supplemented by reading, webinars and other video content, coaching and peer support, coaching feedback.
- Exactly what you will do on the programme will depend partly on you. At the end of 'Impact on Self' you will develop your own personalised growth plan to support your own leadership journey based on previous leadership experience and training, feedback received or gaps identified
- We will develop leadership competencies including behaviours. (Appendix 3)

(see Appendix 1 for a programme outline, programme visual below in Figure 1)

Figure 1:

Accreditation
We will review the various options available to us that may enhance the offer for our people or give them accreditation or certification from a recognised body.

1. With the skills, knowledge and expertise we have internally to deliver our leadership development programme we know that the quality will be high and that there will be quality assurance processes and systems in place.

2. Gaining accreditation for our courses demonstrates to attendees the steps taken to deliver the highest possible training standards. It also enables us to present our knowledge as industry experts and create new alliances and business opportunities.

3. It can also help increase delegate bookings and attendance by providing structured accredited CPD that can help our clinical and non-clinical workforce meet their professional registration requirements i.e. as part of NMC or HCPC revalidation/re-registration CPD hours requirement.

Strategic Priority two: To build and embed our inclusive talent management and succession planning approach

For the past nine years we have been applying talent management and succession planning to executive and SLT roles in order to understand our talent pipeline more effectively.

This has been part of our strategic approach to developing clinical and managerial leadership positions at Board level and key roles below board level (such as clinical, operational and finance Directors).

- We now want to adopt a more inclusive approach to developing talent and will look at identifying critical roles and capabilities at multiple levels this will help increase our leadership and management capacity and capability but importantly identify, develop and engage with our leaders of tomorrow. It may not apply to every role, but we want

to consider succession across different areas in the organisation, different professions and in areas that provide the biggest challenge.

- Good talent management and succession planning with our inclusion lens on, means that we have the right people, with the right values, in the right roles or ready to move into these roles, where diverse skills, talents are maximised and everyone has a clear, achievable personal development plan and are given the opportunity to grow.

- We need to ensure that people have the skills, knowledge and confidence for our organisational success now and in the future. This is an essential driver of our wider learning and development offer and the appraisal experience as well as linking to our retention work and workforce planning approach.

We will review our existing talent management arrangements including:

- Review of talent pipelines from underserved groups.
- Exploration of a sponsorship programme for our underserved groups but actively encourage the participation of underserved groups in leadership and management development opportunities.
- Ongoing review of the appraisal process and system.
- Review of the Trust learning needs analysis (LNA) process, access to CPD, coaching and mentoring.
- Review and promote opportunities for flexible working/portfolio working.
- The quality and availability of support to line managers for talent conversations in being developers of talent and having career conversations.
- Aligning our talent approach to our workforce data and workforce planning approach.
- Develop succession planning systems and processes, talent pools, talent boards.
- Clear career pathways, competency based progression and job descriptions that support inclusivity.

We will then set out a clear structure for talent management and succession planning that considers these aspects as shown in the talent management loop below.

Figure 2: Talent Management Loop

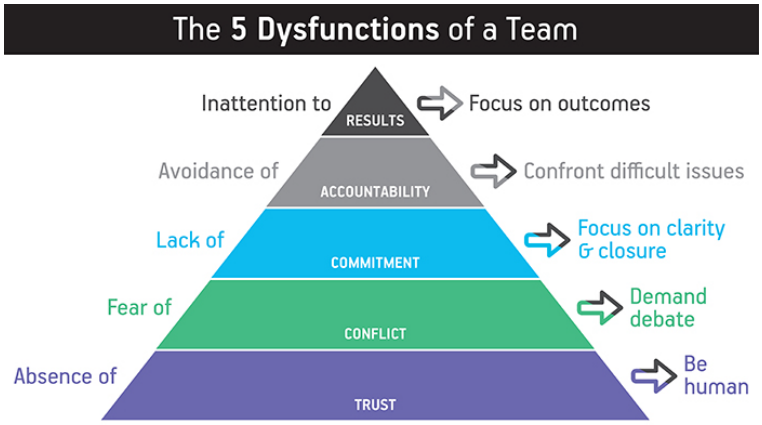
Strategic Priority three: A more collaborative and holistic approach to developing high performing teams

Leadership and management development is hard to separate from team development and we must address the effectiveness of teams alongside the support we give to managers and leaders.

We know that inclusive and compassionate cultures create better conditions for teams to thrive and deliver excellence. As the National Messenger review recommended, we need collaborative and collective leadership to build inclusive and compassionate cultures.

Patrick Lencioni identified five dysfunctions that many teams face, and this model outlines the root causes that can exist within teams and the keys to overcoming them in moving towards creating a high performing team.

Figure 3: Patrick Lencioni's 5 Dysfunctions of a Team



- We will look to strengthen our team development arrangements by introducing a multidisciplinary approach and framework to team and culture development.
- Drawing on the breadth and depth of expertise across our own internal organisation from services including; L&D, Education, QI, OD/EDI, Digital, Psychology, HR, Comms, and Wellbeing services to name a few, we can support teams to flourish in each of 7 components of the McKinsey 7s model (Figure 4).
- This will help provide a holistic approach in identifying and utilising the best intervention for the right scenario, whilst also ensuring the 5 dysfunctions of a team are considered. The NHS staff survey results and other data will also play an important role in mapping out our OD offer and interventions.
- We have been overly reliant on external skills and expertise and therefore investing in our own OD capability and having a structure in which to deliver our high performing teams offer will provide a consistent, quality, and BHFT focused approach that creates the culture we feel we need in our teams to deliver our strategic ambitions.

- A framework will consist of 6 phases; Identification of need, Application, Consultancy, Diagnosis/Triage, Intervention and Evaluation. (Figure 5)

- Following consultancy and diagnostic phases with the relevant team, then a possible triage to the right expertise could lead to a number of interventions such as; psychometric testing, facilitated action learning sets, mediation, 'facilitate your own away day', masterclass, facilitated team workshops or Affina Team Journey.

- However, team development facilitation may not always be the best option and the diagnostic phase could lead to skills profiling, 1-2-1 coaching or facilitated conversations.

- In the stepped process as part of the new framework it will also address any unmet leadership and management development needs as well as any conflict before undergoing team development.

- Our Team Leaders will be provided with the essential tools and foundational basics of high performing teams such as; meeting as a team, setting team goals, how responsibility is shared, and how the team communicates with each other.

Figure 4: McKinsey's 7s Model

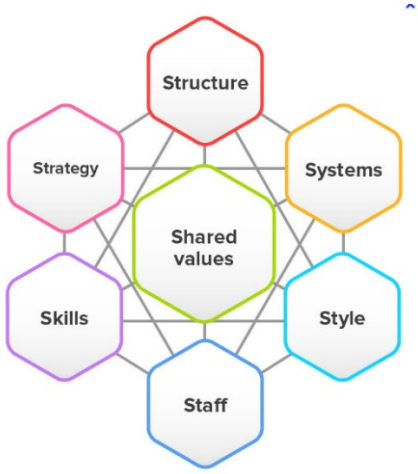
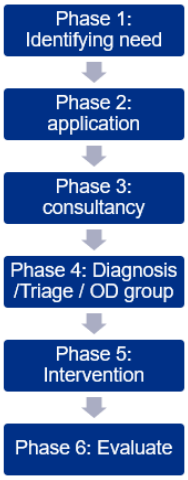


Figure 5: Phases of Team development approach



Conflict Pathway

We also need to give our managers and leaders all the tools to be able to know what steps are available to manage conflict so that when any conflict happens it can be resolved in a timely way, so a creation of a conflict resolution pathway will be developed supported by the early resolution policy developed as part of our Just Culture work.

This pathway will encompass our leadership programme (i.e. conflict management) coaching, behaviour framework, facilitated conversations and mediation. If conflict is then resolved then team development can be explored.

Strategic priority four: To develop, and increase leadership and management diversity that supports inclusion, belonging and our commitment to being an anti-racist organisation

The disproportionate impact of COVID-19, the resurgence of the Black Lives Matter Movement, and subsequent worldwide media coverage on the social injustice and terrible treatment of racially minoritised communities and colleagues has shone a light on inequalities and created a catalyst for change.

NHS leaders have stepped up and need to continue to do so, and do more; role modelling compassionate, inclusive leadership through open and honest conversations, positive action taking, and becoming anti-racist.

We recognise from our workforce data and pay gap reports that those in managerial and leadership posts have tended to be white males. We will actively encourage the participation of women and ethnically diverse groups in management development activities through programmes, as well as ensuring that equal opportunities principles apply to the delivery and design of programmes and the selection of candidates for leadership and management development opportunities and for appointment to leadership and management positions.

Entwined with our equality, diversity and inclusion programme of work we will continue to address inequalities through:

- Identifying and reducing gaps in the number of ethnically diverse staff accessing leadership development opportunities.
- Develop and deliver an anti-racism development programme, particularly targeting our middle and senior managers from 8a upwards.
- Our leadership development and talent management work will be co-produced with our staff networks, and experts by experience where this will add greatest value.
- Our leadership programme will have an inclusivity component throughout it, to ensure our managers and leaders are developed to have the skills, knowledge and confidence to be truly inclusive, and can become anti-racist.
- Promoting the leadership offer and opportunities directly through our staff networks.
- Our female and ethnically diverse workforce is underrepresented in the majority of our senior roles this is highlighted in our gender and ethnicity pay gap report. We need to ensure our female and ethnically diverse colleagues at lower bands are given opportunities to develop, and are supported to apply for posts at band 8A and above. The exploration of a women's network will be helpful in supporting the development of our female workforce.
- Working with the ICS and NHS Leadership Academy on developing opportunities to access programmes specifically designed to support career development for our ethnically diverse staff and wider marginalised staff groups.
- Promoting coaching opportunities to our marginalised staff groups to increase uptake and support development as part of Talent Management approach.
- Ensuring all of our leaders and managers are aware and know about our Public Sector Equality Duty (PSED), the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and how they can take action for positive change.
- Develop FSUG Associate Guardians/champions within each staff network.
- We want to ensure we are retaining, developing and supporting our international recruits, with the level of investment into recruitment, we will explore an Over-seas network.

Strategic priority five: A refresh of our wrap around support to leaders and managers including our coaching, mentoring, action learning sets/reflective practice and easy access to evidence based tools, resources and managers handbook.

Personal Development Plan

A Personal Development Plan is agreed through the appraisal process. However, appraisers need more help in identifying specific leadership and management development needs and deciding how best to meet them. The OD team will design and implement a process to help Appraisers to draw up a more focused development plan.

Ultimately, the Personal Development Plan could be linked to the Trust Leadership and Management competence framework (Appendix 2).

Coaching

Coaching comprises an important strand of the management and leadership strategy and by providing a mechanism for developing a collaborative and transformational leadership style within the Trust. It will promote a culture of empowerment and encourage open and honest communication channels.

Coaching will provide a safe and structured environment for leaders and all staff to be challenged and empowered to explore options, learn new ways of thinking and approaching situations, in order to make better choices and get better results.

Coaching will build on the Trust's commitment to being a learning organisation by encouraging informal, reflective, person centred learning opportunities for its people to develop their self awareness, self belief and confidence, in order to effectively lead and bring about positive change.

We will reinvigorate coaching by establishing a coaching infrastructure supported by a network of internally accredited coaches that will work in tandem with our leadership, management and team development offer, as well as support our talent management approach to ensure all our staff at all levels can benefit from this developmental offer. All attendees going through the essential programme will be given access to their own Coach.

Mentoring

Mentoring in the workplace tends to describe a relationship in which a more experienced colleague shares their greater knowledge to support the development of an inexperienced member of staff. It calls on the skills of questioning, listening, clarifying and reframing that are also associated with coaching.

We will adopt a more structured approach to mentoring, in particular, where developmental gaps have been identified during career development processes.

To raise the profile of mentoring as an important developmental activity, it is recommended that new senior managers within the Trust are themselves mentored by internal or external managers. This approach will implemented to all staff new to the organisation or in new roles. It will be essential to prepare all mentors for their developmental role. As for coaching activity, mentoring provides development for both mentor and mentee.

As well as supporting our staff development mentoring will support our talent management and succession planning. We have a lot of skills, knowledge, experience and overall expertise that could be lost when people leave so we need to find a way to harness this and create the right conditions for mentoring to thrive and be accessed. We will grow the numbers of mentors in the organisation, we will help develop our people to become mentor.

Action Learning Sets and Reflective Leadership Practice

Reflective leadership practice is about having space and time to think about yourself as a manager and leader and is critical in leadership development and self care. Self-reflection accelerates improvement in leadership skills and practice as it involves reflecting on your current level of skills, strengths, challenges and behavioural patterns, which enables development of self-awareness, authenticity learning and growth.
Coming together in a group as part of a group to reflect on leadership practice will also provide an opportunity to share, listen and connect with other leaders and managers across the Trust, and has the potential to develop into ongoing peer support. Peers can also add a perspective that may not have been considered.
Alongside the leadership programme reflective practice groups will take place to support our leaders with their continuous learning and growth in a supportive way.

Online Learning, Evidence Based tools, resources and managers handbook

As part of our blended approach to leadership and talent development some of our delivery and content will be self-directed and access as you need to, we want to ensure our leaders, managers and colleagues have the latest evidence based information to underpin organisational decision-making and high quality patient care.
Opportunities for introducing online leadership and management development will be further researched and implemented as appropriate, enabling staff to learn at their own pace, promoting a culture of self-managed learning.
It is intended to further develop an online community which will provide information for leaders and managers with links to internal and external information, learning and resources.

We also want to develop organisational innovation and transformation through best practice, retention and sharing of knowledge. We are fortunate that we have such access to the BHFT Knowledge and Library service who will play a key part in the delivery of this strategy and also in the creation of an engaging and accessible online learning resource hub. This also supports the Knowledge and Library Strategy 2023-2026.
The online hub will enable delegates to access content and learning resources that will continually be added to and refreshed, to improve and expand their knowledge, skills, and abilities. This will include; TED talks, YouTube videos, research, articles, journal links, case studies, further reading, and much more.

A Managers handbook is also currently available, which has practical steps, signposting and general awareness raising of aspects around being a manager. This handbook will be refreshed, socialised and communicated to all managers and new mangers will receive a digital copy.

Behaviours

An integral part of this strategy is the development and introduction of our new QI informed behavioural framework, which will need to be embedded across our systems, processes, policy's and underpin our leadership development activity. This will also link to our appraisal process and talent management approach. A socialisation and communication plan will need to be put in place to ensure we launch these in an effective way.

To achieve ideal results, leaders must do the hard work of creating a culture where ideal behaviours are expected and evident in every team member. Ultimately, the aggregate of people's behaviours makes up the organisational culture, and culture greatly influences the organisations results. (The Shingo Institute)

We will also reinvigorate a pool of 360 facilitators so that we have capacity in supporting our leaders in a supportive constructive environment to explore their leadership behaviours, promoting honest reflection, identify themes, challenge individual and rater perceptions and support with next steps.

360-degree feedback

360- degree feedback will be included in the leader and management development programme. However, leaders and managers may wish to obtain access to feedback about their impact on others in order to develop their leadership skills outside of this. We will develop appropriately trained 360 feedback facilitators to support this development.

The 360 feedback model for the NHS is currently used to identify the critical attributes and behaviours of successful leaders, it has been developed from significant research including patient and carer representatives and Michael West's research into links between staff engagement and patient safety, and is based on the principles of collective leadership from the Kings Fund, 2014. However, we will build on some of this to create our own 360 feedback model based on our 8 BHFT leadership behaviours (Figure 6).

Figure 6:

NB. Recognition that the framework above was informed by Royal Berkshire Hospital's behaviours development and implementation.

Section 5: Responsibilities for management and leadership development

The People Directorate has a clear role in supporting colleagues with leadership and managerial responsibilities and has a responsibility to support managers in the identification of development needs, to assist in meeting these needs, promoting the transfer of learning to the workplace, designing (and often delivering) appropriate programmes and reporting leadership and management development activity.

As well as having responsibility for their own development, all leaders and managers also have responsibility for ensuring that the work-related development needs, including leadership and management development needs, of the people they manage are identified and met, and that their teams are fully aware of our development provision and how this can be accessed.

It must also be acknowledged that each individual is responsible for their own development and for making best use of the learning opportunities open to them.

Section 6: Monitoring, Evaluation and Review

Monitoring and Evaluation

The impact of leadership, management and talent development interventions, i.e. the degree to which these interventions have influenced performance and contributed towards the Trust's strategic aims and objectives, needs to be evaluated.

The SLT are the primary source of this information and structured feedback will be sought from them. However, there is no simple correlation between development and performance and the difficulty of deciphering the specific impact of any planned training and development intervention, together with the influence of a range of contextual factors, including the role of informal, unplanned learning, must be recognised. Nevertheless, the evaluation process will aim to establish the worth of all development interventions including:

- what participants think and feel about a particular activity
- what participants have learned from an activity
- the effect of the activity on performance.

This will be modelled on the Kirkpatrick model of evaluation whereby we will review the reaction from attendees, their initial learning, behaviour change following the programme, impact, and return on investment (ROI):

This revised approach and its delivery will be monitored and progress measured through a collective range of sources. In addition to personal feedback, learning feedback and staff satisfaction, we would expect to see positive changes through metrics including:

- NHS Staff Survey – specifically leadership score.
- Number of new managers recruited/promoted attendance on programme (%)
- Workforce Race Equality Standard and Workforce Disability Equality Standard – see the disparity reducing between white/'BME' and disabled/non-disabled colleagues.
- Workforce retention figures.
- Staff Friends and Family Test / outcomes for patients.
- CQC Well Led review.
- Trust cultural barometer/heat map – triangulation of data from different sources that show overall performance of team/service area.

An 'audience group' will need to be developed to be able to report and monitor compliance with the 'essential' modules for all people managers. This will be reported using established reporting channels and also shared with relevant directorate leads.

Review of implications of our strategic objectives for leaders and managers

As part of the annual planning process, an annual review will be completed of the particular challenges facing the Trust's leaders and managers and the implications for their development needs.

The objective of this review will be to identify Trust-wide management and leadership development needs and priority needs for specific management groups. This review will inform the focus of leadership and management development activities for the coming year. It will be followed up by a more detailed training needs analysis with relevant management groups.

Section 7: Resourcing and delivery of the Strategy

To support the effective implementation of the leadership, management and talent development strategy in 2023/24 and beyond, the below identifies the projected additional resource implications and investment required.

Element of Leadership Strategy	Approx Cost (£)	Notes
Administration and coordination of the strategy delivery programme, systems/processes. Ensuring new managers and leaders are booked onto the relevant programme, reporting.	Approx cost of Band 4 AfC 1WTE £36,066 Including on-costs.	Day to day admin, bookings, enquiries, coordinating the Coaching/mentoring, team dev, leadership prog, management prog, 360's, mediators, data/evaluations. Intranet pages, comms, hub maintenance.
Leadership, OD skills, delivery of the strategy, operationalising the programme, delivery, design and day-to-day running of the pathways, quality assurance	1 WTE Band 7/Band 8a – between £65,822 – £75,310 Including on-costs 1 WTE Band 6 £56,242 Including on-costs	Strategy is ambitious although with 2 part time Band 6 facilitators this isn't enough resource to realise this strategy ambition. X2 WTE's were supporting delivery of EMP previously, but EMP stopped and resources depleted.
Total recurrent resources required	**£158,130**	
Costs which can be delivered in current leadership budget / other funding streams		
Videoing / creating content for blended approach	TBC through appropriate sourcing £10k *Can be delivered in current budget.*	One off /adhoc costs.
Development of an anti-racism development programme	TBC £15k-£20k *Can be delivered in current budget.*	Will support our anti-racism strategic approach.
Development of our own 360 feedback tool to support our new behaviour framework, rather than using the NHS 360 tool solely.	Setup £1,650 Annual re-current costs Yr1 – £12,210 Y2 onward – £10,560 (user dependent) *Can be delivered in current budget.*	Totara/Nexus offer 360 Feedback Tool. Custom multi-rater and instant personal feedback, based on your own templates. Graphical Report generator includes data, radar graphs and strength finder.
Development of our own in-house Coaches / Mentor's / Mediators / 360 facilitators / Supervisors / Affina Team Coaches	Supervisors.£4,495 x 2 Mediator Course £2,160 x10 *Can be delivered in current budget//utilising TNA process.*	CPD events could be co-developed at system level. Ongoing supervision and CPD costs.
CPD accreditation of programme. Access to qualifications.	CPD certification service. £1,045+VAT Recurrent costs *Can be delivered in current budget/utilising TNA process/levy.*	Other options: University academic credit ILM accreditation. Others: Apprenticeships – use of levy National Programmes.
Develop OD capacity and capability, specifically around cultural interventions and programmes.	CIPD – £1,760 x3 If not available then: Roffey Park - £2,880 x3 *Can be delivered in current budget/utilising TNA process.*	Development of OD skills and knowledge. Accredited programme i.e. Roffey Park Institute or CIPD in OD and/or Org. Des
Exploration of a women's, multi-faith/spirituality network, over-seas network	Chair – ½ day weekly cost TBC. Plus budget for network £3,333 as other networks.	If comes to fruition we would want similar level of support as to the other networks. *To apply to charitable funds when needed.*
Communication and Marketing	£5k estimated by MarComms. *Can be delivered in current budget*	Leaflets, brochures, materials – particularly for staff who don't access computers often.

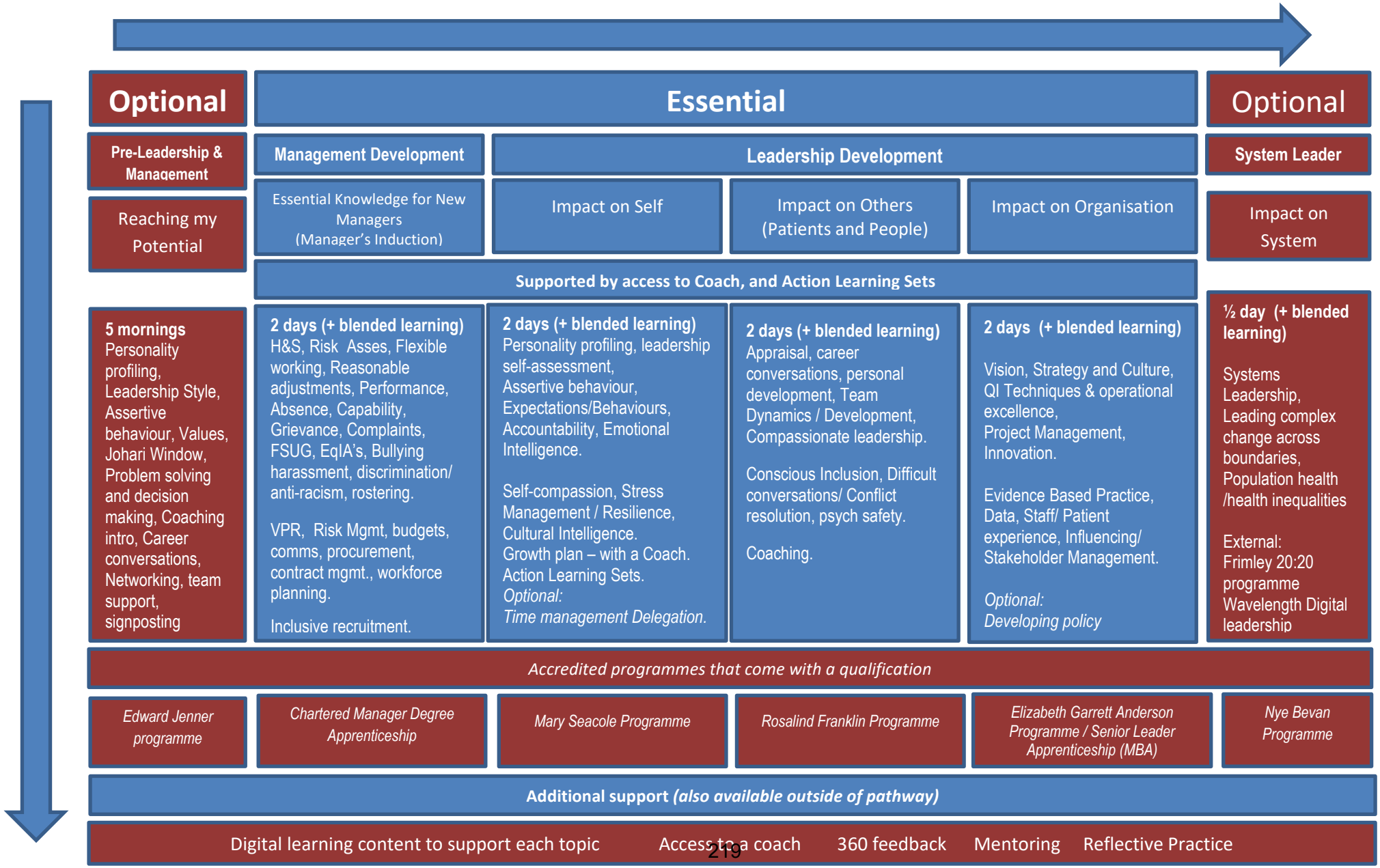
Investment required

To enable delivery of the strategy in 2023/24 and beyond a recurring investment of £158,130 is needed.

Section 8: Timescales / Milestones for delivery of 5 strategic Priorities

Priority	Action	Responsible	Timeline by
To ensure we have inclusive and compassionate leadership and management capacity and capability	Continue pilot	Leadership team /T&F Group	June 23
	Develop new core programme	Leadership team /T&F Group	July 23
	Map gaps	Leadership team /T&F Group	July 23
	Design core programme	Leadership team /T&F Group	July 23
	Comms/Marketing	Leadership team /T&F Group / Comms	Aug 23
	Implement	Leadership team /T&F Group	Sept/Oct 23
To build and embed our inclusive talent management and succession planning approach	Review of talent pipelines / with workforce planning	HR / Talent T+F Group	Oct 23
	Review of appraisal process	Leadership team / Talent T+F Group	Ongoing
	Review of LNA/CPD process	Education team / Talent T+F Group	Oct 23
	Implement career conversations	Leadership team / Talent T+F Group	Oct 23
	Develop competency based progression and talent pools	Education team / HR / Talent T+F Group	Mar 24
	Expansion of Talent / succession planning framework	Talent T+F Group	Mar 24
A more collaborative and holistic approach to developing high performing teams	Develop a conflict pathway	Leadership team / OD Steering Group	Sept 23
	Develop a facilitator workshop for team leads for their own 'away days'	Leadership team / OD Steering Group	Sept 23
	Develop team development framework /process	Leadership team / OD Steering Group	Dec 23
	Develop pool of mediators	OD Steering Group	Apr 24
To develop, and increase leadership and management diversity, that supports inclusion, belonging and our commitment to being an anti-racist organisation	Develop conscious inclusion and cultural intelligence training	EDI team /Staff networks / Leadership T+F Group	Sept 23
	Develop Anti-racist development programme	EDI team / REN	Dec 23
	Explore developing; women's network, Multi-faith network and over-seas network	EDI team / Staff networks	Nov 23
	Engage EbE and staff networks in co-creation	Leadership / OD / Talent – T+F Groups /Staff Networks	June 23
	FSUG associates/Champions	FSUG Lead / Staff Networks	Aug 23
A refresh of our wrap around support to leaders and managers including our coaching, mentoring, action learning sets/reflective practice and easy access to evidence based tools, resources and managers handbook.	Communicate, implement and embed behaviours framework	Leadership team / HR / Leadership T+F Group	Ongoing
	Develop coaching network	Leadership team	Sep 23
	Create mentoring /360 facilitator capability and capacity	Leadership team	Dec 23
	Develop a resource repository	EDI/Leadership team / Staff Networks	Ongoing
	Review/Promote Managers handbook	Leadership team	Nov 23
	Develop reflective practice groups	Leadership T+F Group	Sept 23

Appendix 1 – Management and Leadership development pathway (topical components outlined)



Appendix 2 – Principles underpinning this strategy

1. **COMPETENCE IS LEARNED** – People are not born leaders or managers. We learn to be effective managers through experience. Our effectiveness reflects the combination of experience we have had and our skills at learning from it. Each attendee on the essential route will be supported by developing their own 'growth plan'.

2. **KNOWLEDGE IS NOT ENOUGH** – Managing is a practical activity measured through outcomes. It requires the application of know-how not just the acquisition of knowledge. Therefore as a strengths based approach colleagues will be able to book on to sessions or refresh as needed If already people managers. Each person's leadership journey will be different based on their skills, experience and personal traits.

3. **CONSISTENCY AND PRIOR LEARNING** – If people have already been on, or undertaken leadership and management development they can opt out by sharing prior learning. Mapping of previous programmes will be required i.e. if colleagues have completed the leadership development before, they may be able to step off of the leadership development sessions but would need to do the management development if they hadn't completed management development, and vice versa.

4. **THERE IS NOT ALWAYS A RIGHT ANSWER** – Leadership and Managing is not a perfect science, it involves making judgements in relation to many different variables – how one person leads or manages may not work for a different person. However, it is possible to develop. Each attendee will be given access to a coach.

5. **CLARITY NOT CERTAINTY –** is about ensuring clarity not providing certainty. Clarity in roles, priorities, objectives, performance, measurement, success. This involves people working together, agreeing on general approaches to issues, understanding each other's priorities, finding ways of influencing.

6. **LIFE LONG DEVELOPMENT** – It is not possible to go on a course to become an effective leader or manager – leadership and management development training does not produce a finished product. Although It will be essential for all people managers to undertake both management and leadership core modules.

7. **PRIORITY** – The programme will be for all staff to access. But priority will be given to 'new managers', and those where there is an identified development need i.e. via appraisal / career conversations. Line managers would agree, guide and support attendees accessing elements of or the whole programme if they don't fall into the essential audience.

8. **LEADING AND MANAGING TOGETHER** – most Leadership and Management Development activities to be effective need to involve real groups of managers working together. There is some evidence to support the use of stranger groups (i.e. one person from Berkshire goes away to a programme with people from other organisations) for the development of some specific inter-personal skills across professional functions. Reflective leadership practice/action learning sets will provide a supportive, development space to connect, learn, share and develop with peers.

Appendix 3 – Leadership and management competencies

Competencies are underlying characteristics that lead to superior performance in an individual's job. They include, knowledge and skills, personality traits, and behaviours that help people to be successful.

Competencies go beyond the traditional focus on academic qualifications, technical skills and experience, providing a framework for assessing and developing deeper-seated personal skills. Competencies are also capable of being developed in people rather than being fixed and immovable. They help to identify key areas of development fand enables them to set meaningful and measurable development goals.

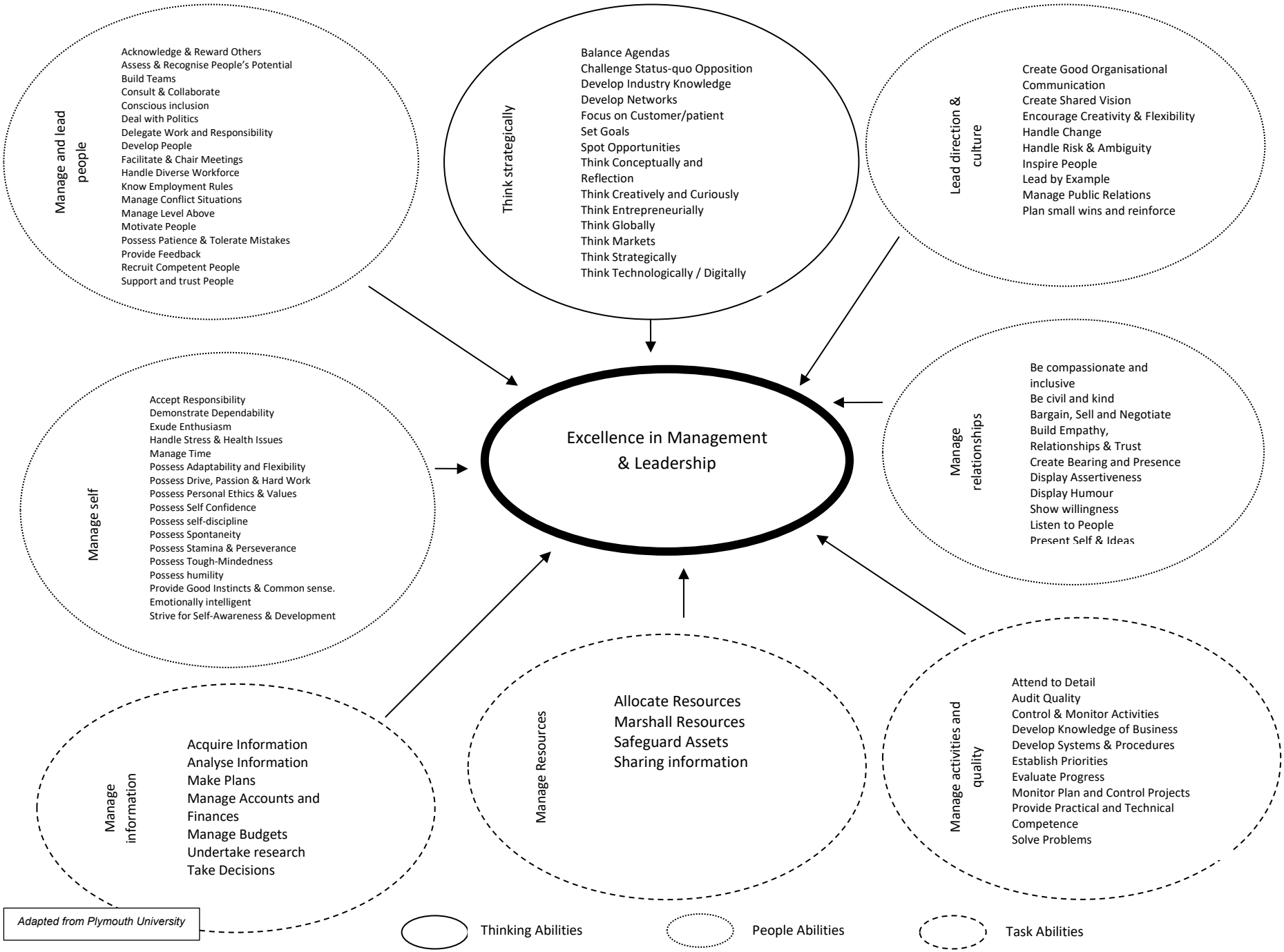
By identifying the key competencies required for leadership success, we can develop a pipeline of potential leaders and prepare them for future leadership roles supporting our talent, succession and workforce planning approaches.

We will further develop a common understanding of expectations of leaders and managers. These standards and competencies will: allow leaders and managers to assess performance and specify development needs; provide a basis to support consistent leadership and management practice; link into other personnel processes, for example, recruitment and selection criteria and processes, promotion assessments, appraisal of performance, reward strategies, and career progression/development.

The definition of effective leadership and management practice has been revised to two main areas of competence for leading BHFT, further work is needed to develop this.

A. Knowledge, Skills, Traits	
Leading	**Managing**
1. Create the right environment	**6.** Manage self, people, and teams
2. Adaptability, innovation and change management	**7.** Communication and Influence
3. Vision and strategic thinking	**8**. Decision making and problem solving.
4. Continuous learning, research and development	**9.** Accountability, responsibility and outcomes
5. Coaching and development	**10.** Financial, resource, and information management
B. Behaviours	
1. Compassion	**5.** Inclusivity
2. Curiosity	**6.** Civility
3. Willingness	**7.** Self discipline
4. Humility	**8.** Perseverance

Each of these competencies (e.g. Create the right environment) has been further disaggregated. The below shows a framework of Excellence in Leadership and Management which could be further developed (i.e for each competence, a list of indicators of success), and particularly helpful when developing growth plans.


Excellence in Management & Leadership
Manage and lead people
Acknowledge & Reward Others
Assess & Recognise People's Potential
Build Teams
Consult & Collaborate
Conscious inclusion
Deal with Politics
Delegate Work and Responsibility
Develop People
Facilitate & Chair Meetings
Handle Diverse Workforce
Know Employment Rules
Manage Conflict Situations
Manage Level Above
Motivate People
Possess Patience & Tolerate Mistakes
Provide Feedback
Recruit Competent People
Support and trust People
Think strategically
Balance Agendas
Challenge Status-quo Opposition
Develop Industry Knowledge
Develop Networks
Focus on Customer/patient
Set Goals
Spot Opportunities
Think Conceptually and Reflection
Think Creatively and Curiously
Think Entrepreneurially
Think Globally
Think Markets
Think Strategically
Think Technologically / Digitally
Lead direction & culture
Create Good Organisational Communication
Create Shared Vision
Encourage Creativity & Flexibility
Handle Change
Handle Risk & Ambiguity
Inspire People
Lead by Example
Manage Public Relations
Plan small wins and reinforce
Manage self
Accept Responsibility
Demonstrate Dependability
Exude Enthusiasm
Handle Stress & Health Issues
Manage Time
Possess Adaptability and Flexibility
Possess Drive, Passion & Hard Work
Possess Personal Ethics & Values
Possess Self Confidence
Possess self-discipline
Possess Spontaneity
Possess Stamina & Perseverance
Possess Tough-Mindedness
Possess humility
Provide Good Instincts & Common sense.
Emotionally intelligent
Strive for Self-Awareness & Development
Manage relationships
Be compassionate and inclusive
Be civil and kind
Bargain, Sell and Negotiate
Build Empathy, Relationships & Trust
Create Bearing and Presence
Display Assertiveness
Display Humour
Show willingness
Listen to People
Present Self & Ideas
Manage information
Acquire Information
Analyse Information
Make Plans
Manage Accounts and Finances
Manage Budgets
Undertake research
Take Decisions
Manage Resources
Allocate Resources
Marshall Resources
Safeguard Assets
Sharing information
Manage activities and quality
Attend to Detail
Audit Quality
Control & Monitor Activities
Develop Knowledge of Business
Develop Systems & Procedures
Establish Priorities
Evaluate Progress
Monitor Plan and Control Projects
Provide Practical and Technical Competence
Solve Problems
Adapted from Plymouth University
Thinking Abilities
People Abilities
Task Abilities

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	12 September 2023
Title	**Audit Committee – 26 July 2023**
	Item For Noting
Purpose	To receive the unconfirmed minutes of the meeting of the Audit Committee of 26 July 2023.
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

Wednesday, 26 July 2023

(Conducted via Microsoft Teams)

Present: Rajiv Gatha, Non-Executive Director, Committee Chair
Mark Day, Non-Executive Director
Naomi Coxwell, Non-Executive Director

In attendance:
Becky Clegg, Director of Finance
Graham Harrison, Head of Financial Services
Debbie Fulton, Director of Nursing and Therapies
Minoo Irani, Medical Director
Amanda Mollett, Head of Clinical Effectiveness and Audit
Clive Makombera, RSM, Internal Auditors
Jenny Loganathan, TIAA
Charmaine Cruz, Ernst and young, External Auditors
Julie Hill, Company Secretary

Item		Action
1.A	**Chair's Welcome and Opening Remarks**	
	Rajiv Gatha, Chair welcomed everyone the meeting. The Chair particularly welcomed Mark Day, Non-Executive Director who had recently joined the Committee.	
1.B	**Apologies for Absence**	
	Apologies for absence were received from: Paul Gray, Chief Financial Officer, Maria Grindley, Ernst and Young, External Auditors and Alison Kennett, Ernst and Young, External Auditors.	
2.	**Declaration of Interests**	
	There were no declarations of interest.	
3.	**Minutes of the Previous Meetings held on 27 April 2023 and 23 June 2023**	
	The Minutes of the meetings held on 27 April 2023 and 23 June 2023 were confirmed as a true record of the proceedings.	

4.	**Action Log and Matters Arising**	
	The Action Log had been circulated. The Committee noted the Action Log.	
5.A	**Board Assurance Framework**	
	The latest Board Assurance Framework had been circulated. It was noted that Risk 6 (Operational Pressures) on the Board Assurance Framework had been updated to reflect the associated risks around larger than optimal ward sizes. The Trust Board had agreed that ward sizes would be reduced over the next two years. The Committee noted the report.	
5.B	**Corporate Risk Register**	
	The Corporate Risk Register had been circulated. It was noted that the Acute Bed Pressures Risk on the Corporate Risk Register had been amended to reflect the associated risks around larger than optimal ward sizes. The Committee noted the report.	
6.	**Single Waiver Tenders Report**	
	A paper setting out the Trust's single waivers approved from 1 April 2023 to 30 June 2023 had been circulated. The Director of Finance presented the paper and reported that the Chief Financial Officer had discussed the high value single waiver tenders with the Chair of the Audit Committee as per the Trust's policy. The Chair confirmed that he was comfortable with the rationale for using single waiver tenders for the reasons set out in the report. Mark Day, Non-Executive Director noted that one of the high value single tender waivers was to fit out Resource House for Mental Health Clinical Services and asked why a second quote for the work had not been obtained. The Chair said that he had raised this with the Chief Financial Officer and had been informed that due to the need to get the site up and running as quickly as possible, there had not been sufficient time to obtain a second quote for the works. The Committee noted the report.	

7.	**Information Assurance Framework Update Report**	

	The Director of Finance presented the paper and highlighted the following points:
	
	• A total of 5 indicators were audited during quarter 1:
	  ○ Mental Health Gatekeeping (Amber for Data Quality and Green for Data Assurance)
	  ○ Inappropriate Out of Area Placements (Green for Data Quality and Green for Data Assurance)
	  ○ Self-Harm Incidents on Mental Health Inpatient Wards (Green for Data Assurance and Amber for Data Quality)
	  ○ Physical Assaults on Staff (per month) (Green for Data Assurance and Amber for Data Quality)
	  ○ Re-admissions (Green for Data Assurance and Green for Data Quality)
	
	• Action plans had been put in place to address the identified issues and previous actions were tracked in the report.
	
	The Committee noted the report.	

8.	**Losses and Special Payments Report**	
	Due to the low number of losses and special payments, there was no update at this meeting. Any losses and special payments relating to quarter 1 will be included as part of the quarter 2 report.	
9.	**Clinical Claims and Litigation Report**	
	The Litigation Activity Quarter 1 had been circulated. The Director of Nursing and Therapies reported that one claim had been opened during quarter 1 (clinical negligence). The Director of Nursing and Therapies reported that three claims had been closed during quarter 1. The Committee noted the report.	
10.	**Clinical Audit Report**	

	The Medical Director presented the paper and highlighted the following points:
	
	• The report provided assurance to the Audit Committee that the Clinical Audit Plan was on track.
	• The following clinical audit reports would be presented to the August 2023 Quality Assurance Committee meeting:
	  ○ POMH Topic 21a: The Use of Melatonin (June - July 2022)
	  ○ POMH Topic 20b: Improving the quality of prescribing valproate in mental health services (Oct 2022)
	  ○ National Clinical Audit of Psychosis (NCAP): Early Intervention in Psychosis (EIP) Re-audit (Feb 2023) (Local outcomes. No national report to be released)	

	○ National Audit of Care at the End of Life- Round 4 (2022-23) (local outcomes) • All published Clinical Audit Reports and the Trust's action plans in relation to the reports were reviewed by the Clinical Effectiveness Group. The Committee noted the report.	
11.	**Anti-Crime Services Report**	
	Jenny Loganathan, TIAA presented the report and highlighted the following points: • TIAA had submitted the Government's Functional Standards Self-Review Return on behalf of the Trust. The Trust had achieved an overall RAG rated Green score • TIAA's Trust Work Plan for 2022-23 had been delivered • The Anti-Crime Specialist had regular liaison meetings with the Director of People, Chief Financial Officer and the Trust's Counter Fraud Champion • The report set out the current state of play in relation to live Anti-Crime investigations • TIAA had completed a benchmarking exercise comparing the number of referrals and investigations in respect of its NHS clients in the South Region of England for 2022-23. The Trust's performance was broadly in line with other mental health trusts • TIAA was continuing to raise awareness about fraud and would be visiting more sites • TIAA was meeting with the Head of Financial Services this week to discuss the Trust's conflict of interest systems and processes The Chair referred to the benchmarking data and pointed out that some of the acute trusts had a higher level of referrals and asked whether a high level of referrals was positive or negative. Jenny Loganathan said that there was a correlation between better fraud awareness and the number of referrals. Ms Loganathan said that it was important that staff knew how to raise fraud concerns and felt confident to do come forward. It was noted that TIAA was reviewing the content of the fraud awareness presentation given at the Trust's Corporate Induction session and would also be providing refresher training. The Chair commented that some of the one of the ongoing investigations related to concerns raised in August 2021. Jenny Loganathan said that this was a particularly complex investigation and confirmed that she would be discussing the case with the Chief Financial Officer when he returned from holiday. Naomi Coxwell, Non-Executive Director said that in the case of criminal investigations whether there was merit in using these as case study examples to raise awareness and to serve as a deterrent. Ms Loganathan accepted the point about the value of using real life examples to make it clear that the Trust took fraud seriously but pointed out that an individual's confidentiality also had to be maintained. Ms Loganathan said that	

	TIAA needed to do more about publicising the more common examples of fraud, for example, time sheet fraud and working whilst sick etc. Mark Day, Non-Executive Director referred to the summary of ongoing investigations and asked whether future reports could include a summary of any actions taken as part of the progress update. The Committee noted the report.	**JL** **JL**
14.	**Internal Audit Progress Report**	

	a) Internal Audit Progress Report
	
	Clive Makombera, RSM, Internal Auditors presented the paper and highlighted the following points:
	
	• Since of last meeting, the Data Security and Protection Toolkit Report had been published, which had a rating of "moderate" assurance. The report included two recommendations:
	  o ensuring that when staff left the Trust, their IT accounts were closed down
	  o recovery time objectives and recovery point objectives for the Trust's key systems within the IT Disaster Recovery Plan to be agreed
	• The Workplan for 2023-24 was on track. RSM was currently discussing the timetable for the Bed Management review
	• Two medium actions were overdue in relation to the Application Audit and a revised timescale for implementing the actions had been agreed with management
	
	The Chair referred to the Data Security and Protection Toolkit Report and asked for more information about why staff who had left the Trust still had access to the Trust's IT systems.
	
	Clive Makombera said that in most cases, line managers had omitted to inform IT when staff had left so they could close down their IT accounts. Mr Makombera said that the management action was around ensuring that all user accounts were reviewed on a bi-monthly basis and removed in a timely manner in line with Trust policy.
	
	Naomi Coxwell, Non-Executive Director referred to the two overdue actions in relation to the Applications Audit and asked whether providing an eight month extension was the right course of action or whether the issue was more to do with the validity of the actions.
	
	Clive Makombera agreed to review the actions with the Trust's management and if necessary, the actions could be re-framed and if appropriate, a shorter timescale for implementation could also be agreed.
	
	b) Procurement and Contract Management Newsletter
	
	The Procurement and Contract Management Newsletter had been circulated for information. The Newsletter included an invitation for members of the Committee to join RSM's free lunchtime webinars.
		CM

	The Director of Finance commented that the Procurement Bill if enacted in its current form would have significant implications for the Trust's procurement systems and processes. **c) NHS News Briefing** The NHS News Briefing had been circulated for information. The Committee noted the reports	
13.	**External Audit Annual Report**	
	The External Auditors' Annual Report which brought together all of the External Auditors' work over the last year had been circulated. Charmaine Cruz, External Auditors, Ernst and Young confirmed that Ernst and Young had given an unqualified opinion on the Trust's annual accounts 2022-23. The Committee noted the report.	
14.	**Minutes of the Finance, Investment and Performance Committee meeting held on 27 April 2023**	
	The minutes of the Finance, Investment and Performance Committee meeting held on 27 April 2023 received and noted. The Chair asked Naomi Coxwell, Chair of the Finance, Investment and Performance Committee if she could provide an update on the Cost of Living in the Thames Valley area research project and on the Trust's recruitment and retention work. Naomi Coxwell reported that the Buckinghamshire, Oxfordshire and Berkshire West and Frimley Integrated Care Systems had commissioned the Universities of Sheffield Hallam and Huddersfield to conduct research into the impact of the high cost of living on the local NHS workforce. It was noted that the data collection component of the project had been completed and had identified the cost of housing (both rented and owner occupier) and the cost and ease of transportation as the key factors impacting on the local NHS workforce. Ms Coxwell said that PwC was working with the researchers and the next stage of the project would be a report by PwC setting out a list of recommendations at the local, regional and national level. Ms Coxwell reported that the Recruitment and Retention item was a progress report. The Chair thanked Naomi Coxwell for her update. The Committee noted the minutes.	
15.	**Minutes of the Quality Assurance Committee held on 30 May 2023**	
	The minutes of the Quality Assurance Committee meetings held on 30 May 2023 were received and noted.	

16.	**Minutes of the Quality Executive Committee Minutes – April 2023, May 2023 and June 2023**	
	The minutes of the Quality Executive Committee meetings held on 17 April 2023, 15 May 2023 and 19 June 2023 were received and noted.	
17.	**Audit Committee's Annual Review of Effectiveness, Terms of Reference Review and Compliance with NHS England's Code of Governance for NHS Provider Organisations**	
	a) Audit Committee Annual Review of Effectiveness The Company Secretary presented the paper and thanked audit committee members and regular attendees for completing the annual review of effectiveness survey. The Company Secretary reported that overall the results were very positive but pointed out that no respondent had indicated that meetings should revert to being purely online and that there was a split between those people who preferred the option of hybrid meetings and those who preferred to continue with online meetings. It was noted that in the comments section, someone had made the point that in their opinion, hybrid meetings did not work as well as face to face or online meetings. Naomi Coxwell, Non-Executive Director reported that the Finance, Investment and Performance Committee had met earlier in the day and had discussed same issue and had agreed that hybrid meetings were not ideal. Ms Coxwell said that her view was that having the option of being able to dial into a face to face meetings was useful to cope with unexpected issues. It was noted that pre-COVID-19 both the Finance, Investment and Performance Committee and Audit Committee meetings were held face to face on the same day. The Chair said that the Audit Committee's regular attendees included external people and this made holding face to face meetings more difficult. The Chair agreed to have a further discussion about whether or not to change to face to face and/or hybrid meetings or whether to keep the meetings purely online. **b) Audit Committee's Terms of Reference Review** The Audit Committee's Terms of Reference had been circulated. The Committee confirmed that the Terms of Reference remained current and that no further changes were required. **c) Audit Committee Compliance with the Code of Governance for NHS Provider Organisations** The Company Secretary reported that the Code of Governance for NHS Provider Organisations had been updated in October 2022 and included a section for audit committees. The Company Secretary reported that the Chief Financial Officer and herself had reviewed the requirements for audit committees and had identified no gaps. The self-assessment was presented to the Committee for assurance. The Committee:	**RG**

	a) Noted the Annual Review of Effectiveness b) Confirmed that there were no changes required to the Committee's Terms of Reference c) Noted compliance with the NHS Provider Code of Governance	
18.	**Annual Work Plan**	
	The Audit Committee's work programme had been circulated. The Committee's Annual Work Plan was noted.	
19.	**Any Other Business**	
	There was no other business.	
20.	**Date of Next Meeting**	
	The next meeting of the Committee was scheduled for 25 October 2023.	

The minutes are an accurate record of the Audit Committee meeting held on 26 July 2023.

Signed: - _____

Date: - 25 October 2023 _____

Trust Board - Meeting Dates for 2024

Meeting	January	February	March	April	May	June	July	August	September	October	November	December
Discursive Trust Board		13		9		11				8		10
Trust Board	9		12		14		9	13 (if required)	10		12	
Audit Committee	17			16		19	24			30		
Finance, Information and Performance (FIP)	17		21	16			24			30		
Quality Assurance Committee (QAC)		27			28			27			26	

Council of Governors Dates 2024

Meeting	January	February	March	April	May	June	July	August	September	October	November	December
Formal Council Meeting			6			12			25			4
Trust Board / Council Meeting		7 (NED)			8 (Board)		17 (NED)				6 (Board)	