

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

TRUST BOARD MEETING

(conducted electronically via Microsoft Teams)

10:00am on Tuesday 10 March 2026

AGENDA

No	Item	Presenter	Enc.
OPENING BUSINESS			
1.	Chair's Welcome and Public Questions	Frances West, Chair	Verbal
2.	Apologies	Frances West, Chair	Verbal
3.	Declaration of Any Other Business	Frances West, Chair	Verbal
4.	Declarations of Interest i. Amendments to the Register ii. Agenda Items	Frances West, Chair	Verbal
5.1	Minutes of Meeting held on 13 March 2026	Frances West, Chair	Enc.
5.2	Action Log and Matters Arising	Frances West, Chair	Enc.
QUALITY			
6.0	Board Story – Mental Health Story	Debbie Fulton, Director of Nursing and Therapies/Vicky Parkin, Nurse Consultant CMHT West/Reuben Pearce, Lead Nurse Consultant	Verbal
6.1	Infection Control and Antimicrobial Action Plan Presentation	Debbie Fulton, Director of Nursing and Therapies/Diana Thackray, Head of Infection Prevention and Control/Ozma Tahir, Interim Chief Pharmacist/Dr Sandhu Sandeep, West Call GP	Verbal
6.2	Quality Assurance Committee a) Minutes of the meeting held on 24 February 2026 b) Learning from Deaths Quarterly Report c) Guardians of Safe Working Report	Sally Glen, Chair of the Quality Assurance Committee Dr Tolu Olusoga, Medical Director	Enc.
6.3	Patient Experience Report	Debbie Fulton, Director of Nursing and Therapies	Enc.
6.4	Freedom to Speak Up Self-Reflection Tool Report	Debbie Fulton, Director of Nursing and Therapies	Enc.
6.5	Experience of Care Framework Report	Debbie Fulton, Director of Nursing and Therapies	Enc.

No	Item	Presenter	Enc.
EXECUTIVE UPDATE			
7.0	Executive Report	Julian Emms, Chief Executive	Enc.
PERFORMANCE			
8.0	Month 10 2025/26 Finance Report	Paul Gray, Chief Financial Officer	Enc.
8.1	Month 10 2025/26 Performance Report	Theresa Wyles, Chief Operating Officer	Enc.
8.2	Finance, Investment and Performance Committee Meeting on 28 January 2026	Sonya Batchelor, Chair, Finance, Investment and Performance Committee	Verbal
STRATEGY			
CORPORATE GOVERNANCE			
9.0	Audit Committee Meeting on 28 January 2026	Rajiv Gatha, Chair, Audit Committee	Enc.
9.1	Council of Governors Update	Frances West, Chair	Verbal
Closing Business			
10.	Any Other Business	Frances West, Chair	Verbal
11.	Date of the Next Public Trust Board Meeting – 12 May 2026	Frances West, Chair	Verbal
12.	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.	Frances West, Chair	Verbal



Unconfirmed minutes

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Minutes of a Board Meeting held in Public on Tuesday, 13 January 2026

(Conducted via Microsoft Teams)

Present:	Mark Day	Interim Trust Chair
	Rebecca Burford	Non-Executive Director
	Sonya Batchelor	Non-Executive Director
	Aileen Feeney	Non-Executive Director
	Rajiv Gatha	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
	Theresa Wyles	Chief Operating Officer
Dr Tolu Olusoga	Medical Director	
In attendance:	Julie Hill	Company Secretary
	Daisy Coates	Interim Service Development Lead for Learning Disabilities <i>(present for agenda item 6.0)</i>
	Becky Chester	Clinical Director <i>(present for agenda item 6.0)</i>
	Kate Townsend	Sustainability Lead Manager <i>(present for agenda item 9.0)</i>
	Dr Laila Salhani-Maat	Consultant in Elderly Care and Clinical Lead for the Urgent Community Response <i>(present for agenda item 9.1)</i>
	Deepa Devadas	Consultant Nurse Practitioner in Frailty, Urgent Community Response Team <i>(present for agenda item 9.1)</i>
Claire Williams	Divisional Director for Community Physical Health <i>(present for agenda item 9.1)</i>	
Observers:	Frances West	Chair Designate
	Emma Copland	CQC
	Katie Lawson-King	CQC

Beth Woolfson NHS England
 Christine Doyle NHS England
 Dr Pooja Kuppili Trust Doctor

26/001	Welcome and Public Questions (agenda item 1)
	<p>The Interim Trust Chair welcomed everyone to the meeting and introduced and welcomed Frances West; the Chair Designate who was observing the meeting. Frances West will take up her post with the Trust on 2 February 2026.</p> <p>There were no public questions.</p>
26/002	Apologies (agenda item 2)
	There were no apologies.
26/003	Declaration of Any Other Business (agenda item 3)
	There was no other business.
26/004	Declarations of Interest (agenda item 4)
	i. Amendments to Register – none.
	ii. Agenda Items – none
26/005	Minutes of the previous meeting held on 11 November 2025 (agenda item 5.1)
	The Minutes of the Trust Board meeting held in public on Tuesday, 11 November 2025 were approved as a correct record.
26/006	Action Log and Matters Arising (agenda item 5.2)
	<p>The schedule of actions had been circulated.</p> <p>The Interim Chair asked Sally Glen, Non-Executive Director, if she was happy with the response to her query about unconscious bias training.</p> <p>Ms Glen reminded the meeting that she had raised the issue of unconscious bias in relation to the Independent Mental Health Review into the Tragedies in Nottingham and the Trust’s work around identifying patients at risk of harming others and those non-compliant with antipsychotics and community treatment orders.</p> <p>Ms Glen confirmed that she was reassured by the response and in particular, she was pleased that the Trust’s reflective peer view process which was designed to surface and</p>

	<p>mitigate unconscious bias through thoughtful and careful challenge would be reviewed in January 2026. Ms Glen also welcomed the fact that unconscious bias considerations was integrated into the Trust's ongoing quality improvement initiatives.</p> <p>The Trust Board: noted the report.</p>
26/007	<p>Learning Disabilities Board Story (agenda item 6.0)</p>
	<p>The Interim Trust Chair welcomed Becky Chester, Clinical Director and Daisy Coates, Interim Service Development Lead for Learning Disabilities.</p> <p>Daisy Coates gave a presentation and highlighted the following points:</p> <ul style="list-style-type: none"> • The Berkshire Intensive Support Team for People with Learning Disabilities (ISTLD) was a multidisciplinary, community-based service covering the whole of Berkshire. The team operated Monday–Friday, 9–5, with an out of hours on call provision and had been established since October 2017. • Referrals were accepted for adults aged 18+ with a confirmed learning disability who already had an open referral to the local Community Team for People with Learning Disabilities. The team supported people whose behaviour was presenting significant challenges such that: <ul style="list-style-type: none"> ○ Hospital admission was being considered, or ○ They were at risk of losing their placement, or ○ Restrictions were required to keep them safe were severely impacting quality of life. • The team aimed to: <ul style="list-style-type: none"> ○ Reduce hospital admissions ○ Reduce behaviours of concern ○ Bring positive change and enhance quality of life <p>Daisy Coates presented the Board Story about “Cecilia” (pseudonym) and highlighted the following points:</p> <ul style="list-style-type: none"> • Cecilia was a young woman with severe learning and physical disabilities, communication challenges, and high care needs. • Cecilia experienced a year-long deterioration in behaviour, isolation, distress, and unexplained weight loss, prompting multidisciplinary intervention. • Daisy described the use of advanced clinical practice skills and reasonable adjustments (flexible appointments, role play, building trust) to enable physical health assessments and collaboration across services (hospital, social care, safeguarding and mental capacity leads). • After ruling out physical health issues, safeguarding led to an unplanned move to a care home, with Daisy supporting the transition reduce Cecilia's distress.

	<ul style="list-style-type: none"> • After the team’s support, positive outcomes for Cecilia included improved engagement, weight gain, participation in health appointments, and relationship-building. <p>Daisy Coates read out a powerful family statement highlighting the team’s person-centred approach, effective transition, advocacy, and lasting impact on Cecilia’s quality of life.</p> <p>The Interim Trust Chair commented that the case study provided a good insight into the work of the service supporting patients who were not able to articulate how they were feeling.</p> <p>Sally Glen, Non-Executive Director, said that it was an inspiring presentation. Ms Glen pointed out that there was a national shortage of learning disability nurses and asked whether the Trust found it hard to recruit and retain its learning disability nurses.</p> <p>Daisy Coates confirmed that the team had a full contingent of learning disability nurses but acknowledged that there were fewer student nurses training to be learning disability nurses.</p> <p>Becky Chester added that the Trust recognised the national shortage of learning disability nurses and was undertaking proactive work around recruitment by supporting people to move into learning disabilities nursing.</p> <p>The Chief Executive asked about the Mental Health Act reforms and the role of the Intensive Support Team in reducing the number of people with learning disabilities detained under the Mental Health Act. The Chief Executive asked whether the Intensive Support Teams had plans in place to build their skills and capacity to strengthen the team.</p> <p>It was noted that the Government had indicated that this aspect of the legislation would not come into effect until there were sufficient resources built up in the community.</p> <p>Becky Chester confirmed that the service was working with the system to provide more support to people with learning disabilities in their own homes.</p> <p>The presentation slides are attached to the minutes.</p> <p>The Interim Chair thanked Becky Chester, Clinical Director and Daisy Coates, Interim Service Development Lead for Learning Disabilities for their presentation and requested that they thank Cecilia’s family for their feedback on the care provided by the service.</p> <p>The Trust Board: noted the Board Story.</p>
26/008	Quality Assurance Committee (agenda item 6.1)
	a) Quality Assurance Committee Meeting on 25 November 2025

Sally Glen, Chair of the Quality Assurance Committee reported that in addition to the standing items on the agenda, the Committee had received a presentation from the Talking Therapies Head of Service on the work the service had done to increase patient outcomes, improve staff morale and the service's quality improvement initiatives.

Ms Glen reported that the Committee had received an update on the Trust's implementation of Martha's Rule which had been adapted for mental health and physical health care settings. The Committee would receive an update on how the Trust was implementing Jess's Rule in respect of the Out of Hours GP service at the next meeting in February 2026.

Ms Glen reported that the Trust had established a steering group to provide robust oversight of the Trust's work around the Sexual Safety Charter to reduce the number of sexual safety incidents.

Ms Glen said that the Committee had noted there was ongoing work to reduce restrictive practices especially prone restraint and the use of seclusion.

b) Learning from Deaths Quarterly Report

The Medical Director reported that in quarter 2, there were no deaths which were a governance cause for concern. There were five cases where care was less optimal and learning had been identified and disseminated. There were eight deaths of patients with a learning disability, and all were reported in line with national guidance to LeDeR who complete independent reviews.

Sonya Batchelor, Non-Executive Director referred to the report and asked for clarification about what was meant by an "expected death."

The Medical Director explained that this typically referred to patients at the end of life, such as those in palliative care and was defined by the clinical judgement that death within 12 months would not be a surprise. The Medical Director added that the focus was on supporting a good death, minimising unnecessary hospital transfers, and ensuring care was tailored to the individual's needs.

Ms Batchelor asked whether the Trust monitored avoidable death trends.

The Medical Director confirmed that year-on-year learning was reviewed, with ongoing work to assess whether previous learnings had led to improvements and to identify further actions.

Ms Glen provided additional assurance that the governance around learning from deaths was robust, with in-depth reviews at the Quality Assurance Committee and there was oversight of the Medical Examiner processes.

c) Guardian of Safe Working Practices Quarterly Report

	<p>The Medical Director reported that there were seven exception reports in the period. These exceptions occurred when doctors worked more than 30 minutes beyond their scheduled end times. The overruns were attributed to emergencies and confirmed that the doctors had received time of lieu as compensation for the additional hours worked.</p> <p>The Trust Board:</p> <ul style="list-style-type: none"> a) Noted the minutes of the Quality Assurance Committee meeting held on 25 November 2025 b) Noted the Learning from Deaths Report c) Noted the Guardian of Safe Working Hours Report.
26/009	Executive Report (agenda item 7.0)
	<p>The Executive Report had been circulated.</p> <p>The following issues were discussed further:</p> <ul style="list-style-type: none"> a) Advanced Foundation Trust Application <p>Chief Executive reported that the Trust was delighted to have been selected as one of only eight trusts to be invited to apply for Advanced NHS Foundation Trust status.</p> <p>The Deputy Chief Executive reported that the Trust's application for Advanced Foundation Trust status was submitted last week. The documentation was included in the meeting papers. It was noted that the Trust Board had delegated approval to sign the self-certification statements and board memorandum to the Interim Trust Chair and Chief Executive. It was noted that the application process would also include a board-to-board meeting between the Trust and NHS England at the end of March 2026.</p> <ul style="list-style-type: none"> b) Equity Partnership Group <p>The Deputy Chief Executive reported that the Trust had established an Equity Partnership Group with external experts and community leaders, chaired by Sally Glen, Non-Executive Director to support the Trust's strategic equity ambitions.</p> <p>Sally Glen, Non-Executive Director reported that the first meeting had included an overview of the current Trust initiatives which had received constructive challenge from the members of the Group.</p> <p>The Interim Trust Chair referred to the impressive biographies of the Equity Partnership Group members and asked how the external members were recruited.</p> <p>The Deputy Chief Executive explained that the Trust had nationally advertised the role and had sought expressions of interest and had received a good response.</p>

	<p>Aileen Feeney, Non-Executive Director asked how the Equity Partnership Group was integrated with the Trust’s existing staff networks and other groups.</p> <p>The Deputy Chief Executive clarified that the Equity Partnership included the Trust’s internal equity leads and was connected to the senior leadership team through the executive leads (Deputy Chief Executive and Director of Nursing and Therapies). This structure was intended to ensure integration across workforce, patient, and community equity work.</p> <p>c) Resident Doctors Industrial Action – The Impact on the Trust</p> <p>The Chief Executive reported that the Trust had successfully managed the recent industrial action by Resident Doctors and had maintained safe service coverage and activity levels. The Chief Executive thanked the Medical Director and his team of their effective handling which had also preserved good workforce relations.</p> <p>The Interim Trust Chair asked whether there remained any tensions between those Resident Doctors who had participated in the industrial action and those who had continued to work.</p> <p>The Medical Director confirmed that there was no tension between the two groups. The Trust had fostered a no-blame culture, respecting individual choice regarding participation in the industrial action.</p> <p>The Trust Board: noted the report.</p>
26/010	<p>Month 08 2025-26 Finance Report (agenda item 8.0)</p>
	<p>The Chief Financial Officer presented the report and highlighted the following points:</p> <ul style="list-style-type: none"> • All internal financial targets were RAG rated “green.” • The planned outturn position for the Trust was a £1.7m surplus. • Workforce numbers remained below plan due to tighter controls and recruitment challenges. • Four out of area placements had created a £120k pressure which was mitigated by pay underspend. • Mental health inpatient beds were under extreme pressure, with increased demand for PICU beds including an increase in the number of requests for prison transfers for assessment or treatment under the Mental Health Act. • 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. There were still some outstanding payments from commissioners which the Trust would continue to pursue. Cash expenditure on capital projects was lower than planned due to profiling. • The Better Payment Practice Code was achieved for all 4 targets.

	<ul style="list-style-type: none"> • Capital expenditure was below CDEL Year to Date primarily due to the profile of expenditure on the Jubilee Ward relocation project. • The Trust had two targets for temporary staffing. There was a requirement to reduce agency expenditure by 30% when compared to the previous year. The target was now being achieved (there was a 32% reduction on agency spend). The bank staffing cost reduction of 10% compared to the previous year was being exceeded by £0.9m year to date. <p>Sonya Batchelor, Chair of the Finance, Investment and Performance Committee, congratulated the Executive Team on the internal financial targets, being green especially the reduction in agency spending.</p> <p>Ms Batchelor reported that the Finance, Investment and Performance Committee would be discussing balance of non-current and recurrent cost saving plans in relation to next year's financial plan to ensure that the Trust sustained its financial performance.</p> <p>Sally Glen, Non-Executive Director referred to the increase in the number of prison transfers and pointed out that the Trust did not have any forensic beds.</p> <p>The Chief Operating Officer explained that the increase in prison referrals was a national trend and commented that these requests were often unplanned and once received, the Trust had 28 days to secure a PICU bed for the prisoner to enable an assessment to be conducted.</p> <p>The Medical Director added that more work was needed upstream, for example, ensuring that people who required a mental health assessment were referred when they first got into prison to ensure a more proactively planned approach.</p> <p>The Interim Trust Chair asked whether the balance between voluntary and detained patients had changed.</p> <p>The Chief Operating Officer confirmed that there was an increase in the number of detained patients. It was noted that the Mental Health Act Governance Board monitored all mental health act detentions and the minutes of the meeting were referred to the Quality Assurance Committee.</p> <p>The Trust Board: noted the report.</p>
26/011	<p>Month 08 2025-26 “True North” Performance Scorecard Report (agenda item 8.1)</p>
	<p>The Month 08 2025-26 “True North” Performance Scorecard Report had been circulated.</p> <p>The Chief Operating Officer presented the report and highlighted the following points:</p> <p>NHS Oversight Framework Metrics</p>

- The Trust remained in segment one of the National Oversight Framework, though it had dropped from 3rd to 9th place in the league table. Financial stability and oversight were critical contributors to this rating.
- Whilst maintaining a strong position, there were challenges in the following areas:
 - **Length of Stay:** 20% of patients stayed over 60 days, slightly below the national median of 23%.
 - **Crisis assessments within 24 hours and the percentage seen face-to-face** were areas for improvement, with a focus on better recording and pathway configuration.
 - **Productivity metric – relative difference in costs** the Trust had achieved 135.35% compared with the national median of 104.85%
 - 0.29% of patients waited **over 52 weeks** for services, which was better than the national median of 0.38%.
 - The annual percentage change in the number of **young people accessing NHS Funded Mental Healthcare** performance was at 14.44% against the national median of 7.26%

Breakthrough Objectives

- **Mental Health Length of Stay: Adult target:** 42 days; actual: 46.41 days. Each additional day was significant, and efforts were ongoing to reduce this.
- **Mental Health Length of Stay: Older adult target:** 80 days; actual: 92.57 days, though improved from earlier in the year (was as high as 122).
- **Clinically ready for discharge days lost:** 503 (target: 250), indicating double the desired level.
- **Occupancy rate:** 97.7% (target: 85%), reflecting a very busy period and high demand for inpatient beds.
- **Acute overspill beds usage** had increased and had continued into the next period. A “made event” (Multi-Agency Discharge Event) was planned at Prospect Park Hospital next month to focus on discharge flow.
- **Physical Health: Community Inpatient Length of Stay** - Actual: 22.35 days (target: 21 days).
- **Physical assaults on staff:** 93 incidents (target: 36), involving 30 patients. This was higher than usual and more widely spread, attributed to higher acuity, prison transfers, and PICU demand.
- **Rapid tranquilisation:** 56 incidents (target: 39), involving 16 patients. A review of countermeasures was underway to identify effective interventions.

Driver Metrics

- **“I Want Great Care” patient satisfaction** scores had dipped to 80–86% (usual: 94–96%), mainly due to a surge in feedback from young people at vaccine clinics, with no underlying quality or safety concerns identified.
- **Staff turnover rate:** 10.28% (target: 10%), indicating good workforce stability.

	<p>Sally Glen, Non-Executive Director, commented that she was pleased about the sustained improvement in perinatal services but was concerned about the high number of physical assaults on staff and noted that a relatively small number of patients had contributed to the total (30 patients).</p> <p>Ms Glen asked about the realism of the sickness absence target (3.5% versus. national average 5.1%).</p> <p>The Chief Operating Officer pointed out that the sickness absence metric was a stretched target and said that there were ongoing executive discussions about its appropriateness and about whether it would be helpful to have interim targets.</p> <p>Sonya Batchelor said that it would be helpful to have a deeper insight into the causes of increased assaults and the use rapid tranquilisation, including the impact of an increase in the number of detained patients at a future Finance, Investment and Performance Committee meeting.</p> <p style="text-align: right;">Action: Chief Operating Officer</p> <p>Ms Batchelor commented that the Trust had a number of ongoing initiatives and warned against the risk of “countermeasure fatigue.”</p> <p>The Chief Operating Officer reported that there was a rapid improvement event planned at Prospect Park Hospital to make sure that staff were focusing on the key countermeasures, that is, those that had the greatest impact.</p> <p>Ms Batchelor asked for clarification about what was meant by “Turbo 10” training.</p> <p>The Chief Operating Officer explained that “Turbo 10” training was short, focussed training often given by a consultant nurse to a small group of staff in response to an incident etc.</p> <p>Ms Batchelor referred to the increase in the use of rapid tranquilisation and commented that it would be helpful to make a distinction between those patients who had indicated that rapid tranquilisation was their preferred option.</p> <p style="text-align: right;">Action: Chief Operating Officer</p> <p>The Trust Board: noted the report.</p>
26/012	“Green Plan” – Sustainability Strategy Update Presentation (agenda item 9.0)
	<p>The Interim Trust Chair welcomed Kate Townsend, Sustainability Lead Manager to the meeting.</p>

The Chief Financial Officer reminded the meeting that the Trust Board had approved the new the Trust's new "Green Plan" Sustainability Strategy at the May 2025 meeting.

Kate Townsend presented an update on the Trust's Green Plan and highlighted the following points:

- **NHS targets:** net zero by 2040 for direct emissions, 2045 for indirect, and an 80% reduction by 2032 (direct) and 2039 (indirect) from a 1990 baseline.
- **NHS England** had achieved a 68% reduction since 1990 and 14% in the last five years. The Trust's own carbon footprint had reduced by 16.7% (scope 1 and 2) from a 2018/19 baseline, but a further 30% reduction was needed in six years to meet midway targets.
- **Key Trust projects:** Solar panel installations at three sites had generated 254 MWh and saved £100,000; at least one new solar installation planned per year.
- **Decarbonisation of West Berkshire Community Hospital** was abandoned due to increased costs, creating a gap in meeting targets. A solar farm project was in pipeline but was subject to Treasury approval.
- **Recent funding:** £245,000 for LED lighting and sub-metering at West Berkshire Community Hospital (estimated 80 tonnes CO2e saved/year), and £135,000 for a nature trail and well-being garden at Prospect Park Hospital.
- **Energy consumption** had reduced 28% since 2019/20 but had plateaued recently. Business miles had increased by 33,000, but carbon emissions and costs had decreased due to more EV use and lower fuel prices. 1:29:26
- **Waste:** Uniform recycling project was underway; all waste now diverted from landfill (18 tonnes CO2e saved/year); clinical waste incineration had reduced below target.
- **Staff Engagement:** Net Zero Heroes group had been established; CPD sessions for clinical teams; travel events and quarterly newsletters planned.
- **Next steps:** Finalise travel/transport strategy, expand EV charging, install more solar panels, deliver board-level sustainability training, appoint clinical lead, and develop a phased plan to eliminate fossil fuel heating.
- **Challenges:** Funding for major decarbonisation projects is limited; PFI estate complexities; need for strategic planning on boiler replacement and infrastructure.

Sonya Batchelor, Non-Executive Director thanked Kate Townsend for her presentation and commented that her passion and knowledge of the sustainability agenda was evident.

Ms Batchelor commented that phasing out fossil fuel would require capital funding.

The Chief Financial Officer said that Kate Townsend was skilled at identifying and applying for national funding at very short notice. The Chief Financial Officer added that both West Berkshire Community Hospital and Prospect Park Hospitals were PFI buildings and this added additional complexity to capital schemes.

Aileen Feeney, Non-Executive Director asked for more information about the planned wellbeing garden and nature trail at Prospect Park Hospital.

	<p>Kate Townsend said that staff and patients were involved in the design of the garden and nature trail which would be a multi-year project.</p> <p>The Interim Trust Chair thanked Kate Townsend for her informative update and said that it would be helpful for the Trust Board to receive regular updates about the implementation of the Green Plan.</p> <p style="text-align: right;">Action: Chief Financial Officer/Company Secretary</p> <p>The Trust Board: noted the presentation.</p>
26/013	Neighbourhood Health Presentation (agenda item 9.1)
	<p>The Interim Trust Chair welcomed Dr Laila Salhani-Maat, Consultant in Elderly Care and Clinical Lead for the Urgent Community Response, Deepa Devadas, Consultant Nurse Practitioner in Frailty, Urgent Community Response Team and Claire Williams, Divisional Director for Community Physical Health to the meeting.</p> <p>The Chief Operating Officer reminded the meeting that the NHS Ten Year Plan included a national commitment to decrease hospitalisations and to treat more people in the community.</p> <p>The Divisional Director for Community Physical Health explained the Trust’s focus on developing a neighbourhood health model within Berkshire Healthcare’s Community Health division. The work began about 18 months ago, initially to address challenges in accessing community services, and had since evolved to align with the national neighbourhood agenda and the “left shift” in care (moving care closer to home and out of hospitals).</p> <p>Dr Salhani-Maat gave a presentation and highlighted the following points:</p> <p>Current Challenges</p> <ul style="list-style-type: none"> • All parts of the health system—primary care, secondary care, ambulance, and community services were under pressure due to an ageing population and increased demand. • The current single point of access (SPA) for community services was administrative led, not clinical, requiring referrers to know exactly which service to request, leading to frustration, inefficiency, and delays when referrals are declined or misdirected. • Multiple referrals were often needed for one patient, and there was duplication of work and fragmentation, both within the Trust and across the wider system. • There were noted inequities, with higher rates of missed appointments (DNAs) in Slough and Reading, attributed to cultural and health literacy barriers.

Vision for Neighbourhood Health

- The vision was to move from siloed services to a community/neighbourhood model, integrating health, social care, and voluntary sector partners to provide seamless, patient-centred care.
- The model aimed to support both crisis management and prevention, leveraging digital solutions and shared care plans accessible across organisations.
- A key feature was a clinical triage system at the point of referral, so one call or form can direct a patient to all needed services, improving experience for patients, referrers, and staff, and optimising resource allocation.
- The neighbourhood approach would include regular multidisciplinary team (MDT) meetings, proactive case finding (using frailty scores and data), and shared care plans visible to all relevant providers.

Proposed Model & Pathways

- The model envisioned a single community team per neighbourhood, with integrated working between community matrons, primary care, voluntary sector, and other services.
- Shared IT and care planning were priorities, with the goal of using connected care and digital respect plans accessible in real time by all providers.
- The intermediate care pathway would allow for both crisis response (e.g., hospital at home) and proactive rehabilitation, with seamless transitions between services based on clinical triage.

Case Study Example

Deepa Devades presented a real patient case study (“Mrs Smith”) to illustrate current pathways and the potential benefits of the neighbourhood model and highlighted the following points:

- Mrs. Smith, an elderly woman with multiple health issues, experienced a decline and was referred to hospital at home after a fall.
- She received input from multiple services (hospital at home, community inpatient rehab, district nursing, dietetics), but care was fragmented, with no single point of contact or coordinated follow-up.
- The neighbourhood model would provide a key contact, coordinated MDT oversight, proactive monitoring, and earlier intervention, reducing crisis admissions and supporting carers more effectively.

Carer and Equity Considerations

- The model emphasised supporting carers, including proactive identification of carer needs, signposting to respite and voluntary sector resources, and working with local authorities to arrange support before crisis points.

	<ul style="list-style-type: none"> Addressing health inequalities was a focus, with ongoing work to understand and reduce missed appointments in deprived and diverse communities through tailored communication and outreach. <p>Sally Glen, Non-Executive Director asked about governance for the integrated model.</p> <p>The Divisional Director for Community Physical Health confirmed that governance structures were being developed in parallel with the model, with plans to include social care, housing, and voluntary sector partners as the model matures. Integration leads were being established across Berkshire to support this.</p> <p>Rebecca Burford, Non-Executive Director asked why Slough and Reading patients were more likely not to attend healthcare appointments.</p> <p>The Divisional Director for Community Physical Health said that there were sometimes cultural reasons for non-attendance. It was noted that the Heart Function Team had analysed the data and had identified that the service should be seeing a higher proportion of men in the Slough area and had used the Health Bus to visit the Slough area to offer healthcare checks and had had a good response.</p> <p>The Chief Executive highlighted the need to consider resourcing, as easier access and more preventative work could increase demand on services. He noted the importance of sharing resources between primary care and community services to avoid duplication and manage capacity.</p> <p>Dr Salhani-Maat agreed, emphasising the need for shared responsibility and flexibility across organisations, with MDTs as the forum for joint decision-making and resource allocation.</p> <p>It was noted that the work was still in an early, formative stage, but it was closely aligned with the national 10-year plan and the “left shift” agenda.</p> <p>The Interim Chair thanked Dr Laila Salhani-Maat, Consultant in Elderly Care and Clinical Lead for the Urgent Community Response, Deepa Devadas, Consultant Nurse Practitioner in Frailty, Urgent Community Response Team and Claire Williams, Divisional Director for Community Physical Health for their presentation and for their work in developing Neighbourhood Health. The Interim Chair requested that the Board’s appreciation and thanks be forwarded to all those involved in the work.</p> <p>The Trust Board: noted the presentation.</p>
26/014	Trust Seal Report (agenda item 10.0)
	<p>It was noted that the Trust’s seal had been affixed to a deed of consent and indemnity in respect of West Berkshire Community Hospital to support the Royal Berkshire NHS Foundation Trust’s intention to have an MRI scanner on the site.</p>

	The Trust Board: noted the report.
26/015	Council of Governors Update (agenda item 10.1)
	<p>The Interim Trust Chair reported that the Company Secretary was surveying the governors with a deadline of 23 January for responses to find out what was working well and areas for improvement. The Interim Trust Chair commented that the timing was ideal and would provide the new Trust Chair with a good insight into the Governors' views and suggestions for changes.</p> <p>The Interim Trust Chair reported that he met with the Lead Governor, the Company Secretary and the Executive Office Manager and Assistant Company Secretary last week to discuss how governors could get more opportunities to meet with patients and families.</p> <p>The Interim Trust Chair requested that Non-Executive Directors consider inviting one or two governors to join them when they were visiting services.</p> <p>The Interim Trust Chair formally thanked the Lead Governor and the other members of the Council of Governors' Appointments and Remuneration Committee for their diligence and hard work in selecting and interviewing candidates for the role of Trust Chair.</p>
26/016	Any Other Business (agenda item 11)
	<p>Mark Day, Interim Trust Chair</p> <p>On behalf of the Trust, the Chief Executive thanked Mark Day for his service as the Trust's Interim Trust Chair and for ensuring a smooth transition from Martin Earwicker, former Trust Chair who left on 31 July 2025 to Frances West, the Trust's new Chair.</p> <p>Mr Day thanked the Chief Executive for his warm words.</p>
26/017	Date of Next Public Meeting (agenda item 12)
	The next Public Trust Board meeting would take place on 10 March 2026.
26/018	CONFIDENTIAL ISSUES: (agenda item 13)
	The Board resolved to meet In Committee for the remainder of the business on the basis that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.

I certify that this is a true, accurate, and complete set of the Minutes of the business conducted at the Trust Board meeting held on 13 January 2026.

Berkshire Intensive Support Team for People with Learning Disabilities (IST-LD)



Who are we?

- Multidisciplinary team
- Community based, covering the whole of Berkshire
- 5 day a week, 9-5 service
- Out of hours on-call
- Established in October 2017

Who can be referred?

- **18+ years** with a confirmed **Learning Disability**.
- Have a **current open referral** to the local **Community Team for People with a Learning Disability (CTPLD)**.
- The person's behaviour should be challenging their service to such an extent that:
 - hospital admission is being considered or
 - they are at risk of having to move home or
 - the restrictions placed on them are having a severe impact on their quality of life.

What are our aims?

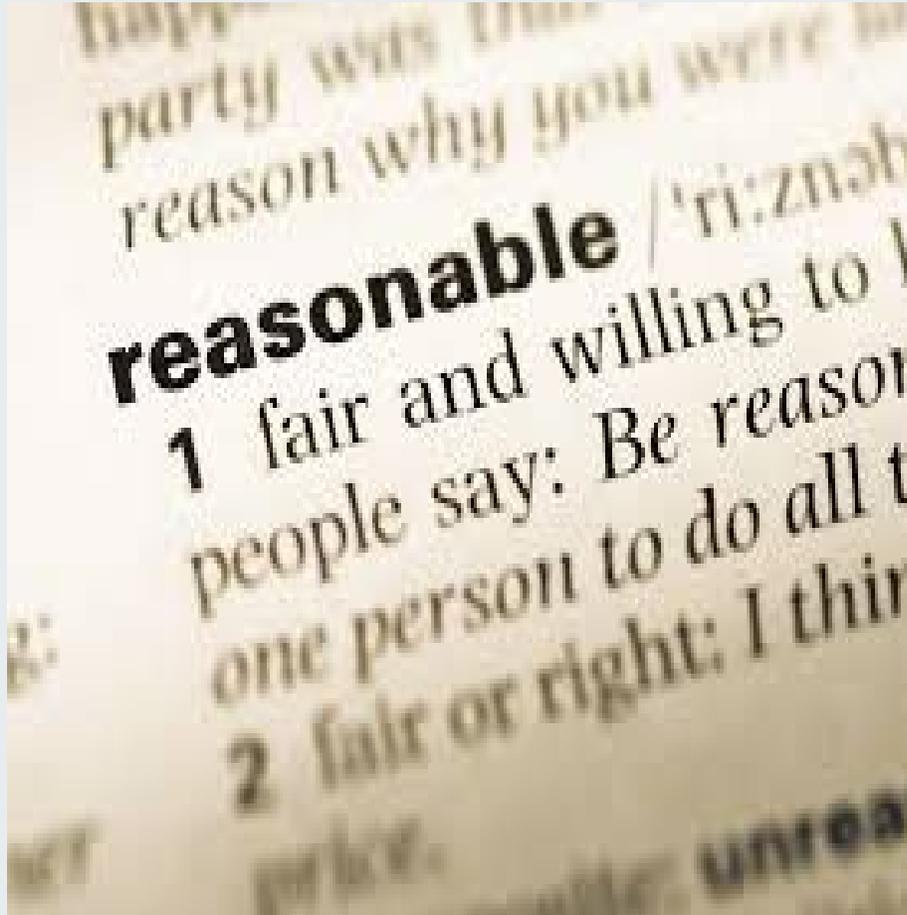
- To reduce hospital admissions
- To reduce behaviours of concern
- To bring positive change / enhance QoL

Cecilia's * Journey (Pseudonym used)



A little bit about Cecilia and the associated complexities of her case.

Reasonable adjustments



Time of day
Appointment length
Examination role play
Cecilia taking the lead
Building trust in others
Supporting
communication

What changes did we see?

No longer self isolating

Gets out and about

Slow and sustained weight increase

Engages in health appointments

Relationships with significant others
reestablished.

Family Statement

Our sister is a young lady with cerebral palsy, a diagnosed learning disability and complex health & communication needs. Just over a year ago, she was referred to RBH for medical review and subsequently, after 6 months, was relocated to a local care home, identified by the local authority, who could care for her ongoing needs.

While this transition was necessary, it was also a very vulnerable and anxious time for her, not fully understanding where she was, why and what her future accommodation and care would be like. Changes in environment, routines, and unfamiliar staff could have been extremely distressing, particularly for someone who finds it hard to communicate pain, anxiety, or unmet needs.

From the very beginning of their involvement the disability nursing team played a central role in making this transition safe, planned, and person-centred.

Family statement contd...

The team worked closely with the local authority, potential care home staff, family members, and other health professionals to build a detailed understanding of our sister as a person, not just her diagnoses. They helped hospital staff understand how she communicates, what signs indicate discomfort or illness and how anxiety presents for her. This meant that staff were not guessing or reacting late, but were confident and proactive in supporting her.

The LD nurses provided clear guidance around her physical health needs, including monitoring long-term conditions, medication support, and escalation plans. Specifically supporting with her mobility and manual handling guidance. They ensured reasonable adjustments were in place so that routine healthcare, such as GP appointments and reviews were accessible and meaningful for her, rather than overwhelming or avoided.

Family statement contd...



Berkshire Healthcare
NHS Foundation Trust

With the collaborative support of the occupational therapist and the speech & language team, the local health professionals have worked together to facilitate a smooth transition and enrich our sister's life and future happiness.

One of the most important impacts of the combined team's involvement has been consistency. The nursing team acted as a bridge between services, reducing fragmentation and preventing issues from escalating into crises. Because of this, our sister has experienced fewer distressing incidents and a much greater sense of stability in her new home. This has resulted in a cohesive and calm transfer of responsibility to the care home staff. For our sister, this has meant feeling understood, safe, and settled. She is calmer, healthier, and better supported to live her life in a way that respects her needs and preferences.

Family Statement contd...



Berkshire Healthcare
NHS Foundation Trust

For us as a family, the nursing team's involvement has brought reassurance and trust. We know that professionals who truly understand learning disability care are advocating for her, supporting the care home staff, and ensuring her health needs are not overlooked.

In summary, the disability nursing team does far more than provide clinical input. They enable safe transitions, build capability within care settings and ensure that people with learning disabilities receive care that is compassionate, coordinated, and equitable.

From our family's experience, their work has made a profound and lasting difference to our sister's quality of life, which we are deeply grateful for that.

Thank you

Questions...?



BOARD OF DIRECTORS MEETING 10.03.26

Board Meeting Matters Arising Log – 2026 – 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
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.	May 2026	MM		
09.09.25	25/163	WRES and WDES	The Trust to consider benchmarking Prospect Park Hospital against other comparable inpatient mental health units.	April 2026	JN	The Trust has contacted Oxford Health, Surrey and Border Partnership and Midlands Partnership (currently the top ranked non-	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
						acute trust in the country) to take part in benchmarking work. Both Oxford Health and SABP have welcomed the opportunity to participate, and Midlands Partnership have a meeting with us in November. We will return to the Board when this exercise is completed.	
11.11.25	25/192	FTSU Guardian's Report	The FTSU Guardian to measure the reach of the FTSU awareness work.	May 2026	MC	Information about the reach of the FTSU awareness work will be included in the next FTSU Guardian's report.	
11.11.25	25/197	Health and Wellbeing Update Report	Members of the Board to promote health and wellbeing support during their visits to services. The Health, Wellbeing and Engagement Manager to provide a summary	March 2026	SM	Completed – attached at appendix 1	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
			sheet for Board Members to use when visiting services.				
11.11.25	25/198	Reducing Violence and Aggression Update Report	Future reports to include numbers of police reports and prosecutions.	May 2026	DF		
13.01.26	26/011	Performance Report	A “deep dive” into the causes of increased assaults and the use rapid tranquilisation, including the impact of an increase in the number of detained patients to be presented at a future Finance, Investment and Performance Committee meeting.	July 2026	TW		
13.01.26	26/011	Performance Report	If possible, when reporting the number of rapid tranquilisation incidents, a distinction to be made between those patients who had indicated that rapid tranquilisation was their preferred option and the rest.	March 2026	TW	At the moment this would require a manual trawl through the incidents. The Trust is exploring if there would be a change on the DATIX system to allow this information to be recorded.	
13.01.26	26/012	“Green Plan” Sustainability Strategy Update	The Board to receive regular updates on the implementation of the “Green Plan”	March 2026	PG	The Board is schedule to receive annual updates on the implementation of the	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
						"Green Plan".	

Wellbeing Support

Wellbeing Support

This sheet gives an overview of some of the support. However, it can sometimes be confusing what is available. If you have any queries or need more information, you can reach out on wellbeing@berkshire.nhs.uk or 0300 365 8880 (Mon to Fri except bank holidays, 8am – 4pm).

Mental Health

Wellbeing Matters

Wellbeing Matters provides a confidential and compassionate space to support both individuals and teams. This includes wellbeing support and follow up for individuals, support post incident for individuals and teams, investigation support and team/manager support. You can access the service by emailing WellbeingMatters@berkshire.nhs.uk or calling the number above.



Employee Assistance Programme (EAP)

Employee Assistance Programme (EAP): Health Assured offer free access to emotional and practical support. You can contact Health Assured, who are entirely independent of the Trust, 24 hours a day, 7 days a week, 365 days a year at 0800 028 0199. You can also download the app <https://www.healthassured.org/wisdom-app/> Unique Code: MHA232705

Other support

Your team may have a Mental Health First Aider that can have supportive conversations and signpost you to help. You can also find a range of supportive apps on the nexus pages. Just search 'supporting your wellbeing'.

Physical Health

Occupational Health & Early Intervention Physio

Our Occupational Health team can support with any health related issue that impacts your work - They can give advice on work-related illnesses and accidents, carry out assessments for new starters and existing employees, monitor the health of employees and look at prevention. It's best for your manager to refer you and they can find out more in the Occupational Health page on Nexus.

Ergonomics

The ergonomic advisory service can help prevent musculoskeletal injuries by providing advice and assessments around manual handling and work environment. This includes manual handling training, display screen equipment (DSE) assessments and moving and handling advice and assessments. Get in touch with ergonomics@berkshire.nhs.uk to find out more.

Other support

There is plenty of other support such as eye tests and the cycle to work scheme. Get in touch or search on nexus to find out more.

Financial Support

Salary Finance

Our financial wellbeing provider, Salary Finance offers a range of benefits to our colleagues, designed to help you take control of your finances and reduce money worries. This includes a learning platform, savings through salary, salary advances and loans. Check out nexus to find out more.



Employee Assistance Programme (EAP)

As well as in the moment emotional support and counselling, Health Assured also provides Legal information on issues that cause anxiety or distress, such as debt management, and consumer, property or neighbour disputes. The Legal Information and Guidance Flyer on nexus provides more detail or you can call Health Assured directly to find out more on 0800 028 0199.

Other Support

There are lots of other financial support and education. This includes pensions sessions from Affinity Connect, links to MoneyHelper, overview of the discounts available. We also partner with local foodbanks to help where needed. We can arrange a 1-1 conversation within the Wellbeing team to help direct you to the best support – just email wellbeing@berkshire.nhs.uk and we'll get something set up.

Wellbeing Champions

We are aiming to have one Wellbeing Champion in each team who will keep up to date with signposting and keep wellbeing a priority in your team. Find out if you have one today and if not, get in touch!

Unsure what support you need? Get in touch...

[@ wellbeing@berkshire.nhs.uk](mailto:wellbeing@berkshire.nhs.uk)

[@ wellbeingmatters@berkshire.nhs.uk](mailto:wellbeingmatters@berkshire.nhs.uk)

[0300 365 8880](tel:03003658880) (Mon to Fri 8am – 4pm)

[Search Wellbeing on Nexus](#)

Trust Board Paper

Board Meeting Date	10 March 2026
Title	Quality Assurance Committee Meeting – February 2026
	Item for Noting
Reason for the Report going to the Trust Board	<p>The Quality Assurance Committee is a sub-committee of the Trust Board. The minutes are presented for information and assurance.</p> <p>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.</p> <p>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.</p>
Business Area	Corporate Governance
Author	Julie Hill, Company Secretary (on behalf of Sally Glen, Committee Chair).
Relevant Strategic Objectives	<p>Harm Free Care – providing safe services</p> <p>Good Patient Experience – improving outcomes</p>

**Minutes of the Quality Assurance Committee Meeting held on
Tuesday, 24 February 2026**

(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
Rebecca Burford, Non-Executive Director
Debbie Fulton, Director of Nursing and Therapies
Alex Gild, Deputy Chief Executive
Daniel Badman, Deputy Director of Nursing for Patient Safety and Quality
Garyfallia Fountoulaki, Clinical Director Community Mental Health
(deputising for Theresa Wyles Chief Operating Officer)
Dr Tolu Olusoga, Medical Director *(present from 10.25)*
Amanda Mollett, Associate Director for Medical Development, Clinical Effectiveness and Clinical Audit
Helen Degruchy, Head of Patient Safety
John Barrett, Patient Safety Partner

In attendance: Julie Hill, Company Secretary
Sue McLaughlin, Senior Nurse Consultant *(present for agenda item 5.0)*
Gwen Bonner, Senior Nurse Consultant *(present for agenda items 5.0 and 5.1)*

Observers: Cassie Finnigan, Head of Mental Health Act
Emma Copland, CQC

Opening Business

1 Apologies for absence and welcome

The Chair welcomed everyone to the meeting. The Chair particularly welcomed Emma Copland, CQC and Cassie Finnigan, Head of Mental Health Act who were observing the meeting.

Apologies were received from: Julian Emms, Chief Executive and Theresa Wyles, Chief Operating Officer.

2. Declaration of Any Other Business

There was no other business declared.

3. Declarations of Interest

There were no declarations of interest.

4.1 Minutes of the Meeting held on 25 November 2025

The minutes of the meeting held on 25 November 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

5.0 Named Worker Presentation

The Chair welcomed Sue McLaughlin, Senior Nurse Consultant.

Sue McLaughlin gave a presentation and highlighted the following points:

Overview & Context

- The Care Programme Approach (CPA) model had been in place for thirty years but was no longer fit for purpose. The Trust was transitioning to the new Named Worker and Care Plan model, which was aligned with NHS England's guidance (which was still in draft).
- The aim was to simplify and streamline care planning, with every patient receiving a named worker and care plan, unlike the previous system where only around 25% had CPA.
- The new care plan was co-designed with carers and service users, and digital systems (RiO) had been updated to support this.
- All patients having an intervention from Berkshire Healthcare must have a named worker and care plan.

Implementation & Progress

- The initiative began in January 2025, with ongoing collaboration with national groups and local partners.
- A new policy and standard work for staff had been ratified, and the care plan was now live in RiO.
- Inpatients were allocated a named worker upon admission.
- Peer review and targeted support were being used to address areas of low compliance and staff confidence. Nurse consultants were providing support to staff.

Challenges

- Technical issues existed between the T-Pro system (used by GPs) and RiO, requiring manual uploads of care plans. Work was ongoing to resolve this.
- Tableau dashboards were used for caseload oversight, but tracking large caseloads (e.g., 1,900 in West Berkshire) remained challenging. Some Trusts were using AI tools to support caseload management, and this was an area which the Trust was considering.
- Staff skill, confidence, and clarity on the named worker role was variable, with some reluctance and anxiety about new responsibilities.
- Disagreements sometimes arose over who should be the named worker when multiple professionals were involved.
- Care plans were sometimes documented in progress notes rather than on the dedicated RiO form, limiting sharing and oversight.

The Chair asked whether the Trust benchmarked the named worker caseload with other trusts.

Sue McLaughlin said that caseloads were benchmarked nationally and with Thames Valley Integrated Care Board colleagues and confirmed that the Trust was not an outlier.

John Barrett, Patient Safety asked whether there was a correlation between caseloads and compliance rates.

Sue McLaughlin said that lower compliance rates were more around cultural factors, for example how teams worked rather than related to caseloads.

The Director of Nursing and Therapies provided assurance that patients who did not have a care plan still had a safety plan which provided information about who to contact if they had a concern.

Sue McLaughlin reported that the Trust had held monthly dashboard reviews and peer review processes were in place for assurance. Pathway audits were used to track patient journeys. It was noted that early discharge planning and clarity of intervention at admission were areas for improvement.

The Chair asked about feedback from staff.

Sue McLaughlin said that staff liked the new streamlined paperwork, but the volume and pace of change was challenging leading to tension and unease for some staff.

Aileen Feeney, Non-Executive Director asked about patient feedback.

Sue McLaughlin said that the Trust had surveyed patients and had received 50 responses so far. It was noted that the feedback was mixed with about half of patients reporting that they knew their named worker and were aware of their care plan.

The Director of Nursing and Therapies suggested also using the data from the I Want Great Care patient feedback tool to supplement the feedback from the survey.

John Barrett, Patient Safety Partner asked whether the Trust had received any negative feedback from the patient survey.

Sue McLaughlin said that the negative feedback was justifiable frustration around delays and waits.

The Chair thanked Sue McLaughlin for her presentation.

It was agreed that the Committee would receive an update at the August 2026 meeting.

Action: Chief Operating Officer/Sue McLaughlin

The Committee noted the presentation.

5.1 Trust Intensive Case Management and Assertive Outreach Highlight Report and Action Plan

The Chair welcomed Gwen Bonner, Consultant Nurse to the meeting. Gwen Bonner reminded the meeting that in response to the Independent Mental Health Homicide Review into the Tragedies in Nottingham, NHS England required all mental health trusts to develop processes to identify and provide outreach services to patients with serious mental illness (psychosis) who were likely to disengage from care and treatment.

Gwen Bonner presented the paper and highlighted the following points:

- The Trust's Assertive Outreach Team action plan had been developed to align with NHS England's Guidance on Intensive and Assertive Mental Health Care 2024.
- Most areas had retained the same RAG rating as the previous update presented to the Committee in August 2025. Progress was being made but not sufficient to change the status from amber to green at this time.
- The only red RAG rated action was around the Depot Shared Care agreements for long-acting injectable medications with some GP practices not signed up.
- If GPs did not prescribe, Trust Psychiatrists would continue to do so, but this had cost implications. Conversations were ongoing with the Integrated Care Board and pharmacy leads to resolve shared care issues.
- The Trust had established an Assertive Outreach Team Oversight Group, and four working groups were in place focussing on data, caseload identification, best practice, and ongoing monitoring.
- Best practice guidance and standard work for clinicians was nearly finalised, with completion expected by March 2026.
- At the moment there was no additional funding to develop the Assertive Outreach Team. A recent business case for additional funding was unsuccessful, but £600,000 had now been secured from the Integrated Care Board from existing Mental Health Investment Standard funding.
- 102 patients had been identified as fitting the Assertive Outreach Team criteria, with cross-checking from Court Liaison and Diversion services.
- A stakeholder event had been in November 2025 which was well attended and included GPs, Probation, and other partners, with positive engagement.

John Barrett, Patient Safety Partner asked why some GP Practices did not want to undertake shared care for Depot prescribing.

Gwen Bonner explained that a key factor was that GPs were not remunerated for this work.

The Director of Nursing and Therapies commented that the Trust had started to put in place a number of actions following the Forbury Gardens incident and therefore had a solid platform in place to develop the Assertive Outreach team.

The Chair requested that the Committee receive an update on work at the November 2026 Committee.

Action: Chief Operating Officer/Gwen Bonner

The Chair thanked Gwen Bonner for her update and acknowledged the significant amount of work that had been undertaken to develop the Assertive Outreach Team model.

The Committee noted the report

5.2 Quality Concerns Register Report

The Director of Nursing and Therapies presented the report and highlighted the following changes since the Quality Concerns Register was last reviewed by the Committee:

The following concern descriptions had been rewritten/updated following the January 2026 Quality and Performance Executive Group meeting to ensure clarity and current accuracy:

- Mental Health bed occupancy
- Community based mental health teams
- Prospect Park Hospital environmental risks and impact on patients and staff

The following concern has been added to the register:

- **CAMH Phoenix service model, clinical pathways, and leadership challenges Paediatric Occupational Therapy** - this had been added due to long waits

Since the last meeting, the following services had been removed from the register:

- **Workforce at Prospect Park Hospital** - given improved position, there were mechanisms as part of safe staffing for close monitoring which would ensure that should the position deteriorate, it can be re-added if necessary.
- **Orchid Ward - clinical and leadership concerns** - following a deep-dive review and subsequent report into the Quality and Performance Executive Group, it was agreed that there were no ongoing concerns specific to Orchid Ward. Quality and safety across the ward were monitored through the monthly Older Persons Mental Health Oversight Group and at the pathway Senior Leadership Team meetings feeding into the Patient Safety and Quality meetings.

John Barrett, Patient Safety Partner referred to the mental health bed occupancy concern and suggested that re-writing the first sentence to make it clearer.

Action: Director of Nursing and Therapies

Aileen Feeney, Non-Executive Director commented that it would be helpful if the Committee could receive an update on the Phoenix service model given that it had been added to the Quality Concerns Register.

Action: Director of Nursing and Therapies

The Chair referred to the concern around bed occupancy and asked why people with psychosis had inpatient stays of 60 days and over.

The Medical Director explained that there were a number of reasons including the Trust not always being proactive around escalating treatment which increased the length of stay.

The Clinical Director Community Mental Health added that a psychosis pathway improvement event was planned, focusing on pre-admission planning, maximising inpatient interventions, and early identification of named workers for aftercare.

The Chair asked whether the Trust was an outlier in terms of length of stay for people with psychosis.

The Clinical Director Community Mental Health said that national benchmarking data showed that the Trust was slightly above the national average for length of stay but the Trust set itself high standards and was keen to reduce the length of stay and to improve flow through Prospect Park Hospital.

The Chair commented that it was positive that Orchid Ward and Prospect Park Hospital workforce had been removed from the Quality Concerns Register.

The Committee noted the report.

5.3 MHRA Medical Beds, Trolleys, Bed Rails, Bed Grab Handles and Lateral Turning Devices: Risk of Death from Entrapment or Falls – Update on the Actions

The Chair reminded the meeting that when the Committee last reviewed the action plan, all the internal actions had been completed but the Trust was awaiting a response from the Integrated Care Board in respect of action no 7: “Implement systems to update risk assessments where the equipment or the patients’ clinical conditions was changed and at regular intervals”.

The Director of Nursing and Therapies presented the report and confirmed that there had been a system agreement reached around this action with local processes established that were supported by patient/carer initiated follow up (with clear advice on how to escalate provided) and the local authority triage of any contacts.

The action plan was now closed.

The Committee noted the report.

5.4 “Jess’s Rule” Implementation Report

The Medical Director presented the paper and reminded the meeting that Jess was a young woman who had multiple GP visits before a cancer diagnosis. It was noted that Jess’s Rule (“*Three strikes and we rethink*”) was a patient-safety initiative promoted by NHS England to encourage diagnostic reflection when patients presented repeatedly with unresolved or worsening symptoms. It was intended as a clinical prompt to support safer decision-making in general practice.

The Medical Director said that the Trust was focussing on implementing Jess’s Rule for WestCall (Out of Hours GP Service). It was noted that currently patients presenting to the

Out-of-Hours service via 111 were triaged, and if they presented three times for the same issue, this was flagged for review.

The Medical Director reported that from the end of March 2026, a new process would be in place: if a patient presented for the same issue three times and it remained unresolved, an automatic flag would be sent to their usual GP. This would prompt the GP to consider a face-to-face review. The flag would be an automatic message sent at the end of the out-of-hours appointment.

The Medical Director added that there was no national mandate or contractual requirement to implement Jess's Rule in out-of-hours services, but the Trust believed it was the right thing to do for patient safety and continuity of care.

The Director of Nursing and Therapies said that the Trust was also exploring the application of Jess's Rule in other self-referral services, such as MSK and podiatry, where similar escalation and flagging mechanisms could be beneficial. This would likely involve a flag back to the patient's GP.

The Committee noted the report.

5.5 Patient Safety and Learning Report

The Head of Patient Safety presented the paper and reported that the use of varied methodologies to review incidents ensured that learning was timely, dynamic, and responsive to emerging issues. It was noted that multi-disciplinary roundtables remained the most utilised methodology and use of after-action review continued to increase.

The Head of Patient Safety said that the continued shift away from automatically investigating by harm category and towards selecting incidents for review based on learning value

- There was a **notable number of near-miss incidents** reviewed—this reflected an intentional cultural change towards identifying opportunities for early learning rather than reacting solely to harm events.
- There was an **increase in pressure ulcer-related learning responses** across community physical health services and district nursing. Although this rise initially appeared concerning, triangulation with neighbouring system providers showed this was a regional pattern likely driven by seasonal pressures and reduced post pandemic vigilance.
- There were several incidents involving **self harm on inpatient wards**, not necessarily associated with moderate or severe harm but considered significant enough to warrant structured learning.

The Head of Patient Safety reported that the Family Liaison Practitioner continued to receive very positive informal feedback from families. It was noted that staff participating in learning responses reported improved confidence, transparency, and psychological safety.

The Committee noted the report.

5.6 Patient Safety Incident Response Plan

The Deputy Director of Nursing for Patient Safety and Quality presented the paper which outlined how the Trust intended to learn from patient safety incidents to continuously improve care quality and safety.

The Deputy Director of Nursing for Patient Safety and Quality highlighted that the key changes since the first Patient Safety Incident Response Plan (January 2024) included:

- Removal of outdated frameworks and appendices
- Updated patient safety profiles
- Revised local priorities
- Inclusion of decision-making questions for learning responses
- Updated definitions of learning methodologies
- Incorporation of Walkthrough Analysis as a tool.
- The removal of the mortality section in favour of an updated Learning from Deaths policy.

The Deputy Director of Nursing for Patient Safety and Quality said that the updates reflected internal stakeholder feedback, review of latest national guidance and evaluation of the initial plan.

The Chair commented that she particularly found the sections on patient safety current issues/challenges and the local patient safety improvement programmes useful.

The Committee approved the updated Patient Safety Incident Response Plan.

5.7 Infection Prevention and Control Quarterly Report

The Infection Prevention and Control Quarterly Report had been circulated.

The Director of Nursing and Therapies presented the report and highlighted that during the quarter there was increased cases of flu and RSV consistent with national trends. It was noted that flu vaccination update was approximately 50% across the workforce including frontline staff.

The Director of Nursing and Therapies reported that NHS England had issued a “Call for Action” around Antimicrobial Resistance and confirmed that the Chief Pharmacist and Infection Prevention and Control Lead would be presenting the Trust’s Antimicrobial Resistance plans at the March 2026 Trust Board meeting. It was noted that future updates on the Trust’s Antimicrobial Resistance work would be presented to the Committee.

The Chair asked for an update on the legionella contamination which was delaying the opening of the Place of Safety.

The Director of Nursing and Therapies reported that legionella had been detected in the pipes of the Place of Safety and confirmed that the Estates team had undertaken the necessary remedial works and had engaged external specialists. It was noted that the Trust was waiting for clear sample results before the Place of Safety could be opened.

Rebecca Burford, Non-Executive Director asked whether the Trust was able to provide incentives to encourage more staff to be vaccinated against flu.

The Director of Nursing and Therapies explained that there was an issue of fairness, given that some people were not able to have the vaccination on medical grounds.

The Committee noted the report.

5.8 Quality Related Board Assurance Framework Risks Report

The quality related Board Assurance Framework Risks had been circulated.

The Committee noted the report.

5.9 Learning from Deaths Quarterly Report

The Associate Director for Medical Development, Clinical Effectiveness and Clinical Audit presented the paper and highlighted the following points:

- Of the second stage reviews concluded in Quarter 3, none of the deaths identified a governance cause for concern (avoidability score of 3).
- 4 reviews identified poor care, all have been reviewed as patient safety reviews and learning was identified and being implemented through Community Mental Health.
- All complaints received from families of individuals who had 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.
- 10 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.

The Associate Director for Medical Development, Clinical Effectiveness and Clinical Audit reported that the Quarter 4 report would include an annual summary of the learning from deaths.

The Medical Director added that the Trust would be reviewing deaths in the past 12-18 months to identify the key learning and the changes to practice that had occurred in response to the learning.

John Barrett, Patient Safety Partner commented that he liked the format of the report which was well laid out with the themes clearly identified.

The Committee noted the report.

Clinical Effectiveness and Outcomes

6.0 Clinical Audit Report

The Associate Director for Medical Development, Clinical Effectiveness and Clinical Audit reported that since the last meeting the following national audits had been published and reviewed at the Clinical Effectiveness Group:

- Prescribing Observatory for Mental Health (POMH) Topic 18c: The Use of Clozapine 2025.
- National Audit of Care at the End of Life (NACEL) Report 2025.
- National Audit of Cardiac Rehabilitation Quality and Outcomes Report – Summary Report 2025.
- National Audit of Inpatient Falls and Fractures (NAIF) – Summary Report 2025.
- Sentinel Stroke National Audit Programme (SSNAP) – Summary Report 2025.

The Chair referred to the Use of Clozapine clinical audit and noted that the Trust continued to prescribe Clozapine to fewer people compared with national benchmarks and there were challenges with blood monitoring.

The Clinical Director Community Mental Health explained that some patients were reluctant to commence Clozapine.

The Medical Director added that clinical pathways had not always followed sequentially (for example, NICE guidance on first- and second-line interventions). It was noted that a forthcoming Psychosis Pathway Improvement Event will examine consistency of patient journeys and escalation to Clozapine where required.

The Clinical Director Community Mental Health said that currently blood monitoring required venepuncture, but the Trust was planning to move toward finger-prick blood testing to improve uptake.

The Chair referred to Inpatient Falls and Fractures clinical audit which referred to using manual handling rather than waiting for hoisting equipment to move a patient following a fall.

The Director of Nursing and Therapies clarified that this referred to a single patient and added that although this was not compliant within the audit scoring, there was no suggestion that staff had not acted appropriately or that this was not in the patient's best interest.

The Chair referred to the End-of-Life clinical audit and noted that the Trust was considering extending Martha's Rule to palliative care.

The Director of Nursing and Therapies explained that at the moment, Martha's Rule did not apply to palliative care patients, but the Trust was proposing to the national pilot group that an additional palliative care targeted question directed at bereaved families and carers be added to check understanding of the treatment plan and whether pain was managed effectively.

The Committee noted the report.

6.1 Quality Accounts 2025-26 – Quarter 3 Report

The Quality Accounts 2025-6 quarter 3 report had been circulated for information.

The Associate Director for Medical Development, Clinical Effectiveness and Clinical Audit The Committee noted the report reminded the meeting that the Quarter 3 version of the Quality Accounts 2025-6 report would be shared with stakeholders.

Members of the Committee were invited to forward any comments on the Quality Accounts 2025-6 Report to the Associate Director for Medical Development, Clinical Effectiveness and Clinical Audit by the end of the week.

It was noted that member of the Committee would be asked to approve the final report electronically prior to its submission to the May 2026 Public Trust Board meeting for approval.

The Chair commented that the Quality Accounts Report was informative and well laid out.

The Committee noted the report.

Update Items for Information

7.0 Guardian of Safe Working Hours Quarterly Report

The Guardian of Safe working hours quarterly report has been circulated.

The Medical Director reported that the Guardian of Safe Working gave assurance that overall, no unsafe working hours patterns had been identified and there were no other patient safety issues requiring escalation.

The Medical Director reported that since the last report to the Committee, there had been seven “hours and rest” exception reports and one “educational” exceptional report.

The Medical Director reported that there were new national rules introduced to ensure that doctors had timely access to systems and were not prevented from exception reporting. Employers would face additional fines to ensure that doctors were not adversely affected by the unnecessary sharing of exception reporting information.

The Medical Director reported that as part of the national Resident Doctors Ten Point Plan, NHS England required every trust to nominate a Non-Executive Director for Board level oversight. In consultation with the Trust Chair, the Medical Director proposed that the Chair of the Committee be the nominated person.

The Chair confirmed that she would be delighted to oversee the implementation of the Resident Doctors Ten Point Plan on behalf of the Trust.

The Committee noted the report.

7.1 Minutes of the Mental Health Act Governance (MHA) Board

The minutes of the Mental Health Act Governance Board meetings held on 6 February 2026 had been circulated.

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

- The Mental Health Act Governance Board had discussed incidents involving patients’ failure to return and patients leaving the ward during October to December 2025 and these incidents were under thematic review with immediate controls implemented.

- The longstanding CQC action (shower facilities in the Seclusion room, Prospect Park Hospital) remained open due to structural estate constraints. Patients had access to alternative shower facilities.
- Monitoring continued for Section 136 and Section 114 delays affecting flow.
- The ECT service had been extremely busy over recent months resulting in some delays. There were no concerns with compliance regarding MHA requirements or ECT clinical standards.

The Chair asked whether the initial Mental Health Act Reforms which related mainly to forensic patients would impact the Trust.

The Medical Director said that the main issue for the Trust was around improving processes in relation to Community Treatment Orders.

The Head of Mental Health Act added that the changes introduced on 18 February 2026 were fixes rather than massive changes. The Head of Mental Health Act said that increased referrals from prisons was continuing to impact the Trust. It was noted that Youth Offending Centres and Immigration Centres would also be able to refer patients to the Trust for mental health inpatient assessment.

The Committee noted the minutes.

7.2 Quality and Performance Executive Group Minutes – November 2026, December 2026, and January 2026

The minutes of the Quality and Performance Executive Group minutes for November 2025, December 2025 and January 2026 had been circulated.

The Committee noted the minutes.

7.3 Non-Executive Directors and Council of Governors Quality Assurance Group – Visits to Services

The following Governor service reports had been circulated:

- CAMHs Children in Care and CAMHs Specialist Community Teams and Learning Disability
- Occupational Therapy (Inpatient Therapy Team)
- Alliance for Cohesion and Racial Equality (ACRE)

John Barrett, Patient Safety Partner commented that the Governor service reports were much easier to read now that they followed a standardised template.

The Chair referred to the CAMHs Children in Care CAMHs Specialist Community Teams and Learning Disability report which stated that there was a waiting list of up to 18 months for the Learning Disability service model and asked for more information.

The Director of Nursing and Therapies said that there were no patients with severe needs waiting for 18 months and agreed to inform the Committee about the current waiting list.

Action: Director of Nursing and Therapies

The Chair thanked the Governors for their reports.

The Committee noted the reports.

8.0 Quality Assurance Committee Horizon Scanning

A presentation on the Phoenix House pathway was added to the Committee's work programme.

Action: Company Secretary

8.1. Any Other Business

There was no other business.

8.2. Date of the Next Meeting

The next meeting was scheduled to take place on 24 February 2026 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 26 May 2026

Signed: -

Date: - 26 May 2026

Board Meeting Date	February 2026
Title	Learning from Deaths Quarter 3 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	<p>The systems and processes for learning from deaths align with and give assurance against the three strategic objectives below:</p> <p>Patient safety We will reduce harm risk for our patients by continuous learning from review of deaths.</p> <p>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.</p> <p>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.</p>
CQC Registration/Patient Care Impacts	No impact
Resource Impacts	None
Legal Implications	New Statutory requirements for Medical Examiners from 9 th September 2024 noted, actions taken to ensure that these requirements are fully met in advance of this date.
Equality, Diversity and Inclusion Implications	<p>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.</p> <p>Ethnicity data is included in the report.</p>
SUMMARY	<p>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.</p> <p>Patient safety Of the second stage reviews concluded in Quarter 3, none of the deaths identified a governance cause for concern (avoidability score of 3).</p> <p>4 reviews identified poor care, all have been reviewed as patient safety reviews and learning is identified and being implemented through Community Mental Health (4).</p> <p>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.</p> <p>Health inequalities 10 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.</p> <p>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.</p>
ACTION	The committee is asked to receive and note the Q3 learning from deaths.

Learning From Deaths Q3 Report (2025/26)



Q3 2025/26

846 deaths were identified on RiO where a patient had died from any cause within a year of contact with any Trust service, of these 125 were submitted for a 1st stage review in line with the learning from deaths policy (12%).

All 125 deaths had first stage review by the Executive Mortality Review Group (EMRG) in Q3, 2nd Stage reviews were requested for 47 (38%). 42 2nd stage reviews were concluded by the Mortality and Patient Safety Review Group during Q3.

Of the second stage reviews concluded in Q3, none of the deaths was a governance cause for concern (Avoidability score of 1,2 or 3) .

Of the reviews concluded in Q3, 4 were assessed as overall poor care following a patient safety review, and learning is detailed in the community mental health section of the report.

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) 1 st stage review	456	453	553	119	105	125	-	349
Total number of 2 nd stage reviews requested (SJR/IFR)	192	203	237	38	40	47	-	125
Total number of deaths to be reviewed through patient safety (PSII and PSR) declared in Quarter	31	31	36	10	11	12	-	33
Total Expected Deaths	-	183	219	45	47	40	-	132
Total Unexpected Deaths	-	270	324	74	58	85	-	217
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	0	0	-	1
Number of Hospital Inpatient deaths reported (Including patients at the end of life and unexpected deaths following transfer)	156	140	159	39	34	36	-	109
Total number of deaths of patients with a Learning Disability (1 st stage reviews)	36	53	49	12	6	10	-	28
Total number of deaths of patients with Learning Disability where care was rated as poor	0	0	0	0	0	0	-	0

2 nd stage Mortality reviews completed (SJR/IFR)	Q3 (42)	Total 2025/2026 (134)	Avoidability score for 2 nd Stage Reviews (only death due to a physical health cause) 2025/2026	Q3 (42)	Total to date (134)	Overall Assessment of Care Q3 (42)	Physical health	Learning Disability	Mental Health	Children and Young People	Total to date 25/26 (134)
Adult Learning Disabilities Services	3	22	Score 1	Definitely avoidable	0	0	1	0	0	0	0
			Score 2	Strong evidence of avoidability	0	0					
Mental Health community, specialist, and inpatient services	18	51	Score 3	Probably avoidable (more than 50:50)	0	1	2	0	4	0	12
			Score 4	Possibly avoidable, but not very likely (less than 50:50)	1	4					
Children's and Young people's Services	0	1	Score 5	Slight evidence of avoidability	2	7	3	2	7	0	72
			Score 6	Definitely not avoidable	25	82					
Physical Health community and Inpatient Service	21	60	51		25	82	5	3	0	0	6
			N/A	Non physical health cause	14	40					

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	5	3	60
Asian or Asian British - Chinese	3	2	67
Asian or Asian British - Indian	7	1	14
Asian or Asian British - Pakistani	5	3	60
Black or Black British - African	3	0	0
Black or Black British - Caribbean	2	1	50
Black or Black British - Other Black Background	1	0	0
Mixed - White and Asian	1	0	0
Mixed - White and Black Caribbean	2	1	50
Not Known - Waiting for first appointment/not recorded	43	13	30
Not stated - refused	5	0	0
Other ethnic category	1	0	0
White - any other white background	8	4	50
White - English/Welsh/Scottish/Northern Irish/British	261	96	37
White - Irish	2	1	50
Grand Total	349	125	36

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	2
Asian or Asian British - Indian	-	-	-	-	-	1	1	2
Asian or Asian British - Pakistani	-	-	-	-	-	3	-	3
Black or Black British - Caribbean	-	-	-	-	-	-	1	1
Mixed - Any other mixed background	-	-	-	-	1	-	-	1
Not Known - Waiting for first appointment/not recorded	-	-	-	-	1	3	4	8
Other ethnic category	-	-	-	-	-	4	-	4
White - any other white background	-	-	-	-	-	1	3	4
White - English/Welsh/Scottish/Northern Irish/British	-	-	1	4	5	69	29	108
White - Irish	-	-	-	-	-	-	1	1
Grand Total	0	0	1	4	7	82	40	134

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



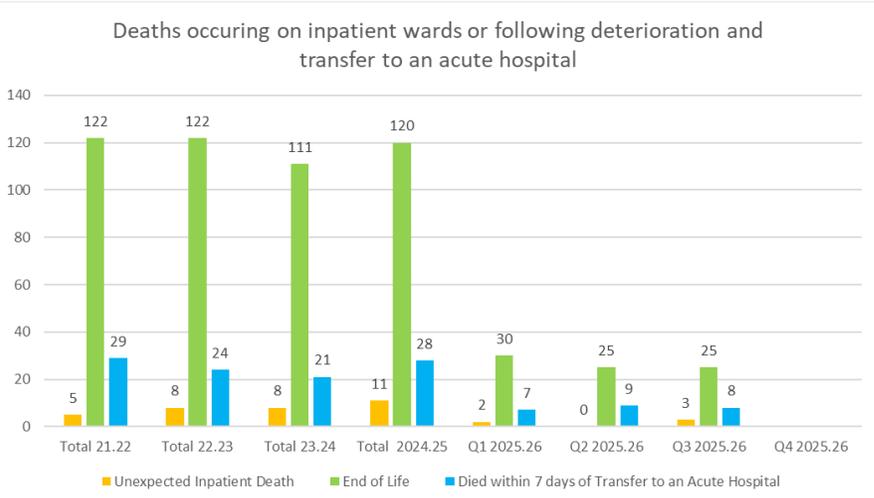
Overall Assessment of Care all 2nd stage reviews completed in 2025/26 (April – March 26 to date will include cases reported as 1st stage reviews in 2024/25)	1 Very Poor Care	2 Poor Care	3 Adequate Care	4 Good Care	5 Excellent Care	Total
Asian or Asian British - Any other Asian Background	-	-	1	1	-	2
Asian or Asian British - Indian	-	1	-	1	-	2
Asian or Asian British - Pakistani	-	-	-	3	-	3
Black or Black British - Caribbean	-	-	1	-	-	1
Mixed - Any other mixed background	-	-	1	-	-	1
Not Known - Waiting for first appointment/not recorded	-	1	2	3	2	8
Other ethnic category	-	-	1	3	-	4
White - any other white background	-	1	3	-	-	4
White - English/Welsh/Scottish/Northern Irish/British	-	9	34	61	4	108
White - Irish	-	-	1	-	-	1
Grand Total	0	12	44	72	6	134

Equality & Diversity Summary Q3 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 one identified as poor care from a total of 12 to date.

Inpatients (Physical Health and Mental Health) Learning From Deaths Q3 Report



In Q3 EMRG reviewed:

36 deaths were reported by inpatient services, 36 from our physical health wards of which 25 were expected end of life deaths, 3 unexpected inpatient deaths all physical health and 8 were categorised as unexpected deaths (transfer and death within 7 days).

2nd stage reviews were requested for all 11 unexpected deaths (8 transfers and 3 inpatients). Of the end of life deaths 23 were closed at 1st stage, 2 SJR were requested following ME review.

11 2nd stage reviews were concluded in Q3. Of which:

- Slight evidence of avoidability (1) and good care: 1
- Definitely not avoidable (10) of which care was :adequate care (1)good care (7) excellent care (2)

Q3 2025/26

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.

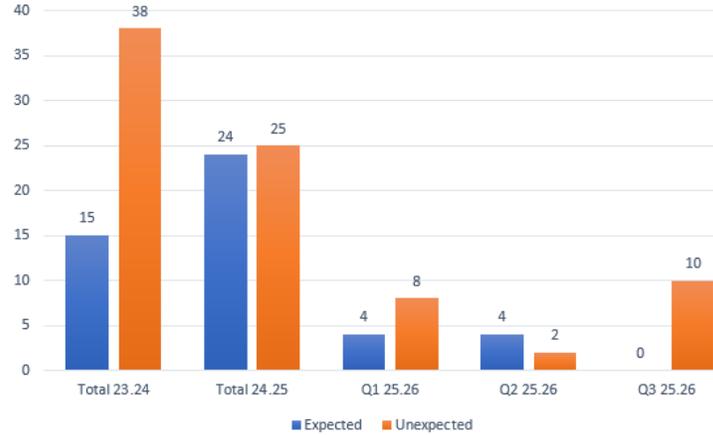
All Inpatient deaths are independently scrutinised by a Medical Examiner in line with the statutory requirement to confirm the cause of death to be detailed on the Medical Certificate of cause of Death (MCCD) or confirm a referral for a coroner review.

Month of death (Note this is not EMRG date)	2023/24	2024/25	April 25	May 25	June 25	July 25	August 25	September 25	October 25	November 25	December 25	Total 2025/26
Total Inpatient deaths reviewed by the Medical Examiner	113	127	13	11	8	8	10	6	12	10	9	87
SJR's requested for Inpatient deaths by Medical Examiner	2	1	1	1	0	0	0	0	0	1	0	3
Coroner Referrals advised by Medical Examiner for Inpatient Deaths	11	3	1	1	0	0	2	0	1	1	1	7

EOL Audit Q3	Total Q3	Narrative
New continuous audit which reviews all physical health inpatient planned End of Life deaths.	21	2/21 patients did not have their religion documented, and 2/21 patients' assessment of spiritual, religious, or cultural needs of the patient and those important to them was not recorded. No actions for improvement have been identified as this was due to a new palliative care clerking role where additional learning has been provided. Non-specialist sites were reminded to contact West Berkshire Community Hospital team and/ or the Clinical Audit & Effectiveness Facilitator for advice and guidance when completing data collection forms and to use the End of Life Assessment and Care Pathway documents on RiO.

Adults with a Learning Disability Learning From Deaths Q3 2025/26

Adults with a Learning Disability



In Q3, 10 deaths of adults with learning disability were reviewed at 1st stage review. 10 were classed as unexpected, 2nd stage reviews were requested for 8 and 2 were closed.

3 2nd stage reviews were concluded in Q3 (detailed in tables below).

Severity of LD	Q3	Total 25/26 (22)
Mild	0	4
Mild to Moderate	1	1
Moderate	1	4
Moderate to Severe	0	2
Severe	0	1
Profound	0	1
Not Known	1	9
Ethnicity	Q3	Total 25/26 (22)
White British	3	21
Asian or Asian British - Pakistani	0	1

	Q3	Total 25/26 (22)
Male	1	10
Female	2	12
The deaths attributed to the following causes:	Q3	Total 25/26 (22)
Diseases of the respiratory system	1	10
Diseases of the heart & circulatory system	0	1
Diseases of the digestive system	0	2
Sepsis or Infection	0	2
Cancer	0	2
Other	2	5
Not known	0	0

	Avoidability score for 2 nd stage reviews (3)	Learning Disability Q3 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	3
N/A	Mental health	0

	Overall Assessment of Care	Learning Disability Q3 25/26
1	Very poor care	0
2	Poor Care	0
3	Adequate Care	0
4	Good Care	2
5	Excellent Care	1



Berkshire Healthcare
NHS Foundation Trust

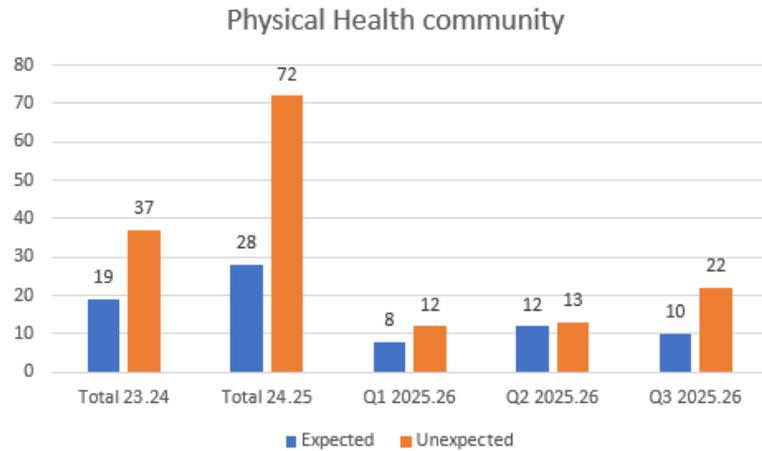
Q3 2025/26

The Learning Disability Service makes contact with the family and/or staff team following the reported death of a person with a learning disability.

In Q3 the following learning was shared within the LD service:

- A reminder of the benefit in completing the CTPLD checklist and to include relevant information in the care plans on Rio
- A reminder to teams of the importance for recording MCAs and risk in the relevant areas of RiO
- Ongoing evidence of good MDT working, coordination of care and communication. Ongoing evidence to show BHFT services were responsive to people's needs and that care was delivered using collaborative, person centred approaches.
- Referrals were triaged and actioned promptly, with interventions and care provided that clearly addressed the referred need. This was largely in the form of brief interventions, but regular consistent follow up from the Podiatry and Community Nursing service also took place to meet the requirement of monitoring and managing pressure areas.

Community Physical Health Learning From Deaths Q3



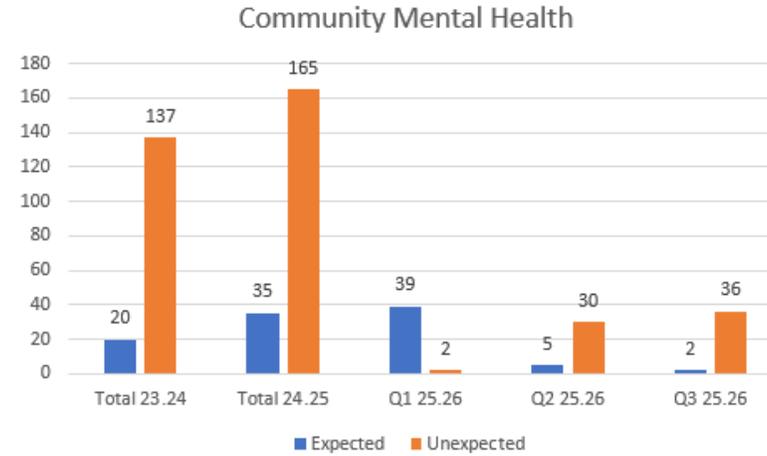
EMRG received 32 1st stage reviews in Q3 of which 2nd stage reviews were requested for 10.

12 2nd stage reviews were completed in Q3. No reviews identified poor care or a governance cause for concern, the following key learning was identified.

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

- Not making appropriate referrals to Tissue Viability Nurses (TVNs) at the point of deterioration being noted delay in the escalation and increase in visits
- Understanding of sepsis tool and documentation accordingly
- Escalation to GP directly if observations are a cause of concern
- Use of NEWS scores in the community to commence
- Understanding BP cuff sizes in relation to obtaining an accurate blood pressure
- Learning in liaising with the families directly in care home settings.
- Ensuring that referrals to BHFT services are made by us when the initial service receiving the referral is a BHFT service and needs to be allocated to another BHFT service.
- Reinforce awareness of NICE NG217 and escalation pathways for seizure clustering key learning around safety netting which has been shared with the teams.

Community Mental Health Learning From Deaths Q3

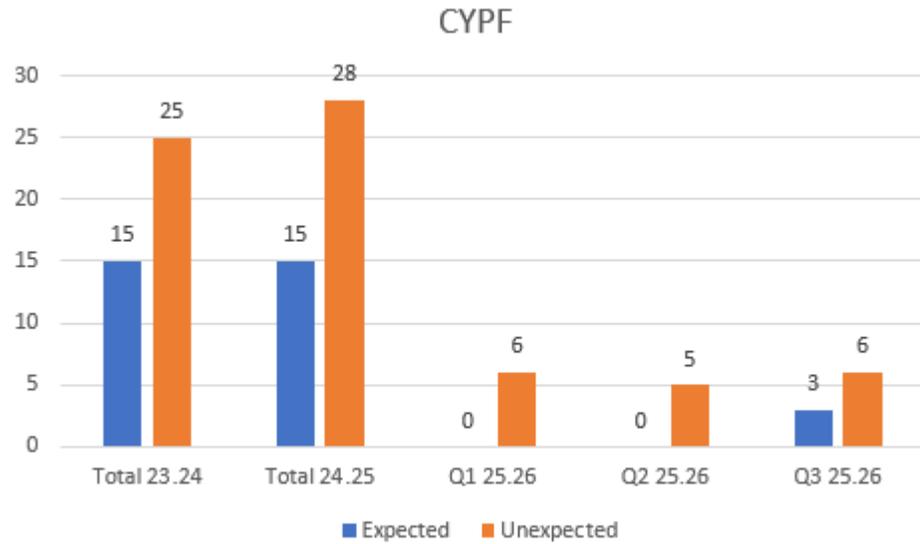


EMRG received 38 1st stage reviews in Q3 of which 2nd stage reviews were requested for 16, with 4 requiring further information.

16 2nd stage reviews were completed in Q3 from a range of community mental health or specialist mental health services 12 in which care was deemed to be adequate or good, and 4 identified poor care.

All 4 cases which identified poor care were reviewed in detail as patient safety reviews and have relevant actions plans in place to ensure improvement. Key learning is summarised below:

- Delay or lack of allocation of the named worker from MHICS (Mental Health Integrated Community Service) and then going onto the CMHT (Community Mental Health Service) pathway and the communication and feedback to the patient.
- Use of IMDT (Integrated Multidisciplinary Team) when patients presentation fits between services to try and identify what the best appropriate pathway should be.
- Triage system within Crisis and CPE (Common Point of Entry). The new professional leading Crisis is using half a day every week listening to live calls so that immediate feedback can be given, two day training with the Crisis team.
- Improvements have been seen especially in Slough CMHT around management of first psychiatric appointments, but some other localities are still struggling with the first appointments so further safety actions to be added to action plan to cover all localities, this links into the wider improvement stream.
- Learning identified around our response to the reported domestic abuse identified in each engagement with each of the parties but no consideration of a DASH risk assessments. There has now been significant improvements in how the DASH assessment is visible on RiO and through e-passport.
- Learning around the impact of the child and how the child's voice was potentially not recognised by our services.



EMRG received 9 1st stage reviews in Q3 all of which were closed. Included, premature births, child with complex life limiting illness an unexpected deaths under universal HV or school nursing and no contact.

There were no 2nd stage reviews concluded in Q3 for the children's and young people service.

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.

Complaints and Inquiries Learning From Deaths Q3

Complaints and MP Inquiries	Q3 25/26	Total 25/26
Community Mental Health team. Complaint raised by a mother due to not being identified as the next of kin for the patient.	1	6

1 complaint was received in Q3 regarding a mother not being considered as next of kin for a patient. A 2nd stage review was requested in addition to the formal complaint response.

In Q3 there were 2 freedom of information requests;

FOI 466 regarding the total number of patients who had / did not have a learning disability and/or autism at their time of their death in financial years 20/21, 21/22, 22/23, 23/4, 24/25

FOI 505 regarding the number of patients who were diagnosed with, or suspected of having, bipolar disorder and were assessed by a CMHT team, are were not section but subsequently died by suicide within 12 months of their final assessment between June 2024 – June 2025.

Prevention of Future Deaths (PFD) reports 2025/26: No PFD's have been received in Q3 2025/26 (or to date this year).

Overall Learning and Summary From Deaths Q3

Of the second stage reviews concluded, none of the deaths were a governance cause for concern (avoidability score of 3).

4 reviews identified poor care learning is identified

All 4 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.

10 reviews related to patients with a learning disability in Q3, 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.

1 complaint received. No concerns were raised by the medical examiner.

Learning Presentations to MAPS (mortality and patient safety) included the following topics:

- Community Physical Health care plan project
- Wound care in the community – The RiO improvement work in relation to Wound Assessment Treatment Plan – impact and progress
- Drugs and Alcohol Teams
- New model being put in place for having oversight of the MH caseload and where patients are on pathway
- Improvement work regarding therapeutic observations at PPH
- Risk training offer

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

This report covers the period 7th November 2025 to the 3rd February 2026

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 7-11-2025 to 3-02-2026. Since the last report to the Trust Board, we have received seven 'hours & rest' exception reports (ER) and one 'educational' exception report (ER), total eight ER.

Introduction

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

Number of doctors in training (total) since Dec 2025: 65 (WTE 62.2)

Number of doctors in training on 2016 TCS since Dec 2025 (total): 65 (WTE 62.2)

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

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	8	8	0
Sexual Health	0	0	0	0
Total	0	8	8	0

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
FY	0	3	3	0
CT	0	4	4	0
ST	0	1	1	0
Total	0	8	8	0

There are now three rotas for out of hours. The established out of hours rota for residential on call covered by the core trainees and GPVTS/FY2 doctors at CT1-3 level; the non residential on call (NROC) out of hours rota covered by higher trainees between 5 PM and 9 AM including cover for POS (place of safety). The NROC is further distinguished as one for general adult + old age (GA and OA) and child and adolescent mental health (CAMHS).

Exception reports by OOH rota (resident on call)				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Psychiatry OOHs Core trainee rota	0	0	0	0
Psychiatry NROC Higher trainee rota- GA and OA	0	1	1	0
Psychiatry NROC Higher trainee rota- CAMHS	0	0	0	0

- The higher trainee SPR rota has been implemented since 1-12-2025, so far any gaps identified have been duly filled. No unsafe working pattern identified.
- The CAMHS higher trainee rota is supernumerary for training need and gaps are not required to be filled. No unsafe working shift pattern identified.

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
Total	3	3	2	0

In this period, we have received eight exception reports. Two ERs have been raised by F1 doctor on an acute adult ward. These individually relate to time worked beyond the work schedule on each occasion to complete urgent ward tasks and documentation that needed to be completed. The F1 doctor has not raised any concerns regarding the work schedule but has had supervision meetings with their clinical supervisor and with GOSW to clarify the issues. Some learning points were discussed and TOIL has been approved as appropriate. Three ERs have been raised from OPMH wards and suggested that there is discrepancy in number of medical doctors between the East and West OPMH teams. There also has been wide variation of workload between these two teams due to gross difference in number of admissions between the East and West OPMH teams. Wider discussions have happened within inpatient teams and SLT, proposal agreed that the medical teams will now be ward based (functional and dementia) instead of East and West. GOSW had a separate meeting with OPMH consultant to explore possible mechanisms to resolve this. OPMH consultant will discuss in supervision with trainee doctors. One ER due to OPPC (oxford MRCPsych course) late finish , TOIL was approved. One ER was educational relating to delays in psychotherapy case allocation and this has been duly escalated to the DME and regularly discussed at RDF. Recent feedback from trainees is that cases are now being allocated in a timely manner, Psychotherapy tutor aware. There has been one ER from the newly configured higher trainee GA/OA rota, due to breach of uninterrupted rest period between 10 PM and 7 AM. The breach period was for 15 minutes and this has mandated a fine payment to the doctor and GOSW pot from the fine monies.

The GOSW has regular discussions with resident doctors regarding the exception reports at the Resident Doctors' Forum (RDF) which is attended by DME and tutors, other educational and training issues are discussed too- these meetings were on 6-11-2025, 4-12-2025 and 8-1-2026. 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. 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) and LNC 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. This will be mandated by the update to NHS 2016 [Terms and Conditions of Service \(TCS\)](#) and any breaches to access and confidentiality will be subject to fines.

We will continue to monitor and raise any issues when they arise. 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 by GOSW to respective supervisors to remind them to action the reports (if not actioned within 7 days and overdue) and agree TOIL when appropriate. GOSW continues to engage with resident doctors one to one when applicable and also via the RDF on a regular basis.

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. With the new reforms resident doctors will have a choice between TOIL and payment. The new reforms are set to take force from 4-2-2026.

a) 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

b) Gaps

(All data provided below for bookings (bank/agency/resident doctors) covers the period 07-05-2025 to 05-08-2025
There has been a substantial reduction in gaps and sickness shifts from previous quarter.

Reason	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Gap	23	23	261.5	261.5
Sickness	25	12	209.5	85
Maternity	0	0	0	0

Total	48	35	471	346.5
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d. Fines

Fines levied by the Guardians of Safe Working should be applied to individual departments, as is the intent of the contract. Fine has been levied during this quarter.

Fines by department		
Department	Number of fines levied	Value of fines levied
psychiatry	1	£ 35.45
Total	1	£ 35.45

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter
£111	£ 22.16	£0	£132.16

Qualitative information

The OOH rota is currently operating at 1:13 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 4 unfilled gaps in shifts 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 decrease in rota gaps due to sickness 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. The GOSW continues to remind the respective consultants to discuss and action the reports on DRS4 and will continue to do so. There continues to remain gaps in resident on call rota, most of them are filled by additional locum work by our doctors. 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 key changes are:

- All educational exception reports will go to the directors of medical education (DME) for approval.
- All other exception reports for hours and rest less than 2 hours to go to HR or medical workforce HR for approval and more than 2 hours will go to GOSW for approval
- The guardian of safe working hours (GoSWH) will retain oversight of all exception reports
- A three-tier system will be used to determine if hours were indeed worked.
- Doctors will have their choice of time off in lieu (TOIL) or pay - except when a breach of safe working hours mandates the award of TOIL.
- Additional fines: fines will be introduced to ensure that doctors have timely access to systems and are not prevented from exception reporting. Employers will face additional fines to ensure that doctors are not adversely affected by the unnecessary sharing of exception reporting information.

The implementation date for the new changes has been set for 04-02-2025. A new exception report policy and SOP has been developed and agreed with the LNC. All resident doctors must have access to the new DRS5 exception reporting system within 7 days of joining and will be expected to do test report. All exception reports are bound by the confidentiality clause, except when a need arises to look into issues relating to training or staffing or patient safety

as appropriate and will be discussed with the RD. Any breaches of this confidentiality will be subject to fines imposed on the Trust.

Further guidance is expected from NHEmployers about standardized template for GOSW report and this will also include a detriment survey, expected to be administered by GOSW.

Actions taken to resolve issues:

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. There are work underway to incorporate the new changes in ER reforms into DRS% upgraded version.

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

GOSW has highlighted the need for additional administrative support for this role (currently none) with medical director and associate director for medical development. This is because it is anticipated there is likely to be an increase in the number of ERs with the reforms. There are also additional responsibilities for GOSW in reporting to board via standardized templates and detriment survey on a regular basis. GOSW needs administrative support to run the RDF on a regular basis. With additional NROC rotas, there is additional work on reporting regarding these rotas and actioning upon any gaps/exceptions reported in relation to these.

Summary

All work schedules are currently compliant with the Contract Terms and Conditions of Service. No review of work schedule or 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.

Next report to be submitted in May 2026.

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

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.

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*.
<p>A doctor must receive:</p> <ul style="list-style-type: none"> 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. 	<p>A doctor must receive:</p> <ul style="list-style-type: none"> at least one 30 minute paid break for a shift rostered to last more than 5 hours a second 30 minute paid break for a shift rostered to last more than 9 hours A third 30-minute paid break for a night shift as described in paragraph 15 of Schedule 2, rostered to last 12 hours or more.

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

Trust Board Paper

Board Meeting Date	10 th March 2026
Title	Patient Experience Report -Quarter 3 (October to December 2025)
	Paper for noting
Reason for the Report going to the Trust Board	<p>This report is written to provide information to the Board in relation to a range of patient experience data available to us.</p> <p>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.</p>
Business Area	Trust Wide
Author	<p>Elizabeth Chapman, Head of Patient Experience (full report)</p> <p>Debbie Fulton; Director Nursing and Therapies (Highlight Report)</p>
Relevant Strategic Objectives	<p>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.</p> <p>Patient safety</p> <p>Ambition: We will reduce waiting times and harm risk for our patients</p> <p>Patient experience and voice</p> <p>Ambition: We will leverage our patient experience and voice to inform improvement</p> <p>Health inequalities</p> <p>Ambition: We will reduce health inequalities for our most vulnerable patients and communities</p>

Highlight Patient Experience Report - Quarter Three 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	146,499	229,798		
Number of iWGC responses received	Number	61,000 year for 10%	13,604	11,107	20,708		
iWGC Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	10%	8.4%	7.6%	9.1%		
iWGC 5-star score	Number	4.75	4.8	4.82	4.74		
iWGC Experience score – FFT (good or very good experience)	%	95%	94.67%	92.56%	88.35% (95.6% excluding imms)*		
Compliments received directly by services	Number	^{24/25} 4904	1682	1285	1430		
Formal Complaints received	Number/ %	^{24/25} 230 (0.032%)	51	58	60		
Formal Complaints Closed	Number	^{24/25} 198	57	61	60		
Formal complaints responded to within agreed timescale	%	100%	100%	100%	100%		
Formal Complaints Upheld/Partially Upheld	%	50%	54%	62%	37%		
Local resolution concerns/ informal complaints Rec	Number	^{2024/25} 189	46	71	43		
MP Enquiries Rec	Number	^{2024/25} 27	12	14	16		
Complaints upheld/ partially by PHSO	Number	^{2024/25} 2	0	0	0		

*FFT shown with and without child immunisation feedback, with rationale for this is detailed within the report under the Children, families and all age section of the report.

There has been an increase in the number of responses through the iWGC survey, these are almost exclusively in relation to responses being received for the childhood immunisation team (over 10,000 received), following significant work to support young people to provide feedback.

The above chart has the positivity score with and without these responses included due to the significant skew in scoring this has caused. Review of the responses does not indicate significant or concerning feedback with much of the less positive qualitative feedback in the survey responses being in relation to the need to have an immunisation, not having biscuits, asks if it could be a slower process for more time out of the classroom and other similar related requests. Reasons given for the lower scores were not within the remit of the immunisation team.

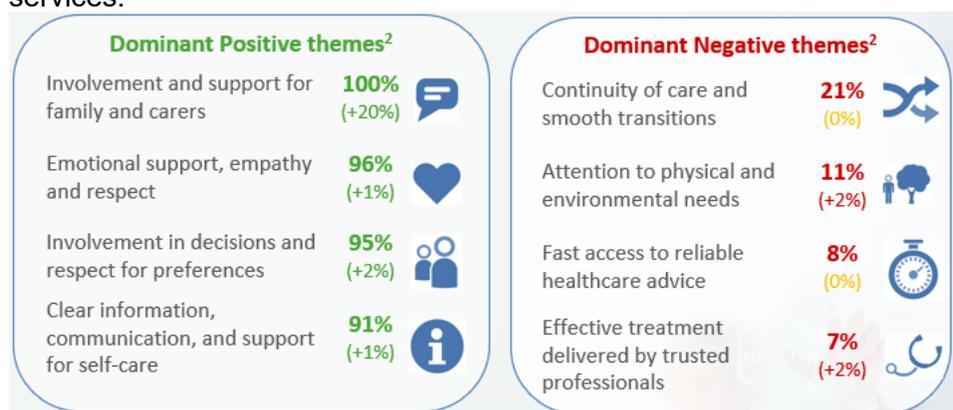
Except for the above, the data continues to show only small variations each quarter. Over the last year we received a significantly lower number of MP enquires compared to previous years (27 in 2024/25 compared to 73 in 2023/24), the numbers are now more in line with pre-election levels.

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.

Overall feedback remains overwhelmingly positive with questions around our staff and involvement continuing to be dominant positive themes. There has been one significant movement this quarter with involvement and support for family and carers jumping by 20% to 100%.

The predominant negative theme continues to be in relation to smooth transition, and much work is being undertaken to improve transition between services particularly across Mental health services.



*Number in brackets shows change from previous quarter

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 Q3 attendances
Asian/Asian British	2.56%	10.14%	10.26%
Black/Black British	2.56%	2.28%	3.19%
Mixed	2.56%	4.12%	3.30%
Not stated	7.69%	28.70%	8.37%
Other Ethnic Group	3.85%	3.66%	1.92%
White	80.77%	51.12%	72.96%

The data indicates that for this quarter Asian patients were much less likely to complain compared to attendance percentage than any other group, they do however provide feedback through completion of the patient survey in line with attendance numbers.

White patients are much less likely to complete the survey as a percentage compared to attendance, although it is recognised that we have a high rate of patients who do not complete the ethnicity section of the feedback survey (around 29%), making it less easy to draw conclusions. 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.

In terms of age the data would indicate that those over 60 years of age continue to be 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.

Further, targeted work is required to improve the recording of patient demographics in relation to complaints, as this will enable us to more accurately analyse data in terms of any differential experience. We have narrative within our survey to encourage people completing our staff survey to complete the demographic data which was agreed in collaboration with our EDI team and staff networks.

Continuing to increase feedback in general will enable services to understand the experience of those using their services and to use this for improvement. This 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.

NHS England have now published their Medium-Term Planning Framework, within this there are two areas specific to patient feedback of relevance to us as detailed below:

Between now and the end of 2025/26, all NHS trusts will be expected to:

1. Capture near real time experiences with a renewed focus on ensuring effective discharge processes. **This is in place through our patient experience survey.**
2. Complete at least one full survey cycle to capture the experience of people waiting for care: Have they had cancellations? Has anyone been in touch? What do they think has got worse since they have been on the waiting list? What information do they need to manage their condition well? This should support delivery teams to improve the experience of waiting and, where necessary, re-prioritise patients who may need to be treated faster. **A survey has been sent out to an initial cohort of patients across our community health services experiencing longer waits, with the review of feedback to take place over March. Outcomes from this will be reported within the quarter 4 report.**

Patient Experience Report Quarter Three 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 iWGC 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.

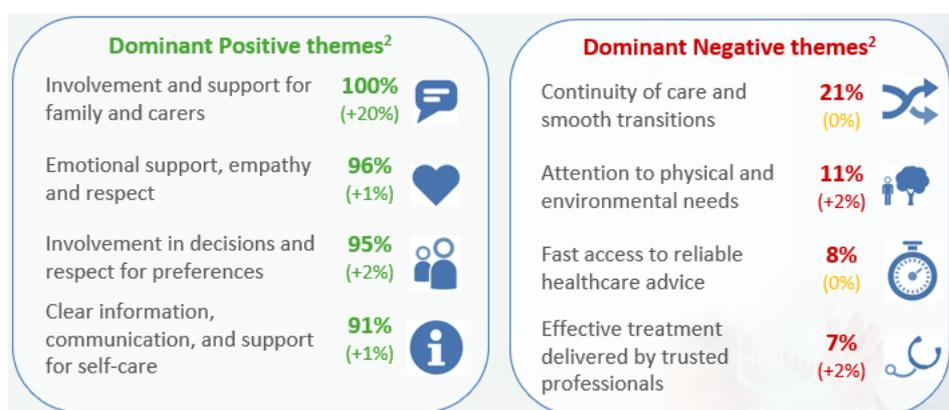
The response rate is calculated using the number of unique/distinct clients rather than the total number of contacts. Patients will continue to be offered the opportunity to give feedback at each appointment.

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	146,499	229,798		
Number of iWGC responses received	Number	13,604	11,107	20,708		
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	8.4%	7.6%	9.1%		
iWGC 5-star score	Number	4.80	4.82	4.74		
iWGC Experience score – FFT	%	94.67%	92.56%	88.35% (95.60% excluding imms) *		
Compliments received directly by services	Number	1682	1285	1430		
Formal Complaints Rec	Number	51	58	60		
Number of the total formal complaints above that were secondary (not resolved with first response)	Number	13	13	19		
Formal Complaints Closed	Number	57	61 *	60		
Formal complaints responded to within agreed timescale	%	100%	100%	100%		
Formal Complaints Upheld/Partially Upheld	%	54%	62%	37%		
Local resolution concerns/ informal complaints Rec	Number	46	71	43		
MP Enquiries Rec	Number	12	14	16		
Total Complaints open to PHSO (inc awaiting decision to proceed)	Number	6	4	5		

*FFT shown with and without child immunisation feedback, with rationale for this is detailed within the report under the Children, families and all age section of the report.

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 2. This is based on qualitative feedback. (+) means that there has been an increase in satisfaction since the last report, (-) means a decrease. The picture shows that there has been a positive decrease or no change across the dominant negative themes.

Appendices 1 and 2 contain our PALS and Complaints information for Quarter 3.

What the data is telling us

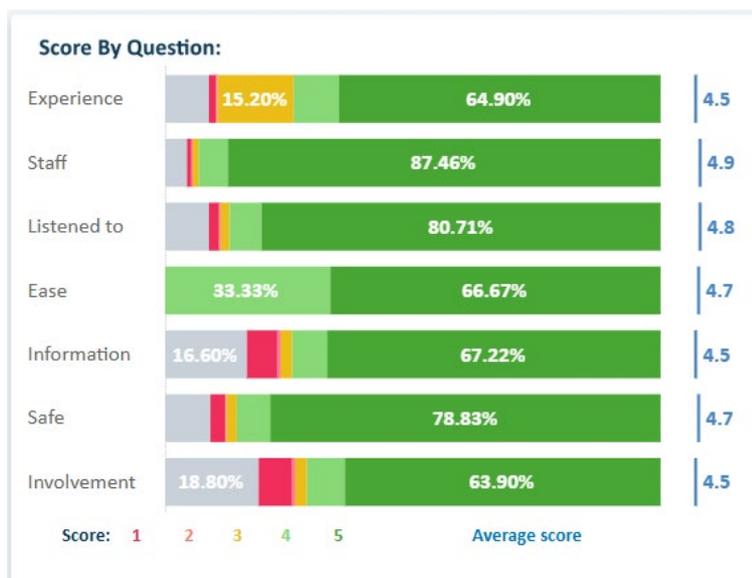
Below are a summary and triangulation of the patient feedback we have received for the divisions.

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	3530	12,229	
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	12.7%	7.7%	10.9%	
iWGC 5-star score	Number	4.78	4.82	4.69	
iWGC Experience score – FFT	%	94.2%	86.4%	83.2%*	
Compliments received directly by services	Number	163	118	123	
Formal Complaints Rec	Number	16	6	12	
Formal Complaints Closed	Number	13	16	10	
Formal Complaints Upheld/Partially Upheld	%	53.8%	62.5%	50%	
Local resolution concerns/ informal complaints Rec	Number	7	11	8	
MP Enquiries Rec	Number	3	7	32	

*97.6% excluding feedback from the young people's immunisation team which account for over 10,000 of the responses and received an 81.2% positive response. Much of the less positive qualitative feedback in the survey responses for the immunisation team was in relation to needing have an immunisation, not having biscuits, asks if it could be a slower process for more time out of the classroom and other similar related requests. Reasons given for the lower scores were not within the remit of the immunisation team.



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.

Of the 12,229 responses, 12,034 responses related to the children’s services within the division; these received, with positive comments about staff being friendly and kind and a few suggestions for further improvement, this included 7 reviews for Phoenix House. 119 of the responses related to learning disability services and 26 to eating disorder services.

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

The CFAA division produce a detailed quarterly report on learning from feedback which is shared with staff for learning and sharing of good practice.

Children’s Physical Health Services

There were three formal complaints for children’s physical health services received this quarter. This related to Children's Occupational Therapy, Children's Speech and Language Therapy and the Eating Disorder Service.

11705 of the 12229 patient survey responses were in relation to children’s physical health services. The 2 services with most responses were the Immunisation and Health Visiting Bracknell; the Immunisation Team received 10884. Health visiting services also receive very positive feedback with positivity score of 99.0%- and 5-star rating of 4.93.

Immunisation Service

The immunisation team has developed feedback stations for gathering feedback during school immunisation sessions with posters to promote, paper copies and pens, this is having a positive impact on responses received back to the team. The overall positivity score from the 10884 responses was 81.2% and a 5-star rating of 4.66. Feedback included that the injection was quick, and nurses were kind. “Everyone was very nice and helpful. It enabled me to feel safe from the flu.” with the themes to improvements being wanting biscuits, not liking immunisations and to provide tissues.

Child and Adolescent Mental Health Services (CAMHS)

For Child and Adolescent Mental Health Services there were six complaints received, of these 2 related to communication, 3 were about care and treatment and 2 were about discharge planning.

There have been 306 responses for CAMHS services received through our patient survey for this Quarter. These include 169 received from those attending our neurodiversity services (positive score 95.78% and star rating of 4.90 with lots of positive comments about staff and the experience).

Adult ADHD Service

There have been two complaints about neurodevelopmental services this quarter. One related to medication and the other to waiting times.

Learning disability

There were no complaints received for the Community Team for People with a Learning Disability but there was one for the Learning Disability Intensive Support Team. This related to bullying and harassment; however, this was able to be escalated and resolved locally and the concern was not upheld.

Overall, there were 119 responses for all Learning Disability services; responses were for the Community Teams for People with a Learning Disability and Learning Disability Intensive Support Team. These received a 96.6% positive score; feedback included that staff provided support, "*[name removed], the LD has been very supportive. He always responded to our enquiries promptly and provided useful information in a timely manner. He has done his best in trying to get the best outcome for our client.*" there were comments for improvements including wanting regular check ins, give patients eye contact, patients didn't feel listened to and wanting more guidance. The 4 response that received with a score below 4 left comments including "I enjoyed telling the Doctor that I was pleased at having an appointment with her. Nothing has really changed for me and the Doctor said that I should have gone to the Neurology appointment as she could not change the medication because of this. I will go to the appointment in March 26. I did not attend because I had a family member visiting."

Regular engagement takes place with patients on the unit including 1;1s and huddles with groups of patients to ensure that their views on the facilities and environment are heard.

Eating disorders

There was one complaint for the Eating Disorder Services which related to clinical care received as the patient was unhappy with their therapist.

Of the 26 feedback responses received, 18 scored a 5 with comments such as "*[Name removed] has put up with me for a very long time now and continues to listen, support and believe me, for which I'll be eternally grateful. My sessions are not easy, but [name removed] supports me through them in her kind, calm way, giving me endless ideas of what to do. Thank you.*" "*I admit I'm not an easy person to work with and must have frustrated my therapist at times. However, I have always felt safe in all of my sessions even when I would completely shut down. My therapist has been a real inspiration to me and hope I can work towards new goals in the future.*" "*My therapist has been extremely helpful with a variety of breathing, meditation and other techniques. I felt in a safe environment to talk about things I have never spoken of before. After many other medical diagnoses, my therapist was there to help me through in sessions. Also going above and beyond.*" Areas for improvement included staff to be more sympathetic and shorter wait times.

In addition, the Family Safeguarding Service have been continuing to improve the patient and family/carer experience by:

- Service-user led activities in the 'Together' Group, which is a co-delivery participation space where service-users suggest psycho-social activities (e.g. some 'summer of fun activities' for families open to children's social care, World Mental Health Day activities, 'couch to 5k'). This group originated from service-user feedback and is entirely co-produced. These are families who have children's social care involvement, and have limited access to such groups and feel stigmatised and

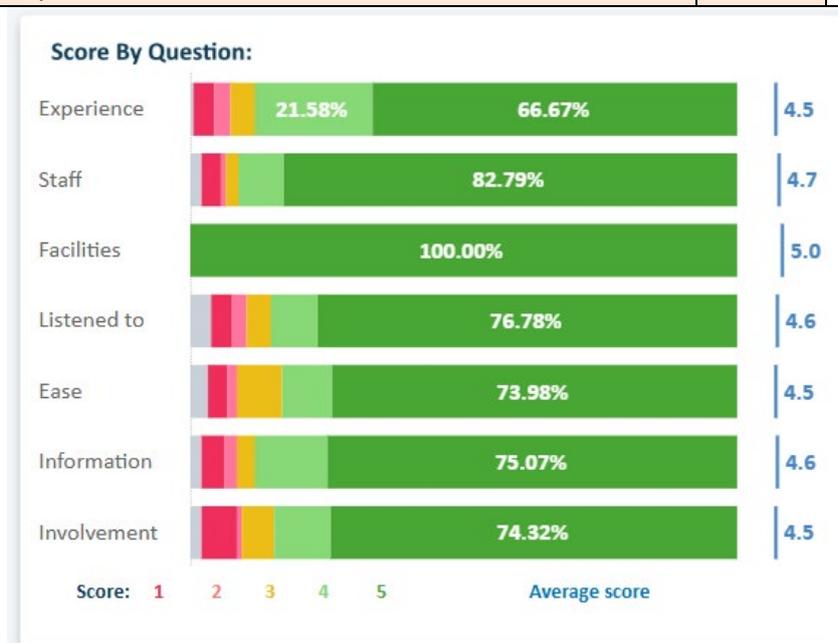
marginalised within 'universal access' (a recent quote from one service user: "these are the only groups I feel I can come too without feeling embarrassed about having a social worker. We all have *stuff* going on and we don't judge each other").

- The service are commencing a participation project (registered as a Trust service-evaluation on around understanding the barriers to our services for different community members. We are inviting those who have declined our service to share their experiences of being offered the service and rational for declining. This will help us to monitor who our service does not reach and potential access barriers.

Mental Health Division

Mental Health East division (Slough, Windsor, Ascot & Maidenhead, Bracknell)
Table 3: Summary of patient experience data.

Patient Experience - Division MHE		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	Number	315	332	366	
Response rate (calculated on number contacts)	%	3.25%	3.37%	3.71%	
iWGC 5-star score	Number	4.64	4.65	4.55	
iWGC Experience score – FFT	%	91.4%	90.7%	88.49%	
Compliments received directly by services	Number	159	50	249	
Formal Complaints Rec	Number	5	14	16	
Formal Complaints Closed	Number	12	7	15	
Formal Complaints Upheld/Partially Upheld	%	58%	57%	26%	
Local resolution concerns/ informal complaints Rec	Number	2	8	4	
MP Enquiries Rec	Number	2	1	2	



16 Formal Complaints were received into the division; in addition, there were 4 informal/locally resolved complaints. 15 complaints were closed during the Quarter. 4 of these were partially upheld and none were fully upheld. they were across CMHTs and Talking Therapies.

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 87 responses, OPMH WAM with 43 responses and CMHT Bracknell with 37 responses.

Across the CRHTT East survey, the average 5-star score was 4.34 with 80.5% positive feedback, a slight decrease in the 5-star score and a slight increase in the percentage positive feedback from last Quarter. 70 of the overall number of responses received (87) scored a 4 or 5-star rating with many comments about staff being supportive, listened, kind and helpful; *“They listened to me. They were very supportive. They made sure I took my medication. They really helped me.”* *“They were very good - especially the first two guys that came out to see me - It was [name removed] and I think the other guy was called [name removed] - they were both so lovely and so kind, and so patient.”*

This Quarter, questions relating to feeling safe and feeling involved were least likely to be positive with areas for improvement and dissatisfaction with the service about wanting more information, longer appointments, and staff to show empathy.

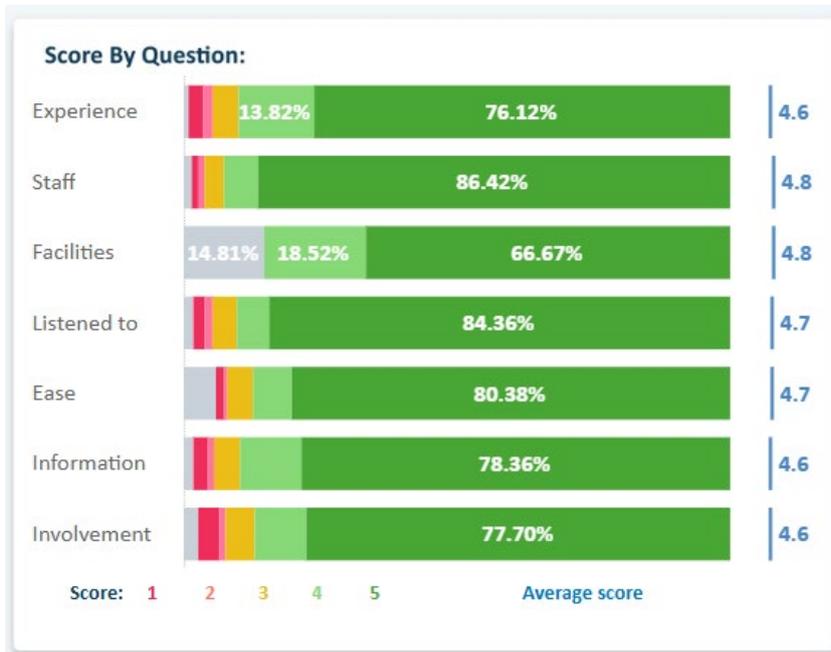
The Memory Clinic – Bracknell received 100% positive score (4.97-star rating) and received positive feedback about staff being professional, helpful, and listened. *“The whole experience was conducted professionally [name removed] [name removed] was exceptional in manner, clarity & was easy to relate to. Nurse [name removed] was also very professional & helpful.”*

CMHT received 96 responses (Bracknell 37, Slough 36, and WAM 23) with 89.6% positive score and 4.51 star with 10 of the total responses scoring less than a rating of 4; comments included *“Appears to be an eagerness to discharge patients back to GPs.”* And *“I’m not being listened to nor given help by any NHS professional I have seen over the last 10 years”*. There were several positive comments that staff listened, were professional, helpful, and understanding examples of comments are *“I came with my father [name removed] for his mental health review. We were treated with care and respect and understanding my dad’s needs,”* *“Dr [Name Removed] listened was understanding offered up an answer, explained to me in understandable terms. Lucky to have him in my corner.”* And *“[name removed] was always available and around to help. She helped me learn the skills from therapy and deal with issues inside and outside of therapy.”* Some of the suggestions for improvement included providing patient with more information and listen to the patient. Further work is being conducted 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	1087	825	
Response rate (calculated on number contacts)	%	4.78%	4.41%	3.42%	
iWGC 5-star score	Number	4.66	4.69	4.68	
iWGC Experience score – FFT	%	90.25%	91.17%	90.38%	
Compliments received directly by services	Number	154	55	62	
Formal Complaints Rec	Number	12	14	14	
Formal Complaints Closed	Number	11	17	14	
Formal Complaints Upheld/Partially Upheld	%	38.4%	53%	57%	
Local resolution concerns/ informal complaints Rec	Number	5	10	1	
MP Enquiries Rec	Number	3	1	5	



14 Formal Complaints were received into the division; in addition, there was 1 informal/locally resolved complaints. 14 complaints were closed during the Quarter. 8 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 CRHTT West with 120 responses, Memory Clinic Newbury with 84 responses and OpCourage Veterans Mental Health Services with 65 responses.

Mental Health West saw a decrease in responses due to an error in the SMS being sent for Talking therapies. Therefore, there was a significant drop in the number of responses for Talking therapies services. This has been rectified.

Questions relating to involvement and information have the least number of positive responses. Examples of feedback include patients were not involved in their decisions regarding their care when accessing Psychological Medicine West, CMHPT and CRHTT.

For CRHTT West there was an 78.3% positivity score and 4.38-star rating. There were lots of positive comments about staff listening, being helpful, and kind, *“I was supported and listened to, I felt that the staff cared and wanted to help me get better. I hit a real low point and thank you so much for your help.”* Some of the areas for improvement included some staff didn’t seem to care, would like more help rather than medication and wanting long term therapy. There were comments for improvement such as wanting more help than just medication, some staff didn’t seem to care, some staff didn’t listen and some patients felt rushed to be discharged. For example, *“It seemed to me like just because I didn’t want medication I was dismissed and didn’t get any help. not sure if that’s a normal thing but it really shouldn’t be some people don’t want to have to rely on medication.”*

The Older Adult Mental Health Service and Memory Clinic combined have received a 96.6% positivity rating (4.84-star rating) some of the feedback included *“I have needed to call here on a few occasions regarding my mother and have always had an amazing, patient, thoughtful, understanding person on the other end of the phone to calm my nerves and give me advice and help. Today we have had an appointment with [name removed] who was lovely and calm and reassuring for my mother, so I thank you all for that.”*

There were 24 responses received for West CMHT teams with 95.8% positivity score and 4.82-star rating, 23 of these were positive with comments received that staff listened and

were supportive, there was 1 negative response for Wokingham there were no comments left for the review.

Most comments were very positive about the staff, including that they listened, were kind and professional. Several of the comments/areas for improvement where they wanted longer sessions and rooms were cold. For example, “[name removed] was really good, she listened, I felt understood, valued, and respected. We had a good conversation. Thanks.”

For Talking Therapies, the overall scores were 90.70% positivity and 4.72-star rating with the Talking Therapies pathway getting the highest scores. Many of the comments were positive about staff having listened, and that they were helpful and kind.

Examples of positive feedback about Talking Therapies included, “Each time I spoke to a therapist I was listened to and encouraged with my ongoing treatment, therapist was very understanding & explained things regarding my condition that I was unaware of.” “I feel like the treatment was high quality, I was listened to when I wanted to share and was never forced to share if I didn’t want to. The providers were really friendly and caring.” and “[name removed] was incredibly attentive throughout the whole of my therapy sessions. It was clear she had my best intentions at heart and suggested tasks that were helpful and supported me through them when they were challenging. [name removed] has undoubtedly changed my life and opened up so many opportunities for me, she is an amazing therapist.” Patients reported that they felt “Everyone was so helpful and treated me so well. I’m very grateful for all of the support, I felt listened and cared for. All the meetings and explanations were very clear, and everyone was able to communicate well. Thank you again for all of the support.”

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.

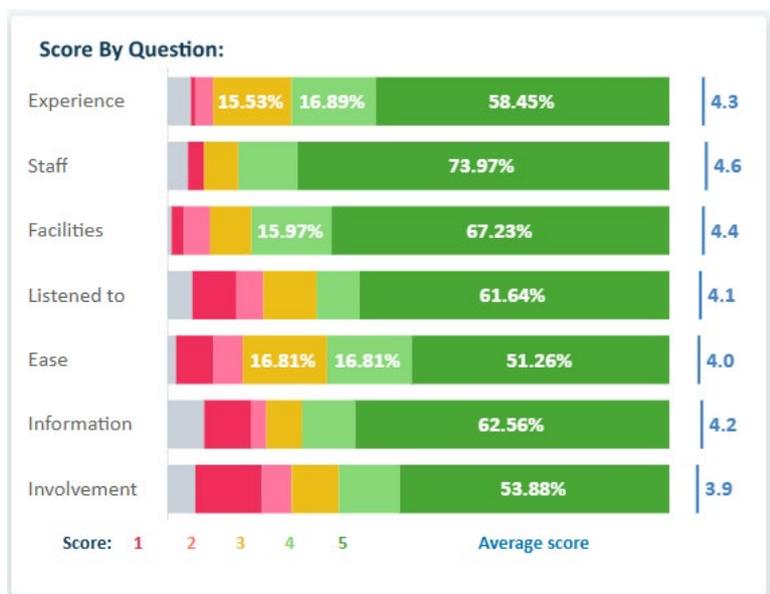
Op COURAGE received 65 responses during the Quarter, their patient survey responses gave a positivity score of 95.4% (4.78-star rating), 3 of the reviews scored less than 4 with comments such as therapist had no military experience and communication with GP was limited.

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	*250	*219	
Response rate	%	133.8%	136.6%	135.2%	
iWGC 5-star score	Number	4.15	4.27	4.24	
iWGC Experience score – FFT	%	74.4%	74.8%	76.74%	
Compliments	Number	18	19	10	
Formal Complaints Rec	Number	9	8	12	
Formal Complaints Closed	Number	10	7	10	
Formal Complaints Upheld/Partially upheld	%	20%	28.5%	20%	
Local resolution concerns/ informal complaints Rec	Number	1	0	0	
MP Enquiries Rec	Number	0	2	2	

*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. Place of safety received a positivity percentage of 83.3% and a five star score of 4.54.



The satisfaction rate was 76.7% with 44 of the 219 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 3.9 and 85 of the 250 giving a score of 3 or less to this question.

The lowest score was in relation to feeling of involvement, all of the wards are currently participating in various programmes as part of the national culture of care programme which focuses on safety and involvement of patients, the aim of the programme is to promote an environment where caring, empathy, and support are central to both service users and staff; there is also ongoing work in relation to improving communication and the involvement of patients making decisions about their care, particularly around managing risk.

The information question asks whether they felt the information they were given was easy to understand, comments relating to ease of also received lower scores with some comments relating to wards are too noisy, food could be improved and medication could be more organised.

There were 12 formal complaints received for mental health inpatient wards during the quarter across all wards.

There were 10 formal complaints closed during the quarter and of these two were partially upheld or upheld; these were for Orchid and Bluebell Ward. The other 8 closed complaints were not upheld.

There were many positive comments received in the feedback including comments such as staff were friendly, helpful, kind, and caring. There were some comments for improvement about listen to patients, more staff and wards being noisy. Examples of the feedback left are *"I think staff listen to me they are attentive helpful help to carry out the tasks. They are all lovely without exemption."* *"[name removed] has always been so kind since I came to the ward, always looks out for me and always asks if I'm ok, she has also given me lots of good advice."* *"Always very welcoming, with a big smile always helps with anything I need and also listens to me all the time."*

In addition to the feedback about the wards, there were 24 responses for a Place of Safety, and the average score was 4.55, with 4 reviews giving a score of less than 4/5. Some comments received were *"Very friendly and professional, caring and providing. Helpful and very understand of others."* *"Whenever I asked staff for assistance they helped asap. Staff especially [name removed] and [name removed] engaged in conversation which made my time here easier. [name removed] also stayed after his shift to offer words of advice,"*

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	2443	2600	
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	8.6%	8.1%	9.7%	
iWGC 5-star score	Number	4.91	4.90	4.88	
iWGC Experience score – FFT	%	97.8%	98.04%	97.1%	
Compliments received directly into the service	Number	69	210	335	
Formal Complaints Rec	Number	4	6	1	
Formal Complaints Closed	Number	1	5	4	
Formal Complaints Upheld/Partially Upheld	%	58.3%	40%	50%	
Local resolution concerns/ informal complaints Rec	Number	1	10	14	
MP Enquiries Rec	Number	0	2	3	



There was one Formal Complaints received this quarter; this related to care and treatment by the District Nursing Service in Slough. Additionally, there were 14 matters resolved locally or informally, and five cases brought to us by MPs.

The Hearing and Balance Service received 149 responses to the patient experience survey with a 97.3% positive score and 4.92-star rating.

East Community Nursing/Community Matrons received 415 patient survey responses with a 98.3% positive scoring, many comments were about staff being kind and professional, for example *“The nurses that visited were so good. They treated me with kindness and respect. I asked a lot of questions, and they took their time to answer them. I understood everything that they said”* *“The nurses are so kind and considerate. They give me 100% of their time and attention. I do not feel that they rush they are all very patient with me and my family. thank you”* *“The Nurses were very professional and knowledgeable. They explained the procedure and process, they were present throughout the treatment, and I had no trouble following their guidance.”* There were also some comments around wanting to know a time the nurses will visit for example *“It’s a shame we aren’t given a rough time that you will be visiting but other than that it’s all great.”*

The wards received 118 feedback responses (61 responses for Jubilee ward 95.1% positive score and 57 responses for Henry Tudor ward with a 98.3% positive score). Positive comments were received in relation to staff being caring, helpful and friendly. Four of the responses scored less than 4, comments for improvement related to needing more staff, quicker response to their calls and wards need cleaning.

Within MSK physio in the East, there was a high number of responses to the patient survey and a high positivity score of 96.8% (4.89-stars), comments were very complimentary about staff being professional and helpful, *"[name removed] was very informative, patient and helpful, she explained in great detail, using a skeleton, the reason for my back pain. She showed me one to one, how to do Pilates exercises to strengthen the muscles around my back. She also printed instructions for me to do regularly at home."* The reoccurring improvement suggestion for this Quarter was for shorter waiting time.

Outpatient services within the locality received a positivity score of 96.95% with 4.89 stars from the 853 responses received. With some very positive feedback including for the UCR & Virtual Community Ward, *"All of the team were fantastic. They were extremely kind and caring. All of our questions were answered, and no stone was left unturned. We appreciate all of their help so much and would be glad to have them care for my husband again in the future."*

The Diabetes Service received 265 feedback responses with 96.6% positivity and some lovely comments including *"Listened to, respected, treated as an individual. Always a bit nerve wracking meeting a new consultant after seeing the same person for so many years but Dr [name removed] put me at ease and I left feeling cared for. Thank you."* Alongside some helpful suggestions for the service to consider around and the rooms being cold and needing heating *"Needed the room to be heated – quite chilly."*

The Assessment and Rehabilitation Centre (ARC) also received positive feedback including *"The staff made everything better, from what could have been a nervous, worrying experience. I came away thankful that at last I was going to find the answer to my health problems - which has been very worrying."*

Community Health services currently have a project group to support increasing feedback. Examples of activities undertaken across the Physical Health Service Division include:

Hearing and Balance Patient focus group to explore departmental patient information, potential changes to follow up appointments.

Dietetics Patient focus groups were arranged to collect feedback with dietetic led Weight management led by an independent focus group moderator and Dietetic Learner programme. Development of new dietetic resources which are reviewed by patient reader (through RBH Patient Experience Team)

Sexual Health Patient focus groups developed for young people and for PrEP. Both going well and good feedback to influence improvements.

Wheelchair DNA reduction project linked to moving from post for appts letters to more digital solutions. Patient Focus Group opinions collected and taken into consideration.

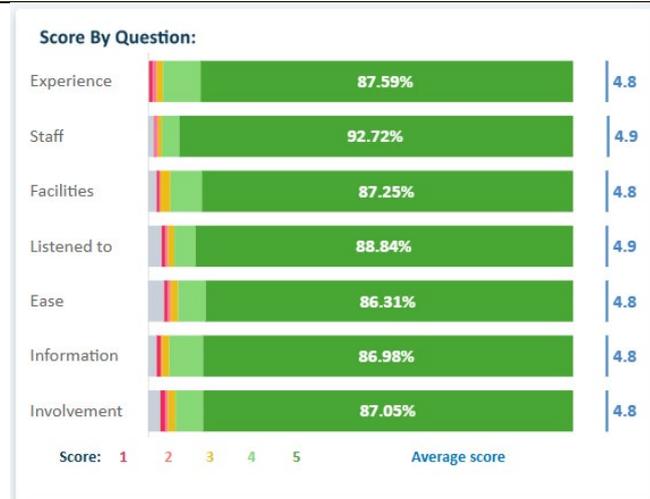
Integrated care the service continues to embed co-production and patient engagement in service development across inpatient and community settings. Feedback from patients and staff identified confusion around returning to driving post-stroke; work is underway to develop a clear professional pathway and patient information to support understanding of clinical and legal responsibilities.

On the inpatient wards, staff are expected to introduce themselves by name and role when entering a patient’s space and to wear visible ID badges, in response to patient feedback. Fortnightly community meetings involving patients and MDT staff continue on both wards, supporting open communication and “You said, we did” learning.

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	3485	4463	
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	7.1%	6.3%	7.8%	
iWGC 5-star score	Number	4.85	4.86	4.85	
iWGC Experience score - FFT	%	96.2%	96.8%	96.6%	
Compliments (received directly into service)	Number	132	399	291	
Formal Complaints Rec	Number	5	9	7	
Formal Complaints Closed	Number	10	10	7	
Formal Complaints Upheld/Partially Upheld	%	36.3%	40%	14%	
Local resolution concerns/ informal complaints Rec	Number	3	24	15	
MP Enquiries Rec	Number	1	0	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 96.6% positive satisfaction and 4.85-star rating and the question on staff receiving a 96.7% positive scoring from the 4463 responses received.

There were 7 Formal Complaints received in Q3, these were split across several different services. The only services with more than one complaint were Out of Hours GP Services and the Integrated Pain and Spinal Service - IPASS. There was only one partially upheld complaint and this related to Care and Treatment on Ascott Ward.

The community hospital wards have received 164 responses through the patient survey receiving an 92.1% positive score and 4.70-star rating, (13 responses scored three and below) questions around feeling listened to and information receive the most results of three and below. Comments include *“The place is actually excellent. The staff are wonderful. The food is great and the cleanliness of the place is very, very good and I think I am very well*

looked after. It is a good very good service. Staffs are all very helpful.,” *“One thing that was really, really good was that the food was excellent. Overall, the experience using the gym with the physiotherapists and the MTAs was excellent. In general, all the help and treatment given was deeply appreciated.”* *“My care was fantastic, all so caring and helpful. It was amazing to think I was being cared for in an NHS facility. It was more like a hotel.”* And *“The staff were very professional and caring. I would like to thank the staff for the care I receive.”* there were some individual comments where patients were less satisfied with answer bell quicker, listen more, food needed improvement and more staff. Comments for reviews with responses that scored below 4 included patients were bored, they wanted more contact with staff, did not feel listened to, call bell wasn’t working, medication not given on time, wanted to shower more and want more exercise. There was one review which received a score of 1, the patient reported that they did not feel listened to and felt some staff did not have empathy.

There were two Formal Complaints for the Out of Hours GP service. These related to communication and attitude of staff.

WestCall received 363 responses through the iWGC questionnaire this Quarter, an increase from the previous quarter (89.8% positive score a slight decrease from last quarter, 4.71-star rating, 37 scores received below 4. Positive comments included *“My whole experience, from 111 to West Call and the Out of Hours service at West Berks Community Hospital, was superb. Sympathy, understanding, efficiency and effectiveness at every level. Especially loved the doctor, whose medical prescriptions have already cleared up my painful symptoms.”* *“Fast response. Clean. Short waiting time-but it was not busy. Received the treatment I needed and starting to feel better. Doctor was amazing, caring and understanding.”* *“The GP on duty Dr [name removed] was absolutely outstanding. He was thorough, considerate, and comprehensive and ensured I fully understood his assessment and instruction. The whole experience at Westcall was brilliant especially being over the Christmas period.”* Areas for improvement included better call back in 2-hour slot given, wait times long and an onsite pharmacy.

The Podiatry Service received 174 patient survey responses. Most responses were very positive receiving five stars (overall 94.8% positivity 4.83-star rating) with examples including *“The staff member I was seen by was very professional, polite, and answered all questions I had. I was worried I would be in a lot of pain while having my whole nail removed, however, I was very pleasantly surprised by the care and attention that went into my treatment. This resulted in a very smooth, very painless procedure. Could not thank her enough!”* *“Friendly and professional welcome, good listening and very good results as I left with my new insoles which fit perfectly.”* and *“Because the team was amazing made me feel comfortable and relax. Couldn’t have asked for anything more. Best treatment I have received from the NHS.”*

There were no formal complaints for the Community Nursing Service.

To provide some context across our East and West District Nursing teams combined there were 15,053 unique patients this Quarter.

784 responses were received for Community nursing (98.5% positive score and 4.94/5 stars) Lots of comments included nurses were kind, caring, and friendly, *“I just wanted to thank your team so much for all the amazing support you gave mum especially over the last year when her catheter was such a challenge. As a result, she saw many of you quite frequently but really appreciated seeing a friendly face coming to try and help her yet again and was very fond of her ‘regulars. Thank you again for everything.,”* *“Catheter Clinic Nurses [name removed] and [name removed] were amazing. Professional, efficient, and friendly. The appointment was quick, problem free and great. Both amazing members of the team.”* and *“All the Nurses that have visited have been first class level. A special thanks to [name removed] and [name removed] they have been very friendly and very professional and [name removed] managed to get GP appt for me which is very hard to do! Appreciate the excellent service.”* There were several positive comments about nurses being caring and

there were very few suggestions for improvement; update patient if the visit changes and would like to be given notice for when nurses will visit.

MSK Physio has received one Formal Complaint in the Quarter. The service has received 816 patient survey responses with a 96.6% positive score (4.86 -star rating), very few areas for improvement were included in the feedback there were a few suggestions including long wait times, waiting area was too small and lack privacy in the rooms and the overall feedback was extremely positive with lots of comments about staff were helpful, professional, kind and listened.

Bladder and Bowel (continence) services received 134 survey responses with 97.8% positivity and 4.88-star rating, with comments about staff listening and being helpful.

Demographic profile of people providing feedback.

Table 8: Ethnicity

Ethnicity	% Complaints received	% Patient Survey Responses	% Breakdown of Q3 attendances
Asian/Asian British	2.56%	10.14%	10.26%
Black/Black British	2.56%	2.28%	3.19%
Mixed	2.56%	4.12%	3.30%
Not stated	7.69%	28.70%	8.37%
Other Ethnic Group	3.85%	3.66%	1.92%
White	80.77%	51.12%	72.96%

The table above shows that during this quarter there was a slightly lower % of complaints received by Black/ Black British, Asian/ Asian British and mixed-race people in relation to the percentage who were seen. For White British there is a slightly higher percentage of complaints compared to attendance . We saw an increase in the % of feedback through the patient survey which aligned to our activity for those people who were Asian/Asian British.

We also saw an increase in feedback through the survey from people who are of Mixed Race, who in previous quarters were less likely to provide feedback this way.

It is recognised that we have a high rate of patients who do not complete the ethnicity section of the feedback survey. 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.

Over 25% people completing the patient survey do not complete the demographic questions and it is therefore less easy to draw conclusions. The survey includes narrative explaining why we value completion of the demographic data.

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.

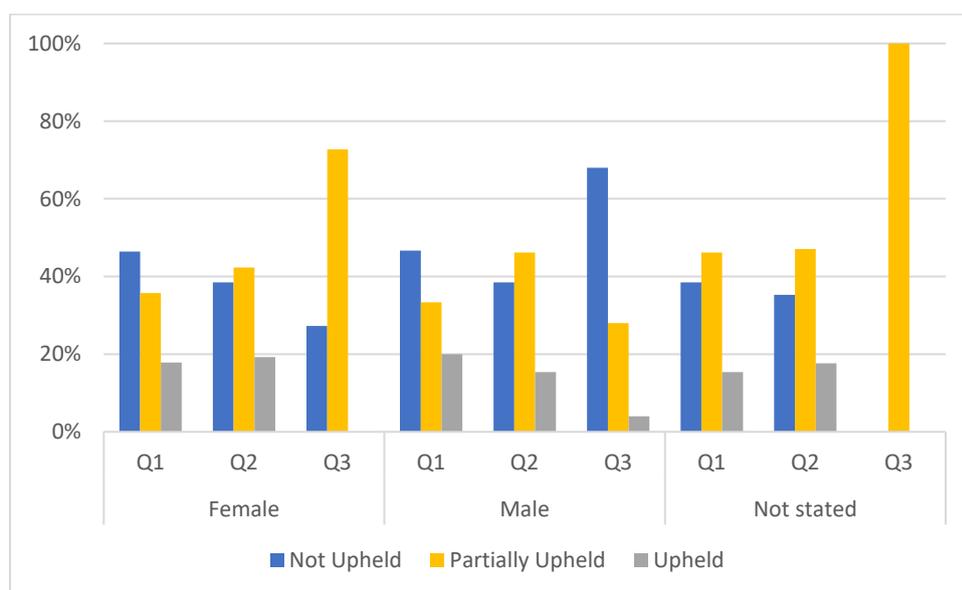
Table 9: Gender

Gender	% Complaints received	% Patient survey responses	% Breakdown of Q3 attendances
Female	44.87%	37.54%	55.38%
Male	55.13%	31.59%	44.58%
Non-binary/ other	0%	2.11%	0.04%
Not stated	0%	28.77%	0.00%

The data for this quarter shows that we continue to be more likely to hear the voice of female attendees through the patient survey and more complaints from men. 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.

Table 9A: Gender by outcome code



Gender	Qtr	Not Upheld	Partially Upheld	Upheld
Female	Q1	46.43%	35.71%	17.86%
	Q2	38.46%	42.31%	19.23%
	Q3	27.27%	72.73%	0.00%
Male	Q1	46.67%	33.33%	20.00%
	Q2	38.46%	46.15%	15.38%
	Q3	68.00%	28.00%	4.00%
Not stated	Q1	38.46%	46.15%	15.38%
	Q2	35.29%	47.06%	17.65%
	Q3	0.00%	100.00%	0.00%
Grand Total	Q1	44.64%	37.50%	17.86%
	Q2	36.84%	43.86%	19.30%
	Q3	54.05%	43.24%	2.70%

The above demonstrates that overall for the 3 quarters there were more complaints not upheld from men and more partially upheld for women. It was fairly even across male and female for those found to be fully upheld.

Table 10: Age

Age Group	% Complaints received	% Patient Survey Responses	% Breakdown of Q3 attendances
0 to 4	0.00%	37.96%	6.53%
5 to 9	5.13%		2.06%
10 to 14	6.41%		3.85%
15 to 19	5.13%		5.28%
20 to 24	11.54%	2.16%	3.64%
25 to 29	8.97%	3.02%	3.37%
30 to 34	6.41%		3.62%
35 to 39	7.69%	3.36%	4.08%
40 to 44	10.26%		3.91%
45 to 49	12.82%	5.37%	3.91%
50 to 54	1.28%		4.13%
55 to 59	6.41%	7.10%	4.83%
60 to 64	5.13%		5.08%
65 to 69	5.13%	8.35%	5.05%
70 to 74	2.56%		5.90%
75 to 79	2.56%	7.22%	8.67%
80 to 84	1.28%		9.26%
85 +	0.00%	25.46%	16.82%
Not known	1.28%		0%

Comparatively, people over 60 years old continue to be 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).

Staff interested in EDI from across the Physical Health Division met in December to share project they were working on – broadly fell into a few areas – equality of access, DNAs, community outreach, and cultural/ disability awareness.

- Plan on a Page next year will look at how service work together to deliver community outreach for populations with poorer health outcomes.
- Dentistry looking at improving the recording of ethnicity.

- Sexual Health have been looking at equitable access to the service - considering deprivation, frailty, and ethnicity. Clinics set up new locations to make access easier.
- Diabetes identified not the most deprived patients but midband that don't attend their educational classes. Often because they feel they are educated through other sources or live with a diabetic.
- Diabetes have noted patients with mental health issues are less likely to attend their appointments, affecting the patient engagement and self-care.
- Diabetes: Attending Divisional Health Inequalities Meetings with aim to work together on common themes. Reviewing data for current access to service as part of QMIS project
- ARC Upton – To hold a patient forum/coffee morning – with more promotion and offer of an extra exercise class for those who are not able to attend more frequently for various reasons.
- Urgent Care: Continue to improve access and timeliness at RPCC, especially at weekends.

Lived Experience Workforce Programme

A copy of the most recent Lived Lens newsletter is attached as an appendix. To highlight the activity this quarter:

- There are currently 32 substantive posts across the Trust.
- The Peer Educator Post became substantive (having been a 12-month secondment) and we have been asked to lead a national Peer Educator Network with a focus on collaboration, development, and co-production.
- Following feedback on our workforce Training Needs Analysis, a new Career Development Subgroup has been created.
- Experience Exchanges continue to be well attended and a great way to bring together learning and collaboration.
- We continue to support our workforce to attend a fully funded, accredited training programme for Lived Experience, as well as locally facilitated training and development at colleague and service level.

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. We have 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
Family Safeguarding Service	More information about the MECS (More emotions, challenging situations) group prior to the group.	We updated our group leaflet and have shared with those referred to the group at the point of referral.
	The link between trauma and emotion dysregulation to be more explicit in the first session of the MECS group.	We changed our initial session to highlight that flight, fight, and freeze are responses to trauma / adversity.
	The MECS Group to be more explicit around how skills might need to be adapted in response to neurodiverse experiences.	We have adapted the content to be more explicit around the purpose of the use of the skills and how they might be adapted in response to neurodiverse experiences. For example, for people who hyperfocus on activities to the detriment of coping with difficult feelings, how to set limits around activities and move between tasks.
	CBT Parental Wellbeing group slides and content to be available for those clients who require 'catch up' sessions after missing one, e.g. to attend child protection meetings and other statutory appointments.	This content also enables service-users to maintain their learning by accompanying the guided self-help resources after the sessions have concluded.
Bluebell Ward, Prospect Park Hospital	More information about S17 Leave.	Information is shared with patients twice a week.
MSK Physiotherapy	Issues with space/privacy and noise at some of our sites.	We are working with estates to find more space and individual clinical rooms at our sites.
	Waiting times for appointments.	We have implemented community assessment days to help reduce waiting lists.
Bladder and Bowel	Patients want to know when they're on the waiting list.	Service now provides a waiting list letter at the point of triage.
Lower Limb Clinic	Concerns re wait times for new assessments	Waiting list letter sent to both GP Practices and patients.
Hearing and Balance	Could text reminders have information about buildings and not just site name? Could the patient information be given in an audible way, rather than as written text? Why don't we fit rechargeable hearing aids?	Looking into whether SMS appointment reminders could include more address information. Exploring software which reads information aloud, as requested by a patient, though may not be accessible to all due to hearing loss.

Service	You said	We did
		New clinical lead will look into rechargeable hearing aids once in post.
Diabetes	Unsure on which contact number to call.	Changed phone line access from 3 different phone numbers to one phone number.
Dietetics	Weight loss programme feedback that it would be nice if audience participated more. Distributing agenda in advance of the weekly session. Wish this session was slightly longer.	Participants are encouraged to participate. This has increased using Chat function. Course content will be included in the updated handbook. Three sessions were shortened to allow a focus group to take place. Sessions have now returned to usual length.
Community Inpatient wards	Ward temperature fluctuations.	Discussed with estates re temperature control and used local methods to resolve issue.
	Staff handled the cutlery using the part that patients are meant to put in their mouth. I would like staff to announce and introduce themselves and who they are.	Cutlery is now wrapped in tissues to ensure safe handling and reduce the risk of cross infection. All staff announce their presence and introduce themselves by name and role when entering the patients space. All staff to wear visible ID badges at all times.
Urgent Care	Signage at Reading Primary Care Centre (RPCC) based at RBH site was poor.	We worked with RBH Facilities to review and improve signage for clearer navigation.
Westcall	Long waiting times at Reading Primary Care Centre.	We reviewed appointment scheduling and staffing levels to better align with demand and reduce waiting times.
	The toilets were not always clean at Reading Primary Care Centre.	We collaborated with RBH Facilities to enhance cleaning schedules and maintain high hygiene standards.
ARC (Assessment and Reablement Clinic)	Need more challenging exercises within the groups.	Reviewing the group class exercises, including a Standard/easier and more challenging elements for some of the exercises.
	The Comprehensive Geriatric Assessment we use are quite lengthy for some of our patients	We are trialling a different model, whereby the nurse and Dr see the patient together, and see the Physio on a separate occasion.

Service	You said	We did
	More information about ongoing classes	Reiterated to the staff to ensure they direct the patients to the board with information displayed already, and to provide patients with a list of possible community classes they can attend.
CBNRT (Community Based Neuro Rehabilitation Team)	Returning to driving post-stroke is confusing for staff and patients.	Developing professional pathway for returning to driving post stroke and developing resources for patients to know their legal obligations

15 Steps

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

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.

Further, targeted work continues to improve the recording of patient demographics in relation to complaints so that we can identify and address any issues that are affecting people and as a result of their personal characteristics (such as information being available in alternative language/font). This will enable us to more accurately analyse data in terms of any differential experience.

Formal Complaints closed during Quarter Three 2025/26

ID	Geo Locality	Service	Description	Outcome code	Outcome	Subjects
10259	Slough	CMHT/Care Pathways	complainant unhappy with care coordinator. Feels they are very unprofessional	Partially Upheld	<p>There is no indication that there have been issues in relation to some elements of the complaint. Unfortunately, as some challenges as noted in the complaint have not been documented it is the investigators view that this may never have been discussed until here may have been a significant life event affecting the patient, which then led to a complaint being made. As indicated by the team, the visits were predominantly without incident and most notably, the complainant partner is hardly mentioned as being present.</p> <p>It is further the view of the investigator that explicit communication is required to ensure that both the patient and his partner are clear as to what the service can offer, what the service does not offer but also what obligations and responsibilities the patient has to his own recovery. Considering the issues raised in this complaint my advice would be a formal meeting with all parties to ensure that there is clarity regarding the issues identified in the complaint. Minutes of that meeting must be made available to all attendees and copies saved on RIO.</p>	Care and Treatment
10311	West Berks	Out of Hours GP Services	Very poor attitude of staff member who called the pt	Local Resolution	Closed: local resolution	Attitude of Staff
10316	Slough	District Nursing	<p>The points raised include:</p> <ul style="list-style-type: none"> •Visits only occur in the afternoon; would prefer mornings or at least a confirmed timeslot. •Being asked to take pictures of their feet themselves which they says they cannot do. •The visits feel rushed and completed as quickly as possible. •Staff are not perceived as kind when attending. 	Not Upheld	The DN service followed procedure and tried to ensure the patient has easy access to onward care	Care and Treatment
10254	Reading	Adult Acute Admissions - Bluebell Ward	Forced medication and allegedly dragging of the pt across the floor with force for refusing medication 7 years ago	Not Upheld	The patient was under section 2 and refused medication and was therefore administer medication via injection under restraint. PMVA was used and there is no evidence of inappropriate treatment	Care and Treatment
10301	Reading	CMHT/Care Pathways	Following on for informal complaint 10015, regarding 'Patient concerns about an appointment they had that left them re-traumatised due to the lines of questioning. They feel they were discriminated against due to their gender and sexual orientation' pt now wishes a formal response	Partially Upheld	<p>Reading CMHS were responsive in addressing the concerns raised by the complainant and ensured that the teams consultant psychologist supported the assessment process to support the complainant accessing the appropriate support, which did lead to referral, acceptance and now accessing DBT within the IMPACT team. CMHS have also reflected on areas of need around trauma informed care and communication, and have organised and completed training, to help ensure that another individual does not experience the distress that the complainant received. It is unclear what level of response that the complainant received after the informal investigation, and clearer communication around an apology and actions completed may have highlighted to him how seriously the team took his concerns and the level of distress that was caused.</p> <p>CRHTT attempted to contact the complainant after his initial complaint, although have never received a response from him as to how he would like to move forward with the complaint and any issues that they could support with addressing. CRHTT also did offer face to face contact with the complainant with female workers as requested, with flexibility with the support. There is some learning around how people communicate patients who are experiencing trauma, and they can be more proactive with communicating feedback from meetings and using trauma informed communication.</p>	Communication
10281	Reading	CAMHS - Rapid Response	Following poor consistant communication with ITT service parent feel consistantly blamed and judged. they feel there is a lack of meaningful help	Partially Upheld	Family therapy was not explained properly. However, general communication was acceptable. Complaints regarding a lack of appropriate support are not upheld. Concerns about the parent feeling dismissed or blamed are partially upheld and upheld.	Communication

10236	West Berks	CMHT/Care Pathways	Feels response is inadequate and wants to know why IO made no contact with them. Outstanding concerns ORIGINAL COMPLAINT BELOW Complainant unhappy that BHFT may have spoken to outside agencies about Pt care GDPR	Not Upheld	Information was shared in line with policy and procedure	Confidentiality
10287	West Berks	CAMHS - Common Point of Entry (Children)	Family extremely concerned the YP has been discharged when there are such high risk concerns around their behaviour	Partially Upheld	The decision to discharge the patient from CAMHS was clinically appropriate based on the evidence at the time. He did not present with acute psychiatric symptoms requiring inpatient care, and a safety plan was in place alongside referrals for further support. However, communication with the family regarding the discharge rationale and escalation options was insufficient, causing distress and misunderstanding. While no lasting clinical detriment occurred and risks were managed through safety planning and multi-agency involvement, we recognise the need to improve clarity and inclusivity in future discharge communications.	Discharge Arrangements
10169	West Berks	CMHT/Care Pathways	Complainant raising concerns about redactions in a Subject Access Request, the way they were referred to in emails that have been shared and delays in their care and treatment	Partially Upheld	The questions and complaints about the patients care have previously been investigated and responded to in 2 complaint responses and no further response can be given beyond what has been provided. We have explained the level of redaction in the records is not fully in line with policies and procedures, and need to apologise for this. Staff email addresses have been redacted where they should not have been. We can provide these documents again with less redaction. The patient will be provided with formal psychological intervention as soon as this is available within Oxfordshire Mental Health Services. Whilst she is waiting she remains able to access the duty service and CRHTT as and when this is necessary. Clinically we believe this will be sufficient.	Medical Records
10272	Bracknell	CYP - ADHD	Unhappy that the ADHD referral has been closed	Not Upheld	The triage process discharged the referral appropriately due to lack of evidence (particularly from school setting) that warranted ADHD assessment. SENCO did not report features of ADHD and indicated referral only being made due to recommendation from autism assessment. The autism assessment clinicians did not make an internal referral and there was a plan recorded in RiO to gather more information to inform whether this was required. However, it appears the referral then came in from school before this could be followed up. Not able to find reason calls not returned – no record of these found	Care and Treatment
10297	Reading	Community Based Neuro Rehab - CBNRT	Funding being withdrawn for special CBNRT equipment Pt says this is seriously affecting them	Not Upheld	The patient is correct in that equipment could not be accessed but it was not a BHFT decision to withhold funding to access the equipment it was due to the sudden collapse of the company providing equipment.	Support Needs (Including Equipment, Benefits, Social Care)
10329	Reading	Integrated Pain and Spinal Service - IPASS	Complainant unhappy the pt was referred to TT, says the pt did not want this. Complainant demands f2f physio with someone different	Case not pursued by complainant	Unable to pursue as complainant would not give their name	
10290	Reading	Adult Acute Admissions - Rose Ward	Pt believes they were given diagnosis whilst in PPH Dec 2024 without assessment, they felt they were not listened to. Believes false info was given by RBC Social Services	Not Upheld	The patients admission was clearly identified as the need to assess and manage his presenting symptoms. His admission was considered necessary to support further assessment and intervention. There is no evidence within the progress notes to suggest that an incorrect date was recorded regarding the reported "citizen's arrest." Information documented appears consistent with the details provided at the time. Review of the Patient MDT Summary demonstrates that nursing staff were actively involved in MDT meetings throughout the patient's admission. They contributed observations and updates on his presentation, and this information was considered within discussions about his treatment and care planning. There is no comprehensive documentation confirming that a detailed discussion about diagnosis took place. However, it is noted that an attempt was made to explain the diagnosis to him, though this was dismissed by the patient during that interaction.	Care and Treatment
10321	West Berks	CYP - ADHD	Unhappy with wait times for referral	Local Resolution	Appt given	Waiting Times for Treatment

10289	Reading	Eating Disorders Service	Pt unhappy with therapist	Partially Upheld	Review of notes and conversations with therapist and manager indicates that the client had progressed well with the therapy and that goals had been met. Therapist had sought supervision throughout her work with this client and particularly when client had shared his feelings with her. The therapist had a structured session with the client following the boundaries of the client/therapist relationship. Client decided to end therapy. From therapist's perspective, therapy ended prematurely prior to a relapse prevention plan being made. Client indicated in his emails that the therapist had been very 'open about her private life'. There is no evidence to support that the therapist did this.	Care and Treatment
10235	Bracknell	Crisis Resolution and Home Treatment Team (CRHTT)	Why were all the calls not taken into consideration? Does the Trust take the pt's feelings and clinical presentation into account when taking calls? Pt feels they have suffered psychiatric harm by the trust	Not Upheld	No new information was brought to light as part of the investigation, apologies were repeated and questions answered	Care and Treatment
10202	Reading	Integrated Pain and Spinal Service - IPASS	JOINT WITH RBH - patient unhappy with the lack of progress following treatment	Not Upheld	The patients care was appropriately managed and directed to the service that best fit their needs	Care and Treatment
10285	Bracknell	Crisis Resolution and Home Treatment Team (CRHTT)	Complaint regarding the conduct, attitude, and complete lack of meaningful support received from the Crisis Team. Pt now feels hopeless and suicidal		The complainant withdrew the complaint	Care and Treatment
10267	Wokingham	Talking Therapies - PWP Team	Unprofessional assessment from TT	Upheld	The client has clearly expressed concerns with the clinical ability – from common factor skills through to clinical decision making. These concerns are not an isolated incident and therefore the member of staff has been placed on a PIP. From my (the IO) understanding of the member of staff's current abilities from the client's complaint as well as the meetings with his manager and the service lead, I agree with the outcome of putting them on a PIP and observing a large quantity of his clinical work.	Care and Treatment
10238	Reading	Common Point of Entry	Pt feels unsupported following their assessment from CPE	Local Resolution		Attitude of Staff
10229	Reading	Adult Acute Admissions - Rose Ward	Pt who has never had S17 leave in 1.5 yrs is due to be discharged on 6/10 Family are unhappy and worried.	Consent Not Granted	No consent received	Discharge Arrangements
10230	Slough	Crisis Resolution and Home Treatment Team (CRHTT)	When CRHTT arrived with autistic pt they asked them to go to New Horizons the next day.	Consent Not Granted		Care and Treatment
10193	Reading	Older Adults Inpatient Service - Orchid ward	Stolen phone dating back to May 2025, family do not understand how pt can sign a declaration form for valuables when they do not have capacity. Also raising historic allegations of section 44 neglect	Partially Upheld	The investigation identified several areas where communication and documentation practices required improvement. Feedback has been provided to the team regarding the importance of introductions during meetings, and steps have been taken to ensure roles and meeting purposes are clearly communicated.	Care and Treatment
10153	Bracknell	CMHT/Care Pathways	Concerns raised that the patient has on multiple occasions been made to feel uncomfortable and intimidated by different staff members. There are also concerns about poor communication, inaccurate reports and intimidating emails being sent by management	Partially Upheld	There were some issues with the way BCMHT managed this situation it very quickly escalated. There were far too many emails. Some of the staff interactions although well meant were not received that way	Attitude of Staff
10240	Reading	Adult Acute Admissions - Bluebell Ward	Complainant raising concerns regarding their experience on the ward.	Not Upheld	The Mental Health Act Assessment was completed appropriately.	Care and Treatment
10184	Reading	PICU - Psychiatric Intensive Care - Sorrel Ward	Disappointed with the ward managers attitude and responses to concerns raised regarding poor communication and attitude of nursing staff toward pt	Not Upheld	Consent was not received so usual process was explained	Attitude of Staff
10320	Reading	CAMHS - Rapid Response	Complainant concerned by interaction with staff during YP's appointment, states police investigation did not find the complainant to be racist	Not Upheld	Complainant admitted to offence when questioned by Police so no further investigation necessary	Communication

10242	Reading	Adult Acute Admissions - Bluebell Ward	Complainant concerned there are not enough staff on the ward leading to sporadic leave that takes place without a risk assessment and only occasional checks when returning to the ward. There are also concerns about the cleanliness of the ward and that it is not autism friendly	Partially Upheld	<p>There is a significant programme of work currently underway within the Trust focused on delivering the Neurodiversity Strategy, which includes specific developments within the inpatient setting. As part of this work, Autism Berkshire recently visited the hospital and provided initial feedback following a review of the wards.</p> <p>All wards have a sensory trolley has been introduced on each ward to enable patients to access sensory items that promote comfort, self-regulation, and wellbeing.</p> <p>Work is also progressing to ensure that all patients admitted to inpatient psychiatric wards receive a Care, Education and Treatment Review (CETR). This process has been initiated and continues to be developed to ensure consistency across all services.</p> <p>A Neurodiversity Project Group has also been established within the hospital to bring together staff involved in this area of work. The purpose of this group is to promote collaboration and to develop a clear, structured action plan setting out how the hospital supports neurodiverse individuals and each ward has its dedicated Neuro Diversity champion.</p>	Environment, Hotel Services, Cleanliness
10232	Bracknell	Crisis Resolution and Home Treatment Team (CRHTT)	Pt triggered to complaint about an unannounced visit by CRHTT on xmas day has they have just received a Security management letter regarding behaviour	Not Upheld	The service followed their procedures and responded to all calls. Additionally, the sending of the zero tolerance letter was inline with policy	Attitude of Staff
10183	Wokingham	CMHT/Care Pathways	Neurodiverse pt sectioned on Rose Ward. States when on the ward pt was held down and given sedation medication. Dr attended a meeting with 3 other people following discharge without prior notice causing major stress and anxiety for the pt. Family also feel the pt should be under LD team and BEDS due to being v underweight	Partially Upheld	The patient was admitted on Rose Ward after much discussion around what the best environment would be for her as she did not meet the criteria for Campion Ward	Care and Treatment
10280	Windsor, Ascot and Maidenhead	Children's Occupational Therapy - CYPIT	Unhappy with EHCP report submitted by OT. Wishes to know 1.what ICB responsibilities are as info provided is not consistant with SEND code of practice. 2. why did the advise not meet SEND requirements 3. communication issues to be prevented 4. If right to provide provider cannot provide advice where do organisation go? 5. Plan to obtain outcome-based advice in line with SEND for the pt	Partially Upheld	<p>There is clear evidence of the patients name being misspelt.</p> <p>The OT report(s) did include information about strengths, needs, recommendations for strategies to be implemented. It lacked explicit detail about where advice/information had been taken from and was not explicit about how the recommendations were providing universal/targeted support which is part of the OAP for schools.</p> <p>It is widely accepted that in the absence of any new information, a report written within 6 months remains appropriate and relevant to submit for an EHCNA request.</p>	Communication
10234	Bracknell	CAMHS - Specialist Community Teams	Passed around teams, told in July they would see a psychiatrist and still waiting despite being told they are at the top of the list - despite being given an appt, wishes this investigated formally	Not Upheld	The patient was seen quicker than the usual waiting time and they had assessments in multiple teams to ensure they were receiving the correct care	Waiting Times for Treatment
10313	Slough	Common Point of Entry	Insensitive MH professional	No Further Action	This moved to a clinical concern process	
10140	Slough	CMHT/Care Pathways	Psychiatrist made adjustments to medication but has been on A/L since leaving no clinical oversight. Pt has deteriorated significantly impacting physical health too. Lack of assistance from Crisis	Consent Not Granted	Not pursued, pt moved away	Care and Treatment
10264	Reading	CMHT/Care Pathways	Pt with paranoid schizophrenia has run out of medication, site mgr of hotel keeps calling and receives no call back	Not Upheld	No consent received, appt's sorted for pt who is happy	Medication
10195	Reading	CMHTOA/COAMHS - Older Adults Community Mental Health Team	Family unhappy that Dr contacted DVLA to advise the pt should not be driving at the present time believes it to be a breach of professional standards	Not Upheld	The complainant accepted the apology, was reassured that we would share learning from his complaint with the wider team to continue to improve our service	Communication

10152	Windsor, Ascot and Maidenhead	Community Hospital Inpatient Service - Henry Tudor Ward	Concerns raised in relation to the patient being given an anticoagulant despite it being stated on his discharge summary that this should not be administered. This led to the patient being re-admitted to Wexham Park Hospital.	Partially Upheld	Medication incidents need to be recorded on Datix at the time and the DOC conversation must take place and be recorded on discovery of the incident. Allowing relatives to remain on the ward outside visiting hours to address concerns/issues should be considered on an individual basis.	Medication
10243	Reading	LD Intensive Support Team	Patient raising concerns in relation to bullying and harassment by staff	Not Upheld	Local resolution	Abuse, Bullying, Physical, Sexual, Verbal
10172	Wokingham	Community Hospital Inpatient Service - Windsor Ward	Family concerned about an incident in which a patient with dementia, Alzheimer's and a fractured pelvis was left unattended and soiled on the toilet for 30 minutes	Not Upheld	Not Upheld.	Care and Treatment
10126	Bracknell	Neurodevelopmental Services	Does not accept the ADHD report and remains disappointed with the assessment process ORIGINAL BELOW Unhappy the way the assessment to carried out and the report has inaccuracies, also sent to the wrong GP and surgery	Partially Upheld	1. The assessment report will be amended in line with the feedback provided and will be reissued. 2. Dr would be happy to offer a further appointment. 3. A brief summary report can also be provided . 4. The team have acknowledged that the experience did not meet the high standards they set for the service and reflected on the reasons for this and what would have provided a better experience. 5. GP details have been updated to ensure named GP is correct on RiO	Communication
10189	Bracknell	Talking Therapies - Admin/Ops Team	Pt states they have not been able to access employment support, they state it was rejected as they are under a secondary service not a primary service	Partially Upheld	The self referral was declined in line with policy however, it was found that the wording on the website could be improved to be clearer to patients.	Access to Services
10188	Bracknell	Mental Health Integrated Community Service	Lack of proper psychological support offered following breach of confidential information sent to the house without permission	Partially Upheld	The alleged breach of confidentiality and mishandling of personal information was not upheld because the sharing of information and details included, is more about clinical processes, standard service practice of sharing assessment details, findings and outcomes with the patient and their GP. A referral to trauma specialised services was not done at the time because the assessing psychologist and the patient, at the time, both agreed that it was not the right time to start any trauma work for personal and other factors. According to the email and records, the referral was declined as the patient and asked for it to be closed	Confidentiality
10225	Reading	Adult Acute Admissions - Snowdrop Ward	Physical assault from another pt on the ward. Complainant feels the pt should have been adequately safeguarded, wish to know if the police are involved	Case not pursued by complainant	Withdrawn	Abuse, Bullying, Physical, Sexual, Verbal
10270	Windsor, Ascot and Maidenhead	Mental Health Integrated Community Service	Lack of support from services whilst on the wait list for EMDR treatment	Local Resolution		Care and Treatment
10261	West Berks	Community Hospital Inpatient Service - Highclere Ward	Unhappy as believes there are outstanding points re clinicians attitude	Not Upheld	Not upheld - this is the final letter confirming that we are not responding further. Signposted to Talking Therapies for support.	Care and Treatment
10197	Windsor, Ascot and Maidenhead	Continence	Family feel suitable product is not being provided to the YP. the family wish 14 pads a day. Family wish compensation for pads bought	Partially Upheld	Continence products are being supplied in line with assessed needs however, there was no discharge letter sent to the complainant so this was outside of process	Support Needs (Including Equipment, Benefits, Social Care)

10210	Windsor, Ascot and Maidenhead	East Berkshire Wheelchair Service	Pt wants a lightweight wheelchair as seen on TV, but service will not support this. Concerns also raised in relation to information provided to age concern	Not Upheld	<p>The patient has requested a lightweight wheelchair or powered chair similar to models he has seen advertised on television. However, these options fall outside the scope of equipment supported by the NHS under the Personal Wheelchair Budget (PWB) scheme.</p> <p>The Service has provided him with consistent and thorough care over the past several months, including liaison with relevant teams and exploration of all clinically appropriate and safe equipment options available through NHS provision. Three suitable options remain available to the patient should he choose to accept them.</p> <p>The Service is bound by established clinical criteria and safety regulations, which cannot be disregarded. All viable options have been carefully reviewed and presented. While the Service is unable to meet the patients specific expectations, every effort has been made to offer appropriate solutions within the framework of safe and approved NHS provision.</p>	Attitude of Staff
10182	Wokingham	Crisis Resolution and Home Treatment Team (CRHTT)	Pt believes their information was shared without permission to their spouse despite specifically requesting for this not to happen	Partially Upheld	<p>It appears the wife was given some basic information regarding involvement but no evidence that staff shared as many details as complainant is reporting.</p> <p>It was found that there was poor communication with the complainant and internal processes not followed correctly regarding the discharge. This has been shared with the management team and staff involved.</p> <p>Staff appeared to take his tone and content of the calls as aggressive/abusive and terminated the calls. This has been raised with staff involved and their managers for reflection.</p>	Confidentiality
10064	Wokingham	Crisis Resolution and Home Treatment Team (CRHTT)	<p>Pt disputes the investigation and wishes a LRM ORIGINAL BELOW</p> <p>Pt feels Crisis East have left them isolated and vulnerable following a suicide attempt, an assessment and being discharged with suicidal thoughts. Pt feels the 2 staff members who visited lacked empathy and understanding</p>	Not Upheld	<p>The patient was not keen on medication; therefore, no medical review was offered. No psychiatrist assessment indicated because he reported that was resourcing that privately.</p> <p>No psychological pathway indicated because he was already having counselling through Priory privately.</p> <p>The transfer or discharge letter did mention that he was advised to self-refer to the Gateway Hub/Common Point of Entry if further mental health interventions were required. I included the contact for Gateway Hub/ Common Point of Entry in the letter.</p>	Attitude of Staff
10162	Wokingham	Community Hospital Inpatient Service - Ascot Ward	<p>Feels there are unresolved issues ORIGINAL COMPLAINT BELOW</p> <p>Complainant concerned that their father appeared covered in plasters and tape whilst on the ward and there was poor communication around his care. They also raised that the consultant was rude and ignored the families concerns about declining health which led to a transfer to the RBH</p>	Partially Upheld	<p>Learning around communication primarily. The tape where the cannula was placed could have been removed sooner.</p>	Care and Treatment
10231	Reading	Adult Acute Admissions - Bluebell Ward	Fellow pt threw milk and water over pt. Complainant wishes to know why the attacker is still on the same ward. Wish to know how will the pt be kept safe	Consent Not Granted	Not pursued as no consent given	Abuse, Bullying, Physical, Sexual, Verbal
10187	Windsor, Ascot and Maidenhead	CMHT/Care Pathways	Pt has concerns about care dating back to 2006 in Fairmile. Wishes to meet with HoS	Partially Upheld	This was a historic allegation that was addressed at the time however, safeguarding procedures were not followed but this has now been reported to the Police, in line with Policy	Care and Treatment
10190	West Berks	Crisis Resolution and Home Treatment Team (CRHTT)	Patient is unhappy about: weekend and out-of-hours psychiatric cover, a lack of support or risk assessment and reassurance that this will not happen again, including information about the correct process at a weekend.	Not Upheld	<p>The call was terminated by the patient before full options could be explored</p> <p>CRHTT could have explored seeing the patient face to face either that evening or the following day</p>	Care and Treatment

10199	Bracknell	Health Visiting	Complainant unhappy by an information disclosure that took place in a Child Protection conference in front of the person concerned without any prior warning. Feels this could have a potentially big impact on them	Partially Upheld	When the initial disclosure was made the HV advised that they would be making a referral to social care and would share this information and his concerns. It would be reasonable for the complainant to understand that he would be cited as the individual making the disclosure and he did not communicate his expectation of remaining anonymous. It is not part of the process to discuss anonymity and would be difficult to guarantee. Although the HV did not communicate with about how his disclosure might be used, they would be required to share this information with relevant partner agencies even without permission, in the interest of safeguarding the child. Best practice would be to share the report with the family prior to the ICPC, even by phone if a face-to-face meeting is not possible, but this did not happen. Discussion of the disclosure within the report with the complainants ex-partner prior to conference would have given her the opportunity to process this information.	Confidentiality
10227	Reading	Adult Acute Admissions - Daisy Ward	Past Care co-ordinator moved roles in LA and was now able to be part of the assessing team for MHA. Believes they have been given forcibly given insulin when it was not needed. Pt concerned about fire risks	Not Upheld	Psychoeducation to be offered to the complainant regarding mental health and physical health, including signposting the complainant to the advocacy services.	Care and Treatment
10186	Slough	Common Point of Entry	Thanked for thorough investigation but, does not think it is accurate, would like a copy of the recording IO listened to as they do not think the word 'empathy' described the call handler at all ORIGINAL COMPLAINT BELOW Referrals from GP triaged without speaking to the pt, meds changed that didn't need to be, in the pt's opinion. CRHTT staff with a poor unhelpful attitude to pt in crisis.	Not Upheld	Not Upheld	Care and Treatment
10196	Wokingham	IPS - Individual Placement support	Unhappy, feels the IPS worker is racist ORIGINAL BELOW Historic complaint raised oct 23 regarding IPS staff member allegedly being racist and unsupportive. Previously dealt with informally	Not Upheld	The investigation found that the situation was handled appropriately, the patients feelings regarding the matter were acknowledged and to try to avoid any further upset for the complainant, he was offered another worker within IPS to continue his support and to ensure he has no further interactions with the member of staff	Communication
10178	Slough	Crisis Resolution and Home Treatment Team (CRHTT)	Attitude of call handler increased pt's anxiety by repeatedly asking how to spell the person name and terminating the calls	Not Upheld	Not Upheld.	Attitude of Staff
10207	West Berks	Mental Health Integrated Community Service	Believes the response is wholly inadequate, factually dismissive of the pt's experience, and they do not accept it as a satisfactory resolution. ORIGINAL COMPLAINT BELOW Concerns about communication, unhappy with the way PALS handled concerns in June 24. Person named in the complaint was the person who called to sort this out. Caused further concerns, therapy given by a trainee, they want a senior clinician and they want to know why this was not handled properly before	Partially Upheld	The verbal complaint should have been passed to the service manager to respond to and not dealt with by SMHP the complaint was referring to. This has been identified as a learning point for administrative staff and the team members therefore this point is upheld. Complaint relating to delay in treatment and treatment being conducted by a trainee under supervision is not upheld and contradictory to evidence in notes and conversations with key members involved in Daniel's care. To resolve, a review has been offered with a senior clinical psychologist and a medication review as he requested with a specialist pharmacist.	Communication
10256	Bracknell	CMHT/Care Pathways	Text re appt's being sent to the wrong phone number (NOK) complained before but still not sorted	Not Upheld	Concerns were by the RBH not BHFT	Confidentiality

Appendix 2: complaint, compliment, and PALS activity

All formal complaints received

Service	2024/25						2025/26								
	Q1	Q2	Q3	Q4	Total for year	% of Total	Q1	Q2	Q3	Compared to previous quarter	Q3 no. of contacts	% contacts Q3	Q4	Total for year	% of Total
Acute Inpatient Admissions – Prospect Park Hospital	8	3	11	5	27	11.74	8	6	8	↑	56	10.71		22	146.67
CAMHS - Child and Adolescent Mental Health Services	10	13	3	5	31	13.48	8	4	8	↑	1102	0.36		20	133.33
CMHT/Care Pathways	12	13	7	9	41	17.83	10	10	10	No change	1739	0.58		30	200.00
Common Point of Entry	2	3	0	1	6	2.61	0	1	4	↑	1290	0.08		5	33.33
Community Hospital Inpatient	4	4	4	1	13	5.65	1	5	1	↓	172	2.91		7	46.67
Community Nursing	6	3	1	1	11	4.78	1	3	1	↓	4808	0.06		5	33.33
Crisis Resolution & Home Treatment Team (CRHTT)	5	3	2	8	18	7.83	3	9	8	↑	1532	0.59		20	133.33
Older Adults Community Mental Health Team	1	0	0	1	2	0.87	0	1	0	↓	3271	0.03		1	6.67
Out of Hours GP Services	2	2	3	5	12	5.22	2	0	2	↑	1696	0.00		4	26.67
PICU - Psychiatric Intensive Care Unit	0	2	2	0	4	1.74	0	1	0	↓	2	50.00		1	6.67
Urgent Treatment Centre	1	0	0	0	1	0.43	0	0	0	No change	1137	0.00		0	0.00
Other services during quarter	17	18	17	12	64	27.83	18	18	18	No change	54888	0.03		54	360.00
Grand Total	68	64	50	48	230	100	51	58	60					169	

Informal Complaints received

Division	Month Received			Grand Total
	October	November	December	
Children Young People and Families		1	1	2
Mental Health	3	1		4
Mental Health Inpatients			1	1
Physical Health	3			3
Grand Total	6	2	2	10

Locally resolved concerns received.

Division	Month Received			Grand Total
	October	November	December	
Children Young People and Families	2	2	2	6
Mental Health East				0
Mental Health West				0
Physical Health	9	10	8	27
Grand Total	12	12	9	33

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.

Outcome	2024/25						2025/26						
	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	4	4		No Change	10	5.71
Locally resolved/not pursued	0	1	1	0	2	1.07	2	3	6		↑	11	6.28
Not Upheld	19	24	29	14	86	45.99	24	19	26		↑	69	39.42
Partially Upheld	9	29	19	13	70	37.43	19	21	21		No Change	61	34.85
Upheld	12	3	7	3	25	13.37	8	10	1		↓	19	10.85
SUI	1	1	1	0	3	1.60	0	1	0		↓	1	0.57
Other	0	0	0	0	0	0.00	0	3	1		↓	4	2.28
Grand Total	41	58	57	30		187	55	61	59			175	100.00

37% of complaints closed last quarter were either partly or fully upheld (excluding those which were not completed through the formal complaint process. This is compared to 62% in Q2. These were spread across several differing services with no themes identified.

Complaints upheld and partially upheld.

Service	Main subject of complaint							Other	Grand Total
	Access to Services	Attitude of Staff	Care and Treatment	Communication	Discharge Arrangements	Medical Records	Confidentiality		
Adult Acute Admissions – Bluebell Ward								1	1
CAMHS - Common Point of Entry (Children)					1				1
CAMHS – Rapid Response				1					1
Children's Occupational Therapy - CYPIT				1					1
CMHT/Care Pathways		1	3	1		1			6
Community Hospital Inpatient Service – Ascot Ward			1						1
Community Hospital Inpatient Service – Henry Tudor Ward								1	1
Continence								1	1
Crisis Resolution and Home Treatment Team (CRHTT)		1					1		1
Eating Disorders Service			1						1
Health Visiting							1		1
Mental Health Integrated Community Service				1			1		2
Neurodevelopmental Services				1					1
Older Adults Inpatient Service - Orchid ward			1						1
Talking Therapies - Admin/Ops Team	1					1			1
Talking Therapies - PWP Team			1						1
Grand Total	1	1	7	5	1	1	3	3	22

Care and Treatment complaint outcomes.

Service	Outcome of Complaints about Care and Treatment			Grand Total
	Not Upheld	Partially Upheld	Upheld	
Adult Acute Admissions - Bluebell Ward	2			2
Adult Acute Admissions - Daisy Ward	1			1
Adult Acute Admissions - Rose Ward	1			1
CMHT/Care Pathways		3	1	4
Common Point of Entry	1			1
Community Hospital Inpatient Service - Ascot Ward		1		1
Community Hospital Inpatient Service - Highclere Ward	1		1	2
Community Hospital Inpatient Service - Windsor Ward	1			1
Crisis Resolution and Home Treatment Team (CRHTT)	2			2
CYP - ADHD	1			1
District Nursing	1			1
Eating Disorders Service		1		1
Integrated Pain and Spinal Service - IPASS	1			1
Older Adults Inpatient Service - Orchid ward		1		1
Talking Therapies - PWP Team			1	1
Grand Total	12	6	1	22

PHSO/LGO

The table below shows the PHSO activity since April 2024:

Month opened	Service	Month closed	Current stage
Sept-24	Community Dental Service	May	Closed
Sept-24	CMHT/Care Pathways	Ongoing	Closed
Oct-24	Older Adults Inpatient Service - Rowan Ward	Aug-25	Closed

Month opened	Service	Month closed	Current stage
Oct-24	IPS - Individual Placement support	June-15	Small financial remedy offered but declined
Dec-24	District Nursing	Ongoing	Documents sent to PHSO
June-25	Place of Safety	Ongoing	Documents sent to LGO
June-25	Place of Safety	Ongoing	Documents sent to LGO
Dec-25	District Nursing	Ongoing	Documents sent to PHSO
Dec-25	CMHT/Care Pathways	Ongoing	Requested documentation being collated

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 Q3 we received one complaint via the CQC relating to various aspects of a patients care including inadequate treatment and discrimination.

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
Received	1237	1012	1289	1366	4904	1682	1285	1430		

Patient Advice and Liaison Service

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.

PALS has continued to facilitate the 'Message to a loved one' service, which involves collating messages for patients, which are then delivered on the ward. This is available across all inpatient areas. The PALS Manager continues in the role Armed Forces Service Network champion and has taken up the role as Freedom to Speak Up champion. PALS also contributes to the co production planning for 16-25 project and trust sustainability work.

Arrangements have been made to attend community meetings on wards at Prospect Park Hospital and in the community. The PALS service conducts outreach at all hospital sites within the organisation. Visits have been held at Upton, King Edward V11 Wokingham St Marks and West Berkshire Community hospitals. This enables the PALS service to engage locally with patients, public and staff and ensure that relevant information is available to all.

A visit to the Wheelchair Clinic has been undertaken following an invitation to talk about PALS and PPI opportunities. PALS will also be attending the Patient Information Point at West Berkshire Community Hospital later this year for the same purpose. PALS attended the Community Appointment Day in Slough, which was organised by the MSK Physiotherapy service. This was an opportunity to engage with patients and staff as an adjunct to clinical care provided on the day.

The service currently reports on a quarterly basis and provides a SITREP weekly, highlighting open queries and themes. There were 392 queries recorded during Quarter 3 and these 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. The volume of calls and e mails coming into the service continues to be high.

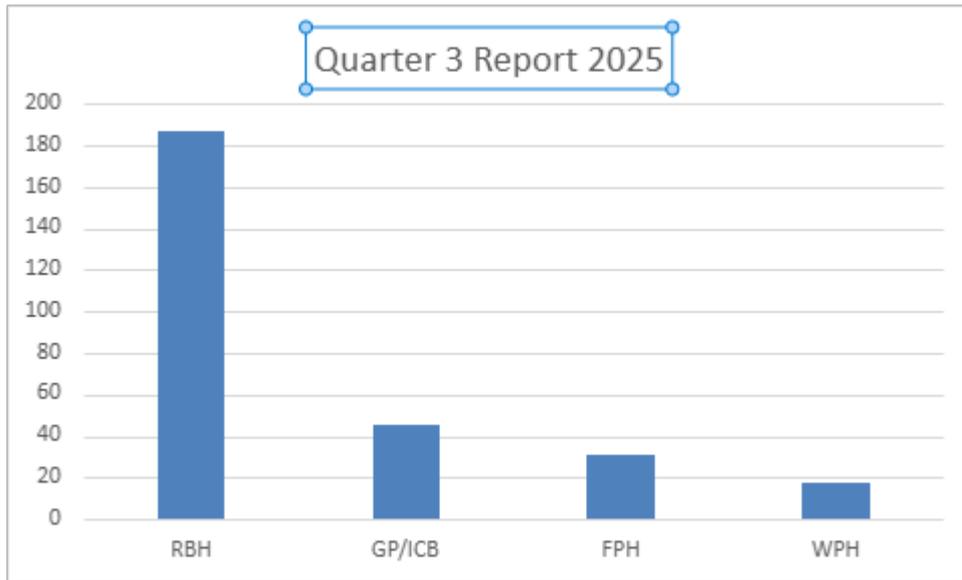
The Patient Experience Team has undertaken work to standardize and streamline the PALS process, to make it more user friendly for the wider team and enable the service to be covered consistently during the absence of the PALS Manager. Via the QMIS process we have implemented and updated Standard Works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

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.

To publicise the PALS service across the Trust, a meeting has been held with the Learning and Development team and the complaints manager. It has been agreed that the Patient Experience Team will be allocated space on the induction process. The Patient Experience Team will be convening to discuss the content to be put forward.

In addition, there were 326 non-BHFT queries recorded. Enquirers and complainants are signposted to the relevant organisation and liaison is conducted with other PALS services to address concerns. The PALS Manager visited the service at the RBH to promote

collaboration and share best practice. Another member of the Patient Experience Team is consistently helping with the recording process to improve the rate of data collection.



The PALS Manager is completing 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 and the services with the highest number of contacts are in the table below:

Service	Number of contacts.
CMHT/Care Pathways	35
CYP ADHD	17
Physiotherapy MSK	14
CYP AAT	10
Physiotherapy (adult)	10
Neuropsychology	7
Integrated Pain and Spinal Service.	7

Appendix 3

15 Steps; Quarter Three 2025/26

During quarter three, there were 6 visits:

Mental Health Services Division		
Prospect Park Hospital		
Ward	Positives	Observations
Oakwood	<p>Sign in book.</p> <p>Staff were welcoming.</p> <p>Up to date picture board.</p> <p>Ward was busy but appeared calm.</p> <p>Clear how many staff were on duty and grades.</p> <p>Lots of evidence of QI work and acting on feedback.</p> <p>The use of the triangular signs on individual rooms were good regarding dietary requirements.</p> <p>IWGC information good and acted on feedback.</p>	<p>Took a couple of minutes to be let in. There was no one on the reception desk.</p> <p>Thank you cards visible, but some were not recent.</p> <p>Directors' poster was out of date – these are being updated across the whole hospital.</p> <p>The fire alarm system in the entrance area had a key in one bit and not another. As there were tables and chairs around it was unclear whether this was a risk that someone could remove it or whether it should be there. Also, should there have been a key in the other lock. Therefore, it was unclear whether there was a risk. There were no instructions i.e. 'do not touch' but there was a folder available. This was fed back to the nurse in charge and after the visit the ward they confirmed that the key had been removed.</p> <p>Patient said that she had not received information about her condition that she had requested a few times. Understood that staff were busy.</p>
Orchid	<p>We were let in by a student nurse.</p> <p>Clear how many staff were on the ward and ratios.</p> <p>Clear which staff member was looking after which patients.</p> <p>Appeared busy but calm.</p> <p>Ward was clean and tidy.</p> <p>IWGC results visible</p> <p>QI work visible.</p> <p>Thank you cards visible and displayed. Liked the positive feedback on the orchid template and laminated for longevity.</p>	<p>Student omitted to let NIC know we were on the ward. He apologised later as he had let other people into the ward. We explained who we were.</p> <p>Hand gel dispenser was empty but were unsure whether this was due to a risk of visitors/patients using it inappropriately or if it had just not been replenished.</p> <p>Possibly student should have had clear information on letting visitors into the ward and processes.</p> <p>This feedback was shared to the nurse in charge who is following up about the hand gel, and sharing the importance of visitor processes as part of handover moving forward.</p>

Place of Safety	<p>Let in by care staff who verified who we were.</p> <p>Not able to access without access from staff.</p> <p>Staff were welcoming and informative.</p> <p>Unit was full but did not feel rushed or pressured.</p> <p>NIC knowledgeable on admission criteria.</p>	<p>Unit very cramped in staff area with little storage. NIC informed us that the unit would be moving to a purpose-built facility elsewhere in the hospital early December.</p>
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Physical Health Services Division

Community Inpatient Wards

Ward	Positives	Observations
Jubilee	<p>We were welcomed to the ward with a smile from all the staff that we met.</p> <p>The Ward Manager knew about 15 Steps and was knowledgeable about the ward.</p> <p>There is a staff photo board near the entrance to the ward.</p> <p>The ward appeared busy but calm.</p> <p>Both patients and staff positively described the layout.</p> <p>Information on staffing was clearly visible.</p> <p>Information for staff and patients is visible.</p> <p>Staff were seen interacting with patients on the ward, who appeared settled and happy.</p> <p>A wonderful noticeboard celebrating staff.</p>	<p>It seemed a little chaotic around the re-gen trolley as lunch was being served.</p> <p>The throughfare between the wards was narrow and at times, congested with people.</p> <p>Could not see iWGC posters; did see this being completed by a patient in paper form.</p> <p>The leaflet rack appeared cluttered and not easily accessible. Would be good to have something similar and as prominent for patients and carers.</p> <p>The nurse in charge welcomed the feedback and recognised that both wall and floor space on the ward was limited. They are going to review the patient information that they have available.</p>

Community Physical Health Services

Service	Positives	Observations
Physiotherapy, Upton	<p>Staff we saw were welcoming and friendly.</p> <p>There is a staff photo board with names and roles.</p>	<p>The first aid box was visibly out of date.</p> <p>Some of the information was out of date.</p> <p>It would be helpful have this updated.</p> <p>The tablet was in sleep mode and when prompted the iWGC app would not launch.</p>

	<p>The reception area was busy, with lots of information.</p> <p>There was a lot of patient information.</p> <p>The clinical cubicles were clean, well laid out and set up ready for the next patient.</p> <p>'You Said, we Did' is colourful with patient quotes.</p> <p>Information that is relevant to patients is easily accessible.</p> <p>Staff are knowledgeable about the service, what it provides and how it adapts based on patient need.</p> <p>There are opportunities to give feedback readily available through paper surveys and the QR codes for iWGC are visible.</p>	<p>The team lead covering that day was receptive to the feedback, particularly about out of date information and the first aid box being checked.</p> <p>The Patient Experience Team have since been in touch with the service about the ipad to see about adjusting the sleep mode activation.</p>
<p>Physiotherapy, Foundation House, Windsor</p>	<p>Staff we saw were welcoming and friendly.</p> <p>There is a staff photo board with names and roles. The reception area was clean, and clear of clutter. There was relevant information on the walls.</p> <p>The admin area staff work in is not cluttered.</p> <p>The clinical cubicles were clean, well laid out and set up ready for the next patient.</p> <p>The clinic and waiting area were calm.</p> <p>Doors were clearly labelled.</p> <p>'You Said, we Did' is colourful with patient quotes.</p> <p>Information that is relevant to patients is easily accessible.</p> <p>Staff are knowledgeable about the service, what it</p>	<p>It would be helpful to add a time period for the results.</p> <p>The Patient Experience team has investigated the sleep mode of the tablet. There is an out of date QR code on one poster to be removed.</p> <p>The receptionist said that she would feed this back to the service (as it a shared reception on site).</p>

	<p>provides and how it adapts based on patient need.</p> <p>There are opportunities to give feedback readily available through paper surveys and the QR codes for iWGC are visible.</p>	
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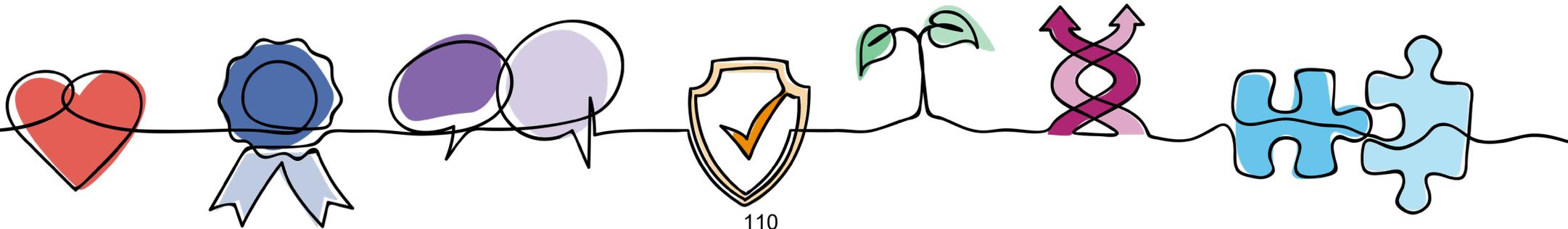
Trust Board Paper Meeting Paper

Meeting Date	10 th March 2026
Title	Freedom to Speak Up Self-Assessment tool
	For Approval
Reason for the Report going to the Trust Board	<p>It is good practice, as detailed by NHS England for the freedom to speak up, self-reflection tool to be reviewed by organisations at least every 2 years, the aim being to identify gaps and areas for improvement as well as areas of good practice on a regular basis.</p> <p>The last version of our self-reflection and planning tool was approved at Board in March 2024 with updates in relation of the identified areas for improvement being presented to the Board 6 monthly.</p> <p>The attached is a refreshed self-assessment for approval alongside some areas of focus to build on our strong position in relation to our freedom to speak up processes as detailed within the self assessment tool.</p>
Business Area	Organisational
Author	Debbie Fulton Director Nursing and Therapies
Relevant Strategic Objectives	<p>The Plan is relevant to the following strategic objectives,</p> <p>Patient safety: Ambition: We will reduce waiting times and harm risk for our patients</p> <p>Health inequalities Ambition: We will reduce health inequalities for our most vulnerable patients and communities</p> <p>Workforce Ambition: We will make the Trust a great place to work for everyone</p>

Freedom to Speak up

A reflection and planning tool

Review undertaken January 2026



Introduction

The senior lead for FTSU in the organisation should take responsibility for completing this reflection tool, at least every 2 years.

This improvement tool is designed to help you identify strengths in yourself, your leadership team and your organisation – and any gaps that need work. It should be used alongside Freedom to speak up: [A guide for leaders in the NHS and organisations delivering NHS services](#), which provides full information about the areas addressed in the statements, as well as recommendations for further reading.

Completing this improvement tool will demonstrate to your senior leadership team, your board or any oversight organisation the progress you have made developing your Freedom to Speak Up arrangements.

You may find that not every section in this tool is relevant to your organisation at this time. For this reason, the tool is provided in Word format to allow you to adapt it to your current needs, retaining the elements that are most useful to you.

If you have any questions about how to use the tool, please contact the national FTSU Team using england.fts-enquiries@nhs.net

The self-reflection tool is set out in three stages, set out below.

Stage 1

This section sets out statements for reflection under the eight principles outlined in the guide. They are designed for people in your organisation's board, senior leadership team or – in the case of some primary care organisations – the owner.

You may want to review your position against each of the principles or you may prefer to focus on one or two.

Stage 2

This stage involves summarising the high-level actions you will take over the next 6–24 months to develop your Freedom to Speak Up arrangements. This will help the guardian and the senior lead for Freedom to Speak Up carry out more detailed planning.

Stage 3

Summarise the high-level actions you need to take to share and promote your strengths. This will enable others in your organisation and the wider system to learn from you.

Stage 1: Review your Freedom to Speak Up arrangements against the guide.

What to do

- Using the scoring below, mark the statements to indicate the current situation.

1 = significant concern or risk which requires addressing within weeks

2 = concern or risk which warrants discussion to evaluate and consider options

3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach

4 = an evidenced strength (e.g., through data, feedback) and a strength to build on

5 = confident that we are operating at best practice regionally or nationally (e.g., peers come to use for advice)

- Summarise evidence to support your score.
- Enter any high-level actions for improvement (you will bring these together in Stage 2).
- Make a note of any areas you score 5s in and how you can promote this good practice (you will bring these together in Stage 3).

Principle 1: Value speaking up.

For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top.

Statements for the senior lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	5
I have led a review of our speaking-up arrangements at least every two years	5
I am assured that our guardian(s) was recruited through fair and open competition	5
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	5
I am regularly briefed by our guardian(s)	5
I provide effective support to our guardian(s)	5
<p>Enter summarised commentary to support your score.</p> <p>Senior Leader responsible for FTSU is Director Nursing and Therapies.</p> <p>Self- assessment review (using 2019 tool) last undertaken January 2024</p> <p>Guardian recruited through Trust recruitment processes.</p> <p>Guardian works 5 days a week across reactive and proactive FTSU/ OD and leadership (2 days ringfenced for reactive FTSU work - the guardian is supported by a Champions network and is also supported to be chair of SE FTSU guardian network.</p> <p>Monthly 1:1 with exec lead and FTSU Guardian, monthly meetings between Guardian, CEO, Deputy Director HR, and Exec Lead. Regular meetings with Non-Executive Director responsible for FTSU. Regular monthly meeting with OD lead.</p>	
<p>High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)</p>	

Statements for the non-executive director lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	5
I am confident that the board displays behaviours that help, rather than hinder, speaking up	5
I effectively monitor progress in board-level engagement with the speaking-up agenda	5
I challenge the board to develop and improve its speaking-up arrangements	5
I am confident that our guardian(s) is recruited through an open selection process	5
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	5
I am involved in overseeing investigations that relate to the board	5
I provide effective support to our guardian(s)	5
<p>Enter summarised evidence to support your score.</p> <p>1:1 catch up between FTSUG and Non-Exec Director Lead/ regular pertinent updates provided and discussed Proactive engagement in self-assessment process Engagement in Trust activity related to FTSU and wider staff wellbeing / organisational culture.</p>	
<p>High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)</p>	

Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture.

Role-modelling by leaders is essential to set the cultural tone of the organisation.

Statements for senior leaders	Score 1–5 or yes/no
The whole leadership team has bought into Freedom to Speak Up	4
We regularly and clearly articulate our vision for speaking up	4
We can evidence how we demonstrate that we welcome speaking up	4
We can evidence how we have communicated that we will not accept detriment	4
We are confident that we have clear processes for identifying and addressing detriment	4
We can evidence feedback from staff that shows we are role-modelling the behaviours that encourage people to speak up	4
We regular discuss speaking-up matters in detail	
<p>Enter summarised evidence to support your score.</p> <p>The Board and Senior Leadership team proactively support FTSU agenda; the area of focus for the organisation is to ensure that all who line manage staff at every level in the organisation act in a manner which supports staff to speak up, that they feel listened to when they do and that their concerns are followed up / escalated appropriately.</p> <p>Speak up / listen up/ Follow up ethos is part of the Trust leadership training programme and active listening is part of leadership competencies for the organisation.</p> <p>FTSU Strategy refreshed in 2023.</p> <p>Speak up policy in place and updated September 2024 in line with national policy</p> <p>Clear message at induction re FTSU and FTSUG provides a slot at induction</p>	

Use of newsletters / intranet pages/ posters alongside visibility of FTSUG, champions who are supporting messaging into their teams/ services, executive/ Non-Executive Gemba, promotion through FTSU month. Safety culture work across the Trust promotes vision for everyone to feel safe to speak up, promotion of FTSU in training such as PMVA. FTSU month. Regular engagement form FTSUG with staff networks and attendance at network meetings. FTSUG and a champion are part of safety culture steering group chaired by Director Nursing & Therapies (with FTSU as a standing agenda item on this meeting).

Feedback from staff who have spoken up collated by FTSUG, used as part of Board reporting, within safety culture programme of work and also work in relation to violence and aggression / anti-racism.

Monthly training / networking for Champions

The Champions are representative of the organisation.

Gender - 22% male and 78% female (Trust 14% and 83%)

Diversity – 66.6% White British and 33.3% ethnically diverse (Trust 64.3% White British and 33.5% Ethnically diverse)

Disability - 18% have a declared disability and 72% non-disabled (Trust 84% no disability declared, 9% have declared disability, 7% not declared)

Attendance by FTSUG at safety Culture Group, Diversity Steering Group and Strategic People Group, Anti Racism Taskforce

FTSUG is Involved in current SE region work and chairs SE FTSUG's meetings

Definition of detriment published on Trust intranet and aligns with NGO guidance; guidance includes what to do if you feel you have suffered detriment

High-level actions needed to bring about improvement (focus on scores 1 ,2 and 3)

Consider how we encourage staff to raise concerns at an earlier stage and support appropriate response to reduce escalation of concerns and possible detriment.

Review investigatory processes to ensure that they are as timely as possible and that those involved are kept updated appropriately - current casework review commencing

Statements for the person responsible for organisational development	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	5
We have included creating a speaking-up culture (separate from the Freedom to Speak Up guardian process) in our wider culture improvement plans	5
We have adapted our organisational culture so that it becomes a just and learning culture for our workers	5
We support our guardian(s) to make effective links with our staff networks	5
We use Freedom to Speak Up intelligence and data to influence our speaking-up culture	5
<p>Enter summarised evidence to support your score.</p> <p>OD lead is an ex-Associate Guardian from a previous Trust, having completed national guardian office induction and training.</p> <p>Implementation of a Just Culture, embracing Safety Culture work & Early Resolution framework via HR policies</p> <p>FTSU data is reviewed alongside HR Heatmap to determine hotspots or teams with poor culture and any EDI links such as microaggressions or other abuse against staff with protected characteristics. FTSU Lead is leading on the development of our cultural barometer, which will in time be used as a helpful diagnostic in cultural improvement and OD interventions. This will explicitly contain FTSU intelligence form staff survey.</p> <p>FTSUG is key member of our VPR group, which uses intelligence to drive our speak up culture. Our FTSUG has led on awareness raising of sexual safety and domestic abuse - encouraging staff to build awareness, signposting and encouraging active action in these space – all linked to the pro-active side of speaking up culture development.</p> <p>Leadership programme includes speak up, listen up, follow up. FTSUG is a facilitator on the programme.</p> <p>FTSUG well linked into all staff networks, attends network events regularly.</p> <p>FTSU Is embedded in corporate induction and with student/ Medic induction – setting the tone for FTSU from the start.</p> <p>FTSUG is a member of our ‘team forum’ – which discusses teams we are working with on a monthly basis and what interventions are appropriate.</p>	

Introduced our behaviour framework that is entwined with safety culture and sets the behavioural expectations and standards for our speaking up and learning culture. – Compassion, Curiosity, Inclusion and Perseverance.

In developing our speaking up culture as part of our wider culture improvement plans, we have introduced a resolution pathway and internal mediation scheme, of which our FTSUG promotes and helps coordinate.

FTSUG contacts those services who score lower on the staff survey results – using data to influence our speak up culture.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Continue the development of the cultural barometer and once developed use it as a diagnostic tool for intervention and support

Statements about how much time the guardian(s) has to carry out their role

Score 1–5 or yes/no

We have considered all relevant intelligence and data when making our decision about the amount of ringfenced time our guardian(s) has, so that they are able to follow the National Guardian’s Office guidance and universal job description and to attend network events

5

We have reviewed the ringfenced time our Guardian has in light of any significant events

5

The whole senior team or board has been in discussions about the amount of ringfenced time needed for our guardian(s)

5

We are confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians

5

Enter summarised evidence to support your score.

The Guardian is able to follow NGO guidance, attends working events and training opportunities and chairs the Southeast FTSUG network. Guardian is part of ICB and other networks including a speak up network outside of the NHS.

Time for Guardian has been part of self-assessment in this and previous self-assessments and FTSUG is in agreement that his time is sufficient.

The Trust have clear agreement with FTSU champions and their managers to demonstrate commitment to fulfil the role and to be able to attend network meetings to support their role alongside their substantive positions within the organisation.

The Champions are representative of the organisation;

Gender - 22% male and 78% female (Trust 14% and 83%)

Diversity – 66.6% White British and 33.3% ethnically diverse (Trust 64.3% White British and 33.5% Ethnically diverse)

Disability - 18% have a declared disability and 72% non-disabled (Trust 84% no disability declared, 9% have declared disability, 7% not declared)

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so.

Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality.

Statements about your speaking-up policy	Score 1–5 or yes/no
Our organisation’s speaking-up policy reflects the 2022 update	5
We can evidence that our staff know how to find the speaking-up policy	4
<p>Enter summarised evidence to support your score.</p> <p>Policy has been reviewed in 2025 and is aligned with the NHSE policy. This includes review by staff-side, network leads, diversity steering group. The latest policy review includes detriment guidance for managers and staff as well a reference to NHSE Sexual Safety Charter and Employers’ Initiative for Domestic Abuse.</p> <p>The policy is held within the policy section of our staff intranet and also within the safety culture / FTSU section there is however always ongoing work to ensure that all staff are aware. Staff network intranet pages also link to FTSU page where there’s a link to the policy. This is covered in induction and staff are reminded at key times throughout the year such as FTSU month, at events and all staff newsletters.</p> <p>We have included into our mid-year appraisal a question for all staff around knowing how to raise a concern. 98.4% staff completing their mid-year appraisal stated that they knew how to raise a concern.</p>	
<p>High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)</p>	

Statements about how speaking up is promoted	Score 1–5 or yes/no
We have used clear and effective communications to publicise our guardian(s)	4
We have an annual plan to raise the profile of Freedom to Speak Up	4
We tell positive stories about speaking up and the changes it can bring	3
We measure the effectiveness of our communications strategy for Freedom to Speak Up	4
<p data-bbox="152 547 931 582">Enter summarised evidence to support your score.</p> <p data-bbox="152 620 2078 727">Guardian is part of corporate induction, Student Induction, International Nurses Induction & Resident Doctor induction; posters newsletters, intranet, attendance at meetings and events, champion and staff networks, training such as PMVA references FTSU, FTSU month activities, visibility of FTSUG - this is an ongoing endeavour to continually raise. There are pages on the intranet specific for FTS.</p> <p data-bbox="152 767 1805 802">We use staff survey results and intelligence to ensure targeted work to publicise our Guardian and have a network of</p> <p data-bbox="152 842 2047 914">Feedback received from inductees on the FTSU session within induction demonstrates that 97% (Q1 2025/2) and 96% (Q2 2025/26) found the session to be useful / very useful with others responding as somewhat useful.</p> <p data-bbox="152 954 2092 1246">Our staff survey results for 2024 demonstrate that 82.3% of staff feel secure raising concerns about unsafe clinical practice (above national average) and this alongside confidence that it would be acted on have seen year on year improvement since 2018 with scores currently 10.7% above national average scores for feeling secure raising the concern and 14.7% above national average scores for confidence that they would be addressed. In terms of feeling safe to speak up about anything of concern, around 75.6% feel safe to do this (10.7% above national average) and 67.2% believe that their concerns would be acted on (14.7% above national average). The People Promise “Raising Concerns” sub score shows a change 2023 to 2024 of 7.16 to 7.26 moving our national ranking from 9th to 3rd. We have a focus on demonstrating positive and decisive action in terms of bullying, harassment and racism experienced by our staff with the aim of supporting improvement in relation to this.</p> <p data-bbox="152 1286 2092 1358">We have included into our mid-year appraisal a question for all staff around knowing how to raise a concern. 98.4% staff completing their mid-year appraisal stated that they knew how to raise a concern.</p>	

Positive stories to demonstrate positive outcomes and impact of speaking up are used at Board and to support some of our improvement work, further work can be continued to raise the profile of these further.

Programme of workshops aimed at encouraging staff to speak up, compassionate leadership and safe cultures being undertaken across the Mental Health wards - series of video clips used to support this and will be delivered over Sept and Oct 23 by a multi-professional group of staff including psychology, nurse consultants and Resident Doctors; following PDSA approach this can be rolled out further.

Guardian has individual objectives for the role and the safety culture steering group has workplan and actions that include continuing to improve on the speak up, listen up, follow up culture across the organisation.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Increase of positive story telling

Principle 4: When someone speaks up, thank them, listen and follow up.

Speaking up is not easy, so when someone does speak up, they must feel appreciated, heard and involved.

Statements about training	Score 1–5 or yes/no*
We have mandated the National Guardian’s Office and Health Education England training	2*
Freedom to Speak Up features in the corporate induction as well as local team-based inductions	5
Our HR and OD teams measure the impact of speaking-up training	2*
<p><i>*We recognise that achieving a culture that encourages speaking up and ensures that staff are listened to, and action taken when they do require a multi-faceted and long-term approach and that e-learning will not achieve that. We ensure that encouraging speaking up is included in induction, the essence of all three e-learning modules is included within leadership and training opportunities. We have made the e-learning essential for certain staff groups such as the people directorate.</i></p> <p>Enter summarised evidence to support your score.</p> <p>In our Leading for Impact – leadership development programme, FTSU Lead runs the second day so FTSU principles are embedded. This is part of our courageous conversations training.</p> <p>MSN sessions are delivered to our manager cohort. Feedback form for evaluation is collected afterwards.</p> <p>FTSUG attends mandated guardian training.</p> <p>To date we have promoted the 3 FTSU e-learning modules and they are available on our training platform but have not mandated. We have agreed staff groups to prioritise for essential training and our FTSU champions promote this training.</p>	

Total number of staff who have completed training modules as of December 2025

Speak Up Core training	Listen Up Managers	Follow Up Leaders
2683	187	114

FTSU features in corporate induction and Resident Doctor Induction and is part of other essential and mandated training / programmes for staff including PMVA, leadership programme for managers, all staff webinars, safety culture training, L1 patient safety training (93% staff have completed this). The delivery of Corporate Induction awareness has been deemed compliant with the learning outcomes of the core training e-learning package.

Feedback form devised for everyone following induction, feedback received from inductees on the FTSU session within induction demonstrates that 97% (Q1 2025/26) and 96% (Q2 2025/26) found the session to be useful / very useful with others responding as somewhat useful.

We measure the impact of our approach through the national staff survey and culture work undertaken into teams and services.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Statements about support for managers within teams or directorates	Score 1–5 or yes/no
We support our managers to understand that speaking up is a valuable learning opportunity and not something to be feared	4
All managers and senior leaders have received training on Freedom to Speak Up	2*
We have enabled managers to respond to speaking-up matters in a timely way	4
We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture	3

**We recognise that achieving a culture that encourages speaking up and ensures that staff are listened to, and action taken when they do require a multi-faceted and long-term approach and that e-learning alone will not achieve that. We ensure that encouraging speaking up is included in induction, the essence of all three e-learning modules are included within leadership and training opportunities. We have made the e-learning essential for certain staff groups such as the people directorate.*

Enter summarised evidence to support your score.

To date we have promoted the 3 FTSU e-learning modules and they are available on our training platform but have not mandated. We have agreed staff groups to prioritise for essential training.

FTSU features in corporate induction and is part of other essential and mandated training / programmes for staff including PMVA, leadership programme for managers, all staff webinars, safety culture training, L1 patient safety training (93% staff have completed this).

There is much focus on safety culture and supporting environments that is psychologically safe and this is included in leadership programme for all managers.

Programme of workshops aimed at encouraging staff to speak up, compassionate leadership and safe cultures is undertaken

We use our managers briefing pack to promote and continue to raise awareness around FTSU

Manager Support Network sessions are delivered to our managers on FTSU/ listen up and follow up

In our Leading for Impact – leadership development programme, FTSU Lead runs the second day, so FTSU principles are embedded. This is part of our courageous conversations training.

Feedback received from inductees on the FTSU session within induction demonstrates that 97% (Q1 2025/26) and 96% (Q2 2025/26) found the session to be useful / very useful with others responding as somewhat useful.

Our 2024 staff survey results indicate that 75.1% staff are confident that if they raised a clinical concern, it would be acted on and around 67.2% are confident that if they raised any concern, it would be acted upon, this is 15.8% and 14.7% respectively higher than national average but also indicates that we have further work to do to continue the improvement journey.

Annual appraisal includes 2 questions for all staff to discussion with their appraiser around FTSU (Do you know how to raise a clinical or non-clinical concern? and please detail anything that you would like to discuss in terms of raising a concern or acting on a concern that is shared with you)

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Increase case studies and cross organisational learning from speaking up

Principle 5: Use speaking up as an opportunity to learn and improve.

The ultimate aim of speaking up is to improve patient safety and the working environment for all NHS workers.

Statements about triangulation	Score 1–5 or yes/no
We have supported our guardian(s) to effectively identify potential areas of concern and to follow up on them	5
We use triangulated data to inform our overall cultural and safety improvement programmes	4
<p>Enter summarised evidence to support your score.</p> <p>Our FTSUG interacts regularly with our staff networks to identify areas of concern and is part of our trust safety culture and strategic people groups, visible and priorities areas of known concern.</p> <p>Data is triangulated including heat map and nation staff survey as well as softer intelligence is used to prioritise FTSUG focus and also safety culture steering group and improvement work across the organisation.</p> <p>Data used from staff survey to inform areas for improvement for example safety culture programme of work at PPH, anti-racism work at PPH and within Wokingham community Nursing which will be used as a pilot PDSA for further programmes of work.</p> <p>Cultural barometer in development, containing FTSU metrics</p>	
<p>High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)</p>	

Statements about learning for improvement	Score 1–5 or yes/no
We regularly identify good practice from others – for example, through self-assessment or gap analysis	4
We use this information to add to our Freedom to Speak Up improvement plan	4
We share the good practice we have generated both internally and externally to enable others to learn	4
<p data-bbox="152 491 931 528">Enter summarised evidence to support your score.</p> <p data-bbox="152 564 1742 601">Review of all nationally available FTSU related reports; self- assessment undertaken by Board in 2021 and 2023</p> <p data-bbox="152 638 2018 711">Shared learning and practice through FTSU network, webinars related to FTSU and safety culture, leadership programmes National Guardian attended Board, FTSUG has attended system meetings for sharing practice.</p> <p data-bbox="152 748 2078 821">Sharing of good practice with FTSUG attending regional and national speak up groups and sessions. ICB have guardian/ exec and non-exec lead meetings established to support cross organisational learning.</p> <p data-bbox="152 858 1973 895">FTSUG and Exec lead have met with differing organisations to discuss our approach - sharing learning and learning from others</p>	
<p data-bbox="152 991 1413 1027">High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)</p>	

Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements.

Statements about how our guardian(s) was appointed	Score 1–5 or yes/no
Our guardian(s) was appointed in a fair and transparent way	5
Our guardian(s) has been trained and registered with the National Guardian Office	5
<p>Enter summarised evidence to support your score.</p> <p>Guardian appointed through usual trust recruitment processes. Guardian registered with National Guardian office and trained, aware of need for annual refresher training.</p>	
<p>High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)</p>	

Statements about the way we support our guardian(s)	Score 1–5 or yes/no
Our guardian(s) has performance and development objectives in place	5
Our guardian(s) receives sufficient one-to-one support from the senior lead and other relevant executives or senior leaders	5
Our guardian(s) has access to a confidential source of emotional support or supervision	5
There is an effective plan in place to cover the guardian's absence	5
Our guardian(s) provides data quarterly to the National Guardian's Office	5
<p data-bbox="143 612 931 647">Enter summarised evidence to support your score.</p> <p data-bbox="143 687 2038 722">Guardian has annual appraisal with Director Nursing and Therapies this includes setting and agreeing objectives for the coming year.</p> <p data-bbox="143 762 2022 834">Monthly 1:1 meeting with Director Nursing & Therapies and HR Deputy Director, monthly catch up between guardian, CEO, Director Nursing & Therapies and Deputy Director HR.</p> <p data-bbox="143 874 1151 909">Guardian also meets with the non-exec Director responsible for FTSU.</p> <p data-bbox="143 949 1252 984">Guardian has access to wellbeing team for support and also FTSUG network.</p> <p data-bbox="143 1024 1527 1059">In the Guardians absence Director of Nursing & Therapies covers along with champion's network</p> <p data-bbox="143 1099 1485 1134">Data provided to guardian office quarterly and is shared with Board through 6 monthly reports.</p>	
<p data-bbox="143 1219 1413 1254">High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)</p>	

Statements about our speaking up process	Score 1–5 or yes/no
Our speaking-up case-handling procedures are documented	4
We have engaged with managers and other key stakeholders on the role they play in handling speaking-up cases	4
We are assured that confidentiality is maintained effectively	4
We ensure that speaking-up cases are progressed in a timely manner within the teams or directorates we are responsible for	4
We are confident that if people speak up within the teams or directorates, we are responsible for, they will have a consistently positive experience	3
<p>Enter summarised evidence to support your score.</p> <p>Policy in place and aligned with national policy.</p> <p>Process in place for recording all contacts with FTSUG and quarterly review of cases between Director Nursing & Therapies and Deputy Director HR</p> <p>Ongoing work as detailed in previous sections to ensure that all staff receive a confidently positive experience when speaking up within teams.</p> <p>Questionnaire to staff who have used FTSU process to ensure that they are satisfied with how the FTSUG approached their concern this includes details of how to raise concerns to either the non-exec or Exec lead if the process/ experience could be improved.</p> <p>Monthly meet between CEO, FTSUG, Director Nursing and Therapies and Deputy Director People to ensure that cases are being progressed.</p>	
<p>High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)</p>	
<p>Actions to increase consistency to response (as detailed in Principle 4)</p>	

Principle 7: Identify and tackle barriers to speaking up.

However strong an organisation's speaking-up culture, there will always be some barriers to speaking up, whether organisation wide or in small pockets. Finding and addressing them is an ongoing process.

Statements about barriers	Score 1–5 or yes/no
We have identified the barriers that exist for people in our organisation	4
We know who isn't speaking up and why	3
We are confident that our Freedom to Speak Up champions are clear on their role	4
We have evaluated the impact of actions taken to reduce barriers?	3
<p>Enter summarised evidence to support your score.</p> <p>FTSU champions have quarterly sessions with Guardian to support, clarity provided regarding role to both champions and their managers.</p> <p>Ongoing conversations with staff network chairs to determine barriers network members face, with network members voices raised to Board through Board report.</p> <p>Attendance of FTSUG at Resident Doctor induction and staff events, proactive visits to sites and teams</p> <p>We know from staff survey services and groups of staff that find speaking up more difficult, targeted work in relation to anti-racism, services where speak has been evidenced as harder - for example PPH programme of work.</p> <p>Use of national staff survey to ascertain confidence in speaking up. Further work to ascertain why in some areas for continued improvement.</p> <p>Use of questions within appraisal to understand who is confident and understanding of process.</p>	

Previous results below

Description	MH & Comm Health Sector 2024 (%)				
	BHFT	Best	Average	BHFT / Best	BHFT / Average
Would feel secure raising concerns about unsafe clinical practice	82.61	82.61	76.27	0	6.34
Would feel confident that organisation would address concerns about unsafe clinical practice	75.27	75.27	61.06	0	14.21
Feel safe to speak up about anything that concerns me in this organisation	75.37	75.37	66.58	0	8.79
Feel organisation would address any concerns I raised	67.15	67.15	54.93	0	12.22
Average Sub Score	37.55	37.55	32.36	0	5.20

FTSU champions have a role descriptor and agreement of their managers for them to participate in the champion role / attend sessions provided for them

Established links with FTSUG and staff networks and regular attendance at trust wide events

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Whilst we know who is not speaking up/ feeling confident through staff survey and questions within appraisal further exploration of why to address this.

Statements about detriment	Score 1–5 or yes/no
We have carried out work to understand what detriment for speaking up looks and feels like	3
We monitor whether workers feel they have suffered detriment after they have spoken up	4
We are confident that we have a robust process in place for looking into instances where a worker has felt they have suffered detriment	4
Our Non-Executive director for Freedom to Speak Up is involved in overseeing how allegations of detriment are reviewed	
<p data-bbox="152 555 931 593">Enter summarised evidence to support your score.</p> <p data-bbox="152 632 1028 667">Exit interviews for those leaving and internal move interviews.</p> <p data-bbox="152 705 1610 740">Staff experience of speaking up captured, with support for those who feel they have suffered detriment.</p> <p data-bbox="152 778 1025 813">Review of feedback from staff who have used FTSU process.</p>	
<p data-bbox="152 868 1413 906">High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)</p>	

Principle 8: Continually improve our speaking up culture.

Building a speaking-up culture requires continuous improvement. Two key documents will help you plan and assess your progress: the improvement strategy and the improvement and delivery plan.

Statements about your speaking-up strategy	Score 1–5 or yes/no
We can evidence that we have a comprehensive and up-to-date strategy to improve the speaking-up culture	5
We are confident that the Freedom to Speak Up improvement strategy fits with our organisation’s overall cultural improvement strategy and that it supports the delivery of related strategies	4
We routinely evaluate the Freedom To Speak Up strategy, using a range of qualitative and quantitative measures, and provide updates to our organisation	4
Our improvement plan is up to date and on track	4
<p>Enter summarised evidence to support your score.</p> <p>Strategy refresh signed off at Board in July 23, aligns with overarching trust strategy, review of metrics to support on-going improvement. Strategy had cross organisational input including from staff networks. Improvement plan to be refreshed with any actions agreed from this self-assessment.</p> <p>Improvement plan as part of self-assessment is presented to Board 6 monthly and is reviewed through the safety culture group. FTSU is a standing agenda item on the Safety Culture Group agenda.</p> <p>Introduction of case studies of issues being raised to aid Board insight and understanding.</p>	
<p>High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)</p>	
<p>formulation of updated improvement plan following approval of self assessment</p>	

Statements about evaluating speaking-up arrangements	Score 1–5 or yes/no
We have a plan in place to measure whether there is an improvement in how safe and confident people feel to speak up	4
Our plan follows a recognised 'plan, do, study, act' or other quality improvement approach	4
Our speaking-up arrangements have been evaluated within the last two years	5
<p>Enter summarised evidence to support your score.</p> <p>We measure improvement through National staff survey.</p> <p>We use exit interviews and questionnaires to support understanding. Alongside this there is a question that is auditable within the mid-year appraisal process.</p> <p>We have evaluated our FTSU arrangements and as part of this re- invigorated our champion network across the organisation, they now have a clear role descriptor and agreement of managers to fulfil this role including attendance at relevant training and development. The network is representative of the organisation including protected characteristics and varying bands/ roles.</p> <p>We have undertaken a self-assessment which is received into the in Public Board alongside the 6 monthly FTSUG Board report.</p>	
<p>High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)</p>	

Statements about assurance	Score 1–5 or yes/no
We have supported our guardian(s) to structure their report in a way that provides us with the assurance we need	4
We have we evaluated the content of our guardian report against the suggestions in the guide	4
Our guardian(s) provides us with a report in person at least twice a year	5
We receive a variety of assurance that relates to speaking up	4
We seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement	
<p>Enter summarised evidence to support your score.</p> <p>Guardian meets with Non-exec and Executive lead regularly to assist in structure of the report.</p> <p>Introduction of case studies of issues being used to aid Board insight and understanding.</p> <p>FTSUG attends board 6 monthly to present report in person and support discussions re FTSU.</p> <p>QAC receives updates on safety culture as part of PSIRF implementation.</p> <p>Case work report and updates in relation to diversity, anti-racism work received at Board.</p> <p>Board -Gemba visits to services including out of hours.</p> <p>Internal audit of FTSU processes were undertaken in 2024/25 with substantial assurance received. This was presented to Audit Committee and full board.</p>	
<p>High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)</p>	

Stage 2: Summarise your high-level development actions for the next 6 – 24 months.

Development areas to address in the next 6–24 months	Target date	Action owner
1. Consider how we encourage staff to raise concerns at an earlier stage and support appropriate response to reduce escalation of concerns and possible detriment.	March 2027	FTSUG and Director Nursing and AHP
2. Review investigatory processes to ensure that they are as timely as possible and that those involved are kept updated appropriately - current casework review commencing	March 2027	Director People
3. Continue the development of the cultural barometer and once developed use it as a diagnostic tool for intervention and support	March 2027	FTSUG
4. Increase of positive story telling	March 2027	FTSUG and Director Nursing and Therapies
5. Increase case studies and cross organisational learning from speaking up	March 2027	FTSUG, Communications Team, Director Nursing and Therapies

Trust Board Paper

Board Meeting Date	10 th March 2026
Title	Experience of Care Framework – self assessment
	Paper for Noting
Reason for the Report going to the Trust Board	<p>Alongside clinical effectiveness and safety, providing a good experience of care is an essential part of an excellent health and social care service. This framework is designed to be used to improve outcomes and experiences for people using services, unpaid carers, staff, volunteers and communities; it is based on policy guidance combined with the reasons the Care Quality Commission (CQC) most frequently give for rating trusts as ‘outstanding’, based on our review of CQC reports from 2018 to 2023.</p> <p>The Experience of Care Framework is referenced within the DHSC/ NHS England ‘Reforming Elective Care of Patients’ document which includes expectations that provider organisations use the framework. There is also an expectation that the baseline assessment be presented to Board by March 2026</p> <p>The attached provides our baseline self -assessment against the areas of practice within the Framework for noting.</p> <p>The framework is grouped under 5 areas:</p> <ul style="list-style-type: none"> • Leadership • Organisational Culture • Collecting Feedback • Analysing Feedback • Learning for Improvement <p>Maturity ratings are assessed against - Excelling / Achieving/ Progressing and insufficient Progress.</p> <p>The expectation is that this framework and our maturity is revisited at least annually.</p> <p>All aspects of this framework are included within current programmes of work/ groups -the leads and groups have supported our initial assessment.</p>
Business Area	Trust Wide
Author	Debbie Fulton; Director Nursing and Therapies

Relevant Strategic Objectives	<p>Patient safety</p> <p>Ambition: We will reduce waiting times and harm risk for our patients</p> <p>Patient experience and voice</p> <p>Ambition: We will leverage our patient experience and voice to inform improvement</p> <p>Health inequalities</p> <p>Ambition: We will reduce health inequalities for our most vulnerable patients and communities</p>
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Experience of Care Framework -Draft baseline assessment

Leadership		
<p>1a. The provider has an experience of care strategy that: is either a stand-alone document or is integrated into a strategy for improving quality.</p> <ul style="list-style-type: none"> • has been co-produced with the community, people using services, unpaid carers, frontline staff, and volunteers. • has been consulted on with key stakeholders, including the community and voluntary sector and the integrated care system partners. • has been signed off by the board. • is reviewed regularly by the board who can support improvement and mitigating actions 	Achieving	<p>Trust strategy in place and meets these requirements. Strategy refresh in progress currently and to incorporate Experience of care</p>
<p>1b. The provider has a delivery plan for experience of care that includes:</p> <ul style="list-style-type: none"> • listening to, collecting and ongoing analysis of both quantitative and qualitative feedback from a variety of local and national sources, including from those in the community who do not currently access services but have a need for them or are likely to in the future. • a timetable for review 	Achieving	<p>Strategy has plan and metrics with review dates and updates to Board. Links to True North Plan on a Page - Good patient experience and supporting our people. Equity Partnership Group CommUNITY forum Co-production Framework</p>
<p>1c. The provider can demonstrate how it works with people using services, unpaid carers, communities and how this informs relevant decisions, in line with the statutory guidance working in partnership with people and communities.</p>	Achieving	<p>Examples of use of co-production Engagement with the community through the CommUNITY forum, lived experience workers, Reading ACRE, and Slough CVS, established patient and carer groups across the system. PCREF self-assessment independently assessed. Whilst mandated for Mental Health we have taken the opportunity to use the framework to cover physical health and children services as part of the 26/27 plan. Equity Partnership Group established. Examples of coproduction in children and young people's services with altered processes as a result. Carers Lead Staff networks (remembering our staff are also part of our communities)</p>

<p>1d. The provider can demonstrate an approach that addresses inequalities in experience of care and both understands and meets the needs of marginalised or underserved communities.</p>	<p>Progressing</p>	<p>Health Inequality Strategy and programmes of work in place with updates provided. Clear picture of the inequalities in access and experience of outcomes. Health inequalities group meets monthly. System working to identify inequalities using population health data. Use of our Health Bus to outreach into marginalised and underserved communities including some joint ventures with other providers Culture , Equity, and Inclusion Framework. Disability confident leaders' status Veteran Aware Stonewall gold award</p>
<p>1e. Where it has identified health inequality gaps between actual and expected service use, the provider can demonstrate:</p> <ul style="list-style-type: none"> • how it is working with people who don't currently access services but have a need to or are likely to need it in the future • how this work informs relevant decisions 	<p>Progressing</p>	<p>Part of our 26/27 onwards Health Inequalities strategy. We are working with reading ACRE and Slough CVS for the 2 most deprived areas in Berkshire but there is further work to do. Neighbourhood health work in partnership with local authorities to also support this agenda. Health inequalities dashboard and population health data</p>
<p>1f. The provider can demonstrate that it's proactively working with the community to understand the reasons behind any difference between actual and expected experience of care and is seeking to improve it.</p>	<p>Achieving</p>	<p>CommUNITY forum Reading ACRE and Slough CVS Equity Partnership Group Staff networks Frimley mirror Board</p>
<p>1g. The provider can demonstrate how it is working in partnership with the local integrated care board and system to improve experience of care.</p>	<p>Progressing</p>	<p>Identification of priorities of focus across the system for improved outcomes. Involvement in provider collaboratives and system initiatives</p>
<p>2a. The provider can demonstrate that experience of care, for both people receiving and providing care, is embedded in all aspects of leadership development.</p>	<p>Achieving</p>	<p>All programmes include content on compassionate leadership, Inclusion, psychological safety, health and wellbeing, and person-centred approaches. We use staff feedback to shape scenarios, reflective discussions, and improvement exercises. Leaders are supported to translate insights into practical changes in culture, communication, and service delivery. This ensures that experience of care is not optional or peripheral, but a fundamental driver of how our leaders think, behave, and make decisions, in which we strive for operational excellence.</p>

<p>2b. The provider can demonstrate how it has involved people using services and unpaid carers in the assessment and appraisal processes for staff. This approach could involve using experience of care feedback data or other forms of evidence, including compliments, complaints, and testimonials.</p>	<p>Progressing</p>	<p>For registered staff this is part of revalidation / medical appraisal processes (experience of care feedback data). Feedback data part of framing service level plan on a page - staff contribution to this is part of the objective setting within appraisals</p>
<p>2c. The provider ensures that experience of care feedback from the community, people using services and unpaid carers is embedded in the organisation's approach to staff and volunteer training.</p>	<p>Achieving</p>	<p>Examples of training being adapted and altered from feedback and incidents. Use of forum Theatre as part of training delivery using feedback Carers and lived experience input into training.</p>
<p>3a. The provider has an executive director lead for experience of care who routinely provides the board with reports and proactively leads this area of work.</p>	<p>Achieving</p>	<p>Director Nursing and Therapies</p>
<p>3b. The provider's executive leadership team is accessible and visible in the organisation and routinely engages with the community, people using services, unpaid carers, staff, and volunteers.</p>	<p>Achieving</p>	<p>Gemba by Exec and SLT included visits specific to antiracism. All staff Briefing. TLMF Attendance at trust events / workshops/ staff networking events Equity Partnership Group</p>
<p>4a. The provider can demonstrate how all healthcare professionals are engaged and provide input into the improvement of services, efficiency changes and how changes impact everyone's experience of care.</p>	<p>Excelling</p>	<p>NSS results re able to make improvements demonstrate us to be in the top 1-2% for questions around making suggestions and improvements within the team and area of work. Established, refined, and embedded quality Improvement processes across the organisation. With vision and strategic priorities widely understood through plan on a page annual processes. Innovation platform QI approach</p>
<p>4b. The provider can demonstrate how it proactively engages with and involves staff networks, such as the LGBTQIA+ staff network and the network for Black and ethnic minority staff.</p>	<p>Achieving</p>	<p>Executive sponsor for each network Regular staff network events (Reading Pride as an example) Diversity Steering group with representation from each network , their sponsors, and relevant organisational leads Staff network steering group Annual report written with networks</p>

<p>4c. The provider understands how change impacts on people using services, unpaid carers, volunteers, and staff and considers this in the planning and implementation of transformational activity.</p>	<p>Progressing</p>	<p>Co-production framework to ensure people are involved in changes and improvement. QI processes use A3 thinking and look at 3Cs (concern/ cause / countermeasure) Ongoing work to understand transformational work in relation to Health inequalities / protected characteristics. Use of community groups to aid this EQIA process reviewed - Manager support network sessions and drops in for all staff to support roll out. Work with Policy scrutiny and diversity steering group to ensure patient and staff policies. PCREF</p>
<p>4d. The provider can demonstrate how healthcare professional and volunteer engagement across the integrated care system are focused on people using services and unpaid carers.</p>	<p>Achieving</p>	<p>Provider collaboratives Quality Improvement across providers Pathway reviews Some joint working with acute providers around health inequalities - joint use of health bus for community engagement Collaborative working on neurodiversity and sharing of good practice. Collaboration with VSCE to support experience of care as well as community engagement</p>
<p>4e. There is clear medical engagement in experience of care as an equal facet of the quality agenda alongside safety and clinical effectiveness.</p>	<p>Progressing</p>	<p>There is evidence of examples of medical engagement in experience of care but this needs to be consistent across all areas. Work is ongoing as part of the medical workforce transformation plan to enhance medical leadership and improve engagement in experience of care.</p>
<p>Organisational Culture</p>		
<p>5a. The provider integrates the experience of the community, people using services, unpaid carers, staff, and volunteers within its organisational development strategy.</p>	<p>Achieving</p>	<p>Wide engagement with staff and communities to support strategy development . Within culture inclusion and equity framework, objectives focus on patient experience, staff experience, and carers experience – with measures including iWGC and carers data.</p>

6a. The provider supports staff to listen and act on the feedback from people using services and unpaid carers.	Achieving	Staff have near real time access to patient survey responses including free text (IWGC) True North Goal (part of plan on a page) to use feedback. Use of QI across the organisation with expectation of using data / feedback to inform approaches to improvement. PSIRF and involvement of those impacted. Carer and patient forums within the trust and part of wider system
6b. The provider routinely compares and combines feedback from different sources to get a complete picture of the experience of care. These sources include the community, people using services, unpaid carers, staff, and volunteers.	Progressing	PCREF Quality improvement programmes Some excellent examples but ongoing to embed across all services. Co-production framework developed to support. Divisional PPSQ receive data from variety of sources for triangulation and escalation to Quality and Performance Executive Group. Staff survey
6c. The provider supports, resources and actively engages with staff networks when delivering its approach to improving experience of care, for example, the LGBTQIA+ staff network and the network for Black and ethnic minority staff.	Achieving	Staff networks involved in / support for organisational initiatives such a black detentions, WRES / WDES improvement initiatives, antiracism. Culture of care
6d. The provider monitors the improvements and impact made against staff survey results.	Achieving	Evidence within People and culture strategy update FTSU self-assessment / plan Board report Culture, Inclusion and Equity framework.
6e. The provider uses positive reporting to identify and celebrate the achievements of staff and volunteers.	Achieving	Staff awards includes volunteer category. Thank you, Thursday. Sharing compliments in quarterly patient experience report. Sharing good news stories at PPSQ's Article in team brief newsletter All staff briefing. 60 seconds with stories
7a. The provider can demonstrate that staff are engaged in the process of setting staffing levels and in developing the workforce.	Achieving	Business cases for new services with safe staffing element now embedded into process alongside QIA. QIA used for any changes in staffing. Staff engagement in ward staffing with ability to show increases/ skill-mix based on feedback. Preceptorship processes for newly registered staff, local induction, and competency frameworks for staff development.

7b.The provider can show how well escalation processes are defined and embedded throughout the organisation to ensure safe staffing.	Achieving	Clear escalation policy and process in place; use of additional staff where needed. Use of safe care tool across wards is detailed within monthly ward safe staffing reports to FIP committee and QPEG
7c.The provider can demonstrate that staff give care that is compassionate.	Achieving	Feed-back from patients through IWGC (emotional support, empathy and respect is one of the sentiment score themes able to be calculated) . Scores for this sentiment theme consistently above 95% Relevant staff survey scores
7d: The provider can demonstrate that staff involve people using services and unpaid carers in making decisions about their care and treatment.	Achieving	Care / safety planning. Feedback through IWGC demonstrates 94% respondents believe that they are involved in decisions and that their preferences are respected. Mechanisms, resources & processes are in place e.g. risk assessment/safety planning, carers invited to MDTs, carer information and advice resources, upskilling staff e.g. Life Beyond the Cubicle training to support a culture of working with carers etc. Some areas/teams more advanced in their application and use of tools. Regular monitoring in place & improvements evidenced. Examples in children and young people's services.
7e: The provider can demonstrate that it provides good emotional, spiritual, and religious support to people using services, unpaid carers, staff, and volunteers.	Achieving	Wellbeing services for staff Chaplaincy services across our wards Multi-faith training has been developed and is available for all staff. Multi-faith projects and e-learning package
8a: The provider has a set of values that have been co-produced with people using services, unpaid carers, volunteers, and staff.	Achieving	Our values were coproduced. Our Behaviours were co-produced
Area 8b: The provider refers to its values in all corporate documents, which reflect the broader values in the NHS Constitution.	Achieving	Detailed within strategies and key trust documents. Also referenced in Induction and leadership programmes.
8c: The provider has an accountability framework to ensure its values are demonstrated by staff and volunteers.	Achieving	Behaviours framework and safety culture charter

8d: The provider has a values-based recruitment and appraisal system in place.	Achieving	Values-based interview questions. Initiatives such as pilot of providing questions pre interview commenced in November 2025. Appraisal process well embedded across the organisation, values based / behaviours questions included
9a: The provider can demonstrate that the information it provides is accessible and clear to people using services, unpaid carers, and the public, and ensures it is available through multiple routes.	Progressing	The website is accessible. Carer information is available via website and as printable PFDs. The comms team have a good awareness, and our brand and templates are designed to be accessible, the standard says we should use clear, easy to understand language. All our professionally designed leaflets, website content, etc meets this standard but further work is required to ensure that all patient letters are written in Plain English. There is ongoing work in terms of Easy Read
9b: The provider can demonstrate that it identifies, records, and shares the communication and information needs and preferences of people receiving care and unpaid carers.	Progressing	e-health passport in place, ongoing embedding of consistent use across all services
9c: The provider co-produces communications with people with lived experience and other stakeholders to ensure communications are clear and readily understood.	Progressing	Good examples but work to embed this throughout. Co-production framework Design of new website is being co-produced.
9d: People are routinely written to in a format that is accessible to them.	Progressing	Our patient letters are not always written in Plain English; there is further work around this. The organisation provides translation and interpretation services
Collecting Feedback		
10a: The provider can demonstrate a comprehensive programme of seeking rapid and real or near real-time feedback from people using services and unpaid carers.	Achieving	IWCG survey is near real time. Separate survey for unpaid carers
10b: The provider can demonstrate an effective approach to collecting and hearing feedback from marginalised or underserved communities.	Achieving	CommUNITY forum Reading ACRE and Slough CVS Equity Partnership Group Outreach Monitoring of IWGC feedback Use of coproduction and Health inequalities programmes of work Further work to embed across all services. Staff networks

10c: The provider can demonstrate that there is a process to collect and hear feedback from volunteers.	Progressing	A handbook provided at induction, details how feedback can be given. Questionnaire sent to all volunteers to ask about their experience of volunteering, understand training needs and how the role could be enhanced. Contact with volunteers when they leave role for feedback. score of progressing as annual cycle of gaining and recording feedback to be established
10d: The provider can demonstrate it supports and uses national patient experience surveys and the Friends and Family Test. It ensures all people who use services and unpaid carers are given the opportunity to feedback, see the results, support co-produced improvements, and see the impact locally.	Achieving	FFT is part of the near real time patient feedback survey. Participation in relevant national surveys such as the community mental health survey
10e: The provider can demonstrate that it uses existing quantitative and qualitative datasets that speak to experiences of care, before beginning to collect new data. This approach will ensure any new data collection is necessary and targeted at evidenced gaps in insight.	Achieving	QI encourages use of available data before seeking further collection.
10f: The provider can demonstrate adherence to best practice guidelines for experience of care.	Achieving	As evidenced by responses within this template
11a: The provider undertakes stakeholder mapping to seek feedback from all relevant groups and communities, ensuring no one is missed and everyone's accessibility and inclusivity needs are considered.	Progressing	Examples of achievement across the organisation with ongoing work to ensure consistency. Equity Partnership and COMMUNITY forum assist with this. Service specific engagement with relevant groups e.g. Dementia Care Advisors, Parent Carer Forums. EqIA's for all service provisions, or changes is ad hoc currently with ongoing work.
11b: The provider can demonstrate its adhering to statutory guidance for improving the quality of care.	Achieving	NHS IMPACT self-assessment CQC ratings Board assurance framework. Quality accounts
11c: The provider is proactive in informing and signposting people to the range of ways they can provide feedback, including through the NHS website and other organisations, such as Healthwatch.	Achieving	Complaints, PALS, FFT detailed on website and in leaflets. Carer information page on website signposting to carer support Elemental platform/ website (social prescribing software for healthcare) in testing
11d: The provider employs a range of methods to collect feedback, considering accessibility and based on the recorded needs and preferences of people using services and unpaid carers.	Achieving	Survey available online, SMS, paper and in differing languages. Face to face and over telephone feedback FTSU

11e: The provider employs a range of methods to collect feedback from people who do not currently access care but who have a need for it or would be likely to need it in the future.	Progressing	CommUNITY forum Focus groups across some services and engagement of public in setting strategy. Use of established groups across the system. Ongoing work to ensure consistency across Community engagement with ACRE and Slough CVS
11f: The provider empowers staff to actively identify, and record communication and information needs and preferences made by people using services and their unpaid carers.	Achieving	e- health passport and RIO preferences
12a: The provider has an accessible and user-friendly complaints policy, which complies with statutory regulations. Information is visible in all locations where care is received and is available from community staff where applicable.	Progressing	Complaint policy is currently under review to be completed by April; review will ensure that it is accessible and user friendly. Current complaints policy is available on the Trust internet
12b: The provider clearly displays information on how to make a complaint on its website, and this is accessible within no more than two clicks from the home page.	Achieving	Website is clear about how to make a complaint within 2 clicks from the home page
12c: The provider offers a discussion with a named contact, and complainants are supported throughout the complaints process.	Achieving	All complaints have an investigating officer who makes/ attempts contact with the complainant.
12d: The provider can provide evidence that practice has changed following complaints.	Achieving	You said we did. Action plans and complaint responses detail changes made
12e: The provider monitors insight arising from complaints, such as patterns and notable variations in experiences of care, to support understanding of and reduce health inequalities, ensuring improvements are sustained.	Progressing	Demographics data analysed as part of patient experience. Themes from complaints identified. Triangulation through PPSQ's Ongoing work to use this as part of monitoring of health inequalities improvement work.
13a: The provider provides information about Patient Advice and Liaison Service (PALS) that is visible in all locations where people use services and is available from community staff where PALS is provided.	Achieving	Available on website, in patient leaflets/ posters
13b: The provider clearly displays information about how to use PALS on its website, and this information is accessible within no more than two clicks from the home page where PALS is provided.	Achieving	Under our contact us section on home page of website
13c: The provider routinely gathers and reports on feedback about how issues have been handled where PALS is provided.	Achieving	This is reported within the quarterly patient experience report
13d: The provider can provide evidence that practice has changed in response to feedback from PALS.	Progressing	The patient experience lead is undertaking work to ensure that this is captured in a way that is easy to disseminate and share

<p>13e: The provider monitors insight arising from PALS, such as patterns and notable variations in experiences of care, to support understanding of and reduce health inequalities, ensuring improvements are sustained.</p>	<p>Progressing</p>	<p>The patient experience lead is exploring how this can be captured and used - currently characteristic information is not routinely captured/ requested at point of contact which is often once only short interaction to signpost or provide information. Work also being undertaken to provide improved theming of PALS enquiries</p>
<p>13f: The provider routinely captures a range of written and spoken qualitative feedback, including through lived experience, focus groups and existing datasets, such as the NHS website.</p>	<p>Achieving</p>	<p>Feedback through IWGC patient survey, complaints both formal and informal, compliments. Focus groups and forums such as patient and carer forums. Lived experience workers / volunteers and staff networks. CommUNITYForum – feedback forms Staff network events</p>
<p>13g: The provider monitors and evaluates the impact and outcomes from quantitative and qualitative evidence as to the experience of care.</p>	<p>Progressing</p>	<p>Evaluation of impact for specific projects and changes but ongoing work for this to be consistent across all services</p>
<p>13h: The provider can demonstrate it uses both quantitative and qualitative evidence about the experience of care at board level and in committees that support improvements</p>	<p>Achieving</p>	<p>Patient story to board Patients experience report to Board includes feedback from patients as well as quantitative data. People and culture strategies updates into Board</p>
<p>14a: The provider supports staff in addressing concerns raised by people using services, unpaid carers, families, and volunteers.</p>	<p>Achieving</p>	<p>Patient experience team provide support and training. Family Liaison practitioner Clinical Director within each division for senior support Carers Lead</p>
<p>14b: The provider has a process for demonstrating how teams can share and learn from responding to concerns raised by people using services, unpaid carers, families, and volunteers.</p>	<p>Achieving</p>	<p>Regular Circulation newsletter Use of feedback as part of Quality Improvement processes Patient safety meetings include complaints. Patient safety reviews include any patient/ carer/ family concerns and are shared at Mortality and Patient Safety Meetings Divisional PPSQs Quarterly Patient Experience Report Carers and patient groups able to provide feedback on learning. Carers hub teams' channel to share information, resources, and learning</p>

14c: The provider can demonstrate that Duty of Candour regulations are well understood and embedded; the provider's processes are clear and transparent.	Achieving	Policy detailing processes. Training for staff Evidence of application which is monitored and supported through patient safety team
Analysing Feedback		
15a: The provider can demonstrate that it routinely and systematically analyses quantitative feedback using appropriate methods and best practice, such as ensuring data is representative and statistical uncertainty is measured.	Progressing	Patients experience report. PPSQ's triangulate data and report up to QPEG. Use of external surveys/ model health data and benchmarking Embedding required to be consistent across the organisation. Workforce analyst supports staff survey analysis PCREF local plan
15b: The provider can demonstrate that it routinely and systematically analyses qualitative feedback using appropriate methods and best practice. This includes not attempting to apply quantitative analysis to qualitative datasets, which will result in a loss of meaning and insight.	Progressing	Use of free text qualitative data in patient survey. Qualitative feedback from patient/ carer focus groups/ forums CommUNITY forum Healthwatch and other qualitative feedback routes Progressing as not consistent across the org and all services PCREF local plan
15c: The provider has dedicated analysis and support to ensure it can best use its experience of care feedback data.	Achieving	Patient experience team QI team Informatics Workforce Analyst Population Health Analyst
15d: The provider ensures that analysing experience of care data is a key component of annual quality accounts.	Achieving	Patients experience section Service improvement section and within annual quality accounts.
15e: The provider's quality accounts include information about experience of care and how the trust is listening and responding to feedback from the community, people using services and unpaid carers. This should include examples of improvements to services or care the provider has made as a result of feedback.	Achieving	As above
16a: The provider highlights areas where experience of care correlates with other quality measures (for example, safety and clinical outcomes).	Achieving	Quality concerns register. PPSQ reporting to QPEG. Performance scorecards Quality Improvement programmes of work
16b: The trust board reports clearly to articulate the relationships between the quality measures (experience of care, safety, and clinical outcomes) and quality improvement.	Achieving	

17a: The provider monitors qualitative and quantitative data from staff, volunteers, communities, people using services and unpaid carers to identify variations and areas for improvement relating to experiences of care.	Achieving	Staff, student and patient surveys used to identify variations and areas for improvement. Accreditation processes across a number of services Carers strategy and self-assessment tool on tableau for all services
Area 17b: Staff and volunteers within the provider are empowered to use feedback to inform continuous improvements in line with NHS IMPACT.	Achieving	Established Quality improvement processes with National staff Survey indicating positive response to relevant questions around staff feeling confident and empowered to make improvements in team and services.
18a: The provider has a process to support staff to continually improve how they gather feedback so they can use this to improve the quality of care.	Achieving	Near real time patient survey and access for staff to feedback in near real time. Quality Improvement approach embedded across the organisation. Patient Experience and QI team for support Co-production framework in place
18b: The provider expects all teams to routinely use qualitative and quantitative data feedback about care experiences to make improvements.	Achieving	Staff have near real time access to patient survey responses including free text. True North Goal (part of plan on a page) to use feedback. Use of QI across the organisation with expectation of using data / feedback to inform approaches to improvement. PSIRF - learning from incidents processes
18c: The provider has an effective approach to sharing learning locally, including recognising and rewarding good practice and identifying opportunities to improve the quality of care.	Achieving	Alternate week circulation newsletter Divisional PPSQs for sharing learning and good practice. Patient safety processes and learning Staff Awards/ compliments as part of our patient experience survey.
Learning and Improvement		
19a: The provider uses shared decision-making tools to help people using services and unpaid carers make informed decisions about treatment and care options.	Progressing	Mechanisms, resources & processes are in place e.g. risk assessment/safety planning, carers invited to MDTs, carer information and advice resources, upskilling staff e.g. Life Beyond the Cubicle training to support a culture of working with carers etc. Some areas/teams more advanced in their application and use of tools. Regular monitoring in place & improvements evidenced.

<p>19b: The provider has a process for demonstrating that people using services and unpaid carers are all involved in care planning, including the statutory duty to involve unpaid carers in discharge planning.</p>	<p>Progressing</p>	<p>As above. IWGC tool demonstrates that 86% respondents believe that family / carers are involved. For MH Processes in place e.g. Standard Work Carers Contact, attendance MDT. Opportunities for holistic approach to care planning. For children and Young People services parents are involved in care planning / evidenced in clinical records Focussing on embedding more consistent practice across the organisation.</p>
<p>19c: The provider can demonstrate that people using services and unpaid carers, understand any roles they may have in the agreed care plan.</p>	<p>Progressing</p>	<p>New approach to assessments, risk, safety, and care planning documentation in MH includes patients' and carers' perspectives/involvement, plus opportunity to share with other professionals. Adopting holistic and collaborative approach. Development of carer groups & concerns about safety panel for MH. Measures in progress e.g. peer reviews to capture qualitative evidence to identify any knowledge/skills gaps and upskill staff. Embedding needed for consistency across organisation</p>
<p>19d: The provider performs highly in those NHS-mandated national survey questions that ask if people felt involved in decisions about care and treatment.</p>	<p>Achieving</p>	<p>In the 2024 CMHT survey ,we scored in the top 20% for being given choice on how your care and treatment would be delivered and national average for agreeing care plan (this is the only mandated survey for our services) and is relevant to a small cohort of our total patient population</p> <p>Involvement in decisions and respect for preferences is a theme able to be extracted from IWGC patient survey. Current rating 93% positive score</p>
<p>20a: The provider has a systematic approach to identifying staff and volunteer training needs to use feedback to drive improvement in experience of care.</p>	<p>Achieving</p>	<p>Part of appraisal process/ robust TNA process across the organisation Part of revalidation processes for registered clinicians to identify how feedback has altered practice / learning from that. Questionnaire sent to all volunteers to ask about their experience of volunteering, understand training needs and how the role could be enhanced.</p>

20b: The provider's board and executive team have a good understanding of how change happens in complex systems, and how change impacts people using services, unpaid carers, volunteers, and staff.	Achieving	Provider Capability Self-Assessment has a confirmed position on relevant domains of People and Culture, Access, and delivery of services as detailed in November 2025 Board.
21a: The provider can demonstrate that staff engage in continuous improvement using an improvement methodology in line with NHS IMPACT.	Excelling	The organisational-wide approach to quality improvement has been in development since 2017 and enables staff to demonstrate their ability to use improvement methods and practices intentionally and systematically, to change processes and generate improved performance. The NHS IMPACT self-assessment was completed with input from a range of colleagues, including leadership teams in 2023
21b: Staff have the capability and capacity to identify areas for quality improvement and undertake these improvements in partnership with people with lived experience.	Achieving	As above .We have built capability through QI training and established a culture where our staff feel confident and empowered to take part in improvement activity in their own area and talk openly and honestly to leaders and managers when they are on Gemba visits. People with lived experience and service-users are involved in co-producing some local improvements and are increasingly involved in our strategic transformation projects.
22a: The provider can demonstrate that results of impact assessments are always included within proposals.	Achieving	EQUIA / QIA processes are part of TBG and strategic prioritisation improvement tickets and policy
22b: The provider can demonstrate how people with lived experience and unpaid carers have been involved at all stages of any service change, and there is evidence of meaningful co-production or co-design within this.	Progressing	We have an organisation approach to, and framework for, co-production. There are many examples of people with lived experience, service-users and carers have been involved at all stages of service improvements. Examples and case studies of meaningful co-production are often shared within the organisation; however, this is not embedded within the practice of all teams and there is more work to do to build capability with colleagues to facilitate co-production.

<p>23a: The provider can demonstrate that staff and volunteers are given the opportunity to contribute and act on ideas for continuous improvement, including recognising and rewarding where staff and volunteers have responded positively to experience of care feedback.</p>	<p>Achieving</p>	<p>Well established Quality improvement processes across the organisation. Demonstration through staff survey results Bright ideas platform Patient Safety Incident Response Framework Application encourages involvement of staff in patient safety reviews. SIRAN accreditation achieved and maintained, Plan on a page development across teams</p>
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Trust Board Paper

Board Meeting Date	10 March 2026
Title	Executive Report
	Item for Noting and Approval of the Modern Day Slavery Statement
Reason for the Report going to the Trust Board	<p>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.</p> <p>The Trust Board is requested to seek note the report and to seek any clarification on the issues covered in the report.</p>
Business Area	Corporate Governance
Author	Chief Executive
Relevant Strategic Objectives	The Executive Report is relevant to all the Trust's Strategic Objectives

Trust Board Meeting – 10 March 2026

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. Modern Slavery Statement

The Modern Slavery Act 2015 is designed to consolidate various offences relating to human trafficking and slavery. The provisions in the Act create a requirement for an annual statement to be prepared that demonstrates transparency in supply chains. In line with all businesses with a turnover greater than £36 million per annum, the NHS is obliged to comply with the Act.

Summary

The legislation addresses slavery, servitude, forced or compulsory labour and human trafficking and links to the transparency of supply chains.

Section 54 of the Act specifically addresses the point about transparency in the supply chains. It states that a commercial organisation (defined as a supplier of goods or services with a total turnover of not less than £36million per year) shall prepare a written slavery and human trafficking statement for the financial year. The statement should include the steps an organisation has taken during the current financial year to ensure that slavery and human trafficking is not taking place in any part of the supply chain or its business. The statement must be approved by the Trust Board.

The Trust will be implementing the requirements of the National Health Service (Procurement, Slavery and Human Trafficking) Regulations 2025 from 17th May 2026 when the Act comes into force. This will include assessing the risk of modern-day slavery and human trafficking in the Trust’s supply chain.

The Trust’s Modern-Day Slavery Statement is attached at appendix 1.

The Trust Board is requested to approve the Modern-Day Slavery Statement which will be included as part of the Trust’s Annual Report for 2025-26.

3. Staff Winter Flu Vaccination Report

Seasonal flu vaccination remains a critically important public health intervention and a key priority for 2025-26 as part of protecting the public and staff over the winter months.

In the Core NHS standard contract for 2025/26, flu vaccinations for frontline healthcare workers is retained as an employer responsibility to offer and deliver the flu vaccine.

The national aim was to offer vaccinations to 100% of frontline healthcare workers, with a minimum uptake of 5% higher than last year. We offer the vaccination to all of our staff, and our aim was to achieve at least 50% this year.

We commenced our vaccination programme at beginning October 2025 and are providing vaccinations through a variety of means including clinics, peer vaccinators and, recognising that many staff live outside of Berkshire and/or work from home also offer vouchers for flu vaccination. Staff are also encouraged to let us know if they have received their vaccine through other means such as GP or local clinic.

We have received acknowledgement from NHS England's regional team that we achieved the increase of 5% above last year's uptake. As of 5th February 2026, (latest national data at time of writing) uptake amongst frontline workers was 49.4%.

Each year we gain feedback from our staff in relation to our flu campaign to further improve our approach and uptake, we are in the process of doing this currently to enable improvement suggestions to be built into next year's campaign.

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

4. Actions to Deliver Agenda for Change Uplift and Fairer Deal for Nurses

On 12th February 2026, the Interim Director General, People and Chief Nursing Officer for NHS England wrote to all trusts detailing commitments being made to recognise the significant value of the nursing profession and to make sure that nurses receive the pay and support deserved.

The commitments as detailed in the letter are:

- making sure every nurse is in the right band, and reviewing all band 5 nurse job descriptions, with additional funding available to support this review process
- making graduate pay a priority as part of ongoing reforms to Agenda for Change staff pay structure.
- launching a national nursing preceptorship to ensure every nurse has the best start to their career, wherever they work.
- reviewing the evidence from the review of band 5 nursing roles to determine whether any further action is required.

The requirements of organisations to support this are:

- To ensure that there are local plans in place to progress band 5 job evaluation process at pace (Nursing Job Evaluation process was an existing requirement).
- To ensure that there is Board-level oversight and engagement with staff side partners.
- For all NHS band 5 nurses to have an assessment of the duties they are being asked to undertake and whether these are consistent with the job description.

In response to the job evaluation process, significant progress has already been made with;

- Review of all Band 5 and 6 job descriptions across the organisation - this will result in a reduction in the number of the differing job descriptions and ensuring that they are aligned to the new national profiles.
- The band 5 new Job descriptions are currently going through the agenda for change job matching process/consistency checking.
- Once the above is completed (expected to be completed for band 5s by end of March 2026); the review of band 5 current duties at service level will be undertaken against these job descriptions to enable conversation where there is not current alignment.
- The job descriptions that have been through this process will be the only ones able to be used across the organisation to ensure that there is no scope creep or roles into job description that does not align with the national profiles.

This process will be replicated for clinical nursing job descriptions and roles at bands 6-8a. Completion of this will be during 2026/27.

In relation to the commitment from NHS England to launch a national preceptorship, it is worth noting that our Multi-disciplinary Preceptorship programme has achieved NHS England the quality kite mark in August 2025.

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

5. National Place Scores 2025

The Patient-Led Assessments of the Care Environment (PLACE) are an annual assessment of the non-clinical aspects of the patient environment, how it supports patients' privacy and dignity, and its suitability for patients with specific needs e.g. disability or dementia. The PLACE assessment tool provides a framework for assessing quality against common guidelines and standards. The environment is assessed using question forms that depend on the services provided by the facility.

The Trust has exceeded the national average and regional average in all 6 domains once again this year. Below is a summary of the Trusts PLACE scores for 2025.

BHFT versus National Averages

Category	BHFT	National Average	Difference
Cleanliness	99.95%	98.55%	+1.40%
Food	94.69%	92.13%	+2.56%
Privacy, Dignity & Wellbeing	97.92%	89.37%	+8.55%
Condition, Appearance & Maintenance	99.40%	97%	+2.40%
Dementia	96.60%	85.68%	+10.92%

Category	BHFT	National Average	Difference
Disability	95.58%	87.12%	+8.46%

Across all sites, the scores increased in nearly every category

Site Name	Cleanliness	Food	Privacy, Dignity & Wellbeing	Condition, Appearance & Maintenance	Dementia	Disability
PROSPECT PARK HOSPITAL	100.00%	93.61%	98.92%	99.68%	97.69%	96.43%
WOKINGHAM HOSPITAL	100.00%	96.70%	97.89%	99.22%	97.48%	97.20%
ST MARKS HOSPITAL	99.88%	96.28%	95.59%	99.24%	93.27%	92.00%
UPTON HOSPITAL	100.00%	98.40%	98.81%	99.12%	95.80%	96.03%
WEST BERKSHIRE COMMUNITY HOSPITAL	99.77%	94.33%	95.56%	98.79%	94.20%	93.04%

Estates and Facility Management teams will review the results and will be putting actions plans in place in preparation for 2026.

Executive Lead: Paul Gray, Chief Financial Officer

Presented by: Julian Emms
Chief Executive
10 March 2026

Appendix 1

Modern Day Slavery Statement

This statement is made pursuant to Section 54 of the Modern Slavery Act 2015 and sets out the steps that Berkshire Healthcare NHS Foundation Trust has taken, and is continuing to take, to make sure that modern slavery or human trafficking is not taking place within our business or supply chain during the year ending 31 March 2026.

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

Our Policies on Slavery and Human Trafficking

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

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

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

- **Recruitment** - We operate a robust recruitment policy, including conducting eligibility to work in the United Kingdom checks for all directly employed staff. Agencies on approved frameworks are audited to provide assurance that pre-employment clearance has been obtained for agency staff, to safeguard against human trafficking or individuals being forced to work against their will.
- **Fair and Equitable Employment Terms** - We have a range of controls to protect staff from poor treatment and/or exploitation, which complies with all respective laws and regulations. These include the provision of fair pay rates, fair terms and conditions of employment, and fair access to training and development opportunities.
- **Safeguarding** - We adhere to the principles inherent within both our safeguarding children

and adults' policies. These are compliant with the Berkshire multiagency agreements and provide clear guidance so that our employees are clear on how to raise safeguarding concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain.

- **Whistleblowing** - We operate a whistleblowing/raising concerns policy so that everyone in our employment knows that they can raise concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain, without fear of reprisals, and the various ways in which they can raise their concerns.
- **Standards of business conduct** - This code explains the manner in which we behave as an organisation and how we expect our employees and suppliers to act.

Our approach to procurement and our supply chain includes:

- Ensuring that our suppliers are carefully selected through our robust supplier selection criteria/processes.
- Requiring that the main contractor provides details of its sub-contractor(s) to enable the Trust to check their credentials.
- Ensuring invitations to tender documents contain a clause on human rights issues.
- Ensuring invitation to tender documents also contains clauses giving the Trust the right to terminate a contract for failure to comply with labour laws.
- Using the standard Supplier Selection Questionnaire (which includes a section on Modern Day Slavery), Trust staff must contact and work with the Procurement department when looking to work with new suppliers so appropriate checks can be undertaken.
- Supplier adherence to our values. We are zero tolerant to slavery and human trafficking and thereby expect all our direct and indirect suppliers/contractors to follow suit.
- Where it is verified that a subcontractor has breached the child labour laws or human trafficking, then this subcontractor will be excluded in accordance with Regulation 57 of the Public Contracts Regulations 2015. The Trust will require that the main contractor substitute a new subcontractor.
- We will be implementing the requirements of the National Health Service (Procurement, Slavery and Human Trafficking) Regulations 2025 from 17th May 2026 when the Act comes into force. This will include the assessing the risk of modern-day slavery and human trafficking in the Trust's supply chain.

Training

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

Our Performance Indicators

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

Trust Board Paper Meeting Paper

Board Meeting Date	10 March 2026
Title	Finance Report January 2026
	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 November 2025.
Business Area	Finance
Author	Chief Finance Officer
Relevant Strategic Objectives	<p>Efficient use of resources</p> <p>Ambition: We will use our resources efficiently and focus investment to increase long term value</p> <p>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.</p>

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Finance Report

Financial Year 2025/26

January 2026

Purpose

To provide the Board and Executive with a summary of the Trust's financial performance for the period ending 31 January 2026.

Document Control

<i>Version</i>	<i>Date</i>	<i>Author</i>	<i>Comments</i>
1.0	09/02/2026	Rebecca Clegg	Draft
2.0	11/02/2026	Paul Gray	Final

Distribution

All Directors.

All staff as appropriate.

Confidentiality

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

Dashboard & Summary Narrative

Target	Year to Date			Forecast Outturn			
	Actual £m/%	Plan £m/%	Achieved	Actual £m/%	Plan £m/%	Achieved	
1	Income and Expenditure Plan	1.7	1.7	Yes	1.7	1.7	Yes
2	CIP - Delivery	14.6	14.6	Yes	17.5	17.5	Yes
3	Cash Balance	52.3	46.6	Yes	45.2	45.2	Yes
4a	Better Payment Practice Code Volume Non-NHS	97%	95%	Yes	95%	95%	Yes
4b	Better Payment Practice Code Value Non-NHS	97%	95%	Yes	95%	95%	Yes
4c	Better Payment Practice Code Volume NHS	98%	95%	Yes	95%	95%	Yes
4d	Better Payment Practice Code Value NHS	99%	95%	Yes	95%	95%	Yes
5	Capital Expenditure not exceeding CDEL	13.0	18.5	Yes	20.8	20.8	Yes
6a	Agency Expenditure Reduction	30%	30%	Yes	30%	30%	Yes
6b	Bank Expenditure Reduction	17%	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 all targets 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. There are some outstanding payments from commissioners which we continue to pursue. Cash expenditure on capital projects is lower than planned due to profiling.
- The Better Payment Practice Code requirements are met for all 4 targets.
- Capital expenditure is below the expenditure limit (CDEL) Year to Date primarily due to the profile of expenditure on the Jubilee Ward relocation project and the creation of Right of Use Assets for NHS Property Services leases.
- The Trust has 2 targets for temporary staffing. There is a requirement to reduce agency expenditure by 30% when compared to the previous year. The target is now being achieved. The bank staffing cost reduction of 10% compared to the previous year is being exceeded by 7% (£1.2m) year to date.

System Position

- BOB ICS submitted a combined break even plan. This included £44m of deficit support and £24m system risk share of which BHFT agreed to a £1.8m share linked to opportunities within the ICB's own MHLDA budgets. Only £140k of savings have been identified in year and therefore there has been a clawback of £1.66m income by the ICB.

1. Income & Expenditure

Jan-26	In Month			YTD			2025/26
	Act £'m	Plan £'m	Var £'m	Act £'m	Plan £'m	Var £'m	Plan £'m
Operating Income	34.1	32.8	1.2	336.3	328.3	8.1	393.9
Elective Recovery Fund	0.4	0.4	0.0	4.0	4.0	0.0	4.8
Donated Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Income	34.5	33.2	1.2	340.4	332.3	8.1	398.7
Staff In Post	23.9	24.4	0.5	238.8	243.4	4.7	292.2
Bank Spend	1.7	1.5	(0.1)	15.1	15.4	0.3	18.5
Agency Spend	0.5	0.4	(0.1)	4.7	3.5	(1.2)	4.2
Total Pay	26.0	26.3	0.3	258.6	262.3	3.8	314.9
Purchase of Healthcare	2.2	1.3	(0.9)	17.5	12.9	(4.7)	15.4
Drugs	0.5	0.6	0.1	5.8	5.6	(0.2)	6.7
Premises	1.8	1.6	(0.2)	18.4	15.7	(2.7)	18.9
Other Non Pay	1.7	1.6	(0.1)	17.9	16.1	(1.8)	19.3
PFI Lease	0.7	0.7	(0.0)	7.3	7.3	(0.0)	8.8
Total Non Pay	7.0	5.8	(1.2)	67.0	57.6	(9.4)	69.1
Total Operating Costs	32.9	32.1	(0.9)	325.6	319.9	(5.7)	384.0
EBITDA	1.5	1.2	(0.4)	14.8	12.4	(2.4)	14.7
Interest Receivable	0.2	0.3	(0.1)	2.4	2.8	(0.4)	3.4
Interest Payable	0.3	0.3	(0.0)	2.9	2.8	(0.1)	3.3
Depreciation	1.2	1.0	(0.2)	10.5	9.2	(1.3)	11.2
Impairments	0.0	0.0	0.0	0.3	0.0	(0.3)	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	1.6	1.3	(0.3)	15.2	13.6	(1.5)	16.2
Reported Surplus/(Deficit)	0.2	0.2	0.0	2.0	1.6	0.4	1.9
Adjustments	0.0	0.0	0.0	0.0	0.0	0.0	(0.2)
PFI IFRS16 Adjustment	(0.2)	(0.2)	(0.0)	(0.4)	0.1	(0.4)	0.0
Adjusted Surplus/(Deficit)	(0.0)	(0.0)	(0.0)	1.7	1.7	0.0	1.7

Key Messages

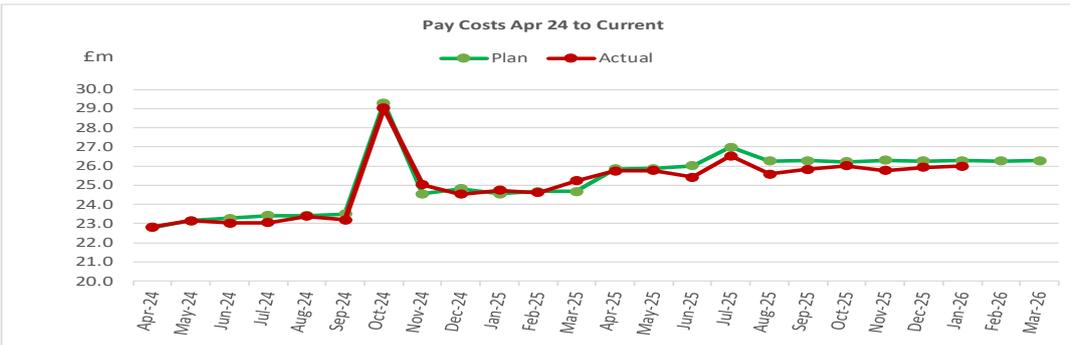
The table above gives the financial performance against the Trust's income and expenditure plan as at 31 January 2026.

The Trust has planned for a £1.7m surplus. Year to date performance is in line with plan.

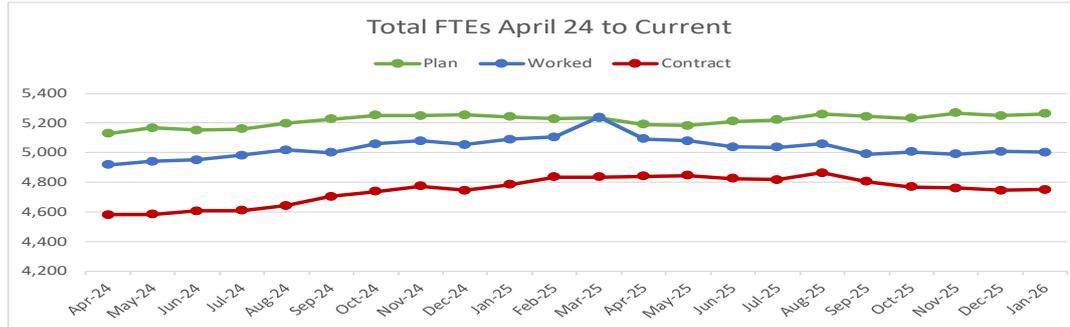
The variance on purchase of healthcare includes overspends on PICU, acute OAPs and specialist placements.

In December funding was transferred from Frimley ICB and BOB ICB to the Trust as part of the removal of the historic Business Transfer Agreement where the use of the NHS Property Services estate was subsidised. This will result in a £4.7m variance on income offset with variances on premises and depreciation for the year.

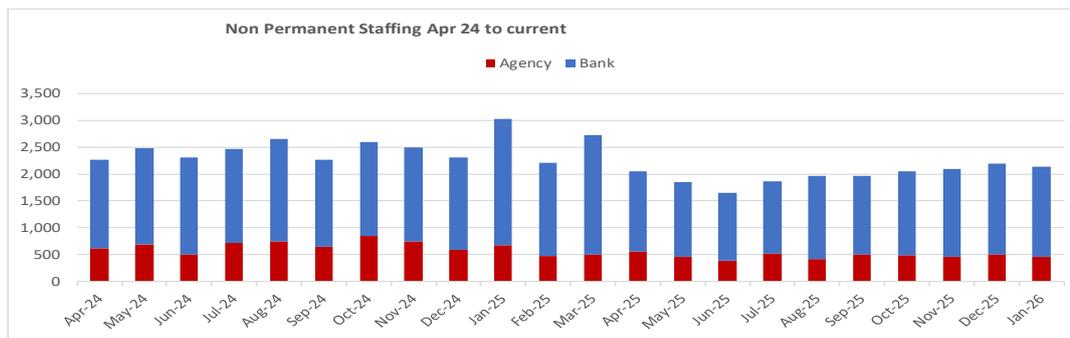
Workforce



Staff Costs	
YTD	£m
2025/26	258.6
2024/25	241.9
▲	7%
Prior Yr	£m
Jan-26	26.0
Jan-25	24.7
▲	5%



FTEs		
Prior Mth	CFTE	WFTE
Jan-26	4,750	5,002
Dec-25	4,745	5,008
	0%	0%
	▲	▼
Prior Yr		
Jan-26	4,750	5,002
Jan-25	4,784	5,091
	-1%	-2%
	▼	▼



Non Permanent Staff Costs		
YTD	Bank	Agency
	£k	£k
2025/26	15,077	4,737
2024/25	18,091	6,803
	-17%	-30%
	▼	▼
Prior Yr	£k	£k
Jan-26	1,681	461
Jan-25	2,360	672
	-29%	-31%
	▼	▼

Key Messages

Pay costs in month were £26m and year to date the Trust's pay expenditure is lower than planned.

As the pay award has been agreed at a higher level than was assumed for planning, this created a further cost pressure for the Trust c£0.3m.

In month, Worked WTEs decreased by 6 and Contracted WTEs increased by 5.

NHSE has 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 is now being achieved year to date for agency. The bank staffing cost reduction of 10% compared to the previous year is being exceeded and is at 17% year to date.

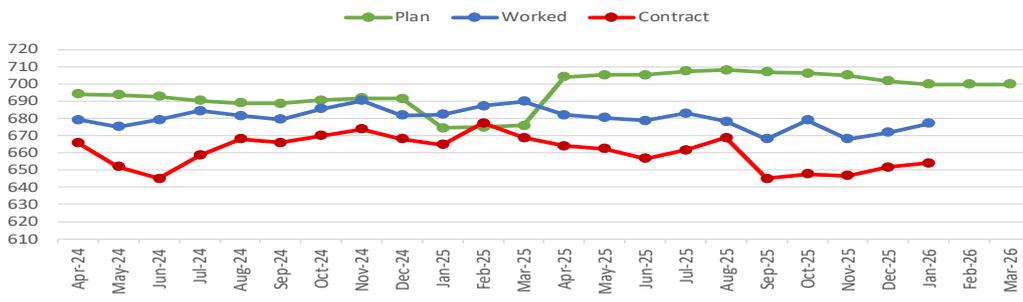
Our bank fill rate remains strong, with monthly performance increasing from 91% to 96% of the overall temporary staffing demand.

Off framework use is now restricted to nurseries only with recruitment to the bank continuing to expand, supporting our strategy to eliminate off-framework reliance and comply with the NHSE mandate for zero Band 2/3 agency usage by the end of this month, where possible.

There were zero non-medical price cap breaches in month, which is now firmly established as our standard position

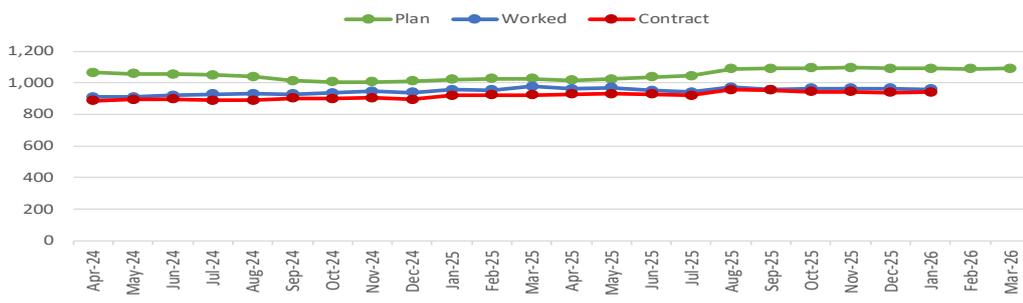
Staff Detail (Division)

Central Services FTEs April 24 to Current



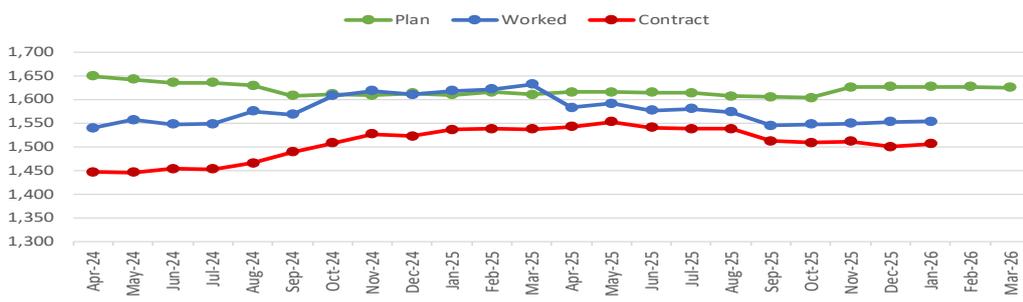
FTEs		
Prior Mth	CFTE	WFTE
Jan-26	654	677
Dec-25	652	672
	0%	1%
	▲	▲
Prior Yr	CFTE	WFTE
Jan-26	654	677
Jan-25	665	682
	-2%	-1%
	▼	▼

Children Family & All Age FTEs April 24 to Current



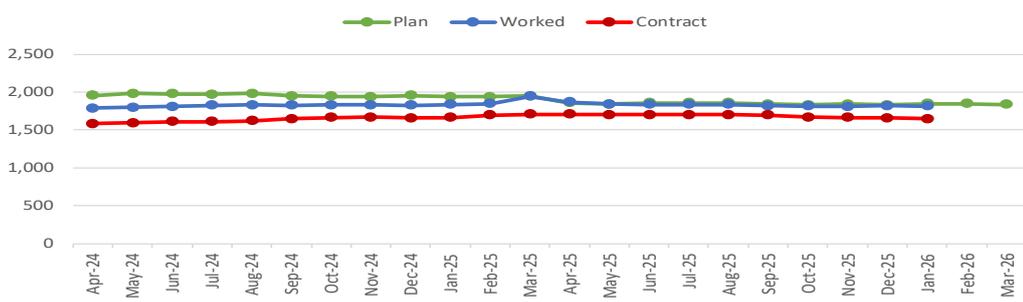
FTEs		
Prior Mth	CFTE	WFTE
Jan-26	941	959
Dec-25	938	964
	0%	-1%
	▲	▼
Prior Yr	CFTE	WFTE
Jan-26	941	959
Jan-25	920	955
	2%	0%
	▲	▲

Community Health FTEs April 24 to Current



FTEs		
Prior Mth	CFTE	WFTE
Jan-26	1,506	1,553
Dec-25	1,500	1,552
	0%	0%
	▲	▲
Prior Yr	CFTE	WFTE
Jan-26	1,506	1,553
Jan-25	1,536	1,618
	-2%	-4%
	▼	▼

Mental Health FTEs April 24 to Current



FTEs		
Prior Mth	CFTE	WFTE
Jan-26	1,649	1,813
Dec-25	1,656	1,820
	0%	0%
	▼	▼
Prior Yr	CFTE	WFTE
Jan-26	1,649	1,813
Jan-25	1,665	1,836
	-1%	-1%
	▼	▼

Key Messages

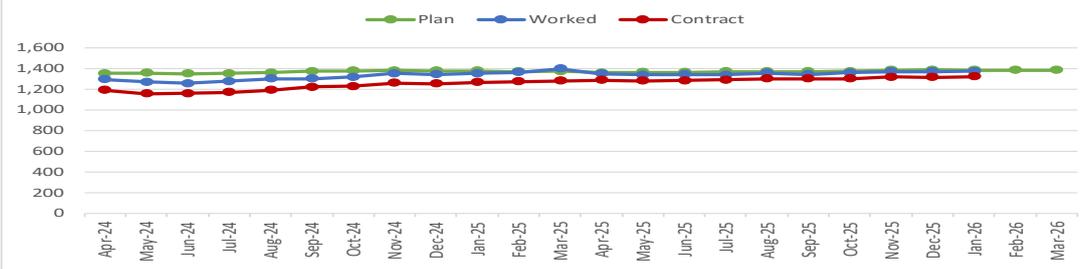
Worked WTEs are below plan for all clinical divisions and Central Services.

We have had some reductions due to MARS across all divisions.

Overall, worked WTEs are 259 lower than plan in January.

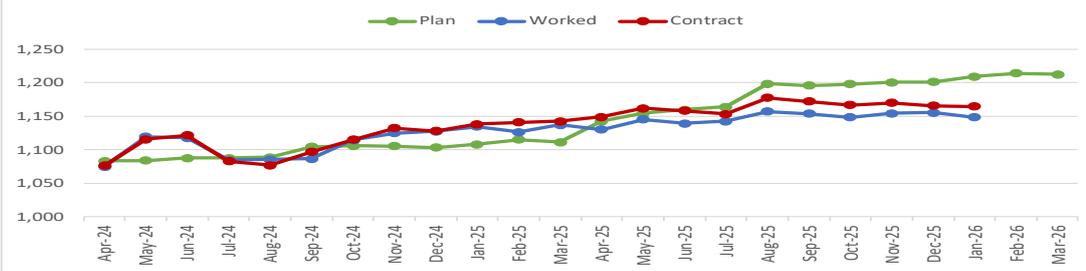
Staff Detail (Staff Group)

Registered Nursing FTEs April 24 to Current



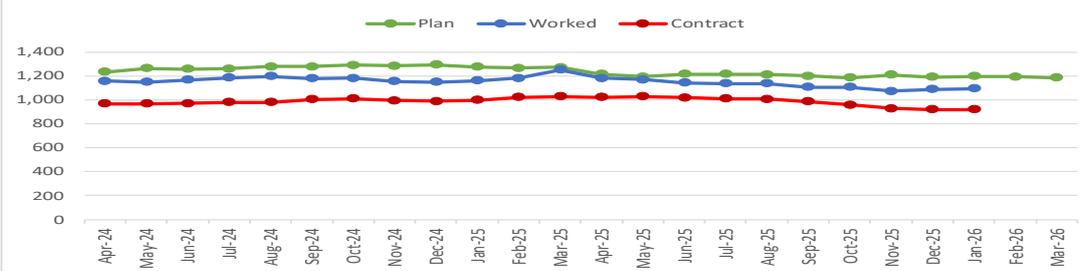
FTEs		
Prior Mth	CFTE	WFTE
Jan-26	1,319	1,371
Dec-25	1,312	1,366
	1%	0%
	▲	▲
Prior Yr		
Jan-26	1,319	1,371
Jan-25	1,263	1,350
	5%	2%
	▲	▲

Other Qualified Non Medical FTEs April 24 to Current



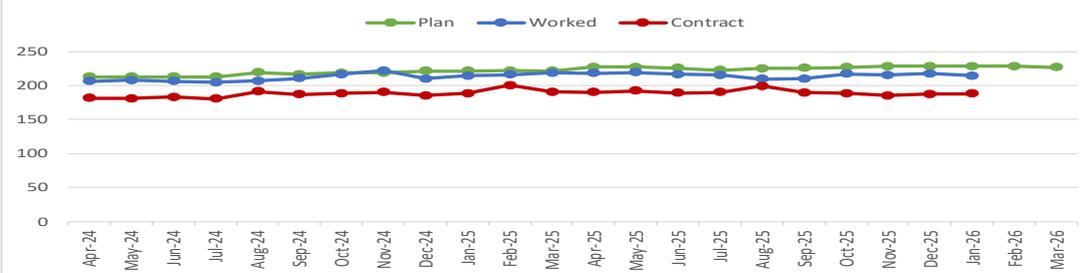
FTEs		
Prior Mth	CFTE	WFTE
Jan-26	1,165	1,148
Dec-25	1,165	1,156
	0%	-1%
	▼	▼
Prior Yr		
Jan-26	1,165	1,148
Jan-25	1,138	1,134
	2%	1%
	▲	▲

Support to clinical staff FTEs April 24 to Current



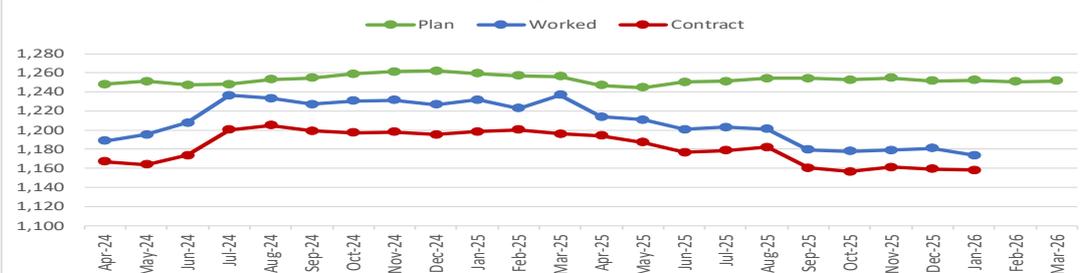
FTEs		
Prior Mth	CFTE	WFTE
Jan-26	920	1,095
Dec-25	920	1,089
	0%	1%
	▼	▲
Prior Yr		
Jan-26	920	1,095
Jan-25	997	1,160
	-8%	-6%
	▼	▼

Medical Staff FTEs April 24 to Current



FTEs		
Prior Mth	CFTE	WFTE
Jan-26	188	214
Dec-25	187	217
	0%	-2%
	▲	▼
Prior Yr		
Jan-26	188	214
Jan-25	189	214
	0%	0%
	▼	▼

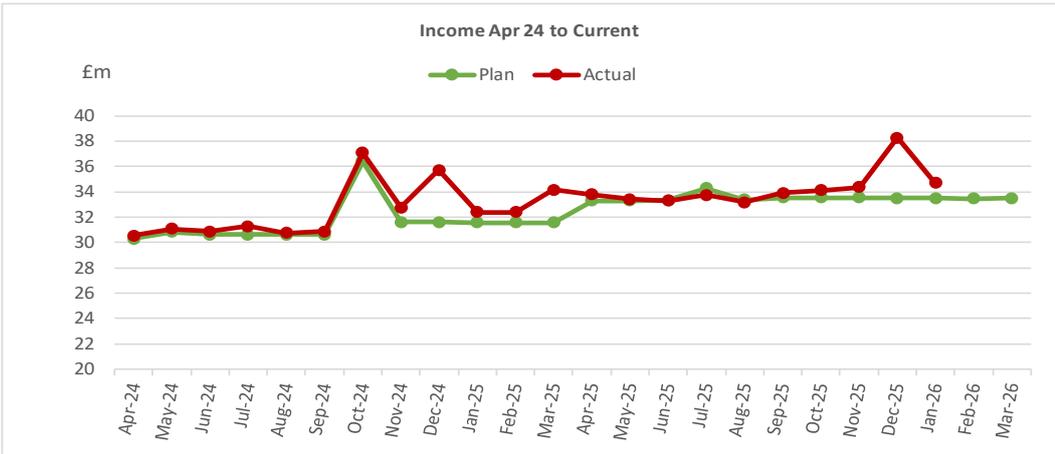
Admin, Estates and Managers FTEs April 24 to Current



FTEs		
Prior Mth	CFTE	WFTE
Jan-26	1,158	1,174
Dec-25	1,159	1,181
	0%	-1%
	▼	▼
Prior Yr		
Jan-26	1,158	1,174
Jan-25	1,198	1,232
	-3%	-5%
	▼	▼

Worked WTE actuals have been much closer to plan since the 2022/23 financial reset. The downward trend in Admin, Estates and Managers appears to have flattened in the last few months. 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	342.8
2024/25	323.3
▲	6%
Prior Yr	£'m
Jan-26	34.7
Jan-25	32.4
▲	7%

Key Messages

Income (including interest receivable) is 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 income by BOB ICB related to the MHLDA cost improvement risk share. Interest received is below plan with interest rates being lower than in 2024/25. The Trust has also received income for new services e.g. MHIST and for settlement of invoices from NHS Property Services which we recognised, along with the related expenditure in month 9.

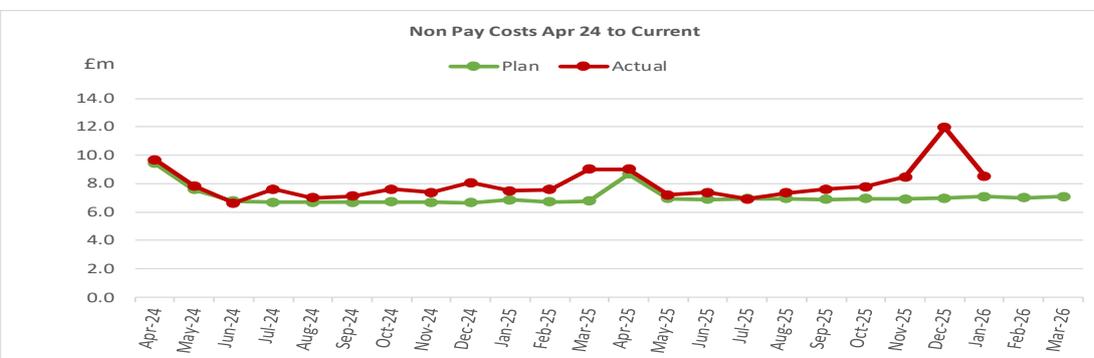
Elective Activity Performance

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.

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

The “true-up” exercise for 2024/25 has now been completed and we have received final payments from both ICBs.

Non Pay

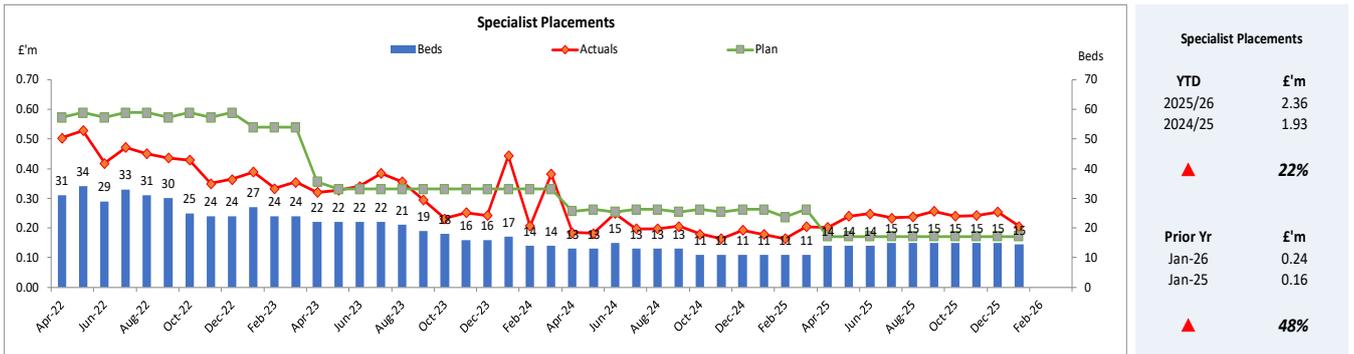
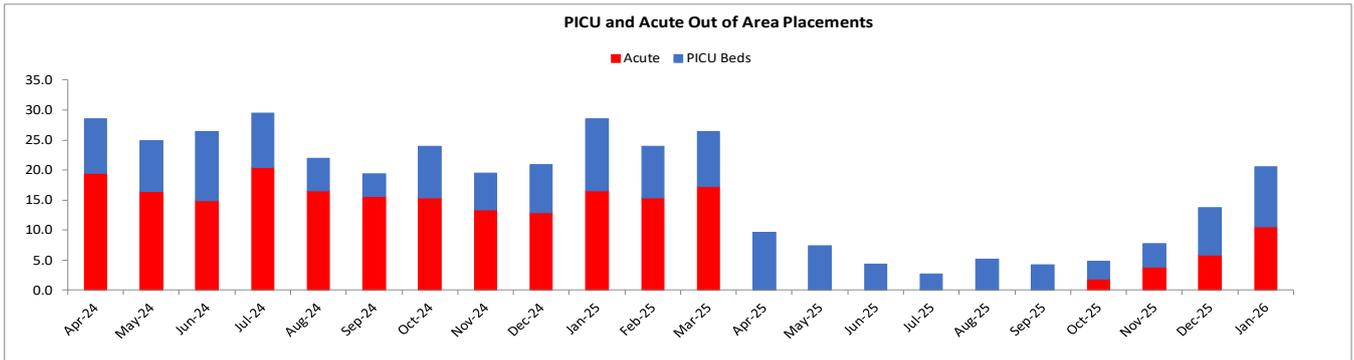


Non Pay Costs	
YTD	£'m
2025/26	82.2
2024/25	76.4
▲	8%
Prior Yr	£'m
Jan-26	8.5
Jan-25	7.5
▲	14%

Key Messages:

As in previous years, the overspend against plan is driven by PICU and specialist placements. We have also recognised additional expenditure for our use of NHS Property Services Estates but this is offset by income received from both ICBs.

Placement Costs



Key Messages

Following the opening of our outsourced ward, we were expecting to have no or minimal Out of Area Placements (OAPs). However, the average number of placements increased from 6 in December to 11 in January, with a year to date overspend of £686k.

We have planned for 5 Psychiatric Intensive Care Unit (PICU) placements in 2025/26. Placement numbers increased from 8 in December to 10 in January resulting in a £1096k overspend year to date.

The total overspend on placements year to date is £1,782k.

There remains a long-standing issue whereby any female requiring a PICU bed must be admitted to an Out of Area Placement (OAP), as there are no local beds available for this group. The demand for PICU beds has also been affected by an increased number of requests for prison transfers for assessment or treatment under the Mental Health Act (MHA).

Throughout the year, there has been a steady increase in lost bed days for patients who are clinically ready for discharge. The delays are partly attributed to a shortage of suitable high-need supported living provision and appropriate nursing home placements for patients with advanced dementia. Further complications arise from delays in funding approval processes within the Integrated Care Boards and Local Authorities, with the Royal Borough of Windsor and Maidenhead and Reading being the primary contributors to these delays. Actions include weekly escalation meetings with counterparts in the LAs and ICBs to improve patient flow and using the process for escalated OAP approvals. This process involves discussions regarding additional escalation for Clinically Ready for Discharge (CRFD) patients, the use of health-funded step-down beds, and the provision of temporary accommodation supported by Crisis Resolution Home Treatment Team (CRHTT).

A Multi Agency Discharge Event (MADE) was held on 2nd February with attendance from Adult Social Care and ICBs. This achieved 16 discharges against the 21 planned. During the week there were 2 OAP PICU discharges, however there has been no decrease in numbers as we needed to transfer 2 patients into OAP PICU beds. The acute OAPs reduced for 10 to 6 and 2 further discharges planned for w/c 9th February. Plans have progressed for discharge during February for 4 patients with the Longest LOS.

Specialist Placements. The average number of placements continues to be 15 and this is above the plan of 11. This has created a cost pressure of £640k year to date. We have now received notification that a preferred provider has achieved the required CQC registration for a specialist nursing home and we have plans for 5 patients to transfer to this provision under S117 before the end of March 2026.

Cost Improvement Programme

Description	Description	Risk	Plan	YTD Actual	YTD Plan	Variance
			£k	£k	£k	£K
Divisional CIPS	Recurrent	Low	5,256	4,380	4,380	0
Balance Sheet Review	Non-Recurrent	Low	3,065	5,329	2,554	2,774
Interest	Recurrent	Low	500	417	417	0
UEC Expenditure	Recurrent	Low	456	380	380	0
Procurement savings	Recurrent	Medium	150	125	125	0
Tax Optimisation	Recurrent	Medium	420	0	350	-350
Contract Contribution	Recurrent	Low	1,850	82	1,542	-1,460
Contract Contribution	Non Recurrent		0	1,460	0	1,460
Annual leave Accrual	Non-Recurrent	Low	250	0	208	-208
Non - recurrent cover for posts	Non-Recurrent	Low	451	376	376	0
Recharge to income	Recurrent	Low	63	53	53	0
Legal Services review	Recurrent	Medium	150	14	125	-111
Expenses Controls	Recurrent	Low	50	42	42	0
Estates Downsizing	Recurrent	Low	130	108	108	0
Discretionary spend controls	Recurrent	Medium	250	0	208	-208
Temporary staffing reduction stretch	Recurrent	Medium	1,500	0	1,250	-1,250
Corporate efficiency stretch	Recurrent	High	1,500	702	1,250	-548
Further workforce controls	Non-Recurrent	High	1,360	1,086	1,133	-47
Other	Recurrent	High	62	0	52	-52
Other - Slippage	Non-Recurrent	Low	0	0	0	0
		Total	17,463	14,553	14,553	0

Key Messages

The Trust's 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 the claw back of income from BOB ICB as a result of the MHLDA risk share not delivering any savings. We have also paid the majority of MARS payments with savings being realised over the year ahead.

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.

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.

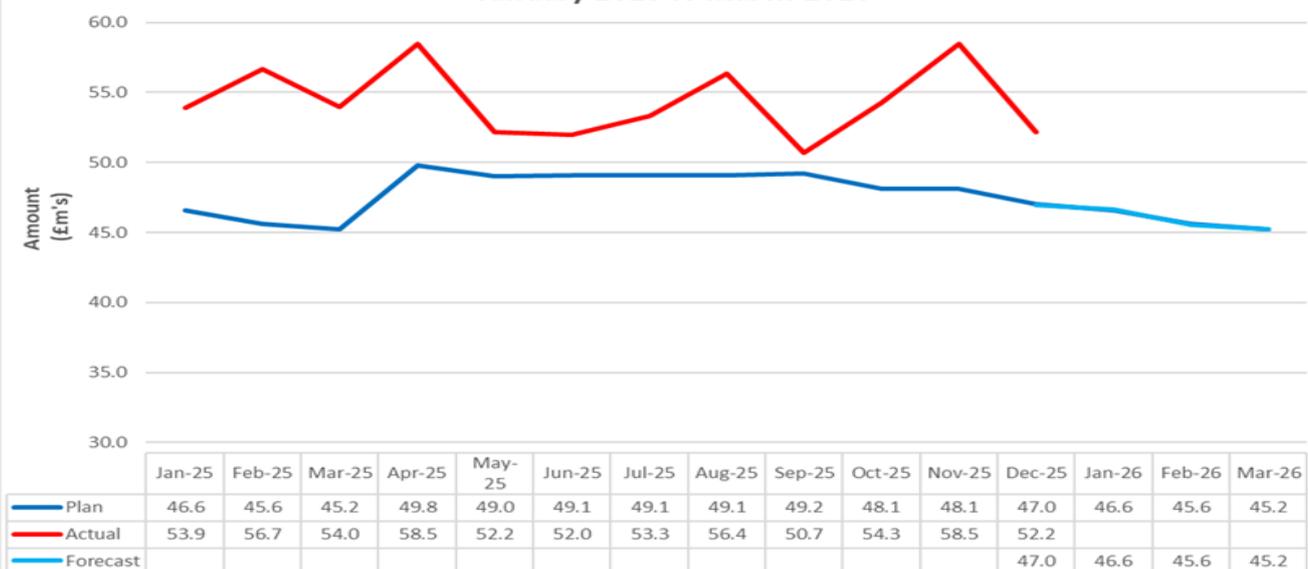
Balance Sheet & Cash

	2024/25	Current Month			YTD		
	Actual £'m	Act £'m	Plan £'m	Var £'m	Act £'m	Plan £'m	Var £'m
Intangibles	0.9	1.5	1.8	(0.3)	1.5	1.8	(0.3)
Property, Plant & Equipment (non PFI)	38.2	38.2	39.5	(1.3)	38.2	39.5	(1.3)
Property, Plant & Equipment (PFI)	44.5	42.0	48.1	(6.1)	42.0	48.1	(6.1)
Property, Plant & Equipment (RoU Asset)	12.8	12.0	19.1	(7.1)	12.0	19.1	(7.1)
Receivables	0.2	0.2	0.2	0.0	0.2	0.2	0.0
Total Non Current Assets	96.6	93.9	108.7	(14.8)	93.9	108.7	(14.8)
Trade Receivables & Accruals	14.2	16.7	12.0	4.7	16.7	12.0	4.7
Other Receivables	0.3	0.4	0.3	0.1	0.4	0.3	0.1
Cash	54.0	52.2	47.0	5.2	52.2	47.0	5.2
Trade Payables & Accruals	(40.9)	(38.9)	(36.4)	(2.5)	(38.9)	(36.4)	(2.5)
Borrowings (PFI and RoU Lease Liability)	(4.4)	(0.4)	(7.0)	6.6	(0.4)	(7.0)	6.6
Other Current Payables	(12.0)	(13.2)	(9.7)	(3.5)	(13.2)	(9.7)	(3.5)
Total Net Current Assets / (Liabilities)	11.2	16.8	6.2	10.6	16.8	6.2	10.6
Non Current Borrowings (PFI and RoU Lease Liability)	(52.2)	(53.6)	(54.8)	1.2	(53.6)	(54.8)	1.2
Other Non Current Payables	(1.6)	(2.7)	(2.4)	(0.3)	(2.7)	(2.4)	(0.3)
Total Net Assets	54.0	54.4	57.7	(3.3)	54.4	57.7	(3.3)
Income & Expenditure Reserve	10.2	11.9	11.9	0.0	11.9	11.9	0.0
Public Dividend Capital Reserve	21.8	21.8	23.7	(1.9)	21.8	23.7	(1.9)
Revaluation Reserve	22.0	20.7	22.0	(1.3)	20.7	22.0	(1.3)
Total Taxpayers Equity	54.0	54.4	57.7	(3.3)	54.4	57.7	(3.3)

Key Messages

Cash is £5.2m higher than plan, the plan being for a reduced balance over the second half of the year. The underspend against the capital plan, due to phasing of large projects is contributing to the higher cash balance.

Cash Plan v Actual v Forecast
January 2025 to March 2026



Capital Expenditure

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
<u>Estates Maintenance & Replacement Expenditure</u>									
Trust Owned Properties	40	17	23	66	117	(51)	150	113	(37)
Jubilee Ward Relocation to St Marks - CIR Funding	97	217	(120)	454	2,166	(1,712)	2,600	2,000	(600)
Trust Wide Anti-Ligature - CIR Funding	193	0	193	280	0	280	0	600	600
West/Reading Consolidation - Bath Road Phase 1&4	28	0	28	402	500	(98)	498	1,277	779
Charles Ward Decant Works - (Jubilee Ward Enabling Works)	(0)	0	(0)	264	0	264	0	264	264
Leased Non Commercial (NHSPS) Other	2	17	(15)	50	367	(317)	400	69	(331)
Leased Commercial	1	0	1	18	36	(18)	36	18	(18)
Environment & Sustainability	21	20	1	94	158	(64)	198	126	(72)
Backlog Maintenance	16	0	16	76	0	76	500	335	(165)
Various All Sites	0	108	(108)	116	963	(847)	680	111	(569)
Statutory Compliance	2	18	(16)	312	163	149	200	350	150
Subtotal Estates Maintenance & Replacement	400	397	3	2,132	4,470	(2,338)	5,262	5,262	0
<u>IM&T Expenditure</u>									
Business Intelligence and Reporting	12	37	(25)	60	37	23	110	110	0
Hardware Purchases - Refresh & Replacement	48	320	(272)	2,816	3,497	(681)	4,136	4,136	0
Teams Rooms Refresh ONLY	0	8	(8)	10	32	(22)	50	50	0
Additional Divisional Spend	0	42	(42)	215	420	(205)	504	504	0
Digital Strategy	56	50	6	391	500	(109)	600	600	0
Pharmacy System Procurement & Population Health	0	50	(50)	0	50	(50)	150	150	0
Subtotal IM&T Expenditure	116	507	(391)	3,493	4,536	(1,043)	5,550	5,550	0
<u>IFRS16 RoU ASSETS - New Leases Net of Disposals and Remeasurements</u>									
St. Marks Charles Ward Block 23	3,050	0	3,050	3,050	1,495	1,555	1,495	3,050	1,555
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	1,831	0	1,831	1,831	6,654	(4,823)	6,654	1,831	(4,823)
Bracknell Healthspace	0	0	0	0	0	0	500	364	(136)
Nicholson House	0	0	0	432	350	82	350	432	82
NHSPS Sites Modifications	425	0	425	2,005	0	2,005	0	3,059	3,059
Lease cars	0	0	0	54	0	54	0	264	264
ColIN	0	0	0	0	150	(150)	200	200	0
Sub Total New Leases (IFRS16)	5,306	0	5,306	7,371	9,451	(2,080)	10,001	10,001	0
Subtotal CapEx Within Control Total	5,821	904	4,917	12,996	18,457	(5,461)	20,814	20,814	(0)
<u>CapEx Expenditure Outside of Control Total</u>									
Place of Safety	0	0	0	959	600	359	600	959	359
Anti-Ligature Toilet Pans & Basins	0	0	0	26	150	(124)	150	248	98
Trust wide Anti-Ligature (PFI)	0	50	(50)	0	400	(400)	500	208	(292)
Other PFI projects	89	73	16	274	583	(310)	730	565	(165)
Subtotal Capex Outside of Control Totals	90	123	(33)	1,259	1,733	(474)	1,980	1,980	0
<u>Central/Donated/Grant Funding</u>									
WBCH Decarbonisation - LED (PDC)	0	0	0	0	0	0	0	184	184
WBCH Decarbonisation - Submetering (ICB - Revenue Grant)	0	0	0	0	0	0	0	61	61
EV Chargepoint (CCH, WBCH, Wokingham, UoR) - PDC	0	0	0	0	0	0	0	65	65
St Marks Block 23 M&E (Air Handling Unit and Electrical Works)	3	0	3	6	0	6	0	600	600
Subtotal Central/Donated/Grant Funding	3	0	3	6	0	6	0	910	910
Total Capital Expenditure - all funding sources	5,914	1,027	4,887	14,262	20,190	(5,928)	22,794	23,704	910

Key Messages

At M10, CDEL schemes were underspent by £5.5m 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 and Backlog Maintenance Programme offset in part by expenditure on the Nicholson House alterations project. IMT is also underspent due to phasing of the Refresh & Replacement Programme, however more orders are due to be raised, which will bring the spend in line with the plan.

Non-CDEL projects for the PFI sites was underspent by £0.4m 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 £2.1m for the year to date. This is mainly due to combined spend on Bath Rd and St Marks leases being lower than planned offset by other NHSPS sites modifications following the move away from BTA leases. The remaining underspend is due to the ongoing delay in lease commencement for Chalvey and Bracknell Health Space Project.

Trust Board Paper Meeting Paper

Board Meeting Date	10 th March 2026
Title	True North Performance Scorecard Month 10 (January 2026) 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	<p>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.</p> <p>Patient safety</p> <p>Ambition: We will reduce waiting times and harm risk for our patients</p> <p>Patient experience and voice</p> <p>Ambition: We will leverage our patient experience and voice to inform improvement</p> <p>Health inequalities</p>

	<p>Ambition: We will reduce health inequalities for our most vulnerable patients and communities</p> <p>Workforce</p> <p>Ambition: We will make the Trust a great place to work for everyone</p> <p>Efficient use of resources</p> <p>Ambition: We will use our resources efficiently and focus investment to increase long term value</p>
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True North Performance Scorecard Highlight Report – January 2026

The True North Performance Scorecard for Month 10 2025/26 (January 2026) 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.

Breakthrough Objectives

- Restrictive Interventions – Rapid Tranquilisation (Intra-muscular) (**Harm Free Care**) – 44 against a target of 39 incidents.
 - A total of 13 patients has contributed to this month’s total. Four patients accounted for 25 incidents with repeated self-harm. Other factors requiring restrictive intervention includes refusing oral medication, physical assault and property damage. Review of countermeasures by ward continues. A workshop is planned for February to focus on Cluster 8 (Personality Disorder) pathway patients, as they have been identified as a challenging cohort.
- Physical Health: Community Inpatient Average Length of Stay (bed days) (**Good Patient Experience**) – 24.35 days against a target of 21 days.
 - Reviewing cases where length of stay is over 50 days (nine patients) who are awaiting social care support. Other themes for delay include patient’s needing night support, medication and additional transport crew to access the property. We compared favourably to the national benchmark average of 27.8 days for 2024/25. The team are reviewing pinch points in flow and variations in the discharge process across wards.
- Physical Assaults on Staff (**Supporting our Staff**) – 39 incidents against a target of 36.
 - There are 20 patients that contributed to the total this month. Top contributing ward was Sorrel with nine incidents. Based on a mean average Campion unit remain top contributor over the last six months followed by Snowdrop and Rose ward. Improvements have been made on adequate representation at countermeasure review meetings on wards and a skills focus on interpersonal communications for Sorrel staff.

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

- Mental Health: Adult Average Length of Stay (bed days) (**Good Patient Experience**) – 41.56 days against a target of 42 days.
 - Impact of OPEL 4 status (Operational Pressures Escalation Level 4) had an impact on shorter lengths of stay. This is the highest level of escalation in the NHS system for managing operational pressures.
 - Countermeasures remain with focus on streamlined patient multi-disciplinary team (MDT) meetings focusing on length of stay and actions to support timely discharge.
- Mental Health: Older Adult Average Length of Stay (bed days) (**Good Patient Experience**) – 75.5 days against a target of 80 days.

- Similar issues to adult mental health wards. OPEL 4 also applied to these wards. Specific challenges on Rowan ward with delays due to sourcing appropriate funding for placements.

Driver Metrics

The following metrics are Red and not performing to plan.

- I Want Great Care Positive Patient Experience Score (**Good Patient Experience**) – at 94.69% against a 95% target. Metric will be reported one month in arrears to allow for manual records to be uploaded.
- Inappropriate Out of Area Placements (OAPs) at the end of the month (Mental Health) – (**Good Patient Experience**) – at 8 against a quarter 4 target of 1 patient.

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

- I Want Great Care Patient Experience Compliance Rate (**Good Patient Experience**) – at 10% against a 10% target. Metric will be reported one month in arrears to allow for manual records to be uploaded.
- Staff turnover (excluding fixed-term posts) (**Supporting our Staff**) – at 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.

Tracker Metrics

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

- Sickness rate (**Supporting Our Staff**) – red at 5.1% against a stretch target of 3.5%. This is an NHS Oversight Framework scoring metric, with the Trust in 5th out of 61 (based on a Q1 score of 4.08%) and the national average at 5.10%.
- Bed days occupied by patients who are discharge ready (Community) (**Patient Experience**) – 809 bed days against a target of 695.
- Clinically Ready for discharge by wards in mental health (including OAPs) (**Patient Experience**) – 642 against a 350-bed day target.
- Talking Therapies Reliable Recovery for those Completing a Course of Treatment (Frimley) (**Good Patient Experience**) – (NHS Oversight Framework Non-scoring metric) - at 46% against a target of 50% by April 2026.
- Self-harm Incidents on Mental Health Inpatient Wards (excluding Learning Disability) (**Harm Free Care**) – at 196 against a revised target of 125 incidents.
- Community Inpatient Occupancy Rate (**Efficient Use of Resources**) – at 90% against a target of 85%.
- Mental Health Acute Occupancy rate (excluding home leave) (**Efficient Use of Resources**) – at 98.8% against an 85% target.
- Mental Health Non-Acute Occupancy rate (excluding home leave) (**Efficient Use of Resources**) – at 97.34% against an 85% target.

NHS Oversight Framework (NOF) Metrics

The NHS Oversight Framework metrics has been published, and relevant metrics for the organisation are shown in the performance report. The metrics are split between scoring and non-scoring indicators. Scoring metrics contribute to the segmentation rating as well and there is an override for finances. The Trust achieved segment 1 in the published scorecard, which is classified as:

‘the organisation is consistently high performing across all domains, delivering against plans’.

No update on the national scores, next published data expected mid-March. We remain ranked 9th nationally (previously 3rd) from all non-acute Trusts with 15 in segment 1.

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
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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)

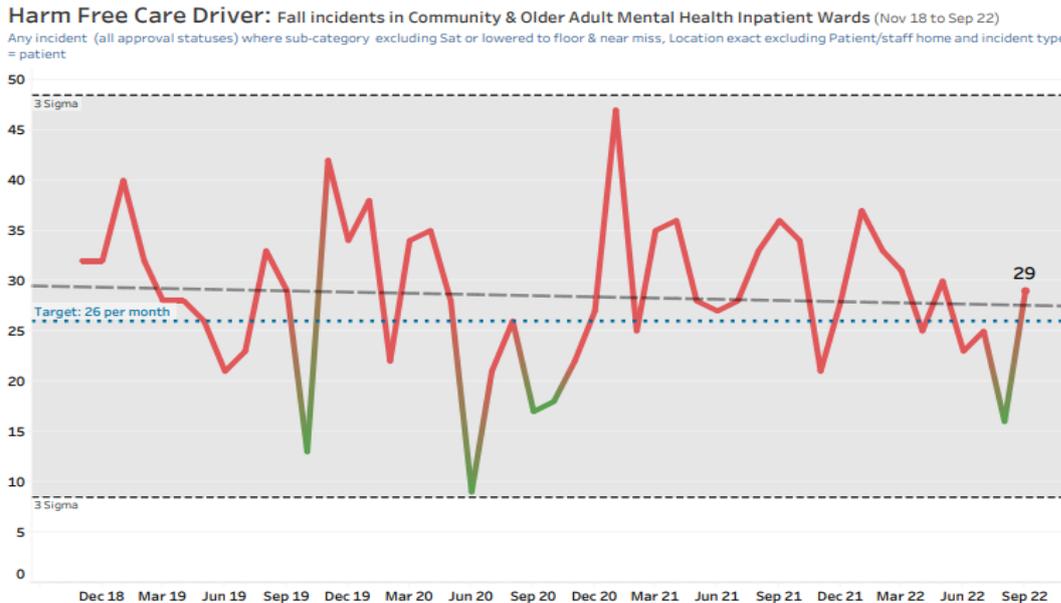
Business Rules for Statistical Process Control (SPC) Charts

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)

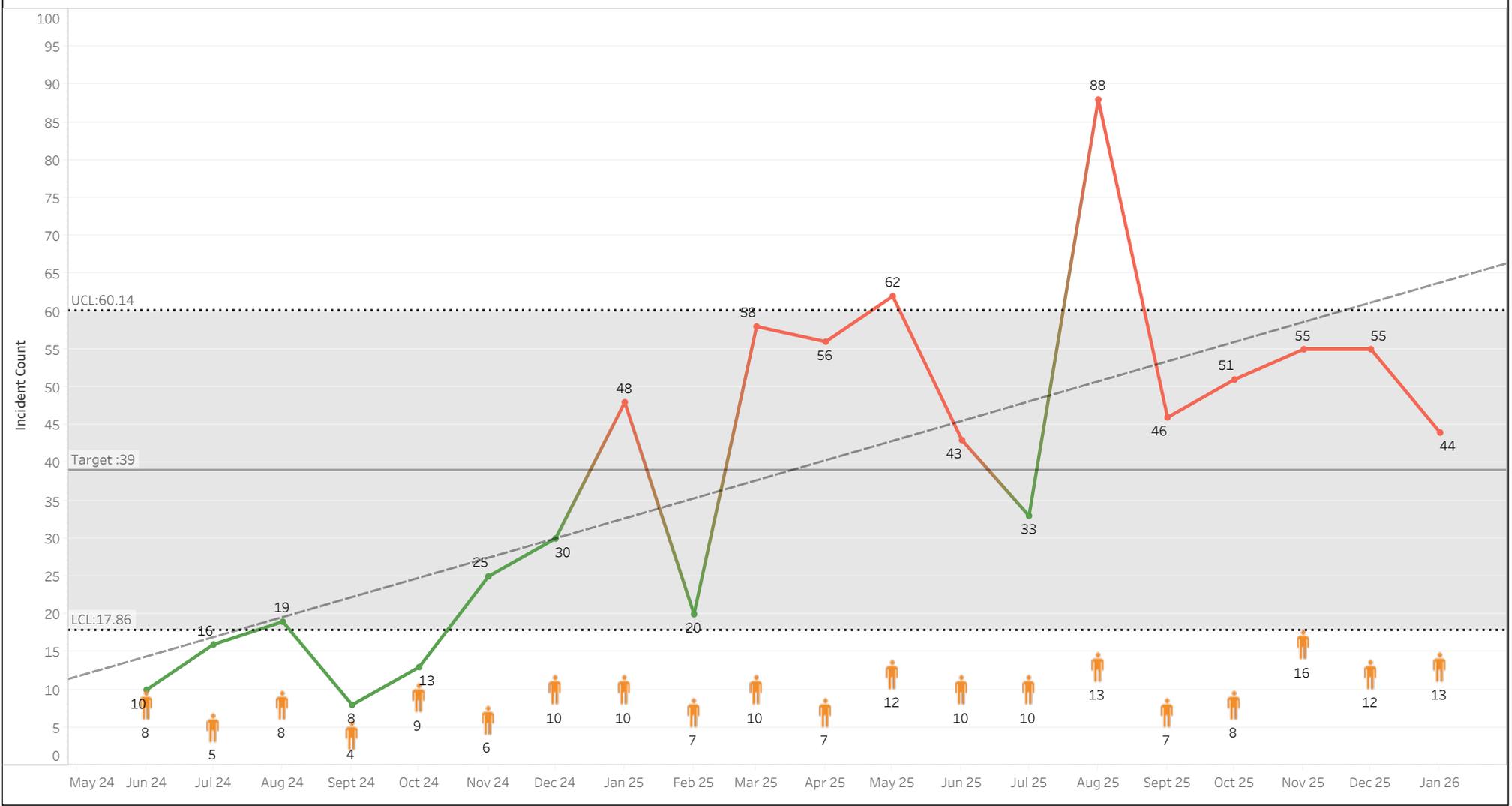
Rules

- 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.

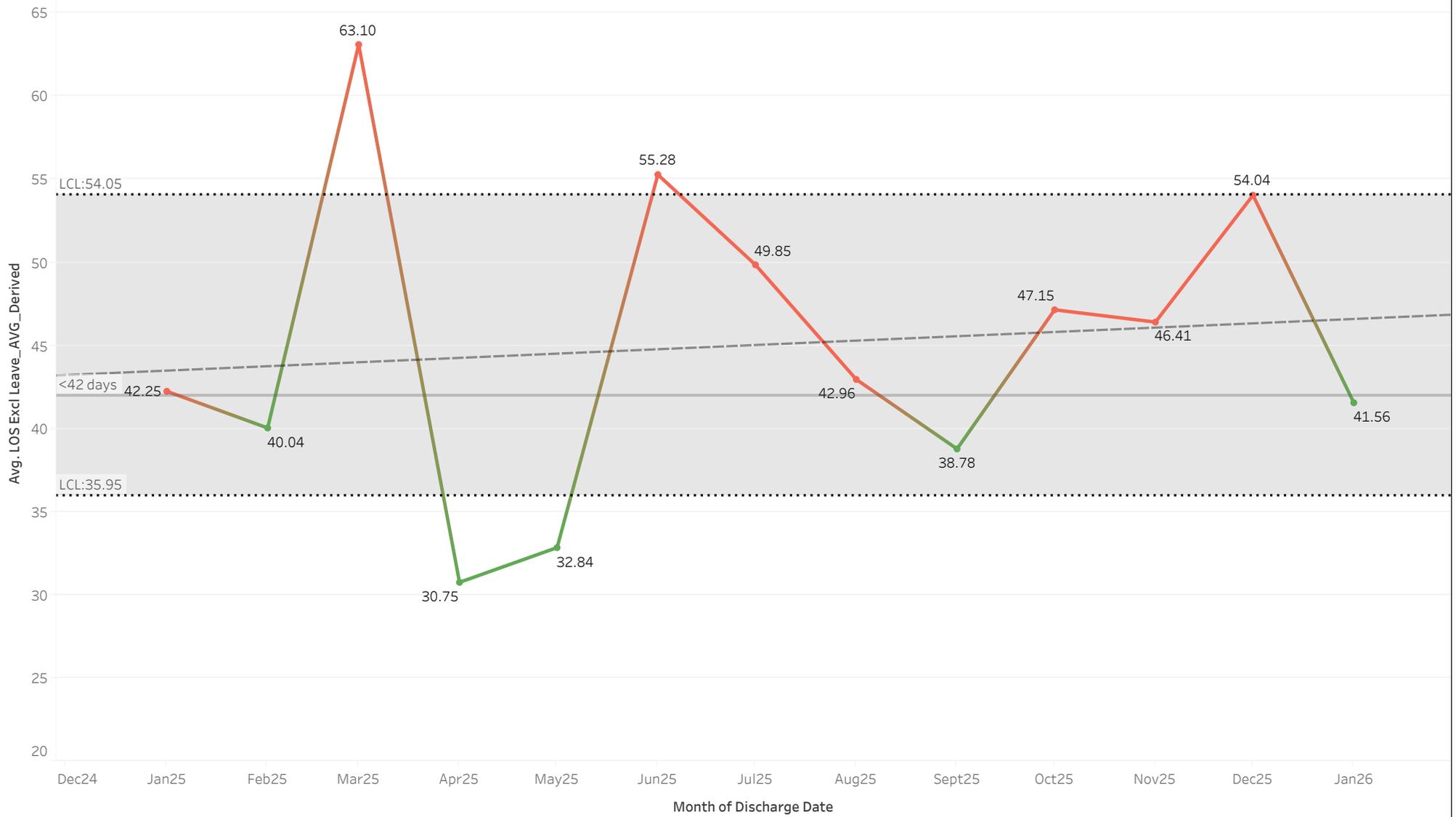
Performance Scorecard - True North Drivers

			Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	
Breakthrough Rapid Tranquilization (Intra-Muscular)	39	Internal	20	58	56	62	43	33	88	46	51	55	55	44	
			Good Patient Experience												
Positive Patient Experience Score %	95% compliance	External	95.19%	95.89%	95.39%	94.52%	94.71%	94.79%	96%	95.03%	86.09%	80.90%	89.70%	94.69%	
Patient Experience Compliance Rate %	10% compliance	External	5.89%	7.29%	7.79%	8.5%	7.79%	8.69%	8.90%	8.40%	5.80%	8.79%	8.40%	10%	
			Feb25	Mar25	Apr25	May25	Jun25	Jul25	Aug25	Sept25	Oct25	Nov25	Dec25	Jan26	
Breakthrough Mental Health: Acute Average Length of Stay (bed days)	<42	External	40.04	63.10	30.75	32.84	55.28	49.85	42.96	38.78	47.15	46.41	54.04	41.56	
Breakthrough Mental Health: Older Adult Average Length of Stay (bed days)	<80	External	77.45	87.56	82.15	109.82	81.82	81.86	73.33	109.60	99.00	92.57	119.50	75.50	
			Feb25	Mar25	Apr25	May25	Jun25	Jul25	Aug25	Sept25	Oct25	Nov25	Dec25	Jan26	
Breakthrough Community Inpatient Average Length of Stay (bed days)	<21	External	24.12	23.90	25.05	23.71	23.95	22.35	23.12	25.34	25.61	22.35	23.17	24.35	

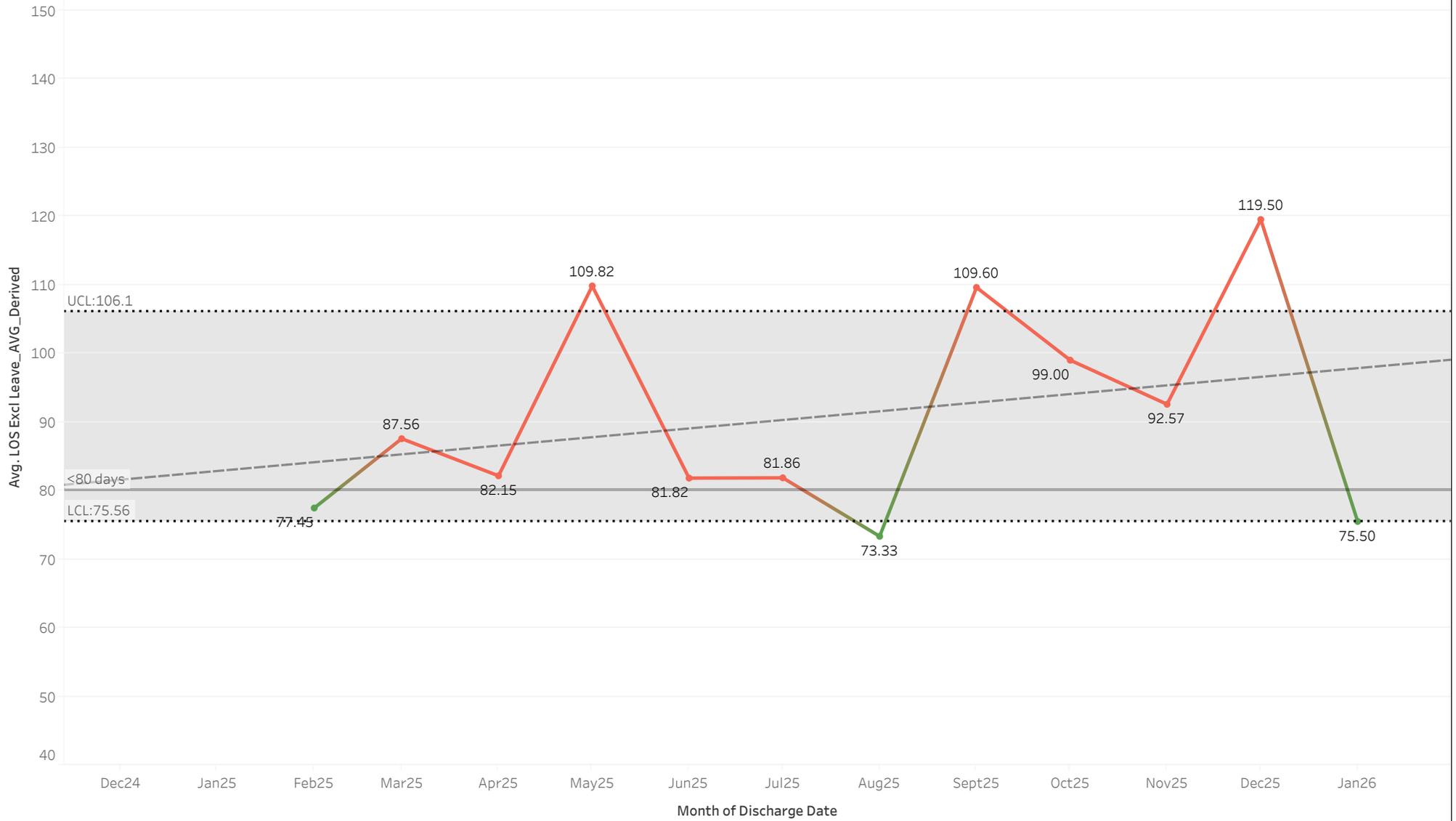
Breakthrough Rapid Tranquilization (Intra-Muscular)



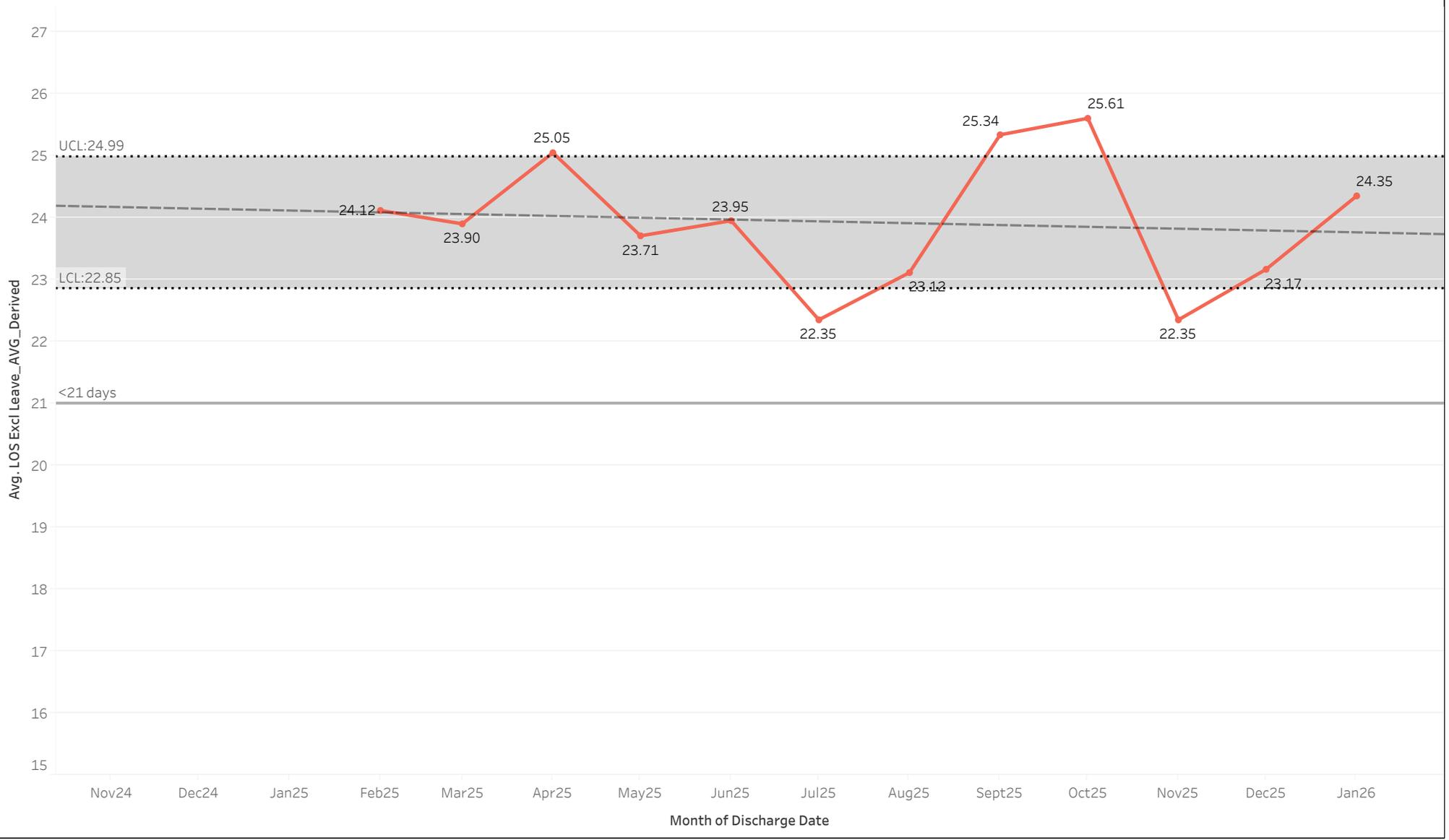
Breakthrough Mental Health: Acute Average Length of Stay (bed days)



Breakthrough Mental Health: Older Adult Average Length of Stay (bed days)



Breakthrough Community Inpatient Average Length of Stay (bed days)



Performance Scorecard - True North Drivers

Supporting Our People

Metric	Target/Threshold	External/Inter..	Feb25	Mar25	Apr25	May25	Jun25	Jul25	Aug25	Sept25	Oct25	Nov25	Dec25	Jan26
Breakthrough Physical Assault on Staff	36 per month	Internal	60	92	98	57	102	93	92	70	68	101	52	39

Metric	Target/Threshold	External/Inter..	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26
Staff turnover (excluding fixed term posts)	10%	External	11.16%	11.09%	10.59%	10.44%	10.07%	10.02%	10.29%	10.35%	10.29%	10.28%	10.19%	10%

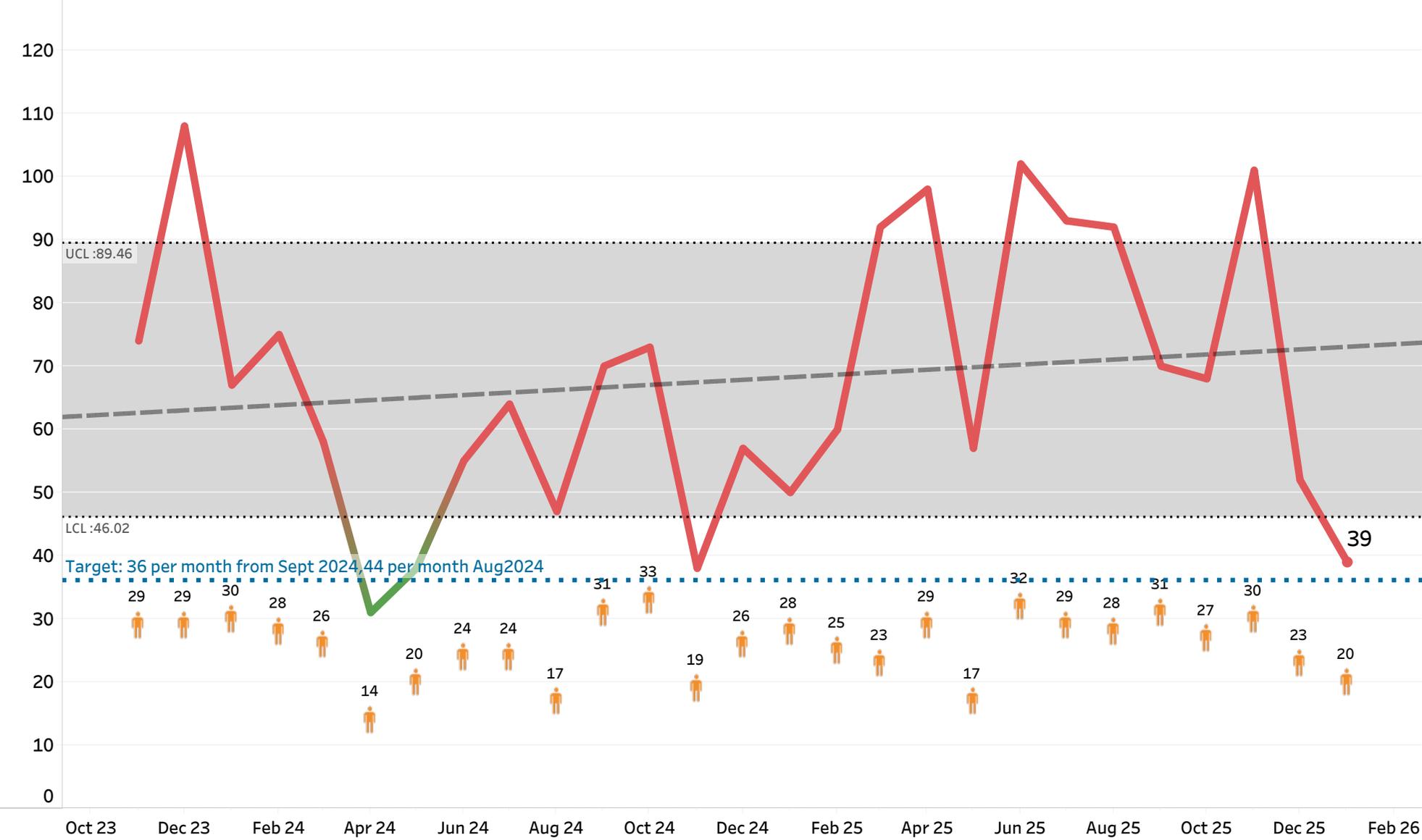
Efficient Use of Resources

Metric	Target/Threshold	External/Inter..	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26
YTD variance from control total (£'k) (NOF Scoring)	0	External	-3000	-3000	0	0	0	0	0	0	0	0	0	0

Metric	Target/Threshold	External/Inter..	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26
Active Inappropriate OAPS at end of month (NOF Non Scoring)	New target (25/26) : Q1 - 3, Q2 - 3, Q3- 3, Q4 - 1 per month	External	1	0	0	0	0	0	0	0	3	4	6	8

Supporting Our People - Breakthrough Objective :Physical Assaults on Staff (Nov 23 to Jan 26)

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



True North Supporting Our People Summary

Metric	Threshold / Target	External/Internal	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26
Statutory Training: Fire: %	90% compliance	Internal	94.8%	94.2%	94.1%	94.8%	94.6%	93.4%	93.9%	93.2%	93.3%	93.9%	93.6%	93.5%
Statutory Training: Health & Safety: %	90% compliance	Internal	98.2%	98.1%	98.4%	98.5%	98.3%	98.3%	98.4%	98.3%	98.3%	98.3%	98.2%	98.4%
Statutory Training: Manual Handling: %	90% compliance	Internal	94.1%	94.4%	94.1%	94.6%	94.6%	94.5%	94.3%	94.2%	94.3%	94.0%	94.6%	94.8%
Mandatory Training: Information Governance: %	95% compliance	Internal	97.1%	96.8%	97.2%	97.7%	97.9%	98.0%	97.7%	97.6%	97.6%	97.5%	97.4%	96.9%
Sickness Rate: % (NOF Scoring)	<3.5%	External	4.3%	3.8%	3.7%	4.1%	4.4%	4.5%	4.3%	4.6%	5.2%	5.1%	5.1%	
PDP (% of staff compliant) Appraisal: %	Target: 95% by end of May 2025	Internal				92.1%	94.5%	95.0%						

True North Supporting Our People Summary (2)

			Feb25	Mar25	Apr25	May25	Jun25	Jul25	Aug25	Sept25	Oct25	Nov25	Dec25	Jan26				
CQC - Quality of Leadership	TBC	External	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding				
			NHS staff survey raising concerns subscore (NOF Scoring)	TBC	External	7.26	7.26	7.26	7.26	7.26	7.26	7.26	7.26	7.26	7.26	7.26		
			Staff Engagement Score (Annual Staff Survey) (NOF Scoring)			10	External	7.4	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5

True North Good Patient Experience

			Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26
A&E: Maximum wait of four hours from arrival to admission/transfer /discharge: % (NOF Non Scoring)	95%	External	99.22	96.40	99.39	99.57	98.89	99.20	99.57	99.31	99.23	99.66	99.03	98.93
Community Health Services: 2 Hour Urgent Community Response % (NOF Scoring)	80%+	External	91.1%	92.2%	93.4%	94.4%	94.7%	92.2%	86.6%	92.9%	93.8%	93.9%	90.6%	86.5%
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	32	29	28	32	32	31	32	1	8	57	37	25
Number of Children on community waiting lists over 52 weeks (NOF Scoring)	TBC	External			55	59	94	123	99	91	93	103	75	72
Attended Community Care Contacts	TBC	External	51,590	55,720	54,324	51,997	46,642	56,527	43,749	46,321	50,953	43,757	45,296	47,350
			Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26
Bed days occupied by patients who are discharge ready Community	695 bed days	External	624	589	635	698	818	759	769	801	824	923	897	809
			Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26
Clinically Ready for Discharge by Wards MH (including OAPS)	250 bed days , 350 bed days Nov25	External	301	360	355	431	316	439	419	548	490	500	363	642
			Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26
Community Dentistry Activity (ytd)	Total Trust UDA per Annum 9037 CDS & 2000 DAC, 919 per month	External	8910	9671	762	1569	2371	3380	3940	4857	5792	6699	7466	8274

True North Good Patient Experience

			Feb25	Mar25	Apr25	May25	Jun25	Jul25	Aug25	Sept25	Oct25	Nov25	Dec25	Jan26
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	99%	100%	98.8%	100%	100%	100%	100%	100%	98.8%	100%	100%	100%
			Feb25	Mar25	Apr25	May25	Jun25	Jul25	Aug25	Sept25	Oct25	Nov25	Dec25	Jan26
CPP - RTT (Referral to treatment) waiting times - Community: incomplete pathways (how many within 18 weeks): Number	TBC	External	102	98	83	80	90	82	82	77	86	93	107	102
Diabetes - RTT (Referral to treatment) waiting times - Community incomplete pathways (how many within 18 weeks): Number	TBC	External	72	84	66	59	49	65	64	59	59	63	93	91
New RTT pathways (clock starts) Children's Community Response	TBC	External	31	35	16	46	48	36	33	43	43	38	36	34
New RTT pathways (clock starts) Diabetes	TBC	External	53	65	53	53	55	41	38	38	48	53	55	58
RTT waiting list, of which children aged 18 years and under (WLMDS)	TBC	External	101	98	83	80	90	82	82	77	86	93	107	102
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 Good Patient Experience

			Feb25	Mar25	Apr25	May25	Jun25	Jul25	Aug25	Sept25	Oct25	Nov25	Dec25	Jan26
Percentage of patients admitted as an emergency within 30 days of discharge (Community Readmission) (NOF Non Scoring)	TBC	External	0%	0%	0.64%	0%	0%	0%	0%	0.63%	0%	0%	0.57%	0.63%
Percentage of Inpatients referred to stop smoking services (NOF Non Scoring)	TBC	External	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	100	99.14	99.78	99.23	99.05	99.48	99.70	95.71	99.12	99.79	98.72	97.40
Fall incidents in Community & Older Adult Mental Health Inpatient Wards	26 Per month	Internal	27	24	25	25	23	24	17	21	23	21	26	25
Health Visiting: New Birth Visits Within 14 days: %	90% compliance	Internal	90.6%	91.1%	89.5%	82.2%	87%	87.3%	91.3%	92.9%	92.5%	92.2%	92.1%	92.6%
Access to Children and Young People's Mental Health Service 0-17 1+ Contact Frimley (NOF Scoring)	9180 ICB level	External	7161	7328	4016	2896	4176	3629	3783	3984	4126	4231	4389	4472
Access to Children and Young People's Mental Health Service 0-17 1+ Contacts BOB (NOF Scoring)	26531 ICB level	External	9852	10076	5020	5047	5151	4547	4710	5182	5312	5403	5502	5659
Access to Children and Young People's Mental Health Service Aged 18-24 1+ Contacts measured from Dat..	26531 ICB level.	External	3925	4012	1604	1681	1663	1688	1714	1723	1714	1720	1747	1744
Access to Children and Young People's Mental Health Service 18-24 1+ Contact Frimley	9180 ICB level.	External	2700	2758	1169	1248	1213	1217	1217	1225	1206	1204	1212	1227
Percentage of people with suspected autism awaiting contact for over 13 weeks (NOF Non Scoring)	TBC	External	95.14%	95.06%	94.85%	94.64%	93.51%	91.47%	92.55%	93.50%	95.16%	92.87%	92.56%	92.61%

True North Good Patient Experience

		Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26
Talking Therapies Reliable Improvement for those completing a course of treatment Frimley	67% to Sep 2025 68% from Oct 2025	External											
		62.5%	70.09%	70.29%	69.59%	67.5%	66%	70%	70%	65%	67%	66%	67%
Talking Therapies Reliable Improvement for those completing a course of treatment BOB	67% to Sep 2025 68% from Oct 2025	External											
		71.09%	68.10%	70.5%	72.39%	70.79%	66%	65%	69%	60%	69%	68%	68%
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											
		43.20%	51.5%	49.39%	50.20%	50.70%	46%	48%	47%	46%	46%	46%	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											
		51%	51.10%	50.60%	53.70%	50.10%	47%	48%	48%	47%	50%	46%	49%

True North Good Patient Experience

			Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26
Access to Perinatal services BOB	611	External	586	584	589	599	605	596	608	624	639	641	643	666
Access to Perinatal Services Frimley	479	External	449	451	448	469	481	488	489	499	496	482	487	486
Number of People accessing Individual Placement Services -Frimley	280 Frimley by March 26	External			336	344	354	355	362	372	373	362	368	368
Number of People accessing Individual Placement Services -BOB	280 BOB by March 26	External	-	-	366	368	384	387	388	383	389	391	393	402
Percentage of patients referred to crisis care teams to receive face to face contact within 24 hours (NOF Scoring)	TBC	External	66%	49%	65%	57.9%	70%	57.1%	55.8%	58.2%	65.0%	51.2%	55.0%	65.5%
Physical Health Checks 7 Parameters for people with severe mental illness (SMI)	90%	Internal	92%	93%	92%	90%	91%	92%	96%	94%	93%	91%	94.3%	92%
Mental Health: Prone (Face Down) Restraint	4 per month	Internal	1	1	0	0	1	1	1	3	1	2	3	1
Patient on Patient Assaults (MH Inpatients)	25 per month	Internal	10	13	16	14	24	32	23	18	4	13	12	24
Mental Health: Uses of Seclusion	13 in month	Internal	7	12	9	9	10	4	8	10	4	13	8	12
Rate of Restrictive Intervention Types per 1000 bed days (NOF Scoring)	TBC	External	96.95	142.89	124.33	157.76	155.19	62.89	111.83	72.31	69.98	110.89	69.25	59.48

True North Harm Free Care Summary

Metric	Threshold/Target	External/Internal	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26
Mental Health: AWOLs on MHA Section	10 per month	Internal	4	4	3	3	6	5	7	8	4	2	2	5
Mental Health: Absconsions on MHA section (Excl: Failure to return)	8 per month	Internal	0	0	2	3	2	0	1	2	7	5	6	4
Mental Health: Readmission Rate within 28 days: %	<8% per month	Internal	1.5	0	5.54	2.62	5.87	4.54	1.32	3.27	6.55	5.45	2.88	1.21
Mental Health 72 Hour Follow Up after Inpatient discharge	80%+	External	91.6%	96.6%	96.9%	97.3%	94.1%	96.7%	95.1%	92.4%	100%	92.8%	94.3%	91.6%
Self-Harm incidents on Mental Health Inpatient Wards (excluding LD)	125 per month	Internal	61	69	84	83	92	110	210	193	235	254	213	196
Patient on Patient Assaults (LD)	4 per month	Null	2	8	1	1	0	1	0	1	3	5	0	2
Self-Harm Incidents within the Community	31 per month	Internal	21	15	21	16	25	24	8	15	16	16	19	15

Efficient Use of Resources

Metric	Threshold / Target	External/Internal	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26
Community Inpatient Occupancy	85%	Internal	86.2%	84.6%	89.3%	87.3%	86.9%	84.8%	81.7%	88.9%	86.7%	86.7%	88.3%	90.0%
CHS Average delay(Exclude Zero delays)	TBC	External	6.0	5.0	5.8	5.5	6.2	5.8	6.5	5.8	6.1	7.2	6.5	5.6
CHS Percentage of patients discharged on discharge ready date	TBC	External	46.6%	39.0%	39.6%	38.9%	39.4%	39.3%	32.7%	26.1%	29.8%	36.6%	31.2%	27.4%
Mental Health: Adult Acute LOS over 60 days % of total discharges (NOF Scoring)	TBC	External	23%	26%	21%	18%	16%	17%	22%	21%	25%	24%	25.5%	28.1%
Mental Health: Older Adult Acute LOS over 90 days % of total discharges (NOF Non Scoring)	TBC	External	53%	55.0%	54%	60%	56.0%	55.0%	48%	48%	52%	54%	66.6%	50%
DNA Rate: %	5% DNAs	Internal	4.5%	4.42%	4.75%	4.91%	5.16%	5.46%	5.16%	5.04%	5.05%	5.11%	4.99%	4.76%
Mental Health: Acute Occupancy rate (excluding Home Leave):%	85% Occupancy	Internal	99.0%	89.6%	94.8%	96%	96.6%	98.2%	97.7%	97.2%	96.5%	97.7%	97.7%	98.8%
Mental Health: Non-Acute Occupancy rate (excluding Home Leave): %	80% Occupancy	Internal	92.56%	89.05%	83.78%	83.78%	80.93%	87.92%	77.56%	82.54%	86.89%	91.34%	93.75%	97.34%
Community Virtual Ward Occupancy Frimley	80%	External	80.5%	69%	83%	80%	75%	94%	77%	85%	81%	85%	81%	97%
Community Virtual Ward Occupancy BOB	80%	External	76.59%	85%	85%	72%	82%	91%	91%	97%	92%	97%	88%	102%
Agency Spend within Ceiling	3.2%	External	1.89%	2%	2.19%	1.79%	1.5%	1.89%	1.60%	2%	1.89%	1.79%	1.89%	1.79%
Year to Date Corporate Cost Reduction	TBC	External	0	0	0	0	0	0	0	0	0	0	0	0

Trust Board Paper

Board Meeting Date	10 March 2026
Title	Audit Committee Meeting – 28 January 2026
	Item for Noting
Reason for the Report going to the Trust Board	<p>The Audit Committee is a sub-committee of the Trust Board. The minutes are presented for information and assurance.</p> <p>The Trust Board is required to identify any areas for further clarification on issues covered by the meeting minutes and to note the content.</p>
Business Area	Corporate
Author	Company Secretary for Rajiv Gatha, Chair of the Audit Committee
Relevant Strategic Objectives	<p>Efficient use of resources</p> <p>Ambition: We will use our resources efficiently and focus investment to increase long term value</p>

Unconfirmed Draft Minutes

Minutes of the Audit Committee Meeting held on

Wednesday, 28 January 2026
(Conducted via Microsoft Teams)

Present: Rajiv Gatha, Non-Executive Director, Committee Chair
Sonya Batchelor, Non-Executive Director
Mark Day, Interim Trust Chair

In attendance: Paul Gray, Chief Financial Officer
Debbie Fulton, Director of Nursing and Therapies
Dr Tolu Olusoga, Medical Director
Clive Makombera, RSM, Internal Auditors
Sharonjeet Kaur, RSM, Internal Auditors
Amanda Mollett, Associate Director for Medical Development, Clinical Effectiveness and Clinica Audit
Kim Hampson, TIAA, Anti-Crime Specialist
Alison Kennett, Ernst and Young, External Auditors
Mark Davison, Chief Information Officer (*present for agenda items 5 and 6*)
Julie Hill, Company Secretary

Observers: Christine Doyle, NHS England
James Beveridge, NHS England

Item		Action
1.A	Chair’s Welcome and Opening Remarks	
	Rajiv Gatha, Chair welcomed everyone the meeting. The Chair particularly welcomed Christine Doyle and James Beveridge from NHS England who were observing the meeting as part of the Trust’s Advanced NHS Foundation Trust application process.	
1.B	Apologies for Absence	
	Apologies were received from the Director of Finance and the Chief Operating Officer.	
2.	Declaration of Interests	

	There were no declarations of interest.	
3.	Minutes of the Previous Meeting held on 22 October 2025	
	The Minutes of the meeting held on 22 October 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.	Cyber Security Annual Report	
	<p>The Chair welcomed the Chief Information Officer to the meeting.</p> <p>The Chief Information presented the report and highlighted the following points:</p> <ul style="list-style-type: none"> • There were no cyber security incidents directly affecting the Trust’s digital systems in 2025 demonstrating that the Trust had effective controls in place. • The top three cyber security risks remained the unchanged, namely: <ul style="list-style-type: none"> ○ Cyber attack ○ Phishing ○ Supply Chain attack • The main focus for 2026 would be refreshed Board training, with government-led cyber security training scheduled for the spring. <p>The Chair commented that it was a comprehensive report. The Chair referred to page 29 of the agenda pack and asked about the processes in place to ensure that new systems were assessed as being appropriate in terms of any cyber security risks prior to their implementation.</p> <p>The Chief Information Officer explained that the process for assessing new systems included pre-procurement questionnaires, review of ISO certifications, Cyber Essentials (and Plus) status, and intelligence from NHS England and the National Cyber Security Centre. The Chief Information Officer said that there would always be ongoing supply chain risks.</p> <p>The Chair asked whether the process for assessing new systems was documented.</p> <p>The Chief Information Officer explained that all process steps for system assessment were documented in accordance with the requirements of the NHS Data Security and Protection Toolkit which was subject to audit.</p> <p>The Chair asked for more information about the mock phishing exercise and noted that 350 recipients had clicked on the link and entered some information.</p>	

6.	Information Governance Annual Report	
	<p>The Chief Information Officer presented the report and highlighted the following points:</p> <ul style="list-style-type: none"> • The NHS Data Security and Protection Toolkit annual assessment of standards was met. • Of the 1,802 Subject Access Requests (SARs) the Trust received, one deadline was extended and two exceeded the timeframe for response. • Of the 540 internally reported information governance incidents, none met the threshold of a reportable breach to the Information Commissioner’s Office • One complaint was made directly to the Information Commissioner’s Office by a member of the public but there was no formal action taken against the Trust. • 97.1% of staff were compliant with information governance training (95% was the requirement). • The key areas of focus for 2026 would be to maintain the quality standards of information governance processes and to address the emerging needs of: <ul style="list-style-type: none"> ○ Artificial Intelligence (AI) continued development building on the starting points set in 2025 in healthcare coupled with robotic process automation. There was a pressing need to understand the new scale and complexity of this technology in the context of the intertwined web of privacy, clinical safety, safeguarding, etc. which may lead to patient harm. ○ Managing data as a strategic asset while ensuring protection and maintaining public trust. The NHS has major opportunities to use data more effectively for care, research, and planning, especially with the rise of AI. However, this depends on maintaining strong public trust in how data is protected. Lost trust could lead to patients avoiding or disengaging from care. Robust confidentiality, privacy, and security must therefore remain central as the organisation makes more use of its data assets. ○ Continuing work started in 2025 on data democratisation – Building on the initial implementation of the patient portal in Bracknell CMHT to roll it out across the Trust. The greatest challenge for Information Governance in 2026 in this project will be the creation of a safe but efficient proxy process that will give the option of another person such as a family member or friend access to the patients’ information on the portal and allow them to help patients with tasks such as rebooking and cancelling appointments. ○ Data Subject Access Request (SAR) processes in the Trust remain managed across different teams leading to inefficiency and poor experience for requestors. In 2025 we saw an increased number of complaints to the Trust regarding SARs and how they had been administered. <p>The Chair referred to the chart on page 52 of the agenda pack which showed the top three incident types over the last year and asked whether the failure to follow policy had been recategorised.</p>	

	<p>The Chief Information Officer explained that the incident categories were refined for 2025 to provide more specificity such as separating out “information shared outside of Trust policy”.</p> <p>The Committee noted the report.</p>	
<p>7.A</p>	<p>Board Assurance Framework</p>	
	<p>The latest Board Assurance Framework (BAF) had been circulated.</p> <p>The Chief Financial Officer presented the report and highlighted that following a discussion at the Trust Board’s annual strategic planning day, the risk descriptions of risks 1 (workforce), risk 4 (system working), risk 6 (finance) had been updated to better reflect the current risk. Risk 7 (cyber security) had been expanded to include the risks of using unauthorised software, including artificial intelligence.</p> <p>Sonya Batchelor, Non-Executive Director confirmed that the revised risk descriptions reflected the discussion at the October 2025 Trust Board meeting.</p> <p>The Committee noted the report.</p>	
<p>7.B</p>	<p>Corporate Risk Register</p>	
	<p>The Corporate Risk Register (CRR) had been circulated. The updates since the last meeting were highlighted in red type.</p> <p>The Chief Financial Officer presented the paper and highlighted the following points:</p> <ul style="list-style-type: none"> • Risk 2 (ligature): All patient toilet upgrades had been completed, removing the ligature risk. Ongoing mental health surveys at Prospect Park Hospital would inform future work. • Risk 3 (service user suicide): Controls amended to include peer review process. • Risk 7 (Prospect Park Hospital physical environment): water safety controls in place following the detection of Legionella on both the Campion Unit and the new Place of Safety requiring remedial works. The opening of the new Place of Safety was delayed by around 6-8 weeks due to the presence of Legionella. • Risk 8 (Jubilee Ward): Ongoing fire risk managed with regular meetings with PFI provider and Berkshire Fire Service. The risk will be fully mitigated when the ward was closed and relocated. Funding for the move had been secured from NHS England. • Risk 10 (long waiters): New referrals to adult neurodiversity service suspended from 1 December 2025, agreed with the Integrated Care Board. Operational teams were identifying and planning for patients waiting over 52 weeks. <p>Mark Day, Interim Trust Chair reported that he had recently visited Prospect Park Hospital and shared that the new Place of Safety was a huge improvement on the current Place of Safety. Mr Day asked for more information about the timeline for resolving the Legionella issue.</p>	

	<p>The Chief Financial Officer explained that there needed to be three clear water samples before the Place of Safety could be opened 30 days after the last clear sample.</p> <p>The Chair referred to the risk 6 and noted that the risk update referred to an audit being completed on an initial sample of 20 contracts and the results being set out in an attached report (which was not attached).</p> <p>The Chief Financial Officer agreed to circulate the Trust’s Contract Lifecycle Management paper to members of the Committee.</p> <p>The Committee noted the report.</p>	PG
7.C	Corporate Risk Register Risks 5 (acute bed pressures) and risk 6 third party “deep dive” reports	
	<p>“Deep dive” reports into Corporate Risk Register risk 5 (acute bed pressures) and risk 6 (third party) had been circulated.</p> <p>The Committee noted the reports.</p>	
8.	Single Waiver Tenders and Provider Selection Regime Direct Awards Report	
	<p>A paper setting out the Trust’s single waivers and provider selection regime direct awards approved from October 2025 to December 2025 had been circulated.</p> <p>The Chief Financial Officer presented the report and said that there were a relatively small number of waivers approved in the period, but an unusually high proportion of non-compliant waivers.</p> <p>The Chair asked for more information about the lack of process in relation to the non-compliant waivers.</p> <p>The Chief Financial Officer reported that the Head of Procurement had retrospectively reviewed the risks and had concluded that:</p> <ul style="list-style-type: none"> • Royal College of Nursing Psychological Interventions Programme waiver was a process failure, but the contract would have been awarded regardless. • Healthcare Communications waiver had a bridging arrangement issue between contract lapse and new award; now resolved with a contract in place. • The removals contract was identified as a compliance issue where a cheaper price might have been possible, but the financial risk was minimal given the low value of the contract. • Two contracts were within the estates area; the Trust’s new Head of Estates would include this in an estates procurement review to clarify processes for waivers and overall procurement. <p>The Chief Financial Officer confirmed that the Head of Procurement had communicated appropriate process reminders to relevant individuals.</p>	

	<p>The Chair commented that he was pleased that the Trust had taken steps to address the areas of non-compliance.</p> <p>The Committee noted the report.</p>	
9.	Information Assurance Framework Update Report	
	<p>The Chief Financial Officer presented the paper and reported that four indicators were audited in quarter 3:</p> <ul style="list-style-type: none"> • High Assurance (Green) <ul style="list-style-type: none"> ○ Mental Health: Inpatient Readmission rate within 28 days ○ Inappropriate Out of Area Placements • Moderate Assurance (Amber) <ul style="list-style-type: none"> ○ Mental Health Inpatient 72 hour follow up appointment (Green for Data Assurance and Amber for Data Quality) • Low Assurance (Red) <ul style="list-style-type: none"> ○ Did Not Attend (DNA) rate <p>The Chief Financial Officer explained that the Did Not Attend) metric received a low confidence rating for data quality due to a recent process change in the sampled team's administrative responsibilities. The Informatics team would re-audit the metric now that changes had been completed and may sample other teams to check for broader issues.</p> <p>The Chief Financial Officer reported that the results of the Did Not Attend re-audit would be included in the April 2026 report.</p> <p>The Chief Financial Officer reported that improvements were made in the 72 hour follow up metric, but recording issues and accuracy persisted.</p> <p>The Chair raised the recurring issue of green data assurance but red data quality especially for the 72 follow up appointment metric.</p> <p>The Chief Financial Officer suggested a short deep dive report on the 72-hour follow-up metric to provide the operational context.</p> <p>The Committee noted the report.</p>	<p>PG</p> <p>PG/TW</p>
10.	Losses and Special Payments Report	
	<i>Due to low numbers, there was no report this quarter.</i>	
11.	Clinical Claims and Litigation Report	
	<p>The Clinical Claims and Litigation Report had been circulated.</p> <p>The Director of Nursing and Therapies presented the report and highlighted the following points:</p> <ul style="list-style-type: none"> • One claim had been closed during the quarter and there were there were seven new claims this quarter: 	

	<ul style="list-style-type: none"> ○ 4 clinical negligence claims ○ 3 employer liability claims ● The settled complaint related to a GP service as the Trust was responsible for the GP practice at the time. <p>Mark Day, Interim Trust Chair referred to a joint claim with the Trust and other providers which had highlighted concerns about communication difficulties between Trust clinicians and clinicians from another provider organisation and asked for more information.</p> <p>The Director of Nursing and Therapies explained that the issue was that when the other provider organisation’s clinicians telephoned the Trust, they spoke to an administrator rather than being put through to a clinician for a direct discussion. The Director of Nursing and Therapies confirmed that the Trust had updated the standard operating procedures to ensure clinician to clinician discussions for any young person in crisis regardless of their GP registration.</p> <p>The Committee noted the report.</p>	
12.	Clinical Audit Report	
	<p>The Clinical Audit Report had been circulated.</p> <p>The Medical Director reported that there were 37 open projects on the Clinical Audit Plan 2025-26 and confirmed that all projects were on track and that the Trust was meeting its responsibilities with regards to clinical audits.</p> <p>The Committee noted the report.</p>	
13.	Anti-Crime Specialist Report	
	<p>Kim Hampson, Anti-Crime Specialist, TIAA reported that since the report had been circulated there were a couple of additional updates.</p> <p>Kim Hampson had met with the Counter Fraud Authority and was preparing a file for the Crown Prosecution Service to consider charges in respect of both the genuine and bogus NHS Professionals staff.</p> <p>Kim Hampson reported that TIAA had agreed to do some proactive work on asset management, prompted by a national fraud prevention notice and recent incidents.</p> <p>The Chair asked about the scope of the asset management proactive work.</p> <p>Kim Hampson said that she was considering focussing on laptops but was happy to other suggestions.</p> <p>The Chair suggested expanding the scope to include iPads and phones.</p> <p>Ms Hampson agreed to discuss the scope of the asset management review with Associate Director of IT and Chief Financial Officer.</p>	KH

	<p>Mark Day, Interim Trust Chair referred to the fraud awareness training section of the report and asked whether staff self-selected to attend fraud awareness training sessions or whether these sessions targeted particular groups of staff.</p> <p>Ms Hampson explained that fraud awareness training was provided at induction for new starters and she provided sessions for staff upon request.</p> <p>Mr Day suggested adopting a risk-based approach to identify high-risk teams for fraud awareness training.</p> <p>The Chief Financial Officer agreed to discuss this with the Head of Financial Services and Kim Hampson.</p> <p>The Committee noted the report.</p>	PG
14.	Internal Audit Report	
	<p style="text-align: center;">a) Internal Audit Progress Report</p> <p>Sharonjeet Kaur, Internal Auditors, RSM presented the report and highlighted the following points:</p> <ul style="list-style-type: none"> • Since the last meeting, two reports had been finalised (General Ledger (substantial assurance) and Mental Capacity Act and DoLs (partial assurance). • The two remaining audits (risk management and medical staffing) were in progress. • Five follow-up actions had been closed since the last meeting; seven medium-rated actions remained overdue but were in progress, with revised dates agreed. <p>The Director of Nursing and Therapies reported that since the agenda pack was circulated, the Mental Capacity Act and DOLs report had been amended, and the safeguarding recommendation was now categorised as a “low” rather than a “medium” risk.</p> <p>The Chair commented that it was unusual for the Trust to receive “partial assurance” for an audit and asked how the Trust’s performance compared with other trusts.</p> <p>Sharonjeet Kaur reported that RSM confirmed that other trusts were experiencing similar issues, particularly around evidencing that patients had been information about their rights. Clive Makombera, Internal Auditors, RSM added that the Trust was not an outlier and said that an action plan had been agreed with the Trust’s management.</p> <p style="text-align: center;">b) DSPT Benchmarking Report 2024-25</p> <p>Ms Kaur reported that the Trust had received a medium risk rating (better than some peers) and high confidence.</p> <p style="text-align: center;">c) NHS News Briefing</p>	

	<i>Circulated for information</i> The Committee noted the reports.	
15.	External Audit Report	
	Alison Kennett, External Auditors, Ernst, and Young confirmed that the external audit of the Trust's 2025-26 accounts had started and confirmed that walkthroughs were completed. Ms Kennett thanked the finance team for their support and confirmed that the audit was progressing efficiently. The Committee noted the update.	
16.	Minutes of the Finance, Investment and Performance Committee meeting held on 22 October 2025	
	The minutes of the Finance, Investment and Performance Committee meeting held on 22 October 2025 received and noted.	
17.	Minutes of the Quality Assurance Committee held on 25 November 2025	
	The minutes of the Quality Assurance Committee meetings held on 25 November 2025 were received and noted.	
18.	Minutes of the Quality Executive Committee Minutes – October 2025, November 2025, and December 2025	
	The minutes of the Quality Executive Committee meetings held on: 27 October 2025, 17 November 2025 and 15 December 2025 were received and noted.	
19.	Annual Work Plan	
	The Committee's Annual Work Plan was noted.	
20.	Any Other Business	
	There was no other business.	
21.	Date of Next Meeting	
	The next meeting of the Committee was scheduled to take place on 22 April 2026.	

The minutes are an accurate record of the Audit Committee meeting held on 28 January 2026.

Signed: - _____

Date: - 22 April 2026 _____