Berkshire Healthcare
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

TRUST BOARD MEETING

(conducted electronically via Microsoft Teams)

10:00am on Tuesday 13 January 2026

AGENDA

No	Item	Presenter	Enc.
OPENING BUSINESS			
1.	Chairman's Welcome and Public Questions	Mark Day, Interim Chair	Verbal
2.	Apologies	Mark Day, Interim Chair	Verbal
3.	Declaration of Any Other Business	Mark Day, Interim Chair	Verbal
4.	Declarations of Interest i. Amendments to the Register ii. Agenda Items	Mark Day, Interim Chair	Verbal
5.1	Minutes of Meeting held on 11 November 2025	Mark Day, Interim Chair	Enc.
5.2	Action Log and Matters Arising	Mark Day, Interim Chair	Enc.
QUALITY			
6.0	Board Story – Learning Disabilities Service	Debbie Fulton, Director of Nursing and Therapies/Becky Chester, Clinical Director/Daisy Coates, Daisy Coates, Interim Service Development Lead for Learning Disabilities	Verbal
6.1	Quality Assurance Committee a) Minutes of the meeting held on 25 November 2025 b) Learning from Deaths Quarterly Report c) Guardians of Safe Working Report	Sally Glen, Chair of the Quality Assurance Committee Dr Tolu Olusoga, Medical Director	Enc.
EXECUTIVE UPDATE			
7.0	Executive Report	Julian Emms, Chief Executive	Enc.
PERFORMANCE			
8.0	Month 08 2025/26 Finance Report	Paul Gray, Chief Financial Officer	Enc.
8.1	Month 08 2025/26 Performance Report	Theresa Wyles, Chief Operating Officer	Enc.
STRATEGY			

No	Item	Presenter	Enc.
9.0	“Green Plan” - Sustainability Strategy Update Presentation	Paul Gray, Chief Financial Officer/Kate Townsend, Sustainability Lead	Enc.
9.1	Neighbourhood Health Presentation	Theresa Wyles, Chief Operating Officer/Dr Laila Salhani-Maat, Consultant in Elderly Care and Clinical Lead for the Urgent Community Response, Berkshire West/Deepa Devadas, Consultant Nurse Practitioner in Frailty, Urgent Community Response Team	Enc.
CORPORATE GOVERNANCE			
10.0	Trust Seal Report	Paul Gray, Chief Financial Officer	Enc.
10.1	Council of Governors Update	Mark Day, Interim Chair	Verbal
Closing Business			
11.	Any Other Business	Mark Day, Interim Chair	Verbal
12.	Date of the Next Public Trust Board Meeting – 10 March 2026	Mark Day, Interim Chair	Verbal
13.	**CONFIDENTIAL ISSUES:** To consider a resolution to exclude the press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.	Mark Day, Interim Chair	Verbal

Berkshire Healthcare
NHS Foundation Trust

Unconfirmed minutes

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Minutes of a Board Meeting held in Public on Tuesday, 11 November 2025

(Conducted via Microsoft Teams)

Present:	Mark Day	Interim Trust Chair
	Rebecca Burford	Non-Executive Director
	Sonya Batchelor	Non-Executive Director *(present from 10.20)*
	Aileen Feeney	Non-Executive Director
	Rajiv Gatha	Non-Executive Director
	Sally Glen	Non-Executive Director
	Julian Emms OBE	Chief Executive
	Alex Gild	Deputy Chief Executive
	Debbie Fulton	Director of Nursing and Therapies
	Paul Gray	Chief Financial Officer
	Theresa Wyles	Chief Operating Officer
	Dr Tolu Olusoga	Medical Director
In attendance:	Julie Hill	Company Secretary
	Helena Gruenstern	Speech & Language Therapist *(present for agenda item 6.0)*
	Lisa Ellis	Neuro-Rehab Service Manager *(present for agenda item 6.0)*
	Mike Craissati	Freedom to Speak Up Guardian *(present for agenda item 6.1)*
	Jane Nicholson	Director of People *(present for agenda items 6.1- 9.0)*
	Ash Ellis	Deputy Director for Leadership, Inclusion and Organisational Experience *(present for agenda item 7.2)*
	Steph Moakes	Health, Wellbeing and Engagement Manager (present for agenda item 7.1)
	Martin Mannix	Director of Estates and Facilities *(present for agenda item 9.1)*
Observers:	Lianne Joyce	Essex Partnership University NHS Foundation Trust
	Sophia Jacques	Cygnet Heath

25/185	**Welcome and Public Questions** (agenda item 1)
	The Interim Trust Chair welcomed everyone to the meeting. There were no public questions. The Interim Trust Chair announced that the meeting would stop at 11.00 hours for a two-minute silence to commemorate Armistice Day.
25/186	**Apologies** (agenda item 2)
	There were no apologies. Apologies for lateness were received from Sonya Batchelor who was experiencing technical issues joining the meeting.
25/187	**Declaration of Any Other Business** (agenda item 3)
	There was no other business.
25/188	**Declarations of Interest** (agenda item 4)
	i. **Amendments to Register –** none.
	ii. **Agenda Items** – none
25/189	**Minutes of the previous meeting held on 09 September 2025** (agenda item 5.1)
	The Minutes of the Trust Board meeting held in public on Tuesday, 09 September 2025 were approved as a correct record.
25/190	**Action Log and Matters Arising** (agenda item 5.2)
	The schedule of actions had been circulated. Sally Glen, Non-Executive Director, asked for an update about raising awareness of unconscious bias for clinicians. The Chief Operating Officer reported that the issue of unconscious bias was discussed at the Assertive Outreach Team Oversight Group in October 2025. The Chief Operating Officer said that unconscious bias training was embedded as part of recruitment training and agreed to discuss whether it would be helpful to offer bespoke training on unconscious bias for clinicians with the Mental Health Division and the Nurse Consultant Network and inform the Board of the outcome of the discussions. **Action: Chief Operating Officer** **The Trust Board:** noted the action log.

25/191	**Community Based Neuro-Rehabilitation Board Story (**agenda item 6.0)
	The Interim Trust Chair welcomed Helena Gruenstern, Speech & Language Therapist and Lisa Ellis, Neuro-Rehab Service Manager to the meeting. Helen Gruenstern and Lisa Ellis presented a patient story about Elaine, who suffered a major stroke in 2021 resulting in global aphasia and severe apraxia of speech. Elaine's communication and independence were severely impacted. It was noted that Elaine received interventions from all disciplines in the team, with therapy blocks over three years, focusing on impairment, activity, and participation, aligned with WHO rehabilitation models. Initial goals included being able to order a coffee in a café and regaining confidence to be seen in public. Over time, Elaine progressed to joining groups and eventually aimed to return to caregiving roles, now using her stroke recovery experience. Helena Gruenstern said that without the team's intervention, Elaine would likely have been socially isolated, dependent on her son, and at risk of carer burnout and mental health decline. The Board watched a video of Elaine describing her stroke, initial confusion, hospital and rehab experiences, and her journey from being unable to speak, read, or walk to regaining confidence, social activity and setting new goals, such as sharing her experience to inspire others. Aileen Feeney, Non-Executive Director praised Elaine for sharing her moving story and asked for clarification on the "goals-based" approach adopted by the Neuro-Rehab service. Helena Gruenstern explained that the team worked with patients for eight weeks, focusing on what was most important to them, ensuring goals were achievable. Sally Glen, Non-Executive Director asked about outcome measures for the service and how team supported people whose first language was not English. Lisa Ellis confirmed that the team contributed to the national Sentinel Stroke National Audit Programme (SSNAP), which was expanding to community data and will help identify inequalities. It was noted that the team also used interpreters and worked with them to adapt therapy sessions. The Chief Executive highlighted the video as a powerful example of the Trust's mission to maximise independence and quality of life. The Chief Executive asked about partnership opportunities to improve patient transitions from acute hospitals. Lisa Ellis described close links with Royal Berkshire therapists and ongoing work to improve referrals from other units. The Chief Operating Officer asked about carer support. Lisa Ellis said that the team involved carers and was currently interviewing carers to better understand their needs. It

	was noted that the team was looking to expand support, including drop-in sessions and website resources. Sonya Batchelor, Non-Executive Director asked about equity of access for ethnic minority groups. Lisa Ellis said that early supported discharge referrals were equitable, but the team reviewed neuro rehab service referrals to ensure equity. Rebecca Burford, Non-Executive Director asked if speech and language therapy included sign language. Helena Gruenstern said that it could if indicated, but generally not unless the patient was deaf and already used sign language. It was noted that the team focussed on total communication, not just verbal. The Interim Trust Chair thanked Helena Gruenstern and Lisa Ellis for sharing Elaine's story and asked for the Board's thanks and appreciation to be passed on to Elaine. The presentation slides are attached to the minutes. **The Trust Board**: noted the Board Story.
25/192	**Freedom to Speak Up** (agenda item 6.1)
	a) Freedom to Speak Up Guardian's Six-Monthly Report The Chair welcomed the Freedom to Speak Up Guardian to the meeting. The Freedom to Speak Up (FTSU) Guardian presented the report and highlighted the following points: • There was a general rise in the number of cases reported over recent quarters. This increase was attributed to changes in national guidance, which now required advice-seeking contacts to be counted as cases, not just those escalated to senior management. In some quarters, spikes may occur due to collective concerns raised by multiple staff members, but this was not the case in the most recent periods. • Data was provided on which divisions and professional groups were raising concerns, with the majority of cases (about 60%) involving poor behaviours within teams, including bullying, harassment, and microaggressions. • The Trust had around 35 FTSU Champions, whose diversity largely matched that of the Trust, though there were gaps (notably among medics). • The FTSU Guardian was working with the Medical Director to address the lack of medical representation and was considering a more targeted approach to fill other gaps, especially in areas where the culture may need improvement.

- Feedback from staff who contacted the FTSU Guardian was generally positive, but there was a need to manage expectations about the Guardian's role, which was to act as a communication channel rather than to investigate or influence outcome.
- Providing appropriate feedback to those who raised concerns was important to minimise the risk of detriment and provide closure, while balancing confidentiality requirements.
- The report also highlighted the challenge of addressing bullying and inappropriate behaviours, and the need for the Trust to support improvement in those displaying such behaviours.

The FTSU Guardian said that the Trust had a positive culture but there was always room for improvement.

The Interim Trust Chair commented that it was timely to receive the FTSU Guardian's report as it was national Anti-Bullying Week.

Sally Glen, Non-Executive Director asked about the definition of "appropriate feedback" and whether there was a shared understanding of what this meant.

The FTSU Guardian acknowledged that appropriate feedback was subjective and often did not meet staff expectations, especially when outcomes were not as desired. The FTSU Guardian added that there was a review of Human Resources casework planned, and this would address what constituted meaningful feedback without breaching confidentiality.

Ms Glen suggested providing information upfront to set expectations. The FTSU Guardian confirmed that he was preparing a Question-and-Answer paper to clarify the FTSU Guardian's role and processes.

Sonya Batchelor, Non-Executive Director asked about quantifying the reach of FTSU activities, such as staff inductions, team visits, webinars, and manager support networks, to understand how many staff had been exposed to FTSU messaging.

The FTSU Guardian described his involvement in staff inductions, team visits, webinars, leadership training, and engagement with staff networks, but acknowledged that more could be done to measure reach. Ms Batchelor requested data on the number of staff touched by these activities, to better understand impact.

Action: FTSU Guardian

The Interim Trust Chair thanked the FTSU Guardian and noted the importance of Board members supporting FTSU during service visits.

The Interim Trust Chair acknowledged the FTSU Guardian's leadership both within the Trust and regionally and thanked him for his work.

The Trust Board: noted the report.

b) Freedom to Speak Up Improvement Plan Report

	The Director of Nursing and Therapies presented the report and highlighted the following points:
	
	• It was good practice, as detailed by NHS England for the freedom to speak up, self-reflection tool to be reviewed by organisations at least every two years, the aim being to identify gaps and areas for improvement as well as areas of good practice on a regular basis.
	• The latest version of our self-reflection and planning tool was approved by the Trust Board in March 2024; within the tool areas for ongoing improvement were identified.
	• It was agreed that progress against these would be presented to the Trust Board on a six-monthly basis, with timing to be such that the plan is available to the Trust Board for the same meetings as the Freedom to Speak Up Guardians Report.
	• There were two areas where there was further ongoing work, and these actions would be carried into the next improvement plan:
	  o the review of casework using a quality improvement approach – this had been delayed until after the Internal Auditors had undertaken their review of casework.
	  o Identifying how to gain positive stories following FTSU contacts – this remained challenging because staff were often reluctant to share their experiences even with anonymity.
	
	The Director of Nursing and Therapies reported that the FTSU Self-Assessment Tool would be revisited between January 2026 and March 2026 with the aim of a revised version being presented to the March Public Board meeting.
	Action: Director of Nursing and Therapies
	The Trust Board: noted the report.

25/193	**Patient Experience Quarterly Report** (agenda item 6.2)
	The Director of Nursing and Therapies presented a paper and highlighted the following points: • There was a recent drop in patient feedback due to a technical issue with the “I Want Great Care” SMS link, which stopped working during a platform transition. The issue was identified and rectified, with retrospective SMS requests sent, though there was concern about delayed feedback affecting response rates. • Staff had made efforts to increase feedback from young people in immunisation services by providing paper forms at sessions, resulting in approximately 2,000 responses. However, this lowered the overall satisfaction score for children and families, as many young people expressed dislike for immunisations which skewed the results. • There has been an increase in MP complaints, returning to pre-election levels after a drop-off last year. • Most complaints were now resolved informally at the local level, which was seen as positive, though it may result in a higher proportion of upheld complaints, as those escalating were more likely to have valid concerns.

	The Interim Trust Chair shared that the SMS issue with “I Want Great Care” had been raised with him during a recent service visit and was pleased to hear it had been resolved. **The Trust Board**: noted the report.
25/194	**Six-Monthly Safe Staffing Report** (agenda item 6.3)
	The Director of Nursing and Therapies presented a paper and highlighted the following points: • NHS England required that NHS trust boards to receive a Six-monthly Safe Staffing Report. The Finance, Investment and Performance Committee received monthly Safe Staffing Reports. • Over the reporting period, staffing across all wards had been assessed as safe with no significant incidents due to staffing identified. There were no expected changes that would alter this assessment in the near future. • The main change over the last six months was on mental health wards, where patient numbers were reduced from 22 to 18 on acute wards, and the configuration changed to two single-sex and two mixed-sex wards. • Benchmarking via the NHS England’s Model Hospital benchmarking model showed slightly lower registered staffing but higher total staffing (including healthcare assistants) compared to peers, supporting confidence in safe staffing levels. • There were improvements in mental health ward staffing, with reduced temporary staffing use and fewer shifts with less than two registered staff, showing positive trends compared to previous years. • The new safer staffing tool for community nursing had been refined and was back in use; the Trust will repeat the assessment in the new calendar year and include results in the next report. All clinical services were currently reviewing staffing, vacancy, and capacity metrics as part of the planning process. The Interim Trust Chair commended the Director of Nursing and Therapies and Director of People for their leadership in significantly reducing the number of shifts with less than two registered nurses on duty at the start of the shift **The Trust Board**: noted the report.
25/195	**Getting the Basics Right for Resident Doctors: Ten Point Plan Report** (agenda item 6.4)
	The Medical Director presented the report and highlighted the following points: • NHS England required Trusts to take action to improve working conditions for resident doctors and this was now part of the NHS Oversight Framework. Key

	issues addressed included access to rest areas, on-call parking, timely work schedules, and payroll accuracy. • Two named leads had been appointed (the Medical Director and a resident doctor peer lead), and a working group had reviewed all requirements to ensure plans were in place. • The Trust was on track to meet all requirements within the set timeframe, with ongoing monitoring and periodic board reporting. The Interim Trust Chair commented that most of the NHS England recommendations were basic good practice and asked if any requirements were surprising or new. The Medical Director identified two main areas for improvement: underpayment records (previously only overpayments were only tracked, leading to unresolved underpayments) and lack of a centralised annual leave approval system for doctors, which could impact the availability of medical cover. The Medical Director confirmed that solutions were being developed, including automation. Sonya Batchelor, Non-Executive Director asked about how resident doctors staff survey results compared to other staff. Ms Batchelor also questioned whether salary underpayment issues might exist elsewhere. The Director of People said that medical staff tended to have lower satisfaction rates in the staff survey, and this was consistent with national trends and recent resident doctor strikes. The Medical Director said that salary issues tended to occur when resident doctors worked for the Trust and for different organisations which was not the case for other staff groups. Rebecca Burford, Non-Executive Director asked if the current holiday booking system had caused any practical issues. The Medical Director explained that bottlenecks can occur during peak periods (summer, Christmas), and interim arrangements were being tightened, with plans for an electronic system to provide oversight. **The Trust Board**: noted the report.
25/196	**Executive Report** (agenda item 7.0)
	The following items were discussed further: **a) Appointment of Theresa Wyles, Chief Operating Officer** The Chief Executive reported that Theresa Wyles had been appointed to the substantive Chief Operating Officer position following a recruitment process after serving in an interim capacity.

b) Jess's Rule

The Interim Trust Chair raised a question regarding Jess's Rule, specifically its application in mental health settings and asked whether the rule applied equally to mental health or if there were differences in implementation.

The Medical Director explained that Jess's Rule was more applicable to the Trust's Out of Hours GP service (WestCall), where there had been cases of patients presenting multiple times without proactive second opinion arrangements.

The Director of Nursing and Therapies clarified that Jess's Rule was focused on physical health and misdiagnosis, and that the Trust will start its focus there. The Director of Nursing and Therapies acknowledged the importance of considering its application in mental health, noting the complexity of missed diagnoses in that area. The Trust will review how Jess's Rule might translate to mental health, as had been done with Martha's Rule.

c) District Nursing Recruitment

Sally Glen, Non-Executive Director asked about district nursing recruitment, referencing the national picture and a noted decrease in recruitment numbers. Ms Glen also asked about career pathways for Band 5 nurses and opportunities for progression, mentioning feedback from district nursing services about limited opportunities.

The Director of Nursing and Therapies explained that the Trust recruited many newly registered staff into community nursing and was developing a consultant nurse structure for community services, with roles in urgent and community response and advanced nurse practitioners.

The Director of Nursing and Therapies added that having fewer senior clinical roles compared to Band 5 roles was challenging but confirmed that clinical pathways existed and were being developed across children's and community services.

Ms Glen further asked about support for student nurses and Band 5s.

The Director of Nursing and Therapies highlighted the Trust's recent quality mark for preceptorship and good conversion rates from student to staff nurse in community nursing, though she acknowledged the challenges of supporting newly registered staff.

The Chief Executive said that national work emphasised the foundational role of district nurses and the need to consider how the role can be made more rewarding, possibly by addressing interface issues and offering varied experiences. The Chief Executive added that the Trust's Neighbourhood work could provide opportunities to strengthen community services and clinical sustainability.

The Trust Board: noted the report.

25/197	**Health and Wellbeing Update Report (agenda item 7.1)**
	The Interim Trust Chair welcomed the Health, Wellbeing and Engagement Manager to the meeting. The Health, Wellbeing and Engagement Manager presented the report and highlighted the following points: • The September step challenge ("Steptember") was successful with over 900 staff participating. • The Wellbeing Matters service saw a 20% increase in individual support requests, with team support remaining steady. A new system had improved confidentiality and reporting, especially for health inequalities and anti-racism work. • Compassionate mind training was being trialled, with one open-access group and one team group. • Financial support for staff was increasing: 15 staff received direct support, 11 received food bank vouchers (some multiple times), and 122 staff used salary advances. The team was monitoring this trend. • Wellbeing at Work sessions launched in March 2025 have had over 2,500 attendees, covering a variety of topics and receiving positive feedback. • The Trust was unsuccessful in the NHS Charities Together grant application but was reapplying and had secured funding from the Berkshire Healthcare Charity to run Citizens Advice Bureau sessions at Prospect Park and Upton Hospitals. • Team capacity had reduced, especially in ergonomics, so some services were being scaled back. The Health, Wellbeing and Engagement Manager requested that Board members promote health and wellbeing support during their visits to services and offered to provide a summary sheet. **Action: Director of People/Health, Wellbeing and Engagement Manager and Board Members** The Interim Trust Chair commented about the breadth of the Trust's health and wellbeing offer and the number of initiatives on offer despite the reduction in the size of the team. The Interim Trust Chair also commended the collaboration between the charity and wellbeing team and the professionalism of the wellbeing seminars and encouraged the Non-Executive Directors to attend the online seminars. **The Trust Board:** noted the report.
25/198	**Reducing Violence and Aggression Update report** (agenda item 7.2)

	The Interim Trust Chair welcomed the Deputy Director for Leadership, Inclusion and Organisational Experience to the meeting. The Director of Nursing and Therapies presented the report and highlighted the following points: • Most assaults (physical and non-physical) continued to occur in mental health settings. If current trends continued, The Trust would see more staff assaults this year than last, mirroring the national trend. • The Crown Prosecutions Service (CPS) had updated its guidance to reinforce prosecution of assaults on health workers, and the Trust had recently achieved a successful prosecution of a repeat offender. It was important to communicate this outcome to staff to encourage reporting. • NHS England had issued a revised Sexual Safety Charter Assurance Framework. The Trust had most of the requirements already. Minor updates included reviewing the chaperone policy and ensuring Board oversight of staff-on-staff allegations. The Deputy Director for Leadership, Inclusion and Organisational Experience reported that nationally there was an increase in staff experiencing abuse, particularly racial abuse from patients, their families and the public and this was reflected locally in the Trust's NHS Staff Survey and Workforce Race Equality Standards results. It was noted that the Trust had recently conducted an abuse survey with 400 responses which was currently being reviewed. Early themes included requests for more and better training, improved resources and equipment, awareness of tools, better technology for lone working devices, sanctions for perpetrators, and improved communication of incident outcomes. The violence prevention working group maintained a continuous focus on these issues. The Deputy Director for Leadership, Inclusion and Organisational Experience reported that the Trust was engaging with the Trust's leaders and managers and with the Race Equality Network along with a rapid improvement event at Prospect Park Hospital to address the issue. The Deputy Chief Executive reported that he had recently attended a meeting of the Trust's Anti-Racism in Healthcare Community Forum with staff representatives and community members and partners and said that attendees were deeply concerned about the rise in racism. The Deputy Chief Executive said that the Anti-racism Task Force had acknowledged the need for assertive action including sanction and consequences for perpetrators. Sally Glen, Non-Executive Director requested that future reports include numbers of police reports and prosecutions and asked about any correlation between inexperienced staff and assaults. **Action: Director of Nursing and Therapies** The Deputy Director for Leadership, Inclusion and Organisational Experience confirmed a correlation with younger, ethnically diverse staff, especially in mental health, and described efforts to address training gaps (e.g., breakaway skills for community nursing).

	Sonya Batchelor, Non-Executive Director expressed concern about rising numbers despite many initiatives. The Director of Nursing and Therapies pointed out that staff were often reluctant to report incidents to the police, especially in mental health, due to concerns about underlying illness versus behaviour. The Director of Nursing and Therapies emphasised the need for ongoing work to support staff in understanding when police reporting was appropriate. The Chief Operating Officer raised the issue of sanctions and the challenge of managing aggressive patients who may return for future care, questioning how the Trust balances patient needs with staff safety. The Interim Trust Chair acknowledged the Board's concern about rising violence and aggression and the importance of ongoing improvement initiatives. **The Trust Board:** noted the report.
25/199	**Month 06 2025-26 Finance Report** (agenda item 8.0)
	The Chief Financial Officer presented the report and highlighted the following points: • The Trust was on track with its financial plan, reporting a £1.3 million surplus year-to-date and forecasting a £1.7 million surplus for the year. All financial target metrics were being met except for the agency reduction target, which was at 28% against a 30% reduction goal; it was expected that this target would be achieved by year end • The reported position included a £0.6 million income clawback from the Integrated Care Board as part of a risk share agreement, with the Trust likely to absorb £1.7m of clawback by year-end, covered non-recurrently. • All divisions except mental health were controlling expenditure within set totals. Mental health faced challenges with talking therapy staffing costs and the cost external placements. • Workforce costs were underspent by £2.4 million year-to-date, with contracted staff numbers up but overall workforce (including temporary staff) flat. Agency spend was £1.1m less and bank spend £2m less than last year, with only a 2% gap to the NHS England agency target. • Cost Improvement Plan schemes were on track, with non-recurrent pay underspends and plan reserve releases offsetting delayed schemes. • Capital expenditure was £3m against a £6m target, with delays due to project phasing (Jubilee Ward), lease timing, and other project timing, but full spend was expected by year-end. • Cash was ahead of plan at £50.7m, aided by capital underspend. Sonya Batchelor, Non-Executive Director commended the finance team and the Trust for outstanding results and acknowledged the achievement meeting the financial performance metrics.

	The Trust Board: noted the report.
25/200	**Month 06 2025-26 "True North" Performance Scorecard Report** (agenda item 8.1)
	The Month 06 2025-26 "True North" Performance Scorecard Report had been circulated. The Chief Operating Officer presented the report and highlighted the following points: • Rapid tranquilisation incidents had increased. In the month, there were 40 incidents (target: 39), with a small number of patients responsible for most incidents. One patient on Rose Ward had 17 incidents, and rapid tranquilisation was part of their agreed treatment plan. • Length of stay for older adult wards performance was 109.6 days (target: 80), with occupancy at 82%, partly due to bed closures for renovation. There was a downward trend in length of stay. Adult wards were at 38.7 days (target: 42), with a four-month reduction trend, though this was affected by discharge patterns. • Lost bed days for adults and older adults were 548 (target: 250), with seven months RAG rated red; countermeasures will be refreshed. • Acute bed occupancy was over 97%. • Assaults on staff were 56 (target: 36). Community hospital length of stay is 25.34 days (target: 21), with occupancy at 89%. • Lost bed days in community hospitals are 801 (target: 695), but there was a downward trajectory. • "I Want Great Care" response rate was 8.4% (target: 10%), likely affected by SMS issues. • Sickness rate was 4.3% (target: 3.5%), with discussions about making this a True North objective for targeted improvement. Sally Glen, Non-Executive Director asked about Snowdrop Ward, noting increased assaults and patient feedback about respect and dignity. The Chief Operating Officer explained the ward had particularly challenging patients, with one patient causing frequent ligature incidents and assaults during intervention. A nurse consultant was working daily with the ward to review care plans and discharge options. Risk had increased during admission for some patients, and onward placements are challenging. The Medical Director added that the Trust was supporting staff to take positive risks and was reviewing best practice from other organisations to help staff care for complex patients. **The Trust Board**: noted the report.
25/201	**Finance, Investment and Performance Committee Meeting Held on 22 October 2025** (agenda item 8.2)

	Sonya Batchelor, Chair of the Finance, Investment and Performance Committee, reported that in addition to the standing agenda items, the Committee received a report on the Trust's work to reduce staff sickness. Ms Batchelor reported that the Committee had also received an update on the Trust's recruitment and retention work and highlighted that there had been a 5% increase in staff numbers (247 new staff) and a reduction in staff turnover from around 17% to 10%. The Interim Trust Chair thanked Ms Batchelor for her update.
25/202	**People and Culture Strategy and Equity Framework Update Report (**agenda item 9.0)
	The Deputy Chief Executive introduced the report and highlighted the strong progress on reducing staff turnover (now around 10% which was at its lowest level at the Trust and now one of the lowest in the region), high staff engagement and improvements across staff equity indicators. The Director of People presented the report and highlighted the following points: • The majority of staff leaving the Trust were retiring or leaving for work-life balance reasons rather than leaving to work elsewhere. • Following an efficiency review and in line with national spending requests, the People Directorate had identified £436,000 in cost reductions by 2026-7 in line with national demands for central services savings. The team was also pursuing cost avoidance, e.g., reviewing whether there was a cheaper option for providing resuscitation training rather than increasing the number of trainers. • There was a national mandate around ensuring that all job descriptions for nursing and midwifery roles from agenda for change band 4 were evaluated in line with new national profiles. Job Descriptions for Band 5 and 6 nursing roles have been finalised and were currently undergoing review with an Equality, Diversity and Inclusion perspective. Work on Band 7 nursing job descriptions was in progress. • A six-month pilot project had been launched whereby job candidates would be provided with the Interview questions in advance. • Direct engagement model for medical resources was being implemented to reduce agency spend. • Mid-year staff appraisals were focused on talent and career progression conversations with 1,350 completed so far, providing new insights and enable targeted talent management support. • The Trust was applying to be an early adopter of the new national electronic staff record (ESR) system, which would allow influence over system design and provide extra support. • The Trust's Anti-Racism Strategy was seen a national exemplar. The Medical Director referred to reducing agency costs for medics and confirmed that controls had been put in place to ensure that there was central control over approvals to use agency staff.

	Sally Glen, Non-Executive Director, asked whether the job evaluation process and review of Band 4 job descriptions was likely to lead to staff leaving. The Director of People said that she thought that this would be unlikely and pointed out that the rationale behind the national initiative was to make sure that there was consistency of roles between trusts. The Director of Nursing and Therapies added that over time the number of job descriptions had significantly increased and that this was an opportunity to tidy up job descriptions and reduce the number of separate job descriptions. The Interim Trust Chair thanked the Director of People and her team for their work. **The Trust Board**: noted the report.
25/203	**Estates Strategy Update Report** (agenda item 9.1)
	The Interim Trust Chair welcomed the Director of Estates and Facilities to the meeting. **a) Current Estates Strategy 2019-2024 and 2025-26 Trust Objectives Progress Update** The Director of Estates and Facilities presented the Estates Strategy progress and highlighted the following points: • Key achievements included maintaining high PLACE scores, efficiency savings through lease renegotiation and asset revaluation, and improved estate utilisation via consolidation. • Major projects included the Jubilee Ward relocation to St Mark's (due August 2026), the opening of the Place of Safety at Prospect Park Hospital, and the asset surveys and reset plan with the Prospect Park Hospital PFI Provider. • The Trust remained first or second regionally in PLACE scores and had maintained high compliance levels. • Sustainability initiatives included solar installations, EV fleet expansion, and heat decarbonisation surveys. • Benchmarking showed that the Trust was in the second quartile for costs despite having two PFI hospitals. • Frimley Integrated Care Board projects included Bracknell Hub construction being largely completed due to open in the new year, Skimped Hill refurbishments, King Edwards Hospital site reconfiguration subject to a number of snagging issues, and the new Chalvey GP Led construction project nearing completion. • Buckinghamshire, Oxfordshire and Berkshire West Integrated Care projects included: completion of phase 1 of the Bath Road consolidation project, the works for phase 4 relocation of Cremyll Road Services to Bath Road was out to tender.

	• West Berkshire projects included supporting the Royal Berkshire Hospital NHS Foundation Trust's MRI scanner project and a feasibility study for a solar farm. A bed strategy was being commissioned to determine future requirements. • The Trust was having early conversations about the potential impact of neighbourhood working on estates. **The Trust Board**: noted the report. **b) New Estates Strategy 2025-2030** The Director of Estates and Facilities presented the report and highlighted the following points: • The Estates strategy development involved six workstreams: financial, space utilisation, governance, clinical needs, sustainability and strategy compilation – bringing together all the workstreams into a coherent single strategy. • Achievements over the last five years included increasing the estate quality (condition B from 44% to 66%), reducing space occupied by 3% despite a 24% increase in headcount, and significant cost savings. • The strategy emphasised form following function, using lease breaks for rightsizing, and introducing sustainability and neurodiversity checklists for new/refurbished properties. • The capital programme for the next five years targeted key clinical and building quality needs. • The Estates team was planning for the PFI expiry and was considering in-house versus outsourced service delivery. The Director of Estates and Facilities thanked everyone involved in the development of the new Estates Strategy. The Interim Trust Chair commented that the Estates Strategy 2025-30 was very comprehensive and was fully aligned with the Trust's strategic priorities. **The Trust Board:** approved the Estates Strategy 2025-30.
25/204	**Trust Strategy Outcome Measures – Three Year Report** (agenda item 9.2)
	The Deputy Chief Executive presented the paper and reported that the Trust was making good progress against the majority of strategic outcomes. It was noted that there were some challenges in respect of the carbon emissions reduction target, and the I Want Great Care patient experience tool had not achieved its target, although there had been continuous improvement. **The Trust Board**: noted the report.

25/205	**NHS England's Provider Capability Self-Assessment Statement** (agenda item 10.0)
	The Deputy Chief Executive reported that the October 2025 Trust Board Discursive meeting had discussed NHS England's Provider Capability Self-Assessment Statement which encompassed the six domains of the Insightful Provider Board Framework and had confirmed "green" compliance across all domains. The Deputy Chief Executive said that the statement was submitted to NHS England by the deadline of 31 October 2025 and was presented to the Public Board meeting today for information. **The Trust Board**: noted the report.
25/206	**Audit Committee Meeting – 22 October 2025** (agenda item 10.1)
	The minutes of the Audit Committee meeting held on 22 October 2025 had been circulated. **The Trust Board:** noted the minutes of the Audit Committee meeting held on 22 October 2025.
25/207	**Trust Seal Report** (agenda item 10.2)
	It was noted that the Trust's seal had been affixed to a four-year lease renewal for Lake Road Health Centre, Portsmouth for the Trust's Veterans Service. **The Trust Board**: noted the report.
25/208	**Council of Governors Update** (agenda item 10.3)
	The Interim Trust Chair reported that the Council of Governors' Appointments and Remuneration Committee had overseen the recruitment of a new Trust Chair and had interviewed five candidates. The Committee's recommended candidate for appointment would be presented to an Extraordinary Council meeting on 12 November 2025.
25/209	**Any Other Business** (agenda item 11)
	There was no other business.
25/210	**Date of Next Public Meeting** (agenda item 12)

	The next Public Trust Board meeting would take place on 13 January 2026.
25/211	**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 11 November 2025.

Signed……. Date 13 January 2026

NHS
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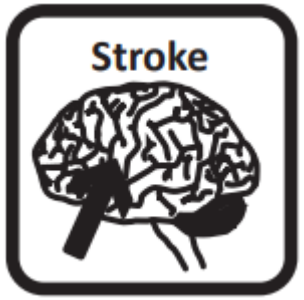
There is life after Stroke, I can do it and so can you

Elaine Hodgins- Service User

Introduction from Helena Gruenstern- Speech and Language Therapist, Community Based Neuro Rehab Team – Berkshire NHS

Background

Nurse in 1976
Hypnotherapy



Large Stroke (TACS, MCA)
May 2021

Global aphasia
Severe apraxia of speech

Community

And many more….

Thanks to cas-aac.org.uk for some of these images

Introduction

My **journey.**

If you don’t know anything, you **needn’t worry** because **time will help** you bring a little bit of you back.

Sadly I **thought** it was the **worst possible** thing to happen to me.

My Stroke

I had my stroke **at home**.

Annie, my **daughter** was **going out** to get meds from the pharmacy and **I stayed at home**.

Suddenly I **couldn't work out where I was**. I went to bed thinking I would feel better after a sleep.

When **Annie** came back home she **called the ambulance**. I was taken to **hospital** and kept in an induced **coma** for **two weeks**.

When I woke up my **first impressions** were 'I have had a **stroke**'.

My Rehabilitation

Newbury **community hospital** for a further **12 weeks** of **rehabilitation**. I certainly **didn't know anything about rehab**. I have **very little memory** of this time. It was a blur!

I was given everything- **physio**, **OT**, **speech therapy**, **psychology**.

I **couldn't**:

- **read** or **write**
- tell the **time**
- **talk**, not even 'hello'
- **walk**
- **wash** or **dress** myself
- **thinking** skills, especially my **memory** was affected.

Feel down thinking back to that time

When I **saw** James, my **son**, for the **first time** I was **shocked** as I remembered him as 11 years old, not the 44 year old man he is now. It **took** me some **time** to **get used** to him **being** a **grown man**.

Back Home

When I got home I more or less said to the doctor '**what's the matter with me**, I can't have had a stroke'. I **didn't want to believe** it. He replied 'I do believe **you have**'.

About a **year after** my **stroke** I **thought** I would **never recover**.

And **look at me now**!

I have received the **best treatment** yet.

My Recovery

Three years on I don't believe how much I have **recovered**. I am able to **remember**.

I've returned to **walking**, saying how I **feel**, making **drinks** and preparing **food**.

Confidence has grown.

I enjoy **going out** and **talking**. I go to **garden centres** and **meet friends** and am now able to **walk around the shops**.

For **longer distances** I use my **mobility scooter**…when the weather is dry!

Book club where I have just started to **read aloud** every week. I've been told this is amazing, but I **just feel normal**.

Hard work to get here. **Sometimes I didn't want to** do it. But my therapists **encouraged** me **to carry on.** I am **so glad I did.**

So you see,
I **can do it** and **so can you**

How long is a piece of string

My **next goal** is to get back to **finishing** my **romance book** that I was writing before the stroke.

I will also **continue** to share my story to **give** other **stroke survivors hope**.

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NHS Foundation Trust

Thank you

Questions…?

www.berkshirehealthcare.nhs.uk

Berkshire Healthcare NHS Foundation Trust

BOARD OF DIRECTORS MEETING 13.01.26

Board Meeting Matters Arising Log – 2026 – Public Meetings

Key:

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

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
12.01.24	24/198	Estates Strategy Update	The Quality Assurance Committee to have an opportunity to discuss the outcome of the Prospect Park Hospital Mental Health Survey.	May 2026	**MM**		
09.09.25	25/163	WRES and WDES	The Trust to consider benchmarking Prospect Park Hospital against other comparable inpatient mental health units.	March 2025	**JN**	The Trust has contacted Oxford Health, Surrey and Border Partnership and Midlands Partnership (currently the top ranked non-	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
						acute trust in the country) to take part in benchmarking work. Both Oxford Health and SABP have welcomed the opportunity to participate, and Midlands Partnership have a meeting with us in November. We will return to the Board when this exercise is completed.	
11.11.25	25/190	Matters Arising	The Chief Operating Officer to discuss with the Mental Health Division and Nurse Consultant Network whether it would be helpful to offer bespoke training on unconscious bias.	January 2026	**TW**	The action update is set out in appendix 1.	
11.11.25	25/192	FTSU Guardian's Report	The FTSU Guardian to measure the reach of the FTSU awareness work.	May 2026	**MC**	Information about the reach of the FTSU awareness work will be included in the next FTSU Guardian's	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
						report.	
11.11.25	25/192	FTSU Improvement Plan Report	The Director of Nursing and Therapies to present the draft FTSU Self-Assessment Tool at the January 2026 In Committee meeting and the final version at the March 2026 Public Board meeting.	January 2026 and March 2026	**DF**	On the agenda for the meeting.	
11.11.25	25/197	Health and Wellbeing Update Report	Members of the Board to promote health and wellbeing support during their visits to services. The Health, Wellbeing and Engagement Manager to provide a summary sheet for Board Members to use when visiting services.	March 2026	**SM**		
11.11.25	25/198	Reducing Violence and Aggression Update Report	Future reports to include numbers of police reports and prosecutions.	May 2026	**DF**		

Appendix 1

Action Update on Unconscious Bias (min no 25/190

Our reflective peer review process (individual and group) is designed to surface and mitigate unconscious bias through thoughtful and careful challenge and debate (evidence based).

Reviews are conducted using predefined criteria with reviewers looking for observable evidence in the written narrative, the language and approach that has been taken, creating space for discussion around alternative views, missing information, blind spots. This process commenced in Sept 2025, and we will undergo our first evaluation in January 2026.

We will also invite a review of the peer reviewers' findings (using a diverse group of carers and service users) as a further check point and challenge for unconscious bias.

Our culture of work does not position unconscious bias as a standalone focus. Instead, it supports the mitigation of unconscious bias through the following mechanisms that strengthen the cultural conditions that allow us to surface bias, challenge this and correct it in a supportive and sensitive way:

- Psychological safety and compassionate leadership
- Inclusion and Equity
- System learning rather than blame culture.

Our Patient Safety Incident and Risk Training include a significant experiential element this allows decisions to be slowed down and analysed, judgements to be revised and scenarios altered to increase awareness of bias. The training focuses on creating safety as we know bias can only be addressed when people feel safe enough to address uncertainty. For example, we have a specific programme of work on our PICU that has created safe space to examine the language being used and the impact of this.

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	13 January 2026
Title	**Quality Assurance Committee Meeting – November 2025**
	Item for Noting
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.
Business Area	Corporate Governance
Author	Julie Hill, Company Secretary (on behalf of Sally Glen, Committee Chair).
Relevant Strategic Objectives	**Harm Free Care** – providing safe services **Good Patient Experience** – improving outcomes

Berkshire Healthcare NHS Foundation Trust

Minutes of the Quality Assurance Committee Meeting held on Tuesday, 25 November 2025

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

Present:	Sally Glen, Non-Executive Director (Chair) Aileen Feeney, Non-Executive Director Rebecca Burford, Non-Executive Director Debbie Fulton, Director of Nursing and Therapies Julian Emms, Chief Executive *(present from 10.20)* Alex Gild, Deputy Chief Executive Daniel Badman, Deputy Director of Nursing for Patient Safety and Quality Theresa Wyles Chief Operating Officer Dr Tolu Olusoga, Medical Director *(present from 10.45)* Amanda Mollett, Associate Director for Medical Development, Clinical Effectiveness and Clinical Audit Helen Degruchy, Head of Patient Safety
In attendance:	Julie Hill, Company Secretary Claire Husbands, Head of Service, Talking Therapies *(present for agenda item 5.0)* Nicola Farrin, Operational and Performance Manager, Talking Therapies *(present for agenda item 5.0)* Reuben Pearce, Lead Consultant Nurse *(present for agenda item 5.6)* Katalin Walsby, Modern Matron *(present for agenda item 5.6)* Versha Mandalia, Associate Consultant Nurse *(present for agenda item 5.6)*
Observers:	Dr Anisha Soor, Registrar *(present from 10.45)* Radhika Gaire, Clinical Director, Community Physical Health

Opening Business

1 Apologies for absence and welcome

The Chair welcomed everyone to the meeting.

Apologies were received from: John Barrett, Patient Safety Partner.

Apologies for lateness due to a meeting clash were received from: Julian Emms, Chief Executive and Tolu Olusoga, Medical Director.

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 19 August 2025

The minutes of the meeting held on 19 August 2025 were confirmed as an accurate record of the proceedings.

4.2 Matters Arising

The Matters Arising Log had been circulated.

It was agreed that the action log would be amended to reflect that the Prospect Park Hospital asset survey would be presented to the May 2026 meeting rather than the February 2026 meeting.

Action: Company Secretary

The Action Log was noted.

Patient Safety and Experience

5.0 Talking Therapies Service Presentation

The Chair welcomed Claire Husbands, Head of Service, Talking Therapies and Nicola Farrin, Operational and Performance Manager, Talking Therapies to the meeting.

Claire Husbands and Nicola Farrin gave a presentation and highlighted the following points:

Background and Context

- The Talking Therapies service faced significant challenges with declining recovery rates during and after the pandemic. Initial assumptions attributed this to pandemic effects, but rates did not improve post-pandemic, prompting a deeper investigation in 2023.
- The service fell below national recovery rates and targets, raising concerns about patient outcomes.

Changes to Key Performance Indicators (KPIs)

- In 2024/25, KPIs shifted from access (volume of people entering the service) to completion of treatment courses
- New quality metrics introduced: reliable recovery (patients must both improve and reach recovery cut-offs) and reliable improvement
- The service was now expected to improve year-on-year against these new metrics.

Data-Driven Quality Improvement Approach

- The team undertook Quality Improvement training in 2023, which helped focus on root causes rather than surface-level data.
- Task and finish groups were established to conduct deep dives into data, identifying issues such as staff not always focusing on recovery cut-offs and the complexity of using ten different questionnaires.
- Training and supervision were refocused to ensure recovery awareness at all stages of the patient pathway.

Staff Wellbeing and Morale

- Staff wellbeing and morale were identified as critical factors. Increased waiting times were shown to negatively impact recovery rates.

- The service reviewed waiting times across different treatment types, noting that high-intensity (Step 3) interventions had particularly long waits.

Key Themes and Interventions

- Deep dives using fishbone analysis identified overarching themes: recovery awareness, recovery culture, and the importance of following NICE guidance.
- Quick wins included moving Step 2 (low intensity) work from telephone to video, merging waiting lists, and improving patient flow.
- Staff turnover had resulted in many newly qualified clinicians, necessitating additional support and training.
- Dedicated training and specialist supervision were developed for cultural and ethnic diversity, with early signs of improved outcomes for these groups.
- Long-term conditions team focused on adapting interventions for patients experiencing pain.

Engagement and Drop-Out Rates

- Engagement and drop-out rates were identified as major drivers of recovery. Longer waiting times were significantly correlated with lower engagement and recovery.
- Projects were initiated to streamline patient flow, including an "assess to treat" model where the assessor continues with the patient's treatment, improving engagement and reducing unnecessary reassessments.

Digital and Face-to-Face Offer

- Patients were offered a choice of digital (Silver Cloud), guided self-help, and group interventions, with plans to expand group options from January 2026.
- Waiting lists for high-intensity interventions (CBT and counselling) were managed by offering patients the shortest waiting list, with assessment by a high-intensity therapist to determine the most suitable intervention.
- The service considered, but did not implement, a senior clinician triage at the assessment stage.

Staff Return to Office and Face-to-Face Capacity

- A formal consultation was held to address the lack of staff offering face-to-face interventions, resulting in most staff now working at least one day per week in the office.
- Challenges remained in balancing office attendance across the week, particularly on Fridays and for part-time staff.
- Space constraints post-COVID required complex scheduling to ensure all staff could offer face-to-face appointments.

Self-Management Toolkit

- A digital self-management toolkit was introduced for patients on waiting lists, which has helped improve recovery rates even before treatment begins.

Outcomes and Impact

- Recovery rates had increased, with positive trends shown in service data.
- The service continued to monitor and refine interventions, with ongoing projects to further improve quality, engagement, and equity.

The Chair asked whether recruiting new staff was an issue.

Claire Husbands said that recruitment had been more of a challenge a couple of years ago, but since then, turnover had significantly reduced.

Aileen Feeney, Non-Executive Director asked whether there were opportunities for using digital to enhance the service.

Claire Husbands reported that the service was working on a big piece of work to automate referrals (the service received 27,000 referrals per annum).

Ms Feeney asked whether co-production had been used in the service.

Claire Husbands reported that the service had engaged with the "Friends of Talking Therapies" in a piece of work to update risk assessment training and safety plans. Ms Husbands said that the service would be starting a project with young people to improve their engagement with the service.

The Chair thanked the presenters for a comprehensive and impactful presentation, noting the significant work undertaken and the positive direction of the service.

The Committee noted the presentation.

5.1 Quality Concerns Register Report

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

- **Audiology** had been re-accredited and removed from the Quality Concern Register.
- **Workforce challenges at Prospect Park Hospital** had improved, with increased numbers of newly qualified staff and reduced turnover, so this had been removed from the Register.
- **Paediatric Occupational Therapy (OT)** was added to the Register due to over 52-week waits; actions included a new advice line and ongoing monitoring of engagement with those waiting.
- **Phoenix House** was also added due to lower-than-expected numbers of young people and a review of the operating model.
- **Senior Leadership Capacity:** Concerns remained about senior leadership capacity at Prospect Park Hospital due to multiple ongoing initiatives, estates and facilities work, and cultural programmes.
- **Bed Occupancy:** Bed occupancy at Prospect Park Hospital was high (97–98%) and not decreasing, which remained a concern.

The Chair commented that she found the Quality Concerns Register a very useful report.

The Committee noted the report.

5.2 Experience of Care Report

The Director of Nursing and Therapies presented the paper and pointed out that there were overlaps with the Experience of Care Framework and the Trust's existing workstreams around reducing health inequalities, equity, quality improvement, co-production.

The Director of Nursing and Therapies said that she was planning to present a draft completed baseline assessment to the January 2026 In Committee meeting for discussion pending presenting the final report to the Public Trust Board meeting in March 2026.

Action: Director of Nursing and Therapies

The Committee noted the report.

5.3 "Martha's Rule Implementation Report

The Director of Nursing and Therapies presented the paper and highlighted the following points:

- **Implementation Update:** Martha's Law had been successfully implemented in both mental health and community wards and was now operating seven days a week. Work was ongoing to extend coverage to out-of-hours periods.
- **Escalation Process:** Since going live in February 2025 in mental health, there had been only one escalation, which was initiated by a staff member. This suggested that there were underlying robust processes for patient safety and escalation.
- **Proactive Deterioration Detection:** The "How are you today?" approach was used to proactively identify patient deterioration, even when not evident in physical observations. This was now digitally integrated with the patient record in physical health and was being shared with mental health services.

The Chair congratulated the Director of Nursing and Therapies for adapting "Martha's" Rule for mental health and community health wards.

The Committee noted the report.

5.4 "Jess's Rule" – Verbal Update

The Chief Operating Officer reported that a working group had been established to assess the implications of Jess's Law for the Trust, particularly in mental health and community settings.

It was noted that Jess's Law was primarily aimed at primary care, for example the Trust's Out of Hours GP service, WestCall, but the Trust was reviewing its applicability to self-referral routes in mental health and MSK physiotherapy. The working group was considering how to track multiple attendances and ensure appropriate escalation or second opinions.

The Chief Operating Officer confirmed that an update on Jess's Rule would be presented at the next meeting.

Action: Chief Operating Officer

Aileen Feeney, Non-Executive Director asked whether Jess's Law would apply to someone on a waiting list.

The Chief Operating Officer said that it could do, but pointed out that it was more likely to be someone who had been referred to the Out of Hours GP service multiple times, but their needs were not met

The Chair thanked the Chief Operating Officer for her update.

5.5 MHRA medical beds, trolleys, bed rails, bed grab handles, and lateral turning devices: risk of death from entrapment or falls - update on actions

The Director of Nursing and Therapies presented the paper and highlighted the following points:

- **National Context:** The Trust was ahead of other organisations in the system, with only a small portion of training outstanding.
- **Training Compliance:** The Trust had achieved 85% compliance staff training meeting the target.
- **Patient-initiated follow-up:** patients could request a follow up meeting if there were changes in their condition.

The Director of Nursing and Therapies suggested that pending any national or system updates, that the Committee would no longer receive a written update at every meeting and that updates would be presented verbally.

Rebecca Burford, Non-Executive Director asked about the outstanding 15% of staff who had not received training.

The Director of Nursing and Therapies confirmed that the 15% of staff who required training would include staff on long term sick and maternity leave and pointed out local managers were responsible for ensuring that other staff were trained.

The Committee:

a) Noted the report
b) Agreed that other than national or system updates, future updates would be verbal rather than written.

Action: Director of Nursing and Therapies

5.6 Sexual Safety Charter Update Report

The Chair welcomed Reuben Pearce, Lead Consultant Nurse, Katalin Walsby, Modern Matron and Versha Mandalia, Associate Consultant Nurse to the meeting.

Reuben Pearce, Katalin Walsby and Versha Mandalia gave a presentation and highlighted the following points:

National and Local Context

- Sexual safety on inpatient mental health wards remained a national concern, highlighted by the 2018 CQC report and 2020 Royal College of Psychiatry standards. NHS England's Culture of Care work also emphasised proactive, standards-based approaches to sexual safety.
- Locally, incidents, complaints, and feedback indicated that patients did not always feel safe from sexual harm or unwanted sexual behaviour, and staff may lack confidence or skills to address such issues.

Sexual Safety Steering Group

- A Sexual Safety Steering Group was established at Prospect Park Hospital, including nurse consultants, clinical leads, safeguarding, patient safety, psychology, therapies, and Datix colleagues.
- The group's remit was to implement sexual safety standards, oversee benchmarking, and develop a three Cs (concerns, causes, countermeasures) plan.
- Each ward now had a named sexual safety lead, providing a clear link between the steering group and day-to-day practice, and acting as a point of contact for advice and escalation.
- Previous reliance on sexual safety "champions" was found insufficient; the new approach emphasised leadership accountability.

Benchmarking and Self-Assessment

- The service conducted a RAG-rated self-assessment against the seven Royal College standards.
- Strengths: Organisational culture and leadership, with visible senior support and will to improve.
- Amber areas: Trauma-informed practice, patient voice in care planning, staff training and supervision, post-incident support, patient-facing information, multi-agency working, and consistency of incident response and data use.
- Two main problem statements were developed: preventing sexual safety incidents and improving response when incidents occurred.

Data and Reporting Improvements

- The group triangulated Datix incident reports, safeguarding referrals, and case reviews/ward feedback to ensure data was meaningful and contextual.
- Datix system had been updated: new codes for sexual language, harassment, and privacy/dignity issues; prompts for staff to record details; and removal of “alleged” from category labels for a more trauma-informed approach.
- These changes had improved data quality, reduced administrative burden, and enabled better trend analysis by ward and incident type.
- Early data showed a richer and more accurate picture of sexual safety incidents, with improved categorisation and follow-up.

Key Progress and Interventions

- In April, the service moved to a hybrid and single-sex ward model, with tighter admission planning to reduce environmental risks and better match patient needs.
- Sexual safety was now a standing item in safety huddles, MDT meetings, and handovers, with daily consideration of who was vulnerable or posed a risk.
- Trauma-informed communication is emphasised, and governance processes for reporting, monitoring, and learning from incidents had been strengthened.
- Updated patient leaflets, posters, and charters have been developed with staff and patient input.

Risks and Ongoing Challenges

- Risks included under-reporting or normalisation of low-level behaviours (e.g., sexualised comments, inappropriate touching), environmental constraints (e.g., ward layout, blind spots), and staff confidence, especially among temporary staff.
- The need to distinguish between trauma-related disinhibition and deliberate predatory behaviour was highlighted, with a commitment to both trauma-informed care and robust action against predatory conduct.

Next Steps

- Review and update the sexual safety policy, flowcharts, and checklists in light of recent changes.
- Plan a sexual safety campaign, possibly during Sexual Abuse Week in February, to raise awareness.
- Launch new patient information materials and deliver leadership and ward-based training on trauma-informed communication.
- Safeguarding team to deliver a sexual safety session as part of Smart Week.
- Develop a new dashboard for monitoring trends and targeting quality improvement.
- Strengthen multi-agency pathways, particularly where safeguarding and Human Resources processes intersect.

The Chair asked whether there was a risk around sexual incidents being normalised.

Reuben Pearce said that cultural aspects of sexual safety and the need for staff to have the language and confidence to address issues was at the heart of sexual safety.

The Chair asked whether newly qualified staff received training on boundaries.

Versha Mandalia confirmed that preceptees received bespoke training on sexual safety.

The Deputy Chief Executive asked whether there was any sharing of learning with other services (e.g., Campion Unit, Phoenix House, community inpatient wards).

Reuben Pearce said that the sexual safety work was currently focussed on Prospect Park Hospital but agreed to consider what learning could be shared across other areas.

The Chair asked whether the Trust benchmarked itself against other similar trusts.

Reuben Pearce said that the sexual safety was part of the Trust's Culture of Care Programme which was supported by a learning network of other trusts which was an opportunity to share good practice and learning.

The Chair thanked Reuben Pearce, Lead Consultant Nurse, Katalin Walsby, Modern Matron and Versha Mandalia, Associate Consultant Nurse for their presentation.

The Committee noted the presentation.

5.7 Prevention of Future Deaths Regulation 28 Reports, Including Responses, and Any Action Report

The Deputy Director of Nursing for Patient Safety and Quality presented the paper and reminded the meeting that five Prevention of Future Deaths Reports had been received between June 2023 and May 2024.

The Deputy Director of Nursing for Patient Safety and Quality confirmed that most of the outstanding actions related to the full implementation of the "One Team" approach across community mental health services. There were no areas where progress was not being made against agreed actions.

The Chair asked about the relationship between the Crisis Team and the Inpatient Teams.

The Deputy Director of Nursing for Patient Safety and Quality confirmed that there was a lot of joint working between the Crisis Inpatient Teams with joint attendance at Multi-Disciplinary Team meetings and discharge planning meetings.

The Chief Operating Officer added that the work between all the community crisis pathways and inpatient bed management around who was a priority for a bed had significantly improved over the last year. It was noted that there were daily meetings for prioritisation and shared accountability between the two teams. It was also noted that colleagues from the acute sector were also part of the conversation now. The Chief Operating Officer said that this was helping to manage those relationships when patients were waiting for a bed.

The Deputy Director of Nursing for Patient Safety and Quality suggested that the Committee receive a presentation from the Community Mental Health team at a future meeting.

Action: Deputy Director of Nursing for Patient Safety and Quality

The Chair commented that the Mental Health Act Governance Board reviewed any incidents involving patients waiting for a bed.

The Committee noted the report.

5.8 Reducing Restrictive Practices Report

The Deputy Director of Nursing for Patient Safety and Quality presented the paper and highlighted the following points:

- **Seclusion Review:** there was ongoing work to reduce the length of time patients spent in seclusion. Consultant Nurse reviews were now triggered earlier (previously at seven days), aiming to further reduce long stays and drive cultural change.
- **Prone Restraint Deep Dive:** the Trust was investigating the use of prone restraint, particularly in police transfers. Data comparison with Oxford Health NHS Foundation Trust showed much lower usage at Berkshire Healthcare, but the aim remained to eliminate prone restraint entirely.

The Chair asked whether more EUPD (Emotionally Unstable Personality Disorder) patients were being admitted.

The Deputy Director of Nursing for Patient Safety and Quality confirmed that admissions for EUPD patients had reduced but those admitted tended to be more complex and stayed longer. The Deputy Director of Nursing for Patient Safety and Quality stressed the importance of clear admission purpose, targeted interventions, and consistent discharge planning.

The Medical Director added that there needed to be consistent responses and support for EUPD patients across inpatient and community services. The Chief Operating Officer commented that this was especially important during transfers of care for high-risk patients.

The Committee noted the report.

5.9 Patient Safety and Learning Report

The Head of Patient Safety presented the paper and reported that the Patient Safety Incident Framework was now business as usual. Most complex investigations focussed on mortality cases within mental health, with learning responses primarily in the mental health division.

The Head of Patient Safety said that the new framework allowed for reviews of near misses, which would not have been examined under the previous system.

The Head of Patient Safety reported that the Family Liaison Practitioner was busier than ever, supporting more patients and families with positive feedback.

It was noted that a recent incident involving a wrong injection was reviewed jointly with the Royal Berkshire Hospital, resulting in more robust learning than if the incident had been reviewed in isolation.

The Committee noted the report.

5.10 Patient Safety and Health Inequalities Framework

The Deputy Director of Nursing for Patient Safety and Quality presented the paper and highlighted the following points:

- In May 2025, NHS England published a framework for use by all NHS providers, particularly managers and leaders implementing strategies to foster a culture of inclusive, safe care.
- This framework was produced in recognition of there continuing to be unfair and avoidable differences in health between groups, populations or individuals arising from unequal distribution of social, environmental, and economic conditions within society. These influence the risk of people becoming ill, their ability to prevent illness, their opportunities to access the right treatment with unwell, resulting in some people having poorer outcomes or longer recovery time than others.
- The framework described national actions being taken and opportunities for providers and Integrated Care Board's to reduce patient safety inequalities.
- The framework reflected the six themes relating to the mechanisms driving heightened risk of preventable harm:
    - Enhancing Communication
    - Encouraging and activating patient engagement in their own care
    - Reducing workforce and system biases
    - Enabling smooth transitions of care
    - Making care accessible
    - empowering insightful data
- The Trust had self-assessed itself against the framework. The Trust was performing well across all domains, with good examples of delivery, but some areas required

further action and development. These will be monitored through the Health Inequalities Steering Group.

The Chair asked about whether the Trust could do more to promote health literacy within the local population.

The Chief Executive queried whether promoting health literacy should be the responsibility of the strategic commissioners rather than trusts. The Chief Executive commented that it was important that the Trust focussed its efforts on areas where it could make the most impact.

The Committee noted the report.

5.11 Infection Prevention and Control Quarterly Report

The Infection Prevention and Control Quarterly Report had been circulated.

The Director of Nursing and Therapies presented the report and highlighted that the Trust's staff flu vaccination take up rate was currently at 37% which was in line with national rates. It was noted that there had been an outbreak of flu on one of the community wards.

The Director of Nursing and Therapies commented that it was predicated to be a tough year for flu based on the experience in the southern hemisphere. It was noted that the Trust's Staff Flu Vaccination Programme would carry on longer than usual to try and increase vaccination rates.

The Committee noted the report.

5.12 Quality Related Board Assurance Framework Risks Report

The quality related Board Assurance Framework Risks had been circulated.

The Committee noted the report.

5.13 Learning from Deaths Quarterly Report

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

- Of the second stage reviews concluded in quarter 2, none of the deaths were a governance cause for concern. Five reviews had identified poor care, and learning had been identified and was being implemented through the relevant divisions which included the following services:
    - Community physical health inpatient transfer (1)
    - Community mental health (3)
    - Mental health inpatient (1)
- All complaints received from families of individuals who had died resulted in a second stage review of the care provided. No concerns were raised by the Medical Examiner on behalf of the next of kin.
- 8 reviews related to patients with a learning disability. All were reported in line with national guidance to LeDeR who completed independent reviews covering the full patient pathway.

The Committee noted the report.

Clinical Effectiveness and Outcomes

6.0 Clinical Audit Report

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

a) **Prescribing Observatory for Mental Health (POMH) Topic 24a: Opioid Medications in Inpatient Mental Health Services**

Berkshire Healthcare had demonstrated mixed performance when benchmarked against the national average. 5 standards have been identified as having further room for improvement.

b) **Summary Report for the National Respiratory Audit Programme (NRAP) – Pulmonary Rehabilitation audit 2025**

The Catching Our Breath report offered valuable insights into the Pulmonary Rehabilitation service performance nationwide, enabling the Trust's Cardiac and Respiratory specialist services to benchmark against national standards. The service met 3 out of 6 KPIs, with strong results in those areas and has met a fourth KPI since this data collection period. For unmet KPIs, an action plan had been developed to investigate and address underlying issues. Although not all targets were achieved, the Service remained accredited by the Royal College of Physicians, confirming that it did meet required accreditation standards.

c) **NCEPOD ICU Rehabilitation audit Summary (ID 11613) - 'Recovery Beyond Survival' - A review of the quality of rehabilitation care provided to patients following an admission to an intensive care unit.**

The national report made 6 key national recommendations, with 3 relevant to Berkshire Healthcare's community services (Recommendations 1,3 and 4). All recommendations were being met. However, the services have identified further actions which will ensure best practice.

d) **Summary Report for the Infants, children, and young people with life-limiting conditions Learning from child death reviews on palliative and end of life care provision by the National Child Mortality Database Programme – July 2025**

The national report made 5 key recommendations, with all 5 relevant to the Specialist Children's service. The current service provision for palliative and end of life care within the division was found to meet the recommendations within the report. The main gap that had been identified was around commissioning of 24/7 all year-round hospice support/specialist hospice outreach services.

The Chair noted that six clinical audit reports were due to be presented to the February 2026 QAC meeting.

It was noted that this was due to delays in national publication timelines, which had affected the scheduling of local reviews. The Associate Director for Medical Development, Clinical Effectiveness and Clinical Audit said that if the volume of clinical audit reports was too many, she would priories those with higher risk and may defer others.

Action: The Associate Director for Medical Development, Clinical Effectiveness and Clinical Audit

The Chair commented that there were long waiting lists for pulmonary rehabilitation services. It was noted that the service had appointed a new nurse which would improve the service's capacity.

The Committee noted the report.

6.1 Quality Accounts 2025-26 – Quarter 2 Report

The Quality Accounts 2025-6 quarter 2 report had been circulated for information.

The Associate Director for Medical Development, Clinical Effectiveness and Clinical Audit confirmed that there were no new or unexpected items in the current report. It was noted that the quarter 3 report would be shared with stakeholders.

The Committee noted the report.

Update Items for Information

7.0 Guardian of Safe Working Hours Quarterly Report

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

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

The Medical Director reported that there had been seven exception reports during the reporting period mainly relating to trainees working up to 30 minutes beyond their scheduled hours, with two instances involving complex patients requiring extra time.

The Committee noted the report.

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

The minutes of the Mental Health Act Governance Board meetings held on 7 November 2025 had been circulated.

The Chair acknowledged the ongoing work to strengthen the Mental Health Act Governance Board and commended the Medical Director for his efforts in improving committee governance.

The Medical Director reported that there was an ongoing issue with achieving “one version of the truth” regarding data flows. It was noted that Prospect Park Hospital staff were working closely with the Mental Health Act Office to ensure consistency and accuracy across all data sources.

The Chair noted that the MHA Governance Board had agreed to benchmark ethnicity data against the local community rather than relying solely on absolute numbers. The Medical Director said that this work was in progress and would continue to be developed.

It was noted that the shower facilities in the seclusion room had been outstanding since 2020. Plans had been drawn up, and it was hoped that the work would be completed by the end of December 2025.

The Committee noted the minutes.

7.2 Quality and Performance Executive Group Minutes – August 2025, September 2025, and October 2025

The minutes of the Quality and Performance Executive Group minutes for August 2025, September 2025 and October 2025 had been circulated.

The Committee noted the minutes.

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

The following Service Visit Reports had been circulated:

- Criminal Justice Liaison and Diversion: Mental Health
- Community Learning Disability Service Team Bracknell.

The Chair thanked the Non-Executive Directors and Governors for their reports.

The Committee noted the reports.

8.0 Quality Assurance Committee Horizon Scanning

The Committee agreed that it would be helpful to have a presentation on the Community Mental Health Crisis Team at a future meeting.

Action: Company Secretary

8.1. Any Other Business

Oliver McGowan Mandatory Training on Learning Disability and Autism

The Director of Nursing and Therapies reported that 95% of staff had completed the tier 1 Oliver McGowan Mandatory Training on Learning Disability and Autism. The Trust had started to deliver tier 2 training which was face to face.

The Director of Nursing and Therapies reported that NHS England was currently reviewing NHS mandatory and statutory training and commented that she hoped there would be an opportunity to provide feedback about the Oliver McGowan training which was repetitive.

The Chair thanked the Director of Nursing and Therapies for her update.

8.2. Date of the Next Meeting

The next meeting was scheduled to take place on 24 February 2026 at 10am. The meeting would be held face to face at London House, Bracknell with the option of attending the meeting via MS Teams.

These minutes are an accurate record of the Quality Assurance Committee meeting held on 25 November 2025

Signed: - _____

Date: - 24 February 2026 _____

Board Meeting Date	November 2025
Title	**Learning from Deaths Quarter 2 Report 2025/26**
	Item for assurance and noting. Discussion where additional assurance required about quality of care, data or learning.
Purpose	To provide assurance to the Trust Board that the Trust is appropriately reviewing and learning from deaths
Format of the Report	The overall format of the report is not nationally prescribed for Mental Health & Community Health NHS Trusts, however there are a number of metrics which are nationally required and are included within this report.
Business Area	Clinical Trust Wide
Author	Associate Director of Medical Development and Clinical Effectiveness & Clinical Audit
Relevant Strategic Objectives	The systems and processes for learning from deaths align with and give assurance against the three strategic objectives below: **Patient safety** We will reduce harm risk for our patients by continuous learning from review of deaths. **Patient experience and voice** We will review all complaints, concerns and feedback (from patient's families and staff, Medical Examiner, Coroner) to inform improvement in the quality and safety of clinical care in our services. **Health inequalities** We will reduce health inequalities for our most vulnerable patients (patients with learning disability, autism, severe mental illness) by reviewing the care provided to patients leading up to their death and learning for improvement.
CQC Registration/Patient Care Impacts	No impact
Resource Impacts	None
Legal Implications	New Statutory requirements for Medical Examiners from 9th September 2024 noted, actions taken to ensure that these requirements are fully met in advance of this date.
Equality, Diversity and Inclusion Implications	A national requirement is that deaths of patients with a learning disability & Autism are reviewed to promote accessibility to equitable care. This report provides positive assurance of learning from these deaths. Ethnicity data is included in the report.
SUMMARY	Since January 2024 the Mortality and Patient Safety meeting (MAPs) brings together the processes for review, Quality Assurance and Learning from all deaths in the trust and this report represents a summary of that function. **Patient safety** Of the second stage reviews concluded in Quarter 2, none of the deaths identified a governance cause for concern (avoidability score of 3). 5 reviews identified poor care, all have been reviewed as patient safety reviews and learning is identified and being implemented through the relevant divisions. Which included the following services: Community physical health inpatient transfer (1), community mental health (3), mental health inpatient (1) **Patient Experience and Voice** All complaints received from families of individuals who have died, resulted in a second stage review of the care provided. No concerns were raised by the medical examiner on behalf of the next of kin. **Health inequalities** 8 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 Q2 learning from deaths.

Learning From Deaths Q2 Report (2025/26)

Berkshire Healthcare NHS Foundation Trust

Figure 1-	22/23	23/24	24/25	Q1 25/26	Q2 25/26	Q3 25/26	Q4 25/26	Total 2025/26
Total deaths screened (Datix) 1st stage review	456	453	553	119	105	-	-	**224**
Total number of 2nd stage reviews requested (SJR/IFR)	192	203	237	38	40	-	-	**78**
Total number of deaths to be reviewed through patient safety (PSII and PSR) declared in Quarter	31	31	36	10	11	-	-	**21**
Total Expected Deaths	-	183	219	45	47	-	-	**92**
Total Unexpected Deaths	-	270	324	74	58	-	-	**132**
Total number of deaths judged > 50% likely to be due to problems with care (Avoidability score of 1, 2 or 3)(concluded in quarter)	0	0	0	1	0	-	-	**1**
Number of Hospital Inpatient deaths reported (Including patients at the end of life and unexpected deaths following transfer)	156	140	159	39	34	-	-	**73**
Total number of deaths of patients with a Learning Disability (1st stage reviews)	36	53	49	12	6	-	-	**18**
Total number of deaths of patients with Learning Disability where care was rated as poor	0	0	0	0	0	-	-	**0**

Q2 2025/26

740 deaths were identified on RiO where a patient had died from any cause within a year of contact with any Trust service, of these 105 were submitted for a 1st stage review in line with the learning from deaths policy (14%).

All 105 deaths had first stage review by the Executive Mortality Review Group (EMRG) in Q2, 2nd Stage reviews were requested for 40 (38%). 40 2nd stage reviews were concluded by the Mortality and Patient Safety Review Group during Q2.

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

Of the reviews concluded in Q2 5 were assessed as overall poor care, and learning is detailed for both physical health and mental health inpatient wards as well as community services.

2nd stage Mortality reviews completed (SJR/IFR)	Q2 (40)	Total 2025/2026 (92)
Adult Learning Disabilities Services	**8**	19
Mental Health community, specialist, and inpatient services	**18**	33
Children's and Young people's Services	**1**	1
Physical Health community and Inpatient Service	**13**	39

	Avoidabilty score for 2nd Stage Reviews (only death due to a physical health cause) 2024/2025	Q2 (40)	Total to date (92)
Score 1	Definitely avoidable	**0**	0
Score 2	Strong evidence of avoidability	**0**	0
Score 3	Probably avoidable (more than 50:50)	**0**	1
Score 4	Possibly avoidable, but not very likely (less than 50:50)	**2**	3
Score 5	Slight evidence of avoidability	**2**	5
Score 6	Definitely not avoidable	**21**	57
N/A	Non physical health cause	**15**	26

	Overall Assessment of Care Q2 (40)	Physical health	Learning Disability	Mental Health	Children and Young People	Total to date 25/26 (92)
1	Very poor care	0	0	0	0	0
2	Poor Care	1	0	4	0	8
3	Adequate Care	5	2	6	0	31
4	Good Care	6	6	8	1	51
5	Excellent Care	1	0	0	0	2
	N/A	0	0	0	0	92

Ethnicity April 2025 – March 2026 (Rolling data to be updated each quarter)	1st Stage Review 2025/26	2nd Stage Review Requested 2025/26	% 2nd stage review requested
Asian or Asian British - Any other Asian Background	2	2	100
Asian or Asian British – Indian	5	1	20
Asian or Asian British – Pakistani	2	2	100
Black or Black British – African	4	0	0
Black or Black British – Caribbean	1	1	100
Black or Black British - Other Black Background	1	0	0
Mixed - White and Black Caribbean	1	1	100
Not Known - Waiting for first appointment/not recorded	29	9	31
Not stated – refused	3	0	0
Other ethnic category	1	0	0
White - any other white background	4	2	50
White - English/Welsh/Scottish/Northern Irish/British	171	60	35
Grand Total	**224**	**78**	35

Ethnicity April 2025 – March 2026 Reviews Concluded at MAPS	Score 1 Definitely Avoidable	Score 2 Strong Evidence of Avoidability	Score 3 Probably Avoidable	Score 4 Possibly Avoidable	Score 5 Slight Evidence of Avoidability	Score 6 Definitely not avoidable	N/A (MH related deaths)	Total
Asian or Asian British - Any other Asian Background	-	-	-	-	-	1	1	2
Asian or Asian British - Pakistani	-	-	-	-	-	2	-	2
Mixed - Any other mixed background	-	-	-	-	1	-	-	1
Not Known - Waiting for first appointment/not recorded	-	-	-	-	1	4	4	9
Other ethnic category	-	-	-	-	-	3	-	3
White - any other white background	-	-	-	-	-	-	2	2
White - English/Welsh/Scottish/Northern Irish/British	-	-	1	3	3	47	18	72
White - Irish	-	-	-	-	-	-	1	1
Grand Total	0	0	**1**	**3**	**5**	**57**	**26**	**92**

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

Berkshire Healthcare NHS Foundation Trust

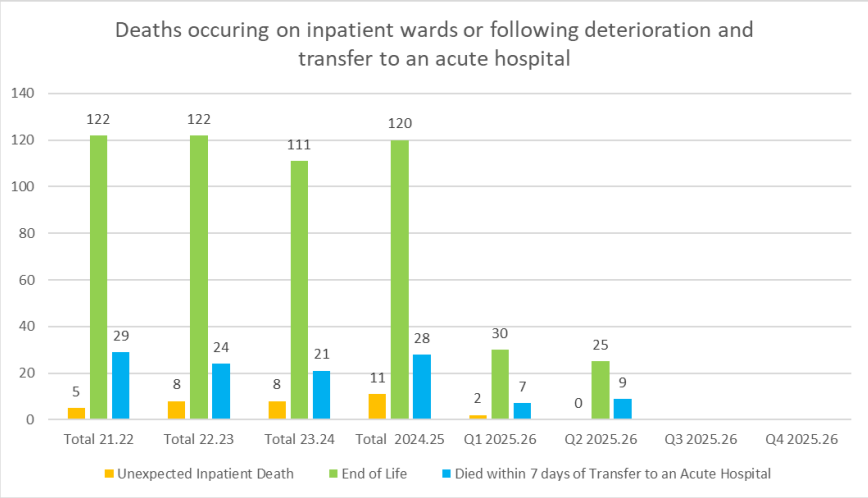
Overall Assessment of Care all 2nd stage reviews completed in 2025/26 (April – March 26 to date will include cases reported as 1st stage reviews in 2024/25)	1 Very Poor Care	2 Poor Care	3 Adequate Care	4 Good Care	5 Excellent Care	Total
Asian or Asian British - Any other Asian Background	-	-	1	1	-	2
Asian or Asian British - Pakistani	-	-	-	2	-	2
Mixed - Any other mixed background	-	-	1	-	-	1
Not Known - Waiting for first appointment/not recorded	-	1	3	4	1	9
Other ethnic category	-	-	1	2	-	3
White - any other white background	-	1	1	-	-	2
White - English/Welsh/Scottish/Northern Irish/British	-	6	23	42	1	72
White - Irish	-	-	1	-	-	1
Grand Total	0	8	31	51	**2**	**92**

Equality & Diversity Summary Q2 2025/26

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

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

Inpatients (Physical Health and Mental Health) Learning From Deaths Q2 Report



In Q2 EMRG reviewed:
34 deaths were reported by inpatient services, 32 from our physical health wards of which 25 were expected deaths and 8 were categorised as unexpected deaths (transfer). 2 deaths following transfer from older adult wards and converted to EOL in the acute.

2nd stage reviews were requested for 9 unexpected deaths (8 transfers) and 1 EOL complaint. 25 were closed at 1st stage, with the information from ME review (including 1 transfer).

6 2nd stage reviews were concluded in Q2. Of which:

- Possibly avoidable (4) and poor care: 1 (reviewed as a PSI)
- Slight evidence of avoidability (5) and good care: 1
- Definitely not avoidable (6) and good care: 3
- Mental health (no avoidability) poor care: 1

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

Month of death (Note this is not EMRG date)	2023/24	2024/25	April 25	May 25	June 25	July 25	August 25	September 25	Total 2025/26
Total Inpatient deaths reviewed by the Medical Examiner	113	127	13	11	8	8	10	6	56
SJRs requested for Inpatient deaths by Medical Examiner	2	1	1	1	0	0	0	0	2
Coroner Referrals advised by Medical Examiner for Inpatient Deaths	11	3	1	1	0	0	2	0	4

EOL Audit Q2	Total Q2	Narrative
New continuous audit which reviews all physical health inpatient planned End of Life deaths.	26	1 cases required scrutiny due to lack of specialist palliative input during a weekend rehabilitation admission. The majority met expected standards, reflecting consistently high quality end of life care. Actions include review of rehabilitation referral pathways from NACEL 2026, increased oversight of weekend cases, targeted training for non-specialist sites, and expansion of quarterly validation from 5 to 10 patients following data quality findings.

Berkshire Healthcare NHS Foundation Trust

Q2 2024/25
All inpatient deaths were reviewed by the Medical Examiner and the cause of death was confirmed.

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

The following learning was identified:
2 poor care cases to be detailed. The deaths occurred in March and Nov 2024 both were reviewed as detailed patient safety reviews .

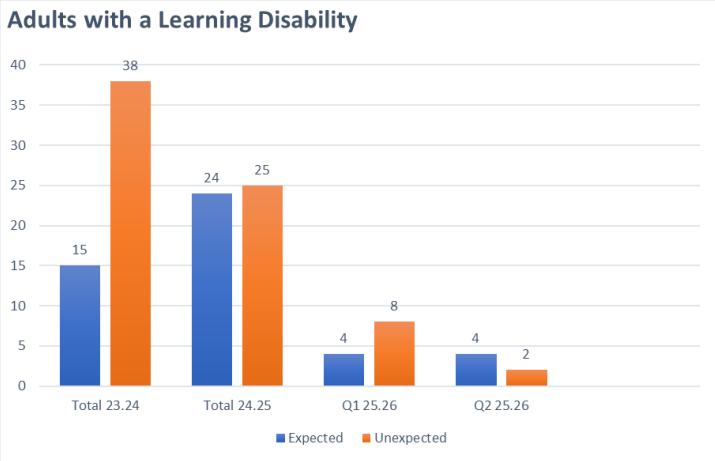
Inpatient Mental Health death reported and reviewed as a PSII and learning has been shared with the CQC and coroner there are a number of actions being implemented and monitored by the patient safety team.

Inpatient physical health ward with learning identified for us and the

- Escalation process: sepsis tool, NEWS guidance, reporting to medical team.
- Action after patient returns from acute hospital due to ill health: review of discharge documentation, medical review and documenting the reason for not following the treatment recommended by the acute hospital
- Review of discharge documentation once discharge date know and in cases of changes: Review of TTO and EDL
- Ward to have robust process to ensure locum doctors have access to necessary documentation especially discharge letters so that accurate information can be shared with the GP for ongoing care.

Learning is addressed through the divisions.

Adults with a Learning Disability Learning From Deaths Q2 2025/26



In Q2, 6 deaths of adults with learning disability were reviewed at 1st stage review. 2 were classed as unexpected and 4 as expected deaths, 2nd stage reviews were requested for 4 and 2 were closed.

8 2nd stage reviews were concluded in Q2 (detailed in tables below).

NHS Berkshire Healthcare NHS Foundation Trust

Q2 2025/26

All deaths related to patients in the community. Of the 8 cases, all were scored as 6 (definitely not avoidable).

In Q2 the following learning was shared within the LD service:

- To ensure new episodes of care are captured through new referrals
- All reasons for referral rejections to be documented on RiO.
- The importance for recording MCAs and risk in the relevant areas of RiO.
- To record all meetings around an individual into RiO.

In Q2 there was also ongoing evidence of:

- Care outcomes being met following assessments.
- Good evidence-based decision making.
- Good interprofessional working with evidence of proactive decision making, timely referrals and effective communication between teams and the individuals family.
- Teams providing compassionate care, that was responsive and in line with best practice.

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

Severity of LD	Q2	Total 25/26 (19)
Mild	2	4
Moderate	0	3
Moderate to Severe	1	2
Severe	0	1
Profound	1	1
Not Known	4	8

Ethnicity	Q2	Total 25/26 (19)
White British	8	18
Asian or Asian British - Pakistani	0	1

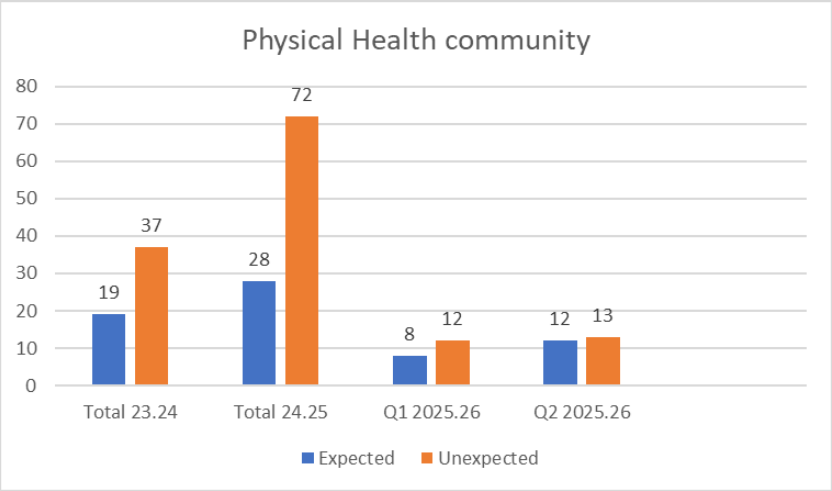
	Q2	Total 25/26 (19)
Male	5	9
Female	3	10

The deaths attributed to the following causes:	Q2	Total 25/26 (19)
Diseases of the respiratory system	3	9
Diseases of the heart & circulatory system	1	1
Diseases of the digestive system	2	2
Sepsis or Infection	1	2
Cancer	0	2
Other	1	3
Not known	0	0

	Avoidabilty score for 2nd stage reviews (8)	Learning Disability Q2 25/26
Score 1	Definitely avoidable	0
Score 2	Strong evidence of avoidability	0
Score 3	Probably avoidable (more than 50:50)	0
Score 4	Possibly avoidable, but not very likely (less than 50:50)	0
Score 5	Slight evidence of avoidability	0
Score 6	Definitely not avoidable	8
N/A	Mental health	0

	Overall Assessment of Care	Learning Disability Q2 25/26
1	Very poor care	0
2	Poor Care	0
3	Adequate Care	2
4	Good Care	6
5	Excellent Care	0

Community Physical Health Learning From Deaths Q2



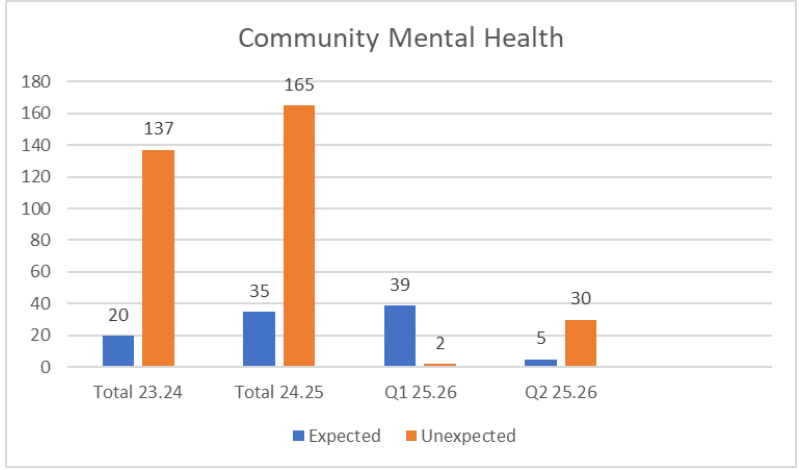
EMRG received 25 1st stage reviews in Q2 of which 2nd stage reviews were requested for 10.

7 2nd stage reviews were completed in Q2. No reviews identified poor care or a a governance cause for concern , the following key learning was identified.

- Challenges of managing acute medical events in the community OOH when there is a respect form advising focus on symptoms
- Learning around how Intermediate Care team communicate with Urgent Care Response team, improvement has been made with a dedicated channel between the teams for quicker escalation
- Clear documentation of communication for other professionals.
- Baseline observations on patients who are unwell and following an admission with an infection.
- Recommend that anticipatory medications are collected by clinicians from pharmacy in cases where carers are identified as experiencing carer stress. This ensures that medications are appropriately explained, safely stored for administration by clinicians to reduce the risk of accidental use by relatives or non-healthcare individuals
- Promote staff awareness of the emotional and logistical pressures carers may face especially when manging multiple responsibilities, therefore to assess the need for practical support to collect medications for example, to reduce carer burden and ensure timely access to medications.

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

Community Mental Health Learning From Deaths Q2



EMRG received 35 1st stage reviews in Q2 of which 2nd stage reviews were requested for 16.

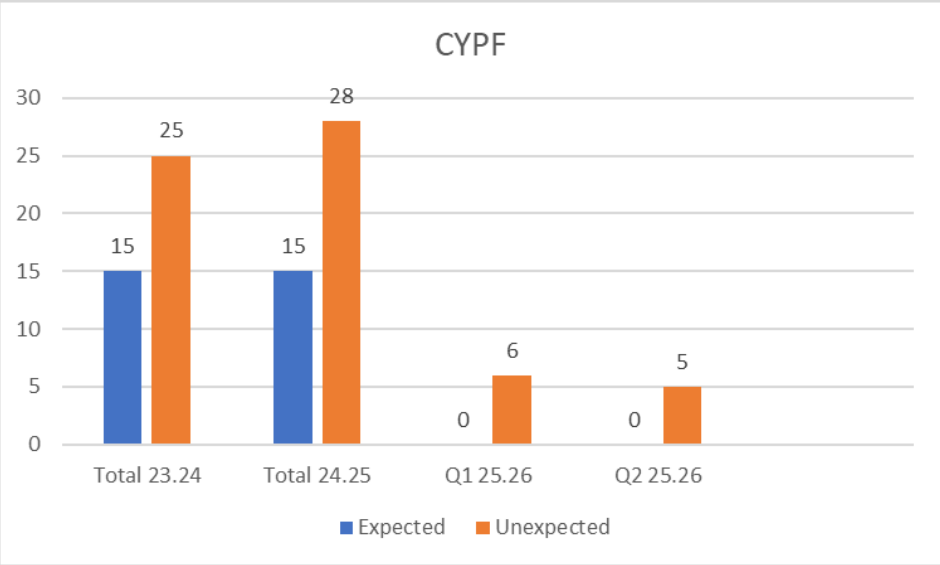
16 2nd stage reviews were completed in Q2 from a range of community mental health or specialist mental health services. 13 in which care was deemed to be adequate or good, and 3 identified poor care.

Areas of learning where we had poor care:

- risk formulation element in the training and how we are auditing it to make sure we are seeing a change in practice
- Incomplete and outdated risk assessments were identified during the review especially when transferring through the different services
- No attempts evident to contact family to involve them in the care plans
- To move towards more referring to close the loop rather than signposting which does not ensure the patient would make contact and sometimes ends up bouncing between services.
- Referrals being completed straight from our site liaison team into talking therapies rather than some patients doing self-referrals
- Ongoing risk assessment work taking place in talking therapies

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

Childrens & Young People: Learning From Deaths Q2



EMRG received 5 1st stage reviews in Q2 . 1IFR requested and a safeguarding rapid review to be carried out for a young person who died in a road traffic collision. 4 closed with a physical health cause of death and will be considered thorough CDOP

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.

One 2nd stage reviews were concluded in Q2 and was good care.

Complaints and Inquiries Learning From Deaths Q2

Complaints and MP Inquiries	Q2 25/26	Total 25/26
Physical health Urgent care – Out of hours GPs – Queried from SCAS around appropriate referral	1	5
Physical health Urgent care – Inpatient ward West Berkshire Community hospital– Concerns around care on the ward.	1	
Physical health Urgent care – Inpatient ward Wokingham hospital– Concerns around care on the ward.	1	

3 complaints were received in total in Q2 relating to aspects of care or treatment prior to death. 2nd stage reviews were requested for all 3 in addition to the formal complaint response.

In Q2 there was one freedom of information request (FOI 311) regarding mental health patients who were in contact with the trust and died in the financial years 2022/23, 2023/24, 2024/25.

Prevention of Future Deaths (PFD) reports 2025/26: No PFD's have been received in Q2 2025/26

Overall Learning and Summary From Deaths Q2

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

5 reviews identified poor care learning is identified

All 5 cases have been reviewed a patient safety reviews and have actions in place to address areas of which require improvement.

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

8 reviews related to patients with a learning disability in Q2, all were reported in line with national guidance to LeDeR, who complete independent reviews covering the full patient pathway, none have been deemed avoidable or a governance cause for concern.

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

Berkshire Healthcare NHS Foundation Trust

Quality Assurance Committee Paper

Meeting Date	November 2025
Title	Guardian of Safe Working Hours Quarterly Report **period 6th August 2025 to the 6h November 2025**
Purpose	To assure the Trust Board of safe working hours for junior doctors in BHFT
Business Area	Medical Director
Authors	Dr Malarvizhi Babu Sandilyan
Relevant Strategic Objectives	1 – To provide accessible, safe, and clinically effective services that improve patient experience and outcomes of care
CQC Registration/Patient Care Impacts	Supports maintenance of CQC registration and safe patient care
Resource Impacts	Currently 1 PA medical time
Legal Implications	Statutory role
Equalities and Diversity Implications	N/A
SUMMARY	This is the latest quarterly Guardian of Safe Working report for consideration by Trust Board. This report focusses on the period 6th August 2025 to the 6h November 2025 Since the last report to the Trust Board, we have received seven exception reports. No fines levied, no work schedule reviews. We do not foresee any problems with the exception reporting policy or process. We do not foresee any significant likelihood of BHFT being in frequent breach of safe working hours in the next quarter.
ACTION REQUIRED	The QAC/Trust Board is requested to: Note the assurance provided by the GOSW.

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

This report covers the period 6th August 2025 to the 6h November 2025

Executive summary

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

This report focusses on the period the period the 06-08-2025 to 06-11-2025. Since the last report to the Trust Board, we have received seven '*hours & rest'* exception reports and zero '*educational'* exception report (ER).

Introduction

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

High level data

Number of doctors in training (total):	63 (FY1 – ST6)
Number of doctors in training on 2016 TCS (total):	63
Amount of time available in job plan for guardian to do the role:	1PA
Admin support provided to the Guardian (if any):	None
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee

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

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Psychiatry	0	7	7	0
Sexual Health	0	0	0	0
Total	0	7	7	0

Exception reports by grade

Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
FY	0	5	5	0
CT	0	1	1	0
ST	0	1	1	0
Total	0	7	7	0

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

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
Total	1	0	6	0

In this period, we have received seven exception reports. Five ERs have been raised by F1 doctor on an acute adult ward. These individually relate to no more than 30 minute of time worked beyond the work schedule on each occasion to complete urgent ward tasks. The F1 doctor has not raised any concerns regarding the work schedule and the narrative provided seem to reflect the unpredictable and urgent issues that arise in an acute ward setting. Two other ERs have been raised from the CAMHS team, where the core and higher trainee stayed back to assess a complex patient, with the agreement of their supervisor, no work schedule review requested. All resident doctors have been given TOIL appropriately which have been accepted.

The GOSW has regular discussions with resident doctors regarding the exception reports at the Resident Doctors' Forum (RDF)- these were on 11-9-2025, 9-10-2025, 6-11-2025. There were no concerns raised by resident doctors in getting their TOIL for the time they have worked extra; resident doctors have been encouraged to raise the exception reports if they have worked beyond their work schedule and if in doubt to contact GOSW or their supervisor, this will be discussed on a regular basis at the RDF, which now happens monthly. GOSW have been liaising with the concerned resident doctors and the medical staffing regarding TOIL or appropriate payment as applicable. TOIL where appropriate, have all been agreed with resident doctors. The number of reports that we have received are keeping in line with historical mean data for this Trust and GOSW meets the resident doctors via the RDF and resident doctors representatives through the MEM (medical education meetings), to encourage raising exception reports where applicable and to address any barriers that resident doctors may face in doing so. Newly joined resident doctors will be sent log in details for the DRS4 online system which is used to exception report.

During this quarter, there have been zero exceptions reported in relation to missed educational opportunities. We will continue to monitor and raise any issues when they arise. GOSW continues to remind the respective consultants to discuss and action the reports on DRS4 and will continue to do so. Individual emails are also sent by GOSW to respective supervisors to remind them to action the reports (if not actioned within 7 days and overdue) and agree TOIL when appropriate.

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

b) Work schedule reviews

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

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

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

c) **Gaps**

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

Reason	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Gap	51	50	496.5	485
Sickness	21	18	194.5	178
Maternity	0	0	0	0
Total	72	68	691	663

d. **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 by department		
Department	Number of fines levied	Value of fines levied
psychiatry	0	£0
Total	0	£0

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

Qualitative information

The OOH rota is currently operating at 1:13 and our system for cover works efficiently, with gaps generally being quickly filled. Our bank doctors continue to be an asset, and we continue to increase this pool. We had 4 unfilled gaps in shifts in this period. For these unfilled gaps, patient safety was not an issue and we have always had at least one resident doctor on duty out of hours at Prospect Park Hospital. There has been a decrease in rota gaps due to sickness during this quarter compared to previous six months.

Issues arising

Exception reporting is at a level more consistent with previous GOSW Board reports. The current level of exception reporting suggests that Junior Doctors are not working unsafe hours. There has been delay in addressing the exception reports within the recommended 7 days from date of submission, this is mostly due to the system not updated in timely manner, but the resident doctors have agreed upon to take TOIL in timely manner (as learnt by GOSW from discussions with resident doctors via email) . The GOSW continues to remind the respective consultants to discuss and action the reports on DRS4 and will continue to do so. Though there are gaps in rota, majority of them have been filled- this is an improvement from previous quarter.

- The GOSW invites the board to be aware of the forthcoming changes to exception reporting and penalties: further details can be found Framework-agreement-exception-reporting-2025.pdf. The key changes are: All educational exception reports will go to the directors of medical education (DME) for approval.
- All other exception reports to go to HR or medical workforce HR for approval
- The guardian of safe working hours (GoSWH) will retain oversight of all exception reports
- A three-tier system will be used to determine if hours were indeed worked.
- Doctors will have their choice of time off in lieu (TOIL) or pay - except when a breach of safe working hours mandates the award of TOIL.
- Additional fines: fines will be introduced to ensure that doctors have timely access to systems and are not prevented from exception reporting. Employers will face additional fines to ensure that doctors are not adversely affected by the unnecessary sharing of exception reporting information.

The implementation date for the new changes has been set for 04-02-2025, however the Trust aims to implement in January 2026. Further guidance from NHSEmployers and BMA is awaited in the light of forthcoming resident doctor industrial action.

A new and additional rota for higher trainees is currently being designed, to give adequate on call experience for the higher trainee resident doctors (ST4-ST6) within BHFT. The proposed date for the higher trainee rota to go alive is 1-12-2025.

Actions taken to resolve issues:

GOSW continues to engage with resident doctors during induction and resident doctors' forum monthly meetings on a regular basis, any issues arising are escalated to DME or LNC, as appropriate. There are work underway to incorporate the new changes in ER reforms into DRS% upgraded version.

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

Next report to be submitted in February 2026.

Summary

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

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

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

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

Appendix A: Glossary of frequently used terms and abbreviations

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

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

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

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

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

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

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

Appendix B

Factsheet: Safety limits and rest

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

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

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

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	13 January 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

Berkshire Healthcare
NHS Foundation Trust

Trust Board Meeting – 13 January 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. Staff Flu Vaccination Report December 2025

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

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

The national aim is to offer vaccinations to 100% of frontline healthcare workers, with a minimum uptake of 5% higher than last year. We were aiming for at least 50% of frontline staff to be vaccinated.

We offer the vaccination to all of our staff.

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

- **Whole organisational uptake of flu vaccination as of 18th December is 45.45%**
- **Frontline workers update of flu vaccination as of 24th December is 49.5%**

Of these 74% have received their vaccine through BHFT vaccination programme and 26% elsewhere (GP or Pharmacy)

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

3. Update on Actions to Prevent Sexual Misconduct in the NHS

On 5th December 2025, NHS England wrote to all NHS Trusts and Integrated care Boards, building on the letter of August 2025 (as reported to September 2025 Public Trust Board) and detailing further actions to support the mitigation of sexual misconduct within the NHS.

A Sexual Safety Charter and framework to support the reduction in sexual misconduct across the NHS was first published in 2023. The framework which is designed to support compliance and assure delivery of the principles set out within the charter was last updated in August 2025. The new actions are as detailed below - along with our approach to ensuring that these actions are taken forward.

Training

- All organisations are invited to put forward two people professionals to take part in national training on sexual misconduct investigations
- To ensure that investigators undertaking investigations related to sexual misconduct have received specialist training aligned to the national framework
- To ensure that responsible officers receive training on sexual safety misconduct cases.

These actions are being taken forward.

Policy

- Review of Chaperone policy to align with national principles.

This is under review currently to ensure alignment with national principles.

Reporting

- Discuss any allegations involving resident doctors with the Postgraduate Dean and determine training versus conduct routes (Maintaining High Professional Standards Framework (MHPS).
- Make DBS barring referrals where legal thresholds are met.
- Engage with police liaison during active investigations, to understand what we can continue while police investigation happens.

These are already part of our processes; we will ensure that these are written explicitly within relevant policies and standard work.

Audit

- Complete the new sexual misconduct audit by Monday 2 February 2026.

This has been completed and submitted, with no significant gaps in our approach identified through completion.

All actions related to violence prevention and reduction including sexual safety are monitored through the Trust Violence Prevention and Reduction group. This group provides a report to the Trust Board twice yearly in May and November, this includes our compliance with the Sexual Safety Charter and actions to further embed the principles set out in the charter.

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

4. Antimicrobial Resistance

In November 2025, NHS England wrote to all Trusts and Integrated Care Board regarding an urgent call to action in relation to Antimicrobial Resistance (AMR)

The background to this call for action being that the World Health Organisation has declared antimicrobial resistance (AMR) as one of the top global public health and development threats.

AMR is listed on the UK Government's National Risk Register. It is associated with twice as many deaths annually as breast cancer and makes infections harder or sometimes impossible to treat, prolonging illness and increasing the risk of harm or death. AMR also drives up healthcare costs and threatens the delivery of safe and effective care across the NHS.

The actions ask that organisations work with their prescribers and clinical leads to make changes required to meet the targets in the national action plan for AMR and:

1. To ensure Board and Executive oversight by arranging a presentation to the Board by both the Infection Control and Amtimicrobial leads to update on the Trust's current situation and action plan. **This is scheduled for the March Board.**

2. Complete the National Infection Prevention and Control board Assurance Framework to help strategic planning and identification of actions. **This has been completed since 2020 and is presented to the Quality Assurance Committee and quality and Performance Executive Group twice a year.**

3. Agree and publish 3 priority areas for improvement, with progress against these reviewed quarterly. **These will be agreed through the Anti-Microbial Stewardship Group, reported as part of the Board presentation with updates to quarterly to the Quality Assurance Committee.**

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

5. Resident Doctors Industrial Action – Impact on the Trust

The resident doctors' strikes have been ongoing due to significant pay disputes. Details of the recent strikes together with our total numbers and rates of resident doctors who participated over the 5-day periods are as follows:

- July 25 to July 30, 2025, -92 shifts out of 200 shifts scheduled -46% strike rate over the 5 days

- November 14 to November 19th, 20025 -42 shifts out of 141 shifts scheduled -30% strike rate over the 5 days

-

- December 17 to December 22, 2025, -27 shifts out of 145 scheduled – 19% strike rate over the 5 days

The BMA has called for a 29% pay rise to restore fair compensation, which has not been met by the government.

Patient Safety has remained the priority during the 15 days of industrial action and the following actions have been taken to minimise any risk:

- Robust planning with all out of hours rotas backfilled with additional staff, we maintained full rota cover with a high percentage of Resident Doctors on the out of hours shifts striking
- Planning to ensure that patients were discharged prior to strikes were appropriate and that admissions occurred in core hours
- Daily sitrep meetings am and pm to review numbers striking and identify any risk and mitigation required
- Consultant, Specialist and Associate Specialist (SAS) doctor and Nurse Consultant cover support
- Clear communication daily with all relevant staff
- Clinics were reviewed with minimal disruption any changes were communicated in advance with patients and rescheduled within 5 days and no impact on waiting times
- Clear communication on public facing website
- Costs - £20K accrual per strike (£60k approx.)

We have maintained good relationships with our Resident Doctors (RD) throughout the action, with several doctors notifying us in advance of their intention to strike to support planning.

We continue to prioritise the 10-point plan for improving RD working lives with regular meetings and a robust action plan to deliver the required changes.

Key areas which are being worked through currently and have potential resource implications due to process and reporting requirements are:

- Rota system and process to be implemented
- Payroll improvement process
- Implementation of the new national framework for exception reporting.

Executive Lead: Dr Tolu Olusoga, Medical Director

6. Application for Advanced Foundation Trust Status

Further to announcement of the Advanced Foundation Trust (AFT) Programme by Secretary of State for Health in November 2025, the Trust has applied to become an AFT effective from April 2026.

The Trust is one of eight nationally to be invited to apply for AFT status in the first wave.

Rationale for the Advanced Foundation Trust Programme, extracts from NHS England's Advanced Foundation Trust Programme – guidance for applicants.

NHS England » Advanced Foundation Trust Programme – guide for applicants

- *As set out in the government's 10 Year Health Plan, we will get the NHS back on its feet is by redistributing power to the frontline: to providers, clinicians, staff, and most importantly, patients and local communities. We will reward and incentivise good performance and re-establish the principle of earned autonomy, which drove substantial improvements in the 2000s.*
- *At the forefront of this will be a reinvigorated and reinvented foundation trust model. Advanced foundation trusts will make use of the foundation trust legal form and maintain the core philosophy of the original policy: that well-governed, capable and entrepreneurial boards are*

best placed to respond to the needs of their communities and deliver improved care, but the focus and ethos of advanced foundation trusts will be different.

- *Becoming an advanced foundation trust will not be about exercising greater autonomy for its own sake. Instead, advanced foundation trusts will be excellent organisations because of how effectively they use their freedoms to work with their patients, staff and communities, partners to improve the broader health of their population and tackle health inequalities. This will include playing a leading role in delivering the 3 shifts: from hospital to community, from analogue to digital, and from sickness to prevention.*
- *Trusts which engage in narrow, organisationally focused behaviours or prioritise status over care quality and what is best for local communities will not pass our advanced foundation trust assessment. It is important we learn the lessons from the original foundation trust programme, including the appalling failures at Mid Staffordshire NHS Foundation Trust and Liverpool Community Health NHS Trust where organisations lost sight of their core purpose. We must ensure that quality is not compromised in the pursuit of becoming an advanced foundation trust. Our expectations, regulation and assessment of advanced foundation trusts reflects this. This is a new model for the 21st century.*
- *Our intention is that by 2035 all trusts have become advanced foundation trusts so that all communities, including those with the highest needs and inequalities, are served by highly capable, innovative, and people-focused organisations. We are therefore committed to supporting multiple waves of applicants in the coming years.*

The Trust's AFT application comprises:

- an application letter from the trust chief executive *(attached)*
- statements of support from relevant ICB(s) *(attached)*
- medium-term financial plan submission – *as approved by the Board and submitted to NHS England*
- signed board statements and supporting memorandum – (attached)
- supporting documentary evidence per information request by NHS England assessment team

The Trust's application will now be assessed by NHS England, culminating in a board-to-board meeting with NHSE and DHSC representatives in March 2026, and a decision panel shortly after.

The Board is asked to note the AFT application further to delegation to Chair and Chief Executive to sign the self-certification statements and approve the final supporting Board Memorandum.

Executive Lead: Alex Gild, Deputy Chief Executive

7. Equity Partnership Group

We are pleased to announce the launch of our Equity Partnership Group (EPG) – a new independent body that will help ensure equity, diversity, and inclusion remain central to everything we do.

Following an open recruitment process, we have recruited a group of independent experts and community leaders, who will provide challenge, accountability, and lived experience insight at a strategic level. Their role is to make sure the voices of undeserved communities shape our decisions, our services, and our long-term plans.

The EPG met for the first time in December 2025 and is chaired by Sally Glen, non-executive director of the board.

What is the Equity Partnership Group?

The EPG has been created to bring independent scrutiny and oversight to our equity commitments. Working alongside senior leaders, members will review data, performance, and plans, identify gaps

and barriers, and support us to embed an evidence-based, outcome-focused approach to tackling inequity across Berkshire.

We are pleased to welcome our members:

- Dr Alice Mpofu-Coles
- Andrea Brookes
- Ceara Webster
- Dipak Mistry
- Jamila Thompson
- Liz Mayers
- Louis Headley
- Makini Jones
- Cllr Dr Nicholas Robertson
- Sarita Rakhra

Together, they bring extensive experience in community leadership, public health, workforce equity, co-production, and lived experience across a range of communities. Their insight and challenge will play a vital role in helping us deliver more inclusive, responsive and equitable healthcare. **A short biography of each member is attached to the executive report.**

Why the Equity Partnership Group matters

Equity Partners will specialise in areas including LGBTQ+, neurodivergence, carers, and race, while also working collectively to address inequity across all themes. By drawing on diverse perspectives, they will help us ensure our approach is robust, transparent, and informed by real-world experience.

This is an important step in strengthening our commitment to being both a great place to get care and a great place to give care.

Executive Lead: Alex Gild, Deputy Chief Executive

Presented by: Julian Emms
Chief Executive
13 January 2026

Date: 5th January 2026

FAO:
Christine Doyle
Deputy Director – System Assurance and Regulation, System Architecture. NHS England.

Dear Christine

Berkshire Healthcare NHS Foundation Trust application for Advanced Foundation Trust status

I am pleased to confirm the Board's application to become an Advanced Foundation Trust on 1st April 2026.

Per the AFT programme guide for applicants, we have submitted required documentation and evidence within the timescale agreed:

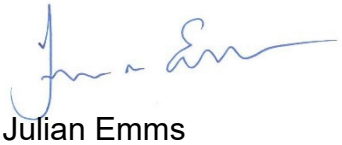
- application letter from the trust chief executive
- letter of support from Thames Valley (designate) ICB
- initial (December 2025) medium-term financial plan submission to NHSE
- signed board statement and supporting memorandum.
- documentary evidence per assessment team request for information

We look forward to working with you and the assessment team towards the Board to Board in March.

The Board of Berkshire Healthcare is excited to develop the opportunities that AFT brings, including Integrated Health Organisation impact, strengthening system leadership, and improving health outcomes for residents and the population.

AFT status will support delivery of our new five-year strategy, continuing the development of our partnership impact to deliver on the ambitions of the Ten-Year Plan.

Yours sincerely,



Julian Emms
Chief Executive

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Deputy Director – System Assurance & Regulation
NHS England
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133-155 Waterloo Road
London SE1 8UG
Email: christine.doyle3@nhs.net

11 December 2025

Dear Christine,

Re: Berkshire Healthcare NHS Foundation Trust's application to become an Advanced Foundation Trust

I am writing to express our support for Berkshire Healthcare NHS Foundation Trust ('BHFT') in their January 2026 application to become an Advanced Foundation Trust ('AFT').

We are delighted that BHFT has been included amongst the first eight Trusts nationally to be invited to apply to become an AFT. We view BHFT as a strong performing Trust in the Thames Valley and a collaborative partner both locally within Berkshire and more widely across the South-East. The Trust has a well-established and experienced leadership team, an engaged workforce, and a systematic approach to continual improvement that is deep-rooted throughout the organisation. We therefore have a good level of confidence regarding the Trust's ability to use the greater autonomy and financial freedoms associated with becoming an AFT to drive forward the ambitions of the 10 Year Health Plan with system partners and in the context of our local commissioning intentions.

Achieving AFT status would be a positive step forward for the Trust and the wider Thames Valley integrated care system. We are also supportive of further exploring the potential for BHFT to also become an Integrated Healthcare Organisation designate where this will best enable delivery of our commissioning intentions, noting that further scoping is required but may include consideration of our Neighbourhood Healthcare service models and our approach to Mental Health service planning and commissioning across Berkshire.

I trust this letter provides you with the necessary assurances regarding our support for this AFT application but please do let me know if you have any questions at this stage.

Yours sincerely

Dr Nick Broughton FRCPsych
Chief Executive
NHS Buckinghamshire, Oxfordshire & Berkshire West ICB and NHS Frimley ICB

cc:
Priya Singh, Chair, NHS Buckinghamshire, Oxfordshire & Berkshire West ICB and NHS Frimley ICB
Julian Emms, Chief Executive / Alex Gild, Deputy Chief Executive, Berkshire Healthcare NHS Foundation Trust

Advanced FT assessment – Board self-certification statements

Berkshire Healthcare NHS Foundation Trust

Date: 02/01/2026

Board certification statements

The wording of the Board Statements should not be adjusted in any way. Where applicants are unable to certify any statement, the memorandum should explain why not and, if applicable, how the trust plans to address this within a reasonable timeframe.

Building on its submission for the Provider Capability Assessment, the board has further assured itself that…

Strategy, leadership and planning

Strategy aligned to key priorities and to deliver national and local priorities and comply with legislation

- It can explain how its existing strategies will deliver the ambitions of the 10 Year Health Plan.
- The trust can evidence its commitment and contribution to date in developing community-based care and neighbourhood working (including in partnership with social care and primary care).
- . The trust will leverage digital technologies across care settings to improve patient care and deliver the ambitions in the 10 Year Health Plan
- The trust can demonstrate its commitment and contribution to date in enabling and delivering improved outcomes for population health and prevention.
- The trust's plans have been developed with system partners, including social care and primary care and align to ICB strategies on delivering a neighbourhood health service.
- The trust has a clear understanding of the causes and presentation of health inequalities and its plans recognise the factors that need to be tackled to address these, with demonstrable impact to date.
- The trust has adopted a credible and recognised corporate improvement methodology, which is actively applied across the organisation.
- The trust actively seeks and applies best practice from elsewhere in the delivery of its corporate and clinical support services and disseminates its own learning to other organisations who may benefit from this insight.

Effective corporate governance arrangements

- The trust has an effective approach to succession planning and successful development of future leaders which has led to substantive appointments to the board.
- The board has the skills and expertise to deliver its strategy against the ambitions of the 10 Year Health Plan.

- The trust's operating model and governance framework is proportionate and responsive to the size and complexity of the organisation and allows the board to govern the organisation effectively.
- It role models a culture of openness and transparency, proactively using peer and independent review.
- It receives timely information in a format that allow board members to appropriately understand and interrogate performance.

Effective mechanisms in place to meaningfully engage with staff and local communities ensuring involvement influences decisions

- Staff and local communities meaningfully shape and inform the board's strategy development and decision-making, leading to decisions that improve experiences and outcomes.

Quality of care (including Quality Governance)

Quality of care

- Its Provider Capability Self -Assessment and any relevant accompanying self-certification provides assurance that any CQC actions resulting from regulatory assessments have been addressed, assured and closed and quality assurance mechanisms are in place to maintain good or outstanding.
- The trust has clinical quality plans that actively progress delivery of the 3 shifts as outlined in the 10 Year Health Plan and the trust own clinical quality strategy.
- The trust is actively engaged with system partners in managing actual or emerging quality concerns and working collaboratively with people who use services, carers and with the wider community to reduce risk and impact for patients.
- Service delivery reflects national guidance, accreditation, and best practice, and seeks to innovate and go further to improve and address unwarranted variation within the trust and across the local system.

Quality governance arrangements are effective in practice

- The trust has a visible impact on quality performance and improvement. There is a distributed leadership approach and cultural tone that is open and focused on high-quality care delivery where quality is everyone's responsibility.
- The trust continuously reviews its quality governance arrangements to ensure these support changes to the operating model of care in the context of delivering the 3 shifts outlined in the 10 Year Health Plan.
- The trust uses insightful triangulation and interrogation of information to inform systemic learning and decision-making and ambitious target setting, leading to improvement in outcomes for patients and population health.
- The trust is transparent and open about all quality outcomes and experiences with a strong reporting culture and clear systems in place to support improvement at all levels of care delivery. Outcomes are made public and feedback and input from stakeholders is evident leading to active improvement in prioritisation, planning and delivery, including action to address unwarranted variation or inequity.

People and culture

Culture and people - highly engaged workforce that is committed to quality improvement

- All staff understand the importance of quality; they are empowered to report concerns and are actively engaged in quality improvements and driving sustainable solutions.
- The trust has fair, just, compassionate and transparent mechanisms and processes that encourage staff at all levels to recognise and acknowledge where services are not meeting organisational expectations of high-quality delivery.
- The trust is working with system partners to develop workforce models that support 10 Year Health Plan ambitions and deliver neighbourhood health services.
- Staff have appropriate skills, and capacity, and they are actively involved in delivering sustainable quality improvements and innovation to shape transformational initiatives to improve quality of care.
- The trust actively identifies and addresses workforce inequalities that impact a fair and inclusive culture and works towards improving equality and equity for its people.
- It has an inclusive education and training programme that values and develops its workforce across all professions to deliver safe and effective care now and into the future.

Access and delivery of services

Performance against standards and targets – satisfactory score against NOF and action plans to improve performance

- The trust has a proven track record of recovering performance against national standards and targets in a timely way.
- The trust balances the delivery of operational performance against national priorities (such as elective, cancer, urgent and emergency care, mental health) and responds to any changes to these as outlined in national planning guidance.
- The trust sets itself ambitious plans to exceed national targets in relation to access and waiting times and supports and identifies initiatives that enable system partners to deliver outcomes for patients.
- The trust explores and shapes system wide solutions to challenges to care delivery that impact inequity of access, unwarranted variation and overall performance.

Productivity and value for money

The applicant demonstrates a clear understanding of productivity opportunities and presents actionable plans to deliver improvements.

- The trust has a proven and consistent track record of delivering measurable productivity and sustained improvements.
- The board and its sub-committees routinely use all available and relevant benchmarking data, to drive and balance both quality and financial improvement.

Financial performance and oversight

Medium-term plan – applicant demonstrates that the trust, unless there are exceptional circumstances, has a high likelihood of:

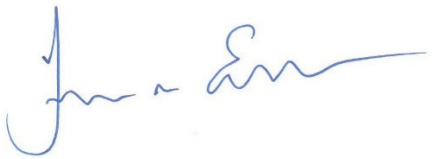
- ***projecting an adjusted surplus position excluding non-recurrent deficit funding in year 1 and achieving a sustainable adjusted surplus position excluding non-recurrent deficit funding by year 3 of the projected period, (as defined under the NOF)***
- ***maintaining a reasonable cash position including working capital for the next 12 months***

- There is a robust medium-term forecast financial plan, and can confirm the following:
    - the financial plan is developed using reasonable (evidence-based) or published assumptions
    - the financial plan aligns with the system transformation strategy and is being developed in conjunction with the system plan, and it is agreed upon with the ICB
    - the financial plan projects an adjusted surplus position in year 1, and it achieves a sustainable adjusted surplus position by year 3 of the projected period, excluding deficit support funding (as defined under the NOF)
    - the trust maintains a reasonable cash position, including sufficient working capital to meet its operational and financial requirements for at least the next 12 months
    - it has undertaken a sensitivity analysis to evaluate reasonable downside scenarios and their mitigations for testing the financial plan
    - the trust will achieve its financial forecast outturn for the current financial year

Financial governance and capital scheme delivery arrangements that are effective in practice.

- The trust has a robust financial governance framework, underpinned by clearly defined roles, responsibilities, and accountabilities for all key financial matters, including the management of financial risk, performance, capital scheme delivery and the timely reporting of audited accounts.
- Within this framework, they and Finance Committee:
    - possess the necessary skills and experience to provide effective leadership and oversight of financial matters
    - receive timely, clear, and comprehensive reporting on the organisation's financial performance and risks to support informed decision-making
    - operate within a strong financial control environment that enables effective assurance and challenge across all aspects of financial delivery, including the achievement of Cost Improvement Plans (CIPs)
- The trust proactively reviews its financial governance framework to ensure it remains robust and supports long-term sustainability. This is demonstrated by regular assessment of value for money, responsiveness to early warning signs – such as inadequate financial information and weak escalation of financial risks –through mechanisms such as in-year reporting, triangulation of board-level information, exception reporting, and assurance from internal audit and other independent reviews
- Financial planning processes are aligned with national and local priorities, including enabling the 3 shifts outlined in the 10 Year Health Plan.
- The trust considers the impact of all financial and operational changes on the quality of care, supporting both current service delivery and long-term sustainability.

Signed on behalf of the Trust Board:



Julian Emms
Chief Executive Officer

Mark Day
Interim Chair

[Name]

[Title], [Trust Name]

v2.3 Final for Submission January 2026 - BHFT AFT Board memorandum

Executive Summary:

- This Board Memorandum has been prepared by the Board of Directors ("the Board") of Berkshire Healthcare NHS Foundation Trust ("the Trust") as part of the application by the Trust for Advanced NHS Foundation Trust ("AFT") status.
- We are delighted to have the opportunity to apply for AFT Status and we welcome this national initiative.
- As outlined in this Board Memorandum, we are confident that we are a strong and adaptable organisation and that we are compliant across all the stated domains with evidence to support these assertions:
    - We are incredibly proud of our staff and the high-quality care they deliver every day. Our workforce is innovative and engaged and our Outstanding CQC rating recognises this continual team effort to provide the best possible care for our population.
    - We have a strong track record of fiscal responsibility, delivering value for money and making optimal use of public resources
    - We have a diverse and experienced leadership team at a Board level and throughout the organisation, and proactively work to develop leaders of the future
    - Importantly we are an active system partner with mature relationships across the areas we serve, with a broad range of examples of where we are already working with partners to innovate and delivering tangible improvements for our residents in line with the ambitions of the 10 Year Health Plan.
- Being an Advanced FT will provide us with enhanced autonomy to accelerate our continued work on the prominent themes in the 10 Year Health Plan and deliver rapid benefits for our residents, whilst providing an additional platform to promote and share good practice nationally and to learn from other high performing organisations
- Being an Advanced FT is also an enabler to holding an Integrated Healthcare Organisation Contract; the Trust has strong aspirations in this area and is keen to explore this further with NHS England and local partners.

BHFT Board self-certification evidence by domain:

Strategy, leadership and planning	
Strategy aligned to key priorities and to deliver national and local priorities and comply with legislation	
1	**It can explain how its existing strategies will deliver the ambitions of the 10 Year Health Plan.**
Self-Assessment	**Fully Assured**

Evidence:	• The Trust has always strived to provide high quality community-based care, supporting our patients to remain well in the community and seeking innovative ways of doing this. This is core to our organisation, and we are pleased that these ambitions are also core to the 10 Year Health Plan.
	• The themes of our existing **Corporate Strategy (2022-25)** are aligned with the ambitions of the 10 Year Health Plan, with particular emphasis on enhancing community-based care for physical and mental health needs, leveraging digital opportunities, and addressing health inequalities. Our developing **Five-Year Strategy for 2026-2030** will build on this strong foundation, outlining the real opportunities for our out-of-hospital physical and mental health services to proactively support people living well at home by delivering the 'three shifts' (for further detail please see strategy documents included in our supporting evidence).
	• A significant amount of work has been undertaken during the time of the current strategy to work with partners and **develop a vision for Neighbourhood Health across Berkshire**; this will be a prominent feature of the refreshed Five-Year Strategy as an enabler for the 'left shift' of care from hospital to community and a continuing shift to more preventative models of care. In addition, both Berkshire West and Berkshire East have been selected for the NHS England Southeast Neighbourhood Health Accelerator programme, providing a shared framework, coaching and maturity matrix to accelerate neighbourhood team development, strengthen MDTs, embed PHM/digital tools and deepen co-production. Berks East/Slough has also been selected to be part of the National Neighbourhood Health Accelerator programme, focussed on Slough initially and spreading the learning and delivery model across the rest of East Berks.
	• Current **Digital Strategy** supports the continued shift from analogue to digital, building on our existing mature digital capabilities as an organisation:
	  ○ The NHS examines the digital maturity of all NHS Trusts and GP Practices each year, and we are proud to have **achieved the highest level of digital maturity of any Trust.** We also **achieved Global Digital Exemplar** in 2021; both of these accolades recognise our proactive commitment to investing in technology and ensuring our services are fit for the future.
	  ○ The latest **Digital Strategy delivers on the NHS 10 Year Plan** by embedding digital first care, integrating national platforms, and driving productivity. Key priorities include expanding online therapy, enabling patient initiated follow up, and connecting services through the NHS App for a seamless patient experience. The strategy strengthens data sharing via national platforms and Shared Care Records, while automation and eScheduling free up clinical time and improve efficiency. Focused initiatives

	on digital inclusion and social prescribing tackle health inequalities, supporting equitable access and better outcomes across communities via targeted use cases using population health management principles, working with partners. We have been successful in securing national funding for patient engagement, NHSapp integration, cyber and back-office enablers. ○ We also **maintain top digital maturity and cyber security standards**, ensuring safe, interoperable care. • Whilst not formalised in a Strategy, work with system partners over recent years has considered themes parallel to the Integrated Healthcare Organisation opportunity that would be unlocked by a successful AFT application. There is strong stakeholder support to explore this further in early 2026.

2	**The trust can evidence its commitment and contribution to date in developing community-based care and neighbourhood working (including in partnership with social care and primary care).**
Self-Assessment	**Fully Assured**
Evidence:	• The Trust is committed to developing and delivering outstanding community-based care, with a wide range of service lines already delivering high quality physical and mental health services in the community. We are proud of all these services, and particular exemplar areas to highlight include: ○ **Virtual Ward pathways co-developed in partnership:** BHFT established virtual wards to support community management of patients and avoid clinically unnecessary admission to acute care within both BOB (40 frailty beds) and Frimley (20 frailty beds) ICBs. The project team developed the Frailty Virtual Ward operational model based on guidance from NHS England including best practice from other areas and expanded the age group from >65 to >18 to meet local need. The virtual wards were developed in collaboration with the local acute Trusts, primary care, VCSE, carers groups and Healthwatch. The impact of this service has been independently evaluated and demonstrated an estimated hospital avoidance rate of 89%, high patient satisfaction, and improving virtual 'length of stay' from 14 days at conception to 5 days. ○ **Mental Health Urgent Care Team**: This team was established to work from community bases in all 6 local authority areas across Berkshire and provide a community response for local residents experiencing a mental health crisis. There is direct access provision to these Teams, via NHS 111 or direct phone contact for patients, carers and other stakeholders such as Thames Valley Police, South Central Ambulance Service and Social Care, for advice and support as well as direct referrals into the Teams. These locally based teams develop a relationship with local service users, and an understanding of the local population needs, alongside community resources which can be beneficial to support the person or their family at the point of need and beyond.

	• The Trust also established a focused **Neighbourhood Health development programme** in early 2025 involving partners across Berkshire including social care and primary care. Alongside this, both Berkshire West and Berkshire East have been selected for the NHS England Southeast Neighbourhood Health Accelerator, providing a shared framework, coaching and maturity matrix to accelerate neighbourhood team development, strengthen MDTs, embed PHM/digital tools and deepen co-production. Berks East/Slough has been selected to be part of the National Neighbourhood Health Accelerator programme, focussed on Slough initially and spreading the learning and delivery model across the rest of East Berks. The overall Neighbourhood Health programme is governed via multi-stakeholder Health and Wellbeing Boards across Berkshire to ensure broad involvement, visibility and accountability. Neighbourhood models and clinical priorities are currently being developed, and additional information on this programme has been included as supporting evidence.

3	**The trust will leverage digital technologies across care settings to improve patient care and deliver the ambitions in the 10 Year Health Plan.**
Self-Assessment	**Fully Assured**
Evidence:	• The Trust is highly digitally mature and routinely embraces technology to improve patient care and increasingly adopt a more proactive and preventative approach, for example: ○ **Heart Function Monitoring**: As part of the Virtual Ward programme, the Trust worked with Docobo (a cloud-based telehealth platform) to embed remote monitoring into the heart function pathway. Patients who are suitable and consent can self-report their health statistics and symptoms into an app; this will alert the relevant BHFT clinical team if a patient goes outside the agreed parameters and proactive action will then be taken. This has digitally enabled proactive approach has helped to prevent patients' conditions deteriorating, avoiding clinically unnecessary ED attendances or admissions whilst increasing levels of patient reassurance. • In addition, as system partners in Berkshire we have developed an **extensive shared-care record – Connected Care** – an 'integrated digital record' for people who are registered with a GP working in Berkshire. The system gives care professionals instant, secure access to medical and social care records across Berkshire, including GPs, community and secondary care clinicians, social workers, and community pharmacists. Anonymised data from this system can also be overlayed with demographic information (including drivers of inequality) via the 'System Insights' tool, meaning it is able to provide an impressive level of insight into local population health needs. ○ **Connected Care:** BHFT, in collaboration with Connected Care, has developed an operational tool to support urgent and emergency care services across the system by showing near real time (midnight the previous day) referrals for BHFT care, including discharge from acute bedded care and step up services from primary care and the community. This powerful resource will provide clear insight into flow and bottlenecks, supporting winter planning and daily operational management across all UEC settings and social care, supporting care closer to home and more effective patient flow within each of our neighbourhood teams.

	It will strengthen system understanding of our patients' needs through population segmentation, with Connected Care providing the ability to analyse patient cohorts such as those with long term conditions and deprivation. o BHFT has also **leveraged Connected Care System Insights data to identify and reduce health inequalities across our population**. By analysing integrated care records and demographic trends, we uncovered gaps in access to physical health checks for individuals with severe mental illness, inequitable use of Mental Health Act provision on a cohort of the population, and disparities in diabetes management among patients from deprived areas. These insights enabled targeted interventions, such as proactive outreach to underrepresented cohorts and collaboration with GP practices, ensuring equitable service delivery and improved health outcomes for vulnerable groups. • As mentioned above, we are proud to have **achieved the highest level of digital maturity of any Trust**, recognising our proactive commitment to investing in technology and ensuring our services are fit for the future. We also **achieved Global Digital Exemplar** in 2021.

4	**The trust can demonstrate its commitment and contribution to date in enabling and delivering improved outcomes for population health and prevention.**
Self-Assessment	**Fully Assured**
Evidence:	• A significant amount of work we do as a Trust is preventative in nature – keeping people well in the community and minimising the need for escalated healthcare. We have developed strong partnerships across our local systems and work proactively with these partners to identify additional preventative opportunities to improve population health. Examples include: • **Community services development:** Beginning in August 2024, we engaged with primary care, secondary care, VCSE and other partners to review frailty pathways, holding two system-wide workshops in October 2024 and February 2025 to revise urgent care and some scheduled care services, developing a single referral process and integrated clinical MDT triage based on a trusted assessor model, supported with the near real time view of activity across urgent pathways. This process has improved efficiency across the system, reducing administrative burden for clinicians referring into BHFT services and supporting more rapid assessment and management of patients in the community, providing care closer to home. • **'Health Bus' and 'Valve Bus'**: We have invested in a mobile service to take Health Checks and targeted Cardiac Checks into local communities where we identified disparities in health outcomes and mortality rates due to inadvertent barriers in accessing services. We spoke to patients, community leaders and local politician to better understand these barriers and used this information to shape our

mobile service. This service has since completed over 500 health assessments, identifying multiple undiagnosed conditions including moderate to severe hypertension and symptoms of heart failure and atrial fibrillation.

- **Paediatric Speech and Language Therapy Enquiries Line**: This service has experienced a significant increase in referrals compared to commissioned activity levels, and we recognised a risk to patient and parent/carer wellbeing whilst awaiting their initial appointment under the traditional pathway. To mitigate this the service developed an Enquiries Line to provide instant advice from a Speech and Language Therapist for parents/carers, early years professionals, and other health professionals, alongside a suite of online resources and workshops. This intervention has received significant praise from users ("this is an amazing service" and "what you have done in early years has been transformative") and it has also improved service efficiency by reducing the number of children ultimately being transferred into the service. Whilst initially a SLT service this is also now being rolled out to OT and Physio services.
- **Memory Clinics:** Beginning January 2025, BHFT undertook a system-wide review of its memory clinics, engaging service users, carers and relevant groups (both professional and voluntary) across Berkshire West and East Berkshire. 50 responses to a survey and 133 participants in focus groups delivered across 6 localities supported the review. Most of the feedback was positive, particularly emphasising kind, caring and professional staff. Areas for improvement included additional support to manage feelings of isolation following diagnosis and a desire for greater support following discharge from the service.

  In response to the review findings, a series of actions were put in place including:

  - Information regarding transport as part of communication and resource infographics, to provide information regarding support services in a variety of formats, in both digital and paper options, to support patients that are digitally excluded.
  - A follow up phone call or 1:1 meeting (based on suitability of the patient and their carers) post diagnosis and discharge, with consistency of support and access across all localities to staff such as Dementia Care Advisors

  In addition, the Trust is partnering with Age Concern and Greenham Trust, by providing Trust owned land to develop the West Berkshire Dementia Hub on a grazing field adjacent to West Berkshire Community Hospital. The Trust's local memory clinic service will be integrated into an innovative community offer (taking learning from Sage House in Chichester) that provides holistic day care and support for families, carers and people living with Dementia. The charity funded development is planned to open in 2028.
- **Head Injury Pilot Pathway**: The Digitally Integrated Head Injury Pathway for Frail Older Adults Across Berkshire West is a pioneering approach that uses digital protocols and shared electronic systems to manage suspected or confirmed head injuries in frail older adults without unnecessary hospital conveyance. Developed collaboratively by BHFT Urgent Community Response (UCR) Team, Virtual Frailty Ward, Royal Berkshire Hospital (RBH), and South-Central Ambulance Service (SCAS), the pathway aligns with national best practice (NICE NG232) and leverages community virtual wards, Single Point of Access (SPOA) referral systems, and clinician access to acute records for seamless care. It has been adopted as a template for the NHSE Southeast Head Injury Guideline, demonstrating scalability and best-practice alignment.

5	**The trust's plans have been developed with system partners, including social care and primary care and align to ICB strategies on delivering a neighbourhood health service.**
Self-Assessment	**Fully Assured**
Evidence:	• The Trust is an **active member of multiple system-wide forums** working to develop the future model of care across Berkshire, with membership spanning a broad range of organisations including social care and primary care amongst others. Governance charts have been provided to evidence these structures. • The **Neighbourhood Health Programme** being led by BHFT in Berkshire West involves all system partners. The initial aims of the emerging model are in line with our ICB prevention strategies which major on: o Supporting complex and frail older adults o Preventing Cardiovascular disease o Better management of respiratory disease o Integrating mental health and long-term physical health support o Diabetes management • A recent example of this neighbourhood-level planning already in action is outlined below: o BHFT has developed a **community Heart Function service** in collaboration with Frimley Health FT to address national evidence for increased prevalence of mortality from heart disease in Asian men and women and co-morbidities such as diabetes, hypertension and obesity in this cohort compared to the general population. Nationally, Asian patients are less likely to receive specialist appointments and have increased 'Did Not Attend' rates for such care. The service engaged with local community leaders and MPs in areas with relevant populations across East Berkshire. Two health buses were deployed in strategic locations across the footprint with a multi-disciplinary clinical team including cardiologists, specialist nurses, medical suppliers and the voluntary sector, accompanied by a media campaign in local print, radio and social media. Over 500 patients were screened by this team, with significant clinical benefits for patients including earlier diagnosis of hypertension in 49% of those attending and referral for specialist interventions including aortic stenosis in moderate and critical cases.

6	**The trust has a clear understanding of the causes and presentation of health inequalities and its plans recognise the factors that need to be tackled to address these, with demonstrable impact to date.**
Self-Assessment	**Fully Assured**
Evidence:	• The Trust has a detailed **Health Inequalities Strategy for 2024-26.** This document provides an overview of the causes and presentations of health inequalities across Berkshire and outlines our framework to tackle these based on established Marmot principles. • Supporting delivery against the Strategy, the Trust has an established **Health Inequalities Quality Improvement Programme** that commenced in 2024 and regularly reports to the Board and sub-committees. The QI initiatives currently cover: o Improving physical health outcomes for people with severe mental illness o Reducing DNAs for our physical health services for people from racialised communities o Improving access to Talking Therapies for people from culturally and ethnically diverse backgrounds o Improving Health Visiting contacts in Reading o Reducing suicide for people with autism o Improving access to child and adolescent mental health services for young people in Slough o Improving physical health outcomes for people with learning disabilities The Trust is making good progress on this Health Inequalities programme of work. A detailed update on this programme was included in our 2024/25 Annual Report to ensure public transparency and to demonstrate the impact of our proactive improvement programme. This update is included in our supporting evidence. • This work is underpinned by **comprehensive datasets** which identify inequalities and monitor progress against addressing these: o We have developed a **Health Inequalities dashboard** for our divisions which identified the Top 10 Health Inequalities in our services, with a focus on geographical areas known to have the highest disparities in health outcomes (Slough and Reading). o We routinely use this data to drive targeted interventions, for example our work on **reducing race-based disparities in detention rates under the Mental Health Act**. See the 'Quality of Care' section below for further narrative on this initiative. • Our work on health inequalities is not limited to this formal programme. Outside of this programme, a good example of the Trust's broader proactivity in addressing health inequalities is the **Frimley Provider Collaborative Integrated Chronic Pain Pathway:** o BHFT led the development of an integrated chronic pain pathway spanning primary care, community services and secondary care that was established to reduce unwarranted variation and inequality across commissioned chronic pain services within Frimley ICB and reduce waiting times. The pathway was developed in collaboration with the Frimley GP Federations,

	representing each Primary Care Network, Frimley Health FT and Surrey & Borders Partnership NHS Trust. As part of development, patient engagement was undertaken in the five most commonly spoken languages across Frimley (English, Nepalese, Polish, Punjab, Urdu) with specific engagement undertaken in our more deprived communities where national evidence shows greater incidence and impact of chronic pain. The pathway was independently tested with and endorsed by impartial national expertise including the vice-chair of the British Pain Society, to ensure that best practice was embedded throughout our care. • We also had a concerted effort to look at our **interpretation and translation services**, improving the quality of the service provided but also making a demonstrable improvement in the fill rate by taking it from 59% to 98%, ensuring equitable access. • Our work on addressing inequalities is underpinned by our long-standing commitment to **meaningfully working with our communities** to better understand their needs and improve population health outcomes. On average we reach approximately 160 residents per week via our engagement initiatives (drop in, online and telephone engagement). This approach includes: o Supporting the establishment and running of a Community Wellbeing Hub, providing clinical support to those accessing the hub both in person and online. o Training a pool of mental health and suicide first aiders, most of whom are community health champions. o Providing clinical input to the Grassroot Community Network, supporting various initiatives designed to improve population health and wellbeing. o Establishing the CommUNITY Antiracism in healthcare forum where communities have another avenue of having their voice heard and celebrated for their work of informing the services and addressing their everyday racism experiences. o This year, BHFT was awarded by the grassroot communities for their input in amplifying their voice. The award went both to the individuals and to the Trust as an organisation. o We meaningfully engage with the communities' calendar year events including but not limited to their annual Health Inequalities conference, Annual Mental Health Experience in the Communities of Faith, Mental Health Awareness Week, Suicide Awareness week, Dying Matters week, FGM Zero Tolerance conference through the lens of trauma, 16Days of Activism Against Gender-Based Violence among others. • As a major employer in Berkshire, we also recognise our responsibility to address inequalities at work that may impact on health outcomes for our workforce. See the 'People and Culture' section further below for additional information.

7	**The trust has adopted a credible and recognised corporate improvement methodology, which is actively applied across the organisation.**
Self-Assessment	**Fully Assured**

Evidence:	• For many years as a Trust, we have recognised the importance of a **strong and consistent corporate improvement methodology** that is ingrained throughout the organisation.
	
	• We began working in a strategic partnership with Catalysis and KPMG in 2016 to develop and embed our own approach to quality improvement (QI). In this time, we have established, refined and embedded 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. This approach has been spread throughout the organisation since 2017 and is now well embedded in our ways of working.
	
	• As part of this programme, we provide QI training at several levels. We are accredited by the Lean Competency System and Cardiff University to deliver Lean training at a White Belt, Yellow Belt and Green Belt level. Since 2018, over 2,000 colleagues have completed the introductory 'White Belt' level and around 170 have been trained to a 'Yellow Belt' level. 25 colleagues have been trained to a Green Belt level. The aim of all our training, support and coaching is to build capability in others. To enable them to demonstrate their ability to use improvement methods and practices intentionally and systematically, to change processes and generate improved performance. This goes beyond the ability to learn and retain knowledge and focusses on creating the potential for sustainable improvement.
	
	• A good example of our QI approach in action is in our Child and Adolescent Mental Health Service and Eating Disorders Service:
	
	  ○ **QI in CAMHS and Eating Disorders Services:** BHFT has c. 20 mental health teams and two eating disorders teams across the Trust. The services have focussed on increasing Quality Improvement capability via the in-house Lean training (yellow and green belt), with 27 members across the teams trained, all leading their own QI projects. Among the quality improvements implemented within these services are:
	
	  ▪ Improving treatment access times through structured discussion at weekly MDT to address barriers to discharge of existing patients. In comparison to 2022, the CAMHS teams achieved a 55% reduction in the average weeks from referral to first appointment and a 53% reduction for specialist community teams.
	
	  ▪ Improving clinical record keeping and staff support by implementing job plans with clear expectations for monthly clinical activity and review during monthly supervision. There was a 69% increase in staff reporting they 'frequently enjoyed work per week' alongside a 25% increase in activity within Adult Eating Disorders care.
	
	• We also applied out Quality Improvement approach to underpin our Health Inequalities programme of work – see supporting evidence for further detail.

8	**The trust actively seeks and applies best practice from elsewhere in the delivery of its corporate and clinical support services and disseminates its own learning to other organisations who may benefit from this insight.**
Self-Assessment	**Fully Assured**
Evidence:	• The Trust actively seeks to learn from others and is a member of a range of national forums designed to disseminate learning and best practice. • A recent example of **learning we have taken from elsewhere to improve our clinical services** relates to Martha's Rule – originally a secondary care initiative to improve patient safety, but as a Trust we recognised an opportunity to adopt learning from this to further improve our community-based services including our Mental Health settings. During the initial acute-focused phase we proactively reached out to the Health Innovation Hub who were commissioned to support acute trusts but welcomed the opportunity to work with us too. This partnership has been helpful and enabled us to be included within the community of practice events that bring together all the local acute trusts to share ideas and learning as part of the phase one pilot. We have subsequently been accepted as a pilot site for our mental and physical health wards and are actively involved in both these networks, and we have also shared our findings with NHS England and the National Mental Health Provider Forum. More detail on this is available in our supporting information pack. • A recent example of **BHFT disseminating our own learning relating to clinical services** include our Liaison & Diversion service. This service showcased a case study via the NHS England SUSTAIN-ING Report highlighting our Professional Nurse Advocate (PNA) programme led by Liaison & Diversion as a leading example of clinical leadership in action, which has been linked to improved staff retention and better patient outcomes. Innovation is also reflected in a successful petition led by our Advanced Practitioner and Court Lead, which secured Ministerial commitment for NHS Liaison & Diversion teams nationally to be able to access the HMCTS Common Platform. This breakthrough addresses long-standing barriers to timely information sharing in courts and sets out clear short-, medium-, and long-term goals for implementation. Achieving this milestone required years of advocacy, collaboration with Police & Crime Commissioners, and engagement with the Local Criminal Justice Board, demonstrating BHFT's influence at a national level. Our Liaison and Diversion team also contributed to the Independent Review chaired by Sir Brian Leveson, which examines efficiency and proportionality in criminal court processes amid record caseloads. BHFT secured an audience to share frontline experiences and influence reforms that impact vulnerable defendants and court-based interventions. • We also seek to share best practice regarding our **corporate support services**, including: o Our CEO recently led a transformational programme of work on temporary staffing arrangements across the South East region, sharing best practice management from our own organisation and disseminating this elsewhere. o Regarding equality in the workplace, our anti-racism work was featured as a case study in NHS Providers' national guide on tackling ethnicity pay gaps, and we presented this and our anti-racism journey at their national conference in Liverpool. We also

	presented and shared our antiracism work with organisations in the ICS, South East Region, National D&I Leaders conference, and at the NHS Race and Health Observatory Roadshow in Brighton. Additionally, we engaged with the Cabinet Office to share our approach to developing ethnicity and disability pay gap reports. Notably, our 2024 disability pay gap was 0%.

Effective corporate governance arrangements	
1	**The trust has an effective approach to succession planning and successful development of future leaders which has led to substantive appointments to the board.**
Self-Assessment	**Fully Assured**
Evidence:	• As a Board we recognise the importance of robust succession planning and have embedded a **strong Talent Management system** within the organisation. For over a decade, Berkshire Healthcare has used this talent review process for its senior leadership team (SLT) to enhance succession planning. This strategic approach helps develop clinical and managerial roles at and below the board level. • We set ourselves an ambition to always have an internal candidate who would be able to be shortlisted for a Board appointment and we ensure appropriate development opportunities are in place to achieve this aim. This has proved successful and the most recent example of this is the internal appointment of our Chief Operating Officer following a competitive external appointment process in October 2025, and prior examples include our Director of Nursing and Therapies and our Chief Financial Officer. We apply this ambition to other Senior Management and Divisional Leadership team appointments, both clinical and managerial. • The Board routinely receives an update on the Talent Management process, outputs and risks. The latest report from September 2025 is included in our supporting information • Three years ago, we replaced the national talent grid with a more **flexible talent cycle model** which enables a more dynamic approach to talent based on experience and individual ambition at different career points. This model is now used in all mid-year reviews for all staff in the organisation (introduced in 2024) and helps us identify talent pools and potential succession pipelines within the various leadership tiers. • We also have a set of **leadership competencies at varying tiers of leadership**, originating from 'aspiring manager' through to 'aspiring Executive', which align to our mid-year reviews. These are also aligned to the national NHS work around leadership competencies. These competencies each have four domains of: Leading and managing change, Leading and Managing people, Leading and Managing resources, Leading and Managing Self, providing staff with a clear framework to guide their development. • Both **management and leadership internal development programmes** have been developed, reviewed and refined to ensure content is aligned to Trust behaviours and competencies. We also ensure new managers are contacted within 4 weeks of joining the Trust,

	provided with the support and development opportunities available to them, and booked on to the Manager development programme. Our newly launched **Manager Support Network** continues to offer skill development and learning opportunities for all our managers and leaders, we also provide an internal coaching network, 360 feedback and a team development offer.

2	**The board has the skills and expertise to deliver its strategy against the ambitions of the 10 Year Health Plan.**
Self-Assessment	**Fully Assured**
Evidence:	• We routinely review the skills and expertise of the Board, including annual internal self-assessment and external independent reviews as appropriate. • DCO Partners Ltd conducted an **independent Well Led development review** of the Trust's governance in 2023. The Reviewers concluded that the Trust had "a highly effective team comprised of talented individuals. There are many very experienced people here, who bring their knowledge to bear in a practical and pragmatic way without ego or grandstanding." This report is included in our supporting evidence. • The Board and sub-committees conduct **annual self-assessments of effectiveness**. The latest assessments demonstrate that Board members are satisfied that the Board and Committees have the necessary skills and expertise. These self-assessments are included in our supporting evidence. • Collectively the Non-Executive Directors have skills and expertise in transformation, finance, HR, audit, legal, digital and clinical and have direct experience of the voluntary and community sector, local authority, NHS and corporate sector. The Non-Executive Directors bring these skills to the Board and provide high levels of scrutiny and challenge as demonstrated in the minutes provided in our supporting evidence. We are confident that we have the leadership skillset required to deliver on our strategic ambitions aligned with the 10 Year Health Plan. • We will continue to review our leadership skillset and capacity as part of our upcoming programme of work to explore the opportunities around becoming an Integrated Healthcare Organisation. Gap analysis will be conducted as part of our due diligence.

3	**The trust's operating model and governance framework is proportionate and responsive to the size and complexity of the organisation and allows the board to govern the organisation effectively.**

Self-Assessment	**Fully Assured**
Evidence:	• Our Trust operates from over 100 sites across Berkshire, including community hospitals, clinics, community hubs and secondary care bases. In 2023 we completed a **review of our operating model** which led to a change in our operational structure, moving our clinical services from six locality-based divisions into three clinically-based divisions – Adult Mental Health, Adult Community Physical Health, and Children, Families & All Age Pathways. This change enabled us to address geographical variation whilst also ensuring that service delivery remained local, delivered by teams working with their local partners and within existing clinical pathways and relationships. A fourth 'Central Services' division encompasses our corporate support service teams. • Our **Risk Registers** are developed from service level upwards, with regular reporting to the Board to ensure agility in our response at the most senior level where required. We have robust monthly review meetings with each Divisional Leadership Team to ensure they are fully supported by the Executive whilst also having autonomy and delegated authority to lead their services effectively. • We routinely review our governance arrangements both internally and externally to ensure that ultimately the Board is governing the organisation effectively. The aforementioned independent Well Led review by DCO Partners Ltd concluded that "the Board is providing leadership in an environment of turbulence and change" and that "there is strong evidence that the Board Committees cover a range of key performance issues and accept this responsibility enthusiastically".

4	**It role models a culture of openness and transparency, proactively using peer and independent review.**
Self-Assessment	**Fully Assured**

Evidence:	• As a Board we place utmost importance in ensuring a positive and open culture throughout our organisation.
	• We are proud that the **2024 Staff Survey Results** demonstrated that 78% of our staff recommend the Trust as a place to work and our Trust significantly exceeded national averages against key metrics that measure openness and transparency, including:
	  ○ 82.3% of staff feel secure raising concerns about unsafe clinical practice
	  ○ 75.1% of staff feel confident that the Organisation would address concerns about unsafe clinical practice
	  ○ 93.8% of staff feel encouraged to report errors/near misses/incidents

	• Our **Annual Quality Accounts and Annual Reports** provide a balanced picture of our services, highlighting significant positive achievements whilst also addressing areas where we want to see further improvement (such as waiting times for our autism assessment service as highlighted in our latest Annual Report). See supporting documents for further information on this. • We welcome and encourage peer and independent reviews of our services. Recent external site visits to BHFT facilities include: ○ **Prospect Park in October 2025, undertaken by NHSE discharge & system flow, community transformation & integration and GIRFT colleagues.** Prospect Park provides physical and mental health services with 24 beds, supported by a multi-disciplinary medical, nursing and therapist team, providing both step-up and step-down care. This external review noted that: "escalation flows attended by relevant partners have had a positive impact on flow", "use of quality improvement methodologies was evident during the visit, indicating a culture of continuous improvement" and that "the staff seen on the day demonstrated strong team working, and were passionate about their work and the difference they made to patient care". ○ **A July 2025 visit to St Marks Hospital, undertaken by NHSE discharge & system flow, ECIST and Chief Allied Health Professions Officer colleagues**. St Marks provides bedded care for rehabilitation, Specialist Nursing, CAMHS, C&YP services and a range of other community services. This external review noted that "A strong Quality Improvement ethos is evident, with the team challenging existing practices and implementing projects aimed at improving outcomes for patients", "The team has a good understanding of the barriers to discharge and is actively working to address them, demonstrating a proactive and solutions-focused mindset".

5	**It receives timely information in a format that allow board members to appropriately understand and interrogate performance.**
Self-Assessment	**Fully Assured**
Evidence:	• The Trust Board undertook an **Annual Review of Effectiveness in October 2025** which included consideration of the reporting available to the Board and supporting committees. This confirmed that all Board members including non-executives are either very satisfied or mostly satisfied with the information available, and that only minor improvements should be considered going forward (including reducing the length of some papers and enhancing some management summaries). • Please also refer to the Well-Led review by DCO Partners included within our supporting evidence.

6	**It understands the key risks to achieving the trust's strategic plans and the potential impact has been modelled and reflected in trust plans appropriately.**
Self-Assessment	**Fully Assured**
Evidence:	• The Trust's **Board Assurance Framework (BAF)** sets out the key risks to the Trust delivering its strategy. The Trust Board hold an annual strategic planning day in October and reviews the risks on the BAF in the light of its strategic discussions and makes any necessary updates. At the October 2025 meeting, the Board concluded that the risks remained current but agreed that risk descriptions needed to be re-framed to align more closely with the current operating landscape. • The BAF, including actions to mitigate the risks, are reviewed quarterly by the Audit Committee. The FIP and QAC Committee also review the relevant risks quarterly. The Executive Committees also review the BAF quarterly. • For more detail, please refer to the BAF and relevant meeting minutes included in our supporting evidence.

Effective mechanisms are in place to meaningfully engage with staff and local communities ensuring involvement influences decisions	
1	**Staff and local communities meaningfully shape and inform the board's strategy development and decision-making, leading to decisions that improve experiences and outcomes.**
Self-Assessment	**Fully Assured**

Evidence:	• Our organisation takes proactive steps to engage staff and communities in the development of our Trust strategy and supporting delivery plans. In 2024 we held **two 'Big Conversation' events** with over 400 staff invited to five different venues across Berkshire to support development of the Trust based on their feedback. Based on these discussions, we implemented a range of improvements including:
	  ○ Improving our recruitment processes to reduce the time required to fill posts.
	  ○ Providing a monthly managers' briefing pack with key information to communicate to teams, in addition to our monthly all staff briefings and weekly clinical and Trust newsletters, as well as enhanced support for managers such as a dedicated Teams channel to provide peer support.

- We currently have **five staff networks** (Pride, Race, Women's, Armed Forces, Purple (incl Carers, and Neurodivergent), which each network has a Chair, an Executive sponsor, and are a part of our governance structure in terms of Diversity Steering Group membership, as well as being part of the policy review process.
- We have a well-established 'Bright Ideas' platform, where staff can offer solutions, QMIS programmes and staff network initiatives.
- Different departments within the Trust also have local mechanisms to ensure staff voices are heard by the Board on specific topics. For example:
    - Staff across all professions contribute to the **development of education priorities** through our annual Training Needs Analysis workshops, CPD surveys, learner evaluations, the in-house placement student experience survey, and the National Education and Training Survey (NETS). These insights are systematically reviewed through the Training and Education Advisory Group (TEAG), which reports directly to SECEG, ensuring issues such as placement quality, safety, inclusion, and access to CPD inform strategic decisions.

      Board members are visibly engaged in education through attendance at clinical education events, endorsement of the Safe Learning Environment Charter (SLEC), NETS results, and oversight of apprenticeship and CPD investment via executive sponsors and stakeholder panels. This structure ensures that Board decisions—such as investment in educator roles, simulation facilities, governance improvements, and sustainable workforce pathways—are grounded in the lived experience of learners, staff, and wider system partners.
- We **engage with local communities via multiple channels** ranging from formal meetings such as Health and Wellbeing Boards attended by elected community representatives, our Antiracism in healthcare CommUNITY Forum, to informal drop-in sessions at local community hubs. For example, when developing our Health Inequalities Strategy, we proactively attended community forums in targeted areas of Reading and Slough based on our knowledge of these communities and how they are disproportionately affected by inequitable access and outcomes. Their input helped to shape this important Strategy and the themes within it.
- Another example of community involvement in improvement programmes is **our One Team Project to improve Mental Health Services in Berkshire.** In July 2023 the One Team project held an event consisting of two workshops that brought together a broad array of key stakeholders, paving the way for improvements in community mental health services throughout Berkshire by harnessing collective expertise and experience. The diverse group of attendees included representatives from the voluntary and community sectors, local authorities, primary care networks, as well as service users and carers, all united by a common goal: to strengthen mental health support and resources in the region for the people that need it.
- We are also proud of our recently launched **Equity Partnership Group** with our inaugural meeting taking place in December 2025. This group brings together expert partners and leaders from the community and our organisation to create positive change. Our members have different backgrounds and experiences, and we work to spot problems, share good ways of doing things, and support projects that help everyone have the same chances. We will meet four times a year to make sure everyone feels respected and heard, as part of our vision to be a great place to give care and a great place to get care. Each of our members adds something special to our group and is

	committed to making a difference across a diverse range of specialisms. Additional information on this group is available in our supporting evidence.

Quality of care (including quality governance)	
Quality of care	
1	**Its Provider Capability Self -Assessment and any relevant accompanying self-certification provides assurance that any CQC actions resulting from regulatory assessments have been addressed, assured and closed and quality assurance mechanisms are in place to maintain good or outstanding.**
Self-Assessment	**Fully Assured**
Evidence:	• The Trust completed the **Provider Capability-Self assessment** and reported this to the Board in October 2025. This confirmed assurance against all aspects of the self-assessment, including assurance regarding CQC actions. The self-assessment and accompanying Board paper from the October 25 Board are included in our supporting evidence for further detail. We are pleased to report that on 2nd December 2025 NHSE confirmed the Board's self-assessment as green across all domains.

2	**The trust has clinical quality plans that actively progress delivery of the 3 shifts as outlined in the 10 Year Health Plan and the trust own clinical quality strategy.**
Self-Assessment	**Fully Assured**
Evidence:	• As outlined in Section 1 (Strategy, Leadership & Planning), the Trust is working to actively progress delivery of the themes in the 10 Year Health Plan in partnership with our local system. Our overarching corporate Strategy is underpinned by the essential aim of delivering high quality clinical services and improving the health of our local population. • The Trust does not therefore have a separate Clinical Quality Strategy – delivering quality care is at the heart of everything we do and thus is core to our overarching Corporate Strategy.

	• We are therefore confident that our clinical quality plans are aligned with the 3 shifts as outlines in the 10YP – see responses in Section one re: strategy and leadership and associated supporting evidence.

3	**The trust is actively engaged with system partners in managing actual or emerging quality concerns and working collaboratively with people who use services, carers and with the wider community to reduce risk and impact for patients.**
Self-Assessment	**Fully Assured**
Evidence:	• The Trust is an active member of many system-wide quality forums where actual and emerging quality issues are discussed. A summary of these meetings including frequency and attendees has been included with our supporting evidence. • As an organisation we strongly believe that we must look outside of our organisational boundaries and seek opportunities to provide solutions to system-wide quality issues where possible. A recent example of this is work we undertook to support the **system-wide Community Equipment service** which was identified as being at significant risk of failure when a major supplier entered administration. This represented risks for a range of patients including those requiring pressure care and those requiring rapid support to prevent admission or facilitate discharge. BHFT collaborated with a range of health and social care partners, including VCSE to ensure that they were able to provide patients with up to date information, coordinating a system-wide perspective on equipment needs when supply of critical equipment was a challenge to secure and implemented new processes on behalf of all system partners to provide feedback to alternative suppliers and modify equipment prior to roll out, such as ordering 'specials'. Patient risk was mitigated by BHFT working collaboratively with social care partners to obtain equipment for both health and social care needs by both organisations, irrespective of who was managing the patient. • Our Continuous Improvement approach ensures we systematically involve partners and people who use our services when we are seeking to make changes and improvements. Recent examples of this collaborative approach include: ○ **Children and Young People Neurodiversity Service Improvement**: Extensive work is underway with partners across Berkshire to improve access to our CYP Neurodiversity services. We have engaged with local schools, local authority education and social care leads, and parent forums to develop and implement changes to the referral and assessment pathways to reduce waiting times for our children and improve access to 'informal' earlier support. Emerging findings suggest these changes have been positively received by referring partners and have resulted in a reduction in referrals since implementation in November 2024 – reversing a historic trend for the first time. See supporting evidence for further info. ○ **Right Care Right Person:** This 2023 National Partnership Agreement set out a collective agreement to work to end the inappropriate involvement of police in responding to people with mental health needs, raising potential concerns regarding patient wellbeing without a police response. BHFT worked proactively with the police service, local authorities, secondary care and

	service users to adapt our MH services to ensure patient safety was maintained seamlessly with alternative provision in place to minimise unnecessary police involvement. The Trust produced regular newsletters to inform stakeholders of progress. ○ The **Trust Suicide Prevention Strategy Group** oversees the Trust Suicide Prevention action plan. The group links closely with the Thames Valley and East and West Berkshire groups to ensure our priorities align with our local communities. We have very strong service user and active carer involvement which helped shape our 6-point plan for 2025/26, and recent patient feedback survey confirmed a range of positive benefits. We share our learning across the Trust, LA and VCSE with a quarterly webinar and through a number of events during the year at the team level and also supporting an annual suicide prevention festival. Further information about this service is available in our supporting evidence.

4	**Service delivery reflects national guidance, accreditation, and best practice, and seeks to innovate and go further to improve and address unwarranted variation within the trust and across the local system.**
Self-Assessment	**Fully Assured**
Evidence:	• The many examples given throughout this Board Memorandum demonstrate how the service delivery across the Trust reflects national guidance, accreditation and best practice. Our QI approach ensures all teams are always seeking to innovate and improve and as a leadership team we enable that grassroots improvement approach. • A good example of how our approach to **continuous improvement supported service accreditation** is in our **Audiology** service: ○ In October 2025, audiology services were assessed and achieved re-accreditation by UKAS - The UK Accreditation Body, noting "There is clear engagement in the adoption of service improvements and assurance was gained that governance arrangements are effective.". The culture of continuous improvement was noted in the summary report which stated "The observations, case reviews, and discussions showed that the service had made significant improvements in ensuring service quality and consistency across paediatric staff" and "staff continue to be seen as keen to deliver high-quality care; the changes since the last service were noticeable, and the service was seen to have good control". • In addition, we proactively use data to identify areas of our service where there is unwarranted variation and take action to address this, for example: ○ The **Mental Health Act Detentions Project** launched in January 2023 in response to national evidence showing that Black people are detained under the Mental Health Act at 4.5 times the rate of their white counterparts, and our data confirmed a local disparity of 3.07 times. Targeted work was undertaken to successfully reduce this variation to 2.69 times by February 2024 and a 16% overall reduction in detentions, with key elements of the project including:

- A strategic partnership with the NHS Race & Health Observatory, acting as critical friends to provide guidance, challenge, and assurance.
- Collaboration with grassroots VCSE organisations in the two localities with the highest Black populations and levels of deprivation, enabling stronger community engagement and empowering people to access mental health services.
- Co-production with people with lived experience, ensuring that service design and delivery are informed by community voices and responsive to the needs of those most affected by health inequalities.

To take this further, in April 2025 the Trust delivered an All-Partnership conference with over 100 delegates, launching Phase 2 of this work which has since been showcased in local and national press. See supporting evidence for further detail.

- An example of how the Trust seeks to innovate and go further to meet specific identified needs and address unwarranted variation in access and outcomes is our **Op Courage South-East initiative:**

  - Op Courage South-East is a specialist NHS mental-health and wellbeing service for veterans, reservists, individuals transitioning out of service, and their families. The service operates across Kent, Surrey, Sussex, Berkshire, Buckinghamshire, Hampshire (including the Isle of Wight), and Oxfordshire. The service is delivered through a provider collaborative led by BHFT as Lead Provider. BHFT subcontracts delivery to Sussex Partnership NHS Foundation Trust (SPFT) and works in formal partnership with the military charity Walking With The Wounded (WWTW). This structure enables a coordinated, region-wide service that combines NHS clinical governance and specialist expertise with voluntary-sector capability and lived-experience support.

    Op Courage SE operates within a broad ecosystem of statutory and non-statutory partners across the region. The service takes a collaborative approach to working with these partners, which:

    - Breaks down organisational silos
    - Enables shared planning, care coordination, and information flow
    - Holistic, whole-person approach
    - Tailored and flexible person-centred care
    - Supports smoother referral pathways and improved continuity of care
    - Reduces duplication and gaps in provision
    - Enhances clinical and social outcomes

    This model ensures that veterans with complex or overlapping needs receive integrated and seamless support across mental-health, social, and practical domains. By uniting NHS mental-health expertise, charity-sector support, and system-wide collaboration, Op Courage SE delivers a comprehensive, trauma-informed, and regionally coordinated service.

Quality governance arrangements are effective in practice	
1	**The trust has a visible impact on quality performance and improvement. There is a distributed leadership approach and cultural tone that is open and focused on high-quality care delivery where quality is everyone's responsibility.**
Self-Assessment	**Fully Assured**
Evidence:	• As outlined in Section 1 (Strategy, Leadership & Planning) the Trust has a robust **Quality Improvement** approach that is spread throughout the organisation. Our **staff survey results** reflect the fact that staff feel empowered with 65.2% of staff feeling able to make improvements happen in their area of work compared to an average of 52.6%. • **Leadership is distributed** across three clinically-based divisions – Adult Mental Health, Adult Community Physical Health, and Children, Families & All Age Pathways, and a fourth 'Central Services' division encompasses our corporate support service teams. • We have robust monthly review meetings with each Divisional Leadership Team to ensure they are fully supported by the Executive whilst also having autonomy and delegated authority to lead their services effectively. • As a Board we undertake **regular visits to clinical and corporate service areas**, meeting the teams and discussing things they are proud of and things they would like to see improved. See our supporting evidence for the latest schedule of these visits and outputs.

2	**The trust continuously reviews its quality governance arrangements to ensure these support changes to the operating model of care in the context of delivering the 3 shifts outlined in the 10 Year Health Plan.**
Self-Assessment	**Fully Assured**
Evidence:	• Our Quality Governance arrangements are embedded within our overarching Corporate Governance model, with quality outcomes and metrics at the heart of what we do. Further detail on this is included in Section 1 (Strategy, Leadership & Planning). • We regularly review our objectives as a Trust, including where our model of care is transitioning in line with the three shifts outlined in the 10 Year Health Plan, and ensure our governance arrangements have appropriate oversight of underlying data via our breakthrough objectives which are aligned with our **True North Goals**. These objectives are mutually agreed upon by both the Executive and Divisional Teams during our annual objective setting discussions and are then reported into our Quality and Performance Executive Group (QPEG). From there, our Divisional Teams work to agree on the relevant contributing Driver metrics. The scorecards and SPC charts are developed to monitor the progress against these metrics effectively.

	• Additionally, there is a comprehensive **Performance Accountability Framework** that incorporates Breakthrough, Driver, and Tracker metrics. This framework is included in QPEG and is accompanied by a summary report when discussed in the Finance Investment and Performance Committee and onward into the Board. • For large-scale transformation programmes, we prepare a key facts document which is presented to the Business, Finance, and Strategy Executive for prioritisation. The progress of these programmes is monitored through scheduled updates during the meetings. Furthermore, all large-scale transformation projects are required to provide a transfer to 'Business As Usual' and a project closure report. • Local team and service transformation programmes receive support from the QI Divisional Business Partner role.

3	**The trust uses insightful triangulation and interrogation of information to inform systemic learning and decision-making and ambitious target setting, leading to improvement in outcomes for patients and population health.**
Self-Assessment	**Fully Assured**
Evidence:	• The Trust regularly reports a **True North Performance Scorecard** to the Board to summarise performance data, including both 'breakthrough' and 'driver' metrics to ensure known and emerging issues are captured. The metrics used are regularly reviewed and refreshed to ensure they are relevant, ambitious, and reflect any service changes required by our strategy and national policy. Our report on our breakthrough objectives from 2025 includes details of specific quality measures that have been improved and sustained – see supporting evidence for further detail. • Quarterly **Patient Safety and Learning reports** are prepared for the Quality Assurance Committee with exception reporting to the Board. These reports include updates on how we have engaged patients, families and staff following any patient safety incidents and actions taken to address root causes. See supporting evidence for examples. • The Trust also has a keen interest in **research and development**, helping to further our understanding across a range of subject areas and ultimately lead to improvements in outcomes and population health. The Trust Research and Development reports are submitted to the Trust Clinical Effectiveness Group. These reports articulate the Research portfolio, Research Delivery, Co-production and Finances. Research is represented on Trust key forums such as Equality Diversity Inclusion, Strategic Peoples Group, Clinical Effectiveness, Divisional PPSQ meetings, Policy Scrutiny Group, Training Education Advisory Group, Consultant Nurses Network and Co-production working parties.

4	**The trust is transparent and open about all quality outcomes and experiences with a strong reporting culture and clear systems in place to support improvement at all levels of care delivery. Outcomes are made public and feedback and input from stakeholders is evident leading to active improvement in prioritisation, planning and delivery, including action to address unwarranted variation or inequity.**
Self-Assessment	**Fully Assured**

Evidence:	• As outlined in Section 1 (Strategy, Leadership & Planning) we are proud that the **2024 Staff Survey Results** demonstrated that 78% of our staff recommend the Trust as a place to work and our Trust significantly exceeded national averages against key metrics that measure openness and transparency, including:
	  ○ 82.3% of staff feel secure raising concerns about unsafe clinical practice
	  ○ 75.1% of staff feel confident that the Organisation would address concerns about unsafe clinical practice
	  ○ 93.8% of staff feel encouraged to report errors/near misses/incidents
	• We routinely discuss **patient and staff stories at our public Board meetings** as a standing agenda item, showing transparency when we haven't got things right and using those experiences to help shape future improvements. We also circulate Clinical News Safety Bulletins internally to ensure shared learning on any near-miss incidents or similar.
	• Quarterly **Patient Safety and Learning reports** are prepared for the Quality Assurance Committee with exception reporting to the Board. These reports include updates on how we have engaged patients, families and staff following any patient safety incidents and actions taken to address root causes. See supporting evidence for examples.
	• Our **Annual Quality Accounts and Annual Reports** provide a balanced picture of our services, highlighting significant positive achievements whilst also addressing areas where we want to see further improvement (such as waiting times for our autism assessment service as highlighted in our latest Annual Report). See supporting documents for further information on this.
	• Whilst we have not had any Prevention of Future Death reports in the past 12 months, as a Trust we are also proud of our strong, positive and transparent **relationship with our local Coroner** and have received feedback on our willingness to engage and learn from all historic cases.

People and Culture	
Culture and people - highly engaged workforce that is committed to quality improvement	
1	**All staff understand the importance of quality; they are empowered to report concerns and are actively engaged in quality improvements and driving sustainable solutions.**
Self-Assessment	**Fully Assured**
Evidence:	• As outlined in Section 1 (Strategy, Leadership & Planning) we are proud that the **2024 Staff Survey Results** demonstrated that 78% of our staff recommend the Trust as a place to work and our Trust significantly exceeded national averages against key metrics that measure openness and transparency, including: o 82.3% of staff feel secure raising concerns about unsafe clinical practice o 75.1% of staff feel confident that the Organisation would address concerns about unsafe clinical practice o 93.8% of staff feel encouraged to report errors/near misses/incidents • We have **established, refined, and embedded an approach to Quality Improvement** that delivers improvements in care and outcomes, as well as engaging, motivating, and empowering colleagues to lead continuous improvement in their daily work. This approach has been spread throughout the organisation since 2016 and is now well embedded in our ways of working – see Section 1 for further discussion. • The **Trust's Quality Management Improvement System (QMIS)** has been in development since 2016 and supports alignment and escalation of performance, quality and safety information through scorecards and a cascading governance structure. 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. The relevant case study from 2024, developed with NHS IMPACT, describes the Trust's Quality Management Improvement System and includes examples of the impact – see supporting evidence. The Trust's management system is further described in the QMIS Handbook. • We have a strong focus on our collective responsibility for quality improvement within our **staff training programmes**. As part of the Leading for Impact training course (day 3) the " Achieving Together" day brings together Quality Improvement, Innovation, Research, Patient Safety, Patient Experience and Data collection to support managers to have a real impact with their teams using practical scenarios. • Berkshire Healthcare is also part of the **Launchpad Programme** which is a programme led by Hampshire and Isle of Wight Healthcare NHS Trust and a consortium of NHS and academic organisations across the South-Central region. The launchpad programme involves three stages of support to help registered health and care professionals working in the region to get involved in research that drives

	sustainable solutions to a range of issues. The Academy of Research and Improvement and information on the programme. This is delivered across the South-Central footprint.

2	**The trust has fair, just, compassionate and transparent mechanisms and processes that encourage staff at all levels to recognise and acknowledge where services are not meeting organisational expectations of high-quality delivery.**
Self-Assessment	**Fully Assured**
Evidence:	• Our Trust values (Caring for you, Committed and Working Together) are embedded into our **Culture, Inclusion and Equity framework 2025-28** by aligning them to the principles that reflect our commitment to inclusion and what we would expect to see from each other in delivering our objectives. This includes commitments around continuous quality improvement, being an evidence-informed organisation, and ensuring high standards of accountability and transparency. • We are confident that staff feel able to acknowledge where services are not meeting organisational expectations, as evidenced by our **staff survey results** previously quoted. • We have well established formal **reporting systems** in place for incidents and risks, and staff are also encouraged to raise concerns with line managers or via our Freedom to Speak Up routes. The Trust undertook a review of our Freedom to Speak Up arrangements in March 2024 using the refreshed self-reflection tool which was discussed at the Board in March 2024 along with a resulting action plan, and a FTSU highlight report was recently considered at the November 25 Board meeting (see supporting documents). • We have a supportive **Staff Performance Management framework** to aid individuals and their managers where development needs are identified to ensure staff are meeting organisational expectations. See supporting evidence for further information.

3	**The trust is working with system partners to develop workforce models that support 10 Year Health Plan ambitions and deliver neighbourhood health services.**
Self-Assessment	**Fully Assured**
Evidence:	• As a Trust we worked with partners to develop our **People and Culture Strategy 2025-28**. Whilst a largely internal document designed to address identified risks to the Trust (including supply of clinical staff, areas of high turnover, inequality in staff progression, and improving

	staff experience) it also focuses on effective workforce planning and the need to consider workforce needs arising from future models of care. • We also undertake regular **Workforce Projection Planning**, projecting up to 5 years ahead to inform our workforce needs and likely pressure points, considering any planned changes to our clinical models. Examples include a report in December 2024 looking at potential workforce gaps up to March 2029, and a recent focused piece of work to model workforce projections at Prospect Park inpatient unit to inform medium-term planning (2025-2030). See supporting evidence for further detail. • In addition, a significant amount of workforce model development has already taken place in line with the themes of the 10-year plan, for example: ○ Developing **Virtual Ward teams** to remotely monitor patients at home alongside primary care, secondary care and social services. ○ **Sub-contracting with VCSE organisations to adapt our staffing models** when trying to engage difficult to reach residents compared to a traditional clinically based staffing model, including supporting us to engage with identified communities whilst developing our Health Inequalities Strategy and Anti-Racism Framework. ○ Our existing multi-stakeholder **Neighbourhood Health programme** of work is considering the likely workforce implications of this programme. The initial focus is on enhancing the Trusts role within neighbourhood-based multi-disciplinary teams – for more detail on this see supporting evidence. • We are also taking a leadership role in system-wide workforce programmes, for example our CEO is Chair of the **Frimley People Board**. In addition, BHFT was the lead organisation for a recent South-East Regional Temporary Staffing work programme, supporting the financial sustainability of local services.

4	**Staff have appropriate skills, and capacity, and they are actively involved in delivering sustainable quality improvements and innovation to shape transformational initiatives to improve quality of care.**
Self-Assessment	**Fully Assured**
Evidence:	• We are assured that **our staff are actively involved in delivering sustainable quality improvements** – see responses in Section 1 (Strategy, Leadership & Planning) regarding our QI approach that is embraced throughout the organisation. • We also **actively seek assurance regarding staff skills and capacity**, undertaking regular workforce reviews including projections of future workforce demands. See responses in the 'Productivity and Value for Money' section for further discussion.

	• We are proud to be a **leading institution for education, training and development** to support our staff to have appropriate skills in the workplace**,** with 95% of our students saying they would recommend us to a peer: o Several of our educators support national education forums such as Preceptorship, and we provide a broad range of placements in community and mental health services for students at regional Higher Educational Institutes (HEIs) and Acute Trusts. o Since 2023, we have supported T-level programmes for Reading and Bracknell Colleges. We have collaborated with Buckinghamshire University to develop a multi-faith learning programme and we have co-led the internationally educated nurse recruitment project with Oxford Health. o BHFT is committed to supporting local Higher Educational Institutes (HEIs) with programme revalidation, Ofsted inspections and nursing and AHP graduate student selection processes. We support local schools with organising career events. BHFT has 3 scheduled School visits in 2026 to low socioeconomic areas in Reading, Slough and West Berkshire to raise awareness about NHS careers. o Our Educator team have achieved several national accolades over the years (Our Library and Knowledge Service achieved the LILAC award in 2022. Our Multi-disciplinary Preceptorship programme has achieved NHSE quality kite mark. We have received commendation from NHSE for being an early adaptor of Safe Learning Environment Charter. We have been invited and presented at the Widening participation forums to share the success of our functional skills programme.

5	**The trust actively identifies and addresses workforce inequalities that impact a fair and inclusive culture and works towards improving equality and equity for its people.**
Self-Assessment	**Fully Assured**
Evidence:	• As a leadership team we are very **vocal about our commitment to equality** and routinely refer to this in our interactions with staff throughout our organisation. We regularly engage with our workforce on this topic and have acted on the Workforce Race Equality Standard (WRES) data and Workforce Disability Equality Standard (WDES) data. Reports are published on our website each year. Our staff recognise this commitment; currently our workforce compliance with mandatory EDI training is just over 97%. • The Trust developed a **Culture, Inclusion and Equity Framework for 2025-28** which majors on equality in the workforce and our commitment to equity for our people. This detailed document is available in our supporting evidence. • We have an established **Antiracism programme of work** including an Action Statement and an action plan across five domains: Recruitment, Retention, Progression and Conditions; Policy and Practice; Education and Engagement; Incidents, Support and Empowerment; and Patient Access, Experience and Outcomes working with our Race Equality Network. Further detail on this has been

	provided in our supporting evidence. Examples include introducing interview questions in advance to support our marginalised and neurodiverse communities, as well as guaranteed interview scheme for ethnically diverse colleagues at 8b+ who meet the essential criteria. • We have earned the **Race Equality Matters (REM) Silver Trailblazer Status**, recognising our commitment to becoming an anti-racist organization. This two-year award highlights our efforts in education, reporting, the anti-racism taskforce, and leadership-led initiatives. Awarded by an expert panel, it confirms the impact of our work with the Race Equality Network and diverse colleagues. REM, a non-profit formed after the 2020 Black Lives Matter movement, helps organizations globally implement solutions to race inequality. • We achieved **Carer Confident Level 2** demonstrating our commitment to supporting carers in our workplace. This accreditation reflects our efforts to help carers identify themselves, involve them in policy development, and offer practical support. We aim to progress to Level 3 Ambassador status. This certification is valid until 15 February 2027. • We were delighted to **retain the highest level of Disability Confident status**, achieving 'Leader' status for 2024/25. Our focus remains on enhancing best practices to support individuals with disabilities in accessing employment. Collaborations with various teams and partners ensure we maintain and improve our 'Leader' status. We've also simplified the reasonable adjustment process based on staff feedback. Changes include a new e-referral form, the Inclusion Passport, and updated intranet resources. These adjustments support employees with long-term disabilities or health conditions to perform effectively in the workplace • **Staff Survey responses** are considered through multiple lenses including ethnicity and disability profiles. Our resulting action plans reflect the steps taken and/or planned in response to this important staff feedback. We also produce a gender, disability and ethnicity pay gap report each year and look at intersectionality. Reports are published on our website. • The EDI section in our Annual report also outlines a lot of our activity in tackling inequality in the workplace.

6	**It has an inclusive education and training programme that values and develops its workforce across all professions to deliver safe and effective care now and into the future**.
Self-Assessment	**Fully Assured**
Evidence	• We have a comprehensive **Learning and Development Policy and supporting plan** which are included within our supporting evidence. • The Board has strong **visibility over education and training** in the Trust. All training initiatives, changes to staff training or competencies are discussed at the Training and Education Advisory Group and then brought to the Safety, Effectiveness and Clinical Effectiveness Group (SECEG) which is co-chaired by the Executive Medical Director and the Executive Director of Nursing and Therapies. SECEG minutes are submitted to QPEG for oversight.

	• Our **central L&D teams and Clinical Education Teams** provide comprehensive, inclusive, and multi-professional education and training offer that supports workforce development across all professions. This includes a substantive educator infrastructure, strengthened apprenticeship governance, high-quality preceptorship recognised by NHSE quality mark, and a robust placement programme across nursing, AHP, psychology, pharmacy, medical and other professions. Our Educators are adequately trained and competent in educational leadership (including knowledge and skills in relation to -EDI strategy, reasonable adjustment, access to work, compassionate leadership etc). • In addition to the central training teams that provide mandatory training and other in-house training programmes, **BHFT has invested in several new roles to strengthen our educational infrastructure**. This includes specialist educators for AHP, Pharmacy and Psychology, a group of nurse consultants for adult and MH services and Advanced practitioners all of whom support education as part of their role. We also have trained up staff members to supervise and assess specific student groups as per the relevant professional standards. • The implementation of the **Educator Workforce Strategy** within BHFT is led by the Training and Education Advisory Group (TEAG). A workshop is scheduled for March 2026 to co-develop a local implementation plan aligned to the nine strategic domains of the national strategy. As part of this work, we intend to develop a maturity matrix for the 9 domains and carryout a maturity review of our educator workforce function to identify strengths and gaps and subsequently develop targeted actions to address these areas. • We also established a **Trust Educator Network** in 2025 to create inclusive opportunities for educators to come together, create an identity, make their voices heard, seek peer support, share good practice and contribute towards education research, governance and improvement plans. We plan to extend this panel to business managers and administrators working in L&D and other education teams, so the group becomes more inclusive and recognise their contributions. We also hope this group will be key to the Educator Workforce implementation plan. ToR is being developed. • We also look outside of our own organisation, and an ICB-wide Education group meets regularly to discuss education issues and share good practice. Conversations are ongoing to share common training across Trusts. Our educators are also leading a project with Dorset and Oxford Community Trusts to develop a new e-learning programme.. • Collectively, these initiatives enable staff to develop the skills required for safe, effective care now and for future workforce needs.

Access and delivery of services	
Performance against standards and targets – satisfactory score against NOF and action plans to improve performance	
1	**The trust has a proven track record of recovering performance against national standards and targets in a timely way.**
Self-Assessment	**Fully Assured**
Evidence:	• We closely monitor our performance against national standards and targets at the Board and throughout our supporting governance structure. Our True North Breakthrough report (i.e. performance report) monitors trends and any potential emerging concerns that need to be proactively addressed. See supporting evidence for examples of these reports and discussion at the Board. • An example of work underway to improve performance against standards and targets is our **Children and Young People Neurodiversity Service Improvement.** This is a national issue and something we are striving to improve locally with our partners: ○ Extensive work is underway with partners across Berkshire to improve access to our CYP Neurodiversity services. We have engaged with local schools, local authority education and social care leads, and parent forums to develop and implement changes to the referral and assessment pathways to reduce waiting times for our children and improve access to 'informal' earlier support. Emerging findings suggest these changes have been positively received by referring partners and have resulted in a 44% reduction in referrals since implementation in November 2024 compared to the same period the previous year – reversing a historic trend for the first time. See supporting evidence for further info. • We are also taking proactive steps to address long waiting times in our **Adult ADHD service**. In December 2025, in agreement with our ICB, a planned pause to new referrals to our Adult ADHD service was implemented. Over the past few years, demand for adult ADHD assessments and ongoing care has grown much faster than anyone anticipated; the service now receives more referrals in a single month than it was originally commissioned to assess in a whole year. This diversion of new referrals away from the Trust will enable us to safely meet the needs of patients already on the waiting list for assessment and those awaiting annual medication reviews, whilst a system-wide solution is developed to meet current demand and be commissioned appropriately. Our ICB has asked the Trust, in conjunction with the BOB Mental Health Provider Collaborative, to lead on developing this solution and an ADHD Board has been established to oversee this programme (chaired by the ICB).

2	**The trust balances the delivery of operational performance against national priorities (such as elective, cancer, urgent and emergency care, mental health) and responds to any changes to these as outlined in national planning guidance.**
Self-Assessment	**Fully Assured**

Evidence:	• As a Trust we refer to national priorities and planning guidance as part of our standard planning processes, and balance delivery of these as appropriate. We also **work closely with partners to support the delivery of national priorities** across the region, including:
	  ○ The **BOB Mental Health Provider Collaborative** brings together Berkshire Healthcare NHS Foundation Trust and Oxford Health NHS Foundation Trust, working closely with Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board and wider system partners to support aligned delivery of mental health priorities across the BOB system. BHFT gains assurance through the Collaborative's established governance arrangements, including Executive Oversight and regular highlight reporting into the Trust Board, with BHFT represented throughout the governance structure and key decision-making forums.
	  ○ The Collaborative supports joint working and alignment of mental health planning across the system, bringing together providers, commissioners, VCSE and local authority partners around a shared transformation portfolio that reflects national priorities and local system needs. While place-based planning remains the primary route for operational delivery, the Partnership Programme Board provides a consistent forum for system-level discussion, coordination and visibility of mental health priorities and proposals.
	  ○ The **Partnership Programme Board** (hosted by the Provider Collaborative) provides oversight of the High Dependency & Secure Care, Adult Inpatient Transformation, and MH LD&A Resource Review and Improvement Programmes. Through this, there is clear evidence of collaborative working against shared priorities for inpatient quality, culture of care, flow, access and out-of-area placement reduction. These arrangements demonstrate how national mental health planning guidance is translated into joint system programmes, shared governance and coordinated service improvement activity, with agreed shared outcome measures used to track progress over time.
	• We also refer to national benchmarking data whilst balancing patient safety and quality of care with operational performance. An example of this is our **ward-size-reduction programme at Prospect Park Hospital**:
	  ○ National benchmarking data revealed that larger ward sizes were associated with increased rates of incidents such as self-harm, physical violence between patients, and the use of restraint. The overall bed base was reduced from 86 to 72 beds, with two wards of mixed gender provision and dedicated male and female wards.
	  ○ In addition to these improvements, a procurement process was undertaken to establish an 18-bed ward within the independent sector to mitigate the reduction at Prospect Park, following a financial review of internal vs external provision. This new facility, named Poppy Ward, is operated by Priory. During this realignment of capacity, we undertook engagement with staff and patients

	to improve the facilities, and our service offer to patients including consideration of additional quiet areas, sensory spaces, additional activities during evenings and weekends and improved communal spaces to promote a greater sense of community.

3	**The trust sets itself ambitious plans to exceed national targets in relation to access and waiting times and supports and identifies initiatives that enable system partners to deliver outcomes for patients.**
Self-Assessment	**Fully Assured**

Evidence:	• The Trust Board is responsible for ensuring our resources are used equitably across the organisation to deliver against all national targets and standards. We recognise that resources nationally are limited and we strive to ensure a fair balance and allocation of resources across all our services. As a minimum we aim to achieve national targets and go above and beyond this where feasible to do so without using resources that would be more appropriately deployed elsewhere.
	• We do have a number of service areas where we have successfully achieved above and beyond the national minimum expectations, including those where ringfenced funding has been provided for specific purposes. For example:
	  ○ Our Virtual Wards routinely exceed the minimum occupancy target of 80%
	  ○ Our Urgent Community Response service has consistently exceeded it's 2-hour response target of 80% for the past 12 months
	• Please see our True North Performance Scorecard for further evidence and Trust data.
	• We also proactively identify opportunities to utilise our resources to support system partners, including the most recent example in **Children's Audiology** where our teams were able to support a reduction in waiting times in other Trusts:
	  ○ The service began a comprehensive improvement programme in 2024 addressing risks highlighted through Paediatric Audiology Services Quality Assessment Tool, PASQAT assessment and created targeted action plans. Key improvements include reducing long waiting times, strengthening competency assurance through peer review, and enhancing data entry processes. Technical issues in audiogram interpretation and clinical environments have been resolved, supported by IT upgrades and equipment calibration. Harm assessments for overdue cases have been completed, and follow-up tracking has been reinforced to ensure patient safety.
	  ○ These actions culminated in successful UKAS IQIPS re-accreditation in October 2025, with inspectors commending the service's strong commitment to continuous improvement. As a result of this progress, the Trust has been asked to support other organisations in improving their audiology services, sharing best practice and lessons learned. Ongoing priorities include maintaining compliance through quarterly audits, continuing peer review and competency checks, monitoring waiting times, and providing regular updates to the Quality Assurance Committee and Board.

4	**The trust explores and shapes system wide solutions to challenges to care delivery that impact inequity of access, unwarranted variation and overall performance.**
Self-Assessment	**Fully Assured**
Evidence:	• As noted above, we work closely with partners and actively seek opportunities to support system partners where possible. Examples given throughout this document evidence this commitment. • Please refer to the example of Adult ADHD services where the Trust is taking a lead role in developing a system-wide solution. • Please also refer to the recent example of supporting audiology services detailed above where we were able to support other organisations by sharing our learning from our own Continuous Improvement work. • Please also refer to the Community Equipment example given in Section 1 above (Strategy, Leadership and Planning) where we took a leadership role in addressing a system-wide service concern.

Productivity and value for money	
The applicant demonstrates a clear understanding of productivity opportunities and presents actionable plans to deliver improvements.	
1	**The trust has a proven and consistent track record of delivering measurable productivity and sustained improvements.**
Self-Assessment	**Fully Assured**
Evidence:	• The Trust has a strong and consistent track record of delivering efficiencies and productivity improvements, including via our Cost Improvement Plans (CIPs) which form a key part of our financial sustainability strategy. • Historically, **annual CIP programmes have achieved targets** through robust governance and divisional oversight, and we are forecasting to achieve our 25/26 savings plan of £17.5 million. We aim for a minimum of 80% recurrent savings within the CIP profile to aid sustainability of these savings and minimise reliance on non-recurring benefits. • The Trust's current cash position is favourable against plan, and the Better Payment Practice Code is achieved for all 4 targets.

	• Regarding staffing efficiencies, we set ourselves two ambitious targets to reduce temporary staffing spend by 30% and reduce bank staffing costs by 10%. The latter is exceeding plan by £1m year to date and the former, more ambitious, target is within £0.1m of the target set. • Please also see examples below re: how the Trust uses benchmarking data to target productivity improvements.

2	**The board and its sub-committees routinely use all available and relevant benchmarking data, to drive and balance both quality and financial improvement.**
Self-Assessment	**Fully Assured**

Evidence:	• The Trust uses a range of benchmarking data on a regular basis to inform decision making. Benchmarking data is integrated within the True North Breakthrough Report (Integrated Performance Report) where relevant and is regularly used to inform target setting and to measure performance.
	• Examples of standalone benchmarking reports used by the Trust include:
	  ○ **Mental Health service Annual Benchmarking** – last in dept review undertaken in 22/23 to review inpatient bed provision average length of stay, workforce ratios, and quality metrics. Full report is included in our supporting evidence.
	  ○ **District Nursing service benchmarking 24/25** – reporting in November 2025, this benchmarking review considered referral rates, average time on caseload, workforce metrics, and patient feedback. This demonstrated positive patient feedback despite a higher than average caseload per WTE.
	  ○ **National Staff Survey** is a crucial benchmarking report reviewed annually by the Board.
	• A suite of financial and productivity benchmarking reports is also used by our finance and operational teams during planning and service delivery. See supporting evidence for a summary of these.

Financial performance and oversight (including financial governance)	
Medium-term plan – applicant demonstrates that the trust, unless there are exceptional circumstances, has a high likelihood of: • ***projecting an adjusted surplus position excluding non-recurrent deficit funding in year 1 and achieving a sustainable adjusted surplus position excluding non-recurrent deficit funding by year 3 of the projected period, (as defined under the NOF)*** • ***maintaining a reasonable cash position including working capital for the next 12 months***	
1	**There is a robust medium-term forecast financial plan, and can confirm the following:** • **the financial plan is developed using reasonable (evidence-based) or published assumptions** • **the financial plan aligns with the system transformation strategy and is being developed in conjunction with the system plan, and it is agreed upon with the ICB** • **the financial plan projects an adjusted surplus position in year 1, and it achieves a sustainable adjusted surplus position by year 3 of the projected period, excluding deficit support funding (as defined under the NOF)** • **the trust maintains a reasonable cash position, including sufficient working capital to meet its operational and financial requirements for at least the next 12 months** • **it has undertaken a sensitivity analysis to evaluate reasonable downside scenarios and their mitigations for testing the financial plan** • **the trust will achieve its financial forecast outturn for the current financial year**
Self-Assessment	**Fully Assured**
Evidence:	• The Trust has a track record of robust financial management; we have historically delivered or exceeded against our financial plans, and we will achieve our forecast financial outturn for the current 25/26 financial year as reported to our Board – see associated minutes. We therefore have a high level of confidence in our financial planning and oversight as a Board and throughout the organisation. • We have developed a robust medium-term forecast financial plan ("MTP") for 2026-2029, based on reasonable evidence-based assumptions considering historic and forecast trends, anticipated income and cost projections, workforce assumptions, and any anticipated non-recurrent financial events. This MTP will be submitted on 17th December in adherence with national timeframes. • Our MTP forecasts a sustainable adjusted breakeven position for the three financial years covered, along with a strong working capital position enabling us to meet our operational and financial requirements throughout. • Our sensitivity analysis considers our main area of material financial risk, being an increase in Psychiatric Intensive Care Bed demand and/or Out of Area placements. An increase of 50% has been modelled which would result in a £1.8m cost pressure to the organisation

	requiring additional savings elsewhere to offset, with a 50% likelihood of this risk materialising. Additional CIP contingency planning is included as standard as part of our financial planning process. Please refer to our MTP Financial Model for further detail. • We have actively engaged with system partners as we developed our MTP and we are in the process of agreeing our income position with our commissioners at the time of this submission. We do not anticipate any issues with this process. • For more detailed evidence please refer to our MTP Financial Model.

Financial governance and capital scheme delivery arrangements that are effective in practice.	
1	**The trust has a robust financial governance framework, underpinned by clearly defined roles, responsibilities, and accountabilities for all key financial matters, including the management of financial risk, performance, capital scheme delivery and the timely reporting of audited accounts.**
Self-Assessment	**Fully Assured**
Evidence:	• The Trust's historically strong financial position is underpinned by good financial governance and grip throughout the organisation, from the Board and Finance, Investment and Performance Committee through to our Divisional leadership teams and individual budget holders. • Our **Financial Scheme of Delegation** sets out clearly defined roles, responsibilities and accountabilities. • The **Finance, Investment and Performance Committee** seeks effective assurance regarding financial performance and risk, including Capex spend and associated capital project delivery, and provides onward assurance to the Board. The remit of this committee is intentionally broader than Finance alone; the Board is of the view that the strength of financial assurance is greater when it is underpinned by a thorough understanding of the Trust's performance and related drivers of spend. • A **self-assessment of the effectiveness of the Finance, Investment and Performance Committee** was submitted to the Committee in July 2025 which provided a high level of assurance regarding these arrangements. Minutes of this meeting are available to review and also evidence the timeliness of our reporting of our audited accounts. • Our Key Financial Controls are reviewed regularly as a core element of our **Internal Audit programme of work**. The latest Internal Audit Key Financial Control review (Debtors) took place in January 2025 and provided the highest level of assurance ('Substantial') regarding our processes.

	• We work hard to ensure the Trust's **financial position is understood throughout the organisation** via staff communications including Team Brief and our Public Board meetings, and we encourage all members of staff to act in a financially responsible way.

2	**Within this framework, they and Finance Committee:** • **possess the necessary skills and experience to provide effective leadership and oversight of financial matters** • **receive timely, clear, and comprehensive reporting on the organisation's financial performance and risks to support informed decision-making** • **operate within a strong financial control environment that enables effective assurance and challenge across all aspects of financial delivery, including the achievement of Cost Improvement Plans (CIPs)**
Self-Assessment	**Fully Assured**
Evidence:	• The Finance, Investment and Performance Committee is chaired by a Non-Executive Director who has finance and transformation skills. The Chair of the Quality Assurance Committee who is a nurse by background is also a member of the Committee and ensures that quality issues are discussed alongside financial discussions. The other Non-Executive Director member of the Committee has a background in digital transformation. The Executive members are the Chief Financial Officer, Director of Finance, Chief Operating Officer, Director of Nursing and Therapies and the Chief Executive. • The Trust Board undertook an **Annual Review of Effectiveness in October 2025** which included consideration of the reporting available to the Board and supporting committees including the Finance, Investment and Performance Committee. This confirmed that all members of the Board including non-executives are either very satisfied or mostly satisfied with the information available, and that only minor improvements should be considered going forward (including reducing the length of some papers and enhancing some management summaries). • The Trust has a longstanding arrangement of **delegated financial controls** whereby the Board agrees Divisional Control Totals with our Divisional Leadership Teams, giving them autonomy and flexibility to manage their budgets alongside clear accountability to deliver within these control totals. Actual and forecast service-level financial performance is a standing agenda item on the regular Executive Team meetings with Divisional Leadership Teams.

3	**The trust proactively reviews its financial governance framework to ensure it remains robust and supports long-term sustainability. This is demonstrated by regular assessment of value for money, responsiveness to early warning signs – such as inadequate financial information and weak escalation of financial risks –through mechanisms such as in-year reporting, triangulation of board-level information, exception reporting, and assurance from internal audit and other independent reviews**
Self-Assessment	**Fully Assured**
Evidence:	• Our **Financial Governance Framework**, along with all our Corporate Governance arrangements as described in Section 1 (Strategy, Leadership and Planning) are regularly reviewed both internally and externally. • Our **Internal Audit programme** is reviewed each year with a strong focus on assuring the adequacy of our Financial Control environment. Our Key Financial Controls are reviewed regularly as a core element of our Internal Audit programme of work. The latest Internal Audit Key Financial Control review (Debtors) took place in January 2025 and provided the highest level of assurance ('Substantial') regarding our processes. • Board level financial information is routinely triangulated within the relevant reports, for example triangulation of staff costs against whole term equivalent headcount data, and external benchmarking is included where possible. • The Trust also undertakes **periodic benchmarking of material areas of financial spend**, for example the key service costs within the two Trust PFIs as reported in the Estates Update 2025-26 – see supporting evidence. • All business cases for revenue and capital spend must **evaluate the return on investment** and thus value for money for the expenditure. Example business cases are included in our supporting information.

4	**Financial planning processes are aligned with national and local priorities, including enabling the 3 shifts outlined in the 10 Year Health Plan.**
Self-Assessment	**Fully Assured**
Evidence:	• Our financial plans support the delivery of our strategic aims which are aligned with the 10 Year Health Plan and local system priorities. We engaged our partners and commissioners during the development of our MTP and are assured that it aligns with national and local priorities. • We have a supporting capital plan and investment commitment from the Board to support our patients, clinical workforce and system partners. This includes investment in digital initiatives as outlines in our supporting information. • For further detailed evidence please see our MTP submission and supporting documents included as evidence.

5	**The trust considers the impact of all financial and operational changes on the quality of care, supporting both current service delivery and long-term sustainability.**
Self-Assessment	**Fully Assured**

Evidence:	• A report was taken to our Quality Assurance Committee in February 2025 to summarise the robust **quality impact assessment process** that is being undertaken as part of the 25/26 planning round. This builds on the process adopted in previous years and must be undertaken in the following situations:
	  ○ Where cost improvement programmes are being planned
	  ○ Where service changes may have a potentially negative impact on quality, safety or workforce
	  ○ For new business or commissioned changes – a business case will not be approved without a QIA.
	• There is an escalation process for discussion of any QIAs that are highlighting potential quality or safety risks. To date, no changes have been agreed where there is a known risk of harm to patients or there are already concerns around ability to deliver safe services.
	• Further detail on this is available in our supporting evidence.

Berkshire Healthcare
NHS Foundation Trust

Equity Partnership Group: Meet our members

The Equity Partnership Group brings together expert partners and leaders from the community and our organisation to create positive change. Our members have different backgrounds and experiences, and we work to spot problems, share good ways of doing things, and support projects that help everyone have the same chances.

We meet four times a year to make sure everyone feels respected and heard, as part of our vision to be a great place to give care and a great place to get care.

Each of our members adds something special to our group and is committed to making a difference across a diverse range of specialisms.

Dr Alice Mpofu-Coles

I am a Senior Research Fellow at the University of Reading, working on community research projects, and sit on the Race Equality and the University of Sanctuary strategy team. My research uses a participatory action research approach to improve community engagement and create, facilitate and highlight diverse spaces where seldom-heard communities can influence policies and decision-making.

I have received numerous local and international awards for my community work, including advocating for refugees, education, and volunteering. I was recently named one of the Leading Women to Watch™ in 2025, alongside women from many countries, by a US-based organisation. I am the current first black female Mayor of Reading, and a local councillor. As a local, national and international speaker, I shine a light on inequalities. My work has seen me engage with universities, NHS bodies, charities, public bodies, community groups, and local authorities.

Andrea Brookes

Born in Northamptonshire, I have worked in IT for most of my life. After being made redundant from Vodafone, I set up my own consultancy business, which I have run for the past 18 years. I am Vice-Chair of Newbury Pride and represent the LGBTQIA+ community on several panels. I advocate for LGBTQIA+ rights and provide support to people within the community who may have all sorts of worries and concerns.

I hold safeguarding and suicide prevention certificates and an enhanced DBS check for Newbury Pride. I am also a member of the local Hate Crime Action Team and the CPS scrutiny panel, where I represent the LGBTQIA+ community. My main area of concern is supporting the trans community, although I represent the whole community.

Ceara Webster

I am a Diversity and Inclusion Adviser with experience of delivering inclusive initiatives across the Environmental and Higher Education sectors. I began my career developing co-design approaches in Scotland to address inequities in accessing nature, particularly between scientists and organisations representing racialised minorities, young people, and disabled people.

I now support the strategic implementation of equity initiatives across a range of protected characteristics in Higher Education to make sure inclusion is embedded institutionally. I am also pursuing a doctoral degree at the University of Glasgow, exploring inequitable access to green and blue spaces and the racialised impacts this has on wellbeing.

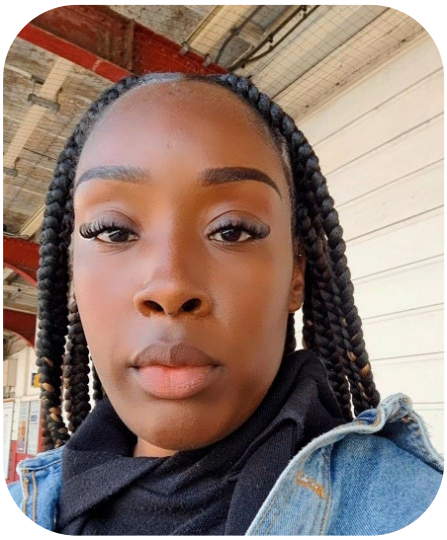
My passion lies in exploring how equitable praxis fosters a sense of belonging for marginalised communities, which I see as fundamental to nurturing wellbeing.

Dipak Mistry

I am passionate about embedding equity across Berkshire Healthcare and ensuring that inclusion is a lived reality for patients, staff, and communities. Joining the Equity Partnership Group allows me to draw on over 19 years of NHS and public sector leadership experience as a Senior HR Professional and Diversity Specialist to challenge systemic inequities and drive meaningful change.

I have led workforce transformation programmes, developed inclusive HR policies, and coached leaders to create compassionate and equitable cultures. My expertise spans governance, scrutiny, and evidence-based approaches, supported by lived experience of inequity and a deep commitment to fairness.

Having advised the NHS, local authorities, Police, Fire & Rescue, and Family Courts, I bring a system-wide perspective to advancing equity. Through the EPG, I aim to ensure that underserved voices shape decisions and help Berkshire Healthcare progresses from aspiration to sustainable equity in every area of care and employment.



Jamila Thompson

I bring lived experience and a strong commitment to advancing equity, diversity, and inclusion across health and care services. My work focuses on racial equity, mental health, maternal health, and children and young people's health.

I hold a BSc in Sociology, MA in Culture, Diaspora, and Ethnicity, an MSc in Social Research, and am currently completing a PhD in Sociology. I combine my academic background with hands-on experience as a teacher, youth advocate, and community practitioner.

I have worked with grassroots organisations and charities such as BLAM UK and Race on the Agenda, supporting young people and families to navigate challenges and access essential services. I have also worked in Education Research with institutions such as King's College London.

In my role with the EPG, I will apply an intersectional perspective to identify inequalities, drive change, and help shape healthcare services that are fair, accessible, and truly inclusive.

Liz Mayers

I am Co-founder and CEO of accrEDIted™ from The EDI Mark C.I.C (formerly EDI Accreditation Ltd). We provide independent, data-driven analysis and accreditation for organisations committed to improving equality, diversity and inclusion for their people.

With more than 20 years' experience in recruitment and executive search, I supported organisations to create diverse and inclusive leadership hiring and development strategies. After many years championing EDI best practice and inclusive talent approaches, I moved in 2020 to focus fully on helping organisations to benchmark and improve EDI across all areas of their strategy.

As a Berkshire resident, I was pleased to be invited to join the Anti-racism CommUNITY Forum for Berkshire Healthcare two years ago. I have loved seeing the impact of its work and look forward to helping to create even greater impact for the diverse communities of Berkshire through my role with the EPG.

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Louis Headley

I joined the Equity Partnership Group because I am committed to improving fairness, accessibility, and meaningful involvement across health and wellbeing services. With my professional background is in Engagement and Development, with experience across both the statutory and voluntary sectors.

Starting as an apprentice in CAMHS, I worked my way up to leadership and focused on participation and involvement. This included contributing to service transformation projects, supporting non-clinical pathways for young people, and creating co-productive workstreams. During this time, I also served as a staff governor representing colleagues' views and concerns.

In my current role, I focus on innovation, service delivery and how non-clinical services can support people to thrive throughout their recovery and wellbeing journeys, alongside the clinical care they receive. Through the EPG, I hope to amplify these values, help shape more equitable systems, and tackle systemic inequity to improve outcomes for all.

Makini Jones

I bring over 15 years of nursing and project management experience, alongside lived experience as a parent carer to a child with special educational needs. My passion lies in ensuring equitable care for all, especially people who experience poorer outcomes due to racial inequality or disability.

In my current role, I focus on advancing equity for both patients and the workforce, recognising the powerful connection between how staff are supported and how care is delivered. I'm committed to driving cultural change where diversity is genuinely celebrated, not simply tolerated, and where inclusion is embedded throughout our systems.

Joining the Equity Partnership Group is an exciting opportunity to collaborate with others who share this vision and to contribute to meaningful, sustainable change that improves experiences and outcomes for everyone.

Cllr Dr Nicholas Robertson

I am profoundly deaf and have worn hearing aids since I was a few weeks old. My lived experience of disability has shaped my determination to improve services for disabled people.

I communicate through lip reading and oral speech, and I understand the additional challenges and stress that come with having a disability.

I am an elected councillor at both Parish and Borough level, serving on the Disability Advisory Access Panel and the Governance and Audit Committee. These roles have given me extensive experience in scrutiny, audit, and public service, ensuring processes are transparent, compliant, and deliver positive outcomes for the community.

As a member of the Equity Partnership Group, I aim to share insights from my own experience and from others, helping to strengthen understanding and support inclusive decision-making.

Sarita Rakhra

I firmly believe that equality should apply to everyone, regardless of their culture, religion, sexual orientation, colour or disability. As an Equity Partnership member, I will work to make sure that everyone is treated fairly, regardless of their starting point. I want to influence change and support the development of tailored service to achieve fair outcomes.

As Head of Section 117 Aftercare and Lead for Learning Disabilities and Autism, I made sure that there was recognition of the barriers underserved communities face, whether cultural, economic, disability-related or systemic.

Within the EOG, I will champion policies that actively reduce these gaps by prioritising inclusive engagement, data-driven decision-making, and culturally competent services. I will advocate for fair allocation of resources, amplify the voices of marginalised groups, and ensure that strategic planning reflects the diverse needs of our population. Through this approach, I aim to drive meaningful, measurable change in access to healthcare for all.

Read more about our equality, diversity and inclusion commitments:

www.berkshirehealthcare.nhs.uk/edi

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper Meeting Paper

Board Meeting Date	13 January 2026
Title	**Finance Report November 2025**
	The paper is for noting.
Reason for the Report going to the Trust Board	This is a regular report which provides an update to the Board on the Trust's Financial Performance. The report provides the Trust's position at the end of November 2025.
Business Area	Finance
Author	Chief Finance Officer
Relevant Strategic Objectives	**Efficient use of resources** **Ambition:** We will use our resources efficiently and focus investment to increase long term value The report gives an overview of the Trust's financial performance including use of revenue and capital funding and delivery against the cost improvement programme. The Trust's results contribute to the performance of BOB ICS.

Berkshire Healthcare NHS
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Finance Report

Financial Year 2025/26

November 2025

Purpose

To provide the Board and Executive with a summary of the Trust's financial performance for the period ending 30 November 2025.

Document Control

Version	*Date*	*Author*	*Comments*
1.0	12/12/2025	Rebecca Clegg	Draft
2.0	05/01/2026	Paul Gray	Final

Distribution

All Directors.

All staff as appropriate.

Dashboard & Summary Narrative

Target		Year to Date Actual £m/%	Year to Date Plan £m/%	Year to Date Achieved	Forecast Outturn Actual £m/%	Forecast Outturn Plan £m/%	Forecast Outturn Achieved
1	Income and Expenditure Plan	1.6	1.6	Yes	1.7	1.7	Yes
2	CIP - Delivery	11.6	11.6	Yes	17.5	17.5	Yes
3	Cash Balance	58.5	48.1	Yes	45.2	45.2	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	99%	95%	Yes	95%	95%	Yes
5	Capital Expenditure not exceeding CDEL	2.4	7.7	Yes	20.8	20.8	Yes
6a	Agency Expenditure Reduction	32%	30%	Yes	30%	30%	Yes
6b	Bank Expenditure Reduction	17%	10%	Yes	10%	10%	Yes

Key Messages

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

- The planned outturn position for the Trust is a £1.7m surplus.
- The Trust has a cost improvement programme of £17.5m. This is being achieved year to date although there are variances on individual lines and we have some high risk schemes.
- The current cash position is ahead of plan. There are still some outstanding payments from commissioners which we continue to pursue. Cash expenditure on capital projects is lower than planned due to profiling.
- The Better Payment Practice Code is achieved for all 4 targets.
- Capital expenditure is below CDEL Year to Date primarily due to the profile of expenditure on the Jubilee Ward relocation project.
- The Trust has 2 targets for temporary staffing. There is a requirement to reduce agency expenditure by 30% when compared to the previous year. The target is now being achieved. The bank staffing cost reduction of 10% compared to the previous year is being exceeded by £0.9m year to date.

System Position

- BOB ICS submitted a combined break even plan. This included £44m of deficit support. There is also £24m of system risk share of which BHFT has agreed to a £1.8m share linked to opportunities within the ICB's own MHLDA budgets. Progress towards the saving target has been slow and at month 8 the Trust has assumed clawback of £1m income year to date in line with the risk share agreement. Agreement has been reached with the ICB that the total clawback will be £1.66m following the release of some allocation balances by the ICB.

1. Income & Expenditure

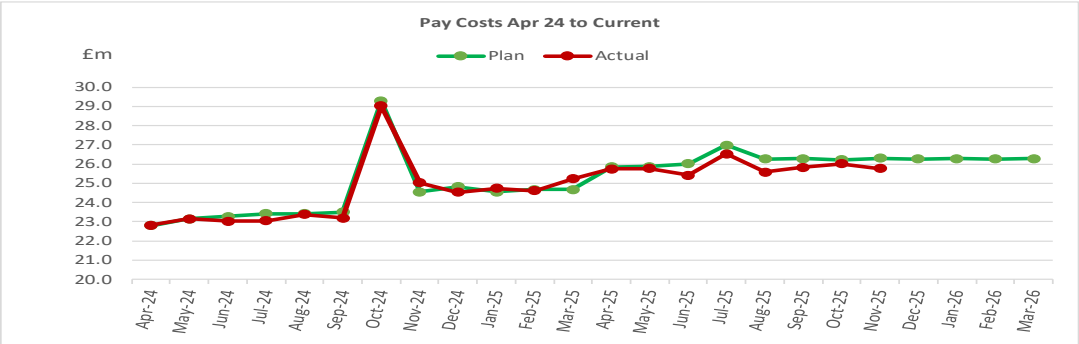
Nov-25	In Month Act £'m	In Month Plan £'m	In Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m	2025/26 Plan £'m
Operating Income	33.7	32.8	0.9	264.6	262.6	2.0	393.9
Elective Recovery Fund	0.4	0.4	0.0	3.2	3.2	0.0	4.8
Donated Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Income	**34.1**	**33.2**	0.9	**267.8**	**265.9**	2.0	**398.7**
Staff In Post	23.7	24.4	0.7	191.2	194.7	3.5	292.2
Bank Spend	1.6	1.5	(0.1)	11.7	12.3	0.6	18.5
Agency Spend	0.5	0.4	(0.1)	3.8	2.8	(1.0)	4.2
Total Pay	**25.8**	**26.3**	**0.5**	**206.7**	**209.8**	**3.1**	**314.9**
Purchase of Healthcare	1.8	1.3	(0.5)	13.1	10.3	(2.8)	15.4
Drugs	0.8	0.6	(0.2)	4.7	4.5	(0.2)	6.7
Premises	1.7	1.6	(0.1)	12.3	12.5	0.2	18.9
Other Non Pay	2.0	1.6	(0.4)	14.1	12.8	(1.3)	19.3
PFI Lease	0.7	0.7	0.0	5.9	5.9	0.0	8.8
Total Non Pay	**7.0**	**5.8**	**(1.2)**	**50.1**	**46.0**	**(4.1)**	**69.1**
Total Operating Costs	**32.8**	**32.1**	**(0.7)**	**256.7**	**255.8**	**(1.0)**	**384.0**
EBITDA	**1.3**	**1.2**	**(0.2)**	**11.1**	**10.1**	**(1.0)**	**14.7**
Interest Receivable	**0.2**	**0.3**	**(0.0)**	**1.9**	**2.3**	**(0.3)**	**3.4**
Interest Payable	0.3	0.3	(0.0)	2.2	2.2	(0.0)	3.3
Depreciation	0.9	0.9	(0.1)	7.7	7.3	(0.4)	11.2
Impairments	0.2	0.0	(0.2)	0.3	0.0	(0.3)	0.0
Disposals	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Remeasurement of PFI	0.0	0.0	0.0	1.4	1.7	0.3	1.7
PDC	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Financing	**1.4**	**1.2**	**(0.3)**	**11.6**	**11.2**	**(0.4)**	**16.2**
Reported Surplus/(Deficit)	**0.1**	**0.3**	**(0.2)**	**1.4**	**1.1**	**0.3**	**1.9**
Adjustments	**0.2**	**0.0**	**0.2**	**0.0**	**0.0**	**0.0**	**(0.2)**
PFI IFRS16 Adjustment	**(0.2)**	**(0.2)**	**(0.0)**	**0.1**	**0.4**	**(0.3)**	**0.0**
Adjusted Surplus/(Deficit)	**0.1**	**0.1**	**0.0**	**1.6**	**1.6**	**0.0**	**1.7**

Key Messages

The table above gives the financial performance against the Trust's income and expenditure plan as at 30 November 2025.

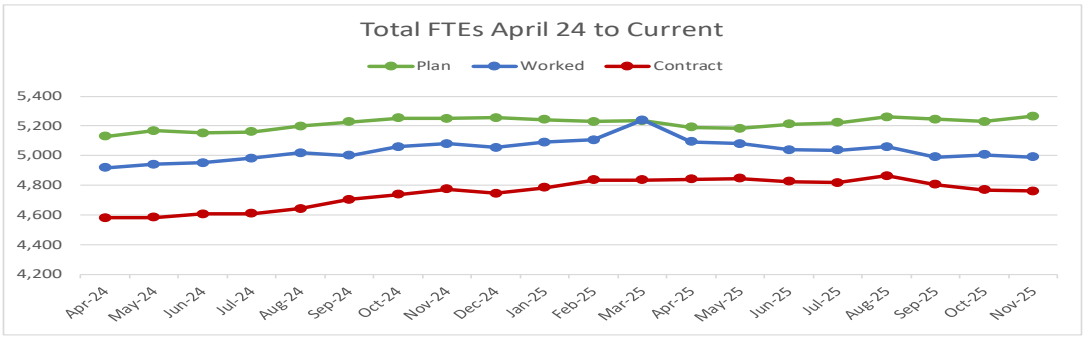
The Trust has planned for a £1.7m surplus. Year to date performance is in line with plan. The variance on purchase of healthcare includes overspends on PICU, acute OAPs and specialist placements.

Workforce



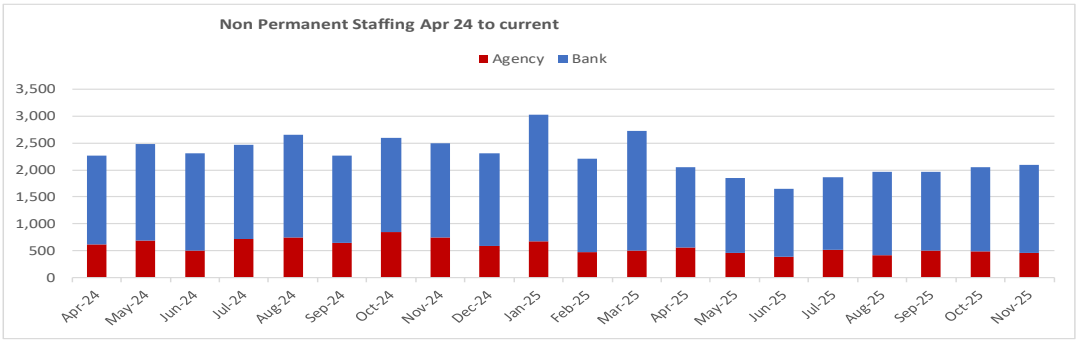
Staff Costs

YTD	£m
2025/26	206.7
2024/25	192.7
▲	7%
Prior Yr	**£m**
Nov-25	25.8
Nov-24	25.0
▲	3%



FTEs

Prior Mth	CFTE	WFTE
Nov-25	4,760	4,989
Oct-25	4,767	5,006
	0% ▼	0% ▼
Prior Yr		
Nov-25	4,760	4,989
Nov-24	4,773	5,081
	0% ▼	-2% ▼



Non Permanent Staff Costs

YTD	Bank £k	Agency £k
2025/26	11,702	3,779
2024/25	14,017	5,541
	-17% ▼	-32% ▼
Prior Yr	**£k**	**£k**
Nov-25	1,630	460
Nov-24	1,752	750
	-7% ▼	-39% ▼

Key Messages

Pay costs in month were £206.7m and year to date the Trust's pay expenditure is lower than planned. As the pay award has been agreed at a higher level than was assumed for planning, this has created a further cost pressure for the Trust c£0.3m.

WTEs decreased in month by 17 (Worked WTEs) and 7 (Contracted WTEs).

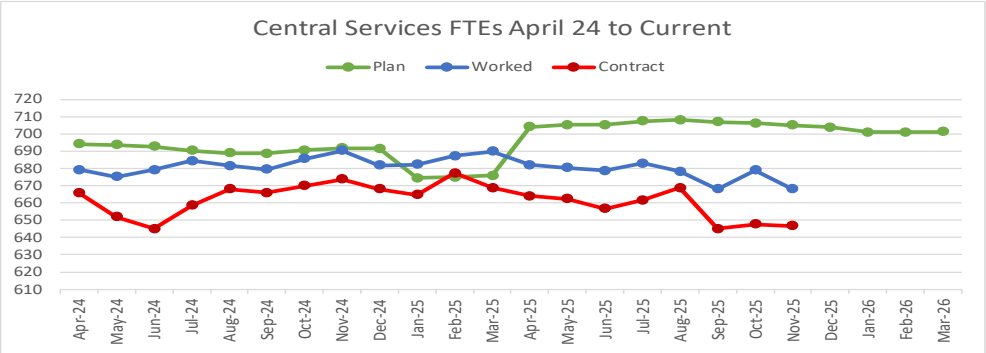
NHSE has mandated 2 new targets for temporary staffing. There is a requirement to reduce agency expenditure by 30% when compared to the previous year. This target is now being achieved year to date for agency. The bank staffing cost reduction of 10% compared to the previous year is being exceeded.

Our bank fill rate remains strong, increasing to 96% of the overall temporary staffing demand.

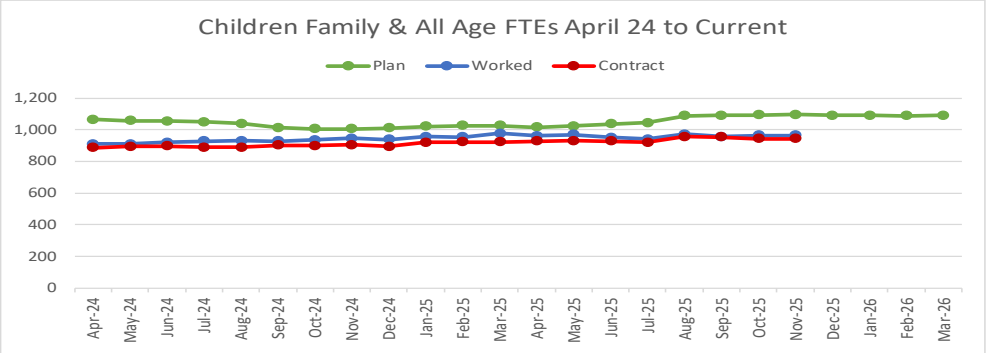
Now restricted to nurseries only, as dental services no longer require off-framework agencies. Recruitment to the bank continues to expand, supporting our strategy to eliminate off-framework reliance and comply with the NHSE mandate for zero Band 2/3 agency usage by January 2026.

There were zero non-medical price cap breaches for the fifth consecutive month.

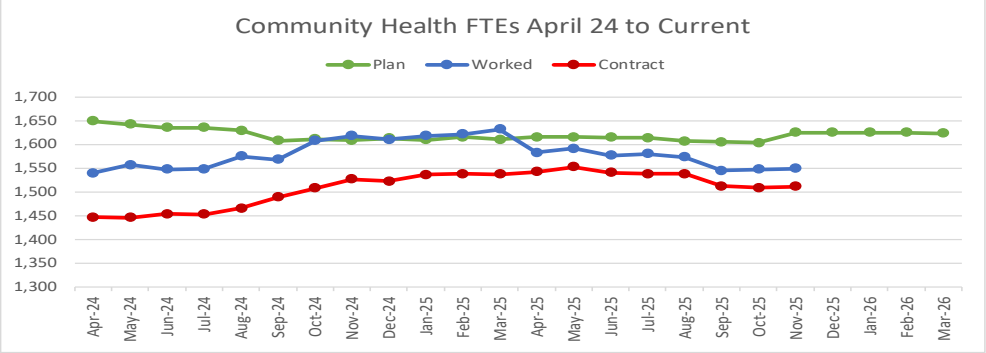
Staff Detail (Division)



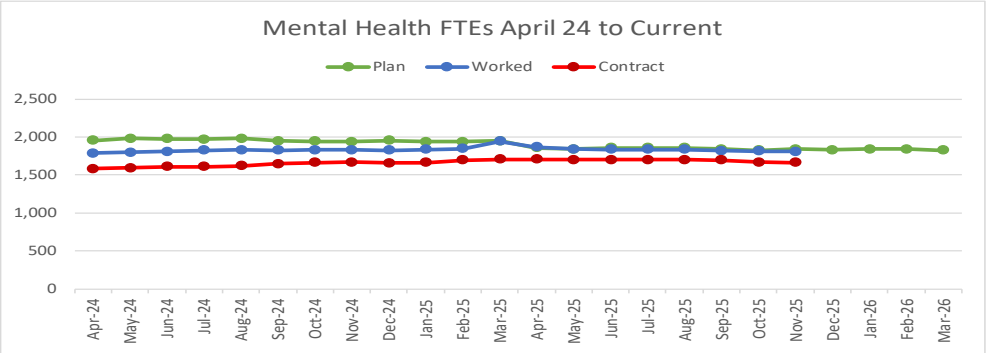
	FTEs	
Prior Mth	CFTE	WFTE
Nov-25	647	668
Oct-25	648	679
	0% ▼	-2% ▼
Prior Yr		
Nov-25	647	668
Nov-24	674	690
	-4% ▼	-3% ▼



	FTEs	
Prior Mth	CFTE	WFTE
Nov-25	942	963
Oct-25	942	964
	0% ▼	0% ▼
Prior Yr		
Nov-25	942	963
Nov-24	904	944
	4% ▲	2% ▲



	FTEs	
Prior Mth	CFTE	WFTE
Nov-25	1,511	1,549
Oct-25	1,508	1,547
	0% ▲	0% ▲
Prior Yr		
Nov-25	1,511	1,549
Nov-24	1,526	1,618
	-1% ▼	-4% ▼



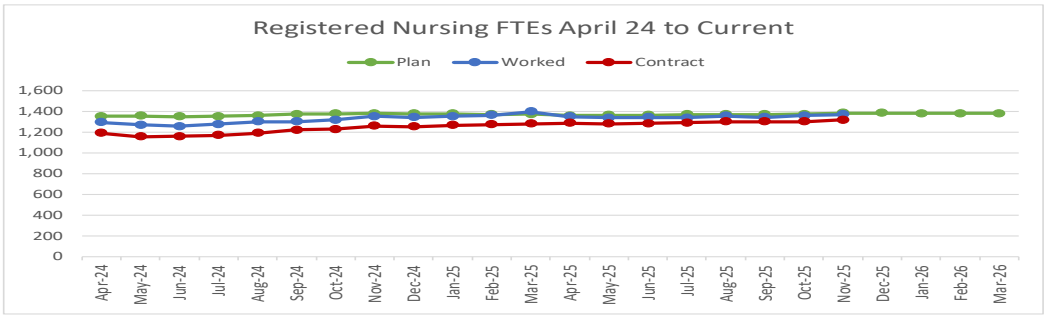
	FTEs	
Prior Mth	CFTE	WFTE
Nov-25	1,660	1,809
Oct-25	1,670	1,816
	-1% ▼	0% ▼
Prior Yr		
Nov-25	1,660	1,809
Nov-24	1,669	1,828
	-1% ▼	-1% ▼

Key Messages

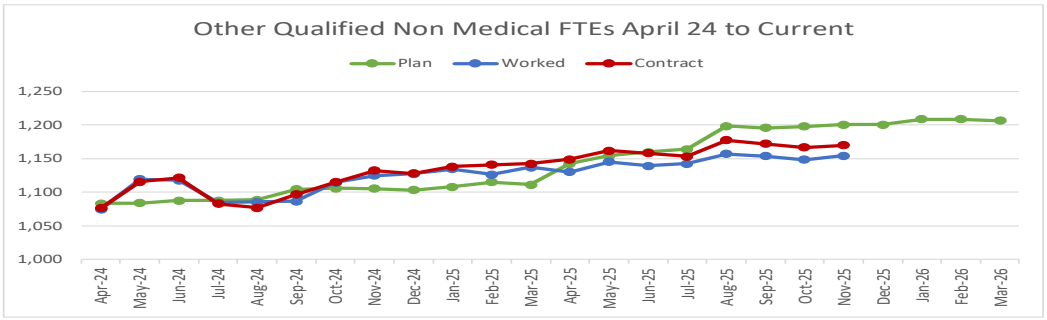
Worked WTEs are below plan for all clinical divisions and Central Services. Contracted WTEs reduced in MH and Central services. We have had some reductions due to MARS across all divisions.

Overall, worked WTEs are 276 lower than plan in November.

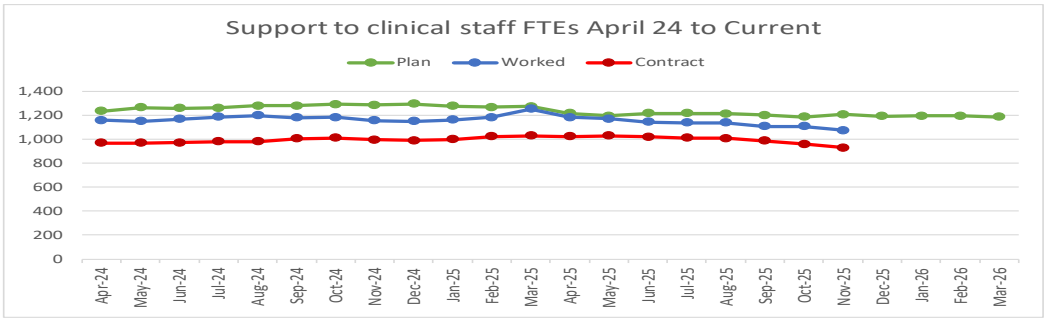
Staff Detail (Staff Group)



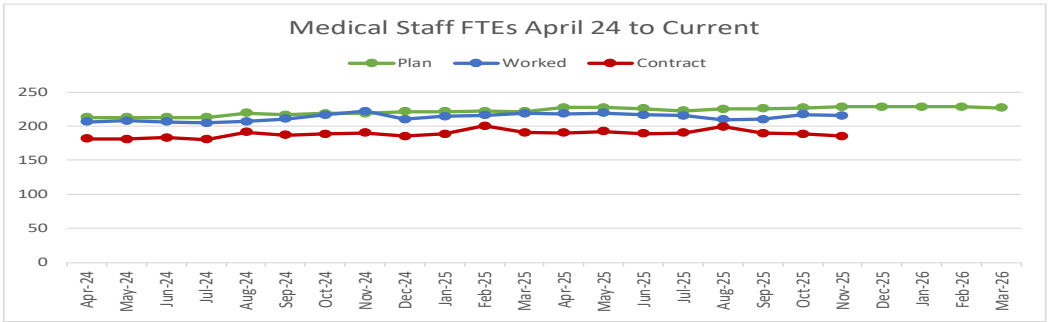
	FTEs	
Prior Mth	CFTE	WFTE
Nov-25	1,314	1,367
Oct-25	1,298	1,356
	1% ▲	1% ▲
Prior Yr		
Nov-25	1,314	1,367
Nov-24	1,257	1,349
	5% ▲	1% ▲



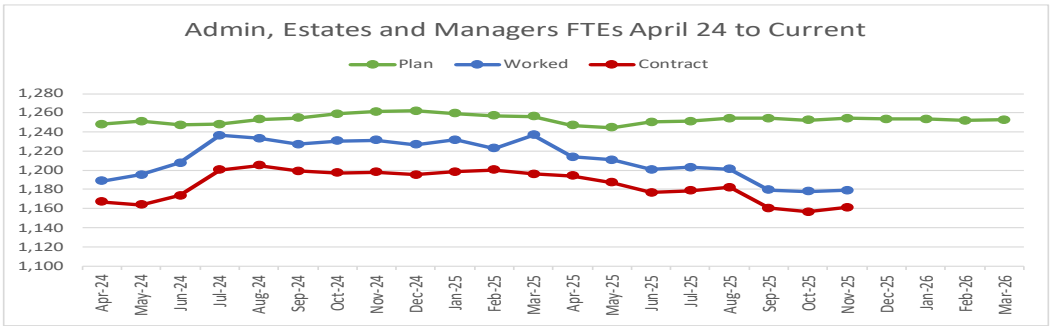
	FTEs	
Prior Mth	CFTE	WFTE
Nov-25	1,170	1,155
Oct-25	1,167	1,149
	0% ▲	1% ▲
Prior Yr		
Nov-25	1,170	1,155
Nov-24	1,132	1,125
	3% ▲	3% ▲



	FTEs	
Prior Mth	CFTE	WFTE
Nov-25	929	1,073
Oct-25	957	1,107
	-3% ▼	-3% ▼
Prior Yr		
Nov-25	929	1,073
Nov-24	996	1,153
	-7% ▼	-7% ▼



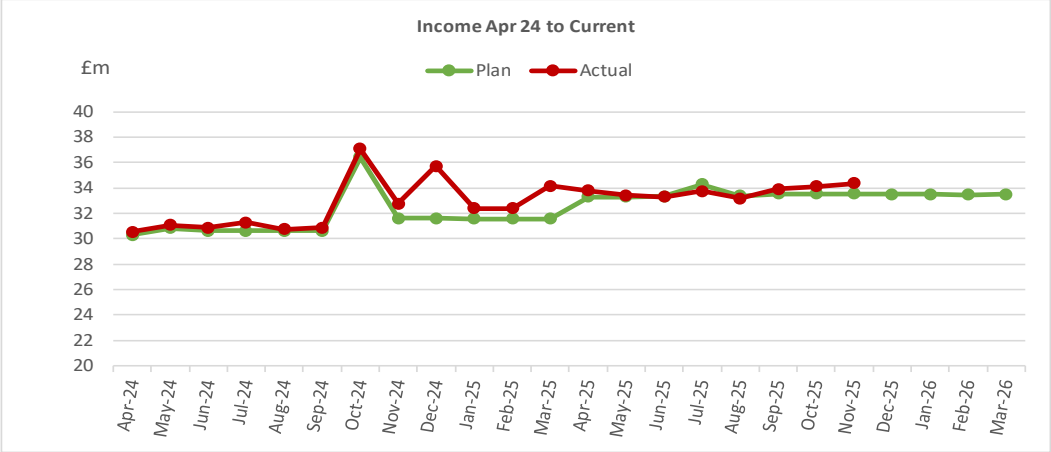
	FTEs	
Prior Mth	CFTE	WFTE
Nov-25	185	215
Oct-25	188	217
	-2% ▼	-1% ▼
Prior Yr		
Nov-25	185	215
Nov-24	190	222
	-2% ▼	-3% ▼



	FTEs	
Prior Mth	CFTE	WFTE
Nov-25	1,161	1,179
Oct-25	1,156	1,178
	0% ▲	0% ▲
Prior Yr		
Nov-25	1,161	1,179
Nov-24	1,198	1,232
	-3% ▼	-4% ▼

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

Income



Income

YTD	£'k
2025/26	269.8
2024/25	255.2
▲	6%

Prior Yr	£'m
Nov-25	34.4
Nov-24	32.7
▲	5%

Key Messages

Income (including interest received) is slightly ahead of plan year to date due to some final settlements from 2024/25 and the release of deferred income. This is offset in part by the clawback of £0.1m by BOB ICB related to the MHLDA cost improvement risk share. Interest received is slightly below plan with interest rates being lower than in 2024/25. The Trust has also received income for new services e.g. MHIST and for settlement of invoices from NHS Property Services.

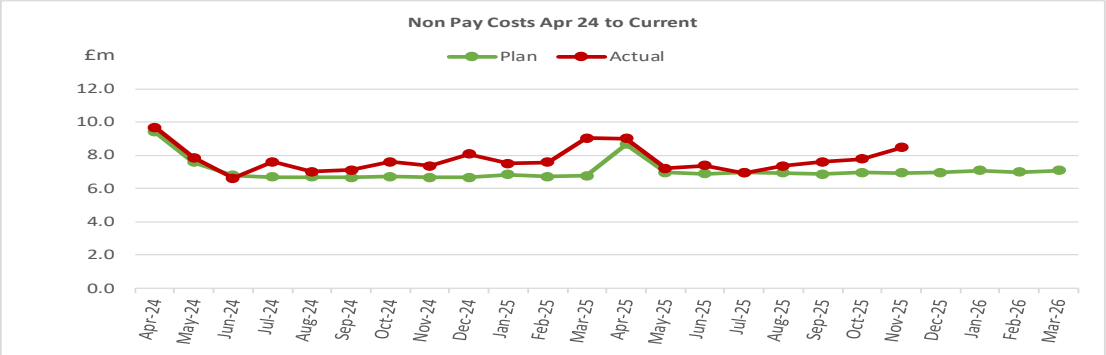
Elective Activity Performance

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

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

The "true-up" exercise for 2024/25 has now been completed and we have received confirmation that payment will be made for the income we accrued at the end of the year.

Non Pay & Placement Costs

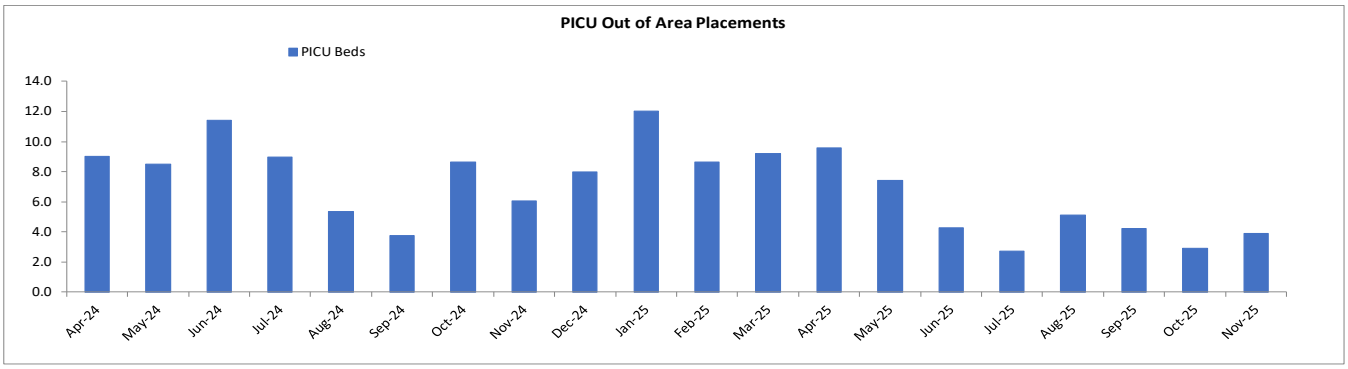


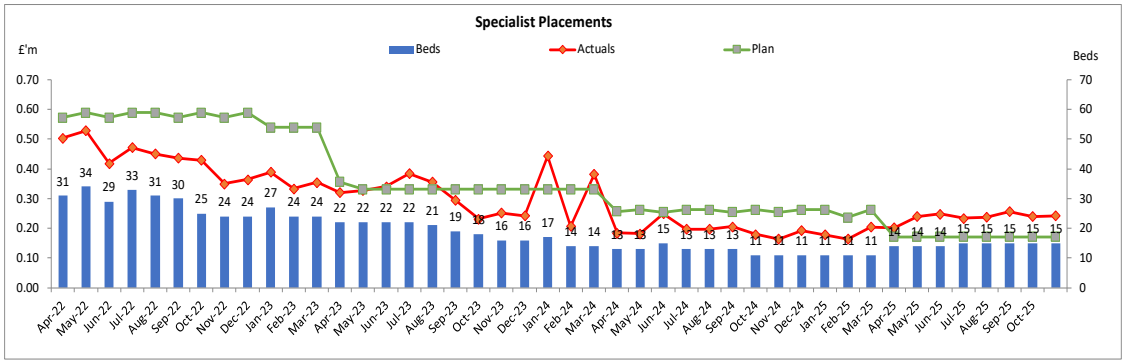
Non Pay Costs

YTD	£'m
2025/26	61.7
2024/25	60.9
▲	1%
Prior Yr	**£'m**
Nov-25	8.5
Nov-24	7.4
▲	15%

Key Messages

As in previous years, the overspend against plan is driven by PICU and specialist placements.





Specialist Placements

YTD	£'m
2025/26	1.90
2024/25	1.56
▲	*22%*
Prior Yr	**£'m**
Nov-25	0.24
Nov-24	0.16
▲	*48%*

Key Messages

Following the opening of our outsourced ward, we were expecting to have no or minimal **Out of Area Placements (OAPs)**. However at the end of October and into November, the number of inappropriate OAPs had increased and in November we had 4, creating a cost pressure of £120k in month. We have planned for 5 **Psychiatric Intensive Care Unit (PICU)** placements in 2025/26. At the start of the year, actuals were higher than plan at April (10) but they reduced and there are currently 4 . However, this is expected to increase. The day rate is also higher than planned. The overspend year to date is £0.5m. There remains a long-standing issue whereby any female requiring a PICU bed must be admitted to an Out of Area Placement (OAP), as there are no local beds available for this group. The demand for PICU beds has also been affected by an increased number of requests for prison transfers for assessment or treatment under the Mental Health Act (MHA).

Throughout the year, there has been a steady increase in lost bed days for patients who are clinically ready for discharge. The delays are partly attributed to a shortage of suitable high-need supported living provisions 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 the Royal Borough of Windsor and Maidenhead and Reading being the primary contributors to these delays.

Actions include weekly escalation meetings with counterparts in the LAs and ICBs to improve patient flow and using the process for escalated OAP approvals. This process involves discussions regarding additional escalation for CRFD patients, the use of health-funded step-down beds, and the provision of temporary accommodation supported by CRHTT.

Cost Improvement Programme

Description	Description	Risk	Plan £k	YTD Actual £k	YTD Plan £k	Variance £K
Divisional CIPS	Recurrent	Low	5,256	3,504	3,504	0
Balance Sheet Review	Non-Recurrent	Low	3,065	3,829	2,043	1,786
Interest	Recurrent	Low	500	333	333	0
UEC Expenditure	Recurrent	Low	456	304	304	0
Procurement savings	Recurrent	Medium	150	100	100	0
Tax Optimisation	Recurrent	Medium	420	70	280	-210
Contract Contribution	Recurrent	Low	1,850	65	1,233	-1,168
Contract Contribution	Non Recurrent		0	1,168	0	1,168
Annual leave Accrual	Non-Recurrent	Low	250	0	167	-167
Non - recurrent cover for posts	Non-Recurrent	Low	451	301	301	0
Recharge to income	Recurrent	Low	63	42	42	0
Legal Services review	Recurrent	Medium	150	18	100	-82
Expenses Controls	Recurrent	Low	50	33	33	0
Estates Downsizing	Recurrent	Low	130	87	87	0
Discretionary spend controls	Recurrent	Medium	250	0	167	-167
Temporary staffing reduction stretch	Recurrent	Medium	1,500	0	1,000	-1,000
Corporate efficiency stretch	Recurrent	High	1,500	702	1,000	-298
Further workforce controls	Non-Recurrent	High	1,360	1,086	907	179
Other	Recurrent	High	62	0	41	-41
Other - Slippage	Non-Recurrent	Low	0	0	0	0
		Total	17,463	11,642	11,642	0

Key Messages

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

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

Our balance sheet release is ahead of plan currently, this includes additional balances that we have been able to release to offset the claw back of income from BOB ICB as a result of the MHLDA risk share not delivering any savings. We have also paid the majority of MARS payments due with savings being realised over the year ahead.

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

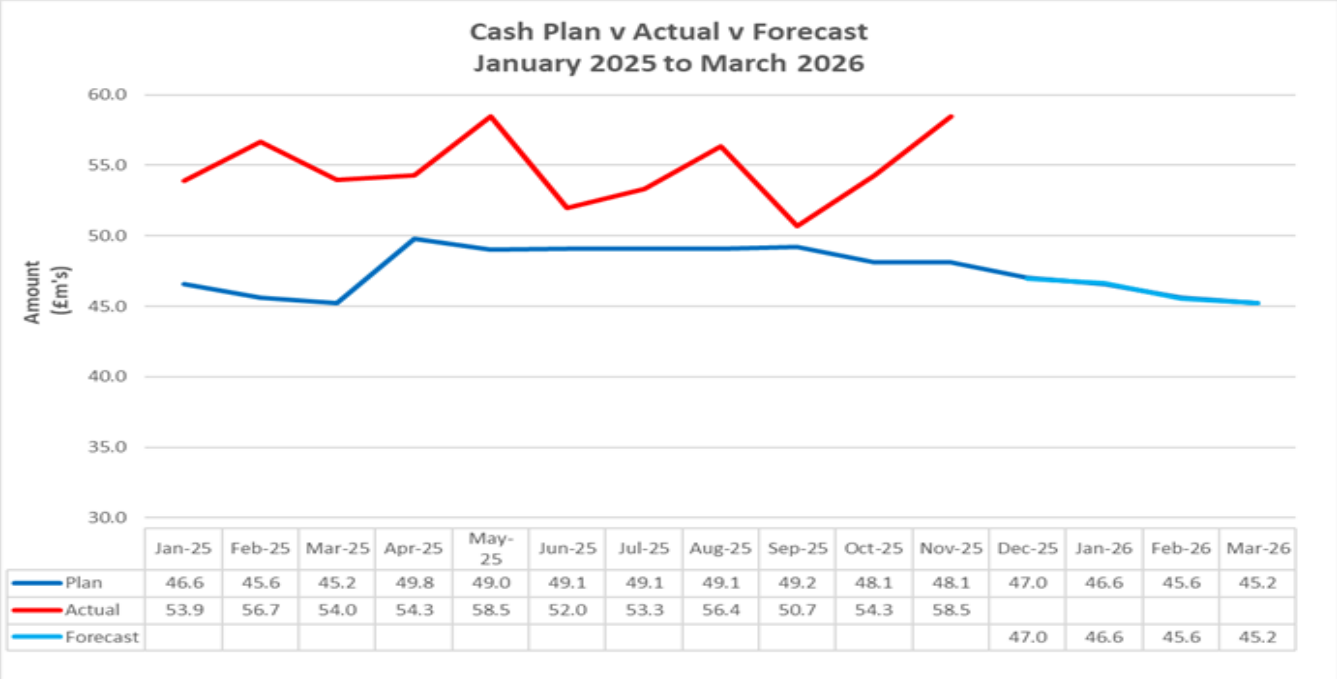
There are several other schemes in the pipeline and we continue to look to ICS partners for ideas for collaboration and for opportunities identified through benchmarking.

Balance Sheet & Cash

	2024/25 Actual £'m	Current Month Act £'m	Current Month Plan £'m	Current Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m
Intangibles	0.9	1.6	1.9	(0.3)	1.6	1.9	(0.3)
Property, Plant & Equipment (non PFI)	38.2	35.7	38.1	(2.4)	35.7	38.1	(2.4)
Property, Plant & Equipment (PFI)	44.5	42.1	48.1	(6.0)	42.1	48.1	(6.0)
Property, Plant & Equipment (RoU Asset)	12.8	11.4	11.1	0.3	11.4	11.1	0.3
Receivables	0.2	0.2	0.2	0.0	0.2	0.2	0.0
Total Non Current Assets	**96.6**	**91.0**	**99.4**	**(8.4)**	**91.0**	**99.4**	**(8.4)**
Trade Receivables & Accruals	14.2	16.4	12.0	4.4	16.4	12.0	4.4
Other Receivables	0.3	0.4	0.3	0.1	0.4	0.3	0.1
Cash	54.0	58.5	48.1	10.4	58.5	48.1	10.4
Trade Payables & Accruals	(40.9)	(39.8)	(36.3)	(3.5)	(39.8)	(36.3)	(3.5)
Borrowings (PFI and RoU Lease Liability)	(4.4)	(0.1)	(7.0)	6.9	(0.1)	(7.0)	6.9
Other Current Payables	(12.0)	(16.1)	(9.7)	(6.4)	(16.1)	(9.7)	(6.4)
Total Net Current Assets / (Liabilities)	**11.2**	**19.3**	**7.4**	**11.9**	**19.3**	**7.4**	**11.9**
Non Current Borrowings (PFI and RoU Lease Liability)	(52.2)	(53.6)	(47.2)	(6.4)	(53.6)	(47.2)	(6.4)
Other Non Current Payables	(1.6)	(2.7)	(2.4)	(0.3)	(2.7)	(2.4)	(0.3)
Total Net Assets	**54.0**	**54.0**	**57.2**	**(3.2)**	**54.0**	**57.2**	**(3.2)**
Income & Expenditure Reserve	10.2	11.5	11.6	(0.1)	11.5	11.6	(0.1)
Public Dividend Capital Reserve	21.8	21.8	23.5	(1.7)	21.8	23.5	(1.7)
Revaluation Reserve	22.0	20.7	22.0	(1.3)	20.7	22.0	(1.3)
Total Taxpayers Equity	**54.0**	**54.0**	**57.2**	**(3.2)**	**54.0**	**57.2**	**(3.2)**

Key Messages

Cash is £10.4m higher than plan, the plan being for a reduced balance over the second half of the year. The underspend against the capital expenditure plan continues to grow which is contributing to the higher cash balance. In month the Trust has received funding from the ICBs to pay over to NHS Property Services, which will not happen until December. There have also been some positive movements on working capital balances.



	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Plan	46.6	45.6	45.2	49.8	49.0	49.1	49.1	49.1	49.2	48.1	48.1	47.0	46.6	45.6	45.2
Actual	53.9	56.7	54.0	54.3	58.5	52.0	53.3	56.4	50.7	54.3	58.5				
Forecast												47.0	46.6	45.6	45.2

Capital Expenditure

Schemes	Current Month			Year to Date			FY	Forecast	FY
	Actual	Plan	Variance	Actual	Plan	Variance	Plan	Outturn	Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Estates Maintenance & Replacement Expenditure									
Trust Owned Properties	1	17	(15)	26	83	(58)	150	113	(37)
Jubilee Ward Relocation to St Marks - CIR Funding	25	217	(192)	238	1,732	(1,494)	2,600	2,000	600
Trust Wide Anti-Ligature - CIR Funding	18	0	18	51	0	51	0	600	(600)
West/Reading Consolidation - Bath Road Phase 1&4	9	0	9	364	500	(136)	498	983	485
Charles Ward Decant Works - (Jubilee Ward Enabling Works)	(8)	0	(8)	60	0	60	0	264	264
Leased Non Commercial (NHSPS) Other	1	57	(56)	47	293	(246)	400	137	(263)
Leased Commercial	0	0	0	17	36	(19)	36	36	0
Environment & Sustainability	5	23	(18)	43	115	(72)	198	187	(11)
Backlog Maintenance	10	10	(10)	47	300	(300)	500	485	15
Various All Sites	7	93	(77)	116	412	(248)	680	121	(589)
Statutory Compliance	7	27	(19)	289	118	171	200	336	136
Subtotal Estates Maintenance & Replacement	**74**	**443**	**(369)**	**1,297**	**3,590**	**(2,292)**	**5,262**	**5,262**	**0**
IM&T Expenditure									
Business Intelligence and Reporting	0	0	0	49	0	49	110	110	0
Hardware Purchases - Refresh & Replacement	6	1,059	(1,053)	94	2,118	(2,024)	4,136	4,136	0
Teams Rooms Refresh ONLY	0	8	(8)	0	16	(16)	50	62	12
Additional Divisional Spend & Teams Room Additions	14	42	(28)	222	336	(114)	504	492	(12)
Digital Strategy	34	50	(16)	301	400	(99)	600	600	0
Pharmacy System Procurement & Population Health	0	0	0	0	0	0	150	150	0
Subtotal IM&T Expenditure	**54**	**1,159**	**(1,105)**	**666**	**2,870**	**(2,204)**	**5,550**	**5,550**	**(0)**
IFRS16 RoU ASSETS - New Leases Net of Disposals and Remeasurements									
St. Marks Charles Ward Block 23	0	0	0	0	0	0	1,495	1,495	0
Bracknell - Frimley Sublease	0	0	0	0	202	(202)	202	202	0
Chalvey Lease	0	0	0	0	600	(600)	600	600	0
Bath Road	0	0	0	0	0	0	6,654	6,654	0
Bracknell Healthspace	0	0	0	0	0	0	500	364	(136)
Nicholson House	0	0	0	432	350	82	350	432	82
Lease cars	0	0	0	54	0	54	0	54	54
CoIN	0	0	0	0	100	(100)	200	200	0
Sub Total New Leases (IFRS16)	**0**	**0**	**0**	**486**	**1,252**	**(766)**	**10,001**	**10,001**	**(0)**
Subtotal CapEx Within Control Total	**128**	**1,602**	**(1,474)**	**2,449**	**7,712**	**(5,262)**	**20,813**	**20,813**	**(0)**
CapEx Expenditure Outside of Control Total									
Place of Safety	219	0	219	954	600	354	600	954	354
Anti-Ligature Toilet Pans & Basins	0	0	0	26	150	(124)	150	248	98
Trust wide Anti-Ligature (PFI)	0	60	(60)	0	290	(290)	500	284	(216)
Other PFI projects	26	93	(67)	195	417	(222)	730	494	(236)
Subtotal Capex Outside of Control Totals	**245**	**153**	**92**	**1,175**	**1,457**	**(282)**	**1,980**	**1,980**	**0**
Donated/Grant Funding									
WBCH Low carbon heating system - Salix Funding	(210)	0	(210)	(0)	0	(0)	0	2,634	2,634
St Marks Block 23 M&E (Air Handling Unit and Electrical Works)	0	0	0	0	0	0	0	550	550
Subtotal Donated/Grant Funding	**(210)**	**0**	**(210)**	**(0)**	**0**	**(0)**	**0**	**3,184**	**3,184**
Total Capital Expenditure - all funding sources	**164**	**1,756**	**(1,592)**	**3,625**	**9,168**	**(5,544)**	**22,793**	**25,977**	**3,184**

Key Messages

At M08, CDEL schemes were underspent by £5.3m against the plan. For 2025/26 RoU assets have been included in the CDEL calculation and we also have 2 schemes funded from the Estates Safety Fund which score against CDEL.

Estates is underspent year to date due to the phasing of expenditure on the Jubilee Ward relocation and Backlog Maintenance Programme offset in part by expenditure on the Nicholson House alterations project. IMT is also underspent due to phasing of the Refresh & Replacement Programme, however orders have now been raised, which will bring the spend in line with the plan.

Non-CDEL spend for PFI sites was underspent by £0.3m YTD, mainly due to the anti-ligature toilets and basins project, where spend is expected later this year.

There is an underspend on IFRS16 Right of Use Assets of £0.8m for the year to date. This is due to the ongoing delay in lease commencement for Chalvey and for the completion of the Bracknell Health Space Project.

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Trust Board Paper Meeting Paper

Board Meeting Date	13th January 2026
Title	**True North Performance Scorecard Month 8 (November 2025) 2025/26**
	The Board is asked to note the True North Scorecard.
Reason for the Report going to the Trust Board	To provide the Board with the True North Performance Scorecard, aligning divisional driver metric focus to corporate level (Executive and Board) improvement accountability against our True North ambitions, and Quality Improvement (QI) break through objectives for 2025/26.
Business Area	Trust-wide Performance
Author	Chief Operating Officer
Relevant Strategic Objectives	The True North Performance scorecard consolidates metrics across all domains. To provide safe, clinically effective services that meet the assessed needs of patients, improve their experience and outcome of care, and consistently meet or exceed the standards of Care Quality Commission (CQC) and other stakeholders. **Patient safety** **Ambition:** We will reduce waiting times and harm risk for our patients **Patient experience and voice** **Ambition:** We will leverage our patient experience and voice to inform improvement **Health inequalities**

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

True North Performance Scorecard Highlight Report – November 2025

The True North Performance Scorecard for Month 8 2025/26 (November 2025) is included. Performance business rule exceptions, red rated with the True North domain in brackets.

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

Breakthrough Objectives

- Restrictive Interventions – Rapid Tranquilisation (Intra-muscular) **(Harm Free Care)** – 56 against a target of 39 incidents.
    - A total of 16 patients has contributed to this month's total. Five patients accounted for 27 incidents. Rose ward is the top contributing ward, followed by Snowdrop. Improvements in the uptake of the reflective learning (Turbo10) sessions to support countermeasures.
- Mental Health: Adult Average Length of Stay (bed days) **(Good Patient Experience)** – 46.41 days against a target of 42 days.
    - Highest contributing ward is Sorrel (94 days) and Snowdrop (70.7 days). Key countermeasures include allocation of a key worker within 72 hours and tasks required to facilitate timely discharge. An issue identified is the lack of step down facilities/placements in Local Authority areas which is impacting discharge.
- Mental Health: Older Adult Average Length of Stay (bed days) **(Good Patient Experience)** – 92.57 days against a target of 80 days.
    - Similar issues to adult mental health wards. The larger programme has been split into smaller projects to allow more effective focus. Leadership oversight and Local Authority relationships remain key challenges but are being progressed.
- Physical Health: Community Inpatient Average Length of Stay (bed days) **(Good Patient Experience)** – 22.35 days against a target of 21 days.
    - Continuing the reducing trend. Top contributing factors to length of stay were Local Authority placements with Reading and Windsor, Ascot and Maidenhead the highest. Five patients had a discharge affected by equipment delays. Counter measures include communication, prompt escalation of issues and shared learning across wards.
- Physical Assaults on Staff **(Supporting our Staff)** – 93 incidents against a target of 36.
    - There are 30 patients that contributed to the total this month. Top contributing wards were Campion, Rose and Snowdrop. Other wards have seen stable activity over the previous months. It can be challenging on busy wards to have adequate representation at countermeasure review meetings and presents a risk to progress which is being addressed.

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

- None noted

Driver Metrics

The following metrics are Red and not performing to plan.

- I Want Great Care Positive Patient Experience Score **(Good Patient Experience)** – at 80.90% against a 95% target. Metric will be reported one month in arrears to allow for manual records to be uploaded. Lower satisfaction rate due to higher numbers due to child immunisation programme figures.
- I Want Great Care Patient Experience Compliance Rate **(Good Patient Experience)** – at 8.79% against a 10% target. Metric will be reported one month in arrears to allow for manual records to be uploaded.
- Inappropriate Out of Area Placements (OAPs) at the end of the month (Mental Health) – **(Good Patient Experience)** – at 4 against a quarter 3 target of 3 patients.

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

- Staff turnover (excluding fixed-term posts) **(Supporting our Staff)** –at 10.28% against a stretch target of 10%.
- Year to Date Variance from Control Total (£'k) **(Efficient Use of Resources)** – at £0k against a target of 0. This is an NHS Oversight Framework scoring metric.

Tracker Metrics

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

- Sickness rate **(Supporting Our Staff)** – red at 5.2% against a stretch target of 3.5%. This is an NHS Oversight Framework scoring metric, with the Trust in 5th out of 61 (based on a Q1 score of 4.08%) and the national average at 5.10%.
- Bed days occupied by patients who are discharge ready (Community) **(Patient Experience)** – 902 bed days against a target of 695.
- Clinically Ready for discharge by wards in mental health (including OAPs) **(Patient Experience) –** 530 against a 250-bed day target.
- Talking Therapies Reliable Recovery for those Completing a Course of Treatment (Frimley) **(Good Patient Experience)** – (NHS Oversight Framework Non-scoring metric) - at 46% against a target of 50% by April 2026.
- Self-harm Incidents on Mental Health Inpatient Wards (excluding Learning Disability) **(Harm Free Care)** – at 236 against a revised target of 125 incidents.
- Did Not Attend Rate (DNA) % **(Efficient Use of Resources)** – at 5.11% against a target of 5%.
- Mental Health Acute Occupancy rate (excluding home leave) **(Efficient Use of Resources)** – at 97.7% against an 85% target.

NHS Oversight Framework (NOF) Metrics

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

> 'the organisation is consistently high performing across all domains, delivering against plans'.

We achieved a rank of 9th nationally (previously 3rd) from all non-acute Trusts with 15 in segment 1. Whilst we are in a strong position but there are challenges in the following areas:

- Maintaining a strong financial position and not being in deficit.
- Percentage of inpatients aged 18-65 with a length of stay over 60 days - Benchmarking shows we have long lengths of stay. We achieved 20.71% (18th out of 47) with the national median at 23.63%.
- Percentage of Crisis Response patients receiving face to face contact within 24 hours – includes all age Urgent referrals to single points of access (including children and Neurodiversity). We achieved 58.36% (29th out of 48) with the national median at 59.52%.
    - Mitigation – reviewing how crisis referral urgency is coded.
- Productivity metric – Relative difference in costs. We achieved 135.35% (60th out of 61) with the national median at 104.85%.
- Percentage of patients waiting over 52 weeks as this will include long waits in children and young people's services. We achieved 0.29% (18th out of 41) with the national median at 0.38%.
- Annual percentage change in the number of young people accessing NHS Funded Mental Healthcare – however taking on west MHST team should show increase for BHFT. We achieved 13.44% (14th out of 49) with the national median at 7.26%.

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

True North Performance Scorecard – Business Rules & Definitions

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

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

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

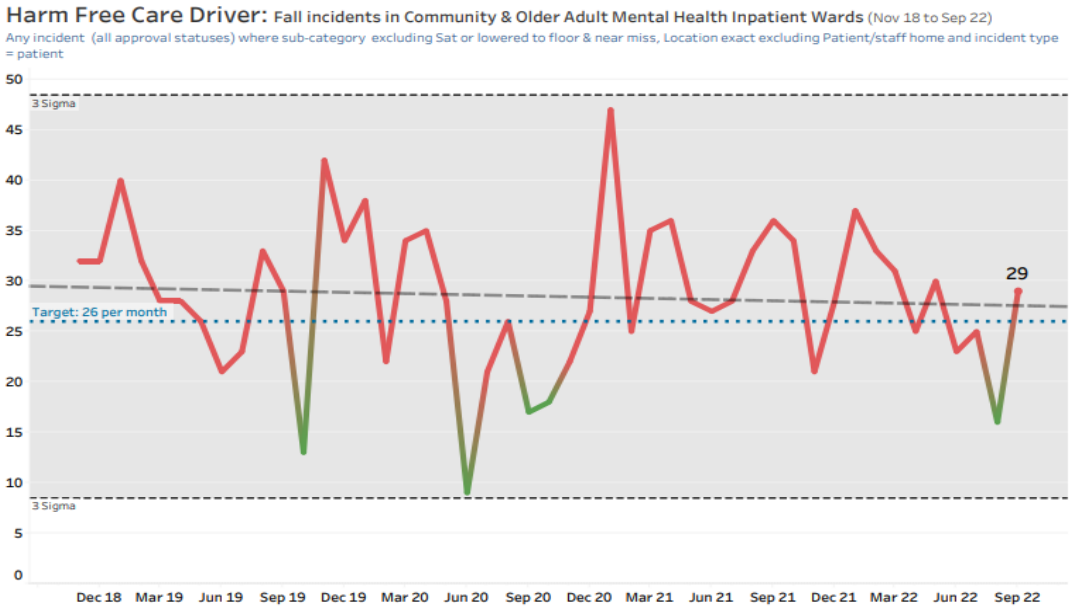
Business Rules for Statistical Process Control (SPC) Charts

Why Use SPC Charts

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

Components of an SPC Chart

The charts have the following components with an example below:



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

Variation

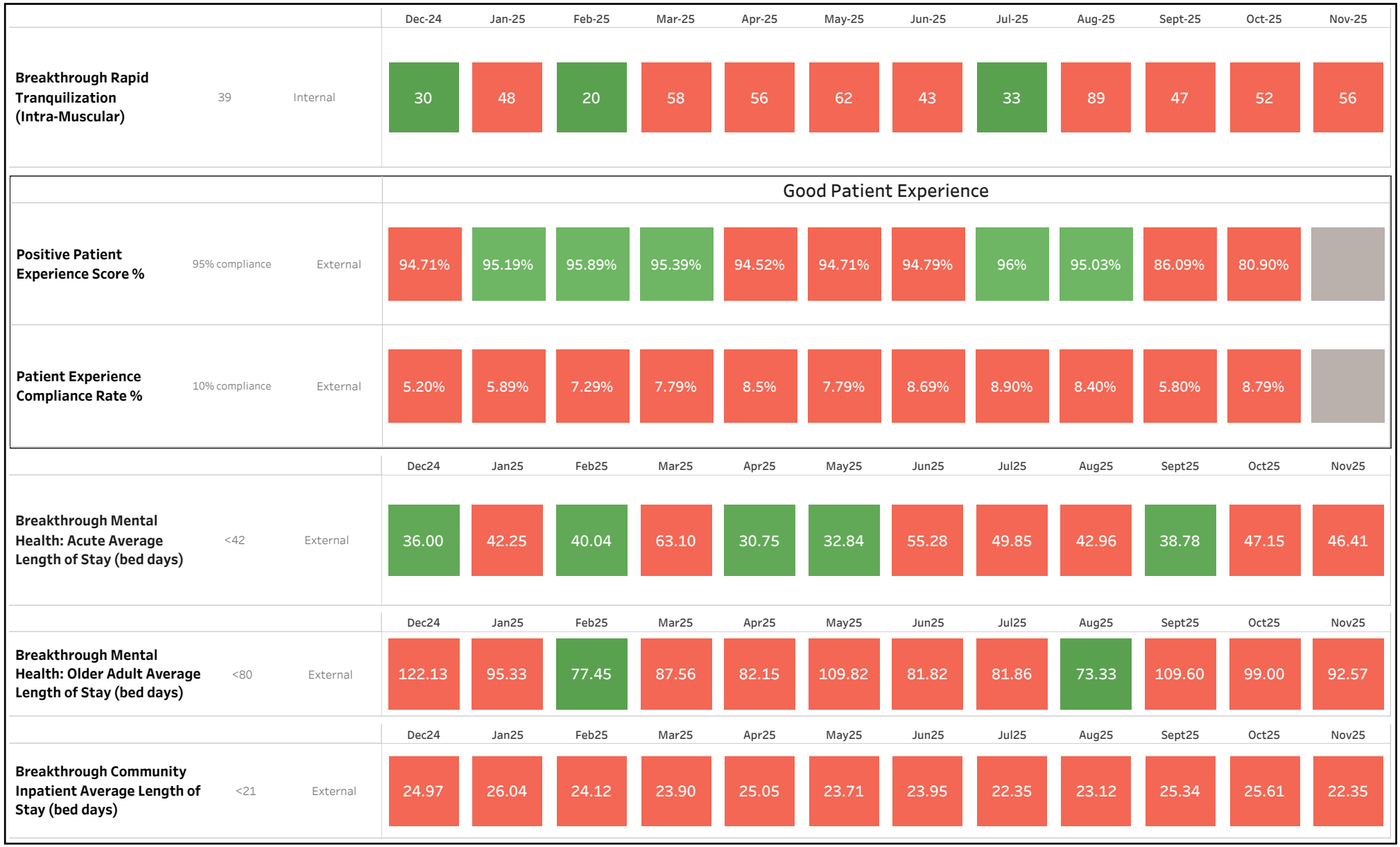
There are 2 types of variation:

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

Rules

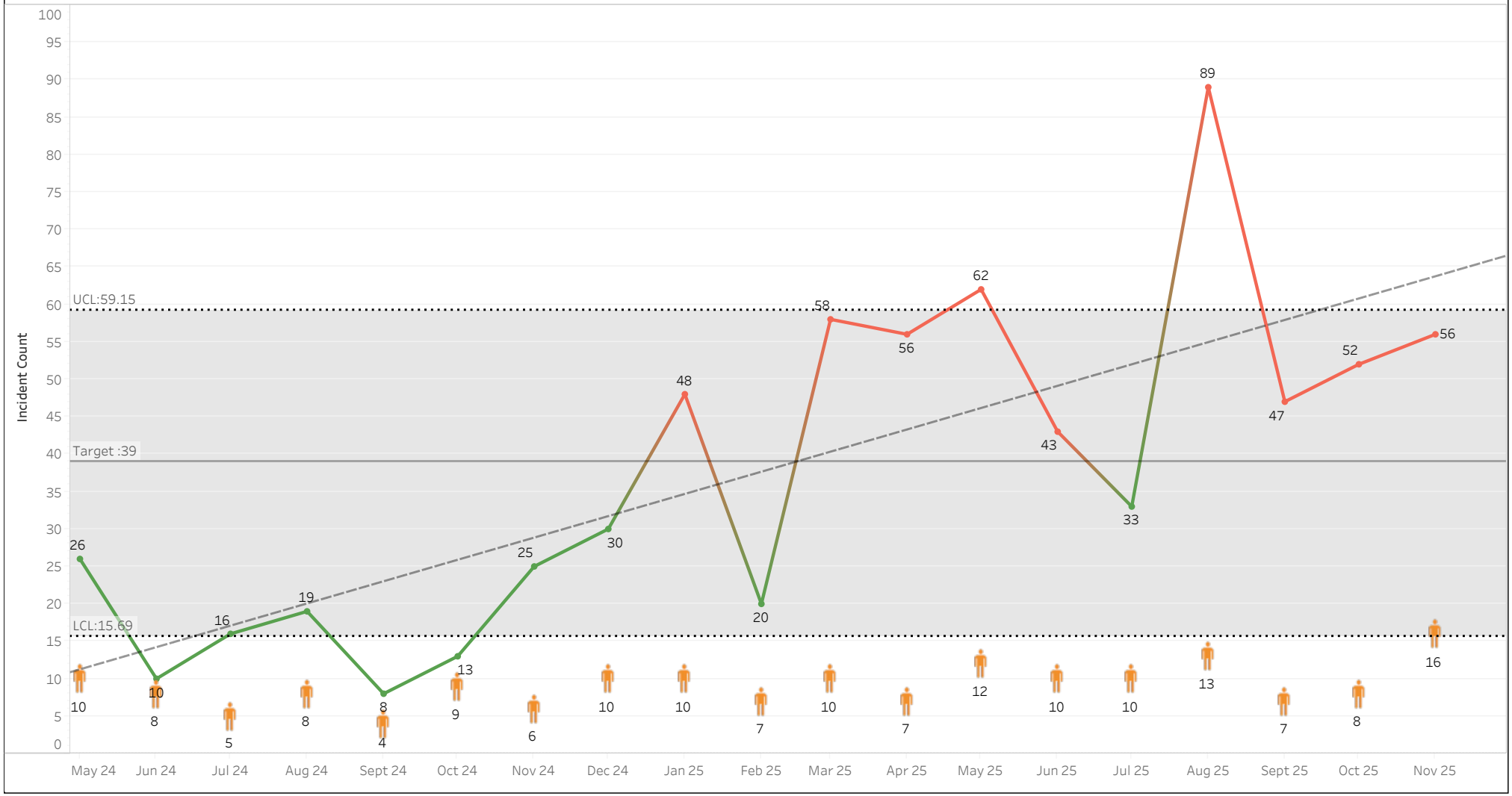
- A series of 6 or more data points above or below the target is statistically relevant. It indicates that something in process has changed.
- A trend: either rising or falling of more than 6 data points – we should investigate what has happened.
    - We should reset baseline following a run of 6 data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

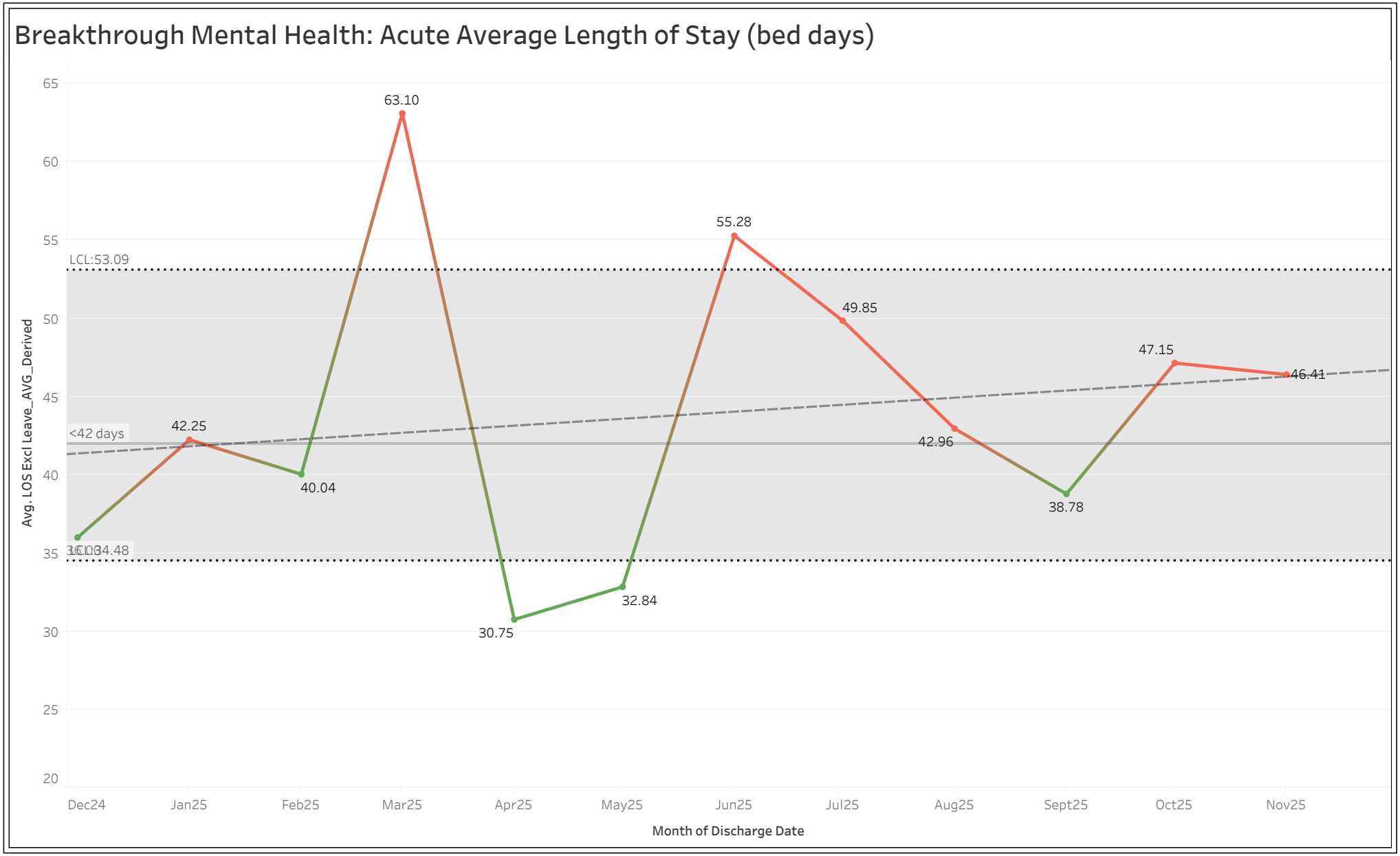
Performance Scorecard - True North Drivers

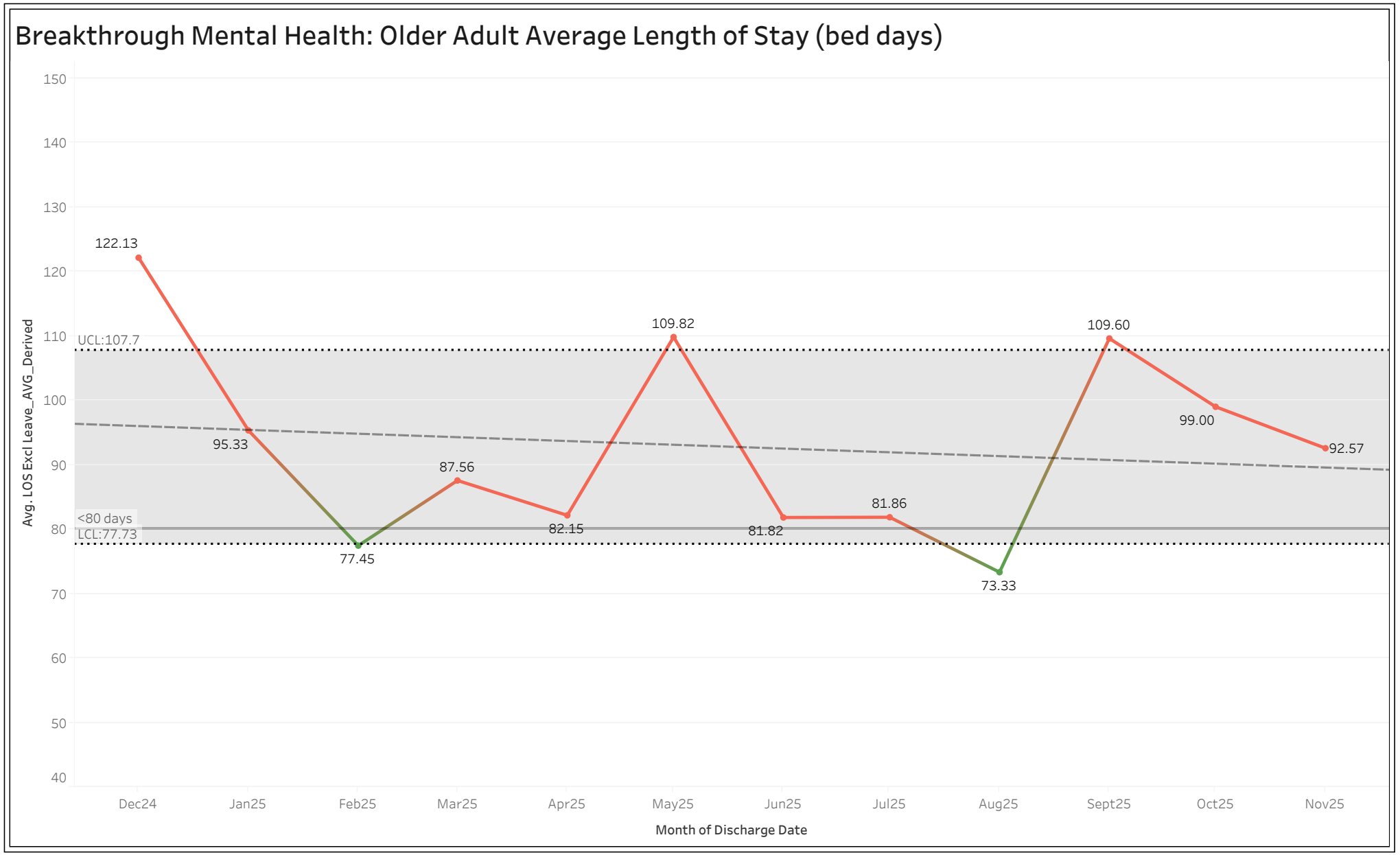


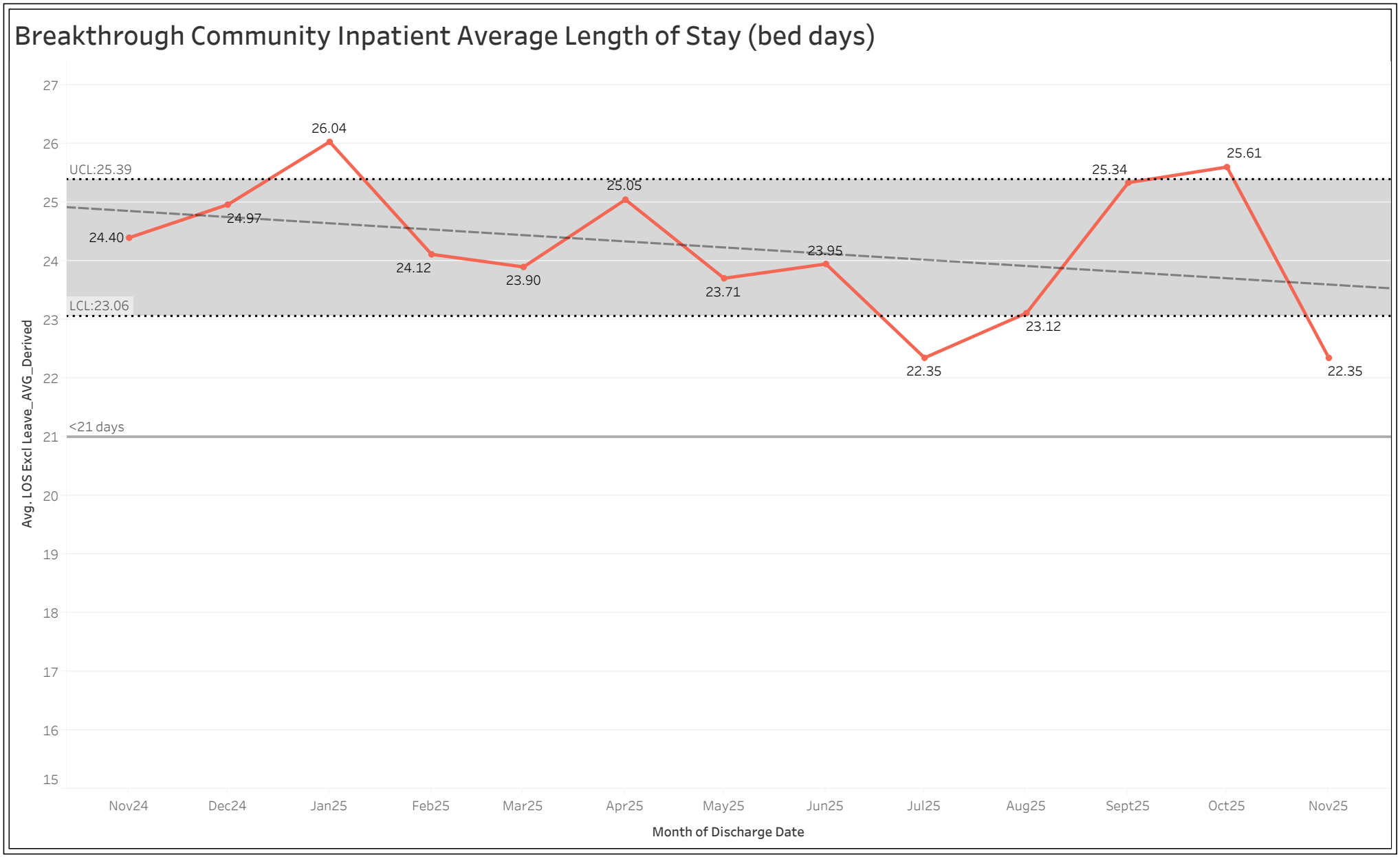
			Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25
Breakthrough Rapid Tranquilization (Intra-Muscular)	39	Internal	30	48	20	58	56	62	43	33	89	47	52	56
			Good Patient Experience											
Positive Patient Experience Score %	95% compliance	External	94.71%	95.19%	95.89%	95.39%	94.52%	94.71%	94.79%	96%	95.03%	86.09%	80.90%	
Patient Experience Compliance Rate %	10% compliance	External	5.20%	5.89%	7.29%	7.79%	8.5%	7.79%	8.69%	8.90%	8.40%	5.80%	8.79%	
			Dec24	Jan25	Feb25	Mar25	Apr25	May25	Jun25	Jul25	Aug25	Sept25	Oct25	Nov25
Breakthrough Mental Health: Acute Average Length of Stay (bed days)	<42	External	36.00	42.25	40.04	63.10	30.75	32.84	55.28	49.85	42.96	38.78	47.15	46.41
			Dec24	Jan25	Feb25	Mar25	Apr25	May25	Jun25	Jul25	Aug25	Sept25	Oct25	Nov25
Breakthrough Mental Health: Older Adult Average Length of Stay (bed days)	<80	External	122.13	95.33	77.45	87.56	82.15	109.82	81.82	81.86	73.33	109.60	99.00	92.57
			Dec24	Jan25	Feb25	Mar25	Apr25	May25	Jun25	Jul25	Aug25	Sept25	Oct25	Nov25
Breakthrough Community Inpatient Average Length of Stay (bed days)	<21	External	24.97	26.04	24.12	23.90	25.05	23.71	23.95	22.35	23.12	25.34	25.61	22.35

Breakthrough Rapid Tranquilization (Intra-Muscular)




Breakthrough Mental Health: Acute Average Length of Stay (bed days)
Avg. LOS Excl Leave_AVG_Derived
65
60
55
50
45
40
35
30
25
20
LCL:53.09
<42 days
63.10
55.28
49.85
47.15
46.41
42.25
40.04
42.96
38.78
30.75
32.84
Dec24
Jan25
Feb25
Mar25
Apr25
May25
Jun25
Jul25
Aug25
Sept25
Oct25
Nov25
Month of Discharge Date


Breakthrough Mental Health: Older Adult Average Length of Stay (bed days)
Avg. LOS Excl Leave_AVG_Derived
150
140
130
120
110
100
90
80
70
60
50
40
UCL:107.7
<80 days
LCL:77.73
122.13
95.33
77.45
87.56
82.15
109.82
81.82
81.86
73.33
109.60
99.00
92.57
Dec24
Jan25
Feb25
Mar25
Apr25
May25
Jun25
Jul25
Aug25
Sept25
Oct25
Nov25
Month of Discharge Date


Breakthrough Community Inpatient Average Length of Stay (bed days)
Avg. LOS Excl Leave_AVG_Derived
27
26
25
24
23
22
21
20
19
18
17
16
15
UCL:25.39
LCL:23.06
<21 days
24.40
24.97
26.04
24.12
23.90
25.05
23.71
23.95
22.35
23.12
25.34
25.61
22.35
Nov24
Dec24
Jan25
Feb25
Mar25
Apr25
May25
Jun25
Jul25
Aug25
Sept25
Oct25
Nov25
Month of Discharge Date

Performance Scorecard - True North Drivers

Supporting Our People

Metric	Target/Threshold	External/Inter..	Dec24	Jan25	Feb25	Mar25	Apr25	May25	Jun25	Jul25	Aug25	Sept25	Oct25	Nov25
Breakthrough Physical Assault on Staff	36 per month	Internal	57	50	60	92	97	58	101	89	89	69	65	93

	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sept 25	Oct 25	Nov 25
Staff turnover (excluding fixed term posts) 10% External	11.57%	11.16%	11.09%	10.59%	10.44%	10.07%	10.02%	10.29%	10.35%	10.29%	10.28%

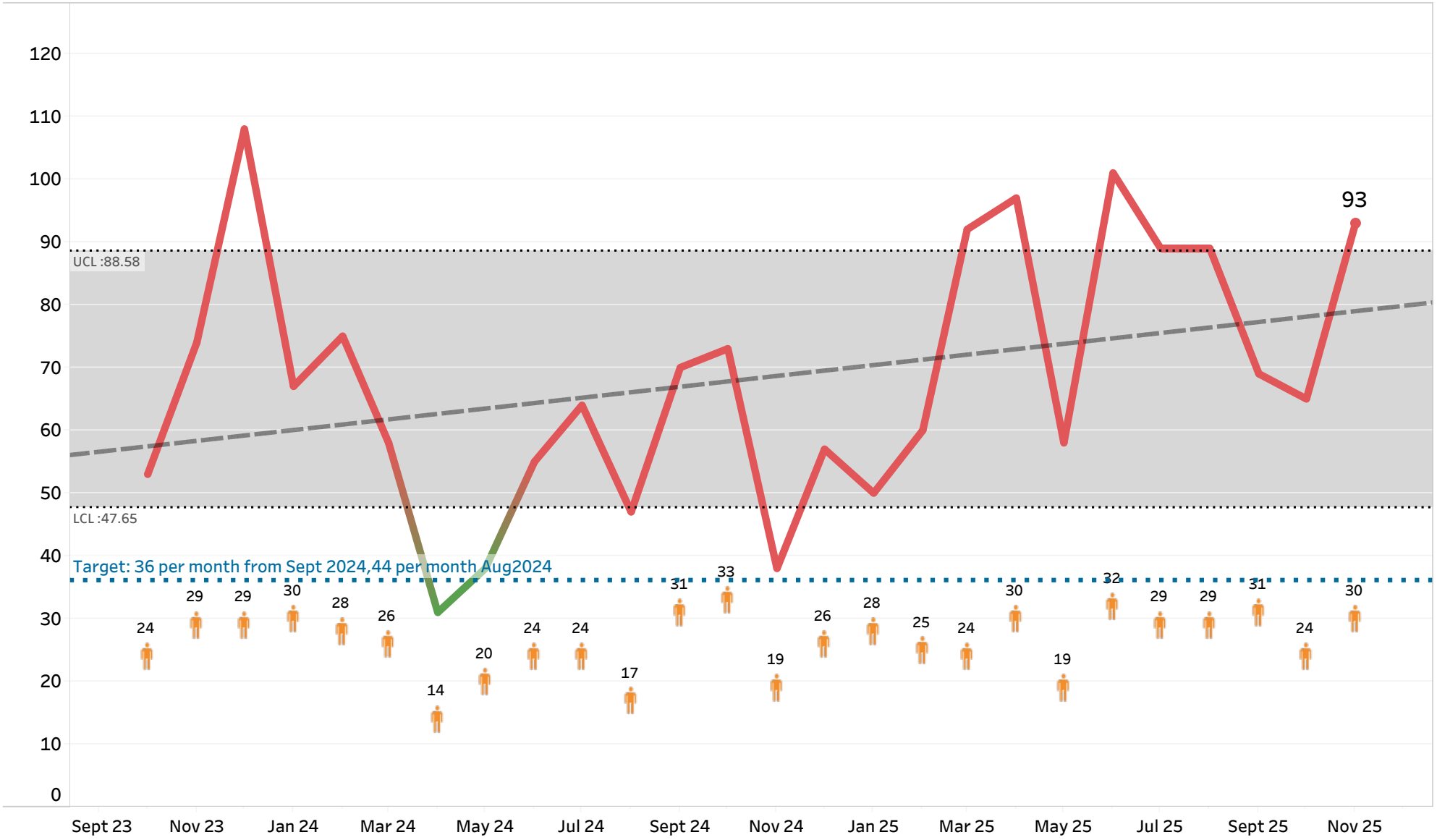
Efficient Use of Resources

	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sept 25	Oct 25	Nov 25
YTD variance from control total (£'k) (NOF Scoring) 0 External	-3000	-3000	-3000	0	0	0	0	0	0	0	0

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

Supporting Our People - Breakthrough Objective :Physical Assaults on Staff (Oct 23 to Nov 25)

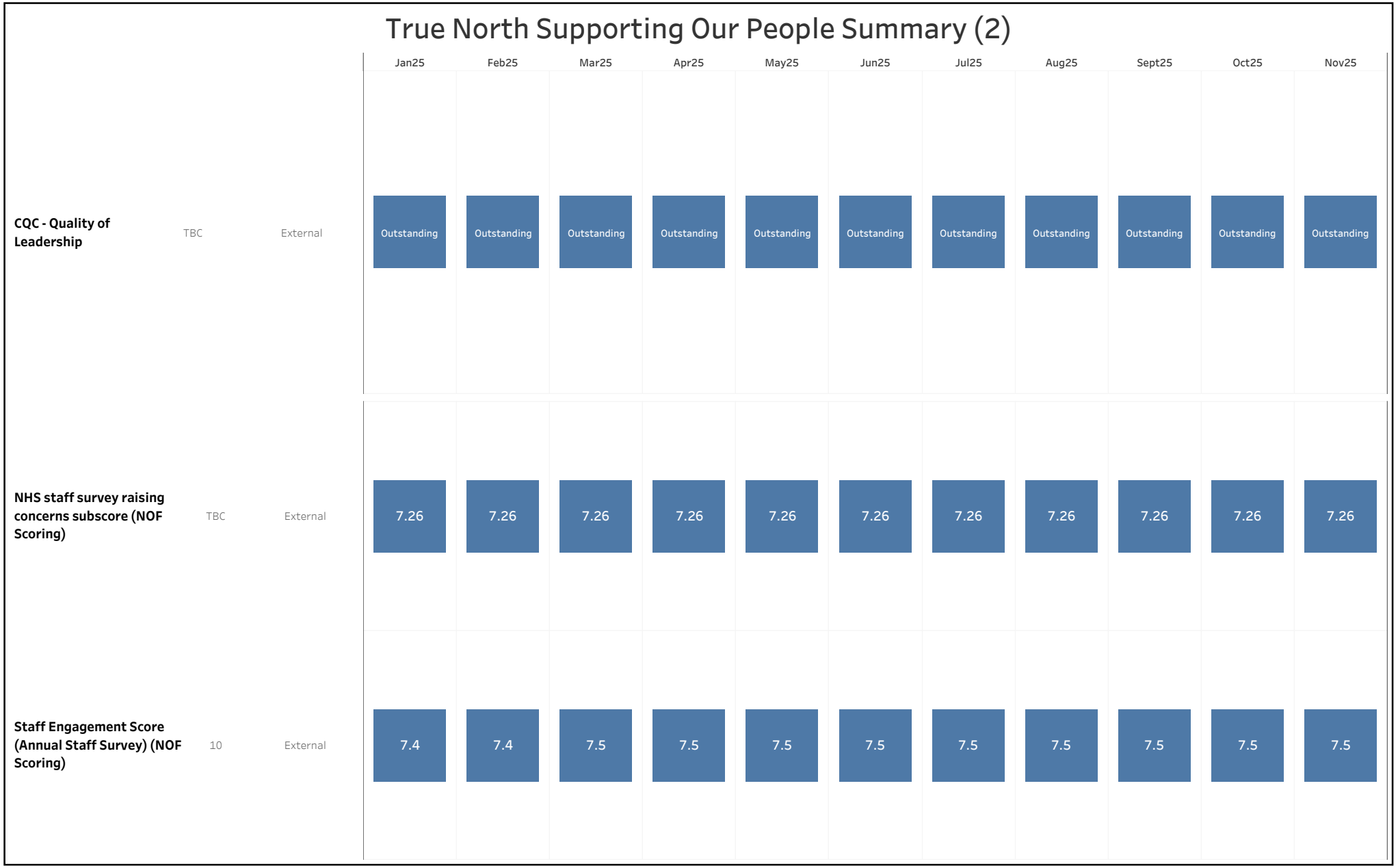
Any incident where sub-category = assault by patient and incident type = staff



True North Supporting Our People Summary

Metric	Threshold / Target	External/Internal	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sept 25	Oct 25	Nov 25
Statutory Training: Fire: %	90% compliance	Internal	94.2%	94.8%	94.2%	94.1%	94.8%	94.6%	93.4%	93.9%	93.2%	93.3%	93.9%
Statutory Training: Health & Safety: %	90% compliance	Internal	98.0%	98.2%	98.1%	98.4%	98.5%	98.3%	98.3%	98.4%	98.3%	98.3%	98.3%
Statutory Training: Manual Handling: %	90% compliance	Internal	94.6%	94.1%	94.4%	94.1%	94.6%	94.6%	94.5%	94.3%	94.2%	94.3%	94.0%
Mandatory Training: Information Governance: %	95% compliance	Internal	97.0%	97.1%	96.8%	97.2%	97.7%	97.9%	98.0%	97.7%	97.6%	97.6%	97.5%
Sickness Rate: % (NOF Scoring)	<3.5%	External	4.8%	4.3%	3.8%	3.7%	4.1%	4.4%	4.5%	4.3%	4.6%	5.2%	
PDP (% of staff compliant) Appraisal: %	Target: 95% by end of May 2025	Internal						92.1%	94.5%	95.0%			

True North Supporting Our People Summary (2)



True North Good Patient Experience

			Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sept 25	Oct 25	Nov 25
A&E: Maximum wait of four hours from arrival to admission/transfer /discharge: % (NOF Non Scoring)	95%	External	98.72	99.22	96.40	99.39	99.57	98.89	99.20	99.57	99.31	99.23	99.66
Community Health Services: 2 Hour Urgent Community Response % (NOF Scoring)	80%+	External	91%	91.1%	92.2%	93.4%	94.4%	94.7%	92.2%	86.6%	92.9%	93.8%	93.9%
Number of Patients not seen on RTT waiting over 52 weeks	0	External	0	0	0	0	0	0	0	0	0	0	0
Number of Adults on community waiting lists over 52 weeks (NOF Scoring)	TBC	External	29	32	29	28	32	32	31	32	1	8	13
Number of Children on community waiting lists over 52 weeks (NOF Scoring)	TBC	External				55	59	94	123	99	91	93	103
Attended Community Care Contacts	TBC	External	57,784	51,590	55,720	54,324	51,997	46,642	56,527	43,749	46,321	50,953	43,757
			Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25
Bed days occupied by patients who are discharge ready Community	695 bed days	External	875	624	589	635	698	825	761	770	801	824	902
			Jan-25	**Feb-25**	**Mar-25**	**Apr-25**	**May-25**	**Jun-25**	**Jul-25**	**Aug-25**	**Sept-25**	**Oct-25**	**Nov-25**
Clinically Ready for Discharge by Wards MH (including OAPS)	250 bed days , 350 bed days Nov25	External	230	301	360	355	431	316	439	428	548	512	530
Community Dentistry Activity (ytd)	Total Trust UDA per Annum 9037 CDS & 2000 DAC. 919 per month	External	8248	8910	9671	762	1569	2371	3380	3940	4857	5792	6699

True North Good Patient Experience

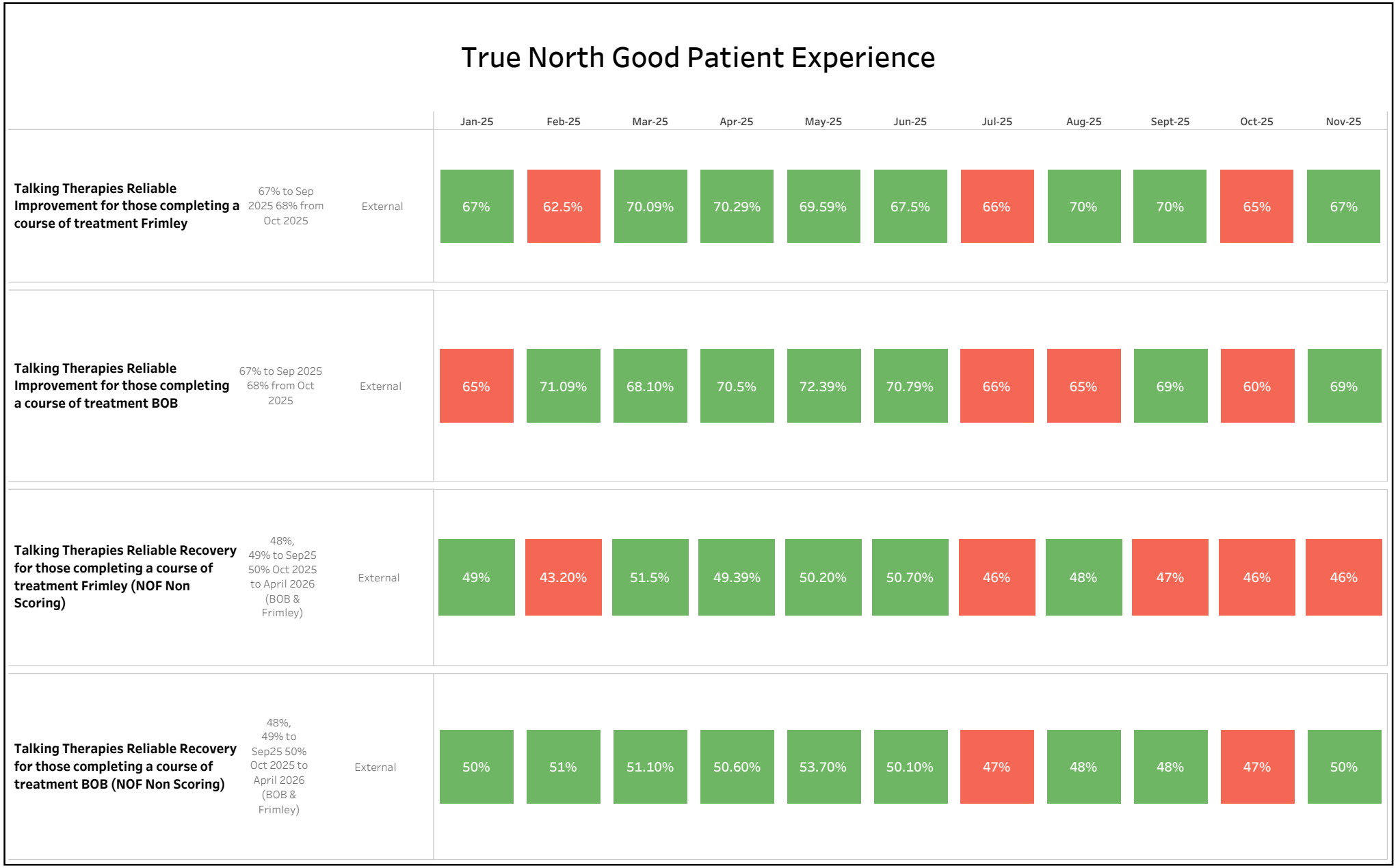
			Jan25	Feb25	Mar25	Apr25	May25	Jun25	Jul25	Aug25	Sept25	Oct25	Nov25
Time to first appointment Diabetes	<18 weeks	External	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Time to first appointment Children's Community Paediatrics	<18 weeks	External	100%	99%	100%	98.8%	100%	100%	100%	100%	100%	98.8%	100%

			Jan25	Feb25	Mar25	Apr25	May25	Jun25	Jul25	Aug25	Sept25	Oct25	Nov25
CPP - RTT (Referral to treatment) waiting times - Community: incomplete pathways (how many within 18 weeks): Number	TBC	External	83	102	98	83	80	90	82	82	77	86	93
Diabetes - RTT (Referral to treatment) waiting times - Community incomplete pathways (how many within 18 weeks): Number	TBC	External	67	72	84	66	59	49	65	64	59	59	63
New RTT pathways (clock starts) Children's Community Response	TBC	External	23	31	35	16	46	48	36	33	43	43	38
New RTT pathways (clock starts) Diabetes	TBC	External	64	53	65	53	53	55	41	38	38	48	53
RTT waiting list, of which children aged 18 years and under (WLMDS)	TBC	External	83	101	98	83	80	90	82	82	77	86	93
Number of 52+ week RTT waits, of which children aged 18 years and under (Waiting List MDS)	TBC	External	0	0	0	0	0	0	0	0	0	0	0

True North Good Patient Experience

			Jan25	Feb25	Mar25	Apr25	May25	Jun25	Jul25	Aug25	Sept25	Oct25	Nov25
Percentage of patients admitted as an emergency within 30 days of discharge (Community Readmission) (NOF Non Scoring)	TBC	External	0%	0%	0%	0.64%	0%	0%	0%	0%	0.63%	0%	0%
Percentage of Inpatients referred to stop smoking services (NOF Non Scoring)	TBC	External	100%	100%	100%	100%	100%						
Proportion of patients referred for diagnostic tests who have been waiting for less than 6 weeks (DM01 - Audiology): %	95% seen	External	96.81	100	99.14	99.78	99.23	99.05	99.48	99.70	95.71	99.12	99.79
Falls incidents in Community & Older Adult Mental Health Inpatient Wards	26 per month	Internal	17	27	24	25	25	23	24	17	21	23	21
Health Visiting: New Birth Visits Within 14 days: %	90% compliance	Internal	83.1%	90.6%	91.1%	89.5%	82.2%	87%	87.3%	91.3%	92.9%	92.5%	92.2%
Access to Children and Young People's Mental Health Service 0-17 1+ Contact Frimley (NOF Scoring)	9180 ICB level	External	7002	7161	7328	4016	2896	4176	3629	3783	3984	4126	4231
Access to Children and Young People's Mental Health Service 0-17 1+ Contacts BOB (NOF Scoring)	26531 ICB level	External	9677	9852	10076	5020	5047	5151	4547	4710	5182	5312	5403
Access to Children and Young People's Mental Health Service Aged 18-24 1+ Contacts measured from Dat..	26531 ICB level.	External	3824	3925	4012	1604	1681	1663	1688	1714	1723	1714	1720
Access to Children and Young People's Mental Health Service 18-24 1+ Contact Frimley	9180 ICB level.	External	2632	2700	2758	1169	1248	1213	1217	1217	1225	1206	1204
Percentage of people with suspected autism awaiting contact for over 13 weeks (NOF Non Scoring)	TBC	External	95.90%	95.15%	95.06%	94.85%	94.63%	93.52%	91.47%	92.55%	93.49%	95.22%	95.23%

True North Good Patient Experience



True North Good Patient Experience

			Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sept 25	Oct 25	Nov 25
Access to Perinal services BOB	611	External	573	586	584	589	599	605	596	608	624	639	641
Access to Perinatal Services Frimley	479	External	457	449	451	448	469	481	488	489	499	496	482
Number of People accessing Individual Placement Services -Frimley	280 Frimley by March 26	External				336	344	354	355	362	372	373	362
Number of People accessing Individual Placement Services -BOB	280 BOB by March 26	External	-	-	-	366	368	384	387	388	383	389	391
Percentage of patients referred to crisis care teams to receive face to face contact within 24 hours (NOF Scoring)	TBC	External	56.0%	66%	49%	65%	57.9%	70%	57.1%	55.8%	58.2%	65.0%	51.2%
Physical Health Checks 7 Parameters for people with severe mental illness (SMI)	90%	Internal	91%	92%	93%	92%	90%	91%	92%	96%	94%	93%	91%
Mental Health: Prone (Face Down) Restraint	4 per month	Internal	3	1	1	0	0	1	1	1	3	1	2
Patient on Patient Assaults (MH Inpatients)	25 per month	Internal	10	10	13	16	14	24	32	23	18	4	13
Mental Health: Uses of Seclusion	13 in month	Internal	6	7	12	9	9	10	4	8	10	4	13
Rate of Restrictive Intervention Types per 1000 bed days (NOF Scoring)	TBC	External	110.53	96.95	142.89	124.33	157.76	155.19	62.89	111.83	72.31	69.98	110.89

True North Harm Free Care Summary

Metric	Threshold / Target	External/Internal	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sept 25	Oct 25	Nov 25
Mental Health: AWOLs on MHA Section	10 per month	Internal	7	4	4	3	3	6	5	7	8	4	2
Mental Health: Absconsions on MHA section (Excl: Failure to return)	8 per month	Internal	2	0	0	2	3	2	0	1	2	7	5
Mental Health: Readmission Rate within 28 days: %	<8% per month	Internal	1.62	1.5	0	5.54	2.62	5.87	4.54	1.32	3.27	6.55	5.45
Mental Health 72 Hour Follow Up after Inpatient discharge	80%+	External	89.4%	91.6%	96.6%	96.9%	97.3%	94.1%	96.7%	95.1%	92.4%	100%	92.8%
Self-Harm Incidents on Mental Health Inpatient Wards (ex LD)	125 per month	Internal	94	61	69	84	83	92	110	204	190	219	236
Patient on Patient Assaults (LD)	4 per month	Null	3	2	8	1	1	0	1	0	1	3	5
Self-Harm Incidents within the Community	31 per month	Internal	30	21	15	21	16	25	24	8	15	16	16

Efficient Use of Resources

Metric	Threshold / Target	External/Internal	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25
Community Inpatient Occupancy	85%	Internal	93.9%	86.2%	84.6%	89.3%	87.3%	86.9%	84.8%	81.7%	88.9%	86.7%	86.7%
CHS Average delay(Exclude Zero delays)	TBC	External	6.3	6.0	5.0	5.8	5.5	6.2	5.8	6.5	5.8	6.1	7.0
CHS Percentage of patients discharged on discharge ready date	TBC	External	36.4%	46.7%	39.3%	39.6%	38.9%	38.9%	38.8%	32.0%	26.1%	29.8%	36.6%
Mental Health: Adult Acute LOS over 60 days % of total discharges (NOF Scoring)	TBC	External	23%	23%	26%	21%	18%	16%	17%	22%	21%	27%	33.3%
Mental Health: Older Adult Acute LOS over 90 days % of total discharges (NOF Non Scoring)	TBC	External	65%	53%	55.0%	54%	60%	56.0%	55.0%	48%	48%	55.5%	42.8%
DNA Rate: %	5% DNAs	Internal	4.66%	4.5%	4.42%	4.75%	4.91%	5.16%	5.46%	5.16%	5.04%	5.05%	5.11%

			Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sept-25	Oct-25	Nov-25
Mental Health: Acute Occupancy rate (excluding Home Leave):%	85% Occupancy	Internal	98.2%	99.0%	89.6%	94.8%	96%	96.6%	98.2%	97.7%	97.2%	96.5%	97.7%
Mental Health: Non-Acute Occupancy rate (excluding Home Leave): %	80% Occupancy	Internal	89.75%	92.56%	89.05%	83.78%	83.78%	80.93%	87.92%	77.56%	82.54%	86.89%	91.34%
Community Virtual Ward Occupancy Frimley	80%	External	79.80%	80.5%	69%	83%	80%	75%	94%	77%	85%	81%	85%
Community Virtual Ward Occupancy BOB	80%	External	100.2%	76.59%	85%	85%	72%	82%	91%	91%	97%	92%	97%
Agency Spend within Ceiling	3.2%	External	2.70%	1.89%	2%	2.19%	1.79%	1.5%	1.89%	1.60%	2%	1.89%	1.79%
Year to Date Corporate Cost Reduction	TBC	External	0	0	0	0	0	0	0	0	0	0	0

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	13 January 2026
Title	**Green Plan update**
	Item Noting/Discussion
Reason for the Report going to the Trust Board	The Trust Board receives an annual update on the Trust's Green Plan.
Business Area	Estates and Facilities / Compliance and Risk Team
Author	Kate Townsend, Sustainability Lead Manager on behalf of Paul Gray, Chief Financial Officer
Relevant Strategic Objectives	**Efficient use of resources** **Ambition:** We will use our resources efficiently and focus investment to increase long term value Sustainability is linked directly to our ambition of using our resources efficiently and focusing on investment to increase long-terms value. Through the net zero target, the Trust will reduce our demand for energy and natural resources, creating a more efficient, higher quality, lower carbon healthcare system. The Green Plan, newly published in May 2025, sets out a number of targets and actions to enable us to be a holistically sustainable healthcare trust.
Summary	This presentation will give the board an update on progress against the Green Plan, setting out contextual information on legislation and mandatory drivers, and then focussing in on progress at a BHFT level. With updates to mid-way targets, the

	presentation will also highlight targets for 2026, and longer-term aims to ensure we reach this ambitious Net Zero target.

NHS
Berkshire Healthcare
NHS Foundation Trust

Sustainability update

for greening Berkshire Healthcare

Kate Townsend, Sustainability Lead Manager
Compliance & Risk

The case for net zero

Berkshire Healthcare NHS Foundation Trust

- The NHS emits 4-5% of the UK's carbon emissions
- The NHS is both at the forefront of dealing with the impacts of climate change, as well as significantly contributing towards it
- We have a legal and social responsibility to address climate change and reduce our carbon emissions.
- The events of climate change massively impact the health and wellbeing of our populations, polluting the air we breathe.
- We were the first national health service to make a pledge to go Net Zero in 2020 and are recognised leaders in tackling the impacts of climate change.
- Clear targets in place: The NHS has set out a target of NZ by 2040 for all direct emissions, and 2045 for all indirect emissions.
    - There is a mid-way target of 80% reduction by 2032 for all our direct emissions, and 80% reduction by 2039 for our supply chain.

Legislative and mandatory drivers

Berkshire Healthcare NHS Foundation Trust

Legislation / Regulation	Requirement	Implication for NHS Organisations
Climate Change Act 2008 (as amended 2019)	UK must achieve Net Zero by 2050	NHS must align policies and operations to meet national decarbonisation targets. Trusts must implement carbon reduction initiatives in estates, transport, and procurement.
Health and Care Act 2022	Organisations must "have regard to" environmental sustainability in decision-making	NHS Trusts and ICBs must integrate Net Zero considerations into procurement, estate planning, and service delivery. Governance structures must demonstrate environmental sustainability in business cases.
Environment Act 2021	Legally binding air quality, water, and waste targets	NHS estates must improve energy efficiency, reduce waste, and support biodiversity. Key targets include reducing PM2.5 air pollution, increasing biodiversity net gain, improving water efficiency, and cutting plastic and food waste. NHS organisations must align estate and procurement policies with these environmental goals.
Procurement Policy Note (PPN) PPN 06/21 & PPN 06/20	Suppliers bidding for contracts over £5m must provide a Carbon Reduction Plan. Net Zero Commitment for under £5m	NHS supply chains must comply with sustainability reporting, ensuring suppliers contribute to Net Zero targets. Procurement teams must incorporate social value into tender evaluations, requiring suppliers to show sustainability improvements. From 2030, all suppliers must demonstrate progress toward Net Zero to qualify for NHS contracts.
Greening Government Commitments (GGCs)	Reduce water & energy use, eliminate avoidable single-use plastics	NHS trusts must track and report sustainability metrics, reduce GHG emissions by at least 50% by 2032, cut overall water consumption, reduce paper use by 50%, and phase out avoidable single-use plastics. Biodiversity action must be integrated into estate management.
Local & Sector-Specific Regulations	Compliance with regional clean air policies (e.g., ULEZ), building efficiency standards (MEES)	NHS estates and transport policies must adhere to emissions restrictions and sustainability standards for infrastructure projects.
Task Force on Climate-related Financial Disclosures (TCFD) (2022)	Large organisations must disclose climate-related financial risks in line with TCFD guidance	NHS suppliers and financial teams may be required to assess and report climate risks. NHS trusts must evaluate exposure to climate-related financial risks for investment and operational planning.

Legislative and mandatory drivers

Berkshire Healthcare NHS Foundation Trust

“Given the global health imperatives, the NHS must stick to its net zero ambitions… Indeed, often health and climate are mutually reinforcing goals” (Lord Darzi, 2024)

CQC: Well Led category:
We understand any negative impact of our activities on the environment and we strive to make a positive contribution in reducing it and support people to do the same.

NHS Standard Contract 25/26:
The Provider must take all reasonable steps to minimise its adverse impact on the environment and to deliver the commitments set out in Delivering a ‘Net Zero’ National Health Service.

NHS Long Term Plan (2019):
The NHS is leading by example in sustainable development and reducing use of natural resource in line with government commitments.

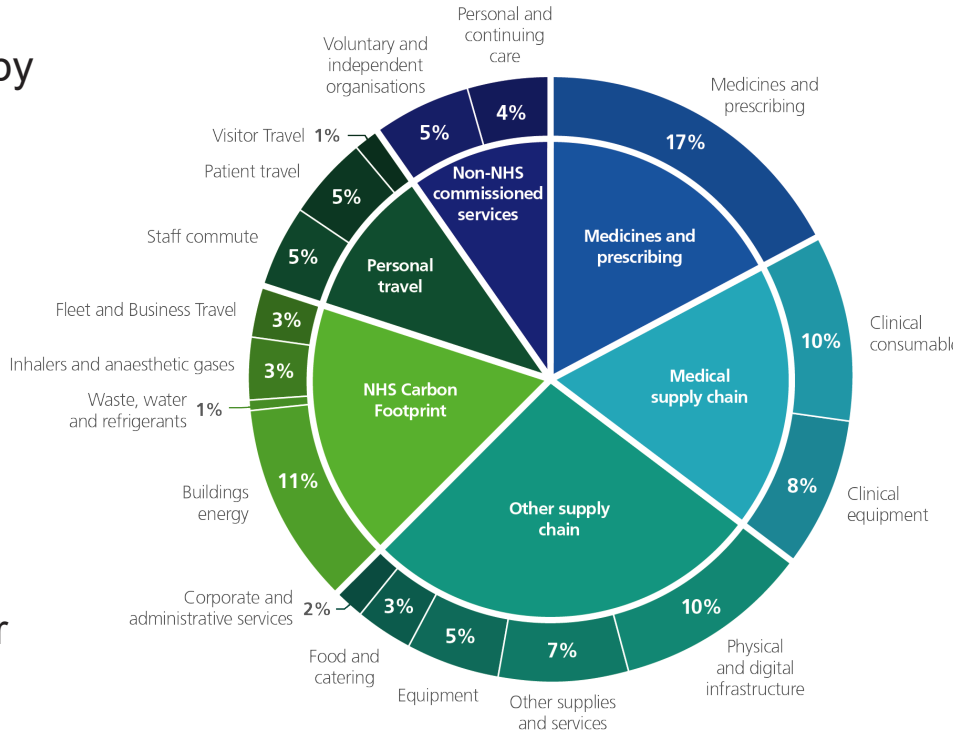
UK Clean Air Strategy (2019):
The NHS pledged to reduce its contribution to air pollution by 50%

Statutory Green Plan Guidance (2025)
Updated guidance to help NHS organisations develop robust plans to achieving net zero

2025 Highlights:

Berkshire Healthcare NHS Foundation Trust

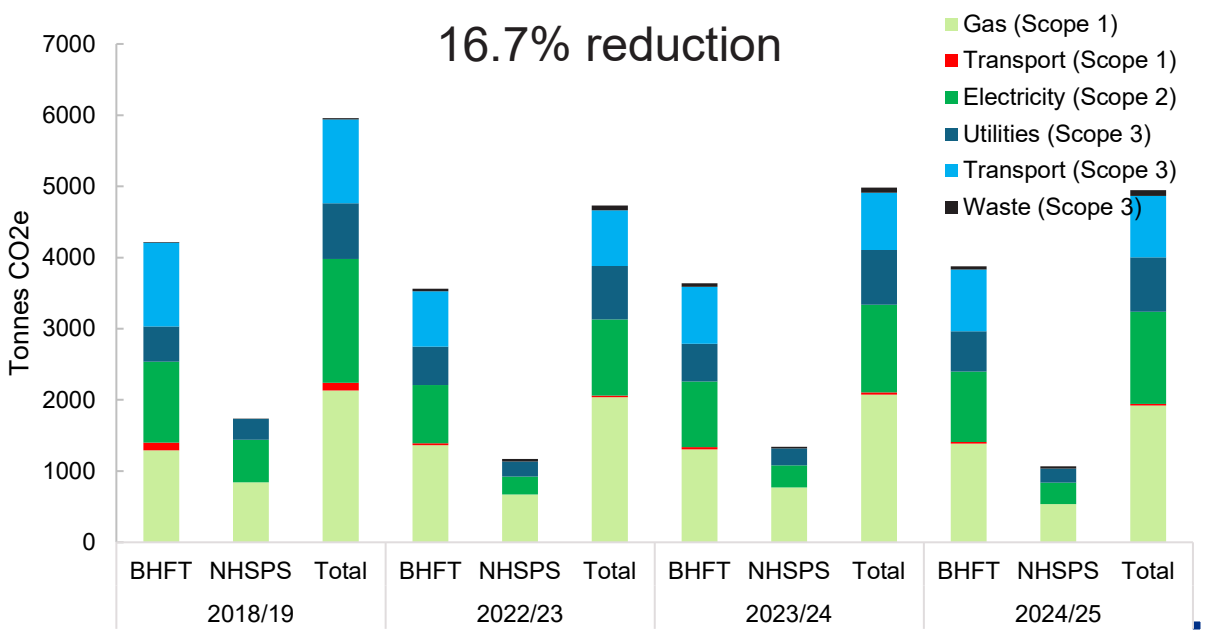
- Five years of a greener NHS: progress and forward look report: Direct emissions down by 68% since 1990, and 14% in last 5 years.
- New methodology represents the most sophisticated and granular footprinting of healthcare to date, adding to international evidence and supporting global efforts to decarbonise healthcare.
- BHFT Trust Green Plan has been published in May 2025 which outlines the next 3 years of actions and targets to support the decarbonisation of the trust.
- First initial analysis of the impact of the solar panels: Since installation, the 3 solar sites have generated 254 mWh of electricity with an estimated cost saving of just under £100k

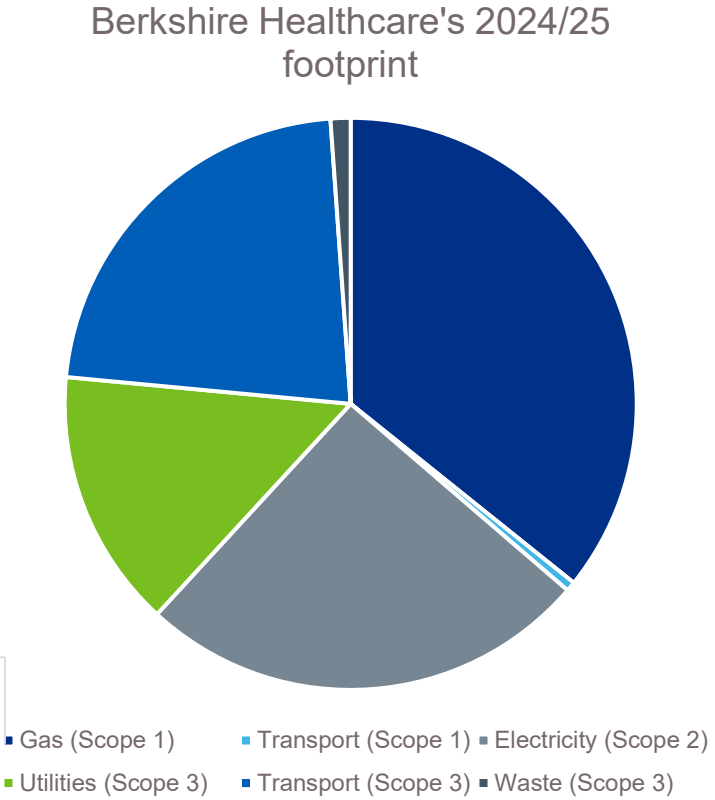


Five years of a Greener NHS: Progress report updated pie chart.

Our carbon footprint

Berkshire Healthcare NHS Foundation Trust

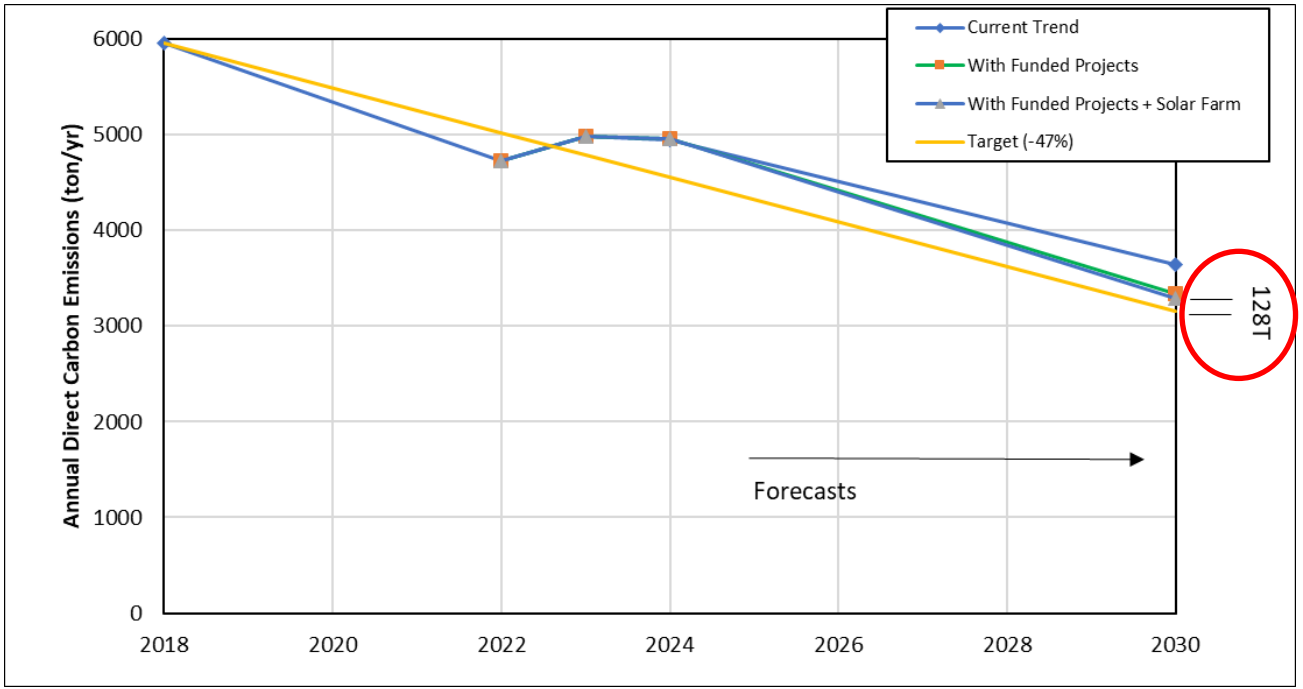




Current projections

Berkshire Healthcare NHS Foundation Trust

- Already reliant on energy efficiency projects to reduce carbon by 300 tonnes by 2030 (within the funded projects estimate)
- Solar farm reduced carbon emissions by 58 tCO2e*.
- If above two targets are complete, there is a 128 tCO2e gap between projections and target.
- *Solar farm ‘red’ risk due to PPA. Could be a 186 tCO2e gap



Our progress: Energy and our Estates

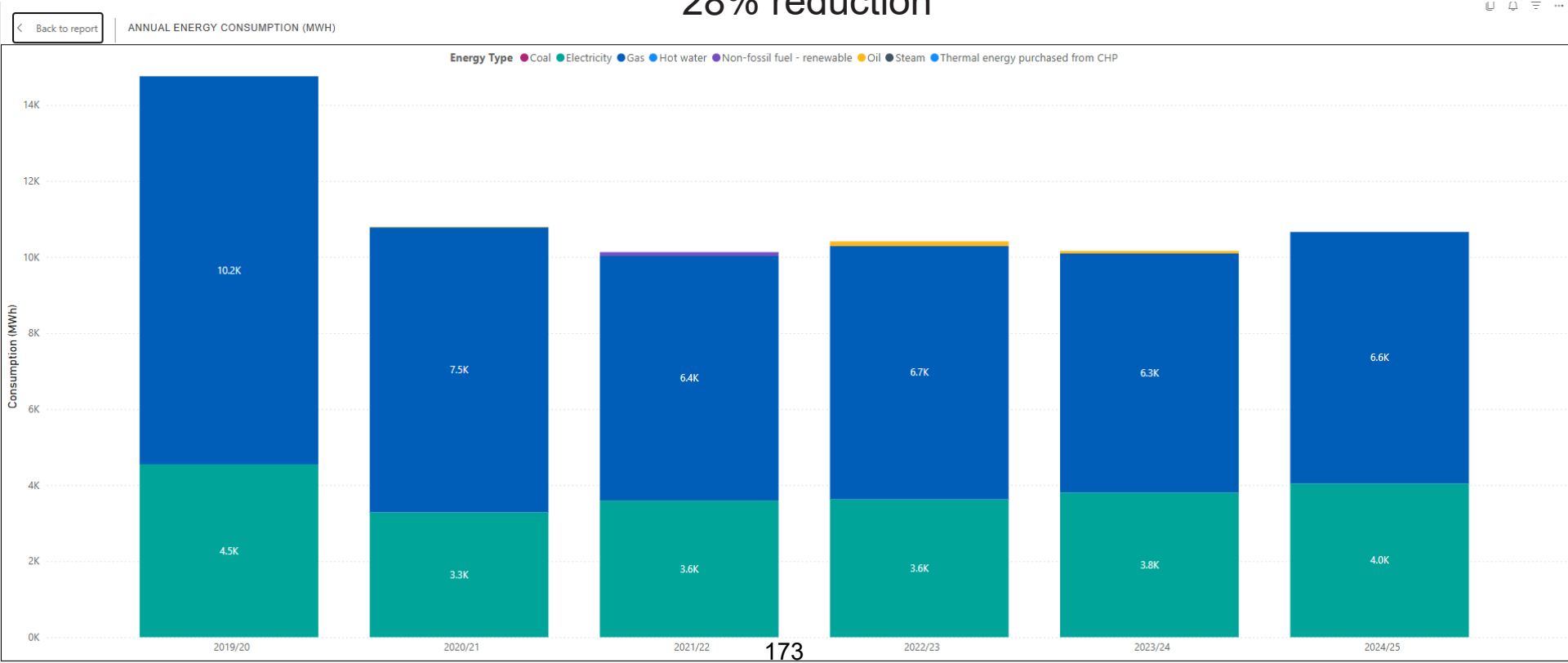
Berkshire Healthcare NHS Foundation Trust

Our Green Plan Goals	What we've done
Install renewable energy technology	✓Solar panels installed at 3 sites - Erlegh House, Church Hill House and London House, saving over 254 mWh of electricity with an estimated cost saving of just under £100k ✓Feasibility studies undertaken for other sites and car park canopies.
Decarbonise heating across all sites	✓Decarbonisation plans / energy audits completed at all major BHFT sites and are guiding net zero planning
Insulation installation	✓Insulation installed at Church Hill House building, and rooftops for Allenby Road and Abell Gardens.
Reduce overall utility consumption	✓Energy consumption intensity has fallen ✓LED lighting installed at all BHFT sites ✓Improve data and monitoring through submetering and SMART metering ✓Focus on necessary BMS upgrades and reduction in energy demand
Decarbonisation Funding	✓£245,000 awarded for LED lights and submetering at WBCH
Nature and biodiversity	✓Awarded £136,000 for a new nature trail and wellbeing garden at PPH ✓Biodiversity enhancement assessments underway at large BHFT sites.

Our progress: Energy Consumption

Berkshire Healthcare NHS Foundation Trust

28% reduction



Our progress: Travel and Transport

Berkshire Healthcare NHS Foundation Trust

Our Green Plan Goals	What we've done
Travel and Transport Strategy	✓ Travel and Transport Strategy final draft now complete, and actions agreed. This will be published in January 2026. ✓ Clean Air Plan developed and approved
EV refresh programme	✓ Review of current EV usage and demand capacity undertaken, with upgraded EV chargers being installed at sites with high demand. ✓ All 8 estates fleet vehicles are now electric with a plan to transition all other fleet detailed in the Travel and Transport Strategy.
Business Miles	✓ Between 2023/2024 – 2024/2025 we have **increased the number of miles** driven by 33,000 miles. However, with the transition to electric vehicles and average prices of petrol/diesel lowering, we have **decreased spending £243,500, and reduced carbon by 1.8 tonnes of carbon since last year.**
Promote, develop and encourage active travel	✓ Offer of salary sacrifice cycle to work schemes ✓ Active travel facilities review done for all trust (including NHS PS) sites

Our progress: Waste

Berkshire Healthcare NHS Foundation Trust

Our Green Plan Goals	What we've done
Promote circular and low impact procurement practices	✓ Uniform recycling project underway to ensure that our old uniforms are not incinerated or put into landfill when new uniforms are rolled out. ✓ Sustainability and IPC group have collaborated to ensure IPC sustainability projects are measured, recorded and celebrated. ✓ NHS SC data identifying items to swap for renewable items. ✓ Daisy-grip reusable tourniquet trial complete and is recommended. Implementation would save £11,286/year and a tonne of landfill waste
Improve waste management to reduce associated costs and carbon	✓ 0 waste to landfill this year, avoiding approx. 18 tonnes of CO_2e ✓ Recycling an average of 150 tonnes of waste per year. ✓ New recycling legislation is in place, and now every sites has a food caddy for recycling food. As well as Dry Mixed recycling being separated and better managed by the waste company.
Clinical waste targets	✓ Target for Clinical waste = Offensive (60): Alternative (20): Incineration (20). We are achieving offensive (57): Alternative (26) and Incineration (17). We are below target for incineration which is the most high cost, high carbon waste stream.

Our progress: Communication and People

Berkshire Healthcare NHS Foundation Trust

Our Green Plan Goals	What we've done
Increase staff-led sustainability action by embedding it into everyday roles, decision-making, and workplace culture	✓ Developed and engaged the Net Zero Heroes group and reached out to do 1hour CPD workshops with clinical teams. ✓ Encouraged net zero heroes to embed sustainability into their appraisal process
Invest and maintain high quality internet / intranet information and guidance for staff and stakeholders	✓ Green newsletter sent quarterly, read by staff (55% open rate). ✓ Presentations underway to promote sustainability to E&F briefing and at Wellbeing events

Actions for 2025/26

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- Publish the Travel and Transport Strategy and start implementing actions
- Conduct a number of Travel events at large sites to promote safe and active travel
- Continue to install more solar panels across our estates – at least one new site per year
- Create and implement multi-year energy and decarbonisation plans for specific sites
- Implement energy efficiency initiatives at major sites to bring down energy demand
- Reduce volume of overall waste through embracing more reusable products
- Expand and upgrade the EV charging availability and applicable policies
- Investigate further opportunities for solar panel installation and pursue solar farm at WBCH
- Develop and implement biodiversity strategy
- Start work on a nature trail/wellbeing garden and encourage community engagement at PPH

What we **need to do**

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Statutory Green Plan Guidance:

- **Reduce greenhouse gas emissions** by 47% by 2032 (from a 2019/2020 baseline)
- **Phase out fossil fuel heating** and replace them with less polluting alternatives
    - *Identifying and prioritising the phasing out of all existing fossil-fuel primary heating systems by 2032 and seeking to remove all oil primary heating systems by 2028*
- **Reduce waste and water** through best practice and innovations

NHS Travel and Transport Strategy:

- From 2026, all **vehicles offered through the NHS salary sacrifice** will be zero emission
- From 2027, **all new vehicles** owned and leased by the NHS will be zero emission vehicles

Government Design for Life Roadmap:

- By 2045 the UK will have transitioned away from all avoidable single-use medtech products towards a functioning circular system.

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Thank you

questions…?

- ✓ Since 2017/18 we've increased the amount of waste we recycle by

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Trust Board Paper

Board Meeting Date	13 January 2026
Title	**Neighbourhood Health**
Purpose	The Board is asked to note the contents of this update.
Reason for the Report going to the Trust Board	The NHS 10-year plan sets out an ambition for Trusts to 'left-shift' and move healthcare services from hospitals to community settings. In addition, new Neighbourhood Health guidelines requires systems to deliver more care at home or closer to home, improve people's access, experiences and outcomes and ensure the sustainability of health and social care delivery. The 2025/6 Operating Planning Guidance sets out a clear message and expectation that we are expected to deliver more with the same or with less. This update sets out how Community Physical Health aims to respond to this ambition and improve care and experience for patients and staff.
Business Area	Community Health Services
Author	Claire Williams, Divisional Director, Community Physical Health Services
Relevant Strategic Objectives	We want to ensure our patients **experience harm free care** by ensuring they receive the right treatment at the right time. We **will support our people** by reducing the administrative burden and co-designing new ways of working. We will support **good patient experience** by providing wrap around support from services both within our Division and externally. We will reduce unwarranted variation to ensure there is a consistent experience. We will make the most **efficient use of our resources** by using technology to streamline processes and

	record keeping and ensuring patients are seen at the right time and the right place.
Summary (only required if the report does not contain a highlight report or an executive summary)	This summarises our ambition and how it aligns to national policy guidelines.

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Neighbourhood Health

Public Board

Why are we changing how we deliver care?

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- Hospital care is costly and often avoidable with early support
- Services are not always joined up making it harder for people to get the help they need
- Often, we treat people when they are ill instead of helping them stay well
- There is a growing demand and the NHS needs smarter ways to use staff, time, and money to help an increasing ageing population
- We need to find a better way to help people look after themselves and help our staff work more efficiently. This could be by using digital and online tools

The problem

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Access to the right care and knowing the system is difficult

- Referrers not clear which services they need
- Referrer experience is inconsistent and frustrating
- Multiple referral forms
- You might not always ‘fit’ service criteria
- Referrals can bounce between services
- Multiple points of clinical triage leading to you telling your story more than once
- Services might decline you when pressurised or have no capacity to accept the referral
- Residents in Slough and Reading are more likely to miss their appointments
- Access to care and treatment is not always the same

Our vision

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Our **vision** is to:

- Move care from hospital to community
- Promote prevention over treatment
- Use innovative digital solutions to help us deliver better care
- Work better together as a neighbourhood

What is a neighbourhood?

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A neighbourhood is a local area where health services, social care, and community organisations work closely together as one team.

Their goal is to help you stay well, provide joined-up care when needed, and support the health and wellbeing of everyone living there.

What could your neighbourhood look like?

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- **A new way of delivering care in your community -** Working together locally health, social care, and community services join forces to support your health and wellbeing.

- **Care Closer to Home -** More help in your neighbourhood, less time in hospital. Focus on prevention, not just treatment.

- **One Team, One Plan -** Doctors, nurses, social care, housing, and community groups work as one team. Everyone sees the same care plan and help you stay well. – GP / vol sector

- **Better Use of Information-** Shared data means quicker decisions and better coordination. If you have an appointment or go into hospital, your team knows straight away.

- **Proactive Care -** Using your clinical information to spot risks early, prevent illness, and make sure support reaches those who need it most.

- **Technology That Helps -** Remote monitoring and home-based support reduce unnecessary hospital visits and improve your experience.

Community Front Door

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- Single Referral Form to describe the patient need
- Expert clinical review of the referral to match you to the right service, the first time
- Tracker to help us understand service capacities

Outcome:

- Improve timely access for referrers and patients
- Better understanding of the problem and the urgency
- Better alignment between demand versus staffing and resources

Neighbourhood Multi-disciplinary Teams Alignment (MDT)

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- Our vision is to work better together as a neighbourhood so that one multi-agency care plan is in place to support you
- We will use data to identify problems before they arise

Outcome:

- Proactive and early management of health conditions across all neighbourhoods
- A single plan in place to keep you well at home
- You are empowered to be in control of your health

Joined Up Integrated Neighbourhood Intermediate Care

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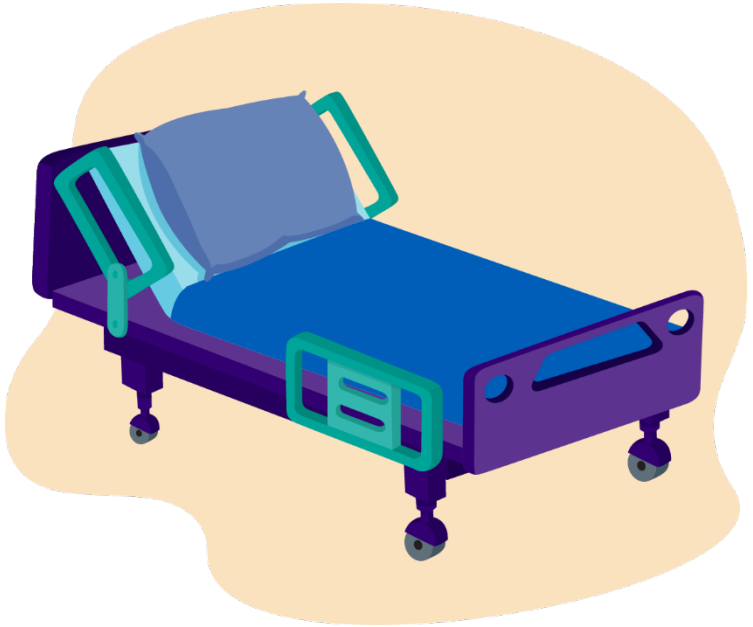
- In a time of crisis our Hospital at Home team will coordinate your care to try and keep you at home or in the community
- We will offer you rehabilitation, this can be either in a community bed or in your own home
- To keep you as independent as possible



Case Study

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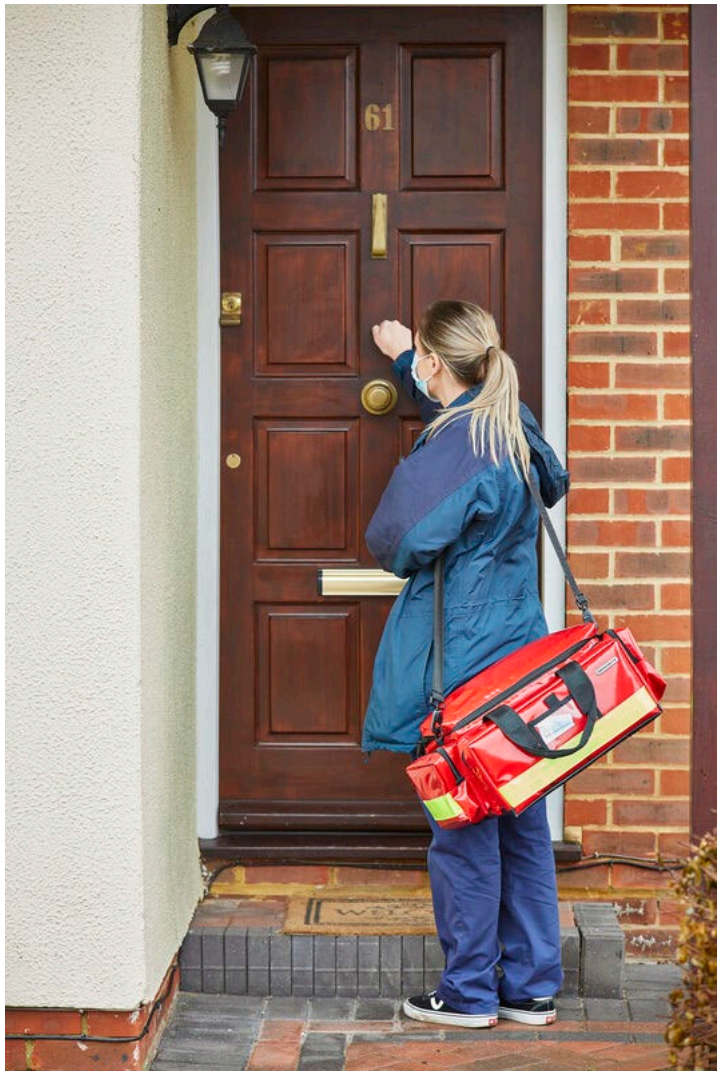

Outcome without a Neighbourhood

- Without a neighbourhood, there can be multiple referrals and multiple assessments.
- The patient received good care, however multiple agencies were involved, high reliance on the GP and care was not joined up and fragmented.
- Regular review by different agencies utilising similar, but different paperwork, which can cause duplication and gaps in communication
- Outcome without a neighbourhood, the patient and their carers will not know who to reach out to for help.
- Help is sought in a crisis, rather than proactive, planned manner.
- The GP is getting multiple requests, from multiple agencies. Adding pressure and causing confusion.
- Without proactive, joined up care, patients can end up reaching crisis that cannot be managed at home.

Outcome with a Neighbourhood

• With a neighbourhood, the point of entry will be simple. There will be easier access and a joined up clinical assessment to ensure all services are coordinated to provide all your care needs

•The patient would have a single key contact to coordinate her care (Community Matron).

•This would make the care joined up and reduce the risk of duplication.

•A shared digital care plan across all agencies involved

•Through the multi-agency MDT we would get the right support for both the patient and her carer – for example, access to local organisations who can help you live better at home

•By providing a holistic and patient centred approach using the patient's clinical information, we can spot risks early which will help prevent health and social crises and would have identified the need for care sooner

•Shared records and digital tools would ensure real-time updates, connected care, and clarity on their escalation plan if the patient becomes unwell.

What could the future look like?

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- **Easier access to care** – simpler and quicker ways to get the help you need
- **Fair access for everyone** – the same clear rules for everyone
- **Care based on need** – people with more urgent health needs are seen sooner
- **Making best use of services** – appointments and staff time are used efficiently to reduce delays
- **Better follow-up care** – easier ways to stay in touch after treatment
- **Skilled and supported staff** – staff have the training and support they need to provide high-quality care
- **Joined-up local services** – healthcare teams work closely together in your local area
- **Digital options first** – using online and digital services where appropriate to make things faster and simpler
- **Focus on staying well** – more support to prevent illness in the first place
- **Stronger community connections** – closer links between health services, local groups and voluntary organisations

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Thank you

Questions…?

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Trust Board Paper

Board Meeting Date	13 January 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's Seal was affixed to a deed of consent and indemnity in respect of West Berkshire Community Hospital for a MRI Scanner on the site.
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