Berkshire Healthcare
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

TRUST BOARD MEETING

(conducted electronically via Microsoft Teams)

10:00am on Tuesday 10 November 2026

AGENDA

No	Item	Category	Presenter	Enc.	Timings
OPENING BUSINESS					
1.	Chair's Welcome and Public Questions	Note	Frances West, Chair	Verbal	10.00
2.	Apologies	Note	Frances West, Chair	Verbal	
3.	Declaration of Any Other Business	Assurance	Frances West, Chair	Verbal	
4.	Declarations of Interest i. Amendments to the Register ii. Agenda Items	Assurance	Frances West, Chair	Verbal	
5.1	Minutes of Meeting held on 08 September 2026	Decision	Frances West, Chair	Enc.	
5.2	Action Log and Matters Arising	Assurance	Frances West, Chair	Enc.	
QUALITY					
6.0	Board Story – Mental Health in Schools Team	Assurance	Debbie Fulton, Director of Nursing and Therapies/Rhona Edwards, Service Manager, Getting Help Service	Verbal	10.05
6.1	Freedom to Speak Up a) Freedom to Speak Up Guardian's Six-Monthly Report b) Development Plan for Freedom to Speak Up Self-Assessment 2026-28	Assurance	Mike Craissati, Freedom to Speak Up Guardian Debbie Fulton, Director of Nursing and Therapies	Enc.	10.30
6.2	Patient Experience Quarterly Report	Assurance	Debbie Fulton, Director of Nursing and Therapies	Enc.	10.45
6.3	Board Report Summary - Thirlwall Inquiry Report and NHS England Actions	Assurance	Debbie Fulton, Director of	Enc.	10.50

No	Item	Category	Presenter	Enc.	Timings
			Nursing and Therapies		
6.4	Six Monthly Safe Staffing Report *(NB the Finance, Investment and Performance Committee reviews the monthly Safe Staffing Reports)*	Assurance	Debbie Fulton, Director of Nursing and Therapies	Enc.	11.00
EXECUTIVE UPDATE					
7.0	Executive Report	Assurance	Julian Emms, Chief Executive	Enc.	11.10
7.1	Reducing Violence and Aggression Update Report	Assurance	Debbie Fulton, Director of Nursing and Therapies	Enc.	11.20
7.2	NHS Staff Standards Report	Assurance	Alex Gild, Deputy Chief Executive/Jane Nicholson, Director of People	Enc.	11.30
PERFORMANCE					
8.0	a) Month 06 2026/27 Finance Report b) Advanced Foundation Trust Financial Flexibilities	Assurance Assurance	Paul Gray, Chief Financial Officer	Enc.	11.40
8.1	Month 06 2026/27 Performance Report	Assurance	Theresa Wyles, Chief Operating Officer	Enc.	11.50
8.2	Finance, Investment and Performance Committee Meeting held on 28 October 2026	Assurance	Sonya Batchelor, Chair, Finance, Investment and Performance Committee	Verbal	12.00
STRATEGY					
9.0	People Progress Report	Assurance	Alex Gild, Deputy Chief Executive/Jane Nicholson, Director of People	Enc.	12.05
9.1	Proposal to Consolidate Community Hospital Beds in Berkshire West Report	Decision	Theresa Wyles, Chief Operating Officer	Enc	12.15
CORPORATE GOVERNANCE					
10.0	Audit Committee Meeting held on 28 October 2026	Assurance	Rajiv Gatha, Chair, Audit Committee	Enc.	12.25
10.1	Council of Governors Update	Note	Frances West, Chair	Verbal	12.30
Closing Business					
11.	Any Other Business	Note	Frances West, Chair	Verbal	
12.	Date of the Next Public Trust Board Meeting – 12 January 2027	Note	Frances West, Chair	Verbal	
13.	**CONFIDENTIAL ISSUES:**	Decision	Frances West, Chair	Verbal	

No	Item	Category	Presenter	Enc.	Timings
	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.				

Unconfirmed minutes

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Minutes of a Board Meeting held in Public on Tuesday, 08 September 2026

(Conducted via Microsoft Teams)

Present:	Frances West	Trust Chair
	Aileen Feeney	Non-Executive Director
	Sonya Batchelor	Non-Executive Director
	Rajiv Gatha	Non-Executive Director
	Sally Glen	Non-Executive Director
	Manjeet Aujla	Non-Executive Director
	Julian Emms OBE	Chief Executive
	Alex Gild	Deputy Chief Executive
	Debbie Fulton	Director of Nursing and Therapies
	Paul Gray	Chief Financial Officer
	Dr Tolu Olusoga	Medical Director
	Theresa Wyles	Chief Operating Officer
In attendance:	Julie Hill	Company Secretary
	Versha Mandalia	Associate Nurse Consultant *(present for agenda item 6.0)*
	Helen Bowden	Named Worker *(present for agenda item 6.0)*
	Jane Nicholson	Director of People *(present for agenda items 7.1, 9.0 and 9.1)*
Observers:	James DeCothi	CQC Inspector
	Brian Wilson	Lead Governor
	Megan Wright	Partnership Governor

26/157	**Welcome and Public Questions** (agenda item 1)
	The Chair welcomed everyone to the meeting and particularly welcomed James DeCothi, CQC Inspector, who was observing as part of the Trust's forthcoming CQC Well-Led inspection.

	The Chair introduced Manjeet Aujla who was attending his first meeting as a Non-Executive Director. The Chair also thanked governors who were observing the meeting. The Chair confirmed that the August Trust Board meeting was cancelled as planned as there were no urgent matters of business. There were no public questions.
26/158	**Apologies** (agenda item 2)
	There were no apologies.
26/159	**Declaration of Any Other Business** (agenda item 3)
	There was no other business.
26/160	**Declarations of Interest** (agenda item 4)
	i. Amendments to Register – none.
	ii. Agenda Items
26/161	**Minutes of the previous meeting held on 14 July 2026** (agenda item 5.1)
	The minutes of the Trust Board meeting held in public on Tuesday, 14 July 2026, were approved as a correct record.
26/162	**Action Log and Matters Arising** (agenda item 5.2)
	The schedule of actions had been circulated. **The Trust Board**: noted the report.
26/163	**Board Story** – **Mental Health Patient** (agenda item 6.0)
	The Chair welcomed Versha Mandalia, Associate Nurse Consultant and Helen Bowden, Named Worker to the meeting. The Director of Nursing and Therapies explained that the presentation reflected the patient's own words, although the patient had chosen not to present personally. Versha Mandalia and Helen Bowden presented the patient's story.

	“Theodora” (a pseudonym) was a 39-year-old woman with a long history of engagement with mental health services. Her story focused on transitions between inpatient and community care, her experience in an out-of-area bed and the factors that supported her recovery. **Continuity of Care Was Critical** • Theodora emphasised the importance of having consistent professionals involved throughout her care journey. • Theodora valued ongoing support from staff who maintained contact with her across different care settings, including during out-of-area placements. • Theodora had three psychiatrists during this episode of care, which she found challenging. **Being Listened To and Treated as an Individual** • Theodora identified communication, honesty, reliability and empathy as the qualities she most valued in healthcare professionals. • She reflected that feeling heard and understood was fundamental to her ability to engage with services and develop trusting therapeutic relationships. **Challenges During an Out-of-Area Placement** • Theodora described difficulties she experienced during an out-of-area admission. • Concerns she raised about aspects of her care were formally escalated and discussed with the external provider. • She found being cared for on a mixed-sex ward particularly challenging, which contributed to safeguarding concerns. • Following her complaints, staff ensured that Theodora's voice was heard directly by those involved in providing her care. **Importance of Housing to Recovery** • One of the most significant positive factors in Theodora's recovery was obtaining her own home in Newbury. • Having secure and independent accommodation provided stability, improved wellbeing and supported her successful transition back into community life. • Her experience demonstrated the important role that housing and wider social factors play in mental health recovery. **Collaborative Working Across Services** • Theodora spoke positively about the coordinated approach taken by inpatient and community teams. • Planning for her admission began before she entered hospital, with different professionals working together to coordinate support.

	The Chief Operating Officer asked whether feedback about Theodora's experience of the outsourced ward had been shared with the provider. Versha Mandalia confirmed that concerns had been raised during the admission and formally fed back to the outsourced ward provider. The Chief Operating Officer suggested that feedback from contract monitoring discussions should be reviewed by Prospect Park Hospital Senior Leadership Team to ensure learning and actions were taken. **Action: Chief Operating Officer** Helen Bowden explained that staff had worked with Theodora to help her express her concerns directly to the provider. She stated that this allowed the patient to explain the impact of the experience herself and encouraged learning. The Medical Director asked whether anything could have been done differently regarding Theodora having three different psychiatrists. Helen Bowden responded that changes in clinicians had not created major difficulties and confirmed that Theodora had adapted well. It was noted that her current psychiatrist used a trauma-informed approach that had helped strengthen her voice and engagement. Sonya Batchelor, Non-Executive Director, thanked the patient for sharing her experience and remarked that the case demonstrated the Trust’s commitment to hearing the patient voice. She linked the story to improvements in patient experience measures and transition outcomes. Aileen Feeney, Non-Executive Director, asked for clarification regarding references to safeguarding concerns. Versha Mandalia explained that the concerns related largely to Theodora's trauma history and difficulties arising from placement on a mixed-sex outsourced ward. The Chair commented that the story brought operational data to life and demonstrated the complexities of managing outsourced placements. The Chair thanked Versha Mandalia and Helen Bowden for sharing Theodora’s story and requested that they thank Theodora on behalf of the Board. Helen Bowden commented that Theodora would appreciate a letter of appreciation from the Board. The Chair confirmed that she would be very happy to write a thank you letter to Theodora. **Action: Chair/Company Secretary** The presentation slides are attached to the minutes.

	The Trust Board: noted the presentation.
26/164	**Patient Experience Quarterly Report** (agenda item 6.1)
	The Director of Nursing and Therapies presented the paper and, for the benefit of the new Non-Executive Director explained the background to the "I Want Great Care" patient feedback tool and highlighted the following points: • The tool had been co-produced with patients, staff and governors and provided a consistent feedback mechanism across Trust services. Feedback, compliments and co-production activity informed service improvement and organisational learning. • Nearly 13,000 responses had been received during the reporting period, including free-text comments. • Complaints represented approximately 0.03% of contacts. The Director of Nursing and Therapies highlighted challenges arising from lengthy AI-generated complaint submissions, which did not always clearly identify the key concerns or desired outcomes. Where appropriate, complainants were asked to provide a concise summary to support resolution. The Chair commented that since joining the Trust she had been impressed by the breadth and quality of information generated through the patient experience programme. Sally Glen, Non-Executive Director, asked whether feedback could identify voices from areas such as Slough and parts of Reading, and demonstrate whether experience was improving in more deprived communities. The Director of Nursing and Therapies explained that current reporting was mainly by division and agreed to explore more detailed geographical analysis. **Action: Director of Nursing and Therapies** The Deputy Chief Executive added that I Want Great Care must be triangulated with community engagement because populations that access services less often may be absent from the dataset. The Chief Executive encouraged use of the I Want Great Care feedback platform not only to assess current services but also to work with patient groups on future models, including self-care, virtual wards, and changing expectations about continuity and support. The Director of Nursing and Therapies said that the next priority was to focus on services with lower positivity scores, while recognising that some service contexts, such as detained mental health care, may affect ratings.

	Sonya Batchelor, Non-Executive Director, commended the Trust's detailed scrutiny of complaints and said it reflected a genuine culture of learning, improvement and leadership commitment to patient experience. **The Trust Board:** received assurance from the report.
26/165	**Quality Assurance Committee** (agenda item 6.2)
	a) Quality Assurance Committee Meeting held on 25 August 2026 Sally Glen, Chair of the Quality Assurance Committee, provided an update from the meeting held on 25 August 2026 and highlighted the following points: • **Carers Strategy** – the Committee received a presentation on the Trust's Carers Strategy. • **Assertive Outreach Programme** – the programme, developed following the Nottingham Homicide Review and supported by £600,000 of external funding, had moved into implementation. It would support patients with complex needs who may be reluctant to engage, with around 120 patients identified and work underway on governance, digital development, service design and success measures. • **Ockenden Report –** the Committee considered the Trust's assessment against relevant recommendations from the Ockenden Review, including organisational learning, governance, staff wellbeing and patient and family engagement. The Committee was assured that existing arrangements aligned well and that no significant concerns had been identified. • **Prospect Park Fire Safety Update -** the Committee reviewed ongoing fire safety remediation works at Prospect Park Hospital and received assurance that appropriate mitigations, oversight and risk management arrangements remained in place, noting the increased operational risk associated with construction activity and scaffolding. • **Patient Safety and Learning Report -** the Committee received the quarterly report and was assured that the Trust remained compliant with the Patient Safety Incident Response Framework. • **CAMHS Waiting Time Performance Metric -** the Committee considered an emerging performance risk associated with national reporting of children waiting over 104 weeks. The Chief Operating Officer clarified that the Trust had no children waiting longer than 52 weeks for mental health services. The issue related solely to how waiting times were calculated and reported nationally when neurodiversity pathways remained open following completion of mental health interventions. **b) Changes to the Committee's Terms of Reference**

	The Board considered proposed amendments to the Committee's Terms of Reference. It was noted that the main change was the transfer of responsibility for oversight of the Clinical Audit Programme from the Audit Committee to the Quality Assurance Committee. Ms Glen reported that the Committee had agreed that this more appropriately aligned clinical audit activities with the Committee's quality and safety remit. **c) NHS Quality Strategy** The Director of Nursing and Therapies reported that the Trust had undertaken a self-assessment exercise against the requirements of the newly published NHS Quality Strategy. The assessment concluded that the Trust's quality improvement arrangements, patient safety programmes and health inequalities work aligned well with the expectations set out in the national framework. The Committee had agreed that the results of the Trust's self-assessment against the requirements of the NHS Quality Strategy should be shared with the Trust Board. **d) Learning From Deaths Quarterly Report** The Medical Director reported that one physical health death had been identified as being potentially avoidable. Two reviews had identified episodes of poor care. Learning from Deaths themes included documentation, communication, escalation and continuity of care, and actions were being progressed within the divisions. Manjeet Aujla, Non-Executive Director asked about the distinction between an avoidable and an unexpected death. The Medical Director explained that avoidability related to whether actions could reasonably have prevented the death, whereas unexpected deaths referred to deaths not anticipated due to clinical circumstances. The Director of Nursing and Therapies further illustrated the difference using examples of expected end-of-life care and sudden unexpected deaths. **e) Guardian of Safe Working Report** The Medical Director reported that five exception reports had been received, one of which was subsequently withdrawn and that no fines had been incurred. **The Trust Board**: a) Received the minutes and reports for assurance. b) Ratified the changes to the Quality Assurance Committee's Terms of Reference.
26/166	**Winter Planning Assurance Report** (agenda item 6.3)

	The Chief Operating Officer outlined the Trust's winter planning arrangements and highlighted the following points: • **Escalation Arrangements:** The Berkshire West winter demand reduction and management group will share learning with the Frimley system. Operational Pressures Escalation Levels (OPEL) action cards define actions for each partner as pressures rise; for the Trust, an OPEL 4 position can reflect mental health bed delays and poor flow, requiring system partners to strengthen discharge planning. Data is submitted through the regional oversight system. • **Operational Preparedness:** Internal operational groups will operate weekly from November through March, with more frequent meetings if required. Infection prevention and control arrangements have been reviewed, and the formal flu vaccination campaign will begin on 1 October. The Chief Operating Officer explained that she would attend the Southeast regional winter-testing session before submitting the detailed assurance template to NHS England. The session would test whether local plans collectively addressed winter pressures, after which the Chair and Chief Executive would provide final sign-off. Sally Glen, Non-Executive Director, asked whether national discussions were taking place on planning for summer heat-related pressures. The Chief Operating Officer explained that the Trust's adverse-weather plan covered winter conditions, excessive summer heat, and drought. It was noted that system-wide work was continuing to develop a more explicit approach to summer pressures following the prolonged period of extreme heat. **The Trust Board:** agreed to delegate authority for signing the final Winter Planning Submission to the Chair and Chief Executive once the Chief Operating Officer had completed regional testing and the plans had been confirmed.
26/167	**Executive Report** (agenda item 7.0)
	The Executive Report had been circulated. The following items were discussed further: **a) NHS Quality Strategy** The Chief Executive reported that the NHS Quality Strategy had been published on 14 July 2026. The Trust's self-assessment demonstrated strong alignment with the national requirements and the Trust's quality work (see minute 26/165 above). **b) Resident Doctors**

	The Chief Executive noted that the resident doctors' dispute related not only to pay but also to wider terms and conditions, working environments, professional development and employment experience. The Medical Director reported that the pay reform measures had been agreed nationally and would be implemented in April 2027, backdated to April 2026. It was noted that the national agreement also addressed wider training issues, including costs incurred by resident doctors during professional development and examinations. It was anticipated that the costs associated with initial examination attempts and certain mandatory training activities would be met centrally, although further operational guidance was still pending. The Medical Director reported that within the Trust, locally employed doctors were already being considered within workforce planning arrangements to ensure they had opportunities for career development and progression similar to those available within formal training pathways. The Medical Director reported that the Trust had implemented all but one action in the national ten-point plan for resident doctors; the outstanding action related to procurement of an electronic rota system. **c) Elective Care Minimum Standards of Patient Experience** Sonya Batchelor, Non-Executive Director asked whether there were any substantive issues for the Trust in relation to the elective care minimum standards of patient experience. The Chief Operating Officer explained that elective care standards were predominantly focused on acute hospital providers. Nevertheless, the Trust had undertaken work to understand how closely its arrangements aligned with the national expectations. The Chief Operating Officer advised that the only area where full assurance had not yet been secured related to the requirement for patients on waiting lists to receive a twelve-week update. Whilst that specific process was not consistently in place, alternative safety-netting arrangements existed for patients awaiting services and there were no significant concerns requiring. **The Trust Board:** received assurance from the report.
26/168	**Health and Wellbeing Report** (agenda item 7.1)
	The Chair welcomed the Director of People to the meeting. The Chair reported that Manjeet Aujla, Non-Executive Director, had been appointed as the Wellbeing Non-Executive Director Lead. **a) Health and Wellbeing Update Report**

	The Director of People presented the paper and reported that over the past six months, the Wellbeing Team had undergone structural changes, reducing some capacity. It was noted that general health and wellbeing support included employee assistance, financial and related initiatives, while Wellbeing Matters was a clinically led psychological support service. Following organisational changes, Wellbeing Matters sat within Organisational Development and Wellbeing within Operational Human Resources. **b) Wellbeing Matters Update Report** The Director of People explained that the Wellbeing Matters service automatically contacted staff after incidents unless they opted out, and staff were also able to self-refer into the service. The service did not provide ongoing treatment; qualified psychology professionals offered first-line intervention and helped staff access appropriate care pathways. The Director of People reported that there had been a decline in the number of staff engaging with the service. The Chief Executive said Wellbeing Matters should not be judged solely by usage levels. Effective supervision, one-to-ones, leadership and early resolution of workplace issues should reduce sources of stress, with results triangulated against staff surveys and workforce information. Sally Glen, Non-Executive Director, asked whether reduced post-incident support might relate to the Patient Safety Incident Response Framework's system-focused approach. The Director of Nursing and Therapies agreed to take the issue of declining engagement with the Wellbeing Matters service to the Safety Culture Group for further exploration. **Action: Director of Nursing and Therapies** The Chair asked whether she could observe a Safety Culture Group meeting to hear the staff perspective. The Director of Nursing and Therapies agreed to forward an invitation to the Chair to attend a Safety Culture Group meeting. **Action: Director of Nursing and Therapies** **The Trust Board:** received assurance from the reports.
26/169	**Month 04 2026-27 Finance Report** (agenda item 8.0)
	The Chief Financial Officer presented the report and highlighted the following key points: • The planned outturn position for the Trust was breakeven. This was phased evenly throughout the year.

- Workforce spending remained below the previous year.
- Cash performance remained strong.
- The Trust had a cost improvement programme of £15.5m which was being achieved year to date.
- The Better Payment Practice Code targets were currently being achieved.
- Capital expenditure was behind plan, mainly due to slippage on the Jubilee Ward relocation project.
- The Trust had two NHS England temporary staffing targets. The agency target was not being achieved at month 4 but was expected to recover through action on specific posts and VAT changes for locum and agency doctors. The bank target was not being achieved and was unlikely to recover in-year, partly reflecting national target-setting rules and the Trust's overachievement in 2025/26.
- Specialist placements continued to create financial pressure, particularly PICU and out-of-area mental health beds. An overspend of approximately £800,000 was reported, and a joint procurement exercise with Oxford Health NHS Foundation Trust was underway to increase female PICU bed capacity.

Sonya Batchelor, Chair of the Finance, Investment and Performance Committee, reported that the Committee had considered the Trust's use of bank staffing and received assurance that it remained the most cost-effective and operationally appropriate workforce solution.

Ms Batchelor raised a query regarding performance reporting, noting that bank staffing metrics were reported as green despite forecasts indicating that nationally set targets would not be achieved. She suggested consideration of whether future reporting should more clearly reflect the forecast position.

The Chief Financial Officer agreed to review the presentation of this metric for future reports.

Action: Chief Financial Officer

The Chief Executive acknowledged the need to reduce agency spending and invited the Director of Nursing and Therapies to explain how the Trust deployed the staff bank.

The Director of Nursing and Therapies explained that temporary staffing within Berkshire Healthcare was overwhelmingly delivered through the Trust's own NHS Professionals bank workforce. Staff wishing to undertake additional hours joined the bank and completed relevant training requirements. This arrangement allowed the organisation to flex staffing levels rapidly in response to fluctuating demand whilst retaining skill, experience and organisational familiarity. She emphasised that the model represented a conscious workforce strategy designed to balance flexibility, responsiveness and value for money.

The Chair observed that the narrative underpinning bank staffing performance was frequently more positive than suggested by headline national metrics and welcomed the additional explanation provided.

	The Trust Board: received assurance that the Trust remained on track to deliver its financial plan.
26/170	**Month 04 2026-27 "True North" Performance Scorecard Report** (agenda item 8.1)
	The Month 04 2026-27 "True North" Performance Scorecard Report had been circulated. The Chief Operating Officer presented the report and highlighted the following points: • The Trust had moved away from amber ratings, with measures now reported as either achieving or not achieving target. The framework comprised breakthrough objectives, driver metrics and national oversight measures linked to organisational priorities. **Length of Stay and Bed Occupancy** • The Trust continued to remain off target against its breakthrough objectives for acute adult and older adult length of stay. Acute adult length of stay stood at 52 days against a target of 42 days. The position had improved during August. • Analysis showed good flow for most patients, with delays concentrated in a smaller long-stay cohort. Focused work was underway with clinical teams to address barriers for adults staying beyond sixty days and older adults staying beyond ninety days. **Violence and Aggression Towards Staff** • Seventy-one incidents had been reported during July, significantly above the target level of thirty-six incidents. Twenty-three patients were associated with these incidents, indicating repeated incidents involving a relatively small group of individuals. • Although performance remained off target, a downward trend had been evident since December. **Restrictive Interventions** • Twenty-eight incidents requiring rapid tranquillisation had occurred during July, compared with a target threshold of thirty-nine. Eleven patients were involved. Oral medication had been offered before use of intramuscular treatment in every case. This represented continuing positive performance. **Children's Community Waiting Times** • A significant improvement was reported in relation to children's community waiting lists. The August 2026 performance figures showed that the number of children

	waiting over fifty-two weeks had reduced substantially from approximately sixty cases to seventeen. **Patient Experience** • Positive patient feedback rates remained above target at 95.89% against the organisational objective of 95%. **National Oversight Framework** • The quarter one national oversight framework scores had now been received but remained subject to national embargo arrangements pending formal publication. The revised methodology now utilised fixed thresholds rather than quartile rankings, which should provide a more transparent assessment of organisational performance irrespective of the performance of other trusts. Sally Glen, Non-Executive Director, queried whether heightened reporting levels might partly reflect the implementation of Operation Cavell and wider efforts to encourage staff to report incidents. The Director of Nursing and Therapies advised that increased reporting was likely to reflect a combination of Operation Cavell, staff engagement, leadership visibility and wider cultural work. She emphasised that violence should not be regarded as inevitable and that reporting remained important for staff welfare and patient care. The Medical Director agreed that increased organisational focus was encouraging more discussions regarding incident reporting and helping staff recognise the importance of formal reporting routes, although it remained too early to understand the full impact. Sally Glen, Non-Executive Director sought an update regarding crisis care access and previously discussed concerns regarding telephone triage and 111 referrals. The Chief Operating Officer reported that approximately 6,500 calls were received by crisis services each month, but only 8-9% required formal crisis intervention. Detailed analysis of referral patterns continued, and work was underway to consider future telephone support models, although no final proposals had yet been developed. **The Trust Board:** received assurance from the report.
26/171	**Finance, Investment and Performance Committee (agenda item 8.2)**
	a) Finance, Investment and Performance Committee meeting held on 22 July 2026 Sonya Batchelor, Chair of the Finance, Investment and Performance Committee reported that the Committee had reviewed progress against the cost improvement plan and had

	welcomed the increased transparency provided through revised reporting arrangements, particularly the separation of recurrent and non-recurrent savings. This had enabled the Committee to gain a clearer understanding of the sustainability of financial recovery plans and productivity programmes. Ms Batchelor drew particular attention to the level of recurrent savings already identified during the year. The Committee recognised that, whilst delivery remained below the overall target profile, considerable progress had nevertheless been achieved. The Committee had noted that approximately £3 million of recurrent savings schemes had already been identified and acknowledged the significant amount of work undertaken by the Trust. Ms Batchelor highlighted that the Committee had acknowledged the sustained reduction in the number of rapid tranquillisation incidents over the past six months. It was noted that the Committee's current focus was on reducing inpatient length of stay. **b) Committee's Terms of Reference** Ms Batchelor reported that the Committee had made some minor changes to its terms of reference, highlighted in red in the agenda pack. The Chair thanked Sonya Batchelor for her update. **The Trust Board**: ratified the changes to the Committee's Terms of Reference.
26/172	**Workforce Race Equality Standard Report** (agenda item 9.0)
	The Deputy Chief Executive explained that the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) reports formed part of a suite of national equality standards designed to provide objective insight into workforce experience and outcomes for colleagues from ethnically diverse backgrounds and disabled staff. He emphasised that the report played an important role in supporting the Trust's wider anti-racism, equality and inclusion agenda and enabled the Board to monitor progress, identify concerns and direct future action. The Director of People advised that the report used current Connected Care demographic data for Berkshire, drawn from individuals registered with local GPs, rather than historical census data. This provided a more contemporary benchmark for assessing workforce representation. The report demonstrated that Berkshire's population was becoming increasingly diverse, particularly amongst younger age groups. Against this benchmark, the Trust's workforce remained slightly under-representative of the local population in some areas, although the organisation continued to make progress in increasing workforce diversity.

	Recruitment analysis showed that white applicants remained more likely to be appointed, although this partly reflected differing application patterns. Ethnically diverse applicants were more likely to apply for highly competitive roles, while white applicants more often applied for roles with fewer candidates. Once applicants without the right to work in the UK were removed, the difference in appointment rates reduced significantly. Casework analysis showed a disproportionate impact on male staff, particularly Black male colleagues, which appeared strongly correlated with workforce profile and job roles. Many male employees from ethnically diverse backgrounds worked in clinical areas where complex behavioural management, observation and restraint created a higher likelihood of formal investigations or casework. The Director of People reported that a detailed review of this area remained underway to better understand both systemic factors and any potential inequalities requiring intervention. Bullying, harassment and abuse remained a significant concern, with staff from ethnically diverse backgrounds reporting higher levels of abuse from colleagues and the public. The Trust continued to respond through its anti-racism programme, violence reduction work, Operation Cavell and wider safety culture initiatives. Manjeet Aujla, Non-Executive Director queried whether the recruitment and progression differences were genuinely attributable to ethnicity or whether they reflected the staff groups and professions in which individuals worked. The Director of People explained that occupational profile appeared to be a major factor. Ethnically diverse staff were disproportionately represented within nursing and healthcare support worker groups, where there were more roles available but also higher numbers of candidates applying for those roles. White staff were more commonly represented in professions such as psychology, where roles generally started at higher bands and attracted fewer applicants. The Director of People added that significant organisational investment in apprenticeships and educational support was designed to remove barriers and enable progression into occupational groups traditionally under-represented with ethnically diverse staff. **The Trust Board:** received assurance from the report.
26/173	**Workforce Disability Equality Standard** (agenda item 9.1)
	The Director of People presented the report and highlighted that approximately nine percent of the workforce had declared a disability. Whilst there had been notable progress across several indicators, disabled staff continued to report a less positive overall experience of work than non-disabled colleagues. Understanding and addressing this gap remained a priority for the organisation.

	Positive findings included evidence of parity in recruitment and promotion outcomes, demonstrating that disabled staff were progressing through organisational processes at comparable rates to non-disabled colleagues. The emphasis of future work would therefore increasingly focus on workplace experience rather than solely organisational processes. Sally Glen, Non-Executive Director observed that disability represented a very broad category encompassing many different experiences and needs. She queried whether the Trust had sufficient insight into the experiences of different groups of disabled staff, noting that colleagues with long-term physical health conditions might experience work very differently from individuals who were neurodivergent. She questioned whether reporting arrangements provided sufficient granularity to identify differing needs across those groups. The Director of People acknowledged the limitations of the current analysis and agreed that more detailed understanding was required. Current evidence suggested that neurodivergent colleagues, particularly those with autism or ADHD, appeared more likely to raise concerns about workplace support, although further work was needed before conclusions could be drawn. The Deputy Chief Executive supplemented this discussion by drawing attention to the proportion of staff who reported receiving appropriate workplace adjustments. The report demonstrated that 82.1% of disabled colleagues felt the Trust was making the adjustments required to support them at work. The Director of People explained that 55 employees had accessed the formal reasonable adjustments process, while approximately 565 adjustments had been arranged informally through line managers. Some managers required further support to implement adjustments effectively, particularly where staff expectations needed to be balanced with organisational requirements. **The Trust Board:** received assurance from the report.
26/174	**Audit Committee Meeting** (agenda item 10.0)
	a) Audit Committee Meeting 22 July 2026 Rajiv Gatha, Chair of the Audit Committee reported that the Audit Committee had reviewed the Board Assurance Framework and had agreed that the current risk score for the Workforce Risk would be reduced due to improvements in recruitment and retention. Mr Gatha reported that the Committee had reviewed the results of its annual effectiveness review and had agreed to place greater emphasis on forward-looking horizon scanning. It was noted that the Trust's Internal Auditors had agreed to run seminars before Audit Committee meetings to facilitate discussion about emerging risks.

	b) Changes to the Committee's Terms of Reference The proposed changes to the Audit Committee's Terms of Reference highlighted in red type had been circulated. Rajiv Gatha highlighted that the main change was to transfer responsibility for overseeing the Clinical Audit Programme from the Audit Committee to the Quality Assurance Committee. It was noted that the Quality Assurance Committee's minutes were presented to the Audit Committee and that this would provide assurance about the delivery of the Clinical Audit Plan. The Chair thanked Rajiv Gatha for his update. **The Trust Board:** a) Received the minutes of the Audit Committee meeting held on 22 July 2026 for assurance. b) Ratified the changes to the Audit Committee's Terms of Reference as highlighted in red type in the agenda pack.
26/175	**Trust Seal Report (agenda item 10.1)**
	The Trust's seal had been affixed to a supplementary lease with Royal Berkshire NHS Foundation Trust for the first floor of the Greenham Trust Wing at West Berkshire Community Hospital, to facilitate expansion of the chemotherapy suite. The expansion also required deeds of variation with both Royal Berkshire NHS Foundation Trust and Sue Ryder, as it involved shared floor space and affected rights of use and the apportionment of service charges. **The Trust Board**: noted the report.
26/176	**Council of Governors Update** (agenda item 10.2)
	The Chair reported that the Health Bill was progressing through parliament and, if enacted, would remove the requirement for NHS foundation trusts to have councils of governors. The Board and Council would review current public and patient engagement activity and any resulting gaps at their joint meeting on 11 November 2026. The Chair reported that the Council of Governors' Appointments and Remuneration Committee was in the process of recruiting a new Non-Executive Director with a partnership background. The interviews were scheduled for 1 October 2026. The Chair thanked Brian Wilson, Lead Governor and Megan Wright, Partnership Governor for attending and observing the Board meeting today.

26/177	**Any Other Business** (agenda item 11)
	There was no other business.
26/178	**Date of Next Public Meeting** (agenda item 12)
	The next Public Trust Board meeting would take place on 10 November 2026.
26/179	**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 due to the confidential nature of the business to be conducted.

I certify that this is a true, accurate, and complete set of the Minutes of the business conducted at the Trust Board meeting held on 08 September 2026.

Signed…….. Date 10 November 2026

NHS
Berkshire Healthcare
NHS Foundation Trust

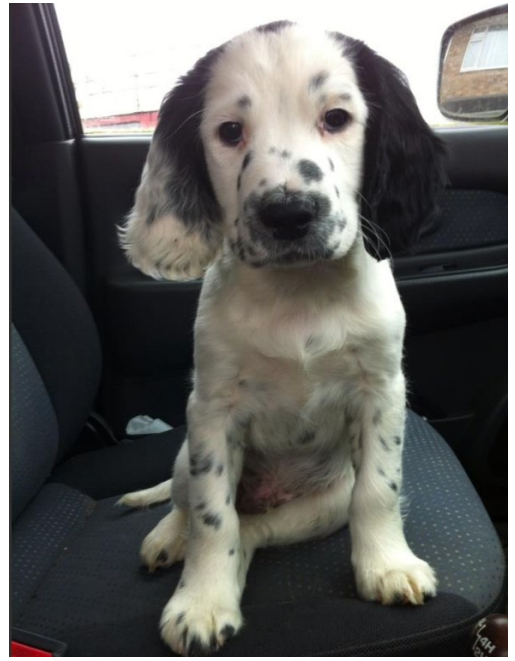
Patient Story to Executive Board

Theadora's Feedback

Patient Story

Berkshire Healthcare
NHS Foundation Trust

Theadora (pseudonym) is a 39-year-old lady with a diagnosis of Complex Post Traumatic Stress Disorder. She has been supported by services within the trust for several years, mainly during inpatient stays. Over the last 3 years Theadora has been building her life in the community, achieving going from hospital to supported accommodation, and then on to a privately rented flat with live in carer support. She had a recent 6-month admission during a period of de-stabilisation in her mental state and is now back in the community in her flat with her carers.



Theadora loves animals and dogs are very important to her and would like to get a dog in the future.

Berkshire Healthcare
NHS Foundation Trust

Could you tell us a little about your experience of being supported by Berkshire Healthcare over the last year or so?



Berkshire Healthcare
NHS Foundation Trust

Thinking about your move from hospital back into the community, what helped that transition feel easier?



Berkshire Healthcare
NHS Foundation Trust

Were there particular people, approaches or moments that made you feel listened to, understood or supported?
What was it about them that made the difference?



Berkshire Healthcare
NHS Foundation Trust

What has helped you stay well since leaving hospital?



Berkshire Healthcare
NHS Foundation Trust

Has anything worked particularly well between the hospital team and the community team from your perspective?



Berkshire Healthcare
NHS Foundation Trust

If you could bottle up one thing Berkshire Healthcare does well, what would you want us to keep doing?



Berkshire Healthcare
NHS Foundation Trust

Is there anything we could do differently that would have made your experience even better?



Berkshire Healthcare
NHS Foundation Trust

What would you want our Trust leadership to hear from your experience?



What does good support look like to you?

Berkshire Healthcare NHS Foundation Trust

- Good Communication
- Good Listening
- Reliable
- Honest
- Empathy

What helped you build trust with the team?

Berkshire Healthcare
NHS Foundation Trust

Seeing them often

Being open from both sides

When did you feel most hopeful?

Berkshire Healthcare
NHS Foundation Trust

When I moved to my own place in Newbury

Berkshire Healthcare NHS Foundation Trust

BOARD OF DIRECTORS MEETING 10.11.26

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
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.	October 2026	**TW**	Discussed at the October 2026 FIP Committee meeting.	
12.05.26	26/085	Six Monthly Safe Staffing Report	Future reports to include a comparison with the same time period to aid comparison.	November 2026	**DF**	Reflected in the report being presented at the meeting.	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
14.07.26	26/130	Finance Report	The Chief Financial Officer to provide a headline forecast report based on the first three months of the financial year to the Finance, Investment and Performance Committee. A summary of the FIP Committee's discussion to be shared with the full Board.	October 2026	**PG**	The forecast was presented to the October 2026 FIP Committee meeting. The minutes of the meeting are circulated with the In Committee meeting papers.	
14.07.26	26/134	Digital Strategy Update Report	The Board to have an opportunity to discuss the digital strategy in more depth at a future Board discursive session, particularly in light of the new national plan's focus on analogue to digital, the Trust's developing five-year strategy, and the appointment of a new Non-Executive Director with digital transformation expertise.	October 2026	**AG**	On the agenda for the October 2026 Trust Board Discursive meeting.	
08.09.26	26/163	Board Story	Feedback from contract monitoring discussions with the outsourced ward provider to be reviewed by the Prospect Park Hospital Senior Leadership Team to ensure learning	November 2026	**TW**	Feedback from contract monitoring discussions with the outsourced ward provider to be reviewed by the	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
			and actions were undertaken.			Prospect Park Hospital Senior Leadership Team to ensure learning and actions were undertaken.	
08.09.26	26/163	Board Story	The Chair to send a letter of thanks to the patient for sharing her experiences of being a mental health inpatient.	September 2026	**FW**	The Chair sent a letter of thanks to the patient who shared her experiences of being a mental health inpatient.	
08.09.26	26/164	Patient Experience Report	The Director of Nursing and Therapies to review whether a more detailed geographical analysis could be provided in future reports.	January 2026	**DF**	Work is ongoing.	
08.09.26	26/168	"Wellbeing Matters" Report	The issue of declining engagement with the Wellbeing Matters service to be discussed with the Safety Culture Group.	November 2026	**DF**	Completed.	
08.09.26	26/168	Health and Wellbeing Report	The Chair to be invited to observe a Safety Culture Group meeting.	November 2026	**DF**	Dates for the next two meetings have been provided to the Chair for her consideration.	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
08.09.26	26/169	Finance Report	The presentation of the bank staffing metric which was currently rated green to be reviewed to ensure it more accurately reflected the forecast position.	November 2026	**PG**	Amended in the finance report.	

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper Meeting Paper

Board Meeting Date	Tuesday 10th November 2026
Title	**Freedom to Speak Up Report**
	Item for Assurance
Reason for the Report going to the Trust Board	It is mandated by NHS England and the National Guardian's Office that all Freedom to Speak Up Guardians submit a Board report at least every 6 months. The Care Quality Commission also assesses the Trust's Speaking Up Culture as part of its Well-Led Inspection. The Board is asked to note the contents and support the recommendations.
Business Area	Quality
Author	Mike Craissati, Freedom to Speak Up Guardian
Relevant Strategic Objectives	**Workforce** **Ambition:** We will make the Trust a great place to work for everyone To strengthen our highly skilled workforce and provide a safe working environment where staff feel safe to speak out, are listened to and the Trust evidence action taken to deal with issues raised with no detriment suffered by staff.

Highlight Report – Freedom to Speak Up
November 2026

1. Why is this coming to the Board?

This report is written to provide information and assurance to the Board in relation to the activities of the Freedom to Speak Up (FTSU) Guardian, the National Guardian's Office (NGO) and to highlight relevant data of concerns raised and other activity generated during the period.

Both NHS England and the NGO set out guidelines and expectations that the FTSU Guardian works alongside Trust Leadership Teams to support the Organisation in becoming a more open and transparent place to work where all staff are encouraged and enabled to speak up safely. Part of the learning process is that the Guardian reports to Trust Board on, at least, a 6 monthly basis outlining the key activities of the Guardian, giving a fair presentation of data around concerns raised and notifies the Board of points of specific interest for the Board to take note of.

2. What are the key points?

Communication: It is key that the FTSU Guardian is seen as being visible and accessible to all staff groups both to raise awareness but also to be available for staff who wish to make contact. To do that the Guardian uses all forms of communication including, but not restricted to, presence at all Inductions, supporting all staff networks as an ally, membership of all groups or committees that are people focussed and promote an inclusive or just culture. During the period the Guardian has played a keen part in helping to promote the Trust's Anti-Racism stance, working with colleagues to help with Violence Prevention & Reduction and Anti Bullying & Harassment workstreams. The introduction of all staff "Lunch & Learn" webinars help communicate to proactive support for a positive culture change towards greater compassion.

Data on Concerns raised: Numbers of cases raised for the period are lower than the previous year but on par with FY2024/25. Levels of concerns that have an element of Bullying & Harassment have increased compared to the previous FY but that is mainly due to the recent introduction of a new category "Inappropriate behaviours". The majority of concerns are raised by non-managerial staff (79%) and mainly from the Admin & Clerical staff group (27%). Poor behaviour between staff accounts for 70% of cases raised with 0 cases with an element of patient safety (these cases are always immediately raised to the Director of Nursing & Therapies, the relevant Divisional or Clinical Director as well as patient safety colleagues).

Impact on staff:

It is recognised that certain staff groups, such as those with protected characteristics, have barriers to overcome before raising a concern. The Guardian is working closely with the staff networks to understand and try to reduce or eliminate these barriers. 84 of the cases raised during the period involve issues around protected characteristics, however it would appear that more staff with ethnically diverse backgrounds are approaching the Guardian for advice or support (if not actually formally raising a concern).

Culture & Learning: The period has shown a number of staff completing the FTSU E-Learning packages. These courses are also a pre-enrolment requirement for all Leaders & Managers attending the Leading for Impact Management training course with the Guardian delivering a module on Civility, Communication & Psychological Safety.

3. Conclusions and Recommendations for consideration by the Board

Whilst numbers of cases raised to the Guardian have fallen, the Guardian's proactive work in raising awareness of FTSU and helping to promote the right behaviours and values within the Trust remains a busy as ever, it seems clear that the staff experience when raising a concern, still needs more effort. Staff are approaching the Guardian at a late stage, when poor behaviours are already embedded, thus making resolution more challenging.

The time taken to deal with concerns and provide an outcome or resolution is something mentioned by staff as being a negative. There is also still a general feeling of not being listened to and not getting appropriate feedback when Managers or Leaders are approached to deal with issues.

In light of the above, the Board is asked to support the following:

- Support and encourage initiatives to address subjective "Staff Experience" concerns, specifically those that include an element of bullying & harassment and/or microaggressions.
- Support and encourage initiatives to minimise the risk of detriment.
- Support and encourage initiatives to improve the quality of feedback to those who raise concerns. This links into issues around detriment, good effective feedback can help provide "closure" to staff.

Mike Craissati - Freedom to Speak Up Guardian

November 2026

Berkshire Healthcare
NHS Foundation Trust

Report to the Meeting of the

Berkshire Healthcare NHS Foundation Trust
Board of Directors

Freedom to Speak up Report for

November 2026

Background

A Freedom to Speak up Guardian (FTSUG) within every Trust was a key recommendation made by Sir Robert Francis QC in the Freedom to Speak Up review 2015. FTSU has also become part of the CQC Well Led inspection component since October 2016.

A standard integrated FTSU policy for the NHS issued in April 2016 is the basis of the Trust's Raising Concerns policy. This national policy has been reviewed with an update published in Q2 22/23.

In line with the above and as part of our regular policy review process, the Berkshire Healthcare FTSU policy was reviewed and updated in September 2023 with minor changes added in 2025.

The FTSU Strategy 2023-26 was also published in June 2023 with an update due later in 2026.

The National Guardian's office (NGO) was established in October 2016 at the same time as it became a contractual obligation for every NHS Provider Organisation to have appointed a FTSU Guardian.

In July 2026 the NGO's funding was removed and many of their were responsibilities passed onto NHS England.

The Role of the Freedom to Speak Up Guardian

"The Freedom to Speak Up Guardian will work alongside Trust leadership teams to support the organisation in becoming a more open and transparent place to work, where all are actively encouraged and enabled to speak up safely." (NGO 2018)

The FTSUG is independent and impartial. The Guardian reports directly to the Chief Executive and has access to anyone in the organisation. There are two main elements to the role.

- To give independent, confidential advice and support to members of staff who wish to speak up that have an impact on patient and staff safety or issues around malpractice, wrongdoing and fraud. This is not exclusive to permanent members of staff but extends to temporary or agency staff, trainees or students, volunteers and trust governors.

- To promote a culture where members of staff feel safe to raise concerns and do not fear adverse repercussions or detriment as a consequence of doing so.

Debbie Fulton, Director Nursing and Therapies is Executive Lead for Freedom to Speak Up and Sally Glen, Non-Executive Director, is nominated Non-Executive Director for Freedom to Speak Up.

Communication

It is crucial that the FTSU role is visible and accessible to all staff. The communications plan outlines how this is achieved.

The plan includes the following (Showing progress on plans and relevant target dates):

- Raising Concerns presence on Nexus
- Presentations and attendance at management/team meetings (ongoing)
- Production and dissemination of posters, leaflets and cards etc (ongoing)
- Virtual or F2F presence at Corporate Induction, Resident Doctor's Induction & Student's Induction
- Supporting all EDI/Staff Networks as an Ally.
- Membership of the Safety Culture Steering Group, Strategic People Group, Diversity Steering Group, Anti-Racism Taskforce, Violence Prevention & Reduction Working Group amongst others
- Managing a cohort of 41 FTSU Champions. The role of the Champions is to support the Guardian by raising awareness of the FTSU process locally and to signpost to the Guardian should any staff member wish to raise a concern. The Champions cover a wide range of pay bands with representation within all Divisions. 40% of Champions are declared staff network members and 37% have also raised concerns to the Guardian prior to becoming a Champion. It is hoped that the cohort fairly represent the diversity of the Organisation. The Medical staffing group now have 2 Consultants as FTSU Champions
    - Gender - 22% male, 78% female (Trust 18% & 82%)
    - Ethnicity – 66% White, 34% Ethnically Diverse (Trust 63.3% & 32.0%)
    - Disability – 18% disabled, 72% non-disabled (Trust 83.7% & 9.6% with 6.7% not declared)
- During the period the Guardian has delivered an ongoing series of "Lunch & Learn" webinars which are available for all staff
- The Guardian is using the 2025 NHS National Staff Survey results to develop a "Culture Barometer" which can be applied to services at Locality 5 where sub-scores can be rated against an average sub-score of the Trust, thus allowing for a targeted approach for service support and culture improvement. This can also be done for responses sorted by protected characteristics. This barometer is based on the 8

questions within the National Staff Survey that are used as a progress metric within the Freedom to Speak Up Vision & Strategy 2023-26
- A series of anonymised success stories have been published to further communicate the role of the Guardian and the FTSU process, these are shown in **Appendix A.**

Contribution to the Regional and National Agenda

The Guardian is Chair of the Southeast Regional FTSU Guardian Network consisting of all NHS Trusts and private providers (including Primary Care) this numbers 237 Guardians representing 142 Organisations and provides input to quarterly meetings between the NGO & regional Chairs.

The Guardian is a member of both a Frimley and a Berkshire West, Oxfordshire & Buckinghamshire (BOB) Guardian ICB Network (now Thames Valley ICB), members include Guardians from the ICB's and all Provider Trusts within the two systems including SECAMB & SCAS.

The Guardian supports a pan-sector networking group which includes Whistleblowing & Speak Up Leads from non-healthcare Organisations such as Berkshire Fire & Rescue, John Lewis Partnership, NatWest Group, ACAS, Compass Group & the Nuclear Decommissioning Authority. This group allows for shared learning outside of the Healthcare model of Speaking Up.

NHS England has recently published the proposed transition arrangements The Future of Freedom to Speak Up. In essence there are no significant changes to the operation of FTSU at a local level though some changes around data collection may be introduced during 2026/27.

Boards are still accountable for ensuring their Organisation:

- Has effective, trusted and accessible Freedom to Speak Up arrangements
- Publishes clear and up-to-date guardian contact details
- Ensures guardians are:
    - Appropriately trained
    - Supported, supervised and protected in role
    - Given sufficient time and senior access to be effective
- Collects and submits accurate national FTSU data
- Uses speaking-up intelligence to support learning, improvement and cultural change

Quarterly submissions to the National Guardian's Office (NGO)

NHS England requests local FTSU data. National quarterly speaking up data is then published via Model Hospital

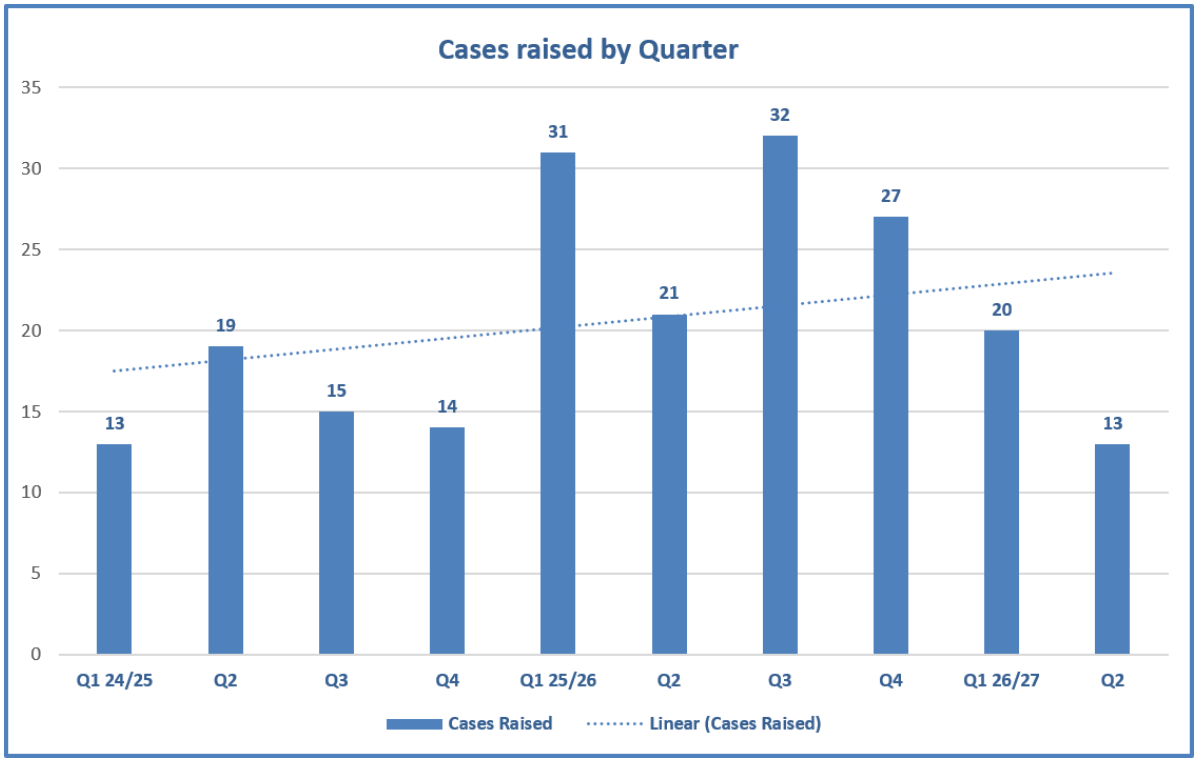
Contacts are described as "enquiries from colleagues that do not require any further support from the FTSUG".

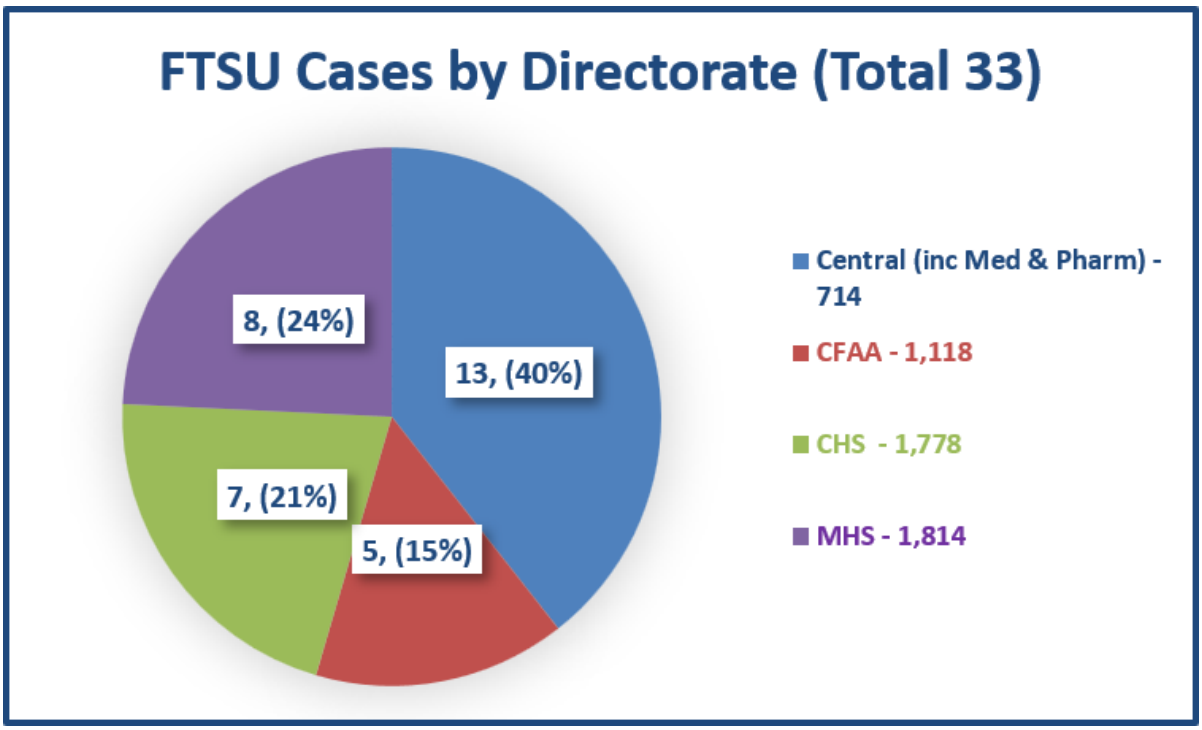
Cases are described as "those concerns raised which require action from the FTSUG".

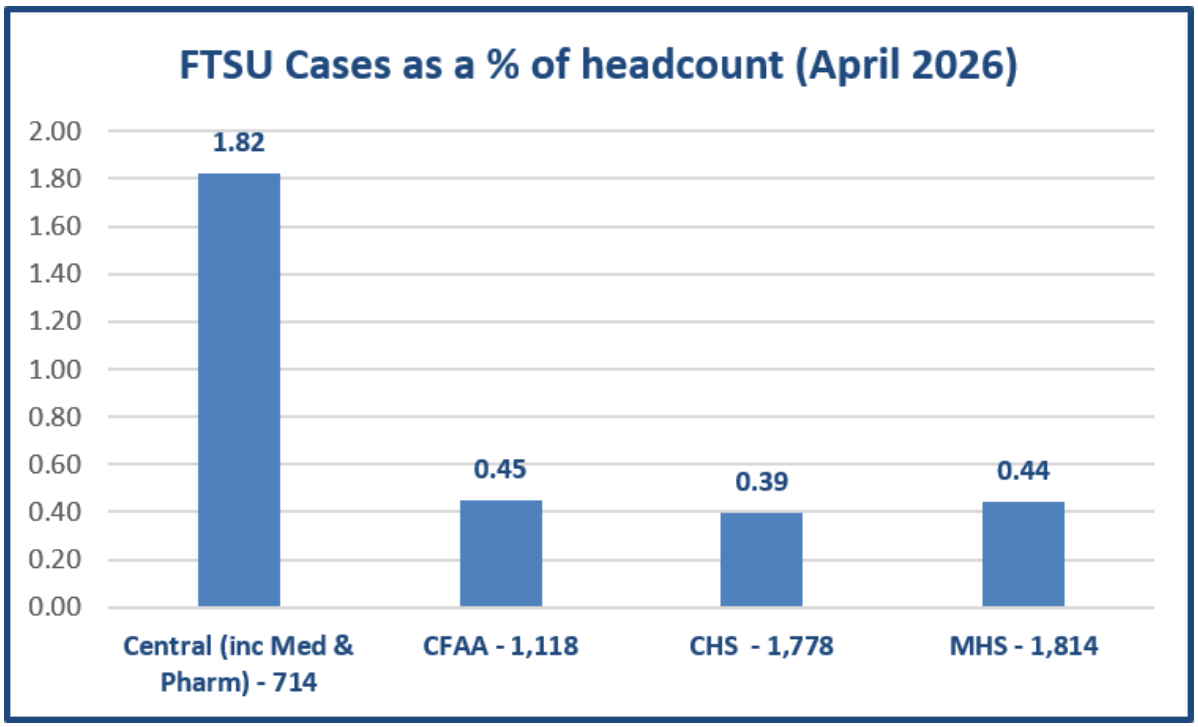
Outlined below are Berkshire Healthcare's submissions to the NGO for FY 2026/27, Q's 1 & 2

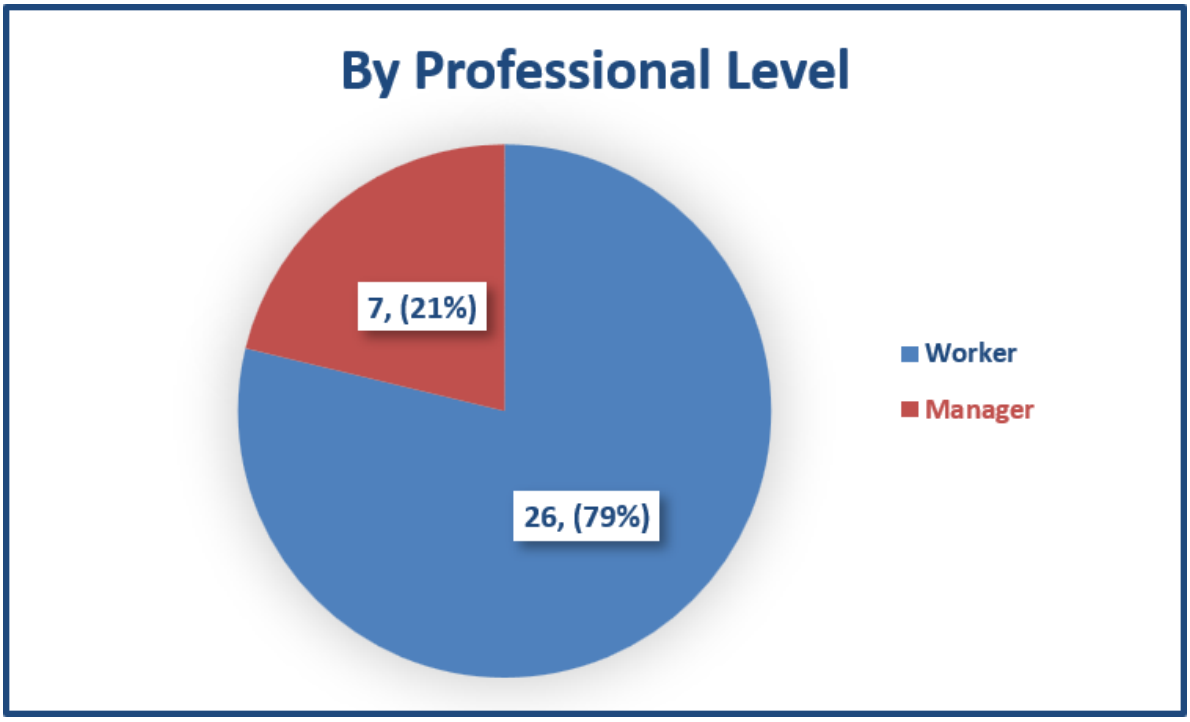
It's difficult to make comparisons with other similar organisations as the data does not provide a narrative regarding how many guardians or champions there are, how many days a week they work and if they have recorded both cases and contacts.

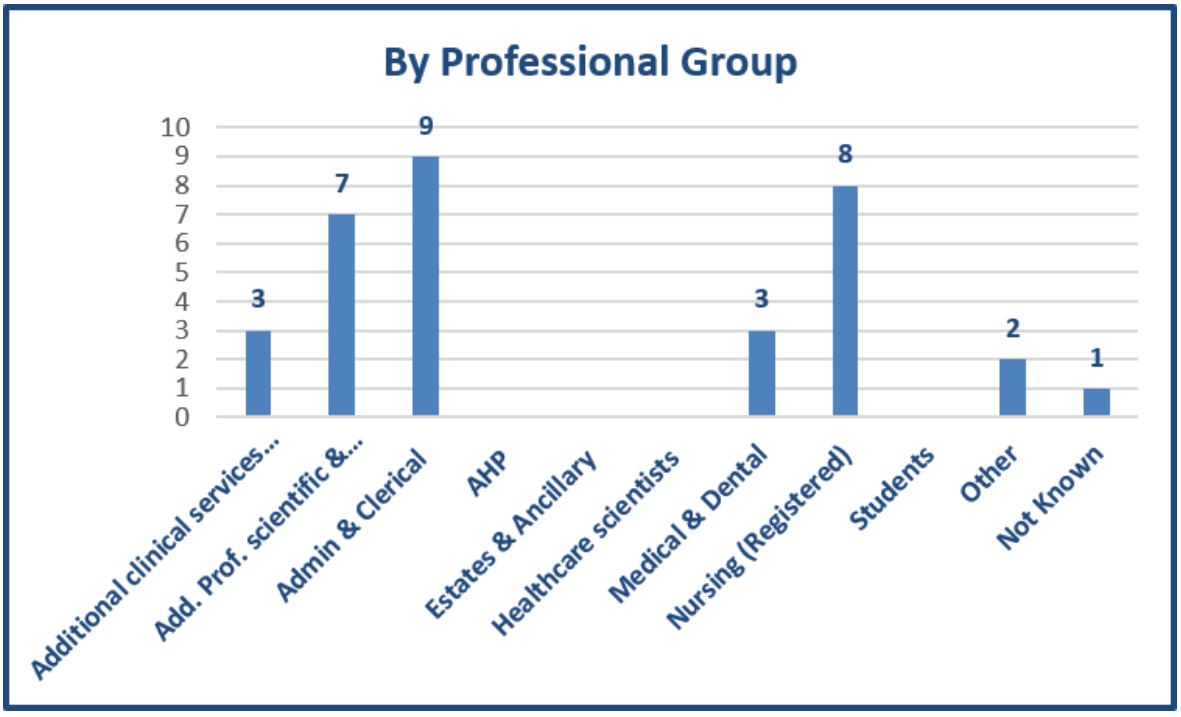
FY 2025/26 Q 1&2 Total cases = 33 (61 for 2024/25 and 111 for 2025/26)

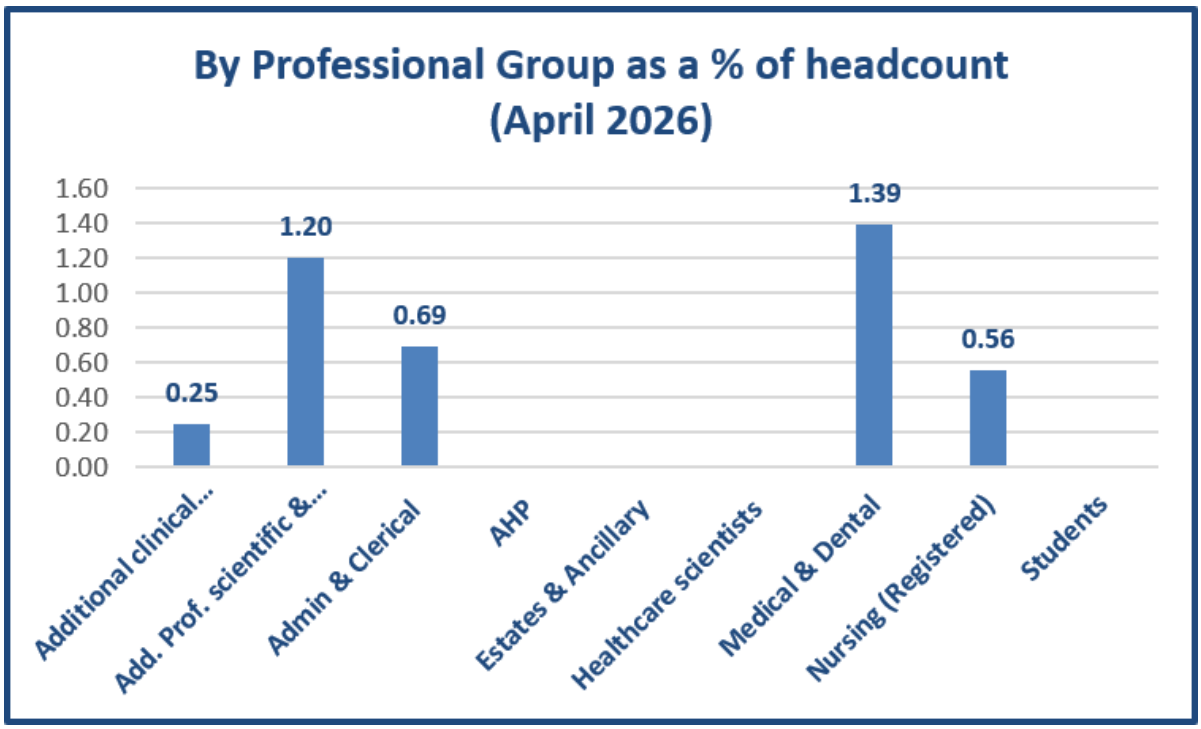


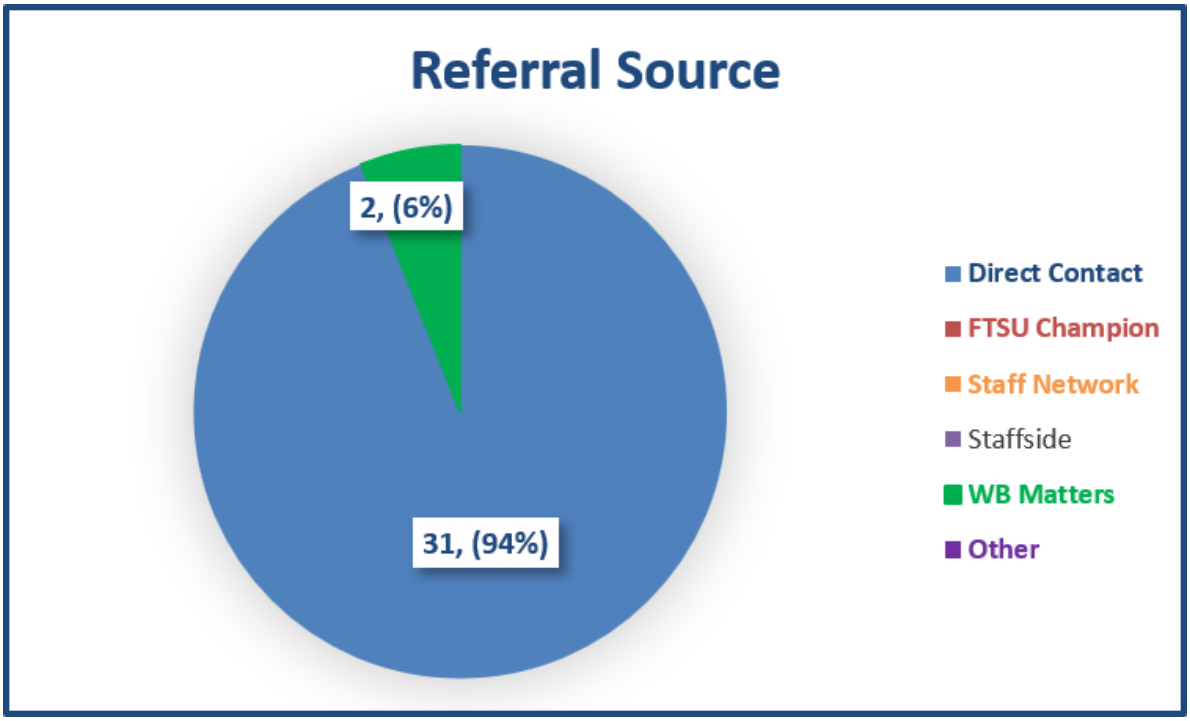

FTSU Cases by Directorate (Total 33)
8, (24%)
13, (40%)
7, (21%)
5, (15%)
Central (inc Med & Pharm) - 714
CFAA - 1,118
CHS - 1,778
MHS - 1,814

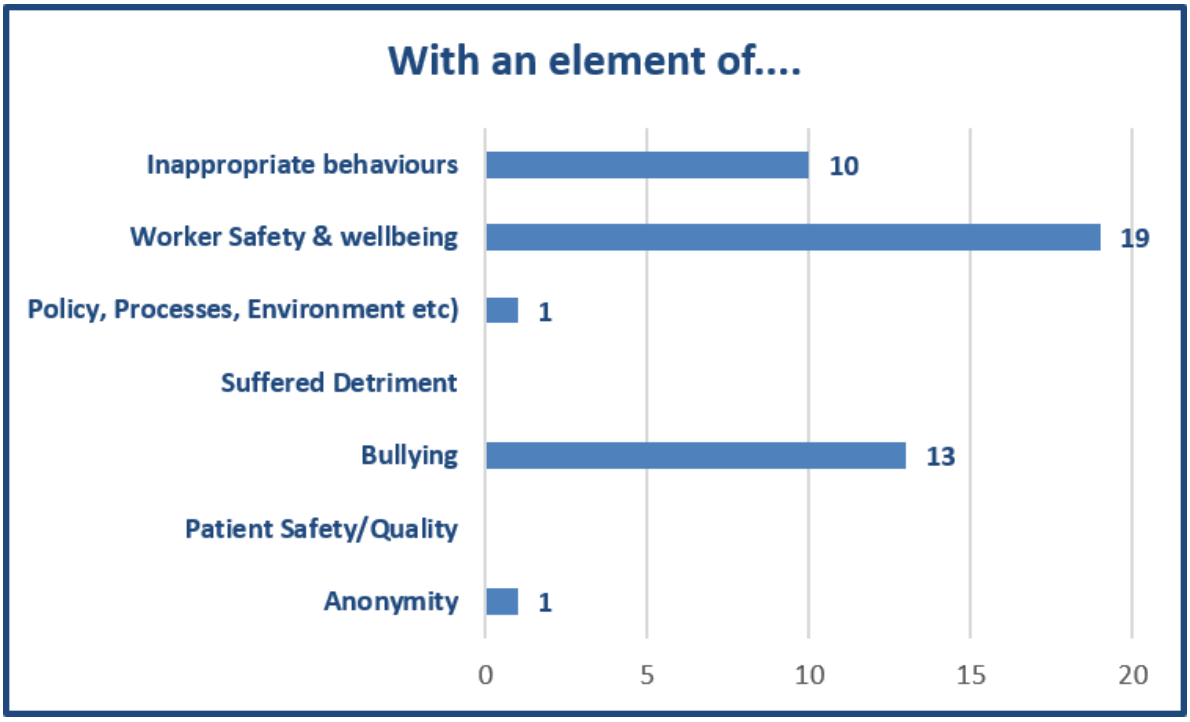

FTSU Cases as a % of headcount (April 2026)
2.00
1.80
1.60
1.40
1.20
1.00
0.80
0.60
0.40
0.20
0.00
1.82
0.45
0.39
0.44
Central (inc Med & Pharm) - 714
CFAA - 1,118
CHS - 1,778
MHS - 1,814

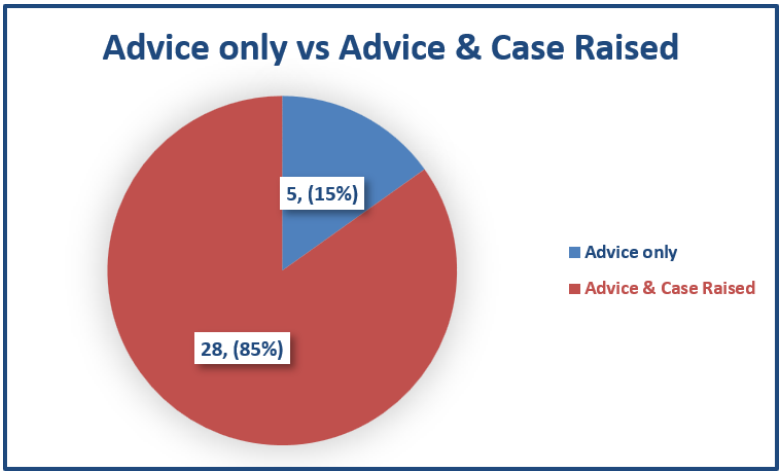

By Professional Level
7, (21%)
26, (79%)
Worker
Manager

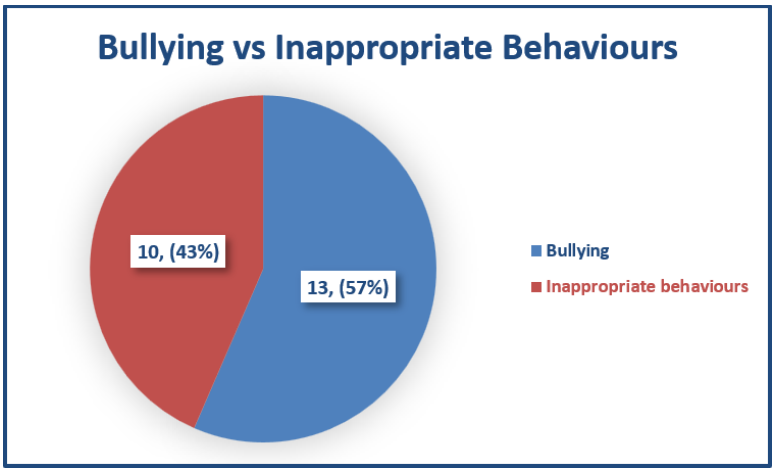

By Professional Group
10
9
8
7
6
5
4
3
2
1
0
3
7
9
3
8
2
1
Additional clinical services...
Add. Prof. scientific &...
Admin & Clerical
AHP
Estates & Ancillary
Healthcare scientists
Medical & Dental
Nursing (Registered)
Students
Other
Not Known


By Professional Group as a % of headcount (April 2026)
1.60
1.40
1.20
1.00
0.80
0.60
0.40
0.20
0.00
0.25
1.20
0.69
1.39
0.56
Additional clinical...
Add. Prof. scientific &...
Admin & Clerical
AHP
Estates & Ancillary
Healthcare scientists
Medical & Dental
Nursing (Registered)
Students


Referral Source
2, (6%)
31, (94%)
Direct Contact
FTSU Champion
Staff Network
Staffside
WB Matters
Other


With an element of....
Inappropriate behaviours
10
Worker Safety & wellbeing
19
Policy, Processes, Environment etc)
1
Suffered Detriment
Bullying
13
Patient Safety/Quality
Anonymity
1
0
5
10
15
20


Advice only vs Advice & Case Raised
5, (15%)
28, (85%)
Advice only
Advice & Case Raised


Bullying vs Inappropriate Behaviours
10, (43%)
13, (57%)
Bullying
Inappropriate behaviours

Inappropriate behaviours – “Any attitude or behaviour that doesn’t constitute bullying or harassment e.g. incivility, actions contrary to an organisation’s values, microaggressions” NGO

Patient Safety concerns – There were no such concerns raised during the period. Any such concerns are forwarded on receipt to the Exec Lead, Deputy Director of Nursing & Deputy Director of Patient Safety & Quality for awareness and oversight.

Assessment of Issues

- The number and type of cases raised fit into the general pattern of cases from previous periods and could be considered the norm.
- Returns show that 0 cases raised via FTSU contains an element of patient safety, the Board can be assured that any other patient safety issues are raised via other routes, handovers etc.
- A high proportion of cases raised are done so where the person raising the concern wishes some form of anonymity or confidentiality having spoken to the Guardian. In such circumstances the Guardian acts as a “go-between” between those raising a concern and the service concerned. Generally, a Commissioning Manager and Investigating Officer will know the identity of the person to aid progress of the case.
- For the period there was 1 case raised anonymously, where the identity of the person is not known to the Guardian
- A significantly high proportion of cases (70%) are around the “staff experience” and specifically from staff who are stating the cause is bullying & harassment (B&H) from fellow staff members (no cases have been received where B&H has been reported as coming from patients or from the public at large – this would normally be highlighted via Datix).
- Turnover of staff who have raised concerns still remains higher than the Trust average but is decreasing year on year. It is difficult to try and determine the reason for this without the benefit of strong exit interview data. General feedback is that those raising concerns via FTSU are happy with the FTSU process and support/advice from the Guardian. It may be that since most of the cases involve poor behaviour of individuals or teams and staff seek advice or support late on when these behaviours are embedded when there is a smaller chance of a positive change in culture then staff feel obliged to leave the service or Organisation.

Quarters 1-3	Turnover
2025/26	25%
2024/25	35%
2023/24	48%
2022/23	52%
2021/22	57%

Improving FTSU Culture

Creating a culture where all staff feel able to speak up and feel valued for doing so is dependent on the organisation showing it is listening and taking their concerns seriously. Giving feedback is one important way the Trust can demonstrate it values staff that speak up. The importance of this stage of the process is not always recognised by managers. Staff who speak up to the FTSUG fear suffering detriment as a result and this can present a barrier.

From personal observations and feedback from those who have spoken up, the following is highlighted:

- To achieve an open culture around speaking up, all elements of good, effective communication need to be included in the process. Speaking Up is only part of this and is relatively easy to address.
- An effective process is only achievable if the other elements are addressed, namely improving the Listening Up Culture, and removing barriers to communication.
- Part of the Listening Up process should include improved feedback to those who raise concerns, including timescales, expectations around outcomes.

Reach of the Guardian (staff contacts)

To help quantify the number of staff contacts over the period (Q1&2 , FY 2026/27), the following should be used as a guide.

- Inductions - 457
- E-Learning - 58
- All staff and/or MSN Webinars - 250
- Leading for Impact attendees - 75
- Presentations at awaydays, team meetings etc – Approx 230
- Mid-Year Appraisal – N/A
- Site visits, walkabouts – 150
- Staff Network meetings - 100
- Nexus data – N/A

The above does not include awareness via Team Brief, actions by FTSU Champions, Staff Side or the cascade effect of awareness raising by colleague to colleague

Learning and Improvement

The FTSU Status Exchange between the Guardian, Chief Executive, Director of Nursing and Therapies and Deputy Director of People continues to provide a good forum for a structured information exchange, triangulation of information, and ensuring action is completed regarding concerns raised.

A regular meeting between the FTSUG and the Deputy Director of People & Senior HR Managers continues as a standard piece of work to enable direct communication about case work in a confidential manner.

The Guardian meets on a six-monthly basis with the nominated Non-Executive Director lead.

The Guardian ensures that any learning from cases raised is communicated to the Organisation through this status exchange, through regular 1:1's with the Executive lead for Freedom to Speak Up. All cases are audited on a quarterly basis to ensure any learning is taken into account and actioned.

Those who raise concerns are offered continual feedback on any investigation work undertaken as a result of speaking up and are supported throughout the whole process, the Guardian also obtains feedback from those who raise concerns on their views of the process and this learning is reviewed and considered by the Guardian.

In the majority of cases, feedback from those who have raised concerns to the Guardian on the process and level of support and advice offered by the Guardian is very positive.

On occasions where reports of case reviews undertaken by the National Guardian's Office or NHS England are published, the Guardian will review these reports and communicate recommendations to the Organisation.

There are a series of E-Learning packages, there are 3 packages aimed at various levels within the Organisation.

All three modules are available for staff on the Trust Nexus e-learning platform.

- **Speak Up** – Core training for all workers, volunteers, students and trainees, aimed at giving all staff an understanding what speaking up is, how to do so and what to expect when they do so.
- **Listen Up** – Aimed at all line management responsibilities, raising awareness of the barriers that can exist when staff wish to speak up and how to minimise them.
- **Follow Up** – For Senior Management groups and Trust Executives, ensuring the Organisation acts on concerns raised, learns from them and uses feedback to help create an open & just culture where all workers are actively encouraged to use their voices to suggest improvements or raise concerns. For ease, this is set at AFC 8A and above.

Completion of these E-Learning packages has been determined as essential training for the following staff groups:

- Board, Executive & SLT
- Elements of the People Directorate (Business Partners, OD/ EDI, L&D)
- Elements of the Nursing & Governance Directorate (Patient Safety & Quality, Safeguarding, Patient Experience)
- All FTSU Champions
- All Leading for Impact Management & Leadership course delegates
- The training has been introduced as a requirement for all staff attending Corporate Induction with guidance given re which level(s) are appropriate.

Statistics for course completions for the last few years are as follows:

ANNUAL TOTALS	Speak Up Core training	Listen Up Managers	Follow Up Leaders	TOTAL
2023/24	147	46	27	220
2024/25	901	22	10	933
2025/26	611	30	14	655
2026/27 (Q 1&2)	411	12	6	429
TOTAL	**2070**	**110**	**57**	**2237**

The core training can be split into 2 modes of delivery, E-Learning and course content delivered at Corporate Induction; this is split as follows for the period

- E-Learning 40 (10%)
- Corp. Induction 371 (90%)

The Guardian and all Champions continually promote the E-Learning packages as well as a link for staff to request Speak Up Awareness sessions for their Teams or Service via their email signatures. This is also available on the Raising Concerns pages on Nexus.

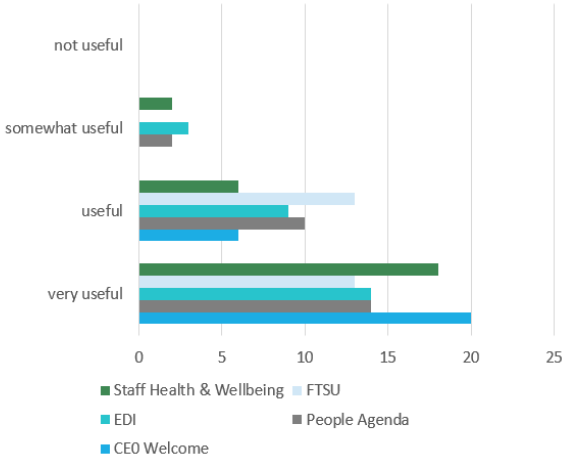
The Guardian now presents a module as part of the Leaders & Managers training course, Leading for Impact. The module deals with the following subjects, Civility, Communications skills, Difficult Conversations & Psychological Safety. These topics align with many of the proactive activities attributed to Freedom to Speak Up principles.

Feedback from Corporate Induction

Independent feedback is collated from those attending Corporate Induction, responses for the period:

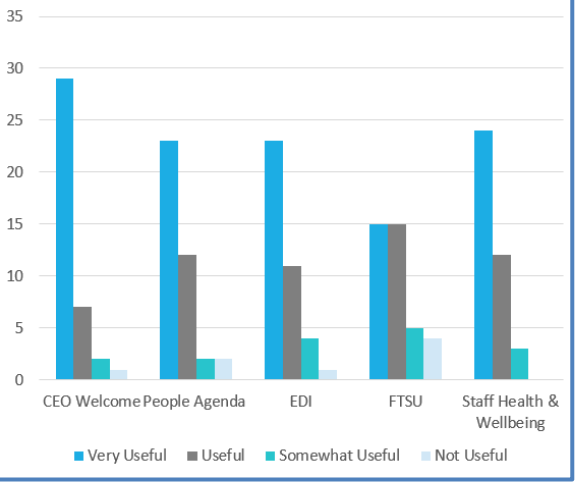
Q1

	CEO Welcome	People Agenda	EDI	FTSU	Staff Health & Wellbeing
Very Useful	20	14	14	13	18
Useful	6	10	9	13	6
Somewhat Useful	0	2	3	0	2
Not Useful	0	0	0	0	0



Q2

	Very Useful	Useful	Somewhat Useful	Not Useful
CEO Welcome	29	7	2	1
People Agenda	23	12	2	2
EDI	23	11	4	1
FTSU	15	15	5	4
Staff Health & Wellbeing	24	12	3	0



Learning – Some follow up actions from cases raised.

- All cases are audited on a quarterly basis to ensure any learning is actioned.
- Where appropriate Services now have the support of an MDT/Organisational Development team. This includes representatives from HR, OD, Psychological Services, FTSU, Patient Safety, EDI leads. Concerns raised from staff within these services have helped to highlight some dysfunctionality or friction within the service. The aim of the MDT is to assist Heads of Service with improving morale, behaviours and efficiency of the service.
- In several cases where the standard of management may be in question, support will be given on a more individual basis to improve management techniques.

It has been highlighted that with larger more complex cases where there may have been a collective concern or group of concerns that, due to the time taken to investigate these concerns, that staff concerned should get better and more frequent feedback. This is being addressed with HR colleagues to align the FTSU process with HR processes.

Examples of non-implementation of learning from concerns raised:

During the period there were no examples where learning from concerns raised (from cases that have been closed) had not been fully implemented.

Recommendations from the FTSU Guardian

The Trust Board is asked to support the following:

- Support and encourage initiatives to address subjective “Staff Experience” concerns, specifically those that include an element of bullying & harassment and/or microaggressions.
- Support and encourage initiatives to minimise the risk of detriment.
- Support and encourage initiatives to improve the quality of feedback to those who raise concerns. This links into issues around detriment, good effective feedback can help provide “closure” to staff.

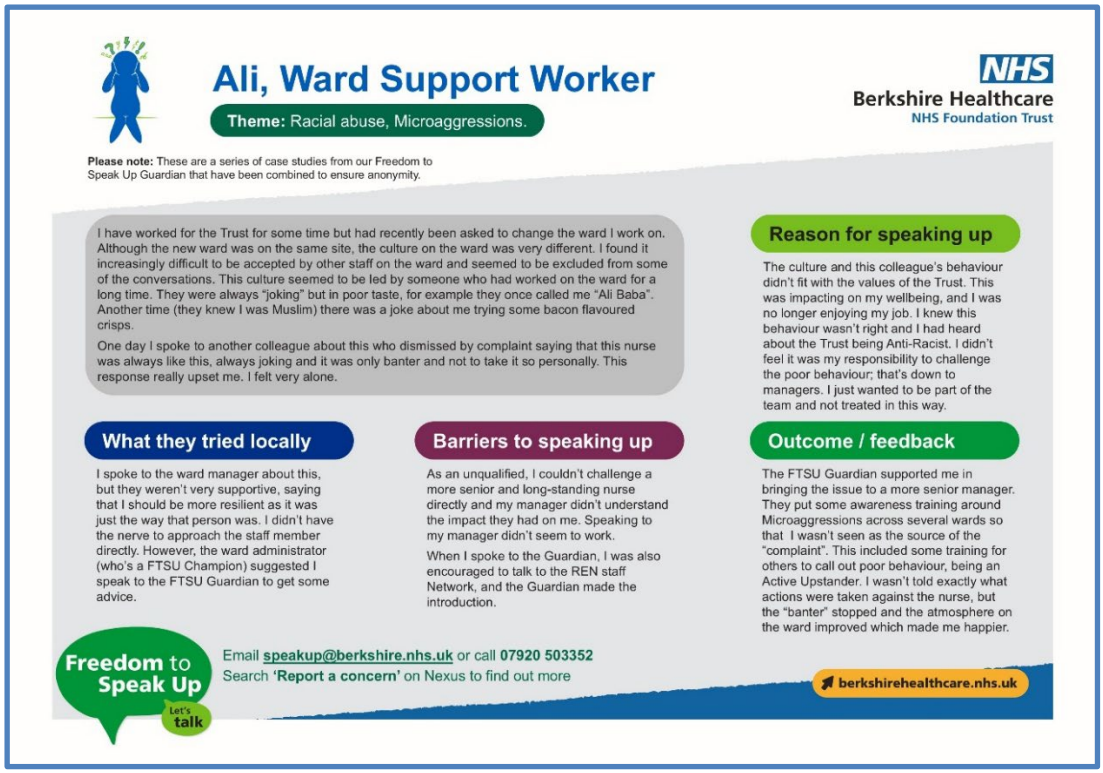
Mike Craissati - Freedom to Speak Up Guardian

November 2026

Appendix A:

The following success stories are collated from a selection of similarly themes case studies to ensure anonymity for both services and staff and represent conversations held during FY 2025/26. These have been publicised via Team Brief during FY2025/26 and also during this period.







Reflections from a manager

Theme: Workplace Bullying

NHS
Berkshire Healthcare
NHS Foundation Trust

Please note: This is a brief, anonymous summary from a real incident written from a manager's viewpoint.

Recently my manager approached me saying that some of my direct reports had come to them via the FTSU Guardian stating that on occasions they felt they were being bullied by me, that my way of asking them to undertake tasks wasn't fair, that extra shifts weren't fairly allocated across the team.

A couple of the team weren't performing as they should, they weren't meeting their objectives, and this was impacting on the team as a whole. They felt that the way I approached this was like bullying and had told my manager such. This wasn't my intention and I was upset by this.

My manager was very supportive and together we worked on a plan to address the allegations and change how my staff felt about me. Also, we agreed that I had to change some of my communication style.

What I did

I attended some management training organized by the FTSU Guardian around how to minimize the risk of firm but fair management being mistaken to bullying type behaviour. About how to allocate tasks, CPD opportunities Etc. in a fair and consistent way. We also set up a facilitated conversation with my staff to help "clear the air" and start afresh.

What changed

Over time the team started to understand that in a busy service extra "asks" are common-place and setting high expectations is normal. By changing the way, I allocated tasks and dealt with issues more fairly led to staff feeling better about working in the team. The way I dealt with real performance issues, making it a more collaborative process with set, agreed goals and timescales made dealing with those issues easier.

What I learned

How I communicate is a key element of good management practice. It's OK to set high standards but equally important to be fair and consistent in how that's done.

Mutually agreeing performance objectives and allowing the staff member to offer their point of view is also important.

Outcome and learning

The atmosphere in the team has changed for the better. By setting a different "tone" or approach and involving the team more in how the team is run is starting to have a positive impact.

Staff are more willing to contribute with team improvement initiatives.

Whilst performance issues can still occur, they are much more collaborative discussions with mutually agreed goals and timescales.

Freedom to Speak Up
Let's talk

Email speakup@berkshire.nhs.uk or call 07920 503352
Search **'Report a concern'** on Nexus to find out more

berkshirehealthcare.nhs.uk



Sam, Community Nurse

Theme: Bullying from colleague

NHS
Berkshire Healthcare
NHS Foundation Trust

Please note: These are a series of case studies from our Freedom to Speak Up Guardian that have been combined to ensure anonymity.

I'm a relatively newly qualified member of the team and joined the Trust 6 months ago. At first, I felt very welcomed to the team and enjoyed learning the ropes, however after a while I started to notice that some of the more senior team members were being less than enthusiastic when I started to make suggestions on how we could improve some of our ways of working. I started getting comments such as "This is the way we've always done this", "It works for us, no need to bring this up with the Manager."

One long standing colleague seemed to be the ring-leader and was increasingly targeting me and even said once that I should "Get back in my box." I was so upset by this, my confidence dropped, I could no longer contribute or say anything when we had team meetings or were all together. The Manager was a friend of this colleague, so I felt unable to go to them for support.

Reason for speaking up

I remembered about a Guardian from Induction and arranged for a confidential chat, we discussed my situation and produced a few options, I was initially scared to go with it but after the Guardian introduced me to a senior manager, I felt I could tell my story, it was either that or leave. The senior manager said they would look into my concerns and keep me in the loop.

What they tried locally

There wasn't much I felt I could do. I spoke to a couple of other newer staff in the Team, their comments didn't help "That's just what she's like", "Keep your head down and don't rock the boat". "The manager will always have her back" and so on. All of this was starting to make me anxious and I couldn't sleep. I had some time off work, and I also contacted the Wellbeing Service.

Barriers to speaking up

As a relatively new member of the team, I thought that I would be more welcomed and that the ideas I had would be listened to (even if not taken up). The atmosphere was quite toxic, I just didn't feel welcomed, it was a downwards spiral. I thought I would have to leave and get another job, which I didn't want to do as I enjoyed the Trust and some of my colleagues were great to work with. I had no voice and felt trapped.

Outcome / feedback

I noticed after a few weeks that the behaviour of the colleague seemed to change, they were less vocal. We had a session around Psychological Safety and how to contribute, we were all involved in doing that and, over time the culture seemed to improve. I'm not sure exactly what was said to the colleague (I was warned I wouldn't get much feedback around that) but I was glad that things were addressed in a way that didn't spotlight me really.

Freedom to Speak Up
Let's talk

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Search **'Report a concern'** on Nexus to find out more

berkshirehealthcare.nhs.uk



Reflections from a manager

Theme: Poor Speak Up Culture

NHS
Berkshire Healthcare
NHS Foundation Trust

Please note: This is a brief, anonymous summary from a real incident written from a manager's viewpoint.

Results from the latest Staff Survey suggested that within one of the services I oversee that staff didn't feel enabled to raise concerns to their Manager, there appeared to be ever increasing staff dissatisfaction, sickness levels were rising and the turnover rate was above that for similar services under my responsibility.

Some of the staff had collectively approached the FTSU Guardian and eventually they agreed for the Guardian to alert myself to their concerns (they wanted to remain anonymous).

Looking into their concerns, I noticed that some of the points they raised were very valid and some of the "disruption" appeared to stem from the fact that the Manager of the service was quite new in post and it was their first major appointment. They appeared to lack some skills in people management, especially around communication and being curious, therefore not encouraging staff to contribute their thoughts and suggestions for service improvement.

What I did

2-fold approach. The Manager was supported in increasing their skills by attending Management & Leadership training course. The Guardian led a survey for staff around levels of Psychological Safety, the results were presented to them (anonymously) and they were tasked with agreeing some countermeasures to improve the culture within the service.

What changed

As the staff "owned" the measures put in place, most of the actions improved the culture, the staff were already contributing on improvements and they felt heard.

The Manager felt supported and better skilled to manage colleagues and slowly the culture in the service became more open and inclusive. This has already led to a drop in turnover.

What my Manager learned

Showing curiosity and asking the team to contribute with the improvement of a team's culture and success is a valuable skill.

Communication style, active listening and being consistent in decision making as also very important.

Having a diverse range of opinions or viewpoints leads to better decision making, leading to better patient care.

Outcome and learning

Creating a culture where staff can contribute and feel heard alongside support for managers in increasing their people management skills leads to higher performing teams with better patient outcomes. It was clear to me that implementing this at the outset is much easier than trying to change culture in a team that may be struggling.

I look forward to the next Staff Survey results to see what impact the changes have had.

Freedom to Speak Up
Let's talk

Email speakup@berkshire.nhs.uk or call **07920 503352**
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berkshirehealthcare.nhs.uk

Development plan for FTSU self-assessment 2026-2028

Development area	Target date	Owner	Update
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	A series of positive stories showing good outcomes have been produced and are being publicised to staff every 2 months via Team Brief. Zero detriment guidance has been published and promoted to staff and managers.
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	Casework review is on-going and some changes/improvements to the process have been identified and being implemented. All staff involved in an investigation receive a weekly check-in and a progress update
Continue the development of the cultural barometer and once developed use it as a diagnostic tool for intervention and support	March 2027	FTSUG	The culture barometer is anticiapted be operational and publicised to managers by Dec 2026. This will include the last 2 years of NSS data. 2026 NSS results will be added as soon as embargo is lifted early 2027.
Increase of positive story telling	March 2027	FTSUG and Director Nursing and Therapies	See 1st development area
Increase case studies and cross organisational learning from speaking up	March 2027	FTSUG, Communications Team, Director Nursing and Therapies	See 1st development area

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 November 2026
Title	**Patient Experience Report -Quarter 2 (July to September 2026)**
	Paper for Assurance
Reason for the Report going to the Trust Board	This report is written to provide information to the Board in relation to a range of patient experience data available to us. It also provides assurance in relation to the Trust handling of formal complaints as set out within The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and by the CQC through the Health and Social Care Act 2008 (regulated activities) Regulations 2014: Regulation 16 receiving and acting on complaints.
Business Area	Trust Wide
Author	Elizabeth Chapman, Head of Patient Experience (full report) Debbie Fulton; Director Nursing and Therapies (Highlight Report)
Relevant Strategic Objectives	Understanding the experience of our patients, how we respond to this, capture and learn from all forms of feedback is fundamental to the provision of safe, caring and effective services. **Patient safety** **Ambition:** We will reduce waiting times and harm risk for our patients **Patient experience and voice** **Ambition:** We will leverage our patient experience and voice to inform improvement **Health inequalities** **Ambition:** We will reduce health inequalities for our most vulnerable patients and communities

Highlight Patient Experience Report
Quarter Two 2026/27

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.

Patient Experience – overall Trust Summary		Target / number 25/26	Q1	Q2	Q3	Q4	Year end
Patient numbers (inc discharges from wards)	Number		159,505	168,469			
Number of iWGC responses received	Number	**61,000 year** for 10%	12,814	11,347			
iWGC Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	**10%**	8.03%	6.73%			
iWGC 5-star score	Number	**4.76**	4.79	4.82			
iWGC Experience score – FFT (good or very good experience)	%	**95%**	95.72%	95.62%			
Compliments received directly by services	Number	**5600**	1484	1479			
Formal Complaints received	Number/ %	**268 (0.038%)**	81	113			
Formal Complaints Closed	Number	**280**	85	95			
Formal complaints responded to within agreed timescale	%	**100%**	100%	100%			
Formal Complaints Upheld/Partially Upheld	%	50%	58.8%	56%			
Local resolution concerns/ informal complaints Rec	Number	**217**	20	17			
MP Enquiries Rec	Number	**56**	16	18			
Complaints upheld/ partially by PHSO	Number	**0**	0	0			

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.

For this quarter the data continues to show only small variations on last year, the exception to this is that we saw a significant rise in the number of complaints compared to quarter one. The total complaints in quarter one was above Q1 -3 of 25/26, this additional increase means that this is the highest number complaints received in a quarter. This is in line with national trend, appears to be impacted to some extent by AI and also needs to be viewed alongside an increase in total contacts. In Quarter two of 2025-26 we saw 146,000 patients and received 58 formal complaints (0.04% contacts resulting in a complaint against current activity of 0.07% contacts resulting in a complaint). The percentage of those upheld/ partially upheld is slightly lower this quarter than quarter two of last year where 62% complaints were upheld/ partially upheld.

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 lower sub scores across all divisions continue to be seen across our mental health inpatient services, although involvement score has improved this quarter to 4 stars from 3.9; ease at 3.8 stars is the areas least likely to score positively. The question around ease for inpatients is "If applicable, was the place where you received your care, assessment and/or treatment suitable for your needs?" The wards all have ongoing work to support improvement.

Overall feedback remains overwhelmingly positive with questions around our staff and involvement continuing to be dominant positive themes.
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.

Ranked themes[2]	% Positive (change)	% Negative (change)
Emotonal support, empathy & respect	94.3% (-1%)	1.4% (0%)
Involvement in decisions & respect for preferences	93.3% (+2%)	2.9% (0%)
Clear informaton, communicaton & support for self care	90.7% (0%)	4.5% (0%)
Effectve treatment delivered by trusted professionals	84.0% (-3%)	7.9% (+2%)
Fast access to reliable healthcare advice	77.4% (-3%)	11.0% (+2%)
Atenton to physical & environmental needs	66.8% (0%)	13.4% (+1%)
Contnuity of care and smooth transitons	55.5% (+8%)	27.7% (-1%)

*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 Q1 attendances
Asian/Asian British	11.10%	8.16%	10.02%
Black/Black British	0.85%	2.63%	3.64%
Mixed	8.52%	3.01%	3.72%
Not stated	18.32%	18.32%	8.82%
Other Ethnic Group	4.96%	4.95%	2.06%
White	62.38%	62.94%	71.74%

It is recognised that around 20% respondents do not provide their ethnicity data on the patient survey.

In terms of gender, around a third of patients do not complete this demographic question within the patient survey, however the data available would indicate that gender does not appear to impact on whether we received feedback or complaints. For this quarter the percentage of complaints not upheld was significantly higher for complaints received via males than females.

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 those over 65 years and much less likely to make a formal complaint than those in younger age brackets.

The 15 steps programme has continued with several visits undertaken during the quarter as detailed in appendix 2.

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 from patient feedback. 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.

Patient Experience Report Quarter Two 2026/27

Introduction

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

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

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

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	159,505	168,469			
Number of iWGC responses received	Number	12,814	11,347			
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	8.03%	6.73%			
iWGC 5-star score	Number	4.79	4.82			
iWGC Experience score – FFT	%	95.72%	95.62%			
Compliments received directly by services	Number	1484	1479			
Formal Complaints Rec**	Number	81	113			
Number of the total formal complaints above that were secondary (not resolved with first response)	Number	19	21			
Formal Complaints Closed**	Number	85	95			
Formal complaints responded to within agreed timescale	%	100%	100%			
Formal Complaints Upheld/Partially Upheld	%	58.8%	56%			
Local resolution concerns/ informal complaints Rec	Number	20	17			
MP Enquiries Rec	Number	16	18			
Total Complaints open to PHSO (inc awaiting decision to proceed)	Number	3	4			

** remaining complaint activity relates corporate services such as medical records, and parking.

The report shows a continued increase in complaint activity during Quarter 2, which mirrors national NHS trends. The increase is particularly notable within Community Mental Health

Teams (CMHTs). Despite rising complaint volumes, complaint rates remain low relative to service contacts, and the Trust continues to receive a significant number of compliments.

113 Formal Complaints were received in Quarter 2, an increase from 81 in Quarter 1 (+40%). Year to date the Trust has received 194 Formal Complaints. Services with the highest numbers of complaints:

CMHT/Care Pathways: 29 complaints (25% of all complaints). Care and Treatment was the predominant issue (21 complaints). Geographically, most CMHT complaints came from Reading (8), Windsor, Ascot and Maidenhead (6) and Wokingham (6).

Acute Inpatient Admissions: 12 complaints

CRHTT: 12 complaints

There were 95 Formal Complaints closed during Quarter 2.

Overall, 56% of complaints closed were either upheld or partially upheld, 31 not upheld (32.6%), 8 locally resolved/not pursued and 4 where consent not granted. Among upheld and partially upheld complaints, Care and Treatment was the most common issue (23 complaints). Followed by Communication (11), Staff Attitude (4), Confidentiality (3).

The report notes that upheld complaints were spread across many services, with no dominant organisational theme identified.

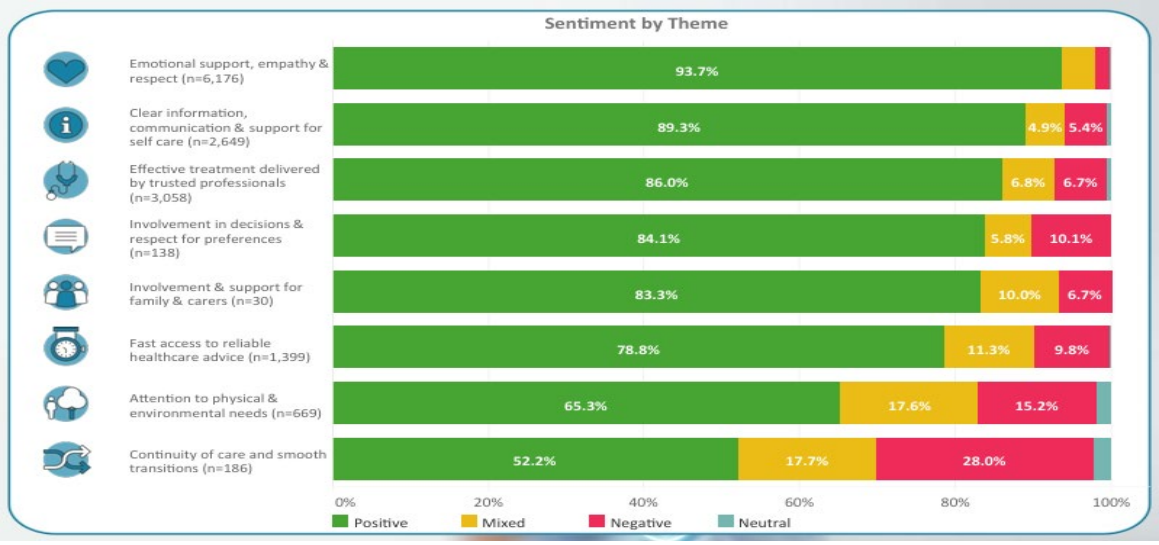
A total of 21 complaints (12.8%) received during the quarter were re-opened complaints, indicating that a proportion of complainants remained dissatisfied with their original response and sought a further review. This is a decrease in percentage of activity compared with 22.2% in Quarter 1.

Complaints remained varied in nature and reflected the breadth of services provided across the Trust. However, a common theme has been communication.

During Quarter 3, the Head of Service Engagement and Experience will conduct a deep dive on Communication complaints – and this will be discussed at the Patient and Carer Engagement and Experience Group.

PALS and Complaints information for Quarter 2 is attached as an appendix to this 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.



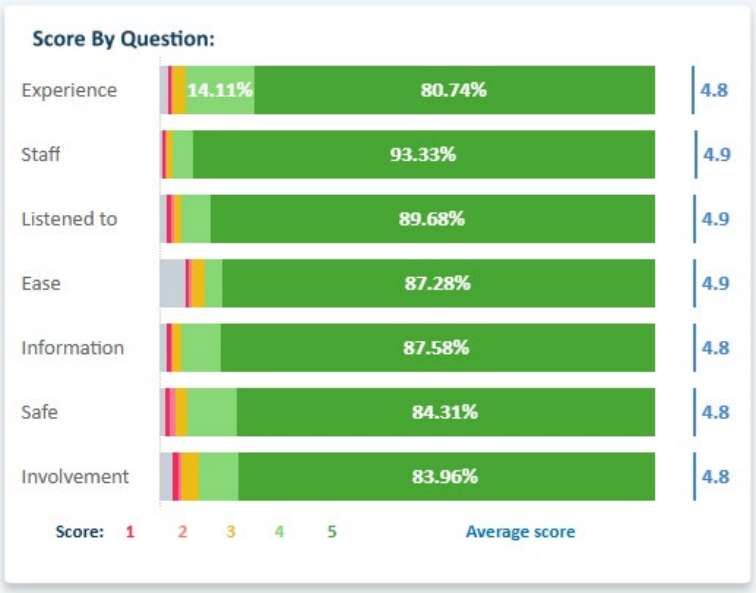
What the data is telling us

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	4503	2899		
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	11.1%	5.4%		
iWGC 5-star score	Number	4.89	4.83		
iWGC Experience score – FFT	%	96.2%	95.7%		
Compliments received directly by services	Number	102	109		
Formal Complaints Rec	Number	17	23		
Formal Complaints Closed	Number	21	19		
Formal Complaints Upheld/Partially Upheld	%	57.1%	71%		
Local resolution concerns/ informal complaints Rec	Number	5	25		
MP Enquiries Rec	Number	8	4		



Of the 2,899 responses, 2,692 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 6 reviews for Phoenix House.

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

There were 23 Formal Complaints received across the Children, Young People & Families Division during Quarter 2.

Of these, 8 related to Physical Health services and 15 related to Mental Health services. Complaints primarily concerned care and treatment, communication with families, access to services and waiting times, with concerns raised across a range of community, specialist, and mental health services. No single dominant theme was identified, with complaints reflecting a broad range of service-specific issues.

During Quarter 1, four MP enquiries were received relating to Children's Services. The majority concerned waiting times and access to services and were across ADHD, Health Visiting, Physiotherapy, and the Anxiety Disorder Treatment Team (ADTT).

Where complaints were upheld or partially upheld, learning commonly related to communication, coordination of care, clarity of information provided to families, and administrative processes.

Children's Physical Health Services
There were eight formal complaints received for Children's Physical Health Services during Quarter 2.

Children's Occupational Therapy and Physiotherapy (CYPIT) received five complaints, with concerns relating to assessments, discharge decisions and whether appropriate support had been provided.

Health Visiting received one complaint as did Specialist School Nursing and Community Paediatrics.

Overall, the main themes were care and treatment, communication with families, and access to services, with concerns focusing on the delivery of care, assessment, and treatment

decisions, and ensuring parents and carers were appropriately supported and informed throughout the care pathway.

2277 of the 2899 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. Health Visiting Bracknell also receive very positive feedback with positivity score of 98.1%- and 5-star rating of 4.96.

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 1655 responses was 94.8% and a 5-star rating of 4.78. Feedback included that the injection was quick, and nurses were kind. "The lady was very kind and helpful in explaining what the vaccine does." with the themes to improvements including not having to wait and watch, wanted more warning and nurses talked to fast.

Child and Adolescent Mental Health Services (CAMHS)
There were six complaints received relating to CAMHS Services during Quarter 2. These were received across CAMHS General, Rapid Response and the Anxiety Disorder Treatment Team.

The majority of complaints related to care and treatment, with concerns focusing on assessments, clinical decision-making, safeguarding, and whether appropriate support had been provided to young people. Complaints also highlighted concerns regarding communication with families and the timeliness of access to support.

There have been 387 responses for CAMHS services received through our patient survey for this Quarter. These include 220 received from those attending our neurodiversity services (positive score 97.73% and star rating of 4.88 with lots of positive comments about staff and the experience).

Adult ADHD Service
There was one formal complaint relating to Neurodevelopmental Services during this Quarter.

The Adult ADHD service received 22 responses with a 3.96 average 5-star score and a 63.6% positive score. Positive feedback included patients felt listened to and staff were helpful. Less positive comments were around lack of communication and long wait time. Work is ongoing within the system to find local resolutions to this this national challenge that demand is significantly higher than capacity for neurodiversity assessment services.

Learning Disability
There was one formal complaint received relating to the Community Team for People with Learning Disabilities (CTPLD).

Overall, there were 126 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 88.9% positive score; feedback included that staff were helpful, "*[Name Removed] had some excellent input which was really helpful for the team, the meeting also gave them the opportunity to raise any challenges they have faced when supporting [Name Removed] and gain some professional advice, so her attendance was very much appreciated."* there were comments for improvements including staff need to listen, poor communication, reports need to be in larger text and plain English and need more support. There were 14 responses that received with a score below 4.

Regular engagement takes place with patients on Campion unit including 1;1s and huddles with groups of patients to ensure that their views on the facilities and environment are heard. We have asked the Ward Manager to share an update on these meetings for inclusion in the Quarter 3 report.

Eating disorders
There were no formal complaints received relating to the Eating Disorders Service.

Of the 33 feedback responses received, 26 scored a 5 with comments such as "*Caring and empathic practitioner who has spent time getting to know me. Guides me and challenges me but does not judge. She provides a safe space which I need*" *"BEDs have been great in the 6 years that I have been with the service. After being signed off and having to re access the service, I was able to pick back up with the same therapist which was really helpful and made the whole process a lot easier. They have also been really flexible around appointments and my working hours which has been great." "[Everyone has always been so kind and supportive throughout the treatment process and I'm very grateful for everything that has been done for me."* Areas for improvement included let the patient know what the appointment is for and provide a treatment timeline.

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").

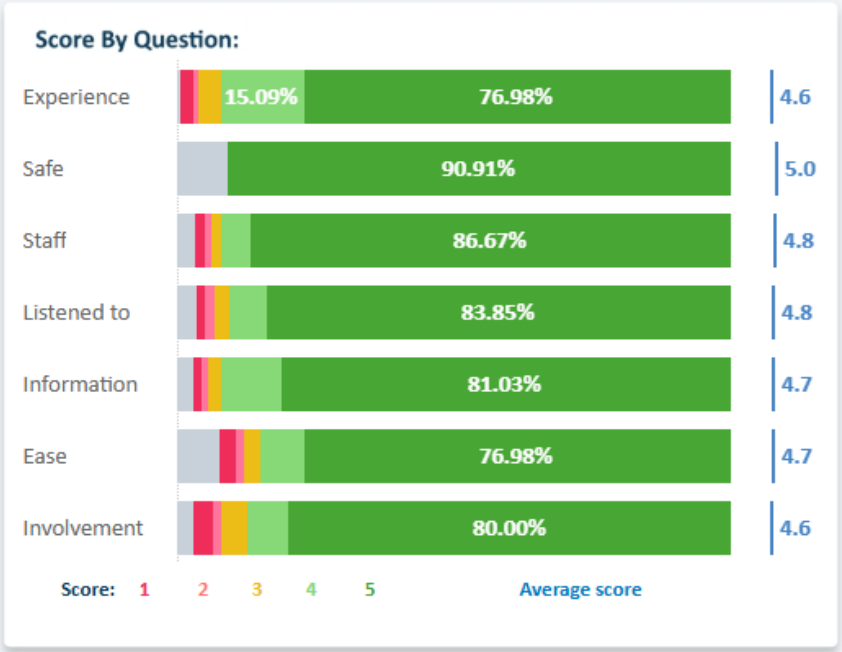
- The service is commencing a participation project (registered as a Trust service-evaluation on around understanding the barriers to our services for different community members. We are inviting those who have declined our service to share their experiences of being offered the service and rational 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**	332	391		
Response rate (calculated on number contacts)	**%**	3.72%	4.11%		
iWGC 5-star score	**Number**	4.69	4.71		
iWGC Experience score – FFT	**%**	92.17%	92.07%		
Compliments received directly by services	**Number**	393	274		
Formal Complaints Rec	**Number**	19	21		
Formal Complaints Closed	**Number**	22	16		
Formal Complaints Upheld/Partially Upheld	**%**	59%	61.54%		
Local resolution concerns/ informal complaints Rec	**Number**	0	4		
MP Enquiries Rec	**Number**	2	5		



There were 21 formal complaints received across Mental Health East services during Quarter 2. Complaints were received across a range of community and specialist mental health services and predominantly related to care and treatment, communication, and access to services. Common concerns included clinical decision-making, continuity of care, discharge arrangements, responsiveness of services, and communication with patients and families. No single theme predominated, with complaints reflecting a broad range of issues across the division.

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 82 responses, Memory clinic Bracknell with 58 responses and Memory Clinic WAM with 34 responses.

Across the CRHTT East survey, the average 5-star score was 4.66 with 90.2% positive feedback. 74 of the overall number of responses received (82) scored a 4 or 5-star rating with many comments about staff being supportive, listened, understanding and helpful; "*All staff member who was involved in my treatment they were kind to me and explained things very well to me and they listened to me and understood my problems and my health. They even explained discharged process to me, and I have handed over to different team for further support..*" "*Support was brilliant, easy to reach out, regular visits, safety net was provided, found crisis team support very helpful.*"

This Quarter, questions relating to ease and feeling involved were least likely to be positive with areas for improvement and dissatisfaction with the service about not feeling listened to, better communication and follow up with patient as promised.

The Memory Clinic – Bracknell received 98.28% positive score (4.90-star rating) and received positive feedback about staff being professional, kind, and helpful. "*[Name Removed] treated my father with respect and patience. She was kind and understanding. I got the impression his welfare was at the top of her priorities.*

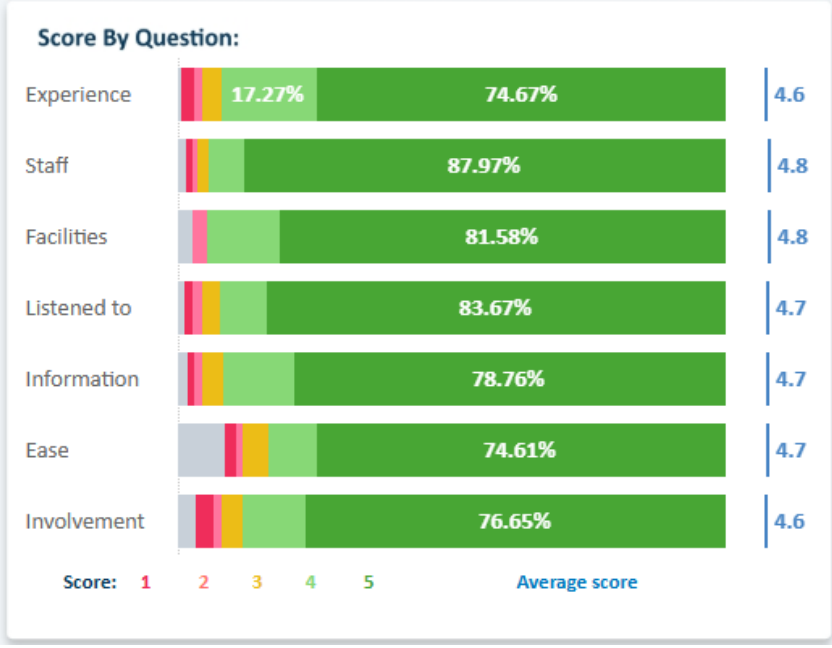
CMHT received 73 responses (Bracknell 16, Slough 23, and WAM 34) with 90.4% positive score and 4.58 star with 6 of the total responses scoring less than a rating of 4; comments included *"I feel like there's more of a tick the boxes approach then actually trying to*

understand what is happening and why." And "Didn't listen to me at all". There were several positive comments including "I felt the appointment was very helpful, and a plan for how to move forward was arranged. I felt supported and reassured by the standard of care.," "*From checking in through to the end of the consultation, I am treated with respect and kindness. I get very anxious for these appointments, but I am always absolutely fine." And "[Name Removed] was very understanding, helpful and listened to me. She was also very supportive with the information she gave to me. The environment was very relaxing, and she gave me positive encouragement"* Some of the suggestions for improvement included staff need to listen more and appointments on time. 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**	1209	1142		
Response rate (calculated on number contacts)	**%**	5.89%	5.66%		
iWGC 5-star score	**Number**	4.69	4.69		
iWGC Experience score – FFT	**%**	92.11%	92.10%		
Compliments received directly by services	**Number**	56	34		
Formal Complaints Rec	**Number**	20	34		
Formal Complaints Closed	**Number**	16	34		
Formal Complaints Upheld/Partially Upheld	**%**	62.5%	51.72%		
Local resolution concerns/ informal complaints Rec	**Number**	3	0		
MP Enquiries Rec	**Number**	1	6		



There were 34 formal complaints received across Mental Health West services during the quarter. Complaints were received across a range of community and specialist mental health services and predominantly related to care and treatment, communication, and access to services.

In terms of outcomes, a substantial proportion of complaints were partially upheld, with none being found to be fully upheld.

There was learning identified around communication with care coordination, discharge planning, and documentation, with a theme of patients stating that they have not been made aware of these aspects of their care.

The Mental Health West division has a wide variety of services reporting into it, including the Talking Therapies service and Court Justice Liaison and Division service (CJLD), as well as secondary mental health services. The 3 services with the most feedback through the patient survey were Talking Therapies – Step 2 with 275 responses, Talking Therapies – Step 3 with 128 responses and CRHTT West with 85 responses.

Questions relating to Involvement and ease have the least number of positive responses. Examples of feedback regarding involvement include patients feeling like they were not involved in decisions regarding their care, when accessing Psychological Medicine Service and Talking Therapies.

For CRHTT West there was an 80.0% positivity score and 4.43-star rating. There were lots of positive comments about staff listening, being helpful, and understanding, "The assessment was carried out sympathetically. In the end we both agreed I didn't need urgent care, but I was provided with several telephone numbers in case I need them. I wasn't even aware of this service, and I was very impressed with how well it worked. Thank you so much.*"* Some of the areas for improvement included discharge was too fast, didn't feel listened to and duty staff were dismissive. There were comments for improvement such as felt medication was given instead of treatment, patients were unsure what to expect and getting through on the phone was often difficult. For example, "*Crisis management is wrong - medicating me rather than treating the root cause, which is my trauma.*"

The Older Adult Mental Health Service and Memory Clinic combined have received a 96.9% positivity rating (4.83-star rating) some of the feedback included *"[Name Removed] was a very understanding and mindful practitioner who was very easy to talk to, her approach to my husband was gentle but also able to couch questions in a good way without making him feel uncomfortable. Appointments and telephone calls were always prompt."*

There were 34 responses received for West CMHT teams with 85.3% positivity score and 4.49-star rating, 29 of these were positive with comments received that staff were professional and kind, there were 3 negative responses for Wokingham and 1 for Reading, comments included that patients did not feel listened to, follow up with patients including felt like they were a checklist, didn't feel listened to, lack of compassion, felt like they were not involved in decisions regarding their care and felt disregarded.

Most comments were very positive about the staff, including that they were professional, kind and listened. Several of the comments/areas for improvement were wait for appointment was too long and parking could be improved. For example, *"[Name Removed] has been especially beneficial and I look forward to speaking with her (and [Name Removed]). She seems to listen very well and provides me some good resources. She has been proactive in arranging my mental health needs and also my needs on my social and family assistance. Could not be better.*

For Talking Therapies, the overall scores were 924.62% positivity and 4.75-star rating with the Talking Therapies – step 2 pathway getting the highest scores. Many of the comments were positive about staff having listened, and that they were understanding and helpful.

Examples of positive feedback about Talking Therapies included, *"My Therapist [Name Removed] is amazing. She is so kind, helpful and supportive and listens to everything I say. Moreover, she is very professional and an asset to talking therapies I cannot thank her enough for all her help and support. Thank you."* "*The session was incredibly personable - did not feel like the therapist was ticking a box or rushing me. I really appreciated how she asked me to expand on things I had spoken about to further understand. Even if they're things I hadn't emphasised."* and *"The therapist I have is amazing, she listened , she cares and shows that I'm not alone which is the one I was worried about but I didn't need to feel that way with her. Every talking therapy session I have we can joke too which is great!! I'm*

going to feel so sad when our sessions end in October, but I hope that if I still need support I can have the same person again because talking to someone new I'd feel like I'd have to start from the beginning."

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.

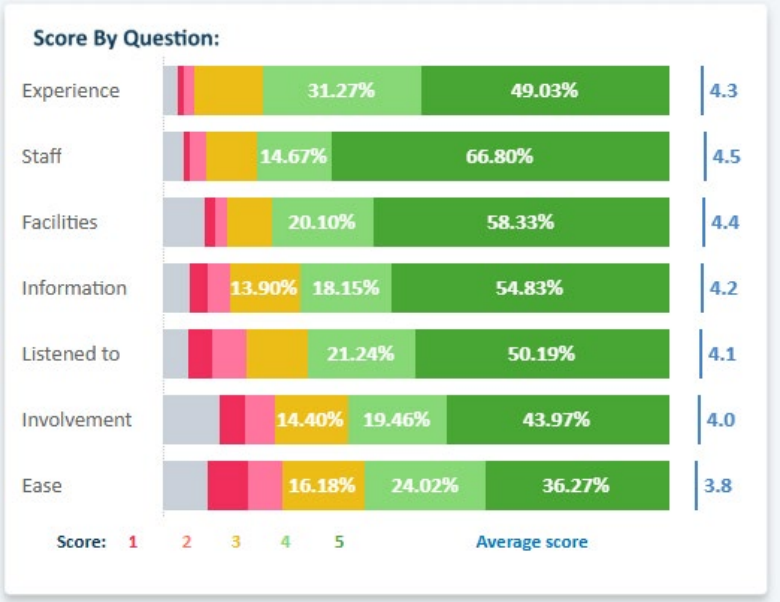
Op COURAGE received 43 responses during the Quarter, their patient survey responses gave a positivity score of 97.7% (4.88-star rating), 1 of the reviews scored less than 4 with the comment that more staff need to be veterans.

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**	226	259		
Response rate	**%**	115.3%	125.7%		
iWGC 5-star score	**Number**	4.12	4.22		
iWGC Experience score – FFT	**%**	71.6%	81.3%		
Compliments	**Number**	32	7		
Formal Complaints Rec	**Number**	10	14		
Formal Complaints Closed	**Number**	11	12		
Formal Complaints Upheld/Partially upheld	**%**	45.4%	45.45%		
Local resolution concerns/ informal complaints Rec	**Number**	1	1		
MP Enquiries Rec	**Number**	0	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 79.4.5% and a five-star score of 4.54.



The majority of inpatient complaints related to care and treatment, communication and one about patient property.

Common improvements identified included strengthening communication with patients and families, improving documentation and ensuring clearer explanations of clinical decisions and care plans.

The satisfaction rate was 81.3% with 43 of the 259 completed questionnaires giving scores of 1-3. The individual question themes would indicate that the question relating to ease received the least positive scores with overall 5-star rating for this question being 3.8 and 63 of the 259 giving a score of 3 or less to this question. The ease question is "If applicable, was the place where you received your care, assessment and/or treatment suitable for your needs?"

The national Culture of care programme has concluded, but local activity aligned to this continues; the programme 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. Internally the work will continue to be progressed and learning shared across wards, and the Lived Experience Workforce Team are supporting the hospital with introducing peer support roles to the wards.

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 wanting more activities, did not feel listened to and food could be improved.

There were many positive comments received in the feedback including comments such as staff were friendly, helpful, caring, and kind. There were some comments for improvement about listening more, food needed improvement and more opportunities to talk to staff. Examples of the feedback left are "*Very supportive and generous staff all in all, the information and care is very considerate, indeed a truly inspirational experience." "The staff listen to me. Even though they are busy they have always tried to help and keep me involved in my care and treatment."*

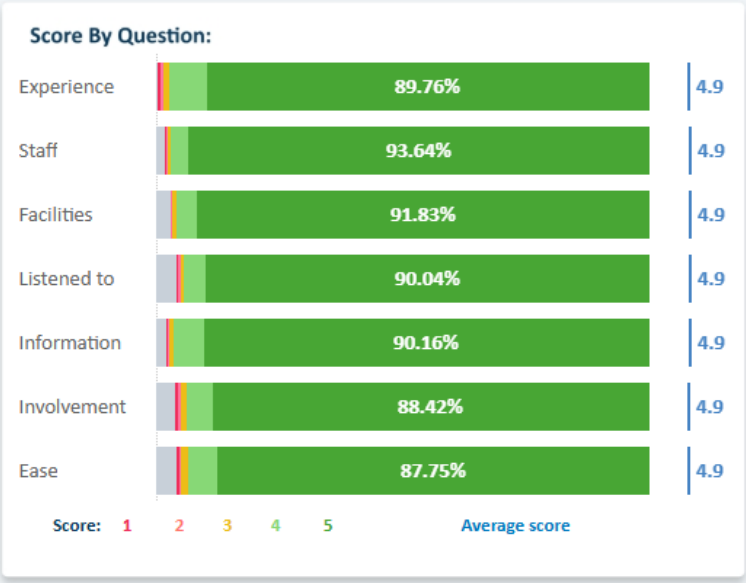
In addition to the feedback about the wards, there were 34 responses for a Place of Safety, and the average score was 4.51, with 7 reviews giving a score of less than 4/5. Some comments received were "*All the APOS staff have been so kind, friendly and helpful and have looked after me extremely well, even providing me with clothes etc which I didn't have when I arrived.*" "*All the mental health care professionals and nursing staff have been very helpful, friendly, kind, and approachable. Food and drink service has been five stars.*"

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	2528	2598		
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	8.0%	8.6%		
iWGC 5-star score	Number	4.87	4.90		
iWGC Experience score – FFT	%	97.2%	97.6%		
Compliments received directly into the service	Number	299	328		
Formal Complaints Rec	Number	4	5		
Formal Complaints Closed	Number	3	4		
Formal Complaints Upheld/Partially Upheld	%	33.3%	100%		
Local resolution concerns/ informal complaints Rec	Number	5	2		
MP Enquiries Rec	Number	1	0		



There were five formal complaints received across Physical Health East services during Quarter 2 and there were no themes.

The Hearing and Balance Service received 194 responses to the patient experience survey with a 97.4% positive score and 4.88-star rating.

East Community Nursing/Community Matrons received 502 patient survey responses with a 99.2% positive scoring, many comments were about staff being kind and caring, for example "*Nurses are very kind every time they visit, and they all treat me with kindness and respect. They are all trying to be as gentle as they can, so I don't feel much pain." "The nurse that came to visit me yesterday for my catheter change was very kind. The procedure was quick and wasn't too painful. She was helpful with also ordering me a bed."* "*All the nurses are kind and friendly. Keep me up to date with my care - call me back to answer any questions they may not have known answer to during visit which is appreciated."* There were also some comments around wanting to be given times for nurses visit for example *"Clearer times as to when the nurses are coming as I care for both mum and dad."*

The wards received 52 feedback responses (22 responses for Jubilee ward 100% positive score and 30 responses for Henry Tudor ward with a 90.0% positive score). Positive comments were received in relation to staff being caring, kind and listened. Two of the responses scored less than 4, comments for improvement related to noise at night, felt they were not listened to and need more staff.

Within MSK physio in the East, there was a high number of responses to the patient survey and a high positivity score of 97.5% (4.86-stars), comments were very complimentary about staff being professional and friendly, *"Everything was very good, appointment was on time staff were friendly & very helpful. The physiotherapist himself was very good & explained everything clearly so was easy to understand, all in all everything you could have hoped for."* The reoccurring improvement suggestion for this Quarter was for more parking.

Outpatient services within the locality received a positivity score of 97.23% with 4.88 stars from the 942 responses received. With some very positive feedback including for the UCR & Virtual Community Ward, *"They were sent to see my husband by our GPs, the nurse that came to our house [Name Removed] was excellent and it was like being seen in hospital but in your home, could not say how impressed we are. The doctor phoned the next day with the results and told us the results. So very happy we have this service."*

The Diabetes Service received 216 feedback responses with 98.1% positivity and some lovely comments including "*The Team always treat me with respect, care, and professionalism. I am very thankful for the service, attention, and for how I feel safe. Thank*

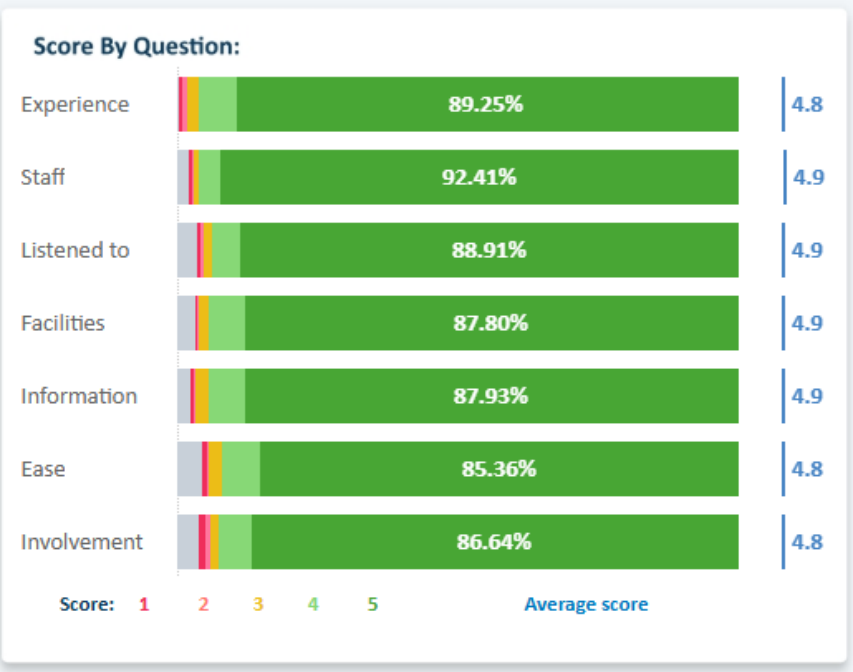
you, Team." Alongside some helpful suggestions for the to improve communication "*More communication between me + what appts + plans.*"

The Assessment and Rehabilitation Centre (ARC) also received positive feedback including "*Brilliant team – wonderful. Everyone was extremely kind, thoughtful, and respectful. A lovely team from [Name Removed] the receptionist to [Name Removed] and the lead nurse and Dr.*''

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	3994	3985		
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	7.0%	7.1%		
iWGC 5-star score	Number	4.87	4.86		
iWGC Experience score - FFT	%	97.0%	96.4%		
Compliments (received directly into service)	Number	586	544		
Formal Complaints Rec	Number	9	10		
Formal Complaints Closed	Number	9	5		
Formal Complaints Upheld/Partially Upheld	%	66.6%	100%		
Local resolution concerns/ informal complaints Rec	Number	8	10		
MP Enquiries Rec	Number	1	0		



The majority of the ten complaints received in Quarter 2 related to care and treatment, with concerns focusing on clinical assessments, treatment decisions, referral pathways, delays in care and ongoing management of health conditions. The other main issues raised was communication.

There are a significant number of services within the division, and a high level of satisfaction received as detailed in the overall divisional scoring of 96.4% positive satisfaction and 4.86-star rating and the question on staff receiving a 96.4% positive scoring from the 3983 responses received.

The community hospital wards have received 190 responses through the patient survey receiving an 86.3% positive score and 4.74-star rating, (20 responses scored three and below) questions around feeling involved and listened to receive the most results of three and below. Comments include *"Because all the staff are kind and helping me get my mobility back as much as they can. I am most grateful to all of them" "All staff from cleaners to physio were professional but also friendly and made my stay so much more tolerable. Cleanliness brilliant. Food was delicious, hot and a brilliant selection. I didn't always know what was on offer - but noticed pineapple juice on the trolley, so asked for it!" "The care and explaining what was happening. Always looked after me. I have loved it here. They got me moving again."* And *"Staff were fantastic, working in extreme heat always kind and caring to my needs, both caters and medical staff. A special mention to the catering staff always helps cheerful."* there were some individual comments would like a sign language interpreter, better communication, would like fresh air and to be include in decisions regarding their care. Comments for reviews with responses that scored below 4 included not given dinner or lunch, would like hot drinks in the day, some nurses are rough, food was poor, nurses took a while to respond, involve patient more and did not feel listened to. There was 1 review which received a score of 1, the comment was that there was no washing powder and they had to wait 4 days for washing to be done.

WestCall received 310 responses through the iWGC questionnaire this Quarter, an increase from the previous quarter (94.8% positive score, 4.77-star rating, 16 scores received below 4. Positive comments included "*The area was clean and looked well kept. There was plenty of seating. Staff were friendly and professional. The Doctor was pleasant and explained the situation and treatment clearly." "The attending doctor and her companion were both patient with my concerns. They also gave me options and explained the case with me in a way I would be able to comprehend. The doctor was gentle enough that I almost did not feel anything during the procedure. Really grateful I got excellent care and treatment. Wound has now healed and dry after I went to have it checked by a nurse." "The Doctor was kind understanding and gave a good assessment of what was wrong. I followed his advice and now the pains has gone very pleased with the outcome."* Areas for improvement included do a more thorough analysis, call in given time slot and better communication.

The Podiatry Service received 215 patient survey responses. Responses were very positive (overall 98.6% positivity 4.89-star rating) with examples including *"The podiatry clinic appeared to be organised and had good hygiene standards. The podiatrist was polite, professional, helpful and had good communication skills."* *"[Name Removed] was amazing, she listened to all my issues patiently and provided clear explanation as to why and what may have caused this. Provided further guidance for do's and don'ts and future course of action."* and *"[Name Removed] was very help full of her advice and caring. She knew what was wrong with my feet by just feeling and has ordered me some innersoles which will help me with my walking. She explained everything I should do and gave me some information for when the innersoles arrive. [Name Removed] is a wonderful addition to the NHS."*

To provide some context across our East and West District Nursing teams combined there were 14,764 unique patients this Quarter.

792 responses were received for Community nursing west (99.2% positive score and 4.93/5 stars) Lots of comments included nurses were kind, caring, and helpful, *"The Nurses in the PICC team are lovely. Thank you for making my journey easier. So kind, patient, thoughtful, always happy cheerful. Thank you for all you do." "We received brilliant service which really helped reduce our anxiety by visiting and supporting mum with understanding her medications, with your kind and patient explanations and help in the last couple of months." and "Everyone was very kind and helpful and explained what was going on."* There were several positive comments about nurses being caring and there were very few suggestions for improvement; sometimes visit feels rushed and would like to be given notice for when nurses will visit.

MSK Physio has received three Formal Complaints in the Quarter. The service has received 572 patient survey responses with a 98.3% positive score (4.88 -star rating), very few areas for improvement were included in the feedback there were a few suggestions including would like appointments to be longer, long waiting time, more privacy and the overall feedback was extremely positive with lots of comments about staff were kind, professional, listened and helpful.

Bladder and Bowel (Continence) services received 98 survey responses with 96.9% positivity and 4.89-star rating, with comments about staff being and friendly.

Demographic profile of people providing feedback.

Table 8: Ethnicity

Ethnicity	% Complaints received	% Patient Survey Responses	% Breakdown of Q2 attendances
Asian/Asian British	11.10%	8.16%	10.02%
Black/Black British	0.85%	2.63%	3.64%
Mixed	8.52%	3.01%	3.72%
Not stated	18.32%	18.32%	8.82%
Other Ethnic Group	4.96%	4.95%	2.06%
White	62.38%	62.94%	71.74%

The percentage of Asian/Asian British people raising a complaint was largely in line with the breakdown of attendance %, for Black/Black British and White British people, the complaints were slightly lower than the attendance %, whilst for mixed and other ethnic groups complaints were higher than attendance. 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.

Table 9: Gender

Gender	% Complaints received	% Patient survey responses	% Breakdown of Q2 attendances
Female	59.83%	37.80%	55.61%
Male	38.46%	29.34%	44.37%
Non-binary/ other	0%	3.30%	0%
Not stated	1.71%	29.56%	0.02%

The data for this quarter shows that we continue to be more likely to hear the voice of female attendees through the patient survey. Complaints for both women and men are broadly aligned to percentage of attendances. When reviewing the main themes of the patient survey there is no discernible difference in overall ratings between male and female

respondents. We are interested to see if there are any themes or areas of note by looking at the outcome of complaints by characteristic and have looked at this information for complaints closed in the Quarter, by gender of the patient where known.

Table 9A: Gender by outcome code

Gender	Rolling Qtr	Not Upheld	Partially Upheld	Upheld
Female	Q3	27.27%	72.73%	0.00%
	Q4	36.00%	48.00%	16.00%
	Q1 26.27	22.86%	68.57%	8.57%
	Q2 26.27	27.27%	57.58%	15.15%
Male	Q3	68.00%	28.00%	4.00%
	Q4	46.15%	53.85%	0.00%
	Q1 26.27	36.36%	59.09%	4.55%
	Q2 26.27	72.73%	27.27%	0.00%
Not stated/Other	Q3	0.00%	100.00%	0.00%
	Q4	50.00%	50.00%	0.00%
	Q1 26.27	0.00%	100.00%	0.00%
	Q2 26.27	0.00%	100.00%	0.00%

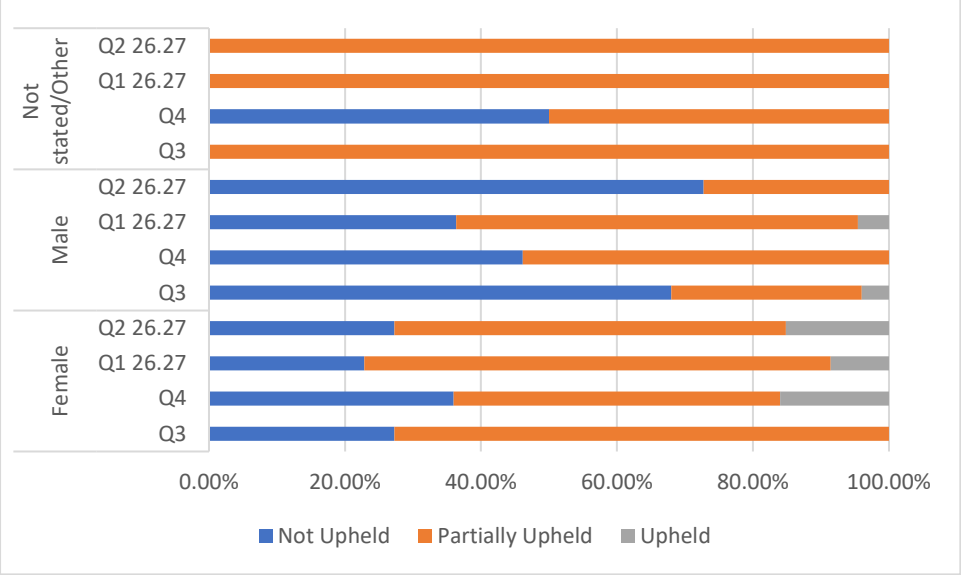


Table 10: Age

Age Group	% Complaints received	% Patient Survey Responses	% Breakdown of Q2 attendances
0 to 4	2.56%	10.63%	5.78%
5 to 9	1.71%		2.64%
10 to 14	8.55%		4.79%
15 to 19	5.98%		5.60%
20 to 24	9.40%	3.95%	3.77%
25 to 29	8.55%		3.59%
30 to 34	4.27%	4.60%	4.00%

Age Group	% Complaints received	% Patient Survey Responses	% Breakdown of Q2 attendances
35 to 39	5.98%		4.17%
40 to 44	11.11%	6.19%	3.78%
45 to 49	5.98%		3.98%
50 to 54	8.55%	9.22%	3.88%
55 to 59	6.84%		4.56%
60 to 64	4.27%	11.24%	4.77%
65 to 69	3.42%		4.82%
70 to 74	0.00%	13.96%	5.70%
75 to 79	3.42%		8.34%
80 to 84	2.56%	12.10%	9.21%
85 +	4.26%		16.63%
Not known	2.56%	28.11%	0%

We continue to see 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 supported the Immunisation service to collect paper feedback at the clinics they held in schools during the quarter, which resulted in a significant increase in school age patient survey feedback compared with previous years.

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).

It is important to understand if everyone is able to access and use the survey; the survey is provided in easy read and several differing languages, and the survey includes narrative explaining why we value completion of the demographic data which enable us to understand further where we might not be hearing the voice of the patient through the survey.

Lived Experience Workforce Programme

To highlight the activity this quarter:

- There are currently 28 substantive posts across the Trust.
- The Peer Educator Post is leading a national Peer Educator Network with a focus on collaboration, development, and co-production.
- Experience Exchanges continue to be well attended and are a great way to bring together learning and collaboration; the Head of Service Engagement and Experience is facilitating an introduction to QI and the Trust Strategy.
- 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.
- A mid-year review of the Development Day in April took place in September. Key updates include the start of a Best Practice Guide, work around attracting Diverse Talent through awareness and outreach, a working group to build a standardised Supervision approach, and continuing to support the wider Trust programme of recruitment.

Lived Experience Advisory Panels (LEAPS)
What we have been doing

- Promoting LEAPs across Berkshire through roadshows, events, social media, posters, booklets, and QR code resources.
- Supporting recruitment of new LEAPs members to increase lived experience involvement.
- Building relationships with services to embed co-production and lived experience perspectives in service improvement.
- LEAPs recruitment and stakeholder engagement, with local charities and stakeholder groups
- Improving LEAPs resources and accessibility to make involvement easier for service users,
  carers, and communities.

Impact

- Increased awareness of LEAPs and involvement opportunities, with new members signing up.
- Expanded engagement with services seeking lived experience input.
- Created more opportunities for people to influence service development and improvement.

Next Steps

- Continue growing LEAPs membership.
- Increase involvement opportunities across services.
- Strengthen co-production and lived experience leadership across Berkshire Healthcare

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
Talking Therapies	Preference for F2F or Video.	Step 2 evidence-based model is telephone or online unless there a clinical need for F2F. We are now offering some of our courses as F2F options. If having support via Silvercloud or Guided Self-help, all

Service	You said	We did
		therapists offer a choice of telephone or video to patients.
	Questionnaires feel like a tick box.	Staff training for January will focus on interpersonal skills. Therapists will review how questionnaires are used in therapy sessions and wellbeing assessments within this to ensure they feel useful.
	Need for more or longer sessions.	We follow NICE guidance around length of appointment. We address expectations of treatment and length of appointments within assessment appointments. In 2027 we will begin looking at a weekly model of therapy which will allow patients to have more consistent contact during therapy.
	Waiting time and access delays are a strong theme.	A focused improvement programme is in place to increase capacity to reduce the backlog and waiting time. Quick wins include updating the DNA standard work to ensure the process is being followed, amending our current Step 2 reoccurring depression pathway and updating our wait time communication text. Longer term improvements will involve reviewing and amending the Step 3 pathway to support quicker access to interventions.
WestCall (GP Out of Hours)	Patients wanted more accurate information about expected call-back and appointment times.	Introduced clearer messaging about response times and improved communication when delays occur.
	Patients wanted better updates when services were running behind schedule.	Reinforced the importance of proactive communication and keeping patients informed of delays.
	Patients said navigating NHS 111 and referral pathways could be confusing.	We have listened to this feedback and recognise that navigating urgent care services can be complex. We continue to signpost patients to the most appropriate service for their needs.
Minor Injuries Unit (MIU)	Patients wanted shorter waiting times and a better understanding of delays.	We continue to encourage staff to keep patients informed of waiting times and provide updates when delays occur.
Urgent community response (UCR) / Virtual Community Ward	Patients highlighted concerns about service capacity and availability.	We have shared this feedback with service leaders as part of ongoing service planning and demand management discussions.
	Patients highlighted occasions when visits did not occur at the expected time.	We continue to encourage teams to communicate any changes to planned visits wherever possible.
Phlebotomy	Patients would like greater flexibility in appointment availability.	We have shared this feedback with service leads to inform ongoing service planning and capacity discussions.

Service	You said	We did
Intermediate Care	Time scales for physio to short – 6 weeks is too short.	Ensure we review patient at 6 weeks and assess need for further intervention.
	Communication with OT difficult.	To ensure we share triage numbers.
	"I did not receive a copy of exercise sheet."	Ensure we write on progress note whether exercise sheet provided so that this can be followed up by key worker.
Audiology	Difficulties getting through on the phone; long waiting times.	Increased administrator telephone availability. Work continues to reduce waits for review patients, with significant reductions for adults and current focus on paediatric patients.
Community Dental	Less waiting time initially, while recognising this may be difficult.	The service is working to reduce the wait from referral to first appointment. Patients are offered the first available appointment, which may not be at their nearest clinic.
Diabetes & Nutrition and Dietetics	Some groups were too large for useful interaction and questions with the dietitian.	The group size was reduced from 40 to 20.
Sexual Health	Provide estimated waiting-time information on arrival and updates while waiting.	Administrative staff routinely update patients on arrival and while they wait; this has been well received.
Wheelchair Services	Keep up the good work; provide a vending machine.	The service continues to maintain standards. A vending machine was explored and trialled but returned because of cost and other issues. Staff now offer tea or coffee, and biscuits or fruit when available, to patients waiting for longer periods.
Heart Function East	Patients would like to see the same nurse, particularly where staffing and Tuesday meetings can result in different nurses.	The team will try to book patients with the same nurse where possible and explain at the start that they may see different nurses from the same trained team.
Lower Limb Service	Patients who work asked for early appointments.	Team members started clinics earlier to accommodate this.
CARSS (Cardiac and Respiratory)	Instructions for finding rehabilitation venues could be clearer.	Venue maps sent to patients were reviewed and updated.
IPASS Spine	Patients did not understand the follow-up process after investigations.	All patients are given MRI information leaflets including timescales. The administrative team is exploring text-message updates for patients awaiting MRI results.
	Patients did not understand the role of pain services and clinicians.	Pre-assessment service introduction sessions are being developed, initially for IPASS Spine patients, to support understanding before opting into treatment.
Adult Speech and Language	Patients were concerned about being overheard during sessions at Wokingham Portacabin.	A white-noise machine is used in the waiting area to provide reassurance.
Podiatry	A patient was unsure what to expect during a foot-ulcer appointment, including possible treatment.	Patients attending with a foot wound now receive an information leaflet explaining what to expect, including

Service	You said	We did
		treatments such as wound debridement.
MSK Physio	Patients raised waiting times and delays.	Community Assessment Days are running at all sites; Saturday clinics continue; digital workstreams are exploring AI for triage and treatment.
	Patients raised concerns about space, noise and privacy.	Clinical space and feedback are under ongoing review, with off-site gym space and clinics used where appropriate.
	Patients raised administration, reception, communication clarity and exercise communication issues.	Actions include process automation, recruitment to further administration post. updated Community Assessment Day and new-patient letters, and exploration of digital self-check-in.
	Patients raised parking and site-access concerns.	Appointment letters remind patients to allow time for parking.
CAMHS Learning disability	Parents reported finding it difficult to complete paper-based recording form for behaviours that challenge. The feedback received explained they do not always have access to a printer, paper forms are more difficult to return to the team, and they may not always have the form to hand	We developed an electronic form, accessible via a QR code so families can easily complete behaviour records online including via their smartphones. This is easier, quicker and more efficient for families. These can more easily be completed 'in the moment' to capture accurate and timely information.
CAMHS getting help	That our referral forms are not easy to follow	We have reviewed our referral forms and have made changes to make them easier to follow
0-19 teams	Feedback received though a focus group with ethnically diverse families Many were unsure what the Health Visiting Service offers beyond baby health checks. Awareness of Health Visiting during pregnancy is low, with little recall of information being provided through antenatal education. Language remains a significant barrier. Many families rely on relatives to translate letters, texts and phone calls. Most women were unaware that interpreting services are available. Face-to-face appointments are strongly preferred over video consultations.	Providing more information in community languages. Investigating short, translated videos explaining the Health Visiting Service and appointments. Greater promotion and routine use of interpreters. Continued flexibility with appointments and reminders. Working closely with community groups, faith organisations and cultural networks to raise awareness of support available.

Service	You said	We did
	Travel costs, transport difficulties and childcare responsibilities can make attending appointments challenging. Families highly value and trust Health Visitors. Wider family members and community influences often play an important role in healthcare decision-making.	

15 Steps

There have been eight ‘15 Steps’ visits during Quarter 2. We are receiving consistently positive feedback about the visits, with services sharing how helpful they are. More information is attached as an 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 analyse data more accurately in terms of any differential experience.

Appendix 2: complaint, compliment, and PALS activity

All formal complaints received.

	2025/26					2026/27						
Service	**Q1**	**Q2**	**Q3**	**Q4**	**Total for year**	**Q1**	**Q2**	**Compared to previous quarter**	**Q2 no. of contacts**	**% contacts Q2**	**Total for year**	**% of Total**
Acute Inpatient Admissions – Prospect Park Hospital	8	6	8	10	32	8	12	↑	189	6.35	20	10.31
CAMHS - Child and Adolescent Mental Health Services	8	4	8	7	27	5	6	↑	3573	0.17	11	5.67
CMHT/Care Pathways	10	10	10	18	48	19	29	↑	3946	0.73	48	24.74
Common Point of Entry	0	1	4	2	7	2	0	↓	2239	0.00	2	1.03
Community Hospital Inpatient	1	5	1	2	9	1	1	No change	455	0.22	2	1.03
Community Nursing	1	3	1	4	9	1	5	↑	14764	0.03	6	3.09
Crisis Resolution & Home Treatment Team (CRHTT)	3	9	8	8	28	6	12	↑	4892	0.25	18	9.28
Older Adults Community Mental Health Team	0	1	0	1	2	0	2	↑	2510	0.08	2	1.03
Out of Hours GP Services	2	0	2	4	8	2	2	No change	5094	0.04	4	2.06
PICU - Psychiatric Intensive Care Unit	0	1	0	0	1	1	0	↓	17	0.00	1	0.52
Urgent Treatment Centre	0	0	0	0	0	2	2	No change	3932	0.05	4	2.06
Other services during quarter	18	18	18	43	97	34	42	↑	126858	0.03	76	39.18
Grand Total	51	58	60	99	268	81	113				194	

The increase in complaint activity is sustained into quarter 2. This aligns with the national picture across provides of NHS services.

CMHT saw the highest increase in the number of Formal Complaints – an increase of over 50%. These were spread across geographical localities as shown in the table below.

	Geographical Locality						
Main subject of complaint	Bracknell	Reading	Slough	West Berks	Windsor, Ascot and Maidenhead	Wokingham	Grand Total
Access to Services					1		1
Attitude of Staff						1	1
Care and Treatment	1	7	2	3	5	3	21
Communication			1	1		1	3
Confidentiality		1					1
Medical Records			1				1

	Geographical Locality						
Main subject of complaint	Bracknell	Reading	Slough	West Berks	Windsor, Ascot and Maidenhead	Wokingham	Grand Total
Waiting Times for Treatment						1	1
Grand Total	1	8	4	4	6	6	29

Informal Complaints received

	Month Received			
Division	July	August	September	Grand Total
Children, Young persons & Families	2	1	0	3
Physical Health	1	1	0	1
Grand Total	3	2	0	5

Locally resolved concerns received.

	Month Received
Division	July
Children Young People and Families	7
Mental Health East	4
Mental Health Inpatients	1
Physical Health	12

An issue with the reporting system has meant that Local Resolution complaint information is currently not available.

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.

	2025/26					2026/27				
Outcome	Q1	Q2	Q3	Q4	Total for year	Q1	Q2	Higher or lower than previous quarter	Total for year	% of 26/27
Consent not granted	2	4	4	1	10	3	4	↑	7	3.89
Locally resolved/not pursued	2	3	6	11	11	7	8	↑	15	8.33
Not Upheld	24	19	26	36	69	19	31	↑	50	27.78
Partially Upheld	19	21	21	52	61	41	45	↑	86	47.78
Upheld	8	10	1	8	18	9	6	↓	15	8.33

	2025/26					2026/27				
Outcome	Q1	Q2	Q3	Q4	Total for year	Q1	Q2	Higher or lower than previous quarter	Total for year	% of 26/27
SUI	0	1	0	0	1	1	0	↓	1	0.56
Other	0	3	1	0	3	5	1	↓	6	3.33
Grand Total	55	61	59	108	281	85	95		180	

A total of 95 formal complaints were closed during the quarter. Of these, 51 (56%) were either partially upheld (45) or upheld (6). 31 complaints were not upheld, 8 were resolved locally or not pursued, and 4 could not be progressed due to consent not being granted. The upheld complaints were spread across a range of services, with no significant themes identified.

Complaints upheld and partially upheld.

	Main subject of complaint											
Service	Alleged abuse/bullying	Access to Services	Attitude of Staff	Care and Treatment	Communication	Confidentiality	Discharge	Medication	Parking	Support Needs	Waiting Times	Total
A Place of Safety				1	1							2
Additional Roles Reimbursement Scheme - ARRS		1										1
Adult Acute Admissions - Rose Ward				1								1
Adult Acute Admissions - Snowdrop Ward					1							1
CAMHS - Rapid Response				1								1
Children's Occupational Therapy - CYPIT				1	1							2
Children's Physiotherapy - CYPIT				1								1
Children's Speech and Language Therapy - CYPIT				1							1	2
CMHT/Care Pathways				4	4			1			1	10
CMHTOA/COAMHS - Older Adults Community Mental Health Team					1							1
Common Point of Entry			1									1
Community Hospital Inpatient Service - Jubilee Ward			1									1
Community Paediatrics						1						1
Community Team for People with Learning Disabilities (CTPLD)				1								1
Crisis Resolution and Home Treatment Team (CRHTT)			2	1		1						4
District Nursing				3								3
Eating Disorders Service				1								1
Estates & Facilities	1								2			3
Health Visiting						1						1
Integrated Pain and Spinal Service - IPASS				1								1
Out of Hours GP Services				1								1
Phoenix				1								1
Psychological Medicine Service				1								1
Psychology Service							1					1
Rose Ward				1								1
Sorrel Ward					1							1

	Main subject of complaint											
Service	Alleged abuse/bullying	Access to Services	Attitude of Staff	Care and Treatment	Communication	Confidentiality	Discharge	Medication	Parking	Support Needs	Waiting Times	Total
Specialist School Nursing										1		1
Talking Therapies - PWP					1							1
Talking Therapies - Wellbeing Service				1								1
Traumatic Stress Service							1					1
Urgent Community Response					1							1
Urgent Treatment Centre				1								1
Grand Total	1	1	4	23	11	3	2	1	2	1	2	51

Care and Treatment complaint outcomes.

	Outcome of complaints about care and treatment			
Service	Not Upheld	Partially Upheld	Upheld	Grand Total
A Place of Safety		1		1
Adult Acute Admissions - Rose Ward		1		1
Bluebell Ward	1			1
CAMHS - Rapid Response		1		1
Children's Occupational Therapy - CYPIT			1	1
Children's Physiotherapy - CYPIT			1	1
Children's Speech and Language Therapy - CYPIT		1		1
CMHT/Care Pathways	4	4		8
Community Dental Services	1			1
Community Team for People with Learning Disabilities (CTPLD)		1		1
Crisis Resolution and Home Treatment Team (CRHTT)	2	1		3
CYP - AAT	1			1
District Nursing		3		3
Eating Disorders Service		1		1
Integrated Pain and Spinal Service - IPASS		1		1
Mental Health Act Department	1			1
Out of Hours GP Services		1		1
Phoenix		1		1
Psychological Medicine Service		1		1
Rose Ward	1	1		2
Snowdrop Ward	1			1
Talking Therapies - Anxiety and Depression	1			1
Talking Therapies - Wellbeing Service		1		1
Traumatic Stress Service	1			1
Urgent Treatment Centre		1		1
Grand Total	14	21	2	37

PHSO/LGO

The table below shows the PHSO activity since April 2025:

Month opened	Service	Month closed	Current stage
June-25	Place of Safety	Closed	Closed with no action
June-25	Place of Safety	Closed	Closed with no action
Dec-25	District Nursing	Closed	Closed with no action
Dec-25	CMHT/Care Pathways	Closed	Closed with no action
Jan-26	IPASS	Ongoing	Documents sent to PHSO
Jan-26	CMHT/Care Pathways	Closed	Closed with no action
Jan-26	CMHT/Care Pathways	Closed	Closed with no action
June-26	CMHT/Care Pathways	Ongoing	Documents sent to PHSO
Aug-26	Mental Health Inpatients	Ongoing	Documents sent to PHSO
Sept-26	Mental Health Inpatients	Ongoing	Documents sent to PHSO

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 quarter two we received 3 complaints via the CQC.

Compliments

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

Year	2025/26					2026/27				
Quarter	Q1	Q2	Q3	Q4	Grand Total	Q1	Q2	Q3	Q4	Grand Total
Received	1682	1285	1430	1275	5672	1484	1479			1484

Patient Advice and Liaison Service (PALS)

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

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.

During the reporting period, PALS continued to provide advice, information, support and informal resolution of concerns across all clinical and corporate services. The service played a key role in facilitating communication between patients and staff, promoting early resolution and supporting positive patient experiences. PALS collaborates with the complaints team to triage queries which may merit a formal investigation.

Key themes identified this quarter included communication (enquiry) care and treatment (concern) and communication (concern).

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. There has been a lot of cross over between the PALS and complaints services.

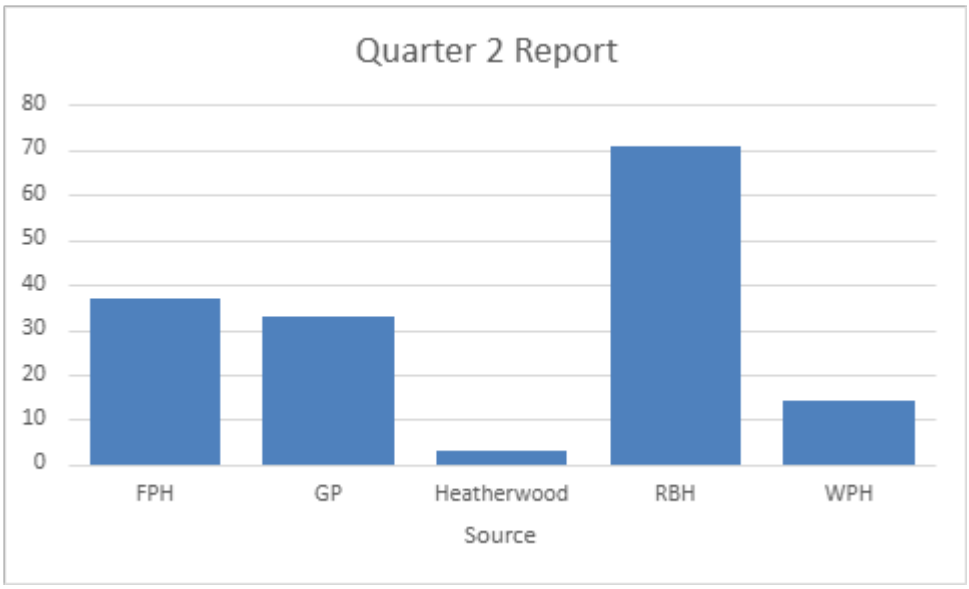
The Patient Experience Team has undertaken work to standardise and streamline the PALS process, to make it more user friendly for the wider team and enable the service to be covered consistently during the absence of the PALS Manager. The PALS Manager has conducted training with the team to assist with this process.

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 service provides a SITREP weekly, highlighting open queries and themes.

There were 368 queries recorded during Quarter 2.

In addition, there were 198 non-BHFT queries recorded. Enquirers and complainants are signposted to the relevant organisation, and liaison is conducted with other PALS

services to address concerns. Another member of the Patient Experience Team is consistently helping with the recording process to improve the rate of data collection.



The PALS Manager 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.

There were a number of reasons for people contacting PALS, the main themes are:

Signposting:

- Patients contacting to confirm/rearrange appointments.
- Concerns for the welfare of patients.
- Patients trying to cancel appointments.
- Practitioners trying to contact services to discuss patients.

Concerns: Care and treatment

- Patients reported concerns regarding:
- Unhappy with care and treatment including communication/diagnosis.
- Unhappy with the level of support provided.
- Access to treatment and diagnosis.
- Concerns about care and potential discharge.

Concerns: Communication:

- Difficulties contacting service/no contact.
- Communication with the service leading to dissatisfaction with care.
- Unhappy with administration/correspondence.
- Unhappiness following an interaction with staff.

PALS continues to provide an essential service in supporting patients, families and carers, ensuring concerns are addressed promptly and lessons are identified to improve patient experience. While communication and care and treatment remain recurring themes, positive feedback continues to highlight the dedication and commitment of Trust staff. Ongoing collaboration with clinical and operational teams will support continuous improvement and help ensure that patient voices remain central to service development.

15 Steps; Quarter Two 2026/27

During quarter two, there were 10 visits:

Mental Health Services Division		
Prospect Park Hospital		
Ward	**Positives**	**Observations**
Physical Health Services Division		
Community Inpatient Wards		
Ward	**Positives**	**Observations**
Highclere Ward, WBCH	Photo boards were up to date, along with contact info for other key staff, such as Safeguarding, the Patient Safety Team, Governance Lead etc Liked the link teams details on board for patients and relatives. Huddle board tidy with current work and staff were able to tell when it's done and how to feedback. The ward proactively reviewed patient feedback. The information on iWGC was up to date and included qualitative feedback. Staff were friendly and were visible in the office for a meet and greet. The ward appeared calm but busy. The outside space was welcoming. Information on the journey for patients was clearly on display, which helped to explain what is going to happen and manage expectation. Did not hear any bells being activated. Relevant information about the therapy available to patients is clear. Good evidence of sharing info and learning. Up to date staffing visible and staffing levels appropriate. Evidence of topical QI work. Very positive conversation with activities coordinator. She was extremely enthusiastic and there were visible signs of activities and engagement for patients.	
Donnington Ward, WBCH	Photo boards were up to date, along with contact info for other key staff, such as Safeguarding, the Patient Safety Team, Governance Lead etc The ward proactively reviewed patient feedback.	

	The information on iWGC was up to date and included qualitative feedback. Staff were friendly. The ward appeared calm. The outside space was welcoming, and staff described supporting patients from the Rainbow Room. Information on the journey for patients was clearly on display, which helped to explain what is going to happen and manage expectation. Did not hear any bells being activated. Nurses on duty and staffing levels were clearly on display and up to date. The ward was clean and uncluttered. Walkways were clear of obstruction and housekeepers were actively on the ward. Equipment was accessible and stored in clearly labelled areas. Relevant information about the therapy available to patients is clear.	
MIU, WBCH	Well signposted. Large noticeboard clearly demonstrating open times and out of hours information. Board depicting staff in the department although some new staff pictures were work in progress. Waiting area was clean and bright. Toys available for children which could be cleaned. Seating available. All of the staff we spoke with were welcoming and friendly. Some patients being treated in the unit. Department felt calm and organised despite the emergencies taking place in the clinic rooms, and the CQC in the unit, the staff (and patients) were visibly calm. No evidence of clutter. Lots of leaflets on a variety of subjects available which were current and could be updated. CQC and QMIS work evident. Proactively collecting patient feedback and displaying the 'you said, we did'.	
Community Physical Health Services		
Service	**Positives**	**Observations**
Podiatry, WBCH	The service and waiting areas were light, bright and not cluttered. All of the staff we spoke with were welcoming, friendly and proud to work in the service.	The Board of Director poster is to be updated.

	The area allocated for the service was clear. They made good use of the limited space available. Proactively collecting patient feedback and displaying the 'you said, we did' There was relevant information about the service available. Patients and families are happy with the service.	The team will update the team photos to include the new uniforms.
PICC Clinic, WBCH	The clinic area was light, bright and not cluttered. There was a TV on, with low volume. The unit was calm. Proactively collecting patient feedback There was relevant information about a number of different services.	
Physiotherapy, WBCH	Reception staff pleasant and welcoming Area was bright and clean Good selection of seating to accommodate patient needs. Staff wellbeing was a focus. Clinic was busy but calm. No clutter and access areas clear. All staff were engaged with patients. Well signposted. Waiting time clearly displayed.	
Health Visiting Clinic, West Berks	Staff member on desk (volunteer) very welcoming. Qualified staff member checked in patients. Lots of interactions between staff and Mums/babies observed. Room very spacious with seating available. Room also available for booked appointments with a clinician. Clear process for monitoring cars in car park. Organised and calm. Area clean. Clear process to monitor who was attending. Clinic had a steady input of Mums and babies. Clear development for new staff.	
Community Dental Service, Skimped Hill H.C, Bracknell	The service and waiting area was light, bright and not cluttered. There is a poster with 'Welcome' in different languages, along with a poster about BSL interpreting. Jill, a volunteer receptionist was welcoming and friendly. The service area was well organised.	The chairs in the waiting area are very narrow. The Trust branded poster with QR code would look more professional.

	Proactively collecting patient feedback There was relevant information about the service available, and the notice boards were clear and up to date. Helpful information about sugar content on display.	The 'What we are Proud of' board had a lot of information. For review.
MSK Physio, Churchill House, Bracknell	The service waiting area was not cluttered. All the staff we spoke with were welcoming and friendly. The areas were clear and well organised. There are prompts for staff on having challenging calls and different pathways on display. Proactively collecting patient feedback and displaying the 'you said, we did'. There was relevant information about the service available, and the notice boards were clear and up to date.	Having dates on the patient feedback would be helpful. The 'What we are Proud of' board had a lot of information. For review.
Podiatry Service, Skimped Hill H.C, Bracknell	The service is signposted well from the main reception. Proactively collecting patient feedback There was some information about feet and lace.	There was a concern that people may feel forgotten – whilst there is a poster on the wall to say that they will be called, it did not say what to happen if they are not. The Learning from Experience Poster is out of date, they will contact PALS for more.

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 November 2026
Title	Board Report Summary: Thirlwall Inquiry Report and NHS England Actions
	Paper for Assurance
Reason for the Report going to the Trust Board	This report is written to support NHS England ask to review the Thirlwall Report published September 2026 and discuss its implications at the Trust Public Board meeting. 1. Consider whether similar events could occur within their organisation. 2. Seek assurance regarding the effectiveness of governance, safeguarding, escalation, and speaking-up arrangements. 3. Confirm safeguarding training compliance for Board members and staff. 4. Ensure staff understand processes for raising and escalating concerns Link to full report: Thirlwall Inquiry report - GOV.UK
Business Area	Trust Wide
Author	Debbie Fulton; Director Nursing and Therapies
Relevant Strategic Objectives	**Patient safety** **Ambition:** We will reduce waiting times and harm risk for our patients **Patient experience and voice** **Ambition:** We will leverage our patient experience and voice to inform improvement **Health inequalities** **Ambition:** We will reduce health inequalities for our most vulnerable patients and communities **Efficient use of resources** **Ambition:** We will use our resources efficiently and focus investment to increase long term value

Berkshire Healthcare
NHS Foundation Trust

Board Report Summary: Thirlwall Inquiry Report and NHS England Actions

The Thirlwall Inquiry was established to examine the circumstances surrounding the events at the Countess of Chester Hospital following the conviction of the former Neonatal nurse for the murders and attempted murders of babies at the hospital.

The inquiry's purpose was to determine how concerns were managed by healthcare organisations and regulators, and make recommendations to strengthen patient safety, safeguarding, organisational culture, and accountability across the NHS. The aim being to provide answers for affected families and ensure that lessons are learned to prevent similar failures in the future.

Following the publication of the inquiry report on 15th September 2026 NHS providers and ICB are asked to review the Inquiry findings at their public board and seek assurance that comparable failures could not occur within their own organisations.

The broader themes relevant to all organisations including those that do not provide neonatal services that emerged are as below, with an emphasis placed on creating a culture of professional curiosity, psychological safety, effective speaking up arrangements, robust safeguarding processes, and strong Board oversight.

- The Patient safety
- Safeguarding
- Freedom to Speak Up
- Professional curiosity
- Leadership and governance
- Organisational culture and accountability

Trust Boards are required to:

1. **Review the Thirlwall Report and discuss its implications at the next public Board meeting.**

2. **Consider whether similar events could occur within their organisation.**

3. **Seek assurance regarding the effectiveness of governance, safeguarding, escalation, and speaking-up arrangements.**

   - The Board as well as Quality Assurance Committee (QAC) receives quality concerns register.
   - The Board receives performance scorecard which includes metrics aligned to our true North strategic goals of harm free care, supporting our staff, great patient experience, and effective use of resources.
   - The board receives quarterly patient experience report which provides feedback from a range of sources including formal complaints and outpatient feedback tool.
   - The Trust patient safety and incident response plan is signed off by QAC and a quarterly report including learning from incidents is provided into QAC.
   - Learning from national reviews is shared into QAC and full board.

- The board receives direct contact with our FTSUG who attends and provides a report into public board six monthly.

- The Board support completion of the FTSU self-assessment document every 2 years with the improvement plan coming to board alongside the FTSUG report.

- Gemba (service visits) are undertaken by Board members to support understanding of service level culture.

- We have a non-exec director identified for FTSU and also for wellbeing.

- A report is shared with Board around wellbeing services.

Recent CQC well -led inspection has highlighted three areas pertinent to this report.

> ‘’*A consistent theme throughout the inspection was the strength of the trust's culture. Staff described a positive and psychologically safe environment to work in’’.*
>
> *‘’Leadership and staff engagement was a key strength identified. The inspection team heard widespread praise for the visibility and accessibility of senior leaders, with regular engagement through approaches such as Gemba visits helping leaders maintain a strong connection with frontline services’’.*
>
> ‘’*The trust’s commitment to staff wellbeing was recognised, including the decision to continue investing in wellbeing support despite financial pressures, reflecting the value placed on supporting colleagues’’.*

4. Confirm safeguarding training compliance for Board members and staff.

- Trust compliance is above 90% for safeguarding adults and children.

- All Board have relevant level of training.

- in addition, recognising newer board members a bespoke sessions will be put on for board delivered by our safeguarding leads in December 2026.

5. Ensure staff understand processes for raising and escalating concerns.

- Our staff survey indicates a positive safety culture with 82% staff reporting safe to raise unsafe clinical practice (6% above peer average) and 73% feeling confident that concerns would be addressed (14% above peer average)

- Whilst we recognise that continued work is required to improve this further , we are able to target to areas with lower scoring.

- 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.

- FTSUG presence is part of corporate induction alongside visibility across the Trust and into staff networks.

Question for discussion:

Does the Board believe that current processes, data, and intelligence received provide the assurance required to satisfy itself that:

1. Staff feel safe and supported to raise concerns without fear of reprisal.
2. Freedom to Speak Up processes are effective and accessible.
3. Concerns are escalated, investigated, and acted upon in a timely manner.
4. Leadership behaviours support openness, transparency, and challenge.
5. Organisational culture supports curiosity, challenge, and continuous improvement.
6. Safeguarding arrangements are robust, well understood, and regularly reviewed.
7. The Board receives sufficient information to identify deteriorating safety concerns at an early stage.
8. Quality and safety intelligence is triangulated effectively to identify emerging risks.
9. Quality and safety intelligence is triangulated effectively to identify emerging risks.
10. Learning from incidents, complaints, safeguarding reviews, and external inquiries is embedded across the organisation.
11. Staff wellbeing and psychological support arrangements are in place, particularly for those working in emotionally demanding services.

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper Meeting Paper

Board Meeting Date	10 November 2026
Title	**6 monthly Safe Staffing Highlight Report (April 2026 – September 2026)**
	Item for Assurance
Reason for the Report going to the Trust Board	This report is presented to the Board to provide assurance in relation to safe staffing on our reports in line with the requirements of the NHS England / Improvement Developing Workforce Safeguards (2018).
Business Area	Organisational
Author	Linda Nelson -Lead Nurse for Professional Practice Debbie Fulton - Director Nursing and Therapies
Relevant Strategic Objectives	The Plan is relevant to the following strategic objectives, **Patient safety** **Ambition:** We will reduce waiting times and harm risk for our patients **Workforce** **Ambition:** We will make the Trust a great place to work for everyone **Efficient use of resources** **Ambition:** We will use our resources efficiently and focus investment to increase long term value

Berkshire Healthcare NHS Foundation Trust

Highlight Report

Six monthly safe staffing report for Board

1. Why is this coming to the Board?

In line with the requirements of the NHS England / Improvement Developing Workforce Safeguards (2018); a report is provided to the Board twice yearly. The expectations under the Developing Workforce Safeguards is that staffing establishments are reviewed and published annually, with a mid-year review and that the review takes into account patient acuity, service developments, staff supply, temporary staffing requirements and quality / safety measures for staff and patients. This report covers the retrospective period April 2026 – September 26.
As part of the safe staffing review, it is also a requirement that both the Director of Nursing and Therapies and the Medical Director confirm in a statement that they are satisfied with the outcome of any assessment that staffing is safe, effective, and sustainable. This statement is detailed below in the summary.

2. What are the key points?

	Mental Health Wards			Community physical health Wards			Learning Disability		
Metrics	**Baseline Sept 24**	**Sept 25**	**Current September 26**	**Baseline Sept 2024**	**Sept 25**	**Current September 26**	**Baseline Sept 2024**	**Sept 25**	**Current September 26**
Vacancy - Registered staffing FTE	27.39 FTE	**17.32↓**	**13.52↓**	28.25	14.36↓	**20.20↑**	2.56	-0.2↓	**-0.2↔**
Use of Temporary staffing	19,988 Shifts	13,532↓	**17548↑**	6,068 shifts	3,897↓	**5401↑**	2,177 shifts	1,562↓	**973↓**
Shifts with less than 2 registered nurses	138	**79↓**	**43↓**	65	**12↓**	**17↑**	0	0↔	**0↔**

Whilst there has been a slight increase in use of temporary staffing over the reporting period for both mental health and Community Health wards in comparison to September 2025, all the metrics remain lower than 2024 baseline. For Mental health wards we continue to see significant improvements in vacancy and shifts with less than 2 registered staff.

Most of the newly recruited nursing staff continue to be recently registered and therefore less experienced. There is a preceptorship programme and structured supervision sessions in place to support these staff which runs through their first year of employment. Alongside this we have Advanced Nurse Practitioners, consultant nurses, senior nurses, and Allied Health Professionals who are supernumerary to the ward establishment and can support the less experienced staff on duty. For our mental health wards there is also specialist practitioners including the Physical Health and Drug & Alcohol leads, and a Duty Senior Nurse is available 24/7.

The Trust achieved the National Preceptorship Quality Mark in July 2025 in recognition of the standard of our preceptorship programme for nursing and Allied Health Professionals.

Temporary staffing, through NHS Professionals (bank staffing) is and will continue to be an important component of our ward staffing as this enables the ability to flex staffing in line with patient need and acuity. A significant proportion of our NHS professionals staffing are our own staff undertaking additional shifts, meaning that continuity and consistency of care is maintained when temporary staffing is used. Only a very small (equivalent of less than 2FTE a month spread across all wards) amount of Agency use where we are unable to secure NHSP.

During this reporting period sickness absence across the wards has generally remained higher than Trust average. The top three sickness absence reasons in terms of number of working days lost due to illness remain the same as in previous reporting periods, these are anxiety/ stress/ depression and other psychiatric illness, chest and respiratory problems and musculoskeletal problems; the most frequent reason in terms of number of staff affected are chest and respiratory problems and cold, cough, flu. Temporary staffing is used to fill gaps in the rota as required when staff absence occurs due to sickness.

As is a requirement when building agreed establishments for wards, a 24% uplift is included to factor in absence such as training, annual leave, and some sickness.

The main ways used to review safe staffing establishments are:

1. Professional judgement (this is what staff and managers believe to be staffing needed).
2. Staffing review tool -Safecare / MHOST tool (this is a national recognised/ NICE approved tool that calculates staffing needed to meet the care of the patients factoring in their acuity and dependency. The safecare tool enables reporting in terms of actual and required staffing expressed in care hours per patient day (CHPPD).

When comparing our CHPPD to our peers using data from the model hospital platform, our data is comparable; we appear to have slightly less registered nursing , particularly across some of our mental health and community wards than our peers but a richer skill mix and either largely comparable or slightly higher total CHPPD when factoring in total nursing.

Within the trust we have a People and Culture Strategy with strategic initiatives related to workforce and we have had several workstreams supported by Quality Improvement methodology to focus on identified areas including staff retention. We also have significant ongoing programmes of work to support our staff including our violence reduction and anti-racism programmes, these are reported to the Board.

There is a process in place for ensuring that apprenticeship offers are targeted to areas most challenged in terms of recruitment.

Our 2025 organisational national staff survey results continue to demonstrate above average scores in relation to flexible working and achievement in good work life balance.
The results have also demonstrated that staff would recommend the organisation as a place to work achieving the best national results for our peer group for the last 5 years and that our staff have development opportunities, scoring best within peer group for opportunities to improve skill and knowledge (79.21%) and access to the right learning and development opportunities when I need them (71.73%).

For community nursing, this report also includes the outputs from our first two data collections using the nationally available community nursing safer staffing tool.

Although there are no national tools available for other community services with nursing, we do now review safe staffing monthly, factoring in actual compared to agreed staffing and other metrics aligned to those used for the wards. There avhe been no areas of concern over the last 6 months.

3. Ongoing Work

- Continue 6 monthly data collection for community nursing using CNSST II to support any planning considerations.

- Continued recruitment and retention effort as detailed within recruitment and retention workstream of the People plan.

4. Summary and Safe Staffing Declaration

Summary position

From all the data available within the report it appears that for our mental health wards that sufficient staffing appears to have been used over the last 6 months to meet the needs/ acuity of the patients and that additional staffing has been used as needed. A review of patient feedback for 1st April to the end of September has demonstrated that overall positivity with experience across the wards averaging 75% whilst satisfaction in relation to experience of staff ranged from 81%.

Our learning disability unit was also deemed have been safely staffed during this reporting period.

For the community wards, all the wards have an establishment with additional staff as needed to meet patient need except for Oakwood, which appears to have slightly less than optimal staffing to meet patient acuity.

A review of patient feedback across the physical health wards between 1st October and the end of March demonstrated that , the positivity score with overall experience was over 93% in terms of overall experience and 89% in relation to staff.

Taking into account that all of our wards have other staff who are not captured in the data such as Occupational and Physiotherapists, senior clinical staff and ward managers who also provide care to patients; factoring this in all of the wards were deemed to be safe.

The only anticipated change across our wards over the coming 6 months is the move of Jubilee ward to the St Marks Hospital site.

Declaration

The Safe staffing declaration provides the opinion of the Medial and Nursing Directors in relation to the position of our staffing across our wards over the last 6 months.
Over the last 6 months the wards have been considered to have been safe with no significant patient safety incidents occurring because of staffing levels. It is however recognised that at times during the reporting period nursing staffing on some of our wards was sub-optimal and consequently it is possible that patient experience was compromised.

Medical staffing numbers remain stable with adequate medical cover available during routine working hours for inpatient mental health and community health wards. Out of hours medical cover is provided by GPs for all our community health wards. Out of hours medical cover is provided by Resident Doctors for the mental health wards and Campion with Consultant Psychiatrists providing on-call cover from home.

Berkshire Healthcare
NHS Foundation Trust

Six-monthly Safe Staffing Board Report
April 2026 – September 2026

Overview.

The purpose of this report is to provide the board with a twice-yearly assessment and assurance in relation to safe staffing on our wards, as required in the NHS Improvement, Developing Working Safeguards document published in 2018.

To meet the requirements of the *Developing Workforce Safeguards* (2018) published by NHS Improvement (NHSI) the Trust need to:

1. Include a specific workforce statement in their annual governance statement – this will be assessed by NHSE.
2. Deploy enough suitably qualified, competent, skilled, and experienced staff to meet care and treatment needs safely and effectively.
3. Have a systematic approach of determining the number of staff and range of skills required to meet the needs of people using the service, always keeping them safe.
4. Use an approach that reflects current legislation and guidance where available.

This report is in addition to the monthly safe staffing report provided to the Finance Investment and Performance Committee and Quality Performance Executive Group and published on the Trust internet; it provides detail on metrics and information used to assess both retrospective staffing safety and prospective staffing requirements.

The main ways used to review safe staffing establishments are:

1. Staffing review tool -Safer Nursing Care Tool (SNCT) /Mental Health Optimal Staffing Tool (MHOST) (these are nationally recognised/ NICE approved tools that calculate staffing needed to meet the care of the patients factoring in their acuity and dependency).
2. Professional Judgement Framework; a guide to applying professional judgement in safe staffing reviews (2023). This considers what managers and staff feel is required alongside other factors such as incidents and red flags.

Wards enter data twice a day into the Safecare facility on Health Roster using the appropriate recognised tool for the ward speciality; this is presented as care hours per patient day (CHPPD). In this way data is collected consistently rather than previously as a 20-day snapshot.

Care Hours Per Patient Day (CHPPD) looks at an average number of hours each patient has of care provision each day, this allows us to benchmark across wards and organisations. Across our wards CHPPD does not include supernumerary staff such as the Ward Managers, Doctors, or Allied Health Professionals / Psychologists and therefore the actual hours of total care received from all clinical professionals is slightly more than the CHPPD indicates.

The minimum staffing expectation of at least two registered staff on each ward for every shift remains a requirement. The exception to this minimum is on Campion ward where it was agreed that a skill-mix of one registered with four support workers was best able to meet with patient need at night. For this reporting period 0.97% of the shifts across the mental health wards had less than 2 registered staff (1.96% in previous 6 months and 2.05% for the same period last year), whilst the west community wards had 0.44% of their shifts and the east community wards had 0.0% of shifts with less than 2 registered nurses.

The sustained reduction in numbers of shifts with less than 2 registered staff across our mental health wards, is mainly due to a reduction in registered nursing vacancy with 12 FTE more registered staff in post than a year ago. This is combined with a consistent vacancy rate over the last 6 months.

Across the wards the e-roster tool (Optima) is used to support with rota completion. Temporary staffing, primarily through NHSP (and agency where this is not possible) provides support to fill any gaps in the

rota or additional need. During the last 6 months 7.78% of our temporary staffing requests were unfilled. This is a slight decrease on the previous 6 months where 8.76% requests were unfilled.

Trusts must have an effective workforce plan that is updated annually and signed off by the Chief Executive and executive leaders. The board should discuss the workforce plan in a public meeting. An effective workforce plan should be multidisciplinary, evidence-based, integrated with finance, activity, and performance plans, and directly involve leaders and managers of the service. The Director of People for the Trust leads on this piece of work.

Within the trust we have 'Our People and Culture Strategy 2025-2028' supported by our Inclusion, Culture and Equity Framework 2025-2028, the key areas of focus being Attract, Develop, Retain, and Improve. These key areas are translated into workstreams with specific measures and outcomes with updates reported to Board.

Our 2025 organisational national staff survey results continue to demonstrate above average scores in relation to flexible working and achieving a good work life balance. We have achieved the best national results for our peer group for the last 5 years and 76.39% would recommend the organisation as a good place to work.
In addition, we scored highly in our peer group for opportunities to improve skill and knowledge (79.21%) and access to the right learning and development opportunities when I need them (71.73%).

There are several initiatives in place to grow the workforce, these include Nurse Associate posts that have now been successfully embedded in several services across the organisation, apprenticeships, and a small number of international recruits. Most of the newly recruited nursing staff, particularly those across our mental health wards continue to be newly registered. There is a preceptorship programme and structured supervision sessions in place to support these staff which runs through their first year of employment. There is a process in place for ensuring that our apprenticeships are focused to areas of staffing challenge.

The Trust achieved the National Preceptorship Quality Mark in July 2025 in recognition of the standard of our preceptorship programme for nursing and Allied Health Professionals.

To improve staff resilience, support and wellbeing, the Professional Nurse Advocate (PNA) programme commenced roll out in June 2021 and there are now 72 PNAs across the trust.

Sickness absence in general is higher than Trust average across our inpatient wards (table 7 & 8) although there are pockets of lower figures especially on Jubilee ward and Sorrel ward. The top three sickness absence reasons in terms of number of working days lost due to illness are: anxiety/ stress/ depression and other psychiatric illness, respiratory problems, and musculoskeletal problems. Temporary staffing is used to fill gaps in the rota as required when staff absence occurs due to sickness.

Prospective changes to wards and staffing

There are no changes anticipated across the mental health wards over the next six months that will impact staffing. For the community physical health wards, it is anticipated that Jubilee ward will be relocating to St. Marks hospital alongside Henry Tudor ward before the end of the financial year.

Summary

In summary, this review of ward staffing indicates that for the mental health and learning disability wards, the agreed establishment can meet the baseline rotas deemed necessary, and that sufficient staffing appears to have been available to meet the needs/ acuity of the patients. It is recognised that vacancy, sickness and fluctuating patient acuity means that additional staffing is required at times and therefore temporary staffing continues to be used; a significant proportion of our temporary staffing are our own substantive staff undertaking additional shifts and staff are moved around the hospital to ensure that staffing is in the right place to best meet patient need.

For the oakwood, the review indicates that total nursing staffing was slightly lower than would be optimal for the acuity of the patients; however, when factoring in therapy staff available the wards were deemed to be safely staffed.

Jubilee ward demonstrates higher staffing than required, this is because of the ward needing to provide additional staffing at night.

To help support this perceived position real time data from our patient experience is reviewed, this is detailed within the main body of the report.

Community Nursing

The CNSST II tool is now being used to provide a twice-yearly snapshot of our community nursing teams. Data was collected in January and June 2026. This can start help to support future planning.

This report also includes assurance in relation to our main community services with nursing. Whilst, with the expectation of community nursing as above, there are no national tools for these services, we are able to use metrics similar to those used on the wards to assist in assessment of safe staffing across these services.

Declaration of safe staffing

Following the publication of Developing Workforce Safeguards (NHSI, 2018) there is a requirement as part of the safe staffing review for the Director of Nursing and Therapies and the Medical Director to confirm in a statement to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.

Declaration by Director of Nursing and Therapies and Medical Director

The Safe staffing declaration provides the opinion of the Medial and Nursing Directors in relation to the position of our staffing across our wards over the last 6 months.
Over the last 6 months the wards have been considered to have been safe with no significant patient safety incidents occurring because of staffing levels. It is however recognised that at times during the reporting period nursing staffing on some of our wards was sub-optimal and consequently it is possible that patient experience was compromised.

Medical staffing numbers remain stable with adequate medical cover available during routine working hours for inpatient mental health and community health wards. Out of hours medical cover is provided by GPs for all our community health wards. Out of hours medical cover is provided by Resident Doctors for the mental health wards and Campion with Consultant Psychiatrists providing on-call cover from home.

Main report

Right Skills, right place, and time

Berkshire Healthcare NHS Foundation Trust has the following wards:
1 Learning disability unit
7 Community hospital wards
7 Mental health wards

All the wards have a staffing establishment that includes an allowance of 24% for planned and unplanned leave (training, annual leave, sickness absence). Table 1 demonstrates the ward establishments, alongside shift patterns agreed with wards and senior leaders (professional judgement) and the establishment required to achieve that shift pattern.

All our Mental Health and Community Wards are staffed to provide two registered staff on every shift and the shifts with less than two registered staff on duty are seen as a red flag and highlighted in the local dashboard (table 2). For Campion Unit (Learning Disability unit) the agreed staffing levels are two registered nurses during the day and one registered nurse at night.

On shifts with less than two registered nursing staff there were senior clinical staff and therapy staff working on the wards, as well as the wider senior leadership team during the week that provided support. Out of Hours there is a senior nurse covering Prospect Park mental health wards as well as on call arrangements covering all wards.

Across Prospect Park Hospital and the community wards that are co-located staff also move around the hospital to accommodate where this is required to meet patient need. Where this movement occurs the safecare tool will continue to reflect the original position and therefore an element of clinical judgement and review of overall position across wards is also used when making the assessment around safe care.

Table 1: Staffing establishment September 2026

Ward	Beds	FTE Establishment in budget 25/26	Professional judgement FTE	Planned shift pattern. (Early-late-night)
Bluebell	**18**	44.7	41.6wte + 1 ward manager + 0.5 DSN + 1 deputy ward manager = 44.1 FTE	7-8-6 activity coordinator inc on the late shift
Daisy	**18**	44.7	41.6wte + 1 ward manager + 0.5 DSN + 1 deputy ward manager =44.1 FTE	7-8-6 activity coordinator inc on the late shift
Rose	**18**	44.7	41.6wte + 1 ward manager + 0.5 DSN + 1 deputy ward manager = 44.1 FTE	7-8-6 activity coordinator inc on the late shift
Snowdrop	**18**	44.7	41.6wte + 1 ward manager + 0.5 DSN + 1 deputy ward manager = 44.1 FTE	7-8-6 activity coordinator inc on the late shift
Orchid	**20**	61.32	57wte + 1 ward manager + 0.5 DSN + 1 deputy ward manager = 59.5 FTE	10-10-10
Rowan	**20**	61.32	57wte + 1 ward manager + 0.5 DSN + 1 deputy ward manager = 59.5 FTE	10-10-10
Sorrel	**11**	42.92	40.6 + 1 ward manager + 0.5 DSN + 1 deputy ward manager = 43.1 FTE	7-7-7
Campion	**9**	33	32+ 1 ward manager = 33FTE	7-7-5
WBCH	**44**	64.3	63.7 + 0.3 on Donnington and 0.3 Highclere as matron development lead. Ward Manager not in budget. = 64.3TFE	14-11-11
Oakwood	**24**	41.7	39.7 + 1 ward manager and 1 dep. ward manager/ matron = 41.7FTE	9-7-4
Wokingham	**40**	55.8	54+ 1 ward manager + 0.8 matron = 55.8FTE	14-11-8
Henry Tudor	**24**	41.5	40.5 + 1 ward manager 41.5FTE	10-9-6
Jubilee	**16**	35.4 (does not factor in additional night staff member being used currently)	34.4 + 1 ward manager *There is a need to provide an additional nurse at night from a safety perspective (This is sourced via NHSP). =53.1FTE	Current 7-5-5 (usual pattern is 7-5-4) additional staff member at night

Establishment Review using Safecare data April 2026 to September 2026

The Safecare tool is a software module within the Optima E- Roster system, it provides information on actual staff levels together with the acuity/ dependency of patients, this has been implemented across all wards and aids understanding of daily staffing need.

When workforce modelling is undertaken for the wards, the Keith Hurst dependency modelling tools are used to assist with the evidence data (these are nationally recognised, NICE approved tools), alongside benchmarking and professional judgement. For Mental Health wards the modelling tool used is the Mental Health Optimal Staffing Tool (MHOST) and the community wards use the Safer Nursing Care Tool (SNCT) as a basis for the dependency calculations. The wards now enter this data via Safecare twice a day, so average dependency is undertaken throughout the year rather than as a 20-day snapshot as it was previously.

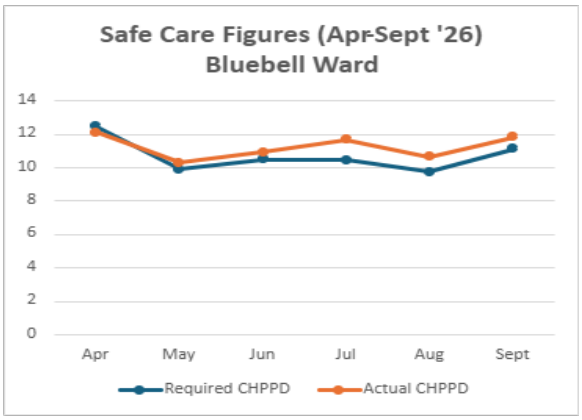
The Professional Judgement Framework is used in relation to all the wards which include red flags as well as the number of other factors such as temporary staffing and sickness levels. An uplift is applied of 24% to allow for absence/ training. Ward managers were consulted regarding the staffing levels on the wards. Feedback was that figures were largely reflective but there were high levels of sickness amongst all levels of staff which was challenging due to unavailability of temporary staffing. There were also high levels of patients needing close observations and one to one supervision.

It is recognised that there is no tool specifically for dementia wards at present. These and older adult Mental Health wards often require increased staffing due to a combination of physical and mental health need that does not appear to be reflective of the available tools.

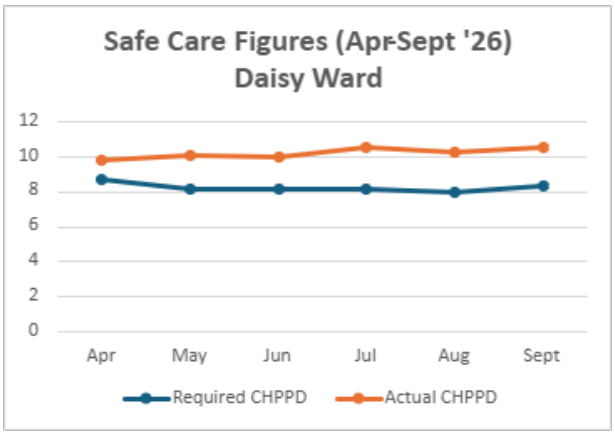
As part of a national review of the MHOST tool by NHSE two of our wards (our older adult dementia ward and one of our acute wards) participated in an enhanced data collection process during May/June 2026. Staff who were not based on the wards but were mental health nurses collected the data to reduce bias and promote objectivity. Data collected will be used to ensure the tool measures evolving patient need and supports safer staffing decisions. NHSE aim for the revised tool to be available in December 2026.

Acute Mental Health Wards April -September 2026.

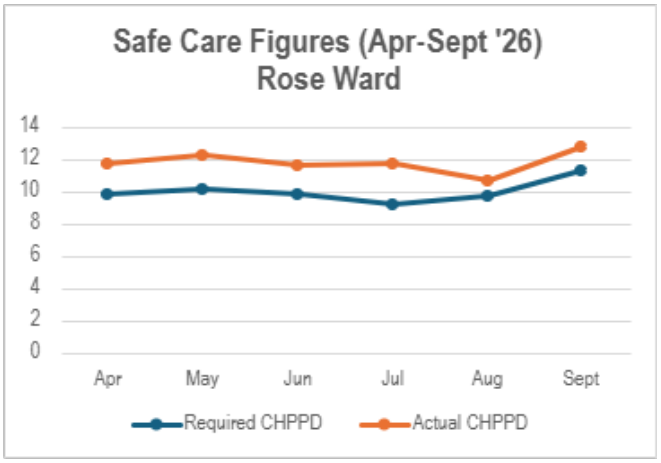
Bluebell Ward



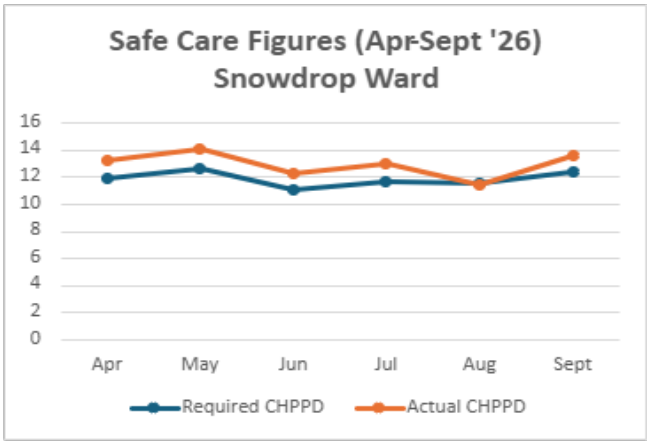
Daisy Ward



Rose Ward

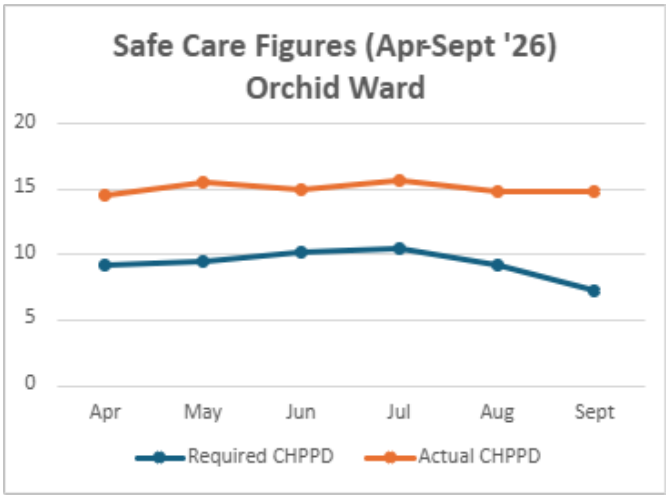


Snowdrop Ward

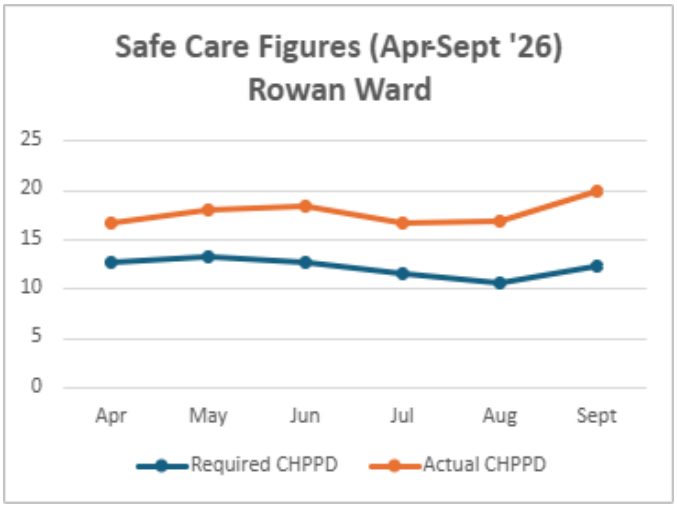


Older Mental Health Wards: April - September 2026

Orchid Ward

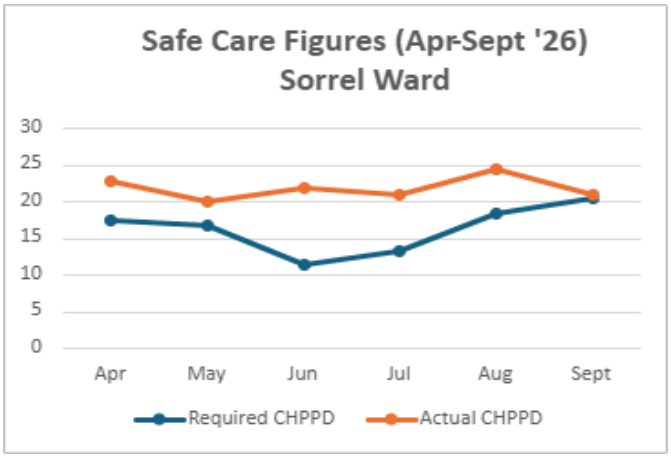


Rowan Ward



PICU: April - September 2026

Sorrel Ward



From the data, across the mental health wards there appears to have been sufficient staff for the acuity of the patients, recognising that total hospital staffing is considered throughout the day/ night, and staff do move to ensure all wards are safely staffed to continue to achieve this (there is a daily huddle involving each ward and senior staff across the mental health wards to review both staffing and patient acuity, this supports ensuring that we have the right staff in the right place).

Patient feedback from the 308 surveys completed for the acute wards from 1st April 2026 to end September 2026 demonstrated a 75% overall positive score and 81% positive score for experience in relation to staff.

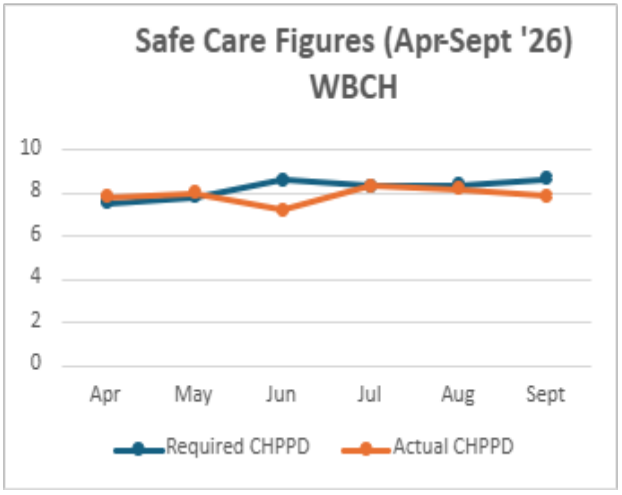
Patient feedback was received from 118 patients across the older adult wards between 1st April 2026 and the end of September 2026 with an 83% positivity score for overall experience and 81.2% for their experience in relation to staff.

Patient feedback was received from 77 patients on Sorrel between 1st April 2026 and end September 2026, 77.19% reported positively in relation to their experience.

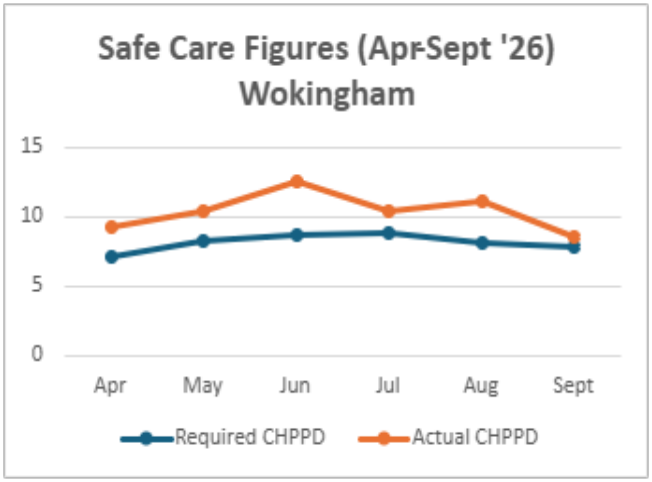
The national Culture of Care Programme that the wards participated in concluded at the end of March 2026 around the feeling of safety for both staff and patients. Work continues locally.

Community Health Wards April – September 2026

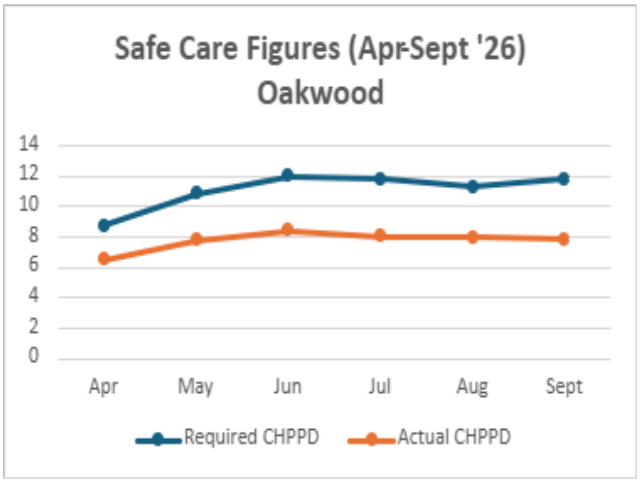
West Berkshire Wards



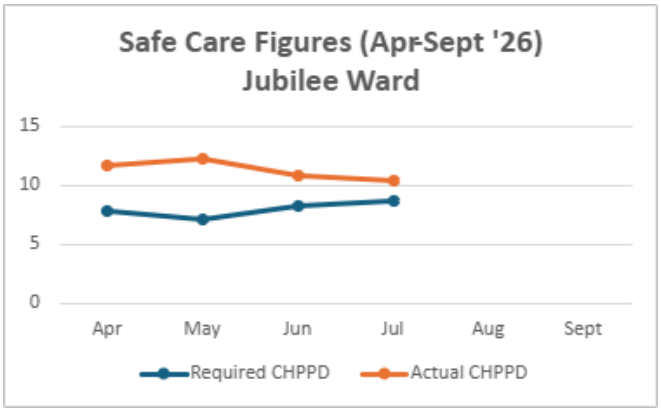
Wokingham Wards



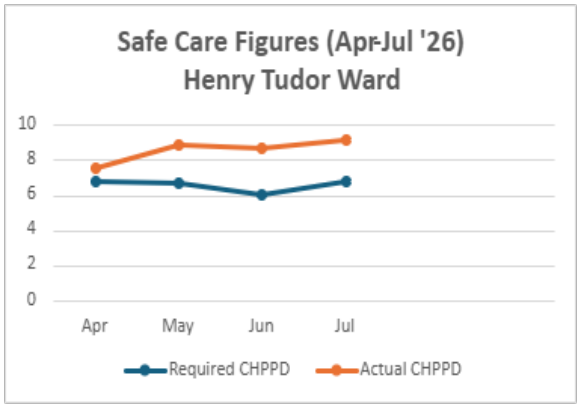
Oakwood Ward



Jubilee Ward*

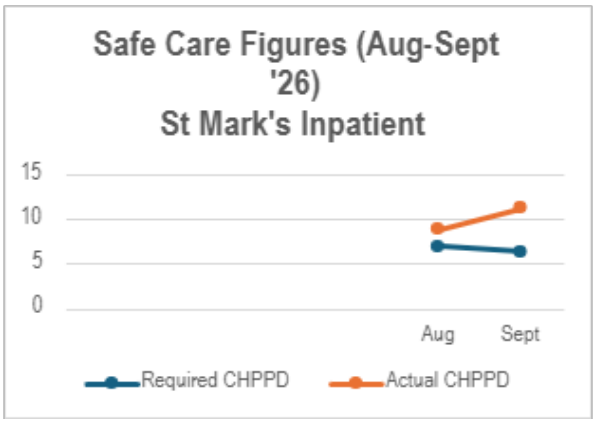


Henry Tudor Ward*



*From August 2026 data for Jubilee and Henry Tudor Ward have been amalgamated as below in preparation for the move of Jubilee ward to the St Marks sight alongside Henry Tudor Ward.

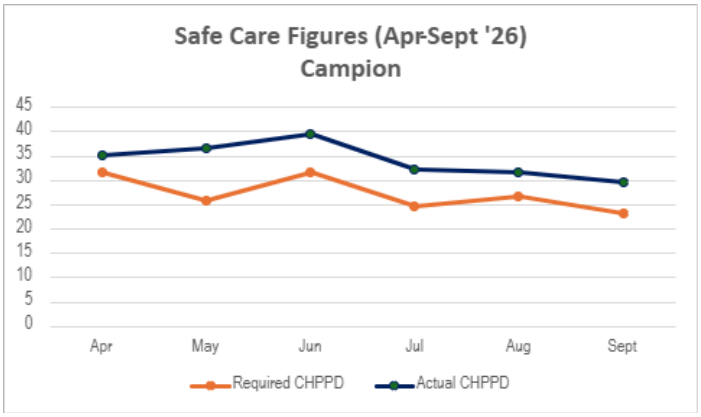
St Marks Inpatient (Jubilee ward data was amalgamated with Henry Tudor ward from the end of July in preparation for the move to St Marks site later this year, the below is therefore amalgamated Jubilee and Henry Tudor ward).



The safecare data indicates that Oakwood ward had less total nursing staff than would be indicated for the acuity and number of patients. However, when factoring supernumerary staff including allied health professional and ward manger/ matrons that are not included in the data the wards were deemed to be safe. All other community wards appear to have had sufficient staff for the acuity of the patients.
Jubilee ward has planned, additional staffing to support the current environment. Work is in progress to relocate them to St Marks Hospital alongside Henry Tudor ward; this relocation is likely to occur by the end of the financial year.

Alongside use of the safecare tool, a review of the patient feedback between 1st April 2026 and end September 2026 has been undertaken, 485 reviews were completed during this period. The data demonstrated that 93.18% patients reported positively for overall experience and 88.55% of patients reported positively in terms of their experience in relation to staff.

Campion Ward April - September 2026



The Safecare data demonstrates that staffing levels were appropriate for the acuity of the patients on Campion ward.

There were 6 patient reviews completed in our patient survey between 1st April 2026 and the end of September 2026 with a 66.67% positivity score for overall experience and 83.33% for their experience in relation to staff.

How we compare to Peers for Care Hours Per Patient Day (CHPPD)
The most recent data available on model Health is from July 2026. This data demonstrates that across all our wards, our CHPPD by ward speciality is broadly aligned with our peers. We have slightly lower registered nursing but have higher overall staffing numbers, indicating a richer skill -mix. . For the learning disability wards we have a slightly lower level of total staffing but higher levels of registered nursing staff, the skill -mix will be impacted by the total patient numbers, given whatever size the ward 2 registered staffing are required.

Ward Speciality	Ward	Total Nursing (Registered and support workers)	Peer Data	Total Registered Nursing	Peer Data
Acute Mental Health Wards	Rose	12.51	9.58	2.96	3.34
	Bluebell	13.93		3.11	
	Daisy	11.76		3.13	
	Snowdrop	14.16		3.47	
Psychiatric Intensive Care	Sorrel	23.26	20.93	5.56	5.05
Older Adult Mental Health	Orchid	16.67	12.45	2.81	4.06
	Rowan	18.92		3.35	
Learning Disability Assessment and Treatment	Campion	38.78	44.04	12.86	10.75
Community Physical Health Wards	Henry Tudor	10.81	7.46	4.18	3.76
	Jubilee	11.38		3.2	
	Oakwood	10.17		2.94	
	Wokingham - Ascot Ward	8.83		3.14	
	Wokingham - Windsor Ward	8.02		2.66	
	West Berks - Donnington	9.36		2.7	
	West Berks - Highclere	8.93		3.65	

Red flags
The ability to achieve a position of at least two registered staff on duty is perceived as a metric of quality (NICE; 2014 and 2018) and less than two registered staff is therefore considered as a red flag incident.

Table 2 demonstrates the number of occasions by ward and month where there were less than two registered nursing staff at the start of the shift.

The total number of shifts with less than 2 registered nurses at the start of the shift has reduced considerably from 108 to 60 with the overall percentage of shifts where there were less than 2 RNs being 0.7% in this 6-month period. This is compared to 1.31% in the previous 6 months and 1.09% this time last year

Across the mental health wards 0.97% of the shifts had less than 2 registered staff (1.96% in previous 6 months and 2.05% for the same period last year), whilst the west community wards had 0.44% of their shifts and the east community wards had 0.0% of shifts with less than 2 registered nurses.

For all the wards where there are less than two registered nurses, senior staff, and ward managers (who are supernumerary to the safe staffing numbers) as well as other clinical staff such as Physiotherapy and Occupational Therapy provide support when available. For the wards at Prospect Park Hospital, the Duty Senior Nurse / senior Night practitioner is also available and able to take an overview of the wards and redeploy staff to areas of most need, as necessary.

Table 2: Wards and number of occasions where there were less than two registered nursing staff on duty.

	April 26	May 26	June 26	July 26	Aug 26	Sept 26	Total for ward
	Total	Total	Total	Total	Total	Total	
Bluebell	2	0	6	1	1	3	**13**
Daisy	0	0	0	0	2	3	**5**
Rose	1	1	0	2	0	3	**7**
Snowdrop	0	0	0	0	3	0	**3**
Orchid	2	0	3	4	2	1	**12**
Rowan	0	0	0	0	0	0	**0**
Sorrel	0	0	0	1	1	1	**3**
Campion	0	0	0	0	0	0	**0**
Donnington	0	0	0	0	0	0	**0**
Highclere	3	1	0	3	2	2	**11**
Oakwood	0	0	0	1	0	0	**1**
Ascot	1	0	1	1	0	2	**5**
Windsor	0	0	0	0	0	0	**0**
Henry Tudor	0	0	0	0	0	0	**0**
Jubilee	0	0	0	0	0	0	**0**
Total for month	**9**	**2**	**10**	**13**	**11**	**15**	**60**

Safety on our wards

The NHSE/I in its workforce safeguarding recommendations recommends organisations need to demonstrate effective governance and commitment to safety so boards can be assured that their workforce decisions, promote patient safety and comply with the Care Quality Commission's (CQC) fundamental standards. Therefore, it is just as important to have the appropriate staff capability alongside the number of staff to ensure that they can deliver a safe and quality service to all patients.

Quality indicators.

To monitor safety of care delivered on the wards the Director of Nursing and Therapies and the board reviews a range of quality indicators monthly alongside the daily staffing levels.

The indicators we use for this are:
Community Wards:

- Falls where the patient is found on the floor (an unobserved fall).
- Developed pressure ulcers.
- Patient on staff assaults.
- Moderate and above medication related incidents.

Mental Health Wards:

- AWOL (Absent without leave) and absconsion.
- Self-harm.
- Falls where the patient is found on the floor (an unobserved fall).
- Patient on patient physical assaults.
- Seclusion of patients.
- Use of prone restraint on patients.
- Patient on staff assaults.

Monthly discussions are held with senior staff from each ward area to discuss staffing data along with the listed indicators. Any concerns are highlighted in the monthly safer staffing board report and inform the safe staffing declaration provided by the Director of Nursing and Therapies. There were no incidents reported to have occurred due to staffing levels during this period.

Table 3: Quality metric for mental health inpatient wards and Campion (April 2026-September 2026).

Ward	AWOL	Falls	Patient on Patient Assault	Patient on Staff Assaults	Prone Restraint	Seclusion	Self-harm
Bluebell	10	15	14	109	0	2	320
Daisy	13	8	21	40	3	6	5
Rose	11	15	32	72	2	0	84
Snowdrop	9	10	3	61	1	1	162
Orchid	1	26	1	13	0	0	1
Rowan	0	19	5	32	0	0	1
Sorrel	3	4	21	32	2	21	6
Campion	2	4	3	17	0	0	11
Total	**49**	**101**	**102**	**376**	**8**	**30**	**590**

* Correct at time of report

There are several Quality Improvement programmes and initiatives being undertaken across the Trust including reducing restrictive practice and reducing assaults. The mental health wards have been participating in the national mental health ward Culture of Care programme (an NHS initiative aimed at improving the quality of care in mental health, learning disability, and autism inpatient settings by fostering a supportive and therapeutic environment for both patients and staff); this supports the embedding of the NHS England Culture of Care Standards using quality improvement and co-production. An element of the programme focuses on safety including risk, violence reduction and reducing restrictive practice.

Table 4: Quality metric for community physical health inpatient wards (April 2026-September 2026).

Ward	Medication incidents (moderate harm and above)	Falls	Pressure Ulcers developed Grade 2 and above where a lapse in care has been identified	Patient on Staff Assaults
Donnington	0	22	0	11
Highclere	0	14	0	2
Oakwood	0	29	0	0
Ascot	0	6	0	2
Windsor	1	14	0	2
Henry Tudor	1	18	0	0
Jubilee	0	4	0	2
Total	**2**	**107**	**0**	**19**

* Correct at time of report

The Trust falls group considers all falls and identifies any areas for improvement. Areas where incidents are higher there is active QI work underway to reduce the number of falls and reduce risk for patients. The number of falls occurring across the wards during this 6-month time period have increased (107 from 85 in previous reporting period). There has been a reduction in alleged patient on staff assaults (34 to 19), with this remaining a key trust initiative to reduce all violence and aggression occurring across the Trust. Developed pressure ulcers where there was a lapse in care was zero for this reporting period as it was in the previous 6 months. The Pressure Ulcer Oversight Group chaired by the Deputy Director of Safety and Quality meets quarterly and has focussed on reducing and minimising the incidents of pressure damage across both in patient and community settings. The continued work has been successful in reducing patient harm from pressure damage in the long term.

Table 5: Percentage Bed Occupancy April 2026 to September 2026

	April 26	May 26	June 26	July-26	Aug-26	Sept-26	Average
Bluebell	96.7%	98.6%	96.7%	99.5%	99.6%	98.3%	98%
Daisy	99.3%	98.6%	97.7%	96.4%	100.2%	98.1%	98%
Rose	96.9%	97.3%	98.3%	97.5%	98.8%	97.0%	98%
Snowdrop	96.9%	98.7%	99.3%	98.9%	99.3%	98.0%	99%
Orchid	90.2%	94.5%	93.8%	93.8%	86.9%	83.7%	90%
Rowan	77.3%	69.5%	81.0%	90.5%	86.1%	71.2%	79%
Sorrel	85.8%	92.7%	80.9%	83.9%	90.0%	89.4%	87%
Campion	60.5%	51.6%	47.1%	68.9%	66.7%	70.7%	61%
Donnington	90.4%	94.5%	93.2%	92.5%	83.6%	88.3%	90%
Highclere	93.8%	92.4%	93.2%	94.4%	90.8%	85.8%	92%
Oakwood	95.0%	92.2%	95.0%	95.4%	89.8%	91.6%	93%
Ascot	97.3%	96.2%	99.6%	100%	99.8%	89.9%	97%
Windsor	97.4%	94.1%	99.6%	96.3%	93.5%	96.3%	96%
Henry Tudor	96.6%	92.3%	93.3%	100.2%	96.3%	95.0%	96%
Jubilee	81.0%	84.3%	92.0%	89.7%	86.9%	83.8%	86%

*Over 95% occupancy is flagged as a potential cause for concern.

Occupancy on the acute mental health wards has been over 95% for the duration of the 6-month period. There have also been high levels of occupancy on some of the CHS wards, especially on Ascot and Windsor wards at Wokingham hospital and Henry Tudor ward.

Rowan ward occupancy is lower than anticipated due to an extensive redecoration programme which has resulted in beds needing to be closed in order that this can be carried out.

Right skills

Recruitment and Retention

Berkshire Healthcare has a People and Culture Strategy supported by a with proactive work streams focusing on improved diversity, reducing violence, recruitment and retention including workforce pipeline, wellbeing, sickness absence.

Vacancies

Across the mental health wards registered nurse vacancies have stayed largely consistent during the last six months; variation demonstrated from 11.12-13.52 WTE.

Unregistered vacancies have varied between 90.27 and 85.42 FTE with a downward trend from April to September 2026. The mental health wards aim to have substantive recruitment into 85% of their vacancies utilising temporary staffing for the remaining need as this provides flexibility to ensure safe staffing is deployed across the wards. Factoring this in, there are less vacancies that we are actively looking to recruit into.

The CHS wards have had some staffing challenges, with registered nursing vacancy increasing slightly over the last 6 months. Although unqualified vacancies appear to be decreasing.

Temporary staffing, primarily through NHS Professionals (and agency where this is not possible), provides support to fill any gaps in the Rota or additional need. During the last 6 months 7.78% of temporary staffing requests were unfilled, this is a decrease in the previous 6 months (8.76%). Campion unit continues to have low vacancy rates.

Table 6: Full Time Equivalent (FTE) vacancy of registered nursing and healthcare worker for April 2026 to September 2026

		Apr	May	June	July	Aug	Sept
MH Wards	Registered	11.48	11.12	13.12	12.52	13.52	13.52
	Unregistered	90.27	90.27	90.07	87.02	86.02	85.42
CHS Wards	Registered	15.62	14.62	13.82	16.01	17.61	20.20
	Unregistered	26.10	23.67	24.45	26.05	29.33	22.72
Campion	Registered	-0.20	-0.20	-0.20	-0.20	-0.20	-0.20
	Unregistered	2.60	2.60	2.60	2.60	2.60	3.00

*Figures to fill to 100% establishment

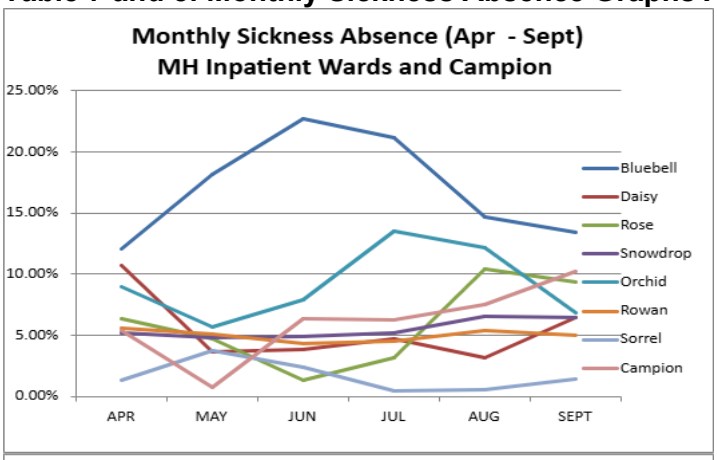
Sickness absence

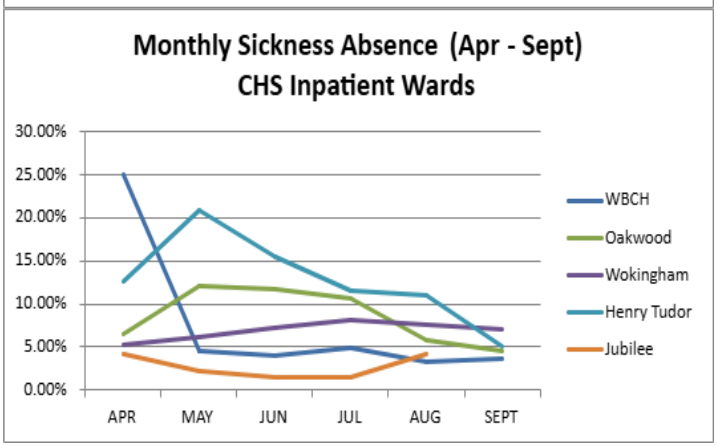
During this reporting period there continues to be challenges which have impacted staffing due to sickness absence amongst our permanent workforce. Sickness absence in general is higher than the trust target of 3.5% and the organisational average of 4.5% as can be seen in table 7 and 8; there are however some significant variations across wards, this is due to a mix of long and short-term absence. There were notably low levels of sickness on Sorrel ward and Jubilee ward during the 6-month period. There were also notable pockets of low sickness levels on Daisy ward and Rose ward.

The top three sickness absence reasons in terms of number of working days lost due to illness are, anxiety/ stress/ depression and other psychiatric illness, respiratory problems, and musculoskeletal problems; the most frequent reason in terms of number of staff affected are chest and respiratory problems, and cold, cough, and flu.

The Trust has a supporting attendance policy which supports appropriate action by staff and managers in relation to sickness related absenteeism. The Trust has occupational Health provision and an Employee Assistance Programme alongside support for support staff with both physical and mental health care needs including a health and wellbeing hub, access to MSK physio and the Professional Nurse Advocacy programme. There is also specific support for staff who have been involved in an incident or who are impacted by incidents of violence and aggression including dedicated support at Prospect Park hospital where most incidents of verbal and physical assaults against our staff occur.

Table 7 and 8: Monthly Sickness Absence Graphs April 2026 – September 2026





Jubilee ward data is amalgamated with Henry Tudor ward from August 2026.

Temporary staffing

Table 9:973 Temporary staffing usage April 2026-September 2026

	Total number temporary staffing shifts requested	Number of temporary shifts requested to fill registered staff gap	Total temporary shifts unfilled
PPH	17548	2064	935
West Community Wards	4126	1115	751
East Community Wards	1275	219	134
Campion	973	384	43

The total number of temporary staff requests was 23922 compared to 23867 in the previous 6 months showing figures are largely unchanged. The unfilled shifts were 7.78%, which has been a decrease from the previous 6 months, which was 8.76%. The need for temporary staff continues to be driven by absences, vacancies and the need to increase staffing due to patient acuity. Historically increased sickness over the winter period drives an increase in temporary staffing. Some feedback from ward managers was that there was difficulty covering non-qualified staff absences due to unavailability of temporary staff.

Agency use across all our wards for both nursing and AHP over the 6-month period has been

equivalent to no more than 2 FTE in total each month spread across all community and Mental health wards. With most individual wards using around the equivalent of no more than 1-2 shifts a month, where they are unable to gain temporary staffing through NHSP and safety would be compromised.

Staff training

Staff training compliance along with clinical supervision is monitored by the divisions and into relevant committees, this along with preceptorship and supportive training and upskilling programmes ensures that staff have the right skills for the roles that they are undertaking. NHS professionals staff also have a training matrix agreed as appropriate for the roles that they are undertaking, with access to Berkshire Healthcare training where this is more specialist such as PMVA.
Ward staff are required to complete a number of statutory, mandatory, and essential training courses dependent on their roles for the purposes of this report key statutory and mandatory training is reviewed.

Table 10: Overview of wards training compliance (as a percentage of required staff trained)

UNIT	Manual Handling relevant risk level (%)	IPC (%) Yearly	PMVA (%)	Inpatient Fire (%)	Annual Resus %	Safeguarding %
Rose Ward	73	100	75.0	96.67	90	100
Snowdrop Ward	90.2	100	84.4	92.9	92.3	100
Bluebell Ward	85	100	78	100	80.0	100
Daisy Ward	87.1	100	80.0	100	76.9	100
Sorrel Ward	85.7	100	88.9	100	81.8	100
Rowan Ward	90.9	100	81	84.4	92.3	100
Orchid Ward	88.6	100	75.0	93.2	76	100
Henry Tudor Ward	100	100		87.2	78.9	100
Jubilee Ward	100	100		96.3	90	100
WBCH	95.4	100		94.2	83.9	100
Oakwood Ward	100	100		90.6	92.3	100
Wokingham	96.5	100		92.2	92.9	100
Campion Unit	96.6	100		87.5	85.7	100

*The aim for all areas is to achieve 85% compliance. The exception to this is safeguarding where we aim for 90%.
* There is a slight lag in records updating following attendance of face-to-face training and therefore reporting may be lower than current actual if staff have recently undertaken within the month prior to training records being obtained.

There continues to be a focus on areas where compliance is not quite at the level we are aiming to achieve. Compliance is monitored through relevant meetings and groups as well as at service level. There continues to be a focus on resus training and staff on all of the wards have dates for completion over the coming months.

Alongside statutory, mandatory, and essential training, a range of leadership and organisational development programmes for both individuals and services are also available for our staff. Oliver McGowan training is being provided to all staff on a rolling 3-year basis; compliance against the e-learning element of the training is above 90% and the face-to-face element of the training is also now being provided.

The wards at Prospect Park hospital have been participating in the national Culture of Care Programme (an NHS initiative aimed at improving the quality of care in mental health, learning disability, and autism inpatient settings by fostering a supportive and therapeutic environment for both patients and staff). Whilst the formal programme has now concluded the leadership team are continuing to support the wards with undertaking work commenced and to spread learning / good practice across wards.

All the wards have access to a range of specialists able to provide support and advice for specific patients/

situations, these include but are not limited to, for Mental health Physical Health, Drug and Alcohol specialist practitioners and the PMVA team, and for all wards tissue viability specialists, Dieticians, speech and language therapists and the infection control team.

Nurse Associates and nurses in training

The Trust currently has 25 nurse associates employed.
Other nursing and Allied Health Professional apprenticeships are also being undertaken by our staff; this assists with supporting a pipeline of new staffing in addition to traditional recruitment. This includes Advanced Practice as well as entry level training.

Preceptorship

There is a preceptorship programme and structured supervision sessions in place to support these staff which runs through their first year of employment. In addition, there is a programme called 'Reaching my potential' which is open to all band 5 staff and aimed at supporting improved resilience and confidence.

The Trust achieved the National Preceptorship Quality Mark in July 2025 in recognition of the standard of Our preceptorship programme for nursing and allied Health Professionals.

Professional Nurse Advocate (PNA) Programme

We currently have 72 qualified PNAs and ongoing interest to complete this programme with some current students as well as an active waiting list. The PNA role involves providing restorative supervision which is aimed at improving wellbeing as staff feel supported and listened to, this in turn supports staff retention. The PNA programme is a Health Education England initiative which is a requirement in midwifery, and it has been rolled out nationally across healthcare.

Services with Nursing in the Community

Community Nursing

Community nursing is the only service outside our inpatient wards for which national tools are available to assess staffing requirements, this is based on both patient acuity and the number of patients seen.

The Community Nursing Safer Staffing Tool (CNSST) is now being used to collect data every 6 months for 14 consecutive days. A minimum of 2 data sets is required to support any prospective staffing considerations. The table below details the 2 data collections that have been made. This information will be used to support prospective planning.

The data shows that between the 2 months there is relatively small fluctuations only in total recommended staffing which would indicate that the number and acuity of patients is relatively stable.

Table 11. CNSST II Data January and June 2026

Locality team	Dates of data collection	Staffing (full time equivalent) numbers available during data collection	Total recommended staffing (full time equivalent) to meet patient visit requirement during data collection	Approx potential gap between optimal and actual staffing for reporting period
Slough	January 26	15.23	14.95	0
	June 26	17.02	14.05	0
Windsor Ascot and Maidenhead	January 26	20.42	22.01	1.5FTE
	June 26	20.56	22.08	1.5 FTE
Bracknell	January 26	18.84	21.66	3 FTE
	June 26	18.7	22.81	4 FTE
Wokingham	January 26	23.00	25.08	2FTE

	June 26	19.65	24.03	4.5 FTE
Reading	January 26	26.18	34.52	8 FTE
	June 26	29.07	33.92	4.5FTE
West Berkshire	January 26	21.89	28.05	6FTE
	June 26	23.37	28.91	4.5FTE

The monthly safe staffing report now also includes our main community services with nursing. We therefore use metrics comparable to those used on the wards to assist in assessment of safe staffing across these services. This data is also used as part of the annual planning cycle to support judgements on current staffing and service delivery in context of national and local requirements.

Overall, over the last six months, staffing levels in all community services have stayed consistent and largely in line with budgeted workforce with some vacancy at one time. All teams use a control total so that they have the ability to use temporary staffing if required. Patient feedback was positive with only 2 services having one monthly score below 4/5 demonstrating high levels of patient satisfaction. This combines with low levels of moderate incidents.

Ongoing work

- Continue 6 monthly data collection for community nursing using CNSST II
- Continued recruitment and retention effort as detailed within recruitment and retention workstream of the People plan.

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 November 2026
Title	**Executive Report**
	Item for Assurance
Reason for the Report going to the Trust Board	The Executive Report is a standing item on the Trust Board agenda. This Executive Report updates the Trust Board on significant events since it last met. The Trust Board is requested to seek note the report and to seek any clarification on the issues covered in the report.
Business Area	Corporate Governance
Author	Chief Executive
Relevant Strategic Objectives	The Executive Report is relevant to all the Trust's Strategic Objectives

Berkshire Healthcare
NHS Foundation Trust

Trust Board Meeting – 10 November 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. Care Quality Commission (CQC) Inspection Activity and Well-Led

Since March 2026, six core service (Assessment Service Group) inspections have been undertaken, as below.

These have been unannounced/short notice planned inspections, meaning that the organisation has had no prior notice given to any services that operate 24/7 and up to 48 hours' notice given for those that are community services.

Core Service	Date on-site inspection undertaken	Current position	Final Report
Wards for people with a learning disability or autism (Campion)	26–27 March 2026	Final report received/published No regulatory action	Assessed as being Good across all key questions and overall
Community-based mental health services for older adults	12–14 May 2026	Draft report awaited	
Wards for older people with mental health problems	30 June–1 July 2026	Final report received/published No regulatory action	Assessed as being Good across all key questions and overall
Community urgent care services	21–22 July 2026	Draft report received; awaiting final report.	
Mental health crisis services and health-based place of safety	21–23 July 2026	Draft report awaited	

Core Service	Date on-site inspection undertaken	Current position	Final Report
Children's Physical Health Services	8–9 October 2026	Draft report awaited	

In addition to the above, we have also received our organisational well-led inspection. The on-site element took place 22–24 September 2026.

The well-led inspection involved a number of focus groups from staff across the organisation as well as individual interviews and data submissions.

Initial feedback is detailed in the attached letter.

The two queries within the letter have both been satisfactorily resolved with no further clarification required.

Timescales for receipt of full draft reports for each of the service line and well-led reviews are around 85 working days from inspection completion, with a period for factual accuracy checks following that before publication.

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

3. Staff Winter Flu Vaccination Report to November 2026

Seasonal flu vaccination remains a critically important public health intervention and a key priority for 2026-27 as part of protecting the public and staff over the winter months.

In the Core NHS standard contract for 2026/27, flu vaccinations for frontline healthcare workers are retained as an employer responsibility to offer and deliver the flu vaccine.

The national aim is to offer vaccinations to 100% of frontline healthcare workers, with an aspiration to achieve at least 60% uptake. We offer the vaccination to all our staff.

The vaccination programme commenced on 1 October 2026, with the expectation that all staff receive an offer and an opportunity to be vaccinated by the end of November, although we will continue to offer vaccination into the new calendar year. Delivery includes bookable clinics, drop-in appointments, peer vaccinators, workplace visits and Trust events or team meetings. Vouchers are also offered, recognising that many staff live outside Berkshire and/or work from home. Staff are encouraged to report vaccination received elsewhere, such as through their GP or a local clinic.

Whole organisational flu vaccination uptake as of 29th October: 36.79%
Frontline healthcare worker uptake: 38.1%

Directorate	% Uptake
Central Services	43.52
Mental Health Services	29.60

Community Health Services	35.63
Children, Family and All Age Services	45.42

NHS England has published top 10 actions to support increased uptake as below:

1. **Make sure colleagues see that vaccination is a board priority with a named executive sponsor.**
   The Director of Nursing and Therapies is the Executive Lead, with the campaign being raised at all-staff briefings, with Trust leaders and managers and in our newsletters/screen savers.

2. **Take the vaccine to where people are.**
   Clinics are delivered across sites, with bookable and drop-in access, workplace vaccination and attendance at Trust events and team meetings. Peer vaccinators support local delivery.

3. **Plan early and sustain the campaign throughout the season.**
   Planning is ongoing with learning from the previous year being taken into the current year's programme. Marcomms are proactively involved in the planning.

4. **Use data at team level and update it regularly.**
   From the end of October, Divisions will be receiving reports that support understanding and visibility of percentage uptake. Divisions continue to raise the importance of the vaccination at team and operational level meetings as well as divisional quality meetings.

5. **Recruit, train and support peer vaccinators.**
   Peer vaccinator preparation forms part of annual planning.

6. **Design communications and engagement around barriers, not just availability.**

   The communications programme includes newsletters, executive all-staff emails, SMS, payslip messages, and self-print posters, with peer vaccinators supporting local promotion. Training covers vaccine hesitancy, non-judgemental discussion, and health literacy techniques, including pictures and plain language.

   Directorate uptake is monitored and there are plans to use regular team-level updates to make progress visible. Board members have received their vaccination, and this is used to support promotion.

7. **Address hesitancy directly.**

   'Let's Talk About Vaccines' training supports listening, exploring concerns and informed choices without judgement. Health literacy learning supports improved communication and checking understanding.

8. **Cost the campaign and make the business case.**
   We have a well-established process and resourcing for the flu campaign.

9. **Build for the long term.**

We have a robust delivery programme through clinics and peer vaccination which are delivered at sites and into teams across our footprint. In addition, we publicise how staff can gain the vaccine from a local pharmacy and have a process for asking staff to report this back to us. We capture and use learning from previous campaigns for future campaigns. We promote the flu vaccination from the Board; Board members have received their vaccination. Peer vaccinators include senior nursing staff from across the Trust.

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

4. Guidance to Support NHS Organisations in the Provision of Single-Sex Services and Facilities

On 15 October 2026, NHS England wrote to all providers asking Chief Executives and Boards to review the newly published guidance documents on single-sex services and facilities and assure themselves that their organisations are prepared and able to respond.

The guidance takes account of the Supreme Court's ruling in the *For Women Scotland* case that 'man', 'woman' and 'sex' in the Equality Act 2010 refer to biological sex. It also takes account of the Equality and Human Rights Commission's revised Services Code of Practice.

Specifically, Boards should ensure that:

- The new guidance is reviewed by relevant board-level leads and those responsible for clinical operations, people, estates and facilities and communications
- Local policies and practices are consistent with the law and the new guidance
- There is a clear plan for addressing any areas where change is required
- They have oversight of a clear plan to meet the NHS Constitution's pledge to eliminate mixed-sex accommodation
- Staff understand what is expected of them and know where to seek advice on complex cases
- Arrangements are in place to support consistent decision-making and escalate difficult issues when needed
- Organisations continue to foster workplaces that are safe, respectful and inclusive, with clear expectations around dignity and protection from bullying, harassment and discrimination
- Plans include arrangements for monitoring impact, responding to issues raised and reviewing or revising decisions where evidence or circumstances change.

We are committed to ensuring that all patients and colleagues are treated with dignity, compassion and respect. This includes protecting everyone's privacy, safety and rights, while meeting our legal responsibilities.

We had already been considering the implications of the Supreme Court ruling and will continue to review our arrangements and policies in line with national guidance and our legal responsibilities. We recognise the importance of implementing any changes sensitively and fairly, with careful consideration of the privacy, dignity and needs of everyone affected.

Staff-related facilities

For staff facilities, the guidance covers staff toilets, changing, washing and showering facilities and relevant accommodation. The Trust must provide suitable, sufficient facilities that protect staff privacy, dignity and safety, supported by evidence.

Actions to be undertaken to ensure compliance with new guidance

1. The Estates team completed a survey in the Trust in 2025 following the initial Supreme Court ruling forming a site baseline. This will be reviewed, updated and extended to cover the new guidance. This will include the evidence to cover facilities, accommodation, privacy, accessibility, signage, alternatives and floor plans. Existing provision, lockable facilities, repurposing and signposting will be considered before confirming any physical gap and developing an indicative solution and cost.

   Site validation is due by the end of November 2026, followed by review in December and development of Estates solutions and costs during December 2026 and January 2027. The consolidated Trust position is due in January 2027.

This will support Board assurance and align with the workforce and policy review, including legal and governance oversight, equality impact assessment, staff (including our networks) and trade union engagement, documented decisions and ongoing monitoring.

Patient-related facilities

Outpatients
The above work covers patient toilets across our sites.

Inpatient care
The guidance means that trans patients and others with the protected characteristic of gender reassignment should normally be accommodated according to their biological sex, while their clinical needs, privacy, dignity and safety, and those of other patients, must continue to be protected.

Where accommodation according to biological sex would not be clinically appropriate, alternative arrangements should be considered on an individual basis. Clinical need remains the priority, and no patient should effectively be left without access to healthcare.

The single-sex accommodation guidance of 2019 has been updated to reflect biological sex and provide clarity around the definition of a breach.

The wards already have in place guidance/standard work to reflect the above, which was revised following the Court ruling. This will be revisited to ensure that all our guidance meets the requirements whilst ensuring dignity, compassion and respect for all individuals. The guidance will be transposed into policy. The aim is for this to be undertaken by the end of December 2026.

A breach occurs where:

- women and men share sleeping accommodation;
- women and men share toilets or bathrooms;
- a patient has to pass through an area occupied by the opposite sex to reach toilets/bathrooms, excluding corridors; or

- a women-only day room is not provided within a mental health inpatient unit.

A breach occurs as soon as the patient is placed in non-compliant accommodation, rather than after a particular period has elapsed. The breach is to all those affected, not just the individual placed in the non-compliant accommodation.

For mental health intensive care units, mixing of sexes in psychiatric intensive care units can occur, but NHS England says this should be avoided wherever possible and should be reported locally.

Women-only day spaces are also specifically required for all mental health wards. All of our mental health wards have this facility in place as well as general day spaces that can be used by all.

Where mixed-sex accommodation is unavoidable, patients and, where appropriate, relatives/carers should be told why, what is being done to resolve it and the anticipated timescale. This must be recorded in patient records.

Where breaches of single-sex accommodation requirements occur, these must continue to be reported nationally as has previously been the case. Monthly reporting processes are already in place to support this.

The Trust should have an executive lead for single-sex accommodation. This is the Director of Nursing and Therapies.

Complex cases should be escalated to operational senior managers in the first instance and ultimately to the Chief Operating Officer/Director of Nursing and Therapies. This process was already in place but will be strengthened within the policy.

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

5. Supporting Families Seeking Information about Historical Burials and Cremations Following Stillbirth or Pregnancy Loss

On 29 October 2026, NHS organisations were asked to strengthen support for families seeking information about the burial, cremation or final resting place of babies following historical stillbirth or pregnancy loss. This follows the Government's apology on 13 October for the distress caused by historic practices and the additional pain experienced by families unable to obtain clear information about what happened to their baby.

Trusts are required to establish a named contact and clear route through PALS, or an equivalent service, for these enquiries. The arrangements should cover the current organisation, predecessor organisations and closed hospital sites, with appropriate coordination and signposting where records are held elsewhere.

The approach should ensure that families receive a compassionate, sensitive and well-coordinated response, recognising that historical records may be incomplete or no longer available. The contact route should be communicated to relevant staff and published clearly on the Trust's website.

The requested arrangements are to be in place within four weeks of the letter dated 29 October 2026. Guidance produced by Sands is also available to help families understand where historical burial and cremation records may be held and how to access practical and emotional support. Tracing a baby's grave or record of cremation | Sands

Board assurance: we will provide clear organisational ownership of this through the Deputy Director of Nursing. We will ensure that we have clear communication and signposting to relevant

support on our Trust internet pages and that our PALS staff are fully prepared for supporting any enquiries within the requested timeframe.

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

6. Summary of the Independent Review into the Prevalence and Support for Mental Health Conditions, ADHD and Autism (Fonagy Review, October 2026)

1. **Executive Overview**

The review was commissioned in December 2025 by Wes Streeting, former Secretary of State for Health and Social Care.

It is a detailed and lengthy report of just over 600 pages which helpfully provides answers to significant trends in the sector over recent years. The report concludes that England is facing a significant rise in mental distress, particularly among children and young people, while demand for ADHD and autism **assessments** has grown to unprecedented levels. However, the evidence suggests that the underlying prevalence of ADHD and autism has remained broadly stable, and that much of the growth reflects better recognition, greater awareness, changing social expectations, and the fact that diagnosis has become a gateway to support.

The review argues that current systems are unsustainable. More than 560,000 people were waiting for ADHD assessments and over 254,000 for autism assessments by the end of 2025.

The central conclusion is that England needs to move from a "diagnosis-dependent" system to a "needs-led plus diagnosis" system, where people receive support according to need rather than having to secure a diagnostic label first.

2. What Has Changed: Mental Health, ADHD and Autism

Mental Health

The strongest evidence of change relates to mental health rather than neurodevelopmental conditions. The review found substantial increases in psychological distress, anxiety, self-harm and emotional difficulties, particularly among young people. Contributing factors include:

- Social media and online influences
- Reduced social connection and belonging
- Financial insecurity
- Educational pressures
- Housing instability
- Poor sleep
- Wider uncertainty about the future

These influences often interact and reinforce one another. The review stresses that many young people are experiencing genuine distress in response to increasingly challenging social environments.

ADHD and Autism

The review found dramatic increases in:

- Referrals
- Completed diagnoses
- Waiting lists
- Public awareness

Recorded autism assessments among some childhood age groups increased more than twenty-fold over the last two decades, while recorded ADHD diagnoses rose sharply, especially among adolescents. However, the available population evidence does not demonstrate an equivalent increase in the true prevalence of these conditions.

The review concludes that:

- ADHD and autism are real and significant conditions.
- Many people remain undiagnosed and unsupported.
- Some misdiagnosis, under-diagnosis and over-diagnosis occur.
- There is no evidence that either over-diagnosis or under-diagnosis is occurring "at scale."

3. Why Demand Has Risen So Rapidly

A major finding is that diagnosis has become the main route to obtaining support across multiple systems.

A diagnosis can unlock:

- Educational support
- SEND provision
- Workplace adjustments
- Welfare benefits
- Health services
- Social care assistance

The review argues that when diagnosis becomes the only reliable pathway to practical help, demand for assessment inevitably rises. People often seek diagnosis because they need support rather than because they are seeking a medical explanation alone.

The report states that services are inadvertently creating demand by linking support too closely to diagnostic categories. Families increasingly feel compelled to pursue diagnoses because without them they struggle to access assistance.

4. Problems with the Current System

Long Waiting Times

The review identifies assessment waiting lists as one of the clearest indicators of system failure.

People commonly wait:

- Months or years for assessment
- Longer still for treatment or support
- Even longer in areas with workforce shortages

The consequences include deterioration in mental health, family stress, educational disruption and increased use of crisis services.

Fragmented Services

Support is often poorly coordinated between:

- NHS services
- Education
- Social care
- Voluntary sector organisations

Families frequently describe having to navigate multiple systems independently, repeating their stories to different professionals and experiencing inconsistent thresholds for access.

Diagnostic Inequalities

The review highlights significant inequalities affecting:

- Girls and women
- Ethnic minority communities
- People living in deprivation
- Adults who were missed during childhood

Access to diagnosis and support can vary considerably depending on geography, socioeconomic status and local service availability.

Independent Assessment Market

The review raises concerns about parts of the rapidly growing private and NHS-funded independent assessment sector.

Specific concerns include:

- Variability in assessment quality
- Limited regulation
- Financial incentives linked to activity
- Inconsistent diagnostic standards

The review therefore recommends stronger national regulation and oversight. Currently, the CQC regulates services which offer both diagnosis and treatment of ADHD and autism, but current legislation does not allow the commission to regulate services which only offer diagnosis and not treatment. Following the publication of the report, the Department of Health and Social Care (DHSC) has asked the Care Quality Commission (CQC) to regulate all diagnostic assessments for autism and ADHD, once new regulations are in place.

5. Key Recommendations and Future Direction

The review proposes a comprehensive programme of reform built around ten recommendations. The most important themes are:

A. Move to a Needs-Led Model

People should be able to access support based on functional difficulties and individual need without requiring a diagnosis as a prerequisite.

This represents the report's most significant recommendation and underpins all others.

B. Earlier Intervention and Prevention

Government should focus more strongly on the root causes of distress through:

- Better public mental health
- Early support in schools
- Family support
- Community-based interventions
- Reduction of social determinants of ill-health

The aim is to prevent escalation before specialist services become necessary.

C. Integrated Mental Health and Neurodevelopmental Services

The review recommends more joined-up services capable of addressing overlapping needs.

Many individuals experience combinations of:

- Anxiety
- Depression
- ADHD symptoms
- Autistic traits
- Educational difficulties

Current pathways often separate these conditions in ways that do not reflect real-world experience.

D. Workforce Expansion

The report recommends investment in:

- Clinical psychologists
- Psychiatrists
- Nurses
- Therapists
- Educational professionals
- Community support workers

Workforce shortages are viewed as a major constraint on service improvement.

E. Stronger Regulation

Recommendations include:

- CQC regulation of all ADHD and autism diagnostic assessments (see above)
- Tighter oversight of providers
- Restrictions on direct-to-public advertising of NHS-funded assessments
- Improved quality assurance across sectors

These changes aim to improve public confidence and ensure consistency.

F. Cross-government mental health strategy

It is expected the review will help inform the above which is currently under development and is due early in the new year.

Lead Executive: Julian Emms, Chief Executive

Presented by:
Julian Emms
Chief Executive
10 November 2026

Care Quality Commission
Citygate
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Julian Emms
Berkshire Healthcare NHS Foundation Trust
London House
London Road
Bracknell
RG12 2UT

29 September 2026

CQC Reference Number: AP27862
Provider ID: RXY

Dear Julian

Re: CQC inspection of Berkshire Healthcare NHS Foundation Trust (Well Led)

Following the feedback meeting on 24 September 2026, with CQC colleagues Serena Coleman, James de Cothi, Zara Church, Emma Copland, Tayo Orisasami and Mariya Stamenova and our Executive Reviewer Buki Adeyemo, I thought it would be helpful to give you written feedback confirming that which was given verbally at the end of the onsite visit to you and your colleagues.

This letter does not replace the draft report we will send to you but simply confirms what we fed back on 24 September 2026 and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report, this correspondence should be used to inform discussions with the board. When scheduling a discussion of this letter, or the draft report, please inform your CQC Senior Regional Media & Communications Adviser, who is copied into this letter.

An overview of our feedback

- A consistent theme throughout the inspection was the strength of the trust's culture. Staff described a positive and psychologically safe environment to work in.

- Leadership and staff engagement was a key strength identified. The inspection team heard widespread praise for the visibility and accessibility of senior leaders, with regular engagement through approaches such as Gemba visits helping leaders maintain a strong connection with frontline services. We

also recognised the openness of leaders to challenge through question and answer sessions and the Equity Partnership Group.

- The trust's commitment to meeting the needs of local communities was also recognised. We heard about multiple initiatives designed to reach underserved groups, as well as the way learning from Safeguarding Adult Reviews has informed practical improvements, including work around fire safety and hoarding.

- We heard how quality improvement was firmly embedded within the trust's culture. Staff across the organisation were able to describe how QI approaches were being used to improve services and outcomes.

- The trust's use of data was impressive. In particular, Connected Care was highlighted throughout our interviews as a major asset that places the organisation in a strong position to respond to future opportunities and challenges.

- The trust's commitment to staff wellbeing was recognised, including the decision to continue investing in wellbeing support despite financial pressures, reflecting the value placed on supporting colleagues.

- We also acknowledged the significant progress made in Equality, Diversity and Inclusion space since the previous Well-Led review and were encouraged by the sustainability of this work and its integration into the wider culture of the organisation.

- We had two queries, one around the governance process of recording informal concerns and how the quality concerns log interacted with wider risk processes. We have already received a response from the trust in relation to the quality concerns log query.

Overall, the Trust demonstrated visible leadership, a strong and inclusive culture, an embedded quality improvement approach, and effective use of data. It also showed a clear commitment to both staff wellbeing and the communities it served.

A draft inspection report will be sent to you in due course, once we have completed our quality assurance processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to Sarah Bellars at Thames Valley ICB and Andrea Lewis at NHSE.

Could I take this opportunity to thank you once again for the arrangements that the trust made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

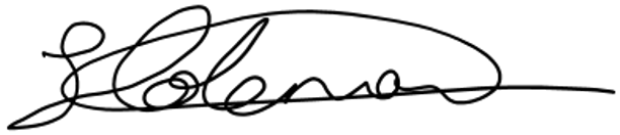
If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

Write to: CQC
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours sincerely



Serena Coleman

Deputy Director of Operations, Mental Health

c.c. Andrea Lewis, Regional Chief Nurse NHSE

Sarah Bellars, Chief Nursing Officer, Thames Valley ICB

John Scott, Senior Regional Media & Communications Adviser, CQC

Board Meeting Date	10 November 2026
Title	**Violence Prevention and Reduction Assurance Report**
	Item for Assurance
Reason for the Report going to the Trust Board	The paper summarises our progress to date against the National violence prevention and reduction standard, and progress with the NHS Sexual Safety Charter, and Employers Initiative Domestic Abuse Charter commitments. The Board is asked to note this report, support the continued action and keep updated as per the Board Assurance Framework, and corporate risk on violence and abuse. As part of the NHS contract and the National violence prevention standards self-assessment we are required to share our violence prevention and reduction performance with the Board – recommended twice a year. All NHS organisations were written to in April 2024 asking them to sign the Sexual Safety Charter if they hadn't already, and to act, as well as report to Board with relevant data.
Business Area	People Directorate, Organisational Experience and Development
Author	Ash Ellis, Deputy Director for Leadership, Inclusion, and Organisational Experience Debbie Fulton, Director Nursing, Therapies and Quality (Exec Sponsor)
Relevant Strategic Objectives	This work links and connects through a few of our strategic objectives. We want to **reduce harm risk for our patients**, we want to make the Trust **a great place to work and receive care**, and we want to **use our resources efficiently**. The threat and impact of violence, aggression, and abuse puts us at risk of achieving these objectives and vision.

Highlight Violence Prevention and Reduction
September 2026

1. **Why is this coming to the Board**
   This report provides the Board with information and assurance on actions and progress to reduce violence and aggression against staff. It also provides assurance on the Worker Protection (Amendment of Equality Act 2010) Act 2023, effective from October 2024, which requires employers to take reasonable steps to prevent sexual harassment and provide a safe working environment.

To support this work, we are using national frameworks as detailed below:

- **NHS England Violence Prevention and Reduction Standards** (latest revision December 2024).

- **Sexual Safety Charter**, signed in September 2023, committing us to zero tolerance of unwanted, inappropriate or harmful sexual behaviour through 10 core principles. NHS England published a revised assurance framework in August 2025 to support implementation.

- **Employers' Initiative on Domestic Abuse Charter**, signed in March 2024, setting out five commitments to support staff affected by domestic abuse.

- **NHS Staff Standards**, published in August 2026, to provide a consistent staff experience and build on the People Promise. The standards cover line management, health and wellbeing, violence prevention, sexual safety, tackling racism and flexible working. Our initial assessment indicates the Trust is well positioned overall.

2. **What are the key points?**

- Staff in mental health services continue to experience most physical and non-physical assaults across the Trust. Compared with 2024/25, 2025/26 data show increases in reported physical and non-physical assaults and racial abuse. Reported physical sexual assaults have decreased, while non-physical sexual safety incidents have increased.

- Police involvement in abuse against staff has remained limited over the past five years: 13% of racial abuse incidents, 8% of sexual safety incidents and 9% of assaults on staff were reported to police. Through Operation Cavell, a joint initiative with Thames Valley Police, we are strengthening collaboration and accountability so offences against staff are recognised, reported and investigated. We are working with police to measure impact and have established key conditions for success, including timely reporting, information provision and staff support. Further communications will form part of our anti-abuse campaign launching in November 2026.

- Lord Mann's recommendations to tackle racism and antisemitism were published on 4 June. Antisemitism and all forms of racism have no place in the NHS and must be identified, challenged and prevented at every level. Locally, we are revising statutory and mandatory EDI training to explicitly include antisemitism, continuing multi-faith education and engagement, and seeking accreditation for theatre-based anti-racism workshops before wider rollout to support practical, culture-changing learning.

- A new Violence Prevention and Reduction eLearning package has been developed and will be mandatory for all staff from early 2027.

- A new learning programme, Courageous Compassion has begun. Participants report greater confidence in supporting staff after patient abuse, managing conflict, addressing inappropriate behaviour, and discussing wellbeing, performance and conduct. Compassionate, confident leadership supports the wider violence prevention agenda by creating psychological safety, resolving conflict early, encouraging reporting and support-seeking, and ensuring unacceptable behaviour is addressed consistently and respectfully.

- To address the impact of racist incidents in our health settings, the Trust co-produced a restorative conversations approach with the CommUNITY Forum, staff and people with lived experience. Grounded in trauma-informed and anti-racist practice, it includes a restorative anti-racism video and practical staff guide to support safe, consistent and confident response. Initially introduced on wards with the highest levels of racist incidents, it supports compassionate conversations about harm, responsibility and behaviour change.

The full report provides detail of all the activity being undertaken to support reducing violence across the trust .

Appendix 1 provides supporting violence prevention and reduction data and analysis.

Violence Prevention and Reduction Assurance Report

1. Introduction

This paper provides an update on our assessment of, and our focus on Violence Prevention and Reduction (VPR) in Berkshire Healthcare. This work overlaps with our Unity Against Racism programme, and includes our work on sexual safety, domestic abuse as well as violence, abuse, and aggression.

Our Trust VPR Working Group continues to meet 6 weekly chaired by the Deputy Director for Leadership, Inclusion and Organisational experience with representatives from across the organisation including staff networks and unions. The Group reports to the Safety Culture Steering Group.

The Trust has also been working on the Culture of Care programme which supports our VPR work, and so isn't separate but is entwined with what we are already doing. This approach ensures care must be trauma informed, neuroinclusive and culturally competent.

We also have a live Violence and Aggression Risk on our Corporate Risk Register, which is reviewed and updated regularly, outlining controls, actions, and progress.

In May 2026, our last assurance report came to Board which outlined our position, and progress. This paper builds on that and provides further progress as to our updated position.

On 4th June Lord Mann's recommendations to tackle racism and antisemitism were published. Antisemitism and all forms of racism have no place in the NHS, and must be actively identified, challenged, and prevented at every level. We had already begun strengthening our response locally: we are revising our statutory and mandatory EDI training to explicitly include antisemitism, we will also be continuing our multi-faith education and engagement work, which references antisemitism. In addition, we have developed theatre-based anti-racism workshops, which we are seeking accreditation for, with the aim of rolling these out more widely to support practical, culture-changing learning across teams.

Over the last 6 months we have commenced a formal partnership with Thames Valley Police through Operation Cavell. The aim of this is to ensure that any incidents of violence and aggression are reported taken seriously and investigated appropriately.

In August 2026, the NHS Staff Standards was published. The Staff Standards enable all staff to get a consistent staff experience and build on the work already achieved through the People Promise. The standards cover line management, health and wellbeing, violence prevention, sexual safety, tackling racism, and flexible working. Therefore, quite a lot of the standards are relevant to this report and the work we do on violence and abuse. A separate report is coming to Board on our position against these standards. Our initial assessment indicates that the Trust is well positioned overall.

2. Our Progress

1. Training Needs Analysis

In a previous paper we reported we undertook Trust-wide risk assessments for all services to inform our violence and abuse training provided to staff. This combined with feedback from our annual abuse survey from staff telling us they want more specific training to their role and/or they don't currently have access to violence prevention training. We are now making great progress with the implementation of our training needs analysis:

- We have now developed a new eLearning package; Violence prevention and reduction, which from early 2027 will be mandatory for all staff. We are now inviting staff to complete this, giving three months to get compliant. This also brings together conflict resolution and therapeutic services training, also reducing duplication for groups of staff.
- We have undertaken a full review and a quality impact assessment for moving to one training model as the Trust currently uses PMVA for mental health services and SCIP for learning disability services. The risk assessment for LD services and staff feedback told us there was a gap in skill and knowledge particularly when incidents of violence and aggression in our LD unit has been consistently high. A full implementation plan has been developed for the transition and managing the risk for moving from one training model to another for LD. This will mean all staff will receive the same level of training in high risk violence and abuse services.
- Breakaway training is also having some changes, some colleagues who currently complete Breakaway training will no longer need to do so, while some colleagues who do not currently undertake it will now be required to complete it.
- Specialist Clinical Holding training is also being developed in conjunction with clinical directors and services where this has been identified through the service violence and abuse risk assessment.

2. Courageous Compassion: conversations that matter – new essential training programme for managers

This essential training for managers is designed to build the confidence and skills needed to navigate challenging workplace conversations with empathy, impact, and compassion. It explores how managers can move beyond instinctive, threat-based responses towards a more thoughtful and compassionate approach, enabling them to respond constructively in complex situations. The programme gives managers practical skills and confidence to lead challenging conversations with empathy and compassion, supporting positive team relationships, wellbeing, and performance.

The Courageous Compassion programme is demonstrating strong early impact in strengthening leadership capability across the Trust. Since July 2026, over 140 managers have attended Module 1, with consistently high levels of engagement and positive feedback. Evaluation findings show significant improvements in managers' confidence to initiate, structure, and navigate difficult conversations, address issues promptly, and respond compassionately in challenging situations. From module 2 participants report applying the learning to a range of workplace scenarios, including supporting staff following incidents of patient abuse, managing staff conflict, addressing inappropriate behaviours, and having constructive conversations about wellbeing, performance, and conduct.
This is particularly important within the Trust's wider violence prevention agenda, as compassionate and confident leadership helps create psychologically safe working environments, supports the early resolution of conflict, encourages reporting and support-seeking following incidents, and promotes a culture where unacceptable behaviours are addressed consistently and respectfully. Demand for the programme remains high, with future cohorts heavily subscribed, indicating strong organisational commitment to developing

the compassionate leadership skills that underpin staff wellbeing, retention, inclusion, and safer workplaces.

3. VPR Policy

As part of our self-assessment against the National VPR Standards one of our remaining gaps and therefore actions was to have a VPR policy. We took the opportunity to review several policies and combine them into one, whilst reducing and streamlining to make it easier for staff. Our new VPR policy is now live and being promoted across the Trust to staff. This policy ensures Berkshire Healthcare takes all reasonable steps to prevent, reduce and manage violence, aggression and abuse in the workplace and supports staff if incidents occur. It aims to:

- Create a safe working environment through effective systems, procedures, and training.
- Equip staff to manage incidents confidently and reduce the risk of recurrence.
- Protect staff from harm.
- Take and promote proactive measures to prevent future violence, aggression and abuse and safeguard wellbeing.
- Ensure good and appropriate wellbeing support is offered post-incident.

4. Operation Cavell

At the end of June 2026, we had a live event to mark the formal launch of our partnership with Thames Valley Police through Operation Cavell. The event provided an opportunity to hear directly from the Police about what this means in practice. We heard from DCI Stuart May, Thames Valley Police, Debbie Fulton, Director of Nursing & Therapies, and Ash Ellis, Deputy Director for Leadership Inclusion and Organisational Experience on:

- Operation Cavell and what it means for our staff
- How the Trust and police will work together
- Why reporting incidents is important and how staff will be supported.
- What the Trust is currently doing to prevent, reduce and manage violence and abuse.

It also provided the opportunity to ask questions, and time for networking and informal discussion with the police and Berkshire Healthcare colleagues.

Operation Cavell is an initiative that promotes joint working between the NHS and Police, it is designed to ensure that assaults and other criminal offences against NHS staff are recognised, reported and investigated as crimes, with staff supported as victims in line with the Victims' Code and the Assaults on Emergency Workers Act 2018.

Trust data shows that across the last 5 years:

- Only 8.5% of physical assaults (Figure 3, Appendix 1) have involved the police.
- Only 9.1% of non-physical assaults (Figure 8, Appendix 1) to staff have involved the police.
- Only 8.2% of sexual safety incidents (Figure 14, Appendix 1) to staff have involved the police.
- Only 12.8% of racial abuse incidents (Figure 17, Appendix 1) to staff have involved the police.

Highlighting a significant gap between incidents experienced by staff and number reported to enable police investigation.

Operation Cavell is being implemented to address this disparity by removing barriers to reporting, clarifying respective police and Trust responsibilities, improving evidence sharing, and ensuring consistent welfare and organisational support for staff. By strengthening collaboration and accountability, Operation Cavell underpins the Trust's approach to violence and provides assurance that incidents are taken seriously, investigated proportionately, and acted upon, rather than being normalised as "part of the job."

This also coincides with work looking at sanctions, in reviewing how we apply sanctions consistently, with these increasing across the last 2 years (Figure 20, Appendix 1).

5. Anti-abuse campaign

Abuse towards NHS staff by patients, families and carers remains a significant issue across Berkshire Healthcare's mental health, physical health, and community services, with the highest prevalence at Prospect Park Hospital, often involving patients with severe mental illness and learning disabilities. National Staff Survey and local data continue to highlight the scale and impact of abuse experienced by staff, including physical violence, harassment, and abuse, with disproportionate impacts on ethnically diverse colleagues.

Since the last report, further staff engagement, stakeholder involvement, and campaign development work has been completed to refine the approach and ensure the campaign is informed by staff experience and organisational priorities and linking with Operation Cavell. This has included continued engagement with Prospect Park Hospital staff, Crisis staff, staff networks and Trust-wide groups, alongside further development of campaign materials, messaging, and implementation plans.

The campaign remains on track and will launch in November 2026, initially at Prospect Park Hospital, and Crisis team as the pilot areas, utilising an inpatient and a community service. The campaign aims to increase reporting, set clear behavioural expectations, support staff wellbeing, and reinforce that abuse towards staff is unacceptable. It will form part of the Trust's wider violence prevention and staff wellbeing programme, using staff lived experience, education, empathy, and clear expectations to help drive cultural change.

6. Bullying and Harassment

A task and finish group was established from the VPR Group and took a QI approach to addressing bullying and harassment. The following progress has been made:

- Clear definitions of both Bullying and Harassment are now included in all relevant People Policies and being shared widely.
- A comms plan for 2026/27 is being finalised to support this workstream to create and raise awareness and be clear around behavioural expectations.
- Related activities include creation of Bullying Active Upstander guidance for staff, an all-staff webinar, a Managers Support Network session offering guidance to managers on the difference between firm management and allegations of bullying, and as part of a short series of scenario-based training videos have been developed around various aspects of violence, one is devoted to dealing with bullying. These will be promoted to services alongside the Anti-Abuse Campaign this November.
- Casework review – Part of the review will focus on numbers of staff reporting bullying via NSS (707 staff on staff incidents) vs bullying related casework (11 cases) and outcomes (2 upheld/partially upheld). There will also be a review of reporting (930 via NSS vs 19 on Datix and 30 FTSU cases).
- Internal survey of staff – A recent survey we created on bullying had some 200 staff provide the following data:
    - 63% had witnessed or experienced bullying in the last year.
    - 33% informed their manager, 4% reported the incident via Datix.
    - Trust support was mixed, 42% didn't feel supported by their manager and 38% didn't feel supported by Trust Support Services.
    - 79% of responses came from Admin, AHP & Nursing staff groups.
    - 45% of respondents worked in MHS Division (19% Central, 9% CFAA & 26% CHS)
- Data shows that those services with the lowest scores around both bullying & respect are in general the busy 24/7 inpatient and community-based services. These services are being prioritised via a QI approach to improve scores and better understand the root causes. Divisional & Service Directors are leading on working through the QI methodology.

7. Behaviours, and Resolution pathway

We continue embedding our behaviour framework throughout the organisation and clarifying expected standards and we have now concluded staff engagement around aligning recruitment questions with our behaviours, which will now move to implementation.
Our Resolution Pathway continues to be improved, promoted via Comms, and is readily available on Nexus, our staff intranet page. We recently held an all-staff webinar on mediation which was well attended by colleagues across the Trust.
As part of this pathway our internal mediation scheme continues to support staff in conflict. Our certified colleagues in workplace mediation have been accessing a structured programme of CPD, supervision, and peer support sessions. In terms of stats, between October 20205 and October 2026:

- We had 18 referrals.
- 6 we managed to close before the start.
- 8 managed to reach agreements.
- 1 partially resolved with ongoing action.
- 1 approval was declined by one party.
- 1 is in progress.
- 1 was unresolved.
- 14 of which were interpersonal conflicts, 2 were disagreements over roles and responsibilities, and 2 were around bullying, harassment and discrimination.
- 8 were from mental health services, 8 from community services, 1 from central services, and 1 from children and family services.
- There were 2 services where more than 1 referral was made.

We have also seen an increase in demand for facilitated conversations. We have further developed a pool of facilitators through a workshop and will be soon providing this offer to our workforce.

8. Incidents, Empowerment and Support Anti-racism Workstream

The VPR Group continues to oversee one of the five Exec led antiracism workstreams. The programme is consolidating and reviewing what actions we have taken and continues to build on those. Some workstreams have achieved their original remit by delivering short and medium-term actions and are now operating effectively within business-as-usual (BAU) arrangements. Other areas of work continue to address longer-term or structural issues, where progress requires sustained leadership and oversight. This workstream now continues as targeted assurance and continuous improvement: the casework review is now well underway and further actions are beginning to be shaped. This is with independent review and scrutiny from a charitable organisation that specialises in this type of work.

To address the ongoing impact of racist incidents within our health settings, the Trust co-produced a restorative conversations approach with the CommUNITY Forum, staff, and people with lived experience. Grounded in trauma-informed and anti-racist practice, this work resulted in a restorative anti-racism video and practical staff guide to help teams respond safely, consistently, and confidently when racism occurs. Rather than being punitive, the approach focuses on accountability, understanding impact, preventing future incidents, and supporting repair. Initially implemented on wards experiencing the highest levels of racist incidents, it helps staff hold conversations about harm, responsibility and behaviour change while maintaining compassionate, clear boundaries. The aim is to build trust, create safer ward environments and improve care quality for everyone.

Also to note, Wellbeing support to staff; From Apr 2026 – Sept 2026 5 of the 114 incidents were of a racism/racist nature. (compared to 47 of 244 in the previous 6 months)

9. Violence and Aggression

There have been a fair few actions taken to support staff in preventing, managing, and reducing violence over the last few months. Some of the key actions have been summarised and highlighted here:

Abuse Survey

The 2026 Abuse Survey highlights positive progress across several key areas relating to staff safety and wellbeing. Compared to previous surveys, staff reported increased confidence in managing incidents of violence, aggression and abuse, alongside greater confidence in their de-escalation skills. Perceptions of how the Trust prepares staff for incidents and responds following incidents have also improved, reflecting the continued investment in violence prevention, training, and support initiatives. Awareness of reporting processes remains high, with most staff indicating they know how to report incidents, and the majority of those who received support following an incident reporting positive experiences, particularly valuing support from managers and colleagues. The survey also identified areas for further improvement, including strengthening confidence that reported incidents result in visible action and feedback, improving consistency of support and follow-up, and providing greater clarity around routes for reporting discrimination, racism and microaggressions. Of particular note, ethnically diverse staff reported higher levels of exposure to violence, aggression, and abuse than White staff, highlighting the importance of continued targeted action through both the Trust's Violence Prevention Programme and Anti-Racism agenda. Overall, the findings indicate a positive trajectory, whilst reinforcing the need to maintain focus on prevention, staff support, equitable experiences and fostering a culture where all concerns are addressed promptly and effectively.

Staff support flowchart

A staff support flowchart was developed by PPH to help staff navigate what they should do following an incident of violence and abuse, including what support is available. This has now been adapted for wider use in the organisation and will be promoted and cascaded over the coming weeks.

Incident reporting

Following staff reporting that they don’t receive timely feedback on incidents they report, the Deputy Director for Leadership, Inclusion and Organisational Experience follows up with managers/handlers when violence and abuse incidents haven’t been reviewed and feedback to those reporting within 8 weeks of the incident– this has made a difference to staff in getting timely responses, and incidents being finalised. When managers finalise incidents, this also now sends automatic feedback to the reporter on any action taken or learning.

Data on violence and aggression is shared in Appendix 1.

10. Sexual Safety Charter

As part of our commitment to the sexual safety charter and ensuring the organisation is actively trying to prevent and address sexual harassment as part of Workers Protection Act 2023, we continue work in several areas since the last report which include:

- Continuing to promote our Sexual Safety learning package that we developed in-house, which has seen more than 490 colleagues undertake it since we launched it. It is also highlighted to all new staff at corporate induction when joining the Trust.
- Wellbeing support to staff; From Apr 2026 – Sept 2026 5 of the 144 incidents had a sexual aspect. (compared to 8 out of 244 the previous 6 months).
- The Personal Safety Team have developed a training session to raise awareness of PMVA and physical interventions and the law to support IOs with PMVA/ sexual safety related investigations. This will include the Personal Safety team observing CCTV.

Although we have more to do, this is around engagement, awareness raising and education, we will also need to continuously monitor quantitative and qualitative data to respond pro-actively to any learning and trends.
Data on sexual safety is shared in Appendix 1 which includes HR and incident data.

11. Domestic Abuse Charter

Being signatories of the Employers Initiative Domestic Abuse (EIDA) charter we continue to raise awareness and promote through our communications, some of our activity includes:

- Promoting EDIA webinars and learning sessions to staff, and utilising National awareness days to raise awareness and signpost.
- Wellbeing support to staff; From Apr 26 – Sept 2026 we worked with 3 people on our wellbeing matters line where domestic violence/abuse was the main theme. (compared to 3 the previous 6 months)

We have active actions in place for all commitments of the Charter. Although there is always more to do, this is generally around continuous engagement, awareness raising, and education.

Appendix 1 – Violence and Aggression prevalence in Berkshire Healthcare

Figure 1: Physical Assaults to Staff - Last 5 Financial Years

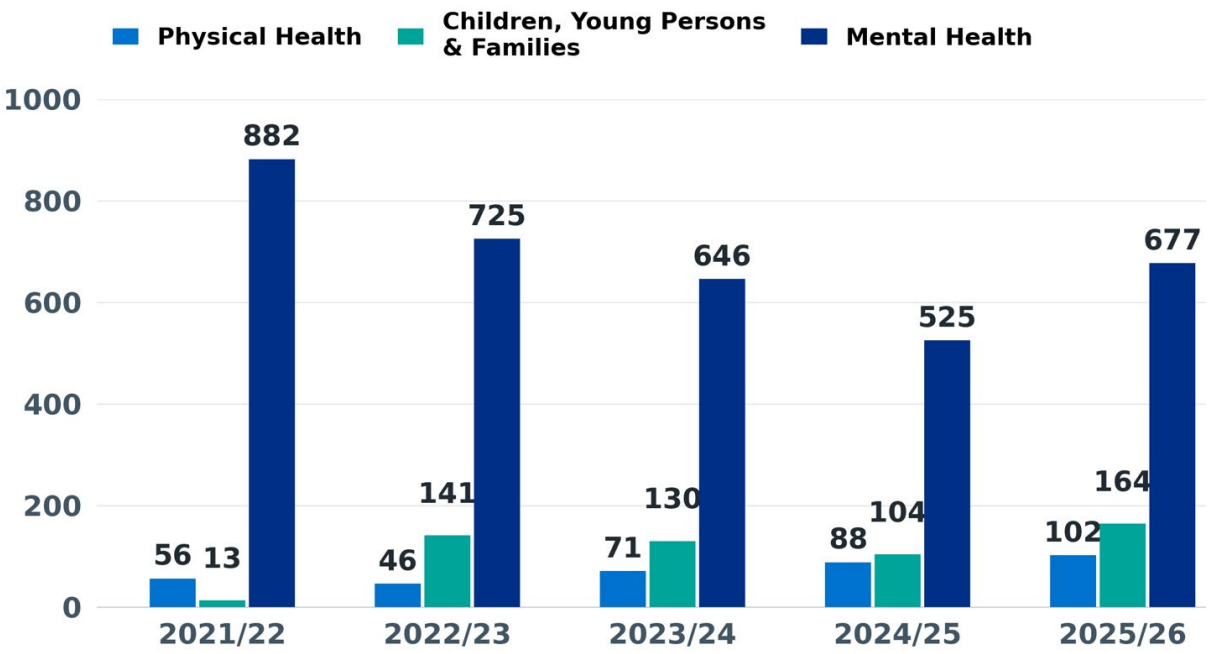


Figure 1 shows that most of our physical assaults happen within our mental health services, but with our physical health services the last 3 years shows an upward trend, as well as a big increase in children, young persons, and family services. Figure 1a below shows the ethnicity of the staff assaulted.

Figure 1a: Physical Assaults to Staff
Ethnicity of Victim - 2025/26

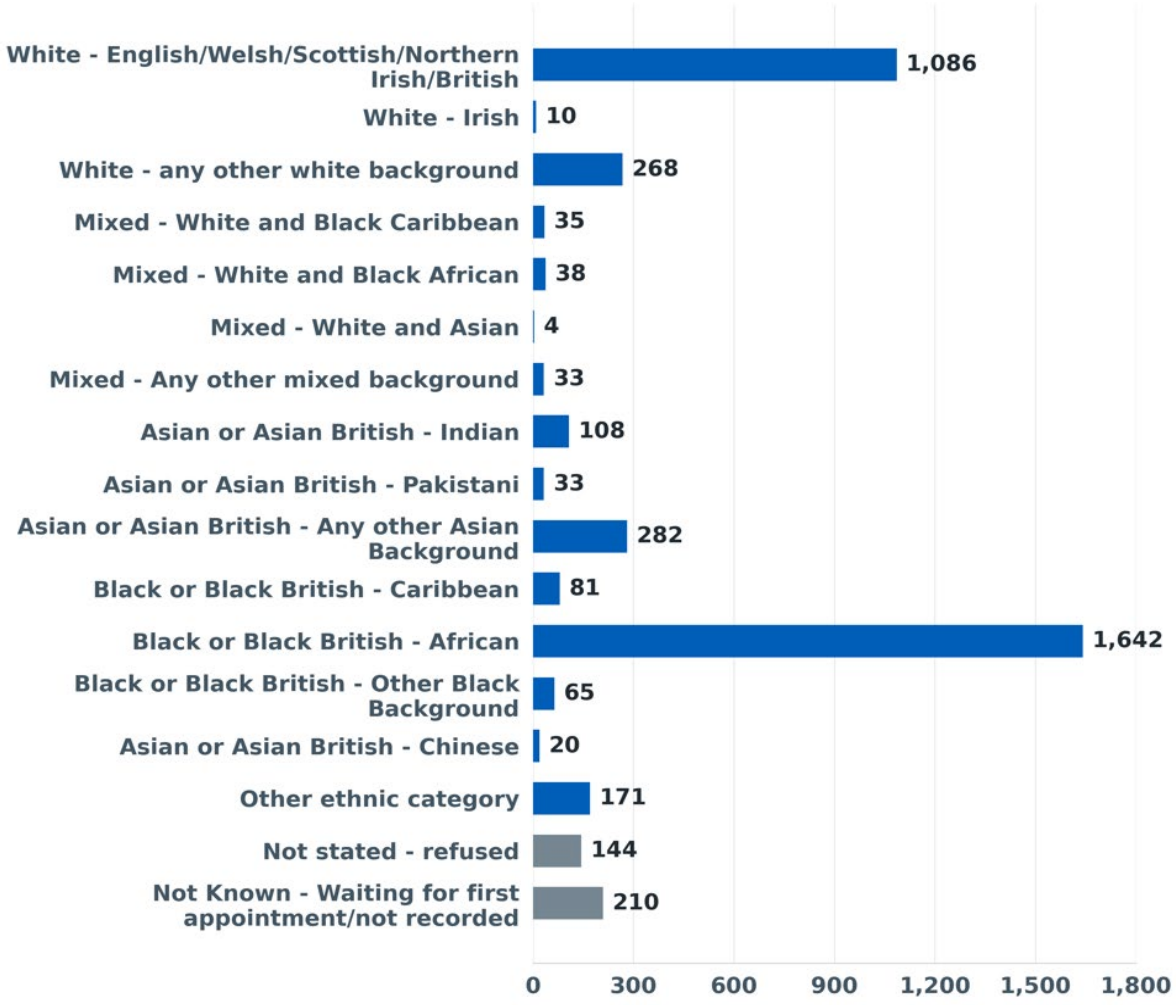
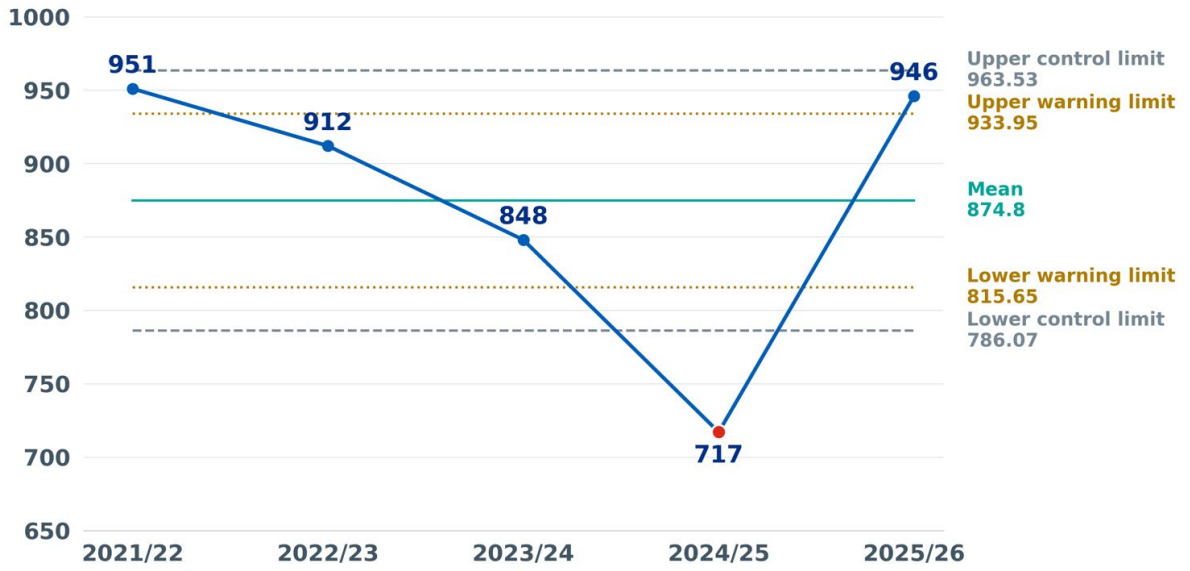


Figure 2: Physical Assaults to Staff - Last 5 Financial Years



‘A control chart plots a process statistic, such as a mean, range, or proportion, over time together with a centre line and upper and lower control limits that distinguish common-cause variation from special-cause variation. Points outside the control limits or non-random patterns within them indicate that the process should be investigated for assignable causes of variation.’

Figure 2 shows that the previous 3 years have seen a decrease each year in assaults reported, with this year coming back to a similar position from 4 years ago (951 in 2021/22).

Figure 3: Physical Assaults to Staff

Police Involved - Last 5 Financial Years

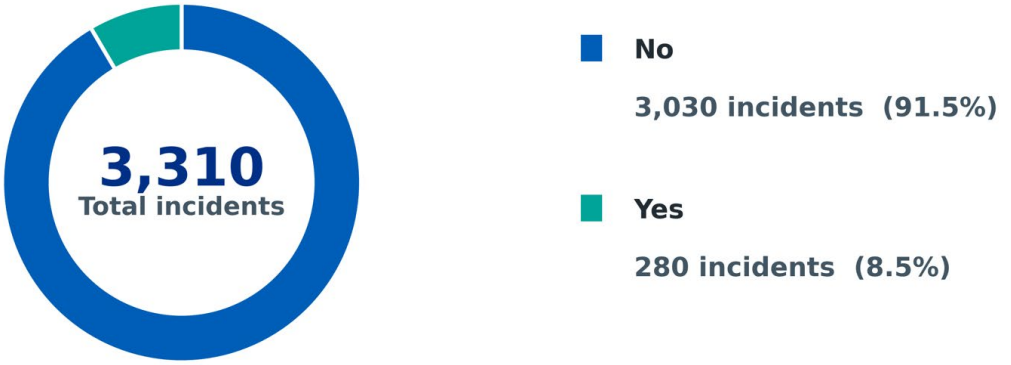


Figure 3 above shows us that only 8.5% of physical assaults were reported to the police across the last 5 years.

Figure 4: Type of Physical Assault to Staff

Last 5 Financial Years

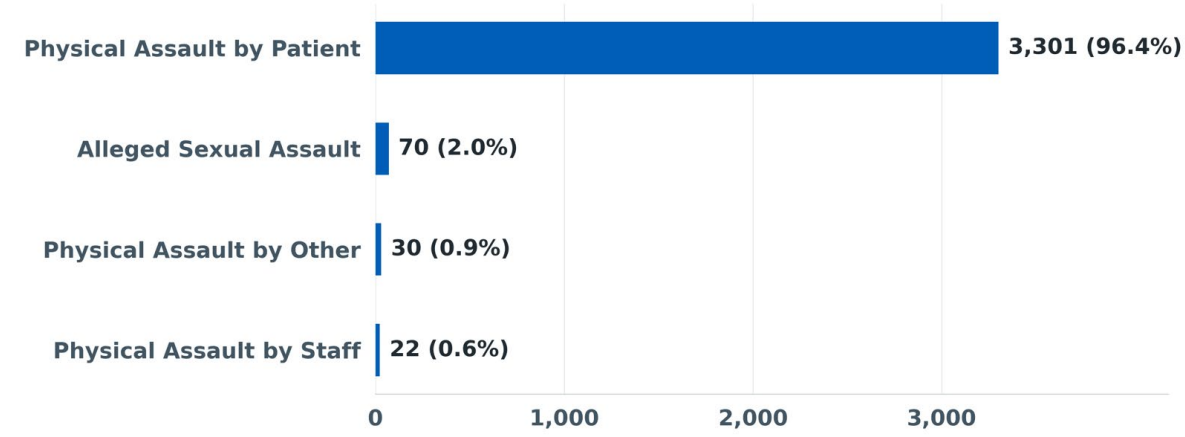


Figure 4 shows the type of assault across the last 5 years towards staff as mostly been physical.

Figure 5: Non-Physical Assaults to Staff - Last 5 Financial Years

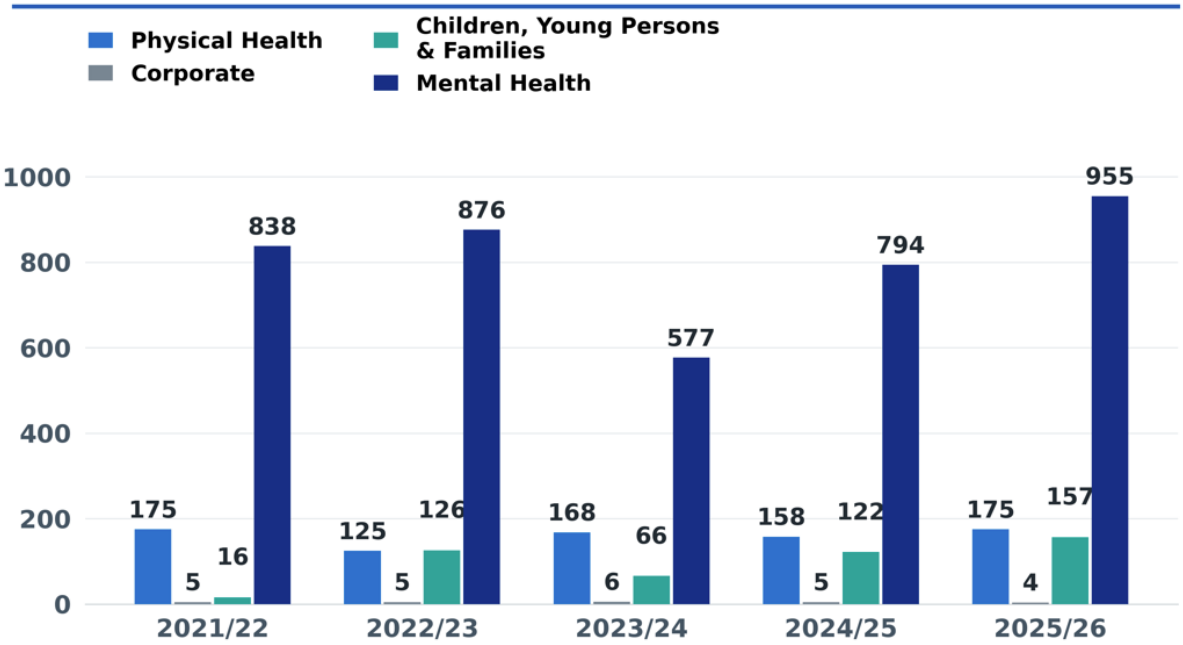


Figure 5 shows that the majority of non-physical assaults happen in our mental health services. Noting an increase in both other operational service areas.

Figure 6: Type of Non-Physical Assault

Last 5 Financial Years

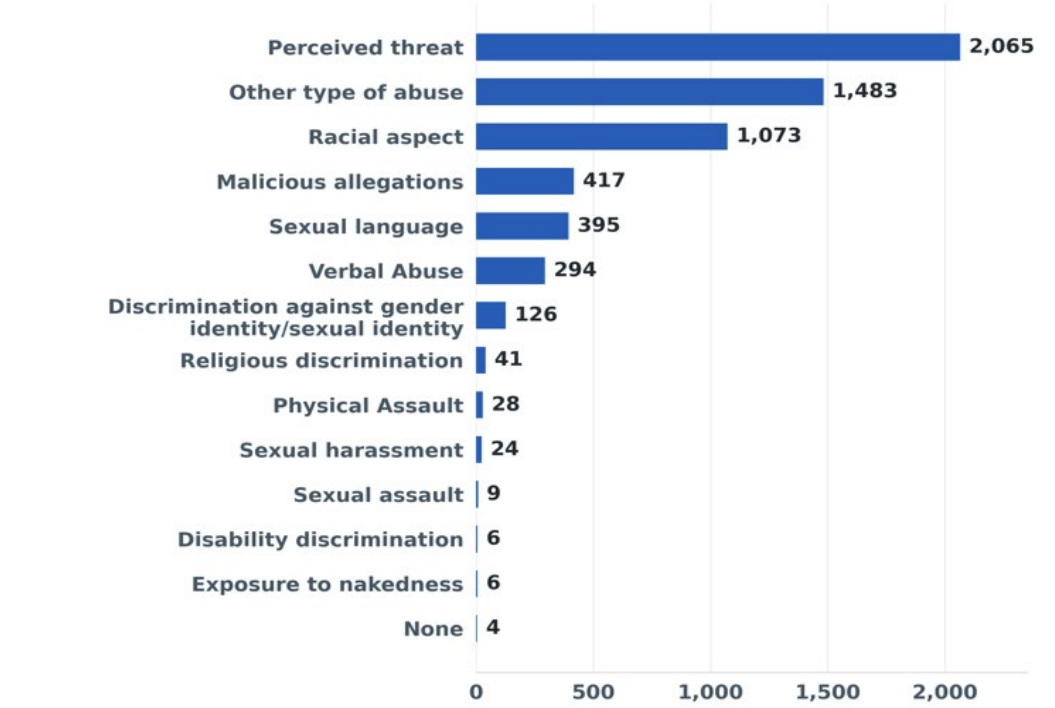


Figure 6 shows that the majority of non-physical assaults over the last 5 years are that of a threatening nature. 'Other type of abuse' pertains to everything else such as weight discrimination for example.

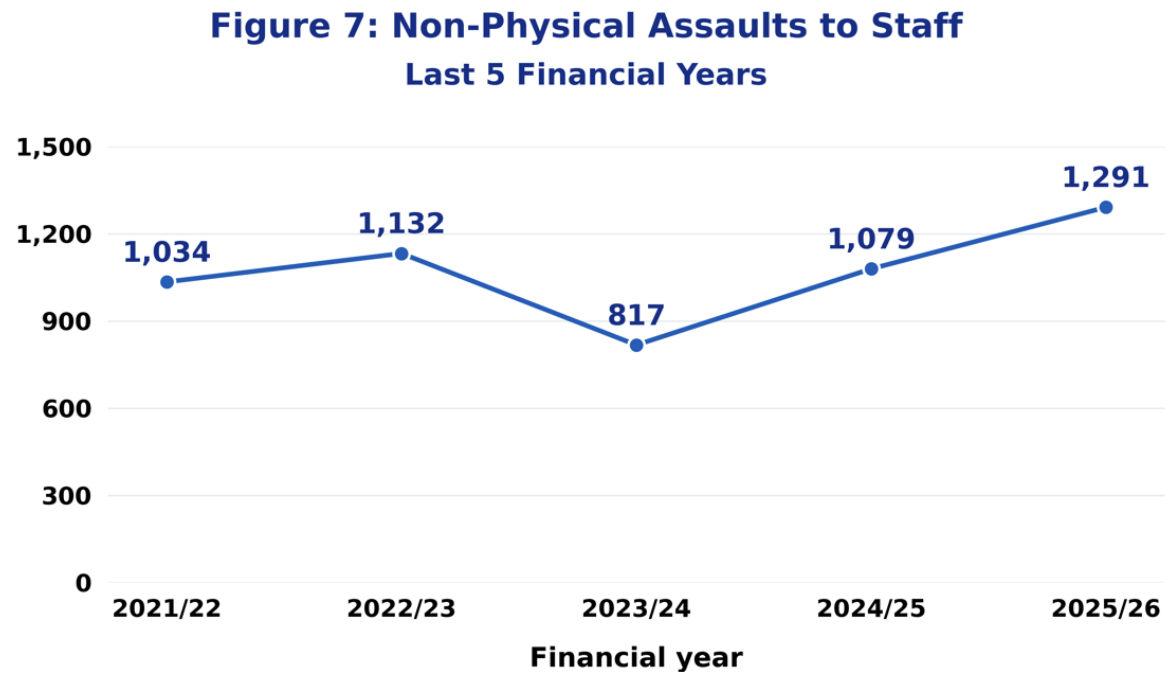


Figure 7 shows us that non-physical assaults are on an increase across the past 5 years.

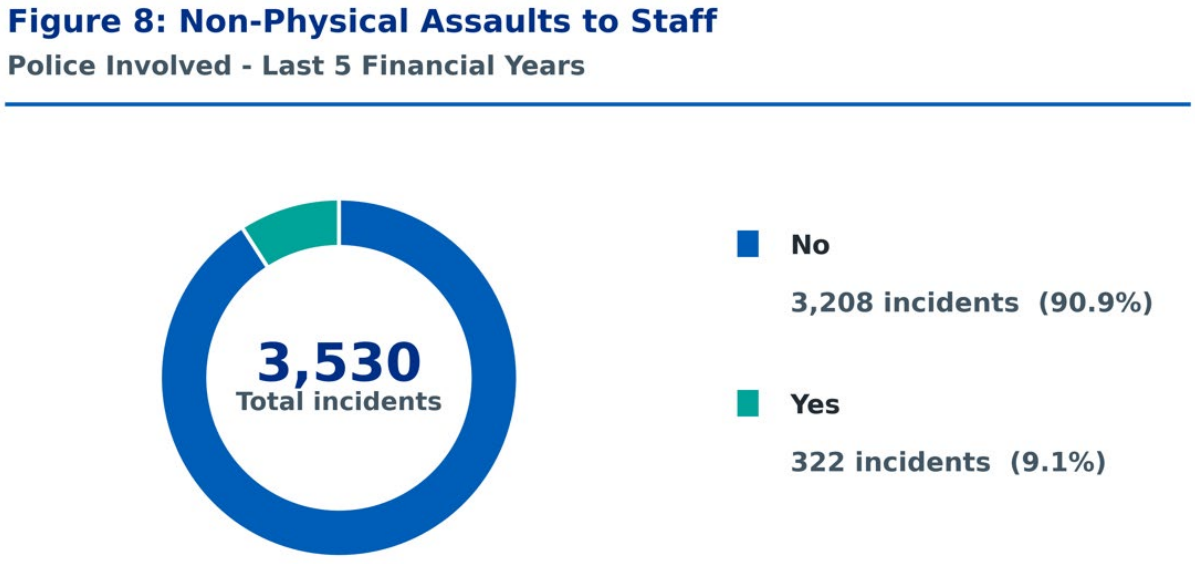


Figure 8 shows that police were involved in only 9% of non-physical assaults to staff across the last 5 years

Figure 9: Physical Sexual Assaults to Staff

Last 5 Financial Years

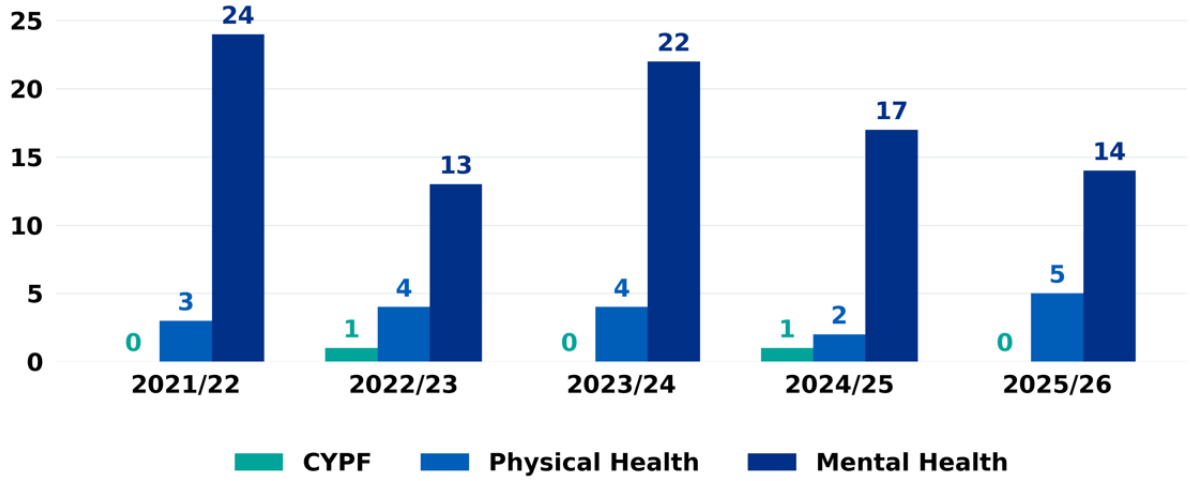


Figure 9 shows that the majority of physical sexual assaults happen in our mental health services, which is a continuing trend each year, although the number reported have reduced the last 3 years.

Figure 10: Physical Sexual Assaults to Staff

Last 5 Financial Years

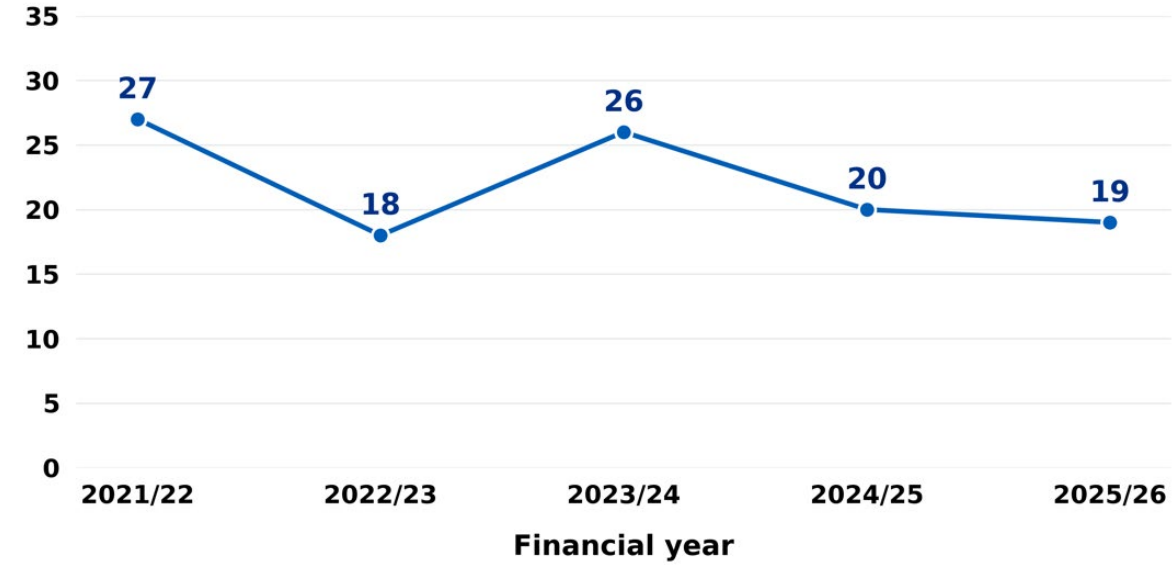


Figure 10 shows physical sexual assaults appear to be on a gradual downward trend across the last 5 years.

Figure 11: Sexual Safety Incidents to Staff

Last 5 Financial Years

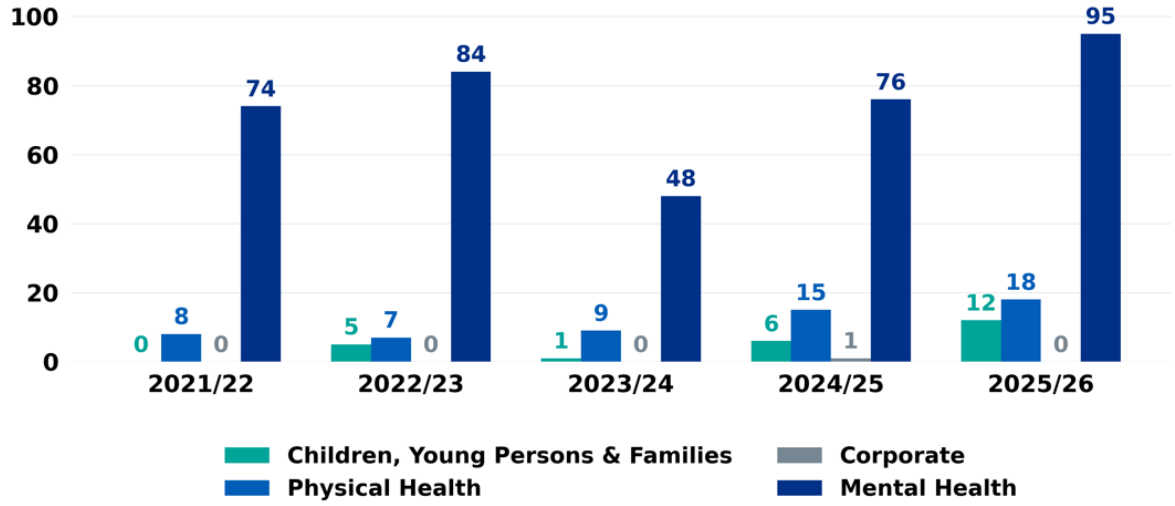


Figure 11 shows that the majority of sexual incidents happen in our mental health services, which is a continuing trend each year, with an increase each year across the last 3 years in the other clinical service areas as well.

Figure 12: Sexual Safety Incidents to Staff

Last 5 Financial Years

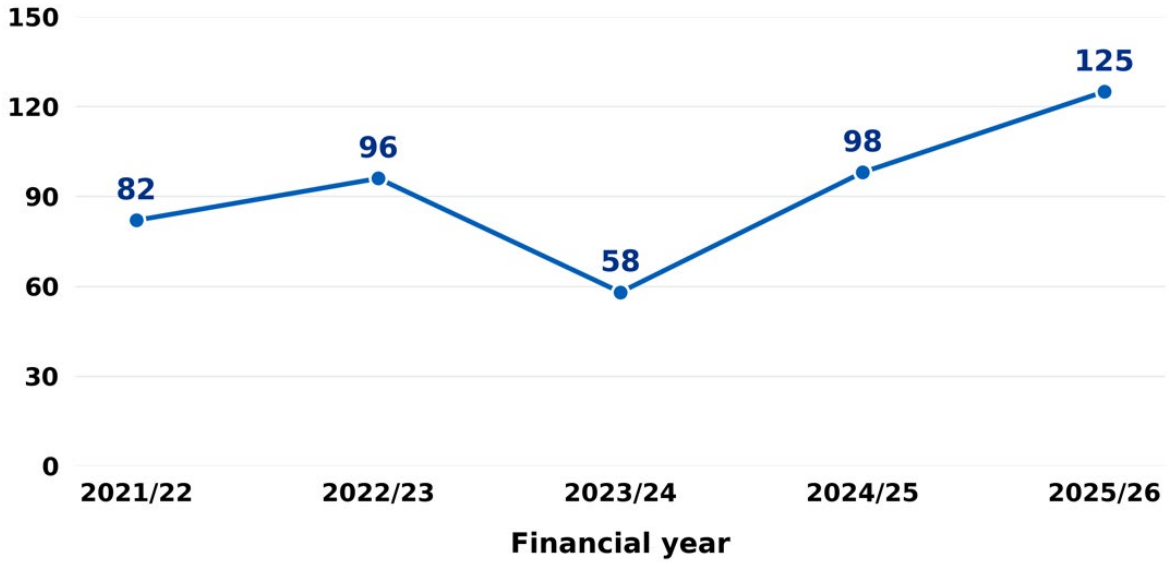


Figure 12 shows sexual safety incidents to staff appear to be on a gradual upward trend across the last 5 years.

Figure 13: Types of Sexual Safety Incidents to Staff

Last 5 Financial Years

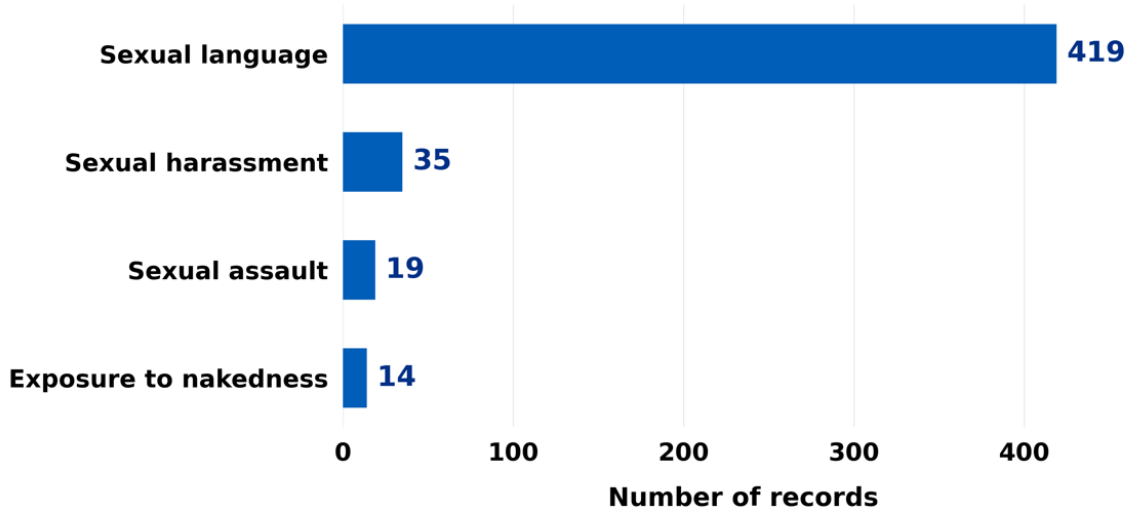


Figure 13 above shows that the type of sexual safety incident to staff by a long way is 'language'.

Figure 14: Sexual Safety Incidents

Police Involvement

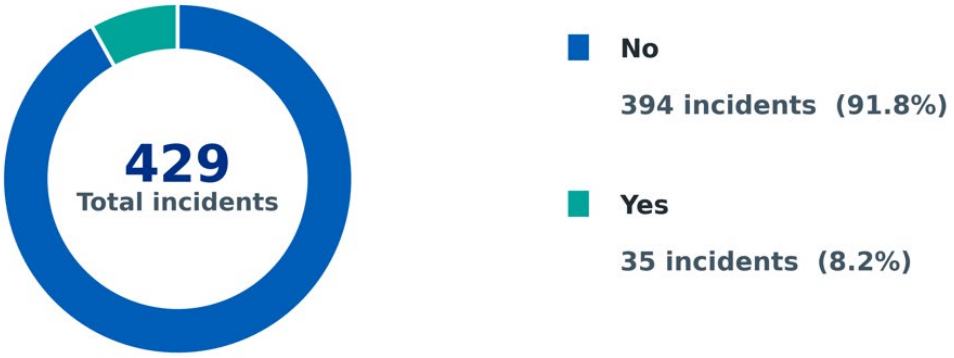


Figure 14 shows that police were involved in 8% of all sexual safety incidents towards staff across the last 5 years.

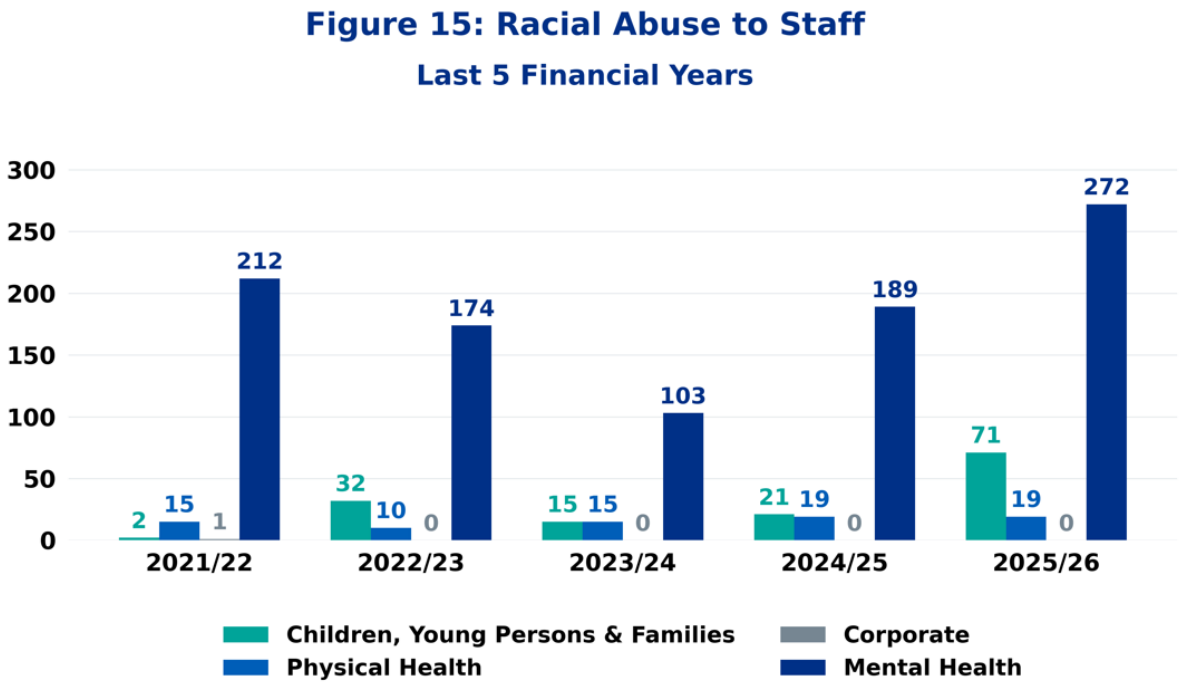


Figure 15 shows that the majority of racial abuse happens in our mental health services, the same for the last 5 years. We also have a high proportion of Ethnically diverse staff who work in mental health inpatients with over 60%. The last 2 years has seen a rise in racial abuse in our children, young persons, and Family services.

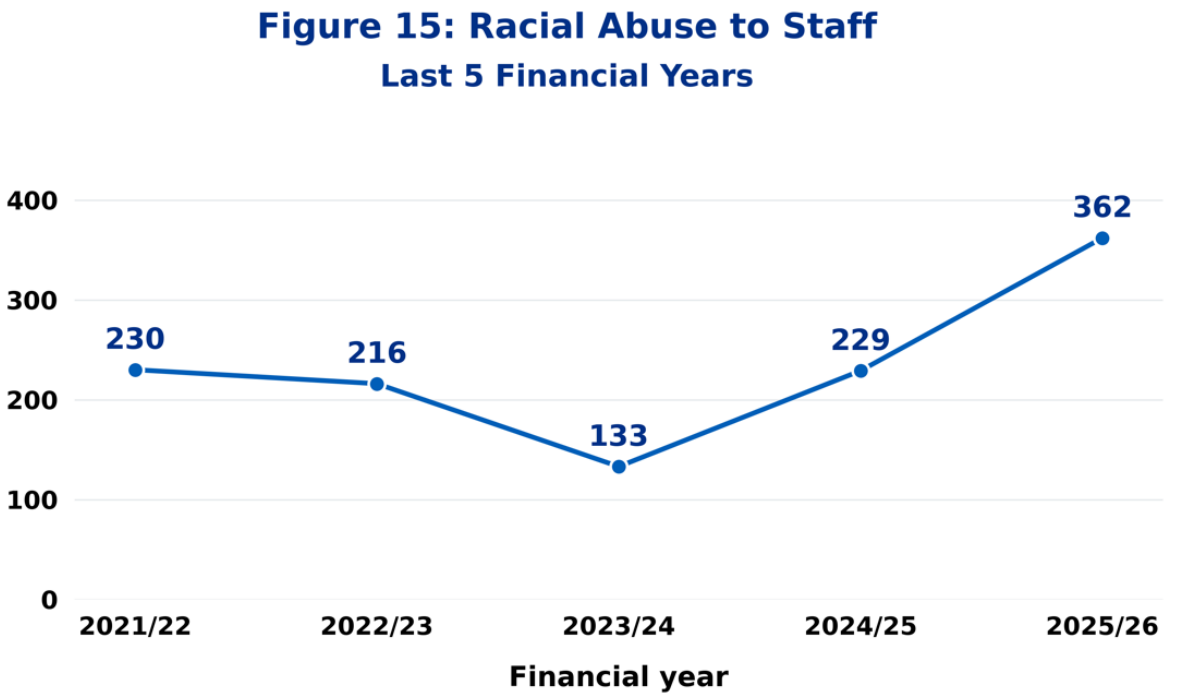


Figure 15 shows that racial abuse across 5 years is on an incline, with a large increase the last two years. Our anti-racism programme and work to support staff reporting could be a factor for this.



Figure 17 above shows that the police were involved in 13% of all racial incidents across the last 5 years.

Figure 18: Sexual Safety HR Cases April 2019 to September 2026

Date	Early Resolution	Disciplinary	Whistleblowing
April 2026 - September 2026	0	4	0
April 2025 – March 2026	0	6	0
April 2024 – March 2025	1	3	0
April 2023 – March 2024	0	2	0
April 2022 – March 2023	1	4	0
April 2021 – March 2022	0	1	0
April 2020 – March 2021	0*	11	0
April 2019 – March 2020	0*	4	0

*Grievance and Dignity at Work Policy. We made some changes to our policies and trackers in April 2021 (replaced grievance and dignity at work policies with early resolution)

Notes:

- Most allegations are against males and of these, the majority are from ethnically diverse backgrounds.
- Most incidents occurred in mental health services and pertain to allegations between patients and staff members.
- Most cases close at fact find with no case to answer; where cases have progressed to a hearing via a disciplinary process, the staff members have all been summarily dismissed.

In April 2020 – March 2021, 3/11 cases related to simultaneous allegations (i.e. same allegation opened on the same day) from the same patient towards different staff members and a further 2/11 cases relate to the simultaneous allegation from the same patient towards different staff members

Figure 18 shows that there are no real trends or patterns for sexual safety HR casework across the last 7.5 years, with disciplinaries averaging around 4 per year. Data includes cases which closed in the informal stage or with no case to answer.

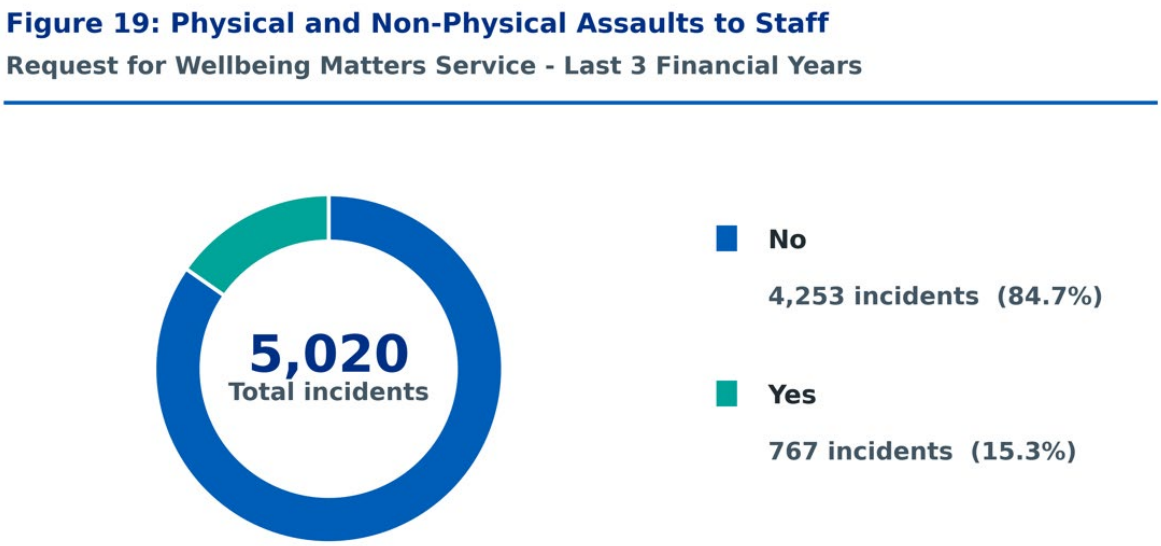
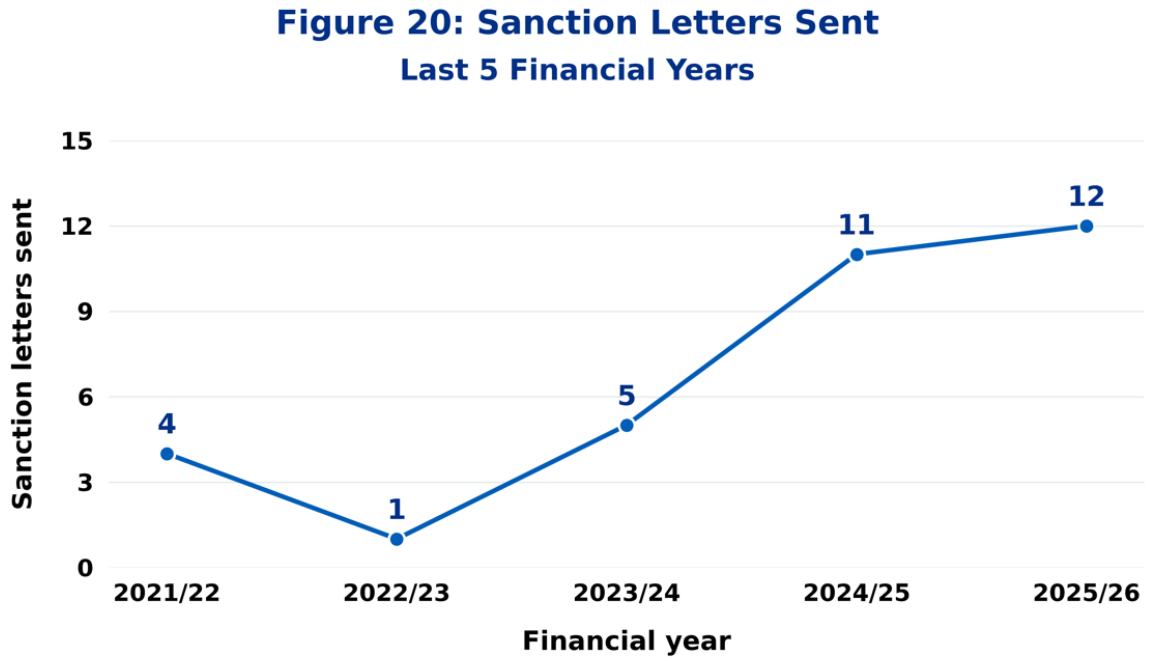


Figure 19; when staff report incidents they are asked whether they want support from our Wellbeing Matters service, which is then followed up by our Wellbeing Matters team. This shows that more staff choose not to access support, although there is still a fair amount of staff that say yes to wanting wellbeing support.

Figure 20: Sanction Letters Sent to Patients by Year, and Type of Sanction



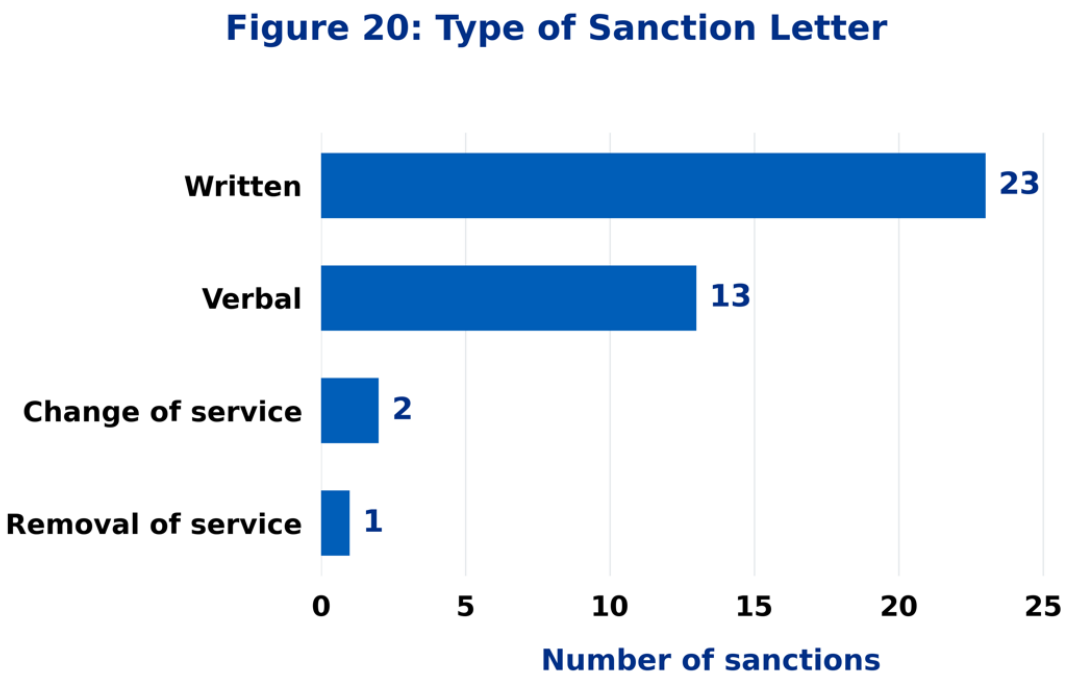


Figure 20: We can see that the last few years sanction letters sent to patients have increased, with the type of sanction used by the Trust being mainly written or verbal.

Figure 21: Violence and abuse incidents against staff over the past 6 months, and their religion

Figure 21a the number of incidents involving staff from each religion

Religion	Incidents (number) April to September 2026
Atheism	15
Buddhism	1
Christianity	116
Hinduism	6
I do not wish to disclose my religion/belief	15
Islam	8
Other	1
Grand Total	**162**

Figure 21b - the % of total incidents and the religion of those staff involved

Religion	% of incidents April to September 2026
Atheism	9%
Buddhism	1%

Christianity	72%
Hinduism	4%
I do not wish to disclose my religion/belief	9%
Islam	5%
Other	1%

The data above shows that staff whose religion is christianity are invovled the most in incidents, with still 9% chosing not to share their relgious beliefs.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	Tuesday 10th November 2026
Title	**NHS Staff Standards**
	Item for Assurance
Reason for the Report going to the Trust Board	To provide Board assurance on the Trust's initial assessment against the national NHS Staff Standards and the outstanding improvement actions. The standards underpin the NHS Oversight Framework. The Board is asked to note the assessment and latest position.
Business Area	People Directorate
Author	Jane Nicholson / Karen Smythe
Relevant Strategic Objectives	Workforce
Summary	The initial gap analysis indicates that the Trust is well positioned against the NHS Staff Standards, with established governance and improvement activity and no significant new risks identified. Q1 2026/27 results place the Trust in Segment 1. The NHS Staff Standards value is 8.01/10, with an individual NOF metric score of 1.21.

Berkshire Healthcare
NHS Foundation Trust

NHS Staff Standards 2026

People Directorate

Background: Transformation context for NHS Staff Standards

Berkshire Healthcare NHS Foundation Trust

NHS Staff Standards in the 10 Year Health Plan:

"A positive of work and the workplace should not be a 'nice to have'. We will work with the Social Partnership Forum to develop a new set of staff standards, which will for the first time outline minimum standards for modern employment. They will underpin the NHS Oversight Framework, and poor performance on staff-related outcomes will act as an early warning signal for CQC."

Fit for the Future: The 10 Year Health Plan for England, Pg 105, July 2025

The 10 Year Workforce Plan will set out action to deliver a new workforce model, to support delivery of the 10 Year Health Plan. We will deliver that change by making sure that staff are better treated, have better training, more fulfilling roles, and hope for the future

NHS Staff Standards: Key Messages

Berkshire Healthcare NHS Foundation Trust

Why?

There has been considerable focus on improving staff experience via the NHS People Promise with many organisations working hard to drive improvements, which is reflected in some of the 2025 NHS Staff Survey results. But this has been inconsistent across the NHS and more needs to be done to bring all organisations up to the required level and ensure staff experience is treated as a priority. In line with the 10 Year Health Plan's commitments, the NHS Staff Standards will, for the first time, set a national required standard which employers must meet.

What?

The new standards focus on six key areas for organisations to improve staff experience: 1) promoting flexible working; 2) line management; 3) health andwellbeing; 4) violence reduction and prevention; 5) tacklingracism; and 6) championing sexual safety in the workplace

Who?

Acute trusts, ambulance trusts, and mental health and community trusts are in scope of the new standards. However, all organisations delivering NHS services should reflect on the new standards and seek to improve their staff experience in these key areas. The standards apply to NHS employed staff; this includes appropriate and proportionate application for bank staff and students. There is encouraged alignment for agency staff via contractual and commissioning mechanisms.

How?

Regions and organisation boards should begin reviewing their existing staff experience provision and monitoring to ensure their policies, procedures and operational initiatives reflect the requirements of the new standards. Delivery against the standards will be measured with a new score that will be part of the NHS Oversight Framework.

The Bottom Line?

Employers are expected to implement the NHS Staff Standards from within existing budgets. The standards reflect minimum actions for employers which they should reasonably be expected to have in place, or be working towards already, to bring all organisations to the same national minimum expectation. This is about building on existing work rather than introducing new funded programmes

Executive Summary

Berkshire Healthcare NHS Foundation Trust

Overall assessment. The gap analysis indicates that Berkshire Healthcare is well positioned against the NHS Staff Standards, with established governance and improvement activity. The review identifies no significant new risks. The published Q1 2026/27 results place the Trust in Segment 1, the highest performing segment. Within People NOF, the NHS Staff Standards value is 8.01/10, with a NOF metric score of 1.21.

Current ratings. The assessment rates line management, health and wellbeing, violence prevention and reduction, and tackling racism Green. Sexual safety is Amber/Green and flexible working is Amber.

Remaining gaps. Incorporate sexual safety into mandatory training and clarify lawful information-sharing. Strengthen flexible working reporting and the Board-owned action plan. Clarify non-medical job planning requirements.

Next steps. Progress outstanding actions through existing governance and strengthen evidence of their impact on staff experience. Use the national self-assessment tool, once available, to validate the assessment and update the Board on any change in position.

Board decision requested. Note the initial assessment, support the proposed assurance approach and agree that the relevant governance groups progress identified actions.

People - NOF

Berkshire Healthcare NHS Foundation Trust

Domain metrics

Metric ▲	Sub-domain	Value	National benchmark	Score	Rank
Healthcare Worker Flu Vaccination Rate	People and culture	**49.40%**		2.48	19
NHS staff standards score	People and culture	**8.01 out of 10**		1.21	5
NHS staff survey engagement theme sub-score	People and culture	**7.48 out of 10**		1	1
National Education and Training Survey satisfaction rate	People and culture	**86.13%**		1.15	5
Sickness absence rate	People and culture	**4.66%**		1.52	6
Temporary staffing agency	Workforce			2	
Temporary staffing bank	Workforce			1	
Temporary staffing cost relative band score	Workforce			1	

Monitors workforce stability, staff retention, and organisational culture, including vacancy rates, staff turnover, and employee survey results. A well-supported, stable workforce is essential to delivering safe, effective care and sustaining long-term service improvement.

Aim of the **NHS Staff Standards**

Berkshire Healthcare
NHS Foundation Trust

Case for Change

Improvements to support staff experience have been inconsistently applied by organisations across the NHS.

- **Lack of mandation for existing frameworks means workforce benefits have been patchy and inconsistent across the NHS.**
- **Better staff engagement is associated with improved experience and job satisfaction.**
- **Staff burnout, stress and fatigue are consistently linked to patient safety incidents and adverse events.**
- **Higher staff turnover is associated with higher patient mortality.**
- **The productivity loss from absenteeism, presenteeism, lost capacity, and harm to staff is a serious issue across the NHS.**

Scope

Staff in Scope

The standards apply to NHS employed staff in secondary care; this includes appropriate and proportionate application for bank staff and students. There is encouraged alignment for agency staff via contractual and commissioning mechanisms

Organisations in Scope

- Secondary Care providers, including acute trusts, ambulance trusts, and mental health and community trusts
- All organisations delivering NHS services should consider the new standards
- Options for expanding the scope of mandating the standards across Primary Care and other NHS services will be considered

Objectives

It is intended that the NHS Staff Standards will achieve…

1. **Improvements in staff experience**
2. **Reductions in turnover and increased retention**
3. **Positive impact on service delivery**
4. **Increase the priority level organisations give to staff experience**

NHS Staff Standards

NHS Staff Standards aim to reduce variability and improve consistency of staff experience across the NHS and will work alongside other initiatives like the NHS People Promise.

They will set a national required standard, providing a clear framework of accountability for improving staff experience. Setting out the areas employers should prioritise and focus on, this will make improving staff experience a priority for boards, alongside areas like finance and operational performance.

The standards will cover:



Gap Analysis Overview

Berkshire Healthcare NHS Foundation Trust

Standard area	Overall RAG	Rationale	Key gaps / assurance questions	Immediate assurance focus
Line Management		Leadership strategy, competencies, guidance and development support are established, with delivery overseen through existing leadership and staff forums.	Overall position is strong. Job plans mainly for medics.	Complete the manager passport, defining expectations and required training.
Health & Wellbeing		Proactive wellbeing support is underpinned by inclusive policies, union partnership, a Board Wellbeing Guardian and the Wellbeing Matters service.	Overall position is strong. No material gap identified.	Launch the autumn True North project to reduce sickness absence.
Violence Prevention & Reduction		Established reporting, support, training, governance and staff-voice arrangements are reinforced by Op Cavell and the “Not Part of the Job” campaign.	Overall position is strong. TNA work is in progress	Maintain existing governance and complete TNA recommendations.

Gap Analysis Overview

Berkshire Healthcare NHS Foundation Trust

Standard area	Overall RAG	Rationale	Key gaps / assurance questions	Immediate assurance focus
Championing Sexual Safety		Most requirements are met through established governance, HR processes, staff communication, trauma-informed support and partnership routes.. We were an early adopter of the Safe Learning Environment Charter.	Clarify the lawful process for sharing concerns or allegations with future employers and host organisation	Add into EDI mandatory e-learning and clarify employment-check and safeguarding processes.
Tackling Racism		A strong framework combines strategy, practical guidance, governance, inclusive recruitment, training and case review. WRES results are improving and Berkshire Healthcare is a Race Equality Trailblazer.	No material gaps identified in the current review. Continue evidencing impact on staff experience, reporting and fair processes.	Continue to monitor through existing anti-racism governance, WRES and workforce data, staff voice routes, Board objectives and casework review.
Promoting Flexible Working		Strong uptake is supported by Board sponsorship, a nationally aligned policy, central HR oversight, e-rostering and staff-survey evidence.	No formal reporting of the volume or type of flexible working request	Establish reporting process as required.

Berkshire Healthcare
NHS Foundation Trust

NHS Staff Standards 2026 Appendix

People Directorate

NHS Staff Standards – overview of the standards

Berkshire Healthcare NHS Foundation Trust

LINE MANAGEMENT

Staff can expect supportive, fair, developmental and compassionate line management, enabled by employer support for line managers, to help staff to perform well, feel valued and fulfil their potential.

Actions for employers

Employers must:

- Embed the NHS Leadership and Management Framework across strategies, policies, training, appraisal and recruitment, and require all managers to complete the self-assessment tool
- Ensure line managers have access to comprehensive line management training through the NHS Leadership and Management Framework (with a focus on first-time managers) and monitor and address line management quality
- Ensure job plans accurately allocate sufficient time for line management responsibilities
- Ensure all role descriptions have clear, accurate and up-to-date job descriptions and review role changes promptly through agreed processes when requested, in accordance with the NHS Job Evaluation Scheme
- Ensure all line managers have appropriate supervision and mentoring for their own line managers and ensure that line management policies are accessible to enable timely and effective people management
- Ensure board-level oversight on how line managers are enabled by collecting and acting on feedback from line managers
- Work in partnership with trade unions through local arrangements to review workforce data, culture, health and safety risks and equality impacts

So that line managers are enabled to:

- Deliver high-quality appraisals, regular feedback and meaningful development and career support to their line reports
- Model inclusive, respectful behaviours, provide compassionate support, and foster psychologically safe teams that are well-led, connected and feel able to raise concerns or problems

NHS Staff Standards – overview of the standards

Berkshire Healthcare
NHS Foundation Trust

HEALTH & WELLBEING

Staff can expect their organisation to protect their health, safety and wellbeing at work. Employers are responsible for supporting staff wellbeing, preventing ill-health associated with work and helping staff to feel safe, cared for, and able to perform well.

Actions for employers:

- Appoint a Health and Wellbeing Guardian at board level
- Use the NHS Health & Wellbeing Framework to produce a localised Health & Wellbeing Strategy that is built on workforce data and provides needs-driven health and wellbeing support
- Take steps to ensure that, where practicable, staff have access to safe, non-clinical environments to take their rest periods
- Ensure that all staff, regardless of work location or shift pattern, have reliable access to nutritious food and drink. Alternatively, employers should ensure that there are safe options available for staff to store and prepare their own food
- Ensure all managers are supported to complete mandated competencies on safety, health and wellbeing so that all staff can expect health & wellbeing conversations to be embedded into 1-1s and appraisals
- Ensure managers are trained on how to discuss reasonable adjustments with disabled staff and staff with alternative needs
- Ensure protection and provision for pregnant and breastfeeding staff and for those experiencing perimenopause and menopause
- Ensure all staff have access to Occupational Health and Wellbeing support and local services
- Work in partnership with trade unions through local arrangements to review data and monitor progress

NHS Staff Standards – overview of the standards

Berkshire Healthcare
NHS Foundation Trust

VIOLENCE PREVENTION & REDUCTION

Staff have a right to feel safe and supported at work, in an environment that takes meaningful action to prevent violence, aggression, intimidation or abuse in any form. Staff should have access to simple, safe and supportive channels for reporting violence in the workplace; timely, compassionate support after any violent or harmful incident; and the right training to equip them with the confidence and knowledge to keep themselves and others safe.

Actions for Employers:

- Implement and embed the Violence Prevention Reduction (VPR) standard, as well as having a named Senior Responsible Officer for VPR with an annual VPR improvement plan
- Ensure that reporting systems are in place and actively promoted, so that all staff feel supported to report any incident of violence or abuse, irrespective of a patient's circumstances or condition
- Accurate and timely data should be recorded to inform strategies on tackling and preventing violence and feed into national VPR data collections
- Staff who are subject to violence or abuse should have access to high quality post incident psychological and welfare support. Managers as well as HR policies and procedures should provide the right support following incidents and during investigations
- Ensure that all staff receive training appropriate to their role
- Ensure the appropriate Health and Safety Committee/Forum is engaged in VPR planning and monitoring
- Work in partnership with trade unions through local arrangements, staff networks and local VPR groups to provide assurance on support for staff and to encourage staff to call out where organisations are failing. This should ensure that staff voice shapes local improvements

NHS Staff Standards – overview of the standards

Berkshire Healthcare
NHS Foundation Trust

CHAMPIONING SEXUAL SAFETY

Staff have a right to feel safe and supported at work, in an environment that is free from sexual harassment, abuse and unwanted or inappropriate sexual behaviours. Staff can expect: their organisation to take clear, consistent action to prevent sexual misconduct and harassment; promote a culture of transparency and openness that ensures incidents are reported and acted upon promptly and appropriately; training to be provided on how to recognise and report inappropriate behaviours; and a victim centred approach, with support provided to those affected and lessons learned to reduce the risk of future incidents.

Actions for employers:

- Fully implement the actions set out in the sexual safety in healthcare organisational charter, assessing progress using the sexual safety charter assurance framework, ensuring board level ownership and accountability
- Ensure all staff to complete Understanding sexual misconduct in the workplace e-learning
- Ensure that investigators of sexual misconduct allegations receive specialist training
- Ensure they have robust staff policies and processes for dealing with sexual misconduct and that staff do not suffer detriment as a consequence of reporting, in line with victimisation legislation
- Share concerns about employees with future employers and host organisations
- Ensure all staff are familiar with the sexual misconduct people policy framework so that they understand how to recognise and report sexual misconduct, and what actions should be taken when sexual misconduct is reported and where staff are the perpetrators, including the other policies that might be used
- Work in partnership with trade unions and staff networks through local arrangements to provide assurance on support for staff, to shape local plans and to encourage staff to call out where organisations are failing

NHS Staff Standards – overview of the standards

Berkshire Healthcare
NHS Foundation Trust

TACKLING RACISM

Staff should feel safe and supported at work, in an environment where their organisation takes sustained and meaningful action to prevent all instances of racism and discrimination in the workplace.

Actions for employers:

- Set consequential outcomes for misconduct at the individual level, from penalties for certain behaviours and/or repeated incidents to potential refusal of care for patients in non-emergency situations, and consequences for organisational performance and professional non-compliance
- Work with Trade Unions to ensure representation of the staff voice; ensuring policies are fair/proportionate; support staff to speak up; and support during formal procedures to ensure racism is taken seriously
- Ensure implementation and monitoring of the six High Level Impact Actions as part of the NHS EDI Improvement Plan
- Ensure every board member has a published Specific Measurable Achievable Relevant Time-bound objective on tackling racism
- Implement inclusive recruitment and talent management practices including recruitment and career progression plans for equity of opportunity
- Work to create inclusive cultures that encourage staff at all levels to report, and for employers to consistently work to root out racist behaviour
- Where appropriate, evaluate and implement the recommendations of key leading bodies on good practice
- Update emergency protocols and responses to include adequate and appropriate responses that help to maintain safe working environments
- Update grievance, disciplinary and investigative processes so they are responsive to the experiences of racism and discrimination and are void of biased applications in their process. Ensure they encourage thorough and unbiased investigation, with careful examination of evidence
- Where appropriate, evaluate and implement the recommendations of key leading bodies on good practice

NHS Staff Standards – overview of the standards

Berkshire Healthcare NHS Foundation Trust

PROMOTING FLEXIBLE WORKING

NHS staff can expect flexible working (flexibility in how, where and when they work) to be openly encouraged and supported, fairly and equitably considered, and embedded into everyday practice, creating a "flexible first" culture, rather than treated as an exception. Requests must be considered objectively and not unreasonably refused, and where they cannot be agreed, alternatives will be explored.

Actions for employers:

- Appoint a board level flexible working champion who is responsible for promoting and leading improvements in flexible working
- Implement a Flexible Working Action Plan using organisational workforce data which is owned by the Board
- Implement preference-based team e-rostering for all frontline workers (where operationally appropriate)
- Collect data on the number of flexible working requests which are approved or rejected, the types of flexible working requests, and broken down by protected characteristic, staff groups / professions, bands and at department level
- Publish this data for staff and linked to the Flexible Working Action Plan set out what actions will be taken to improve areas of concern
- Work in partnership with Trade Unions through local partnership arrangements to assess progress
- Ensure that managers, leaders and staff members have training in line with their roles to ensure they are confident to lead flexible teams
- Include flexible working as an option in all job adverts, job interviews, pre-retirement conversations, and line manager conversations such as appraisals or regular one to one discussion
- Ensure your organisation is following the guidance set out in The National Flexible Working People Policy Framework and reference this within the local flexible working policy

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper Meeting Paper

Board Meeting Date	10 November 2026
Title	**Finance Report September 2026**
	The paper is for assurance
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 September 2026.
Business Area	Finance
Author	Chief Finance Officer
Relevant Strategic Objectives	**Efficient use of resources** **Ambition:** A financially and environmentally sustainable organisation. 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.

Berkshire Healthcare NHS
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Finance Report
Financial Year 2026/27
September 2026

Purpose

To provide the Board and Executive with a summary of the Trust's financial performance for the period ending 30 September 2026.

Document Control

Version	*Date*	*Author*	*Comments*
1.0	13/10/2026	Rebecca Clegg	Draft
2.0	13/10/2026	Paul Gray	Final

Distribution

All Directors.
All staff as appropriate.

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Dashboard & Summary Narrative

Target		Year to Date Actual £m/%	Year to Date Plan £m/%	Year to Date Achieved	Forecast Outturn Actual £m/%	Forecast Outturn Plan £m/%	Forecast Outturn Achieved
1	Income and Expenditure Plan	0.0	0.0	Yes	0.0	0.0	Yes
2	CIP - Delivery	7.6	7.6	Yes	15.5	15.5	Yes
3	Cash Balance	50.6	48.5	Yes	48.2	44.4	Yes
4a	Better Payment Practice Code Volume Non-NHS	98%	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	99%	95%	Yes	95%	95%	Yes
4d	Better Payment Practice Code Value NHS	98%	95%	Yes	95%	95%	Yes
5	Capital Expenditure not exceeding CDEL	2.8	4.1	Yes	13.1	13.1	Yes
6a	Agency Expenditure (under)/over YTD Cap	0.2	0.0	No	0.0	0	Yes
6b	Bank Expenditure (under)/over YTD Cap	1.9	0.0	No	2.3	0	No

Key Messages

The table above provides a high level summary of the Trust's performance against key financial duties and other financial indicators. The position is positive with most targets being achieved for the year to date. The key points to note are:

The planned outturn position for the Trust is breakeven. This is phased evenly throughout the year.

The Trust has a cost improvement programme of £15.5m which is being achieved year to date.

The Better Payment Practice Code targets are currently being achieved.

Capital expenditure is behind plan mainly due to slippage on the Jubilee Ward relocation project.

The Trust has 2 targets for temporary staffing, set by NHSE as part of the planning guidance. The agency target is not being achieved at month 6 but likely to recover as a result of action on specific posts and changes to VAT for locum/agency doctors supply. The bank target is not being achieved and is unlikely to recover in year. It was set by applying national rules to our 2025/26 expenditure and we over achieved against the NHSE target set for that year.

1. Income & Expenditure

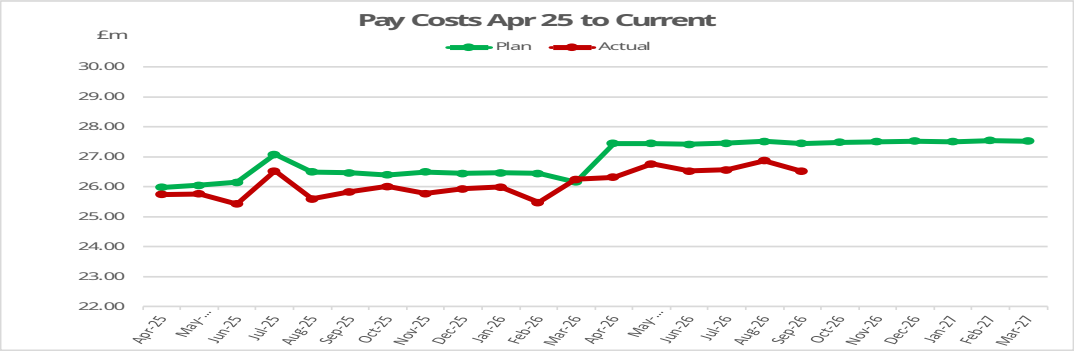
Sep-26	In Month Act £'m	In Month Plan £'m	In Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m	2026/27 Plan £'m
Operating Income	34.4	35.0	(0.6)	209.4	209.4	(0.0)	419.6
Elective Recovery Fund	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Donated Income	0.0	0.0	(0.0)	0.0	0.2	(0.2)	0.3
Total Income	**34.4**	**35.1**	(0.7)	**209.4**	**209.6**	(0.2)	**420.0**
Staff In Post	24.6	25.4	0.8	147.8	151.6	3.8	304.3
Bank Spend	1.6	1.3	(0.3)	9.5	7.8	(1.7)	15.6
Agency Spend	0.3	0.3	0.0	2.2	2.0	(0.2)	4.0
Total Pay	**26.5**	**27.0**	**0.5**	**159.5**	**161.4**	**1.9**	**323.8**
Purchase of Healthcare	1.6	1.5	(0.1)	10.6	8.7	(1.9)	17.2
Drugs	0.6	0.6	0.0	3.0	3.6	0.6	7.1
Premises	1.9	1.9	(0.0)	11.7	11.2	(0.5)	22.4
Other Non Pay	1.9	2.0	0.0	11.9	11.8	(0.2)	23.5
PFI Lease	0.7	0.8	0.1	4.5	4.6	0.2	9.3
Total Non Pay	**6.6**	**6.7**	**0.0**	**41.7**	**39.9**	**(1.8)**	**79.6**
Total Operating Costs	**33.1**	**33.7**	**0.6**	**201.3**	**201.4**	**0.1**	**403.5**
EBITDA	**1.3**	**1.4**	**0.1**	**8.1**	**8.2**	**0.1**	**16.5**
Interest Receivable	**0.3**	**0.2**	**0.0**	**1.3**	**1.3**	**(0.0)**	**2.7**
Interest Payable	0.3	0.3	(0.0)	1.7	1.7	(0.0)	3.4
Depreciation	1.0	1.1	0.0	6.6	6.5	(0.0)	13.2
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Disposals	0.0	0.0	(0.0)	0.0	0.0	(0.0)	0.0
Remeasurement of PFI	0.0	0.0	0.0	1.6	1.4	(0.2)	1.4
PDC	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Financing	**1.3**	**1.4**	**0.0**	**9.9**	**9.7**	**(0.2)**	**18.0**
Reported Surplus/(Deficit)	**0.2**	**0.2**	**(0.0)**	**(0.5)**	**(0.1)**	**(0.4)**	**1.2**
Adjustments	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**(0.0)**	**(1.2)**
PFI IFRS16 Adjustment	**(0.2)**	**(0.2)**	**0.0**	**0.5**	**0.1**	**0.4**	**0.0**
Adjusted Surplus/(Deficit)	**(0.0)**	**0.0**	**(0.0)**	**(0.0)**	**0.0**	**(0.0)**	**0.0**

Key Messages

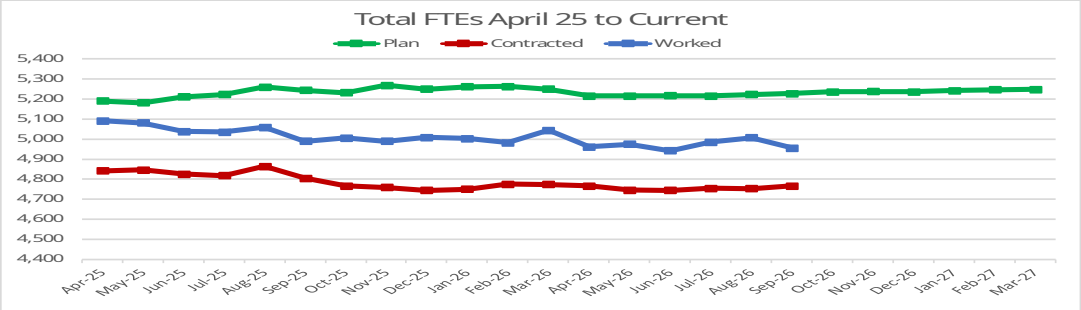
The table above gives the financial performance against the Trust's income and expenditure plan as of 30 September 2026.

The Trust is planning to breakeven in the current year and is on track to deliver this year to date.

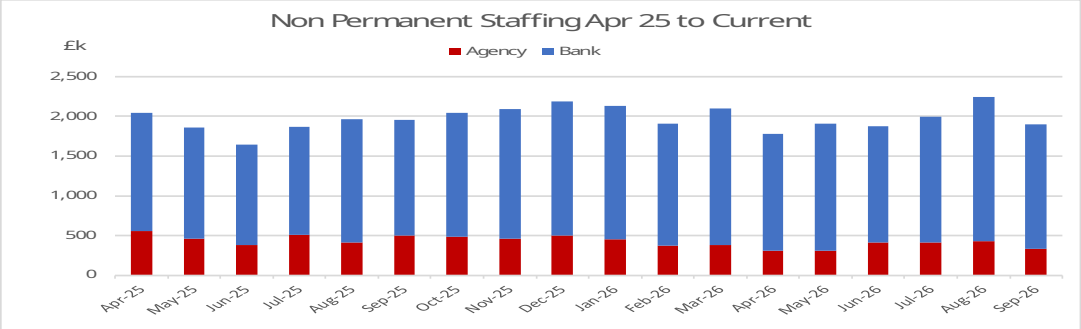
Workforce



Staff Costs	
YTD	£'k
2026/27	159.5
2025/26	154.9
	3%
Prior Year	**£'k**
Sep-26	26.5
Sep-25	25.8
	3%



Prior Mth	FTE's CFTE	WFTE
	£k	£k
Sep-26	4,767	4,955
Aug-26	4,754	5,006
	0%	-1%
Prior Year		
Sep-26	4,767	4,955
Sep-25	4,805	4,990
	-1%	-1%



Non Permanent Staff Costs		
YTD	Bank £k	Agency £k
2026/27	9,494	2,203
2025/26	8,514	2,823
	12%	-22%
Prior Year		
Sep-26	1,566	335
Sep-25	1,457	502
	7%	-33%

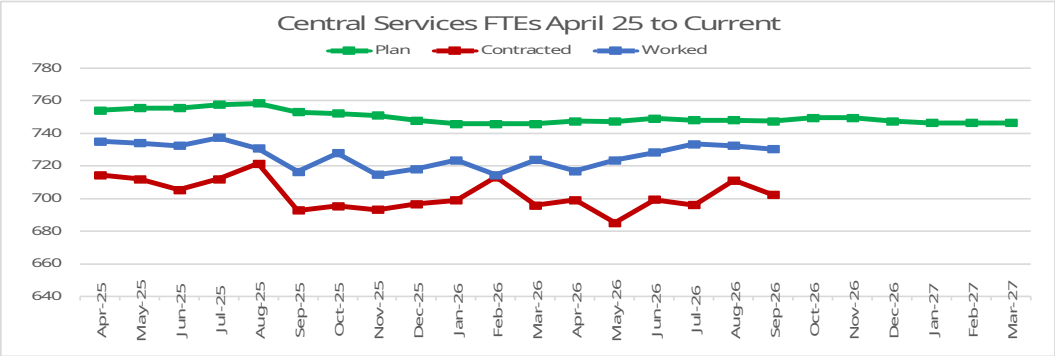
Key Messages

Pay costs in month were £26.5m, which is below plan.

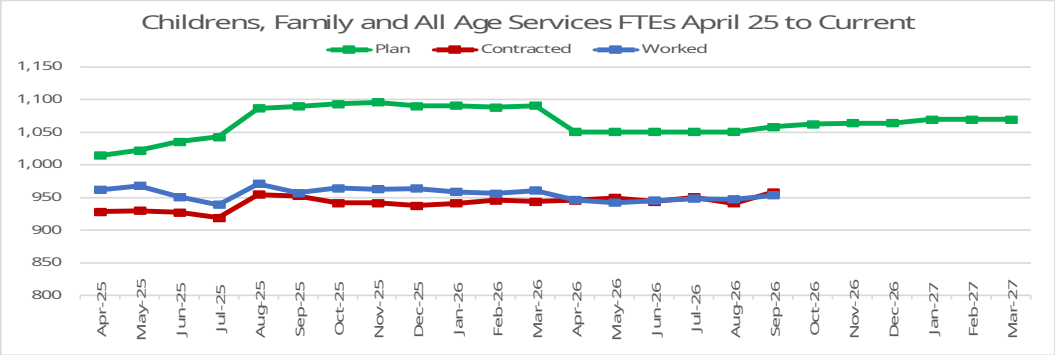
In month, Worked WTEs decreased by 51, the spike in summer largely driven by annual leave cover for annual leave. Contracted WTEs increased by 13 in month with a reduction following the Drs Rotation (-9) offsetting an increase as MHST trainees start (+17).

For 2026/27, NHSE has set expenditure caps for each Trust for bank and agency expenditure. For Agency, the Trust's cap has been exceeded marginally but it expected that this will recover by the end of the year. The cap for bank staff expenditure is a challenge and the Trust is not achieving it year to date and it is unlikely that this will recover by year end. This is in part due to the way the target has been set but there has also been an increase in the cost of bank usage compared with the first 6 months of last year this started in Q3 of 2025/26. Both measures are included in the National Oversight Framework.
Our bank fill rate remains strong, with monthly performance at 94.6% of the overall temporary staffing demand.
Off-framework Agency Usage remains low with only a slight increased with 8 unfilled shifts in September compared with 7 in August,. This is extremely positive news and reflects the continued success of recruitment and workforce planning initiatives. We continue to work closely with the Nursery Manager and NHSP to support recruitment and further reduce reliance on off framework agency staffing.
We continue to report zero breaches against the Agenda for Change price caps. The remaining breaches relate solely to medical staffing. In addition to the two administrative agency workers who have now successfully transitioned to the bank, a number of clinicians have either migrated to the bank, secured substantive posts, or reached the end of their placements. These changes have further reduced agency utilisation, decreased reliance on temporary staffing, and strengthened compliance with NHS England requirements.

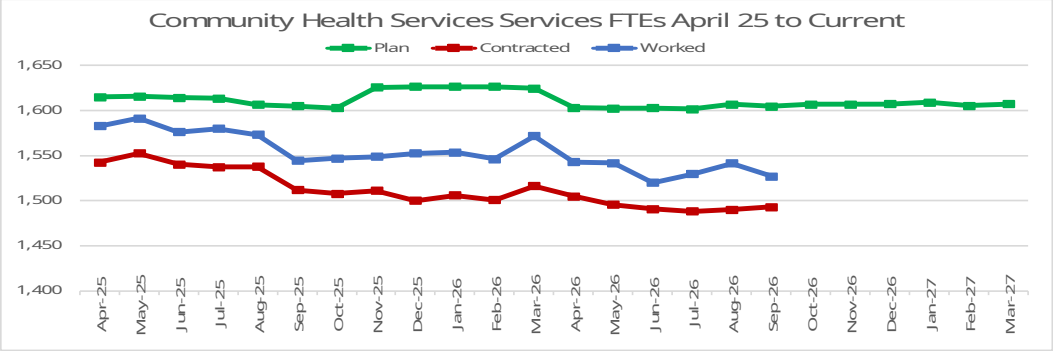
Staff Detail (Division)



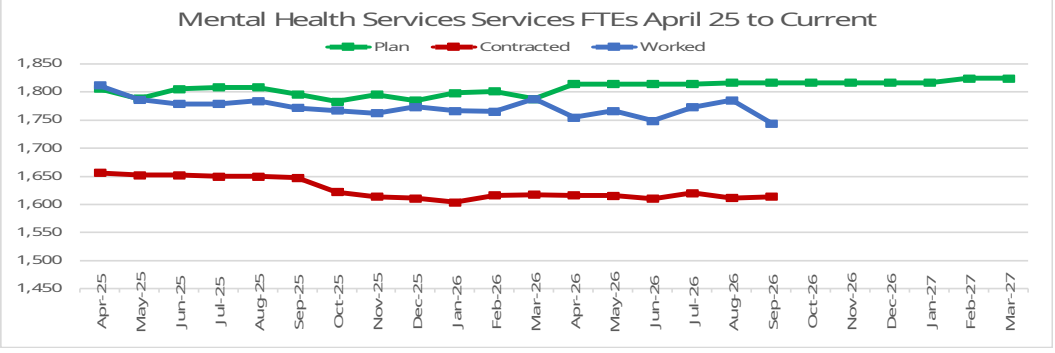
	FTE's	
Prior Mth	CFTE £k	WFTE £k
Sep-26	702	730
Aug-26	711	732
	-1%	0%
Prior Year		
Sep-26	702	730
Sep-25	693	717
	1%	2%



	FTE's	
Prior Mth	CFTE £k	WFTE £k
Sep-26	958	954
Aug-26	941	947
	2%	1%
Prior Year		
Sep-26	958	954
Sep-25	952	957
	1%	0%



	FTE's	
Prior Mth	CFTE £k	WFTE £k
Sep-26	1,493	1,527
Aug-26	1,490	1,541
	0%	-1%
Prior Year		
Sep-26	1,493	1,527
Sep-25	1,512	1,544
	-1%	-1%



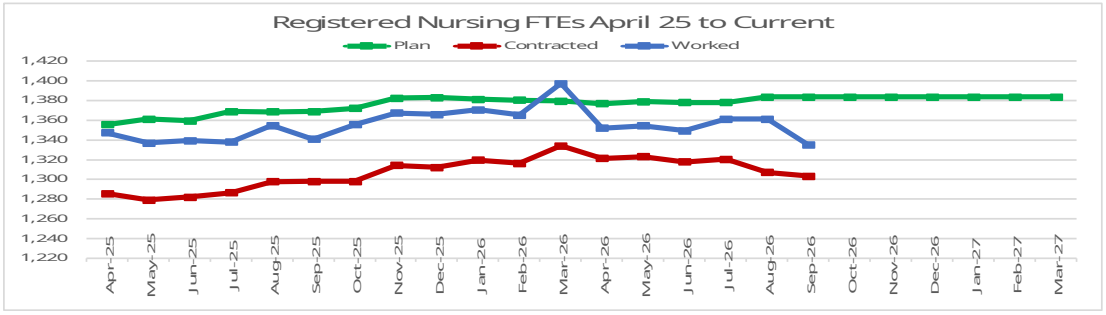
	FTE's	
Prior Mth	CFTE £k	WFTE £k
Sep-26	1,613	1,744
Aug-26	1,611	1,785
	0%	-2%
Prior Year		
Sep-26	1,613	1,744
Sep-25	1,647	1,772
	-2%	-2%

Key Messages

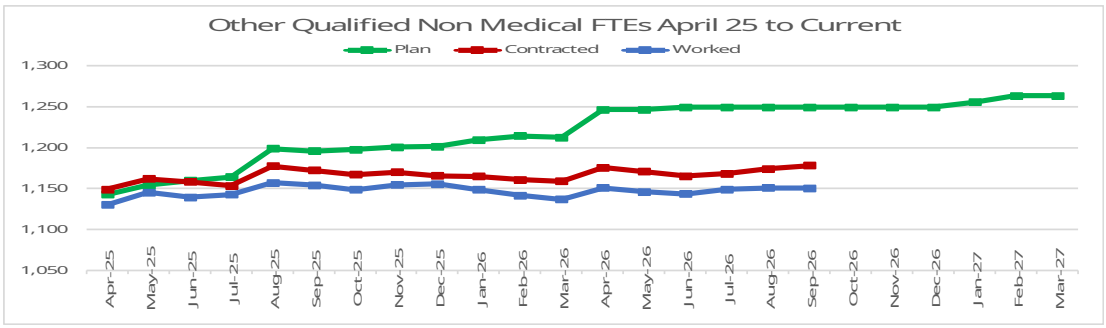
Worked WTEs are below plan for all clinical divisions and Central Services.

Worked WTEs are 272 lower than plan in September.

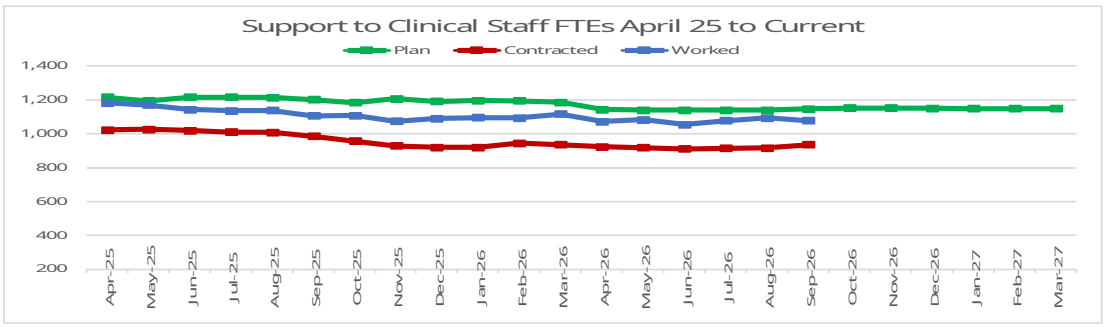
Staff Detail (Staff Group)



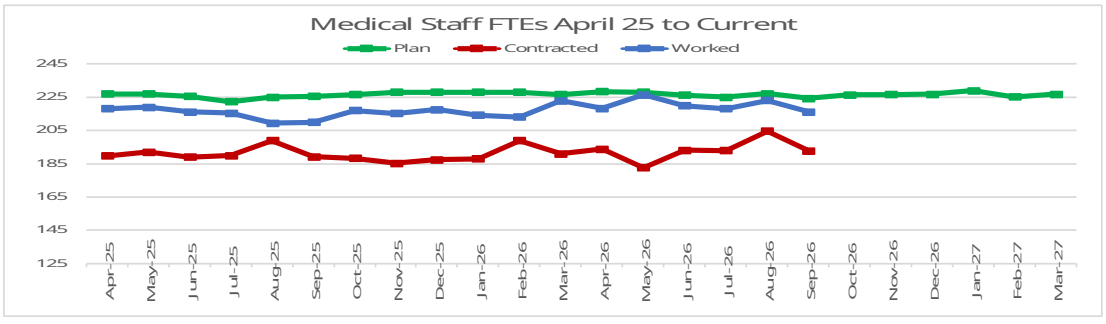
	FTE's	
Prior Mth	CFTE £k	WFTE £k
Sep-26	1,303	1,335
Aug-26	1,307	1,361
	0%	-2%
Prior Year		
Sep-26	1,303	1,335
Sep-25	1,298	1,341
	0%	0%



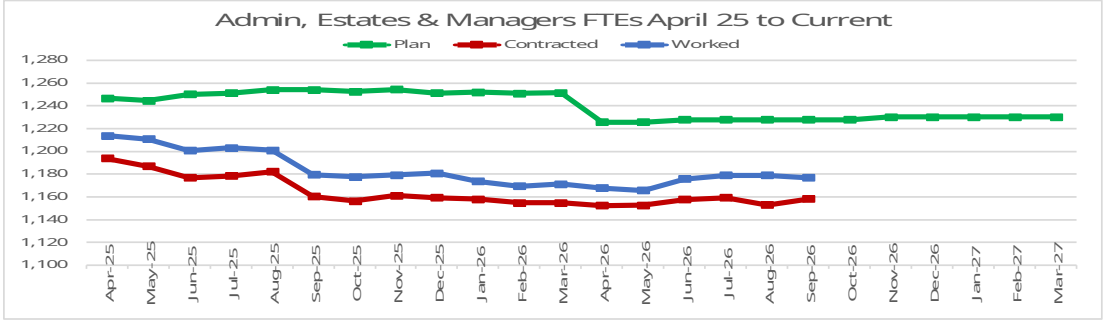
	FTE's	
Prior Mth	CFTE £k	WFTE £k
Sep-26	1,178	1,150
Aug-26	1,174	1,151
	0%	0%
Prior Year		
Sep-26	1,178	1,150
Sep-25	1,172	1,154
	0%	0%



	FTE's	
Prior Mth	CFTE £k	WFTE £k
Sep-26	935	1,077
Aug-26	915	1,092
	2%	-1%
Prior Year		
Sep-26	935	1,077
Sep-25	985	1,106
	-5%	-3%



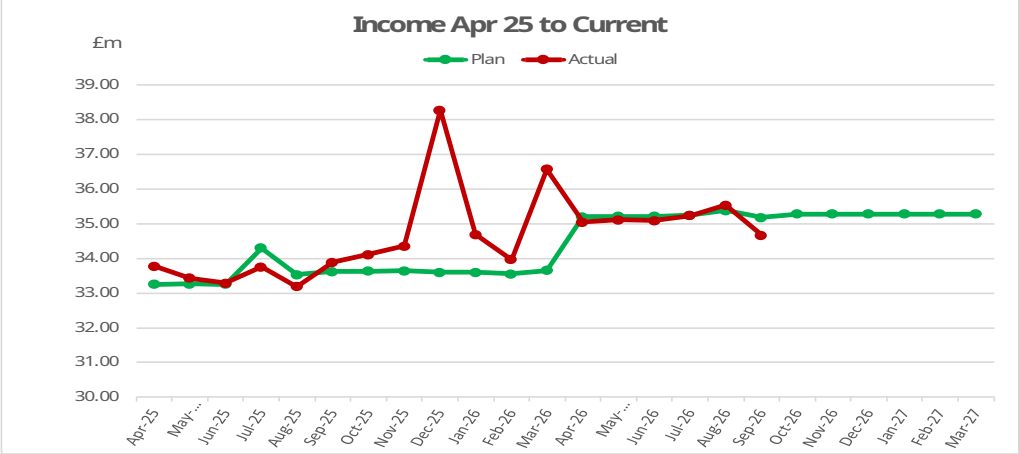
	FTE's	
Prior Mth	CFTE £k	WFTE £k
Sep-26	193	216
Aug-26	205	223
	-6%	-3%
Prior Year		
Sep-26	193	216
Sep-25	189	210
	2%	3%



	FTE's	
Prior Mth	CFTE £k	WFTE £k
Sep-26	1,158	1,177
Aug-26	1,153	1,179
	0%	0%
Prior Year		
Sep-26	1,158	1,177
Sep-25	1,161	1,179
	0%	0%

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

Income

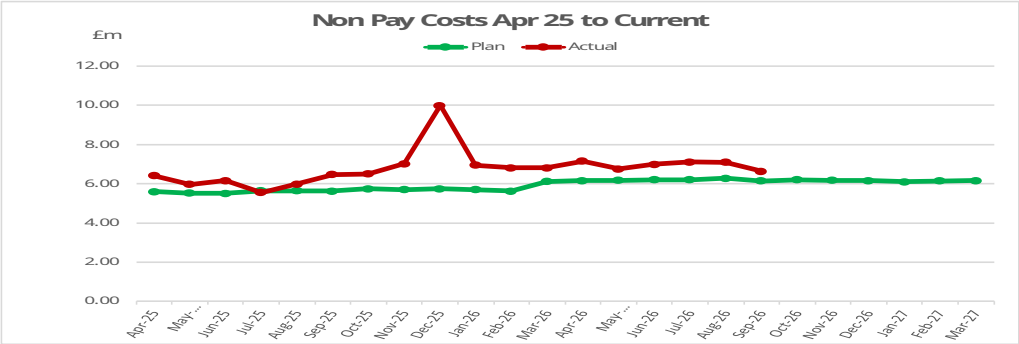


Income	
YTD	£'k
2026/27	210.7
2025/26	201.3
	5%
Prior Year	**£'k**
Sep-26	34.7
Sep-25	33.9
	2%

Key Messages

Income is in line with plan, with all contract finance schedules now agreed with NHS commissioners.

Non Pay

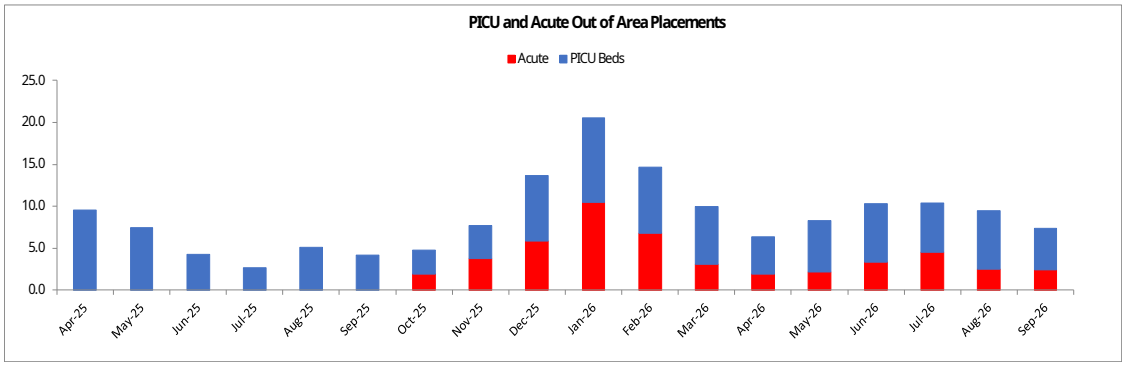


Non Pay	
YTD	£'k
2026/27	41.7
2025/26	36.5
	14%
Prior Year	**£'k**
Sep-26	6.6
Sep-25	6.5
	3%

Key Messages:

As in previous years, the overspend against the non-pay plan is driven by OAPS and PICU placements. This is offset in part by an underspend against specialist placements. The run rate has improved in month.

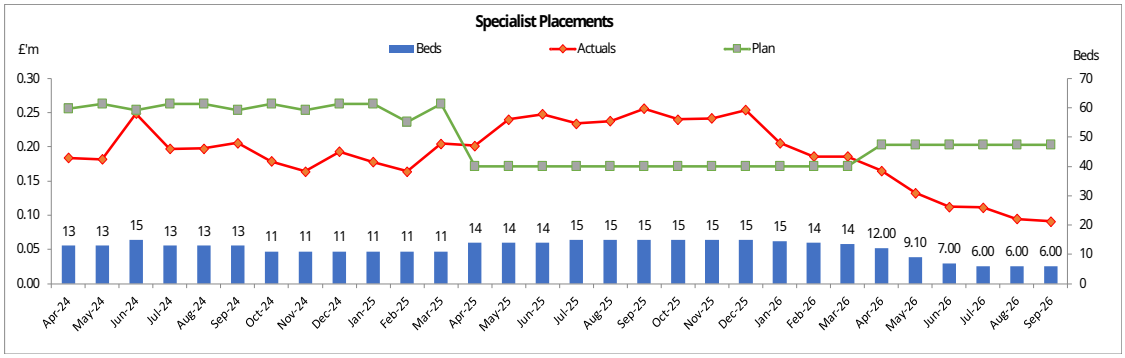
Placement Costs



OAPs

YTD	£'m
2026/27	2.9
2025/26	1.6
	77%

Prior Yr	£'m
Sep-26	0.3
Sep-25	0.2
	47%



Specialist Placements

YTD	£'m
2026/27	0.71
2025/26	1.42
	-50%

Prior Yr	£'m
Sep-26	0.09
Sep-25	0.26
	-64%

Key Messages

PICU and Acute OAPs

Following the opening of our outsourced ward, we were expecting to have minimal Out of Area Placements (OAPs). The average number of placement remained the same as in the previous month at 2.5 with the year to date overspend remaining at £510k.

We have planned for 3.5 Psychiatric Intensive Care Unit (PICU) placements in 2026/27. The number of placements has decreased from 7 in August to 5 in September causing a £134k overspend in month and a £1.3m year to date overspend. There remains a long-standing issue of a lack of female PICU placement beds locally alongside some very complex patients who have required significant additional levels of observations in the region of £80K per patient per month. Alternative male PICU provision has also been required following safeguarding incidents between patients or assaults on staff.

The total overspend on placements is £1.7 year to date.

In recent months, 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 Board and Local Authorities, with Reading being the top contributor to these delays. Actions include weekly escalation meetings with counterparts in the LAs and ICB 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 (currently red flagged by LA so unable to place), and the provision of temporary accommodation supported by Crisis Resolution Home Treatment Team (CRHTT). There are fortnightly LOS meetings with all the ward teams chaired by an Executive Director to focus on supporting clinical treatment decisions and discharge planning which has resulted in a reduction in the percentage of patients staying over 90 days.

Specialist Placements

The average number of placements is planned to be 13, with actual placements at 7 in September resulting in an underspend of £511k year to date.

Cost Improvement Programme

Scheme	(Non)/Recurrent	Risk	FY Plan £k	YTD Plan £k	YTD Actual £k	Variance £k
Corporate Services Review (Full Year Effect)	Recurrent	Low	595	297	297	0
Corporate Services Review (26/27 schemes)	Recurrent	High	1,000	500	0	-500
Operational services Review (26/27 schemes)	Recurrent	Low	6,800	3,400	3,400	0
Operational services Review (26/27 schemes)	Recurrent	Medium	2,039	1,020	0	-1,020
Locum VAT review (26/27)	Recurrent	Medium	450	225	55	-170
Locum VAT review (prior years)	Non recurrent	Medium	1,486	744	0	-744
Income generation	Recurrent	Low	520	250	250	0
MARS	Recurrent	Low	250	124	124	0
Other pay schemes	Recurrent	Low	50	24	24	0
Other pay schemes	Non recurrent	Medium	428	96	0	-96
Other non pay schemes	Recurrent	Low/Medium	1,378	688	648	-40
Asset Life	Recurrent	Low	100	50	50	0
Opt to tax	Recurrent	High	400	200	0	-200
Establishment controls	Non recurrent	Low	0	0	2,770	2,770
		Total	**15,496**	**7,618**	**7,618**	**0**
	Recurrent	Total	13,582	6,778	4,848	**-1,930**
	Non recurrent	Total	1,914	840	2,770	**1,930**

Key Messages

The Trust's financial plan includes £15.5m of cost improvement plans.

Some of the schemes from 2025/26 have been brought forward to the current year.
The locum VAT scheme is not currently delivering, partly due to phasing. We now have clear guidance from HMRC that suppliers should not add VAT to invoices with effect from 17 July 2026 and have written to all supplies to highlight this.

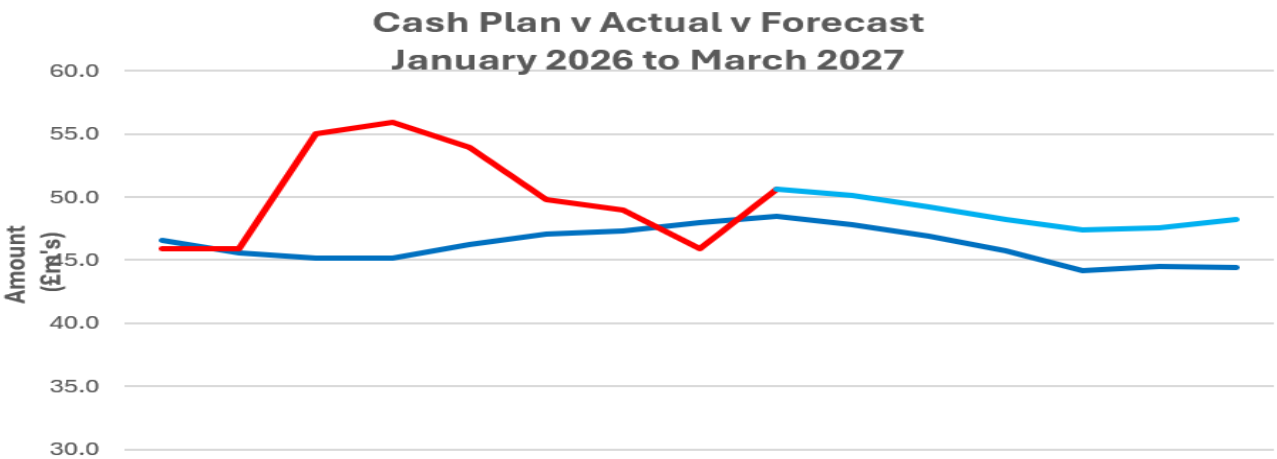
Balance Sheet & Cash

	2025/26 Actual £'m	Current Month Act £'m	Current Month Plan £'m	Current Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m
Intangibles	1.6	1.2	0.5	0.7	1.2	0.5	0.7
Property, Plant & Equipment (non PFI)	41.6	40.1	43.0	(2.9)	40.1	43.0	(2.9)
Property, Plant & Equipment (PFI)	45.3	45.3	43.0	2.3	45.3	43.0	2.3
Property, Plant & Equipment (RoU Asset)	16.0	14.0	17.1	(3.1)	14.0	17.1	(3.1)
Receivables	0.2	0.2	0.2	0.0	0.2	0.2	0.0
Total Non Current Assets	**104.7**	**100.8**	**103.8**	**(3.0)**	**100.8**	**103.8**	**(3.0)**
Trade Receivables & Accruals	15.4	21.7	9.5	12.2	21.7	9.5	12.2
Other Receivables	0.2	0.3	0.3	0.0	0.3	0.3	0.0
Cash	55.0	50.6	48.4	2.2	50.6	48.4	2.2
Trade Payables & Accruals	(42.2)	(40.8)	(35.4)	(5.4)	(40.8)	(35.4)	(5.4)
Borrowings (PFI and RoU Lease Liability)	(8.2)	(7.2)	(7.5)	0.3	(7.2)	(7.5)	0.3
Other Current Payables	(13.8)	(15.5)	(9.4)	(6.1)	(15.5)	(9.4)	(6.1)
Total Net Current Assets / (Liabilities)	**6.4**	**9.1**	**5.9**	**3.2**	**9.1**	**5.9**	**3.2**
Non Current Borrowings (PFI and RoU Lease Liability)	(49.1)	(47.7)	(46.7)	(1.0)	(47.7)	(46.7)	(1.0)
Other Non Current Payables	(1.4)	(1.4)	(1.6)	0.2	(1.4)	(1.6)	0.2
Total Net Assets	**60.6**	**60.8**	**61.4**	**(0.6)**	**60.8**	**61.4**	**(0.6)**
Income & Expenditure Reserve	13.0	11.8	12.2	(0.4)	11.8	12.2	(0.4)
Public Dividend Capital Reserve	24.6	25.2	27.1	(1.9)	25.2	27.1	(1.9)
Revaluation Reserve	23.0	23.8	22.0	1.8	23.8	22.0	1.8
Total Taxpayers Equity	**60.6**	**60.8**	**61.4**	**(0.6)**	**60.8**	**61.4**	**(0.6)**

Key Messages

Net current assets are £9.1m compared with the plan of £5.9m.

Cash is above plan by £2.1m. The shortfall in income from the ICB has now been resolved and work is ongoing to resolve the issues around securing cash payment from Local Authorities.



	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Plan	46.6	45.6	45.2	45.2	46.2	47.1	47.3	48.0	48.5	47.8	46.9	45.7	44.2	44.5	44.4
Actual	45.9	45.9	55.0	55.9	53.9	49.8	49.0	45.9	50.6						
Forecast									50.6	50.1	49.2	48.2	47.4	47.6	48.2

Capital Expenditure

Schemes	Current Month			Year to Date			FY	FY	FY	FY
	Actual £'000	Revised Plan £'000	Variance £'000	Actual £'000	Revised Plan £'000	Variance £'000	Plan (NHSE Submission) £'000	Plan (Revised) £'000	Forecast Outturn £'000	Variance to Revised Plan £'000
Estates Maintenance & Replacement Expenditure										
Trust Owned Properties General Pool	0	50	(50)	0	150	(150)	330	380	380	0
Jubilee Ward Relocation to St Marks - CIR Funding	198	420	(222)	761	2,520	(1,759)	2,520	2,520	2,589	69
Jubilee Ward Relocation to St Marks - CDEL	197	0	197	762	0	762	0	1,038	1,424	386
Skimped Hill - Ground foor reconfiguration	3	0	3	30	0	30	500	500	500	0
Leased Non Commercial (NHSPS) Other	2	52	(50)	5	155	(153)	525	525	525	0
Environment & Sustainability	2	35	(33)	3	135	(132)	400	400	400	0
Backlog Maintenance	30	35	(5)	190	105	85	500	500	500	0
Various All Sites	13	118	(105)	9	356	(347)	1,200	1,300	1,018	(282)
Statutory Compliance	0	15	(15)	0	45	(45)	150	150	150	0
Subtotal Estates Maintenance & Replacement	**445**	**725**	**(280)**	**1,760**	**3,466**	**(1,708)**	**6,125**	**7,313**	**7,768**	**455**
IM&T Expenditure										
Business Intelligence and Reporting	5	15	(10)	24	30	(6)	70	70	70	0
Hardware Purchases Refresh	(4)	0	(4)	728	0	728	4,593	2,950	2,950	0
Teams Rooms Refresh	0	8	(8)	11	50	(39)	100	100	100	0
Additional Divisional Spend	27	33	(7)	61	200	(139)	400	400	400	0
Digital Strategy	39	35	4	243	210	33	450	450	450	0
Subtotal IM&T Expenditure	**67**	**92**	**(25)**	**1,067**	**490**	**577**	**5,613**	**3,970**	**3,970**	**0**
IFRS16 RoU ASSETS										
Chalvey Lease	0	0	0	0	0	0	600	600	600	0
Other Property Leases	(94)	0	(94)	(94)	0	(94)	500	500	500	0
Lease cars	0	8	(8)	8	48	(40)	100	100	100	0
CoIN	0	17	(17)	45	98	(53)	200	200	200	0
Sub Total New Leases (IFRS16)	**(94)**	**25**	**(119)**	**(41)**	**146**	**(187)**	**1,400**	**1,400**	**1,400**	**0**
Subtotal CapEx Within Control Total	**417**	**842**	**(424)**	**2,786**	**4,102**	**(1,318)**	**13,139**	**12,684**	**13,138**	**455**
CapEx Expenditure Outside of Control Total										
Other PFI projects	0	0	0	12	0	1	0	0	161	161
PPH Windows	1	0	1	2	0	2	0	2,204	2,204	0
Subtotal Capex Outside of Control Totals	**1**	**0**	**1**	**14**	**0**	**3**	**0**	**2,204**	**2,365**	**161**
Projects funded externally										
Patient Access and Patient Engagement Portal	0	0	0	0	0	0	125	125	475	350
Bracknell Forest 6-8 Bedded LD Crisis Facility (PDC)	0	0	0	0	0	0	100	100	0	(100)
EV Chargepoint scheme - London Hse (PDC)	0	0	0	0	0	0	0	0	30	30
St Marks Block 23 M&E (Air Handling Unit) (Donated)	2	0	2	18	0	18	0	0	600	600
PPH Nature Trail Project (Charitable Fund)	0	0	0	0	0	0	0	0	135	135
Subtotal Projects funded externally	**2**	**0**	**2**	**18**	**0**	**18**	**225**	**225**	**1,240**	**1,015**
Total Capital Expenditure - all funding sources	**420**	**842**	**(421)**	**2,819**	**4,102**	**(1,297)**	**13,363**	**15,112**	**16,743**	**1,631**

Key Messages

At M06, total capital expenditure was £2.8m year to date, £1.3m below the revised plan. CDEL schemes were underspent by £1.3m against plan. Estates remains underspent, primarily due to delays on the Jubilee Ward Relocation project and slippage across a number of other schemes; however, expenditure is expected to increase later in the year as these projects progress. IM&T expenditure is £0.6m ahead of plan year to date, driven mainly by accelerated spend on hardware purchases, specifically purchase of Surface Pro for Business devices, which support mobile and flexible working requirements across the Trust, together with ongoing digital investment programmes.

Total capital expenditure across all funding sources is forecast at £16.7m, £1.6m above revised plan. This increase reflects additional externally funded schemes, including £475k PDC funding for the Patient Engagement Portal, £30k from the EV Charge Point Accelerator Scheme, and £600k NHSPS contribution to the St Marks Block 23 M&E Air Handling Unit replacement project, as well as additional spend on Jubilee Ward which has been approved by the Board.

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper Meeting Paper

Board Meeting Date	10 November 2026
Title	**Advanced Foundation Trust Financial Flexibilities Assurance 2026**
	The paper is for assurance
Reason for the Report going to the Trust Board	This report is to give assurance to the Board on the Trust's compliance with the use of AFT financial flexibilities in 2026/27.
Business Area	Finance
Author	Chief Finance Officer
Relevant Strategic Objectives	**Efficient use of resources** **Ambition:** A financially and environmentally sustainable organisation. 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.

Enhanced Freedoms for Advanced Foundation Trusts – Assurance Process

Introduction

As an Advanced Foundation Trust (AFT), the Trust has acquired enhanced financial freedoms, which are outlined within this paper along with the assurance process that the Trust is required to follow to secure access to these freedoms in 2026/27.

Enhanced Freedoms

The financial flexibilities for AFTs provide the opportunity to access any surplus in aggregate positions from 2024/25 onwards to support capital or non-recurrent revenue expenditure in future years.

This is a separate allocation which is calculated based upon:

- 2024/25 adjusted financial surplus position (excl. DSF)
- 2025/26 adjusted financial surplus position (excl. DSF / additional DSF)
- Less any surplus used to provide additional CDEL in 2025/26
- Less any surplus to be used to fund non-recurrent revenue costs.

This flexibility is different to that earned by virtue of being in National Oversight Framework segment 1 as the period over which funding can be carried forward is longer and aggregate surpluses can be used for non-recurrent revenue purposes as well as capital expenditure.

The freedom to carry forward capital from one year to the next only applies to the AFT Financial Flexibilities allocation. All other capital allocations remain subject to their respective rules, e.g. underspends on core allocation or bespoke adjustments cannot be carried forward from one year to the next.

Assurance Process

Assurance should be provided to NHS England that planned utilisation of financial flexibility is:

- within the limit of the AFT's flexibility;
- affordable within existing cash balances given no additional revenue or capital cash support will be provided to support these investments; and
- The revenue financial flexibility should only be used to support transformation or revenue costs associated with capital.

To take advantage of these financial flexibilities in 2026/27, the Trust is required to complete a board assurance statement and share this with the South East Regional Team. This is to be completed before the end of November 2026.

After M8, further amendments to the freedom and flexibility allocation will not be made. This is to allow sufficient time to for capital to be effectively managed and any unused 2026/27 capital will be lost and cannot be carried forward to future years.

Planned utilisation of financial flexibilities in 2027/28 as part of the forthcoming plan update process, with assurance being completed as part of the plan process.

The Trust's Position

Flexibility available to the Trust is £6,625k comprising of the surpluses from 2024/25 (£4,925k) and 2025/26 (£1,700k). The unplanned deficit support funding that the Trust received at the end of 2025/26 is not available for flexible use. However, we have benefitted from the cash associated with that allocation and we are using it to fund the PPH Windows Replacement scheme.

In the 2026/27 financial plan we assumed use of £4,355k of the brought forward surplus to support the capital position, as follows

Scheme	**£000s**
Trust Owned Properties	380
Leased Non-Commercial NHSPS including Skimped Hill	1,025
Estate Backlog Maintenance	500
Estates Statutory Compliance	150
Environment & Sustainability	400
Estates Various All sites (includes some backlog)	1,300
Property leases – Chalvey	600
Total	**4,355**

We now have some slippage against our capital programme in relation to new Right of Use Assets for Chalvey and the Nicholson's House Replacement so will reduce our use of the available flexibility by £1.1m in 2026/27. The balance of £3,370k will be available to use in future years.

Further work is ongoing in relation to progress on the Jubilee Ward project and any further slippage expected will be reflected in the final value of the flexibility requested for the current year by the month 8 deadline.

The Trust has cash available to fund the use of brought forward surpluses on capital expenditure. This was included in our plan for 2026/27. As operation CDEL has been constrained in recent years, the Trust's internally generated cash has not been fully utilised.

Conclusion

The Board is asked to confirm that assurance can be given to NHSE regarding the Trust's use of AFT financial flexibilities in 2026/27.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Meeting Paper

Board Meeting Date	10th November 2026
Title	**True North Performance Scorecard Month 6 (September 2026) 2026/27**
	Item for Assurance
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 2026/27.
Business Area	Trust-wide Performance
Author	Chief Operating Officer
Relevant Strategic Objectives	The True North Performance scorecard consolidates metrics across all domains. To provide safe, clinically effective services that meet the assessed needs of patients, improve their experience and outcome of care, and consistently meet or exceed the standards of Care Quality Commission (CQC) and other stakeholders. **Patient safety** **Ambition:** We will reduce waiting times and harm risk for our patients **Patient experience and voice** **Ambition:** We will leverage our patient experience and voice to inform improvement

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

True North Performance Scorecard Highlight Report – September 2026

The True North Performance Scorecard for Month 6 2026/27 (September 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 to the report.

Breakthrough Objectives

- Mental Health: Adult Average Length of Stay (bed days) **(Good Patient Experience)** – 48.13 days against a target of 42 days.
    - The average length of stay has decreased for the month and continues a downward trend since April 2026.
    - Continuous reduction for 5 months of those staying on a ward for over 60 days, 17.9% last month compared to 21.1%. Sorrel (55.6%) and Bluebell (33.3%) were the top contributors.
    - Lost bed days also improved for the 3rd month totalling 292 days for 16 patients. These indicators triangulate to contribute to average length of stay metric.
    - A Multi-Agency Discharge Event (MADE) has commenced, focused on accelerating safe and timely discharge. Previous MADE activity resulted in 25 discharges, providing confidence that the current event will support improved patient flow and discharge performance.
    - Countermeasures remain with focus on streamlined patient multi-disciplinary team (MDT) meetings focusing on length of stay and actions to support timely discharge.

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

- Restrictive Interventions – Rapid Tranquilisation (Intra-muscular) **(Harm Free Care)** – 4 against a target of 39 incidents.
    - Four patients contributed to the metric this month. In all cases oral medication was offered first with intramuscular only used as a last resort. Current countermeasures under review to understand impact of interventions on the metric.
- Mental Health: Older Adult Average Length of Stay (bed days) **(Good Patient Experience)** – 69.75 days against a target of 80 days.
- Physical Assaults on Staff **(Supporting our People)** – 27 incidents against a target of 36.
    - A total of 18 patients has contributed to the total this month out of 27 in total. Top contributing ward Daisy with 7 incidents. Focus remains on length of stay which impacts this metric. Countermeasures are being scaled down to one main activity, the 'Who is caring for me' piece of work. An audit is planned for December 2026 to review the metric and countermeasures.

Driver Metrics

The following metrics are Red and not performing to plan.

- Number of children on community waiting lists over 52 weeks (excluding neurodiversity) **(Good Patient Experience)** – 8 against a target of 0. This is a new NHS Oversight Framework (NOF) scoring metric.
- Sickness rate **(Supporting Our People)** – red at 4.74% against a revised target of 4.1%. This is an NHS Oversight Framework scoring metric, with the Trust ranked 6th out of 61 based on the latest Q1 score of 4.66%.

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

- I Want Great Care Positive Patient Experience Score **(Good Patient Experience)** – at 95.09% against a 95% target. Metric will be reported one month in arrears to allow for manual records to be uploaded.
- Number of children on mental health waiting lists over 52 weeks **(Good Patient Experience)** – 0 against a target of 0.
- 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 and override metric.
- Inappropriate Out of Area Placements (OAPs) at the end of the month (Mental Health) – **(Good Patient Experience)** – at 0 against a target of 0.

Tracker Metrics

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

- Percentage of acute mental health admissions with no contact with community mental health services in the previous year **(Good Patient Experience)** – 7.21% against a target of 5%.
- Percentage of Children and Young People Mental Health clients waiting over 104 weeks for a full stop clock (Mental Health Services Data Set) (NOF Scoring) **(Good Patient Experience)** – 44% against a 5% target.
- Clinically ready for discharge by wards in mental health (including OAPs) **(Good Patient Experience) –** 409 against a 250-bed day target.
- Talking Therapies reliable recovery for those completing a course of treatment **(Good Patient Experience)** - at 46% against a target of 51%.
- Talking Therapies finished course of Treatment **(Good Patient Experience)** – 681 against a target of 854.
- Mean length of stay for adult acute and psychiatric intensive care unit patients **(Good Patient Experience)** – (NHS Oversight Framework scoring metric) 43.9 days against a target of 40 days.
- Mental Health acute occupancy rate (excluding home leave) **(Efficient Use of Resources)** – at 97.8% against a 90% target.
- Mental Health non-acute occupancy rate (excluding home leave) **(Efficient Use of Resources)** – at 80.8% against an 80% target.

- Variance from agency cap year to date **(Efficient Use of Resources)** – 296 against a target to be confirmed.
- Variance from bank cap year to date **(Efficient Use of Resources)** – 1874 against a target to be confirmed.

NHS Oversight Framework (NOF) Metrics

The latest published NHS Oversight Framework metrics are for quarter 1 2026/27, and relevant metrics for the organisation are shown in the performance report. A number of these contribute to the overall segmentation and there is an override for Trusts in financial deficit. The Trust is in segment 1 in which is classified as:

- Segment 1: NHS England's highest-performing segment, indicating strong organisational performance with a narrow range of challenges and consequently lower requirements for support and intervention.
- Advanced Foundation Trust clear escalation routes and 6-month leeway for resolving non-urgent issues or declines.

Summary of Position at Quarter 1 2026/27:

- 3rd out of 8 in Segment 1
- In quartile 1 for 3 domains, quartile 2 for 3
- Improved or stayed in the same domains, except for one (Access to Services)
- Top 5 for 7 national metrics, and in four we are 1st
- Relevant NOF Metrics included in Corporate and Divisional scorecards

The next published report for quarter 2 2026/27 is expected in December/January. Overall positive performance, but challenges in the following metrics:

- Percentage of children and young person's mental health related waits that are over 104 weeks **(Access to Services),** slight worsening, ranked 42nd.
- Percentage of patients in mental health crisis to receive face-to-face contact within 24-hours **(Patient Safety)** – ranked 40th.
- Relative difference in costs **(Finance, Productivity and innovation)** – Ranked 58th out of 61 trusts.
- Mean length of stay for acute and psychiatric intensive care unit patients (days) **(Experience of Care)** – ranked 28th.

Business Rules

(Note - These rules only apply to Drivers and Trackers. Breakthrough Objectives are reported in detail at QPEG every 3 months.)

Rule	Metric Status	Business rules and actions
1	The **Driver** metric is **Green** for the current reporting period	• Note success. • No actions required.
2	The **Driver** metric is **Green** for 6 or more consecutive reporting periods	• Note success and share learning. • Consider reviewing threshold. • Consider stepping down to a Tracker metric.
3	The **Driver** metric is **Red** for the current reporting period	• Note metric performance. • Provide a verbal update on contributing factors.
4	The **Driver** metric is **Red** for 3 or more consecutive reporting periods	• Note metric performance. • Consider requesting a written countermeasure summary report for the next meeting.
5	The **Tracker** metric is **Green** for the current reporting period	• Note success. • No actions required.
6	The **Tracker** metric is **Green** for 6 or more consecutive reporting periods	• Note success and share learning. • Consider reviewing threshold.
7	The **Tracker** metric is **Red** for 2 or 3 consecutive reporting periods	• Note metric performance. • Consider reviewing threshold. • Provide a verbal update on contributing factors.
8	The **Tracker** metric is **Red** for 4 or more consecutive reporting periods	• Note metric performance. • Consider reviewing threshold. • Consider requesting a written countermeasure summary report for the next meeting, • Consider escalating to a Driver metric.

APPENDIX A - Revised Business Rules – Applying to SPC Charts

Rule	Metric Status	Business rules and actions
1	The **Driver** metric is **below target** for the current reporting period	• Note success. • No actions required.
2	The **Driver** metric is **below target** for 6 or more consecutive reporting periods	• Note success and share learning. • Consider reviewing threshold. • Consider stepping down to a Tracker metric.
3	The **Driver** metric is **above target** for the current reporting period	• Note metric performance. • Provide a verbal update on contributing factors.
4	The **Driver** metric is **above target** for 3 or more consecutive reporting periods	• Note metric performance. • Consider requesting a written countermeasure summary report for the next meeting.
5	The **Tracker** metric is **below target** for the current reporting period	• Note success. • No actions required.
6	The **Tracker** metric is **below target** for 6 or more consecutive reporting periods	• Note success and share learning. • Consider reviewing threshold.
7	The **Tracker** metric is **above target** for 2 or 3 consecutive reporting periods	• Note metric performance. • Consider reviewing threshold. • Provide a verbal update on contributing factors.
8	The **Tracker** metric is **above target** for 4 or more consecutive reporting periods	• Note metric performance. • Consider reviewing threshold. • Consider requesting a written countermeasure summary report for the next meeting, • Consider escalating to a Driver metric.

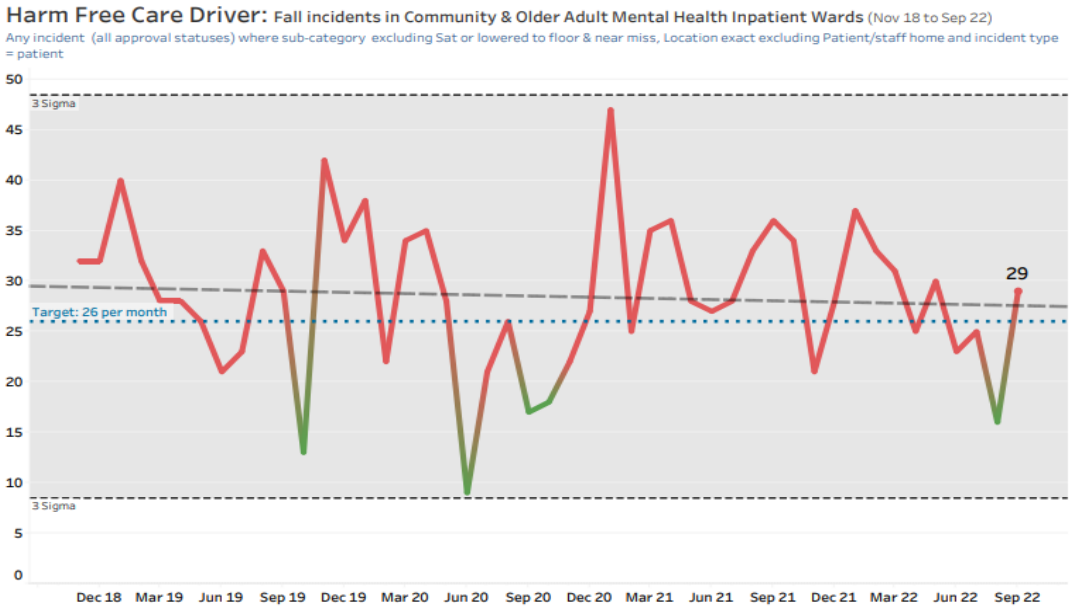
Business Rules for Statistical Process Control (SPC) Charts

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)

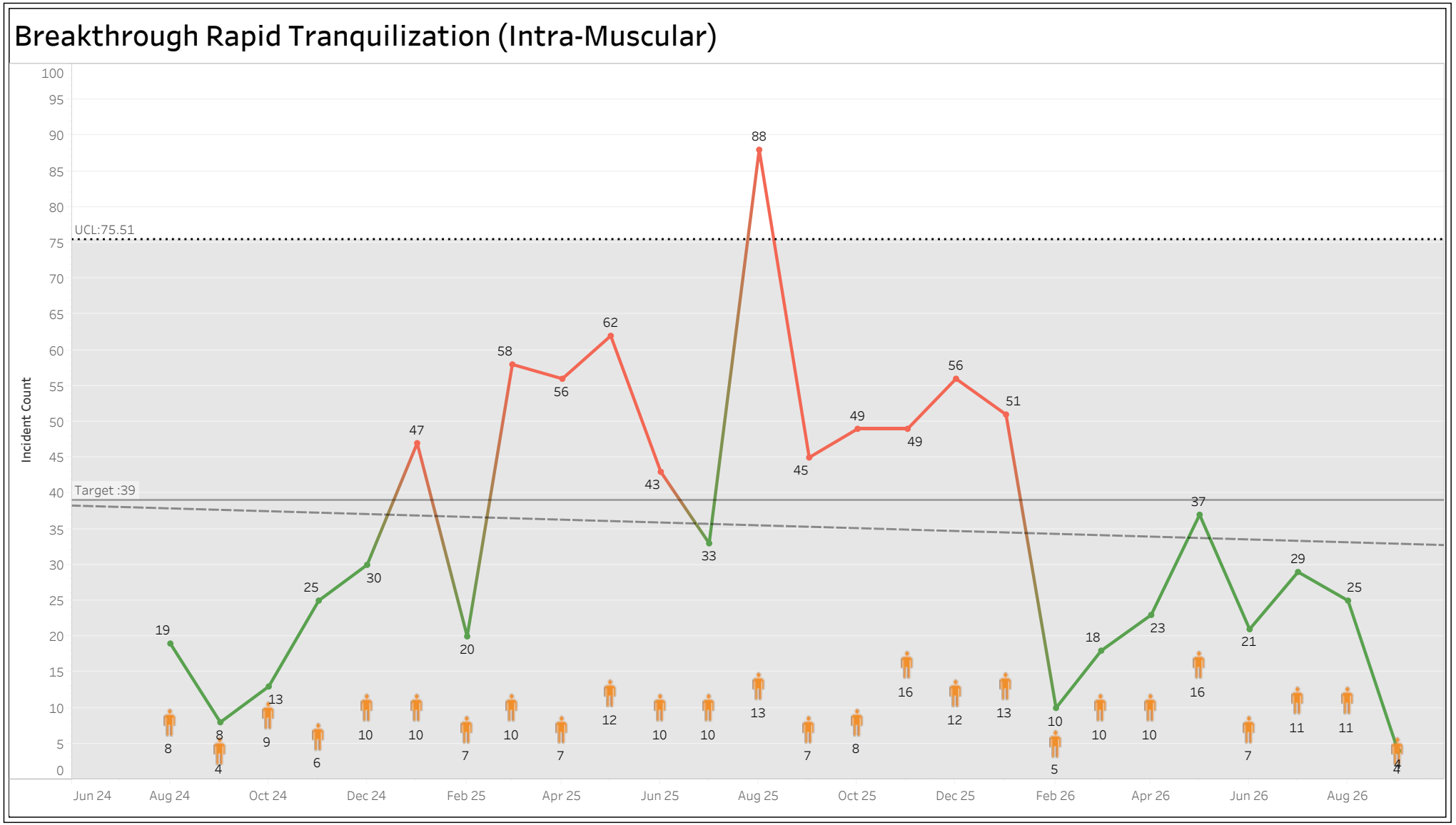
Rules

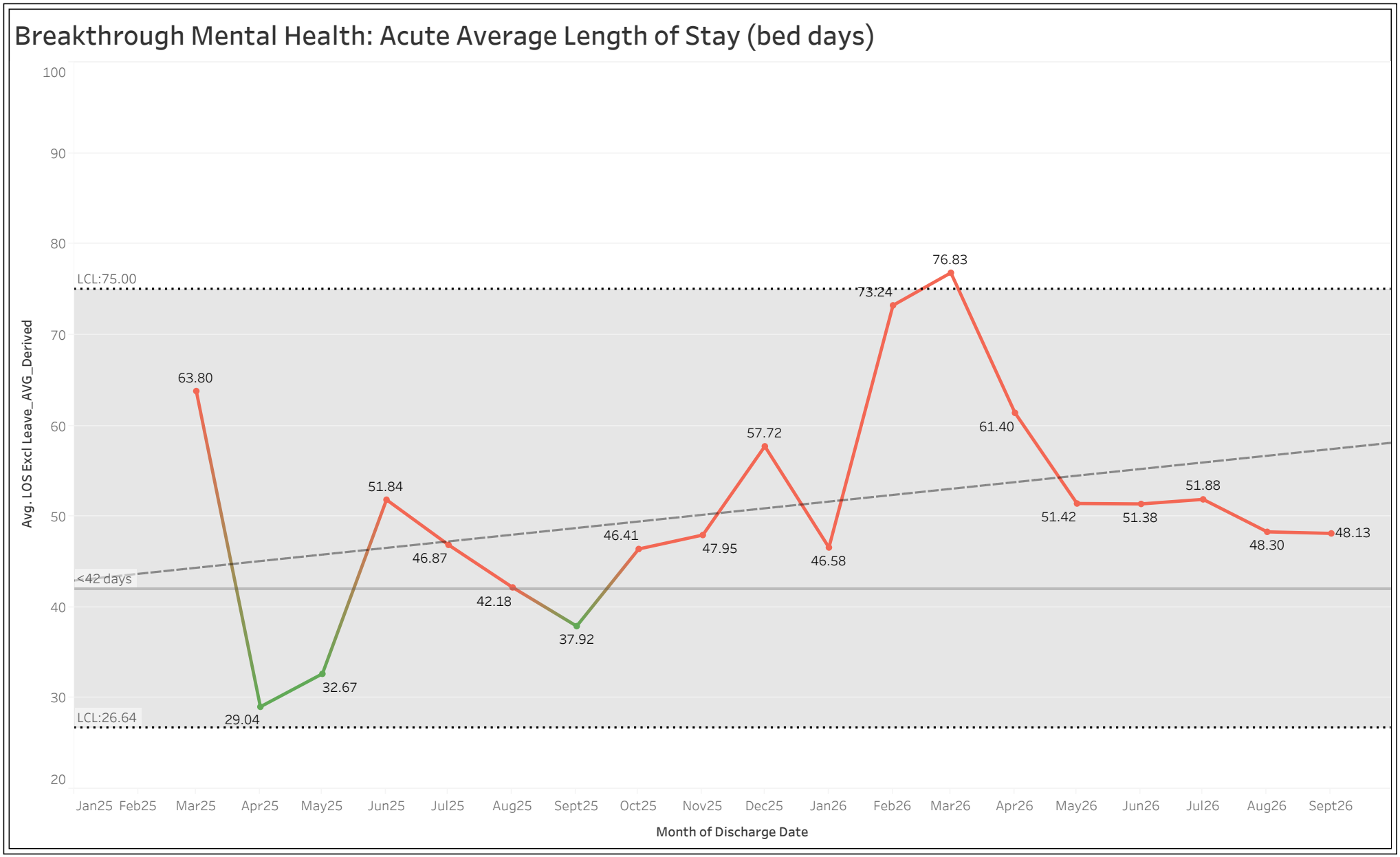
- A series of 6 or more data points above or below the target is statistically relevant. It indicates that something in process has changed.
- A trend: either rising or falling of more than 6 data points – we should investigate what has happened.
    - We should reset baseline following a run of 6 data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

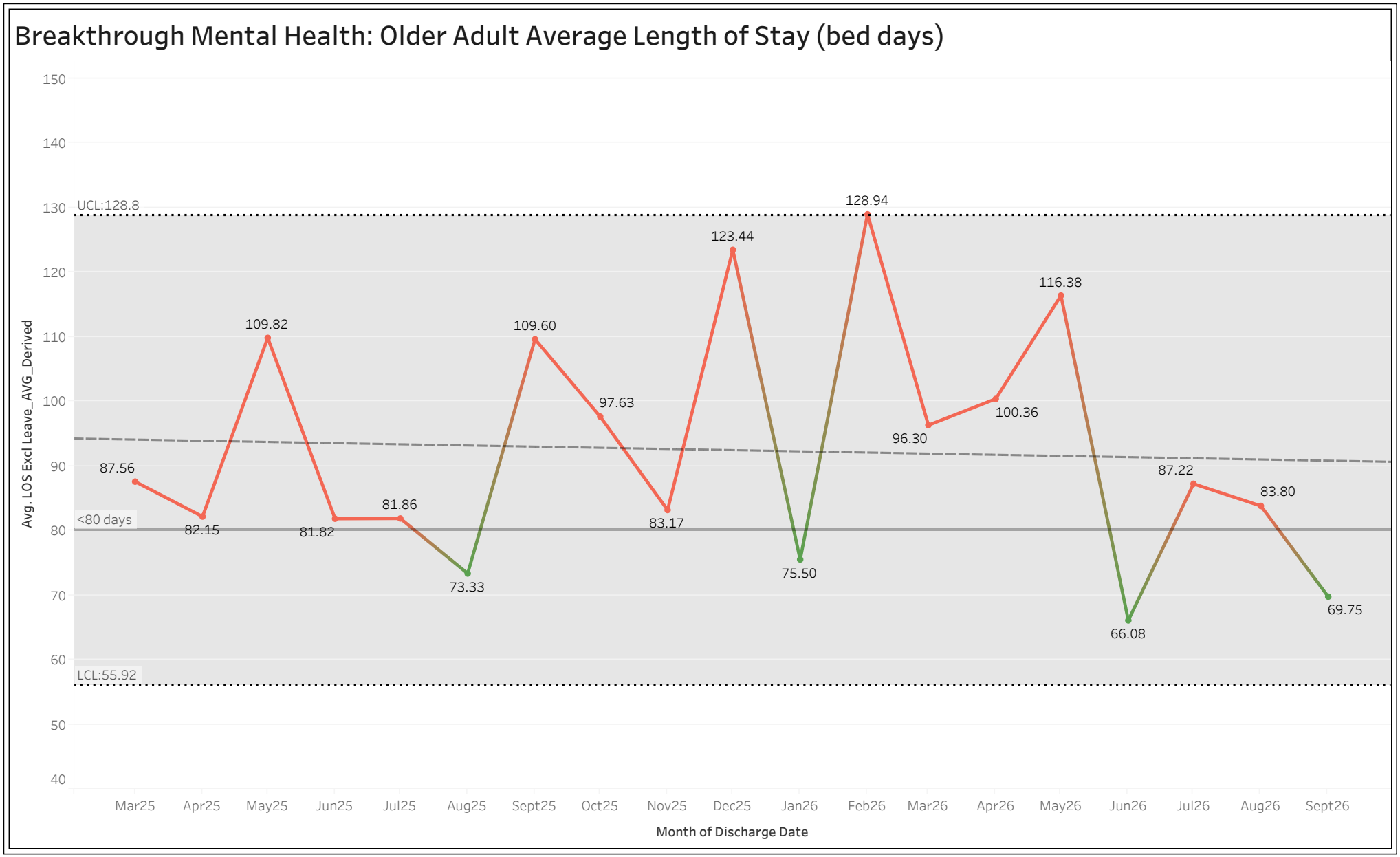
Performance Scorecard - True North Drivers



			Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sept-26
Breakthrough Rapid Tranquilization (Intra-Muscular)	39	Internal	49	49	56	51	10	18	23	37	21	29	25	4
			Good Patient Experience											
Positive Patient Experience Score %	95% compliance	External	80.90%	89.70%	94.69%	96.20%	96.5%	96.29%	96.29%	95.09%	95.89%	95.79%	95.09%	
Number of Children on community waiting lists over 52 weeks (Exclude Neurodiversity) (NOF Scoring)	0	External	93	103	75	72	82	58	61	86	85	83	9	8
Mental Health Services Waiting over 52 weeks- Children	0	External	7	3	7	7	7	4	8	3	0	0	3	0
Breakthrough Mental Health: Acute Average Length of Stay	<42 April 26	External	46.41	47.95	57.72	46.58	73.24	76.83	61.40	51.42	51.38	51.88	48.30	48.13
Breakthrough Mental Health: Older Adult Average Length of Stay (NOF Scoring)	<80	External	97.63	83.17	123.44	75.50	128.94	96.30	100.36	116.38	66.08	87.22	83.80	69.75


Breakthrough Rapid Tranquilization (Intra-Muscular)
Incident Count
UCL:75.51
Target :39
100
95
90
85
80
75
70
65
60
55
50
45
40
35
30
25
20
15
10
5
0
Jun 24
Aug 24
Oct 24
Dec 24
Feb 25
Apr 25
Jun 25
Aug 25
Oct 25
Dec 25
Feb 26
Apr 26
Jun 26
Aug 26


Breakthrough Mental Health: Acute Average Length of Stay (bed days)
Avg. LOS Excl Leave_AVG_Derived
100
90
80
70
60
50
40
30
20
LCL:75.00
LCL:26.64
<42 days
63.80
29.04
32.67
51.84
46.87
42.18
37.92
46.41
47.95
57.72
46.58
73.24
76.83
61.40
51.42
51.38
51.88
48.30
48.13
Jan25
Feb25
Mar25
Apr25
May25
Jun25
Jul25
Aug25
Sept25
Oct25
Nov25
Dec25
Jan26
Feb26
Mar26
Apr26
May26
Jun26
Jul26
Aug26
Sept26
Month of Discharge Date


Breakthrough Mental Health: Older Adult Average Length of Stay (bed days)
Avg. LOS Excl Leave_AVG_Derived
150
140
130
120
110
100
90
80
70
60
50
40
UCL:128.8
LCL:55.92
<80 days
87.56
82.15
109.82
81.82
81.86
73.33
109.60
97.63
83.17
123.44
75.50
128.94
96.30
100.36
116.38
66.08
87.22
83.80
69.75
Mar25
Apr25
May25
Jun25
Jul25
Aug25
Sept25
Oct25
Nov25
Dec25
Jan26
Feb26
Mar26
Apr26
May26
Jun26
Jul26
Aug26
Sept26
Month of Discharge Date

Performance Scorecard - True North Drivers

Supporting Our People

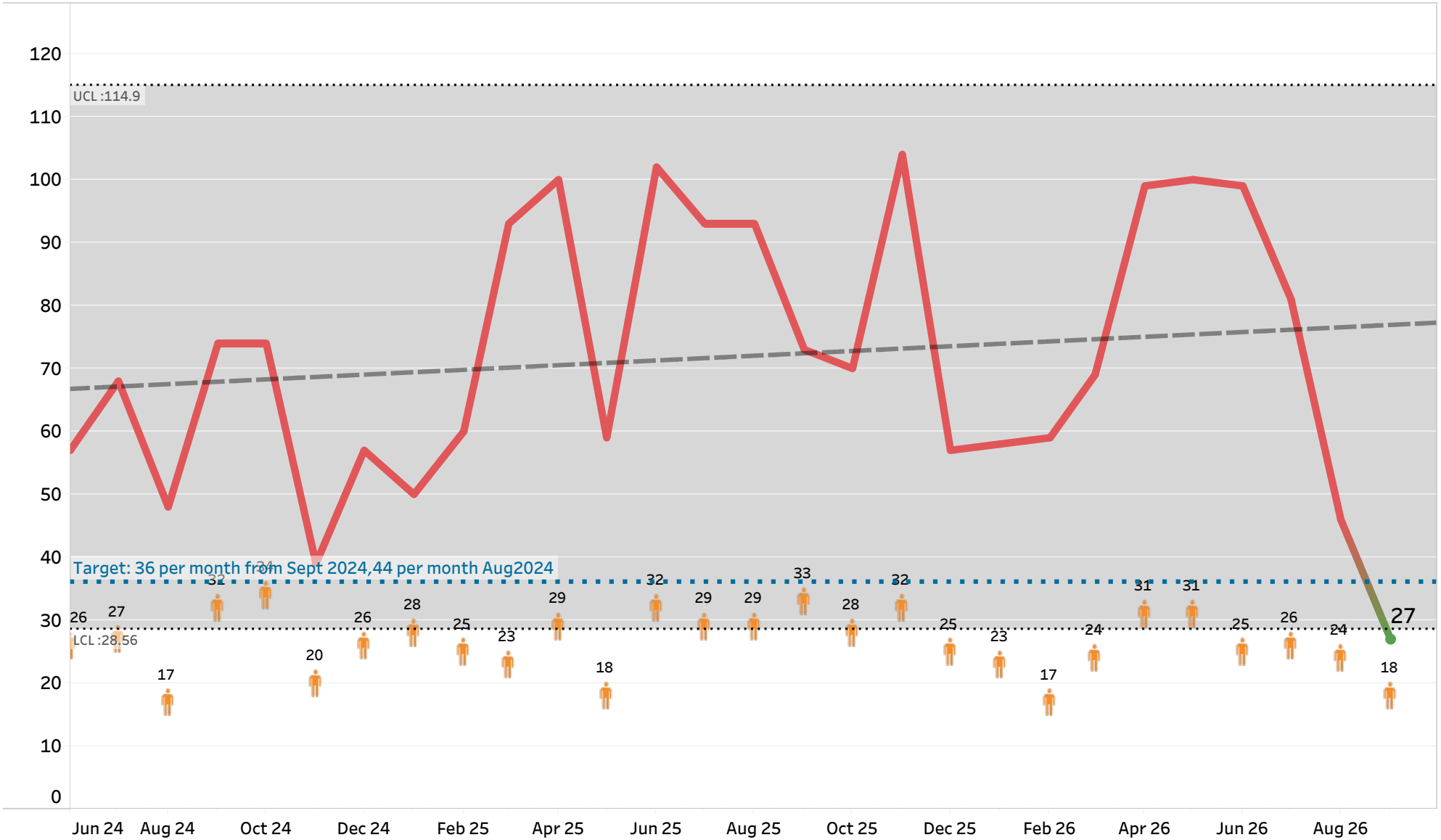
Metric	Target/Threshold	External/Inter..	Oct25	Nov25	Dec25	Jan26	Feb26	Mar26	Apr26	May26	Jun26	Jul26	Aug26	Sept26
Breakthrough Physical Assault on Staff	36 per month	Internal	70	104	57	58	59	69	99	100	99	81	46	27
Sickness Rate: % (NOF Scoring)	<3.5%,4.1% April 26	External	5.25%	5.12%	5.14%	5.12%	4.66%	4.32%	4.13%	4.08%	4.37%	4.73%	4.74%	

Efficient Use of Resources

Metric	Target/Threshold	External/Inter..	Oct25	Nov25	Dec25	Jan26	Feb26	Mar26	Apr26	May26	Jun26	Jul26	Aug26	Sept26
YTD variance from control total (£'k) (NOF Scoring)	0	External	0	0	0	0	0	0	0	0	0	0	0	0
Active Inappropriate OAPS at end of month	Q4-1 ,New target 26/27:0	External	3	4	6	8	1	1	0	4	3	2	1	0

Supporting Our People - Breakthrough Objective :Physical Assaults on Staff (Jun 24 to Sept 26)

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



True North Supporting Our People Summary

Metric	Current Tar..	External/Internal	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sept 26
Statutory Training: Fire: %	90%	Internal	93.3%	93.9%	93.6%	93.5%	92.8%	93.2%	94.2%	95.1%	95.7%	95.8%	97.1%	98.3%
Statutory Training: Health & Safety: %	85%	Internal	98.3%	98.3%	98.2%	98.4%	98.4%	98.2%	98.4%	98.6%	98.7%	98.6%	98.9%	98.7%
Statutory Training: Manual Handling: %	85%	Internal	94.3%	94.0%	94.6%	94.8%	94.8%	95.2%	95.5%	95.2%	95.5%	96.0%	95.8%	95.4%
Mandatory Training: Information Governance: %	95%	Internal	97.6%	97.5%	97.4%	96.9%	96.9%	97.2%	97.2%	97.2%	97.4%	97.7%	97.7%	97.5%

			Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sept 26
Staff turnover (excluding fixed term posts)	10%	External	10.29%	10.28%	10.19%	10%	9.910%	10.05%	10.19%	10.27%	10.04%	10.11%	9.939%	9.480%
PDP (% of staff compliant) Appraisal: %	Target: 95% by end of May 2025	Internal							44%	91.0%	95.8%			

True North Good Patient Experience

			Oct25	Nov25	Dec25	Jan26	Feb26	Mar26	Apr26	May26	Jun26	Jul26	Aug26	Sept26
Percentage of patients admitted as an emergency within 30 days of discharge (Community Readmission) (NOF Scoring)	95%	External	0%	0%	0.57%	0%	0%	0.62%	0%	0%	0%	0%	0%	0%
Percentage of Inpatients referred to stop smoking services (NOF Scoring)	95%	External	0%	0%	0%	0%	0%	0%	40%	41.1%	37.2%	32.3%	50%	
Percentage of people accessing mental health services with at least 2 contacts and a paired outcome score (Adults) (NOF Scoring)	12%	External							17%	16%	20.5%	18.6%	19%	21.8%
Percentage of acute mental health admissions with no contact with community mental health services in the previous year	5%	External	3.79%	5%	6%	8.20%	7.00%	6.5%	3.40%	5%	5%	8.59%	5.12%	7.21%
Percentage of people accessing mental health services with at least 2 contacts and a paired outcome score (children) (NOF Scoring)	28%	External	14.0%	16%	16%	18%	14.0%	17%	36.3%	28.8%	36%	49.7%	40.9%	33.3%
Proportion of patients referred for diagnostic tests who have been waiting for less than 6 weeks (DM01 - Audiology): %	95% seen	External	99.12	99.79	98.72	97.40	100	97.93	99.23	98.81	100	99.09	99.70	97.20
Fall incidents in Community & Older Adult Mental Health Inpatient Wards	26 Per month	Internal	23	21	26	25	15	20	24	30	32	23	19	24
Health Visiting: New Birth Visits Within 14 days: %	85% compliance	Internal	92.5%	92.2%	92.1%	92.6%	93.8%	90.6%	77.5%	78.9%	90.1%	91.7%	92.2%	91.8%

True North Good Patient Experience

			Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sept 26
Community Health Services: 2 Hour Urgent Community Response %	80%+	External	93.8%	93.9%	90.6%	86.5%	91.5%	93.0%	93.7%	97.8%	90.4%	91.2%	86.6%	88.5%
Percentage of CYPMH Clients waiting over 104 Week for a full stop clock (MHSDS) (NOF Scoring)	5%	External						40%	41%	41%	42%	44%		

			Oct25	Nov25	Dec25	Jan26	Feb26	Mar26	Apr26	May26	Jun26	Jul26	Aug26	Sept26
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	98.8%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

			Oct25	Nov25	Dec25	Jan26	Feb26	Mar26	Apr26	May26	Jun26	Jul26	Aug26	Sept26
Number of Adults on community waiting lists over 52 weeks (NOF Scoring)	0	External	8	71	51	38	23	12	10	3	1	0	0	0

			Oct25	Nov25	Dec25	Jan26	Feb26	Mar26	Apr26	May26	Jun26	Jul26	Aug26	Sept26
Percentage of Intermediate Care Beds occupied by people with no criteria to reside (NOF Scoring)	TBC	External	20.9%	23.5%	22.3%	19.0%	21.5%	23.8%	19.4%	21.7%	19.8%	17.2%	18.4%	18.0%

			Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sept-26
Clinically Ready for Discharge by Wards MH (including OAPS)	250 bed days , 350 bed days Nov25	External	482	500	363	628	452	558	400	541	497	477	354	409

True North Good Patient Experience

				Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sept 26
Talking Therapies Reliable Improvement for those completing a course of treatment	69%		External	62%	68%	67%	68%	69%	68%	70%	67%	68%	69%	68%	69%
Talking Therapies Reliable Recovery for those completing a course of treatment	51%, April 26	52%	External	46%	48%	46%	47%	47%	47%	48%	48%	48%	47%	47%	46%
Talking Theraphies Finished Course of Treatment	854		External	927	799	839	865	768	766	681	693	718	855	727	681

True North Good Patient Experience

			Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sept 26
Access to Perinal services	960	External	1,177	1,164	1,169	1,189	1,219	1,231	1,243	1,243	1,258	1,260	1,286	1,307
Percentage of patients referred to crisis care teams to receive face to face contact within 24 hours (NOF Scoring):All Ages	80%	External	65%	52%	54%	66%	64.4%	57.9%	67%	55.0%	67%	67%	71.9%	81.8%
Physical Health Checks 7 Parameters for people with severe mental illness (SMI)	90%	Internal	93%	91%	94.3%	92%	91%	93%	92%	89%	92%	92%	90%	91%
Mental Health: Prone (Face Down) Restraint	4 per month	Internal	1	2	3	1	0	1	5	2	0	0	1	0
Patient on Patient Assaults (MH Inpatients)	25 per month	Internal	4	13	12	24	11	26	18	29	9	9	16	11
Mental Health: Uses of Seclusion	13 in month	Internal	4	13	8	12	5	9	13	10	10	7	12	4
Rate of Restrictive Intervention Types per 1000 bed days (NOF Scoring)	TBC	External	69.98	110.89	69.25	59.48	20.65	27.3	53.65	51	42.7	50.2	40.29	19.8
Mean length of stay for adult acute and psychiatric intensive care unit patients (NOF Scoring)	40 days	External	42.87	44.64	50.31	48.47	56.73	66.66	71.57	61.52	51.3	47	46.94	43.9

True North Harm Free Care Summary

Metric	Threshold / Target	External/Internal	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sept 26
Mental Health: AWOLs on MHA Section	10 per month	Internal	4	2	2	6	3	9	10	7	1	3	7	10
Mental Health: Absconsions on MHA section (Excl: Failure to return)	8 per month	Internal	7	5	6	5	0	4	3	1	5	1	4	3
Readmission Rate with in 14 days (NOF Scoring)	0%	Null	0%	0%	0%	0%	0%	0%	4.59%	0%	2.70%	1.5%	1.3%	0%
Mental Health 72 Hour Follow Up after Inpatient discharge (NOF Scoring)	80 %	External	100%	92.8%	94.3%	91.6%	97%	90.6%	94%	90%	96.3%	90.7%	95.8%	90%
Self-Harm incidents on Mental Health Inpatient Wards (excluding LD)	125 per month	Internal	235	259	226	282	163	171	108	118	93	109	75	78
Patient on Patient Assaults (LD)	4 per month	Null	3	5	0	2	3	0	1	0	0	0	0	4
Self-Harm Incidents within the Community	31 per month	Internal	16	16	19	15	29	13	19	25	27	32	13	13

Efficient Use of Resources

Metric	Proposed Targe..	External/Internal	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sept-26
Community Inpatient Occupancy	95%	Internal	86.7%	86.7%	88.3%	90.0%	87.2%	90.5%	92%	90.1%	90.5%	92.9%	85.7%	87.7%
Mental Health: Adult Acute LOS over 60 days % of total discharges Age 64 and Under	TBC	External	25%	24%	28.9%	28.1%	29.4%	30%	29.6%	21.3%	20.1%	19%	21.0%	17.8%
Mental Health: Older Adult Acute LOS over 90 days % of total discharges age 65+	TBC	External	52%	54%	56.0%	54%	61%	70%	47.3%	53.3%	41.2%	34.8%	35.8%	33.3%
DNA Rate: %	5% DNAs	Internal	5.05%	5.11%	4.99%	4.76%	4.73%	4.96%	4.79%	4.76%	4.90%	5.20%	4.90%	4.59%

			Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sept-26
Mental Health: Acute Occupancy rate (excluding Home Leave):%	90%	Internal	96.5%	97.7%	97.7%	98.8%	98.6%	97.9%	97.5%	98.2%	99.5%	98.0%	98.7%	97.8%
Mental Health: Non-Acute Occupancy rate (excluding Home Leave): %	80% Occupancy	Internal	86.89%	91.34%	93.75%	97.34%	87.25%	82.15%	84.20%	84.29%	86.29%	90.29%	87.03%	80.80%
Year to Date Corporate Cost Reduction	95%	External	0	0	0	0	0	0	0	0	0	0	0	0
Planned Surplus/Deficit (NOF Scoring)	0	External	174	132	97	-4	52	-8	0	0	0	0	0	0
Relative Difference in Cost (NOF Scoring)	95%	External												
Percentage of clinical trials set up within 90 days (NOF Scoring)	0.95	External							100%	100%	100%	100%	100%	100%
Variance from agency cap YTD	TBC	External							-17	-21	64	145	198	296
Variance from bank cap YTD	TBC	External							203	532	724	1032	1578	1874

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	Tuesday 10th November 2026
Title	**People Progress Report** **November 2026**
	Item for Assurance
Reason for the Report going to the Trust Board	To provide a regular half yearly update to the board on our progress and next steps on delivery of each workstream in the People & Culture strategy
Business Area	People Directorate
Author	Jane Nicholson, Director of People
Relevant Strategic Objectives	This programme primarily supports the following strategic objectives: **Workforce** **Ambition:** We will make the Trust a great place to work for everyone **Efficient use of resources** **Ambition:** We will use our resources efficiently and focus investment to increase long term value However, the programme has impacts on all of our strategic objectives.

Summary	This shows our progress against major KPIs and programmes of work

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NHS Foundation Trust

People Progress Report

Update – October 2026

People Directorate Division

Team name: **People Directorate Division**

Team plan on a page 2026/27

Berkshire Healthcare NHS Foundation Trust

Our **mission** is to **maximise independence and quality of life**

Our **vision** is to be **a great place to get care, a great place to give care**

Harm-free care

Providing safe services

1. We will use workforce forecasts to anticipate workforce supply and demand and support service transformation
2. We will train, develop and grow our people to deliver safe care
3. We will embed compassionate leadership to create a safe environment for patients, families, carers, and staff
4. We will equip staff with the right competencies and behaviours to give great care

Great patient experience

Improving outcomes

1. We will develop high performing teams who deliver a good patient experience, and support our diverse populations
2. We will support service transformation to achieve sustainable efficiencies
3. We will provide great patient care through essential skills compliance.

Supporting our people

A great place to work

1. We will nurture a culture of wellbeing, respect, compassion and inclusivity
2. We will act to reduce incidents of abuse of any kind
3. We will deliver our unity against racism actions, removing barriers to equity and improving diversity in leadership
4. We will ensure high quality appraisal and career conversations to support development and progression of staff, retaining skills and experience
5. We will improve the ability of our managers to resolve difficult staff issues fairly and compassionately

Efficient use of resources

A financially and environmentally sustainable organisation

1. We will work within our financial control totals
2. We will use quality improvement and digital transformation to improve our processes and deliver efficiencies for our people
3. We will reduce sickness absence improve staff experience, and service capacity for patient care.

With partners: **We will work with our health, social care** and **voluntary sector partners** to **develop proactive, integrated healthcare focused** on the **needs** of **patients, communities** and **populations we serve.**

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People Directorate Metrics Overview

Overview of KPIs

Berkshire Healthcare NHS Foundation Trust

Retention:

Remained steady at approximately 88% throughout the past three months.

Target : **90%**
August 2026 figure: **89.05%.**

Supporting Attendance:

Target: **4.1%**
Rolling 12 month sickness August 2026: **4.68%**

Recruitment:

Time to hire
Target: **less than 42 days**
August 2026: **39.7 days**

Casework:

Closure times have improved in August 2026, but increasing volume remains a concern; leadership capability is a key lever.

Temporary staffing:

Agency spend is within target and AfC price-cap breaches are zero; medical breaches remain a watchpoint.

Delivery risks:

Overall risk is moderate: constrained capacity, technology dependencies and compliance demands may delay delivery.

Workforce Measures

Supporting our people
A great place to work

NHS
Berkshire Healthcare
NHS Foundation Trust

Our key trust workforce and People Directorate Division Driver measures:

	Target	August 2026 or latest metric	Outcome	
Retention	**90%**	**89.05%**	**Only began measuring from Apr26**	
Staff* Engagement	**7.5 or better**	**7.22***	**Q1 Pulse Results – declined from main staff survey**	
Sickness Absence (rolling)	**4.1% (Y26/27)**	**4.68%**	**Ongoing until March 2027**	
		Improved	**Declined**	**Stayed the Same**
WRES	**The disparity reducing and inequality of experience being removed. (9 indicators)**	**5**	**4**	**0**
WDES		**4**	**5**	**0**

We will also continue to monitor tracker metrics for turnover and monthly sickness absence

* Based on the Q1 (26/27) pulse survey results – these always report lower than main staff survey

People Directorate - Critical Programmes of Work – August 2026 update

Berkshire Healthcare NHS Foundation Trust

Casework Review

Commenced February 2026

Four workstreams:

- PPH Inequalities
- Manager Support & Casework Capability
- Medical Leadership
- Casework Process & Employee Experience Improvement

Progress Update:
Two of the workstreams are nearing the end of their work.

Sickness (True North Goal)

Commenced May 2026

Progress Update:

A root cause analysis approach has been produced, identifying mental health, MSK and long term absence as the key drivers of lost working days. Stakeholder engagement planned with DSG, SPG and union colleagues to inform next phase.

Job Evaluation Review (DHSC Mandated)

Commenced May 2025

Work will commence with nursing bands 4 to 8a.

Progress Update:
B5 complete, B6 consistency checking underway. B7 job descriptions have been completed.

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NHS Foundation Trust

People Directorate Metrics Update

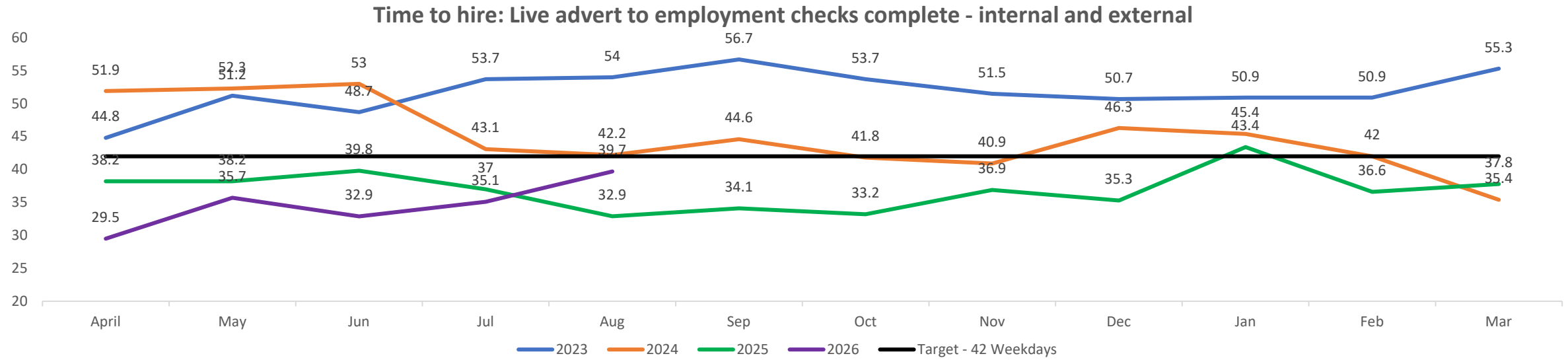
HR Ops Team

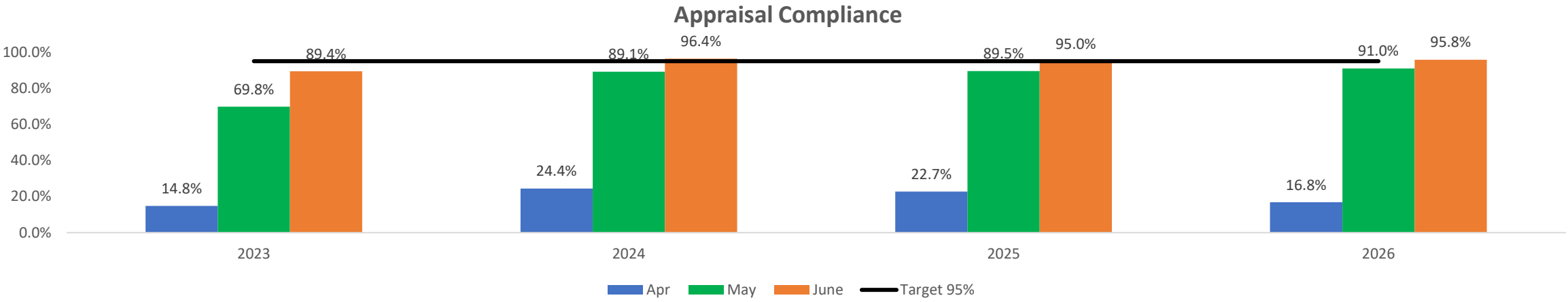
Driver Metrics

By Team: HR Operations

Supporting our people
A great place to work

NHS
Berkshire Healthcare
NHS Foundation Trust



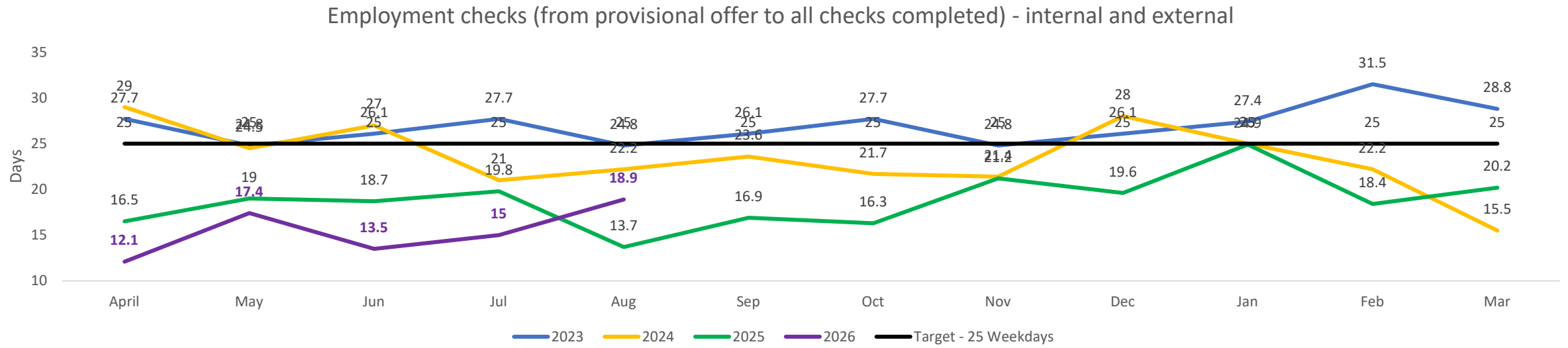


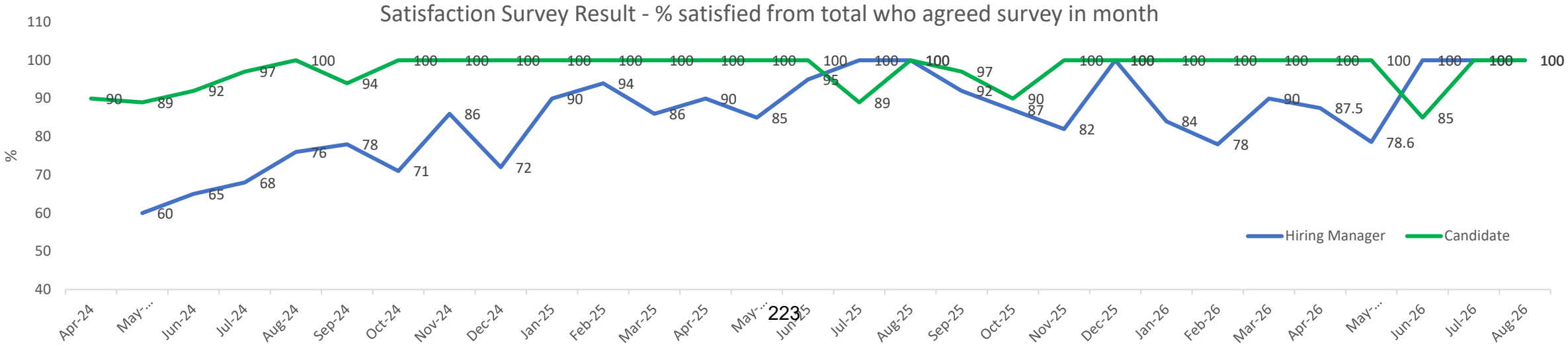
Tracker Metrics

Supporting our people
A great place to work

NHS
Berkshire Healthcare
NHS Foundation Trust

By Team: HR Operations - Recruitment



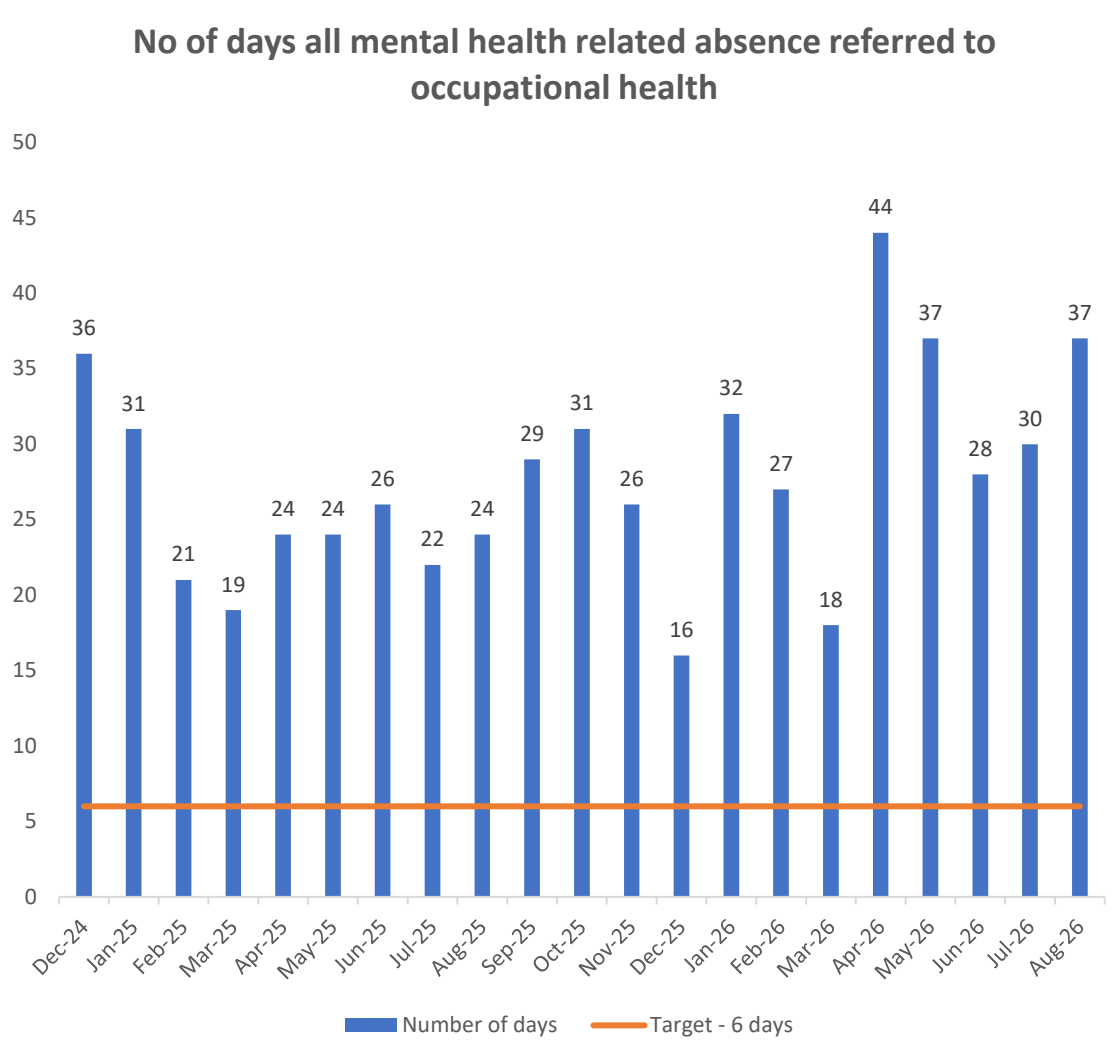


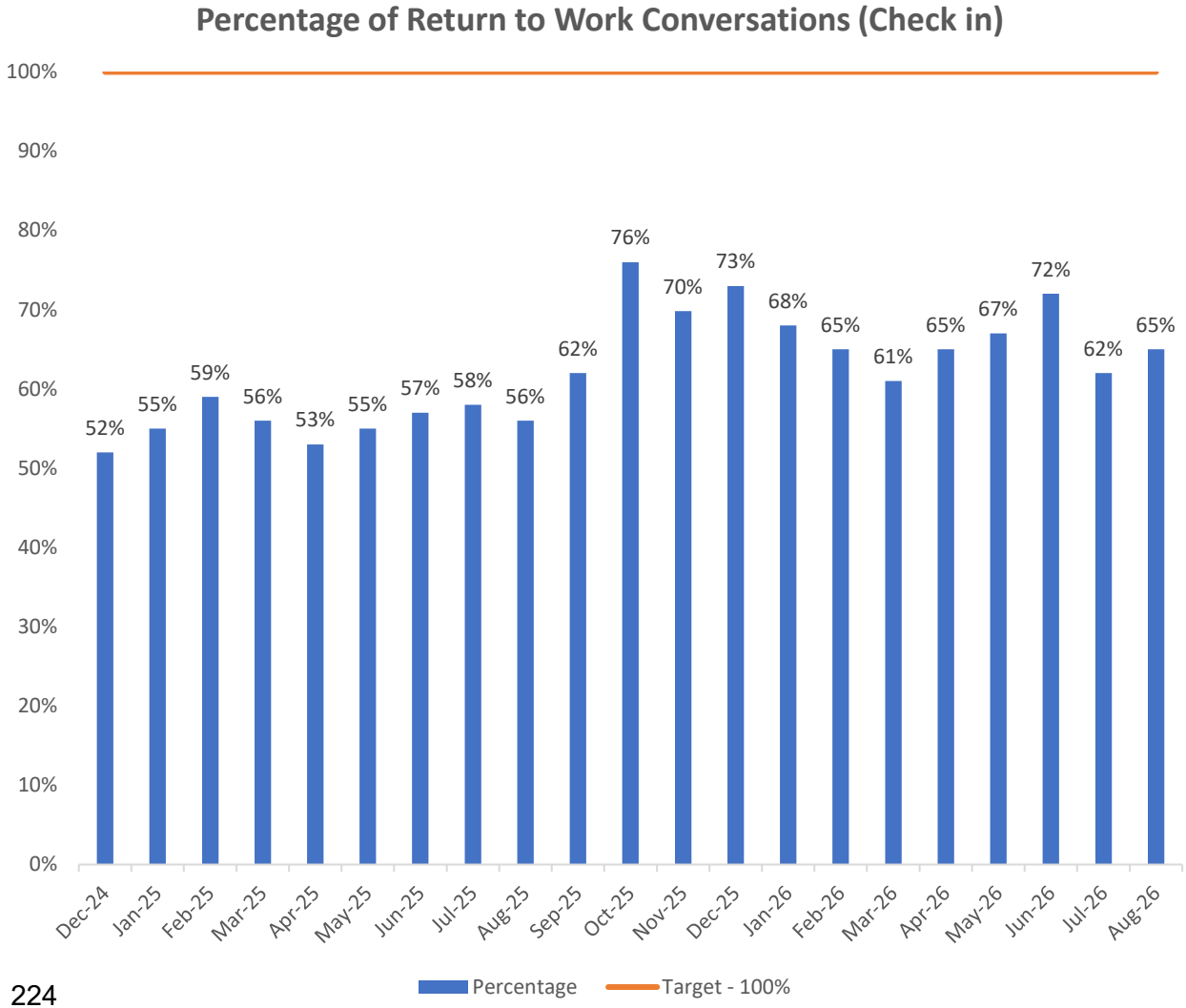
Tracker Metrics

Efficient use of resources
A financially and environmentally sustainable organisation

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By Team: HR Operations – Supporting Attendance





Casework Update (April to September 2026)

Berkshire Healthcare NHS Foundation Trust

Current live cases

- Disciplinary – 22
- Resolution – 15
- Capability (sickness, at hearing stage) – 12
- Performance improvement (at hearing stage) – 2

Live tribunal cases – 12

- 5 further potential claims in ACAS early conciliation.

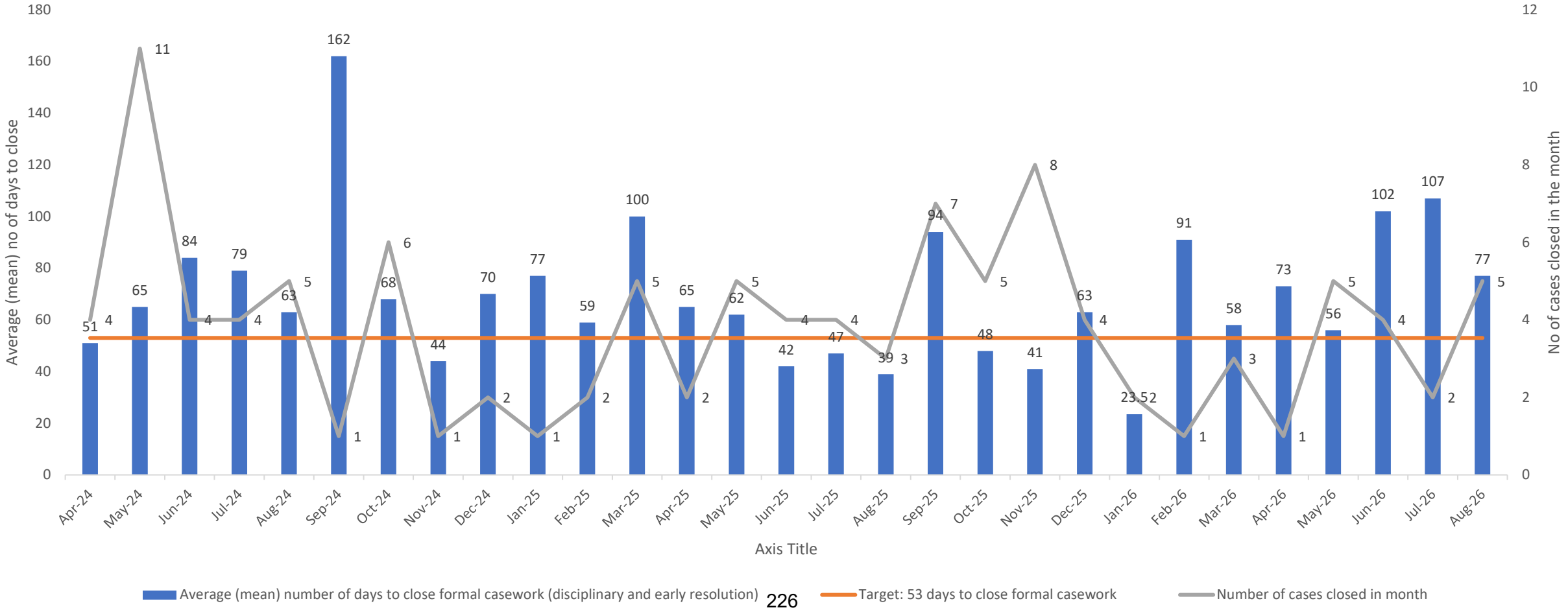
Tracker Metrics

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A great place to work

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By Team: HR Operations – Casework

Average (mean) number of days to close formal casework (disciplinary and early resolution)/number of cases closed in month



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People Directorate Metrics Update

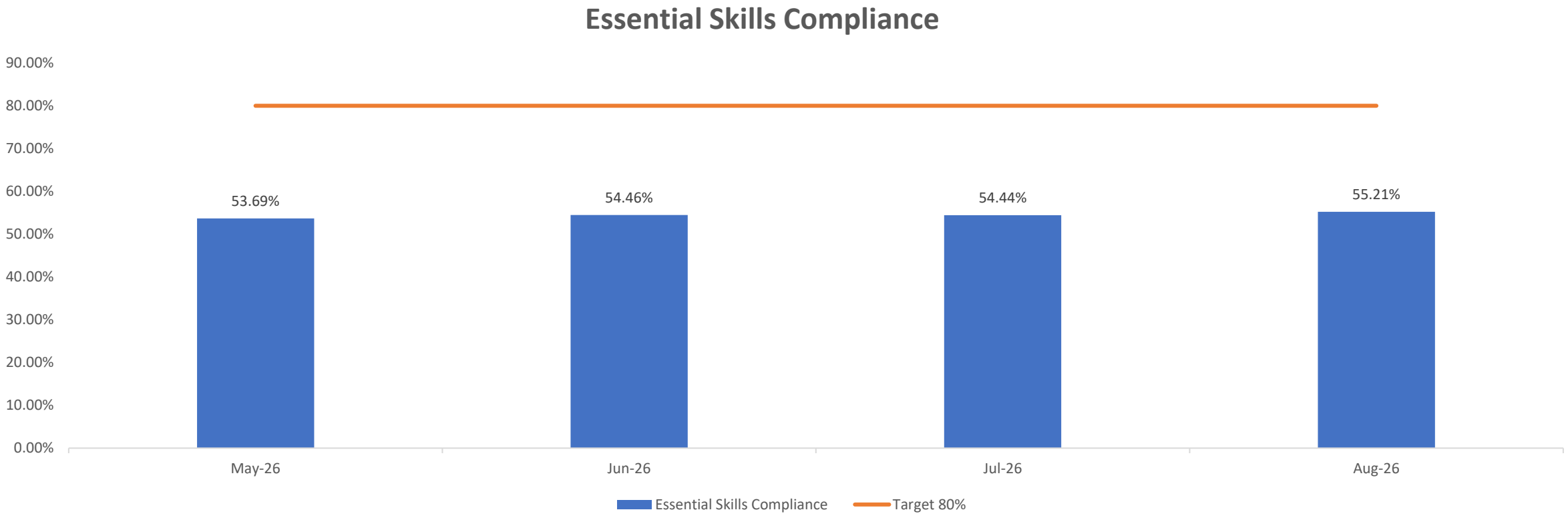
Clinical Education

Driver Metrics

Harm-free care
Providing safe services

NHS
Berkshire Healthcare
NHS Foundation Trust

By Team: Clinical Education



Tracker Metrics

Supporting our people
A great place to work

NHS
Berkshire Healthcare
NHS Foundation Trust

By Team: Clinical Education - Apprenticeships

26/27 Financial Year Spend

Annual Plan 26/27	£1,618,200
Allocated Spend	£1,594,347
Remaining	**£23,853**

Forecasted future spend based on current centrally-funded learners

FY	**26/27**	**27/28**	**28/29**	**29/30**
Budget	£1,618,200	£1,618,200	£1,618,200	£1,618,200
Spent	£1,594,347	£1,353,060	£690,565	£110,403
Remaining	**£23,853**	**£265,139**	**£927,634**	**£1,507,796**

Clinical Apprenticeship Centrally-Funded Starts since 25/26 vs. 26/27 planned starts

Programme	Starts 25/26	Predicted Starts 26/27	Total
Nursing Associate	6	5	11
Nurse Degree Full-Course	2	1	3
Nurse Degree Top-up	3	3	6
Nurse Degree PGDip	2	2	4
Physiotherapy	0	1	2
Occupational Therapy	1	3	4
Audiology	0	0	0
Podiatry	4	0	4
Dietetics	0	0	0
Speech & Language Therapy	0	0	0
Total	18	229 15	33

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People Directorate Metrics Update

Leadership and OD

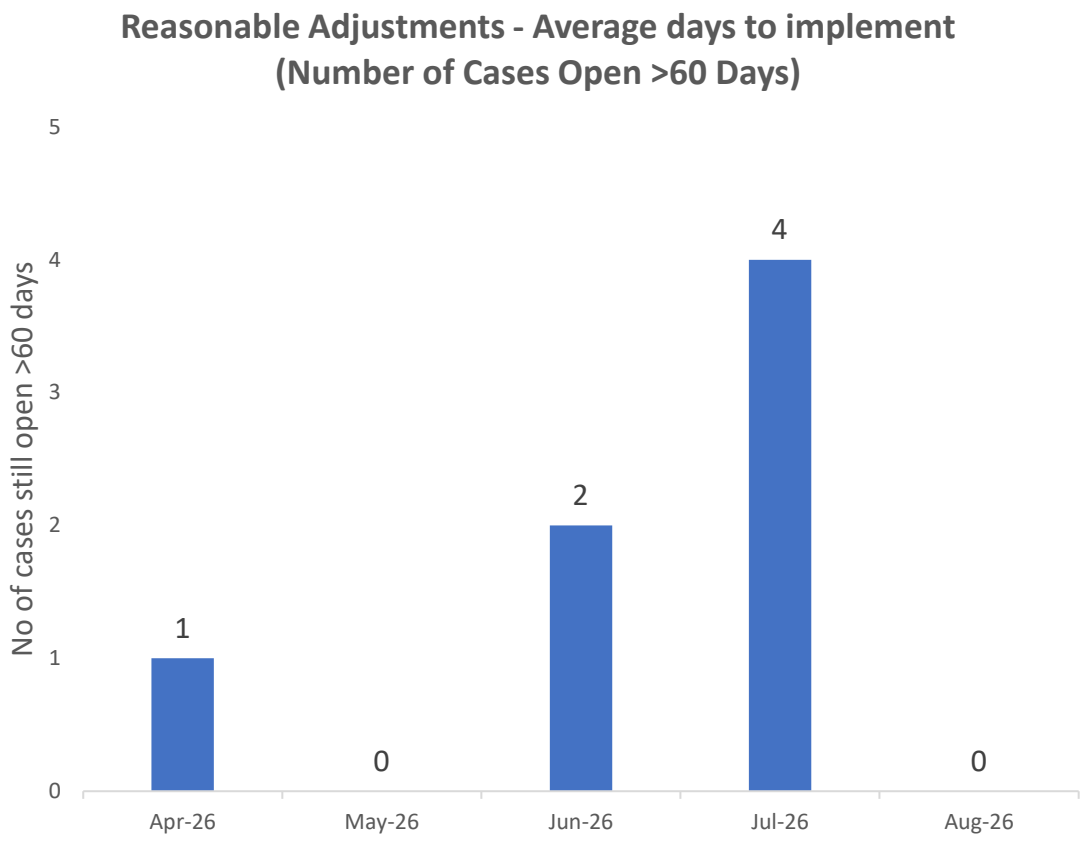
Driver Metrics

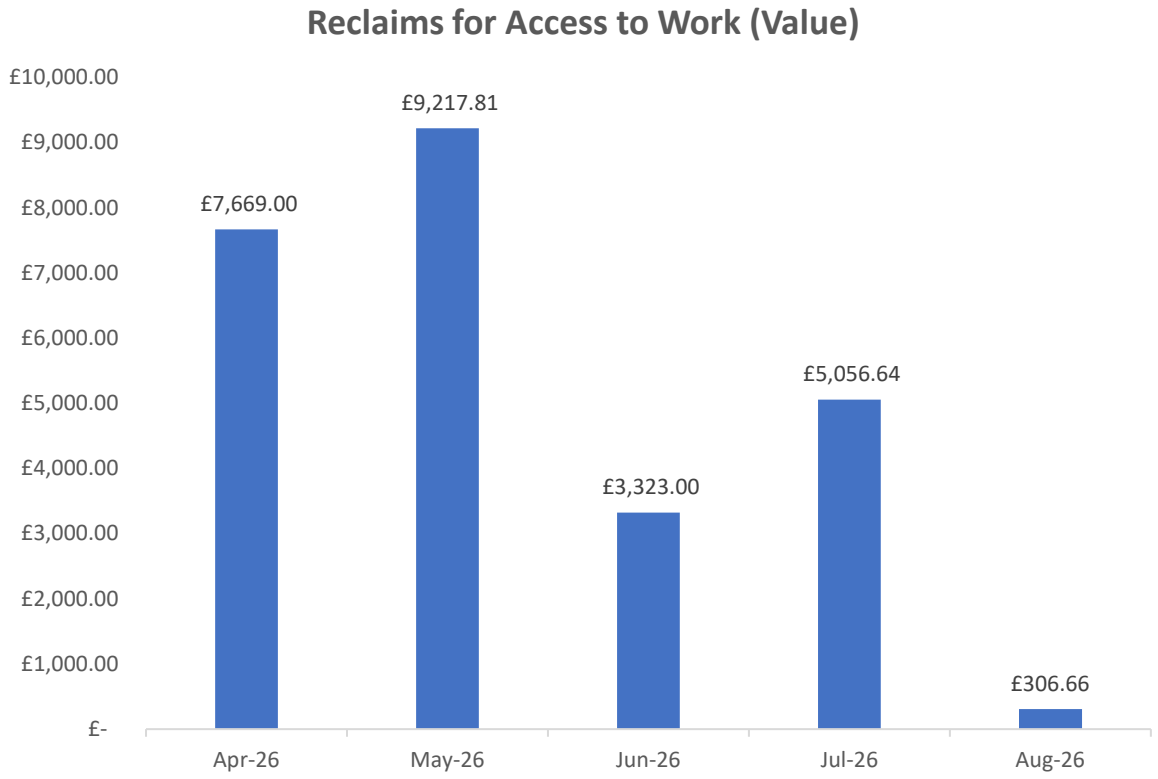
Berkshire Healthcare NHS Foundation Trust

By Team: EDI

Supporting our people
A great place to work

Efficient use of resources
A financially and environmentally sustainable organisation





231 Total reclaims Apr-Aug26 £25,573.11

Driver Metrics

Supporting our people
A great place to work

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By Team: Leadership & OD

Mandatory Compassionate Leadership Programme for Managers

- High casework volumes are being driven in part by managers' limited confidence and capability to model compassionate leadership and hold impactful conversations with team members..
- As a trust we want to develop management capability to conduct open/courageous conversations to ensure managers can navigate and implement day to day people management practices with compassion and promoting positive outcomes for staff and patients.

Impact: Reduction in case work and subsequent demand on HR services. More efficient use of management and HR/OD resource. Improved management capability in handling day to day people issues

Outcome: Continued increase in staff survey scores, managers reporting feeling supported and confident in leading open conversations with team members. Earlier resolution before they escalate into formal casework

Measure: Will commence from August 2026 with a target of 95% compliance.

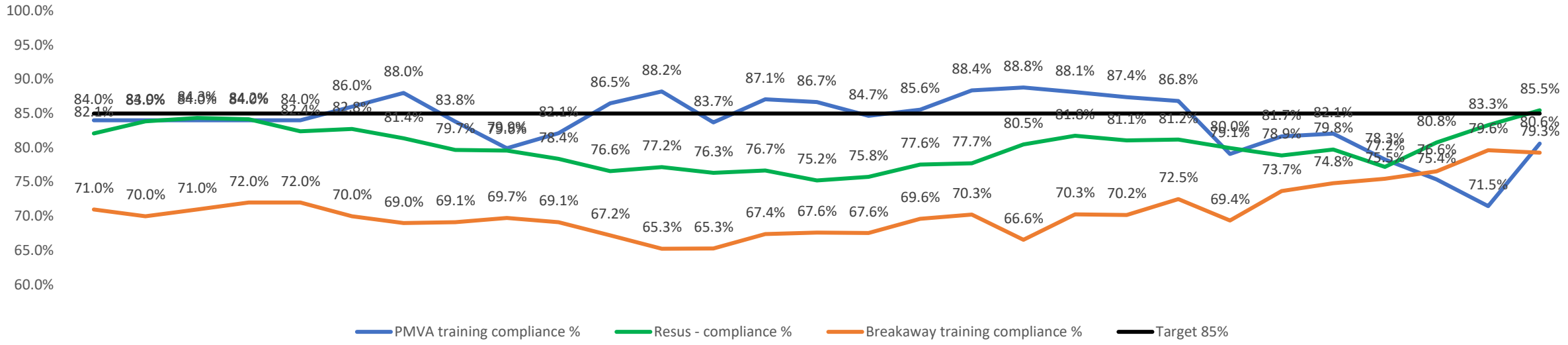
August 2026: 82.4% - No of DNA (on the day) 14 [232]

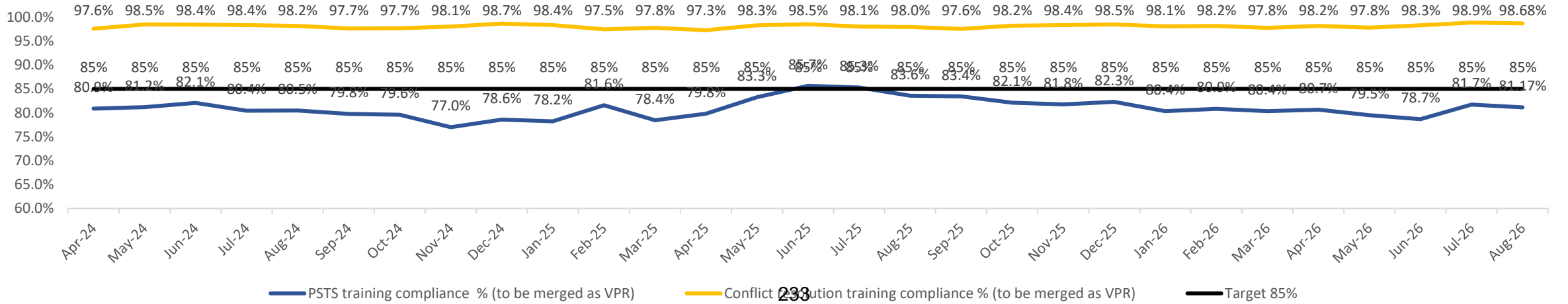
Driver Metrics

Supporting our people
A great place to work

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By Team: Violence Prevention & Reduction / Resus





Berkshire Healthcare
NHS Foundation Trust

People Directorate Metrics Update

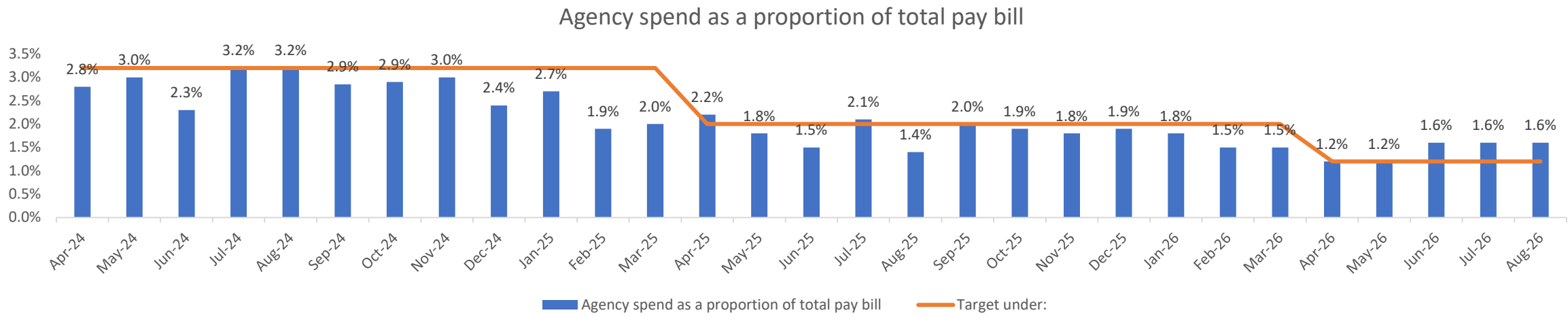
Workforce Insights and Temporary Staffing

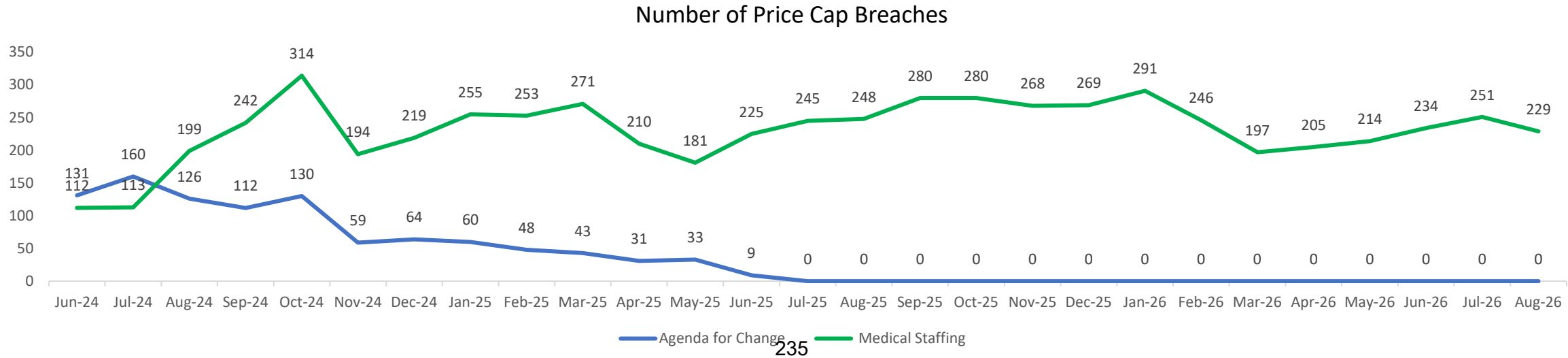
Driver Metrics

Efficient use of resources
A financially and environmentally sustainable organisation

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NHS Foundation Trust

By Team: Workforce & Temporary Staffing





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People Directorate Detailed Programme Update

NHS
Berkshire Healthcare
NHS Foundation Trust

Programmes and Project Updates – September 2026

Berkshire Healthcare – People Directorate – Critical Programmes – Update for September 2026

Trust Strategy Objectives	✓
A great place to work for everyone	✓

Which Strategies does this relate to?

People & Culture Strategy	✓

Trust POAP	
Harm-free care	
Good patient experience	
Supporting our people	✓
Efficient use of resources	

Programme SRO

Jane Nicholson

Support from other Services

Operations
IT
Clinical

Priority Themes & Programmes of Work

Key Areas of Focus & Programme of Work	Programme Update & RAG Rating	Project end date	Measures
RETAIN			
Job Evaluation Review	This has been a busy period for this project with the commencement of the band 5 roll out work, and submission of the action plan to the national team. All managers who have band 5 nurses within their teams have been asked to meet individually with each nurse to agree the job description. The plan is for this work to have been completed by the end of the calendar year. Along side this, the consistency checking for band 6 and band 7 job descriptions has been completed. We are currently planning to begin the roll out of band 6 post holders to the standardised job descriptions during November. Our CNO is up to date and in agreement with the plan and progress, and all the above has been completed with full partnership working.	October 2028	Progress in line with action plan, including dates. National reporting requirements met.
Casework Review	Workstreams are continuing to progress their mini A3 and actions, with oversight of the steering group. Two of the working groups are nearing the end of their work, which is sooner than expected, and their progress has been shared with the steering group at the last meeting which was the beginning of September. A log of actions arising from the four workstreams has been set up and overseen by the steering group.	March 2027	Completion of A3s in workstreams. On-gong progress and action as identified in workstreams.
IMPROVE			
Sickness Review	Reduction of sickness absence became a True North goal with effect from April 26. With support from the QI team, a scoping meeting has taken place, and this work is alongside some changes to the HR support given to managers in supporting attendance. A timeline for this work is now in place, work is continuing on current state with agreement that problem statement will be ready for the next meeting in September 2026. Recommendation from meeting in September to go to DSG and SPG for discussion and comment	TBD	HR team continue to report KPIs on monthly basis in divisions, with a particular focus on 100+ days absence

RAG Rating

Progress delayed	
Some but not all aspects delayed	
All on time and to plan	

Risks & Mitigations

Budget Update

Issues for the TBG/SPG/Board/B&F

Upcoming Activity

Casework Review update to FIP & SPG – October 2026

Berkshire Healthcare – People Directorate – Important Programmes of work – September 2026

Trust Strategy Objectives	✓
A great place to work for everyone	✓

Which Strategies does this relate to?

Trust POAP	
Harm-free care	
Good patient experience	
Supporting our people	✓
Efficient use of resources	

Programme SRO

Jane Nicholson

Support from other Services

Violence Reduction – Wellbeing Matters
IMT – Digital Transformation
IG
Research

Priority Themes & Programme of Work

New programmes of work can only be added if an existing project is complete

Key Areas of Focus & Programmes of Work	Update on Programme & RAG Rating	Project End Date	Measures
ATTRACT Workforce planning	**Clinical Psychology Workforce Planning –** The project scope and review methodology have been agreed with key stakeholders. Workforce and service data has been gathered, with initial analysis underway to establish the current workforce baseline, understand service demand, and identify opportunities for comparative analysis across Psychological Services. **– September 26**	Ongoing	Measured by planned productivity savings Performance against planned workforce WTE in business plan
IMPROVE Anti racism overview (see detail below)	MDES action plan in place. ixed event delivered. Restorative roll out continues. Black History Month programme finalised. Hair kits to launch in October. Sharing practice with peers, ICBs, trusts inside and outside region. CommUNITY forum event planned for November. Drafted anti-racism e-learning module for views and approach through safety culture, commUNITY forum.	Ongoing	WRES / WDES metrics agreed and improving year on year
DEVELOP Appraisal	**Appraisal – Compliance – 22/06/26 – 95.47% (won't be reported again until mid- year)**	Only reports in appraisal months	Target 95%
VPR overview (see detail below)	VPR Standard, Sexual Safety Charter, Domestic Abuse Charter – ongoing actions. VPR policy: now published. NHSE Level 3 VPR course to be delivered to managers Trust wide, planned for Nov 26. TNA project plan is underway to implement recommendations.	Ongoing	Refreshed strategy, new policy in place. Completed TNA and recommendations. Compliance of personal safety training.
Compassionate leadership *Implementation of mandated compassionate leadership programme for managers*	Summary report drafted and developed following the completion of module 2, reflective practice session this month. 65 staff attended. "courageous conversations" videos recorded and planned to be used at next event. Dashboard reports designed and sent to directors reporting manager engagement across their divisions. Planning continuing for 2 more cohorts running over the next 2 weeks.	Ongoing	Improved responses in the manager, and team scores of the staff survey
OMMT	Looking at sustainability from September working with Frimley and RBH to set up courses, two people booked on train the trainer course within our Trust funded by the system. NHSP employing Lived experience co-facilitators, dates for Oct / Sept Tier 2 to be added to Nexus eLearning delivered by UTS, should be delivering in-house from beginning November. Current compliance Aug 26 = Tier 1 &2 45.59%, Tier 1= 67.51%, Tier 2 = 38.39%	Ongoing	Deliver +95% course occupancy for all courses.

RAG Rating

Progress delayed	
Some but not all aspects delayed	
All on time and to plan	

Risks & Mitigations

BAF workforce risk reduced to Moderate.

Budget Update

Crocus suite now open. ISS to explore recharging ISS for incurred costs/damages.

Issues for the TBG/SPG/Board

Upcoming Activity

Loop roll out to AFC staff

Berkshire Healthcare – Learning & Development – Projects of work Update for September 2026

Trust Strategy Objectives	✓
A great place to work for everyone	✓

Which Strategies does this relate to?

Support from other Services

Procurement Team
Clinical Education
Risk Team
Think-Learn
Estates Team
BOB & Frimley ICS/ICB's

Programme SRO

Tracey Slegg

Trust POAP	
Harm-free care	✓
Good patient experience	✓
Supporting our people	✓
Efficient use of resources	✓

Priority Themes & Projects of Work
New projects of work can only be added if an existing project is complete

Key Areas of Focus & Title of Projects	Update on Project & RAG Rating	Project end date	Measures
IMPROVE **DNA**	DNAs lowest point in 2026 – 279 (holiday period) Team is mtg to discuss current monitoring of DNAs in October	Nov 2026	Average DNAs for 25/26 to be less than 640 per month. We will have DNA costs per course
Compliance	Identify top contributors for low compliance. Set up test with campion allowing admin to book staff directly and add to e-roster at same time compliance reports will be compared after bookings have been made / attended –. Extended test to HVs Reading and Crisis resolution review September 26 results show increase in Compliance for the test groups (3 exceptions Breakaway PSTS for CRHTT and CALS for Community Nursing Reading)	September 26	Increased compliance in targeted areas
Review of training framework outcome metrics (formerly CSTF	Review of competencies completed. Summary of BHFT status has been shared with national working group 14/10/25. NHSE presented that training framework will be published April 27 and be competence based – opportunity to become 'Early adopter' for implementation	Awaiting NHSE outcomes April 27	New framework in place
Appraisal Workflow to be updated	Stakeholder mtg 28/7/26 Appraisal Workflow details to be updated re questions and talent pool questions. Updates will be released with the new form in Jan 27.	Dec 26	New updated appraisal form to be launched
Supporting the VPR strategy	Audiences completed changes needed for Tier 3 for go live Mid Oct. Non-clinical to be omitted from Tier 1 audience until Jan 27– Personal safety team to issue Comms before launch.	October 26	Implementation of audience changes in Nexus eLearning
Automation – Induction and SMART week	Induction Launch August 26 automatic JIS and reminders. SMART week mtgs set up, working with ward admin / block booking for SMART week	Dec 2026	Time saving – positive feedback

RAG Rating

Progress delayed	
Some but not all aspects delayed	
All on time and to plan	

Risks & Mitigations

Totara contract ends in October which co-incides with mid year appraisals. Procurement have identified a new risk regarding TOTARA financial viability. Risk to be logged on corporate risk register, contingency planning underway. Response from Totara being reviewed by Graham Harrison.

Budget constraints for any additional developments within the Nexus platform.

Team resources due to high workload and sustaining of Oliver McGowan inhouse

First Aid at Work – contract has now been extended to 1st Dec 26. Personal Safety team will be delivering this from Sept 26.

TBG/SPG/Board

Upcoming Activity

OMMT – sustainability going forward
Induction invites – automation
SMART week review

Berkshire Healthcare – Candidate Attraction – Projects of work Update for September 2026

Trust Strategy Objectives	✓
A great place to work for everyone	✓

Which Strategies does this relate to?

Trust POAP	
Harm-free care	✓
Good patient experience	✓
Supporting our people	✓
Efficient use of resources	✓

Programme SRO

Tracey Slegg

Support from other Services

IMT – Digital Transformation
EDI
Finance

Priority Themes & Projects of Work
New projects of work can only be added if an existing project is complete

Key Area of Focus & Projects Title	Update on Project & RAG Rating	Project end date	Measures
ATTRACT **Recruitment Improvement**	This month we have met all four of our key metrics, with 100% manager and candidate satisfaction. The team are now embedding an 'end to end' recruitment service so managers and candidates will have a dedicated point of contact. This is a learning curve for the team but generally going well so far. Work continues with updating our interview questions to align with our trust behaviours. This will be presented to SPG in October. The sharing interview questions pilot has been running for nine months. The survey findings were shared with SPG last month. WG to meet to discuss next steps. Following research on AI in recruitment, Willo to be trialled – a platform that works as a first round of video interviews. Met with Oxford Health who have implemented this. Business case being written to request funding for this.	Ongoing	Time to hire: Improvement to 2023/24 average figure of 64 days external to average 41.9 days and 37.7 days internal to 22 days internal.
ID Card Software	Current ID card software is unsupported. Finances secured to move this project forward. Currently working with our Procurement team on contractual details. DPIA now completed. Work continues between Procurement and Estates to ensure system compatible with our main door access systems. Decision made to implement this project in two steps due to urgency due to unreliability of existing platform. Platform will be sourced and then door accesses to be reviewed thereafter.	October 2026	
Candidate attraction and talent acquisition	We continue to support managers with hard-to-fill vacancies. We continue to try and support Medical Staffing in their attraction efforts too. Work underway to produce a new video to recruit Psychiatrists. Supporting NED recruitment next month.	December 2026	Recruit to 100 hard to fill vacancies, prioritised through the recruitment plan.
Anti racism	We continue to monitor ethnicity of candidates for Band 8b and above roles. Data analysed to understand why ethnically diverse candidates are rejected at application stage – data shows 52% did not have relevant experience. Decision made to continue with this pilot. Further work to be done to embed with recruiting managers, and the EDI team will support managers to make consistent shortlisting decisions.	Ongoing	Anti racism target
RETAIN **Final year placement students**	Recruitment Assessment Day held for Mental Health Nurses which was a success with 18 offers made. A wash up has also been held. We continue to work with the small cohort of candidates who still do not have roles. We continue to support apprentices as well to gain roles.	Ongoing	Maintain number of final year students placements con verted into substantive posts upon course completion at 30
Our People First	Decision made by SPG to continue with Our People First, as we have seen a steady increase of internal staff successfully securing jobs and manager feedback has been robust that they wish us to continue. This work is now BAU.	Close	We will review the data in 3, 6 and 9 monthly intervals. Will consider the number and nature of posts that are being advertised internally first, and the impact that has had on our internal appointments. The data will identify trends.

RAG Rating

Progress delayed	
Some but not all aspects delayed	
All on time and to plan	

Risks & Mitigations

We have seen an increase in the number of AI applications so need to agree our trust's stance on how we want to manage this going forward. It is having an impact on time to hire, with recruiting managers taking longer to shortlist and resulting in candidates with strong applications on paper, which do not follow through at interview. This is wasting valuable manager time, so we need to agree an approach.

Budget Update

Issues for the TBG/SPG/Board

Upcoming Activity

Berkshire Healthcare –Clinical Education Team Critical Projects – Update for September 2026

Which Strategy does this relate to?

Trust Strategy outline to 2025. People & Culture Strategy

Trust POAP	
Harm-free care	✓
Good patient experience	✓
Supporting our people	✓
Efficient use of resources	✓

Programme SRO

Pearly Thomas

Support from other Services

DoN and Professional leads
EDI team, tableau team
Training compliance team

Next Steps

Priority Themes & Projects of Work. New projects of work can only be added if an existing project is complete

Key Area of Focus & Projects Title	Update on Project & RAG Rating	Project end date	Measure
ATTRACT Preregistration & WP	• **Pre-Registration Training and placements:** • Annual Education Quality review completed with positive feedback from NHSE. No concerns raised . • BH-CARES: Placements completed with positive feedback. Project report and roll out actions to TEAG • **Widening participation:** • School visits update: Two visits agreed; one completed. Second visit is booked for July 2026, cancelled by school, awaiting new date. • T level first cohort has commenced placement; next cohort arrives in November	September 2026	Placement capacity will increase by 50% in the selected learning environment
DEVELOP **Training , skills, Apprenticeships, and CPD**	• **Apprenticeship 3–5-year training plan**: First joint meeting took place in August 2026. Scenario based workforce modelling now completed and will be presented at October Apprenticeship Stakeholder Panel. • Apprenticeship process and investment: A number of changes to June panel decisions all approved and candidates progressing with enrolment.	First Draft by December 2026	Apprenticeship funding is planned , prioritised and fully utilised
RETAIN **Good learner and stakeholder experience**	• **Apprenticeship end of programme survey completed**. Reports to TEAG in October 2026 • CPD survey report - due January 2027. • **CPE efficiency workstream** : 2027 training schedule is under development, compliance targets and outreach activities agreed, CPE JD review in progress.	Dec 2026	Survey result will show positive learner experience
IMPROVE **Service improvement**	• **Quality Improvement Outcome Framework (QIOF):** A quality improvement approach that helps the Library and Knowledge Service measure outcome and service impact, identifying improvement opportunities and demonstrating value. NHSE QIOF review is scheduled. • **ASCENT / Essential skills compliance:** Aims to achieve an average compliance of 60% on essential training courses delivered by clinical educators; by December 2026 and 80% compliance by December 2027. Currently at 56.8 % . Assurance paper shared with JN&HI. • **CPD process automation workflow**: To develop automations to improve CPD process. Due to complete Aug 2026. Work is progressing jointly with Totara. Delayed due to long term sickness and stafing issues.	November 2026 December 2027 March 2027	Report on the conversations shared by NHSE End of project reports

RAG Rating

Progress delayed	
Some but not all aspects delayed	
All on time and to plan	

Risks & Mitigations

Improvement projects are slightly delayed due to staffing issues and long- term sickness in the team and internal restructuring and Totara-Think Learn Merge. Still aims to complete by the final deadlines.

New restrictions for CPD requests from NHSE capped at £1000 pp in a financial year.

Issues for the Trust Board/ SPG

Upcoming Activity

Berkshire Healthcare – Workforce & Temporary Staffing – Projects of work Update for September 2026

Trust Strategy Objectives	✓
A great place to work for everyone	✓

Which Strategies does this relate to?

Trust POAP	
Harm-free care	
Good patient experience	
Supporting our people	✓
Efficient use of resources	✓

Programme SRO

Vicki Smith

Support from other Services

Informatics (data warehouse and BI) for the use of Optima data

Priority Themes & Projects of Work

New projects of work can only be added if an existing project is complete

Key Area of Focus & Projects Title	Update on Project & RAG Rating	Project end date	Measures
ATTRACT Temp staffing fill and pipeline	• Adequate temporary staffing fill to meet our needs. AfC Bank fill was c93.7% in August • c 8.9fte being filled by agency AfC staff.	Ongoing	Bank fill %
	• CSWD cohort of 16 have commenced in placement within MH Inpatients. Next cohort interviews w/c 7th September	Ongoing	
IMPROVE Future solution readiness	• Awaiting pre-readiness activities identified for NHS People Portal (now aligned with Transforming People Services Programme) – working through data completeness and quality tasks, with 3rd party systems/software and contracts identified. Awaiting receipt of the supporting report to further help guide actions. Wave announcement not likely until Q3/4. • E-Manager contract due to expire in March 2027, extension option of 1 year to be utilised. • Positions created in ESR for the nursing B5/6 roles following creation of consistent JDs. Awaiting details to assign to staff.	Ongoing	
Using our data	• Real time data is now accessible to our Data Warehouse Team and visualisations into Tableau built, focussing on sickness to support trend analysis, operational grip and HR actions – manual reporting significantly reduced. Some warehouse/Tableau challenges with annual leave tracking and building in short term sickness triggers. • Review of unrostered AfC staff scheduled for this month • Medical rostering specification in progress and commercials progressing for the direct award. Implementation provisionally scheduled to commence in October. • Review of People Dashboard completed – focus needed on medical workforce data request • 5 year clinical role forecast completed and being socialised with stakeholders • Insights Manager preparing planning activity with psychological therapies, project approach drafted and needs sign off before work commences.	Ongoing December 2026 Trust Board	Fit for purpose Tableau dash boards
NHSP	• Persistent KPI failure on local team ticket closures and time to hire (TTH is not linked to service credits) however fill rates remain strong and one of the best in region. • Improvement plans for PMVA compliance, pipeline management and nursery recruitment remain in development. PMVA backlog being worked through now Crocus Suite is available with high numbers booked for August/September.	Ongoing	KPI/SLA achievement
AfC Agency	• All AfC rates for framework supply are below SE ceiling set. No AfC price cap breaches in place and off framework breaches remain isolated to nurseries but reducing (7 shifts in August). • New AfC agency price caps released however requested changes are being declined • Long term agency workers now minimal with exits in place – 2 NMNC agency staff transferred to bank.	Ongoing	Compliance against ratecard
National targets	• 1.6% of the total pay bill was spent on agency staffing (YTD 1.41%) • 14% of total agency staffing costs are attributable to AfC staffing • Finance data indicates we failed to meet the agency reduction targets (>30%) in M3 and M4.	Ongoing	Reduction %'s

RAG Rating

Progress delayed	
Some but not all aspects delayed	
All on time and to plan	

Risks & Mitigations

Budget Update

Within control totals

Issues for the TBG/SPG/Board

Upcoming Activity

NHS People Portal data activities
Medical rostering implementation (awaiting contractual sign off)

Berkshire Healthcare – EDI – Projects of work Update for September 2026

Trust Strategy Objectives	✓
A great place to work for everyone	✓

Which Strategies does this relate to?

CIE Framework

Equality & Diversity Policy

People

Trust POAP	
Harm-free care	✓
Good patient experience	✓
Supporting our people	✓
Efficient use of resources	✓

Programme SRO

Ash Ellis

Support from other Services

HR
Marcomms
SME's /lived experience,
Health Inequalities
L&D
Staff Networks
Execs

Priority Themes & Projects of Work
New projects of work can only be added if an existing project is complete

Key Area of Focus & Projects Title	Update on Project & RAG Rating	Project end date	Measures
IMPROVE **ANTIRACISM** Restorative Justice Videos	Discussed restorative conversation with community to pilot across services. Delivered Mixed session. Sharing practice with Health Watch, RBH, ICBs. Anti-racism e-learning module in development. Black History Month programme finalised	Nov 2026	Project implemented
CommUNITY forum projects	**Hair kits and resources:** To launch in Black History Month **Multifaith Project:** Closure report in progress **Food and nutrition:** Discussing project deliverables with supplier. Recipes selected. **Annual Event:** Agenda finalised sign ups commencing	Sept 26 Sept 26 Nov 26 Dec 26	Feedback loop with commUNITY
Theatre Forum Workshop	Charging framework with finance to offer externally as well as internally	Sept 26	Training launched
Race Equity Audit actions	Triangle of Care project progressing. Further work with wards to cascase Campion learning with videos..	Sept/Nov 26	Actions delivered
GTRSB Research Health Framework	Steering group finalisation planned to commence community engagement.	July 27	Project implemented
Black History Month Programme	Programme finalised and ready for comms release.	Dec 26	Improved engagement numbers
DISABILITY INCLUSION AIS	Grab bag distribution plan in train (hold) Purple Postcard idea with Purple coffee house in progress	Mar 27	TBC
Reasonable Adjustment A3	Reclaims for unclaimed coaching in progress. Audits continue	Nov 26	Improvements delivered reclaim rate improved
PRIDE INCLUSION Trans and Non-Binary A3	Trans and non-binary guide, finalised by marcomms. TNB A3 progress continues. Proposal for silvercloud	October 2026	Footprint and impact of project shared
Pride	Delivered Reading Pride and seeking feedback for evaluation. (to close)	Oct 26	Sustained engagement
DEVELOP **ALL** Stat and Man training changes	**Staff networks:** WRES and WDES priorities confirmed. Plans in progress. To discuss menopause action plan. **Stat and Man:** Finalising In house Module for working group to review.	Sept 26	New offer created and live
EDS2	Reviewed and added contributions from health inequalities and patients, to share with DSG	Mar 27	Report complete
Income generation	Charging framework for finance review for external workshop offer.	Mar 27	Plan in place

RAG Rating

Progress delayed	
Some but not all aspects delayed	
All on time and to plan	

Risks & Mitigations

- Persistent RA cases over 60 days
- New starter
- Restructure

Budget Update

DWP reclaims being tracked with Finance

Issues for the TBG/SPG/Board

Upcoming Activity

- Restorative conversations roll out
- Racist incidents CPD workshop offer
- CommUNITY forum
- Restructure
- Black History Month
- Purple postcards

Berkshire Healthcare – Leadership & OD – Projects of work Update for September 2026

Trust Strategy Objectives	✓
A great place to work for everyone	✓

Which Strategies does this relate to?

People Strategy

Culture Inclusion Equity Framework

Leadership, Management and Talent Development Strategy

Trust POAP	
Harm-free care	✓
Good patient experience	✓
Supporting our people	✓
Efficient use of resources	✓

Programme SRO

Ash Ellis

Support from other Services

HR,
Communications,
Subject Matter Experts,
L&D,
Staff Networks

Priority Themes & Projects of Work
New projects of work can only be added if an existing project is complete

Key Area of Focus & Projects Title	Update on Project & RAG Rating	Project end date	Measures
Talent Management	The second Career Development workshop was delivered to 70 colleagues, with both sessions now recorded and available on Nexus. Appraisal training is planned to support managers in preparing for effective mid-year conversations. Ongoing development support is also being provided to Talent Pool members, with a focus on maximising the value of their mid-year career conversations.	Ongoing	90% of staff have had talent conversations. 90% positive feedback from talent pool members. 100% coach/career conversation given to all those indicating they are leaving. Equity with white staff - currently 65.2%
Development of internal 360 feedback tool	Development of the 360-feedback tool continues to progress. Focus groups are scheduled for 8, 19, 27 and 30 October, with invitations shared with colleagues who expressed an interest in contributing. These sessions will help shape and refine the tool ahead of development. Initial discussions have also taken place with the developers, who are preparing to begin the build phase in November following completion of the focus groups.	Dec 2026	New 360 tool in place Pool of 360 feedback facilitators trained and ready
NHSE Operational Management Programme	Following the KPMG session, opportunities to integrate key themes into existing L&OD and QI provision are being explored, with a focus on sustainable in-house delivery. We are awaiting the QI team's proposals before developing a joint plan for consideration by the COO and Board.	Dec 2026	Programme integrated into BAU programmes
IMPROVE Team Development	OD consultancy support is ongoing with a team experiencing significant interpersonal challenges. The work was commissioned by an Executive Team member, who will be updated on the outcomes of the sessions.	Ongoing	ToR in situ and group in place Affina plan developed and approach developed. Pool of facilitators developed and able to offer facilitated conversations
Courageous Compassion Leadership programme	The second Module 1 cohort was successfully delivered, with 72 managers in attendance. Initial feedback has been positive, with the content, approach and demonstration videos particularly well received. Feedback is currently being reviewed to identify key themes, learning and any improvements that can be incorporated into future delivery. Planning is now underway for the third cohort on 7 October, building on the learning and feedback from the first two cohorts.	Ongoing	Compassionate leadership staff survey results 100% attendance and compliance of all managers

RAG Rating

Progress delayed	
Some but not all aspects delayed	
All on time and to plan	

Risks & Mitigations

Consultation has end. 1 staff member at risk of redundancy. Risk to delivery over coming months whilst we recruit 2x B7 OD Partners and 1x 8B L&OD Lead

Budget Update

Ongoing review of Leadership requests for funding through TNA process.

Exploring opportunities for income generation

Issues for the TBG/SPG/Board

Updating SPG on NHSE operational management programme and how we are utilising talent pool members. Exec Discursive on Exec development, also Managers Passport (Checklist) (Aug26)

Upcoming Activity

Talent pool engagement
Compassionate leadership delivery
Team Dev ToR document draft
OD team JD's and resourcing
OD Lead interview design
Bespoke programme with Roffey Park scheduled for 15 & 16 Dec

Berkshire Healthcare – Wellbeing Matters and Ergonomics – Projects of work Update for September 2026

Trust Strategy Objectives	✓
A great place to work for everyone	✓

Which Strategies does this relate to?

Trust Strategy outline to 2025

People & Culture Strategy

Trust POAP	
Harm-free care	✓
Good patient experience	✓
Supporting our people	✓
Efficient use of resources	✓

Programme SRO

Ash Ellis

Support from other Services

HR,
Communications,
Subject Matter Experts,
L&OD,
IM&T
L&D

Priority Themes & Projects of Work
New projects of work can only be added if an existing project is complete

Key Area of Focus & Projects Title	Update on Project & RAG Rating	Project end date	Measures
RETAIN **WBM – SSPI offer**	We will focus on improving visibility of SSPI offer to increase referrals for this work from under-represented teams - including use of MSN, Wellbeing at Work, and EKM sessions to promote.	April 2027	Uptake / usage
IMPROVE **WBM – Reflective practice groups/ SPACE review**	We will lead a review of SPACE group intervention, to consider options for long-term future of reflective practice groups in Berkshire Healthcare. BG presented at next safety culture group.	April 2027	Delivery of actions identified by the review
WBM – admin processes	We will explore how we could use technology and digital transformation to optimise administrative processes. Meeting with PCMIS	April 2027	Efficiencies / productivity
Ergonomics –DSE process	Too many referrals, long delays. Need better screening process. Document produced with need to be automated, to take to automation team for support.	December 2026	Reduction in referrals / DSE Assessments
DEVELOP **WBM – Compassionate Mind Training**	Continuing training for the team and roll out. Starting to think about adaptations once certifications gained. Theoretical understanding, but hands on compassion habits. (reducing 10 sessions into 6) Team 6 session model in progress with DL. 1 day model for individuals to follow.	April 2027	Delivery of training as BAU
WBM – Wellbeing Conversation Training	Now launched HEARTS, had 3 sessions – needs some tweaking with feedback	April 2027	Training embedded
Ergonomics - review of training provision	To review the training offered, is it needed, is it a the right level etc. Already developed a targeting email to those who are not compliant	Not yet commenced	

RAG Rating

Progress delayed	
Some but not all aspects delayed	
All on time and to plan	

Risks & Mitigations

WBM lead role recruitment – appointment made. Gap until September. Ash covering.

Workload of team – still carrying staff benefits admin, picking up comms role etc

All WBM actions are somewhat paused until the new Lead begins..

Budget Update

Issues for the TBG/SPG/Board

Upcoming Activity

WBM lead role appointed – starting 1st September

Berkshire Healthcare – Violence Reduction & Prevention, Resuscitation – Projects of work Update for September 2026

Trust Strategy Objectives	✓
A great place to work for everyone	✓

Which Strategies does this relate to?

People Strategy

Culture Inclusion Equity Framework

VPR Strategy

Trust POAP	
Harm-free care	✓
Good patient experience	✓
Supporting our people	✓
Efficient use of resources	✓

Programme SRO

Ash Ellis

Support from other Services

Clinical Leads / Service Leads
Communications, L&D, HR
Patient Experience
Wellbeing Matters

Priority Themes & Projects of Work

New projects of work can only be added if an existing project is complete

Key Area of Focus & Projects Title	Update on Project & RAG Rating	Project end date	Measures
DEVELOP **Violence Prevention Reduction**	VPR Standard - ongoing actions. Staff standards – rag rating gap analysis being completed at VPR working group. Next VPR course for managers planned for Nov 26. New VPR e-learning package in final stages, with EDI team for final review.		Progress against the VPR standard Managers trained in VPR course
Sexual Safety	Sexual Safety Charter – ongoing actions. Learning on SS being monitored. Mapped to the new Staff Standards.	Ongoing	Progress against the charter
Bullying	Bullying and Harassment action plan developed with actions commenced. Survey results to present and share. Casework review developing training for HR & IO's. QI approach to tackle B&H in lowest scoring L5 services underway with DD' & Clin. Dirs on board. Mainly concentrating on busy 24/7 in- & out-patient services.	Ongoing	Staff survey indicator – improvement on score
Personal Safety (PS) and Resus (R) Training	R: Plan to review and streamline all ILS courses and creation of e-learning for blended learning. Working group to be set up at next Resus Committee meeting.	Ongoing	Creation of Resus e-learning
	PS: Training for IOs on PMVA to support investigations – waiting to hear from HR to provide next steps for training delivery	July 26	Training delivered to IOs
Training Needs Analysis (TNA)	PS: Trust-wide TNA and Workforce Risk Ax – Implement target groups and monitor compliance. To inform improving processes with L&D/HR including the link with job adverts, job descriptions, OH and any exemptions. TNA includes introducing clinical holding training and policy development – now underway. Project plan in progress to commenced to implement the 14 recommendations. This includes review of PMVA and SCIP for Campion – EQIA underway. New VPR e-learning package in final stages, with EDI team for final review.	Oct 2026	Completion of TNA and risk assessments. Training compliance of all personal safety training.
Clinical Development	PS: FAAW training can be rolled out from Sept onwards. PS: 2 Tutors attending Oliver McGowan train the trainer course in Sept to be able to deliver this in-house. L&D leading roll out of this course.	Ongoing	Creation of course Delivering FAAW. Delivering Oliver McGowan
	PS: Promotion of courses on Trust website and social media to income generate. Offer of bespoke course on Trust website (inc. VPR course). Working with Clinical Ed team to advertise courses on separate web page.	No yet commenced	Advertisement of courses externally.

RAG Rating

Progress delayed	
Some but not all aspects delayed	
All on time and to plan	

Risks & Mitigations

Crocus suite is now open.
Volume of OMMT will impact Personal Safety Team

Budget Update

Personal safety Team continuing to income generate. L&D income generating for Oliver McGowan.
Crocus Suite - Estates to claim back cost from leaks from ISS.

Issues for the TBG/SPG/Board

TNA recommendations to be implemented.
Personal Safety Team will be delivering First Aid at Work from Sept 26 (2 booked on train the trainer in Aug) and Oliver McGowan from Sept onwards.

Upcoming Activity

Project plan to implement TNA recommendations.
Next VPR Management course commencing Nov 26.

NHS
Berkshire Healthcare
NHS Foundation Trust

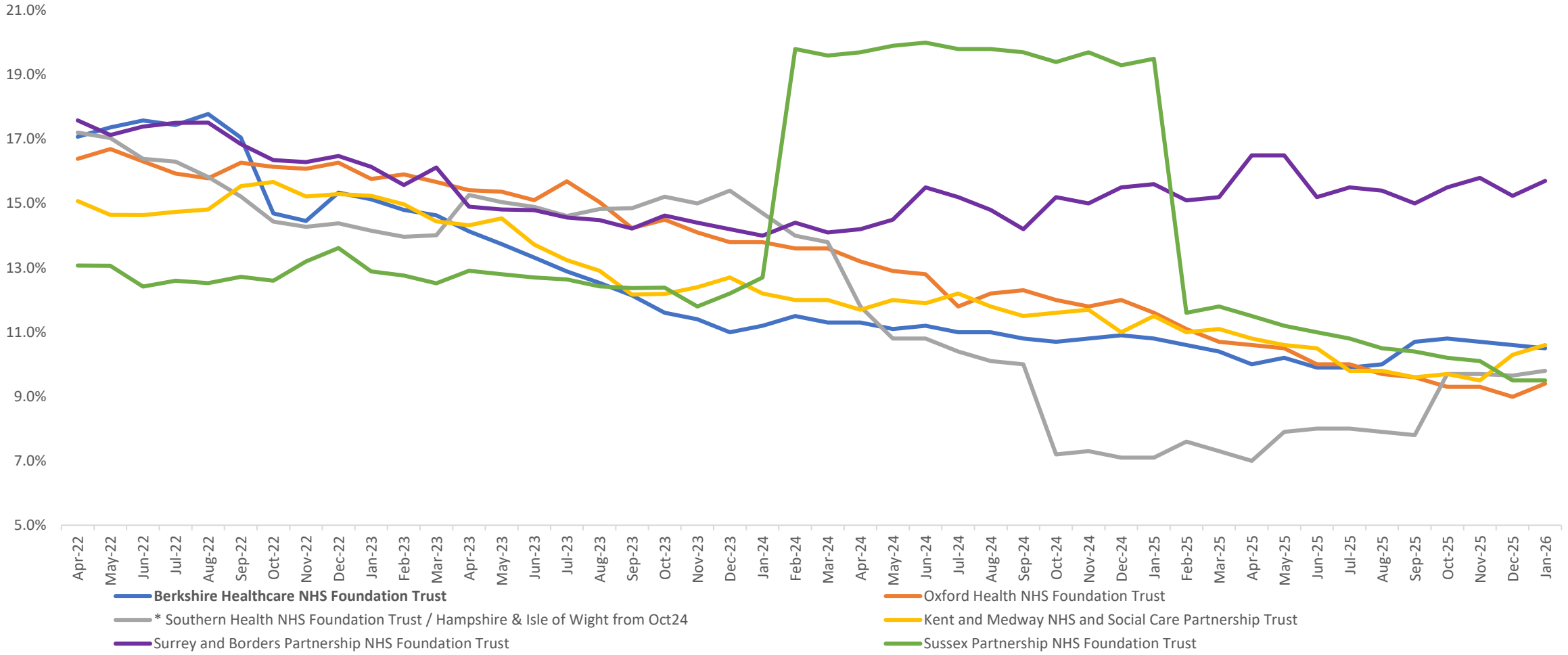
Appendix

NHS
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System Metrics

Turnover Benchmarking - ICS

Berkshire Healthcare NHS Foundation Trust

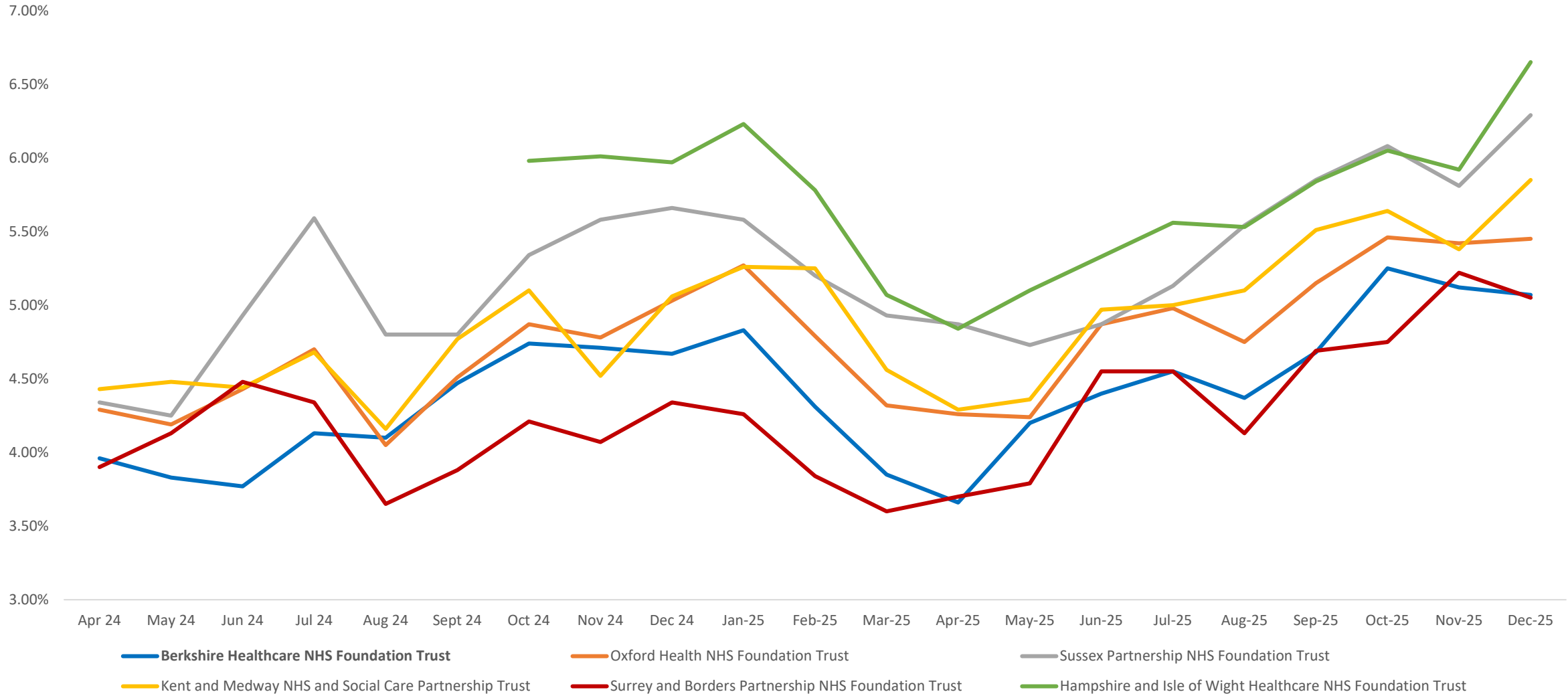


* Hampshire & Isle of Wight formed in Oct24, merged Solent & Southern Health

Source: NHS Digital – turnover calculation differs to Berkshire Healthcare methodology but is a consistent calculation across each of the ICS Partners

Sickness Benchmarking - ICS

Berkshire Healthcare NHS Foundation Trust



Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 November 2026
Title	Proposal to consolidate community hospital beds in Berkshire West from 3 to 2 sites with a reduction of 3 beds.
	Item for Decision
Reason for the Report going to the Trust Board	Seek Board approval to progress with a public engagement approach on a proposal to consolidate rehabilitation beds at Wokingham and West Berkshire Community Hospitals, closing Oakwood Ward and increasing capacity at Highclere Ward. The routine operating bed base would reduce from 108 to 99 beds. Six escalation beds would be available at Wokingham Hospital, providing maximum capacity of 105 beds. The actual reduction in beds available to the system at times of significant pressure is therefore 3 beds.
Business Area	Community Health Inpatients
Author	Theresa Wyles COO
Relevant Strategic Objectives	**Patient safety** **Ambition:** We will reduce waiting times and harm risk for children and young people requiring mental health support. **Patient experience and voice** **Ambition:** We will use patient experience, outcome measures and service intelligence to inform improvement. **Quality and performance**

	Ambition: We will strengthen data quality, reporting controls and operational oversight to support accurate national reporting.
Summary	This paper proposes a clinically and operationally sustainable configuration for community rehabilitation beds across Berkshire West. Services would be concentrated at Wokingham Hospital and West Berkshire Community Hospital, enabling stronger clinical oversight, more resilient multidisciplinary staffing and better use of the most suitable estate. The distinction between routine and maximum capacity is central to the proposal. The routinely open bed base would reduce by nine beds, from 108 to 99. However, six beds would be available for escalation at Wokingham Hospital, allowing capacity to flex to 105 when system pressures require it. Measured against the current 108-bed position, the maximum bed capacity available to the Berkshire West system would therefore reduce by 3 beds, not nine. The preferred option provides the strongest overall balance of clinical quality, workforce resilience, estate suitability, operational flexibility and value for money. It is expected to deliver a recurrent net financial benefit of between £700k and £800K. Implementation would be contingent on delivery of flow improvements, completion of equality and quality impact assessments, staff consultation, estates and medical-cover readiness, and continuing assurance that patients can access timely rehabilitation.

Berkshire West Community Rehabilitation Bed Consolidation

Proposal to consolidate inpatient rehabilitation provision from three sites to two

Board decision summary	
Purpose	To support the Board's understanding of, and seek approval to progress, the preferred model for the Berkshire West community rehabilitation bed base.
Proposal	Consolidate routine rehabilitation provision from three sites to two: Wokingham Hospital and West Berkshire Community Hospital. Oakwood Ward would close as a standalone rehabilitation site and capacity at Highclere Ward would increase.
Bed impact	The routine operating bed base would reduce from 108 to 99 beds. Six escalation beds would be available at Wokingham Hospital, providing maximum capacity of 105 beds. The actual reduction in beds available to the system at times of significant pressure is therefore 3 beds. There is a bed space in West Berkshire Hospital that is currently used as office space and this could be repurposed to a clinical space subject to some remedial estates work.
Decision requested	Approve progression of the preferred model to engagement and implementation planning, with final implementation conditional on completion of the stated assurance requirements.

Executive summary

This paper proposes a clinically and operationally sustainable configuration for community rehabilitation beds across Berkshire West. Services would be concentrated at Wokingham Hospital and West Berkshire Community Hospital, enabling stronger clinical oversight, more resilient multidisciplinary staffing and better use of the most suitable estate.

The distinction between routine and maximum capacity is central to the proposal. The routinely open bed base would reduce by nine beds, from 108 to 99. However, six beds would be retained for escalation at Wokingham Hospital, allowing capacity to flex to 105 when system pressures require it. Measured against the current 108-bed position, the maximum bed capacity available to the Berkshire West system would therefore reduce by three beds, not nine.

The preferred option provides the strongest overall balance of clinical quality, workforce resilience, estate suitability, operational flexibility and value for money. It is expected to deliver a recurrent net financial benefit of £700k-800k. Implementation would be contingent on delivery of flow improvements, completion of equality and quality impact assessments, staff consultation, estates and medical-cover readiness, and continuing assurance that patients can access timely rehabilitation.

Purpose and recommendation

The purpose of this paper is to provide the Board with a clear account of the proposed consolidation, the resulting bed numbers, the case for change, the principal risks and the controls required before implementation.

1. The proposal moves routine rehabilitation activity from three sites to two.
2. Routine capacity would reduce from 109 to 100 beds, with six escalation beds available, resulting in maximum system capacity of 106 beds and an actual net reduction of three beds.
3. Approve progression of the preferred model to engagement, staff consultation and detailed implementation planning.
4. Require final implementation to remain subject to the assurance conditions set out in this paper.

Current and proposed model

Capacity comparison			
Measure	**Current position**	**Proposed position**	**Change**
Routine beds	108	99	Reduction of 9
Escalation beds	Not separately identified in the current 108-bed total	6 escalation beds at Wokingham Hospital	Provides flex during significant pressure
Maximum beds available to the system	108	105	**Net reduction of 3**
Routine rehabilitation sites	3	2	Consolidation of one site

Under the preferred model, routine rehabilitation services would operate from Wokingham Hospital and West Berkshire Community Hospital. Oakwood Ward would close as a standalone rehabilitation site, capacity at Highclere Ward would increase, and six escalation beds would be retained at Wokingham Hospital for use during periods of significant system pressure.

Clinical quality and Patient Outcomes

Oakwood's single-bedded environment does not support easy or continuous observation of patients. This creates an inherent patient safety risk and means that admission criteria must be tightly restricted to exclude patients whose clinical presentation, cognitive impairment, behaviour or level of dependency requires enhanced observation or rapid senior clinical review. Concentrating rehabilitation provision on two sites would enable a greater presence of senior clinical staff within each service, rather than requiring them to provide cover across three separate locations. This would strengthen day-to-day clinical oversight, multidisciplinary decision-making, improve rehabilitation planning, timely response to clinical escalation and discharge coordination, while supporting safer and more consistent care. Delivery of these benefits will depend on clear admission criteria, timely assessment, active rehabilitation and robust discharge planning across both sites.

Activity, access and equity

Reading residents already use the wider Berkshire West rehabilitation bed base. During 2025, 60.2% of the 392 admissions for Reading residents were to sites other than Oakwood. This indicates that cross-locality access is already established, although travel implications for patients, carers and families require specific mitigation.

At 100 routinely open beds, provision would equate to 16.3 beds per 100,000 population and would remain above both the Berkshire East level and the benchmarking mean. The six escalation beds provide additional protection during significant demand or flow pressure. Ongoing monitoring will need to test access and outcomes by locality and protected characteristic, with particular attention to Reading residents affected by the closure of Oakwood as a standalone site.

Flow and operational dependencies

The proposal is not predicated on bed reduction alone. Its safe delivery depends on improving patient flow across the pathway, including reducing No Criteria to Reside delays, strengthening referral and pathway discipline, implementing the Berkshire-wide discharge and flow dashboard, redesigning Community In-reach and Flow services, and establishing effective system-level oversight.

The retained escalation capacity should be governed by agreed activation and deactivation arrangements so that it remains genuinely available when required and does not become a substitute for sustained improvement in flow.

Financial implications

The preferred model is expected to deliver a recurrent net financial benefit of £700-800k. The financial model includes a non-recurrent travel provision of £100k. Financial delivery should be tracked alongside quality, workforce, access and flow measures so that savings are not considered in isolation from patient and system impact.

Principal risks and mitigations

Risk	Potential impact	Mitigation and assurance
Flow improvements are not delivered	Pressure on routine capacity, delayed transfers and increased use of escalation beds	System-level oversight; flow dashboard; pathway discipline; monitoring of No Criteria to Reside and discharge performance
Travel and access consequences	Additional burden for some Reading residents, carers and families	Targeted engagement; equality impact assessment; access monitoring; use of the non-recurrent travel provision
Workforce transition	Loss of staff, reduced morale or gaps in skill mix	Formal staff consultation; detailed workforce plan; phased transition and readiness review

Medical cover and clinical model	Insufficient senior input or inconsistent clinical oversight	Detailed medical-cover model and confirmation of multidisciplinary arrangements before implementation
Estates readiness	Proposed capacity cannot open safely or to timetable	Completion of estates works and formal operational readiness checks
Partner confidence	Loss of support or concern about broader system capacity	Continued partner engagement, transparent reporting and agreement of escalation arrangements

Implementation approach

Subject to Board approval, engagement would commence through Q3 2026/27, with formal staff consultation planned for Q4. Implementation would commence from April 2027 only after the required governance approvals and readiness conditions have been met.

Before implementation, the Board should receive assurance that:

- Equality and quality impact assessments are complete, and any material mitigations are funded and deliverable.
- The workforce and medical-cover models are agreed, consulted on and sufficiently staffed.
- Estates works and expanded capacity at Highclere Ward are operationally ready.
- Flow trajectories, escalation triggers and system oversight arrangements are agreed with partners.
- Arrangements to mitigate travel and access impacts are in place.
- Quality, safety, patient experience, access, flow, workforce and financial measures are defined for post-implementation monitoring.

Conclusion

The preferred model consolidates rehabilitation provision onto two sites while preserving flexibility for periods of pressure. Although the routine operating base reduces by nine beds, the retention of six escalation beds means that the maximum capacity available to the system reduces from 108 to 105—an actual net reduction of three beds. On the evidence presented, the model offers a balanced approach to quality, workforce resilience, estate suitability, operational flexibility and value for money, provided that the identified dependencies and safeguards are delivered.

The Board is asked to approve progression of the preferred model to engagement and implementation planning, noting that final implementation remains conditional on completion of the assurance requirements described above.

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 November 2026
Title	**Audit Committee Meeting – 28 October 2026**
	Item for Assurance
Reason for the Report going to the Trust Board	The Audit Committee is a sub-committee of the Trust Board. The minutes are presented for information and assurance. The Trust Board is asked to note the minutes and identify any areas where further clarification is required.
Business Area	Corporate
Author	Company Secretary, on behalf of Rajiv Gatha, Chair of the Audit Committee
Relevant Strategic Objectives	**Efficient use of resources**
Escalation and Assurance Report	No items were identified for escalation to the Trust Board. The following items provide assurance to the Trust Board in the following areas. **Board Assurance Framework (BAF) and Corporate Risk Register** The BAF and risk appetite approach were being reviewed against good practice. The highest corporate risks—violence and aggression and the Prospect Park Hospital environment—remain the highest scoring risks and were subject to substantial mitigations.

	Digital and Cyber Risk The digital BAF risk now included cyber detection and response. Further assurance was requested on business continuity and post-incident remediation. **Information Assurance Framework** Four performance indicators were audited during quarter 2. One indicator was rated green (high confidence) and three indicators were rated amber (medium confidence). Data quality weaknesses in operational reporting require continued monitoring and remediation. The Committee will continue to monitor progress through the Information Assurance Framework. **Claims and Litigation** Claims had returned to usual levels after the first-quarter increase. No common theme was identified; monitoring will continue. **Counter-Fraud** Planned counter-fraud work covered AI-related recruitment and other staff fraud risks. The new lead was encouraged to share learning from other organisations. **External Audit** Planning for the 2026/27 external audit has begun, with work expected from early January. Proposed AI use will be covered in the audit planning report. **Committee Effectiveness** Annual effectiveness assessments for the Finance, Investment and Performance Committee and Quality Assurance Committee were positive, with minor improvement opportunities.

Berkshire Healthcare
NHS Foundation Trust

Unconfirmed Draft Minutes

Minutes of the Audit Committee Meeting held on

Wednesday, 28 October 2026
(Conducted via Microsoft Teams)

Present: Rajiv Gatha, Non-Executive Director, Committee Chair
Sonya Batchelor, Non-Executive Director

In attendance: Paul Gray, Chief Financial Officer
Debbie Fulton, Director of Nursing and Therapies
Dr Tolu Olusoga, Medical Director
Rebecca Clegg, Director of Finance
Claire Friend, TIAA, Anti-Crime Specialist
Alison Kennett, Ernst and Young, External Auditors
Clarence Mpofu, Barts Assurance, Internal Auditors
Karen Swainson, Barts Assurance, Internal Auditors
Julie Hill, Company Secretary

Item		Action
1.A	**Chair's Welcome and Opening Remarks**	
	Rajiv Gatha, Chair, welcomed everyone to the meeting.	
1.B	**Apologies for Absence**	
	Apologies were received from: Ben Lazarus, Ernst and Young, External Auditors	
2.	**Declaration of Interests**	
	There were no declarations of interest.	
3.	**Minutes of the Previous Meeting held on 22 July 2026**	
	The Minutes of the meeting held on 22 July 2026 were confirmed as a true record of the proceedings.	

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4.	**Action Log and Matters Arising**	
	The Action Log had been circulated. The Committee noted the Action Log.	
5.A	**Board Assurance Framework (BAF)**	
	The Chief Financial Officer presented the paper and highlighted the following points: • Following a discussion at the Trust Board Discursive meeting in October 2026, work had commenced to review the Board Assurance Framework against current best practice and to consider the Trust's approach to risk appetite. • Internal audit support had been engaged to help inform the review. • **Risk 1 (Workforce**) had been updated to include targeted recruitment activity to fill hard-to-fill posts (medical and community nursing) and challenges associated with AI use within job application processes. • Changes were made to some target risk scores following review by risk owners: ○ The target score for **Risk 4 (System Working)** was increased. ○ The target score for **Risk 5 (Health Inequalities)** was reduced in recognition of progress made. • The risk description of **Risk 7 (Digital)** was amended to specifically include the Trust's ability to detect and respond to cyber incidents. The Chair asked for more information about why the target risk scores for Risks 4 and 5 had changed. The Chief Financial Officer agreed to find out and include this in the minutes. The Chair observed that, while the digital risk provided considerable assurance concerning how cyber risks were identified and attacks detected, there appeared to be less explicit assurance about business continuity and remediation following a successful cyber incident. He suggested that the BAF should include greater detail on remediation and continuity planning. The Chief Financial Officer agreed to take this away for consideration. Sonya Batchelor, Non-Executive Director, sought clarification regarding Risk 8 (Sustainability) and, specifically, references to a low risk of a fine. She explained that she had received different views as to whether a financial penalty could arise and requested definitive clarification. The Chief Financial Officer agreed that this would be clarified outside the meeting. Ms Batchelor also requested that future versions of the BAF identify when a risk score had most recently changed, so that members could readily understand the chronology of movements between the initial and revised	**PG/JH** **PG** **PG**

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	scores. The Company Secretary agreed to incorporate this requirement into the wider review of the BAF template. The Committee also discussed whether a future deep dive on digital risk should be undertaken. Ms Batchelor said that it was important that the discussion drew upon the expertise of Manjeet Aujla, Non-Executive Director who had a background in digital and appropriate operational subject-matter experts. The Company Secretary noted that deep dives had previously been undertaken by the Audit Committee but that, given the cross-cutting nature of digital, the matter could also lend itself to a future Board discussion so that all Non-Executive Directors could participate. **Post-meeting note**: **Risk 4 (System Working)** – the target risk score had been increased to reflect that success in partnership working depended on external partners. **Risk 5 (Health Inequalities)** – the target risk score had been decreased to reflect that the Trust has a reducing health inequalities strategy in place but the gap in assurance around the Thames Valley Integrated Care Board's reducing health inequalities governance and work programme is unclear during the establishment of the Thames Valley Integrated Care Board and this keeps the current risk score high. The Committee noted the report.	**JH** **JH**
5.B	**Corporate Risk Register**	
	The Corporate Risk Register (CRR) had been circulated. The updates since the last meeting were highlighted in red type. The Chief Financial Officer presented the paper and highlighted the following points: • **CRR 7 – Physical environment Prospect Park Hospital** – safety works concerning curtains and shower rails at Prospect Park Hospital had been completed. • **CRR 10 – Long Waiting Times for Services** – there had been significant progress in reducing the number of children on community waiting lists over 52 weeks (excluding neurodiversity) - the number had reduced to single figures. Sonya Batchelor, Non-Executive Director, asked that the minutes formally record the Non-Executive Directors' recognition of this progress, particularly the completion of the physical-environment works at Prospect Park Hospital and the significant improvement in long waits for children.	

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	The Chair then considered the overall risk profile rather than individual risk entries. He noted that violence and aggression and the Prospect Park Hospital physical environment carried the highest current scores of 20 and asked the Director of Nursing and Therapies whether these appropriately represented the Trust's most significant risks and whether the scale of management response and resource was commensurate with them. The Director of Nursing and Therapies confirmed that, in her view, the risks were appropriately positioned. Considerable resource and activity were being directed towards the Prospect Park Hospital environment and violence prevention and reduction. She stressed the impact of violence on patients, staff and the organisation and referred to recent partnership work with the police. The intention was that the position on both risks would improve over time as the work underway took effect. The Committee noted the report.	
6.	**Single Waiver Tenders and Provider Selection Regime Direct Awards Report**	
	A paper setting out the Trust's single waivers and provider selection regime direct awards approved from July 2026 to September 2026 had been circulated. The Chief Financial Officer presented the paper and highlighted the extension relating to the provider of much of the Trust's commercial software, including Microsoft licences. He also confirmed that no contracts had been awarded under the Provider Selection Regime during the reporting period. Sonya Batchelor, Non-Executive Director, requested further information concerning expenditure relating to Advantage Football Mentoring. She asked for greater context about the service, the number of individuals supported and whether alternative funding options, including funding from the football club, had been explored. The Chief Financial Officer agreed to provide further information. The Committee noted the report.	**PG**
7.	**Information Assurance Framework Update Report**	
	The Chief Financial Officer presented the paper and reported that four indicators were audited during the quarter: • **Mental Health: Inpatient Readmission rate within 14 days** (high assurance – green) • **Did Not Attend (DNA) rate** (moderate assurance – amber) • **72-hour follow-up** (moderate assurance – amber)	

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	• **Mental Health: Older Adult Average Length of Stay** (moderate assurance – amber) The Chief Financial Officer reported that a task and finish group led by the new Director of Mental Health Services was focused on improving the 72-hour follow-up data quality position and had set an ambition to improve data quality by 50% over the following quarter. The Director of Nursing and Therapies provided additional assurance from a Gemba visit to Prospect Park Hospital undertaken with Manjeet Aujla, Non-Executive Director. She explained that wards were actively checking discharge dates through the daily status exchange. Staff were verifying that the date recorded on RiO (electronic patient record system) was correct and amending records where necessary, providing direct evidence that the data-quality issue was being addressed operationally. Sonya Batchelor, Non-Executive Director, asked for more information about the issues with the DNA indicator. The Chief Financial Officer explained that the Trust appeared to be overstating the number of DNAs. The position did not currently present a risk to achievement of the Trust target, but the underlying recording problem required resolution. The RiO User Group and Data Quality Forum were considering the issue. Ms Batchelor asked how the Committee would obtain ongoing assurance that the position was improving. The Chief Financial Officer confirmed that, given the issues identified through the audits, progress would continue to be reported through the Information Assurance Framework. The Chair noted that, within a sample of 83 records recorded as DNA, only 46% had actually met the definition of a DNA. He queried whether there was a converse risk that genuine DNAs might be recorded incorrectly as something else. The Director of Nursing and Therapies considered this unlikely because clinicians were required to outcome contacts and clinical notes would ordinarily evidence where a patient had been seen. She explained that misclassification was more likely to occur where DNA was selected from a drop-down list when, for example, a member of staff had been absent, or the patient had cancelled at short notice. The Chair also requested further details concerning a case identified as a near miss within the 72-hour follow-up audit. The Chief Financial Officer said that he did not have the detail available and agreed to provide it following the meeting. Ms Batchelor, Non-Executive Director, questioned an older action concerning dual entry of physical-assault information, observing that the stated closure	**PG** **PG**

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	date was 31 October 2025. She requested confirmation as to whether dual entry remained possible and whether the action could now be closed. The Chief Financial Officer agreed to clarify the position. The Committee noted the report.	**PG**
8.	**Losses and Special Payments Report**	
	Due to low numbers of losses and special payments, there was no report this quarter. The Chief Financial Officer reported that the cumulative total was currently below £5,000, which accounted for the absence of a report over the previous two quarters.	
9.	**Clinical Claims and Litigation Report**	
	The quarterly Clinical Claims and Litigation Report had been circulated. The Director of Nursing and Therapies presented the report and highlighted the following points: • Four claims had been closed in quarter 2 (three clinical negligence and one employer liability claims) • There were four new claims opened in quarter 2 (two clinical negligence and two public liability claims) • The number of claims received during the quarter had returned to a level more normally experienced by the Trust following the increase seen in Quarter 1. The Chair asked whether there was any particular reason why the number of claims had increased during quarter 1. The Director of Nursing and Therapies advised that no particular underlying theme had been identified to explain the Quarter 1 increase. The claims related to different periods and services and there was no obvious pattern. She considered the Quarter 1 increase likely to have been anomalous, although the position would continue to be monitored. The Committee noted the report.	
10.	**Policy Reviews**	

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	The Director of Finance presented the proposed changes to the Reservation of Powers Policy to the Board and Delegation of Powers and Standing Financial Instructions. The Director of Finance explained that the current review had been relatively light touch following more substantial work undertaken two years previously. She also noted that the Health Bill, if passed, would require aspects of the Scheme of Reservation and Delegation to be revisited. The Chair sought assurance that there were no material changes of concern. The Director of Finance confirmed that the amendments principally concerned references, consistency between documents, gender-related wording and presentation, with the format aligned more closely to the Trust's general policy format. Sonya Batchelor, Non-Executive Director, queried whether the documents would be reconsidered if the role of Governors changed. The Director of Finance confirmed that the normal review cycle was two years, or earlier where circumstances or legislation changed. Karen Swainson, Barts Assurance, Internal Auditors, identified several technical amendments for consideration, including updating the reference to the managing conflicts of interest guidance, replacing references to NHS Internal Audit Standards with the Global Internal Audit Standards, and removing an obsolete reference to the Healthcare Commission. The Director of Finance agreed to make the necessary changes. Claire Friend, TIAA, Anti-Crime Specialist, also identified wording within the fraud and corruption section requiring amendment and agreed to provide this directly to the Director of Finance. The Committee then discussed how staff were made aware of the Scheme of Reservation and Delegation and Standing Financial Instructions. The Director of Finance explained that rather than requiring all staff to undertake a single comprehensive training programme, relevant requirements were incorporated into role-specific training, including Essential Knowledge for Managers and training for budget managers. Controls within systems also supported compliance. Karen Swainson, Barts Assurance, Internal Auditors, referred to work by another organisation to develop a concise two-page guide for budget holders signposting them to the relevant parts of the Standing Financial Instructions and Scheme of Delegation. She offered to share this once available, subject to the originating organisation being content for it to be shared. Members considered that such an approach could be useful. The Chair observed that the current assurance did not suggest a material control failure in this area, but that the position should be reconsidered if evidence emerged of staff regularly contravening the requirements.	**RC** **KS**

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	The Committee approved the proposed changes to the Reservation of Powers Policy to the Board and Delegation of Powers and Standing Financial Instructions subject to the addition of the minor changes identified by the Internal Auditors and Anti-Crime Specialist.	
11.	**Anti-Crime Update Report**	
	a) Progress Report Claire Friend, Anti-Crime Specialist, TIAA, introduced herself to the Committee following the retirement of her predecessor and noted her extensive counter-fraud experience. Ms Friend advised that management responses had been received in relation to the asset-management review and that the report had been reissued for any further comments. Ms Friend reported that preparations were also being made for International Fraud Awareness Week from 16 to 20 November, including counter-fraud materials and possible visits to Trust sites. It was noted that upcoming work would include consideration of staff-fraud risks, including risks associated with the use of AI in recruitment and issues concerning staff working while on sickness absence. The Chair observed that the overall themes were broadly consistent with those previously reported. Given Claire Friend's experience elsewhere, the Chair said that he welcomed future insight on good practice elsewhere that might beneficially be applied within the Trust. The Committee noted the report.	
12.	**Internal Audit Report**	
	a) Progress Report Karen Swainson, Barts Assurance, Internal Auditors, presented the Internal Audit progress report. She advised that 16 audit actions were currently recorded on the recommendation tracker, comprising both legacy actions handed over by the previous internal auditors and actions from the current provider. Five actions had fallen due for the meeting and all five had been implemented within their original timescales, which was welcomed as a positive position. In relation to delivery of the audit plan, Ms Swainson reported that the Quarter 2 review of high-risk patient management arrangements/Community Treatment Order referrals had been delayed due to availability, with fieldwork	

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	commencing on 13 October. The report was expected to come to the next meeting. Ms Swainson confirmed that the delay would not affect Internal Audit's ability to deliver its programme before the end of the financial year. In terms of quarter 3 audits, it was noted that the key financial controls audit had been approved and fieldwork was commencing. In addition, the Audit Planning Memorandum for the sickness absence processes audit has been issued and is awaiting management agreement prior to fieldwork commencing. For Quarter 4, scoping work had begun for the review of AI and digital devices. Internal Audit was considering a maturity-assessment approach that would compare the Trust's position with other organisations. The remaining two Quarter 4 audits would enter planning shortly. Ms Swainson also explained that relevant publications were shared with the Chief Financial Officer monthly, so that important developments could be disseminated within the organisation without waiting for the next Committee meeting. The Chair commended the clarity and layout of the new Internal Audit report, considering it a significant improvement on the previous versions. Sonya Batchelor, Non-Executive Director, similarly welcomed the clear visibility that there were no overdue audit actions. The Committee noted the report.	
13.	**External Audit Report**	
	Alison Kennett, Ernst and Young, External Auditors, advised that the 2026/27 external audit had not yet commenced, although planning work was underway. The external auditors were engaging with the Trust's Finance Team regarding the timing of information and data provision. The audit itself was expected to commence in early January 2027. The Chair reiterated his previous request for information on the use of AI within the external-audit process. Alison Kennett confirmed that this was expected to be addressed in the external audit planning report, which would come to the January meeting. The Chair confirmed that this timing was acceptable. The Chair thanked Ms Kennett for her update.	
14.	**Minutes of the Finance, Investment and Performance Committee meeting held on 22 July 2026**	
	The minutes of the Finance, Investment and Performance Committee meeting held on 22 July 2026 were received and noted.	

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	Sonya Batchelor, Non-Executive Director, highlighted encouraging performance trends reported through the Finance, Investment and Performance Committee, including improvement in rapid tranquillisation and physical assaults. She particularly welcomed that a breakthrough objective relating to physical assaults was reported as being on target and stressed the value of having reliable data-assurance arrangements alongside positive performance trends.	
15.	**Minutes of the Quality Assurance Committee held on 25 August 2026**	
	The minutes of the Quality Assurance Committee meeting held on 25 August 2026 were received and noted.	
16.	**Minutes of the Quality Executive Committee – July 2026, August 2026 and September 2026**	
	The minutes of the Quality Executive Committee meetings held in July 2026, August 2026 and September 2026 were received and noted.	
17.	**Draft Audit Committee Annual Report to the Council of Governors**	
	The Company Secretary presented the draft annual Audit Committee report to the Council of Governors, which would be updated following the present meeting before submission in December. She explained that annual reporting was good practice given the Council of Governors' role in appointing the external auditors and the resulting relationship between the two bodies. Sonya Batchelor, Non-Executive Director, commended the report as a clear and useful summary of the Committee's work and suggested that other Non-Executive Directors might also find the document valuable. The Company Secretary confirmed that she would be happy for it to be shared. Karen Swainson, Barts Assurance, Internal Auditors, suggested that, under the external-certifications section, the report should more prominently state that the Trust had achieved the highest rating for the NHS Data Security and Protection Toolkit audit, as whilst this was mentioned later in the document it could usefully be highlighted earlier as well. The Company Secretary thanked Ms Swainson for her suggestion. The Committee noted the report.	**JH** **JH**
18.	**Board Sub-Committee Annual Review of Effectiveness Reports**	

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	The Company Secretary presented the report and explained that the Committee had previously completed its own effectiveness assessment and that the purpose of the current item was to provide assurance to the Trust Board that the Audit Committee had also received the outcomes of the annual effectiveness assessments undertaken by the Finance, Investment and Performance and Quality Improvement Committees. The results for both committees were positive, with only minor areas for improvement identified. The Report was noted.	
19.	**Annual Work Plan and Horizon Scan for Future Agenda Items**	
	The Chair invited suggestions for future seminar topics, horizon-scanning subjects or other items to be incorporated into future meetings. No additional proposals were raised during the meeting, although members were invited to contact the Chair or the Company Secretary subsequently should further suggestions arise. The Committee's Annual Work Plan was noted.	
20.	**Items for Escalation to the Trust Board**	
	The Chair invited members to identify any matters arising from the meeting that required formal escalation to the Board. No specific matter was identified for escalation.	
21.	**Any Other Business**	
	There was no other business.	
22.	**Date of Next Meeting**	
	The next meeting of the Committee was scheduled to take place on 27 January 2027.	

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

Signed: - _____

Date: - **27 January 2027** _____

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