Berkshire Healthcare
NHS Foundation Trust

ANNUAL REPORT AND ACCOUNTS

2020/21

Berkshire Healthcare NHS Foundation Trust
Annual Report and Accounts 2020/21

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

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CHAIR AND CHIEF EXECUTIVE'S REPORT

This year, COVID-19 has seen all of us face a challenge of a scale we have not seen before. Such challenges not only test us, severely at times, but also bring out the best in our people: their commitment, compassion and innovation. The response of our staff has been exceptional. The outbreak of the pandemic has seen us rapidly develop the way we deliver effective services whilst maintaining the safety of our patients, staff and partners.

Patient safety has been of paramount importance this year and best practice guidance has been implemented to minimise the risk posed by the pandemic. Many of our teams have rapidly adapted their services to manage patients remotely using digital means where clinically appropriate. Where face-to-face contact is required, enhanced infection control practices are being used by staff to maintain safety, including the appropriate use of Personal Protective Equipment (PPE).

Our Trust Board has continued to monitor all areas of patient safety through scrutiny of a variety of patient safety metrics. Robust governance, patient safety, incident and mortality reporting systems are maintained throughout the Trust, with these processes used to highlight areas for improvement in a timely manner allowing for learning. In spite of the challenges of COVID-19, the Board has continued to move forward with development of its strategic initiatives. For example, although our national NHS Staff Survey results have highlighted the very high level of staff engagement, we recognise that there are still some staff who feel less positive.

The Trust's new People Strategy which includes enhanced staff wellbeing, recruitment and retention and equality, diversity and inclusion programmes is focused on making the Trust outstanding for everyone.

COVID-19 has made it imperative, and enabled us through the removal of normal constraints, to move quickly to deliver joined up care across the health system demonstrating the art of the possible. The acceleration of the development of our system working and the positive experience of remote working are among the many areas that we can embed for the future. We continue to work closely with our partners in acute and primary care, and local authorities to deliver ever more joined up care and have played a full part in the development of the two Integrated Care Systems of which we are part and to which we are fully committed.

Board meetings have been held virtually throughout the year with recordings of our public sessions available on our website, together with the Board papers, enabling easy access for the public. In addition, our Governor meetings have been conducted virtually which again increases democratic accountability, and with the support of governors we have been working to increase the diversity of members. The support and scrutiny of our governors plays an important part in holding the Trust to account and helping increase the understanding of the communities we serve, and we are grateful for their support.

It is essential that patients have a positive experience of our services and we continue to utilise Trust-wide systems to measure and learn from this experience. We prioritise learning from patient experience surveys, complaints and compliments and aim to continuously improve on and learn from

this important feedback. We are conscious that whilst much is being done to address health inequalities, there are still some communities where more needs to be done. Our new health inequality strategy, currently being developed, will take a more holistic and system wide approach.

We take great pride in continuing to be rated as Outstanding by the Care Quality Commission, and all of our services are individually rated as either outstanding or good.

We would like to thank our staff for the tremendous efforts they have gone to in continuing to provide services in the face of the pandemic. They have acted admirably under challenging circumstances; whether caring for patients using PPE, running services in a different way to maintain safety, being redeployed to a different team, or working from home to help stop the spread of the virus. Each and every one of them has played their part.

Lastly, we would like to thank the general public for all the messages of support and thanks this year. You have overwhelmed us with your generous donations and have continually given us your compassion in these difficult times. We have really appreciated it.

Martin Earwicker — Trust Chair

Julian Emms — Chief Executive

PERFORMANCE REPORT

Overview

The purpose of this section is to provide an understanding of the Trust, as well as setting out our performance in 2020-21.

Brief History and Summary Information

Berkshire Healthcare NHS Trust was established in 2001. The Trust successfully gained NHS Foundation Trust status in May 2007. The Trust was issued with its provider licence in April 2013. In line with the Trust's provider licence, the principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

The Trust is the main provider of mental health and community health services to a population of around 900,000 people across Berkshire. We operate from over 100 sites across the county, including 323 inpatient beds across 16 wards over 8 locations. The majority of our healthcare and therapy services are provided to people within their own homes.

The Trust employs approximately 4,800 staff which includes medics, registered nurses, therapists, psychologists, and both clinical and non-clinical support staff.

We work with our health and social care partners across two Integrated Care Systems; Berkshire West, Oxfordshire and Buckinghamshire Integrated Care System and Frimley Health and Care Integrated Care System.

The Trust is commissioned to provide services and works closely with its two main Clinical Commissioning Groups (CCGs); Berkshire West, covering Reading, West Berkshire and Wokingham and Berkshire East covering Bracknell, Slough, Windsor and Maidenhead. In addition, there are a smaller number of services that are commissioned by NHS England and NHS Specialist Commissioning. In addition to our NHS partners, the Trust works with our six local unitary authorities, West Berkshire, Reading, Wokingham, Windsor and Maidenhead, Slough and Bracknell Forest.

We are structured to reflect the localities in which our services are delivered, with Community Health and Community Mental Health services in both the East and West of the county. In addition to these services, we operate a Mental Health Inpatient service at Prospect Park Hospital in Reading, and our Children and Young People Service which spans our geography. All these services are supported by our central corporate teams.

Our Information Management and Technology programme is a key enabler for the delivery of all our strategic goals and has been key to how we are been able to adapt our services in response to the COVID-19 pandemic. In 2017 we achieved "Global Digital Exemplar – Mental Health" development status and in April 2020 we became the first and only NHS Mental Health provider to gain Global Digital Exemplar accreditation. This status along with the supporting investment has enabled us to become one of the most digitally mature NHS providers.

In November 2019, the Trust underwent a comprehensive Inspection by the Care Quality Commission which resulted in the Trust being awarded an overall "Outstanding" rating, including outstanding in the well-led domain for the second year running.

Ratings	
Overall trust quality rating	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Good ●
Are services responsive?	Outstanding ☆
Are services well-led?	Outstanding ☆

Our Trust Vision and Values

We are committed to our vision:

"To be recognised as the leading community and mental health service provider, by our patients, staff and partners"

We have three core values which guide us in the way we behave and what we prioritise.

During the year, we have reflected and reviewed our forward visions and published our 3 three-year Trust Strategy at the end of March 2021. This builds upon existing commitments set out in the NHS Long Term Plan published in June 2019 and the Integrated Care System's five-year plan submissions in November 2019.

The Trust's current Strategy can be accessed from the Trust's website at:
https://www.berkshirehealthcare.nhs.uk/about-us/key-documents/corporate-strategy/

Performance Overview

This year has been like no other. All of our staff, both clinical and non-clinical, have given everything over the past year, responding to both the first wave of the COVID-19 pandemic at the beginning of the year and the subsequent second wave in late 2020 and the early part of 2021. Their dedication, hard work and resilience has been remarkable.

During this unprecedented year, our services have been forced to adapt their service models to adhere to changing guidance and restrictions, at all times ensuring that staff well-being and patient care is not compromised. After each wave, we have taken the time to review the impact and lessons learnt, meaning we have been better equipped and prepared at each subsequent stage of our response.

During the first wave of the pandemic, and in line with NHS England and Improvement guidance, a significant number of our community services were suspended, enabling staff to be redeployed into those services continuing to operate. At the same time, we have come together with system partners and worked together as never before.

We have supported the redesigned of patient pathways which reduced the length of time taken for patients to transition into the community from our acute hospitals, as well as increasing the support and speed of response to patients in the community. This combined with our increased support for NHS 111 services have helped to maximise acute hospital capacity during the pandemic.

Our Mental Health services have come under increasing pressure, exacerbated by the repeated lockdowns and the resultant impact it has had on our population's mental health. As the year has progressed, the demand for our services has increased, with pressures being experienced across both our community teams and inpatient units. As we move into the new financial year, we expect these pressures to grow and will work with system colleagues to ensure funding is invested to support these services.

We must also recognise the impact of COVID-19 on the welfare of our staff and colleagues from across our systems. The demands of dealing with the pandemic have increased the levels of stress, anxiety and exhaustion on a workforce that has given everything over the past year. To address this, and in collaboration with our partners, we have established staff support hubs, to support our staff through these challenging times.

Our on-going investment in IT and the benefits realised from our Global Digital Exemplar Programme have been key to our pandemic response. To support our patients and allow our services to continue we rapidly moved to enable services to expand their use of online appointments. This led to an increase from 300 online appointments a month to 8,000. As restrictions ease, we acknowledge that this number will decrease as face to face services are reinstated, however, we do expect that this move to digital healthcare for many will remain, with positive feedback from both staff and patients.

Our ability to utilise technology has helped safeguard our staff, ensuring that those that can, have been able to work from home. A flexibility which we plan to keep in place to support our workforce.

In December 2020, the Trust was selected to support the roll out of the national COVID-19 vaccination programme. The team have worked tirelessly administering vaccines to our staff and staff from our health and social care partners. By the end of March 2021, we have delivered over 24,000 doses of vaccine and by the end of May 2021 we expect that this number will have increased to over 36,000.

Despite all of the challenges over the past year, we have continued our commitment to providing high quality services that meet the requirements of our Care Quality Commission registration and in compliance with the conditions of our provider licence.

The NHS financial regime under which the Trust has operated in 2020-21 has been substantially different to previous years. This included a commitment from the Department of Health and Social Care that our financial performance would not be adversely impacted by the costs incurred in responding to the COVID-19 pandemic. As a result, sufficient funding has been provided to cover the £10.5m of marginal costs incurred in our pandemic response. We have further benefited from £1.7m of additional funding arising from increases to our annual leave provision, which increased due to the inability of staff to take annual leave during the year, and £2.2m of centrally funded Personal Protective Equipment.

The Trust closed 2020-21 with a surplus of £0.9m. The Trust saw a net cash inflow of £12.7m and closed with a cash reserve of £39.1m. During the year we continued to invest in our estate and IT infrastructure and spent a total of £8.4m, including £0.6m of centrally funded schemes.

The Board of Directors is responsible for preparing this Annual Report and the Annual Accounts and the Directors consider the Annual Report and Accounts, taken as a whole, to be fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy.

The Trust's accounts have been prepared under a direction issued by NHS Improvement under the National Health Service Act 2006. Accounting policies for pensions and other retirement benefits (as set out in the notes to the accounts) and details of senior employees' remuneration can be found in the remuneration report.

The external auditor for Berkshire Healthcare NHS Foundation Trust, as appointed by the Council of Governors, is Deloitte LLP. The Trust's internal auditors are RSM Risk Assurance Services LLP as appointed by the Trust Board.

Principal Risks and Uncertainties

A key role for the Trust Board and the Executive Team is to manage and mitigate risks to the delivery of our strategic objectives and we therefore operate a robust risk management process that ensures that all key risks are identified, and that mitigation action is taken to address these. Our Board Assurance Framework and Corporate Risk Register are regularly reviewed by both the Trust Board and its Sub-Committees and by the relevant Executive Groups.

Our key risks relate to the safety of and quality of care we provide to our patients, as well as to the Trust's financial sustainability. We spend considerable time ensuring that financial pressures do not compromise safety and quality. Our key risks include:

- Inability to recruit and retain sufficient staff which could impact our ability to meet our commitment to providing safe, compassionate, high quality care and a good patient experience for our service users. Whilst our retention has improved over the past year, the longer-term impact of COVID-19 on the workforce is only beginning to be understood as well as its impact on future recruitment and attrition
- Inability to meet the rising demand for our services due to high referral rates, with this risk increased further as a result for the COVID-19 pandemic. This is a particular risk for Mental Health Inpatient, Community Nursing, Child and Adolescent Mental Health Services and the Common Point of Entry service.
- The risk of our network and infrastructure being the subject of malware attack which could compromise systems leading to unavailability of clinical systems, loss of data, ransom demands for data and mass disruption. Along with our Quality Improvement Programme, we have strategic initiatives in place to address and mitigate these risks. Additionally, we continue to invest in our IT Team and infrastructure to defend against the on-going cyber risk.

Despite the progress made and increasing the proportion of the population that has been vaccinated, we must still acknowledge the on-going risk that COVID-19 represents to the operations of the Trust, our workforce, and our patients. We continue to adhere to national guidance as well as working closely with our system partners in our collective response to the pandemic. The Department of Health and Social Care, NHS England and NHS Improvement continue to make funding available to support our pandemic response and address the increasing need for our services.

Moving into 2021-22, the majority of our services are back operating, although the on-going impact of COVID-19 restrictions is still impacting operations, with personal protective equipment and infection control restrictions reducing the number of patients we can see compared to pre-COVID-19. This has adversely impacted the number of patients waiting for treatment and this is a key area of focus for us in the coming year.

Going Concern

After giving due consideration to the principal risks and uncertainties contained in the Board Assurance Framework, Corporate Risk Register, and making additional enquiries wherever deemed

appropriate, the Trust Board has a reasonable expectation that the Berkshire Healthcare NHS Foundation Trust has adequate resources to continue the provision of its services for the foreseeable future. The Trust has agreed financial allocations with all primary commissioners for the coming year ensuring it can continue and expand the provision of services to our population.

For this reason, the Trust continues to adopt the going concern basis in preparing the accounts.

Equality of Service Delivery

In February 2021, our Board approved our new 3-year Equality, Diversity, and Inclusion Strategy which includes targeted interventions for both our workforce as well as patients and communities who use our services.

We are clear on our responsibilities under the public sector equality duty, which include:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

We have identified clear areas of focus. These include addressing differentials in experience – particularly for our BAME, disabled and LGBT staff who experience disproportionality in levels of bullying and harassment from patients, peers, and managers.

For our patients, our focus is the collaborative approach to identifying and resourcing work to reduce health inequalities. This work will be supported by ensuring the demographics of the people who use our services are captured more consistently so that we can ensure there are no inequalities in access. We currently report the demographics of those patients and service users who have made formal complaints via our patient experience report, but we plan to expand this to all patient feedback with the implementation of our new patient experience measurement tool. This information will also be used to ensure no inequalities in experience across our services.

For our staff, we will focus on ensuring no differential in career progression and recruitment. This includes reviewing our recruitment processes to ensure they support applications from diverse applicants and that equal opportunities are given for career progression and talent management. We are also reviewing our leadership training offer for managers to ensure it supports the development of an inclusive culture in the organisation and will be supported by the 2 modules of the *Ready for Change* programme promoting allyship, cultural and emotional intelligence.

All this work and been designed in collaboration with our 3 staff networks, BAME, Purple, and PRIDE, and these groups are key in supporting our priorities.

There are set Key Performance Indicators for all the work identified in the Equality, Diversity and Inclusion Strategy and these will be monitored regularly via the Diversity Steering Group, Strategic

People Group and reported periodically to the Trust Board. Further progress will also be measured through the Workforce Race Equality Standard and Workforce Disability Equality Standard reports which are published annually.

NHS Improvement Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential level of support needed. The framework looks at five themes:

1. Quality of care
2. Finance and use of resources
3. Operational performance
4. Strategic change
5. Leadership and improvement capability (well-led)

Based on information from these themes, each provider is placed into one of four segments, from '1', those providers able to operate with the maximum level of autonomy and with the lowest level of perceived risk, to '4', those providers deemed to require the most support. A Trust will usually only be placed in segments '3' or '4' if they have been found to be in breach, or suspected breach, of their licence.

Throughout the year, we have operated in compliance with our NHS Provider Licence and continue to be in segment 1 within NHS Improvement's Single Oversight Framework. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Social, Community, Anti-Bribery and Human Rights Issues

The Board of Directors conducts its business in an open and transparent way. We are committed to the prevention of bribery as well as combating fraud. To limit our exposure to bribery we have in place a Standards of Business Conduct Policy, a Freedom to Speak Up policy: Raising Concerns Policy and our Duty of Candour and Being Open policy.

We hold a register of interest for directors, staff, and governors and ask staff not to accept gifts or hospitality that will compromise them or the Trust. We employ TIAA, our local counter fraud specialists who investigate, as appropriate, any allegations of fraud, bribery or corruption supported by our Counter Fraud policy.

As a public sector body, we are committed to fully meet our obligations under all aspects of Human Rights Act 1998, Mental Health Capacity Act 2005 and the Equality Act 2010 and ensure we have supporting policies in place within the Trust including Mental Capacity Act and Deprivation of Liberty Safeguard policy, Section 132 Detained Patient's Rights policy and Equal Opportunities and Diversity policy. Trust policies are available to all staff and are routinely updated and reviewed.

Better Payment Practice Code

The Trust aims to pay suppliers and providers of goods and services promptly and has a target of paying 95% of all invoices within 30 days of receipt. The Trust did not make any payments in respect of interest under the Late Payment of Commercial Debts (Interest) Act 1998 during 2020-21.

During the year the Trust responded to national procurement guidance to reduce the time to pay suppliers in order to support our suppliers during the pandemic.

The actual performance for the Trust for financial year 2020/21 was as follows:

Non-NHS Payables

	No of Invoices (count)	% of activity	Value of Invoices (£'000s)	% of value
Paid within 30 days	23,041	95%	82,846	96%
Paid over 30 days	1,097	5%	3,610	4%
Total	**24,138**	**100%**	**86,456**	**100%**

NHS Payables

	No of Invoices (count)	% of activity	Value of Invoices (£'000s)	% of value
Paid within 30 days	730	93%	5,260	65%
Paid over 30 days	59	7%	2,820	35%
Total	**789**	**100%**	**8,080**	**100%**

Sustainability and Climate Change

Overview

The Trust recognises that it has a responsibility to maximise its contribution to a sustainable National Health Service, combat climate change and to reduce its own carbon footprint in line with NHS England's net zero target by 2045.

The whole year has been obviously focused on dealing with and managing the COVID-19 pandemic situation, which has had a huge impact upon every aspect of the Trust's service delivery and operational activities. This of course includes sustainability and climate change agendas.

The advent of the Greener NHS Programme and the NHS England net zero target by 2045 provides future direction and opportunities for the Trust to embrace and shape actions that will allow us to become a net zero carbon emitting organisation.

The Trust has used national guidance to help develop and update its current Sustainable Development Management Plan (SDMP). This plan sets out the strategic direction for the Trust with regards to sustainability, climate change mitigation and adaptation and how, as an organisation, it will work to achieve its Sustainable Development Policy, which is to:

"Provide healthcare that is sustainable, efficient, flexible and resilient; taking every reasonable opportunity to enrich the health and wellbeing of the communities we serve."

The Trust's Sustainable Development Management Plan sets out five overarching sustainability goals that are supported by a number of key objectives. These goals are:

1. Provision of sustainable healthcare
2. Partnerships that embrace sustainability and maximise efficiency
3. Working towards sustainable and climate ready environments
4. Enhance and optimise the estate
5. Measure, monitor and purchase sustainably

Year on Year Progress

During 2020-21, the focus on embedding sustainability and tackling climate change has had to, understandably, shift. To this end there has been very little direct action to report on for the last financial year in relation to this subject matter. What we have seen is:

- an incredible reduction in business miles as a significant number of staff worked from home, fully embracing technology to allow new ways of working. This will have a positive impact on the associated carbon emissions from transport sources.
- A significant increase in the creation of single use plastic waste as a direct result of the vital use of Personal Protective Equipment. This is an unavoidable consequence of the global COVID-19 pandemic over the last year.
- The reduced energy consumption, cost, and carbon emissions as a result of the occupation of the Trust's buildings being much reduced due to direct action in relation to the pandemic and national lockdown instructions.
- An increase in the realisation and actual use of technology to deliver health services. This has a huge potential in changing, going forward, the Trust's estate and the need to keep and maintain poor building stock.

Summary of Performance – Non-Financial and Financial

The information presented in the table below represents the apportioned data for the sites that the Trust occupies. As well as providing the information on waste and utilities, the Trust is also able to provide data on direct business transport miles as well as the associated carbon emissions (tonnes of CO_2e) for all the specific areas reported on.

		2019/20		2020/21			2019/20	2020/21
Area		**Non-financial data (applicable metric)**	**Tonnes CO_2e***	**Non-financial data (applicable metric)**	**Tonnes CO_2e***		**Financial data (£)**	**Financial data (£)**
Waste minimisation & management	General (t)	274	5.85	258	5.51	Total cost of waste disposal	£170,920	£215,126
	Recycling (t)	149	3.18	107	2.29			
	Clinical (t)	100	2.14	107	2.28			
	Total	523	11.17	472	10.08			
Finite Resources	Water (M^3)	54,510	20	45,093	15	Water	£163,166	£100,546
	Electricity (GJ)	20,801	1,451	15,923	1,130	Electricity	£942,996	£808,185
	Gas (GJ)	40,038	2,043	33,733	1,723	Gas	£383,260	£295,427
Business transport	Vehicle miles	3,647,499	1,063	1,819,822	529	Cost	£1,825,724	£935,597
Total CO2e			4,588		3,407			

*Please note, all conversion factors used to calculate the tonnes CO_2e were extracted from the UK Government Conversion Factors for greenhouse gas (GHG) reporting (2019, version 1.2)

Waste data notes

- It is not possible to provide specific cost by waste stream because the Trust does not receive this information from the two Private Finance Initiative (PFI) hospital sites, which are responsible for approximately half of the Trust's annual total waste generation.
- It is suspected that the impact of the pandemic has changed the waste profile, which has resulted in a marked reduction in total waste generated by weight by the Trust.
- There has been a marginal reduction in general waste, a more noticeable reduction in recycled waste and a slight increase in clinical waste. It is difficult to explain definitively these changes due to the unprecedented year as a result of the pandemic. The reduction in general and recycling could be attributed to staff working from home. The increase in clinical waste can be attributed to the increase in use of Personal Protective Equipment and inpatient care due to the pandemic.
- Recycling figures include dry mixed recycling, food waste recycling and confidential waste.
- Despite a reduction in tonnage, the cost of removal of waste from our sites reflects that there has been an increase in volume but not weight, therefore more collections are required which has reflected on the costs incurred.
- With the change in the total weight of waste produced, we have also seen a reduction in associated carbon emissions.

Finite Resources notes

- All three utilities have seen a reduction in consumption and cost due to reduced demand across the Trust, with administration centres being near empty because staff were working from home as one of the key measures to combat the pandemic.
- The Trust was also able, where feasible, to provide some of its clinical services remotely, which will have contributed to the reduction in utility usage.
- Obviously, reduction in consumption also results in a reduction in costs and also associated carbon emissions.

Business transport

- Due to the change in working practices as a result of the pandemic, there has been a huge reduction in business miles, which has resulted in a much-reduced expenditure and associated greenhouse gas emissions.
- This has resulted in a 50% reduction in recorded business miles, which had the same impact on expenditure, with a reduction of just under £900,000 and a cut of 534 tonnes of associated CO2e emissions.

Carbon emissions

- CO2e emission levels for the individual reported resources directly reflect the consumption levels. Total CO2e emissions for 2020-21 are 3,407, which is a reduction of 1,181 tonnes when compared to 2019-20. This equates to a 26% reduction in associated carbon emissions.
- This huge reduction in CO2e emissions is clearly a direct result in the reduction of utility consumption and business miles for the year. Both of which were a consequence of the necessary actions that the Trust took in response to the pandemic.
- The carbon data included in this report will be utilised to measure and monitor the Trust's efforts to contribute to the NHS England target of becoming Net zero by 2045.

Governance, Partnerships and Monitoring

The governance structure to support and drive forward the Sustainable Development Management Plan has been established in accordance with Department of Health and Social Care guidance and recognised best practice. We have established collaborative working relationships with key public service providers across Berkshire.

The Trust has a dedicated Sustainability Manager who champions and coordinates our work on sustainability and climate change. Statutory reporting operates through a number of routes, including the Estate Return Information Collection, the Care Quality Commission and NHS England and Improvement.

There are changes being implemented by NHS England and Improvement which has meant that the NHS Sustainable Development Unit has become the Greener NHS Team. Along with these changes are the advent of new reporting regimes and monitoring. These are not yet in place for the Trust to engage with and contribute to.

Future priorities and targets

Our Sustainable Development Management Plan continues to inform our activities and we have confirmed specific targets against our overarching goals. This document was meant to undergo a comprehensive review and update in 2020-21. This did not take place due to the pandemic for a number of reasons. The Trust has understandably focused on providing the necessary services and action to respond to the COVID-19 pandemic. Guidance and strategic direction from NHS England and Improvement in support of the Greener NHS programme has not yet been published

The evolution of the new normal post COVID-19 will have the potential to make a significant difference in reducing the impact upon the environment from the Trust's operational activities and presents huge opportunities for the organisation to become a leading sustainable community and mental health provider.

The Greener NHS programme and the net zero carbon emissions target are set to shape a new direction for the NHS as a whole in relation to climate change. This will also shape how the Trust has to make major changes in how it delivers healthcare services in a carbon neutral way.

The Trust will further develop and expand the levels of engagement across the organisation and its service delivery partners. This will be achieved by implementing a detailed and innovative communications strategy and campaign, which will directly inform, support, and promote the Trust's new Green Plan.

Emergency Preparedness, Resilience and Response

In line with its statutory obligations under the Civil Contingencies Act 2004, the Trust has in place arrangements for EPRR (Emergency Preparedness, Resilience and Response). We undertake joint emergency planning with healthcare partners, local authorities and other emergency services. This work is undertaken through regional fora, such as the Local Health Resilience Partnership Framework and the Berkshire Resilience Group.

The Development and improvement of the Trust's integrated emergency management system is overseen by the EPRR Governance Group. This Group reports to the Executive Non-Clinical Risk Management Committee, chaired by the Deputy Chief Executive and Chief Financial Officer. The designated Accountable Emergency Officer for the Trust is the Chief Operating Officer, who is responsible for ensuring our compliance against NHS England's Core Standards for EPRR.

Berkshire Healthcare is assessed against the NHS EPRR Core Standards on an annual basis. Provider organisations are required to undertake a self-assessment against the relevant individual core standards and rate their compliance. These assessments are reviewed and assured by the Clinical Commissioning Groups. NHS provider organisations are then required to publish their compliance rating in their Annual Reports.

In a letter dated 20th August 2020, NHS England and Improvement informed all NHS Foundation Trusts and Trusts of the assurance process for 2020-21. The letter stated that, in view of the current COVID-19 response and upcoming winter pressures, conducting the detailed EPRR process of previous years would be excessive. The letter set out an amended process for 2020-2021 which required the Berkshire West Clinical Commissioning Group (as commissioner) to provide an updated assurance position of any organisations that were rated partially or non-compliant in 2019-20. The Trust was substantially compliant with all core standards and was expected to be fully compliant by March 2020.

NHS England South EPRR Assurance compliance ratings

To support a standardised approach to assessing an organisation's **overall preparedness rating** NHS England have set the criteria as set out overleaf. For assurance purposes in 2020-2021, Berkshire

Healthcare remains substantially compliant (89-99% compliant) with 53 of the 54 applicable core standards; work is continuing to address the one ongoing issue.

Compliance Level	Evaluation and Testing Conclusion
Full	The organisation is **100%** compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is **89-99%** compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is **77-88%** compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation is compliant with **76%** or less of the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

Equality, Diversity and Inclusion

The Trust's Equality, Diversity and Inclusion strategy 2020-2023 has been approved by Trust Board and sets out the equality objectives that will support both staff and patients across the organisation. The Diversity Steering Group continues to provide leadership, scrutiny and accountability to ensure all Equality, Diversity and Inclusion has been in line with these objectives.

There is now a dedicated Equality, Diversity and Inclusion Team to support the important work of this strategy, including a lead for workforce and a lead for patients and communities. This team will support all work aligned to the strategy priorities and will work with Divisions and Services in the identification of their priorities, ensuring they align with the strategy.

The National NHS Staff Survey results for 2020 showed we are not making the progress that we want around Equality, Diversity and Inclusion and we have identified the need for sustained improvement in our strategy. We are committed to driving the changes needed to make Berkshire Healthcare NHS Foundation Trust outstanding for everyone.

We continue to focus on how we can reduce health inequalities and ensure our services are accessible to everyone in the communities in which we serve.

Equality, Diversity and Inclusion Strategy Priorities

Our 2020-2023 strategy identifies five key priorities for our people and six priorities for our patients and communities with a focus on creating a culture of inclusion and belonging and eliminating differentials in experience:

<u>Our People:</u>

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

Our patients:

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

Public Sector Equality Duty

The Public Sector Equality Duty (PSED) requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people when carrying out their activities.

The Trust's Equality, Diversity and Inclusion strategy supports compliance under the Public Sector Equality objectives, as required by the Equality Act 2010.

1. Reduce bullying and harassment as reported by staff, and in particular, Black, Asian and Minority Ethnic (BAME) and disabled staff, in the annual National NHS Staff Survey. We are working to reduce experiences of bullying and harassment for all our staff and to equalise the experience between BAME/Disabled and white/non- disabled staff so that there is no gap or differential in experience. The 2020 National NHS Staff Survey data showed that there remains a 5% gap between our BAME and white staff experiencing bullying and harassment from patients and staff. Additionally, there is a gap of 7% in the experiencing bullying and harassment from managers. There has been no significant change in this data in the 2019-2020 National NHS Staff Survey.

2. Increase the diversity of our workforce with particular focus in year 2 of the strategy on inclusive recruitment with some work in progress already.

3. Ensure there is no difference in perceptions of equal opportunity in career progression between white and BAME staff (as measured by our annual National NHS Staff Survey). The National NHS Staff Survey results from 2020 have shown an improvement of 2% from the previous year but a gap of 14% remains between BAME staff in comparison to their white colleagues.

4. Significantly improve the wellbeing of all staff and a reduction in the proportion of staff experiencing stress related illness. Stress related illness remains the top cause of work-related absence and we now have a dedicated post focusing on wellbeing across the Trust and an outstanding offer of mental health support for our staff in response to their needs during the COVID-19 pandemic. There is also a named Non-Executive Director with the responsibility of a wellbeing guardian.

   The wellbeing of our people is at the centre of our organisational culture and we want to make sure our people feel well and supported at work. One of our key responsibilities is our duty of care to protect the health and safety at work of people and this includes understanding if they are at extra risk from COVID-19. We have done much work already to protect our vulnerable staff groups including shielding those who are extremely clinically vulnerable and making adjustments to the working arrangements of everyone who has been identified as high risk in the workplace.

5. Ensure the roll out and consistent offer of reasonable adjustments for disabled people, in particular, implementation of the NHS Accessible information standard for all disabled patients who use our services. The National NHS Staff Survey results showed there was a 2.4% improvement in staff saying their manager has made adequate reasonable adjustments to enable them to carry out their work but there is still more work required to ensure all managers are equipped to support their teams.

6. Focusing on training and development of our leaders and managers to make sure that they are equipped to support their teams with inclusive behaviours and that they take the necessary action to create an organisational culture that supports inclusion and belonging for all.

7. We remain committed to continue to make meaningful improvements to the experience of our LGBT+ staff and patients. Berkshire Healthcare is aiming for improved scores in our National NHS Staff Survey, achieving the Gold status within the new Stonewall framework with a submission date of October 2021. We have identified the need to develop a pathway for our Trans patients with processes for recording data on electronic records.

8. Engage with diverse groups in our communities, in particular Black, Asian and Minority Ethnic, Lesbian, Gay, Bisexual and Trans, and disabled people to inform our understanding of their priorities regarding health inequalities, with a view to identifying resources needed to address these and put in place the required actions to ensure equity of access in both Mental and Community Health Services.

There are named senior Equality, Diversity and Inclusion leads for the six Divisions and they are working with the Equality, Diversity and Inclusion team to identify key priorities for the next year for their staff and patients linking back to their divisional workforce data and key strategy priorities.
The Trust has three established staff networks:

- BAME (Black, Asian and Minority ethnic people);
- Purple (Disabled staff); and
- Pride (Lesbian, Gay, Bisexual and Trans)

The Networks continue to support the progress in addressing the associated inequalities with these protected characteristics. Each of the Staff Networks has an Executive Director sponsor who is responsible for supporting the development of each Network.

This year, the Network activity has been limited by the COVID-19 pandemic and support focused on staff wellbeing, the education and rollout of the COVID-19 vaccination programme and promoting shared experiences. However, our networks have supported the development of our People Strategy and Equality, Diversity and Inclusion Strategy.

Workforce Equality, Diversity and Inclusion

As at March 2021, the Trust employed 4,721 members of staff:

- 82.7% were female and 17.3% were male
- 25.8% of staff were from visible minority ethnic backgrounds, compared with 20% of the Berkshire population (2011 census); 8.7% were from non-British white backgrounds compared to 7% of the Berkshire population.
- 5% were disabled people
- Electronic Staff Record and the National NHS Staff Survey do not record gender identity and therefore we are unable to report the number of Trans staff employed within the Trust.

Equality and Diversity of the workforce is monitored through the people dashboard and data is now available to Divisions via tableau (updated quarterly):

Table 1: Workforce Diversity

	March 2020		**March 2021**	
	%	**Staff**	**%**	**Staff**
Total		***(4,475)***		***(4,721)***
Age				
16 – 25 years	6.3%	281	6.7%	318
26 – 35 years	21.9%	978	22.3%	1,053
36 – 45 years	26.0%	1,162	25.2%	1,189
46 – 55 years	27.0%	1,209	26.6%	1,256
56 – 65 years	17.1%	767	17.3%	817
66 plus years	1.7%	78	1.9%	88
Ethnicity				
White British	61.7%	2,762	61.4%	2,897
White Other and Irish	8.7%	391	8.7%	410
Mixed	2.3%	104	2.4%	115
Asian or Asian British	11.4%	508	11.8%	599
Black or Black British	9.6%	428	10.0%	470

	March 2020		March 2021	
	%	Staff	%	Staff
Other Ethnic Group	1.5%	69	1.6%	74
Not specified	4.8%	213	4.2%	196
Gender				
Women	82.4%	3,686	82.7%	3,905
Men	17.6%	789	17.3%	816
Not specified	0	0	0	0
Disability				
Disabled staff	4.8%	214	5.0%	236
Religion				
Christian	50.1%	2,243	48.8%	2,306
Atheist	13.9%	620	15.0%	709
Islam	3.6%	163	4.2%	196
Hindu	3.3%	146	3.2%	151
Other	10.5%	472	11.5%	541
Not Stated	18.6%	831	17.3%	818
Sexual Orientation				
LGBT	2.5%	114	2.9%	138
Heterosexual	83.2%	3,721	84.3%	3,982
Not Stated	14.3%	640	12.7%	601

Senior Management and Leadership ethnic diversity

Senior Managers/Leaders As at 31st March 2021	Gender		Ethnicity		
	Male	Female	White	Non-White Minority ethnic	Undisclosed
Non-Executive Board (7)	57.1%	42.9%	57.1%	14.3%	28.6%
Executive Board (6)	66.7%	33.3%	66.7%	16.7%	16.7%
Directors (Locality, Clinical and other)	15.8%	84.2%	57.9%	21.1%	21.1%
Heads of Service	15.2%	84.8%	72.7%	27.3%	0.0%
Senior Managers (8c and above)	36.8%	63.2%	81.6%	7.9%	10.5%
Berkshire Healthcare staff (total headcount)	816	3905	3307	1218	196

The most significant change in the ethnic diversity of senior management and leadership has been an increase from 18.8 % in 2020 to 27.3 % in 2021 in the non-white minority ethnic workforce in heads of service roles.

There has however been a reduction in Agenda for Change band 8C and above postholders in the non-white minority ethnic group that reduced from 11.8 % in 2020 to 7.9 % the past year. The undisclosed category for this group has increased by nearly 5 %.

Equality Impact

The Trust continues to publish equality impact analyses with corresponding policies. The Trust Board papers also include an equality impact paragraph as part of the cover sheet to ensure that equality is taken into account. A new equality impact assessment has been developed that is now part of the business case approval process. Equality questions were included in the quality impact assessment in the recovery of services following wave 1 of the COVID-19 pandemic.

NHS Equality Delivery System (EDS)

We are awaiting the release of the Equality Delivery System (EDS) 3 and remain in contact with NHS England to track progress. In the interim, the Trust will use the EDS 2 as a framework for the priorities around equality, diversity and inclusion.

A new cycle of formal review was agreed by the Trust Board in 2020 and evidence against the Trust's EDS objectives will be reviewed on a four-yearly cycle, providing the time needed to undertake the actions identified with our community partners. We will assess our performance against the objectives in year 1 to identify priorities for focus aligned to our strategy.

National NHS Staff Survey 2020

The overall engagement score for the 2020 National NHS Staff Survey score is 7.5, this is the highest for all combined Trusts.

However, there were no significant changes in the scores compared to the previous year for equality and diversity or safe environment/bullying and harassment.

"89% (compared with 87% in 2019) of our staff feel the organisation acts fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age (compared to 83% of the national average)"

We do however recognise that there is a gap of 14% between or BAME and white staff and have started some targeted work through our BAME Transformation Programme, sponsored by our BAME staff network, to equalise the experience of all our staff regarding career progression.

The Trust is committed to providing a culture of belonging for every employee within the organisation. The findings from the results of the National NHS Staff Survey have been incorporated in the development of both the overall Trust Strategy and the Trust's People strategy to ensure the golden thread of equality, diversity and inclusion is included in all work across the Trust and remains a significant focus for the organisation in 2021-22.

Stonewall Equality Workplace Index

Berkshire Healthcare retained membership during 2020. However, due to the COVID 19 pandemic, a decision was made by Stonewall not to run the Workplace equality index 2020 but instead to support organisations on an individual basis to prepare for the new criteria being launched for 2021. This decision was partly made to ensure the public sector was not disadvantaged due to significant pressures on services and people during this time. We participated in the light touch feedback sessions for 2020 and the feedback from our Stonewall account manager was overall extremely positive. We have developed a clear action plan for the 2021 submission and aim to achieve at least

the gold standard as part of the new awards, as well as a continued aspiration to achieve the top 100. The next submission for the Stonewall equality index is due in October 2021.

Race equality

The BAME Network currently has 308 members and is the most established of the three staff networks. The BAME Committee continues to be integral in developing the Workforce Race Equality Standard (WRES) action plan and reviewing the National NHS Staff Survey data as well as supporting the BAME transformation programme.

The WRES action plan was approved in 2020 and is embedded within the Equality, Diversity and Inclusion strategy.

The work to deliver the change needed to support our BAME staff continues to be a priority within the Trust with a particular focus on reducing bullying and harassment and ensuring equality of opportunity in career progression.

The review of the "*Making it Right"* programme suggested that an alternative approach is required to ensure there is a sustained cultural change in the organisation. The new "*Ready for Change*" programme will focus on the leaders and managers in the Trust and includes 2 modules:

Module 1: Towards Allyship

Participants will explore practical steps towards Allyship. They will learn about the lived experiences of BAME, LGBT+ and staff with a disability through shared stories to facilitate appreciation of the scale of the challenge faced by certain sections of the workforce. Participants will engage critically with notions of social power and privilege. Privilege can stem from a range of sources such as one's language, religion, gender, sexual orientation, physical and mental ability, race, country of origin, socio-economic status etc. Participants will be challenged to acknowledge and own their privileges. The goal is not to make anyone feel guilty but challenged to use their privilege and take an active role as an ally and support disadvantaged colleagues.

Module 2: Emotional and Cultural Intelligence

As we are a diverse workforce, this module aims to help staff develop skills to engage strategically in diverse groups. Participants will explore how they could interact with others, with more social-emotional skills and will learn essential social intelligence competencies to enable them to read emotions and adapt culturally to improve interactions with colleagues from diverse backgrounds.

The "*Ready for Change"* Programme will be delivered as development modules together with the full offer of leadership training and development which is currently under review. Berkshire Healthcare aims to have leadership development programmes in place for newly promoted and recruited managers to include specific reference to their communication and response to bullying and harassment.

The National NHS Staff Survey 2020 (table below) highlighted that there has been little sustained progression in the experience of our BAME staff compared to white staff and highlights the continued need for focused and targeted work, a key priority in the Equality, Diversity and Inclusion strategy.

The Trust will continue to prioritise equality of opportunity for BAME staff, discrimination from managers, harassment, bullying or abuse from colleagues or patients.

Question		2019	2020
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	White	22%	20%
	BAME	30%	31%
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	White	15%	18%
	BAME	20%	23%
Percentage believing that the trust provides equal opportunities for career progression or promotion	White	91%	92%
	BAME	76%	78%
In the last 12 months have you personally experienced discrimination at work from any of the following? Manager / team leader or other colleagues	White	6%	5%
	BAME	13%	12%

Disability Equality

The Purple Network currently has 270 members. They have continued to support their members during the COVID-19 pandemic through virtual coffee mornings and have contributed to the wellbeing assessments for all staff.

The Workforce Disability Equality Standard (WDES) came into force in April 2019 and incorporates a set of specific measures that will enable NHS organisations to compare the experience of disabled and non-disabled staff. The action plan in 2020 was developed with the Purple Network and is embedded within the Equality, Diversity and Inclusion strategy and associated priorities.

The 2020 WDES data as well as the National NHS Staff Survey results (table overleaf) showed some improvement in the provision of reasonable adjustments for our disabled staff, but we recognise that there is still more work to be done. The Equality, Diversity and Inclusion team have planned targeted work around reasonable adjustments to support the recruitment, selection and retention of our disabled workforce. Unfortunately, due to the COVID-19 pandemic the communication plan was suspended and has been identified as an immediate priority in this strategy. This will support managers to understand their responsibility around making reasonable adjustments and the Equality, Diversity and Inclusion team have produced a guide for staff and managers to support the reasonable adjustments policy and will be published in April 2021 to be included in appraisal discussions.

A review of the Trust's performance against the Accessible information standard was undertaken and a set of recommendations have been agreed and prioritised for implementation to ensure consistency across the Trust this year.

The 2020 National NHS Staff Survey has shown some encouraging improvements for our disabled staff with a 4% increase in the perception equal opportunities for career progression. Steady improvement

is seen in the scores across all five areas, but we recognise that there is still a gap in the experience of bullying and harassment between our disabled and non-disabled staff that we aim to eliminate through the Equality, Diversity and Inclusion strategy priorities and associated workstreams.

Question		2019	2020
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	Non-disabled	23.1%	20.3%
	Disabled	**30.2%**	**30%**
Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	Non-disabled	14.4%	13.3%
	Disabled	**23.2%**	**21.2%**
Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion	Non-disabled	87.7%	84.1%
	Disabled	**85.8%**	**90%**
Percentage of staff satisfied with the extent to which their organisation values their work	Non-disabled	61.1%	66.5%
	Disabled	**53.8%**	**55.2%**
Percentage of disabled staff saying their employer has made adequate adjustment(s) to enable them to carry out their work	**Disabled**	**74.6%**	**77%**

Sexual Orientation and Trans Equality

The Pride network membership has grown significantly, and they currently have 154 members and allies. Our aim is to ensure that the voices of the whole LGBT community are represented.

The 2020 National NHS Staff Survey continues to demonstrate the low self-declaration rates around Sexual orientation. We know there is some work to do to understand why not everyone feels comfortable and willing to disclose their sexual orientation and gender identity and to ensure that the Trust "feels like a safe place" for people to bring their whole self to work and be accepted.

	ESR	NSS
Staff that identified as heterosexual	**84.25%**	**89.3%**
Staff that identified as LGBT+ (On ESR staff could select LGBT+ compared to the NSS where staff selected Lesbian, Gay, Bisexual)	**2.88%**	**4.5%**
Other / prefer not to say / not stated	**12.88%**	**7.7%**

The Pride Network had a successful re-launch celebration event in February 2020, which had personal stories from LGBT+ employees and allies and a presentation from Mermaids charity around improving the experience of Trans staff and patients.

The 2020 Stonewall Equality Index was suspended due to the COVID-19 pandemic, but Berkshire Healthcare is aiming to achieving the Gold status within the new Stonewall framework with a submission date of October 2021

Reading Pride 2020 was cancelled due to the COVID-19 pandemic, but we are planning for the 2021 event. The Trust continues to be a key member of the Thames Valley LBGT+ Employers Network and is co-chaired by the Equality, Diversity and Inclusion Manager for the Trust. This forum brings together over 30 employers from the public and private sector across Thames Valley.

The Trust has continued to support funding the clinical supervision of four counsellors at the local charity, Support U team. This service has worked with LGBT+ patients to access the support they needed within a safe space and seen a significant increase in demand for their services during lockdown.

The Trust is leading on a trans patients improvement project. The project aims to improve the experience of our Trans patients through improved systems, processes and training. This project was paused during the COVID-19 pandemic but has now resumed.

Register of interests

The Trust maintains a Register of Interests for all members of the Trust Board providing details of any Company Directorships and any other relevant significant business interests held that may conflict with any management responsibilities. This Register is published on the Trust's website at: https://www.berkshirehealthcare.nhs.uk/about-us/key-documents/reports-policies-and-procedures/ or may be obtained upon request to the Trust's Company Secretary.

Stakeholder relations

Berkshire Healthcare is a key partner in two Integrated Care Systems. East Berkshire is a partner in Frimley Health and Care. West Berkshire is part of the wider Berkshire West, Oxfordshire and Buckinghamshire (BOB) Integrated Care System with a dedicated Berkshire West Integrated Care Partnership. The purpose of these partnerships is to:

- Improve the health and wellbeing of the population served by the organisations within the Integrated Care System or Partnership. This includes the experience of the people who use our services, as well as improving the outcomes of care and treatment; and
- Improve the use of our collective resources as a whole system.

These arrangements include work on some key priorities that we are contributing to, and which reflect the NHS Long Term Plan that was published in 2019:

- Working with Primary Care Networks to deliver integrated Health and Social Care Teams, known as Multidisciplinary Teams (MDTs), delivering care and treatment in a more joined up way both in community settings and in Care Homes
- We lead on behalf of the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System, the Ageing Well programme of work that aims to transform the out of hospital health and social care services to provide care and support to people in their older years, including prevention and:
- Delivering a Community Health Urgent Crisis Response service that provides a rapid (within 2 hours) response to a patient in crisis and a 2-week reablement response for patients that need care to prevent them moving into crisis
- Working with Primary Care Networks and other partners, including the voluntary and community sector to deliver community based mental health services providing a stronger focus on prevention and maintaining well health
- Improving services for people in crisis; and enabling more children and young people to access mental health services
- Reducing the number of people that receive acute mental health inpatient care out of our area
- Continuing the development of our electronic Shared Care record, known as Connected Care – which will also include a "patient portal" so that people can view and contribute to aspects of their own record; and
- Continuing joint planning about our use of our buildings, a shared approach to workforce planning and development of our support workforce.

We work closely with our six Unitary Authority partners and have links with community and voluntary sector organisations at neighbourhood level. This includes building on the work we have started to reach out to groups of people who may not readily access services, but who have specific health needs. We participate in and have constructive relationships with the six Health and Wellbeing Boards, Local Integration Groups and Unitary Authority Health Scrutiny arrangements.

We had regular meetings with representatives from all six Health Watch Groups in Berkshire - which is coordinated by our Patient Experience Team. This will continue when safe to do so. In 2020, we commenced a programme of work that will enable us to measure more effectively how patients experience our services – this is part of our Quality Improvement Programme and will complement the "Friends and Family" test which asks whether patients would recommend our services to their friends and family.

Julian Emms
Chief Executive
11 June 2021

OPERATING REVIEW AND SERVICE DEVELOPMENTS

Operational goals and priorities

The operational goals in 2020-21 were to ensure the safe delivery of the Trust's services, support partners to meet changes in provision and demands and respond to regional and national requirements and guidelines for service delivery.

Operational priorities for 2020-21 for each clinical service were different as some services were suspended, some had to implement new ways of working, some moved to digital delivery and some services were expanded and staff were redeployed to them to support service delivery.

Clinical services responded to two waves of the COVID-19 pandemic, meeting the increased demands from this and the impact of it on their service delivery.

A number of priorities and programmes were also progressed during the year:

The priorities for the Trust over the year were:

- **To provide safe services, prevent harm and harm to others** by reducing self-harm, suicide, falls, medication errors, pressure ulcers and preventable deaths from septicaemia.
- **To strengthen our highly skilled and engaged workforce and provide a safe working environment** by achieving high levels of staff engagement across our services, increasing the numbers of our staff feeling they can make improvements at work and recommending our Trust as a place to receive treatment. To reduce our vacancy level, staff turnover rate and sickness levels. To reduce staff assaults and promote an inclusive and compassionate culture with zero tolerance of aggression, bullying and exclusion.
- **To provide good outcomes from treatment and care** by achieving 95% satisfaction in our Friends and Family Test and use of patient feedback to inform decisions.
- **To deliver services that are efficient and financially sustainable** by achieving our financial targets, improving productivity and reducing the use of agency staff.

In addition, the following key improvement programmes were prioritised:

- Roll out of the Quality Improvement programme
- Reduction in the use of Out of Area Placements
- Implementation of the Emotionally Unstable Personality Disorder Pathway
- Development of new model for CAMHs Tier 4 service provision
- Build of new Learning Disability in-patient facility
- Development of BAME transformation programme
- Delivery of mental health gateway provision

Service Review and Developments

Improvement in Community Physical Health Services for Adults

The East Berkshire Musculoskeletal Physiotherapy Service have made several changes this year as a result of the COVID-19 pandemic, with many service staff redeployed during the first wave to support the wards and other community services. Appointments, classes, and management of student placements have shifted from face-to-face to virtual. Supervision is mainly being held virtually and in-service training has become more accessible through recorded sessions. Ten whole-time-equivalent, newly qualified physiotherapists have also been inducted into the workforce whilst adhering to the COVID-19 restrictions.

The Hearing and Balance Service has undergone significant sustained structural and contractual changes over the last few years following the exit from their Any Qualified Provider (AQP) Contract. The team successfully responded to the COVID-19 pandemic, with services being paused and 80% of the team redeployed across the county to support staff swabbing. The COVID-19 lockdown also provided the service with an opportunity to make several improvements, including implementing streamlined referral triaging processes and improving self-management resources. Remote consultation, telemedicine support and monitoring for hearing aid patients were also implemented.

The Diabetes service has adapted its service delivery during the COVID-19 pandemic, with Consultant and Diabetes Specialist Nursing Services delivering virtual outpatient appointments. Carbohydrate and Insulin Calculation Education for people with Type 1 Diabetes has been adapted to be provided virtually with excellent feedback from participants. Structured group patient education for people with Type 2 diabetes has also moved to a virtual offering. The service is still undertaking face to face one-to-one consultations for people who do not have the means to access education virtually.

The Service achieved accreditation for their diabetes education provision from the Quality Institute for Self-Education and Training in January 2021. In December 2020, one of the services educators was awarded the X-PERT Educator of the Year award. Insulin pump renewals and Flash Glucose monitoring education and training have continued virtually throughout the year. A more efficient Nurse Led Triage clinic was commenced in December 2020 resulting in a reduction in the time that Consultants require to review new referrals. An Integrated Diabetes Specialist Nursing Service commenced in East Berkshire to support upskilling of Primary Care staff, reduce variation, and achieve improved patient outcomes.

The Community Dietitians have produced a number of 10-15-minute-long nutrition training videos to support care home staff during COVID-19 and beyond. These videos focus on identifying and treating malnutrition which can impact morbidity and mortality. The Dieticians have also worked with the clinical transformation team to implement the Malnutrition Universal Screening Tool on the RiO Electronic Patient Record system, and this has been commended by the British Association for Parenteral and Enteral Nutrition (BAPEN) as part of their COVID-19 Service Improvement and Innovation Awards.

The Sexual Health Service at the Garden Clinic have introduced a number of measures to improve the safety and welfare of its vulnerable patients. Custom designed Proformas have been introduced onto the Electronic Patient Record (EPR) and flow charts have been developed to help manage patients. In

addition, 'Ghost profiles' have been created on the EPR to flag vulnerable patients, thus allowing them to be triaged effectively by an appropriate member of the team. Bespoke training sessions and monthly safeguarding meetings are also in place. A Virtual Safeguarding Learning Session was delivered in June 2020 to share learning with neighbouring sexual health services, local authority commissioners and Public Health England. Commissioners have submitted this work to Public Health England as a best practice example, and the write-up is available in the Public Health England National Library. Another Quality Improvement project is looking at capacity and demand in the HIV service. This includes improving the consultation documentation, training on the Electronic Patient Record system and restructuring the layout of clinics to improve efficiency.

East Berkshire Specialist Wheelchair Service has successfully managed their waiting list by introducing virtual assessments and additional welfare calls to shielding patients. The service has adapted their building and ways of working to meet the new COVID-19 guidelines and reopened to patients as soon as it was possible to do so after redeployments. The service has also reached the finals of Health Service Journal Patient Safety Awards for their work on "Achieving Gold Standard in Patient Safety through Quality Improvement and ISO13485."

Berkshire Community Dental Service and Specialist in Special Care Dentistry have set up an Urgent Dental Care Hub for patients that are shielding, high risk and vulnerable during the COVID-19 pandemic. They have also gained assistance from an Oral Surgeon to reduce the need for people to access Oral Surgery in hospitals. Emergency dental care has continued to be provided for the general public who cannot access a dentist. Dentists and dental nurses from the team were also redeployed to help swabbing and work on the wards.

The Cardiac and Respiratory Specialist Services (CARRS) in Berkshire West have utilised telephone and video calls to continue managing patients. Although both Pulmonary and Cardiac rehabilitation was cancelled in March 2020 due to COVID-19, both have since been recommenced safely by offering patients a face to face assessment, discharge assessment and an online programme of exercise via the British Lung Foundation website/British Heart Foundation. Follow-up telephone calls are made during the programme to help patients further. In the future, this programme will allow for the provision of a remote arm of the programme alongside the usual day classes. Online pre-recorded education videos have also been developed to assist in patient education (which could save a home visit) and for training purposes for new staff or other services in the Trust. The Respiratory Service have also developed a paper-free RiO assessment form for the Home Oxygen Service and have also moved to a more user-friendly software database for all the patients requiring an oxygen prescription.

The West Berkshire Adult Speech and Language Therapy Service (ASLT) have transformed their service delivery to offering remote/telephone/video appointment as a result of the pandemic. Home visits using Personal Protective Equipment and COVID-19 safe clinic environments have also continued for urgent care to avoid hospital admission. Clear screens were installed in clinics to enable staff to offer therapy without wearing a mask. This is essential for patients that need visual clues and to be able to see the clinician's face. Remote consultation has also allowed the team to run groups and offer therapy successfully to patients requiring Lee Silverman Voice Treatment and those with Parkinson's Disease. Remote training has also been provided to ward staff and redeployed staff to ensure they are aware of patients with feeding/swallowing problems and dysphagia diet descriptors.

Berkshire West Community Nursing have continued providing a full range of services during the pandemic, including a two-hour response to those in need. Face-to-face contact with colleagues has reduced and the team have adapted to new ways of communicating by further embracing new technology and supporting one another in different ways. The Intravenous (IV) HiTech service has been redesigned to improve patient access to care and enhance practice development opportunities for community nursing teams. Peripheral Inserted Central Catheter (PICC) clinics were established at three sites in the Berkshire West area and patient support embedded into the existing community nursing service. The transition from clinic-based care to care in the home, when needed for the patients, is now seamless because the service is still being delivered by the community nursing team.

The Reading Community Nursing service have also used Quality Improvement methodology to review their process for triaging patient referrals into the service. As a result, three clinical nurse advisors have been put in place to support reviewing referrals and completing urgent visits. This allows patients to be seen quicker. A referral processor has also been employed to help manage the high proportion of blood tests.

East Berkshire Community Nursing are working with East Berkshire Clinical Commissioning Group to implement a Care Home Support Team pilot. This team will enhance the care of residents of care homes and prevent inappropriate non-elective admissions to hospital. The team will consist of senior nurses that will support care homes by providing clinical advice, training, and education to care staff, thus upskilling, and empowering them to deliver an even greater standard of care for their residents. The team is also involved in the care homes multidisciplinary teams' meetings to implement clinical decisions that lead to a better outcome for the resident.

The East Berkshire Lower Limb clinics have relocated to a purpose-built clinic area at St Marks's Hospital. This has resulted in more clinic sessions being offered, with more space for equipment and supplies. Furthermore, as the adaptations took place during the pandemic, the building fulfilled COVID-19 guidelines from the outset.

The East Berkshire Assessment and Rehabilitation Centre (ARC) has undergone substantial improvement in recent times. The service has flexed to better support elderly frail patients since the onset of the COVID-19 pandemic and they now assess their patients by conducting home visits. The Geriatricians in the ARC are then able to follow up with a virtual consultation, having a clear picture of the patient's medical history and recent diagnosis, along with the diagnostics. Community Matrons have been brought into the ARC to support admission avoidance. They engage with the geriatricians and follow up patients that need further interventions. The ARC service also carries out welfare checks for all patients discharged from the community hospital wards to try to prevent unnecessary readmission. Ward rounds also take place on both East inpatient wards and, during the COVID-19 pandemic, representatives from the medical team, therapy team and social workers join a twice-daily virtual ward round that allows all teams to have an early overview of the patients' discharge pathway, ready for when the patient is medically optimised for discharge.

The In-Reach team have extended their hours during the COVID-19 pandemic and are working 7 days a week liaising with the acute hospitals to manage the safe discharge of patients into either the community inpatient beds or support discharges back into the community. The team also facilitate admission avoidance referrals. Recently the team have based themselves on the inpatient wards.

Community Health Inpatient Services

Berkshire West Community Health Inpatient Services are implementing FLOW, a Bed Management Dashboard containing real-time bed occupancy data about patients on community wards. The technology alerts staff to breaches of individual discharge dates, exceeded length of stay and delayed discharges. A Bed Request Portal will also allow the service to maintain the waiting list for community inpatient beds and prioritise them for admission.

Falls technology is also being implemented in Berkshire West to provide early warning of a possible patient movement from a bed or chair which could lead to a fall or injury.

Point of Care Testing (POCT) allows diagnostic tests to be administered outside of a central laboratory at or near the location of the patient. Rapid access to pathology test results is critical to high quality and efficient modern healthcare. POCT will allow the service to reduce emergency bed days and patient safety risks associated with transporting and processing delays.

The NHS Professionals (NHSP) Pool of Staff has been developed to create a specific group of staff who are willing to work across all community inpatient units at short notice. This helps to ensure that all wards are monitored and supported.

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

The WestCall GP Out-Of-Hours Service are using Electronic Prescribing to reduce the number of unnecessary face-to-face interactions between clinicians and patients. This also allows clinicians to send controlled drug prescriptions directly to dispensing chemists without the need for a wet signature. Wastage of paper is also reduced, as well as the need to safely provide, store and distribute paper prescriptions securely to printers. Remote consultation using Trust issued laptops and good IT systems has also created flexibility in allowing clinicians to log in from home at times of increased service demand for triaging patients. This enables safe clinical triage and diagnosis of conditions as patients can be visually seen. It has also improved the resilience of the service in coping with periods of increased activity.

The HealthHub/WestCall Operations Team have ceased all referrals being sent via Fax, with referrals now received by email and urgent referrals only by phone. A COVID-19 management administration role has also been created to help manage COVID-19 swabbing. The process for referrals for West Berkshire District Nurses has been streamlined and the team are also engaged in a pathways project to enable a swift interaction with the Royal Berkshire Hospital to support patients' discharge.

The Urgent Treatment Centre have enhanced x-ray opening hours to align with the Centre's opening hours. Screens have been installed at reception with screening questions introduced for all patients when booking in (either via phone or in person). A 'Hot Room' has been introduced. The service has also implemented a booked appointments system for patients presenting with minor injury and minor illness. This allows for better social distancing and reduced waiting times in the waiting room. A pager system has also been introduced to allow patients to wait in their own vehicles. Mobile X-ray facilities are also available for COVID-19 positive patients so that they do not need to attend Accident and Emergency.

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

The Children, Young People and Families (CYPF) division have worked with the Trust's Human Resources team to develop a new approach to recruitment advertising. Quality Improvement training has been given to 50% of services and in November 2020, the division held a live online training event to showcase good practice and support teams that have not had such training. Huge changes were made to the way that services have been delivered due to the to the COVID-19 pandemic. With schools and children's centres being shut, services moved quickly and seamlessly to telephone and then online delivery of appointments to minimise the impact of COVID-19. They have continued to use all available clinical capacity throughout the pandemic. Teams have also continued to offer direct face to face contact using Personal Protective Equipment, for children/young people and/or families with significant and specific needs. Staff have also been working more flexible hours meaning that families can have more choice in their appointments. 80 CYPF staff were redeployed during the first wave of the pandemic to support colleagues in adult services.

All CYPF services have been involved in the provision of services to children with Special Education Needs and Disability (SEND), and a quality assurance checking process for this is being established across teams. Services continue to contribute to partnership quality audits with a new audit cycle currently being developed. Bracknell Forest services have implemented a standardised Education Health and Care Plan (ECHP) audit tool. A centralised e-mail in-box and new ECHP coordinator administration role has been also been established to facilitate the receipt of requests for our teams to contribute to an EHCP assessment.

The School-aged Immunisation Service achieved their target of 90% of school leaver's boosters before the COVID-19 lockdown was announced in March 2020. Following government guidance, the school-aged immunisation service face-to-face delivery was suspended, and a large number of the team were redeployed to other areas including inpatient units, COVID-19 testing and supporting the respiratory team. Those staff that remained in the service received a large number of calls from parents, and a new 0300 number was set up to separate out booking and general queries from advice and support requests. The immunisation service resumed in June 2020, and the team were quick to re-engage with the schools and initiate their catch-up programmes.

The autumn term has seen the team deliver a Flu programme like never before, with a 10% rise in target to 75% of the school-aged population to be immunised and an additional year group of Year 7 added to the cohort already including Reception to Year 6. This resulted in a cohort size of approximately 99,000 children across Berkshire and meant that every secondary school in Berkshire would also have to be visited as well as every primary school. School restrictions and significant pupil absence have necessitated a creative and flexible response from the team which they have delivered every day. This has included drive-thru Flu clinics in East and West Berkshire and Saturday clinics in Slough, to target their lowest area of up-take.

The Health Inequalities Immunisation Nurse was successful in gaining a £50,000 award from NHS charities/Captain Sir Tom Moore, to set up a health bus which will enable immunisations in the first instance. Other Berkshire Healthcare clinical services will also be able to use this mobile clinical space in the future.

The School Nursing Service has had a challenging year as their ability to work with and within schools has been significantly disrupted due to the COVID-19 pandemic. The National Child Measurement Programme was discontinued following government COVID-19 guidance and, due to school closures, some health promotion activities were no longer possible. Face-to-face consultations were quickly replaced firstly by telephone and then by virtual consultations. Safeguarding meetings and staff training were also attended virtually, and a School Nursing advice and support line was set up to support families across all four localities. Social media blogs were written in conjunction with Health Visiting to provide additional health advice around common issues such as bedwetting and sleep. The school nursing teams also made a film to let the children/young people know that they understood the issues they were facing. Finally, the Bracknell Forest School Nursing team are evaluating a Quality Improvement initiative relating to non-attendance at their enuresis clinic.

The Health Visiting (HV) Service have responded to the COVID-19 pandemic by reviewing their service provision. This has included the development of an online virtual antenatal presentation which allows parents to view the session at a convenient time. A daily (Monday to Friday) Safeguarding Duty Health Visitor has also been introduced in West Berkshire and Reading to provide social care teams with priority access to, and response from the service. This role also facilitates better allocation of safeguarding cases amongst the team. Management of Domestic Abuse Incident Forms have been recently been trialled in Reading and this has reduced the workload pressure on both the Health Visiting and School Nursing teams. Contact is being made with parents at 4-weeks and 12-14 weeks in response to the number of non-accidental injuries, domestic violence incidents and the negative impact of lockdown and other restrictions.

Parents have reported that they found these additional contacts very supportive, particularly at that time when the service were offering very limited face to face contact. This initiative has been submitted as a case study to the Institute of Health Visiting and has been chosen for national publication. Many Health Visiting contacts with parents were offered virtually by video link during the first lockdown and this made asking parents about domestic abuse incidents challenging. It was often difficult for practitioners to know if anyone else was present in the room, but out of site of the camera and/or the conversation were being overheard. As a result, a Reading Health Visiting and Safeguarding Lead designed an "Over the Shoulder" poster containing the details of the Domestic Helpline. This poster provided an unobtrusive backdrop during online contacts to offer sign-posting information to parents. The Bracknell Forest Health Visiting team have used Quality Improvement methods to help meet their New Birth Visits target. In addition, meetings have been established with social care to highlight issues, with particular emphasis on the under 1 age group given the increased safeguarding concerns highlighted by the pandemic.

The Children and Young People's Integrated Therapy Team (CYPIT) across Berkshire West has faced many challenges and realised many opportunities during the pandemic. With face to face visits suspended briefly, except for those requiring essential therapy intervention, the team worked quickly to identify the risks to the complex children and families they work with and put safe and effective measures in place to meet children's therapy needs. Virtual assessments and appointments were rolled out, and many children were motivated by the 'virtual' therapists. It was also a great opportunity to put therapy strategies directly into the hands of parents and families, with support and guidance from the team as required. Personal Protective Equipment allowed teams to shift the balance between virtual and face-to-face appointments to best meet the needs of individual children and families.

The Autumn term created an additional challenge with many children having grown or changed over lockdown and the summer. The team continued working tirelessly in response to this, to reassess needs, train school/nursery staff and continue to empower all those working with the children to set up robust therapy plans that will continue to guide families, nurseries and schools though future lockdowns. The team also managed large numbers of EHCP (Education, Health and Care Plan) requests, with a high success rate in meeting the statutory deadlines in the face of an 800% increase in demand in some areas over the past 4 years.

CYPIT teams have also worked together to improve the quality and efficiency of services throughout the year. The Early Years Team have improved the process by which preschool children are referred to Speech and Language Therapy and have sent helpful leaflets to all early years settings in Berkshire West. The Speech and Language Therapy service had to cease their early years drop-in sessions and are now using digital platforms to inform service development. A review of Speech and Language Therapy, Physiotherapy and Occupational Therapy training offered to special schools is also underway to make this training more integrated. Finally, the teams have produced an advice and support pack for schools and families and have ventured into the world of social media to deliver information and support.

The Children and Young People's Integrated Therapy Team (CYPIT) in East Berkshire have developed three key areas of Occupational Therapy training which can be delivered virtually. Work is also being undertaken to address the increasing demand, waiting times and staffing pressure in Occupational Therapy. Service user feedback is being used to inform training and outcomes to children and young people. The team have prioritised supporting each other and have developed opportunities for sharing experiences, ideas, worries and successes through regular virtual coffee mornings, team quizzes and the CYPIT wellbeing team.

Children in Care Team. All staff roles have been assigned a Looked After Children training level commensurate to their role, and this has been added to the Trust's safeguarding training strategy. This training is delivered online with extra sessions being offered to improve compliance. At the start of the pandemic, the team moved quickly to undertaking virtual assessments. Face-to-face assessments are undertaken for those young people/carers who request it or when it is felt to be clinically appropriate. The team are collecting feedback on the current mode of health assessment delivery and this will be used to inform service delivery in the future.

The Special Schools Nursing (SSN) team in Berkshire West has expanded their team to include nursery nurses. This role is being developed within the special schools and the team to enhance their integration. Two members of the team are working with other Trust professionals to help deliver an epilepsy training day to highlight their role within special schools in caring for children with epilepsy.

The Community Children's Nursing (CCN) Team in West Berkshire have worked on numerous quality and governance challenges. The improvements have included; starting an 8am-8pm service on Tuesdays to Thursdays (which will operate from Monday to Friday by mid-2021), standardising supplies and medical devices provided to families, updating all equipment and completing an equipment audit, developing Standard Operating Procedures and guidelines, developing the new role of the nursery nurse in the team, training and signing off staff competence in end of life provision and streamlining stock and storeroom processes.

The Community Children's Nursing Team in East Berkshire and Woodlands Children's Respite have reduced sickness levels to their target of 3.5% for 6 months. This has resulted in reduced spend on agency and NHS Professionals staff. Knowledge, competence, and confidence in end of life care has also been improved. The children's respite service has changed their name to the Woodlands Children's Respite and has introduced clearer criteria for entry into the unit. Their assessment process has also been standardised to ensure that the service is fair and equitable to all children. The Community Children's Nursing service were only able to make face-to-face visits for emergency and essential reasons at the start of the pandemic. Video consultations were set up to ensure that all families continued to receive a good quality service and to help identify any early deterioration requiring escalation to emergency services. Families have missed the home visits but are appreciative of the video contact as an alternative.

The Community Paediatric Service have made good progress in digital transformation over the past 18 months. Service delivery was quickly switched from face-to-face to video and telephone consultations at the start of the pandemic. In doing so, the service continued to successfully meet all new referrals received within 18 weeks. The service moved to sending out all physical correspondence electronically to local authorities/social care, special schools, local hospitals, parents where consent received and increasingly to tertiary hospitals. This has resulted in reduction of stationery (paper and envelopes), printing costs, staff costs and postage. This also led to quicker delivery and responses where required. Towards the end of 2020 the service also transitioned to EPRO, the Trust's preferred digital dictation software, which has realised many benefits.

The service also carries out the initial health assessments for Children in Care and have worked with the Digital Transformation team to produce a summary information sheet that pulls required information from the patient's electronic RIO clinical record. This saves time when compiling relevant information.

The CYPF Dietetics Service have reduced plastic use and costs associated with enteral feeding. They have produced an ancillary guide on setting up Home Enteral Feeding contract deliveries to patients. A revised policy and guidelines have been developed on the use of ancillaries in children under 1 year old for enteral feeding. In addition, provision of replacement gastrostomy buttons has been reviewed, with a revised procedure and guidance put in place with our third-party provider (Abbott). This has resulted in a significant reduction in expenditure on these products. The team have developed consistent and good quality enteral feeding resources, assessment paperwork, patient advice sheets and risk assessments across clinical teams working in in the Trust. A parental advice booklet has been developed for families starting blended diet via enteral feeding route. Pathways and guidance have been developed to improving clinical decision making and work is also in place to help manage patients with Avoidant Restrictive Food Intake Disorder, including a pathway and supervision sessions to support staff.

CYPF Neurodiversity- Autism Assessment Team and Attention Deficit Hyperactivity Disorder (ADHD) Team

The Autism Assessment Team and ADHD Team have worked in partnership with East and West Clinical Commissioning Groups to respond to the high demand on their services. Demand, capacity, workforce, and transformation modelling has been carried out to ensure the service meets the present

and future anticipated needs of children and young people across East and West Berkshire. The teams have also responded quickly to the pandemic and moved seamlessly to telephone and then online delivery of appointments to minimise the impact of COVID-19. Staff have also been working more flexible hours meaning that families can have more choice in their appointments.

The 5-18-year autism and 6-18-year ADHD teams have been piloting and evaluating their own digital assessments during the pandemic with promising results. A project has also been started with the Digital Transformation Team to utilise a more advanced digital platform to deliver online assessments. Modified face-to-face autism assessments have also been identified, whereby a parent/carer is coached by a clinician to administer the assessment. This has allowed the team to conclude assessments for all age groups. Trainee placements continue to be offered for Children's Well-being Practitioners working across the autism and ADHD teams. 24/7 online support continues to be offered through the online SHaRON Jupiter platform to support families who have a child with autism or who are awaiting an autism assessment. A new SHaRON online support system is also planned for parents and carers of children with ADHD. Both teams have now completed Quality Improvement training and have implemented improvement practices.

The CYPF ADHD Team are working with the adult ADHD team to pilot a group to support young people who are transitioning from the CYPF ADHD Team to the adult ADHD Team. A growth at home research project has also been initiated to train parents/carers to undertake routine physical monitoring of their child's weight and blood pressure at home if their child is prescribed ADHD medication. Two nurses have also been funded to undertake training to qualify as Non-Medical Prescribers. **The Autism Assessment Team** has completed a procurement process to establish an online assessment as part of their core offer.

Child and Adolescent Mental Health (CAMH) Services

Staff from the CAMHS Common Point of Entry (CPE) team, the all-age Eating Disorders Service and locality based CAMHS Community Teams completed the Trust Quality Management Improvement System Training (QMIS) at the start of the year. Quality Improvement work has focused on reducing waiting times, improving access to services, and delivering services online to maintain them throughout the COVID-19 pandemic. All CAMH services have been maintained throughout the pandemic, with assessments and treatment being offered both by telephone and video consultation. Alongside this, a protocol was implemented to allow clinicians in all teams to safely provide face-to-face appointments where necessary.

The teams have collected feedback from service users and staff throughout the year and are using that to build a new model of care that will blend the use of digital technology and in-person services in the future. The Service have also seen an unprecedented rise in the numbers of young people needing urgent and emergency mental health care through the latter half of this year. In response, the CAMHS Rapid Response team put in place provision over extended hours at the beginning of the pandemic and now work longer hours over 7-days per week. A new pathway has also been implemented through the NHS 111 service that allows them to send referrals directly through to CAMHS. The team have also worked closely with colleagues at the Royal Berkshire Hospital and Wexham Park Hospital to implement new pathways to divert referrals from Accident and Emergency, enabling young people presenting in crisis to be seen in a community setting.

The CAMH Common Point of Entry (CPE) team have implemented several quality improvements to help manage demand and reduce waiting times. These include; implementing visual management systems, enhancing team communication to enable staff to focus on daily priorities, holding regular meetings with external early help services and internal CAMH teams, reviewing skill mix to manage changes in demand, reviewing the triage/assessment process and reviewing service user feedback to inform development. Improvements in team efficiency have resulted in twice as many direct patient consultations being carried out in 2020 compared with 2019. Waiting times for young people referred for urgent assessment have consistently been below 2 weeks and average waiting times for routine referrals have reduced from 10 weeks to 4 weeks.

Willow House, our 9-bedded general adolescent in-patient unit, was closed for 3 weeks earlier in the year for essential building work to maintain the fabric of the building. This closure coincided with the first COVID-19 lockdown and the inpatient team worked tirelessly to support other CAMHS and mental health services through this period as well as setting up new infection prevention and control processes to enable the unit to re-open as planned. The team have worked hard to address staffing challenges throughout the year to keep beds open and get back up to full capacity.

New community based CAMHS Getting Help Teams have been set up in the three East Berkshire localities this year, alongside a new schools-based mental health team in Slough. This has enabled early access to evidence-based treatment for young people presenting with early onset and lower risk mental health needs such as anxiety and low mood. Staff in these teams have worked closely with local authorities, schools, and voluntary sector youth services to develop supportive resources, including the #Coping guides for children young people and families, webinars and training sessions on topics such as managing anxiety for professional colleagues and delivering on-line therapy. Funding has also been obtained from the local Clinical Commissioning Group to roll out the schools-based mental health support teams to Bracknell and the Royal Borough Windsor and Maidenhead. Although the Trust do not provide Getting help and schools-based services in the West of the county, the team have continued providing clinical resources into these services in Reading and West Berkshire and have worked in partnership with Wokingham Local Authority on their review and redesign of emotional wellbeing and mental health services.

The CAMHS Professional Lead for Psychological Therapies and colleagues from the CAMHS Anxiety and Depression service, supported by colleagues in the Children and Young People's Neurodiversity Services have set up a new service to support NHS staff with concerns about their own children's wellbeing. Psychological therapists have also been involved in providing psychological support hubs to Trust and other health staff.

CAMHS clinical leads from across the service ran their first online workshop within two weeks of going into the first lockdown. This first session focused on training clinicians to deliver therapy through digital media and was attended by over 70 staff. Monthly Clinical Effectiveness Seminars have moved online, with 60-70 staff attending training each month on topics such as understanding and adapting psychological therapy to manage suicidality in autistic children and young people, assessment, and evidence-based trauma interventions and Dialectical Behavioural Therapy skills. A monthly programme of clinical training has also been put in place to support staff to continue to learn and upskill clinicians elsewhere in the service.

The CAMHS Anxiety and Depression Service launched a new SHaRON (Support, Hope and Resources Online Network) for parents and carers of children and young people needing treatment for anxiety. The service was also rapidly rolled out to the new Getting Help Teams in East Berkshire and over 400 parents and carers are now registered to use the network. The team also run their monthly pre-assessment workshops online. This workshop is often attended by approximately 50 parents and is available for them to watch again later.

CAMHS Psychiatry Quality Improvement Project. In response to high vacancies and an expectation of growth in demand against a national workforce shortage, a Quality Improvement project was launched with the aim of ensuring that scarce consultant psychiatry resources are used wisely and creating jobs that our consultants love doing to both enhance recruitment and maximise retention. The project has resulted in the implementation of a psychiatry assistant pilot, a new system of caseload management and a review of job plans and the job planning process. As a result, the service has successfully recruited to a number of hard to recruit roles, the vacancy level is below the national average and the Trust is growing its reputation as a good place to work.

A new Trust Research & Development Lead has been appointed and the service have set up a CAMHS Research Development Group to take a more proactive approach to developing research ideas and opportunities. A number of CAMHS medics are leading on research and other important national projects.

In addition, a number of CAMHS staff, including psychiatrists, psychologists and members of the leadership team are engaged in teaching, including training programmes run by the Charlie Waller institute at the University of Reading.

COVID Symptom Checker Tool for people with learning disabilities. Members of the Learning Disability Service, including the Consultant Nurse for People with Learning Disability and a Consultant Psychiatrist, have developed a tool to help the family and carers of people with learning disabilities identify if the symptoms they are experiencing may be due to COVID-19 or something else, and to recommend appropriate action based on these symptoms. This is important for people with learning disabilities as it is easy for carers and health professionals to think that the person's health problem is due to something else - we call this diagnostic overshadowing. Respiratory problems are much more likely for people with learning disabilities and prior to the COVID-19 pandemic over 40% of deaths of people with learning disabilities were reported to be due to respiratory disease. It is important that respiratory symptoms are spotted early for people with learning disabilities, in order to seek medical attention when needed. It is also important that while COVID-19 is a significant risk to people with learning disabilities, it should not be assumed that symptoms are just COVID-19 related and we should therefore also consider potential differential diagnoses to COVID-19 and other common acute respiratory disorders.

The COVID-19 Symptom Checker gives some guidance on what the symptoms the person is displaying could be and, while is not an exhaustive list, the tool can help decision making and support people with learning disabilities to get the right care and treatment, in the right place and at the right time. Whilst this guidance aims to support decision making, the service recognises that everyone is unique and different and what is one person's baseline is different to another person. Based on this, the symptom checker is to be used in collaboration with the person, using existing knowledge about the person and in line with their health passport or care/support plans and with people that know the

person best. The symptom checker is not a definitive guide for all situations, and it is important to recognise that the virus can mutate and change. Therefore, if you continue to be worried for a person's health and wellbeing you should seek further advice/help from NHS 111/999 services as appropriate to the urgency. The symptom tracker can be downloaded from the following site:

https://www.berkshirehealthcare.nhs.uk/our-services/mental-health-and-wellbeing/learning-disabilities-ctpld/

The United Kingdom Learning Disability Consultant Nurse Network (UKLDCNN) and the National Mental Health and Learning Disability Nurse Directors Forum (NMHLDNDF) have provided endorsement of the tool.

Respiratory Health Pathway. Members of staff from the Learning Disability Service have collaborated in the development of a Respiratory Health Pathway with the aim of seeking to maintain optimal respiration condition and reducing the risk of deterioration e.g. chest infections, pneumonias, reliance on antibiotics admission to hospital. The pathway includes a number of separate yet interlinked areas: nutrition and hydration; swallow safety; oral hygiene; chest management strategies; head and body posture with potential for the need to consider reflux and constipation. It provides a framework to identify and meet individual needs and to create an individualised management system for that person that includes input from a wide variety of disciplines/agencies. It also seeks to provide staff with tools and processes that will help improve health outcomes. The pathway involves an initial triage assessment, followed by a more detailed Community Respiratory Assessment – which informs the development of multi-agency management guidelines and tools for recording. It is flexible to enable proactive use, starting when the person's respiratory health is stable, but it can also be used in a reactive way, triggered by an acute event requiring a specific response.

Occupational boredom prevention programme. Analysis of complaints made to the Community Team for People with Learning Disabilities (CTPLD) duty line identified that over 50% of complaints related to boredom due lack of home-based activities for people with a Learning disability during the first COVID-19 national lockdown. A number of potential risks were identified related to this, including behaviour becoming difficult to manage, boredom, mental health issues including depression, a loss of daily living skills and a decrease in mobility. The aim of this CTPLD project was to help prevent boredom and thus reduce the number of complaints received from Bracknell CTPLD clients, family members and support providers by 60% by September 2020. All Berkshire CTPLD Occupational Therapists worked together to put in place a weekly activity email for service-users and their carers. As a result of the countermeasures, the team have seen a decrease of 65.6% of boredom-related complaint calls to Bracknell CTPLD duty line. The project has now been shared across the United Kingdom through Occupational Therapy networks and weekly resource emails are sent to over 250 people across the UK.

Improvements in Mental Health Services for Adults, including Talking Therapies (TT) and Older People's Mental Health Team (OPMH)

Talking Therapies (TT)

The Gateway was launched on 8th December 2020 to integrate the access points for Talking Therapies (TT) and Common Point of Entry Team (CPE). This has resulted in one central point of access for all

Trust mental health treatments. The centralised referral and phone system have resulted in an increase in the number of referrals to TT and a significant decrease in the number of self-referrals to CPE. The gateway also allows a stepped care model to operate that facilitates to the most appropriate treatment pathways for the patient with reduced delay/assessment time. The Gateway system has also allowed GPs calls to be prioritised, with positive GP feedback. A daily multidisciplinary Integrated Referrals Meeting (IRM) has also been det up to allow clinicians to clarify treatment pathway queries. In addition, a Clinical Escalation Call Group allows staff to transfer calls or speak to a senior clinician regarding any safeguarding concerns.

The Talking Therapies Extended Trauma Pathway (ETP) has seen significant improvement this year. The Talking Therapies team have worked with the Berkshire Traumatic Stress Service (BTSS) to develop a more coordinated approach to assessment and treatment of clients with Post Traumatic Stress Disorder (PTSD) and have developed the ETP. Over 70 therapists have now been trained to offer trauma-focused treatment to clients with what is termed complicated PTSD, and this compliments the treatment already offered for clients with a single incident/series of single incidents of trauma. This also bridges the gap between the services offered by BTSS who treat complex PTSD. Two group supervision sessions per month have been set up to discuss these cases, as well as a weekly referral meeting to discuss cases and decide on the most appropriate part of the trauma pathway for assessment and for treatment. This meeting also links into the Integrated Referral Meetings which are part of the Gateway (mentioned above). The team are looking to move this model to 'business as usual' in 2021, meaning that clients who have received an ETP assessment will receive a trauma focused therapy from the same clinician where appropriate.

The Counselling Team in Talking Therapies are now offering a Brief Counselling Intervention to those who are experiencing low mood due to the impact of COVID-19 on their lives. The intervention involves 3 to 4 sessions which focus on compassionate listening and the 'here and now' impact of COVID-19. This has proven to be extremely successful.

Couples Therapy for Depression is now being delivered by Talking Therapies, and the number of couples referred to this service is increasing.

Psychological Wellbeing Practitioner (PWP) Online Groups. With the outbreak of the global pandemic, Talking Therapies moved overnight to become a remote workforce in order to safeguard both patients and staff. They adapted quickly to meet patient needs whilst still delivering a quality service. Workshops that had been delivered face-to-face were quickly and successfully moved to online delivery with positive feedback from patients. Having a place to be each week was reported to also aid patients' recovery.

The East Berkshire Wellbeing Service was launched across the three East Berkshire localities in May 2020 during the COVID-19 pandemic. The service has received over 400 referrals to date, and have supported people by providing practical, situational, and social support. All staff were recruited and trained in a brand-new job role and have adapted to working from home. The team are also networking with external services within the community to ensure that relationships are established to best support clients.

The Talking Therapies East Employment Team provides practical employment support to clients accessing Talking Therapies. This support includes helping clients to find work, return to work after

sick leave, and retain their current employment. The teamwork in collaboration with the Psychological Wellbeing Practitioners (PWPs) and Wellbeing Service Practitioners and have received over 1000 referrals to date with an average of 63% success rate since May 2020.

Adult Mental Health Services

The Berkshire West Community Mental Health Team (CMHT) have been working remotely since the start of the pandemic and this resulted in reduced travel time leading to increased productivity and better organisation of diaries. A system has been put in place to ensure the most vulnerable patients are having their needs met, and a wait list management tool has also been implemented to allow for regular contact with those waiting for the service. Support for staff has been increased in light of remote working, and staff "check in" 3 times a week to keep an eye on each other and quickly respond to any problems. Protected time has also been introduced for staff to focus on essential administrative tasks without interruption. A fortnightly multidisciplinary panel is held to discuss the pathway for people with Emotionally Unstable Personality Disorder (EUPD). This is extremely helpful in reviewing patients' needs and the most appropriate treatment pathway for them.

The Mental Health Integrated Community Health Service (MHICS) is being introduced in four east Berkshire Primary Care Networks (PCN) to support patients with Severe or Significant Mental Illness (SMI). Each PCN consists of a small team of Mental Health Practitioners, Community Connectors, Clinical Psychologists, administrators, with additional psychiatry and pharmacy support. This innovative service will help adults of all ages with SMI to access crucial support and guidance on a broad range of issues that are affecting their mental health, such as problems with housing, employment, social isolation, relationships, and debt. The service also includes brief evidence-based psychological interventions and support with medication. Being based in primary care means that people with SMI, and their carers where appropriate, can access specialist support closer to their homes and feedback from the initial pilot sites tell us that patients and primary care colleagues welcome this service.

The Crisis Resolution and Home Treatment Team (CRHTT) and the NHS 111 service have launched a new initiative that allows for NHS 111 direct referrals to CRHTT. This has enabled faster access to support for people experiencing acute mental health distress and reduced the burden on NHS 111 during the COVID-19 pandemic. CRHTT is also now available 24 hours/day, 365 days/year, to South Central Ambulance Service (SCAS) and Thames Valley Police in West Berkshire through a dedicated Professionals Line. CRHTT West has implemented a joint initiative to refer people directly to the Samaritans.

This service is aimed at people who are not necessarily in an acute crisis but may still require help and support over the phone. East CRHTT have reviewed their response times and have introduced an emergency response timeframe of 1-2 hours into the service, allowing calls that are identified as being a priority to be managed quicker. In addition, East CRHTT have employed a full-time pharmacist into the service to support clinicians and service users alike with medication optimisation, medicine reconciliation work and concordance strategies with service users. Both services are working directly with the Clinical Commissioning Groups to review crisis provision and to develop Crisis Cafes which will be available out of hours in local communities to support the needs of people experiencing an acute Mental Health need.

There are also now four active non-medical prescribers in CRHTT with another six due to complete the course in the coming months. This has led to more timely medication reviews and access to treatment. The team have also worked with the University of West London as part of a doctoral research project to develop a Brief Suicide Specific Psychological Intervention (BSPI) Toolkit and two-day training package on using BSPI skills. CRHTT had to adapt to new ways of working due to COVID-19, and status exchange meetings have been set up to coordinate operation of the service with a high number of staff working at home. Furthermore Multi-disciplinary Team meetings, and Quality Improvement have been delivered remotely. Reflective (SPACE) groups have also been offered twice weekly, allowing staff to gain support whether at home, isolating or in the office during the pandemic. Learning and development events for CRHTT have also been delivered remotely, and this new approach allows CRHTT to be very responsive to sharing learning from Serious Incidents and to implement relevant training.

The Intensive Management of Personality - disorder and Clinical Therapies Team (IMPACTT) have continued developing the Mental Health Pathway for patients with Emotionally Unstable Personality Disorder (EUPD).

The Psychologically Informed Consultation and Training (PICT) Team is a collection of senior psychologists and psychotherapists with specialist knowledge of working with people with personality disorders. The recovery journeys for these patients are very difficult if they do not feel that staff know how to best help them. The PICT work focuses on developing and delivering training packages for professionals working across secondary care and primary care sectors, helping to dispel the stigma of this diagnosis, and working with staff to improve their confidence and skills in working with these difficulties and so improve patient journeys and evidence base practice.

The Service User Network (SUN) is a new initiative that provides community-based, open access peer support groups across geographic locations across Berkshire to those with personality disorder difficulties but who may have found it difficult to engage with other therapy services or are waiting to access these. People can access between 2-3 groups local to where they live, for as long as they find these groups helpful. A remote pilot of SUN has recently been completed, and this has proved increasingly popular and well used. Groups will remain online for now but will move to community-based locations once it is safe to do so.

The Assertive Intervention Stabilisation Team (ASSIST), which was initially developed in East Berkshire, has been adapted and extended across Berkshire to provide support to people with Emotionally Unstable Personality Disorder (EUPD) who may be experiencing such increased levels of distress that they may be considered for inpatient admission. Evidence suggests that inpatient admissions for people with these difficulties hold a risk of becoming lengthy and can actually be counterproductive to recovery. The ASSIST service work with other Trust teams, including CRHTT and mental health inpatients, to support the prevention of admission or enable safe, speedy discharge if admission was unavoidable. The team are working mostly remotely as a result of the COVID-19 pandemic, but plan to return to face to face work as soon as it is safe to do so.

Dialectical Behaviour Therapy (DBT) and Mentalization Based Treatment (MBT) teams worked hard during the initial COVID-19 lockdown to deliver their intensive therapy remotely, thus enabling patients to continue accessing their therapy at a time when its more needed than ever. Within approximately three weeks from the start of lockdown, the full therapy programme had moved to an

online platform. Although some of the patients and staff found this transition difficult, attendance has slightly improved and this development has encouraged the IMPACTT team to consider whether a remote therapy offer, alongside in-person working, is something that would be beneficial to continue once it is safe to return to face-to-face work.

The Individual Placement and Support (IPS) Employment Service supports clients with severe mental health issues to gain, sustain and retain rewarding, paid work. Throughout the COVID-19 pandemic, ongoing restrictions, and partial redeployment to other services in the pandemic's first wave, the team have adapted well to working remotely with clients, clinical teams, and employers. The team have also rolled out job retention support for all Community Mental Health Team/Early Intervention in Psychosis clients across Berkshire who are struggling in work due to their mental health. They have also started working with some east Berkshire primary care clients with severe mental health issues, in partnership with Berkshire Healthcare's Mental Health Integrated Community services team. NHS England and Improvement has prioritised the expansion of IPS services over the next three years and the service intend to play their part in achieving this ambition.

The Perinatal team have developed online group therapy remotely during the COVID-19 pandemic**.** This has given their clients the opportunity to remain engaged with the service and receive treatment whilst also being able to seek support from peers during a very difficult period. Clinical data and patient feedback indicate that the positive results are compatible with face to face groups and the service intends to develop this form of provision further.

The Placement Review Team is a project hosted by the Out of Area Placements Team (OAPs). They have carried out successful placement reviews of patients funded by East Berkshire Clinical Commissioning Group. This has improved the experience of service users by bringing them closer to home and in more independent accommodation. The Clinical Commissioning Group have extended the project as a result.

Additionally, The Trust OAPs team continue to make progress in moving patients from long term rehabilitation/independent hospitals, often far away from home, to closer and less restrictive environments. They have also supported many hospital discharges, appropriately, from our local psychiatric hospital to reduce pressures on in patient wards

Older Peoples Mental Health Services (OPMH)

Cognitive Stimulation Therapy (CST) is an evidence-based group intervention recommended by NICE for people with mild-moderate dementia. Due to COVID-19 it has not been possible to deliver CST since March 2020, and this is likely to be the case for several months to come. As a result, the OPMH team have set up a working group with representation from each of the 6 localities to adapt the CST course content for online delivery and to establish the most effective way to facilitate groups online.

With patients' consent, staff liaised with their relatives to ensure they would have the necessary support to log onto Microsoft Teams and for the first few sessions in each course a member of staff was available to call any patients who had not joined the call or who appeared to be having difficulty on the call. Feedback from patients, carers and staff has been very positive including notable improvements in the confidence and social interactions of most participants. Online delivery also made it possible to host groups for patients from more than one locality. Whilst services hope to be

able to return to face to face delivery of CST in 2021, having an on-line version could enable services to engage patients who are not able to or do not wish to attend CST in person.

In addition, during the development of the online CST group, the team were very mindful of the fact that not all patients and carers are comfortable with technology and therefore would be unlikely to engage. To address this, an OPMH Speech and Language Therapist suggested piloting use of the 'Daily Sparkle', a publication originally developed for use in Care Homes. The Daily Sparkle is available both as an App or in hard copy so it meets the needs of people who would otherwise be digitally excluded. Family carers will be given advice, support, and information on how to use the Daily Sparkle to engage the person with dementia in conversations/activities and then contacted after 1 month for feedback and further support. The pilot is underway and will be evaluated early in the new year and, if successful, will be rolled out to all localities.

Delivering the Berkshire Healthcare Understanding Dementia Course Online. Since 2006, the OPMH Service have delivered an Understanding Dementia Course across all Berkshire localities for family carers of patients that are newly diagnosed with dementia. Face-to-face delivery of this course had to be stopped in March 2020 due to Coronavirus restrictions and a cross-locality working party was convened to adapt the course for online delivery. PowerPoint sessions were adapted into short 15-20-minute sections interspersed by facilitated questions and discussions. Some simple 'Joining Instructions' were also produced for participants, with some localities offering pre-course slots to practice joining Teams and mastering its functions. 'Key Messages' were also reviewed, as well as the range of options to be offered (including a preference to wait for a face to face course and an offer of written advice and support in caring for someone with dementia). All localities are now delivering this course online, with a high level of overall satisfaction. In addition, some family carers, who would be unable to access the face-to-face course, have been able to access our online course and when face to face sessions can resume, the option of attending the course online will remain.

Blended assessments. Whilst older people are amongst those most at risk from COVID-19, it is recognised that some of them are the not able to use technology and, due to sensory impairment, can find it difficult to communicate by telephone. Where this is the case, it is only possible to complete a comprehensive assessment by spending some time with a patient in person. To minimise the length of face to face contact, the team has adapted their process so that, with the patient's consent, as much collateral history is gathered remotely from a Carer and then a shorter face to face appointment is completed with the patient.

The Dementia Focus Group started to meet virtually in 2020. This group is overseen by Bracknell Forest Dementia Service Development Coordinator, and consists of people with dementia and carers, who are interested in supporting service improvement ideas and projects. A number of project ideas have been implemented including weekly virtual information sessions and COVID-19 prompt cards to help remind patients and carers about key COVID-19 messages.

A Prescription Project has been implemented which has resulted in a quicker process that contains fewer steps, avoids interruption in medication, produces less paperwork and results in fewer queries for staff.

Reading OPMH team have implemented remote 'Team Formulation' in response to the COVID-19 pandemic. This has allowed the Multidisciplinary Team (MDT) to continue meeting to develop shared case conceptualizations of the most complex patients during lockdown.

Mental Health Inpatients

Reducing the use of prone restraint is a key focus of Mental Health Inpatient Services at Prospect Park Hospital. Prone is defined as a type of physical restraint, holding a person chest down, whether the patient placed themselves in this position or not, is resistive or not and whether the person is face down or has their face to the side. Physical restraint and seclusion are seen as a last resort and only used when non-physical and de-escalation interventions have failed. There are risks documented with this position of restraint. Benchmarking data published in October 2020 demonstrates that prone restraint has continued to reduce in the Trust.

Managing COVID-19 at Prospect Park Hospital. Colleagues from Prospect Park Hospital and the Trust Quality Improvement Team collaborated to use Quality Improvement principles to implement a more proactive approach to managing their COVID-19 response. A first version of a daily COVID-19 huddle was developed within an hour of starting the work and this was tested, adjusted, and standardised over subsequent days.

Patient Experience

Since quarter four 2012-13 compliments have been routinely reported directly by services through the web based Datix system. This is a way of sharing good practice and praise through our localities and across the organisation. The system continues to be developed, following feedback from our staff to capture a variety of compliments, including people verbally saying "thank you", as well as gestures such as flowers and cards, and with implementation of a batch upload option for multiple compliments. 4,177 compliments were reported during 2020-21: a slight decrease from 5,666 in 2019-20.

Our online web system to log concerns that they have dealt with at a local level; referred to as local resolution continues to be supported by the Patient Experience Team, with information provided to our Clinical Directors via a real time dashboard. This is an additional tool for measuring quality, before the escalation to a more formal complaint and is driven by our front-line services resolving concerns effectively, with support and training available from the Complaints Office and wider Learning and Development department.

The number of formal complaints received about the Trust has decreased slightly to 213 in 2020-21 compared to 231 in 2019-20, 230 in 2018-19, 209 in 2016-17 and 2017-18, 218 in 2015-16 and 244 in 2014-15. The Trust actively promotes feedback as part of 'Learning from Experience', which within the complaints office includes activity such as enquiries, services resolving concerns informally, working with other Trusts on joint complaints, and responding to the office of Members of Parliament who raise concerns on behalf of their constituents.

Our patient experience team have continued to support people investigating complaints to maintain contact with complainants and we have consistently achieved response rates of over our 85% target, as shown in the table below:

Q1 Cumulative	Q2 Cumulative	Q3 Cumulative	Q4 Cumulative
100%	99%	100%	100%

During quarter two, the Trust had one instance of not responding to a complainant in the agreed timescale. The service have put actions in place locally to stop this from recurring.

Our complaint handling and response writing training which is available to staff has been adapted to be provided online over MS Teams and continues to take place on a regular basis across the different localities, in addition to bespoke, tailored training for specific teams which has taken place to staff groups and teams.

The past year brought temporary changes to the complaints process, for example the Complaints Office supporting Investigating Officers with compiling response to complaints, triaging complaints in a different way to escalate concerns about patient safety, and following a review, placing a small number of formal complaints on hold (or paused). All the complaints that were paused have since been responded to in full. The Parliamentary and Health Service Ombudsman (PHSO) has a backlog of 3,000 cases to be reviewed and are responding to cases where they can have the most impact. Over the past year there have not been any cases taken forward for investigation by the PHSO (we have received 5 requests for further information and two requests to further attempt local resolution at a Trust Level).

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

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

FFT reporting to NHS England started again from January 2021 with the new FFT question (rating of care rather than recommendation to others) which was due to be launched from 1 April 2020 (and paused). The Trust started the new FFT locally from 1 September 2020 in readiness for the NHS England launch. The response rate is low (5% Trust wide for Quarter four) and the Patient Experience Team are working with services to overcome their individual challenges with collecting this. In line with the Quality Account, we will be reporting the FFT in this report from Quarter one 2021-22.

In response to the pandemic, the formal quarterly meetings with the Healthwatch organisations was paused. There continues to be on-going engagement through monthly informal catch ups, ad hoc case specific contacts and the Trust has engaged with Healthwatch West Berkshire and commissioned a feedback project as part of the 'Ageing Well' programme. As a direct result of Healthwatch feedback, Trust has revised the annual review of Unreasonably Persistent Complainants to include Governors.

Our complaints process works alongside our Serious Incidents processes and Mortality Review Group having a direct link to ensure that any complaint involving a patient death is reviewed. Weekly and monthly meetings with the Patient Safety Team now take place to ensure that we are working effectively.

The two volunteers who are part of the Patient Experience Team have not been actively supporting the Trust over the past year due to the pandemic (one is based at St Marks Hospital and the other is based at Prospect Park Hospital in Reading).

The Patient Experience Team set up the 'Message to a loved one' service in April 2021, whereby friends and family can forward messages, which are then sent on to patients on the ward. There has been positive feedback about this facility, which has been embedded and will continue moving forward.

ACCOUNTABILITY REPORT

Directors' Report

The Board of Directors comprises five Executive Directors and six Non-Executive Directors, plus the Chair and Chief Executive of the Trust. The Chair and the Non-Executive Directors are appointed for three-year terms of office by the Council of Governors. At the end of the first three-year term of office, the Council of Governors can re-appoint the Chair and the Non-Executive Directors for a further three-year term of office.

Up until December 2016, formal meetings of the Board of Directors were held every month (except August). Following the Board's evaluation of its effectiveness in October 2016, it was agreed that the Board needed more time to discuss strategic issues and therefore from January 2017, the formal public Board of Directors meets seven times a year and holds four private discursive meetings. An additional meeting is scheduled in August if required. At the formal public Board meetings, no business can be conducted unless at least one third of Directors are present, including at least one Executive Director and one Non-Executive Director. Due to the COVID-19 social distancing requirements, from May 2020 our public Board meetings have been recorded and the recording of the full meeting has been published on the Trust's website along with the Board agenda and papers. Members of the Public are also invited to submit questions to the Trust Board in advance of the meetings. The questions are answered by the relevant Executive Director at the meeting and the full responses are included as part of the meeting minutes.

The Board is responsible for:

- the exercise of the powers and the performance of the NHS Foundation Trust
- setting strategy, following discussion with the Council of Governors
- ensuring the provision of safe, high quality services
- ensuring the highest level of corporate governance
- ensuring that the Trust operates an effective process for the management and mitigation of risk.

The Non-Executive Directors are 'held to account' for the performance of the Board by the Council of Governors. The Board meets formally with the Council twice a year and Governors normally meet Non-Executive Directors on a further two occasions each year. Executive Directors routinely attend Council of Governor meetings and the Chief Executive presents to Council a quarterly performance report covering key aspects of the Trust's performance, both financial and service related.

During the year, the Council of Governors approved the re-appointment Naomi Coxwell, Non-Executive Director. The Council of Governors also agreed to extend the terms of office by a further year of the following Non-Executive Directors because of the COVID-19 pandemic: Chris Fisher, Mehmuda Mian and David Buckle.

Directors in post during 2020-21 are shown in the following table:

Name	Position	From	To
Martin Earwicker	Chair (Non-Executive Director)	01.12.16	30.11.22
Naomi Coxwell	Non-Executive Director	13.12.17	12.12.23
David Buckle	Non-Executive Director	01.06.15	31.05.22
Mark Day	Non-Executive Director	01.09.16	31.08.22
Chris Fisher	Non-Executive Director	01.10.14	30.09.21
Aileen Feeney	Non-Executive Director	01.11.19	31.10.22
Mehmuda Mian	Non-Executive Director	01.06.15	31.05.22
Julian Emms	Chief Executive	01.03.05	N/A
Debbie Fulton	Director of Nursing and Therapies	01.12.18	N/A
Alex Gild	Deputy Chief Executive and Chief Financial Officer	01.04.11	N/A
Minoo Irani	Medical Director	19.07.16	N/A
Kathryn MacDermott	Acting Executive Director Strategy	14.12.19	N/A
David Townsend	Chief Operating Officer	01.01.13	N/A

Board assessment and review

The Board commissioned an independent consultancy firm, Ernst and Young Global Ltd (EY) to conduct an external Governance review during 2015-16. Ernst and Young had no other connection with the Trust. The Trust Board was satisfied that this review and other audit activity demonstrated that it had an effective system of internal controls. Ernst and Young made a number of recommendations to further enhance the Trust's governance arrangements. The Trust developed an action plan to address each of the recommendations and the September 2016 Trust Board meeting agreed that the actions had been implemented and approved the closure of the action plan.

In January 2018, the Trust conducted an internal self-assessment against NHS Improvement's Well-Led Development Framework. The Trust identified a number of areas for further development, including developing a three-year strategy document, presenting the quarterly Quality Concerns paper to the Trust Board as well as to the Quality Assurance Committee and developing visual performance management as part of the Trust's Quality Improvement Programme work. An action plan was developed to address the gaps identified and was approved at the February 2018 Trust Board meeting. The completed action plan was signed off by the Trust Board at its February 2019 meeting.

At its meeting in February 2019, the Trust Board discussed the timing of its next external Well-Led Review and agreed that it would not add value if the external Well-Led review replicated the Care Quality Commission's Well-Led inspection which had rated the Trust as "Outstanding" in the Well-Led domain. The Trust Board requested that the Executive Team undertake a self-assessment exercise against NHS Improvement's Well-Led Framework with a view to identifying any areas which required further improvement.

The Executive Team identified the following areas:

- The Trust's strategy needed to align with the NHS Long Term Plan. The Trust also needed to consider how the new GP Contract and developments in system working would impact the Trust.
- The NHS Five-Year Forward View for Mental Health set out the national priorities in relation to Mental Health but there was no national policy in relation to Community Services. The Trust needed to develop a Community Services strategy which was aligned to the NHS Long Term Plan.
- The Trust's new performance management reporting system aligned to the Quality Improvement's True North objectives (introduced in May 2019) would further improve the Trust's processes for manging risks, issues and performance.

- The Trust needed to give further consideration the involvement of service users and support for carers. The Trust has since developed a Carers Strategy.

At its meeting in April 2019, the Trust Board agreed to delay commissioning an external Well-Led Review until the work to address the gaps identified above had been completed. The Trust's focus over the last year has been on its response to the COVID-19 pandemic.

The Trust Board undertook its annual review of effectiveness in October 2020. Overall the results were very positive. The Trust Board continued to appreciate the opportunity to discuss strategy at the Discursive meetings. The Trust Board acknowledged that holding virtual meetings via Microsoft Teams because of the COVID-19 social distancing requirements had changed the dynamics of holding face to face meetings, but it was universally acknowledged that the Trust Board had adapted well and that meetings continued to be run effectively.

Focus on quality

The Trust's latest comprehensive inspection by the Care Quality Commission took place in November and December 2019. The Trust received an overall rating of "Outstanding". The Care Quality Commission's ratings in respect of the five quality domains in set out below:

CQC Domains	Rating	
Are Services Safe?	Good	
Are Services Effective?	Good	
Are Services Caring?	Good	
Are Services Responsive?	Outstanding	
Are Services Well-Led?	Outstanding	
Overall Rating	**Outstanding**	

The Care Quality Commission re-inspected the WestCall GP Out of Hours Service in September 2019 and rated the service overall as "Good". The service was also rated "Good" across all the Care Quality Commission domains (Well-Led, Safe, Caring, Responsive and Effective). The Care Quality Commission had last inspected the service in July 2018 and had given a "Requires Improvement" rating.

In April 2017, the Trust launched its Quality Improvement Programme with the aim of enabling the organisation to apply a consistent approach to continuous improvement by developing the ability of each and every staff member to become problem solvers and make improvements to the way we deliver care for our patients.

Quality of service and patient experience remain top priorities for the Trust Board with quality being set at the top of the Trust Board's agenda each month. Non-Executive Directors continue to make Board visits to services, but these are conducted virtually due to the COVID-19 social distancing requirements. The Trust's programme of 15 Step Visits was paused at the start of the COVID-19 pandemic.

One of the principles of Quality Improvement is to increase Executive Directors' value adding activity, with value being defined by the customer. The ultimate customer in Healthcare is the patient/service user, but for some services could be another team or partner organisation. One of the things we have introduced to support our goal of increasing Executive Director value is through Gemba visits/walks. Gemba is a Japanese word defined as "the actual place" and in Quality Improvement "where value is added". Gemba is the place where real value is created or delivered for the customer – so this is normally where care givers are directly helping patients/service users, as that is what they value.

The purpose of a Gemba visit is to take time to observe and interact with people at the Gemba, to learn and understand what is really happening.

There are a number of benefits from this:

- People going to Gemba can see and understand how things are really done to help them with their own "value adding" work.
- Leaders can support front line staff by seeing and hearing about the improvement work and identify things which can be escalated and supported.
- People can see how our Quality Management Improvement System is operating at the Gemba to help with their Quality Improvement training, learning and the development of Quality Improvement in our Trust.
- It provides an opportunity to practise Quality Improvement skills and Quality Improvement leadership behaviours

The Board agenda includes a patient story at the start of the meeting.

The Quality and Performance Executive Group, chaired by the Chief Executive meets monthly to review quality related issues, such as serious incidents, quality concerns and the minutes of the locality and service monthly Patient, Safety and Quality meetings. The meeting also reviews performance and waiting times. The Quality Assurance Committee, which meets quarterly, continues to provide an

opportunity for Non-Executive and Executive Directors to debate and scrutinise the Trust's quality strategy, processes and performance in greater depth and to provide a forward-looking perspective on the quality agenda.

In accordance with national guidance, from March 2020, the Trust has re-configured its services in order to focus its resources on meeting the challenges posed by COVID-19. This has included scaling back or pausing non-essential services as defined by NHS England and where appropriate, significantly increasing the volume of online and/or telephone consultations.

Non-Executive Directors have paused their physical visits to services due to the COVID-19 pandemic but have participated in a comprehensive programme of virtual visits to services conducted via Microsoft Teams.

NHS Foundation Trust Code of Governance compliance

Berkshire Healthcare NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a "comply or explain" basis, including membership of Trust Board Committees, their terms of reference and Trust Board performance assessments. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the United Kingdom Corporate Governance Code updated in 2016.

As a Trust we are committed to high standards of corporate governance. For the year ended 31 March 2021, the Board considers that it was, throughout the year, fully compliant with the provisions of the NHS Foundation Trust Code of Governance.

Modern Day Slavery Statement

This statement is made pursuant to Section 54 of the Modern Slavery Act 2015 and sets out the steps that Berkshire Healthcare NHS Foundation Trust has taken, and is continuing to take, to make sure that modern slavery or human trafficking is not taking place within our business or supply chain during the year ending 31 March 2021.

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

Our Policies on Slavery and Human Trafficking

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

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

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

- **Recruitment** - We operate a robust recruitment policy, including conducting eligibility to work in the United Kingdom checks for all directly employed staff. Agencies on approved frameworks are audited to provide assurance that pre-employment clearance has been obtained for agency staff, to safeguard against human trafficking or individuals being forced to work against their will
- **Equal Opportunities** - We have a range of controls to protect staff from poor treatment and/or exploitation, which complies with all respective laws and regulations. These include provision of fair pay rates, fair terms and conditions of employment, and fair access to training and development opportunities
- **Safeguarding** - We adhere to the principles inherent within both our safeguarding children and adults' policies. These are compliant with the Berkshire multiagency agreements and provide clear guidance so that our employees are clear on how to raise safeguarding concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain.
- **Whistleblowing** - We operate a whistleblowing/raising concerns policy so that everyone in our employment knows that they can raise concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain, without fear of reprisals, and the various ways in which they can raise their concerns.
- **Standards of business conduct** - This code explains the manner in which we behave as an organisation and how we expect our employees and suppliers to act.

Our approach to procurement and our supply chain includes:

- Ensuring that our suppliers are carefully selected through our robust supplier selection criteria/processes
- Requiring that the main contractor provides details of its sub-contractor(s) to enable the Trust to check their credentials
- Randomly request that the main contractor provide details of its supply chain
- Ensuring invitation to tender documents contain a clause on human rights issues
- Ensuring invitation to tender documents also contains clauses giving the Trust the right to terminate a contract for failure to comply with labour laws
- Using the standard Supplier Selection Questionnaire that has been introduced (which includes a section on Modern Day Slavery)

- Trust staff must contact and work with the Procurement department when looking to work with new suppliers so appropriate checks can be undertaken.
- Supplier adherence to our values. We are zero tolerant to slavery and human trafficking and thereby expect all our direct and indirect suppliers/contractors to follow suit.
- Where it is verified that a subcontractor has breached the child labour laws or human trafficking, then this subcontractor will be excluded in accordance with Regulation 57 of the Public Contracts Regulations 2015. The Trust will require that the main contractor substitute a new subcontractor.

Training

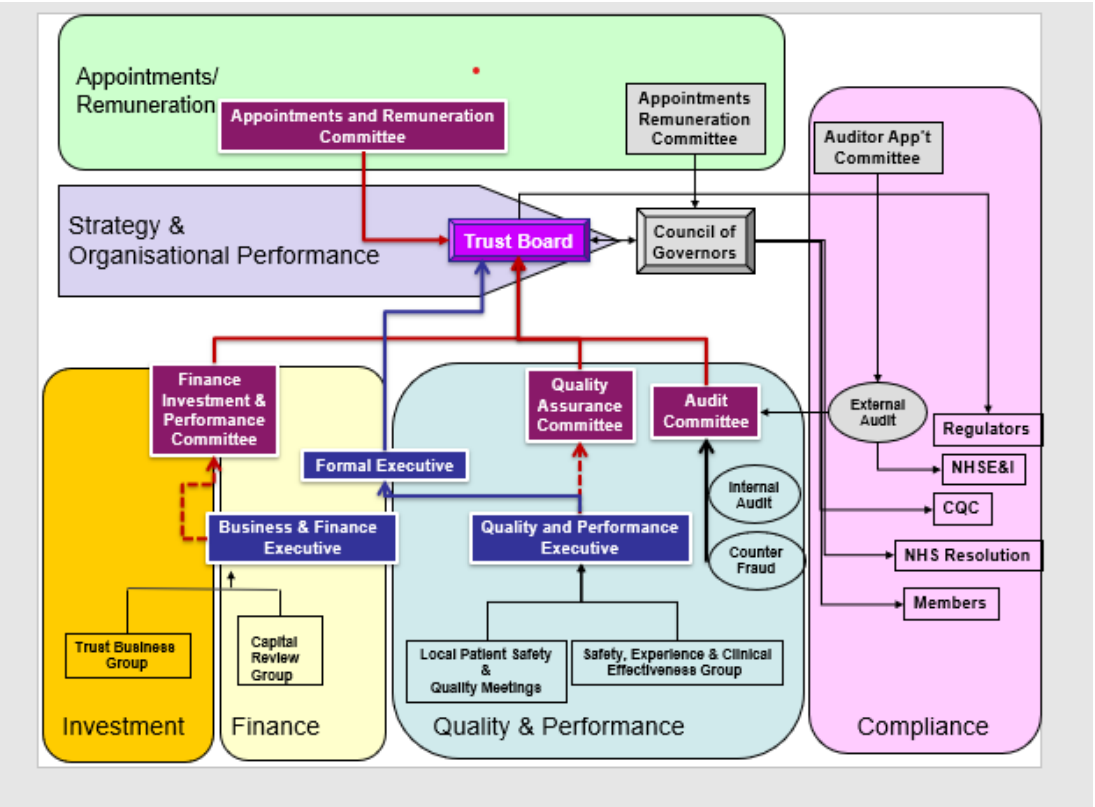
Advice and training about modern slavery and human trafficking is available to staff through our mandatory safeguarding children and adults training programmes, our safeguarding policies and procedures, and our safeguarding leads. It is also discussed at our corporate induction training which is mandatory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

Our Performance Indicators

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

Governance framework

The Trust operates a comprehensive structure and reporting arrangements which facilitate robust governance throughout the organisation involving the Council of Governors, the Board of Directors and various committees. The diagram below provides a view of the high-level governance and reporting arrangements that were in place during 2020-21 to provide appropriate governance and assurance.



The effectiveness of the Trust's governance arrangements is regularly assessed, including through internal and external audit. The Trust Board places great emphasis on the achievement of high-quality services and uses several different sources of information to monitor and triangulate performance and to provide robust assurance. The Trust Board receives a detailed True North Performance Scorecard report at each meeting which presents information across the whole spectrum of the Trust's activity with reference to quality measures. This report is scrutinised further on behalf of the Trust Board by the Finance, Investment and Performance Committee.

Streams of assurance on quality include internal and external audit activity, patient and staff satisfaction surveys, quarterly patient experience reports to the Trust Board and virtual and physical or virtual visits to clinical services conducted by members of the Trust Board. During the COVID-19 pandemic, Non-Executive Directors in particular participated in virtual meetings with clinical services.

Reports are also received on subjects such as compliments and complaints, learning from deaths, serious incidents requiring investigations (including details of any lessons learned), infection prevention and control and compliance with Care Quality Commission regulations. These and other information sources are used to provide assurance to the Trust Board in relation to its duty to provide regular declarations on quality to NHS Improvement.

Clinical Directors are responsible for maintaining a focus on local quality issues and for ensuring that best practice is identified and shared across the organisation. This is supported by the corporate governance arrangements in place and by the patient safety function which undertakes activity to monitor the Trust's compliance with the Care Quality Commission's regulations.

The Trust operates fully in compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 5: Fit & Proper Persons and all Directors are required to meet these requirements and to declare such annually. In addition, in the case of all new Directors, appropriate checks are made in accordance with the fit and proper person regulations before an appointment can be confirmed. In addition, members of the Trust Board are required to abide by the Board's Code of Conduct which reflects the high standards of probity and responsibility which is required of all Board members.

In line with constitutional requirements, the Trust maintains a register of interests for Directors which is available on the Trust's website or from the Company Secretary. The Company Secretary attends the Trust Board and its Sub-Committee meetings and produces detailed minutes of the discussions. Any individual concerns about a proposed course of action would be recorded in the minutes in line with requirements of the NHS Foundation Trust Code of Governance.

Trust Board Committees

During 2020-21 the Trust Board had five standing committees that helped it discharge its duties.

Audit Committee

The Audit Committee, comprising only Non–Executive Directors is responsible for making sure the Trust governs itself well by concluding on the adequacy of the Trust's systems of internal control and its assurance framework. The main role and responsibilities are set out in the terms of reference approved by the full Trust Board, which are consistent with national guidance.

These responsibilities include:

- monitoring the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance and reviewing significant financial reporting judgements contained in them
- reviewing the Trust's internal financial controls and the internal control and risk-management systems
- monitoring and reviewing the effectiveness of the Trust's internal audit function
- reviewing and monitoring the external auditor's independence and objectivity, and the effectiveness of the audit process, taking into consideration relevant requirements
- monitoring progress and output from the Trust's clinical audit activity; and
- Reviewing the annual clinical audit plan.

The Audit Committee has met these responsibilities by:

- Overseeing internal audit, counter fraud, and external audit services by:
    - reviewing the audit and counter fraud strategies and annual plans
    - receiving progress reports
    - considering the major audit findings and management's responses
    - holding discussions with internal and external audit
    - ensuring co-ordination between external and internal auditors
    - reviewing the external audit management letter; and

    - reviewing clinical audit summary reports.
- Reviewing and monitoring compliance with the Trust's Standing Orders and standing financial instructions
- Monitoring and advising the Trust Board on the Trust's Board Assurance Framework and Corporate Risk Register
- Reviewing schedules of losses and special payments
- Reviewing the annual accounts of the Trust before submission to the Trust Board and Charitable Funds Trustees, focusing particularly on:
    - changes in and compliance with accounting policies and practices
    - major judgmental areas
    - significant adjustments resulting from the audit
- Receiving and reviewing minutes from the Finance, Investment and Performance Committee and the Quality Assurance Committee
- Ensuring that both internal and external auditors have full, unrestricted access to all the Trust's records, personnel, and the Audit Committee members.

The Audit Committee reviewed financial and operating performance and compliance against national and regulatory standards. The Committee's review was supported by reporting from the Chair of the Finance, Investment and Performance Committee.

In depth reviews of strategic and operational risks have further supported the Committee's understanding and review of the key issues facing the Trust.

During 2012-21, there were no significant issues considered by the Committee in relation to the Trust's financial statements. The continuing effectiveness of both the internal and external auditors is monitored by the Committee, as is the Committee's own effectiveness through self-assessment against best practice standards.

The Audit Committee also considers the key risks identified by the External Auditor and uses its resources and the internal audit programme to provide assurance around the following key areas: management override, property valuations and completeness of accruals.

Auditor's Independence

The Trust requires its Auditors to demonstrate the policies and procedures they use to ensure they remain independent while carrying out their duty.

During the year the only work appointed by the Trust has been the audit, and the independent examination of the charity (which is non-audit but clearly audit related assurance services).

At its meeting in March 2021, the Council of Governors appointed Ernst & Young as the Trust's External Auditors from April 2021.

Finance, Investment and Performance Committee

The Finance, Investment and Performance Committee, comprising both Non-Executive and Executive Directors is responsible for reviewing financial and operational performance and for reviewing and providing expert comment on all significant financial investment and disinvestment decisions. They also scrutinise reporting on safe staffing and business development activity.

Quality Assurance Committee

This Committee provides a forum for detailed scrutiny and consideration of the Trust's quality agenda. Comprising both Non-Executive and Executive Director membership, the Committee obtains assurance on behalf of the Board on the quality of clinical services. This includes reviewing the quarterly reports on the Learning from Deaths and receiving the Guardians of Safe Working Hours of Doctors and Dentists in Training reports.

Appointments and Remuneration Committee

The Appointments and Remuneration Committee is comprised of all Non-Executive Directors and is chaired by Mark Day, Non-Executive Director. The Committee is responsible for ensuring that there is a robust process in place for appointing Executive Directors and Very Senior Managers and for determining Executive Director and Very Senior Managers remuneration.

The Chief Executive attends meetings but is not present for discussions relating to his own remuneration or terms and conditions. The Committee is supported by the Director of People and the Company Secretary.

More information about Non-Executive and Executive Director remuneration can be found in the Remuneration Report later in this report.

The Appointments and Remuneration Committee should not be confused with the Council of Governors Appointments and Remuneration Committee, which considers the appointment and conditions of Non-Executive Directors.

Attendance at Board meetings and Committees 2020-21

Board Meetings

Name	Position	Meetings attended/possible*
Martin Earwicker	Chair	12/12
David Buckle	Non-Executive Director	12/12
Naomi Coxwell	Non-Executive Director, *Senior Independent Director*	12/12
Mark Day	Non-Executive Director	12/12
Chris Fisher	Non-Executive Director, *Vice-Chair*	12/12
Aileen Feeney	Non-Executive Director	11/12
Mehmuda Mian	Non-Executive Director	10/12
Julian Emms	Chief Executive	12/12
Debbie Fulton	Director of Nursing and Therapies	12/12

Name	Position	Meetings attended/possible*
Alex Gild	Deputy Chief Executive and Chief Financial Officer	11/12
Minoo Irani	Medical Director	12/12
Kathryn MacDermott	Acting Executive Director of Strategy	11/12
David Townsend	Chief Operating Officer	12/12

**Includes attendance at both the Public Trust Board meetings and four private discursive meetings.*

Audit Committee Meetings

Name	Position	Meetings attended/possible*
Chris Fisher (Chair)	Non-Executive Director	4/4
Naomi Coxwell	Non-Executive Director	4/4
Mehmuda Mian	Non-Executive Director	4/4

*The April 2020 Audit Committee meeting was cancelled to enable the Trust to focus on responding to the COVID-19 pandemic. This was in accordance with NHS England and Improvement's letter to NHS Foundations Trusts: *Reducing burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic.*

Finance, Investment and Performance Committee Meetings

Name	Position	Meetings attended/possible
Naomi Coxwell (Chair)	Non-Executive Director	4/4
Mark Day	Non-Executive Director	4/4
David Buckle	Non-Executive Director	4/4
Julian Emms	Chief Executive	4/4
Alex Gild	Chief Financial Officer	3/4
David Townsend	Chief Operating Officer	4/4
Debbie Fulton	Director of Nursing and Therapies	3/4

Appointments and Remuneration Committee Meetings

Name	Position	Meetings attended/possible
Mark Day (Chair)	Non-Executive Director	5/5
Martin Earwicker	Trust Chair	5/5
David Buckle	Non-Executive Director	4/5
Naomi Coxwell	Non-Executive Director	4/5
Aileen Feeney	Non-Executive Director	4/5
Chris Fisher	Non-Executive Director	5/5
Mehmuda Mian	Non-Executive Director	5/5
Julian Emms	Chief Executive	5/5

Quality Assurance Committee

Name	Position	Meetings attended/possible
David Buckle	Non-Executive Director	4/4
Mehmuda Mian	Non-Executive Director	4/4
Aileen Feeney	Non-Executive Director	4/4
Julian Emms	Chief Executive	3/4
Minoo Irani	Medical Director	4/4
Debbie Fulton	Director of Nursing and Therapies	4/4
David Townsend	Chief Operating Officer	4/4

All Board Committees are supported by the Company Secretary and such other senior personnel as required.

Board members

Martin Earwicker – Chair

Martin Earwicker became Chair of Berkshire Healthcare NHS Foundation Trust in December 2016, prior to this he was Vice Chair of Dorset County Hospital NHS Foundation Trust. He retired from being Vice Chancellor of London South Bank University in 2013. Before this he was Director and Chief Executive of the Science Museum Group. However, his main career was in scientific research working for the Ministry of Defence interspersed with senior appointments in Whitehall; for the last five years of which he was Chief Executive of the Ministry of Defence's Research Laboratories, the Defence Science and Technology Laboratory.

In addition to his interest in health, he is a keen supporter of Further Education colleges, and has been chair for more than six years each of two Further Education colleges: Tower Hamlets College in the east end of London serving a particularly disadvantaged community, and Farnborough College of Technology, which he still chairs. He is also a Trustee of his local Citizens Advice Bureau.

He read Physics at Surrey University graduating in 1970. He was appointed a Fellow of the Royal Academy of Engineering in 2000 and has been a vice president of the Academy and was awarded an Honorary Doctorate of Surrey University in 2009. He is an Emeritus Professor of London South Bank University.

Naomi Coxwell – Non-Executive Director, Chair of the Finance, Investment and Performance Committee and Senior Independent Director

Naomi Coxwell joined Berkshire Healthcare as a Non-Executive Director on 13 December 2017. She lives in Farnham, Surrey and is also a Non-Executive Director for Arco - a safety specialist company, James Walker Group Ltd - a global manufacturing and engineering firm, and Citizens Advice Hart - providing free, impartial and confidential advice for the benefit of the Hart community.

Naomi is a former Vice President of BP and has worked in the oil and gas industry for over 30 years. She is a graduate of Exeter University where she received a bachelor's degree in Geology in 1984, and has studied at The Warton School, University of Pennsylvania, where she received BP's Chief Financial Officer Excellence certificate in 2012.

Naomi started her career in 1984 with Petrofina and was one of the first women to work as a Geologist on offshore rigs in the United Kingdom. She joined BP in 2000 and spent the following 16 years working overseas in increasingly senior positions. She has led diverse, multicultural teams in the development of strategy, management of risk, and in driving continuous improvement across six continents.

Naomi believes that that the physical and psychological health of individuals is the single biggest contributor to societal strength and productivity and sees Berkshire Healthcare as being a major contributor to that cause.

Dr David Buckle – Non-Executive Director

David worked as a GP in Woodley, Berkshire for 30 years. In 1995 he was awarded Fellowship of the Royal College of General Practitioners. He later became senior partner and was a GP trainer for many years. In 2000 he joined the local Primary Care Trust (PCT) Board and later became the clinical chair for Berkshire PCT. That decision started a long career of clinical leadership and then medical management.

Having been a Medical Director for an NHS Primary Care Trust and then a Commissioning Support Unit, David was appointed Medical Director to Herts Valleys Clinical Commissioning Group in spring 2015.

David was appointed a Non-Executive Director for Berkshire Healthcare Foundation NHS Trust in 2015. Having enjoyed this role, it encouraged David to expand his Non-Executive roles and in September 2018 he became an Associate Non-Executive Director for East and North NHS Hertfordshire Hospital Trust.

David has been a member of the Society for the Assistance of Medical Families for nearly 30 years and early this year he was voted president of the charity. He has also been appointed a trustee for the Stroke Association which is a large national charity.

David believes that his clinical knowledge his understanding of primary care and the wider NHS will help strengthen BHFT for the benefit of patients.

Mark Day – Non-Executive Director and Chair of the Appointments and Remuneration Committee

Mark Day joined Berkshire Healthcare as a Non-Executive Director on 1 September 2016. Mark is a member of the Professional Council of the Global Executive Network and until recently was the Chairman of Haven West Berkshire Homeless Charity. Haven operates a Soup Kitchen in Newbury for the homeless and vulnerable in West Berkshire.

Mark started his career with Crookes Healthcare (subsequently Boots Pharmaceuticals) and then moved to the Automobile Association where he embarked on his Human Resources career path. A number of different Human Resources related roles were undertaken until the organisation was acquired by the Centrica Group. Feeling that the time was right for a move into a different industry sector mark joined the Board of the Hospital Saving Association as Director of Human Resources.

Shortly after joining the Hospital Saving Association (subsequently becoming Simplyhealth) Mark assumed Director responsibility for the customer service operation and focussed on improving the personal service provided by the organisation. In addition to achieving consistent years of being in the

Sunday Times 100 Best Companies to Work For, many industry awards were achieved for the exceptional service provided to both corporate clients and individual customers.

Mark firmly believes that people can be the only true differentiator in organisations and is keen to see Berkshire Healthcare continue to provide support across our communities based on this principle.

Chris Fisher – Non-Executive Director, Chair of the Audit Committee

Chris Fisher took up the role as Non-Executive Director on 1 October 2014. He lives with his family in Maidenhead and most of his career has been spent in the area.

He trained as an accountant locally and qualified in 1983 whilst working for the Avis Europe group of companies where he held a number of senior positions in financial, commercial and operational roles over a period of almost 22 years.

He completed an MBA at Henley in 2001 and joined the NHS the same year as Finance and Performance Director for a local Primary Care Trust. He went on to lead on commercial matters for the regional Strategic Health Authority in Newbury before taking planned partial early retirement in 2009.

Most recently, he led the project on behalf of Heatherwood and Wexham Park Hospital NHS Foundation Trust for its acquisition by Frimley Park Hospital and previously he was project director for Berkshire Healthcare's acquisition of the east and west Berkshire community health services provider organisations.

Other interests include golf and walking his dogs. Chris has also recently become a grandfather.

Aileen Feeney, Non-Executive Director

Aileen Feeney joined Berkshire Healthcare NHS Foundation Trust as a Non-Executive Director in November 2019. Her career spanned both the commercial and charity sectors, most recently as Chief Executive for a UK-wide patient support charity.

Aileen spent most of her career in the Energy industry, in senior leadership roles that focussed on strategic business and technology transformation both in the UK and overseas.

Aileen holds several voluntary positions including being Lay Member for NHS Blood & Transplant, Trustee of a mental health support charity, a Member of Wokingham School's Circle Trust and a business mentor for the Prince's Trust.

Aileen has lived with her family in Berkshire for over 25 years. She has an Honours Degree in Biomedical Electronics, is a Chartered Engineer and an Associate of the London College of Music.

Mehmuda Mian – Non-Executive Director

Mehmuda Mian practised as a solicitor specialising in commercial and professional indemnity litigation. Her commitment to rigorous, high standards in public life led her to take on a regulatory

function at the Law Society, investigating complaints against solicitors, and also chairing independent review panels for the NHS. She left to take up an appointment at the Police Complaints Authority. Mehmuda was subsequently appointed as one of the first Commissioners to the Independent Police Complaints Commission and is a former BBC Trustee, Non-Executive Director of the Independent Safeguarding Authority, and of the Disclosure and Barring Service.

Mehmuda is currently a Non-Executive Director on the Independent Press Standards Organisation.

Julian Emms – Chief Executive

Julian was appointed Chief Executive in July 2012, following a nine-month period during which he was the acting Chief Executive. Julian started his career in the Probation Service as a Support Worker and went on to undertake a variety of roles in the service over a 10-year period before joining the NHS in 1997.

An NHS Executive Director since 2004 Julian has wide ranging experience in organisational leadership and service improvement. Julian was part of the Trust's successful NHS foundation trust application in 2007 and was the project director who oversaw the integration of community health services into the Trust in 2011.

Julian's senior management roles prior to becoming a director were all joint posts with social care and focused on providing better integrated care for local people.

Julian is also the chair of the NHS Benchmarking mental Health Reference Group, a position he has held since January 2016.

Debbie Fulton - Director Nursing and Therapies

Debbie qualified as a nurse in 1989. She has enjoyed a varied career having held a variety of nursing as well as clinical and operational management positions across Berkshire since 1998 and prior to that as a nurse and ward manager at Frimley Park Hospital. Before commencing her current post in December 2018, Debbie has worked within Berkshire Healthcare since the merger with East and West Community organisations in 2011.

During her time with the Trust, Debbie has held both Clinical and Locality Director positions and from July 2015 was the deputy director of nursing for patient safety and quality.

Debbie lives locally in Berkshire she has 2 grown up children and became a grandmother in 2017, a role which she very much enjoys.

Alex Gild – Deputy Chief Executive and Chief Financial Officer

Alex joined the Trust in September 2006. A business graduate and a qualified accountant he started his NHS finance career as a trainee finance assistant in 1996 and had spells working in the acute trusts in Oxford (Radcliffe Infirmary, Oxford Radcliffe and Nuffield Orthopaedic) before latterly joining South Central Strategic Health Authority.

Alex was Deputy Director of Finance at Berkshire Healthcare NHS Foundation Trust and was appointed Director of Finance, Performance and Information in April 2011 (his title changed to Chief Financial Officer in March 2017) and was appointed Deputy Chief Executive in April 2019. Alex is a member of the Board of Trustees of the Healthcare Financial Management Association and was President of the Association in 2018. In September 2020 Alex joined the national board for NHS Procurement and Supply and was appointed Chair of the southern region board.

Dr Minoo Irani – Medical Director

Minoo has been working in Berkshire as Consultant Community Paediatrician since 2001 and has held positions as Lead Paediatrician, Clinical Director, Lead Clinical Director and Acting Medical Director in the Trust before being appointed as Medical Director in July 2016. Minoo has a master's in health management from Imperial College, London and professional qualifications from the United Kingdom, India and the United States.

Kathryn MacDermott - Acting Executive Director of Strategy

Kathryn started in the NHS over thirty years ago with Wandsworth Community Health Trust as Head of Research for an Admission Avoidance and Early Discharge programme of work.

She has worked in community health and primary care, commissioning and transformation. Kathryn joined Berkshire Healthcare in April 2019 as Director of Strategic Planning. She was appointed as Acting Executive Director of Strategy in December 2019.

David Townsend – Chief Operating Officer

David started working for the NHS in 2004 having worked in senior roles for leading private sector, customer focused businesses. These included BP, MacDonalds, Initial and major international food producer Geest Plc. In addition to his commercial responsibilities, he led a number of transformational projects and spent 10 years in senior leadership positions.

His first role with the NHS was to set up a new collaborative organisation for the South-Central region to which he was appointed Managing Director. In 2010, David was appointed Director of Operations for Berkshire Healthcare and Chief Operating Officer in 2013.

None of the Directors have any declared political activities and all are considered independent.

Board composition

Board composition is determined to be appropriate for purpose. Non-Executive Directors with specific skills have been appointed to ensure good balance. These include skills in finance, commercial operations and strategy and clinical practice and quality. The Executive Director membership is as set out within statute, Chief Executive, Finance, Medical and Nursing Directors plus the Chief Operating Officer and the Director of Strategy

Directors Expenses

Directors are entitled to claim expenses in accordance with their terms and conditions of appointment. Expenses primarily relate to travel and car parking charges and for 2020-21, 4 Directors (out of 13) claimed expenses with an aggregate value of £875.81

Remuneration report

Chair and Non-Executive Director Remuneration

The remuneration and expenses of the Chair and Non-Executive Directors are determined by the Council of Governors on the recommendation of the Council of Governors' Appointments and Remuneration Committee. The Committee takes account of relevant market data, including the NHS Providers' Chairs and Non-Executive Directors Annual Remuneration Survey. The Council of Governors' Appointments and Remuneration Committee comprises of four Governors and is chaired by the Trust Chair. When the Committee is reviewing issues pertaining to the Chair, the Lead Governor chairs the meeting and the Trust Chair is not present.

The remuneration of Non-Executive Directors is comprised solely of their annual fee.

Non-Executive Directors' remuneration was reviewed in 2013. The Council of Governors' Appointment and Remuneration met in July 2019 and compared the current level of Non-Executive Director remuneration with other local NHS foundation trusts and with the benchmarking data provided by NHS Providers. The Committee agreed to remove the special responsibility allowances for the Vice Chair, the Senior Independent Director, and the Chair of the Audit Committee and to increase Non-Executive Director remuneration to £15,000 per annum.

The Council of Governors will have regard to NHS Improvement's paper "Structure to Align Remuneration for Chairs and Non-Executive Directors of NHS trusts and NHS Foundation trusts" published in November 2019 when appointing new Non-Executive Directors.

The Committee also reviewed the Chair's remuneration but was satisfied that the level of his remuneration was in line with other local NHS foundation Trusts and with the national benchmark salary data provided by NHS Providers.

Senior Managers Remuneration

Remuneration of the Trust's 'senior managers' (the Chief Executive, Executive Directors and Very Senior Managers (VSMs) is determined by the Trust Board's Appointments and Remuneration Committee. The Trust Board's Appointments and Remuneration Committee comprises all the Non-Executive Directors and is chaired by Mark Day, Non-Executive Director. The Chief Executive attends the meetings except when the Committee is discussing his terms and conditions and remuneration. The meeting is supported by the Director of People and the Company Secretary.

The Committee does not routinely apply inflationary uplifts or increases and only applies uplifts of any kind where this is thought justified by the context. The primary aim of the Committee is to ensure that Executive and Very Senior Manager remuneration is set at an appropriate level to ensure good value for money, whilst enabling the Trust to attract and retain high quality Directors. Executive Directors and Very Senior Manager remuneration does not currently include a specific performance related element.

Senior Managers Remuneration Policy

The Committee reviewed the Trust's remuneration policy for Executive Directors and Very Senior Managers in April 2019. In developing a new remuneration policy, the Committee was mindful of NHS Improvement's guidance on Very Senior Managers Pay and the remuneration section of the United Kingdom Corporate Governance Code 2018 which identified the following as best practice:

- **Clarity** – the remuneration arrangements should be transparent
- **Simplicity** – remuneration structures should avoid complexity and should be easy to understand
- **Risk** – remuneration arrangements should ensure reputational and other risks from excessive rewards and behavioural risks that can arise from target-based incentive plans
- **Predictability** – the range of possible values and rewards to individual directors should be identified and explained at the time of approving the policy

The Committee also identified the following key considerations for the new remuneration policy:

- **Trust's Values and Behaviours** - to reflect the values of the organisation and ensure the setting of salaries and the annual awards are fair, consistent and recognise not only the contribution of the individual but also the overall performance of the Trust.
- **Trust's Equalities and Diversity Strategy** - The Committee should ensure any changes to senior salaries consider any gender or unconscious bias that may occur. Pay decisions must always consider experience, competence, skills, responsibility, accountability and performance.
- **Hays Directors Pay and Reward Review December 2018** - Following the independent review, it was agreed that the role of the Chief Operating Officer and the Director of Nursing and Therapies are comparable in terms of accountabilities and responsibilities and this should be reflected when setting the remuneration for the Director of Nursing and Therapies.

New Executives

The Chair and the Chief Executive would determine the salaries for new starters. This would take account of:

- NHS Improvement and other external salary benchmarking data
- Market conditions, for example, reviewing the number of quality candidates applying and the salary expectations
- Review of experience at Very Senior Manager or equivalent level

- Consideration of the gender pay gap and any unconscious bias

Annual Pay Review of Executives

The Committee agreed that the annual pay review for Executive Directors and Very Senior Managers would take account of:

- The Trust's performance against targets set at the start of the annual performance cycle; the outcome of the Care Quality Commission's Well Led assessment; financial stability; and an assessment against national agreed contracts and performance benchmark data for comparable organisations
- NHS Improvement and NHS Provider's national salary benchmark data
- Local recruitment markets (for example, local NHS Trusts' ability to recruit and staff turnover etc)
- The annual award for all Agenda for Change staff
- A review performance of the individual:
    - If performance is not satisfactory, the individual will not be considered for either a consolidated or non-consolidated pay award
    - Base pay position against the NHS Improvement benchmark will take place, if performance is 'good' then consideration of a consolidated or a non-consolidated award would take place
    - If the individual is in the upper quartile of the pay range of NHS Improvement's benchmarks, consideration would be given to awarding a non-consolidated pay increase in line with the Agenda for Change award
    - If the individual's salary is below the upper quartile pay range, the Committee will consider awarding consolidated pay awards until the individual reaches the upper quartile (subject to satisfactory performance).
- In addition, for individuals to be eligible for a pay award:
    - They must have had a satisfactory appraisal in the last 12 months
    - Their performance and/or capability is not being formally managed
    - They do not have a live formal disciplinary sanction on their record
    - They must be up to date with all their statutory and mandatory training
    - If they are a line manager, the appraisals for all their team are completed
    - If there is something beyond their control which has stopped them from achieving any of the above, then this will be taken into consideration
- Review of exceptional performance:
    - If the performance of the individual has been exceptional, the Committee will determine whether an additional non-consolidated payment should be awarded
    - If the individual earns above the Prime Minister's salary, the Chair will refer the case to NHS Improvement for review and comment prior to submission to the Department of Health and Social Care for the Secretary of State's opinion.
- Gender pay gap and unconscious bias consideration –the Committee will assure itself that no pay discrimination occurs when determining base pay or performance awards. The Committee will use evidence and test the reliability of that evidence when making decisions.

Pay decisions will be based on evidence, experience, competence, skills, responsibility, accountability, and performance.

- The Committee recognises that salary uplifts are not automatic and are dependent on the performance of the Trust and on the performance of the individual being satisfactory.
- The Committee retains the right not to award any salary uplifts.

Where any senior manager is paid above the Prime Minister's salary (currently c£150,000 per annum), the Appointments and Remuneration Committee will have satisfied itself that the actual level of remuneration paid is reflective of the individual post holder's level of responsibility and performance and that the remuneration has been considered against appropriate benchmark information, local recruitment market conditions and the need to provide a reward package that ensure the recruitment and retention of high calibre senior executives.

Executive and Very senior manager contracts provide for a period of notice of six months on the part of the Trust as agreed by the Appointments and Remuneration Committee. A senior manager may suffer loss of office in a number of situations and in such cases the six-month notice period normally applies, however, the Trust can, at its discretion, choose to make payment in lieu of all or part of the notice period. Where loss of office is due to circumstances where summary dismissal applies, such as gross misconduct or serious performance failure for example, no notice period would apply. If loss of office was due to redundancy then the notice period would apply, as would any redundancy provisions applying generally in the NHS at the point in time; the principle being that very senior managers would be treated neither no less nor no more favourably than other Trust staff.

Annual Statement on Remuneration

In December 2018, the Trust commissioned Hays Executive to undertake a review of Executive pay and rewards to provide an independent external view of the current relevant market pay and reward data, taking into consideration of the health sector and direct peer organisations. The review concluded that the remuneration of Executives and Very Senior Managers was broadly in line with other comparable organisations.

The Hays review identified a small gender pay gap in relation to the Director of Nursing role which was traditionally a female role and therefore there was a risk that any national benchmarking data perpetuated the gender pay gap.

The Committee addressed the gender pay gap as part of the Director of Nursing and Therapies recruitment process which concluded in June 2019.

Gender pay reporting occurs each March and the Trust's gender pay gap is 19%. Further information about the Trust's gender pay gap can be obtained from the Cabinet Office website at: https://gender-pay-gap.service.gov.uk/Employer/C7N4Lu7y/2019

The Committee considers the pay and conditions of other employees, for example, the agenda for change pay settlement and the current pay settlement for senior civil servants when considering remuneration policy but does not actively consult with employees.

During 2020-21, the Trust did not operate a performance related element to very senior managers' remuneration.

The Appointment and Remuneration Committee met on 13 October 2020 to review Executive and Very Senior Managers' remuneration. The Appointments and Remuneration Committee noted that the NHS Improvement's comparator salary information was based on 2016 data and had not been updated. The Committee therefore agreed that salary uplifts for qualifying staff would be based on the individual's total (consolidated and non-consolidated) salary for 2017-18. After considering NHS Improvement's guidance on very senior managers' pay, the Appointments and Remuneration Committee agreed the following salary uplifts in line with the Trust's remuneration policy:

- Chief Executive: 2.6% non-consolidated pay uplift on 2019-20 total salary
- Deputy Chief Executive and Chief Financial Officer: 2.6% non-consolidated pay uplift on 2019-20 total salary
- Acting Executive Director of Strategy: 2.6% consolidated pay uplift on 2019-20 total salary
- Chief Operating Officer: 2.6% non-consolidated pay uplift on 2019-20 total salary
- Medical Director: 2.6% partly consolidated pay uplift on 2019-20 total salary*
- Director of Nursing and Therapies: salary was uplifted by £13,692, £7,192 of which was consolidated**

*The Medical Director received a 2.6% partly consolidated pay award because his remuneration was below NHS Improvement's benchmark upper quartile benchmark when compared with similar trusts.

**The Director of Nursing and Therapies was appointed to the substantive role in July 2019 and her salary was not reviewed in 2019-20. As a newly appointed Executive Director, she was appointed at the lower quartile of NHS Improvement's benchmark salaries for Chief Operating Officer. As stated above, the Appointments and Remuneration Committee has determined that the duties and accountabilities of the Director of Nursing and Therapies role are comparable to those of the Chief Operating Officer and therefore the Director of Nursing and Therapies' remuneration is based on benchmarking data for Chief Operating Officers.

Following the October 2020 meeting, NHS England and Improvement wrote to trusts with a request that Appointments and Remuneration Committees award a 1.03% consolidated pay award to all Very Senior Managers and Executives even if their salaries are at or above NHS improvement's the upper quartile benchmark point. The Appointments and Remuneration Committee met on 8 December 2020 to review their remuneration decisions in the light of NHS England and Improvement's letter. The Appointments and Remuneration Committee agreed that as the remuneration decisions had been implemented including back pay from April 2020, the Committee agreed not to change the previously agreed pay award for 2020-21 but would consider consolidating the 1.03% pay award as part of its discussions about the pay award for 2021-22.

Other very senior managers received 2.6% consolidated pay award. The only non-cash element of the most senior managers' remuneration packages is pension related benefits accrued under the NHS

Pension Scheme. Contributions are made by both the employer and employee in accordance with the rules of the Scheme.

All of the senior managers are employed on contracts of service and are substantive employees of the Trust. Their contracts are open ended employment contracts which can be terminated by the Trust by six months' notice. Other Trust staff are covered by the terms and conditions of the national NHS 'Agenda for Change' provisions.

All other Trust staff are covered by national NHS Agenda for Change and Medical and Dental pay and conditions.

The Trust Board sets the organisation's corporate objectives annually and these are used as the basis for developing personal objectives for the Chief Executive and Executive Directors. Performance is closely monitored through the year and in the context of annual appraisal.

Mark Day, Chair, Appointments and Remuneration Committee

Details of remuneration for Directors and senior managers are set out in the tables below:

Salaries and Allowances (*the following information is subject to audit)*

				2020/21						2019/20					
Name	Title	From	To	Salary and fees (in bands of £5,000) *	Taxable benefits (total to the nearest £100)	Annual performance related bonuses (in bands of £5,000)	Long-term performance related bonuses (in bands of £5,000)	Pension related benefits (in bands of £2,500)**	Total (in bands of £5,000)	Salary and fees (in bands of £5,000) *	Taxable benefits (total to the nearest £100)	Annual performance related bonuses (in bands of £5,000)	Long-term performance related bonuses (in bands of £5,000)	Pension related benefits (in bands of £2,500)**	Total (in bands of £5,000)
				£000s	£00s	£000s	£000s	£000s	£000s	£000s	£00s	£000s	£000s	£000s	£000s
Executive Directors															
Julian Emms	Chief Executive	01/04/2020	31/03/2021	205 - 210	0	0	0	125.0 - 127.5	330 - 335	205 - 210	0	0	0	40.0 - 42.5	245 - 250
Deborah Fulton	Director of Nursing & Therapies	01/04/2019	31/03/2021	145 - 150	0	0	0	110.0 - 112.5	255 - 260	125 - 130	0	0	0	147.5 - 150.0	270 - 275
Alex Gild	Dep CEO & CFO	01/04/2019	31/03/2021	155 - 160	0	0	0	57.5 - 60.0	215 - 220	155 - 160	0	0	0	145.0 - 147.5	300 - 305
Dr Minoo Irani	Medical Director	01/04/2019	31/03/2021	185 - 190	0	0	0	107.5 - 110.0	295 - 300	180 - 185	0	0	0	95.0 - 97.5	275 - 280
Kathryn MacDermott*	Acting Director of Strategy	01/12/2019	31/03/2021	115 - 120	0	0	0	67.5 - 70.0	180 - 185	35 - 40	0	0	0	0.0 - 2.5	35 - 40
Beverly Searle**	Director of Corporate Affairs	01/12/2019	31/12/2019	-	-	-	-	-	-	100 - 105	0	0	0	0.0 - 2.5	100 - 105
David Townsend	Chief Operating Officer	01/12/2019	31/03/2021	145 - 150	0	0	0	7.5 - 10.0	155 - 160	140 - 145	0	0	0	5.0 - 7.5	145 - 150
Non Executive Directors															
David Buckle	Non Executive Director	01/04/2017	31/03/2021	10 - 15	0	0	0	0	15 - 15	10 - 15	0	0	0	0	10 - 15
Naomi Coxwell	Non Executive Director	13/12/2017	31/03/2021	10 - 15	0	0	0	0	15 - 15	10 - 15	0	0	0	0	10 - 15
Mark Day	Non Executive Director	01/04/2017	31/03/2021	15 - 20	0	0	0	0	15 - 15	10 - 15	0	0	0	0	10 - 15
Martin Earwicker	Chair	01/04/2017	31/03/2021	45 - 50	0	0	0	0	45 - 50	45 - 50	0	0	0	0	45 - 50
Aileen Feeney	Non Executive Director	01/11/2019	31/03/2021	10 - 15	0	0	0	0	15 - 15	05 - 10	0	0	0	0	05 - 10
Christopher Fisher	Non Executive Director	01/04/2017	31/03/2021	10 - 15	0	0	0	0	15 - 15	15 - 20	0	0	0	0	15 - 20
Ruth Lysons***	Non Executive Director	01/04/2015	31/03/2020	-	-	-	-	-	-	05 - 10	0	0	0	0	05 - 10
Mehmuda Mian	Non Executive Director	01/06/2015	31/03/2021	10 - 15	0	0	0	0	15 - 15	10 - 15	0	0	0	0	10 - 15

Notes

*Kathryn MacDermott commenced her role as Acting Executive Director of Strategy on 10 December 2019

**Beverley Searle terminated from her appointment as Director of Corporate Affairs on 31 December 2019

***Ruth Lysons, Non-Executive Director's term of office ended on 31 October 2019

No members of the Trust Board received an annual or long-term performance related bonus in 2020-21 (2019-20 £nil)

Pension Related Benefits are calculated in accordance with the Finance Act 2004. This is commonly referred to as the "HMRC method". The amount included is based on the increase in the director's accrued pension in the year. This will generally take into account an additional year of service together with any increases in pensionable pay. This amount is then multiplied by 20 to calculate the amount to be included in the Remuneration Report.

Pension Benefits (the following information is subject to Audit)

Name	Title	From	To	Real increase in pension at pensionable age (bands of £2,500) £,000s	Real increase / (decrease) in pension lump sum at aged 60 (bands of £2,500) £,000s	Total accrued pension at pensionable age at 31 March 2021 (bands of £5,000) £,000s	Lump sum at pensionable age related to accrued pension at 31 March 2021 (bands of £5,000) £,000s	Cash Equivalent Transfer Value at 1 April 2020 £,000s	Real increase / (decrease) in Cash Equivalent Transfer Value £,000s	Cash Equivalent Transfer Value at 31 March 2021 £,000s	Employer's contribution to stakeholder pension £,000s
Executive Directors											
Julian Emms	Chief Executive	01/04/2020	31/03/2021	2.5 - 5.0	0.0 - 2.5	70 - 75	160 - 165	1,321	92	1,413	0
Deborah Fulton	Director of Nursing & Therapies	01/04/2020	31/03/2021	2.5 - 5.0	2.5 - 5.0	45 - 50	45 - 50	607	76	683	0
Alex Gild	Dep CEO & CFO	01/04/2020	31/03/2021	0.0 - 2.5	(2.5) - 0.0	50 - 55	105 - 110	806	38	844	0
Dr Minocher Irani	Medical Director	01/04/2020	31/03/2021	2.5 - 5.0	0.0 - 2.5	70 - 75	150 - 155	1,372	89	1,461	0
Kathryn MacDermott	Acting Director of Strategy	01/04/2020	31/03/2021	2.5 - 5.0	10.0 - 12.5	30 - 35	95 - 100	676	106	782	0
David Townsend	Chief Operating Officer	01/04/2020	31/03/2021	0.0 - 2.5	2.5 - 5.0	25 - 30	85 - 90	0	0	0	0

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Following the government's announcement that all public sector pension schemes will be required to provide the same indexation on the Guaranteed Minimum Pension (GMP) as on the remainder of the pension, the NHSPS has revised its method to calculate the CETV values. The real increase in CETV will therefore be impacted as it will include any increase in CETV due to the change in GMP methodology.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period. Where a member has a CETV of £0 the member has reached Normal Retirement Age.

McCloud Judgement

The 'McCloud judgment' was a Supreme Court case in which the Court ruled that the additional final salary protections that were given to certain older members of public service pension schemes were age discriminatory. The judgement applies to all public service pension schemes, including the Local Government Pension Scheme ('LGPS'), and the inequalities identified must be remedied.

The NHS Pensions Agency are still assessing the impact of the McCloud judgement in relation to changes to benefits in 2015. The benefits and related CETVs disclosed do not allow for any potential future adjustments that may arise from this judgement.

Top to Median Staff Pay Multiple (Ratio) (*the following information is subject to audit*)

The NHS Foundation Trust provides information on the ratio between the highest paid executive director compared to the median total remuneration for all employees, including agency, bank and other staff of the NHS Foundation Trust. In calculating the median total remuneration, all payments to employees that constitute salary are included, such as basic pay, and enhancements for unsocial, night-time or weekend working. Overtime is not included as that is not regarded as salary. Employer pension contributions and cash equivalent transfer value of pensions are also excluded.

In 2020-21, two employees (2019-20 three employees) received remuneration, on an annualised basis, in excess of the annualised remuneration of the highest paid director.

	2020-21	**2019/20**
Band of Highest Paid Directors Remuneration (£'000)	£205-£210	£205-£210
Median Total Remuneration	£33,221	£28,471
Remuneration Ratio	**6.23**	**7.37**

Julian Emms,
Chief Executive
11 June 2021

Staff Report

For the last several years, staff engagement has been a strategic organisational development objective for Berkshire Healthcare. We recognise the importance of high levels of staff engagement as a direct contributor to, not only patient care, the patient experience and high-quality outcomes, but also to the ability to recruit and retain our workforce.

We are really pleased that our overall rating for staff engagement in the NHS National Staff Survey has increased this year to 7.5 after from (7.3 last year). This is the highest engagement score for any combined community and mental health score and one of the best scores in the NHS.

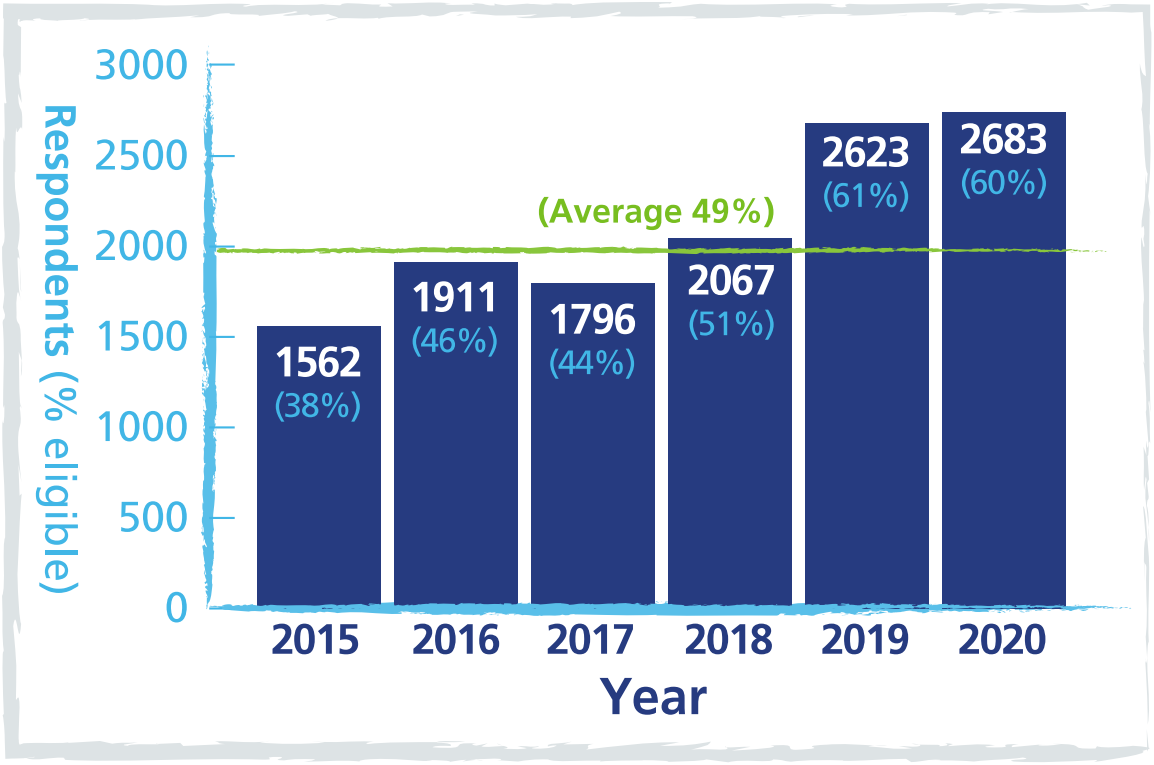
High levels of engagement start with good managers who lead with compassion and care and being part of a team with caring and supportive colleagues. We can only thrive and perform well at work if we feel engaged, valued, and physically and psychologically supported by our leaders and our colleagues. This has been particularly important during such a difficult year. The Executive Team has also held regular web briefings to ensure clear, timely and quality information reaches our people and to ensure that, as an Executive Team, they hear feedback from people and can respond to questions openly and in the moment.

NHS national staff survey			Berkshire Healthcare		
EEI	Qs	Statement	2018	2019	2020
Motivation	2a	Often/always look forward to going to work	63.2	65.8	66
	2b	Often/always enthusiastic about my job	77.8	78.6	78.3
	2c	Time often/always passes quickly when I am working	83.9	82	82.8
Advocacy	18a	Care of patients/service users is organisations top priority	82	83.9	87.7
	18c	Would recommend organisation as a place to work	68	70.4	77.8
	18d	If friends or relatives needed treatment would be happy with the standard of care provided by organisation	73.1	74.4	80.1
Involvement	4a	Opportunities to show initiative in my role	78.1	76.7	78.6
	4b	Able to make suggestions to improve the work of my team/dept	80.6	81.6	81.9
	4d	Able to make improvements happen in my area of work	64.3	65.7	66.5
Response rate	%		51	61	60

Participation Rates

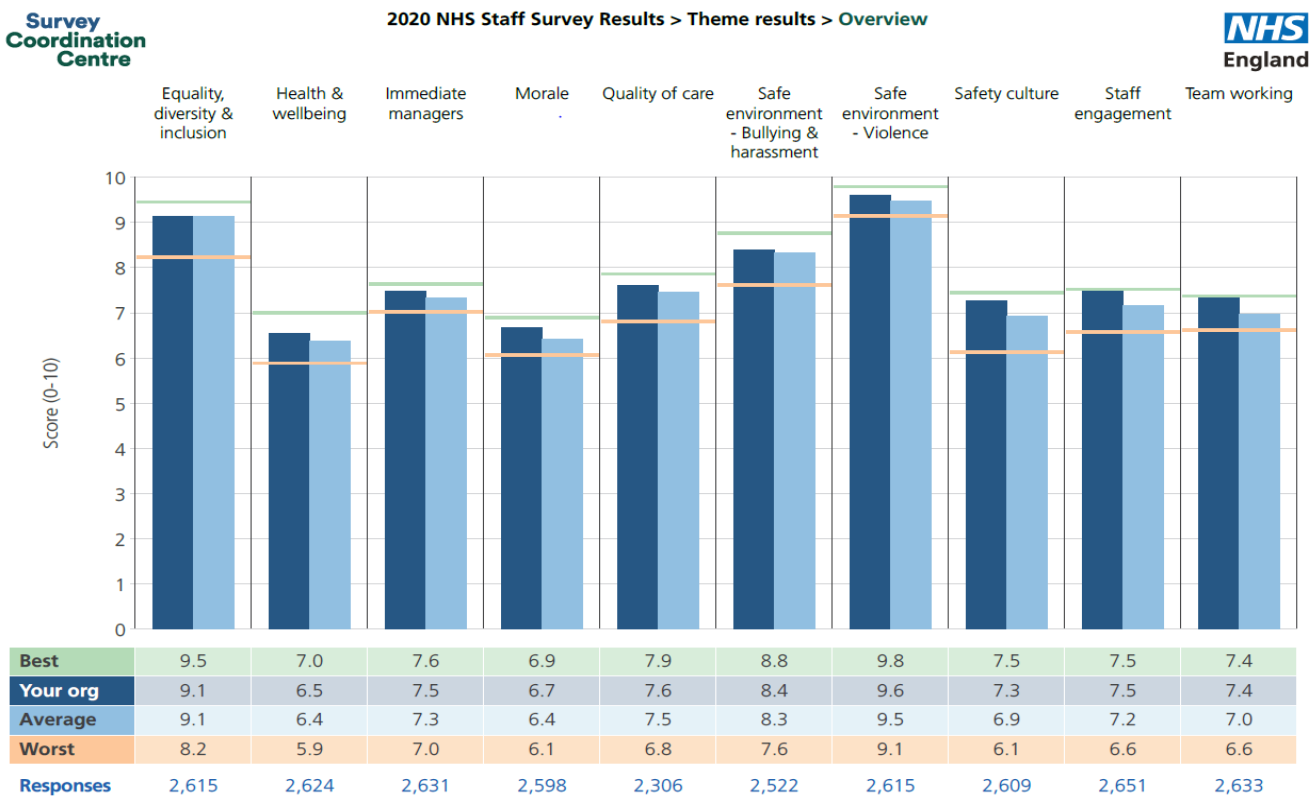
The number of staff participating in the Staff Survey has continued to increase. The percentage response rate has dropped slightly to 60% due to having higher staff numbers overall but remains well above the average percentage response rate of 49%.

The diversity of our respondents broadly reflects the diversity of our workforce. However, we do note that a greater percentage of our staff report as being LGBT and disabled in the Staff Survey than on our workforce systems. We need to address the under-reporting of our LGBT and disabled staff.



Themes

The table below shows the ten themes from the survey that give a high-level overview of the results. This year, we have again improved or sustained our score in every theme. Our scores are above average for combined Trusts in all of the themes, except equality and diversity where we are the same as the average. We recognise that a significant number of our staff from minority groups have a poorer experience and the priority of our Equality and Diversity Strategy is to address this to ensure the same outstanding experience for all.



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	7.0	7.6	6.9	7.9	8.8	9.8	7.5	7.5	7.4
Your org	9.1	6.5	7.5	6.7	7.6	8.4	9.6	7.3	7.5	7.4
Average	9.1	6.4	7.3	6.4	7.5	8.3	9.5	6.9	7.2	7.0
Worst	8.2	5.9	7.0	6.1	6.8	7.6	9.1	6.1	6.6	6.6
Responses	2,615	2,624	2,631	2,598	2,306	2,522	2,615	2,609	2,651	2,633

Two of the areas with most significant improvement this year were:

- Health and Wellbeing
- Safety Culture

The wellbeing of our people is at the centre of our organisational culture. The health and wellbeing response is heartening as it reflects the strengthened focus and support that we gave to people in response to the COVID-19 pandemic to ensure that they remained safe. This included proactive wellbeing conversations to promote early identification of potential health and wellbeing concerns; and wellbeing hubs that focus on building resilience and providing rapid psychological support to people where needed.

The increase in the Safety Culture theme is a positive response to the work we continue to do in this space. It reflects the impact of the "Speak Up" Campaign and the use of "Just Culture" principles to continuously improve patient safety. "Just Culture" is an approach which puts equal emphasis on accountability and learning. This has helped create a cultural strength in the confidence of staff to raise and learn from safety incidents. We now rank 4th in the country for all NHS trusts for safety.

Our scores for staff involvement were also some of the highest in the NHS. These scores show that people feel empowered to show initiative and make improvements in their area of work. This reflects the success of our Quality Improvement Programme launched in 2017. This well-established programme provides groups of staff and services with the training and tools to take ownership for developing and implementing the improvements to their patient care, service delivery and areas of working.

At Berkshire Healthcare, we aspire to be an outstanding organisation for everyone: our people, our patients, their families, and their carers. For the people who work here that means we want Berkshire Healthcare to be a great place to work where everyone feels they belong, can bring their true self to work and can thrive and grow

Whilst we recognise that we have very positive scores in comparison with similar Trusts, we know that there are some staff for whom the experience is not as good, and we have prioritised our focus on those areas.

The table below compares the NHS Staff Survey data for the last three years:

	2020/21		**2019/20**		**2018/19**	
	Trust	**Benchmarking Group**	**Trust**	**Benchmarking Group**	**Trust**	**Benchmarking Group**
Equality, diversity and inclusion	9.1	9.1	9.0	9.1	9.0	9.2
Health and wellbeing	6.5	6.4	6.2	6.1	6.1	6.1
Immediate managers	7.5	7.3	7.4	7.2	7.2	7.2
Morale	6.7	6.4	6.4	6.3	6.3	6.2
Quality of appraisal	N/A	N/A	6.2	5.7	5.8	5.5
Quality of care	7.6	7.5	7.5	7.4	7.4	7.4
Safe environment - bullying and harassment	8.4	8.3	8.3	8.2	8.2	8.2
safe environment - violence	9.6	9.5	9.6	9.5	9.5	9.5
Safety culture	7.3	6.9	7.2	6.8	7	6.8
Staff engagement	7.5	7.2	7.4	7.1	7.3	7
Teamworking	7.4	7.0	7.3	6.9	N/A	N/A

Other mechanisms for gathering staff feedback:

The free text section of the Staff Survey also provides vital qualitative feedback, giving us a richer understanding of our staff experience. This year the free text questions were conducted differently to previous years. This space was used to ask questions related to how people felt working through Covid-19. There were two specific questions asked:-

Q21a Thinking about your experience of working through the COVID-19 pandemic, what lessons should be learned from this time?

Q21b What worked well during COVID -19 and should be continued?

We had just over 1,800 responses to each question and the NHS Staff coordination centre will be providing an in-depth report which analyses these responses. Here are some examples of what was said:

Question 21a

"Working flexibly at home is very effective for staff wellbeing."

"Regular team meetings are supportive to the work we do but as important to our wellbeing. We are all in it together. There was more comradery. People are willing to help others that need help.

"More difficult for new staff in the organisation to get to know their team. Can feel quite lonely no matter the level of support received. Unable to shadow other members of staff so this has limited learning experiences."

Question Q21b

"Home working and flexible working is very much appreciated. It's amazing the amount of stress commuting can bring to your day."

"For me, as a person with a disability meaning I cannot drive, being able to access meetings and training remotely has improved my work/life balance and wellbeing considerably."

"Our Exec team have done everything they can to ensure clear, timely and quality information reaches us. We had weekly live briefings with all Execs present at the height of the pandemic, which can be watched at a later date, these have now dropped quite rightly to fortnightly. These are completely open we can ask any questions either anonymously or otherwise and receive an answer- these are published live. All questions and answers are then published on our intranet. Our senior managers have remained completely accessible throughout and they are clearly well supported themselves because they have managed to stay calm."

*A "typical comment" is an example piece of feedback that has been identified as statistically representative.

Engaging our People: The Next Three Years

The national NHS Staff Survey is just one mechanism for receiving feedback from our people. In order to understand the experience of our workforce, we also take into account the key workforce data that we collect regularly as part of our *People Dashboard*, feedback from exit surveys and other surveys and workshops we run throughout the year.

From this feedback, we have listened to people and developed a new People Strategy with four key priority themes and strands of work that sit below these. These priorities are:

1. Growing and retaining for the future
2. Looking after our people

3. Belonging to our organisation
4. Finding new ways of working

Through these work strands and a focus on our key priorities, we can maintain constant improvement within Berkshire Healthcare and for everyone that uses our services.

Equality, Diversity and Inclusion

We are proud of the wide diversity of our 4,500 staff and want everyone to feel valued and that they belong. However, in order to be outstanding for everyone, we need to address the unacceptable differentials in experience and identified inequalities that some staff report. Therefore, Equality, Diversity and Inclusion remains an area of focus and this year we have developed and launched a new Equality, Diversity and Inclusion Strategy to tackle the issues that some of our staff face.

Health, Wellbeing and Safety (including Bullying and Harassment)

There are 20 questions in the staff survey which cover health, wellbeing and safety at work (not including safety culture questions). Questions related to topics such as additional paid/unpaid work, work related stress, MSK health issues, attendance at work when unwell, physical violence, bullying and discrimination.

We are proud to note that, overall, our Wellbeing Score has increased from 6.2 to 6.5 which is a statistically significant increase. This means that people feel that we have offered a much higher level of wellbeing support to them this year. This reflects the priority we have given to keeping our staff healthy and well during the COVID-19. We are taking the lessons that we have learnt during COVID-19 to sustain and expand our ongoing staff wellbeing offer. This will include annual health and wellbeing assessments for everyone who works for us.

Work Pressures

Work pressure is a clear theme that continues to emerge as one of our lowest scoring questions for the Trust. This is a theme important to address but is challenging because the NHS continues to face regional and national staffing shortages creating consequent workforce pressures on people. However, this year, COVID-19 has also created specific workforce pressures including increased gaps as staff needed to shield or self-isolate as well as the greater acuity of some of our patients.

Divisional and operational teams continue to look at local working hours and pressures as a priority area. Broader organisational work is picked up by the Health and Wellbeing Group and there has been an increased focus on both the recruitment and retention of staff in key areas leading to sustained reductions in staff turnover.

Recruitment and Retention Initiatives

We want Berkshire Healthcare to be a place where people want to work and stay, and it is a Trust priority to reduce staff turnover and improve our staff retention rate. We have made this the focus of our new People Strategy and have implemented a number of initiatives which are starting to have

a positive impact. Our level of turnover as a Trust has reduced from 16% in April 2019 to 13% in February 2021.

Information about the Trust's staff turnover figures can be accessed via the NHS Digital website at: https://digital.nhs.uk/data-and-information/find-data-and-publications/supplementary-information/2018-supplementary-information-files/leavers-and-joiners/all-staff-turnover-by-region-nationality-and-age-supplementary-information

We continue to face staff shortages in key clinical areas and have focused our efforts on retaining as many of the students that we train as possible as well as exploring new recruitment pipelines.

Staff numbers (the following information is subject to audit)

Average number of employees (whole time equivalent basis)

	2020-21	2020-21	2020-21	2019-20
	Permanent	Other	Total Number	Total Number
Medical and dental	186	13	199	188
Ambulance staff	3	0	3	4
Administration and estates	612	66	678	607
Healthcare assistants and other support staff	75	161	236	79
Nursing, midwifery and health visiting staff	1,037	140	1,177	1,138
Nursing, midwifery and health visiting learners	978	23	1,001	1,104
Scientific, therapeutic and technical staff	787	38	825	776
Healthcare science staff	198	0	198	199
Total average numbers	**3,876**	**441**	**4,317**	**4,095**
Of which: Number of employees (WTE) engaged on capital projects:	14	0	14	45

Payments and Trade Union Time

Total number of employees who were relevant Trade Union officials during 2020/21

Number of employees who were relevant Trade Union officials during 2020-21	Full-time equivalent employee number
21	18.25

Table 2 - Percentage of time spent on facility time

Percentage of time relevant Trade Union officials employed by the Trust during 2020-21 spent on working on facility time:

Percentage of time	Number of employees
0%	0
1-50%	21
51-99%	0
100%	0

Table 3 - Percentage of pay bill spent on facility time

The percentage of the total pay bill spent on paying employees who were relevant Trade Union officials for facility time during 2020-21:

First Column in Table 2 above	Figures
Total cost of facility time	£22,794 (per annum)
Total pay bill	£205,224, 000 (per annum)
The percentage of the total pay bill spent on facility time.	<0.01%

The Trust does not allow Trade Union representatives to attend meetings during work time which are defined by ACAS as: “time for which there is no specific right to be paid including meeting full-time officers, attending regional or branch meetings”.

The following information is subject to audit

Compensation Schemes – Exit Packages 2020/21

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	-	4	**4**
£10,001 - £25,000	-	-	**-**
£25,001 - 50,000	2	1	**3**
£50,001 - £100,000	-	2	**2**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**2**	**7**	**9**
Total resource cost (£)	61,399	167,933	229,332

Compensation Schemes – Exit Packages 2019-20

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	1	3	**4**
£10,001 - £25,000	-	1	**1**
£25,001 - 50,000	1	-	**1**
£50,001 - £100,000	-	-	**-**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**2**	**4**	**6**
Total resource cost (£)	45,000	28,000	**73,000**

Exit packages: other (non-compulsory) departure payments

	2020-21		2019-20	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£0	Number	£0
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	3	10
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	2	112	1	18
Total	**2**	**112**	**4**	**28**

Off Payroll Arrangements Disclosure

The NHS Foundation Trust reports arrangements whereby individuals are paid through their own companies (and so are responsible for their own tax and national insurance arrangements, not being classed as Trust employees). The costs of these off-payroll engagements are recorded in the expenditure of the Trust, within consultancy costs. The Trust made zero "off payroll" payments from 1 April 2020 to 31 March 2021. The Trust's disclosure is below:

Highly paid off-payroll worker engagements as at 31 March 2021 earning £245 per day or greater

Number of existing engagements as of 31 March 2021	**0**
Of which...	
Number that have existed for less than one year at time of reporting.	0
Number that have existed for between one and two years at time of reporting.	0
Number that have existed for between two and three years at time of reporting.	0
Number that have existed for between three and four years at time of reporting.	0
Number that have existed for four or more years at time of reporting.	0

Table 2: All highly paid off-payroll workers engaged at any point during the year ended 31 March 2021 earning £245 per day or greater

Number of off-payroll workers engaged during the year ended 31 March 2021	**0**
Of which:	
Not subject to off-payroll legislation *	0
Subject to off-payroll legislation and determined as in-scope of IR35 *	0

Subject to off-payroll legislation and determined as out-of-scope of IR35 *	0
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: number of engagements that saw a change to IR35 status following review	0

* A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Trust must undertake an assessment to determine whether that worker is in scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes

Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2020 and 31 March 2021

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	**0**
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	**0**

Sickness Absence Figures

The Trust's Sickness Absence Figures are published on the NHS Digital website at: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Counter fraud activity

The Trust operates a robust arrangement for minimising the risk of fraud and meets the requirements of the Secretary of State that each health body nominate an officer to act as its Local Counter Fraud Specialist. As well as handling suspected cases of fraud, the service provides awareness and education support to help embed an 'anti-fraud' culture throughout the organisation. There is a clear policy on counter fraud together with other provisions to support staff in raising concerns about possible fraudulent activity.

Health and Safety

The Trust's arrangements for the health and safety of staff, patients, visitors and others are set out in a clear organisational policy that emphasises the organisation's commitment to providing a safe place to work and a healthy environment for all. A comprehensive suite of policies and procedures are in place to ensure that risks to the health and safety of all are minimised and these policies and procedures are reviewed regularly to ensure the effectiveness of the Trust's health and safety management system.

The Trust produces an annual Health and Safety report, which reviews the Trust's performance on a range of categories, comparing results to the previous year and national figures. Key points of note include:

- The Trust received no Enforcement Notices in 2020.

- There were 9 incidents reported under the RIDDOR regulations in the year 2020, showing a decrease of four incidents compared to 2019. Manual Handling, Assaults and Slips, Trips & Falls are the main incident types, there have been 4 COVID-19 RIDDOR reports under the criteria Case of Disease, RIDDOR reportable incidents.

- During 2020 the Trust reported 578 physical assaults against staff. This is a decrease of 48 (7.6%) compared to 2019. It also reported 426 Non-Physical Assaults against staff, an increase of 113 (36%) over the previous year.

- Four fires were reported during 2020. One was accidental and three were arson. This is a reduction of 33% on the previous year.

- Compliancy in statutory training: Fire Awareness – The number of staff trained throughout 2020 has averaged 90.75% over the year. This falls short of the Trust's target of 95% compliance.

- Compliancy in statutory training: Health & Safety - The number of staff trained throughout 2020 has averaged 95.87%. This is above the Trust's target of 90% compliance.

Julian Emms
Chief Executive

11 June 2021

COUNCIL OF GOVERNORS

The Trust's Council of Governors plays a crucial role in the governance of the Trust providing a forum through which the Board of Directors is accountable to the local community. The Council discharge a number of key responsibilities including:

- Representing the interests of the Trust's members and stakeholder organisations in the governance of the Trust
- Appointing or removing the Chair and other Non-Executive Directors
- Approving the appointment (by the Non-Executive Directors) of the Chief Executive
- Deciding the remuneration, allowances and other terms and conditions of office of the Non-Executive Directors
- Holding the Non-Executive Directors to account for the performance of the Board
- Considering the annual accounts, plus any report of the external auditor on them, and the annual report
- Appointing the External Auditors
- Developing and approving the Trust's membership strategy
- Providing views to the Board of Directors on the Trust's forward planning
- Undertaking functions requested from time to time by the Board of Directors
- Attending events in order to engage with members and the public
- Attendance at the Annual Members Meeting.

Membership of Council

During 2020/21 there were 32 positions on the Council of Governors:

- 23 elected from the public and staff constituencies
- 9 appointed from local authorities, universities and voluntary organisations

The elected governors were drawn from the following constituencies:

- Public constituency – total of 19
- Staff constituency – total of 4

The following table shows the attendance record of Governors at Council meetings during the year. Due to COVID-19 social distancing requirements, the meetings were held virtually.

Name	Constituency	Meetings attended/possible
Linda Berry	Public – Bracknell	0/2
Pat Rodgers	Public – Bracknell	0/2
Gerry Barber	Public – Bracknell	0/3
Raymond Fox	Public – West Berkshire	3/4
Verity Murricane	Public – West Berkshire	3/4
Susana Carvalho	Public – West Berkshire	3/4

Name	Constituency	Meetings attended/possible
John Barrett	Public – Windsor, Ascot & Maidenhead	4/4
Tom O'Kane	Public – Windsor, Ascot & Maidenhead	4/4
Gillian Mohamed	Public – Windsor, Ascot & Maidenhead	3/4
Amrik Banse	Public – Slough	0/4
Nigel Oliver	Public – Slough	0/4
Andrew Horne	Public – Wokingham	4/4
Joan Rosalind Moles	Public – Wokingham	4/4
David Lloyd-Williams	Public – Wokingham	0/2
Jon Wellum	Public Reading	2/2
Paul Myerscough	Public – Reading	4/4
Tom Lake	Public – Reading	4/4
Julia Prince	Staff – Clinical	3/4
Guy Dakin	Staff – Non-Clinical	4/4
June Carmichael	Staff - Non-Clinical	3/4
Natasha Berthollier	Staff – Clinical	2/4
Isabel Mattick	LA – Bracknell	3/4
Deborah Edwards	LA - Reading	4/4
Graham Bridgman	LA – West Berkshire	2/4
Atiq Sandhu	LA – Slough	0/4
Julian Shape	LA – Windsor and Maidenhead	1/4
Jenny Cheng	LA – Wokingham	3/4
Arlene Astell	Reading University	2/4
Suzanna Rose	British Red Cross	4/4
Linda Goddard	Alzheimer's Society	1/2

LA = Local Authority

During 2020-21 there were four meetings of the Council which were conducted virtually because of COIVD-19 social distancing requirements. Publicity was given through the Trust's website. From September 2020, the recording of the full Council meetings has been published on the Trust's website along with the agenda and meeting papers.

In September 2020, the Trust held a virtual Annual Members Meeting where the Trust's Annual Report and Accounts were presented.

The annual election of Lead and deputy Lead Governor also took place in September 2020 with Governors appointing Paul Myerscough as Lead Governor and appointing Susana Carvalho as Deputy Lead Governor. The Council has also put in place a structure of committees and steering groups to help fulfil its duties and each Committee reports back to the full Council at each Council meeting. The Committees/Groups are:

- Membership and Engagement Group
- Living Life to the Full Group
- Appointments and Remuneration Committee
- Quality Assurance Group

Strong working relationships continue between the Council and Board of Directors with regular engagement, involving Executive and Non-Executive Director attendance at virtual Council meetings, joint meetings between Council and the Board, including two meetings a year specifically with Non-Executive Directors. The Chief Executive attends all meetings of the full Council and other Executive Directors attend as and when required. The meetings held with Non-Executive Directors have been useful in supporting Governors to discharge their duty to hold the Non-Executive Directors to account for the performance of the Board and for seeking assurance on service quality and financial sustainability.

For new Governors joining the Trust during the year induction training was provided involving the Trust Chair and Company Secretary.

Governors have an opportunity to submit written questions in advance of the informal Joint meetings with the Trust Board and Council of Governors. The Chief Executive and other Executive Directors provide written answers to the questions at the meetings. The Chair holds regularly informal virtual "Coffee Morning" sessions which are open to all governors. This provides an opportunity for governors to raise issues with the Chair and to discuss relevant issues in between the formal meetings.

The Trust's Constitution sets out the process for the Council of Governors to remove the Trust's Chair and Non-Executive Directors in the event that all other means of engaging with the Trust Board have been exhausted.

In March 2021, the Council of Governors appointed Ernst and Young as the Trust's External Auditors from April 2021.

Farewell and welcome

In 2020-21 a number of Governors left, and we welcomed others. Whilst it is always disappointing to lose enthusiastic and experienced Governors, Council benefits immensely from the injection of different perspectives and ideas that new Governors bring.

Our thanks go to our departing Governors: Linda Berry, Public Governor, Gerry Barber, Public Governor, Pat Barker, Public Governor, David Lloyd-Williams, Susanna Carvalho, Tom Wedd, Public Governor, Linda Jacobs, Alzheimer's Society and Ruth McEwan, Reading Borough Council.

We warmly welcomed: Deborah Edwards, Reading Borough Council, Jon Wellum, Public Governor and Richard Noakes, Younger People with Dementia.

Governor Expenses

The role of Governor is unpaid; however, they are entitled to claim reimbursement of expenses, such as travel and subsistence costs. During 2021-22 no governor claimed expenses due to meetings being conducted online via Microsoft Teams.

Elections

Public and Staff Governors are elected by the membership of the relevant constituency and they serve for a period of three years. They can be re-elected and can serve for a maximum of nine consecutive years.

All elections were completed and supervised by Civica Election Services and were conducted in accordance with the Trust's Constitution.

The following position was uncontested:

Reading: Public Governor

Partnership Governors are appointed by the relevant organisation.

Register of interests

A register of interests is maintained for Governors. It is available by contacting the Trust's Company Secretary.

Membership

Berkshire Healthcare became an NHS Foundation Trust in 2007. This status allows us to make a range of decisions independently from direct government control. NHS Foundation Trusts are accountable to their staff, patients and local communities through their members and governors. All NHS Foundation Trusts have a duty to engage with their local communities and encourage local people to become members of their organisations.

As an NHS Foundation Trust, we were required to maintain a membership which is representative of the communities we serve. Our Members and Governors help us shape our plans for the future and make sure that the services we provide reflect what is needed locally.

Anyone over the age of 12 can become a member of our Trust, although we do not actively look to recruit anyone under the age of 16. The Marketing and Communications Team is currently responsible for recruiting and engaging with our membership.

Between April 2020 to March 2021, our membership numbers remained stable, decreasing by 598 from 13,028 to 12,430.

During this period, our focus has been on maintaining membership numbers rather than growing them, as we are comfortably over our target number of 10,000 members. However, we have worked closely with a range of our services to encourage them to promote membership to their patient groups.

Our staff automatically become members but can opt out if they choose to do so.

Engagement with our members

Over the last year, engagement with our members has included an invitation to attend our virtual Annual General Meeting, information about voting for governors, and quarterly digital newsletters covering key health topics and information, including COVID-19 updates, such as visiting information, changes to services and vaccination signposting.

2020 was the first year that Reading Pride has been cancelled, we were therefore unable to take part as we would have done in previous years. If it goes ahead this year, then we will be participating as we usually do. We are currently awaiting confirmation.

Our current membership numbers in each local authority are shown below.

Current public membership by local authority area on 1 April 2021

Locality	Public	% of Membership	Base	% of Locality
Bracknell	921	12.00	123,416	13.39
Reading	1,937	25.24	165,151	17.91
Slough	744	9.70	150,992	16.38
West Berkshire	735	9.58	159,855	17.34
Windsor and Maidenhead	654	8.52	151,957	16.48
Wokingham	998	13.01	170,560	18.50
Rest of England	1,406	18.32	0	0.00
Out of Trust Area	278	3.62	0	0.00
Total	**7,673**	**100**	**921,931**	**100**

Most of our members live in Berkshire, however a few live further away and have an interest in our organisation. They may be:

- carers who look after, or are responsible for, someone who uses our services
- members of staff
- someone who has moved away from the county and wishes to maintain links with us

These members are part of our 'Rest of England' constituency. The 'Out of Trust Area' category refers to members whose postcode is not recognised.

The table below shows the size of our current membership and the movement in numbers of members compared to 2019-2020.

Membership size and movements on 1 April 2021

Public constituency	2019/2020	2020/2021	Percentage change
At year start (April 1)	7,628	7,717	+1.1%
New members	158	40	-74.7%
Members leaving	69	84	+21.7%
At year end (31 March)	7,717	7,673	-0.57%
Staff constituency	**2019/2020**	**2020/2021**	**Percentage change**
At year start (April 1)	4,923	5,311	+7.8%
New members	875	716	-18%
Members leaving	487	1,270*	+160%*
At year end (31 March)	5,311	4,757	-10%

*We started a new quarterly staff data cleanse in March 2021, so the figures for the 'staff members leaving constituency' increased sharply in comparison to the year 2019-20, as shown in the table above. After this big staff data cleanse, we anticipate that our future figures will remain roughly the same.

The above table shows that fewer public members signed up in the year 2020-2021, but our total membership figures have remained consistent at around 12,000.

Public membership analysis

The following table shows our public membership by age, ethnicity, socio-economic background and gender. Membership population figures have been provided by CIVICA Group, our database provider, and are taken from the 2011 census.

The index column displays how on target we are with representing the communities we serve. A score under 100 means there is an under representation and a score above 100 indicates an over representation.

Analysis of public membership on 1 April 2021

Red indicates under representation in the particular membership

category **Green** indicates over representation in the particular

membership category

Age	No. of public members	Population	Index
0-16	6	209,390	0
17-21	128	50,762	30
22+	6,148	661,783	112
Not stated*	1,391	0	0
Age 22+	6148	661,783	112
Gender	**No. of public members**	**Population**	**Index**
Unspecified*	736	0	0
Male	2,521	459,694	66
Female	4,410	462,237	115
Other	6	0	0
Prefer not to say	0	0	0
Ethnicity	**No. of public members**	**Population**	**Index**
Asian	627	111,616	63
Black	247	29,968	93
Mixed	145	22,158	74
Other	1,228	8,250	1672
White	5,422	689,878	88

ONS/Monitor Classifications	No. of public members	Population	Index
AB	2,136	114,246	88
C1	2,203	112,957	92
C2	1,405	66,575	100
DE	1,569	68,799	110
Wellbeing Acorn Group	**No. of public members**	**Population**	**Index**
Health Challenges	651	65,531	119
At Risk	1,369	153,314	107
4Caution	2,199	240,629	110
Healthy	2898	452,472	77
Not Private Households	0	9,985	0
Not available	556	0	0
Total membership	**7,673**	100	0

*Not all members have provided full details for classification.

Plans for 2021-2022

We have been focussing on managing the COVID-19 pandemic, and as such, some of our membership activity has been temporarily paused, including the development of our membership strategy. Our strategy was due to be refreshed at the beginning of 2021 but has been put on hold. We will review our membership strategic goals and activity for the 2021-2022 period and will launch our new 2021-2024 strategy by the end of the year.

For the remainder of the 2021 calendar year, we will use our social media channels and e-newsletters to maintain levels of engagement and we'll continue to communicate key information to all our members when required. We will also be focusing on improving the quality of our public and staff member data, which will include updating key classifications such as ethnicity, to help make sure we maintain a good representation of our communities.

Contacting our Governors or Directors

Details of our Governors, as well as our Executive Directors and Non-Executive Board members, can be found in the 'About us' section of our website: www.berkshirehealthcare.nhs.uk

PUBLIC DISCLOSURES

Accounts note

NHS Improvement has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Financial Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2020-21 NHS Foundation Trust Annual Reporting Manual issued by NHS Improvement. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are

meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Cost allocation

Berkshire Healthcare NHS Foundation Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.

Berkshire Healthcare NHS Foundation Trust

Annual accounts for the year ended 31 March 2021

Foreword to the accounts

Berkshire Healthcare NHS Foundation Trust

These accounts, for the year ended 31 March 2021, have been prepared by Berkshire Healthcare NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006

Signed .....

Name **Julian Emms**
Job title **Chief Executive**
Date **11/06/2021**

Statement of accounting officer's responsibilities

Statement of the chief executive's responsibilities as the Accounting Officer of Berkshire Healthcare NHS Foundation Trust.

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Berkshire Healthcare NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Berkshire Healthcare NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum.*

Julian Emms, Chief Executive
Date: 11th June 2021

Annual Governance Statement 2020/21 – Berkshire Healthcare NHS Foundation Trust

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Berkshire Healthcare NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively, and economically. The system of internal control has been in place in Berkshire Healthcare NHS Foundation Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The existing comprehensive Risk Management Strategy has been reviewed and approved by the Executive and the Board. It has been disseminated through the Trust. The Deputy Chief Executive & Chief Financial Officer and Director of Nursing and Therapies provide overall leadership for integrated governance at Board level. The Medical Director is the Caldecott Guardian. The Deputy Chief Executive & Chief Financial Officer is the Senior Information Risk Owner.

The Chief Executive chairs the Executive Business and Finance Committee which has oversight of the Board Assurance Framework (BAF) and Corporate Risk Register (CRR). The B&F Executive Committee comprises the Deputy Chief Executive & Chief Financial Officer in their role as Chair of the Non-Clinical Risk Management Committee, the Director of Nursing and Therapies in their role as Chair of the Safety, Experience & Clinical Effectiveness Group together with the rest of the Executive Directors and senior management representatives. The Committee meets monthly and reviews the BAF and entire CRR as standing items every two months.

The Executive routinely oversees the effectiveness of all other Committees within the governance structure through the receipt of minutes and reports via each of the two Formal Executive Committees (B&F, Quality and Performance).

The Trust operates in a complex environment with many services dispersed around the county. Each service has its own Risk Register regularly reviewed through line management arrangements. The Trust's Operational Leadership Team (chaired by Chief Operating Officer) has responsibility for ensuring that all locality Risk Registers are up to date and show a true reflection of the risks that may face that service. Directors leading corporate services have the responsibility for ensuring similar Risk Registers are in place for support services. Escalation of appropriate local service level risks to the CRR is undertaken if necessary following review by the relevant Executive Director.

Risk Management training is part of the corporate induction for all new staff. In addition, all existing staff are required to undertake all mandatory training in the year, to comply with the CQC's Essential Standards of Care; this training includes Fire, Lifting and Handling and Health and Safety. Clinical staff undertake additional clinical mandatory training, which includes an update on clinical risk management.

All Policies and Procedures are published on the Trust intranet and are available to all staff. Relevant Policies include as example, Serious Untoward Incidents, Health and Safety, Infection Control, Information Governance and Freedom to Speak Up (Whistle Blowing) policy.

The Trust Audit Committee as the senior Board Sub Committee responsible for corporate governance assurance continues to review risk reporting and risk management and has done so during 2020/21. The Audit Committee continues to seek best practice guidance with which to inform it.

The risk and control framework

The Trust's Risk Strategy seeks to minimise risk to the Trust's stakeholders through a comprehensive system of internal controls, risk management and assurance processes, whilst maximising the potential for flexibility, innovation, and best practice in the delivery of its strategic objectives. It seeks to deliver high quality, safe services for service users and secure the health, safety, and welfare at work of all employees and others on the Trust premises.

The Trust uses a standardised risk assessment tool that enables risks to be graded and scored. The tool requires the individual reporting the risk to determine the risk level at the time of detection and to forecast the risk level that will be achieved following implementation of a risk mitigation plan. The risks to delivery of corporate objectives on the BAF and relevant risks on CRR have been reviewed in detail by the Board and Audit Committee during the year, with a new format BAF produced enhancing the oversight and review of risks for Board and Executive committees. The BAF risks are now routinely reviewed at Board sub-committees (quality and finance), alongside quarterly review at the Audit Committee.

The Trust recognises that it is not possible or always desirable to eliminate all risks and that systems should not stifle innovation. When all reasonable control mechanisms have been put in place some residual risk will inevitably remain in many Trust processes and this level of risk must be accepted. Risk acceptance within the Trust is systematic, explicit, and transparent. Where residual risk remains the risk will remain on the BAF, CRR or local risk register. This ensures that it is reviewed through the control systems rather than having been removed from the register and therefore out of sight.

The Safety, Experience & Clinical Effectiveness Group chaired by the Executive Director of Nursing & Therapies provides oversight for quality governance arrangements within the Trust; Divisional Patient Safety and Quality Groups provide service reporting oversight, these groups report to the Quality and Performance Executive Committee chaired by the CEO and is the lead Executive committee for assuring the quality and safety of services, through to the Board Quality Assurance Committee and the Audit Committee, with the Audit Committee providing overall governance assurance and scrutiny.

Routine assurance of compliance with CQC registration requirements and fundamental standards of care is undertaken by the Divisional Patient Safety and Quality Groups. Clinical services review their compliance with CQC standards annually with assurance provided to the Executive (through receipt of reports at the Quality and Performance Executive Committee) and Board (through the work of the Quality Assurance Committee) of the quality of care and compliance with regulations. Where recommendations for improvement arise from the internal inspections, service level action plans are developed and followed up to ensure continuous improvement.

The Trust was subject to core services and well led inspections by the CQC in November and December 2019, which in March 2020 resulted in an “Outstanding” overall rating for the organisation and its services. The Trust achieved “Good” ratings across inspection domains for Safety, Effectiveness and Caring. The Trust was rated ‘Outstanding’ in the Responsive and Well Led domains, confirming the leadership and governance arrangements within the Trust are of a high quality and robust. This is the second year running the Trust has been rated “Outstanding” in the well led domain.

Performance information related to quality and patient safety metrics are reviewed and cross referenced with other intelligence available to the governance team prior to inclusion in Trust performance and quality reporting. The metrics are regularly reviewed with the governance and performance team. Governance of data quality in relation to quality metrics is overseen by the Audit Committee through review of the Trust’s Information Assurance Framework.
The Trust completes the Data Security and Protection Toolkit each year and in this year has achieved a “standards exceeded” green rating, supported by over 95% of staff completing annual information governance training.

Ultimate responsibility for Information Security rests with the Chief Executive of the Trust. This responsibility is delegated to the Deputy Chief Executive & Chief Financial Officer as SIRO. Responsibility is further delegated to all staff developing, introducing, managing, and using information and information technology systems through the medium of the Information Governance policy.

The Trust IT Compliance & Audit Manager is responsible for the co-ordination of all aspects of computer security and for ensuring that the Trust Information Governance Policy and practice is consistent with those defined and published by the NHS.

Service managers are responsible for the protection of all information and information technology assets within their department.

Line Managers are responsible for ensuring that their permanent and temporary staff and contractors are aware of the following:

- The information security policies applicable in their work areas.
- Their personal responsibilities for information security.
- How to access advice on information security matters.

All staff must comply with Information Governance security procedures including the maintenance of data confidentiality and data integrity. Failure to do so may result in disciplinary action. The Information Security Policy is maintained, reviewed, and updated by the Trust. This review takes place annually.

Contracts with external contractors that allow access to the Trust's information systems must always be in operation before access is allowed. These contracts will ensure that the staff or sub-contractors of the external organisation will comply with all appropriate security and confidentiality policies.

The Trust is ever conscious of cyber security risk and is performing strongly against NHS Improvement's cyber security standards and achieved cyber essentials plus re-accreditation in 2020/21. The Trust also welcomed the ICO during 2020/21 to review cyber security and information governance arrangements, receiving a high assurance audit rating from the ICO team in both domains. The Executive Committee, Audit Committee and Board receive regular updates on risks and mitigations in this area.

The BAF contains the following key business and operating risks (in year and future):

Key Risk	**How they are managed / mitigated**
Failure to recruit, retain and develop the right people in the right roles at the right time and at the right cost could impact on our ability to meet our commitment to providing safe, compassionate, high quality care and a good patient experience for our service users	• Development of People and Equality, Diversity and Inclusion Strategies approved by Board in November 2020 • Strategic People Group and Diversity Steering Group provides oversight of this work monthly • FIP reporting of recruitment and retention
Failure to achieve system defined target efficiency and cost base benchmarks lead to an impact on funding flows to the Trust, and underlying cost base exceeding funding. Risk is described in the context of system funding allocations (CCG, spec comm budgets etc) being allocated and controlled at ICS level, flowing to providers on a risk share and/or relative efficiency basis	• The Trust has delivered better than plan in 2020/21. • Trust planning and delivering expenditure and resources within system funding allocations
There is a risk that the Integrated Care Systems may not deliver the transformational change required to meet the healthcare needs of the population because of the need to focus on the COVID-19 response which would impact the pace of the Trust's work to re-model the way services	• Strong Trust representation on both the East and West Integrated Care Systems • Trust participation in the development of the Five-Year System Plans • Trust is lead for BOB ICS on Ageing Well programme, developing community

are delivered	services to meet new national response targets of 2-hour crisis and 2-day rehab. • Trust CEO chairs Frimley ICS people programme board and Berkshire West ICP executive, where system priorities alongside covid response are being determined.
There is a risk that other providers may acquire the Trust's adult and children's community services which would impact organisational sustainability and reduce the Trust's scope to develop new models of out of hospital care	• Robust business development and horizon scanning process in place • Decision making tool aligned with the Quality Improvement Programme in place to assess whether to bid for individual tender opportunities • Programme of regular meetings with the Commissioners • Trust participation in Clinical Networks
There is a risk that the changes to Integrated Care Systems and the Commissioning landscape may destabilise the collaborative working relationships with key strategic partners that have been in place resulting in the Trust losing influence in key decisions leading to less effective services for local people There is a risk that the development of Provider Collaboratives may divert management and clinical time and resources from front line service delivery. There is a risk that not participating in the development of the Provider Collaboratives will weaken the influence of the Trust in future decisions	• Senior management focused on provider collaboration development and value add across a range of initiatives, including Thames Valley mental health forensic and CAMHS inpatients services, MSK and chronic pain management pathway developments. This is alongside pre-existing partnership collaboration with LAs, acute and primary care • CEO and senior management directly engaged and influencing in White Paper directed transition of integrated care systems for both BOB and Frimley.
There is a risk of a rise in demand for community and mental health services and a lack of available capacity will have a significant adverse impact on some services. Services have been impacted by the pandemic which has led to an increase in the number of services with demand challenges and the need for response to unmet and increased activity. The services with the greatest risk are Mental Health Inpatient, Community Nursing, Neurodiversity (ASD & ADHD) and Common Point of Entry currently	• Project work on PICU demand and 60day+ length of stay is being progressed by PPH team using QI methodology. • 21/22 investment agreed with commissioners to improve wait times for CAMHS ASD/ADHD services as required by CQC • Workforce Strategy has been developed and presented to board Focussed support for recruitment & retention continues for services that have workforce gaps • The development of a new Emotionally Unstable Personality Disorder Pathway is progressing and on track with roll out of all elements of new pathway scheduled for early 21/22 • QI Strategic Initiative underway to review demand and capacity of clinical services. Project team in place. A3 completed. Goals to provide planning tool, dashboard, improve position for "stressed" services and develop capability to avoid and reduce impacts.
Trust network and infrastructure at risk of malware attack which could compromise systems leading to unavailability of clinical systems, loss of data, ransom demands for data and mass disruption	• The Trust has achieved Cyber Essentials Plus re-accreditation • Latest anti-malware software is installed on all computers and servers

	• Alerts are received from NHS Digital regarding the high priority vulnerabilities requiring attention • External hosting arrangements are risk assessed and cyber security obligations built into the contracts. • ICO audit in 2020 gave high assurance to cyber security and information governance arrangements
COVID 19 and planning for potential future infection surge 1. There is a risk that the Trust may be unable to maintain the standards of safe and high-quality care for patients we aspire to as an organisation because of the challenges of responding to potential further waves of COVID-19. 2. There is a risk that there may be insufficient staff to provide safe care due to staff acquiring Covid 19 infection (asymptomatic and symptomatic) or having to self-isolate. 3. There is a risk that staff who have chosen not to or are unable to have the Covid 19 vaccine could potentially transmit infection to patients and other staff in the trust. 4. There is a risk that lessons from previous Covid infection surges will not be fully learned and essential improvements may not be implemented as population infection rates reduce 5. There is a risk that patients have an adverse outcome resulting from unmet healthcare needs and waiting times because of Covid 19 surge pressure on services. There is a risk that the Trust may be unable to maintain the standards of safe and high-quality care for patients we aspire to as an organisation because of the challenges of managing services during future waves of the COVID-19 pandemic where staff in medium and low priority services may have to be redeployed to support critical and high priority services. Routine face to face appointments have been replaced with remote consultations were appropriate. Urgent face to face and crisis appointments have continued throughout. The impact of COVID-19 on services and staff and their ability to remain resilient and at work needs to be a continued focus.	• Non-patient facing staff have been able to work at home • Fortnightly virtual all staff Teams live meetings ensure that staff are informed and have a means to ask questions • Sufficient central supply of Personal Protective Equipment • Online and telephone consultations have enabled service users to access services • Surge and Winter Planning Task and Finish Group established led by Regional Director (West) • Systems established Winter planning processes in place • Lateral-flow self-testing commenced week beginning 23 November 2020 • Sit Rep process is in place • System reporting to Public Health England also in place • Staff vaccination uptake monitored this enables targeted approach to support where uptake is lower for example by service or ethnic groups

The above BAF risks can also be deemed to be “principal” risks to maintaining the NHS Foundation Trust licence condition 4 (FT governance). Further risk control and mitigation assurance is described throughout this Annual Governance Statement in terms of the governance structures and processes (Board and Executive and local level) that the Trust operates to minimise risk against this operating licence condition.

Risk management is embedded in the organisation through for example a locality represented environment, health & safety committee reporting into the Executive non-clinical risk committee. Local risk registers are directly managed at business unit and service level with local risks and mitigation overseen by and reported up through the Operational and Senior Leadership Teams for escalation

through to an Executive Director and the BAF / Corporate Risk Register. Local risk registers are used as a key business planning tool supporting service delivery.

Incident reporting enables the Trust to understand and manage risks associated with patients and staff. Incidents, investigation outcomes and trends are reviewed and discussed at business unit and service level and reported to the Quality and Performance Executive Committee with Board level scrutiny undertaken by the Finance, Audit and Quality Assurance Committees. Reporting trends are monitored to ensure all services in the Trust are reporting and if concerns are raised staff are reminded of their responsibility to report. As learning outcomes are shared across the organisation staff can see the value of reporting and the resulting change.

As a Foundation Trust the Board of Directors is accountable to the Council of Governors. The Trust's Council comprises a mix of appointed and publicly elected Governors. The Board provides the Council with information on key strategic risks and performance at each Council meeting. In addition the Trust reports all Serious Incidents to the Commissioners as part of the contractual arrangements and works with Local Authority Health Overview and Scrutiny Committees and Health and Wellbeing Boards to address issues raised by the public and/or local councillors.

The Trust has mechanisms in place to assure the Trust Board that workforce issues are a focus and priority.

Each month key workforce data including turnover, vacancies, sickness, appraisals, and training are reported to the Executive Quality and Performance committee and the reports from this meeting are reviewed at the Finance, Investment & Performance sub-committee of the Board. The Board also receives a six-monthly report on formal HR processes including disciplinary and grievance activity.

Alongside workforce metrics, committees also review the monthly Safe Staffing report, which includes a declaration from the Director of Nursing and Therapies. Our staffing levels are reviewed and any changes to staffing and skill-mix are supported by a QIA. An incident reporting system is used to report risks from reduced staffing and processes are in place to support escalation and actions to mitigate risk.

The Finance, Investment and Performance committee reviews turnover and retention workstreams/assurance. Biannually a report is submitted to the Trust Board covering key elements of the People (Workforce) Strategy, and progress on actions. The Deputy Chief Executive and Director of People attend the Board to present the report and take any questions, feedback, and respond to concerns. The People Strategy covers all aspects of the workforce and the report explains what we are doing today to resolve current issues, and what the plans are for managing longer term issues and those priority areas identified in the NHS Long term Plan and the workforce risk on the Board Assurance Framework.

Every six months a detailed safe staffing report is presented to the Quality and Performance Executive Committee and the Board, this report details use of evidence-based tools (where they exist), professional judgement, outcomes alongside other staff and workforce data to provide a triangulated view of safe staffing.

The Board Assurance Framework captures the risks associated with the workforce and currently identifies the recruitment and retention of the workforce as a key priority. This risk is discussed at the monthly Strategic People Group, attended by Divisional Directors and some Service Leads. The risks are discussed, and mitigations are agreed and reported back through Executive Committee to the Trust Board.

If a concern arises then a Non-Executive may lead a discussion with Executive Directors and other key individuals. After one such discussion, the Director of People reports quarterly to the Finance, Investment and Performance Board on retention actions, impact, and metrics. The Board has appointed a Non-Executive Wellbeing Guardian to provide scrutiny and assurance to the work of the Trust in support of our staff and the requirements of the NHS People plan.

The paragraph immediately below this one is prescribed wording for this governance statement (alternative being “is fully compliant”), in relation to specific “must do” compliance actions identified in our CQC Outstanding rating inspection report.

The foundation trust is not fully compliant with the registration requirements of the Care Quality Commission.

The foundation trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months as required by the guidance.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. The foundation trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency, and effectiveness of the use of resources

The Board of Directors receives a report on key performance indicators at its formal public meetings. These indicators cover service activity, quality, patient safety and cost as well as the patient experience. In addition, there are indicators that monitor the utilisation of the workforce and key assets.

The Finance, Investment & Performance sub-committee of the Board scrutinises this financial and performance information in detail on a regular basis, providing further assurance to the Board of Directors.

The Business and Finance Executive committee review and scrutinises monthly performance and signals where further work needs to be undertaken to understand the data and/or improve performance. The Operational Leadership Team's divisional performance review meetings chaired by the Chief Operating Officer, review service performance routinely and drill down to individual service lines.

The above system ensures that the Trust performs within the agreed parameters of economy, efficiency and effectiveness and should those parameters be breached, is able to quickly identify issues and put in place plans to improve performance.

Through the audit programme internal and external audit provide further external assurance to the Board on economy, efficiency, and effectiveness of use of resources.

Information governance

The Trust had one reportable incident in the 2020/21 which was notified to the ICO.

A Health Visitor had a virtual meeting with a family, this was a split meeting due to mother and child being in refuge, the father joined only the first part of the meeting. At the start of the meeting the Health Visitor introduced herself including the locality she covers. The father then came to the area and found the refuge the mother and child were in. The mother and child were moved to a new refuge in another area to safeguard them.

Following consultation with the ICO no further action was taken due to the individual circumstances of the case, the Health Visitor did not directly disclose the placement of the mother and child, even without introducing the locality she covers the father would still have been aware that he was meeting with Berkshire Healthcare Trust and would have been able to easily find that we only provide Health Visiting services in four localities, so there is a high chance, with how determined the father was to find them, this still would have happened without the Health Visitor naming a locality. The father had

already, with minimal information in another area under another organisation, already tracked the mother and child down causing them to be moved into our area.

The Trust also proactively reported two information governance breaches and one information security issue which were not formally reportable but the Trust made the decision to notify the ICO for transparency. No action was taken by the ICO on these and they were not investigated outside of the local Trust incident investigation and review processes.

The Trust continues to support services reporting breaches of all severity levels, the Information Governance Team review and grade all breaches and for those which are not notifiable to the ICO the local teams manage review, actions and learning from these with the IG Team monitoring any reoccurring breach types as teams and individuals making repeat breaches to take appropriate supportive action as required.

Data quality and governance

- The Deputy Chief Executive & Chief Financial Officer is responsible for data quality processes and assurance.

- The Board and Executive level integrated performance report is underpinned by data recording and monitoring systems.

- The governance of data quality is overseen by the Audit Committee and Business and Finance executive committee, which reviews improvement progress in the Trust's Information Assurance Framework.

- The Information Assurance Framework identifies the critical local and national performance indicators across safety, quality, and finance that governance committees of the Trust require data quality assurance of.

- The framework oversees a quarterly process of data source assurance and in-depth data quality audits undertaken by our internal data quality team, with feedback and improvement action followed up to improve completeness and accuracy of data.

- Internal team reviews are supplemented by internal and external audit reviews of data quality.

- The Trust is very high scoring on the national data quality maturity index for Trust collected and returned data via national minimum datasets.

- Staff using Trust information systems to record data are trained and supervised in the use of systems and accurate and timely recording, supported by policies and operating procedures.

The Board and senior management team gains further assurance on service quality via visits to divisions to review delivery of the quality agenda and reviewing feedback from patient and staff surveys, safety, and outcome reports to Trust board.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The process that has been applied in maintaining and reviewing the effectiveness of the system of internal control has been supported by:

- NHSI: Single Oversight Framework Segmentation
- Regular review of strategic-level risks and the BAF by the Executive, Audit and Board sub Committees, and the Board of Directors;
- The Audit Committee in delivering its agreed Audit plan and maintaining a senior oversight of the activity of Board sub committees within the Trust's governance structure;
- The Executive Business and Finance Committee and Executive oversight of the Governance structure;
- Executive responsibility for the delivery of effectiveness, efficiency, and economy;
- Detailed processes undertaken by the Executive to verify compliance with CQC registration and NHS Foundation Trust Licence Conditions.
- Attainment of 'Outstanding' overall core services rating from the November 2019 CQC inspection, and 'Outstanding' for Well Led.
- Review of feedback from Staff and Patient Surveys
- Positive assurance rating provided by internal audit on arrangements for risk management and BAF

The Trust's internal auditors, RSM have provided the following positive head of internal audit opinion for the 12 months ended 31st March 2021:

"The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective"

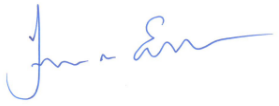
In providing this positive opinion RSM did not highlight any issues that needed to be reported in this governance statement.

The Trust and RSM have undertaken a range of reviews of financial, clinical, and operational issues during the year including board assurance framework & corporate risk register and mandatory Information governance audits.

Audit recommendations are reviewed by the Audit Committee and are implemented according to an agreed timescale. Regular reviews are undertaken by the internal auditors to ensure any actions have been delivered as agreed.

Conclusion

No significant internal control issues have been identified by the Trust in 2020/21 and the Trust's Annual Governance Statement is a balanced reflection of the management position throughout the year.



Signed……..

Chief Executive Date: 11/06/2021

Independent auditor's report to the Council of Governors and Board of Directors of Berkshire Healthcare NHS Foundation Trust

Report on the audit of the financial statements

Opinion

In our opinion the financial statements of Berkshire Healthcare NHS Foundation Trust (the 'foundation trust'):

- give a true and fair view of the state of the foundation trust's affairs as at 31 March 2021 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We have audited the financial statements which comprise:

- the statement of comprehensive income;
- the statement of financial position;
- the statement of changes in taxpayers' equity;
- the statement of cash flows; and
- the related notes 1 to 25.

We have also audited the information in the Remuneration Report and Staff Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes on page 71;
- the table of pension benefits of senior managers on page 72;
- the table of pay multiples on page 74; and
- the table of exit packages on page 83.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)), the Code of Audit Practice and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the foundation trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern
In auditing the financial statements, we have concluded that the accounting officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the foundation trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this report.

The going concern basis of accounting for the foundation trust is adopted in consideration of the requirements set out in the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts , which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it anticipated that the services which they provide will continue into the future.

Other information
The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The accounting officer is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Responsibilities of accounting officer
As explained more fully in the statement of accounting officer's responsibilities, the accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the foundation trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the foundation trust without the transfer of the foundation trust's services to another public sector entity.

Auditor's responsibilities for the audit of the financial statements
Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Extent to which the audit was considered capable of detecting non-compliance with laws and regulations, including fraud
We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of non-compliance with laws and regulations, including fraud. The extent to which our procedures are capable of detecting non-compliance with laws and regulations, including fraud is detailed below.

We considered the nature of the foundation trust and its control environment, and reviewed the foundation trust's documentation of their policies and procedures relating to fraud and compliance with laws and regulations. We also enquired of management , internal audit and local counter fraud about their own identification and assessment of the risks of non-compliance with laws and regulations.

We obtained an understanding of the legal and regulatory framework that the foundation trust operates in, and identified the key laws and regulations that:

- had a direct effect on the determination of material amounts and disclosures in the financial statements. This included the National Health Service Act 2006.
- do not have a direct effect on the financial statements but compliance with which may be fundamental to the foundation trust's ability to operate or to avoid a material penalty. These included the Data Protection Act 2018 and relevant employment legislation.

We discussed among the audit engagement team including relevant internal specialists such as valuations and IT specialists regarding the opportunities and incentives that may exist within the organisation for fraud and how and where fraud might occur in the financial statements.

As a result of performing the above, we identified the greatest potential for fraud in the following areas, and our specific procedures performed to address it are described below:

- accruals and deferred income recorded at 31 March 2021 and the timing of their recognition at year-end is subject to potential management bias: we tested a sample of accruals to supporting documentation to assess whether the liability had been incurred as at 31 March 2021; we reviewed movements in the largest accruals year on year and evaluated for consistency with our understanding of the Trust and, where

considered appropriate, corroborated the reason for movement to supporting information; we performed testing for unrecorded liabilities based on payments made and expenses recorded in the period after year end up to the date of signing; we tested a sample of deferred income items to supporting documentation and evaluated management's assessment as to whether the criteria for revenue recognition had been met as at 31 March 2021 and the value to be deferred.

In common with all audits under ISAs (UK), we are also required to perform specific procedures to respond to the risk of management override. In addressing the risk of fraud through management override of controls, we tested the appropriateness of journal entries and other adjustments; assessed whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluated the business rationale of any significant transactions that are unusual or outside the normal course of business.

In addition to the above, our procedures to respond to the risks identified included the following:

- reviewing financial statement disclosures by testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described as having a direct effect on the financial statements;
- performing analytical procedures to identify any unusual or unexpected relationships that may indicate risks of material misstatement due to fraud;
- enquiring of management, internal audit and external legal counsel concerning actual and potential litigation and claims, and instances of non-compliance with laws and regulations;
- enquiring of the local counter fraud specialist and review of local counter fraud reports produced; and
- reading minutes of meetings of those charged with governance, and reviewing internal audit reports.

Report on other legal and regulatory requirements

Opinions on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the parts of the Remuneration Report and Staff Report subject to audit have been prepared properly in accordance with the National Health Service Act 2006; and
- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Use of resources

Under the Code of Audit Practice and Schedule 10(1(d)) of the National Health Service Act 2006 , we are required to report to you if we have not been able to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Our work in respect of the foundation trust's arrangements is not complete at the date of our report on the financial statements. We will report the outcome of our work on the foundation trust's arrangements and include any additional exception reporting in respect of significant weaknesses in our audit completion certificate and our separate Auditor's Annual Report. We are satisfied that the remaining work is unlikely to have a material impact on the financial statements.

Respective responsibilities of the accounting officer and auditor relating to the foundation trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

The accounting officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the use of the foundation trust's resources.

We are required under the Code of Audit Practice and Schedule 10(1(d)) of the National Health Service Act 2006 to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our work in accordance with the Code of Audit Practice, having regard to the guidance, published by the Comptroller & Auditor General in April 2021, as to whether the foundation trust has proper arrangements for securing economy, efficiency and effectiveness in the use of resources against the specified criteria of financial sustainability, governance, and improving economy, efficiency and effectiveness.

The Comptroller & Auditor General has determined that under the Code of Audit Practice, we discharge this responsibility by reporting by exception if we have reported to the foundation trust a significant weakness in arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021 by the time of the issue of our audit report. Other findings from our work, including our commentary on the foundation trust's arrangements, will be reported in our separate Auditor's Annual Report.

Annual Governance Statement and compilation of financial statements

Under the Code of Audit Practice, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit; or
- proper practices have not been observed in the compilation of the financial statements.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in respect of these matters.

Reports in the public interest or to the regulator

Under the Code of Audit Practice, we are also required to report to you if:

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the foundation trust, or a director or officer of the foundation trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

We have nothing to report in respect of these matters.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have completed our work in respect of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (as reported in the Matters on which we are required to report by exception – Use of resources section of our report). We are satisfied that our remaining work in this area is unlikely to have a material impact on the financial statements.

Use of our report

This report is made solely to the Council of Governors and the Board of Directors ("the Boards") of Berkshire Healthcare NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Ben Sheriff FCA (Key Audit Partner)

For and on behalf of Deloitte LLP

Appointed Auditor

St Albans, United Kingdom

14 June 2021

Independent auditor's certificate of completion of the audit to the council of governors and board of directors of Berkshire Healthcare NHS Foundation Trust

Issue of opinion on the audit of the financial statements

In our audit report for the year ended 31 March 2021 issued on 14 June 2021 we reported that, in our opinion, the financial statements:

- gave a true and fair view of the state of the foundation trust's affairs as at 31 March 2021 and income and expenditure for the year then ended;
- had been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and
- had been prepared in accordance with the requirements of the National Health Service Act 2006.

Foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

As part of our audit, we are required to report to you if we are not able to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

As at the date of issue of our audit report for the year ended 31 March 2021 on 14 June 2021, we had not completed our work on the foundation trust's arrangements and had nothing to report in respect of this matter as at that date.

Certificate of completion of the audit

In our audit report for the year ended 31 March 2021 issued on 14 June 2021, we explained that we could not formally conclude the audit on that date until we had completed our work in respect of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have now completed our work in this area.

No matters have come to our attention since that date that would have a material impact on the financial statements on which we gave our opinion.

We have nothing to report in respect of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

We certify that we have completed the audit of Berkshire Healthcare NHS Foundation Trust in accordance with requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Ben Sheriff (Senior Statutory Auditor)
For and on behalf of Deloitte LLP
Appointed Auditor
St Albans, United Kingdom
7 September 2021

Statement of Comprehensive Income
For the Year ended 31 March 2021

	Note	2020/21 £000	2019/20 £000
Operating income from patient care activities	3	274,671	253,210
Other operating income	4	26,528	22,684
Total operating income from continuing operations		**301,199**	**275,894**
Operating expenses	5.1, 7	(295,400)	(269,509)
Operating surplus from continuing operations		**5,799**	**6,385**
Finance income	9	6	186
Finance expenses	10	(3,989)	(3,915)
PDC dividends payable		(883)	(1,697)
Net finance costs		**(4,866)**	**(5,426)**
Surplus for the year from continuing operations		**933**	**959**
Other comprehensive expenditure			
Will not be reclassified to income and expenditure:			
Impairments	6	(1,810)	(3,023)
Revaluations	12.1	379	176
Other reserve movements		(1)	(1)
Total other comprehensive expenditure		**(1,432)**	**(2,848)**
Total comprehensive expense for the period		**(499)**	**(1,889)**

Statement of Financial Position as at 31 March 2021

	Note	31 March 2021 £000	31 March 2020 £000
Non-current assets			
Intangible assets	11.1	5,372	6,797
Property, plant and equipment	12.1	93,879	94,839
Total non-current assets		**99,251**	**101,637**
Current assets			
Inventories	13	160	171
Trade and other receivables	14.1	9,385	11,413
Cash and cash equivalents	15.1	39,097	26,406
Total current assets		**48,642**	**37,990**
Current liabilities			
Trade and other payables	16.1	(29,659)	(24,760)
Other liabilities	17.1	(6,215)	(2,492)
Borrowings	18	(1,569)	(1,467)
Provisions	19.1	(455)	(247)
Total current liabilities		**(37,898)**	**(28,966)**
Total assets less current liabilities		**109,995**	**110,661**
Non-current liabilities			
Borrowings	18	(25,465)	(27,034)
Provisions	19.1	(2,549)	(1,939)
Total non-current liabilities		**(28,014)**	**(28,973)**
Total assets employed		**81,981**	**81,687**
Financed by			
Public dividend capital		20,021	19,228
Revaluation reserve		31,962	33,393
Income and expenditure reserve		29,998	29,066
Total taxpayers' equity		**81,981**	**81,687**

The notes on pages 119 to 163 form part of these accounts.

Name Julian Emms
Position Chief Executive
Date 11th June 2021

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2021

	Note	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2020 - brought forward		**19,228**	**33,393**	**29,066**	**81,687**
Comprehensive Expense					
Surplus for the year				933	**933**
- Impairments	6	-	(1,810)	-	**(1,810)**
- Revaluations	12.1	-	379	-	**379**
Total Comprehensive Expense		**-**	**(1,431)**	**933**	**(498)**
Public dividend capital received		793	-	-	**793**
Other reserve movements		-	-	(1)	**(1)**
Taxpayers' and others' equity at 31 March 2021		**20,021**	**31,962**	**29,998**	**81,981**

Statement of Changes in Equity for the year ended 31 March 2020

	Note	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2019 - brought forward		**18,029**	**36,240**	**28,108**	**82,377**
Comprehensive Expense					
Surplus for the year				959	**959**
- Impairments	6	-	(3,023)	-	**(3,023)**
- Revaluations	12.1	-	176	-	**176**
Total Comprehensive Expense		**-**	**(2,847)**	**959**	**(1,888)**
Public dividend capital received		1,199	-	-	**1,199**
Other reserve movements		-	-	(1)	**(1)**
Taxpayers' and others' equity at 31 March 2020		**19,228**	**33,393**	**29,066**	**81,687**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. Additional PDC may also be issued to NHS foundation trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable to the Department of Health and Social Care as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the NHS foundation trust.

Statement of Cash Flows
For the Year ended 31 March 2021

	Note	2020/21 £000	2019/20 £000
Cash flows from operating activities			
Operating surplus		5,799	6,385
Non-cash income and expense:			
Depreciation and amortisation	5.1	7,956	6,794
Net impairments	6	1,459	1,703
Income recognised in respect of capital donations	4	(5)	-
Decrease in receivables and other assets		2,173	657
Decrease/(increase) in inventories		11	(21)
Increase in trade and other payables		4,419	437
Increase in other liabilities		3,723	203
Increase in provisions		697	152
Other movements in operating cash flows		(1)	(1)
Net cash used in operating activities		**26,232**	**16,309**
Cash flows used in investing activities			
Interest received		6	186
Purchase of intangible assets		(890)	(2,899)
Purchase of property, plant, equipment and investment property		(6,971)	(6,943)
Receipt of cash donations to purchase capital assets		5	-
Net cash used in investing activities		**(7,850)**	**(9,656)**
Cash flows from financing activities			
Public dividend capital received		793	1,199
Capital element of PFI, LIFT and other service concession payments		(1,467)	(1,234)
Interest paid on PFI, LIFT and other service concession obligations		(3,989)	(3,755)
PDC dividend paid		(1,028)	(2,054)
Net cash used in financing activities		**(5,691)**	**(5,844)**
Increase/(decrease) in cash and cash equivalents		**12,691**	**809**
Cash and cash equivalents at 1 April		**26,406**	**25,597**
Cash and cash equivalents at 31 March	15.1	**39,097**	**26,406**

NOTES TO THE ACCOUNTS

Note 1 Accounting policies and other information

1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2020/21 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Standards, amendments and interpretations in issue but not yet effective or adopted

Accounting standards that have been issued but have not yet been adopted.

The Department of Health Government Accounting Manual (GAM) does not require the following Standards and Interpretations to be applied in 2020/21. These standards are still subject to HM Treasury FReM adoption and are therefore not applicable to DH group accounts in 2020/21.

- **IFRS 16 Leases** - will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

  IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the trust will not recognise a right of use asset or lease liability for short-term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

- **IFRS 17 Insurance Contracts** – Application required for accounting periods beginning on or after 1 January 2023, but not yet adopted by the FReM: early adoption is not therefore permitted.

- **IFRS 14 Regulatory Deferral Accounts**, Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DHSC group bodies. The European Financial Reporting Advisory Group recommended in October 2015 that the Standard should not be endorsed as it is unlikely to be adopted by many EU countries.

The Foundation Trust will assess the impact of these standards after issue of the Annual Reporting Manual 2021/22 by NHS Improvement.

1.2.1 Early adoption of standards, amendments and interpretations.

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

1.3 Critical accounting estimates and judgements

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Critical accounting judgements

• Income is derived by block contract from Clinical Commissioning Groups and NHS England and the Unitary Authorities of Berkshire. All these contracts are subject to variations which may result in judgements being made by management on the timing and amount of income to be allocated to the correct financial reporting year. Other income is received for Education & Training and Research & Development, where the level of income recognised is subject to judgement made by management on the terms and conditions of those contracts and the expenditure which may not be evenly distributed through the financial year.

Key Sources of Estimation Uncertainty

The judgements and key sources of estimation uncertainty that have a significant effect on the material amounts recognised in the financial statements in the current or next financial year are detailed below:

- Assets valuations are provided by District Valuation office on annual basis. Valuations are subject to general price changes in the property values across the UK. Asset values might vary from the real market value when assets are disposed.

- Determination of useful lives for property, plant and equipment - estimated useful lives for Trust's assets are based on common, widely used assumptions for each asset type except where specialist information is available from professional bodies. The Trust reviews these lives on a regular basis as part of the process to assess whether assets have been impaired.

- Accruals are based on estimates and judgements of historical trends and anticipated outcomes. At the end of each accounting period, management review items that are outstanding and estimate the amount to be accrued in the closing financial statements of the foundation trust. Any variation between the estimate and the actual is recorded under the relevant heading within the accounts in the subsequent financial period.

- Provisions for pension and legal liabilities are based on the information provided from NHS Pension Agency, NHS Litigation Agency and the Trust's own sources. Pension provision is based on the life expectancy of the individual pensioner as stated in the UK Actuarial Department most recent life tables which change annually. All provisions are estimates of the actual costs of future cash flows and are dependent on future events. Any differences between expectations and the actual future liability will be accounted for in the period when such determination is made.

1.4 Going Concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity’s services in the public sector is normally sufficient evidence of going concern.

After making enquiries, the directors have a reasonable expectation that the services provided by the NHS foundation trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury’s Financial Reporting Manual.

1.5 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

The Trust receives the majority of its income from customers on a block contract arrangement which means that payments against the contract are received equally in twelfths across the financial year and which is not directly linked to specific satisfaction of performance obligations.

Revenue from NHS Contracts

The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

2020/21

The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at a Integrated Care System level. The related performance obligation is the delivery of healthcare and related services during the period, with the trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

Comparative period 2019/20

In the comparative period (2019/20), the trust's contracts with NHS commissioners included those where the trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

In 2019/20 the Provider Sustainability Fund and Financial Recovery Fund enabled providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatment provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset. The Trust does not accrue for un-receipted income and subsequently does not provide for any specific allowance for unsuccessful compensation claims and doubtful debts for measurement of expected credit losses over the lifetime of the asset.

Other Operating Income

The Trust receives income from other sources which is not directly related to the delivery of healthcare services. This includes income to support training and development of staff; managed estates services; property rental; and crèche services. Income is also recognised in respect of donations received for the purchase of capital assets or contributions to expenditure. Other operating income is recognised on an accrual basis when the delivery of the activity has occurred.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.6 Expenditure on Employee Benefits

Short-term Employee Benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees.

Annual Leave Entitlement

The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period. The permitted carry forward is five days except in exceptional circumstances where an employee is on maternity or long-term sickness absence.

Maternity and Paternity Leave Entitlements

The cost of the entitlement for employees on maternity or paternity at the end of the period is recognised in the financial statements. The carry forward is based on statutory maternity pay entitlement applicable at the end of the period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

National Employment Savings Trust ('NEST')

In 2014/15, the Trust implemented auto-enrolment for eligible employees in the National Employment Savings Trust ('NEST'), which is a scheme set up under the Pensions Act 2008. NEST is regulated by The Pensions Regulator the UK regulator of workplace pension schemes.

NEST is a defined contribution, off Statement of Financial Position scheme. The value of employer contributions in 2020/21 was £58K (2019/20: £53K).

1.7 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.8 Property, Plant and Equipment

Recognition

Property, Plant and Equipment is capitalised where:

it is held for use in delivering services or for administrative purposes;

it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;

it is expected to be used for more than one financial year; and

the cost of the item can be measured reliably.

In addition, for Property, Plant and Equipment to be capitalised must:

individually have a cost of at least £5,000; or

form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or

form part of the initial setting-up cost of a new building or refurbishment, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Land and buildings are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any accumulated depreciation and impairment losses.

The review of valuations for Land and Buildings is performed by the District Valuer Services, which is a specialist property arm of the Valuation Office Agency. Valuations are reviewed on the 31st March of each calendar year, with a full physical inspection every five years, an interim physical verification at three years and a desktop review in all other years. The last full physical inspection was performed on 31st March 2021.

Current values in existing use are:

- Land and non-specialised buildings – market value for existing use; and
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Revaluation surpluses and impairments due to changes in valuations are reflected in Other Comprehensive Income in the Statement of Comprehensive Income, the Statement of Changes in Taxpayers Equity and Notes 6 Impairments and 12.1 Property, Plant and Equipment.

The value of land for existing use purposes is assessed at existing use value. For non-operational properties including surplus land, the valuations are carried out at open market value.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

For all categories of non-property assets, the Trust considers that depreciated historical cost is an acceptable proxy for current value in existing use, as the useful economic lives used are considered to be a realistic reflection of the lives of assets and the depreciation methods used reflect the consumption of the asset.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Revaluation and impairment

Land and buildings are fully revalued every five years with an interim revaluation every financial year. All revaluations are performed by a professional qualified valuer who is a member of the Royal Institute of Chartered Surveyors.

Further revaluations may be done at any other time particularly where there have been additions, dilapidation or part disposal of an asset or on the occurrence of an event likely to cause impairment.

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income.

Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised. Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Depreciation

Items of Property, Plant and Equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

The standard useful life for Property, Plant and Equipment held by the NHS foundation trust is:

- Buildings (excluding dwellings): 35 years
- Furniture & Fittings: 7 years
- Transport Equipment: 7 years
- Plant & Machinery: 5 years
- Information Technology: 4 years
- Software and Licenses: 3 years

Where there is a valid and reasonable expectation of the Trust that the economic useful life of Property Plant or Equipment is different to the standard, this will be assessed on a case by case basis taking into account the materiality of the initial investment and expected timing for replacement. The useful life will then be adjusted accordingly.

Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

De-recognition

Assets intended for disposal is reclassified as 'Held for Sale' once all of the following criteria are met:

- The asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e. management are committed to a plan to sell the asset;
- a programme has begun to find a buyer and complete the sale;
- the asset is being actively marketed at a reasonable price;
- the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and,
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the assets on the revaluation reserve is transferred to Income and Expenditure reserve. For donated assets, a transfer is made to or from the relevant reserve to the profit/loss on disposal amount so that no profit or loss is recognised in income and expenses. The remaining surplus or deficit in the donated asset reserve is then transferred to Income and Expenditure reserve.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.9 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

In 2020/21 this includes assets donated to the trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

1.10 Government grants

Government grants are grants from government bodies other than revenue from NHS bodies for the provision of services. Revenue grants are treated as deferred income initially and credited to income to match the expenditure to which they relate. Capital grants are treated as income and the receipt credited to the Statement of Comprehensive Income. The associated asset is treated in a manner consistent with the depreciation and impairment charges for that asset. Assets purchased from government grants are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations and impairments are taken to the revaluation reserve and, each year, an amount equal to the depreciation charge on the asset charged to the Statement of Comprehensive Income.

A grant for an asset may be received subject to a condition that it is to be returned to the grantor if a specified future event does or does not occur. For example, a grant may need to be returned if the foundation trust ceases to use the asset purchased with that grant for a purpose specified by the grantor. In these cases, a return obligation does not arise until such time as it is expected that the condition will be breached and a liability is not recognised until that time. Such a condition would not therefore require the grant to be treated as deferred.

1.11 Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. The underlying assets are recognised as Property, Plant and Equipment at their fair value. An equivalent financial liability is recognised in accordance with IAS 17.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

Payment for the fair value of services received;

Payment for the PFI asset, including finance costs; and

Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

The PFI assets are recognised as a property, plant and equipment when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacements

Components of the assets replaced by the operator during the contract are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the Trust to the operator for use in the scheme:

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

Other assets contributed by the Trust to the operator:

Assets contributed (e.g. cash payments, surplus property) by the trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.12 Intangible Assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets.

Expenditure on research is not capitalised.

Expenditure on internally generated assets is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware e.g. an operating system is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

For all categories of intangible assets, the Trust considers that depreciated historical cost is an acceptable proxy for current value in existing use, as the useful economic lives used are considered to be a realistic reflection of the lives of assets and the depreciation methods used reflect the consumption of the asset.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. The expected useful life for software is 3 years.

1.13 Inventories

Inventories are valued at the lower of cost and net realisable value using the weighted average cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

In 2020/21, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

1.14 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management.

1.15 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The trust as a lessee

Finance Lease

Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

The trust as a lessor

Finance Lease

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

Operating leases

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

1.16 Provisions

The NHS foundation trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2021:

		Nominal rate
Short-term	Up to 5 years	0.51%
Medium-term	After 5 years up to 10 years	0.55%
Long-term	Exceeding 10 years	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2020:

	Inflation rate
Year 1	1.90%
Year 2	2.00%
Into perpetuity	2.00%

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.95% in real terms.

Clinical negligence costs

The NHS Resolution operates a risk pooling scheme under which the NHS foundation trust pays an annual contribution to the NHS Resolution, which, in return, settles all clinical negligence claims. Although the NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by the NHS Resolution on behalf of the NHS foundation trust is disclosed at note 19.2.

Non-clinical risk pooling

The NHS foundation trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.17 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 20 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 20, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

- Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.18 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.19 Corporation Tax

The Trust is a Health Service body within the meaning of s519A Income and Corporation Taxes Act (ICTA) 1988 and accordingly is exempt from taxation in respect of income and capital gains within the categories covered by this. There is a power for the Treasury to dis-apply the exemption in relation to specified activities of a Foundation trust (s519A (3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the scope of corporation tax in respect of activities which are not related to the provision of health care. Where trading activities are undertaken that are commercial in nature the profits per activity are below the £50,000 corporation tax threshold as per the HMRC 'Guidance on the Tax Treatment of Non-Core Healthcare Commercial Activities of NHS Foundation Trusts.

1.20 Value Added Tax

Most of the activities of the NHS foundation trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.21 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS foundation trust has no beneficial interest in them. However, they are disclosed in note 16.2 in accordance with the requirements of HM Treasury’s *FReM*.

1.22 Financial assets and financial liabilities

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018. IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

1.22a Financial Assets

Recognition

Financial assets are recognised when the Trust becomes party to the contractual provision of the financial instrument or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are de-recognised when the contractual rights have expired or when the asset has been transferred and the Trust has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

Financial assets are initially recognised at fair value plus or minus directly attributable transaction costs for financial assets not measured at fair value through profit or loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices, where possible, or by valuation techniques.

Financial assets are classified into the following categories: financial assets at amortised cost, financial assets at fair value through other comprehensive income, and financial assets at fair value through profit and loss. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

For all financial assets measured at amortised cost or at fair value through other comprehensive income, lease receivables and contract assets, the Trust will recognise a loss allowance, previously classified as impairment or bad debt provisions, representing expected credit losses on the financial instrument.

Financial assets measured at amortised cost are those held whose objective is to hold financial assets in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most financial assets at amortised costs and other simple debt instruments. After initial recognition, these financial assets are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

Financial assets at amortised costs are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets. The Trust's financial assets at amortised cost comprise current investments, cash and cash equivalents, NHS receivables, accrued income and 'other receivables'.

All other financial assets and financial liabilities are recognised when the trust becomes a party to the contractual provisions of the instrument.

Impairment of financial assets

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the Trust recognises a loss allowance representing expected credit losses on the financial instrument.

The Trust will adopt the simplified approach to impairment, in accordance with IFRS 9, and measure the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses.

For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 1), and otherwise at an amount equal to 12-month expected credit losses (stage 2).

The Department of Health and Social Care (DHSC) provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies and the Trust will not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

1.22b Financial Liabilities

Financial liabilities are recognised when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been extinguished — that is, the obligation has been discharged or cancelled or has expired. Loans from the Department of Health are recognised at historic cost. Otherwise, financial liabilities are initially recognised at fair value plus or minus directly attributable transaction costs for financial liabilities not measured at fair value through profit or loss.

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from the Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the amortised cost of the financial liability.

1.23 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.24 Charitable Funds

Under the provisions of IFRS 10 Consolidated Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. In accordance with IAS 1 Presentation of Financial Statements, restated prior period accounts are presented where the adoption of the new policy has a material impact. As the charitable income during the financial year was £273K, compared to the Trust's revenue of £301,199K, the funds are not considered sufficiently material for consolidated account to be prepared. The position is reviewed annually, to confirm whether or not the charity's funds are material enough for consolidation to be appropriate. Separate accounts for the NHS charity will be produced. An outline of the charity is as follows:
The Berkshire Health Charitable Fund is registered with the Charity Commission under reference number 1049733. Trustees of the charity are also employees of the NHS foundation trust. Details of the charity can be obtained from www.charitycommission.gov.uk

Note 2 Operating Segments

IFRS 8 'Operating Segments' requires disclosure of the results of the significant operating segments. A business or operating segment is a group of assets and operations engaged in providing core or non-core services that are subject to risks and returns that are different from those of other business or operating segments. In line with the standard, based on the internally reported activities, the foundation trust identifies that all activity is healthcare related and a large majority of the foundation trust's revenue is received from within UK government departments.

The Trust operates as a single operating segment. The Board of Directors, led by the Chief Executive is the Chief Operating Decision Maker within the Trust. It is only at this level that revenues are fully reported and the overall financial and operational performance of the Trust is assessed. As all decisions affecting the foundation trust's future direction and viability are made based on the overall total presented to the board, the foundation trust is satisfied that the single segment of healthcare is appropriate and consistent with the principles of IFRS 8.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	2020/21 £000	2019/20 £000
Mental health services		
Block contract income	124,762	112,387
Clinical income for the secondary commissioning of mandatory services	-	315
Other clinical income from mandatory services	2,959	2,573
Community services		
Community services income from CCGs and NHS England	120,311	109,387
Community services income from other commissioners	16,877	18,502
All services		
Additional pension contribution central funding	8,461	7,880
Other clinical income	1,301	2,166
Total income from activities	**274,671**	**253,210**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2020/21 £000	2019/20 £000
CCGs and NHS England	255,722	233,795
Local Authorities	13,759	14,259
Other NHS foundation trusts	2,959	2,789
NHS Trusts	792	777
NHS Other	71	3
NHS injury scheme (was RTA)	12	52
Non-NHS: other	1,356	1,535
Total income from activities	**274,671**	**253,210**
Of which:		
Related to continuing operations	274,671	253,210
Related to discontinued operations	-	-

Note 4 Other operating income

	2020/21	2019/20
	£000	£000
Other operating income from contracts with customers:		
Research and development	751	780
Education and training	4,650	4,857
Car Parking	97	254
Catering	40	159
IT Recharges	181	956
Sustainability and Transformation Fund income	-	2,416
Reimbursement and top up funding	6,424	-
Creche Services	1,388	1,779
Property Rental	2,614	2,525
Managed Estates Services	7,328	7,430
Other income	761	1,467
Other non-contract operating income		
Contributions to expenditure - consumables (inventory) donated from DHSC group bodies for COVID response	2,242	-
Receipt of capital grants and donations	5	-
Charitable and other contributions to expenditure	47	61
Total other operating income	**26,528**	**22,684**
Of which:		
Related to continuing operations	26,528	22,684
Related to discontinued operations	-	-

4.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2020/21	2019/20
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	2,492	2,289
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	1,846	4,173

4.2 Transaction price allocated to remaining performance obligations

	2020/21	2019/20
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	£000	£000
- within one year	6,215	2,492
- after one year, not later than five years	-	-
- after five years	-	-
Total revenue allocated to remainig performance obligations	**6,215**	**2,492**

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 4.3 Income from activities arising from commissioner requested services

Under the terms of its Provider License, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2020/21	2019/20
	£000	£000
Income from services designated (or grandfathered) as commissioner requested services	264,909	243,164
Income from services not designated as commissioner requested services	36,290	32,730
Total	**301,199**	**275,894**

Note 4.4 Total benefits obtained from the apprenticeship fund	2020/21 £000	2019/20 £000
Cash income received from the apprenticeship levy scheme where the Trust is accredited training provider	30	24
Total benefit obtained from the apprenticeship levy	**30**	**24**

Note 5.1 Operating expenses

	2020/21	2019/20
	£000	£000
Services from NHS foundation trusts	2,225	2,132
Services from NHS trusts	612	637
Services from CCGs and NHS England	24	26
Purchase of healthcare from non-NHS bodies	13,861	11,888
Employee expenses - executive directors	1,193	1,135
Employee expenses - non-executive directors	146	138
Employee expenses - staff	216,162	195,437
Supplies and services - clinical	4,390	4,662
Supplies and services - clinical: utilisation of consumables donated from DHSC group bodies for COVID response	2,242	-
Supplies and services - general	1,595	1,198
Establishment	3,391	3,453
Research and development	289	180
Transport	1,710	2,869
Premises	17,477	17,308
Movement in credit loss allowance: contract receivables/assets	75	-
Increase in other provisions	790	193
Change in provisions discount rate(s)	31	73
Drug costs	5,112	5,421
Rentals under operating leases	3,662	3,350
Depreciation on property, plant and equipment	5,649	5,156
Amortisation on intangible assets	2,307	1,638
Impairments	1,459	1,703
Audit fees payable to the external auditor:		
- audit services - statutory audit	81	74
- audit related assurance services	-	7
Internal Audit Fees	75	55
Clinical negligence	1,129	807
Legal fees	503	511
Consultancy costs	155	127
Training, courses and conferences	715	1,009
Service Element of PFI Unitary Payments	6,362	6,474
Redundancy	27	80
Early retirements	9	96
Hospitality	2	1
Other services (external Payroll Services)	52	53
Losses, ex gratia & special payments	134	144
Other	1,752	1,475
Total	**295,400**	**269,509**
Of which:		
Related to continuing operations	295,400	269,509
Related to discontinued operations	-	-

Note 5.2 Other auditor remuneration

The cost of other remuneration paid to the auditor, which included audit related assurance services were £0K (2019/20 £7K). The fees have been disclosed VAT exclusive.

The external auditor is also appointed by the Berkshire Healthcare Charitable Fund, the results of which are not consolidated into these financial statements. Details are included in the Charitable Fund's financial statements which are available on the Charity Commission's website. The independent examination fee paid in 2019/20 was £4,000 excluding VAT.

Note 5.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2.0m (2019/20: £2.0m).

Note 6 Impairment of assets

	2020/21	2019/20
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Over specification of assets	865	12
Abandonment of assets in course of construction	182	
Changes in market price	-	107
Other	411	1,584
Total net impairments charged to operating surplus / deficit	**1,459**	**1,703**
Impairments charged to the revaluation reserve	1,810	3,023
Total net impairments	**3,269**	**4,726**

Over specification of assets of £865k includes £750k impairment relating to the capital expenditure scheme in respect of improvements to the leasehold property. These works were valued on the basis of the potential increase in market rental of the property. As the potential market rental increase did not reflect the value of the expenditure, the difference resulted in the impairment. The total value of the work was £932k. The increase in market rental was equivalent to £182k resulting in an impairment of £750k (prior year spend in respect of that property was £2,270k and that resulted in the impairment of £1,270k recognised last year). The capital expenditure on the leasehold property is included in "Building excluding dwellings" of Note 12.1 Property, Plant & Equipment. The impairment costs is shown in Note 5.1 Operating expenses – Impairments.

Abandonment of an asset in the course of a construction relates to the capital expenditure scheme, which was expected to be funded centrally, however it was abandoned at the planning and design stage as the funding was no longer available for that scheme.

The 'Other' impairment includes £316k impairment due to a change of valuation of the existing asset from Modern Equivalent Asset to the Existing Use Value. This change has resulted following a review of the asset, which concluded that it will be more appropriate to value the asset as a non-specialised building. The building contains a mix of office and clinical consulting rooms, which although are being used by clinicians, the simple set up is not sufficient to consider the building specialist akin to a hospital building. The balance of £95k consists of £50k impairment of land and £45k impairment of the donated property.

Note 7 Employee benefits

	Permanent	Other	2020/21 Total	2019/20 Total
	£000	£000	£000	£000
Salaries and wages	148,962	-	**148,962**	**137,196**
Social security costs	14,249	-	**14,249**	**13,783**
Apprenticeship levy	731	-	**731**	**678**
Employer's contributions to NHS pensions	27,875	-	**27,875**	**25,903**
Pension cost - other	58	-	**58**	**53**
Other employment benefits	1,912	-	**1,912**	**-**
External Bank Staff	-	19,984	**19,984**	**16,005**
Agency/contract staff	-	4,207	**4,207**	**4,865**
Total gross staff costs	**193,787**	**24,191**	**217,978**	**198,483**
Total staff costs	**193,787**	**24,191**	**217,978**	**198,483**
Included within:				
Costs capitalised as part of assets	623	-	**623**	**1,911**

Note 7.1 Average number of employees (WTE basis)

	Permanent	Other	2020/21 Total	2019/20 Total
	Number	Number	Number	Number
Medical and dental	186	13	**199**	**188**
Ambulance staff	3	-	**3**	**4**
Administration and estates	612	66	**678**	**607**
Healthcare assistants and other support staff	75	161	**236**	**79**
Nursing, midwifery and health visiting staff	1,037	140	**1,177**	**1,138**
Nursing, midwifery and health visiting learners	978	23	**1,001**	**1,104**
Scientific, therapeutic and technical staff	787	38	**825**	**776**
Healthcare science staff	198	-	**198**	**199**
Social care staff	-	-	**-**	**-**
Other	-	-	**-**	**-**
Total average numbers	**3,876**	**441**	**4,317**	**4,095**
Of which:				
Number of employees (WTE) engaged on capital projects	14	-	**14**	**45**

Note 7.2 Retirements due to ill-health

During 2020/21 there were 5 early retirements from the trust agreed on the grounds of ill-health (8 in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is £124K (£416K in 2019/20).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 7.3 Directors' remuneration

The aggregate amounts payable to directors were:

	2020/21	2019/20
	£000	£000
Salary	1,201	959
Taxable benefits	0	0
Performance related bonuses	0	0
Employer's pension contributions	148	106
Total	**1,349**	**1,065**

Further details of directors' remuneration can be found in the Remuneration Report.

Note 8 Operating leases

Note 8.1 Berkshire Healthcare NHS Foundation Trust as a lessee

	2020/21	2019/20
	£000	£000
Operating lease expense		
Minimum lease payments	3,662	3,350
Contingent rents	-	-
Less sublease payments received	-	-
Total	**3,662**	**3,350**

	31 March 2021	31 March 2020
	£000	£000
Future minimum lease payments due:		
- not later than one year;	2,729	2,924
- later than one year and not later than five years;	7,686	8,675
- later than five years.	6,822	5,973
Total	**17,237**	**17,572**
Future minimum sublease payments to be received	-	-

Operating leases relate to rental of properties and lease cars. Operating leases are charged to operating expenses on a straight-line basis over the term of the lease.

Note 9 Finance income

	2020/21	2019/20
	£000	£000
Interest on bank accounts	6	186
Total	**6**	**186**

Note 10 Finance expenditure

	2020/21	2019/20
	£000	£000
Interest expense:		
Main finance costs on PFI	1,984	2,070
Contingent finance costs on PFI	1,886	1,685
Total interest expense	**3,870**	**3,755**
Other finance costs	120	160
Total	**3,989**	**3,915**

Note 11.1 Intangible assets - 2020/21

	Software licences	Total
	£000	£000
Valuation/gross cost at 1 April 2020 - brought forward	**14,537**	**14,537**
Additions	984	**984**
Impairments	(101)	**(101)**
Gross cost at 31 March 2021	**15,420**	**15,420**
Amortisation at 1 April 2020 - brought forward	**7,740**	**7,740**
Provided during the year	2,307	**2,307**
Amortisation at 31 March 2021	**10,047**	**10,047**
Net book value at 31 March 2021	**5,372**	**5,372**
Net book value at 1 April 2020	**6,797**	**6,797**

Note 11.2 Intangible assets - 2019/20

	Software licences	Total
	£000	£000
Valuation/gross cost at 1 April 2019 - as previously stated	**11,335**	**11,335**
Additions	2,899	**2,899**
Impairments	(2)	**(2)**
Reclassifications	305	**305**
Valuation/gross cost at 31 March 2020	**14,537**	**14,537**
Amortisation at 1 April 2019 - as previously stated	**6,102**	**6,102**
Provided during the year	1,638	**1,638**
Amortisation at 31 March 2020	**7,740**	**7,740**
Net book value at 31 March 2020	**6,797**	**6,797**
Net book value at 1 April 2019	**5,233**	**5,233**

Note 11.3 Intangible assets financing 2020/21

	Software licences	Total
	£000	£000
Net book value at 31 March 2021		
Purchased	5,372	**5,372**
Finance leased	-	**-**
Donated	-	**-**
NBV total at 31 March 2021	**5,372**	**5,372**

Note 11.4 Intangible assets financing 2019/20

	Software licences	Total
	£000	£000
Net book value 31 March 2020		
Purchased	6,797	**6,797**
Finance leased	-	**-**
Donated	-	**-**
NBV total at 31 March 2020	**6,797**	**6,797**

Note 12.1 Property, plant and equipment - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2020 - brought forward	**15,896**	**68,104**	**1,988**	**2,508**	**65**	**25,843**	**2,791**	**117,195**
Valuation/gross cost at start of period as FT								**-**
Additions - purchased	-	1,874	2,626	198	-	2,269	505	**7,472**
Additions - assets purchased from cash donations / grants	-	-	-	-	-	5	-	**5**
Impairments	(91)	(2,881)	(188)	-	-	(9)	-	**(3,168)**
Reclassifications	-	1,510	(1,733)	-	-	19	204	**-**
Revaluations*	110	(2,203)	-	-	-	-	-	**(2,092)**
Valuation/gross cost at 31 March 2021	**15,915**	**66,405**	**2,693**	**2,706**	**65**	**28,127**	**3,500**	**119,411**
Accumulated depreciation at 1 April 2020 - brought forward	**-**	**-**	**-**	**2,018**	**65**	**18,534**	**1,738**	**22,355**
Provided during the year	-	2,472	-	153	-	2,758	266	**5,649**
Impairments	-	-	-	-	-	-	-	**-**
Revaluations	-	(2,472)	-	-	-	-	-	**(2,472)**
Accumulated depreciation at 31 March 2021	**0**	**0**	**0**	**2,171**	**65**	**21,292**	**2,004**	**25,532**
Net book value at 31 March 2021	**15,915**	**66,405**	**2,693**	**535**	**-**	**6,835**	**1,496**	**93,879**
Net book value at 1 April 2020	**15,896**	**68,104**	**1,988**	**489**	**-**	**7,309**	**1,054**	**94,839**

* Revaluations were performed on the 31st March 2021

Note 12.2 Property, plant and equipment - 2019/20

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2019 - as previously stated	**15,877**	**72,456**	**593**	**2,231**	**65**	**23,062**	**2,759**	**117,043**
Additions - purchased	-	1,106	3,134	279	-	2,625	221	**7,365**
Impairments	-	(3,436)	(1,288)	-	-	-	-	**(4,724)**
Reclassifications	-	182	(451)	(2)	-	156	(189)	**(304)**
Revaluations**	19	(2,204)	-	-	-	-	-	**(2,185)**
Valuation/gross cost at 31 March 2020	**15,896**	**68,104**	**1,988**	**2,508**	**65**	**25,843**	**2,791**	**117,195**
Accumulated depreciation at 1 April 2019 - as previously stated	**-**	**-**	**-**	**1,893**	**65**	**16,060**	**1,541**	**19,559**
Provided during the year	-	2,361	-	125	-	2,474	196	**5,156**
Reclassifications	-	-	-	-	-	-	1	**1**
Revaluations	-	(2,361)	-	-	-	-	-	**(2,361)**
Accumulated depreciation at 31 March 2020	**0**	**0**	**0**	**2,018**	**65**	**18,534**	**1,738**	**22,355**
Net book value at 31 March 2020	**15,896**	**68,104**	**1,988**	**489**	**-**	**7,309**	**1,054**	**94,839**
Net book value at 1 April 2019	**15,877**	**72,456**	**593**	**337**	**-**	**7,002**	**1,219**	**97,483**

Note 12.3 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021							
Owned	15,915	8,075	2,693	528	6,830	1,492	**35,533**
On-SoFP PFI contracts and other service concession arrangements	-	55,506	-	-	-	-	**55,506**
Donated	-	2,824	-	6	5	5	**2,840**
NBV total at 31 March 2021	**15,915**	**66,405**	**2,693**	**535**	**6,835**	**1,497**	**93,879**

Note 12.4 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020							
Owned	15,896	7,895	1,988	483	7,309	1,049	**34,619**
On-SoFP PFI contracts and other service concession arrangements	-	57,341	-	-	-	-	**57,341**
Donated	-	2,868	-	6	-	5	**2,879**
NBV total at 31 March 2020	**15,896**	**68,104**	**1,988**	**489**	**7,309**	**1,054**	**94,839**

Note 12.5 Valuation methods for land and buildings - 2020/21

	Land	Buildings excluding dwellings
	£000	£000
DRC - Modern Equivalent asset basis (no alternative site)	11,900	55,506
Market Value in existing use	3,015	10,899
Fair value (surplus PPE land and buildings)	1,000	-
	15,915	**66,405**

Note 13 Inventories

	31 March 2021	31 March 2020
	£000	£000
Drugs	160	171
Total inventories	**160**	**171**

Drug inventories recognised in expenses for the year were £1,355K (2019/20: £1,637K). Write-down of inventories recognised as expenses for the year were £0K (2019/20: £0K).

As part of the COVID response in 2020/21, the Trust received £2,242K of personal protective equipment ('PPE') inventories from Department of Health and Social Care. These consumable items were centrally procured by DHSC and donated to Trust. The value of these items have been treated as a donation with the total amount of the items being purchased for the Trust being recognised as a contribution to expenditure within Note 4 Other Operating Income. Due to the low value of consumable stock items being held, the Trust has historically treated all personal protective equipment as being fully consumed in the period in which it is purchased, and as a result of this, the Trust records £nil balance of inventory for PPE as at year end 31st March 2021. The value of stock donated to the Trust is recorded as fully utilised within Note 5.1 Expenditure: Supplies and services - clinical.

Note 14.1 Trade receivables and other receivables

	31 March 2021	31 March 2020
	£000	£000
Current		
Contract receivables	4,868	7,508
Allowance for other impaired receivables	(75)	-
Prepayments (non-PFI)	2,621	2,826
PDC dividend receivable	464	319
VAT receivable	1,405	615
Other receivables	102	145
Total current trade and other receivables	**9,385**	**11,413**

Note 14.2 Allowances for Credit Losses - 2020/21

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2020 - brought forward	**-**	**-**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	-	-
Allowances at start of period for new FTs		
Transfers by absorption		
New allowances arising	-	75
Changes in existing allowances		
Reversals of allowances	-	-
Utilisation of allowances (write offs)	-	-
Changes arising following modification of cotractual cash flows		
Foreign exchange and other changes		
Transfer to FT upon authorisation		
Allowances as at 31 Mar 2021	**-**	**75**

Trust made no allowances for credit loses during 2019/20.

Note 15.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2020/21	2019/20
	£000	£000
At 1 April	**26,406**	**25,597**
Net change in year	12,691	809
At 31 March	**39,097**	**26,406**
Broken down into:		
Cash at commercial banks and in hand	11	12
Cash with the Government Banking Service	39,086	26,394
Total cash and cash equivalents as in SoFP	**39,097**	**26,406**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**39,097**	**26,406**

Note 15.2 Third party assets held by the NHS foundation trust

Berkshire Healthcare NHS Foundation Trust held cash and cash equivalents which relate to monies held by the foundation trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2021	31 March 2020
	£000	£000
Bank balances	164	159
Total third party assets	**164**	**159**

Note 16.1 Trade and other payables

	31 March 2021 £000	31 March 2020 £000
Current		
Trade payables	7,411	7,599
Capital payables	1,913	1,433
Social security costs	2,246	2,070
VAT payable	27	25
Other taxes payable	1,572	1,409
Other payables	375	359
Accruals	16,114	11,865
PDC dividend payable	-	-
Total current trade and other payables	**29,659**	**24,760**

Note 17.1 Other liabilities

	31 March 2021 £000	31 March 2020 £000
Current		
Deferred income: contract liabilities	6,215	2,492
Total other current liabilities	**6,215**	**2,492**

Note 18 Borrowings

	31 March 2021 £000	31 March 2020 £000
Current		
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	1,569	1,467
Total current borrowings	**1,569**	**1,467**
Non-current		
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	25,465	27,034
Total non-current borrowings	**25,465**	**27,034**

Note 19.1 Provisions for liabilities and charges analysis

	Pensions - other staff	Injury Benefits	Other legal claims	Re-structurings	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000	£000
At 1 April 2020	**931**	**374**	**-**	**-**	**-**	**881**	**2,186**
Change in the discount rate	20	18	-	-	-	(7)	**31**
Arising during the year	53	0	767	34	30	22	**907**
Utilised during the year	(107)	(17)	-	-	-	-	**(124)**
Reversed unused	(82)	-	-	-	-	(35)	**(117)**
Unwinding of discount	107	17	-	-	-	(5)	**120**
At 31 March 2021	**923**	**393**	**767**	**34**	**30**	**857**	**3,004**
Expected timing of cash flows:							
- not later than one year;	104	16	-	34	30	271	**455**
- later than one year and not later than five years;	416	64	767	-	-	437	**1,684**
- later than five years.	403	313	-	-	-	149	**865**
Total	**923**	**393**	**767**	**34**	**30**	**857**	**3,004**

Pensions - Other Staff

This relates to former NHS employees whose contract of employment was terminated prior to their normal retirement age, with the effect that the employing authority became responsible for making up any shortfall in pension contributions as a result of that termination up until the death of either the former employee or any remaining survivor. The provision is adjusted annually, taking into Government Actuarial Department changes to life expectancy for England and Wales. Where the pension is no longer payable, then this is reversed unused.

Timing and expectation of the provision and future cashflows is based on historical payments to the NHS Pension Agency for pensions currently paid up to the end of each financial year.

Injury Benefits

This relates to injury benefits arising to individuals as a result of an accident at work, which is paid by the NHS Pensions Agency and then reimbursed by the foundation trust.

Timing and expectation of the provision and future cashflows is based on historical payments to the NHS Pension Agency for pensions currently paid up to the end of each financial year.

Other

This relates to the following items:

- Provisions in respect of Liability to Third Party ('LTPS') scheme claims against the Trust handled by NHS Resolution where the foundation trusts maximum exposure is £10,000 per claim; and

- Dilapidation provisions in respect of leased and rented property

- Other Legal Claims relate to claims made against the Trust, but which are not covered by NHS Resolution, and can include employment related cases

- Timing of cash flows for LTPS claims are expected to occur within one year of current year end but may be subject to on-going litigation by the claimant. Claims not upheld or not proceeded with will result in provisions being reversed

- Timing of cash flows for dilapidation provisions is based on the expected termination of the current leasehold agreement. Payment and timing of settlement for dilapidations may be subject to uncertainty due to early termination, extension of lease beyond its current expected termination date, or negotiation with leasehold provider over value of dilapidation works required.

Note 19.2 Clinical negligence liabilities

At 31 March 2021, £12,251K was included in provisions of the NHS Resolution in respect of clinical negligence liabilities of Berkshire Healthcare NHS Foundation Trust (31 March 2020: £13,463K).

Note 20 Contingent assets and liabilities

	31 March 2021	31 March 2020
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(22)	(50)
Gross value of contingent liabilities	**(22)**	**(50)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(22)**	**(50)**

Note 21 Contractual capital commitments

	31 March 2021	31 March 2020
	£000	£000
Property, plant and equipment	480	431
Intangible assets	541	-
Total	**1,021**	**431**

Note 22 On-SoFP PFI, LIFT or other service concession arrangements

The foundation trust operates two PFI schemes:

Prospect Park Hospital, Reading Berkshire

This PFI scheme is to design, build, maintain and operate (through facilities management and related services) a 120 beds mental health inpatient hospital facility. The hospital became operational in March 2003. At the end of the contract the hospital buildings will revert to the Trust's ownership.

The contract has a 32 year-term, ending in 2033, and sees the Trust making a minimum unitary base payment that totals £4.02m annually. It is charged monthly and adjusted for RPI and according to any adverse performance against output measures describing all relevant aspects of the contract. Rates and utilities are borne separately by the Trust.

West Berkshire Community Hospital, Newbury, Berkshire

This PFI was originally managed by the former Berkshire West PCT prior to its dissolution on the 31st March 2013, when the PFI contract was transferred to the foundation trust. This facility operates services such as day case surgery and outpatient facilities. There are also a number of inpatient wards. At the end of the PFI contract the hospital building will revert to the Trust's ownership.

The contract has a 32 year-term, ending in 2033. The Trust makes a minimum unitary base payment that totals £1.46m annual. It is charged monthly adjusted for RPI, and according to any adverse performance against output measures describing all relevant aspects of the contracts. Rates and utilities are borne separately by the Trust.

Both PFI contracts were deemed as off-balance sheet when the Full Business Cases were approved prior to their design and construction. Following adoption of IFRS the Trust considers the contracts under IFRIC 4 Determining Whether an Arrangement Contains a Lease and IFRIC 12 Service Concession Arrangements and recognised the schemes as 'on-Statement of Financial Position'.

The substance of the two contracts is that the trust has a finance lease and annual payments comprise three elements - finance lease rental, service charges and replacements of the asset components (lifecycle replacements). The element of annual finance lease rental is further split into three components: repayment of the finance lease principal, a finance cost and contingent rental representing the inflation increases. An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period. The implicit rate of interest for Prospect Park Hospital is 7.31%, whilst for West Berkshire Community Hospital it is 6.61%.

Total obligations for on-statement of financial position PFI contracts due:

Note 22.1 Imputed finance lease obligations

	31 March 2021	31 March 2020
	£000	£000
Gross PFI, LIFT or other service concession liabilities	**75,309**	**79,313**
Of which liabilities are due		
- not later than one year;	5,437	5,337
- later than one year and not later than five years;	22,557	22,329
- later than five years.	47,315	51,647
Finance charges allocated to future periods	(48,275)	(50,812)
Net PFI, LIFT or other service concession arrangement obligation	**27,034**	**28,501**
- not later than one year;	1,569	1,467
- later than one year and not later than five years;	7,053	6,734
- later than five years.	18,412	20,300

Note 22.2 Total On-SoFP PFI, LIFT and other service concession arrangement commitments

Total future payments committed in respect of PFI, LIFT or other service concession arrangements	31 March 2021	31 March 2020
	£000	£000
	181,540	**165,581**
of which due:		
- not later than one year;	11,990	11,973
- later than one year and not later than five years;	51,035	48,873
- later than five years.	118,515	104,735
	181,540	**165,581**

Note 22.3 Payments committed in respect of the service element

	31 March 2021	31 March 2020
	£000	£000
Charge in respect of the service element of the PFI, LIFT or other service concession arrangement for the period	**89,962**	**86,268**
Commitments in respect of the service element of the PFI, LIFT or other service concession arrangement:		
- not later than one year;	6,521	6,636
- later than one year and not later than five years;	27,756	26,544
- later than five years.	55,685	53,088
Total	**89,962**	**86,268**

Note 22.4 Analysis of amounts payable to service concession operator

	31 March 2021	31 March 2020
	£000	£000
Unitary payment payable to service concession operator (total of all schemes)	**11,698**	**11,463**
Consisting of:		
- Interest charge	1,984	2,070
- Repayment of finance lease liability	1,467	1,234
- Service element	6,362	6,474
- Contingent rent	1,886	1,685
Total amount paid to service concession operator	**11,698**	**11,463**

Note 23 Financial instruments

Note 23.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS trust has with clinical commissioning groups and the way those clinical commissioning groups are financed, the NHS foundation trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS foundation trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS trust in undertaking its activities.

The Foundation Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Foundation Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Foundation Trust treasury activity is subject to review by the Trust's internal auditor.

The Foundation Trust's financial instruments, other than those used for treasury risk management purposes, comprise cash and liquid resources and various items such as trade debtors and creditors that arise directly from its operations. The Trust does not undertake speculative treasury transactions.

Liquidity risk

The Foundation Trust's net operating costs are mainly incurred under legally binding contracts with local Clinical Commissioning Groups, NHS England and local authorities, which are financed from resources voted annually by Parliament. Under Payment by Results, the Foundation Trust is paid for activity on the basis of nationally set tariffs. For contracted activity, the Foundation Trust is paid in 12 monthly instalments throughout the year, which significantly reduces the Foundation Trust's liquidity risk. Performance in excess of contracted levels is paid in accordance with the terms of the legally binding contracts. The Foundation Trust finances its capital programme through internally generated resources and external borrowing where appropriate.

Foreign currency risk

The Foundation Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations therefore the exposure to currency rate fluctuations is low.

Interest-Rate Risk

None of the Foundation Trust's financial assets or liabilities carries any real exposure to interest-rate risk. The Foundation Trust's owned assets are funded by public dividend capital, which is non-interest bearing and of unlimited term. The PFI assets, are funded by way of a Finance Lease which are at a fixed rate of interest over the full remaining term of the PFI contracts.

Credit Risk

Due to the fact that the majority of the trust's income comes from legally binding contracts with other government departments and other NHS Bodies the trust does not believe that it is exposed to significant credit risk. The maximum exposures as at 31st March 2021 are in receivables from customers, as disclosed in the **Note 14.1 Trade and other receivables.**

Note 23.2 Carrying values of financial assets

	Loans and receivables	Total
	£000	£000
Carrying value and fair value of financial assets 31 March 2021		
Receivables excluding non-financial assets	4,868	**4,868**
Cash and cash equivalents at bank and in hand	39,097	**39,097**
Total at 31 March 2021	**43,965**	**43,965**

	Loans and receivables	Total
	£000	£000
Carrying value and fair value of financial assets 31 March 2020		
Receivables excluding non-financial assets	7,363	**7,363**
Cash and cash equivalents at bank and in hand	26,406	**26,406**
Total at 31 March 2020	**33,769**	**33,769**

Note 23.3 Financial liabilities

	Other financial liabilities	Total
	£000	£000
Liabilities as per SoFP as at 31 March 2021		
Obligations under PFI, LIFT and other service concession contracts	27,034	**27,034**
Trade and other payables excluding non-financial liabilities	24,627	**24,627**
IAS 37 provisions which are financial liabilities	2,237	**2,237**
Total at 31 March 2021	**53,898**	**53,898**

	Other financial liabilities	Total
	£000	£000
Liabilities as per SoFP as at 31 March 2020		
Obligations under PFI, LIFT and other service concession contracts	28,501	**28,501**
Trade and other payables excluding non-financial liabilities	21,256	**21,256**
IAS 37 provisions which are financial liabilities	2,186	**2,186**
Total at 31 March 2020	**51,943**	**51,943**

Note 23.4 Maturity of financial liabilities

	31 March 2021	31 March 2020
	£000	£000
In one year or less	30,519	26,840
In more than one year but not more than five years	24,241	23,449
In more than five years	48,180	52,466
Total	**102,940**	**102,755**

This table replaces the previous maturity analysis for financial liabilities. Previously this analysis has been performed on book values. However IFRS 7 (para B11D) requires this analysis to be based on undiscounted future contractual cash flow (i.e. gross liabilities including finance charges). Prior Year has been restated.

Note 23.5 Fair values of financial assets at 31 March 2021

	Book value	Fair value
	£000	£000
Cash and cash equivalents at bank and in hand	39,097	39,097
Total	**39,097**	**39,097**

Note 23.6 Fair values of financial liabilities at 31 March 2021

	Book value	Fair value
	£000	£000
IAS 37 provisions which are financial liabilities	2,237	2,237
Obligations under PFI, LIFT and other service concession contracts	27,034	27,034
Other	24,627	24,627
Total	**53,898**	**53,898**

Note 24 Losses and special payments

	2020/21		2019/20	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	1	-	4	-
Fruitless payments	1	-	1	-
Bad debts and claims abandoned	-	-	-	-
Stores losses and damage to property	2	1	21	21
Total losses	**4**	**1**	**26**	**21**
Special payments				
Losses of Personal Effects	3	3	1	0
Personal Injury with Advice	8	47	5	56
Other Employment	2	10	1	65
Other Ex-gratia Payments	29	26	5	1
Special severance payments	2	112	1	18
Total special payments	**44**	**198**	**13**	**141**
Total losses and special payments	**48**	**199**	**39**	**162**

Note 25 Related parties

Berkshire Healthcare NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health. During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Berkshire Healthcare NHS Foundation Trust. The foundation trust considers material transactions as those being where the income or expenditure is over £250,000 per annum.

The Department of Health is regarded as a related party. During the year Berkshire Healthcare NHS Foundation Trust had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

	Income		Expenditure		Receivables		Payables	
	2020/21	2019/20	2020/21	2019/20	2020/21	2019/20	2020/21	2019/20
	£000	£000	£000	£000	£000	£000	£000	£000
NHS Foundation Trusts								
Frimley Health NHS Foundation Trust	636	598	1,258	1,328	91	127	492	538
Oxford Health NHS Foundation Trust	40	90	289	371	87	55	128	111
Oxford University Hospitals NHS Foundation Trust	475	446	0	40	0	14	0	26
Royal Berkshire NHS Foundation Trust	4,191	4,495	2,448	2,274	118	414	137	100
South Central Ambulance Service NHS Foundation Trust	464	383	139	148	72	78	58	55
Central and North West London NHS Foundation Trust	0	0	258	0	0	0	0	0
NHS Trusts								
Avon and Wiltshire Mental Health Partnership NHS Trust	597	609	607	607	0	2	0	84
Pennine Acute Hospitals NHS Trust	0	0	50	0	0	0	50	285
Clinical Commissioning Groups								
NHS Berkshire West CCG	133,591	118,955	0	95	153	1,015	957	698
NHS Buckinghamshire CCG	1,606	1,848	0	0	3	21	0	3
NHS East Berkshire CCG	90,394	88,019	74	0	39	206	1,998	921
NHS Oxfordshire CCG	89	246	0	20	2	43	172	20
NHS North East Hampshire and Farnham CCG	192	0	0	0	5	0	68	0
NHS England and other associated organisations								
NHS England - Core	7,760	3,204	720	155	92	1,079	895	154
South West Regional Office	1,559	6,995	0	0	0	1,498	0	506
South East Regional Office	16,520	9,283	0	0	0	17	0	0
Other NHS Bodies								
Health Education England	3,631	4,462	0	0	15	501	1,288	642
NHS Resolution (formerly NHS Litigation Authority)	26	0	1,252	923	0	0	0	0
NHS Property Services	7,270	6,945	6,260	5,753	2,432	8	1,873	11
Department of Health and Social Care	244	237	0	6	0	0	55	174
Supply Chain Coordination Ltd								
Local and Unitary Authorities								
Bracknell Forest Borough Council	3,742	3,825	0	476	59	92	57	7
Reading Borough Council	2,881	2,915	0	13	253	84	6	90
Slough Borough Council	1,042	1,122	48	104	27	99	52	179
West Berkshire Council	2,429	2,335	122	19	212	59	122	5
Windsor and Maidenhead (Royal Borough of)	490	642	2	22	38	29	73	17
Wokingham Council	3,362	3,706	94	145	405	143	260	56
Other Whole of Government Account Organisations								
HM Revenue & Customs - VAT	0	0	0	0	1,405	615	22	25
HM Revenue & Customs - Other taxes and duties and NI contributions	0	0	14,980	14,461	0	0	3,823	3,479
NHS Pension Scheme	0	0	27,875	25,903	0	0	32	2,561
NHS Professionals	0	0	0	0	0	21	0	837
Berkshire Health Charitable Fund	24	37	0	0	0	0	0	0
Total	**283,255**	**261,397**	**56,476**	**52,863**	0 **5,508**	**6,220**	**12,618**	**11,584**