NHS
Berkshire Healthcare
NHS Foundation Trust

Five-Year Health Inequalities Strategy

Working with our community to provide equitable and accessible health services for all.

2026 - 2031

www.berkshirehealthcare.nhs.uk

Structure

Acknowledgements

This strategy is co-authored with Ana Popa, Health Inequalities Lead; **Yvonne Mhlanga,** Mental Health Act Detention (MHAD) Programme Manager; and **Cecily Mwaniki,** Health Inequalities Engagement Officer, **with contributions from many colleagues who are taking this work forward across Berkshire.**

Introduction

We have worked hard since we published the 2025/26 Health Inequalities Strategy to co-produce this new version for 2026 - 2031 with our communities.
We believe that this strategy is stronger because of that approach. We have made huge progress in the last year, and we now have a much clearer picture of where inequalities in access, outcomes and experience exist within the services we provide. We have a responsibility to look at these variations and address those that we can.

Unfortunately, we do this against a backdrop of increasing health inequalities in society since we published the 2025/26 strategy. While the structural drivers of health inequalities are beyond the control of Berkshire Healthcare, we are committed to improving the drivers of inequalities that are within our scope. This strategy sets out our commitment to do so.

The following pages provide:

- A picture of what we are already doing
- The definition of health inequalities and why this is important
- Data on our population health
- Berkshire community voices
- Our ambition and what we aim to achieve in the next five years
- Our commitments to action

We hope you find this strategy ambitious, clear and transparent about the challenges we face, and something that you feel able to work with us on.

We look forward to working with you to deliver this strategy.

What we've achieved so far

We have taken a systematic approach to looking at and profiling our service data through a health inequalities lens of access, outcomes and experience and have agreed on the top ten areas of focus for reducing inequalities in our services.
We've built an understanding across the Trust on health inequalities and how we can tackle them. Teams now include actions to address health inequalities in their **annual team Plan on a Page**.

We've continued to work on making a positive difference for Black people who have been detained under the Mental Health Act (MHA), and/or are at risk of their mental health deteriorating to the point where detention may be required. At the start of this programme of work, Black people in Berkshire were 4.5 times more likely to be detained under the MHA than white people. With our partners, we have reduced this to 2.69 times across Berkshire (average), but with an increasing trajectory, there is still work to do.

We have continued to build our Quality Improvement approach to tackling health inequalities within our services, delivering improvements in cancer mortality for people with Severe Mental Illness in Reading by focusing on significantly raising awareness of cancer in the community and building connections with external stakeholders and organisations, including **Citizens Advice Reading, Reading Borough Council, Reading Alliance for Cohesion and Racial Equality (ACRE)** and **Solutions 4 Health**. We will continue to work with these organisations to improve the experience and outcomes of people and communities living with Severe Mental Illness.

The second Quality Improvement project aimed to reduce the inequality in access to the Nutrition and Dietetics service, with 30% of Asian / Asian British patients being discharged unseen, twice the percentage of white patients. Through improved communications, the team has reduced the percentage of Slough residents who have been discharged from the service with no contacts from 32% to 24% (less than 20% in July 2025). This has been achieved by working with communities to better understand how messages about our services can be shared. As well as continuing to monitor the impact of the change, the service will continue to review countermeasures to reduce the percentage further and will share the learning from these changes with other services.

In 2024, we launched our interim Health Inequalities Strategy with a commitment to co-produce a longer-term strategy and develop dedicated programmes of work in the two most deprived areas in Berkshire - Reading and Slough. This new strategy represents a co-produced approach, though we recognise that we still have more to do. Throughout 2024 and 2025, we worked with **Voluntary, Community and Social Enterprise organisations (VCSE)** across Berkshire to understand what the community identified as priorities for addressing health inequalities. Additionally, in Reading and Slough, we have worked with Reading Alliance for Cohesion and Racial Equality (ACRE), **Slough Council of Voluntary Services (CVS)** and Reading and Slough Public Health colleagues to build two additional health inequalities initiatives in these two most deprived areas in Berkshire.

As a Mental Health Trust, we have a duty to ensure that we are compliant with the **Patient and Carer Race Equality Framework**, known as **PCREF.** However, we aimed to go beyond the statutory minimum and set a more ambitious goal of establishing an approach to patient and carer feedback across all our services, supported by a clear plan to deliver this ambition.

We have established an **Equity Partnership Group** that brings together the health inequalities work, the **Culture, Inclusion and Equity Framework** and community engagement work. As part of our ambition, we have taken on board the need to understand and act in a co-productive way. We now have a Co-production Framework for staff, supporting service teams to understand how and when to include patient and carer voices in the review and design of services. Scaling this up across all services is part of the new Health Inequalities Strategy.

We use the **Marmot principle** to frame our approach to social value and have mapped the contribution the Trust can make for each of the eight principles. We are actively promoting careers at Berkshire Healthcare in schools in Berkshire's most deprived areas. Alongside this Health Inequalities Strategy, we have strategies covering the Anti-racism, the Neurodiversity, the Culture, Inclusion and Equity Framework and the Friends, Families and Carers Strategy. We are also currently designing and delivering neighbourhood health services which will strengthen the role and impact of prevention as a central element of the developing neighbourhood health services.

As part of the new Health Inequalities Strategy, we will explore the potential to become a Marmot Trust and what this would mean for the Berkshire population.

Search 'Reducing Health Inequalities' on Nexus

Or visit: https://www.berkshirehealthcare.nhs.uk/strategies to see all of our strategies

What are health inequalities

Health inequalities are the unjust and avoidable differences in people's health across the population and between specific population groups. They are the result of a complex combination of social, economic, environmental, political, and cultural factors that affect the population of a local area, or place. As such, health inequalities are caused by many structural factors outside the control of Berkshire Healthcare. In many ways the patients that interact with Berkshire Healthcare services do so because of these structural factors that have already impacted their lives.

There are also several factors that can mitigate the impact of the structural causes of health inequalities. These include genetics, health behaviours, our sense of wellbeing, and access to healthcare services supporting people to prevent ill health and importantly, treating them quickly and appropriately when people do experience ill health.

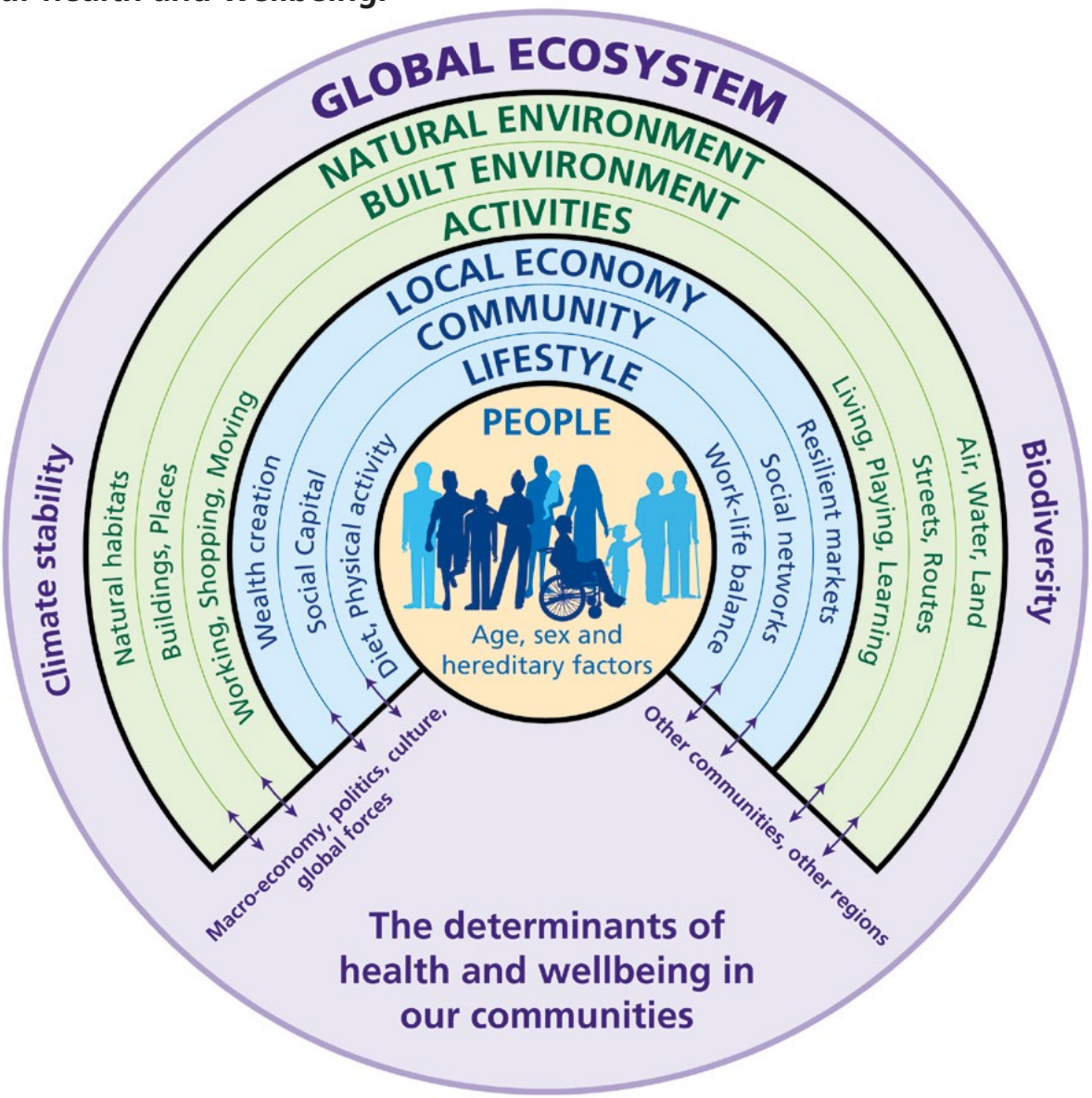
In England, there is a systematic relationship between deprivation and life expectancy, sometimes known as the social gradient in health (Fair Society Healthy Lives full report). The most recent data available shows that at a national level in 2020–2022, women living in the least deprived 10% of areas could, at birth, expect to live to 86.1 years old, whereas women in the most-deprived 10% of areas could expect to live to 77.7 years – a gap in life expectancy of 8.4 years (Healthy life expectancy by national area deprivation, England and Wales - Office for National Statistics). For men, this gap was even wider, with a difference of 10.4 years (Healthy life expectancy by national area deprivation, England and Wales - Office for National Statistics) between the life expectancy for those in the least deprived 10% of areas (83.0 years) and the most deprived 10% of areas (72.6 years). In recent years, inequalities in life expectancy by deprivation have widened. (What Is Happening To Life Expectancy In England? | The King's Fund). Having a learning disability, physical disability, mental illness or being an unpaid carer will also negatively impact on a person's life expectancy.

In 2010 Professor Sir Michael Marmot (Fair Society Healthy Lives full report) highlighted that poor health outcomes are not exclusively the result of genetics, personal health choices, or the availability of medical treatment, despite the significance of these aspects, but that differences in health reflect the differing social, environmental and economic conditions of local communities.

Professor Marmot set out eight principles for a fairer, healthier society:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure a healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill health prevention
7. Tackle racism and its outcomes*
8. Tackle climate change and health equity in unison*

The picture below is typically used to illustrate the various layers that impact on our health and wellbeing.



These multiple layers illustrate the complexity of health and health inequalities.
They also provide many 'lenses' through which we can view health inequalities.

Berkshire Healthcare is a community and mental health provider serving the population of Berkshire, with specialist children's and court justice mental health services delivered across Thames Valley and Hampshire. We lead the specialist OpCourage armed forces mental health service in partnership across southeast England. We recognise that inequalities can manifest in various ways, such as uneven access to services, unequal availability of services, and variable experience with services. All of these can lead to inequalities in outcomes across different groups of people.

We recognise that as a community and mental health Trust our primary area of influence in reducing health inequalities is around ensuring equitable availability, outcomes and experience of the services we provide. However, we also recognise that up to 80% of health inequalities are linked to the wider determinants of health. We have developed other strategies, for Anti-racism, Neurodiversity, the Culture, Inclusion and Equity Framework, Veteran's service and the Friends, Families and Carers services, to span the wider determinants of health and are exploring plans to address

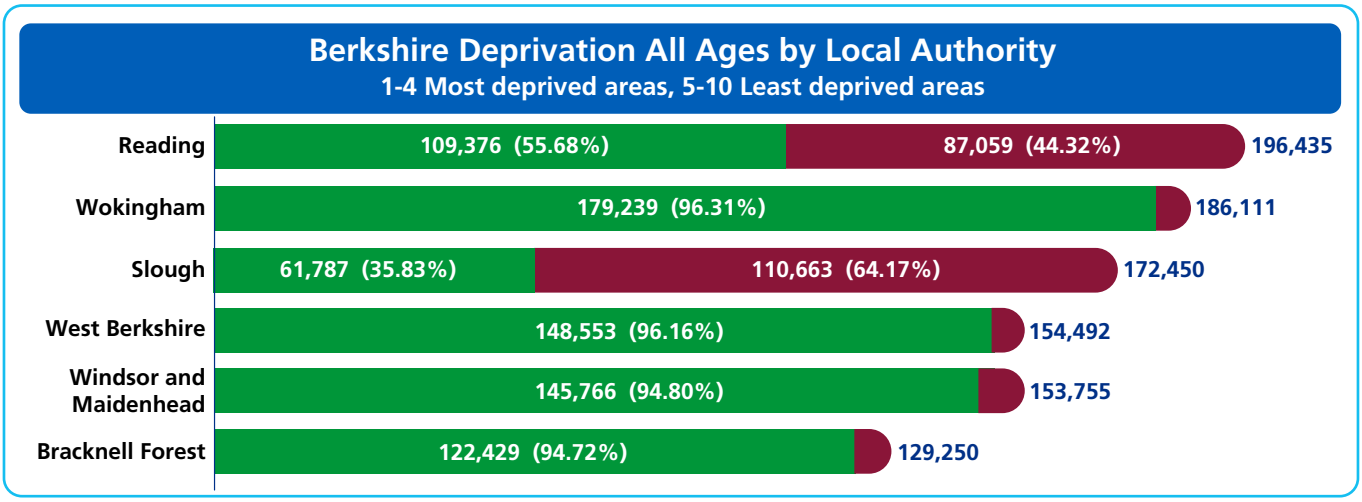
inequalities through some of our day-to-day activities, such as developing more inclusive recruitment practices. A significant new way of working for us is the collaboration with the local authority public health teams across Berkshire to identify the areas we could and should be working together on to make a difference.

The Government and Department of Health and Social Care have a national drive on reducing health inequalities through the CORE20PLUS5 framework (NHS England » Core20PLUS5 (adults) – an approach to reducing healthcare inequalities). The approach targets nationally known inequality areas and allows the local NHS to add five key local health inequality areas (the plus 5 areas). Berkshire Healthcare has an important role to play in contributing to these nationally defined areas and local plus 5 areas, and works closely with the six Berkshire Health and Wellbeing Boards. In addition, we have also set some Berkshire Healthcare priorities based on our data.

What does this mean for Berkshire?

The Office for National Statistics (ONS) releases data on deprivation across England every four years (Healthy life expectancy by national area deprivation, England and Wales - Office for National Statistics). These figures, known as the Index of Multiple Deprivation (IMD), combine information from seven domains: I**ncome; Employment; Education; Skills and Training; Health and Disability; Crime; Barriers to Housing and Services; Living Environment**, by residential postcode, to produce an overall relative measure of deprivation.

The table below illustrates what this means across Berkshire:



The most deprived places in Berkshire are Slough and Reading:

Reading and Slough have higher levels of deprivation, to the extent that residents in both areas are considered twice as disadvantaged as residents in the other parts of Berkshire.

- **Slough is more deprived** than England's average, with the majority of Slough's population living in deprived areas.
- **Slough and Reading** have a high proportion of **children under the age of 4 years** and adults **over the age of 70 years** living in areas of severe deprivation.

44% of residents in Reading and 64% of residents in Slough are currently in the most deprived areas (defined as IMD Score 1 - 4), compared with Bracknell Forest, West Berkshire, Wokingham, Windsor, and Maidenhead, each of which has less than 6% residents living in this level of deprivation.

Children born in the most deprived areas will typically live shorter and less healthy lives. Reading and Slough have the highest number of children aged under five years in Berkshire. They also have the highest number of children under five living in the most deprived areas. More than 65% of the children under five in Slough and 47% of the children under five in Reading live in the most deprived areas of the boroughs.

Places with high levels of income deprivation have a higher rate of poor physical and mental health:

All of the factors that make up the Index of Multiple Deprivation contribute to health inequalities, but income deprivation is a significant factor. Areas with higher levels of income deprivation are more likely to have a range of health conditions, including severe mental illness, obesity, diabetes and learning disabilities.

Race and deprivation are also significant drivers of health inequalities:

40% of those identifying as Asian or Asian British and 44% of those identifying as Black or Black British live in the most deprived places in Berkshire. Reading and Slough have the highest number of people from racialised/ethnic communities living in the most deprived areas.

What we know

Community voices

What matters to communities is equitable healthcare where their voice is heard through the spirit of co-production. This means driving strong and meaningful connections to help address access and poor experience while tackling systemic discrimination and racism, and fostering culturally relevant communication. It also means ensuring services are designed with communities, not just for them, and advocating for early intervention by using familiar safe spaces and trusted voices.

For communities, this is about:

- Valuing community assets - existing community resources, local knowledge and social networks like hubs, faith forums, arts etc (the Community Creative Health Initiatives)
- Addressing discrimination by eliminating systemic barriers like racism and bias
- Empowerment and involvement in the spirit of co-production in designing solutions, not just being consulted, to build trust and ensure relevance
- Cultural relevance by ensuring services and information, including health literacy, are delivered with or by trusted, relatable people from their own communities and not just imposed by outsiders
- Healthcare that is easy to access, both digitally and physically, and where people feel respected and heard by staff

Berkshire Healthcare has used a pragmatic approach of making every community contact/ forum count by **discovering** where they are, **engaging, empowering,** and collaborating with them through both INREACH (CommUNITY Forum; every two months) and OUTREACH (weekly communities' calendar year events and activities; some of which are in the evenings and weekends) work rooted in trust, respect, and value for each. This has included work with the communities of faith whose voice is very insightful and the monthly Health Inequalities conversation with the VCS CEOs of our two deprived areas of focus, Slough CVS and Reading ACRE. This blended approach has helped us embrace the community's voice in aligning with what the data is telling us.

From these, two key areas of focus have been established:

Mental health inequalities: Underuse of services among ethnic minority groups and men is influenced by stigma and cultural barriers. There is a need for culturally tailored support, safe spaces, community champions and peer mentoring to improve access and engagement. A stronger focus on men's and young people's mental health, alongside women's health, is also required. This approach would help build community resilience and improve mental health literacy through open conversations about issues such as anxiety, depression, social isolation and stress, which are increasingly affecting young people, migrant communities, asylum seekers and refugees

Challenges in accessing healthcare services due to language barriers, lack of awareness and transport issues. This can lead to people accessing services only when needs have reached crisis point.

Children and families: challenges in early maternity care, high childhood obesity and emotional health needs calls for parenting support, safe spaces and addressing domestic violence, FGM, and menopause.

Physical health: Heavy burden of diabetes, hypertension, cardiovascular and respiratory illness; barriers to GP/specialist access; need for integrated diet, exercise and mental health interventions.

In summary:

Inequalities are experienced across children's, adults', mental and physical health services, with ethnic groups facing the most significant gaps. Berkshire Healthcare is committed to continuing its engagement with communities and the VCSE in delivering its Health Inequalities Strategy and improving outcomes.

This is further underpinned by:

- Our vision, values, anti-racism action statement and carer charter
- Patient Carer Race Equality Framework (PCREF)
- NICE guidelines on community engagement
- Working in Partnership with People and Communities: Statutory Guidance and NHS Standard Contract
- Culture of Care Framework

From Berkshire Healthcare service data

What the service data is telling us:

Mental health: access gaps and high physical health burden

Berkshire Healthcare service data shows that people with **Severe Mental Illness** (SMI) experience significantly higher prevalence of diabetes, hypertension, heart failure and coronary heart disease (CHD) across Berkshire, with Reading and Slough showing the largest inequalities.

Our access data reveals that Asian/Asian British and Black/Black British groups are underrepresented in our community mental health service team caseloads and face longer waits, with some Black demographic groups waiting significantly longer.

Regardless of ethnicity, people from the most deprived areas also face delays, with the people from the most deprived areas waiting up to 17 weeks longer.

Children, families and young people: underrepresentation and long waits

Asian and Black children are significantly underrepresented in mental health services for children and young people (CAMHS) and neurodiversity services, with Asian children also experiencing the longest waits.

Our data also tells us that maternal and perinatal mental health services show underrepresentation and longer waits for Asian and Black women, with data highlighting disparities by ethnicity and local authority area.

Learning disabilities: lower identification and longer waits

People living with a learning disability have a higher prevalence of mental illness, heart failure, chronic heart disease (CHD), hypertension and diabetes. Our data reveals that people with a learning disability face longer waits for Adult Community Mental Health Team (CMHT) services and longer waits for community physical health services.

Community physical health: ethnic and geographic variation

Across respiratory, cardiovascular and musculoskeletal (MSK) services, Asian and Black groups are underrepresented despite a known higher need.

Diabetes services: high burden, uneven access

Diabetes prevalence is highest in Slough. Asian and Black communities are underrepresented in the Berkshire Healthcare caseloads despite a higher disease burden. Wait times vary, with some groups waiting up to 11 weeks, compared to 6–7 weeks for others.

In summary:

Inequalities in access and outcomes can be seen across all three divisions – community physical health, mental health and children and families. Patients from ethnic backgrounds face the most significant gaps, while deprivation is also seen to influence access. Data completeness issues (especially ethnicity recording) obscure the true scale of need and therefore, better integration, equity-focused pathways and improved data quality are essential. We are committed to making the changes we can make as a healthcare provider of community physical and mental health services across Berkshire for children, young people, adults, and older adults.

Our **Ambition**

We will reduce health inequalities by ensuring equitable access to our services and improving health outcomes for our most vulnerable patients and communities. We will address the wider determinants of health by looking at our day-to-day activities to see where we can generate wider social, economic and environmental benefits.

The priorities for 2026 onwards

The Community priorities

Throughout 2024 and 2025, Berkshire Healthcare worked with Reading ACRE (Alliance for Cohesion and Racial Equality) and Slough CVS (Council of Voluntary Services) to engage local communities on the areas of health inequalities that matter most to them. Out of this engagement, two flagship health inequalities projects have been jointly agreed. The first focuses on men's mental health in Reading, responding to community concerns showing poorer mental health indicators, access gaps, and long waits for psychological therapies amongst young men, particularly those from Black/Black British and Asian/Asian British backgrounds. Building on existing biweekly men's mental health forums facilitated with Cognitive Behavioural Therapy (CBT) input, the project will increase awareness and encourage open conversations about men's mental health among minority communities in Reading through community engagement and peer discussions with the overall aim to improve health-seeking behaviour on mental health issues.

The project will define a clear cohort (likely ages 16–24), map access and waiting time disparities, strengthen outreach with culturally competent partners such as ACRE, and develop measurable outcomes linked to improved early identification and engagement.

The second flagship project responds to consistent data insights and community intelligence, identifying significant inequalities in women's and perinatal mental health access and experience in Slough. Trust level health inequalities reviews and Slough focused discussions highlight the underrepresentation of Asian, Asian British, Black and Black British women within perinatal and maternal mental health services, alongside longer waits, variable engagement, and gaps in ethnicity data that limit service responsiveness and equity (but not limited to these ethnicities and will be wider community-focused). Community feedback gathered through Slough CVS and voluntary sector partners further indicates that stigma, language barriers, low health literacy, and fear or mistrust of statutory services continues to prevent timely access to support, particularly for women from migrant, asylum seeking, and racially minoritised communities. Covering pregnancy through up to two years post birth, this project prioritises perinatal mental health and nutrition as areas where community led, culturally competent approaches are most likely to address identified access gaps.

The project will work through trusted community groups, train community champions, and use conversational, non clinical engagement methods to improve health literacy, confidence, and awareness of support pathways.

Both projects will be structured using the new project charter template, with clear SMART objectives, risk and benefit tracking, and defined data collection plans aligned to the Health Equity Assessment Tool.

Working with our partners

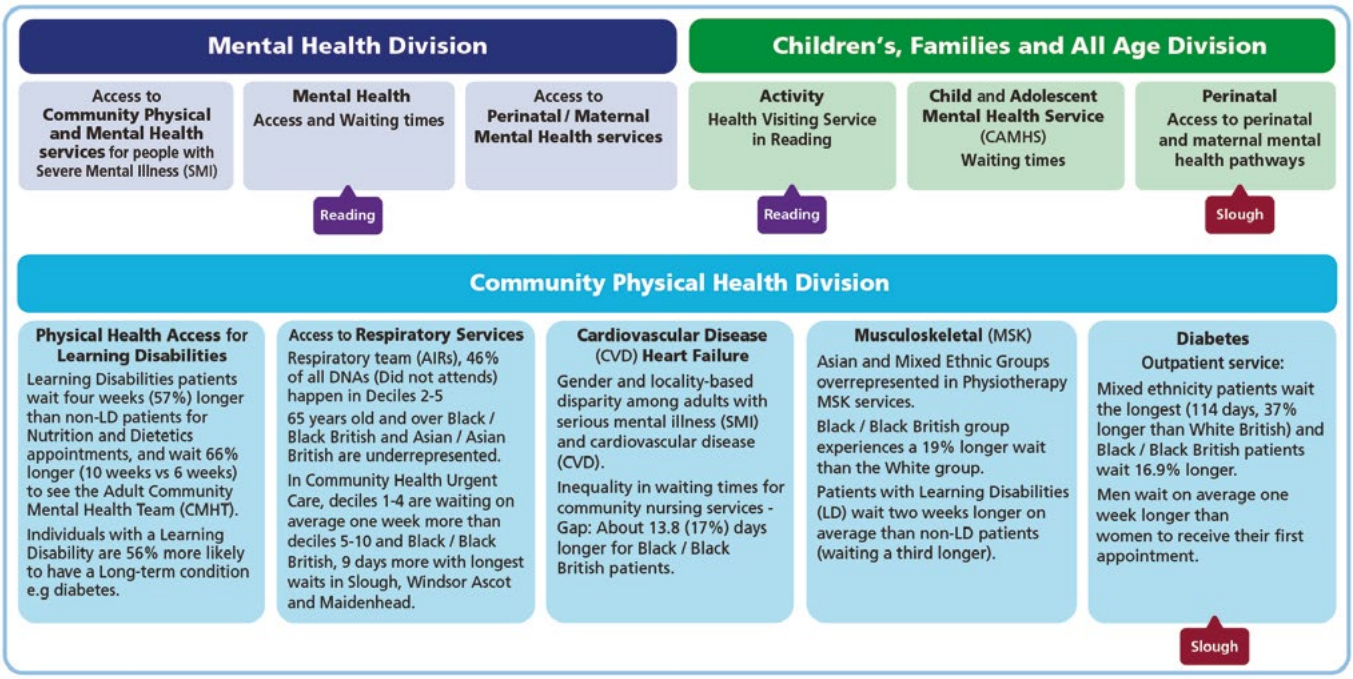
We will explore the opportunity to formally become a Marmot Trust. This would mean that we explicitly recognise that health and health inequalities are mostly shaped by the social determinants of health: the conditions in which people are born, grow, live, work and age, and take action to improve health and reduce health inequalities. That we can and will support people in ill health and reduce any inequalities in our service offer, but that we will also work with our partners to tackle the systemic causes of these inequalities.

In developing this strategy, we have worked closely with the Slough and Reading Public Health teams. Each of the six local authorities across Berkshire has a Health and Wellbeing Board with a clear Health and Wellbeing Strategy setting out the priority areas for each Place, built on the population need data set out in the Joint Strategic Needs Assessment.

Working in partnership strengthens our ability to make a difference beyond the three domains of access, outcomes and experience and allows us to influence the structural causes of health inequalities. Berkshire Healthcare will work proactively with the Berkshire local authorities to ensure we are active participants in delivering the wider health and wellbeing plans.

Berkshire Healthcare Priority areas

Top 10 priorities for BHFT 2026–2029



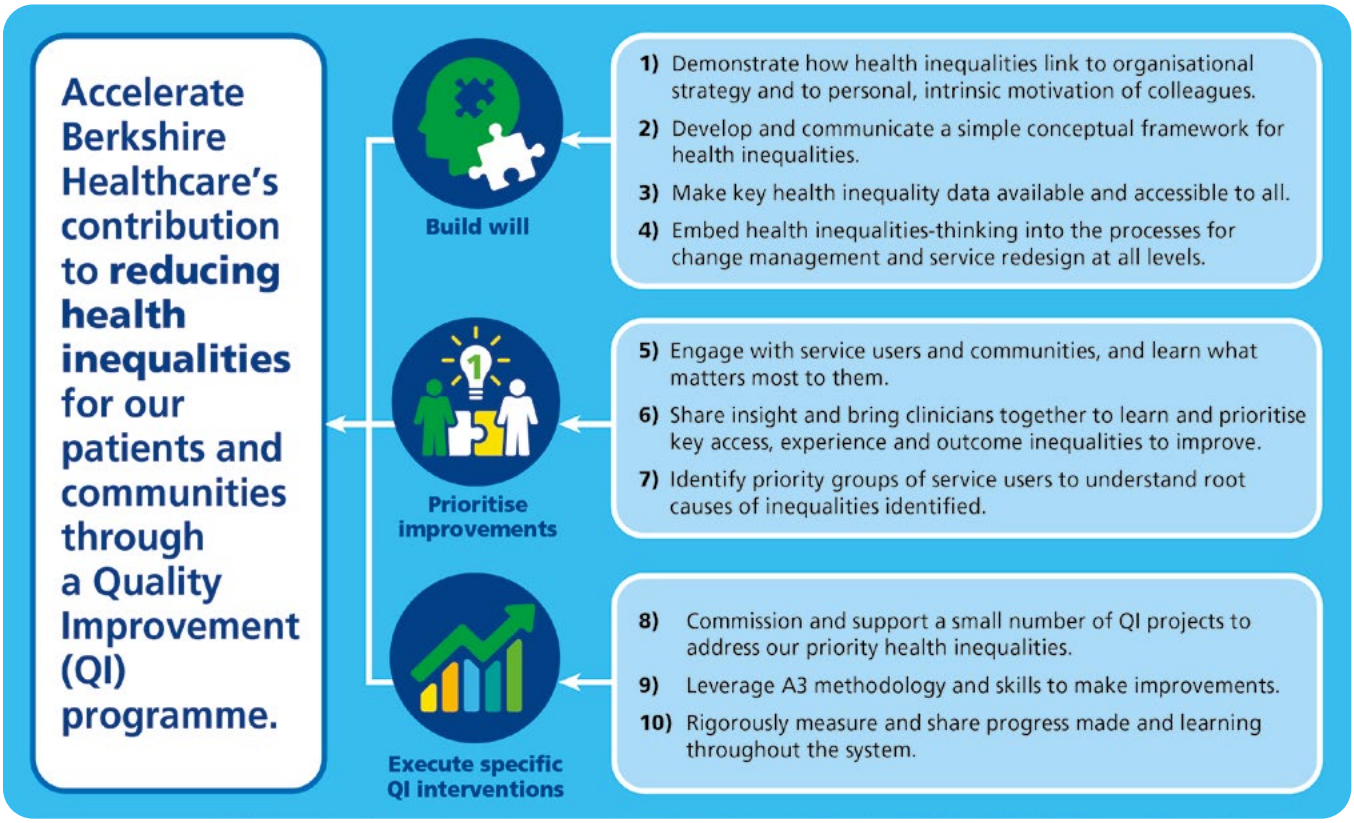
The **Top 10 areas** highlight the priority inequalities across Berkshire Healthcare's Mental Health, Children, Families and All Age Services Division (CFAA) and Community Physical Health Division, focusing on where the greatest gaps in access, outcomes and need are emerging.

These areas span Severe Mental Illness (SMI) access, mental health and mental health services for children and young people (CAMHS) waiting times, perinatal care, physical health access for people with learning disabilities, respiratory and cardiovascular disease, MSK (musculoskeletal) and diabetes.

By reviewing current interventions, gathering community and service feedback, and agreeing on shared aims and thresholds, these priorities will shape the development of the **Health Inequalities Progress Dashboard** and guide targeted action in **Reading** and **Slough.**

QI supported health Inequality work

Since 2023, we have embedded health inequalities thinking into our Quality Management Improvement System and all Quality Improvement (QI) training, encouraging teams to use health inequalities data in developing and agreeing their scorecard and driver metric focus. We have worked with teams to demonstrate how health inequalities link to quality improvement and organisational strategies, and have helped colleagues to understand and reduce inequalities in their services. We have also supported QI Yellow Belt and Green Belt practitioners in operational teams to lead local projects and progress their Plan-on-a-Page objectives.



We will continue to leverage the **Quality Management Improvement System (QMIS**) and our A3 problem solving approach to support colleagues in leading Quality Improvement (QI) projects to improve equity, with a focus on the areas identified by our data and our communities. This includes the work to improve equity of access to the Health Visiting service in Reading.

Our new Yellow-Belt and Green-Belt QI trainees will also be supported to apply a health inequalities lens to their work and demonstrate improvements in these areas.

The improvement projects to be initiated in the year ahead will be aligned to team-level improvement priorities, either identified through local improvement huddles or as driver metrics for their team. QI projects supported by Green Belts are selected through divisional project prioritisation processes as well as annual discussion at divisional Objective Dialogue. Progress on these projects will be reported through the usual QMIS channels, and highlights and learning will be provided to the Health Inequalities Oversight Group.

Mental Health Act Detentions

As of April 2026, Black people were still 2.25 times as likely as white people to be detained under the Mental Health Act. Various studies on disparities in the use of the Mental Health Act among ethnic groups found either no explanation for the variation in risk of detention, or inadequate evidence to support explanations such as **"higher co-morbid drug use in ethnic groups, language barriers, poorer detection of mental illness and greater stigma of mental health issues".**

This is an unacceptable health inequality, and Berkshire Healthcare has had a dedicated programme of work over the last two years, focusing on the drivers of these inequalities and identifying the interventions we need to make to eradicate this variation.

We have:

- **Increased engagement:** Notable increase in engagement from Black communities through outreach work, workshops collaboratively held in community spaces and acting on feedback.
- **Improved Pathways:** Standard Operating Procedures (how a service works) and referral pathways are being updated to reflect Equality & Quality Impact Assessment (EQIA) findings, making services more accessible and equitable.
- **Community Collaboration:** Stronger links with voluntary sector partners Reading ACRE, Slough CVS and the Berkshire Healthcare CommUNITY Forum with new support offers and feedback mechanisms in place.
- **Co-production of Advance Choice Documents:** started in September 2025, with positive input and active engagement from Black people with lived experience of living with mental health conditions, and from carers who have supported their loved ones who have been detained.
- **Enhanced Staff Awareness:** Continuous engagement with Berkshire Healthcare staff to raise awareness and link the impact of the project in fostering positive behavioural changes.

The MHA detentions programme has provided real, practical examples of systematic racism and ways to proactively mitigate that impact, and is linked to our Anti-racism Strategy found here Unity Against Racism | Nexus.

The learning from the MHA Detentions programme of work is fundamental to changing the way mental health services are delivered and the experience people have of them. The programme of work has now transferred to the Mental Health Division to inform practice and service design.

The key areas include:

Equality in Detentions:

Our aim is to achieve parity across all ethnicities in hospital detentions, ensuring that these figures accurately reflect the demographic profile of the total Berkshire population by the year 2030. As part of this and completing the MHAD programme, we aim to remove the variation in detention rates for Black people compared to White by the end of 2027/28. This commitment is integral to promoting fairness and addressing disparities within our healthcare system.

Reducing Detentions and Readmissions:

We are dedicated to lowering both the total number of detentions and the frequency of readmissions to hospital. A key strategy in this effort is the widespread adoption of the Advanced Choice Document by 2027/28, which empowers patients to make informed decisions about their care and supports preventative approaches.

We will continue working in partnership with police services and other non-health partners to improve the overall level of cultural competency and the ability to tackle the structural causes of increased detentions.

Enhancing Collaborative Communication:

Ongoing collaboration and communication remain central to our mission of strengthening partnerships and providing robust support for our patients. It is also a key element of the Patient Carer Race Equality Framework (PCREF) that we are committed to delivering. By consistently engaging with stakeholders and responding to feedback ("You said, we did"), we will build a more culturally appropriate, connected and responsive healthcare environment.

We set ourselves the timescale of 2027 in line with our PCREF local plan but recognise that engagement is an ongoing relationship, and we must be open to listening, learning and improving on an ongoing basis. Continued meaningful engagement with local Black communities to build trust in the service, promote the benefits of talking therapies and CBT, and to inform the design and delivery of services in the future.

Data and reporting:

Enhance the quality of data collected in the Trust to improve population health planning and support delivery of the Patient and Carer Race Equality Framework (PCREF), reporting to the Trust Equity Partnership.

PCREF and the coproduction work

The Patient and Carer Race Equality Framework (NHS England » Patient and carer race equality framework) sets out how to tackle racism in mental health services and includes how we develop services with local communities. As part of PCREF, we have developed our organisational approach to co-production and started to support and coach colleagues in working together with service users, carers and communities to improve our services. Our approach recognises that co-production is an aspiration and should not be thought of in 'all or nothing' terms. Any form of consultation, involvement or collaboration with communities and people who use our services can be meaningful if it is done thoughtfully and with careful consideration.

In 2025, we co-produced and published an organisational Co-production Framework, which sets out the levels, methods and opportunities for co-production with examples throughout. We have also developed a co-production toolkit, which provides practical, straightforward guidance for colleagues.

The work will continue alongside this strategy to provide accessible training to raise understanding and awareness among leaders and colleagues, as well as creating and sharing resources for communities and patients explaining what co-production is, how it works, and its value.

We will also be supporting colleagues at all levels to deliver on our Plan-on-a-Page commitment to **"always include patients, carers and partners as we make changes to services"** focusing on improving equity in access, experience and outcomes.

Social value

Addressing inequality by generating social value in our activities:

Social value initiatives can tackle health inequalities by addressing the underlying social factors that influence our health. By enhancing social value, we positively influence critical factors such as access to education, employment opportunities, social networks, and overall wellbeing.

The following factors show social value actions that could be taken, mapped against the key social determinants of health areas for action as recommended in the Marmot Review [(Fair Society Healthy Lives full report).]

Targeted recruitment:

We will target schools in the more deprived areas in Berkshire to promote Berkshire Healthcare and NHS careers.

Health literacy:

Health literacy covers both personal health literacy, defined as "being able to find, understand, and use information and services to inform health-related decisions and actions for yourself and others", and organisational health literacy - organisations enabling people to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.

The learning from community engagement and the quality improvement (QI) project on the Nutrition and Dietetics service in Slough suggests that Berkshire Healthcare could significantly improve our health literacy in enabling people to find, understand and use information about Berkshire Healthcare services. This, and the work to improve personal health literacy, will be co-produced with our VCSE partners and will inform the communications strategy of the developing integrated neighbourhood teams.

Seldom heard voices:

In addition to improving our approach to health literacy, we also need to improve how we, as Berkshire Healthcare, reach into and hear from communities whose voices are less often heard. This is not a homogenous group, and we are committed to working with our VCSE and community colleagues to ensure all voices are heard.

Our other strategies:

Anti-racism: anti-racism-strategy-update-for-june-2023.pdf

Corporate Strategy: bh402-corporate-strategy-20232025-digital-bookletfinalpdf.pdf

Culture, Inclusion and Equity Framework: edi-strategy-202124pdf.pdf

Friends, Families and Carers Strategy: bh1246-friends-family-and-carers-strategy.pdf

Neurodiversity: PowerPoint Presentation

Search **'Reducing Health Inequalities'** on Nexus

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RACE EQUALITY MATTERS TRAIL BLAZER

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CareQuality Commission Inspected and rated Outstanding

#NoExcuseForAbuse We will be polite and kind and we expect you to treat our staff in the same way. We will take action against anyone who is verbally, racially, physically or sexually abusive, including stopping access to our services.