Royal Berkshire
NHS Foundation Trust

Public Board - 28 January 2026

MEETING
28 January 2026 09:00 GMT

PUBLISHED
26 January 2026

Agenda

Location	Date	Time
Seminar Room, Trust Education Centre, Royal Berkshire Hospital	28 Jan 2026	09:00 GMT

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1	Apologies for Absence and Declarations of Interest (Verbal)	Oke Eleazu		-
1.1	Paul da Gama, Umesh Jetha			-
2	Staff Story (Verbal)	Dom Hardy	09:00	-
3	Patient Story (Verbal)	Katie Prichard-Thomas	09:30	-
4	Minutes for Approval: 26 November 2025 & Matters Arising Schedule	Caroline Lynch	10:00	3
5	Minutes of Board Committee Meetings and Committee Updates:		10:05	-
5.1	People Committee: 1 December 2025	Parveen Yaqoob		10
5.2	Audit & Risk Committee: 12 & 18 November 2025 & 12 January 2026	Mike McEnaney		21
5.3	Finance & Investment Committee: 19 November 2025 & 21 January 2026	Mike O'Donovan		28
5.4	Charity Committee: 2 December 2025	Catherine McLaughlin		31
5.5	Quality Committee: 3 December 2025	Helen Mackenzie		33
6	Chief Executive's Report	Steve McManus	10:40	43
7	Integrated Performance Report	Helen Troalen	11:00	49
8	Standing Orders	Caroline Lynch	11:30	77
9	Work Plan	Caroline Lynch	11:35	95
10	Date of Next Meeting: Wednesday 25 March 2026 at 09.00am			-

Board of Directors

Wednesday 26 November 2025
09.00 – 11.55
Seminar Room, Trust Education Centre, Royal Berkshire Hospital

Present

Mr. Oke Eleazu	(Chair)
Mr. Steve McManus	(Chief Executive)
Mr. Don Fairley	(Chief People Officer)
Mr. Dom Hardy	(Chief Operating Officer)
Dr. Minoo Irani	(Non-Executive Director)
Mr. Umesh Jetha	(Non-Executive Director)
Dr. Janet Lippett	(Chief Medical Officer)
Mrs. Helen Mackenzie	(Non-Executive Director)
Mr. Mike McEnaney	(Non-Executive Director)
Ms. Catherine McLaughlin	(Non-Executive Director)
Mr. Mike O'Donovan	(Non-Executive Director)
Mrs. Katie Prichard-Thomas	(Chief Nursing Officer)
Mr. Andrew Statham	(Chief Strategy Officer)
Ms. Helen Troalen	(Interim Chief Finance Officer)
Prof. Parveen Yaqoob	(Non-Executive Director)

In attendance

Ms. Suzanne Emerson-Dam	(Acting Chief People Officer)
Mrs. Caroline Lynch	(Trust Secretary)

There were three Governors and three members of staff present.

166/25 Patient Story and Staff Story

The Chief Medical Officer highlighted that 20 November 2025 was Carers' Rights Day and Carers provided care worth an estimated £184bn annually. The Chief Medical Officer introduced Karen, Carers Lead for the Trust and Sharon, Associate Chief Nurse, Patient Experience, Workforce & Education. Karen provided an overview of the definition of a Carer as well as statistical information regarding Carers in the region and their health. Karen highlighted the Carers Charters and Carers Passport that had been implemented in the Trust.

Karen advised that a complaint had been raised by a patient's carer as a result of their experience with the Trust. The patient who had been fit and healthy now required 24 hour care and had attended the Trust on a number of occasions over several years. Each admission resulted in a poor experience for the patient, their carers as well as staff. The team had worked with the patient's carer and ensure that a Care plan was in place and this was reviewed at each admission or on an annual basis. As part of this the Trust worked collaboratively with the patient's GP as well as South Central Ambulance Trust (SCAS) and the voluntary sectors to avoid a hospital admission where possible. The Board heard the direct message of thanks from the patient's wife and noted that she had personally raised funds for the Royal Berks Charity by running the Reading Half Marathon. Karen highlighted other carer's stories and it was important to empower patients to make their own decisions where possible. Karen advised that further opportunities included better and earlier identification of Carers, collaborative working with the local authorities as well as improved working with the voluntary sector. The Board

noted that it was important to ensure that carers were engaged as soon as possible. Staff were provided with carers awareness training at induction as well as other events and training courses being available. The Chief Executive highlighted that as part of the work on Martha's rule it was important to value input from both patients and their Carers.

Karen introduced the Staff Story and highlighted that 25% of Trust staff were unpaid Carers and the Trust provided paid Carers leave. In 2021, 36 members of staff were registered as Carers and this was now 120 although it was considered that a number of staff did not recognise themselves as Carers. Karen advised that next steps included training seminars for managers and two volunteers had been recruited to focus on carer recruitment. The Board noted that it was important to provide flexibility to staff to support them in their caring roles. The Chief Executive advised that it was important to recognise that some staff did not consider themselves as Carers and may be struggling to cope.

The Chief Medical Officer advised that it was important to ensure managers provided flexibility for staff as this benefited both staff themselves as well as the organisation by retaining them.

The Board thanked the team for their presentation.

167/25 Minutes for approval: 24 September 2025 and Matters Arising Schedule

The minutes of the meeting held on 24 September 2025 were agreed as a correct record and signed by the Chair.

The Board received the matters arising schedule. All actions had been completed.

168/25 Minutes of Board Committee Meetings and Committee Updates

People Committee: 4 September 2025

The Board noted that the People Committee had discussed the Resident Doctors' 10 point plan and an action plan was being developed. The Chief Medical Officer confirmed that a full map and gap analysis had been undertaken and this would be submitted to the People Committee in December 2025. Work was also ongoing to recruit a peer Resident Doctor to enable full implementation of the 10 point plan.

The Board noted that the People Committee had also received a number of assurance reports including the Guardian of Safe Working report noting an increase in exception reporting. The Committee had also discussed sickness absence noting an increase in mental health sickness absence. The Acting Chief People Officer advised that as part of the Improving Together work the directorate had focused on sickness absence encouraging managers to correctly categorise sickness that had resulted in an increase in reported sickness for mental health.

Audit & Risk Committee: 10 September 2025

The Chair of the Audit & Risk Committee advised that the Committee had noted the on-going work by Counter Fraud in relation to raising awareness on failure to prevent fraud. The Committee had also received an internal audit report on estates project management rated as 'partial assurance with improvements required'. An update had been scheduled for the January 2026 meeting. The Chief Strategy Officer advised that learning from the audit included all Trust projects not just those involving estates. Following the audit the Estates Programme Committee terms of reference had been updated and the renamed as the Capital Programme Committee to ensure all Trust projects were being monitored. In response to a query regarding the reduced number of contractors on the Reading site, the Chief Executive advised that the Trust had balanced the deployment of capital versus cash over the year to ensure that the critical key estate was as functional as possible . In addition, the Trust had insourced its estates team. The Board noted that the estates master planning work would inform the Trust strategy and capital spend.

Finance & Investment Committee: 17 September 2025 and 22 October 2025

The Chair of the Finance & Investment Committee advised that Month 6 financial performance was on plan to deliver the target deficit. The second half of the year would prove more challenging. The efficiency savings programme was on target although there was a need to identify more recurrent savings for 2026/27. The Trust's cash position was being closely monitored and, although cash management had improved, the Trust would need to make a cash support application.

The Committee had also had a focused on business planning as a draft submission was required by the Trust in December 2025. The savings challenges for 2026/27 would be in line with the current year. The Chief Strategy Officer advised that the Trust was required to achieve a breakeven position over the next two years.

The Board received the revised terms of reference for the Finance & Investment Committee that had been updated to include the establishment of a Cash Committee. The Board approved the revised terms of reference.

Charity Committee: 5 November 2025

The Chair of the Charity Committee advised that the Committee had approved the Knowledge & Development and Charity Grants panel terms of reference. The Committee had also endorsed the ambassador programme proposal and received the ethical standards policy. The Committee had discussed small community events noting that this were not resulting in profit and this would be considered as part of the Charity refresh.

The Chair highlighted that a recruitment firm had been engaged to undertake the recruitment process for the new Chief Executive and the vacancy was now live.

169/25 Chief Executive's Report

The Chief Executive advised that there was a heightened focus on maternity services nationally due to the national maternity investigation that included Oxford University Hospitals (OUH). The Chief Executive emphasised the importance of the Trust listening to our patients and our staff. The Chief Medical Officer and Chief Nursing Officer were working to support the maternity team and had also linked with the Regional Chief Midwife. The Board noted that the Trust had received strong external assurance on its maternity services from the Care Quality Commission (CQC) as well as regional NHSE colleagues. The Chief Nursing Officer advised that she was working with the communications team to ensure women in the community could access help and support for maternity services. However, community midwives worked closely with all mothers.

The Chief Executive highlighted the Prevention of Future Deaths (PFD) notice issued to the Trust following the tragic event of a baby who had died in June 2024. The PFD related to training compliance within the maternity team. The Trust had acted upon this and had robust ways to learn from such incidents. The Chief Medical Officer advised that was disappointing that the Trust had not achieved training compliance prior to the inquest. An investigation had been undertaken at the time of the incident. A programme of work was ongoing to review the various action plans from complaints, investigations etc in order to collate these in one place to enable teams to monitor completion.

The Board noted that the Trust's Provider Capability Assessment had been submitted to NHS England (NHSE) following approval by the Board. The Regional NHSE team would be asked to review the Trust's submission and confirm the outcome to the national team. It was agreed that the Chief Executive would confirm the outcome of the regional assessment.

Action: S McManus

The Chief Executive expressed his thanks to all team who ensured that services were run safely during the recent period of Resident Doctors' industrial action in November 2025.

The Board noted that the 2025 Staff Survey closed at the end of the week. Currently, nearly 4000 staff had completed the survey meaning the Trust could achieve its best ever response rate. The Chief Executive thanked all staff for contributing to the survey. Early insights from the staff survey were available in January 2026 although the full results were embargoed until February/March 2026.

The Chief Executive highlighted the upcoming changes to the Executive team with Paul De Gama joining the Trust from January 2026 as Chief People Officer and Frances Khatcherian joining in March 2026 as Chief Finance Officer. The Chief Executive thanked Helen Troalen for her work as interim Chief Finance Officer who would remain with the Trust until March 2026.

The Board noted that, following the Trust's visit to Amphia Hospital in Breda, a reciprocal visit took place in November 2025. This provided opportunities for our teams to engage with colleagues from Amphia and showcase our services. The Executive Management Committee (EMC) had discussed the learning opportunities and supported the exploration of a longer term collaboration. The Chief Executive thanked colleagues from the University of Reading who had hosted dinner for the Amphia team.

The Board noted a significant amount of work was on-going in relation to the business planning process. The draft business plan was due for submission was due in December 2025 and this would be reviewed by the Finance & Investment Committee prior to this. The final business plan would be submitted in February 2026.

The Chief Executive highlighted that the work had started on the West Berkshire Community Hospital (WBCH) MRI project and acknowledged the Chief Strategy Officer for this complex programme of work. This would be an excellent for service users in West Berkshire. The Chief Executive thanked the Newbury and Thatcham Building Trust's generosity for the project.

The Board noted the success of the Interventional Radiology (IR) team that had undertook the UKs first thyroid artery embolization (TAE) as part of the TArGET study to assess this new minimally invasive option to treat large thyroid nodules.

170/25 Integrated Performance Report (IPR)

The Chief Operating Officer introduced the IPR and highlighted that the IPR had been discussed at EMC earlier that week. There were three main indicators to highlight to the Board, the first being the patient safety incidents reported per 1000 bed days. The number of incidents had reduced for three consecutive months and this metrics was now alerting. However, the watch metrics, medication incidents, patient falls, and pressure ulcers per 1000 bed days were all under target and reducing. EMC had agreed this required a detailed review and data had been shared with specialties and Care Groups would review responses. The conclusions from this review would be reported to the Quality Governance Committee and onwards to the Quality Committee as part of the routine report.

The second indicator was Cancer 62-day with strong performance for the 28-day diagnosis standard. The current improvement work was delivering with significant improvement in gynaecology referrals seen with 2 weeks and almost all lower gastrointestinal referrals that were now nurse triaged. There was a variable 62-day-performance and it was noted that lower performance tended to follow peak holiday periods. This indicated a need for teams to ensure consistent levels of service were in place during these times as well as continuing with the detailed improvement work and extending this to head and neck and haematology.

The third indicator was the productivity measure and EMC had discussed the improving trend over the last four months although the indicator was still below March 2020 levels. It was considered that the improvement was as a result of the stable workforce numbers and improved

outpatient activity levels. It was agreed that the same data would be reviewed for two years prior to March 2020 in order to establish whether this was typical. In addition, this reinforced the need to continue to take advantage of all productivity opportunities as well as continuing to reduce workforce costs. The Board discussed the productivity metric noting that the workforce was stable despite an increase in activity that demonstrated an increase in productivity. In additional budget holders had held vacancies in order to achieve their cost improvement programmes.

The Chief Operating Officer highlighted that overall, the IPR demonstrated that the Trust was on target to deliver the 2025/26 operating plan as was as on target to deliver the budget as well as being close to trajectory on the main performance standards and delivering stable performance across other areas such as the workforce stability indicator.

The Board discussed the Winter plan, in particular, that there were two areas that were partially assured and a temporary escalation policy had been put in place to mitigate the risks discussed at the least meeting. The capacity of the new Urgent Care Centre located on the Reading site was being used each day. This included a 10% overflow from General Practice therefore diverted capacity, 20% referred by the NHS 111 service, 40 – 50% diverted from the Emergency Department (ED) and the remainder walk-ins. The ED continued to receive circa 440 patients daily. The Chair of the Quality Committee raised a query regarding speciality responses to ED. The Chief Medical Officer and the Chief Operating Officer had met with the general surgical team and a protocol had been developed for referrals from ED. The teams were using the Alertive application to request these referrals. A Rapid Process Improvement Workshop (RPIW) had taken place for the ED and paediatrics team and this had resulted in the length of stay for paediatric patients being significantly reduced as well as an increase in patients being referred to the Same Day Emergency Care (SDEC) team. The Chief Operating Officer advised that the ED team were trialling having a Consultant in the department for 3 days a week and the site team had noted the impact of this on decision making. The Chief Medical Officer advised that additional staff were being included in all tiers of the on-call rota with the exception of the Registrar rota. However, overnight rotas attracted a premium rate of pay. The Chief Operating Officer stated that the teams were managing this with Rapid Assessment and Treatment Initiative (RATI) payments. However, this was not sustainable.

The Board discussed the distance travelled by patients and queried whether there were specific plans at service level to increase services at other sites. The Chief Strategy Officer highlighted that the Trust Strategy focus was to do thing differently and learning obtained from colleagues from Amphia had demonstrated that a service by service review was not appropriate. However, there was a need to measure this metric as the current approach had not delivered improvement. In addition, the IPR would be aligned with the new Strategy refresh.

The Board discussed the learning from incidents to reduce harm metric. The Chief Nursing Officer advised that there had been a detailed review on the reduction in reported incidents although this was a sensitive indicator and the decrease had been from 10 to 9 a day. A high number of incidents reported with no/low harm demonstrated a strong safety culture. Therefore, the Trust was keen to increase reporting and work was on-going with the communications team to raise awareness. The mid to longer term plan was to replace the current incident reporting system to make it easier for staff to report incidents. The Chief Nursing Officer advised that the Patient Safety Incident Framework (PSIRF) reviewed themes of incidents and therefore focussed on higher harm incidents. The Board noted that the EMC had reviewed the proposal to include the National Patient Safety Syllabus (NPSS) training into local compliance for all staff and, due to the on-going review of all Mandatory & Statutory Training (MAST) it had been agreed that this would be discussed at a future meeting.

171/25 Trust Strategy Refresh

The Chief Strategy Officer introduced the Trust Strategy 2025 – 2030 and advised that an extensive engagement exercise had been undertaken as part of the Strategy refresh. The

Trust Strategy was aligned with the NHS England (NHSE) 10 Year Health Plan and included the need for change to meet patients' needs, capitalising on innovation needs and implementation of technology as well as working with patients and carers to enhance their experience of care.

The Board noted that the Strategic Objectives had been updated and the Strategy included four strategic programmes:

- Experience First
- Royal Berks @ Home
- Care where I am
- Future ready spaces

The Chief Strategy Officer advised that there was a launch plan for the organisation including different forms of media and expressed his thanks to the strategy and communications team.

The Board discussed the outcome measures of the Strategy. The Chief Strategy Officer advised that as part of the Operating Plan submission the Trust would be required to provide a narrative and the Strategy would be used for this. The Strategic metrics would be included in the Integrated Performance Report (IPR) to enable the Board to monitor progress.

The Chief Executive highlighted that the Trust Strategy had been refreshed over a number and years and the word transformation had been used on a number of occasions. However, the language used by staff in the organisation was innovation and it was important for public messaging to signal what the future would look like.

The Board thanked the teams for their work and approved the Trust Strategy refresh.

172/25 Board Assurance Framework (BAF)

The Trust Secretary introduced the BAF that had been reviewed by the Audit & Risk Committee. As part of the next review cycle the BAF would be updated to reflect the revised Strategic Objectives set out in the Trust Strategy refresh. The Trust Secretary highlighted that SO5 required reviewed by the interim Chief Finance Officer including Net Carbon.

Action: H Troalen

173/25 Corporate Risk Register (CRR)

The Chief Nursing Officer introduced the CRR and advised that, following discussion at the Audit & Risk Committee, there would a be a focus on maternity risks at the next Integrated Risk Management Committee. The Chief Nursing Officer advised that risk rating for 'outbreaks of infectious conditions' was due to availability of side rooms to isolate patients. It was agreed that the Executive leads would be asked to review the risk ratings including their rationale for the target risk rating with the Head of Risk. **Action: K Prichard-Thomas**

174/25 Work Plan

The Trust Secretary introduced the work plan that had been updated for 2026.

175/25 Date of Next Meeting

It was agreed that the next meeting would be held on Wednesday 28 January 2026 at 09.00

SIGNED:

DATE:

Public Board of Directors Matters Arising Schedule **Agenda Item 4**

Date	Minute Ref	Subject	Matter Arising	Owner	Update
26 November 2025	169/25	Chief Executive's Report: Provider Capability Assessment	It was agreed that the Chief Executive would confirm the outcome of the regional assessment.	S McManus	The regional team have confirmed they agreed with the Trust's ratings.
26 November 2025	172/25	Board Assurance Framework (BAF)	The Trust Secretary highlighted that SO5 required reviewed by the interim Chief Finance Officer including Net Carbon.	H Troalen	Completed.
26 November 2025	173/25	Corporate Risk Register (CRR)	It was agreed that the Executive leads would be asked to review the risk ratings including their rationale for the target risk rating with the Head of Risk.	K Prichard-Thomas	In-Progress. This would be completed by the Integrated Risk Management Committee in February 2026.

People Committee Chairs Report

Royal Berkshire NHS Foundation Trust

Committee Chair: Parveen Yaqoob

Committee Date: 1 December 2026	
Agenda Item 3: Chief People Officer Report	**Substantial Assurance**
Agenda Item 4: Workforce Information & KPIs	**Reasonable Assurance**
Agenda Item 5: Sexual Safety Charter Update and Action Plan	**Reasonable Assurance**
Agenda Item 6: 10-Point Plan to Improve Resident Doctors' Working Lives	**Reasonable Assurance**
Agenda Item 7: Equality, Diversity and Inclusion	**Substantial Assurance**
Agenda Item 8: Guardian of Safe Working	**Reasonable Assurance**
Agenda Item 9: Nursing & Midwifery Safer Staffing Review	**Substantial Assurance**

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE (ALERT)

- The need to complete Up the Anti training

MAJOR ACTIONS AGREED (ADVISE)

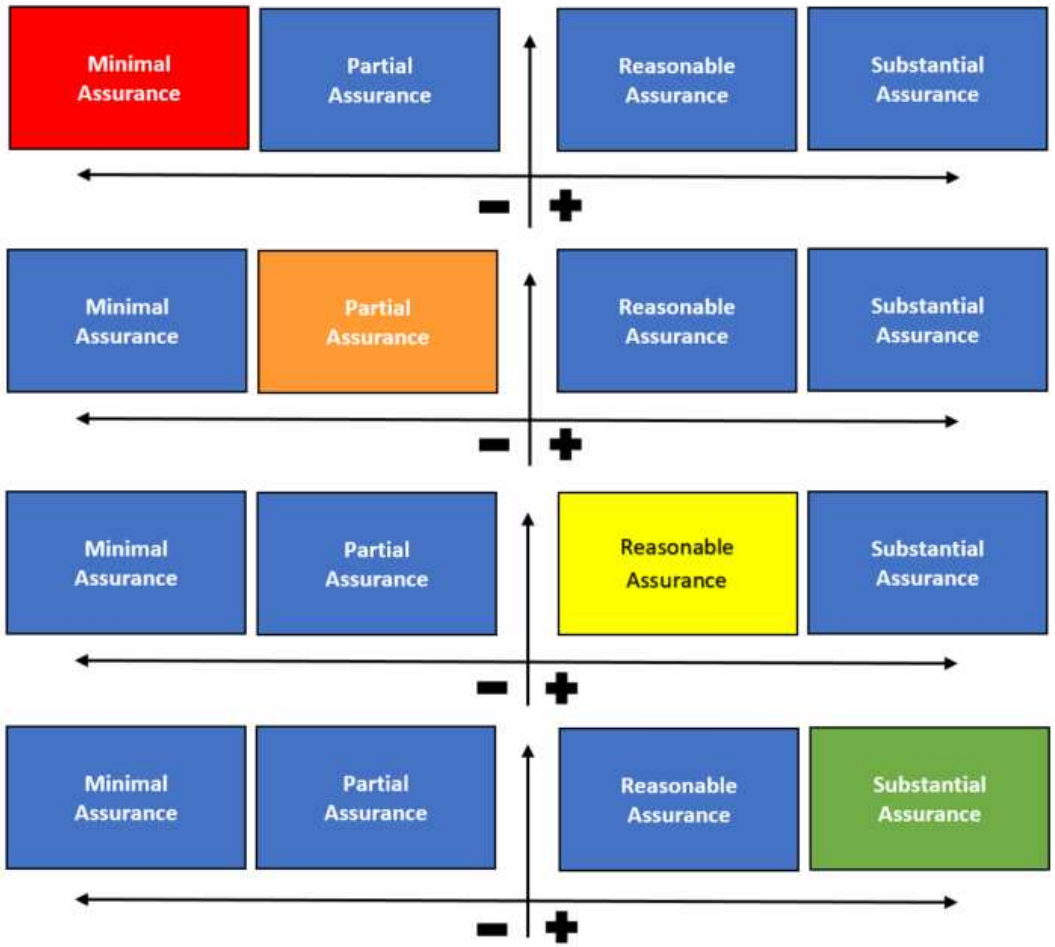
- N/A

POSITIVE ASSURANCES TO PROVIDE (ASSURE)

- Best ever staff survey result invalidated response rate of 61.2%
- Funding secured for new preventative health programme
- Improved appraisal rates with targeted action on non-compliance
- Continued reduction in bank/agency usage and spend, with impact on other indicators to be monitored
- Appropriate implementation of the Sexual Safety Charter action plan and Datix confidentiality work
- Work undertaken to further understand and support Generation Z staff members as part of Equality, Diversity and Inclusion work
- Record Global Majority representation in leadership (+2.5% in year)
- Trust was on track to complying with Resident Doctor 10-point plan
- Assurance received relating to maternity safer staffing that safety action 5 of the Maternity Incentive Scheme (MIS) Year 7 was being met

DECISIONS MADE (APPROVE)

- To approve the recommendation of 1 WTE Band 6 Speech & Language Therapists and 1 WTE ICU Physiotherapist as part of the AHP recommendations as set out in the Nursing & Midwifery Safer Staffing Review



Management cannot clearly articulate the matter or issue; something has arisen at Committee for which there is little or no awareness and no action being taken to address the matter; there are a significant number of risks associated where it is not clear what is being done to control, manage or mitigate them; and the level of risk is increasing.

There is partial clarity on the matter to be addressed; some progress has been made but there remain a number of outstanding actions or progress against any plans so will not be delivered within agreed timescales; independent or external assurance shows areas of concern; there are increasing risks that are only partially controlled, mitigated or managed.

There is evidence of a good understanding of the matter or issue to be addressed; there are plans in place and these are being delivered against agreed timescales; those that are not yet delivered are well understood and it is clear what actions are being taken to control, manage or mitigate any risks; where required there is evidence of independent or external assurance.

There is evidence of a clear understanding of the matter or issue to be addressed; there is evidence of independent or external assurance; there are plans in place and these are being actively delivered and there is triangulation from other sources (e.g. patient or staff feedback)

Royal Berkshire NHS Foundation Trust

Minutes

People Committee

Monday 1 December 2025
14.00 – 16.00
Boardroom, Level 4

Members

Prof. Parveen Yaqoob	(Non-Executive Director) (Chair)
Ms. Suzanne Emerson-Dam	(Acting Chief People Officer)
Dr. Minoo Irani	(Non-Executive Director)
Dr. Janet Lippett	(Chief Medical Officer)
Ms. Catherine McLaughlin	(Non-Executive Director)
Ms. Katie Prichard-Thomas	(Chief Nursing Officer)

In Attendance

Ms. Karolyn Baker	(Associate Chief Nurse, Workforce, Improvement & Standards)
Miss. Kerrie Brent	(Corporate Governance Manager)
Mr. Dwayne Gillane	(Associate Director Occupational Health and Wellbeing) (up to minute 54/25)
Mrs Caroline Lynch	(Trust Secretary)
Mr. Steve McManus	(Chief Executive Officer) (up to minute 50/25)
Ms. Jess Palmer	(Guardian of Safe Working) (for minute 53/25)
Ms. Hannah Saker	(CQC Inspector) (Observing)
Mr. Pete Sandham	(Associate Director for Staff Experience and Inclusion)
Ms. Emily Stannard	(Staff Inclusion and Experience Manager) (for minute 48/25)

Apologies

44/25 Declarations of Interest

There were no declarations of interest.

45/25 Minutes for Approval: 4 September 2025 & Matters arising Schedule

The minutes of the meeting held on 4 September 2025 were approved as a correct record and were signed by the Chair.

The Committee received the matters arising scheduled.

Minute: 33/25: People Strategy 2023/27 Progress Report: The Chief Medical Officer advised that due to the on-going judicial review and an update from the GMC being issued an update on the Leng review would be scheduled for a future meeting. **Action: J Lippett**

46/25 Chief People Officer Report

The Deputy Chief People Officer introduced the report and provided an update on the Staff Survey that concluded on 28 November 2025. [s22, FOI Act]. Early data suggested that nationally, response rates had reduced in year. The final validated response rate would be

confirmed in December 2025. The final results would be embargoed until March 2026. However, once received they would provide an opportunity to analyse performance and commence action planning ahead of 2026. A review would also be undertaken as to the changes that contributed in making a difference to the improved response rate ahead of the 2026 survey.

The Associate Director for Staff Experience and Inclusion confirmed that initial results would be presented to the Committee in February 2026, enabling early data to inform improvement planning. The full results would be scheduled for review at the July 2026 meeting.

Action: C Lynch

The Deputy Chief People Officer reported that funding had been secured for approximately 15 months from NHS Charities Together to support the launch of a preventative health programme. This was scheduled to launch in January 2026 and a dedicated practitioner had been recruited for the duration of the programme. The programme aimed to establish two new pathways: one focused on diabetes prevention and another on the management of work-related stress. This included a direct referral route into the regional diabetes prevention pathway for staff identified as being at high risk, alongside evidence-based workshops designed to help individuals manage and reduce the impact of work-related stress. The programme would be embedded within the overall staff health check programme. The Committee acknowledged the positive progress in relation to sickness absence management and early prevention and noted the importance of addressing pre-conditions and proactively supporting the younger workforce. The Associate Director of Occupational Health and Wellbeing confirmed that this formed part of the long-term plan, with the aim of progressively reducing the access for staff health checks across all age groups.

The Committee received an update on the on-going review of Nursing & Midwifery job profiles that confirmed that the Trust was ahead and leading the way across the South East region.

The Deputy Chief People Officer reported that in November 2025, four employees had been recognised with the Chief People Officer 'Outstanding Award'. The awards highlighted contributions across a range of areas, including the learning culture, language initiatives, post Covid-19 impact, the What Matters and Up the Anti programmes, as well as the Vaccination Centre and Health & Wellbeing Centre.

The Committee agreed that the key messages for the Board were to advise on the best ever staff survey response rate and the funding received for new preventative health programme.

47/25 Workforce Information & Key Performance Indicators (KPIs) Quarter 3 2025/26

The Deputy Chief People Officer introduced the driver metrics for Quarter 3. Overall, employee turnover rate continued to improve at 9.99% and was slightly above the national average.

Appraisal compliance was also progressing and the 90% target had been achieved for the first time. The Deputy Chief People Officer advised that Planned Care Group would be undertaking a pilot appraisal window in 2026 and if successful this would be further implemented across the Trust. The Committee noted the improvement and discussed non-compliant staff. Work was on-going to identify how long individuals had been non-compliant and information would be shared with the People and Change Partners to enable further discussions with the relevant managers.

Sickness absence remained an area of continued focus, with on-going work supported through the Improving Together programme. Significant effort had been made to encourage managers to avoid using the 'other' category when recording sickness. Whilst reported levels of mental

health related absence appeared to increase, this reflected more accurate recording rather than a substantial rise in cases

The Trust had experienced an increase in reported musculoskeletal incidents and this was being closely monitored. Additional sessions had been delivered for Care Groups with support from the Associate Director of Occupational Health and Wellbeing, and plans were in place to extend these further, with a strong focus on prevention.

Sickness absence levels remained high although performance compared favourably at a regional level. The Trust continued to identify and pursue opportunities for improvement.

The Deputy Chief People Officer highlighted that temporary staffing costs had reduced significantly through a marked decrease in agency usage, supported by strengthened relationships and initiatives encouraging staff to join the bank. However, on-going organisational changes within NHS Professionals had impacted performance. Discussions were on-going to address this.

The Committee discussed Mandatory and Statutory Training (MAST) compliance rate for medics that was lower than expected. The Deputy Chief People Officer confirmed that this continued to be reviewed along with compliance across rotations.

The Deputy Chief People Officer provided an update on the development of a medical staff bank within the Acute Provider Collaborative. Work was on-going to manage MAST compliance on rotation and to review rates of pay with Buckinghamshire Healthcare NHS Trust. Oxford University Hospitals and Frimley Health NHS Foundation Trust would also be invited to participate in this initiative. In addition, the South East temporary staffing collaborative had been working to collate rates from each trust for visibility and proposed levels of bank rates and trusts had been encouraged to pay within that.

The Committee noted the strong uptake of the 'Up the Anti' training, though full completion across the Board has not yet been achieved. It was agreed that further reminders would be required and this would be incorporated into the key messages for the Board.

The Committee discussed the need to consider how impact was measured triangulated with finance, safety and quality and people. The Deputy Chief People Officer confirmed that the tracking of the stability index would be crucial. Triangulation narrative would be included in any future reports. **Action: S Emerson-Dam**

48/25 Sexual Safety Charter Update and Action Plan

The Staff Inclusion and Experience Manager introduced the report that provided an update on the Trust's action plan and delivery highlights relative to the NHS Sexual Safety Charter.
The Committee noted that the 2024 Staff Survey results reported that 2.41% of staff had experienced unwanted behaviour of a sexual nature in the workplace from staff or colleagues in the preceding 12 months. This was a 1% decrease from 2023 and when benchmarked equated to the 8th lowest experience of such unacceptable conduct across the NHS acute trusts. The Trust continued to target reducing this.

In addition, in the same survey, 7.66% of staff had been the target of unwanted behaviour of a sexual nature in the workplace from patients, service users, relatives and the public. This was a 0.4% decrease from 2023 and when benchmarked equated to the 51st lowest experience of such unacceptable conduct across the NHS acute sector. This was lower than the national benchmark average for acute trusts.

The Committee noted that, as part of the Trust commitment to full delivery of the 10 charter principles in summer 2024, a baseline assessment had been completed and an action plan developed. The action plan identified the following key themes for on-going development and commitment to the charter principles: training, culture and awareness, data triangulation, elevated prevalence rates in some services and monitoring and governance.
Overall, good progress was reported along with improving data trends evidencing a reduction in colleagues experience of unacceptable conduct. The Committee noted that the launch of the 'Up the Anti' campaign had impacted positively.

The Staff Inclusion and Experience Manager reported that a range of training and prevention resources, including e-learning modules on Learning Matters and face-to-face sessions, had been made available to all staff. Plans were in place to develop in-house delivery of this training, to be implemented monthly across the Trust. In addition, the Trust's Behaviours Framework had been updated to incorporate clear expectations regarding sexual misconduct, alongside revisions to relevant policies and procedures.

The Committee discussed incident reporting and the need to address the issues of reporting confidentially through Datix. In addition, the Committee noted that the Freedom To Speak Up Guardian (FTSUG) could be contacted for confidential reporting. The Chief Nursing Officer cautioned against establishing alternative mechanisms, highlighting the potential risks this could create. The Chief Medical Officer advised that the General Medical Council (GMC) survey enabled Resident Doctors' to report anonymously.

The Committee acknowledged that, whilst the annual Staff Survey provided a valuable measure of improvement, there remained a need to establish how the Trust monitored the cause and effect of interventions through in-year monitoring beyond the survey. **Action: S Emerson-Dam**

The Committee noted that amber and red letters sent to patients currently lacked clear narrative addressing unwanted negative sexual behaviour. It was agreed that any letters relating to exclusion as a result of this should explicitly reference such issues where relevant, ensuring this type of behaviour was highlighted. **Action: S Emerson-Dam**

The Committee received assurance that the action plan was being implemented and the on-going issue related to confidentiality on Datix was being progressed.

49/25 10-Point Plan to Improve Resident Doctors' Working Lives

The Chief Medical Officer introduced the report and highlighted that a gap analysis had been undertaken of the Trust's position against the 10-point plan. Following the submission of baseline data in September 2025, the Deanery had also prepared a score. The Committee noted that there remained an on-going issue in relation to timely receipt of information [s43, FOI Act].

The Committee noted that several areas awaited national work that was on-going. Overall, the Trust reported well and assurance was provided that the Trust was on target for compliance with 10-point plan.

The Committee noted that that four candidates had applied for the appointment of a resident doctor peer representative. However, interviews had been rescheduled for this week. Once in post they would be asked to review and confirm agreement with the assessment.

The Chief Medical Officer advised that there was a need to identify a board-level governance framework to monitor and report payroll accuracy and begin national reporting as required.

The Committee noted the gap analysis and supported progression of the action plan in its delivery. The Chief Medical Officer would update the work plan with regular reporting and the resident doctor peer representative would be invited to present the item. **Action: J Lippett**

The Chief Executive reported that the Executive Management Committee had discussed the Trust's capability to deliver against the action plan, with assurance provided that this could be achieved. However, it was noted that timely receipt of information from the Deanery was essential in delivery.

The Chief Medical Officer advised that strengthened Executive presence at Resident Doctor Forums would be beneficial.

The Committee noted that the Chief People Officer designate, Paul Da Gama, had contributed to the development of the 10-point plan, and his involvement would therefore provide valuable insight to support learning.

50/25 Equality, Diversity and Inclusion (EDI) Update

The Associate Director Staff Experience and Inclusion introduced the report and provided an overview of EDI related activity over the past six months across a range of inclusion in progression of the People Strategy ambition for Inclusion.

The Committee noted that circa 800 colleagues had connected with a range of educational interventions to elevate and inform anti-discrimination practice across the Trust as part of the 'Up the Anti' programme. Impact evaluation continued and to date 98% of participants post training completion stated that they felt confident in managing incidents of discrimination, compared to only 48% pre-training.

Following an increase in young leavers, and in collaboration with Henley Business School, the Trust contributed to research gaining a deeper insight into the needs and experiences of younger talent. The study focused on Generation Z typically defined as those born between 1997 and 2012. The draft research report was currently under review, with early findings highlighting perceptions around the need to strengthen non-clinical career pathways.

The Committee noted that the staff networks continued to provide inclusive and collaborative spaces for members to connect, share and mobilise to pursue improvement and action in EDI. The Trust Secretary highlighted the importance of reporting from all staff network groups.

The Associate Director Staff Experience and Inclusion highlighted that the focus on Global Majority representation in senior roles continued with on-going improvement delivered to date with reporting indicating the highest ever percentage of colleagues from a global majority background in leadership positions in the Trust's history. The focus on Global Majority representation in senior roles continued, with on-going progress achieved to date.

The Committee noted the importance of reviewing the wider Equality, Diversity and Inclusion work as well as Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) to ensure the Trust was achieving the ambition to deliver "an inclusive culture that celebrates and drives the power of diversity as a source of strength".

The Committee noted the importance of reviewing the wider Equality, Diversity and Inclusion work alongside WRES and WDES to ensure the Trust continued to deliver on its ambition of "an inclusive culture that celebrates and harnesses the power of diversity as a source of strength."

The Committee discussed the work to deliver an EDI maturity matrix to monitor and support local EDI performance across individual services.

In addition, an Equity Advisory Group would be set up to provide guidance on Trust-wide policies and initiatives and to triangulate work streams.

The Committee agreed that good assurance had been provided in relation to Equality, Diversity and Inclusion. Key messages for the Board included the work undertaken to further understand and support Generation Z staff members. In addition, reporting highlighted positive progress, with the highest proportion of colleagues from Global Majority backgrounds now in leadership positions in the Trust's history.

51/25 Board Assurance Framework

The Committee received the Board Assurance Framework. The Trust Secretary advised that Strategic Metric 2 title would be updated to 'Supporting Our People to Thrive' following approval of the refreshed Trust Strategy. This section would be further reviewed for any necessary changes and would require a broader review in light of the new strategy. **Action: C Lynch**

The Committee agreed that assurance had been received in relation to the Sexual Safety Charter action plan and its implementation. It was therefore agreed that this would be moved into the control assurance section. **Action: C Lynch**

The 10 Point Plan would also be incorporated into the control assurance section as this would be reported on a regular basis. **Action: C Lynch**

It was further agreed that the incoming Chief People Officer would be asked to review this as part of the next review cycle. A further update would be provided at the next meeting.
Action: C Lynch

52/25 Corporate Risk Register

The Committee received the Corporate Risk Register.

The Chief Nursing Officer highlighted that the Operational Management Team had recently approved 'Operation Cavell', a campaign led by Thames Valley Police. The campaign's main objectives, supported by a Memorandum of Understanding, were to encourage staff to report any crime they experience, reinforce that such incidents should not be accepted as part of their role, and strengthen support and supervision arrangements to enable closer collaboration with Thames Valley Police.

53/25 Guardian of Safe Working Report

The Guardian of Safe Working advised that 195 exception reports were submitted in Quarter 3. This represented a 51% increase from the previous quarter and a 23% increase year on year. This was likely a direct result of the changeover period and did not raise any specific concerns. General Medicine had reported a significant increase of 125 from 35 with increases across on call shifts.

The Committee noted positive updates including improved coding on locum shifts that had led to a more accurate set of reasons for shift requests as well as the upgrade to DRS 5 that had proved to be a significant improvement in comparison to DRS 4.

In addition, following lengthy negotiation with NHS Employers and British Medical Association (BMA) the exception reporting reforms announced in April 2025 had now been formalised and added to version 13 of the terms and conditions. These would come into effect on 4 February 2026. Key changes include improved confidentiality for exception reports, a streamlined approval process via a non-clinical member of staff, and access fines.

The Committee discussed the increase in Ophthalmology exception reports from 2 to 22, noting that this likely reflected both increased awareness of reporting mechanisms and the challenges associated with high patient volumes in Eye Casualty. Feedback and data on these exception reports had been shared with the department's clinical leads who were reviewing Eye Casualty staffing arrangements.

The Resident Doctors' Forum was scheduled to meet later that week. Views on the 10-Point Plan had been mixed, with some questioning as to whether the actions outlined represented what should already be standard practice. Others noted the value of acknowledging these commitments and the visible progress being made. Overall, satisfaction levels remained high, with the Trust regarded as a good place to work. The majority of issues raised related to the Deanery and information on rotations.

The Committee noted that resident doctors at the Trust had the highest rates of strike action. This was attributed to the strong support for their action alongside a high level of consultant willingness to cover shifts.

The Committee agreed the key messages for the Board included advising of the on-going lack of centralised data that was now being gradually addressed. While the data had always existed, it had not previously been accessible in a usable format. In addition, new exception reporting reforms version 13 processes and the introduction of standardised templates were being implemented.

54/25 Nursing & Midwifery Safer Staffing Review

The Associate Chief Nurse introduced the report that highlighted the outcome of the annual Nursing, Midwifery & Allied Health Professionals (AHP) safer staffing skill mix review and the roster review, both of which had been completed in September 2025. This was a mandatory process as recommended by NHSE for Nursing and Midwifery.

This annual Safer Staffing Skill Mix Review demonstrated the Trust's robust leadership and commitment to maintaining safe staffing levels across Nursing, Midwifery, and AHP workforces.

The Committee noted that there were no professional recommendations requested within nursing or midwifery. However, adjustments to budget envelopes were recommended.

The professional recommendations for Allied Health Professionals (AHP) had been benchmarked against Buckinghamshire Hospital NHS Trust and had demonstrated a shortfall in ICU and the acute team. The recommendations were as follows:

- 1 WTE band 6 – Speech and Language Therapist – with plan to review activity across the next year and review in next safer staffing review as 2 WTE requested by team.

- 1 WTE Band 6 – ICU Physio

The Committee noted that there had been no change in establishment for 5-years despite the rise in acuity of patients.

The Committee noted that the AHP element differed from nursing, as there was currently no nationally recognised, research□based tool to assess workload and recommend safe staffing levels. Over recent years, the Trust leaders had been engaged in developing audits and benchmarking to build a robust case for assessing safe staffing levels in the absence of national evidence□based guidance and through using professional judgement, care quality KPI's, speciality guidance, benchmarking and audit results.

The Committee received assurance in relation to maternity safer staffing that safety action 5 of the Maternity Incentive Scheme (MIS) Year 7 was being met.

The Committee supported the professional recommendations for an additional 1 WTE Band 6 Speech and Language therapist and 1 WTE Band 6 ICU Physiotherapist that could be phased and either funded following internal budget reconfiguration within the Care Group or through investment as part of planning and budget discussions.

55/25 Work Plan

The Committee received the work plan that had been updated for 2026. This would be further reviewed with the incoming Chief People Officer ahead of the next meeting. **Action: C Lynch**

56/25 Key Messages for the Board

The Committee agreed the following key messages for the Board:

- Advise of best ever staff survey result invalidated response rate of 61.2%
- Advise of funding secured for new preventative health programme
- Advise of the need to complete Up the Anti training
- Advise of improved appraisal rates with targeted action on non□compliance
- Advise of ADVISE on continued reduction in bank/agency usage and spend, with impact on other indicators to be monitored
- Assurance on appropriate implementation of the Sexual Safety Charter action plan and Datix confidentiality work
- Strong assurance on Equality, Diversity and Inclusion, including support for Generation Z staff
- Record Global Majority representation in leadership (+2.5% in year)
- Assurance that the Trust was on track to complying with Resident Doctor 10□point plan
- Assurance received relating to maternity safer staffing that safety action 5 of the Maternity Incentive Scheme (MIS) Year 7 was being met
- Approved recruitment of 1 WTE Band 6 Speech & Language Therapists and 1 WTE ICU Physiotherapist as part of the AHP recommendations for inclusion in the budget setting review process

57/25 Reflections of the Meeting

The Trust Secretary led the discussion.

58/25 Date of the Next Meeting

It was agreed that the next meeting scheduled for February 2026 would need to be rescheduled.
Action: C Lynch

Chair:

Date:

Audit & Risk Committee

Wednesday 12 November 2025
9.30 – 11.30
Boardroom, Level 4, Royal Berkshire Hospital

Members

Mr. Mike McEnaney	(Non-Executive Director)
Mr. Mike O'Donovan	(Non-Executive Director)
Mrs. Helen Mackenzie	(Non-Executive Director)
Mr. Umesh Jetha	(Non-Executive Director)

In attendance

Advisors

Mr. Charles Medley	(Director, KPMG)
Mr. James Shortall	(Local Counter Fraud Specialist) (LCFS)
Mr. Stephen Turner	(Partner, Deloitte)

Trust Staff

Mr. Mike Clements	(Director of Finance)
Mr. Oke Eleazu	(Chair of the Trust)
Mrs. Caroline Lynch	(Trust Secretary)
Ms. Darcie Mansell	(Information Governance Officer)
Ms. Katie Prichard-Thomas	(Chief Nursing Officer)
Ms. Helen Troalen	(interim Chief Financial Officer)

122/25 Declarations of Interests

There were no declarations of interest.

123/25 Minutes for approval: 10 September 2025 and Matters Arising Schedule

The minutes of the meeting held on 10 September 2025 were agreed as a correct record and signed by the Chair.

Minute 105/25 (83/25, 25/25, 02/25,113/24): Minutes for approval: 21 November 2024: HFMS Ltd Annual Report & Accounts 2023/24: The interim Chief Finance Officer advised that terms of reference for the review of HFMS Ltd had been developed and were being reviewed by the Chief Strategy Officer. The terms of reference would be submitted to the Committee in due course. **Action: A Statham**

Minute 108/25: Internal Audit Progress Report: The Chief Strategy Officer advised that a number of actions had been completed on the estates programme management review and had been reviewed by internal audit. A further update would be provided to the Committee in January 2026. **Action: A Statham**

124/25 Local Counter Fraud Progress Report

The Local Counter Fraud Specialist (LCFS) highlighted that International Fraud Awareness week was the following week and a series of sessions had been arranged supporting by the Communications team. The Committee noted that all new joiners to the Trust were met by the Counter Fraud Champion and details of the LCFS were provided via communications bulletins. The Committee noted there had been no referrals received since the last meeting. The LCFS advised that normally one of two referrals were seen every quarter. However, other trusts were also receiving low numbers of referrals.

The LCFS highlighted the six possible proactive activity options. The Committee agreed that a review of outliers and anomalies within overtime claims should be undertaken.

Action: J Shortall

The interim Chief Finance Officer confirmed that a review 'high-earners' within the consultant cohort, particularly locum doctors would be undertaken by the finance team.

Action: H Troalen

125/25 Internal Audit Progress Report

The Director, KPMG, advised that good progress had been made to complete the internal audit programme by the end of the year. Fieldwork for the access and activity data, Care Group financial controls and Patient Safety Incident Review Framework (PSIRF) had either been completed or commenced. The Committee noted that the PSIRF review would include the new arrangements, lessons learned and a number of workshops would be held to understand any barriers. The Chief Nursing Officer advised that the PSIRF investigations were submitted to the Quality Committee as per the previous arrangements. The Committee discussed the need for explicit reporting from the Quality Committee to the Board to enable other Non-Executive Directors to be more informed on incidents and learning.

The Director, KPMG, introduced the Artificial Intelligence (AI) benchmarking review and advised that this was advisory only. The Trust benchmarked in line or just below other organisations. However, the average benchmark was not high. The Director, KPMG, advised organisations that scored higher were those with more access to funding as well as links with universities. The Committee noted that the suggested actions for the Trust had been discussed with the Chief Operating Officer. The Committee considered that the actions from the review should be discussed by the Digital Hospital Committee. The interim Chief Finance Officer would liaise with the Chief Operating Officer who chaired this Committee. **Action: H Troalen**

The Committee recommended that the Chief Operating Officer should attend a future meeting to discuss the Digital risks set out in the Board Assurance Framework (BAF).

Action: D Hardy

The Director, KPMG, introduced the workforce planning review that had been rated as 'significant assurance with minor improvement opportunities'. There were two medium and one low rated recommendations. The Chief Nursing Officer queried the recommendation in relation to ward-level reviews as there were robust safer staffing review carried out bi-annually that set the workforce requirements for nursing and wards could not amend these. In addition, the Care Group Directors of Nursing should be the action owners. It was agreed that the recommendation would be reviewed with the Chief Nursing Officer.

Action: C Medley

The Committee also noted that the action dates were not aligned with the planning process. These would be reviewed with the interim Chief Finance Officer. **Action: C Medley**

The Director, KPMG, introduced the research projects financial management review that had been rated as 'significant assurance with minor improvement opportunities'. There were five medium and three low rated recommendations. These included matching accruals on research as well as ensuring that project coding was visible at the outset as well as throughout the project. The interim Chief Finance Officer advised that both she and the Director of Finance would ensure oversight and support were provided to the Research & Innovation accountant.

126/25 Internal Audit Recommendations

The Director of Finance introduced the report and highlighted that four new reports with 31 actions had been added since the last meeting. There were four overdue recommendations.

The Committee noted two requests to extend the target dates: the Data Security & Protection (DSP) toolkit with a proposed completion date of 31 January 2026 and Integrated Board Reporting – use of ESR data with a proposed completion date of 31 December 2025. The Committee approved the extensions.

127/25 External Audit Progress Report

The Partner, Deloitte, advised that the planning phase for the year-end audit was on-going and the review of HFMS Ltd and Royal Berks Charity were near completion. There were no issues and some final points were being clarified in relation to the Royal Berks Charity and classification of assets for HFMS Ltd.

The Committee noted that HFMS Ltd annual report and accounts required submission to Companies House by 31 December 2025 and the Royal Berks Charity to the Charity Commission by 31 January 2026. A further meeting would be scheduled for the Committee to receive both sets of annual reports and accounts. **Action: C Lynch**

128/25 Board Assurance Framework (BAF)

The Trust Secretary introduced the BAF that was due for submission to the public Board at the end of November 2025. The relevant sections of the BAF had been reviewed by the Quality and Finance & Investment committees as well as the Integrated Risk Management Committee (IRMC). There was an action from the Finance & Investment Committee for Strategic Objective 5 (S05) to be updated. **Action: H Troalen**

129/25 Corporate Risk Register (CRR)

The Chief Nursing Officer introduced the CRR that due for submission to the public Board at the end of November 2025. The Committee discussed maternity risks. The Chief Nursing Officer advised that maternity risks were included within the Urgent Care Group risk register and reviewed regularly by the IRMC. Any reputational risk was discussed as part of the regular review. However, a regular review of the maternity risk register would be arranged as part of the IRMC work plan. **Action: K Prichard-Thomas**

The Chair of the Quality Committee highlighted that the Trust had received external assurance on its maternity services. Therefore, it was not considered that this required escalation to the CRR.

The Committee noted that all risks were currently being reviewed. The Committee recommended that the title of risk 4182 should be updated. **Action: H Troalen**

130/25 Losses & Special Payments

[s43, FOI Act]

131/25 Use of Single Tenders

The Committee noted that 13 single tender waiver contracts had been awarded from 1 August 2025 to 31 October 2025. The interim Chief Finance Officer highlighted the definition of a single tender waiver had been included in the report and advised that the average usage was circa 5 – 10% of total non-pay spend. Further trend analysis and clarity had also been incorporated into the report. The Committee agreed that a target of 5% of non-pay spend should be set. This would then ensure that reporting would be on an exception basis. It was agreed that further discussion with the Chair would be undertaken. **Action: H Troalen**

132/25 Use of Significant Contracts

The Committee noted that three significant contracts had been awarded since the last meeting [s43, FOI Act]

133/25 Bank Account Authorisations

The Committee noted that there had been no amendments to the Trust of the Royal Berks Charity signatory panel since the last meeting.

134/25 Non-NHS Debt Report

The Committee noted that non-NHS debt was £7.8m as at 31 October 2025. [s43, FOI Act]

[s43, FOI Act] In terms of debt related to private patients this was often related to debts being paid by insurance companies. [s43, FOI Act] The Committee noted that private patient was located within the Planned Care Group.

135/25 Freedom to Speak Up (FSTU) Guardian Report

The Committee received the report that set out activity and progress since the last report in May 2025 and included Quarter 1 and 2 data submitted to the National Guardian's Office (NGO) for 2024/25. The Chief Nursing Officer advised that the Trust had a good range of FTSU ambassadors and was compliant with the NGO self-assessment.

The Committee noted that as part of the on-going work to replace the current risk management system a module would be developed for FTSU. The Chief Nursing Officer highlighted that the Trust's 2024 Staff Survey results had highlighted a 13% improvement in relation to staff feeling safe and able to speak up. The Chair of the Committee advised that he personally held one-to-one meetings as well as meeting with the FTSU Guardian on a monthly basis. At these meetings feedback from individuals was considered and the FTSU Guardian and her team were committed to their work.

136/25 Declaration of Interests, Gifts & Hospitality Update

The Trust Secretary introduced the report and highlighted that as at 31 October 2025, 81% of staff classed as decision-makers, budget holders, procurement staff, senior managers, medical consultants, Board Members and staff on band 8d and above had completed declarations. The Committee considered that this demonstrated that the process was embedded in the organisation.

137/25 Trust Seal Update

The Committee noted 18 uses of the Trust Seal from July 2024 to August 2025.

138/25 Work Plan

The Committee received the forward work plan to the end of November 2026.

139/25 Key Messages to the Board

It was agreed that key issues to draw to the attention of the Board included:

- Counter Fraud were raising awareness and the Committee had noted a low level of referrals
- An additional meeting would be scheduled for review of the Royal Berks Charity & HFMS Ltd annual report and accounts
- Two internal audit reports received rated as significant assurance with minor improvement opportunities'
- Receipt of the AI benchmarking report
- BAF and CRR to be realigned following approval of the Trust Strategy refresh
- FTSU report provided good assurance
- Good assurance provided by the Declaration of Interests report

140/25 Reflections of the Meeting

Mike O'Donovan led the discussion.

141/25 Date of Next Meeting

It was agreed that the next meeting would take place Wednesday 14 January 2026 at 09.30.

Chair:

Date:

Audit & Risk Committee

Tuesday 18 November 2025
12.00 – 12.30
Video Conference Call

Members

Mr. Mike McEnaney	(Non-Executive Director) (Chair)
Mrs. Helen Mackenzie	(Non-Executive Director)
Mr. Mike O'Donovan	(Non-Executive Director)

In attendance

Advisors

Mr. John Oladimeji	(Manager, Deloitte)
Mr. Stephen Turner	(Partner, Deloitte)
Mr. Sam Williams	(Manager, Deloitte)

Trust Staff

Mr. Mike Clements	(Director of Finance)
Mrs. Caroline Lynch	(Trust Secretary)
Ms. Charlene Sables	(Deputy Director of Finance, Financial Control)

Apologies

Mr. Umesh Jetha	(Non-Executive Director)

142/25 Declarations of Interests

[The Director of Finance and Trust Secretary declared an interest in relation to HFMS Ltd]

143/25 HFMS Ltd Annual Report & Accounts 2024/25

The Committee received the HFMS Ltd annual report and accounts for 2024/25.

The Director of Finance highlighted that there had been a slight reduction in income for 2024/25 due to this being the first year that the Lighthouse Laboratory was no longer in operation. However, HFMS Ltd remained profitable.

The Manager, Deloitte highlighted that main findings of the audit included the valuation of the West Berkshire Community Hospital (WBCH) project: circa £170k had been accrued in excess of the certified valuation amount. There had been one adjustment although this was below the materiality level.

The Director of Finance advised that other audit findings related to processing controls were acknowledged and these were included in the improvement work for the finance directorate and would be included as part of the planning for the follow year audit. The Chair of the Committee highlighted that the issue of assets under construction had been raised in the previous year audit and there was a need to ensure learning from this.

The Committee noted the reduction in the valuation of Melrose House. The Director of Finance confirmed that properties were valued on an annual basis and this reduction represented the market value of the property.

The Committee noted that one Director of HFMS Ltd was a voting member of the Trust Board. This amendment would be made. **Action: H Troalen**

The Committee agreed that a recommendation should be submitted to the Board of HFMS Ltd to approve the annual report and accounts 2024/25 subject to the amendment discussed to the annual report. **Action: H Troalen**

144/25 Charity Annual Report & Accounts 2024/25

The Committee received the Charity annual report and accounts for 2024/25.

The Director of Finance highlighted the increase in both legacies for 2024/25. In addition, there had been an increase in spend resulting in a reduced reserves: £1m reduction. As a result, the risk on the Charity risk register had been removed.

The Manager, Deloitte, highlighted findings from the audit including the use of vesting certificates. The terms had not been met at year end date but had been shortly afterwards. Therefore, this had been corrected. In addition, there had been some misstatement within accruals due to aged items that were duplicate or had already been paid. The Director of Finance advised that the staff undertaking charity transactions were not part of the finance team and there was a need to ensure learning from other audits were shared with the Charity team. There was also a need to ensure wider learning in relation to vesting certificates. The issue was due to the item being part funded by the Charity and part funded by another charity.

The Committee noted that the list of Committee members and those members that formed the quorum would need to be amended. **Action: C Lynch**

The Committee agreed that a recommendation should be submitted to the Charity Committee to approve the annual report and accounts for 2024/25. **Action: H Troalen**

The Committee thanked the audit and finance teams for their work undertaken for both the HFMS and Charity accounts.

145/25 Date of Next Meeting

It was agreed that the next meeting would be held on Wednesday 14 January 2026 at 9.30.

Chair:

Date:

Finance & Investment Committee Part I

Wednesday 19 November 2025
11.00 – 12.00
Boardroom, Level 4, Royal Berkshire Hospital

Members

Mr. Mike O'Donovan	(Non-Executive Director) (Chair)
Mr. Dom Hardy	(Chief Operating Officer)
Mrs. Janet Lippett	(Chief Medical Officer)
Mr. Mike McEnaney	(Non-Executive Director)
Ms. Catherine McLaughlin	(Non-Executive Director)
Mr. Andrew Statham	(Chief Strategy Officer)
Ms. Helen Troalen	(interim Chief Finance Officer)

In Attendance

Ms. Helen Challand	(Deputy Director of Turnaround)
Mr. Oke Eleazu	(Chair of the Trust)
Mrs. Caroline Lynch	(Trust Secretary)
Mr. Steve McManus	(Chief Executive)
Mrs. Tracey Middleton	(Director of Estates & Facilities) (from minute 158/25)

154/25 Declarations of Interest

There were no declarations of interest.

155/25 Minutes for Approval: 22 October 2025 & Matters Arising Schedule

The minutes of the meeting held on 22 October were approved as a correct record and signed by the Chair.

The Committee received the matters arising schedule.

Minute 138/25: Month 6 Finance Report including Financial Improvement Plan & Capital Programme 2025/26: The interim Chief Finance Officer advised that work was on-going to devolve patient income to the Care Groups either from 2026/27 or mid-year 2025/26. However, work was currently being undertaken to ascertain how income was captured in order to do this.

Minute 139/25: Committee Terms of Reference & Constituting a Cash Committee: The Trust Secretary advised that the terms of reference were scheduled for approval by the Board on 26 November 2025.

156/25 Month 7 Finance Report including Financial Improvement Plan & Capital Programme 2025/26

The interim Chief Finance Officer reported Month 7 was a £8.53m deficit that was in line with budget. The Committee discussed the risk in relation to drug income. The interim Chief Finance Officer advised that drugs income was set at the 2024/25 level and there had

been no uplift for the current year. This would be discussed as part of the planning process for 2026/27.

The Committee noted that overspend in the corporate areas related to under-delivery of cost improvement programmes. Some areas had high targets, eg over 10% and where some elements were not initially allocated, these had not been progressed.

Efficiencies were ahead of plan with £20.27m delivered against a plan of £16.42m. £41.05m had been identified against the full year target of £40.60m.

The interim Chief Finance Officer advised that there was a focus on headcount reduction and this would be a priority for 2026/27.

157/25 Business Plan 2026/27

The Chief Strategy Officer introduced the report that set out the planning timeline. The Committee noted that the requirement was to achieve a break-even position over a 3 year period as well as the development of a 4 year capital plan. The Chief Strategy Officer advised that, currently, based on estimated returns received from teams there was a £30m gap from the target deficit. Further meetings had been scheduled and future submissions were expected.

The Committee discussed the Trust's efficiency in relation to the NHS England (NHSE) productivity pack as well as benchmarking from the National Cost Collection. The Chief Strategy Officer advised that it was anticipated that there would be a gap between the Trust's submission and the ICB income offer. The Committee noted that the business plan included a target £10m deficit for year 1 with a £0 deficit in year 2.

The Committee noted that the draft submission in December did not require Board approval. However, the final submission in February 2026 would require formal Board approval. An additional Committee would be scheduled for December 2025 to enable review of the draft submission. **Action: C Lynch**

158/25 Finance Improvement Plan 2026/27

The Chief Operating Officer advised that that £14.7m of efficiency and productivity savings had been identified as at the end of October 2025. Work was on-going to develop a 3-year programme approach. The Chief Operating Officer confirmed that the ratio of recurrent versus non-recurrent savings was currently 50:50 although this was improving slightly due to the on-going business planning process and the need to identify savings for 2026/27. It was anticipated that a ratio of 75:25 would be achieved although further work was required.

The Committee discussed the importance of identifying transformation schemes to achieve significant savings and ensuring that teams had to the capacity to undertake these schemes.

159/25 Key Messages to the Board

Key messages for the Board included:

- Financial performance was on plan at Month 7
- Draft business plan 2062/27 to be submitted on 17 December and an additional meeting would be scheduled to provide the Committee with an overview
- Finance improvement plan received and thanks to the teams for their work on this.

160/25 Date of Next Meeting

It was agreed that the next meeting would be scheduled for December 2025.

Action: C Lynch

SIGNED:

DATE:

Royal Berkshire NHS Foundation Trust

Minutes

Charity Committee

Tuesday 2 December 2025
16.00 – 16.15
Boardroom, Level 4

Present

Ms. Catherine McLaughlin	(Non-Executive Director) (Chair)
Mr. Jonathan Barker	(Public Governor, Reading)
Dr. Janet Lippett	(Chief Medical Officer)
Dr. Sunila Lobo	(Public Governor, Reading)
Mrs. Caroline Lynch	(Trust Secretary)
Ms. Adenike Omogbehin	(Staff Representative)
Ms. Jo Warrior	(Charity Director)

In attendance

Ms. Charlene Sables	(Deputy Director of Finance – Financial Control)

Apologies

Mr. Mike Clements	(Director of Finance)
Dr. Minoo Irani	(Non-Executive Director)
Mr. Umesh Jetha	(Non-Executive Director)
Mr. John Stannard	(Patient Representative)

42/25 Declarations of Interest

There were no declarations of interest.

43/25 Royal Berks Charity Annual Report & Financial Statements 2024/25

The Deputy Director of Finance, Financial Control introduced the report and provided an overview of the key areas such as income, reserves, in-year staffing costs, operating expenses etc. The Committee noted that there were minor amendments required in relation to the membership of the Charity Committee.

The Committee noted that external auditors were required to undertake additional statutory testing. Therefore, the auditors fees had increased during 2024/25 in comparison to the previous year. However, it was not anticipated that there would be any increase during 2025/26.

The Deputy Director of Finance, Financial Control, confirmed that a review was on-going in relation to an investment house for charity funds.

The Committee approved the Royal Berks Charity annual report and financial statements for 2024/25 subject to the minor amendments discussed earlier in the meeting. **Action: C Lynch**

44/25 Date of the Next Meeting

It was agreed that the next meeting would be held on Wednesday 4 March 2026 at 10.00.

SIGNED:

DATE:

Quality Committee Chairs Report

Royal Berkshire NHS Foundation Trust

Committee Chair: Helen Mackenzie

Committee Date 3/12/2025	
Agenda Item Mortality Metrics	**Substantial Assurance**
Agenda Item Fuller Report	**Substantial Assurance**
Agenda Item Quality Governance Arrangements	**Substantial Assurance**
Agenda Item Maternity Quality Assurance	**Partial Assurance**

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE (ALERT)

- Alert regarding the increase in complaints received and a detailed review was on-going
- Alert regarding C Diff threshold 25/26 would be met and likely exceeded

MAJOR ACTIONS AGREED (ADVISE)

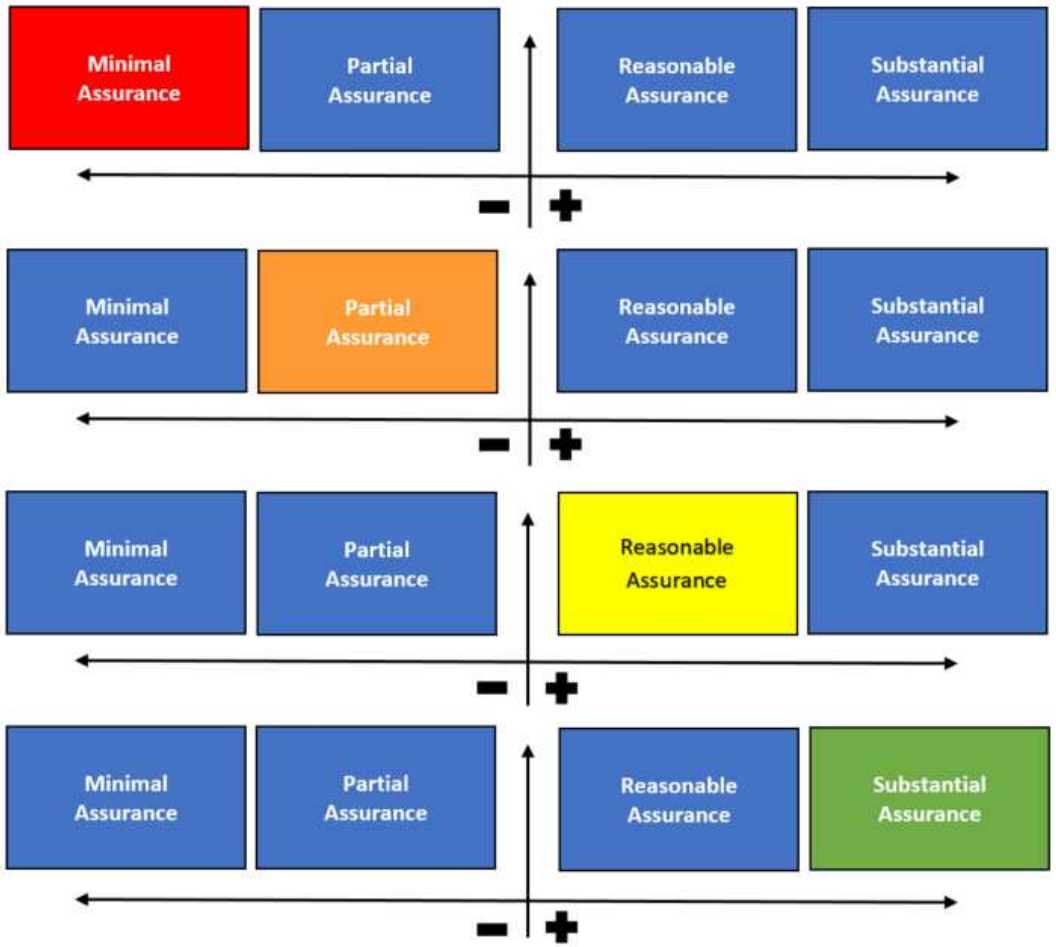
- Advise further assurance being sought on completed actions in response to investigations, reviews and lessons learned
- Advise the Board of the review of the Claims report and the proposal for future reporting to the Committee.
- Advise of the good results from the Adult Inpatient Survey
- Advise on the progress of the Improving Together programme.
- Advise that the Joint Targeted Area Inspection (JTAI) Action Plan had been completed.
- Advise there were 7 patient safety incident investigations commissioned in quarter 2, 4 involved deteriorating patients, 1 medicine safety, 2 maternity
- Advise that progress is being made on the Quality Strategy
- Advise that inquests noted in the minutes have been held and Trust submissions were accepted without questions

POSITIVE ASSURANCES TO PROVIDE (ASSURE)

- Assurance received on governance arrangements for quality governance
- Assurance received on the Fuller 2 recommendations report
- Additional assurance received on Winter preparedness

DECISIONS MADE (APPROVE)

- Approved local agreed hip fracture percentage of patients receiving surgery within 36 hours metric had been revised from 75% to 60%



Management cannot clearly articulate the matter or issue; something has arisen at Committee for which there is little or no awareness and no action being taken to address the matter; there are a significant number of risks associated where it is not clear what is being done to control, manage or mitigate them; and the level of risk is increasing.

There is partial clarity on the matter to be addressed; some progress has been made but there remain a number of outstanding actions or progress against any plans so will not be delivered within agreed timescales; independent or external assurance shows areas of concern; there are increasing risks that are only partially controlled, mitigated or managed.

There is evidence of a good understanding of the matter or issue to be addressed; there are plans in place and these are being delivered against agreed timescales; those that are not yet delivered are well understood and it is clear what actions are being taken to control, manage or mitigate any risks; where required there is evidence of independent or external assurance.

There is evidence of a clear understanding of the matter or issue to be addressed; there is evidence of independent or external assurance; there are plans in place and these are being actively delivered and there is triangulation from other sources (e.g. patient or staff feedback)

Royal Berkshire NHS Foundation Trust

Minutes

Quality Committee

Wednesday 3 December 2025
10.00 – 12.30
Boardroom, Level 4

Members

Mrs. Helen Mackenzie	(Non-Executive Director) (Chair)
Mr. Dom Hardy	(Chief Operating Officer)
Dr. Minoo Irani	(Non-Executive Director)
Dr. Janet Lippett	(Chief Medical Officer)
Mrs. Katie Prichard-Thomas	(Chief Nursing Officer)
Prof. Parveen Yaqoob	(Non-Executive Director)

In Attendance

Ms. Sarah Bailey	(Interim Director of Midwifery) (for minute 76/25)
Mr. Oke Eleazu	(Chair of the Trust)
Ms. Jess Higson	(Deputy Chief Nursing Officer)
Mrs. Caroline Lynch	(Trust Secretary)

Apologies

74/25 Declarations of Interest

There were no declarations of interest.

75/25 Minutes for Approval: 1 September 2025 and Matters Arising Schedule

The minutes of the meeting held on 1 September 2025 were approved as a correct record and signed by the Chair.

The Committee noted the matters arising schedule.

Minute 57/25: Minutes for Approval and Matters Arising Schedule: Prevention of Future Deaths (PFD) Report Response: The Chief Medical Officer advised that a Learning from Death report would be provided to the next meeting. **Action: J Lippett**

Minute 58/25: Maternity Quality Assurance Report including Maternity Incentive Scheme (MIS) and Perinatal Mortality (PNM): The Chief Nursing Officer advised that National Patient Safety Syllabus (NPSS) training had been discussed by the Executive Management Committee and a decision as to whether to introduce this on local compliance profiles had been paused until the review of Mandatory & Statutory Training (MAST) had been completed. A further update would be provided at the next meeting.
Action: K Prichard-Thomas

Minute 60/25: Quality Governance Committee Exception Report: The Chief Medical Officer confirmed that Dr. Andrew Jacques had been appointed as replacement for Dr. Emma Vaux who was retiring from the role.

Minute 61/25: Emergency Department (ED) Standards Performance: The Committee noted that meetings were still in place with general surgery and ED teams and clear expectations had been set for improvement in both teams.

Minute 67/25: Care Quality Commission (CQC) IR[ME]R Inspection Update: The Chief Nursing Officer advised that the CQC had now removed the Improvement Notice issued following inspection of Nuclear Medicine and had advised that they would revisit in early 2026 to ascertain how changes had been embedded in the service. An internal Peer Review was planned with medical physics expertise before the end of the calendar year.

The Chair of the Committee advised that it had been agreed that there would be clear reporting on significant patient issues and lessons learned. All PFDs and high risk inquests would be reported to the Committee going forward.

76/25 Maternity Quality Assurance Report including Maternity Incentive Scheme (MIS) and Perinatal Mortality (PNM)

The interim Director of Midwifery introduced the report and provided a detailed overview of current open patient safety incidents and Maternity and Newborn Safety Investigations (MNSI) cases. The Trust had referred a case to MNSI in August 2025. [s40(2), FOI Act]. The report was currently being checked for factual accuracy and included safety recommendations and safety prompts. [s40(2), FOI Act]

The interim Director of Midwifery advised that one case had been referred to MNSI in September 2025. However, the case was declined by them as they considered it did not meet the threshold. [s40(2), FOI Act]

The Committee noted details of two patient safety incident investigations that were on-going. [s40(2), FOI Act]. A report with actions had been developed and, following a round table multidisciplinary review, had been returned to the patient safety team. [s40(2), FOI Act]

The interim Director of Midwifery advised that three cases were being reviewed under the Patient Safety Incident Framework (PSIRF) through after action reviews.

The Committee noted that work was on-going to collate safety actions from complaints, internal and external reviews to ensure actions were achievable as well as agreed by all teams/action owners. A risk and action planning meeting would be established to provide oversight and monitoring of all actions and this would be based within Urgent Care Group.

The Committee noted that an update would be provided at the next meeting in relation to the NHS England (NHSE) Quality Assurance visit on screening. The team were meeting NHSE on a fortnightly basis. A specialist consultant had been engaged to support the process. Initial findings from the visit had resulted in one urgent recommendation as well as five other recommendations and an action plan was already in place. The five recommendations related to the environment.

The interim Director of Midwifery advised that two members of Maternity and Neonatal Voices Partnership (MNVP) would be involved in the Perinatal Mortality Review Tool meetings going forward. However, training would be provided ahead of this as these meetings could be distressing for individuals.

The Committee discussed outcomes for black women and noted that these women often presented late to the maternity unit with reduced foetal movements. Work was on-going with both the communications team as well as MNVP and community groups to understand

the reason for this. The Chief Nursing Officer advised that Equality Diversity & Inclusion data, as required by NHSE, was being captured and aligned with the maternity watch metrics.

[s30, FOI Act] The Chief Medical Officer emphasised that the PFD related to the action plan that had detailed the need for specific training on foetal head impaction. Unfortunately, by the time of the inquest compliance with the training was very low in medical staff. The Chief Medical Officer confirmed that training compliance for medics was now 100%. The Committee noted that the Chief Medical Officer had met with the legal team that was supporting the Trust at the inquest to review the case. It was agreed that further assurance was required on completion of action plans with evidence to support this.

The Chief Nursing Officer advised that she had met with the Regional Chief Midwife and the regional team had offered support to the Trust to develop an overarching improvement plan for all actions. Feedback from the regional team was that the Trust's maternity services were not alerting any concerns currently.

The Chief Nursing Officer advised that proactive communications were planned to include making it easier for women to provide feedback. A workshop was scheduled in order to ensure MNVP were included as part of the on-going experience of care work in addition to planning a branded maternity campaign with mothers included in the design work. The Committee noted that the negative social media was still on-going and it was important to encourage women to seek professional advice.

The Committee agreed that the Board would be advised that further assurance was being sought on required actions in maternity and lessons learned.

77/25 Increasing Benchmarking Mortality Metrics

The Chief Medical Officer introduced the report on the increased HSMR, explaining that whilst the Trust's mortality metrics (HSMR and SHMI) had risen, the actual number of deaths remains within normal variation. The main contributors to the elevated metrics were changes in Same Day Emergency Care (SDEC) activity classification and a high episode-per-spell ratio, particularly affecting Cerner trusts. A short working group had been established to address the episode-per-spell issue and progress was being made. No new or unknown care issues had been identified, and the quality of coding remained high. Ongoing assurance processes were in place to monitor any underlying problems whilst the metrics stabilised.

The Chief Medical Officer advised that the report had been reviewed by the Executive Management Committee (EMC) and Quality Governance Committee and both had considered this provided good assurance that this was related to a data issue.

The Committee considered the report provided assurance on mortality metrics. A further update would be provided to the Committee in June 2026. **Action: J Lippett**

78/25 Fuller 2 Response

The Chief Medical Officer introduced the report that set out an overview of the recommendations from the Fuller Report Phase 2 relevant to the Trust, along with a summary of outstanding actions required to achieve compliance. It was noted that approval had been given for the implementation of routine Disclosure & Barring Service (DBS)

checks and for the development of a comprehensive proposal to consider the repatriation of Mortuary services under RBFT management.

The Chief Medical Officer advised that the proposal had been discussed at the EMC and the DBS checks had been supported with the suggestion that designated individuals could enrol on the DBS self-check service. The EMC had also approved the mortuary governance structure and, going forward, an annual report would be scheduled for the Committee. **Action: J Lippett**

The Chief Medical Officer advised that there had been a detailed discussion regarding repatriation of the mortuary services into Trust management. Whilst this was not required for the Fuller 2 recommendations the team had been advised that a proposal could be developed although it may not be possible to implement this. The Chief Medical Officer highlighted that the Mortuary also provided services to HM Coroner and the Coroner had confirmed their assurance on the report and compliance with the Fuller 2 recommendations.

The Committee noted that audits were carried out by the Mortuary team and these would be reported to the Health & Safety Committee.

The Committee considered that the Fuller 2 recommendations report provided good assurance.

79/25 Referral to Treatment (RTT)

The Chief Operating Officer introduced the report and highlighted that some specialities were struggling to meet demand and further transformation work was planned in order to mitigate this risk. However, the Trust's performance was ahead of other trusts and, despite, some data quality and capacity issues, it was considered that the Trust's performance would remain ahead of other trusts subject to funding.

The Committee noted that actions highlighted by the Trainee Leadership Board (TLB) presentation to a Board seminar were already being carried out.

The Committee noted the increased volume of dermatology referrals. The Chief Operating Officer advised that additional capacity and outsourcing had been put in place to manage the increasing volume of routine referrals and two week waits.

The Committee agreed that the Board should be advised that actions were progressing with the aim to achieve the target by 2029, noting the remaining challenge regarding first outpatient appointments.

The Chief Operating Officer advised that commissioners would not be finalising the trajectory until 2026/27 although it was anticipated that the Trust would have a view prior to this.

80/25 Quarter 2 Patient Safety Report

The Deputy Chief Nursing Officer introduced the report and highlighted that the second cohort of 3 wards had started the process for their Clinical accreditation in November 2025.

The Committee noted that the second pilot site for the Martha's rule would be Kennet & Loddon who would be piloting the daily patient wellness process using EPR. A third pilot site would be in maternity. The Chief Nursing Officer advised that clinical teams would review patients as usual and this was not intended be an additional task. It was agreed

that the Chief Nursing Officer would confirm what outcome data was collected via Martha's rule and include this in future reports. **Action: K Prichard-Thomas**

The Deputy Chief Nursing Officer advised that there had been a reduction in the number of incidents reported. It was noted that a high reporting of incidents indicated a strong safety culture. Work was on-going during Quarter 3 in order to ensure that reporting remained consistent. It was agreed that an update on this would be provided at the next meeting. **Action: K Prichard-Thomas**

The Deputy Chief Nurse highlighted the lessons learned themes from incidents including several incidents that related to Nasogastric (NG) tube placement and feed administration. The associated policy had been reviewed to strengthen safety checks and staff training and was due for approval at the Policy Approval Group over the next week. [s43, FOI Act]

The Committee discussed the Patient Safety Incident Response Framework (PSIRF) methodology and noted that incidents investigated under PSIRF were not based on significance or level of harm but rather focused on the learning opportunity from incidents. The Chief Nursing Officer advised on the process in relation to a severe harm case. This included rapid review, scrutiny at Patient Safety Incident Review Group (PSIRG) and if the incident related to a PSIRF priority and no new learning was identified then improvement work would continue through the relevant PSIRF priority work stream and monitored through an overarching action plan. However, if PSIRG identified new learning after scrutiny of the incident then an agreed appropriate PSIRF methodology would be used to identify learning and the patient/family would be engaged and invited to contribute. The Committee discussed the possibility of arranging PSIRF training for the Board.

The Committee noted the details of two potential high risk inquests.

The Committee agreed that the Board would be advised the Committee was assured on governance arrangements for patient safety.

81/25 Integrated Performance Report (IPR) Quality Watch Metrics

The Committee received the watch metrics.

The Chief Medical Officer highlighted that the stroke metric (proportion of people with high risk transient ischaemia attack (TIA) fully investigated and treated within 24 hours) was alerting. This was due to capacity in the clinical team. However, assurance was provided that the protocol provided advice on immediate treatment that the GP could instigate prior to a full assessment by the specialist team.

The Chief Medical Officer advised that, following discussion at the last meeting, it was proposed to reduce the 'fractured neck of femur surgery within 36 hours' metric target from 75% to 60%. The target was locally defined for monitoring so change was within the scope of the Trust The previous target was now deemed unachievable due to both patients not being medically well enough to have surgery within this timeframe as well the complexity of fractures. In addition, an unachievable target was demoralising for the team as opposed to setting a stretch target that encouraged improvement. The Committee noted that, generally, most patients would receive surgery within 40 hours following stabilisation.

The Committee agreed that the Board would be advised that the Committee approved the revised target for this metric.

82/25 Quality Governance Committee Report

The Chief Nursing Officer highlighted the Trust was likely to breach C. diff target in 2025/26. Close monitoring was continuing and cases were being actively reviewed and a dedicated action group, chaired by the Chief Nursing Officer, had been set up to manage this. The Committee agreed that the Board would be alerted to this.

The Committee discussed the vaccination programme nothing that eligible patients would receive both Flu and COVID vaccine. However, staff would only receive the Flu vaccine.

The Committee agreed that the Board would be advised of assurance on governance processes in place.

83/25 Quarter 2 Patient Relations Report

The Chief Nursing Officer advised that there had been a significant increase in the number of complaints received over the last three months. However, in terms of activity this equated to less than 0.1%. Work was on-going in relation to improving response rates although this was challenged by both volume of complaints as well as vacancies in the complaints team. Work was on-going in relation to the recommendations from the external review. The Committee noted that Improving Together work had been undertaken with the team and key performance indicators were being developed. The Chief Nursing Officer advised that 80 to 90% of complaints were acknowledged within three days. The Committee recommended that the Chief Nursing Officer should consider how the metrics could be reported regularly to the Committee in addition to examples of complaints and any lessons learned. **Action: K Prichard-Thomas**

The Committee noted that the complaints, patient safety and legal team met on a weekly basis to review all cases and this enabled triangulation of all incidents, complaints and legal cases. The Chief Nursing Officer advised that in the event of a patient safety investigation, both the patient and their family were involved from the outset and had the ability to shape the investigation.

The Chief Nursing Officer advised that a detailed review was being undertaken in relation to the increase in complaints. An initial review had not identified any similar themes or a particular area of concern. A further update on this review would be provided to the next meeting. **Action: K Prichard-Thomas**

The Committee agreed that the Board would be alerted to the increase in complaints and that a detailed review was being undertaken.

84/25 Quality Strategy Update

The Committee received the annual update that set out progress against the Quality Strategy. The Chief Nursing Officer advised that the Quality Strategy would be updated following the approval of the Trust Strategy refresh. The Chief Nursing Officer highlighted that areas rag rated as red had been discussed at the Committee previously.

The Committee agreed that the Board should be advised of the progress on the Quality Strategy.

85/25 Joint Targeted Area Inspection (JTAI) Action Plan

The Committee received and noted the action plan had been completed.

86/25 Winter Preparedness

The Chief Operating Officer advised that the Board Assurance Statement for the Winter Plan had highlighted two areas of 'partial assurance'. An Equality, Quality Impact Assessment (EQIA) had been developed and a temporary escalation protocol had been developed. This would enable patients due for discharge that day being moved to a designated ward space in order to support patient flow through the organisation.

The Committee considered the report provided additional assurance on the Winter preparedness.

87/25 Improving Together Update

The Committee received the report and noted that this had been reviewed by the EMC. The Chief Medical Officer confirmed that maturity assessments were being developed.

The Committee agreed that the Board would be advised of progress on the Improving Together programme.

88/25 Legal Services and Claims Report

The Chief Nursing Officer introduced the report and advised that work was on-going by Kennedys to review the NHS Resolution scorecard that enabled trusts to analyse their claims data and a full update on this would be provided in the next report.

The Committee noted that Getting It Right First Time' (GIRFT) litigation packs were published in February 2025 and a review was being undertaken by the legal team including a detailed review of three key specialities.

The Chief Nursing Officer highlighted the section related to high risk inquests and the categorisation of these. It was noted risk levels could change as new information emerged and occasionally inquest dates could change. The Chief Nursing Officer confirmed that the Board would be informed of any high risk inquests via the weekly briefing from the Chief Executive. In addition, a legal update would be included in the quarterly patient safety report to the Committee. The Chief Nursing Officer confirmed that triangulation of complaints, claims and inquests would be included in the annual legal report.

The Committee discussed the number of inquests for the Trust and noted that a bi-annual report would be provided going forward. The next phase would involve a review of the number of inquests including case complexity.

The Committee agreed that the Board would be advised of the report and the on-going work to review the format and reporting cycle.

89/25 Adult Inpatient Survey Action Plan

The Committee received the action plan. It was agreed that the Board would be advised of the good results.

90/25 Work Plan

The work plan for 2026 was noted.

91/25 Key Messages for the Board

The Committee agreed the following key messages for the Board:

- Assurance received on governance arrangements for patient safety and quality governance
- Advise further assurance being sought on required actions in maternity and lessons learned
- Alert regarding the increase in complaints received and a detailed review was on-going
- Alert regarding C Diff threshold 25/26 would be met and likely exceeded
- Assurance received on the Fuller 2 recommendations report.
- Advise that the Joint Targeted Area Inspection (JTAI) Action Plan had been completed.
- Additional assurance received on Winter preparedness
- Advise of the good results from the Adult Inpatient Survey
- Advise on the progress of the Improving Together programme.
- Advise the Board of the review of the Claims report and the proposal for future reporting to the Committee.
- Advise the local agreed hip fracture percentage of patients receiving surgery within 36 hours metric had been revised from 75% to 60%

92/25 Date of Next Meeting

It was agreed that the next meeting would be held on Wednesday 2 February 2026 at 10.00.

SIGNED:

DATE:

NHS
Royal Berkshire
NHS Foundation Trust

Title:	**Chief Executive Report**
Agenda item no:	6
Meeting:	Board of Directors
Date:	28 January 2026
Presented by:	Steve McManus, Chief Executive
Prepared by:	Caroline Lynch, Trust Secretary

Purpose of the Report	• To update the Board with an overview of key issues since the previous Board meeting. • To update the Board with an overview of key national and local strategic environmental and planning developments • This includes items that may impact on policy, quality and financial risks to the Trust.

Report History	None

What action is required?	
Assurance	
Information	For information and discussion: The Board is asked to note the report
Discussion/input	
Decision/approval	

Resource Impact:	None
Relationship to Risk in BAF:	
Corporate Risk Register (CRR) Reference /score	
Title of CRR	

Strategic objectives This report impacts on	
Delivering the highest quality care for all	✓
Supporting our people to thrive	✓
Partnering for impact	✓
Driving improvement and enabling innovation	✓
Building a sustainable future together	✓

Well Led Framework applicability:			Not applicable ☐
1. Leadership ☐	2. Vision & Strategy ☐	3. Culture ☐	4. Governance ☐
5. Risks, Issues & ☐ Performance	6. Information ☐ Management	7. Engagement ☐	8. Learning & Innovation ✓

Publication						
Published on website		Confidentiality (FoI)	Private		Public	✓

Strategic Objective 1: Delivering the highest quality care for all

Operational Status

1.1 Teams across the Trust have been working hard over the last two months to maintain high standards of care at the height of the winter period. Along with the impact of seasonal illness, teams have also absorbed the impact of a further round of resident doctor industrial action immediately prior to Christmas. Performance against key operational standards was strong in December but has been more challenged this month owing particularly to slow rates of discharge over holiday periods and the impact that this and infection control measures have had on patient flow through the Reading site.

1.2 The measures taken as part of winter preparedness have helped mitigate this to an extent but at times there have been delays to ambulance handovers, delays in admitting patients from the Emergency Department (ED) and capacity challenges on the trauma pathway. The Trust has remained at Opel 4 during this month as a result of that increased operational pressure. These issues are being effectively addressed and we expect the position to improve over the second half of this month.

Maternity and Neonatal Services

1.3 NHS maternity & neonatal services continue to experience significant national reform aimed at improving safety, personalisation, and equity of care. Recent policy direction includes the implementation of NHS England's (NHSE) three-year delivery plan, which prioritises safer and more personalised maternity and neonatal services, expanded specialist provision such as pelvic health and bereavement support, and strengthened involvement of women and families in service design.

1.4 This falls against the backdrop of continued national scrutiny following the independent investigation launched into maternity and neonatal services across key NHS trusts to identify urgent improvements and ensure consistent standards of care. Collectively, these changes signal a sustained national commitment to addressing variation, strengthening accountability, and delivering safer, more equitable maternity services.

1.3 Our Maternity & Neonatal leadership team are responding well to these challenges, working closely with partners such as the Maternity and Neonatal Voices Partnership (MNVP) and Healthwatch and implementing national recommendations such as the Maternity Outcomes Signal System (MOSS), Maternity Care Bundles and National Maternity Operational Pressures Situational Reports. Reports are shared through Quality Committee and also through the Maternity & Neonatal Safety & Compliance Group that the Board Safety Champion leads.

Strategic Objective 2: Supporting our people to thrive

2025 Staff Survey

2.1 The 2025 National Staff Survey has closed with the Trust delivering its highest ever response rate. Results from the survey remain under strict embargo pending National publication. The embargo is expected to be lifted around mid-March 2026. With the historic positive relationship between strong engagement in the survey and performance, we are optimistic about maintaining our position from 2024 which saw the Trust ranked as one of the very best in England on overall measures of staff experience at work. A full report will be presented to Board in March/April 2026 including headline improvement focus for the year ahead.

2026 CARE awards

2.2 Nominations for this year's CARE awards opened on Monday 12 January 2026. There are 12 categories spanning areas including Team of the Year, Innovation of the Year, and Outstanding Contribution to Education. We have launched our communications encouraging teams across the organisation to take a moment to recognise colleagues who have made a difference to our patients, community, and experience of working at the Trust. The award event takes place in May 2026 and, as always, we will be involving our Care Groups, Estates, and Corporate leadership teams in the judging process, as well as the Board.

Kings New Year Honours

2.3 Congratulations to Anna Horwood, Emeritus Professor of Orthoptics who was awarded an MBE in the King's New Years Honours list. Anna has been with the Trust for 44 years, and this honour is in recognition of her services to Orthoptics and Research in Visual Development, specialising in children's vision.

2.4 Anna's research has informed the way orthoptists and ophthalmologists think about visual development and misalignment of the eyes, specifically her work into the development of a child's ability to focus, move their eyes together, and the relationship between the two. This research has changed the way we think about the development of binocular vision - the ability of both eyes to work together to create a single image.

Strategic Objective 3: Partnering for impact

Operational Planning 2026 – 2029

3.1 In October 2025, NHS England (NHSE) and the Department of Health and Social Care (DHSC) issued planning guidance for the period of 2026/27 to 2028/29. Mandating the development of a three-year plan and a four-year capital plan. For final submissions in February 2026. The guidance included the requirement to deliver a balanced plan in each year whilst deficit support funding is phased out. To achieve this in the next three years the Trust must address its underlying deficit position. This will require the Trust to improve its financial position by approximately £10.0m per annum over this period.

3.2 The Trust has submitted its draft plan to NHSE, indicating that we will be compliant with the operational and financial requirements set out in the guidance. The plan is dependent upon delivering a similar efficiency programme as 25/26 for each of the next 2 years and receiving more income from commissioners than has been contained in provisional offers, and the Trust receiving an allocation from the ICBs innovation and transformation fund.

3.3 The Trust is engaged with the ICB on these matters. In parallel clinical and operational teams are refining their delivery plans, focusing on building operational resilience and identifying robust efficiency and quality improvement programmes.

3.4 The Trust is required to make a final submission of its plans to NHSE on the 12 February 2026 following Board discussion and approval on 5 February 2026.

Christmas Concert

3.5 The Royal Berks Charity again hosted our Christmas Carol Concert at Reading Minster on Friday 5 December 2025. Approximately 600 people attended including hospital staff, local choirs and schools, and members of the wider community. The event raised over £8,000 for our Christmas Appeal supporting our Elderly Care wards.

Christmas Appeal

3.6 Thanks to the generosity of our community and supporters, we successfully received just over 900 presents as part of our Christmas appeal, ensuring that every one of our patients received a gift. We were supported by over 31 organisations in addition to individual members of our community. The quality of the donated presents was extremely high this year, with volunteers commenting on the notably generous size of many of the gifts while wrapping them and bagging them for distribution. All wards expressed their thanks upon delivery, highlighting how much the gifts were appreciated by patients and staff alike. Children's ward, paediatric ED, Dingley and our nursery were overwhelmed with the gifts we provided them.

3.7 We were particularly touched to receive a message of thanks from an adult patient who had been unexpectedly admitted over Christmas and said that receiving a gift made a world of difference to her stay in hospital. The appeal once again demonstrated the kindness of our supporters and community and had a very positive impact across the hospital. Wrapping and delivery of gifts was done in record time this year with many corporate partners and Trust volunteers who helped. The volunteer's team are looking forward to leading the appeal again this year.

Media Engagement

3.8 Over the past year, the Trust has been featured in high profile national and regional broadcast and print media coverage with 61 items on Sky News, BBC TV, ITN, BBC Radio 4, ITV Meridian, BBC TV South, BBC Radio Berkshire, Heart fm and local newspapers. The coverage has showcased our staff and their achievements around winter pressures, cancer care, innovative digital healthcare, VIP visits and industrial action.

3.9 The Trust's Communications team has developed strong and productive relationships with broadcasters and the press to raise the profile of the Trust on the national stage and present RBFT as a transparent, open and well led organisation.

3.10 Last week, BBC Radio Berkshire dedicated a 4 hour morning programme to the Trust, featuring multiple teams and highlighting pivotal work being delivered and Sky News ran the first in a series of reports around our cancer care.

Strategic Objective 4 – Driving improvement and enabling innovation

Improving outcomes for patients living with Hepatitis B

4.1 We have recently received central funding extended for an additional two-years for 'opt-out' testing in ED to increase diagnosis of people living with Hepatitis B in the community. During the 12-month pilot period we saw detection rates double.

4.2 Gastroenterology and Hepatology colleagues have also recently published a research study looking back on 700 patients at the Trust over a 10-year period which shows the clear benefits of taking a more proactive approach to identifying people living with chronic Hepatitis B a condition that can have severe impacts, including liver cancer, if left untreated.

AI Stroke Software – largest UK study published

4.2 A major study published in the Lancet has shown that the introduction of artificial intelligence (AI) imaging software across NHS stroke networks significantly increased access to life-saving treatment for patients with severe stroke in England. The study was authored by colleagues from the Trust in collaboration with Health Innovation Network Oxford and Thames Valley, and Brainomix 360.

4.3 The research, conducted across 107 hospitals found those implementing the software doubled the rate of endovascular thrombectomy — a specialist procedure that restores blood flow in patients with large vessel occlusion stroke, and reduced the time for transfer to a specialist centre by more than an hour. The study included over 450,000 stroke patients between 2019 and 2023, making it the largest global evaluation to date of AI in stroke care.

Acute Provider Collaborative (APC) Clinical Services Programme

4.4 Implementation of the Thames Valley Fracture Liaison Service began in September 2024. A team of consultants, nurses and patients from the acute trusts developed harmonised pathways, established a peer-to-peer support network, and led primary care engagement to drive service improvements. Frimley Health Foundation Trust have approved their business case and are currently onboarding to the Thames Valley programme.

4.5 The initial assessment of data demonstrated that Oxford University Hospitals and the Trust have identified and treated an additional 1010 patients between September 2024 to November 2025, in comparison to the same period in 2022/3. Based on calculations by the Royal Osteoporosis Society, this will lead to 194 avoided fractures, 1977 avoided bed days and equates to net savings in the acute trusts of £1.358m.

4.6 Buckinghamshire Healthcare Trust completed recruitment in December 2025 and as of January 2026 have already identified 50 patients for assessment (included in the numbers above). The APC has also been contacted by the Royal Osteoporosis Society and NHS Confederation, who have asked to produce a case study on the success of the programme.

4.7 This is a really good example of the impact of larger scale collaboration between organisations is having on the real world impact for patients.

Strategic Objective 5: Building a sustainable future together

Financial Position

5.1 The Trust has reported delivery of the planned financial position at the end of Month 9 which is a deficit of £9.33m. The Trust carries out detailed forecasting and scenario modelling each month and continues to report a forecast outturn that is in line with the £7.8m deficit plan.

5.2 The Trust was successful in applying for cash support. The application was routine given the planned in-year deficit and NHSE has now deposited the agreed amount with the Trust.

5.3 The receipt of cash to cover the planned deficit enable the Trust to keep the planned capital investments on target, ensuring we can do necessary maintenance and upgrade work on our estates, refresh our digital assets and upgrade and replace equipment.

New Hospital Programme

5.4 On Friday 16 January 2026 the National Audit Office (NAO) released a report on the New Hospital Programme (NHP). While the overall tone of the report indicated improvements in the delivery capability of the NHP programme, the report contained an NAO estimate of 2045-46 for the earliest completion of a new Royal Berkshire Hospital. This is 2-3 years longer than implied by the NHP in January 2025. We are seeking to explore the differences between these estimates and will report back to the Board when we have this clarity.

NHS
Royal Berkshire
NHS Foundation Trust

Title:	**Integrated Performance Report (IPR)**
Agenda item no:	7
Meeting:	Board of Directors
Date:	28 January 2026
Presented by:	Helen Troalen, interim Chief Finance Officer
Prepared by:	Executive Team

Purpose of the Report	The purpose of this report is to provide the Board with an analysis of quality performance to the end of December 2025

Report History	New report

What action is required?	
Assurance	
Information	The Board is asked to note the report
Discussion/input	
Decision/approval	

Resource Impact:	None
Relationship to Risk in BAF:	n/a
Corporate Risk Register (CRR) Reference /score	
Title of CRR	

Strategic objectives This report impacts on (tick all that apply)**:**							
Provide the highest quality care for all							✓
Invest in our people and live out our values							✓
Deliver in partnership							✓
Cultivate innovation and improvement							✓
Achieve long-term sustainability							
Well Led Framework applicability:						Not applicable ☐	
1. Leadership ☐		2. Vision & Strategy ☐		3. Culture ☐		4. Governance ☐	
5. Risks, Issues & Performance ☐		6. Information Management ☐		7. Engagement ☐		8. Learning & Innovation ☐	
Publication							
Published on website		Confidentiality (FoI)		Private		Public	✓

NHS
Royal Berkshire
NHS Foundation Trust

Integrated Performance Report

December 2025

Improving together to deliver
outstanding care for our community

Improving Together

Guide to statistical process control (SPC)

NHS Royal Berkshire NHS Foundation Trust

Introduction to SPC:
Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in doing so, guides us to take the most appropriate action. The Improving Together methodology incorporates the use of SPC Charts alongside the use of Business Rules to provide aggregated view of how each KPI is performing with statistical rigor.

The main aims of using statistical process control charts is to understand what is different and what is normal, to be able to determine where work needs to be concentrated to make a change.

A SPC chart plots data over time and allows us to detect if:

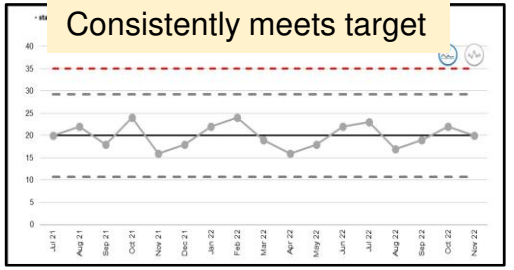
- The variation is routine, expected and stable within a range. We call this '*common cause*' variation, or
- The variation is irregular, unexpected and unstable. We call this '*special cause*' variation and indicates an irregularity or that something significant has changed in the process

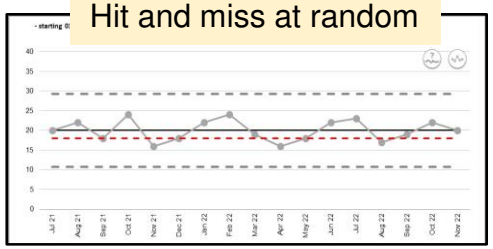
Each chart shows a VARIATION icon to identify either common cause or special cause variation. If special cause variation is detected the icon can also indicate if it is improving (blue) or worsening (orange).

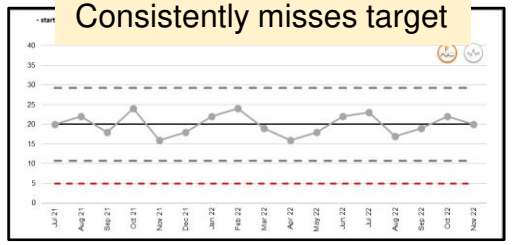
Where we have set a target, the chart also provides an ASSURANCE icon indicating:

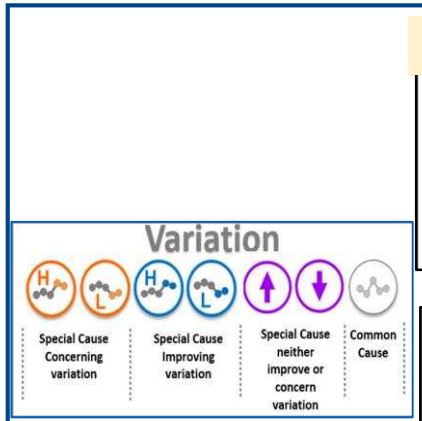
- If we have consistently met that target (blue icon),
- If we hit and miss randomly over time (grey icon), or
- If we consistently fail the target (orange icon)

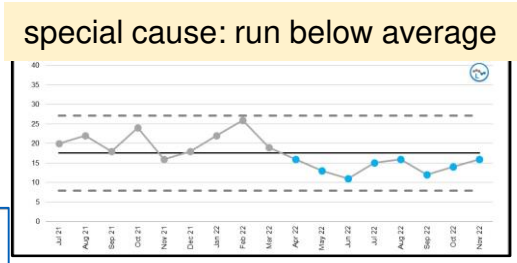
For each of our strategic metrics and breakthrough priorities we will provide a SPC chart and detailed performance report. We apply the same Variation and Assurance rules to watch metrics but display just the icon(s) in a table highlighting those that need further discussion or investigation.

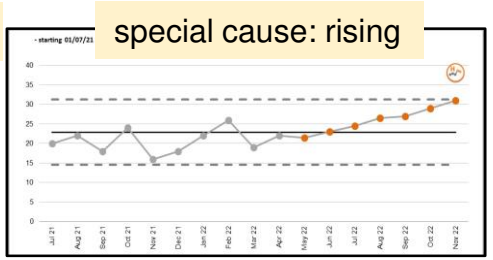


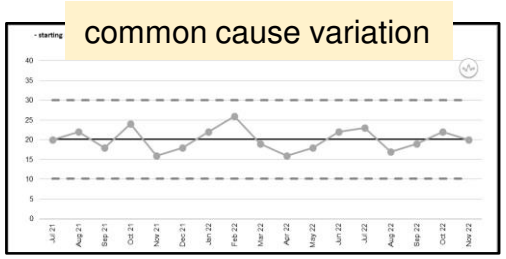


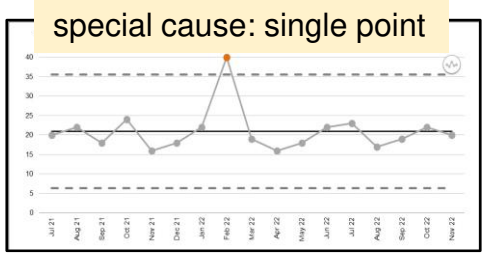










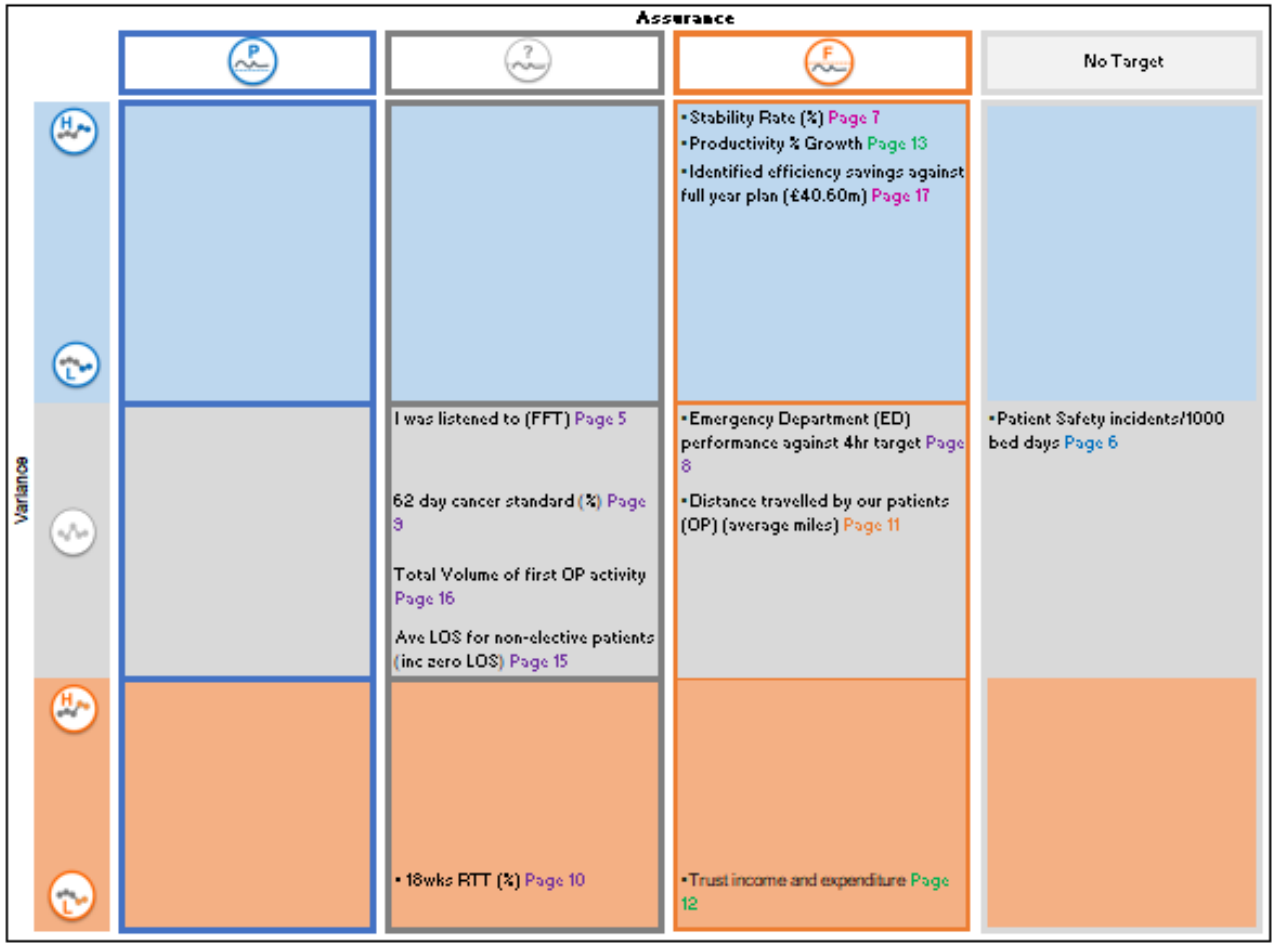


December 2025 performance summary

Royal Berkshire NHS Foundation Trust

The data in this report relates to the period up to 31st December The key messages from the report are:

- **ED Performance:** Performance was above trajectory by 6.5% in December despite the onset of seasonal pressures and bank holiday impacts on internal and external capacity.
- **Cancer performance:** performance against the 28-day faster diagnosis standard remains compliant with the Trust's planned trajectory for 2025-26. Performance against the 62-day standard met the Trust's planned trajectory as well as the national ambition in November and is forecast to do so in December as well. Improvement actions continue to be worked on for the most challenged pathways through weekly Cancer Action Group meetings.
- **Financial performance:** at the end of December the income and expenditure deficit of £(9.33)m YTD is within the agreed plan. We have now delivered £25.55m of the £40.60m efficiency savings plan. We are delivering the action plan required to deliver our full year plan and are focused on embedding recurrent actions going into 2026/27.
- **Cash** support application has been approved for January drawdown. Further applications will be submitted for March and April drawdown.
- This month we have seen 17 of the 110 **watch metrics** measure outside of statistical control.



Royal Berkshire
NHS Foundation Trust

Strategic Metrics

Strategic objective: **Provide the highest quality care for all**

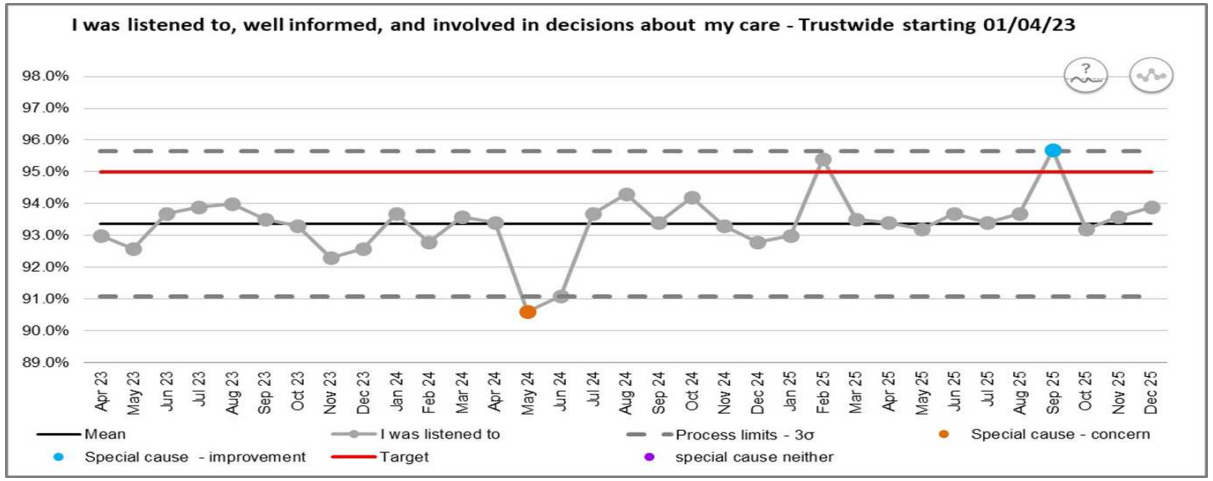
Strategic metric: I was listened to, well informed & involved in decisions about my care

Board Committee: Quality committee

SRO: Katie Prichard-Thomas

Assurance	Variation
	

Royal Berkshire NHS Foundation Trust



	July-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
I was listened to, well informed & involved in decisions about my care (FFT) Q2	93.4%	93.7%	95.7%	93.2%	93.60%	93.9%
Inpatient FFT satisfaction rate	93%	94%	96%	95%	96%	94%
Outpatient FFT satisfaction rate	95%	96%	95%	95%	96%	96%
Maternity FFT satisfaction rate	99%	98%	97%	95%	98%	97%
Emergency Departments FFT satisfaction rate	83%	81%	78%	78%	83%	83%
Day Case FFT satisfaction rate	99%	98%	97%	99%	99%	98%
Paediatrics (IP only) FFT satisfaction rate (%)	94%	93%	77%	96%	100%	89%
Overall Trust FFT satisfaction rate	93%	94%	93.7%	93.3%	94.2%	94%

This measures: The percentage of patients completing the Friends and Family Test (FFT) Trust-wide who feel that they have been 'listened to and involved in decisions about their care'

How are we performing:

- This metric now includes the Trustwide overall FFT Satisfaction score, currently **94%** with a target of **95%.**
- Satisfaction score for FFT Question 2 for October is **93.9%;** overall stable although below the Trust target of **95%**.

Actions and next steps

- Trust Response Rate was 6.8% in December (a reduction from 7.8**%** in November).
- New Experience of Care Committee under development and Trust Strategy Strategic Programme
- Redesign of 'You said, We Did' posters in process with Comms, Patient Information Manager and Patient Experience Lead. Aim February completion.
- Meeting with Woodley Ward team planned in February. Learning from this model FFT ward pilot will be rolled out trust wide.
- Outpatient and Day Case Departments to have their reusable FFT results posters delivered in January, as well as new Patient Experience notice board posters and templates.
- Positive improvement & support provided by DDaT following implementation of automated process for sending out FFT and referral confirmation texts to patients, removing requirement for manual process every 48 hours.

Risks

- KPIs for FFT to be reviewed, to remove duplicates and refresh reporting metrics

Strategic objective: **Provide the highest quality care for all**

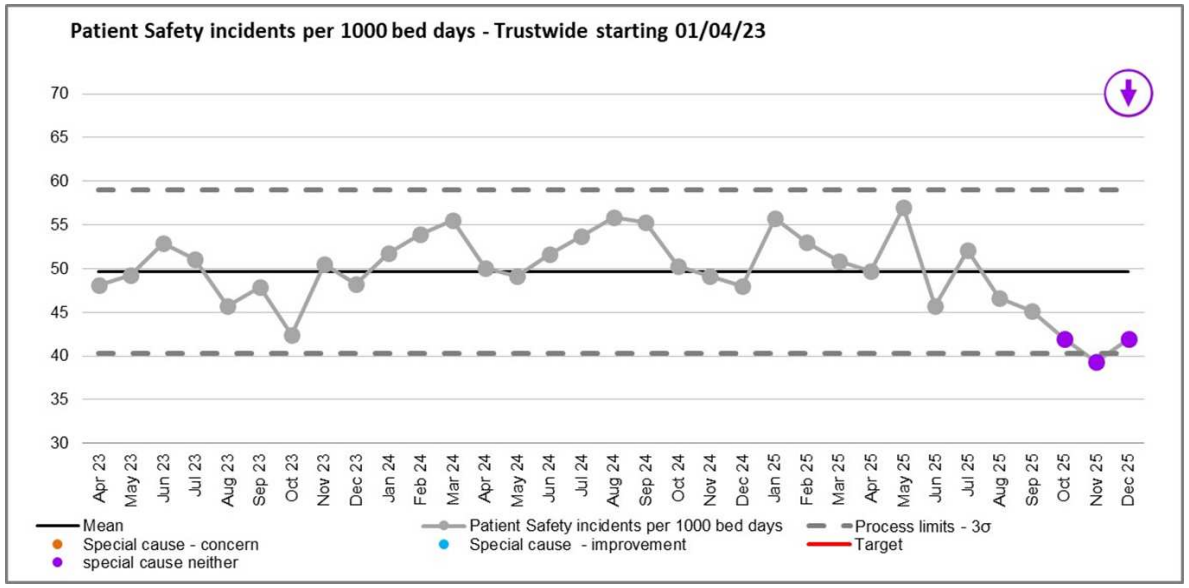
Strategic metric: Learning from incidents to reduce harm

Board Committee: Quality committee

SRO: Katie Prichard-Thomas

Assurance	Variation
N/A	↓

Royal Berkshire NHS Foundation Trust



	July-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Patient Safety incidents per 1000 bed days	52.06	46.58	45.29	41.98	39.34	41.98
Patient Safety incidents/100 admissions	10.24	9.41	9.08	7.84	6.55	8.75
No. of Deteriorating patient incidents	10	8	7	7	10	9
FFT question: I felt safe during my visit to the hospital (%)	92.3%	89.8%	93.1%	91.2%	92.8%	92.1%
Total Calls for Concern from patient and family	23	24	34	27	23	20

This measures: Patient Safety incidents per 1000 bed days across all units. With the change to the patient safety incident response framework (PSIRF) the focus is on the stability of our incident reporting

How are we performing:

- The number of incidents per 1000 bed days are increasing and are above the threshold of 40 and returned back to control limits .
- A deep dive has been completed and highlights key areas where reporting has decreased.
- Care groups aware and working with teams to encourage reporting.
- PSIRF training report taken to EMC on 12 January 2026 and NPSS patient safety e-learning approved for local compliance.

Actions and next steps

- Continued communications to care groups and via work vivo to encourage reporting.
- NPSS level 1 training to be set as local compliance for all staff and level 2 for clinical staff. Learning Matters to be configured and comms planned.
- KPMG audit has been completed and presented at Audit and Risk. Action plan to be completed over next 6 months.

Risks:

- Decrease in the number of reported incidents.
- Number of total staff who have completed NPSS e-learning remains low (14% of Trust staff). This should increase with changes to learning matters.
- Replacement/upgrade of the datix system for managing incidents, risk and complaints will be going to tender in Feb 2026 with a plan for purchase and implementation in 2026/27.

Strategic objective: **Invest in our people and live out our values**

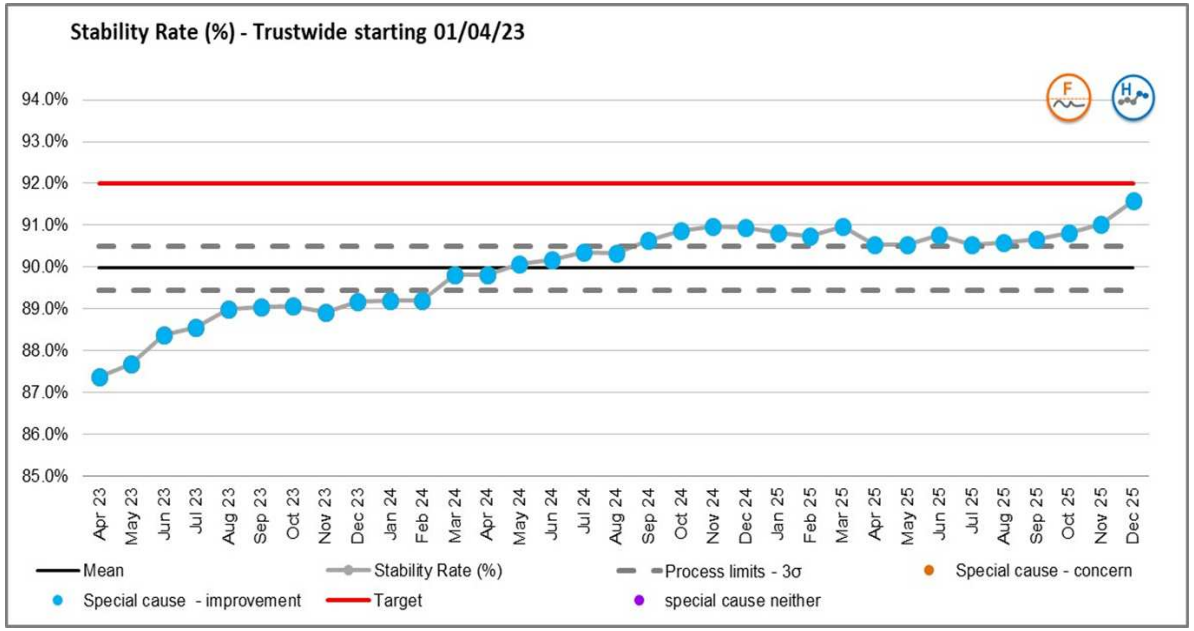
Strategic metric: Improve retention

Board Committee: People Committee

SRO: Paul da Gama

Assurance	Variation
F	H

Royal Berkshire NHS Foundation Trust



	July-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Stability Rate (%)	90.53%	90.59%	90.67%	90.81%	91.03%	91.60%
Turnover rate %	9.72%	9.93%	9.99%	9.85%	9.60%	9.36%
Vacancy rate	1.79%	2.58%	3.92%	2.05%	2.17%	2.25%
Sickness absence (rolling 12 month)	3.81%	3.86%	3.85%	3.79%	3.77%	Arrears

This measures: Stability measures the % of total staff in post at a point in time who have more than one year of service at the Trust.

How are we performing:

- Stability rate trend continues to improve and is getting closer to achieving our 92% target (which would place us in the top decile Nationally).

Actions and next steps:

- The Trust is continuing to prioritise work designed to tackle unacceptable behaviours and improve safety of colleagues at work through our *Up the Anti* (anti-discrimination), Violence Aggression & Abuse, and Sexual Safety work streams. These workstreams include training, improved reporting mechanisms, and additional support for staff when incidents occur. Next steps include rolling out an in-house sexual safety training programme for leaders.
- This year has seen the Trust's best-ever Staff Survey response rate at 62.2% (4165 Respondents), leaders are expected to receive departmental insights in January/February and will be commencing departmental improvement plans.
- The Employee Relations team, People and Change Partners and Care Groups have been collaborating to have a tighter control on managing sickness absence through a variety of information sharing sessions. The Occupational Health and Wellbeing team continues to offer a wide variety of offerings to support staff.

Risks:

- Return to work form completion rates and impact on health and wellbeing due to winter pressures.

Strategic objective: **Deliver in partnership**

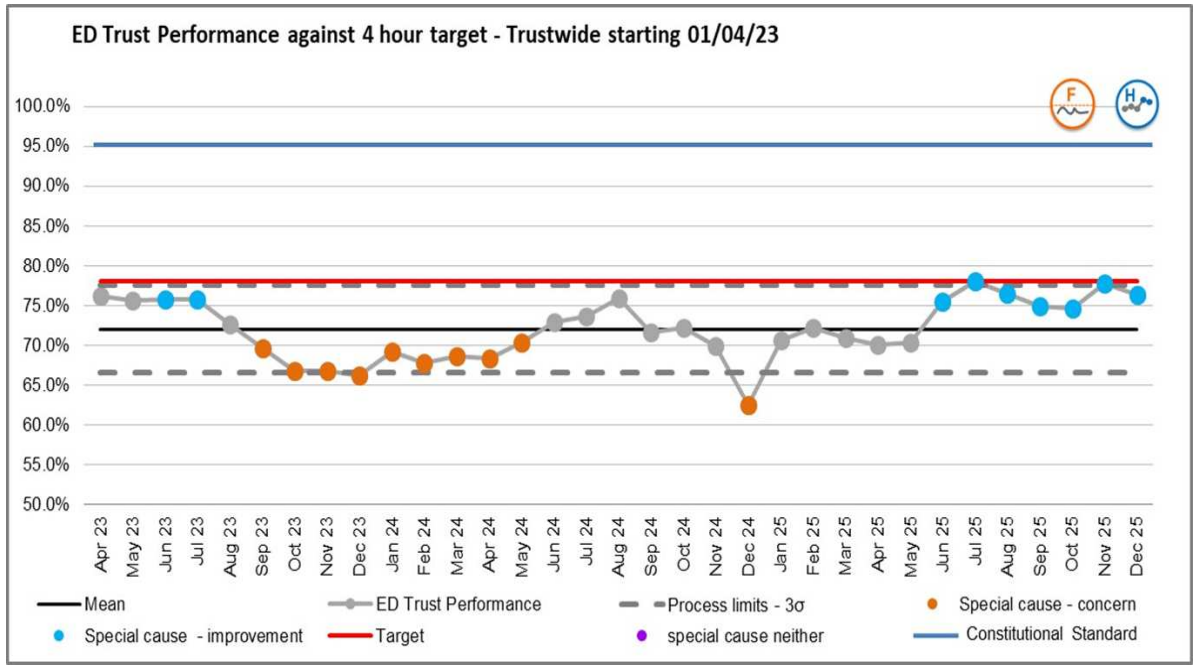
Strategic metric: Performance against 4hr Emergency Pathway target

Board Committee: Quality Committee

SRO: Dom Hardy

Assurance	Variation
F	H

Royal Berkshire NHS Foundation Trust



	July-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
4hour Performance (%)	78.09%	76.44%	74.87%	74.69%	77.77%	76.36%
4hr Performance (%) Trajectory	71%	75%	74%	75%	73%	70%
Average daily Type 1 attendance	398	368	403	418	410	397
Total Breaches	3951	3508	4385	4640	3866	4093
Ambulance Handover: 30 Minutes	156	139	165	246	193	246
12 hours from arrival in ED (%)	2.73%	3.43%	2.68%	2.85%	2.10%	2.32%

This measures: The number of patients experiencing excess waiting times (>4hr) for emergency service. While the constitutional standard remains at 95%, NHS England has set the target of consistently seeing 78% of patients within 4 hours by the end of March 2026

How are we performing:

- 76.4% all types of patients were seen within 4 hours – 6.5% above plan.
- Despite all the efforts across Berkshire West UEC pathways, ED has seen almost 500 more patients than the same time last year.
- There was a slight increase in Ambulance handovers >30 minutes although the overall demand remains consistent with seasonal pattern, and flat against least years conveyances.
- RBFT ED T1 performance 67.1%, ED team continue to monitor compliance to the 4hr standard by individual areas, Minor Injuries, Paediatrics and Adults.
- Ongoing monitoring of patients awaiting a bed for admission at 7am, shows a slight reduction when compared to December 2025

Actions and next steps:

- Working with UCC, to profile capacity in line with demand of peaks
- Further refining the application of the Temporary Escalation Space Standard Operating Procedure on wards
- Improved coordination and use of community beds

Risks: Corporate Risk 4172

- Significant increase in Mental Health demand as well as incidences of violence and aggression towards staff; and associated costs. Additionally increased LOS
- Demand for ED sustained, above the anticipated UCC volume
- Dependence on specialties to see referred patients in a timely manner

Strategic objective: **Deliver in partnership**

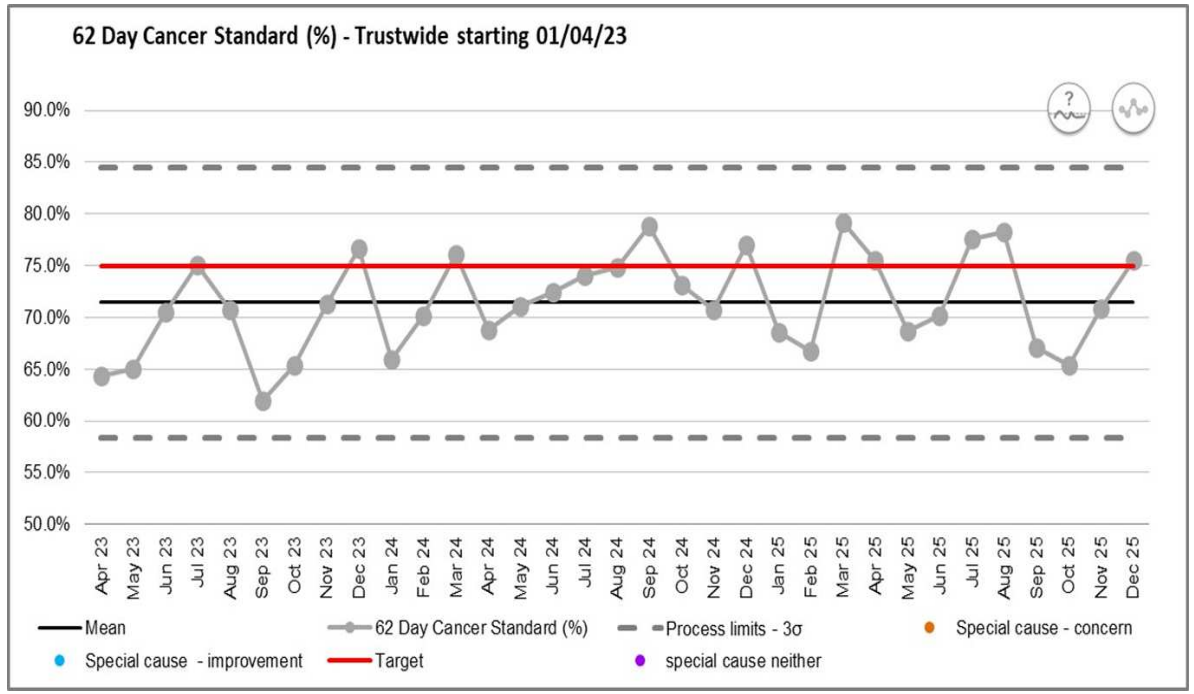
Strategic metric: Reduce waits of over 62 days for Cancer patients

Board Committee: Quality Committee

SRO: Dom Hardy

Assurance	Variation
?	

Royal Berkshire NHS Foundation Trust



	July-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Cancer 62 day %	77.6%	78.3%	67.1%	72.3%	74.1%	75.5%
Cancer 62 day % Trajectory	72.0%	72.0%	73.0%	73.0%	73.0%	73.0%
No. on PTL over 62 days	262	345	366	263	207	202
% on PTL over 62 days	8.5%	11.3%	12.2%	9.6%	7.7%	8.4%
Cancer 28 day Faster Diagnosis (80% standard)	80.4%	79.7%	77.1%	81.7%	80.7%	85.2%

This measures: The percentage of patients with confirmed cancer receiving first definitive treatment within 62 days of referral to the Trust. The national target is 85%. The 2025 National Operating Plan expectation is to achieve performance to 75% by March 2026.

How are we performing:

- In November 74.1% of patients were treated within 62 days. December's unvalidated performance is 75.5%. This will likely improve post-validation.
- The total number of patients on the Patient Tracking List waiting over 62 days at the end of December was 202,down from 207 in November. Predominantly within Lower Gastrointestinal (LGI), Urology, Upper Gastrointestinal (UGI) & Lung
- RBFT remains part of NHSE's tiering process with the OUH and BHT

Actions and next steps:

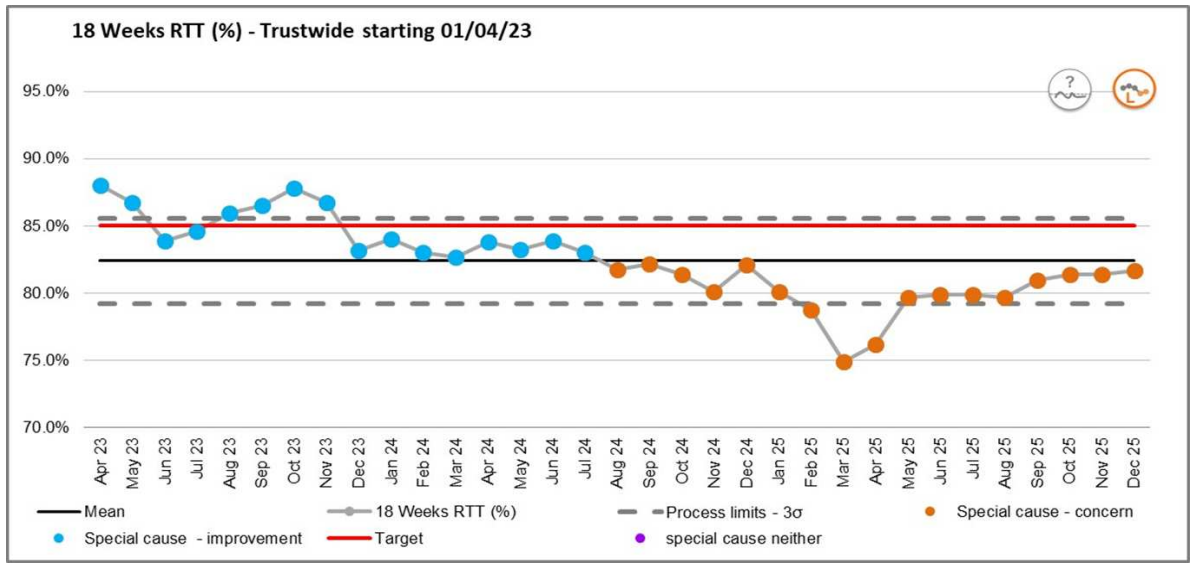
- Gynaecology are focusing on reducing length of wait for patients requiring an inpatient hysteroscopy (IPH) by ringfencing theatre and pre-op slots
- LGI are focusing on increasing the % of patients who are triaged through nurse-led protocol who go straight to test without needing an outpatient appointment
- Urology are focusing on reducing triage times from receipt of referral and reviewing demand and capacity for prostate biopsies. MRI capacity is a bottleneck for the prostate pathway, so Radiology are exploring actions to reduce length of wait for a scan

Risks: Corporate Risk 4241

- Continued delays to some parts of pathways in Gynaecology, Gastroenterology and Urology
- High reliance on insourcing/outsourcing

Strategic objective: **Deliver in partnership**

Strategic metric: Maximising Elective Activity: Achievement of the <18 week Referral to Treatment (RTT) standard



	July-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
18 Weeks RTT (%)	79.91%	79.65%	80.93%	81.38%	81.36%	81.69%
18 Wks RTT (%) Trajectory	80%	80%	80%	80%	80%	80%
Total Elective Activity (No.) (provisional)	4806	4240	4920	4982	4,425	4,333
% of plan for Daycases (cumulative)	98.80%	98.33%	98.26%	97.73%	97.41%	96.61%
% of plan for Inpatients (cumulative)	97.71%	97.01%	94.39%	95.30%	97.39%	96.12%
% of plan for Outpatient Attendances (News & Follow Ups (cumulative)	112.63%	110.92%	110.53%	109.51%	110.81%	109.51%

Board Committee: Quality Committee

SRO: Dom Hardy

Assurance	Variation
?	L

Royal Berkshire NHS Foundation Trust

This measures: The measure shows the Trust performance against the national Referral to Treatment standard. The national standard is 92%. The 2025 National Operating Plan expectation is to achieve performance to 85% by March 2026. RBFT trajectory is 80% with a commitment to improve on this by up to a further two percentage points

How are we performing:

- Performance against the headline RTT standard is beginning to improve as a combined result of RTT-specific validation and Master waiting list data cleansing actions. The PTL size is beginning to reduce. We are on track with our plans to improve to 82.5% by the end of March.
- However a number of specialties continue to have extended waits for first outpatient appointment. Without intervention over the remainder of the year, this will adversely impact on 26/27 performance.

Actions and next steps:

- Continue to drive improvement in the diagnostic waiting times
- Q4 drive to undertake significant additional first OPA activity to reduce waiting times. This is an NHSE funded initiative.
- LLM Development and Pathways Insight and Coordination Solution (PICS) is well underway. With early results looking promising. Parallel running of PICs is delayed as a result of resourcing challenges making data feeds available.
- TV Innovation fund bid to support backlog clearance in 26/27.

Risks: Corporate Risk 5995

- Capacity to sustain performance against standard

Strategic objective: **Cultivate Innovation and Improvement**

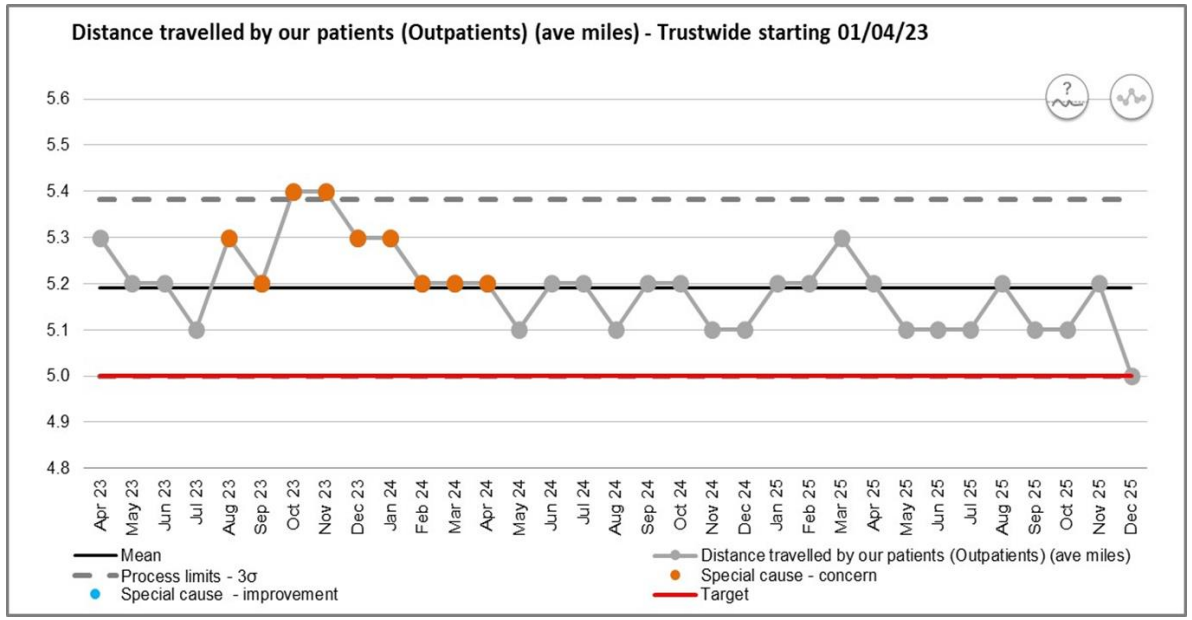
Strategic metric: Distance travelled by our patients (outpatients)

Board Committee
Quality Committee

SRO: Andrew Statham

Assurance	Variation
?	

Royal Berkshire NHS Foundation Trust



	July-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Distance travelled by our patients (average miles) (Outpatients including Virtual Attendances and Advice & Guidance\)	5.1	5.2	5.1	5.1	5.2	5
Number of Virtual attendances	11107	8833	10709	11189	9713	9922
Advice & Guidance (A&G) activity	2008	1795	1954	1817	1899	1899
Face to face (FTF) activity at non RBH sites	10148	8536	9592	10169	9703	8471

This measures: We are tracking the **average miles travelled** for patients that attended an outpatient (OP) appointment, including virtual appointments. Delivering our strategy would result in this metric falling over time.

How are we performing:

- In December, the average distance travelled by our patients for outpatients was 5 miles – this is the first time we have achieved this target.
- Use of non-RBH sites remains variable over the last 6 months with no positive or negative trend

Actions and next steps

- One workstream within the Transformation Outpatient Programme aims to implement four new remote monitoring models across ENT, Urology, IBD and Obstetrics, with ENT as the initial priority and a planned go-live by April 2026.
- The 6-4-2 planning meetings continue to be held weekly, and the monthly utilisation report continues to be shared with DMs for review of percentage booking against use.

Risks:

- Activity plan risks (see deliver in partnership)
- Ongoing inability to deliver some activity from non-RBH sites and additional costs of multisite delivery e.g. equipment and staff travel

Strategic objective: **Achieve long-term sustainability**

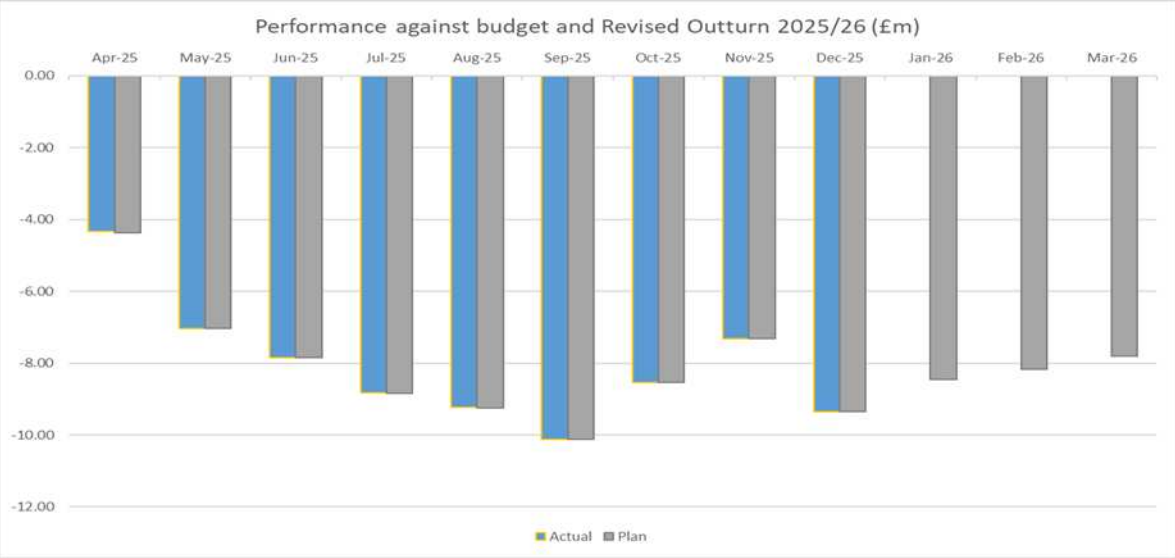
Strategic metric: Trust income & expenditure performance

Board Committee
Finance & Investment

SRO: Helen Troalen

Assurance	Variation
F	L

Royal Berkshire NHS Foundation Trust



Metric Description	July-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Income as % of plan	105.17%	99.15%	101.99%	103.57%	102.14%	103.64%
Pay as a % of plan	107.64%	97.26%	100.94%	102.17%	101.71%	103.39%
Non-Pay as a % of plan	100.84%	102.42%	103.51%	106.30%	103.34%	103.49%
Cost Improvement Plans (CIP) delivered (cumulative) (£)	£9.53m	£12.57m	£17.16m	£20.27m	£22.94m	£25.55m
Value weighted activity actual in month (£m)	£42.79m	£39.76m	£38.39m	£44.89m	£38.56m	£37.79m
Bank and Agency Spend actual (cumulative) (£m)	£5.88m	£7.34m	£8.74m	£10.34m	£11.85m	£13.34m
Cash Position (£m)	£17.15m	£25.92m	£18.81m	£21.96m	£19.76m	£5.35m

This measures: Our 2025/26 performance against our financial plan for the year. The full year plan deficit for 2025/26 is £7.80m.

How are we performing:

- At YTD M09, December 2025, the deficit of £(9.33)m is in line with plan
- Income is £9.51m ahead of plan driven by income derived from non-patient care, grant income, sales of goods and education income.
- Pay is £(5.20)m adverse to plan, driven by non-delivery of corporate and care group savings targets. The current position includes premium rate payments for additional activity as we entered the winter period.
- Non-pay is adverse to plan by £(4.36)m mainly due to both high-cost drugs and clinical supplies.

Actions and next steps

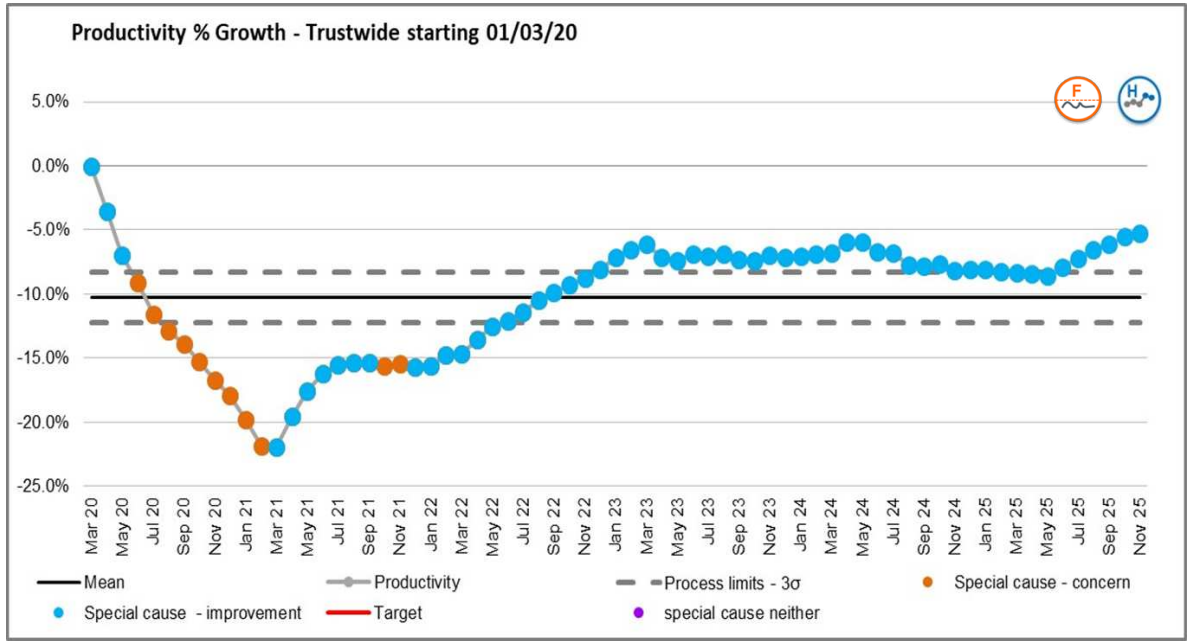
- Delivery of the agreed ten-point action plan to ensure the Trust meets its financial plan.
- A continued focus on the reduction of WTE in line with plan

Risks:

- Risk - non delivery of efficiency plans due to winter pressure (Corporate Risk 4182) and increase on monthly target.
- Risk – if any further industrial action is planned for the winter period

Strategic objective: **Achieve long-term sustainability**

Strategic metric: Productivity (Activity/Wholetime Equivalent)



	July-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Productivity % Growth	-7.2	-6.5	-6.1	-5.5	-5.3	Arrears
Cost Weighted Activity (CWA) % Growth	14.4%	15.2%	15.6%	16.3%	16.7%	Arrears
Whole Time Equivalent (WTE) % Growth	23.2%	23.2%	23.1%	23.1%	23.1	Arrears

Board Committee
Finance & Investment

SRO: Helen Troalen / Andrew Statham

Assurance	Variation
F	H

Royal Berkshire NHS Foundation Trust

This measures: Productivity, here measured by 'output per worker' in the Trust as approximated by the value of all NHS patient activity delivered in the month divided by the wholetime equivalent workforce. The measure is reported on a 12month moving average basis to account for seasonal variation

How are we performing:

- Output per worker' fell significantly during COVID-19 as activity reduced and the Trust employed more people to support the pandemic effort.
- Since 2021, productivity has continued to improve as the Trust's activity levels returned to and then exceeded 19/20 levels. This trend has returned in 25/26
- In November, the Trust performs 5.3% below 2019/20 levels of productivity as workforce growth (23%) exceeds activity growth (17%).
- The National outcomes framework indicates RBFT productivity improvement in the last 12 months is in the top quartile of acute trusts.

Actions and next steps:

- EMC has reviewed the latest productivity data from NHSE and Model Hospital and is in the process of using this to develop the 26-27 plans
- We are targeting 75% recurrent savings and have asked teams to identify workforce savings.
- In addition to savings the operating framework requires the Trust to improve our output on both the elective and non-elective pathway

Risks:

- The Trust is now in the second half of the financial year where we typically use more labour so do not expect the WTE % growth to decrease.

Royal Berkshire NHS Foundation Trust

Breakthrough Priorities

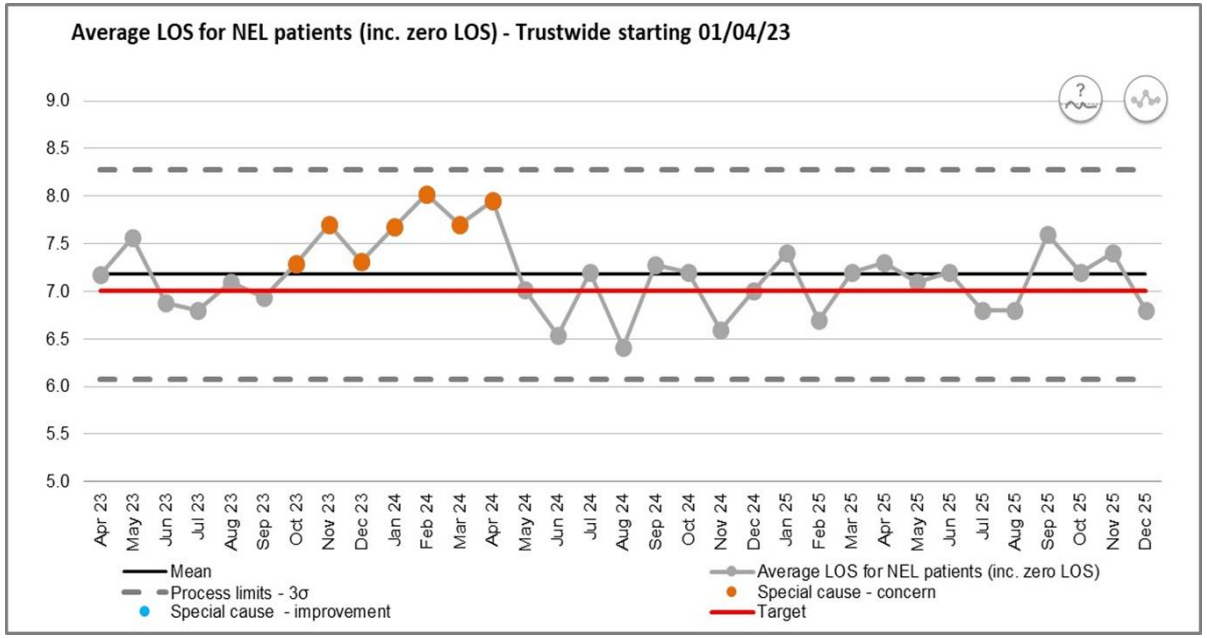
Breakthrough priority metric: Average Length of Stay (LOS) for non-elective patients (inc. zero LOS)

Board Committee: Quality Committee

SRO: Dom Hardy

Assurance	Variation
?	

Royal Berkshire NHS Foundation Trust



	July-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Ave LOS for NEL patients (inc. zero LOS	6.80	6.90	7.60	7.10	7.40	6.8
Bed Occupancy (%)	84%	83%	86%	86%	85%	81%
No. of patients with zero day LoS	591	539	715	677	555	677
Ave number patients > 7 days	242	244	262	248	250	236
Ave number patients > 21 days	79	95	96	85	80	80
Ave no. of patients through discharge lounge per day	20	19	19	19	19	15

This measures: Our objective is to reduce the average Length of Stay (LOS) for non-elective (NEL) patients to:

- Maximise use of our limited bed base for patients that need it most
- Reduce harm from unwarranted longer stays in hospital
- Positively impact ambulance handover times and ED performance

How are we performing:

- LOS has improved (0.6 days) in Dec to 6.8 days
- Excluding same day admissions this is 7.3 days against a target of 7.3 days
- Jan is likely to see a rise in LOS with some very long staying patients being discharged

Actions and next steps

- Continued drive for improved accuracy of targeted day of discharge, December was low at 53% vs the target of 60%
- Continued focus on early use of Discharge Lounge. Dec saw 48% of patients discharged by midday (target = 50%).
- Usage of the discharge lounge fell to 430 patients in Dec (target = 500) with 224 patients before 12pm. Reduction was primarily due to transport uncertainty. This is being addressed with the provider.
- Agreed a new process to highlight community bed capacity and demand and identifying patients 1 working day in advance
- Winter meeting set up with Community Hospital and Local Authority partners.

Risks:

- Winter pressure and increased patient moves / discharge to non-optimal ward
- Temporary escalation space policy may have unintended consequence on reduced TDD compliance

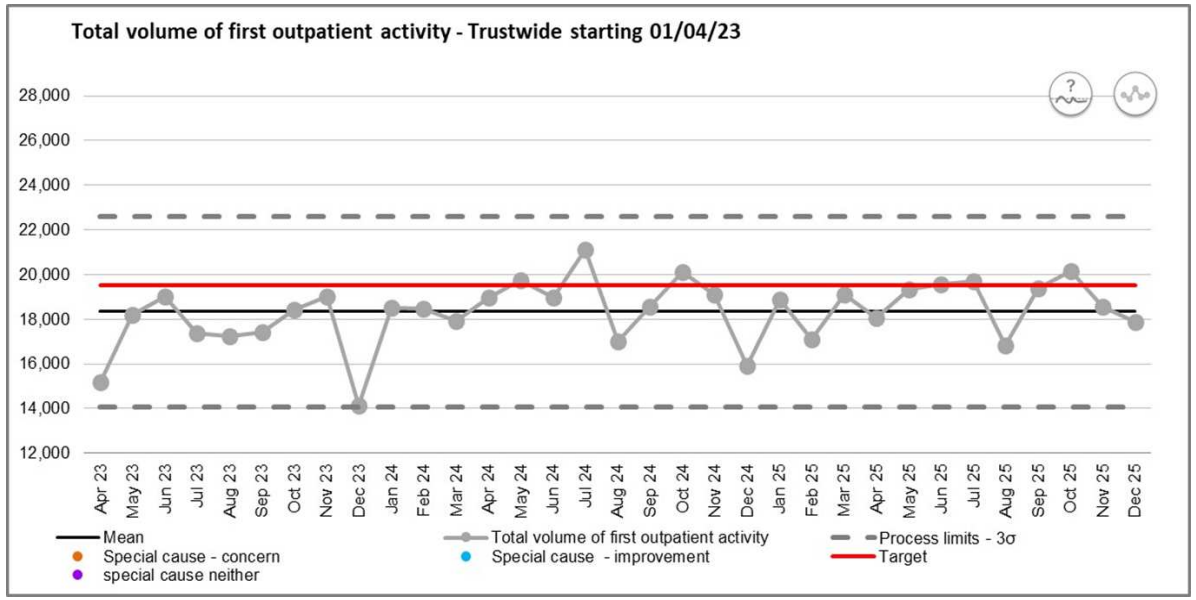
Breakthrough priority metric: Total Volume of first Outpatient (OP) Activity

Board Committee: Quality Committee

SRO: Andrew Statham

Assurance	Variation
	

Royal Berkshire NHS Foundation Trust



	July-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Total Volume of first outpatient activity	19,721	16,810	19,396	20,161	18,577	17,864
First outpatient activity Plan	21,317	18,536	20,390	21,317	18,536	19,463
% of patients waiting over 12 weeks All patients, wait to first assessment	86.37%	79.79%	77.48%	73.73%	71.50%	75.55%
No. of patients waiting >52wks RTT national standard	37	32	40	34	37	45
% OP that did not attend/were not brought (1st OP Appt)	7.8%	6.3%	8.0%	8.1%	8.5%	8.5%
% triage within 2 working days for all GP referrals (including 2 week wait, urgent and routine)	44.50%	32.6%	47.46%	40.5%	46.4%	48.5%

This measures: The volume of first outpatient activity (OPA), including outpatient procedures, being undertaken.

First OPA is the largest and most modifiable aspect of the elective pathway and is the biggest contributor to waiting times delays.

To support our patients and deliver our financial plan we are seeking to increase our OPA to 19,540k per month

How are we performing:

- Completed data for December shows that we delivered 17.9k 1st OPA which is lower than our plan in-month and does not hit our target. This data is provisional and may increase as the data is refreshed in coming weeks.

Actions and next steps

- Q4 intervention focused on increased 1st OPA and OPPROC activity. Focus will be targeted on challenged services, but open to all services.
- The Transformation Outpatient programme continues to focus on delivering:
  - Four new remote monitoring models with initial focus on ENT.
  - Improve patient initiated follow up through both EPR and Royal Berkshire Connect integration, with continued engagement with specialties.
  - Standardising patient letter appointment templates.
  - Reduce triage turnaround time.
  - Trialling an opt-in service for MSK CSS Physio.

Risks: Corporate Risk 5698

- Delivery of the financial benefits from the OP transformation programme will require teams to revise both contingent and ordinary capacity. Advanced planning by teams will be essential for success.

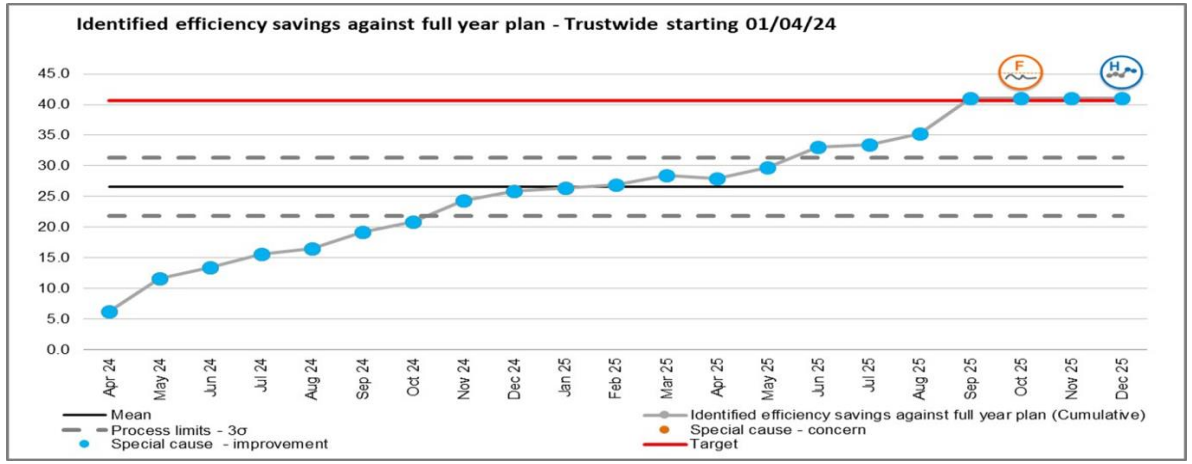
Breakthrough priority metric:
Identified efficiency savings against full year plan (£40.60m)

Board Committee: Finance & Investment Committee

SRO: Dom Hardy

Assurance	Variation
F	H

Royal Berkshire NHS Foundation Trust



	July-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Cumulative identified efficiency savings against full year plan (£40.60m)	£33.44m	£35.26m	£41.05m	£41.05m	£41.05m	£41.05m
Total Delivery against identified efficiency savings (%)	28.50%	35.64%	41.8%	49.4%	55.88%	62.22%
Delivery against identified efficiency savings: Corporate Services (%)	24.67%	29.98%	33.09%	38.88%	48.17%	50.61%
Delivery against identified efficiency savings: Commercial (Procurement & Income) %	32.62%	38.4%	47.90%	56.08%	60.69%	64.41%
Delivery against identified efficiency savings: Other local opportunities (%)	27.44%	36.07%	40.37%	50.99%	58.35%	68.13%
Identified efficiency savings %: Recurrent	47.30%	49.24%	49.89%	43.99%	43.72%	39.8%
Identified efficiency savings %: Non-recurrent savings	52.70%	50.86%	50.11%	56.01%	56.28%	60.2%

This measures: The achievement of our efficiency savings plans against the full year plan of £40.60m:

- 43.99% of the schemes identified are recurrent,
- 56.01% of the schemes identified are non-recurrent

How are we performing

- Our efficiency savings target is £40.60m for the 2025/26 financial year
- At year-to-date M09 December 2025, we have identified all our efficiency savings plan and delivered £25.55m

Actions and next steps:

- Fully track the progress of care groups and corporate directorates to ensure the ten-point action plan continue to be delivered
- Urgent care is £(0.22)m behind forecast, the requirement is to remain on budget for the rest of the year.
- Planned care holding vacancies to deliver the WTE efficiencies
- Additional action is required across the board to deliver the WTE efficiencies by March 2026

Risks: - Corporate Risk 4182
The non delivery of identified efficiency savings.

Royal Berkshire
NHS Foundation Trust

Watch Metrics

Summary of alerting watch metrics

Royal Berkshire NHS Foundation Trust

Introduction:

Across our five strategic objectives we have identified 110 metrics that we routinely monitor, we subject these to the same statistical tests as our strategic metrics and report on performance to our Board committees.

Should a metric exceed its process controls we undertake a check to determine whether further investigation is necessary and consider whether a focus should be given to the metric at our performance meetings with teams.

If a metric be significantly elevated for a prolonged period of time we may determine that the appropriate course of action is to include it within the strategic metrics for a period.

Alerting Metrics December 2025:

In the last month 17 of the 110 metrics exceeded their process controls, two more than last month. These are set out in the table opposite.

There are no new alerting watch metrics this month.

A number of the alerting relate to the operational pressures experienced in the Trust and the focus being given to enhancing flow and addressing diagnostic and cancer performance is expected to have impact on these metrics as well as the strategic metrics covered in the report above, this includes those relating to cancer, stroke and infection control.

Provide the highest quality of care for all

- Never Event
- C.diff (Cumulative – Trust Apportioned) 39 cases against a threshold of 39.
- Complaints turnaround time within 25 days (63% Trustwide)
- Sustained increase in number of child protection and adult safeguarding concerns raised by the Trust.
- Mixed sex accommodation breaches remains high(269)
- Continued increase in DoLs applications for last 3 months

Invest in our staff and live out or values

- % of staff from global majority backgrounds in senior AFC Bands 8a and above, currently sitting at 22.65%, with a target of 25.00%
- Rolling 12 month Sickness Absence data is in arrears but unlikely to meet target based on previous months and winter pressures
- Violence, Aggression and Abuse from patients towards staff has increased

Deliver in Partnership

- Proportion of patients with high risk TIA fully investigated and treated within 24 hours
- Proportion of patients admitted directly to an acute stroke unit within 4 hours of hospital arrival
- Cancer – Incomplete 104 days
- Diagnostics Waiting < 6 weeks (DM01) (%)

Achieve long term sustainability

- Debtors (£m)
- Cash Position (£m)
- Pay cost vs Budget (£m)
- Better Payment Practice Code

Strategic Objective: **Provide the highest quality care for all**

Watch metrics

SROs: Katie Prichard-Thomas

Janet Lippett

NHS Royal Berkshire NHS Foundation Trust

Metric	Variati	Assura	Target	Oct-25	Nov-25	Dec-25	Dec-24
Never Events			0	0	0	1	0
Pressure ulcer incidence per 1000 bed days			1.00	0.40	0.42	0.15	0.05
Category 2 avoidable pressure ulcers			5	1	0	2	1
Category 3 avoidable pressure ulcers			0	0	0	1	1
Category 4 avoidable pressure ulcers			0	0	0	0	0
Unstageable avoidable pressure ulcers			0	0	0	0	0
Patient Falls per 1000 bed days			5.00	3.58	2.97	3.94	4.83
Patient falls resulting in harm (PSIRF methodology applied)			-	0	0	2	0
No. of DOLS applications applied for			-	22	32	37	25
No. of detentions under the MH act to RBH			-	2	5	5	2
% of staff: Safeguarding children L1 training			90.00%	92.10%	96.80%	97.10%	96.80%
No. of child safeguarding concerns by the Trust			-	172	174	136	140
No. of adult safeguarding concerns by the Trust			-	82	65	83	28
No. of safeguarding concerns against the Trust			-	17	0	5	4
Unborn babies on child protection (CP) / child in need plans (CIP)			-	44	0	43	46
C.Diff (Cumulative - Trust Apportioned)			39	36	38	39	44
C.Diff lapses in care			-	6	2	3	0
MRSA Bacteraemia (avoidable)			0	0	1	0	0
E.coli (Trust Apportioned) Bloodstream Infections			-	7	8	8	7
E.coli (Trust Apportioned) Bloodstream Infections (Cumulative)			92	56	64	72	77
MSSA surveillance (trust acquired)			-	6	4	3	3
Hand Hygiene			95.00%	94.12%	94.71%	96.06%	95.70%
VTE inpatient (excluding short stay/maternity) risk assessment / prescription compliance			95.00%	96.80%	Arrears	Arrears	94.80%
Hospital Acquired Thrombosis (HAT) rate / 1000 inpatient admissions			0.00	1.04	Arrears	Arrears	1.30
Medication incidents per 1000 bed days			0.00	5.78	5.52	7.09	6.32

Strategic Objective: **Provide the highest quality care for all**

Watch metrics

SROs: Katie Prichard-Thomas

Janet Lippett

NHS Royal Berkshire NHS Foundation Trust

Metric	Variation	Assurance	Target	Oct-25	Nov-25	Dec-25	Dec-24
No. of compliments			-	59	28	52	77
FFT Satisfaction Rates Inpatients: i.Inpatients			95%	95%	96%	94%	95%
FFT Satisfaction Rates Inpatients: ii.ED			95%	78%	83%	83%	75%
FFT Satisfaction Rates Inpatients: iii.OPA			95%	95%	96%	96%	95%
FFT Satisfaction Rates Inpatients: iv.Daycases			95%	99%	99%	98%	95%
FFT Satisfaction Rates Inpatients: v.Children and Young People			95%	96%	100%	89%	95%
Mixed sex accommodation - breaches			0	303	269	264	339
Myocardial Ischaemia National Audit Project (MINAP): Door-to-Balloon target of less than 90 minutes			97%	85%	100%	Arrears	78%
Myocardial Ischaemia National Audit Project (MINAP): Call-to-Balloon target of less than 120 minutes			86%	90%	89%	Arrears	80%
Myocardial Ischaemia National Audit Project (MINAP): Call to Balloon target less of than 150 minutes			82%	100%	100%	Arrears	100%
No. of Patient Safety Incident Investigations (PSII)			-	1	0	4	2
No. of SWARM huddles			-	0	0	0	4
No. of After Action reviews			-	0	2	0	1
No. of Multidisciplinary Team (MDT) reviews			-	1	2	2	1
No. of Thematic reviews			-	0	0	0	3
Number of Complaints			-	73	51	54	27
Complaints turnaround time within 25 days (%)			80%	54%	40%	63%	73%

Mortality Metrics	Variation	Assurance	Target	Oct-24	Nov-24	Dec-24	Dec-23
Crude mortality			-	1.20	1.40	1.40	1.60
HSMR			100.0	97.0	98.1	101.0	82.9
SMR			100.0	97.5	98.3	100.2	83.0
SHMI			1.00	1.04	1.04	1.05	1.00

Strategic Objective: **Provide the highest quality care for all**

Maternity Watch metrics

SROs: Katie Prichard-Thomas

Janet Lippett

NHS Royal Berkshire NHS Foundation Trust

Metric	Variation	Assurance	Target	Oct-25	Nov-25	Dec-25	Dec-24
Deliveries			-	444	364	409	376
Bookings			-	490	502	442	495
% of Inductions of labour			-	27.1%	27.8%	22.7%	34.0%
Perinatal mortality rate (rolling year per 1000 births)			5.03	0.04	0.04	0.05	0.34
Number of occassions MLU service suspended for 4 hours or more			4	6	4	8	2
Midwifery staffing vacancy rate			-	0.7%	0.0%	0.0%	0.0%
Midwifery staffing turnover			14.0%	15.1%	10.8%	11.7%	9.5%
Midwife : birth ratio (utilised workforce)			1.22	1.24	1:19	0.00	1:19
FFT Satisfaction Rates Maternity			95.00%	95.00%	98.00%	97.40%	96.50%
No. of complaints - Maternity			3	4	6	5	1
Complaints response Rate			80.00%	60.00%	50.00%	0.00%	-
Number of Rapid Reviews			-	5	3	5	0
No. of After Action reviews			-	0	2	0	2
Percentage of babies born with features associated with potential hypoxia			1.50%	0.00%	0.00%	0.23%	1.33%
No. of Patient Safety Incident Investigations (PSII)			-	1	0	1	0

Strategic Objective: **Invest in our people and live out our values**

Watch metrics:

SRO: Paul da Gama

Royal Berkshire NHS Foundation Trust

Metric	Variation	Assurance	Target	Oct-25	Nov-25	Dec-25	Dec-24
% of staff from global majority backgrounds in senior AFC Bands 8a and above	H	F	25.00%	22.01%	22.01%	22.65%	19.55%
Rolling 12 month Sickness absence	H	F	3.3%	3.8%	3.8%	Arrears	3.7%
% Fill rate of Registered Nurse Shifts (RN)	L	P	90.0%	94.0%	94.6%	93.2%	96.7%
% Fill rate of Care Support Worker Shifts (CSW)	L	P	90.0%	94.8%	98.2%	95.6%	105.0%
Completed Mandatory Training		P	90.0%	92.3%	91.7%	92.8%	93.0%
Appraisals	H	F	90.0%	89.0%	88.7%	90.3%	89.1%
Nurse Staffing Red Flags			-	40	22	54	42

Strategic Objective: **Invest in our people and live out our values**

Watch metrics:

SRO: Paul da Gama

Royal Berkshire NHS Foundation Trust

Metric	Variation	Assurance	Target	Oct-25	Nov-25	Dec-25	Dec-24
RIDDOR reportable Incidents			-	1	0	0	5
Abuse/V&A (Patient to staff)			-	60	55	75	64
Body fluid exposure/needle stick injury			-	20	17	16	15
Environment Related Incidents			-	11	12	13	20
Conflict Resolution		?	90%	88%	89%	90%	88%
Fire (Annual)		?	90%	92%	93%	93%	91%
Moving and Handling Level 1	H	?	90%	96%	96%	95%	91%
Moving and Handling Level 2		?	90%	89%	89%	89%	94%
Health and Safety Training			-	95%	96%	96%	97%
Slips and Trips			-	4	5	5	2
Musculoskeletal - Inanimate object			-	3	2	1	1
Total non clinical incidents reported			-	247	259	234	279

Strategic Objective: **Delivering in partnership**

Watch metrics

SRO: Dom Hardy

Royal Berkshire NHS Foundation Trust

Metric	Variation	Assurance	Target	Oct-25	Nov-25	Dec-25	Dec-24
Fractured Neck of Femur: Surg in 36 hours			75.0%	52.0%	57.0%	57.0%	42.9%
Proportion of patients admitted directly to an acute stroke unit within 4 hours of hospital arrival		F	90.0%	75.0%	79.0%	69.0%	56.0%
Proportion of patients spending 90% of their inpatient stay on a specialist stroke unit (national target)	H	?	80.0%	86.0%	91.0%	94.0%	84.0%
Proportion of people with high risk TIA fully investigated and treated within 24hrs (IPM national target)	H	F	90.0%	91.0%	94.0%	87.0%	77.0%
Cancer 31 day wait: to first treatment		?	96.0%	95.3%	91.5%	95.1%	97.7%
62 Day screen Ref		?	85.0%	75.0%	77.8%	93.8%	78.9%
Cancer Incomplete 104 days		F	0	80	57	48	70
Average waiting times in diagnostic (DM01) services	L	?	6	4	4	0	5
Diagnostics Waiting < 6 weeks (DM01) (%)		F	99.0%	88.4%	83.2%	0.0%	87.4%

Strategic Objective: Cultivate Innovation and Improvement

Watch metrics

SRO: Andrew Statham

Royal Berkshire NHS Foundation Trust

Metric	Variation	Assurance	Target	Oct-25	Nov-25	Dec-25	Dec-24
% OP appointments done virtually			-	19.7%	19.2%	20.0%	19.4%
Number of OPPROC			-	16311	13486	12798	11806
Number of MDT OP			-	891	837	769	694
Number of PIs			-	140	140	142	127
Number of active research trials			-	189	195	199	158
Number of projects supported by HIP			-	63	63	64	58

Strategic Objective: **Achieve long-term sustainability**

Watch metrics

SRO: Helen Troalen

NHS Royal Berkshire NHS Foundation Trust

Metric	Variation	Assurance	Target	Oct-25	Nov-25	Dec-25	Dec-24
Pay cost vs Budget (£m)			-	-0.73	-0.59	-1.15	0.13
Non pay cost vs Budget (£m)			-	-1.32	-0.69	-0.73	-4.23
Income vs Plan (£m)			-	2.04	1.22	1.95	2.57
Daycase actual vs Plan (£m)			-	-0.11	-0.32	-1.22	0.83
Elective actual vs Plan (£m)			-	0.23	-0.03	-0.58	0.42
Outpatients actual vs Plan (£m)			-	0.73	1.12	0.28	0.13
Non-elective actual vs plan (£m)			-	0.96	-0.50	-0.36	-0.26
A&E actual vs plan (£m)			-	0.35	0.65	-0.03	0.04
Drugs & devices actual vs plan (£m)			-	1.01	0.33	1.02	1.17
Other patient income (£m)			-	0.05	-0.26	-0.14	0.05
Delivery of capital programme (£m)			-	2.58	6.64	2.67	1.58
Cash position (£m)			-	21.96	19.72	5.35	6.17
Agency spend % of total staff cost (%)			-	0.4%	0.4%	0.4%	1.1%
Creditors (£m)			-	-139.28	-94.86	-82.79	-70.51
Debtors (£m)			-	51.28	51.65	52.77	46.52
Better Payment Practice Code (BPPC) *paying supplier invoices within 30 days of date of invoice (%) YTD			95.00%	73.10%	89.30%	88.80%	78.80%
Better Payment Practice Code (BPPC) *paying supplier invoices within 30 days of date of invoice (%) In Month			95.00%	54.70%	86.20%	85.30%	76.20%

NHS
Royal Berkshire
NHS Foundation Trust

Title:	**Standing Orders**
Agenda item no:	8
Meeting:	Audit & Risk Committee
Date:	14 January 2026
Presented by:	Caroline Lynch, Trust Secretary
Prepared by:	Caroline Lynch, Trust Secretary

Purpose of the Report	The Trust's Standing Orders are reviewed on an annual basis. No changes have been made.

Report History	Audit & Risk Committee 14 January 2026

What action is required?	
Assurance	
Information	
Discussion/input	
Decision/approval	The Board is asked to approve the Standing Orders

Resource Impact:	None
Relationship to Risk in BAF:	n/a
Corporate Risk Register (CRR) Reference /score	n/a
Title of CRR	n/a

Strategic objectives This report impacts on (tick all that apply)::**	
Delivering the highest quality care for all	✓
Supporting our people to thrive	✓
Partnering for impact	✓
Driving improvement and enabling innovation	✓
Building a sustainable future together	✓

Well Led Framework applicability:			Not applicable ☐
1. Leadership ☐	2. Vision & Strategy ☐	3. Culture ☐	4. Governance ☐
5. Risks, Issues & Performance ☐	6. Information Management ☐	7. Engagement ☐	8. Learning & Innovation ☐

Publication						
Published on website		Confidentiality (FoI)	Private		Public	

Royal Berkshire
NHS Foundation Trust

Board of Directors

Standing Orders

Agreed:	September 2014
Last Reviewed	January 2026

CONTENTS

INTRODUCTION

Statutory Framework

The Royal Berkshire NHS Foundation Trust (the Trust) is a public benefit corporation authorised by the Independent Regulator of NHS Foundation Trusts under the Health and Social Care Act 2012.

The Trust's principal places of business are:

Royal Berkshire Hospital London Road Reading RG1 5AN	West Berkshire Community Hospital Benham Hill Thatcham Berkshire RG18 3AS
Bracknell Healthspace Eastern Gate Brants Bridge Bracknell Berkshire RG12 9RT	Townlands Memorial Hospital York Road Henley-on-Thames Oxfordshire RG9 2DR
Prince Charles Eye Unit King Edward VII Hospital St Leonard's Road Windsor SL4 3DP	Windsor Dialysis Satellite Unit 1 Maidenhead Road Windsor SL4 5EY
Princes House 73a London Rd Reading Berkshire RG1 5UZ	Dingley Child Development Centre Erlegh House, Earley Gate, Whiteknights Road, University of Reading Campus, Reading RG6 6BZ.

NHS Trusts are governed by statute, mainly the Health and Social Care Act 2012, by their constitutions and by the terms of their authorisation by the Independent Regulator (the Regulatory Framework).

The functions of the Trust are conferred by the Regulatory Framework.
As a body corporate the Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable. The Trust also has a common law duty as a bailee for patients' property held by the Trust on behalf of patients.

Delegation of Powers

Under the Standing Orders relating to the Arrangements for the Exercise of Functions (SO 4) the Board exercises its powers to make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee appointed by virtue of SO 5 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Board thinks fit or as NHS

England may direct. Delegated Powers are covered in a separate document (Reservation of Powers to the Board and Delegation of Powers). That document is incorporated within the Standing Financial Instructions (SFIs) and has effect as if incorporated into the Standing Orders (SOs).

1. INTERPRETATION

1.1 Save as permitted by law, and subject to the Constitution, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which he/she should be advised by the Chief Executive or Secretary).

1.2 Any expression to which a meaning is given in the Health Service Acts or in the Regulations or Orders made under the Acts shall have the same meaning in this interpretation and in addition:

"ACCOUNTABLE OFFICER" shall be the Officer responsible and accountable for funds entrusted to the Trust. He/She shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

"TRUST" means the Royal Berkshire NHS Foundation Trust.

"BOARD" means the Board of Directors as constituted in accordance with the Constitution of the Trust.

"COUNCIL OF GOVERNORS" means the Council of Governors as constituted in accordance with the Constitution, which has the same meaning as the Board of Governors in the 2003 Act.

"BUDGET" shall mean a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

"CHAIR" is the person appointed by the Council of Governors to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall be deemed to include the Deputy Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

"CHIEF EXECUTIVE" shall mean the chief executive officer of the Trust.

"COMMITTEE" shall mean a committee appointed by the Board.

"COMMITTEE MEMBERS" shall be persons formally appointed by the Board to sit on or to chair specific committees.

"DEPUTY CHAIR" means the non-executive Director appointed by the Trust to take on the Chair's duties if the Chair is absent for any reason.

"DIRECTOR" means a member of the Board of Directors.

"HE/SHE & HIS/HERS" shall refer to the appropriate postholder and are to be read as the gender of that post which may change.

"FUNDS HELD ON TRUST" shall mean those funds which the Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept. Such funds may or may not be charitable.

"MOTION" MEANS a formal proposition to be discussed and voted on during the course of a meeting.

"NOMINATED OFFICER" means an officer charged with the responsibility for discharging specific tasks within SOs and SFIs.

"NON-EXECUTIVE DIRECTOR" means a Director, including the Chair of the Trust, who does not hold an executive office of the Trust

"OFFICER" means an employee of the Trust.

"SECRETARY" means the Secretary of the Trust or any other person appointed to perform the duties of the Secretary, including a joint, assistant or deputy secretary.

"SFIs" means Standing Financial Instructions.

Senior Independent Director –A Non-executive director of the Trust appointed to provide a sounding board for the Chair of the Trust and to serve as an intermediary for the other directors when necessary

"SOs" means Standing Orders.

2. THE TRUST

2.1 All business shall be conducted in the name of the Trust.

2.2 All funds received in trust shall be in the name of the Trust as corporate trustee. In relation to funds held on trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

2.3 The Trust has resolved that certain powers and decisions may only be exercised or made by the Board in formal session. These powers and decisions are set out in "Reservation of Powers to the Board" (included in the Standing Financial Instructions) and have effect as if incorporated into the Standing Orders.

2.4 **Composition of the Trust Board** - In accordance with the Constitution the composition of the Board of the Trust shall be:

The Chair of the Trust

Up to 7 non-executive Directors

Up to 7 executive Directors including:

- the Chief Executive (the Chief Officer)

- the Chief Finance Officer
- a registered medical or dental practitioner
- a registered nurse or midwife
- up to 3 other executive directors

2.5 **Appointment of the Chair and Non-Executive Directors** – In accordance with the Constitution the Chair and the other non-executive Directors are appointed and removed by the council members at a general meeting. The appointment process followed will be in accordance with the terms of the Constitution.

2.6 In accordance with the Constitution the non-executive Directors of the Trust will appoint and remove the Chief Executive as a director of the Trust. The appointment of the Chief Executive is subject to the approval of a majority of the members of the Council of Governors present and voting at a meeting of the Council of Governors.

2.7 **Terms of Office of the Chair and Non-Executive Directors** – The Chair and the non-executive Directors are to be appointed for a period of office of three years in accordance with the terms and conditions of office decided by the Council of Governors at a general meeting.

2.8 **Terms of Office of Executive Directors** - The Board Nomination and Remuneration Committee of non-executive Directors shall decide the terms and conditions of office including remuneration and allowances of executive Directors.

2.9 **Appointment of Deputy Chair** - For the purpose of enabling the proceedings of the Trust to be conducted in the absence of the Chair of the Trust, the Council of Governors may appoint a non-executive Director to be Deputy Chair for such a period, not exceeding the remainder of his/her term as non-executive Director of the Trust, as they may specify on appointing him/her. If the Chair is unable to discharge their office as Chair of the Trust, the Deputy Chair of the Board of Directors shall be acting Chair of the Trust.

2.10 Any non-executive Director so elected may at any time resign from the office as Deputy Chair by giving notice in writing to the Chair and the Directors of the Trust who may thereupon appoint another non-executive Director as Deputy Chair in accordance with paragraph 2.9.

2.11 **Powers of Deputy Chair** - Where the Chair of the Trust has died or has otherwise ceased to hold office or where he/she has been unable to perform his/her duties as Chair owing to illness, absence from England and Wales or any other cause, references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform his/her duties, be taken to include references to the Deputy Chair.

2.12 **Senior Independent Director role** -

- Be available to Directors, Governors, members of the Trust or other stakeholders if they have concerns relating to matters which contact through the normal channels of Chair of the Trust, Chief Executive, Secretary or Chief Finance Officer has failed to resolve, or for which such contact is inappropriate

- Attend sufficient meetings of Governors to give them an opportunity to express concerns

- Convene and chair meetings of the Board, or any part of a Board meeting, at which matters concerning the Chair of the Trust are considered.

3. MEETINGS OF THE BOARD OF DIRECTORS

3.1 **Calling Meetings** - Ordinary meetings of the Board shall be held at such times and places as the Board may determine.

3.2 Meetings of the Board will be called by the Secretary, or by the Chair of the Trust, or by four Directors (a minimum of one Executive and one Non Executive Director) who give written notice to the Secretary specifying the business to be carried out. The Secretary shall send a written notice to all Directors as soon as possible after the receipt of such a request. The Secretary shall call a meeting on at least fourteen but not more than twenty-eight days' notice (except in the case of emergencies) to discuss the specified business. If the Secretary fails to call such a meeting then the Chair or four Directors, whichever is the case, shall call such a meeting.

3.3 **Notice of Meetings** – Save in the case of emergencies or the need to conduct urgent business, the Secretary shall give to all Directors at least fourteen days written notice of the date and place of every meeting of the Board of Directors.

3.4 Before each meeting of the Board, a notice of the meeting, specifying the business proposed to be transacted at it, shall be delivered to every Director, sent electronically or by post to the usual place of residence of such Director, so as to be available to him/her at least 5 clear days before the meeting (or less at the agreement of the Chair of the Committee/Board). 'Clear days' excludes bank holidays and weekends.

3.5 Lack of service of the notice on any director shall not affect the validity of a meeting.

3.6 Failure to serve such a notice on more than 2 Directors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post.

3.7 In the case of a meeting called by Directors or the Chair in default of the Secretary, the notice shall be signed either by those Directors or the Chair and no business shall be transacted at the meeting other than that specified in the notice.

3.8 **Setting the Agenda** - The Board may determine that certain matters shall appear on every agenda for a meeting of the Board and shall be addressed prior to any other business being conducted.

3.9 A Director desiring a matter to be included on an agenda shall make his/her request in writing to the Secretary at least 10 clear days before the meeting, subject to SO 3.3. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chair.

3.10 **Chair of Meeting** - The Chair of the Trust, or in their absence the Deputy Chair of the Board, and in their absence one of the other non-executive Directors in attendance is to chair meetings of the Board.

3.11 If the Chair is absent from a meeting temporarily on the grounds of a declared conflict of interest the Deputy Chair, if present, shall preside. If the Chair and Deputy Chair are absent, or are disqualified from participating, such non-executive Director as the Directors present shall choose who shall preside.

3.12 **Annual General Meeting -** In accordance with the Constitution the Trust will hold a members meeting (the "Annual General Meeting") within nine months of the end of the financial year.

3.13 **Notices of Motion** - A Director of the Trust desiring to move or amend a motion shall send a written notice thereof at least 10 clear days before the meeting to the Secretary, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda subject to SO 3.7.

3.14 **Withdrawal of Motion or Amendments** - A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

3.15 **Motion to Rescind a Resolution** - Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding 6 calendar months shall bear the signature of the Director who gives it and also the signature of 4 other Directors. When any such motion has been disposed of by the Board, it shall not be competent for any Director other than the Chair to propose a motion to the same effect within 6 months; however the Chair may do so if he/she considers it appropriate.

3.16 **Motions** - The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

3.17 When a motion is under discussion or immediately prior to discussion it shall be open to a Director to move:

- An amendment to the motion.
- The adjournment of the discussion or the meeting.
- That the meeting proceed to the next business. (*)
- The appointment of an ad hoc committee to deal with a specific item of business.
- That the motion be now put. (*)

* In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a Director who has not previously taken part in the debate and who is eligible to vote. No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

3.18 **Chair's Ruling** - Statements of Directors made at meetings of the Board shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

3.19 **Voting** - Every question at a meeting shall be determined by a majority of the votes of the Directors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a second or casting vote.

3.20 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Directors present so request.

3.21 If at least one-third of the Directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained.

3.22 If a Director so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

3.23 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

3.24 The Board may agree that its members can participate in its meetings by telephone, video or computer link. Participation in the meeting in this manner shall be deemed to constitute presence in person at such meeting.

3.25 A resolution in writing signed by all of the Directors entitled to receive notice of a meeting of the Board of Directors shall be as valid and effectual as if it had been passed at a meeting of the Board of Directors duly convened and held and may consist of several documents in the like form each signed by one or more directors.

3.26 A resolution in electronic form sent to all of the Directors entitled to receive notice of a meeting of the Board of Directors by electronic communication (for the purposes of this provision "electronic communication" means a communication transmitted (whether from one person to another, from one device to another or from a person to a device or vice versa) (a) by means of an electronic communications network; or (b) by other means but while in an electronic form) to the electronic addresses notified to the Trust by each of the directors, shall be as valid and effectual as if it had been passed at a meeting of the Board of Directors duly convened and held provided that each and every director entitled to receive a notice of a meeting of the Board of Directors responds by electronic communication to the electronic address from which the resolution in electronic form was transmitted from, confirming their acceptance of the resolution.

3.27 An acting director who has been appointed formally to carry out a vacant Director's duties during a period of temporary incapacity, shall be entitled to exercise the voting rights of the executive Director. An officer attending the Board to represent an executive Director during a period of incapacity or temporary absence without being formally appointed to the Board may not exercise the voting rights of the executive Director. An officer's status when attending a meeting shall be recorded in the minutes.

3.28 **Minutes** - The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

3.29 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

3.30 Minutes shall be circulated in accordance with the Boards' wishes.

3.31 **Suspension of Standing Orders** - Except where this would contravene any statutory provision or any direction made by the Secretary of State, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Board are present, including one executive Director and one non-executive Director, and that a majority of those present vote in favour of suspension.

3.32 A decision to suspend SOs shall be recorded in the minutes of the meeting and the circumstances subsequently reviewed by the Audit & Risk Committee.

3.33 A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the Directors.

3.34 No formal business may be transacted while SOs are suspended.

3.35 **Variation and Amendment of Standing Orders** - These Standing Orders shall be amended only if:

- a notice of motion under Standing Order 3.13 has been given; and
- no fewer than half the total of the Trust's non-executive Directors vote in favour of amendment; and
- at least two-thirds of the Directors are present ; and
- the variation proposed does not contravene a statutory provision or direction made by the Secretary of State.

3.36 **Record of Attendance** - The names of the Directors present at the meeting shall be recorded in the minutes.

3.37 **Quorum** -.Seven Directors, including not less than three executive Directors and not less than four non-executive Directors shall form a quorum.

3.38 An officer in attendance for an executive Director but without formal acting up status may not count towards the quorum.

3.39 If a Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SO 6 or 7) he/she shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least two executive Directors to form part of the quorum shall not apply where the executive Directors are excluded from a meeting.

4. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

4.1 The Board may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee, appointed by virtue of SO 5.1 or 5.2 below or by a Director or an officer of the Trust in each case subject to such restrictions and conditions as the Board considers appropriate.

4.2 **Emergency Powers** - The powers which the Board has retained to itself within these Standing Orders (SO 2.3) may in emergency be exercised by the Chief Executive and the Chair of the Trust after having consulted at least two Non Executive Directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board for ratification.

4.3 **Delegation to Committees** – The Board shall agree from time to time to the delegation of executive powers to be exercised by committees which it has formally constituted. The constitution and terms of reference of these committees, and their specific executive powers shall be approved by the Board.

4.4 **Delegation to Officers** - Those functions of the Trust which have not been retained as reserved by the Board or delegated to an executive committee or committee shall be exercised on behalf of the Board by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain an accountability to the Board.

4.5 The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board as indicated above.

4.6 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board or the Chief Finance Officer or other executive Director to provide information and advise the Board in accordance with any statutory requirements or the Independent Regulator.

4.7 The arrangements made by the Board as set out in the "Reservation of Powers to the Board and Delegation of Powers" shall have effect as if incorporated in these Standing Orders.

5. COMMITTEES

5.1 **Appointment of committees** - The Board may appoint committees of the Board, consisting wholly or partly of Directors of the Trust or wholly of persons who are not Directors of the Trust.

5.2 A committee appointed under SO 5.1 may, subject to such directions as may be given by the Independent Regulator or the Board appoint committees of the Board consisting wholly or partly of members of the committee.

5.3 The Standing Orders of the Board, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees of the Board.

5.4 Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide. Such terms of reference shall have effect as if incorporated into the Standing Orders.

5.5 All Board committees will be chaired by a non-executive director.

5.6 Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Board.

5.7 The Board shall approve the appointments to each of the committees which it has formally constituted.

5.8 Where the Trust is required to appoint persons to a committee and/or to undertake statutory functions as required by NHS England, and where such appointments are to operate independently of the Board such appointment shall be made in accordance with applicable statute and regulations and with the guidance issued by NHS England.

5.9 The Committees established by the Board are:

- Nominations and Remuneration
- Audit and Risk
- Quality
- Charity
- Finance & Investment
- People

At least three Non-Executive Directors and two Executive Directors are members of each Committee (other than the Audit & Risk and Charity Committees)

5.10 **Confidentiality** - A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Board or shall otherwise have concluded on that matter.

5.11 A Director of the Trust or a member of a committee shall not disclose any matter reported to the Board or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board or committee shall resolve that it is confidential.

6. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

6.1 **Declaration of Interests** - Directors must declare interests which are relevant and material to the NHS Foundation Trust of which they are a Director. All existing Directors should declare such interests. Any Directors appointed subsequently should do so on appointment.

6.2 Interests which should be regarded as "relevant and material" are as specified in the Constitution.

6.3 If Directors have any doubt about the relevance of an interest, this should be discussed with the Secretary.

6.4 At the time Directors' interests are declared, they should be recorded in the Board minutes. Any changes in interests should be declared at the next Board meeting following the change occurring.

6.5 Directors' Directorships of companies likely or possibly seeking to do business with the NHS should be published on the Trust's website.

6.6 During the course of a Board meeting, if a conflict of interest is established, the Director concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

6.7 **Register of Interests** – In accordance with the Constitution, the Secretary will ensure that a Register of Interests is established to record formally declarations of interests of Directors.

6.8 These details will be kept up to date by means of, as a minimum, an annual review of the Register.

6.9 All appropriate staff will be asked to declare any interest and a record of interests will be kept.

6.10 The Register of Board interests will be available to the public.

7. DISABILITY OF DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

7.1 Subject to the following provisions of this Standing Order, if a Director of the Trust has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board at which the contract or other matter is the subject of consideration, he/she shall at the meeting and as soon as practicable after its commencement disclose the fact

and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

The above SO applies if the pecuniary interest relates to the spouse or a cohabiting partner.

7.2 The Board shall exclude a Director from a meeting of the Board while any contract, proposed contract or other matter in which he/she has a pecuniary interest, is under consideration.

7.3 Standing Order 7 applies to a committee of the Board as it applies to the Board and applies to any member of any such committee (whether or not he/she is also a Director) as it applies to a Director.

8. STANDARDS OF BUSINESS CONDUCT

8.1 **Policy** - Staff must comply with the national guidance contained in Managing Conflicts of Interest in the NHS: Guidance for staff and organisations". The following provisions should be read in conjunction with this document.

8.2 **Interest of Officers in Contracts** - If it comes to the knowledge of a Director or an officer of the Trust that a contract in which he/she has any pecuniary interest not being a contract to which he/she is themself a party, has been, or is proposed to be, entered into by the Trust he/she shall, at once, give notice in writing to the Secretary of the fact that he/she is interested therein. In the case of married persons or persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

8.3 An officer must also declare to the Chief Executive any other employment or business or other relationship of his, or of a cohabiting partner, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust. A register of declared interests of staff shall be kept and maintained by means of an annual review.

8.4 **Canvassing of, and Recommendations by, Directors in Relation to Appointments** - Canvassing of Directors of the Trust or members of any committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

8.5 A Director of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this Standing Order shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

8.6 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

8.7 **Relatives of Directors or Officers** - Candidates for any staff appointment shall when making application disclose in writing whether they are related to any

Director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him/her liable to instant dismissal.

8.8 The Directors and every officer of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature that Director or officer is aware. It shall be the duty of the Chief Executive to report to the Trust any such disclosure made.

8.9 On appointment, Directors (and prior to acceptance of an appointment in the case of executive Directors) should disclose to the Board whether they are related to any other Director or holder of any office under the Trust.

8.10 Where the relationship of an officer or another Director to a Director of the Trust is disclosed, the Standing Order headed `Disability of Directors in proceedings on account of pecuniary interest' (SO 7) shall apply.

8.11 All managers must comply with The Code of Conduct for NHS Managers Directions 2002

9. CUSTODY OF SEAL AND SEALING OF DOCUMENTS

9.1 **Custody of Seal** - The Common Seal of the Trust shall be kept by the Trust Secretary in a secure place

9.2 **Sealing of Documents** - Where a seal is required to be affixed to a document it will be witnessed and sealed by the signature of two of the below

- the Chief Executive
- the Chair of the Trust
- any other Executive Board Director
- Secretary

9.3 As a general guide the seal should be used for:

- all land and property transactions which are required to be executed as a Deed
- any other contract required to be executed under seal rather than as a simple contract

9.4 Before any building, engineering, property or capital document is sealed it must be approved and signed by the Chief Finance Officer (or an officer nominated by him/her) and authorised and countersigned by the Chief Executive (or an officer nominated by him/her who shall not be within the originating Directorate).

9.5 **Register of Sealing** - An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the

persons who shall have approved and authorised the document and those who attested the seal.

10. SIGNATURE OF DOCUMENTS

10.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

10.2 The Chief Executive or nominated officers shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board or committee to which the Board has delegated appropriate authority.

11. MISCELLANEOUS

11.1 **Standing Orders to be given to Directors and Officers** - It is the duty of the Chief Executive to ensure that existing Directors and officers and all new appointees are notified of and understand their responsibilities within Standing Orders and SFIs. Updated copies shall be issued to staff designated by the Chief Executive. New designated officers shall be informed in writing and shall receive copies where appropriate of SOs.

11.2 **Documents having the standing of Standing Orders** - Standing Financial Instructions and Reservation of Powers to the Board and Delegation of Powers shall have the effect as if incorporated into SOs.

11.3 **Review of Standing Orders** - Standing Orders shall be reviewed annually by the Secretary to the Trust. The requirement for review extends to all documents having the effect as if incorporated in SOs. The Board of Directors will subsequently review and approve the Standing Orders annually.

NHS
Royal Berkshire
NHS Foundation Trust

Board Work Plan 2026

Focus	Item	Lead	Freq	Jan-26	Mar-26	May-26	Jul-26	Sep-26	Nov-26
Delivering the highest quality of care for all	Winter Plan	DH	Annually						
Supporting our people to thrive	Patient Story	Exec	Every						
	Staff Story	Exec	Every						
0	Quarterly Forecast	HT	Quarterly						
	2026/27 Budget	HT	Annually						
	2026/27 Capital Plan	HT	Annually						
	Operating Plan/ Business Plan 2026/27	AS	Annually						
	The Green Plan	HT	Annually						
Driving improvement and enabling innovation	Standing Financial Instructions	HT	Annually						
	Trust Strategy Refresh	AS	Nov-25						
Other / Governance	Chief Executive Report	SM	Every						
	Board Assurance Framework	CL	Bi-Annually						
	Corporate Risk Register	KP-T	Bi-Annually						
	Integrated Performance Report (IPR)	Exec	Every						
	NHSE Annual Self-Certification	HT/CL	Annually						
	Standing Orders Review	CL	Annually						
	Board Work Plan	CL	Every						