Royal Berkshire
NHS Foundation Trust

Public Board - 25 November 2026

MEETING

25 November 2026 09:00 GMT

PUBLISHED
23 November 2026

Agenda

Location	Date	Time
Seminar Room, Trust Education Centre, Royal Berkshire Hospital	25 Nov 2026	09:00 GMT

	Item	Owner	Time	Page
1	Apologies for Absence and Declarations of Interest (Verbal)	Oke Eleazu		-
2	Patient Story (Verbal)	Katie Prichard-Thomas	09:00	-
3	Staff Story (Verbal)	Andrew Statham	09:30	-
4	Minutes for Approval: 23 September 2026 & Matters Arising Schedule	Caroline Lynch	10:00	3
5	Board Committee Chair Assurance Reports:		10:05	-
5.1	Innovation & Transformation Committee: 16 September 2026	Umesh Jetha		9
5.2	People Committee: 21 September 2026	Catherine McLaughlin		11
5.3	Finance & Investment Committee: 21 October 2026 & 18 November 2026	Mike O'Donovan		13
5.4	Audit & Risk Committee: 11 November 2026	Mike McEnaney		17
6	Chief Executive's Report	James Blythe	10:30	19
7	Integrated Performance Report	Frances Khatcherian	10:50	24
8	Trust Response to Thirlwall Inquiry	Katie Prichard-Thomas	11:15	54
9	Maternity & Neonatal 10 Point Plan	Katie Prichard-Thomas	11:30	60
10	Board Assurance Framework	Caroline Lynch	11:45	65
11	Corporate Risk Register	Katie Prichard-Thomas	11:50	74
12	Work Plan	Caroline Lynch		78
13	Date of Next Meeting: Wednesday 27 January 2027 at 09.00am			-
14	Minutes of Board Committee Meetings (To Note)			-
14.1	Quality Committee: 3 September 2026			79
14.2	Audit & Risk Committee: 9 September 2026			85
14.3	Innovation & Transformation Committee: 16 September 2026			90
14.4	Finance & Investment Committee: 16 September 2026 & 21 October 2026			94
14.5	People Committee: 21 September 2026			99

Royal Berkshire NHS Foundation Trust

Minutes

Board of Directors

Wednesday 23 September 2026
09.00 – 11.55
Seminar Room, Trust Education Centre, Royal Berkshire Hospital

Present

Mr. Oke Eleazu	(Chair)
Mr. James Blythe	(Chief Executive)
Mr. Dom Hardy	(Chief Operating Officer)
Dr. Minoo Irani	(Non-Executive Director)
Mr. Umesh Jetha	(Non-Executive Director)
Mrs. Frances Khatcherian	(Chief Finance Officer)
Dr. Janet Lippett	(Chief Medical Officer)
Mr. Mike McEnaney	(Non-Executive Director)
Ms. Catherine McLaughlin	(Non-Executive Director)
Mr. Mike O'Donovan	(Non-Executive Director)
Ms. Katie Prichard-Thomas	(Chief Nursing Officer)
Mr. Andrew Statham	(Chief Strategy Officer)

In attendance

Mr. Dwayne Gilliane	(Associate Director of Occupational Health & Wellbeing)
Mrs. Caroline Lynch	(Trust Secretary)

Apologies

Mr. Paul da Gama	(Chief People Officer)
Dr. Rupa Joshi	(Non-Executive Director)

There were seven members of staff and three members of the public present.

133/26 Star Cards

The Chief Strategy Officer provided an overview of Star Cards that were used by staff and patients to recognise the efforts of members of staff. The Communications team received circa 60 to 70 nominations a month and all nominees were advised accordingly. A monthly winner was then selected by the Executive team. The Chair had proposed that winners should be invited to the Board meeting to be presented with a certificate and gift card and, going forward, this would be on a quarterly basis.

The Chief Executive advised that the Star Card winners for May to August 2026 were Beth, Stephen, Angie and Jade and read out each of their nominations. The Chief Executive and Chair presented Beth, Stephen and Angie with their awards. The Chief Nursing Officer would present Jade with her award at a later date as Jade had been unable to attend the meeting.

The Board congratulated the winners on their awards.

134/26 Patient Story

The Chief Operating Officer introduced Ange, Director of Nursing, Urgent Care who advised that the story was to highlight the impact of patients presenting to the Emergency Department (ED)

with a mental health crisis. Ange introduced the Ian's wife and daughter who advised that Ian had attended the ED and had spent 7 days there which had resulted in frustration for both the family and staff. Ian's daughter provided an overview of her dad's successful career and had been a very independent man. However, Ian had attempted suicide which had led to his presentation at ED. Ian's wife and daughter highlighted a number of issues with the area where Ian had been placed including a blocked sink and had not been offered a shower for a number of days. The family visited every day and Ian had been on a trolley rather than a bed. The family also highlighted an issue in relation to communication and had issued a formal complaint to Berkshire Healthcare Foundation Trust (BHFT) as they had not carried out a formal assessment for Ian and had suggested he could return home. The family created an emergency exit plan as they considered that it was not appropriate for Ian to return home. Ian was eventually discharged to Prospect Park Hospital where he spent 3 months. Ange highlighted that there were lessons for the Trust in relation to improving both engagement with the family and improving environment in ED although it was not an appropriate place for patients with mental health issues to stay for long periods of time.

135/26 Staff Story

Jess, Lead Nurse for ED, advised that Ian's story highlighted the difficulties in caring for mental health patients in ED. Patients were placed in a quiet side room although there was further learning highlighted by the family such as staff not sitting outside the room but engaging more with the patient themself. Jess advised that staff in ED were often fatigued and not fully equipped to care for mental health patients. Work was ongoing in collaboration with BHFT and the Physiological Medicine Service (PMS) team focussing on patient experience. The escalation process had been streamlined and BHFT staff attended the Trust's bed meetings. The Trust also shared data with BHFT in relation to patients attending ED who had not previously accessed BHFT services. The lessons learned from Ian's experience had been shared with staff including the importance of engaging with patients rather than just observing and each patient needing to be assessed individually.

The Chief Executive advised that whilst the Trust continued to work with BHFT it was important to address issues within the Trust. The Board noted that Ian's family had raised an informal complaint with the Trust as they considered it was important to share their experience.

The Board thanked Ian's family for attending to present his story.

136/26 Minutes for approval: 29 July 2026 and Matters Arising Schedule

The minutes of the meeting held on 29 July 2026 were agreed as a correct record and signed by the Chair. There were no matters arising.

137/26 Minutes of Board Committee Meetings and Committee Updates

Finance & Investment Committee: 15 July and 16 September 2026

The Chair of the Finance & Investment Committee advised that the Committee had discussed Month 3 financial position at its July meeting. This was on budget although there was a need to identify additional recurrent savings. The Committee had reviewed the Estates Master Plan and had reviewed and recommended the capital programme for 2026/27 to the Board. At the September meeting the Committee had reviewed the Month 5 financial position and also reviewed the Long Term Resourcing Model (LTRM) with a focus on income and transformation. The Chief Finance Officer confirmed that the there was important focus on identifying recurrent savings and scenarios on the impact of the Trust's financial position had been discussed with the Executive Management Committee (EMC). The Chief Executive advised that the discussion held with EMC had been difficult and this demonstrated their understanding of the challenge.

Charity Committee: 25 August 2026

The Chair of the Charity Committee advised that the Committee had approved grant application and noted the receipt of grants of £100k secured in Quarter 2, 2026/27. The Committee had also approved specialist consultancy support for the development of the Charity's major appeal. The Chair of the Charity Committee highlighted the rescheduling of the 'Thankathon' to November 2026 and sought Board members support for the event.

The Board discussed the use of charitable funds noting that this could not be used for funding core equipment for the Trust.

Quality Committee: 3 September 2026

The Chair of the Quality Committee advised that, at the September meeting, the Committee received the baseline assessment for the maternity and neonates 10 point plan. The Committee had also received an update on the clinical accreditation scheme, had noted the majority of actions from the patient safety internal audit had been completed. C Diff. infection rates remained below the threshold. The Committee had noted the themes from moderate or above incidents in maternity related to theatre capacity and induction of labour delays.

The Chair of the Quality Committee advised that the Executive Management Committee (EMC) had agreed to add National Patient Safety Syllabus (NPSS) training to role specific profiles and this was a Chief Nursing Officer driver metric. Training compliance was improving and the patient safety team were working with managers on this.

Audit & Risk Committee: 10 September 2026

The Chair of the Audit & Risk Committee advised that the committee had received two internal audit reports on Mortality and Care Group Risk Management both rated as 'significant assurance with minor improvement opportunities' although the Committee had challenged the rating on the Care Group Risk management review due to the number of medium level recommendations. The Committee had also received an update on the finance and procurement function improvement plan noting good progress with further work to be undertaken.

Innovation & Transformation Committee: 16 September 2026

The Chair of the Innovation & Transformation Committee advised that the inaugural meeting was held on 16 September 2026. The Committee had developed a shared understanding of the strategic programmes and discussed the mobilisation of governance arrangements. In addition, it had been agreed that all programmes would be assessed to clarity the scope, outcomes and benefits.

138/26 Chief Executive's Report

The Chief Executive highlighted the ongoing dispute of the portering team that related to the change to move extra contractual payments for all overtime to the NHS Professionals (NHSP) which was in line with overtime arrangements for all other areas in the Trust. Industrial action had now been confirmed for 48 hours for the following week. Business continuity planning was ongoing led by the Director of Operations, Planned Care. The Chief Strategy Officer and Chief People Officer were due to meet with the GMB union and ACAS the following day.

The Chief Executive highlighted that the Thirlwall report had been published. The Trust had received guidance from NHS England (NHSE) and there were two immediate actions in relation to sudden infant death and the installation of cameras in the neonatal unit. A further Board discussion would be scheduled in relation to learning in relation patient harm and the need to submit a Board assurance report in October and November 2026. The Chief Nursing Officer

advised that the Thirlwall report provided an opportunity for the Trust to review all recommendations and reevaluate how the Board can obtain assurance.

The Board discussed the National Oversight Framework (NOF) indicators and the Chief Strategy Officer advised that these were included in the Integrated Performance Report (IPR) although it was agreed this could be made clearer in future reports. **Action: A Statham**

139/26 Integrated Performance Report (IPR)

The Chief Operating Officer introduced the IPR and highlighted that themes of variation included the impact of increasing urgent and emergency care demand on non-elective care and the sustained increase in Emergency Department (ED) resulting in additional pay costs impacting on the financial position. Improvement work in ED was ongoing in addition to liaison work with Berkshire Healthcare Foundation Trust (BHFT). The Chief Operating Officer highlighted that avoidable absence metric had increased in the people metrics. In addition, the impact of demand, seasonal pressure as well as achieving productivity and significant financial controls were onerous for staff although the Trust's Health & Wellbeing offer as well as adhering to the Trust's CARE values and celebrating success continued.

The Board discussed the increased attendances at ED. The Chief Operating Officer confirmed that detailed analysis of patients attending was available and Connected Care data also provided an overview of the increase in attendances by GP practice. The Trust was fully engaged with the Primary Care Alliance (PCA) and also continued to work with the Integrated Care Board (ICB). The Chief Executive highlighted that there was a planned Board seminar and the Chief Executives of the PCA and ICB were both attending and this provided an opportunity to discuss the planning process for 2027/28.

140/26 Maternity & Neonatal 10 Point Plan Assurance Process – Baseline Assessment.

The Chief Nursing Officer introduced the report and advised that the template for submission had been shared with the Chair of the Quality Committee. The Chair of the Quality Committee advised that there were areas of non-compliance in the baseline assessment although this provided an overall understanding of the current status. The Board approved the baseline assessment to be submitted to NHSE. **Action: K Prichard-Thomas**

141/26 Maternity Triage Review

The Chief Nursing Officer advised that the Trust was required to submit a gap analysis to NHSE by 7 October 2026. The Board noted there were 60 standards within the 10 principles. Key areas included the Maternity Assessment Unit (MAU) being considered as an emergency department and the risk associated with that. Work with the Digital team was required in relation to Birmingham Symptom-Specific Obstetric Triage System (BSTOS) integration with the Electronic Patient Record (EPR) and the requirement for new reporting. The Board noted that other organisations would have a similar galp in relation to the new reporting requirements.

The Chief Executive highlighted the challenge of the MAU being used as an emergency department as this would be onerous on maternity services and would also impact on other services.

The Chief Nursing Officer advised that all national requirements were included in the ongoing perinatal service review and this would include a focus on what services needs in the future would need to be. Progress on the service review would be reported via the EMC and Quality Committee. Following the NHS Insights visit the Trust was aligned on the improvement required. In addition, the Trust's maternity service was rated on the national heatmap as the second best maternity service in the region.

The Board approved the submission of the gap analysis. **Action: K Prichard-Thomas**

142/26 Winter Plan

The Chief Operating Officer introduced the Winter Plan that had been review by both EMC and Quality Committee as well as a number of other forums.

The Chief Operating Officer highlighted the risk in relation to a potential bed deficit as set out in the report and advised that an event had been planned to share the Trust's Winter Plan with system partners and review their own Winter plan.

The Chief Operating Officer highlighted key messages were for patients to have their vaccines, staff to continued focus on flow and discharge and for system partners to ensure capacity was available as much as possible.

The Board noted that the Trust would again use temporary escalation spaces in order to support patient flow noting that the definition of 'corridor care' was when a patient was place in this space for more than 45 minutes.

The Board approved the Winter Plan and the Board Assurance Statement to be submitted and signed by the Chief Executive and Chair. **Action: D Hardy**

143/26 Work Plan

The Trust Secretary advised that the work plan for 2027 would be provided at the next meeting. **Action: C Lynch**

144/26 Date of Next Meeting

It was agreed that the next meeting would be held on Wednesday 25 November 2026 at 09.00

SIGNED:

DATE:

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

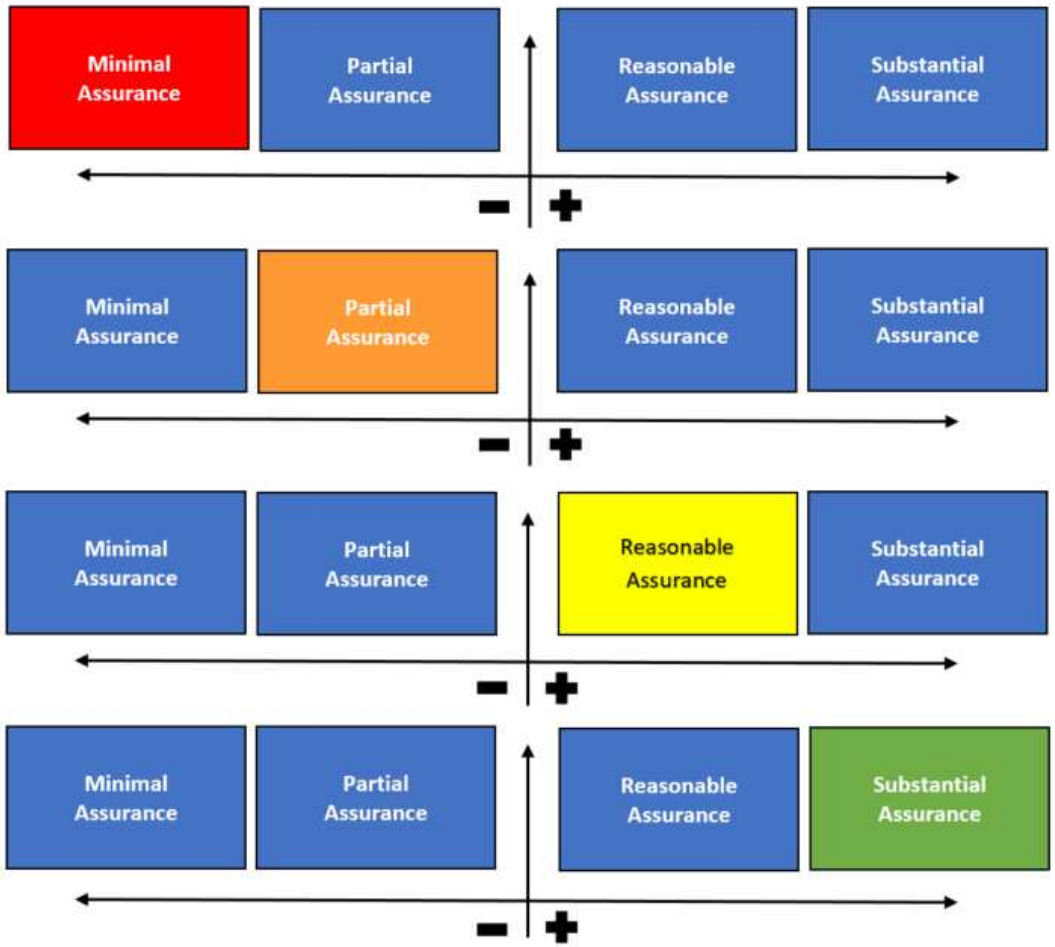
Date	Minute Ref	Subject	Matter Arising	Owner	Update
23 September 2026	138/26	Chief Executive's Report	The Board discussed the National Oversight Framework (NOF) indicators and the Chief Strategy Officer advised that these were included in the Integrated Performance Report (IPR) although it was agreed this could be made clearer in future reports.	A Statham	Metrics within the NOF are marked on the IPR with an asterisk.
23 September 2026	140/26	Maternity & Neonatal 10 Point Plan Assurance Process – Baseline Assessment.	The Board approved the baseline assessment to be submitted to NHSE.	K Prichard-Thomas	Completed. Submitted to NHSE 25 September 2026
23 September 2026	141/26	Maternity Triage Review	The Board approved the submission of the gap analysis.	K Prichard-Thomas	Completed. Submitted to NHSE 25 September 2026
23 September 2026	142/26	Winter Plan	The Board approved the Winter Plan and the Board Assurance Statement to be submitted and signed by the Chief Executive and Chair.	D Hardy	Completed.
23 September 2026	143/26	Work Plan	The Trust Secretary advised that the work plan for 2027 would be provided at the next meeting.	C Lynch	Completed.

Innovation & Transformation Committee Chairs Report

Royal Berkshire NHS Foundation Trust

Committee Chair: Umesh Jetha

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE (ALERT)	MAJOR ACTIONS AGREED (ADVISE)
• Change capability remains a material weakness across the Trust, with variation in approach, capacity and discipline. • Resourcing gaps in programme and change roles risk slowing progress • Dependencies across Digital, Data, Sustainability and Transformation are not yet fully understood or sequenced, creating potential bottlenecks. • Benefits realisation risk — measurable, committed benefits are not consistently evidenced across initiatives	• A structured review of all existing programmes using the Trust's change framework to assess maturity, clarify scope/outcomes/benefits. • Each strategic initiative will be required to present gate status, readiness criteria, maturity timelines and committed benefits to provide the Board with transparent delivery risk. • Resourcing plan required to secure dedicated programme and change capability for mobilisation and execution. • Work to align enabling strategies, particularly Digital, to ensure realistic sequencing, capacity and capability. • Establishment of a value-led assurance approach, with benefits forming the basis of scrutiny
POSITIVE ASSURANCES TO PROVIDE (ASSURE)	**DECISIONS MADE (APPROVE)**
• The Committee has established the foundations of a more disciplined, evidence-based assurance model for transformation. • Members now have a shared understanding of the Trust's strategic portfolio and value enablers, enabling more effective scrutiny going forward. • There is clear recognition of the maturity journey required and commitment to strengthening governance, capability and benefits focus. • Early alignment on the importance of benefits-led transformation to support the Trust's financial position	• Agreement to adopt a consistent assurance framework for all programmes, including maturity assessment and gate-based readiness. • Approval to commence the portfolio-wide review of existing programmes. • Approval to develop a Trust-wide change capability uplift plan. • Approval to strengthen Digital and enabling strategy alignment as a prerequisite for programme mobilisation



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.

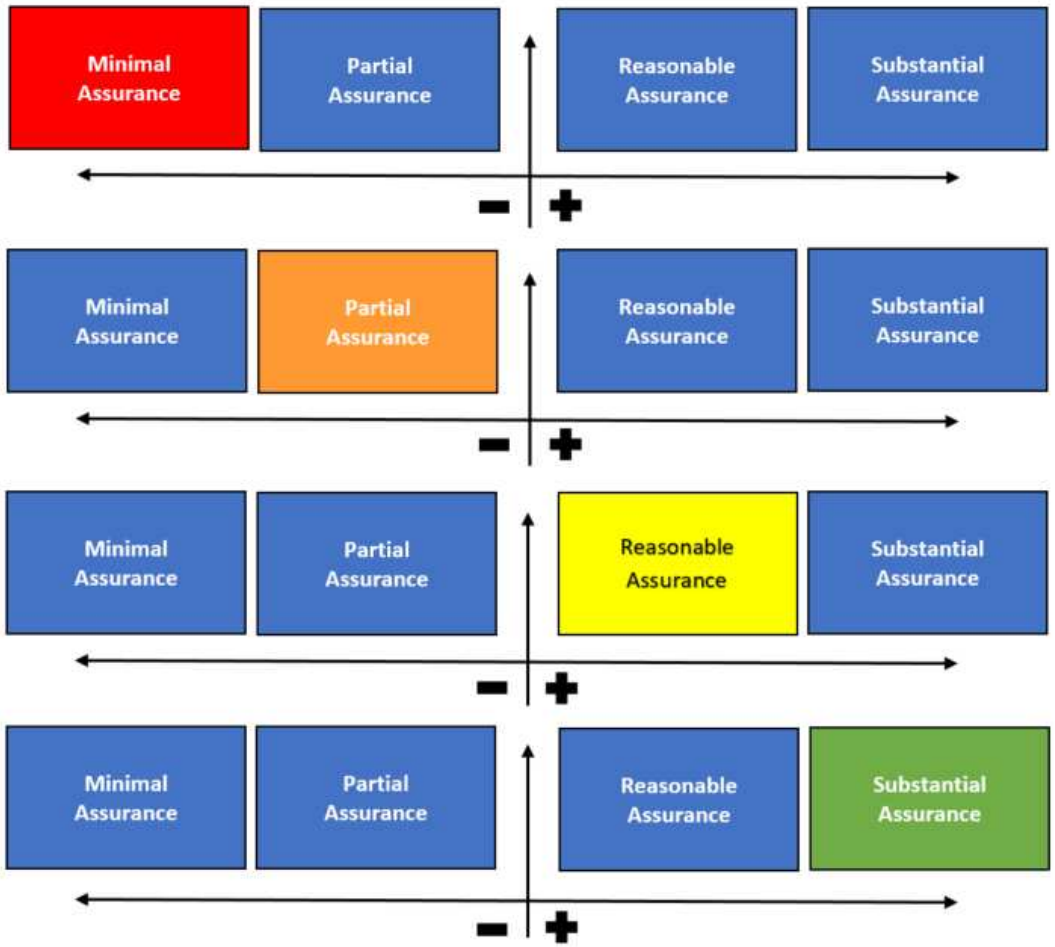
There is evidence of a clear understanding of the matter or issue to be addressed; there is evidence of independent or external assurance; there are plans in place and these are being actively delivered and there is triangulation from other sources (e.g. patient or staff feedback)

People Committee Chairs Report

Committee Chair: Catherine McLaughlin, Non-Executive Director

Royal Berkshire NHS Foundation Trust

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE (ALERT)	MAJOR ACTIONS AGREED (ADVISE)
	• Supported the preferred approach of bespoke rotas within the 10-Point Plan to Improve Resident Doctors' Working Lives recognising the benefits aligned to resident doctor preferences • Noted the launch of the Rise Above leadership development framework to support senior leadership talent and development
POSITIVE ASSURANCES TO PROVIDE (ASSURE)	**DECISIONS MADE (APPROVE)**
• Noted the increase in exception reporting with assurance that this was an anticipated consequence of national reforms and increased confidence in reporting • Noted the positive progress in relation to Violence, Aggression and Abuse, including the success of Operation Cavell, enhanced staff support and the development of a Trust strategy • Noted progress against the 2025 Staff Survey Improvement Plan and the launch of the 2026 Staff Survey on 22 September 2026 • Noted the initial assessment against the NHS Staff Standards, with further work required • Noted progress with the national Job Evaluation programme, including staff engagement activity and the planned consultation process with assurance that required national timelines would be met	• Approved Annual Medical Revalidation Report 2025/26 and recommended that the Chief Executive sign the statement of compliance on behalf of the Board • Approved the Nursing & Midwifery Safer Staffing review recommendations providing substantial assurance regarding safer staffing arrangements



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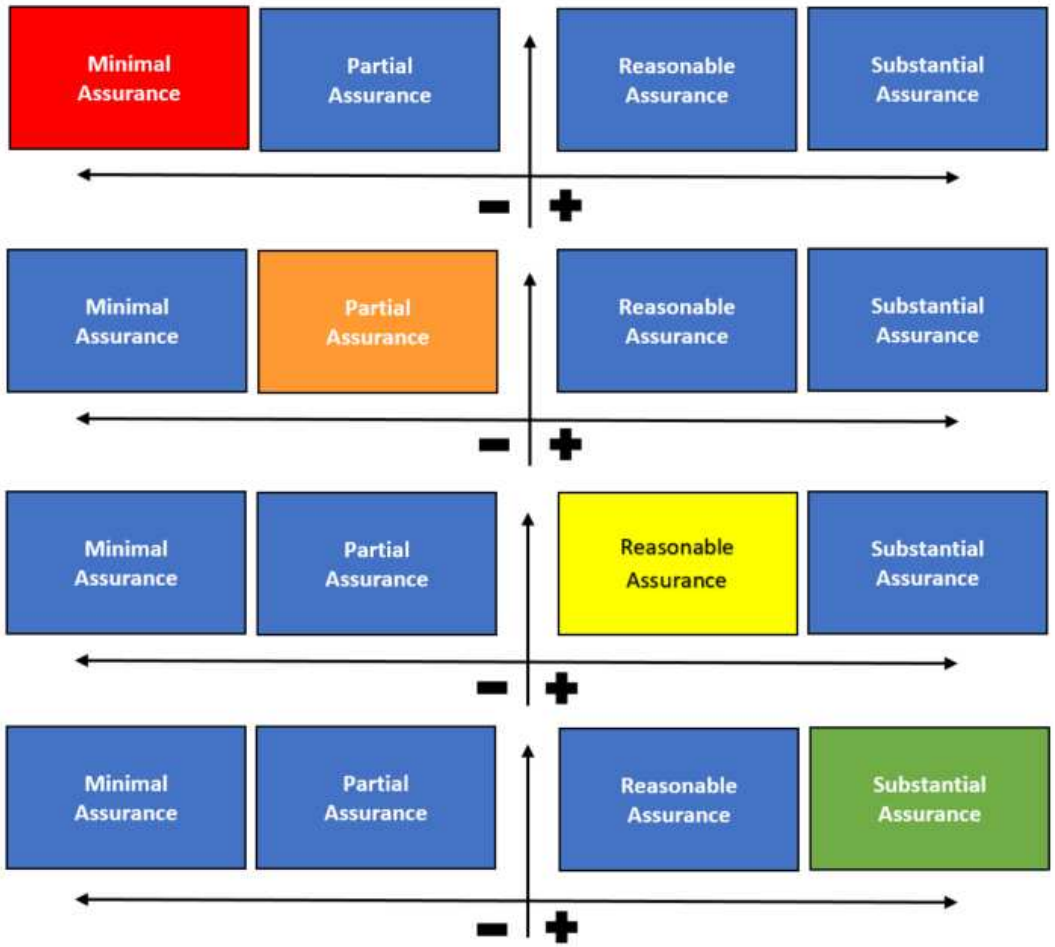
Finance & Investment Committee Chairs Report

Committee Chair: Mike O'Donovan

21 October 2026	
Agenda Item 3: Month 6 Finance Report	**Reasonable Assurance**
Agenda Item 5: Financial Route Map	**Substantial Assurance**
Agenda Item 6: Business Planning 2027/28	**Reasonable Assurance**
Agenda Item 6.1: Budget Setting Principles	**Reasonable Assurance**

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE (ALERT)	MAJOR ACTIONS AGREED (ADVISE)
• Noted the operational pressures that the organisation was currently facing now and in the coming months and the need to ensure that maintaining quality and safety standards was a priority. • The 2027/28 budget-setting principles and timetable were noted. Delivery of next year's financial goals would require strategic programmes to generate recurrent transformation and clearly attributable benefits • Noted ICB Commissioning Intentions	
POSITIVE ASSURANCES TO PROVIDE (ASSURE)	**DECISIONS MADE (APPROVE)**
	• Recommendation to approve the Financial Route Map



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Finance & Investment Committee Chairs Report

Royal Berkshire NHS Foundation Trust

Committee Chair: Mike O'Donovan Non-Executive Director

18 November 2026	
Agenda Item 3: Month 7 Finance Report	**Reasonable Assurance**
Agenda Item 4: Financial Improvement Plan	**Reasonable Assurance**
Agenda Item 5: Business Planning 2027/28	**Substantial Assurance**
Agenda Item 11: Board Assurance Framework	**Substantial Assurance**
Agenda Item 12: Corporate Risk Register	**Substantial Assurance**

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE (ALERT)

- Need to resolve outstanding income issue with the ICB to underpin full delivery of 2026/27 financial plan

MAJOR ACTIONS AGREED (ADVISE)

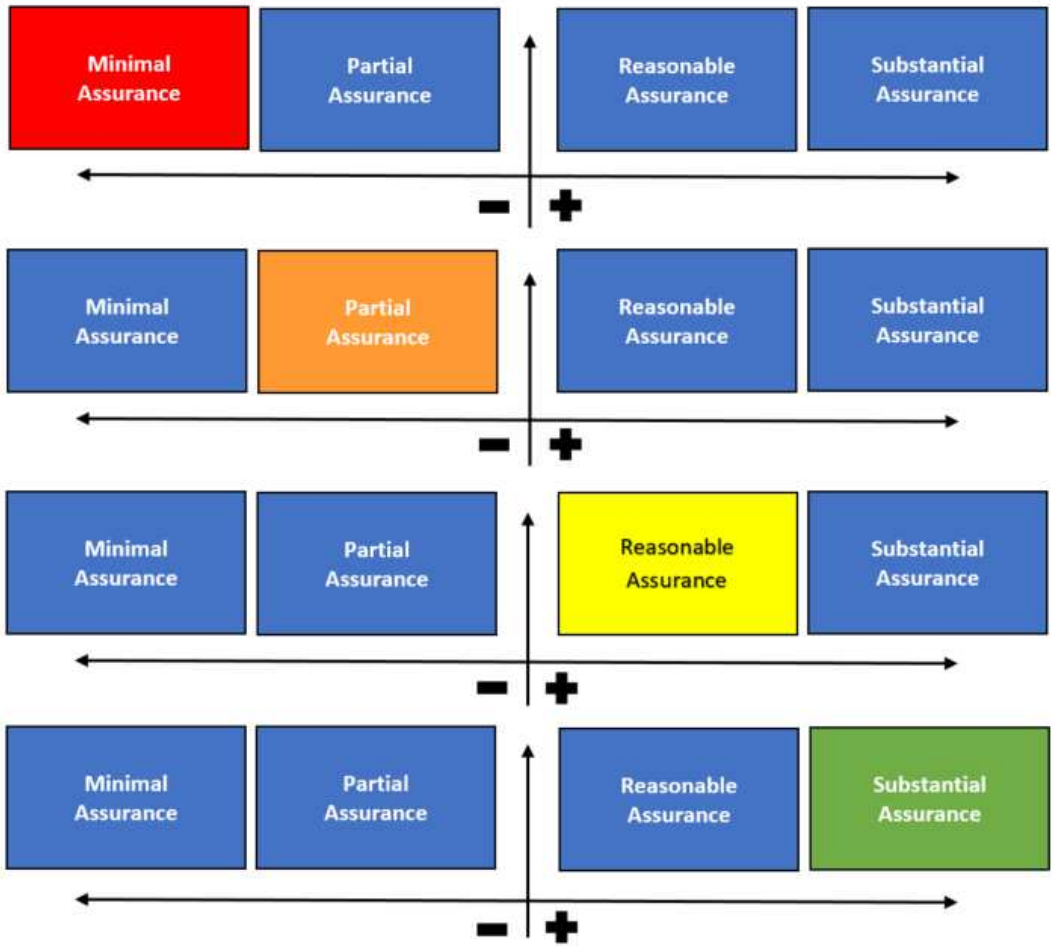
- The 2027/28 Business Planning process was on track and on timetable with the next iteration to be submitted to the January 2027 meeting.

POSITIVE ASSURANCES TO PROVIDE (ASSURE)

- On plan at end of Month 7 with high level of confidence that full year budget will be met
- On track to deliver the full Financial Improvement Plan target of £43.4m, though there is a need for a higher level of recurrent savings.

DECISIONS MADE (APPROVE)

- Agreed the update of the Board Assurance Framework
- Agreed the update of the Corporate Risk Register, with a request to review whether the Maternity Fire Risk could be downgraded



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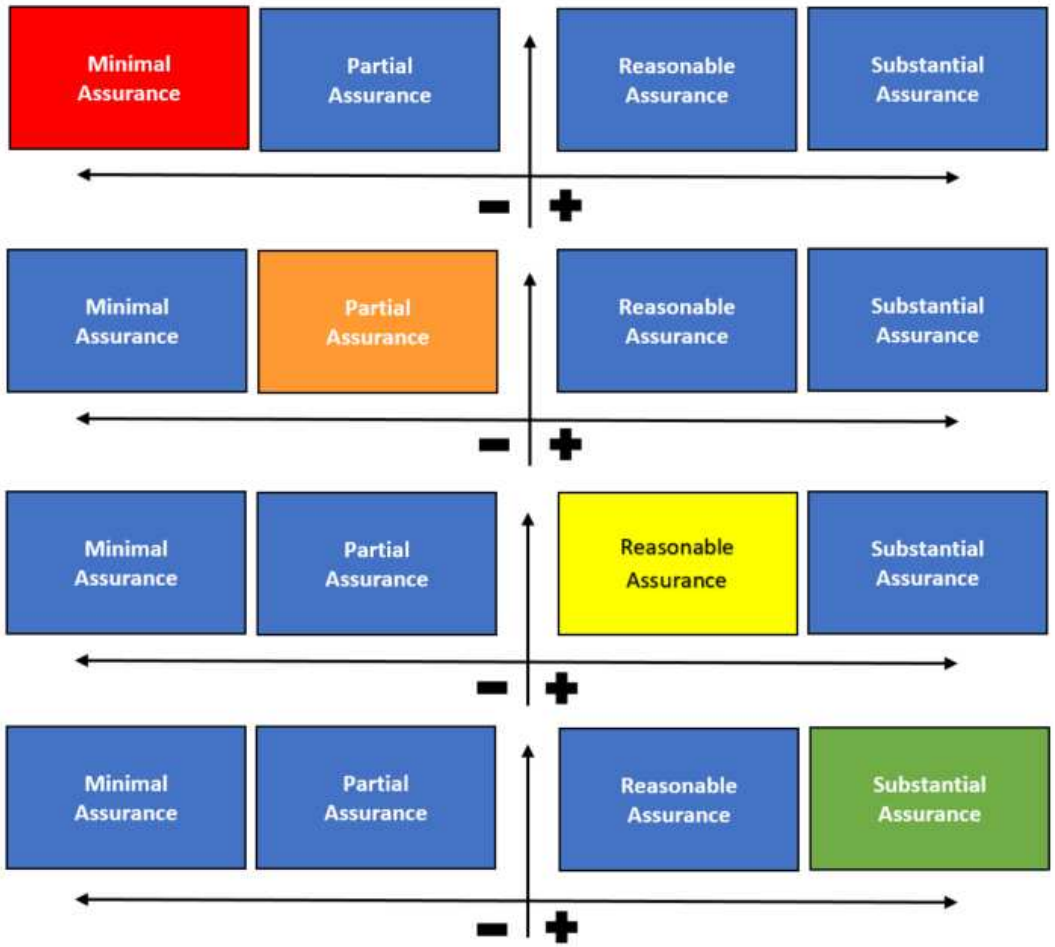
Audit & Risk Committee Chairs Report

Committee Chair: Mike McEnaney

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE (ALERT)	MAJOR ACTIONS AGREED (ADVISE)
POSITIVE ASSURANCES TO PROVIDE (ASSURE) • Noted progress on the Finance & Procurement Improvement Plan	**DECISIONS MADE (APPROVE)** Recommendation to the Charity Committee to approve the Charity Annual Report & Accounts for 2025/26. Recommendation to HFMS Ltd to approve the Annual Report & Accounts for 2025/26



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NHS
Royal Berkshire
NHS Foundation Trust

Title:	**Chief Executive's Report**
Agenda item no:	6
Meeting:	Board of Directors
Date:	25 November 2026
Presented by:	James Blythe, 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

NHS England (NHSE) Maternity Assurance Visit

1.1 Maternity services continue to attract a significant national focus in the context of recent reviews and inquiries. In this context, a NHS England South-east Regional Perinatal Team assurance visit took place on the 9 September 2026. The team fed back that there was a demonstration of strong leadership grip, visible executive oversight, well established governance processes, and a positive culture amongst frontline staff.

1.2 We continue to address issues which the board has previously discussed including a relatively high stillbirth rate. Current maternity safety investigations continue to identify recurring themes around foetal monitoring, recognising and escalating risk, multidisciplinary team (MDT) decision-making, and timely clinical response. We know that increasing complexity and demand is putting pressure on our maternity services, and through the perinatal services review that we launched in the summer, have made some immediate improvements.

1.3 The team was assured that there were credible plans to deliver sustained improvements and have been asked to provide assurance on progress in early 2027.

Easing Winter Pressures

1.4 We have continued to see high numbers of patients attending our Emergency Department over the last 2 months. October 2026 saw a 5% increase compared with last year. Analysis has shown that a significant number of those attending are presenting with minor illness and could be seen in primary care settings. To support this, we have worked with the Thames Valley Integrated Care Board (TVICB) and the Primary Care Alliance (PCA) to ensure that an additional 50 slots exclusively for patients attending the ED are now available each day. Patients who are eligible for these slots will be re-directed from the ED following clinical review. This will continue through to the end of the financial year.

1.5 Whilst this is a positive development, it is mitigating the impact of failure demand rather than addressing the cause. The IPR demonstrates that we are continuing to see sustained pressure on our emergency care pathway from high volumes of attendances. We have an unusually low conversion of attendances to admissions and this reinforces the point that many of these patients are in the wrong place. Through winter, our messaging is and must remain clear – the Emergency Department is for emergencies, and care for other needs can be accessed more quickly and appropriately through general practice, pharmacies and 111.

Strategic Objective 2: Supporting our people to thrive

Staff Safety Pioneers Programme – Violence and Aggression

2.1 I made addressing the issue of rising violence and aggression against staff a key priority for me personally when I started in role. I am therefore very pleased that the Trust has been selected as one of 15 NHS Staff Safety Pioneer organisations, receiving financial support to develop a more systematic and evidence-led approach to reducing harm to staff. The ambition is to apply the same principles to staff safety that we use for patient safety through frameworks such as PSIRF, moving beyond responding to individual incidents to understanding the underlying causes of harm, identifying systemic risks and taking preventative action.

2.2 We have agreed to focus initially on reducing violence and aggression, including understanding and addressing the causes of incidents, strengthening staff training and confidence, and improving support for affected colleagues. The wider ambition is to develop a sustainable approach to reducing all forms of staff-related harm, with learning that can be shared across the NHS

Portering Industrial Action

2.3 I am pleased to report that we have reached agreement with the GMB union on issues around additional hours payments which led to a period of industrial action by some of our porters. The agreement will see additional hours managed via NHSP bringing it in line with the system used by other Trust colleagues, giving us consistency and clarity in additional hours arrangements.

2.4 The Trust's offer covers a period of financial support during the transition to the new arrangements as well as improved access to additional NHSP portering shifts and opportunities for career progression. We are also recruiting more porters to help with workloads – 11 have already started and a further six are being recruited. Additionally, in recognition of the valuable role our porters play in the delivery of safe patient care, we have committed to a comprehensive independent review of the portering service which will look at new pay banding opportunities recognising specialist skills; rotas; working conditions and other service improvements.

2.5 I would like to thank all those involved in the very complex negotiations, as well as colleagues who volunteered to carry out non-clinical support roles during the strikes to ensure we maintained safe patient care.

Consultant Industrial Action

2.4 Consultant industrial action was planned for the end of November 2026 with a 48 hour Christmas level workforce presence only. However, this was called off as the BMA and Government have agreed to resume talks. The BMA are keen to make it clear that the Industrial Action has only been paused leaving the option open for further action should an agreement not be reached.

Establishing Shadow Board

2.5 Proposals to develop and deliver our inaugural RBFT Shadow Board have been agreed, with cohort onboarding planned for March 2027. The Shadow Board's vision is to create a diverse, confident and senior leadership ready pipeline whilst embedding inclusive thinking into organisational governance and decision making. The Shadow Board aims to deliver mutual benefit – both to participants and to organisational thinking.

Awards

Women's Well-being Champion Award

2.6 Our Inclusion Midwife, Csilla Dorogi-Lawrence, received the Women's Well-being Champion Award at the Grassroots Community Awards Ceremony hosted by Utulivu Women's Group and ACRE Reading. Alongside her fantastic work with our Maternity and Neonatal Voices Partnership, this award recognises the incredible work Csilla has done in building trust and improving maternity experiences for women and families within our communities.

Pride of Reading

2.7 Dibyaa Maharjan, a member of staff in our Acute Stroke Unit picked up the Healthcare Worker of the Year award at Pride of Reading celebrations at the beginning of November 2026. Dibyaa was nominated by a colleague who said, "Dibyaa is the lynchpin of our team. She lives our Trust's values every day, with her compassion extending to patients, peers and colleagues alike. She consistently brings kindness, empathy, and professionalism to everything she does." Dibyaa was especially noted for the support she gives to patients from the Nepali community when facing language barriers that affect their ability to communicate with healthcare professionals, even with translation services.

Estates and Facilities Award

2.8 Our Estates and Facilities team were recently named winners of the Diversity and Inclusion Award at the IHEEM Healthcare Estates Awards. The team received the award for their important work on the What Matters Programme, which is helping to build a more inclusive culture across the service. The award recognises the positive difference for colleagues and the services they support.

Strategic Objective 3 – Partnering for Impact

System Initiatives

3.1 On 30 September 2026 the ICB released its commissioning intentions for the business planning cycle 2027/28. This document sets out a shared direction for the Thames Valley health and care system that puts improving outcomes for our population at the heart of ICB's ambition.

3.2 The ICB intends to redesign and commission services around population needs and care pathways rather than organisational boundaries, with future funding increasingly linked to improvements in outcomes and equity rather than activity growth. To support this, approximately £59 million (1% of system allocation) will be invested in priority pathways, beginning with urgent and emergency care, alongside the development of new provider and contracting models.

3.3 The ICB has invited place partnerships to identify priority programmes aligned with its intentions. Engagement with Place partners has produced 6 Place priorities that will be used to coordinate a set of proposals focused on neighbourhood services, proactive care, community-based alternatives to admission, urgent care capacity and expansion of the Royal Berks @ Home model.

Local Government Reorganisation: Ridgeway Council update

3.4 The proposed three-council model remains unchanged, with Ridgeway Council still bringing together West Berkshire with most of South Oxfordshire and Vale of White Horse.

3.5 Ridgeway would be slightly larger than previously proposed, with eight South Oxfordshire parishes now remaining within Ridgeway rather than transferring to Greater Oxford. Its estimated population would be around 429,000.

3.6 Implementation has been delayed by one year. Elections to the new shadow councils are now planned for May 2028, with the new councils taking responsibility for services from 1 April 2029. Existing councils would therefore continue for an additional year.

3.7 The Government's position is once again provisional. The previous decision to proceed with implementation has been replaced by a new "minded-to" decision, allowing councils, MPs and other interested parties a further opportunity to make representations before a final decision.

3.8 If the proposal proceeds, the Trust will aim to use this opportunity to improve the current variation in care co-ordination arrangements between the three Berkshire local authorities and the teams supporting a population which is resident in south Oxfordshire but accesses RBFT for hospital-based care.

Strategic Objective 4 – Driving improvement and enabling innovation

University Department Accreditations

4.1 We are delighted to be able to add two more departments to our portfolio of University Departments of Excellence bringing the total to 12. After a stringent application process, Diabetes and Endocrine and Ear, Nose and Throat (ENT) were awarded University Department status through the Trust and University of Reading Recognition of Excellence Scheme

4.2 The award recognises departments that demonstrate excellence across clinical care, education and workforce development, and research and innovation. It celebrates teams that are not only delivering outstanding services today but are also helping to shape the future of healthcare through partnership working, teaching, research and continuous improvement. Previously successful department cited that University status has helped with recruitment and retention of staff and also attracted greater research opportunities including with commercial partners.

4.3 Every four years University departments are asked to provide evidence of ongoing excellence in clinical care, education and research and this month, Urology and Radiology, reaccredited their status.

Strategic Objective 5: Building a sustainable future together

Financial Position – Month 7

5.1 The Trust remains close to its year-to-date financial plan at Month 7, reporting a deficit of £2.04m against a planned £2.05m. However, the underlying deficit, excluding non-recurrent support and savings, is £20.74m, £18.69m adverse to plan. Closing this underlying gap remains dependent on delivering recurrent efficiencies and maintaining tight financial control.

5.2 Efficiency delivery is progressing, with £44.31m of schemes identified against the £43.69m annual target, although a significant proportion of delivery remains non-recurrent. Income is ahead of plan but continues to carry risk relating to commissioner agreement, while pay pressures, particularly medical staffing and bank usage, require continued management.

5.3 The Executive team continues to maintain tight focus on recurrent efficiency delivery, workforce costs and income, with the Board receiving detailed assurance through the Finance & Investment Committee.

NHS
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Title:	**Integrated Performance Report (IPR)**
Agenda item no:	7
Meeting:	Board of Directors
Date:	25 November 2026
Presented by:	Frances Khatcherian, Chief Finance Officer
Prepared by:	Executive Team

Purpose of the Report	The purpose of this report is to provide an analysis of quality performance to the end of October 2026

Report History	Executive Management Committee 23 November 2026

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)**:**							
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	✓

NHS
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NHS Foundation Trust

Integrated Performance Report

October 2026

Improving together to deliver
outstanding care for our community

Improving Together

Guide to statistical process control (SPC)

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

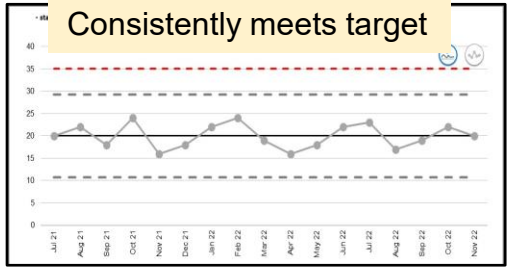
Each chart shows a VARIATION icon to identify either common cause or special cause variation. If special cause variation is detected the icon can also indicate if it is improving (blue) or worsening (orange).

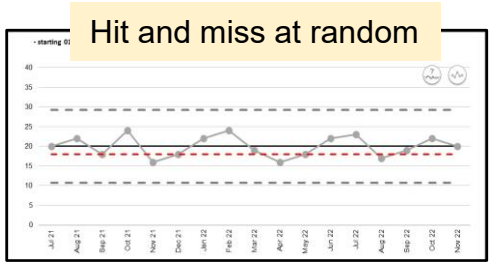
Where we have set a target, the chart also provides an ASSURANCE icon indicating:

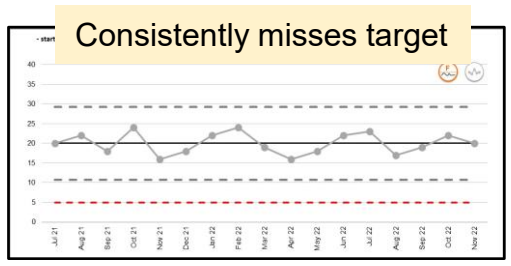
- If we have consistently met that target (blue icon),
- If we hit and miss randomly over time (grey icon), or
- If we consistently fail the target (orange icon)

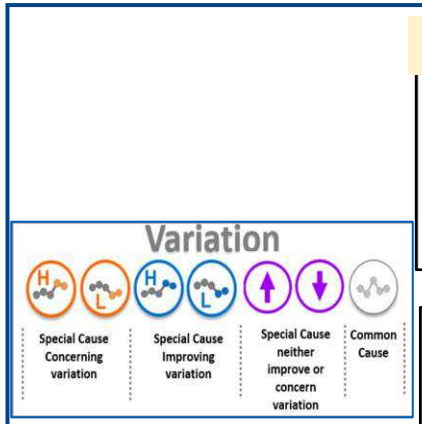
For each of our strategic metrics and breakthrough priorities we will provide a SPC chart and detailed performance report. We apply the same Variation and Assurance rules to watch metrics but display just the icon(s) in a table highlighting those that need further discussion or investigation.

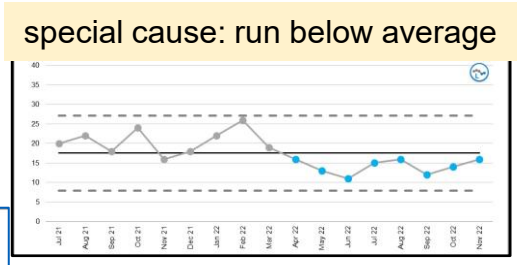


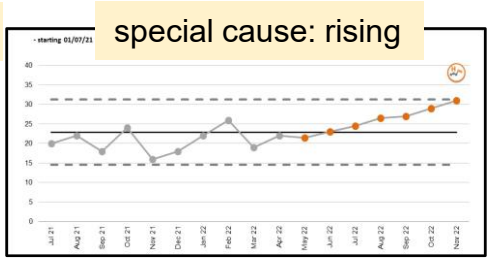


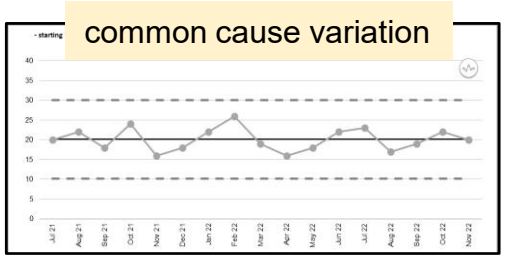


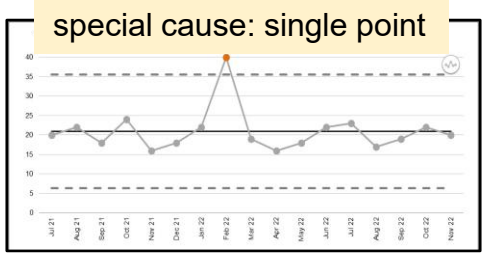












October 2026 performance summary

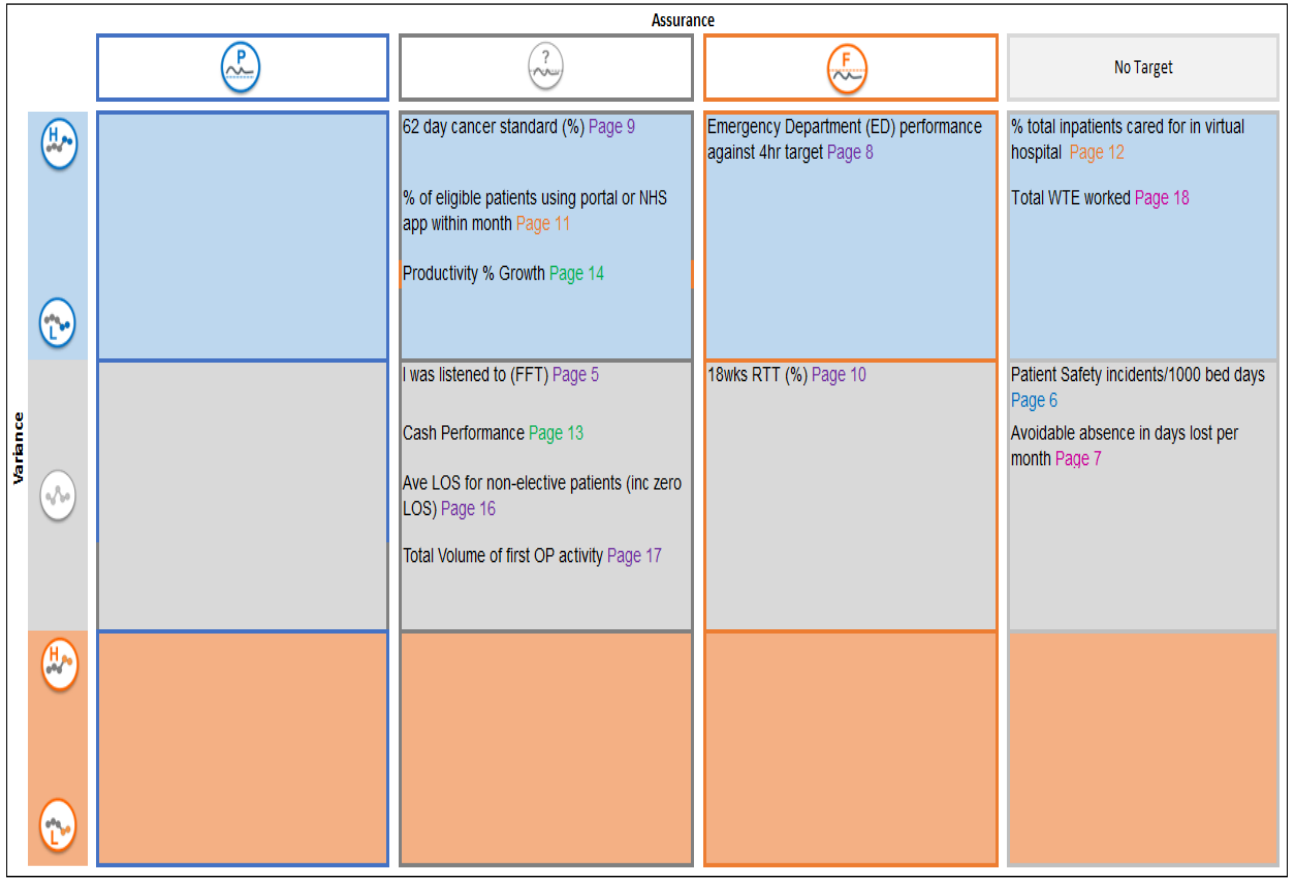
Royal Berkshire NHS Foundation Trust

The data in this report relates to the period up to 31st October 2026.

The key messages from the report are:

- **ED Performance:** Emergency Department services continued to face significant operational challenges during October 2026, reflecting sustained levels of activity, greater complexity of patient need and delays in discharge and onward transfer. These factors continued to impact patient flow and contribute to longer stays. Work to improve patient access and reduce pressure on the Emergency Department remained a priority, with continued emphasis on directing patients to the most appropriate care setting through SDEC, EDAU and Urgent Care Centre services. For October, All Types performance was recorded at 75.08%, with Type 1 performance at 63.94%.

- **Cancer performance:** September performance (month arrears) shows all cancer access standards ahead of the Trust's planned trajectory with the exception of 62FDT which has dipped as a result of higher breaches in the Lower GI pathway. Improvement actions continue, with the most challenged pathways reviewed weekly Cancer Action Group meetings.
- **Financial performance:** At M07, the Trust delivered a £2.04m year-to-date deficit against a planned deficit of £2.05m. Financial Improvement Plan delivery stands at £24.05m, equivalent to 55% of the £43.69m full-year target, with continued focus on delivering the remaining balance..
- **Cash:** The Trust's cash position remains resilient, with balances forecast to reduce during the second half of 2026/27 but remain above plan. Continued focus on cash preservation, income recovery and cost improvement delivery will be critical to maintaining financial sustainability.
- This month we have seen 14 of the 121 **watch metrics** measure outside of statistical control.



Royal Berkshire
NHS Foundation Trust

Strategic Metrics

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

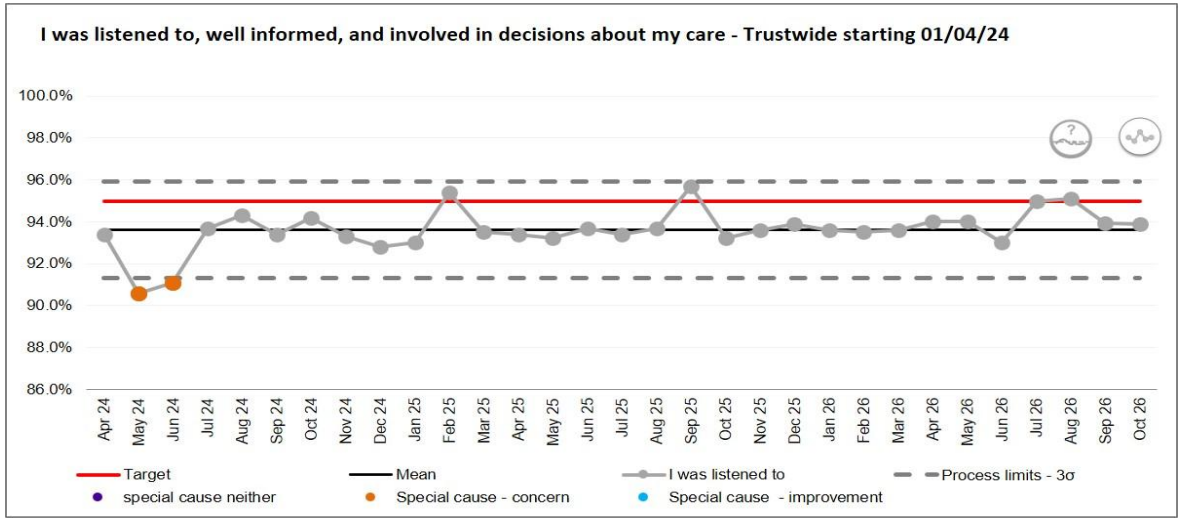
Strategic metric: I was listened to, well informed & involved in decisions about my care

Board Committee: Quality committee

SRO: Chief Nursing Officer

Assurance	Variation
?	

NHS Royal Berkshire NHS Foundation Trust



Insight Metrics	May-26	Jun-26	Jul-26	Aug-26	Sept-26	Oct-26
I was listened to, well informed & involved in decisions about my care (FFT) Q2	94.0%	93.0%	95.0%	95.1%	93.9%	93.9%
FFT Overall satisfaction rate	93.5%	92.8%	93.0%	93.6%	93.1%	93.5%
FFT Overall response rate	6.9%	6.9%	9.2%	7.7%	6.4%	6.0%
Number of complaints	70	87	79	63	64	77
Complaints turnaround in 25 days	60%	72%	78%	73%	64%	53%
Percentage of complaints acknowledged within 3 days	71%	80%	70%	70%	17%	81%

*** Denotes metric is part of the NHS Oversight Framework dataset**

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 we are performing:

- Performance on FFT Q2 remains stable at 93.9%. Overall satisfaction rate has also remained at 93%.
- Complaints closed within 25 working days has dropped again in October (25% reduction over 3 months). This may be attributable, to the late logging of those complaints during September (17%) as this would have extended the overall timeline.
- Complaints logged within 3 days has improved which should lead to better performance in turnaround next month.

Actions and next steps:

- New analytics system within the Experience First strategic programme is about to launch with four pilot wards / departments. This will provide thematic analysis and triangulation of data.
- Patient Experience and Practice Development teams delivered a presentation on shared decision-making at the Fundamentals of Care sessions, raising staff awareness and supporting greater patient involvement in care decisions.
- A national expert in Patient Experience visited in October to support the team to implement improvements including real-time feedback.

Risks:

- Planned implementation of a new complaints case management and analytics software will no longer go ahead due to issues with the developer. Workload and staffing will be reviewed of light of this. A complaints module will be considered as part of the Datix replacement programme.

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

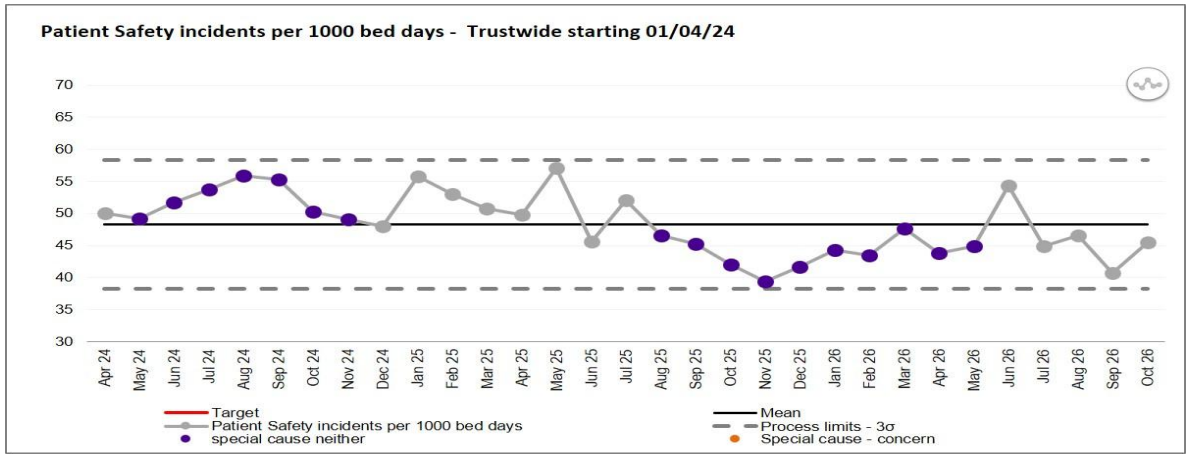
Strategic metric: Learning from incidents to reduce harm

Board Committee: Quality committee

SRO: Chief Nursing Officer

Assurance	Variation
N/A	

Royal Berkshire NHS Foundation Trust



Insight Metrics	May-26	Jun-26	Jul-26	Aug-26	Sept-26	Oct-26
Patient Safety incidents per 1000 bed days	44.85	54.34	44.84	46.50	40.74	45.50
***% of patient safety incidents that are low/no harm**	95.31%	95.47%	95.31%	95.77%	96.12%	96.34%
No. of Deteriorating patient incidents	5	6	7	5	4	2
FFT question: I felt safe during my visit to the hospital (%)	89.00%	91.00%	97.00%	91.80%	90.34%	88.46%
Total Calls for Concern from patient and family	37	45	33	38	45	31
National Patient Safety Syllabus training compliance: Level 1	47.4%	52.9%	56.7%	60.6%	64.5%	66.0%
National Patient Safety Syllabus training compliance: Level 2	40.3%	45.6%	49.2%	51.1%	54.6%	56.1%

*** Denotes metric is part of the NHS Oversight Framework dataset**

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:

- Incident reporting per 1,000 bed days increased but remains within the control limits. This can be viewed positively as an indicator of a strong and improving safety culture.
- There is a continued upward trend on compliance with the National Patient Safety Syllabus for Level 1 and Level 2 training.
- There was a decrease in the number of total calls for concern from patients and families.

Actions and next steps:

- Replacement/upgrade of the Datix Incident Management system is currently under review. Plan to draft new specification by end November.
- Current PSIRF plan is under review and out to consultation with the Care Groups and will then go to Quality Governance Committee for approval.
- Chief Nursing Informatics Officer working with Digital, Data and Technology (DDaT) to develop digital oversight governance process.
- Associate Director of Nursing for Patient safety due to start in post December 2026.

Risks:

- Lack of specialty and department level breakdown of training data.
- Lacking oversight of digital patient safety themes.

Strategic objective: **Supporting our people to thrive**

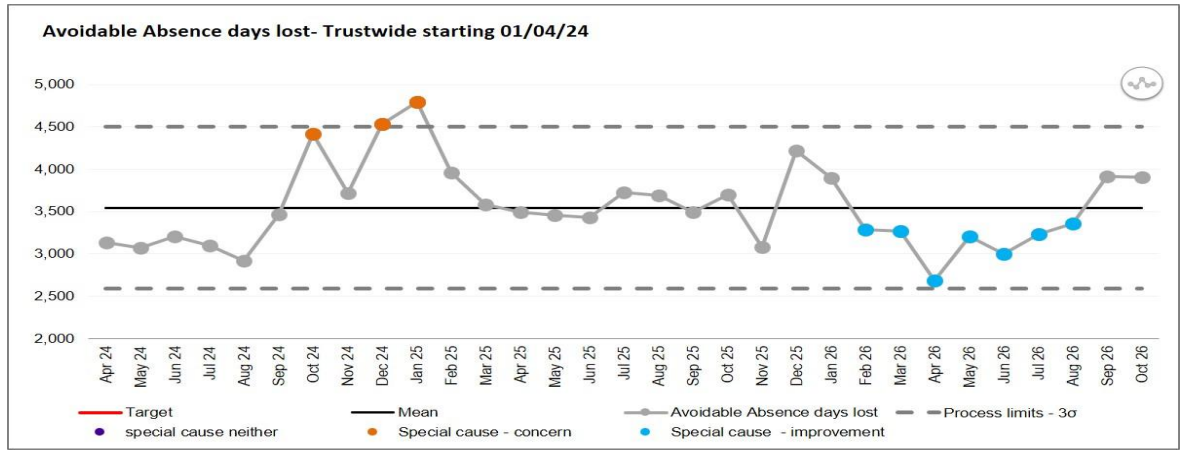
Strategic metric: Reducing avoidable absence

Board Committee: People Committee

SRO: Chief People Officer

Assurance	Variation
N/A	

Royal Berkshire NHS Foundation Trust



Insight Metrics	May-26	Jun-26	Jul-26	Aug-26	Sept-26	Oct-26
Avoidable absence in days lost per month	3203	3003	3235	3355	3913	3909
Stress, anxiety & depression absence (no. of days lost)	1345	1410	1736	1785	1566	1447
Incidents of violence and aggression (patients, relatives, visitors to staff)	88	91	90	71	78	83
Total number of freedom to speak up referrals	8	15	15	12	8	24
Number staff accessing health prevention offer	111	54	21	87	60	8
Statutory and mandatory training compliance	93.07%	93.42%	93.32%	93.62%	92.65%	92.58%

*** Denotes metric is part of the NHS Oversight Framework dataset**

This measures: Avoidable absence, including anxiety, stress, depression, back problems, musculoskeletal problems and cough, colds and flu, measured in days lost per month.

How are we performing

- Total Avoidable absence YTD is currently 8.9% lower than the previous year while Stress/Anxiety & Depression is 3.9% lower against a target of delivering a 5% reduction in 2026/27. The rate of improvement has continued to slow but is expected to achieve the year end target.
- Total absence rates increased in October to 3.79% (against a target of 3.5%) but the rolling year rate of 3.45% remained better than the target of 3.7%.
- Trust absence rates benchmark well against regional and national rates.

Actions and next steps:

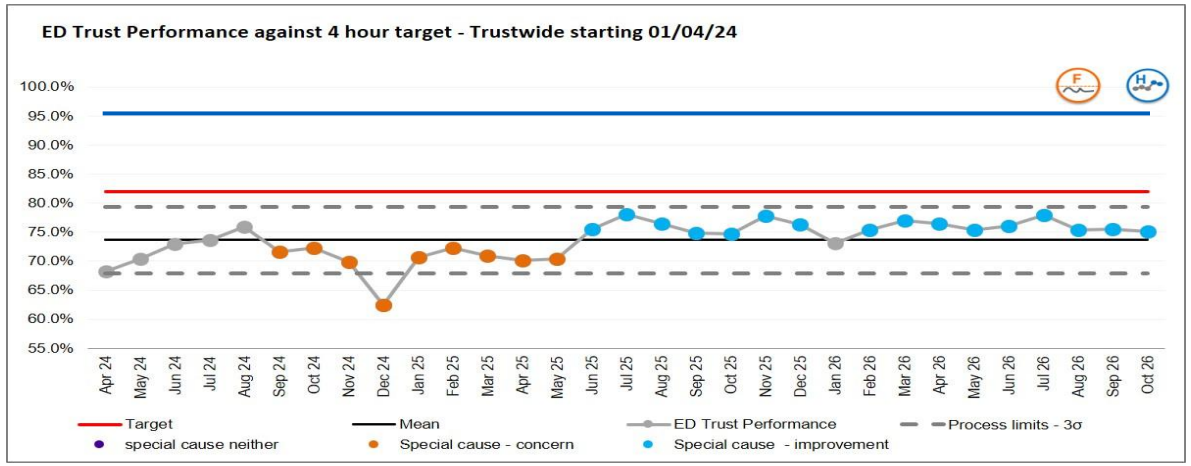
- Staff Survey 2025 Action Plans are now operational, with many departments committed to reducing burnout in their areas.
- Information webinars from the E-Rostering and Occupational Health teams were held in May 2026, to help managers manage sickness absence in their teams. Webinars for leaders in Facilities are currently being arranged.
- People and Change Partners are developing their Strategic People Plans for their respective care groups which will outline the key people priorities over the next few years.

Risks:

- Financial constraints are putting pressure on staffing and other resources.
- Staff survey results show that unacceptable behaviours from patients are on the rise.

Strategic objective: **Partnering for Impact**

Strategic metric: Working together: Performance against 4hr Emergency Pathway target*



Insight Metrics	May-26	Jun-26	Jul-26	Aug-26	Sept-26	Oct-26
*Performance against 4 hour std (%)	75.42%	76.06%	77.99%	75.37%	74.57%	75.08%
Average time to Clinician - all arrivals (minutes)	80	85	75	81	93	83
Number of redirects from ED to Urgent Care Centre (UCC)	1061	1034	1000	1029	1113	1139
Average Handover time (SCAS)	18:27	20:26	18:59	18:09	19:17	21:25
*Number of >12hr LOS from arrival in ED (% of total volume)	4.9%	6.1%	4.7%	4.1%	3.9%	4.6%
Number of >12hr Decision To Admit (DTA) LOS in ED	17	47	17	47	40	123
*Number patients who received corridor care >45 minutes within the previous 24-hour period	-	0	0	0	0	0

* Denotes metric is part of the NHS Oversight Framework dataset

Board Committee: Quality Committee

SRO: Chief Operating Officer

Assurance	Variation
F	H

Royal Berkshire NHS Foundation Trust

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 82% of patients within 4 hours by the end of March 2027.

How are we performing:

- There has been an improvement in performance for the second month in both All Types and Type 1 ED performance. Type 1 = 63.94%.
- ED attendances in October were in line with October 2025.
- There was also a slight decrease in the average LOS for both admitted (1=-1mins for admitted and -10mins for non- admitted).
- The main challenge for October was the increase in the number of patient waiting move than 12hrs from decision to admit to being transferred to a bed.

Actions and next steps:

- Focus on increasing utilisation of the UCC pathway.
- Working through Winter Plan actions to ensure improve patient flow.
- Work with ward teams to improve earlier decision making to increase bed flow earlier in the day.
- Re-focus on ambulance handover processes.

Risks: Corporate Risk 4172

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

Strategic objective: **Partnering for Impact**

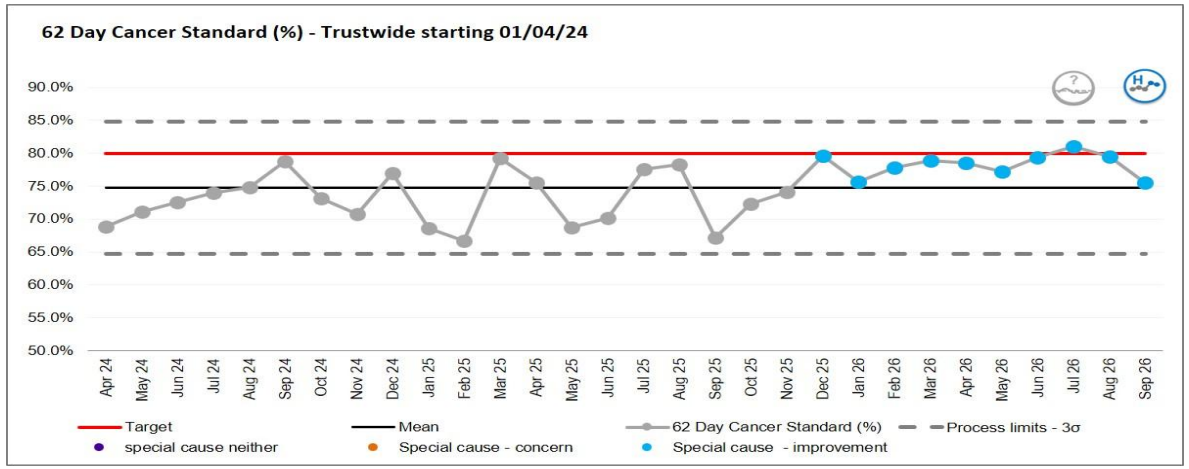
Strategic metric: Improve waiting times: Reduce waits of over 62 days for Cancer patients

Board Committee: Quality Committee

SRO: Chief Operating Officer

Assurance	Variation
?	H

Royal Berkshire NHS Foundation Trust



Insight Metrics	May-26	Jun-26	Jul-26	Aug-26	Sept-26	Oct-26
*Cancer 62 day %	77.2%	79.4%	81.1%	79.5%	75.5%	Arrears
Cancer 62 day % Trajectory	75.2%	75.3%	76.2%	76.0%	77.0%	Arrears
*Performance against 28 day faster diagnostic standard (FDS) (%)	86.0%	84.7%	84.4%	83.1%	84.0%	84.9%
31-day cancer standard performance (combined)	92.9%	94.8%	93.0%	91.5%	95.5%	95.5%
31-day cancer standard trajectory	90.0%	90.0%	91.1%	91.0%	91.1%	92.0%
Percentages of cancers diagnosed at stages 1 & 2	45.8%	53.4%	46.6%	39.8%	Arrears	Arrears

* Denotes metric is part of the NHS Oversight Framework dataset

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%. Trusts are expected to achieve 80% performance by March 27.

How are we performing:

- In September 75.5% of patients were treated within 62 days, down from 79.5% in August. This was driven by an increase in breaches for Lower Gastrointestinal (LGI), Upper Gastrointestinal (UGI) and Urology, as well as a rise in screening pathway breaches.
- Total number of patients on the Patient Tracking List (PTL) waiting over 62 days at the end of October was 236, down from 244 in September. The tumour sites with the most patients on the PTL over 62 days are LGI, Gynaecology and Urology.

Actions and next steps:

- Gynaecology are exploring additional theatre lists to increase inpatient hysteroscopy and surgical capacity, as well as introducing Penthrox for pain relief during outpatient hysteroscopies.
- LGI will be running additional waiting list initiatives to increase capacity for endoscopy and surgical procedures over the next few months, utilising external funding from the Thames Valley Cancer Alliance (TVCA).
- Urology are focusing on reducing length of wait for flexible cystoscopy and transurethral resection of bladder tumour (TURBT) for bladder.

Risks: Corporate Risk 4241

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

Strategic objective: **Partnering for Impact**

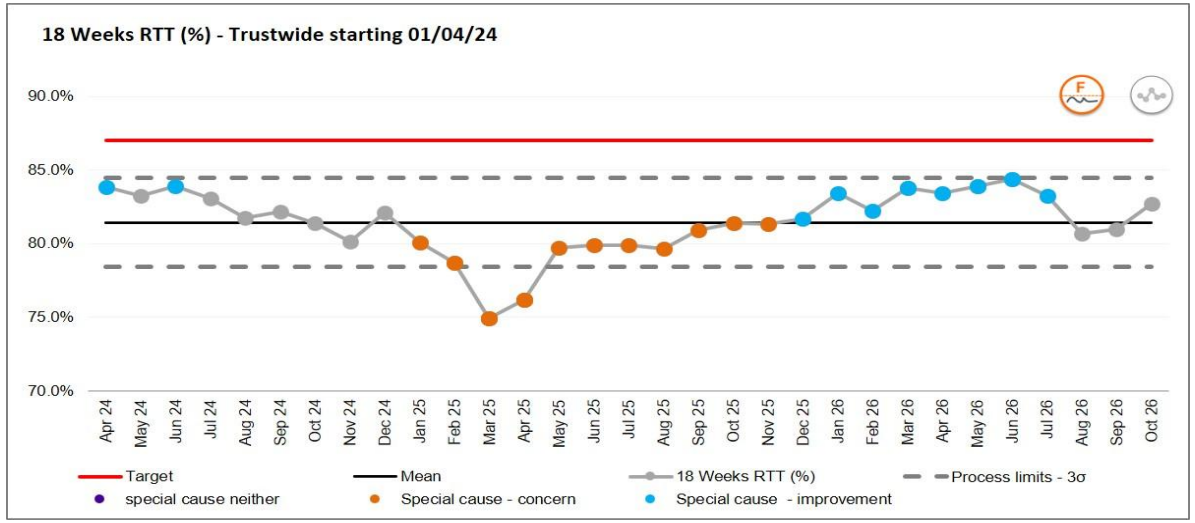
Strategic metric: Maximising Elective Activity: Achievement of the <18 week Referral to Treatment (RTT) standard

Board Committee: Quality Committee

SRO: Chief Operating Officer

Assurance	Variation
F	

Royal Berkshire NHS Foundation Trust



Insight Metrics	May-26	Jun-26	Jul-26	Aug-26	Sept-26	Oct-26
*18 Weeks RTT (%)	83.09%	84.38%	83.27%	80.65%	82.68%	Arrears
% referrals returned with advice to referrer	13.3%	13.5%	14.1%	14.3%	13.6%	14.3%
% plan for first outpatients	31.18%	32.45%	31.98%	31.38%	32.35%	32.37%
% plan for combined daycase and inpatients (cumulative)	94.18%	98.06%	100.10%	97.75%	98.22%	99.10%
*% patients waiting less than 6 weeks for diagnostics (DM01)	81.50%	82.90%	82.90%	89.90%	94.70%	91.40%
*Number of patients waiting more than 52 weeks for treatment (RTT)	39	30	37	41	19	Arrears

* Denotes metric is part of the NHS Oversight Framework dataset

This measures: Performance against the Referral to Treatment standard (92%). The 2026 National Operating Plan expectation is to achieve 7 percentage point improvement by March 2027 (87%) and return to 92% by March 2029. RBFT has submitted intention to comply with these expectations.

How are we performing:

- RTT Performance reporting is currently in arrears as a result of NHSE request to extend reporting deadline - to allow for increased validation prior to month end reporting. This is expected to remain until the end of this year.
- We expect performance in October to be c. 82%.
- 2026/27 core focus of recovery actions remain on maximising first assessment activity and driving down first assessment waiting times as well as chronological booking for individual stage of treatment.
- We expect performance to continue to reduce slightly through Q3 as we deploy automations focused on improved data quality. Before improving again in Q4.

Actions and next steps:

- Continue to drive improvement in the 1st OPA waiting times.
- Continue to focus on reducing tip-over demand whilst driving down volume of long wait pathways.
- Large Language Model Development and Pathways Insight & Coordination Solution (PICS) has been delayed but expect parallel running to commence during Nov.
- Allocation of TV Innovation Funds to maximise stage of treatment backlog reduction.

Risks: Corporate Risk 5995

- Capacity to sustain performance against standard.

Strategic objective: **Driving improvement and enabling innovation**

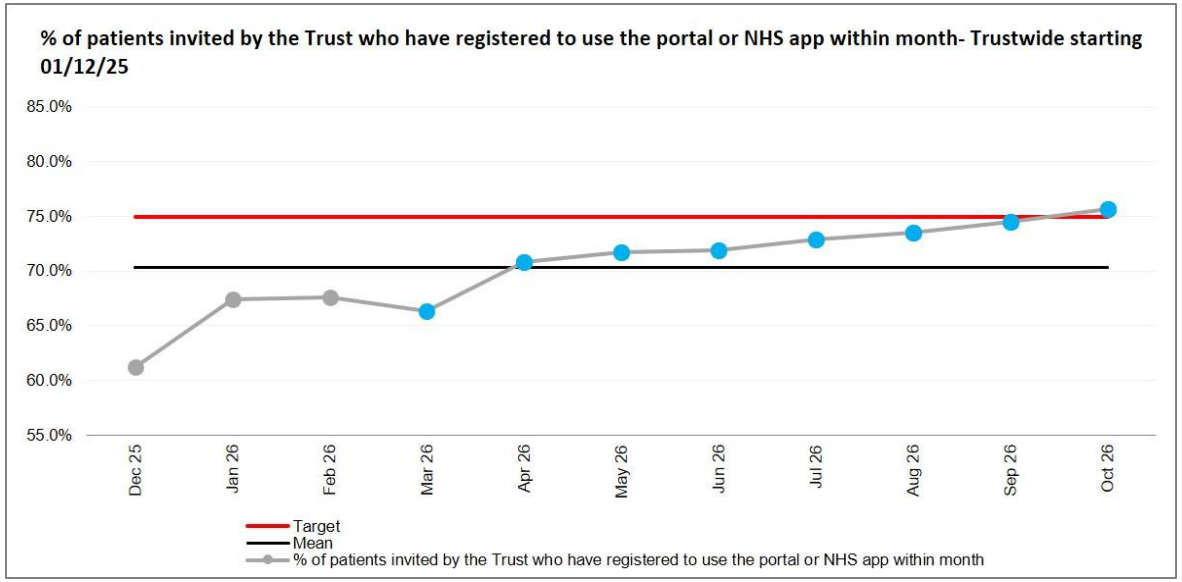
Strategic metric: Digitally enabling our patients

Board Committee
Quality Committee

SRO: Chief Strategy Officer

Assurance	Variation
?	H

Royal Berkshire NHS Foundation Trust



Insight Metrics	May-26	Jun-26	Jul-26	Aug-26	Sept-26	Oct-26
Cumulative % of patients eligible who are registered	71.7%	71.9%	72.9%	73.5%	74.5%	75.7%
Number of logins via NHS App or patient portal	240,901	268,972	306,958	295,745	341,170	337,258
Total number of letters viewed in the portal / NHS app in month	127,753	149, 287	162,971	141,817	174,373	156,117
Advice and guidance (A&G) activity	2706	2907	3098	2588	2779	2801

*** Denotes metric is part of the NHS Oversight Framework dataset**

This measures: The percentage of eligible patients accessing our patient-facing portal (Royal Berkshire Connect), including via the NHS App. This is calculated by dividing the number of patients registered by number of invites sent since we first used the portal. The Trust target is 75%.

How are we performing:

- 75.7% of patients eligible have now registered for the patient portal or NHS App with a further climb was seen in October and made the first month above target since we started recording.
- We continue to look at how we can target higher adoption in groups with lower adoption rates (0-19) and 65+.

Actions and next steps:

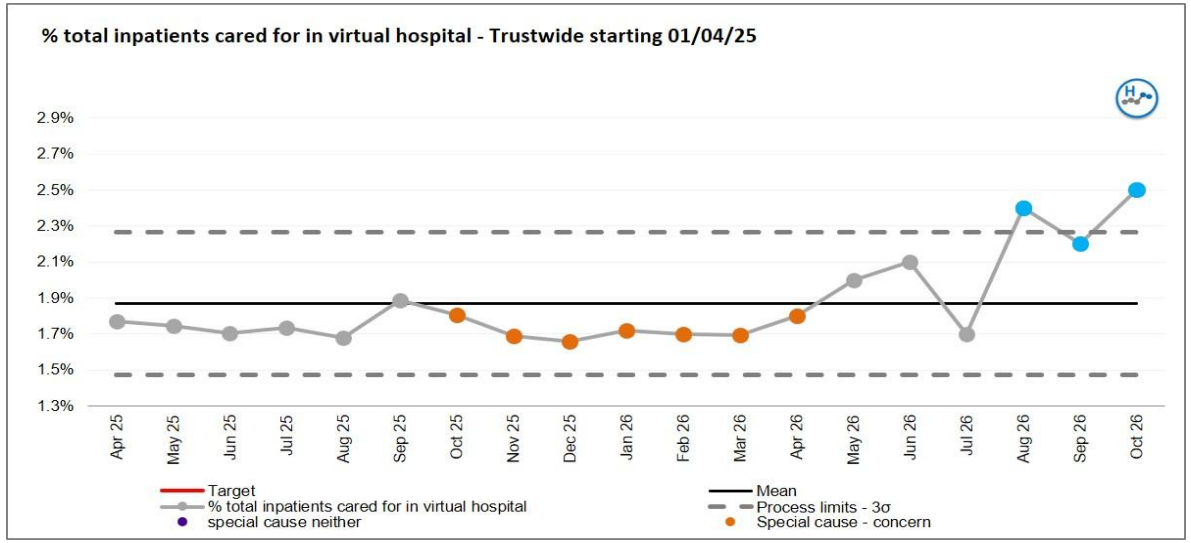
- We are working with Paediatrics to focus on uptake in 0-19 age range to improve utilisation rates.
- We have sent out messaging to those currently registered with the portal but not yet making use of paperless to increase paperless rate.
- Make discharge summaries available in a paperless format in addition to clinic and appointment letters which already are for those not opted out.
- Quotes received for enhancements to the existing portal which we are factoring into financial planning.

Risks:

- Adoption is lower in 0-19 aged patients, and we have had some issues/complaints from parents in some circumstances, we are mitigating through a new working group for this age group.

Strategic objective: **Driving improvement and enabling innovation**

Strategic metric: Percentage of total inpatients cared for by our virtual hospital at home



Insight Metrics	May-26	Jun-26	Jul-26	Aug-26	Sept-26	Oct-26
% total inpatients cared for in virtual hospital	2.0%	2.1%	1.7%	2.4%	2.2%	2.5%
Daily Average Virtual Hospital Activity	96	85	100	97	118	116
Daily Average Virtual Hospital Performance against plan (%)	120%	106%	125%	121%	148%	145%
Number of Virtual attendances	9490	11,790	10,941	9310	11,265	10,650
Distance travelled by our patients (average miles) (Outpatients including Virtual Attendances and Advice & Guidance)	4.5	4.6	4.5	4.6	4.6	4.6

*** Denotes metric is part of the NHS Oversight Framework dataset**

Board Committee
Quality Committee

SRO: Chief Strategy Officer

Assurance	Variation
N/A	

Royal Berkshire NHS Foundation Trust

This measures: The metric currently shows the percentage of all total inpatients cared for by our virtual hospital at home. This metric and its insights will be amended as required as the Royal Berks @ Home programme is scoped and enters delivery.

How are we performing:

- In October, 2.5% of all inpatients were cared for in our virtual hospital.
- This is an improving trend.

Actions and next steps:

- Pathways for Phase One confirmed.
- DDAT review of the platforms delivering remote monitoring complete.
- Finance Lead confirmed.
- Long term resource model to confirm benefits and costings.
- Set up monthly governance meetings.

Risks:

- There is a risk that limited programme resource capacity could impact the timely delivery of milestones.
- Focus on the key benefits that will free up bed capacity.
- Mitigation is to ensure close governance and a phased delivery plan that is owned and reviewed monthly.

Strategic objective: **Building a sustainable future together**

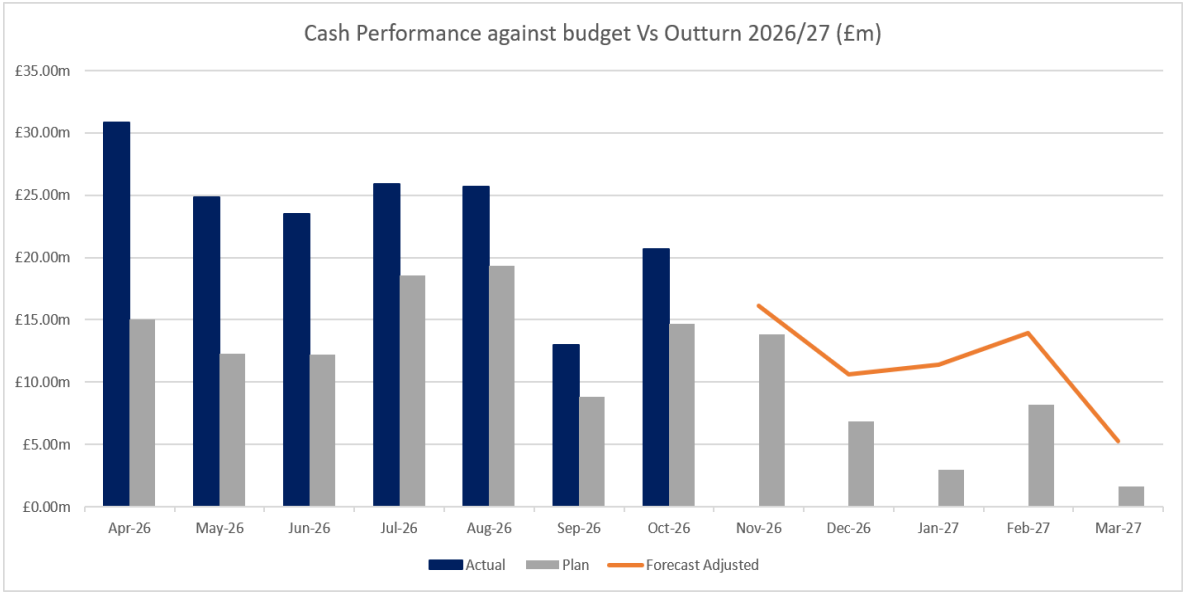
Strategic metric: Cash performance (£)

Board Committee
Finance & Investment

SRO: Chief Finance Officer

Assurance	Variation
	

Royal Berkshire NHS Foundation Trust



Insight Metrics	May-26	Jun-26	Jul-26	Aug-26	Sept-26	Oct-26
Cash Performance (£m)	£24.82m	£23.51m	£25.92m	£25.67m	£13.01m	£20.68m
Underlying financial position (£m)	£(3.41)m	£(3.90)m	£(3.21)m	£(3.05)m	£(3.24)m	£(1.87)m
In-month variance to plan: Pay (£m)	£0.26m	£(0.19)m	£(0.9)m	£(1.21)m	£(0.41)m	£(1.09)m
In-month variance to plan: Non-Pay (£m)	£0.59m	£(0.64)m	£(0.65)m	£0.51m	£(0.63)m	£(1.84)m
In-month WTE (incl bank and agency	6366	6421	6433	6485	6418	6486

*** Denotes metric is part of the NHS Oversight Framework dataset**

This measures: RBFT's cash position at M07 £20.68m is ahead of plan. The graph shows in-month performance against adjusted plan, with a straight-line projection to year-end. The forecast deteriorates later in the year, although the cash position remains positive (above zero) in Q4.

How are we performing:
Cash Performance: At the end of M7, the bank cash balance was £20.68m, £6.02m above the original plan.
Forecast: The year-end cash is forecast at £5.25m, £3.60m ahead of plan. The salary review includes £2m (1%) growth above the current run rate in the second half, in line with the prior-year trend. Successful delivery of the CIP is essential to maintaining cash resilience and managing liquidity risk.

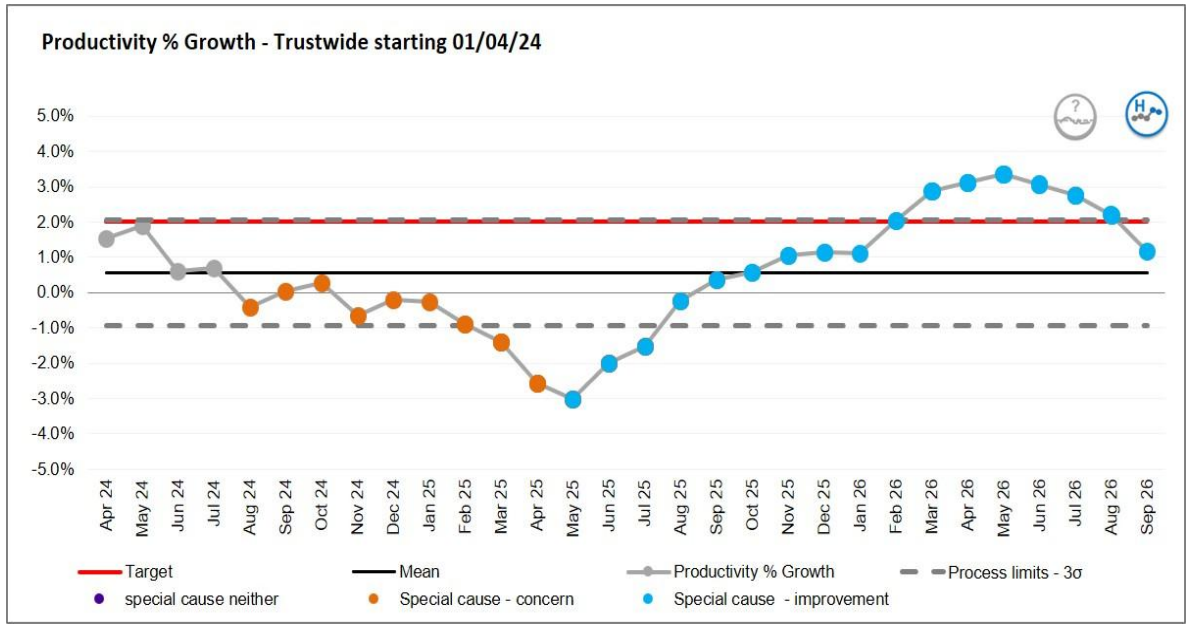
Actions and next steps:
- Accelerate cash collection and control discretionary spend.
- Convert recurring efficiencies into actual cash savings.
- Optimise supplier payment terms.
- Capital payment profile kept under review; any acceleration assessed for cash impact before commitment.

Risks:
- Performance-related income (£5m): the forecast assumes £5m of the planned £11m over-performance, but payment remains unagreed.
- £0.47m unfunded industrial action cost remains unresolved at M02
- Inability to pay suppliers on time.

Opportunities:
- Reduced clawback (£4.4m).
- Capital slippage (£1.67m): based on progress to date and the uncommitted capital programme.

Strategic objective: **Building a sustainable future together**

Strategic metric: Productivity Growth



Insight Metrics	May-26	Jun-26	Jul-26	Aug-26	Sept-26	Oct-26
*Year-on-year Productivity % Growth (activity/WTE)	3.4%	3.1%	2.7%	2.2%	1.2%	Arrears
Cost Weighted Activity (CWA) % Growth	3.4%	3.3%	3.3%	3.0%	2.2%	Arrears
Whole Time Equivalent (WTE) % Growth	0.1%	0.2%	0.5%	0.8%	1.0%	Arrears

* Denotes metric is part of the NHS Oversight Framework dataset

Board Committee
Finance & Investment

SRO: Chief Strategy Officer

Assurance	Variation
?	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 wholetime equivalent (WTE) growth against activity growth year on year. The measure is reported on a 12-month moving average basis to account for seasonal variation.

How are we performing:

- In September, productivity was 1.2% higher than the 12 months previously - driven by continued growth in activity delivered by a fixed workforce base. Rate of improvement has slowed due a decline in the increase in activity growth and an increase in workforce growth over the period.
- The National outcomes framework indicates RBFT productivity improvement in the last 12 months is in the top quartile of acute trusts with a year-on-year productivity improvement of 6% on the NHSE metric.

Actions and next steps:

- Teams have now fully identified their cost improvement plans for 26/27, supported by the financial improvement programme.
- Business planning for 27/28 will be a focus of activity in Q3. The framework under development with teams continues to emphasise productivity improvement supported by both continuous and step change programmes.

Risks:

- There remains the risk that the Trust will not be able to recover the income from activity growth in Non-elective pathways.

Royal Berkshire NHS Foundation Trust

Breakthrough Priorities

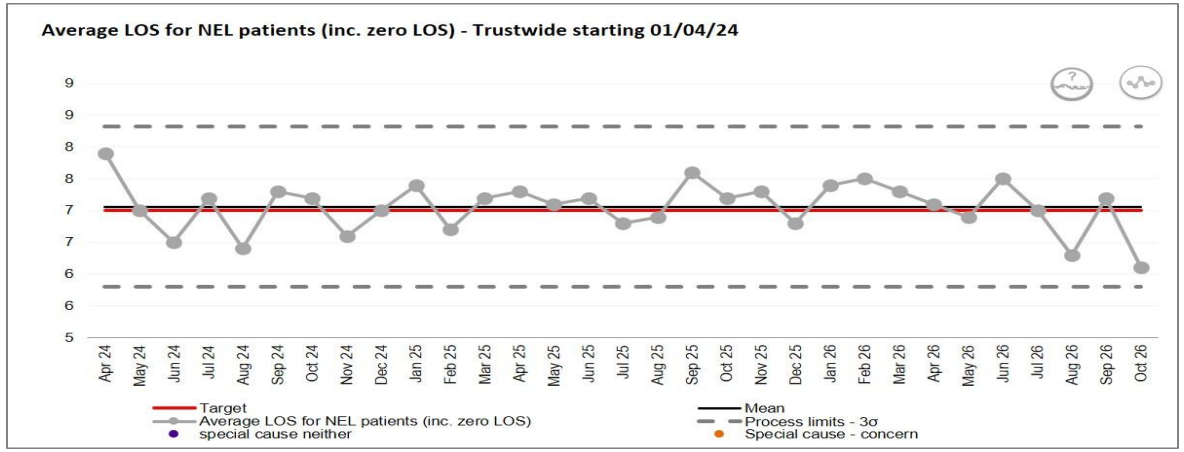
Breakthrough priority metric: Safest place
Average Length of Stay (LOS) for non-elective patients

Board Committee: Quality Committee

SRO: Chief Operating Officer

Assurance	Variation
?	

Royal Berkshire NHS Foundation Trust



Insight Metrics	May-26	Jun-26	Jul-26	Aug-26	Sept-26	Oct-26
Ave LOS for NEL patients (inc. zero LOS	6.9	7.5	7.0	6.3	7.2	6.1
Wait time (days) for a community hospital bed in Berkshire West	3.1	3.8	2.9	3.0	2.9	3.2
% of core inpatients who are ready for discharge but require support	11.1	10.1	10.7	11.7	11.5	Arrears
Average number of Community Hospital empty beds overnight	7.0	8.0	6.0	10.0	10.0	5.0
Average number of days patients wait for Social Care packages at home in Berkshire West	3.2	4.2	3.1	4.4	3.7	4.6
Average number of days patients wait for a Health Care(reablement) package of care at home in Berkshire West	2.0	1.9	1.4	1.8	1.6	1.7

* Denotes metric is part of the NHS Oversight Framework dataset

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 (reduce) ambulance handover times and ED performance

How are we performing:

- The average LOS (incl zero LOS) in October was below target at 6.1 days.

Actions and next steps:

- The Targeted discharge date (DC) (predicted on the day before DC) across the wards have improved and is just under the 60% target at 57.4%.
- Refining new process to highlight community bed demand and capacity, with new targets anticipated for winter.
- Resilience meetings along with improved communication with Local Authorities to commence to ensure visibility and improvement of Domiciliary and Car Home Pathways.
- Opening the DC Lounge on Saturday AM.
- Uptake of new Discharge and Flow Dashboard.

Risks:

- Enhanced therapeutic observations and care patients needing Care at Home or Care Homes take longer to find appropriate care.
- Increased patient moves / discharge to non-optimal ward.
- Ward closures and delays for patients needing isolation period Community Hospital ward closures preventing use of their beds.

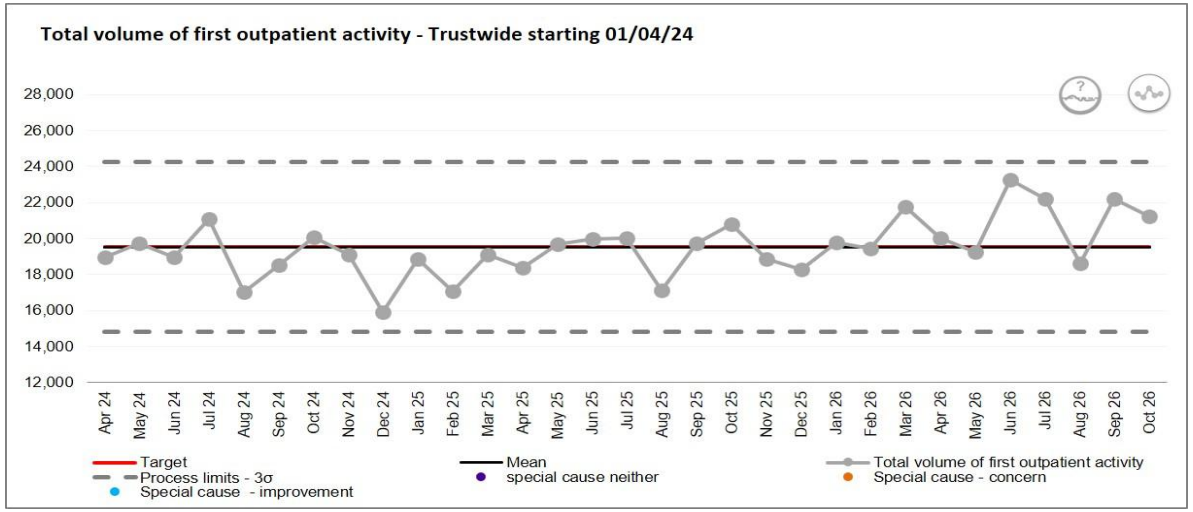
Breakthrough priority metric: Improving elective performance
Total Volume of first Outpatient (OP) Activity

Board Committee: Quality Committee

SRO: Chief Strategy Officer

Assurance	Variation
?	

Royal Berkshire NHS Foundation Trust



Insight Metrics	May-26	Jun-26	Jul-26	Aug-26	Sept-26	Oct-26
Total Volume of first outpatient activity	19,277	23,259	22,204	18,634	22,230	21,262
First outpatient activity Plan	19,842	19,843	19,842	19,842	19,843	19,839
Average wait for first outpatient appointment	57.6	64.2	58.5	60.9	68.2	64.2
% patients waiting over 12 weeks for first assessment	70.20%	69.52%	65.80%	68.93%	68.49%	68.05%
% OP that did not attend/were not brought (1st OP Appt)	7.5%	7.4%	7.4%	7.2%	8.0%	8.6%
% triage within 2 working days for all GP referrals (including 2 week wait, urgent and routine)	50.9%	65.3%	49.8%	56.4%	60.2%	55.9%

* Denotes metric is part of the NHS Oversight Framework dataset

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 October shows that we delivered over 21k 1st OPA, and remains above plan for the year.

Actions and next steps

- Operational teams remain focused on increasing 1st OPA activity with the aim of reducing waiting times to 1st assessment and reducing unnecessary appointments.
- The digital team will continue to work with specialties to develop and enhance remote monitoring dashboards, support the implementation of GIRFT principles by reducing unnecessary follow-up activity, improve patient oversight, and release outpatient capacity.

Risks: Corporate Risk 5698

- Sustained focus on first OP delivery is required to deliver the Trust's plan for the year.
- Implementing reform to follow up activity is essential to creating capacity and avoiding a backlog in the wider elective pathway.

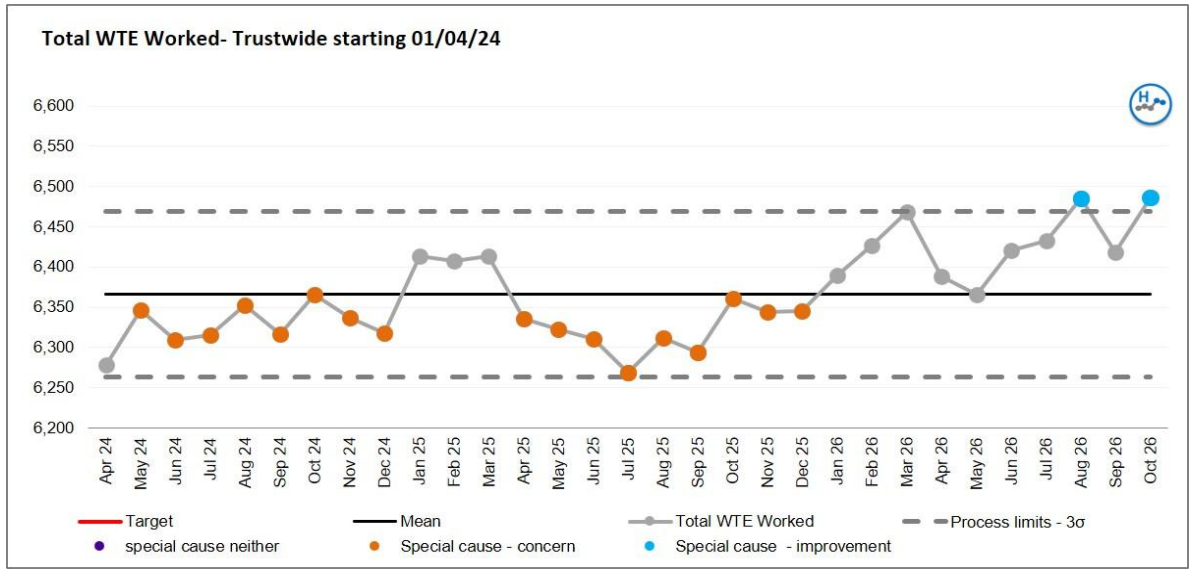
Breakthrough priority metric: Future workforce
Future fit workforce (total wholetime equivalent worked)

Board Committee: Finance & Investment Committee

SRO: Chief People Officer

Assurance	Variation
N/A	

Royal Berkshire NHS Foundation Trust



Insight Metrics	May-26	Jun-26	Jul-26	Aug-26	Sept-26	Oct-26
Total WTE worked	6366	6421	6433	6485	6418	6486
Contracted worked WTE	6130	6152	6121	6150	6103	6139
***Bank WTE**	228	262	308	331	321	346
***Agency WTE**	7	8	4	4	-6	1
Internal promotion (all bands) proportion vacancies filled with internal applicants (%)	42%	41%	38%	51%	49%	42%

* Denotes metric is part of the NHS Oversight Framework dataset

This measures: the total whole time equivalent (WTE) worked per month. There is no target shown on the chart as the target changes each month based on the Trust workforce plan.

How are we performing:

- Workforce growth: October worked WTE was 6,486, up 68 on September and 199 above plan, driven by higher substantive and bank staffing.
- Changes in staffing arrangements: Reduced agency usage and the deliberate move from overtime to bank have contributed to increased bank expenditure.
- Operational pressures: Ongoing maternity-related costs, increased patient acuity, service demand, sickness and vacancies continue to drive additional bank requirements.

Actions and next steps:

- Care groups continue to work on Cost Improvement (CIP) schemes to identify recurrent savings. This will support the headcount reduction required by the end of the financial year.
- Workforce controls continue to be refined and improved across Care Groups, Corporate, Digital Data and Technology (DDaT) and Estates and Facilities. Focus is on wider understanding of the service and efficiencies in ways of working to identify truly necessary vacancies only.

Risks:

- Ongoing variance to plan presents a risk to delivery of the plan balancing workforce with patient safety & experience, activity levels and income and maintaining cancer standards. Ongoing need to develop CIP schemes to deliver workforce plans by March 2027.

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 121 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 October 2026:

In the last month 14 of the 121 metrics exceeded their process controls. These are set out in the table opposite.

There is one new alerting watch metrics this month:

- C.Diff (Cumulative – Trust Apportioned)

A number of the alerting relate to the operational pressures experienced in the Trust and the focus being given to enhancing flow and addressing 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.

Delivering the highest quality of care for all

- Perinatal Mortality Rate (rolling year per 1000 births)
- C.Diff (Cumulative – Trust Apportioned)
- E.coli (Trust acquired) Bloodstream Infections (Cumulative)
- FFT Satisfaction Rates ED
- Mixed sex accommodation – breaches
- Complaints response Rate - Maternity

Supporting our people to thrive

- % of staff from global majority backgrounds in senior AFC Bands 8a and above
- Rolling 12-month Sickness Absence

Partnering for Impact

- Proportion of patients admitted directly to an acute stroke unit within 4 hours of hospital arrival
- Cancer – Incomplete 104 days

Driving improvement and enabling innovation

- Cyber Risk average (out of 25) on Datix Level 1, 2, & 3 includes Security, Infrastructure, application cyber risk
- Windows 11 across End User Device (EUD) Operating System (%)

Building a sustainable future together

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

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

Watch metrics

SROs: Katie Prichard-Thomas

Janet Lippett

NHS Royal Berkshire NHS Foundation Trust

	Metric	Variation	Assurance	Target	Aug-26	Sep-26	Oct-26	Oct-25
	Pressure ulcer incidence per 1000 bed days			1.00	0.11	0.57	0.32	0.40
	Category 2 avoidable pressure ulcers			5	0	1	2	1
*	Category 3 avoidable pressure ulcers			0	1	2	1	0
*	Category 4 avoidable pressure ulcers			0	0	0	0	0
	Unstageable avoidable pressure ulcers			0	0	0	0	0
*	Patient Falls per 1 000 bed days			5.00	4.28	3.72	4.14	3.58
*	Patient falls resulting in harm (PSIRF methodology applied)			-	1	2	5	0
	No. of DOLS applications applied for			-	19	18	23	22
	No. of detentions under the MH act to RBH			-	1	2	4	2
	% of staff: Safeguarding children L1 training			90.00%	96.90%	96.70%	96.20%	92.10%
	No. of child safeguarding concerns by the Trust			-	135	145	143	172
	No. of adult safeguarding concerns by the Trust			-	66	58	61	82
	No. of safeguarding concerns against the Trust			-	5	0	7	17
	Unborn babies on child protection (CP) / child in need plans (CIP)			-	47	41	37	44
*	C.Diff (Cumulative – Trust Apportioned)			39	10	11	19	36
	C.Diff lapses in care			-	1	1	8	6
*	MRSA Bacteraemia (avoidable)			0	0	1	0	0
	E.coli (Trust Apportioned) Bloodstream Infections			-	9	7	8	7
*	E.coli (Trust Apportioned) Bloodstream Infections (Cumulative)			77	47	54	62	56
	MSSA surveillance (trust acquired)			-	3	1	3	6
	Hand Hygiene			95.00%	94.57%	95.22%	97.68%	94.12%
	VTE inpatient (excluding short stay/maternity) risk assessment / prescription compliance			95.00%	93.90%	95.60%	97.00%	96.80%
	Hospital Acquired Thrombosis (HAT) rate / 1000 inpatient admissions			0.00	0.95	1.61	0.70	1.04
	Medication incidents per 1000 bed days			-	8.15	5.84	6.63	5.78
*	% of inpatients making a supported quit attempt with an in-house tobacco dependence treatment service			-	4.76%	3.68%	Arrears	-

*** Denotes metric is part of the NHS Oversight Framework dataset**

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

Watch metrics

SROs: Katie Prichard-Thomas

Janet Lippett

NHS Royal Berkshire NHS Foundation Trust

Metric	Variation	Assurance	Target	Aug-26	Sep-26	Oct-26	Oct-25
FFT Satisfaction Rates Inpatients			95.0%	94.2%	93.0%	96.0%	95.0%
FFT Satisfaction Rates ED			95.0%	80.2%	79.0%	78.0%	78.0%
FFT Satisfaction Rates Outpatients			95.0%	95.6%	95.2%	96.0%	95.0%
FFT Satisfaction Rates Daycases			95.0%	99.2%	97.6%	98.6%	99.0%
FFT Satisfaction Rates Children and Young People			95.0%	91.7%	78.5%	93.0%	96.0%
Mixed sex accommodation - breaches			0	17	78	110	303
Myocardial Ischaemia National Audit Project (MINAP): Door-to-Balloon target of less than 90 minutes			97.0%	75%	92.9%	Arrears	84.6%
Myocardial Ischaemia National Audit Project (MINAP): Call-to-Balloon target of less than 120 minutes			86.0%	25.0%	84.6%	Arrears	90.0%
Myocardial Ischaemia National Audit Project (MINAP): Call to Balloon target less of than 150 minutes			82.0%	75%	84.6%	Arrears	100.0%
Never Events			0	0	0	1	0
PSIRF: No. of Patient Safety Incident Investigations (PSII)			-	1	0	1	1
PSIRF: No. of After Action reviews			0	1	1	0	0
PSIRF: No. of Multidisciplinary Team (MDT) reviews			-	0	2	1	1
PSIRF: No. of Thematic reviews			-	0	1	0	0
No. of compliments			-	42	66	63	73

Metric	Variation	Assurance	Target	Apr-26	May-26	Jun-26	Jun-25
Crude mortality			-	1.70	1.50	1.37	1.30
HSMR			100.00	107.70	107.70	106.80	114.20
SMR			100.00	108.70	108.70	108.00	114.70
* SHMI			1.00	1.13	1.13	1.13	1.14

*** Denotes metric is part of the NHS Oversight Framework dataset**

Strategic Objective: **Delivering 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	Aug-26	Sep-26	Oct-26	Oct-25
	Deliveries			-	390	402	400	444
	Bookings			-	400	446	522	490
*	% of Inductions of labour			-	29.7%	27.5%	29.0%	27.1%
	Perinatal mortality rate (rolling year per 1000 births)	H	?	4.77	4.96	5.16	5.00	3.80
	Number of occassions MLU service suspended for 4 hours or more	L	?	4	0	0	0	6
	Midwifery staffing vacancy rate	L		-	0.0%	2.4%	1.4%	0.7%
	Midwifery staffing turnover	L	F	14.0%	9.2%	8.5%	Arrears	15.1%
	Midwife : birth ratio (utilised workforce)		?	1.22	1.21	1.22	Arrears	1.24
	FFT Satisfaction Rates Maternity		?	95.00%	95.71%	94.00%	95.00%	95.00%
	No. of complaints - Maternity	H	?	3	5	4	12	4
	Complaints response Rate		F	80.00%	25.00%	33.00%	14.00%	-
	Number of Patient Advice and Liaison Service (PALS)			-	9	6	2	-
	Number of Rapid Reviews			-	5	6	7	-
	PSIRF: No. of Patient Safety Incident Investigations (PSII)			-	3	1	1	-
	PSIRF: No. of After Action reviews			-	1	1	2	-
	PSIRF: Number of MDT reviews	↑		-	3	1	4	-
	PSIRF: Number of thematic reviews	↑		-	2	1	1	-
	Babies born with features associated with potential hypoxia	L	?	1.50%	0.00%	0.00%	0.24%	0.00%

*** Denotes metric is part of the NHS Oversight Framework dataset**

Strategic Objective: **Supporting our people to thrive**

Watch metrics:

SRO: Paul da Gama

Royal Berkshire NHS Foundation Trust

	Metric	Variation	Assurance	Target	Aug-26	Sep-26	Oct-26	Oct-25
	% of staff from global majority backgrounds in senior AFC Bands 8a and above	H	F	25.00%	25.00%	24.90%	24.30%	22.01%
*	Rolling 12 month Sickness absence	L	F	3.3%	3.5%	3.5%	Arrears	3.8%
	% Fill rate of Registered Nurse Shifts (RN)		P	90.0%	91.5%	93.0%	94.7%	94.0%
	% Fill rate of Care Support Worker Shifts (CSW)	L	P	90.0%	95.2%	96.0%	93.5%	94.8%
	Appraisals		?	90.0%	87.4%	89.9%	89.3%	89.0%
	Nurse Staffing Red Flags			-	40	46	43	40
	Stability Rate (%)	H	P	90.0%	92.7%	93.0%	92.7%	90.8%
	Turnover rate % (excluding fixed term temps and non-execs)	L	P	13.0%	8.1%	7.7%	7.9%	9.9%
	Vacancy rate	L	P	7.0%	1.4%	1.7%	0.6%	2.1%

*** Denotes metric is part of the NHS Oversight Framework dataset**

Strategic Objective: **Supporting our people to thrive**

Watch metrics:

SRO: Paul da Gama

Royal Berkshire NHS Foundation Trust

Metric	Variation	Assurance	Target	Aug-26	Sep-26	Oct-26	Oct-25
RIDDOR reportable Incidents			-	3	4	0	1
Body fluid exposure/needle stick injury			-	20	15	20	20
Environment Related Incidents			-	15	10	8	11
Conflict Resolution	H	?	90%	95%	94%	94%	88%
Fire (Annual)		P	90%	92%	92%	91%	92%
Moving and Handling Level 1	H	P	90%	95%	95%	94%	96%
Moving and Handling Level 2	L	?	90%	88%	88%	88%	89%
Health and Safety Training	L		-	96%	96%	95%	95%
Slips and Trips			-	1	5	5	4
Musculoskeletal - Inanimate object			-	5	6	6	3
Total non clinical incidents reported			-	232	241	245	247
Incidents of violence and aggression (patients, relatives, visitors to staff) - other			-	-	54	46	-

*** Denotes metric is part of the NHS Oversight Framework dataset**

Strategic Objective: **Partnering for Impact**

Watch metrics

SRO: Dom Hardy

Royal Berkshire NHS Foundation Trust

Metric	Variation	Assurance	Target	Aug-26	Sep-26	Oct-26	Oct-25
Fractured Neck of Femur: Surg in 36 hours		?	60.0%	51.0%	55.2%	Arrears	49.0%
Proportion of patients admitted directly to an acute stroke unit within 4 hours of hospital arrival		F	90.0%	75.0%	67.0%	76.0%	75.0%
Proportion of patients spending 90% of their inpatient stay on a specialist stroke unit (national target)		?	80.0%	93.0%	90.0%	89.0%	86.0%
Proportion of people with high risk TIA fully investigated and treated within 24hrs	H	?	90.0%	92.0%	96.0%	95.0%	91.0%
Cancer Incomplete 104 days	L	F	0	50	47	47	80
Average waiting times in diagnostic (DM01) services	L	?	6	4	3	4	4
* 30 day readmissions			-	451	446	459	523

*** Denotes metric is part of the NHS Oversight Framework dataset**

Strategic Objective: **Driving improvement and enabling innovation**

Watch metrics

SRO: Andrew Statham

NHS Royal Berkshire NHS Foundation Trust

	Metric	Variation	Assurance	Target	Aug-26	Sep-26	Oct-26	Oct-25
	% OP appointments done virtually			-	19.0%	20.2%	19.9%	19.7%
	Number of OPPROC			-	14989	17739	15243	16556
	Number of MDT OP			-	670	889	784	891
	Total Number of projects supported by Health Innovation Partnership (HIP)			-	66	66	66	63
	Number of Principal Investigators (PIs)			-	178	178	178	140
	Number of active research trials open to recruitment			-	376	376	376	189
	% of commercial Studies opened < 60 days (from site selection to opening of studies)			-	50.0%	50.0%	0.0%	-
*	% of commercial studies recruiting 1st participant <30 days of Trust approval / Sponsor green light			-	-	-	0.0%	-
*	% of non-commercial studies opened <60 days (from site selection to opening of study)			-	-	-	0.0%	-
	% of non-commercial studies recruiting 1st participant <30 days of Trust approval / Sponsor green light			-	-	-	0.0%	-
*	Data Quality Maturity Index			95.0%	Arrears	Arrears	Arrears	-
	Cyber Risk average (out of 25) on Datix Level 1, 2, & 3 includes Security, Infrastructure, application cyber risk		F	6	12	12	12	-
	Windows 11 across End User Device (EUD) Operating System (%)	H	F	95.0%	77.6%	82.9%	87.8%	-

*** Denotes metric is part of the NHS Oversight Framework dataset**

Strategic Objective: **Building a sustainable future together**

Watch metrics

SRO: Frances Khatcherian

Royal Berkshire NHS Foundation Trust

	Metric	Variation	Assurance	Target	Aug-26	Sep-26	Oct-26	Oct-25
	Pay cost vs Budget (£m)			-	-1.21	-0.41	-1.09	-0.73
	Non pay cost vs Budget (£m)			-	0.51	-0.63	-1.84	-1.32
	Income vs Plan (£m)			-	0.78	0.66	2.95	2.04
	Daycase actual vs Plan (£m)			-	0.84	0.13	0.97	-0.11
	Elective actual vs Plan (£m)			-	0.27	-0.41	0.71	0.23
	Outpatients actual vs Plan (£m)			-	0.84	0.13	0.97	0.73
	Non-elective actual vs plan (£m)			-	0.74	1.83	1.09	0.96
	A&E actual vs plan (£m)			-	0.69	0.67	1.23	0.35
	Drugs & devices actual vs plan (£m)			-	-0.17	0.67	-0.10	1.01
	Other patient income (£m)			-	-0.53	-0.04	0.75	0.05
	Delivery of capital programme (£m)			-	3.54	2.37	3.54	2.58
	Agency spend % of total staff cost (%)			-	4.1%	4.2%	4.6%	0.4%
	Creditors (£m)			-	-98.36	-81.44	-96.58	-139.28
	Debtors (£m)			-	46.17	42.81	48.47	51.28
	Better Payment Practice Code (BPPC) *paying supplier invoices within 30 days of date of invoice (%) YTD			95.00%	87.60%	87.20%	84.70%	73.10%
	Better Payment Practice Code (BPPC) *paying supplier invoices within 30 days of date of invoice (%) In Month			95.00%	89.80%	85.70%	70.40%	54.70%
*	Planned surplus or deficit (£m)				0.10	0.32	0.59	-
*	Variance to plan year-to-date (£m)				0.19	0.19	0.01	-

*** Denotes metric is part of the NHS Oversight Framework dataset**

NHS Oversight Framework: current performance overview

Overall NOF position

Segment: **3** Rank: **33** Trend: **Improving**

1 Population health

Supported quit attempts		1.32%

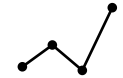
2 Access to services

RTT within 18 weeks		80.65%
Over-52-week waits		41
Diagnostics over 6 weeks		10.1%
28-day faster diagnosis		83.3%
62-day cancer standard		73.5%
4-hour urgent care		75.37%
12-hour waits		4.1%

3 Experience of care

Inpatient survey satisfaction	8.3 out of 10	–
Staff advocacy	7.54 out of 10	–

4 Effectiveness of care

Summary Hospital-level Mortality Indicator		1.08
Delayed induction		30.9%
30-day readmissions		613

5 Patient safety

Clinical audit outliers	*Quarterly*	–
MRSA cases		0
E. coli infections		9
C. difficile cumulative		28
Falls causing harm		1
Grade 3/4 pressure ulcers		1
Incidents resulting in harm		4.23%

6 Finance, productivity & innovation

Planned surplus / deficit	-1.45%	£(2.96)m
Variance to plan YTD	0%	£0.00m
Relative cost difference	88.61%	–
Productivity growth		2.4%
Trials within 90 days		50%
Data Quality Maturity Index	*Subsequent months in arrears*	95%

7 People

Sickness absence rolling 12m		3.9%
Staff engagement	7.34 out of 10	
Education & training survey	75.8%	
NHS staff standards	7.83 out of 10	
Flu vaccination rates	44.8%	
Temporary staffing		331

Royal Berkshire
NHS Foundation Trust

Title:	**Thirlwall Inquiry update paper**
Agenda item no:	8
Meeting:	Public Board
Date:	25 November 2026
Presented by:	Katie Prichard-Thomas, Chief Nursing Officer
Prepared by:	Karolyn Baker, Associate Chief Nurse

Purpose of the Report	• To present the Inquiry findings to the public Board, support assessment of whether similar events could occur within RBFT, provide assurance that effective safeguards are in place, and identify any risks requiring urgent escalation to the regional team.

Report History	• Report submitted to EMC October 2026

What action is required?	
Assurance	√
Information	√
Discussion/input	√
Decision/approval	The Board is asked to: • note the findings and national recommendations arising from the Thirlwall Inquiry; • note updated implementation progress, including completed actions and outstanding work, supported by the multidisciplinary working group and recommendation leads; • seek assurance that robust safeguards are in place across the Trust, recognising that no organisation can provide an absolute guarantee against similar events; • support continued delivery of outstanding actions and seek assurance that the working group will complete the remaining gap analysis, confirm resource requirements and develop implementation plans with relevant stakeholders through the Trust's established governance processes; • agree that this report will be presented at each Quality Committee meeting to scrutinise progress, risks, resource implications and compliance, support escalation of issues and consider implications for the RBFT assurance statement, with oversight through EMC and the Trust Board until all relevant actions are completed, evidenced and embedded; and • agree that any identified risks requiring urgent regional escalation are escalated without delay.

Resource Impact:	Some of the changes required to Buscot ward area has been funded through the fire safety funding stream, it is unclear currently if funding will be released from NHSE for ongoing projects.
Relationship to Risk in BAF:	
Corporate Risk Register (CRR) Reference /score	
Title of CRR	

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	

1 Executive Summary

The Thirlwall Inquiry identified serious and systemic failures in patient safety, leadership, governance, safeguarding and organisational culture, including repeated missed opportunities to recognise, escalate and act on concerns about unexpected neonatal deaths and deterioration. The findings require NHS organisations to test whether similar events could occur locally and to obtain clear assurance that effective safeguards, escalation routes and oversight arrangements are in place.

The recommendations relevant to Royal Berkshire NHS Foundation Trust include strengthened Board oversight of deaths and safety intelligence; clear escalation of concerning data; improved safeguarding and Sudden and Unexpected Death in Children processes; secure insulin access and storage; implementation of the National Bereavement Care Pathway; stronger Freedom to Speak Up arrangements; and a culture of professional curiosity in which concerns are welcomed, investigated and acted upon.

Implementation is underway, supported by a multidisciplinary working group and identified recommendation leads. CCTV for insulin storage has been installed, and procurement of biometric access controls has commenced. The Actions table records completion of the mortality concerns escalation route, neonatal data reporting, Board reporting and alerts arrangements, and communication of the Sudden and Unexpected Death in Children requirements. Mortality governance and safeguarding training remain in progress. Implementation of the National Bereavement Care Pathway is also in progress, with a gap analysis to be undertaken by SANDS Consultancy, while guidance from NHS England on in-cot cameras is awaited. Further assurance is required on outstanding actions, including those without a recorded progress update, and on agreed timescales, resource implications and evidence of completion.

The assurance statement emphasises the need for robust safeguards across the whole Trust, not only neonatal and maternity services, while recognising that no organisation can provide an absolute guarantee against similar events. It commits to risk identification, transparency, professional curiosity and challenge, professional standards for all teams and embedding new regulations relating to non-clinical staff. Ward-to-Board oversight will support scrutiny of outliers in practice and ensure that concerns receive further assurance or escalation.

The Board is asked to note the Inquiry findings and updated implementation progress, scrutinise whether effective safeguards are in place across RBFT, and support continued delivery of the outstanding actions. The report will be presented at each Quality Committee meeting to provide assurance on progress, support escalation of issues and enable in-depth discussion of implications for the RBFT assurance statement.

2. Background

The Thirlwall Inquiry was established following the convictions of former neonatal nurse Lucy Letby. The Inquiry examined events at the Countess of Chester Hospital between 2015 and 2018 and considered wider implications for NHS patient safety, governance, leadership, safeguarding, and organisational culture. The final report was published on 15 September 2026 and identified significant failures by individuals, organisations and regulatory systems in recognising, escalating and responding to patient safety concerns

3. Key findings

The Inquiry concluded that there were multiple missed opportunities to identify and respond to concerns about unexpected neonatal deaths and clinical deterioration. Clinicians raised concerns repeatedly; however, these were not effectively heard, investigated, or acted upon by management and wider systems.

Key themes included:

- Failure of leadership and governance to respond appropriately to emerging patient safety concerns.
- An organisational culture where concerns raised by clinicians were challenged or discounted rather than investigated.
- Weaknesses in safeguarding processes and recognition of deliberate harm as a potential cause of patient deterioration.
- Poor escalation pathways and inadequate use of patient safety intelligence and clinical data.
- Insufficient support for staff who raised concerns.
- A focus on organisational reputation at times taking precedence over patient safety.
- Deficiencies in regulatory oversight, oversight mechanisms and accountability arrangements.

4. Key National Recommendations

The Inquiry made 17 recommendations for NHS providers, regulators and the Government, 8 of these are not directed at Trust level.

- A multidisciplinary working group, with representatives from maternity, neonatology, paediatrics, safeguarding, Corporate Governance and Digital, Data and Technology (DDaT), has been established to review the recommendations, undertake a gap analysis and ensure that the Trust achieves compliance within the timescales set out in the Thirlwall Inquiry report. Leads have been identified to coordinate the actions arising from each recommendation. Clear governance and reporting arrangements will ensure that Quality committee and Trust Board are kept informed of implementation progress, compliance and emerging risks.

- Where changes are required to achieve compliance with the recommendations, implementation plans will be developed with the relevant stakeholders and agreed through the Trust's established governance processes. Existing governance and reporting arrangements may need to be revised to ensure that Quality Committee and Trust Board receive appropriate oversight and assurance on progress, risks and compliance.

Key national recommendations relevant to the Trust Board include:
Patient Safety and Clinical Surveillance

- Fit all cots and incubators in neonatal units with in-cot cameras providing livestreamed video so parents can observe their baby remotely at any time. Funding should be centrally managed and ring-fenced, with NHS England setting out an implementation roadmap by 31 March 2027.
- Introduce digital access-control devices so that only authorised people can access insulin and every access event is recorded and meet the GIRFT safe insulin-use requirements.
- Put effective mechanisms in place for Board-level monitoring of every death of a baby or child.

- Establish a clear, predetermined route to senior management for escalation of concerning data trends or patterns.
- Escalate data requiring immediate action to the Medical Director and Board without delay; otherwise report to the Board at least every six months on alerts, investigation requirements and action plans.

Safeguarding and Sudden Unexpected Death

- Review national safeguarding guidance and safeguarding training requirements, ensuring that staff and Board members receive training appropriate to their roles, including how to respond to concerns or suspicions of deliberate harm by staff.
- Amend existing hospital employment contracts and ensure agency, bank and new contracts require compliance with relevant safeguarding guidance, including the Suspicion of Deliberate Harm Protocol.
- Ensure safeguarding responsibilities are actively considered whenever deliberate harm is suspected.
- Communicate the clarification on the applicability of the Sudden and Unexpected Death in Children process to all relevant staff and the Board within seven days and ensure it operates alongside internal reporting processes.
- Prepare and distribute a one-page document detailing every step a medical examiner must take when dealing with a neonatal death.

Leadership and Accountability

- Support regulation and stronger accountability arrangements for NHS managers.
- Develop mechanisms to prevent senior leaders who fail in their responsibilities from moving between organisations without appropriate scrutiny.
- Enhance training for NHS leaders in patient safety, governance and risk management.
- Review the Inquiry findings at the next available public Board meeting, assess whether similar events could occur locally, seek assurance that effective safeguards are in place, and urgently escalate identified risks to the regional team.

Speaking Up and Organisational Culture

- Strengthen Freedom to Speak Up arrangements.
- Create a culture of professional curiosity in which concerns are welcomed, challenged appropriately, investigated and acted upon.
- Ensure staff and Board members feel empowered and confident to speak up, and that those raising concerns are protected and supported.

Bereavement Care

- Implement the National Bereavement Care Pathway for stillbirth and neonatal death nationally and within every Trust, with appropriate support for families experiencing neonatal loss.

5. Actions

Recommendation	Deadline	Progress update
1 — CCTV and monitoring: All cots and incubators in all neonatal units should be fitted with baby monitors (in-cot cameras with livestreaming video), so that parents can observe their baby remotely at any time. Funding should be centrally managed and ring-fenced to ensure consistency and implementation across all neonatal units at speed. NHS England should set out an implementation roadmap by 31 March 2027. Responsible: NHS England / all neonatal units.	31 Mar 2027	Awaiting guidance from NHSE
2.i Install CCTV focused on insulin storage until biometric access is in place, retaining recordings for at least 28 days.	CCTV: 30 November 2026	Complete
2.ii — Insulin: Meet access-control and storage requirements in the GIRFT neonatology guide to safe insulin use.	Biometric access: 31 March 2027	biometrics procurement process has commenced.
2.iii — Insulin laboratory testing: Make the October 2025 GIRFT guidance on handling insulin requests in hypoglycaemia investigations mandatory and nationally applicable. Responsible: NHS England / relevant national body.	No date stated	Pharmacy actions governance arrangements and compliance confirmed.
3 — National Bereavement Care Pathway: Implement the	31 August 2027	In progress, gap

pathway for stillbirth and neonatal death.		analysis to be undertaken by SANDS Consultancy
4.i — Safeguarding: Provide role-appropriate safeguarding training to all staff and Board members, including Non-Executive Directors, covering how to respond to concerns or suspicions of deliberate harm by staff.	Not stated	In progress
5.b — Digital interoperability: Harmonise computer systems across the NHS so neonatal data can be entered once, reviewed promptly and used for continuous monitoring. Responsible: NHS England / NHS organisations.	Dec 2028	Awaiting commencement
6.i — Mortality governance: Put effective mechanisms in place for Board-level monitoring of every death of a child or baby. Responsible: All hospital Trusts.	31 Mar 2027	In progress
6.ii — Escalation of mortality concerns: Establish a clear, predetermined route to senior management for escalation of concerning data trends or patterns. Responsible: All hospital Trusts.	31 Mar 2027	Complete
7.i — Neonatal data reporting: Name and train a lead reporter to enter MBRRACE data at least weekly, review real-time neonatal and maternity data viewers, interpret the data and discuss it with clinicians. Responsible: Hospitals with a neonatal unit.	At least weekly	Complete
7.ii — Board reporting and alerts: Escalate data requiring immediate action to the Medical Director and Board immediately; otherwise report to the Board at least every six months on alerts, investigation needs and action plans. Responsible: Lead reporter / Trust.	Immediate or at least every 6 months	Complete
8.i.b — Sudden and Unexpected Death in Children (SUDIC): Urgently brief relevant staff and the Board that the SUDIC process applies to unexpected deaths, or collapses leading to death, of anyone under 18 where no clear pre-existing medical cause is apparent, including neonatal deaths. SUDIC reporting must run alongside internal reporting processes.	28 September 2026	Complete
9.iii — Protocol implementation: Embed the Suspicion of Deliberate Harm Protocol and guidance throughout the hospital. Responsible: All Trusts.	On national publication	Awaiting national guidance
11.iii — Medical examiner safeguarding checks: Require medical examiners to ask directly about harm or safeguarding concerns and, where a concern may exist, ensure same-day recording of contact details for every doctor or nurse who attended the baby. Responsible: Medical examiners / Trusts.	Same day where concern arises	In progress
13.ii — Senior manager moves: Require Trusts seeking approval to move a senior manager to show the move is not due to capability or misconduct and that the manager meets the fit and proper person test; do not seek or grant approval without this evidence. Responsible: NHS England / Trusts.	No date stated	Awaiting commencement
13.iii Duty of candour for managers. Apply an individual duty of candour to every manager and include it in the managers' code of conduct and employment contracts. National bodies / all Trusts	No date stated	Awaiting commencement
From NHSE letter, published 22nd September 2026 — Board review of the Thirlwall report: Review the findings at the next available public board meeting, assess whether similar events could occur locally, seek assurance on safeguards for babies and children, promote professional curiosity and speaking up, and urgently escalate identified risks to the regional team.	Not mandated; due for discussion at public board 25 November 2026	In progress

6. Governance framework

The Thirlwall Working Group will maintain the master action and assurance tracker, coordinate delivery across Maternity, Neonatal, Paediatrics and corporate workstreams, triangulate evidence, and identify overdue actions, gaps, risks and dependencies. Maternity Governance and Paediatric Governance will provide formal maternity and neonatal assurance within their remit, oversee relevant Perinatal Service Review outcomes, and submit evidence and exceptions through Urgent Care Governance as the formal care group governance route, with escalations taken through to Quality Governance Committee. At a time to be agreed, responsibility for the Thirlwall Working Group's programme of work will transfer to the Perinatal Service Review.

This report will be presented at each Quality Committee meeting to provide strategic assurance on progress against each recommendation relevant to RBFT, support escalation of issues and enable in-depth discussion of their implications for the RBFT assurance statement. The Trust Board will receive scheduled updates and significant exceptions or escalations.

7. Assurance statement

The Board is asked to seek assurance that RBFT has robust safeguards to prevent a situation similar to the Letby case, while recognising that no organisation can provide an absolute guarantee. As such events could occur anywhere, safeguards must apply across the Trust, not only in neonatal and maternity services. We will maintain structures that identify risk and ensure transparency, promote professional curiosity and challenge where further assurance is needed, uphold professional standards processes for all teams, and fully embed new regulations relating to non-clinical staff. Reporting through established governance structures will maintain ward-to-Board oversight of quality and safety, supporting Board scrutiny of outliers in practice and ensuring that concerns are addressed through further assurance or escalation.

8. Conclusion

The Thirlwall Inquiry reinforces the need for sustained Board scrutiny and a culture that prioritises patient safety across the Trust. Progress has been made, but further assurance is required that outstanding actions are delivered and safeguards are effective and embedded. The multidisciplinary working group and recommendation leads will complete the remaining gap analysis, confirm resource requirements and monitor delivery against the relevant timescales. Regular reporting to the Quality Committee, with oversight through EMC and the Trust Board, will support escalation of issues and review of the RBFT assurance statement until all relevant actions are completed, evidenced and embedded.

NHS
Royal Berkshire
NHS Foundation Trust

Title:	**Progress Report against the NHS England 10-Point Plan for Maternity and Neonatal Services**
Agenda item no:	9
Meeting:	Board of Directors
Date:	25 November 2026
Presented by:	Katie Prichard- Thomas, Chief Nursing Officer Janet Lippett, Chief Medical Officer
Prepared by:	Sarah Bailey Interim Director of Midwifery

Purpose of the Report	• To provide Trust Board with progress report against the NHS England 10-Point Plan for Maternity and Neonatal Services, prior to regional submission by 31st December 2026. • To seek oversight, scrutiny sign-off on progress compliance position, supporting evidence, identified gaps in assurance and improvement actions. • To confirm continued use of existing governance routes to monitor delivery of improvement actions ahead of the December 2026 progress return.

Report History	Urgent Care Board: 18 November 2026 Executive Management Committee: 23 November 2026

What action is required?	
Assurance	Board is asked to receive assurance on the progress report, noting areas assessed as compliant, partially compliant, non-compliant or not applicable, and the supporting evidence log.
Information	The report summarises Royal Berkshire NHS Foundation Trust's progress position across 26 deliverables in the 10-Point Plan.
Discussion/input	
Decision/approval	Board is asked to approve the progress position for regional return, subject to confirmation of the named Executive sign-off and final evidence references.

Resource Impact:	No immediate additional resource request is made through this report. Some improvement actions may require prioritisation of staff time, governance capacity, digital support, training release and neonatal medical workforce planning; any material resource implications will be escalated through the relevant governance routes.
Relationship to Risk in BAF:	This report supports strategic oversight of maternity and neonatal safety, quality, governance, workforce resilience, patient experience and inequalities. It aligns to the Board's responsibility to assure safe, responsive and equitable maternity and neonatal services.
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	**x**
Supporting our people to thrive	**x**
Partnering for impact	**x**
Driving improvement and enabling innovation	**x**
Building a sustainable future together	**x**

Well Led Framework applicability:								Not applicable ☐
1. Leadership	x☐	2. Vision & Strategy	x ☐	3. Culture	x ☐	4. Governance	x ☐	
5. Risks, Issues & Performance	x ☐	6. Information Management	x ☐	7. Engagement	x ☐	8. Learning & Innovation	x ☐	
Publication								
Published on website		Confidentiality (FoI)		Private		Public	x	

1 Executive Summary

- NHS England requires Trust Boards to submit progress against the 10-Point Plan for Maternity and Neonatal Services to regional teams by 31 December 2026. Royal Berkshire NHS Foundation Trust has assessed all 26 deliverables within the 10-Point Plan.

- The September 2026 baseline identified established compliance and gaps in evidence, assurance or implementation. Actions 1 (Martha's Rule) and 10 (post-death care) are fully compliant. Action 4, "Amos into Action" staff listening events, is led by NHS England as opposed to individual Trusts.

- Most deliverables were completed upon regional submission; 6 of the 26 remain partially compliant. One has not commenced in regards to inequalities training to be delivered from NHSE and awaiting details

Summary by Action - Progress Report	Total	Current Status					RAG (deliverables)		
Action		Not Started	On hold	In progress	Complete	Completed at baseline	Red	Amber	Green
1. Listening to women and families by rolling out Martha's Rule	1	0	0	0	1	0	0	0	1
2. Listen to women and their families using real-time and transparently reported outcomes and experience and clinical audit that are acted upon at board level	3	0	0	1	2	0	0	1	2
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care	2	0	0	0	2	0	0	0	2
5. Addressing inequalities in maternity and neonatal outcomes	3	1	0	1	1	0	0	1	1
6. Ensuring 24/7 safety and responsiveness of services	7	0	0	1	5	0	0	1	5
7. Trust review of homebirth services	2	0	0	0	2	0	0	0	2
8. Responding to incidents, complaints and concerns with humanity and candour	3	0	0	2	1	0	0	2	1
9. Deliver safe and effective triage in maternity services	3	0	0	1	2	0	0	1	2
10. Post death care	2	0	0	0	2	0	0	0	2

- RBFT received regional feedback about our baseline assessment submission in October 2026 and received positive assurance on Martha's Rule, outcomes and experience reporting, executive accountability, several workforce requirements and post-death care, with improvement and governance activity evident in inequalities, homebirth, patient safety and maternity triage. The regional team confirmed actions 1 and 10 as fully compliant and all other actions as partially compliant, agreeing with 22 of the Trust's 26 deliverable ratings. These changes have been made to the baseline assessment, appendix 1.

- The Board is asked to approve the progress position for regional submission, note the supporting evidence and outstanding gaps, and support continued monitoring through existing governance arrangements. Broader discussion on the 10-point plan to take place at Quality Committee on the 30th November 2026.

2. Key Issues: Overall baseline position as of September 2026:

The September 2026 baseline assessment covered 26 deliverables. Actions 1 and 10 were fully compliant overall:

- **Action Point 1** - Listening to women and families by rolling out Martha's Rule.

- **Action Point 10** - Post death care.

Within the September 2026 baseline, the only non-compliant deliverable concerned Board oversight of maternity triage quality and performance, including waiting times, delays and inequalities. Across the remaining seven applicable actions, most deliverables were partially compliant. Progress against these gaps is set out in Section 3.

Action 1 – Martha's Rule. Compliance is supported by the Trust's established Call for Concern service. Further strengthening of maternity and neonatal implementation is under way following additional NHS England funding: this includes strengthening the neonatal referral pathway, embedding personal wellness questions across maternity and neonatal services, and delivering staff training through the Practice Education and Call for Concern teams.

3. Progress and summarised actions since Baseline Assessment September 2026.

Deliverable	Status	Progress / evidence	Next actions / evidence submitted
3.2 – Clinical leadership involvement	Compliant	Women's Services Clinical Director attended the September Quality Committee.	Director of Midwifery; Paediatrics Clinical Director and Clinical Director for women's services to contribute and attend Board discussions on maternity or neonatal matters. Evidence- Minutes of Quality Committee September 2026.
5.3 – Maternal Care Bundle	Compliant	Compliance reported monthly through PQOM; implementation updates provided through PQOM and a half-yearly Quality Committee paper presented in September 2026.	Continue reporting through existing arrangements. Evidence Minutes of Quality Committee September 2026.
6.6 – Workforce pressures and escalation	Compliant	Six-monthly staffing reviews provide oversight; escalation guidance aligns with the regional framework. Executive responsibilities reviewed on 20 October 2026.	Evidence – perinatal staffing paper to EMC 23rd November 2026; Birthrate Plus assessment planned for early 2027. Escalation Guideline.
7.1 – Homebirth review	Compliant	Review submitted to and approved by the Quality Committee in February 2026.	Evidence Quality Committee minutes
8.2 – Complaints and learning	Compliant	Complaint themes and actions reported to the Quality Committee through PQOM.	Evidence Quality Committee minutes 2026.
6.3 – Neonatal establishment	Compliant rating; full compliance subject to Board acceptance	Staffing paper confirms nursing alignment with current BAPM standards and medical staffing meeting MIS Year 8 requirements; action plan addresses 2025 BAPM medical staffing requirements.	Both papers scheduled for EMC on 23 November 2026. Board acceptance required for full compliance.

Deliverable	Status	Progress / evidence	Next actions / evidence submitted
9.1 – Triage audit and resources	Compliant rating; subject to Board agreement	Triage benchmarking to be shared with the Board; resource and cost proposals prepared.	Perinatal Service Review Team to present paper to EMC on 23 November and Public Board on 25 November 2026. Actions expected complete by July 2027.
9.3 – Triage improvement delivery	Compliant rating; delivery plan subject to Board approval	Trust reports being on track; action plan and project costs developed from the baseline assessment.	Board approval 23rd November 2026 to enable a full delivery plan for completion by 27 July 2027.
2.3 – Outcomes and experience by ethnicity and deprivation	Partially compliant	Some outcomes information reaches Board through PQOM; comprehensive live reporting by ethnicity and deprivation is not yet available. Maternity leads met Informatics in October 2026.	Develop comprehensive dashboard. Interim local equity dashboard to use available monthly outcomes data, including preterm birth, haemorrhage, mortality, severe tears, booking gestation and neonatal admissions. Start in December PQOM; Q1/Q2 thematic equity safety report to December Quality Committee.
5.2 – Inequalities dashboard review	Partially compliant	NHS England maternity inequalities dashboard is now included in PQOM but uses 2025 data.	Supplement with local monthly equity data as described in 2.3. Quality Committee to review dashboard and associated actions in December 2026.
6.7 – Specialist-role resilience	Partially compliant	Specialist staff can be redeployed during pressure; update-day training covers infant feeding, bereavement, screening and diabetes. Assurance remains incomplete on cover and skills across all specialist roles.	Compliance Lead Midwife to review resilience arrangements and identify further actions by 31 December 2026.
8.1 – Embedding PSIRF	Partially compliant	Daily clinician incident review and Rapid Review escalation are in place. Learning and actions monitored locally and through PQOM; obstetric involvement is limited.	Agree sustainable local processes and establish weekly multidisciplinary incident review. Recruited safety and administration staff to commence by January 2027.

Deliverable	Status	Progress / evidence	Next actions / evidence submitted
8.3 – Compassionate debriefing and family contacts	Partially compliant	Open learning, family engagement and duty-of-candour processes exist; consistency of compassionate debriefing and named family contacts is not fully assured. Staff support includes TRIM, midwifery advocacy and psychological support.	Strengthen arrangements with the new perinatal patient safety lead and administrative support. Monitor progress through maternity and neonatal governance and PQOM.
9.2 – Triage quality and performance oversight	Partially compliant	Comprehensive electronic reporting is not yet available. Monthly manual BSOTS audits measure arrival-to-triage time but do not cover subsequent care and review.	DDAT to develop comprehensive reporting. Dashboard targeted for end of November 2026; reporting delivery date also described as awaiting DDAT confirmation. Continue manual audits in the interim.

4. Conclusion

The assessment demonstrates progress against the 10-point plan and provides an opportunity for continued Trust Board oversight. Most deliverables are complete; 6 remain partially compliant. Continued focus is required on inequalities reporting, neonatal medical workforce planning, specialist-role resilience, embedding PSIRF, compassionate debriefing and maternity triage resourcing and performance.

The following actions are fully compliant:

- **Action Point 1** - Listening to women and families by rolling out Martha's Rule.
- **Action 3 -** Dual board- level accountability between Medical Directors and Chief Nursing Officers for maternity and neonatal care.
- **Action Point 7** - Trust review of home birth service.
- **Action Point 10** - Post death care.

The Board is asked to approve the progress position for NHS England regional submission by 31 December 2026; note the six partially compliant deliverables; and support continued monitoring of the associated actions through established governance routes.

5. Attachments

The following documents are available on request:

- Appendix 1: NHS England 10-Point Plan Submission B – Progress Report.

Royal Berkshire
NHS Foundation Trust

Title:	**Board Assurance Framework**
Agenda item no:	10
Meeting:	Board of Directors
Date:	25 November 2025
Presented by:	Caroline Lynch, Trust Secretary
Prepared by:	Caroline Lynch, Trust Secretary

Purpose of the Report	To provide the Board with a summary of the Trust's Key risks reviewed by Board sub-Committees and relevant Executive leads.

Report History	EMC 9 November 2026 Audit & Risk Committee 11 November 2026 Finance & Investment Committee 18 November 2026

What action is required?	
Assurance	
Information	The Board is asked to note the updates on the Framework in relation to the assurances, gaps and actions in place to manage strategic risks.
Discussion/input	
Decision/approval	

Resource Impact:	Not applicable
Relationship to Risk in BAF:	Not applicable
Corporate Risk Register (CRR) Reference /score	Not applicable
Title of CRR	Not applicable

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 ☐

- Board understands the internal and external factors affecting delivery of the plan.
- Main risks are identified. No significant control issues/ gaps and clear responsibilities.
- Effective process in place to monitor, understand and address current & future risks

Publication						
Published on website		Confidentiality (FoI)	Private		Public	✓

1 Purpose

1.1 The Board of Directors has the overall responsibility for ensuring that systems and controls are in place that are sufficiently robust to mitigate risks which may threaten the achievement of the

Trust's Strategic Objectives.

1.2 The Board achieves this primarily through the work of its sub committees, the use of Internal Audit and other independent inspection and by the systematic collection and scrutiny of performance data to evidence the achievement of the Trust's objectives.

1.3 The Board Assurance Framework (BAF) is designed to provide the Board with a simple but comprehensive method for oversight and management of the Principal Risks to the Trust's objectives.

2. Current Position

2.1 The Board Assurance Framework has previously been reviewed by the Quality Committee: 22 April and 3 September 2026, Finance & Investment Committee: 20 May and 16 September 2026 and People Committee on 7 May 2026.

2.2 Reviews have also been undertaken with the Chief Finance Officer, Director of Estates & Facilities, Chief Strategy Officer, Chief Medical Officer, Chief Nursing Officer and Chief Operating Officer.

2.3 The BAF risk statements for 5.1, 5.2 and 5.3 and risk description have been updated

2.4. An additional risk has been added - 5.6. If we do not take action on the environmental sustainability agenda, we risk impact on the Trust's reputation

Strategic Objective 1

- The Control Assurance section has been updated to include Response to Fuller (Mortuary) Enquiry report, Mortuary HTA inspection reports, Learning from Deaths quarterly report and Perinatal Quality Oversight Model Report & Perinatal Mortality Review Report
-
- The Improvement/Action section has been updated to include Perinatal Service Review and Maternity and Neonatal 10 Point plan assurance report

Strategic Objective 2

<u>The Control Assurance section has been updated as follows:</u>

- International recruitment programme and birthrate plus, staff psychology support services and sexual safety charter signatory removed

- Talent Management Framework/succession planning, Staff Health & Wellbeing (HWB) Strategy 2025- 28, Occupational HWB services and Management training on staff HWB / people management, Up the Anti Programme, Sexual Safety Charter added

<u>The Gap in Assurance section has been updated as follows:</u>

- Talent Management Framework/succession planning fully embedded, appraisal compliance plan, and Development of management competencies throughout the whole organization removed

- Clear Employee Value Propositions, apprenticeship levy, Capacity of staff physiotherapy service to deliver proactive training to reduce MSK issues, resourcing the Staff Psychological Support Service to develop the service including potential 1-1 support, pace across EDI agenda, Workforce impacts of 3 shifts and delivery of Scaling People Services agenda added

<u>The Improvement/Action section has been updated as follows:</u>

- Audit appraisal effectiveness evaluation, creation of lifetime employee value propositions, senior leadership programme and Align RISE and Leadership with National management and Leadership framework, NHS Health & Wellbeing Framework Assessment Tool ongoing monitoring, recruit to vacant OH posts, staff preventative health pathway to commence February 2026, review OH triage process for referrals, target OH/ER training to managers in areas with high absence, CPO Driver Metric Focus on Global Majority Representation at Band 8A +Programmes to tackle poor behaviours and drive civility and Update Behaviours Framework, Up the Anti (Anti-Discrimination Trust Wide Programme added.

Strategic Objective 3

- Minor changes only

Strategic Objective 4

- Launch of online Improving Together training, Bi-annual review of benchmarking data on productivity and efficiency and Quarterly NOF updates, Scoping of the four strategic programmes and Reading and Thames Valley Innovation Partnership Implementation of Strategic Partnership reviews recommendations added to the control assurance section
- Detailed delivery plans for the strategic programmes including benefits identification, Alignment of strategic programmes and key enablers (esp digital and capital) and Board and executive governance of the strategic programmes added to the gap in assurance section
- Proteus engagement with key programmes, Development of programme delivery plans and benefits and revised governance on innovation and transformation added to the improvement/action section.
- Innovation & Transformation Committee added as responsible Committee for Transformation Programmes.

Strategic Objective 5

- Existing Green Plan, Land Search completed, New Hospital Alliance mobilised and Political support for land purchase added to the control assurance section.
- Secure options agreements on preferred sites and Complete due diligence on preferred sites added to the improvement/action section.

3. Next Steps

3.1 The Board is asked to note the updates to the Board Assurance Framework.

4. Attachments

4.1 The following are attached to this report:

Appendix 1 – Board Assurance Framework

Trust Board Assurance Framework

November 2026

Summary Board Assurance Framework 2026					
Strategic Objective	**BAF Risk**		**Risk Appetite Description**	**Sub Committee**	**Lead Director**
Strategic Objective 4: Driving improvement and enabling innovation	4.1	If we do not continue to invest in digital infrastructure and development we will not be able to deliver Our Strategy and our Clinical Services Strategy and we will face challenges in running a modern efficient healthcare service	The Trust will actively seek and encourage a culture of innovation and improvement. It is willing to accept a relatively high level of risk associated with opportunities where positive quality of care, service delivery and financial benefits and rewards can be anticipated.	Quality Committee	Chief Operating Officer
	4.2	If we fail to realise benefits/secure commercial advantage from innovation, transformation, improvement and digital investments we will face income shortfalls and will not to be able to deliver our efficiency targets 4 x 4		Finance & Investment Committee Innovation & Transformation Committee	Chief Strategy Officer
Strategic Objective 5: Building a sustainable future together	5.1	If the organisation does not generate sufficient cash to meet its day to day liquidity requirements and capital programme the organisation will fail	The Board's key objective is to be financially sustainable, with its primary concern being the optimal value for money. The Board will view risk and reward and consider return on investment and other benefits or constraints when pursuing business opportunities. There is a low appetite for risk unless the Trust is living within its means. However, the Trust has got a moderate risk appetite for investment decisions that have significant benefit for patients or staff as long as there is a clear understanding of the risks and mitigations are identified.	Finance & Investment Committee	Chief Finance Officer
	5.2	If we do not robustly represent the organisation in national and regional and Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System decision making, we will fail to secure sufficient income to deliver our Strategy and strategic objectives.		Finance & Investment Committee	Chief Finance Officer
	5.3	If we do not take action on financial sustainability agenda we risk impact on the Trust's reputation		Finance & Investment Committee	Chief Finance Officer
	5.4	If we do not create and maintain a built environment suitable for current and future needs, we risk delivery of Our Trust Strategy: 5 x 3		Finance & Investment Committee	Chief Strategy Officer
	5.5	If the Trust is not successful in converting the future promise of a new hospital and bring it to fruition sooner than 2040, we risk the ability to deliver on our mission over the long term 5 x 3		Finance & Investment Committee	Chief Strategy Officer
	5.6	If we do not take action on the environmental sustainability agenda, we risk impacting on the Trust's reputation		Quality Committee	Chief Strategy Officer

Strategic Objective 4: Driving improving and enabling innovation				
Identified Strategic Risks that we the Board have agreed as having the potential to impact on our ability to deliver this strategic objective - • The capability culture and capacity in the organisation to deliver change • Our continued commitment to invest in and develop our digital environment • Our ability to realise benefits/secure commercial advantage from innovation, investment and digital investment				
Key Controls	**Control Assurance**	**Gap in Assurance**	**Improvement / Action**	**Responsible Committee**
• Improving Together (IT)	• Integrated Performance Report • NHS Impact CQI (Improving Together) Maturity Matrix • Launch of online Improving Together training		• Full implementation of Improving Together programme	• Quality Committee
• Trust Transformation Programme • Digital Hospital Committee • Target Operating Model and revised DDaT structure	• Turnaround and Transformation reports to F&I • System Transformation Board • Digital Strategy • Monthly finance reports • Commercial strategy updates	• Confirmation of 2026/27 Trust Projects and associated benefits • Progress of APC and system savings	• Reporting on progress to EMC and ITC • Executive engagement with APC and SRTB – focus on actions and delivery • Bi-annual review of benchmarking data on productivity and efficiency	• Innovation & Transformation Committee • Finance & Investment Committee
		• Recruitment to new DDaT structure within the current financial envelope	• Implementation of the 2026/27 roadmap of projects that digitally enable clinical improvement •	• Finance and Investment Committee
• Commercial Strategy	• Annual update on R&I to Quality Committee/R&I Strategy • Reading and Thames Valley	• Cycle of reporting on commercial strategy • Commercial capacity within the organisation	• Commercial Strategy (part of the Finance Strategy) to be added to work plan bi-annually	• Finance & Investment Committee

• R&I programme	Innovation Partnership Implementation of Strategic Partnership reviews recommendations			• Quality Committee

Strategic Objective 5: Building a sustainable future together

Identified Strategic Risks that we the Board have agreed as having the potential to impact on our ability to deliver this strategic objective:

If the organisation spends at a rate greater than the rate of income received, it will continue to be in an overall deficit position and thus not generate sufficient cash to meet its day to day liquidity requirements, Furthermore, if the organisation continues to rely on non-recurrent income, such as deficit support funding, to fund the recurrent cost base then there is a risk to long-term sustainability. There is currently revenue cash support available for planned revenue deficits to ensure providers do not have to reduce capital investment to achieve liquidity. However, should the Trust exceed the planned deficit then there isa risk to capital investment which in turn risks aging equipment replacement and critical infrastructure upgrades not being action.

Key Controls	Control Assurance	Gap in Assurance	Improvement / Action	Responsible Committee
Finance				
• Standardised Annual Planning following NHSE guidance and tinetable • Medium-term planning • Internal performance management system: • Monthly financial reporting system • Run rate reporting • Standardised monthly forecasting • Standardised internal expenditure controls (enhancements to the SFIs) including workforce controls • Standing Financial Instructions (SFIs) • Daily/ weekly/ monthly cash management processes	• All annual plans: capital, revenue, efficiency, workforce and activity approved through EMC, Board committees and Board • External Audit annual process • Internal Audit annual work plan • Counter Fraud Annual Plan • Executive and Board "go and Sees" giving the opportunity to triangulate activity, workforce and finance data with service experience • Detailed Monthly and Quarterly submissions to NHS England and TV ICB • Standardised revenue forecasting shared with EMC, F&I and Board identifying mitigating actions where required • Capital forecasting shared with CPC identifying mitigating actions where required • Budget approval process • Monthly reports to EMC, Finance & Investment Committee, minutes to demonstrate appropriate discussions • Monthly performance meetings with Care Groups and corporate areas • HFMA Financial Sustainability checklist • Monthly Efficiency & Productivity Committee • Financial performance as a driver metric for all care groups/ corporate directorates • Cash Committee set up within the Trust governance framework to ensure executive and non-executive oversight of cash preservation decisions	• Standardardised benchmarking of expenditure using NHSE performance packs, model hospital and service line reporting (SLR) • Lack of oversight of income delivery by care groups • Lack of alignment between workforce and finance on WTE figures • Lack of recognition of WTE plans for 25/26 by care groups and corporate directorates • Refresh Finance Strategy (aligned to Trust Strategy & NHSE 10 Year Plan) • Application of new NHSE guidance on Strengthening Financial Management to be reviewed to identify any gaps. Review likely to identify a gap in non-pay controls and the requirement for a finance recovery committee	• Using the RBFT LTRM, develop a robust 3-year revenue operating plan and 4-year capital plan that delivers all performance requirements following NHSE guidance, business rules and timetable • Continue to review how to getter better traction with run rate improvement, deciding on how best to progress income improvements and costing methodologies within the finite resources of the finance team • Further develop a more robust approach to forecasting which incorporates a review of robustness of the prior period forecast. • Continue to seek to convert efficiencies into recurrent savings in 2025/26 and build a consistent approach to efficiencies expecting no more than 1/3rd to be delivered non-recurrently each year • Complete actions in the finance function improvement plan	Finance & Investment Committee Finance & Investment Committee Finance & Investment Committee Finance & Investment Committee Audit & Risk Committee

Estates & Facilities				
• Management of backlog maintenance including Critical Infrastructure Risks • Food safety/catering standards • Estates Programme Committee • Estates Maintenance supply and management arrangements • Estates Governance & Compliance Oversight Group	• NHS Premises Assurance Model (PAM) • External Regulator Inspections (e.g. Fire) • MODEL hospital • ERIC (Estates Reference Information Collection) • Six Facet Survey • PLACE assessment • Estates management and governance process including Hospital Technical Management (HTM) compliance • Capital prioritisation process • Audit processes • Estates & Facilities Improving Together metrics • Estates & Facilities Health & Safety dashboard report • Geo-technical site survey with specific recommendations and actions • Estates Masterplan	• Capacity, resourcing and expertise constraints in the directorate (National shortage and market salaries of project management and engineers with estate skills) • HTM compliance due to backlog maintenance • High and medium Critical Infrastructure Risks • Exponential increase in running costs (utilities and maintenance) as a result of the New Hospital Programme review announcement and increasing backlog maintenance. • Sources of capital for major estate programme and to address backlog maintenance • Effective utilisation of estate	• Prioritisation and risk management of backlog maintenance and Critical Infrastructure Risks • Review of risk register ratings and mitigations in light of the New Hospital Programme review announcement. • Investment plans and funding related to Estates Strategy/Masterplan. • Delivery of Masterplan, development control plan and asset management plan.	• Finance & Investment Committee • Audit & Risk Committee • Finance & Investment Committee
• Net Zero Carbon Plan		• Funding and delivery of Net Zero action plan • Tracking and measurement of in year carbon reduction • Lack of dedicated resource	• Revenue/budget setting to consider and reflect allocation and resources • Mapping capex with carbon impact • Establish resources/commitment/capital/revenue to deliver published Green Plan intentions	• Quality Committee
• New Hospital	• Government confirmation of funding of £2bn for a new hospital in 2040 • Proposals with NHP to progress land purchase • Stakeholder support to explore how to bring forward the new hospital • New Hospital Alliance mobilsed • Land search completed.	• Promise of new hospital is subject to multiple general elections • Focus of NHP is on wave 1 and 2 Trusts • Decision making at NHP is subject to political influence • Trust has no access to funding until 2030 •	• Continue to engage with NHP through the wave 3 engagement process • Complete land acquisition business case	• Finance & Investment Committee
Health & Safety				
• Health & Safety Policy • Health & safety mandatory training • Risk Assessments / Corporate Risk Register • Health & Safety governance processes	• Health & safety Committee reporting to IRMC/EMC/Audit & Risk Committee/ Board • Health & Safety dashboard • RIDDOR reporting • Contractor reporting on Specialist compliance on critical estates safety • Health & Safety Moment at Public Board • Big 4 Health & Safety messages • Health & Safety Training •	• Contractor assurance required validation • Security Manager to be recruited • Substantive Health & Safety Advisor not in post • Face to Face manual handling	• Streamline automatic data collection and dashboard in IPR with thematic analysis • Reshaping delivery of hard FM Services • Advisory assurance by Internal Audit (to move to S02)	• Audit & Risk Committee

Royal Berkshire
NHS Foundation Trust

Title:	**Corporate Risk Register**
Agenda item no:	11
Meeting:	Public Board
Date:	25 November 2026
Presented by:	Katie Prichard-Thomas, Chief Nursing Officer
Prepared by:	Dawn Estabrook, Head of Risk

Purpose of the Report	To update the Board on the Trust's Management of risk including the review of the Corporate Risk Register

Report History	Integrated Risk Management Committee: 30 October 2026 Executive Management Committee: 9 November 2026 Audit & Risk Committee: 11 November 2026 Finance & Investment Committee: 18 November 2026

What action is required?	
Assurance	✓
Information	✓
Discussion/input	✓
Decision/approval	✓

Resource Impact:	
Relationship to Risk in BAF:	
Corporate Risk Register (CRR) Reference /score	
Title of CRR	

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	

1 Executive Summary

This report provides the Board with an update on the Trust's corporate risks and recommendations from the Integrated Risk Management Committee (IRMC) on Friday 30 October 2026

2 Corporate Risk Register

The table below outlines the current corporate risks

Risk ID	Title	Current Risk Rating	Previous Risk Rating	Target Risk Rating	Board Sub-Committee
5080	Fire Safety	20	20	4	Audit & Risk
7442	Maternity Block Fire Safety Risk	20	20	6	Finance & Investment
4183	Management of Estates Infrastructure / Backlogged Maintenance	20	20	6	Finance & Investment
4170	Risk of Cyber-Attack	16	16	8	Finance & Investment
6320	New Hospital	16	16	4	Finance & Investment
4172	ED Capacity & compliance	16	16	8	Quality
4839	North Block East Wing	15	15	6	Audit & Risk
6302	Failure of Trust central digital connectivity centre	15	15	4	Finance & Investment
7824	Porters IA - risk to patient flow and consequence risk of harm because of implications of ongoing industrial action	15	N/A	4	People
5995	Failure to achieve elective standards targets	12	12	6	Quality

7695	Complaints response times – reputational and compliance risk	12	12	4	Quality
4241	Compliance with cancer standards due to capacity issues in diagnostic modalities	12	12	8	Quality
7718	Cash & Working Capital	12	12	4	Finance & Investment
7823	E-Financials unsupported and moving finance ledger systems	12	N/A	4	Finance & Investment
4182	Risk to achieving in-year financial targets	12	12	4	Finance & Investment
5698	Risk to compliance of DM01 Standard	12	12	4	Quality
6571	Risk of failure of Trust communication platform	12	12	4	Finance & Investment
6319	Age and condition of Trust lifts	12	12	9	Finance & Investment
699	PTL Dashboard - Lack of Access & Information	12	12	4	Quality
5697	Violence and aggression against staff	12	12	4	People
4460	Outbreaks of infectious conditions	12	9	9	Quality
5717	Risk following significant power failure incident	9	9	4	Audit & Risk

2.1 One corporate risk has been closed and moved to Estates & Facilities risk register since the last report to Board in May 2026:

- Risk 5601 Potential geological/sink hole risk across RBH Estate

2.2 Two new corporate risks have been added since the last report to Board:

- 7824 Porters Industrial Action
- 7823 E-Financials unsupported and moving finance ledger systems
- 7718 Cash & Working Capital
- 7695 Complaints response times – reputational and compliance risk

2.3 Two new potential corporate risks are to be scoped ahead of the Integrated Risk Management Committee in February 2027

- The impact of climate changes/patterns on service operations
- Martyns Law potential financial, operational and compliance risk

A full review of the corporate risk target risk ratings was undertaken by the Chief Operating Officer, Chief Strategy Officer and Head of Risk in August 2026 and approved at the IRMC meeting. The Head of Risk will complete the same piece of work with the Care Groups for their L3 risks.

3 Conclusion

The Board is asked to consider whether the BAF or CRR reflects those operational or strategic risks that will impact on the Trust's ability to operate as desired and achieve its strategic objectives.

Board Work Plan 2026/27

NHS Royal Berkshire NHS Foundation Trust

Focus	Item	Lead	Freq	Nov-26	Jan-27	Mar-27	May-27	Jul-27	Sep-27	Nov-27
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	■	■	■	■	■	■	■
	Star Cards	AS	Quarterly		■		■			■
0	Quarterly Forecast	FK	Quarterly		■			■		
	2027/28 Capital Plan	FK	Annually			■				
	Operating Plan/ Business Plan 2027/28	AS	Annually	■	■					■
	The Green Plan	AS	Annually	■						■
Driving improvement and enabling innovation	Standing Financial Instructions	FK	Annually			■				
Other / Governance	Chief Executive Report	JB	Every	■	■	■	■	■	■	■
	Board Assurance Framework	CL	Bi-Annually	■			■			■
	Corporate Risk Register	KP-T	Bi-Annually	■			■			■
	Integrated Performance Report (IPR)	Exec	Every	■	■	■	■	■	■	■
	NHSE Annual Self-Certification	FK/CL	Annually				■			
	Standing Orders Review	CL	Annually		■					■
	Board Work Plan	CL	Every	■	■	■	■	■	■	■

Royal Berkshire NHS Foundation Trust

Notes

Quality Committee

Thursday 3 September 2026
10.00 – 12.20
Boardroom, Level 4

Members

Dr. Minoo Irani	(Non-Executive Director) (Chair)
Ms. Suzanne Byrne	(Non-Executive Director)
Mr. Dom Hardy	(Chief Operating Officer)
Dr. Rupa Joshi	(Non-Executive Director)
Dr. Janet Lippett	(Chief Medical Officer)
Mrs. Katie Prichard-Thomas	(Chief Nursing Officer)

In Attendance

Mr. James Blythe	(Chief Executive)
Ms. Helen Challand	(Deputy Chief Nurse) (for minute 65/26)
Dr. Bryn Kemp	(Clinical Director, Women's Services) (up to minute 64/26)
Mrs. Caroline Lynch	(Trust Secretary)
Ms. Leslie Mokogwu	(Head of Research & Innovation) (for minute 74/26)
Ms. Elizabeth Williams	(interim Head of Midwifery) (up to minute 64/26)

Apologies

60/26 Declarations of Interest

There were no declarations of interest.

61/26 Minutes for Approval: 1 July 2026 and Matters Arising Schedule

The minutes of the meetings held on 1 July 2026 were approved as a correct record and signed by the Chair.

The Committee noted the matters arising schedule. All actions had been completed or scheduled.

62/26 Perinatal Mortality Report Quarter 1 2026/27

The interim Head of Midwifery introduced the report and advised that the Trust's perinatal mortality for Quarter 1 was 1.66 per 1000 births. This was below the national perinatal mortality rate. The Committee noted that Friends & Family data for maternity remained high and was 95% in June 2026.

The interim Head of Midwifery highlighted that key themes from incidents were Maternity Assessment Unit (MAU) triage timeliness and theatre capacity for category 1 and 2 Caesarean sections. The Committee noted that there had been 2 Caesarean sections per day increase.

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The Committee noted that the two Maternity Outcome Signal System (MOSS) signals had been cancelled by NHSE due to data issues relating to the coding of births by site. Importantly, the learning from both reviews aligned with wider improvement themes that form part of the perinatal service review.

The Committee discussed the six amber rated actions in relation to Maternity Incentive Scheme compliance. The interim Head of Midwifery confirmed that action related to Electronic Patient Record (EPR) changes had been escalated and was being monitored by the Digital Data & Technology governance meetings.

63/26 Perinatal Quality Surveillance Model Report

The Committee noted that a perinatal service review had been commissioned and this would be carried out over the next 6 to 9 months. The Chief Nursing Officer advised that a Head of Compliance for Maternity and neonates had recently been recruited. Funding had been agreed for 3.5 Whole Time Equivalent (WTE) Band 6 midwives.

The Trust was required to submit its baseline assessment of the Maternity and Neonatal 10 Point Plan to NHS England (NHSE) by 25 September 2026 and this had been scheduled for the public Board in September 2026. The full assessment was due for submission in December 2026.

The Clinical Director, Women's Services provided an overview of the foetal growth surveillance that identified that the incidence of small for gestational age newborns was decreasing and compliance with gestational date of birth was increasing.

The Committee note that key themes from the NHSE Insights view including growth pathway, capacity/space in the unit and theatre capacity for Caesarean section and subsequent impact on patient flow. All these themes were included in the perinatal service review.

64/26 Maternity Incentive Scheme (MIS) Year 8 Mid-Point Review

The Committee received the report noting that the Trust had achieved all 10 safety actions for Year 7. For 2026/27 there were six safety actions; two were currently complete, four were in progress and three were highlighted as a challenge to achieve compliance. These were Safety Actions A, C & F. The Committee noted that the Safety action A related to the requirement to uplift neonatal medical staffing in line with British Association of Perinatal Medicine (BAPM) standards for a high activity local neonatal unit. However, compliance could be achieved if the Trust could demonstrate a plan to implement this. The Committee noted that any concerns in relation to achieving compliance would be escalated to the Executive Management Committee.

The Chief Nursing Officer advised that an NHS England (NHSE) Insights visit to the maternity and neonatal unit was scheduled for the following week; this was a planned visit and not in relation to any concerns regarding the Trust.

A further update on the final submission would be provided at the next meeting.

Action: K Prichard-Thomas

65/26 Patient Safety Quarter 1 Report

The Deputy Chief Nurse introduced the report and advised that interviews had been recently held for the Associate Director of Nursing for Patient Safety and an internal candidate had been appointed following a robust interview process.

The Committee noted that the internal Clinical Accreditation Scheme (CAS) was established as an internal Trust-wide quality improvement and assurance programme. Further measures included strengthening regular assurance processes, expanding peer reviewer and Patient Leader participation and further aligning specialist team input. The Committee considered it would be useful to understand how the internal review process aligned with external reviews. **Action: K Prichard-Thomas**

The Deputy Chief Nursing highlighted that patient safety incident reporting had increased during Quarter 1 2026/27 and this included an enhanced number of near misses demonstrating an improve reporting and safety culture. Rapid reviews were taking place across all Care Groups with actions demonstrated within 48 hours of the incident.

The Committee noted the incident theme related to unendorsed clinical results. The Deputy Chief Nurse advised that a Digital Data & Technology (DDaT) working group had been established with senior clinical involvement and there was a focus on high risk results. Often unendorsed results related to when clinicians had checked results on the Electronic Patient Record (EPR) but had not marked this on the system itself. The Committee discussed the overdue patient safety actions. The Deputy Chief Nurse advised that there was no impact on patient safety and the overdue status related to the need to evidence that an action had been closed. Work was ongoing with the teams to assist them in closing these actions and, in some cases, some incidents had multiple associated actions.

The Committee noted that learning from incidents was disseminated via a number of forums including the 'Big 4' monthly newsletter, the monthly senior nursing forum as well as via the clinical governance route.

66/26 Learning from Deaths Report

The Chief Medical Officer introduced the report and highlighted that benchmarking data in relation to trusts that did not include Same Day Emergency Care (SDEC) data from the admitted patient care data set had been included in the report; this demonstrated that the Trust's position was similar to other hospitals. There was an increase in the expected mortality rate and a decrease in the observed mortality rate.

The Chief Medical Officer highlighted that there had been an overall reduction in the number of outstanding Structured Judgement Review (SJRs) between May and June 2026.

67/26 Integrated Performance Report (IPR) Quality Watch Metrics

The Chief Medical Officer introduced the report and highlighted that the Cancer 104 day standard remained non-compliant. However, Cancer harm reviews were undertaken on all patients. These often related to complex patients or patients receiving treatment both at the Trust and other hospitals. The Committee recommended that data provided should include more commentary in subsequent reports. **Action: J Lippett**

68/26 Quality Governance Committee Report

The Chief Nursing Officer introduced the report and highlighted that teams had raised delays in Category 2 Caesarean sections due to theatre capacity pressures as discussed in the maternity report.

The Quality Governance Committee had also approved a Ketamine Standard Operating Procedure (SOP) for Broadmoor theatre staff.

The Committee noted that C.Diff. rates remained below threshold as a result of the improvement work implemented as part of learning from incidents. The Trust was the 3rd best in the South East region.

69/26 Human Tissue Authority (HTA) Inspection Report and Action Plan

The Chief Medical Officer introduced the report and advised that the Associate Director of Operations, Networked Care, had been named as the Designated Individual (DI) for HTA. The inspection by the HTA in June 2026 had identified no critical but five major and one minor gap. The Committee discussed the process for the mortuary noting that Berkshire Surrey Pathology Services (BSPS) had carried out an audit for HTA compliance prior to the inspection. However, the audits were not carried out as frequent as required. The Chief Medical Officer confirmed that the Trust held the licence for HTA and now the DI was a member of the Trust staff this provided further assurance as the DI had the authority to ensure that compliance was maintained by BSPS.

70/26 Clinical Audit Programme Annual Report

The Chief Medical Officer introduced the report and highlighted that the Trust had been identified as an outlier by the National Joint Registry (NJR) for a statistically higher than expected standardised revision rate (SRR) for knee replacements although the teams had been aware of this prior to the data being made available. The team had acted upon this as soon as they were aware.

The Committee noted that the mandated national clinical audits were routinely reported in the Quality Account.

71/26 Patient Relations Quarterly Report

The Chief Nursing Officer introduced the report and advised that benchmarking data would be included in the next quarterly report. There had been an increase in complaints received, similar to other trusts, and this spanned all three Care Groups. The Committee noted that, as well as the increase in the complaints, the complexity had also increased and it was considered that this was due to people using Artificial Intelligence (AI) to assist them in raising their concerns.

The Committee noted that the planned implementation of Quail would enable complaint themes to be analysed.

The Committee discussed the importance of early resolution and how a call to complainants often helped either resolve or enable responses to be better tailored to individuals. The Care Group leadership also provided support to their teams in responding to complaints.

72/26 Learning Disabilities Report

The Committee received the report that set out the current state and ongoing development of learning disability service provision within the Trust.

73/26 Autism and Neurodiversity Patient Report

The Committee received the report that set out the Trust's progress in improving access, experience and outcomes for autistic and neuro-divergent patients through service development, staff training and patient engagement initiatives.

The Chief Nursing Officer highlighted the small risk in relation to the Oliver McGowan Mandatory Training programme due to the current financial challenges.

74/26 Research & Innovation Update

The Head of Research & Innovation introduced the report that set out an annual review of all Research & Innovation activity. The Head of Research & Innovation highlighted the patient story at the public Board related to a renal patient who had been recruited to a clinical trial and the sponsors of the trial had made the treatment available to the patient free of charge as the medication was not available in the UK.

The Committee noted that there were no longer national leagues tables for Research & Innovation although the Trust recruited a similar number of patients and clinical trials as Buckinghamshire Healthcare NHS Trust. The Head of Research & Innovation highlighted that work was on going to develop a driver metric for the department.

75/26 Winter Plan

The Chief Operating Officer and advised that the Winter Plan and corresponding Board Assurance Framework would be submitted to the public Board in September 2026.

The Chief Operating Officer advised that the challenge during the Winter period would be to maintain patient flow on a daily basis through use of SDEC and the virtual hospital service. The Trust continued to work with Primary Care colleagues and Berkshire Healthcare Foundation Trust (BHFT) in relation to community bed capacity as well as discharge of mental health patients. The Committee noted that the Trust raised awareness with Primary Care colleagues of the number of their patients attending the Emergency Department (ED) as the number continued to increase. The Winter Plan therefore set out how the risk could be mitigated.

The Committee approved the seasonal influenza staff and patient vaccination plan and considered that the Winter Plan for 2026/27 provided reasonable assurance of mitigation in part of the risks and 'assurance checklist assessment supported to go to Board.

76/26 Board Assurance Framework (BAF)

The Committee received the BAF and noted the changes including Perinatal Service Review and Maternity and Neonatal 10 Point plan assurance report added to the improvement/action section.

77/26 Corporate Risk Register (CRR)

The Committee received the CRR and noted that risk 4460: Outbreaks of infectious Conditions had been removed although this would be monitored on the Infection Prevention & Control risk register**.**

78/26 Work Plan

The Committee received the work plan.

79/26 Key Messages for the Board

The Committee agreed the following key messages for the Board:

- Moderate or above incidents in maternity have recurring themes which also

triangulate with wider safety pressures (theatre capacity, induction of labour delays). Delays in Category 2 emergency caesarean sections due to theatre capacity pressures.

- Partial assurance at midpoint review; assurance that the trust will be able to submit full compliance for year 8 of MIS on 2/3/2027.
- Patient safety incidents in Q1 show upward trend. Of 58 moderate harm incidents, majority were related to maternity, falls, treatment/ procedure. Recurring themes include unendorsed clinical results, NEWS2 implementation delays, breast screening follow-up.
- Clinical accreditation scheme (internal) has resulted in 8 gold and 4 silver awards for 12 clinical services.
- Majority of actions arising from the internal audit of patient safety (25/26) have been completed.
- Seasonal influenza staff and patient vaccination plan (2026/27) approved.
- Winter Plan for 2026/27 provides reasonable assurance of mitigation in part of the risks.

80/26 Reflections of the Meeting

The Trust Secretary led a discussion.

81/26 Date of Next Meeting

It was agreed that the next meeting would be held on Monday 30 November 2026 at 10.00.

SIGNED:

DATE:

Audit & Risk Committee

Wednesday 9 September 2026
9.30 – 11.30
Boardroom, Level 4

Members

Mr. Mike McEnaney	(Non-Executive Director) (Chair)
Dr. Minoo Irani	(Non-Executive Director)
Mr. Mike O'Donovan	(Non-Executive Director)

In attendance

Advisors

Mr. Charles Medley	(Director, KPMG)
Ms. James Shortall	(Local Counter Fraud Specialist (LCFS)
Ms. Chloe Wilkinson	(Partner, Ernst & Young (EY)

Trust Staff

Mrs. Frances Khatcherian	(Chief Finance Officer)
Mrs. Caroline Lynch	(Trust Secretary)
Ms. Katie Prichard-Thomas	(Chief Nursing Officer) (from minute 113/26)

100/26 Declarations of Interests

There were no declarations of interest.

101/26 Minutes for approval: 8 July 2026 and Matters Arising Schedule

The minutes of the meeting held on 8 July 2026 were agreed as a correct record and signed by the Chair.

The Committee received the matters arising schedule. All actions were completed or on the agenda.

The Chair welcomed the Partner, EY, to her first meeting. The Committee noted that the engagement letter with the Trust was being finalised and then engagement with the finance team and other key officers would be scheduled. In addition, EY would be liaising with Deloitte, the Trust's previous external auditors.

102/26 Local Counter Fraud Progress Report

The Local Counter Fraud Specialist (LCFS) introduced the report and advised that local proactive exercise provided an opportunity for areas to be reviewed and, therefore, the report would set out observations rather than findings. The exercise to review high earners was ongoing and would, for example, review overtime shifts worked and whether the amounts claimed correlated with activity. A list of the top 10 high earners had been received and job plans were currently being reviewed. To date, one member of staff had been identified as having no job plan and a part-time member of staff held a minimal contract and therefore undertook a significant number of additional shifts. There had been a delay in managing to

hold meetings with Consultant staff due to busy diaries. The Chief Finance Officer advised that the Financial Improvement Programme would be reviewing all controls in relation to all grades of medical staff.

[s40(2), FOI Act]

The LCFS advised that in relation to referral rates a discussion had been held with the Counter Fraud champion and it had been agreed that training materials would be reviewed and updated. The Counter Fraud Champion provided an update on Counter Fraud at Trust induction and during Fraud Awareness week there was a focus on raising awareness with operational staff. Overall, the majority of referrals received relating to phishing emails and these were always identified early and reported. In addition, the Trust carried out an annual penetration test that tested this area.

[s31, FOI Act]

103/26 Internal Audit Progress Report

The Director, KPMG, introduced the report and advised that three reviews had been completed and fieldwork for a further three reviews was in progress. Therefore, the internal audit plan was on target.

The Director, KPMG, introduced the Care Group Risk Management review and advised that a rating of 'significant assurance with minor improvement opportunities' had been issued; five medium and one low recommendation. The target date for the first recommendation was March 2027 rather than 2026 as set out in the report.

The purposes of the review was to establish that identified risks were recorded, monitored and actions implemented. The review had identified some risks more than 10 years plus Committee noted that risks were identified as well as some risks 5 to 10 years old. Therefore, a finding had been issued in relation to this.

The Committee queried the overall rating in light of five medium recommendations being issued. The Director, KPMG, advised that whilst there had been five medium recommendation issues there were no instances of risk not being correctly captured.

The Director, KPMG, introduced Mortality review and advised that a rating of 'significant assurance with minor improvement opportunities' had been issued; six medium and three low recommendations. The Committee noted that a Mortality report was issued to the Quality Committee on a regular basis. The Chair of the Quality Committee advised that the Committee had received assurance regarding the reduction of the number of overdue Structured Judgement Reviews (SJRs).

The Committee queried whether a SJR was carried out independently of the team where the patient had been managed. It was agreed that this would be confirmed. **Action: C Medley**

The Committee discussed the finding in relation to the Mortality & Morbidity Lead. The Director, KPMG, advised that this finding related to the need for enhanced visibility of the role in the organisation to ensure staff understood the role.

104/26 Internal Audit Recommendations

The Chief Finance Officer introduced the report and highlighted that there was one overdue action linked to the Patient Safety Incident Response Framework (PSIRF) audit. A total of 235 out of 240 actions had been completed.

105/26 Finance and Procurement Function Improvement Plan

The Chief Finance Officer introduced the report and advised the improvement plan had been developed in response to the income accrual issue identified earlier in the year. There were 38 actions; 15 had been completed, 22 were in progress and 1 was outstanding. Additional workstream had been included in relation to the grip and control and cash.

The Committee noted that the grip and control workstream included a vacancy control and the introduction of a non-pay control panel as part of the Financial Improvement Programme. Additional criteria had also been included in the vacancy control panel, for example, the cost centre being within budget. In addition, a balance sheet forum had been established to ensure that the team rather than individuals were reviewing the balance sheet, therefore clarifying roles and responsibilities in relation to accountability.

The Chief Finance Officer advised that she had recently been made aware that the finance system would be unsupported from June 2027. Therefore, there was a need to replace the finance system. This risk would be added to the Corporate Risk Register (CRR).

Action: F Khatcherian

106/26 Non-Audit Services

The Chief Finance Officer confirmed that EY were not undertaking any non-audit services for the Trust.

107/26 Losses & Special Payments

The Committee noted that there had been one payment of £50 for loss of property since the last meeting and 91 cases of other losses totalling £65,287 had been made since the last meeting. There had been two special payments to the value of £81.

108/26 Use of Single Tenders

The Committee noted that 8 single tender waiver (STW) contracts had been awarded since the last meeting The Chief Finance Officer advised that STW spend for the period was 4.51% of the addressable spend which was below the target of 5%. The Committee noted that there an error in the report in relation to a duplication of spend on specialist consumables in clinical engineering.

The Committee noted a number of STWs related to estates work and queried why the companies were on a framework. It was agreed that the Chief Finance Officer would confirm whether Seville Developments Ltd were on the framework. In addition, future reports would include an explanation as to why the company used was not on a framework for any spend over £50k. **Action: F Khatcherian**

The Chief Finance Officer confirmed that the next update would also set out a year to date spend by supplier. **Action: F Khatcherian**

109/26 Use of Significant Contracts

The Committee noted that no significant contracts had been awarded since the last meeting.

110/26 Bank Account Authorisations

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

111/26 Non-NHS Debt Report

The Committee noted that non-NHS debt was £9.7m as at 31 August 2026. The Committee noted that £7.8m of debt was over 360 days. The Chief Finance Officer advised that the Trust was required to provide for aged debt. It was agreed that the provision for bad debt would be reviewed. **Action: F Khatcherian**

112/26 Data Security Protection (DSP) Toolkit 2025/26

The Trust Secretary advised that the Trust had attained 'Approaching Standards' classification for the 2025/26 DSP Toolkit submission and had provided evidence for 44 out of the 47 required outcomes. For the three outcomes that had not met the criteria an action plan had been developed and the Trust would be required to complete these by 31 December 2026.

The Trust Secretary advised that the details of the 2026/27 DSP Toolkit had recently been published with a further strengthened focus on Cyber Security. In addition, organisations would only be able to select one outcome for internal audit rather than the previous three.

113/26 Treasury Policy

The Chief Finance Officer introduced the Treasury Policy and advised that no substantial changes had been made. The Committee approved the policy. It was agreed that a version of the Treasury Policy with tracked changes would be circulated to the Committee to enable the specific changes to be reviewed. **Action: F Khatcherian**

114/26 Work Plan

The Committee received the work plan. The Trust Secretary advised that the work plan for the next 12 months would be submitted to the next meeting. **Action: C Lynch**

115/26 Key Messages to the Board

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

- Two internal audit reports received rated as 'significant assurance with minor improvement opportunities'
- One overdue internal audit recommendation
- Assurance received from the finance and procurement improvement plan
- Provision for bad debt to be reviewed

116/26 Reflections of the Meeting

Mike O'Donovan led the discussion.

117/26 Date of Next Meeting

It was agreed that the next meeting would take place Wednesday 11 November 2026 at 9.30.

118/26 Private Meeting with Internal Audit

A private meeting with KPMG was not held.

119/26 Private Meeting with External Audit

A private meeting with EY was not held.

120/26 Private Meeting of the Committee

A private meeting of the Committee was not held.

Chair:

Date:

Royal Berkshire
NHS Foundation Trust

Minutes

Innovation & Transformation Committee

Wednesday 16 September 2026
10.50 – 11.55
Boardroom, Level 4, Royal Berkshire Hospital

Members

Mr. Umesh Jetha	(Non-Executive Director) (Chair)
Mr. Dom Hardy	(Chief Operating Officer)
Mrs. Frances Khatcherian	(Chief Finance Officer)
Dr. Janet Lippett	(Chief Medical Officer)
Mr. Mike McEnaney	(Non-Executive Director)
Ms. Catherine McLaughlin	(Non-Executive Director)
Mr. Mike O'Donovan	(Non-Executive Director) (Chair)
Ms. Katie Prichard-Thomas	(Chief Nursing Officer)
Mr. Andrew Statham	(Chief Strategy Officer)

In Attendance

Mr. James Blythe	(Chief Executive)
Mr. Paul Da Gama	(Chief People Officer)
Mr. Oke Eleazu	(Chair of the Trust)
Mrs. Caroline Lynch	(Trust Secretary)

01/26 Declarations of Interest

There were no declarations of interest.

02/26 Terms of Reference

The Committee received the Terms of Reference that had been reviewed by the Board. The feedback included the scope of the Committee being too wide. It was agreed that the Terms of Reference would be reviewed in Quarter 3 2026/27. **Action: C Lynch**

03/26 Strategic Programme Gateways

The Chief Strategy Officer introduced the report that set out the oversight framework through which the Committee would monitor the strategic programme portfolio, including periodic review of whether the programmes remained the right organisational priorities and regular assessment of progress through defined programme gateways from initiation through to benefits realisation. It was agreed that an annual review of programmes would be added to the Committee work plan. **Action: C Lynch**

The Chief Strategy Officer advised that a progress report would be submitted to the Executive Management Committee (EMC) monthly and to each meeting of the Committee.

The Committee noted that enablers for the strategic programmes included digital and data, workforce transformation and development, estates, finance and contracting and transformation and improvement. The Committee discussed capacity for delivery of the strategic programmes. The Chief Strategy Officer highlighted that the digital and data team had a number of change initiatives, for example, mobilisation of Ambient Voice Technology

(AVT) and migration to nhs.net. However, work was ongoing to understand the digital requirements of all the strategic programmes. The Committee discussed the impact of other business as usual in addition to future needs of the organisation such as an Electronic Patient Record, a new finance system as well as other change programmes.

04/26 Strategic Programme Portfolio

The Chief Strategy Officer advised that good progress had been made although the programmes were at different levels of maturity. Further work on the scope of the programmes would be undertaken including establishing the benefits of each programme.

Experience First

The Chief Nursing Officer highlighted that the vision statement of the programme was to be a national exemplar for patient, carer and family experience. There were three workstreams: digital enablement, driving improvement through patient feedback and access and navigation.

A Committee had been established to oversee the programme and there had been good engagement from patient leaders and governors and a contract with an external NHS patient experience expert had been established. The Chief Nursing Officer advised that the timeline for the programme could be increased although there were both capacity and estates restrictions as well as the need to await any national changes to the Friends & Family test. Key milestones for the programme included recruitment to key posts as well the ability to use real-time surveys. Benefits from the programme included a reduction in complaints resulting in a cost avoidance for other staff required to carry out investigations.

Future Ready Spaces

The Chief Strategy Officer introduced the programme and advised that benefits included instances of where buildings were empty and could be disposed of, improving current buildings and therefore achieving cost reductions as well as improving staff and patient experience.

The Development Control Plan (DCP) would set out the proposal to utilise existing estate outside Reading and was also linked to the Land Purchase work. Capacity for the DCP was being mobilised. The Committee discussed the need to ensure staff were engaged in relation to prioritisation of improvements planned and/or relocation.

The Committee noted that the output of the DCP would be submitted to the Finance & Investment Committee. The Committee discussed the timeline for the programme noting this was longer than the other strategic programmes. It was agreed that the programme was linked to the DCP timeline. Therefore, it was considered that the timeline would need to be expanded. **Action: A Statham**

The Chief Finance Officer highlighted that capital funding timelines would also need to be included each of the programmes to enable the Committee to monitor progress. **Action: A Statham**

Care Where I Am

The Chief Operating Officer introduced the programme and advised that the overall aim was to minimise attendances and admissions to the Trust working with other partners in the system. The benefits included reduction of non-elective admissions, improvement of the Emergency Department (ED) 4-hour target and improved waiting lists. The Committee discussed the risks in relation to funding required introduce the proposed service changes as well as the risk of a reduction in income for the Trust.

The Chief Operating Officer advised that Programme Director was being recruited and engagement with both staff and partners was ongoing.

Royal Berks @ Home

The Chief Medical Officer introduced the programme and highlighted that there were some similar elements in the Care Where I Am programme. However, this programme focused on a cohort of patients that had already been presented to the Trust. The focus of the programme was first outpatient appointments, average length of stay as well as increasing the number of patients cared for by the Virtual Hospital Service. Benefits included a reduction in bed days and follow-up appointments and increasing the number of first outpatient appointments. The Committee noted that a baseline exercise would be undertaken to identify opportunities across all areas, including services not currently delivering remote monitoring. The Chief Medical Officer advised that there were currently 7 platforms that were delivering remote monitoring across the Trust and these would need to be reviewed by the Digital, Data & Technology (DDaT) team. The Committee noted that the baseline exercise would be undertaken from now until December 2026 and the design period would be undertaken during Quarter 4 2026/27. Mobilisation of the programme would then begin from Quarter 1 2027/28.

Corporate Service Transformation

The Chief People Officer advised that the overall scope of the programme had recently been expanded in order to include administrative staff and would review the function and process in all services. [s43, FOI Act]

Perinatal Service Review

The Chief Nursing Officer advised that this programme would be monitored via the Quality Committee governance structure.

05/26 Key Messages for the Board

Key messages for the Board included:

- Agreement to adopt a consistent assurance framework for all programmes, including maturity assessment and gate-based readiness.
- Approval to commence the portfolio-wide review of existing programmes.
- Approval to develop a Trust-wide change capability uplift plan.
- Approval to strengthen Digital and enabling strategy alignment as a prerequisite for programme mobilisation
- Change capability remains a material weakness across the Trust, with variation in approach, capacity and discipline.
- Resourcing gaps in programme and change roles risk slowing progress
- Dependencies across Digital, Data, Sustainability and Transformation are not yet fully understood or sequenced, creating potential bottlenecks.
- Benefits realisation risk — measurable, committed benefits are not consistently evidenced across initiatives
- The Committee has established the foundations of a more disciplined, evidence-based assurance model for transformation.
- Members now have a shared understanding of the Trust's strategic portfolio and value enablers, enabling more effective scrutiny going forward.
- There is clear recognition of the maturity journey required and commitment to strengthening governance, capability and benefits focus.

- A structured review of all existing programmes using the Trust's change framework to assess maturity, clarify scope/outcomes/benefits.
- Each strategic initiative will be required to present gate status, readiness criteria, maturity timelines and committed benefits to provide the Board with transparent delivery risk.
- Resourcing plan required to secure dedicated programme and change capability for mobilisation and execution.
- Work to align enabling strategies, particularly Digital, to ensure realistic sequencing, capacity and capability.
- Establishment of a value-led assurance approach, with benefits forming the basis of scrutiny

06/26 Date of Next Meeting

It was agreed that the next meeting would take place in December 2026.

Action: C Lynch

SIGNED:

DATE:

Finance & Investment Committee Part I

Wednesday 16 September 2026
9.30 – 10.15
Boardroom, Level 4, Royal Berkshire Hospital

Members

Mr. Mike O'Donovan	(Non-Executive Director) (Chair)
Mr. Dom Hardy	(Chief Operating Officer)
Mr. Umesh Jetha	(Non-Executive Director)
Mrs. Frances Khatcherian	(Chief Finance Officer)
Mr. Mike McEnaney	(Non-Executive Director)
Ms. Catherine McLaughlin	(Non-Executive Director)
Ms. Katie Prichard-Thomas	(Chief Nursing Officer)
Mr. Andrew Statham	(Chief Strategy Officer)

In Attendance

Mr. James Blythe	(Chief Executive)
Mr. Oke Eleazu	(Chair of the Trust)
Mrs. Caroline Lynch	(Trust Secretary)

107/26 Declarations of Interest

There were no declarations of interest.

108/26 Minutes for Approval: 15 July 2026 & Matters Arising Schedule

The minutes of the meeting held on 15 July 2026 were approved as a correct record and signed by the Chair.

The Committee received the matters arising schedule. All actions were completed or scheduled on the work plan.

109/26 Month 5 Finance Report including Financial Improvement Plan 2026/27

The Committee noted that Month 5 financial performance was a deficit of £2.93m: £0.03m favourable to plan. Income was £2.69m above budget. Non-pay was broadly in line with plan. The Committee noted that £37.54m of cost savings had been identified out of the £43.69m target. The Chief Operating Officer advised that there was a level of confidence that the cost improvement plans (CIPs) for 2026/27 would be delivered as the Trust was in a similar position when compared to the previous year. The Committee noted that there was a focus on identifying increasing recurrent savings and this was a focus for the performance review meetings scheduled for the following week. The Chief Finance Officer advised that approval processes would also be strengthened in relation to recruitment to vacancies held for a long period of time. The Chief Nursing Officer highlighted that clinical representation would need to be part of the approval process as some vacancies were held due to being unable to recruit.

The Chief Strategy Officer advised that the Executive Management Committee (EMC) had

discussed the Financial Improvement Plan and topics raised included the Trust's productivity overall, under-recovered income as well as the cultural impact of strengthening further controls on vacancies.

The Chief Executive advised that the Trust's income and productivity were included in planning discussions with the Integrated Care Board (ICB).

Discussions were continuing in relation to workforce expenditure controls for the second half of the year. It was noted that EMC would be advised of the position on 28 September 2026 and determine whether additional controls were required to be implemented. The Committee noted that further work was being undertaken to understand any Equality, Quality Impact Assessment implications.

The Committee discussed the Trust's cash position in relation to capital spend. The Chief Finance Officer advised that oversight of capital spend was being reviewed and as discussed, a further update would be submitted to the next meeting.

110/27 Long Term Resourcing Model (LTRM)

The Chief Strategy Officer introduced the report and highlighted that the model was reliant on assumptions and forecast in relation to the payment regime. The modelling indicated that whilst a 3% CIP significantly improved the Trust's financial position it was insufficient to achieve a sustainable financial balance over the medium term. A residual deficit remained throughout the planning period highlighting the requirement for additional recurrent improvements

The Committee discussed the need for clarity in relation to the risks and benefits of the Trust's strategic programmes as well as the need for transformational change. The Chief Executive provided an overview of the discussion held at EMC in relation to the challenge for CIP delivery every year and the need for transformation change. It was agreed that a further update on the LTRM, aligned to the budget setting process, would be submitted to the November meeting. **Action: A Statham**

111/27 Key Messages for the Board

Key messages for the Board included:

- Financial performance on budget at Month 5 although there was a need to increase the run rate of efficiency savings delivery with further recurrent savings required
- The LTRM provided clear indication of actions required to deliver medium term financial sustainability although the challenge was substantial and would require new initiatives in optimising income and transformative change. The LTRM would be updated over the next 3 months.

112/26 Date of Next Meeting

It was agreed that the next meeting would take place on Wednesday 21 October 2026 at 9.30am.

SIGNED:

DATE:

Royal Berkshire
NHS Foundation Trust

Minutes

Finance & Investment Committee Part I

Wednesday 21 October 2026
9.35 – 11.00
Boardroom, Level 4, Royal Berkshire Hospital

Members

Mr. Mike O'Donovan	(Non-Executive Director) (Chair)
Mr. Dom Hardy	(Chief Operating Officer)
Mr. Umesh Jetha	(Non-Executive Director)
Mrs. Frances Khatcherian	(Chief Finance Officer)
Mr. Mike McEnaney	(Non-Executive Director)
Ms. Katie Prichard-Thomas	(Chief Nursing Officer)
Mr. Andrew Statham	(Chief Strategy Officer)

In Attendance

Mr. James Blythe	(Chief Executive)
Mr. Oke Eleazu	(Chair of the Trust)
Mrs. Caroline Lynch	(Trust Secretary)

Apologies

Ms. Catherine McLaughlin	(Non-Executive Director)

124/26 Declarations of Interest

There were no declarations of interest.

125//26 Minutes for Approval: 16 September 2026 & Matters Arising Schedule

The minutes of the meeting held on 16 September 2026 were approved as a correct record and signed by the Chair.

The Committee received the matters arising schedule. All actions were completed or scheduled on the work plan.

126/26 Month 6 Finance Report

The Committee received the Month 6 Finance Report. The Trust was on plan at the halfway point of the financial year and there was a level of confidence in relation to delivery of the year-end deficit target. The underlying monthly position had improved, although the current run rate remained adverse to plan and delivery depended on mitigations and resolution of outstanding income with the Integrated Care Board (ICB).

The Committee discussed the cashflow forecast. [s43, FOI Act] The Committee supported continued escalation and engagement to secure an equitable income baseline for 2027/28, reflecting activity delivered by the Trust.

The Committee noted that capital expenditure remained behind plan. The Committee agreed that clearer reporting of budget, committed expenditure, actual spend and forecast outturn would be helpful. The Chief Finance Officer advised that the capital programme

would be reviewed through the Executive Management Committee (EMC). Potential mitigations included reprioritisation between schemes, bringing forward critical infrastructure and moving eligible expenditure from revenue to capital. A further update would be provided to the Committee. **Action: F Khatcherian**

The Committee discussed sustained urgent and emergency care demand. The Chief Operating Officer confirmed that increased attendances to the Emergency Department was materially above comparator areas and had been sustained throughout the year. Additional urgent care centre funding and work with system partners on discharge pathways would provide some support, although the Winter period would present a challenge.
The Committee noted that financial controls were robust although it was agreed that operational pressure, vacancy controls and reduced staffing resilience could increase risks to quality, safety, patient experience, staff morale and temporary staffing expenditure. These issues would be considered further by the Quality Committee.

127/26 Financial Improvement Plan

The Committee received the Financial Improvement Plan update. The Chief Finance Officer highlighted that the cost improvement programme (CIP) had increased by approximately £2.8m since the previous month. The Trust expected to deliver its plan, supported by immediate controls covering overtime, workforce productivity, discretionary expenditure, commercial opportunities and non-pay review.

The Committee discussed the gap between recurrent and non-recurrent savings, which could increase the opening challenge for 2027/28. The Committee supported a stronger emphasis on service transformation rather than continued cost reduction through vacancy holding and other short-term measures.

The Chief Finance Officer highlighted the intention to link savings requirements to strategic programmes and areas moving towards 75% recurrent delivery. The Committee suggested a top-down opportunity analysis so that targets reflected the differing productivity opportunities of services and care groups, rather than relying solely on a uniform percentage target. **Action: F Khatcherian**

128/26 Financial Route Map

The Committee received the Financial Route Map, noting that it had been submitted to NHS England (NHSE) following approval by the Chair and Chief Executive. [s43, FOI Act]

It was agreed that a recommendation would be submitted to the Board to approve the Financial Route Map. **Action: M O'Donovan**

129/26 Business Planning 2027/28

The Committee received the report in relation to the ICB commissioning intentions. The Committee discussed the proposal for locally directed transformation investment and the developing dialogue with local authorities, primary care, community and mental health partners across six focus areas.

The Committee considered that, overall, the commissioning intentions lacked prioritisation, quantified activity assumptions and clarity on the financial baseline. It was agreed that the Trust should secure recognition of the activity it delivered in order to avoid a reduction in income.

The Committee discussed the need to use objective system data to identify pressures and productivity opportunities across primary, community and acute care. The Committee

supported targeted investment linked to clear outcomes, shared accountability and integrated pathway redesign, rather than adding new provision without changing existing models of care.

The Committee supported early engagement with Berkshire West Place partners and the development of business cases and partnership proposals to secure an appropriate share of the £59m transformation fund.

130/26 Business Planning Principles

The Committee received the proposed budget-setting principles and timetable for 2027/28. The principles included limited growth and inflation assumptions, savings plans identified at cost-centre level, workforce changes linked to pay schemes and a target of 75% recurrent delivery.

The overall savings requirement was anticipated to exceed £30m. Current planning assumptions allocated a proportion to care groups and corporate services, with approximately £7m associated with strategic programmes. The Committee noted that this remained a top-down assumption and bottom-up benefits analysis, including cost avoidance and productivity, was still being developed.

The Committee recommended that strategic programme benefits should be assigned to the operational budgets where they would be realised, with clear ownership and mechanisms for identification and delivery. Plans would also be compared with the Long-Term Resourcing Model (LTRM) and rebased as assumptions developed.

The Chief Finance Officer advised that a draft budget would be submitted to the Finance and Investment Committee and Board in November 2026, with further iterations prior to final approval. **Action: F Khatcherian**

131/26 Key Messages for the Board

Key messages for the Board included:

- Noted the operational pressures that the organisation was currently facing now and in the coming months and the need to ensure that maintaining quality and safety standards was a priority
- Recommendation to approve the Financial Route Map
- Noted ICB commissioning intentions
- The 2027/28 budget-setting principles and timetable were noted. Delivery of next year's financial goals would require strategic programmes to generate recurrent transformation and clearly attributable benefits.

132/26 Date of Next Meeting

It was agreed that the next meeting would take place on Wednesday 18 November 2026 at 9.30am.

SIGNED:

DATE:

Royal Berkshire NHS Foundation Trust

Minutes

People Committee

Monday 21 September 2026
13.00 – 15.00
Boardroom, Level 4

Members

Ms. Catherine McLaughlin	(Non-Executive Director) (Chair)
Mr. Suzanne Byrne	(Non-Executive Director)
Mr. Paul da Gama	(Chief People Officer)
Dr. Rupa Joshi	(Non-Executive Director)
Dr. Janet Lippett	(Chief Medical Officer)
Ms. Katie Prichard-Thomas	(Chief Nursing Officer)

In Attendance

Ms. Karolyn Baker	(Associate Chief Nurse) (from minute 39/26 to 41/26)
Miss. Kerrie Brent	(Corporate Governance Manager)
Mr. James Blythe	(Chief Executive)
Ms. Monica Canosa	(Medical Education Service Manager) (from minute 38/26 to 40/26)
Ms. Dawn Estabrook	(Head of Risk) (from minute 35/26 to 37/26)
Mr. Dwayne Gillane	(Associate Director Occupational Health & Wellbeing)
Dr. Isma Noaman	(Guardian of Safe Working) (from minute 38/26 to 40/26)
Mr Pete Sandham	(Associate Director Staff Experience and Inclusion)

Apologies

29/26 Declarations of Interest

There were no declarations of interest.

30/26 Minutes for Approval: 7 May 2026 & Matters Arising Schedule

The minutes of the meeting held on 7 May 2026 were approved as a correct record and were signed by the Chair.

The Committee received the matters arising schedule.

Minute 14/26: Minutes for Approval: 20 February 2026 & Matters Arising Schedule: Work Plan: A meeting had been scheduled on 28 September 2026 to review the work plan.

31/26 Chief People Officer Report

The Chief People Officer introduced the report and provided an update on the implications of national changes related to fixed-term contracts for locally employed doctors. It was reported that approximately 107 doctors were currently employed on fixed-term contracts and reviews were on-going to determine where permanent employment arrangements should be offered. Particular challenges were highlighted in relation to the F3 programme and the potential impact. The Committee agreed to continue monitoring developments.

An update was provided on the work being undertaken with Buckinghamshire Healthcare NHS Trust and Oxford University Hospitals NHS Foundation Trust to explore opportunities for a shared People Services. The Committee noted that a business case had been developed and would be considered through the appropriate Acute Provider Collaborative and Trust governance arrangements. [s43 FOI Act]

The Committee noted progress in responding to the Equality and Human Rights Commission Code of Practice, with a working group established to review implications for staff, patients and Trust facilities. Work was ongoing to update relevant policies and identify any estate requirements. The Committee also noted changes to the Trust's approach to Certificates of Sponsorship that would be restricted to roles where there was a clear workforce requirement that could not be met through domestic recruitment.

An update was received regarding the possible industrial action by Portering staff. The Committee noted the background to the dispute, the on-going engagement with staff and trade unions, and the mitigations being developed to maintain services during the proposed days of action. The Committee also discussed the importance of transparent and equitable arrangements for the allocation of additional shifts across staff groups. In addition, the importance of understanding the potential financial impact of the proposed changes was noted. It was confirmed that this had been addressed through the Equality Impact Assessment undertaken as part of the consultation process.

The Committee received an update on the national Job Evaluation programme and noted that the Trust was ahead of many organisations in preparing for implementation. The Committee noted the planned consultation approach and associated staff engagement activities.

The Committee noted updates on proposed employment rights reforms, workforce controls, temporary staffing expenditure and productivity. It was confirmed that robust governance processes remained in place and that agency expenditure remained amongst the lowest in the South East region. The importance of ensuring that workforce measures did not adversely impact patient safety, patient experience or staff wellbeing was highlighted and that future efficiencies would require transformational improvements in productivity and service delivery.

The Committee noted progress against leadership development and staff wellbeing initiatives, including the launch of the ‘Rise Above’ targeted programme, wellbeing events, staff health programmes and measures to support stress reduction. An update on uptake of the stress management programme would be provided at a future meeting. **Action: D Gillane**

32/26 Workforce Information & Key Performance Indicators (KPIs) 2025/26

The Chief People Officer introduced the report and highlighted the key workforce metrics for Quarter 1. Appraisal compliance was reported at 90.93%, an increase of approximately 3.3% from Quarter 4 and exceeding the Trust target of 90%. This was primarily as a result of the focused window undertaken by Planned Care. The approach had resulted in appraisal compliance of approximately 96% and enabled greater focus on the quality of appraisal discussions. It was highlighted that this approach would be further considered as to whether the model should be adopted more widely across the organisation.

The Committee noted that turnover had reduced to 8.3%, vacancy levels remained on track and sickness absence was approximately 10% lower than the same period in 2025/26. In addition, the Trust had maintained the lowest sickness absence rate in the South East for nine consecutive months. Agency expenditure continued to perform better than planned.

33/26 Employee Relations Quarterly Report

The Chief People Officer introduced the report that provided an overview of employee relations activity, including case management, dismissals, employment tribunals and wider workforce trends. It was noted that the Trust did not currently have a dedicated Employee Relations case management system.

The Committee noted that 13 cases had resulted in dismissal during Quarter 1. Of that, four related to disciplinary dismissals, six related to sickness absence and three dismissals during probationary periods.

The Committee welcomed the enhanced visibility of employee relations activity and sought assurance regarding the reporting and oversight of employment tribunal cases and related risks. It was confirmed that significant or high-risk cases would continue to be escalated through established mechanisms, including Non-Executive Director briefings where appropriate.

34/26 NHS Staff Standards

The Chief People Officer introduced the report and advised that the NHS Staff Standards had been introduced nationally during summer 2026 and set out clear expectations for organisations across six key areas. The Standards formed part of the National Oversight Framework (NOF) metrics and organisations would be required to report against them.

The Committee noted that many of the measures were derived from NHS Staff Survey outcomes. Whilst the Trust benchmarked favourably against comparable organisations and continued to achieve a strong staff survey response rate in excess of 60% there was an importance of focusing on the experiences of all staff and avoiding complacency regarding future improvement opportunities.

The Committee welcomed the report as a useful baseline assessment and highlighted the importance of understanding whether staff were experiencing the impact of improvements as a result of the actions being taken. There was a need for continued visibility of progress through this meeting.

The Committee noted that further work was required to strengthen Executive and Board ownership of the Standards, including confirmation of a Board-level champion role as well as the Health and Wellbeing Guardian and Flexible Working Champion. It was agreed that discussions would take place with Non-Executive Directors regarding these responsibilities.

Action: P da Gama/C McLaughlin

35/26 Staff Survey Improvement Plan

The Associate Director Staff Experience and Inclusion introduced the report that provided an overview of key actions delivered in response to the 2025 Staff Survey results, particularly in relation to reducing negative experiences, supporting opportunities for growth and development, and strengthening staff voice.

The Committee noted that the 2026 Staff Survey would launch on 22 September 2026 and would be promoted through a comprehensive communications campaign, including local leadership engagement and highlighting improvements made in response to the 2025 survey feedback.

The Committee received assurance that staff without regular access to computers were able to participate easily in the survey. It was confirmed that paper surveys and targeted engagement

activities were available for relevant staff groups and that the Trust had achieved its highest response rate in the previous survey through these approaches.

36/26 Violence, Aggression & Abuse Update

The Head of Risk introduced the report and provided an update on progress against the national Violence Prevention and Reduction Standards and related requirements within the NHS Staff Standards.

The Committee noted the positive progress made, including the success of 'Operation Cavell', the strong partnership with Thames Valley Police and the support provided to staff involved in court proceedings from the Chief Executive.

The Committee received an update on work on-going to strengthen communication, training and partnership working, including proposals to establish a Violence Prevention and Reduction Champion role linked to the Board.

The Committee highlighted the importance of supporting staff to report incidents and noted that confidence in reporting would continue to be monitored through the Staff Survey. The Committee discussed the distinction between incidents involving patients with capacity and those associated with illness or lack of capacity, and the importance of appropriate support and de-escalation measures.

The Committee noted that personal safety alarms were available to staff and that work was on-going to ensure these were provided to staff who required them.

The development of a Trust Violence Prevention and Reduction Strategy would help identify future priorities and resource requirements.

37/26 Talent Management Update including Succession Planning

This item was deferred.

38/26 10 Point Plan to Improve Resident Doctors' Working Lives

The Resident Doctor Peer Lead introduced the report and provided an update on progress against the Trust's 10 Point Plan to Improve Resident Doctors' Working Lives. The Committee noted progress in improving communication and engagement with Resident Doctors, alongside enhancements to working environments, annual leave arrangements and study leave reimbursement processes.

The Committee noted that the remaining areas of focus included payroll processes and the timely issue of rotas and work schedules. It was reported that payroll error rates were low, affecting only a small proportion of doctors, although further improvements continued to be pursued.

The Committee discussed the requirement to issue rotas within nationally prescribed timescales and noted the Trust's preference for producing bespoke rotas that accommodated individual leave requests and preferences. Whilst this approach could affect compliance with the national metric, feedback from Resident Doctors demonstrated a clear preference for bespoke rotas over generic rota templates.

The Committee received assurance that the Trust's approach reflected the preferences of Resident Doctors and supported the continued use of bespoke rotas.

39/26 Guardian of Safe Working Report

The Guardian of Safe Working introduced the report covering the period 21 April to 31 July 2026. The Committee noted that 311 exception reports had been submitted during the period, an increase from 175 in the previous quarter. It was advised that this reflected increased awareness and engagement with exception reporting following the national reforms, rather than a deterioration in working conditions. The Committee received assurance that similar increases in exception reporting had been reported nationally following the reforms.

The Committee noted the work on-going with departments reporting the highest levels of exception reporting to understand underlying causes, identify improvement actions and monitor progress. It was also noted that limitations within the DRS5 system increased the need for triangulation with Medical Education, Medical Workforce and clinical departments.

The Committee noted that work was on-going to improve communication and engagement with Resident Doctors, including the development of a dedicated Workvivo page.

40/26 Nursing & Midwifery Safer Staffing Review

The Associate Chief Nurse introduced the bi-annual Nursing, Midwifery and AHP Safer Staffing Review. The review considered progress against recommendations from the previous review, emerging workforce pressures and whether actions arising from earlier reviews had been reflected within the 2026/27 budget setting process.

The Committee noted that the review had been considered by the Executive Management Committee and that no additional establishment uplifts were recommended as a direct outcome of the review. However, a number of targeted workforce changes had already been supported through existing Care Group governance and business planning processes, including maternity services and the maternity block moves. The Committee noted the total uplift of 13.78 Whole Time Equivalent (WTE), of which 1.72 WTE related to Maternity services.

The Committee received an update on work to improve the capture of supervisory staff undertaking direct clinical duties through the workforce system. It was noted that this would provide greater visibility of staffing deployment and support future workforce planning. The Committee also noted that supervisory staff regularly provided direct patient care and supported enhanced observations when required.

The Committee noted that a full safer staffing review, including the Safer Nursing Care Tool audit, would be submitted in December 2026.

The Committee approved the recommendations set out in the report.

41/26 Annual Medical Revalidation Report 2025/26

The Committee received the Annual Medical Revalidation Report for 2025/26 and noted the progress made during the year, including the completion of a peer review with Frimley Health NHS Foundation Trust and improvements to arrangements for locally employed doctors.

The Committee received assurance regarding appraisal capacity and was advised that no doctor had been refused an appraisal due to a lack of capacity.
The Committee recommended that the Chief Executive sign the Statement of Compliance on behalf of the Trust Board. **Action: J Lippett**

42/26 Work Plan

The Committee received the work plan. An updated work plan for 2027 would be submitted to the next meeting. **Action: C Lynch**

43/26 Key Messages for the Board

The Committee agreed the following key messages for the Board:

- Approved Annual Medical Revalidation Report 2025/26 and recommended that the Chief Executive sign the statement of compliance on behalf of the Board
- Approved the Nursing & Midwifery Safer Staffing review recommendations providing substantial assurance regarding safer staffing arrangements
- Supported the preferred approach of bespoke rotas within the 10-Point Plan to Improve Resident Doctors' Working Lives recognising the benefits aligned to resident doctor preferences
- Noted the increase in exception reporting with assurance that this was an anticipated consequence of national reforms and increased confidence in reporting
- Noted the positive progress in relation to Violence, Aggression and Abuse, including the success of Operation Cavell, enhanced staff support and the development of a Trust strategy
- Noted progress against the 2025 Staff Survey Improvement Plan and the launch of the 2026 Staff Survey on 22 September 2026
- Noted the initial assessment against the NHS Staff Standards, with further work required
- Noted progress with the national Job Evaluation programme, including staff engagement activity and the planned consultation process with assurance that required national timelines would be met
- Noted the launch of the Rise Above leadership development framework to support senior leadership talent and development

44/26 Reflections of the Meeting

The Chief Nursing Officer led a discussion.

45/26 Date of the Next Meeting

It was agreed that the next meeting would be held on Thursday 3 December 2026 at 14.00.

Chair:

Date: