

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

TRUST BOARD MEETING

(conducted electronically via Microsoft Teams)

10:00am on Tuesday 08 September 2026

AGENDA

No	Item	Category	Presenter	Enc.	Timings
OPENING BUSINESS					10.00-10.05
1.	Chair's Welcome and Public Questions	Note	Frances West, Chair	Verbal	
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 14 July 2026	Decision	Frances West, Chair	Enc.	
5.2	Action Log and Matters Arising	Assurance	Frances West, Chair	Enc.	
QUALITY					10.05-10.40
6.0	Board Story – Mental Health Patient	Assurance	Debbie Fulton, Director of Nursing and Therapies/ Versha Mandalia, Associate Nurse Consultant/Helen Bowden, Named Worker	Verbal	
6.1	Patient Experience Quarterly Report	Assurance	Debbie Fulton, Director of Nursing and Therapies	Enc.	
6.2	Quality Assurance Committee a) Minutes of the meeting held on 25 August 2026 b) Terms of Reference c) National Patient Safety Strategy d) Learning from Deaths Quarterly Report	Assurance and ratification of the changes to the Quality Assurance Committee's Terms of Reference	Sally Glen, Chair of the Quality Assurance Committee Dr Tolu Olusoga, Medical Director	Enc.	

No	Item	Category	Presenter	Enc.	Timings
	e) Guardians of Safe Working Report				
6.3	Winter Planning Assurance Report	Decision	Theresa Wyles, Chief Operating Officer	Enc.	
EXECUTIVE UPDATE					10.40-10.55
7.0	Executive Report	Assurance	Julian Emms, Chief Executive	Enc.	
7.1	a) Health and Wellbeing Update Report b) Wellbeing Matters Update Report	Assurance	Alex Gild, Deputy Chief Executive/Jnae Nicholson, Director of People	Enc.	
PERFORMANCE					10.55-11.10
8.0	Month 04 2026/27 Finance Report	Assurance	Paul Gray, Chief Financial Officer	Enc.	
8.1	Month 04 2026/27 Performance Report	Assurance	Theresa Wyles, Chief Operating Officer	Enc.	
8.2	a) Finance, Investment and Performance Committee meeting held on 22 July 2026 b) Changes to the Committee's Terms of Reference	Assurance and ratification of the changes to the Committee's Terms of Reference	Sonya Batchelor, Chair, Finance, Investment and Performance Committee	Verbal Enc.	
STRATEGY					11.10-11.20
9.0	Workforce Race Equality Standard Report	Assurance	Alex Gild, Deputy Chief Executive/Jane Nicholson, Director of People	Enc	
9.1	Workforce Disability Equality Standard Report	Assurance	Alex Gild, Deputy Chief Executive/Jane Nicholson, Director of People	Enc.	
CORPORATE GOVERNANCE					11.20-11.25
10.0	Audit Committee Meeting a) Minutes of the meeting held on 22 July 2026 b) Changes to the Committee's Terms of Reference	Assurance and ratification of the Committee's Terms of Reference	Rajiv Gatha, Chair, Audit Committee	Enc.	
10.1	Use of the Trust Seal	Note	Paul Gray, Chief Financial Officer	Enc.	
10.2	Council of Governors Update	Note	Frances West, Chair	Verbal	
Closing Business					11.25-11.30
11.	Any Other Business	Note	Frances West, Chair	Verbal	

No	Item	Category	Presenter	Enc.	Timings
12.	Date of the Next Public Trust Board Meeting – 10 November 2026	Note	Frances West, Chair	Verbal	
13.	CONFIDENTIAL ISSUES: To consider a resolution to exclude the press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.	Decision	Frances West, Chair	Verbal	



Unconfirmed minutes

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Minutes of a Board Meeting held in Public on Tuesday, 14 July 2026

(Conducted via Microsoft Teams)

Present:	Frances West	Trust Chair
	Mark Day	Non-Executive Director
	Sonya Batchelor	Non-Executive Director (<i>not present for agenda item 10.1</i>)
	Aileen Feeney	Non-Executive Director
	Rajiv Gatha	Non-Executive Director
	Sally Glen	Non-Executive Director
	Julian Emms OBE	Chief Executive
	Alex Gild	Deputy Chief Executive
	Debbie Fulton	Director of Nursing and Therapies
	Paul Gray	Chief Financial Officer
	Dr Tolu Olusoga	Medical Director
	Theresa Wyles	Chief Operating Officer
In attendance:	Julie Hill	Company Secretary
	Jane Nicholson	Director of People
	Ash Ellis	Deputy Director for Leadership, Inclusion and Organisational Experience (<i>present for agenda item 7.1 and 9.1</i>)
	Karla Inniss	Head of Inclusion, OD and Organisational Equality and Diversity (<i>present for agenda item 9.1</i>)
	Stephen Strang	Workforce Planning and Insights Manager (<i>present for agenda item 7.1</i>)
	Mark Davison	Chief Information Officer (<i>present for agenda item 9.2</i>)
	Kate Townsend	Sustainability Lead Manager (<i>present for agenda item 9.3</i>)

26/118	Welcome and Public Questions (agenda item 1)
	The Chair opened the meeting and confirmed that the scheduled August public Board meeting had been cancelled, as there were no pressing matters requiring a meeting during that period. There were no public questions.
26/119	Apologies (agenda item 2)
	There were no apologies.
26/120	Declaration of Any Other Business (agenda item 3)
	There was no other business.
26/121	Declarations of Interest (agenda item 4)
	i. Amendments to Register – none.
	ii. Agenda Items Sonya Batchelor, Non-Executive Director declared an interest in agenda item 10.1 (appointment of a new Senior Independent Director) and withdrew from the meeting.
26/122	Minutes of the previous meeting held on 12 May 2026 (agenda item 5.1)
	The Minutes of the Trust Board meeting held in public on Tuesday, 12 May 2026 were approved as a correct record.
26/123	Action Log and Matters Arising (agenda item 5.2)
	The schedule of actions had been circulated. The Trust Board: noted the report.
26/124	Board Story – Mental Health in Schools (agenda item 6.0)
	The Mental Health in Schools Board Story was postponed to the November 2026 meeting.

26/125	Annual Complaints Report (agenda item 6.1)
	The Director of Nursing and Therapies presented the paper and explained that it brought together information already seen by the Board through quarterly patient experience reporting. It was noted that the complaints percentage remained broadly consistent with previous years and that there were no exceptional issues to draw to the Board's attention. Sally Glen, Non-Executive Director asked whether complaints data had provided any earlier indication of concerns relating to speech and language therapy and occupational therapy, particularly in relation to children's services and the Quality Concerns Register. The Director of Nursing and Therapies explained that those services had been placed on the Quality Concerns Register because of known long waits, rather than because of concerns about the quality of clinical care or treatment. She confirmed that complaints were used as part of triangulation and would prompt further review if a pattern of concerns emerged, but that the complaints report did not indicate specific quality concerns in those areas. Sonya Batchelor, Non-Executive Director asked that the Board formally acknowledge the team's achievement in maintaining a 100% response rate to complaints and the very low level of complaints overall, reported as 0.038%. The Chair agreed and thanked staff for their work in ensuring complaints were addressed. The Chair asked whether learning was captured when the Trust contributed to multi-agency complaint responses led by other organisations. The Director of Nursing and Therapies confirmed that the Trust investigated its own element of care in the same way as for a complaint directed solely to the Trust and provides that information to the lead organisation so that a single coordinated response can be sent to the complainant. The Trust Board: noted the assurance contained in the report.
26/126	Medical Appraisal and Revalidation Annual Report (agenda item 6.2)
	The Medical Director presented the report and advised that, subject to Board approval, the confirmation statement would require signature by the Chair or the Chief Executive. He confirmed that there were no additional matters to highlight beyond the report. Sally Glen, Non-Executive Director asked whether job planning formed part of the appraisal process for consultants.

	The Medical Director explained that job planning was a separate process, with its own annual cycle from December to March, and reported that the revised process had resulted in 100% job planning approvals. Ms Glen also asked whether appraisal discussions included doctors' interests in quality improvement, audit or research. The Medical Director confirmed that the appraisal process covered the doctor's full scope of practice, including the six supporting areas required by the General Medical Council, and that the individual doctor and appraiser discussed which areas they wished to focus on. Aileen Feeney, Non-Executive Director sought clarification on the two doctors who had not been appraised. The Medical Director explained that deferrals can occur for reasons such as insufficient evidence, maternity leave, sickness or sabbatical. In the two cases referred to, one doctor had been on long-term sabbatical and subsequently left the organisation, while the other had been on sickness absence and the appraisal process was now being progressed following their return. The Medical Director assured the Board that, where doctors left the Trust, relevant information was transferred to the next employer so that any outstanding issues could be followed up. Sonya Batchelor, Non-Executive Director asked whether the two doctors who had not been appraised were connected to the two fines referenced elsewhere in the papers. The Medical Director clarified that the fines related to resident doctor rotas and were entirely separate. The Chair asked whether annual appraisal was linked to doctors' registration and revalidation requirements. The Medical Director confirmed that every doctor must be appraised annually and underwent revalidation every five years. The Trust Board: a) Noted the assurance contained in the report. b) Approved the Trust Chair or the Chief Executive signing the statement of compliance.
26/127	Quality Assurance Committee (agenda item 6.3)
	a) Quality Assurance Committee Meeting held on 26 May 2026

Sally Glen, Chair of the Quality Assurance Committee provided an update from the Quality Assurance Committee, noting that Aileen Feeney, Non-Executive Director had chaired the meeting.

It was noted that the Committee had received two frontline staff presentations. The first related to the Mental Health Crisis Team transformation, including embedding a single assessment model and non-medical prescribing, with a focus on consistency across six localities.

Ms Glen reported that the Committee had noted the pressure on the service due to increased referrals and acknowledged the team's work in managing transformation in a pressured environment. The second presentation related to Phoenix, the Tier 4 CAMHS day service, which remained on the Quality Concerns Register. The Board noted the major transformation programme under way, including development of clinical pathways, workforce and therapeutic environment improvements, and engagement with patients, carers and families.

Ms Glen highlighted the Patient Safety Learning Report and the continued embedding of the Patient Safety Incident Response Framework. It was noted that 37% of learning responses related to low or no harm incidents, demonstrating a shift towards learning from all incidents, identifying risk earlier and implementing improvements before harm occurred.

b) Learning from Deaths Report

The Medical Director presented the report and confirmed that, following feedback from the previous meeting, the report had been made clearer in relation to avoidability. For physical health deaths, a judgement was made as to whether the death was avoidable; in quarter four, none were deemed avoidable. For deaths relating to mental and physical health, the Trust also assesses the overall quality of care. In 10 cases there were aspects of care that fell below the expected standard and learning had been identified.

The Medical Director also reported that 15 reviews related to individuals with a learning disability and had been reported in line with national guidance. There were no family complaints requiring a second stage review in the quarter.

c) Guardian of Safe Working Practices

The Medical Director presented the Guardian of Safe Working Report and explained that a new system for recording exception reports had been introduced in February 2026. It was noted that there had been 16 exception reports in the period, slightly higher than the previous quarter but not at a level of concern. Two fines of £106.32 each had been levied in relation to doctors working beyond their regular hours.

The Medical Director confirmed that these cases involved newly qualified doctors who had continued working beyond their expected finish time, partly because they felt unable to

	leave while senior colleagues remained at work. The Trust was working with those doctors to reinforce that it was appropriate to leave when their shift ended. Sonya Batchelor, Non-Executive Director asked for assurance that the issue did not reflect a broader culture of newly qualified doctors feeling obliged to remain because senior colleagues were still present. The Medical Director confirmed that Trust's approach was that staff should work smartly and leave at the appropriate time to maintain work-life balance. The Chair asked how the Trust monitored doctors who undertook additional shifts, including agency shifts, which could potentially exceed safe working thresholds. The Medical Director advised that doctors working beyond 48 hours were required to sign a waiver and that further work was under way to tighten oversight of doctors and those taking additional shifts. The planned electronic rostering system, including bank and agency functionality, would support clearer tracking of additional hours. The Trust Board: noted the reports for assurance.
26/128	Executive Report (agenda item 7.0)
	The Executive Report had been circulated. The following items were discussed further: a) Nursing Band 5 Job Evaluation The Chief Executive highlighted the significant work being undertaken to review, align and standardise nursing job descriptions. The Chief Executive acknowledged the scale, complexity and sensitivity of the work, noting that it was progressing well and that the Trust was ahead of many others nationally. The Director of Nursing and Therapies added that realigning job descriptions was relatively straightforward, but that the associated individual conversations with staff would be the more significant element. More than 300 staff would require individual discussions. The Trust aimed to complete the work well ahead of the national deadline and before the new financial year. Future work would extend to other bands, with an approved pool of job descriptions to avoid unnecessary proliferation of local variations. Sonya Batchelor, Non-Executive Director acknowledged the scale and complexity of the work and asked about the potential financial implications, including whether staff might be found to be working above their current band and whether back pay could be required. The Director of Nursing and Therapies explained that national provision had been made through the pay uplift and that, while she did not believe the Trust had many staff working above band, individual cases may emerge. Jane Nicholson advised that principles used previously for band 3 and 4 reviews would be followed and agreed with unions, and that legal limitations would also apply to back pay.

	The Chief Financial Officer confirmed that the Trust had received a small uplift from April to cover expected costs, but that any payments relating to periods before April would create an additional unfunded pressure. He did not expect the overall impact to be material, but a retrospective calculation would be undertaken once costs were clearer. Sally Glen, Non-Executive Director asked whether staff side representatives were content with the process and whether local university education provision aligned with the refreshed national job profiles. The Director of Nursing and Therapies confirmed that local universities had always had to meet professional standards and that students are supported through placement competency assessment. The Director of Nursing and Therapies also confirmed that staff side colleagues and full-time officers had been engaged early, were involved in consistency checking, and were supportive of the Trust's approach. b) NHS England's Head of Cyber Security Letter to Trusts Mark Day, Non-Executive Director asked about cyber security and emergency preparedness, referencing recent cyber incidents affecting other organisations. The Deputy Chief Executive explained that the Chief Operating Officer and the divisions were reviewing emergency preparedness, given recent examples of significant disruption at other trusts and organisations. It was noted that, while the Trust had business continuity arrangements and had itself managed previous disruption to systems, the changing context meant the Board needed assurance that robust plans were in place for a significant system failure. The Trust Board: noted the report for assurance.
26/129	Ethnicity and Disability Pay Gap Reports (agenda item 7.1)
	The Chair welcomed the Director of People, Ash Ellis, Deputy Director for Leadership, Inclusion and Organisational Experience and Stephen Strang, Workforce Planning and Insights Manager to the meeting. The Deputy Chief Executive explained that unlike the gender pay gap, the ethnicity and disability pay gap reports were not mandated in the NHS but were good practice and consistent with the Trust's Inclusion and Equity Strategy. The Deputy Chief Executive highlighted the transparency provided by the analysis, particularly in relation to the ethnicity median pay gap and differences in starting pay points, while noting that the disability pay gap showed broad parity and was slightly in favour of disabled staff.

	The Director of People thanked colleagues involved in developing the reports. The Director of People explained that the disability report was broadly reassuring, with no material pay gap identified. In relation to ethnicity, she highlighted that ethnically diverse staff were clustered both in medical staffing and in lower-banded roles, and that demographic differences may contribute to the analysis. The Director of People said that the key question for further work was why white staff appeared to start higher within pay bands when entering roles. It was noted that pay point under Agenda for Change was linked to experience, but the Trust needed to understand whether decisions to appoint at higher pay points were equitable and consistently evidenced. Sonya Batchelor, Non-Executive Director welcomed the quality and clarity of the reports and asked about timescales for further analysis of starting pay points. The Director of People explained that the work would be taken to the People Directorate Programme Board and scoped as a project with the recruitment team. A sample of recent appointments would be reviewed to understand the rationale for starting pay decisions and whether additional assurance processes were required. Sally Glen, Non-Executive Director asked whether ethnicity data had been stratified further, noting that aggregated data can mask differences between ethnic groups. The Director of People agreed and noted that different ethnic groups can have very different outcomes. It was noted that additional information was available in the appendices to the report and that further specific analysis could be provided if required. In relation to disability, the Director of People noted that future analysis should consider whether staff with different types of disability experience different outcomes, for example neurodivergent staff compared with staff with physical disabilities. The Chief Operating Officer added that the national NHS Staff Survey data suggested disabled staff report lower perceptions of fairness and experience, which should be considered alongside the pay gap findings. The Chair asked whether employee relations casework had been analysed in relation to disabled staff. The Director of People confirmed that such analysis existed and undertook to share the relevant casework report with the Chair. Action: Director of People The Chair thanked the Director of People and her team for the depth and quality of the work. The Trust Board: noted the assurance contained in the reports.
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26/130	Month 02 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. • All main commissioner contracts had been agreed and signed off. • 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. • All key financial metrics were green except the bank reduction target. • The Trust had two targets for temporary staffing, set by NHS England as part of the planning guidance. The agency target was being achieved. • The bank target was not being achieved; however, it was set by applying national rules to the Trust's 2025/26 expenditure and the Trust overachieved against the NHS England target set for that year. The bank reduction target would remain challenging and should be considered in the context of the overall financial and pay position. Pay was £0.5m under plan for the first two months, supported by vacancies, while agency costs were £0.4m lower than the same period last year. • There were ongoing non-pay risks, particularly out of area placements and PICU. The Trust was above plan for placements, creating approximately £0.2m of pressure, partly offset by lower spend on specialist placements. • The capital plan was £15.1m, with a forecast overspend largely related to items for which cash had already been received. Cash was ahead of plan at the end of March due to timing differences, late-year income and capital slippage. Sonya Batchelor, Non-Executive Director asked for a revised forecast for PICU and out of area placements, and for further analysis of recurrent and non-recurrent savings within the cost improvement programme. The Chief Financial Officer confirmed that the Trust continued to forecast delivery of the plan but agreed to provide a headline forecast based on the first three months and further detail through the Finance and Investment Committee. Action: Chief Financial Officer The Chair asked that a summary of the Committee's discussion be brought back to a future Board meeting, potentially through a discursive session. Action: Chief Financial Officer Sally Glen, Non-Executive Director asked whether the Trust had a credible rationale for bank usage, given that bank staff provide flexibility and continuity of care. The Director of Nursing and Therapies confirmed that 70% of bank staff were the Trust's own staff undertaking additional hours, and that using the bank was a conscious decision

	to maintain quality, flexibility and continuity. Bank staff received training alongside substantive staff and were often already familiar with the patients and services. The Trust Board noted the report and took assurance from the overall financial position, while recognising the need for continued focus on emerging risks.
26/131	Month 02 2026-27 “True North” Performance Scorecard Report (agenda item 8.1)
	The Month 02 2026-27 “True North” Performance Scorecard Report had been circulated. The Chief Operating Officer presented the report and highlighted the following points: • The acute length of stay breakthrough objective - performance was 50 days against a target of 42 days. Although still above target, the position was improving and the proportion of patients staying over 60 days had reduced from 29% in April to 21% in month two. • The Chief Operating Officer and Medical Director were undertaking fortnightly long length of stay reviews with clinical teams, alongside a May sprint cycle involving senior colleagues working with ward teams, patients and carers to identify improvement actions. • The clinically ready for discharge target remained above target, with 579 days lost against a target of 350. Reading was the largest contributor, and the Chief Operating Officer had met Reading Local Authority and Integrated Care Board colleagues to explore process improvements, while recognising the complexity of local placements. • Out of area placements remained above plan, including four inappropriate out of area placements and ongoing female PICU demand. Work was progressing through the mental health provider collaborative to jointly procure a female provision that better meets Thames Valley demand. • Older adult occupancy was around 85%, with length of stay at 104 days against an 80-day target; teams were focused on improving discharge planning, particularly where patients require onward placement. Sally Glen, Non-Executive Director asked about crisis response performance and whether NHS 111 option two referrals were affecting the percentage of patients receiving face-to-face contact within 24 hours. The Chief Operating Officer explained that the Trust had directed 111 mental health crisis calls into local services to support local access. Over time, demand through that route had increased significantly, and 111 referrals carry a defined response time not based on clinical need. This was affecting overall demand and response performance. A senior oversight group had been established, and the issue was being considered through the productivity and efficiency programme, particularly in relation to overnight models of support.

	Sonya Batchelor, Non-Executive Director welcomed the sustained green performance on rapid tranquillisation and commended the work on length of stay. Ms Batchelor asked whether the 42-day target was realistic and whether the target of zero children waiting more than 52 weeks was achievable. The Chief Operating Officer confirmed that the 42-day target was stretching but appropriate, as reducing length of stay supported flow and reduced the number of patients waiting in the community. The Medical Director added that external pressures, including potential demand from prisons and the need to support staff wellbeing and address violence and aggression, could affect sustainability. The Chief Operating Officer explained that an improvement plan was in place to address children waiting over 52 weeks, including additional capacity over the summer, recruitment to replicate the advice and information line model in the west, and validation of waiting lists to ensure consistent counting. The Chief Operating Officer confirmed that the Trust had moved from segment 1 to segment 2 of the National Oversight Framework. The Chief Operating Officer explained that, while the Trust's league table position had improved, segmentation had changed and further clarity was awaited on revised scoring metrics. The Chief Executive confirmed that, provided the Trust remained in segment one or two, there was no immediate concern in relation to foundation trust status. The Trust Board: received assurance from the report.
26/132	People Progress Report (agenda item 9.0)
	The Director of People reported that the workforce risk on the Board Assurance Framework had been reviewed, and the risk score had been reduced slightly to reflect a more stable position. The Director of People presented the paper and highlighted the following points: • There was a move from measuring turnover to measuring retention, with a target of maintaining retention around 90%; current performance was at 88.6%. • Sickness absence averaged 4.6% against an in-year target of 4.1% and a longer-term ambition of 3.5%. A deeper review of sickness absence would commence in September, with support from the Quality Improvement team. • The People Directorate was focussing on three major projects:

	○ the job evaluation review, which was progressing well with union and operational support; ○ the casework review, which had four workstreams and was progressing to plan; and ○ the sickness absence work described above. Sally Glen, Non-Executive Director asked about the increase in employment tribunal cases and whether this reflected a national trend and whether there was any learning. The Director of People confirmed that tribunal cases were increasing nationally. The removal of tribunal fees and use of AI to develop claims had reduced some of the barriers to making a tribunal case. It was noted that the Trust was seeing increasingly complex cases and that the casework review was intended to identify learning. The Director of People outlined the casework review focus areas, including disproportionate involvement of men and particularly Black men at Prospect Park Hospital, review of the Maintaining High Professional Standards processes for medics, support for leaders and managers, and streamlining processes while remaining fair and compliant with ACAS guidance. The Chair thanked the Director of People for a comprehensive report. The Trust Board: noted the assurance contained in the report.
26/133	Anti-Racism Strategy – Progress, Delivery and Programme Review Report (agenda item 9.1)
	The Chair welcomed Karla Inniss, Head of Inclusion, Organisational Development (OD) and Organisational Equality and Diversity to the meeting. The Deputy Chief Executive reminded the meeting that the Board had committed three years earlier to an anti-racism action statement. This had moved the Trust from observing persistent inequity in the data to taking credible action shaped by those affected. The Deputy Chief Executive highlighted the importance of engaging communities and staff in defining actions and closing the feedback loop, supported by collective leadership from the Board and executive colleagues. The Head of Inclusion, OD and Organisational Equality and Diversity presented the paper and highlighted the following points: • The work had been directed by staff and shaped with communities, including the Race Equality Network, Equity Partnership Group and Community Forum. • Anti-racism was now more visible in organisational culture, and tangible actions, including storytelling, skin tone bias tools, multi-faith work and longer-term community connections, had built trust and credibility.

- Across the five workstreams, 75 actions had been identified, with 50 complete and 25 in progress, many relating to embedding work already launched.
- Learning from the programme included the complexity and long-term nature of addressing patient disparities, the importance of combining data with lived experience, and the value of sustained leadership involvement.
- There had been significant progress, including 45% of senior appointments being to ethnically diverse staff, closure of the Continuing Professional Development gap, improved career perception and reduced staff-to-staff bullying and harassment gaps.
- Further work remained on senior representation, abuse against staff, consistent practice, patient access and outcomes, and disproportionate disciplinary processes.

Aileen Feeney, Non-Executive Director asked whether progress was being communicated sufficiently across the wider organisation, given that survey results do not always reflect the breadth of work taking place.

The Head of Inclusion, OD and Organisational Equality and Diversity explained that engagement scores for ethnically diverse staff had improved and that the team continued to use pop-ups, site visits, accredited offers and targeted engagement to reach staff. She noted that some progress is felt through qualitative feedback before it appears fully in quantitative metrics.

Ms Feeney also asked about reciprocal or reverse mentoring.

The Head of Inclusion, OD and Organisational Equality and Diversity explained that she was cautious about models that can be exploitative or tick-box if not designed well and considered that the Trust's current approach of building racial literacy through proximity to actions and escalation routes was more impactful.

Sally Glen, Non-Executive Director asked for clarification on wording in the report relating to complexity across professions, including allied health professionals and psychology.

The Head of Inclusion, OD and Organisational Equality and Diversity explained that the data had been disaggregated by role type to understand senior representation and what actions might be required in different professions.

The Chair commended the Trust's work and its commitment to taking proactive action to tackle racism.

The Chair also paid tribute to the work of the Head of Inclusion, OD and Organisational Equality and Diversity and Deputy Director for Leadership, Inclusion and Organisational Experience for their significant contribution in implementing the anti-racism strategy.

The Trust Board: noted the assurance contained in the report.

26/134	Digital Strategy Update Report (agenda item 9.2)
	The Chair welcomed Mark Davison, Chief Information Officer to the meeting. The Deputy Chief Executive reported that the current digital strategy was coming to its conclusion and that future digital priorities would be integrated into the implementation plan for the Trust's new five-year strategy and the 3P objectives (people, productivity and partnerships). The Chief Information Officer presented the report and advised that the strategy had delivered against its intended outcome measures, including increased patient engagement with digital healthcare and significant efficiency and productivity benefits across 24 programmes and projects. The Chief Information Officer Mark highlighted three key continuing risk areas: • Community services scheduling, where the NHS market did not yet offer a sufficiently mature enterprise resource management solution; • Efficient medicines management, including pharmacy integration, future replacement of robots and medicines prescribing solutions; and • Modern digital staff management, given that the Trust was not an early implementer of the new national staff record solution and may need to continue with existing systems until at least 2029 or 2030. • There was ongoing work on ambient voice technology and AI to reduce clinical recording burden, with procurement activity planned during the year and implementation expected from early 2027. Aileen Feeney, Non-Executive Director acknowledged the progress and asked about the reported 492,000 hours saved. The Chief Information Officer explained that the figure was cumulative across the five-year plan and that, once annual planning baselines are reset, earlier savings are no longer tracked in the same way, although savings from current projects continue to be identified. Ms Feeney also asked how staff were responding to the 24 deployed robots. The Chief Information Officer said that while initial responses had been mixed, teams had now embedded their use; when removal of some robots was proposed, teams highlighted that staff time had already been redeployed to other activities. The Chair proposed that digital strategy should be considered 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. Action: Deputy Chief Executive

	The Trust Board agreed that the report provided assurance and that a fuller discussion should be scheduled.
26/135	Trust's Green Plan Progress Report (agenda item 9.3)
	The Chair welcomed Kate Townsend, Sustainability Lead Manager to the meeting. The Sustainability Lead Manager gave a presentation and highlighted the following points: • The Trust had secured five external funding awards since the end of the previous year, covering LED lighting, a nature trail and wellbeing garden, electronic vehicle charging and infrastructure, and sub-metering. The awards totalled £474,000 and more than doubled the sustainability funding available in-year. • Further bids were in the pipeline, although a bid for rooftop solar at 25 Erleigh Road had been unsuccessful and would be funded through the Trust's own capital budget. • The Trust's Travel and Transport Strategy had been published in January 2026. Travel and transport remained the Trust's second largest carbon hotspot, with around 889 tonnes of carbon emitted annually, equivalent to approximately 500 cars. The strategy included moving salary sacrifice vehicles to electric vehicles by the end of the year and owned and leased fleet vehicles by the end of the following year. Electronic vehicle charging infrastructure was being upgraded and an electronic vehicle charging infrastructure strategy had been published. • Travel across the Trust was around 2.5 million miles annually, with 95% undertaken through grey fleet, and staff engagement, education and awareness would be essential to support more sustainable travel choices. • The Trust's carbon footprint had reduced by 4.8% since the previous year and by 21% against baseline. However, current projections indicated a gap against the midway target unless large-scale and radical projects were implemented. • A key focus for the Trust was prioritising renewable energy projects, including the solar farm and rooftop solar at Prospect Park Hospital, and removing fossil fuels from Trust-owned sites where the organisation had greater control. The Sustainability Lead Manager asked the Board to: • Note the heightened risks for 2026 with the "super" El Nino event, with a pledge to strengthen resilience for our staff and patients. • Support the production of a climate change risk assessment which should be incorporated into the organisation's risk register and reported on in the Annual Board report • Continue to endorse the Green Agenda, sustainability capital projects and sustainability engagement events • Continue to commit to making a plan to move away from fossil fuels Sonya Batchelor, Non-Executive Director welcomed the presentation and noted that, without a transformational project, achieving the 2040 net zero target would be

	challenging. Ms Batchelor suggested a transparent Board-level discussion on the scale of investment, potential NHS England funding and transformational options. The Chair agreed to meet the Lead Sustainability Manager to discuss how the Board's commitments could be translated into action. The Chair thanked Kate for the comprehensive and timely presentation. The Trust Board: a) Confirmed their support for the actions identified above. b) Noted the assurance set out in the presentation.
26/136	Fit and Proper Persons Test Assurance Report (agenda item 10.0)
	The Company Secretary presented the report and confirmed that the required Fit and Proper Persons checks had been completed. The Company Secretary highlighted two minor changes to the declarations of interest register: • The Deputy Chief Executive's declaration was updated to "no interests to declare". • Sonya Batchelor, Non-Executive Director's entry was updated from Interim Chief Executive to Chief Executive of OneCan Trust. The Trust Board: noted the assurance contained in the report. <i>(Sonya Batchelor, Non-Executive Director left the meeting for this item).</i>
26/137	Appointment of a New Senior Independent Director (agenda item 10.1)
	The Chair reported that following Mark Day's departure from the Board, the Council of Governors extraordinary meeting on 15 July 2026 would be asked to approve the appointment of Aileen Feeney, as the Trust's Vice Chair with effect from 1 August 2026. The Chair proposed that Sonya Batchelor, Non-Executive Director be appointed as the new Senior Independent Director from 1 August 2026, subject to consultation with the Council of Governors. The Trust Board: approved the appointment of Sonya Batchelor, Non-Executive Director as the Senior Independent Director from 1 August 2026 subject to consultation with the Council of Governors at the Extraordinary meeting on 15 July 2026. Action: Company Secretary

26/138	Audit Committee Meeting (agenda item 10.2)
	Rajiv Gatha, Chair of the Audit Committee reported that the Audit Committee had met in June to review and approve the Annual Accounts and Annual Governance Statement. It was noted that the Committee approved both documents. Ernst and Young, the Trust's External Auditors had confirmed that they would issue an unqualified audit opinion and had identified no significant issues with the accounts or value for money arrangements. A small number of minor adjustments had been identified. Mr Gatha confirmed that the Committee had challenged key judgements in the accounts and was satisfied that they presented a true and fair view of the Trust's position. It was noted that Ernst and Young had specifically thanked the Chief Financial Officer, Director of Finance and Head of Financial Services and the finance team for their preparedness and responsiveness, which had enabled a smooth audit process. The Chair thanked Rajiv Gatha for his update.
26/139	Council of Governors Update (agenda item 10.3)
	The Chair reported that she had chaired the Council of Governors Appointment and Remuneration Committee, with Sally Glen, Non-Executive Director supporting the panel as a Non-Executive Director member, to interview for a Non-Executive Director with transformation and digital expertise. A provisional offer had been made, subject to approval by the Council of Governors at the Extraordinary meeting on 15 July 2026. The Chair reported that she and the Lead Governor had met the newly elected and appointed governors and had jointly conducted an induction session. It was noted that the Trust had taken the decision to run the public governor elections to ensure that the Council remained quorate. The Chair reported that the Joint Board and Council of Governors meeting in November 2026 would consider the Trust's community engagement work following the proposed removal, through the NHS Bill currently progressing through Parliament, of the requirement for NHS Foundation Trusts to have Councils of Governors.
26/140	Any Other Business (agenda item 11)
	Farewell to Mark Day, Vice-Chair The Chair noted that this was Mark Day, Vice-Chair's last Board meeting. Mr Day would be stepping down from his role having served nearly ten years, including in the role of Interim Chair.

	On behalf of the Board, the Chair thanked Mark Day for his significant contribution to the work of the Trust. The Chair added her personal thanks to Mr Day for all his help and support when she took up her post as Chair in February 2026. Mr Day thanked the Chair for her kind words and said that it had been a privilege to be a member of the Board and commented that Berkshire Healthcare was a special organisation.
26/141	Date of Next Public Meeting (agenda item 12)
	The next Public Trust Board meeting would take place on 08 September 2026.
26/142	CONFIDENTIAL ISSUES: (agenda item 13)
	The Board resolved to meet In Committee for the remainder of the business on the basis that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.

I certify that this is a true, accurate, and complete set of the Minutes of the business conducted at the Trust Board meeting held on 14 July 2026.

Signed..... Date 08 September 2026

BOARD OF DIRECTORS MEETING 08.09.26

Board Meeting Matters Arising Log – 2026 – Public Meetings

Key:

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

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
12.01.24	24/198	Estates Strategy Update	The Quality Assurance Committee to have an opportunity to discuss the outcome of the Prospect Park Hospital Mental Health Survey.	August 2026	PG	Reports relating to the Prospect Park PFI Contract will be considered by the full Board and there is a standing item on the In Committee Board agenda.	
13.01.26	26/011	Performance Report	A “deep dive” into the causes of increased assaults and the use rapid tranquilisation, including the	October 2026	TW		

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
			impact of an increase in the number of detained patients to be presented at a future Finance, Investment and Performance 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		
14.07.26	26/129	Ethnicity and Disability Pay Gap Reports	The Chair to receive a copy of the latest Employee Casework Report.	July 2026	JN	The latest Employee Casework Report was shared with the Chair.	
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		
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	October 2026	AG	On the agenda for the October 2026 Trust Board Discursive meeting.	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
			the appointment of a new Non-Executive Director with digital transformation expertise.				
14.07.26	26/137	Appointment of a New Senior Independent Director	The Council of Governors to be consulted on the appointment of a new Senior Independent Director.	July 2026	JH	The Council of Governors' Extraordinary meeting held on 15 July 2026 fully supported the appointment of Sonya Batchelor, Non-Executive Director as the new Senior Independent Director.	

Trust Board Paper

Board Meeting Date	08 September 2026
Title	Patient Experience Report - Quarter 1 (April to June 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 one 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				
Number of iWGC responses received	Number	61,000 year for 10%	12,814				
iWGC Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	10%	8.03%				
iWGC 5-star score	Number	4.76	4.79				
iWGC Experience score – FFT (good or very good experience)	%	95%	95.72%				
Compliments received directly by services	Number	5600	1484				
Formal Complaints received	Number/ %	268 (0.038%)	81				
Formal Complaints Closed	Number	280	85				
Formal complaints responded to within agreed timescale	%	100%	100%				
Formal Complaints Upheld/Partially Upheld	%	50%	58.8%				
Local resolution concerns/ informal complaints Rec	Number	217	20				
MP Enquiries Rec	Number	56	16				
Complaints upheld/ partially by PHSO	Number	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 complaints in quarter 4 of last year compared to any previous quarter (99); this increase was across multiple services and divisions. For quarter one we have seen some reduction to 81 although this is still above quarters 1-3 of last year.

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 are seen across our mental health inpatient services with ease and involvement being less likely to score positively (under 4 stars).

The wards all have ongoing work to support improvement, 3 of our wards were participating in the full NHS England Culture of Care programme, with the other mental health wards participating in bespoke elements of the programme which was offered to all Mental Health Trusts as part of their transformation programme. This national programme has now concluded but we will continue this work locally.

Overall feedback remains overwhelmingly positive with questions around our staff and involvement continuing to be dominant positive themes. The most significant movement this quarter was involvement and support for family and carers which moved from 100% to 89%, however this was 80% in Q2 and appears to be one of the themes that fluctuates more than others.

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)
Emotional support, empathy & respect	94.3% (-1%)	1.4% (0%)
Involvement in decisions & respect for preferences	93.3% (+2%)	2.9% (0%)
Clear information, communication & support for self care	90.7% (0%)	4.5% (0%)
Effective treatment delivered by trusted professionals	84.0% (-3%)	7.9% (+2%)
Fast access to reliable healthcare advice	77.4% (-3%)	11.0% (+2%)
Attention to physical & environmental needs	66.8% (0%)	13.4% (+1%)
Continuity of care and smooth transitions	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	12.12%	8.36%	10.09%
Black/Black British	3.03%	2.67%	3.40%
Mixed	3.03%	2.62%	3.57%
Not stated	9.09%	25.17%	8.11%

Ethnicity	% Complaints received	% Patient Survey Responses	% Breakdown of Q1 attendances
Other Ethnic Group	2.02%	4.93%	2.21%
White	70.71%	56.24%	72.62%

The table above shows that during this quarter complaints received were broadly in line with attendance percentages. For feedback responses this was the case for most ethnic groups except White, however it is recognised that a quarter of respondents do not provide their ethnicity data on the feedback form.

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 impact on whether we received feedback from complaints.

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 3.

3. Conclusions and Recommendations for consideration by the Board

It is the view of the Director of Nursing and Therapies that there are no specific new themes or trends identified 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 One 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				
Number of iWGC responses received	Number	12,814				
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	8.03%				
iWGC 5-star score	Number	4.79				
iWGC Experience score – FFT	%	95.72%				
Compliments received directly by services	Number	1484				
Formal Complaints Rec**	Number	81				
Number of the total formal complaints above that were secondary (not resolved with first response)	Number	19				
Formal Complaints Closed**	Number	85				
Formal complaints responded to within agreed timescale	%	100%				
Formal Complaints Upheld/Partially Upheld	%	58.8%				
Local resolution concerns/ informal complaints Rec	Number	20				
MP Enquiries Rec	Number	16				
Total Complaints open to PHSO (inc awaiting decision to proceed)	Number	3				

** There were 5 formal complaints received that were not attached to a clinical service/Division, and they cover Information Governance, Records Access and the Complaints Department. There was one formal complaint closed that was for the Complaints Office so not included in a Divisional breakdown.

During Quarter 1, the Trust received 81 complaints, representing a 18.2% reduction compared to Quarter 4, when 99 complaints were received. Complaint closure activity also reduced slightly, with 81 complaints closed during Quarter 1 compared with 90 closures in Quarter 4.

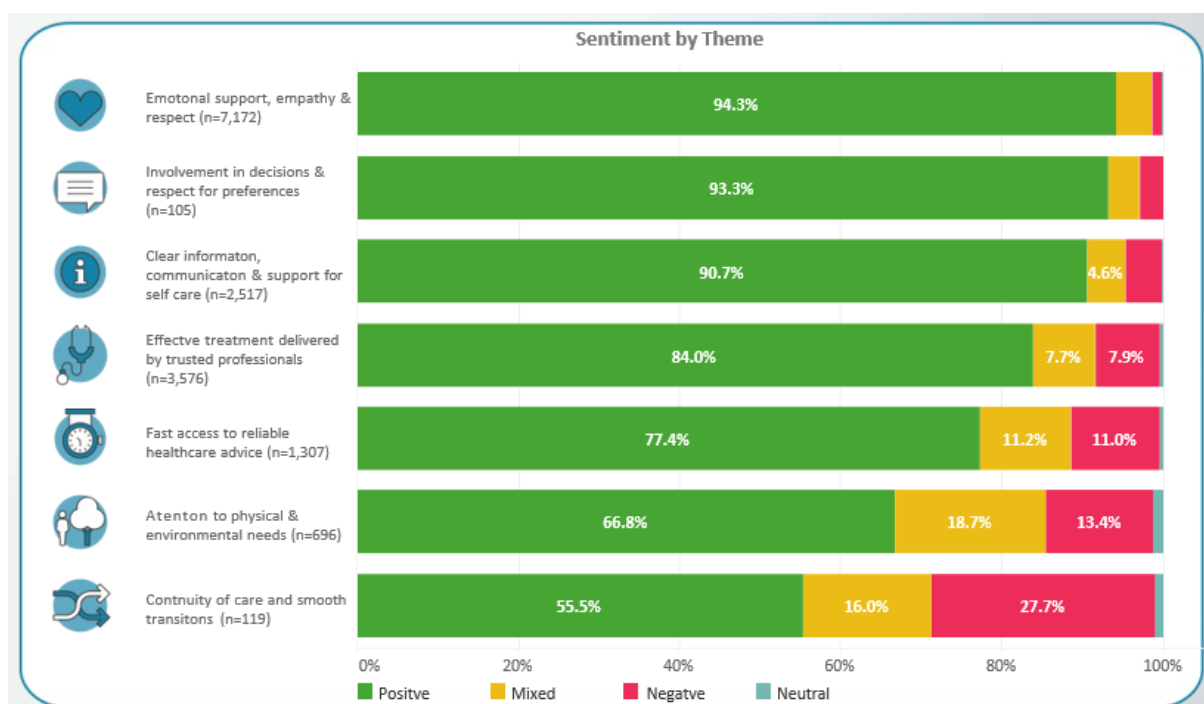
A total of 18 complaints (22.2%) received during the quarter were re-opened complaints, indicating that a proportion of complainants remained dissatisfied with their original response and sought a further review.

The most common themes identified during the quarter were:

- Care and treatment, including concerns regarding clinical decision-making, assessments and ongoing support.
- Communication, particularly around information sharing, responsiveness and patient experience.
- Waiting times and access to services, including ADHD, CAMHS and specialist service pathways.
- Medical records and discharge arrangements, where complainants challenged the accuracy of records or decisions regarding discharge from services.

While these themes were seen across a number of services, no single emerging trend or systemic concern was identified. Complaints remained varied in nature and reflected the breadth of services provided across the Trust.

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.



Appendices contain the PALS and Complaints information for Quarter 1.

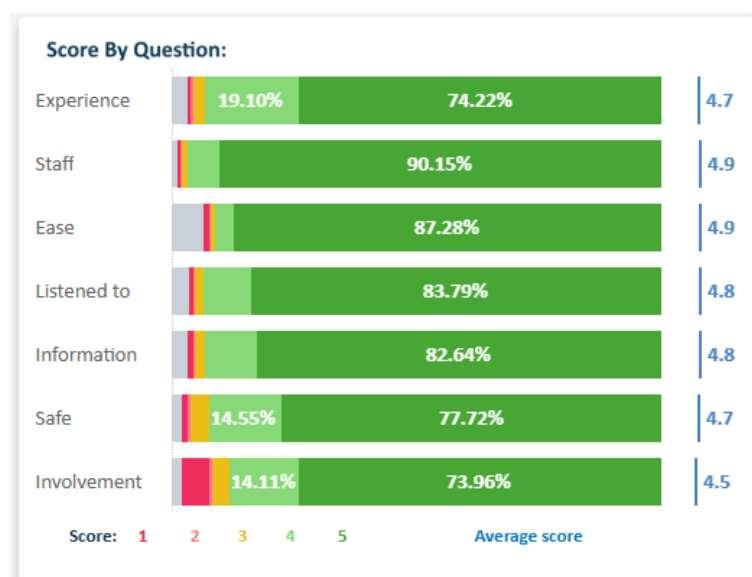
What the data is telling us

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



Of the 4,503 responses, 4,362 responses related to the children's services within the division; these received, with positive comments about staff being helpful and kind and a few suggestions for further improvement, this included 3 reviews for Phoenix House. 118 of the

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 17 formal complaints received across the Children, Young People & Families Division during Quarter 1. Of these, 9 related to Physical Health services and 8 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, eight MP enquiries were received relating to Children's Services. The majority concerned waiting times and access to services, particularly within ADHD, CAMHS and Speech and Language Therapy services.

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

Several investigations resulted in actions to improve how services communicate decisions, involve families in care planning, and ensure records and documentation accurately reflect clinical discussions and agreed actions. Reviews also highlighted opportunities to enhance consistency across care pathways and provide clearer information about assessments, referrals and ongoing support.

Children's Physical Health Services

There were nine formal complaints received for Children's Physical Health Services during Quarter 1.

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

Children's Speech and Language Therapy (CYPIT) received three complaints, covering communication (1), care and treatment (1) and access to services (1). These complaints reflected concerns about communication with families, service provision and whether assessments and recommendations fully met the child's needs.

Health Visiting received three complaints, primarily concerning the level of support provided to families, communication and follow-up arrangements. Both the Community Paediatrics Service and Eating Disorders Service received one complaint each, relating to care and treatment.

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.

4036 of the 4503 patient survey responses were in relation to children's physical health services. The 2 services with most responses were the Immunisation and ADHD Team Children & Young People. ADHD Team Children & Young People services also receive very positive feedback with positivity score of 93.7%- and 5-star rating of 4.81.

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 3565 responses was 96.3% and a 5-star rating of 4.71. Feedback included that the injection was quick, and nurses were kind. "Very kind and helpful and made me feel safe." with the themes to improvements including make it less painful, wanted to be told before they were injected and would rather have the nose spray.

Child and Adolescent Mental Health Services (CAMHS)

There were four formal complaints received relating to CAMHS Services during Quarter 1. These were received across CAMHS General, CAMHS Getting Help and CAMHS Rapid Response.

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 306 responses for CAMHS services received through our patient survey for this Quarter. These include 194 received from those attending our neurodiversity services (positive score 95.31% and star rating of 4.84 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 complaint concerned the management of a referral within the service, specifically relating to concerns that the patient had been discharged without notification and the accuracy of information held within records.

The Adult ADHD service received 30 responses with a 3.83 average 5-star score and a 56.7% positive score. Positive feedback included patients felt listened to and staff were kind. 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) concerning the adequacy of care planning, responsiveness of the service, communication with the family, and the management of risk for a patient with complex needs.

Overall, there were 118 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 92.4% positive score; feedback included that staff were helpful, *"Both [Name Removed] and her colleague did a great assessment for my aunty. They were very helpful, caring and listened to our concerns. Thank you to them both."* there were comments for improvements including staff need to listen, want longer appointments, service is slow and want to be treated in a calm way. The 7 responses that received with a score below 4 left comments including "Sometimes I feel like nothing gets done quickly and I get upset."

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

Eating disorders

There was one formal complaint received relating to the Eating Disorders Service. This related to concerns about the patient's care, whether reasonable adjustments had been appropriately considered, communication with the family, and the handling of safeguarding concerns.

Of the 33 feedback responses received, 31 scored a 5 with comments such as *"I had an assessment at the Erlegh House centre with [Name Removed]. [Name Removed] made me feel comfortable and welcome. I felt that she really listened to what i had to say and was easy to talk to. I didn't feel pressured into anything I wasn't ready to challenge and there was lots of time available to discuss everything without feeling rushed. Thank you!"* *"[Name Removed] was great she made me feel comfortable explaining what I have been experiencing and I felt listened too. Which after my session felt good to know I'm not alone and will get support to get better."* *"[Name Removed] is supportive, kind, a great listener and always goes over and above to help me on my journey even when I question the steps she'd like me to take. I would never have survived without her being there. She doesn't judge or criticise and most of all she believes in me. Thank you."* Areas for improvement included listen to patient instead of their patient and shorter wait times.

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

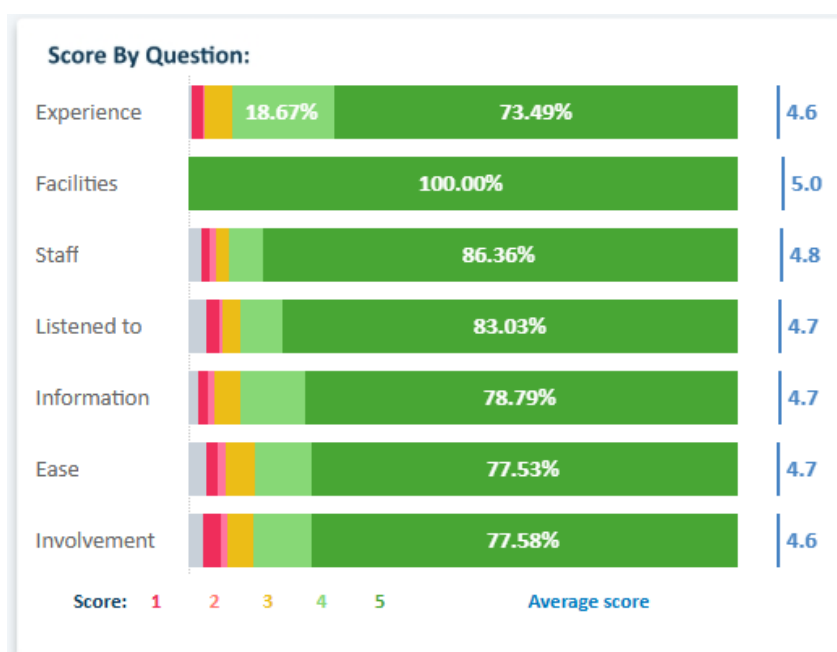
- Service-user led activities in the 'Together' Group, which is a co-delivery participation space where service-users suggest psycho-social activities (e.g. some 'summer of fun activities' for families open to children's social care, World Mental Health Day activities, 'couch to 5k'). This group originated from service-user feedback and is entirely co-produced. These are families who have children's social care involvement and have limited access to such groups and feel stigmatised and marginalised within 'universal access' (a recent quote from one service user: "these are the only groups I feel I can come too without feeling embarrassed about having a social worker. We all have *stuff* going on and we don't judge each other").
- The service 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			
Response rate (calculated on number contacts)	%	3.72%			
iWGC 5-star score	Number	4.69			
iWGC Experience score – FFT	%	92.17%			
Compliments received directly by services	Number	393			
Formal Complaints Rec	Number	19			
Formal Complaints Closed	Number	22			
Formal Complaints Upheld/Partially Upheld	%	59%			
Local resolution concerns/ informal complaints Rec	Number	0			
MP Enquiries Rec	Number	2			



There were 19 formal complaints received across Mental Health East services during Quarter 1. 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. A smaller number of complaints related to medication management, confidentiality, waiting times and the accuracy of clinical records. Overall, no single theme predominated, with complaints reflecting a broad range of issues across the directorate.

Of the complaints closed within Mental Health East, a significant proportion were partially upheld or upheld, demonstrating that learning opportunities were identified across a number of services. The most common areas for learning related to communication, care coordination, service responsiveness and clinical documentation.

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 55 responses, CMHT WAM with 44 responses and Memory Clinic Bracknell with 38 responses.

Across the CRHTT East survey, the average 5-star score was 4.52 with 87.3% positive feedback. 48 of the overall number of responses received (55) scored a 4 or 5-star rating with many comments about staff being supportive, listened, kind and helpful; *“Dr [Name Removed] listened to me and I feel his diagnosis was correct. I trust he will follow up on helping me to get the treatment I need to get well.”* *“The service wasn’t very good, it was excellent! Excellent! [Name Removed] was amazing, she helped me so much, she gave medicine. [Name Removed] was an inspiration - I want to be just like her. Excellent service. My whole family loves the Crisis Team. I’m feeling so much better now because of them.”*

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 100% positive score (4.88-star rating) and received positive feedback about staff being professional, understanding, and listened. *“Made to feel*

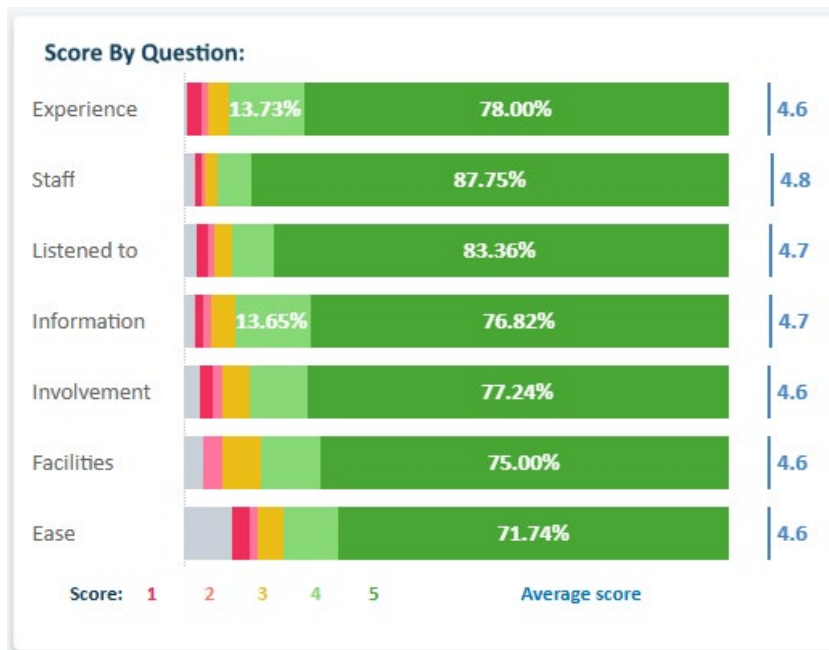
very relaxed and comfortable. Felt Dr listened and was very informative, pleasant and understanding.”

CMHT received 95 responses (Bracknell 38, Slough 24, and WAM 44) with 93.7% positive score and 4.68 star with 6 of the total responses scoring less than a rating of 4; comments included *“Receptionist was struggling. Dr [Name Removed] told me he’d call me yesterday and didn’t. I feel nobody is listening to me.”* And *“The consultant says little or nothing and doesn’t seem to have any great knowledge of bipolar disorder. He gives no opinion or advice I may as well been sitting in there on my own.”*. There were several positive comments that staff it was really good session. The Doctor was such great was listening to me very carefully and discussed what I needed. Can’t ask for more.”, *“Psychiatrist is fantastic Dr [Name Removed] is the best consultant I have ever had. He is kind caring and compassionate and makes sure I have understood everything that is going on. He involves me in my care, he is wonderful.”* And *“I saw [Name Removed] two times for initial assessment to see what kind of therapy I required. Both times I saw [Name Removed] she was very kind, professional and really listened.”* Some of the suggestions for improvement included long wait for appointment and various issues regarding prescriptions. 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			
Response rate (calculated on number contacts)	%	5.89%			
iWGC 5-star score	Number	4.69			
iWGC Experience score – FFT	%	92.11%			
Compliments received directly by services	Number	56			
Formal Complaints Rec	Number	20			
Formal Complaints Closed	Number	16			
Formal Complaints Upheld/Partially Upheld	%	62.5%			
Local resolution concerns/ informal complaints Rec	Number	3			
MP Enquiries Rec	Number	1			



There were 20 formal complaints received across Mental Health West services during the quarter. Complaints were received from a range of services including CMHT/Care Pathways, Crisis Resolution and Home Treatment Teams, Talking Therapies, Psychological Medicine Services and Community Mental Health Services.

In terms of outcomes, a substantial proportion of complaints were partially upheld or upheld, with learning identified around communication, care coordination, discharge planning and documentation. Where complaints were upheld, actions included process reviews, staff reflection and training, improvements to communication practices, and strengthening care planning processes. Overall, the complaints highlighted opportunities to improve patient experience whilst also demonstrating that learning and service improvements were identified through the complaints process.

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 320 responses, Talking Therapies – Step 3 with 195 responses and CRHTT West with 88 responses.

Questions relating to facilities and ease have the least number of positive responses. Examples of feedback regarding facilities include patients having issues with parking when accessing Talking therapies, CMHPT and PMS West.

For CRHTT West there was an 81.8% positivity score and 4.40-star rating. There were lots of positive comments about staff listening, being helpful, and kind, “They were so gentle, listened well. Communication was clear. They showed empathy. CRHTT looked for many ways to support me. I felt genuine care. I was given time to explain myself. Everything was perfect!” Some of the areas for improvement included discharge was too fast, didn’t feel listened to and found it hard to understand information given. There were comments for improvement such as wanting to be given the medication they were prescribed, they felt rushed, some staff could be more sensitive and differing opinions felt confusing. For example, “*Some information was difficult to understand as it is a lot of information to take in when I was recovering from discharge from hospital admission.*”

The Older Adult Mental Health Service and Memory Clinic combined have received a 96.2% positivity rating (4.86-star rating) some of the feedback included “*The assessment was not rushed, undertaken with the greatest respect and empathy. My husband was completely at*

ease and quite enjoyed the attention. Everything that was necessary was explained carefully."

There were 40 responses received for West CMHT teams with 90.0% positivity score and 4.64-star rating, 36 of these were positive with comments received that staff listened and were supportive, there were 4 negative responses for Wokingham, comments included that patients did not feel listened to, follow up with patients including felt staff were rude, long wait to get an appointment, some staff members are difficult and the service needed better communication with patients.

Most comments were very positive about the staff, including that they were kind, caring and helpful. Several of the comments/areas for improvement were wait for appointment was too long and communication could be improved. For example, *"[Name Removed] is exceptionally good at putting you at ease. She is genuinely kind and cares about your mental health. She has given me some great advice and has made waiting for therapy easier to tolerate."*

For Talking Therapies, the overall scores were 92.58% positivity and 4.71-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, *"From the first call I felt comfortable with [Name Removed] and she really seemed to care about creating the best therapy and helping to get the to root cause of why I felt the way I did."* *"I was given the time, encouragement and safe space (my own home) to say what I needed to. I was encouraged to think of situations and reflect on past and future events and communication that will support my recovery and those that have brought me here. I was offered the appropriate support for my individual needs and recovery and tools to help me do this. Both the initial assessment and work related Talking therapy session very supportive and gave me pathway option to aid my recovery."* and *"My therapist, [Name Removed], was exceptionally kind, non-judgemental, really listened to me and I came away feeling optimistic about my sessions to come. The venue wasn't ideal for me, largely due to my agoraphobia and my having not been there before so I was stressed to start with but I was quite calm once we started. Also I was really pleased that she made a second appointment there and then for next week, so no hanging around waiting to hear via email etc."*

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.

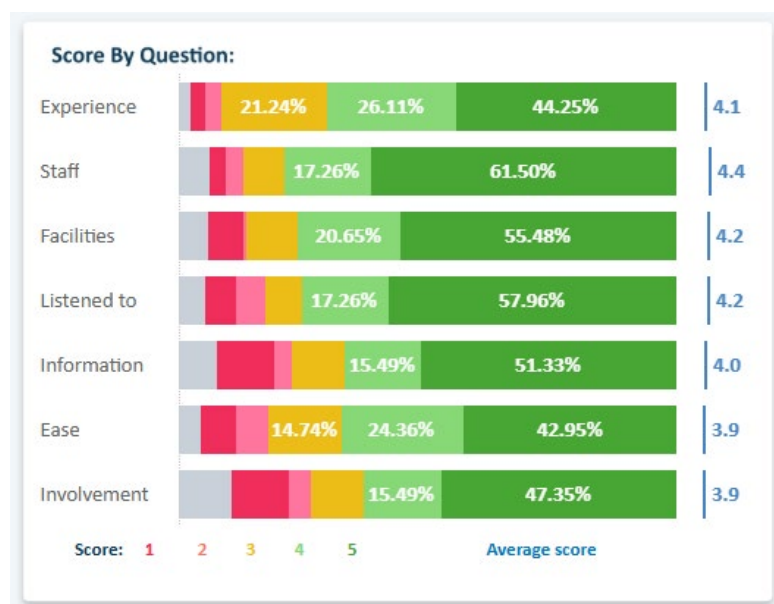
Op COURAGE received 40 responses during the Quarter, their patient survey responses gave a positivity score of 97.5% (4.84-star rating), 1 of the reviews scored less than 4 with the comment that advice was not helpful.

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			
Response rate	%	115.3%			
iWGC 5-star score	Number	4.12			
iWGC Experience score – FFT	%	71.6%			
Compliments	Number	32			
Formal Complaints Rec	Number	10			
Formal Complaints Closed	Number	11			
Formal Complaints Upheld/Partially upheld	%	45.4%			
Local resolution concerns/ informal complaints Rec	Number	1			
MP Enquiries Rec	Number	0			

*This excludes the number of surveys completed for Place of Safety, as whilst we collect feedback on people's experience, it is not an inpatient ward. Place of safety received a positivity percentage of 90.5% and a five-star score of 4.50.



The majority of inpatient complaints related to care and treatment, including concerns regarding medication management, restraint, Mental Health Act processes, ward environments, clinical decision-making and the quality of care provided during admission. Other themes included communication, discharge arrangements, attitude of staff, and the accuracy of clinical records.

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

Several complaints also led to reviews of ward processes, staff practice and record keeping, with actions put in place to improve patient experience and safety.

The satisfaction rate was 71.6% with 62 of the 226 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 3.9 and 22 of the 29 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?"

Work has concluded on the culture of care programme; which focuses on safety and involvement of patients, the aim of the programme is to promote an environment where caring, empathy, and support are central to both service users and staff; there is also ongoing work in relation to improving communication and the involvement of patients making decisions about their care, particularly around managing risk. 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, kind, and supportive. There were some comments for improvement about some staff being rude, more staff and wanting more gym time. Examples of the feedback left are *"I stayed in sorrel ward, this was my second admission, the staff on the ward are nothing short of fantastic, always ready to offer support or provide a sympathetic ear thanks. Your sorrel ward staff and people in general. Thoroughly recommend."* *"The staff and the colleagues at the hospital were very supportive of my mental health issues and provided the necessary medications for me to get better. Meals were given on time and the rooms were cleaned on a daily basis."*

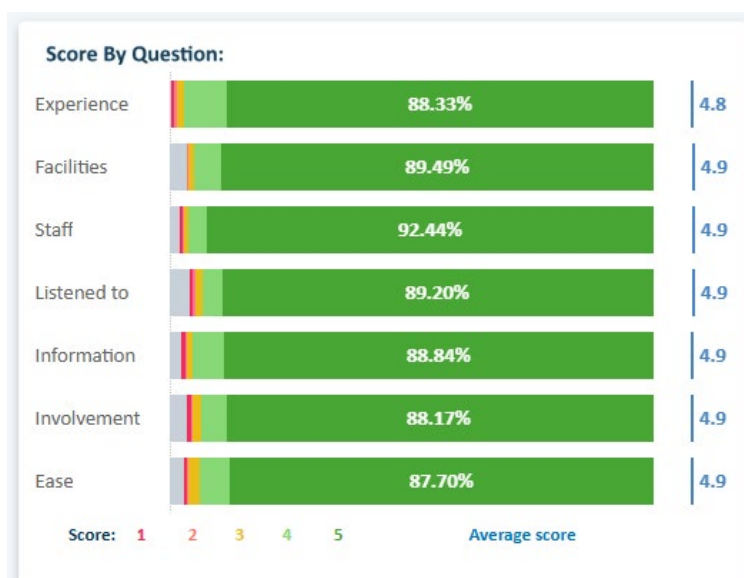
In addition to the feedback about the wards, there were 20 responses for a Place of Safety, and the average score was 4.58, with 2 reviews giving a score of less than 4/5. Some comments received were *"Highly professional staff all very friendly, helpful kind, efficient and caring."* *"Excellent staff who made me feel safe. Found common ground with people e.g. football which broke the ice in getting to know each other."*

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



There were four formal complaints received across Physical Health East services during Quarter 1.

The Hearing and Balance Service received 191 responses to the patient experience survey with a 96.9% positive score and 4.85-star rating.

East Community Nursing/Community Matrons received 496 patient survey responses with a 98.8% positive scoring, many comments were about staff being kind and professional, for example *"The nurses are kind and quick with my injections as I do not like them. Get it over with quickly without showing me the needle, they listen and know."* *"They look after mum so well. They are kind and understanding. It's a hard job they do but they always take their time and are professional in what they do."* *"I was treated with kindness and respect at each visit. Nurses are all kind and professional and have nothing to complain about. I am happy that they are seeing me at home."* There were also some comments around wanting nurses to stay longer for example *"Nothing, maybe stayed longer and had a cup of tea."*

The wards received 80 feedback responses (42 responses for Jubilee ward 100% positive score and 38 responses for Henry Tudor ward with a 94.7% positive score). Positive comments were received in relation to staff being kind, helpful and friendly. Two of the responses scored less than 4, comments for improvement related to staff are always rushing, felt they were not listened to and staff need more training.

Within MSK physio in the East, there was a high number of responses to the patient survey and a high positivity score of 96.1% (4.82-stars), comments were very complimentary about staff being professional and helpful, *"[Name Removed] was excellent. He listened carefully whilst I explained my condition. Very professional in manner and easy to talk to. I look forward to having the physio sessions that he has proposed."* The reoccurring improvement suggestion for this Quarter was for more parking.

Outpatient services within the locality received a positivity score of 96.83% with 4.87 stars from the 789 responses received. With some very positive feedback including for the UCR & Virtual Community Ward, *"Your team have given the most amazing care to my mother. Dr [name removed] is fantastic, the time he spent with my mother and the phone calls to see how she got on at the hospital appointment amazed us. Thank you."*

The Diabetes Service received 244 feedback responses with 97.1% positivity and some lovely comments including *"The special diabetes nurse was very kind and professional. She was listening to my concerns and was trying to see what else she can improve with my treatment, although the numbers looks great. She was empathetic and didn't give any feeling I'm overreacting to what I'm going through."* Alongside some helpful suggestions for the

service to listen to patients more “*Given me more time & to be listened to more about what is going on in my body.*”

The Assessment and Rehabilitation Centre (ARC) also received positive feedback including “*My therapist, [Name Removed], was excellent. She was emphatic, intelligent and articulate. Her approach was collaborative and foreground my needs and integrated that with both abilities, capabilities, and limitations.*”

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

Examples of activities undertaken across the Physical Health Service Division include:

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

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

Sexual Health Patient focus groups developed for young people and for Pre-Exposure Prophylaxis (PrEP). Both going well and good feedback to influence improvements.

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

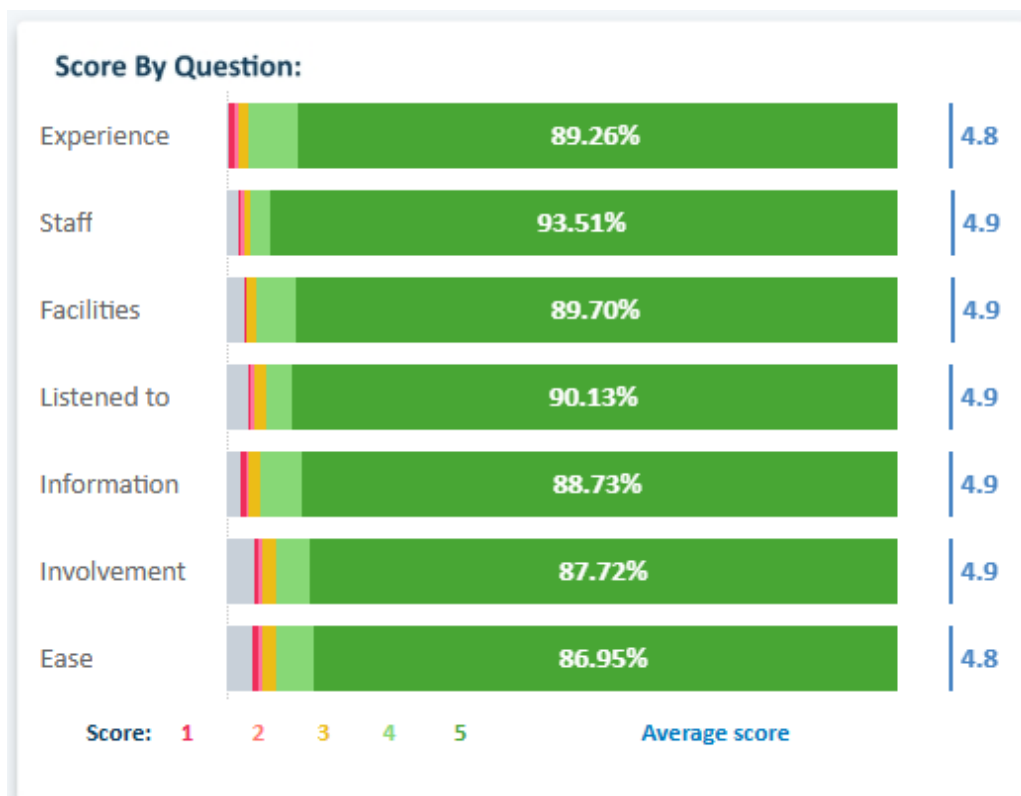
Integrated care the service continues to embed co-production and patient engagement in service development across inpatient and community settings. Feedback from patients and staff identified confusion around returning to driving post-stroke; work is underway to develop a clear professional pathway and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

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

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

Table 7: Summary of patient experience data.

Patient Experience - Division CHW		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	Number	3994			
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	7.0%			
iWGC 5-star score	Number	4.87			
iWGC Experience score - FFT	%	97.0%			
Compliments (received directly into service)	Number	586			
Formal Complaints Rec	Number	9			
Formal Complaints Closed	Number	9			
Formal Complaints Upheld/Partially Upheld	%	66.6%			
Local resolution concerns/ informal complaints Rec	Number	8			
MP Enquiries Rec	Number	1			



The majority of the nine complaints received in Quarter 1 related to care and treatment, with concerns focusing on clinical assessments, treatment decisions, referral pathways, delays in care and ongoing management of health conditions. Other issues raised included communication, confidentiality, medication management, and access to appropriate services.

Where complaints were partially upheld, learning related primarily to communication, documentation, and patient involvement in decision-making. Examples included improving communication regarding treatment decisions, ensuring patients are kept informed throughout referral pathways, strengthening risk assessment processes, and improving how concerns are discussed with patients and families.

For complaints that were not upheld, investigations found that clinical care and processes were generally appropriate; however, several investigations still identified opportunities to reinforce good practice around record keeping, communication and explaining clinical decisions more clearly.

There are a significant number of services within the division, and a generally high level of satisfaction received as detailed in the overall divisional scoring of 97.0% positive satisfaction and 4.87-star rating and the question on staff receiving a 96.5% positive scoring from the 3994 responses received.

The community hospital wards have received 163 responses through the patient survey receiving a 93.9% positive score and 4.76-star rating, (10 responses scored three and below) questions around feeling involved and ease receive the most results of three and below. Comments include *"Absolutely happy in this place. The staff are amazing the food is good, the room is very clean."*, *"The staff are amazing, very caring, helpful and efficient. Having MS, it is important when caring for me that you listen and understand due to my spasms which they always did. They were always there when I needed them."* *"I have no issue with most staff they are all brilliant particularly the tea lady. Absolutely brilliant. Student nurse she's kind and proactive and HCA who gave me shower this morning."* And *"I was taken very good care by everyone. Staff were friendly and helpful and do an amazing job. Thank you to everyone for helping me back on my feet, literally."* there were some individual comments bed and chair could be more comfortable, better communication with RBH

regarding transfer, would like night lights and better Wi-Fi. Comments for reviews with responses that scored below 4 included food was poor, didn't communicate with patient, physios not friendly, would like more physio and did not feel listened to. There were 2 reviews which received a score of 1, 1 of the reviews left no comments and 1 said that staff are busy.

WestCall received 295 responses through the iWGC questionnaire this Quarter, a decrease from the previous quarter (92.2% positive score, 4.77-star rating, 23 scores received below 4. Positive comments included *"All staff I encountered were kind, caring and empathetic. The whole place was meticulously clean, and the doctor who treated me was knowledgeable, proficient and made me feel supported and looked after."* *"The reception staff were welcome, friendly and helpful. I was seen very quickly by Dr [Name Removed] who was professional, very thorough and kind to both myself and my baby daughter. He explained what he thought to be the reason behind her symptoms but also sought a second opinion from a paediatric doctor."* *"The reception staff and nurse who dealt with me were lovely and smiley and friendly. The doctor who saw me promptly at my appointment time and was thorough and explained everything clearly. I was treated in a very professional manner throughout. I cannot fault. Thank you."* Areas for improvement included never received call bac, waited a long time after booked appointment slot and better communication.

The Podiatry Service received 209 patient survey responses. Responses were very positive receiving five stars (overall 99% positivity 4.94-star rating) with examples including *"[Name Removed] was fantastic as a podiatrist. She was very friendly and helpful too. She provided a very good assessment of my condition and gave me some great exercises and advice to follow up on."* *"The professional I saw was kind, able to understand my needs, extremely helpful in terms of next steps. I was quite overwhelmed by the time given to me by this professional around my issue. A really positive experience, which I was a little apprehensive about when first hearing the idea of an appointment with the Podiatry team."* and *"The whole experience has been amazing since phoning up my GP surgery and within hours getting an appointment so quickly. [Name Removed] the podiatrist was so friendly and helpful and really went the extra mile thank you to everyone."*

To provide some context across our East and West District Nursing teams combined there were 14,118 unique patients this Quarter.

824 responses were received for Community nursing (99.2% positive score and 4.96/5 stars) Lots of comments included nurses were kind, friendly, and helpful, *"Excellent service, very kind and professional nurses. Very friendly made me feel at ease."* *"The district nurse took the time and trouble to look after me and i appreciate it. My arm is very comfortable and redressed. I would like to thank them for their help and looking out for me."* and *"To all you wonderful nurses, thank you to all that came to see my mum in the last days of her wonderful life, for all the exceptional care, dignity and compassion you showed her. You are truly special people doing incredibly difficult work. Thank you!"* 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 one Formal Complaint in the Quarter. The service has received 657 patient survey responses with a 98.6% positive score (4.89 -star rating), very few areas for improvement were included in the feedback there were a few suggestions including would like appointments to be longer, more appointments to choose from and wanted hands on treatment and the overall feedback was extremely positive with lots of comments about staff were friendly, professional, listened and helpful.

Bladder and Bowel (continence) services received 114 survey responses with 90.4% positivity and 4.74-star rating, with comments about staff listening and being helpful.

Demographic profile of people providing feedback.

Table 8: Ethnicity

Ethnicity	% Complaints received	% Patient Survey Responses	% Breakdown of Q1 attendances
Asian/Asian British	12.12%	8.36%	10.09%
Black/Black British	3.03%	2.67%	3.40%
Mixed	3.03%	2.62%	3.57%
Not stated	9.09%	25.17%	8.11%
Other Ethnic Group	2.02%	4.93%	2.21%
White	70.71%	56.24%	72.62%

The percentage of Asian/Asian British people raising a complaint was in line with the breakdown of attendance %, for Black/Black British people, the complaints were slightly lower than the attendance %. For White British people there is a slightly lower percentage of complaints compared to 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.

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

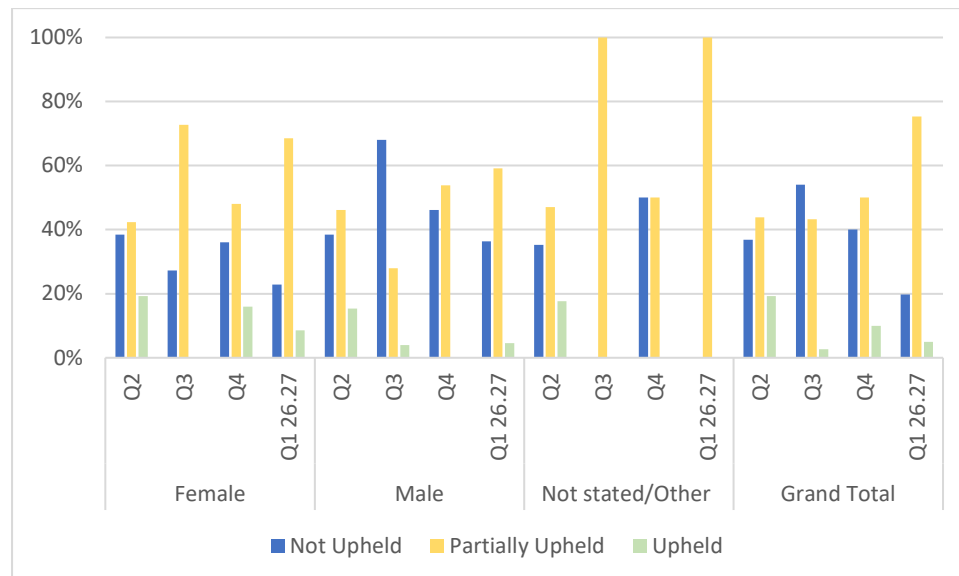
Table 9: Gender

Gender	% Complaints received	% Patient survey responses	% Breakdown of Q1 attendances
Female	58.59%	36.18%	55.48%
Male	41.41%	29.09%	44.50%
Non-binary/ other	0%	2.98%	0%
Not stated	0%	31.74%	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	Q2	38.46%	42.31%	19.23%
	Q3	27.27%	72.73%	0.00%
	Q4	36.00%	48.00%	16.00%
	Q1 26.27	22.86%	68.57%	8.57%
Male	Q2	38.46%	46.15%	15.38%
	Q3	68.00%	28.00%	4.00%
	Q4	46.15%	53.85%	0.00%
	Q1 26.27	36.36%	59.09%	4.55%
Not stated/Other	Q2	35.29%	47.06%	17.65%
	Q3	0.00%	100.00%	0.00%
	Q4	50.00%	50.00%	0.00%
	Q1 26.27	0.00%	100.00%	0.00%
Grand Total	Q2	36.84%	43.86%	19.30%
	Q3	54.05%	43.24%	2.70%
	Q4	40.00%	50.00%	10.00%
	Q1 26.27	19.75%	75.31%	4.94%

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

Table 10: Age

Age Group	% Complaints received	% Patient Survey Responses	% Breakdown of Q1 attendances
0 to 4	1.01%	18.20%	6.46%
5 to 9	7.07%		2.64%
10 to 14	6.06%		4.60%
15 to 19	8.08%		5.70%
20 to 24	7.07%	3.46%	3.50%
25 to 29	1.01%		3.50%
30 to 34	7.07%	3.84%	3.64%
35 to 39	9.09%		3.70%
40 to 44	16.16%	5.74%	3.72%
45 to 49	1.01%		4.02%
50 to 54	9.09%	8.57%	3.92%
55 to 59	7.07%		4.45%
60 to 64	8.08%	11.13%	5.08%
65 to 69	1.01%		4.80%
70 to 74	4.04%	11.11%	5.48%
75 to 79	0.00%		8.27%
80 to 84	2.02%	10.43%	9.40%
85 +	4.04%		17.10%
Not known	1.01%	26.52%	0%

Comparatively, people over 60 years old continue to be more likely to give feedback via the patient survey and are less likely to make a formal complaint, this is a trend following previous reporting periods. Interestingly, we 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).

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.

- The LX Development Day took place in April was well attended, with support from our Deputy Director of Nursing and Director of Nursing and Therapies.
- Work to roll out our Lived Experience Advisory Panels (LEAPS) is well underway with the launch planned for Quarter 2.
- Initial work is underway to introduce LX roles into Prospect Park Hospital.
- The Head of Service Engagement and Experience presented at the CBNRT away day, and initial conversations are planned to introduce peer volunteers to this pathway.

Understanding the experience of waiting

The NHS Medium Term Plan includes a requirement for NHS providers to capture the experience of people waiting for care where their waits are over 52 weeks. The aim of this is to support delivery teams to improve the patient experience of waiting and, where necessary, to re-prioritise patients who may need to be treated faster. We have reviewed all services where waits for care and treatment are over 18 weeks and undertaken an initial survey, we will continue to do this focusing to differing services through the year.

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.

There continues to be a number of engagement and co-production activities that take place within Divisions, an example is within the Perinatal Service which has led a service improvement project looking at implementing focus groups.

Based on feedback to the Immunisation Team, the following information has been shared:

Additional Interventions to support anxious CYP

Support Type	Description
EMLA Cream	Topical anaesthetic cream to be applied by parents in advance .
Freeze Spray	Quick-acting cold spray to numb the injection site.
Buzzy Bee	A vibration device that helps reduce pain and anxiety during injection.
Fidget Toys	Sensory tools to help with distraction and calming.
Longer Appointments	Available for children who need extra time or reassurance .
Sensory Room	Use of a calm, low-stimulation space for children with sensory needs.
Therapy Dog Clinics	Sessions supported by trained therapy dogs to reduce anxiety.
AndY Pathway	A CBT and desensitisation research project with Reading University.
VR Pathway	A virtual reality-based desensitisation project with Oxford University.



Information for
parents and carers



Is your child anxious about having vaccinations?

We are here to support you!

- We can now offer immunisation clinics in various locations.
- We can offer dog therapy clinics and also 1-1 sessions with a vaccinator.
- Home Visits are considered.
- We have experienced vaccinators who can address barriers like fear and pain.
- We use fidget tools, distraction techniques, buzzy bee devices, and freeze spray.
- We also consider environmental factors and sensory issues within clinic areas.



If you have any questions, please do not hesitate to contact us.



Scan me

NHSimmunisations-reading@berkshire.nhs.uk

0300 365 0077 (Mon to Fri 9am – 4pm)

Scan QR code to book a clinic appointment

Co-production continues to develop across the Physical Health Services division, although maturity varies between services. Several services are involving patients, carers and communities in improvement work; however, much activity remains focused on engagement, consultation and feedback rather than full co-production.

Good practice is emerging in CBNRT, Community Dental, Wheelchair Services, Specialist Services and MSK, with opportunities to embed co-production more consistently across all service areas.

Examples include:

- CBNRT progressing a formal co-production programme and developing patient recruitment processes.
- Development of a Neurodiverse Passport in partnership with user groups and system partners.
- Wheelchair Services working alongside patients and carers to develop a Wheelchair Skills Programme.
- Bladder & Bowel Services co-producing a dementia and continence leaflet with dementia groups.
- MSK services involving patients in pathway redesign and service improvement initiatives.
- Diabetes and Nutrition & Dietetics using patient feedback to shape patient information resources.
- Work to develop culturally appropriate patient information resources and leaflet translation projects.
- Patient forum – Friends of Talking Therapies– meets over Teams quarterly to discuss service improvements, innovations and to gather feedback. This quarter they discussed the introduction of smart referrals and Step 3 group courses.
- Talking Therapies Thames Valley Network – monthly meetings with patients from Berkshire, Bucks and Oxford to gather feedback on projects being carried out across Thames Valley.

Services plan to build on existing engagement through outreach, patient forums, co-production programmes and lived experience involvement.

Areas of focus include:

- Launching formal CBNRT co-production activity.
- Developing MSK pathway redesign and Community Assessment Days.
- Continuing Wheelchair Service Patient Focus Groups.
- Progressing Diabetes UK, World Continence Week and Health Bus engagement.
- Expanding Sexual Health outreach with underserved communities.

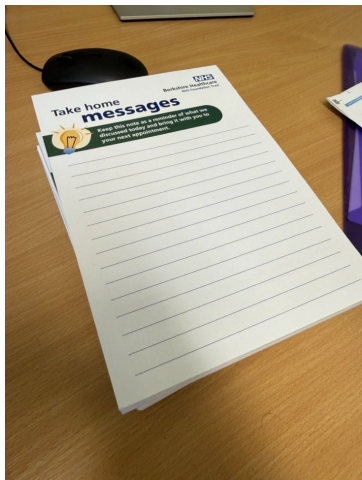
Some examples of services changes and improvements are detailed below. The Head of Service Engagement and Experience is attending the Senior Leadership Team meetings for both Prospect Park Hospital and Community Mental Health Services to support their collection and reporting of patient experience activities.

Service	You said	We did
Audiology	Improve phone access	Improved call answering and response times.
Community Dental	Reception support required	Recruited additional receptionist/admin support.
Diabetes & Nutrition, Dietetics	Delays getting through by telephone	Introduced a dedicated telephone rota.
Sexual Health	Lack of PrEP appointments	Additional clinics introduced to increase capacity.
Integrated Services East	Progression within exercise classes requested	Reviewed exercises and added progression across programmes.
	Would prefer to see the same therapist	Caseload models are being introduced to improve consistency.
Intermediate Care	Need a clearer understanding of the support provided	All clinicians now provide an explanation of service provision during assessment visits.

Service	You said	We did
CBNRT	Patients wanted to know when ward appointments would take place	Working with nursing teams to improve appointment scheduling and timetabling.
IPASS	Further information regarding triage decisions	Patients are contacted directly to discuss referrals and gather additional information where appropriate.
MSK Services	Signage at clinic locations unclear	Additional signs installed and check-in information improved.
	Concerns regarding space, noise and privacy	Ongoing review of clinical environments and use of alternative spaces.
	Waiting times and delays	Community Assessment Days, waiting list initiatives and recruitment activity undertaken.
	Need clearer information about parking	Parking information reinforced within appointment communications.
	Need better communication regarding treatment	Ongoing shared decision-making and staff development activity.
	Unclear administration processes	Work underway to improve system integration and automation.
Community Nursing (West Berkshire)	You do not know who to contact	Developed a 'Who to Call When' leaflet.
Community Nursing (Reading)	Patients unaware when visits move	Patients are now contacted when visits are rescheduled.
OOH Community Nursing	Request for notification of arrival times	Staff contact patients where there is a clear need to support access arrangements.
Wokingham Inpatients	Bathrooms are not user friendly	Bathrooms reviewed and improvements underway, including additional mirrors.
	Unable to access hairdresser facilities	Mobile sinks purchased and introduced.
	Gym too hot to use	Activities moved and equipment relocated to cooler areas.
Oakwood	Communication and staff interactions	Feedback shared with staff and compassionate communication reinforced.
	Special diet meals arriving late	Patients requiring special diets are now prioritised for meal provision.
Bladder & Bowel Service	Continence products not always suitable	Samples are now provided before main orders are processed.
CARSS Cardiac Rehabilitation	Drinking water requested at sessions	Bottled water made available at venues.
WestCall	Long callback times	Callback processes reviewed and prioritisation strengthened.
	Waiting times on site	Communication regarding delays improved.
UCR / Virtual Ward	Communication and advice not always clear	Shared decision-making and communication standards reinforced.
	Difficult navigation to clinics	Directions, pathways and signage improved.
	Unclear visit schedules	Communication regarding timing of visits strengthened.
	Need clearer care plans and explanations	Improved communication with patients and families.
Phlebotomy	Appointments running late.	Better communication regarding delays introduced.

Service	You said	We did
Talking Therapies Step 2	Technology and system issues such as bad connection, calls dropping and video link not working were a moderate theme.	We have updated our patient communications to let patients know if the link doesn't work the therapist would instead telephone the patient.
	Waiting time and access delays are a strong theme.	NHSP hours being offered to PWP's to support an increase in wellbeing assessments, S3 clinicians offering wellbeing assessments and recruitment is underway.
	Lack of clarity around next steps.	We have updated our patient communications to give patients a clearer understanding of what being placed on a waitlist means and what happens next.
	Tick box perception of wellbeing assessments.	Working alongside Thames Valley Network to share best practice around how to support wellbeing assessments to feel less like a tick box exercise.
Talking Therapies Step 3	Waiting time for S3 treatment was identified as a strong theme.	We continue to offer and review our new shortest wait offer. Clients are placed on the shortest waitlist while ensuring they are getting the treatment indicated by nice guidelines.
	Wider work is under way to address capacity and flow in the service. Including improving guidance around stepped care principles and widening our offer of workshops, groups and digital interventions where appropriate.	
Adult Eating Disorder service	Client expressed verbally that chairs were uncomfortable during a group session.	The chairs were switched for the next session and the client confirmed in their feedback that the improvement was beneficial.
	Service users raised concerns about receiving quicker responses and ample notice for their appointments.	The Service is transitioning at the end of July to using Portasana to make the process of booking and re-scheduling appointments more efficient.
	Service users expressed their discomfort due to the heat.	The service has decided to rent AC units to accommodate the hot weather.
	The clinical spaces are not soundproof and therefore were hindering therapy and confidentiality.	Sound-proofing work commenced – acoustic panels put in place and further improvements being discussed.
CYP Eating Disorder service	You are not always able to attend the parent psycho-education group.	The team is looking at developing a more accessible way to deliver this including video seminars to be viewed at a time more convenient to parents.
	The journey of what treatment may look like is not always clear from the outset.	Guide for families about the journey and what it may look like is in the process of being developed.
	You wanted connection with young people who have progressed through recovery.	'From me to you' letter written by previous service-user available to encourage and support those starting treatment.
CAMHS Anxiety Disorder treatment Team	More Wipe board pens are required in the waiting room.	Placed new pens in the area on the same day as the feedback was received.

Service	You said	We did
	That you would like to know about your next steps after group.	We have introduced a review appointment at the end of each group.
CAMHS Common Point of Entry	The clock is too loud.	We have replaced it with a quieter clock.
	The Coping Guide that you sent out was out of date	Links have been replaced and QR codes updated.
CAMHS Getting Help West	The handout layouts were confusing at times.	We have edited the Worry Management booklet to make it easier to understand/follow
CAMHS Getting Help East	Room 19 is outdated and unwelcoming.	We have painted the room, deep cleaned the floors, fitted a smaller desk and have put up vibrant posters.
	The referral form isn't user friendly for people with dyslexia.	We have created a more accessible form.
CAMHS Specialist Community teams	The waiting room is too hot.	We contacted estates to turn off the heating.
0-19 Services	It would be useful to have fun facts/useful information on the walls at baby clinic.	This is currently being actioned by the service.
Autism Assessment Team (AAT) and ADHD teams	The clinic environment is not always comfortable.	We have created a poster which is now displayed in all clinic rooms used by AAT and ADHD, letting children, young people and their families know that they can request various adjustments to help them feel more comfortable during appointments, e.g. the lights on/off, the window open/closed, a drink of water, a movement break, fidget toys etc.
	AAT: Families fed back that they have not been receiving their reports in a timely manner.	We have now set targets for staff to work towards so that we can be clearer with them about the expected timescales for receiving reports. We also have a PSDA huddle ticket in progress looking at how we can use Co-pilot to make the process of clinical report writing more efficient and consistent between clinicians.
Immunisation	'Let us know the day before'.	We reviewed the communications currently shared with parents and schools. Following this review, we updated the Lead Nurse email to remind parents, on the day of vaccination, to ensure their child has eaten breakfast and has access to snacks. We also reinforced with schools the importance of providing pupils with water and biscuits following vaccination to support their wellbeing and minimise the risk of fainting or feeling unwell.
	'Make it hurt less'. 'I felt scared/tell me it would hurt'.	We provide and promote a range of different options for reducing pain and fear surrounding vaccinations displayed on posters shared in settings and services.

Service	You said	We did
		Staff reminded not to say injections do not hurt.
	Slough schools requested increased engagement with parents and young people.	The immunisation team designed produced and delivered; • A Webinar • Attended Assemblies and PSHE • A poster for year 11 students
Community Paediatrics	Improve reception/ check-in process.	Implemented a structured front-desk protocol with clear accountability, real-time tracking and staff training to prevent patients being overlooked at reception.
	Participation 'Take home message' Pad.	The 'Take-home Message' pads were launched on 18 June 2026 and have proved to be a valuable resource across a range of clinics. They have facilitated the sharing of important information with patients, including contact details for CYPIT therapy services, which some families have accessed before receiving their clinic report. Informal feedback from families has also been very positive, with many reporting that the 'Take-home Message' sheet, served as a useful reminder of the agreed management plan, particularly as they had previously found it difficult to recall all the information discussed once they had left the consultation. An added benefit is the QR code at the back of the A5 sheet that takes the patient and their family directly to our Community Paediatric webpage, where they have easy access to our relevant resources and websites, including the link for booking blood tests. 

15 Steps

There have been eight '15 Steps' visits during Quarter One. We are receiving consistently positive feedback about the visits, with services relaying 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 more accurately analyse data in terms of any differential experience.

Appendix 2: complaint, compliment, and PALS activity

All formal complaints received.

	2024/25					2025/26					2026/27					
Service	Q1	Q2	Q3	Q4	Total for year	Q1	Q2	Q3	Q4	Total for year	Q1	Compared to previous quarter	Q1 no. of contacts	% contacts Q1	Total for year	% of Total
Acute Inpatient Admissions – Prospect Park Hospital	8	3	11	5	27	8	6	8	10	32	8	No change	177	4.52	8	9.88
CAMHS - Child and Adolescent Mental Health Services	10	13	3	5	31	8	4	8	7	27	5	↓	3531	0.14	5	6.17
CMHT/Care Pathways	12	13	7	9	41	10	10	10	18	48	19	↑	5115	0.37	19	23.46
Common Point of Entry	2	3	0	1	6	0	1	4	2	7	2	No change	149	1.34	2	2.47
Community Hospital Inpatient	4	4	4	1	13	1	5	1	2	9	1	↓	451	0.22	1	1.23
Community Nursing	6	3	1	1	11	1	3	1	4	9	1	↓	14583	0.01	1	1.23
Crisis Resolution & Home Treatment Team (CRHTT)	5	3	2	8	18	3	9	8	8	28	6	↓	4786	0.13	6	7.41
Older Adults Community Mental Health Team	1	0	0	1	2	0	1	0	1	2	0	↓	2255	0.00	0	0.00
Out of Hours GP Services	2	2	3	5	12	2	0	2	4	8	2	↓	5664	0.04	2	2.47
PICU - Psychiatric Intensive Care Unit	0	2	2	0	4	0	1	0	0	1	1	↑	19	5.26	1	1.23
Urgent Treatment Centre	1	0	0	0	1	0	0	0	0	0	2	↑	4091	0.05	2	2.47
Other services during quarter	17	18	17	12	64	18	18	18	43	97	34	↓	126822	0.03	34	41.98
Grand Total	68	64	50	48	230	51	58	60	99	268	81				81	

Informal Complaints received

Division	Month Received			Grand Total
	April	May	June	
Children, Young persons & Families			1	1
Mental Health		1	2	3
Physical Health	1			1
Grand Total	1	1	3	5

Locally resolved concerns received.

Division	Month Received			Grand Total
	April	May	June	
Children, Young persons & Families	1	1		2
Mental Health		1		1
Physical Health	1	6	5	12
Grand Total	2	8	5	15

KO41a Return

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

Formal complaints closed

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

Outcome of formal complaints closed.

Outcome	2025/26					2026/27						
	Q1	Q2	Q3	Q4	Total for year	Q1	Q2	Q3	Q4	Higher or lower than previous quarter	Total for year	% of 26/27
Consent not granted	2	4	4	1	10	3				↑	3	3.53
Locally resolved/not pursued	2	3	6	11	11	7				↓	7	8.24

Outcome	2025/26					2026/27						
	Q1	Q2	Q3	Q4	Total for year	Q1	Q2	Q3	Q4	Higher or lower than previous quarter	Total for year	% of 26/27
Not Upheld	24	19	26	36	69	19				↓	19	22.35
Partially Upheld	19	21	21	52	61	41				↓	41	48.24
Upheld	8	10	1	8	18	9				↑	9	10.59
SUI	0	1	0	0	1	1				↑	1	1.18
Other	0	3	1	0	3	5				↑	5	5.88
Grand Total	55	61	59	108	281	85					85	

A total of 85 formal complaints were closed during the quarter. Of these, 50 (61.7%) were either partially upheld (41) or upheld (9). 19 complaints were not upheld, 7 were resolved locally or not pursued, and 3 could not be progressed due to consent not being granted. There was also one Serious Incident (SUI). The upheld complaints were spread across a range of services, with no significant themes identified.

Complaints upheld and partially upheld.

Service	Main subject of complaint											Grand Total
	Access to Services	Admission	Attitude of Staff	Care and Treatment	Communication	Confidentiality	Discharge Arrangements	Environment, Hotel Services, Cleanliness	Medical Records	Medication	Waiting Times for Treatment	
Adult Acute Admission Bluebell Ward				2	1					1		4
Adult Acute Admission Daisy Ward				3								3
Adult Acute Admission Rose Ward			1	1								2
CAMHS - Anxiety Disorder Treatment Team (ADTT)							1					1
CAMHS - Getting Help East					1							1
CAMHS - Rapid Response				1								1
CAMHS General				1			1					2
Children's Occupational Therapy - CYPIT									1			1

Service	Main subject of complaint											Grand Total
	Access to Services	Admission	Attitude of Staff	Care and Treatment	Communication	Confidentiality	Discharge Arrangements	Environment, Hotel Services, Cleanliness	Medical Records	Medication	Waiting Times for Treatment	
Children's Speech and Language Therapy - CYPIT	1			2	1							4
CMHT/Care Pathways				8	3	1	2				1	15
CMHTOA/COA MHS - Older Adults Community Mental Health Team			1									1
Community Dental Services					1							1
Community Hospital Inpatient Service - Donnington Ward							1					1
Community Hospital Inpatient Service - Henry Tudor Ward				1								1

Service	Main subject of complaint											Grand Total
	Access to Services	Admission	Attitude of Staff	Care and Treatment	Communication	Confidentiality	Discharge Arrangements	Environment, Hotel Services, Cleanliness	Medical Records	Medication	Waiting Times for Treatment	
Community Paediatrics				1								1
Community Team for People with Learning Disabilities (CTPLD)				1								1
Complaints					1	1						2
Crisis Resolution and Home Treatment Team (CRHTT)		1		2	1							4
CYP - ADHD										1	1	2
Eating Disorders Service				1								1
Estates & Facilities						1						1
Health Visiting			1						1			2
IMPACTT			1									1
Integrated Pain and Spinal Service - IPASS				1								1

Service	Main subject of complaint											Grand Total
	Access to Services	Admission	Attitude of Staff	Care and Treatment	Communication	Confidentiality	Discharge Arrangements	Environment, Hotel Services, Cleanliness	Medical Records	Medication	Waiting Times for Treatment	
Mental Health Integrated Community Service			1									1
Neurodevelopmental Services							1					1
Neuropsychology					1					1		2
Older Adults Inpatient Service - Orchid ward				1				1				2
Out of Hours GP Services				2							1	3
Phoenix			1									1
Physiotherapy Musculoskeletal				1								1
Podiatry				1								1
Psychological Medicine Service			1	1		1	2		1			6
Psychology Service			1	1								2
Sexual Health						1						1

Service	Main subject of complaint											Grand Total
	Access to Services	Admission	Attitude of Staff	Care and Treatment	Communication	Confidentiality	Discharge Arrangements	Environment, Hotel Services, Cleanliness	Medical Records	Medication	Waiting Times for Treatment	
Specialist School Nursing				1								1
Talking Therapies - Anxiety and Depression				1								1
Talking Therapies - Employment Service	2											2
Talking Therapies - PWP					2							2
Traumatic Stress Service				1		1						2
Urgent Community Response										1		1
Urgent Treatment Centre				1								1
Grand Total	3	1	8	36	12	6	8	1	3	4	3	85

Care and Treatment complaint outcomes.

Service	Outcome of complaints about care and treatment			Grand Total
	Not Upheld	Partially Upheld	Upheld	
Adult Acute Admissions - Bluebell Ward		2		2
CAMHS - Rapid Response			1	1
CAMHS General	1			1
Children's Speech and Language Therapy - CYPIT		2		2
CMHT/Care Pathways	1	5		6
Community Hospital Inpatient Service - Henry Tudor Ward		1		1
Community Paediatrics	1			1
Community Team for People with Learning Disabilities (CTPLD)		1		1
Crisis Resolution and Home Treatment Team (CRHTT)	1	1		2
Eating Disorders Service		1		1
Integrated Pain and Spinal Service - IPASS		1		1
Older Adults Inpatient Service - Orchid ward		1		1
Out of Hours GP Services	1	1		2
Physiotherapy Musculoskeletal	1			1
Podiatry	1			1
Psychological Medicine Service		1		1
Psychology Service		1		1
Specialist School Nursing	1			1
Talking Therapies - Anxiety and Depression			1	1
Traumatic Stress Service		1		1
Grand Total	8	19	2	29

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	Ongoing	Documents sent to PHSO
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

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 one we received any complaint 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				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.

PALS also contributes to the co production planning for 16-25 project. A survey has been sent to interested parties, and a stakeholder event took place in May. Follow up events to be held to develop strategy.

PALS also contributes to the Trust sustainability Green Plan. The emphasis at the moment is on promoting more sustainable travel options with sustainability events being held across Berkshire this year. PALS has been invited to speak at the Newbury Climate Forum to discuss Net Zero Heroes and Trust sustainability strategy. Invitation deferred pending the recruitment of a new sustainability manager.

The PALS service conducts outreach at all hospital sites within the organisation. Visits have been held at West Berkshire Community and Prospect Park hospitals. This enables the PALS service to engage locally with patients, public and staff and ensure that relevant information is available to all. A visit to the Patient Information Point at West Berkshire Community Hospital was undertaken following an invitation to talk about PALS and PPI opportunities.

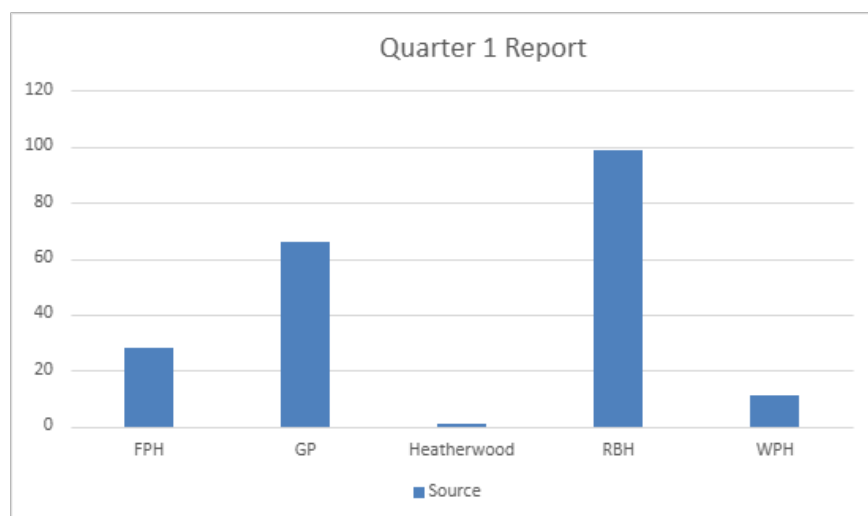
The service currently reports on a quarterly basis and provides a SITREP weekly, highlighting open queries and themes. There were 429 queries recorded during Quarter 1, and these were acknowledged within the five working day target. The recording of queries has improved with the involvement of other team members. Team members have been working with the PALS Manager to familiarise with the response and recording processes. The volume of calls and e mails coming into the service continues to be high. There has been a lot of cross over between the PALS and complaints services.

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

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

To publicise the PALS service across the Trust it has been agreed that the Patient Experience Team will be allocated space on the induction process. The Patient Experience Team has convened and draft content agreed.

In addition, there were 226 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:

Main Theme	Number of contacts
Communication. (Enquiry).	45
Care and Treatment. (Concern).	43
Communication. (Concern).	40

Main Theme	Number of contacts
Management and Administration	29
Access to service. (Enquiry).	28
Access to services. (Concern).	19

PALS recorded queries from a wide range of services, those with the most contacts are:

Location of service	Number of contacts
Prospect House. Reading CMHT.	12
New Horizons. Slough CMHT.	12
Patients home	12
St Marks Hospital	11
London House	11
Hillcroft House. Newbury CMHT	11

Appendix 3

15 Steps; Quarter One 2026/27

The 15 Steps programme was relaunched in April 2024, and during quarter one, there were 8 visits:

Mental Health Services Division		
Prospect Park Hospital		
Ward	Positives	Observations
Rose Ward	Welcomed in. Good information at entrance. Given safety alarm by NIC before going into the unit. Correct process undertaken to sign in and out. All staff had lanyards and/or yellow name badges for identification. Clear sign in process. Good evidence of QMIS and regular huddles. The ward felt calm and well managed. There was a clear plan of who was looking after what patient and what the expectations were. Communal areas were clean and clear. Cleaning being undertaken at visit. Picture noticeboard of staff up to date. Lots of information given which would be helpful for new starters or patients. Activities clearly going on and good interaction with patients.	There was no hand gel available outside the ward, however this has been removed due to patients accessing it and is now inside the ward. Lack of pictures décor around the ward, feeling a little plain. There was a leak in the dining room ceiling which according to staff had been going on for some time. There was a machine in there to collect the water with a tube from the ceiling. EFM aware and managing. Garden areas were a bit sparse, and this was work in progress with a bid for some extra and new garden furniture in place.
Snowdrop Ward	Ward manager was available should we need her. White board showing how many staff on and what expected etc. White board with staff and patients allocated so clear who was looking after who. Communal areas felt warm and friendly. Appeared a bit chaotic but safe. Posters in dining room useful on choking and what to do. Tree of hope on wall brightened the ward area. Outside areas were welcoming and user friendly.	Had to request safety alarms and there were hardly any available, so we shared one. There was no hand gel available outside the ward, however this has been removed due to patients accessing it and is now inside the ward.

		Query whether patient names should be fully written on the white board due to confidentiality. Could do with more display boards in the dining area to make the use of posters and pictures easier. Photo board not up to date or complete. Did not appear to be any activities being undertaken with patients at the time.
Physical Health Services Division		
Community Inpatient Wards		
Ward	Positives	Observations
Henry Tudor	Greeted positively by ward manager, ward sister and clinical director. Good information on patient feedback displayed. Staff photo board visibly displayed and appeared current. Ward was busy but appeared calm and under control. Display of staff tasks available on board. QI work in place and regular huddles undertaken. Buzzers were answered in a timely way. No visible clutter in corridors. There were several patients in the day room interacting and participating in rehab activities. Day room was inviting with TV, activities and fish tank etc. Thank you cards and feedback displayed. Other relevant information available for patients and visitors.	Unclear what numbers of staff were on duty in line with the expectation number. Used the task board and patient allocation to try and verify. Fire exit in the ward was blocked with equipment despite signage to say don't leave equipment there, was addressed.
Community Physical Health Services		
Service	Positives	Observations
Physio, St Mark's	Receptionist and team lead very welcoming. IWGC available and fed back. Building was light and airy. Waiting area had an assortment of chairs allowing for disabilities and needs. There were patients being seen but department was calm and running effectively.	Signposting from main reception was a bit confusing. Difficult to see the physio sign on the side of the building and only noticed when walking back.

	Clear areas for group activities and single usage consultation rooms. QI work being undertaken and active. Leaflets available for patients.	
Podiatry, St Mark's	Waiting area is bright and airy. Lots of information available which is laminated. IWGC actively encouraged and feedback is clearly visible for patients. Well signposted from reception. Disabled access toilet available. There were patients being seen but department was calm and organised. Patients informed to take a seat and wait. List of staff clearly displayed. Clinic rooms clean and spacious. Leaflets available for patients. Signage was clear. Clear acting on feedback displayed for patients. QI work in progress with evidence of regular meetings.	Some of the Trust literature such as the executive team poster and some plan on a page information was not current, to be updated.
Health Visiting Clinic, Brambles Children's Centre, Wokingham	All staff we saw were welcoming and friendly. The clinic area was light, bright and not cluttered. The clinic areas and weighing spaces were clean and clear of clutter Staff were available to support with the babies There was relevant information about the HV service, support, and signposting	The gate to enter the site was next to the refuse and clinical waste storage area but this is not our site so unable to influence and no option to give feedback.
Health Visiting Clinic, Whitley Family Hub - Reading	All staff we saw were welcoming and friendly. The clinic area was light, bright and not cluttered. The clinic areas and weighing spaces were clean and clear of clutter Staff were available to support with the babies and parents/carers Staff were efficient in cleaning and prepping ready for the next visitor Proactively collecting patient feedback There was relevant information about the HV service, support, and signposting	
Podiatry, Tilehurst Clinic Reading	Entrance spacious. Waiting area clean and tidy with a selection of chairs and good information on the wall. Staff friendly and welcoming. Free parking available.	Had some difficulty accessing the clinic as the front door was locked but this was likely due to the clinic being finished. Gained access via the dental service where

	There were no patients at the time of the visit and staff were due to go on home visits. A lot of leaflets and information on waiting room walls. Some were for other services based here too but interrelated well. Clear instructions on wall.	staff member was very helpful. There was a buzzer system for podiatry and 2 other services. Notice would benefit from being larger.
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Trust Board Paper

Board Meeting Date	8 September 2026
Title	Quality Assurance Committee Meeting – 25 September 2026
	Item for Assurance and ratification of changes to the Quality Assurance Committee's Terms of Reference
Reason for the Report going to the Trust Board	The Quality Assurance Committee is a sub-committee of the Trust Board. The minutes are presented for information and assurance. Circulated with the minutes are the quarterly Learning from Deaths and Guardians of Safe Working Hours Reports. NHS England requires NHS provider organisations to present these reports to the Trust Board. The Trust Board is required to identify any areas for further clarification on issues covered by the meeting minutes and associated reports and to note the content. The Trust Board is also requested to ratify changes to the Quality Assurance Committee's Terms of Reference (the proposed changes are highlighted in red type). The key change is transferring responsibility for overseeing the annual Clinical Audit Programme from the Audit Committee to the Quality Assurance Committee.
Business Area	Corporate Governance
Author	Julie Hill, Company Secretary (on behalf of Sally Glen, Committee Chair).

Relevant Strategic Objectives	Harm Free Care – providing safe services Good Patient Experience – improving outcomes
Escalation and Assurance Report	Carers Strategy The Committee received a positive update on delivery of the Carers Strategy and was assured that carers are increasingly influencing service improvement, policy development and transformation programmes across the Trust. Particular assurance was provided regarding co-production, partnership working across the system, support for young carers and the development of digital resources for carers. The Committee recognised the breadth of work underway and the strong organisational commitment to hearing and responding to carers' voices. Assertive Outreach Programme The Committee reviewed progress on implementation of the Assertive Outreach Programme and was assured that the programme has progressed from planning into delivery following confirmation of funding. Governance arrangements, digital developments and service design work are now established, with initial implementation focusing on Reading and Slough. The Committee welcomed the proactive approach to supporting patients who may be reluctant to engage with services and noted the strong emphasis on partnership working, continuity of care and co-production. Ockenden Final Report Review The Committee considered a review of the themes arising from the Ockenden Report and received assurance that the Trust's existing arrangements for quality improvement, organisational learning, patient and family involvement, staff wellbeing and governance align well with the report's recommendations. No significant assurance gaps were identified.

	NHS England National Quality Strategy The Committee reviewed the Trust's assessment against the NHS England National Quality Strategy and received assurance that existing quality improvement, patient safety and health inequalities programmes are consistent with the expectations set out within the strategy. Whilst work continues to reduce inequalities in experience and outcomes, no significant compliance concerns were identified. The Committee agreed to circulate the Trust's self-assessment against the National Quality Strategy to the Trust Board (on the agenda for the meeting). Learning from Deaths Quarterly Report The Committee considered the quarterly Learning from Deaths report and agreed that the Board should be sighted on a case where learning was identified regarding discharge prescribing and medicines reconciliation processes. A Patient Safety Review has been completed, and improvement actions are already underway. The Committee received assurance that lessons have been identified and are being actively addressed through established governance arrangements. Prospect Park Hospital Fire Safety Programme The Committee received an update on fire safety remediation works at Prospect Park Hospital. Whilst the Committee was assured that mitigations are in place to manage the additional risks created by scaffolding and construction activity, the Committee considered it important that the Board remains sighted on progress until the programme is complete. CAMHS 104-Week Waiting Time Risk The Committee discussed the emerging performance risk associated with national reporting of CAMHS waits exceeding 104 weeks. The Committee noted that the issue arises primarily from national reporting definitions and the trajectory
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	submitted by the Trust rather than deterioration in service delivery. Notwithstanding this, the Committee recognised the potential impact on external performance assessment and agreed that the Board should continue to receive updates as validation work progresses.
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**Minutes of the Quality Assurance Committee Meeting held on
Tuesday, 25 August 2026**

(conducted via MS Teams)

Present: Sally Glen, Non-Executive Director (meeting chair)
Aileen Feeney, Non-Executive Director
Debbie Fulton, Director of Nursing and Therapies
Theresa Wyles, Chief Operating Officer
Alex Gild, Deputy Chief Executive
Dr Tolu Olusoga, Medical Director
Amanda Mollett, Associate Director for Medical Development, Clinical Effectiveness and Clinical Audit
Dan Badman, Deputy Director of Patient Safety and Quality.
Helen de Gruchy, Head of Patient Safety
John Barrett, Patient Safety Partner

In attendance: Frances West, Trust Chair
Julie Hill, Company Secretary
Garyfallia Fountoulaki, Clinical Director, Community Mental Health
James DeCothi, CQC
Katie Humphrey, Carers' Lead

Opening Business

1 Apologies for absence and welcome

Apologies were received from Julian Emms, Chief Executive.

The Chair welcomed James DeCothi, CQC, who was observing the meeting as part of the Trust's CQC Well-Led inspection. The Chair also welcomed Frances West, Trust Chair, who was observing the meeting as part of her induction process.

The Chair advised that the Mental Health Act Patient Flow and Detention agenda item (5.9) related to the Quality Concerns Register and would therefore be discussed immediately after the Quality Concerns Register agenda item.

2. Declaration of Any Other Business

There was no other business declared.

3. Declarations of Interest

There were no declarations of interest.

4.1 Minutes of the Meeting held on 26 May 2026

The minutes of the meeting held on 26 May 2026 were confirmed as an accurate record of the proceedings.

4.2 Matters Arising

The Matters Arising Log had been circulated.

The Action Log was noted.

Patient Safety and Experience

5.0 Carers' Strategy Update

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

Katie Humphrey gave a presentation and highlighted the following points:

Key achievements over the last year included:

- Increased visibility of carers across trust-wide strategies and governance activity.
- Improved annual self-assessment processes supported by a live dashboard, with updated data due in September.
- Enhanced quality of action plans driven through the Carer Champions network.
- Greater use of co-production, community engagement, surveys and focus groups to capture carer feedback and translate this into practical improvements.
- Website improvements, including enhanced accessibility and translation functionality.
- Strengthened partnership working across the Integrated Care Board, local authorities and voluntary sector organisations.
- Joint events delivered during Carers Week in collaboration with local authority partners.
- Development of shared learning resources and e-learning across partner organisations.

Current priorities included:

- Implementation of the Unpaid Carers Discharge Toolkit and associated admission and discharge processes.
- Evaluation of the Concerns About Safety Panel following six activations.
- Review of feedback relating to the new approach to risk assessment, including issues concerning consent recording, confidentiality and information sharing.
- Refresh of the Working Carers Network.
- Carer involvement within the Assertive Outreach programme.
- Support for the Improving Mental Health Outcomes for 16-25 Year Olds programme, particularly addressing concerns regarding transition from child to adult services.
- Participation as one of twelve trusts involved in national work relating to the Patient and Carer Race Equality Framework.
- Development of digital innovations, including SilverCloud access, patient portal functionality and proxy access arrangements.

- Expansion of resources through the Carers Hub and updates to guidance materials.

Future challenges identified included:

- Increasing focus on young carers.
- Emerging national requirements around identifying young carers within households.
- Alignment with Thames Valley Integrated Care Board developments.
- Workforce capacity to engage consistently with training and carer initiatives.
- Ensuring equitable experiences for carers from ethnically and racially diverse communities.

The Chair thanked Katie Humphrey for her update and commented that she was particularly impressed by the number of quality improvement initiatives being taken forward as part of the Carers' Strategy. The Chair also welcomed the recognition of the challenges around the transition from child to adult mental health services.

John Barrett, Patient Safety Partner paid tribute to the work of Katie Humphrey in driving the Trust's carers strategy.

Aileen Feeney, Non-Executive Director commented that the number of initiatives in place to support carers was impressive. Ms Feeney acknowledged the challenges around the transition from child to adult mental health services especially when young people may not want their parents to be involved in their care and treatment.

Katie Humphrey acknowledged that balancing confidentiality and consent issues whilst continuing to hear and consider carers' views was challenging but supporting carers even when patients chose not to involve family members directly was important.

The Trust Chair said that she welcomed the alignment of the Carers' Strategy with the ambitions set out in the NHS Ten-Year Plan and with the Trust's Corporate Strategy particularly around the move from analogue to digital, the patient portal and access to digital services (SilverCloud).

The Chair thanked Katie Humphrey for her presentation.

The Committee noted the presentation.

5.1 Assertive Outreach Team Presentation

The Chair welcomed Garyfallia Fountoulaki, Clinical Director, Community Mental Health, to the meeting.

The Committee received an update from Garyfallia Fountoulaki regarding implementation of the Assertive Outreach Team (AOT) programme developed in response to recommendations arising from the Nottingham homicide investigation. The report provided assurance on progress against the ten national recommendations and outlined implementation plans.

Key updates included:

Programme Development

- The programme had progressed from planning into implementation following confirmation of £600,000 of funding. The initial proof-of-concept model would focus on Reading and Slough, reflecting the areas of greatest identified need.
- A total of 121 patients meeting the proposed Assertive Outreach profile had been identified across Berkshire, with around half residing within Reading and Slough.

Governance Arrangements

A dedicated governance structure had been established, encompassing three principal workstreams: model and service interface, workforce development and digital development. Oversight arrangements would be provided by the Quality and Performance Executive Group, the Quality Assurance Committee and the Integrated Care Board.

Digital Innovation

A real-time electronic alert system was now live, displaying a prominent warning banner within patient records identifying individuals within the target cohort. The Trust was working with Connected Care partners to establish similar visibility across partner organisations.

Future ambitions included:

- Development of performance dashboards.
- Integration with bed management systems.
- Identification of potential relapse indicators.
- Development of digital health passports.
- Improved cross-agency information sharing.

Workforce

Workforce developments included:

- Recruitment of dedicated consultant psychiatrist input.
- Planned nursing, nurse consultant, pharmacy, occupational therapy and psychology support.
- Extensive patient and carer co-production activity.
- Publication of best practice guidance and implementation of standard work.

Service Improvements Already Delivered

- Best practice guidance published on Nexus.
- Standard operating procedures established.
- Named worker arrangements implemented with 92% compliance.
- Review and refinement of disengagement and DNA guidance.
- Extensive co-production involving carers and patients.

Performance Framework

The proposed measures of success, included:

- Number of patients supported.
- Bed occupancy and utilisation.
- Admissions and readmissions.
- Use of Section 136.

- Patient and carer experience.
- Recalls and relapse.
- Emergency Department contacts and crisis service interventions.

Aileen Feeney, Non-Executive Director, asked whether the Trust was using AI to identify patients who met the criteria for the Assertive Outreach programme.

Garyfallia Fountoulaki explained that the Trust was already using digital tools and confirmed that going forward this would likely include the use of AI which would be useful in identifying vulnerable patients whose needs may otherwise remain hidden and using technology to identify patterns and deterioration earlier.

John Barrett, Patient Safety Partner asked whether it would be challenging to recruit a Consultant Psychiatrist.

Garyfallia Fountoulaki said that, although recruitment to the consultant psychiatrist role had not yet been successful, she was confident that future recruitment rounds would secure suitable candidates. The role would require significant flexibility and partnership working across multiple agencies.

The Director of Nursing and Therapies referred to the proposed performance metrics and suggested including an additional measure relating to carer involvement.

Action: Chief Operating Officer

The Trust Chair commented that Reading and Slough were urban areas and suggested consideration of geographical equity, particularly regarding future rollout to more rural localities.

The Chief Operating Officer commented that the Trust would use an intensive case management model to support the 50% of the patient cohort located outside Reading and Slough.

Aileen Feeney, Non-Executive Director asked about patients who had no fixed abode.

Garyfallia Fountoulaki reported that the Trust was working closely with homeless charities and confirmed that homelessness and substance misuse would not exclude individuals from support and emphasised the importance of multi-agency working.

The Chair asked about continuity of care.

Garyfallia Fountoulaki explained that the proposed model would focus on strong therapeutic relationships whilst avoiding dependency on individual staff members through team-based approaches and buddy arrangements.

The Chair said that she would be interested in receiving a presentation on how the Assertive Outreach model was working once it was up and running.

The Director of Nursing and Therapies said that it would be a good topic for a future Board Story.

Action: Director of Nursing and Therapies

Garyfallia Fountoulaki asked whether the Committee was happy with the format of the report which had been designed to meet the requirements of the Integrated Care Board.

The Committee confirmed that the format of the report met their requirements.

The Chair requested an update on the Assertive Outreach Programme in six months' time.

Action: Chief Operating Officer

The Committee noted the presentation.

5.2A Quality Concerns Register Report

The Committee reviewed the latest Quality Concerns Register and discussed emerging quality risks across inpatient and community services. It was noted that no new concerns had been formally added to the register since the previous meeting and no concerns had been removed.

The Director of Nursing and Therapies said that the August 2026 meeting of the Quality and Performance Executive Group had discussed issues around the Mental Health Act patient flow and detention and had agreed that this should be added to the Quality Concerns Register. It was noted that there was a separate paper setting out the current challenges at 5.2B below).

The Chair commented that there was a slight increase in the length of stay on some wards.

The Director of Nursing and Therapies said that reported length of stay data should be interpreted carefully because the metric was calculated at the point of discharge. Consequently, a number of complex long-stay discharges occurring in the same reporting period may temporarily increase reported averages before improvements become visible.

The Chief Operating Officer added that the wards had been very busy over the summer which was unusual for the time of year. The Chief Operating Officer said that long-stay patients remained a significant challenge and provided examples where patients remained clinically ready for discharge but were unable to leave due to delays securing external placements, legal arrangements or clinical oversight by receiving organisations.

John Barrett, Patient Safety Partner referred to the Talking Therapies quality concerns and asked whether the consultation with staff about providing more face-to-face consultations had been concluded.

The Director of Nursing and Therapies confirmed that the consultation had been completed and agreed to update the narrative.

Action: Director of Nursing and Therapies

The Committee noted the report.

5.2B Mental Health Act Patient Flow and Detention Concern

The Chief Operating Officer presented an overview of the challenges regarding patient flow and pressures relating to detention and made the following points:

- Demand for inpatient beds remained high.
- The Trust must maintain arrangements under Section 140 for urgent admissions.
- Patients were sometimes held within the Place of Safety facility whilst awaiting beds.

- Oversight arrangements had been strengthened through daily reviews and standardised prioritisation processes.
- Escalation procedures for out-of-area placement requests have been reinforced.

Further developments included:

- New approaches to patients subject to Section 135 warrants.
- Greater use of direct ward admissions where appropriate.
- Consideration of safeguarding risks alongside admission prioritisation.
- Improved monitoring of delays and lost capacity resulting from Section 140 admissions.

The Chief Operating Officer explained that the Committee was due to have a presentation from the Bed Management team but due to staff being on leave, this had been re-arranged for the November 2026 meeting.

Action: Chief Operating Officer

Aileen Feeney, Non-Executive Director said that she had recently visited the Bed Management Team along with Sonya Batchelor, Non-Executive Director and the Director of Nursing and Therapies. Ms Feeney shared that she had been very impressed by the work of the Bed Management Team.

The Medical Director pointed out that there were risks associated with patients waiting for admission in the community. The Medical Director also stressed the additional workload pressures for the Crisis Resolution and Home Treatment Teams supporting these individuals.

Ms Feeney commented that the new Place of Safety would provide a better environment for patients whilst acknowledging that it would not increase capacity.

The Committee noted the report and fully supported the issue being added to the Quality Concerns Register.

5.3 Ockenden Final Report June 2026

The Director of Nursing and Therapies presented the paper and explained that although the Ockenden Report related primarily to maternity services, there were a number of underlying themes which were applicable to all NHS provider organisations.

The Director of Nursing and Therapies explained that the approach mirrored the exercise previously undertaken following publication of the 2022 Ockenden review. The recommendations had been carefully reviewed and mapped against existing Trust arrangements to determine whether any significant gaps existed in governance, culture, patient experience, staff wellbeing, family involvement or quality improvement processes.

The Director of Nursing and Therapies concluded that there were no significant assurance gaps. Whilst maternity-specific recommendations had not been incorporated, the broader organisational themes had been thoroughly assessed against existing Trust systems and processes.

Particular areas of assurance included:

- Established mechanisms for involving patients, carers and families.
- A strong organisational culture emphasising learning and improvement.
- Well-developed quality improvement methodology.
- Robust arrangements for listening to patient experience and feedback.
- Comprehensive staff engagement and wellbeing programmes.
- Mature governance and investigation processes

The Director of Nursing and Therapies added that the Trust had previously undertaken a comprehensive Experience of Care Self-Assessment, providing further assurance around how the organisation captures and responds to patient and carer feedback.

It was also noted that a significant source of assurance was identified through the Trust's participation in the Royal Society of Psychiatrists' Safety Incident Response Accreditation Network (SIREN) accreditation programme. The Committee noted that this externally assessed framework provided assurance regarding family involvement, investigation quality, staff wellbeing, staff engagement and organisational learning. The Committee was advised that relatively few NHS organisations currently held this accreditation and provided an additional layer of independent scrutiny.

The Chair welcomed the comprehensive mapping exercise and agreed that many of the themes identified by Ockenden were relevant to all healthcare providers.

The Chair suggested adding assurance around continuity of care arrangements, particularly for vulnerable patients.

Action: Director of Nursing and Therapies

The Director of Nursing and Therapies said that the Ockenden Report's recommendations also linked into the Fuller Report relating to mortuary and post-death care services. Although the Trust did not operate mortuary or cold storage facilities, the Trust had reviewed local arrangements to ensure appropriate and dignified post-death care was consistently delivered whilst patients awaited transfer to funeral directors.

The Committee noted the report.

5.4 National Quality Board Quality Strategy

The Director of Nursing and Therapies presented the report and explained that the National Quality Strategy largely consolidated existing national policy expectations rather than introducing fundamentally new requirements. The Strategy brought together a range of existing quality, safety and improvement expectations within a single national framework.

The Director of Nursing and Therapies confirmed that the Trust's new strategy aligned closely with the direction of travel set out in the National Quality Strategy with strong alignment with the Trust's quality improvement methodology, strategy and values, patient experience initiatives, equality and health inequalities programmes and learning and improvement processes.

The Committee agreed that there were no significant gaps but acknowledged that there was work in train to address inequalities and variation in access and experience.

The Chair requested that the report be shared with the Trust Board.

Action: Company Secretary

The Committee noted the report.

5.5 Patient Safety and Learning Report

The Head of Patient Safety presented the report and highlighted the following points:

Highlights included:

- Full compliance with Patient Safety Incident Response Framework requirements.
- Three patient safety investigations initiated during Quarter 1, all relating to mortality cases.
- Continued use of multiple learning response methodologies, including multidisciplinary roundtables the most frequently used.
- Approximately one-third of learning responses related to low or no-harm incidents.

Positive developments included:

- Robust processes had now been established to gather feedback from both families and staff involved in patient safety learning responses.
- Divisional learning events addressing record keeping and documentation quality.
- Workshops addressing transitions to adult services.
- Establishment of a Crisis Senior Oversight Group.

The Head of Patient Safety paid tribute to the work of the Family Liaison Practitioner and shared recent feedback received from the family of a deceased patient. The feedback highlighted the compassion, sensitivity and emotional support provided throughout both the investigation process and subsequent inquest proceedings. It was noted that the role provided an important source of continuity and support for bereaved families during highly distressing circumstances.

John Barrett, Patient Safety Partner asked whether there was a business need for another Family Liaison Practitioner.

The Head of Patient Safety said that whilst demand fluctuated, the current model was functioning effectively and that it remained important to build family engagement skills more widely across the organisation rather than becoming overly reliant on a single specialist role.

The Committee welcomed evidence that learning reviews were increasingly informing wider quality improvement work. Discussion focused on the cultural evolution associated with PSIRF and the move away from blame-focused investigations towards system learning and improvement.

The Head of Patient Safety reported that she would be giving a presentation on the different methodologies used to review incidents at the November 2026 meeting.

The Chair asked whether staff felt supported to speak openly during learning reviews.

The Head of Patient Safety confirmed that feedback obtained following investigations demonstrated consistently high levels of psychological safety and confidence amongst participants, although officers recognised that embedding this culture consistently across all services remained an ongoing objective.

The Committee noted the report.

5.6 Infection Prevention and Control Quarterly Report

The Director of Nursing and Therapies presented the report and confirmed that there were no significant concerns and that all reportable infections had undergone appropriate review process during the reporting period. It was noted that none of the reported infections had been attributed to lapses in care or failures of infection prevention practice. Whilst some learning opportunities had been identified through individual reviews; there were no cases in which Trust care had been found to have contributed directly to an infection event.

The Chair noted reductions in COVID-19 and norovirus activity when compared to previous reporting periods and welcomed the continued vigilance demonstrated by clinical services in maintaining infection control standards. The Chair also welcomed the focus on mouth care for inpatients.

The Director of Nursing and Therapies reported that the Trust had been advised that deliveries of the flu vaccination would be later than normal with deliveries planned for the beginning of October.

The Committee noted the report.

5.7 Quality-related Board Assurance Framework Risks Report

The quality-related Board Assurance Framework risks had been circulated.

The Deputy Chief Executive referred to BAF Risk 3 (Patient Voice) and pointed out that the risk needed to be updated to reflect that the Equity Partnership Group was now up and running and therefore there was no longer a gap in control.

Action: Company Secretary

The Deputy Chief Executive referred to BAF Risk 5 (Reducing Health Inequalities) and pointed out the risk needed to be updated to reflect that the Health Inequalities Strategy had just been published and the development of health inequalities dashboards.

Action: Company Secretary

The Committee noted the report.

5.8 Learning from Deaths Quarterly Report

The Associate Director for Medical Development, Clinical Effectiveness and Clinical Audit presented the paper and highlighted that two deaths reviewed during the reporting period had been categorised as involving poor care.

Case One: A Physical Health Patient

The first case concerned a patient admitted to physical health inpatient services with a history of chronic kidney disease and hypertension. During admission the patient had been prescribed additional hypertension medication and was subsequently discharged. The patient later died from COVID-19 and pneumonia approximately three weeks after discharge.

The case had originally been referred for review by a renal consultant who raised concerns regarding the prescribing of two hypertension medications and whether this may have contributed to the patient's deterioration. A Patient Safety Review identified learning associated with discharge prescribing processes and medicines reconciliation arrangements.

A comprehensive action plan had been established and that work to improve discharge documentation and prescribing systems was already underway. There were recognised limitations within the format of discharge summaries, which could result in ambiguity regarding prescribing responsibilities following discharge. Improvement work had commenced before completion of the formal review process due to the significance of the identified concerns.

It was noted that this case had received an avoidability score of three, indicating a higher degree of concern than was typically observed within Learning from Deaths reviews.

Case Two: Community Mental Health Patient

The second case involved a patient known to community mental health services who subsequently died from pneumonia associated with ketamine use. Members heard that the patient also experienced significant malnutrition, an eating disorder and complex mental health needs.

The patient had been referred to the Crisis Resolution and Home Treatment Team by their GP but had not engaged with appointments before eventually being discharged back to primary care. Review findings identified learning relating to risk assessment, clinical documentation, consideration of mental capacity and application of Mental Health Act powers.

Members explored whether the patient might have met criteria for the developing Assertive Outreach Programme. Officers advised that whilst aspects of disengagement from services were relevant, the patient's diagnostic profile would not necessarily have met the eligibility criteria being developed for the Assertive Outreach cohort.

The Chair noted that the prescribing-related case was unusual in terms of both its avoidability score and the nature of the identified learning. The Chair welcomed the proactive response by clinical and pharmacy teams and the fact that improvement work had commenced before completion of the formal review process.

The Committee noted the report.

5.9 Mental Health Act Patient Flow and Detentions Quality Concern

See minute 5.2B above

Clinical Effectiveness and Outcomes

6.0 Clinical Audit Report

The Associate Director for Medical Development, Clinical Effectiveness and Clinical Audit presented the paper and reported that two clinical audit reports had been published since the last meeting:

POMH Topic 20c: The quality of valproate prescribing in adult mental health services

Berkshire Healthcare performed well when benchmarked against the Total National Sample, with all seven standards above the national average and improvement demonstrated across all seven areas since the 2022 audit. Standard 5 achieved 100% compliance for women under 55. Although overall performance was strong, three key standards were identified for further improvement, and an action plan is in place to address these.

POMH Topic 22b: The use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services

The audit comprised three overall practice standards and one treatment target. The three practice standards included eight sub-standards. Berkshire Healthcare performed well against the Total National Sample, achieving above the national average in six of the eight sub-standards and the treatment target. Three key standards were identified as requiring further improvement.

The Committee noted the report.

6.1 Quality Accounts 2026-27 Quarter 1 Report

The Quality Accounts 2026-27 Quarter 1 Report had been circulated.

The Committee noted the report.

Corporate Governance

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

The Company Secretary presented the paper and thanked those who had completed the survey. The Company Secretary said that the results were very positive. The review demonstrated strong levels of satisfaction amongst members regarding the operation of the Committee, the quality of information received and the effectiveness of the Chair.

It was noted that one recurring theme identified through the survey related to meeting scheduling with an overlap between Quality Assurance Committee meetings and Medical Staffing Committee meetings, creating practical difficulties for some attendees.

The Company Secretary confirmed that this issue had been resolved by changing the start time of the meeting to 10.30.

The Committee considered a number of proposed amendments to its Terms of Reference.

The most significant proposed change arose from discussions with the Audit Committee regarding oversight of clinical audit activity. Members heard that responsibility for receiving assurance on the annual clinical audit programme and audit outcomes currently sat within the Audit Committee Terms of Reference. It was proposed that this responsibility should transfer formally to the Quality Assurance Committee because it aligned more closely with the Committee's role in overseeing clinical quality, patient safety and effectiveness.

The Committee agreed that this proposal would provide a clearer line of accountability and improve alignment between clinical audit work and the Committee's broader quality assurance responsibilities.

The Committee:

- a) Noted the report.
- b) Agreed to ask the Trust Board to ratify changes to the Committee's Terms of Reference.

Update Items for Information

8.0 Guardian of Safe Working Hours Quarterly Report

The Guardian of Safe Working Hours Quarterly Report had been circulated.

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

- Since the last report, there had been five exception reports (one was subsequently withdrawn).
- There were no fines levied in the reporting period.
- There was continuing work aimed at improving working conditions for resident doctors.

The Committee noted the report.

8.1 Mental Health Act Annual Report

The Mental Health Act Annual Report had been circulated.

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

- There was increased use of informal admissions converting to formal detentions.
- There were five CQC visits completed during the year with reports awaited.
- One prolonged prone restraint incident was reviewed with further learning activity underway.

The Committee noted the report.

8.2 Mental Health Act Quarterly Report

The Mental Health Act Quarterly Report had been circulated.

The Committee noted the report.

8.3 Place of Safety Annual Report

The Place of Safety Annual Report had been circulated.

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

- There were pressures affecting the Place of Safety capacity.
- Around 122 patients were unable to access Place of Safety services during the year due to occupancy pressures.

The Committee noted the report.

8.4 Place of Safety Quarterly Report

The Place of Safety Quarterly Report had been circulated.

The Committee noted the report.

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

The minutes of the Mental Health Act Governance Board meetings held on 27 July 2026 had been circulated.

The Committee noted the minutes.

8.6 Annual Safeguarding Report

The Annual Safeguarding Report had been circulated.

The Director of Nursing and Therapies reported that, since April 2026, there were now separate adult and children safeguarding boards for the three West of Berkshire local authorities, increasing the number of boards from two (one for adults and one for children) to six, which created additional resourcing issues for the Trust.

The Committee noted the report.

8.7 Quality and Performance Executive Group Minutes – May 2026, June 2026 and July 2026

The minutes of the Quality and Performance Executive Group for May 2026, June 2026 and July 2026 had been circulated.

The Chief Operating Officer reported that the Quality and Performance Executive Group had escalated two issues to the Committee:

Prospect Park Fire Safety Programme

- There were ongoing fire safety remedial works at Prospect Park Hospital which required extensive scaffolding.
- Mitigations had been implemented but some residual risks remain.

CAMHS 104-Week Wait Performance Measure

- Differences in interpretation regarding inclusion of neurodiversity assessment waits have significantly affected reported performance.
- The Trust's stated trajectory of zero 104-week waits means this measure will remain a significant performance risk for the remainder of the year.

The Committee noted the minutes.

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

The following Governor service reports had been circulated:

- Hi-Tech Care Visit – Brant's Bridge
- Individual Placement and Support Service
- Bracknell Healthspace, Brant's Bridge

The Chair thanked the governors for their reports.

The Committee noted the reports.

9.0 Quality Assurance Committee Horizon Scanning

The Chair suggested a presentation on how mental health inpatient wards met the physical health needs of patients, particularly in relation to nutrition. It was noted that this was in response to a national news story about the death of a patient from malnutrition on a mental health ward.

Action: Director of Nursing and Therapies/Company Secretary

10.0 Items for Escalation to the Trust Board

The Committee agreed to escalate the following issues to the Trust Board:

- Carers Strategy progress.
- Assertive Outreach Team implementation.
- Ockenden Report assurance review.
- NHS England Quality Strategy assurance review.
- Learning from Deaths findings, particularly the avoidable death case.
- CAMHS 104-week wait issue.
- Prospect Park fire safety and associated mitigations.

11.0 Any Other Business

There was no other business.

12.0 Date of the Next Meeting

The next meeting was scheduled to take place on 25 November 2026. The meeting would be held face-to-face at London House, Bracknell, with the option of attending via MS Teams.

These minutes are an accurate record of the Quality Assurance Committee meeting held on 25 August 2026.

Signed: -

Date: - 25 November 2026

TRUST BOARD

Quality Assurance Committee

Terms of Reference

Purpose

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

Document Control

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

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10	August 2024	Julie Hill	Changes to the attendees including a Patient Safety Partner and the Patient Safety Specialists to be invited to attend the meeting. Mental Health Act Governance Board minutes added Reference made to hearing the patient voice
11	August 2025	Julie Hill	Changes to the attendees updated to remove reference to the Lead Clinical Director as this post no longer exists
13	August 2026	Julie Hill	The Committee to be responsible for overseeing the Clinical Audit Plan (this is currently in the Audit Committee's Terms of Reference). Other minor changes to the Terms of Reference.

This document is unrestricted.

Quality Assurance Committee - Terms of Reference

1. Constitution

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

2. Membership

The Committee's membership will comprise:

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

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

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

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

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

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

3. Frequency of Meetings

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

4. Purpose

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

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

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

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

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

The Trust's Audit Committee will have overall responsibility for independently monitoring, reviewing and reporting to the Trust Board on all aspects of governance, risk management and internal control. On behalf of the Trust Board, the Audit Committee has overall responsibility for overseeing the Board Assurance Framework. The Quality Assurance Committee will be

responsible for reviewing the quality related risks on the Board Assurance Committee. Any comments made by the Committee will be reported to the Audit Committee as part of the Board Assurance update report.

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

5. Reporting

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

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

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

6. Duties

a. Governance, internal control and risk management

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

b. Audit

7. The Committee shall ensure that there is an effective Clinical Audit process. This includes reviewing the annual clinical audit plan and receiving regular reports on both progress against plan and status of relevant action plans.

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

To receive summary reports of national clinical audits.

a. Quality and safety

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

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

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

To receive and consider reports from the Health Service Ombudsman

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

To receive the quarterly Patient Safety and Learning Report.

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

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

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

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

To receive the Mental Health Act Governance Board minutes

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

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

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

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

To receive the Annual Safeguarding Report

To receive the Infection Prevention and Control quarterly and annual reports

7. Reporting to the Board

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

Version 13 Approved by the Trust Board in **September 2026 TBC**

For review: **August 2026**

Quality Assurance Committee

Meeting Date	August 2026
Title	NHSE quality Strategy for NHS Funded Care in England and initial self-assessment of Service providers responsibilities to support implementation.
Purpose	To ensure that the QAC has understanding of the new strategy published July 2026 and the provider responsibilities within this
Business Area	Nursing & Governance
Author	Debbie Fulton, Director Nursing and Therapies
Relevant Strategic Objectives	Relevant to all four true north goals
Resource Impacts	N/A
Legal Implications	N/A
SUMMARY	On 14th July 2026 NHSE published the NHSE Quality Strategy for NHS funded care in England on behalf of the National Quality Board. A brief summary of the priorities and delivery of these is included within the attached report alongside the provider responsibilities identified to deliver on this strategy. Our own trust strategy 2026- 2031 aligns well to this strategy which sets out to achieve • improved health outcomes • improved patient satisfaction with NHS services • reduced health inequalities The paper also includes our initial self-assessment against the provider responsibilities. We are in a strong position in terms of all that is asked of providers within the NHS strategy, not only does it align well to our own Trust strategy it requires and focuses to the strong quality improvement approach, inequalities, experience of care and culture that we already have in place and as areas for continual focus and ongoing improvement. Link to full strategy: https://www.england.nhs.uk/publication/quality-strategy-for-nhs-funded-care-in-england/
ACTION REQUIRED	QAC is asked to: • Note review the priorities and our initial self-assessment and ensure that these continue to be embedded in all that we do.

NHSE Quality Strategy for NHS- funded care in England
(published on behalf of the National Quality Board 14th July 2026)
and
Initial self-assessment of Service providers responsibilities to support implementation.

What the strategy sets out to achieve

The strategy provides a new structured approach to making quality the organising principle for all NHS activity in England over the next decade. Its purpose is to ensure people receive high-quality care consistently across all NHS-funded services. By doing so, it aims to:

What is meant by high quality care?

- **safety** – reducing the risk of unintended or unexpected harm to patients arising from the provision of healthcare.
- **effectiveness** – providing evidence-based care that improves outcomes for people.
- **experience** – delivering co-ordinated, compassionate and responsive care that meets people's needs.

All 3 must improve together. Focusing on one alone will not deliver consistently high-quality care.

What the strategy aims to achieve

The strategy focuses on:

- improving health outcomes and healthy life expectancy
- reducing healthcare inequalities
- improving satisfaction with NHS services

Initial priorities for the strategy

- improving outcomes and reducing unwarranted variation across major conditions and priority groups through implementation of the National Cancer Plan and modern service frameworks
- making sustained improvements in maternity and neonatal services
- strengthening patient safety across all settings
- improving experience of care and restoring trust in NHS services
- reducing inequalities across safety, effectiveness and experience
- monitoring clinical and population health outcomes

How this will be delivered

The strategy sets out 10 enablers to create the conditions for improvement across the system. Each enabler links to further detail on how it will be delivered:

- clarifying who is responsible and accountable for quality at every level of the healthcare system.
- setting clear priorities to improve the quality of care while adopting a transparent, co-ordinated and value-based approach
- strengthening leadership and management capability to create the right culture and conditions for improvement
- listening to and working with people and communities on what matters to them.
- using data to manage quality, inform decisions and support accountability at all levels.
- increasing transparency, making the NHS the world's leading healthcare system for public access to information on care quality
- developing and embedding technology to underpin quality management and improvement
- aligning incentives and rewards with accessible, high-quality and productive care
- promoting research and innovation to support continuous improvement in clinical care and how the NHS operates
- creating a more co-ordinated and improvement-focused approach to regulation

Building on the 10 enablers, the strategy also outlines how quality management systems provide local organisations with a structured way to plan, deliver, monitor and improve quality.

Provider responsibility

Whilst quality management is a shared responsibility across the system. Service providers hold accountability and are responsible for delivering high-quality care and demonstrating continuous improvement, with greater autonomy for how to achieve this within a clear set of rules.

They are accountable for:

- the quality of the services they deliver, including clinical outcomes, experience and safety.
- ensuring care meets professional standards, regulatory requirements and agreed contractual expectations, supported by effective clinical and corporate governance.

Boards, executives, practice partners and clinical leaders are accountable for the quality of care their organisation plans, commissions or delivers, including day-to-day oversight, proactive improvement and responding when things go wrong.

Leaders must actively measure, manage and improve quality. This accountability must be exercised locally through robust governance, transparent reporting and effective oversight, with national leadership ensuring that quality management is recognised as a core responsibility that results in action and improvement.

Putting the strategy into action

This strategy focuses on creating the conditions that enable staff to deliver high-quality care in partnership with people and communities, in environments where staff, learners and volunteers are trusted, supported and listened to.

National policy can set direction, but improvement happens in practice. Everyone has a role to play.

Individuals and teams must continuously learn and improve, using data and insight from across the whole team, alongside feedback from people who use services and communities, to identify opportunities for quality improvement.

Providers are responsible for delivering safe, effective care and a positive experience.

Boards and leaders must create environments where quality is actively planned, monitored, improved and assured.

Service providers responsibilities to support implementation of the strategy.

Core quality responsibilities for Providers			
	Responsibility	Where we are now against this responsibility	Actions for ongoing improvement / to meet requirement
Quality Planning	Set a clear vision and priorities to deliver high-quality, cost-effective care and reduce inequalities, involving people using services, unpaid carers, local communities and staff.	Trust Strategy 2026-31 Trust and Service Plan on a Page Coproduction framework Lived experience and peer support workers within organisations. Lived Experience Advisory Board and Equity Partnership Board established. Our People and Culture Strategy 2025-28 Culture, Inclusion and Equity Framework 2025-2028 Neurodiversity Strategy Health Inequalities Strategy 2026-2031 PCREF Plan and Self- Assessment Friends, Family and Carere Charter and strategy (2025-2030) Coproduction framework and toolkit	Ongoing work to embed coproduction across the organisation as relevant to individual services. Continued improvement in focus to inequalities and use of data around this to shape service provision
	Develop a credible integrated plan to deliver priorities, including robust demand and capacity modelling,	Trust Strategy 2026- 2031 implementation plan being	Development of implementation plan and ensuring that all teams and

	with alignment across quality, finance, activity and workforce, and clear outcomes measures.	developed, to include key metrics for ongoing monitoring. Strategies above have implementation plans and ongoing work in place	services understand their contribution to this.
	Work in partnership with strategic commissioners to improve quality and outcomes, and reduce inequalities, including developing new neighbourhood health models.	Leading development of proactive care and MDT led Neighbourhood Health models with primary care alliance in Berkshire West. In East Berkshire formed the new East Berkshire Partnership Group to enable provider delivery alignment with primary care and Frimley Health FT. Innovation funding of >£3m allocated across Berkshire supporting scaling of new neighbourhood models and inequalities focus including complex care, frailty, CYP, Diabetes and CVD. Engaged in Wave 1 National Neighbourhood Implementation Project led by the ICB/Las for Slough and East Berkshire. Contracts agreed with commissioners including assuring delivery of quality and outcomes standards in line with NOF and CQC etc. Trust Health Inequalities strategy 2026-2031 is aligned to commissioner intentions including	Commissioner restructuring completing and clarity on funding models post Innovation Fund During remainder of 2026/27 assess impact of IF schemes on system agreed outcomes and Trust objectives.

		focus to Reading and Slough deprived populations and top 10 divisional health inequalities target areas. Mental Health Provider Collaborative working in partnership with ICB to improve key system outcomes across PICU, rehab, ADHD, inpatient care standards, patient transport.	
	Ensure plans reflect agreed commissioned activity levels and align to overall ICB strategy	Formal contract agreement and relevant schedules for activity plans. Medium Term Planning submission considering strategic commissioning intentions published by Thames Valley ICB, and through Trust strategy and place partnership engagement with ICB representatives including response to the Innovation Fund.	
Quality Improvement	Implement continuous improvement in line with annual planning, this strategy and legal and contractual requirements, including: ○ board capability and leadership development. ○ improvement training for staff ○ involvement and feedback of people using services, unpaid carers and communities, for	The Quality Management Improvement System (QMIS) has been in development since 2017 and encompasses our whole-organisation approach to QI. The management system supports annual planning, strategic alignment and escalation of performance, quality and safety information through scorecards and a cascading governance structure, as well as leadership behaviour development	On-boarding new board members On-going coaching and learning for leaders. Continue to spread and support the routine involvement of service users in all QI efforts. Develop colleagues' skills and confidence in co-production of improvements and transformation projects, large and small.

	example, lived experience partners, patient safety specialists and partners. o delivery of statutory quality functions	and prioritisation of improvement goals. Our whole board have been engaged with development of their understanding and capability for improvement, including executive principle-based behaviour coaching and Gemba visits, and training for the board in the practical use of QMIS. To support improvement, as part of the whole-Trust approach to QI, we have trained teams since 2017 in commons way of working, using the QI tools and methods to solve problems and improve performance. We also provide ad-hoc and targeted QMIS training and coaching for teams. To further build skills for improvement, we have provided 'white belt' online introductory learning to around 2,000 colleagues, as well as more advanced 'yellow belt' and 'green belt' training to around 150 colleagues. There are systems in place to support improvement at all levels, which includes involvement of service-users, carers and communities. There are many examples of patients and carers	
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		being involved in QI work and as equal partners in the management system.	
Quality control	Maintain day-to-day operational management to monitor and sustain quality, including: ○ use of real-time and trend data to monitor quality and outcomes ○ incident recording and risk management processes ○ governance and escalation processes ○ communication (for example, structured handovers, such as SBAR, and huddles) ○ proactive, dynamic risk assessment to identify and respond to emerging risks. ○ standardised processes developed with frontline teams to improve reliability and reduce variation. ○ real-time corrections to processes and clear escalation routes.	QMIS helps day-to-day operational management of quality through the use of: 1) Visual management tools, such as the scorecard, which helps teams to track performance at Trust, divisional and team levels. Each scorecard includes a set of measures of quality or performance that can be influenced and improved at Trust, division, service or team level. The scorecard metrics focus on the four areas of True North and link the Trust's True North goals with day-to-day activities. This is replicated up to Trust-level and at the Quality and Performance Executive Group (QPEG), which oversees and monitors the True North dashboard and breakthrough objectives. 2) Unit Leadership Team (ULT) meetings happen monthly and bring together key team members to discuss and report on scorecard metrics. The main purpose is to review these metrics and report progress using countermeasure summary reports.	Improve the use of visual management at every level to support use of real-time and trend data to monitor quality and outcomes. Continue to support the embedding of QMIS throughout the organisation.

		3) Improvement huddles are regular team meetings where staff come together to identify, prioritise, and act on improvement ideas that support service, patient and organisational priorities.	
Quality Assurance	Put in place effective governance to ensure clear visibility of quality, including: ○ clinical leadership ○ use of data and insight, including feedback from users and staff ○ Equality and Quality Impact Assessments and assessments of cost-effectiveness. ○ incident management and risk recording	Clear governance reporting structure for quality, safety and risk in place Clear leadership structure in place to include clinical Directors/ governance leads as well as ,medical and non-medical consultants. Equality and Quality Impact assessment for policies, business cases, changes to service provision. Service/ divisional and Trust performance scorecards in place - monitored through quality and performance meetings. Realtime patient experience tool (iWGC) used across the organisation. Coproduction framework in place Utilisation of staff survey results Incident management processes with robust oversight and weekly oversight meeting.	

		Internal audit programme to review key governance processes. Staff survey results 2025: My immediate manager values my work 82.71%. My immediate manager encourages me at work 78%. My immediate manager asks for my opinion 69.41%	
	Commission and take part in patient safety investigations, audits and other learning responses (for example, peer and invited reviews), ensuring actions are implemented.	Patient Safety Incident Response Framework and Plan in place Robust governance for ensuring oversight of completion of investigations/ reviews through Mortality and Patient Safety meetings. RCPSYCH SIRAN Re – accreditation achieved 2024 -cover the below which is self and peer assessment. • Service user and carer engagement and involvement in investigation processes. • Clinical engagement in investigation processes • The support offered to those affected by patient safety incidents. • The quality of investigations completed and demonstrating effective learning from these. • The efficacy of patient safety governance processes	

		• Leadership relating to patient safety and safety culture in an organisation	
	Comply with minimum practice standards, oversight and regulatory frameworks.	NICE quality standards are considered, reviewed and implemented as appropriate. Regulatory frameworks are implemented as appropriate	
Local actions to strengthen leadership and management capability for quality			
Leadership Creating an open curious and compassionate culture Focusing on peoples experience of care Making quality everyone's responsibility. Strengthening leadership locally	Establish governance, accountability and behavioural standards: align job descriptions, objectives, supervision and appraisal to agreed quality and expected behaviours. This includes responsibility and timelines for actions and escalation to the organisation's board.	We have a well-developed leadership model and clear trust behaviours. Our Appraisal window 1st April- 31st May ensures that staff have objectives aligned to trust priorities, with trust and team plan on a page undertaken prior to appraisal window (95% achievement of completed appraisals during this window) Staff survey results also demonstrate 95% score for this question) We are reviewing and aligning all job descriptions in line with the national job evaluation review, and these include expected behaviours. Supervision policy in place	Ongoing work to ensure that staff perceive their appraisal to be meaningful in setting clear objectives (41.49% in 2025 survey against peer average 36.37%)
NHS leadership and management framework	Lead through system partnerships: build collective leadership with partners to ensure a whole-system approach to quality management.	Active participation in relevant system meetings including system Quality Group, mortality and learning groups	

Staff standards	Risk appetite and behaviours: set and review risk appetite and embed intelligent risk-taking behaviours aligned to quality goals.		This is a gap; risk appetite has not been considered or set in relation to quality goals.
	Co-produce a strategy with people who use and deliver services: balance all 3 domains of quality and take a value-based, population-health approach to decision-making.	Strategy refresh for our Trust Strategy 2026-2031 has incorporated people who use and deliver services. Strategy incorporates the 3 domains within it, in addition POAP -which has 4 clear focuses. 1. harm free care. 2. Great Patient experience 3. Supporting our staff 4. Efficient use of resources	
	Enable data-driven improvement: resource teams and build capability to interrogate data and intelligence, manage quality and drive improvement.	1. BHFT has invested in dedicated data warehouse, performance, analytics, business intelligence and data quality capability The Trust has established specialist teams covering Analytics, Business Intelligence, Data Warehouse Development, Data Quality and Performance Management. This provides the infrastructure needed to turn operational data into actionable intelligence while ensuring confidence in the information used for decision-making. 2. Data is embedded within the Trust's Quality Improvement methodology	

		BHFT uses a Quality Improvement (QI) approach to support improvement, based on data, improving performance, linking data from frontline services through to Board reporting via the True North Performance Scorecard. This creates a “golden thread” from ward and service level to executive and Board oversight, combining qualitative insight with performance metrics. 3. Building capability through self-service intelligence A key strategic objective is to develop a culture where managers and clinical teams can interrogate and use data themselves rather than relying solely on central reporting teams. This is supported through: • Self-service Business Intelligence and Tableau dashboards • Data quality dashboards available to frontline teams • Training and support to improve understanding and use of information. • Promotion of evidence-based decision making across services. 4. Strong focus on data quality and information assurance BHFT recognises that clinical, operational and financial decisions depend on high-quality data. The	
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		Trust operates a formal Information Assurance Framework (IAF) that: • Audits priority indicators. • Validates data quality and reporting accuracy. • Tracks improvement actions. • Provides assurance to QPEG, Executive Committees and Audit Committee. 5. Improvement is driven through governance and accountability Performance data is actively used within: • Quality and Performance Executive Group (QPEG) • Finance, Performance and Risk governance. • Divisional reviews • Service-level performance management. • Board and Committee reporting. • Digital Clinical Leadership Group (DCLG) Business rules and escalation processes ensure that deteriorating performance triggers improvement actions and oversight. 6. Digital transformation is being used to improve data capture and insight BHFT is increasingly using digital technologies to improve both data quality and productivity, including: • Data warehouse development	
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		• Automation and intelligent automation • Patient Portal • Ambient Voice Technology (AVT) • Digital-first pathways • Population Health Management and risk stratification approaches These initiatives aim to improve the quality, timeliness and completeness of data while enabling better operational and strategic decision making.	
	Create the conditions for quality improvement: ensure teams have the time and capacity to undertake quality management and improvement activities.	We have refined and embedded the Quality Management Improvement System (QMIS), and an approach to QI, that delivers improvements in care and outcomes, as well as engaging, motivating and empowering colleagues to lead continuous improvement in their daily work. QMIS also means teams can maximise the problem-solving power of all colleagues, as well as our patients and carers - giving them the opportunity to fix the issues they face in their everyday work - and to apply QI practices to their contribution to the organisational 'True North' goals. NHS Staff Survey results demonstrate that colleagues feel able to make improvements happen in their area of	Continue to support the embedding of QMIS throughout the organisation. Continue the routine coaching and training leaders and their teams in the tools, systems and behaviours required to create the conditions for QI.

		work, able to make suggestions to improve the work of their team, and to be involved in making changes in their teams (BHFT score highest of all NHS Trusts in the questions in NHS Staff Survey 2025). Staff survey 2025: We each have a voice that counts 7.31. We are compassionate and inclusive 7.94 I am able to make suggestions to improve the work of my team 80.32%. I am able to make improvements happen in my area of work 66.45%.	
	Co-design services with people who use and deliver services, using evidence and innovation: apply the latest guidance, research and innovations.	Coproduction Framework Forums in place to enable engagement and where appropriate co-design of services . this includes Community Forum, Carer and lived experience groups. Hearing Voice of Patient included in Board Assurance Framework Experience of Care Framework self-assessment completed and signed off in Board March 26, relevant groups are taking forward actions where we	

		have rated ourselves as progressing and an annual review will be undertaken of our position	
	Develop team leadership and performance: grow high-performing teams that practise collective leadership to deliver shared quality goals.	Quality Improvement training includes a focus to this, with QMIS handbook to support. Our two introductory leadership programmes are essential for all new managers and managers joining the trust. The new Compassionate Leadership programme is essential training for all managers in the trust. Staff survey 2025: We are a team 7.43. Understanding and kind to one another 79.89%	
	Assure education quality and protect educator capacity: meet education and training standards set out in the <u>NHS Education Quality Framework</u> and by regulators; sustain a workforce focused on care quality and improvement.	Training matrix for staff for clarity on expected training. Training aligned with relevant accreditations and national requirements. Learning and development team have practice educators and teams who deliver relevant face to face trainings. Education quality Framework met.	

		QI training rolled out for all teams and clinical training uses learning form incidents to help inform content	
Culture	Provide leadership development for quality: equip leaders across organisations, networks and partners to build a shared listening and learning culture focused on quality.	Our leadership development and talent programmes support the development of future leaders and encourage compassionate leadership behaviours at all levels, with a competency framework. The Trust has implemented programmes focused on preventing bullying, harassment, violence and sexual misconduct, reinforcing expectations for professional behaviours across all staff groups. Leadership development programmes include content on psychological safety, inclusive leadership, speaking up, managing inappropriate behaviour, compassion and creating respectful team cultures. Organisational values are actively reinforced through recruitment, appraisal, leadership development and staff recognition processes.	
	Assess quality culture regularly: review team, organisational and network culture through routine governance activity to identify gaps and areas for improvement.	Annual staff survey and quarterly Pulse survey undertaken annually. Surveys specific to programmes of work e.g. abuse and bullying.	

		Team surveys undertaken focused to culture	
	Strengthen quality culture through targeted support: provide timely and effective interventions to address identified gaps using approaches such as Patient Safety Incident Response Framework (PSIRF), Freedom To Speak Up and relevant staff survey insights.	Staff survey data proactively used to provide targeted support and improvement where needed. PSRIF and PSIRP in place to support learning from incidents and ongoing improvement. FTSU self-assessment undertaken alternate years with ongoing improvement plan in place and reviewed at Safety Culture meeting and full Board. We have developed a culture assessment tool that brings together data from incident reports, employee relations casework, staff survey responses, and FTSU cases to identify services and teams that would benefit from targeted support. This is co-ordinated by a small group multi-disciplinary team led by our OD experts. Trust level Staff survey 2025: My organisation acts on concerns raised by patients / service users 86.59%. My immediate manager care about my concerns 80.62%	Ongoing improvement work to ensure that targeted support with effective interventions is always able to responsive and timely. Focus to teams where data and intelligence suggests a less positive culture than our teams with a strong positive culture

		I feel safe raising concerns about unsafe clinical practice 81.64%. Care of patients is my organisations top priority 87.85%	
	Align HR and organisational development mechanisms to reinforce culture: ensure appraisals, mandatory training and improvement-focused development are consistent with the expectations set out in this strategy.	We have a behaviours framework (compassion, curiosity, inclusive, perseverance) that is embedded through all people processes i.e. recruitment, training, policies etc. This is aligned to behaviours that enable a culture focused to quality improvement. The tone is set from induction re: behaviours, sexual safety, FTSU etc. Organisational values are actively reinforced through recruitment, appraisal, leadership development and staff recognition processes. Coaching, 360 feedback, and mentoring opportunities are available to support personal growth, career development and leadership capability. Leaders are encouraged to use positive feedback and strengths-based conversations to reinforce good practice and support staff development.	Review and gap analysis of new NHS staff standards published July 2026 with focus to any areas for improvement -Currently in progress.

		The Trust promotes a Just and Learning Culture, encouraging staff to raise concerns, report incidents and share learning without fear of blame. Freedom to Speak Up arrangements are embedded across the organisation, providing safe and accessible mechanisms for staff to raise concerns. Staff are encouraged to contribute ideas and feedback through listening into action events, engagement sessions, Exec Briefings, Trust Leaders forums, staff surveys, and team discussions, Plan On A Page, as well as our Bright Ideas platform. Organisational learning from incidents, complaints, compliments and staff feedback is shared across services to support continuous improvement – we have L&D News and Circulation that go to all staff. All staff have annual Appraisal (within April/ May window) with mid -year review - POAP to support objectives. Platform for training and recently reviewed training matrix	
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		Panels for CPD and apprenticeships decision making to promote equity and fairness. Self-assessment against NHS Staff standards published July 2026	
	Apply NHS England's best-practice guidance and the <u>Experience of Care Improvement Self Assessment (formerly framework)</u> to identify gaps and embed improvement actions.	Experience of care self- assessment completed , presented to Board in March 2026. Relevant areas for ongoing improvement within established programmes of work Initial self-assessment demonstrated achievement of 71% standards and progression/ on-going work for remaining 29% (no areas that we are not focusing too were found)	Continued to focus to areas that we have self-assessed as progressing rather than achieving within the experience of care. These areas focused to • Health inequality • Working with ICB around experience of care • Coproduction • Triangulation to understand experience of care across all services. • Accessible information for all and coproduction of this • Routine feedback from volunteers • Feedback form people who do not access care. • Consistent and routine systematic analysis of qualitative feedback by all teams/ services
Engagement	Review staff engagement mechanisms: assess existing approaches, identify themes from feedback and intelligence, and develop plans to address gaps.	We actively engage with our staff using several routes. Our People and Culture Strategy and associated action plans were developed following	

		feedback from our staff after engaging through trust LIA workshops. We have the highest staff engagement score in our sector and have held this position for 4 out of the last 5 years. Mechanisms used to support staff engagement and understanding of intelligence/ feedback include: Annual staff survey/ Quartley pulse survey Other surveys such as Violence , Prevention and reduction Gemba Listening into action style events Monthly all staff briefing where any staff member can attend and ask anything. Quarterly Mangers and leaders Forum Staff networks Joint Staff side committee Examples of using feedback 1.anti racism 2.VPR 3. Focus to specific areas in staff survey	
	Monitor learner experience: act on insights from the <u>National Education and Training Survey</u> (NETS), <u>GMC National</u>	Non-medical Education: The Trust has a robust process for monitoring learner experience and driving continuous improvement of clinical	

	<u>Training Survey</u> and Educator Voice Survey to drive continuous improvement.	education programmes. Independent assurance is provided through the NHS England National Education and Training Survey (NETS), complemented by Trust end-of-programme evaluations for apprenticeships, clinical placements, and Continuing Professional Development (CPD). Berkshire Healthcare achieved the highest NETS scores across all domains within the Integrated Care System in 2025, providing strong external assurance of the quality of the Trust's learning environment. NETS findings are triangulated with local learner evaluations to identify strengths, prioritise improvement actions and inform targeted quality improvement plans. Feedback from educators is gathered through the Trust's Clinical Educator Connect network, established in November 2025 and regular practice assessor workshops. educator workforce. Survey findings and action plans are reviewed through the Training and Education Advisory Group (TEAG), with assurance provided to the Safety, Experience and Clinical Excellence Group (SECEG), ensuring appropriate	NETS Results to safety culture group with focus to lower scoring which was around understanding FTSU processes
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		oversight and governance of learner experience and education quality. Medical: We analyse feedback from national and trust surveys, focusing on the overall picture and any outlier results. Key findings, together with any cautions regarding interpretation, are summarised and reviewed at the Medical Education Meeting, where an appropriate action plan is developed. Progress against actions is monitored through the Medical Education Meeting, and completed actions are recorded. Next review by the Director of Medical Education (DME): October 2026	
	Embed engagement insights in governance: ensure staff and learner feedback is routinely prioritised and addressed through business-as-usual management and governance arrangements.	Our Safety Culture Group gives us a forum to review engagement insights and agree actions to take forward. Staff and learner feedback through surveys, listening events, all staff briefings with Q&A and Trust leaders and managers events are all part of routine practice.	
	Strengthen engagement practice through targeted support: provide timely and effective support to teams and networks to improve the effectiveness and impact of engagement activity.	Coproduction framework and toolkit in place for engagement with patients as detailed elsewhere in document. Quality Improvement through QMIS rolled out across all services as	Ongoing work to embed co-production framework and toolkit

		detailed elsewhere in document - this provides opportunity for ensuring staff engagement. Network engagement events. Engagement with system meetings, provider collaboratives and other activities in place	
	Implement fair recognition and reward processes: ensure staff recognition and reward mechanisms are transparent and equitable.	Current nursing job description alignment and conversations to ensure fair pay for role undertaken in progress. Review and presentation to Board gender, ethnicity and disability pay gaps. Work undertaken to ensure that there is fair access and award of the clinical excellence award scheme. Use of agenda for change guidance for recognition and reward processes	Action identified from pay gap papers to review the starting point of AfC candidates as some difference between ethnically diverse and white candidates.

QPEG/QAC	August 2026
Title	Learning from Deaths Quarter 1 Report 2026/27
	Item for assurance and noting. Discussion where additional assurance required about quality of care, data or learning.
Purpose	To provide assurance to the Trust Board that the Trust is appropriately reviewing and learning from deaths
Format of the Report	The overall format of the report is not nationally prescribed for Mental Health & Community Health NHS Trusts, however there are a number of metrics which are nationally required and are included within this report.
Business Area	Clinical Trust Wide
Author	Associate Director of Medical Development and Clinical Effectiveness & Clinical Audit
Relevant Strategic Objectives	The systems and processes for learning from deaths align with and give assurance against the three strategic objectives below: Patient safety We will reduce harm risk for our patients by continuous learning from review of deaths. Patient experience and voice We will review all complaints, concerns and feedback (from patient's families and staff, Medical Examiner, Coroner) to inform improvement in the quality and safety of clinical care in our services. Health inequalities We will reduce health inequalities for our most vulnerable patients (patients with learning disability, autism, severe mental illness) by reviewing the care provided to patients leading up to their death and learning for improvement.
CQC Registration/Patient Care Impacts	No impact
Resource Impacts	None
Legal Implications	New Statutory requirements for Medical Examiners from 9 th September 2024 noted, actions taken to ensure that these requirements are fully met in advance of this date.
Equality, Diversity and Inclusion Implications	A national requirement is that deaths of patients with a learning disability & Autism are reviewed to promote accessibility to equitable care. This report provides positive assurance of learning from these deaths. Ethnicity data is included in the report.
SUMMARY	Patient safety For all deaths of a physical health cause, we are required to make a judgement on if they are deemed to have been avoidable. Of the second stage reviews concluded in Quarter 1, one of the deaths were deemed to have been avoidable (avoidability score of 3 or less). For all deaths, both mental health and physical health. We are required to make a judgment on the overall assessment of care. 2 reviews identified poor care, all have been reviewed as patient safety reviews and learning is identified and being implemented through physical health inpatients and mental health community services. Patient Experience and Voice No complaints were received from families of individuals who have died, and no concerns were raised by the medical examiner on behalf of the next of kin. Health inequalities 13 reviews related to patients with a learning disability, all were reported in line with national guidance to LeDeR, who complete independent reviews covering the full patient pathway. Ethnicity data is now included and is detailed in line with 2nd stage review outcomes of avoidability (for deaths of a physical health cause) and overall assessment of care (for all deaths). Learning themes arising from second stage reviews were identified and noted by Clinical Directors and Governance leads for implementation for service improvement.

ACTION	The committee is asked to receive and note the Q1 learning from deaths.
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Learning From Deaths Q1 Report (2026/27)

Figure 1	23/24	24/25	25/26	Q1 26/27	Q2 26/27	Q3 26/27	Q4 26/27	Total 2026/27
Total deaths screened (Datix) 1 st stage review	453	553	521	120	-	-	-	120
Total number of 2 nd stage reviews requested (SJR/IFR)	203	237	176	40	-	-	-	40
Total number of deaths to be reviewed through patient safety (PSII and PSR) declared in Quarter	31	36	37	10	-	-	-	10
Total Expected Deaths	183	219	197	41	-	-	-	41
Total Unexpected Deaths	270	324	326	79	-	-	-	79
Total number of deaths judged > 50% likely to be due to problems with care (Avoidability score of 1, 2 or 3) (concluded in quarter)	0	0	1	1	-	-	-	1
Number of Hospital Inpatient deaths reported (Including patients at the end of life and unexpected deaths following transfer)	140	159	147	28	-	-	-	28
Total number of deaths of patients with a Learning Disability (1 st stage reviews)	53	49	45	13	-	-	-	13
Total number of deaths of patients with Learning Disability where care was rated as poor	0	0	0	0	-	-	-	0

Q1 2026/27

754 deaths were identified on RiO where a patient had died from any cause within a year of contact with any Trust service, of these 120 were submitted for a 1st stage review in line with the learning from deaths policy (16%).

All 120 deaths had 1st stage reviews by the Executive Mortality Review Group (EMRG) in Q1, 2nd Stage reviews were requested for 40 (33%).

36 2nd stage reviews were concluded by the Mortality and Patient Safety Review Group during Q1.

Of the 2nd stage reviews concluded in Q1, 1 of the deaths was a governance cause for concern (Avoidability score of 1,2 or 3) .

Of the reviews concluded in Q1, 2 were assessed as overall poor care following a patient safety review, and learning is detailed in the inpatient and community sections of the report.

2 nd Stage Mortality Reviews Completed (SJR/IFR)	Q1 (36)	Total 2026/2027 (36)
Adult Learning Disabilities Services	13	13
Children's and Young People's Services	0	0
Mental Health Inpatients	1	1
Mental Health Community and Specialist Services	11	11
Physical Health Community Services	5	5
Physical Health Inpatients	6	6

	Avoidability Score for 2 nd Stage Reviews (only death due to a physical health cause) 2026/2027	Q1 (36)	Total to Date (36)
Score 1	Definitely avoidable	0	0
Score 2	Strong evidence of avoidability	0	0
Score 3	Probably avoidable (more than 50:50)	1	1
Score 4	Possibly avoidable, but not very likely (less than 50:50)	1	1
Score 5	Slight evidence of avoidability	2	2
Score 6	Definitely not avoidable	23	23
N/A	Non physical health cause	9	9

128

	Overall Assessment of Care Q1 (36)	Physical Health	Learning Disability	Mental Health	Children and Young People	Total to Date 26/27 (36)
1	Very poor care	0	0	0	0	0
2	Poor Care	1	0	1	0	2
3	Adequate Care	3	3	6	0	12
4	Good Care	7	9	5	0	21
5	Excellent Care	0	1	0	0	1
	N/A	0	0	0	0	0

Ethnicity April 2026 – March 2027 (Rolling data to be updated each quarter)	1st Stage Review 2026/27	2 nd Stage Review Requested 2027/27	% 2 nd Stage Review Requested
Asian or Asian British – Any other Asian Background	1	0	0
Asian or Asian British – Chinese	0	0	0
Asian or Asian British – Indian	4	0	0
Asian or Asian British – Pakistani	3	1	33
Black or Black British – African	1	0	0
Black or Black British – Caribbean	1	0	0
Black or Black British – Other Black Background	1	0	0
Mixed – Any other mixed background	2	0	0
Mixed – White and Asian	1	1	100
Mixed – White and Black Caribbean	0	0	0
Not Known – Waiting for first appointment/not recorded	7	4	57
Not stated – Refused	3	1	33
Other ethnic category	1	0	0
White – Any other white background	6	3	50
White – English/Welsh/Scottish/Northern Irish/British	86	28	33
White - Gypsy or Irish Traveler	1	0	0
White – Irish	2	2	100
Grand Total	120	40	33

Ethnicity April 2026 – March 2027 Reviews Concluded at MAPS	Score 1 Definitely Avoidable	Score 2 Strong Evidence of Avoidability	Score 3 Probably Avoidable	Score 4 Possibly Avoidable	Score 5 Slight Evidence of Avoidability	Score 6 Definitely Not Avoidable	N/A (MH related deaths)	Total
Asian or Asian British – Chinese	-	-	-	-	-	-	2	2
Asian or Asian British – Indian	-	-	-	-	-	-	-	-
Asian or Asian British – Pakistani	-	-	-	-	-	-	-	-
Black or Black British – African	-	-	-	-	-	-	-	-
Black or Black British – Caribbean	-	-	-	-	-	-	-	-
Mixed – Any other mixed background	-	-	-	-	-	-	-	-
Mixed – White and Black Caribbean	-	-	-	-	-	-	-	-
Not Known - Waiting for first appointment/not recorded	-	-	-	-	-	1	1	2
Not stated – Refused	-	-	-	-	-	1	-	1
Other ethnic category	-	-	-	-	-	3	-	3
White – Any other white background	-	-	-	-	-	-	-	-
White – English/Welsh/Scottish/Northern Irish/British	-	-	1	1	2	18	6	28
White – Irish	-	129	-	-	-	-	-	-
Grand Total	0	0	1	1	2	23	9	36

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

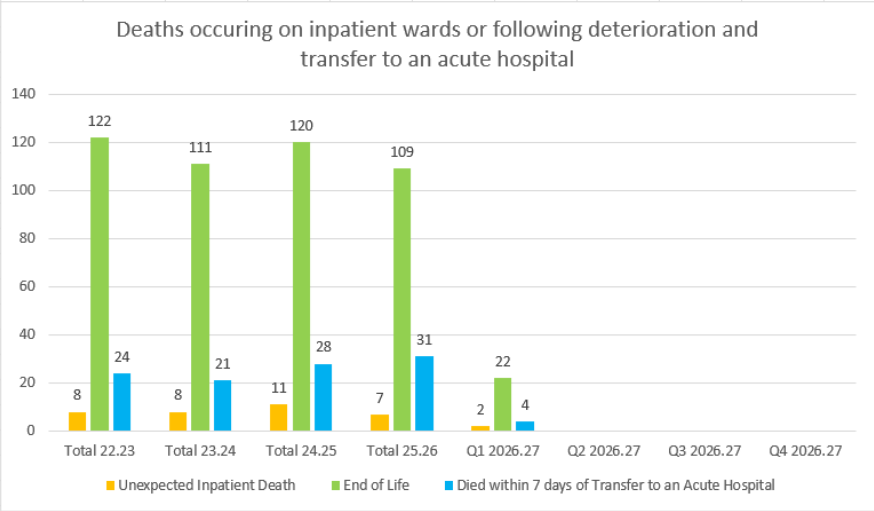
Overall Assessment of Care all 2 nd stage reviews completed in 2026/27 (April 26 – March 27 to date will include cases reported as 1 st stage reviews in 2025/26)	1 Very Poor Care	2 Poor Care	3 Adequate Care	4 Good Care	5 Excellent Care	Total
Asian or Asian British – Any other Asian Background	-	-	-	-	-	-
Asian or Asian British – Indian	-	-	-	-	-	-
Asian or Asian British – Pakistani	-	-	-	-	-	-
Asian or Asian British – Chinese	-	-	2	-	-	2
Black or Black British – African	-	-	-	-	-	-
Black or Black British – Caribbean	-	-	-	-	-	-
Mixed – Any other mixed background	-	-	-	-	-	-
Mixed – White and Black Caribbean	-	-	-	-	-	-
Not Known – Waiting for first appointment/not recorded	-	-	1	1	-	2
Not stated – Refused	-	-	-	1	-	1
Other ethnic category	-	-	-	-	-	-
White – Any other white background	-	-	-	3	-	3
White – English/Welsh/Scottish/Northern Irish/British	-	2	9	16	1	28
White – Irish	-	-	-	-	-	-
Grand Total	0	2	12	21	1	36

Equality & Diversity Summary Q1 2026/27

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

Of the 2nd stage reviews concluded, there were no cases identified as poor care for patients from a BAME group from a total of 0.

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



In Q1, EMRG reviewed: 28 inpatient deaths. 26 were from physical health wards of which: 22 were expected end of life and 4 were unexpected (1 rehabilitation inpatient and 3 transfers with death within 7 days).

2 inpatient deaths were from mental health wards, each unexpected (1 inpatient, and 1 transfers with death within 7 days).

2nd stage reviews were requested for all unexpected physical health deaths. Of the 22 expected end of life physical health deaths, 22 were closed at 1st stage review and there were no SJRs requested following Medical Examiner review. A 2nd stage review was requested for 4 physical health inpatient deaths (3 transfers within 7 days of death, and 1 unexpected inpatient death), and 2 mental health inpatient deaths (1 unexpected inpatient death, and 1 transfer within 7 days of death).

Q1 2026/27

All inpatient deaths were reviewed by the Medical Examiner and the cause of death was confirmed. In line with our Learning from Deaths Policy, 2nd stage reviews are requested and reviewed for all relevant deaths.

Of the 7 inpatient 2nd stage reviews concluded:

- 3 were assessed as score 6 (definitely not avoidable) and received a care rating of good.
- 2 were assessed as score 6 (definitely not avoidable) and received a care rating of adequate.
- 1 was assessed as score 5 (slight evidence of avoidability) and received a care rating of good.
- 1 was assessed as score 3 (probably avoidable, more than 50:50) and received a care rating of poor.

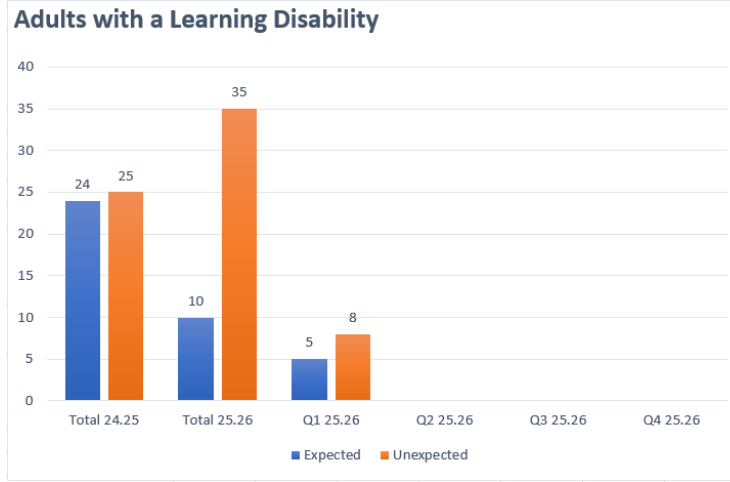
The poor care case was reviewed through the Patient Safety Incident Investigation process. Learning identified the need for improved documentation of prescribing decisions and monitoring plans, and adherence to medicines reconciliation and pharmacy review processes. Actions have been incorporated into the Safety Improvement Action Plan.

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

Month of death (Note this is not EMRG date)	2024/25	2025/26	April 26	May 26	June 26	July 26	August 26	September 26	October 26	November 26	December 26	January 27	February 27	March 27	Total 2026/27
Total Inpatient deaths reviewed by the Medical Examiner	127	114	8	8	8	-	-	-	-	-	-	-	-	-	24
SJRs requested for Inpatient deaths by Medical Examiner	1	7	2	0	0	-	-	-	-	-	-	-	-	-	2
Coroner Referrals advised by Medical Examiner for Inpatient Deaths	3	9	1	0	1	-	-	-	-	-	-	-	-	-	2

EOL Audit Q1	Total Q1	Narrative
New continuous audit which reviews all physical health inpatient planned End of Life deaths.	23	All 14 audited cases met the expected standard of care, with no variation in care quality identified by demographic characteristics or for deaths occurring during out-of-hours periods on weekdays or at weekends. The single Category 2 death related to a sudden deterioration, with no concerns regarding the care provided. Work is underway to explore culturally competent approaches to end-of-life care, and a future divisional audit of ReSPECT forms is planned once the electronic version is further embedded into practice. Berkshire Healthcare has been invited to share learning at the Thames Valley Regional Learning from Deaths Meeting regarding legal questions used within palliative care reviews to support symptom assessment, communication and recognition of patient and carer concerns.

Adults with a Learning Disability (LD) Learning From Deaths Q1 2026/27



In Q1, 13 deaths of adults with learning disability were reviewed at 1st stage review. 8 were classed as unexpected and 5 as expected deaths, 2nd stage reviews were requested for 10, 2 were closed at 1st stage review, and 1 case required further information.

13 2nd stage reviews were concluded in Q1 (detailed in tables below).

Severity of Learning Disability	Q1	Total 26/27 (13)
Mild	6	6
Mild to Moderate	-	-
Moderate	-	-
Moderate to Severe	-	-
Severe	3	3
Profound	-	-
Not Known	4	4

Ethnicity	Q1	Total 26/27 (13)
White - English/Welsh/Scottish/Northern Irish/British	9	9
White - any other white background	3	3
Not Known	1	1

	Q1	Total 26/27 (13)
Male	5	5
Female	8	8

The deaths attributed to the following causes:	Q1	Total 26/27 (13)
Diseases of the respiratory system	10	10
Diseases of the heart & circulatory system	-	-
Diseases of the digestive system	1	1
Sepsis or infection	1	1
Cancer	1	1
Other	-	-
Not known	-	-

	Avoidability Score for 2 nd Stage Reviews (13)	Learning Disability Q1 26/27
Score 1	Definitely avoidable	0
Score 2	Strong evidence of avoidability	0
Score 3	Probably avoidable (more than 50:50)	0
Score 4	Possibly avoidable, but not very likely (less than 50:50)	0
Score 5	Slight evidence of avoidability	1
Score 6	Definitely not avoidable	12
N/A	Mental health	0

	Overall Assessment of Care	Learning Disability Q1 26/27
1	Very poor care	0
2	Poor Care	0
3	Adequate Care	3
4	Good Care	1
5	Excellent Care	9

Q1 2026/27

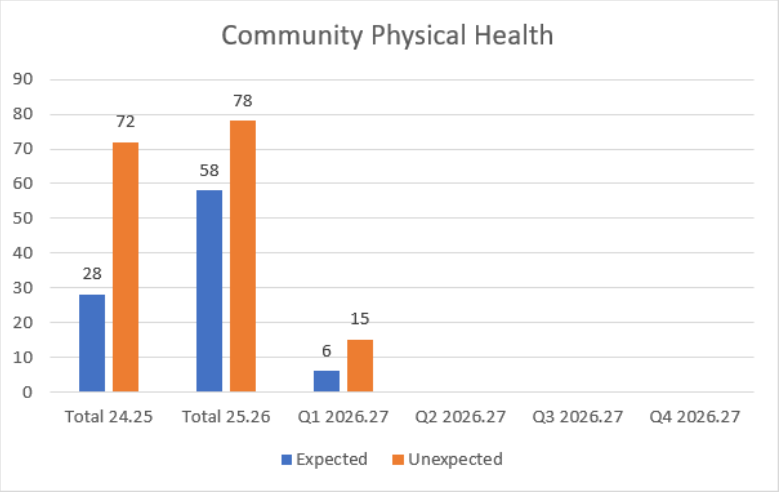
In Q1, the following learning was shared within the LD service:

- Ensure timely and appropriate communication when acknowledging referrals and discharging patients, including use of CTPLD Care Plans to evidence care, reviews and outcomes.
- Maintain contemporaneous RiO records, including clinical decision-making, rationale and multidisciplinary involvement.
- Apply triage processes consistently to assess need and prioritise care according to urgency.
- Review and address challenges in tracking internal referrals following changes to internal referral processes.
- Continue to use Mental Capacity Act documentation within RiO.

In Q1, the following actions were identified within the PH service:

- Address delays in initial visits that fall outside service standards.
- Improve identification and flagging of learning disabilities and access needs to support timely assessment.
- Ensure discussions with GPs, including those relating to abnormal blood results, are documented in RiO.
- Consider referral to CTPLD services where patients with a learning disability are not engaging with health services.

Community Physical Health Learning From Deaths Q1



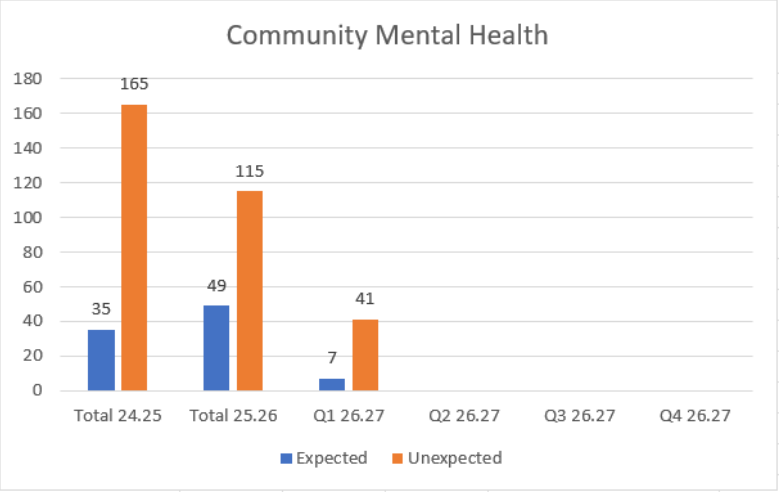
EMRG received 21 1st stage reviews in Q1 of which 2nd stage reviews were requested for 8, with 1 requiring further information.

The concluded reviews did not identify any deaths judged more than 50% likely to be due to problems with care.

Learning implemented by the division to address key issues identified include:

- **Documentation and care planning:** Clinical documentation, treatment escalation planning and ReSPECT documentation required strengthening to ensure records accurately reflected clinical decisions and goals of care.
- **Physical deterioration and monitoring:** Learning focused on infection control processes, monitoring of deteriorating patients and ensuring timely review and escalation when concerns are identified.
- **Mental health and self-neglect:** Earlier recognition of self-neglect, non-engagement and low mood was identified as important, alongside appropriate escalation and joint working with mental health services.
- **Partnership working:** Learning highlighted the importance of effective communication and collaboration between community, mental health, drug and alcohol, and other partner services to support coordinated care.

Community Mental Health Learning From Deaths Q1

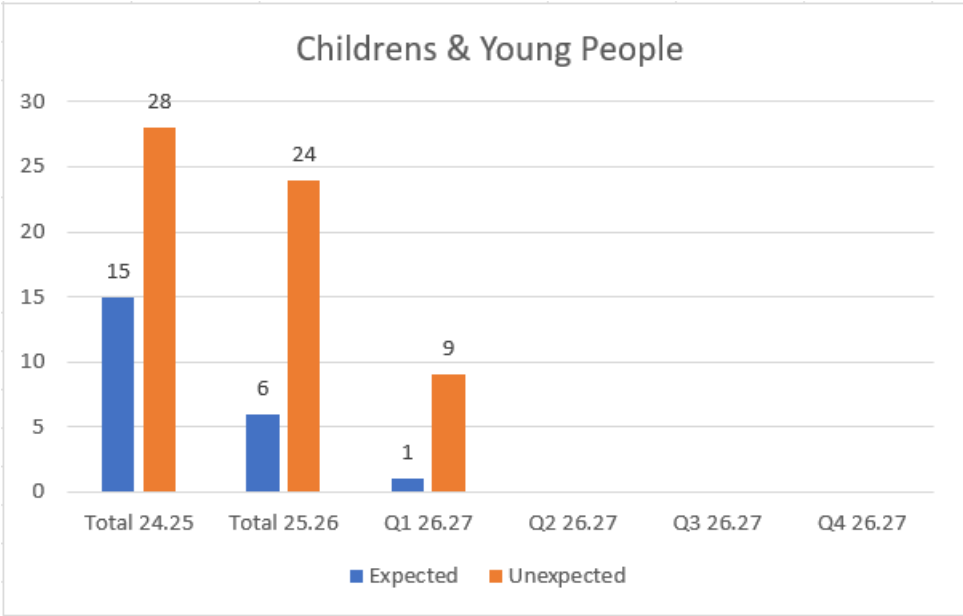


EMRG received 48 1st stage reviews in Q1 of which 2nd stage reviews were requested for 16, with 2 requiring further information.

The concluded reviews identified learning across community and specialist mental health services.

Learning implemented by the division to address key issues identified include:

- **Documentation:** Clinical documentation, risk assessment, capacity considerations, MDT discussions and decision-making were not always recorded consistently, limiting assurance and continuity of care.
- **Engagement and follow-up:** Learning identified the need to strengthen management of non-engagement, follow-up arrangements and ongoing review of patients with complex and enduring needs.
- **Communication and involvement:** Opportunities were identified to improve communication with families and carers, recording of discussions, and communication between services and partner organisations.
- **Risk assessment and escalation:** Learning highlighted the importance of recognising vulnerability, safeguarding concerns and complex presentations, with timely escalation and multidisciplinary oversight where risks remain unresolved.
- **Care coordination and pathways:** Learning identified opportunities to strengthen referral pathways, service coordination and continuity of care to support patients receiving care across multiple services.



EMRG received 10 1st stage reviews in Q1, all of which were closed. Included, premature births, child with complex life limiting illness an unexpected deaths under universal HV or school nursing and no contact.

There were no 2nd stage reviews concluded in Q1 for the children's and young people service.

Deaths of children and young people are reviewed by the Berkshire Child Death Overview Panel (CDOP) and there is cooperation with local authority safeguarding practice reviews as required.

Complaints and Inquiries Learning From Deaths Q1

Complaints and MP Inquiries	Quarter	Total
No new complaints to MAPS.	Q1	0

To date, there are no new complaints received in 26/27; however, there was a local resolution to an informal complaint, which was reviewed alongside a Specialist Judgement Review regarding concerns around patient's care at the time of death.

There has been 1 Freedom of Information Request in Q1 26/27 (FOI 037), relating to deaths for Q1 25/26 from a regular requester and the questions were around patients dying following electroconvulsive therapy sessions, seclusion, restraint or medication error.

Prevention of Future Deaths (PFD) reports 2026/27: No PFD’s have been received in Q1.

Overall Learning and Summary From Deaths Q1

Of the second stage reviews closed, 1 death was identified as a governance cause for concern (avoidability score 3). This related to a death with a physical health cause. Learning highlighted the need for improved documentation of prescribing decisions and monitoring plans, and adherence to medicines reconciliation and pharmacy review processes.

For all deaths, both physical health and mental health, we review whether the care provided was excellent, good, adequate, poor or very poor using the SJR methodology. 2 reviews identified poor care and learning has been identified for the services.

Both cases have been reviewed as patient safety reviews and have actions in place to address areas requiring improvement.13 reviews related to patients with a learning disability in Q1, all were reported in line with national guidance to LeDeR, who complete independent reviews covering the full patient pathway.

No cases were identified as poor care and none were deemed a governance cause for concern. No concerns were raised by the Medical Examiner.

Learning from Deaths themes from 2026/27

Top themes broken down by division:

Community Mental Health

- Documentation
- Engagement and follow-up
- Communication and family involvement
- Risk assessment and care coordination

Community Physical Health

- Documentation and care planning
- Deterioration, monitoring, and escalation
- Self-neglect and engagement
- Partnership working

Inpatient Mental Health

- Access to services
- Communication, and family involvement
- Safety-netting and follow-up

Inpatient Physical Health

- Recognition and escalation of deterioration
- End of life care planning
- Documentation and communication

Children & Young People/ Learning Disability

- Documentation and recording keeping
- Communication and referrals
- Learning disability identification
- Mental Capacity Act documentation

Overarching themes across all divisions and services:

- Documentation and record keeping
- Communication and partnership working
- Risk assessment, and escalation
- Care planning and continuity of care

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

This report covers the period 9th May 2026 to the 4th August 2026

Executive summary

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

This report focusses on the period of 9th May 2026 to 4th of August 2026. Since the last report to the Trust Board, we have **received five exception reports ER), one ER has been withdrawn.**

Introduction

Number of doctors in training (total):	65 (WTE 62.2)
Number of doctors in training on 2016 TCS (total):	65 (WTE 62.2)
Amount of time available in job plan for guardian to do the role:	1PA
Admin support provided to the Guardian (if any):	None
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee

Exception reports dashboard

Number of exception reports submitted over the last quarter

Number of exception reports submitted over the last quarter:	5
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Categories of exception reports submitted

Type	Outcome				Number
	Pay	TOIL	Penalty / Fine	For Info	
Additional hours an unscheduled early start					0
Additional hours an unscheduled late finish	0	3	0		3
Breaches of non-resident on-call patterns	1		0		1

The inability to take contractual breaks			0		0
Inadequacy of clinical support					0
Inadequacy of rostered skills mix					0
Raising concerns of a suspected non-compliant rota pattern					0
Detriment or threat of detriment related to exception reporting					0
Information breach					0
Access and completion resolved in time					N/A
Access and completion breaches					0
Access and completion test					0
Other: optional free text box					
Total					4

Experiences of actual or threatened detriment

Quarterly survey response rate	4
Doctors experiencing actual detriment as a result of exception reporting	0
Doctors feeling that they are not discouraged from exception reporting	0

Withdrawals

Number of exception reports withdrawn over the last quarter	1
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Personally identifiable data related to exception reporting must not be shared without the doctors' specific consent, except where a senior manager or member of the board of directors is presented with an overriding public interest or has a legal obligation.

Number of exception reports disclosures over the last quarter	0
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Work schedule reviews related to exception reporting pattern/instances

Number work schedules reviews related to exception reporting patterns or instances	0
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Rota gaps on all shifts

Total number of rota gaps on all shifts over the last quarter	Core trainee rota: 66 rota gaps+ 39 sickness gaps= total 105; 15 shifts were not covered Higher trainee SpR rota: 15 gaps, all covered
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The Guardian of Safe Working Hours is required to report any escalated issues in relation to working hours, raised in exception reports, to the relevant executive director, or equivalent, for decision and action, where these have not been addressed at departmental level.

No issues needed to be escalated during this quarter

The Guardian of Safe Working Hours is required to report issues, with certain posts, that cannot be remedied locally and require a system-wide solution. The board is required to raise the system-wide issue with partner organisations (for example, NHS England) to find a solution.

No issues during this quarter

Escalations

None escalated

Recommendations

Members of the Board are requested to receive assurance that the working hours of doctors in training are safely rostered and that their working hours are compliant with the TCS.

Qualitative information

There are now three on call rotas for out of hours (OOH). The established out of hours rota for residential on call covered by the core trainees and GPVTS/FY2 doctors at CT1-3 level; the non residential on call (NROC) out of hours rota covered by higher trainees between 5 PM and 9 AM including cover for POS (place of safety). The NROC is further distinguished as one for general adult + old age (GA and OA) and child and adolescent mental health (CAMHS). The CAMHS rota is for meeting training needs of higher trainees and not aimed at service provision and therefore only filled ad hoc based on number of CAMHS trainees and their OOH experience requirements.

The GOSW has regular discussions with resident doctors regarding the exception reports at the Resident Doctors' Forum (RDF) which is attended by DME and tutors, other educational and training issues are discussed too- these meetings were held on 7-5-2026, 4-6-2026 and 2-7-2026. There were no concerns raised by resident doctors in getting their TOIL or payment for the ERs or any access/breach issues. Newly joined resident doctors are being sent log in details for the DRS4 online system which is used to exception report.

GOSW quarterly survey (July 2026) free text responses: *There are no work schedules available when I try to select my work schedule when exception reporting. This has not prevented me from being able to exception report and receive the TOIL.*

There has been a great improvement in the system, the application of stricter confidentiality parameters and subsequently deeper trust in the system and ability to raise exception reporting. The role of GOSW and their ability to initiate, maintain and monitor such process while advocating for trainees' needs, protected time and importance of work life balance was both necessary and strongly implemented. Thank you

Fines

Fines levied by the Guardians of Safe Working should be applied to individual departments, as is the intent of the contract. **No fine has been levied during this quarter.**

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter
£318.48	£ 0	£0	£318.48

The OOH rota is currently operating at 1:13 and our system for cover works efficiently, with gaps generally being quickly filled. Our bank doctors continue to be an asset, and we continue to increase this pool. There has been few unfilled gaps as noted above. For these unfilled gaps, patient safety was not an issue and we have always had at least one resident doctor on duty out of hours at Prospect Park Hospital. GOSW continues to engage with resident doctors during induction and resident doctors' forum monthly meetings on a regular basis, any issues arising are escalated to DME or LNC, as appropriate.

Summary

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

Resident doctors are strongly encouraged to make exception reports by the Guardian at induction and at every resident doctor forum. Resident doctors are assured that it is a neutral act and asked to complete exceptions so that the Guardian of Safe Working can understand working patterns in the Trust. Exception reporting is a neutral action and is encouraged by the Guardian and Directors of Medical Education. We continue to promote the use of exception reporting by resident doctors and make sure that they are aware that we will support them in putting in these reports.

The GOSW asks the Board to note the report and recommendations.

Next report to be submitted in November 2026.

Report compiled by Dr Malarvizhi Babu Sandilyan, Guardian of safe working hours, BHFT on 4-8-2026

Trust Board Paper

Board Meeting Date	8th September 2026
Title	Winter Planning Assurance Board approval
	Item for Approval
Reason for the Report going to the Trust Board	Trust Boards are accountable for providing the assurance on the plans ahead of winter, ensuring they mitigate against key delivery challenges and risks, and include robust plans under three demand levels: baseline, moderate and extreme.
Business Area	Operations
Author	Theresa Wyles COO
Relevant Strategic Objectives	Patient safety Ambition: We will reduce waiting times and harm risk for our patients Patient experience and voice Ambition: We will leverage our patient experience and voice to inform improvement Health inequalities Ambition: We will reduce health inequalities for our most vulnerable patients and communities Workforce Ambition: We will make the Trust a great place to work for everyone

Summary	The board assurance document has been completed alongside a refreshed winter reliance plan which will be tested through regionally led exercise on the 14th September 2026. Additionally, we will be undertaking a Berkshire system resilience desk top exercise scheduled during September. A system wide winter demand reduction and management group is being stood up in Berkshire West with recommended actions shared with Frimley and Berkshire East colleagues. OPEL action cards available within the resilience plan and provide a framework for system response to escalating pressures. Our daily performance and OPEL score is reported through a data feed into SHREWD which is overseen by the ICB winter lead. Operational colleagues will participate in all system escalation calls as arranged and calls will be covered by the on-call Director during weekends and bank holidays. We also have an internal winter operational management team which will be stood up from the beginning of November and operate through until March 2027. Review of IPC requirements and Flu vaccination programme have been completed with the vaccination programme due to commence from the 1st October 2026 The Board is required to approve the assurance template no later than the 30th September 2026 with signature required from the Chair and CEO.
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Trust Board Paper

Board Meeting Date	08 September 2026
Title	Executive Report
	Item for Noting
Reason for the Report going to the Trust Board	The Executive Report is a standing item on the Trust Board agenda. This Executive Report updates the Trust Board on significant events since it last met. The Trust Board is requested to seek note the report and to seek any clarification on the issues covered in the report.
Business Area	Corporate Governance
Author	Chief Executive
Relevant Strategic Objectives	The Executive Report is relevant to all the Trust's Strategic Objectives

Trust Board Meeting – 08 September 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. Understanding the Offer to Resident Doctors

This briefing summarises the offer agreed with the British Medical Association (BMA) for resident doctors, including further pay increases, reimbursement of mandatory training costs, additional training places, improved job opportunities and action on working conditions.

The offer aligns with the 10-Point Plan, against which the Trust is already making substantial progress.

Pay reform

Pay reform aims to accelerate progression and better align pay with capability, experience and responsibility.

- New pay nodes would be linked to training competencies.
- Earlier Annual Review of Competence Progressions (ARCPs) would enable eligible doctors to progress sooner.

It would also support less-than-full-time progression, create an enhanced ARCP route for Locally Employed Doctors, and increase Clinical Academic pay premia from £5,600 to £10,000.

The pay element will be backdated to April 2026 and is expected to be implemented during 2027.

Reimbursing costs

- Mandatory training costs would be reimbursed more consistently.
- Eligible Royal College membership, portfolio and exam fees would be reimbursed through employers.
- Exam fee reimbursement would cover two attempts.
- A BMA, Department of Health and Social Care and NHS England working group would confirm covered fees.

- Equivalent arrangements would also be agreed for dentists in training.
- These arrangements would also apply to Locally Employed Doctors.

NHS England guidance is awaited. Reimbursement is expected to be backdated to April 2026, subject to funding confirmation.

Training opportunities

The offer would increase training opportunities and give resident doctors a role in decisions about the distribution of training places.

Improving working lives

The offer builds on existing work to improve resident doctors' working lives, including the 10-Point Plan and Medical Education and Training Review. Progress is reported to the Quality Assurance Committee and monitored by the Resident Doctor Working Group and Peer Lead. From 2027, employers must also report progress in annual accounts.

Executive Lead: Dr Tolu Olusoga, Medical Director

3. NHS England Quality Strategy for NHS-Funded Care in England (published on behalf of the National Quality Board on 14 July 2026)

What the strategy sets out to achieve

The quality strategy aims to ensure high-quality care is available to everyone, everywhere, with reducing unwarranted variation and tackling health inequalities identified as essential to achieving this aim.

It emphasises the three core domains of quality as patient safety, clinical effectiveness, and patient experience.

The strategy is a call to action for leaders, clinicians and staff across the NHS; it brings together existing commitments from the government's 10-year plan to ensure that quality is treated as the primary purpose, that approaches are values-based and resources are directed to the interventions that deliver the greatest benefit for patients and communities.

How this will be delivered

The strategy identifies ten enablers to create the conditions for improvement across the system.

- Clarifying who is responsible and accountable for quality at every level of the healthcare system.
- Setting clear priorities to improve the quality of care while adopting a transparent, co-ordinated and value-based approach.
- Strengthening leadership and management capability to create the right culture and conditions for improvement.
- Listening to and working with people and communities on what matters to them.
- Using data to manage quality, inform decisions and support accountability at all levels.

- Increasing transparency, making the NHS the world's leading healthcare system for public access to information on care quality.
- Developing and embedding technology to underpin quality management and improvement.
- Aligning incentives and rewards with accessible, high-quality and productive care.
- Promoting research and innovation to support continuous improvement in clinical care and how the NHS operates.
- Creating a more co-ordinated and improvement-focused approach to regulation.

The strategy sets out national, system and provider responsibilities to support delivery, recognising that everyone has a role to play. It also recognises that, while national policy can set direction, improvement is delivered in practice.

Providers are responsible for the quality of care provided, their organisational plans, day-to-day oversight, proactive improvement and responding when things go wrong.

An initial assessment has been undertaken against the provider responsibilities that will support national and local implementation of this strategy. This self-assessment includes how we deliver against quality planning, quality improvement, and quality control across the organisation.

The aims of the strategy and the enablers that support delivery align well with our Trust strategy, our quality improvement ways of working, work programmes and areas of focus, with no significant gaps identified.

The full self-assessment was presented to our Quality Assurance Committee in August 2026 (and is circulated with the Quality Assurance Committee minutes at agenda item 6.2 C), and any updates will continue to be provided through the committee.

Link to full strategy: [NHS England » Quality strategy for NHS-funded care in England](#)

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

4. Elective Care Minimum Standards of Patient Experience

To provide assurance that the Trust is meeting NHS England's Minimum Standards of Patient Experience for elective care and applying them appropriately within planned community services.

The Board is asked to note that the Trust is broadly aligned with these standards through established referral management, booking, waiting list validation, patient tracking and communication processes. The standards apply mainly to planned, non-urgent community pathways and support good practice in keeping patients informed throughout their care.

The Trust can provide assurance that the standards are being met where applicable, with ongoing oversight through routine planned service governance and local improvement activity where required.

Executive Lead: Theresa Wyles, Chief Operating Officer

Presented by: Julian Emms
Chief Executive
08 September 2026

Trust Board Paper Meeting Paper

Board Meeting Date	8 th September 2026
Title	Health & Wellbeing Update
Purpose	Item for Assurance
Reason for the Report going to the Trust Board	The health and wellbeing update is scheduled for review every six months. The paper is presented for information and assurance.
Business Area	People Directorate
Author	Jane Nicholson, Director of People Hardip Johal, Wellbeing & People Engagement Manager

Report to Trust Board – August 2026
Health, Wellbeing, Engagement & Rewards Update

Executive Summary

The Health & Wellbeing Update report provides a comprehensive overview of the Trust's initiatives and progress in enhancing staff health, wellbeing, engagement, and rewards. The report highlights the following key points:

1. Over the past six months, the Wellbeing Team has undergone structural changes reducing some capacity. The team has been divided and aligned to two services within the People Directorate: Wellbeing Matters now sits within Organisational Development, while Wellbeing sits within Operational HR.
2. Wellbeing at Work Series: 20 sessions on wellbeing topics (Wellbeing and Wellbeing Matters) reached over 1,000 attendees, with high satisfaction and the introduction of regular mindfulness sessions.
3. Ongoing Wellbeing Benefits: Continued provision of eye test vouchers, physio, salary finance, milestone awards, and cycle-to-work schemes.
4. Employee Assistance Programme: Health Assured is the continued provider, delivering emotional support and counselling with strong improvements in anxiety and depression scores among users.
5. Financial Wellbeing Support: Robust support includes salary advances, loans, savings, and food bank vouchers. Demand is steady and now being tracked for better monitoring.
6. Capacity Challenges and Roadmap: Reduced team capacity has limited delivery of some projects. Future priorities include increasing staff survey participation and exploring new wellbeing funding opportunities.

Review:

The Health and Wellbeing team have delivered the following outcomes, since the last board update in November.

Activity	Target staff group	Data and impact
Our Wellbeing at Work series has continued to be popular over the past six months. These are regular sessions dedicated to supporting our people's wellbeing which came out of the Wellbeing Review. Each session will focus on a different theme, providing practical advice, expert insights and a chance to connect with colleagues. All sessions are recorded so that staff can watch back if they can't attend the live session.	All staff	General Wellbeing at work Sessions: 4 sessions delivered (not including Wellbeing Matters) Attendees: approx. 250
We continue to offer and administrate various wellbeing support and benefits as part of business as usual. This includes: - Access to eye test vouchers - Early access physio service (provided by Optima Health) - Salary Finance - Milestone awards – from April, these awards are limited to 25 and 40 years of NHS service only - Cycle to Work and access to vouchers through Vivup We have highlighted some key data from these services on the right	All eligible staff	Milestone Awards Between Dec and March 2026, we have issued: BHFT/NHS service milestone (1-40 years): 647 (now ended) Between April to July 2026, we have issued: NHS service milestone (25 and 40 years): 55 Retirement awards January 2026 – June 2026: 108 Vivup (November 2025 – July 2026) Cycle to Work 27 orders, 20 accepted, 5 cancelled, 2 rejected Average order value £1,118.31 Employer savings £6,734.51 Lifestyle Savings (Vouchers) 336 gift cards purchased £42,299* (£2085 savings)

Activity	Target staff group	Data and impact
		Top suppliers: Sainsbury's, Tesco & Asda Most saved: Sainsbury's, Tesco & Airbnb
Employee Assistance Programme (Health Assured) A recent procurement exercise with 3 additional trusts in the BOB ICB has been completed and Health Assured has won the contract. This is currently going through contracting and should be in place by the start of November. By tendering together, we were able to deliver a cost saving.	All Staff	Health Assured (Dec 25 – May 26) Calls – 582 545 for emotional support/counselling (top themes - anxiety, low mood and concerns over own health) 37 for advice (top themes – employment, divorce & separation and access to service) 0 for coaching After engaging in structured therapy: • 70% improvement in the Generalised Anxiety Disorder (GAD-7) scores • 70% improvement in the Patient Health Questionnaire (PHQ-9) scores Net Promoter Score (NPS) is 84.3 (across Health Assured)
Financial wellbeing support Since the cost of living crisis began in 2023, we have ensured that we have a robust financial support offer available to staff. This support makes a huge difference to the individuals who are facing very difficult situations. This includes access to Salary Finance for advances, loans, savings and education, as well as internal 1-1's with our team to help staff explore what financial support is available and support with food bank vouchers, salary advances etc where possible. The input to these conversations vary – some are	All staff	Internal Support: November 2025 – July 2026 5 staff given financial support 4 food bank vouchers issued to 4 staff members Salary Finance Nov 2025– July 2026 Borrow: 105 applications 58 full loans offered 47 declined and debt advice signposted

Activity	Target staff group	Data and impact
simple signposting, others can be more complex work including arranging salary advances, benevolence payments, housing support etc. Links are often made to other wellbeing support as well such as Wellbeing Matters. The demand on this work has been variable and as a result, wasn't previously tracked. The trend this year has turned to constant and relatively steady and is now being tracked in order to monitor usage.		Of the 35 loans issued. 25 full loans 10 starter loans £4,604.41 average loan value Reasons for loans: - 14 – debt consolidation - 6 – home - 5 – car - 10 – other Advance: 35 advance registrations 111 active users 1,545 advances @ average £162.30 Save: 15 active save accounts £720.56 average savings per user

Future Roadmap:

Upcoming project delivery and likely timescales are captured below.

Activity	Target staff group	Intended benefit
Staff Survey 2026 The 2026 Staff Survey will open mid-September and run until 28 November 2026.	All staff	Increasing employee voice.
HR Roadshows Wellbeing will be a key part of this year's HR roadshows, providing colleagues with an opportunity to find out more about the wellbeing support available to them.		To raise awareness of the wellbeing offer



Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Meeting Date	8 th September 2026
Title	Wellbeing Matters Update Report
	Item for Assurance
Purpose	Provide an update on Wellbeing Matters activity over the 6-month period January-June 2026. An executive summary is followed by a detailed report and appendices.
Business Area	People Directorate, Central Services
Author	Dr Hannah Faust, Consultant Psychologist for Wellbeing Matters Ash Ellis, Deputy Director for Leadership, Inclusion and Organisational Experience Dr Bridget Gemal, Director of Psychology and Psychological Therapies
Relevant Strategic Objectives	True North Goal 2: Supporting our staff
SUMMARY	1) Strong impact, staff satisfaction despite organisational change Wellbeing Matters continues to deliver significant positive outcomes for staff who access the service, including a significant improvement in wellbeing scores, reduced functional impairment, progress towards individual goals, and exceptionally high satisfaction. 2) Declining post-incident engagement is the key risk Uptake and engagement have declined, with staff opting into support falling by 14%, engagement reducing from 35% to 24% and individual SSPI interventions decreasing by 38%. This requires investigation and consideration of more proactive outreach. 3) Organisational reach has reduced Team interventions fell from 102 to 71, with teams reached reducing from 103 to 69. While interventions remain positively evaluated, and are on par with earlier reporting periods, the reduction may reflect operational pressures, organisational change and reduced service capacity. 4) Preventative work remains effective, but access is uneven Wellbeing at Work, mindfulness and wellbeing training continue to reach significant numbers of staff and demonstrate positive outcomes. However, frontline and inpatient staff face particular barriers to participation due to staffing pressures and shift patterns.

	5) Protecting capacity, visibility and access is the strategic priority Organisational restructuring and reductions in administrative, communications and training capacity has affected service visibility and reach. The focus should be on maintaining core support, strengthening referral pathways and post-incident access, improving feedback rates, and sustaining high-impact preventative interventions.
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Wellbeing Matters Update Executive Summary

Overall Assurance

Wellbeing Matters continues to deliver strong outcomes, high satisfaction and measurable improvements in staff wellbeing, functioning and goal attainment. The key challenge is maintaining visibility, reach and access during a period of organisational change and reduced service capacity.

Key Outcomes

- 165 wellbeing assessments completed, up 6% on the previous period, alongside 396 follow-up appointments.
- Among staff with matched outcome measures, average Warwick Edinburgh Mental Health Scale (WEMWBS) scores improved by 10.16 points, with 83% achieving at least a three-point improvement.
- Average WSAS scores reduced by approximately five points, indicating improved day-to-day functioning.
- All clients demonstrated progress towards their identified goals, with an average 2.23-point improvement.
- Staff satisfaction remained exceptionally high at 4.9/5, with all respondents reporting that the service provided support and had a positive impact.
- Preventative activity maintained strong reach, with 837 staff attending Wellbeing at Work sessions, and positive outcomes from psychological wellbeing training.
- Wellbeing training reached 128 staff, a 29% increase on the previous reporting period, despite the loss of Mental Health First Aid and REACTMH training provision.
- The internally developed HEARTS Wellbeing Conversations model has been successfully launched and embedded within the Essential Knowledge for Managers programme.

Key Risks

Post-incident support is the most significant area requiring attention. Datix referrals where staff opted in for support fell by 14%, engagement with support fell from 35% to 24%, and individual SSPI interventions reduced by 38%. This is concerning given the potential impact of unmet support needs following traumatic workplace incidents. The increasing proportion of incidents involving racial abuse and sexual assault/incidents further reinforces the need for accessible, timely and targeted support. The decline in uptake may indicate unmet support needs following workplace incidents and warrants further investigation.

Organisational reach has also reduced. Team interventions fell from 102 to 71, while the number of teams reached reduced from 103 to 69. Although feedback remains positive, this reduction may relate to operational pressures, organisational change, or stretched service capacity, all of which would suggest a need for wellbeing support, or reduced promotion of the Wellbeing Matters offer.

Access to preventative support remains uneven, particularly for frontline and inpatient staff affected by staffing pressures and shift patterns. The sustainability of SPACE groups is also becoming increasingly challenging due to a declining facilitator pool and limited coordination capacity.

Organisational context and risk

Utilisation continues across a diverse workforce, although uptake remains predominantly female and opportunities exist to better understand engagement amongst underrepresented groups

The reporting period has coincided with significant organisational change, including the transfer of Wellbeing Matters into the 'Organisational Experience and Development' function,

and reductions in administrative, communications, training and assistant psychology capacity. These changes create a risk that reduced capacity and promotion could affect the level of impact and organisational reach. The introduction of a dedicated clinical record system (PCMIS) is positive, strengthening confidentiality, record management and reporting, although feedback response rates have declined following the transition to text-based requests.

Actions and next steps

1. Strengthen post-incident support
 - Understand the reasons for reduced uptake and engagement.
 - Consider more proactive outreach following significant incidents.
 - Ensure clear referral and escalation pathways, particularly for higher-risk incident types.
2. Protect service visibility and access
 - Strengthen promotion, communication and referral routes into Wellbeing Matters.
 - Target outreach towards teams and staff groups showing lower engagement and poorer wellbeing and functioning on organisational KPI's.
 - Consider practical solutions to improve accessibility for stretched frontline teams and shift-based staff.
3. Maintain and expand high-impact preventative work
 - Continue to develop Wellbeing at Work, Mindfulness, HEARTS Wellbeing Conversations, Wellbeing Skills Training, and Compassionate Mind Training.
 - Use the evidence of positive outcomes to support further preventative initiatives.
4. Improve measurement and feedback
 - Investigate the reduction in feedback response rates following PCMIS implementation.
 - Ensure outcome and experience data remain sufficiently robust to demonstrate impact and inform service development.
5. Monitor capacity and sustainability
 - Assess the impact of organisational changes and reduced staffing capacity on service delivery. Reduced administrative, communications and training capacity may impact future visibility, reach and delivery.
 - Review the sustainability of and options in regard to SPACE groups and team-based interventions.

In summary, Wellbeing Matters is delivering demonstrable value for staff who engage with the service, but the Trust should now prioritise protecting capacity, strengthening proactive work to improve access, and sustaining preventative work so that service impact is maintained during organisational change.

Wellbeing Matters Full Report

Introduction

This report provides a detailed update on Wellbeing Matters provision within Berkshire Healthcare NHS Foundation Trust, covering activities, outcomes, and feedback from January - June 2026. Data from January to June 2026 will be presented according to category of work. Data from the previous 6-month period will be provided for comparison where appropriate.

1.0 Individual Support

1.1 Wellbeing Assessments and Support

This comprises a rapid psychological wellbeing assessment, facilitated by a psychological therapist, and up to three sessions (with flex for more depending on level of need) of self-care and follow-up support. According to clinical need, referral to relevant and effective treatment is initiated, as is linking with existing primary and secondary care mental health services, and third sector/specialist NHS staff pathways. Our commitment is to provide a wrap-around service, ensuring clients “land” in a service that is experienced as helpful and appropriate.

1.1.1 User Data

Main presenting problems were anxiety/stress (49%); depression/low mood (11%); bereavement (8%); relationship distress (8%); distress associated with physical health (8%); trauma (2%); other (14%). The data regarding activity usage per staff group, ethnicity and gender is presented in Appendix 1, and information regarding location of onwards referrals is presented in Appendix 2.

1.1.2 Activity Data

165 individual wellbeing assessments were completed for Berkshire Healthcare staff during the 6 months January-June 2026. For comparison, in the previous 6 months, the service delivered 156, reflecting a 6% increase in assessments.

396 follow-up appointments (average of 2.4 per user) were completed. The benefit of these follow-ups is demonstrated in the outcome and feedback data below.

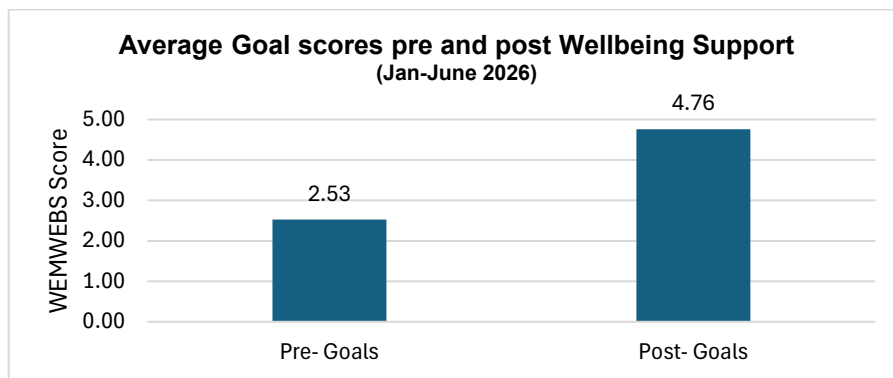
1.1.3 Outcome Data

To understand impact, staff are asked to complete the WEMWBS (Warwick Edinburgh Mental Wellbeing Scale, a 14-item scale measuring mental wellbeing) before the first session, and again at the final session. A wellbeing-related GBO (Goal Based Outcomes measure) is collaboratively defined in the first session (e.g. ‘to sleep better’) and rated and is re-rated at the end. The WSAS (Work and Social Adjustment Scale) is also administered pre and post, assessing the impact of mental health on a person’s ability to function in various areas of life – work, home management, social leisure, private leisure and personal or family relationships. The scale helps indicate how mental health difficulties affect daily tasks and overall functioning.

Within this reporting period, 42 matched pairs of WEMWBS, GBO’s and WSAS were collected.

1.1.3.1 Goal Based Outcome Measure (GBO)

GBO’s are rated from 0-10 in terms goal achievement (0 being not at all and 10 fully achieved). All individuals made positive improvements in their GBO when comparing pre and post wellbeing assessment and support. Average improvement was 2.23 steps (range 1-5 steps).

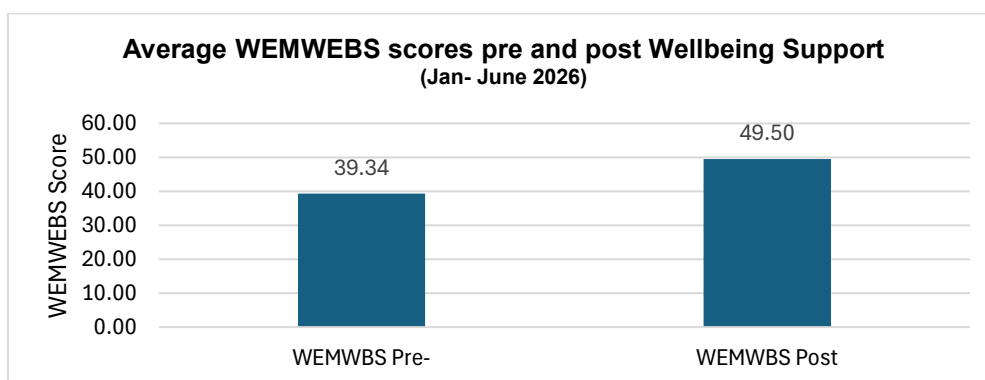


1.1.3.2 Warwick Edinburgh Mental Wellbeing Scale (WEMWBS)

The WEMWBS total score is between 14 and 70, with higher scores representing better wellbeing. An increase of 3 or more points is considered meaningful positive change in psychological wellbeing (Johnson et al. 2012).

At the end of care 85% of clients made at least a 3-point improvement; 80% made at least a 6-point improvement; 69% made at least an 8-point improvement; and 50% made at least an 11-point improvement.

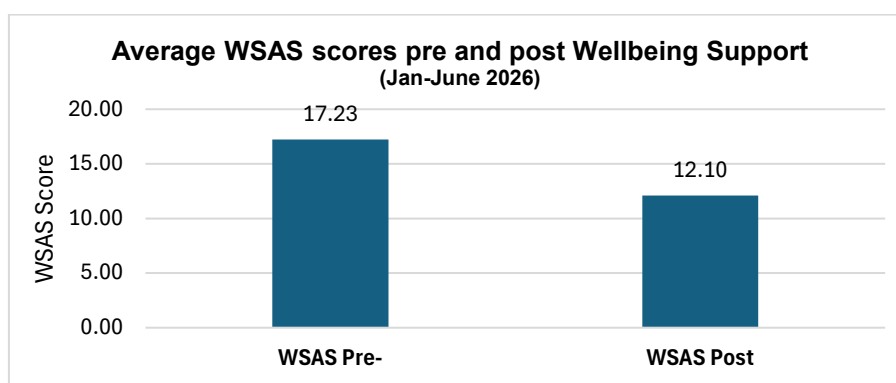
The average improvement was an increase of 10.16 points on average (from 39.34 to 49.50), indicating meaningful positive change.



1.1.3.3 Work and Social Adjustment Scale (WSAS)

The maximum score of the WSAS is 40, with lower scores indicating less impairment in functioning. A WSAS score between 10-20 suggests significant functional impairment.

The average WSAS score across 42 individuals decreased from 17.23 pre-wellbeing assessment and support to 12.10 post-support. This shows a decrease of approximately 5 points on average, indicating improved levels of functioning.



1.1.4 Feedback Data

In addition to the outcome measures, at discharge; staff are asked how valuable they found the wellbeing assessment and support. For this reporting period we received a 30% response rate and an overall average satisfaction rating of 4.9/5 stars.

100% rated “Strongly Agree” or “Agree” in terms of feeling supported and valued. Staff highlighted compassionate, empathetic and non-judgemental support; accessibility and responsiveness; and the follow-up contact and continuity in care.

82% of staff valued the onwards referrals and signposting advice – which sets Wellbeing Matters apart from the EAP - and highlighted improved mental health and emotional relief as outcomes.

1.2 Other Individual Interventions

Individual Staff Support Post Incident

Overall, 168 Datix reports were received where the person completing the form had opted into post-incident support, reflecting a 14% decrease compared to previous reporting period. 24% of opted-in Datix’s actually engaged in support, compared to 35% in the previous reporting period. During the six months of reporting, Wellbeing Matters delivered 48 initial Individual Staff Support Post Incident (SSPI) interventions, which reflects a decrease of 38% of initial sessions compared to previous reporting period. In summary, both the reporting of incidents and engagement in SSPI support is significantly down on the previous reporting period.

79% of these were incidents at Prospect Park Hospital. 21% related to racial abuse, which reflects a 25% proportional increase on previous reporting period. 10% of the incidents were related to sexual assault/incident, which reflects a very significant proportional increase on previous reporting period (750%). Of all incidents, the categories most reported were assault (50%), assault non-physical 37% and Self Harm (13%) – and this is in line with previous reporting period.

For this reporting period we received only an 8% response rate for individual SSPIs – a significant decrease in feedback. 100% of feedback was rated as “Strongly Agree” or “Agree” regarding positive experience and impact on future work¹. Staff strongly valued the space to reflect on difficult events, felt it helped them feel a sense of hope regarding future work, and helped them feel valued.

See Appendix 3 for user feedback data and thematic analysis.

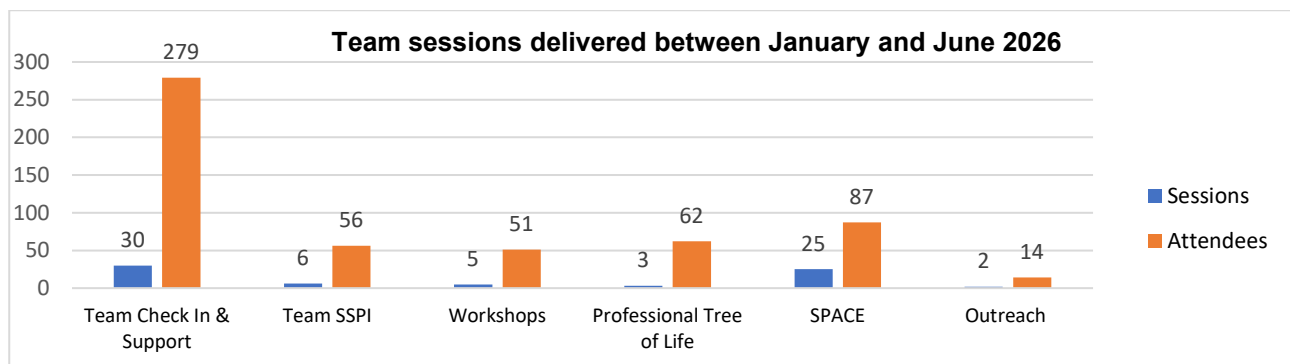
Support during Investigations.

The service also delivered 9 support during investigation interventions, which is comparable to the previous reporting period (7). However, no feedback forms were received for this intervention.

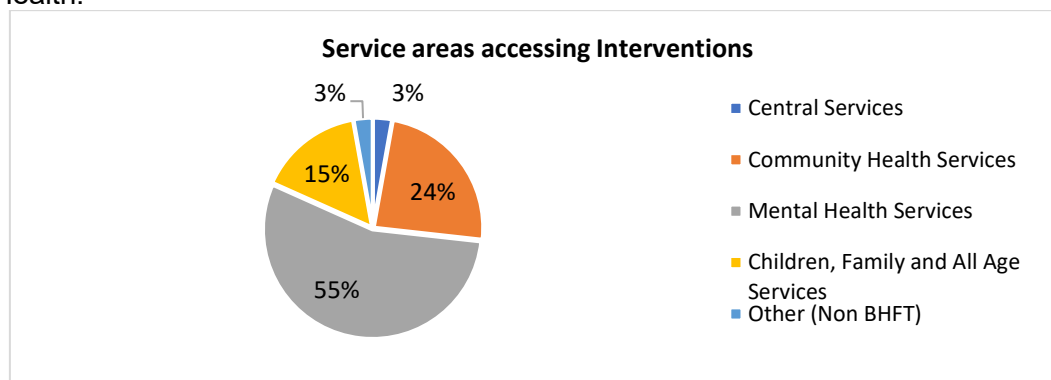
2.0 Team Support

2.1 Activity Data

Wellbeing Matters delivered 71 Team Interventions to 549 Berkshire Healthcare staff between January-June 2026 (NB some individuals may have attended more than once). During the previous 6 months there were 102 team interventions, reflecting a 30% decrease.



The interventions have reached 69 different teams across the organisation, in comparison with 103 Berkshire Healthcare teams in the previous 6-months, reflecting a 33% decrease. However, this level of activity is comparable with data from earlier reporting periods, suggesting a possible peak in the last reporting period. The division with most Team usage was Mental Health.



2.1.1 Team Staff Support Post Incident (Team SSPI)

6 Team SSPI sessions were facilitated. Unfortunately, very limited user feedback was received so cannot be meaningfully reported on here.

2.1.2 Team Check-In and Support Sessions

30 Team Check-In and Support Sessions were facilitated. Feedback form completion was comparable to previous reporting period. Staff satisfaction was rated over 70% Strongly Agree or Agree regarding usefulness and positive impact on team cohesion and understanding. Staff reported appreciating the protected time with colleagues to reflect together, which resulted in a sense of valuing, and reported finding the psychological theory and techniques useful. See Appendix 4 for user feedback data and thematic analysis.

2.1.3 Workshops

5 workshops were delivered to teams on a range of topics, developed in collaboration with teams and managers to fit the needs of their workforce.

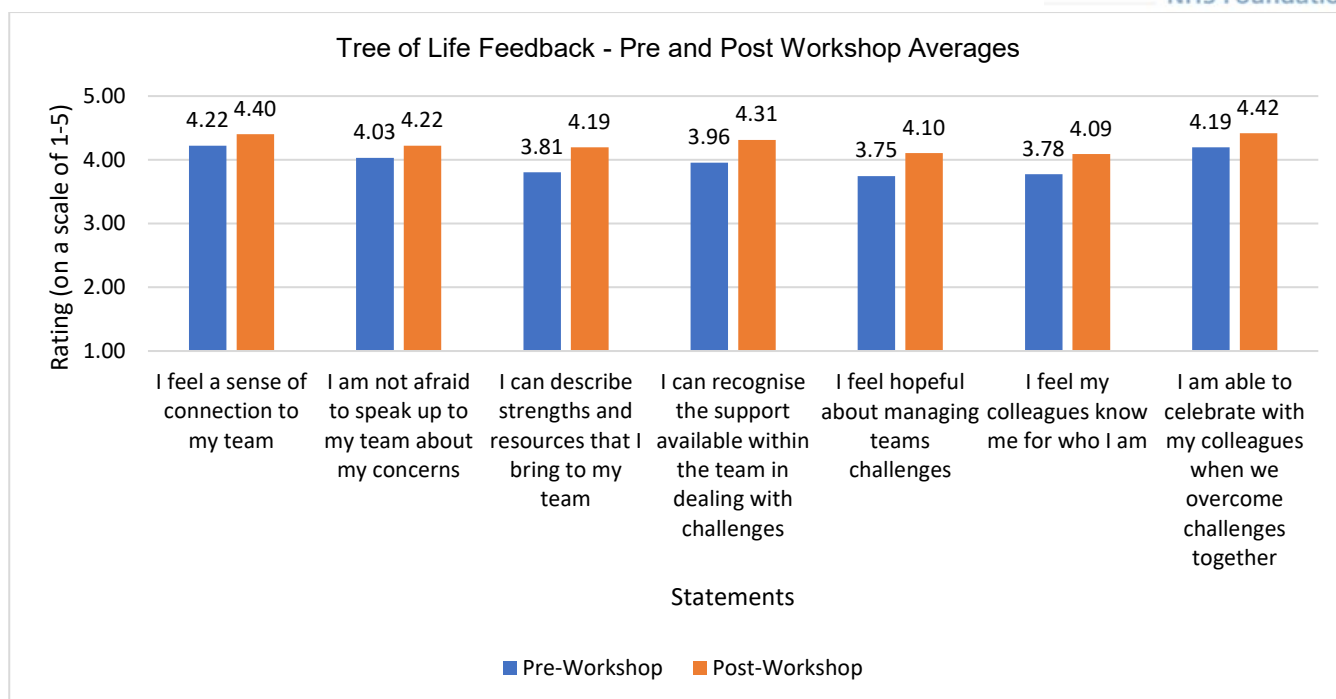
- Average rating of 4.5 (out of 5) in terms of how valuable staff found these sessions.
- Average rating of 4.3 regarding likelihood of recommending the workshop.
- Staff knowledge and understanding of the workshop topics increased by an average of 1.0 points between before and after the workshop.
- Staff confidence in using the knowledge gained increased by an average of 1.0 points.

2.1.4 Professional Tree of Life (PTOL)

Professional Tree of Life is a psychological intervention for teams which is grounded in Narrative Therapy and uses the metaphor of a tree to facilitate discussions about different aspects of our professional lives, both individually and within the teams. It uses a creative strengths-based approach to promote staff connections, team self-care and support.

3 teams engaged in PTOL, comprising a total of 62 staff. Of these:

- 87% rated it as either 4 or 5 star (out of 5)
- 84% said they would be either Likely or Extremely Likely to recommend to a colleague.
- Average scores increased across all targeted domains aimed at improving team cohesion post intervention.



Regarding user feedback, staff reported that the intervention helped with communication, getting to know colleagues better, connection and cohesion.
See Appendix 4 for user feedback data and thematic analysis.

2.1.5 SPACE groups

Wellbeing Matters clinicians directly facilitated SPACE groups to 6 Berkshire Healthcare teams, all at PPH. In total 25 SPACE group sessions were delivered by WBM, reflecting a 33% increase on previous reporting period.

In addition, Wellbeing Matters in collaboration with Consultant Nurses, coordinate Trust-wide SPACE groups facilitated by PNAs or psychologists employed elsewhere in the Trust but trained, supervised and supported by Wellbeing Matters. It continues to be difficult to capture reliable activity data for these groups due to the disparate facilitators, and it is a hugely under-reported area. Only 4 facilitators consistently report on their SPACE group activity, they have run 8 groups in total with over 35 staff attending in total in this reporting period. All groups are encouraged to complete the Trust-wide SPACE group feedback form to help understand the experience and impact of the SPACE groups. Feedback when received (this is limited) is overwhelmingly positive, with staff valuing the opportunity to come together as a team to support each other, highlighting the benefits to team cohesion and team problem-solving as an important aspect of support received.

3.0 Training

3.1. MHFA and Wellbeing Conversations (REACTMH and HEARTS)

Training in this area is an area of change for the team. As a result of financial cost-savings, MHFA was terminated in March 2026. REACTMH training licence (wellbeing conversations) also expired. A new wellbeing conversation training has been developed in-house by the team – Wellbeing Conversations HEARTS model – and this has been facilitated three times in the latter part of this reporting period. With the trainer role being lost in the financial cost-saving, Wellbeing Conversation HEARTS training will now be delivered by the clinical team.

Wellbeing Matters delivered these trainings to 128 staff members - Mental Health First Aid (18 staff, final session ran March 2026), the three-year MHFA refresher (30 staff), REACTMH (44 staff) and Wellbeing Conversations HEARTS (36 staff) - which is now embedded in the Essential Knowledge for Managers training. Overall, there was an increase of 29% in the number of staff trained compared to the previous reporting period despite MHFA training ending midway through the reporting period.

See Appendix 5 for user feedback data.

3.2. Wellbeing Skills Training

Wellbeing Matters continue to deliver this evidence-based training, which has been shown to improve psychological wellbeing in the workforce (Prudenzi et al., 2022). This intervention is an example of proactive wellbeing support, and as such is thought to bring greater return on investment to the organisation when compared to reactive support (Deloitte, 2022). The training is based on the ACT (Acceptance and Commitment Therapy) psychological model.

Participants were recruited from the PPH workforce, via ward managers and direct referral. The training group was delivered in person at PPH, with three weekly 2-hour sessions of training, facilitated by Wellbeing Matters Clinical Psychologists and Assistant Psychologist.

Despite 24 participants being signed up to the training, only 5 staff attended the group. This shows the ongoing challenge of enabling staff to engage and attend such training, especially in the inpatient mental health unit. Reasons for non-attendance included staffing levels, demands of the wards, being on A/L, and shift pattern not matching training sessions.

Outcome headlines for those who completed the course:

- WEMWBS scores increased on average 9 points (anything over 3 is considered to be meaningful change)
- All participants either strongly agreed or agreed that the training was well facilitated, that it was useful, and that they would recommend it to their colleagues.

3.3 Compassionate Mind Training

Compassionate Mind Training (CMT) helps develop a kinder, more supportive inner voice, grounded in an understanding of how our minds work and why we struggle. By cultivating compassion for ourselves and others, we can improve emotional resilience. Based upon the highly regarded work of Professor Paul Gilbert, this evidence-based 8-week programme has been shown to significantly decrease levels of self-criticism, depression, anxiety and stress, improve staff wellbeing and reduce burnout (Irons & Heriot-Maitland, 2020).

This reporting period, Wellbeing Matters facilitated 2 CMT groups – one for individuals (mixed group) recruited via trust-wide communications and sign up via Nexus eLearning, and the other for a whole Team (recruited following Manager Briefing advertisement). Delivery for both was online. 40 participants started the training, 18 participants stopped attending part way through the group. Overall, we received 22 sets of matched pair data – on the WEMWBS (measuring psychological wellbeing) the Compassionate Engagement Action Scale (CEAS, measuring self-compassion) and the Copenhagen Burnout Inventory (CBI, measuring burnout).

Outcome headlines:

Significant improvement in psychological wellbeing:

- Average WEMWBS score increased post-training by from 46.75 to 51.3.
- The mean change pre- and post- training was 4.5 (Research suggests any improvement above 3 reflects meaningful improvement in psychological wellbeing (Johnson et al, 2012).

Positive trend in self-compassion rating

- Average CEAS self-compassion subscale score increased from 30.55 to 35.82
- The mean change pre- and post- training was over 5.0 points (Using Reliable C change Index a change of 2.5 points is regarded as a reliable improvement on the CEAS)
- A 5-point improvement is an unambiguous improvement.

Positive trend in burnout rating

- Average CBI scores decreased post-training from 49 to 33.5.
- The mean change pre- and post- training was over 15 points.
- This represents a positive reduction in staff-reported levels of burnout in the workplace.

On a scale of 0-5:

- Knowledge and understanding compassion increased by an average of 2.3 points.
- Confidence increased by an average of 1.6 points following training.

User feedback headline:

Participants reported an increased awareness of their emotions and internal world, improved self-compassion skills, and improved coping, resilience and emotional regulation. A number also highlighted how the skills-focus in training has resulted in better wellbeing, increased awareness of self-criticism, and improved ability to manage difficult situations both at work and home.

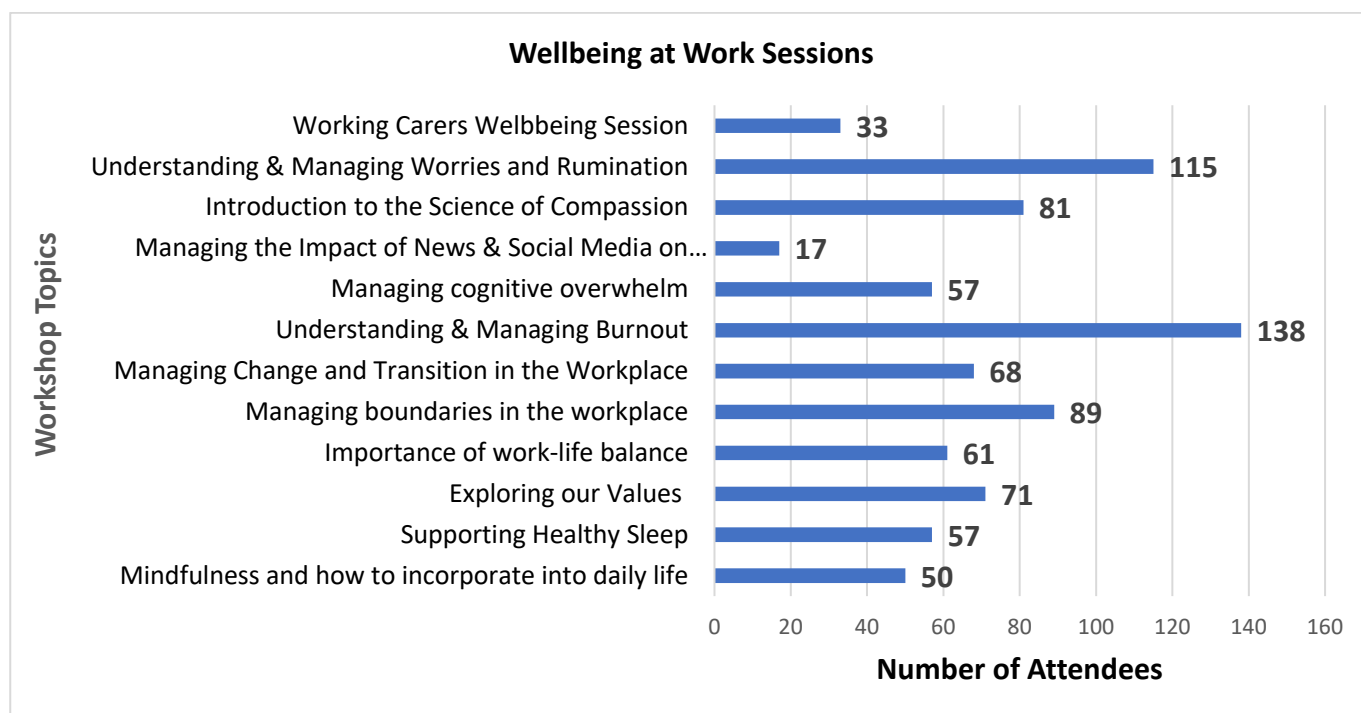
See Appendix 5 for user feedback data.

3.4 Wellbeing at Work sessions

The Wellbeing at Work series, which emerged from the Trust-wide Wellbeing Review, continues to build momentum. Workshop topics are wide-ranging across both mental and physical health. Only those within the Wellbeing Matters remit (psychoeducational workshops) are reported on here. These interventions reached 837 attendees reflecting approximately 15% of the Berkshire Healthcare workforce. Key feedback relating to workshops is collected using a 1-5 scale (with 1 being low and 5 being high):

- Average rating of **4.6** for how valuable staff found these sessions.
- Average rating of **4.7** regarding likelihood of recommending the workshop.
- Staff knowledge and understanding of the workshop topics increased by an average of 1.1.
- Staff confidence in using the knowledge gained increased by an average of 1.1 points.

User feedback is also overwhelmingly positive, serving the function of expanding reach, normalising emotional impact and responses at work, delivering bite-sized psychoeducation sessions and coping strategies, and improving awareness of support available.



A new innovation in this reporting period was to facilitate short, practical mindfulness sessions, intended to provide a structured space for staff away from their daily work to practice mindfulness skills, and gain associated benefits. Wellbeing Matters delivered **10 mindfulness drop-in sessions** in the reporting period, and these were attended by **285 staff**. Feedback was overwhelmingly positive.

See Appendix 5 for user feedback.

4.0 Developments & Challenges

➤ Service changes

Wellbeing Matters has now moved into 'Organisational Experience and Development' as a stand-alone team. Associated staffing changes, including changes in operational and clinical leadership, reduction in administrative, assistant psychologist, communications and training roles

and capacity, are now in place. We are working to mitigate the impact of these changes on operational/administrative functions, communications, and potentially in clinical delivery.

➤ **Reduction in some areas of activity**

It is too early to fully assess the impact of recent changes, and following three years of significant and sustained build at each reporting period, a plateauing of activity might be expected. However, as already noted, the six months in this reporting period saw significant change and transition for the team, and the impact of such changes (including loss of the communications officer role and of the long-term team leads) was expected to affect visibility/promotion, WBM team morale, and/or workforce focus on productivity and outreach, especially in regard to Team Interventions.

➤ **Post-incident support**

Datix support requests and uptake of support offered both decreased, alongside a reduction in individual and team SSPI sessions delivered. This requires further analysis. The reduction in Datix requests requires scrutiny, particularly given the work undertaken between WBM, Datix and Patient Safety to improve the flow of support requests into the team. The downturn in SSPI activity is concerning, particularly at PPH where significant in-house provision exists and a proactive approach is already taken. A review of the offer will be required.

We continue to encounter barriers to accessing those who have been affected by incidents at work. Training for ward and deputy ward managers is underway to promote and reinforce the importance of referral of staff post-incident. In the future universal proactive outreach support after incidents associated with significant harm, could increase access but would exceed current administrative capacity. This approach would also require privacy policy changes and careful consideration of contact methods, as many frontline staff do not regularly use work email.

Lastly, requests for support following racial abuse and sexual assault/incidents increased. This increase is positive in the context of known under-reporting and may be associated with Trust-wide work on anti-racism and sexual safety.

➤ **Digital record system and feedback**

While PCMIS enhances the confidentiality and is able to manage both individual and team records, guide outreach, and provide more reliable reporting, we have seen a downturn in service-user feedback. Staff are now sent texts with a link to our service-user feedback form held within PCMIS, instead of emailed requests with an MSForm. It is unclear whether this change has driven the reduced response rate, or whether this is part of a general dip in engagement. This will need monitoring and outreach to service-users to understand further.

➤ **Growth of Compassionate Mind Training**

Three CMT groups have now been completed – one with a team and two with individuals recruited via Nexus eLearning. All trained WBM clinicians are now certified in CMT. Work is underway between WBM and Dr Deborah Lee to pool resources and expertise and finalise shorter, more focused CMT offers for the NHS workforce: one for teams (6x1 hour weekly sessions) and one for individuals (1 day). These offers will complement and cohere with the broader Compassionate Leadership training although, unlike the leadership offer, CMT is not mandated and will therefore require organisational and managerial buy-in to gain traction. Of note, while 5 teams expressed interest in the Team CMT offer, 4 clinical and 1 non-clinical, concerns about time demands meant none of these teams were enabled to engage.

➤ **Growth of Wellbeing at Work sessions**

Further workshop topics have been developed in line with stakeholder feedback, to include managing the psychological demands of supervising others, exploring our values, managing cognitive overwhelm and managing wellbeing during the winter. We continue to add to our repertoire of topics, including practical mindfulness sessions, with a growing library of session recordings now available on Nexus for staff to access flexibly at a time that suits them.

➤ **Casework review**

WBM are working into Workstream 4 to try and support improvements in the experience of casework, using knowledge gained from working with staff going through investigation processes. Staff feedback, improved guidance, and a focus on trauma-informed care are areas of focus for WBM in this workstream.

➤ **SPACE groups**

Facilitator pool has dwindled over the past 6-12 months, as workplace demands take precedence, whilst concurrently the commitment and investment needed to sustain a SPACE group does not seem a priority for teams/managers. Overall, the sustainability of SPACE as a Trust-wide intervention is not currently clear, and further discussion under the Safety Culture Steering Group is planned.

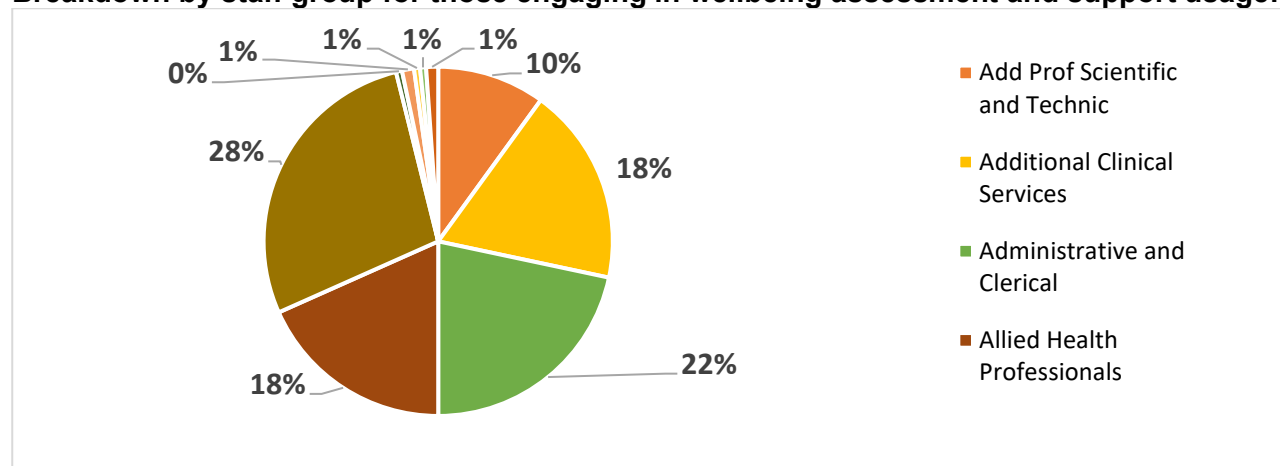
Recommendations and Next Steps

The Board is asked to:

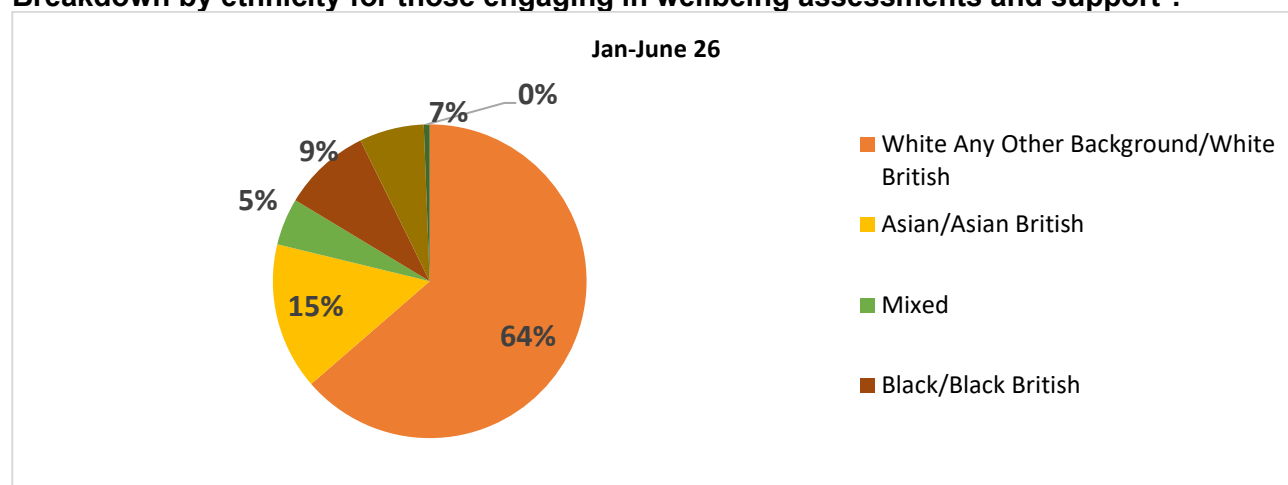
1. Note the assurance provided by positive wellbeing, functioning and satisfaction outcomes achieved by Wellbeing Matters during January to June 2026.
2. Note the reduction in post-incident support engagement and team-based intervention activity as a strategic risk to staff support, visibility and reach.
3. Endorse targeted work to understand and address barriers to post-incident support, including consideration of more proactive outreach following significant incidents.
4. Endorse actions to maintain visibility, accessibility and organisational reach during ongoing organisational change, with particular attention to frontline, inpatient and shift-based staff.
5. Note the potential impact of reduced administrative, communications and training capacity on service delivery, measurement and reach.
6. Receive a briefer update report on service activity, outcomes, access, post-incident engagement and capacity risks within the next reporting cycle.

APPENDIX I

Breakdown by staff group for those engaging in wellbeing assessment and support usage:

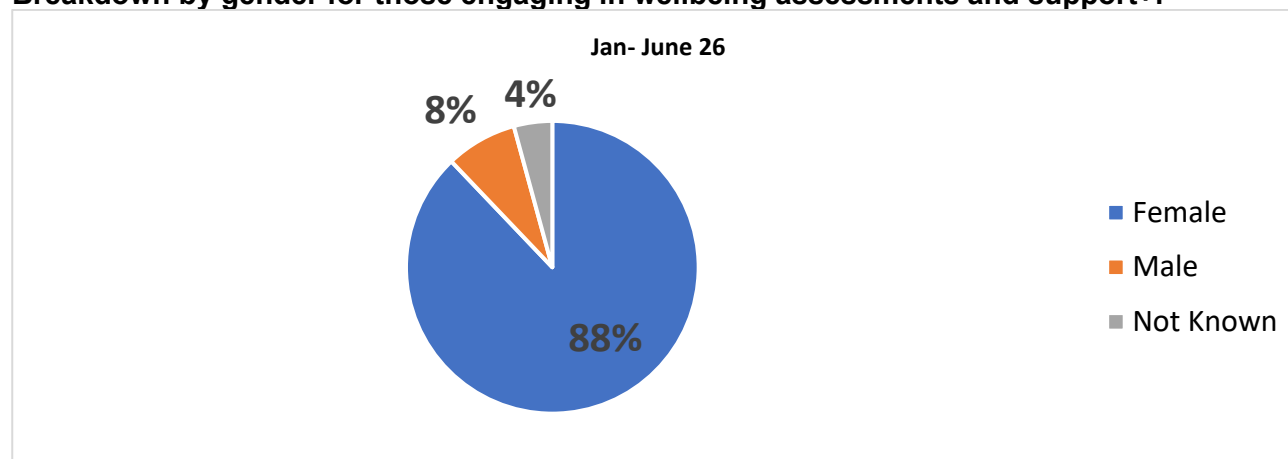


Breakdown by ethnicity for those engaging in wellbeing assessments and support*:



*Trust-wide data for workforce 31/03/26: 63% White, 15% Asian, 14% Black, 3% Mixed, not stated (3%), Other (2%).

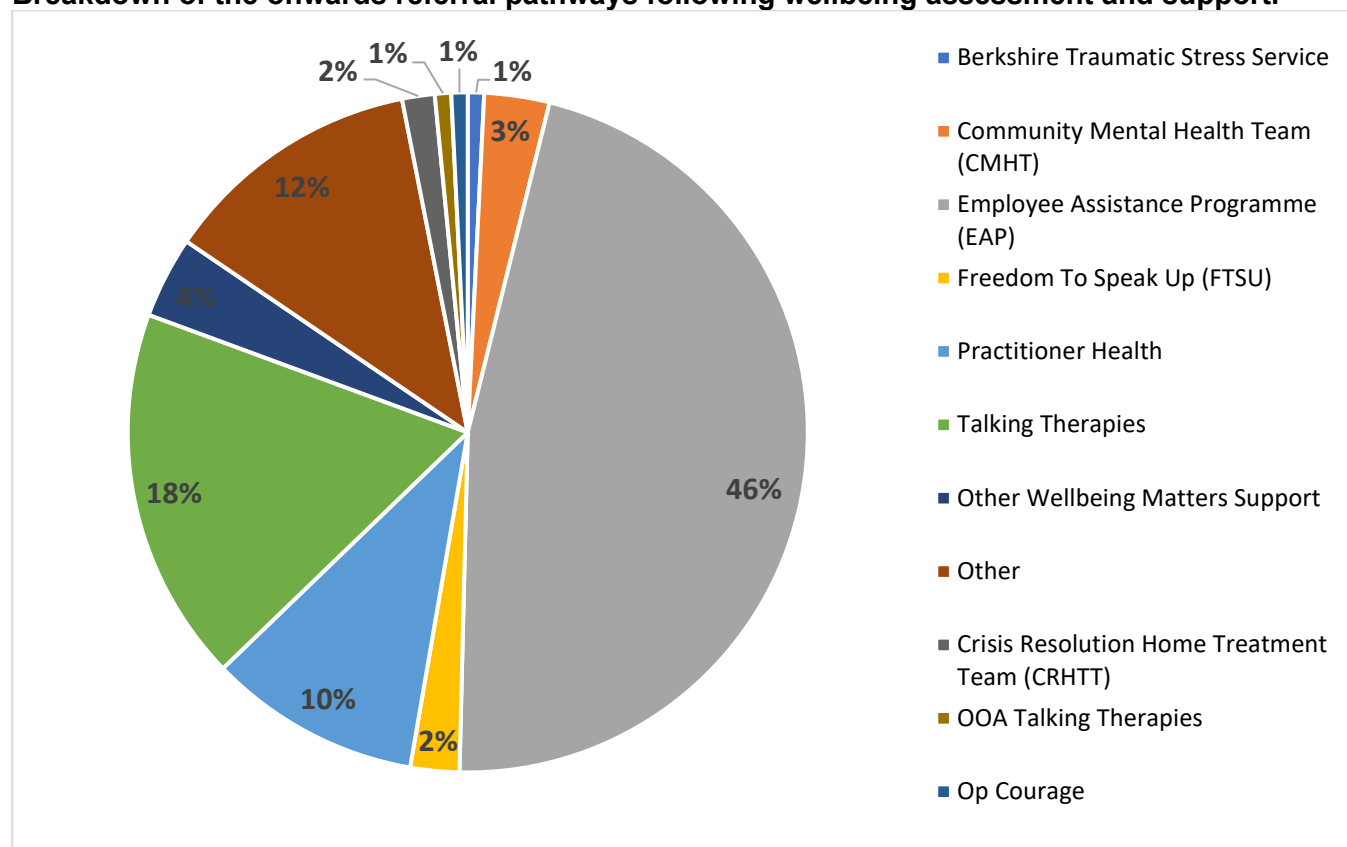
Breakdown by gender for those engaging in wellbeing assessments and support+:



+Trust-wide data for workforce 31/03/26 – 17.5% male and 82.5% female

APPENDIX 2

Breakdown of the onwards referral pathways following wellbeing assessment and support.



APPENDIX 3 - User Feedback & Thematic Analysis for individual support

Includes:

- Wellbeing assessment and support
- Individual SSPI

Wellbeing Assessment and Support

Table 1: Feedback - Wellbeing Line experience and impact ratings.

Rated on a 5-point Likert Scale (0=Strongly Disagree, 5=Strongly Agree).

	Feedback Item	Strongly Agree	Agree
EXPERIENCE	Staff listened to me with compassion	95%	5%
	There was adequate flexibility of support	80%	20%
	Support was scheduled in appropriate timeframe	84%	16%
	Would recommend to this support to others	92%	8%
	I was supported and cared for in a way that respected my culture, beliefs and values	88%	12%
IMPACT	Helped me better understand my situation	81%	19%
	Offered appropriate resources and self-care tools	78%	22%
	Helped me feel supported and valued	83%	17%
	Signposting/referrals options were suitable to my needs	82%	18%

Thematic Analysis of Qualitative Feedback Data

Several themes were present in the wellbeing assessment and support feedback. The top themes are presented below with example quotes:

Theme 1: Compassionate Listening and Validation

Staff consistently highlighted the importance of feeling heard and understood as a primary benefit of their sessions.

- *"I felt so heard by [clinician] and I just wanted to voice my appreciation and also voice how amazing she is not only as a clinician but in general as a person!"*
- *"The most useful was to be listened and being seen that I do need support due to complex of my situation."*
- *"She was so easy to talk to and made it feel a safe space and easy to open up about how I was feeling."*

Theme 2: Proactive signposting and pathway navigation

Clinicians were highly praised for going beyond the session to secure external support and help users navigate complex waiting lists.

- *"[Clinician was] compassionate and went over bound to find the right pathway and fill in counselling due to waiting time."*
- *"She continually went out of her way to make sure I got the support I needed from other services and sent me so many amazing signposting options."*
- *"The ground work that was done for me to look for the appropriate support and shared with me."*

Theme 3: Continuity and reliability

Users felt significantly more supported when clinicians maintained contact while they were on waiting lists or awaiting the outcome of a referral.

- *"She constantly checked in on me whilst I have been on a waiting list and has validated every feeling and situation I have been going through."*

- *“Great to be followed up whilst referrals came to fruition”*
- *“I always came away knowing actions were going to be taken.”*

Theme 4: Practical skills building

Staff reported that the sessions moved beyond just talking to providing them with tangible tools to manage their mental health.

- *“I now feel I have the appropriate tools for when I hit a low mood. I better understand the triggers and ways to reduce stress.”*
- *“I felt as though they came away with meaningful suggestions and onward referrals.”*

Individual SSPI

Table 2: Staff Satisfaction - individual SSPI experience and impact ratings at discharge.

Rated on a 5-point Likert Scale (0=Strongly Disagree, 5=Strongly Agree).

	Feedback Item	Strongly agree	Agree
EXPERIENCE	The session/s was useful	50%	50%
	The session provided me with a space to reflect upon difficult events	100%	0%
	I felt able to share ideas and concerns	50%	50%
	The session felt meaningful to me	100%	0%
	I would recommend the session to others	100%	%
	The session was well facilitated	100%	0%
	The session respected my culture, beliefs and values	100%	0%
	The clinician listened to me with compassion	100%	0%
IMPACT	Supported me to continue in my work	0%	100%
	The session helped me feel a sense of hope about future work	100%	0%
	The session helped me understand how I responded to the situation	25%	75%
	The session helped me to feel valued	100%	0%

APPENDIX 4 - User Feedback & Thematic Analysis for team support

Includes:

- Team Check-In and Support Sessions
- Professional Tree of Life

Team Check-In and Support Sessions

Table 5: Team Check-In and Support Sessions experience and impact ratings.

Rated on a 5-point Likert Scale (0=Strongly Disagree, 5=Strongly Agree).

	Feedback Item	Strongly Agree	Agree
EXPERIENCE	The session was useful	67%	14%
	I felt able to share my ideas or concerns	69%	19%
	The session felt meaningful to me	48%	14%
	I would recommend the session to others	62%	14%
	The session was well facilitated	55%	35%
IMPACT	The supported me to continue in my work	47%	11%
	The session helped me feel a sense of hope about future work	35%	12%
	Being offered the session helped me feel valued	75%	15%
	The session helped my team to support one another	70%	15%
	The session will have a positive impact on team functioning	65%	15%

Thematic Analysis of Qualitative Feedback Data

Theme 1: Safe and connecting space

Staff consistently highlighted the importance of having time with colleagues to connect and understand each other

- *“Having protected time with colleagues to hear different viewpoints”*
- *“I felt comfortable to express myself”.*
- *“Time to reflect together”*

Theme 2: Learning, Insight, and Personal Development

Staff valued gaining psychological insight, practical tools, and increased self-awareness, particularly around stress and trauma.

- *“I liked the idea of the push and pull affect on thoughts. And how with using techniques to help break the pull “*
- *“The theory was a good foundation and mindfulness as an intro.”*
- *“There were certain aspects about burnout - identifying how that looks like and the impact it has on our lives. It was helpful to know how deep the impact was. I also found the grounding techniques helpful to do in between sessions if required.”*

Professional Tree of Life

Thematic Analysis of Qualitative Feedback Data

Theme 1: Time and space to reflect

A strong theme was that staff valued having protected time away from everyday work pressures to pause, reflect and think more deeply. People appreciated being given space to consider their own journey, their team, and the wider service in a way they would not usually have time for during normal working routines.

Example feedback:

- *"Time and space to reflect."*
- *"Helpful to have the space/time to think about this."*
- *"Space away from regular job demands."*

Theme 2: Getting to know colleagues better

Many people found it helpful to learn more about colleagues on a personal level, including their journeys, motivations, strengths and reasons for working in mental health. This helped staff understand each other beyond their professional roles.

Example feedback:

- *"Learning more about my colleagues personally."*
- *"Really valuable to understand colleagues' personal journeys and motives."*
- *"Got to know each other better."*

Staff valued dedicated time to connect with colleagues and strengthen relationships. Opportunities to hear from team members they do not usually work.

- *"Having time to connect with colleagues."*
- *"Hear the different voices of team members who I don't often meet."*
- *"Very good – got everyone together."*
- *"Being together."*

Theme 3: Team connection and bonding

A key theme was the value of bringing the whole team together. Staff described the session as helpful for building relationships, improving team spirit and strengthening the sense of connection across the service.

Example feedback:

- *"The whole team coming together."*
- *"Team building and bonding by sharing about our tree of life."*
- *"Nice to see the connection in the team."*

Theme 4: Open conversation and sharing

Staff appreciated the chance to talk openly, listen, exchange ideas and hear different viewpoints. The session appeared to create a safe and supportive space for meaningful discussion.

Example feedback:

- *"Good chance to talk openly."*
- *"Listening and exchanging ideas with colleagues."*
- *"Time and space to talk and explore things that we wouldn't usually talk about."*

The Tree of Life framework was described as clear, intuitive, and easy to understand. The use of metaphor helped staff talk about individuals and the team in a meaningful but grounded way.

- *"Easy to understand, well explained."*
- *"Good way to use trees to talk about individuals and team."*
- *"Putting all the trees together in a forest."*

APPENDIX 5 - User Feedback & Thematic Analysis for training

Includes:

- MHFA
- REACT MH
- Wellbeing conversations - HEARTS
- Compassionate Mind Training

MHFA

Feedback Headlines:

Theme 1: Impact on managerial confidence and capability:

- *"This course was highly informative and practical, enhancing my confidence to identify, approach and support colleagues experiencing mental health challenges in the workplace."*
- *"Really enjoyed the course and it has increased my confidence and knowledge in managing these situations. I will be able to support my team better because of this course. Thank you"*
- *"I will definitely use the tools I learn in this course"*

Theme 2: Value of interactive elements:

- *"Sessions were engaging and enjoyable – it was the first time I had attended an online course of this format (e.g. with break-out rooms) and found it to be an interesting new experience."*
- *"The course was well delivered by the facilitators. It was very interactive and easy to follow."*

REACT MH

Feedback Headlines

Theme 1: Building communication skills

- *"How to start a conversation and to get information to try and help others"*
- *"Chance to practise what I have learned."*

Theme 2: Bridging theory into practice

- *To practice using the tool with people I support or line manage".*
- *"To start using it in conversations going forward with colleagues, and family."*
- *"An understanding of the model and how to apply it in practice."*

Wellbeing conversations - HEARTS

Theme 1: The value of the framework

- *"The Hearts model as a framework [was useful], I realise I already do this but might help feel less overwhelming in tricky situations."*
- *"It was consolidated really well and nice and clear."*

Theme 2: Compassionate focus

- *"[Learned] not to make them too scripted and trust my instinct as a human being"*
- *"Curiosity and compassion as leaders is vital."*
- *"Importance of having wellbeing conversations and its foundations on compassionate leadership."*
- *"The HEARTS model - keeping it real and being led by the employee"*

Compassionate Mind Training

What did you find most useful about the training?

1. Psychoeducation and Theoretical Frameworks:

- *"I really liked the psychoeducation, learning about how the tricky brain has evolved, our threat, drive and soothe systems and how these come in to play before, during and after difficult situations."*

- *"Understanding old and new brain, and compassionate self as a wise individual to reflect on as guidance."*
- *"Understanding how our evolved minds/ threat/ drive soothe systems can throw up tricky situations for us but realising this is normal and there are methods to understand and reframe our approach to challenging scenarios."*

2. Practical Tools and Mindfulness Exercises:

- *"The memorable and in-depth way this was taught has really embedded it for me and I've been practicing noticing when my different systems come online and when my tricky brain is stuck in a loop."*
- *"I really liked the mindfulness exercises. I found them really useful to use in being more compassionate to myself."*
- *"The colour coded model that showed the three zones (blue, red and green) and the exercise we did where we looked at a threat based situation... and thinking about what could help."*

3. Interactive and Relational Learning:

The collaborative nature of the sessions, combined with the supportive delivery, created a safe space for participants to share personal experiences.

- *"It was good to have discussions from others to hear about their experiences as this is very helpful in realising 'it's not just me' and also getting other perspectives and ideas."*
- *"The combination of exercises and theory and discussion of personal experiences was really helpful."*
- *"The Wellbeing Matters team delivered the sessions with kindness and created a great environment for us to work through the content."*

4. Personal Impact and Application:

Participants reported that the training provided tangible benefits to their well-being and gave them a greater sense of confidence in managing their emotions.

- *"It created a sense of calm on a Monday afternoon and I also learnt that I am not too bad at putting compassion into place in my life than I realised."*
- *"Personally I enjoyed thinking of a compassionate character to embody and tying into my daily gratitude list who has been compassionate to me today."*
- *"Learning practical tools to support having a more compassionate approach to self/ others to get more from life essentially."*

How do you think the training will support you at work?

Theme 1: Emotional Regulation and Self-Compassion:

- *"It has already helped me be kinder to myself generally and notice when my self critical voice is limiting me."*
- *"I think I will be more aware of the feelings that come up in me and be able to look at any given situation from outside rather than just being in a state of distress."*
- *"Learning to be more grateful and less self-critical but show more understanding on my actions and feelings."*

Theme 2: Enhanced Interpersonal Dynamics and Empathy:

- *"Again being more aware of why people in my personal life or at work behave or react in a negative way not as a personal attack but maybe because they are dealing with a difficult situation and need help."*
- *"I think it'll help me with my imposter syndrome, it'll help me start to move away from my people pleasing tendencies and focus on finding a compromise that works for me too."*
- *"It's helped with supporting my children and helping them understand their own feelings too."*

Theme 3: Practical Tooling and Resilience Building:

- *"As I said the model about threat based situations will be really useful when I have something coming up that is making me feel anxious."*
- *"I liked how we practiced them [mindfulness exercises] during the training before moving on to continue that at home."*
- *"It is useful to have and to consult when needed ie the notes, the practices will be useful for all aspects of my life."*

APPENDIX 6 - User Feedback & Thematic Analysis for Wellbeing at Work

Wellbeing at Work

What did you find useful about the workshop?

Theme 1: Practical Coping Strategies & Tools

- *"The three good things exercise as I work from home and live alone - a nice reminder at the end of each day".*
- *"The coping mechanisms".*
- *"Discussing boundaries and relaxation strategies to use".*
- *"Particularly liked the wellbeing chart and the coping strategies, will be helpful to share with my team".*
- *"I liked the 5 minute exercise at the start and the DEARMAN resource".*

Theme 2: Setting Boundaries & Managing Expectations

- *"Tips for communicating boundaries and tips for creating boundary between work and home".*
- *"Lovely to hear from others and know that I was not the only one facing specific struggles with NHS expectations etc."*
- *"Phrases to use when I need to set boundaries".*
- *"Tips for setting boundaries and the use of technology to do so more efficiently".*
- *"Delegating/prioritising - what we can control - acceptance".*

Theme 3: Understanding Well-being Concepts:

- *"Coping mechanisms and understanding the factors behind SAD".*
- *"Different things to try when you are battling with sleep and the importance of sleep".*
- *"Understanding how to manage cognition overload".*
- *"It really put into perspective how much I rely on my phone and the impact it has on me".*

Theme 4: Empowerment through Normalization:

- *"I liked the experience sharing and doing the body scan".*
- *"They way the presenters kept it real, suggesting small ways to incorporate into routine rather than having to do full sessions".*
- *"I found the information very useful, and honesty around not always knowing about medications etc".*
- *"Reinforced some things I already knew and was helpful in improving my confidence".*

Trust Board Paper Meeting Paper

Board Meeting Date	8 September 2026
Title	Finance Report July 2026
	The paper is for noting.
Reason for the Report going to the Trust Board	This is a regular report which provides an update to the Board on the Trust's Financial Performance. The report provides the Trust's position at the end of July 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 FOUNDATION TRUST

Finance Report
Financial Year 2026/27
July 2026

Purpose

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

Document Control

Version	Date	Author	Comments
1.0	11/08/26	Rebecca Clegg	Draft
2.0	19/08/26	Paul Gray	Final

Distribution

All Directors.

All staff as appropriate.

Confidentiality

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

Dashboard & Summary Narrative

Target		Year to Date			Forecast Outturn		
		Actual £m/%	Plan £m/%	Achieved	Actual £m/%	Plan £m/%	Achieved
1	Income and Expenditure Plan	0.0	0.0	Yes	0.0	0.0	Yes
2	CIP - Delivery	5.1	5.1	Yes	15.5	15.5	Yes
3	Cash Balance	49.0	47.3	Yes	44.4	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	98%	95%	Yes	95%	95%	Yes
4d	Better Payment Practice Code Value NHS	98%	95%	Yes	95%	95%	Yes
5	Capital Expenditure not exceeding CDEL	1.3	2.4	Yes	12.7	13.1	Yes
6a	Agency Expenditure (under)/over YTD Cap	0.1	0.0	No	0	0	Yes
6b	Bank Expenditure (under)/over YTD Cap	1.0	0.0	No	0.0	0	Yes

Key Messages

The table above provides a high level summary of the Trust's performance against key financial duties and other financial indicators. The 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 4 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

Jul-26	Act £'m	In Month Plan £'m	Var £'m	Act £'m	YTD Plan £'m	Var £'m	2026/27 Plan £'m
Operating Income	35.0	33.3	1.7	139.6	139.3	0.3	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	0.1	(0.1)	0.3
Total Income	35.0	33.4	1.6	139.6	139.5	0.2	420.0
Staff In Post	24.6	23.7	(0.9)	98.6	100.8	2.3	304.3
Bank Spend	1.6	1.3	(0.3)	6.1	5.2	(0.9)	15.6
Agency Spend	0.4	0.3	(0.1)	1.5	1.3	(0.1)	4.0
Total Pay	26.6	25.3	(1.3)	106.2	107.4	1.2	323.8
Purchase of Healthcare	2.0	1.5	(0.6)	7.2	5.8	(1.3)	17.2
Drugs	0.4	0.6	0.2	1.9	2.4	0.5	7.1
Premises	2.0	1.9	(0.1)	7.9	7.5	(0.4)	22.4
Other Non Pay	2.0	2.0	0.0	8.1	7.8	(0.3)	23.5
PFI Lease	0.8	0.8	(0.0)	3.0	3.1	0.1	9.3
Total Non Pay	7.1	6.7	(0.4)	28.0	26.6	(1.4)	79.6
Total Operating Costs	33.7	32.0	(1.7)	134.2	134.0	(0.2)	403.5
EBITDA	1.3	1.4	0.1	5.4	5.5	0.0	16.5
Interest Receivable	0.3	0.2	0.0	0.9	0.9	(0.0)	2.7
Interest Payable	0.3	0.3	(0.0)	1.2	1.1	(0.0)	3.4
Depreciation	1.1	1.1	(0.0)	4.4	4.4	(0.1)	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	1.4	1.4	(0.0)	7.2	6.9	(0.3)	18.0
Reported Surplus/(Deficit)	0.2	0.2	(0.0)	(0.9)	(0.6)	(0.3)	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	0.9	0.6	0.3	0.0
Adjusted Surplus/(Deficit)	0.0	0.0	(0.0)	(0.0)	0.0	(0.0)	0.0

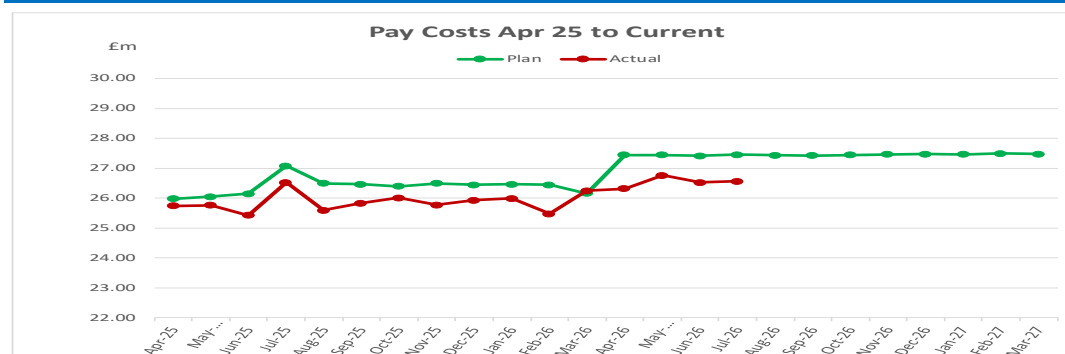
Key Messages

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

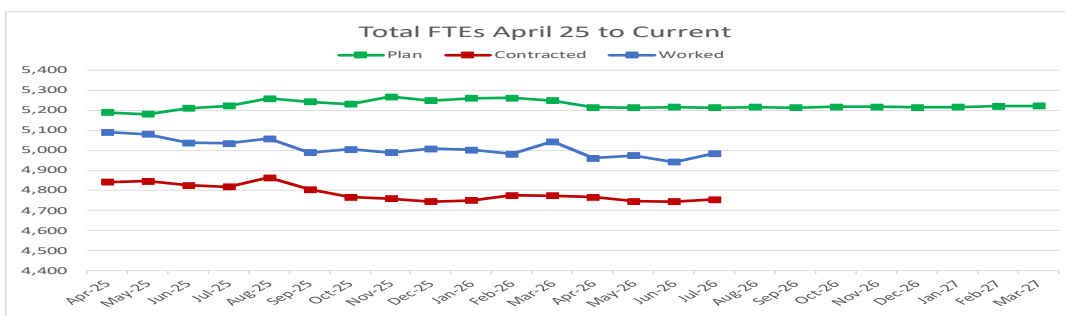
The Trust is planning to breakeven in the current year and is on track to deliver this year to date.

Adjustments have been made to income and pay plans in month to align to the current view on the pay award and also the final outcome on the innovation fund bids. Our plan assumed that we would receive a fair share of the innovation funding for left shift but the funding has been used to support other programmes of work. We assumed workforce expenditure against this funding. The income and expenditure plans have now been scaled back to the final agreed values for the Trust. This skews the in month income and pay variances but the year to date variances are correct with the plan aligned to our internal control totals.

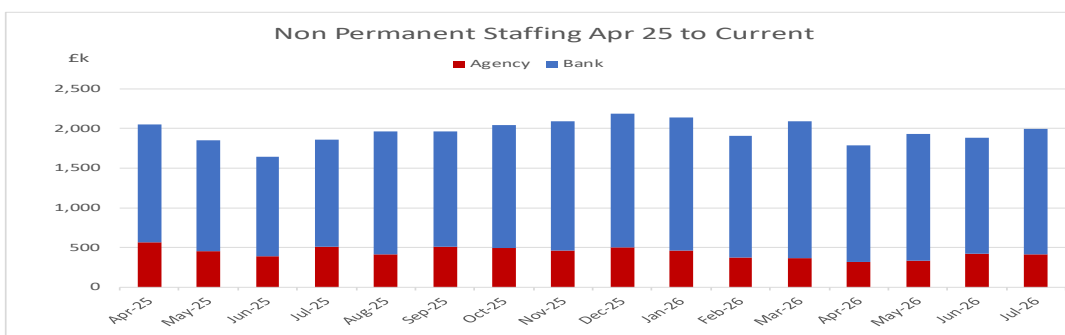
Workforce



Staff Costs	
YTD	£'k
2026/27	106.2
2025/26	103.5
	▲ 3%
Prior Year	£'k
Jul-26	26.6
Jul-25	26.5
	▼ 0%



Prior Mth	FTE's	WFTE
	£k	£k
Jul-26	4,755	4,985
Jun-26	4,744	4,942
	▲ 0%	▲ 1%
Prior Year		
Jul-26	4,755	4,985
Jul-25	4,818	5,035
	▼ -1%	▼ -1%



Non Permanent Staff Costs		
YTD	Bank	Agency
	£k	£k
2026/27	6,112	1,481
2025/26	5,505	1,908
	▲ 11%	▼ -22%
Prior Year		
Jul-26	1,578	415
Jul-25	1,353	510
	▲ 17%	▼ -19%

Key Messages

Pay costs in month were £26.6m, which was above plan as the plan was adjusted to reflect final outcome of the innovation fund bids.

In month, Worked WTEs increased by 42, primarily bank cover on MH and CH inpatients, some of which was cover for summer annual leave. Contracted WTEs increased by 10 including 4 in CJLD.

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. Both measures are included in the National Oversight Framework.

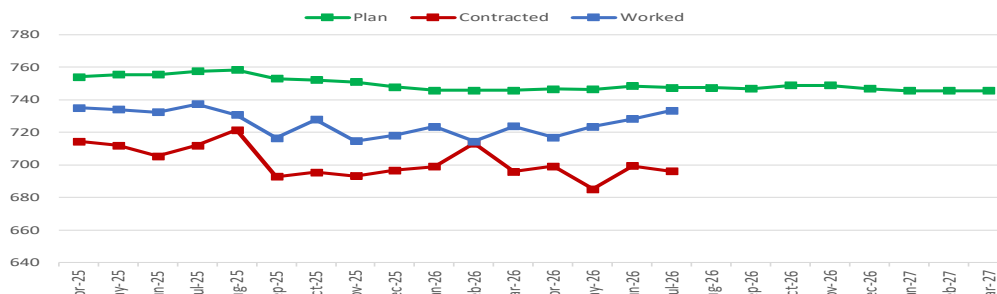
Our bank fill rate remains strong, with monthly performance at 93.6% of the overall temporary staffing demand.

Off framework agency usage remains limited to nurseries only. Usage reduced further to just 9 shifts in July, down from 12 shifts in June. This reflects the continued success of recruitment and workforce planning initiatives.

We continue to report zero breaches against the Agenda for Change price cap. The remaining breaches relate solely to medical staffing. We expect medical staffing breaches to reduce over the coming months as recruitment activity continues and workforce stability improves. In line with NHS England requirements, the Trust's remaining two non-clinical agency workers, one within Estates and one within Finance, are now nearing completion of their bank registration process. Once complete, this will further reduce agency reliance and eliminate non-clinical agency usage.

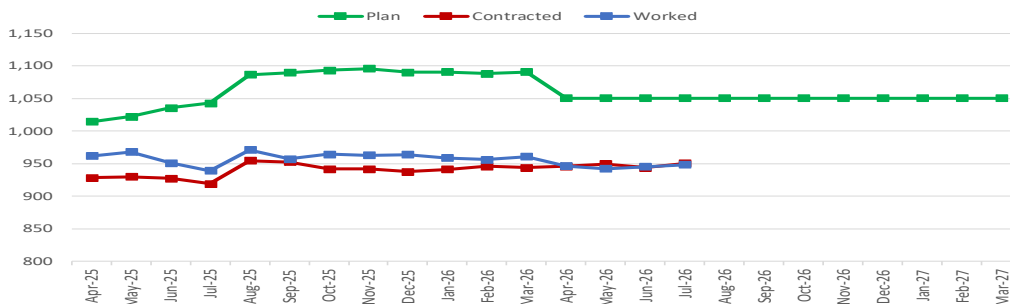
Staff Detail (Division)

Central Services FTEs April 25 to Current



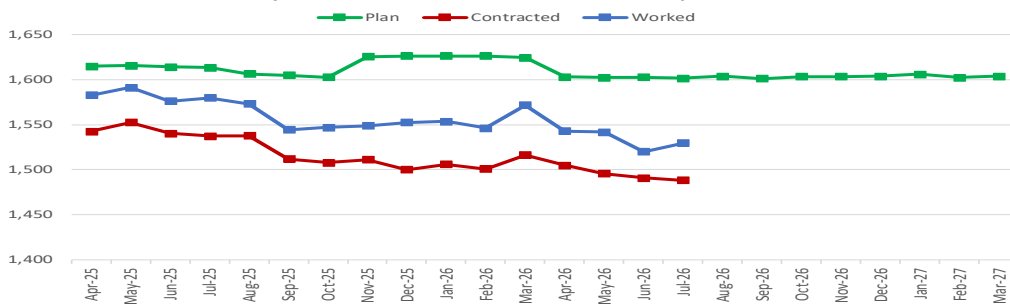
FTE's		
Prior Mth	CFTE £k	WFTE £k
Jul-26	696	733
Jun-26	699	728
	0%	1%
	▼	▲
Prior Year		
Jul-26	696	733
Jul-25	712	737
	-2%	-1%
	▼	▼

Childrens, Family and All Age Services FTEs April 25 to Current



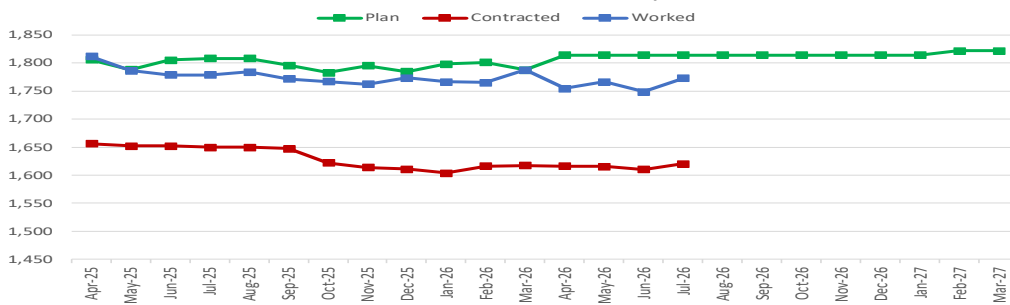
FTE's		
Prior Mth	CFTE £k	WFTE £k
Jul-26	950	949
Jun-26	944	946
	1%	0%
	▲	▲
Prior Year		
Jul-26	950	949
Jul-25	919	939
	3%	1%
	▲	▲

Community Health Services Services FTEs April 25 to Current



FTE's		
Prior Mth	CFTE £k	WFTE £k
Jul-26	1,488	1,530
Jun-26	1,491	1,520
	0%	1%
	▼	▲
Prior Year		
Jul-26	1,488	1,530
Jul-25	1,538	1,580
	-3%	-3%
	▼	▼

Mental Health Services Services FTEs April 25 to Current



FTE's		
Prior Mth	CFTE £k	WFTE £k
Jul-26	1,620	1,773
Jun-26	1,610	1,749
	1%	1%
	▲	▲
Prior Year		
Jul-26	1,620	1,773
Jul-25	1,650	1,779
	-2%	0%
	▼	▼

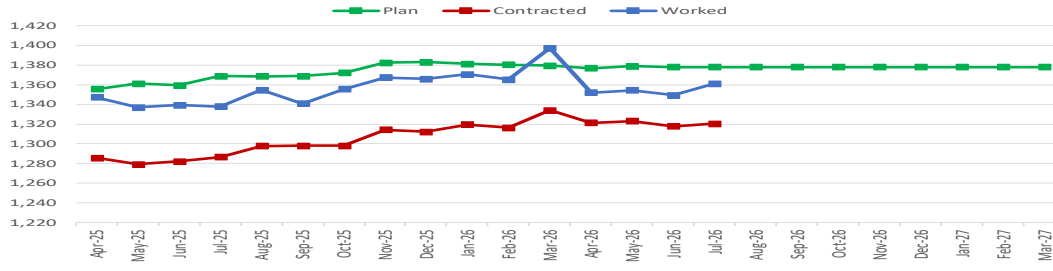
Key Messages

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

Worked WTEs are 229 lower than plan in July.

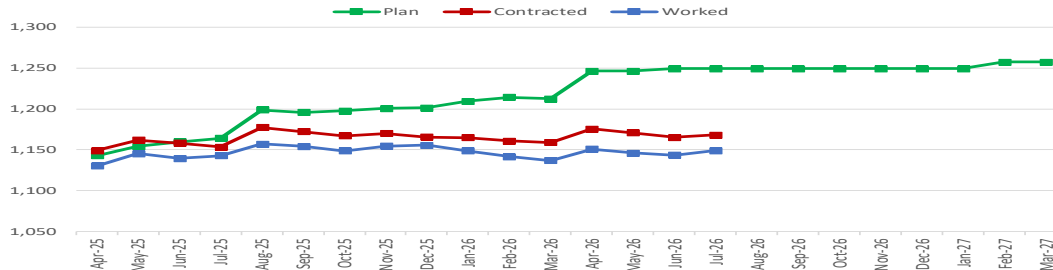
Staff Detail (Staff Group)

Registered Nursing FTEs April 25 to Current



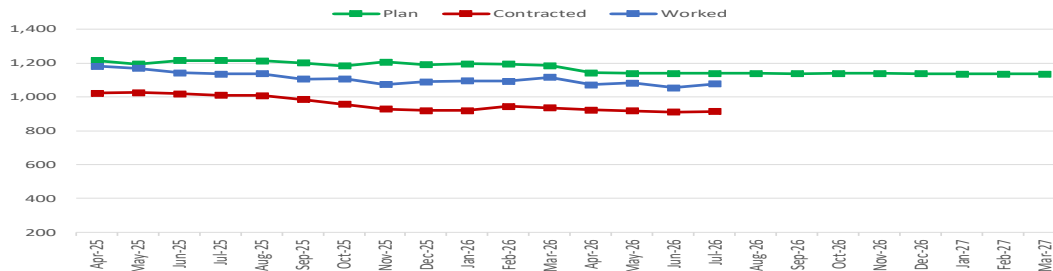
Prior Mth	FTE's CFTE £k	WFTE £k
Jul-26	1,320	1,361
Jun-26	1,318	1,349
	0%	1%
Prior Year		
Jul-26	1,320	1,361
Jul-25	1,287	1,338
	3%	2%

Other Qualified Non Medical FTEs April 25 to Current



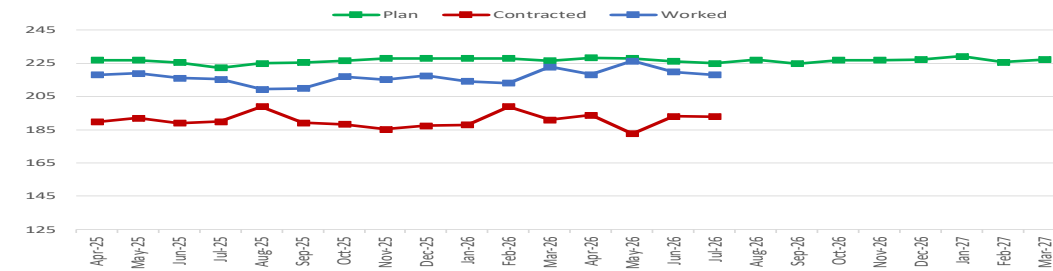
Prior Mth	FTE's CFTE £k	WFTE £k
Jul-26	1,168	1,149
Jun-26	1,165	1,144
	0%	0%
Prior Year		
Jul-26	1,168	1,149
Jul-25	1,154	1,143
	1%	1%

Support to Clinical Staff FTEs April 25 to Current



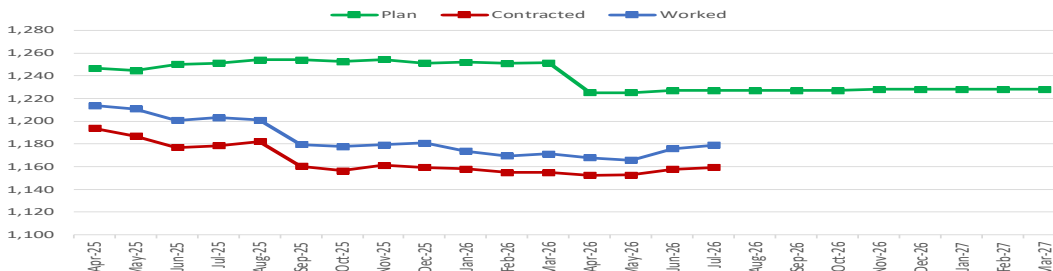
Prior Mth	FTE's CFTE £k	WFTE £k
Jul-26	914	1,077
Jun-26	911	1,054
	0%	2%
Prior Year		
Jul-26	914	1,077
Jul-25	1,010	1,136
	-9%	-5%

Medical Staff FTEs April 25 to Current



Prior Mth	FTE's CFTE £k	WFTE £k
Jul-26	193	218
Jun-26	193	220
	0%	-1%
Prior Year		
Jul-26	193	218
Jul-25	190	215
	2%	1%

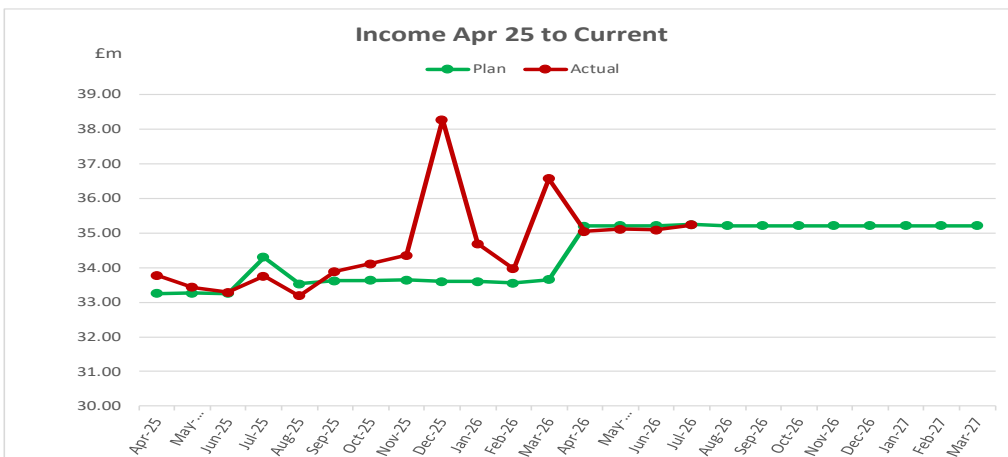
Admin, Estates & Managers FTEs April 25 to Current



Prior Mth	FTE's CFTE £k	WFTE £k
Jul-26	1,159	1,179
Jun-26	1,158	1,176
	0%	0%
Prior Year		
Jul-26	1,159	1,179
Jul-25	1,178	1,203
	-2%	-2%

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

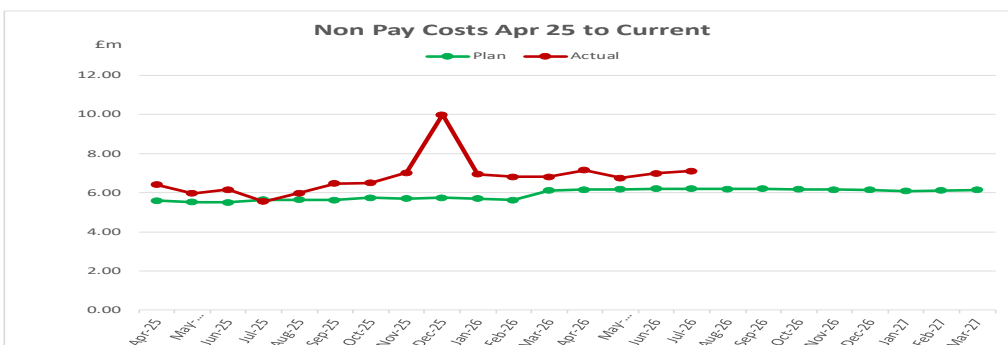


Income	
YTD	£'k
2026/27	140.5
2025/26	134.3
▲	5%
Prior Year	£'k
Jul-26	35.2
Jul-25	33.8
▲	4%

Key Messages

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

Non Pay

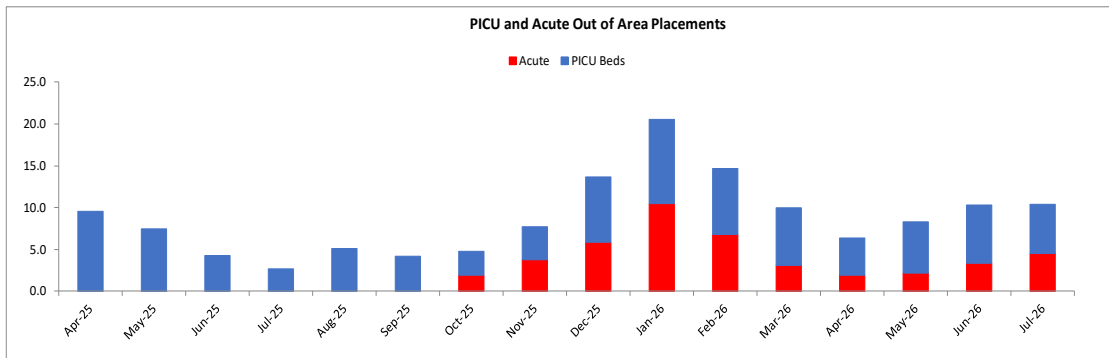


Non Pay	
YTD	£'k
2026/27	28.0
2025/26	24.1
▲	16%
Prior Year	£'k
Jul-26	7.1
Jul-25	5.6
▲	28%

Key Messages:

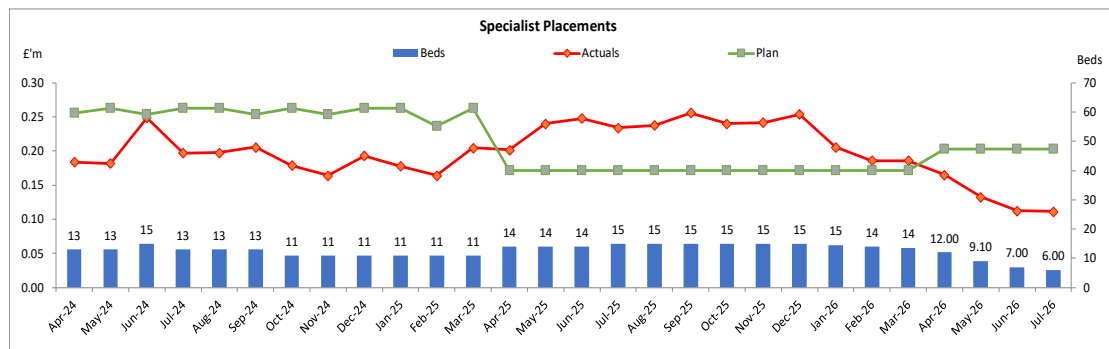
As in previous years, the overspend against the non-pay plan is driven by OAPS and PICU placements. This is offset in part by an underspend against specialist placements.

Placement Costs



OAPs

YTD	£'m
2026/27	1.9
2025/26	1.1
	▲ 74%
Prior Yr	£'m
Jul-26	0.7
Jul-25	0.2
	▲ 308%



Specialist Placements

YTD	£'m
2026/27	0.52
2025/26	0.92
	▼ -44%
Prior Yr	£'m
Jul-26	0.11
Jul-25	0.23
	▼ -52%

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 number of placements has increased from 3 in June to 4.5 in July, causing an overspend of £205k in month and a year to date overspend of £441k.

We have planned for 3.5 Psychiatric Intensive Care Unit (PICU) placements in 2026/27. The number of placements has decreased from 7 in June to 6 in July causing a £289k overspend in month and a £687k year to date overspend. There remains a long-standing issue of a lack of female PICU placement beds locally. The demand for PICU beds has also been affected by an increased number of requests for prison transfers for assessment or treatment under the Mental Health Act (MHA).

The total overspend on placements is £1128k 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 contributors 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).

Specialist Placements

The average number of placements is planned to be 13, with actual placements reducing from 7 in June to 6 in July resulting in an underspend of £291k 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	198	198	0	
Corporate Services Review (26/27 schemes)	Recurrent	High	1,000	334	0	-334	
Operational services Review (26/27 schemes)	Recurrent	Low	6,800	2,272	2,272	0	
Operational services Review (26/27 schemes)	Recurrent	Medium	2,039	680	0	-680	
Locum VAT review (26/27)	Recurrent	Medium	450	150	0	-150	
Locum VAT review (prior years)	Non recurrent	Medium	1,486	496	0	-496	
Income generation	Recurrent	Low	520	167	167	0	
MARS	Recurrent	Low	250	83	83	0	
Other pay schemes	Recurrent	Low	50	16	16	0	
Other pay schemes	Non recurrent	Medium	428	64	0	-64	
Other non pay schemes	Recurrent	Low/Medium	1,378	459	432	-27	
Asset Life	Recurrent	Low	100	33	33	0	
Opt to tax	Recurrent	High	400	133	0	-133	
Establishment controls	Non recurrent	Low	0	0	1,884	1,884	
		Total	15,496	5,085	5,085	0	
		Recurrent	Total	13,582	4,525	3,201	-1,324
		Non recurrent	Total	1,914	560	1,884	1,324

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

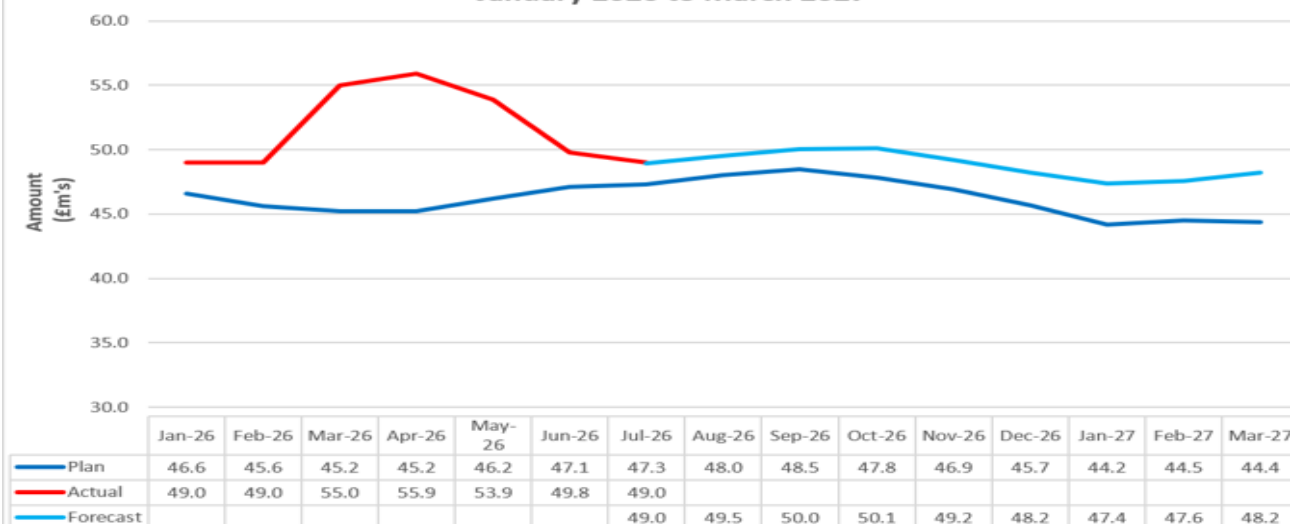
	2025/26	Current Month			YTD		
	Actual £'m	Act £'m	Plan £'m	Var £'m	Act £'m	Plan £'m	Var £'m
Intangibles	1.6	1.3	0.6	0.7	1.3	0.6	0.7
Property, Plant & Equipment (non PFI)	41.6	39.7	42.6	(2.9)	39.7	42.6	(2.9)
Property, Plant & Equipment (PFI)	45.3	45.6	43.2	2.4	45.6	43.2	2.4
Property, Plant & Equipment (RoU Asset)	16.0	14.7	17.7	(3.0)	14.7	17.7	(3.0)
Receivables	0.2	0.2	0.2	0.0	0.2	0.2	0.0
Total Non Current Assets	104.7	101.5	104.3	(2.8)	101.5	104.3	(2.8)
Trade Receivables & Accruals	15.4	23.2	9.5	13.7	23.2	9.5	13.7
Other Receivables	0.2	0.3	0.3	0.0	0.3	0.3	0.0
Cash	55.0	49.0	47.3	1.7	49.0	47.3	1.7
Trade Payables & Accruals	(42.2)	(41.0)	(35.4)	(5.6)	(41.0)	(35.4)	(5.6)
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)	(15.9)	(9.4)	(6.5)	(15.9)	(9.4)	(6.5)
Total Net Current Assets / (Liabilities)	6.4	8.4	4.8	3.6	8.4	4.8	3.6
Non Current Borrowings (PFI and RoU Lease Liability)	(49.1)	(48.6)	(47.4)	(1.2)	(48.6)	(47.4)	(1.2)
Other Non Current Payables	(1.4)	(1.5)	(1.6)	0.1	(1.5)	(1.6)	0.1
Total Net Assets	60.6	59.8	60.1	(0.3)	59.8	60.1	(0.3)
Income & Expenditure Reserve	13.0	11.4	11.8	(0.4)	11.4	11.8	(0.4)
Public Dividend Capital Reserve	24.6	24.6	26.2	(1.6)	24.6	26.2	(1.6)
Revaluation Reserve	23.0	23.8	22.0	1.8	23.8	22.0	1.8
Total Taxpayers Equity	60.6	59.8	60.1	(0.3)	59.8	60.1	(0.3)

Key Messages

Net current assets are £8.4m compared with the plan of £4.8m. The variance is related to a higher than planned cash balance and variances on receivables and payables.

There was a higher than planned cash balance at the end of 2025/26 linked in part to capital slippage which has continued into the first months of 2026/27. We have received the £1.3m deficit support funding which was agreed and included in our position for 2025/26. Receivables are higher than anticipated, relating to recharges to London ICBs and delays in settlement of the Trust's invoice to RBH for the provider-to-provider charges for 2025/26 (this is offset by equal opposite delay in the Trust settling the RBHs invoice sitting within payables). The Trust had not settled payment of the Q2 invoices for NHSPS at month 4 pending resolution over the amount to be paid for rental and services charges.

**Cash Plan v Actual v Forecast
January 2026 to March 2027**



Capital Expenditure

Schemes	Current Month			Year to Date			FY	FY	FY	FY
	Actual	Revised Plan	Variance	Actual	Revised Plan	Variance	Plan (NHSE Submission)	Plan (Revised)	Forecast Outturn	Variance to Revised Plan
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
<u>Estates Maintenance & Replacement Expenditure</u>										
Trust Owned Properties General Pool	0	50	(50)	0	50	(50)	330	380	380	0
Jubilee Ward Relocation to St Marks - CIR Funding	190	420	(230)	433	1,680	(1,247)	2,520	2,520	2,589	69
Jubilee Ward Relocation to St Marks - CDEL	190	0	190	433	0	433	0	1,038	969	(69)
Skimped Hill - Ground floor reconfiguration	6	0	6	19	0	19	500	500	500	0
Leased Non Commercial (NHSPS) Other	(1)	52	(53)	1	52	(51)	525	525	525	0
Environment & Sustainability	0	35	(35)	1	65	(64)	400	400	400	0
Backlog Maintenance	34	35	(1)	136	35	101	500	500	500	0
Various All Sites	2	118	(117)	2	119	(117)	1,200	1,300	1,300	0
Statutory Compliance	2	15	(13)	2	15	(13)	150	150	150	0
Subtotal Estates Maintenance & Replacement	423	725	(302)	1,026	2,016	(990)	6,125	7,313	7,313	0
<u>IM&T Expenditure</u>										
Business Intelligence and Reporting	0	0	0	0	15	(15)	70	70	70	0
Hardware Purchases Refresh	0	0	0	7	0	7	4,593	2,950	2,950	0
Teams Rooms Refresh	3	8	(5)	8	33	(26)	100	100	100	0
Additional Divisional Spend	17	33	(16)	33	133	(100)	400	400	400	0
Digital Strategy	39	35	4	156	140	16	450	450	450	0
Subtotal IM&T Expenditure	60	77	(17)	203	322	(119)	5,613	3,970	3,970	0
<u>IFRS16 RoU ASSETS</u>										
Chalvey Lease	0	0	0	0	0	0	600	600	600	0
Other Property Leases	0	0	0	0	0	0	500	500	500	0
Lease cars	0	8	(8)	0	32	(32)	100	100	100	0
CoIN	0	17	(17)	45	64	(19)	200	200	200	0
Sub Total New Leases (IFRS16)	0	25	(25)	45	96	(51)	1,400	1,400	1,400	0
Subtotal CapEx Within Control Total	483	827	(344)	1,274	2,434	(1,160)	13,139	12,684	12,683	0
<u>CapEx Expenditure Outside of Control Total</u>										
Other PFI projects	0	0	0	12	0	1	0	0	161	161
PPH Windows	1	0	1	1	0	1	0	2,204	2,204	0
Subtotal Capex Outside of Control Totals	1	0	1	13	0	2	0	2,204	2,365	161
<u>Projects funded externally</u>										
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	100	0
EV Chargepoint Accelerator scheme - London Hse (PDC)	0	0	0	0	0	0	0	0	30	30
St Marks Block 23 M&E (Air Handling Unit) (Donated)	4	0	4	13	0	13	0	0	600	600
Subtotal Projects funded externally	4	0	4	13	0	13	225	225	1,205	980
Total Capital Expenditure - all funding sources	488	810	(322)	1,256	2,370	(1,126)	13,038	14,787	15,578	791

Key Messages

At M04, CDEL schemes were underspent by £1.2m against plan. Estates is underspent year to date, primarily due to delays on the Jubilee Ward relocation Project. IM&T is also underspent due to the lower than anticipated spend on additional divisional equipment.

At M04, Trust also received confirmation of £475k PDC funding for the Patient Engagement Portal for this financial year. The total approved funding amounts to £990k, and remaining expenditure is profiled across future financial years. In addition, the Trust received confirmation of £30k funding from the EV Charge Point Accelerator Scheme. Total capital expenditure across all funding sources is forecast at £15.6m, £0.8m above the revised plan, reflecting the increase in externally funded projects.

Trust Board Paper Meeting Paper

Board Meeting Date	8 th September 2026
Title	True North Performance Scorecard Month 4 (July 2026) 2026/27
	The Board is asked to note the True North Scorecard.
Reason for the Report going to the Trust Board	To provide the Board with the True North Performance Scorecard, aligning divisional driver metric focus to corporate level (Executive and Board) improvement accountability against our True North ambitions, and Quality Improvement (QI) break through objectives for 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
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True North Performance Scorecard Highlight Report – July 2026

The True North Performance Scorecard for Month 4 2026/27 (July 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 (attached at appendix 1).

Breakthrough Objectives

- Mental Health: Adult Average Length of Stay (bed days) **(Good Patient Experience)** – 52.31 days against a target of 42 days.
 - The average length of stay has a slightly increasing trend for the last 3 months but reduced from the peak of 73.98 days in March 2026.
 - Countermeasures remain with focus on streamlined patient multi-disciplinary team (MDT) meetings focusing on length of stay and actions to support timely discharge.
- Mental Health: Older Adult Average Length of Stay (bed days) **(Good Patient Experience)** – 96 days against a target of 80 days.
 - Similar issues to adult mental health wards and countermeasures.
- Physical Assaults on Staff **(Supporting our People)** – 71 incidents against a target of 36.
 - A total of 23 patients has contributed to the total this month out of 71 in total. The trend is downward since December 2025. Focus remains on length of stay which impacts this metric. Countermeasures remain with key activities focused on improved communication strategies to de-escalate situations and relaxing restrictions which is a significant cause for violence and aggression, especially on Sorrel ward.

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

- Restrictive Interventions – Rapid Tranquilisation (Intra-muscular) **(Harm Free Care)** – 28 against a target of 39 incidents.
 - Eleven 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.

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**) – 83 against a target of 0. This is a new NHS Oversight Framework (NOF) scoring metric.
- Sickness rate (**Supporting Our People**) – red at 4.37% against a revised target of 4.1%. This is an NHS Oversight Framework scoring metric, with the Trust in 10th out of 61 (based on the latest Q3 score of 5.15%) and the national median at 6.22%.
- Inappropriate Out of Area Placements (OAPs) at the end of the month (Mental Health) – (**Good Patient Experience**) – at 2 against a target of 0.

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 95.89% 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.

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 (NOF Scoring) (**Good Patient Experience**) – 8.59% against a target of 5%.
- Clinically ready for discharge by wards in mental health (including OAPs) (**Good Patient Experience**) – 425 against a 350-bed day target.
- Talking Therapies reliable recovery for those completing a course of treatment (**Good Patient Experience**) – (NOF scoring metric) – at 47% against a target of 51%.
- Percentage of patients referred to crisis care teams to receive face to face contact within 24 hours (**Good Patient Experience**) – (NHS Oversight Framework scoring metric) at 62.2% against a target of 80%.
- Mean length of stay for adult acute and psychiatric intensive care unit patients (**Good Patient Experience**) – (NHS Oversight Framework scoring metric) 47 days against a target of 40 days.
- Readmission rate within 14 days of discharge (NOF Scoring) (**Harm Free Care**) – 1.5% against a target of 0%.
- Mental Health acute occupancy rate (excluding home leave) (**Efficient Use of Resources**) – at 98% against an 85% target.
- Mental Health non-acute occupancy rate (excluding home leave) (**Efficient Use of Resources**) – at 90.29% against an 80% target.

- Variance from agency cap in month (**Efficient Use of Resources**) – 81 against a target to be confirmed.
- Variance from agency cap year to date (**Efficient Use of Resources**) – 145 against a target to be confirmed.

NHS Oversight Framework (NOF) Metrics

The latest published NHS Oversight Framework metrics remain for quarter 4, and relevant metrics for the organisation are shown in the performance report. There are some contextual metrics in this regime for 2025/26, which are changing for 2026/27. Scoring metrics contribute to the segmentation rating as well as an override for financial deficit. The Trust is at segment 2 in the latest published scorecard, which is classified as:

- Segment 2 organisations are high-performing providers with only limited or targeted support needs.
- They are performing well overall against the national metrics, but may have some areas requiring improvement, unlike Segment 1 (best performers with minimal issues).
- Advanced Foundation Trust clear escalation routes and 6-month leeway for resolving non-urgent issues or declines.

National scores published for quarter 4, we improved to 15th nationally (previously Q1 - 3rd, Q2 - 9th, Q3 - 17th) from all non-acute Trusts with 14 in segment 1. The next published report for quarter 1 2026/27 is expected in September. There are challenges in the following metrics:

- Percentage of patients waiting over 52 weeks for community services, slight worsening, ranked 25th out of 42 trusts. Our score 0.33% against a median of 0.19%.
- Percentage of inpatients with over 60-day length of stay with a worsening position. Ranked 37th out of 47 trusts. Our score 30.25% against a median of 24.52%.
- Relative difference in costs – remained in second from last position. Ranked 60th out of 61 trusts. Metric value at 135.35% compared to a median of 104.85%. Material changes have been implemented to improve position through the activity recording project, should see improvements in quarter one position published in August/September.
- Percentage of patients in mental health crisis to receive face-to-face contact within 24-hours – slight worsening for Q4. Ranked 37th out of 45 trusts. Our score 62.65% against a median of 71.97%.

True North Performance Scorecard – Business Rules & Definitions

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

Driver - True North / break through objective that has been prioritised by the organisation as its area of focus	Tracker Level 1 - metrics that have an impact due to regulatory compliance	Tracker - important metrics that require oversight but not focus at this stage in our performance methodology
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Rule #	Metric	Business Rule	Meeting Action
1	Driver is Green in current reporting period	Share success and move on	No action required
2	Driver is Red in current reporting period	Share top contributing reason , the amount this contributor impacts the metric, and summary of initial action(s) being taken	Standard structured verbal update
3	Driver is Red for 2+ reporting periods	Produce full structured countermeasure summary	Present full written countermeasure analysis and summary
4	Driver is Green for 6 reporting periods	Retire to Tracker level status	Standard structured verbal update and retire to Tracker
5	Tracker 1 (or Tracker) is Green in current reporting period	No action required	No action required
6	Tracker is Red in current reporting period	Note metric performance and move on unless they are a Tracker Level 1	If Tracker Level 1 , then structured verbal update
7	Tracker is Red for 4 reporting periods	Switch to Driver metric	Switch and replace to Driver metric (decide on how to make capacity i.e. which Driver can be a Tracker)

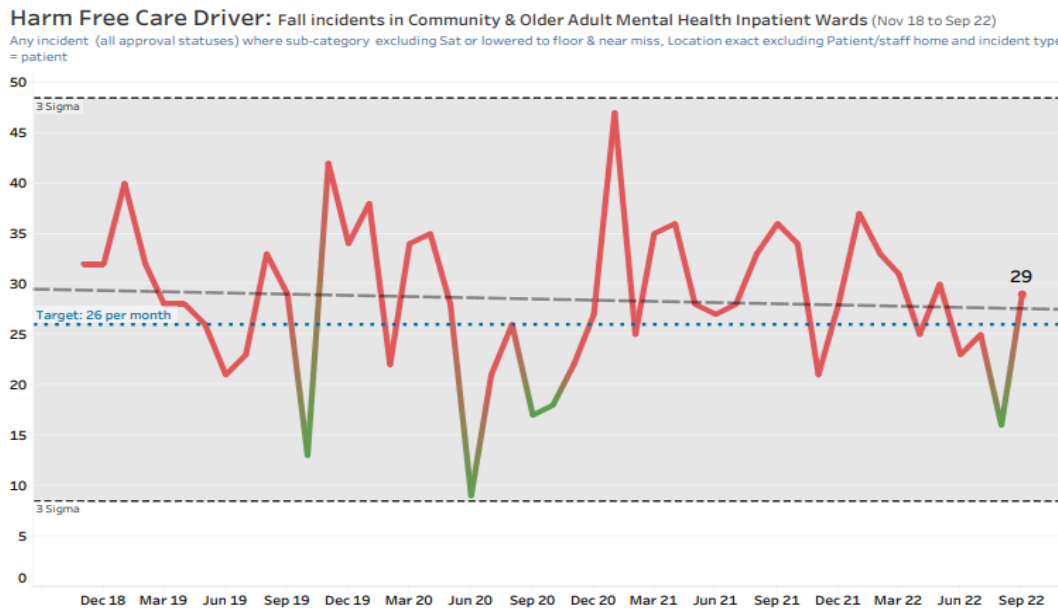
Business Rules for Statistical Process Control (SPC) Charts

Why Use SPC Charts

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

Components of an SPC Chart

The charts have the following components with an example below:



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

Variation

There are 2 types of variation:

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

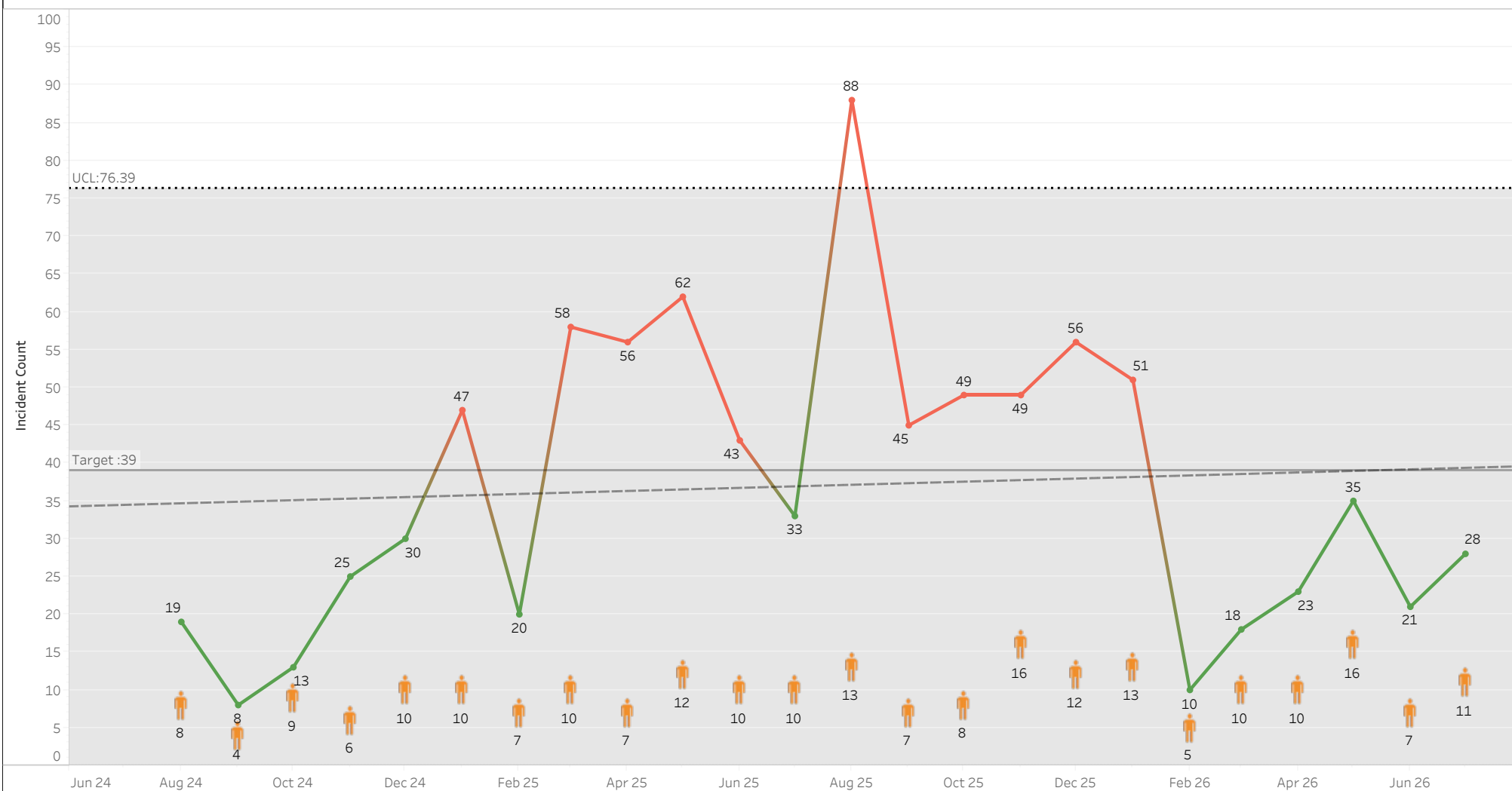
Rules

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

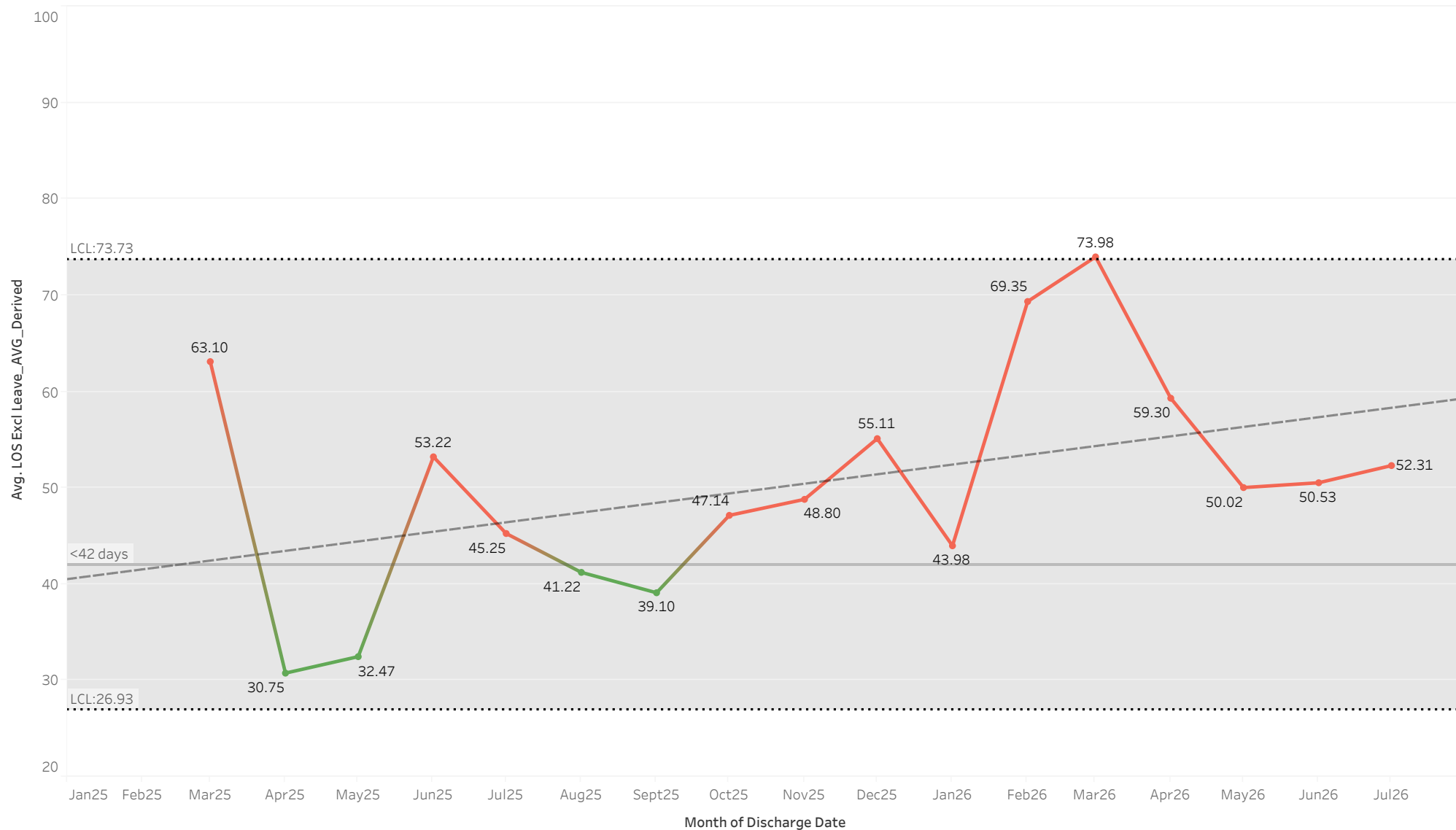
Performance Scorecard - True North Drivers

			Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Breakthrough Rapid Tranquilization (Intra-Muscular)	39	Internal	88	45	49	49	56	51	10	18	23	35	21	28
			Good Patient Experience											
Positive Patient Experience Score %	95% compliance	External	95.03%	86.09%	80.90%	89.70%	94.69%	96.20%	96.5%	96.29%	96.29%	95.09%	95.89%	
Number of Children on community waiting lists over 52 weeks (Exclude Neurodiversity) (NOF Scoring)	0	External	99	91	93	103	75	72	82	58	61	86	85	83
Mental Health Services Waiting over 52 weeks-Children	0	External			7	3	7	7	7	4	8	3	0	0
			Aug25	Sept25	Oct25	Nov25	Dec25	Jan26	Feb26	Mar26	Apr26	May26	Jun26	Jul26
Breakthrough Mental Health: Acute Average Length of Stay (bed days)	<42 April 26	External	41.22	39.10	47.14	48.80	55.11	43.98	69.35	73.98	59.30	50.02	50.53	52.31
			Aug25	Sept25	Oct25	Nov25	Dec25	Jan26	Feb26	Mar26	Apr26	May26	Jun26	Jul26
Breakthrough Mental Health: Older Adult Average Length of Stay (bed days) (NOF Scoring)	<80	External	73.33	109.60	99.00	92.57	119.50	75.50	128.94	113.45	95.58	104.56	66.08	96.00

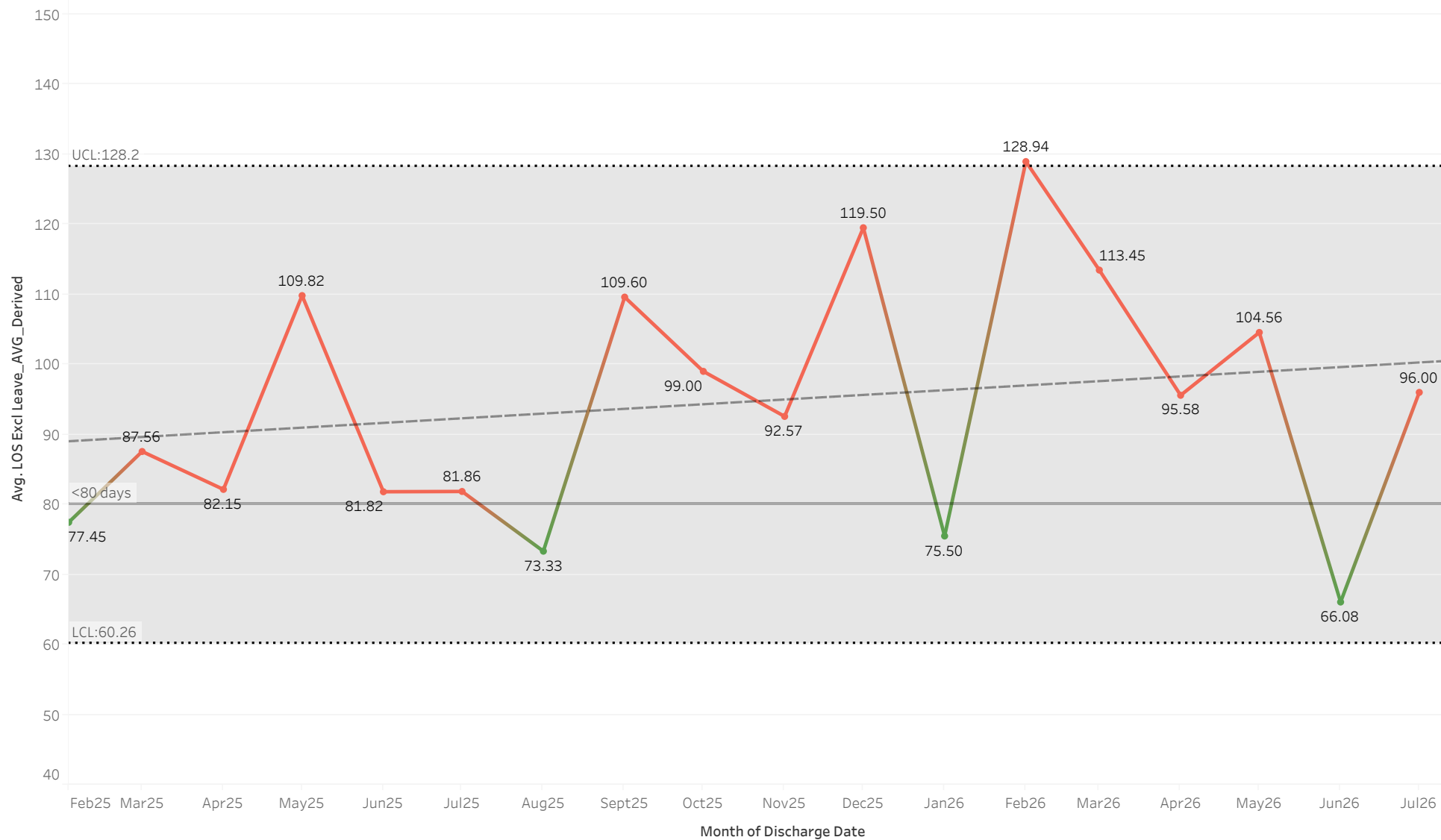
Breakthrough Rapid Tranquilization (Intra-Muscular)



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



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

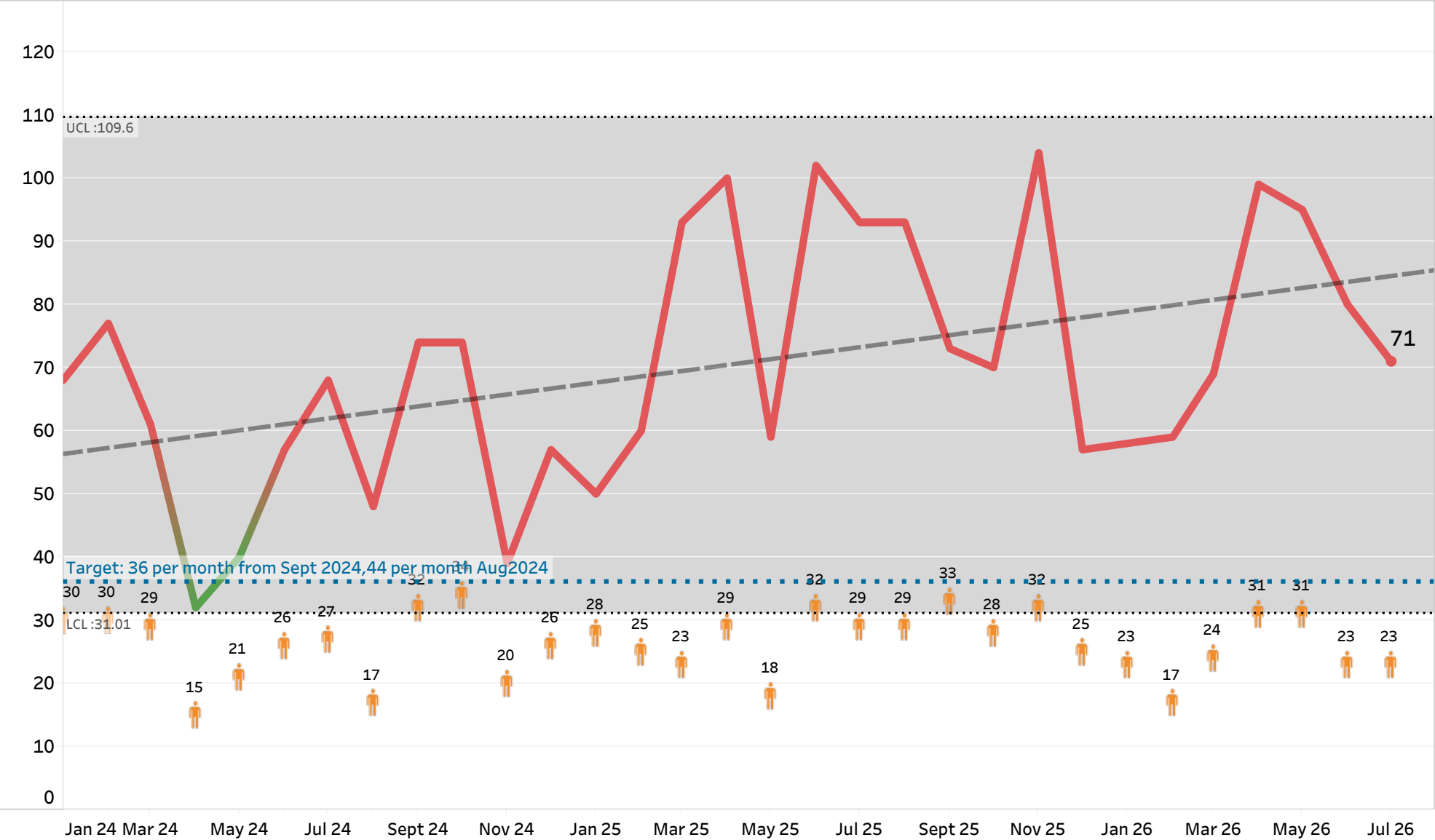


Performance Scorecard - True North Drivers

Supporting Our People														
Metric	Target/Threshold	External/Inter..	Aug25	Sept25	Oct25	Nov25	Dec25	Jan26	Feb26	Mar26	Apr26	May26	Jun26	Jul26
Breakthrough Physical Assault on Staff	36 per month	Internal												
			93	73	70	104	57	58	59	69	99	95	80	71
Sickness Rate: % (NOF Scoring)	<3.5%,4.1% April 26	External												
			4.39%	4.66%	5.25%	5.12%	5.14%	5.12%	4.66%	4.32%	4.13%	4.08%	4.37%	
Efficient Use of Resources														
YTD variance from control total (£'k) (NOF Scoring)	0	External												
			0	0	0	0	0	0	0	0	0	0	0	0
			Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26
Active Inappropriate OAPS at end of month (NOF Non Scoring)	Q4-1 ,New target 26/27:0	External	0	0	3	4	6	8	1	1	0	4	3	2

Supporting Our People - Breakthrough Objective :Physical Assaults on Staff (Jan 24 to Jul 26)

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



True North Supporting Our People Summary

Metric	Threshold / Target	External/Internal	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26
Statutory Training: Fire: %	90% compliance	Internal	93.9%	93.2%	93.3%	93.9%	93.6%	93.5%	92.8%	93.2%	94.2%	95.1%	95.7%	95.8%
Statutory Training: Health & Safety: %	90% compliance	Internal	98.4%	98.3%	98.3%	98.3%	98.2%	98.4%	98.4%	98.2%	98.4%	98.6%	98.7%	98.6%
Statutory Training: Manual Handling: %	90% compliance	Internal	94.3%	94.2%	94.3%	94.0%	94.6%	94.8%	94.8%	95.2%	95.5%	95.2%	95.5%	96.0%
Mandatory Training: Information Governance: %	95% compliance	Internal	97.7%	97.6%	97.6%	97.5%	97.4%	96.9%	96.9%	97.2%	97.2%	97.2%	97.4%	97.7%
			Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26
Staff turnover (excluding fixed term posts)	10%	External	10.29%	10.35%	10.29%	10.28%	10.19%	10%	9.910%	10.05%	10.19%	10.27%	10.04%	10.05%
PDP (% of staff compliant) Appraisal: %	Target: 95% by end of May 2025	Internal									44%	91.0%	95.8%	

True North Good Patient Experience

			Aug25	Sept25	Oct25	Nov25	Dec25	Jan26	Feb26	Mar26	Apr26	May26	Jun26	Jul26
Percentage of patients admitted as an emergency within 30 days of discharge (Community Readmission) (NOF Scoring)	95%	External	0%	0.63%	0%	0%	0.57%	0%	0%	0.62%	0%	0%	0%	0%
Percentage of Inpatients referred to stop smoking services (NOF Scoring)	95%	External	0%	0%	0%	0%	0%	0%	0%	0%	40%	41.1%	37.2%	32.3%
Percentage of people accessing mental health services with at least 2 contacts and a paired outcome score (Adults)	12%	External									17%	16%	20.5%	18.6%
Percentage of acute mental health admissions with no contact with community mental health services in the previous year (NOF Scoring)	5%	External	4.90%	3.69%	3.79%	5%	6%	8.20%	7.00%	6.5%	3.40%	5%	5%	8.59%
Percentage of people accessing mental health services with at least 2 contacts and a paired outcome score (children)	28%	External	7.00%	11%	14.0%	16%	16%	18%	14.0%	17%	36.3%	28.8%	36%	49.7%
Proportion of patients referred for diagnostic tests who have been waiting for less than 6 weeks (DM01 - Audiology): %	95% seen	External	99.70	95.71	99.12	99.79	98.72	97.40	100	97.93	99.23	98.81	100	99.09
Fall incidents in Community & Older Adult Mental Health Inpatient Wards	26 Per month	Internal	17	21	23	21	26	25	15	20	24	30	31	24
Health Visiting: New Birth Visits Within 14 days: %	90% compliance	Internal	91.3%	92.9%	92.5%	92.2%	92.1%	92.6%	93.8%	90.6%	77.5%	78.9%	90.1%	91.7%

True North Good Patient Experience

			Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26
Community Health Services: 2 Hour Urgent Community Response % (NOF Scoring)	80%+	External	86.6%	92.9%	93.8%	93.9%	90.6%	86.5%	91.5%	93.0%	93.7%	97.8%	90.4%	91.2%
Percentage of CYPMH Clients waiting over 104 Week for a full stop clock (MHSDS)	5%	External								40%	41%	41%		
Time to first appointment Diabetes	<18 weeks	External	Aug25	Sept25	Oct25	Nov25	Dec25	Jan26	Feb26	Mar26	Apr26	May26	Jun26	Jul26
			100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Time to first appointment Children’s Community Paediatrics	<18 weeks	External	100%	100%	98.8%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Number of Adults on community waiting lists over 52 weeks (NOF Scoring)	0	External	32	1	8	71	51	38	23	12	10	3	1	0
			2025-08	2025-09	2025-10	2025-11	2025-12	2026-01	2026-02	2026-03	2026-04	2026-05	2026-06	2026-07
Percentage of Intermediate Care Beds occupied by people with no criteria to reside (NOF Scoring)	Tbc	External	44.3%	48.8%	49.5%	44.7%	47.4%	48.0%	47.9%	51.0%	45.3%	47.5%	50.9%	47.0%
			Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Clinically Ready for Discharge by Wards MH (including OAPS)	250 bed days , 350 bed days Nov25	External	419	525	482	500	363	629	452	564	400	541	497	425

True North Good Patient Experience

			Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26
Talking Therapies Reliable Improvement for those completing a course of treatment	69%	External												
			67%	70%	62%	68%	67%	68%	69%	68%	70%	67%	68%	69%
Talking Therapies Reliable Recovery for those completing a course of treatment (NOF Scoring)	51%, April 26	52% External												
			48%	47%	46%	48%	46%	47%	47%	47%	48%	48%	48%	47%
Talking Theraphies Finished Course of Treatment	854	External												
			702	932	927	799	839	865	768	766	681	693	718	855

True North Good Patient Experience

			Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26
Access to Perinal services	960	External	1,139	1,163	1,177	1,164	1,169	1,189	1,219	1,231	1,243	1,242	1,258	1,257
Percentage of patients referred to crisis care teams to receive face to face contact within 24 hours (NOF Scoring)	80%	External	57.9%	59%	65%	52%	54%	66%	64.4%	57.9%	67%	55.0%	70.7%	62.2%
Physical Health Checks 7 Parameters for people with severe mental illness (SMI)	90%	Internal	96%	94%	93%	91%	94.3%	92%	91%	93%	92%	89%	92%	92%
Mental Health: Prone (Face Down) Restraint	4 per month	Internal	1	3	1	2	3	1	0	1	5	2	0	0
Patient on Patient Assaults (MH Inpatients)	25 per month	Internal	23	18	4	13	12	24	11	26	18	29	9	9
Mental Health: Uses of Seclusion	13 in month	Internal	8	10	4	13	8	12	5	9	13	10	10	7
Rate of Restrictive Intervention Types per 1000 bed days (NOF Scoring)	TBC	External	111.83	72.31	69.98	110.89	69.25	59.48	20.65	27.3	53.65	51	42.7	50.2
Mean length of stay for adult acute and psychiatric intensive care unit patients (NOF Scoring)	40 days	External	54.73	49.23	42.87	44.64	50.31	48.47	56.73	66.66	71.57	61.52	51.3	47

True North Harm Free Care Summary

Metric	Threshold / Target	External/Internal	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26
Mental Health: AWOLs on MHA Section	10 per month	Internal	7	8	4	2	2	6	3	9	10	7	1	3
Mental Health: Absconsions on MHA section (Excl: Failure to return)	8 per month	Internal	1	2	7	5	6	5	0	4	3	1	5	1
Readmission Rate with in 14 days (NOF Scoring)	0%	Null	0%	0%	0%	0%	0%	0%	0%	0%	4.59%	0%	2.70%	1.5%
Mental Health 72 Hour Follow Up after Inpatient discharge (NOF Scoring)	80 %	External	95.1%	92.4%	100%	92.8%	94.3%	91.6%	97%	90.6%	94%	90%	96.3%	90.7%
Self-Harm incidents on Mental Health Inpatient Wards (excluding LD)	125 per month	Internal	210	193	235	259	226	282	163	171	108	115	92	98
Patient on Patient Assaults (LD)	4 per month	Null	0	1	3	5	0	2	3	0	1	0	0	0
Self-Harm Incidents within the Community	31 per month	Internal	8	15	16	16	19	15	29	13	19	25	27	32

Efficient Use of Resources

Metric	Proposed Target	External/Internal	Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Community Inpatient Occupancy	95%	Internal	81.7%	88.9%	86.7%	86.7%	88.3%	90.0%	87.2%	90.5%	92%	90.1%	90.5%	92.9%
Mental Health: Adult Acute LOS over 60 days % of total discharges Age 64 and Under (NOF Scoring)	TBC	External	22%	21%	25%	24%	28.9%	28.1%	29.4%	30%	29.6%	21.3%	20.1%	19%
Mental Health: Older Adult Acute LOS over 90 days % of total discharges age 65+ (NOF Non Scoring)	TBC	External	48%	48%	52%	54%	56.0%	54%	61%	70%	47.3%	53.3%	41.2%	34.8%
DNA Rate: %	5% DNAs	Internal	5.16%	5.04%	5.05%	5.11%	4.99%	4.76%	4.73%	4.96%	4.79%	4.76%	4.90%	5.20%
			Aug-25	Sept-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Mental Health: Acute Occupancy rate (excluding Home Leave):%	90%	Internal	97.7%	97.2%	96.5%	97.7%	97.7%	98.8%	98.6%	97.9%	97.5%	98.2%	99.5%	98.0%
Mental Health: Non-Acute Occupancy rate (excluding Home Leave): %	80% Occupancy	Internal	77.56%	82.54%	86.89%	91.34%	93.75%	97.34%	87.25%	82.15%	84.20%	84.29%	86.29%	90.29%
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	29	216	174	132	97	-4	52	-8	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%
Variance from agency cap in month	TBC	External									-17	-4	85	81
Variance from agency cap YTD	TBC	External									-17	-21	64	145

Trust Board Paper

Board Meeting Date	08 September 2026
Title	Finance, Investment and Performance Committee Meetings – Updated Terms of Reference
	Item for Ratification
Reason for the Report going to the Trust Board	The Finance, Investment and Performance Committee is a sub-committee of the Trust Board. The Committee reviewed its terms of reference at its meeting on 22 July 2026 and agreed that references to the Trust's investment policy and the Prudential Borrowing Code should be deleted. The Committee also agreed that in view of the Trust's more stable staffing position, that the Committee would no longer oversee the Trust's Recruitment and Retention work. The Trust Board would continue to receive regular updates on matters relating to People. The Board is requested to ratify and changes to the Committee's Terms of Reference as highlighted in red.
Business Area	Corporate
Author	Company Secretary for Sonya Batchelor, Chair of the Finance, Investment and Performance Committee.
Relevant Strategic Objectives	Efficient use of resources Ambition: We will use our resources efficiently and focus investment to increase long term value

Finance, Investment & Performance Committee

Terms of Reference

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Confidentiality

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Disclaimer

Document Control

Version	Date	Author	Comments
1.0	28 Jan 08	Philippa Slinger	
2.0	5 Feb 08	Philippa Slinger	Following comments by F&I Chair
3.0	5 March 08	Garry Nixon	Following Approval by Board
4.0	7 May 09	John Tonkin	Amendments following F&I Committee meeting 29 April 2009
5.0	16 August 2010	John Tonkin	Amendments following F&I Committee meeting 28 July 2010
6.0	10 March 2011	John Tonkin	Amendment to include scrutiny of integrated performance information following agreement at Board meeting 8 March 2011
7.0	8 May 2012	John Tonkin	Amendment to membership on recommendation of Committee following Board consideration on 8 May 2012
8.0	25 February 2015	John Tonkin	Amended following review by F,I&P Committee – for Board approval – June 2015
9.0	22 February 2017	Julie Hill	Amended following review by F,I&P Committee – for board approval July 2017
10	June 2019	Julie Hill	Amended following review by F,I&P Committee – for board approval September 2019
11	August 2020	Julie Hill	Updated in August 2020
12	July 2021	Julie Hill	Updated in August 2021 following review by F,I &P Committee approval August 2021 –Board approved September 2021
13	July 2024	Julie Hill	Updated in July 2024 - Section 5.2.6 relating to reviewing credit ratings benchmarking of investments and borrowing activities was deleted
14	July 2026	Julie Hill	Updated in July 2026 – removal of references to investment policy and removal of references to workforce related issues.

1. Authority

- 1.1 The Finance, Investment & Performance Committee is constituted as a Standing Committee of the Trust Board of Directors. Its constitution and terms of reference shall be set out as below, subject to amendment at future Board of Directors meetings.
- 1.2 The Committee is authorised by the Trust Board to request the attendance of individuals and authorities from within and outside the Trust if it considers this necessary to discharge its duties.

2. Purpose

- 2.1. To conduct independent and objective review of financial ~~and investment~~ policy and to review financial and operational performance information and issues. To discharge this duty the Committee will:
 - 2.1.1 scrutinise and review current financial performance, ensuring that there are robust plans in place to correct any material adverse variances from financial plan.
 - 2.1.2 scrutinise and review organisational performance as reported within the Trust's True North Performance Scorecard in accordance with the agreed business rules ensuring that there are robust plans in place to correct any material adverse variances from target.
 - 2.1.3 Identify areas of organisational performance for more in-depth review and scrutiny
 - 2.1.4 ~~review the Trust's Investment Strategy and Policies and~~ maintain scrutiny and oversight of investments and significant transactions ensuring compliance with the regulator and Trust Policy.
 - 2.1.5 examine the Trust's medium-term financial strategy and provide assurance that the Trust's future strategic service plans support continued compliance with NHS Improvement's Provider Licence and the NHS ~~Single~~ National Oversight Framework.
 - 2.1.6 review the progress against national requirements for maintaining safe staffing on the Trust's inpatient wards
 - 2.1.7 review the relevant risks on the Board Assurance Framework.
 - 2.1.8 ~~Oversee the Trust's People Strategy's recruitment and retention work on behalf of the Trust Board~~
 - 2.1.9 ~~Review the Trusts Employee Casework~~
 - 2.1.10 Review any ad hoc areas delegated by the Trust Board

3. Membership

- 3.1 The members of the Committee shall be as follows:
 - Three Non-Executive Directors
 - Chief Executive
 - Chief Financial Officer (Lead Executive Director)

- Chief Operating Officer
- Director of Nursing & Therapies or Deputy Director of Nursing

The Director of Finance will be in attendance at the meetings

- 3.2 The Chair of the Audit Committee shall not be a member.
- 3.3 The Chair of the Committee will be a Non-Executive Director.
- 3.4 A quorum shall be three members, including at least two Non-Executive Directors.

4. Frequency and Administration of Meetings

- 4.1 The Committee will meet at least 4 times a year. It may meet more frequently at any time should circumstances require.
- 4.2 The Committee will be supported by the Company Secretary who will agree the agenda for the meetings and the papers required, directly with the Chair.
- 4.3 Minutes of all meetings shall be formally recorded and submitted, together with recommendations where appropriate, to the Board of Directors.

5. Remit

- 5.1 Financial Policy and Performance
 - 5.1.1 To review and scrutinise current financial performance and assess adequacy of proposed rectification to bring performance in line with plan (where necessary).
 - 5.1.2 To scrutinise projected financial performance with particular reference to reviewing sustainability against Board objectives on risk ratings and liquidity.
 - 5.1.3 To examine the Trust's annual financial plan and maintain an oversight of Trust's income sources and contractual safeguards.
 - 5.1.4 To initiate in-depth investigations and receive reports on key financial, investment and performance issues affecting the Trust.
 - 5.1.5 The committee will review long term financial projections, those overarching the more detailed review of annual budget proposals.
- 5.2 ~~Investment Policy and Performance~~ Business Developments
 - 5.2.1 ~~To assess whether adequate systems are in place to ensure that financial considerations are properly incorporated within capital investment decisions~~
 - 5.2.2 ~~To scrutinise all investment proposals for financial implications and consistency with strategic plans prior to submission to the Board when required.~~
 - 5.2.3 To receive and scrutinise future service and business development proposals, including enhancements to existing contracts, acquisitions, etc to ensure proper financial evaluation, including impact on future risk ratings.
 - 5.2.4 To ensure adequate safeguards on investment of funds.

~~To receive reports as appropriate on actual or potential breaches of the Prudential Borrowing Code~~

5.2.5 To review investment performance and risk.

5.2 Organisational Performance Assurance

5.3.1 To review and scrutinise organisational performance as reported within the Trust's True North Performance Scorecard report in accordance with the business rules

5.3.2 To assess the appropriateness of remedial action to address material variances from target and to monitor progress.

5.3.3 To consider the overall adequacy of the True North performance Scorecard and the monitoring metrics and to recommend changes as necessary to maintain appropriate levels of Board assurance.

5.3.4 ~~To oversee the Trust's People Strategy's recruitment and retention work.~~

5.5 To review any other ad hoc areas as delegated by the Trust Board

Amended: July 2026

Approved by Trust Board: September 2026 TBC

For review: July 2027

WRES 2025/2026 – Board Summary

Board Meeting Date	8 th September 2026
Title	Workforce Race Equality Standard 2025/26: Results and Analysis
	Item for Assurance
Reason for the Report going to the Trust Board	The Workforce Race Equality Standard provides a national framework for assessing differences in workforce representation, experience and outcomes between ethnically diverse and White staff. This paper presents the Trust's 2025/26 WRES results and additional analysis undertaken to understand the factors contributing to the headline indicators. The Board is asked to: • note the 2025/26 WRES results and the areas of improvement and deterioration; • consider the additional analysis explaining how workforce composition, demographic, professional and labour market factors influence some of the headline results; • discuss the continuing differences in staff experience, particularly those relating to discrimination, harassment and bullying; and • support continued organisational focus and further investigation in the areas highlighted by the report.
Business Area	People Directorate
Author	Stephen Strang, Workforce Planning and Insights Manager Edited by: Ash Ellis, Deputy Director for Leadership, Inclusion and Organisational Experience Executive Sponsor and authorised for submission: Alex Gild, Deputy Chief Executive And Jane Nicholson, Director of People
Relevant Strategic Objectives	Workforce This report directly supports the Trust's ambition to make the Trust a great place to work for everyone. It provides evidence on differences in workforce representation, recruitment, development, progression, disciplinary outcomes and staff experience between ethnically diverse and White staff. The findings identify areas of improvement, areas where headline differences are influenced by workforce composition and areas where meaningful differences remain and require continued organisational focus.

Overview:

[Click here to view full WRES paper](#)

The Workforce Race Equality Standard (WRES) provides a national framework for assessing differences in workforce representation, experience and outcomes between ethnically diverse (ED) and White staff.

The Trust's ethnically diverse workforce now represents **33.9% of all staff**, continuing the long-term increase in workforce diversity. Analysis of the 2025/26 WRES indicators shows a mixed picture, with improvements in some areas and deterioration in others. Additional analysis has been undertaken to understand the factors driving the results and support informed interpretation of the headline indicators. The findings demonstrate that some differences are strongly influenced by workforce composition, age profile, profession mix and labour market factors, whilst some staff experience indicators remain consistent with inequity and continue to require organisational focus.

WRES Indicator Scorecard:

Indicator	2025/26 Result	Change	Key Context
Workforce Representation (WRES 1)	33.9%	Improved	Workforce diversity continues to increase.
Recruitment (WRES 2)	1.5 (White likelihood)	Worsened	Influenced by application patterns, right to work status and workforce composition
Disciplinary (WRES 3)	1.47 (ED likelihood)	Improved	Workforce gender composition explains vast majority of the difference
CPD Access (WRES 4)	1.05 (White likelihood)	Improved	Wider definition of development activity used this year is responsible for the vast majority of improvement
Patient/Public Harassment (WRES 5)	13.7pp (Gap)	Worsened	Workforce composition at PPH vs non PPH contributes significantly but unexplained differences remain regardless
Staff Abuse (WRES 6)	4.6pp (Gap)	Improved	Gap narrowed compared with previous year
Career Progression (WRES 7)	5.4pp (Gap)	Improved	Higher progression rates for ethnically diverse staff compared to white staff
Discrimination (WRES 8)	5.9pp (Gap)	Slightly worsened	Staff experience gap remains
Board Representation (WRES 9)	25.0pp (Gap)	Worsened	Indicator highly sensitive to small changes in Board membership due to small board numbers

Key Finding 1: Senior Representation Requires Context: [Click here to view full WRES paper](#)

The headline WRES indicator shows ethnically diverse staff represent **22.0% of Agenda for Change Bands 8a-9** compared with **33.9% of the workforce overall**. However, additional analysis demonstrated that Berkshire's younger population is substantially more ethnically diverse than its older population and that age is strongly associated with organisational seniority. Senior representation would therefore be expected to differ from overall workforce representation to some extent. **The initial 22.0% figure relates only to Agenda for Change Bands 8a-9 and excludes senior medical and Very Senior Manager (VSM) posts, which sit outside the Agenda for Change framework.**

The analysis also found that representation falls below the age-adjusted Berkshire benchmark across all workforce age groups rather than being unique to senior age groups. Profession mix, workforce structure and recent international recruitment activity conducted at a national and local level all contribute to the observed pattern. When equivalent non-Agenda for Change senior roles are mapped to equivalent Agenda for Change bands based upon salary, ethnically diverse representation increases from **22.0% to 29.5% in senior roles**, reducing the variance against the Berkshire benchmark to the smallest observed across the workforce of all age banding groups.

Importantly, ethnically diverse candidates were more likely than White candidates to be appointed following interview for Bands 8a-9 roles and ethnically diverse staff were **1.84 times more likely** to receive promotion at Band 8a and above. Current evidence therefore does not indicate that senior recruitment or promotion processes are disadvantaging ethnically diverse staff.

Board takeaway: Workforce demographics, profession mix, workforce structure and career pipeline factors explain a substantial proportion of the observed senior representation difference. Current evidence does not indicate systemic organisational barriers to progression into senior roles.

Key Finding 2: Recruitment, Disciplinary and Progression Indicators Are Strongly Influenced by Workforce Composition:

Click here to view full WRES paper

The recruitment indicator worsened during 2025/26, with White applicants 1.50 times more likely to be appointed overall. However, analysis identified several contributing factors, including applicant pool composition, repeat applications, competition levels and right-to-work status. Notably, this pattern was not evident within senior recruitment, where ethnically diverse applicants were slightly more likely to be appointed following interview for Bands 8a-9 posts.

The disciplinary indicator improved from 1.98 to 1.47. Analysis identified workforce gender composition as the primary explanatory factor. Males are approximately 3.5 times more likely to enter the formal disciplinary process than females, and the ethnically diverse workforce contains more than double the proportion of males compared with the White workforce. Modelling suggests that around 80% of the observed disparity is explained by gender composition alone.

Group	White Male	ED Male	ED Female	White Female
Formal disciplinary rate %	1.7%	1.5%	0.6%	0.4%

Career progression indicators also improved. Ethnically diverse staff were more likely to receive promotion overall and substantially more likely to receive promotion at senior levels. While perceptions of career progression continue to differ between groups, the gap narrowed significantly during 2025/26.

Board takeaway: Several workforce indicators change materially when workforce composition and labour market factors are considered, highlighting the importance of understanding the drivers behind headline disparities.

Key Finding 3: Staff Experience Remains the Most Significant Area of Concern:

Unlike representation, recruitment and disciplinary outcomes, meaningful differences remain within staff experience indicators.

The largest disparity relates to harassment, bullying and abuse from patients, relatives and the public, where the gap widened to **13.7 percentage points**. Discrimination indicators also remain more than twice as likely to be reported by ethnically diverse staff. While working environment, particularly within Prospect Park Hospital (PPH), contributes significantly to these outcomes, differences remain evident even when comparing staff working within similar environments.

These findings suggest that both environment and ethnicity influence staff experience outcomes. While workforce composition explains part of the variation observed, meaningful differences remain and continue to be consistent with inequity.

Board takeaway: Staff experience indicators relating to discrimination, harassment and bullying remain the most significant unresolved inequalities identified within the report and should remain a key organisational focus.

Key Messages for the Board:

Click here to view full WRES paper

- Ethnically diverse staff now represent 33.9% of the Trust workforce.
- Senior representation is substantially more favourable when workforce demographics and equivalent non-AfC senior roles are considered.
- No evidence was identified that current senior recruitment or promotion processes disadvantage ethnically diverse staff.
- Promotion of band 7 Ethnically Diverse staff however remains an area requiring investigation.
- Recruitment and disciplinary indicators appear strongly influenced by workforce composition, environmental and labour market factors.
- Staff experience indicators remain the strongest area of concern and continue to show differences consistent with inequity.
- The analysis reinforces the importance of understanding the underlying drivers behind disparities rather than relying solely on headline indicators.

Further information:

The full WRES report provides detailed methodology, analysis and recommendations and is available [here](#).

Workforce Race Equality Standard (WRES) 2025/2026

Please help shape future papers by completing [this feedback survey](#) to share your insights.

Author:

Stephen Strang, Workforce Planning and Insights Manager (Author)
Ash Ellis, Deputy Director for Leadership, Inclusion, Organisational Experience (Editor)
Alex Gild, Deputy Chief Executive (Exec Sponsor)

Acknowledgement: The author would like to thank Charlotte Sadler, Data Quality Analyst (NHS Graduate Trainee), for her support in sourcing and validating Berkshire Connected Care data used within the demographic benchmarking and senior representation analysis presented in this report.

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The Workforce Race Equality Standard (WRES) provides a national framework for assessing racial inequalities within NHS organisations. Whilst the indicators highlight differences in representation, experience and outcomes between Ethnically Diverse and White staff, they do not account for factors such as workforce age profile, labour market demographics, profession mix, workforce composition or career pathway dynamics. These factors are therefore considered throughout this analysis when interpreting the findings.

To support interpretation, Berkshire Connected Care data was used to model expected ethnically diverse representation based on the demographic profile of Berkshire residents. Connected Care combines GP registration data across Berkshire and provides a local population benchmark against which workforce representation can be assessed.

To ensure consistency with NHS WRES reporting, detailed ethnicity categories within the Connected Care dataset were mapped to the NHS ethnic group classifications used throughout this report. A breakdown of the [Berkshire population ethnicity profile](#), together with the [mapping methodology](#) used to derive the ethnically diverse benchmark, is available.

The analysis demonstrates that Berkshire's younger population is substantially more ethnically diverse than its older population. As organisational seniority is strongly associated with age, lower representation at senior levels would be expected when compared with the workforce overall. This highlights the importance of using age-adjusted benchmarks when assessing representation.

When compared with the Berkshire demographic model, all workforce groups demonstrate lower ethnically diverse representation than would be expected within the local population. This finding indicates that any under-representation observed is not unique to senior grades and exists across the workforce more broadly.

Further analysis considered the composition of the Trust's senior workforce. Standard WRES analysis focuses on Agenda for Change Bands 8a-9. However, a significant proportion of senior leadership, clinical leadership and professional leadership roles are held by staff in non-Agenda for Change roles. When equivalent non-Agenda for Change senior roles are incorporated, ethnically diverse representation increases from 22.0% to 29.5%.

Whilst this remains below the Berkshire demographic model, the variance reduces substantially. Senior representation then demonstrates the smallest gap against its modelled benchmark when compared with other workforce groupings. This suggests that senior representation is more aligned with local demographic expectations than is apparent from Agenda for Change analysis alone.

Board voting membership was also examined using age-adjusted demographic benchmarking. Whilst Board representation remains lower than overall workforce representation, the average age of Board voting members is 56.4 years. At this age, Berkshire's population is 21.09% ethnically diverse, compared with Board representation of 23.1%. Board voting membership therefore exceeds the age-adjusted Berkshire benchmark by 2.01 percentage points.

Overall, the findings indicate that workforce age profile, profession mix, workforce structure and career pipeline factors explain a substantial proportion of the observed differences in senior representation. Whilst continued monitoring remains important, the evidence suggests that representation challenges are not confined to senior grades and that age-adjusted demographic context is essential when interpreting the WRES indicators.

Workforce differences are often structural, and in many areas are explained by workforce composition and other contextual factors.

Differences in outcomes do not automatically indicate inequity and must be interpreted in context.

Differences in outcomes do not automatically indicate inequity and must be interpreted in context.

Structural explanations should not be interpreted as race-neutral phenomena. Workforce structures themselves may have developed through historical, social, educational and organisational factors, some of which may also be associated with inequity.

This analysis is based on the principle that observed differences may arise from a range of factors, including workforce structure, labour market dynamics, career pathways, and wider population trends.

To support clear interpretation, differences are described using three categories:

- Where differences can be explained → **Structural disparities**
- Where differences remain → **Unexplained differences**

- Where patterns persist within comparable groups → **Consistent with inequity**

Limitations

This analysis seeks to explain observed differences using available workforce, recruitment and staff survey data. Not all potentially relevant factors are measurable within these datasets. Findings should therefore be interpreted as evidence of contribution rather than definitive proof of causation unless explicitly stated.

The purpose of this approach is not to assume inequity, nor to dismiss it, but to ensure interpretation is grounded in evidence and context.

WRES Indicator Overview (2025/2026):

[Contents page](#)

Overall results show mixed progress, with improvements in some areas and widening gaps in others.

Overall results show mixed progress, with improvements in some areas and widening gaps in others.

Likelihood ratios are used where appropriate to support comparison. A value of **1.00 represents parity** between groups. Values above 1.00 indicate a higher likelihood, and values below 1.00 indicate a lower likelihood relative to the comparator group.

The table below summarises all WRES indicators, including current position, change from last year, and direction of the gap. The remainder of this paper provides detailed analysis to explain the drivers behind these results.

Indicator	Metric	Ethnically Diverse (ED) (25/26)	White (25/26)	Gap (difference between groups, 25/26)	Change in gap vs 24/25	Direction (difference between groups)
1	Workforce representation across AfC Bands 1–9 and VSM	See Appendix A	See Appendix A	Varies by band	–	See Appendix A
2	Likelihood of being appointed from shortlisting	0.67	1.50	ED candidates 33% less likely than White candidates	↑ 0.07	Gap widened
3	Likelihood of entering the formal disciplinary process	1.47	0.68	ED staff 47% more likely than White staff	↓ 0.51	Gap narrowed
4	Likelihood of accessing non-mandatory training (CPD)	0.95	1.05	ED staff 5% less likely than White staff	↓ 0.24	Gap narrowed
5	Staff experiencing harassment, bullying or abuse from patients, relatives or the public	30.2%	16.5%	13.7pp gap	↑ 3.1pp	Gap widened
6	Staff experiencing harassment, bullying or abuse from staff	19.0%	14.4%	4.6pp gap	↓ 1.6pp	Gap narrowed
7	Staff believing organisation provides equal opportunities for career progression	59.8%	65.2%	5.4pp gap	↓ 6.8pp	Gap narrowed
8	Staff experiencing discrimination from manager / team leader or colleagues	10.7%	4.8%	5.9pp gap	↑ 0.3pp	Gap widened
9	Board voting membership vs overall workforce	-11pp	+14pp	25pp gap	↑ 21pp	Gap widened

The WRES provides a national framework for assessing racial inequalities within NHS workforces. However, the indicators do not adjust for:

- Age
- Gender
- Professional distribution
- Labour market factors
- International recruitment and workforce composition factors
- **Long-term occupational and career choices across population groups**

These structural elements may reflect broader societal and historical patterns and, in some circumstances, contribute to the persistence of unequal outcomes including patterns of access, opportunity and representation. However, within this paper they are primarily considered as measurable explanatory factors unless evidence suggests otherwise.

This paper therefore starts from a central question:

To what extent are observed differences in senior representation explained by workforce composition, demographic patterns and progression dynamics, and where do unexplained differences remain?

Senior Representation: A Data-Led Explanation:

[Indicator 1 Data](#)

Berkshire Connected Care modelling demonstrates that ethnically diverse representation falls below the Berkshire demographic benchmark across all workforce groups. Whilst representation within Agenda for Change Bands 8a-9 is lower than expected, the inclusion of equivalent non-Agenda for Change senior roles increases representation from 22.0% to 29.5% and reduces the variance to the smallest observed across the workforce.

The analysis below explores the workforce, demographic and career pipeline factors contributing to this pattern.

1. Headline Position

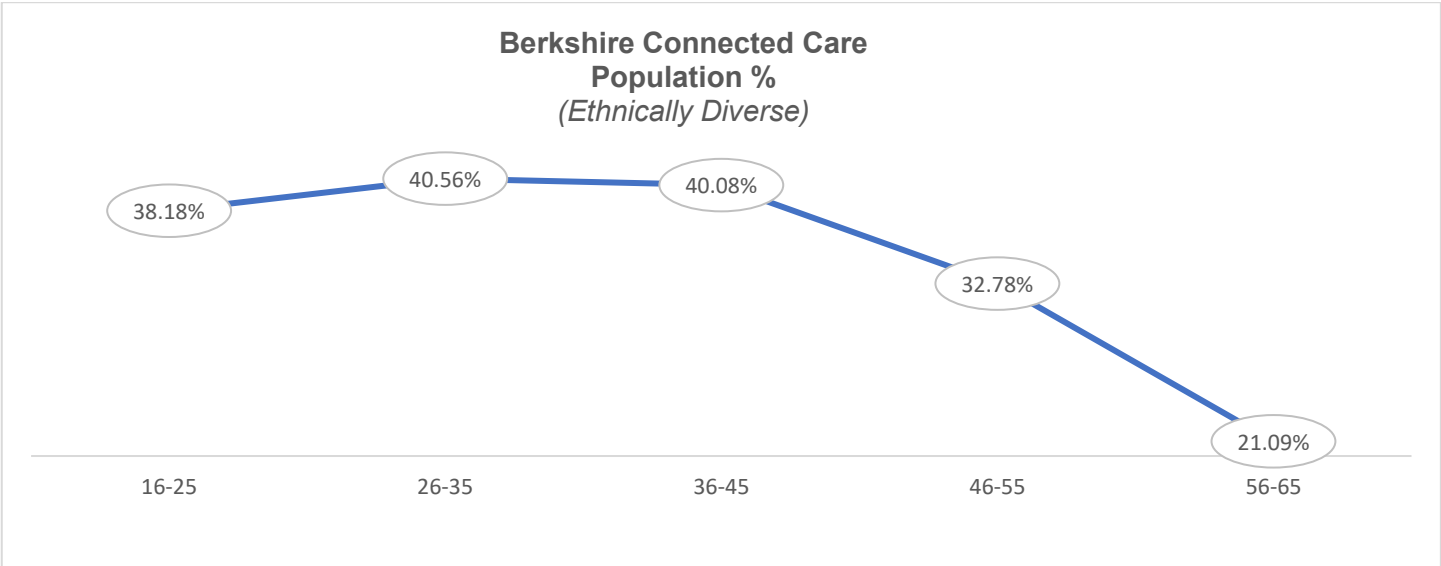
Ethnically diverse staff represent 33.9% of the Trust workforce compared with 22.0% of staff within Agenda for Change Bands 8a-9. On the surface, this suggests lower representation within senior roles than within the workforce overall.

The purpose of this analysis is to understand the extent to which this difference may be explained by workforce demographics, profession mix, workforce structure and career pipeline factors, and to identify where unexplained differences remain.

2. Age Profile and Expected Representation

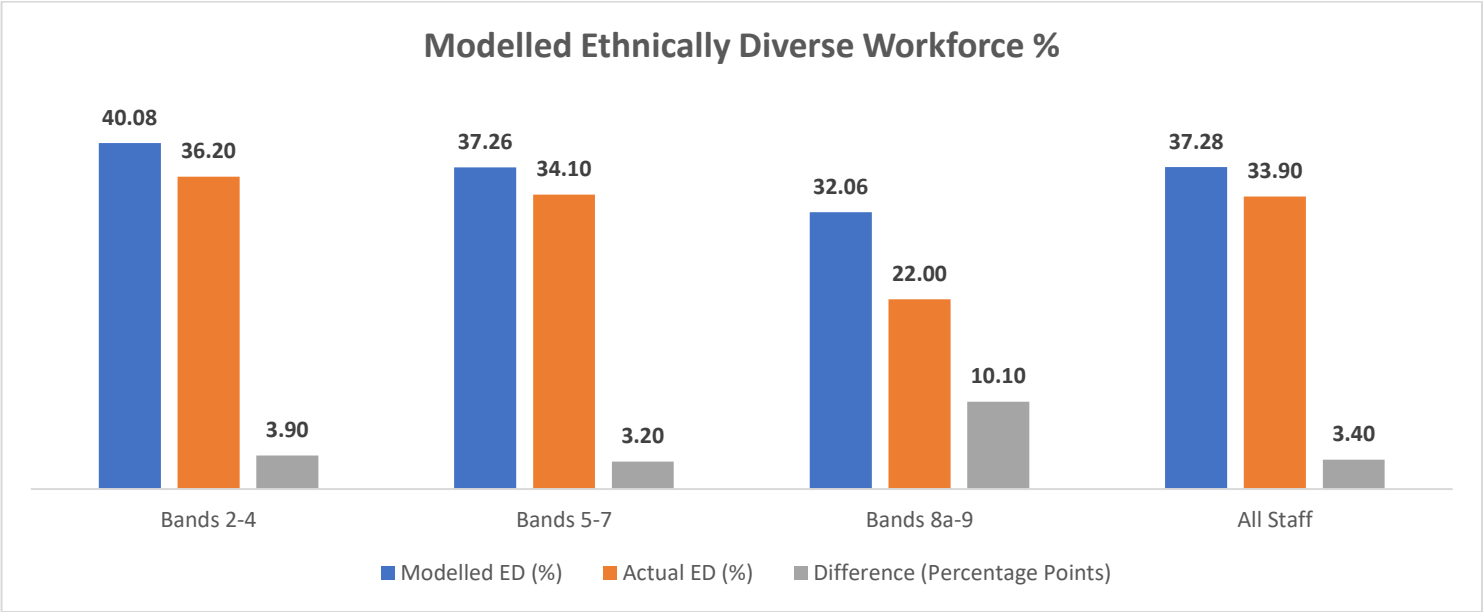
To better understand expected levels of representation, Berkshire Connected Care data was used to model ethnically diverse representation based upon the age profile of Berkshire residents.

The analysis demonstrates that Berkshire's younger population is substantially more ethnically diverse than its older population.



This is important because organisational seniority is strongly associated with age. Senior positions are more commonly occupied by older workforce cohorts, whilst newer entrants to the workforce are more likely to sit within younger cohorts.

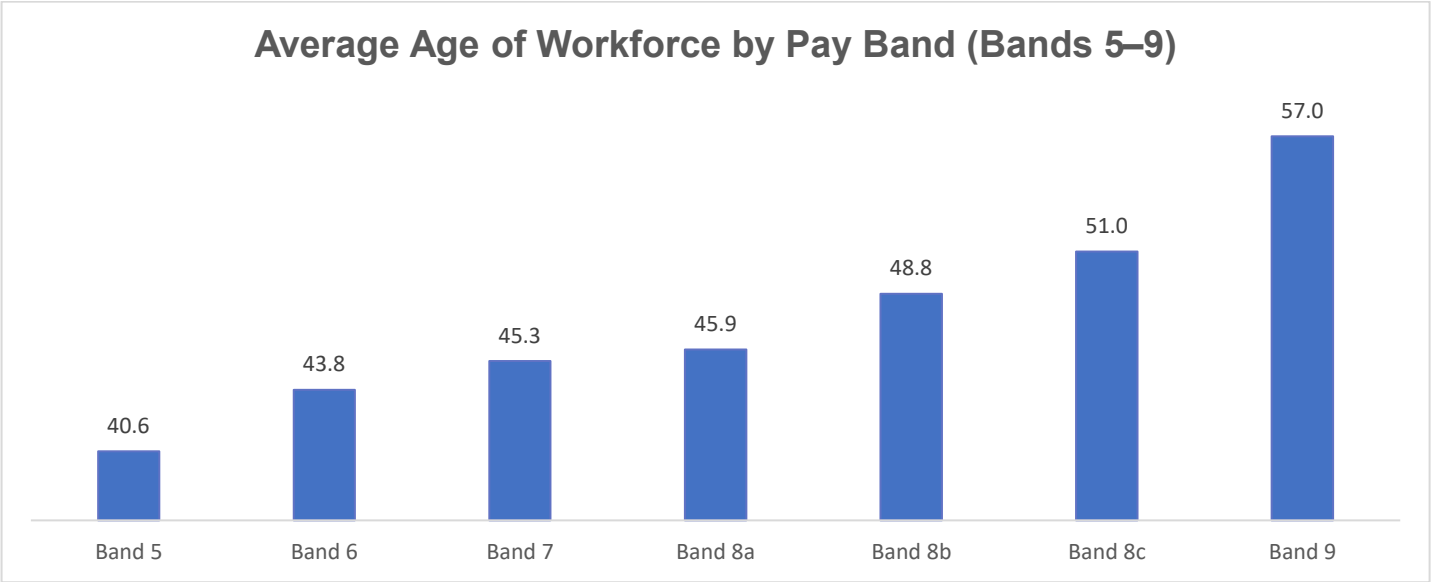
Using the average age profile of each pay band group, a modelled level of expected representation was calculated.



The modelling confirms that representation is lower than the Berkshire demographic benchmark across all workforce groupings.

This is a significant finding because it demonstrates that any under-representation identified is not unique to senior grades. Representation falls below the modelled Berkshire benchmark throughout the workforce. When Agenda for Change bands alone are considered, Bands 8a-9 show the largest gap against the age-adjusted benchmark. However, this position changes materially when equivalent non-Agenda for Change senior roles are incorporated which will be addressed later within this paper.

The analysis also confirms that lower representation within senior grades would be expected to some extent due to the relationship between age and organisational seniority.



3. Role and Profession Composition

Workforce composition analysis demonstrates that professions are not evenly distributed across pay bands. Professional distribution shows:

Clinical Psychologists

- Represent approximately 0.7% of the Bands 2-7 workforce.
- Represent approximately 19.5% of the Bands 8a-9 workforce.

- 18.4% of the Trust's Qualified Clinical Psychologist workforce are ethnically diverse.
- Nationally, approximately 12.1% of registered Clinical Psychologists are ethnically diverse.

Additional Clinical Services

- Represent approximately 27.1% of Bands 2-7.
- Represent approximately 0.6% of Bands 8a+.
- 39.0% of the Trust's Additional Clinical Services workforce are ethnically diverse.

This demonstrates that workforce groups with higher ethnically diverse representation are often concentrated within occupations with relatively limited direct progression routes into senior grades.

For example, Additional Clinical Services is primarily comprised of support and associate-level occupations such as Healthcare Assistants, Assistant Practitioners and Assistant Psychologists. These roles are an important part of the workforce and can provide progression routes into registered professional, specialist and leadership careers. However, progression often requires staff to undertake additional professional qualifications or training before accessing those pathways. As a result, progression may take longer or involve additional barriers compared with professions where staff enter the workforce through a registered professional route from the outset. Given that Additional Clinical Services roles represent approximately 27.1% of the Bands 2-7 workforce but only 0.6% of the Bands 8a-9 workforce, the demographic profile of this staff group may have an indirect influence on the ethnic composition of senior grades.

In contrast, certain professional groups account for a substantial proportion of the Trust's senior workforce despite demonstrating lower levels of ethnically diverse representation nationally.

This analysis does not explain why staff are distributed across professions. Wider educational, labour market, professional and societal factors may all contribute. However, it demonstrates that profession mix is likely to influence the demographic profile of senior grades and should therefore be considered when interpreting representation data.

➡ **Key implication:** The demographic profile of senior grades is influenced not only by progression processes but also by the professional groups from which senior positions are predominantly drawn.

4. Workforce Growth, International Recruitment and Career Pipeline Effects

Workforce demographics have also been influenced by significant changes in NHS recruitment patterns over recent years. Appendix analysis demonstrates that the proportion of NHS staff who are non-British nationals increased substantially between 2016 and 2022, largely driven by national international recruitment programmes.

Within Berkshire Healthcare:

- Higher ethnically diverse representation is concentrated within Bands 2-7.
- Visa holders are disproportionately represented within lower and middle pay bands.
- Approximately 3.2% of staff within Bands 8a-9 currently hold visas.

Nationality is not being used as a proxy for ethnicity. Rather, it is considered to understand the impact of international recruitment on workforce composition and career pipeline dynamics.

These findings suggest that recent international recruitment activity has increased diversity within lower and middle pay bands more rapidly than within senior grades.

Given the relatively small proportion of visa holders currently occupying senior positions, and the time typically required to gain experience and progress through organisational hierarchies, these changes are unlikely to be fully reflected within the senior workforce at present.

This is particularly relevant when considered alongside the Connected Care age profile, which shows that younger Berkshire residents are significantly more diverse than older age groups. The Trust workforce reflects a similar pattern, with newer workforce cohorts generally displaying greater levels of diversity than workforce cohorts currently occupying many senior roles.

➡ **Key implication:** Recent workforce growth and international recruitment activity are likely to have increased diversity within emerging workforce cohorts, but the full impact of these changes may not yet be visible within senior grades due to normal career progression timescales.

5. Looking Beyond Agenda for Change Bands 8a-9

The standard WRES approach uses Agenda for Change Bands 8a-9 as a proxy measure for senior representation. However, a significant proportion of senior leadership, clinical leadership and professional leadership roles sit outside Agenda for Change pay structures, particularly within medical and other professional staff groups.

To better understand representation across the wider senior workforce, non-Agenda for Change roles were mapped to equivalent levels of organisational seniority.

When equivalent non-Agenda for Change senior roles are incorporated into the analysis, ethnically diverse representation within the senior workforce increases from 22.0% to 29.5%.

These roles include senior medical consultants, non-consultant career grade doctors, executive directors and other senior positions operating outside Agenda for Change pay structures but broadly equivalent in organisational seniority to Bands 8a-9.

Using the same Berkshire demographic benchmark, the comparison becomes:

Workforce Group	Modelled Ethnically Diverse (%)	Actual Ethnically Diverse (%)	Difference
Bands 2-4	40.08%	36.20%	-3.9pp
Bands 5-7	37.26%	34.10%	-3.2pp
Senior Workforce (AfC and Equivalent Non-AfC)	32.06%	29.50%	-2.6pp

This materially changes the interpretation of senior representation.

Whilst representation remains below the Berkshire demographic benchmark, the difference reduces substantially when the full workforce is considered.

Importantly, after incorporating equivalent non-Agenda for Change roles, the senior workforce demonstrates the smallest variance from its expected demographic benchmark of any workforce grouping examined.

An important consideration is that the observed representation pattern is not mirrored by senior appointment outcomes. Analysis elsewhere within this paper demonstrates that ethnically diverse candidates are more likely than White candidates to be appointed following interview for Bands 8a-9 roles and that ethnically diverse staff are more likely to receive promotion at Band 8a and above. Whilst representation remains below the Berkshire benchmark, these findings do not provide evidence that current senior recruitment or promotion processes are disadvantaging ethnically diverse staff.

6. Interpretation

Taken together, the evidence suggests that several structural factors contribute to observed representation patterns:

- Berkshire's age profile.
- The relationship between age and organisational seniority.
- Professional composition within senior grades.
- The concentration of highly diverse workforce groups within occupations that have fewer direct routes into senior grades.
- The impact of recent international recruitment on emerging workforce cohorts.
- The concentration of a proportion of senior roles outside Agenda for Change pay structures.

The analysis demonstrates that representation is below the Berkshire demographic benchmark across all workforce groups rather than being unique to senior grades.

Furthermore, once the full senior workforce is considered, senior representation is substantially closer to its expected benchmark than is apparent when examining Agenda for Change Bands 8a-9 alone.

7. Key Conclusion

The Berkshire Connected Care analysis demonstrates that ethnically diverse representation is lower than the Berkshire demographic benchmark across all workforce groups.

Whilst senior representation remains below the level modelled for the local population, this pattern is not unique to senior grades.

Age profile, profession mix, international recruitment, workforce structure and career pipeline dynamics all appear to contribute to the observed differences. When equivalent non-Agenda for Change senior roles are incorporated, ethnically diverse representation increases from 22.0% to 29.5%, reducing the variance from the Berkshire benchmark to approximately 2.6 percentage points.

Indeed, after adjustment for non-Agenda for Change roles, the senior workforce demonstrates the smallest variance from its expected demographic benchmark of any workforce grouping examined.

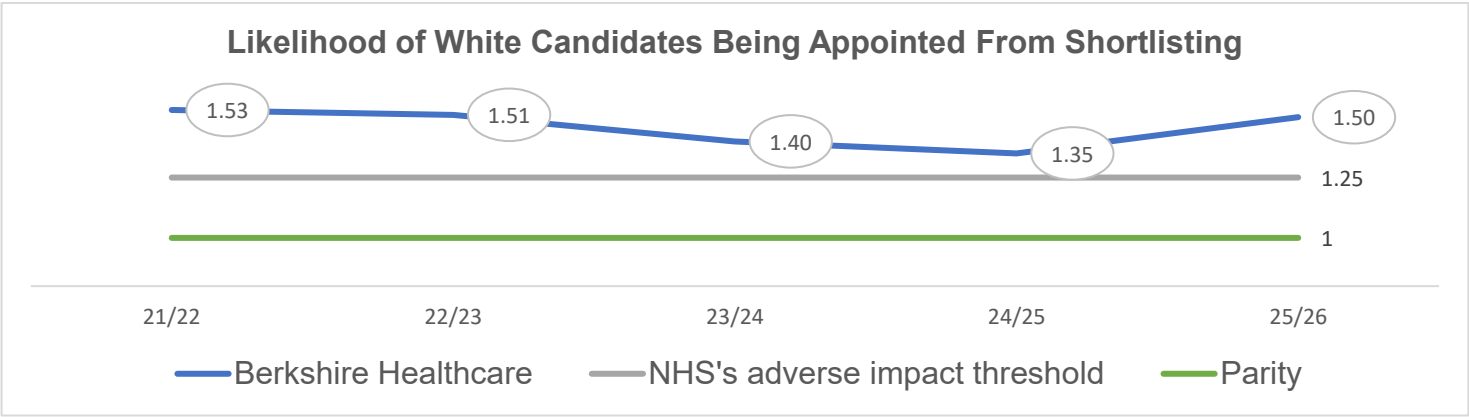
The findings therefore suggest that the observed differences in senior representation are heavily influenced by workforce demographics and workforce composition. Whilst continued monitoring remains appropriate, the evidence challenges the interpretation that senior representation should be viewed in isolation as the Trust's primary representation concern.

Indicator-Level Insights:

[Indicator 2 Data](#)

There is no evidence uncovered of disadvantage in senior appointments.

Indicator 2: Recruitment - Five-Year Trend



The chart above shows that the relative likelihood of White candidates being appointed has increased slightly in the most recent year, following two consecutive years of improvement. A score of 1.50 means that White candidates were 1.5 times more likely than ethnically diverse candidates to be appointed following shortlisting during 2025/26.

Headline:

- White candidates **1.50x more likely to be appointed**

Structural Drivers

1. Applicant Pool

- **77% of applications from Ethnically diverse candidates**
- **21% from White candidates**

**Previous analysis (2024/25) also showed substantially higher application rates among ethnically diverse staff, reinforcing the role of applicant pool composition as a key driver.*

➡ Extremely different applicant pools

2. Repeat Applications (applications from candidates who have applied two or more times)

- ED repeat applications: **40%**
- White: **30%**

**This finding is presented as evidence of a behavioural difference within applicant pools rather than evidence of either advantage or disadvantage. The underlying reasons may vary and require separate analysis.*

3. Competition Levels

- ED candidates more likely to interview for roles with **5 or more candidates interviewing**
- White candidates more likely to:
 - Be sole applicant interviewing(**15% vs 11%**)

➡ Increased applicants interviewing increases rejection rates, whilst fewer applicants interviewing increases success likelihood.

4. Right-to-Work Impact

- White candidates are 1.50 times as likely to be appointed
- White candidates with the visa status “British citizen with right to work in the UK” are **1.15** times as likely to be appointed

➡ When comparing British citizens with right to work only, the **disparity reduces by ~70%**, suggesting that differences in candidate profiles and right-to-work status account for a substantial proportion of the observed variation. The underlying reasons for these differences require further exploration and may include a range of labour market, recruitment process and workforce factors.

Likelihood to be appointed after interview attendance by band cluster (British Citizen with RTW in the UK Only)

**Analysis in this section relates specifically to candidates recorded within TRAC as "British Citizen with Right to Work".*

Band Group	Relative Likelihood of White candidate being appointed after attending an interview	Favours
Bands 2–4	1.59 times as likely	White Candidates
Bands 5–7	1.15 times as likely	White Candidates
Bands 8a–9	0.96 times as likely	Ethnically Diverse Candidates

➡ **Ethnically Diverse** staff are more likely to be appointed after attending interview for senior positions (**bands 8a – 9**)

✔ Key conclusion:

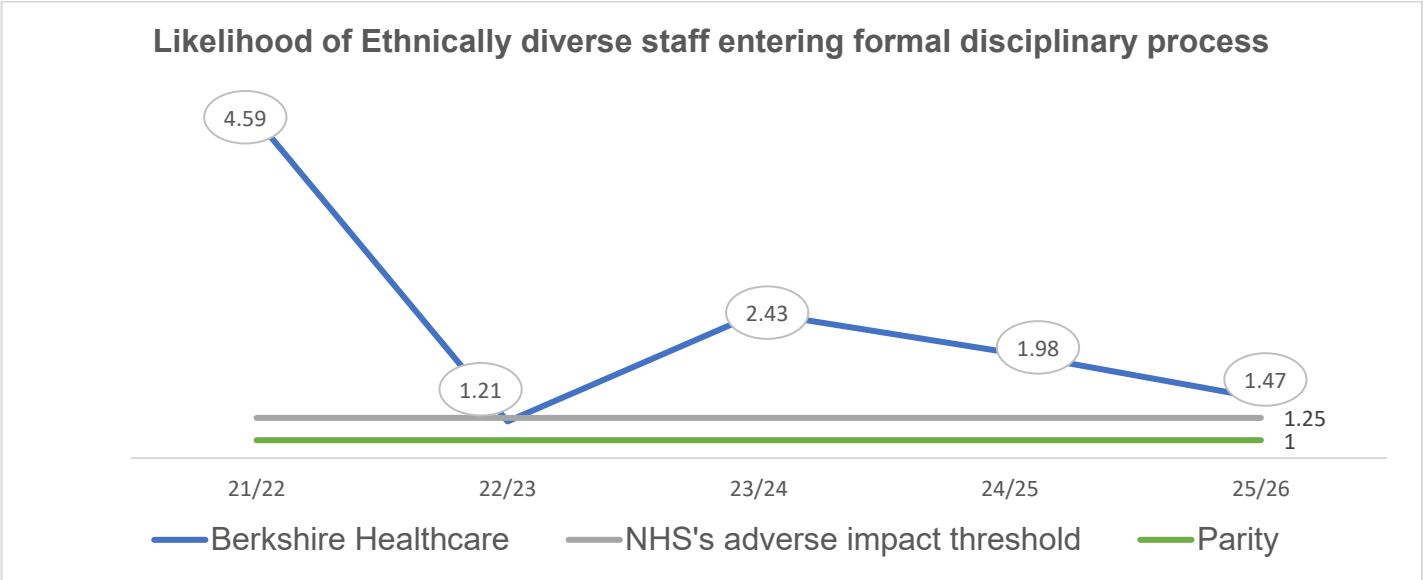
Recruitment disparity is **not evident at senior levels** and the available evidence suggests that **applicant pool composition, competition dynamics, international recruitment and workforce composition factors appear to** explain a substantial proportion of the observed difference. However, **further analysis could provide additional insight** into remaining unexplained variation.

Indicator 3: Disciplinary

[Indicator 3 Data](#)

Workforce Composition, Particularly Gender, Appears to Explain Most of the Observed Gap.

Five-Year Trend



The chart above shows that the gap has narrowed significantly over the past year, representing the largest improvement across all indicators.

- Males are approximately **3.5 times more likely** to enter the formal disciplinary process than females.
- The Ethnically Diverse workforce contains **more than double the proportion of males** compared to the White workforce (**26% vs 12%**).
- This difference in workforce composition has a substantial impact on the headline WRES indicator.

Gender Standardisation Analysis

To estimate the impact of workforce composition, a modelling exercise was undertaken whereby the White workforce was adjusted to have the same gender profile as the Ethnically Diverse workforce.

Using actual White male disciplinary rates (1.67%), the number of White male disciplinary cases was recalculated assuming males represented **26% of the White workforce**, equivalent to the Ethnically Diverse workforce.

This increased the expected number of White disciplinary cases from **7 to 18**.
As a result:

- The reported WRES likelihood ratio falls from **1.47** to approximately **1.10**
- Around **80% of the observed disparity is removed** through gender standardisation alone

This indicates that the majority of the headline difference is attributable to differences in workforce composition rather than differences in disciplinary outcomes within comparable gender groups.

Intersectionality

Group	% of each workforce group entering the disciplinary process
White male	1.7%
ED male	1.5%
ED female	0.6%
White female	0.4%

Analysis by gender shows that males are substantially more likely to enter the disciplinary process regardless of ethnicity. When comparing like-for-like groups:

- Among males, rates are very similar (**1.7% White vs 1.5% Ethnically Diverse**)
- Among females, rates are also relatively similar (**0.4% White vs 0.6% Ethnically Diverse**)

The remaining differences are small in absolute terms and are not consistent in direction across groups. Taken together, these findings suggest that gender is a substantially stronger predictor of disciplinary outcomes than ethnicity within the available data.

✔ Key conclusion:

The observed disciplinary disparity appears to be driven predominantly by workforce composition, particularly gender. Ethnically Diverse staff are significantly more likely to be male, and males are substantially more likely to enter the formal disciplinary process. Modelling indicates that equalising gender composition between workforce groups reduces the WRES likelihood ratio from **1.47 to approximately 1.10**, suggesting that gender differences explain the majority of the observed disparity.

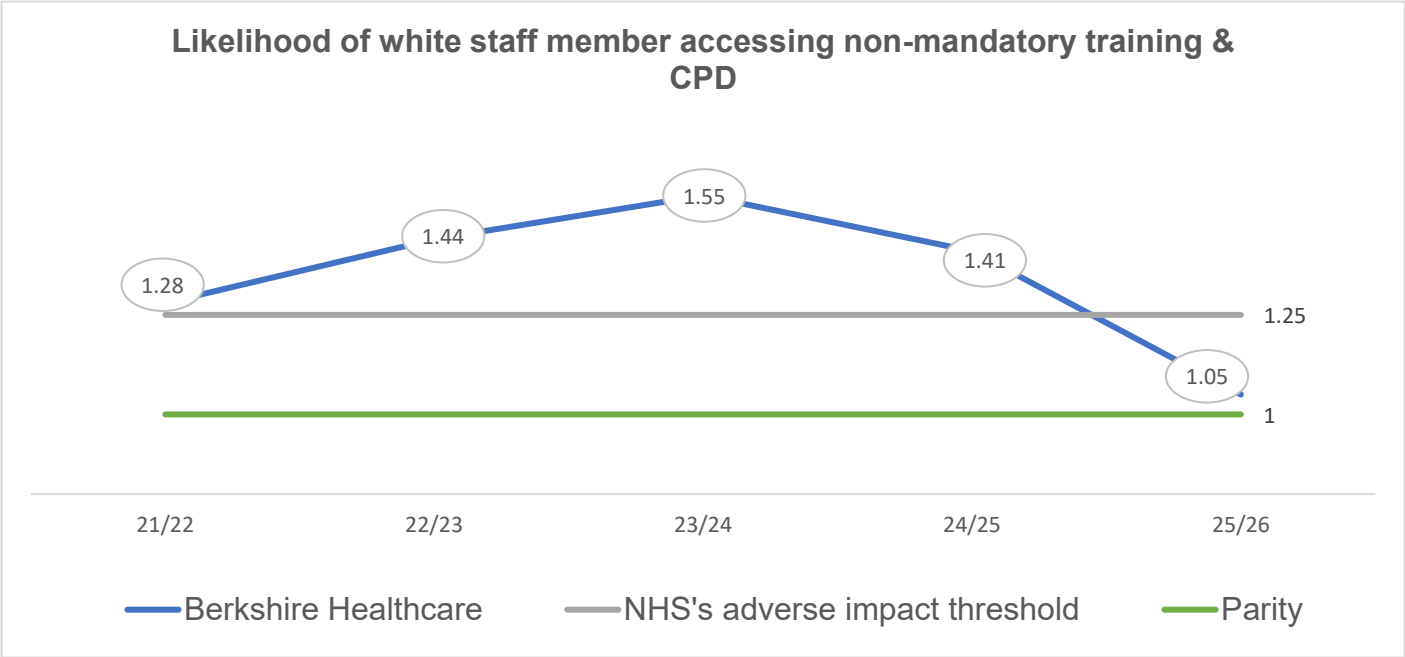
While a small residual difference remains, the available evidence does not indicate a strong or consistent pattern of disadvantage when comparing staff within the same gender group. Consequently, workforce composition appears to be the primary measurable driver within the available dataset of this indicator.

Indicator 4: CPD

[Indicator 4 Data](#)

Headline improvement reflects better data coverage rather than a clear change in access.

Five-Year Trend



The chart above shows a marked movement towards parity in the latest year. However, this shift must be interpreted alongside changes in data scope.

- Headline improved (which includes CPD, Apprenticeship and In-House Training): **1.41 → 1.05**
- CPD-only (like-for-like with what was included in last year's submission): **1.41 → 1.36**

Key conclusion:

The apparent improvement is primarily driven by expanded data coverage in 2025/26 rather than a change in underlying access.

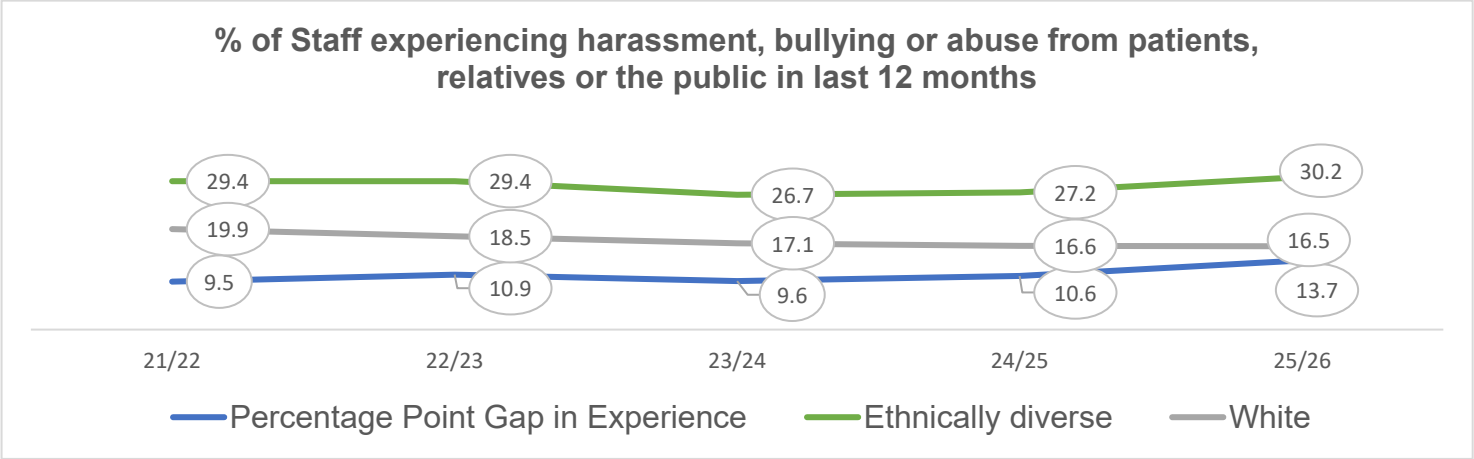
When comparing like-for-like data, differences in access to CPD-funded training persist. While differences in [access to other forms of development are more balanced](#), this presents a mixed picture which requires further understanding before drawing conclusions regarding equity.

Indicators 5, 6, 8: Staff Experience

Patterns in staff experience are consistent with inequity and are amplified in higher-risk environments.

Indicator 5: Harassment, Bullying or Abuse from Patients, Relatives or the Public [Indicator 5 Data](#)

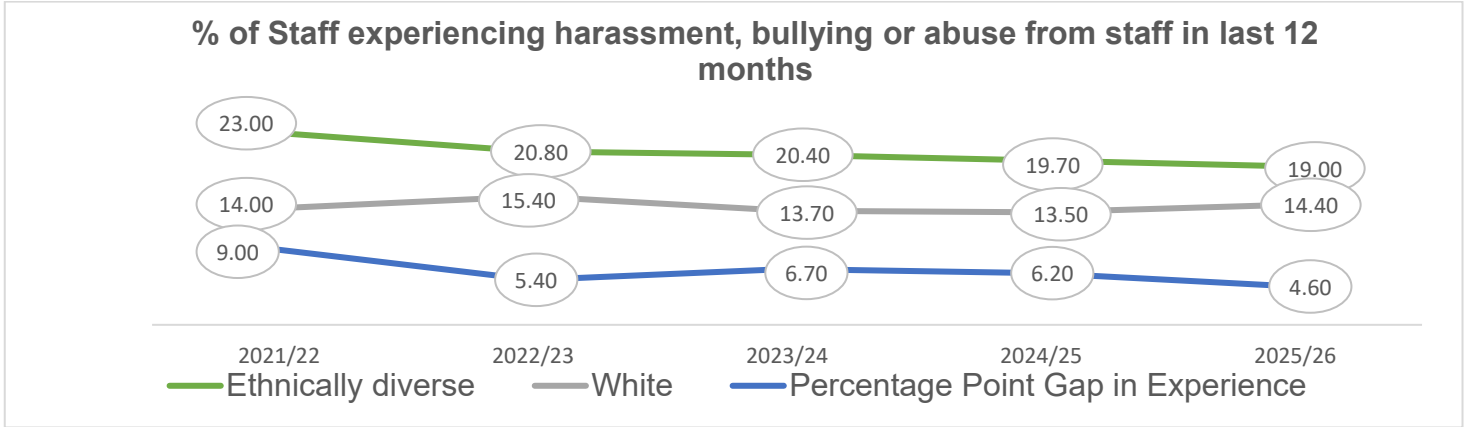
Five-Year Trend



The chart above shows that the gap in reported experience has widened in the most recent year.

Indicator 6: Harassment, Bullying or Abuse from Staff [Indicator 6 Data](#)

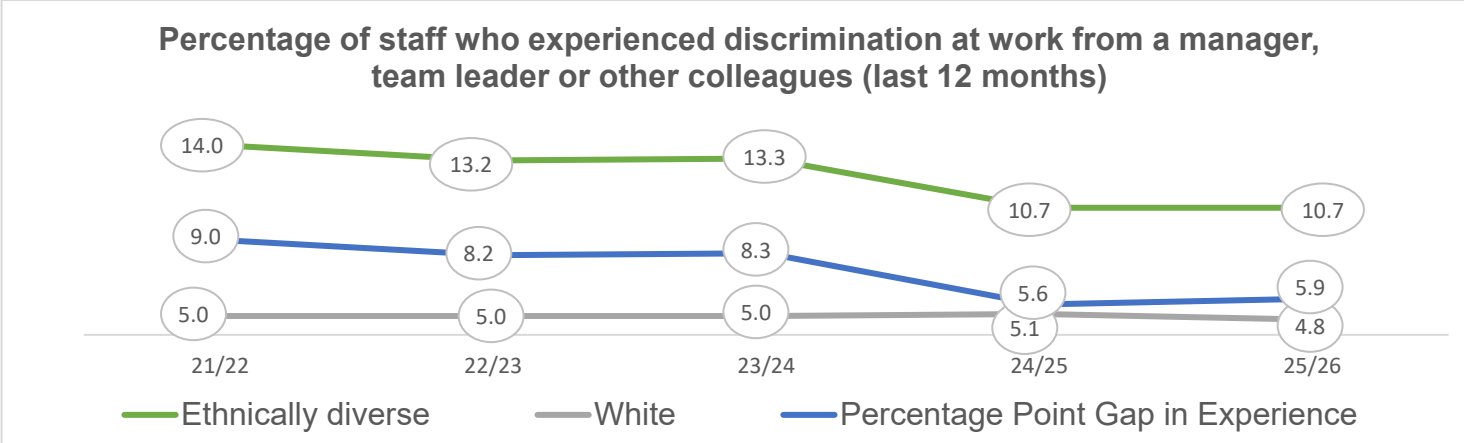
Five-Year Trend



The chart above shows a continued reduction in the gap over time, driven by improving outcomes for Ethnically diverse staff, alongside a slight increase in reported experience for White staff. Any level of bullying, harassment or abuse is unacceptable for any member of staff.

Indicator 8: Discrimination from Manager, Team Leader or Colleagues [Indicator 8 Data](#)

Five-Year Trend



The chart above shows a largely stable position over time, with a slight widening of the gap in the most recent year driven by improved outcomes for White staff rather than deterioration for Ethnically diverse staff.

Combined Analysis and Key Drivers

While these indicators measure different aspects of staff experience, they show a consistent pattern when analysed in detail.

1. Work Environment as a Primary Driver Mental Health Inpatients (PPH)

Analysis shows that working environment, particularly PPH, is a significant factor shaping outcomes:

- **65.5% of staff at PPH** report experiencing abuse from patients/public, compared with **17.4% across the rest of the Trust**
- At PPH:
 - Ethnically diverse staff: **70.1%**
 - White staff: **46.2%**
- Outside PPH:
 - Ethnically diverse staff: **21.8%**
 - White staff: **15.8%**

This demonstrates that:

- The **environment itself is a strong driver of incidents** This pattern is consistent with findings reported in other inpatient mental health settings nationally.
- The baseline level of risk is significantly higher within PPH

2. Interaction Between Environment and Ethnicity

While environment is the dominant factor, ethnicity remains important:

- The **ethnicity gap is present both within and outside PPH**
- However, the scale of the gap differs:
 - Around **6** percentage points **outside PPH**
 - Around **23.9** percentage points **within PPH**

This suggests that while differences between ethnic groups exist across the Trust, they are substantially more pronounced within PPH. This is particularly important given that approximately 72% of the PPH workforce is Ethnically Diverse, compared with around 31% across the remainder of the Trust. As a result, a disproportionate share of Ethnically Diverse staff work within the setting where the largest differences in reported experience are observed.

Importantly:

- PPH represents only **~7.2% of the workforce**, but
- Accounts for **18.1% of the Ethnically Diverse workforce**

This means that Ethnically Diverse staff are overrepresented within the Trust's highest-risk environment. Consequently, both workforce distribution and differences observed within the environment itself are relevant when interpreting Trust-wide staff experience outcomes. The reasons for this workforce distribution have not been explored within the scope of this analysis. From an EDI perspective, this pattern may warrant further investigation to understand whether it reflects wider workforce, recruitment, career pathway or organisational factors.

3. Workforce Composition Across Environments

An additional factor influencing these indicators is the changing distribution of the workforce across environments. PPH represents a higher-risk setting for all staff. The proportion of the Trust's Ethnically diverse workforce working within this environment has increased over time, from approximately **16.5%** in March 25 to **18.1%** in March 26.

This means that a greater share of the Ethnically diverse workforce is now working in an environment with a significantly higher baseline likelihood of experiencing negative incidents.

As a result, even if the underlying conditions and relative experiences within each setting remained unchanged, the overall likelihood of Ethnically diverse staff reporting negative experiences at a Trust-wide level could increase. This reflects a **composition effect**, where changes in where staff work influence aggregate outcomes.

This insight helps explain part of the observed **increase in the overall gap over time**, rather than the underlying difference between ethnic groups within the same setting.

It is important to note that this does not explain the persistent differences observed between Ethnically diverse and White staff within PPH itself, where a gap remains even when comparing like-for-like environments.

This is an important consideration when interpreting year-on-year changes, as increases in reported experience may reflect changes in workforce distribution rather than a change in underlying conditions or behaviours.

4. Interpretation

These findings suggest that:

- Environment appears to explain a significant proportion of exposure to negative staff experience
- However, **ethnicity continues to influence outcomes within those environments**
- In higher-risk environments such as PPH, **differences are more pronounced**

5. Indicator 6 and 8 Alignment

A similar pattern is observed for:

- Harassment from staff (Indicator 6)
- Discrimination (Indicator 8)

In both cases:

- PPH staff report the highest levels of negative experiences
- Differences between Ethnically diverse and White staff remain present
- The gap reduces outside PPH, but does not disappear

✔ **Key conclusion:**

Staff experience is influenced by both working environment and ethnicity. While environment appears to explain a significant proportion of variation, differences between Ethnically diverse and White staff persist within the same settings.

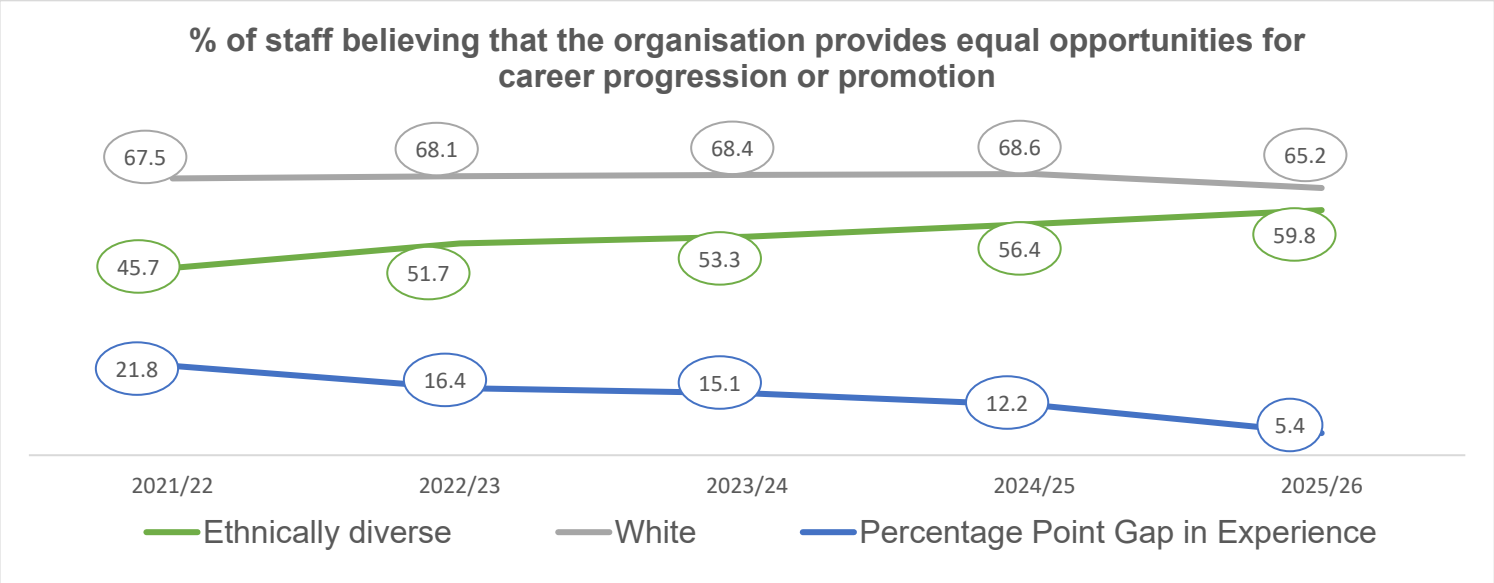
These findings are consistent with the presence of inequity, particularly in higher-risk environments, although further analysis would be required to fully isolate contributing factors.

Indicator 7: Career Progression

Indicator 7 Data

Progression outcomes and staff perceptions of fairness do not fully align.

Five-Year Trend



The chart above shows a sustained narrowing of the gap over the past five years. While this reflects consistent improvement for both Ethnically diverse and White staff over this period, the reduction in the most recent year is partly driven by a notable decline in the proportion of White staff reporting that career progression is fair. The underlying reasons for this change are not yet understood.

- Gap reduced: **21.8pp (21/22) → 5.4pp (25/26)**
- ED staff now report **more favourable outcomes trend**

However, outcome data presents a more nuanced picture. Overall, Ethnically diverse staff are more likely to receive a promotion than White staff, with this effect most pronounced at senior levels, where Ethnically diverse staff are **1.84 times as likely to be promoted at Band 8a and above**.

This pattern is not consistent across all grades. At Band 7, Ethnically Diverse staff are less likely to be promoted than White staff. This may be influenced by workforce composition, profession mix and the concentration of nursing and midwifery staff at Band 7. In particular, Band 7 roles are heavily concentrated in nursing and midwifery, which make up 41.6% of the Band 7 workforce, but only 24% of the Band 8a workforce.

Given that 39.6% of the nursing and midwifery workforce is Ethnically Diverse, this may create a structural constraint on progression, where a large proportion of Ethnically Diverse staff are concentrated in roles with fewer pathways into senior positions. However, further analysis is required to determine the extent to which these factors explain the observed difference. This remains an important area for future investigation.

✔ **Key conclusion:**

Where progression outcomes have been more favourable for Ethnically diverse staff, this suggests that outcomes data alone does not fully explain staff perceptions of fairness.

This therefore raises a broader question regarding what shapes perception beyond direct experience.

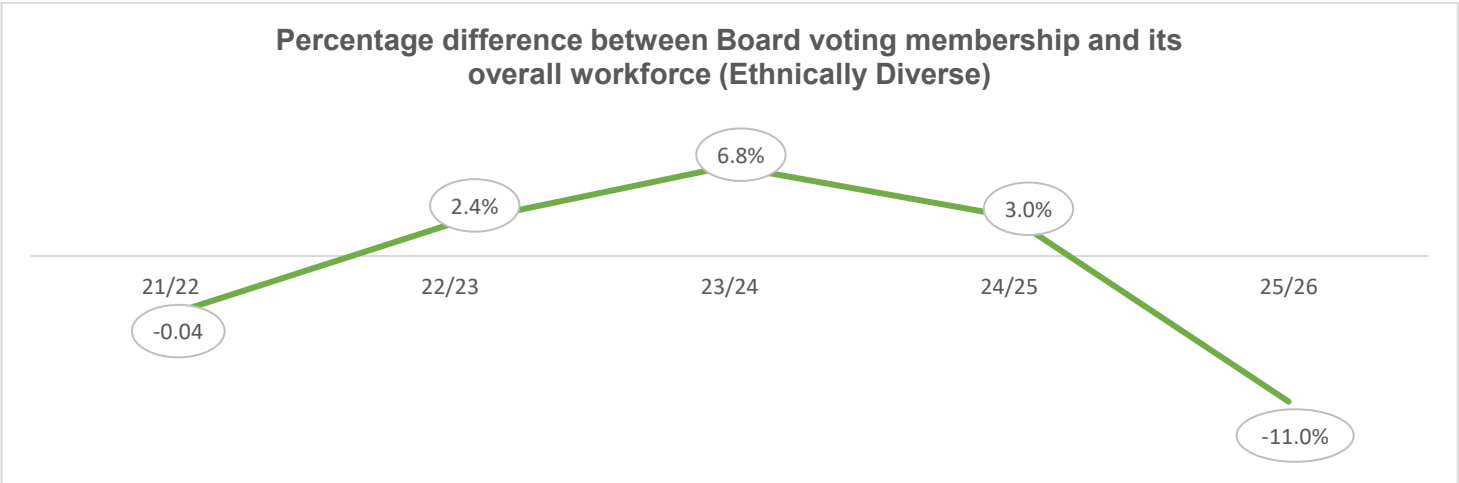
Interpretation should consider how organisational messaging is understood. For example, the visibility of positive action initiatives may be interpreted by some staff as an acknowledgement of past inequality, which may influence perceptions of fairness.

This does not provide evidence of causal impact but highlights an important contextual factor when interpreting staff survey responses.

Indicator 9: Board Representation

[Indicator 9 Data](#)

Board representation appears lower when compared with the Trust workforce overall, but exceeds the Berkshire age-adjusted benchmark for the population cohort from which Board members are most commonly drawn. The analysis below demonstrates how comparator selection can materially influence interpretation of this indicator.



Interpretation

The WRES indicator compares Board voting membership with overall workforce representation. For 2025/26, Board voting membership is 23.1% ethnically diverse compared with overall workforce representation of 33.9%.

Whilst this indicates lower representation than the workforce overall, Board members are typically drawn from older and more experienced workforce cohorts. The average age of the Trust's Board voting members is 56.4 years.

Using Berkshire Connected Care data, the Berkshire population aged 56-65 is 21.09% ethnically diverse.

Comparison Group	Ethnically Diverse (%)
Berkshire population aged 56-65	21.09%
Board voting membership	23.10%
Difference	+2.01pp

Using an age-adjusted comparator, Board voting membership exceeds the expected Berkshire benchmark.

This demonstrates that the interpretation of Board representation is highly dependent upon the comparator selected. Whilst Board representation remains lower than the workforce as a whole, it is higher than the age-adjusted local population benchmark for the demographic group from which Board members are most commonly drawn.

Key Conclusion

Board representation should be considered in the context of workforce age profile and local demographics.

Whilst the national indicator highlights a difference between Board voting membership and overall workforce representation, age-adjusted analysis demonstrates that Board voting membership exceeds the relevant Berkshire demographic benchmark. This suggests that demographic context is an important consideration when interpreting Board representation and assessing whether observed differences represent a meaningful disparity.

Conclusion:

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The central finding of this paper is that observed differences in workforce outcomes do not follow a single narrative and must be interpreted in context.

Using the framework set out earlier:

- **Structural disparities:**
Differences in senior representation and elements of recruitment are largely explained by measurable workforce composition factors. Furthermore, promotion and recruitment outcomes at senior levels are at least as favourable for Ethnically Diverse staff as for White staff, suggesting that current senior appointment processes are unlikely to explain the observed representation profile.
- **Unexplained differences:**
Some indicators show remaining variation which is not fully explained by available data and requires further analysis.
- **Patterns consistent with inequity:**
Staff experience indicators, particularly those relating to discrimination, harassment, and bullying, show consistent differences that persist within comparable environments.

In practice, some indicators span more than one category, reflecting the complexity of workforce dynamics.

For the disciplinary indicator specifically, the observed difference is largely explained by workforce composition, particularly gender. **When comparing like-for-like groups, remaining differences are small and not consistent in direction, indicating no clear underlying pattern.**

Overall, the analysis demonstrates that many headline disparities change materially when relevant workforce factors are considered. This reinforces the importance of moving beyond headline comparisons and examining the underlying drivers of observed outcomes before drawing conclusions regarding inequity. At the same time, areas remain where differences are either not fully understood or are consistent with inequity and therefore warrant continued attention and further analysis.

Final Thought:

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A single narrative of inequity does not explain all outcomes, but areas of concern remain and require targeted action.

This paper demonstrates that workforce data requires careful interpretation. While many observed differences are driven by workforce structure, targeted areas consistent with inequity remain. In other areas, variation is small or not consistent in direction and should be interpreted cautiously, ensuring differences are neither assumed nor dismissed without appropriate context.

Appendices:

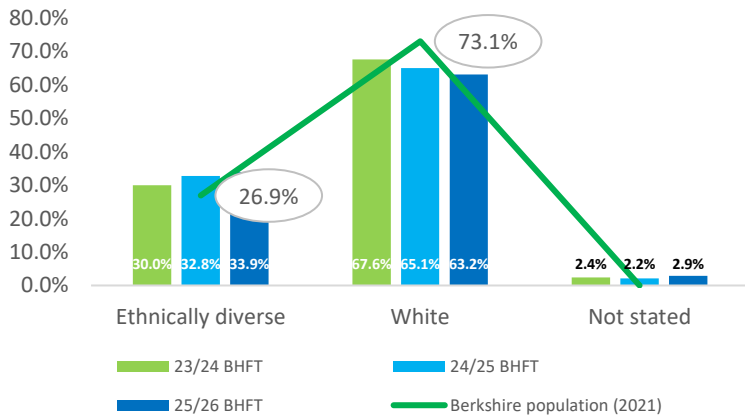
Workforce Profile:

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BHFT Workforce compared to Berkshire Population (from census data, 2021)

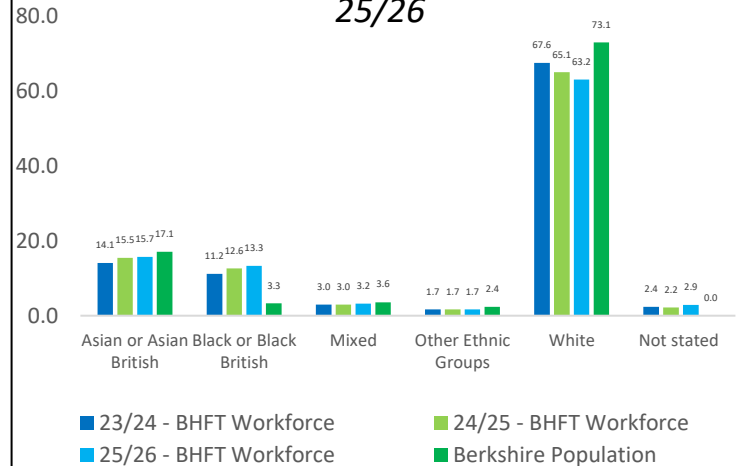
Workforce % Ethnicity Profile

25/26



Workforce % ethnicity breakdown

25/26



Comparison of BHFT Workforce Ethnicity with Berkshire Population Benchmark (Census 2021)

Group	2023/24 BHFT (%)	2024/25 BHFT (%)	2025/26 BHFT (%)	Berkshire population (%) (2021 Census)	Difference vs Berkshire (pp, 2025/26)
Ethnically diverse	30.0%	32.8%	33.9%	26.9%	7
White	67.6%	65.1%	63.2%	73.1%	-10
Not stated	2.4%	2.2%	2.9%	0%	3

Further breakdown of ethnicity

Detailed Ethnicity Breakdown: BHFT Workforce Compared to Berkshire Population (Census 2021)

	Asian or Asian British	Black or Black British	Mixed	Other Ethnic Groups	White	Not stated
	(Indian, Pakistani, Bangladeshi, any other Asian background)	(Caribbean, African, any other Black background)	(White & Black Caribbean, White & Black African, White & Asian, any other mixed background)	(Chinese, any other ethnic group)	(British, Irish, any other White background)	
23/24 - BHFT Workforce	14.1% (738)	11.2% (584)	3% (158)	1.7% (85)	67.6% (3530)	2.4% (124)

24/25 - BHFT Workforce	15.5% (893)	12.6% (693)	3% (163)	1.7% (95)	65.1% (3580)	2.2% (119)
25/26 - BHFT Workforce	15.7% (851)	13.3% (720)	3.2% (172)	1.7% (93)	63.2% (3422)	2.9% (157)
Berkshire Population (ONS census)	17.1%	3.3%	3.6%	2.4%	73.1%	0
Difference in % points – 25/26 BHFT workforce vs Berkshire population	-1.47	9.98	-0.30	-0.70	-9.74	2.72

Workforce Profile by Ethnicity Group

	Ethnically Diverse	White
% working full time	77	57
Average FTE	0.91	0.85
Average age (years)	43.3	45

Ethnic composition of workforce within each age grouping

	Ethnically Diverse (%)	White (%)
16–25	36.8%	60.9%
26–35	34.4%	61.9%
36–45	37.6%	59.3%
46–55	35.8%	61.6%
56–65	25.3%	72.2%
66+	25.2%	72.0%

Ethnicity by Age Group in England and Wales (Census 2021) – Demonstrating Declining Diversity with Age

Age range	% which are White: English, Welsh, Scottish, Northern Irish or British	% which are Ethnically diverse
16-25 years	69	31
26-35 years	68	32
36-45 years	65	35
46-55 years	77	23

56-65 years	84	16
66 plus years	90	10
Average age	42.7	31.6

**Average Age by Pay Band
Demonstrating Increasing Age with
Seniority**

Pay Band	Average age (years)	Number of posts
Band 1 and below	18	4
Band 2	44.8	73
Band 3	45	790
Band 4	42.6	799
Band 5	40.6	735
Band 6	43.8	981
Band 7	45.3	1081
Band 8a	45.9	441
Band 8b	48.8	173
Band 8c	51	69
Band 8d	54.8	35
Band 9	57	10
Consultant	52	97
Non-Consultant Career Grade	49.2	80
Executive Board Member	53.7	6
VSM	58	3
Trainee Grade	34.4	38
Total (Trust average)	44.4	5415

**Ethnic Diversity in Berkshire and
England & Wales (1991–2021)**

Year	National ED	Berkshire (estimated range using ratio between 2021 actual figures vs 2021 national actual figures)
1991	5.9%	~8–9%
2001	8.7%	~12–13%
2011	14.0%	~20–21%
2021	18.3%	26.9% (Actual)

**Average Length of Time in Current
Grade (Months) by AfC Band and
Role**

Row Labels	Average of month in grade
Band 2	68.00
Band 3	46.75
Band 4	48.03

Band 5	36.40
Band 6	51.92
Band 7	48.84
Band 8 - Range A	48.75
Band 8 - Range B	46.85
Band 8 - Range C	56.49
Band 8 - Range D	72.18
Band 9	45.22
Consultant	95.58
Executive Board Member	123.50
Non-Consultant Career Grade	70.38
Trainee Grade	11.34
Under Band 1	2.75
VSM	126.00
Grand Total	48.66

Average Time in Grade (Months) by AfC Band Group

Row Labels	Average of month in grade
Bands 2-4	48
Bands 5-7	47
Bands 8a - 9	50

Ethnically diverse workforce representation by profession compared to national registration rates

Profession type	National reg. rate (%)	Overall % ED Workforce	Bands 8a–9 % ED Workforce
Pharmacist	58.8%	46.7%	37.1%
Medical	44.9%	53.3%	—
Dental Officer	38.1%	81.3%	—
Specialist Dentist	38.1%	0.0%	—
Nursing and Midwifery Registered	38.0%	39.6%	32.0%
Social Worker	32.1%	25.7%	28.6%
Additional Clinical Services	26.9%	39.0%	0.0%
Administrative and Clerical	26.9%	27.9%	21.8%
Estates and Ancillary	26.9%	27.6%	—
Other - Add Prof Scientific and Technical	26.9%	27.4%	14.6%
Students	26.9%	50.0%	—
Unknown Profession	26.9%	33.3%	0.0%
Physiotherapist	20.4%	26.9%	10.9%

Psychotherapist	20.0%	23.1%	20.0%
Pharmacy Technician	19.0%	25.0%	—
Audiologist	16.0%	70.0%	100.0%
Dietitian	15.4%	23.1%	0.0%
Art Therapist	14.7%	12.5%	0.0%
Occupational Therapist	12.7%	20.6%	9.1%
Qualified Clinical Psychologist	12.1%	18.4%	15.5%
Podiatrist	11.2%	34.4%	0.0%
Speech & Language Therapist	10.1%	13.5%	0.0%
Osteopath	9.0%	50.0%	—
Paramedic	4.5%	16.7%	26.7%

Distribution of workforce across Bands 2–7 and Bands 8a–9 by profession, and relative concentration at senior bands

Profession type	% of Bands 2–7 workforce	% of Bands 8a–9 workforce	Difference (8a–9 minus 2–7)
Qualified Clinical Psychologist	0.7%	19.5%	18.8%
Administrative and Clerical	23.6%	32.7%	9.1%
Pharmacist	0.2%	4.8%	4.6%
Physiotherapist	4.2%	6.3%	2.1%
Paramedic	0.2%	2.1%	1.9%
Other - Add Prof Scientific and Technical	4.9%	6.6%	1.7%
Psychotherapist	0.1%	1.4%	1.3%
Social Worker	1.4%	1.9%	0.6%
Unknown Profession	0.0%	0.3%	0.3%
Audiologist	0.2%	0.4%	0.3%
Art Therapist	0.1%	0.3%	0.1%
Medical	0.0%	0.0%	0.0%
Dental Officer	0.0%	0.0%	0.0%

Specialist Dentist	0.0%	0.0%	0.0%
Osteopath	0.0%	0.0%	0.0%
Podiatrist	0.7%	0.4%	-0.2%
Students	0.3%	0.0%	-0.3%
Pharmacy Technician	0.3%	0.0%	-0.3%
Estates and Ancillary	0.7%	0.0%	-0.7%
Dietitian	1.4%	0.3%	-1.1%
Occupational Therapist	2.7%	1.5%	-1.2%
Speech & Language Therapist	2.4%	0.8%	-1.5%
Nursing and Midwifery Registered	29.0%	20.2%	-8.8%
Additional Clinical Services	27.1%	0.6%	-26.6%

Ethnic distribution of staff on visas

Metric	Ethnically Diverse	White	Not stated
Percentage of all visa holders by ethnicity	89.2%	8.2%	2.6%

Proportion of staff on visas and under sponsorship by AfC band grouping

Metric	Bands 2–4	Bands 5–7	Bands 8a–9
Total staff	1662	2797	728
Number of staff on a visa	252	268	23
Percentage of staff on a visa	15.2%	9.6%	3.2%
Number of staff under sponsorship	85	126	4
Percentage of staff under sponsorship	5.1%	4.5%	0.5%

Number and proportion of staff on visas by profession

Profession type	Total staff	Number of staff on a visa	Percentage of staff on a visa
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Audiologist	10	5	50.0%
Podiatrist	32	7	21.9%
Additional Clinical Services	1218	227	18.6%
Medical	199	37	18.6%
Physiotherapist	234	37	15.8%
Occupational Therapist	131	15	11.5%
Dietitian	65	7	10.8%
Nursing and Midwifery Registered	1438	143	9.9%
Students	14	1	7.1%
Pharmacist	45	3	6.7%
Dental Officer	16	1	6.3%
Administrative and Clerical	1296	76	5.9%
Paramedic	24	1	4.2%
Qualified Clinical Psychologist	174	7	4.0%
Speech and Language Therapist	111	4	3.6%
Estates and Ancillary	29	1	3.4%
Other – Additional Professional Scientific and Technical	266	8	3.0%
Social Worker	74	2	2.7%
Art Therapist	8	0	0.0%
Osteopath	2	0	0.0%
Pharmacy Technician	12	0	0.0%
Psychotherapist	13	0	0.0%
Specialist Dentist	1	0	0.0%
Unknown	3	0	0.0%
Total	5415	582	10.7%

Number and proportion of staff under sponsorship by profession (as at 31 March 2026)

Profession type	Total staff	Number of staff under sponsorship	Percentage of staff under sponsorship
Audiologist	10	5	50.0%
Podiatrist	32	7	21.9%
Physiotherapist	234	20	8.5%
Additional Clinical Services	1218	97	8.0%
Medical	199	12	6.0%
Occupational Therapist	131	7	5.3%
Dietitian	65	3	4.6%
Paramedic	24	1	4.2%

Nursing and Midwifery Registered	1438	54	3.8%
Speech and Language Therapist	111	3	2.7%
Pharmacist	45	1	2.2%
Qualified Clinical Psychologist	174	2	1.1%
Administrative and Clerical	1296	13	1.0%
Other – Additional Professional Scientific and Technical	266	2	0.8%
Art Therapist	8	0	0.0%
Dental Officer	16	0	0.0%
Estates and Ancillary	29	0	0.0%
Osteopath	2	0	0.0%
Pharmacy Technician	12	0	0.0%
Psychotherapist	13	0	0.0%
Social Worker	74	0	0.0%
Specialist Dentist	1	0	0.0%
Students	14	0	0.0%
Unknown	3	0	0.0%
Total	5415	227	4.2%

Staff survey indicators equated to “likelihood to” scores in order to rank order levels of observed disparity’s.

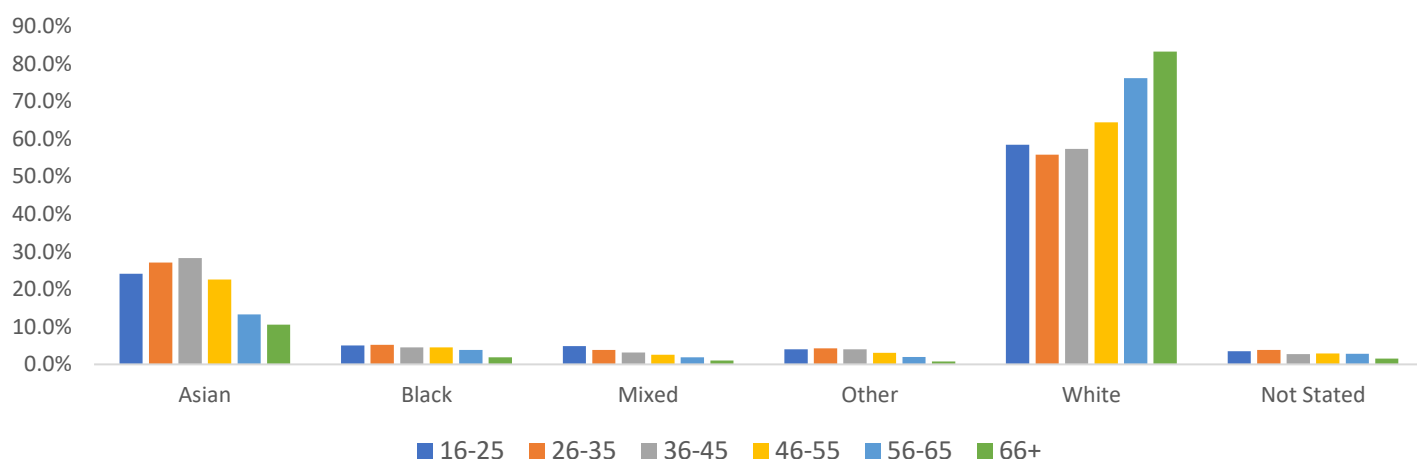
Group with greatest likelihood	Likelihood score	Indicator	Ranking WRES Indicators by Level of Observed Disparity (Adverse Impact Ratio)
Ethnically Diverse	2.23	Percentage of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months	Yes
Ethnically Diverse	1.83	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	Yes
White	1.5	Likelihood of being appointed from shortlisting	Yes
Ethnically Diverse	1.47	Likelihood of entering the formal disciplinary process	Yes
Ethnically Diverse	1.32	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	Yes
White	1.09	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	No
White	1.05	Likelihood of accessing non-mandatory training and continuous professional development (CPD)	No

Connected Care Berkshire Population by Ethnicity Type %

Ethnicity	16-25	26-35	36-45	46-55	56-65	66+	Overall
Asian	24.1%	27.1%	28.3%	22.6%	13.3%	10.6%	21.2%

Black	5.0%	5.2%	4.5%	4.5%	3.8%	1.9%	4.1%
Mixed	4.9%	3.8%	3.2%	2.6%	1.9%	1.0%	2.9%
Other	4.0%	4.3%	4.0%	3.1%	2.0%	0.8%	3.0%
White	58.5%	55.8%	57.4%	64.4%	76.2%	83.3%	65.9%
Not Stated	3.5%	3.8%	2.7%	2.9%	2.8%	1.5%	2.8%
Ethnically Diverse	38.1%	40.5%	40.0%	32.7%	21.0%	14.4%	31.2%

Connected Care Berkshire Population %



Below is how the detailed ethnicity types under the connected care data has been mapped to align with NHS reporting specifications.

Detailed Ethnicity	NHS Ethnic Group
African	Black
Any other Asian background	Asian
Any other Black, Black British, or Caribbean background	Black
Any other ethnic group	Other
Any other Mixed or multiple ethnic background	Mixed
Any other white background	White
Arab	Other
Bangladeshi	Asian
Caribbean	Black
Chinese	Asian
English, Welsh, Scottish, Northern Irish or British	White
Gypsy or Irish Traveller	White
Indian	Asian
Irish	White

Not stated	Not Stated
Pakistani	Asian
Refused and not stated group	Not Stated
Roma	White
White and Asian	Mixed
White and Black African	Mixed
White and Black Caribbean	Mixed

WRES Indicators:

1. Percentage of staff in each of the Agenda for Change (AfC) Bands 1-9 and Very Senior Manager (VSM) roles (including executive board members) compared with the percentage of staff in the overall workforce

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Workforce Profile – Non-Clinical Staff 2024-26 (across 3 years)

Pay Band	2024 Non-Clinical Workforce Data				2025 Non-Clinical Workforce Data				2026 Non-Clinical Workforce Data			
	Total Staff	White	Ethnically diverse	Ethnicity Unknown	Total Staff	White	Ethnically diverse	Ethnicity Unknown	Total Staff	White	Ethnically diverse	Ethnicity Unknown
Under Band 1	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)	2	0 (0%)	0 (0%)	0 (0%)
Band 1	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)
Band 2	65	49 (75%)	16 (25%)	0 (0%)	53	42 (79%)	10 (19%)	1 (2%)	44	36 (82%)	8 (18%)	0 (0%)
Band 3	298	221 (74%)	74 (25%)	3 (1%)	309	225 (73%)	79 (26%)	5 (2%)	285	200 (70%)	79 (28%)	6 (2%)
Band 4	305	217 (71%)	79 (26%)	9 (3%)	316	222 (70%)	88 (28%)	6 (2%)	313	217 (69%)	90 (29%)	6 (2%)
Band 5	153	110 (72%)	41 (27%)	2 (1%)	150	104 (69%)	44 (29%)	2 (1%)	154	102 (66%)	50 (32%)	2 (1%)
Band 6	163	111 (68%)	50 (31%)	2 (1%)	162	110 (68%)	48 (30%)	4 (3%)	156	106 (68%)	47 (30%)	3 (2%)
Band 7	126	84 (67%)	39 (31%)	3 (2%)	130	86 (66%)	43 (33%)	1 (1%)	127	82 (65%)	43 (34%)	2 (2%)
Band 8a	95	69 (73%)	22 (23%)	4 (4%)	106	76 (72%)	26 (25%)	4 (4%)	115	81 (70%)	28 (24%)	6 (5%)
Band 8b	55	40 (73%)	14 (25%)	1 (2%)	69	52 (75%)	16 (23%)	1 (1%)	61	43 (70%)	16 (26%)	2 (3%)
Band 8c	35	29 (83%)	5 (14%)	1 (3%)	38	32 (84%)	5 (13%)	1 (3%)	40	34 (85%)	4 (10%)	2 (5%)
Band 8d	15	12 (80%)	1 (7%)	2 (13%)	16	13 (81%)	2 (13%)	1 (6%)	16	12 (75%)	3 (19%)	1 (6%)
Band 9	4	3 (75%)	1 (25%)	0 (0%)	9	8 (90%)	1 (11%)	0 (0%)	6	5 (83%)	1 (17%)	0 (0%)
VSM	8	6 (75%)	1 (13%)	1 (13%)	8	6 (75%)	1 (13%)	1 (13%)	8	7 (88%)	0 (0%)	1 (13%)
Total	1329	956 (72%)	344 (26%)	29 (2%)	1366	976 (71%)	363 (27%)	27 (2%)	1325	925 (70%)	369 (28%)	31 (2%)

Workforce Profile - Clinical Staff 2024-256 (across 3 years)

Pay Band	2024 Clinical Workforce Data				2025 Clinical Workforce Data				2026 Clinical Workforce Data			
	Total Staff	White	Ethnically diverse	Ethnicity Unknown	Total Staff	White	Ethnically diverse	Ethnicity Unknown	Total Staff	White	Ethnically diverse	Ethnicity Unknown
Under Band 1	7	5 (71%)	2 (29%)	0 (0%)	13	5 (39%)	8 (62%)	0 (0%)	4	3 (75%)	1 (25%)	0 (0%)
Band 1	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)
Band 2	183	70 (38%)	105 (58%)	8 (4%)	56	23 (41%)	31 (55%)	2 (4%)	29	13 (44%)	15 (52%)	1 (3%)

Band 3	354	226 (64%)	122 (34%)	6 (2%)	505	244 (48%)	250 (50%)	11 (2%)	505	227 (45%)	267 (53%)	11 (2%)
Band 4	515	384 (75%)	122 (24%)	9 (1%)	546	367 (67%)	171 (31%)	8 (2%)	486	338 (70%)	143 (29%)	5 (1%)
Band 5	500	268 (54%)	219 (44%)	13 (2%)	542	294 (54%)	237 (44%)	11 (2%)	581	288 (50%)	267 (46%)	26 (4%)
Band 6	784	542 (69%)	225 (29%)	17 (2%)	832	543 (65%)	267 (32%)	22 (3%)	825	526 (64%)	275 (33%)	24 (3%)
Band 7	869	631 (73%)	218 (25%)	20 (2%)	929	668 (72%)	243 (26%)	18 (2%)	954	662 (69%)	272 (29%)	20 (2%)
Band 8a	296	222 (75%)	68 (23%)	6 (2%)	319	240 (75%)	75 (24%)	4 (1%)	326	245 (75%)	75 (23%)	6 (2%)
Band 8b	113	91 (81%)	19 (17%)	3 (2%)	112	91 (81%)	18 (16%)	3 (3%)	112	84 (75%)	25 (22%)	3 (3%)
Band 8c	35	31 (89%)	4 (11%)	0 (0%)	32	27 (84%)	5 (16%)	0 (0%)	29	23 (79%)	6 (21%)	0 (0%)
Band 8d	20	18 (90%)	2 (10%)	0 (0%)	16	15 (94%)	1 (6%)	0 (0%)	19	17 (89%)	2 (11%)	0 (0%)
Band 9	6	6 (100%)	0 (0%)	0 (0%)	3	3 (100%)	0 (0%)	0 (0%)	4	4 (100%)	0 (0%)	0 (0%)
VSM	1	0 (0%)	1 (100%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)
Total	3683	2494 (68%)	1106 (30%)	82 (2%)	3905	2520 (65%)	1306 (33%)	79 (2%)	3874	2400 (69%)	1348 (35%)	96 (2%)

Workforce Profile – Medical & Dental staff 2024-2026 (across 3 years)

	2024 Clinical (Medical & Dental) Workforce				2025 Clinical (Medical & Dental) Workforce				2026 Clinical (Medical & Dental) Workforce			
Pay Band	Total Staff	White	Ethnically diverse	Ethnicity Unknown	Total Staff	White	Ethnically diverse	Ethnicity Unknown	Total Staff	White	Ethnically diverse	Ethnicity Unknown
Consultants	91	37 (41%)	52 (57%)	2 (2%)	101	42 (42%)	58 (57%)	1 (1%)	98	35 (36%)	57 (58%)	6 (6%)
Snr Medical Manager	1	0 (0%)	1 (100%)	0 (0%)	2	0 (0%)	2 (100%)	0 (0%)	1	0 (0%)	1 (100%)	0 (0%)
Non-consultant Career Grade	81	30 (37%)	44 (54%)	7 (9%)	84	25 (30%)	53 (63%)	6 (7%)	80	21 (26%)	50 (63%)	9 (11%)
Trainee Grade	35	13 (37%)	18 (51%)	4 (11%)	40	13 (33%)	22 (55%)	5 (13%)	38	11 (29%)	12 (32%)	15 39%)
Other	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)
Total	208	80 (39%)	115 (55%)	13 (6%)	225	80 (36%)	133 (59%)	12 (5%)	216	67 (31%)	119 (55%)	30 (14%)

Workforce Profile – All staff 2023-2025 (across 3 years)

	2024 All Staff Workforce Data				2025 All Staff Workforce Data				2026 All Staff Workforce Data			
Pay Band	Total Staff	White	Ethnically diverse	Ethnicity Unknown	Total Staff	White	Ethnically diverse	Ethnicity Unknown	Total Staff	White	Ethnically diverse	Ethnicity Unknown
Under Band 1	7	5 (71%)	2 (29%)	0 (0%)	13	5 (39%)	8 (62%)	0 (0%)	4	3 (75%)	1 (25%)	0 (0%)
Band 1	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)
Band 2	248	119 (48%)	121 (49%)	8 (3%)	109	65 (60%)	41 (38%)	3 (3%)	73	49 (67%)	23 (32%)	1 (1%)
Band 3	652	447 (69%)	196 (30%)	9 (1%)	814	469 (58%)	329 (40%)	16 (2%)	790	427 (54%)	346 (44%)	17 (2%)
Band 4	820	601 (73%)	201 (25%)	18 (2%)	862	589 (68%)	259 (30%)	14 (2%)	799	555 (69%)	233 (29%)	11 (1%)
Band 5	653	378 (58%)	260 (40%)	15 (2%)	692	398 (58%)	281 (41%)	13 (2%)	735	390 (53%)	317 (43%)	28 (4%)
Band 6	947	653 (69%)	275 (29%)	19 (2%)	994	653 (66%)	315 (32%)	26 (3%)	981	632 (64%)	322 (33%)	27 (3%)
Band 7	995	715 (72%)	257 (26%)	23 (2%)	1059	754 (71%)	286 (27%)	19 (2%)	1081	744 (69%)	315 (29%)	22 (2%)
Band 8a	391	291 (74%)	90 (23%)	10 (3%)	425	316 (74%)	101 (24%)	8 (2%)	441	326 (74%)	103 (23%)	12 (3%)
Band 8b	168	131 (78%)	33 (20%)	4 (2%)	181	143 (79%)	34 (19%)	4 (2%)	173	127 (73%)	41 (24%)	5 (3%)
Band 8c	70	60 (86%)	9 (13%)	1 (1%)	70	59 (84%)	10 (14%)	1 (1%)	69	57 (83%)	10 (14%)	2 (3%)
Band 8d	35	30 (86%)	3 (9%)	2 (6%)	32	28 (88%)	3 (9%)	1 (3%)	35	29 (83%)	5 (14%)	1 (3%)
Band 9	10	9 (90%)	1 (10%)	0 (0%)	12	11 (92%)	1 (8%)	0 (0%)	10	9 (90%)	1 (10%)	0 (0%)
VSM	9	6 (67%)	2 (22%)	1 (11%)	8	6 (75%)	1 (13%)	1 (13%)	8	7 (88%)	0 (0%)	1 (13%)
Consultants	91	37 (41%)	52 (57%)	2 (2%)	101	42 (42%)	58 (57%)	1 (1%)	98	35 (36%)	57 (58%)	6 (6%)
Snr Medical Manager	1	0	1 (100%)	0	2	0 (0%)	2 (100%)	0 (0%)	1	0 (0%)	1 (100%)	0 (0%)
Non-consultant Career Grade	81	30 (37%)	44 (54%)	7 (9%)	84	25 (30%)	53 (63%)	6 (7%)	80	21 (26%)	50 (63%)	9 (11%)

Trainee Grade	35	13 (37%)	18 (51%)	4 (11%)	40	13 (33%)	22 (55%)	5 (13%)	38	11 (29%)	12 (32%)	15 (39%)
Other	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)
Up to and including Band 4	1727	1172 (68%)	520 (30%)	35 (2%)	1798	1128 (63%)	637 (35%)	33 (2%)	1666	1034 (62%)	603 (36%)	29 (2%)
Band 5 to 7	2595	1746 (67%)	792 (31%)	57 (2%)	2745	1805 (66%)	882 (32%)	58 (2%)	2797	1766 (63%)	954 (34%)	77 (3%)
8a to 9 (AFC only)	674	521 (77%)	136 (20%)	17 (3%)	720	557 (77%)	149 (21%)	14 (2%)	728	548 (75%)	160 (22%)	20 (3%)
Total	5220	3530 (68%)	1565 (30%)	124 (2%)	5496	3576 (65%)	1802 (33%)	118 (2%)	5416	3422 (63%)	1836 (34%)	157 (3%)

**Ethnically Diverse
Representation by Pay Band
Group – Agenda for Change
Staff Only**

Band group	Ethnically diverse	White	Not stated	Total	Ethnically diverse (%)	Difference vs Berkshire (26.9%)
Up to Band 4	602	1031	29	1662	36.2%	+9.3pp
Band 5–7	954	1766	77	2797	34.1%	+7.2pp
Band 8a+	160	548	20	728	22.0%	-4.9pp

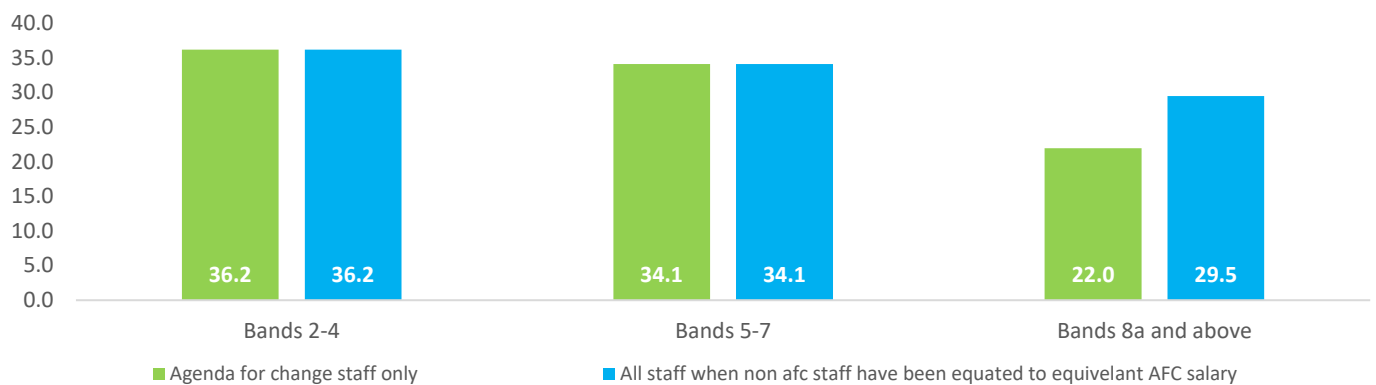
Includes Agenda for Change staff only. Non-AfC staff such as medical staff are excluded.

**Ethnically Diverse
Representation by Pay Band
Group – All Staff Using AfC-
Equivalent Pay Mapping**

Band group	Ethnically diverse	White	Not stated	Total	Ethnically diverse (%)	Difference vs Berkshire (26.9%)
Up to Band 4	602	1031	29	1662	36.2%	+9.3pp
Band 5–7	954	1766	77	2797	34.1%	+7.2pp
Band 8a+	278	614	50	942	29.5%	+2.6pp

Includes all staff. Non-AfC roles have been mapped to an equivalent AfC pay band based on salary.

Ethnically Diverse Workforce by Pay Band: Agenda for Change Staff Compared with All Staff (AFC-Equivalent)



Ethnically Diverse Representation at Senior Pay Levels Under Different Workforce Definitions

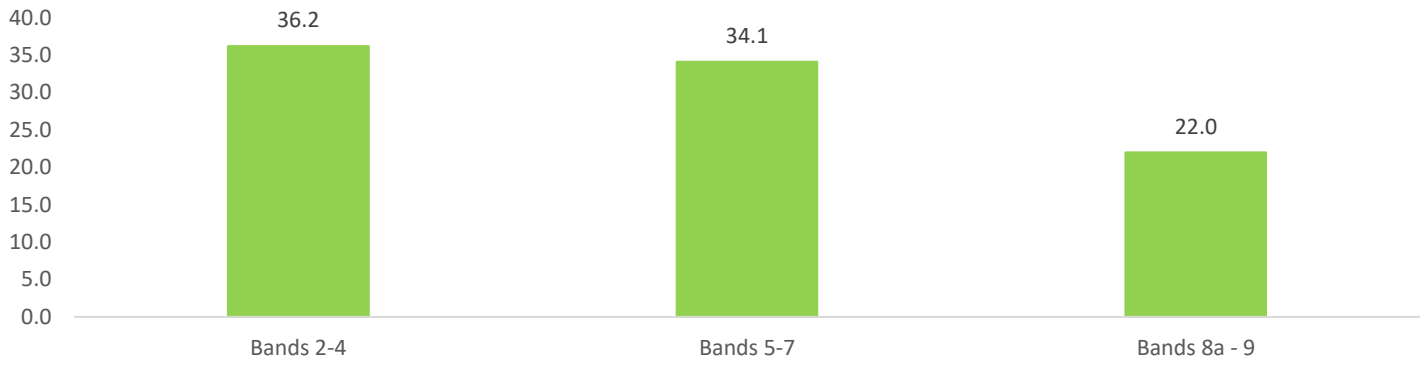
Measure	Ethnically Diverse %	Difference vs Berkshire (26.9%)
AfC Staff Only (Band 8a+)	22.0%	-4.9pp
All Staff (AfC Equivalent Band 8a+)	29.5%	+2.6pp

AFC Only Staff in post (All Nationalities)

	Ethnically Diverse	White	Not Stated	Ethnically Diverse %	Total Staf
Bands 2-4	602	1031	29	36.2	1662
Bands 5-7	954	1766	77	34.1	2797
Bands 8a - 9	160	548	20	22.0	728

Ethnically Diverse %

All staff

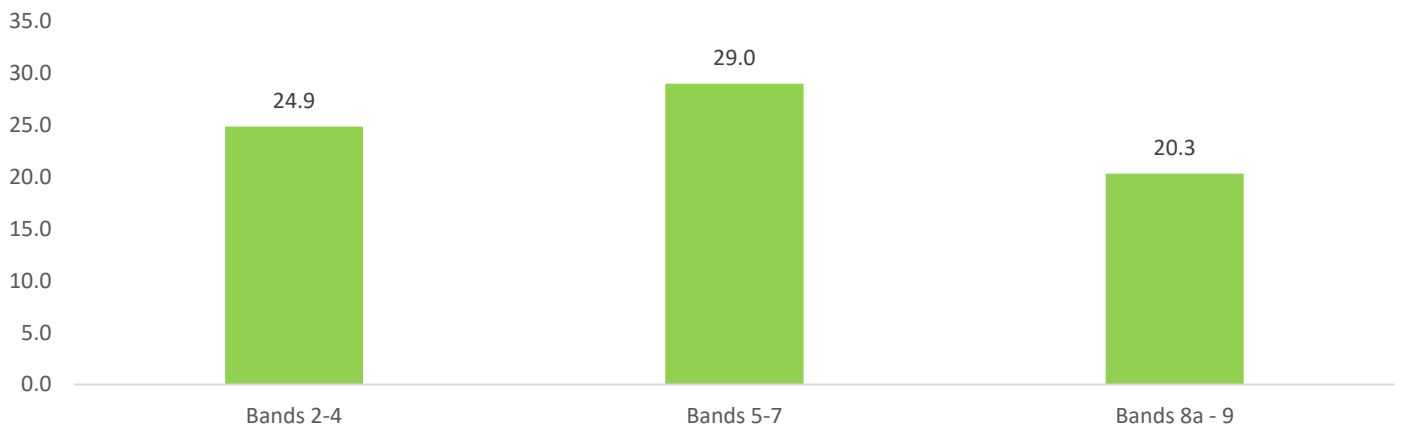


Staff in post (UK Nationals only)

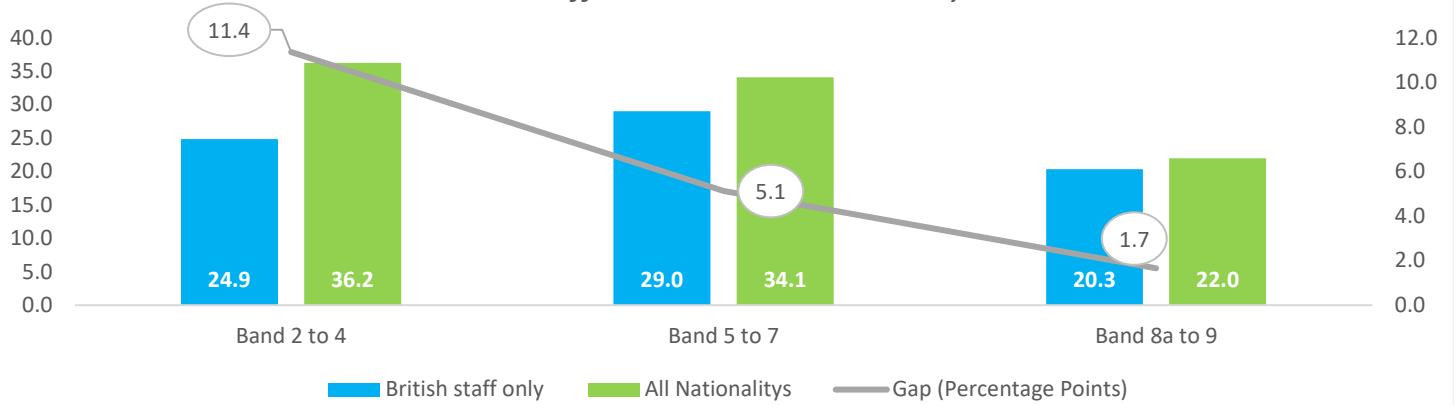
	Ethnically Diverse	White	Not Stated	Ethnically Diverse %	Total Staf
Bands 2-4	317	939	19	24.9	1275
Bands 5-7	687	1617	66	29.0	2370
Bands 8a - 9	139	528	17	20.3	684

Ethnically Diverse %

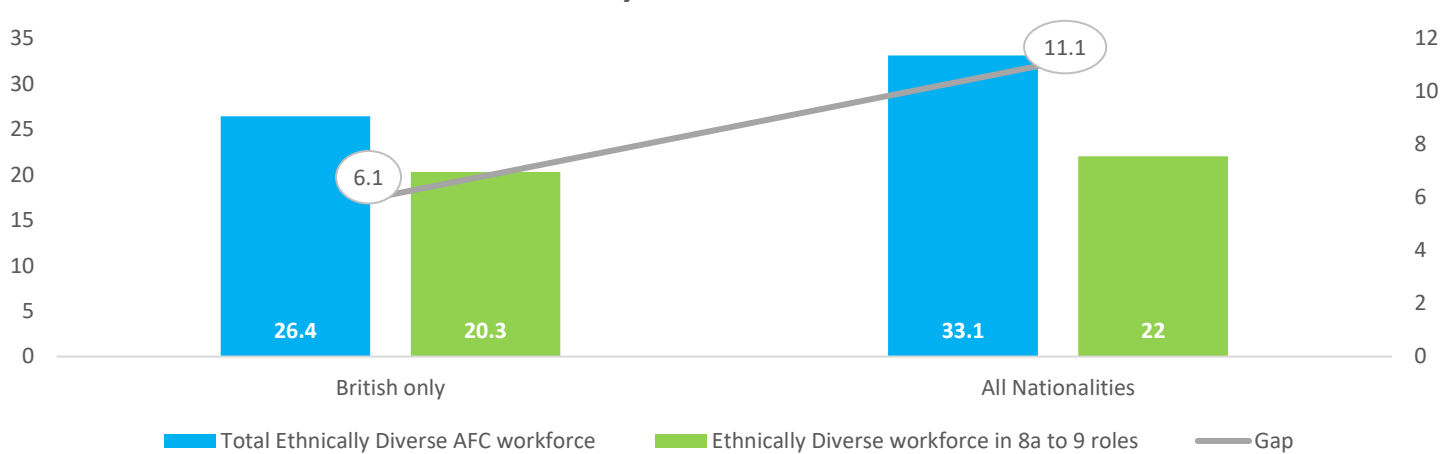
UK Nationals Only



Ethnically Diverse representation % All staff vs British Nationals only



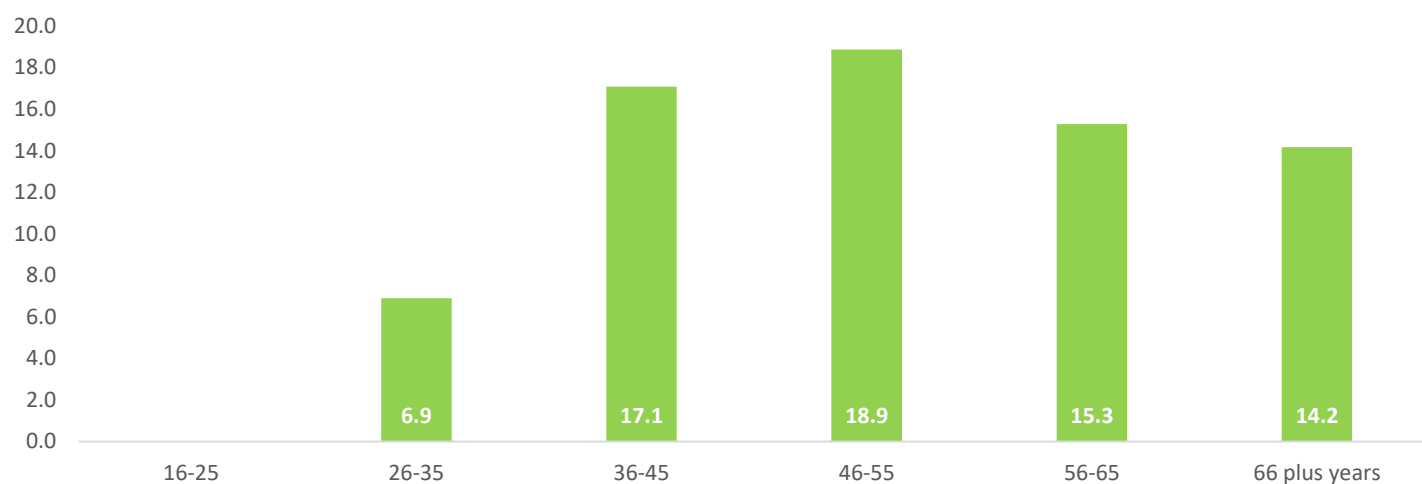
Ethnically Diverse workforce %



% of workforce by age band which make up AFC band clusters workforce

Row Labels	16-25	26-35	36-45	46-55	56-65	66 plus years
Bands 2-4	59.2	30.6	27.7	28.9	36.5	38.1
Bands 5-7	40.8	62.5	55.3	52.2	48.2	47.8
Bands 8a - 9	0.0	6.9	17.1	18.9	15.3	14.2

% of age ranges which are in band 8a - 9 positions



Modelled
Expected
Ethnically
Diverse
Representation
by Pay Band
Based on
Census Age
Profile

Band	Avg Age	Assigned Age Band	Local Population % ED	Posts	Expected ED Count	Expected % ED
Under B1	18	16–25	38%	4	1.5	38%
Band 2	44.8	36–45	40%	73	29.3	40%
Band 3	45	36–45	40%	790	316.6	40%
Band 4	42.6	36–45	40%	799	320.2	40%
Band 5	40.6	36–45	40%	735	294.6	40%
Band 6	43.8	36–45	40%	981	393.2	40%
Band 7	45.3	46–55	33%	1081	354.4	33%
Band 8a	45.9	46–55	33%	441	144.6	33%
Band 8b	48.8	46–55	33%	173	56.7	33%
Band 8c	51	46–55	33%	69	22.6	33%
Band 8d	54.8	56–65	21%	35	7.4	21%
Band 9	57	56–65	21%	10	2.1	21%
Consultant	52	46–55	33%	97	31.8	33%
Exec Board	53.7	56–65	21%	6	1.3	21%
Non-consultant	49.2	46–55	33%	80	26.2	33%
Trainee	34.4	26–35	41%	38	15.4	41%
VSM	58	56–65	21%	3	0.6	21%

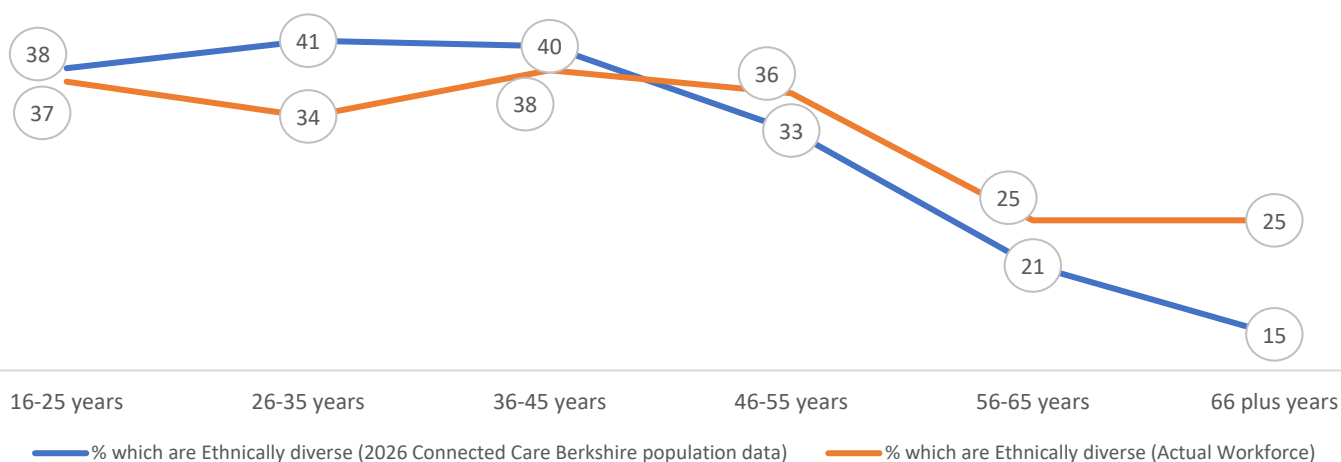
Actual and Modelled
Ethnically Diverse
Representation by Pay
Band Group

Pay band group	Modelled ethnically diverse (%)	Actual ethnically diverse (%)	Difference: actual vs modelled
Bands 2–4	40.08%	36.20%	-3.9pp
Bands 5–7	37.26%	34.10%	-3.2pp
Bands 8a–9	32.06%	22.00%	-10.1pp
All staff	37.28%	33.90%	-3.4pp

**Ethnically Diverse Representation
by Age Group: Connected Care
Berkshire data Compared with BHFT
Workforce**

Age range	% which are Ethnically diverse (2026 Connected Care Berkshire population data)	% which are Ethnically diverse (Actual Workforce)
16-25 years	38	37
26-35 years	41	34
36-45 years	40	38
46-55 years	33	36
56-65 years	21	25
66 plus years	15	25

Comparison between Ethnic Diversity in Local Population vs Trust Workforce
(By age range group)



NHS National Workforce – Proportion of Non-UK / Non-British Staff (Trend)

Year	% Non-UK / non-British staff
2009	~11.9%
2016	~13.0%
2023	~20.4%
NHS Digital / NHS England Workforce Statistics (Hospital and Community Health Services workforce nationality data), September 2023. The trend has been widely reported using analysis of NHS workforce nationality data, including by The Guardian , Sky News , The Telegraph , iNews and other national media outlets.	

Estimated NHS Nursing Career Progression Timelines (Band 5 to Band 8a)

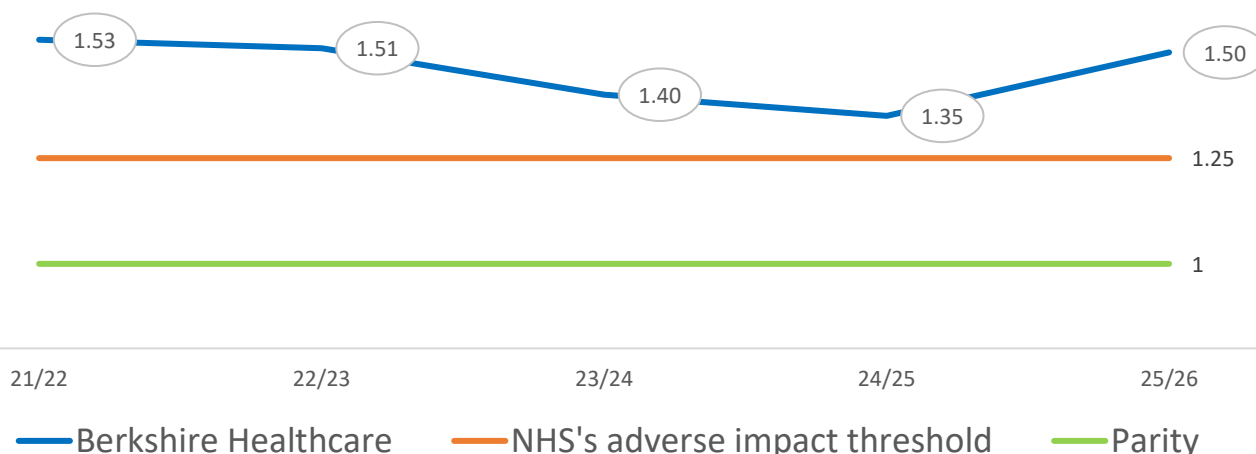
Career step	Typical time frame	Evidence / method
Band 5 → Band 6	~2–4 years	Typical progression based on role expectations and career pathway guidance Source Link
Band 6 → Band 7	~3–5 years	Requires additional experience, leadership responsibility or advanced clinical practice Source Link
Band 7 → Band 8a	~3–6+ years (estimated)	No standard timeframe; derived from evidence that only ~14% of nurses reach Band 7+ within 9 years plus additional leadership/experience requirements for Band 8a
Overall (Band 5 → Band 8a)	Typically >8–10+ years	Inferred from cumulative progression timelines and observed constraints in progression to senior roles

2. Relative likelihood of staff being appointed from shortlisting

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WRES Indicator 2 – Likelihood of White applicants being appointed from shortlisting	21/22	22/23	23/24	24/25	25/26	Change (24/25 → 25/26)	Direction
Berkshire Healthcare	1.53	1.51	1.40	1.35	1.50	+0.15	Worsening
NHS Trusts (National)	1.61	1.54	1.62	1.77	–	–	–

Likelihood of White Candidates Being Appointed From Shortlisting



External Hires by Band and Ethnicity (Headcount)

Row Labels	Asian	Black	Mixed	Not Stated	Other	White	Ethnically Diverse	Grand Total
Band 2	3	3	1	0	0	5	7	12
Band 3	7	19	5	9	4	40	35	84
Band 4	15	8	8	4	1	69	32	105
Band 5	19	39	5	7	2	47	65	119
Band 6	8	10	4	4	1	58	23	85
Band 7	9	21	3	7	1	36	34	77
Band 8a	3	2	0	3	0	8	5	16
Band 8b	3	2	0	1	1	3	6	10
Band 8c	0	0	1	1	0	2	1	4
Band 8d	0	0	0	0	0	0	0	0
Band 9	0	0	0	0	0	0	0	0
Non Agenda for change	11	2	2	64	1	9	16	89
Grand Total	78	106	29	100	11	277	224	601

Ethnicity Composition of External Hires by Pay Band

Pay band	Total hires (n)	% Ethnically Diverse Hires	% White Hires	% Ethnicity Not Stated Hires
Band 2	12	58	42	0
Band 3	84	42	48	11
Band 4	105	30	66	4
Band 5	119	55	39	6
Band 6	85	27	68	5
Band 7	77	44	47	9
Band 8a	16	31	50	19
Band 8b	10	60	30	10
Band 8c	4	25	50	25
Band 8c	0	0	0	0

Band 9	0	0	0	0
Non-AfC	89	18	10	72
Total	601	37	46	17

External Hires by Band and Ethnicity (% of Total Hires)

Row Labels	Asian	Black	Mixed	Not Stated	Other	White	Ethnicall y Diverse
Band 2	25	25	8	0	0	42	58
Band 3	8	23	6	11	5	48	42
Band 4	14	8	8	4	1	66	30
Band 5	16	33	4	6	2	39	55
Band 6	9	12	5	5	1	68	27
Band 7	12	27	4	9	1	47	44
Band 8a	19	13	0	19	0	50	31
Band 8b	30	20	0	10	10	30	60
Band 8c	0	0	25	25	0	50	25
Band 8d	0	0	0	0	0	0	0
Band 9	0	0	0	0	0	0	0
Non Agenda for change	12	2	2	72	1	10	18
Grand Total	13	18	5	17	2	46	37

Recruitment Outcomes by Ethnicity (All Applicants)

Recruitment stage	Ethnically Diverse	White
Applications shortlisted	15,668	4,294
Offered interview	1,559	1,422
% of shortlisted offered interview	10.1%	33.1%
Attended interview	1,141	1,081
% of interviews attended	73.2%	76.0%
Offered job	382	522
% offered job (of those interviewed)	33.5%	48.3%
% offered job (of those offered an interview)	24.5%	36.7%
Likelihood to be appointed (of those interviewed)	0.69	1.44
Likelihood to be appointed (of those offered an interview)	0.67	1.50

Application Profile

Applications	Ethnically Diverse	White	Ethnicity Not Disclosed
Total Applications	15668	4294	316
% of total applications	77.27	21.18	1.56
% of total applications of known ethnicity	78.49	21.51	n/a
% of applications from repeat applicants	40	30	26
Number of times a candidate made 10 or more unique applications	78	12	1

Offered Interview Profile

Offered Interview	Ethnically Diverse	White	Ethnicity Not Disclosed
Total Interviews	1559	1422	67
% of total interviews	51	47	2.20
% of total applications of known ethnicity	52	48	n/a
Total interviews of candidates without immediate right to work status	395	5	8
% offered interview where 5 or more were interviewing	59	50	52
% offered interview where they are the only candidate interviewing	11	15	22

Scenario Based Testing

Scenario	Ethnically Diverse	White
Baseline (attended interview → offer)	0.69	1.44
Internal applicants only	0.74	1.35
Candidates with right to work only	0.78	1.28
British citizens with UK right to work only	0.85	1.18
Public adverts only	0.57	1.76
Hidden adverts only	0.96	1.05
Internal-only adverts	0.88	1.13
Band 8a–9 adverts only	1.08	0.93

Recruitment Outcomes by Pay Band for British Citizens Only (Interview-to-Offer Stage)

Pay band	Interviews attended (ED)	Interviews attended (White)	Offers (ED)	Offers (White)	Offer rate (ED)	Offer rate (White)	Relative likelihood (White ÷ ED)
Band 2	6	14	4	8	66.7%	57.1%	0.86
Band 3	52	109	13	50	25.0%	45.9%	1.83
Band 4	51	130	15	60	29.4%	46.2%	1.57
Band 5	105	115	45	49	42.9%	42.6%	0.99
Band 6	67	104	37	61	55.2%	58.7%	1.06
Band 7	89	97	36	54	40.4%	55.7%	1.38
Band 8a	20	25	6	7	30.0%	28.0%	0.93
Band 8b	10	14	4	6	40.0%	42.9%	1.07
Band 8c	9	8	4	4	44.4%	50.0%	1.13
Band 9	2	1	2	1	100.0%	100.0%	1.00

Recruitment Outcomes by Pay Band Group for British Citizens Only (Interview-to-Offer Stage)

Band grouping	Interviews attended (ED)	Interviews attended (White)	Offers (ED)	Offers (White)	Offer rate (ED)	Offer rate (White)	Relative likelihood (White ÷ ED)
Bands 2–4	109	253	32	118	29.4%	46.6%	1.59
Bands 5–7	261	316	118	164	45.2%	51.9%	1.15
Bands 8a–9	41	48	16	18	39.0%	37.5%	0.96

Appointment Outcomes Following Interview by Staff Group (British Citizens Only)

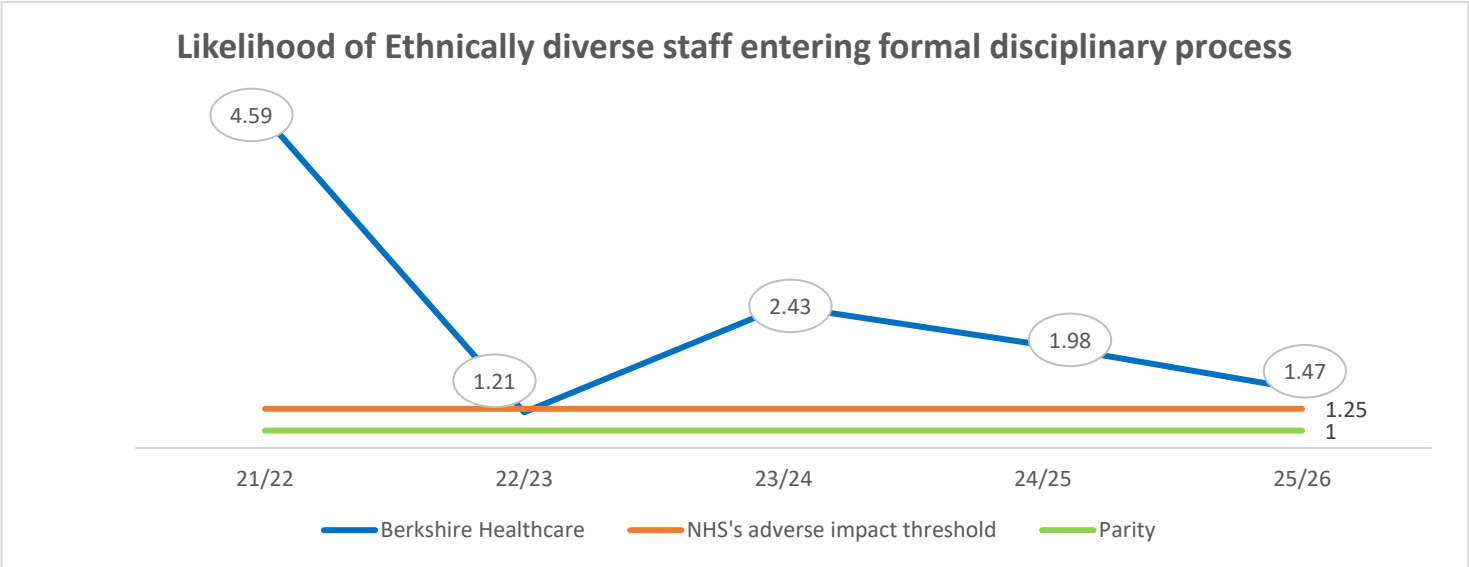
Staff group	Interviews attended (ED)	Interviews attended (White)	Offers (ED)	Offers (White)	Offer rate (ED)	Offer rate (White)	Relative likelihood (White ÷ ED)
Additional Clinical Services	67	179	27	89	40.3%	49.7%	1.23
Additional Professional Scientific and Technical	28	63	16	30	57.1%	47.6%	0.83
Administrative and Clerical	87	137	26	55	29.9%	40.1%	1.34
Allied Health Professionals	35	119	15	61	42.9%	51.3%	1.20
Medical and Dental	12	5	9	2	75.0%	40.0%	0.53
Nursing and Midwifery Registered	195	121	80	67	41.0%	55.4%	1.35
Students	1	3	1	3	100.0%	100.0%	1.00

3. **Relative likelihood of staff entering the formal disciplinary process**

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WRES Indicator 3: Likelihood of Ethnically diverse staff entering formal disciplinary process	21/22	22/23	23/24	24/25	25/26	Change (24/25 → 25/26)	Direction
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Berkshire Healthcare	4.59	1.21	2.43	1.98	1.47	-0.51	Improving
NHS Trusts (National)	1.14	1.14	1.09	1.11	–	–	–



Disciplinary Outcomes by Gender

Gender	Incidents	% of total incidents	Staff in post	% of staff in post	% disciplinary rate (incidents ÷ staff)	Likelihood Ratio
Female	20	1	4361	1	0.5%	0.29
Male	14	0	897	0	1.6%	3.39

Intersectionality Disciplinary Data

Gender	Incidents	% of total incidents	Staff in post of row category	% of staff in post	% of disciplinarys to total staff
Ethnically Diverse Female	8	24	1358	26	0.6
White Female	12	35	3003	57	0.4
Ethnically Diverse Male	7	21	478	9	1.5
White Male	7	21	419	8	1.7

Gender Composition of our workforce by ethnicity

Gender	Incidents
% of Ethnically Diverse Workforce Which is Male	26
% of White Workforce Which is Male	12

% Of Workforce Who Entered Disciplinary (Intersectionality) Disciplinary Data

Gender	%
White Male	4.9
Ethnically Diverse Male	4.3
Ethnically Diverse Female	1.7
White Female	1.2

**Likelihood Score
Ethnically Diverse Female vs White Female**

Gender	Incidents
Ethnically Diverse Female	1.47
White Female	0.68

**Likelihood Score
Ethnically Diverse Male vs White Male**

Gender	Incidents
Ethnically Diverse Male	0.88
White Male	1.14

Disciplinary Data by Pay Band

Band	Incidents	% of total incidents	Headcount in workforce	% of workforce	difference between % of incidents and workforce contribution
3	12.0	35.3	790	14.6	20.7
2	2.0	5.9	73	1.3	4.6
8b	2.0	5.9	173	3.2	2.7
8c	1.0	2.9	69	1.3	1.6
7	7.0	20.6	1081	20.0	0.6
8a	2.0	5.9	441	8.1	-2.2
6	4.0	11.8	981	18.1	-6.3
5	2.0	5.9	735	13.6	-7.7
4	2.0	5.9	799	14.8	-8.9

Disciplinary Data by Division

Division	Incidents	% of total incidents	Headcount in workforce	% of workforce	Difference between % of incidents and workforce contribution
Mental Health Services	20.0	58.8	1812	33.5	25.3
Community Health Services	9.0	26.5	1778	32.8	-6.3
Central Services	2.0	5.9	707	13.1	-7.2

Children Family and All Age Services	3.0	8.8	1118	20.6	-11.8
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Disciplinary Data by Position Title

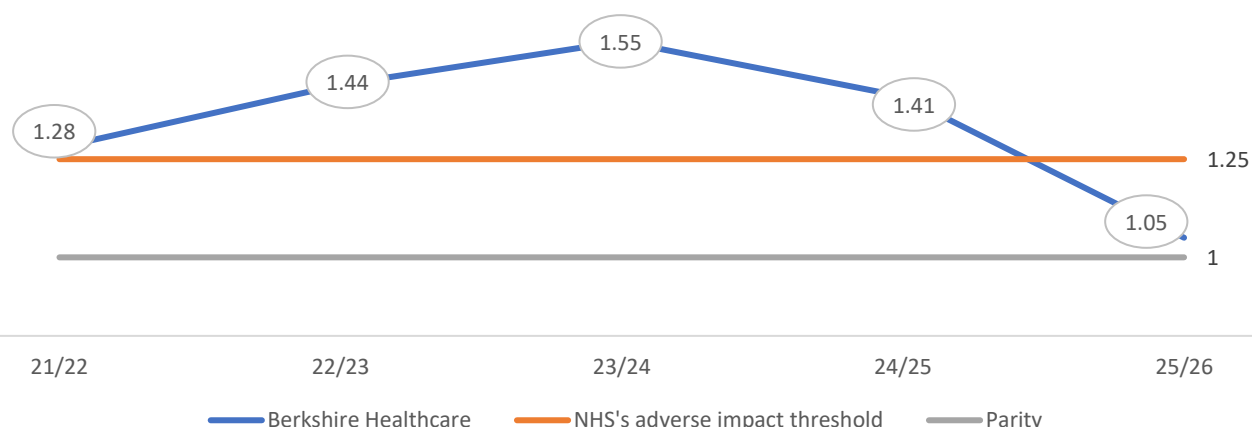
Position Title	Incidents	% of total incidents	Headcount in workforce	% of workforce	difference between % of incidents and workforce contribution
Healthcare Assistant	8.0	23.5	408	9.0	14.5
Community Psychiatric Nurse	5.0	14.7	417	9.2	5.5
Ward Manager	2.0	5.9	26	0.6	5.3
Nursery Cook	1.0	2.9	3	0.1	2.8
Paramedic	1.0	2.9	5	0.1	2.8
Pre-registration Pharmacy Technician	1.0	2.9	6	0.1	2.8
Behaviour Therapist	1.0	2.9	8	0.2	2.7
Pharmacy Technician	1.0	2.9	12	0.3	2.6
Advanced Paramedic Practitioner	1.0	2.9	13	0.3	2.6
Phlebotomist	1.0	2.9	14	0.3	2.6
Podiatrist Specialist	1.0	2.9	14	0.3	2.6
Personal Assistant	1.0	2.9	15	0.3	2.6
Manager	2.0	5.9	167	3.7	2.2
Pharmacist	1.0	2.9	44	1.0	1.9
Clinical Psychologist	1.0	2.9	126	2.8	0.1
Administrator	5.0	14.7	719	15.9	-1.2
Senior Manager	1.0	2.9	230	5.1	-2.2

4. Relative likelihood of staff accessing non-mandatory training and continued professional development

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WRES Indicator 4: Likelihood of accessing non-mandatory training and CPD (White vs Ethnically diverse staff)	21/22	22/23	23/24	24/25	25/26	Change (24/25 → 25/26)	Direction
Berkshire Healthcare	1.28	1.44	1.55	1.41	1.05	-0.36	Improving
NHS Trusts (National)	1.14	1.12	1.06	1.02	–	–	–

Likelihood of white staff member accessing non-mandatory training and CPD



2025/26 breakdown of non-mandatory training and CPD access

2025/26 component	Ethnically diverse staff	White staff	Ethnicity not stated	Ethnically diverse uptake %	White uptake %	Likelihood ratio*
Apprenticeships – total staff undertaking	52	90	3	3.04%	2.69%	1.13
CPD funded – total staff undertaking	126	334	10	7.37%	10.00%	0.74
In-house training – total staff undertaking	1475	2757	128	86.31%	82.52%	1.05

Access to non-mandatory training and/or CPD by profession, 2025/26

Profession	Total staff	Accessed training/CPD	Uptake %
Medical	199	67	34
Unknown	3	2	67
Speech and Language Therapist	6	5	83
Pharmacist	45	38	84
Dental Officer	16	14	88
Audiologist	10	9	90
Pharmacy Technician	12	11	92
Estates and Ancillary	29	27	93
Grand Total	5415	5115	94
Paramedic	24	23	96
Speech & Language Therapist	105	101	96
Nursing and Midwifery Registered	1438	1389	97
Administrative and Clerical	1296	1254	97
Dietitian	64	62	97
Occupational Therapist	131	127	97
Qualified Clinical Psychologist	174	169	97

Social Worker	74	72	97
Other - Add Prof Scientific and Technic	266	259	97
Physiotherapist	234	228	97
Additional Clinical Services	1218	1187	97
Art Therapist	8	8	100
Dietician	1	1	100
Osteopath	2	2	100
Podiatrist	32	32	100
Psychotherapist	13	13	100
Specialist Dentist	1	1	100
Students	14	14	100

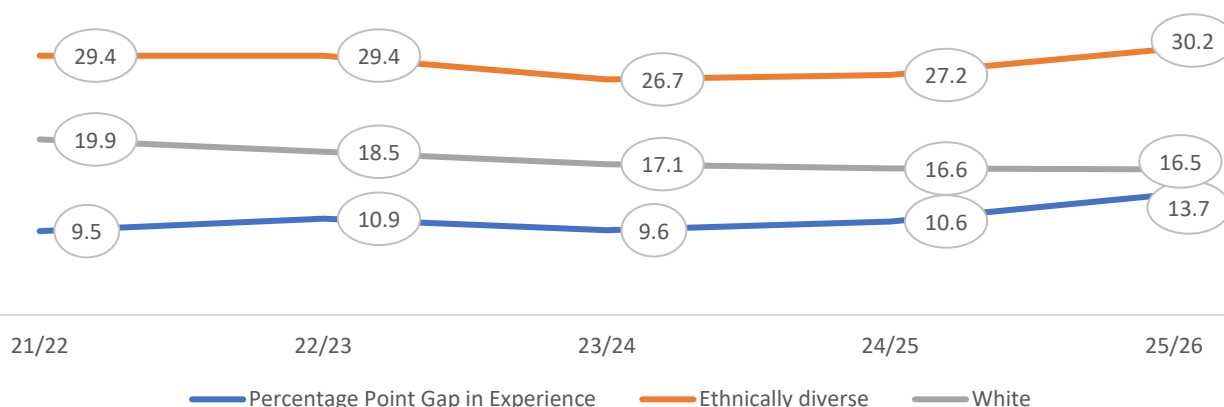
5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public

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WRES Indicator 5: Difference in experience (percentage point gap)	21/22	22/23	23/24	24/25	25/26	Change (24/25 → 25/26)	Direction
Berkshire Healthcare (gap)	+9.5pp	+10.9pp	+9.6pp	+10.6pp	+13.7pp	+3.1pp	Worsening
NHS Trusts (gap)	+6pp	+2.2pp	+3.7pp	+5.0pp	–	–	–

WRES Indicator 5: Difference in experience (percentage point gap)	Group	21/22	22/23	23/24	24/25	25/26
Berkshire Healthcare	Ethnically diverse	29.4%	29.4%	26.7%	27.2%	30.2%
	White	19.9%	18.5%	17.1%	16.6%	16.5%
NHS Trusts (National)	Ethnically diverse	32.0%	29.2%	27.8%	28.6%	–
	White	26.0%	27.0%	24.1%	23.6%	–

% of Staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months



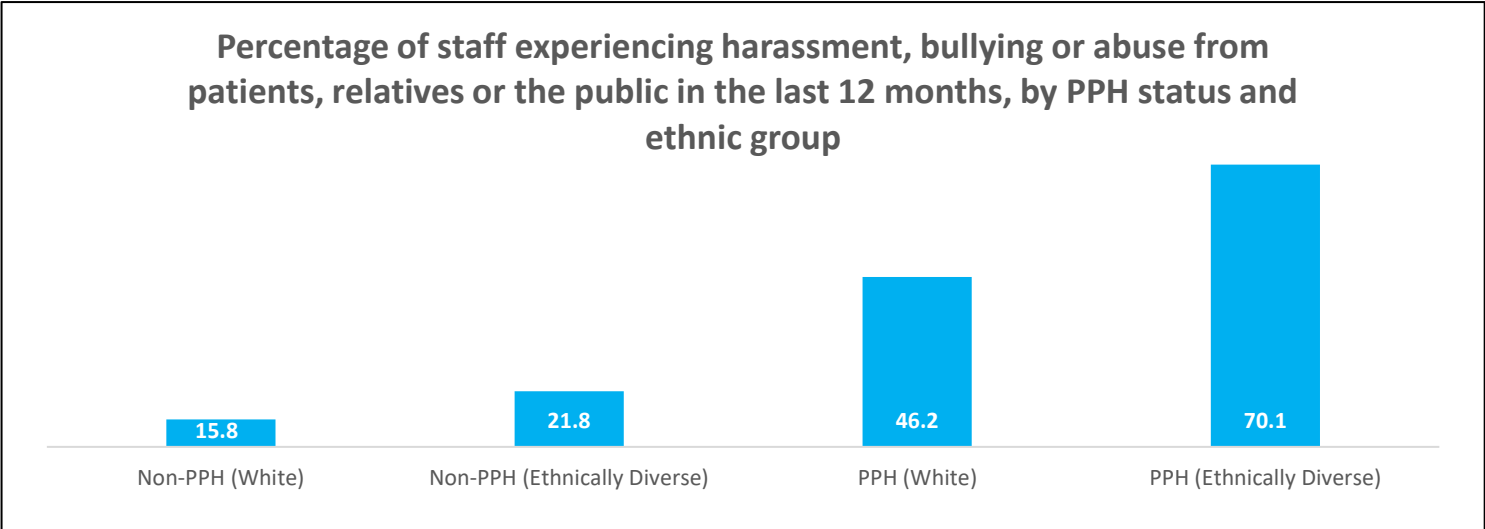
PPH vs Non PPH Scores

Metric	All staff	PPH only	Non PPH
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Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the general public in the last 12 months	20.7%	65.5%	17.4%
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Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months, by PPH status and ethnic group

Description	Non-PPH (White)	Non-PPH (Ethnically Diverse)	PPH (White)	PPH (Ethnically Diverse)
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	15.8	21.8	46.2	70.1



Percentage point gap in experiences of harassment, bullying or abuse from patients, relatives or the public between White and ethnically diverse staff, comparing PPH and non-PPH staff

Description	Non-PPH gap (Ethnically Diverse minus White)	PPH gap (Ethnically Diverse minus White)	Difference between PPH and Non-PPH gaps
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	6.0 percentage points	23.9 percentage points	17.9 percentage points

Workforce representation of PPH staff as a percentage of total workforce, 2025–2026

Metric	2025	2026
% of workforce made up by PPH	7.6%	7.2%

Percentage of ethnically diverse workforce working at PPH, 2025–2026

Metric	2025	2026
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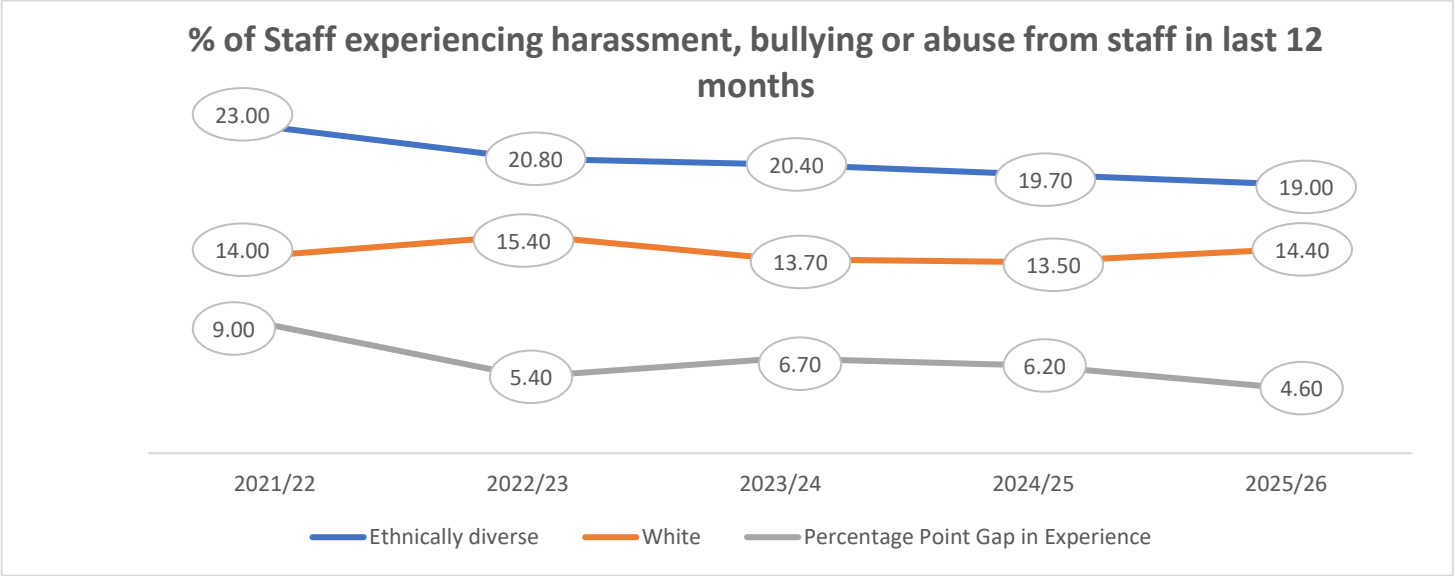
Percentage of trusts total ethnically diverse workforce working at PPH	16.5%	18.1%
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6. Percentage of staff experiencing harassment, bullying or abuse from staff

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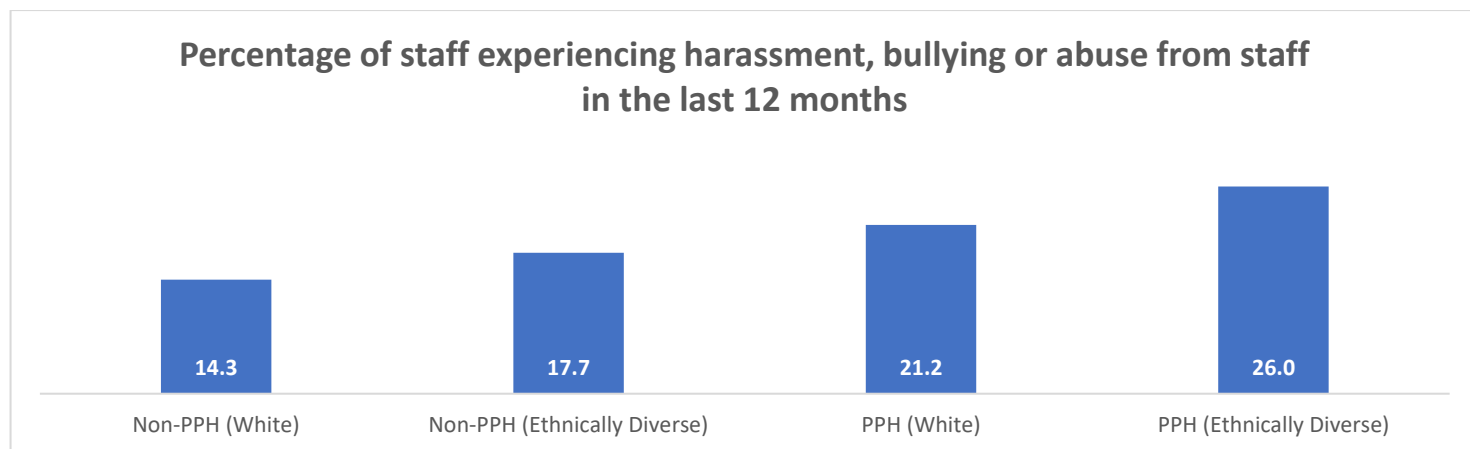
WRES Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff (last 12 months)	2021/22	2022/23	2023/24	2024/25	2025/26	Change (24/25 → 25/26)	Direction
Berkshire Healthcare	9.00	5.40	6.70	6.20	4.60	-1.6pp	Improving
NHS Trusts (national)*	5.00	4.60	4.20	4.10	–	–	–

WRES Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff (last 12 months)	Group	21/22	22/23	23/24	24/25	25/26
Berkshire Healthcare	Ethnically diverse	23.0%	20.8%	20.4%	19.7%	19.0%
	White	14.0%	15.4%	13.7%	13.5%	14.4%
NHS Trusts (National)*	Ethnically diverse	23.0%	27.6%	24.9%	24.0%	–
	White	18.0%	23.0%	20.7%	19.9%	–



Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months, by PPH status and ethnic group

Description	Non-PPH (White)	Non-PPH (Ethnically Diverse)	PPH (White)	PPH (Ethnically Diverse)
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	14.3	17.7	21.2	26.0



Gap in percentage points between Ethnically Diverse Staff and White Staff

Metric	All staff	PPH only	Non PPH
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	4.6%	4.8%	3.4%

7. Percentage of staff believing the Trust provides equal opportunities for career progression or promotion

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WRES Indicator 7: Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	21/22	22/23	23/24	24/25	25/26	Change (24/25 → 25/26)	Direction
Berkshire Healthcare	-21.80	-16.40	-15.10	-12.20	-5.40	-6.8pp	Improving
NHS Trusts (National)*	-14.00	-14.60	-10.60	-9.50	–	–	–

WRES Indicator 7: Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	Group	21/22	22/23	23/24	24/25	25/26
Berkshire Healthcare	Ethnically diverse	45.7%	51.7%	53.3%	56.4%	59.8%
	White	67.5%	68.1%	68.4%	68.6%	65.2%
NHS Trusts (National)*	Ethnically diverse	47.0%	44.4%	48.8%	49.6%	–

White

61.0%

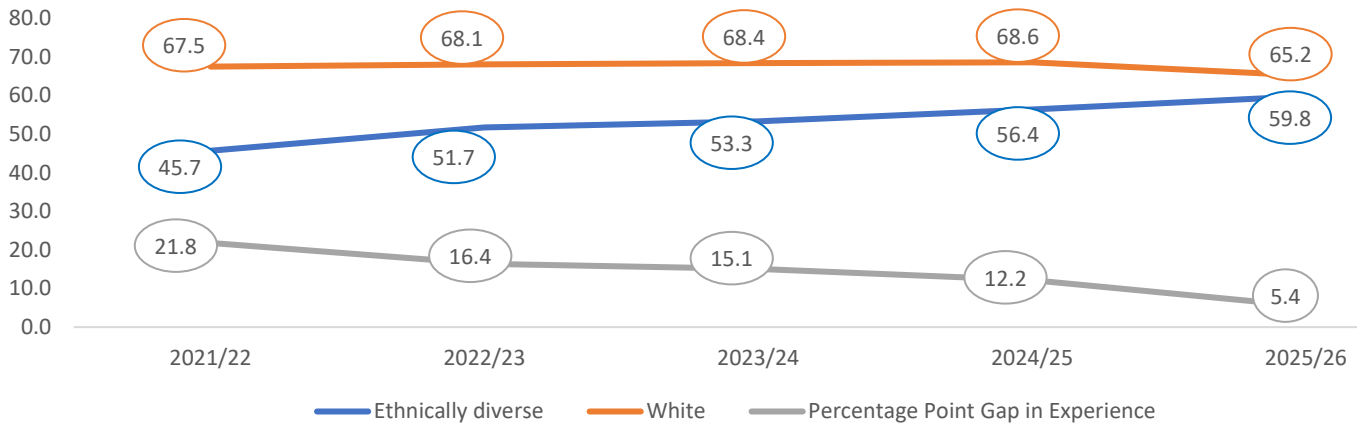
59.0%

59.4%

59.1%

–

% of staff believing that the organisation provides equal opportunities for career progression or promotion



Internal promotion rates by starting band and ethnicity

Internal promotions (from band)	Ethnically Diverse promoted / total	Ethnically Diverse % promoted	White promoted / total	White % promoted	Relative likelihood (ED vs White)
Overall	121 / 1693	7.2%	225 / 3569	6.3%	1.14
Band 2	12 / 42	28.6%	9 / 64	14.1%	2.03
Band 3	19 / 332	5.7%	35 / 485	7.2%	0.79
Band 4	28 / 263	10.7%	36 / 590	6.1%	1.74
Band 5	23 / 284	8.1%	40 / 406	9.9%	0.82
Band 6	22 / 321	6.9%	47 / 663	7.1%	0.97
Band 7	7 / 294	2.4%	38 / 783	4.9%	0.49
Band 8a	8 / 104	7.7%	10 / 329	3.0%	2.53
Band 8b	2 / 38	5.3%	7 / 148	4.7%	1.11
Band 8c	0 / 10	0.0%	3 / 60	5.0%	N/A
Band 8d	0 / 4	0.0%	0 / 30	0.0%	N/A
Band 9	0 / 1	0.0%	0 / 11	0.0%	N/A
Band 8a+	10 / 157	6.4%	20 / 578	3.5%	1.84
Band 7+	17 / 451	3.8%	58 / 1361	4.3%	0.88

Change in profession mix between Band 7 and Band 8a, with ethnically diverse workforce representation context

Profession type	Band 7 (%)	Band 8a (%)	Difference (pp)	Overall % ethnically diverse
Nursing and Midwifery Registered	41.6%	24.0%	-17.6	39.6%
Other – Additional Professional Scientific and Technical	16.2%	8.2%	-8.0	27.4%
Speech & Language Therapist*	4.9%	0.0%	-4.9	13.5%
Occupational Therapist	4.4%	1.6%	-2.9	20.6%

Dietitian	2.7%	0.2%	-2.5	23.1%
Social Worker	4.3%	2.0%	-2.3	25.7%
Podiatrist	1.2%	0.5%	-0.7	34.4%
Pharmacy Technician	0.2%	0.0%	-0.2	25.0%
Additional Clinical Services	1.0%	0.9%	-0.1	39.0%
Unknown Profession	0.1%	0.0%	-0.1	33.3%
Art Therapist	0.3%	0.5%	0.2	12.5%
Psychotherapist	0.0%	0.5%	0.5	23.1%
Audiologist	0.2%	0.7%	0.5	70.0%
Speech and Language Therapist*	0.0%	1.1%	1.1	13.5%
Physiotherapist	7.0%	9.1%	2.0	26.9%
Paramedic	0.5%	3.2%	2.7	16.7%
Pharmacist	0.6%	6.8%	6.2	46.7%
Qualified Clinical Psychologist	3.0%	14.7%	11.8	18.4%
Administrative and Clerical	11.7%	26.1%	14.3	27.9%

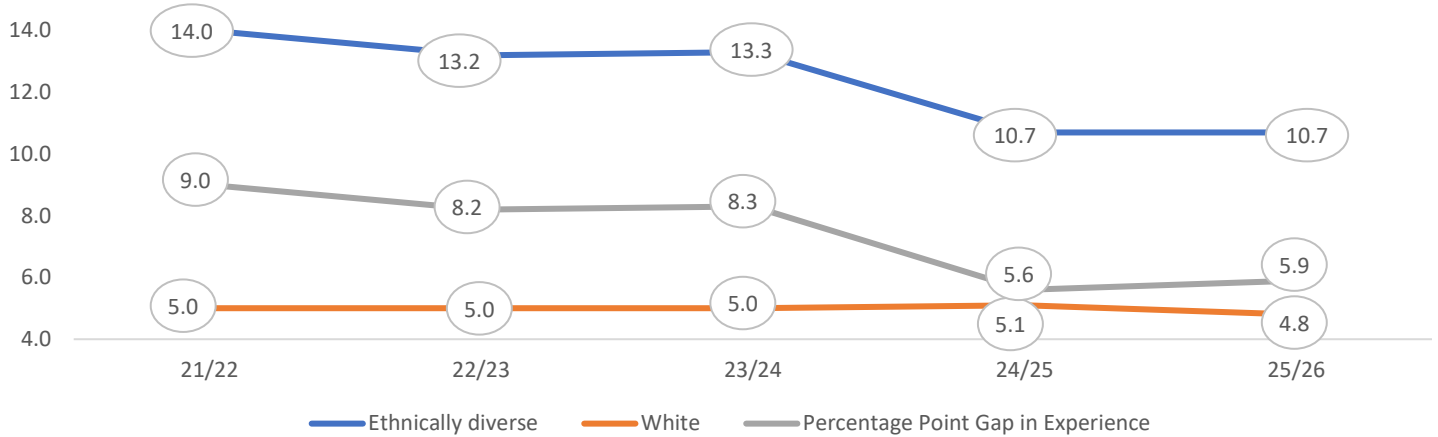
8. Percentage of staff personally experiencing discrimination at work from their manager/team leader or colleagues

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WRES Indicator 8: Percentage of staff who experienced discrimination at work from a manager, team leader or other colleagues (last 12 months) - Percentage Point Gap	21/22	22/23	23/24	24/25	25/26	Change (23/24 → 25/26)	Direction
Berkshire Healthcare	9.00	8.20	8.30	5.60	5.90	+0.3 ↑	Worsening
NHS Trusts (National)*	8.00	10.00	8.80	8.30	–	–	–

Percentage of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months	Group	21/22	22/23	23/24	24/25	25/26
Berkshire Healthcare	Ethnically diverse	14.0%	13.2%	13.3%	10.7%	10.7%
	White	5.0%	5.0%	5.0%	5.1%	4.8%
NHS Trusts (National)*	Ethnically diverse	14.0%	17.0%	15.5%	15.0%	–
	White	6.0%	7.0%	6.7%	6.7%	–

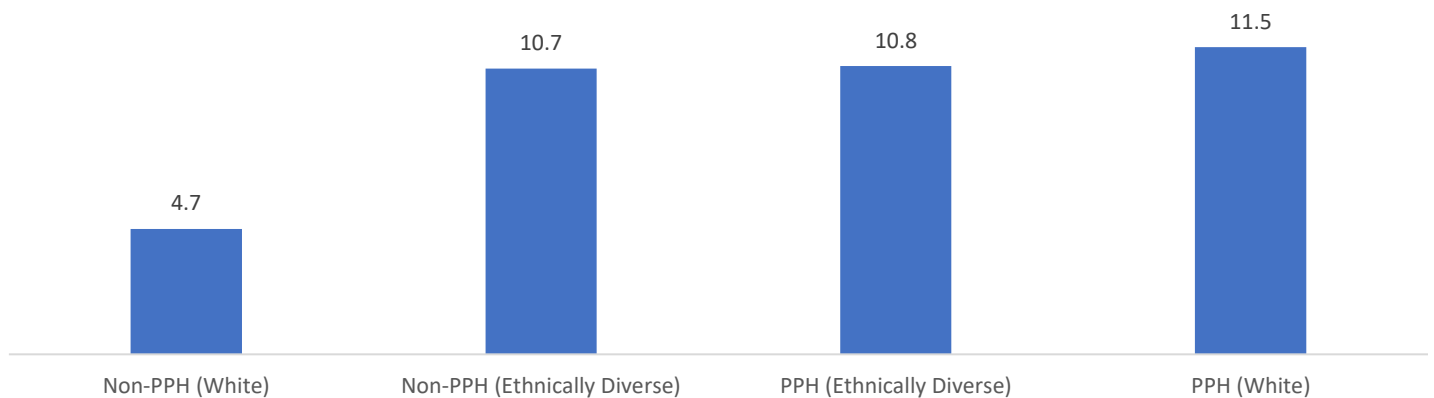
Percentage of staff who experienced discrimination at work from a manager, team leader or other colleagues (last 12 months)



Percentage of staff experiencing discrimination from staff in the last 12 months, by PPH status and ethnicity

Description	Non-PPH (White)	Non-PPH (Ethnically Diverse)	PPH (Ethnically Diverse)	PPH (White)
Percentage of staff experiencing discrimination from staff in the last 12 months	4.7	10.7	10.8	11.5

Percentage of staff experiencing discrimination from staff in the last 12 months



Percentage point gap in experiences of discrimination from staff between White and ethnically diverse staff, comparing PPH and non-PPH staff

Description	Non-PPH gap (Ethnically Diverse minus White)	PPH gap (Ethnically Diverse minus White)	Difference between PPH and Non-PPH gaps
Percentage of staff experiencing discrimination from staff in the last 12 months	+6.0 percentage points	-0.7 percentage points	-6.7 percentage points

9. Percentage difference between Board voting membership and its overall workforce [Back to contents](#)

Percentage difference between Board voting membership and its overall workforce (Ethnically Diverse)	2021/22	2022/23	2023/24	2024/25	2025/26	Change (24/25 → 25/26)	Direction
-							
Berkshire Healthcare	-0.04	2.4%	6.8%	3.0%	-11.0%	-14.0pp	Worsening
NHS Trusts (national)*	0.13	13.2%	-	-	-	-	-

Board voting membership composition by ethnicity

Year	Total board voting members	Ethnically diverse	White	% ethnically diverse
2025 submission	14	5	9	35.7%
2026 submission	13	3	10	23.1%

Overall workforce ethnicity comparison

Year	% ethnically diverse workforce	% ethnically diverse board	Difference (Board – Workforce)
2024/25	32.80%	35.70%	+3.0pp
2025/26	33.90%	23.10%	-10.8pp

Board membership movement between submissions (anonymised)

Movement type	Total individuals	Ethnically diverse	White
Members included in 2024/25 who left before 2025/26	4	2	2
Members newly included in 2025/26	3	0	3
Net change	-1	-2	1

Structural factors affecting comparability

Factor	Detail
Dual incumbency (handover period)	One board-level role was represented by two individuals in the 2024/25 submission, both included due to overlap during a transition period
Impact on 2024/25 position	This increased the recorded number of ethnically diverse board members in that year
2025/26 position	The same role is represented by a single individual following completion of the transition
Turnover profile	All new joiners to the Board in 2025/26 were White, while leavers were evenly split by ethnicity

WDES 2025/2026 – Board Summary

Board Meeting Date	8 th September 2026
Title	Workforce Disability Equality Standard 2025/26: Results and Analysis
	Item for Assurance
Reason for the Report going to the Trust Board	The Workforce Disability Equality Standard provides a national framework for assessing differences in workforce representation, employment outcomes and workplace experience between disabled and non-disabled staff. This paper presents the Trust's 2025/26 WDES results and additional analysis undertaken to understand the factors influencing the headline indicators. The Board is asked to: • note the Trust's continued improvement in recorded disability representation and the broadly favourable recruitment and promotion outcomes for disabled staff; • consider the significant and widespread differences that remain in the workplace experiences of disabled and non-disabled staff, particularly in relation to wellbeing, harassment, development, engagement and organisational voice; • support a targeted review of the small number of capability cases involving disabled staff; • consider the opportunities to improve organisational understanding and oversight of reasonable adjustment requests, implementation and outcomes; and • support continued improvement activity focused on translating progress in workforce representation into a more equitable day-to-day experience for disabled staff. This reflects the report's central conclusion that the principal challenge is now staff experience rather than representation, recruitment or promotion.
Business Area	People Directorate
Author	Stephen Strang, Workforce Planning and Insights Manager Edited by: Ash Ellis, Deputy Director for Leadership, Inclusion and Organisational Experience Executive Sponsor and authorised for submission: Alex Gild, Deputy Chief Executive And Jane Nicholson, Director of People
Relevant Strategic Objectives	Workforce, primary objective This report directly supports the Trust's ambition to make the Trust a great place to work for everyone. It provides evidence on disability representation, recruitment, progression, capability processes, reasonable adjustments, wellbeing, engagement and workplace experience. The findings show positive progress in representation and employment outcomes, but also identify significant differences in the day-to-day experiences of disabled and non-disabled staff that require continued organisational attention. The report finds less favourable results for disabled staff across 96 of approximately 100 comparable Staff Survey questions, with the largest differences concentrated around wellbeing, burnout, workplace experiences, appraisal and development, and staff voice and involvement.

The Trust's recorded disabled workforce now represents **9.6% of all employees**, exceeding the estimated **7.5% local workforce benchmark**. Disability representation has increased consistently over recent years, supported by improved disclosure and workforce data quality. The 2025/26 Workforce Disability Equality Standard (WDES) indicators present a mixed picture. Workforce outcomes relating to representation, recruitment and promotion remain broadly positive, whilst staff experience indicators continue to show notable differences between disabled and non-disabled staff. Additional analysis has been undertaken to better understand the factors influencing these results and to support informed interpretation of the headline indicators.

Whilst disabled staff continue to experience favourable recruitment outcomes and slightly higher promotion rates than non-disabled staff, significant differences remain in areas relating to wellbeing, workplace experience, organisational voice and reasonable adjustments. The evidence suggests that the principal challenge is no longer representation or progression, but ensuring disabled staff experience the same levels of support, wellbeing and inclusion as their non-disabled colleagues.

WRES Indicator Scorecard:

Indicator	2025/26 Result	Change	Key Context
Workforce Representation (WDES 1)	9.60%	Improved	Exceeds local workforce benchmark of 7.5%
Recruitment (WDES 2)	0.98 (Non-disabled likelihood)	Improved	Disabled applicants slightly more likely to be appointed following shortlisting
Capability Process (WDES 3)	2.3 (Disabled likelihood)	Worsened	Based on very small numbers and requires case-level review
Harassment, Bullying & Abuse (WDES 4a-c)	5.2pp to 9.5pp gaps	Mostly worsened	Largest disparity relates to experiences from colleagues
Reporting Harassment Incidents (WDES 4d)	3.9pp gap	Deteriorated	Disabled staff reporting rates declined whilst non-disabled rates improved
Career Progression Perceptions (WDES 5)	7.9pp gap	Worsened	Actual promotion outcomes remain favourable for disabled staff
Pressure to Attend Work When Unwell (WDES 6)	3.2pp gap	Improved	Lowest gap seen within the last five years
Adequate Adjustments (WDES 8)	82.10%	Slightly improved	Positive position, although almost one in five staff report unmet needs
Staff Engagement (WDES 9)	0.51 score gap	Worsened	Linked to lower organisational voice and influence scores

Key Finding 1: Representation and Progression Are Stronger Than Often Assumed:

Disability representation has increased from 6.4% to 9.6% over the last four years and now exceeds the estimated local workforce benchmark. Representation has improved across clinical, non-clinical, medical and senior workforce groups.

Recruitment outcomes also remain positive. Disabled applicants were slightly more likely than non-disabled applicants to be appointed following shortlisting, whilst promotion rates remained marginally higher for disabled staff (7.2% compared with 6.7%).

However, disabled staff remain less likely to believe the Trust provides equal opportunities for career progression. The evidence suggests that this perception may be influenced more by appraisal quality, development experiences and confidence in career pathways than by promotion outcomes themselves.

Board takeaway: The evidence does not suggest that disabled staff are experiencing poorer recruitment or promotion outcomes. Future focus should therefore extend beyond workforce metrics and consider the broader factors shaping staff perceptions of opportunity and career development.

Key Finding 2: The Most Significant Challenge Is the Wider Staff Experience Gap:

Across approximately 100 comparable Staff Survey questions, disabled staff reported more favourable outcomes than non-disabled staff on only four questions. Disabled staff scored lower across all People Promise themes reviewed, with the largest differences relating to wellbeing, burnout, appraisal experience, organisational voice and involvement.

Disabled staff also continued to report higher levels of harassment, bullying and abuse from colleagues, managers and members of the public. Of particular concern, reporting rates among disabled staff declined during the year whilst reporting rates among non-disabled staff improved.

The report concludes that these differences are unlikely to be driven by isolated issues and instead appear to reflect a smaller number of interconnected factors influencing multiple aspects of workplace experience.

Board takeaway: The most significant inequalities identified within the report relate to staff experience rather than workforce representation. Wellbeing, workplace experience, development and organisational voice should remain priority areas for improvement.

Key Finding 3: Reasonable Adjustments May Be a Key Organisational Lever:

The majority of disabled staff (82.1%) reported that reasonable adjustments had been implemented effectively. However, almost one in five staff requiring adjustments reported unmet needs.

Further analysis identified a significant disconnect between reported need and formal adjustment processes. Whilst 565 staff reported needing reasonable adjustments within the Staff Survey, only 55 staff utilised the Trust's formal adjustment process during the reporting period.

The Trust currently lacks a complete picture of adjustment requests, implementation, delays and outcomes. Whilst the report stops short of concluding that adjustment issues directly cause the wider staff experience gap, it identifies reasonable adjustments as one of the clearest organisational factors capable of influencing wellbeing, workplace experience, organisational voice and inclusion.

Board takeaway: Improving oversight and understanding of reasonable adjustments may provide one of the greatest opportunities to improve disabled staff experience across multiple domains simultaneously.

Other Key Findings:

Capability Processes

Disabled staff were reported as 2.3 times more likely to enter the formal capability process. However, the indicator was based on only five disabled staff over the two-year reporting period and should therefore be interpreted cautiously. The report recommends a targeted case-level review rather than drawing broad conclusions from the headline ratio alone.

Wellbeing

The WDES indicator relating to pressure to attend work when unwell improved significantly and is now at its most favourable position in five years. However, wider Staff Survey findings suggest that disabled staff remain substantially more likely to experience ill health, stress and burnout, indicating that wellbeing remains a significant area of inequality.

Board Representation

Disabled staff remain slightly underrepresented amongst Board voting members. However, due to the small size of the Board, a single appointment can materially change this position and year-on-year changes should be interpreted with caution.

Key Messages for the Board:

[Click here to view full WDES paper](#)

- Disability representation now exceeds the estimated local workforce benchmark and continues to improve.
- Disabled applicants continue to experience favourable recruitment outcomes and slightly higher promotion rates than non-disabled staff.
- The principal challenge identified by the report is not representation or progression, but the wider workplace experience of disabled staff.
- Wellbeing, burnout, workplace experience, organisational voice and development opportunities represent the largest areas of difference.
- Harassment, bullying and abuse, particularly from colleagues, remain important areas of concern.
- The capability indicator requires further review but should be interpreted cautiously due to the very small number of cases involved.
- Improving understanding and oversight of reasonable adjustments may offer one of the most effective opportunities to improve disabled staff experience across multiple aspects of working life.

Further information:

The full WRES report provides detailed methodology, analysis and recommendations and is [available here](#).

Workforce Disability Equality Standard (WDES) 2025/2026

Please help shape future papers by completing [this feedback survey](#) to share your insights.

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This report presents Berkshire Healthcare NHS Foundation Trust's Workforce Disability Equality Standard (WDES) submission for 2025/26 and provides additional analysis to help interpret the nationally mandated indicators.

The Trust has continued to improve disability representation within its workforce. Disabled staff now account for 9.6% of the workforce, exceeding the local workforce benchmark of 7.5%. Analysis suggests that this improvement reflects both workforce changes and increased disability disclosure and recording. However, 363 staff (7%) have not disclosed a disability status, compared with 3% for ethnicity and 0% for gender, indicating further opportunities to improve data quality and staff confidence in disclosure.

Several workforce indicators remain positive. Disabled applicants were slightly more likely than non-disabled applicants to be appointed following shortlisting, and disabled staff continued to experience slightly higher promotion rates than non-disabled staff.

Despite these positive workforce outcomes, disabled staff continue to report less positive workplace experiences than non-disabled staff. Additional analysis found less favourable outcomes for disabled staff across 96 of 100 comparable NHS Staff Survey questions. The largest differences were concentrated around wellbeing, burnout, negative workplace experiences, appraisal and development experiences, and staff voice and involvement.

Disabled staff also continued to report higher levels of harassment, bullying and abuse from patients, service users, managers and colleagues. The largest difference related to harassment, bullying and abuse from colleagues, reported by 20.0% of disabled staff compared with 10.5% of non-disabled staff. Disabled staff were also less likely to report incidents, creating a 3.9 percentage point reporting gap.

The Trust recognises that disability does not exist in isolation. Individuals may experience multiple and overlapping characteristics and identities, including ethnicity, sex, age, sexual orientation, religion or belief, and socio-economic background. Whilst this report focuses on disability as defined within the WDES, understanding these wider experiences remains an important part of the Trust's equality, diversity and inclusion approach.

Reasonable adjustments remain an important area for focus. Whilst Berkshire Healthcare continues to perform strongly on this indicator, with 82.1% of disabled staff reporting that appropriate adjustments had been made, almost one in five disabled staff still reported that their adjustment needs had not been fully met. The Trust also outperformed the most recently available national NHS benchmark of 75.3%.

The available data does not fully explain why some staff feel their adjustment needs have not been met. Experiences may reflect a range of factors, including whether adjustments were requested, agreed locally, delayed, declined or dependent on external support processes. Understanding this area in greater detail may help the Trust better understand wider issues relating to wellbeing, engagement, burnout and job satisfaction. However, the current evidence does not demonstrate a direct causal relationship.

Disabled staff were more likely than non-disabled staff to enter the formal capability process during 2025/26. However, this indicator was based on only 5 disabled staff entering the formal process over the two-year reporting period. The result is therefore highly sensitive to small changes in case numbers and should be interpreted alongside detailed case review rather than the headline ratio alone. It should also be recognised that the indicator relates only to staff who reach the formal capability stage and excludes cases managed on health grounds. In addition, the indicator does not capture employees managed through earlier stages of the Supporting Attendance Policy or other informal processes. As a result, the available data provides only a partial view of the wider experience of disabled staff within attendance and capability-related processes.

Overall, the findings suggest that the Trust's principal challenge is no longer representation, recruitment or promotion, but ensuring that disabled staff experience the same levels of inclusion, wellbeing, opportunity and organisational support as non-disabled colleagues. Future improvement activity should therefore focus on understanding and addressing the factors that contribute to less positive workplace experiences. This should include continued partnership working with the Purple Network, alongside further work relating to reasonable adjustments, wellbeing, inclusion and staff voice.

The Trust recognises that disability equality is not measured solely through workforce representation or compliance with statutory standards, but through the day-to-day experiences of disabled colleagues. Whilst positive progress has been made in representation and workforce outcomes, the findings highlight the need for continued action to remove barriers, strengthen inclusion and ensure disabled staff can thrive throughout their careers.

1. Introduction

The Workforce Disability Equality Standard (WDES) was introduced by NHS England to help NHS organisations understand the experiences of disabled staff and identify whether disabled and non-disabled staff experience different outcomes.

This report presents Berkshire Healthcare NHS Foundation Trust's WDES submission for 2025/26 alongside additional workforce analysis to help interpret the nationally mandated indicators.

The purpose of this report is not only to identify differences between disabled and non-disabled staff, but also to explore what may be driving those differences and where further improvement may be needed. Whilst disparities in outcomes and experiences may indicate inequity, they can also be influenced by factors such as workforce composition, staff group profile, age, recruitment patterns, disclosure rates, data quality and other organisational factors. Findings should therefore be interpreted within the wider workforce context.

2. WDES Indicator Overview (2025/2026):

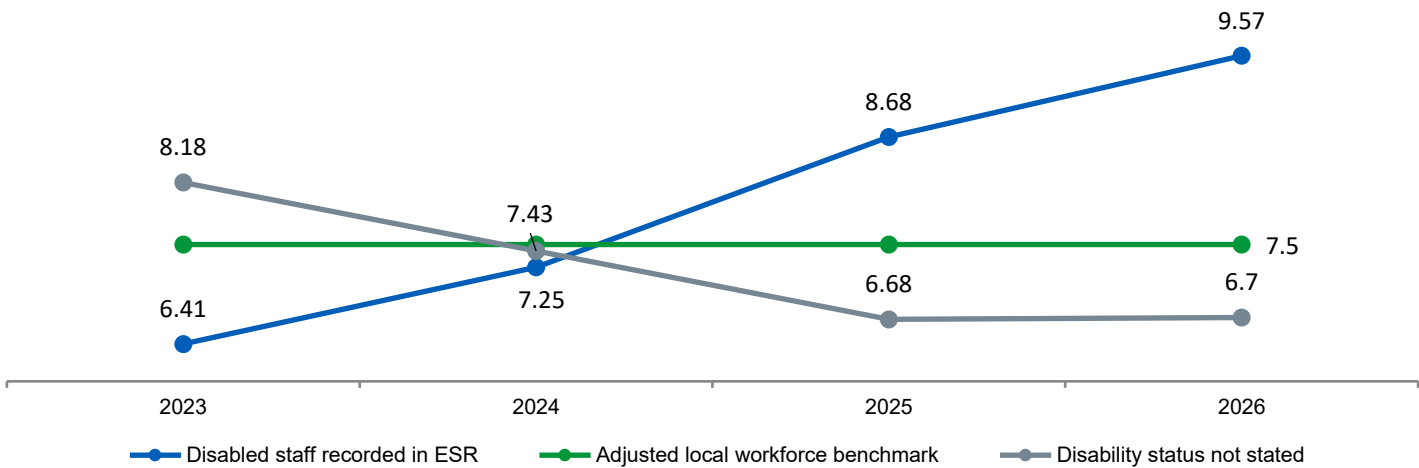
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No.	Indicator / metric	2025/26 position	Trend vs 2024/25	Board read
1	Workforce representation	9.6% overall; above 7.5% benchmark	Improving	Positive ●
2	Appointment from shortlisting	Non-disabled applicants 0.98× as likely; parity = 1.00	Improving	Positive ●
3	Capability process	1.30 from parity; 2.3× likelihood ratio	Deteriorating	Concern ●
4a–c	Harassment / bullying / abuse	Gaps from 5.2pp to 9.5pp	Mostly worse	Concern ●
4d	Reporting HBA incidents	3.9pp reporting gap	Deteriorating	Concern ●
5	Career progression perceptions	7.9pp experience gap	Worse	Watch ●
6	Pressure to work when unwell	3.2pp gap; lowest in 5 years	Improving	Positive ●
7	Feeling valued	8.6pp gap	Narrower but still high	Watch ●
8	Adequate adjustments	82.1% adequate	Slightly better	Positive ●
9	Staff engagement	0.51 score gap	Worse	Concern ●

3. Workforce Profile and Disability Data Quality

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The proportion of staff recorded as disabled within ESR has continued to increase year on year, rising from 6.4% in 2022/23 to 7.3% in 2023/24, 8.7% in 2024/25 and 9.6% in 2025/26.



The chart above shows a sustained increase in disability representation over the last four years. Representation now exceeds the Trust's local workforce benchmark of approximately 7.5%, which reflects the estimated economically active disabled population within Berkshire.

The reduction in unknown disability status suggests that disability disclosure and workforce data quality are improving.

Analysis of workforce records indicates that the increase in disability representation is not solely due to recruitment and retention. Of the 4,141 staff employed continuously between April 2024 and April 2026, 154 changed their recorded disability status during this period. This included 109 staff whose status changed from non-disabled to disabled and 44 staff whose status changed from not stated to disabled. These findings suggest that both improved disability disclosure and changes in the circumstances or reporting of existing staff have contributed to the increase, alongside workforce movement. The available data does not identify the specific reasons for these changes, which may include increased disclosure, improved recording practices, developing health conditions or changes in individual circumstances.

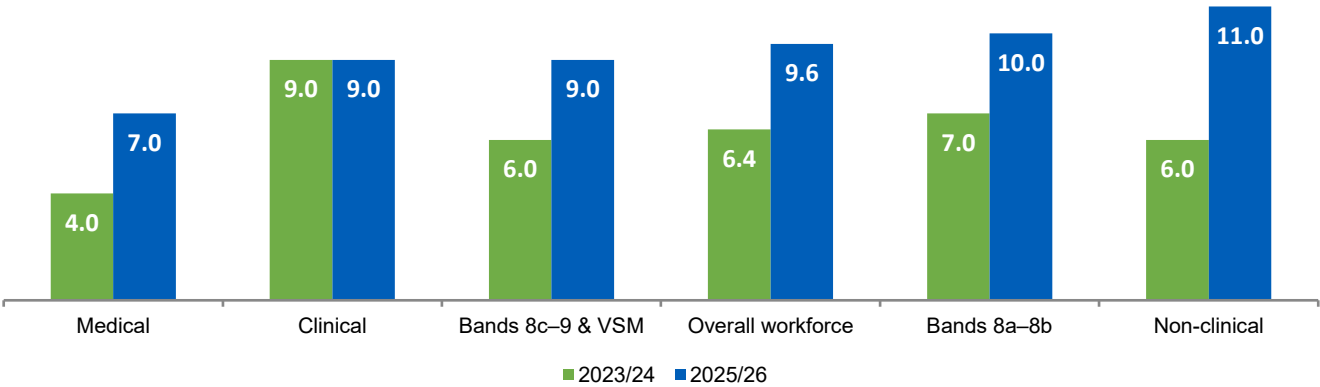
Despite this progress, data quality remains an important challenge.

At the time of the 2025 NHS Staff Survey, approximately 9.2% of the workforce was recorded within ESR as having a disability. In contrast, 27% of Staff Survey respondents identified as disabled. This suggests that disability remains under-recorded within workforce systems and means that direct comparisons between ESR and Staff Survey data should be treated with caution. Improving disability disclosure and recording will therefore remain important for future workforce analysis and will help ensure disabled colleagues are accurately reflected in workforce planning and improvement activity.

4. Workforce Representation and Progression

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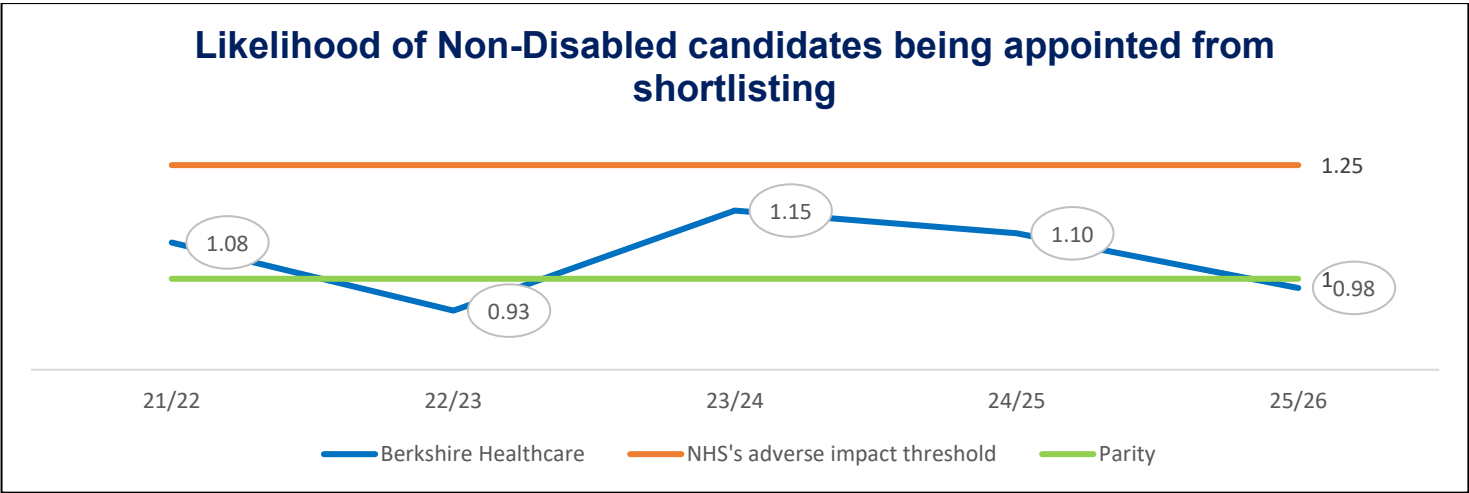
Indicator 1 – Workforce Representation



The chart above shows improvements in disability representation across multiple workforce groups. The largest increase was seen within the non-clinical workforce. Representation also increased within clinical services, medical staff and senior pay bands. Improvements were evident within both Bands 8a-8b and Bands 8c-VSM, suggesting that progress has not been limited to a single part of the organisation.

Overall, the data demonstrates continued progress in disability representation across the Trust. Whilst this is positive, representation alone does not guarantee an equitable workplace experience. The following sections therefore focus on whether disabled staff experience the organisation differently from their non-disabled colleagues.

Indicator 2 – Relative Likelihood of Appointment



The likelihood of a non-disabled applicant being appointed from shortlisting was 0.98. A score below 1.0 indicates that disabled applicants were slightly more likely to be appointed than non-disabled applicants following shortlisting. This is the second time in the last five years that disabled applicants have experienced a more favourable appointment outcome than non-disabled applicants and suggests that disability is not currently associated with poorer appointment outcomes following shortlisting. Additional analysis found that disabled applicants who attended interview were more likely to be appointed than non-disabled applicants. However, disabled applicants appeared less likely to attend interview once invited.

This suggests that, where barriers exist, they may be more likely to occur before interview rather than during final recruitment decisions.

Whilst the overall indicator is positive, analysis of recruitment to Band 8a and above roles found less favourable outcomes for disabled applicants. Although based on relatively small numbers, this is an area that may warrant monitoring in future years.

Career Progression

The Trust also undertook additional analysis of promotion outcomes.

During 2025/26, 7.2% of disabled staff received a promotion compared with 6.7% of non-disabled staff. This continues the pattern seen during the previous year.

At first glance, these findings appear inconsistent with Staff Survey results, which show that disabled staff are less likely to believe the organisation provides equal opportunities for career progression and promotion. However, promotion data does not currently show poorer progression outcomes for disabled staff.

This suggests that perceptions of career progression may be influenced by factors beyond promotion outcomes alone. These may include the visibility of opportunities, confidence in accessing career pathways and wider workplace experiences.

The NHS People Promise findings provide additional context. Disabled staff reported lower scores than non-disabled staff within the overall *We Are Always Learning* theme, with the largest difference relating to appraisal experience. This suggests that perceptions of career progression may be shaped not only by promotion outcomes, but also by the quality of appraisal conversations, access to development opportunities and confidence that development pathways work equally well for disabled staff.

5. Workforce Experience

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The headline finding from the Staff Survey is that disabled staff continue to report less positive workplace experiences than non-disabled staff across almost all comparable measures.

4 of approximately 100 comparable positive-scoring Staff Survey questions were more favourable for disabled staff.

Across approximately 100 comparable positive-scoring NHS Staff Survey questions, disabled staff reported more favourable outcomes than non-disabled staff on only four questions. Whilst this is not a WDES indicator, it provides important context and suggests that the experience gap extends well beyond the nationally mandated measures.

The NHS People Promise analysis provides further insight into where these differences are most pronounced. Disabled staff scored lower than non-disabled staff across every People Promise element and Staff Survey theme reviewed.

The largest differences were concentrated around:

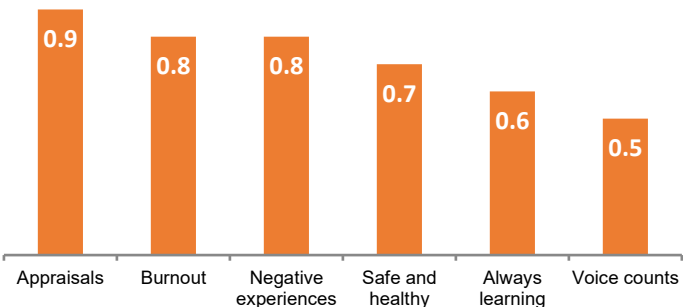
- wellbeing and workplace health;
- burnout and negative experiences;
- appraisal and development experience;
- raising concerns and organisational voice;
- involvement and influence.

These findings suggest that the less positive experiences reported by disabled staff are unlikely to be driven by isolated issues. Instead, a smaller number of interconnected factors may be influencing multiple aspects of working life.

High-level People Promise themes

● Safe and healthy	6.2 vs 6.9 (gap 0.7)
● Always learning	5.9 vs 6.6 (gap 0.7)
● Voice that counts	6.9 vs 7.5 (gap 0.6)
● Staff engagement	7.1 vs 7.6 (gap 0.5)

People Promise Score Gap Between Disabled and Non-Disabled Staff (2025 NHS Staff Survey)



Indicator 4 – Harassment, Bullying and Abuse

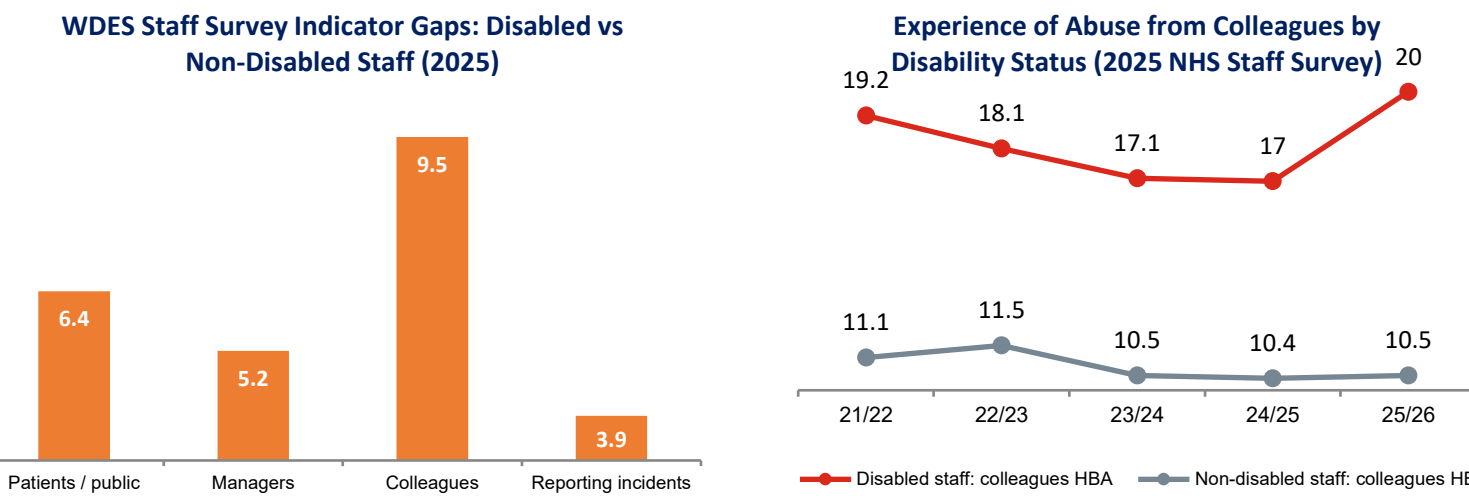
Disabled staff continued to report higher levels of harassment, bullying and abuse from all measured sources. This remains an important equality and workforce experience issue because of its potential impact on inclusion, wellbeing, psychological safety and retention.

The largest disparity related to harassment, bullying and abuse from colleagues. Disabled staff also reported less positive experiences relating to managers and members of the public.

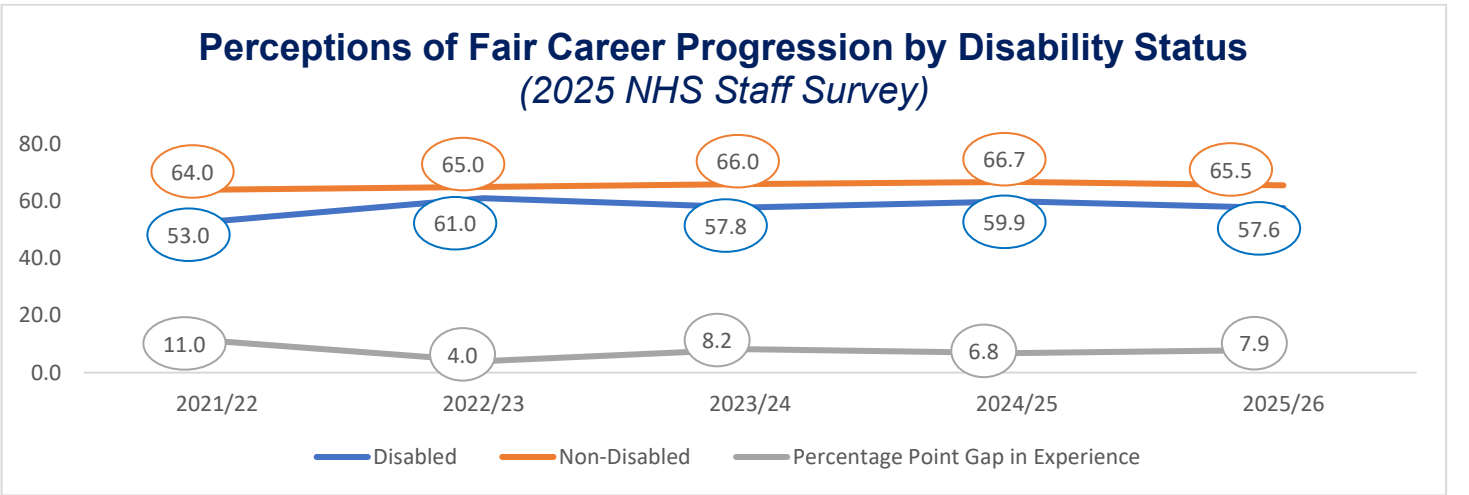
Of particular concern is the deterioration in reporting behaviour. Reporting rates amongst disabled staff declined whilst reporting rates amongst non-disabled staff improved, creating a new reporting gap.

The People Promise analysis provides additional context. Disabled staff reported lower scores relating to raising concerns and negative workplace experiences, suggesting that confidence in reporting concerns and organisational response may require further exploration.

Further analysis will be undertaken to understand whether these differences are associated with particular staff groups, service settings, clinical roles or organisational factors, enabling targeted action where required.



Indicator 5 – Career Progression Perceptions



Disabled staff were less likely than non-disabled staff to believe that the organisation provides equal opportunities for career progression and promotion. However, this finding should be considered alongside the Trust's recruitment and promotion data, which does not currently show poorer progression outcomes for disabled staff and has, in recent years, shown slightly more favourable recruitment and promotion outcomes.

The gap widened during 2025/26 despite disabled staff continuing to experience slightly more favourable promotion outcomes than non-disabled staff.

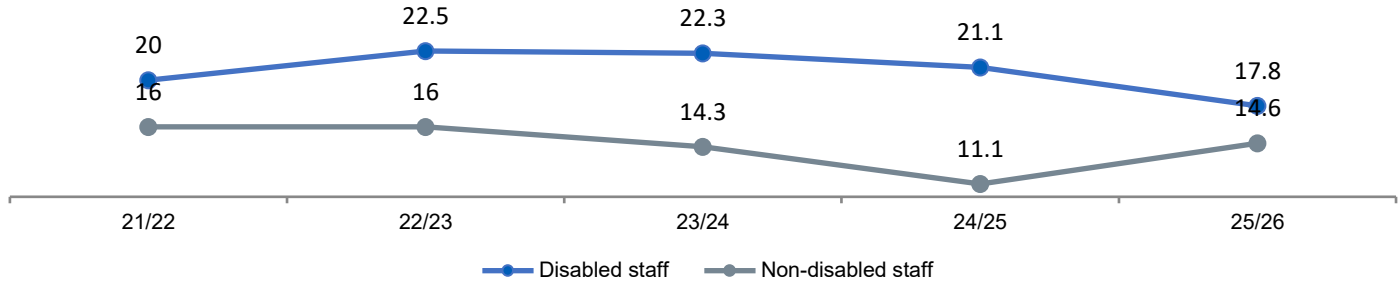
The People Promise findings provide additional context. Disabled staff scored substantially lower than non-disabled staff in appraisal experience, development opportunities and the overall *We Are Always Learning* theme.

This suggests that perceptions of career progression may be influenced by more than promotion outcomes alone. Factors such as appraisal quality, access to development opportunities and confidence in future career pathways may also play an important role.

The findings therefore suggest that the gap may reflect wider experiences relating to development and progression rather than promotion outcomes alone.

Indicator 6 – Pressure to Attend Work When Unwell

Pressure to Work When Unwell by Disability Status
(2021–2025 NHS Staff Survey)



This indicator represents one of the strongest improvements within the 2025/26 WDES submission.

The proportion of disabled staff reporting pressure to attend work when unwell reduced substantially and is now at its lowest level within the period analysed. At the same time, the equivalent score for non-disabled staff deteriorated, resulting in the smallest gap observed over the last five years.

However, this positive finding should be considered alongside wider Staff Survey evidence. Whilst the gap relating to pressure to attend work when unwell has narrowed, the two largest differences across 100 comparable Staff Survey questions both relate to wellbeing and health.

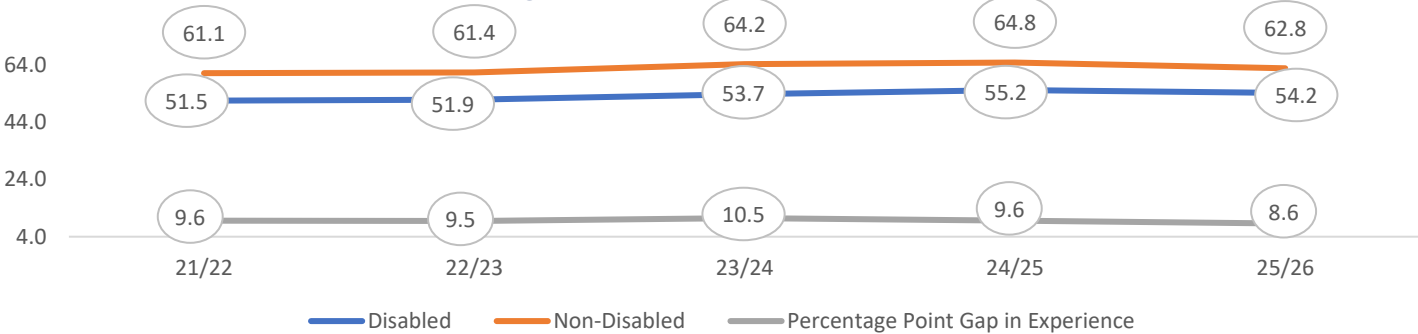
Only 36.6% of disabled staff reported that they had not attended work when not feeling well enough to perform their duties, compared with 57.4% of non-disabled staff, creating a 20.8 percentage point gap. Similarly, only 50.6% of disabled staff reported that they had not felt unwell due to work-related stress compared with 70.2% of non-disabled staff, creating a gap of 19.6 percentage points.

Taken together, these findings suggest that whilst disabled and non-disabled staff are becoming more similar in their experiences of feeling pressure to attend work when unwell, disabled staff remain substantially more likely to experience ill health and work-related stress in the first place. The challenge may therefore be less about pressure to attend work when unwell and more about understanding the factors contributing to the wider wellbeing disparities experienced by disabled staff.

This finding is consistent with the wider People Promise analysis, which identified wellbeing, burnout and negative workplace experiences as some of the largest areas of difference between disabled and non-disabled staff. Taken together, the evidence suggests that wellbeing remains one of the most significant areas of inequality within the Staff Survey and continues to warrant particular attention.

Indicator 7 – Feeling Valued

% of staff saying that they are satisfied with the extent to which the organisation values their work



Disabled staff remained less likely than non-disabled staff to feel that the organisation values their work. Although the gap narrowed slightly during 2025/26, this was largely driven by worsening scores amongst non-disabled staff rather than improvement amongst disabled staff.

Importantly, this is not the largest area of difference within the Staff Survey. Thirty-seven other comparable questions demonstrated larger gaps between disabled and non-disabled staff.

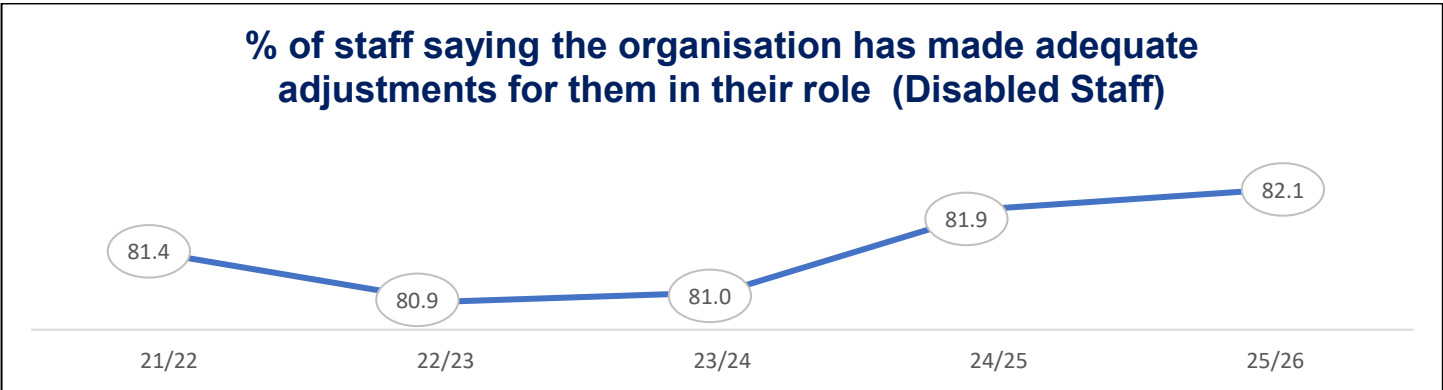
The largest differences continue to relate to wellbeing, stress, exhaustion, workplace health and confidence in organisational support.

The People Promise findings provide additional context. Disabled staff scored lower across every People Promise element reviewed, with the largest differences relating to wellbeing, burnout, development, appraisals and staff voice.

This suggests that feeling valued may not be an isolated issue, but instead reflects wider experiences relating to support, development, wellbeing and organisational responsiveness.

Whilst recognition remains important, the findings suggest that addressing wider issues relating to wellbeing, inclusion, development and staff voice is likely to be necessary to fully close the gap.

Indicator 8 – Adequate Adjustments



The proportion of disabled staff reporting that reasonable adjustments had been adequately implemented increased slightly to 82.1%.

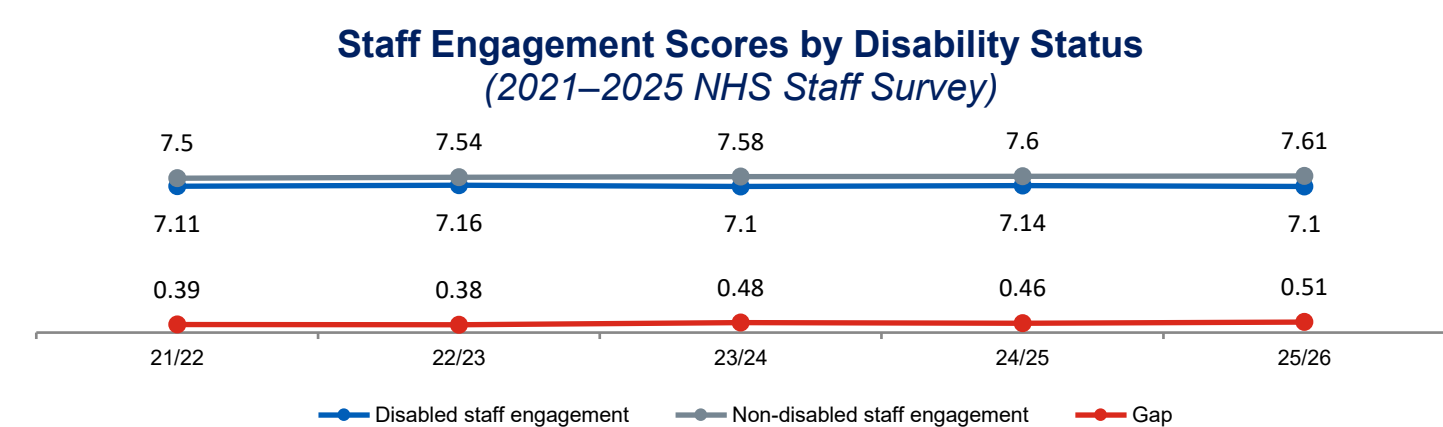
Whilst this represents a positive result, almost one in five disabled staff requiring a reasonable adjustment still reported that their needs had not been fully met.

The Staff Survey identified 565 staff who reported requiring a reasonable adjustment. However, only 55 staff used the Trust's formal reasonable adjustment process during the reporting period. This may reflect non-disclosure, support being managed informally, or differences in how adjustment needs are identified and recorded.

Given the role reasonable adjustments play in reducing workplace barriers, improving the Trust's understanding of adjustment needs, requests and outcomes may provide an important opportunity to improve staff experience.

Further consideration of this issue is explored within the cross-cutting analysis section of this report.

Indicator 9 – Staff Engagement



The engagement gap widened during 2025/26, with engagement amongst non-disabled staff increasing slightly whilst engagement amongst disabled staff reduced slightly.

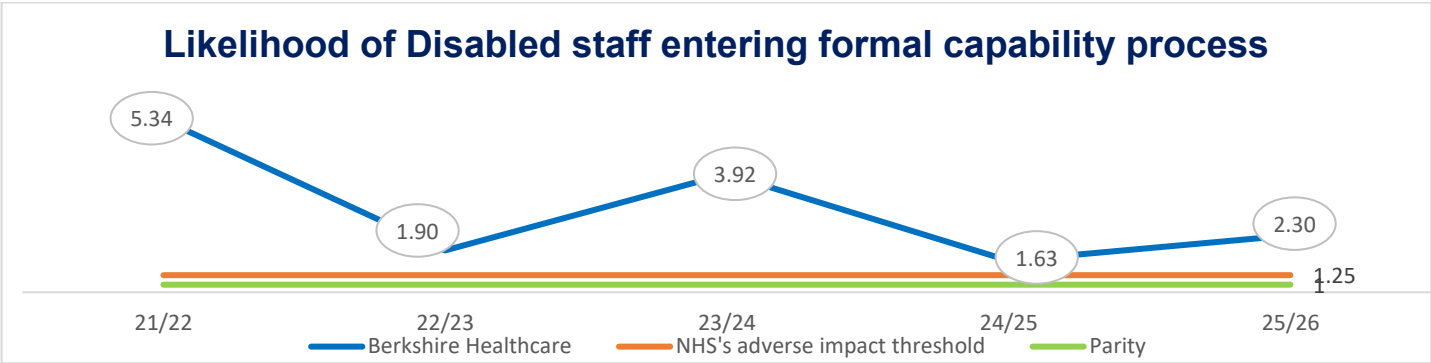
Further analysis found that disabled staff scored lower than non-disabled staff across every component of the engagement score. The largest difference related to feeling able to make improvements happen within the workplace.

The People Promise analysis supports this finding. Disabled staff scored lower than non-disabled staff within both the Staff Engagement theme and the *We Each Have a Voice That Counts* People Promise element, particularly in relation to involvement and raising concerns.

These findings suggest that disabled staff may experience lower levels of influence, involvement and organisational voice than non-disabled colleagues.

6. Capability Processes

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Indicator 3 remains an important assurance issue within the WDES submission.

Disabled staff were 2.3 times more likely than non-disabled staff to enter the formal capability process during 2025/26, compared with 1.63 in the previous year. On the surface, this appears to be one of the more significant disparities within the WDES.

However, the indicator is based on very small numbers. Over the two-year reporting period used for this measure, 5 disabled staff entered the formal capability process, compared with 19 non-disabled staff. Whilst the relative likelihood ratio is high, the actual number of disabled staff involved is small.

It is also important to understand how the indicator is calculated. WDES uses a rolling two-year reporting period, meaning that some cases included in this year's submission had already contributed to the previous year's result. Of the five disabled staff included in the current calculation, three had already been included in the previous year's submission. Only two new cases were added within the newly included reporting period. This demonstrates how small changes in case numbers can have a substantial impact on the reported indicator.

Had approximately two fewer disabled staff entered the formal capability process, the indicator would have been close to parity. The current score should therefore be interpreted with caution and alongside a review of individual cases rather than the headline ratio alone.

This does not rule out the possibility of bias, discrimination, inconsistent policy application or other organisational factors. However, the available data is not sufficient to draw firm conclusions about the reasons behind the difference.

The most appropriate next step is therefore a targeted case-level review. This should consider whether the small number of cases share any common characteristics, including service area, staff group, role type, disability-related adjustment needs, absence or performance context, management decision points and final outcomes. It should also consider whether appropriate workplace adjustments and support arrangements were explored and implemented before progression into formal processes.

This report therefore identifies capability processes as an area for targeted review during 2026/27. Whilst conclusions should be drawn cautiously due to the small number of cases involved, the Trust recognises the importance of reviewing all available evidence to ensure disabled staff are not experiencing disadvantage within formal employment processes.

7. Board Representation

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Board voting member representation remains slightly below overall workforce representation.

However, the number of Board voting positions is small, meaning that a single appointment can have a significant impact on the overall position. Year-to-year changes should therefore be interpreted with caution.

Whilst disabled staff remain slightly underrepresented at Board level, the difference is small and should be considered in the context of the limited number of positions available.

8. Cross-Cutting Analysis: What May Explain the Wider Experience Gap? [Contents page](#)

One of the most significant findings in this report is that disabled staff report less positive experiences than non-disabled staff across almost all comparable Staff Survey measures.

The NHS People Promise analysis suggests that these differences are not evenly distributed across organisational life. The largest gaps were concentrated around:

- wellbeing, health and burnout;
- negative workplace experiences;
- development and appraisal experience;
- voice, involvement and confidence in raising concerns.

This suggests that the wider experience gap is unlikely to be driven by dozens of unrelated issues. Instead, a smaller number of underlying factors may be influencing multiple aspects of working life at the same time.

No single factor is likely to fully explain the differences identified in this report. Workplace experience is influenced by organisational, managerial and individual factors, and disabled staff are not a single homogenous group. Nonetheless, one area appears particularly important: reasonable adjustments.

Reasonable adjustments are one of the most direct ways of reducing workplace barriers associated with disability. Where appropriate adjustments are not made, disabled staff may continue to experience barriers affecting wellbeing, development opportunities, workplace relationships and overall workplace experience.

The Staff Survey identified 565 staff who reported requiring a reasonable adjustment. However, only 55 staff used the Trust's formal reasonable adjustment process during the reporting period. Whilst many adjustments may be agreed informally, this means that most adjustment activity sits outside formal reporting arrangements. The significant difference between disability disclosure in ESR (9.2%) and the Staff Survey (27%) also suggests that not all disability-related support needs are formally disclosed, recorded or managed through formal adjustment processes.

As a result, the Trust does not currently know:

- whether disabilities have been formally disclosed;
- whether adjustments have been requested;
- whether adjustments have been implemented;
- whether delays or barriers have occurred;
- whether experiences differ between staff groups or services.

Discussions with the Equality, Diversity and Inclusion Team highlighted that the Trust does not currently have a complete picture of reasonable adjustment activity. Formal requests can be influenced by factors such as procurement processes, IT system compatibility and delays to external support, including Access to Work assessments. Some support may also be agreed and managed informally without entering the formal process.

This means that it is difficult to determine how much reasonable adjustments contribute to the wider staff experience differences identified in this report. Future analysis could usefully explore whether adjustment requests are linked to events such as joining the Trust, changing role, newly disclosing a disability or changes in individual need.

Whilst the available evidence does not demonstrate a direct causal relationship, reasonable adjustments remain one of the clearest organisational factors capable of influencing a wide range of workplace experiences. Improving understanding, oversight and organisational learning in this area may therefore provide an opportunity to improve disabled staff experience across multiple domains.

9. Conclusions [Contents page](#)

The Trust has continued to make positive progress in disability representation and maintains favourable workforce outcomes in several important areas.

Disability representation has continued to improve, whilst disabled applicants continue to experience favourable recruitment outcomes and slightly higher promotion rates than non-disabled staff.

However, significant experience gaps remain.

Disabled staff continue to report less positive experiences across a wide range of Staff Survey measures, particularly in relation to wellbeing, negative workplace experiences, appraisal and development experience, and staff voice. These findings

suggest that the principal challenge facing the organisation is no longer representation, recruitment or promotion, but ensuring that disabled staff experience the same levels of inclusion, wellbeing, opportunity and organisational support as non-disabled colleagues.

The report identifies several areas for further improvement and investigation.

Disabled staff continue to report higher levels of harassment, bullying and abuse than non-disabled staff, particularly in relation to colleagues. Reporting rates amongst disabled staff have also deteriorated, indicating a need to better understand both confidence in reporting and perceptions of organisational response.

The formal capability process also remains an important assurance issue. Although disabled staff were more likely than non-disabled staff to enter the process, the indicator is based on a small number of cases and should therefore be interpreted with caution. The most appropriate next step is a targeted case-level review rather than broad conclusions regarding systemic inequity.

The analysis also highlights the importance of reasonable adjustments. Whilst most disabled staff report that appropriate adjustments have been made, the Trust currently has limited information about many adjustment requests and outcomes. Improving understanding and oversight in this area may help the organisation better understand and address some of the wider experience gaps identified throughout this report.

It is also important to recognise the progress made in recent years, including the introduction of the Inclusion Passport, strengthened neuroinclusion support, improvements to reasonable adjustment guidance and processes, and the continued contribution of the Purple Network in promoting disability inclusion across the Trust.

Overall, the evidence suggests that future improvement activity should focus on:

- improving disability disclosure and data quality;
- undertaking a targeted review of capability cases involving disabled staff;
- strengthening understanding of harassment, bullying and negative workplace experiences;
- improving understanding and oversight of reasonable adjustment requests and outcomes;
- improving appraisal and development experiences for disabled staff;
- strengthening staff confidence in raising concerns and organisational response;
- understanding the relationship between disability, wellbeing, burnout and workplace experience;
- ensuring improvements in representation translate into improvements in lived experience.

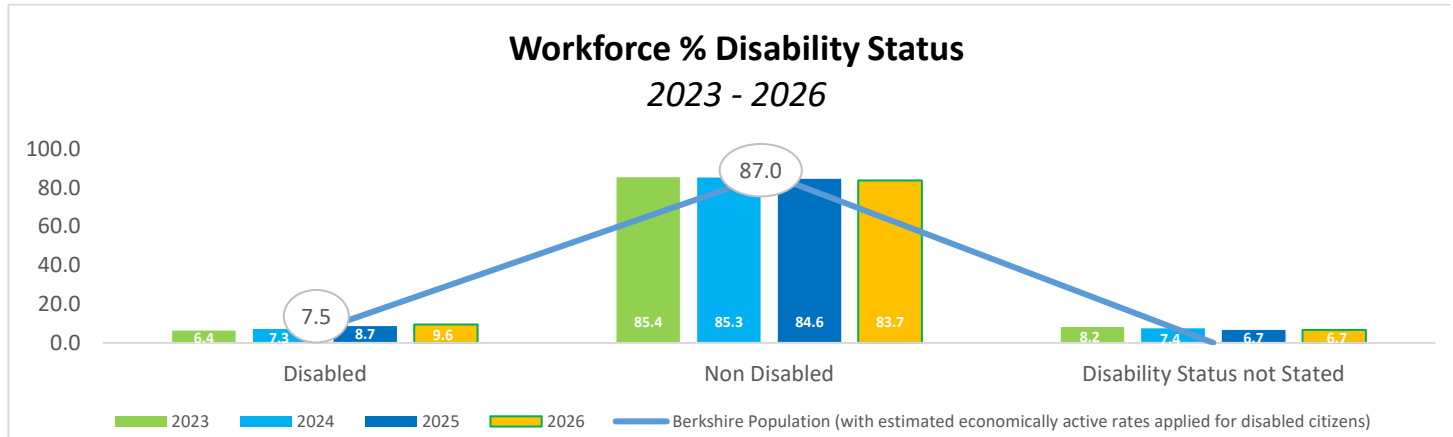
The Trust is committed to creating an environment where disabled staff feel valued, included, supported and able to achieve their full potential. The findings within this report will inform future improvement activity aimed at reducing experience gaps, strengthening inclusion and ensuring disabled staff can thrive throughout their careers.

Appendices:

Workforce Profile:

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BHFT Workforce compared to Berkshire Population (from census data, 2021)



BHFT workforce Disability Status % compared to Berkshire population (Census 2021)

Group	2023	2024	2025	2026	Berkshire Population (with estimated economically active rates applied for disabled citizens)
Disabled	6.4	7.3	8.7	9.6	7.5
Non-Disabled	85.4	85.3	84.6	83.7	87.0
Disability Status not Stated	8.2	7.4	6.7	6.7	0.0

Headcount of staff by Disability status 2023 - 2026 (plus year-on-year change)

	Disabled	Non-Disabled	Disability Status not Disclosed
2023	318	4237	406
2024	378 (+60)	4447 (+210)	387 (-19)
2025	477 (+99)	4652 (+205)	367 (-20)
2026	518 (+41)	4534 (-118)	363 (-4)

Working Patterns by Disability Status (Average FTE and Full-time / Part-time Split)

Disability Status	Average FTE	% Full-time	% Part-time
Disabled	0.9	69	31
Non-Disabled	0.88	64	36
Disability Status Not stated	0.84	56	44
Total	0.89	64	36

Average age by Disability Status

	Disabled	Not Disabled
Average age of workforce	43 years and 10 months	44 years and 10 months

Understanding which staff have changed disability Status

	Disabled
April 26 staff	5412
April 26 staff who were working for trust in April 24	4141
Number of staff from above who changed disability status in that time	154
% of staff who changed disability status in that time	3.71%

ESR reported Disability vs Staff Survey Reported Disability

	Disabled
October 25 staff (total headcount)	5429
October 25 staff recorded as having a disability	500
% of October 25 staff recorded with a disability	9.2
October 25 staff recorded with no disability status	393
2025 staff surveys completed	3351
2025 staff survey eligible sample	5406
2025 staff surveys completed who stated they had a disability	904

WDES Indicators:

- Percentage of staff in each of the Agenda for Change (AfC) Bands 1-9 and Very Senior Manager (VSM) roles (including executive board members) compared with the percentage of staff in the overall workforce

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Non-Clinical Workforce (Disability Status Representation)

Pay Band	2024 Non-Clinical Workforce Data				2025 Non-Clinical Workforce Data				2026 Non-Clinical Workforce Data			
	Total Staff	Disabled	Non-Disabled	Not stated	Total Staff	Disabled	Non-Disabled	Not stated	Total Staff	Disabled	Non-Disabled	Not stated
Under Band 1	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)
Band 1	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)
Band 2	65	3 (5%)	55 (85%)	7 (11%)	53	5 (9%)	43 (81%)	5 (9%)	44	4 (9%)	34 (77%)	6 (14%)
Band 3	298	15 (5%)	272 (91%)	11 (4%)	309	24 (8%)	274 (89%)	11 (4%)	285	27 (9%)	251 (88%)	7 (2%)
Band 4	305	19 (6%)	259 (85%)	27 (9%)	316	30 (10%)	262 (83%)	24 (8%)	313	35 (11%)	256 (82%)	22 (7%)
Band 5	153	12 (8%)	130 (85%)	11 (7%)	150	15 (10%)	125 (83%)	10 (7%)	154	17 (11%)	129 (84%)	8 (5%)
Band 6	163	9 (6%)	149 (91%)	5 (3%)	162	14 (9%)	142 (88%)	6 (4%)	156	15 (10%)	136 (87%)	5 (3%)
Band 7	126	8 (6%)	111 (88%)	7 (6%)	130	10 (8%)	114 (88%)	6 (5%)	127	8 (6%)	113 (89%)	6 (5%)
Band 8a	95	6 (6%)	83 (87%)	6 (6%)	106	9 (9%)	92 (87%)	5 (5%)	115	15 (13%)	95 (83%)	5 (4%)
Band 8b	55	8 (15%)	45 (82%)	2 (4%)	69	12 (17%)	55 (80%)	2 (3%)	61	10 (16%)	49 (80%)	2 (3%)
Band 8c	35	0 (0%)	27 (77%)	8 (23%)	38	2 (5%)	29 (76%)	7 (18%)	40	4 (10%)	29 (73%)	7 (18%)
Band 8d	15	1 (7%)	12 (80%)	2 (13%)	16	1 (6%)	14 (88%)	1 (6%)	16	1 (6%)	14 (88%)	1 (6%)
Band 9	4	0 (0%)	3 (75%)	1 (25%)	9	2 (22%)	6 (67%)	1 (11%)	6	2 (33%)	3 (50%)	1 (17%)
VSM	8	1 (13%)	5 (63%)	2 (25%)	8	1 (13%)	6 (75%)	1 (13%)	8	1 (13%)	6 (75%)	1 (13%)
Total	1322	82 (6%)	1151 (87%)	89 (7%)	1366	125 (9%)	1162 (85%)	79 (6%)	1325	139 (11%)	1115 (84%)	71 (5%)

Clinical Workforce (Disability Status Representation)

Pay Band	2024 Clinical Workforce Data				2025 Clinical Workforce Data				2026 Non-Clinical Workforce Data			
	Total Staff	Disabled	Non-Disabled	Not stated	Total Staff	Disabled	Non-Disabled	Not stated	Total Staff	Disabled	Non-Disabled	Not stated
Under Band 1	7	1	6	0 (0%)	13	3 (23%)	10 (77%)	0 (0%)	4	0 (0%)	4 (100%)	0 (0%)
Band 1	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)
Band 2	183	8 (4%)	164 (90%)	11 (6%)	56	3 (5%)	50 (89%)	3 (5%)	29	4 (14%)	24 (83%)	1 (3%)
Band 3	354	8 (2%)	324 (92%)	22 (6%)	505	10 (2%)	471 (93%)	24 (5%)	505	11 (2%)	471 (93%)	23 (5%)
Band 4	515	54 (11%)	439 (85%)	22 (4%)	546	72 (13%)	452 (83%)	22 (4%)	486	66 (14%)	397 (82%)	23 (5%)
Band 5	500	39 (8%)	436 (87%)	25 (5%)	542	53 (10%)	466 (86%)	23 (4%)	581	59 (10%)	478 (82%)	44 (8%)
Band 6	784	79 (10%)	664 (85%)	41 (5%)	832	76 (9%)	715 (86%)	41 (5%)	825	78 (9%)	708 (86%)	39 (5%)

Band 7	869	71 (8%)	748 (86%)	50 (6%)	929	91 (10%)	787 (85%)	51 (6%)	954	109 (11%)	796 (83%)	49 (5%)
Band 8a	296	18 (6%)	267 (90%)	11 (4%)	319	24 (8%)	286 (90%)	9 (3%)	326	28 (9%)	290 (89%)	8 (2%)
Band 8b	113	5 (4%)	104 (92%)	4 (4%)	112	5 (5%)	103 (92%)	4 (4%)	112	6 (5%)	103 (92%)	3 (3%)
Band 8c	35	1 (3%)	33 (94%)	1 (3%)	32	0 (0%)	31 (97%)	1 (3%)	29	1 (3%)	27 (93%)	1 (3%)
Band 8d	20	2 (10%)	17 (85%)	1 (5%)	16	2 (13%)	13 (81%)	1 (6%)	19	2 (11%)	16 (84%)	1 (5%)
Band 9	6	2 (33%)	3 (50%)	1 (17%)	3	0 (0%)	2 (67%)	1 (33%)	4	0 (0%)	3 (75%)	1 (25%)
VSM	1	0 (0%)	1 (100%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)
Total	3683	288 (8%)	3206 (87%)	189 (5%)	3905	339 (9%)	3386 (87%)	180 (5%)	3874	364 (9%)	3317 (86%)	193 (5%)

Medical and Dental Workforce

(Disability Status Representation)

Pay Band	2024 Clinical (Medical & Dental) Workforce				2025 Clinical (Medical & Dental) Workforce				2026 Clinical (Medical & Dental) Workforce			
	Total Staff	Disabled	Non-Disabled	Not stated	Total Staff	Disabled	Non-Disabled	Not stated	Total Staff	Disabled	Non-Disabled	Not stated
Consultants	91	4 (4%)	47 (52%)	40 (44%)	101	6 (6%)	53 (53%)	42 (42%)	98	8 (8%)	53 (54%)	37 (38%)
Non-consultant Career Grade	81	3 (4%)	42 (52%)	36 (44%)	84	4 (5%)	44 (52%)	36 (43%)	80	6 (8%)	45 (56%)	29 (36%)
Trainee Grade	35	1 (3%)	1 (3%)	33 (94%)	40	3 (8%)	7 (18%)	30 (75%)	38	1 (3%)	4 (11%)	33 (87%)
Total	207	8 (4%)	90 (44%)	109 (53%)	225	13 (6%)	104 (46%)	108 (48%)	216	15 (7%)	102 (47%)	99 (46%)

Entire Workforce

(Disability Status Representation)

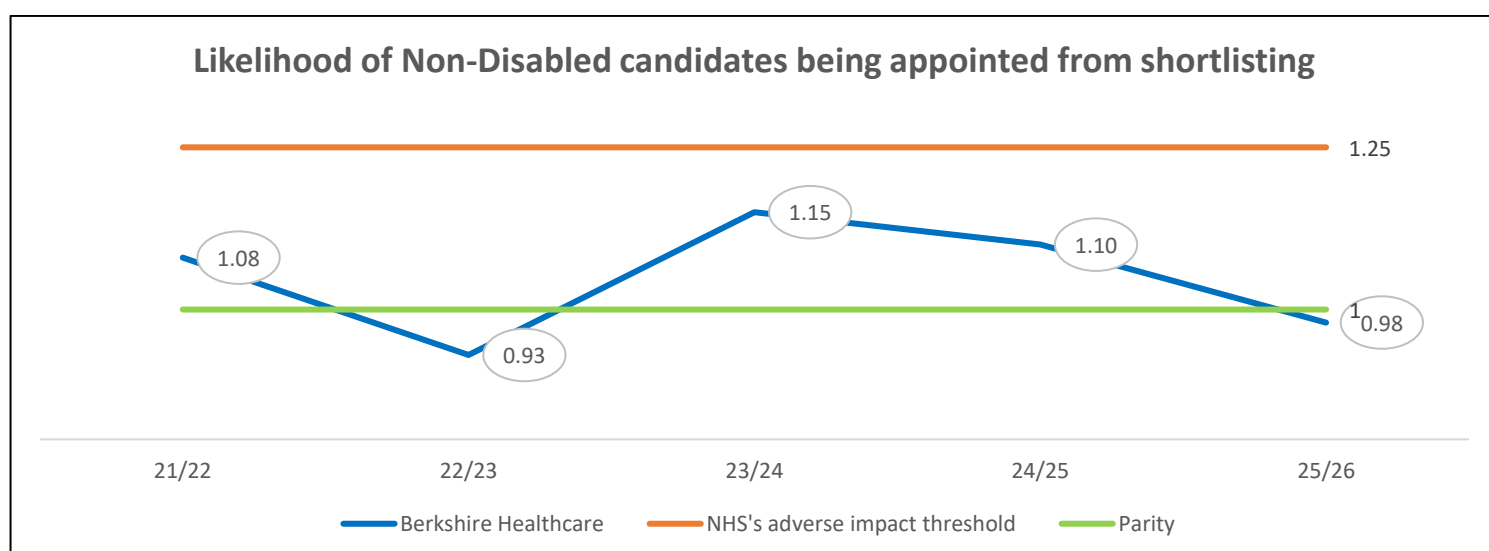
Pay Band	2024 All Staff Workforce Data				2025 All Staff Workforce Data				2026 All Staff Workforce Data			
	Total Staff	Disabl ed	Non-Disabl ed	Not stated	Total Staff	Disabl e d	Non-Disable d	Not stated	Total Staff	Disabled	Non-Disabled	Not stated
Under Band 1	7	1 (14%)	6 (86%)	0 (0%)	13	3 (23%)	10 (77%)	0 (0%)	4	0 (0%)	4 (100%)	0 (0%)
Band 1	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)
Band 2	248	11 (4%)	219 (88%)	18 (7%)	109	8 (7%)	93 (85%)	8 (7%)	73	8 (11%)	58 (79%)	7 (10%)
Band 3	652	23 (4%)	596 (91%)	33 (5%)	814	34 (4%)	745 (92%)	35 (4%)	790	38 (5%)	722 (91%)	30 (4%)
Band 4	820	73 (9%)	698 (85%)	49 (6%)	862	102 (12%)	714 (83%)	46 (5%)	799	101 (13%)	653 (82%)	45 (6%)
Band 5	653	51 (8%)	566 (87%)	36 (6%)	692	68 (10%)	591 (85%)	33 (5%)	735	76 (10%)	607 (83%)	52 (7%)
Band 6	947	88 (9%)	813 (86%)	46 (5%)	994	90 (9%)	857 (86%)	47 (5%)	981	93 (9%)	844 (86%)	44 (4%)
Band 7	995	79 (8%)	859 (86%)	57 (6%)	1059	101 (10%)	901 (85%)	57 (5%)	1081	117 (11%)	909 (84%)	55 (5%)
Band 8a	391	24 (6%)	350 (90%)	17 (4%)	425	33 (8%)	378 (89%)	14 (3%)	441	43 (10%)	385 (87%)	13 (3%)
Band 8b	168	13 (8%)	149 (89%)	6 (4%)	181	17 (9%)	158 (87%)	6 (3%)	173	16 (9%)	152 (88%)	5 (3%)
Band 8c	70	1 (1%)	60 (86%)	9 (13%)	70	2 (3%)	60 (86%)	8 (11%)	69	5 (7%)	56 (81%)	8 (12%)
Band 8d	35	3 (9%)	29 (83%)	3 (9%)	32	3 (9%)	27 (84%)	2 (6%)	35	3 (9%)	30 (86%)	2 (6%)
Band 9	10	2 (20%)	6 (60%)	2 (20%)	12	2 (17%)	8 (67%)	2 (17%)	10	2 (20%)	6 (60%)	2 (20%)
VSM	9	1 (11%)	6 (67%)	2 (22%)	8	1 (13%)	6 (75%)	1 (13%)	8	1 (13%)	6 (75%)	1 (13%)
Consultants	91	4 (4%)	47 (52%)	40 (44%)	101	6 (6%)	53 (53%)	42 (42%)	98	8 (8%)	53 (54%)	37 (38%)
Non-consultant Career Grade	81	3 (4%)	42 (52%)	36 (44%)	84	4 (5%)	44 (52%)	36 (43%)	80	6 (8%)	45 (56%)	29 (36%)
Trainee Grade	35	1 (3%)	1 (3%)	33 (94%)	40	3 (8%)	7 (18%)	30 (75%)	38	1 (3%)	4 (11%)	33 (87%)

Bands 1-4	1727	108 (6%)	1519 (88%)	100 (6%)	1798	147 (8%)	1562 (87%)	89 (5%)	1662	147 (9%)	1433 (86%)	82 (5%)
Bands 5-7	2595	218 (8%)	2238 (86%)	139 (5%)	2745	259 (9%)	2349 (86%)	137 (5%)	2797	286 (10%)	2360 (84%)	151 (5%)
Bands 8a-8b	559	37 (7%)	499 (89%)	23 (4%)	606	50 (8%)	536 (89%)	20 (3%)	614	59 (10%)	537 (87%)	18 (3%)
Bands 8c-9 & VSM	124	7 (6%)	101 (82%)	16 (13%)	122	8 (7%)	101 (83%)	13 (11%)	122	11 (9%)	98 (80%)	13 (11%)
Total	5212	378 (7%)	4447 (85%)	387 (7%)	5496	477 (9%)	4652 (85%)	367 (7%)	5415	518 (10%)	4534 (84%)	363 (7%)

2. Relative likelihood of staff being appointed from shortlisting

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Likelihood of Non-Disabled candidates being appointed from shortlisting	21/22	22/23	23/24	24/25	25/26	Change (24/25 → 25/26)	Direction
Berkshire Healthcare	1.08	0.93	1.15	1.10	0.98	-0.12	Improving
NHS Trusts (National)	1.09	0.99	0.98	0.95	–	–	–



Recruitment Outcomes by Disability Status (All Applicants) of those who attended interview (rather than just invited to interview)

Recruitment stage	Disabled	Non-Disabled
Applications shortlisted	1,253	18,706
Offered interview	335	2,629
% of shortlisted offered interview	26.7%	14.1%
Attended interview	233	1,974
% of interviews attended	69.6%	75.1%
Offered job	103	797
% offered job (of those interviewed)	44.2%	40.4%

Likelihood to be appointed	1.09	0.91
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Recruitment Outcomes by Disability Status (Internal Applicants Only)

Recruitment stage	Disabled	Non-Disabled
Applications shortlisted	161	1,335
Offered interview	74	575
% of shortlisted offered interview	46.0%	43.1%
Attended interview	66	498
% of interviews attended	89.2%	86.6%
Offered job	46	332
% offered job (of those interviewed)	69.7%	66.7%
Likelihood to be appointed	1.04	0.96

Recruitment Outcomes by Disability Status (Band 8a to 9 only)

Recruitment stage	Disabled	Non-Disabled
Applications shortlisted	98	739
Offered interview	32	181
% of shortlisted offered interview	32.70%	24.50%
Attended interview	27	151
% of interviews attended	84.40%	83.40%
Offered job	10	64
% offered job (of those interviewed)	37.00%	42.40%
Likelihood to be appointed	0.87	1.15

External Hires by Band and Disability Status (Headcount)

Row Labels	Disabled	No Disability	Not stated	Grand Total
Band 2	1	10	1	12
Band 3	7	70	7	84
Band 4	13	82	10	105
Band 5	7	104	8	119
Band 6	13	69	3	85
Band 7	8	64	5	77
Band 8a	1	12	3	16
Band 8b		9	1	10
Band 8c	1	3	0	4
Band 8d				
Band 9				
Non-Agenda for change	3	17	69	89
Agenda for change only	51	423	38	512
Grand Total	54	440	107	601

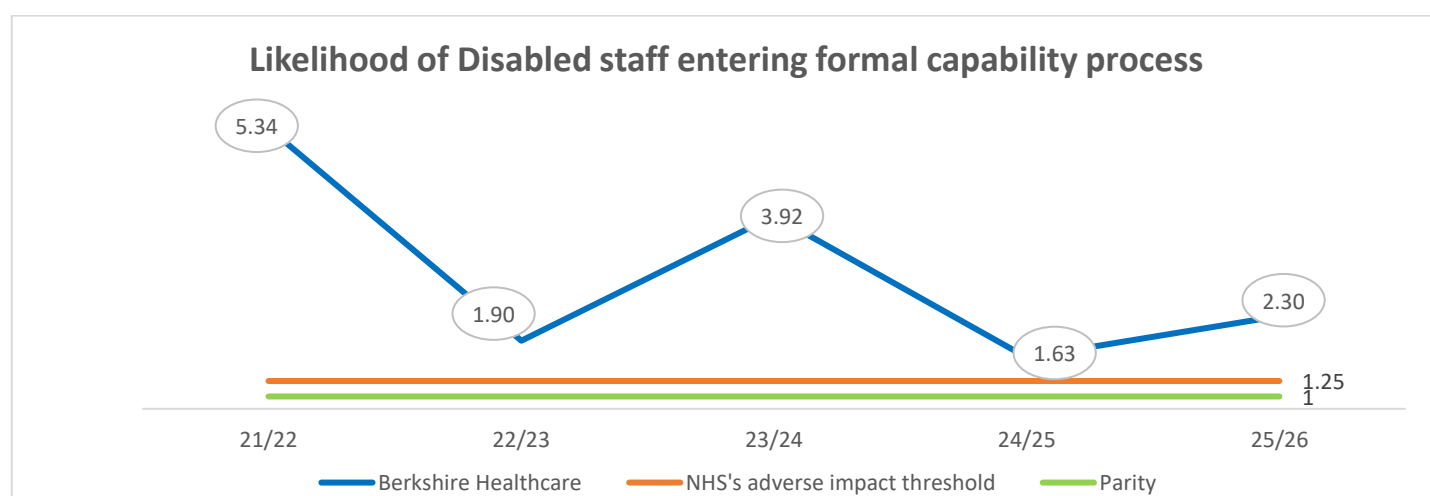
Disability Status Composition of External Hires by Pay Band

Pay band	Total hires (n)	% Disabled Hires	% No Disability Hires	% Disability Status Not Stated Hires
Band 2	12	8	83	8
Band 3	84	8	83	8
Band 4	105	12	78	10
Band 5	119	6	87	7
Band 6	85	15	81	4
Band 7	77	10	83	6
Band 8a	16	6	75	19
Band 8b	10	0	90	10
Band 8c	4	25	75	0
Band 8c	0	0	0	0
Band 9	0	0	0	0
Non-Agenda for change	89	3	19	78
Agenda for change only	512	10	83	7
Total	601	9	73	18

3. Relative likelihood of staff entering the formal capability process

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WDES Indicator 3: Likelihood of Disabled staff entering formal capability process	21/22	22/23	23/24	24/25	25/26	Change (24/25 → 25/26)	Direction
Berkshire Healthcare	5.34	1.90	3.92	1.63	2.30	+0.67	Worsening
NHS Trusts (National)	2.01	2.17	2.04	2.26	–	–	–



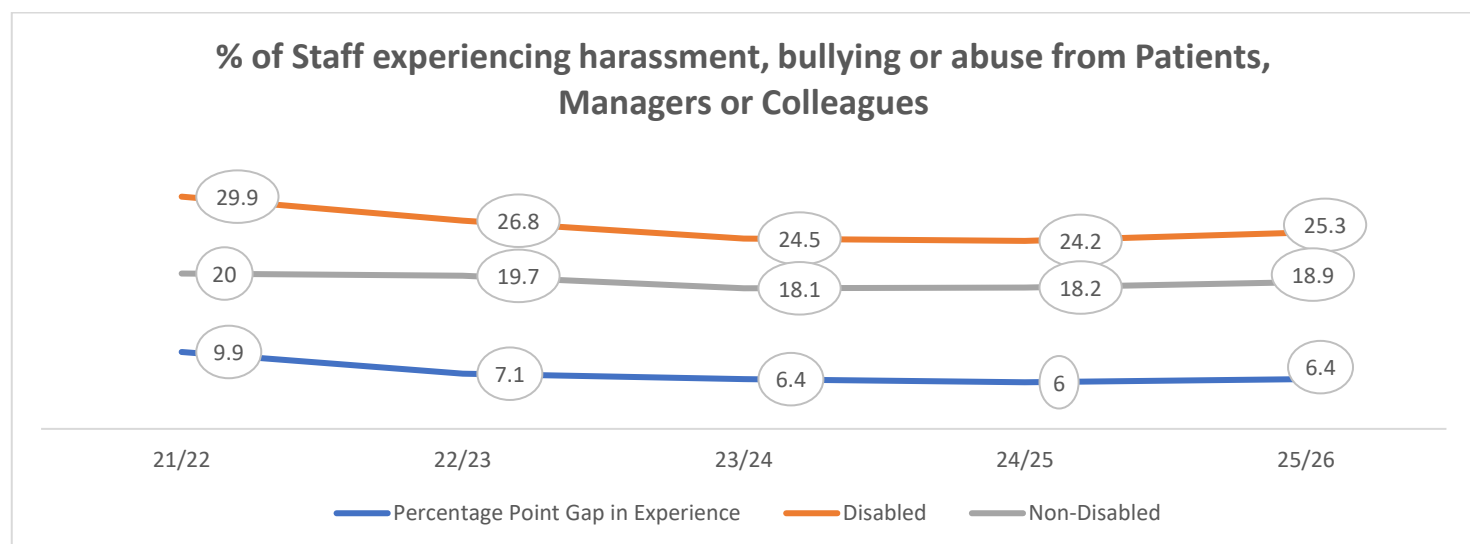
Measure	Disabled staff	Non-disabled staff	Relative likelihood
Staff in post used for indicator	518	4534	-

Actual number entering formal capability process over previous 2 years	5	19	2.30
Actual rate entering formal capability process	0.97%	0.42%	2.30
Scenario 1: if 2 disabled staff entered the process	2	19	0.92
Scenario 2: if 3 disabled staff entered the process	3	19	1.38
Estimated parity point	approximately 2 to 3 disabled staff	19	approximately 1.00

4a. Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patients, service users, relatives or the public in the last 12 months.

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WDES Indicator 4a: Difference in staff experiencing harassment, bullying or abuse from patients, service users, relatives or the public in the last 12 months. (percentage point gap)	21/22	22/23	23/24	24/25	25/26	Change (24/25 → 25/26)	Direction
Berkshire Healthcare (gap)	9.9	7.1	6.4	6	6.4	+0.4pp	Worsening
NHS Trusts (gap)	7.2	7.2	6.7	6.2	–	–	–

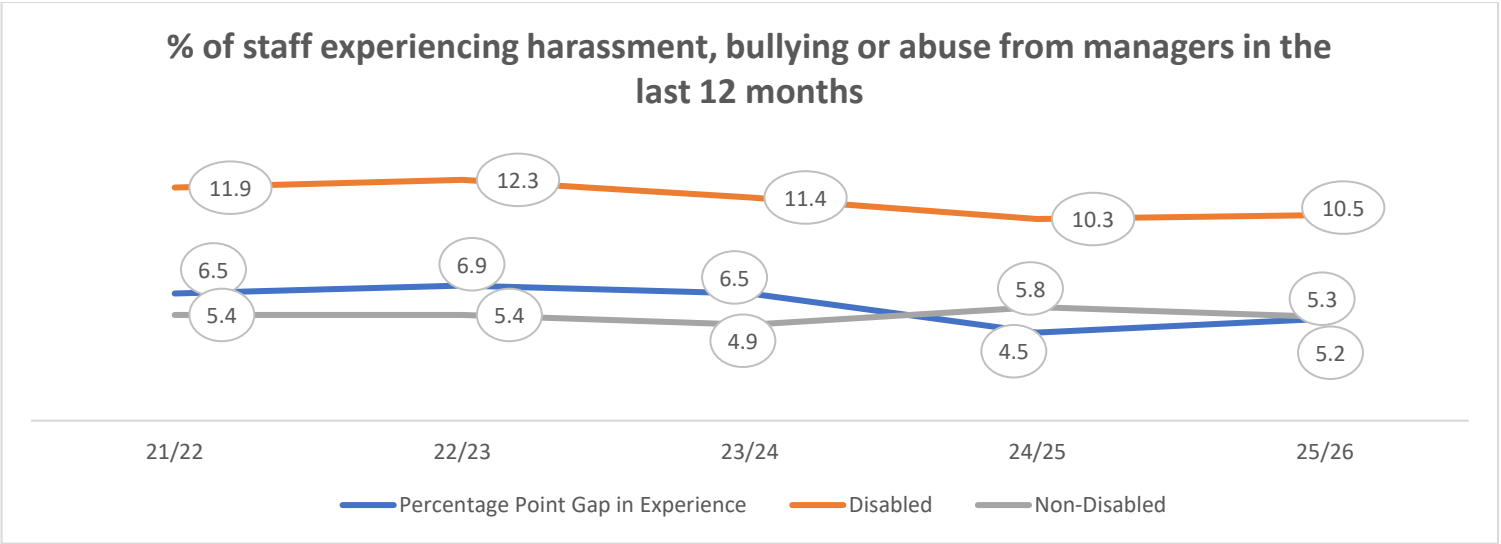


WDES Indicator 4a: Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patients, service users, relatives or the public in the last 12 months.	Group	21/22	22/23	23/24	24/25	25/26
Berkshire Healthcare	Disabled	29.9%	26.8%	24.5%	24.2%	25.3%
	Non-Disabled	20.0%	19.7%	18.1%	18.2%	18.9%

4b. Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months.

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WDES Indicator 4b: Difference in staff experiencing harassment, bullying or abuse from managers in the last 12 months. (percentage point gap)	21/22	22/23	23/24	24/25	25/26	Change (24/25 → 25/26)	Direction
Berkshire Healthcare (gap)	6.5	6.9	6.5	4.5	5.2	+0.7pp	Worsening
NHS Trusts (gap)	7.4	7.0	6.4	6.3	–	–	–



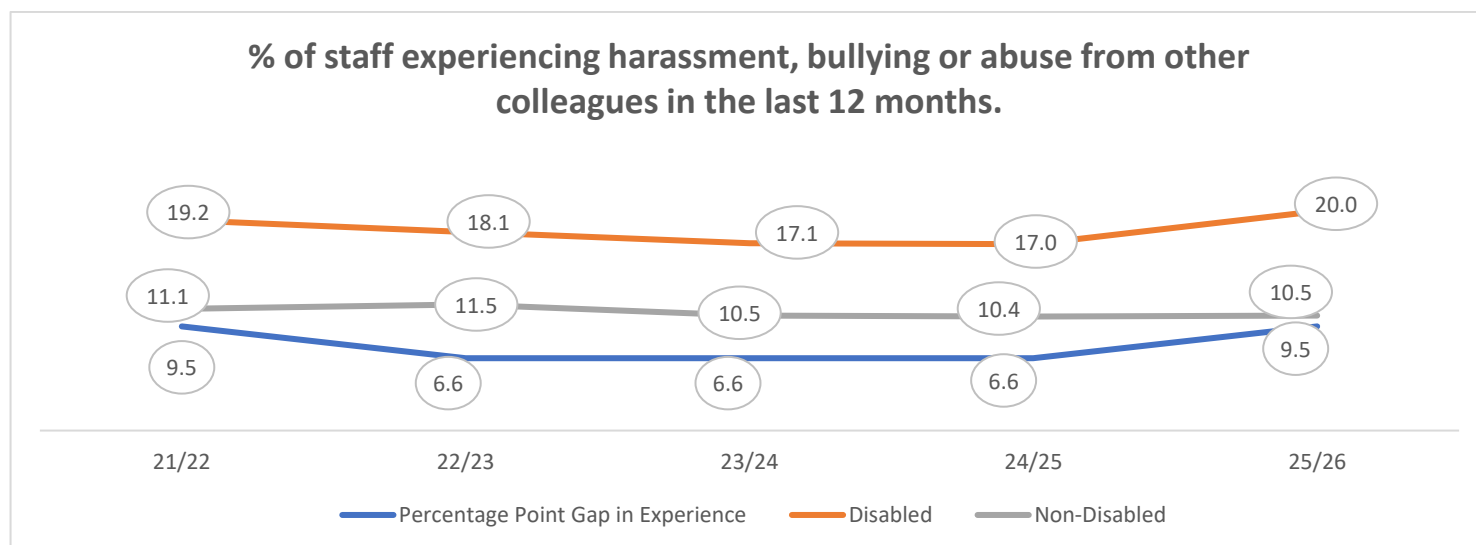
WDES Indicator 4b: % of staff experiencing harassment, bullying or abuse from managers in the last 12 months.	Group	21/22	22/23	23/24	24/25	25/26
Berkshire Healthcare	Disabled	11.9%	12.3%	11.4%	10.3%	10.5%
	Non-Disabled	5.4%	5.4%	4.9%	5.8%	5.3%

4c. Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months.

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WDES Indicator 4c: Difference in staff experiencing harassment, bullying or abuse from	21/22	22/23	23/24	24/25	25/26	Change (24/25 → 25/26)	Direction
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other colleagues in the last 12 months. (percentage point gap)							
Berkshire Healthcare (gap)	9.5	6.6	6.6	6.6	9.5	+2.9pp	Worsening
NHS Trusts (gap)	8.7	8.4	8.4	8.3	–	–	–



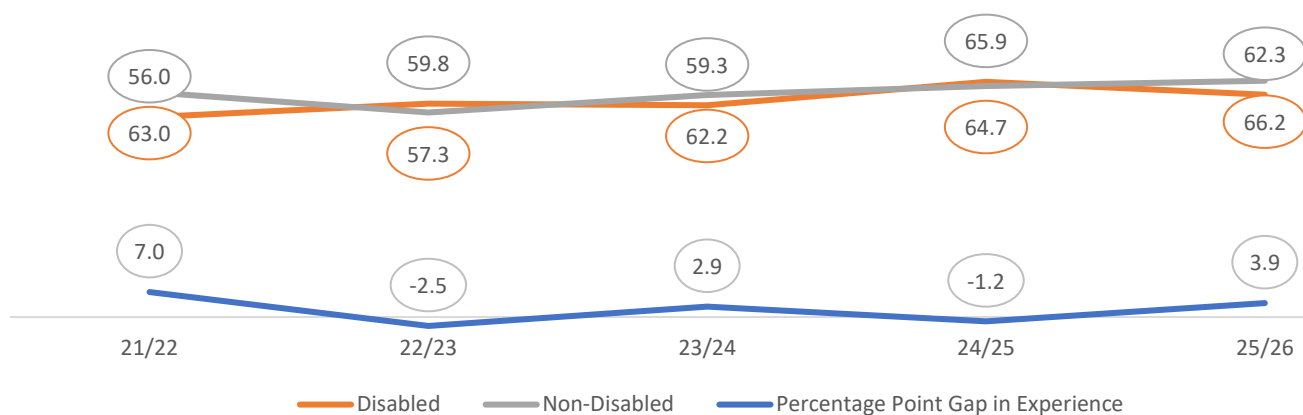
WDES Indicator 4c: % of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months.	Group	21/22	22/23	23/24	24/25	25/26
Berkshire Healthcare	Disabled	19.2%	18.1%	17.1%	17.0%	20.0%
	Non-Disabled	11.1%	11.5%	10.5%	10.4%	10.5%

4d. Percentage of staff reporting harassment, bullying or abuse in the last 12 months.

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WDES Indicator 4d: Difference in Harassment, bullying or abuse – reporting it (percentage point gap)	21/22	22/23	23/24	24/25	25/26	Change (24/25 → 25/26)	Direction
Berkshire Healthcare (gap)	7.0	-2.5	2.9	-1.2	3.9	+5.1pp	Worsening
NHS Trusts (gap)	1.4	1.9	1.1	0.6	–	–	–

% of staff reporting harassment, bullying or abuse in the last 12 months.

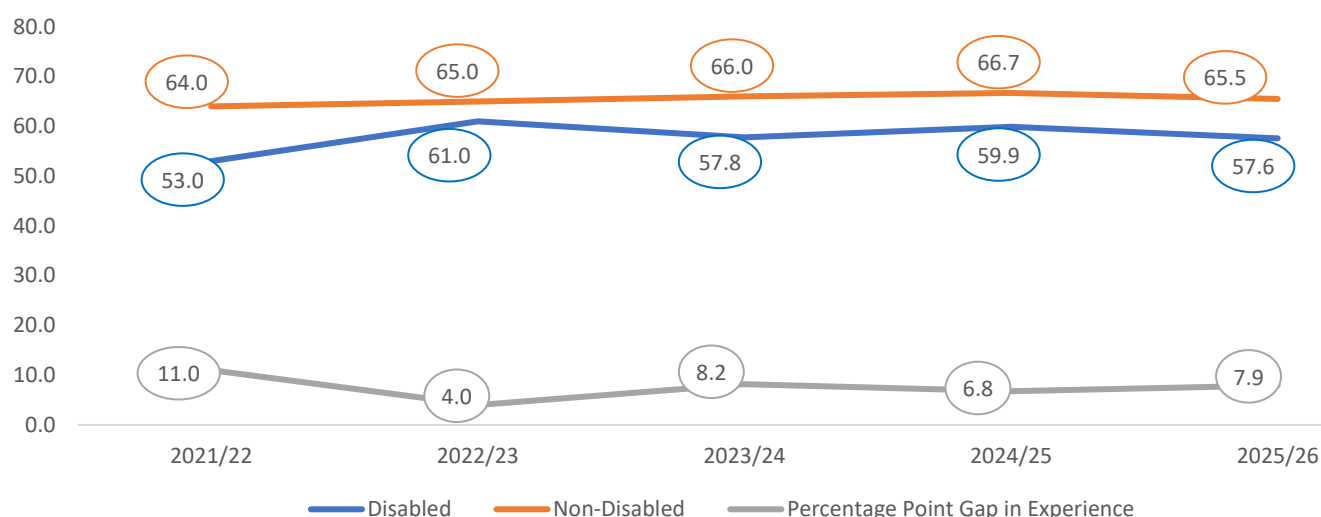


WDES Indicator 4d: % of staff reporting harassment, bullying or abuse in the last 12 months.	Group	21/22	22/23	23/24	24/25	25/26
Berkshire Healthcare	Disabled	56.0%	59.8%	59.3%	65.9%	62.3%
	Non-Disabled	63.0%	57.3%	62.2%	64.7%	66.2%

5. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion. [Back to contents](#)

WDES Indicator 5: Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion – percentage point gap	2021/22	2022/23	2023/24	2024/25	2025/26	Change (24/25 → 25/26)	Direction
Berkshire Healthcare	11.0	4.0	8.2	6.8	7.9	+1.1pp	Worsening
NHS Trusts (national)*	6.0	5.8	5.9	6.1	–	–	–

% of staff believing that the organisation provides equal opportunities for career progression or promotion



WDES Indicator 5: Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion		Group	21/22	22/23	23/24	24/25	25/26
Berkshire Healthcare		Disabled	53.0	61.0	57.8	59.9	57.6
		Non-Disabled	64.0	65.0	66.0	66.7	65.5

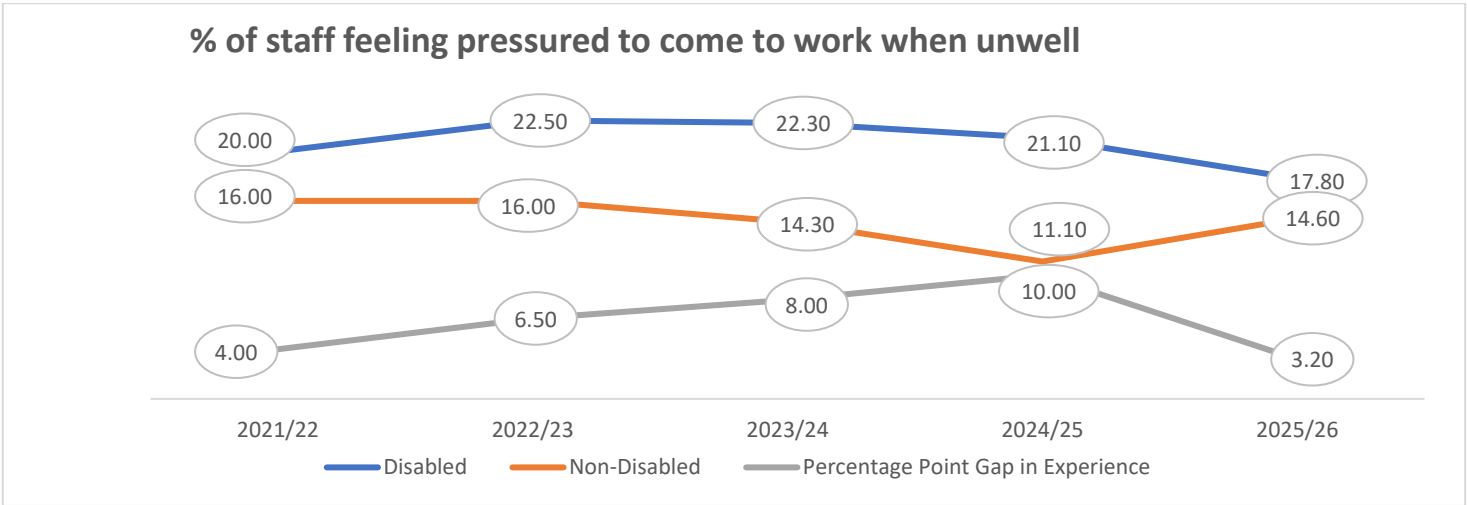
Internal Promotion Rates by Disability Status and Band

Band	Total Disabled Staff	Total Disabled Staff Promoted	% Disabled Staff Promoted	Total Non-Disabled Staff	Total Non-Disabled Staff Promoted	% Non-Disabled Staff Promoted	Likelihood of promotion (Disabled vs Non-Disabled Staff)
All AfC staff (Bands 2–9)	470	34	7.2	4682	312	6.7	1.09
Band 2	9	1	11.1	53	21	39.6	0.28
Band 3	34	5	14.7	92	47	51.1	0.29
Band 4	102	10	9.8	765	54	7.1	1.39
Band 5	68	7	10.3	720	55	7.6	1.35
Band 6	90	6	6.7	601	65	10.8	0.62
Band 7	107	5	4.7	873	40	4.6	1.02
Band 8a	35		0	931	18	1.9	0
Band 8b	18		0	392	9	2.3	0
Band 8c	2		0	164	3	1.8	0
Band 8d	3		0	61		0	n/a
Band 9	2		0	30		0	n/a
Band 8a+	60	0	0	1578	30	1.9	0
Band 7+	167	5	3	2451	70	2.9	1.05

6. Percentage of staff feeling pressured to come to work when unwell

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WDES Indicator 6: Percentage of staff feeling pressured to come to work when unwell - percentage point gap	2021/22	2022/23	2023/24	2024/25	2025/26	Change (24/25 → 25/26)	Direction
Berkshire Healthcare	4.00	6.50	8.00	10.00	3.20	-6.8pp	Improving
NHS Trusts (national)*	8.0	7.9	8.1	7.6	–	–	–



WDES Indicator 6: Percentage of staff feeling pressured to come to work when unwell	Group	21/22	22/23	23/24	24/25	25/26
Berkshire Healthcare	Disabled	20.0%	22.5%	22.3%	21.1%	17.8%
	Non-Disabled	16.0%	16.0%	14.3%	11.1%	14.6%

q11c During the last 12 months have you felt unwell as a result of work related stress?	Organisation Overall		Disabled		No-Disability	
Option	Count	Percent	Count	Percent	Count	Percent
Yes	1177	35.3%	446	49.4%	710	29.8%
No	2162	64.7%	456	50.6%	1669	70.2%
Total Responses	3339	100.0%	902	100.0%	2379	100.0%

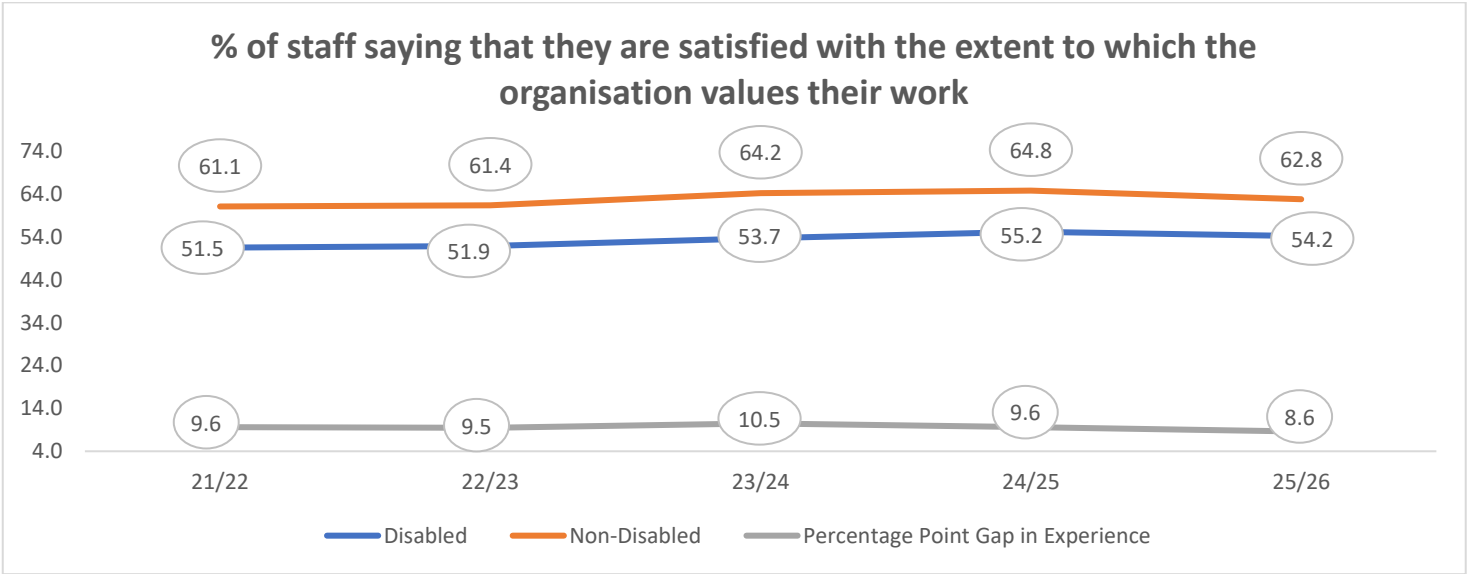
q11d In the last three months have you ever come to work despite not feeling well enough to perform your duties?	Organisation Overall		Disabled		No-Disability	
Option	Count	Percent	Count	Percent	Count	Percent
Yes	1605	48.2%	571	63.4%	1011	42.6%
No	1728	51.8%	330	36.6%	1364	57.4%
Total Responses	3333	100.0%	901	100.0%	2375	100.0%

q11e Have you felt pressure from your manager to come to work?	Organisation Overall		Disabled		No-Disability	
Option	Count	Percent	Count	Percent	Count	Percent
Yes	249	15.8%	100	17.8%	145	14.6%
No	1326	84.2%	461	82.2%	847	85.4%
Total Responses	1575	100.0%	561	100.0%	992	100.0%

7. Percentage of staff saying that they are satisfied with the extent to which the organisation values their work.

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WDES Indicator 7: Percentage of staff saying that they are satisfied with the extent to which the organisation values their work - Percentage Point Gap	21/22	22/23	23/24	24/25	25/26	Change (23/24 → 25/26)	Direction
Berkshire Healthcare	9.60	9.50	10.50	9.60	8.60	-1.0pp	Improving
NHS Trusts (National)*	9.9	9.9	10.9	11.1	–	–	–



Percentage of staff saying that they are satisfied with the extent to which the organisation values their work	Group	21/22	22/23	23/24	24/25	25/26
Berkshire Healthcare	Disabled	51.5%	51.9%	53.7%	55.2%	54.2%
	Non-Disabled	61.1%	61.4%	64.2%	64.8%	62.8%

37 Staff Survey Questions with larger gap

Question	Yes	No	Difference
In last 3 months, have not come to work when not feeling well enough to perform duties	36.6%	57.4%	-20.8%
In last 12 months, have not felt unwell due to work related stress	50.6%	70.2%	-19.6%
Never/rarely feel every working hour is tiring	49.2%	64.9%	-15.7%
In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	56.0%	70.7%	-14.6%
Never/rarely exhausted by the thought of another day/shift at work	36.8%	51.1%	-14.2%
I can eat nutritious and affordable food at work	53.4%	66.9%	-13.5%
Feel organisation would address any concerns I raised	57.5%	70.7%	-13.2%
Never/rarely lack energy for family and friends	33.8%	46.6%	-12.8%
Achieve a good balance between work and home life	58.0%	70.7%	-12.7%
Never/rarely feel burnt out because of work	27.7%	40.0%	-12.3%
Would feel confident that organisation would address concerns about unsafe clinical practice	65.1%	76.7%	-11.6%
Feel supported to develop my potential	59.6%	71.0%	-11.4%
I don't often think about leaving this organisation	43.2%	54.5%	-11.3%
Appraisal left me feeling organisation values my work	31.5%	42.7%	-11.2%
Never/rarely worn out at the end of work	16.3%	27.4%	-11.1%
Feel safe to speak up about anything that concerns me in this organisation	66.8%	77.7%	-10.9%
Able to make improvements happen in my area of work	58.6%	69.5%	-10.9%
Team has enough freedom in how to do its work	58.8%	68.9%	-10.1%
Time often/always passes quickly when I am working	71.5%	81.5%	-10.0%
Organisation is committed to helping balance work and home life	60.4%	70.4%	-10.0%
Would recommend organisation as place to work	69.4%	79.1%	-9.8%
Immediate manager asks for my opinion before making decisions that affect my work	63.0%	72.5%	-9.5%
Appraisal helped me improve how I do my job	21.5%	31.0%	-9.5%

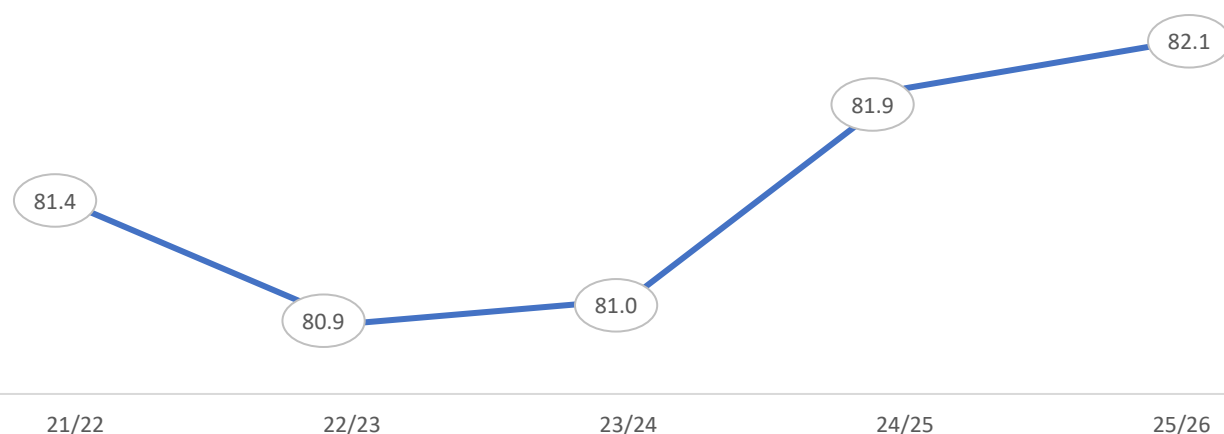
Not experienced harassment, bullying or abuse from other colleagues	80.0%	89.5%	-9.5%
Receive the respect I deserve from my colleagues at work	73.2%	82.6%	-9.3%
Involved in deciding changes that affect work	52.7%	61.9%	-9.2%
Opportunities to show initiative frequently in my role	71.7%	80.9%	-9.2%
Team deals with disagreements constructively	58.8%	68.0%	-9.2%
Feel valued by my team	71.9%	80.9%	-9.1%
Enough staff at organisation to do my job properly	40.3%	49.4%	-9.1%
Never/rarely frustrated by work	22.1%	31.0%	-8.9%
Organisation takes positive action on health and well-being	67.5%	76.3%	-8.8%
Staff involved in an error/near miss/incident treated fairly	66.6%	75.3%	-8.7%
Teams within the organisation work well together to achieve objectives	61.7%	70.4%	-8.7%
Able to meet conflicting demands on my time at work	47.1%	55.7%	-8.7%
Appraisal helped me agree clear objectives for my work	35.1%	43.6%	-8.6%
Satisfied with extent organisation values my work	54.2%	62.8%	-8.5%

8. Percentage of staff saying the organisation has made adequate adjustments for them in their role.

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WDES Indicator 8: Percentage of staff saying the organisation has made adequate adjustments for them in their role	21/22	22/23	23/24	24/25	25/26	Change (23/24 → 25/26)	Direction
Berkshire Healthcare	81.4	80.9	81.0	81.9	82.1	-0.2pp	Improving
NHS Trusts (National)*	n/a	73.0	74.5	75.3	–		

% of staff saying the organisation has made adequate adjustments for them in their role (Disabled Staff)



Reasonable adjustment % by Portfolio

Division	Portfolio	Response Rate %
Central Services	Chief Executive Speciality	Not Enough Responses
Central Services	Operations Speciality	Not Enough Responses
CFAA	Children in Care Speciality	Not Enough Responses
Community Health	Community Health Directors Speciality	Not Enough Responses
Mental Health	MH Directors Speciality	Not Enough Responses
Central Services	Nursing & Governance Speciality	100.0%
CFAA	Learning Disabilities Speciality	94.1%
Central Services	Deputy Executive Speciality	93.8%
CFAA	CAMHS Speciality	91.3%
CFAA	Children, Family and Neurodiversity Speciality	89.5%
Mental Health	Mental Health Community Speciality	84.1%
Central Services	Medical Director Speciality	82.4%
Comparator (Organisation Overall)	Comparator (Organisation Overall)	82.1%
Central Services	Finance, Estates & Facilities Management Speciality	81.3%
Community Health	Community Health Scheduled Care Speciality	78.8%
Community Health	Community Health Urgent Care Speciality	76.7%
Mental Health	Mental Health Operations and Business Strategy Speciality	74.0%
CFAA	Specialist Children's Services Speciality	72.7%

Mental Health	MH Inpatients Speciality	72.7%
Mental Health	Mental Health Urgent Care Speciality	60.0%

Reasonable adjustments for disabled staff by service

Response	Organisation Overall	Central Services	CF&AAS	Community Health	Mental Health
Yes	462 (82.1%)	91%	89%	78%	77%
No	101 (17.9%)	9%	11%	22%	23%
No adjustment required	333 (37.2%)	58	68	103	104

Note: Percentages for "Yes" and "No" are calculated using only respondents who indicated that they required a reasonable adjustment (n=563). The percentage for "No adjustment required" is calculated using all respondents to the question (n=896).

Reasonable adjustments requests submitted via official route (April 25 - March 26)

Response	Organisation Overall
Total Requests made	195
Total staff who made 1 or more requests	55
% of total requests accepted	Unknown
% of staff who had all requests accepted	Unknown

Formal reasonable adjustment requests compared with staff survey responses

Service	Formal reasonable adjustment requests	Staff reporting, they required a reasonable adjustment	% of staff requiring an adjustment who submitted a formal request
Children, Young People and Families	18	114	16
Community Health	6	154	4
Corporate Services	6	97	6
Mental health Services	24	198	12

Total number of formalised reasonable adjustment requests by request type

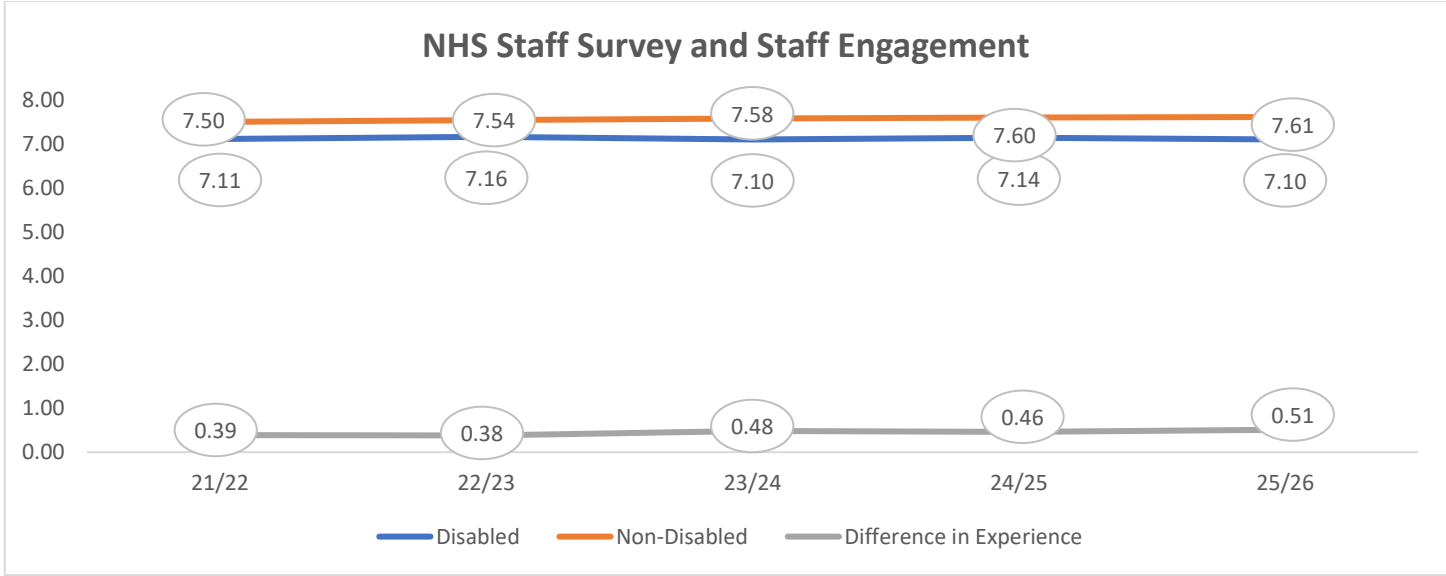
Row Labels	Count of request types	% of total Request Types
Training and Education	60	31

Software	59	30
Hardware	39	20
Blank or n/a	17	9
Accessories	11	6
Office equipment	5	3
Service	3	2
Other	1	1

9. Staff Engagement Score.

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WDES Indicator 9: NHS Staff Survey and staff engagement - Percentage Point Gap	21/22	22/23	23/24	24/25	25/26	Change (23/24 → 25/26)	Direction
Berkshire Healthcare	0.39	0.38	0.48	0.46	0.51	+0.05 ↑	Worsening
NHS Trusts (National)*	–	–	–	–	–	–	–



2024 vs 2025
Engagement
Score
Questions

Staff Survey question	Disabled 2024	Disabled 2025	Disabled change	Non-disabled 2024	Non-disabled 2025	Non-disabled change	2024 gap	2025 gap	Gap movement
Often/always look forward to going to work	0.58	0.57	-1.3pp	0.65	0.64	-0.8pp	-7.1pp	-7.6pp	Widened by 0.5pp

Often/always enthusiastic about my job	0.70	0.69	-1.6pp	0.76	0.76	-0.5pp	-6.2pp	-7.2pp	Widened by 1.0pp
Time often/always passes quickly when I am working	0.71	0.72	+0.4pp	0.80	0.82	+1.9pp	-8.5pp	-10.0pp	Widened by 1.5pp
Opportunities to show initiative frequently in my role	0.73	0.72	-1.4pp	0.81	0.81	+0.2pp	-7.6pp	-9.2pp	Widened by 1.6pp
Able to make suggestions to improve the work of my team/dept	0.74	0.75	+1.4pp	0.83	0.83	+0.2pp	-9.0pp	-7.8pp	Narrowed by 1.2pp
Able to make improvements happen in my area of work	0.61	0.59	-1.9pp	0.69	0.70	+0.9pp	-8.1pp	-10.9pp	Widened by 2.8pp
Care of patients/service users is organisation's top priority	0.85	0.84	-0.3pp	0.90	0.89	-1.3pp	-5.8pp	-4.8pp	Narrowed by 1.0pp
Would recommend organisation as place to work	0.73	0.69	-3.6pp	0.80	0.79	-1.2pp	-7.3pp	-9.7pp	Widened by 2.4pp

If friend/relative needed treatment would be happy with standard of care provided by organisation	0.75	0.77	+1.6pp	0.81	0.83	+2.2pp	-5.5pp	-6.1pp	Widened by 0.6pp
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WDES Indicator 9: NHS Staff Survey and staff engagement - Percentage Point Gap	Engagement score gap between marginalised group and comparator
Disability Status Disabled (compared with non-disabled)	0.51
Sexuality Gay, Lesbian, Bi-sexual and other (compared with heterosexual)	0.32
Gender Female (compared with male)	0.26
Ethnicity Ethnically Diverse (Compared with white)	-0.38

Number of times group scored highest score compared to comparator group out of 101 positive scoring questions (100 for disabled)

	Total	%
Disabled Staff (compared to non-Disabled staff)	4/100	4
Gay, Lesbian, Bi-sexual and other staff (compared to Heterosexual staff)	8/101	8
Female Staff (compared to Male staff)	16/101	16
Ethnically Diverse Staff (compared to White staff)	53/101	52

4 questions out of 100 where Disabled staff scored higher than non-disabled staff

Question	Disabled	Non-Disabled	Total
Don't work any additional paid hours per week for this organisation, over and above contracted hours	85.03%	81.23%	3.80%

Organisation offers me challenging work	76.05%	74.32%	1.74%
Not experienced physical violence from patients/service users, their relatives or other members of the public	90.34%	89.14%	1.21%
Not experienced physical violence from other colleagues	98.75%	98.74%	0.01%

Top 10 largest gaps between Disabled and non-disabled scores

Question	Disabled	Non-Disabled	Total
In last 3 months, have not come to work when not feeling well enough to perform duties	36.63%	57.43%	-20.81%
In last 12 months, have not felt unwell due to work related stress	50.55%	70.16%	-19.60%
Never/rarely feel every working hour is tiring	49.17%	64.86%	-15.69%
In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	56.05%	70.67%	-14.62%
Never/rarely exhausted by the thought of another day/shift at work	36.81%	51.05%	-14.25%
I can eat nutritious and affordable food at work	53.43%	66.93%	-13.50%
Feel organisation would address any concerns I raised	57.48%	70.70%	-13.23%
Never/rarely lack energy for family and friends	33.81%	46.57%	-12.76%
Achieve a good balance between work and home life	57.98%	70.69%	-12.71%
Never/rarely feel burnt out because of work	27.67%	39.97%	-12.31%

People Promise and Staff Survey Theme Scores by Disability Status

Section / Theme	Description	Organisa tion Overall	Disabled Staff	Non- disabled Staff	Disabled vs Non- disabled Gap
People Promise element 1: We are compassionate and inclusive	Compassionate culture sub-score	7.9	7.6	8.0	-0.4
	Compassionate leadership sub-score	7.8	7.5	7.9	-0.4
	Diversity and equality sub-score	8.7	8.5	8.8	-0.4
	Inclusion sub-score	7.4	7.1	7.6	-0.5
	Overall “We are compassionate and inclusive” score	8.0	7.7	8.1	-0.4
People Promise element 2: We are recognised and rewarded	Overall “We are recognised and rewarded” score	6.7	6.4	6.8	-0.4

People Promise element 3: We each have a voice that counts	Autonomy and control sub-score	7.4	7.0	7.5	-0.5
	Raising concerns sub-score	7.3	6.9	7.4	-0.6
	Overall “We each have a voice that counts” score	7.3	6.9	7.5	-0.5
People Promise element 4: We are safe and healthy	Health and safety climate sub-score	6.3	6.0	6.4	-0.4
	Burnout sub-score	5.5	4.9	5.7	-0.8
	Negative experiences sub-score	8.3	7.7	8.5	-0.8
	Overall “We are safe and healthy” score	6.7	6.2	6.9	-0.7
People Promise element 5: We are always learning	Development sub-score	6.9	6.6	7.0	-0.4
	Appraisals sub-score	5.8	5.2	6.1	-0.9
	Overall “We are always learning” score	6.4	5.9	6.6	-0.6
People Promise element 6: We work flexibly	Support for work-life balance sub-score	7.2	6.8	7.3	-0.6
	Flexible working sub-score	7.0	6.9	7.1	-0.2
	Overall “We work flexibly” score	7.1	6.8	7.2	-0.4
People Promise element 7: We are a team	Team working sub-score	7.3	6.9	7.4	-0.4
	Line management sub-score	7.6	7.4	7.7	-0.4
	Overall “We are a team” score	7.5	7.2	7.6	-0.4
Theme: Staff Engagement	Motivation sub-score	7.3	7.0	7.5	-0.5
	Involvement sub-score	7.3	6.9	7.5	-0.6
	Advocacy sub-score	7.7	7.4	7.9	-0.5
	Overall “Staff Engagement” score	7.5	7.1	7.6	-0.5
Theme: Morale	Thinking about leaving sub-score	6.6	6.2	6.7	-0.5
Theme: Morale	Work pressure sub-score	6.2	5.8	6.3	-0.5
Theme: Morale	Stressors sub-score	6.9	6.6	7.0	-0.4
Theme: Morale	Overall “Morale” score	6.5	6.2	6.7	-0.5

Highest-Level People Promise and Theme Scores

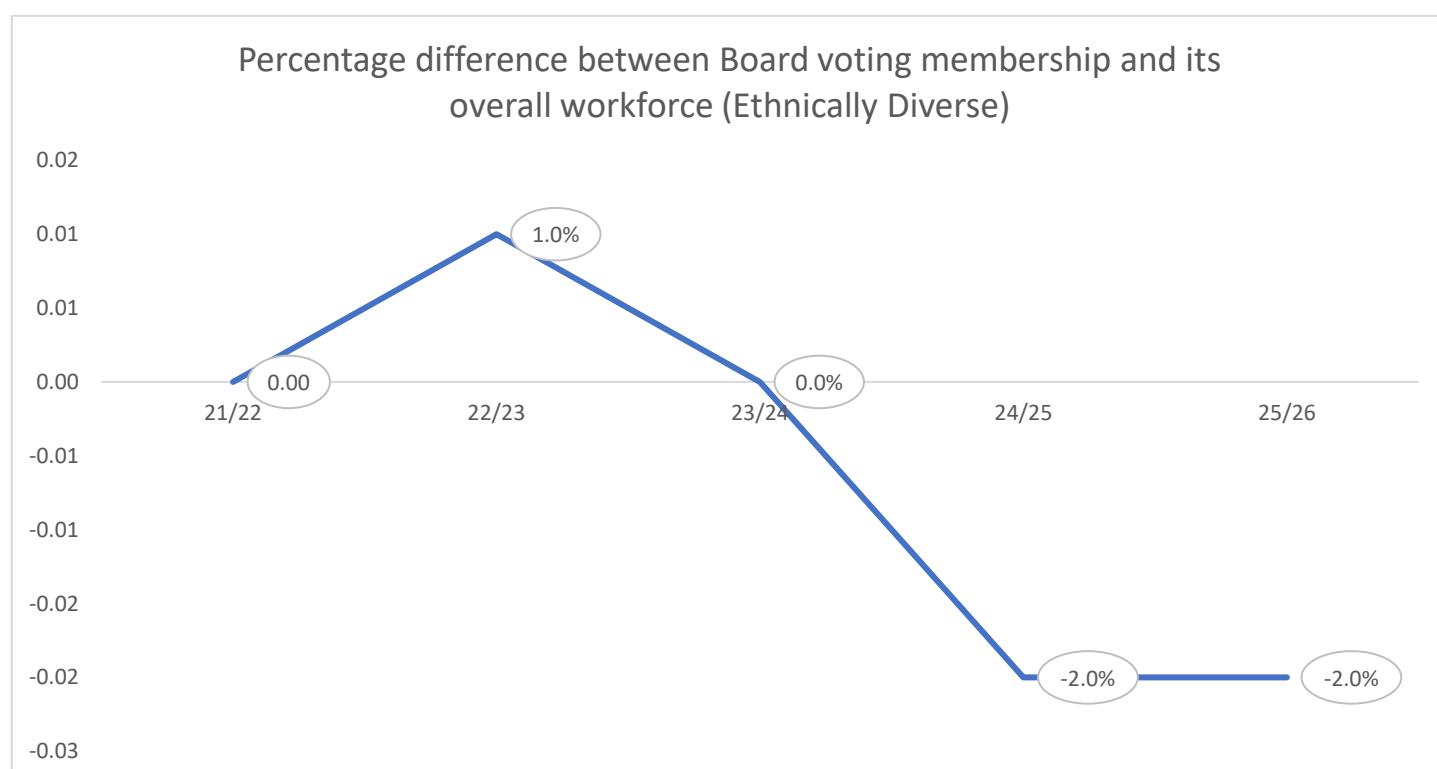
Area	Organisation Overall	Disabled Staff	Non-disabled Staff	Gap	Interpretation
We are safe and healthy	6.7	6.2	6.9	-0.7	Largest overall People Promise gap

We are always learning	6.4	5.9	6.6	-0.6	Second-largest People Promise gap
We each have a voice that counts	7.3	6.9	7.5	-0.5	Material gap around voice and influence
Staff Engagement	7.5	7.1	7.6	-0.5	Consistent with WDES Indicator 9
Morale	6.5	6.2	6.7	-0.5	Suggests wider experience pressure
We are compassionate and inclusive	8.0	7.7	8.1	-0.4	Gap present but not the largest
We are recognised and rewarded	6.7	6.4	6.8	-0.4	Consistent with feeling valued gap
We work flexibly	7.1	6.8	7.2	-0.4	Overall gap lower, but work-life balance sub-score wider
We are a team	7.5	7.2	7.6	-0.4	Gap present but comparatively smaller

10. Percentage difference between Board voting membership and its overall workforce

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Percentage difference between Board voting membership and its overall workforce (Disabled Workforce) -	21/22	22/23	23/24	24/25	25/26	Change (24/25 → 25/26)	Direction
Berkshire Healthcare	n/a	1.0%	0.0%	-2.0%	-2.0%	0pp	No Change
NHS Trusts (national)*	n/a	n/a	n/a	n/a	-	-	-



Trust Board Paper

Board Meeting Date	08 September 2026
Title	Audit Committee Meeting – 22 July 2026
	Item for Assurance and for ratification of changes to the Audit Committee's Terms of Reference
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. The Committee reviewed its terms of reference and made a number of proposed changes highlighted in red type. The key changes were around updating the governance risk management and internal control section and transferring responsibility for overseeing the Clinical Audit Plan to the Quality Assurance Committee. The Board is requested to ratify and proposed changes.
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	Board Assurance Framework The Audit Committee reviewed the Board Assurance Framework and agreed to reduce the score for Risk 1 (Workforce) from 6 to 3, to reflect reduced staff turnover and a low vacancy rate. The Committee also agreed to amend the risk description of Risk 7 (Digital) to better reflect the organisation's capability to detect and respond to cyber incidents. Counter Fraud Functional Standard Return 2025-26 The Counter Fraud Functional Standard Return is an annual self-assessment used by organisations providing NHS-funded services to summarise their counter fraud, bribery and corruption work. It evaluates compliance and results in a red, amber or green (RAG) rating. The Audit Committee noted with assurance that the Trust's overall self-assessment rating was GREEN. Internal Audit Three-Year Plan The Audit Committee reviewed and approved the Internal Audit Three-Year Plan. The plan is flexible, with the timing and topics of audit reviews able to be amended to meet the Trust's requirements. Annual Review of Effectiveness and Changes to the Committee's Terms of Reference The Committee's Annual Review of Effectiveness was positive. A key area identified for improvement was the need for more future-focused discussion and horizon scanning of emerging risks. The Internal Auditors agreed to include this as part of the pre-meeting Audit Committee seminar sessions. The agenda template had also been amended to include a standard item on horizon scanning. The Committee reviewed its terms of reference. The proposed amendments are shown using tracked changes and are presented to the Trust Board for ratification.
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Unconfirmed Draft Minutes

Minutes of the Audit Committee Meeting held on

Wednesday, 22 July 2026
(Conducted via Microsoft Teams)

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

In attendance: Paul Gray, Chief Financial Officer
Debbie Fulton, Director of Nursing and Therapies
Dr Tolu Olusoga, Medical Director
Kim Hampson, 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 and Becky Clegg, Director of Finance.	
2.	Declaration of Interests	
	There were no declarations of interest.	
3.	Minutes of the Previous Meetings held on 22 April and 17 June 2026	
	The Minutes of the meeting held on 22 April 2026, and 17 June 2026 were confirmed as a true record of the proceedings.	

4.	Action Log and Matters Arising	
	The Action Log had been circulated. The Committee noted the Action Log.	
5.A	Board Assurance Framework (BAF)	
	The latest Board Assurance Framework (BAF) had been circulated. The updates since the last meeting were highlighted in red type. The Chief Financial Officer presented the report and highlighted the following points: • Risk 1 (Workforce) – historically this had been one of the Trust’s highest rated risks. However, significant improvement had been achieved in staff turnover and staffing levels, particularly within high-risk clinical areas. It was therefore proposed to reduce the risk score from 6 to 3. The Committee was satisfied that sustained improvements in vacancies, turnover and staffing justified the revised assessment. • Risk 7 (Digital) – the digital risk had been updated to reflect the increasing impact of artificial intelligence on Trust services. The Trust was seeing a rise in lengthy complaints, subject access requests and tribunal correspondence generated using AI tools. AI-generated job applications were also creating additional operational pressures. These developments were generating new risks which required ongoing mitigation. • Risk 8 (Sustainability) – the risk had been updated to reflect heat resilience concerns and the need to support staff working in extreme temperatures. The Chair suggested that the initial risk score should be accompanied by dates to improve tracking over time. Sonya Batchelor, Non-Executive Director referred to Risk 4 (Partnership working) and commented that the target risk score of 4 was overly ambitious particularly because the Trust could influence but not directly control outcomes. Karen Swainson, Barts Assurance, Internal Auditors agreed that target risk scores should be realistic around what could be achieved. Ms Swainson queried Risk 7 (Digital), where the current and target risk scores remained unchanged at 15. The Chief Financial Officer confirmed that this reflected the nature of the operating environment and acknowledged that certain risks could not reasonably be reduced further.	JH PG

	Ms Batchelor referred to Risk 6 (Sustainability) and noted that one of the consequences of the risk was that the Trust could face litigation if it failed to meet national carbon reduction legislation. Ms Batchelor asked for more information about which target the Trust had to meet and an indication about the level of any potential fine. Ms Batchelor asked that future reports outline the specific legislative requirements, relevant targets and timescales to help the Committee better understand the risk and associated assurance arrangements. The Chair suggested that the risk description for Risk 7 (Digital) should be amended to better reflect the organisation's capability to detect and respond to cyber incidents. Mark Day, Non-Executive Director referred to Risk 7 (Digital) and questioned where these risks were receiving detailed scrutiny and assurance beyond the Board Assurance Framework. Sonya Batchelor confirmed that oversight of digital risks sat primarily within the Finance, Investment and Performance Committee, and noted that the Trust had recently appointed a new Non-Executive Director with a digital background and said that this would increase Board-level digital expertise and would strengthen scrutiny in this area. The Committee was satisfied that detailed oversight rests with FIP Committee, with Audit Committee receiving assurance through the BAF. The Chair asked whether the current likelihood score of Risk 3 (Failing to Hear the Patient Voice) should be lowered in view of the significant amount of work done to increase patient feedback. The Director of Nursing and Therapies acknowledged substantial progress but advised that implementation was not yet consistent across all services. While the Trust was performing reasonably well, there remained further improvement opportunities before a reduction in the risk score could be justified. The Medical Director agreed describing the work as a continuing programme of improvement. The Chair referred to Risk 6 (Finance) and queried why the likelihood score remained high given the Trust's strong track record in delivering financial plans and efficiency targets. The Chief Financial Officer explained that the risk reflected longer-term recurrent sustainability and the continuing reliance on non-recurrent measures to achieve financial balance. The focus had shifted from system control totals towards the Trust's own financial sustainability. Sonya Batchelor, Non-Executive Director, supported maintaining the current risk position, highlighting the ongoing reliance on non-recurrent efficiencies and the need to ensure that recurrent savings plans remained achievable.	PG JH
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	The Committee: a) Noted the report. b) Approved reducing the risk score for Risk 1 (Workforce) from 6 to 3. c) Approved changing the risk description of Risk 7 (Digital) to reflect the Trust's capability to detect and respond to cyber incidents.	
5.B	Corporate Risk Register	
	The Corporate Risk Register (CRR) had been circulated. The updates since the last meeting were highlighted in red type. Sonya Batchelor, Non-Executive Director, referred to CRR 7 (Physical Environment Risk – Prospect Park Hospital) and asked for more information about the risk around non-collapsible curtains within mental health inpatient environments. The Director of Nursing and Therapies explained that current curtain systems at Prospect Park Hospital complied with all Never Event requirements. She noted that there were different types of anti-ligature curtain systems available, including magnetic-release systems and ceiling-mounted anti-ligature solutions. While some variation remained across sites, all systems in use were compliant. The Director of Nursing and Therapies reported that ongoing maintenance was essential, including replacement of anti-pick materials as they deteriorated over time. The Chief Financial Officer advised that replacement window programmes were underway in high-risk areas, with new windows incorporating integrated blinds designed to eliminate curtain rails entirely and therefore remove the risk source through improved design. The Medical Director said that the Trust had done everything it could to mitigate the risk, but the Prospect Park Hospital environment would never be risk-free. The Chair referred to CRR 5 (Acute Bed Pressures) and queried why the consequence score for the risk had increased from the initial risk score of high to the current risk score of severe. The Medical Director explained that bed pressures had become increasingly systemic. Delays in patient flow were affecting places of safety, community services and acute hospital partners. Patients were remaining in inappropriate settings for longer periods and there was an increased risk of patient harm. Additional pressures were arising from prison discharges involving patients requiring admission to mental health services. Although multiple improvement	

	initiatives were underway, these issues collectively justified the increased consequence score. The Committee noted the report.	
6.	Single Waiver Tenders and Provider Selection Regime Direct Awards Report	
	A paper setting out the Trust's single waivers and provider selection regime direct awards approved from April 2026 to June 2026 had been circulated. The Chief Financial Officer presented the paper and highlighted that the most significant waiver related to the Southeast Pharmacy Procurement Services contract. It was noted that recent changes to public procurement rules and the requirement for Cabinet Office approval had delayed the tender process, necessitating a temporary extension of the existing arrangement. The tender was now underway, and the extension was required only until completion of the procurement process. Mark Day, Non-Executive Director asked whether repeat reporting of the same waiver remained necessary. The Chief Financial Officer advised that each approved extension should continue to be reported as part of good governance arrangements. The Committee noted the report.	
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) • Did Not Attend Rate (moderate assurance) • Mental Health Acute Average Length of Stay (moderate assurance) • 72-hour follow-up (low assurance) The Chief Financial Officer referred to the 72-hour follow-up indicator and explained that, whilst improvements had been made, recording issues and accuracy challenges persisted. It was noted that both digital solutions and targeted staff training interventions had been introduced to improve performance. System-generated notifications and reminders were now being used alongside awareness sessions to improve compliance. Because these changes had been introduced shortly before the	

	most recent audit, the Trust hoped to see measurable improvements in future reports. The Committee noted the report.	
8.	Losses and Special Payments Report	
	<i>Due to low numbers of losses and special payments, there was no report this quarter.</i>	
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 cases were closed in the quarter, with two being settled and two repudiated. • There were 11 claims opened in the quarter representing a significant proportion of the total litigation activity seen across the previous financial year during which 16 new cases were opened across all four quarters. The Committee sought assurance that the increase reflected AI-generated correspondence rather than deterioration in clinical quality and was assured that no emerging themes indicating systemic weaknesses had been identified. The Committee also sought assurance that no common themes from claims indicated weaknesses in governance or internal controls. The Director of Nursing and Therapies reported that there was clear evidence of the impact of AI-generated claims correspondence. The Trust was receiving lengthy letters of claim containing extensive legal references, many of which were inaccurate or cited non-existent legislation. Whilst the increase had generated additional workload. The Director of Nursing and Therapies added that many claims would be robustly challenged, said that she did not expect all claims to result in settlement. Clarence Mpofu, Barts Assurance, Internal Auditors confirmed that similar patterns were being observed elsewhere across NHS organisations and that AI-generated complaints were creating significant additional administrative and investigative burdens. The Committee noted the report.	

10.	Clinical Audit Report	
	The Clinical Audit Report had been circulated. The Medical Director presented the report and advised that there were currently 46 clinical audit projects open during the financial year and eight projects with active action plans being monitored through the Clinical Effectiveness Group. The Chair questioned whether the Audit Committee was still required to routinely review the clinical audit report, given that the work received detailed scrutiny through the Quality Assurance Committee. Karen Swainson, Barts Assurance, Internal Auditors advised that many organisations route clinical audit exclusively through quality committees and that this approach was acceptable. The Company Secretary agreed to review the Committee's Terms of Reference. The Committee noted the report.	JH
11.	Counter Fraud Report	
	a) Progress Report Kim Hampson, Counter Fraud Specialist, TIAA presented the paper and reported that criminal charges had now been authorised in relation to a longstanding bribery investigation and that the first court hearing was scheduled for early August. The Chief Financial Officer placed on record the Committee's thanks to the counter-fraud team and all staff involved, recognising the substantial work undertaken over approximately five years to gather evidence and progress the case to prosecution. b) Counter Fraud Functional Standard Return 2025/26 The Counter Fraud Functional Standard Return 2025/26 had been circulated. It was noted that the Trust's overall self-assessment rating was GREEN The Committee noted the reports.	
12.	Internal Audit Report	
	a) Progress Report	

Karen Swainson, Barts Assurance, Internal Auditors presented the paper and highlighted the following points:

- The Quarter 1 Data Security and Protection Toolkit audit had received a low-risk assurance outcome, equivalent to substantial assurance and the highest available assurance rating.
- The review identified strong Board-level oversight, effective incident management arrangements, and positive staff awareness and training arrangements. Five low-priority actions had been raised relating primarily to policy updates. Importantly, the independent audit findings fully aligned with the organisation's self-assessment.
- There were 22 audit recommendations currently being tracked. Eight actions had fallen due for this meeting; six had been completed and two had been extended. Both overdue actions showed clear evidence of progress and there were no concerns regarding eventual completion.

b) Internal Audit Plan 2026/27

Ms Swainson presented the three-year internal audit strategy and annual plan. It was noted that the plan remained flexible and could be amended in response to emerging risks.

Sonya Batchelor, Non-Executive Director queried whether the Cost Improvement Programme review should be brought forward from year three.

The Chief Financial Officer explained that priorities had been carefully balanced across the three-year plan but acknowledged that the programme would remain dynamic and could be revised if required.

The Chair asked Barts Assurance when they first engaged with the Trust and Executive Directors on the development of the three-year internal audit plan, whether anything had surprised them during that process.

Ms Swainson confirmed that Barts Assurance's initial discussions with the Trust had been open and honest and said that there were no issues of concern or surprises during the discussions.

The Chief Financial Officer commended Barts Assurance for developing a three-year rather than a single-year internal audit plan.

c) Internal Audit Charter 2026/27

Karen Swainson presented the paper and reported that the Audit Charter established internal audit's position within Berkshire Healthcare NHS Foundation Trust and defines the scope of internal audit activities.

The Committee:

- a) Noted the report.

	b) Approved the three-year Internal Audit Plan whilst acknowledging that the plan may change during the course of the next three years. c) Approved the Internal Audit Charter 2026/27.	
13.	External Audit Report	
	Alison Kennett, Ernst and Young, External Auditors advised that preparations for the 2026/27 audit would commence later in the year. Future reports would include information regarding the external auditors' use of AI-enabled audit tools. No additional issues were raised. The Chair thanked Ms Kennett for her update.	
14.	Minutes of the Finance, Investment and Performance Committee meeting held on 22 April 2026	
	The minutes of the Finance, Investment and Performance Committee meeting held on 22 April 2026 were received and noted.	
15.	Minutes of the Quality Assurance Committee held on 26 May 2026	
	The minutes of the Quality Assurance Committee meetings held on 26 May 2026 were received and noted.	
16.	Minutes of the Quality Executive Committee – April 2026, May 2026 and June 2026	
	The minutes of the Quality Executive Committee meetings held in April 2026, May 2026 and June 2026 were received and noted. Sonya Batchelor, Non-Executive Director reflected on the size of the Quality and Performance Executive Group and asked whether effectiveness reviews were undertaken. The Director of Nursing and Therapies explained that formal effectiveness reviews were not conducted in the same manner as Board committees. It was noted that the Group served both assurance and developmental purposes, with members attending both for discussion and organisational learning. Divisions also conducted more detailed performance and quality discussions through their own governance structures. The Medical Director added that staff also attended the meetings as part of their development.	

17.	Annual Review of Effectiveness and Terms of Reference Review	
	The Company Secretary presented the report and thanked those people who had completed the Audit Committee's Annual Review of Effectiveness. The Company Secretary reported that a key theme was the desire for greater future-focused discussion and horizon scanning of emerging risks. The Chair referred to the Audit Seminar with the Internal Auditors prior to the meeting and reported that discussions had already commenced with Internal Audit regarding future development sessions supporting this ambition. Sonya Batchelor, Non-Executive Director queried references within the Terms of Reference concerning assurance over achievement of corporate objectives. The Company Secretary explained that the wording was intended to reflect the Committee's role in assuring governance, controls and risk-management processes supporting corporate objectives rather than direct performance oversight. The Company Secretary agreed to review the wording in the Terms of Reference relating to corporate priorities. Karen Swainson, Barts Assurance, Internal Auditors confirmed that the Terms of Reference were generally robust and aligned with good practice. Ms Swainson pointed out there was an error in the Terms of Reference. The "NHS Audit Committee Handbook 2005" should be replaced with "NHS Audit Committee Handbook 2025". It was noted that the Committee had agreed to amend the Terms of Reference to remove the requirement of the Committee to receive the Clinical Audit Programme report. The Committee: a) Noted the report. b) Agreed to amend the Committee's Terms of Reference which would be presented to the September 2026 Trust Board meeting for ratification.	JH JH JH JH
18.	Annual Work Plan and Horizon Scan for Future Agenda Items	
	The Committee's Annual Work Plan was noted.	
19.	Any Other Business	
	There was no other business.	
20.	Date of Next Meeting	

	The next meeting of the Committee was scheduled to take place on 28 October 2026.	
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The minutes are an accurate record of the Audit Committee meeting held on 22 July 2026.

Signed: - _____

Date: - 28 October 2026 _____

DRAFT

Terms of Reference

Audit Committee

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Purpose

This document contains the terms of reference for the Trust Audit Committee.

Document Control

Version	Date	Author	Comments
1.0	12 Mar 08	Garry Nixon	Initial Draft for Committee Chair
2.0	14 Mar 08	Garry Nixon	Updated following Committee Chair comments
3.0	1 May 08	Garry Nixon	Updated following Audit Committee consideration
4.0	22 May 09	John Tonkin	Revised per Internal Audit Report Recommendations on Integrated Governance –
5.0	28 May 09	Clive Field	Minor amendments
6.0	12 August 2010	John Tonkin	Revision following Audit Committee review July 2010
7.0	14 Sept 2010	John Tonkin	Revision following Board consideration 14 Sept 2010
8.0	8 May 2012	John Tonkin	Revision following Board consideration 8 May 2012
9.0	12 April 2013	John Tonkin	General revision to reflect changes in past year
10.0	23 May 2013	John Tonkin	Revision following Board discussion on 14 May 2013
11.0	11 June 2013	John Tonkin	Board approved – 11 June 2013
12.0	13 May 2014	John Tonkin	Board approved - 13 May 2014
13.0	27 July 2016	Julie Hill	Revision following Audit Committee review – October 2016
14.0	08 November 2016	Julie Hill	Board approved – 08 November 2016
15.0	July 2018	Julie Hill	Revision following Audit Committee review – July 2018 – Board approved September 2018
16.0	July 2019	Julie Hill	Revision following Audit Committee review – July 2019 – Board approved September 2019
17.0	October 2020	Julie Hill	Revision following Audit Committee review – October 2020
18.0	July 2022	Julie Hill	Revision following Audit Committee review – July 2022
19.0	July 2026	Julie Hill	Revision following Audit Committee review – July 2026

Document References

Document Title	Date	Published By
NHS Audit Committee Handbook	2025	HFMA
The NHS Foundation Trust Code of Governance for NHS Trusts	2022	NHS England

Authority

- 1.1 The Audit Committee is constituted as a Standing Committee of the Trust Board of Directors. Its constitution and terms of reference shall be set out as below, subject to amendment at future Board of Directors' meetings.
- 1.2 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.
- 1.3 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary.

Purpose

- 2.1 To conclude upon the adequacy and effective operation of the Trust's overall internal control system and independently review the framework of risks, controls and related assurances that underpin the delivery of the Trust's objectives.
- 2.2 To review the disclosure statements that flow from the Trust's assurance processes ahead of its presentation to the Trust Board, including:
 - a. Annual Governance Statement, included in the Annual Report and Accounts and the Annual Plan together with the external and internal auditors' opinions.
 - b. Annual Plan declarations relating to the Board Assurance Framework.

Membership

- 3.1 The membership of the Committee shall comprise three Non-Executive Directors, at least one of whom shall have recent and relevant financial experience, plus, ex officio, the Chair of the Finance, Investment & Performance Committee. The Chair of the Quality Assurance Committee will attend as and when there are appropriate matters to discuss with the Audit Committee.
- 3.2 The Chair of the Trust and the Chief Executive shall **not** be members.
- 3.3 The Chair of the Committee will be a Non-Executive Director and will not be a member of any other standing Committee of the Board.
- 3.4 A quorum shall be two members.

In attendance at meetings

- 4.1 The Committee will be supported by the following in attendance:
 - Chief Financial Officer
 - Director of Finance
 - Medical Director (or deputy)
 - ~~Head of Clinical Effectiveness and Audit~~
 - Director of Nursing and Therapies (or deputy)

- The Company Secretary

4.2.1 The Committee can invite the Chair and Chief Executive as well as other Trust Directors or Officers to attend to discuss specific issues as appropriate.

4.3 The Committee will be attended by representatives of the following:

- External Audit
- Internal Audit
- Counter Fraud
- ~~Clinical Audit~~

4.4 The Committee will consider the need to meet privately, at least once a year, with both the internal and external auditors. The internal and external auditors may request a private meeting with the Committee at any time.

Frequency and Administration of Meetings

5.1 The Committee will meet at least 4 times a year. It may meet more frequently at any time should circumstances require.

5.2 It will be supported by the Company Secretary who will agree the agenda for the meetings and the papers required, directly with the Chair.

5.3 Minutes of all meetings shall be formally recorded and submitted, together with recommendations where appropriate, to the Board of Directors.

Duties

Governance Risk Management and Internal Control

6.1 ~~The Committee shall review the establishment and maintenance of an effective system of integrated Governance, risk management and internal control, across the Trust's clinical and non-clinical activities that support the achievement of its objectives~~

The Committee will contribute to the overall delivery of the Trust's objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes across the Trust's clinical and non-clinical activities that support the achievement of its objectives.

6.2 The Committee shall ensure that the Board Assurance Framework is effective in enabling the monitoring, controlling and mitigation of risks to the Trust's strategic objectives.

6.3 In particular, the Committee will review the adequacy of the following:

- a. All risk and control related disclosure statements, together with any accompanying Head of Internal Audit statement, external audit opinion or other independent assurances, prior to endorsement by the Board;

- b. The underlying assurance processes that indicate the following:
 - ~~The degree of the achievement of corporate objectives~~
 - The effectiveness of the management of principal risks
 - The appropriateness of the disclosure statements
 - c. The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements.
- 6.4 The Committee shall request and review reports and positive assurances from Directors and managers on the overall arrangements for governance including ~~clinical audit~~, data quality, risk management and internal control.

Audit & Counter Fraud

- 6.5 The Committee shall ensure that there is an effective internal audit function ~~and clinical audit~~ that provide appropriate independent assurance to the Audit Committee and includes the following:
- a. Review the Internal Audit Plan, operational plan and programme of work and recommend this for acceptance by the Trust Board of Directors.
 - b. The review of the findings of internal audits and the management response.
 - c. Discussion and agreement with the External Audit of the nature and scope of the External Audit annual plan.
 - d. The review of all external audit reports, including the agreement of the annual audit letter before submission to the Board and any work completed outside the External Audit annual plan.
 - e. Review and approval of the Counter Fraud Plan and operational plans.
 - f. The review of the findings of the Counter Fraud plan and the management response.

Clinical Audit

~~The Committee shall ensure that there is an effective Clinical Audit process. This includes reviewing the annual clinical audit plan and receiving regular reports on both progress against the plan and the status of relevant action plans.~~

~~The Committee shall ensure that Internal Audit, External Audit and Clinical Audit recommendations are implemented promptly by management~~

Financial Reporting

- 6.6 The Committee shall review the Annual Accounts and Financial Statements before submission to the Board.
- 6.7 It will ensure that the financial systems for financial reporting to the Board are subject to review as to completeness and accuracy of the information provided to the Board.

- 6.8 It will review the annual accounts of the Charitable Trustees prior to submission.

Reporting

- 6.09 The Committee will routinely review the minutes of:

- Finance, Investment & Performance Committee
- Quality Assurance Committee
- Quality and Performance Executive Committee

and will review the work of other committees within the organisation whose work can provide relevant assurance to the Committee.

- 6.10 The Minutes of the Audit Committee will be formally submitted to the Trust Board.

- 6.11 The Chair of the Committee shall report to the Board any concerns and assurances relating to the Trust and the Committee's work.

- 6.12 The Audit Committee Chair will produce an Annual Audit Report setting out the work of the Committee and highlighting any issues raised during the course of year by the Trust's Internal and External Auditors and the Counter Fraud Specialist. It will report annually to the Council of Governors Trust Board through an 'Audit and Governance Report' which will include the following:

- a. The fitness for purpose of the assurance framework.
- b. The completeness and embeddedness of risk management.
- c. The integration of Governance arrangements.
- d. The Committee's self-assessment and any action required.

Other functions

- 6.13 The Committee will review and monitor compliance with Standing Orders and Standing Financial instructions.

- 6.14 It will review the following:

- a. Schedules of losses & compensations and making recommendations to the Board
- b. Any decision to suspend Standing Orders
- c. Decision to waive the competitive tendering rules when requested by the Board
- d. The Trust's Litigation activity
- e. Information Governance and Caldicott Guardian Annual Report

- 6.15 It will approve changes in accounting policies.

- 6.16 It will review the performance of the Audit Committee through self-assessment and independent review to be completed at least annually. It

will also review the output from the annual self-assessment exercises conducted by other Board Committees.

- 6.17 It will provide oversight of the Trust's processes for ensuring robust data quality and will review periodic reports on data quality performance.
- 6.18 The Committee shall provide assurance on the quality checks of data used in the preparation of the Performance Assurance Framework.
- 6.20 The Committee will provide assurance on the system for identifying cost improvement plans, including the process for ensuring that there are no adverse impacts on quality.

Amended: July 2026

Board approved: September 2026 To be confirmed

Next review: July 2027

Trust Board Paper

Board Meeting Date	08 September 2026
Title	The Use of the Trust Seal Report
	Item for Noting
Reason for the Report going to the Trust Board	In accordance with the Trust's Standing Orders, the Trust Board is informed each time the Trust's Seal is affixed to documents. The Trust is entering into a supplementary lease with Royal Berkshire NHS Foundation Trust on the 1st floor of the Greenham Trust Wing, West Berkshire Community Hospital to facilitate expansion of the chemotherapy suite. That also requires Deeds of variation with both the Royal Berkshire Sue Ryder as the expansion takes in some shared floor space which impacts on both the Royal Berkshire and Sue Ryder as regards rights of use and apportionment of service charges.
Business Area	Corporate
Author	Company Secretary
Relevant Strategic Objectives	Efficient use of resources Ambition: We will use our resources efficiently and focus investment to increase long term value