Berkshire Healthcare
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

TRUST BOARD MEETING

(conducted electronically via Microsoft Teams)

10:00am on Tuesday 09 September 2025

AGENDA

No	Item	Presenter	Enc.
OPENING BUSINESS			
1.	Chairman's Welcome and Public Questions	Mark Day, Interim Chair	Verbal
2.	Apologies	Mark Day, Interim Chair	Verbal
3.	Declaration of Any Other Business	Mark Day, Interim Chair	Verbal
4.	Declarations of Interest i. Amendments to the Register ii. Agenda Items	Mark Day, Interim Chair	Verbal
5.1	Minutes of Meeting held on 08 July 2025	Mark Day, Interim Chair	Enc.
5.2	Action Log and Matters Arising	Mark Day, Interim Chair	Enc.
QUALITY			
6.0	Board Story - Children in Care - Hearing the Voice of the Young Person in Relation to Health Assessments	Debbie Fulton, Director of Nursing and Therapies/Fiona Nyquist, Specialist Nurse for Looked After Children/Katy Parker-Johnson, Specialist Nurse for Children and Young People	Verbal
6.1	Patient Experience Quarterly Report	Debbie Fulton, Director of Nursing and Therapies	Enc.
6.2	Quality Assurance Committee a) Minutes of the meeting held on 19 August 2025 b) Committee's Terms of Reference c) Learning from Deaths Quarterly Report d) Guardians of Safe Working Report	Sally Glen, Chair of the Quality Assurance Committee Amanda Mollett, Head of Clinical Effectiveness and Audit	Enc.
6.3	Trust Intensive Case Management & Assertive Outreach Position Action Plan Update Report	Garyfallia Fountoulaki, Clinical Director, Community Mental Health	Enc.
6.4	Winter Planning 2025-26 Board Assurance Statement	Debbie Fulton, Director of Nursing and Therapies	Enc.
EXECUTIVE UPDATE			

No	Item	Presenter	Enc.
7.0	Executive Report	Julian Emms, Chief Executive	Enc.
PERFORMANCE			
8.0	Month 04 2025/26 Finance Report	Paul Gray, Chief Financial Officer	Enc.
8.1	Month 04 2025/26 Performance Report	Garyfallia Fountoulaki, Clinical Director, Community Mental Health	Enc.
8.2	Finance, Investment and Performance Committee Meeting held on 23 July 2025	Sonya Batchelor, Chair, Finance, Investment and Performance Committee	Verbal
STRATEGY			
9.0	a) Workforce Race Equality Standard Report b) Workforce Disability Equality Standard Report c) Workforce Race and Disability Standard Reports Presentation	Alex Gild, Deputy Chief Executive/Jane Nicholson, Director of People/Stephen Strang, Workforce Planning and Insights Manager	Enc.
CORPORATE GOVERNANCE			
10.1	Audit Committee Meeting – 23 July 2025	Rajiv Gatha, Chair, Audit Committee	Enc.
10.2	Trust Seal Report	Paul Gray, Chief Financial Officer	Enc.
10.2	Council of Governors Update	Mark Day, Interim Chair	Verbal
Closing Business			
11.	Any Other Business	Mark Day, Interim Chair	Verbal
12.	Date of the Next Public Trust Board Meeting – 11 November 2025	Mark Day, Interim Chair	Verbal
13.	**CONFIDENTIAL ISSUES:** To consider a resolution to exclude the press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.	Mark Day, Interim Chair	Verbal

Berkshire Healthcare
NHS Foundation Trust

Unconfirmed minutes

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Minutes of a Board Meeting held in Public on Tuesday, 08 July 2025

(Conducted via Microsoft Teams)

Present:	Martin Earwicker	Trust Chair
	Mark Day	Non-Executive Director
	Rebecca Burford	Non-Executive Director
	Sonya Batchelor	Non-Executive Director
	Aileen Feeney	Non-Executive Director
	Sally Glen	Non-Executive Director
	Julian Emms OBE	Chief Executive
	Alex Gild	Deputy Chief Executive
	Debbie Fulton	Director of Nursing and Therapies
	Paul Gray	Chief Financial Officer
	Dr Tolu Olusoga	Medical Director
	Theresa Wyles	Interim Chief Operating Officer
In attendance:	Julie Hill	Company Secretary
	Versha Mandalia	Associate Nurse Consultant *(present for agenda item 6.0)*
	Kate Penhaligon	Head of Research and Development *(present for agenda item 6.4)*
	Jane Nicholson	Director of People *(present for agenda item 9.0)*
	Mark Davison	Chief Information Officer *(present for agenda item 9.1)*

Observers: Felicity Copper, member of the public
Nii Wallace-Davies, member of the public

25/109	**Welcome and Public Questions** (agenda item 1)
	The Chair welcomed everyone to the meeting including the observers. There were no public questions.
25/110	**Apologies** (agenda item 2)
	Apologies were received from: Rajiv Gatha, Non-Executive Director.
25/111	**Declaration of Any Other Business** (agenda item 3)

	There was no other business.
25/112	**Declarations of Interest** (agenda item 4)
	i. **Amendments to Register –** none.
	ii. **Agenda Items** – none
25/113	**Minutes of the previous meeting held on 13 May 2025** (agenda item 5.1)
	The Minutes of the Trust Board meeting held in public on Tuesday, 13 May 2025 were approved as a correct record.
25/114	**Action Log and Matters Arising** (agenda item 5.2)
	The schedule of actions had been circulated. **The Trust Board:** noted the action log.
25/115	**Mental Health Services Board Story – (**agenda item 6.1)

	The Chair welcomed Versha Mandalia, Associate Nurse Consultant, to the meeting.
	
	Versha Mandalia introduced a video in which Amy, a 27-year-old former patient shared her journey with mental health services, particularly her experience at Prospect Park Hospital. Versha Mandalia reported that Amy had been involved with mental health services since the age of 12 and had multiple admissions including a two year stay at Prospect Park Hospital.
	
	During the video Amy made the following points:
	
	• **Challenges and Experiences:**
	  ○ Amy described the distressing nature of her admissions, including being detained, restrained, and the impact of these experiences on her mental health.
	  ○ She highlighted the lack of hope given by some professionals, who predicted a bleak future for her.
	• **Positive Interactions:**
	  ○ Despite the challenges, Amy recounted positive interactions with staff who showed genuine care and small acts of kindness that made a significant difference.
	  ○ Examples included staff offering extra blankets, juice, and engaging in activities like watching videos or playing guitar, which helped her feel more human and less like a patient.
	• **Restraint and Trauma:**
	  ○ Amy discussed the traumatic impact of restraints, especially given her complex PTSD and autism, and the need for more de-escalation techniques to avoid such measures.

	- She emphasised the importance of understanding the patient's perspective to improve care and reduce re-traumatisation. **Recovery and Contribution:** - Amy had not had any psychiatric admissions since her discharge in March 2020 and now lived independently. - She was involved in the Culture of Care Programme at Prospect Park Hospital, using her lived experience to help shape services and support other patients. - Amy felt empowered by her role and was determined to contribute to better mental health services, showing that recovery was possible. The Chair said that Amy's video was very powerful and thought provoking and asked for more information about the Culture of Care Programme. Versha Mandalia explained that the Culture of Care Programme was an NHS England initiative which ffocused on improving the culture of mental health, learning disability, and autism inpatient services. It aimed to create safer, more therapeutic, and equitable environments for both patients and staff. Aileen Feeney, Non-Executive Director said that it was a very moving video and asked how the Trust supported people with lived experience when they were sharing personal traumatic experiences. Versha Mandalia said that it was important people with lived experience were supported and that they were encouraged to step back if sharing their experiences was becoming too upsetting. Sally Glen, Non-Executive Director asked about the support for staff who worked with patients with high levels of patient distress and trauma. Versha Mandalia said that there was a lot of evidence about vicarious trauma and its impact on staff. It was note that staff were able to access psychological wellbeing support at Prospect Park Hospital including post incident and trauma support. Staff could also access the Trust's Wellbeing Matters support. Rebecca Burford, Non-Executive Director noted Amy's traumatic experience of being restrained and asked whether there was a process whereby staff could reflect whether the restraint was necessary and/or could have been done in a less traumatic way. Versha Mandalia pointed out that Amy's experience was four years ago and that since then, the Trust had undertaken a significant amount of work around reducing the incidence of restraints. It was noted that Amy had acknowledged that improvements had been made around the use of restraint at Prospect Park Hospital. The Medical Director added that the Restrictive Practice Intervention Group reviewed all incidences of restraint to provide assurance that restraint was only used when absolutely necessary and to identify any learning. Mark Day, Non-Executive Director asked how many people with lived experience were supporting the Trust to improve services. The Director of Nursing and Therapies explained that there were 58 people with lived experience (some paid, some unpaid) working with the Trust.

	On behalf of the Board, the Chair thanked Amy for sharing her story. The Chair also thanked Versha Mandalia for attending the meeting. **The Trust Board**: noted the video.
25/116	**Annual Complaints Report** (agenda item 6.2)
	The Director of Nursing and Therapies presented a paper and reported that it was a statutory requirement for the Board to receive an Annual Complaints Report. It was noted that the Trust reported complaints on a quarterly basis alongside other patient experience measures The Director of Nursing and Therapies said that the report included a breakdown of complaints by theme as requested by the Board. It was noted that 50% of complaints related to care and treatment. Sally Glen, Non-Executive Director, commented that it was not clear from the report what learning had been identified from complaints. The Director of Nursing and Therapies explained the NHS England was quite prescriptive around the content of the Annual Complaints Report and said that learning from complaints and incidents was included in the quarterly Patient Safety and Learning Report which was presented to the Quality Assurance Committee. The Director of Nursing and Therapies stressed the importance of learning from complaints and incidents and embedding that learning into practice. The Director of Nursing and Therapies agreed to make the Patient Safety and Learning Report more explicit around whether the learning identified was around a complaint or an incident. **Action: Director of Nursing and Therapies** **The Trust Board**: noted the report.
25/117	**Medical Appraisal and Revalidation Annual Report** (agenda item 6.3)
	The Medical Director presented the paper and reported that 135 completed appraisals were confirmed during 2024-35 for 140 doctors with a connection to the Trust. Four appraisals were approved as delayed in respect of four doctors on long term sick leave. One Consultant who was working flexibly from overseas failed to complete the appraisal and was not approved and was currently being followed up. **The Trust Board:** a) Noted the report. b) Approved the Trust Chair or the Chief Executive signing the statement of compliance.
25/118	**Research and Development Annual Report** (agenda item 6.4)
	The Chair welcomed the Head of Research and Development to the meeting.

	The Director of Research and Development presented the report and highlighted the following points: • The majority of the Trust's research activity involved hosting national projects that were sponsored by other organisations and pharmaceutical and industry companies. • Research visibility had increased throughout Berkshire Healthcare and clinical divisions were integrating Research into their performance, quality and business forums. • The Trust was ranked 10th out of 48 similar Trusts (Mental Health and Community Trusts) for the number of National Institute for Health and social care Research studies hosted by the Trust, and we were 18th out of 48 similar Trusts for the number of participants that we have recruited. • The Trust had an ambition to recruit 734 participants to National Portfolio Clinical Research projects in 2025/26. This was based on the current portfolio of open National studies and studies that are in set-up. Mark Day, Non-Executive Director commented that it was a comprehensive report and noted that section 3 of the summary paper included a request that the Board provided support to the operational delivery of the renewed Research Strategy and direction of travel for research across the Trust and asked for more information. The Head of Research and Development explained that this was about members of the Board being advocates for research. This could include talking about research with staff when visiting services etc. Mr Day suggested that it would be helpful if the Head of Research and Development could provide Board members, particularly the Non-Executive Directors with some examples of research activity when they were visiting services. The Head of Research and Development agreed to discuss the issue with Mark Day, Non-Executive Director. **Action: Head of Research and Development** Sally Glen, Non-Executive Director noted that there were over 600 mental health participants in research over the last year and asked about ethical oversight of research. The Head of Research and Development explained that the Health Research Authority reviewed any research ethical considerations centrally before the Trust hosted the research projects. Sonya Batchelor, Non-Executive Director asked whether there was adequate funding for the Trust's research function. The Head of Research and Development said that funding was non-recurrent and explained that the new Research and Development Strategy which was currently being developed included an ambition to increase opportunities to undertake commercial and industry research in order to subsidise the Trust's research activities. The Chair thanked the Head of Research and Development for her report. **The Trust Board**: noted the presentation.
25/119	**Quality Assurance Committee** (agenda item 6.5)

	a) Minutes of the Meeting held on 27 May 2025 Sally Glen, Chair of the Quality Executive Committee, reported that in addition to the standing agenda items, the Committee had received a presentation on the Right Care, Right Person initiative which aimed at reducing police involvement in dealing with people in mental distress. The Committee noted that the Trust had a good working relationship with Thames Valley Police. Ms Glen reported that the Committee had also received an update on the Trust's work to implement the National Patient Safety Alert in relation to bed rails. It was noted that a regional approach was being considered to oversee patients discharged from the Trust's services with bed rails in the community. **b) Learning from Deaths Quarterly Report** The Medical Director reported that in the last quarter, none of the deaths were a governance cause for concern. Two reviews had identified poor care, but this was not a contributory factor to the patients' death and learning had been identified and was being implemented through the relevant divisions. The Chair commented that he was pleased that the Learning from Deaths report now included ethnicity data. **c) Guardian of Safe Working Hours** The Medical Director reported that there were only two exception reports where resident doctors worked over their contracted hours over the last quarter and this was being addressed through time of in lieu. **The Trust Board:** a) Noted the minutes of the Quality Assurance Committee meeting held on 27 May 2025 b) Noted the Learning from Deaths Report c) Noted the Guardian of Safe Working Hours Report.
25/120	**Executive Report** (agenda item 7.0)
	The following items were discussed further: **a) Martha's Rule** The Chief Executive paid tribute to the Director of Nursing and Therapies and her team for developing an adapted version of Martha's Rule appropriate to a mental health and community trust. The original Martha's Rule applied to acute hospitals. **b) NHS Ten Year Plan** The Chair said that it would be helpful for the Board to have an opportunity to discuss the NHS Ten Year Plan at a future meeting.

	The Chief Executive said that the NHS Ten Year Plan was published after the Board papers had been circulated and agreed that an update on the NHS Ten Year Plan and the implications for the Trust's strategy would be presented to a future Board meeting. **Action: Deputy Chief Executive/Company Secretary** **The Trust Board:** noted the report.
25/121	**Month 02 2025-26 Finance Report** (agenda item 8.0)
	The Chief Financial Officer presented the report and highlighted the following points: • The planned outturn position for the Trust was a £1.7m surplus. • The Trust had a cost improvement programme of £17.5m. This was being achieved year to date although there were variances on individual lines and there were some high-risk schemes. • The current cash position was ahead of plan due to slippage on capital expenditure and a higher than planned opening cash balance. • The Better Payment Practice Code was achieved for all 4 targets. • Capital expenditure spend was below CDEL year to date. The Capital Plan for 2025-26 included the relocation of Jubilee Ward, the new Place of Safety at Prospect Park Hospital and the decarbonisation project at West Berkshire Community Hospital which was externally funded via the SALIX scheme. • The Trust had two new targets for temporary staffing. There was a requirement to reduce agency expenditure by 30% when compared to the previous year. Whist costs had reduced, the target had not yet been met, but this was in part due to phasing and overall, the shortfall was only £0.1m year to date. The bank staffing cost reduction of 10% compared to the previous year was being exceeded. • All divisions were now operating recruitment controls to manage recruitment in line with the financial plan. • Following the opening of Poppy Ward (the Trust's outsourced ward), there were very low numbers of inappropriate out of area placements. The focus was now on reducing the number of Psychiatric Intensive Care Unit (PICU) and specialist placements which were higher than planned. Sonya Batchelor, Non-Executive Director, congratulated the Chief Financial Officer and his team for a positive start to the financial year. Sally Glen, Non-Executive Director asked whether the number of female PICU beds was sufficient. The Interim Chief Operating Officer said that the Trust was working with its partners at Oxford Health and Surrey and Borders NHS Foundation Trust to review the demand for female PICU beds across the system. The review would start in September 2025. **The Trust Board**: noted the report.
25/122	**Month 02 2025-26 "True North" Performance Scorecard Report** (agenda item 8.1)
	The Month 02 2025-26 "True North" Performance Scorecard Report had been circulated.

	The Interim Chief Operating Officer presented the report and highlighted the following points: • The Trust had received confirmation from NHS England that the Trust was placed in segment 1 (for the highest performing trusts) under the new Performance Oversight Framework. The Trust had an initial meeting with the NHS England's Southeast Regional Team on 10 July 2025. • **Restrictive Interventions** – there was an upward trend in patients requiring rapid tranquilisation. Work was underway to ensure that the patient voice was heard and to understand the distress experienced by patients. • **Adult Acute Mental Health Length of Stay** performance was 32.8 days against a target of 42 which reflected effective discharge planning processes. • There had been zero **inappropriate out-of-area placements** for three months. • **Perinatal Access:** there continued to be challenges around access, with a transformation programme underway to increase the number of referrals to the service. The Chair referred to Clinical Ready for Discharge performance which was below target and asked what was driving those delays. The Interim Chief Operating Officer explained that most of the delays were because patients were waiting for a social care package of care or a suitable placement. The interim Chief Operating Officer said that the Trust was working with Integrated Care Board colleagues to reduce delays. Sally Glen, Non-Executive Director, congratulated the Trust on reducing the acute mental health average length of stay. **The Trust Board**: noted the report.
25/123	**Trust Strategy Outcome Measures – Year Two Progress Report (**agenda item 9.0)
	The Deputy Chief Executive presented the report and highlighted the following points: • The paper reviewed performance against key outcome measures aligned with the Trust's corporate strategy, focusing on strategic impact themes and supporting updates from digital, people and culture, and the green plan later on the agenda. • **Reduced Staff Turnover Rate:** Noted the lowest turnover rate in the Trust, especially in acute adult wards which was now below the 10% stretch target, reflecting improved stability and culture. • **Improved Mental Health Inpatient Services:** Positive impact from reconfiguring acute adult wards to 18 beds per ward and introducing two single-sex wards at Prospect Park Hospital, contributing to staff and patient experience improvements. • **Digital Progress:** Ongoing digital initiatives were supporting time-to-care improvements, with further details provided in the digital update. • **Reducing Carbon Emissions:** The Trust's performance was slightly behind target but was expected to catch up due to recent investments and actions outlined in the Green Plan 2025-28. • **Financial Performance:** on plan for quarter one, with a higher proportion of recurrent cost savings compared to other providers, improving the underlying financial position.

	• **Patient Experience:** Uptake of the "I Want Great Care" tool is below the 10% target but improving, with ongoing efforts to enhance patient feedback and learning. • **Strategic Refresh:** The outcome measures were under review as part of the Trust strategy refresh process. • Proposed new measures and contextual updates would be brought to the October 2025 Board Strategy session, including the NHS Ten-year Plan and the Trust's future system role. **The Trust Board**: noted the report.
25/124	**People and Culture Strategy Progress Report** (agenda item 9.1)
	The Chair welcomed the Director of People to the meeting. The Director of People presented the paper and highlighted the following points: • **Staff Turnover and Retention** – staff turnover was continuing to decline. • **Sickness Absence** – some progress was being made following the Sickness Absence Review last year, however, the Trust was still not meeting the proposed national target in the new NHS Workforce Plan of 4.2% (the Trust's performance was currently 4.5%). However, our absence rates were still amongst the best in the Southeast. • Improvements had been made to the time to hire and compliance with core training requirements. • The Trust had recently completed a Mutually Agreed Resignation Scheme exercise. • Trust was conducting a pilot scheme whereby interview questions would be shared with candidates in advance of an interview to support neurodivergent people. The Chair commented that there had been impressive progress made across a number of areas and paid tribute to the Director of People and her team. The Director of Nursing and Therapies reported that the Oliver McGowan Mandatory training was RAG rated red and said that the Trust was starting to do its own tier 2 training whilst waiting for the system to develop a system wide training course. Sally Glen, Non-Executive Director asked for more information about the nursing job evaluation review. The Director of People explained that the national team was introducing new guidelines on nursing roles at each level. The Director of Nursing and Therapies added that there were national job profiles for various nursing roles, but over time people had not adhered to those profiles. The aim of the exercise was to streamline job profiles which would be matched to the national evaluation for that job profile. Sonya Batchelor, Non-Executive Director, commented that the downward trend line in reducing the time to hire was impressive. Ms Batchelor commented that she had recently attended the Trust's Corporate Induction Programme for new starters and said that the Chief Executive attended all Corporate Inductions sessions which set a positive tone for staff joining the Trust.

	Ms Batchelor asked whether there were sufficient resources to deliver all the Trust's people-related initiatives. The Director of People said that the Trust was prioritising its initiatives to ensure that the organisation was not overloaded and that most of the projects were focussed on continual improvements rather than new initiatives. The Chair thanked the Director of People for her report. **The Trust Board**: noted the report.
25/125	**Digital Strategy Update Report** (agenda item 9.2)
	The Chair welcomed the Chief Information Officer to the meeting. The Deputy Chief Executive introduced the item and said that the NHS Ten Year Plan emphasised a shift from analogue to digital and that the Trust was ahead in adopting new technologies to support patient self-care and other digital initiatives. The Chair commented that sharing data across other organisations was challenging across the NHS. The Chief Information Officer said that the Trust was working with smaller voluntary organisations who supported the Trust and who were not in a position to invest in digital infrastructure themselves to give them access to the Trust's digital systems The Chief Information Officer said that the Trust was the only cloud infrastructure hosted digital trust in the country and that this meant making the transition from analogue to digital easier for the Trust than for other trusts. The Chief Information Officer said that financial constraints would inevitably impact the scalability of digital transformation work the Trust could deliver. Aileen Feeney, Non-Executive Director noted that the expansion of the digital agenda across the Trust had resulted in saving 250,000 hours of operational time and asked whether there were monetary or headcount reductions as a result. The Chief Information Officer said that it was often difficult to quantify the financial savings especially if the savings in hours were across a small team. The Chief Information Officer reported that the Trust was focussing on improving productivity by upskilling staff to handle more sophisticated roles whist automating simpler administrative tasks. The Chief Financial Officer said that it was important that the Trust prioritised its investments in digital. The Chief Executive commented that the NHS Ten Year Plan included a commitment to develop the NHS App to provide a single source of truth for patient records and pointed out the Trust had been using the Connected Care system for a number of years which was a separate electronic record platform which enabled patient records to be accessed by partner organisations.

	The Chief Information Officer said that at the national level legislative changes would be required to facilitate a single patient record. The Chair thanked the Chief Information Officer for his report. **The Trust Board**: noted the report.
25/126	**Trust's Green Plan 2025-28** (agenda item 9.3)
	The Chief Financial Officer presented the paper and highlighted the following points: • All NHS organisations were required to have a Green Plan in place. • The Green Plan 2025-28 set out the Trust's ambitions for environmental sustainability over the next three years. • The Green Plan was developed by the former Sustainability Manager in consultation with a number of staff across the organisation and had been agreed by the Trust's Green Group • The Trust had secured over £2.0m of public sector funding to replace the existing gas heating system at West Berkshire Community Hospital with heat pumps which would cut carbon emissions by around 350 tonnes annually. • As a community and mental health trust operating across a wide geographical area, travel related carbon emissions made up a large proportion of the Trust's overall carbon footprint (around 20%). The Trust had reduced business mileage but achieving further reductions would require a strategic shift towards sustainable travel which was a key focus of the separate Travel and Transport Strategy 2025. • The Board would receive an update on the implementation of the Green Plan 2025-28 annually. Sonya Bachelor, Non-Executive Director, commented that achieving Net Zero Scope 3 would be really challenging and said that it was important to phase the Trust's Net Zero work. The Chief Financial Officer agreed and said that the Trust was initially focussing on reducing the emissions it directly controlled. **The Trust Board**: approved the Trust's Green Plan 2025-28.
25/127	**Fit and Proper Persons Test Assurance Report** (agenda item 10.0)
	The Company Secretary presented the paper which provided assurance that the Trust had completed the annual fit and proper person test checks and that all Board members remained fit and proper persons. The Company Secretary reminded members of the Board to inform her if their interests changed during the year to ensure that the published Register of Board Members Interests published on the Trust's website remained up to date. **The Trust Board**: noted the report.

25/128	**Minor Changes to the Trust's Constitution** (agenda item 10.1)
	The Company Secretary presented the paper and reported that the proposed minor changes to the Trust's Constitution were necessary to reflect the Procurement Act 2023 (which came into force on 24 February 2025). It was noted that the Council of Governors had approved the proposed changes. **The Trust Board**: approved the proposed changes to the Trust's Constitution as set out in the report.
25/129	**Audit Committee Meeting – 23 April 2025** (agenda item 10.2)
	The minutes of the Extraordinary Audit Committee meeting held on 18 June 2025 had been circulated. **The Trust Board:** noted the minutes of the Audit Committee meeting held on 18 June 2025.
25/130	**Council of Governors Update** (agenda item 10.3)
	The Chair reminded the meeting that the Council of Governors was responsible for appointing Non-Executive Directors and the Chair. Unfortunately, due to a lack of suitable candidates, the Council of Governors' Appointments and Remuneration Committee had paused the recruitment process for a new chair. New Recruitment Consultants would be appointed, and the recruitment process would re-start in September 2025. The Chair paid tribute to the Trust's outstanding Governors particularly for their commitment to patients. The Chair commented that there was a suggestion in the NHS Ten Year Plan that governors would not be part of the new NHS Foundation Trust model but said that he hoped that the Governor role would continue.
25/131	**Any Other Business** (agenda item 11)
	Farewell to Martin Earwicker, Chair The Chief Executive reminded the meeting that this was Martin Earwicker's last Board meeting and that he would be leaving the Trust on 31 July 2025 having served for 8.5 years. The Chief Executive said that Martin Earwicker was well known and respected across the Trust and that the Trust had greatly benefitted from his wisdom and insights. Martin Earwicker thanked the Chief Executive for his warm words and said that Berkshire Healthcare was an outstanding Trust and that it had been his privilege to serve as chair.

	On behalf of the Board, the Chief Executive thanked Martin Earwicker for his significant contribution to the work of the Trust and wished him well in his role as Chair of Hampshire Hospitals NHS Foundation Trust.
25/132	**Date of Next Public Meeting** (agenda item 12)
	The next Public Trust Board meeting would take place on 09 September 2025.
25/133	**CONFIDENTIAL ISSUES:** (agenda item 13)
	The Board resolved to meet In Committee for the remainder of the business on the basis that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.

I certify that this is a true, accurate and complete set of the Minutes of the business conducted at the Trust Board meeting held on 08 July 2025.

Signed……. Date 09 September 2025

Berkshire Healthcare NHS Foundation Trust

BOARD OF DIRECTORS MEETING 09.09.25

Board Meeting Matters Arising Log – 2025 – Public Meetings

Key:

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

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

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
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12.01.24	24/198	Estates Strategy Update	The Quality Assurance Committee to have an opportunity to discuss the outcome of the Prospect Park Hospital Mental Health Survey.	January 2026	**MM**		
11.03.25	25/038	Nottingham Independent Mental Health Homicide Review Report	The Board to receive an update at the September 2025 meeting.	September 2025	**TW**	On the agenda for the meeting.	
13.05.25	25/085	Reducing Violence and Aggression	The Interim Chief Operating Officer to ask the Criminal Justice Panel for a summary report on the number of referrals and those cases that had resulted in a prosecution over the last year.	September 2025	**TW**	See appendix 1	
08.07.25	25/116	Annual Complaints Report	The Patient Safety and Learning Report which is presented to the Quality Assurance Committee to be more explicit about around whether the learning identified was in connection with a complaint or an incident.	November 2025	**DF**	The information will be included from the quarter 2 report (the quarter 1 report submitted to the August 2025 Quality Assurance Committee had already been drafted).	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
08.07.25	25/118	Research and Development Annual Report	The Head of Research and Development to discuss with Mark Day, Non-Executive Director how Non-Executive Directors could support research and development when they visited services.	September 2025	**KP**	The Head of Research and Development has had a conversation with Mark Day, Interim Chair and has agreed to provide Non-Executive Directors with some guidance on how Non-Executive Directors can support research and development when they are visiting services.	
08.07.25	25/120	Executive Report	The Board to receive an update on the NHS Ten Year Plan and the implications for the Trust's Strategy at the future meeting.	October 2025	**AG/JH**	To be discussed as part of the Trust's Strategic Planning Day in October 2025.	

Appendix 1

Report on the work of the Criminal Justice Panel – September 2025

The Criminal Justice Mental Health Panel (CJMH Panel) facilitates collaboration between Thames Valley Police, Criminal Justice, and Mental Health Services to support individuals with mental health needs involved in criminal investigations. The panel aims to improve justice outcomes, safeguard individuals, and protect the public by sharing information and supporting decision-making across agencies.

• **Panel Purpose and Context:** The panel addresses cases involving mental health needs and criminal offenses, promoting justice, safeguarding, public protection, and mental wellbeing through inter-agency cooperation.

• **Eligible Cases:** The panel focuses on prolific offenders within mental health services, issues with criminal justice case progression, and escalation concerns.

• **Home Office Guidance:** Panel discussions are guided by Home Office approved questions assessing the impact of prosecution on offenders' health, treatment plans, risk of reoffending, harm to others, and treatment engagement.

• **Membership Composition:** Members include representatives from Forensic Services in Oxford Health NHS Foundation Trust, Thames Valley Police, Probation Service, Berkshire NHS Foundation Trust, Local Authority AMHPs, and South Central Ambulance Service, covering diverse roles from psychiatrists to police officers.

• **Member Responsibilities:** Members contribute professional expertise, prepare in advance, actively participate, arrange cover if absent, complete agreed actions, and update clinical records as needed.

• **Accountability and Reporting:** Members are accountable within their own agencies' governance structures and report to quality, safeguarding, and performance forums.

• **Confidentiality and Information Sharing:** Information exchange is controlled and conducted for legitimate policing purposes, complying with data protection laws and agreements among agencies.

• **Meeting Operations:** Panels meet monthly in each county with a chair from TVP or NHS Mental Health Trust, require quoracy from both organizations, and follow a structured agenda including patient discussions and new referrals

Referrals into the panel over the past 12 months:

17 individual cases have been referred into the panel and discussed across the past 12 months, some of these remain on the panel 'open cases' list for discussion and updates each month particularly in those people who have criminal justice proceedings or

investigations ongoing. Others have been presented as at times of crisis they are people who would routinely encounter TVP due to their propensity to risks to others or patterns of offending behaviour. The panel is used as a platform to communicate appropriate pathways for those people into the attending multi-agency representatives.

Cases resulting in a prosecution over the past 12 months:

One person was charged and convicted of assault against two staff members and received a hospital order outcome. This is important as although the end result is the same (he remains an In-Patient in PPH) it supports the appropriate clinical pathways for future care provision in his case.

Another person was charged with possession of drugs, assault, assault on Emergency Workers and criminal damage. He received a caution for these offences and a community resolution for another criminal damage charge.

A third person was charged with 3 assaults, however there was no further action taken and TVP referred the case back to Mental Health Services. This was picked up by the Criminal Justice Panel and the person responsible was challenged by the senior Justice Gateway Officer about why TVP didn't retain ownership of their care and safeguarding responsibilities towards PPH patients and staff.

Helen Robson

Service Director MH Urgent Care

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	9th September 2025
Title	**Patient Experience Report -Quarter 1 (April – June 2025)**
	Paper for noting
Reason for the Report going to the Trust Board	This report is written to provide information to the Board in relation to a range of patient experience data available to us. It also provides assurance in relation to the Trust handling of formal complaints as set out within The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and by the CQC through the Health and Social Care Act 2008 (regulated activities) Regulations 2014: Regulation 16 receiving and acting on complaints.
Business Area	Trust Wide
Author	Elizabeth Chapman, Head of Patient Experience (full report) Debbie Fulton; Director Nursing and Therapies (Highlight Report)
Relevant Strategic Objectives	Understanding the experience of our patients, how we respond to this, capture and learn from all forms of feedback is fundamental to the provision of safe, caring and effective services. **Patient safety** **Ambition:** We will reduce waiting times and harm risk for our patients **Patient experience and voice** **Ambition:** We will leverage our patient experience and voice to inform improvement **Health inequalities** **Ambition:** We will reduce health inequalities for our most vulnerable patients and communities

Highlight Patient Experience Report - Quarter one 2025/26

1. Why is this coming to the Board?

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

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

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

2. What are the key points?

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

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

Patient Experience – overall Trust Summary		Target	Q1	Q2	Q3	Q4	Year end
Patient numbers (inc discharges from wards)	Number		162,555				
Number of iWGC responses received	Number	**61,000 year** for 10%	13,604				
iWGC Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	**10%**	8.4%				
iWGC 5-star score	Number	**4.75**	4.8				
iWGC Experience score – FFT (good or very good experience)	%	**95%**	94.67%				
Compliments received directly by services	Number	24/25 **4904**	1682				
Formal Complaints received	Number/ %	24/25 **230 (0.032%)**	51				
Formal Complaints Closed	Number	24/25 **198**	57				
Formal complaints responded to within agreed timescale	%	**100%**	100%				
Formal Complaints Upheld/Partially Upheld	%	50%	54%				
Local resolution concerns/ informal complaints Rec	Number	2024/25 **189**	46				
MP Enquiries Rec	Number	2024/25 **27**	12				
Complaints upheld/ partially by PHSO	Number	2024/25 **2**	0				

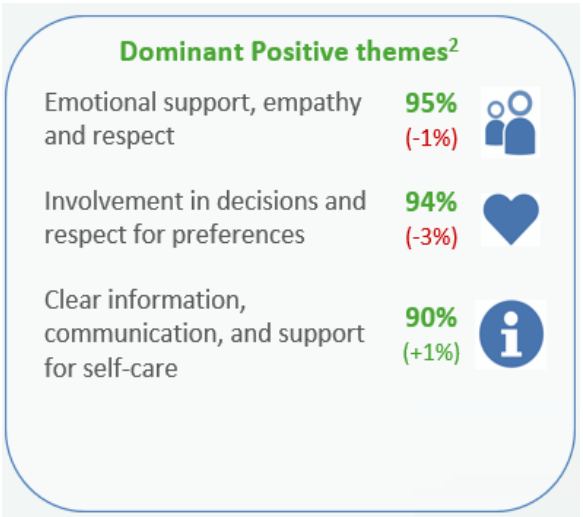
The data continues to show only small variations each quarter although we have over the last year received a significantly lower number of MP enquires compared to previous years (27 in 2024/25 compared to 73 in 2023/24), the numbers are starting to increase to pre-election levels. During quarter one we have seen the proportion of total new complaints received that are secondary (further queries or not content with initial response) at the higher end of benchmarking against quarters last year; this is something to keep under review to ensure that initial responses are adequately addressing an individuals concerns.

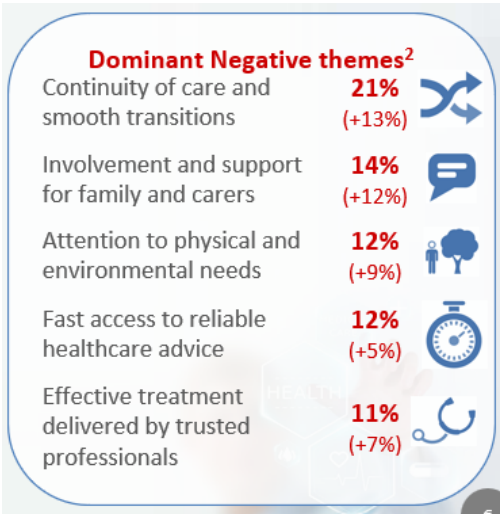
During this quarter we have continued to see an increase in the number of feedback forms received with services focusing on achievement of this, and whilst we did not achieve our aim of 10% patients providing feedback by year end 24/25, for June we achieved our highest percentage to date at 8.8%.

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

The lowest sub scores across all divisions remain within the mental health inpatient services, where feeling informed, involved and listened to remaining lower in terms of star rating than other services. The wards all have ongoing work to support improvement, 3 of our wards are participating in the full NHS England Culture of Care programme, and our other mental health wards are participating in bespoke elements of the programme which was offered to all Mental Health Trusts as part of their transformation programme. This programme aims to improve the culture of inpatient mental health and learning disability wards for patients and staff so that they are safe, therapeutic, and equitable places to be cared for, and fulfilling places to work. The full report provides some detail on pages 9 and 10 of feedback received through this programme, areas of focus and how the service is addressing the themes.

Overall feedback remains overwhelmingly positive with questions around our staff and involvement continuing to be dominant positive themes. There is very little movement from the last quarter in terms of these themes that are dominant positive or negative although we have seen a reduced satisfaction in terms of involvement for family and careers and continuity of care/ smooth transitions; this should be reviewed for the next quarter to see if this position remains the same. We have a carers lead within the organisation and proactively work on ensuring processes aligned with Triangle of Care and much work is undertaken to support services in the provision of support for loved ones and there is currently work being undertaken to improve transition between services within Mental health and between child and adult services.

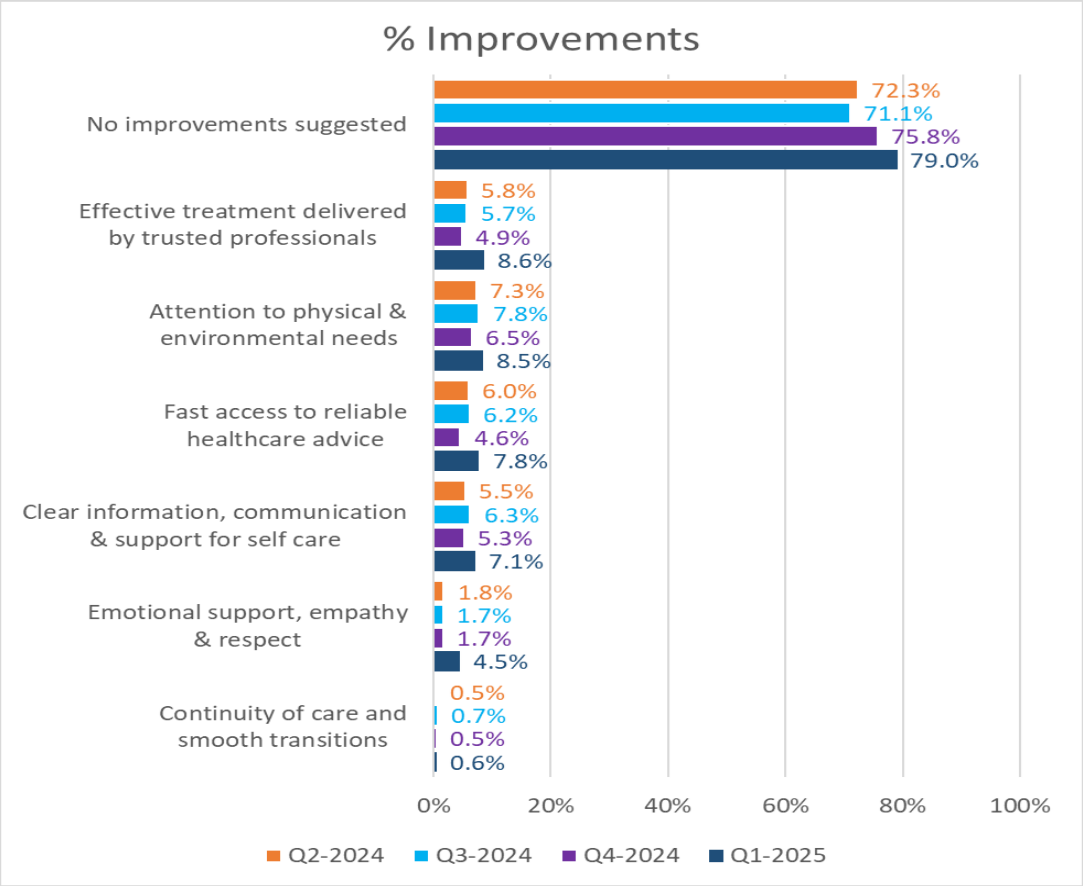




*Number in brackets shows change from previous quarter

91% of the respondents provided a reason for the rating they gave and 76% of feedback contained improvement suggestions. The themes of these improvements are detailed below.

79% of these specifically stated that no improvements were necessary (**+3%**).



What are the implications for EDI and the Environment?

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

Ethnicity	% Complaints received	% Patient Survey Responses	% Breakdown of Q4 attendances
Asian/Asian British	10.94%	8.60%	9.70%
Black/Black British	4.69%	2.90%	3.37%
Mixed	0.00%	2.70%	3.41%
Not stated	7.81%	22.80%	8.91%
Other Ethnic Group	3.12%	4.80%	2.00%
White	71.87%	58.30%	72.61%

The data indicates for this quarter that those of Asian and Black ethnicity have a slightly higher percentage of complaints than their attendance and slightly lower completion of the patient Survey. This is different from most of the quarterly reporting since this ethnicity data has been provided because we have previously seen these groups of patient raising less complaints compared to their percentage attendance. There continues to be a high percentage (around a quarter of all respondents) who are not providing ethnicity data when completing a survey so there is less confidence that we know the true percentage completion groups by demographics.

In terms of gender, we continue to see a slightly higher percentage of males making formal complaints and lower completion of the patient survey compared to women. We continue to see a high percentage of people who are not completing some of the demographic questions including gender. The data would indicate that there is no discernible difference between the upholding or not of a complaint based on gender of complainant.

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

Services are able to drill down into the feedback given by characteristics, this not only helps services to ensure that they are being as inclusive and accessible as possible but also supports wider pieces of work such as the Neurodiversity Strategy and Patient and Carer Race Equality Framework (PCREF).

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

3. Conclusions and Recommendations for consideration by the Board

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

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

Berkshire Healthcare
NHS Foundation Trust

Patient Experience Report Quarter 1 2025/26

Introduction

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

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

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

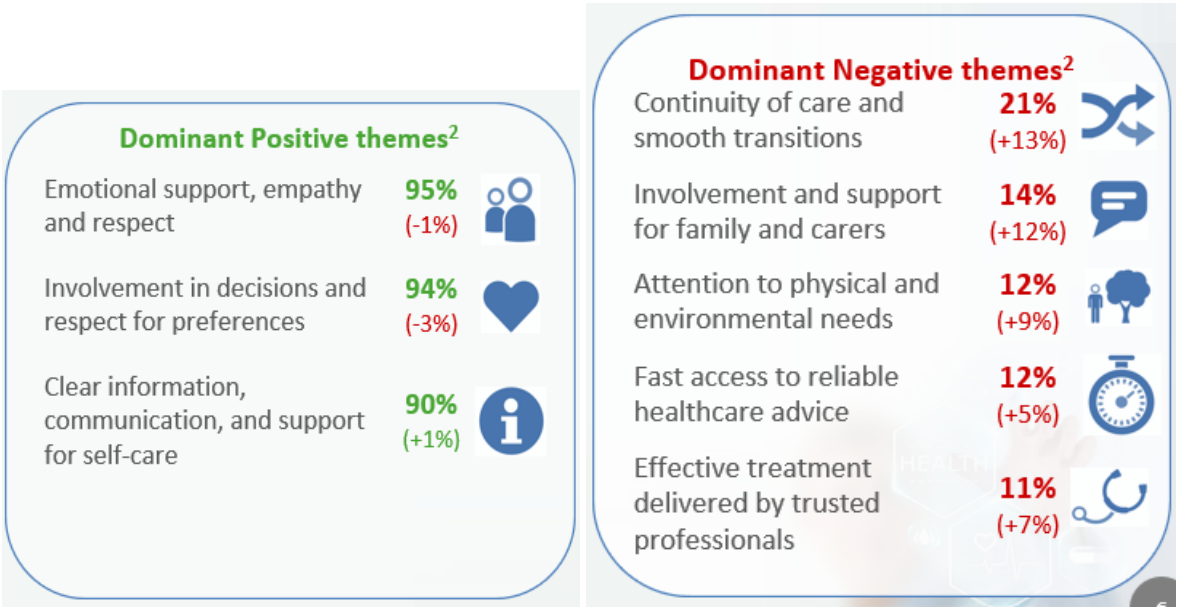
From April 2024, the response rate has been calculated using the number of unique/distinct clients rather than the total number of contacts. Patients will continue to be offered the opportunity to give feedback at each appointment.

Table 1

Patient Experience – overall Trust Summary		Qtr 1	Qtr 2	Qtr 3	Qtr 4	Year end
Distinct patient numbers (inc patient discharges)	Number	162,555				
Number of iWGC responses received	Number	13,604				
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	8.4%				
iWGC 5-star score	Number	4.80				
iWGC Experience score – FFT	%	94.67%				
Compliments received directly by services	Number	1682				
Formal Complaints Rec	Number	51				
Number of the total formal complaints above that were secondary (not resolved with first response)	Number	13				
Formal Complaints Closed	Number	57				
Formal complaints responded to within agreed timescale	%	100%				
Formal Complaints Upheld/Partially Upheld	%	54%				
Local resolution concerns/ informal complaints Rec	Number	46				
MP Enquiries Rec	Number	12				
Total Complaints open to PHSO (inc awaiting decision to proceed)	Number	6				

There has been an increase in the number of formal complaints received and closed this quarter, but the amount of informal complaints/local resolutions has slightly decreased. There has also been an increase in number of MP enquiries received for the second quarter in a row; with enquires now returning back to pre – election levels.

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



The brackets () in the picture above shows the comparison to the report for Quarter 4. (+) means that there has been an increase in satisfaction since the last report, (-) means a decrease. The picture shows that there has been a decrease in the experience of patients across all dominant negative themes. There has been an increase in the number of responses overall, and Divisions need to monitor these themes to identify any themes or opportunities for impact.

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

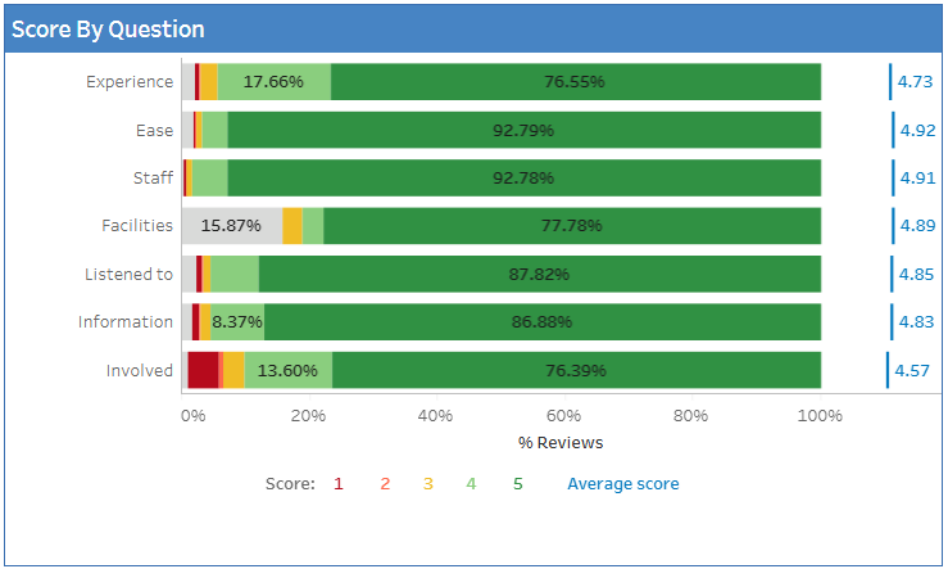
What the data is telling us

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

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

Table 2: Summary of patient experience data.

Patient Experience - Division CFAA and LD		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	Number	4956			
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	12.7%			
iWGC 5-star score	Number	4.78			
iWGC Experience score – FFT	%	94.2%			
Compliments received directly by services	Number	163			
Formal Complaints Rec	Number	16			
Formal Complaints Closed	Number	13			
Formal Complaints Upheld/Partially Upheld	%	53.8%			
Local resolution concerns/ informal complaints Rec	Number	7			
MP Enquiries Rec	Number	3			



For children's services further work has been undertaken with the services, young people and parents/carers to promote increasing the number of responses, this has included the design and layout of the new posters that will now be used across CFAA services. The Vaccination team has continued to collect feedback through paper forms, and the response rate is continuing to increase.

Of the 4956 responses, 4860 responses related to the children's services within the division; these received 94.2% positivity score, with positive comments about staff being friendly and kind and a few suggestions for further improvement, this included 9 reviews for Phoenix House. Seventy-two of the responses related to learning disability services and 24 to eating disorder services.

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

Children's Physical Health Services

There were four formal complaints for children's physical health services received this quarter. Two related to Children's Occupational Therapy (about waiting times to access the service) and two related to Children's Speech and Language Therapy (which were about physical care).

4408 of the 4956 patient survey responses were in relation to children's physical health services. The 2 services with most responses were the Immunisation and Health Visiting Wokingham – 6-8 Week contact; the Immunisation Team received 3576 (36.1% response rate) of these responses which scored positively receiving a rating of 4.74 and feedback included they were kind; injection was quick, and nurses were friendly. "*She was extremely kind and comforting. I could trust her. She was gentle and told me everything she would do before so I would know.*" health visiting services also receive very positive feedback with positivity score of 100%- and 5-star rating of 4.99.

Child and Adolescent Mental Health Services (CAMHS)

For Child and Adolescent Mental Health Services there were 8 complaints received, of these one related to waiting times, two were for care and treatment, two were medication and three were about communication

There have been 452 responses for CAMHS services received through our patient survey for this Quarter. These include 303 received from those attending our neurodiversity services

(positive score 96.70% and star rating of 4.91 with lots of positive comments about staff and the experience).

Adult ADHD Service

There was one formal complaint about the delay in being able to access medication.

Learning disability

There was one complaint received for the Community Team for People with a Learning Disability. This related to support needs not being met.

Overall, there were 72 responses for all Learning Disability services; responses were for the Community Teams for People with a Learning Disability, Learning Disability Inpatient Unit and Learning Disability Intensive Support Team. These received a 94.4% positive score; feedback included that staff provided support, "*I'm very happy and truly enjoy working with [name removed]. We always receive support and guidance whenever needed. [name removed] is patient, attentive, and works collaboratively to help find effective solutions."* there were comments for improvements including explain tests, more time, and more visits, staff attitude and parking. The 6 responses that received with a score below 5 left comments in the free text boxes, for Campion Unit comments included some staff are unapproachable and stern and to speak directly to patient.

Eating disorders

There were 2 complaints received for the Eating Disorder Services. This related to being unhappy with the care and treatment.

Of the 24 feedback responses received, 22 scored a 5 with comments such as "*[name removed] is always exceptionally patient, understanding and most of all believes what I say. [name removed] gives me time and goes over and above to support me between sessions should I reach out for additional help. I can't thank her enough for all the support she has given me along my very long road requiring support and guidance which she is able to provide in abundance with professionalism and vast knowledge. Thank you.*," *"All of the staff members were lovely. I was quite anxious to go to the appointment, but they made me feel much more at ease. The separate room that I was taken into was spacious enough that it didn't seem intimidating, so I think that made it a lot better." "I have made so much progress since being with this service. I have worked with several other services and none of them were as supportive, understanding, helpful or motivating as this service is. I'm listened to, I'm validated, I'm challenged (in a good way). This service is open to supporting a huge variety of eating disorder presentations"* Areas for improvement included better communication around appointment times and shorter wait times.

Mental Health Division

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

Patient Experience - Division MHE		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	**Number**	315			
Response rate (calculated on number contacts)	**%**	3.25%			
iWGC 5-star score	**Number**	4.64			
iWGC Experience score – FFT	**%**	91.4%			
Compliments received directly by services	**Number**	159			
Formal Complaints Rec	**Number**	5			
Formal Complaints Closed	**Number**	12			
Formal Complaints Upheld/Partially Upheld	**%**	58%			

Local resolution concerns/ informal complaints Rec	**Number**	2			
MP Enquiries Rec	**Number**	2			

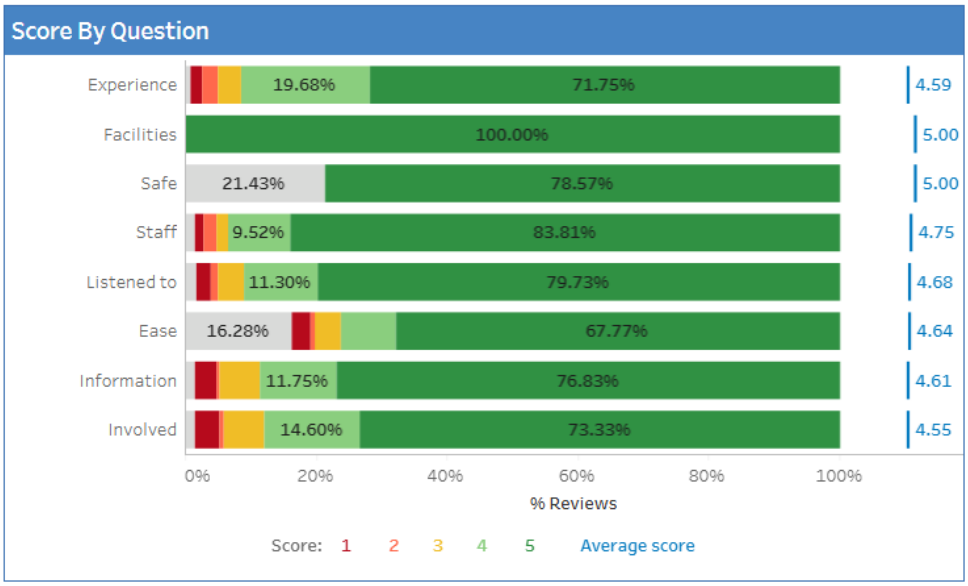


Table 3: Summary of patient experience data.

5 Formal Complaints were received into the division; in addition, there were 2 informal/locally resolved complaints. 12 complaints were closed during the Quarter. 7 of these were either fully or partially upheld and they were across CMHTs, CRHTT and MHICS.

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

The services receiving the majority of iWGC responses were Crisis Response Home treatment Team (CRHTT) East with 110 responses, IPS Employment Service with 26 responses and CMHT/Care pathways.

Across the CRHTT East survey, the average 5-star score was 4.46 with 87.3% positive feedback, a slight increase in the 5-star score and a slight decrease in the percentage positive feedback from last Quarter. 96 of the overall number of responses received (110) scored a 4 or 5-star rating with many comments about staff being helpful, listened, kind and supportive; "*The service was excellent. Everyone that I spoke to on the phone was so kind, was so nice, everyone. Really supportive." "It was a very good service. I was listened to. They treated me kindly. They gave the chance to talk, and I felt that they understood me."*

This Quarter, questions relating to information and feeling involved were least likely to be positive with areas for improvement and dissatisfaction with the service about poor communication, appointment missed or rescheduled and didn't feel listened to.

The IPS Employment Service received 100% positive score (4.87-star rating) and received positive feedback about staff being supportive, helpful and friendly. "*[name removed] was very professional and supportive. She helped me build a professional CV. Very positive and encouraging staff. She motivated me and gave me courage and confidence in job applications and interview techniques. [name removed] was easily approachable and non-judgmental. So grateful for her invaluable advice and support."*

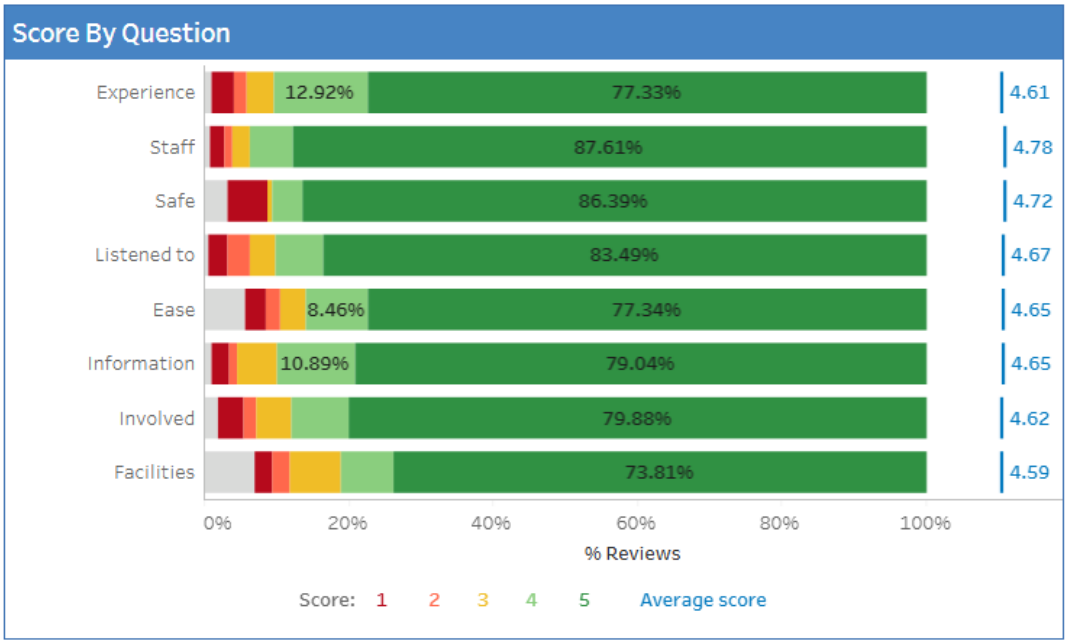
CMHT received 51 responses (Bracknell 11, WAM 16 and Slough 24) with 90.2% positive score and 4.67 star with 5 of the total responses scoring less than a rating of 4; comments

included "*We were doing a needs assessment, but the CMHT person gave little hope of getting what I know i need. It left me panicky.*" There were several positive comments that staff were friendly, professional, understanding and listened examples of comments are "*The dr was lovely and came across as very caring. She seemed knowledgeable and was humorous. It's quite difficult to get on my good side quickly, but she managed to do so within minutes. She exuded warmth and compassion.*", "*As always [name removed] [name removed] is very supportive and works with me to find a good balance in life. I have been stable for the last few years with [name removed] [name removed]'s invaluable help." And "I felt Dr [name removed] did an excellent job in dealing with me as a patient. She listened to how I have been affected by my mental health issues and my work situation and some of my life history. We also talked about medication and she was willing to listen to my thoughts on trying another medication that I felt might work better. She wasn't sure if it would be the right one for me so she was cautious. But we agreed if we tried it the medication will either work or it won't. So I was happy with that and I am coming off another medication that I have felt has not worked for me. The Dr was very polite and understanding and made me feel valued. Also [name removed] was involved in my meeting which I was happy for her to be in there. Also she did suggest the managing emotions programme if I was interested in it or not and I did say I would have a think about it."* Some of the suggestions for improvement included listen to patient complaint and read patients record. Further work is being carried out with Mental Health services to improve uptake as part of the wider patient experience improvement plan.

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

Table 4: Summary of patient experience data.

Patient Experience - Division MHW		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	**Number**	1138			
Response rate (calculated on number contacts)	**%**	4.78%			
iWGC 5-star score	**Number**	4.66			
iWGC Experience score – FFT	**%**	90.25%			
Compliments received directly by services	**Number**	154			
Formal Complaints Rec	**Number**	12			
Formal Complaints Closed	**Number**	11			
Formal Complaints Upheld/Partially Upheld	**%**	38.4%			
Local resolution concerns/ informal complaints Rec	**Number**	5			
MP Enquiries Rec	**Number**	3			



12 Formal Complaints were received into the division; in addition, there were 5 informal/locally resolved complaints. 11 complaints were closed during the Quarter. 5 of these were either fully or partially upheld and they were from services across the geographical localities and services.

The Mental Health West division has a wide variety of services reporting into it, including the Talking Therapies service and Court Justice Liaison and Division service (CJLD), as well as secondary mental health services. The 3 services with the most feedback through the patient survey were Talking Therapies Step 2 with 205 responses, CRHTT West with 167 responses and Talking Therapies – Step 3 with 106 responses.

Questions relating to involvement and facilities have the least number of positive responses. Examples of feedback include patients were not involved in their discharge when accessing Talking Therapies and CRHTT.

For CRHTT West there was an 82.6% positivity score and 4.37-star rating. There were lots of positive comments about staff being supportive, helpful, and kind, "*team were always on time and helpful. seeing them really uplifted my mood. reassured me at discharge and helped make sure the perinatal team was ready and aware I would be coming to them. Also, after discharge there was an issue with the GP and my medication, and when I contacted crisis, they were so quick to help me and sort my meds. Excellent, excellent service."* Some of the areas for improvement included more information around discharge process, would like more information on medication and better communication from the service.

The Older Adult Mental Health Service and Memory Clinic combined have received a 99.2% positivity rating (4.95-star rating) some of the feedback included *"Dr [name removed] listened to why I was there, and she clearly understood my problem. She asked lots of questions and was so kind and understanding. She explained what the situation was in a way that I could completely understand it. She also gave me some excellent advice and told me how to proceed if it happened again. It is not nice having a mental health problem and Dr [name removed] completely put me at ease. I feel very fortunate to have been looked after by this very kind and highly professional lady."*

There were 41 responses received for West CMHT teams with 92.7% positivity score and 4.58-star rating, 38 of these were positive with comments received that staff listened and were kind, there were 3 negative responses for Reading and Wokingham with reviews stating that patients felt like staff were rude and didn't listen.

Most comments were very positive about the staff, including that they listened, were helpful and supportive. Several of the comments/areas for improvement were that the rooms felt bare and need some decoration and wait to be seen was long. For example, *"[name removed] was very helpful and kind. Her direction was always clear and concise. She explained things very well. She helped me become more functional and built my confidence in approaching tasks. My anxiety has reduced over the time I have been under her care, and I am able to do more on my own. I'm very grateful to her."*

For Talking Therapies, the overall scores were 90.05% positivity and 4.71 star rating with the employment pathway getting the highest scores. Many of the comments were positive about staff having listened, and that they were kind and understanding.

Examples of positive feedback about Talking Therapies included, "*I was seen quickly, and received at all stages of the process an extremely high standard of care. I felt listened to, taken seriously and cared for in a way that I haven't in previous mental health support settings and have noticed genuine improvement as a result of the treatment. I will genuinely miss my sessions with [name removed], and although grateful to be feeling better am sad for them to end!"* "*I found the therapy exactly what I needed at this time. The therapist was extremely kind, I felt very comfortable discussing all my problems. I looked forward every week to speak to her. The therapy has meant that I have a better understanding of my past also my current grief. I feel much calmer. The therapy has helped me move on. I am very grateful to have had the chance to have the therapy and lucky to have such a lovely kind therapist."* and *"Just a wonderful experience from start to finish. Every person I spoke to made me feel like I was the most important thing going on at that moment. The therapists I dealt with were incredible, [name removed] was especially amazing. Have never felt so seen or heard in my life."* Patients reported that they felt "*I felt listen to and the advice given was very helpful and the care and attention was appreciated. I also felt at ease, and I trusted the whole process and the lady I spoke to."*

Op Courage

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

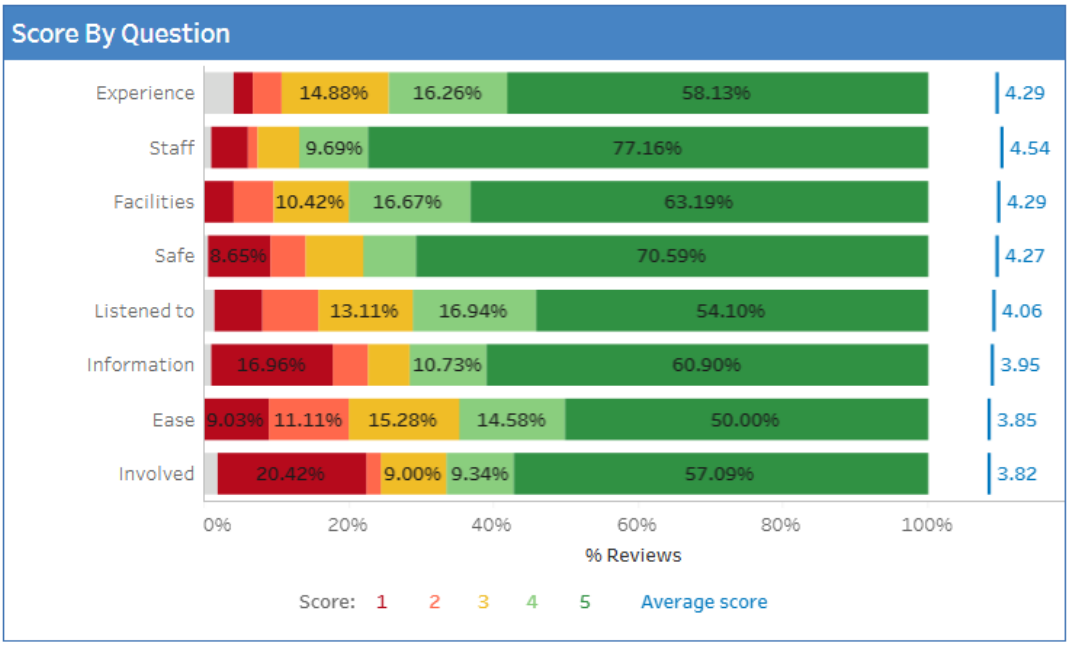
Op COURAGE received 60 responses during the Quarter, their patient survey responses gave a positivity score of 88.3% (4.68-star rating), 4 of the reviews scored less than 4 with comments regarding staff being too direct, hard to understand what the doctor was saying and they were told to self-refer when they wanted treatment.

Mental Health Inpatient Division

Table 5: Summary of patient experience data.

Patient Experience - Division MH Inpatients (wards)		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received*	**Number**	289			
Response rate	**%**	133.8%			
iWGC 5-star score	**Number**	4.15			
iWGC Experience score – FFT	**%**	74.4%			
Compliments	**Number**	18			
Formal Complaints Rec	**Number**	9			
Formal Complaints Closed	**Number**	10			
Formal Complaints Upheld/Partially upheld	**%**	20%			
Local resolution concerns/ informal complaints Rec	**Number**	1			
MP Enquiries Rec	**Number**	0			

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



The satisfaction rate was 74.4% with 62 of the 278 completed questionnaires giving scores of 1-3. The individual question themes would indicate that the question relating to involved received the least positive scores with overall 5-star rating for this question being 3.82 and 91 of the 283 giving a score of 3 or less to this question. The Ease question asks whether they felt involved in their care, comments relating to ease of access and information also received lower scores with some comments relating to patients wanting more information, food could be improved and would like more activities. Some of the wards are currently participating in a national culture of care programme which focuses on safety and involvement of patients (this is detailed alongside actions being undertaken further down in this section); there is also ongoing work in relation to improving communication and the involvement of patients making decisions about their care, particularly around managing risk. Feeling listened to and involved in care are also lower scores for the inpatient wards, People with lived experience are supporting ongoing work to support improvements.

There were 9 Formal Complaints received for mental health inpatient wards during the quarter across all wards. This is a slight increase from the previous quarter.

There were 10 Formal Complaints closed during the quarter and of these 2 were partially upheld or upheld.

There were many positive comments received in the feedback including comments such as staff were helpful, kind, listened and supportive. There were some comments for improvement about listen to patients, more staff and wards being noisy. Examples of the feedback left are "*I felt safe and welcome here. The staffs are amazing, funny and caring. At times I felt they are going way beyond their way to provide the best possible care I could get. I'm grateful that I was referred to this facility.*" "*Meeting all the nice staff and other patients on the ward. The food is always nice especially the puddings. There are always staff around to help if needed." "Speaking with [name removed], the staff members are lead very well, with professionalism and fairness. I understand that the quality of care and the structured days are done very well to ensure the very best treatment for each and every one that is being submitted into the hospital. To have the activities that break up the day and also the time spent discussing any sort of problem or something that could be on your mind, the staff all seem open to listen and have brilliant advice."*

As detailed above and last quarter, the wards are currently participating in the national Culture of Care programme and an element of this is the collation of patient feedback and

hearing of the patient voice from a care and experience perspective; we are gathering this via several differing ways including:

- **Ward Culture of Care Project Teams** – Cross-disciplinary teams, including lived experience input, identify areas for improvement.
- **Community Meetings & Coffee Mornings/Evenings** – Offering spaces for patients and carers to share experiences and influence change.
- **National and Local Surveys** – The Culture of Care Patient Care Survey and Patient Experience Survey.
- **Semi-Structured Interviews on Physical Assaults/QI Project** – Capturing both patient and staff perspectives on safety, emotional impact, and reporting barriers.
- **External Engagement** – CommUNITY Forum and Every Little Thing Festival provide broader lived experience input.
- **Senior Leadership Team (SLT) Monthly Night Drop-Ins** – Provides and informal opportunity for patients to talk to SLT members at night.

The main areas for improvement identified last quarter are:

- **Ward Environment & Activities** – Patients would value more structured activities, better backup plans for cancellations, and improved outdoor and sensory spaces.
- **Patient Involvement & Choice** –some patients report feeling excluded from decision-making, lacking choices in care, and experiencing boredom.
- **Physical Assaults, Safety and Boundaries** – some patients *(and staff)* have shared concerns about physical assaults, inconsistent boundary-setting/differing expectations.
- **Community Meetings & Representation** – Patients want meetings to be more meaningful, with more senior staff involvement and clearer pathways for influencing change.
- **Personalised and Inclusive Care** – Suggestions include torch filters for night-time observations, sensory-soothing environments, and reducing biases in care.

The steps we are currently undertaking to address these are:

- **Enhancing Community Meetings** – Strengthening patient involvement, increasing senior staff presence, and creating clearer pathways for patient-led change.
- **Ward Culture of Care change ideas include** Rose Ward is enhancing its garden to create a therapeutic, neurodivergent-inclusive environment.
- **Addressing Physical Assaults and Boundaries** – Expanding physical assault interviews to older adult wards, launching a Quality Improvement project to address concerns, and embedding professional boundaries training into staff development e.g. newly qualified, B4, risk training. Feedback used within Culture of Care /Patient and Carer Race Equality Framework /Unity Against Racism project work to develop scripts and training videos based on real patient experiences.
- **Strengthening Lived Experience Partnerships** – Expanding engagement through lived experience and external forums to further integrate patient voices.
- **Personalised Risk and Carer Involvement** – Continuing support for individualised risk assessments and introducing a clearer mechanism for hearing carers' concerns (Martha's Rule). Introduction of coffee evening for carers at PPH in April

In addition to the feedback about the wards, there were 32 responses for a Place of Safety and the average score was 4.71. Some comments received were "*[name removed] and [name removed] were very helpful. They made feel at peace and secure. They are very good*

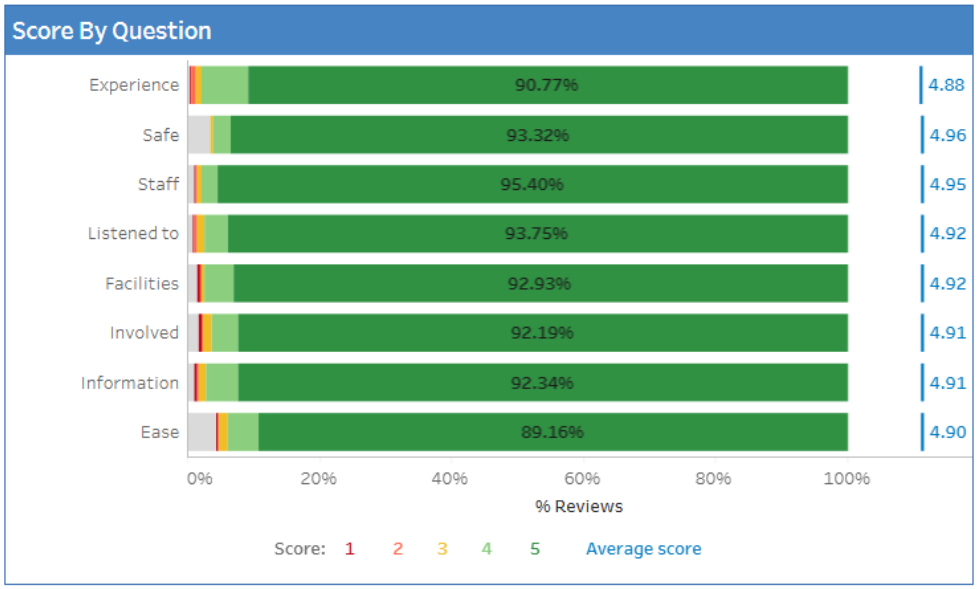
support workers. It was a joy to be looked after by such good company." "*I felt all staff appeared kind, caring and well aligned. There is a genuine vibe here.*" And "*I felt I was treated with respect and kept safe as much as possible.*"

Community Health Services Division

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

Table 6: Summary of patient experience data.

Patient Experience - Division CHE		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	Number	2676			
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	8.6%			
iWGC 5-star score	Number	4.91			
iWGC Experience score – FFT	%	97.8%			
Compliments received directly into the service	Number	69			
Formal Complaints Rec	Number	4			
Formal Complaints Closed	Number	1			
Formal Complaints Upheld/Partially Upheld	%	58.3%			
Local resolution concerns/ informal complaints Rec	Number	1			
MP Enquiries Rec	Number	0			



The 4 Formal Complaints received this quarter related to different services.. The one Formal Complaint that was closed, was for the Wheelchair Service and this was not upheld.

The Hearing and Balance Service received 127 responses to the patient experience survey with a 95.3% positive score and 4.83-star rating.

East Community Nursing/Community Matrons received 608 patient survey responses with a 99.3% positive scoring, many comments were about staff being kind and professional, for example "*I was treated with kindness and respect and each visit, I was listened to and nurses tried everything that they could to help me, I am pleased visits have been increased to help manage my condition" "The matron was professional, went and beyond to go through my medication and sort it out with my chemist. The chemist has now agreed to deliver my*

medication all thanks to the matron." "*I was impressed how quick the nurses came, even though they were covering a large area, my problem has been solved with no issues. I was treated with kindness respect"* There were also some comments around wanting more time with the nurse for example *"Stay longer for a chat and cup of tea."*

The wards received 113 feedback responses (41 responses for Jubilee ward 100% positive score and 72 responses for Henry Tudor ward with a 94.4% positive score). Positive comments were received in relation to staff being friendly, helpful and kind. 6 of the responses scored less than 4, comments for improvement related to room temperature, more staff, answering the bell, food and responding to toilet requests more quickly.

Within MSK physio in the East, there was a high number of responses to the patient survey and a high positivity score of 95.8% (4.89-stars), comments were very complimentary about staff being professional and helpful, *"The physiotherapist [name removed] was very professional and friendly. He treated me with dignity and kindness and explained treatment well and clearly. I feel very much reassured with the progress of treatment with my Right foot and back. I do recommend the MSK physiotherapy in church hill house in Bracknell."* The reoccurring improvement suggestion for this Quarter was for more parking.

Outpatient services within the locality received a positivity score of 98.7% with 4.91 stars from the 784 responses received. With some very positive feedback including for the UCR & Virtual Community Ward, *"Friendly nurses, helpful when questioning certain issues and informative. It's reassuring to know they are available for the future should we need; they provide a 1st class service."*

The Diabetes Service received 229 feedback responses with 98.3% positivity and some lovely comments including "*[name removed] made me feel comfortable with her pleasant approach to educating me on diabetes treatment. With a great technique to convey what was taught, I found the whole experience most educational and helpful in moving forward in my journey.*" Alongside some helpful suggestions for the service to consider around the rooms being cold and "*Do more classes like these to get more knowledge."*

The Assessment and Rehabilitation Centre (ARC) also received positive feedback including "*As always [name removed] was welcoming and enthusiastic. He showed delight at [name removed] progress and praised the fact that he had taken the advice from the previous session and acted on it. He asked [name removed] to demonstrate and enthused about the improvement. He discussed the results of [name removed] assessment at Brants Bridge and asked if any questions. He checked how much better [name removed] felt about his abilities compared to his first session and was delighted that he could now be discharged. He finished by walking with [name removed] back to the car and wishing him well.*"

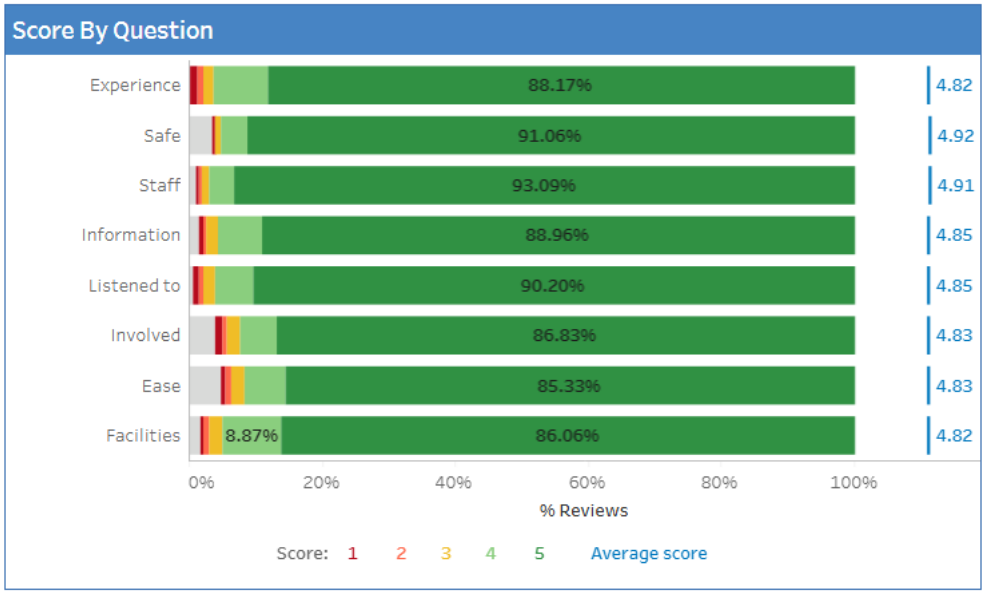
Community Health services currently have a project group to support increasing feedback.

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

Table 7: Summary of patient experience data.

Patient Experience - Division CHW		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	Number	4168			
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	7.1%			
iWGC 5-star score	Number	4.85			
iWGC Experience score - FFT	%	96.2%			
Compliments (received directly into service)	Number	132			
Formal Complaints Rec	Number	5			
Formal Complaints Closed	Number	10			
Formal Complaints Upheld/Partially Upheld	%	36.3%			

Local resolution concerns/ informal complaints Rec	Number	3			
MP Enquiries Rec	Number	1			



There are a significant number of services within the division and a generally high level of satisfaction received as detailed in the overall divisional scoring of 96.2% positive satisfaction and 4.85-star rating and the question on staff receiving a 97.0% positive scoring from the 4168 responses received.

There were 5 Formal Complaints received in Q1, these were split across several different services.

The community hospital wards have received 205 responses through the patient survey receiving an 93.2% positive score and 4.61-star rating, (14 responses scored 3 and below) questions around information and feeling listened to receive the most results of 3 and below. The scores below 4 for feeling listened to and information were for Ascot Ward and Oakwood Ward, patients want to feel more involved in their care and listened too by nurses. Comments include *"From the moment I came here I was treated carefully and kindly with full explanations of my treatment not just nursing but all staff and I have been very impressed. All the info has been made available to my three daughters has helped enormously as I was recently widowed," "Absolutely wonderful care staff. They were so understanding to my issues of not wanting to be a burden to them and made it very clear that they wanted to help get me better so to buzz as many times I needed them. Thank you all." "Great team all work hard to get you on your feet with confidence to be independent again also show great care and kindness …feel listened to …Thank you so much for rehab again"* And *"My stay here has been brilliant. All the nurses were very kind caring and sociable. My two physios [name removed] and [name removed] were absolutely brilliant in my physio, both physically and mentally."* there were some individual comments where patients were less satisfied with noise on the wards, more physiotherapy, food needed improvement and more staff. Comments for reviews with responses that scored below 4 included didn't feel listened to, wanted more food options, wanted to go home, more understanding for patients who are blind and/or deaf, slow prescription, not commode, staff didn't listen, felt ignored, wanted more interaction, not informed of families time of arrival, onsite doctor needed, some staff need more training and wanted more physiotherapy. There were 3 reviews which received a score of 1, 1 of these however, said the service was excellent.

Of the 2 Formal Complaints for the Out of Hours GP service, 1 related to staff attitude and one was about waiting times.

WestCall received 354 responses through the iWGC questionnaire this Quarter (89.6% positive score, 4.67-star rating, 37 scores received below 4. Positive comments included "*I would have put excellent if that option had been available. All the staff from the receptionist when I went in the nurse who did the obs and the doctor I saw finally treated me with respect and courtesy. I was listened to, replied to and informed in a pleasant and acceptable way. In fact, the whole thing was pleasant except the journey home! Thank you for asking." "I was treated kindly by all members of staff, particularly the paramedic who listened carefully, asked relevant questions and responded with a range of prescription medications to treat my symptoms. All areas of the hospital were exceptionally clean, bright and welcoming. The free weekend parking was an unexpected bonus." "I honestly believe that without the help of the West Call out of hours I would have ended up in hospital the next day as has happened on some occasions when i have had tonsilitis. I was seen in good time with no wait and the gentleman was able to give me the antibiotics that very rapidly improved my situation. All the people were friendly and helpful. Great service"* Areas for improvement included long wait times, did not feel listened to and poor staff attitude.

The Podiatry Service received 242 patient survey responses. Most responses were very positive receiving 5 stars (overall 95.9% positivity 4.88-star rating) with examples including *"I self-referred to Tilehurst Podiatry Clinic and was grateful to be given an appointment soon after I applied. I saw [name removed] who was friendly, polite, competent and gave me useful advice about preventative measures. The appointment brought immediate relief to my swollen, painful toe. I was pleased to know that there was a procedure that could be done if the problem kept recurring. Good result and very informative.*" *"Both podiatrists I met were very knowledgeable and keen to share the information received from my previous appointment and X-ray. A thorough assessment was made and recommendation for the next step in my treatment pathway. Also, lovely, friendly people, thank you!"* and *"Reception were friendly & helpful, re parking & location. [name removed], who I saw, is lovely, very kind, caring & patient. I had a very in-depth examination & came away with modified inserts to my new trainers. Plus, with hope to improve my pain level in my feet. I can't praise this department enough."*

There was one Formal Complaint for the Community Nursing Service. This related to attitude of staff.

To provide some context across our East and West District Nursing teams combined there were 15,890 unique patients this Quarter.

784 responses were received for Community nursing (97.6% positive score and 4.94/5 stars) Lots of comments included nurses were kind, helpful, and friendly, *"[name removed] explained all about what she was going to do, to change my dressing and finish the PICC. She booked my future my future appointments for me. The staff in the department are very friendly and put me completely at ease."*, *"[name removed] did fantastic job with catheter change. I have a lot of pain issues due catheter change and [name removed], give me a top maximum care to treat me gently, she is fantastic nurse, I cannot highly speak enough about [name removed] in Wokingham community nurse. I'm so glad to have [name removed] today I can't thank her enough." and "Dn's are very helpful and kind. The always make the pt and family feel comfortable as they do not rush. If pt's family has inquiries, DN's always explain and answer them and do not make you feel as you are holding them up."* There were several positive comments about nurses being caring and there were very few suggestions for improvement; would like to know when they will visit and would like the nurses to stay longer.

MSK Physio has received one Formal Complaint in the Quarter. The service has received 599 patient survey responses with a 97.2% positive score (4.90 -star rating), very few areas for improvement were included in the feedback there were a few suggestions including parking, long wait times, rooms were too hot and lack privacy in the rooms and the overall feedback was extremely positive with lots of comments about staff were helpful, professional, friendly and listened.

Bladder and Bowel (continence) services received 113 survey responses with 93.8% positivity and 4.85 star rating, with comments about staff listening and being kind.

Demographic profile of people providing feedback.

Table 8: Ethnicity

Ethnicity	% Complaints received	% Patient Survey Responses	% Breakdown of Q1 attendances
Asian/Asian British	10.94%	8.60%	9.70%
Black/Black British	4.69%	2.90%	3.37%
Mixed	0.00%	2.70%	3.41%
Not stated	7.81%	22.80%	8.91%
Other Ethnic Group	3.12%	4.80%	2.00%
White	71.87%	58.30%	72.61%

The table above shows that during this quarter there was a slightly higher % of complaints received by Black/ Black British people in relation to %, this is the same as in the previous quarter. Those identifying as white and of mixed race are also less likely to provide feedback via our survey; although it is recognised that we have a high rate of patients who do not complete the ethnicity section of the feedback survey (15%). Intelligence such as this feeds into our wider work to ensure that we capture the outcomes and experience of all people who use our services.

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

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

Table 9: Gender

Gender	% Complaints received	% Patient survey responses	% Breakdown of Q1 attendances
Female	51.56%	39.30%	55.35%
Male	48.44%	29.80%	44.61%
Non-binary/ other	0%	2.00%	0%
Not stated	0%	29.20%	0.03%

The data for this quarter shows that we are more likely to hear the voice of female attendees either through complaints or the patient survey. When reviewing the main themes of the patient survey there is no discernible difference in overall ratings between male and female respondents.

As we start to investigate the data further, we are starting to see if there are any themes or areas of note by looking at the outcome of complaints by characteristic. To start, we have looked at this information for complaints closed in the Quarter, by gender. For Quarter Two we will be looking closer at the outcome of complaints by ethnicity. The data shows us that:

Table 9A: Gender by outcome code

Gender - as stated	Not Upheld	Partially Upheld	Upheld	Grand Total
Female	46.43% (increase from 33.33%)	35.71% (decrease from 61.11%)	17.86% (increase from 5.56%)	100.00%
Male	46.67% (decrease from 68.75%)	33.33% (increase from 18.75%)	20.00% (increase from 12.50%)	100.00%
Not stated	38.46% (decrease from 50%)	46.15% (increase from 41.67%)	15.38% (increase from 8.33%)	100.00%
Grand Total	44.64% (decrease from 50%)	37.50% (decrease from 41.30%)	17.86% (increase from 8.70%)	100.00%

The above demonstrates no significant difference between gender when looking at whether complaints a re upheld or not.

Table 10: Age

Age Group	% Complaints received	% Patient Survey Responses	% Breakdown of Q1 attendances
0 to 4	3.13%	20.60%	6.54%
5 to 9	3.13%		2.45%
10 to 14	7.81%		3.97%
15 to 19	7.81%		5.56%
20 to 24	12.50%	3.50%	3.19%
25 to 29	12.50%		3.22%
30 to 34	9.38%	4.00%	3.58%
35 to 39	9.38%		4.10%
40 to 44	6.25%	5.20%	3.65%
45 to 49	3.13%		3.81%
50 to 54	7.81%	8.10%	4.11%
55 to 59	6.25%		4.63%
60 to 64	4.69%	9.80%	5.28%
65 to 69	0.00%		4.94%
70 to 74	3.13%	11.40%	5.91%
75 to 79	0%		8.25%
80 to 84	1.56%	11.00%	9.78%
85 +	1.56%		17.03%
Not known	0.00%	26.40%	0%

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

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

Ongoing improvement

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

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

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

Some examples of services changes and improvements are detailed below. The Head of Service Engagement and Experience is attending the Senior Leadership Team meetings for both Prospect Park Hospital and Community Mental Health Services to support their collection and reporting of patient experience activities.

Service	You said	We did
Immunisation	‘I don’t want the vaccines to hurt’	The service promotes different options for reducing pain and fear surrounding vaccinations prior to vaccination:
CAMHS Children in Care	Concerns regarding young people's transition into adulthood and their access to information about adult mental health services.	The team is currently developing a concise information pack to effectively provide care leavers with the necessary guidance. Following feedback, the team is also in the process of creating an

		information leaflet about the team for young people.
Family Safeguarding	Clients wanted to learn from previous group members about their experiences of the group,	We invited service-users who have 'graduated' from previous groups to return to support new group members with this meet and greet process. We are planning for how to integrate this into next term's groups.
	Clients wanted the CBT Parental Wellbeing group materials to be more accessible for those who were unable to attend the group consistently due to work / other safeguarding children's meetings.	We reviewed the content and looked at creating more visual aids to support understanding of the materials - ongoing. Other changes In the Protective and Adverse Childhood Experiences group, we have offered in person 'drop in' sessions to supplement the online sessions for those who would prefer a hybrid offer. For other professionals The service has been asked to provide a wellbeing offer (derived from our CBT Parental Wellbeing group) to foster carers. This will be delivered across 3 x 2 hour sessions in August and September. Request for more training in managing personal and professional boundaries in emotive safeguarding children work. More motivational Interviewing refresher training.
Community Paediatrics	More detailed information for autism assessments is needed - Pre, during and post	•Specialist Nurse Practitioner recruited provides care, support and advice for children waiting for an assessment and post assessment including diagnosis •Leaflets and website updated with more detailed information

	Around the duration of assessments. Appointment time given is around two hours, however this can vary at time of assessment. Sometimes this can be shorter and not meetings parents' expectations.	To amend information on appointment letter and mange parents' expectations of duration of assessments from a minimum to maximum range. To also re-communicate this at the time of assessment.
	The waiting area at Fir Tree House at Upton Hospital could do with a quiet calm area. Especially as many neurodivergent children wait in that waiting room with people coming in and out it came be quiet distressing. My son was constantly flinching and the sound of the door buzzer, so we really could have done with a separate sensory room to wait in.	To improve signage to side waiting room and for reception staff to let families know of a separate quiet waiting area.
Health Visiting	Previous focus group work with parents / carers of new babies identified the request for our new birth information, usually added to the child's red book, to be available in a digital format.	This work is well underway, and we hope to be able to trial its use soon with our Wokingham families before rolling out to all areas.
CAMHS Rapid Response team	Concerns were raised about the clinic rooms in the Maples Unit and that conversations could be heard from the waiting room.	An acoustic assessment is being undertaken and further soundproofing to be fitted once completed.
Autism Assessment and ADHD teams	More timely support whilst waiting.	'Welcome letter' with signposting to autism and/or ADHD support services/resources now sent immediately after referral accepted (eliminating hidden wait) with bespoke signposting provided where needed; clear information included on what to expect whilst waiting and when/how to get in touch.
	Improvements needed to waiting area.	Neuro-affirmative visual information boards created in clinic waiting areas.
Weight Off Your Mind – Dietetics	Lots of content delivered very quickly can be bit overwhelming.	To introduce breaks inbetween topics to promote Q+A and reflection time.

	I find the focus on the food such as on GI's today much more beneficial than mindfulness eating. It would be good to get more recipe suggestions	Discussed meal planning and recipes in green week.
MSK Physiotherapy	Long wait for appointments.	Saturday clinics, Blitz clinics, Quality improvement work focusing on activity Activity. Recruitment underway currently, Waiting list initiative group
Podiatry	Clinics need A/C units.	Aircon Units have been installed in Wokingham and hired for Skimped Hill and St. Marks but very noisy during a consultation.
Wokingham Wards	Patient wanted 7-day physio (including weekends)	Staff encourage patients to complete self-conducted exercises from their prescribed exercise sheets. Therapy for patients continues as weekends with support staff following the therapy care plans.
	Patients voiced that the ward was hot and that lighting contributed to this.	We dimmed the lights from the early morning and patients felt this made ward more relaxing.
	Patients liked to spend more time in the garden.	Activities Coordinator and Therapy Team carrying out more sessions outdoors in the shade- to make use of the area.
Henry Tudor Ward and Jubilee Ward		
	Ward is too cold.	Radiators were turned up and timings adjusted. Extra blankets available.
	Ward is too hot.	Air conditioners hired. Ice lollies available.
Donnington Ward and Highclere Ward	Patient feedback told us they would like more choices about their meals.	We re-introduced self-completion menu cards.
Oakwood Ward	‘Communications between staff and patient could be better. Some staff to improve bedside manner. If you don’t listen nothing else is worth it. Don’t shout at patients/raised voices.’	Staff have reflected on this feedback, which is also shared at the Divisional Quality Meetings. Further training is being implemented focussing on Communication Skills and Compassion, and the ward will be monitoring the experience of this more closely, through speaking with patients and their loved ones and iWGC feedback.

	More information to be given to patients about what the planned treatment is and the goals of the treatment.	To communicate patients' expectations on admissions, therapy goals and treatment. The Therapy Team has devised a therapy information leaflet, which is being finalised.
	'I'm registered blind, certain people do not understand I'm blind and deaf. You should have a blind and deaf sign/poster on the room door'	Communication card created by the RNID is in use and is individualised according to patient's needs.
Taking Therapies	Wait times for appointments are too long.	Our wellbeing assessment wait times are improving. Core clients are typically waiting 10 days less in June than in April and May. Treatment waiting times continue to be within the 28 day target. We are addressing the ongoing delayed wait time for wellbeing assessment by restructuring capacity within the team to offer additional wellbeing assessments in place of direct to digital welcome calls, which are now provided by Service Leads. We are also introducing a process with our team leads to review clinical hours weekly and will offer additional wellbeing assessments or take on clients awaiting therapist reallocation to improve overall wait times for assessment and treatment at Step 2. We are implementing new structures to allow clients to be seen at step 3 by the therapist with the shortest wait time.
	Requests for Face-to-Face Treatment.	Talking Therapies are currently reviewing how to create more face-to-face appointments. The efficacy of delivering Step 2 treatment via telephone is well researched and the team now offer video appointments as standard for wellbeing assessment and guided self-

		help. Clients who request telephone at their first treatment session are provided with this. Step 2 does not routinely offer face to face appointments, however clients with a clinical need for face-to-face sessions can be offered this option. We are always reviewing our offerings and ensuring we keep a certain amount of clinical space available to offer face-to-face sessions when this is required.
	Request for more information before therapy.	Letters being sent out are being updated to better reflect what therapy involves. There will also be a section in the Step 3 assessment tool that prompts the therapist to explain therapy and its requirements in more detail to clients.
	Sessions too short at Step 2.	We have developed session plans for each intervention at Step 2, detailing routine areas to cover in each session, such as check-in, homework review, and client feedback. In addition, we have provided detailed guidance on session focus based on clients' progress in treatment, along with related homework tasks. These will go live from 01/08/25 and will be reviewed in November 2025.

15 Steps

There have been nine '15 Steps' visits during Quarter One. We are receiving consistently positive feedback about the visits, with services relaying how helpful they are.

The Head of Service Engagement and Experience is supporting NHSE by continuing to lead an end-to-end review of the 15 Steps programme, this has been delayed due to NHSE priorities and is being restarted during Quarter 2. Insight from our services, Governors and Non-Executive Directors is integral to this piece of work and a schedule of visits has been shared. There has previously been a good level of participation and as these have dropped off, we are looking at how we can re-engage their involvement.

Lived Experience Workforce Programme

In 2021, the Head of Service Engagement and Experience began scoping the Lived Experience (LX) offer, resource, capacity and capability in the Trust. A small team have been working since then to form three themed groups; Support, Supervision, Appraisal and development, Finance and Recruitment, and Culture. Since its inception, the Lived Experience Workforce Programme has been supporting services (corporate and operational), individuals and the wider NHS and VCSE system to provide a safe infrastructure for titled LX roles to develop and thrive.

Highlights of the programme to date include:

- Multiple nominations of LX staff in the Annual Staff Awards, with LX staff winning the Respect for Everyone Award in 2024 and the Non-Clinical Staff Member of the Year Award in 2025
- Successfully bid and received funded training places from NHSE enabling Peer Support Worker and Supervisor courses; the money from this being reinvested into the Lived Experience Advisory Panels (LEAPS) and to fund the current Peer Educator secondment
- Wider Trust and System support by LX staff e.g. BOB MHA Detention Programme, Recruitment Transformation
- Away day in February 2025 – 26 out of 33 substantive LX titled roles across 7 services took part
- A co-produced LX Plan on a Page – used both within the Patient Experience Team and for LX staff to use in their services
- Regular online Experience Exchanges
- Involvement in the Trust wide Co-Production programme
- An established Peer Support staff group
- An all staff LX Newsletter – due to be launched by August 2025

Summary

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

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

Formal Complaints closed during Quarter One 2025/26

ID	Geo Locality	Service	Description	Outcome code	Outcome	Subjects
9946	Bracknell	CMHT/Care Pathways	Unhappy with resonse ORIGINAL COMPLAINT BELOW Complainant raising concerns about appropriateness of admission and being forced to take medication	Not Upheld	Not Upheld	Admission
9913	Reading	Crisis Resolution and Home Treatment Team (CRHTT)	Concerns around Migrant Help referral, Data Access and 3rd party misrepresentation Pt wishes MH referal to be closed immediately Investigation inot the conduct of MH nurses who refused to listen to pt Ensure all personnal data is handled within GDPR regs and not shared without pt consent	Not Upheld	The patient was closed to services before the complaint was made and a system has now been put in place to manage referrals from third parties	Communication
9956	West Berks	CAMHS - ADHD	Complainant unhappy with the wait for patient to receive medication due to needing to be re-assessed	Not Upheld	Directed to ICB as nothing for BHFT to answer	Medication
9849	Bracknell	Crisis Resolution and Home Treatment Team (CRHTT)	Unhappy with response wishes clarity ORIGINAL BELOW 19 Jan, experience with call handler did not go well, call ended by clinician. Pt tried to call to speak to the same person, they were not available, advised they would get a call back which did not happen. Called 111 advised call back within 4 hours, no call	Partially Upheld	Urgent Escalation with relevant services IT and Webex to resolve the issue of calls dropping/ending unexpectedly. The IO recommends the team to include management continue to be responsive to all communications in a timely manner.	Care and Treatment

9922	West Berks	CMHTOA/COAMHS - Older Adults Community Mental Health Team	Complainant unhappy the pt is deemed capable of living alone and 2 days later the Pt was found unresponsive. Pt admitted to RBH to increase blood sugar and temperature	Not Upheld	From the information reviewed it was found that the patient continues to struggle with alcohol use in addition to experiencing a mild form of Dementia. The distress the family have experienced when finding their mother so physically unwell and requiring treatment for Pneumonia in the Royal Berkshire Hospital was acknowledged. However, the IO did not feel that our service would have been able to prevent this from occurring. It is clear that the patient requires further assessment of her mood through our CMHT and a further capacity assessment regarding her alcohol use. This is in addition to a full social care needs assessment and carers assessment by the Local Authority.	Care and Treatment
9897	Bracknell	CAMHS - ADHD	Parent unhappy as YP is finding it difficult to access the support and help that they need	Partially Upheld	There was confusion about the provision available to the young person as the terminology for their education status was not clearly documented. There was an apology for this and for the lack of clarity over how their complaint was being responded to. The clinical care that they received was appropriate and they were seen within the expected timescales, as the confusion did not lead to a delay.	Access to Services
9912	Reading	Common Point of Entry	Pt wishes to be reviewed, feels the teams have ignored them despite them having a suicide plan and having under gone severe trauma from the age of 5	Not Upheld	Clinical plan was confirmed with the patient.	Care and Treatment
9819	Reading	Adult Acute Admissions - Rose Ward	Pt feels they have taken a big step backwards since admission to Rose ward from Daisy and Bluebell. Following incident on the ward 6/1 where the pt states they were pinned down they now feel let down and unsupported. Pts states threats are made against family visits for control. very unhappy with key nurse.	Partially Upheld	Availability of appropriate number of keys and alarms Supervision arrangements for inexperienced staff members working with/ key nursing complex patients Formulation of complex patients to support safe care planning Improvement plan based on audit outcome of 1-1 and care planning Clear documentation on decision making and sharing decisions with patients	Care and Treatment
9919	West Berks	CAMHS - ADHD	complaint regarding delay in ADHD diagnosis and failure to provide support, causing distress to YP	Not Upheld	ADHD wait times are long due to demand on the service. Team working hard to reduce these. Support is offered in local services with or without a diagnosis.	Care and Treatment
9850	Reading	Adult Acute Admissions - Rose Ward	Historic complaint relating to March 2023, MHA with physical health issues	Not Upheld	Not Upheld.	Care and Treatment

9921	Reading	Other	Adult pt with ADHD cannot get their medication since changing their GP practice Oxford to Reading	Not Upheld	The wait for appointment is not due to any error or oversight by service. The patient was discharged by Oxford Service with a clear plan for GP to take over prescribing and monitoring of ADHD medication in primary care and the Consultant Psychiatrist provided a prescription sufficient to enable this transfer to primary care. This would have maintained ADHD treatment. However the patient did not collect the prescription (which was then rendered invalid). The root cause appears to be that the final prescription from Oxford Health was not collected. As a result this meant this became restarting/titration of medication and the GP referred to our service asking for this. This meant that the position changed from what would have been a request to enter into shared care with the GP for a patient already on medication (prescribed by GP) to a request for us to start medication again for a patient no longer taking medication.	Medication
9893	Windsor, Ascot and Maidenhead	Crisis Resolution and Home Treatment Team (CRHTT)	Pt seen by PMS then Crisis has medication issues as they make them sick, CPE sent the letter to GP for meds. Clarity needed re what services we offer, what support can they get whilst waiting and how do they get different meds	Not Upheld	Not Upheld	Care and Treatment
9896	Reading	Crisis Resolution and Home Treatment Team (CRHTT)	Pt unaware why they have been sectioned	Not Upheld	Not Upheld	Communication
9930	Reading	Crisis Resolution and Home Treatment Team (CRHTT)	Unhappy with the call handlers not letting the pt speak to find out what they were calling for	Not Upheld	Closed Informally	Communication
9846	Reading	Out of Hours GP Services	OOH GP diagnosed gastro issues and sent pt home, 3 days later pt presented at A&E with a ruptured appendix and Sepsis. 2 elements relate direct to RBH	Partially Upheld	The investigation found that the GP did carry out the correct investigations however, the illness had not progressed to the stage where it was obvious what the patient was experiencing. At the time they were experiencing more general pain and gastrological issues, and this led the clinician to their diagnosis. It was only when more classical symptoms of appendicitis became apparent that the correct diagnosis was able to be made. It was however felt that the clinician could have offered to examine the patient in person the second time that they called in to the service.	Care and Treatment
9864	Reading	Adult Acute Admissions - Bluebell Ward	Unhappy about the sectioning and the restraint used. Feels they are being threatened with Sec3. Highly sexual comments about female staff member	Not Upheld	The patients phone was taken and medication given in line with policy and procedure and to support their own wellbeing. It was found that comments were made by staff but this was in the context of challenging his sexual behaviour	Attitude of Staff

9905	Reading	Out of Hours GP Services	Unhappy with response ORIGINAL BELOW Serve pain in the back following a long walk. Previous surgery on the back was October 2024. Nurse practioner just prescribed more pain killers with no examination and was very dismissive	Partially Upheld	The clinician had conducted a thorough and complete assessment of the patient's complaint and had formulated a reasonable management plan to optimise analgesia and seek onward referral through her GP. No indication that her presentation met threshold for immediate MRI scanning on day of attendance. The patient was offered immediate pain relief and the clinician established she had adequate analgesia to manage her symptoms until reviewed by her own GP. The attitude of the clinician is not possible to objectively review from analysis of documented notes. The patient/professional interaction is subjective in nature and not formerly recorded. Nevertheless, it is clear that patient had perceived attitude of clinician as being dismissive and uncaring when managing her complaint.	Care and Treatment
9876	Slough	Psychological Medicine Service	Relative unhappy with communication which is affecting patient care.	Partially Upheld	It was found that the diagnosis was made clear during family meeting. However, the discharge summary has not been sent out in timely manner where the diagnosis is formalised. As part of the investigation this has not been done. There is evidence that medical review has taken place and medication was reviewed and optimised. Additional complications number of admissions to general hospital and on-going poor physical health.	Communication
9936	Reading	Adult Acute Admissions - Bluebell Ward	Unhappy with the use of the MHA. Dr talking about religion and medicating pt without explanation. Pt now refusing meds as ward would not let them attend a passport appointment	Not Upheld	Whilst the patient has raised concerns regarding difficult experiences in hospital, there is no further action or learning to take from this complaint. The patient was not allowed to attend an appointment at the embassy for clinical reasons which were discussed between the wider MDT and the patient herself was informed. For the medication, it is not best practice for this to be changed without patient input however clinical risk in regards to her physical health took precedence and she was informed at the next opportunity. Finally, for her S17, this may have felt like too much of a brief period of time spent at home however it has been increased and best practice has been followed with this to ensure that the patient is safe and able to manage at home before longer periods of leave have been agreed.	Communication
9908	West Berks	CMHT/Care Pathways	failure to provide therapy following GP referral, quality of the service from Hillcroft house and alleged abuse from professional staff.	Partially Upheld	There were delays in the assessment taking place but this was in an effort to ensure she had a broader assessment that would prevent her having to undergo multiple assessments. The member of staff did offer a private appointment and this is being followed up by the Trust.	Access to Services

9904	Windsor, Ascot and Maidenhead	Eating Disorders Service	Unhappy as treatment offered was already completed at previous Trust. Unhappy at the extended wait times now for treatment.	Upheld	There is a learning for the clinicians involved which the whole team will also benefit from about how to listen to and respond to patient feedback about their care plan. We will ensure this is communicated with the team. Because her treatment was delayed we have concluded that the appropriate course of action is to prioritise her on the treatment waiting list for ongoing care.	Care and Treatment
9853	Windsor, Ascot and Maidenhead	CAMHS - Anxiety Disorder Treatment Team (ADTT)	Pt requested medication, after being advised this could be done they now need to be refered on another wait list for an additional 6 months. Family very concerned for the YP	Partially Upheld	There was an error with a clinician providing incorrect advice to the GP, this was amended and corrected advice given. The patient was correctly told they were not under CMHT care. Evidence showed the patient was kept in over night as per their wishes and discharged following further assessment. They also received appropriate and prompt follow up after this. Advice was given about available support and how to seek compensation.	Medication
9892	Wokingham	Integrated Pain and Spinal Service - IPASS	Unhappy with response ORIGINAL COMPLAINT Pt states they need an MRI and that this has been advised to them. Believes BHFT are blocking care to them.	Not Upheld	IPASS to familiarize themselves with FOI processes and ensure that details of the FOI website for BHFT are sent to patients on request IPASS to fully investigate how an email was sent to an incorrect address and ensure that all staff have up-to-date Information Governance training	Care and Treatment
9861	Reading	A Place of Safety - Patient Admitted to POS	Pt feels a number of areas have been over looked ORIGINAL COMPLAINT BELOW Concerns raised regarding the nurse is APOS and to cover the sectioning Dr's	Not Upheld	Not Upheld.	Care and Treatment
9940	Windsor, Ascot and Maidenhead	Crisis Resolution and Home Treatment Team (CRHTT)	Pt feels female staff member failed them.	Not Upheld	Not Upheld	Communication
9883	Reading	CMHT/Care Pathways	Husband concerned about deterioration in his wife's mental health and the lack of support he is getting from mental health services.	Not Upheld	No consent provided	Care and Treatment

9840	West Berks	Acute Dietetics	Deceased pt - Advised specialist nurse would visit weekly to turn PEG, why did they show family how to do this but not return? family believe this led to infection which led to pt death. Physio took 3 weeks, OOH support poor. Felt final weeks of life were confussing, uncomfortable as a direct result of poor discharge and care put in place	Partially Upheld	EOL care pathways for community services to be reviewed. Acute discharge planning – improved communication needed.	Care and Treatment
9961	Windsor, Ascot and Maidenhead	CMHT/Care Pathways	Pt feels medically neglected by CMHT. One team assessment given, pharmacist recommended medication to GP without meeting pt. CMHT refusing to offer support	Partially Upheld	Local resolution	Care and Treatment
9931	Reading	Psychological Medicine Service	Poor communication with the ward and the Dr. Complainant does not believe a MH assessment was carried out and is unhappy they were not communicated with. No discharge paperwork	Not Upheld	Not Upheld.	Care and Treatment
9942	Windsor, Ascot and Maidenhead	Crisis Resolution and Home Treatment Team (CRHTT)	Pt advised Crisis they would be in contact and visit but it took 12 hours for this to happen	Partially Upheld	Discussion in team meeting to remind what services fall under WAM MHS duty under new One Team arrangements	Care and Treatment

9985	Windsor, Ascot and Maidenhead	CMHT/Care Pathways	Unhappy with the empathy within the meeting and wants claims info ORIGINAL BELOW SLT Meeting request. MEP service called to advise the pt is unable to attend course on 7 May due to their risk. Request for advised meeting date	Upheld	The patient can contact the Duty Team and Crisis Resolution Home Treatment Team (CRHTT) if she needs urgent support. The Systems Training for Emotional Predictability and Problem Solving (STEPPS) Programme will continue. The STEPPS team will explore the possibility of providing recorded materials or sessions that can be accessed remotely. This would allow the patient to review the content at her convenience and email any questions, which would be addressed the next working day. The patient will continue to work with her assigned worker within the Crisis Resolution Home Treatment Team (CRHTT), whom she has found very helpful. We will arrange a diagnostic assessment with a psychiatrist to address the concerns about her diagnosis. The expected waiting time for this assessment is 6-8 weeks.	Communication
9874	West Berks	Mental Health Integrated Community Service	Patient has found communication with the MHICS team to be distressing.	Not Upheld	Not Upheld.	Communication
9923	Reading	Crisis Resolution and Home Treatment Team (CRHTT)	Poor call handling from Crisis to a Student in Crisis. promised a call back from a team lead which did not happen	Upheld	The service has begun to explore issues around complex trauma, Attention Deficit Hyperactive Disorder (ADHD), and Autism. Training programmes are being explored and prioritised for the team, and experts in these areas are being contacted to help train the team going forward.	Care and Treatment
9984	Reading	Musculoskeletal Community Specialist Service	shoulder pain since 2023. MRI 2024 clear but needed physio. 3 x private steroid injections and physio, now needs surgery. Pt feels misdiagnosis has affected their income	Not Upheld	The investigation has not shown any delays in assessing, investigating or treating the shoulder. It is likely that due to a number of contributary factors the consultant you have been referred to has a different clinical opinion resulting in a different approach.	Care and Treatment
10003	Reading	Adult Acute Admissions - Rose Ward	Pt unhappy with a staff member being unsupportive and wishes to appeal their Section 2 Tribunal decision	Case not pursued by complainant	withdrawn by patient	Care and Treatment
9952	West Berks	CAMHS General	Complainant feels ignored, wants an explanation as to why case was closed, want accountability for lack of reasonable adjustments made and reassessment of case and urgent support.	Case not pursued by complainant	No consent received	Communication

9917	Reading	Crisis Resolution and Home Treatment Team (CRHTT)	Not happy says we did not answer all the points ORIGINAL BELOW Unhappy with the medical review letter and being discharged from the service. Feels our muddled and inconsistant information gathering may jeopardize their chances in a pending court appearance	Not Upheld	Not Upheld.	Communication
9938	Reading	Neurodevelopmental Services	Delay in receiving medication and treatment following ADHD diagnosis in January 2024. Wishes an investigation into the delay, where they are on the list, what steps are being taken to support pts in this position	Not Upheld	Not Upheld.	Waiting Times for Treatment
9899	Windsor, Ascot and Maidenhead	Mental Health Integrated Community Service	Complainant concerned that not all elements of their complaint were addressed in the previous response ORIGINAL COMPLAINT Family advise service did not re-book a psychiatrist appt so were offered 12 March. Family concerns this will pt 4 and half months on meds that were masking the problems. Also Specialist counselling was not booked. Asked service lead to call, they said they would call after the MDT on Tuesday, no one called back	Partially Upheld	System to book doctors follow up appointments to be reviewed by CMHT WAM. Given complaints from mum, follow up appointments will need second staff. This is short term measure until both the patient and their parent gain trust with services.	Care and Treatment

9949	Reading	Adult Acute Admissions - Daisy Ward	Concerns raised in relation to the location of the discharge arrangements for this patient as the parents feel this will impact his recovery. They also feel information given in the discharge planning meeting was incorrect.	Partially Upheld	The investigation was twofold, the information provided and the language used at a discharge meeting could have been delivered more sensitive, therefore, we have partially upheld the complaint. The second part of the complaint related to the nearest relative not having sufficient English to understand or communicate with the care team is unfounded as there is evidence that the nearest relative had many conversations with a number of the healthcare team and there was no issues with communication. IO will speak with the Head of Service and Service manager of the Slough CMHT to provide feedback from investigation. Delivery sensitive information can be discussed during supervision with the staff members involved.	Discharge Arrangements
10018	Windsor, Ascot and Maidenhead	CMHT/Care Pathways	CCO meetings booked and they do not turn up	Local Resolution	Not pursued as happy with meetings	Care and Treatment
9971	Bracknell	Eating Disorders Service	Family feel no one has helped the YP and now the YP has been admitted to the Frimley on a feeding tube, they feel fobbed off	Upheld	The families experience of being passed between services with limited care planning and no clear case holder/responsible team is evident in the clinical notes as well as in the interviews completed with staff/clinicians involved in the case. SOPs/processes for management of re-referrals and process for transition between teams does not appear to have been followed. There appeared to be a lack of understanding from the GP about CAMHS capacity to and remit to complete physical health checks.	Care and Treatment
9988	West Berks	CAMHS - Common Point of Entry (Children)	parent unhappy with content of letter summarising a conversation with the pt which was also sent to the GP. They feel elements were misinterpreted and they want the letter corrected	Partially Upheld	The original CPE assessment letter to GP was in parts somewhat ambiguous and conflated home and school issues which led to parent wanting clarity and any misinterpretations to be acknowledged and rectified. Further, some of the wording used may have been better considered. Whilst the second letter went some way towards this it did not satisfy the clarity the parent desired and again some of wording used could have been more considered. Update letter to GP done which was acceptable to the family.	Communication
9990	Windsor, Ascot and Maidenhead	Traumatic Stress Service	pt missed scheduled appt as the link did not work, despite calls to the service and messages left pt has not heard back. worried Mondays f2f will be jeopardised. Want to know how they can reach the psychiatrist when they need to	Upheld	The clinician and client used different links for the appointment. The link did not appear in the clinician's Outlook calendar at the time of the appointment and there was a mis communication where the clinician thought the link she should use was the one from a previous appointment with the client. It is not clear why two different links then did appear in the clinician's Outlook calendar for that appointment, and we have been unable to determine why this was the case.	Communication

9959	Slough	Children's Occupational Therapy - CYPIT	Pt with a Buckinghamshire GP waiting for a referral for over 5 yrs has been discharged. Parents unhappy they will have to start all over again	Partially Upheld	There were failings in the initial processing of the OT referral which meant the referral was accepted when it shouldn't have been due to the current commissioning. These issues will be resolved as part of the new commissioning process. There was a lack of clear communication, particularly around next steps including the referral to the paediatrician, discharge from the service and what this means, the diagnostic procedure for DCD. The therapist has reflected on the situation and acknowledged/identified that she should have contacted the family to discuss the situation. Father appeared to be confused/not understand the process of the referral to the paediatrician and the purpose of this referral i.e. to confirm or rule out a diagnosis for his daughter. There was also confusion about how the paediatrician appointment has been offered where the OT referral was discharged. He is understanding to a degree about the 'boundaries' and commissioning but does not feel it is fair to make his daughter wait again.	Discharge Arrangements
9970	Reading	Adult Acute Admissions - Rose Ward	Following a response that took 3 months pt wishes a formal complaint to address several issues regarding their MH and Inpt stay on Rose Ward plus req for psychologist assessment paperwork. Input wanted from Psychiatrist, Hospital Mgt, and dept responsible for ensuring NICE guidelines are followed	Not Upheld	Not Upheld.	Medication
9980	Bracknell	CMHT/Care Pathways	why no psychology support for psychosis, medication error, only given 1 day to respond to a letter before police were sent	Partially Upheld	Apology given for medication error - also raised as an incident.	Care and Treatment
9996	Bracknell	East Berkshire Wheelchair Service	Pt wishes for a power wheelchair	Not Upheld	Not Upheld.	Support Needs (Including Equipment, Benefits, Social Care)
10013	Reading	Adult Acute Admissions - Rose Ward	Unhappy with the way staff communicated with NR	Not Upheld	From the evidence, the IO found that the conversation between the nearest relative and the staff who spoke with them was nothing out of the ordinary as due process was followed to the latter.	Communication
10021	Reading	Crisis Resolution and Home Treatment Team (CRHTT)	Pt is unhappy at entries in their notes, believes they are untrue	Upheld	Discharge letter contained inaccurate and poorly written information. Letter has been recalled from GP and removed from RiO records. New letter has been written and sent to GP and complainant.	Medical Records

10041	West Berks	Psychology Service	Pt who waited 2 yrs for a therapist in Reading, had 1 appt before they were off sick without advising the pt. Trfd to Wokingham, had 3 sessions turned up for the 4th to be advised there was no appt and then that therapist was off sick. Pt in need of support other than phone calls.	Partially Upheld	In once instances attempts were made to contact the patient to cancel the appointment but these did not seem to get through. In another, it was found that more effort could have been made to advise the patient that the appointment was cancelled in a more timely manner. The complainant has had two therapists go off on long term sickness which is unfortunate however, one has now returned and she has agreed to see them in future.	Care and Treatment
9989	Bracknell	Eating Disorders Service	Overall approach to care. feels misinterpreted and has faced bias, also feels staff have been dismissive and they lack the resources to manage the pts condition	Not Upheld	LOCAL RESOLUTION	Care and Treatment
10008	Reading	Community Dietetics	Complainant concerned that her son's referral was declined and that he has not had appropriate support from the service	Partially Upheld	To discuss learnings from complaint with staff in PSQ section of team unity meeting. Review referral screening and triage process for weight management. Review with Leads in context of Care Aims principles and decide any learning/training that team would benefit from.	Care and Treatment
10000	Reading	Out of Hours GP Services	Delays in call back then when appt was given it was cancelled without telling them. Seeking apology	Upheld	Call back not made within the target time frame when case upgraded to within 1 hour triage response. Appointment given was cancelled accidentally by operation room administrative staff leading to delay in being seen. One to one feedback and training to operation staff member involved to reduce risk of misprocessing of cases in future. Apology given to family.	Waiting Times for Treatment
9964	Wokingham	CMHT/Care Pathways	Feel the response is a commentary lacking any firm actions leaving them continuously chasing. Still no agreed process for urgent psychiatric input ORIGINAL COMPLAINT BELOW Family feel there is poor service following recent organisation changes. They want short term psychiatric support and proactive support from CRHTT	Upheld	Apology given for the distress caused by delays, lack of communication and insufficient responses; not the standard of care or communication we aim to provide.	Care and Treatment

9979	Reading	Neurodevelopmental Services	Complaint regarding continued delays for medciation review appt. 18 month meds review due Feb 25 but not offered until 13 may 25	Partially Upheld	The expectations set to clients for ADHD medication reviews to be made more transparent: that waits for standard scheduled reviews could be longer than 18 months and requests for an early review due to concerns need to be raised directly by a client's GP. A system is required to ensure that client correspondence requiring a follow-up action or communication are not missed, that works within the response time that is communicated in the service's inbox automatic reply. Feedback to all staff managing client correspondence to include empathetic acknowledgment when concerns or issues are raised.	Waiting Times for Treatment
10029	Reading	Adult Acute Admissions - Snowdrop Ward	pt feels there has been inappropriate treatment decisions, feels they should not be prescribed lithium due to its side effects, wants their case reviewed by a different psychiatrist	Local Resolution	Pt is happy with local resolution	Care and Treatment

Appendix 2: complaint, compliment and PALS activity

All formal complaints received

	2024/25						2025/26								
Service	Q1	Q2	Q3	Q4	Total for year	% of Total	Q1	Compared to previous quarter	Q1 no. of contacts	% contacts Q1	Q2	Q3	Q4	Total for year	% of Total
Acute Inpatient Admissions – Prospect Park Hospital	8	3	11	5	27	**11.74**	8	↑	186	4.30				8	53.33
CAMHS - Child and Adolescent Mental Health Services	10	13	3	5	31	**13.48**	8	↑	2578	0.31				8	53.33
CMHT/Care Pathways	12	13	7	9	41	**17.83**	10	↑	5084	0.20				10	66.67
Common Point of Entry	2	3	0	1	6	**2.61**	0	↓	2281	0.00				0	0.00
Community Hospital Inpatient	4	4	4	1	13	**5.65**	1	No change	500	0.20				1	6.67
Community Nursing	6	3	1	1	11	**4.78**	1	No change	5853	0.02				1	6.67
Crisis Resolution & Home Treatment Team (CRHTT)	5	3	2	8	18	**7.83**	3	↓	4682	0.06				3	20.00
Older Adults Community Mental Health Team	1	0	0	1	2	**0.87**	0	↓	2255	0.00				0	0.00
Out of Hours GP Services	2	2	3	5	12	**5.22**	2	↓	6933	0.03				2	13.33
PICU - Psychiatric Intensive Care Unit	0	2	2	0	4	**1.74**	0	No change	10	0.00				0	0.00
Urgent Treatment Centre	1	0	0	0	1	**0.43**	0	No change	4292	0.00				0	0.00
Other services during quarter	17	18	17	12	64	**27.83**	18	↑	116974	0.02				18	120.00
Grand Total	68	64	50	48	230	100	51							51	

Informal Complaints received

	Month Received			
Division	**April**	**May**	**June**	**Grand Total**
Children Young People and Families	2	2		4
Mental Health	1	2	2	2
Mental Health Inpatients				3
Physical Health		2		2
Grand Total	**3**	**6**	**2**	**11**

Locally resolved concerns received

	Month Received			
Division	**April**	**May**	**June**	**Grand Total**
Children Young People and Families			3	3
Mental Health East	1			1
Mental Health West	1			1
Physical Health	10	14	6	30
Grand Total	**12**	**14**	**9**	**35**

KO41a Return

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

Formal complaints closed

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

Outcome of formal complaints closed

	2024/25						2025/26						
Outcome	Q1	Q2	Q3	Q4	Total for year	% of 24/25	Q1	Q2	Q3	Q4	Higher or lower than previous quarter	Total for year	% of 25/26
Consent not granted	0	1	0	0	1	0.53	2				↑	2	3.64
Locally resolved/not pursued	0	1	1	0	2	1.07	2				↑	2	3.64
Not Upheld	19	24	29	14	86	45.99	24				↑	24	43.64
Partially Upheld	9	29	19	13	70	37.43	19				↑	19	34.55
Upheld	12	3	7	3	25	13.37	8				↑	8	14.55
SUI	1	1	1	0	3	1.60	0				No Change	0	0.00
Grand Total	**41**	**58**	**57**	**30**		**187**	**55**					**55**	

78% of complaints closed last quarter were either partly or fully upheld in the quarter (compared to 48% in Q3 and 83% in Q4). These were spread across several differing services with no themes identified.

Complaints upheld and partially upheld

	Main Subject of Complaint							
Row Labels	Access to Services	Care and Treatment	Communication	Discharge Arrangements	Medical Records	Medication	Waiting Times for Treatment	Grand Total
Acute Dietetics		1						1
Adult Acute Admissions - Daisy Ward				1				1
Adult Acute Admissions - Rose Ward		1						1
CAMHS - ADHD	1							1
CAMHS - Anxiety Disorder Treatment Team (ADTT)						1		1
CAMHS - Common Point of Entry (Children)			1					1
Children's Occupational Therapy - CYPIT				1				1
CMHT/Care Pathways	1	3	1					5
Community Dietetics		1						1
Crisis Resolution and Home Treatment Team (CRHTT)		3			1			4
Eating Disorders Service		2						2
Mental Health Integrated Community Service		1						1
Neurodevelopmental Services							1	1
Out of Hours GP Services		2					1	3
Psychological Medicine Service			1					1
Psychology Service		1						1
Traumatic Stress Service			1					1
Grand Total	2	15	4	2	1	1	2	27

Care and Treatment complaint outcomes

	Outcome of Complaints about Care and Treatment			
Service	**Not Upheld**	**Partially Upheld**	**Upheld**	**Grand Total**
Acute Dietetics		1		1
Adult Acute Admissions - Rose Ward		1		1
CMHT/Care Pathways	0	2	1	3
Community Dietetics	0	1		1
Crisis Resolution and Home Treatment Team (CRHTT)		2	1	3
Eating Disorders Service	0		2	2
Mental Health Integrated Community Service		1		1
Out of Hours GP Services		2		2
Psychology Service		1		1
Grand Total	0	11	**2**	**14**

PHSO/LGO

There have been two new complaints brought by the PHSO/LGO in Q1 and 6 cases to remain open with them.

The table below shows the PHSO activity since January 2024:

Month opened	Service	Month closed	Current stage
Feb-24	CAMHS - Specialist Community Team	Awaiting update	Documents sent to PHSO
Feb-24	CAMHS - Specialist Community Team	June-24	Apology given and closed by the PHSO
Sept-24	Community Dental Service	Ongoing	Documents sent to PHSO
Sept-24	CMHT/Care Pathways	Ongoing	Documents sent to PHSO
Oct-24	Older Adults Inpatient Service - Rowan Ward	Ongoing	Documents sent to PHSO
Oct-24	IPS - Individual Placement support	Ongoing	Small financial remedy offered

Dec-24	District Nursing	Ongoing	Documents requested by PHSO
June-25	Place of Safety	Ongoing	Documents sent to LGO
June-25	Place of Safety	Ongoing	Documents sent to LGO

CQC

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

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

In Q1 we did not receive any complaints via the CQC.

Compliments

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

Year	**2024/25**					**2025/25**				
Quarter	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
Received	1237	1012	1289	1366	4904	1682				

Patient Advice and Liaison Service (PALS)

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

formal investigation. Specific cases are discussed with the Head of Patient Experience during 1:1 with an opportunity to escalate if required.

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

The NHS Ratings and Reviews service on NHS.uk has been hidden from public view from 20 June 2025.This decision follows a comprehensive review of the service’s usage, technical sustainability, and alignment with strategic priorities.

The PALS service conducts outreach at all hospital sites within the organisation. Visits have been held at Upton, King Edward V11 and Wokingham hospitals. This enables the PALS service to engage locally with patients, public and staff and ensure that relevant information is available to all. Work has been undertaken to update the PALS page on the new website and to provide input regarding the induction process, which will raise awareness further amongst new members of staff.

The PALS Manager gave a presentation at the carers group meeting at Prospect Park Hospital. This was an opportunity to raise awareness of the service and other opportunities for carer involvement. The PALS manager has also attended virtual co production training in preparation for involvement in 16-25 transition project.

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

There were 526 queries recorded during Quarter 1. All these queries were acknowledged within the 5 working day target. The recording of queries has improved with the involvement of other team members. Team members have been working with the PALS Manager to familiarise with the response and recording processes. It was with regret that our volunteer finally retired this year. The volume of calls and e mails coming into the service continues to be high. The PALS Manager undertook PICT training to gain further insight into dealing with difficult conversations.

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

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

In addition, there were 397 non-BHFT queries recorded. Enquirers and complainants are signposted to the relevant organisation and liaison is conducted with other PALS services to address concerns. Another member of the Patient Experience Team is consistently helping with the recording process to improve the rate of data collection. The PALS Manager has completed Citizen Developer training with the aim of developing an automated response method when dealing with non BHFT queries. It is hoped that this will provide a timelier response for patients and the public and free up more time to develop our service.

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

Service.	Number of contacts.
CMHT/ Care Pathways	44
Physiotherapy MSK	24
CAMHS ADHD	20
District Nursing	18
Continence service	16
Neuropsychology	15
Community Dental Service	14

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	09 September 2025
Title	**Quality Assurance Committee Meeting –19 August 2025**
	Item for Noting and Ratification of the minor change to the Committee's Terms of Reference
Reason for the Report going to the Trust Board	The Quality Assurance Committee is a sub-committee of the Trust Board. The minutes are presented for information and assurance. The Quality Assurance Committee made a minor change to its terms of reference, namely deleting the Lead Clinical Director (a post which no longer exists) from the Committee's membership. The Board is requested to ratify the change to the Committee's Terms of Reference. Circulated with the minutes are the quarterly Learning from Deaths and Guardians of Safe Working Hours Reports. NHS England requires NHS provider organisations to present these reports to the Trust Board. The Trust Board is required to identify any areas for further clarification on issues covered by the meeting minutes and associated reports and to note the content.
Business Area	Corporate Governance
Author	Julie Hill, Company Secretary (on behalf of Sally Glen, Committee Chair).

Relevant Strategic Objectives	**Harm Free Care** – providing safe services **Good Patient Experience** – improving outcomes

Berkshire Healthcare NHS Foundation Trust

Minutes of the Quality Assurance Committee Meeting held on Tuesday, 19 August 2025

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

Present: Sally Glen, Non-Executive Director (Chair)
Aileen Feeney, Non-Executive Director
Debbie Fulton, Director of Nursing and Therapies
Julian Emms, Chief Executive
Theresa Wyles, Interim Chief Operating Officer
Dr Tolu Olusoga, Medical Director *(present from 5.1)*
Helen Degruchy, Head of Patient Safety / Patient Safety Specialist
John Barrett, Patient Safety Partner

In attendance: Nicole Morris, deputising for Julie Hill, Company Secretary
Mark Hinchcliffe, Deputy Director of Improvement and Transformation *(present for agenda item 5.1)*
Katie Humphrey, Carers Lead *(present for agenda item 5.2)*
Dr Gwen Bonner, Trust Lead for Preventing Harm to Others *(present for agenda item 5.7)*

Opening Business

1.0 Apologies for absence and welcome

The Chair welcomed everyone to the meeting.

Apologies were received from: Rebecca Burford, Non-Executive Director, Alex Gild, Deputy Chief Executive, Dan Badman, Deputy Director of Nursing Julie Hill, Company Secretary.

Apologies for lateness were received from Tolu Olusoga, Medical Director.

2.0 Declaration of Any Other Business

There was no other business declared.

3.0 Declarations of Interest

There were no declarations of interest.

4.1 Minutes of the Meeting held on 27 May 2025

The minutes of the meeting held on 27 May 2025 were confirmed as an accurate record of the proceedings.

4.2 Matters Arising

The Matters Arising Log had been circulated.

The Action Log was noted.

Patient Safety and Experience

5.1 Trust's Co-Production Work Update

The Chair welcomed Mark Hinchcliffe, Deputy Director of Improvement and Transformation to the meeting.

Mark Hinchcliffe gave a presentation and highlighted the following points:

- Co-production is a topic that often generates strong views and robust conversations. Typically, people with experience in Co-production are passionate about its benefits and can be critical when it is not fully implemented. This can sometimes create barriers for those less experienced or new to the approach.
- The Co-production framework for the Trust has been designed to be accessible, inclusive and practical. The framework also outlines the benefits of Co-production for both patients and the Trust, and noted the work completed by the CAMHS team in Wokingham as an example of best practice.
- Co-production can take many forms, however teams are encouraged to start small and learn over time.
- The common barriers to Co-production are often strong opinions, lack of experience, and practical uncertainties. To help teams overcome these, there needs to be practical support and consistent, simple answers to frequently asked questions.
- Strategic changes and practical daily support are both necessary to implement Co-production. The Quality Improvement team have outlined 6 key strategic objectives: Leadership commitment, methods and assets, opportunities, reward and recognition, training and development, review and evaluation.
- In order to embed Co-production within the Trust, Mark Hinchcliffe asked for leaders to foster a culture of openness, share positive examples and regularly to engage with service users and carers. There is a need to value all feedback, even when it is difficult, and to support a gradual culture change towards more inclusive practices.

Aileen Feeney, Non-Executive Director highlighted that there could be confusion within teams regarding the overlap between Co-production and other Quality Improvement methodologies, like QMIS (Quality Management Improvement System).

Mark Hinchcliffe acknowledged this and clarified that while there is overlap, Co-production is not intended to replace standard Quality Improvement activities but should be seen as a consideration within any change process. Mark Hinchcliffe noted that not all Quality Improvement activities require full Co-production, but when projects are focused on patient or carer experience, then Co-production should be more prominent.

Ms Feeney asked how the team will manage expectations when involving external participants in co-production, especially when their desired outcomes (such as achieving 100% of their suggestions) may not be feasible due to financial or practical constraints.

Mark Hinchcliffe noted this as a common barrier and emphasised the importance of open and honest conversations, listening to concerns and engaging participants with the realities of what can be achieved.

Mark Hinchcliffe confirmed Katie Humphrey is actively engaged with the coproduction workstream. The Chair noted the overlap between Co-production and the work being led by Katie Humphrey, Carers Lead on listening to carers and families

John Barrett, Patient Safety Partner reflected on the comments regarding honestly and noted on the transparency by colleagues in RBWM when outlining the Councils funding.

The Chair noted the greater emphasis on empowering communities within the 10 Year Forward Plan and commented that there is already a degree of Co-production within mental health services, and particularly children's services when working with families. The group discussed the benefit of listening to feedback.

The Chair acknowledged this and noted the need for the Board to be curious and ask when visiting services during Gemba visits.

The Chief Executive gave the opinion that Co-production should be prioritised for new transformation schemes, especially those affecting service access or pathways.

The Director of Nursing and Therapies noted the overlap between Co-production and other workstreams, such as Experience of Care and Planned Care Reforms, and the need to integrate these efforts to avoid duplication and maximize impact.

The Chair asked for Mark Hinchcliffe, Katie Humphrey, the Director of Nursing and Therapies and the Interim Chief Operating Officer to review how Co-production and Experience of Care work can be brought together, with a plan to report back to the Committee on their approach and progress.

Action: Director of Nursing and Therapies, Interim Chief Operating Officer

The Chair thanked Mark Hinchcliffe, Deputy Director of Improvement and Transformation for their presentation.

The Committee noted the presentation.

5.2 Carers Strategy Update Presentation

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

Katie Humphrey gave a presentation and highlighted the following points:

- The refreshed Carers Strategy was developed collaboratively with carers and aligns the six strengthened standards with the Carers Charter. The standards focus on identifying, recognizing, informing, involving, guiding, supporting carers; and ensuring staff confidence in embedding these practices.
- The annual self-assessment reviews show year-on-year improvement, with 67 service returns for 2025 to date. With plans to aggregate and align data for future reporting.
- Training for staff includes the voluntary e-learning induction (with nearly 1,000 completions in 12 months), as well as embedding carer perspectives in various programmes, with ongoing updates to reflect new standards.
- There are new digital innovations such as the e-health passport for carers on Rio, online support networks, and efforts to improve main carer registration and communication. Technical challenges are being addressed for future rollout.
- There has been practical involvement of carers in service changes, risk and safety planning as well as physical environment improvements, with the aim to embed carer engagement in everyday practice and quality improvement activities.
- Ongoing priorities include sharing learning across teams, evolving Co-production, and empowering services to confidently include carers and families in improvement work.

The Chair reflected on a recent service visit and asked for examples of good practice in outpatient services, noting that staff seemed unsure how to define carers and mainly focused on signposting.

Katie Humphrey explained that signposting is often more common in outpatient settings due to less direct carer interaction, but resources and examples of good practice are available on the ‘Carers Hub’ Teams Channel. There are efforts being made to identify Carer Champions in each team, where successful approaches can be shared across services.

John Barrett, Patient Safety Partner asked about the total number of services expected to complete the self-assessment review, referencing the 67 responses received and seeking clarity on the overall target.

Katie Humphrey confirmed there were over 70 services last year, however, there have been some amalgamations since then, and not all teams (e.g. corporate services) are required to

participate. Katie Humphrey noted that she is satisfied with the number of responses received thus far but will be follow-up with key teams who are yet to respond.

The Chair thanked Katie Humphrey, Carers Lead for their presentation and asked for an update to the Committee in 6-months' time.

Action: Company Secretary

The Committee noted the presentation.

5.3 Quality Concerns Status Report

The Chair noted that no services have been added since the register was last presented to the Committee and that three services had been removed.

The Committee noted the report.

5.4 Hearing and Balance Service – Verbal Update

The Director of Nursing and Therapies reported that NHS England conducted quality assurance visits nationally to all paediatric Hearing and Balance services. The feedback received was positive, with NHS England suggesting that the Hearing and Balance service could be a designated centre to support others.

The Director of Nursing and Therapies noted the importance ensuring that becoming a designated centre does not impact the services own delivery. However, the service has agreed to support with the competency assessment and training across BOB and Frimley systems.

The Director of Nursing and Therapies explained that despite the positive assurance from NHS England, the service is still awaiting the outcome of the IQIPS re-accreditation for Audiology.

It was noted that there has been a reduction in the number of concerns or issues in audiology over the past three months.

The Interim Chief Operating Officer commented that there has been an improvement with more registered staff in place and noted whether the targeted actions have contributed to the positive changes.

The Committee noted the update.

5.5 National Patient Safety Alert – Bed Rails Update Report

The Director of Nursing and Therapies presented the paper and gave the opinion that the red rating for the second action to be uplifted from red to amber, noting the Trust's training compliance rating is currently at 78.5% with a target of 85%.

The Director of Nursing and Therapies explained that the transition to a new provider has been managed carefully, with two organisations stepping in nationally and supporting local stores, along with decontamination and data management for a large patient base.

The Chair acknowledged the good progress made and noted for the topic to come back to the Committee for the next meeting.

Action: Company Secretary

The Committee noted the report.

5.6 Out of Sight and Ockenden Reviews - Combined Action Plan for the Quality and Safety of Mental Health and Learning Disability Wards

The Director of Nursing and Therapies presented the paper and explained that the Out of Sight and Ockenden reviews, along with other relevant national reports on inpatient services, have been consolidated into a single action plan to avoid duplication, as many

recommendations overlap. The report now indicates where each action is monitored or reported, ensuring ongoing oversight.

The Director of Nursing and Therapies asked the Committee if they were in agreement for this agenda item to be removed, as the work continues and is tracked through other forums. The Committee agreed.

The Committee noted the report.

5.7 Action Plan Relating to the Independent Mental Health Homicide Review (Nottingham) Report - Update on Progress

The Chair welcomed Dr Gwen Bonner, Trust Lead for Preventing Harm to Others to the meeting.

Dr Gwen Bonner gave a verbal update and highlighted the following points:

- An Assertive Outreach Team (AOT) oversight group has been established, chaired by Susanna Yeoman, with Dr Gwen Bonner as a member, linking to the broader harm prevention agenda.
- Two Psychiatrists have identified about 100 cases for focused attention, with ongoing refinement of this caseload.
- Existing engagement with public protection agencies is ongoing and effective.
- Work has been done to standardise DNA (Did Not Attend) policies, coordinated with the One Team model to avoid duplication.
- Carer engagement events have been held to gather feedback on assertive outreach, with support for a dedicated model, especially in areas with larger cohorts.
- Training on psychosocial interventions and risk management is being rolled out for this client group.
- The action plan is being consolidated into four workstreams, reporting to the AOT steering group and PPSQ meetings, to streamline oversight and avoid duplication.

The Chair raised the issue of the Depo share care pathway, noting difficulties in getting GPs to administer depot injections. The Interim Chief Operating Officer explained that some practices are more willing than others, and there are particular challenges in Slough. The Interim Chief Operating Officer noted that ADHD prescribing has been a more immediate challenge, however, the Depot pathway issue will need renewed focus.

The Chair highlighted the increased use of Community Treatment Orders (CTOs) and questioned whether this trend is appropriate or overly restrictive. The Interim Chief Operating Officer explained that the oversight of CTOs is not directly within the Mental Health Oversight Group's remit but is monitored through MDTs and other governance structures. Dr Gwen Bonner confirmed that concerns regarding CTO management would be addressed collaboratively.

The Chair noted the importance of the work that's being undertaken and thanked Dr Gwen Bonner, Trust Lead for Preventing Harm to Others for the update.

The Chair asked for an update to the Committee in 6-months' time.

Action: Company Secretary

The Committee noted the update.

5.8 Patient Safety and Learning Report

The Head of Patient Safety presented the paper and highlighted the following:

- The Trust's approach to investigations has shifted to be more responsive to the family voice, with one recent case escalated to a full investigation due to strong family concerns about the care provided.
- Most of the learnings from patient safety investigations are now integrated into the broader Trust improvement workstreams, rather than being standalone actions for individual teams.

The Chair referenced the update within the report regarding patients with a dual diagnosis of a mental health condition and a learning disability and asked whether there is a gap in joint working for these patients.

The Head of Patient Safety explained that this is relation to a complex case involving a patient with both mental health and learning disability needs, where services did not collaborate effectively. The Interim Chief Operating Officer explained that this incident led to Clinical Directors developing a joint working protocol to improve wraparound care for such patients.

The Chair queried the availability of Psychiatrists with learning disability expertise, recognising the recruitment difficulties in this area. The Medical Director acknowledged that there is a shortage, however, the Trust has staff with learning disability expertise.

The Committee noted the report.

5.9 Sexual Safety Highlight Report

The Director of Nursing and Therapies noted the Nurse Consultants Network are conducting a review on the Royal College of Psychiatrists' standards on sexual safety, with a full report to be expected at the next meeting.

The Chair noted that the agenda item will come back to the Committee in 6-months' time.

Action: Company Secretary

The Committee noted the report.

5.10 Infection Prevention and Control Quarterly Report and Board Assurance Framework

The Director of Nursing and Therapies reported that the Trust is preparing to start the flu vaccination campaign, with a target to increase uptake by 5%. Covid-19 vaccinations will not be offered to healthcare staff this year, as it is not recommended for the general staff population, and the focus will be on flu vaccinations.

The Committee noted the report.

5.11 Quality Related Board Assurance Framework Risks Report

The quality related Board Assurance Framework Risks had been circulated.

The Committee noted the report.

5.12 Learning from Deaths Quarterly Report

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

- Of the second stage reviews concluded in Quarter 1, one death was identified a governance cause for concern (avoidability score of 3).
- As well as the case above, there were two additional deaths where the review indicated poor care. Learning is being identified and being implemented through the relevant divisions. Two of the cases relate to community nursing and one to community mental health teams.

The Committee noted the report.

Clinical Effectiveness and Outcomes

6.1 Clinical Audit Report

The Clinical Audit Report had been circulated.

The Medical Director highlighted that there are 9 open action plans which continue to be monitored by the Clinical Effectiveness Group.

The Committee noted the report.

6.2 Quality Accounts 2025-26 – Quarter 1 Report

The Quality Accounts 2025/26 Q1 report had been circulated.

The Committee noted the report.

Corporate Governance

7.0 Quality Assurance Committee's Annual Review of Effectiveness and Terms of Reference Review

The Chair noted feedback regarding being unable to see the full comments from the survey and would ask the Company Secretary to share all comments.

Action: Company Secretary

The Chair confirmed no changes to the Terms of Reference.

Update Items for Information

8.0 Guardian of Safe Working Hours Quarterly Report

The Medical Director presented the paper and highlighted the following:

- Six exception reports and advice submitted, with one resulted in a contractual breach and a GOSW fine.
- The exception which incurred the fine was a missed educational opportunity which the team are supporting them with.
- Another case involved a trainee staying beyond their scheduled hours due to a complex patient, highlighting the need to balance clinical judgment with safe working practices.
- Due to recent changes, the team must rely on the resident doctor's judgment for exception reporting, as questioning their decisions is no longer permitted.

The Chair asked if there is an issue regarding Consultants to action issues within 7-working days.

The Medical Director noted these as common issues of the past due to upcoming changes, which are expected to shift responsibility for processing these reports to medical staffing.

The Committee noted the report.

8.1 Minutes of the Mental Health Act Governance Board

The minutes of the Mental Health Act Governance Board had been circulated

The Chair queried the delayed admissions following mental health assessments, highlighting that some patients are waiting, in a place of safety, for 5 days to be admitted.

The Medical Director confirmed that there have been occasions where patients have had to wait before being admitted. However, the Medical Director explained that this has been raised as a concern and raised with the mental health division regarding the impact on patients' safety while waiting, but also to ensure that this practice does not being normalised within the division.

The Chair also noted the issue regarding shower facilities within seclusion has been outstanding from 2020.

The Chair queried the note regarding the state of the hospital building impacting on the quality of care.

The Interim Chief Operating Officer explained that staff at PPH are experiencing fatigue due to ongoing surveys, invasive works, frequent process changes related to fire safety and other building issues. The Chair acknowledged this and recognised the importance of how these challenges impact both staff and patients.

8.2 Standing Item - Council of Governors' Quality Assurance Group - Visit Reports to Services (if any)

There were no governor service reports since the last meeting.

8.3 Annual Safeguarding Report

The Annual Safeguarding report had been circulated.

The Chair acknowledged the breadth of safeguarding activity across the Trust, noting the subcomponents which come under 'safeguarding' and highlighted the complexity of working with six locality authorities.

The Chair noted the Safeguarding service as one that would be interesting to visit as part of the Non-Executive Director visits.

The Committee noted the report.

8.4 Quality and Performance Executive Group Minutes: May 2025, June 2025 and July 2025

The minutes of the Quality and Performance Executive Group minutes for May 2025, June 2025 and July 2025 had been circulated.

The Committee noted the minutes

Closing Business

9.0 Quality Assurance Committee Horizon Scanning

The following items were identified for future agendas:

- Lived Experience
- Co-production
- Update on Experience of Care framework

10.0 Any Other Business

There was no other business.

11.0 Date of the Next Meeting

The next meeting was scheduled to take place on 25 November 2025 at 10am. The meeting would be held face to face at London House, Bracknell with the option of attending the meeting via MS Teams.

These minutes are an accurate record of the Quality Assurance Committee meeting held on 19 August 2025.

Signed: - _____

Date: -

Berkshire Healthcare
NHS Foundation Trust

TRUST BOARD

Quality Assurance Committee

Terms of Reference

Purpose

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

Document Control

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

10	August 2024	Julie Hill	Changes to the attendees including a Patient Safety Partner and the Patient Safety Specialists to be invited to attend the meeting. Mental Health Act Governance Board minutes added Reference made to hearing the patient voice
11	August 2025	Julie Hill	Changes to the attendees updated to remove reference to the Lead Clinical Director as this post no longer exists

This document is unrestricted.

Quality Assurance Committee - Terms of Reference

1. Constitution

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

2. Membership

The Committee's membership will comprise:

- 3 Non-Executive Directors
- Chief Executive
- Chief Operating Officer
- Medical Director
- Director of Nursing and Therapies
- A Patient Safety Partner will be invited to attend the meeting.
- The Patient Safety Specialists to be invited to attend the meeting.

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

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

~~The Lead Clinical Director, T~~the Deputy Chief Executive, the Deputy Director of Patient Safety and the Head of Clinical Audit and Effectiveness will routinely attend Committee meetings and other directors and managers will attend meetings when requested by the Committee.

The Clinical Lead(s) for the Clinical Audit(s) under discussion will be invited to attend the meeting.

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

3. Frequency of Meetings

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

4. Purpose

The Quality Assurance Committee fulfils a scrutiny role on behalf of the Board on service quality. This will include, but not be restricted to, review of infection control performance, organisational learning from serious incidents, performance against quality priorities, CQC inspection reports, Trust safeguarding assurance, quality concerns relating to staffing, mortality review systems and processes assurance and ensuring there are processes in place to hear the patient voice.

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

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

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

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

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

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

5. Reporting

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

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

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

6. Duties

a. Governance, internal control and risk management

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

b. Audit

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

To receive summary reports of national clinical audits.

c. Quality and safety

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

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

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

To receive and consider reports from the Health Service Ombudsman

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

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

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

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

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

To receive the Mental Health Act Governance Board minutes.

To receive the Annual Mental Health Act Report and the Annual Place of Safety Report

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

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

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

7. Reporting to the Board

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

Version 10 Approved by the Trust Board in September

For review: August 2025

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	August 2025
Title	**Learning from Deaths Quarter 1 Report 2025/26**
	Item for assurance and noting. Discussion where additional assurance required about quality of care, data or learning.
Purpose	To provide assurance to the Trust Board that the Trust is appropriately reviewing and learning from deaths
Format of the Report	The overall format of the report is not nationally prescribed for Mental Health & Community Health NHS Trusts, however there are a number of metrics which are nationally required and are included within this report.
Business Area	Clinical Trust Wide
Author	Associate Director of Medical Development and Clinical Effectiveness & Clinical Audit
Relevant Strategic Objectives	The systems and processes for learning from deaths align with and give assurance against the three strategic objectives below: **Patient safety** We will reduce harm risk for our patients by continuous learning from review of deaths. **Patient experience and voice** We will review all complaints, concerns and feedback (from patient's families and staff, Medical Examiner, Coroner) to inform improvement in the quality and safety of clinical care in our services. **Health inequalities** We will reduce health inequalities for our most vulnerable patients (patients with learning disability, autism, severe mental illness) by reviewing the care provided to patients leading up to their death and learning for improvement.
CQC Registration/Patient Care Impacts	No impact
Resource Impacts	None
Legal Implications	New Statutory requirements for Medical Examiners from 9th September 2024 noted, actions taken to ensure that these requirements are fully met in advance of this date.
Equality, Diversity and Inclusion Implications	A national requirement is that deaths of patients with a learning disability & Autism are reviewed to promote accessibility to equitable care. This report provides positive assurance of learning from these deaths. Ethnicity data is included in the report.
SUMMARY	Since January 2024 the Mortality and Patient Safety meeting (MAPs) brings together the processes for review, Quality Assurance and Learning from all deaths in the trust and this report represents a summary of that function. **Patient safety** Of the second stage reviews concluded in Quarter 1, One of the deaths identified a governance cause for concern (avoidability score of 3). A full patient safety review was undertaken with actions and learning identified. The case related to a patient under the care of community nursing who died of sepsis. 3 reviews identified poor care (including the case above), learning is identified and being implemented through the relevant divisions. Two of the cases relate to community nursing and one to community mental health teams. **Patient Experience and Voice** All complaints received from families of individuals who have died, resulted in a second stage review of the care provided. No concerns were raised by the medical examiner on behalf of the next of kin. **Health inequalities** 11 reviews related to patients with a learning disability, all were reported in line with national guidance to LeDeR, who complete independent reviews covering the full patient pathway. Ethnicity data is now included and is detailed in line with 2nd stage review outcomes of avoidability (for deaths of a physical health cause) and overall assessment of care (for all deaths). Learning themes arising from second stage reviews were identified and noted by Clinical Directors and Governance leads for implementation for service improvement.

ACTION	The committee is asked to receive and note the Q4 learning from deaths.

Learning From Deaths Q1 Report (2025/26)

Berkshire Healthcare NHS Foundation Trust

Figure 1-	22/23	23/24	24/25	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26	Total 2025/26
Total deaths screened (Datix) 1st stage review	456	453	553	119	-	-	-	**119**
Total number of 2nd stage reviews requested (SJR/IFR)	192	203	237	39	-	-	-	**39**
Total number of deaths to be reviewed through patient safety (PSII and PSR) declared in Quarter	31	31	36	9	-	-	-	**9**
Total Expected Deaths	-	183	219	45	-	-	-	**45**
Total Unexpected Deaths	-	270	324	74	-	-	-	**74**
Total number of deaths judged > 50% likely to be due to problems with care (Avoidability score of 1, 2 or 3)(concluded in quarter)	0	0	0	1	-	-	-	**1**
Number of Hospital Inpatient deaths reported (Including patients at the end of life and unexpected deaths following transfer)	156	140	159	36	-	-	-	**36**
Total number of deaths of patients with a Learning Disability (1st stage reviews)	36	53	49	5	-	-	-	**5**
Total number of deaths of patients with Learning Disability where care was rated as poor	0	0	0	0	-	-	-	**0**

Q1 2025/26

716 deaths were identified on RiO where a patient had died from any cause within a year of contact with any Trust service, of these 119 were submitted for a 1st stage review in line with the learning from deaths policy (17%).

All 119 deaths had first stage review by the Executive Mortality Review Group (EMRG) in Q1, 2nd Stage reviews were requested for 39 (33%). 52 2nd stage reviews were concluded by the Mortality and Patient Safety Review Group during Q1.

Of the second stage reviews concluded, one of the deaths was a governance cause for concern (Avoidability score of 1,2 or 3) and deemed to be poor care (community physical health).

Of the reviews concluded in Q1 3 were assessed as overall poor care, and learning is detailed for both community physical health and community mental health.

2nd stage Mortality reviews completed (SJR/IFR)	Q1 (52)	Total 2025/2026 (52)
Adult Learning Disabilities Services	11	11
Mental Health community, specialist, and inpatient services	15	15
Children's and Young people's Services	0	0
Physical Health community and Inpatient Service	26	26

	Avoidabilty score for 2nd Stage Reviews (only death due to a physical health cause) 2024/2025	Q1 (52)	Total to date (52)
Score 1	Definitely avoidable	0	0
Score 2	Strong evidence of avoidability	0	0
Score 3	Probably avoidable (more than 50:50)	1	1
Score 4	Possibly avoidable, but not very likely (less than 50:50)	1	1
Score 5	Slight evidence of avoidability	3	3
Score 6	Definitely not avoidable	36	36
N/A	Non physical health cause	11	11

	Overall Assessment of Care Q1 (52)	Physical health	Learning Disability	Mental Health	Children and Young People	Total to date 25/26 (52)
1	Very poor care	0	0	0	0	0
2	Poor Care	2	0	1	0	3
3	Adequate Care	7	2	9	0	18
4	Good Care	16	9	5	0	30
5	Excellent Care	1	0	0	0	1
	N/A	0	0	0	0	0

Ethnicity April 2025 – March 2026 (Rolling data to be updated each quarter)	1st Stage Review 2025/26	2nd Stage Review Requested 2025/26	% 2nd stage review requested
Asian or Asian British - Any other Asian Background	1	1	100
Asian or Asian British - Indian	2	0	0
Asian or Asian British - Pakistani	1	1	100
Black or Black British - African	3	0	0
Black or Black British - Other Black Background	1	0	0
Not Known - Waiting for first appointment/not recorded	15	5	33
Not stated - refused	1	0	0
Other ethnic category	1	0	0
White - any other white background	1	0	0
White - English/Welsh/Scottish/Northern Irish/British	93	32	34
Grand Total	**119**	**39**	**33**

Ethnicity April 2025 – March 2026 Reviews Concluded at MAPS	Score 1 Definitely Avoidable	Score 2 Strong Evidence of Avoidability	Score 3 Probably Avoidable	Score 4 Possibly Avoidable	Score 5 Slight Evidence of Avoidability	Score 6 Definitely not avoidable	N/A (MH related deaths)	Total
Asian or Asian British - Any other Asian Background	-	-	-	-	-	-	1	1
Asian or Asian British - Pakistani	-	-	-	-	-	1	-	1
Mixed - Any other mixed background	-	-	-	-	1	-	-	1
Not Known - Waiting for first appointment/not recorded	-	-	-	-	-	4	-	4
Other ethnic category	-	-	-	-	-	2	1	3
White - any other white background	-	-	-	-	-	-	1	1
White - English/Welsh/Scottish/Northern Irish/British	-	-	1	1	2	29	8	41
Grand Total	0	0	**1**	**1**	**3**	**36**	**11**	**52**

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

Berkshire Healthcare NHS Foundation Trust

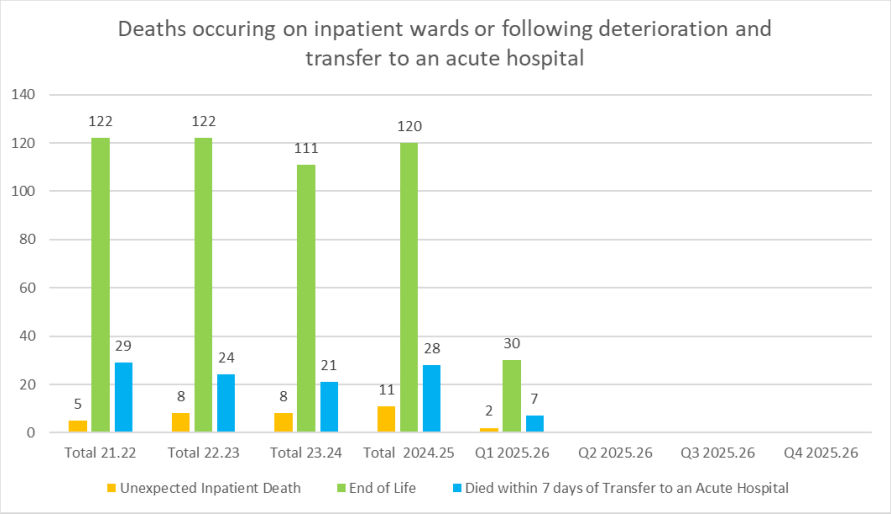
Overall Assessment of Care all 2nd stage reviews completed in 2025/26 (April – March 26 to date will include cases reported as 1st stage reviews in 2024/25)	1 Very Poor Care	2 Poor Care	3 Adequate Care	4 Good Care	5 Excellent Care	Total
Asian or Asian British - Any other Asian Background	-	-	1	-	-	1
Asian or Asian British - Pakistani	-	-	-	1	-	1
Mixed - Any other mixed background	-	-	1	-	-	1
Not Known - Waiting for first appointment/not recorded	-	-	1	2	1	4
Other ethnic category	-	-	1	2	-	3
White - any other white background	-	-	1	-	-	1
White - English/Welsh/Scottish/Northern Irish/British	-	3	13	25	-	41
Grand Total	0	**3**	**18**	**30**	**1**	**52**

Equality & Diversity Summary Q1 2025/26

The data for our 1st stage reviews shows an adequate conversion rate to 2nd stage reviews for BAME groups to allow a full review of care.

Of the 2nd stage reviews concluded none were identified as probably avoidable (3) or poor care.

Inpatients (Physical Health and Mental Health) Learning From Deaths Q1 Report



In Q1 EMRG reviewed:
39 deaths were reported by inpatient services, 36 from our physical health wards of which 30 were expected deaths and 6 were categorised as unexpected deaths. 3 deaths following transfer from older adult wards and converted to EOL in the acute

2nd stage reviews were requested for 3 unexpected deaths 3 unexpected were closed at 1st stage, with the information from ME review. 2nd stage reviews were request for all 3 mental health transfers.

7 2nd stage reviews were concluded in Q1 (1 older adults MH). All were given an avoidability score of 6 (definitely not avoidable) and care was deemed good (5) or excellent (1).

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

Month of death (Note this is not EMRG date)	2023/24	2024/25	April 25	May 25	June 25	Total 2024/25
Total Inpatient deaths reviewed by the Medical Examiner	113	127	13	11	8	32
SJRs requested for Inpatient deaths by Medical Examiner	2	1	1	1	0	2
Coroner Referrals advised by Medical Examiner for Inpatient Deaths	11	3	1	1	0	2

EOL Audit Q4	Total Q1	Narrative
New continuous audit which reviews all physical health inpatient planned End of Life deaths.	29	Most cases met the expected standard of care, with consistently positive performance in pain management, emotional and psychological support, and advance care planning. These results reflect strong attention to both physical and emotional needs and effective use of anticipatory planning practices. A further action will see the Clinical Audit & Effectiveness Facilitator conduct additional data analysis in Quarter 2, including the day of death, to assess whether reduced medical staffing over weekends impacts care quality or delays anticipatory end of life planning. Findings and outcomes from this analysis will be reviewed and discussed at the next quarterly meeting to identify further opportunities for improvement.

Berkshire Healthcare NHS Foundation Trust

Q1 2024/25
All inpatient deaths were reviewed by the Medical Examiner and the cause of death was confirmed.

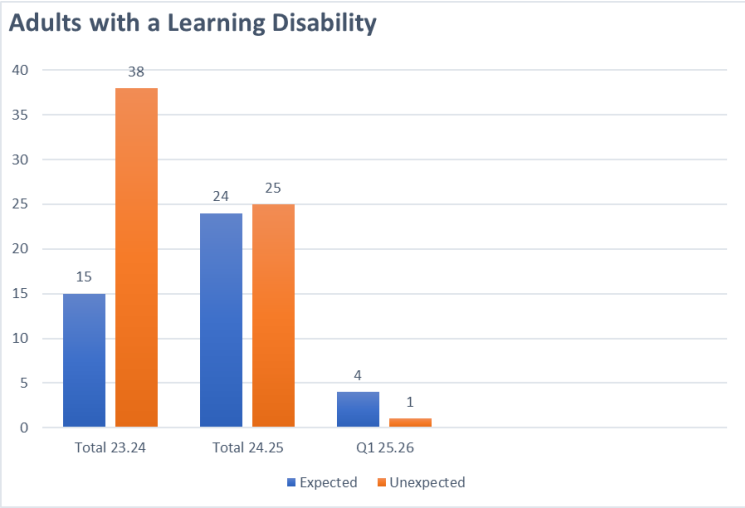
In line with our learning from deaths policy, 2nd stage reviews are requested and reviewed for all relevant deaths.

The following learning was identified:
- There is clear evidence in the notes that the medical and nursing team were responding to changes in the patient's physical health. However, there is no documentation that the medical team had any conversation directly with the family and this could have avoided the family feeling as if they were not informed appropriately.
- Near misses / falls lowered to the floor should be communicated to family to avoid anxiety when they hear patient has had a "fall" and explain what had been put in place to mitigate
- Staff understanding of use of term 1:1 and Baywatch and communication of this with family needs to be clear on how this has been assessed and when it is in use to avoid misunderstanding.
- DOLS should've been considered for care planning. Staff to ensure DOLs is considered and applied as per the needs of the patient.
- Escalation process: sepsis tool, NEWS guidance, reporting to medical team.
- Action after patient returns from acute hospital due to ill health: review of discharge documentation, medical review and documenting the reason for not following the treatment recommended by the acute hospital.
- Review of discharge documentation once discharge date know and in cases of changes: Review of TTO and EDL.
- Ward to have robust process to ensure locum doctors have access to necessary documentation especially discharge letters so that accurate information can be shared with the GP for ongoing care.

Staff to ensure robust handover process is in place

Learning is addressed through the divisions.

Adults with a Learning Disability Learning From Deaths Q1 2025/26



In Q1, 5 deaths of adults with learning disability were reviewed at 1st stage review. 1 was classed as unexpected and 4 as expected deaths, 2nd stage reviews were requested for all.

11 2nd stage reviews were concluded in Q4 (detailed in tables below).

The age at time of death ranged from 28 to 82 years of age (median age: 65 yrs.)

Severity of LD	Q1	Total 25/26 (11)
Mild	2	2
Moderate	3	3
Moderate to Severe	1	1
Severe	1	1
Profound	0	0
Not Known	4	4

Ethnicity	Q1	Total 25/26 (11)
White British	10	10
Asian or Asian British - Pakistani	1	1

	Q1	Total 25/26 (11)
Male	4	4
Female	7	7

The deaths attributed to the following causes:	Q1	Total 25/26 (11)
Diseases of the respiratory system	6	6
Diseases of the heart & circulatory system	0	0
Sepsis or Infection	1	1
Cancer	2	2
Other	2	2
Not known	0	0

	Avoidabilty score for 2nd stage reviews (11)	Learning Disability Q1 25/26
Score 1	Definitely avoidable	0
Score 2	Strong evidence of avoidability	0
Score 3	Probably avoidable (more than 50:50)	0
Score 4	Possibly avoidable, but not very likely (less than 50:50)	0
Score 5	Slight evidence of avoidability	0
Score 6	Definitely not avoidable	10
N/A	Mental health	1

	Overall Assessment of Care	Learning Disability Q1 25/26
1	Very poor care	0
2	Poor Care	0
3	Adequate Care	2
4	Good Care	9
5	Excellent Care	0

NHS Berkshire Healthcare NHS Foundation Trust

Q1 2025/26

All deaths related to patients in the community. Of the 11 cases, all were scored as 6 (definitely not avoidable).

In Q1 the following learning was shared within the LD service:

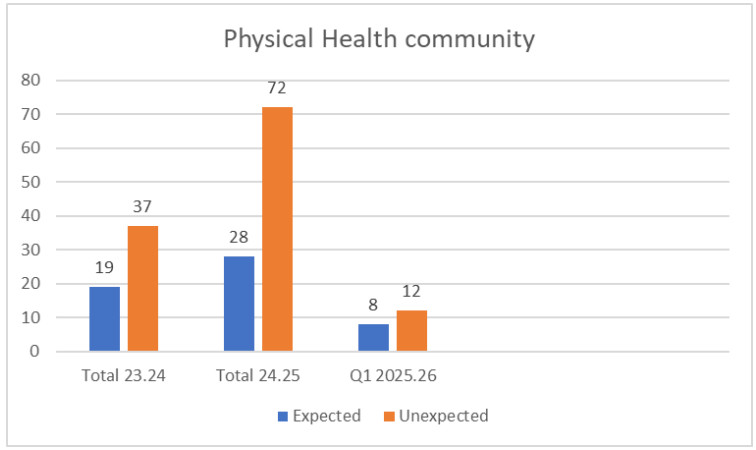
- the importance of completing relevant forms on RiO rather than the progress notes.
- To make the Joint Working with People with the Dual Diagnosis of Mental Illness and Learning Disability into a policy to increase its visibility, use and understanding among services.
- To hold a shared learning event on the PSII review across the relevant services to improve understanding and knowledge of different services criteria and expertise. Also to support cohesive approaches towards joint working and development of shared formulations across multiple teams Training on suicide risk, as the current provision is based on mental health service requirements.

In Q1 there was also examples of:

- Positive feedback from families with regards to patients care.
- collaboration with community physical to allow a patient to be cared for at home.

The Learning Disability Service continues to support the local LeDeR programmes by supplying the details of our SJR's in relation to those people whose death was reported to the service.

Community Physical Health Learning From Deaths Q1



EMRG received 20 1st stage reviews in Q4 of which 2nd stage reviews were requested for 19.

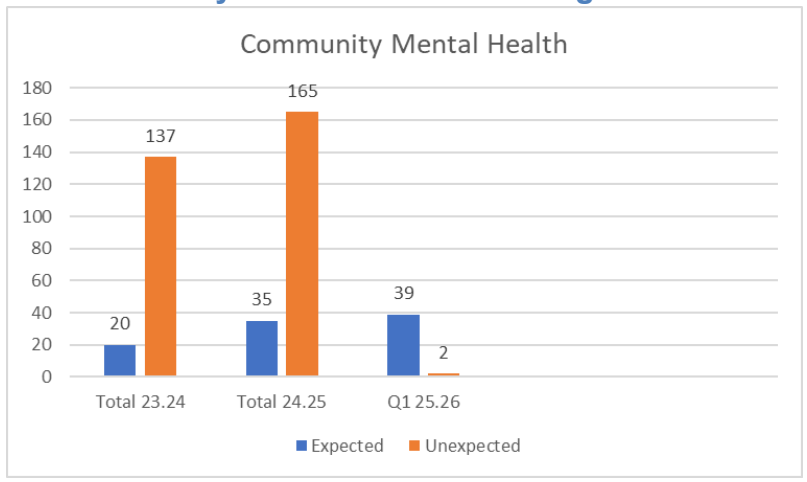
20 2nd stage reviews were completed. Two cases were identified as poor care of which one was a governance cause for concern and a patient safety review was undertaken the avoidability score was given as 3 probably avoidable (more than 50;50) .

Learning from this case was as follows:
Cause of death was Sepsis case linked to pressure ulcers
Similar learning themes to ones reports before. This was exacerbated by the fact that the period of care fell over long bank holiday periods. Critical learning identified that this community nursing team does not have handovers for patients seen in the afternoon. It highlighted discrepancies between morning visits which have handovers and the opportunity for senior oversight and the afternoon visits with no handover. There was also no escalation made by her live in carers for the deterioration. Actions for improvement are being led by the patient safety team and governance lead for physical health.

Learning from the second case deemed poor care (avoidability 4 Possibly avoidable, but not very likely (less than 50:50)
Cause of death was infection linked to a long term catheter
Learning from this case was as follows:
Under care of community nursing team for catheter care and management of ulcerated left leg. Wife was carer. Some psychological services supporting him. Learning identified around escalation, better use of NEWS2 and more work around follow ups

Learning is implemented by the divisions to address the key issues identified above.

Community Mental Health Learning From Deaths Q1



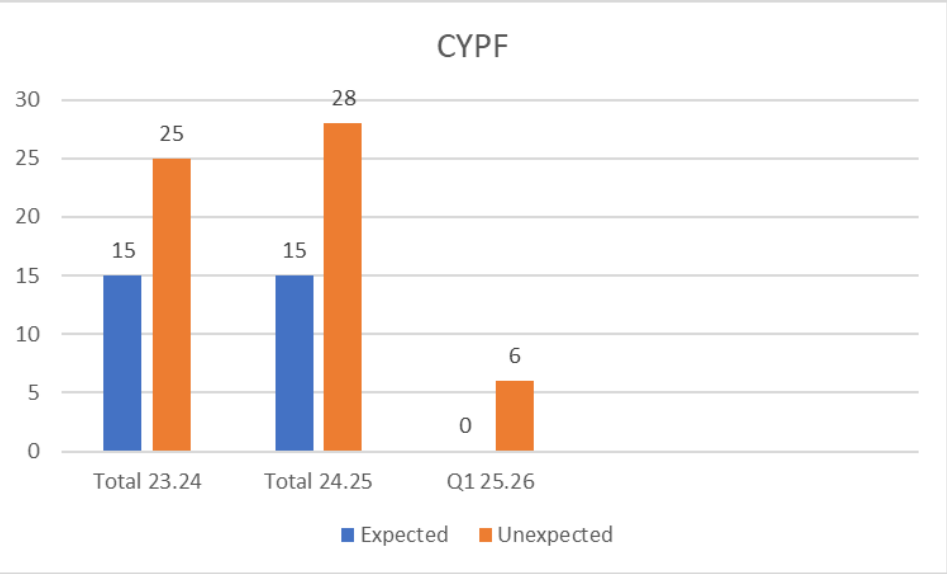
EMRG received 41 1st stage reviews in Q1 of which 2nd stage reviews were requested for 12.

14 2nd stage reviews were completed in Q1 from a range of community mental health or specialist mental health services. 13 in which care was deemed to be adequate or good and none were identified as avoidable and 1 poor care.

Areas of learning include: Poor care case
Review identified admin discrepancies following the use of spreadsheets which were not centrally accessible to everyone within the team. This has now transitioned to a centralised caseload data tracking system. Mental Health Practitioner allocated to patient had 60 on their caseload at the time. Patient unable to read or write, no assurance that patient able to access information in the opt-in letter sent to him. Other communication issues. Actions identified as part of the patient safety review to ensure these issues are addressed.

Learning is implemented by the divisions to address the key issues identified above.

Childrens & Young People: Learning From Deaths Q1



EMRG received 6 1st stage reviews in Q1 .

6 deaths reported were closed at first stage review. Deaths of children and young people are reviewed by the Berkshire Child Death Overview Panel (CDOP) and there is cooperation with local authority safeguarding practice reviews as required.

No 2nd stage reviews were concluded in Q1.

Complaints and Inquiries Learning From Deaths Q1

Complaints and MP Inquiries	Q1 25/26	Total 25/26
Communication and Clinical Care (District Nursing)	2	2

2 complaints were received in total in Q1 relating to aspects of care or treatment prior to death. A 2nd stage review was requested in addition to the formal complaint response.
In Q1 there was one freedom of information request (FOI 75) - The request relates to Coroners' Prevention of Future Deaths Reports (PFDs or Reg 28 letters) issued for deaths ruled to have been caused by suicide.

Prevention of Future Deaths (PFD) reports 2025/26: No PFD's have been received in Q1 2025/26

Overall Learning and Summary From Deaths Q1

Of the second stage reviews concluded, one of the deaths were a governance cause for concern (avoidability score of 3) a patient safety review was completed and learning identified.

3 reviews identified poor care (including the case identified as a governance cause for concern) learning is identified for District Nursing and Community Mental Health.

All 3 cases have been reviewed a patient safety reviews and have actions in place to address areas of which require improvement.

The number of inpatient deaths and community learning disability deaths remains a similar number.

11 reviews related to patients with a learning disability in Q1, all were reported in line with national guidance to LeDeR, who complete independent reviews covering the full patient pathway, none have been deemed avoidable or a governance cause for concern.

2 complaints received from families of individuals who have died resulted in a second stage review of the care provided. No concerns were raised by the medical examiner.

Berkshire Healthcare NHS Foundation Trust

Quality Assurance Committee Paper

Meeting Date	August 2025
Title	Guardian of Safe Working Hours Quarterly Report 7th May 2025 to the 5th August 2025
Purpose	To assure the Trust Board of safe working hours for junior doctors in BHFT
Business Area	Medical Director
Authors	Dr Malarvizhi Babu Sandilyan
Relevant Strategic Objectives	1 – To provide accessible, safe, and clinically effective services that improve patient experience and outcomes of care
CQC Registration/Patient Care Impacts	Supports maintenance of CQC registration and safe patient care
Resource Impacts	Currently 1 PA medical time
Legal Implications	Statutory role
Equalities and Diversity Implications	N/A
SUMMARY	This is the latest quarterly Guardian of Safe Working report for consideration by Trust Board. This report focusses on the period 7th May 2025 to 5th August 2025. Since the last report to the Trust Board, we have received six exception reports, one of which has resulted in contractual breach incurring GOSW fine. We do not foresee any problems with the exception reporting policy or process. We do not foresee any significant likelihood of BHFT being in frequent breach of safe working hours in the next quarter.
ACTION REQUIRED	The QAC/Trust Board is requested to: Note the assurance provided by the GOSW.

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

This report covers the period 7th May 2025 to the 5th August 2025

Executive summary

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

This report focusses on the period the period the 07-05-2025 to 05-08-2025. Since the last report to the Trust Board, we have received five *'hours & rest'* exception reports and one educational exception report (ER).

Introduction

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

High level data

Number of doctors in training (total):	60 (FY1 – ST6)
Number of doctors in training on 2016 TCS (total):	60
Amount of time available in job plan for guardian to do the role:	1PA
Admin support provided to the Guardian (if any):	None
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee

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

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Psychiatry	0	6	4	2
Sexual Health	0	0	0	0
Total	0	6	4	2

Exception reports by grade

Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
FY	0	0	0	0
CT	0	5	3	2
ST	0	1	1	0
Total	0	6	4	2

Exception reports by rota				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Psychiatry OOHs Core trainee rota	0	4	2	2

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

In this period, we have received six exception reports. One exception report (ER) relates to missed educational opportunity due to the doctor completing tasks arising from the on call shift during their normal working day. One ER relate to busy work during the 9-5 shift that meant the doctor was unable to achieve the necessary breaks. Four ERs relate to out of hours core trainees rota, resident doctors having to work extra hours due to increased workload during the OOH shift. None of these reports have necessitated review of work schedules or rota reviews. There has been a reduction in the gaps of OOH rota; some have not been filled adequately due to last minute sickness, rota gaps and long term sickness. This has been highlighted in previous GOSW reports. One of the ER has resulted in contractual breach that incur a financial penalty: this related to a on call shift exceeded more than 13 hours in length due to the resident doctor having to stay back for 4.5 hours beyond the end time of the OOH shift due to a rota gap during night shift that could not be covered adequately. The resident doctor will be paid the penalty amount for the additional hours and the GOSW fine will be levied for the additional 1.5 hours that exceeded the 13 hours shift. There have not been any exception reports relating to resident doctors industrial action that took place in July 2025.

The GOSW has regular discussions with resident doctors regarding the exception reports at the Resident Doctors' Forum (RDF)- these were on 1-5-25, 5-6-2025 and 3-7-2025. There were no concerns raised by resident doctors in getting their TOIL for the time they have worked extra; resident doctors have been encouraged to raise the exception reports if they have worked beyond their work schedule and if in doubt to contact GOSW or their supervisor, this will be discussed on a regular basis at the RDF, which now happens monthly. There are two outstanding exception reports waiting to be actioned. GOSW have been liaising with the concerned resident doctors and the medical staffing regarding TOIL or appropriate payment as applicable. TOIL where appropriate, have all been agreed with resident doctors. The number of reports that we have received are keeping in line with historical mean data for this Trust and GOSW meets the resident doctors via the RDF and resident doctors representatives through the MEM (medical education meetings), to encourage raising exception reports where applicable and to address any barriers that resident doctors may face in doing so. Newly joined resident doctors will be sent log in details for the DRS4 online system which is used to exception report.

During this quarter, there have one exception reported in relation to missed educational opportunities. This has been discussed at the medical education meeting with the DMEs; no remedial action is necessary at this point as the ER relates to an isolated incident and not indicative of any wider problem. We will continue to monitor and raise any issues when they arise. The GOSW continues to remind the respective consultants to discuss and action the reports

on DRS4 and will continue to do so, individual emails are also sent to respective supervisors to remind them to action the reports (if not actioned within 7 days and overdue) and agree TOIL when appropriate.

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

b) Work schedule reviews

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

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

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

c) **Gaps**

(All data provided below for bookings (bank/agency/resident doctors) covers the period 07-05-2025 to 05-08-2025)

Reason	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Gap	31	30	334.5	329
Sickness	19	18	173.5	168
Maternity	0	0	0	0
Total	50	48	508	497

d. **Fines**

Fines levied by the Guardians of Safe Working should be applied to individual departments, as is the intent of the contract. The previous GOSW fine money sum or £186.3 has been used for purchasing laptop charging cables for resident doctor office. GOSW fine for sum of £ ** has been levied during this quarter for one exception report resulting contractual breach.

Fines by department		
Department	Number of fines levied	Value of fines levied
psychiatry	1	£111
Total	1	£111

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter
£186.3	£111	£186.3	£111

Qualitative information

The OOH rota is currently operating at 1:14 and our system for cover works efficiently, with gaps generally being quickly filled. Our bank doctors continue to be an asset, and we continue to increase this pool. We had 2 unfilled gaps in this period. For these unfilled gaps, patient safety was not an issue and we have always had at least one resident doctor on duty out of hours at Prospect Park Hospital. There has been a substantial decrease in rota gaps during this quarter compared to previous six months.

Issues arising

Exception reporting is at a level more consistent with previous GOSW Board reports. The current level of exception reporting suggests that Junior Doctors are not working unsafe hours. There has been delay in addressing the exception reports within the recommended 7 days from date of submission during this quarter (due to the consultant and resident doctor being on leave), the GOSW continues to remind the respective consultants to discuss and action the reports on DRS4 and will continue to do so. The gaps in number of shifts due to sickness compared to previous quarter remains at lower level. Although majority of these have been filled, there still remains some shifts that are unfilled due to various reasons (last minute sickness, gaps in communication between resident doctors and medical staffing) which the GOSW have highlighted to DMEs and medical staffing at the MEM.

The GOSW invites the board to be aware of the forthcoming changes to exception reporting and penalties: further details can be found Framework-agreement-exception-reporting-2025.pdf. The implementation date for the new changes has been set for 12-09-2025, further guidance is awaited in the light of recent resident doctor industrial action.

A new and additional rota for higher trainees is currently being designed, to give adequate on call experience for the higher trainee resident doctors (ST4-ST6) within BHFT. GOSW will report on this rota as and when it is implemented in forthcoming months.

Actions taken to resolve issues:

There still remains some shifts that are unfilled due to various reasons (last minute sickness, gaps in communication between resident doctors and medical staffing) which the GOSW have highlighted to DMEs and medical staffing at the MEM. GOSW has been reassured by medical staffing some mitigating measures have been put in place- e.g.; dedicated medical staffing personnel to liaise with resident doctors regarding rota gaps, dedicated medical staffing email address created and monitored for communication regarding rota gaps and cover arrangements. GOSW will continue to monitor the situation via discussions with resident doctors and via the exception reports.

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

GOSW continues to remind consultants of importance of addressing exception reports within 7 working days.

Next report to be submitted in November 2025.

Summary

All work schedules are currently compliant with the Contract Terms and Conditions of Service. No review of OOH rota required. The GOSW gives assurance to the Trust Board that overall, no unsafe working hours patterns have been identified, and no other patient safety issues requiring escalation have been identified.

Resident doctors are strongly encouraged to make exception reports by the Guardian at induction and at every resident doctor forum. Resident doctors are assured that it is a neutral act and asked to complete exceptions so that the Guardian of Safe Working can understand working patterns in the Trust.

The GOSW asks the Board to note the report and the proposed actions.

Report compiled by Dr Malarvizhi Babu Sandilyan, Guardian of safe working

Appendix A: Glossary of frequently used terms and abbreviations

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

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

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

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

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

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

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

Appendix B

Factsheet: Safety limits and rest

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

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

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

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	9 September 2025
Title	Trust Intensive Case Management & Assertive Outreach Position Action Plan Update Report
	Item for Noting
Reason for the Report going to the Trust Board	The purpose of this report is to provide an update on progress on the actions outlined in the Trust Case Management and Outreach Position Action Plan. The action plan has been developed to align with NHS England's Guidance on Intensive and Assertive Community Mental Health Care (2024). The report was discussed at the August 2025 Quality Assurance Committee meeting.
Business Area	Mental Health Division
Authors	Gwen Bonner Susanna Yeoman Seb Byrne James Jeffs Sharif Ghali
Relevant Strategic Objectives	**Patient safety** **Ambition:** We will reduce waiting times and harm risk for our patients **Patient experience and voice** **Ambition:** We will leverage our patient experience and voice to inform improvement **Health inequalities** **Ambition:** We will reduce health inequalities for our most vulnerable patients and communities

Summary	Areas of focus on this update: • Identifying patient cohorts, refining data, and developing best practice guidance within existing resources, as no additional funding for standalone Assertive Outreach Teams is available. Approximately 100 cases have been identified however further work is needed to triangulate. • Public protection, forensic pathways, preventing harm to others: Regular attendance at Multi-Agency Public Protection Arrangements and Multi-Agency Risk Assessment Conference meetings ensures health input into public protection processes with monitoring processes in place; strong partnerships with probation services, criminal justice panel, and forensic collaborations are in place to manage risks, with regular meetings and effective information sharing however further work is needed in terms of firming up information sharing arrangements for this cohort. • DNA (Did Not Attend) policy – standard work is in place through One Team guidance however further work needed to develop and embed policy and monitor compliance. • Named worker and cover arrangements: A trust-wide program is embedding named workers for patients, with monitoring of cover arrangements during absences to ensure consistent care. • Family involvement: carer engagement exercises have been conducted to improve family involvement in treatment planning. • Carer safety panel in place. • Training: PSI programme being rolled out to support skills development; risk training and standard work in place and will be reviewed further later in the year. • Stakeholder engagement event planned for October 2025. • Review of internal and external report formats to be undertaken to prevent duplication and consolidate reporting. • We have formed a newly established Assertive Outreach Team Oversight Group to oversee and monitor all actions, including partner collaboration where required, reporting to Patient Safety and Quality meetings.

BHFT Intensive Case Management & Assertive Outreach Position Action Plan – Updated August 2025

Background - the NHSE request:

Integrated Care Boards (ICBs) have been requested by NHS England to take a whole population view to determine how to meet the needs of the small group of individuals who require intensive and assertive community care described in *NHSE – Guidance to ICBs on Intensive and Assertive Community MH Care (July 2024).* This document identifies 5 'Key Messages':

- Services have a duty to engage with people with SMI and their families/carers
- Intensive and assertive community care requires dedicated staff
- 'No wrong door' approach
- Continuity of care is vital
- Holistic and engaging care

Services are expected to deliver this specific approach where required, while also ensuring that they can provide the best possible care to all people with severe mental illness (SMI), including stepping up and down intensity in response to people's fluctuating needs.

During 2024, ICBs were asked to work with all Mental Health NHS Trusts to provide a costed proposal for Assertive Outreach Team (AOT) or Intensive Case Management (ICM) to meet the needs of this group of patients, ie, those with a serious mental illness (psychosis), who are likely to disengage from care and treatment. Subsequent communications indicated that there was no additional funding to provide a designated service, and so systems are now required to focus on a wider action plan at Trust level, to demonstrate strengthening in service delivery for this group, across the whole community mental health pathway.

Since April 2025, this work is now progressing under a newly established BHFT AOT Oversight Group, reporting into PPSQ.

	Action Area	Clinical Risk	Action taking place /status	Notts findings	Action Needed (short, medium & long-term)	Time frame	Lead	Progress & Updates
1	**Implementation of an Intensive Case Management (ICM) model within CMHTs/OA to meet the fidelity model**	High	Intersectionality work to date Identify patient cohort per team Develop short, medium and long-term actions to address gaps identified. Identify short term actions to strengthen provision for this group. Develop best practice document based on national recommendations, clinical evidence and stakeholder feedback.	No intensive case management or assertive outreach offer	Ensure all practicable efforts are made to engage patients ……this includes referring people who find it difficult to engage with services to a team that provides assertive and intensive support *CQC Special Review (2024) Part 2: Recommendation 2(b)*	Initial cohort by end of April 25 Triangulation: Sept 2025 Model and guidance Dec 2025	Dr James Jeffs & Dr Sharif Ghali	**Sept 24** Clinical workshop scheduled for October 24 Provisional cohort through intersectionality dataset review, needs refining **Dec 24** 2 PA's (sessions) of medical leadership has been identified to carry out a review of data and best practice models. They are also refining the cohort as it is unlikely there will be any additional dedicated AOT funding. **Feb 25** Will not be able to provide standalone AOT teams which is where the evidence base for the model is strongest. Will meet with BOB and Frimley colleagues to ensure alignment across the ICB's as the offer develops within our existing resource. **Aug 2025** **Patient Cohort** Work is continuing to refine the patient cohort meeting criteria (psychosis; risk of non engagement; 2+ admissions). Our latest report (duplicates removed) indicates approx. 100 cases known to BHFT, and no strong indication of a hidden group outside current BHFT services, including patients discharged in the last two years.

								Ongoing work is needed with other teams and agencies (including Liaison & Diversion, Substance Use Disorder services, Homelessness, Probation) to triangulate data and identify any further cases. Information Governance advice is being sought to allow us to share data for this purpose. **Model** Medical Leads are defining options for service delivery, including what is achievable based on existing resource, as well as an option for the evidence based standalone AOT in the eventuality that funding may be allocated in future. **Best Practice Guidance** Medical leads are collating guidance based on national recommendations, clinical evidence and stakeholder feedback, for Trust approval and roll out to teams. **Alignment** Liaison is in place with Frimley/ BOB ICBs and Provider Trust colleagues to share approaches.
2	**Harm to others**	High	Steering group Case reviews Partnerships with probation including approved premises and early release Criminal justice panel and information sharing SLA			September 25	Gwen Bonner	**Nov 24** work is progressing at pace with regular interface meeting with Probation, TVP and Forensic colleagues **Feb 25** Regular representation at the Forensic provider collaborative, criminal justice panels implemented and demonstrating effective partnership working RCRP – focus on increasing use of Part 3 of the MHA **Aug 25** No further updates – remains GREEN
3	**24/7 service aware of patients on intensive list**	Medium	We have a 24/7 service, but the service is not aware of this list of patients, however out of hours have access to RIO. System needed to identify and flag patient group on health and system partner systems	Engagement challenges not followed up through consistent approach	Require an agreed and consistent patient criteria to develop this list. There is currently no list.	RIO workstream commencing August 2025	Jane Brooks and AO Oversight Group	**Feb 25** Working with the medical leads to refine the initial cohort for flags to be added to RIO **August 25** Initial cohort list has now been created (100 names). Workstream is due to commence to explore creating a 'flag' on RIO Preliminary carer feedback suggests quality of care out of hours could be improved for this cohort. This will be a key area to address in best practice guidance.
4	**Staff available by telephone to support a crisis out of hours**	Medium	In place SCAS 111, and direct access to CRHTT	No contact OOHs		Already established	Kenny Byrne / CRHT	**Feb 2025** In place **Aug 2025**

								No further update
5	**DNA policy review for patients who do not engage**	High	DNA guidance is now live on nexus. Discharge MDTs for patients with psychosis is part of standard work	Spells of attempts to engage but periods identified where no contact for weeks was made.	Ensure there is a SOP in place for EIP and CMHTs to follow when a patient DNAs appointments, and follow up actions are defined *CQC Special Report (2024) Recommendation 2c* DNA policy to be reviewed to ensure alignment with new NHS ICM/AO guidelines. SOP required.	DNA guidance April 25 Guidance document Nov 2025 RIO Workstream commencing August 2025	Seb Byrne/Tracy Gilzene	Monitoring compliance with the One team IMDT's to review service users DNA' for new patient assessments and those who are under CMHT but are not engaging with planned care interventions. **Nov 24** MDT policy being updated to reflect named worker. **August 25** BHFT's newly transformed 'One Team' CMH model has refreshed discharge guidance regarding DNA *(Guidance for DNA Process: Disengagement or Difficulty to Contact Clients*)**.** This specifically addresses DNA with a requirement for IMDT discussion to review risks prior to CMHT discharge and consider whether further engagement or escalation is needed. This has been communicated and reinforced with teams, and will be further highlighted in the Best Practice Guidance for ICM. Standard work has been defined, to be included in Best Practice Guidance document Reporting from Tableau can highlight patients that have not been seen or their last appointment was a DNA; this is a new reporting tool and will highlight which patients will need additional oversight and creates a live Reporting system available to track DNAs – to be further explored how this can be used for monitoring and assurance.
6	**Sub forensic public protection/sub MAPPA/MARAC**	High	Ensuring health attendance at MAPPA/MARAC meetings MARF for patients who are not managed through standardised public protection process. Need to ensure plans are shared and followed Work to improve timely access to forensic assessment and admission as required	Delays in admission a factor in the increase of risk Out of area placements a common occurrence in Notts - linked to poorer patient outcomes. Patient was unable to access specialist crisis team care. Problems communicating discharge decisions and difficulties in		April 25	MAPPA – Gwen Bonner MARAC – Sue Carrington MARF – Jacob Daly/Catherine Mboche Odei RCRP – Jacob Daly Forensic and probation interface – Gwen Bonner/Alan Buckley/Vicki Parkin	**Nov 25** Regular attendance at these meetings. Interface with Forensic colleagues and access to inpatient and community pathway being led by Nurse Consultant **Feb 25** Lead for RCRP working with AMHP and TVP colleagues to ensure part 3 of the MHA is being considered as appropriate Further assurance needed in relation to MARAC attendance **August 2025** Berkshire Healthcare are represented at all the: MARACs across Berkshire and attendance is recorded.

				transitions of care between inpatient and community services. Discharged despite high risk noted by community team and police				
7	**Co-produced care plans accessible to patients**	Medium	Care plans to be standardised but with options to adapt the format to meet specific needs. Trust wide plan for Patient portal is now is in the early stages	Lack of holistic approach to care planning which led to missing risk factors and create person-centred plans. Patient's wishes were at the forefront of medication treatment decisions but were not considered in relation to other risk factors.	All elements of accessibility to be considered, including those with cognitive impairment		Sue McLaughlin	**Feb 24** This is on track and will be delivered by June 25 with further work needed to improve compliance **Aug 25** Care plans are now live in RiO and can be adapted as required, they can print off as an editable letter in various fonts or be used electronically. We have provided guidance on adjustments and an adapted format for those with neurodiversity. An audit is now in place to monitor quality, and this has highlighted areas where staff need support. Additional guidance and examples have been provided along with bespoke learning sessions for the teams.
8	**Share care plans with other areas as needed and homelessness risk e.g between area or service**	Medium	This is variable and needs further work	Liaison with family, police, university not evident during periods of discharge from inpatient care.		IG issues: Jan 2026	Dr James Jeffs & Dr Sharif Ghali (Gemma Hayward assisting)	Records on all on the electronic patient record and access to the GP via connected care. This info can be reviewed on the connected care – BI team have access to the connected care data to create reports from. **Feb 25** Patient portal work is going and being led by our digital transformation team. **August 25** We have identified some IG issues which need to be addressed before data and records can be shared. This includes IG for data triangulation to confirm the patient cohort, as well as reviewing the status of some data sharing agreements with relevant partner organisations
9	**Named Worker in place**	High	Trust wide programme to embed	Consistent care coordinator deemed a positive influence in Notts case.	Principles for key worker will be in place at end of Sept, Trust wide engagement Oct/Nov. Implementation Dec – March 2025	December 2025 – review target	Sue McLaughlin	This work is on track. Proposals for involvement with staff will be ready at the end of Oct and staff involvement will take place in Nov and Dec. **Feb 25** Move from Care Co-ordinator to Named worker has commenced and initial evaluation underway **August 25**

								The named worker system has been implemented across all teams, policy ratified, and standard work completed. A range of workshops have been delivered to all professional groups. A compliance target of 80 % by October has been set and some teams have already achieved this. A staff survey has provided feedback on the new system and update based on this feedback will be implemented in September. A service user and carer survey is underway. We are reporting AMBER to reflect that the 80% target has not been reached
10	**Cover arrangements for named worker**	Medium	Cover arrangements are in place and monitored through audit	Consistent approach during period of leave were not exemplified	Ongoing monitoring of compliance	October 2025	Sue McLaughlin/Kishan Waas	**Feb 25** Working with Place based teams to ensure their duty functions are robust and able to provide cover in the absence of the allocated named worker **Aug 25** Guidance has been provided on expectations of Duty who cover for named workers if there is short term/unexpected absence. Standard work for duty is being tested in West Berks CMHT. This will inform wider roll out of the principles when reviewed in September 2025. A peer review of duty (including cover for named worker) is being organised with the patient safety team for October 2025. A quarterly audit examines compliance with a range of standards and named worker cover will be included from September 2025 onwards.
11	**Single point of access and process for managing on the day demand**	Medium	ARRS MHPs in some PCNs EIP working with ARMS (At Risk Mental State) Care navigators in SPA 24/7 crisis services HOLT (Homeless Outreach Liaison Team) services Known patient FastTrack pathway		Work undertaken to broaden and standardise offers.	CRHT Triage Dec 2025	Kenny Byrne	Nov 24 Been implemented via our One Team transformation and now in PDSA cycles. First formal review has been held **Feb 25** All access routes now using the standard triage and one team assessment tools with access to service and place MDT's **August 2025** Standard triage is embedded and working well in CPE. CRHT triage being reviewed as part of One team monitoring.
12	**Depot shared care pathway**	Medium	Inconsistent approaches across PCNs Impact on flow Depot passport needs to be rolled out	No evidence of discussion around the value of depot medicine or a community treatment order (CTO) until his fourth admission		March 26	Vicky Parkin – depot passports	Nov 24 Indication that some PCN's are withdrawing from existing shared care arrangements **Feb 25** Escalated to ICB's but unlikely to improve GP engagement with depot shared care **Mitigation**

								Patients will remain on CMHT caseloads with responsibility for prescribing and administering provided by our community mental health teams **Aug 2025** – Depot passport workstream developed a depot passport for people receiving depots and is now on RIO. Further work underway with two CMHTs with support of QI team to review processes for depot clinics. Action remains RED as further work is in train towards resolution with PCNs around shared care arrangements. Mitigation remains in place with CMHTs prescribing and administering where GPs have withdrawn.
13	**COMHAD cohort**	Medium	Specialist dual diagnosis leads within some services		Identify Nurse Consultant lead	December 24	Helen Philips	**Feb 25** 2 Associate Nurse Consultant roles with strong links to specialist drug and alcohol services. **Aug 25** Lead Nurse for Drug and Alcohol is now a member of the AO Oversight group to assist with expertise and networks.
14	**Workforce Training**	Medium	PSI Lead Nurse Consultant 5 day risk and safety planning training focusing on harm to self and others		Prioritise attendance on training	March 25	Nicola Moone	**Nov 24** initial cohorts have attended the training and roll out programme is ongoing **Aug 25** Programme roll out has continued and PSI training programme being embedded to upskill our workforce
15	**Family and Carer Involvement**	High	Carer engagement exercise – specific to this patient cohort, to be conducted across all 6 localities.	Engagement and involvement of families was lacking, carer concerns were not acted upon Families concerns not acted upon consistently, who felt excluded from treatment planning.	Ensure that staff are aware of the importance of engaging patients' families and carers *CQC Special Report Part 2: Recommendation 1(d)*	Data gathering July 2025 Thematic analysis October 2025 Guidance document Nov 2025 Carer Safety Panel comms Sept 2025	Dr James Jeffs & Dr Sharif Ghali	**Aug 2025** Carers meetings completed, carers survey closed 31st July. Initial findings have been collated, and thematic analysis will be undertaken to ensure all feedback is noted. Importance of listening to carers and families has been shared with teams; will be reinforced at further PPSQ updates (September 2025) and included in Best Practice Guidance. Carer Safety panels, established as part of the Suicide Prevention agenda, are to be re-launched as part of our comms for the AOT project. This will enable carers to have a clear route for concerns to be heard

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	9th September 2025
Title	**Winter Planning 2025-26 – Board Assurance Statement**
	Approval
Reason for the Report going to the Trust Board	The Trust Board is accountable for providing the assurance on the plans ahead of winter, ensuring they mitigate against key delivery challenges and risks, and include robust plans under three demand levels: baseline, moderate and extreme.
Business Area	Operations
Author	Theresa Wyles Interim COO
Relevant Strategic Objectives	**Patient safety** **Ambition:** We will reduce waiting times and harm risk for our patients **Patient experience and voice** **Ambition:** We will leverage our patient experience and voice to inform improvement **Health inequalities** **Ambition:** We will reduce health inequalities for our most vulnerable patients and communities **Workforce** **Ambition:** We will make the Trust a great place to work for everyone

Summary	The board assurance document has been completed alongside a refreshed winter reliance plan which will be tested through regionally led exercise on the 8th September 2025. Additionally, we have a Berkshire system resilience desk top exercise scheduled for the 13th October 2025. Operational colleagues will particate in all system escalation calls as arranged and calls will be covered by the on-call Director during weekends and bank holidays. OPEL action cards available within the resilience plan and provide a framework for system response to escalating pressures. Our daily performance and OPEL score is reported through a data feed into SHREWD which is overseen by the ICB winter lead. We also have an internal winter operational management team which will be stood up from the beginning of November and operate through until March 2026. Review of Infection Pprevetion and Control requirements and Flu vaccination programme have been completed. The Board is required to approve the assurance template no later than the 30th September 2025 with signature required from the Chair and Chief Executive.

Winter Planning 25/26

Board Assurance Statement (BAS)

NHS Trust

Introduction

1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the CEO and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please double-click on the template header and add the Trust's name.

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 25/26 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 25/26 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2025.**

Provider:	Berkshire Healthcare Trust

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the Trust Winter Plan for 2025/26.	Yes	The winter resilience plan has been updated for 2025/26
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	In progress
The Trust's plan was developed with appropriate input from and engagement with all system partners.	Yes	Development of Opel action cards competed with system partners and ICB and is use. Data added to SHREWD provides whole system awareness
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.		Regional test exercise scheduled for 8th September and Berkshire test exercise scheduled for 13th October
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.		Chief Operating Officer
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.	Yes	
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	Yes	
The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against the	Yes	Achieving 4 hour target – MIU Achieving 2 hour response in UCR

Provider:	Berkshire Healthcare Trust

trajectories already signed off and returned to NHS England in April 2025.		RTT pathway achieving target Opel action cards in place to support the necessary escalation and reprioritisation of resources.

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)	
Prevention			
1. There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.	yes		Response plan to improve flu uptake Attached at appendix 1 Attached at appendix 2 Updates are reported into public board throughout winter.
Capacity			
2. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.	yes	Ability to flex capacity in Virtual Wards and UCR during periods of peak demand.	• Division has detailed/real time data sets to monitor demand/capacity across all services. • Flexibility can be applied if patients are known to be discharged early and staffing level and skill mix is available. • Work progressing to improve access across urgent care pathways, QI work with bed flow and Home First pathways with the LAs. • A review of the consultant model is underway in the east inpatients and UCR services to support the support the

				interface between acute and community pathways • We have embedded SDEC/SPOA pathways to avoid inappropriate transfers and admissions to ED in the west and this is in development in the east • Newly agreed pathway now in place to site fast track referrals to inpatient beds by patients seen by geriatrician in the acute
3.	Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	yes	Weekend and bank holiday staffing levels across UEC services including OOH GP	• All clinical rotas have been planned 4 months in advance and checked for correct skill mix cover. • Director on call is also available to support OOH. • Access to NHSP as required to meet increased demand • Business impact and BCP's will be reviewed during Oct 25.
4.	Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.	yes		• Acute and Community OPEL framework agreed to flex criteria, open closed capacity and except all pathways where safe to transfer during escalated pressure.

				• Core BHFT CH services have live data available on SHREWD platform to system partners
5.	Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	N/A	N/A	N/A
Infection Prevention and Control (IPC)				
6.	IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	yes		EPRR manage the Winter resilience plan which supports the Major Incident Plan and Trust policy ICC011 (Communicable Diseases and Outbreak Management). IPCT have inputted into the 2025/26 plan
7.	Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.	yes		Centralised ESR list of all staff who are FIT tested, ongoing FIT testing available and additional testing sessions can be arranged with EFM. PPE team hold sufficient stock for a peak in demand
8.	A patient cohorting plan including risk-based escalation is in place and	yes		IPC patient pathway (v8)

	understood by site management teams, ready to be activated as needed.			Details also available within the On Call Directors pack
Leadership				
9.	On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Yes		All On Call rotas are in place Winter operational group to be stood up in November and meet weekly throughout the winter period
10.	Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Yes		Use of SHREWD to support system understanding of OPEL pressures across all providers
Specific actions for Mental Health Trusts				
11.	A plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	Yes	All crisis services operating 24/7	All Crisis Services and Liaison Services operating 24/7. NHS111 flows through into local Crisis services 24/7. Older Age Crisis work covered by extended CMHT hours and defaults to CRHTT overnight. YP Crisis Services covered by CAMHs Rapid Response Teams 24/7. Crisis Cafes open every evening in the East, Mon to Fri in the West. On Call Director Escalation process OOHs, including Consultant on call.

12.	Any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.			Multi-Agency Risk Framework Plans developed for identified Frequent Attenders to Place of Safety. Monitoring of repeated referrals to Urgent Care Services and repeated admissions to In-Patient Services to identify service users who require more proactive and multi-agency care planning. Frequent Attenders to the ED being monitored and targeted multi-agency plans being developed in collaboration with Acute Trusts and LAs. Patients known to Criminal Justice and MH services referred into the Criminal Justice Panel for direct lines of communication and proactive pathway planning. High risk patients across adult, MH and CYP service have information that identifies advanced care plans/safety plans to support admission avoidance.

Berkshire Healthcare NHS Foundation Trust: Response to NHS England Urgent and Emergency Care Plan 2025/26

Strategies to Improve Flu Uptake this Winter

Introduction

The NHS England urgent and emergency care plan for 2025/26 seeks to improve vaccination rates for frontline staff towards the pre-pandemic uptake level of 2018/19. Prior to the COVID pandemic uptake across all vaccination programmes were significantly higher, with greater trust and acceptance around the importance of vaccination. The introduction of the COVID vaccine and the move towards mandated vaccines for health and social care staff led to a decline in uptake rates (especially COVID and flu) as well as increased scepticism around vaccines.

This coming winter (2025/26), as an organisation we need to aim to improve uptake by at least 5% on the 2024 flu uptake figure, with an ambition to eventually return towards the pre-pandemic uptake level of 2018/19. In 2024/25 Berkshire Healthcare achieved an uptake of 43% (49% (non-patient facing) and 42% for patient facing staff) for the annual flu vaccine, this needs to be increased to around 50% this winter, in line with the Urgent and emergency care plan 2025/26, though our aspiration would be significantly higher.

Improving Flu Vaccination Rates this Winter

As winter approaches, the importance of flu vaccination cannot be overstated. To enhance flu uptake this winter, we will implement the following measures:

1. Education - promoting the importance of flu vaccine

As an organisation seeking to improve flu vaccination rates, we need to ensure that all staff have access to trust wide communications including when messages surrounding flu are sent in team brief, circulation and discussed in all staff briefings.

Some key areas to focus on:

- Educating all staff with evidence-based information surrounding what flu is, how it can be transmitted and how having a flu vaccination can prevent transmission and protect patients, colleagues and family members
- Ensuring that inpatient areas and areas without individual access to laptops or work phones to have print out versions of circulation, team brief and posters displayed in communal areas.

- Screensavers with key flu messages
- Weekly updates in the trust Team Brief
- Dedicated staff vaccination inbox, whereby individual queries can be raised and discussed
- The use of the Health Bus to go to more sites across Berkshire
- Question and answer session on monthly all team briefing (via Teams)
- Focus on hospitalisation rates, outbreaks and staff sickness last year.

2. Expanding Access to Vaccination Sites

To make flu vaccinations more accessible, we continue to offer clinics across all 6 localities of Berkshire as well as drop in clinic provision, attendance at large meetings and events, and a roving model to take the vaccine to inpatient staff and other Berkshire Healthcare staff working across different bases.

3. Targeted Campaigns for low up take teams/ services

- To review 2024/25 flu data and look at areas of lowest uptake
- Different ways to target:
    - Follow-up non responders – this means making a targeted contact to any member of staff who does not complete a yes or no consent form via not only a work contact but a personal email or phone. This is because not all staff have access to a work device
    - Offer advice/ health promotion webinars around the flu vaccine
    - Seeking views from staff who declined the flu vaccine or did not respond last year to understand if any barriers and their views on vaccination
- Service flu champions – someone who is pro vaccination and who can ensure posters and leaflets are circulated, emails sent out and material is displayed in staffing areas
- Incentives – if everyone who completes a yes or no consent form could have the chance to win a voucher may encourage consent return.

Conclusion

To boost vaccination uptake, a new strategy is needed to increase consent returns. This includes reinforcing messages about vaccination's importance to staff, especially frontline healthcare workers, and targeting those who do not complete a consent form with reminders.

Although Berkshire Healthcare has not traditionally used targeted contact, guidance suggests that tailored communication can enhance uptake and should be considered this winter.

Trust Improvement	KLOE	Assured, Partially Assured, Not Assured	Comments/exceptions	Highlights/ evidence	Support regions require
FHCW flu vaccination uptake should be increased in all Trusts	The Trust has fully developed plans to improve flu vaccine uptake among front line staff, with a named Executive Lead for staff vaccination and Executive Winter Director responsible for flu in place by July 2025.	Assured	Communication plan and response plan in place for the BHFT staff vaccination programme		
	Plans must demonstrate how the Trust will make a step change to improve vaccination rates for frontline staff towards the pre-pandemic levels. This means that for 2025/26, there is an emphasis on increasing uptake by 5 percentage points from the 2024/25 final position.	Assured	As per response document		
	The Trust is able to demonstrate a 100% occupational health vaccination offer for eligible staff throughout the programme; October 2025 to March 2026, that includes onsite bookable and walk-in appointments, detailing how success will be monitored.	Assured	Clinics, including bookable and walk in's are currently scheduled from October - December 2025 and will be available across all 6 localities (at a BHFT main site). On top of this and from January 2026 onwards will be an ad hoc roving model, utilising trained peer vaccinators to capture any vaccines still outstanding.		
	Plans confirm that in and out-of-hours arrangements are in place to advertise available flu clinics and other opportunities for staff vaccination with a focus on delivering vaccination close to areas of practice e.g. mobile units or on-ward vaccination.	Assured	Weekly team briefings, screen savers, reminders via Cinnamon system, dedicated Nexus page		
	The Trust has mechanisms in place to ensure frontline staff details on ESR are correct to enable accurate reporting on FDP	Assured	Meeting in place to discuss with workforce and ensure accuracy, in previous years some discrepencies around what name is recorded on ESR and with employer vs what is their registered name with GP		
	The Trust has communication plans in place to advise staff of the need for vaccination, it's importance and value together with plans to monitor success. The Trust has vaccine champions to drive uptake.	Assured	Peer vaccinators in place, communications plan has been drawn up, trust has a comms lead for flu programme.		
Discharge to care home	**KLOE**				
Vaccination of patients being discharged to Care Home - *indicate n/a if this is not applicable to the Trust (e.g for ambulance trusts)*	The Trust can demonstrate plans showing how all eligible long-term inpatient and patients who are being transferred to a care home are offered a flu vaccination prior to discharge.	Assured	Plan developed along with SOP on how to identify long term inpatients with a stay of (28 days+) to include notification of patients being discharged to care homes.		
Clinical at-risk	**KLOE**				
Vaccination of other eligible individuals - *indicate n/a if this is not applicable to the Trust (e.g for ambulance trusts)*	The Trust will provide flu vaccination to pregnant women in maternity settings from 1 September 2025 in line with JCVI guidance.	Assured	We will offer to pregnancy staff - TO NOTE we do not provide maternity services		
	Arrangements to sign post vaccinations to other providers or opportunistically vaccinating other eligible patients are in place.	Assured	via staff vaccination inbox and face to face during flu appointments we can signpost staff		
RSV	**KLOE**				
Year-round RSV vaccination of pregnant women - *indicate n/a if this is not applicable to the Trust (e.g for ambulance trusts)*	Plans should be in place to ensure all pregnant women are offered the RSV vaccination from 28 weeks gestation.	Assured	to note : We do not deliver maternity services.		

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	09 September 2025
Title	**Executive Report**
	Item for Noting
Reason for the Report going to the Trust Board	The Executive Report is a standing item on the Trust Board agenda. This Executive Report updates the Trust Board on significant events since it last met. The Trust Board is requested to seek note the report and to seek any clarification on the issues covered in the report.
Business Area	Corporate Governance
Author	Chief Executive
Relevant Strategic Objectives	The Executive Report is relevant to all the Trust's Strategic Objectives

Berkshire Healthcare
NHS Foundation Trust

Trust Board Meeting – 09 September 2025

EXECUTIVE REPORT – Public

1. Never Events

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

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

2. Appointment of an Interim Chair

Martin Earwicker stepped down as the Trust's Chair on 31 July 2025 after serving for 8.5 years. Unfortunately, the first recruitment round to find a replacement chair was unsuccessful. The post has been re-advertised with a view to appointing a new Chair by the end of the year. In the meantime, the Council of Governors agreed to appoint Mark Day, Vice Chair, as the Trust's interim Chair until a new chair is in post.

As an NHS Foundation Trust, the majority of voting members on the Board must be Non-Executive Directors. Until a new Chair is appointed there are equal numbers of Executive Directors and Non-Executive Directors on the Board. In the event of a vote at the Board, the Interim Chief Operating Officer will abstain from voting. The reason for the abstention will be recorded in the minutes of the meeting.

Executive Lead: Julian Emms, Chief Executive

3. New Regulation for NHS Managers

In November 2024, the Department of Health and Social Care (DHSC) consulted on whether to introduce regulation for managers in the NHS. The proposals have been shared as part of the Government's Ten-year National Health Service Plan, and the formal response which outlines the intention for new regulation to apply to board level members in the NHS and their direct reports, was published by the DHSC on 21 July 2025.

Key points

- There has been a decision to introduce a form of regulation, this will be a statutory barring scheme.
- It is different to other regulation that exists; in that it is not a register for which individuals must meet a set of educational and fitness standards to be able to practise in a particular role.

- It will be a register which identifies those individuals who are unfit to be appointed to a board level role or a senior direct reporting role.
- The Health and Care Professions Council (HCPC) will hold responsibility for the scheme.

Next steps

- There will be a formal consultation on the method of regulation. This is likely to happen in late 2026
- Draft legislation will be prepared which will follow the usual parliamentary passage to become legislation.
- In parallel, the HCPC will formally consult on rules and processes including a Code of Conduct as well as engaging with stakeholders on the design of the scheme.
- When the scheme infrastructure has been designed and approved, ahead of its implementation, there will be a period of up to 12 months, in which the requirements will be clearly articulated to those who will be subject to the scheme.

Executive Lead: Julian Emms, Chief Executive

4. Sexual Safety Charter and Actions to Tackle Sexual Misconduct in the NHS

On 20th August 2025, NHS England wrote to all NHS Trusts and Integrated Care Boards advising of the publication of a refreshed Sexual Safety Assurance Framework. This is to support achievement of the commitments within the NHS England Sexual Safety Charter published in September 2023, and to ensure that identification and action is being taken against potential perpetrators of sexual misconduct in the NHS. This is also a requirement under the Worker Protection (amendment of Equality Act 2010) Act 2023 which came into force in October 2024, placing a legal duty on employers to take reasonable steps to prevent sexual harassment and create a safe working environment.

The letter asks providers to:

- **Begin self-assessment against the Sexual Safety Charter Assurance Framework.**
  Self-assessment had been undertaken under the previous framework; a review of this updated framework will be undertaken/coordinated through our internal Violence Prevention and Reduction Group, overseen by the Director of Nursing and Therapies as Executive lead with continued 6 monthly reporting to the Board as part of the Violence Prevention and Reduction Assurance Report. The next report will be presented to Board in November 2025.

- **Encourage staff to complete the e-learning on sexual misconduct and consider specialist training.**
  This is already available, being promoted and completed by staff across the organisation.

- **Review staff policies and processes to ensure appropriate sharing of concerns about healthcare professionals with future employers and host organisations.**

All relevant policies were reviewed as part of our work toward the commitments within the Charter, we will review to ensure that this is explicit within relevant policies.

- **Ensure all employee relations issues are appropriately recorded and investigated**. Processes are in place to ensure that issues and concerns are recorded and investigated.

- **Review chaperoning policies.**
  This was reviewed as part of the work towards the commitments within the charter and will be reviewed further as part of this process.

- **Monitor unusual access to patient records and ensure safeguarding oversight.**
  Processes are in place for auditing of patient records access where required.

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

5. Provider Capability

As part of the NHS Oversight Framework, NHS England will use an assessment of provider capability alongside providers' NHS Oversight Framework segments to judge what actions or support are appropriate at each trust.

This is a key element of NHS England's new approach to provider oversight, intended to provide oversight teams with a more holistic view of trusts while giving their boards a framework within which to assess their governance, grip and ability to deliver. It will also inform whether trusts go forward to apply for new Foundation trust status or are considered for the National Provider Improvement Programme (NPIP).

NHS England's Executive team agreed to the approach at a recent meeting and are now circulating to all NHS Trusts and foundation trusts to get the process started.

Process
The first stage of this assessment involves trust boards assessing their organisation's capability against a range of criteria derived from last year's Insightful Provider Board document and submitting these self-assessments to regions.

Oversight teams in each region will review these, triangulating with their own views of the provider, its track record of delivery and any relevant information from third parties before assigning a capability rating. Across the year, should events contradict the self-assessments, teams may consider revising the rating, so it is a real-time view of management control and grip.

Timing
In terms of timing, providers are being given 8 weeks from the day they receive the documentation (due by 21 October) to carry out and return the self-assessment, and regions 4 weeks to review the returns and assign a capability rating. The aim is to have capability ratings in place by the end of November in order to identify NPIP candidates in December.

Materials
The national team have developed a self-assessment template which all providers must use and accompanying guidance for providers, which is designed to help providers in making their self-assessment, set out the process and what they can expect along the way. The self-assessment template is attached for information; there is also supporting guidance.

Next steps
The Company Secretary is coordinating the Board's self-assessment, with sign-off at the October Board meeting prior to submission to NHS England by 21 October 2025.

Executive Lead: Julian Emms, Chief Executive

6. Medium Term Planning

The move towards a more strategic and thoughtful approach to medium term planning is essential across the NHS. The 10 Year Health Plan (10YHP) sets a clear expectation that all organisations prepare robust five-year plans. These plans will need to address the delivery of core quality and performance standards including financial sustainability alongside the actions to drive the reforms set out in the 10YHP that will support this.

NHS England (NHSE) has shaped a shared view of what effective multi-year planning should look like in this context. A first draft of a Planning Framework has been published (appendix 2) designed to inform the development of five-year plans covering the period from 2026/27 to 2030/31. It outlines:

- clear roles and responsibilities for planning in the context of the new NHS operating model.
- core planning activities that can be adapted to suit local needs and circumstances.

The framework sets out a two-phase process to support the development of credible integrated plans:

- *Phase One* – Running through to the end of September, this phase focuses on laying strong foundations for effective planning. It involves building a robust evidence base, including data-driven insights into population health needs, service demand, workforce supply and capacity, and financial outlooks.
- *Phase Two* – Launching in early October, this phase will coincide with the publication of multi-year 'planning guidance' and allocations, enabling Integrated Care Boards and providers to fully develop their medium-term plans and take them through boards for assurance and sign off in December.

NHS England will continue to develop specific planning requirements and ways of working over the coming weeks, alongside the joint work on implementing the 10 Year Health Plan. NHS England are not yet able to confirm specific allocations and delivery expectations and expect all organisations to make progress to:

- assess capability, capacity, and preparedness against this framework.
- review strategy against the direction set out in the 10 Year Health Plan to identify and any gaps
- continue to develop understanding of productivity and efficiency opportunities and work through how they will be delivered through the Cost Improvement Programme
- develop, where not already in place, a shared view on service reconfiguration opportunities and plans, including addressing fragile services

Executive Lead: Alex Gild, Deputy Chief Executive

Presented by: Julian Emms
Chief Executive

	The Board is satisfied that...		*(Mitigating/contextual factors where boards cannot confirm or where further information is helpful)*
Strategy, leadership and planning	• The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners • The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE • The board has the skills, capacity and experience to lead the organisation • The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served	**Confirmed**	*If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*
Quality of care	• Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients • Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	**Confirmed**	*If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*
People and Culture	• Staff feedback is used to improve the quality of care provided by the trust • Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels • Staff can express concerns in an open and constructive environment	**Confirmed**	*If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*
Access and delivery of services	• Plans are in place to improve performance against the relevant access and waiting times standards • The trust can identify and address inequalities in access/waiting times to NHS services across its patients • Appropriate population health targets have been agreed with the ICB	**Confirmed**	*If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*
Productivity and value for money	• Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	**Confirmed**	*If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*
Financial performance and oversight	• The trust has a robust financial governance framework and appropriate contract management arrangements • Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes • The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	**Confirmed**	*If the Board cannot make the relevant certifications in this domain, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*
	In addition, the board confirms that it has not received any relevant third-party information contradicting or undermining the information underpinning the disclosures above.	**Confirmed**	*If the Board cannot make this certification, reasons why should be described here, as well as actions the board is taking to address them and relevant factors that NHSE, as regulator, needs to know:*

Signed on behalf of the board of directors

Signature

Name

Date

Planning Framework for the NHS in England

DRAFT version 1.0

Contents

Introduction

The Ten Year Health Plan (10YHP) sets out the need for a significant change to the way we organise, deliver and fund services. To support this, a new model of planning is required to meet the challenges and changing needs of England's population and, crucially, build the foundation for the transformation of our services.

The 10YHP makes clear that change needs to be delivered at scale, embedding new ways of working that transform the experience of staff and patients alike. This can only happen through coordinated bottom-up action. Leaders will need to come together alongside the citizens they serve and all those with a role in delivering improved health outcomes, to plan and transform services.

Delivering this change needs a different approach to planning across the NHS and with its partner organisations. Annual funding settlements and planning cycles have made it difficult to focus on thoughtful, long-term strategic planning of services. To break this cycle, this framework shifts the focus towards a rolling five-year planning horizon. Planning across the NHS needs to become a continuous, iterative process that supports transformational change, delivering the three shifts set out in the 10YHP and taking full advantage of breakthroughs in science and technology.

All organisations will be asked to prepare credible, integrated five-year plans and demonstrate how financial sustainability will be secured over the medium term. This means developing plans that:

- build and align across time horizons, joining up strategic and operational planning
- are co-ordinated and coherent across organisations and different spatial levels
- demonstrate robust triangulation between finance, quality, activity and workforce

We have been working closely with colleagues across the NHS to shape a shared view of what effective multi-year planning should look like in the current context. In response to the initial questions and feedback received, we are pleased to share the first draft version of a Planning Framework to support the development of five-year plans covering the period 2026/27 to 2030/31.

This draft framework is intended as a guide for local leaders responsible for shaping medium-term plans. It provides clarity on roles and responsibilities within the context of the new NHS operating model outlined in the 10YHP. It sets out core principles and key planning activities, which should be adapted based on local needs and circumstances.

Annex A outlines national expectations and an indicative timetable for plan development. We will continue to refine specific requirements and ways of working in collaboration with you.

Principles for effective, integrated planning

Planning should be a collective activity which draws input from staff, patients, people and communities. It is also a cumulative process, with each stage building on previous work. This framework is built around the five core principles shown below.

Table 1: Principles for effective, integrated planning

	Principle	Description
1	**Outcome-focused**	Planning should be anchored in delivering tangible and measurable improvements in outcomes for patients and the public, and improved value for taxpayers. Involving patients, carers, and communities is critical for ensuring that plans deliver better outcomes and services that are responsive to local needs.
2	**Accountable and transparent**	Effective planning requires clarity on roles, responsibilities, and accountabilities. Governance structures must support transparent decision-making, provide regular oversight and constructive challenge, and ensure alignment with strategic objectives at organisation, place and system level.
3	**Evidence-based**	The decisions made as part of planning should be underpinned by robust analytical foundations, including population health analysis, demand and capacity modelling, workforce analytics, and financial forecasts. This should be informed by best practice and benchmarking.
4	**Multi-disciplinary**	Planning must bring together staff from across different functional areas (finance, workforce, clinical etc) to ensure that work is co-ordinated and that those responsible for delivery have shaped its content.
5	**Credible and deliverable**	Plans must set ambitious yet achievable goals. They should clearly articulate the resources required, realistically reflect workforce and financial constraints, and include mitigation strategies for key risks. Robust triangulation between finance, performance, workforce and quality is critical.

Roles, responsibilities and accountabilities

In line with the new NHS operating model signalled in the 10YHP, the diagram below summarises the core planning roles, responsibilities for:

- A smaller centre focused on setting strategy, establishing clear priorities and mandating fewer targets, and equipping local leaders to improve outcomes.
- ICBs as strategic commissioners, with a core focus on improving the population's health, reducing health inequalities, and improving access to consistently high-quality services.
- Providers focused on excellent delivery on waiting times, access, quality of care, productivity and financial management, as well as working partnership to improve health outcomes.

The role of the Board

The boards of individual ICBs and providers are ultimately accountable for the development and delivery of their plans. Boards are expected to play an active role in setting direction, reviewing drafts, and constructively challenging assumptions – rather than simply endorsing the final version of the plan. Boards should ensure that the plan is evidence-based and realistic in scope, aligns with the organisation's purpose and the wider system strategy, and supports the delivery of national ambitions

Boards should also set the conditions for continuous improvement, ensuring there is a clear data-driven and clinically led improvement approach in place. A systematic approach to building improvement capacity and capability at all levels is essential. This is vital to ensure organisations are ready to both deliver plans and lead wider transformation, including shifting more care from hospital to community, expanding digitisation, and driving year-on-year improvements in productivity.

Accountability at the level of individual organisations sits alongside the duty to collaborate. Effective planning requires organisations to work constructively across the system to deliver shared objectives. ICBs and providers can achieve this by:

- Engaging early and consistently in the planning process, ensuring alignment on priorities, assumptions, and planning parameters.
- Sharing data, forecasts and risk insights to build a common evidence base and support transparency in decision-making.

- Jointly developing scenarios and trade-offs, particularly where financial, workforce, or capacity constraints exist.
- Identifying and agreeing key system priorities and setting out clearly how each organisation's plan contributes to their delivery.
- Identifying and assessing improvement capability and ensuring there are clear roles in leading improvement across the system.
- Using system governance mechanisms, such as partnership boards or planning groups, to manage dependencies and resolve tensions.
- Ensuring mutual assurance, where ICBs and providers understand and can explain how their plans both stand alone and integrate into the wider system plan.

This will help deliver the ambition for integrated, place-based care while maintaining clear lines of statutory accountability.

We will continue to develop this picture as new ways of working take shape (Neighbourhood Health Providers and Integrated Health Organisations).

Key NHS planning roles and responsibilities

Providers:

- Develop strategic, operational and financial plans to deliver on national and local priorities, including pathway redesign and service development.
- Develop and continuously improve the foundations for integrated planning including robust demand and capacity modelling and triangulation across quality, finance, activity and workforce plans.
- Ensure strong clinical leadership in plan development and linked decision making.
- Collaborate with system, place and provider collaborative partners to ensure plans support the delivery of the best outcomes for local populations and the most effective use of collective resources.
- Work with ICBs to ensure plans reflect agreed commissioned activity levels and align to the overall system strategy.

Regions:

- Support ICBs and providers to 'create the conditions' for effective, integrated planning across the region, including assessment of planning maturity.
- Lead those planning activities where a regional or cross-system response is required e.g. strategic infrastructure planning, long term workforce planning, education and training capacity planning.
- Support and assure ICB and provider responses to nationally mandated elements of NHS planning including risk assessment, coordinating appropriate support, and plan acceptance.
- Work closely with national teams to design national planning products and processes and support capability and capacity building.

ICBs:

- Set overall system strategy to inform allocation of resources to improve population health outcomes and ensure equitable access to healthcare.
- Lead system level strategic planning, ensuring effective demand management and optimal use of collective resources.
- Set commissioning intentions and outcome-based service specifications to enable providers to undertake effective operational planning aligned to national and local priorities.
- Convene and co-ordinate system-wide planning activities e.g. pathway redesign, neighbourhood health, fragile services, capital and estates.
- Work closely with region on planning activities where a cross-system or multi-ICB response is required.
- Co-ordinate system response to nationally determined NHS planning requirements, working with region and providers.

National:

- Set strategic direction and national priorities and standards for the NHS.
- Develop and continuously improve the national planning framework, including specific requirements for the nationally co-ordinated element of NHS planning.
- Support capability and capacity building across the system and promote sharing and adoption of best practice.
- Deliver centrally developed resources, such as analytical tools, data packs, modelling assumptions, and templates to reduce duplication and ensure consistency.
- Provide guidance and technical support to underpin planning and assurance processes
- Work closely with regions, ICBs and providers on the design and refinement of national planning products and processes.

The integrated planning process

Planning is a continuous cycle that is linked to strategy, delivery and performance management. The most technically sound plan will fail if it does not command the support of the staff who must deliver it and the patients and public whose care it is designed to improve. A robust process ensures the plan is well-informed, broadly supported, and feasible to implement. This section sets out a two-phase process to support the development of credible, deliverable integrated plans.

The aim of the initial phase is to lay the foundations for success. This involves:

- setting up the integrated planning process and governance at organisation, place and system level
- building a robust evidence base including data-driven insights into population needs, service demand, workforce supply and capacity, and finances.

In the second phase, plans are fully developed, triangulated and assured through a multidisciplinary process, and finally signed off by boards. These phases are not rigid and the core activities across these phases may overlap and interact with each other. Table 2 sets out the core activities for ICBs, providers and place partners for each phase. Supporting resources will be shared on the Futures NHS Planning platform. We will continue to develop this into a library of planning best practice, including supporting models and tools, and encourage all organisations to contribute their own best-practice examples and experiences[1].

Phase one

The first step is to establish clear roles and responsibilities and multidisciplinary planning teams to drive and co-ordinate the activities set out in table 2. In phase one these should include:

- Population health needs assessment, identifying underserved communities and surfacing inequalities.
- Identifying service and pathway redesign opportunities, including where services are vulnerable to becoming unsustainable because of size, workforce shortages, infrastructure, or unmet demand.
- Demand and capacity analysis, including a bottom-up assessment to ensure demographic and technological changes are anticipated (demand), and productivity, workforce and estates factors are explicitly considered (capacity)

[1] Please get in touch at england.ops-planning@nhs.net

- Identifying opportunities to improve productivity and efficiency (this should be a continuous process).
- Financial analysis to establish a baseline underlying position and cost drivers, including a clear understanding of unit costs.
- Reviewing and refreshing the organisation's clinical strategy to ensure it is up to date and aligned to the 10YHP.
- Reviewing the organisation's improvement capability.
- Reviewing strategic estates plans, opportunities for disposals and consolidation and where new additional or different estate is needed for transformation or performance improvement

Executives and boards should ensure that structures and processes are in place to support integrated planning e.g. through a programme board or steering group that meets regularly to drive the planning process forward. As noted in section 2, formal arrangements should also be in place to support effective planning with system partners, including the independent sector. This includes joint planning sessions with local authorities to align with their strategies at place, and structured collaboration with the VCSE sector, who often have deep community roots and provide vital services.

Phase two

The development of integrated plans should build on robust population health improvement and clinical strategies that reflect both local needs and national ambitions, including the three shifts set out in the 10YHP. Informed by the foundational activities and analysis undertaken during phase one, the integrated plan should bring together:

- **Service plans** that address key opportunities to redesign pathways to better meet local needs, improve access, quality, and productivity
- **Workforce plans** to deliver the right workforce with the right skills aligned to finance and activity plans. Over a five-year horizon, roles and required skills will evolve e.g. driven by digital transformation and new treatments. Plans will need reflect this as well as setting out the measures to attract staff and improve staff retention
- **Financial plans** that show how the organisation intends to live within its means and secure financial sustainability over the medium-term while delivering on operational and quality priorities
- **Quality improvement plans** to improve patient care, experience and outcomes
- **Digital plans** that build digital capability, leverage data for better decision-making, support improved population health, enable improved patient care and experience, and drive efficiency and integration

- **Infrastructure and capital plans** that maximise the utilisation of existing assets and capital investment in the most effective way, to deliver objectives on transformation and performance improvement over the medium term

Organisations should also be considering how they mobilise their improvement capability to deliver these plans.

Triangulation

Triangulation is a critical part of the integrated planning process, ensuring that each element of the plan reinforces the others, making the plan internally consistent and realistic. As a minimum, this involves:

- a common data set and shared set of planning assumptions at the outset, so that everyone is planning on the same basis.
- holding regular reconciliation meetings, where - for example, finance, HR, and operational leads review draft numbers together to identify and resolve discrepancies.

Integrated planning tools or models that combine activity, workforce, and finance projections can help ensure consistency and provide transparency around how changes in one area of the plan affects others.

Triangulation is not only an internal NHS exercise, it also involves aligning NHS plans with those of local government and other partners. A truly integrated plan will consider the local authorities' plans for public health, social care, and broader community development.

Plan Assurance

Having an aligned, integrated plan is not enough – the plan must also be credible, deliverable and affordable. Credibility means the plan's assumptions and targets are evidence-based and convincing to stakeholders (including regulators and the public). Deliverability means that the plan can realistically be executed with the available resources and operating environment. Affordability means the plan's financial assumptions are sustainable and align with available funding and budgetary limits.

Executives and boards are expected to rigorously test the plan before finalising it using robust assurance processes. This includes formal challenge sessions during the plan's development, to critically test assumptions and proposals, and request revisions if needed. Scenario planning and sensitivity analysis should play a key role in supporting this process to:

- provide a clear, quantitative measure of the plan's key financial and non-financial risks and focus attention on how these can be managed.
- systematically identify the most critical and uncertain assumptions and quantify the impact of this uncertainty.

Declaring a plan “deliverable” is not a one-off event – it requires ongoing oversight once implementation begins. Best practice involves setting up a robust delivery monitoring mechanism as part of the planning framework. Learning should be captured as part of this process to help inform continuous improvement across the planning and delivery cycle.

Table 2: Core activities across the integrated planning cycle:

<table>
<tr><th></th><th>ICB</th><th>Provider[2]</th><th>Place partners</th></tr>
<tr><td rowspan="2">Phase one: Setting the foundations</td><td colspan="2">Perform a refresh of the clinical / organisational strategy as required to ensure they are updated to reflect changes in national policy (e.g. the 10YHP) or local context. Review organisational improvement capability.

Establish appropriate governance structures and agree responsibilities and ways of working to support the integrated planning process, including engagement with patients and local communities</td><td rowspan="2">Provide place-level input on population needs and local priorities including Joint Strategic Needs Assessment (JSNA)</td></tr>
<tr><td>Assess population needs, identifying underserved communities and surfacing inequalities, and share with providers

Review quality, performance and productivity of existing provision using data and input from stakeholders, people and communities

Develop initial forecasts and scenario modelling for demand and service pressures

Generate actionable insights to inform service and pathway design with providers

Create outline commissioning intentions for discussion with providers</td><td>Review quality, performance and productivity at service level as well as the organisation’s underlying capabilities (workforce, infrastructure, digital and technology)

Establish a robust financial baseline based on underlying position and drivers of costs

Identify key sources of unwarranted variation and improvement opportunities through benchmarking and best practice

Identify service and pathway redesign opportunities including reviewing fragile services

Undertake core demand and capacity analysis and develop initial forecasts and scenario modelling</td></tr>
</table>

[2] Individually and jointly across provider collaboratives

	ICB	Provider[3]	Place partners
Phase two: Integrated planning	Develop an evidence-based five-year strategic commissioning plan to improve population health and access to consistently high –quality services	Develop a credible, integrated organisational five-year plan that demonstrates how national and local priorities will be delivered, including securing financial sustainability	Lead the co-design of integrated service models at place level Develop Neighbourhood Health Plan and supporting place-based delivery plans
	Bring together neighbourhood health plans into a population health improvement plan in discussion with people, communities and partners Iterate initial forecasting and scenario modelling for demand and service pressures Finalise commissioning plans to inform provider plan development Undertake QEIAs to support informed decision-making through the planning process Ensure improvement resources are aligned to the priority areas of the plan	Iterate core demand and capacity analysis and scenario modelling to reflect service redesign opportunities Develop clear service level plans that meet national and local priorities, including implementation plans best practice care pathways Triangulate and finalise finance, workforce, activity and quality plans Undertake QEIAs to support informed decision-making through the planning process Ensure improvement resources are in place to deliver plans	

[3] Individually and jointly across provider collaboratives

The national planning architecture

This framework has been developed as a guide for local leaders across England responsible for the development of the strategic and operational plans that will deliver on local priorities as well as our shared national ambitions for the NHS as set out in the 10YHP. These plans are the cornerstone of a wider national planning architecture designed to ensure that:

- plans are developed based on appropriate, accurate and timely information.
- plans are developed on a consistent basis to support aggregation, reporting, and oversight and accountability.
- planning activities at local, regional and national level align and support each other.

As set out in the 10YHP, five-year organisation plans together with neighbourhood health plans will be the core outputs of integrated local planning processes. They are described at a high level in Table 3. NHS England and DHSC will issue specific guidance to support their respective development. Given these changes, we will also work with government to review the requirement for ICBs and their partner trusts to prepare a five-year joint forward plan (JFP) and joint capital resource use plan (JCRUP).

Relationship between key elements of the national planning architecture

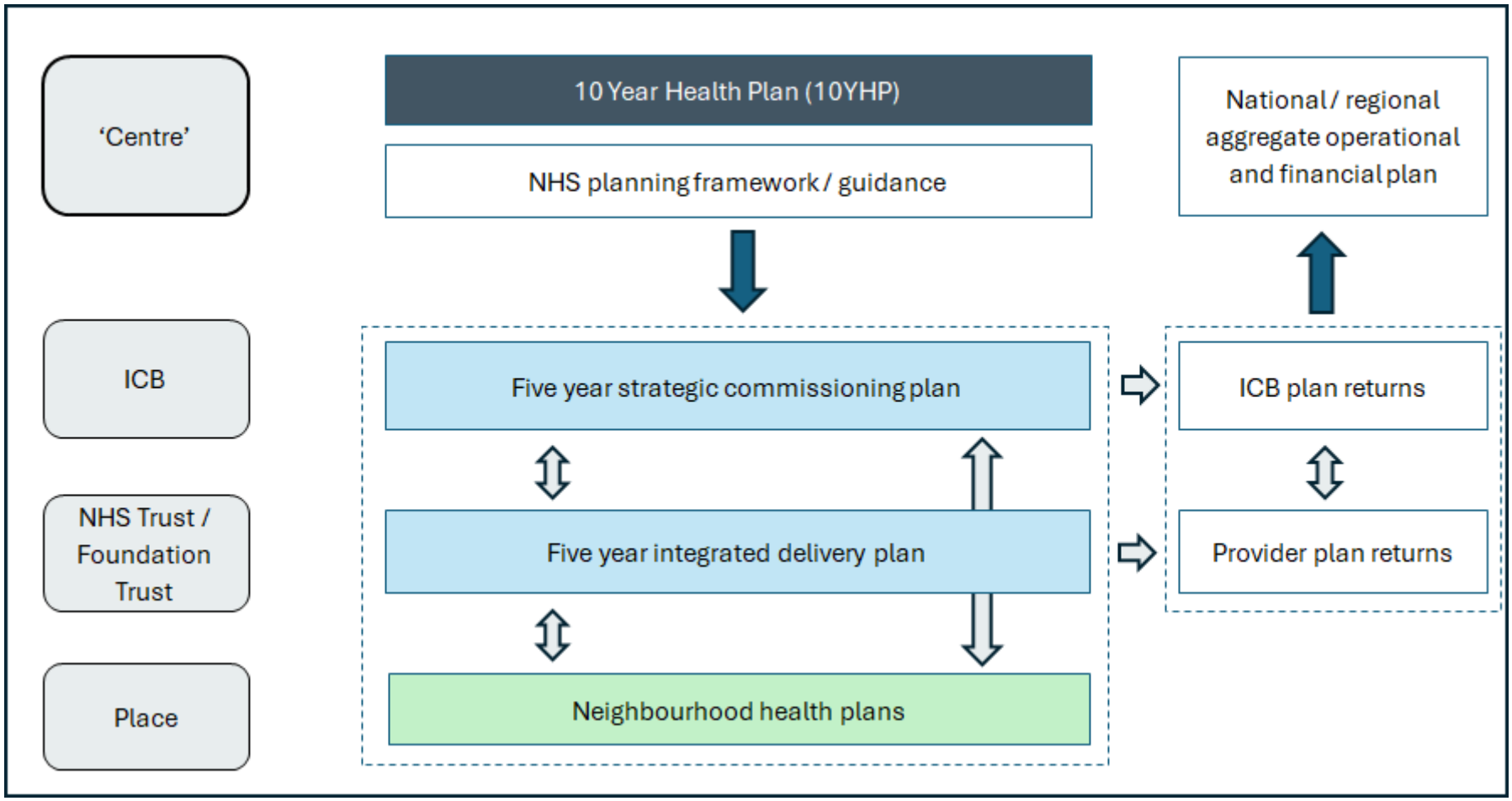


Table 3: Core planning outputs

Output	Description
Five-year strategic commissioning plans (ICBs)	Describes how, as a strategic commissioner, an ICB will improve population health and access to consistently high –quality services across its footprint. We will work with ICBs to develop specific guidance. As minimum, we expect that plans will: • set out the evidence base and overarching population health and commissioning strategy • bring together local neighbourhood health plans into a population health improvement plan (PHIP), including how health inequalities will be addressed • describe new care models and investment programmes that maximise value for patients and taxpayers aligned to 10YHP • demonstrate how the ICB will align funding and resources to meet population needs, maximise value, and deliver on key local and national priorities • describe how the core capabilities set out in ICB blueprint will be developed. ICBs will be expected to refresh these plans annually as part of establishing a rolling five-year planning horizon for the NHS.

Five-year integrated delivery plans (NHS Trusts and NHS Foundation Trusts)	Demonstrates how the organisation will deliver national and local priorities and secure financial sustainability. We will work with providers to develop specific guidance. As minimum, we expect that plans will:
	• set out the evidence base and organisation's strategic approach to:
	  ○ improving quality, productivity, and operational and financial performance
	  ○ meeting the health needs of the population it serves and how this approach contributes to delivering the overall objectives of the local health economy

	• describe the actions that will support delivery of the trust's objectives, including key service development and transformation schemes and how these will impact quality and support operational and financial delivery • summarise how the underpinning capabilities, infrastructure and partnership arrangements required to deliver the plan will be developed e.g. workforce skills, digital capability, and estate. Providers will be expected to refresh these plans annually as part of establishing a rolling five-year planning horizon for the NHS.
Neighbourhood health plans	These will be drawn up by local government, the NHS and its partners at single or upper tier authority level under the leadership of the Health and Wellbeing Board, incorporating public health, social care, and the Better Care Fund. The plan should set out how the NHS, local authority and other organisations, including social care providers and VCSE, will work together to design and deliver neighbourhood health services. DHSC will publish separate guidance to support their development.
National plan returns	We will engage with ICBs and providers on the specific requirements for the national plan returns. Five-year organisational plans will be expected to fully align with and support numerical returns. The existing set of annual finance, workforce, activity and performance templates will be redesigned and streamlined to better support integrated planning. There will be separate returns from ICBs and trusts rather than a single 'system return'. ICBs and providers will need to work together to ensure that these are fully aligned.

Annex A: Development of plans for the five-year period from 2026/27 to 2030/31

We are issuing this framework to help inform the development of plans for the five-year period from 2026/27 to 2030/31. We will continue to work with you to develop specific requirements and ways of working.

Where not already in progress, ICBs and providers must now begin to lay the foundations for developing their five-year plans. This includes the critical work to secure financial sustainability over the medium term. The national planning timetable aligns with the phased approach set out in this framework:

- Phase one will run to the end of September. During this period, NHSE England and DHSC will work together to translate the 10YHP and spending review outcome into specific multi-year priorities and allocations.
- Phase two will launch at the end of September / early October with the publication of multi-year guidance and financial allocations. This will enable ICBs and providers to fully develop their medium-term plans and take them through board assurance and sign off processes in December.

During the initial planning phase, we are asking you to focus on:

- setting up your integrated planning process and establishing a multidisciplinary planning team to co-ordinate activity across functions.
- assessing your organisation's capability, capacity and preparedness against this framework. Key gaps, areas for concern and risks should be discussed at the earliest opportunity with your regional NHS England team, who will work with you to identify potential solutions and support.
- reviewing your clinical strategy against the direction set out in the 10YHP to identify and address any gaps .
- developing a transparent articulation of your underlying financial position
- continuing to develop your understanding of productivity and efficiency opportunities and how they will be delivered, building on the work done through the planning process for 2025/26. Build your Cost Improvement Plans (CIPs) by identifying areas of opportunity.
- developing, where not already in place, a shared view on service reconfiguration opportunities and plans, including approaches to address fragile services.
- assessing and improving the maturity of core demand and capacity planning within your organisation and across the wider system.
- working with NHS England to assess the impact of rebasing fixed payments.

December plan returns will include firm financial, workforce and operational plans for the first year, which providers and ICBs will be held to account for delivering. Regional teams will lead on the review of these submissions and work with organisations to conclude the plan acceptance process during the first half of quarter four. A high-level timeline is shown below.

We will issue allocations based on the statutory ICB footprints for April 2026 and ask ICBs to prepare and submit plans on that basis. Where ICBs are entering into clustering arrangements ahead of a planned future merger they will need to work together to appropriately reflect these arrangements in their plans.

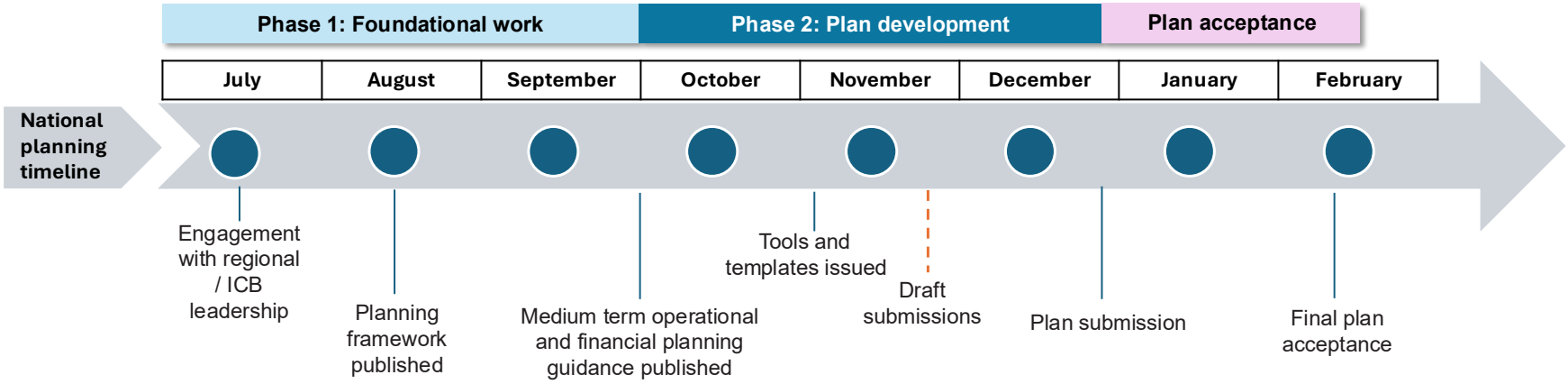
Specialised Services, Health and Justice, Vaccinations and Screening

ICBs have already taken on delegated commissioning responsibility for certain specialised services and will also take on a greater leadership role from April 26 for the commissioning of screening services, vaccination services (building on existing partnership arrangements already in place with ICBs), and health and justice services. It is anticipated that full commissioning accountability for these services will transfer to ICBs from April 27.

ICBs will need to work in close partnership with their NHS England Regional Teams to prepare for these changes, including establishing a single (one per NHS Region) ‘Office for Pan-ICB Commissioning’ to ensure appropriate ‘at-scale’ commissioning of these services continues, and a concentration of expert commissioning capability maintained. The Offices will support all ICBs equally and collectively across a Region in discharging these new responsibilities and future accountabilities. Further details on the requirements and timetable for transition will follow.

It is therefore critical that ICBs, in partnership with their NHS England Regional Teams, ensure these services are fully factored into medium terms plans and that those plans begin to realise the benefits of whole pathway and population-based commissioning, including the opportunities that upstream interventions can have in reducing demand for specialised services.

Indicative timetable for 2026/27 – across two phases



Regional activities	Develop medium-term strategic framework Engage with ICBs and providers to identify support needs		Risk-based planning support to ICBs and providers		Review of draft plans	Plan assurance and acceptance	
ICB activities	Set up process, governance and build a robust evidence base	Create outline commissioning intentions and discuss with providers	Integrated planning		Finalise plans & board sign-off	Respond to outcome of plan assurance	Prepare to implement plans
Provider activities	Set up process, governance and build a robust evidence	Complete foundational work	Integrated planning		Finalise plans & board sign-off		
Outputs		Underlying financial position Block contract reviews		Draft Planning returns	Five year plans National returns		

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper Meeting Paper

Board Meeting Date	9 September 2025
Title	**Finance Report July 2025**
	The paper is for noting.
Reason for the Report going to the Trust Board	This is a regular report which provides an update to the Board on the Trust's Financial Performance. The report provides the Trust's position at the end of July 2025.
Business Area	Finance
Author	Chief Finance Officer
Relevant Strategic Objectives	**Efficient use of resources** **Ambition:** We will use our resources efficiently and focus investment to increase long term value The report gives an overview of the Trust's financial performance including use of revenue and capital funding and delivery against the cost improvement programme. The Trust's results contribute to the performance of BOB ICS.

Berkshire Healthcare NHS
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Finance Report

Financial Year 2025/26

July 2025

Purpose

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

Document Control

Version	*Date*	*Author*	*Comments*
1.0	07/08/2025	Rebecca Clegg	Draft
2.0	26/08/2025	Paul Gray	Final

Distribution

All Directors.

All staff as appropriate.

Dashboard & Summary Narrative

Target		Year to Date Actual £m/%	Year to Date Plan £m/%	Year to Date Achieved	Forecast Outturn Actual £m/%	Forecast Outturn Plan £m/%	Forecast Outturn Achieved
1	Income and Expenditure Plan	1.0	1.0	Yes	1.7	1.7	Yes
2	CIP - Delivery	5.8	5.8	Yes	17.5	17.5	Yes
3	Cash Balance	53.3	49.1	Yes	45.2	45.2	Yes
4a	Better Payment Practice Code Volume Non-NHS	99%	95%	Yes	95%	95%	Yes
4b	Better Payment Practice Code Value Non-NHS	98%	95%	Yes	95%	95%	Yes
4c	Better Payment Practice Code Volume NHS	99%	95%	Yes	95%	95%	Yes
4d	Better Payment Practice Code Value NHS	98%	95%	Yes	95%	95%	Yes
5	Capital Expenditure not exceeding CDEL	1.1	3.2	Yes	20.8	20.8	Yes
6a	Agency Expenditure Reduction	25%	30%	No	30%	30%	Yes
6b	Bank Expenditure Reduction	21%	10%	Yes	10%	10%	Yes

Key Messages

The table above provides a high level summary of the Trust's performance against key financial duties and other financial indicators. The current position is positive with only one target not being achieved year to date. The key points to note are:

- The planned outturn position for the Trust is a £1.7m surplus.
- The Trust has a cost improvement programme of £17.5m. This is being achieved year to date although there are variances on individual lines and we have some high risk schemes.
- The current cash position is ahead of plan. However, we have significant underpayment from commissioners offset by invoices from NHS Property Services which have been held pending agreement of funding arrangements with BOB and Frimley ICBs.
- The Better Payment Practice Code is achieved for all 4 targets.
- Capital expenditure spend is below CDEL Year to Date.
- The Trust has 2 targets for temporary staffing. There is a requirement to reduce agency expenditure by 30% when compared to the previous year. Although costs have reduced, the target has not yet been met. This is in part due to phasing and overall the shortfall is only £0.1m year to date. The bank staffing cost reduction of 10% compared to the previous year is being exceeded by £0.8m year to date.

System Position

- BOB ICS submitted a combined break even plan. This included £44m of deficit support. There is also £24m of system risk share of which BHFT has agreed to a £1.8m share linked to opportunities within the ICB's own MHLDA budgets. Progress towards the saving target has been slow and at month 4 the Trust has assumed clawback of income for Q1 in line with the risk share agreement.
- Contract finance schedules have been agreed with BOB ICB and Frimley ICB.

1. Income & Expenditure

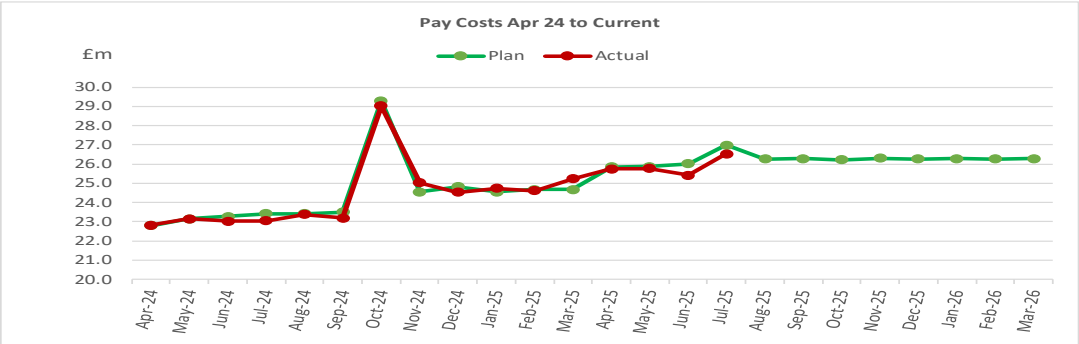
Jul-25	In Month Act £'m	In Month Plan £'m	In Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m	2025/26 Plan £'m
Operating Income	33.1	33.6	(0.5)	131.6	131.4	0.2	393.9
Elective Recovery Fund	0.4	0.4	0.0	1.6	1.6	0.0	4.8
Donated Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Income	**33.5**	**34.0**	(0.5)	**133.2**	**133.0**	0.2	**398.7**
Staff In Post	24.7	25.1	0.4	96.0	97.2	1.1	292.2
Bank Spend	1.4	1.5	0.2	5.5	6.1	0.6	18.5
Agency Spend	0.5	0.4	(0.2)	1.9	1.4	(0.5)	4.2
Total Pay	**26.5**	**27.0**	**0.5**	**103.5**	**104.7**	**1.3**	**314.9**
Purchase of Healthcare	1.5	1.3	(0.3)	6.2	5.1	(1.1)	15.4
Drugs	0.4	0.6	0.1	2.2	2.2	0.0	6.7
Premises	1.1	1.6	0.4	5.9	6.3	0.3	18.9
Other Non Pay	1.7	1.6	(0.1)	6.8	6.4	(0.4)	19.3
PFI Lease	0.7	0.7	(0.0)	2.9	2.9	0.0	8.8
Total Non Pay	**5.6**	**5.8**	**0.2**	**24.1**	**23.0**	**(1.1)**	**69.1**
Total Operating Costs	**32.1**	**32.7**	**0.7**	**127.6**	**127.7**	**0.1**	**384.0**
EBITDA	**1.4**	**1.3**	**(0.2)**	**5.7**	**5.4**	**(0.3)**	**14.7**
Interest Receivable	**0.3**	**0.3**	**(0.0)**	**1.0**	**1.1**	**(0.1)**	**3.4**
Interest Payable	0.3	0.3	(0.0)	1.1	1.1	(0.0)	3.3
Depreciation	1.0	0.9	(0.0)	3.7	3.7	(0.0)	11.2
Impairments	0.1	0.0	(0.1)	0.1	0.0	(0.1)	0.0
Disposals	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Remeasurement of PFI	0.0	0.0	0.0	1.4	1.7	0.3	1.7
PDC	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Financing	**1.4**	**1.2**	**(0.2)**	**6.4**	**6.5**	**0.1**	**16.2**
Reported Surplus/(Deficit)	**0.3**	**0.3**	**(0.0)**	**0.3**	**(0.1)**	**0.3**	**1.9**
Adjustments	**(0.0)**	**0.0**	**(0.0)**	**(0.0)**	**0.0**	**(0.1)**	**(0.2)**
PFI IFRS16 Adjustment	**(0.1)**	**(0.2)**	**0.0**	**0.8**	**1.1**	**(0.3)**	**0.0**
Adjusted Surplus/(Deficit)	**0.2**	**0.2**	**0.0**	**1.0**	**1.0**	**0.0**	**1.7**

Key Messages

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

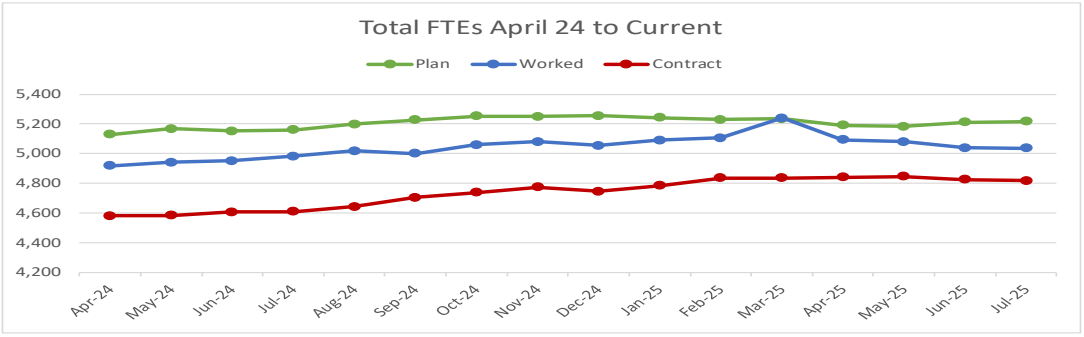
The Trust has planned for a £1.7m surplus. Year to date performance is in line with plan. The variance on purchase of healthcare relates to PICU and specialist placements.

Workforce



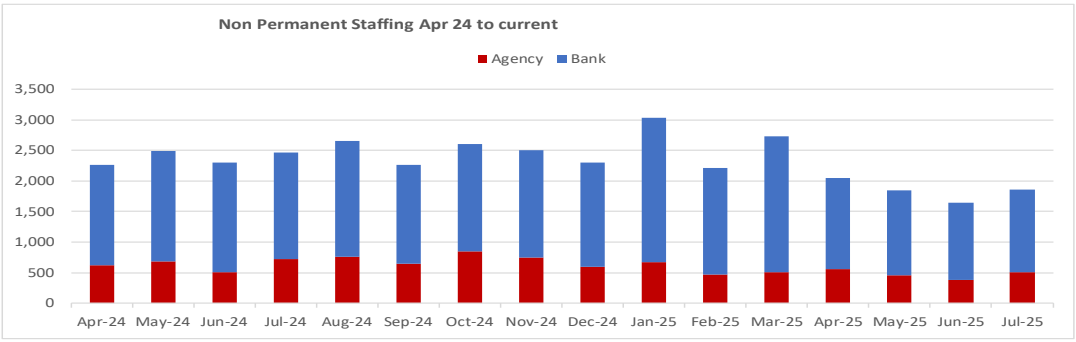
Staff Costs

YTD	£m
2025/26	103.5
2024/25	92.0
▲	12%
Prior Yr	**£m**
Jul-25	26.5
Jul-24	23.0
▲	15%



FTEs

Prior Mth	CFTE	WFTE
Jul-25	4,818	5,035
Jun-25	4,825	5,039
	0% ▼	0% ▼
Prior Yr		
Jul-25	4,818	5,035
Jul-24	4,609	4,982
	5% ▲	1% ▲



Non Permanent Staff Costs

YTD	Bank £k	Agency £k
2025/26	5,505	1,908
2024/25	6,993	2,535
	-21% ▼	-25% ▼
Prior Yr	**£k**	**£k**
Jul-25	1,353	510
Jul-24	1,744	723
	-22% ▼	-29% ▼

Key Messages

Pay costs in month were £26.5m and year to date the Trust's pay expenditure is lower than planned. The increase cost in month is due to an accrual for the difference between planned pay award and the final agreement back dated to the start of the year. This is matched by additional income and plans have been adjusted. The 2025/26 pay award will be made, along with the back pay in August. As the pay award has been agreed at a higher level than was assumed for planning, this will create a further cost pressure for the Trust c£0.3m.

WTEs reduced in month by 3 (Worked WTEs) and 7 (Contracted WTEs)

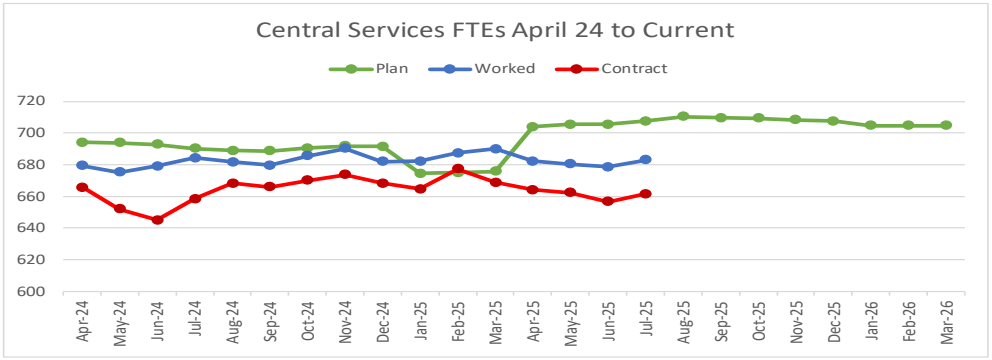
NHSE have mandated 2 new targets for temporary staffing. There is a requirement to reduce agency expenditure by 30% when compared to the previous year. This target has not yet been met but this is in part due to phasing and overall the shortfall is only £0.1m year to date. The bank staffing cost reduction of 10% compared to the previous year is being exceeded.

Our bank fill rate remains strong, meeting 90% of the overall temporary staffing demand.

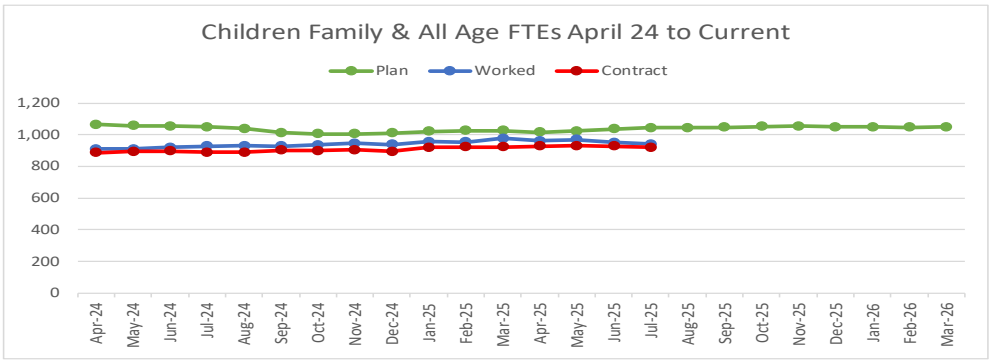
Off-framework agency usage has seen a slight increase, rising to 8%, primarily within our dental and nursery services. To address this, we continue to engage additional framework suppliers and have recently added a new dental nurse to the staff bank. We are aiming to fully eliminate reliance on off-framework agencies.

Non-medical price cap breaches were zero, which is a substantial improvement from the previous month and compared with the previous year.

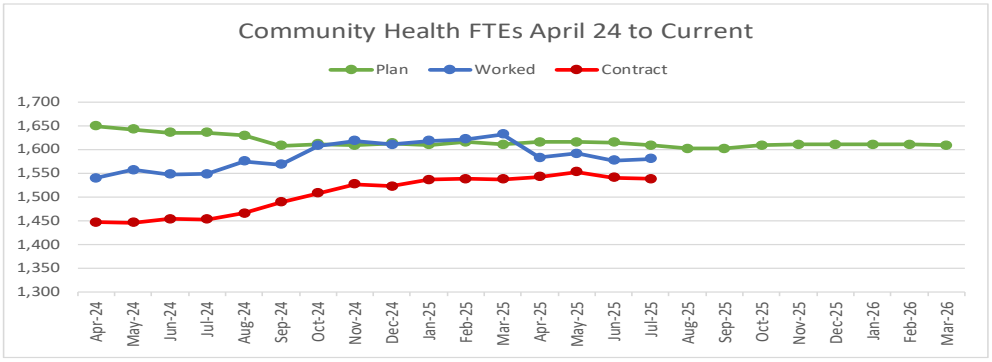
Staff Detail (Division)



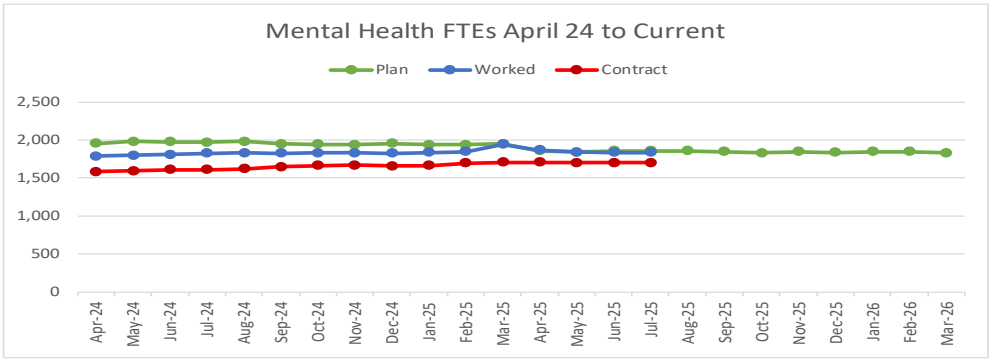
	FTEs	
Prior Mth	CFTE	WFTE
Jul-25	662	683
Jun-25	657	679
	1% ▲	1% ▲
Prior Yr		
Jul-25	662	683
Jul-24	658	684
	0% ▲	0% ▼



	FTEs	
Prior Mth	CFTE	WFTE
Jul-25	919	939
Jun-25	927	951
	-1% ▼	-1% ▼
Prior Yr		
Jul-25	919	939
Jul-24	889	927
	3% ▲	1% ▲



	FTEs	
Prior Mth	CFTE	WFTE
Jul-25	1,538	1,580
Jun-25	1,540	1,576
	0% ▼	0% ▲
Prior Yr		
Jul-25	1,538	1,580
Jul-24	1,453	1,548
	6% ▲	2% ▲



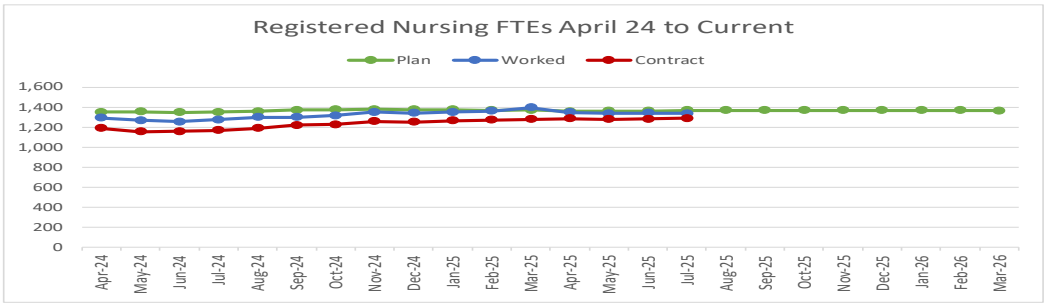
	FTEs	
Prior Mth	CFTE	WFTE
Jul-25	1,700	1,834
Jun-25	1,701	1,833
	0% ▼	0% ▲
Prior Yr		
Jul-25	1,700	1,834
Jul-24	1,609	1,823
	6% ▲	1% ▲

Key Messages

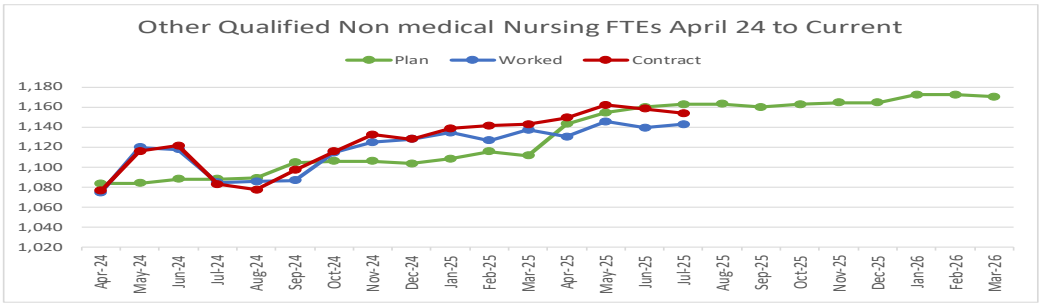
Worked WTEs are below plan for all clinical divisions and Central Services.

Overall, worked WTEs are 181 lower than plan in July.

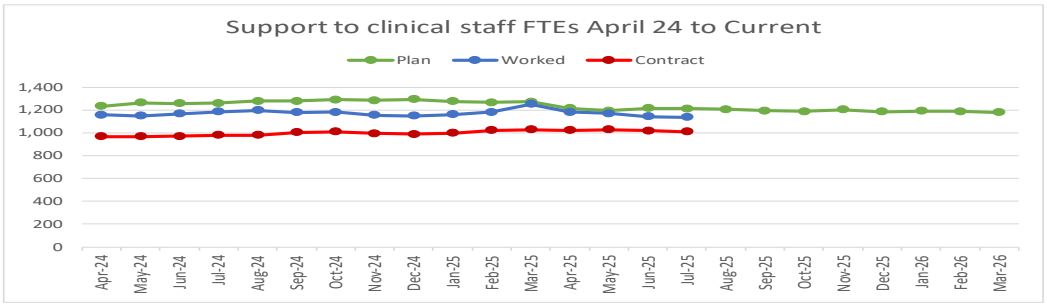
Staff Detail (Staff Group)



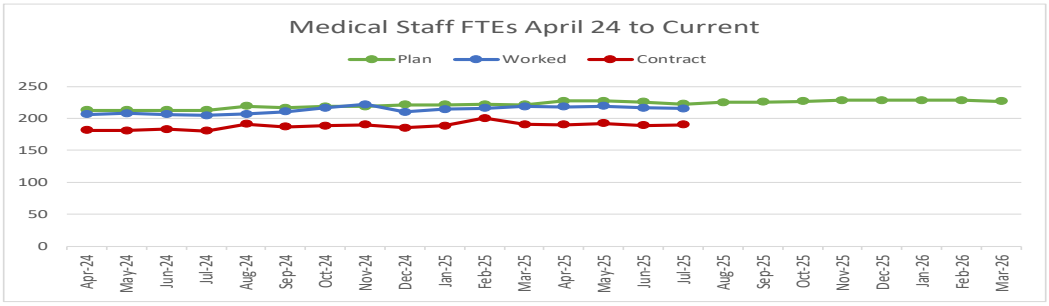
	FTEs	
Prior Mth	CFTE	WFTE
Jul-25	1,287	1,338
Jun-25	1,282	1,339
	0% ▲	0% ▼
Prior Yr		
Jul-25	1,287	1,338
Jul-24	1,168	1,273
	10% ▲	5% ▲



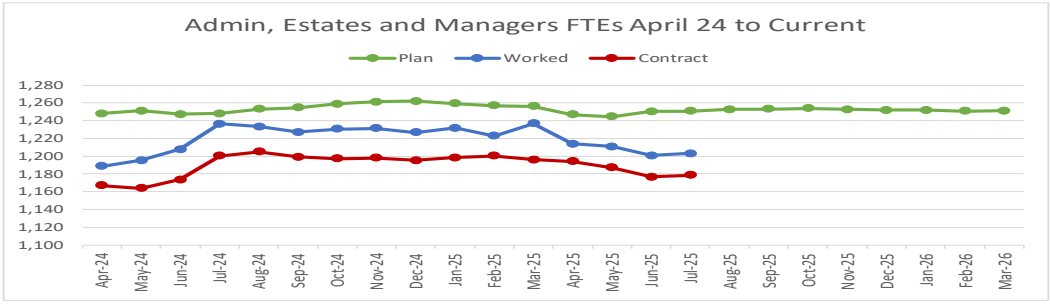
	FTEs	
Prior Mth	CFTE	WFTE
Jul-25	1,154	1,143
Jun-25	1,158	1,139
	0% ▼	0% ▲
Prior Yr		
Jul-25	1,154	1,143
Jul-24	1,083	1,084
	7% ▲	5% ▲



	FTEs	
Prior Mth	CFTE	WFTE
Jul-25	1,010	1,136
Jun-25	1,019	1,143
	-1% ▼	-1% ▼
Prior Yr		
Jul-25	1,010	1,136
Jul-24	978	1,184
	3% ▲	-4% ▼



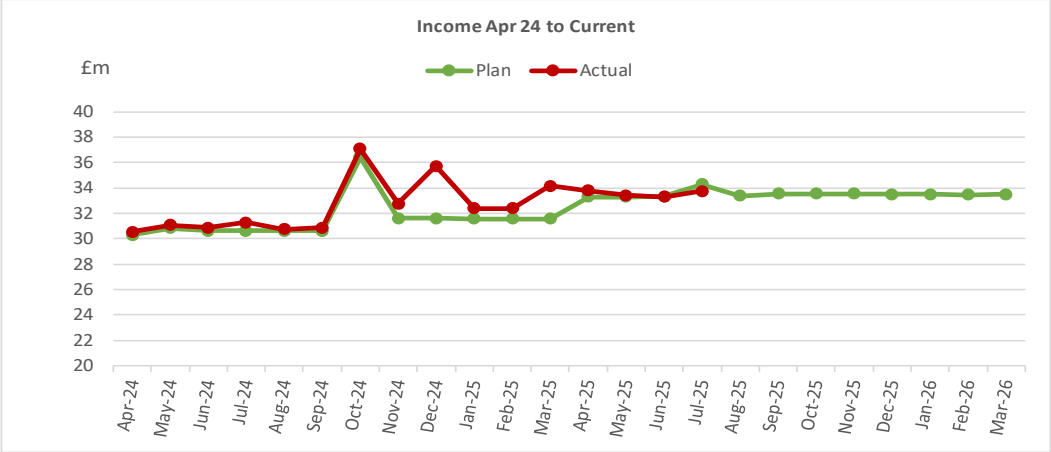
	FTEs	
Prior Mth	CFTE	WFTE
Jul-25	190	215
Jun-25	189	216
	0% ▲	0% ▼
Prior Yr		
Jul-25	190	215
Jul-24	180	205
	5% ▲	5% ▲



	FTEs	
Prior Mth	CFTE	WFTE
Jul-25	1,178	1,203
Jun-25	1,177	1,201
	0% ▲	0% ▲
Prior Yr		
Jul-25	1,178	1,203
Jul-24	1,200	1,237
	-2% ▼	-3% ▼

Worked WTE actuals are much closer to plan since the 2022/23 financial reset. We are still seeing a gap between worked and contracted WTEs for all staff groups which highlights the continued use of agency and bank staff to fill substantive vacancies.

Income



Income	
YTD	**£'k**
2025/26	134.3
2024/25	123.8
▲	**8%**
Prior Yr	**£'m**
Jul-25	33.8
Jul-24	31.3
▲	**8%**

Key Messages

Income (including interest received) is slightly ahead of plan year to date due to some final settlements from 2024/25 and the release of deferred income. This is offset in part by the clawback of £0.3m by BOB ICB related to the MHLDA cost improvement risk share. Interest received is slightly below plan with interest rates being lower than in 2024/25 and receipts from commissioners being below agreed contract levels.

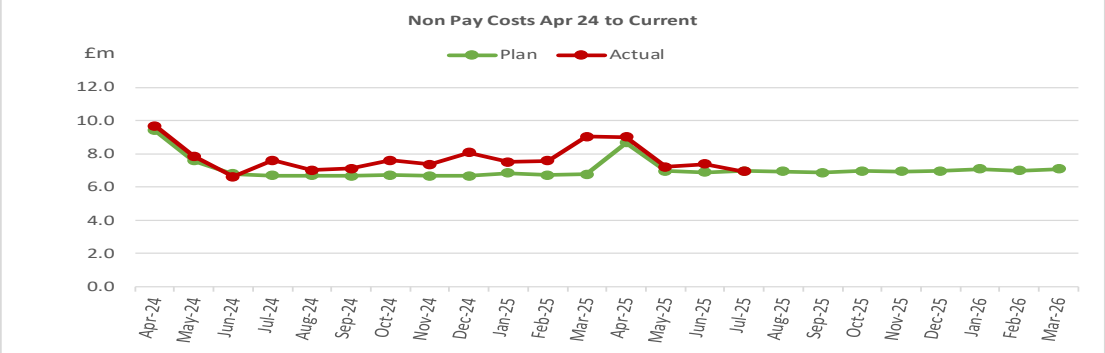
Elective Activity Performance

In 2024/25 the Trust received payment for all elective activity above the 2019/2020 baseline. In 2025/26, the funding available to the ICS to support this activity is curtailed which means that the Trust only has £4.8m of planned income from BOB ICB. We are currently achieving the required level of activity to secure this funding. Negotiations with Frimley ICB on the level of funding for 2025/26 continue although they acknowledge the level of performance we expect from them based on our expected activity and the financial risk it will present.

We have not included a CIP for elective income in the current year.

There will be a "true-up" exercise for 2024/25 later in the year but it is unlikely that the Trust will receive any additional income, rather just confirmation of the income that we have already assumed.

Non Pay & Placement Costs



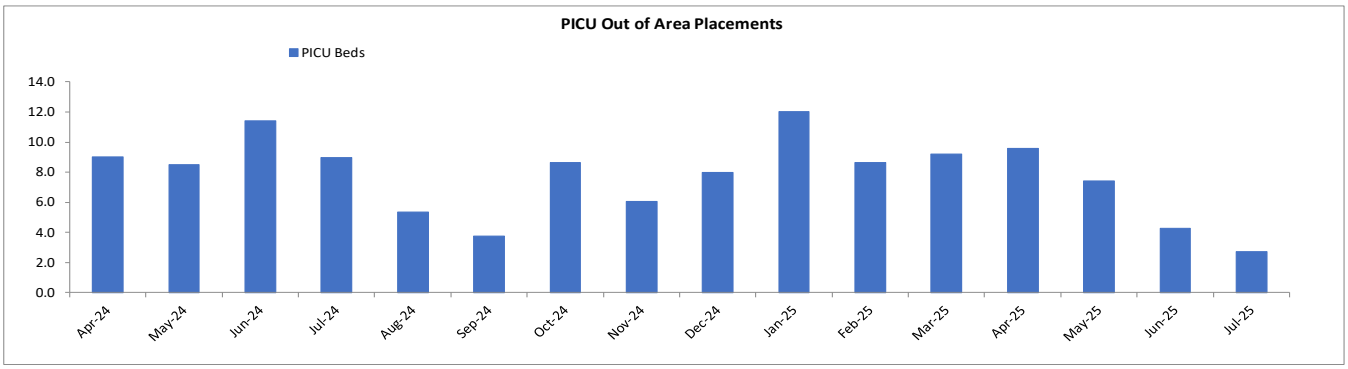
Non Pay Costs

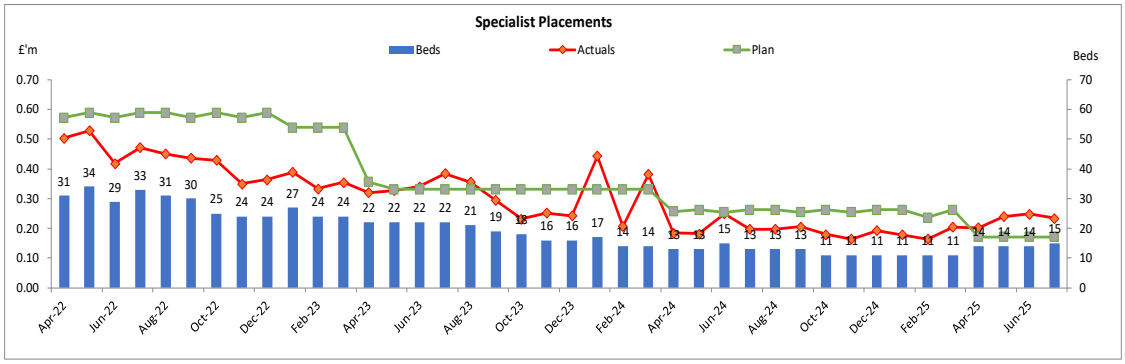
YTD	£'m
2025/26	30.5
2024/25	31.8
▲	-4%

Prior Yr	£'m
Jul-25	6.9
Jul-24	7.6
▲	-9%

Key Messages

As in previous years, the overspend against plan is driven by MH placements although this has improved in the current month.





Specialist Placements

YTD	£'m
2025/26	0.92
2024/25	0.81
▲	*14%*

Prior Yr	£'m
Jul-25	0.23
Jul-24	0.20
▲	*19%*

Key Messages

Out of Area Placements. Following the opening of our outsourced ward, we now have very low numbers of OAPs, which is in line with plan. We currently have 2 OAPs one of which is being recharged to another ICS.

PICU. We have planned for 5 PICU placements in 2025/26. At the start of the year, actuals were higher than plan at April (10) but have reduced over the last three months and there are currently 3.

Specialist Placements. The average number of placements has increased to 15 and this is above the plan of 11. We are looking at options to recharge at least one of these to another NHS organisation, but in the meantime this had created a cost pressure of £0.2m.

Cost Improvement Programme

Description	Description	Risk	Plan	YTD Actual	YTD Plan	Variance
			£k	£k	£k	£K
Divisional CIPS	Recurrent	Low	5,256	1,752	1,752	0
Balance Sheet Review	Non-Recurrent	Low	3,065	2,002	1,022	980
Interest	Recurrent	Low	500	167	167	0
UEC Expenditure	Recurrent	Low	456	152	152	0
Procurement savings	Recurrent	Medium	150	50	50	0
Tax Optimisation	Recurrent	Medium	420	0	140	-140
Contract Contribution	Recurrent	Low	1,850	33	617	-584
Contract Contribution	Non Recurrent		0	584	0	584
Annual leave Accrual	Non-Recurrent	Low	250	0	83	-83
Non - recurrent cover for posts	Non-Recurrent	Low	451	150	150	0
Recharge to income	Recurrent	Low	63	21	21	0
Legal Services review	Recurrent	Medium	150	0	50	-50
Expenses Controls	Recurrent	Low	50	17	17	0
Estates Downsizing	Recurrent	Low	130	43	43	0
Discretionary spend controls	Recurrent	Medium	250	0	83	-83
Temporary staffing reduction stretch	Recurrent	Medium	1,500	121	500	-379
Corporate efficiency stretch	Recurrent	High	1,500	168	500	-332
Further workforce controls	Non-Recurrent	High	1,360	562	453	108
Other	Recurrent	High	62	0	21	-21
Other - Slippage	Non-Recurrent	Low	0	0	0	0
		Total	17,463	5,821	5,821	0

Key Messages

The Trust's initial financial plan includes £17.5m of cost improvement plans.

Schemes are broadly phased in equal 12ths. Some of the schemes should deliver in full later in the year but timing is difficult to predict. Additional balance sheet release while positive from the perspective of CIP performance, is being used to balance off the overall position and it needs to be monitored closely throughout the year and in the context of any emerging risks.

Our balance sheet release is ahead of plan currently, this includes additional balances that we have been able to release to offset in the Q1 claw back of income from BOB ICB as a result of the MHLDA risk share not delivering any savings.

Most of the divisional schemes have been in place from the start of the year. The total includes central services, where there continue to be some gaps in the programme offset by underspending against control totals. This is being addressed alongside the national programme around corporate costs. This will also contribute to the corporate efficiency stretch target once agreed.

There are several other schemes in the pipeline and we continue to look to ICS partners for ideas for collaboration and for opportunities identified through benchmarking.

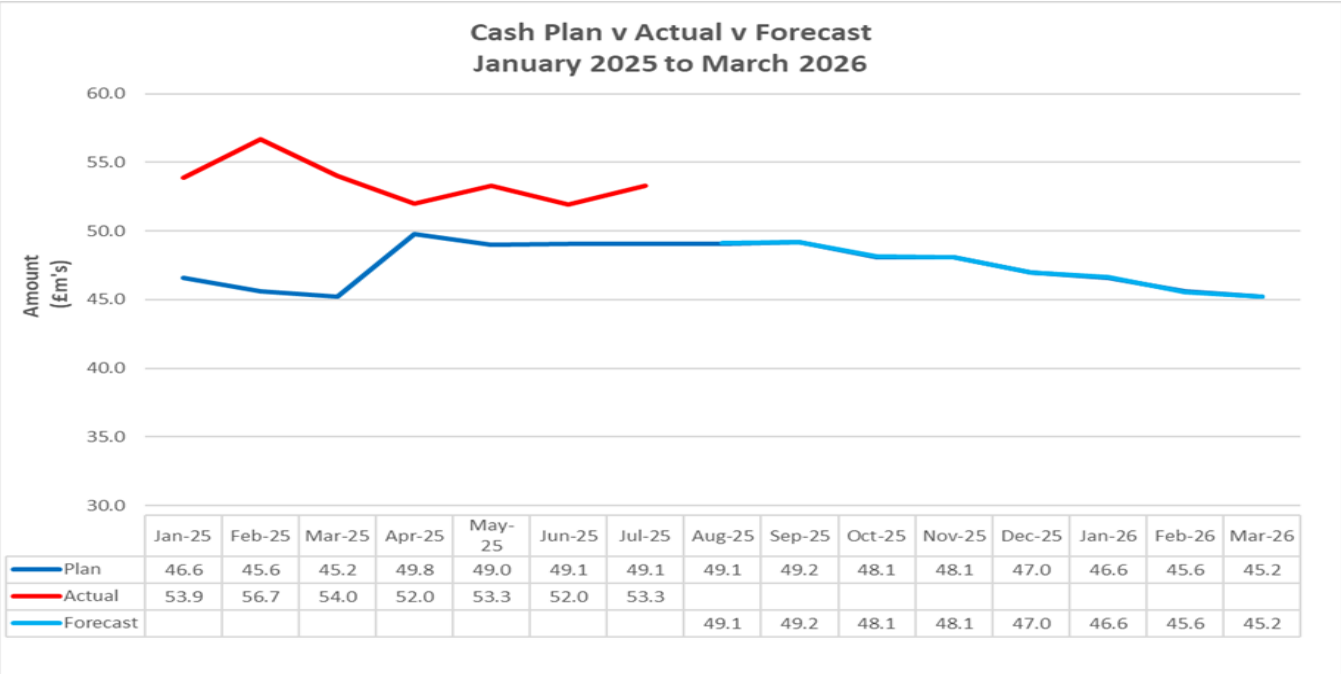
Balance Sheet & Cash

	2024/25 Actual £'m	Current Month Act £'m	Current Month Plan £'m	Current Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m
Intangibles	0.9	1.9	2.1	(0.2)	1.9	2.1	(0.2)
Property, Plant & Equipment (non PFI)	38.2	36.8	35.0	1.8	36.8	35.0	1.8
Property, Plant & Equipment (PFI)	44.5	42.5	48.0	(5.5)	42.5	48.0	(5.5)
Property, Plant & Equipment (RoU Asset)	12.8	12.3	12.0	0.3	12.3	12.0	0.3
Receivables	0.2	0.2	0.2	0.0	0.2	0.2	0.0
Total Non Current Assets	**96.6**	**93.7**	**97.3**	**(3.6)**	**93.7**	**97.3**	**(3.6)**
Trade Receivables & Accruals	14.2	22.4	12.0	10.4	22.4	12.0	10.4
Other Receivables	0.3	0.3	0.3	0.0	0.3	0.3	0.0
Cash	54.0	53.3	49.1	4.2	53.3	49.1	4.2
Trade Payables & Accruals	(40.9)	(44.1)	(35.2)	(8.9)	(44.1)	(35.2)	(8.9)
Borrowings (PFI and RoU Lease Liability)	(4.4)	(2.1)	(6.9)	4.8	(2.1)	(6.9)	4.8
Other Current Payables	(12.0)	(14.4)	(9.7)	(4.7)	(14.4)	(9.7)	(4.7)
Total Net Current Assets / (Liabilities)	**11.2**	**15.4**	**9.6**	**5.8**	**15.4**	**9.6**	**5.8**
Non Current Borrowings (PFI and RoU Lease Liability)	(52.2)	(53.6)	(49.4)	(4.2)	(53.6)	(49.4)	(4.2)
Other Non Current Payables	(1.6)	(2.7)	(2.4)	(0.3)	(2.7)	(2.4)	(0.3)
Total Net Assets	**54.0**	**52.8**	**55.1**	**(2.3)**	**52.8**	**55.1**	**(2.3)**
Income & Expenditure Reserve	10.2	10.3	10.4	(0.1)	10.3	10.4	(0.1)
Public Dividend Capital Reserve	21.8	21.8	22.6	(0.8)	21.8	22.6	(0.8)
Revaluation Reserve	22.0	20.7	22.0	(1.3)	20.7	22.0	(1.3)
Total Taxpayers Equity	**54.0**	**52.8**	**55.1**	**(2.3)**	**52.8**	**55.1**	**(2.3)**

Key Messages

Our cash balance is higher than plan. Cash receipts arising from contract income are below plan, with an increase of £7.7m in accrued income from £3m at year end 2024/25, to £10.7m at month 4 2025/26. The majority of the increase is from NHS organisations, including the ICBs, NHS England and Berkshire Local Authorities.

The reduction in cash receipts is offset by a delay in settling invoices to NHS Property Services for Q1 and Q2 totalling around £6.3m. Invoices are not being paid until arrangements around the move to market rents, and removal of subsidy has been discussed and agreed with the ICBs and the funding required has been transferred to the Trust.



	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Plan	46.6	45.6	45.2	49.8	49.0	49.1	49.1	49.1	49.2	48.1	48.1	47.0	46.6	45.6	45.2
Actual	53.9	56.7	54.0	52.0	53.3	52.0	53.3								
Forecast								49.1	49.2	48.1	48.1	47.0	46.6	45.6	45.2

Capital Expenditure

Capital Programme

Schemes	Current Month			Year to Date			FY	Forecast	FY
	Actual £'000	Plan £'000	Variance £'000	Actual £'000	Plan £'000	Variance £'000	Plan £'000	Outturn £'000	Variance £'000
Estates Maintenance & Replacement Expenditure									
Trust Owned Properties	9	17	(8)	17	17	1	150	112	(38)
Jubilee Ward Relocation to St Marks - CIR Funding	18	216	(198)	37	864	(827)	2,000	2,000	0
Trust Wide Anti-Ligature - CIR Funding	5	0	5	13	0	13	600	600	0
West/Reading Consolidation - Bath Road Phase 1&4	42	83	(42)	307	333	(26)	498	983	485
Charles Ward Decant Works - (Jubilee Ward Enabling Works)	4	17	(12)	12	17	(5)	100	157	57
Leased Non Commercial (NHSPS) Other	21	33	(12)	47	63	(17)	300	149	(151)
Leased Commercial	(0)	0	(0)	12	36	(24)	36	36	0
Environment & Sustainability	1	23	(22)	34	23	11	198	187	(11)
Backlog Maintenance	3	50	(47)	9	100	(91)	500	500	0
Various All Sites	14	95	(81)	104	122	(18)	680	150	(530)
Statutory Compliance	61	18	42	67	28	38	200	388	188
Subtotal Estates Maintenance & Replacement	**177**	**552**	**(375)**	**660**	**1,603**	**(943)**	**5,262**	**5,262**	**0**
IM&T Expenditure									
Business Intelligence and Reporting	0	0	0	49	0	49	110	110	0
Hardware Purchases - Refresh & Replacement	19	0	19	81	0	81	4,136	4,136	0
Teams Rooms Refresh ONLY	0	0	0	0	0	0	50	50	0
Additional Divisional Spend & Teams Room Additions	32	42	(10)	114	168	(54)	504	504	0
Digital Strategy	39	50	(11)	156	200	(44)	600	600	0
Pharmacy System Procurement & Population Health	0	0	0	0	0	0	150	150	0
Subtotal IM&T Expenditure	**90**	**92**	**(2)**	**401**	**368**	**33**	**5,550**	**5,550**	**0**
IFRS16 RoU ASSETS - New Leases Net of Disposals and Remeasurements									
St. Marks Charles Ward Block 23	0	0	0	0	0	0	1,495	1,495	0
Bracknell - Frimley Sublease	0	0	0	0	202	(202)	202	202	0
Chalvey Lease	0	0	0	0	600	(600)	600	600	0
Bath Road	0	0	0	0	0	0	6,654	6,654	0
Bracknell Healthspace	0	0	0	0	0	0	500	500	0
Nicholson House	0	0	0	0	350	(350)	350	350	0
Lease cars	0	0	0	0	0	0	0	0	0
CoIN	0	0	0	0	50	(50)	200	200	0
Sub Total New Leases (IFRS16)	**0**	**0**	**0**	**0**	**1,202**	**(1,202)**	**10,001**	**10,001**	**0**
Subtotal CapEx Within Control Total	**267**	**644**	**(377)**	**1,060**	**3,173**	**(2,113)**	**20,813**	**20,813**	**0**
CapEx Expenditure Outside of Control Total									
Place of Safety	61	0	61	691	600	91	600	804	204
Anti-Ligature Toilet Pans & Basins	1	0	1	25	150	(125)	150	248	98
Trust wide Anti-Ligature (PFI)	0	50	(50)	0	70	(70)	500	391	(109)
Other PFI projects	0	63	(63)	9	103	(94)	730	537	(193)
Subtotal Capex Outside of Control Totals	**61**	**113**	**(52)**	**725**	**923**	**(199)**	**1,980**	**1,980**	**0**
Donated/Grant Funding									
WBCH Low carbon heating system - Salix Funding	103	0	103	150	0	150	0	2,634	2,634
Subtotal Donated/Grant Funding	**103**	**0**	**103**	**150**	**0**	**150**	**0**	**2,634**	**2,634**
Total Capital Expenditure - all funding sources	**432**	**758**	**(326)**	**1,935**	**4,096**	**(2,161)**	**22,793**	**25,427**	**2,634**

Key Messages

At M04, CDEL schemes were underspent by £2.1m against the plan. For 2025/26 RoU assets have been included in the CDEL calculation and we also have 2 schemes funded from the Estates Safety Fund which score against CDEL.

Estates is underspent year to date due to the phasing of expenditure on the Jubilee Ward relocation offset in part by expenditure on the Nicholson House alterations project.

Non-CDEL spend for PFI sites was underspent by £0.2m YTD, mainly due to the anti-ligature toilets and basins project, where spend is expected later this year.

There is an underspend on IFRS16 Right of Use Assets of £1.2m for the year to date. This is due to the ongoing delay in lease commencement for Chalvey, which was expected to commence early in 2024/2025 and has continued to slip, but which is now estimated to commence in Q2/Q3 2025. Nicholson House and Bracknell projects have also slipped.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper Meeting Paper

Board Meeting Date	9th September 2025
Title	**True North Performance Scorecard Month 4 (July 2025) 2025/26**
	The Board is asked to note the True North Scorecard.
Reason for the Report going to the Trust Board	To provide the Board with the True North Performance Scorecard, aligning divisional driver metric focus to corporate level (Executive and Board) improvement accountability against our True North ambitions, and Quality Improvement (QI) break through objectives for 2025/26.
Business Area	Trust-wide Performance
Author	Chief Operating Officer
Relevant Strategic Objectives	The True North Performance scorecard consolidates metrics across all domains. To provide safe, clinically effective services that meet the assessed needs of patients, improve their experience and outcome of care, and consistently meet or exceed the standards of Care Quality Commission (CQC) and other stakeholders. **Patient safety** **Ambition:** We will reduce waiting times and harm risk for our patients **Patient experience and voice** **Ambition:** We will leverage our patient experience and voice to inform improvement **Health inequalities**

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

True North Performance Scorecard Highlight Report – July 2025

The True North Performance Scorecard for Month 4 2025/26 (July 2025) is included. Performance business rule exceptions, red rated with the True North domain in brackets.

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

Breakthrough and Driver Metrics

- Restrictive Interventions – Rapid Tranquilisation (Intra-muscular) **(Harm Free Care)** – 32 against a target to be confirmed.
    - The number of patients requiring rapid tranquilisation has had a positive trend in the last 3 months. Seventy percent of the instances this month relate to one patient on Rose ward, the remainder of incidents spread across the remaining wards. A total of 10 patients have contributed to this month's total with the top contributing location as Rose ward. The teams are reviewing countermeasures and a target.
- Mental Health: Adult Average Length of Stay (bed days) **(Patient Experience)** – 48.85 days against a target of 42 days.
    - Highest contributing wards, Snowdrop, Rose and Sorrel. Bluebell ward has completed its fishbone analysis and has had the lowest Length of Stay for 4 months and is sharing its learning. Top contributors to length of stay are medications review and finding suitable placements. Countermeasures include working with Local Authority partners and reviewing flow throughout the pathway.
- Mental Health: Older Adult Average Length of Stay (bed days) **(Patient Experience)** – 81.86 days against a target of 80 days.
    - Similar issues to adult mental health wards. There are some patients with long stays and barriers to discharge that are being reviewed. Wards are not at full capacity and challenges in obtaining suitable placements.
- Physical Health: Community Inpatient Average Length of Stay (bed days) **(Patient Experience)** – 22.35 days against a target of 21 days.
    - Continuing the reduction for 3 months. 55% of discharges were 21 days or less, 17% were between 22-28 days. Top contributing factors to length of stay were Local Authority placements and out of area packages of care. The teams are reviewing the standard work for escalation which is complex.
- Physical Assaults on Staff **(Supporting our Staff)** – 70 against a target of 36.
    - There are 26 patients that contributed to the total this month. Top contributor was Snowdrop ward. There is an increasing trend over the last 2 years. The team are reviewing how risk of harm to others is identified for a patient to inform areas of focus. There is a review of patients who carried out assaults over the last 3 months and what risk and safety plan details were documented. Planning for a rapid improvement event in September.

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

- None noted.

Driver Metrics

The following metrics are Red and not performing to plan.

- I Want Great Care Positive Patient Experience Score **(Patient Experience)** – at 94.65% against a 95% target. Reports being updated by supplier and will be reported one month in arrears to allow for manual records to be uploaded. When available figures will be updated.
- I Want Great Care Patient Experience Compliance Rate **(Patient Experience)** – at 6.70% against a 10% target. Reports being updated by supplier and will be reported one month in arrears to allow for manual records to be uploaded. When available figures will be updated.

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

- Staff turnover (excluding fixed-term posts) **(Supporting our Staff)** –at 10.02% against a stretch target of 10%.
- Year to Date Variance from Control Total (£'k) **(Efficient Use of Resources)** – at £0k against a target of 0. This is an NHS Oversight Framework scoring metric.
- Inappropriate Out of Area Placements (OAPs) at the end of the month (Mental Health) – **(Patient Experience)** – at 0 against a quarter 2 target of 3 patients.

Tracker Metrics

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

- Sickness rate **(Supporting Our Staff)** – red at 4.4% against a stretch target of 3.5%. This is an NHS Oversight Framework scoring metric, but to date no national target available.
- Bed days occupied by patients who are discharge ready (Community) **(Patient Experience)** – 773 bed days against a target of 695.
- Clinically Ready for discharge by wards in mental health (Including OAPs) **(Patient Experience) –** 415 against a 250-bed day target.
- Health Visiting: New Birth Visits Within 14 days **(Patient Experience)** – 87.3% against a target of 90% per month. A review of the booking process has highlighted some opportunities for improvement which should improve the compliance rate.
- Talking Therapies Reliable Improvement for those Completing a Course of Treatment (Frimley) **(Patient Experience)** – at 66% against a target of 67% by September 2025.
- Talking Therapies Reliable Improvement for those Completing a Course of Treatment (BOB) **(Patient Experience)** - at 66% against a target of 67% by September 2025.
- Talking Therapies Reliable Recovery for those Completing a Course of Treatment (Frimley) **(Patient Experience)** – (NHS Oversight Framework Non-scoring metric) - at 46% against a target of 49% by September 2025.

- Talking Therapies Reliable Recovery for those Completing a Course of Treatment (BOB) **(Patient Experience)** - (NHS Oversight Framework Non-scoring metric) - at 47% against a target of 49% by September 2025.
- Access to Perinatal Services – Assessments (BOB) **(Patient Experience)** – 595 against a target of 611 per month.
- Mental Health Acute Occupancy rate (excluding home leave) **(Efficient Use of Resources)** – at 98.2% against an 85% target.
- Mental Health: Non-Acute Occupancy Rate (excluding home leave) **(Efficient Use of Resources)** – at 87.92% days against a target 80%.
- Self-harm Incidents on Mental Health Inpatient Wards (excluding Learning Disability) **(Harm Free Care)** – at 108 against a target of 61 incidents. Target under review.

True North Performance Scorecard – Business Rules & Definitions

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

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

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

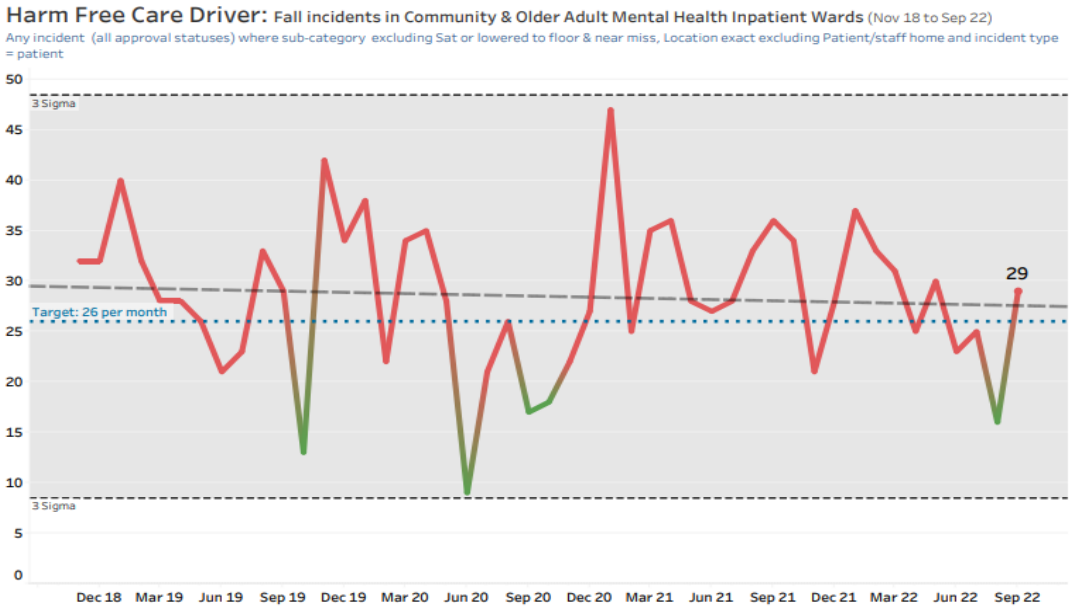
Business Rules for Statistical Process Control (SPC) Charts

Why Use SPC Charts

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

Components of an SPC Chart

The charts have the following components with an example below:



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

Variation

There are 2 types of variation:

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

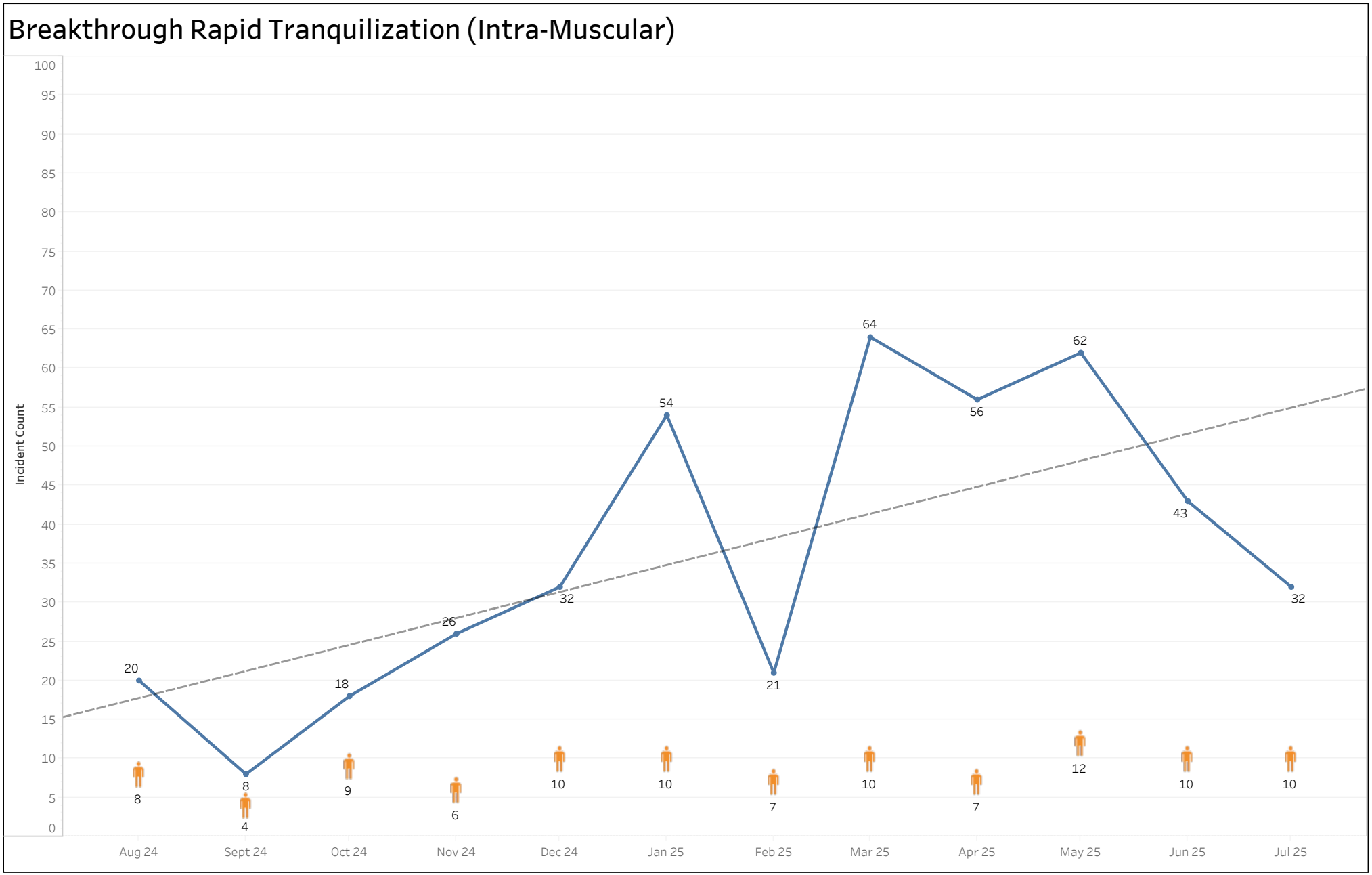
Rules

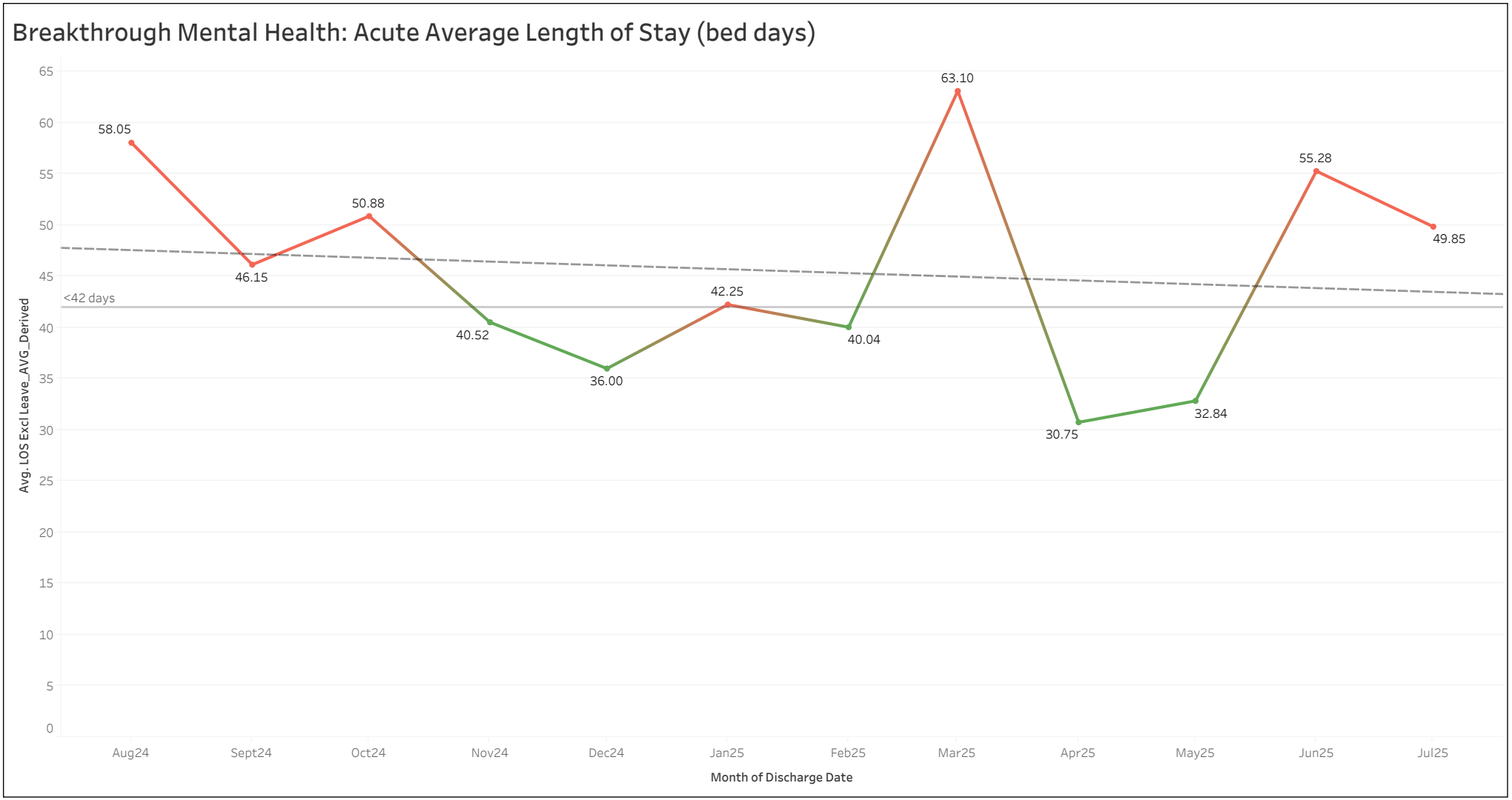
- A series of 6 or more data points above or below the target is statistically relevant. It indicates that something in process has changed.
- A trend: either rising or falling of more than 6 data points – we should investigate what has happened.
    - We should reset baseline following a run of 6 data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

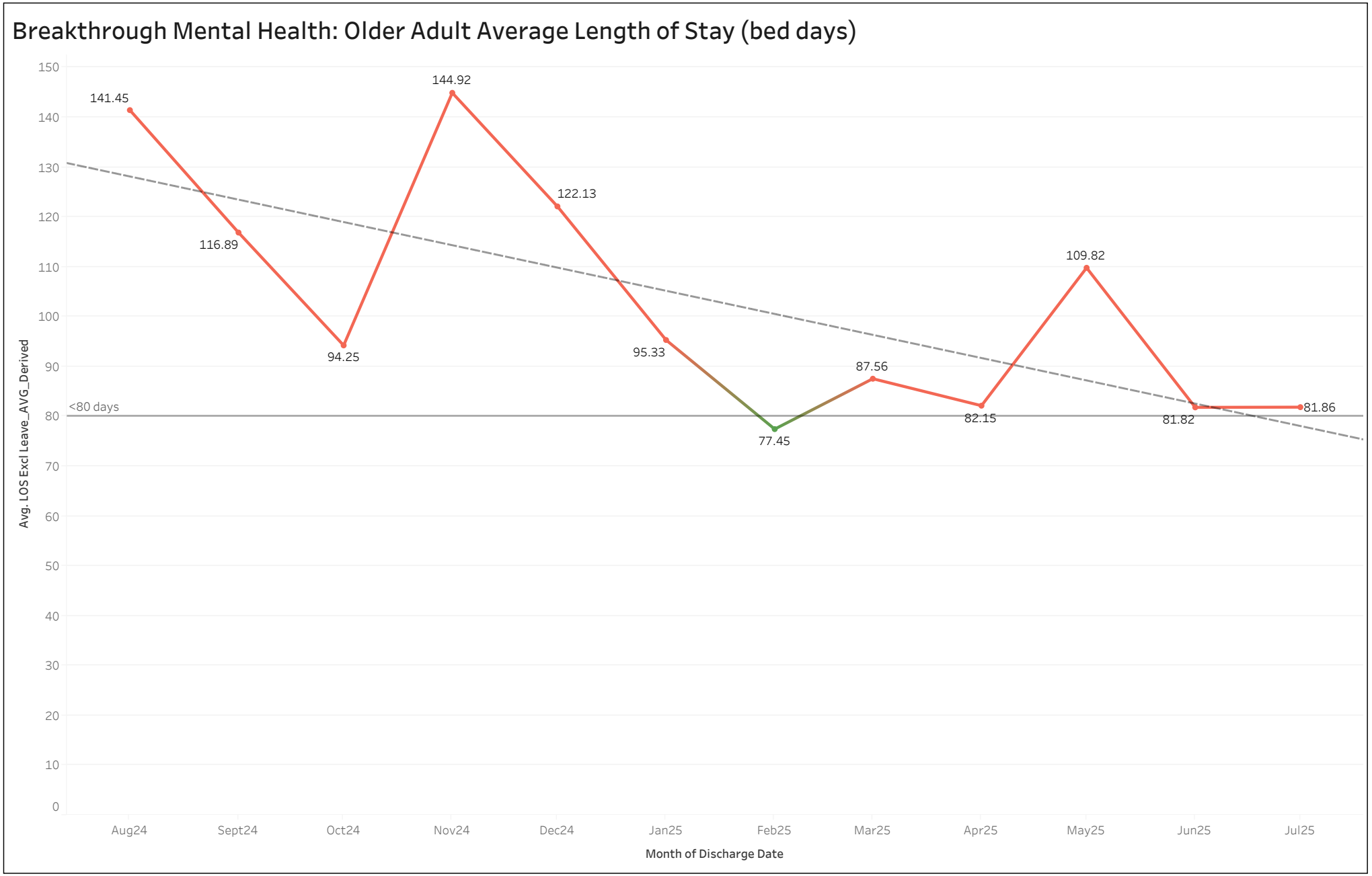
Performance Scorecard - True North Drivers

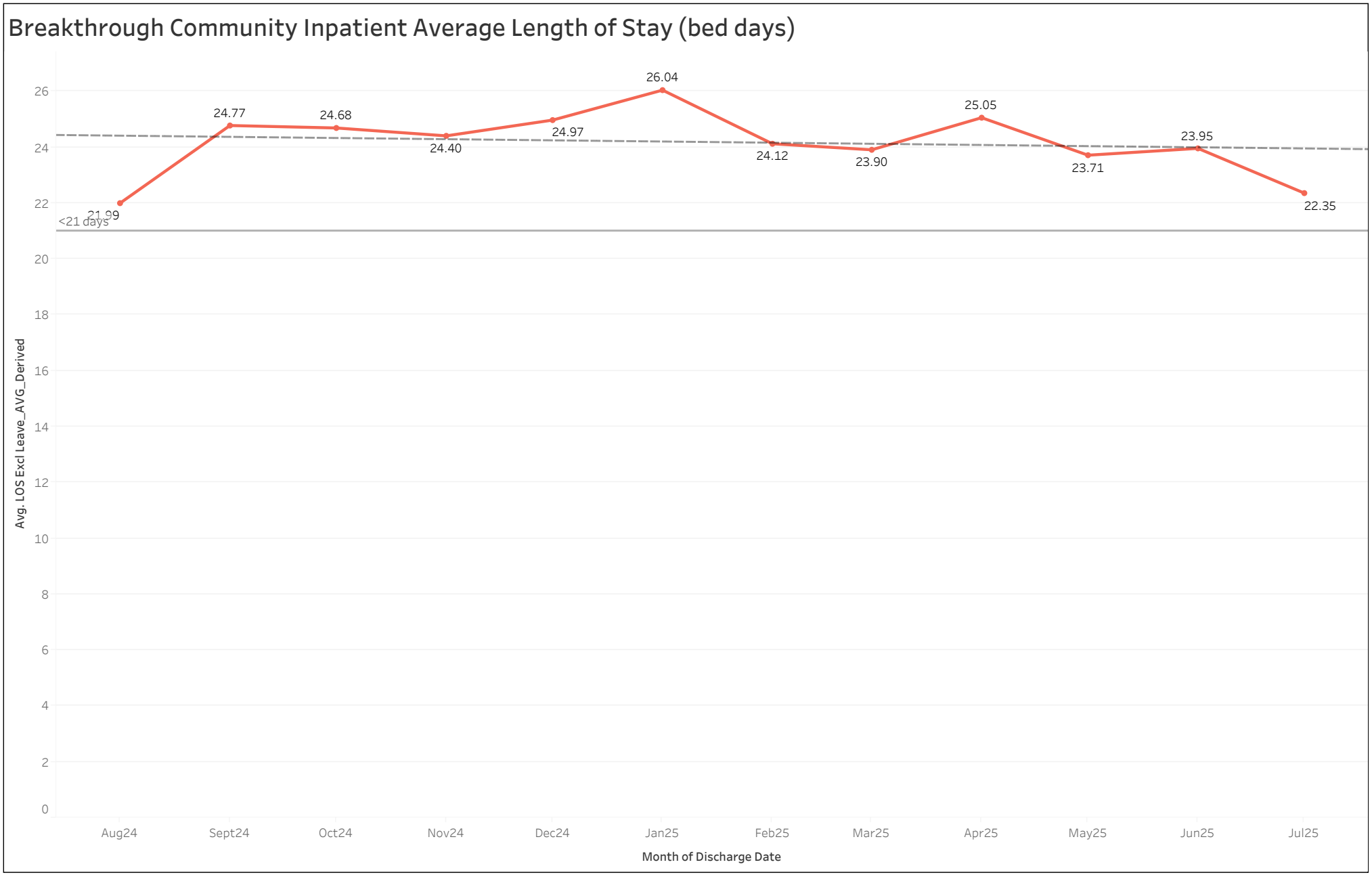
			Aug-24	Sept-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Breakthrough Rapid Tranquilization (Intra-Muscular)	TBC	Internal	20	8	18	26	32	54	21	64	56	62	43	32
			Patient Experience											
Positive Patient Experience Score %	95% compliance	External	94.19%	95.09%	94.19%	95.09%	94.71%	95.19%	95.89%	95.39%	94.52%	94.71%	94.65%	
Patient Experience Compliance Rate %	10% compliance	External	6.20%	4.39%	4.29%	4.10%	5.24%	5.89%	7.29%	7.79%	8.5%	7.39%	6.70%	
			Aug24	Sept24	Oct24	Nov24	Dec24	Jan25	Feb25	Mar25	Apr25	May25	Jun25	Jul25
Breakthrough Mental Health: Acute Average Length of Stay (bed days)	<42	External	58.05	46.15	50.88	40.52	36.00	42.25	40.04	63.10	30.75	32.84	55.28	49.85
			Aug24	Sept24	Oct24	Nov24	Dec24	Jan25	Feb25	Mar25	Apr25	May25	Jun25	Jul25
Breakthrough Mental Health: Older Adult Average Length of Stay (bed days)	<80	External	141.45	116.89	94.25	144.92	122.13	95.33	77.45	87.56	82.15	109.82	81.82	81.86
			Aug24	Sept24	Oct24	Nov24	Dec24	Jan25	Feb25	Mar25	Apr25	May25	Jun25	Jul25
Breakthrough Community Inpatient Average Length of Stay (bed days)	<21	External	21.99	24.77	24.68	24.40	24.97	26.04	24.12	23.90	25.05	23.71	23.95	22.35

Breakthrough Rapid Tranquilization (Intra-Muscular)




Breakthrough Mental Health: Acute Average Length of Stay (bed days)
Avg. LOS Excl Leave_AVG_Derived
65
60
55
50
45
40
35
30
25
20
15
10
5
0
<42 days
58.05
46.15
50.88
40.52
36.00
42.25
40.04
63.10
30.75
32.84
55.28
49.85
Aug24
Sept24
Oct24
Nov24
Dec24
Jan25
Feb25
Mar25
Apr25
May25
Jun25
Jul25
Month of Discharge Date


Breakthrough Mental Health: Older Adult Average Length of Stay (bed days)
Avg. LOS Excl Leave_AVG_Derived
150
140
130
120
110
100
90
80
70
60
50
40
30
20
10
0
141.45
116.89
94.25
144.92
122.13
95.33
77.45
87.56
82.15
109.82
81.82
81.86
<80 days
Aug24
Sept24
Oct24
Nov24
Dec24
Jan25
Feb25
Mar25
Apr25
May25
Jun25
Jul25
Month of Discharge Date


Breakthrough Community Inpatient Average Length of Stay (bed days)
Avg. LOS Excl Leave_AVG_Derived
Month of Discharge Date
<21 days
21.99
24.77
24.68
24.40
24.97
26.04
24.12
23.90
25.05
23.71
23.95
22.35
Aug24
Sept24
Oct24
Nov24
Dec24
Jan25
Feb25
Mar25
Apr25
May25
Jun25
Jul25

Performance Scorecard - True North Drivers

Supporting our Staff

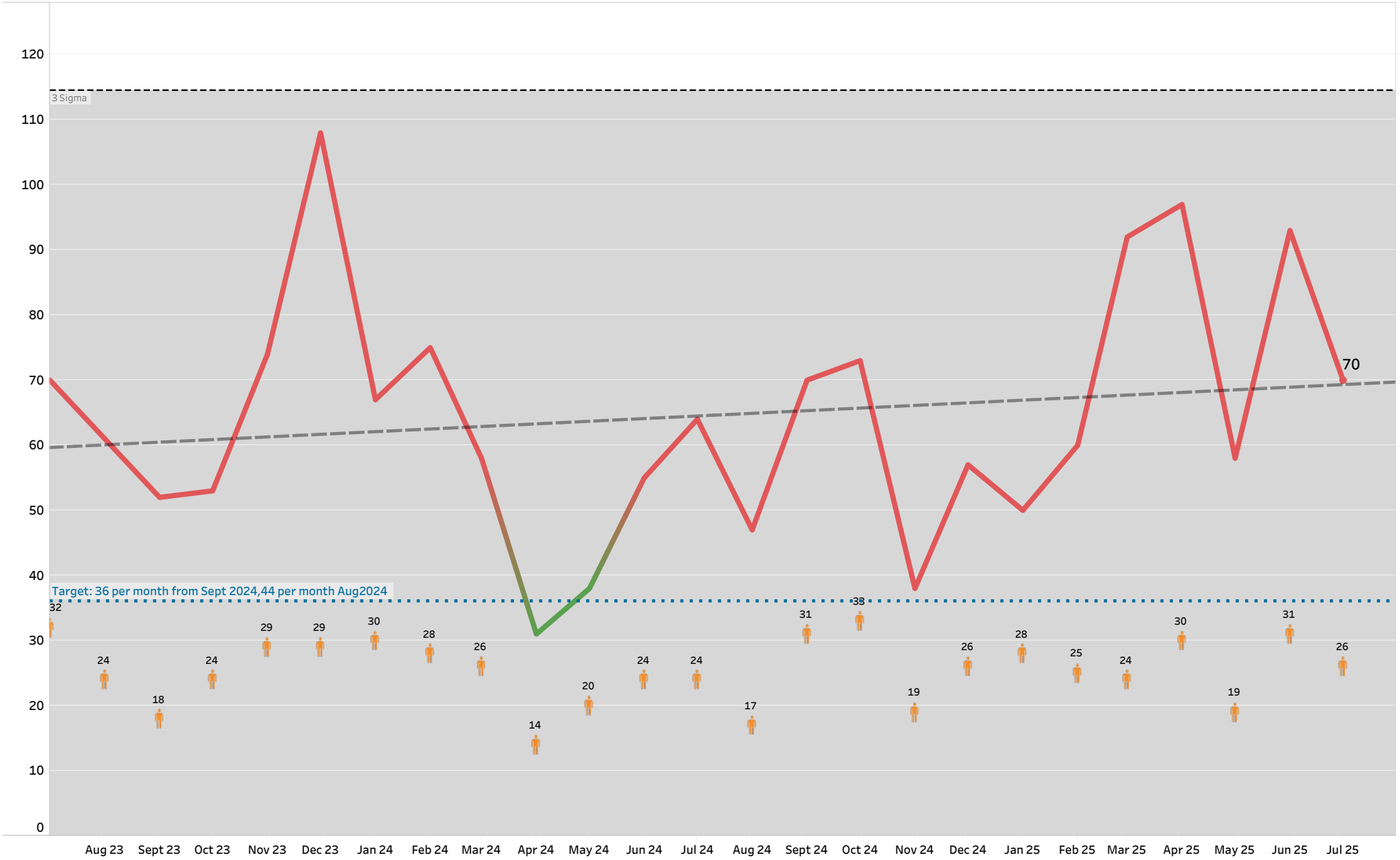
Metric	Threshold / Target	External/Internal	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25
Breakthrough Physical Assaults on Staff	36 per month	Internal	47	70	73	38	57	50	60	92	97	58	93	70
Staff turnover (excluding fixed term posts)	10%	External	12.32%	12.07%	11.54%	11.57%	11.51%	11.57%	11.16%	11.09%	10.59%	10.44%	10.07%	10.02%

Efficient Use of Resources

			Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25
YTD variance from control total (£'k) (NOF Scoring)	0	External	-9	-16	-17	-2	-1	-3000	-3000	-3000	0	0	0	0
Active Inappropriate OAPS at end of month (NOF Non Scoring)	New target (25/26) : Q1 - 3, Q2 - 3, Q3- 3, Q4 - 3 - 1 per month	External	4	7	4	0	1	1	1	0	0	0	0	0

Supporting Our Staff - Breakthrough Objective :Physical Assaults on Staff (Jul 23 to Jul 25)

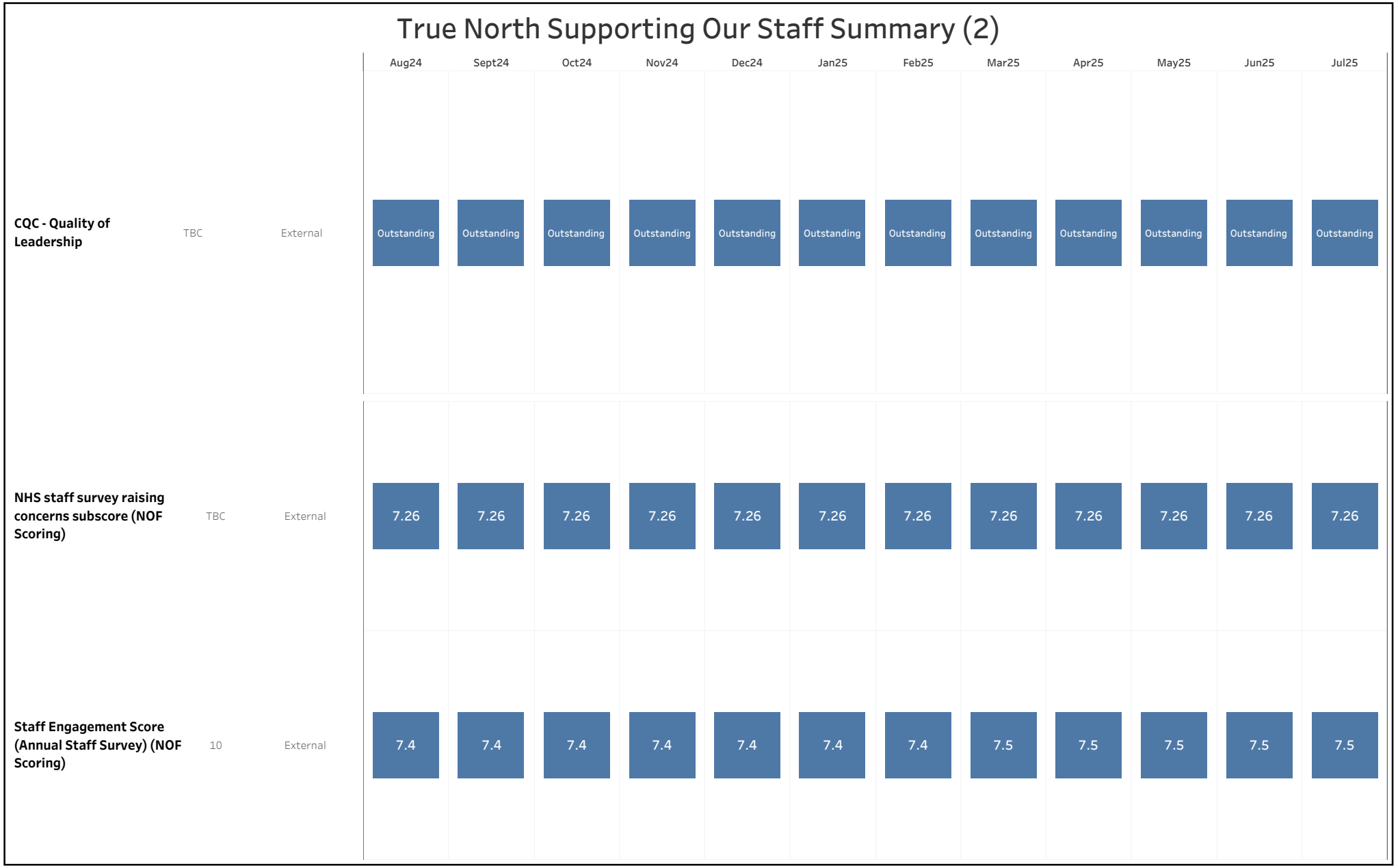
Any incident where sub-category = assault by patient and incident type = staff



True North Supporting Our Staff Summary

Metric	Threshold / Target	External/Internal	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25
Statutory Training: Fire: %	90% compliance	Internal	95.5%	95.9%	96.0%	96.1%	96.2%	94.2%	94.8%	94.2%	94.1%	94.8%	94.6%	93.4%
Statutory Training: Health & Safety: %	90% compliance	Internal	97.6%	97.6%	97.6%	97.8%	98%	98.0%	98.2%	98.1%	98.4%	98.5%	98.3%	98.3%
Statutory Training: Manual Handling: %	90% compliance	Internal	94.9%	94.2%	94.5%	93.7%	94.9%	94.6%	94.1%	94.4%	94.1%	94.6%	94.6%	94.5%
Mandatory Training: Information Governance: %	95% compliance	Internal	97.8%	98.0%	97.5%	97.7%	97.2%	97.0%	97.1%	96.8%	97.2%	97.7%	97.9%	98.0%
Sickness Rate: % (NOF Scoring)	<3.5%	External	4.1%	4.5%	4.7%	4.8%	4.8%	4.8%	4.3%	3.8%	3.7%	4.1%	4.4%	
PDP (% of staff compliant) Appraisal: %	Target: 95% by end of May 2025	Internal										92.1%	94.5%	95.0%

True North Supporting Our Staff Summary (2)



True North Patient Experience

			Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25
A&E: Maximum wait of four hours from arrival to admission/transfer /discharge: % (NOF Non Scoring)	95%	External	99.31	99.17	99.05	99.31	99.03	98.72	99.22	96.40	99.39	99.57	98.89	99.20
Community Health Services: 2 Hour Urgent Community Response % (NOF Scoring)	80%+	External	91.4%	89.2%	91.4%	90.9%	91.9%	91%	91.1%	92.2%	93.4%	94.4%	94.7%	92.2%
Number of Patients not seen on RTT waiting over 52 weeks	0	External	0	0	0	0	0	0	0	0	0	0	0	0
Number of Adults on community waiting lists over 52 weeks (NOF Scoring)	TBC	External	21	27	21	21	92	29	32	29	28	32	32	31
Number of Children on community waiting lists over 52 weeks (NOF Scoring)	TBC	External									55	59	94	123
Attended Community Care Contacts	TBC	External	49,825	51,827	57,889	54,278	51,266	57,784	51,590	55,720	54,324	51,997	46,642	56,527
			Aug-24	Sept-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Bed days occupied by patients who are discharge ready Community	695 bed days	External	830	886	876	849	977	889	624	589	636	702	825	773
			Aug-24	**Sept-24**	**Oct-24**	**Nov-24**	**Dec-24**	**Jan-25**	**Feb-25**	**Mar-25**	**Apr-25**	**May-25**	**Jun-25**	**Jul-25**
Clinically Ready for Discharge by Wards MH (including OAPS)	250 bed days	External	248	291	147	186	224	230	301	360	355	431	316	415
Community Dentistry Activity (ytd)	Total Trust UDA per Annum 9037 CDS & 2000 DAC. 919 per month	External	4560	4723	5576	6383	7167	8248	8910	9671	762	1569	2371	3380

True North Patient Experience

			Aug24	Sept24	Oct24	Nov24	Dec24	Jan25	Feb25	Mar25	Apr25	May25	Jun25	Jul25
Time to first appointment Diabetes	<18 weeks	External	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Time to first appointment Children's Community Paediatrics	<18 weeks	External	100%	100%	100%	100%	100%	100%	99%	100%	98.8%	100%	100%	100%

			Aug24	Sept24	Oct24	Nov24	Dec24	Jan25	Feb25	Mar25	Apr25	May25	Jun25	Jul25
CPP - RTT (Referral to treatment) waiting times - Community: incomplete pathways (how many within 18 weeks): Number	TBC	External	159	156	146	132	110	83	102	98	83	80	90	82
Diabetes - RTT (Referral to treatment) waiting times - Community incomplete pathways (how many within 18 weeks): Number	TBC	External	86	77	61	63	69	67	72	84	66	59	49	65
New RTT pathways (clock starts) Children's Community Response	TBC	External	44	72	56	28	36	23	31	35	16	46	48	36
New RTT pathways (clock starts) Diabetes	TBC	External	61	71	63	57	53	64	53	65	53	53	55	41
RTT waiting list, of which children aged 18 years and under (WLMDS)	TBC	External	158	155	145	131	110	83	101	98	83	80	90	82
Number of 52+ week RTT waits, of which children aged 18 years and under (Waiting List MDS)	TBC	External	0	0	0	0	0	0	0	0	0	0	0	0

True North Patient Experience

			Aug24	Sept24	Oct24	Nov24	Dec24	Jan25	Feb25	Mar25	Apr25	May25	Jun25	Jul25
Percentage of patients admitted as an emergency within 30 days of discharge (Community Readmission) (NOF Non Scoring)	TBC	External	0%	0.42%	0.41%	0%	0%	0%	0%	0%	0.64%	0%	0%	0%
Percentage of Inpatients referred to stop smoking services (NOF Non Scoring)	TBC	External	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
Proportion of patients referred for diagnostic tests who have been waiting for less than 6 weeks (DM01 - Audiology): %	95% seen	External	96.39	98.40	98.62	98.48	96.32	96.81	100	99.14	99.78	99.23	99.05	99.48
Falls incidents in Community & Older Adult Mental Health Inpatient Wards	26 per month	Internal	28	37	10	18	22	17	27	24	25	25	23	24
Health Visiting: New Birth Visits Within 14 days: %	90% compliance	Internal	94.6%	90.2%	84.3%	89.1%	90.1%	83.1%	90.6%	91.1%	89.5%	82.2%	87%	87.3%
Access to Children and Young People's Mental Health Service 0-17 1+ Contact Frimley (NOF Scoring)	9180 ICB level	External	6221	6370	6538	6719	6857	7002	7161	7328	4016	2896	4176	3629
Access to Children and Young People's Mental Health Service 0-17 1+ Contacts BOB (NOF Scoring)	26531 ICB level	External	8638	8821	9054	9275	9466	9677	9852	10076	5020	5047	5151	4547
Access to Children and Young People's Mental Health Service Aged 18-24 1+ Contacts measured from Dat..	26531 ICB level.	External	3339	3430	3546	3653	3716	3824	3925	4012	1604	1681	1663	1688
Access to Children and Young People's Mental Health Service 18-24 1+ Contact Frimley	9180 ICB level.	External	2327	2385	2446	2511	2569	2632	2700	2758	1169	1248	1213	1217
Percentage of people with suspected autism awaiting contact for over 13 weeks (NOF Non Scoring)	TBC	External	88.97%	90.36%	90.88%	91.49%	92.89%	95.93%	95.19%	95.08%	94.87%	94.66%	93.58%	91.60%

True North Patient Experience

			Aug-24	Sept-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Talking Therapies Reliable Improvement for those completing a course of treatment Frimley	67% to Sep 2025 68% from Oct 2025	External	65.40%	69%	68%	66%	67.60%	67%	62.5%	70.09%	70.29%	69.59%	67.5%	66%
Talking Therapies Reliable Improvement for those completing a course of treatment BOB	67% to Sep 2025 68% from Oct 2025	External	64.5%	69%	69%	71%	64.60%	65%	71.09%	68.10%	70.5%	72.39%	70.79%	66%
Talking Therapies Reliable Recovery for those completing a course of treatment Frimley (NOF Non Scoring)	48%, 49% to Sep25 50% Oct 2025 to April 2026 (BOB & Frimley)	External	51.39%	52%	50%	51%	50.20%	49%	43.20%	51.5%	49.39%	50.20%	50.70%	46%
Talking Therapies Reliable Recovery for those completing a course of treatment BOB (NOF Non Scoring)	48%, 49% to Sep25 50% Oct 2025 to April 2026 (BOB & Frimley)	External	48.19%	48%	50%	51%	45.70%	50%	51%	51.10%	50.60%	53.70%	50.10%	47%

True North Patient Experience

			Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25
Access to Perinal services BOB	611	External	580	588	587	575	579	573	586	584	588	597	604	595
Access to Perinatal Services Frimley	479	External	439	458	467	464	464	458	449	452	449	470	482	488
Number of People accessing Individual Placement Services -Frimley	280 Frimley by March 26	External									336	344	354	355
Number of People accessing Individual Placement Services -BOB	280 BOB by March 26	External	-	-	-	-	-	-	-	-	366	368	384	387
Percentage of patients referred to crisis care teams to receive face to face contact within 24 hours (NOF Scoring)	TBC	External	70%	55.0%	64%	61%	68%	56.0%	66%	49%	65%	57.9%		
Physical Health Checks 7 Parameters for people with severe mental illness (SMI)	90%	Internal	94%	90%	91%	93%	94%	91%	92%	93%	92%	90%	91%	92%
Mental Health: Prone (Face Down) Restraint	4 per month	Internal	0	0	1	1	2	3	1	1	0	0	1	1
Patient on Patient Assaults (MH Inpatients)	25 per month	Internal	5	8	7	9	14	10	10	13	16	14	24	32
Mental Health: Uses of Seclusion	13 in month	Internal	7	8	2	8	9	6	7	12	9	9	10	4
Rate of Restrictive Intervention Types per 1000 bed days (NOF Scoring)	Null	External	93.96	69.66	74.4	91.87	98.78	110.53	96.95	142.89	124.33	157.76	155.19	120.24

Efficient Use of Resources

Metric	Threshold / Target	External/Internal	Aug-24	Sept-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
Community Inpatient Occupancy	85%	Internal	86.9%	92.4%	91.7%	91.3%	91.8%	93.9%	86.2%	84.6%	89.3%	87.3%	86.9%	84.8%
CHS Average delay(Exclude Zero delays)	TBC	External	6.2	6.7	6.7	6.0	6.9	6.4	6.0	5.0	5.7	5.4	6.2	5.8
CHS Percentage of patients discharged on discharge ready date	TBC	External	39.8%	38.8%	39.8%	33.7%	33.9%	35.0%	46.7%	39.3%	39.0%	37.7%	38.9%	37.7%
Mental Health: Adult Acute LOS over 60 days % of total discharges (NOF Scoring)	TBC	External	35.1%	24.3%	29.3%	24%	16.9%	26.4%	24%	27.0%	14.0%	14.0%	19.3%	20%
Mental Health: Older Adult Acute LOS over 90 days % of total discharges (NOF Non Scoring)	TBC	External	41.6%	55.5%	50%	61.5%	60%	50%	45.4%	56.2%	57.0%	63.6%	45.4%	50%
DNA Rate: %	5% DNAs	Internal	4.97%	4.96%	4.91%	4.87%	4.47%	4.66%	4.5%	4.42%	4.75%	4.91%	5.16%	5.46%
Mental Health: Acute Occupancy rate (excluding Home Leave):%	85% Occupancy	Internal	99.2%	96.8%	97.4%	97.6%	98.4%	98.2%	99.0%	89.6%	94.8%	96%	96.6%	98.2%
Mental Health: Non-Acute Occupancy rate (excluding Home Leave): %	80% Occupancy	Internal	88.40%	90.10%	80.82%	86.14%	87.79%	89.75%	92.56%	89.05%	83.78%	83.78%	80.93%	87.92%
Community Virtual Ward Occupancy Frimley	80%	External	51.30%	61.29%	77.29%	84%	73.5%	79.80%	80.5%	69%	83%	80%	75%	94%
Community Virtual Ward Occupancy BOB	80%	External	87.90%	79.40%	76.90%	79.60%	91.29%	100.2%	76.59%	85%	85%	72%	82%	91%
Agency Spend within Ceiling	3.2%	External	3.20%	2.90%	2.90%	3%	2.39%	2.70%	1.89%	2%	2.19%	1.79%	1.5%	1.89%
Year to Date Corporate Cost Reduction	TBC	External	0	0	0	0	0	0	0	0	0	0	0	0

True North Harm Free Care Summary

Metric	Threshold / Target	External/Internal	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25
Mental Health: AWOLs on MHA Section	10 per month	Internal	7	9	5	3	11	7	4	4	3	3	6	6
Mental Health: Absconsions on MHA section (Excl: Failure to return)	8 per month	Internal	1	1	1	1	1	2	0	0	2	3	2	0
Mental Health: Readmission Rate within 28 days: %	<8% per month	Internal	5.25	3.83	0	1.53	1.47	1.62	1.5	0	5.54	2.62	5.87	4.54
Mental Health 72 Hour Follow Up after Inpatient discharge	80%+	External	91.4%	100%	91.0%	88.3%	93.4%	89.4%	91.6%	96.6%	96.9%	97.3%	94.1%	96.7%
Self-Harm Incidents on Mental Health Inpatient Wards (ex LD)	61 per month	Internal	46	72	68	101	55	94	61	69	84	83	92	108
Patient on Patient Assaults (LD)	4 per month	Null	0	0	0	2	0	3	2	8	1	1	0	1
Self-Harm Incidents within the Community	31 per month	Internal	7	17	15	25	23	30	21	15	21	16	25	24

Berkshire Healthcare
NHS Foundation Trust

WRES 2024/2025:

Condensed Board Report

Please help shape future papers by completing this feedback survey to share your insights.

Board Meeting Date	September 2025
Title	**Workforce Race Equality Standard (WRES) 2024/2025**
Board required action	Item for Noting Item for Discussion
Reason for the Report going to the Trust Board	This report sets out our 2024 data and approach to action against the Workforce Race Equality Standard (WRES) metrics that are part of the NHS Standard contract. **Full detailed reports are available to the Board.**
Business Area	People Directorate, Organisational Experience and Development.
Author	**Stephen Strang**, Workforce Planning and Insights Manager (Author) **Ash Ellis**, Deputy Director for Leadership, Inclusion, Organisational Exp (Editor) **Alex Gild**, Deputy Chief Executive (Exec Sponsor)
Relevant Strategic Objectives	Make Berkshire Healthcare a great place to work for our people. Anti-racism commitment in addressing staff experience differential.
Summary	This report provides a comprehensive analysis of workforce race equality at Berkshire Healthcare NHS Foundation Trust (BHFT) for 2024/25. It examines key Workforce Race Equality Standard (WRES) indicators, workforce demographics, recruitment patterns, disciplinary actions, training access, and staff experiences related to discrimination, harassment, and promotion. The report highlights progress, ongoing challenges, and contextual factors influencing outcomes, with a focus on ethnicity and intersectional variables such as gender and age.

Introduction:

This report does not seek to speak on behalf of those who have experienced discrimination or inequality, nor does it rely on anecdotal evidence. We acknowledge that racism and bias often go unreported or are difficult to quantify. Discrimination is a critical factor in workforce inequality and other influences, such as structural bias, leadership demographics and cultural shaped behaviours, also play roles. Recognising these complexities supports a more tailored and effective response.
Our responsibility is to improve our understanding and actions over time, recognising that data supports this approach.

Since its introduction in 2015/16, the Trust has consistently submitted data for the nine WRES indicators, aiming to understand and tackle the root causes of inequality. The Trust uses a data driven approach to analyse Workforce Race Equality Standard (WRES) indicators, identifying patterns and disparities. While statistics can't capture every individual's experience, they reveal structural inequities that must be addressed.

This report presents the latest WRES data, exploring underlying factors, linking to Trust-wide initiatives, and identifying areas for further analysis or intervention.

Board WRES report:

The Trust made progress in 8 out of 9 Workforce Race Equality Standard (WRES) indicators in 2024/25, with only Indicator 5, relating to harassment or abuse from patients, relatives, or the public, showing a worsening outcome and increased disparity for ethnically diverse staff.

One consistent theme in the data, is the significant influence of the mental health and learning disability inpatient wards at **Prospect Park Hospital (PPH)**. Although these wards at PPH accounts for only **7.6%** of the workforce, it appears to drive disproportionality across four indicators, particularly those based on the staff survey (Indicators 5, 6, and 8). These wards also have a higher concentration of ethnically diverse staff (**71.5%** compared to **29.6%** in the rest of the Trust) meaning localised challenges may skew Trust wide outcomes. Future analysis will explore removing data from these specific PPH teams to better understand the Trust's position excluding this outlier environment.

Workforce Profile Highlights

- **Age and Demographics**: Ethnically diverse staff at the Trust are, on average, 2.1 years younger than white staff, compared to an 11.1-year age gap in the national population. This age disparity challenges the use of ethnicity demographics alone for benchmarking, as senior roles at the Trust are typically held by older staff.
- **Work Patterns**: Ethnically diverse staff work an average of 0.06 FTE more than white staff. As most WRES indicators use headcount rather than FTE, this could understate equity.
- **Representation**: The proportion of ethnically diverse staff in the workforce increased by 2.8 percentage points (PP), from 29.99% in March 24 to 32.79% March 25, representing a relative increase of 9.3% compared to the previous year.
- **Ethnic Group Distribution**: Black or Black British staff comprise 12.6% of the workforce, far higher than their 3.3% share of the local population, while all other ethnic groups are underrepresented compared to local population.

Summary of WRES Indicator Outcomes

Indicator 1: Workforce Representation by Agenda for Change (AfC) Band

- Ethnically diverse representation has increased across AFC clinical, AFC non-clinical, and medical/dental staff in 2024/25
- Non-AfC roles were mapped to equivalent AfC bands based upon full time salary to show equivalent representation for all staff in the Trust, which show a decreasing rate in ethnically diverse representation at higher bands although representation appears much higher in these bands with medical staffing included rather than AFC staff only:
    - Bands 1–4: 35.4%
    - Bands 5–7: 32.2%
    - Bands 8a+: 29.4%

Indicator 2: Likelihood of Appointment from Shortlisting

- White candidates' likelihood reduced from **1.4** (23/24) **to 1.35** (24/25), reflecting improving equity.
- A revised calculation method revealed historical inaccuracies due to the inclusion of "reserve" interviewees.
- When excluding candidates without right to work status, the likelihood score dropped further to **1.28**.
- Application clustering among candidates without right to work, as well as ethnically diverse candidates with right to work, leads to high competition for a limited number of roles. This can contribute to disparities in recruitment outcomes that are not necessarily indicative of discrimination within the recruitment process.
- Female candidates **(1.47)** were more likely to be appointed than males, indicating gender to be a bigger influence on recruitment outcomes than ethnicity
- Ethnically diverse females were **1.16 times** more likely to be appointed than white males.
- Ethnically diverse candidates made up **67.6%** of eligible applications but applied for multiple roles at a higher rate.
- **45.1%** of external hires in 24/25 were Ethnically Diverse candidates compared to **26.9%** Berkshire population

Indicator 3: Disciplinary Process

- The comparative likelihood of disciplinary action for ethnically diverse staff compared to white staff decreased to **1.98**, down from **2.43** in 23/24.
- Alternative calculations using FTE and April 2024 baselines yielded a higher likelihood of **2.16**.
- Disproportionality is concentrated in PPH, especially among male healthcare assistants, indicating the need to consider local context beyond ethnicity. Using alternative calculation above and removing PPH reduced score to **1.6**.

Indicator 4: Access to Non-Mandatory Training/CPD

- White staff were **1.41 times** more likely to access training compared to ethnically diverse staff, an improvement from the **1.55** recorded in 23/24.
- Theories tested using April 2024 workforce figures rather than March 25 to provide more reflective scores reduced the disparity to **1.22**.
- Only funded training was included. We currently do not monitor access to wider training and development.
- Additional Clinical Services (predominately Healthcare Support workers) staff had notably lower access rates.

Indicator 5: Harassment from Patients/Relatives/Public

- Ethnically diverse staff reported a **27.2%** experience rate (up **0.5pp** from **26.7%**), while white staff reported a reduction (down **0.5pp**), widening the gap of inequity by **1percentage point (pp)**.
- PPH accounted for **71.4%** of patient on staff incidents (from Datix) despite comprising only **7.6%** of the workforce.

Indicator 6: Harassment from Staff

- Ethnically diverse staff reported a **4.1pp** reduction (from **20.4%** to **15.4%**).
- White staff reported a **0.2pp** reduction (from **13.7%** to **13.5%**) reducing the inequity gap by **4.8pp**.
- However, PPH again skewed the data, accounting for **45.7%** of staff-on-staff incidents (from Datix).

Indicator 7: Equal Opportunities for Career Progression

- Ethnically diverse staff reported improvement to **56.4%** (up **3.1pp** from **53.3%**)
- White staff reported improvement to **68.6%** (up **0.2pp** from **68.4%**), reducing the inequity gap by **2.9pp**. (Rates of staff perception and experience).
- There is a disparity between staff perception and our data. Promotion data showed **16.9%** of ethnically diverse AfC staff experienced a promotion throughout 24/25, compared to just **7.9%** of white staff (Actual rates of staff promotion).

Indicator 8: Discrimination from Managers/Colleagues

- Discrimination reported by ethnically diverse staff fell from **13.3% to 10.7%**, while the rate for white staff slightly worsened from **5%** in 23/24 to **5.1%** in 24/25, reducing the inequity gap by **2.7pp**

Indicator 9: Board Representation

- With Ethnically diverse board voting membership at **35.71%,** this is **3pp** above the **32.79%** representation of Ethnically Diverse staff in the Trust's overall workforce. This is **3.8pp lower** than 2023/24 due to changes in Board membership.
- Despite the reduction, representation remains above workforce levels and more closely aligned with community demographics reducing the inequity gap by **3.8pp.**

Conclusion:

This year marks a meaningful shift in our approach to the Workforce Race Equality Standard (WRES) data, moving beyond mere tracking of scores to questioning their underlying causes. While the nine national indicators remain central to assessing progress, the Trust's genuine commitment to fairness and equity suggests developing additional internal metrics. These could better capture the lived experiences of our workforce and local efforts.

For example, if Indicator 7 measures perceptions of promotion fairness, an internal "Indicator 7b" could track actual promotion rates by ethnicity. Though not prescribing specifics, evolving the framework to include both perceptions and outcomes seems timely.

We achieved significant progress in eight of nine WRES indicators this year, a commendable feat. However, Indicator 5 (harassment from patients, relatives, or the public) worsened for ethnically diverse staff, widening disparities. This underscores that progress is nonlinear, requiring sustained effort for cultural change.

Gaps persist. Indicator 4 reveals ethnically diverse staff are nearly twice as likely to face disciplinary action as white colleagues. Indicator 8 shows a large disparity in perceived promotion fairness, despite ethnically diverse staff being promoted at higher rates. This paradox urges exploration of deeper factors influencing perceptions of fairness.

Unequal outcomes often stem from discrimination or systemic bias, which we address through antiracism workstreams. Yet, we must also examine other variables, like age distribution, job clustering, or geographic placement, to fully understand issues and devise lasting solutions.

Prospect Park Hospital (PPH) exemplifies how workforce composition impacts outcomes. With a high concentration of ethnically diverse staff (71.5% in affected teams), the site's elevated risk of incidents and disciplinaries disproportionately skews Trust-wide

WRES scores. White staff, more dispersed across lower-risk settings, experience less impact. This highlights composition as a driver of inequality, even with shared risks. Tackling PPH's challenges is key to reducing Trust-level disparities.

This ties into Roger Kline's "snowy white peaks" concept, noting white predominance in senior NHS roles. Our WRES data compares us nationally but prompts: What does equity mean? Treating it as identical outcomes ignores differences in age and career stages between white and ethnically diverse staff. Senior roles demand experience, often acquired later. Expecting parity without accounting for this could imply younger ethnically diverse staff should match older white colleagues' positions. Thus, true equity may focus on fair progression relative to career stage, with barriers removed.

Nearly 60% of our medical workforce is ethnically diverse yet underrepresented in some senior Agenda for Change (AfC) bands. Data points to varying application patterns, professional registration rates, recruitment clustering, and interview competition by ethnicity. Ethnically diverse applicants often target high-demand roles with lower success rates, while white candidates are more likely sole interviewees, boosting their chances. Targeted interventions, informed by this data, can enhance equity and address external factors.

Our workforce is 83% female, with ethnically diverse female candidates more likely recruited than white males. This raises: When marginalised groups are overrepresented (e.g., women Trust-wide or ethnically diverse staff in medicine), explanations include non-discriminatory factors like education paths or cultural preferences. Yet, underrepresentation defaults to discrimination. Consistency demands considering structural factors in all cases; this may explain persistent perceptions.

Perceptions linger that ethnically diverse staff progress slower than white counterparts, based on staff surveys rather than outcomes. This fosters a feedback loop: Concerns are voiced, acknowledged as inequality evidence, reinforcing perceptions. Breaking it requires clear communication balancing progress, outcomes, and gaps.

We must scrutinise indicator calculations. Indicator 2 (appointment likelihood from shortlisting) may be inconsistently reported nationally by many NHS trusts. Indicators 3 (disciplinary likelihood) and 4 (training/CPD access) use full-time equivalent bases, potentially skewing results amid shifting composition. Clarity on data timing (financial year start or end) is needed.

This analysis explores race-related inequities and their outcomes, with commitment to broader inequities in future. We acknowledge potential overlooked perspectives and welcome feedback via the page-footer survey to refine our approach.

Ultimately, we aspire for such papers to become obsolete, not from halted work, but from equality so ingrained that its pursuit is unremarkable. Until then, we commit to deep listening, brave questioning, and decisive action, guided by data and lived experience.

For the full version of this paper

***** *For deeper insights or historical trends of any WRES indicator you can find a full version of this paper on our trusts website or by contacting Ash Ellis ash.ellis@berkshire.nhs.uk 07342061967.*

The full version of this paper includes the contents below.

Berkshire Healthcare
NHS Foundation Trust

Workforce Race Equality Standard (WRES)
2024/2025

Please help shape future papers by completing this feedback survey to share your insights.

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Executive Summary:

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A key driver of disproportionality is Prospect Park Hospital's (PPH) mental health and learning disability inpatient wards. Although just 7.6% of the workforce, they heavily influence four indicators—especially staff survey-based ones (5, 6, and 8)—due to their high proportion of Ethnically diverse staff (71.5% vs. 29.6% elsewhere). Future analysis will consider excluding these teams to clarify the Trust's overall position.

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- Despite the reduction, representation remains above workforce levels and more closely aligned with community demographics reducing the inequity gap by **3.8pp.**

Conclusion

The Trust continues to make measurable progress on race equality, with continual improvements and contextual analysis (particularly around the stated wards at PPH) offering a more nuanced understanding of underlying disparities. Improvements in recruitment fairness, access to training, and promotion equity are notable, but persistent inequalities in disciplinary outcomes and harassment from service users require sustained action. Ongoing refinement in how indicators are calculated, particularly factoring in FTE, workforce dynamics, and localised environments, will be crucial to ensuring accurate WRES insights and effective anti-racist action.

Introduction:

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This report does not claim to speak for those who have experienced discrimination, nor does it rely on anecdotal evidence. While racism and bias are often underreported and complex, recognising their role—alongside factors such as structural bias, leadership demographics, and cultural behaviours—enables more effective action.

Since 2015/16, the Trust has submitted data for all nine WRES indicators, using a data-driven approach to identify disparities and address systemic inequalities. While statistics cannot capture every experience, they highlight patterns that demand action.

This report presents the latest WRES data in comparison with previous years and national scores, explores underlying causes, links to Trust-wide initiatives, and identifies priorities for further analysis and intervention.

Year on Year Indicator Scores and Equity Shifts (2024/25 vs 2023/24)

Meaningful progress requires defining success in equity terms. Disparities can widen even when overall experiences improve, or narrow even as they worsen. For example:

- If bullying among Ethnically diverse staff falls from 20% to 15%, but among White staff from 18% to 8%, the equity gap grows.
- If both groups report worse outcomes but the gap narrows, equity may have improved.

The same applies to "relative likelihood" indicators (e.g., disciplinary action, access to development), where 1.00 reflects parity and deviations signal inequality.

Our goal is to both improve overall experience and reduce disparities. Future actions will therefore define success through clear, measurable outcomes and engagement benchmarks, enabling stronger evaluation

The table below presents Berkshire Healthcare's Workforce Race Equality Standard (WRES) indicator scores for the 2024/25 financial year, alongside a comparison to the previous year (2023/24). It highlights whether outcomes for both Ethnically Diverse and White staff/candidates have improved, declined, or remained the same.

Directional arrows provide a quick visual reference:

- **Green** arrows indicate improvement
- **Red** arrows indicate deterioration
- **Black** arrows indicate no change

In addition to individual group performance, the table also captures **changes in equity** between the two groups. For example, even where both groups have improved, the equity gap may have widened if one group improved more significantly than the other. To reflect this, an additional column presents changes in equity variance between 2023/24 and 2024/25, with coloured ticks or crosses indicating whether the shift represents a positive or negative movement in fairness and parity between groups.

	2024/2025 score with variance rate since 23/24	

WRES Indicator	Metric Descriptor	Ethnically Diverse	White	Change in Equity score variance since 23/24
1 Take me to Data	Percentage of staff in each of the Agenda for Change (AfC) Bands 1-9 and Very Senior Manager (VSM) roles (including executive board members) compared with the percentage of staff in the overall workforce	See appendices	See appendices	
2 Take me to Data	Likelihood of being appointed from shortlisting	**0.74** (Previous score n/a)	**1.35** (↓ 0.05)	0.05 ✓
3 Take me to Data	Likelihood of entering the formal disciplinary process	**1.98** (↓ 0.45)	**0.5** (Previous score n/a)	0.45 ✓
4 Take me to Data	Likelihood of accessing non-mandatory training and continuous professional development (CPD)	**0.71** (Previous score n/a)	**1.41** (↓ 0.14)	0.14 ✓
5 Take me to Data	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	**27.2** (↑ 0.5)	**16.6** (↓ 0.5)	1 ×
6 Take me to Data	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	**15.4** (↓ 5)	**13.5** (↓ 0.2)	4.8 ✓
7 Take me to Data	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	**56.4** (↑ 3.1)	**68.6** (↑ 0.2)	2.9 ✓
8 Take me to Data	Percentage of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months	**10.7** (↓ 2.6)	**5.1** (↑ 0.1)	2.7 ✓
9 Take me to Data	Percentage difference between Board voting membership and its overall workforce	**+3% points** (↓ 3.8)	**-1%point** (Previous score n/a)	3.8 ✓

Ranking Indicators by Level of Inequity

To better illustrate areas of inequity, we have translated raw percentage scores in the instance of the staff survey scores into "likelihood to score" ratios. This enables consistent comparison across indicators and aligns with the NHS's adverse impact threshold of **1.25**. Five indicators listed below exceed the specified threshold. Rows highlighted in orange indicate instances where 24/25 indicator scores surpass the 1**.25** mark, signifying potential areas of concern. Conversely, rows shaded in green denote indicators for which equity does not currently reflect parity or the desired standard yet has not reached the adverse concern threshold of **1.25**.

Group with greatest likelihood	Likelihood score	Indicator	Above NHS adverse impact rate of 1.25
Ethnically Diverse	2.1	8. Percentage of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months	Yes
Ethnically Diverse	1.98	3. Likelihood of entering the formal disciplinary process	Yes
Ethnically Diverse	1.64	5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	Yes
White	1.41	4. Likelihood of accessing non-mandatory training and continuous professional development (CPD)	Yes
White	1.35	2. Likelihood of being appointed from shortlisting	Yes

White	1.22	7. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	No
Ethnically Diverse	1.14	6. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	No

Key Themes and Insights:

The appendices of this paper contain a detailed breakdown of each WRES indicator and a profile of the Trust's workforce composition.

Growing Representation and How This Impacts Indicator Scores Workforce profile in appendices

The proportion of Ethnically diverse staff in the Trust increased from **29.99% in March 2024** to **32.79% in March 2025**, compared to **26.9%** in the local population (2021 Census). This suggests the Trust employs a notably higher percentage of Ethnically diverse staff (+5.87pp), which could be even greater when accounting for the **2.15% of staff with unknown ethnicity**.

However, this overall figure is skewed by the overrepresentation (compared to Berkshire population rates) of **Black or Black British staff**, who make up **12.6%** of the Trust workforce but only **3.33%** of the local population. As a result, all other ethnic groups (including White), are underrepresented in comparison to their local population proportions.

The changing composition of the workforce, with Ethnically diverse staff increasing from **29.99%** at the beginning of the reporting year to **32.79%** at the end, significantly affects indicator calculations. For instance, the additional **3.8%** of Ethnically diverse staff who joined later in the year had less time within the organisation than White staff. This reduced tenure means they likely had fewer opportunities to access Continuing Professional Development (CPD) or training and potentially less exposure to workplace situations that could lead to disciplinary actions.

This dynamic has a notable impact on specific indicators, such as Indicator 3: "Likelihood of staff entering the formal disciplinary process." When calculated using the year-end workforce headcount (**32.79%** Ethnically diverse staff), the likelihood of Ethnically diverse staff facing disciplinary action is reported as **1.98**. However, if the calculation used the workforce composition from the beginning of the year (**29.99%** Ethnically diverse staff), this figure increases to **2.29**, representing a significant rise. This discrepancy highlights how using year-end figures can misrepresent experiences from earlier in the year when fewer Ethnically diverse staff were employed, potentially distorting results.

The table shows that by year end, there are 222 more Ethnically diverse staff, and 39 fewer White staff compared to the beginning of the year.

		March 2024 workforce		March 2025 workforce	
		Ethnically Diverse	White	Ethnically Diverse	White
Headcount	Workforce Headcount	1580	3615	1802	3576
	Disciplinary Headcount	16	16	16	16
	Ratio	0.0101	0.0044	0.0089	0.0045
	Likelihood to face disciplinary	2.29	0.44	1.98	0.50

Age Profile Differences

Analysis of the Trust's workforce showed that **White staff are, on average, 2.1 years older** than Ethnically diverse staff. National census data supports this trend, showing average ages of **42.7 years for White** individuals and **31.6 years for Ethnically diverse** individuals.

These age differences may affect expectations around workforce diversity, particularly in senior roles. For example, if the Ethnically diverse population skews significantly younger, it may contribute to lower representation in senior roles, such as heads of service or Board members, where longer professional experience is typically required.

Full-Time Equivalent (FTE) Differences

Ethnically diverse staff have an average FTE of **0.91**, compared to **0.85** for White staff. This difference in working hours may affect exposure to workplace processes, such as disciplinary procedures, as staff with higher FTE are present more often, potentially increasing their likelihood of involvement in incidents or related outcomes.

Since indicators are based on headcount rather than hours worked, they do not account for FTE variations. Consequently, even minor differences in FTE could slightly skew results, as longer hours may heighten exposure to workplace risks or pressure points.

Indicator 1 – Percentage of Staff in Each Agenda for Change (AfC) Band Compared to Overall Workforce Representation

This indicator assumes equal representation across all AfC pay bands is the ideal. However, achieving this would require a substantial reduction in Ethnically diverse staff in medical roles, where their representation significantly exceeds both the Trust average and local population rates.

To provide a more holistic view, in addition to the WRES nationally mandated breakdowns (AfC clinical, AfC non-clinical, and medical/dental), we've included adjusted figures where non-AfC staff salaries are mapped to equivalent AfC bands:

Predicted Ethnically Diverse Representation Based on Registration Rates compared to actual workforce rates

Grouping	Predicted Representation (AfC only)	Predicted Representation All Roles (AfC Equivalent)	Berkshire Population Benchmark	Actual Workforce April 24 All Roles (AfC Equivalent)
Band 1–4	26.9%	26.92%	26.9%	35.4%
Band 5–7 (Including medical & Dental)	29.07%	29.14%	26.9%	32.2%
Band 8a+ (Including medical & Dental)	25.96%	30.07%	26.9%	29.4%
All Staff	27.9%	28.57%	26.9%	32.8%

Two key drivers of the lower predicted representation in Bands 8a+ (AfC-only data) are:

1. **Nursing and midwifery** (higher ethnic diversity) make up a large portion of Bands 5–7 but fewer 8a+ roles.
2. **Clinical psychologists**, who make up **20%** of our Band 8a+ roles, have lower national ethnic diversity (**12.1%**).

This indicates that comparing workforce data solely to local population rates (as in Indicator 1) may not provide a comprehensive understanding of expected representation when considering professional registration data. Factors such as higher rates of Ethnically Diverse individuals pursuing medical careers compared to their proportion in the local population, and comparatively fewer from these groups entering Psychology careers, result in increased representation within the medical and dental workforce and contribute to lower proportions in the Trust's senior AFC workforce.

All workforce figures exceed both the Berkshire population rates and predicted benchmarks, except for Band 8a and above, which falls **0.67** percentage points below expected levels. The underrepresentation at senior levels warrants further exploration. One potential contributing factor may be the differing age profiles between Ethnically diverse and White populations (nationally, the average age of White people is over **11 years higher**). However, it is important not to overlook how discrimination plays a role in this systemic disparity.

Indicator 2 – Relative Likelihood of Staff Being Appointed from Shortlisting

Reporting Limitations

In previous years, our score for this indicator was derived from our Applicant Tracking Systems (ATS) summary report. However, this report incorrectly categorised candidates marked as "Interview: Reserve" under the "shortlisted" group, even though these individuals were not actually offered interviews. Ethnically diverse applicants were disproportionately represented within the reserve category, resulting in an inflated number of "shortlisted" candidates and consequently skewed appointment likelihoods, which appeared lower than they truly were. This raises an important question about why such a high proportion of Ethnically diverse candidates are being placed on reserve lists.

For the 2024/25 reporting cycle, we manually produced a refined dataset for the first time, allowing us to exclude "Interview: Reserve" candidates from our calculation. Had we followed the previous method, our indicator score would have been **1.52**, falsely suggesting a deteriorating position. With the corrected approach and full year data, our actual score is **1.35**, a decrease from the prior year, but one that reflects greater accuracy. Due to this change in methodology, our score is not directly comparable to previous years.

We have shared these findings with NHS England, as it is understood that approximately **90%** of NHS Trusts use the same ATS platform. This suggests that similar inaccuracies may exist nationally, potentially affecting the reliability of the aggregated WRES data across the system.

External Recruitment Rates

When assessing the equity of our recruitment outcomes, a key metric to consider is the percentage of Ethnically diverse external hires. While no single indicator can offer a complete picture, this measure provides valuable insight into how representative our recruitment outcomes are. In 2024/25, **45.1%** of our external hires were Ethnically diverse, which is **18.2 percentage points** higher than the Berkshire population benchmark of **26.9%**. This is a positive indication of the inclusivity of our recruitment practices and reflects progress in attracting a more diverse workforce.

However, senior recruitment presents a more complex picture. Among hires at Bands 8b to 9, 2 out of 8 hires (**25%)** were from Ethnically diverse backgrounds. While this is below the Trust-wide average, there are several contextual factors to consider. Firstly, small sample sizes mean percentages can shift significantly with just one additional hire. Secondly, disparities in professional registration rates affect the available talent pool. Only **12.1%** of registered clinical psychologists are from Ethnically diverse backgrounds, and while they are virtually absent from the wider workforce between Bands 2 to 8a, they make up around one third of our Band 8b to 9 workforce. This concentration at senior levels, combined with the low national diversity rate for this profession, has a clear impact on representation in our senior recruitment data. In contrast, **44.9%** of doctors and **38.5%** of nurses and midwives are from Ethnically diverse backgrounds. However, even these professions are not equally distributed across the bands. Nursing and midwifery, for example, account for **27%** of the workforce up to Band 8a, but just **13%** between Bands 8b and 9. Further evidence of this pattern can be seen in our non-Agenda for Change recruitment, which is predominantly medical, where **67.9%** of hires were from Ethnically diverse backgrounds.

We must also consider age. The White population in England and Wales is, on average, 11 years older than the Ethnically diverse population. Given that senior roles typically require experience built up over time, we would need to consider how age demographics contribute to representation across grades. Taken together, these factors provide context for interpreting our recruitment data and highlight the need for a nuanced and informed approach when evaluating diversity at senior levels.

Impact of Right-to-Work (RTW) Status

An increasing proportion of applicants lack immediate RTW status. When focusing only on candidates with RTW status, the score for White candidates drops from **1.35** to **1.28**. This shift is likely influenced by the differing application patterns of candidates with and without RTW status. Candidates without immediate RTW often face limitations regarding the types of roles they can apply for, particularly where sponsorship is required. This creates a phenomenon of application clustering, which is discussed further in this paper. Essentially, this clustering increases competition for the same roles, heightening the likelihood of unsuccessful applications for candidates applying to roles where competition is already high.

Data shows that **71.5%** of candidates without RTW were interviewing for roles with five or more shortlisted applicants, compared to **57.7%** of candidates with RTW. This highlights a key point of divergence between the two groups: the competitiveness of the vacancies they can access.

To ensure fair comparison of recruitment outcomes for Ethnically diverse and White candidates, it may be prudent to exclude candidates without RTW from the data analysis, as they present an unequal comparison between the two groups. By focusing solely on candidates with RTW, we can mitigate the impact of these limitations and isolate more accurate insights into recruitment trends. Including candidates without RTW may skew the analysis, often leading to an overemphasis on this issue rather than revealing deeper insights into other factors that may contribute to the disparity in scores.

Shortlisting Conversion Rates

To detect potential bias at the interview stage, we compared the likelihood of progressing from application to interview. At this stage, protected characteristics are hidden from hiring managers, limiting bias (though not eliminating it entirely e.g., a candidate referencing education history in a non-UK country).

After removing non-RTW candidates, White applicants were **2.07** times more likely to be shortlisted than Ethnically diverse applicants, much higher than the likelihood of appointment at interview (**1.28**). This prompts further questions i.e. If bias is considered less prevalent during shortlisting, why does greater disparity appear at this stage compared to interviews? Might this reflect the effects of application clustering (discussed in the next section), where Ethnically diverse candidates are more likely to apply for roles that attract a high volume of applicants? These patterns may also help explain why Ethnically diverse candidates are disproportionately represented in the “interview: reserve” category.

Application Clustering and Competition

Shortlisting patterns reveal a structural difference in the types of roles that candidates from different ethnic backgrounds are typically applying for. For the purpose of this paper, a *highly competitive role* is defined as one with five or more candidates interviewed.

- **53.6%** of shortlisted Ethnically diverse candidates were interviewed for highly competitive roles, compared with **48.4%** of White candidates.
- In contrast, **13.75%** of White candidates interviewing, were interviewing for roles as the sole candidate, compared with **9.9%** of the Ethnically diverse candidates interviewing for a role.

At first glance, this could be misinterpreted as Ethnically diverse candidates applying for less competitive roles at a lower rate. The data however suggests that these candidates are more likely to apply for highly competitive roles, which naturally reduces their representation in interviews for less competitive posts.

Given that **67.6%** of all right-to-work eligible applications came from Ethnically diverse candidates (a figure that is significantly higher than the proportion of Ethnically diverse residents in the local Berkshire population), encouraging even greater application numbers from this group for less competitive roles may have limited effect on the overall disparity. In contrast, increasing the number of White applicants for highly competitive roles or reducing applications from Ethnically diverse candidates for those same roles might alter the pattern, but these approaches would not align with the principles of fair and inclusive recruitment.

The following example illustrates how application clustering can affect success rate data:

Job	Interviewed Candidates	Offer Outcome
1	1 White	1 White
2	1 White	1 White
3	1 White, 1 Ethnically Diverse	1 Ethnically Diverse
4	1 Ethnically Diverse	1 Ethnically Diverse
5	1 Ethnically Diverse	1 Ethnically Diverse
6	5 Ethnically Diverse	1 Ethnically Diverse

In this scenario, Ethnically diverse candidates received more offers overall (four compared with two), but their success rate appears lower due to the competition in job 6, where five Ethnically diverse candidates were interviewed for a single role. This created four unsuccessful outcomes that influenced the success rate figures:

- White candidates: 2 offers from 3 interviews, a success rate of **66%**
- Ethnically diverse candidates: 4 offers from 8 interviews, a success rate of **50%**

Crucially, Ethnically diverse candidates were successful in the only instance where they were interviewed alongside a White candidate (job 3). This highlights how outcome data can be shaped by the structure of competition, particularly when several strong candidates from the same background are applying for the same post, rather than indicating any issue with the decision-making process itself.

Broader Implications and Contributing Factors

The high volume of application activity from Ethnically diverse candidates appears to be influenced by both the number of applications and the breadth of roles applied for.

- **67.6%** of right-to-work eligible applications came from Ethnically diverse candidates.
- **59.6%** of these applications were from distinct individuals (i.e. each person counted once), compared with **63.3%** for White candidates. This suggests a higher proportion of repeat applications among Ethnically diverse candidates, which could reflect different job-seeking strategies, or broader systemic racism, social and economic factors.

This increased application volume contributes to a reduced likelihood of Ethnically diverse candidates being the only person interviewed and increases the chance of competing within larger interview pools. These structural patterns help explain some of the variation in success rates.

Age and Banding as Additional Influences

National data shows that Ethnically diverse populations are, on average, younger than White populations. As a result, younger applicants (who are more likely to be from Ethnically diverse backgrounds) may be more inclined to apply for lower-banded roles, which generally require less experience or fewer qualifications.

Lower-banded roles often have fewer eligibility barriers and attract a wider applicant pool. This means:

- More people apply for each vacancy.
- More candidates are shortlisted and interviewed.
- The chances of success for any individual applicant are reduced.

Application data from the first seven months of 2025 supports this pattern. The average age of applicants increases with banding from Band 6 upwards. Bands 2 to 4 consistently receive the highest number of applications and interviews and are also where younger and Ethnically diverse applicants are concentrated.

These findings suggest that application clustering, shaped by a range of structural and demographic factors including age and job banding, may have a significant influence on recruitment outcomes. Further analysis of these patterns may support the development of more informed and targeted approaches to addressing variation under Indicator 2.

Gender Disparities in Recruitment and Impact on Ethnicity Outcomes

Among RTW-eligible applicants, females were **1.47** times more likely to be appointed than males, and White candidates **1.28** times more likely than Ethnically diverse candidates, suggesting gender has a strong influence. Interview success rates show (these are ratios of success from interview to offer):

1. White females: **0.36** (**highest**)
2. Ethnically diverse females: **0.29**
3. White males: **0.25**
4. Ethnically diverse males: **0.20** (**lowest**)

Appendix data indicates White candidates have more female applicants, while Ethnically diverse candidates have more male applicants. This gender distribution may widen ethnicity disparities, as males face lower appointment rates.

Indicator 3 – Likelihood of staff entering the formal disciplinary process

Questioning the Representativeness of the Standard Calculation Method
Given the significant growth in our Ethnically diverse workforce and their higher average FTE, there are valid concerns that the standard Indicator 3 methodology may understate disciplinary risk.

The current approach uses headcount at the end of the reporting year, which presents two key limitations:

1. **FTE Variation**: Staff working more hours are more likely to have greater exposure to operational, interpersonal, or procedural risks that may lead to disciplinary action. A headcount only measure does not reflect this.
2. **Timing of Starters**: In a year of high recruitment, many Ethnically diverse staff may have joined late in the year and had limited time in post, potentially lowering their exposure. This inflates the denominator and can artificially reduce the calculated likelihood of disciplinary action for this group.

Using the national methodology, the relative likelihood of Ethnically diverse staff entering disciplinary processes is **1.98**. When adjusting the calculation to use FTE and start of year headcount, the figure increases to **2.16**, providing a fairer, though still imperfect, reflection of exposure over time.

The most accurate approach would involve using average headcount over the full year, but this is not currently feasible with available data. Nevertheless, our internal adjustment offers a more realistic basis for decision making and should be considered in future workforce monitoring.

The Trust has a review of casework practices scheduled for September 25, which forms part of our antiracism action plan.

Outliers in Disciplinary Data Beyond Ethnicity
Within WRES Indicator 3, as well as ethnicity, deeper analysis reveals that other outliers may also be influencing the Trust's disciplinary figures, particularly Prospect Park Hospital (PPH), Healthcare Assistants (HCAs), and male staff.

1. **Prospect Park Hospital as a Structural Outlier**
   PPH comprises only 7.6% of the Trust's workforce but accounts for 22.9% of all disciplinary FTEs in 24/25. Ethnically diverse staff make up 32.8% of the Trust wide workforce but are disproportionately concentrated at PPH, suggesting that the environment itself may be contributing to inflated disciplinary rates. When PPH's inpatient data is excluded, the relative likelihood of disciplinary action for Ethnically diverse staff drops from 2.16 to 1.60, a notable reduction.
2. **Healthcare Assistants (HCAs)**
   HCAs represent 8% of the Trust's workforce yet account for 31% of disciplinary cases. While the role has a high proportion of Ethnically diverse staff (53.5%), the disparity appears to relate to role specific risk than to ethnicity alone. Comparatively, Community Psychiatric Nurses (also a highly diverse group) are underrepresented in disciplinary cases. This suggests the need to examine the HCA working environment, support mechanisms, and role clarity.
   Like indicator 2 likelihood to be appointed from shortlisting, we can also see that using the preferred calculation, White male staff (2.9) are more likely to face disciplinary action than Ethnically Diverse females (2.3), demonstrating that gender appears to have an impact on outcomes. This also adds relevance to the outlier work environment being Prospect Park Hospital as we can see that 68% of the substantive workforce in PPH are additional clinical services staff (often healthcare assistant) compared to just 21% for the rest of the Trust.
3. **Gender-Based Disparities**
   Male staff comprise 18% of the workforce but are involved in 35.4% of disciplinary cases, making them 2.5 times more likely to face disciplinary action than female staff (0.4). Indicating that gender may be a strong predictor of disciplinary risk. Further intersectional analysis showed that White and Ethnically diverse females had the lowest disciplinary rates, while male staff (regardless of ethnicity) had the highest.

The MH and LD wards at Prospect Park were such outliers that we recalculated the indicator score without them using the adjusted calculation which uses FTE and March 24 workforce figures. Excluding these wards, the score dropped from **2.16** to **1.6**, highlighting their substantial influence on the indicator.

Indicator 4 – Likelihood of Staff Accessing Non-Mandatory Training and Continued Professional Development (CPD)

Understanding What is Counted as "Training and CPD"
In reviewing this indicator, it became evident that the Trust's submissions only reflect **centrally funded training and CPD**. This is likely a small subset of the total non-mandatory learning opportunities available across the organisation. As a result, both the current and historic data reported under this indicator only provide a partial view of staff access to professional development. The technical guidance from NHS England is vague and we know other Trusts report in a similar way to us. Key categories such as **Apprenticeships, Leadership Development, Non-Mandatory eLearning, Quality Improvement training**, and **Medical CPD** are not currently included due to long-standing limitations in tracking and recording this data. However, efforts are now underway to explore how these activities can be captured more effectively going forward. With **59%** of the medical and dental workforce being Ethnically diverse, and many Additional Clinical Services staff, who are also highly represented among diverse groups, participating in non-funded training and CPD, this issue is especially significant.

Interpreting the Current Score
Despite the narrow scope, the reported likelihood of White staff accessing funded training or CPD **fell from 1.55 in 2023/24 to 1.41 in 2024/25**. While this is a like-for-like comparison, it does indicate some progress in narrowing disparities.

Revisiting the Calculation Methodology
As with Indicator 3, it's important to consider the limitations of the calculation method. Although FTE has less obvious relevance in this context, the **workforce snapshot timing** is still critical. Newer staff will more likely have had less time to undertake funded training than someone who was a part of the workforce at the beginning of the year.
When recalculating the score using workforce figures from the **start of the reporting year**, the likelihood for White staff accessing CPD drops further to **1.22**. This would place the Trust below the NHS's "potential adverse impact" threshold of **1.25**, indicating greater equity than the official score suggests.

Access by Staff Group
Further analysis revealed clear differences in access across staff groups. Allied Health Professionals (AHPs) accounted for **26.7%** of funded training uptake, and Additional Professional Scientific and Technical staff for **17.5%**, despite making up only **11.3%** and **10.3%** of the workforce, respectively. These groups also have lower ethnic diversity than the Trust average. In contrast, staff within **Additional Clinical Services** (which includes Healthcare Assistants) represented only **9.7%** of training uptake, despite comprising **24.8%** of the workforce—a group with significantly higher ethnic diversity. This disparity echoes the earlier findings in Indicator 3, where Healthcare Assistants were disproportionately represented in disciplinary action.

Indicator 5, 6 and 8 – Staff Experience of Negative Workplace Behaviours

The three indicators have been grouped together on the basis that much of the analysis is applicable across them.

- **Indicator 5** saw an increase in Ethnically diverse staff reporting harassment, bullying, or abuse from patients, relatives or the public (27.2%, up from 26.7%), while the rate among White staff decreased, further widening the inequality gap.
- **Indicator 6** showed improvement, with Ethnically diverse staff reporting harassment, bullying or abuse from colleagues decreasing (15.4%, down from 20.4%). With only a 0.2% reduction among White staff, the gap of inequality narrowed significantly, although it still exists.
- **Indicator 8** also showed a reduction in reports of discrimination at work from managers, team leaders or colleagues among Ethnically diverse staff (10.7%, down from 13.3%). By contrast, White staff reported a slight increase, again closing but not eliminating the inequality gap.

This could potentially be partially explained by our antiracism work, and drive and push to our staff not to accept or normalise these behaviours, asking staff to report and re-energising our leadership development.

Factors Impacting All Three Indicators
Outlier "Teams" and Workforce Composition
Survey data is available at both team and ethnicity level. Review of the team level data highlights three outlier teams, all within mental health or learning disability services at the Trust's inpatient mental health hospital (PPH). These three teams have an Ethnically diverse workforce of 71.5%, compared with 29.6% across the rest of the Trust.

Incident reporting data provides important context: 1,121 of the Trust's 1,570 patient-on-staff incidents (71.4%) were recorded within these three teams alone. Of these, 70.4% were reported by Ethnically diverse staff, closely mirroring the proportion of the workforce in those teams. However, 332 incidents were reported by White staff in these same teams, equivalent to 74% of all incidents raised by staff of all ethnicity's staff across the other 107 teams combined. This suggests that the environment at PPH is one which carries a heightened likelihood of staff experiencing incidents, regardless of ethnicity, though ethnicity may still influence total rates. Because Ethnically diverse staff are so heavily represented within these teams, their experiences disproportionately shape the overall Trust-wide results.

Worked Example: How Workforce Composition Affects Inequality Scores
To illustrate how workforce composition interacts with workplace environments, consider the following simplified example:

- At PPH, assume **40% of staff experience harassment, bullying or abuse from patients, relatives or the public**, regardless of ethnicity.
- Across the rest of the Trust, assume **5% of staff experience this**, again with no difference by ethnicity.
- Within each environment, there is therefore *parity* between Ethnically diverse and White staff.

However, because 71.5% of staff at PPH are Ethnically diverse (compared with 29.6% across the rest of the Trust), when results are combined at a Trust-wide level this parity disappears. The aggregated figures would show **11% of Ethnically diverse staff** experiencing harassment, bullying or abuse compared with **6% of White staff**, despite no inequality being present within either environment individually.

This demonstrates how workforce distribution within different environments, particularly those with higher baseline risks of negative behaviours, can create apparent Trust-wide inequalities. Currently, staff survey data is not available at a level that would allow analysis of ethnicity results by specific team or workplace, meaning we cannot confirm whether the survey results mirror this scenario. What we can say with certainty is that the over-representation of Ethnically diverse staff in higher-risk environments such as PPH has a material impact on the Trust's overall inequality scores.

Full-Time Equivalent (FTE) Differences
As referenced earlier, Ethnically diverse staff also work a higher average FTE. This potentially results in greater workplace exposure time, which, could also contribute to differences across the three indicators.

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

Perceptions of Inequality Remain Strong
Although the level of agreement among Ethnically diverse staff has increased from **53.3%** to **56.4%**, there remains a **12.2pp** gap between Ethnically diverse and White staff in terms of their perception that the Trust offers equal opportunities for career progression. This disparity indicates that Ethnically diverse staff continue to feel that there are unequal opportunities, which contributes to an ongoing narrative of unfairness.

Promotion Rates
Ethnically diverse staff were promoted at more than twice the rate of White staff during 2024/25 (**16.9%** vs. **7.9%**), indicating strong actual progression.

Progress Seen Across Most Pay Bands
This trend of higher promotion rates for Ethnically diverse staff was visible across most Agenda for Change bands, apart from Bands 8c and 8d, where low volumes distorted the outcome. More White staff are appointed into these roles.

In response to this, we introduced a guaranteed interview for Ethnically diverse candidates at all roles from band 8b upwards who meet essential criteria, removed desirable criteria in those job specifications, alongside a reflection form for appointing managers to complete where Ethnically diverse staff are not appointed to these roles.

Aspirations Among Internal Ethnically Diverse Staff
Over half (**51.6%**) of Ethnically diverse staff applied for at least one internal role, compared to **19.5%** of White staff, showing high levels of career seeking activity.

	Headcount of workforce (April 24)	% of workforce excluding unknown (April 24)	Unique applications	% of April 24 workforce who made an application
Ethnically Diverse	1580	30.4	816	51.6
White	3614	69.6	706	19.5

Likely Influence of Pay Band Distribution
The higher application and promotion rates may reflect the fact that Ethnically diverse staff are concentrated in lower bands, where opportunities for progression are more frequent.

Exploring the Perception Gap
It is important to assess whether higher participation in promotion processes by Ethnically diverse staff correlates with both increased progression rates and a greater number of unsuccessful applications. Given the pronounced disparity in the representation of Ethnically diverse staff at senior levels (with notably higher proportions in the medical workforce and lower rates in the AFC workforce) these perceptions may also arise from the comparatively low representation of Ethnically diverse staff in AFC roles, which could be interpreted as evidence of diminished fairness.

Implications for Engagement
Further understanding about inequity for senior positions may be needed, combining historical understanding on this topic in conjunction with insights within this paper (e.g. age profile and over representation in medical staffing accounting for variance in AFC senior posts).

If the Trust fails to bridge the gap between staff perceptions and measurable progress, we risk undermining trust, despite evidence of real improvement.

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

Board voting membership Ethnically diverse rates compared to rates of Ethnically diverse staff in overall workforce numbers, continue to be higher (by **+3%** which is lower than in 23/24 when it was **+6.8%**).

This suggests that there is reduced inequality to speak of in this indicator.

Conclusion:

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This year marks a meaningful shift in our approach to the Workforce Race Equality Standard (WRES) data, moving beyond mere tracking of scores to questioning their underlying causes. While the nine national indicators remain central to assessing progress, the Trust's genuine commitment to fairness and equity suggests developing additional internal metrics. These could better capture the lived experiences of our workforce and local efforts.

For example, if Indicator 7 measures perceptions of promotion fairness, an internal "Indicator 7b" could track actual promotion rates by ethnicity. Though not prescribing specifics, evolving the framework to include both perceptions and outcomes seems timely.

We achieved significant progress in eight of nine WRES indicators this year. However, Indicator 5 (harassment from patients, relatives, or the public) worsened for Ethnically diverse staff, widening disparities. This underscores that progress is nonlinear, requiring sustained effort for cultural change.

Gaps persist. Indicator 4 reveals Ethnically diverse staff are nearly twice as likely to face disciplinary action as White colleagues. Indicator 8 shows a large disparity in perceived promotion fairness, despite Ethnically diverse staff being promoted at higher rates. This paradox urges exploration of deeper factors influencing perceptions of fairness.

Unequal outcomes often stem from discrimination or systemic bias, which we continue to address through our antiracism workstreams. We also examine other variables, like age distribution, job clustering, or geographic placement, to fully understand issues and devise lasting solutions.

Prospect Park Hospital (PPH) exemplifies how workforce composition impacts outcomes. With a high concentration of Ethnically diverse staff (71.5% in affected teams), the site's elevated risk of incidents and disciplinaries disproportionately skews Trust-wide WRES scores. White staff, more dispersed across lower-risk settings, experience less impact. This highlights composition as a driver of inequality, even with shared risks. Tackling PPH's challenges is key to reducing Trust-level disparities.

This ties into Roger Kline's "snowy White peaks" concept, noting White predominance in senior NHS roles. Our WRES data compares us nationally but prompts: What does equity mean? Treating it as identical outcomes doesn't consider i.e. differences in age and career stages between White and Ethnically diverse staff. Senior roles demand experience, often acquired later. Thus, true equity may focus on fair progression relative to career stage, with barriers removed.

Nearly 60% of our medical workforce is Ethnically diverse yet underrepresented in some senior Agenda for Change (AfC) bands. Data points to varying application patterns, professional registration rates, recruitment clustering, and interview competition by ethnicity. Ethnically diverse applicants often target high-demand roles with lower success rates, while White candidates are more likely sole interviewees, boosting their chances. Targeted interventions, informed by this data, can enhance equity and address external factors.

Perceptions linger that Ethnically diverse staff progress slower than White counterparts, based on staff surveys rather than outcomes. This fosters a feedback loop: Concerns are voiced, acknowledged as inequality evidence, reinforcing perceptions. Breaking it requires clear two-way communication balancing progress, outcomes, and gaps.

We must scrutinise indicator calculations. Indicator 2 (appointment likelihood from shortlisting) may be inconsistently reported nationally by many NHS trusts. Indicators 3 (disciplinary likelihood) and 4 (training/CPD access) use full-time equivalent bases, potentially skewing results amid shifting composition. Reviewing data timing (financial year start or end) is needed.

This analysis explores race-related inequities and their outcomes, with commitment to broader inequities in future. We acknowledge potential overlooked perspectives and welcome feedback via the page-footer survey to refine our approach.

Ultimately, we aspire for such papers to become obsolete, not from halted work, but from equality so ingrained that its pursuit is unremarkable. Until then, we commit to deep listening, brave questioning, and decisive action, guided by data and lived experience.

Next Steps:

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Several provisional recommendations have been made attributed to improving the process revolving the entire WRES process and where possible attributed to a particular indicator.

These actions may not all be possible, or not all possible in the short term, and so these suggestions along with those made by relevant stakeholders will be reviewed and agreed as part of the process of agreeing an action plan in response to this years paper and in collaboration with our staff networks and Diversity Steering Group.

You can find a list of provisional recommendations in the table below.

Provisional Recommendation	Relevant WRES Indicator(s)
Use start-of-year workforce snapshot for Indicator 3 and 4 to avoid skew from late joiners	3, 4
Use FTE-based calculations for Indicators 3 to reflect differential exposure	3
Pilot average annual headcount approach for more stable workforce metrics	3, 4
Resolve ATS shortlisting inaccuracies (e.g. “reserve” status inflating rates)	2
Ask NHS England to update ATS reporting guidance	2
Develop internal “Indicator 7b” to track actual promotion rates by ethnicity	7
Create metric for workplace incident exposure (e.g. patient-on-staff at PPH)	5
Track shortlisting by whether candidate met essential criteria	2
Track if interviewed candidates were deemed appointable, regardless of outcome	2
Create candidate experience survey in ATS to capture fairness perceptions	2, 7, 8
Introduce RAG rating thresholds for likelihood indicators (1–1.1 = Green, etc.)	2, 3, 4
Create likelihood scoring system for staff survey indicators	5, 6, 7, 8
Improve training and CPD tracking systems to capture all non-mandatory learning	4
Develop matrix of all Trust-offered training & CPD	4
Ensure full training/CPD capture by 2026/27 reporting cycle	4
Continue to track CPD applications and outcomes by ethnicity for fairness	4
Prioritise CPD access for HCAs and Additional Clinical Services staff	4
Analyse flexible working request outcomes by ethnicity and FTE	4, 7
Review standard application form to reduce identifiability (e.g. education location, registration number)	2
Provide internal candidates with personalised shortlisting feedback	2
Undergo further detailed examination of indicator 2 in next year’s paper. E.g. looking at outcomes by band, and age (if possible, within TRAC)	2, 7
Explore Offering developmental (mock) interviews to candidates who narrowly miss shortlisting criteria, to provide exposure and prepare them for future opportunities.	2, 7
Improve feedback templates for unsuccessful applicants	2
Trial appointable candidate banks to reduce clustering impact	2, 7
Review guaranteed interview scheme for Bands 8b+, including perceived fairness	7
Launch perception-focused communications strategy highlighting positive outcomes	7
Continue to use 360-degree manager feedback, and promote EDI data dashboard use at local level for inclusive planning and action	8
Continue to encourage manager peer-support and zero-tolerance harassment policies	6, 8
Introduce team-level interventions at PPH to improve culture and reduce incidents	5, 6
Continue de-escalation and environment training at PPH	5
Investigate causes of disproportionate ethnic diversity in MH/LD PPH workforce	1, 5
Review Datix data for ethnicity of both perpetrators and victims of incidents	5
Explore rebalance of workforce at PPH to align with Trust-wide diversity profile	1, 5
Maintain board-level ethnic diversity through inclusive succession planning	9
Benchmark against mental health Trusts in the South East instead of NHS overall	General
Conduct longitudinal analysis on age and senior representation	1
Share professional registration rates to highlight diversity benchmarks	1
Conduct staff focus groups on recruitment fairness perceptions	2, 7
Review support for managers recruiting staff without immediate right to work	2

Develop pathway for staff to raise recruitment fairness concerns	2, 7
Address underreporting of ethnicity by contacting staff via email or Teams	General
Analyse national MH incident data to understand environmental drivers	5
Leverage WRES staff survey to refine future reports and priorities	General
Continue to strengthen Ethnically diverse staff networks and involve in solutions	General
Continue with the essential management and leadership development on anti-racism and bias for leaders	8
Align WRES action plan with Trust anti-racism and NHS equality frameworks	General
Pilot excluding PPH from Trust-wide metrics to assess impact	General
Publish simplified WRES summary for staff transparency	General
Convene Anti-Racism taskforce to prioritise recommendations and track progress	General
Benchmark progress annually against peer NHS Trusts	General
Investigate whether there is any correlation between disciplinaries occurring in first year	3

Short Version Appendices:

Workforce Profile:

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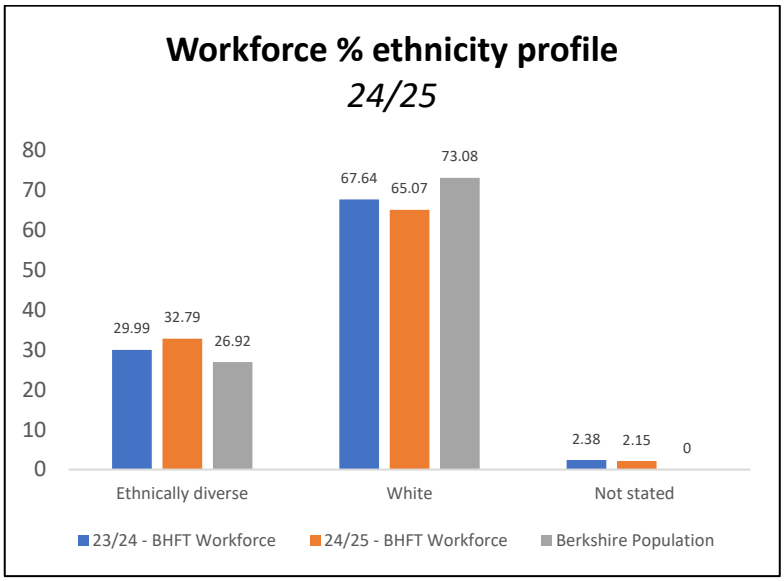
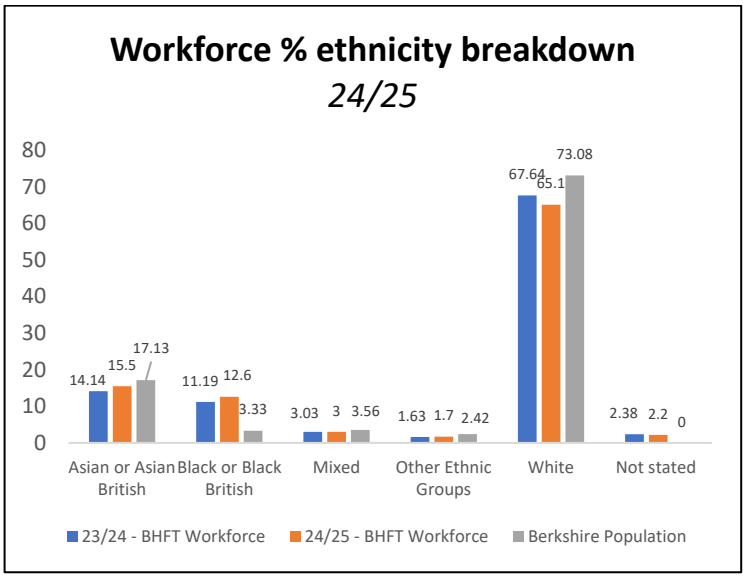
BHFT Workforce compared to Berkshire Population *(from census data,2021)*





	Ethnically diverse	White	Not stated
23/24 - BHFT Workforce	29.99%	67.64%	2.38%
24/25 - BHFT Workforce	32.79%	65.07%	2.15%
Berkshire Population	26.92%	73.08%	0
Difference in % points – 24/25 BHFT workforce vs Berkshire population	5.87	-8.01	2.15

Further breakdown of ethnicity

	Asian or Asian British *(Indian, Pakistani, Bangladeshi, any other Asian background)*	Black or Black British *(Caribbean, African, any other Black background)*	Mixed *(White & Black Caribbean, White & Black African, White & Asian, any other mixed background)*	Other Ethnic Groups *(Chinese, any other ethnic group)*	White *(British, Irish, any other White background)*	Not stated
23/24 - BHFT Workforce	14.14% (738)	11.19% (584)	3.03% (158)	1.63% (85)	67.64% (3,530)	2.38% (124)
24/25 - BHFT Workforce	15.5% (893)	12.6% (693)	3% (163)	1.7% (95)	65.1% (3,580)	2.2% (119)
Berkshire Population	17.13%	3.33%	3.56%	2.42%	73.08%	0

Difference in % points – 24/25 BHFT workforce vs Berkshire population	-1.63	+9.27	-0.56	-0.72	-7.98	+2.2

Workforce Profile: Full-Time Status and Age

	Ethnically Diverse	White
% who work full time	77.7	57.9
Average FTE	0.91	0.85
Average age	42.7	44.8
% contribution to trusts 16-25 years' workforce	36.9	61.7
% contribution to trusts 26-35 years' workforce	33.9	64.0
% contribution to trusts 36-45 years' workforce	36.9	60.6
% contribution to trusts 46-55 years' workforce	34.4	63.6
% contribution to trusts 56-65 years' workforce	24.5	74.0
% contribution to trusts 66 plus years workforce	21.3	74.3

2021 census population data England and Wales

Age range	% which are White: English, Welsh, Sottish, Northern Irish or British	% which are Ethnically diverse
16-25 years	69.0	31.0
26-35 years	68.0	32.0
36-45 years	65.0	35.0
46-55 years	77.0	23.0
56-65 years	84.0	16.0
66 plus years	90.0	10.0
Average age	42.7	31.6

Average Age of Workforce by Band

	Average age of BHFT staff in band	Above below trust average age (43.9 years)	Difference between trust average age and average age of staff in band
Under Band 1	18.9	↓	-25.0
Band 2	43.4	↓	-0.5
Band 3	45.0	↑	1.1
Band 4	41.4	↓	-2.5
Band 5	40.2	↓	-3.7
Band 6	43.4	↓	-0.5
Band 7	45.0	↑	1.1
Band 8 - Range A	45.8	↑	1.9
Band 8 - Range B	48.3	↑	4.4
Band 8 - Range C	52.0	↑	8.1
Band 8 - Range D	55.3	↑	11.4
Band 9	56.3	↑	12.4

Board Director	**54.7**	↑	**10.8**
Consultant	**51.2**	↑	**7.3**
NED	**61.7**	↑	**17.8**
Non-consultant Career Grade	**48.2**	↑	**4.3**
Trainee Grades	**34.0**	↓	**-9.9**
VSM	**57.0**	↑	**13.1**
Grand Total	**43.9**		

National Registration Rates and Predicted Workforce Diversity (All Staff)

Profession Type	National Registration Rate for Ethnically Diverse (%)	Positions in workforce (Up to band 4)	Expected number of Ethnically diverse staff in posts up to band 4	Positions in workforce (Band 5 - 7)	Expected number of Ethnically diverse staff in posts band 5 to 7	Positions in workforce (Band 8a and above)	Expected number of Ethnically diverse staff in posts band 8a and above	Grand Total
Psychological Therapies								
Cognitive Behavioural Therapist	20		0	120	24	27	5.4	147
Counsellor/Psychotherapist	20		0	41	8.2	15	3	56
Family & Systemic Therapist (Registration rates unknown)	26.9		0		0	10	2.69	10
Psychological Wellbeing Practitioner	20		0	51	10.2		1.8	60
Qualified Clinical Psychologists	12.1		0	36	4.356	147	17.787	183
Allied Health Professions								
Art therapist	14.7		0	5	0.735	2	0.294	7
Audiologist	16		0	8	1.28	3	0.48	11
Dietician	15.4		0	62	9.548	3	0.462	65
Drama therapist	14.7		0	1	0.147	1	0.147	2
Occupational Therapist	12.7		0	123	15.621	9	1.143	132
Osteopath	9		0	2	0.18		0	2
Physiotherapist	20.4		0	184	37.536	39	7.956	223
Podiatrist	11.2		0	27	3.024	3	0.336	30
Speech & Language Therapist	10.1		0	104	10.504	8	0.808	112
Other Clinical Roles								
Nursing and Midwifery Registered	38		0	1242	471.96	150	57	1392
Paramedic	4.5		0	11	0.495	10	0.45	21
Pharmacists	58.8		0	8	4.704	32	18.816	40
Pharmacy Technician	19		0	11	2.09		0	11
Social worker	32.1		0	53	17.013	10	3.21	63
Dentists	38.1		0	1	0.381	17	6.477	18
Qualified doctors	44.9		0	13	5.837	194	87.106	207
Other Roles (No Registration Required)								

No registration required or not immediately obvious	26.9	1676	450.844	561	150.909	257	69.133	2494
Roles with Unknown Registration rates								
Registration data not available	26.9	122	32.818	95	25.555		0	217
Grand Total		1798	484	2759	804	946	284.5	5503
% of Expected Ethnically Diverse Workforce			26.92		29.14		30.07	28.57

When analysing all staff, including medical professionals, the predicted rate of Ethnically diverse staff increases at higher pay bands. This is largely because medical professions, particularly doctors, have a high national registration rate of Ethnically diverse individuals.

National Registration Rates and Predicted Workforce Diversity (AfC-Only Staff)

Profession Type	National Registration Rate for Ethnically Diverse (%)	Positions in workforce (Up to band 4)	Expected number of Ethnically diverse staff in posts up to band 4	Positions in workforce (Band 5 - 7)	Expected number of Ethnically diverse staff in posts band 5 to 7	Positions in workforce (Band 8a and above)	Expected number of Ethnically diverse staff in posts band 8a and above	Grand Total
Psychological Therapies								
Cognitive Behavioural Therapist	20		0	120	24	27	5.4	147
Counsellor/Psychotherapist	20		0	41	8.2	15	3	56
Family & Systemic Therapist (Registration rates unknown)	26.9		0		0	10	2.69	10
Psychological Wellbeing Practitioner	20		0	51	10.2	9	1.8	60
Qualified Clinical Psychologists	12.1		0	36	4.356	147	17.787	183
Allied Health Professions								
Art therapist	14.7		0	5	0.735	2	0.294	7
Audiologist	16		0	8	1.28	3	0.48	11
Dietician	15.4		0	62	9.548	3	0.462	65
Drama therapist	14.7		0	1	0.147	1	0.147	2
Occupational Therapist	12.7		0	123	15.621	9	1.143	132
Osteopath	9		0	2	0.18		0	2
Physiotherapist	20.4		0	184	37.536	39	7.956	223
Podiatrist	11.2		0	27	3.024	3	0.336	30
Speech & Language Therapist	10.1		0	104	10.504	8	0.808	112
Other Clinical Roles								
Nursing and Midwifery Registered	38		0	1242	471.96	150	57	1392
Paramedic	4.5		0	11	0.495	10	0.45	21
Pharmacists	58.8		0	8	4.704	32	18.816	40
Pharmacy Technician	19		0	11	2.09		0	11
Social worker	32.1		0	53	17.013	10	3.21	63
Dentists	38.1		0	0	0	0	0	0
Qualified doctors	44.9		0	0	0	0	0	0
Other Roles (No Registration Required)								

No registration required or not immediately obvious	26.9	1663	447.347	561	150.909	242	65.098	2466
Roles with Unknown Registration rates								
Registration data not available	26.9	120	32.28	95	25.555		0	215
Grand Total		1783	479.63	2745	798.05	720	186.88	5248
% of Expected Ethnically Diverse Workforce			26.90		29.07		25.96	27.9

WRES Indicators:

1. **Percentage of staff in each of the Agenda for Change (AfC) Bands 1-9 and Very Senior Manager (VSM) roles (including executive board members) compared with the percentage of staff in the overall workforce**

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Workforce Profile – Non-Clinical Staff 2023-25 (across 3 years)

Pay Band	2023 Non-Clinical Workforce Data				2024 Non-Clinical Workforce Data				2025 Non-Clinical Workforce Data			
	Total Staff	White	Ethnically diverse	Ethnicity Unknown	Total Staff	White	Ethnically diverse	Ethnicity Unknown	Total Staff	White	Ethnically diverse	Ethnicity Unknown
Under Band 1	2	1 (50%)	1 (50%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)
Band 1	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)
Band 2	60	48 (80%)	12 (20%)	0 (0%)	65	49 (75%)	16 (25%)	0 (0%)	53	42 (79.2%)	10 (18.9%)	1 (1.9%)
Band 3	275	215 (78%)	58 (21%)	2 (1%)	298	221 (74%)	74 (25%)	3 (1%)	309	225 (72.8%)	79 (25.6%)	5 (1.6%)
Band 4	298	208 (70%)	77 (26%)	13 (4%)	305	217 (71%)	79 (26%)	9 (3%)	316	222 (70.3%)	88 (27.8%)	6 (1.9%)
Band 5	143	107 (75%)	34 (24%)	2 (1%	153	110 (72%)	41 (27%)	2 (1%)	150	104 (69.3%)	44 (29.3%)	2 (1.3%)
Band 6	153	107 (70%)	42 (27%)	4 (3%)	163	111 (68%)	50 (31%)	2 (1%)	162	110 (67.9%)	48 (29.6%)	4 (2.5%)
Band 7	123	80 (65%)	40 (33%)	3 (2%)	126	84 (67%)	39 (31%)	3 (2%)	130	86 (66.2%)	43 (33.1%)	1 (0.8%)
Band 8a	95	65 (68%)	27 (29%)	3 (3%)	95	69 (73%)	22 (23%)	4 (4%)	106	76 (71.7%)	26 (24.5%)	4 (3.8%)
Band 8b	66	54 (82%)	11 (17%)	1 (1%)	55	40 (73%)	14 (25%)	1 (2%)	69	52 (75.4%)	16 (23.2%)	1 (1.4%)
Band 8c	33	28 (85%)	4 (12%)	1 (3%)	35	29 (83%)	5 (14%)	1 (3%)	38	32 (84.2%)	5 (13.2%)	1 (2.6%)
Band 8d	16	13 (81%)	1 (6%)	2 (13%)	15	12 (80%)	1 (7%)	2 (13%)	16	13 (81.3%)	2 (12.5%)	1 (6.3%)
Band 9	8	5 (62%)	3 (38%)	0 (0%)	4	3 (75%)	1 (25%)	0 (0%)	9	8 (88.9%)	1 (11.1%)	0 (0%)
VSM	9	6 (67%)	2 (22%)	1 (11%)	8	6 (75%)	1 (12.5%)	1 (12.5%)	8	6 (75%)	1 (12.5%)	1 (12.5%)
Total	**1272**	**937 (73.7%)**	**312 (24.5%)**	**32 (2.5%)**	**1329**	**956 (72%)**	**344 (26%)**	**29 (2%)**	1366	**976 (71.4%)**	**363 (26.6%)**	**27 (2%)**

Workforce Profile - Clinical Staff 2023-25 (across 3 years)

Pay Band	2023 Clinical Workforce Data				2024 Clinical Workforce Data				2025 Clinical Workforce Data			
	Total Staff	White	Ethnically diverse	Ethnicity Unknown	Total Staff	White	Ethnically diverse	Ethnicity Unknown	Total Staff	White	Ethnically diverse	Ethnicity Unknown
Under Band 1	13	9 (69%)	4 (31%)	0 (0%)	7	5 (71%)	2 (29%)	0 (0%)	13	5 (38.5%)	8 (61.5%)	0 (0%)
Band 1	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)
Band 2	167	79 (47%)	83 (50%)	5 (3%)	183	70 (38%)	105 (58%)	8 (4%)	56	23 (41.1%)	31 (55.4%)	2 (3.6%)
Band 3	358	235 (66%)	114 (32%)	9 (2%)	354	226 (64%)	122 (34%)	6 (2%)	505	244 (48.3%)	250 (49.5%)	11 (2.2%)
Band 4	484	363 (75%)	110 (23%)	11 (2%)	515	384 (75%)	122 (24%)	9 (1%)	546	367 (67.2%)	171 (31.3%)	8 (1.5%)
Band 5	468	254 (54%)	200 (43%)	14 (3%)	500	268 (54%)	219 (44%)	13 (2%)	542	294 (54.2%)	237 (43.7%)	11 (2%)
Band 6	811	580 (71%)	207 (26%)	24 (3%)	784	542 (69%)	225 (29%)	17 (2%)	832	543 (65.3%)	267 (32.1%)	22 (2.6%)
Band 7	760	557 (73%)	181 (24%)	22 (3%)	869	631 (73%)	218 (25%)	20 (2%)	929	668 (71.9%)	243 (26.2%)	18 (1.9%)
Band 8a	271	203 (75%)	60 (22%)	8 (3%)	296	222 (75%)	68 (23%)	6 (2%)	319	240 (75.2%)	75 (23.5%)	4 (1.3%)

Band 8b	98	79 (81%)	17 (17%)	2 (2%)	113	91 (81%)	19 (17%)	3 (2%)	112	91 (81.3%)	18 (16.1%)	3 (2.7%)
Band 8c	26	20 (77%)	6 (23%)	0 (0%)	35	31 (89%)	4 (11%)	0 (0%)	32	27 (84.4%)	5 (15.6%)	0 (0%)
Band 8d	18	18 (100%)	0 (0%)	0 (0%)	20	18 (90%)	2 (10%)	0 (0%)	16	15 (93.8%)	1 (6.3%)	0 (0%)
Band 9	3	3 (100%)	0 (0%)	0 (0%)	6	6 (100%)	0 (0%)	0 (0%)	3	3 (100%)	0 (0%)	0 (0%)
VSM	1	0 (0%)	1 (100%)	0 (0%)	1	0 (0%)	1 (100%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)
Total	**3478**	**2400 (69%)**	**983 (28.3%)**	**95 (2.7%)**	**3683**	**2494 (68%)**	**1106 (30%)**	**82 (2%)**	**3905**	**2520 (64.5%)**	**1306 (33.4%)**	**79 (2%)**

Workforce Profile – Medical & Dental staff 2023-2025 (across 3 years)

Pay Band	2023 Clinical (Medical & Dental) Workforce				2024 Clinical (Medical & Dental) Workforce				2025 Clinical (Medical & Dental) Workforce			
	Total Staff	White	Ethnically diverse	Ethnicity Unknown	Total Staff	White	Ethnically diverse	Ethnicity Unknown	Total Staff	White	Ethnically diverse	Ethnicity Unknown
Consultants	**93**	39 (42%)	52 (56%)	2 (2%)	**91**	37 (41%)	52 (57%)	2 (2%)	101	42 (41.6%)	58 (57.4%)	1 (1%)
Snr Medical Manager	**0**	0	1	0	**1**	0	1 (100%)	0	2	0 (0%)	2 (100%)	0 (0%)
Non-consultant Career Grade	**82**	30 (37%)	48 (58%)	4 (5%)	**81**	30 (37%)	44 (54%)	7 (9%)	84	25 (29.8%)	53 (63.1%)	6 (7.1%)
Trainee Grade	**27**	11 (41%)	14 (52%)	2 (7%)	**35**	13 (37%)	18 (51%)	4 (11%)	40	13 (32.5%)	22 (55%)	5 (12.5%)
Other	**0**	0	0	0	**0**	0	0	0	0	0	0	0
Total	**202**	**80 (40%)**	**114 (56%)**	**8 (4%)**	**208**	**80 (39%)**	**115 (55%)**	**13 (6%)**	225	**80 (35.6%)**	**133 (59.1%)**	**12 (5.3%)**

Workforce Profile – All staff 2023-2025 (across 3 years)

Pay Band	2023 All Staff Workforce Data				2024 All Staff Workforce Data				2025 All Staff Workforce Data			
	Total Staff	White	Ethnically diverse	Ethnicity Unknown	Total Staff	White	Ethnically diverse	Ethnicity Unknown	Total Staff	White	Ethnically diverse	Ethnicity Unknown
Under Band 1	15	10 (66.7%)	5 (33.3%)	0 (0%)	**7**	5 (71.4%)	2 (28.6%)	0 (0%)	13	5 (38.5%)	8 (61.5%)	0 (0%)
Band 1	0	0 (0%)	0 (0%)	0 (0%)	**0**	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)
Band 2	227	127 (55.9%)	95 (41.9%)	5 (2.2%)	**248**	119 (48%)	121 (48.8%)	8 (3.2%)	109	65 (59.6%)	41 (37.6%)	3 (2.8%)
Band 3	633	450 (71.1%)	172 (27.2%)	11 (1.7%)	**652**	447 (68.6%)	196 (30.1%)	9 (1.4%)	814	469 (57.6%)	329 (40.4%)	16 (2%)
Band 4	782	571 (73%)	187 (23.9%)	24 (3.1%)	**820**	601 (73.3%)	201 (24.5%)	18 (2.2%)	862	589 (68.3%)	259 (30%)	14 (1.6%)
Band 5	611	361 (59.1%)	234 (38.3%)	16 (2.6%)	**653**	378 (57.9%)	260 (39.8%)	15 (2.3%)	692	398 (57.5%)	281 (40.6%)	13 (1.9%)
Band 6	964	687 (71.3%)	249 (25.8%)	28 (2.9%)	**947**	653 (69%)	275 (29%)	19 (2%)	994	653 (65.7%)	315 (31.7%)	26 (2.6%)
Band 7	883	637 (72.1%)	221 (25%)	25 (2.8%)	**995**	715 (71.9%)	257 (25.8%)	23 (2.3%)	1059	754 (71.2%)	286 (27%)	19 (1.8%)
Band 8a	366	268 (73.2%)	87 (23.8%)	11 (3%)	**391**	291 (74.4%)	90 (23%)	10 (2.6%)	425	316 (74.4%)	101 (23.8%)	8 (1.9%)
Band 8b	164	133 (81.1%)	28 (17.1%)	3 (1.8%)	**168**	131 (78%)	33 (19.6%)	4 (2.4%)	181	143 (79%)	34 (18.8%)	4 (2.2%)
Band 8c	59	48 (81.4%)	10 (16.9%)	1 (1.7%)	**70**	60 (85.7%)	9 (12.9%)	1 (1.4%)	70	59 (84.3%)	10 (14.3%)	1 (1.4%)
Band 8d	34	31 (91.2%)	1 (2.9%)	2 (5.9%)	**35**	30 (85.7%)	3 (8.6%)	2 (5.7%)	32	28 (87.5%)	3 (9.4%)	1 (3.1%)
Band 9	11	8 (72.7%)	3 (27.3%)	0 (0%)	**10**	9 (90%)	1 (10%)	0 (0%)	12	11 (91.7%)	1 (8.3%)	0 (0%)
VSM	10	6 (60%)	3 (30%)	1 (10%)	**9**	6 (66.7%)	2 (22.2%)	1 (11.1%)	8	6 (75%)	1 (12.5%)	1 (12.5%)
Consultants	**93**	39 (42%)	52 (56%)	2 (2%)	**91**	37 (41%)	52 (57%)	2 (2%)	101	42 (41.6%)	58 (57.4%)	1 (1%)
Snr Medical Manager	**0**	0	1	0	**1**	0	1 (100%)	0	2	0 (0%)	2 (100%)	0 (0%)
Non-consultant Career Grade	**82**	30 (37%)	48 (58%)	4 (5%)	**81**	30 (37%)	44 (54%)	7 (9%)	84	25 (29.8%)	53 (63.1%)	6 (7.1%)
Trainee Grade	**27**	11 (41%)	14 (52%)	2 (7%)	**35**	13 (37%)	18 (51%)	4 (11%)	40	13 (32.5%)	22 (55%)	5 (12.5%)
Other	**0**	0	0	0	**0**	0	0	0	0	0	0	0
Up to and including Band 4	**1657**	**1158 (69.9)**	**459 (27.7%)**	**40 (2.4%)**	**1727**	**1172 (67.9%)**	**520 (30.1%)**	**35 (2%)**	**1798**	**1128 (62.7%)**	**637 (35.4%)**	**33 (1.8%)**
Band 5 to 7	**2458**	**1685 (68.6%)**	**704 (28.6%)**	**69 (2.8%)**	**2595**	**1746 (67.3%)**	**792 (30.5%)**	**57 (2.2%)**	**2745**	**1805 (65.8%)**	**882 (32.1%)**	**58 (2.1%)**

8a to 9 (AFC only)	634	488 (77%)	129 (20.3%)	17 (2.7%)	674	521 (77.3%)	136 (20.2%)	17 (2.5%)	720	557 (77.4%)	149 (20.7%)	14 (1.9%)
Total	4952	3417 (69%)	1409 (28.5%)	135 (2.7%)	5220	3530 (67.6%)	1565 (30%)	124 (2.4%)	5496	3576 (65.1%)	1802 (32.8%)	118 (2.1%)

All Staff – With Agenda for Change (AfC) Equivalent Banding Based on Salary

Band group	Not stated	White	Ethnically Diverse	Total staff	% Which are Ethnically Diverse
Up to band 4	33	1128	637	1798	35.4
Band 5 - 7	61	1809	889	2759	32.2
Band 8a and above	24	644	278	946	29.4
Grand Total	118	3581	1804	5503	32.8
Berkshire Population					26.9

2. Relative likelihood of staff being appointed from shortlisting

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WRES Indicator	Metric Descriptor		21/22	22/23	23/24	24/25	Change since 23/24	
2	Relative likelihood of White applicants being appointed from shortlisting across all posts compared to Ethnically diverse applicants *(A value above 1 indicates that White candidates are more likely to be appointed than Ethnically diverse candidates, and a value below 1 indicates that White candidates are less likely to be appointed than Ethnically diverse candidates)*	Berkshire Healthcare	1.53	1.51	1.4	1.35	-0.05	↓
		NHS Trusts	1.61	1.54	1.62			

External Recruitment hires by Ethnicity (24/25)

	Not Stated	Ethnically Diverse	White	Grand Total	% of hires which are Ethnically diverse
Band 2	3	33	24	60	55
Band 3	5	87	73	165	52.7
Band 4	7	83	119	209	39.7
Band 5	2	78	76	156	50
Band 6	4	52	63	119	43.7
Band 7	3	30	70	103	29.1
Band 8a	1	6	24	31	19.4
Band 8b		1	4	5	20
Band 8c		0	1	1	0
Band 8d		0	1	1	0
Band 9		1		1	100
AFC only	25	371	455	851	43.6
Band 8b - 9	0	2	6	8	25

All non-AFC	1	38	17	56	67.9
Grand Total	26	409	472	907	45.1

Likelihood to be appointed from shortlisting (candidates with RTW only)

WRES Indicator	Metric Descriptor		White	Ethnically Diverse	Difference
2	Relative likelihood of applicants being appointed from shortlisting across all posts	Actual reported scores	1.35	0.74	0.61
	(A value above 1 indicates that White candidates are more likely to be appointed than Ethnically diverse candidates, and a value below 1 indicates that White candidates are less likely to be appointed than Ethnically diverse candidates)	Non reported scores (RTW applicants only)	1.28	0.78	0.5

Application clustering for candidates with and without RTW

WRES Indicator	Metric Descriptor		Interviews	Interviews for jobs with 5 or more candidates interviewing	% of candidates interviewing for job with 5 or more candidates interviewing
2	Relative likelihood of applicants being appointed from shortlisting across all posts	Candidate with RTW	4,545	2621	57.7
	(A value above 1 indicates that White candidates are more likely to be appointed than Ethnically diverse candidates, and a value below 1 indicates that White candidates are less likely to be appointed than Ethnically diverse candidates)	Candidate without RTW	610	436	71.5

Likelihood to be shortlisted from application

WRES Indicator	Metric Descriptor		White	Ethnically Diverse	Difference
2	Relative likelihood of being shortlisted from application across all posts	Candidates with RTW only	2.07	0.48	1.59
	Relative likelihood of being appointed from shortlisting across all posts		1.28	0.78	0.5

Applications Totals and Unique applications

Across the reporting period,

- Ethnically diverse candidates submitted 12,999 applications, of which 7,752 were unique (59.6%).

- White candidates submitted 6,242 applications, with 3,954 being unique (63.3%).

Ethnic Group	Expected % of total applications (Berkshire population)	Actual % of total applications	% points difference
Ethnically Diverse	26.9%	67.6%	+40.7
White	73.1%	32.4%	-40.7

Application Clustering and Its Impact on Recruitment Outcomes

Roles with 5 or More Candidates Interviewing:

- Ethnically diverse candidates: 53.6% of all interviews were for highly competitive roles
- White candidates: 48.4% of all interviews were for highly competitive roles

Roles with Only 1 Candidate Interviewing:

- Ethnically diverse candidates: 9.9% of all interviews were for roles where only 1 candidate was interviewing.
- White candidates: 13.75% of all interviews were for roles where only 1 candidate was interviewing.

Likelihood to be appointed from shortlisting from candidates with RTW only (Ethnicity vs Gender)

WRES Indicator	Metric Descriptor		White	Ethnically Diverse	Male	Female
2	Ethnicity	**Non reported scores (RTW applicants only)**	**1.28**	**0.78**		
	Gender				**0.68**	**1.47**

Intersectional Analysis of Recruitment Outcomes

Ethnic Group	Interview to offer ratio
White female	0.36
Ethnically diverse female	0.29
White male	0.25
Ethnically diverse male	0.20

Interview totals (RTW only) and disparity in male contribution to Ethnically diverse and White totals

	Ethnically Diverse	White
Male applications	645	329
Female applications	1557	1873
Total applications	2202	2202
% which were male	29.3	14.9

*The same number of interviews were offered to both Ethnically diverse and White candidates, based on known gender; this is accurate and not a reporting error.

The table examines whether differences in average national age between Ethnically Diverse and White populations correlate with their application patterns. Due to data retention limits on TRAC, matching periods (such as FY 24/25) could not be reviewed, but the insights still reveal recruitment trends relevant to other findings in this paper.

We analysed the average application age for each Agenda for Change band from 1 January to 17 July 2025, as well as the average number of applications and interviews per band.

Arrows indicate if the value in the column is above or below the Trust average for that metric.

*Applications between 1.1.25 - 18.7.25	Average of Age of applicants	Above or below average	Average number of applications per job	Above or below average	Average number of interviews	Above or below average
Band 2	33.7	↓	26.8	↑	5.0	↑
Band 3	35.4	↑	36.3	↑	5.8	↑
Band 4	34.4	↓	25.0	↑	4.0	↑
Band 5	31.9	↓	22.4	↑	3.1	↓
Band 6	36.4	↑	8.8	↓	2.5	↓
Band 7	39.9	↑	6.3	↓	2.4	↓
Band 8a	40.4	↑	4.0	↓	2.5	↓
Band 8b	44.2	↑	9.6	↓	2.9	↓
Band 8C	46.8	↑	10.2	↓	3.1	↓
Band 8D	67.8	↑	2.0	↓	2.0	↓
Grand Total	35.2		15.4		3.2	

3. Relative likelihood of staff entering the formal disciplinary process

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WRES Indicator	Metric Descriptor		21/22	22/23	23/24	24/25	Change since 23/24	
3	Relative likelihood of Ethnically diverse staff entering the formal disciplinary process compared to White staff *(A value of "1.0" for the likelihood ratio means that Ethnically diverse and White staff are equally likely to enter formal disciplinary proceedings, whilst a value above 1 indicates that Ethnically diverse staff are more likely to enter formal disciplinary proceedings than White staff, and a value below 1 indicates that Ethnically diverse staff are less likely to enter formal disciplinary proceedings than White staff)*	Berkshire Healthcare	4.59	1.21	2.43	1.98	-0.45	↓
		NHS Trusts	1.14	1.14	1.09			

Understanding the Specifications of how we Report

WRES Indicator 3 currently uses:

- Workforce headcount as of 31st March 2025, and
- Headcount of staff entering disciplinary processes during 2024/25.

While this aligns with national guidance, two issues limit accuracy:

1. **Timing of Workforce Snapshot**

Using end-of-year data overlooks staff turnover. For example, if many Ethnically diverse staff joined late in the year, they had less time to be exposed to disciplinary risk—yet are fully counted in the denominator. A 1st April 2024 snapshot would better reflect actual exposure.

2. **Headcount vs. FTE**

Using headcount ignores differences in working hours. Our data shows Ethnically diverse staff tend to work more hours (higher FTE), so FTE provides a fairer measure of exposure to risk.

These two factors significantly affect outcomes—our Indicator 3 score ranges from 1.89 to 2.29 depending on methodology.

Recommendation:
For internal analysis, use FTE and a 1st April 2024 snapshot to ensure a more accurate, fairer assessment of disciplinary risk by ethnicity.

Examining the indicator score by using varying calculations (FTE and workforce snapshot date)

Below are 4 calculation of indicator 3 which provides the likelihood score based upon using either headcount or FTE, and fixed staff position at the beginning or end of the reporting period.

When done on headcount of March 2025 workforce (Actual WRES submission)

	Ethnically Diverse	White
Likelihood to face disciplinary	1.98	0.50

When done on FTE of March 2025 workforce

	Ethnically Diverse	White
Likelihood to face disciplinary	1.89	0.53

When done on FTE of April 24 workforce (Recommended internal submission)

	Ethnically Diverse	White
Likelihood to face disciplinary	2.16	0.46

When done on headcount of April 24 workforce

	Ethnically Diverse	White
Likelihood to face disciplinary	2.29	0.44

Outliers in the Dataset

Using the preferred methodology (based on FTE and a fixed workforce snapshot as of April 2024), we identified notable outliers in the data that suggest unequal outcomes may be influenced by factors beyond ethnicity alone.

1. Disciplinary Cases at Prospect Park Hospital (PPH)

The first table shows the recommended submission for indicator 3, using FTE and workforce figures from the start of the reporting period for the entire Trust. The second table presents the same calculation but excludes MH and LD wards' workforce for comparison.

When done on FTE of April 24 workforce (Recommended submission)

	Ethnically Diverse	White
Likelihood to face disciplinary	2.16	0.46

When done on FTE of April 24 workforce with PPH removed

	Ethnically Diverse	White
Likelihood to face disciplinary	1.6	0.62

2. **Disciplinary Cases based upon position title**

The table below shows disciplinary actions by position title during the reporting period.

FTE of disciplinary cases = Total FTE of all staff with position title who had disciplinary in reporting period.
% of total cases = The % the total FTE for that position title contributed out of all disciplinary cases in reporting period.
FTE of April 24 Workforce = FTE of that position title within the workforce at begging of reporting period.
% of total workforce = % of total workforce that position title holds at the beginning of the reporting period.
Difference between % of cases vs % of workforce = PP difference between positions titles rate of total workforce and rate of total cases.

% of workforce which are Ethnically diverse = Of the total workforce that position title held at beginning of the reporting period, rate in which that workforce is Ethnically diverse.

Position Title	FTE of disciplinary cases	% of total cases	FTE of April 24 Workforce	% of total workforce	Difference between % of cases vs % of workforce	% of workforce which are Ethnically diverse
Healthcare Assistant	9.5	31.0	364.6	8.0	23.0	53.5
Head of Service	1.9	6.1	22.7	0.5	5.6	22.0
Assistant Practitioner	2.6	8.6	198.7	4.3	4.3	27.4
Estates Supervisor	1.0	3.3	1.0	0.0	3.2	0.0
Mental Health & Wellbeing Practitioner	1.0	3.3	1.8	0.0	3.2	0.0
Staff Nurse	3.0	9.8	310.2	6.8	3.0	44.7
Adviser	1.0	3.3	12.7	0.3	3.0	47.3
Speciality Doctor	1.0	3.3	30.5	0.7	2.6	61.6
Cognitive Behavioural Therapist	0.8	2.6	5.6	0.1	2.5	24.6
Social Worker	1.0	3.3	39.6	0.9	2.4	29.3
Psychotherapist	0.8	2.6	31.5	0.7	1.9	23.5
Physiotherapist	1.0	3.3	83.6	1.8	1.4	38.2
Senior Manager	1.0	3.3	194.5	4.3	-1.0	20.9
Administrator	4.0	13.1	649.4	14.2	-1.1	27.1
Community Psychiatric Nurse	1.0	3.3	350.6	7.7	-4.4	43.0

The table below shows disciplinary actions by staff group during the reporting period like the table above.

Staff group	FTE of all cases	% of all cases	% Staff group makes up of total workforce	% of staff group which are Ethnically diverse (April 24)
Nursing and Midwifery Registered	5	16.4	25.6	33.4
Administrative and Clerical	7	22.9	25.2	25.8
Additional Clinical Services	13.1	42.9	23.9	32.9
Allied Health Professionals	1	3.3	10.3	20.5
Add Prof Scientific and Technic	2.6	8.5	9.7	23.8
Medical and Dental	1	3.3	3.8	55.2
Students			0.7	13.0
Estates and Ancillary			0.5	26.8
Healthcare Scientists	0.9	2.8	0.3	56.7
Grand Total	30.56			29.8

3. Disciplinary Cases for Male Staff

Similar to tables above, the table below shows disciplinary data based upon gender.

Gender *When done on FTE of April 24 workforce*	April 24 workforce FTE	% of workforce	Disciplinary FTE	% of total disciplinaries	Likelihood to face disciplinary
Male	823.05	18.0	10.8	35.4	2.5
Female	3,746.78	82.0	19.70	64.6	0.4

The table below examines disciplinary data based upon gender and sex variations.

Ethnicity AND Gender *When done on FTE of April 24 workforce*	April 24 workforce FTE	Disciplinary FTE	Ratio	Likelihood to face disciplinary compared to White female *(Who have lowest scoring ratio)*
ED Male	378.71	6.0	0.0158	4.0
White Male	419.90	4.8	0.0114	2.9
ED female	1060.39	9.5	0.0089	2.3
White Female	2,603.64	10.2	0.0039	n/a

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

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WRES Indicator	Metric Descriptor		21/22	22/23	23/24	24/25	Change since 23/24
4	Relative likelihood of White staff accessing non-mandatory training and continuous professional development (CPD) compared to Ethnically diverse staff *(A value of "1.0" for the likelihood ratio means that White and Ethnically diverse staff are equally likely to access non-mandatory training or CPD, whilst a value above 1 indicates that White staff are more likely to access non-mandatory training or CPD than Ethnically diverse staff, and a value below 1 indicates that White staff are less likely to access non-mandatory training or CPD than Ethnically diverse staff.)*	Berkshire Healthcare	1.28	1.44	1.55	1.41	-0.14 ↓
		NHS Trusts	1.14	1.12	1.06		

Understanding what is being reported on

Unlike Indicator 3, where FTE may affect exposure to disciplinary processes, access to non-mandatory training or CPD is not directly influenced by FTE. Therefore, adjusting this indicator using FTE is less appropriate. Instead, we propose using the workforce composition from the start of the reporting year (March 24) rather than the end (March 25), as staff who join later in the year will have had less time available to access development opportunities, potentially skewing the results.

Additionally, only funded non-mandatory training and CPD are currently included in this indicator due to data limitations. Work is underway to build a comprehensive training matrix and improve data collection so future submissions more accurately reflect access across all available opportunities.

Below is a revised calculation using the workforce baseline from the beginning of the year.

When workforce totals were done at end of the financial year (Actual submission)

	Ethnically Diverse	White
Likelihood to access non mandatory training or CPD	0.71	1.41

When workforce totals were done at beginning of the financial year (Recommended submission)

	Ethnically Diverse	White
Likelihood to access non mandatory training or CPD	0.82	1.22

Training and CPD rates by staff group

Staff group	Total number of courses	% of total CPD funded courses	% of this staff group makes up our overall workforce	% of this staff group which are Ethnically diverse (April 24)	Number of staff who are Ethnically diverse
Nursing and Midwifery	181	38.1	25.3	31.7	427
Allied Health Professionals	127	26.7	11.3	17.9	107
Add Prof Scientific and Technic	83	17.5	10.3	22.8	125
Additional Clinical Services	46	9.7	22.9	31.1	379
Administrative and Clerical	29	6.1	24.8	24.9	329
Medical and Dental	5	1.1	3.9	51.7	108
Students	2	0.4	0.6	14.7	5
Healthcare Scientists	2	0.4	0.2	53.8	7
Estates and Ancillary	0	0.0	0.6	24.2	8
Grand Total	556			28.1	1495

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

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			2021/2022		2022/2023		2023/2024		2024/2025		Change since 23/24	
WRES	Metric Descriptor		Ethnically diverse	White	Ethnically diverse	White	Ethnically diverse	White	Ethnically diverse	White	Ethnically diverse	White
5 Staff Survey Q14A	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	Berkshire Healthcare	29.4	19.9	29.40	18.50	26.7	17.1	27.2	16.6	+0.5	-0.5
		NHS Trusts	32	26	29.20	27						

Data relating to "outlier" teams (MH and LD wards at PPH)

- **Headcount of the three teams:** 417
- **Total Trust headcount (September 2024):** 5,503
- **Percentage of total workforce in these three teams:** 7.6%

- **Headcount of Ethnically diverse staff in these three teams:** 298
- **Total headcount of Ethnically diverse staff in the Trust:** 1,804
- **Percentage of total Trust headcount of Ethnically diverse staff working in these three teams:** 16.51%

Datix incident rates (Public on staff) from reporting period

Public on staff					
Team/s	% of team which are Ethnically diverse	Incidents raised by Ethnically Diverse staff	Incidents raised by all staff	% of all incidents in this team which were raised by Ethnically Diverse staff	% Of all incidents in the trust which were attributed to this team
MH Inpatient (and management) or Campion	66.3	7	15	46.7	18.1
Rest of the trust	27.0	18	68	26.5	81.9

Datix incident rates (Patient on staff) from reporting period

Patient on staff					
Team/s	% of team which are Ethnically diverse	Incidents raised by Ethnically Diverse staff	Incidents raised by all staff	% of all incidents which were raised by Ethnically Diverse staff	% Of all incidents in the trust which were attributed to this team
MH Inpatient (and management) or Campion	66.3	789	1121	70.4	71.4
Rest of the trust	27.0	204	449	45.4	28.6

Example which demonstrates workforce composition in challenging working environments ion overall inequity rates at a Trust wide level – Actual Workforce Numbers

Staff in post numbers	MH/ LD wards at PPH	Rest of trust (excluding MH/ LD wards at PPH)	All trust
ED	298	1506	1804
White and non-known	119	3580	3699
All staff	417	5086	5503

Dummy figures if ED staff and White Staff experienced equal rates of experiencing harassment, bullying or abuse from patients, relatives or the public

(Not real figures) Staff numbers who experience harassment, bullying or abuse from patients, relatives or the public	MH/ LD wards at PPH (40%)	Rest of trust (excluding MH/ LD wards at PPH) (5%)
ED	119.2	75
White and non-known	47.6	179

(Not real figures) Staff numbers who experience harassment, bullying or abuse from patients, relatives or the public	Total number of staff who experience harassment, bullying or abuse from patients, relatives or the public	Total % of staff who experience harassment, bullying or abuse from patients, relatives or the public
ED	195	11

White and non known	227	6

6. Percentage of staff experiencing harassment, bullying or abuse from staff

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WRES	Metric Descriptor		2021/2022		2022/2023		2023/2024		2024/2025		Change since 23/24	
			Ethnically diverse	White	Ethnically diverse	White	Ethnically diverse	White	Ethnically diverse	White	Ethnically diverse	White
6 Staff Survey Q14b/c	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	Berkshire Healthcare	23.0	14.0	20.8	15.4	20.4	13.7	**15.4**	**13.5**	-5	-0.2
		NHS Trusts	23.0	18.0	27.6	23.0						

Datix incident rates (Staff on staff) from reporting period

Staff on staff					
Team/s	% of team which are Ethnically diverse	Incidents raised by Ethnically Diverse staff	Incidents raised by all staff	% of all incidents which were raised by Ethnically Diverse staff	% Of all incidents in the trust which were attributed to this team
MH Inpatient (and management) or Campion	66.3	10	16	62.5	45.7
Rest of the trust	27.0	4	18	22.2	52.9

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

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WRES	Metric Descriptor		2021/2022		2022/2023		2023/2024		2024/2025		Change since 23/24	
			Ethnically diverse	White	Ethnically diverse	White	Ethnically diverse	White	Ethnically diverse	White	Ethnically diverse	White
7 Staff Survey Q15	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	Berkshire Healthcare	45.7	67.5	51.7	68.1	53.3	68.4	**56.4**	**68.6**	+3.1	+0.2
		NHS Trusts	47.0	61.0	44.4	59.0	**48.8**	59.4				

Actual Promotion Rates by Ethnicity

The table below presents Agenda for Change (AfC) staff, showing the number of employees in post as of April 2024, how many received a promotion to a higher band, and the resulting promotion rate by ethnicity.

	Staff in post – April 24		April 24 - March 25 internal promotions		% of staff promoted	
	White	Ethnically Diverse	White	Ethnically Diverse	White	Ethnically Diverse
Band 2	118	123	22	26	18.6	21.1
Band 3	460	197	38	32	8.3	16.2
Band 4	613	208	64	43	10.4	20.7

Band 5	371	254	46	66	12.4	26
Band 6	673	280	51	53	7.6	18.9
Band 7	733	257	41	20	5.6	7.8
Band 8a	300	92	12	6	4	6.5
Band 8b	140	35	2	1	1.4	2.9
Band 8c	62	10	1	0	1.6	0
Band 8d	36	2	2	0	5.6	0
Band 9	9	2	0	0	0	0
Grand Total	3515	1460	279	247	7.9	16.9

Application Rates: Internal Ethnic Diversity Breakdown

	Headcount of workforce (April 24)	% of workforce (April 24)	Total applications	Unique applications	% of April 24 workforce who made an application
ED	1580	29.7	1498	816	51.6
White	3614	67.9	1166	706	19.5

*Unique applications = Distinct individuals, as some staff made more than 1 application.

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

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			2021/2022		2022/2023		2023/2024		2024/2025		Change since 23/24	
WRES	Metric Descriptor		Ethnically diverse	White	Ethnically diverse	White	Ethnically diverse	White	Ethnically diverse	White	Ethnically diverse	White
8 Staff Survey Q16b	Percentage of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months	Berkshire Healthcare	14.0	5.0	13.2	5.0	13.3	5.0	**10.7**	**5.1**	-2.6	+0.1
		NHS Trusts	14.0	6.0	17.0	7.0						

Datix incident rates (Staff on staff - Discrimination) from reporting period

Team/s	% of team which are Ethnically diverse	Incidents raised by Ethnically Diverse staff	Incidents raised by all staff	% of all incidents which were raised by Ethnically Diverse staff	% Of all incidents in the trust which were attributed to this team
MH Inpatient (and management) or Campion	66.3	3	5	60	71.4
Rest of the trust	27	1	2	50	28.6

9. Percentage difference between Board voting membership and its overall workforce

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			2020/2021		2021/2022	
WRES	Metric Descriptor		2021/2022	2022/2023	2023/2024	2024/2025

9 Board Representation	Percentage difference between Board voting membership and its overall workforce (Ethnically Diverse)	**Berkshire Healthcare**	-4.4%	+ 2.4%	+6.8%	+3%
		NHS Trusts	12.6%	13.2%		

Berkshire Healthcare
NHS Foundation Trust

WDES 2024/2025:
Condensed Board Report

Please help shape future papers by completing this feedback survey to share your insights.

Board Meeting Date	September 2025
Title	**Workforce Disability Equality Standard (WDES) 2024/2025**
Board required action	Item for Noting Item for Discussion
Reason for the Report going to the Trust Board	This report sets out our 2024 data and approach to action against the Workforce Disability Equality Standard (WDES) metrics that are part of the NHS Standard contract. **Full detailed reports are available to the Board.**
Business Area	People Directorate, Organisational Experience and Development.
Author	**Stephen Strang**, Workforce Planning and Insights Manager (Author) **Ash Ellis**, Deputy Director for Leadership, Inclusion, Organisational Exp (Editor) **Alex Gild**, Deputy Chief Executive (Exec Sponsor)
Relevant Strategic Objectives	Make Berkshire Healthcare a great place to work for our people. Commitment in addressing staff experience differential.
Summary	This report presents the 2024-2025 Workforce Disability Equality Standard (WDES) data for Berkshire Healthcare NHS Trust, highlighting progress, disparities, and areas for improvement regarding disabled and non-disabled staff experiences. It provides detailed analysis on representation, recruitment, engagement, and workplace culture affecting disabled staff.

Introduction:

This report analyses workplace disability inequality within the Trust using a data driven approach to the Workforce Disability Equality Standard (WDES) indicators, implemented in the NHS since 2019/20. The author, acknowledging their position of privilege and lack of lived experience with disability related inequality, avoids anecdotal evidence and focuses on systematic data analysis to identify patterns and disparities.

The report explores underlying factors such as inaccessible environments, lack of reasonable adjustments, occupational segregation, and societal attitudes, alongside discrimination, to inform sustainable change. By linking the latest WDES data to Trust wide initiatives and identifying areas for further intervention, it underscores that action is needed even when discrimination is not fully proven, as ableism and bias can go underreported.

Board WDES report:

Workforce Profile Highlights

- **Representation**: The proportion of known disabled staff in the workforce increased from **7.24% (378 staff)** in March 2024 to **8.68% (477 staff)** by March 2025, an increase of **1.4 percentage points** (or 19.9% as a growth rate).
- **Age**: Disabled staff are, on average, 1.7 years younger than non-disabled staff at the Trust.
- **Work Patterns**: Disabled staff work an average of 0.02 FTE more than non-disabled staff. As most WDES indicators use headcount rather than FTE, this could misrepresent levels of equity.

WDES Indicator Outcomes

Indicator 1 – Representation by AfC Band

- Disclosed Disability representation rose across all four band clusters:
  - Bands 1–4: ↑ from 6.3% to 8.2%
  - Bands 5–7: ↑ from 8.4% to 9.4%
  - Bands 8a–8b: ↑ from 6.6% to 8.3%
  - Bands 8c–9 & VSM: ↑ from 5.6% to 6.6%
- Although 8c remains below the Trust average at 2.9%, every other band in cluster “Band 8c-9 & VSM” is above it.
- Representation improved among clinical, non-clinical, and medical/dental staff.

The percentage of unknown disability status fell slightly from 7.4% to 6.7%, though 48% of the medical and dental workforce still has unreported disability status data. Unknown includes the 3 states “Not Declared”, “Prefer Not To Answer” and “Unspecified”.

Indicator 2 – Likelihood of Appointment from Shortlisting

- The disparity between disabled and non-disabled candidates decreased (likelihood ratio down from 1.15 to 1.10).
- A review of processes found some disabled candidates placed on “interview reserve” lists, raising questions about consistent execution of the Guaranteed Interview Scheme, which needs further exploration.
- Appointment likelihood by gender and disability showed:
  1. Disabled females – most likely to be appointed
  2. Non-disabled females
  3. Non-disabled males
  4. Disabled males – least likely to be appointed
- The difference between female and male appointment likelihood (1.47) is more significant than that between disabled and non-disabled candidates (1.10), suggesting gender is a strong determinant in appointment outcomes.
- A greater portion of the disabled candidates interviewed were male (28.3%) compared to the portion of non-disabled candidates which were male (23.23%) which is potentially worth noting when considering the point above.

Indicator 3 – Disciplinary Process

- Disabled staff were recorded as being 1.63 times more likely to face disciplinary compared to non-disabled staff, which whilst still significant disparity has significantly reduced from 23/24 when disabled staff were recorded as being 3.92 times more likely.
- The small data pool means a single case could significantly shift the score; one fewer case would reduce the ratio to 1.08.
- This volatility limits the statistical confidence of any deeper conclusions and highlights the need for caution when interpreting small sample indicators.

Indicator 4 – Harassment, Bullying or Abuse

4a – From patients/public

- Disabled staff: ↓ from 24.5% to 19.8%
- Non-disabled staff: ↑ from 18.1% to 18.2%
- Inequity gap narrowed from 6.4 to 1.6 percentage points.

4b – From managers

- Disabled staff: ↓ from 11.4% to 7.0%
- Non-disabled staff: ↑ from 4.9% to 5.8%
- Inequity gap narrowed from 6.5 to 1.2 percentage points.

4c – From colleagues

- Disabled staff: ↓ from 24.5% to 17.1%
- Non-disabled staff: ↓ slightly from 10.5% to 10.4%
- Inequity gap reduced from 14 to 6.7 percentage points.

4d – Reporting incidents

- Disabled staff: ↑ from 59.3% to 65.2%
- Non-disabled staff: ↑ from 62.2% to 64.7%
- Inequity gap reversed from a 2.9-point deficit to a 1.6-point lead in favour of disabled staff.

Indicator 5 – Equal Opportunities for Career Progression

- Perceived opportunity improved among disabled staff: ↑ from 57.8% to 59.9%
- Non-disabled staff reported a higher perception: ↑ to 66.7% from 66%.
- However, actual promotions tell a different story:
  - 15.1% of AfC disabled staff were promoted vs. 10.5% of non-disabled staff.
  - This points to a potential disconnect between staff perceptions and reported outcomes, which may benefit from closer exploration.

Indicator 6 – Pressure to Work When Unwell

- Disabled staff: ↓ from 22.3% to 21.1%.
- Non-disabled staff: ↓ from 14.3% to 11.1%.
- Disabled staff remain nearly twice as likely to feel pressured.
- Over the 24/25 financial year, 76.7% of disabled staff had a sickness episode, compared to 70.0% of non-disabled staff (likely to be impacted by disability-related absence), meaning this indicator may also be influenced by differences in sickness rates. In other words, disabled staff may more frequently encounter situations of feeling pressured to work while unwell due to more instances of this being a possibility.

Indicator 7 – Feeling Valued by the Organisation

- Disabled staff: ↑ from 53.7% to 55.2%.
- Non-disabled staff: ↑ from 64.2% to 64.8%..
- Despite improvements, a notable gap in perceived value remains.

Indicator 8 – Reasonable Adjustments

- Disabled staff: ↑ from 81% to 81.9%.
- A small but welcome increase in reported satisfaction with adjustments.

Indicator 9 – Engagement (NHS Staff Survey)

- Disabled staff: unchanged at 7.1
- Non-disabled staff: unchanged at 7.6
- All nine engagement sub-scores which make up the overall engagement score favoured non-disabled staff, indicating a persistent engagement gap, with the cause of these scores being reviewed with the Purple Network.

Indicator 10 – Board Representation

- In 2024, voting board membership matched overall disability workforce representation.
- In 2025, this dropped by 2 percentage points due to a growing workforce, and a static number of disabled board members.

Conclusion:

This year's Workforce Disability Equality Standard (WDES) submission has highlighted several encouraging developments across multiple indicators, alongside areas that continue to require focused attention. Most notably, significant improvements were seen in disabled staff's experience of bullying, harassment and abuse (Indicator 4), with reductions across all measured sources, and in reporting rates, where for the first time, disabled staff surpassed their non-disabled colleagues in their likelihood to report incidents. Such progress reflects the positive impact of targeted interventions and sustained efforts to improve the organisational culture.

However, disparities still exist. Disabled staff remain more likely to experience negative behaviours at work, and the gap in staff perceptions of equal opportunities for career progression (Indicator 5) persists despite strong evidence of improved promotion rates for disabled staff this year. This disconnect, between perception and outcome highlights the complex

relationship between experience, identity, and organisational messaging and reinforces the importance of aligning not just policy and practice, but also narrative and trust.

Several themes emerged across the indicators that suggest underlying structural and contextual influences on WDES outcomes. For example, higher average sickness rates among disabled staff affect scores related to presenteeism (Indicator 6), while differences in average FTE may contribute to increased exposure to risk and incidents. As highlighted earlier in the paper, metrics based solely on headcount rather than exposure, adjusted or time-sensitive measures can skew interpretations. This is particularly true for Indicators 3 and 10, where small data volumes and static board composition mean that even a single change can disproportionately impact the Trust's scores.

The Trust has taken meaningful steps to support disabled colleagues, such as launching a Quality Improvement project focused on the timeliness and accessibility of reasonable adjustments, and continuing to fund and strengthen the Purple Staff Network. However, sustainable improvement will require continued action to integrate disabled voices at every level of the organisation, ensure psychological safety in speaking up, and build robust systems for capturing data that reflect the complexity of workforce dynamics.

The improvements made this year are a testament to the efforts of our staff, equality networks, and leadership but the journey toward equity is ongoing. The Trust remains committed to embedding inclusion at every level and ensuring that disability is not just accommodated, but actively supported and empowered in our workplace.

For the full version of this paper

***** *For deeper insights or historical trends of any WDES indicator you can find a full version of this paper on our trusts website or by contacting Ash Ellis ash.ellis@berkshire.nhs.uk 07342061967.*

The full version of this paper includes the contents below.

Berkshire Healthcare
NHS Foundation Trust

Workforce Disability Equality Standard (WDES)
2024/2025

Please help shape future papers by completing this feedback survey to share your insights.

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Executive Summary:

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Workforce Profile Highlights

- **Representation**: The proportion of known disabled staff in the workforce increased from **7.24% (378 staff)** in March 2024 to **8.68% (477 staff)** by March 2025, an increase of **1.4 percentage points** (or 19.9% as a growth rate).
- **Age**: Disabled staff are, on average, 1.7 years younger than non-disabled staff at the Trust.
- **Work Patterns**: Disabled staff work an average of 0.02 FTE more than non-disabled staff. As most WDES indicators use headcount rather than FTE, this could misrepresent levels of equity.

WDES Indicator Outcomes

Indicator 1 – Representation by AfC Band

- Disclosed Disability representation rose across all four band clusters:
  - Bands 1–4: ↑ from 6.3% to 8.2%
  - Bands 5–7: ↑ from 8.4% to 9.4%
  - Bands 8a–8b: ↑ from 6.6% to 8.3%
  - Bands 8c–9 & VSM: ↑ from 5.6% to 6.6%
- Although 8c remains below the Trust average at 2.9%, every other band in cluster "Band 8c-9 & VSM" is above it.
- Representation improved among clinical, non-clinical, and medical/dental staff.

The percentage of unknown disability status fell from 7.4% to 6.7%, though 48% of the medical and dental workforce still has unreported disability status data. Unknown includes the 3 states "Not Declared", "Prefer Not To Answer" and "Unspecified".

Indicator 2 – Likelihood of Appointment from Shortlisting

- The disparity between disabled and non-disabled candidates decreased (likelihood ratio down from 1.15 to 1.10).
- A review of processes found some disabled candidates placed on "interview reserve" lists, raising questions about consistent execution of the Guaranteed Interview Scheme, which needs further exploration.
- Appointment likelihood by gender and disability showed:
  1. Disabled females – most likely to be appointed
  2. Non-disabled females
  3. Non-disabled males
  4. Disabled males – least likely to be appointed
- The difference between female and male appointment likelihood (1.47) is more significant than that between disabled and non-disabled candidates (1.10), suggesting gender is a strong determinant in appointment outcomes.
- A greater portion of the disabled candidates interviewed were male (28.3%) compared to the portion of non-disabled candidates which were male (23.23%) which is potentially worth noting when considering the point above.

Indicator 3 – Disciplinary Process

- Disabled staff were 1.63 times more likely to face disciplinary compared to non-disabled staff, which whilst still significant, disparity significantly reduced from 23/24 when disabled staff were 3.92 times more likely.
- A small data set means a single case could significantly shift the score; one fewer case would reduce the ratio to 1.08.
- This volatility limits the statistical confidence of any deeper conclusions and highlights the need for caution when interpreting small sample indicators.

Indicator 4 – Harassment, Bullying or Abuse

4a – From patients/public

- Disabled staff: ↓ from 24.5% to 19.8%
- Non-disabled staff: ↑ from 18.1% to 18.2%
- Inequity gap narrowed from 6.4 to 1.6 percentage points.

4b – From managers

- Disabled staff: ↓ from 11.4% to 7.0%
- Non-disabled staff: ↑ from 4.9% to 5.8%
- Inequity gap narrowed from 6.5 to 1.2 percentage points.

4c – From colleagues

- Disabled staff: ↓ from 24.5% to 17.1%
- Non-disabled staff: ↓ slightly from 10.5% to 10.4%
- Inequity gap reduced from 14 to 6.7 percentage points.

4d – Reporting incidents

- Disabled staff: ↑ from 59.3% to 65.2%
- Non-disabled staff: ↑ from 62.2% to 64.7%
- Inequity gap reversed from a 2.9-point deficit to a 1.6-point lead in favour of disabled staff.

Indicator 5 – Equal Opportunities for Career Progression

- Perceived opportunity improved among disabled staff: ↑ from 57.8% to 59.9%
- Non-disabled staff reported a higher perception: ↑ to 66.7% from 66%.
- However, actual promotions tell a different story:

- 15.1% of AfC disabled staff were promoted vs. 10.5% of non-disabled staff.
- This points to a potential disconnect between staff perceptions and reported outcomes, which may benefit from closer exploration.

Indicator 6 – Pressure to Work When Unwell

- Disabled staff: ↓ from 22.3% to 21.1%.
- Non-disabled staff: ↓ from 14.3% to 11.1%.
- Disabled staff remain nearly twice as likely to feel pressured.
- Over the 24/25 financial year, 76.7% of disabled staff had a sickness episode, compared to 70.0% of non-disabled staff (likely to be impacted by disability-related absence), meaning this indicator may also be influenced by differences in sickness rates. In other words, disabled staff may more frequently encounter situations of feeling pressured to work while unwell due to more instances of this being a possibility.

Indicator 7 – Feeling Valued by the Organisation

- Disabled staff: ↑ from 53.7% to 55.2%.
- Non-disabled staff: ↑ from 64.2% to 64.8%..
- Despite improvements, a notable gap in perceived value remains.

Indicator 8 – Reasonable Adjustments

- Disabled staff: ↑ from 81% to 81.9%.
- A small but welcome increase in reported satisfaction with adjustments.

Indicator 9 – Engagement (NHS Staff Survey)

- Disabled staff: unchanged at 7.1
- Non-disabled staff: unchanged at 7.6
- All nine engagement sub-scores which make up the overall engagement score favoured non-disabled staff, indicating a persistent engagement gap, with the cause of these scores being reviewed with the Purple Network.

Indicator 10 – Board Representation

- In 2024, voting board membership matched overall disability workforce representation.
- In 2025, dropped by 2 percentage points due to a growing workforce, and a static number of disabled board members.

Conclusion

The 2025 WDES results reflect meaningful progress across most areas, with positive trends in both staff experience and equity. Notably, 8 of 11 measurable indicators show reduced disparities between disabled and non-disabled staff with 1 remaining static. However, gaps persist, particularly in areas such as pressure to work when unwell, and disciplinary rates. Sustaining progress while targeting these priority areas will be key to driving equity and fostering a culture of inclusion.

Introduction:

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This report analyses workplace disability inequality within the Trust using a data driven approach to the Workforce Disability Equality Standard (WDES) indicators, implemented in the NHS since 2019/20. The author, acknowledging their position of privilege and lack of lived experience with disability related inequality, avoids anecdotal evidence and focuses on systematic data analysis to identify patterns and disparities.

The report explores underlying factors such as inaccessible environments, lack of reasonable adjustments, occupational segregation, and societal attitudes, alongside discrimination, to inform sustainable change. By linking the latest WDES data to Trust wide initiatives and identifying areas for further intervention, it underscores that action is needed, as ableism and bias can go underreported.

Background:

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Introduced by NHS England in 2019, WDES is a mandatory framework under the NHS Standard Contract to improve inclusion and address inequalities for disabled staff. It compares disabled and non-disabled staff experiences across ten indicators: workforce metrics (1–3), staff survey results (4–9), and board representation (10).

This report presents the Trust's 2024/25 WDES data, reflecting on trends and the impact of past initiatives. Submissions and action plans are published annually for transparency. Success is defined in equity terms, recognising that disparities may widen even where experiences improve.

Year on Year Indicator Scores and Equity Shifts (2024/25 vs 2023/24)

To measure progress meaningfully, it is important to define what success looks like in equity terms. Often, disparities between groups can appear to shrink or grow regardless of whether absolute experiences have improved. For example:

- If bullying among disabled staff falls from 20% to 15% but drops further for non-disabled staff (18% to 8%), the gap worsens.
- If both groups decline but the gap narrows, equity may still have improved.

The same applies to "relative likelihood" indicators (e.g., disciplinary action or appointments), where 1.00 reflects parity and any movement away signals inequality.

The Trust's ambition is to reduce disparities while improving overall experience, with future actions guided by clear, measurable outcomes and engagement benchmarks for stronger evaluation.

The table below presents Berkshire Healthcare's Workforce Disability Equality Standard (WDES) indicator scores for the 2024/25 financial year, alongside a comparison to the previous year (2023/24). It highlights whether outcomes for both Disabled and Non-Disabled staff/candidates have improved, declined, or remained the same.
Directional arrows provide a quick visual reference:

- **Green** arrows indicate improvement
- **Red** arrows indicate deterioration
- **Black** arrows indicate no change

In addition to individual group performance, the table also captures **changes in equity** between the two groups. For example, even where both groups have improved, the equity gap may have widened if one group improved more significantly than the other. To reflect this, an additional column presents changes in equity variance between 2023/24 and 2024/25, with coloured ticks and crosses, showing whether the shift represents a positive or negative movement in fairness and parity between groups.

		2024/2025 score with variance rate since 23/24		
WDES Indicator	**Metric Descriptor**	**Disabled**	**Non-Disabled**	**Change in Equity score variance since 23/24**
1 Take me to Data	Percentage of staff in Agenda for Change pay bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.	See appendices	See appendices	
2 Take me to Data	Likelihood of being appointed from shortlisting	**0.91** (Previous score n/a)	**1.1** (↓ 0.05)	0.05 ✓
3 Take me to Data	Likelihood of entering the formal disciplinary process	**1.63** (↓ 2.29)	**0.62** (Previous score n/a)	2.29 ✓
4a Take me to Data	Harassment, bullying or abuse in the last 12 months – From patients, their relatives or public	**19.8** (↓ 4.7)	**18.2** (↑ 0.1)	4.8 ✓
4b Take me to Data	Harassment, bullying or abuse in the last 12 months – from Managers	**7** (↓ 4.4)	**5.8** (↑ 0.9)	5.3 ✓
4c Take me to Data	Harassment, bullying or abuse in the last 12 months – from colleagues	**12.2** (↓ 4.9)	**10.4** (↓ 0.1)	4.8 ✓
4d Take me to Data	Harassment, bullying or abuse – reporting it	**65.2** (↑ 5.9)	**64.7** (↑ 2.5)	3.4 ✓
5 Take me to Data	Percentage of staff believing the Trust provides equal opportunities for career progression or promotion	**59.9** (↑ 2.1)	**66.7** (↑ 0.7)	1.4 ✓
6 Take me to Data	Percentage of staff feeling pressured to come to work when unwell	**21.1** (↓ 1.2)	**11.1** (↓ 3.2)	2 ✗

7 Take me to Data	Percentage of staff saying that they are satisfied with the extent to which the organisation values their work	**55.2** (↑ 1.5)	**64.8** (↑ 0.6)	0.9 ✓
8 Take me to Data	Percentage of staff saying the organisation has made adequate adjustments for them in their role	**81.9** (↑ 0.9)	n/a	n/a
9 Take me to Data	NHS Staff Survey and the engagement of Disabled staff	**7.1** (↔ 0)	**7.6** (↔ 0)	**0** ↔
10 Take me to Data	Board membership	**-2%** (↓ 2)	**8%** (↑ 8)	2 ✗

Ranking Indicators by Level of Inequity

To better illustrate areas of inequity, we have converted staff survey percentage scores into "likelihood to" ratios, enabling consistent comparison across indicators. This was done by first expressing each group's percentage as a ratio (e.g., 40% = **0.40**) and then dividing the higher-scoring group by the lower to calculate a likelihood ratio. This approach aligns with the NHS's adverse impact threshold of **1.25**, commonly used to flag meaningful disparities.

Two indicators listed below exceed this threshold. Rows highlighted in orange indicate instances where 2024/25 scores surpass the **1.25** mark, suggesting potential areas of concern. Rows shaded in green represent indicators where equity has not yet reached the concern threshold but still falls short of full parity.

Group with greatest likelihood	Likelihood score	Indicator	Above NHS adverse impact rate of 1.25
Disabled	1.9	Percentage of staff feeling pressured to come to work when unwell	Yes
Disabled	1.63	Relative likelihood of staff entering the formal disciplinary process	Yes
Disabled	1.21	Harassment, bullying or abuse in the last 12 months – from Managers	No
Disabled	1.17	Harassment, bullying or abuse in the last 12 months – from colleagues	No
Disabled	1.17	Percentage of staff saying that they are satisfied with the extent to which the organisation values their work	No
Non-Disabled	1.11	Percentage of staff believing the Trust provides equal opportunities for career progression or promotion	No
Non-Disabled	1.1	Likelihood of being appointed from shortlisting	No
Disabled	1.09	Harassment, bullying or abuse in the last 12 months – From patients, their relatives or public	No
Non-Disabled	1.07	NHS Staff Survey and the engagement of Disabled staff	No
Disabled	1.01	Harassment, bullying or abuse – reporting it	No

Key Themes and Insights:

The appendices of this paper provide a detailed breakdown of each WDES indicator and a profile of the Trust's workforce composition relating to disability.

Increasing Disability Representation and Its Impact on Indicator Scores
The proportion of disabled staff in the Trust increased from **7.24%** (378 staff) in March 2024 to **8.68%** (477 staff) in March 2025, an increase of **1.4 percentage points**, or **19.9%** as a rate of growth. This upward trend reflects either improved self-reporting, improvements in inclusive recruitment, or both.

However, changes in workforce composition can influence WDES indicator outcomes. For example, if a large proportion of new disabled joiners entered the workforce late in the year, year-end headcount figures could distort indicators that are based on full-year staff experience, particularly those involving disciplinary likelihood.

Age Profile Differences
On average, disabled staff are **1.7** years younger than non-disabled staff at the Trust. While seemingly small, this difference could influence leadership representation or engagement in longer-term development initiatives. It may also influence the

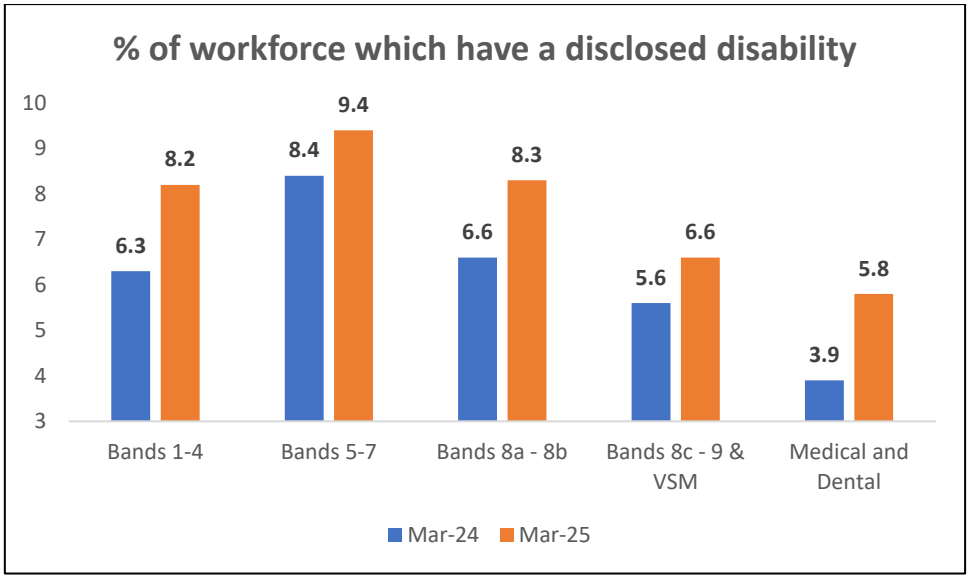
interpretation of indicator scores relating to Board membership (Indicator 10) and senior AfC band representation (Indicator 1). Age and tenure should be considered along with any identified systemic barriers for future interventions in leadership representation.

Full-Time Equivalent (FTE) Differences
Disabled staff work an average of **0.02 FTE** more than non-disabled staff. While this difference is small, it may still contribute to variation in experience-based indicators such as:

- Indicator 6 (pressure to work when unwell)
- Indicator 3 (disciplinary likelihood)
- Indicator 4 (harassment and abuse)

These indicators are calculated using headcount-based denominators, meaning they do not account for differences in the number of hours worked. As a result, even small differences in FTE may introduce a slight distortion, as staff working more hours have more potential for exposure to risk, incidents, or pressure points. That said, the FTE variation observed here is minimal and unlikely to be the primary cause of any disparity. It is noted simply as a contextual factor worth keeping in mind when interpreting experience-based indicators.

Indicator 1 – Representation Across Agenda for Change Bands
Representation increased across all AfC band clusters between March 2024 and March 2025:



Although the 8c–9/VSM group remains the least represented overall, all bands in this cluster except for band 8c (which have **2.9%** of its workforce having a disclosed disability) are now above the Trust average, suggesting a narrowing of the leadership representation gap, but further work to understand this potential outlier would be useful when reviewing leadership representation.

However, the disability status of a significant portion of staff remains unknown, particularly among medical and dental staff, where **48%** have not disclosed. This poses a data quality issue and efforts to improve declaration rates must remain.

Indicator 2 – Likelihood of Appointment from Shortlisting
The likelihood of non-disabled candidates being appointed reduced from **1.15** to **1.10**, reflecting progress. However, a review of shortlisting behaviour indicated that several disabled applicants were flagged as “interview reserve” candidates. This raises concerns about full implementation of the Guaranteed Interview Scheme and is currently under review.

An intersectional analysis showed the following order of appointment likelihood:

1. Disabled females: **0.32** (most likely)
2. Non-disabled females: **0.31**
3. Non-disabled males: **0.23**
4. Disabled males: **0.13** (least likely)

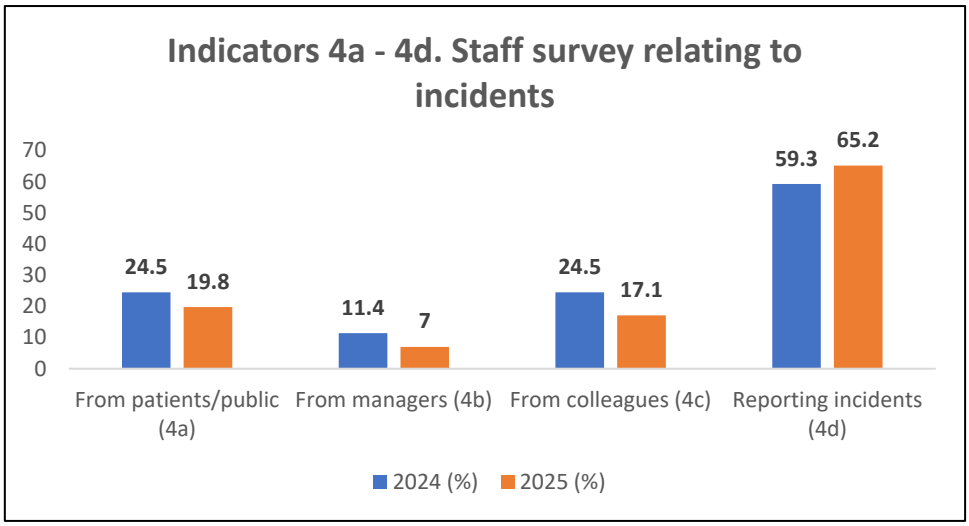
This raises questions about how gender intersects with disability status in recruitment outcomes. For instance, female candidates overall were 1.47 times more likely to be appointed than males, a stronger disparity than that seen between disabled and non-disabled candidates (1.10 likelihood).

This suggests that gender, alongside disability, is influencing recruitment outcomes in ways that may not be immediately visible in headline WDES scores.

Indicator 3 – Disciplinary Process
The likelihood of disabled staff entering the formal disciplinary process fell from being **3.92** as likely compared to non-disabled staff, down to **1.63** as likely, a great improvement. However, this data is highly sensitive to small sample sizes. Just one fewer case in the 2-year reporting period, would reduce the likelihood ratio from **1.63** to **1.08** (near parity).

Given this volatility, drawing systemic conclusions is difficult. Nonetheless, it is encouraging that the trend is downward.

Indicator 4 – Harassment, Bullying or Abuse
Disabled staff experienced marked improvements across all four domains of reported abuse and harassment, with a **5.9 percentage point increase** in the proportion of those reporting incidents. Encouragingly, for the first time, a **higher** proportion of disabled staff **(65.2%)** reported concerns than non-disabled staff (**64.7%**), signalling positive movement in psychological safety and trust in reporting mechanisms. This may reflect ongoing cultural work within the Trust to challenge unacceptable behaviours and foster a more supportive environment.
Despite these gains, disabled staff continue to report higher overall rates of harassment, bullying, or abuse than non-disabled colleagues. While gaps have narrowed, disparities remain and require sustained attention and action.



Understanding the Role of FTE Exposure
Although the difference in average FTE between disabled and non-disabled staff is small **(0.02)**, staff working more hours may naturally face greater exposure to challenging or risk-prone environments, particularly in patient-facing roles. Since the **survey data is based on headcount rather than hours worked**, even minimal differences in FTE can contribute to skewed interpretation at scale. For example, a staff member working full time has more potential for exposure than someone working one hour per week, highlighting the need to consider FTE contextually when analysing experience-based indicators. This is not a sole explanation for disparity but represents a variable to bear in mind.

Understanding Perceptions of Harassment and Organisational Culture
Differences in reported experiences may also be shaped by how individuals perceive and interpret workplace behaviours. Disabled staff, particularly those with a history of marginalisation, may possess a heightened awareness of behaviours that signal exclusion or mistreatment. This is not a sign of oversensitivity, but an adaptive response informed by lived experiences.

Research supports this view: workers from marginalised groups often exhibit stronger emotional and psychological responses to interpersonal conflict and may be more attuned to perceived injustices (Okechukwu et al., 2014; Fox & Stallworth, 2005). Attribution theory and social context also play a role, how we interpret workplace behaviours is shaped by our history, identity, and expectations (Hershcovis & Barling, 2010).

These insights remind us that perception is not separate from reality. Instead, they emphasise the need for a culture that recognises and validates diverse experiences and that invests in **qualitative listening, trauma informed leadership**, and continuous learning to reduce harm and build trust.

Datix Data Gap
An attempt was made to explore patterns in Datix reports, but this was not possible because disability status is not currently recorded, unlike ethnicity. Without this data, we are unable to assess whether formally reported incidents reflect similar patterns to those observed in the staff survey. Capturing disability status in reporting systems, while safeguarding confidentiality, could enhance our ability to identify themes and take targeted action in the future.

Indicator 5 – Perceived Equal Opportunities for Career Progression
Disabled staff reported a modest improvement in perception of equal opportunity, from **57.8% to 59.9%**, though this remains behind non-disabled staff at **66.7%**. The perception gap (**6.8 percentage points**) signals ongoing concerns about fairness and inclusivity in career development.

Yet the actual promotion data tells a more positive story:

- **15.1% of AfC disabled staff** were promoted in 2024/25
- Compared to **10.5% of AfC non-disabled staff**

This is an encouraging outcome, but it also highlights a difference between lived experience and statistical progress.

Understanding Perceptions of Inequity in Career Progression Despite Positive Trends
The research and theories discussed earlier, particularly those discussing perceptual thresholds and increased awareness of systemic inequities, offer important insight into how disabled staff may experience and interpret fairness in progression pathways.

Although 2024/25 data shows higher promotion rates for disabled staff, many continue to report **lower confidence in recruitment and progression systems**. This underscores that equity is not solely about outcomes, but also about how processes are experienced. Contributing factors may include:

- **Cumulative experiences of exclusion**: Ongoing or historical exposure to ableism—whether subtle or explicit—can foster a well-founded expectation of disadvantage, even when metrics improve.
- **Interpretation shaped by prior barriers**: Past exclusion may lead staff to approach processes with caution, particularly where ambiguity exists.
- **Lack of visible representation**: Many areas of leadership include staff with disclosed disabilities, but lots of conditions are non-visible, and people choose not to widely share personal information. This can lead to perceptions of underrepresentation, even when inclusion efforts are present.

Valuing Perceptions as Indicators of Systemic Barriers
These perspectives do not diminish the progress made. Rather, they remind us that **perception is a legitimate indicator of organisational climate**. A truly inclusive system is one in which staff feel as supported and empowered as they are in measurable terms. Building this trust requires more than metrics, it requires representation, transparency, co-designed processes, and meaningful engagement with lived experience.

Indicator 6 – Pressure to Work When Unwell
This indicator reflects the percentage of staff who reported feeling pressured by their manager to attend work despite not feeling well enough to perform their duties. In 2024/25:

- **Disabled staff:** ↓ from 22.3% to 21.1%
- **Non-disabled staff:** ↓ from 14.3% to 11.1%

Although both groups improved, disabled staff remain almost twice as likely to report pressure, highlighting a continued inequality that warrants deeper understanding.

How the Survey Question Works
The NHS Staff Survey routes respondents through a sequence of related questions:

1. **Q11d** – “In the last 3 months, have you come to work despite not feeling well enough to perform your duties?”
2. **Q11e** – “On those occasions, have you felt pressure from your manager to attend work?”

Only staff who answered “yes” to Q11d are asked Q11e. This means the WDES indicator is not based on the whole workforce, but only on the subset of staff who both felt unwell *and* still came to work. Staff who felt unwell but chose to stay home, often precisely because they did **not** feel pressure to attend, are excluded from the calculation.

Organisational Context and Disability Sickness
Disabled staff continue to show higher sickness incidence (76.7% vs 70.0% for non-disabled staff). This has two effects:

- A larger proportion of disabled staff are eligible for Q11d, because they have been unwell.
- From this larger base, more disabled staff then flow into Q11e, where the WDES figure is drawn.

Therefore, the reported gap is shaped not only by differences in perceived managerial pressure, but also by structural differences in sickness patterns.

Worked Example of the Question Pathway
To illustrate:

- Imagine 100 disabled staff. 77 report being unwell. Of those, 40 attend work while unwell, and 20 feel pressured. This results in 20% of disabled staff overall being counted in the WDES measure.
- Now imagine 100 non-disabled staff. 70 report being unwell. Of those, 30 attend work while unwell, and 15 feel pressured. This results in 15% overall being counted.

In both groups, half of those who worked while unwell felt pressured. The *rate of pressure itself* is identical. But because more disabled staff experience sickness and therefore enter the question pathway, the overall percentage appears higher. This structural difference creates a statistical artefact that should be recognised in interpretation.

Perceptual Factors and Organisational Culture
Alongside these structural effects, perceptions of pressure cannot be separated from organisational culture. Disabled staff may be more attuned to subtle signals of expectation, especially where past experiences include stigma, scrutiny of sickness, or a culture of presenteeism.

Importantly, this is not an overreaction, but a valid and trauma-informed response shaped by previous exposure to environments where being unwell has carried negative consequences. Trauma informed leadership recognises that perceived pressure reflects broader organisational patterns. Building truly supportive workplaces involves more than process compliance, it requires trust, understanding, and psychological safety.

Indicator 7 – Feeling Valued by the Organisation
Disabled staff reported improved perceptions this year, with 55.2% agreeing that the organisation values their work, up from 53.7% in 2024. However, this remains 9.6 percentage points lower than the 64.8% reported by non-disabled staff, highlighting a persistent disparity in perceived value.

This perception gap may be partly shaped by **the psychological and contextual factors** outlined earlier in the paper, particularly around heightened sensitivity to organisational injustice (Okechukwu et al., 2014; Hershcovis & Barling, 2010). The cumulative impact of negative workplace experiences, even when improving, can still inform how valued staff feel within their teams and by the wider organisation. More work is needed to understand this score by listening to our people.

Indicator 8 – Reasonable Adjustments
The proportion of disabled staff who feel the Trust has made adequate adjustments to support them rose slightly this year from **81% to 81.9%**, continuing a now four year plateau at around 81%. While this figure remains **well above the NHS average** (73.4% in the last reported year), nearly 1 in 5 disabled colleagues still feel that their needs are not being adequately met.

Given the relatively static trend, this year's marginal improvement may be partly due to the **quality improvement project** aimed at enhancing the **timeliness and accessibility of workplace adjustments**, which included changes to the request process and the **introduction of the Inclusion Passport**. However, despite structural progress, the lived experience of a sizable minority of disabled staff suggests further action is needed to make support more consistent and responsive.

As referenced earlier in the paper, perceptions of fairness and inclusion are influenced not only by process but by **individual sensitivity to workplace experiences**. Disabled staff may be more attuned to delays or inconsistencies, particularly where adjustments are pivotal to their day-to-day functioning. Continued co-design of processes and greater transparency on adjustments uptake may be key next steps in addressing this.

Indicator 9 – Engagement
The overall **engagement score** for disabled staff remained unchanged at **7.1**, compared to **7.6 for non-disabled staff**, a **0.5-point gap** that has now persisted for four years. While this appears modest, analysis of the nine engagement sub questions shows a **consistent pattern of lower scores** among disabled staff across all categories, with relative likelihood scores for disabled staff ranging from **0.88 to 0.94**.

This engagement gap reflects a blend of **systemic experience and structural difference**. Earlier sections of the paper referenced how **higher FTE rates** and **elevated sensitivity to perceived injustice** may contribute to lower engagement for disabled staff, even when objective measures (like promotion rates or CPD access) show progress. This reinforces the idea that perception must be considered alongside performance when assessing inclusion outcomes.

The Trust continues to take active steps to amplify the voices of disabled staff, including via a well-supported Purple Staff Network, protected time for the Chair, executive sponsorship, and involvement in policy co-design and strategic forums such as the Diversity Steering Group. These mechanisms demonstrate clear intent to hear and act on feedback from disabled colleagues, and may play a vital role in shifting long-term engagement levels, particularly if paired with work to address sub-question gaps around autonomy, involvement and motivation.

Indicator 10 – Board Representation
For 2024/25, disabled staff are **underrepresented on the voting Board by 2 percentage points**, down from 0% the previous year. However, this figure may appear more significant than it truly is, given the small size of the Board and minimal underlying change.

The number of disabled Board members remained constant at **1**, while the total number of voting members rose from **13 to 14** following a single additional appointment. At the same time, the proportion of disabled staff in the overall workforce increased, raising the threshold for proportional parity.

This means the entire shift in Indicator 10 was driven by **a single personnel change**, highlighting how sensitive this metric is to even one appointment. Had that new member identified as disabled, representation would have reached **15.38%**, making disabled staff **overrepresented by 7 percentage points** on the Board.

This volatility, caused by a small dataset, is similar to the dynamic explored earlier in the paper regarding disciplinary data. While it's important to monitor representational trends, it's equally critical not to overinterpret minor numerical shifts when so few individuals affect the outcome. Future reporting should continue to accompany Indicator 10 results with context about absolute numbers to ensure proportionate and informed interpretation.

Conclusion:

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This year's Workforce Disability Equality Standard (WDES) submission has highlighted several encouraging developments across multiple indicators, alongside areas that continue to require focused attention. Most notably, significant improvements were seen in disabled staff's experience of bullying, harassment and abuse (Indicator 4), with reductions across all measured sources, and in reporting rates, where for the first time, disabled staff surpassed their non-disabled colleagues in their likelihood to report incidents. Such progress reflects the positive impact of targeted interventions and sustained efforts to improve the organisational culture.

However, disparities still exist. Disabled staff remain more likely to experience negative behaviours at work, and the gap in staff perceptions of equal opportunities for career progression (Indicator 5) persists despite strong evidence of improved promotion rates for disabled staff this year. This disconnect, between perception and outcome highlights the complex relationship between experience, identity, and organisational messaging and reinforces the importance of aligning not just policy and practice, but also narrative and trust.

Several themes emerged across the indicators that suggest underlying structural and contextual influences on WDES outcomes. For example, higher average sickness rates among disabled staff affect scores related to presenteeism (Indicator 6), while differences in average FTE may contribute to increased exposure to risk and incidents. As highlighted earlier in the paper, metrics based solely on headcount rather than exposure, adjusted or time-sensitive measures can skew interpretations. This is particularly true for Indicators 3 and 10, where small data volumes and static board composition mean that even a single change can disproportionately impact the Trust's scores.

The Trust has taken meaningful steps to support disabled colleagues, such as launching a Quality Improvement project focused on the timeliness and accessibility of reasonable adjustments, and continuing to fund and strengthen the Purple Staff Network. However, sustainable improvement will require continued action to integrate disabled voices at every level of the organisation, ensure psychological safety in speaking up, and build robust systems for capturing data that reflect the complexity of workforce dynamics.

The improvements made this year are a testament to the efforts of our staff, equality networks, and leadership but the journey toward equity is ongoing. The Trust remains committed to embedding inclusion at every level and ensuring that disability is not just accommodated, but actively supported and empowered in our workplace.

Next Steps:

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A number of provisional recommendations have been made attributed to improving the process revolving the entire WDES process and where possible attributed to a particular indicator.

These actions may not all be possible, or not all possible in the short term, and so these suggestions along with those made by relevant stakeholders will be reviewed and agreed as part of the process of agreeing an action plan in response to this year paper, in collaboration with our staff networks and Diversity Steering Group.

You can find a list of provisional recommendations in the table below.

Provisional Recommendation	Relevant WDES Indicator(s)
Review feasibility of automated emails to staff with "unknown" or "not disclosed" disability status to encourage updates every 6 months	General
Prioritise capturing disability status in medical and dental staff where 48% is unknown	Indicator 1
Explore unknown rates of disability status by age range within the workforce and attempt to understand any emerging patterns	Indicator 1
Review option to capture disability status in Datix reporting to enable incident analysis by disability	Indicator 4, 5
Benchmark WDES indicators against South East mental health trusts instead of NHS overall	General
Develop new internal equality metrics aligned to Trust priorities	General
Audit whether ATS can identify whether candidates: (1) met essential criteria; (2) were appointable, regardless of outcome	Indicator 2
Resolve "interview: reserve" classification issue to ensure accurate shortlisting reporting	Indicator 2
Review standard application form to review and remove where possible, areas of potential identifying info (e.g. school names)	Indicator 2
Launch an applicant experience survey post-interview to assess perceived fairness, particularly among disabled candidates	2, 5, 7

Improve personalised feedback for internal disabled applicants; review use of automated templates	2
Consider whether disciplinaries cluster in first year of employment as part of the casework review	Indicator 3
Advocate to NHS England for FTE-based calculations and start-of-year figures for Indicator 3	Indicator 3
Develop a RAG rating system for likelihood indicators (e.g. 1–1.1 = green)	Indicator 2, 3
Create likelihood scores for survey-based indicators (engagement, value, pressure, etc.)	Indicator 4, 5, 6, 7, 8
Work with Purple Network to understand perceptions of unfairness in progression	Indicator 5, 7
Continue with 360-degree feedback for managers, as well as management and leadership development to support to more inclusive management practices. Continue to embed inclusion passport and awareness around reasonable adjustments	Indicator 8
Continue to improve reasonable adjustments processing and communication for disabled staff, sharing data with the Purple Network to monitor progress	Indicator 8
Pilot satisfaction survey or tracking system post-adjustment implementation	Indicator 8
Maintain Purple Staff Network activities and funding and continue to include the network in policy co-design	Indicator 9
Look into whether it is possible to introduce new sickness rates metrics/data collection e.g. sickness rates by disability status	Indicator 6
Include absolute numbers alongside % in Indicator 10 to contextualise Board change and pair representation data with tenure and turnover analysis at Board level	Indicator 10
Confirm Guaranteed Interview Scheme is fully implemented for disabled applicants, especially at senior levels	Indicator 2

Short Version Appendices:

Workforce Profile:

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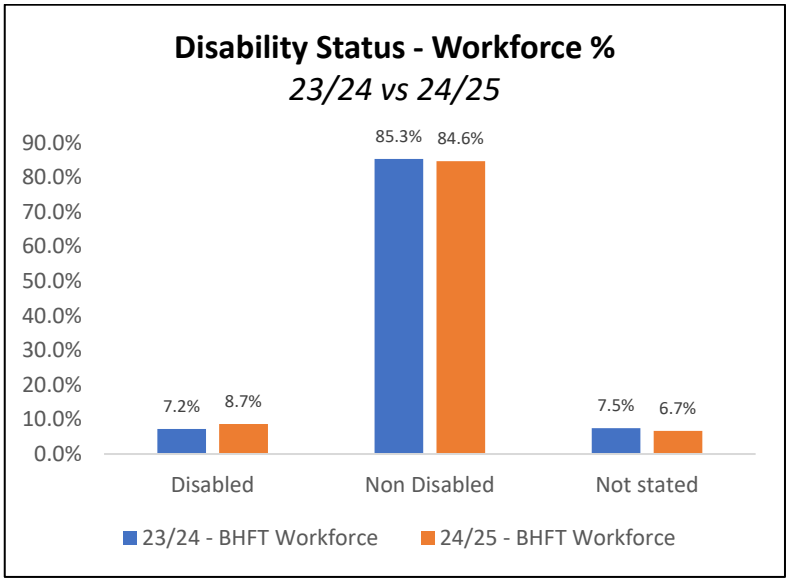
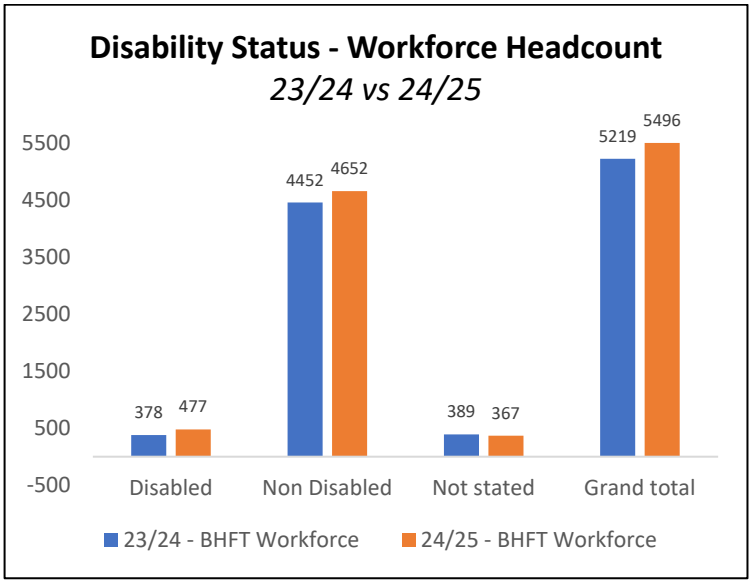
BHFT Workforce compared to Berkshire Population (from census data,2021)





	Disabled	Non-Disabled	Not stated
23/24 - BHFT Workforce	7.24%	85.30%	7.45%
24/25 - BHFT Workforce	8.68%	84.64%	6.68%
Berkshire Population	13%	87%	0%
Predicted economically active disabled population***	7.50%	87%	0%
Difference in % points – 24/25 BHFT workforce vs Predicted economically active disabled population	1.18%	-2.36%	6.68%

***While specific Berkshire population data on how many of the 13% have disabilities preventing them from entering the workforce cannot be attained, nationally, 42.3% of individuals with disabilities were neither working nor actively seeking work. (Gov.UK, 2023)
Applying this figure to our Berkshire population rates implies that approximately 7.5% of the assumed population of Berkshire with disabilities can enter the workforce. Consequently, this indicates that we have more staff with disabilities than the proportion of the Berkshire population with disabilities.

Workforce Profile: Full-Time Status and Age

	Disabled	Non-Disabled
% who work full time	69.3	64.9
Average FTE	0.89	0.87
Average age	42.13	43.79
% contribution to trusts 16-25 years' workforce	12.6	86
% contribution to trusts 26-35 years' workforce	11.1	85
% contribution to trusts 36-45 years' workforce	8.7	86.1
% contribution to trusts 46-55 years' workforce	7.3	86.4
% contribution to trusts 56-65 years' workforce	7.9	81.6

% contribution to trusts 66 plus years workforce	**6**	**70.5**

*Note that when comparing the % each of the groups make towards the stated age range of the workforce, the calculations include staff where their disability status is not known, although this group (disability status not known) was not included in the data presented. This is why the rates between the 2 groups do not combine to make 100%.

WDES Indicators:

1. **Percentage of staff in each of the Agenda for Change (AfC) Bands 1-9 and Very Senior Manager (VSM) roles (including executive board members) compared with the percentage of staff in the overall workforce**

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Workforce Profile – Non-clinical Staff 2023-25

Pay Band	2023 Non-Clinical Workforce Data				2024 Non-Clinical Workforce Data				2025 Non-Clinical Workforce Data			
	Total Staff	Disabled	Non-Disabled	Not stated	Total Staff	Disabled	Non-Disabled	Not stated	Total Staff	Disabled	Non-Disabled	Not stated
Under Band 1	2	0 (0%)	2 (100%)	0 (0%)	**0**	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)
Band 1	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)
Band 2	60	3 (5%)	50 (83.3%)	7 (11.7%)	65	3 (4.6%)	55 (84.6%)	7 (10.8%)	53	5 (9.4%)	43 (81.1%)	5 (9.4%)
Band 3	275	14 (5.1%)	248 (90.2%)	13 (4.7%)	298	15 (5%)	272 (91.3%)	11 (3.7%)	309	24 (7.8%)	274 (88.7%)	11 (3.6%)
Band 4	298	16 (5.4%)	254 (85.2%)	28 (9.4%)	305	19 (6.2%)	259 (84.9%)	27 (8.9%)	316	30 (9.5%)	262 (82.9%)	24 (7.6%)
Band 5	143	10 (7%)	126 (88.1%)	7 (4.9%)	153	12 (7.8%)	130 (85%)	11 (7.2%)	150	15 (10%)	125 (83.3%)	10 (6.7%)
Band 6	153	7 (4.6%)	141 (92.2%)	5 (3.3%)	163	9 (5.5%)	149 (91.4%)	5 (3.1%)	162	14 (8.6%)	142 (87.7%)	6 (3.7%)
Band 7	123	10 (8.1%)	103 (83.7%)	10 (8.1%)	126	8 (6.3%)	111 (88.1%)	7 (5.6%)	130	10 (7.7%)	114 (87.7%)	6 (4.6%)
Band 8a	95	8 (8.4%)	81 (85.3%)	6 (6.3%)	95	6 (6.3%)	83 (87.4%)	6 (6.3%)	106	9 (8.5%)	92 (86.8%)	5 (4.7%)
Band 8b	66	5 (7.6%)	55 (83.3%)	6 (9.1%)	55	8 (14.5%)	45 (81.8%)	2 (3.6%)	69	12 (17.4%)	55 (79.7%)	2 (2.9%)
Band 8c	33	0 (0%)	26 (78.8%)	7 (21.2%)	35	0 (0%)	27 (77.1%)	8 (22.9%)	38	2 (5.3%)	29 (76.3%)	7 (18.4%)
Band 8d	16	1 (6.3%)	13 (81.3%)	2 (12.5%)	15	1 (6.7%)	12 (80%)	2 (13.3%)	16	1 (6.3%)	14 (87.5%)	1 (6.3%)
Band 9	8	1 (12.5%)	6 (75%)	1 (12.5%)	4	0 (0%)	3 (75%)	1 (25%)	9	2 (22.2%)	6 (66.7%)	1 (11.1%)
VSM	9	1 (11.1%)	6 (66.7%)	2 (22.2%)	8	1 (12.5%)	5 (62.5%)	2 (25%)	8	1 (12.5%)	6 (75%)	1 (12.5%)
Total	**1281**	**76 (5.9%)**	**1111 (86.7%)**	**94 (7.3%)**	**1322**	**82 (6.2%)**	**1151 (87.1%)**	**89 (6.7%)**	1366	**125 (9.2%)**	**1162 (85.1%)**	**79 (5.8%)**

Workforce Profile – Clinical Staff 2023-25

Pay Band	2023 Clinical Workforce Data				2024 Clinical Workforce Data				2025 Clinical Workforce Data			
	Total Staff	Disabled	Non-Disabled	Not stated	Total Staff	Disabled	Non-Disabled	Not stated	Total Staff	Disabled	Non-Disabled	Not stated
Under Band 1	13	2 (15.4%)	11 (84.6%)	0 (0%)	7	1	6	0 (0%)	13	3 (23.1%)	10 (76.9%)	0 (0%)
Band 1	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)
Band 2	167	8 (4.8%)	147 (88%)	12 (7.2%)	183	8 (4.4%)	164 (89.6%)	11 (6%)	56	3 (5.4%)	50 (89.3%)	3 (5.4%)
Band 3	358	13 (3.6%)	318 (88.8%)	27 (7.5%)	354	8 (2.3%)	324 (91.5%)	22 (6.2%)	505	10 (2%)	471 (93.3%)	24 (4.8%)
Band 4	484	45 (9.3%)	417 (86.2%)	22 (4.5%)	515	54 (10.5%)	439 (85.2%)	22 (4.3%)	546	72 (13.2%)	452 (82.8%)	22 (4%)
Band 5	468	39 (8.3%)	405 (86.5%)	24 (5.1%)	500	39 (7.8%)	436 (87.2%)	25 (5%)	542	53 (9.8%)	466 (86%)	23 (4.2%)
Band 6	811	53 (6.5%)	708 (87.3%)	50 (6.2%)	784	79 (10.1%)	664 (84.7%)	41 (5.2%)	832	76 (9.1%)	715 (85.9%)	41 (4.9%)
Band 7	760	53 (7%)	653 (85.9%)	54 (7.1%)	869	71 (8.2%)	748 (86.1%)	50 (5.8%)	929	91 (9.8%)	787 (84.7%)	51 (5.5%)
Band 8a	271	14 (5.2%)	247 (91.1%)	10 (3.7%)	296	18 (6.1%)	267 (90.2%)	11 (3.7%)	319	24 (7.5%)	286 (89.7%)	9 (2.8%)
Band 8b	98	6 (6.1%)	87 (88.8%)	5 (5.1%)	113	5 (4.4%)	104 (92%)	4 (3.5%)	112	5 (4.5%)	103 (92%)	4 (3.6%)
Band 8c	26	0 (0%)	24 (92.3%)	2 (7.7%)	35	1 (2.9%)	33 (94.3%)	1 (2.9%)	32	0 (0%)	31 (96.9%)	1 (3.1%)
Band 8d	18	2 (11.1%)	14 (77.8%)	2 (11.1%)	20	2 (10%)	17 (85%)	1 (5%)	16	2 (12.5%)	13 (81.3%)	1 (6.3%)
Band 9	3	0 (0%)	3 (100%)	0 (0%)	6	2 (33.3%)	3 (50%)	1 (16.7%)	3	0 (0%)	2 (66.7%)	1 (33.3%)
VSM	1	0 (0%)	1 (100%)	0 (0%)	1	0 (0%)	1 (100%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)

Total	3478	235 (6.8%)	3035 (87.3%)	208 (6%)	3683	288 (7.8%)	3206 (87%)	189 (5.1%)	3905	339 (8.7%)	3386 (86.7%)	180 (4.6%)

Workforce Profile – Medical & Dental staff 2023-2025

Pay Band	2023 Clinical (Medical & Dental) Workforce				2024 Clinical (Medical & Dental) Workforce				2025 Clinical (Medical & Dental) Workforce			
	Total Staff	Disabled	Non-Disabled	Not stated	Total Staff	Disabled	Non-Disabled	Not stated	Total Staff	Disabled	Non-Disabled	Not stated
Consultants	93	3 (3.2%)	48 (51.6%)	42 (45.2%)	91	4 (4.4%)	47 (51.6%)	40 (44%)	101	6 (5.9%)	53 (52.5%)	42 (41.6%)
Non-consultant Career Grade	82	4 (4.9%)	42 (51.2%)	36 (43.9%)	81	3 (3.7%)	42 (51.9%)	36 (44.4%)	84	4 (4.8%)	44 (52.4%)	36 (42.9%)
Trainee Grade	27	0 (0%)	1 (3.7%)	26 (96.3%)	35	1 (2.9%)	1 (2.9%)	33 (94.3%)	40	3 (7.5%)	7 (17.5%)	30 (75%)
Total	202	7 (3.5%)	91 (45%)	104 (51.5%)	207	8 (3.9%)	90 (43.5%)	109 (52.7%)	225	13 (5.8%)	104 (46.2%)	108 (48%)

Workforce Profile – All staff 2023-2025 (across 3 years)

Pay Band	2023 All Staff Workforce Data				2024 All Staff Workforce Data				2025 All Staff Workforce Data			
	Total Staff	Disabled	Non-Disabled	Not stated	Total Staff	Disabled	Non-Disabled	Not stated	Total Staff	Disabled	Non-Disabled	Not stated
Under Band 1	15	2 (13.3%)	13 (86.7%)	0 (0%)	7	1 (14.3%)	6 (85.7%)	0 (0%)	13	3	10	0 (0%)
Band 1	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)
Band 2	227	11 (4.8%)	197 (86.8%)	19 (8.4%)	248	11 (4.4%)	219 (88.3%)	18 (7.3%)	109	8 (7.3%)	93 (85.3%)	8 (7.3%)
Band 3	633	27 (4.3%)	566 (89.4%)	40 (6.3%)	652	23 (3.5%)	596 (91.4%)	33 (5.1%)	814	34 (4.2%)	745 (91.5%)	35 (4.3%)
Band 4	782	61 (7.8%)	671 (85.8%)	50 (50%)	820	73 (8.9%)	698 (85.1%)	49 (6%)	862	102 (11.8%)	714 (82.8%)	46 (5.3%)
Band 5	611	49 (8%)	531 (86.9%)	31 (5.1%)	653	51 (7.8%)	566 (86.7%)	36 (5.5%)	692	68 (9.8%)	591 (85.4%)	33 (4.8%)
Band 6	964	60 (6.2%)	849 (88.1%)	55 (5.7%)	947	88 (9.3%)	813 (85.9%)	46 (4.9%)	994	90 (9.1%)	857 (86.2%)	47 (4.7%)
Band 7	883	63 (7.1%)	756 (85.6%)	64 (7.2%)	995	79 (7.9%)	859 (86.3%)	57 (5.7%)	1059	101 (9.5%)	901 (85.1%)	57 (5.4%)
Band 8a	366	22 (6%)	328 (89.6%)	16 (4.4%)	391	24 (6.1%)	350 (89.5%)	17 (4.3%)	425	33 (7.8%)	378 (88.9%)	14 (3.3%)
Band 8b	164	11 (6.7%)	142 (86.6%)	11 (6.7%)	168	13 (7.7%)	149 (88.7%)	6 (3.6%)	181	17 (9.4%)	158 (87.3%)	6 (3.3%)
Band 8c	59	0 (0%)	50 (84.7%)	9 (15.3%)	70	1 (1.4%)	60 (85.7%)	9 (12.9%)	70	2 (2.9%)	60 (85.7%)	8 (11.4%)
Band 8d	34	3 (8.8%)	27 (79.4%)	4 (11.8%)	35	3 (8.6%)	29 (82.9%)	3 (8.6%)	32	3 (9.4%)	27 (84.4%)	2 (6.3%)
Band 9	11	1 (9.1%)	9 (81.8%)	1 (9.1%)	10	2 (20%)	6 (60%)	2 (20%)	12	2 (16.7%)	8 (66.7%)	2 (16.7%)
VSM	10	1 (10%)	7 (70%)	2 (20%)	9	1 (11.1%)	6 (66.7%)	2 (22.2%)	8	1 (12.5%)	6 (75%)	1 (12.5%)
Consultants	93	3 (3.2%)	48 (51.6%)	42 (45.2%)	91	4 (4.4%)	47 (51.6%)	40 (44%)	101	6 (5.9%)	53 (52.5%)	42 (41.6%)
Non-consultant Career Grade	82	4 (4.9%)	42 (51.2%)	36 (43.9%)	81	3 (3.7%)	42 (51.9%)	36 (44.4%)	84	4 (4.8%)	44 (52.4%)	36 (42.9%)
Trainee Grade	27	0 (0%)	1 (3.7%)	26 (96.3%)	35	1 (2.9%)	1 (2.9%)	33 (94.3%)	40	3 (7.5%)	7 (17.5%)	30 (75%)
Bands 1-4	1657	101 (6.1%)	1447 (87.3%)	109 (6.6%)	1727	108 (6.3%)	1519 (88%)	100 (5.8%)	1798	147 (8.2%)	1562 (86.9%)	89 (4.9%)
Bands 5-7	2458	172 (7%)	2136 (86.9%)	150 (6.1%)	2595	218 (8.4%)	2238 (86.2%)	139 (5.4%)	2745	259 (9.4%)	2349 (85.6%)	137 (5%)
Bands 8a-8b	530	33 (6.2%)	470 (88.7%)	27 (5.1%)	559	37 (6.6%)	499 (89.3%)	23 (4.1%)	606	50 (8.3%)	536 (88.4%)	20 (3.3%)
Bands 8c-9 & VSM	114	5 (4.4%)	93 (81.6%)	16 (14%)	124	7 (5.6%)	101 (81.5%)	16 (12.9%)	122	8 (6.6%)	101 (82.8%)	13 (10.7%)
Total	4759	318 (6.4%)	4237 (85.4%)	406 (8.2%)	5005	378 (7.3%)	4447 (85.3%)	387 (7.4%)	5271	477 (8.7%)	4652 (84.6%)	367 (6.7%)

2. Relative likelihood of staff being appointed from shortlisting

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WDES Indicator	Metric Descriptor		21/22	22/23	23/24	24/25	Change since 23/24	
2	Relative likelihood of Non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts.	Berkshire Healthcare	1.08	0.93	1.15	1.1	-0.05	↓

	*(*A figure above 1:00 indicates that Non-Disabled staff are more likely than Disabled staff to be appointed from shortlisting.)*	**NHS Trusts**	**1.11**	**1.08**	**0.99**			

Likelihood to be appointed from shortlisting from candidates with RTW only

WDES Indicator	Metric Descriptor		Disabled	Non-Disabled	Difference
2	Relative likelihood of Non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts.	**Actual reported scores**	**0.91**	**1.1**	**0.19**
	*(*A figure above 1:00 indicates that Non-Disabled staff are more likely than Disabled staff to be appointed from shortlisting.)*	**Non reported scores (RTW applicants only)**	**0.87**	**1.15**	**0.28**

Application rates

	Disabled	Non-Disabled
Applications	**2,010**	**37,204**
Applications with right to work	**1,807**	**17,511**
% of applications with right to work	**89.9**	**47.07**

Likelihood of being shortlisted from application compared to likelihood of appointment from interview

WDES Indicator	Metric Descriptor		Disabled	Non-Disabled	Difference
2	Relative likelihood of being shortlisted from application across all posts	**Candidates with RTW only**	**0.89**	**1.12**	**0.23**
	Relative likelihood of being appointed from shortlisting across all posts		**0.91**	**1.1**	**0.19**

Likelihood to be appointed from shortlisting from candidates with RTW only (Disability status vs Gender)

WDES Indicator	Metric Descriptor		Disabled	Non-Disabled	Male	Female
2	Disability status	**Non reported scores**	**0.91**	**1.1**		

	Gender	(RTW applicants only)			0.68	1.47

Intersectional Analysis of Recruitment Outcomes

Disability and Gender groups	Interview to offer ratio %
Disabled female	0.32
Non-disabled female	0.31
Non-disabled male	0.23
Disabled male	0.13

Interviews by Disability and Gender

Interviews by Disability and Gender	Disabled	Non-Disabled
Male	150	1,046
Female	380	3,450
Total applications	530	4,496
% which were male	28.3	23.3

External Hires by Disability Status

	No	Disability status unknown	Yes	Grand Total	% of hires which have disclosed disability
Band 2	58	1	3	62	4.8
Band 3	155	9	10	174	5.7
Band 4	172	18	29	219	13.2
Band 5	146	3	15	164	9.1
Band 6	103	9	12	124	9.7
Band 7	81	12	15	108	13.9
Band 8a	30	3	2	35	5.7
Band 8b	5	1		6	0
Band 8c	1	0		1	0
Band 8d	1	0		1	0
Band 9	1	0		1	0
AFC only	753	56	86	895	9.6
Band 8b - 9	8	1	0	9	0
All non AFC	24	34	2	60	3.3
Grand Total	777	90	88	955	9.2

3. Relative likelihood of staff entering the formal disciplinary process

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WDES Indicator	Metric Descriptor		21/22	22/23	23/24	24/25	Change since 23/24	
3	Relative likelihood of Disabled staff entering the formal disciplinary process compared to non-disabled staff *(*A figure above 1:00 indicates that Disabled staff are more likely than Non-Disabled staff to enter the formal capability process.)*	Berkshire Healthcare	5.34	1.9	3.92	1.63	-2.29	↓
		NHS Trusts	1.94	2.01	2.17			

The Impact of Small Data Samples on the Likelihood Score

During analysis, it became clear that the small size of the data sample significantly influences the resulting likelihood score, potentially leading to misleading trust-wide conclusions. The score is based on the number of staff entering the formal capability process over a two-year period, excluding cases related to ill health. This number is halved to reflect a one-year period and then divided by the group's headcount as of March 2025, resulting in a ratio for both disabled and non-disabled staff. These ratios are then compared to produce a likelihood score.

However, for disabled staff, the number of cases (excluding ill health) over the two-year period was just 3, equating to 1.5 once halved for the calculation. Drawing conclusions from such a small sample is highly unreliable; a change of just one case over two years would entirely shift the narrative.

To illustrate this, if just one fewer disabled staff member had entered the formal capability process over two years, the halved figure would reduce from 1.5 to 1.0. This alone would cause the likelihood score to drop from 1.63 to 1.08, almost reaching parity.

This demonstrates the volatility of the metric when derived from such small numbers. If just one more or one fewer case can meaningfully change the outcome, it raises serious concerns about the robustness of any conclusions drawn. Statistical reliability requires a tolerance for normal variation and variation of a single individual in a group of 477 should be interpreted with caution.

	March 25 workforce headcount	Average number of staff entering the formal capability process over the last 2 years for any reason. (i.e. Total divided by 2.)	Of these, how many were on the grounds of ill-health?	Likelihood of staff entering the formal capability process
Actual reported score (Disabled)	477	4	2.5	1.63
Actual reported score (non-disabled)	4652	12	2.5	0.62
Score if just 1 fewer disabled staff had a disciplinary (Disabled)	**477**	**3.5**	**2.5**	**1.08**

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

WDES	Metric Descriptor		2021/2022		2022/2023		2023/2024		2024/2025		Change since 23/24	
			Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled
4a Staff Survey Q14A	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	Berkshire Healthcare	30%	20%	27%	20%	24.5%	18.1%	**19.8%**	**18.2%**	-4.7	+0.1

		NHS Trusts	33%	25%	33%	26 %						

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

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			2021/2022		2022/2023		2023/2024		2024/2025		Change since 23/24	
WDES	Metric Descriptor		Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled
4b Staff Survey Q14b	Percentage of staff experiencing harassment, bullying or abuse from managers in last 12 months	Berkshire Healthcare	12%	5%	12%	5%	11.4%	4.9%	**7%**	**5.8%**	-4.4	+0.9
		NHS Trusts	17%	9.6%	16.1%	9.2%						

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

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			2021/2022		2022/2023		2023/2024		2024/2025		Change since 23/24	
WDES	Metric Descriptor		Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled
4c Staff Survey Q14c	Percentage of staff experiencing harassment, bullying or abuse from colleagues in last 12 months	Berkshire Healthcare	19%	11%	18%	12%	17.1%	10.5%	**12.2%**	**10.4%**	-4.9	-0.1
		NHS Trusts	25%	16.4%	24.8%	16.5%						

4d Reporting harassment, bullying or abuse

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			2021/2022		2022/2023		2023/2024		2024/2025		Change since 23/24	
WDES	Metric Descriptor		Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled
4d Staff Survey	Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	Berkshire Healthcare	56%	63%	59.8%	57.3%	59.3%	62.2%	**65.2%**	**64.7%**	+5.9	+2.5
		NHS Trusts	49.9%	48.6%	51.3%	49.5%						

This indicator is the one with the lowest variance and is so close to parity between the two groups that no additional investigation has been deemed necessary to understand the variance.

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

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		2021/2022		2022/2023		2023/2024		2024/2025		Change since 23/24	
WDES	Metric Descriptor	Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled

5 Staff Survey Q15	Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion.	Berkshire Healthcare	53%	64%	61%	65%	57.8%	66%	**59.9%**	**66.7%**	+2.1	+0.7
		NHS Trusts	51.3%	57.2%	52.1%	57.7%						

Actual Promotion Rates by Disability status

The table below presents Agenda for Change (AfC) staff, showing the number of employees in post as of April 2024, how many received a promotion to a higher band, and the resulting promotion rate by disability status.

	Staff in post – April 24		April 24 - March 25 internal promotions		% of staff promoted	
	Non-Disabled	Disabled	Non-Disabled	Disabled	Non-Disabled	Disabled
Band 2	222	9	45	3	20.3	33.3
Band 3	612	22	61	8	10.0	36.4
Band 4	713	77	89	18	12.5	23.4
Band 5	557	51	106	7	19.0	13.7
Band 6	837	90	89	14	10.6	15.6
Band 7	875	78	55	5	6.3	6.4
Band 8a	362	24	17	1	4.7	4.2
Band 8b	158	14	3		1.9	0.0
Band 8c	63	1	1		1.6	0.0
Band 8d	33	4	2		6.1	0.0
Band 9	7	2			0.0	0.0
Grand Total	4439	372	468	56	10.5	15.1

Application Rates: Internal Disability Breakdown

Although we are currently unable to isolate internal applications specifically linked to promotion, we can examine internal job application activity as a proxy.

- In April 2024, disabled staff made up 8.7% of the Trust's overall workforce.
- However, they accounted for 10.1% of all internal job applications, though some individuals submitted multiple applications.

This shows that disabled staff apply for roles at a higher rate than their contribution to the workforce.

6. Percentage of staff feeling pressured to come to work when unwell

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			2021/2022		2022/2023		2023/2024		2024/2025		Change since 23/24	
WDES	Metric Descriptor		Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled
6 Staff Survey Q11e	Percentage of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	Berkshire Healthcare	20%	16%	22.5%	16%	22.3%	14.3%	**21.1%**	**11.1%**	-1.2	-3.2
		NHS Trusts	29.9%	22.1%	27.7%	19.9%						

Staff who had a recorded instance of sickness in 24/25

	Disabled	Non-Disabled
Staff who worked in 24/25	532	5184
Staff who had at least 1 instance of recorded sickness	408	3627
% of staff who had at least 1 instance of recorded sickness	76.69	69.97

7.Percentage of staff saying that they are satisfied with the extent to which the organisation values their work

			2021/2022		2022/2023		2023/2024		2024/2025		Change since 23/24	
WDES	Metric Descriptor		Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled
7 Staff Survey Q4b	Percentage of staff saying that they are satisfied with the extent to which their organisation values their work.	Berkshire Healthcare	52%	61%	52%	61%	53.7%	64.2%	**55.2%**	**64.8%**	+1.5	+0.6
		NHS Trusts	35.1%	44.9%	35.2%	45%						

8. Percentage of staff saying the organisation has made adequate adjustments for them in their role

			2021/2022	2022/2023	2023/2024	2024/2025	Change since 23/24
WDES	Metric Descriptor		Disabled	Disabled	Disabled	Disabled	Disabled
8 Staff Survey Q30b	Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	Berkshire Healthcare	81%	81%	81%	**81.9%**	+0.9
		NHS Trusts	72.2%	73.4%			

9. NHS Staff Survey and the engagement of Disabled staff

			2021/2022		2022/2023		2023/2024		2024/2025		Change since 23/24	
WDES	Metric Descriptor		Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled	Disabled	Non-disabled
9a Staff survey engagement Score	The staff engagement scores for Disabled and Non-Disabled staff	Berkshire Healthcare	7.1	7.5	7.1	7.5	7.1	7.6	**7.1**	**7.6**	0	0
		NHS Trusts	6.5	7	6.4	6.9						
9b	Has Berkshire Healthcare taken action to facilitate the voices of Disabled staff in your organisation to be heard? Please provide an example		Yes									
9b comments			The voices of disabled colleagues are heard via an active, up and running Purple Staff Network, whose Chair has protected time of half a day each week, admin support and a budget for network activities, and a dedicated team's channel for members It also has a Deputy Network Chair and committee members. The Purple Staff Network has Executive level sponsorship (Chief Financial Officer). We had additional sub-groups of carers network and the 'Through the Looking Glass' support group for neurodivergent colleagues The voice of disabled staff is also sought in the co-production of new strategies, policies, and our Staff Network leads have regular meetings with our EDI Leads to help support the implementation of our strategies, as well as being pivotal members on forums such as Diversity Steering Group (DSG), and Staff Network Steering Group. As part of Equality Impact Assessment template and resource revision we have also emphasised the importance of impact and intersectionality when reviewing decisions, polices, events and beyond.							

What does the staff survey engagement section score mean?

The staff engagement score is calculated as the mean of the 9 sub-scores below where at least two of the three sub-scores have been assigned.

Motivation

- Often/always look forward to going to work
- Often/always enthusiastic about my job
- Time often/always passes quickly when I am working

Advocacy

- Care of patients/service users is organisation's top priority
- Would recommend organisation as a place to work
- If friends or relatives needed treatment, would be happy with the standard of care provided by organisation

Involvement

- Opportunities to show initiative in my role
- Able to make suggestions to improve the work of team/dept
- Able to make improvements happen in my area of work

Understanding our scores for each of the 9 sub scores

Below, we present the scores for each of the nine sub-indicators from the 2024 Staff Survey, broken down by disabled and non-disabled staff. Alongside each, we have included the percentage point difference between the two groups. To provide additional context, we have also calculated a likelihood ratio, which offers a more nuanced view of disparity between the groups. This is important because a smaller percentage point difference can, in some cases, represent a much larger difference in relative experience.

For example, if 5% of disabled staff report a particular experience compared to 10% of non-disabled staff, this reflects a 5 percentage point difference, but non-disabled staff are twice as likely to report the experience. In contrast, if 85% of disabled staff report something versus 95% of non-disabled staff, the absolute percentage point gap is larger at 10 points, but the relative difference is smaller, non-disabled staff are only about 1.12 times more likely to report the experience. Therefore, the likelihood score provides insight into the proportional difference in experience between the two groups, not just the absolute gap.

Staff Engagement Question	Disabled	Non-Disabled	% Points Difference	Disabled Likelihood Score	Non-Disabled Likelihood Score
Able to make improvements happen in my area of work	60.5	68.6	8.1	0.88	1.13
Able to make suggestions to improve the work of my team/dept	73.6	82.6	9.0	0.89	1.12
Often/always look forward to going to work	58.1	65.1	7.1	0.89	1.12
Time often/always passes quickly when I am working	71.1	79.6	8.5	0.89	1.12
Opportunities to show initiative frequently in my role	73.1	80.7	7.6	0.91	1.10
Would recommend organisation as place to work	73.0	80.3	7.2	0.91	1.10
Often/always enthusiastic about my job	70.3	76.4	6.2	0.92	1.09
If friend/relative needed treatment would be happy with standard of care provided by organisation	75.1	80.6	5.6	0.93	1.07
Care of patients/service users is organisation's top priority	84.5	90.3	5.8	0.94	1.07

The analysis demonstrates a consistent pattern of disparity between disabled and non-disabled staff across the nine sub-group questions. When these questions are converted to a likelihood score, the highest score for non-disabled staff is 1.13, while the lowest is 1.07, indicating that the variation in inequity among the questions is only 0.06.

Furthermore, when evaluating the scores, it is evident that the highest inequity score of 1.13 remains below the NHS threshold of 1.25, which is considered indicative of an inequity with potential adverse effects.

Work has been initiated with the Purple network to improve the Trust's understanding of these scores.

10. Board membership 2024/25

WDES	Metric Descriptor	2021/2022	2022/2023	2023/2024	2024/2025

9 Board Representation	Percentage difference between Board voting membership and its overall workforce (Disabled)	**Berkshire Healthcare**	Data not available	1%	0%	-2%
		NHS Trusts	Data not available	Data not available	Data not available	
		Number of Disabled Voting Board Members		1	1	1
		Total Number of Voting Board Members		13	13	14

Understanding WDES Indicator 10

When comparing two percentages, such as 30% and 40%, confusion can arise about whether the comparison reflects an absolute difference or a relative difference. The absolute difference is the difference in percentage points, calculated by subtracting the smaller percentage from the larger one: 40% - 30% = 10 percentage points. The relative difference, however, expresses the absolute difference as a percentage of the initial value: (10 / 30) × 100 = 33.33%.

WDES Indicator 10, which compares the proportion of disabled staff on an organisation's board to the Disabled proportion in the overall workforce, can be misunderstood without clear terminology. For clarity, Indicator 10 measures the absolute difference in percentage points. For example, if the board has 30% Disabled representation and the workforce has 40%, the absolute difference is 40 - 30 = 10 percentage points. Explicitly stating this ensures the data is communicated effectively, enhancing its impact and understanding for all readers.

Interpretation

While the number of disabled voting Board members remained unchanged (1 person) between 2023/24 and 2024/25, the overall representation score decreased due to two interacting factors:

- The total number of voting members increased by one (from 13 to 14), and that new appointment was not disabled.
- The proportion of disabled staff in the overall workforce increased, raising the benchmark for proportional representation.

This small dataset means that **one single appointment** shifts the Trust's representation score significantly. For example, if one disabled person had been appointed instead of a non-disabled member, disabled Board representation would rise to **15.38%**, a swing that would result in **overrepresentation by around 7 percentage points**.

This mirrors issues discussed earlier in the paper (e.g. disciplinary data) where small numerators or denominators can lead to disproportionate statistical shifts. The Trust should bear this in mind when interpreting Indicator 10 results and when considering Board succession strategies.

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2024/25 WRES & WDES Report:

Insights for a Fairer Future

Our Approach

Berkshire Healthcare NHS Foundation Trust

- WRES (since 2016): tracks racial equality in representation, opportunity & experience
- WDES (since 2019): tracks equity for disabled staff in employment & workplace experience
- This year: focus on **year-on-year changes in equity gaps**
- One of the most detailed Trust-level investigations to date
- Insights relevant nationally as well as locally
- Linked to strategic priorities: wellbeing, outcomes, compliance, reputation

2025 Performance Snapshot

Berkshire Healthcare
NHS Foundation Trust

WRES Indicator	Metric Descriptor	Ethnically Diverse (24/25 score with difference between 23/24 score)	White (24/25 score with difference between 23/24 score)	Change in Equity score variance since 23/24

WDES Indicator	Metric Descriptor	Disabled (24/25 score with difference between 23/24 score)	Non-Disabled (24/25 score with difference between 23/24 score)	Change in Equity score variance since 23/24

“Snowy White Peaks”

Berkshire Healthcare NHS Foundation Trust

- Roger Kline’s 2014 *Snowy White Peaks* showed senior NHS roles were predominantly white
- **National 2021 Census**: avg age White 42.7, Ethnically Diverse 31.6 (11-year gap)
- **Our workforce average age** = 43.9; senior roles skew older still
- Including/excluding medical staff changes diversity picture significantly
- **Professions differ**: some more ethnically diverse, others much less for example;
    - Medics 44.9%,
    - Clinical Psychologists 12.1%

Workforce Composition (PPH)

Berkshire Healthcare NHS Foundation Trust

- Prospect Park Hospital (PPH) = 7.6% of workforce
- PPH = 23% of disciplinaries
- PPH = 71% of patient-on-staff incidents
- PPH = 46% of staff-on-staff incidents
- 71.5% of PPH staff are ethnically diverse (vs 29.6% Trust-wide)
- PPH heavily shapes Trust-level WRES outcomes
- Inequities here = environment effect, not simply ethnicity

RTW & Application Clustering

Berkshire Healthcare NHS Foundation Trust

- Sponsorship-eligible roles attract larger applicant pools
- **71.5% of no RTW candidates** were interviewed for roles with **5+ interviewees**, vs **57.7% with RTW**
- This leads to **greater competition**, reducing success rates for no RTW candidates
- RTW candidates only, **ED candidates** are still more likely to be clustered in competitive roles (53.6% vs 48.4%)
- **67.6% of RTW applications** came from ED candidates
- **Younger age profile** of ED population may contribute to application patterns
- Application clustering can lower success rates without bias being present (see example on the right)

Job	Interviewed Candidates	Offer Outcome
1	1 White	1 White
2	1 White	1 White
3	1 White, 1 Ethnically Diverse	1 Ethnically Diverse
4	1 Ethnically Diverse	1 Ethnically Diverse
5	1 Ethnically Diverse	1 Ethnically Diverse
6	5 Ethnically Diverse	1 Ethnically Diverse
Total	3 x White 8 x Ethnically Diverse	2 x White 4 x Ethnically Diverse
Ratio		White **(0.66)** Ethnically Diverse **(0.5)**

Gender Impact on Recruitment Outcomes

Berkshire Healthcare NHS Foundation Trust

- Female candidates: **1.47x** more likely to succeed after interview than males
- Suggests **gender may influence outcomes more than ethnicity or Disability alone**
- Success rates by Ethnicity with Gender, alongside Disability Status with Gender **below**:

Ethnicity + Gender	Success Ratio
White Female	0.36
Ethnically Diverse Female	0.29
White Male	0.25
Ethnically Diverse Male	0.20

Disability + Gender	Success Ratio
Disabled Female	0.32
Non-Disabled Female	0.31
Non-Disabled Male	0.23
Disabled Male	0.13

- **Demographic mix matters** when interpreting Ethnicity or Disability outcomes
- Example: If females succeed at higher rates, **ethnic groups with more females may appear to outperform others,** even if success by ethnicity is equal

Equal Opportunities for Career Progression

Berkshire Healthcare NHS Foundation Trust

Ethnicity	Ethnically Diverse	White
BHFT	56.4%	68.6%

Disability	Disabled	Non-Disabled
BHFT	59.9%	66.7%

- Both Ethnically Diverse Staff and Disabled Staff feel lesser rates of fairness around career progression
- Promotion rates higher for ethnically diverse AfC staff compared to White staff (**16.9%** vs **7.9%**)
- Promotion rates higher for Disabled AfC staff compared to Non-disabled staff (**15.1%** vs **10.5%**)
- Over half (**51.6%**) of ethnically diverse staff applied internally vs **19.5%** of white staff
- Disparity exists between perceptions and actual promotion rates
- Perception gap may reflect historical, structural, and visibility issues at senior levels

Challenges

Berkshire Healthcare NHS Foundation Trust

- Understanding full contributors to inequity (e.g., age, site, profession)
- Outcomes vs perceptions don’t always align
- Prospect Park as a dominant outlier (affecting 8 of 22 indicators)
- National factors outside control (e.g., registration by profession)
- Indicator definitions/calculations sometimes distort outcomes

Strategic Actions for 25/26

Berkshire Healthcare NHS Foundation Trust

- Strengthen data quality & reporting (inc. new feedback mechanisms)
- Escalate concerns on indicator calculations to NHS England
- Develop comms strategy to share both progress & challenges
- Targeted People Plan for Prospect Park Hospital

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Questions / Reflections

www.berkshirehealthcare.nhs.uk/careers

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	09 September 2025
Title	**Audit Committee Meeting – 23 July 2025**
	Item for Noting
Reason for the Report going to the Trust Board	The Audit Committee is a sub-committee of the Trust Board. The minutes are presented for information and assurance. The Trust Board is required to identify any areas for further clarification on issues covered by the meeting minutes and to note the content.
Business Area	Corporate
Author	Company Secretary for Rajiv Gatha, Chair of the Audit Committee
Relevant Strategic Objectives	**Efficient use of resources** **Ambition:** We will use our resources efficiently and focus investment to increase long term value

Berkshire Healthcare
NHS Foundation Trust

Unconfirmed Draft Minutes

Minutes of the Audit Committee Meeting held on

Wednesday, 23 July 2024
(Conducted via Microsoft Teams)

Present:	Rajiv Gatha, Non-Executive Director, Committee Chair Sonya Batchelor, Non-Executive Director Mark Day, Non-Executive Director
In attendance:	Paul Gray, Chief Financial Officer Debbie Fulton, Director of Nursing and Therapies Dr Tolu Olusoga, Medical Director Sharonjeet Kaur, RSM, Internal Auditors Amanda Mollett, Head of Clinical Effectiveness and Audit Kim Hampson, TIAA, Anti-Crime Specialist Ben Lazarus, Ernst and Young, External Auditors Nyan Joseph, Ernst and Young, External Auditors Graham Harrison, Head of Financial Services Julie Hill, Company Secretary

Item		Action
1.A	**Chair's Welcome and Opening Remarks**	
	Rajiv Gatha, Chair welcomed everyone the meeting.	
1.B	**Apologies for Absence**	
	Apologies were received from: Becky Clegg, Director of Finance and Clive Makombera, Internal Auditors, RSM.	
2.	**Declaration of Interests**	
	There were no declarations of interest.	
3.	**Minutes of the Previous Meetings held on 23 April 2025 and 18 June 2025**	
	The Minutes of the meetings held on 23 April 2025 and 18 June 2025 were confirmed as a true record of the proceedings.	

4.	**Action Log and Matters Arising**	
	The Action Log had been circulated. The Committee noted the Action Log.	
5.A	**Board Assurance Framework**	

	The latest Board Assurance Framework (BAF) had been circulated.
	
	The Chief Financial Officer presented the report and highlighted the following points:
	
	• **BAF Risk 1 (Workforce)** – the Trust was running two pilot projects
	  ○ A pilot which focussed on advertising vacancies internally and only going out to external advert if there were no suitable internal candidates
	  ○ A pilot which shared interview questions in advance to support the Trust's Neurodiversity Strategy
	• **BAF Risk 4 (System Working)** – the risk description had been revised to reflect the impact on the Trust of the changes to NHS England and the Integrated Care Boards.
	• **BAF Risk 7 (Cyber Security)** – the risk had been updated to reflect that the Trust had retained its annual national Cyber Essentials Plus accreditation and had achieved the standards set out in the annual Data Security and Protection Toolkit which provided external assurance about the Trust's IT and cyber security systems and processes.
	• **Risk 8 (Sustainability)** – the risk had been updated to reflect that the July 2025 Trust Board meeting had agreed the Green Plan 2025-28.
	
	The Chair congratulated the Trust on retaining its Cyber Essentials Plus accreditation and achieving the standards set out in the Data Security and Protection Toolkit.
	
	The Committee noted the report.	

5.B	**Corporate Risk Register**	
	The Corporate Risk Register (CRR) had been circulated. The Chief Financial Officer presented the paper and reported that the updates since the last meeting were highlighted in red type. The Committee noted the report.	
6.	**Single Waiver Tenders and Provider Selection Regime Direct Awards Report**	
	A paper setting out the Trust's single waivers and provider selection regime direct awards approved from April 2025 to July 2025 had been circulated.	

	The Committee noted the report.	
7.	**Information Assurance Framework Update Report**	
	The Chief Financial Officer presented the paper and reported that five indicators were audited in quarter 1: • **Mental Health Inpatient: Acute Average Length of Stay** (Green for Data Assurance and Amber for Data Quality • **Community Health Inpatient: Average Length of Stay** (Green for Data Assurance and Amber for Data Quality) • **Mental Health: Inpatient Readmission rate within 28 days** (Green for Data Assurance and Amber for Data Quality) • **Positive Patient Experience Score %** (Green for Data Assurance and Amber for Data Quality) • **Mental Health 72 Hour Follow Up after Inpatient Discharge** (Green for Data Assurance and Amber for Data Quality). The Chief Financial Officer reported that improvements had been made in the 72 hour follow up metric, but recording issues and accuracy persisted. The Chief Financial Officer reported that the Trust was looking at automating the list of patients discharged to improve compliance with the 72 hour follow up target. Sonya Batchelor, Non-Executive Director asked whether staff understood the importance of data quality and accuracy. The Director of Nursing and Therapies said that staff were aware of the importance of data quality and accuracy but referred to the 72 hour follow up target and gave the example of a patient discharged at 9pm but staff not doing the paperwork until after midnight and therefore unless the member of staff remembered to manually change the time on the system to 9pm, the patient discharge data would show that the patient was discharged the following day. The Director of Nursing and Therapies said that a digital would reduce human error and improve compliance with the indictor and would also reduce the burden on staff. The Director of Nursing and Therapies referred to the Patient Experience indicator and commented that some of the data quality issues stemmed from patients incorrectly reporting, for example, recording negative feedback despite providing positive comments. The Committee noted the report.	
8.	**Losses and Special Payments Report**	
	Due to the small number of losses and special payments during quarter 1 there was not report. The October 2025 Report will both quarter 1 and quarter 2 losses and special payments.	

9.	**Clinical Claims and Litigation Report**	
	The Clinical Claims and Litigation Report had been circulated. The Director of Nursing and Therapies reported that since the last report to the Committee, there was one litigation claim closed and there were four new claims opened (2 clinical negligence claims and 2 employer liability claims). Sonya Batchelor, Non-Executive Director noted that one of the claims dated back to 2021 and asked for an explanation. The Director of Nursing and Therapies explained that claims were handled by NHS Resolution and that there were a number of reasons for historic claims. Some claims were very complex especially if they were joint claims and involved another organisation and, in some cases, families waited until the outcome of an inquest before making a claim. Ms Batchelor thanked the Director of Nursing and Therapies for her explanation. The Committee noted the report.	
10.	**Clinical Audit Report**	
	The Clinical Audit Report had been circulated. The Medical Director reported that the Clinical Audit Plan 2025-26 was on track and that the Trust was meeting its responsibilities with regards to clinical audits. The Committee noted the report.	
11.	**Anti-Crime Specialist Report**	
	The Chair welcomed Kim Hampson, Anti-Crime Specialist, TIAA to the meeting. The Anti-Crime Specialist Report had been circulated. Mark Day, Non-Executive Director referred to page 131 of the agenda pack and noted that there was a low response rate to the annual Counter Fraud Awareness Staff Survey and asked whether there was any learning from organisations which had a higher response rate. Kim Hampson said that the Trust's response rate was in line with other trusts but commented that there tended to be a higher response rate when managers circulated the survey to their teams. Ms Hampson said that this was something she would discuss with the Trust's management for next year's survey. **The Committee**: noted the report.	**KH**
12.	**Internal Audit Report**	

	a) Internal Audit Progress Report
	
	Sharonjeet Kaur, Internal Auditors, RSM presented the paper and highlighted the following points:
	
	• There was good progress against the Internal Audit Plan 2025-26.
	• Since the last meeting, the following reviews had been finalised:
	  ○ **Cyber Assessment Framework aligned Data Security and Protection Toolkit** Independent Assessment Rating (medium/confidence level high)
	  ○ **Safety Planning** (reasonable assurance)
	• The draft **Controlled Drugs** review report had been issued
	• The following reviews were in progress:
	  ○ **Human Resources Case Work – Disciplinary Processes**; and
	  ○ **Mental Capacity**
	• Since the last meeting, there was one overdue high action for Mental Health Acute Admissions where verbal assurance had been received that this had been implemented but evidence was awaited before the action could be closed. There were two medium overdue actions which were in progress and revised due dates had been agreed with the Trust's management.
	
	b) Information Reports
	
	The following information reports were included as part of the Internal Auditors Report:
	
	• RSM News Briefing June 2025
	• Employment Rights Bill
	• Driving Value from Artificial Intelligence
	• NHS Audit Chairs Forum
	• Failure to Prevent Fraud Briefing
	• Cost Improvement and Efficiency Programmes Benchmarking
	
	Kim Hampson, Anti-Crime Specialist, TIAA reported that the NHS Counter Fraud Authority had issued guidance in relation to the Failure of Prevent Fraud requirement, and this would be shared with the Committee as part of TIAA's update to the October 2025 meeting.
	
	The Chair referred to the Cost Improvement and Efficiency Programmes Benchmarking Report and asked for RSM's view on how the Trust conducted its Cost Improvement Programme.
	
	Sharonjeet Kaur said that the Trust was performing well compared to other trusts and was delivering its required savings.
	
	The Chair commented that the fact that the Trust had a track record in delivering its annual Cost Improvement programme provided good assurance but said that there were always improvements that could be made and therefore it was helpful to receive the benchmarking report.
	
	The Committee noted the report
		KH

13.	**External Audit Report**	

	Ben Lazarus, External Auditors, Ernst, and Young (E&Y) reported that this was a quieter period for the External Auditors now that the audit had been completed. It was noted that the Finance Team and the External Auditors were meeting to debrief and to identify any learning for next year's audit. Ben Lazarus reported that he was discussing with the Chief Financial Officer whether or not Ernst and Young would continue to undertake the independent review of the Trust's Charitable Accounts. The Chair asked whether the Charitable Accounts would be discussed at the next Audit Committee meeting. The Chief Financial Officer said that the Trust needed to confirm who would be undertaking the independent review but pointed out that the Trust's Charity was small and that he did not envisage any issues with the independent review. It was noted that the Charity Commission required that the accounts were submitted by the end of January 2026. The Committee noted the update.	
14.	**Minutes of the Finance, Investment and Performance Committee meeting held on 23 April 2025**	
	The minutes of the Finance, Investment and Performance Committee meeting held on 23 April 2025 received and noted.	
15.	**Minutes of the Quality Assurance Committee held on 27 May 2025**	
	The minutes of the Quality Assurance Committee meetings held on 27 May 2025 were received and noted.	
16.	**Minutes of the Quality Executive Committee Minutes – 28 April 2025, 19 May 2025 and 16 June 2025**	
	The minutes of the Quality Executive Committee meetings held on: 28 April 2025, 19 May 2025 and 16 June 2025 were received and noted.	
17.	**Audit Committee – Annual Review of Effectiveness and Terms of Reference Review**	
	The Company Secretary presented the report and thanked those people who had completed the Audit Committee's Annual Review of Effectiveness. The Company Secretary said that the results were positive and that the only suggestion for improvement was a request around whether the External Auditors could provide benchmarking reports and other information reports in the same way as those provided by the Internal Auditors Ben Lazarus, External Auditors, Ernst and Young confirmed that he had discussed the request with his colleagues and had agreed that Ernst and Young would share benchmarking reports and other information with the Committee.	**BL**

	The Company Secretary referred to the Committee's Terms of Reference and asked whether anyone had any proposed changes. The Committee confirmed that there were no changes required to the Committee's Terms of Reference. The Committee noted the report.	
18.	**Annual Work Plan**	
	The Committee's Annual Work Plan was noted.	
19.	**Any Other Business**	
	There was no other business.	
20.	**Date of Next Meeting**	
	The next meeting of the Committee was scheduled to take place on 22 October 2025.	
21.	**Private Meeting between the Committee and the Internal and External Auditors**	
	It is good practice for the members of the Audit Committee to meet in private with the Internal and External Auditors annually.	

The minutes are an accurate record of the Audit Committee meeting held on 23 July 2025.

Signed: - _____

Date: - **22 October 2025** _____

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	9 September 2025
Title	**The Use of the Trust Seal Report**
	Item for Noting
Reason for the Report going to the Trust Board	In accordance with the Trust's Standing Orders, the Trust Board is informed each time the Trust's Seal is affixed to documents. The Trust's Seal was affixed to documents pertaining to three condition surveys (fire engineer, condition and mental health) of Prospect Park Hospital. The Trust's Seal was also affixed to a three-year lease of the first and fourth floors of Nicholson's House.
Business Area	Corporate
Author	Company Secretary
Relevant Strategic Objectives	**Efficient use of resources** **Ambition:** We will use our resources efficiently and focus investment to increase long term value