Royal Berkshire
NHS Foundation Trust

Public Board - 24 September 2025

MEETING

24 September 2025 09:00 BST

PUBLISHED
22 September 2025

Agenda

Location	Date	Time
Seminar Room, Trust Education Centre, Royal Berkshire Hospital	24 Sep 2025	09:00 BST

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1	Apologies for Absence and Declarations of Interest (Verbal)	Oke Eleazu		-
1.1	Umesh Jetha			-
2	Staff Story (Verbal)	Andrew Statham	09:00	-
3	Patient Story (Verbal)	Katie Prichard-Thomas	09:20	-
4	Minutes for Approval: 30 July 2025 & Matters Arising Schedule	Caroline Lynch	09:40	3
5	Minutes of Board Committee Meetings and Committee Updates:		09:45	-
5.1	Charity Committee: 4 August 2025	Catherine McLaughlin		11
5.2	Audit & Risk Committee: 9 July 2025 & 10 September 2025	Mike McEnaney		16
5.3	Quality Committee: 21 July 2025 & 1 September 2025	Helen Mackenzie		22
5.4	Finance & Investment Committee: 23 July 2025 & 17 September 2025	Mike O'Donovan		35
5.5	People Committee: 7 July 2025 & 4 September 2025	Parveen Yaqoob		38
6	Chief Executive's Report	Steve McManus	10:00	43
7	Acute Provider Collaborative Update	Steve McManus	10:30	49
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9	Winter Plan 2026/27	Dom Hardy	11:05	80
10	Work Plan	Caroline Lynch	11:20	99
11	Date of Next Meeting: Wednesday 24 September 2025 at 09.00am			-

Royal Berkshire NHS Foundation Trust

Minutes

Board of Directors

Wednesday 30 July 2025
09.00 – 11.45
Seminar Room, Trust Education Centre, Royal Berkshire Hospital

Present

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

In attendance

Mrs. Caroline Lynch	(Trust Secretary)

Apologies

Mr. Oke Eleazu	(Chair)

There were five Governors, ten members of staff and one member of the public present.

110/25 Patient Story

The Chief Medical Officer introduced Kirsten, the Patient Experience Programme Manager. Kirsten highlighted that the Trust had circa 300 volunteers undertaking various roles; welcomers, buggy drivers, ward-based, end of life champions, patient leaders etc. Kirsten highlighted that the Trust approved a protocol for Pet Therapy in June 2025. Approximately six owners and their dogs supported the programme and had made over 75 visits to the Trust. Research demonstrated that pet therapy was good for patients and reduced depression as well the need for pain relief. The pet therapy programme had received positive feedback both from clinical teams as well as patients. Members of the clinical teams highlighted that when the dogs came to visit there was a 'buzz' on the wards and patients, their relatives and staff were all smiling. The visits supported those patients who had no visitors and also encouraged them to have conversations with other patients. In some cases where patients had their own pets at home the visits also encouraged them to want to go home too. The Board noted that one young person had been a long-term patient and when the dogs visited her, she benefited from the non-clinical interaction. This patient was then discharged two months later.

The Board greeted four of the volunteer owners and their dogs. One of the volunteers read a card he had received from a deceased person's relative. It stated that during the visit from the dog it was the last smile they had seen their mum smile.

The Board thanked the volunteers for bringing their dogs to visit and for their work on the Pet Therapy programme.

111/25 Staff Story

The Chief People Officer introduced Ali and Rob from the Virtual Hospital Service (VHS) team. Rob explained that the team had originally developed as a team of four people during the Covid pandemic. This was because of the need to respond and think differently. The Trust was the first in the country to provide the virtual hospital service. Following this the team considered other services that could be part of the service and the scope of work increased dramatically. The team now consisted of 35 members across a range of professions including nurses, doctors and physician associates. The work of the virtual hospital team was integrated into multidisciplinary team meetings and ward rounds. The team worked with both the urgent care teams in the community and GPs. Patients were managed at home and if required could be brought into the hospital.

Ali provided an example of the benefits of the virtual hospital service to patients. The team had developed an IV antibiotic service and one patient who required 24 antibiotic infusion was able to have a midline insertion and reviewed by the team enabling him to continue working rather than being an inpatient.

The virtual hospital service team had saved 5.6 bed day in the last 3 to 4 months. This was circa 2,044 bed days a year. Since 2022 the team had treated 10,000 patients. The team were continuing to consider ways to expand the service and a pilot with the trauma and orthopaedics service for post-operative wound surveillance would begin in August 2025. Further work was on-going to raise awareness of the virtual hospital service. The Board noted that the NHS England Regional Advisor had highlighted during a visit that the complexity of patients managed by the service was impressive.

The Board thanked Rob and Ali for their presentation and supported the further development of the virtual hospital service.

112/25 Minutes for approval: 28 May 2025 and Matters Arising Schedule

The minutes of the meeting held on 28 May 2025 were agreed as a correct record and signed by the Chair. The Board received the matters arising schedule. All actions had been completed or scheduled.

113/25 Minutes of Board Committee Meetings and Committee Updates

Charity Committee: 7 May 2025

The Chair of the Charity Committee advised that she had recently taken on the role as Chair with the Chief Medical Officer as the Executive lead. The Committee had reviewed the Charity Strategy and recommended it should be refreshed in light of the NHS changing landscape. The Charity had approved £150k for the Knowledge and Development Fund noting that this was to support training over and above that provided by the Trust. There was a Knowledge and Development Fund Panel that review applications for funding.

The Chair of the Charity Committee highlighted the upcoming Walk for Wards event on Sunday 1 September 2025.

The Board received the Charity Committee terms of reference. It was agreed that, subject to the inclusion of the Chief Medical Officer as Executive lead, the Board approved the terms of reference.

Audit & Risk Committee: 14 May 2025 and 9 July 2025

The Chair of the Audit & Risk Committee highlighted the work undertaken by Counter Fraud to review staff declarations versus registers at Companies House. 13 cases had been followed up. The Committee had also received the draft Counter Fraud plan for 2025/26 for review and input. External audit had completed the year-end audit and had issued an unqualified statement. Issues raised as part of the Value for Money work included the Trust's financial sustainability. The external audit team had noted an improved process with the finance team. Internal audit had completed a number of reviews including the Data Security & Protection Toolkit as well as the financial directorate review. External audit had also carried out a cashflow management review. A number of actions had already been completed and progress was reviewed at each meeting. The Chair of the Audit & Risk Committee highlighted that the number of outstanding actions for internal audit reviews had reduced to 5 demonstrating good progress.

Quality Committee: 19 May 2025 and 21 July 2025

The Chair of the Quality Committee advised that the Prevention of Future Deaths (PFD) noticed had been issued to the Trust and the Trust recognised the seriousness of this. The Committee had discussed this at its May meeting and had reviewed the comprehensive response to the Coroner at the July meeting.

The Committee reviewed the Integrated Performance Report (IPR) watch metrics at each meeting and undertook detailed review in a number of areas including Referral to Treatment and 62-day cancer standards. Associated actions were in place and activity was ahead of plan. Cancer harm reviews were also undertaken by consultants in relation to patients waiting for treatment. The Committee had noted that the backlog of reviews had reduced.

The Committee had discussed the complaints service and noted that the Chief Nursing Officer had commissioned an external review.

The Chair of the Charity Committee had discussed perinatal mortality and noted that this was 2.44 per 1000 births. There had been a reduction in neonatal admissions. The Board Maternity Safety Champion had recommended issues such as the experience of black women, anal sphincter injury and the development of a clinical dashboard should be highlighted to the Board. The Chief Nursing Officer advised that all perinatal mortality reviews led to improvements being made. Work was ongoing to ensure that staff listened to women and the language they used when contacting or presenting to the maternity unit. In addition, there was a cultural element of encouraging women to contact the maternity unit early in their pregnancy and this was also an area of focus.

Finance & Investment Committee: 21 May 2025 and 18 June 2025

The Chair of the Finance & Investment Committee advised that at its May meeting the Committee had noted that the Trust's financial performance was on plan and good progress had been made on the cost efficiency programme with £28m of the £40.6m target being identified.

The Committee had discussed the Trust's requirement for cash support and both system and regional colleagues had been made aware of this.

Financial performance was also on target in June 2025 and the Committee had received an update on commissioner contracts although these were now completed.

The Committee had also met in July 2025 and noted that Quarter 1 financial position had been achieved. Full identification of the cost efficiency programme was anticipated by September 2025.

The Chief Nursing Officer highlighted that the Equality Quality Impact Assessment (EQIA) tracker would be submitted to the Finance & Investment Committee and updates on the EQIA process would be submitted to the Quality Committee.

The Chair of the Finance & Investment Committee highlighted that there was a high level of confidence that the Quarter 2 position would be achieved and cash was being closely monitored. The Chief Operating Officer advised that there was a level of control and governance with Care Groups and corporate areas. Bespoke interventions were being made with areas and progress was being achieved. The interim Chief Finance Officer advised that risks were being monitored and there was a need to ensure that the Trust delivered its activity plan.

People Committee: 7 July 2025

The Chair of the People Committee advised that there had been some initial scoping in relation to scaling people services across the system. However, there was not yet a timeline or roadmap to achieve this. The Committee had received an update on the Health & Wellbeing Strategy noting that the Trust had received an award for this. The Committee had also received an update from the Guardian of Safe Working (GSW) on exception reporting from resident doctors. The Committee had noted a good culture in the Trust in resident doctors feeling able to report.

The Committee had also received the annual reports for the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) along with improvement plans. The Committee was assured on the improvement plans. However, the Committee remained concerned in relation to incidents of violence and aggression received by staff from patients and by staff from other staff members.

The Committee had also approved the Safer Staffing review.

114/25 Chief Executive's Report

The Chief Executive advised that there had been several national reports issued such as the 10 Year Plan, the Dash review, the Leng review and the National Oversight Framework as well as structural changes at a national level. There had been an external review of the Trust's maternity and neonatal service as well as an external of the Urgent & Emergency Care pathway. The national independent investigation into maternity services had been announced. 10 organisations would be selected although these had not yet been announced. It was not anticipated that the Trust would be selected for this. The Trust's maternity service had been inspected by the Care Quality Commission (CQC) and had been rated as 'good'. The full report from the recent external review was awaited although feedback had been positive with outstanding feedback received regarding the Trust's bereavement service, how we listen & respond to the experiences of women and their partners as well as noting the collaborative multi professional team being one of the best seen regionally.

The Chief Executive highlighted that the Trust had an on-going active role in Health Equalities via a number of areas including its Meet PEET (Patient Experience & Engagement Team) service working in the more socio-economic challenged areas in the community providing health checks.

The Trust had also been selected as a pilot site for Martha's rule in the Emergency Department (ED). The pilot was being implemented to test and learn how the three components of Martha's rule could be applied in the ED. The Board noted that the Call 4 Concern had been embedded in the organisation for a number of years and the Trust had applied to be a pilot site as this would provide an opportunity to influence the future application of Martha's rule in ED.

The Chief Executive highlighted events hosted recently by the Trust including the Volunteers Supper on 11 June 2025 and the Cultural Celebration Event on 19 June 2025 in addition to the

Trust's reaccreditation with Veteran Aware status and being awarded the Gold Award in the Armed Forces Employer Recognition scheme. The Trust had also been awarded Employer of the Year at the Thames Valley Chamber of Commerce Awards. The award recognised our commitment to staff development, encouraging a supportive workplace, and having a strong values-based culture.

The Board noted that preparation and planning for resident doctors Industrial Action had been undertaken ahead of the period from 25 to 30 July 2025. The consequences of the financial impact of this were yet to be established. The Chief Medical Officer advised that there had been very little impact on the non-elective activity as a result of the excellent planning undertaken. Safe staffing levels had been reviewed on a daily basis and there had been no patient safety incidents. The Trust had seen a high strike rate circa 75 – 85% over the weekend period. The Chief Operating Officer advised that 3 day cases had been cancelled and 479 outpatient appointments had required rescheduling, 74 of which had been 2 week wait referrals. More than half of appointments had already been rescheduled. The Board noted the risk in relation to staff fatigue as consultants had worked hard to maintain services during the industrial action.

The Chief Executive highlighted the Strategic Partnership Event with the University of Reading was held early in July 2025. This was to celebrate the inaugural lectures of our five new Joint Professors. The Trust Strategy refresh was due to be review by the Board in August 2025 and would be presented to the public Board in November 2025. There had been good feedback received from a range of stakeholders throughout the engagement period.

The Frederick Potts Unit had opened in July 2025. The Chief Executive explained that the building had been named after Private Frederick Potts who had served in the 1st Berkshire Yeomanry of the British Army and had been awarded the Victoria Cross. The family of Frederick Potts would be attending the official opening ceremony planned for August 2025.

The Chief Executive advised that the Trust had received confirmation of funding from the New Hospital Programme to undertake land searches over the coming year. The Board noted that Director of Estates & Facilities was undertaking a strategic review of the Trust's estate following the announcement of the delay for the new hospital.

The Chief Executive thanked the Trust Secretary and the finance team for their work on the Annual Report & Accounts. The Annual Report had been laid before Parliament and planning was on-going for the Annual General Meeting on 17 September 2025.

The Board noted that the actions required following the Mortuary inspection had all now been completed. The second part of the Fuller review was expected imminently and the implications of this would need to be reviewed. This would be submitted to a future Quality Committee.

115/25 Integrated Performance Report (IPR)

The Chief Strategy Officer highlighted that the Friends & Family test metric remained static at circa 93%. This had been discussed at the Executive Management Committee (EMC) and agreed that there needed to be a focus on those areas where satisfaction was lower. Incidents remained as expected and work was on-going to embed the Patient Safety Incident Response Framework (PSIRF) training in the organisation. Board members had also been asked to complete this training. The Chief Strategy Officer advised that it was important to note that the Standardised Hospital-Level Mortality Indicator (SHMI) metric was not alerting.

There had been more C.Diff. cases in Quarter 1 and it was important to note that C.Diff. cases had increased both regionally and nationally. The Infection Prevention & Control (IPC) team had been asked to review this using PSIRF and Improving Together methodology.

The stability rate remained good as well as associated turnover. Bank and agency spend was significantly lower than in the previous year with agency spend at 0.04% in comparison to 6% in

the previous year. The Trust had the lowest agency spend in the South East region. The workforce controls in place had impacted on the agency and bank spend. However, the number of staff being recruited was increasing and the teams were reviewing this.

The Emergency Department (ED) performance had improved demonstrating the concerted effort of the ED team. The Urgent Care Centre (UCC) would move to the Royal Berkshire Hospital site from 1 July 2025 and it was anticipated that this would result in increased attendances. The Board discussed paediatric ED performance and noted that circa 100 paediatric patients presented daily. The interface between minor injuries and paediatric ED as well as between the ED team and the paediatric team were discussed. The Board noted that a Rapid Process Improvement Work (RPIW) was planned for September 2025.

The 62-day cancer standard metric was in line with the previous month although behind trajectory. It was anticipated this metric would increase following validation. Improvement plans were in place for gynaecology, urology and lower gastrointestinal. The Chief Operating Officer advised that the number of patients in the 62-day cancer standard was small resulting in variation in the month. There had been an increase in gynaecology and urology 2 week wait referrals and lower gastrointestinal referrals were stable. The volumes of 28-day faster diagnosis standard patients had increased although performance was above plan.

Activity targets had been achieved for Quarter 1 and, in some areas, had been exceeded. Follow-up appointments were significant over plan and this being discussed with the teams to ensure resource was directed to first outpatient appointments. The Board noted that the Chief Executive team reviewed outpatient transformation work as part of their week Improving Together huddle and noted that some specialities were using an Artificial Intelligence (AI) tool in relation to those patients that were high risk for Do Not Attends (DNA)s) and by calling patients ahead of their scheduled appointment had seen a dramatic reduction in the number of their DNAs. This demonstrated the financial benefits achieved by the transformation programme.

The Chief Strategy Officer advised that financial performance was on plan in line with the planned £7.8m deficit for 2025/26. Pay spend had increased related to elective activity and non-pay was over plan largely due to high-cost drugs variance although mitigated by drug income. Work was on-going to forecast for the remainder of the year and efficiency cost savings requirements had increased.

116/25 NHS 10 Year Plan

The Chief Strategy Officer introduced the report and advised that, as part of the Trust Strategy refresh, a full engagement programme was being undertaken with staff, patients and other stakeholders. The NHS 10 Year Plan set out the three shifts: from hospital to community, from analogue to digital and from sickness to prevention; and five enablers:

- new NHS operating model
- a new transparency and quality of care
- an NHS workforce fit for the future
- powering transformation and innovation to drive healthcare reform and productivity
- a new financial foundation.

The NHS 10 Year Plan would need to be considered as part of the Trust Strategy refresh and further discussion with the Board was planned for August 2025 although the Plan was well aligned with the Trust's existing Strategy and Clinical Services Strategy.

The Board discussed the challenge of the 10 Year Plan and the need to focus on funding and resources needed to deliver.

117/25 NHS Oversight Framework

The Chief Operating Officer introduced the report and advised that the Trust had been placed in segment 3. There was an increased focus on key standards and whilst the Trust's rating on productivity was good, if the Trust had not set a deficit budget for 2025/26 it would have been placed in segment 1. It was agreed that the interim Chief Finance Officer would review comparable trusts in relation to segment rating. **Action: H Troalen**

118/25 Work Plan

The Trust Secretary introduced the work plan and advised that the Winter Plan would be submitted to the September meeting and updates to Executive leads would be made.

Action: C Lynch

119/25 Date of Next Meeting

It was agreed that the next meeting would be held on Wednesday 24 September 2025 at 09.00

SIGNED:

DATE:

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

Date	Minute Ref	Subject	Matter Arising	Owner	Update
28 May 25	83/25	Chief Executive's Report	The Board discussed the Model ICB blueprint and the challenge for BOB ICB having recently undergone a major organisational restructure. It was considered that the Board Assurance Framework (BAF) should be updated accordingly in relation to the risks and opportunities of ICB reform.	A Statham	In progress.
30 July 25	117/25	NHS Oversight Framework	The Chief Operating Officer introduced the report and advised that the Trust had been placed in segment 3. There was an increased focus on key standards and whilst the Trust's rating on productivity was good, if the Trust had not set a deficit budget for 2025/26 it would have been placed in segment 1. It was agreed that the interim Chief Finance Officer would review comparable trusts in relation to segment rating.	H Troalen	Since the publication of the national league tables it has been possible to look for peer comparators in segment one. There is only one in the South East. A review would be undertaken and prepared by the strategy team.
30 July 25	118/25	Work Plan	The Trust Secretary introduced the work plan and advised that the Winter Plan would be submitted to the September meeting and updates to Executive leads would be made.	C Lynch	Item on the agenda.

Charity Committee Notes

Monday 4 August 2025
14.00 – 15.40
Room 3, Level 4

Present

Ms. Catherine McLaughlin	(Non-Executive Director) (Chair)
Dr. Minoo Irani	(Non-Executive Director)
Dr. Sunila Lobo	(Public Governor, Reading)
Ms. Adenike Omogbehin	(Staff Representative) (from minute 17/25)
Ms. Jo Warrior	(Charity Director)

In attendance

Miss. Kerrie Brent	(Corporate Governance Manager)
Mrs. Helen Troalen	(interim Chief Finance Officer)

Apologies

Mr. Jonathan Barker	(Public Governor, Reading)
Mr. Mike Clements	(Director of Finance)
Mr. Oke Eleazu	(Chair of the Trust)
Dr. Janet Lippett	(Chief Medical Officer)
Mrs. Caroline Lynch	(Trust Secretary)

[The meeting was not quorate]

15/25 Declarations of Interest

There were no declarations of interest.

16/25 Minutes for Approval: 7 May 2025 and Matters Arising Schedule

The minutes of the meeting held on the 7 May 2025 were noted and would be submitted to a future meeting for approval. **Action: C Lynch**

The Committee received the matters arising schedule. All matters had been completed or were included as items on the agenda.

18/25 Charity Director's Report

The Charity Director introduced the report and highlighted that the Charity had received a further £25k gift from a major donor to purchase a second incubator for the neonatal unit following a visit to the unit to meet the team and hear more about the impact their earlier donation had made.

The Committee noted that Jacobs had raised circa £44k, exceeding their original target of £39k, to enhance the Cardiology Outpatients waiting area. Cisco UK had completed their

Camino Trail challenge raising over £17.5k to support environmental and sustainability projects. Loddon Brewery achieved £5k target towards a Billirubin machine for the Maternity unit. Ridge continued to sponsor the NHS Big Tea and Big Bake events for a fourth consecutive year.

The Charity Director highlighted that £76k of grant funding had been received in Quarter 1 to support the purchase of an echocardiography machine for the Cardiology department at West Berkshire Community Hospital. Further bids that totalled circa £157k had been submitted in support of a range of projects.

The Charity had secured a ballot place in the London Marathon 2026 for the first time. Following a robust application process Andrew Haydon, Palliative Care Clinical Nurse Specialist had been allocated the space. A second runner who had received their own place was also raising funds for the Charity.

The Charity Director confirmed that the NHS Big Bake and Big Tea events held had generated a total of circa £7k with more events scheduled through the year. Upcoming events include Walk for Wards and the NHS Christmas Concert.

The Charity Director advised that the Charity had increased its local press promotion and submitted two stories a week with a plan to continue, as well as increasing engagement across social media and communications including the use of Google analytics. The Public Governor, Reading, suggested the use of case studies for donors and fundraisers. The Corporate Governance Manager advised that Charity events could also continue to be promoted through the Trust's membership magazine.

The Charity Director advised that the Legacy and In-Memory Office role had been considered and revised to provide a cost saving and change of focus from administration to income generation.

17/25 Finance Update

The Charity Director provided an overview of the Quarter 1 finance report. The year to date Charity fund balances had reduced by £92k. This reflected a positive movement, demonstrating the commitment to deploying funds in line with the planned expenditure target. Income was £348k, £73k less than income generated when compared to 2024/25 and £23k behind plan. The reduction was primarily attributable to movement in legacy accruals impacting current period performance. Approved expenditure was £439k due to a number of projects awaiting completion.

The Committee noted the operating costs ratio to fundraising income that confirmed that operating costs were not considerable at one third compared to the income.

The Committee discussed the need to re-consider an investment institution. The interim Chief Finance Officer would review this with the Director of Finance and a report would be submitted to the next meeting for consideration. **Action: H Troalen**

The Charity Director advised that there was an on-going challenge in relation to how legacies were accrued for. The interim Chief Finance Officer agreed to review this with the Director of Finance. **Action: H Troalen**

The Committee agreed that a summary of the cost of community events compared to net contribution would be provided for future events as part of the Charity Director report. **Action: J Warrior**

The Committee discussed the need to include the individual fund balances as part of future reports. **Action: M Clements**

18/25 Charity Strategy Refresh and Operational Plan 2025/28

The Charity Director introduced the draft strategy refresh that would continue to be developed and aligned to the overall Trust refresh strategy. The strategy would consider the NHS 10-year plan and how the Charity could support the Trust in delivering this. The strategy was developed around four strategic priorities: upgrading equipment and technology, championing staff education and wellbeing, enhancing healthcare environments, and ensuring financial stability and growth. The Committee noted the Operational Plan that identified measures of success and timelines to ensure delivery and impact.

The interim Chief Finance Officer suggested the need to work with individual fund holders to maximise use of their funds and consider the needs for the patient cohorts in that area including maximising digital use.

The Committee agreed that the strategy priorities should be reduced to three and the priority related to ensuring financial stability and growth be removed, as this should underpin all of the Charity's work. **Action: J Warrior**

The Committee agreed that the strategy should be reduced in length to a maximum of three pages and be produced from the donors perspective. In addition, how success would be measured should be revisited. A further suggestion was to include case studies throughout the document. **Action: J Warrior**

The Committee suggested a further emphasis on what the Charity could do above and beyond the Trust. In addition, how the donor could measure success via the website. The Committee agreed that the function of the Charity was to enhance patient experience over and above that of which the NHS provided. In addition doners should be able to see on the website how the charity has impacted patient experience. **Action: J Warrior**

The Committee suggested the use of a similar method to the Staff Survey response to promote 'your money did this' good news stories. This could also be included in the Trust's Membership magazine. **Action: J Warrior**

The Committee discussed the need to ensure that the Charity demonstrated and promoted ethics in relation to how charitable donations were spent within the strategy and on the website. The Charity Director would submit a report on ethical practices to the next meeting. **Action: J Warrior**

The Committee discussed the need to review the standard operating procedures and how decisions were made. The Charity Director would review this with the Trust Secretary and Chief Medical Officer ahead of the next meeting. **Action: J Warrior**

19/25 Ambassador Programme

This item was deferred to the next meeting.

20/25 Knowledge Development Fund Banding Analysis 2024/25

The Committee received the report that outlined the applications received during 2024/25 and provided an analysis of the staff job bands of the successful grant recipients. The Committee

noted that a total of circa £74k had been awarded to applicants across a range of roles, from Agenda for Change (AfC) Band 2 to Very Senior Manager (VSM) level as well as resident doctors and consultant pay scales. The analysis indicated that the number of applications approved was fairly consistent across job bandings.

The Charity Director confirmed that all staff levels had equal opportunity in receiving information about how to access the fund and how to apply for it through continued communications.

The Committee discussed the panel membership that included education leads, nursing, doctors, non-clinical staff. The Charity Director confirmed that the chair of the panel was on a rotation basis. The Committee agreed that the membership should be reviewed as part of the review of how decisions were made. The Charity Director would review this with the Trust Secretary and the Chief Medical Officer. **Action: J Warrior**

19/25 Charity Risk Register

The Charity Director introduced the updated risk register. The most significant current risk related to data protection specifically the potential loss of donor information in the event of a Cyber Security breach. The Charity Director highlighted that whilst there was no personal financial data stored the reputational impact remained. A second risk involved business continuity due to the specialised roles within the Charity team, long-term absence of key staff could disrupt operations, donor engagement and income generation. The third risk related to potential reputational concerns arising from the Charity's level of reserves, noted by the Charity Commission in 2023. A formal communication had been sent to the Commission outlining the steps taken to reduce these reserves, and a response was awaited.

The Committee discussed whether the reserves held risk would be removed once formal confirmation was received from the Charity Commission.

The Committee noted that the level of reserves held should be further reviewed.
Action: J Warrior

20/25 Work Plan

The Committee received the work plan. The Committee suggested the need for a workshop in September 2025 to further review the strategy and standard operating procedures. The Charity Director would discuss this with the Trust Secretary. **Action: J Warrior**

21/25 Key Messages to the Board

The Committee noted the following key messages:

- There was a need to continue to develop the refresh of the Charity Strategy 2025/28
- There was a need to review the standard operating procedures and how decisions were made
- Reviewed the Knowledge and Development Fund analysis
  Received the updated Risk Register
- Finance was on plan at the end of Quarter 1 although there was a concern in relation to the lack of investment

22/25 Reflections of the Meeting

The Charity Director led the reflections.

23/25 Date of the Next Meeting

It was agreed that the next meeting would be held on Wednesday 5 November 2025 at 10.00.

SIGNED:

DATE:

Audit & Risk Committee

Wednesday 9 July 2025
9.30 – 11.15
Boardroom/Video Conference Call, Level 4, Royal Berkshire Hospital

Members

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

In attendance

Advisors

Mr. John Oladimeji	(Manager, Deloitte)
Mr. James Shortall	(Local Counter Fraud Specialist) (LCFS)
Mr. Neil Thomas	(Partner, KPMG)
Mr. Stephen Turner	(Partner, Deloitte)

Trust Staff

Miss. Kerrie Brent	(Corporate Governance Manager)
Mr. Mike Clements	(Director of Finance)
Mr. Oke Eleazu	(Chair of the Trust)
Ms. Helen Troalen	(interim Chief Financial Officer)
Ms. Katie Prichard-Thomas	(Chief Nursing Officer)

82/25 Declarations of Interests

There were no declarations of interest.

83/25 Minutes for approval: 14 May 2025 and Matters Arising Schedule

The minutes of the meeting held on 14 May 2025 were agreed as a correct record and signed by the Chair.

The Committee received the matters arising schedule.

Minute 25/25: (02/25) (107/24) (96/24): Minutes for approval: 21 November 2024 and Matters Arising Schedule: Non-NHS Debt: The interim Chief Finance Officer would discuss the two actions related to the fundamental review of private patients transformation project and debt recovery with the Trust Secretary. **Action: H Troalen**

Minute 25/25: (02/25) (108/24): Minutes for approval: 21 November 2024 and Matters Arising Schedule: Local Counter Fraud: The interim Chief Finance Officer would consider options on how Counter Fraud training could be delivered to staff. **Action: H Troalen**

Minute 54/25: Finance Directorate Review: The Partner, KPMG confirmed that the external audit findings could also be added to KPMG's JIRA system. **Action: N Thomas**

Minute 25/25 (02/25) (113/24): Minutes for approval: 21 November 2024 and Matters Arising Schedule: HFMS Ltd Annual Report & Accounts 2023/24: The Committee noted that the HFMS Ltd governance review was awaited and had been for some time. The interim Chief Finance Offer would ensure that the review was undertaken. **Action: H Troalen**

Minute 60/25: Use of Single Tenders: The Chair would liaise with the interim Chief Finance Officer in relation to the content of future reports. **Action: M McEnaney**

84/25 Local Counter Fraud Report & Annual Report 2025/26

The LCFS introduced the report and advised that all high-risk payroll matches as part of the National Fraud Initiative (NFI) exercise had been reviewed with one match subject to further investigation.

The LCFS advised that, good progress had been made to follow up the identified Companies House matches identified as part of the NFI work who had not yet made a declaration. There were two cases that were not listed on the Trust's Electronic Staff Record (ESR). It was anticipated that this could relate to staff that had left the Trust. The LCFS would update the NFI accordingly. **Action: J Shortall**

The LCFS highlighted that fraud awareness training had been scheduled for the Finance, Procurement teams and People directorate and this would include the Failure to Prevent Fraud Offence. The LCFS and Trust's Counter Fraud Champion would attend the Failure to Prevent Fraud Offence webinar on 15 July 2025 in preparation for this as well as ensuring that Trust's procedures reflected the six principles. Although, it was noted that a number of these related to standard practice in the NHS.

The LCFS presented the annual report for 2025/26. The Committee noted work was on-going in relation to the review of the Trust's Fraud Risk Assessment (FRA) and cross-check against the NHS Counter Fraud Authority (NHSCFA) fraud risk hub to ensure that all relevant risks had been captured. This work would be augmented in 2025/26 to include any amendments required by the Failure to Prevent Fraud Offence effective from 1 September 2025.

The Committee reflected the need for further work in relation to 'access to and completion of training' as recognised in the 2024/25 ratings against the Functional Standards submitted in May 2025. However, noted the on-going discussions in relation to how best to extend the reach of fraud awareness training.

85/25 External Audit Progress Report

The Committee noted that there was no progress report for this meeting.

The Partner, Deloitte, advised that the Annual Report & Accounts 2024/25 year-end audit had completed in line with the national timetable. A meeting would be scheduled with the interim Chief Finance Officer, Director of Finance and Trust Secretary to discuss improvements going forward. **Action: S Turner**

The Partner, Deloitte, advised that planning would commence in relation to the audit of subsidiaries Healthcare Facilities Management Services Limited (HFMS) and Royal Berks Charity.

86/25 Internal Audit Progress Report

The Partner, KPMG, introduced the progress report and Rostering Assignment report.

The Partner, KPMG, advised that Artificial Intelligence (AI) deployment benchmarking review had commenced. In addition, good progress had been made in relation to fielding and scoping of fieldwork in relation to Research Post Award, Access and Activity Data and Estates Management. The final reports would be submitted to the September meeting.
Action: N Thomas

The Patient Safety Incident Response Framework (PSIRF) review was anticipated for completion by October 2025 and would be reported to the November meeting.
Action: N Thomas

The Partner, KPMG, highlighted that the actions on the roster assignment review had been finalised. The Committee noted that one finding linked to three actions was removed in relation to the processing of bank shifts with NHS Professionals. This was due to the fact that the matter raised had already been actioned and therefore no further action was required. The Chief Nursing Officer confirmed that there had been sufficient Executive involvement in the input and timely responses had been provided for the audit. However, there had been a number of changes made to the original scope and the review had largely considered medical staffing than nursing. As part of the review it was recognised that the Trust should update its rostering policy to reflect the different rostering practices that were reasonable within specific areas.

The Committee recommended that the scope of future audits were agreed with the relevant stakeholders.

87/25 Internal Audit Recommendations

The interim Chief Finance Officer advised that 1 additional action had been added in-month and there were currently only 6 overdue recommendations.

The Committee recommended that future reports should set out the original completion date as well as the revised completion date. **Action: H Troalen**

88/25 Finance Function Review and Working Capital and Cash Forecasting Review

The interim Chief Finance Officer advised that good progress had been made across a number of identified actions in the KPMG review. However, further work was required to accelerate progress in inventory management. The interim Chief Finance Officer would review this with the Head of Procurement. **Action: H Troalen**

The interim Chief Finance Officer advised that a review of the recommendations would be undertaken to assess whether they were appropriate and any suggested amendments would be reported at the next meeting. This would include the recommendations in relation to the number of payment runs and the number of days to close month-end and ensuring that the balance between accurate and timely reporting.

The Committee considered that the report did not currently provide sufficient assurance. There was a need ensure that the report reflected a schedule for completion by priority and identified the responsible owner to ensure high-priority actions were progressing and on target. **Action: H Troalen**

89/25 Board Risk Appetite Statement

The Chief Nursing Officer introduced the Trust's risk appetite statement as part of the annual review cycle. This had been reviewed in detail by the Integrated Risk Management Committee (IRMC) and Executive Management Committee (EMC), and each risk appetite statement had been reviewed by the relevant Executive lead.

The Chief Nursing Officer provided a summary of key changes to the statement that included the length of the statement, consistency of language as well as ensuring the statement was representative of the Trust's financial position. Further to this, reference to Cyber Security had been added following the NHS England Board Seminar. A benchmarking exercise against similar organisations had been completed. The Chief Nursing Officer advised that, there was a need to embed the risk appetite statement into the Trust's risk management processes as well as increasing awareness.

The Committee discussed strategic objective one 'provide highest quality care for all' and considered that the statement should reflect that services could only be delivered within allocated resources and contractual commitments. The Chief Nursing Officer confirmed that the opening statement stated that the Board acknowledged the interconnectivity and interdependence of the strategic objectives. In addition, as part of the benchmarking exercise against other trusts it was identified that each strategic objective statement was set out separately. The Chair suggested that a discussion was held in relation to how the current appetite would support the need to restrict services where activity was not commissioned or funded in relation to the financial context.

The Chief Nursing Officer would develop a report that provided context of the practical application of each statement including a rationale for changes as well as the level of risk appetite ensuring that the language was clear and understandable.

Action: K Prichard-Thomas

The Chair of the Finance & Investment Committee would provide feedback to the Chief Nursing Officer in relation to strategic objective 5 'achieve long-term sustainability'.

Action: M O'Donovan

The Chief Nursing Officer would circulate the previous risk appetite statement to clarify the changes made. **Action: K Prichard-Thomas**

The Committee agreed that the statement should be submitted to the private Board for further discussion. **Action: K Prichard-Thomas**

90/25 Losses and Special Payments

[s43, FOI Act]

91/25 Use of Single Tenders

The Committee noted that 13 single tender waiver contracts had been awarded since the last meeting. [s43, FOI Act]

92/25 Schedule of Significant Contracts

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

93/25 Bank Account Authorisations

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

94/25 Non-NHS Debt Report

The Committee noted that non-NHS debt was £8.3m as at 31 May 2025. The increase in other debt was related to £917k of activity invoiced in May 2025.

The Director of Finance advised that resource had been allocated to progress private patient debt recovery and a Credit Controller had been appointed. Therefore it was anticipated that progress would be made in relation to recovering debt.

The interim Chief Finance Officer highlighted than a review would be undertaken in relation to the levels of overseas debt and whether this was reasonable and related to emergency rather than planned treatment.

95/25 Health & Safety Annual Report 2024/25

The Committee received the detailed annual report for 2024/25.

The Committee recommended that an executive summary should be provided as part of future reporting. **Action: D Fairley**

96/25 Data & Security Protection Toolkit (DSPT)

The Committee noted that the Trust had submitted the 2024/25 DSPT on 30 June 2025. The Trust was able to submit evidence to meet the minimum expected standard on 43 out of 47 outcomes. Currently the Trust was showing as 'Standards not met'. For those four outcomes that the Trust was unable to provide evidence, improvement plans had been submitted to NHSE alongside the submission. Once these improvement plans had been reviewed and approved by NHSE and evidence provided for the remaining 43 outcomes was satisfactory the Trust will be awarded the 'Approaching standards' classification.

97/25 Work Plan

The Committee received the work plan. The work plan would be updated to reflect that the external audit plan would be submitted in November 2025.

The Committee recommended that the Executive team should consider the governance arrangements for the Health & Safety Committee. **Action: C Lynch**

98/25 Key Messages for the Board

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

- Year-end audit completed and meeting organised to discuss future improvements
- The need for further work in relation to access and completion of fraud awareness training
- Significant assurance received from the Rostering Assignment internal audit review
- Progress update on Finance Function Review received
- Board Risk Appetite Statement to be submitted to the Board for further discussion
- Health & Safety Annual Report 2024/25 received
- Noted the submission of Data & Security Protection Toolkit (DSPT) 2024/25

99/25 Reflections of the Meeting

Helen Mackenzie led a discussion.

100/25 Date of Next Meeting

It was agreed that the next meeting would be held on Wednesday 10 September 2025 at 09.30.

101/25 Private Meeting with Internal Audit

A private meeting with KPMG was held.

102/25 Private Meeting with External Audit

A private meeting with Deloitte was held.

103/25 Private Meeting of the Committee

A private meeting of the Committee was held.

Chair:

Date:

Royal Berkshire NHS Foundation Trust

Minutes

Quality Committee

Monday 21 July 2025
10.00 – 12.00
Boardroom, Level 4

Members

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

In Attendance

Ms. Christine Harding	(Director of Midwifery) (up to minute 38/25)
Mrs. Caroline Lynch	(Trust Secretary)
Mr. Steve McManus	(Chief Executive)

36/25 Declarations of Interest

There were no declarations of interest.

37/25 Minutes from the previous meeting: 19 May 2025 and Matters Arising Schedule

The minutes of the meeting held on 19 May 2025 were approved as a correct record and signed by the Chair.

The Committee noted the matters arising schedule.

Minute 19/25 (04/25): Minutes from the previous meeting: 3 February 2025 and Matters Arising Schedule: Integrated Performance Report (IPR) Quality Watch Metric: A further update in relation to hip fracture performance would be provided at a future meeting. **Action: J Lippett**

Minute 26/25: Winter Plan: The Chief Operating Officer advised that, in line with the previous year, the Trust was seeking to minimise any special preparation for Winter and maximising the focus on patient pathways. NHS England (NHSE) had altered the timetable and had requested a system-wide Winter Plan by the end of September 2025. The Winter Plan would be submitted to the September 2025 meeting. **Action: D Hardy**

38/25 Maternity Quality Assurance Report including Maternity Incentive Scheme (MIS) and Perinatal Mortality (PNM)

The Director of Midwifery introduced the report and highlighted that there was an on-going reduction in relation to perinatal mortality. Currently peri-natal mortality was 2.44 per 1000 births against a national rate of 5.04. Work had been undertaken to reduce the number of babies admitted to the neonatal unit as well as factors associated with brain injury. Therefore, the whole pathway had improved.

Work was also on-going in relation to the reduced foetal movements pathway as there had been increase in neonatal mortality for black women.

The Director of Midwifery advised that, in relation to the screening incident, work was on-going with the action plan. An improved failsafe process was now in place and capacity requirements were being achieved. Key performance indicators (KPIs) for all screening had been developed and a screening consultant had been engaged to the end of the year. Over 50 elements of evidence had been provided for the inspection in September and following the regional insight meeting the final report was awaited. However, actions were already being taken in relation to the feedback received from the meeting.

The Committee noted the letter received from NHSE in relation to the rapid independent investigation into maternity and neonatal services. However, the Trust had not been one of the trusts selected for this. The Committee noted that trusts would be selected based on criteria such as performance as well as complaints from families.

The Committee discussed the point that public expectations were extremely high for services and this resulted in a number of complaints. The Director of Midwifery advised that most complaints received in maternity related to communication. The service was due to launch the 'Here to Help' campaign to respond to peoples' needs and they would be able to call a maternity co-ordinator and the service would be available 24 hours, 7 days a week.

The Board Safety Champion advised that he had discussed the report with both the Director of Midwifery and the Chief Nursing Officer specifically in relation to perinatal mortality for black women. The actions from NHSE provided good assurance and overall, the report provided positive assurance particularly in relation to the reduction of avoidable neonatal admissions which had been an area for Improving Together.

39/25 Integrated Performance Report (IPR) Quality Watch Metrics

The Committee noted that the item was not available at the point of despatch. The Chief Medical Officer advised that there were no new alerting metrics and the watch metrics would be available in the IPR for July Board.

40/25 Quality Governance Committee Exception Report

The Chief Nursing Officer introduced the report and provided an overview of the issues within the complaints service and advised that an external review had been commissioned. The Committee noted complaints compliance had increased to 62% in June 2025 and there was good engagement from the Care Groups. In addition, the Directors of Nursing met with the complaints team on a weekly basis.

The Chief Nursing Officer highlighted that the Planned Care Group had reconfigured the vascular access service to mitigate the staffing challenges. There were plans to increase the size of the team with additional recruitment and governance structures would be changed. It was planned for Theatre 19 to be used for the insertion of lines and this would be monitored by the IV Steering Group. Referral criteria would be in place and this would be escalated if required either via the Care Group performance meetings or via the Chief Nursing Officer. The Committee noted that the Planned Care team were working closely with the Infection Prevention & Control to in relation to IC Net for Surgical Site Surveillance. Whilst the module was funded, implementation had been delayed due to the Data Digital & Technology (DDaT) prioritisation work. This would be reviewed at the next Quality Governance Committee and monitored by the Planned Care Group.

The Chief Medical Officer advised that there had been a recent Quality Governance Committee held and the Committee had noted that outstanding cancer harm reviews had been reduced significantly and reviews for 2025 were now being undertaken.

The Committee noted that a rapid review had been undertaken in relation to the insulin device error incident and the Insulin & Diabetic Working Group focused on learning from the incident including education programmes and cascading the learning throughout the organisation.

The Committee discussed the procedural documents compliance rate of 84%. The Trust Secretary advised that this related to the central repository comprising over 2000 procedural documents. The Care Quality Commission recommended a compliance level of at least 80%. However, the Trust set its own compliance level of 85% and this had been achieved recently. In addition, although the Trust monitored compliance with review dates, legally all documents were valid even though the review was overdue. The Chief Medical Officer added that a new Chief Pharmacist was in post and a review was being undertaken in relation to streamlining and speeding up the approval process for Patient Group Directions (PGDs).

The Committee discussed themes from the Cancer Harm reviews. The Chief Medical Officer advised that themes were shared with both clinical and operational teams and these included, for example, histopathology capacity and data issues in relation to pathways. Issues were also monitored by the Cancer Action Group. The Chief Operating Officer advised that a Cancer Strategy Group had been recently established and would also monitor any issues raised at the Quality Governance committee.

The Committee noted that the End-of-Life team had achieved 9 out 10 measures scoring above the national average in the National Audit results.

41/25 Cancer 62-Day Standard

The Chief Operating Officer highlighted that the report set out an update on the 28-day and 31-day standard as well as the 62-day Referral To Treatment (RTT) standard performance. The Committee noted that the Trust's cancer information performance would be discussed as part of the cancer tiering meetings with NHS England (NHSE) and the Integrated Care Board (ICB). A report on the NHS Operating Framework

The Committee noted that there were capacity issues within those specialities with the highest volumes of patients: gastrointestinal, urology and gynaecology. These areas were being reviewed at a more detailed level to understand root causes and improve performance. The Committee noted that additional funding was being sought from the Thames Valley Cancer Alliance to support an increase in diagnostics for lower gastrointestinal pathway. The Chief Operating Officer confirmed that there was an overall increase in gynaecology cancer referrals generally across the local area.

The Committee noted haematology performance in relation to the 28-day standard. The Chief Medical Officer advised that these were a small number of patients and would review accordingly. **Action: J Lippett**

It was agreed that a further update would be submitted to the Committee in December 2025. **Action: D Hardy**

42/25 Patient Safety Report Quarter 1 2025/26

The Chief Nursing Officer introduced the report and highlighted that, following the launch of the Clinical Accreditation Scheme (CAS) in January 2025, the next cohort of wards would be Redlands, Mortimer and Whitley.

The Committee noted that the Trust had been selected as a pilot area for Martha's Rule roll out. The Trust had been recognised as an exemplar for the service as the Trust's Call 4 Concern service had been in place since 2009.

The Chief Nursing Officer highlighted the Quarter 1 Patient Safety Incident Response Framework (PSIRF) report and advised that work was ongoing to include evidence of learning via a learning zone on the Trust's intranet platform, Workvivo. The Committee noted the case study set out in the report and queried why a Trauma & Orthopaedic opinion was required. The Chief Nursing Officer would confirm further details of the case.

Action: K Prichard-Thomas

The Chief Nursing Officer highlighted that patients and families had multiple ways in which to raise any concerns including via the Ward Manager or Matron in addition to using the Call 4 Concern process. The Committee discussed the incidents set out in the report and noted issues related to the Electronic Patient Record (EPR). The Chief Operating Officer advised that there were capacity issues in the Digital, Data & Technology (DDaT) team. However, this would not prevent staff from operating without EPR changes being implemented. The Chief Medical Officer advised that a formal process was now in place for EPR changes aligned to the Improving Together programme. However, any issues that impacted on patient safety would be prioritised.

The Committee considered that the report provided good assurance and the detail provided was useful.

43/25 Joint Targeted Area Inspection (JTAI) Action Plan

The Chief Nursing Officer introduced the improvement plan and highlighted that the Trust had received positive feedback on the overall process. Areas for improvement included capturing the voice of the child in social care referrals and ensuring that strategy meetings took place.

A further update on the action plan would be submitted to the December meeting.

Action: K Prichard-Thomas

44/25 Mortality Review

The Chief Medical Officer introduced the report and advised that expected deaths had been reducing. Observed deaths had increased slightly and the Chief Medical Officer would be reviewing this and report back to the Committee. **Action: J Lippett**

The Committee discussed the impact of Finished Consultants Episodes (FCEs) recorded on the Electronic Patient Record (EPR) on mortality data and patients' pathways through the Emergency Department (ED). Following the implementation of the Same Day Emergency Centre (SDEC) coding had been implemented swiftly. The Chief Medical Officer advised that there was an action plan in relation to FCEs. However, these EPR changes were not prioritised from a financial and clinical perspective previously. The Committee noted that the increase in mortality from 2024 to 2025 related to the coding for SDEC.

It was agreed that data analysis from Telstra would be made available to the Committee on the electronic board platform. **Action: C Lynch**

The Chief Medical Officer provided a detailed overview of the governance processes in place in relation to mortality and highlighted that mortality data was provided in the IPR watch metrics.

45/25 Prevention of Future Deaths (PFD) Report Response

The Committee received the report that set out the detailed response to the Coroner in relation to the PFD issued to the Trust. The Committee noted that where other parties had been requested to provide further guidance they had declined. The Chief Medical Officer advised that the response would be submitted by the end of the week and a meeting had been scheduled with the Coroner the following week.

The Chief Medical Officer advised that the Trust recognised the seriousness of the PDF and ensured that the response was focused and provided detailed answers to the issues raised by the Coroner. The Committee noted that nationally, following the implementation of PSIRF, there had been an increase in PFDs issued by coroners.

The Chief Medical Officer advised that there was need to ensure that witnesses called to inquests were aware of the Trust's mortality processes and the improvement work that had been undertaken.

The Committee discussed whether an external review of the Trust's mortality processes should be undertaken. The Chief Medical Officer advised that the Royal College had previous undertaken a review. The Committee agreed that an internal audit should be considered or an external peer review. **Action: J Lippett**

The Committee discussed the governance process of its role in providing assurance to the Board. It was agreed that a learning from deaths report would be submitted to a future meetings. **Action: J Lippett**

46/25 Patient Survey (Care Quality Commission (CQC): Child & Young People Improvement Plan 2024

The Chief Nursing Officer introduced the report and advised that overall results were positive. The survey was carried out by Picker and included 54 trusts. The Committee noted that the improvement plan progress was monitored by the Paediatric Clinical Governance and Children & Young People ground. It was agreed that the Chief Nursing Officer would clarify the reference as to whether this was a CQC moderated report and provide assurance that the action plan had been completed.

Action: K Prichard-Thomas

47/25 Patient Safety Incident Response Framework (PSIRF) Annual Report 2024/25

The Committee received the annual report for 2024/25. The Chief Nursing Officer highlighted that this was the first annual report and the implementation of PSIRF was a significant cultural change. During the last quarter of 2024/25 there had been significant progress. A discussion with the Executive Management Committee (EMC) was planned in relation to PSIRF training and work was on-going with the Care Group in relation to this.

48/25 Infection Prevention & Control Annual Report 2024/25

The Committee received the annual report for 2024/25. The Chief Nursing Officer advised that targets were set nationally based on performance from the previous year. The Committee noted that Surgical Site Infection Surveillance (SSIS) showed improvement in large bowel surgery outcomes although knee replacement SSIs remained a concern.

The Committee noted that work was on-going with the Infection Prevention & Control team in relation to implementation of IC Net for Surgical Site Surveillance. This would also provide useful for benchmarking.

49/25 Final Patient Experience Year End Annual Report 2024/25

The Committee received the annual report for 2024/25. The Committee recommended that future reports should highlight any areas of risk. **Action: K Prichard-Thomas**

50/25 Patient Relations Annual Report 2024/25

The Committee received the annual report for 2024/25. The Committee considered it would be useful to include learning and triangulation between incidents and claims in future reports. **Action: K Prichard-Thomas**

The Committee discussed Parliamentary and Health Service Ombudsman (PHSO) Referrals set out in the report and noted the financial settlement. The Chief Nursing Officer advised that this related to the delay in treatment that the Trust had recognised in its response.

The Committee discussed the themes from complaints received. The Chief Medical Officer confirmed that complaints relating to consultants were considered during revalidation. In addition, there was an automatic prompt in the event of an individual consultant receiving three complaints.

51/25 Safeguarding, Mental Health & Learning Disabilities Annual Report 2024/25

The Committee received the annual report for 2024/25 that provided good assurance.

52/25 Work Plan

The Committee noted the work plan.

53/25 Key Messages for the Board

The Committee agreed the following key messages for the Board:

- Good assurance received in relation to Maternity services and perinatal mortality and actions taken following the scanning incident discussed. The NED maternity safety champion highlighted the following items to be noted by the Board; experience of black women, anal sphincter injury and the development of a clinical dashboard.
- An external review of complaints function commissioned as complaints management continued to be challenging.
- Assurance received on actions in relation 62-day cancer pathway and noted services under pressure.
- Cancer harm review backlog reduced
- Mortality review metrics had seen a slight increase and further work is in progress to understand underlying causes

- Detailed discussion was held on the PFD comprehensive response to the Coroner and agreed that either an internal audit or external peer review be considered to ensure actions and learning was embedded.
- Annual Reports received provided good assurance

54/25 Reflections of the meeting

The Chief Operating Officer led a discussion.

55/25 Date of the Next Meeting

It was agreed that the next meeting would be held on Monday 1 September 2025 at 14.00.

SIGNED:

DATE:

Royal Berkshire NHS Foundation Trust

Minutes

Quality Committee

Monday 1 September 2025
14.00 – 15.55
Boardroom, Level 4

Members

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

In Attendance

Ms. Hannah Berrington	(Director of Operations, Urgent Care)
Ms. Christine Harding	(Director of Midwifery) (for minute 58/25)
Mrs. Caroline Lynch	(Trust Secretary)
Mr. Steve McManus	(Chief Executive)

Apologies

Mr. Dom Hardy	(Chief Operating Officer)

56/25 Declarations of Interest

There were no declarations of interest.

57/25 Minutes for Approval: 21 July 2025 and Matters Arising Schedule

The minutes of the meeting held on 21 July 2025 were approved as a correct record and signed by the Chair.

The Committee noted the matters arising schedule.

Minute 19/25 (04/25): Integrated Performance Report (IPR) Quality Watch Metric: The Chief Medical Officer highlighted that national average for hip fracture patients having surgery within 36 hours was now running consistently between 50% to 60%. The Trust achieved 57% in the previous month with the target being set at 75%. The Committee considered whether a revised Trust target should be set. It was agreed that the Chief Medical Officer would submit a proposal to a future meeting for consideration.

Action: J Lippett

Minute 44/25: Mortality Review: The Chief Medical Officer advised that the Telstra analysis on mortality had provided good assurance that the rising ratios were most likely due to a data quality issue. A further report bringing together the Trust's, the Telstra work and next steps would be submitted to the next meeting. **Action: J Lippett**

Minute 45/25: Prevention of Future Deaths (PFD) Report Response: The Chief Medical Officer confirmed that the Learning from Deaths report was routinely reviewed by the Quality Governance Committee and provided to the Quality Committee via the Quality Governance Committee report. It was agreed that a separate report would be provided to the Committee going forward. **Action: J Lippett**

The Chief Medical Officer provided an overview of the recent positive meeting with the Coroner. Work was on-going to provide the Coroner with direct access to the Trust's Electronic Patient Record (EPR). **Action: J Lippett**

[s40, FOI Act]

Minute 46/25: Patient Survey (Care Quality Commission (CQC): Child & Young People Improvement Plan 2024: The Chief Nursing Officer confirmed that following CQC moderation the inpatient survey results had not altered.

58/25 Maternity Quality Assurance Report including Maternity Incentive Scheme (MIS) and Perinatal Mortality (PNM)

The Director of Midwifery highlighted the Picker maternity survey results for 2025 had been recently published. Specific areas for improvement in the 2025 survey was antenatal care, labour and immediate postnatal service. Themes included 'not being listened to', communication, as well as conflicting information. The Director of Midwifery provided an overview of improvement plans and advised that individual working groups had been established to lead the response to each theme.

The Committee noted the local survey into care provided to black African women and commended the maternity team for undertaking this. The Director of Midwifery advised that women currently under the care of the maternity service were approached and black African women specifically were surveyed to receive direct feedback.

The Committee noted that the 2 PSII investigations were not causing concern currently. The Committee noted that a PSIRF training proposal had been discussed by the Executive Management Committee (EMC) and this training was being embedded into the organisation. The National Patient Safety Syllabus (NPSS) training was available on-line and the EMC had discussed the training proposal and agreed that this would be considered in the future once a review had been completed of all Mandatory & Statutory Training (MAST) requirements. The Chief Nursing Officer advised that NPSS training compliance for senior leaders and Board members was currently at a good rate. The Committee requested that the outcome of the MAST review should be reported to the Committee when completed. **Action: K Prichard-Thomas**

59/25 Integrated Performance Report (IPR) Quality Watch Metrics

The Committee received the watch metrics. The Chief Medical Officer advised that the Trust's number of Never Events was comparable with other acute trusts in the system.

60/25 Quality Governance Committee Exception Report

The Chief Nursing Officer introduced the report and highlighted that the Trust's compliance with procedural documents was 85% in July 2025 for the first time in a long period although work would continue to improve this. The Committee queried whether actual numbers could be provided as part of the procedural documents section. **Action: C Lynch**

The Committee noted the key messages in the report. The Chief Medical Officer advised that the report had been developed prior to the Mortality review data being made available.

The Committee noted issues raised by the Mortality Surveillance Group. The Chief Medical Officer advised that these were being monitored and in the event of these being significant issues the Committee would be advised accordingly. **Action: J Lippett**

The Committee discussed Getting It Right First Time (GIRFT) reviews and compliance with the recommendations. The Chief Medical Officer advised that work was ongoing to meet each of the specialities to review their compliance with their GIRFT recommendations.

The Committee discussed the clinical governance review report, referring back to the recent PFD received. The Chief Medical Officer advised that some teams were being supported to improve documentation. However, the majority of the minutes received were of good quality.

61/25 Emergency Department (ED) Standards Performance

The Director of Operations, Urgent Care, introduced the report and advised that current ED performance against the agreed trajectory was monitored via two reporting streams: Type 1 activity and all types of activity. The Trust was not meeting the Type 1 activity. However, all other types were being met. The Trust had submitted its trajectory to the Integrated Care Board in March 2025 and the Trust Board along with the actions required by the Trust as well as system partners in order to achieve the standard for Type 1 activity.

The Director of Operations, Urgent Care, advised that the ED team had undertaken a significant amount of work and improvements had been achieved specifically in paediatric ED.

The Committee recognised the significant work undertaken by the ED team. It was agreed that a copy of the NHS England visit feedback would be circulated to the Committee.
Action: D Hardy

62/25 Clinical Audit Programme Annual Report

The Committee received the report that highlighted that the Trust continued to perform well in a number of national audits that published reports in 2025 including National Cardiac Audit Programme and Falls and Fragility Fractures Audit Programme. The Chief Medical Officer advised that action plans from the national audits were reviewed at specialty clinical governance followed by Care Group Clinical Governance Committees.

The Committee noted that the Trust was an outlier on national bariatric surgery. The Chief Medical Officer advised that cases had now been uploaded retrospectively.

63/25 Patient Relations Report

The Chief Nursing Officer introduced the report and advised that a standardised report template was being developed for future reports. In Quarter 1 the number of complaints had increased slightly. Work was on-going to understand whether the backlog in the service was impacting on the number of complaints being received.

The fact finding undertaken by the external review had been completed and the final report was due by the end of September 2025. Early indications on recommendations had been received and some changes in the team were being made in September and October 2025. It was anticipated that the recommendations being actioned would result in improvement in the service and an overview as well as the outcome of the external review would be submitted to the next meeting. **Action: K Prichard-Thomas**

The Chief Nursing Officer advised that round table discussions regarding complaints had been held with Care Groups and there was good oversight and monitoring. However, work was required to improve complaint response times. The Committee queried the longest overdue complaint. The Chief Nursing Officer advised that this was 12 weeks due to the complexity of a complaint that spanned multiple specialties or involved another process such as a PSIRF investigation. The Committee noted that the highest numbers of complaints received were in Urgent and Planned Care groups.

The Chief Nursing Officer advised that work was on-going to implement an Artificial Intelligence (AI) tool to assist with complaints and this would enable an acknowledgement of receipt as well as categorisation of complaints.

64/25 Learning Disabilities Report

The Chief Nursing Officer introduced the report and highlighted that the Trust had raised concerns as learning disabilities and autism were not being reviewed across the system due to the role of Local Area Coordinator (LAC) remaining vacant due to a recruitment freeze at the Integrated Care Board (ICB). The Learning from Lives and Deaths (LeDeR) National programme that reviewed deaths of people with a Learning Disability and/or Autism was led by the ICB. The Chief Nursing Officer confirmed that Structured Judgement Review (SJRs) were discussed at the Mortality Surveillance Group and any deaths related to patients with learning disabilities and/or autism would include attendance from the Learning Disability team. Therefore, this was included as part of the Trust's mortality governance process. It was agreed that details would be included in the next update to the Committee. **Action: K Prichard-Thomas**

65/25 Autism Report

The Chief Nursing Officer introduced the report and highlighted that the Trust's compliance with Oliver McGowan Mandatory Training Tier 1, Part I was 87.4% against the national target of 95%. A proposal in relation to Tier 1, Part 2 and Tier 2 training had been discussed by the Executive Management Committee and, noting that this was an extensive period of time required, it had been agreed that this would be reviewed once the on-going review of all Mandatory & Statutory Training (MAST) had been completed.

The Chief Nursing Officer advised that neurodiversity patient group was being established and, as part of this there would be a survey for staff to complete on their view of patient experience. The Group lead would also be engaging with the Staff Neurodiversity Forum.

66/25 Winter Plan 2025/26

The Director of Operations, Urgent Care, advised that the Winter Plan and the associated Board Assurance statement would need to be submitted to the NHS England at the end of September 2025. Ahead of this, the Winter Plan would be reviewed by the Operational Management Team and EMC.

The Committee noted that, during Winter, the Trust's on-call processes ensured that decisions were made quickly where required. For example, the Director of the Day chaired the twice daily site meetings and issues were escalated to the Director on-call if required.

The Committee considered that the Board Assurance Statement was comprehensive noting actions and improvements in relation to the bed base gap. It was noted that the EQIA, that was not available for the committee, would need to be considered by the Board.

Action: D Hardy

The Committee considered that the Winter Plan provided good assurance and once fully completed would be submitted to the Board in September 2025. **Action: D Hardy**

67/25 Care Quality Commissioner (CQC) IR[ME]R Inspection Update

The Chief Nursing Officer introduced the action plan developed following the CQC IR[ME]R inspection. Once actions had been completed the CQC would remove the improvement notice. A Task & Finish Group had been established to deliver the action plan to the CQC ahead of the deadline of 29 September 2025 and was being considered across the breadth of relevant services. The Chief Nursing Officer confirmed that this inspection did not affect the Trust's overall CQC rating and confirmation of the action plan being completed would be provided to the next meeting. **Action: K Prichard-Thomas**

68/25 Board Assurance Framework (BAF)

The Trust Secretary introduced the BAF and advised that on-going reviews were scheduled although there had been some delays due to the holiday period. The amendment recommended by the Committee at the last meeting had been actioned.

The Committee recommended that the Winter Plan should be added to Strategic Objective 1. **Action: C Lynch**

69/25 Corporate Risk Register (CRR)

The Chief Nursing Officer introduced the CRR and advised that reviews were currently on-going with the Executive leads.

The Committee discussed the risk ratings in relation to ED and Cancer performance that had not changed since January 2025. The Committee discussed the challenge for the Trust and whilst there were some elements the Trust was performing well on, ahead of the upcoming Winter period, there was no planned for change these risk ratings.

70/25 Work Plan

The Committee recommended that Learning from Deaths (mortality review) and the Fuller 2 report would be scheduled on the work plan.
Action: C Lynch

71/25 Key Messages for the Board

The Committee agreed the following key messages for the Board:

- Assurance received that the Maternity survey into the experience of black women in the trust and actions being taken to address issues raised.
- Assurance received from the maternity Picker survey on areas addressed last year and noted the areas for improvement focus over this year on antenatal care, immediate post-natal care and focus on customer care
- Alert that a high-risk inquest had been scheduled for September 2025
- Assurance received on actions to achieve 4-hour ED standard
- Assurance received on the Winter Plan and recommended to the Board
- Assurance received on the CQC IR[ME]R action plan

- Assurance received that an internal audit on mortality process and the learning from recent Prevention of Future deaths would be completed as part of 2026/27 internal audit plan and that the plan would be submitted to the committee by April 2026.

72/25 Reflections of the meeting

The Chief Medical Officer led a discussion.

73/25 Date of the Next Meeting

It was agreed that the next meeting would be held on Wednesday 3 December 2025 at 10.00.

SIGNED:

DATE:

Finance & Investment Committee Part I

Wednesday 23 July 2025
11.00 – 12.00
Boardroom, Level 4, Royal Berkshire Hospital

Members

Mr. Mike O'Donovan	(Non-Executive Director) (Chair)
Mr. Dom Hardy	(Chief Operating Officer)
Mr. Minoo Irani	(Non-Executive Director)
Ms. Katie Prichard-Thomas	(Chief Nursing Officer)
Mr. Andrew Statham	(Chief Strategy Officer)
Ms. Helen Troalen	(Interim Chief Finance Officer)

In Attendance

Ms. Helen Challand	(Deputy Director of Financial Turnaround)
Mr. Mike Clements	(Director of Finance)
Mr. Oke Eleazu	(Chair of the Trust)
Mrs. Caroline Lynch	(Trust Secretary)
Mr. Steve McManus	(Chief Executive)
Mrs. Tracey Middleton	(Director of Estates & Facilities) (from minute 107/25)

Apologies

Mr. Mike McEnaney	(Non-Executive Director)
Ms. Catherine McLaughlin	(Non-Executive Director)

104/25 Declarations of Interest

There were no declarations of interest.

105/25 Minutes for Approval: 18 June 2025 (Part 1) & Matters Arising Schedule

The minutes of the meeting held on 18 June 2025 were approved as a correct record and signed by the Chair.

The Committee received the matters arising schedule.

Minute 91/25: Month 2 Finance Report & Capital Programme 2025/26: The Chief Operating Officer confirmed that process and controls for the use of Rapid Assessment Treatment initiatives (RATI) would be discussed with Planned Care Group as part of the routine performance review meetings and the Care Group would be advised that a reduction in their forecast would be anticipated.

106/25 Month 3 Finance Report & Capital Programme 2025/26

The interim Chief Finance Officer advised that the Quarter 1 financial position and forecast had been reviewed and actions had been agreed with the Executive Management Committee. Month 3 year to date was a deficit of £7.84m in line with budget. The interim Chief Finance Officer advised that forecast on run rate methodology had been discussed with all the senior finance team. Further clarity was required in relation to Planned Care

Group performance in relation to plan for Whole Time Equivalents (WTEs) aligned to the efficiency programme. Work streams were on-going to develop the forecast.

Work was on-going with system partners in relation to cash movement within the system as well as how cash would be managed internally. Month 3 closing cash position was £7.43m. Contract values had been agreed and there was a need to ensure activity was in line with plan and budget. Funded capacity was being triangulated with Indicative Activity Plans (IAPs) to ensure there was no risk to income. Work was also on-going to review the September cash position. The Committee noted that a proposal had been submitted to the national team in relation how cash could be moved within the system.

The Director of Finance highlighted that profiling of income and expenditure run rate had been set out in the report. All directorates had been asked to develop a detailed forecast and actions for recovery if this demonstrated they were over plan. The Committee noted that WTE reductions had been incorporated into budgets. The Chief Operating Officer advised that a large number of vacant posts could be removed to ensure increase in recurrent savings was achieved. The Chief Nursing Officer advised that the Equality Quality Impact Assessment (EQIA) process would be followed in relation to removal of vacant posts.

The Committee discussed the savings plan gap for 2025/26. The Chief Operating Officer advised that delivery of budget including identification and delivery of recurrent savings was a cultural shift for some parts of the organisation. However, it was anticipated that a fully defined cost efficiency programme would be completed by September 2025.

The Committee discussed cash and capital. The Chief Executive advised that the capital programme had been prioritised for the three areas of medical equipment, estates and facilities and Digital Data & Technology (DDaT). As part of this gateway decisions had been put in place aligned with the cash position. The interim Chief Finance Officer advised that this was an area of high priority and a cash forecast over a rolling 12-month period was being developed.

The Committee considered that assurance had been provided by the actions put in place. An update would be provided to the Board in August 2025 and the next forecast would be submitted to the September meeting. **Action: H Troalen**

107/25 Financial Improvement Plan 2025/26

The Committee noted that £33.04m of savings had been identified as at June 2025 against the target of £40.60m for 2025/26.

The Committee noted that contingent labour costs related to bank and agency costs as well as premium rate activity, for example, in endoscopy. Reducing Whole Time Equivalents (WTEs) was a combination of the Mutually Agreed Resignation Scheme (MARS), vacancies being held as well as reduction of contingent labour costs.

The Committee noted that commercial savings were composed of procurement as well as estates and facilities and work was on-going with the teams to establish those elements that could be recurrent savings.

108/25 Key Messages to the Board

Key messages for the Board included:

- [s43, FOI Act]

- Cash forecast over a rolling 12 month being developed
- Granular forecast being prepared and any new material issues identified to be submitted to the August Board ahead of the next meeting in September 2025

109/25 Date of Next meeting

It was agreed that the next meeting would be scheduled for Wednesday 17 September 2025 at 11.00am.

SIGNED:

DATE:

Royal Berkshire NHS Foundation Trust

Minutes

People Committee

Monday 7 July 2025
09.30 - 11.20
Boardroom, Level 4

Members

Prof. Parveen Yaqoob	(Non-Executive Director) (Chair)
Mr. Don Fairley	(Chief People Officer)
Dr. Minoo Irani	(Non-Executive Director)
Ms. Catherine McLaughlin	(Non-Executive Director)
Ms. Katie Prichard-Thomas	(Chief Nursing Officer)

In Attendance

Ms. Karolyn Baker	(Associate Chief Nurse, Workforce, Improvement & Standards) (for minute 24/25)
Mrs. Natalie Bone	(Corporate Governance Officer)
Mr. Dwayne Gillane	(Associate Director Occupational Health and Wellbeing)
Mrs Caroline Lynch	(Trust Secretary)
Mr. Steve McManus	(Chief Executive Officer)
Ms. Jess Palmer	(Guardian of Safe Working) (For minute 21/25)
Mr. Pete Sandham	(Associate Director for Staff Experience and Inclusion)

Apologies

Dr. Janet Lippett	(Chief Medical Officer)

15/25 Declarations of Interest

There were no declarations of interest.

16/25 Minutes for Approval: 6 February 2025 & Matters arising Schedule

The minutes of the meeting held on 6 February 2025 were approved as a correct record and were signed by the Chair.

Minute 50/24 (43/25, 21/24) Minutes for approval and Matters Arising Schedule: Guardian of Safe Working:

The Chief People Officer advised the Trust's success surrounding out of hours food provision had not been shared with system partners as the relevant information had not been collated and provided by the relevant team. It was agreed to close this action, given the time elapsed.

17/25 Chief People Officer Report

The Chief People Officer introduced the report and provided an overview of the ongoing work in relation to the Scaling People Services work stream. The Acute Provider Collaborative (APC) within the Buckinghamshire, Oxfordshire, and Berkshire Integrated Care System (BOB ICS), commenced discussions in October 2023 regarding consolidating or scaling corporate services. Further discussion was ongoing to ascertain whether Frimley Healthcare would also become part

of the APC moving forward. Some progress had been made, and a positive position had been reached. The Committee discussed the need for funding and commitments from all partners in the APC in order to progress this work stream.

The Chief People Officer highlighted the need to progress the work, due to the financial challenges across the system. However, funding was required. The Trust itself was ready to move to the next phase. However, there was currently no formal timeline or roadmap.

The Committee noted the update regarding the revised Nursing and Midwifery National profiles to re-band the current band 2/3 Health Care Assistants (HCAs). The arrangements had been finalised, and those staff identified eligible would receive appropriate pay arrears.

The Committee noted that NHS England (NHSE) had requested all nursing and midwifery job descriptions (Bands 4-9) for review to ensure they are correct and consistent with the appropriate banding. The Trust had already made positive steps to standardise and evaluate these job descriptions.

The Committee noted that there had been 31 successful applications including 24 from the Trust for Cohort 9 of the Henley Business School (HBS) Chartered Management Degree Apprenticeship (CMDA) and 7 from other NHS organisations. 50% of the Trust's delegates were from a Global Majority (GM) and were predominately Band 6/7's, 50% were on a Gold pathway and 50% were on a Green pathway.

The Chief People Office highlighted that the Trust had recently won the 'Employer of the Year' at the recent Thames Valley Chambers of Commerce Awards. The Trust had been recognised for its strong value-based culture aligned with its extensive employee development opportunities.

The Committee discussed the investment made in employee development and considered whether the value for money was quantifiable. For example, this data was included in Model Hospital and, if so, how is the Trust benchmarked against other NHS Providers. It was agreed that the Chief People Officer would review whether this could be undertaken. **Action: D Fairley**

The Committee noted that external funding for the delivery of NHS Staff Health Checks ended on 31 March 2025. Due to the ongoing financial position of the organisation, it had not been possible to create a substantive post for the Staff Health Checks Project Lead post. However, going forward, a limited service was being provided by the Health & Wellbeing team.

The Chief People Officer highlighted that NHSE had published guidance for 2025/26 Winter vaccinations eligibility and the key points from this guidance were that healthcare workers and maternity patients would not be eligible for COVID-19 vaccinations, only Flu. However, the vaccination centre would continue to be available for staff within the eligibility criteria for COVID - 19 as well as the public Maternity patients would be offered Flu vaccinations alongside Respiratory syncytial virus (RSV) appointments.

The Committee discussed the changes to the COVID-19 vaccination criteria and the need to ensure the messaging was clear. It was noted that this guidance could impact the Flu vaccination uptake.

The Committee discussed workforce reductions and whether front line staff would be impacted as this had been raised by Governors. The Chief People Officer advised that the intention was to reduce the bank and agency expenditure in the first instance. However, as part of budget planning, departments across the Trust had been asked to reduce in their headcount as well as being asked to consider how services could be reconfigured with a reduced team or with

vacancies on hold. The Mutually Agreed Resignation Scheme (MARS) had been launched with the aim of reducing payroll costs and headcount. This was targeted to specific areas, mainly corporate, and involved relatively small numbers. The Trust would incur costs initially, with cost savings identified for the next financial year.

18/25 Workforce Information & Key Performance Indicators (KPIs) Quarter 1 2025/26

The Chief People Officer highlighted that the workforce dashboard indicated areas in amber currently under review. However, this provided assurance that some indicators demonstrated that the Trust was a good employer. Appraisal uptake remained low. However, this remained a priority for the Executive Management team. The Committee sought assurance that the trajectory would improve.

19/25 NHS Staff Survey Results Improvement Plan

The Chief People Officer introduced the results of the improvement plan highlighting that the Trust ranked third in the 2024 NHS Staff Survey. Leadership teams within areas with low response rates had improvement plans in place.

The Chief Executive advised that a significant amount of work had been undertaken by the Communications team and the "You said, we did" phrase had been refreshed to "Because We Care" for a campaign providing feedback on the results of the last survey as well as the lead up to the next Staff Survey in October 2025.

20/25 Health & Wellbeing Strategy

The Chief People Officer advised that the updated strategy set out how the Trust would sustain and continue to improve the Health & Wellbeing offer to staff over the next 4 years.

The Chief Executive suggested that the Health & Wellbeing strategy should be aligned to both the Staff Survey results and the What Matters 2024 output. **Action: D Gillane**

21/25 Guardian of Safe Working Report

The Guardian of Safe Working advised that the Trust had reported a stable quarter highlighting a reduction in locum shift requests and in the non-descript locum requests. The team were reviewing ways to support the General Surgical teams at present due to an increase in reporting. There had been a significant increase in exception reports from General Surgery, and increases had also been seen in Respiratory Medicine, Urology, and Ophthalmology. The team were currently providing support to these departments.

The Committee discussed whether data was available in relation to when Senior House Officer (SHO) shifts were covered by Consultants.

The Guardian of Safe Working advised that this granular data was not available. Locum shifts were recorded on Patchwork and as stated in previous reports, this was often selected as the default reason; therefore the prevalence of rota gaps was not completely clear. A project had been completed by Medical Workforce to provide more useful options in Patchwork and there was ongoing reinforcement with teams to select the reason appropriately.

The Resident Doctors' forum had discussed the new framework for exception reporting. The Committee agreed that it was important to ensure that Resident Doctors felt confident to report without risk of detriment.

22/25 Workforce & Race Equality Standard (WRES) Annual Report

The Associate Director for Staff Experience & Inclusion presented the report outlining the Trust's performance against the percentage of staff in each of the AfC Bands 1-9 and Very Senior Manager (VSM) compared with the percentage of staff in the overall workforce indicator had marginally improved. This indicator had improved successively for nine years. However, the pace of the improvement had slowed relative to previous years.

Since 2016 the 'representation gap' (difference between overall and senior workforce compositions) remained largely unchanged.

The percentage of the workforce whereby there were nil ethnicity details declared had also improved, decreasing to 11% in 2025 compared to 16% in 2023.

The Committee agreed that the report should be published in line with National reporting requirements.

23/25 Workforce Disability Equality Standard (WDES) Annual Report

The Associate Director for Staff Experience & Inclusion presented the report, outlining that the report was similar to the previous WRES report indicating the continued commitment to delivering equity. The report included the first Disability Pay Gap Report, and with a mean disability pay gap of 12% was reported as of the 31 March 2025.

The WDES Improvement Plan 2025-2027 had been developed to address the key thematic improvement priorities and to maintain delivery on previous priority actions. The increase in disabled colleagues' experience of harassment, bullying or abuse from other colleagues and continued high levels of such behaviour experienced from patients was a concern. However, experience of this behaviour from managers had improved significantly in year.

The Committee considered that the Trust should continue to challenge itself, for example, in relation to making reasonable adjustments for disabled colleagues and how these were implemented.

The Committee agreed that the report should be published in line with National reporting requirements.

The Committee agreed that innovative solutions were required to address inequalities. It was suggested that short videos featuring lived experience of discrimination and of allyship could raise awareness. It was also agreed that it was important to include the Global Majority forum and other stakeholders in formulating solutions.

24/25 Bi Annual Safer Staffing Review Report May 2025

The Assistant Chief Nurse presented the report, highlighting that the Trust utilised the Safer Nursing Care Tool (SNCT) for adults, the emergency department, acute medicine, children and young people and the Birth rate plus tool for midwifery services. These evidence-based tools were recommended by the National Institute for Health and Care Excellence (NICE) to set appropriate establishments and ensure safer staffing within the acute trusts.

The Committee noted that, following the bi-annual skill mix review undertaken in May 2025 and covering 26 ward areas, the recommendations from the previous year had been revisited. These meetings included multi-professional representation with finance colleagues also present to provide budget information.

To comply with the National Safer Staffing guidance, an SNCT peer review was undertaken over 30 days in March 2025 to ensure an adequate data was available to support calculation of the establishments. Wards with less than 15 inpatient beds took part in the SNCT data collection as a baseline of acuity and dependency. Although evidence from the original validation of the tool was not supportive of setting the appropriate establishment with this reduced number of beds, it provided guidance and was used in conjunction with professional judgement and quality KPIs.

The Committee approved the Nursing Midwifery and AHP establishments and the key recommendations from the report and confirmed the Trust had a robust process demonstrating processes were safe, within the budget noting that this would be utilised evidence for the Maternity Incentive Scheme (MIS) for maternity staffing in 2026/27

25/25 Work Plan

The Committee received the work plan.

26/25 Key Messages for the Board

The Committee agreed the following key messages for the Board:

- Noted the update on Scaling People Services work stream
- Reviewed workforce information and KPIs, noting further need to focus on appraisal rates
- Health & Wellbeing Strategy reviewed, noting recent awards won by the Trust
- Guardian of Safe Working exception data reviewed, noting the actions in relation to increased reporting in certain areas
- WRES & WDES improvement plans reviewed
- Approved the safer staffing review for nursing and midwifery AHPs

27/25 Reflections of the Meeting

The Trust Secretary led the discussion.

28/25 Date of the Next Meeting

It was agreed that the next meeting would be held on Thursday 4 September 2025 at 1400.

Chair:

Date:

NHS
Royal Berkshire
NHS Foundation Trust

Title:	**Chief Executive Report**
Agenda item no:	6
Meeting:	Board of Directors
Date:	24 September 2025
Presented by:	Steve McManus, Chief Executive
Prepared by:	Kerrie Brent, Corporate Governance Manager

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				
Provide the highest quality care for all				✓
Invest in our people and live out our values				✓
Deliver in Partnership				✓
Cultivate innovation and improvement				✓
Achieve Long Term-Sustainability				✓
Well Led Framework applicability:			Not applicable ☐	
1. Leadership ☐	2. Vision & Strategy ☐	3. Culture ☐	4. Governance	☐
5. Risks, Issues & ☐ Performance	6. Information ☐ Management	7. Engagement ☐	8. Learning & Innovation	✓

Publication						
Published on website		Confidentiality (FoI)	Private		Public	✓

1. Strategic Objective 1: Provide the Highest Quality Care for all

CQC IR[ME]R Inspection

1.1 Following an announced inspection on 16 July 2025 of the Nuclear Medicine Department, the Trust has been issued an Improvement Notice under the Health and Safety at Work Act 1974 (Section 19) and the Ionising Radiation (Medical Exposure) Regulations 2017 ('IR(ME)R') Regulation 6 Employer's duties: establishment of general procedures, protocols and quality assurance programmes.

1.2 The Trust is required to submit an action plan to the Care Quality Commission (CQC) by 29 September 2025 which should outline how each contravention and area for improvement will be addressed and a proposed timescale for completion. IR[ME]R inspectors would then consider whether a return inspection was required to monitor against the action plan and the contraventions identified within this Improvement Notice must be compliant by October 27 2025. The Nuclear Medicine team are being supported through a task and finish group approach to ensure response and action deadlines are achieved led by the Chief Nursing Officer, Head of Compliance and Planned Care Group leadership team.

1.3 An exercise is being undertaken to review the compliance status of all Employer's Procedures Trust-wide to ensure that they were in-date and included the November 2024 IR[ME]R update.

NHS Oversight Framework Segmentation

1.4 The Government published provider league tables on 9 September 2025 as part of the NHS Oversight Framework. This confirmed that for Quarter 1 2025-26, the Trust has been placed in segment 3. This is because, in spite of strong performance across many of the metrics used to determine segmentation, having a deficit plan automatically meant that a Trust could be no higher than segment 3.

1.5 Following an internal analysis, it was suggested that we are among the higher performing acute Trusts in segment 3 and for context, only 1 acute trust in the region featured in segments 1 or 2.

Provider Capability Assessment

1.6 As part of the NHS Oversight Framework (NOF), NHS England (NHSE) has shared provider capability self-assessments template with each trust. NHSE will consider not only an organisation's delivery, as evidenced by its NOF segment, but also its capability. The rating of provider capability will help inform the response to NOF segmentation and may also inform any decisions about entry into the National Provider Improvement Program (NPIP), as well as trusts being considered for new Foundation Trust status.

1.7 The aim is to ensure that NHS England has a holistic view of providers, not just focussed on delivery of national programmes but also capturing wider information relevant to grip and governance. It is also intended to be a development tool, helping Boards to reflect on their competencies, develop robust approaches to internal assurance, and encourage continuous improvement.

1.8 The capability rating will be based on an annual self-assessment by provider Boards and submission to NHSE, with supporting evidence. We are currently collating the evidence for our self-assessment with a view to this being submitted to the private in October 2025 for approval prior to submission.

1.9 NHSE will review the self-assessment, triangulated with NHS England views of the provider's track record to date and any third-party information (including CQC), to provide an overall view on the Board's capability. They will also seek Integrated Care Board (ICB) views on the provider capability self-assessments for the providers in their systems.

CQC Adult Inpatient Survey 2024

1.10 In August 2025, the Trust received its 2024 adult inpatient survey results which were published by the CQC in September 2025 and are available via the CQC website. The survey involved 131 NHS Trusts in England and looks at the experiences of 62,444 people who stayed at least one night in hospital during November 2024. The national average and the Trust response rate was 41%. Overall, the results were positive and below are a few highlights from our patient feedback:

1.11 Patients felt overall they had a very good experience (8.4/10) and felt treated with kindness and compassion (9.2/10) which benchmarked "about the same" when compared with other trusts.

1.12 Patients felt treated with dignity & respect (9.4/10), felt doctors answered their questions in a way they could understand (9.1/10) and felt there were enough nurses on duty to care for them (8.2/10) which were all "somewhat better than expected" when compared with other trusts.

1.13 There were no areas of patient feedback where we compared "worse" than other trusts.

1.14 This feedback is also analysed by PICKER against 61 Trusts and the Trust ranked tenth in overall positivity score, an improvement from fourteenth in the previous survey. These results have been shared with Care Groups and teams throughout the organisation and reported to via the appropriate Committee routes. The results alongside an improvement plan are due to presented at Quality Committee in December 2025.

1.15 The areas of most significant improvement were highlighted either through a decline in comparison to our 2023 performance or to the PICKER average and relate to; (1) staff explaining reasons for changing wards at night and (2) information given about care provided through our virtual ward. Work has been underway with our improvement team to celebrate this feedback through local media channels and work is underway to mirror the standardised staff survey posters that can be seen across the organisation.

2. Strategic Objective 2: Invest in our people and live out our values

Executive Recruitment

Chief People Officer

2.1 Following an assessment day, involving stakeholder sessions and interviews, we are delighted to have made an offer for the appointment of a Chief People Officer. This appointment is subject to formal approval. We had very good representation internally and from system partners across the Integrated Care Board (ICB) as part of the recruitment process.

Chief Finance Officer

2.2 We have shortlisted candidates for assessment for the recruitment of a Chief Finance Officer. Interviews will take place on 1 October 2025 and will follow the same process as for the Chief People Officer appointment.

2025 Staff Survey

2.3 The 2025 Staff Survey launches across the Trust on the 24 September 2025. In the run up to survey launch we have delivered our 'Because we CARE' communications campaign, that focussed on sharing, organisation wide, colleagues lived experience of improvements and developments that have been delivered over the past 12 months to continue to enhance colleagues experience at work. Throughout the survey period, we are inviting colleagues to tell us about the things they care about across a wide range of staff experience areas. A communications and engagement plan and has been developed and will be delivered throughout the survey period.

2.4 We are seeking to further improve on last year's excellent results and deliver on our aspiration to be the best place to work in NHS.

Defence Employer Recognition Scheme

2.5 In June, the Trust held a special Forces Forum at Brock Barracks where it re-signed its Armed Forces Covenant. This demonstrated the Trust's commitment to the Armed Forces and made pledges to signify our important partnership working, continual support for our patients, visitors and staff to ensure they are treated fairly and receive equitable access to health services. This work builds on the Trust's reaccreditation with Veteran Aware status (February 2025) and achievement of the Gold Award in the Armed Forces Employer Recognition scheme where a signing event was held and attended by the Lieutenant Colonel for the battalion, the South East Region MOD representative, community partners and staff from our Forces Forum.

2.6 As part of the Defence Employer Recognition Scheme the Trust has held a Silver award for a number of years, and this year has gone through a rigorous application process involving national selection boards chaired by a senior military officer. Each application is considered against a range of criteria including support in place for reservists and cadet forces along with positive advocacy for the Armed Forces community. This month we were delighted to hear that we have been successful in achieving a Gold award following a strong application showing our commitment to the community, with several initiatives in place.

2.7 Our Forces Network continues to hold regular meetings, with talks from external military organisations and lived experiences from colleagues with a Forces connection including acting as mentors for service leavers joining us and we continue to have a strong partnership with Brock Barracks and more recently the local working in partnership with our local cadet force.

2.8 We are also registered with the Forces Families website and the Career Transition Partnership recruitment service as part of our commitment to supporting both those with serving relatives and those starting a civilian career. Our commitment to the Forces Community is not limited to our staff but also encompasses our patients and the community we are here to serve.

3. Strategic Objective 3: Deliver in Partnership

Amphia Visit

3.1 A team of eight clinical and managerial leaders visited Amphia Hospital, Breda in the Netherlands last week. During the two-day trip, funded by the Royal Berks Charity Learning and Knowledge Fund the team were welcomed by Robert Wagenmaker, Amphia's Chief Executive Officer and his colleagues and treated to an extensive tour of the facilities and services in their brand-new hospital. Using our Improving Together methodology and leadership skills of curiosity and humility we identified learning objectives around patient flow, out of hospital care and research and innovation, which were more than met. Despite an entirely different funding mechanism through insurance rather than taxation it was clear that the challenges facing Amphia and the Netherlands are the same as we experience here; rising demand, multi-morbidity and staff shortages.

3.2 We will be sharing more of our learning through Board and committees over the next few months but key highlights included the virtual hospital services, focus on patient flow through ergonomically designed wards, sustainability through the use of heat exchange pumps and a clear focus on wellbeing for staff and patients through dietary and lifestyle advice and support. The 10 Year Plan strategic objectives of digital, prevention and community were also evident.

3.3 We look forward to welcoming a delegation from Amphia to the Trust in November 2025 and plans are underway to put together a programme as informative, impressive and enjoyable as theirs was. As well as sharing knowledge in the short term we hope this will become a longer term partnership.

4. Strategic Objective 4 – Cultivate Innovation & Improvement

Trust Strategy Refresh

4.1 Our engagement period for the Trust Strategy refresh has now concluded. We have engaged with over 2,500 people and received more than 800 survey responses. Alongside our staff, volunteer, and partner organisation workshops, we have also undertaken 34 engagement events in the community across Berkshire West

4.2 We've heard lots of positive feedback, and the most consistent feedback from our patients and community has been their pride in our staff and volunteers, and the compassion and professionalism they show in delivering our services. It has also identified areas where we can do more to improve our services, whether that be delivering more services in the community and closer to patients homes, using digital advances to support our care and communications, improving our estate and building on our prevention work.

4.3 Thanks to all those that contributed, the strategy will be shaped by this engagement by the Strategy and Partnerships team with an aim to finalise and publish at November Public Board.

Frederick Potts Unit

4.2 The Frederick Potts Unit was formally opened last month by Mr Andrew Try, Lord Lieutenant for the Royal County of Berkshire, with staff from the Trust and descendants of Trooper Frederick Potts VC in attendance.

4.3 The unit is the result of a 17 million pound investment in elective recovery and months of work focussed on providing the best patient care and experience.

4.4 The facility is now fully operational, treating thousands of patients a month in a state of the art clinical environment.

Mortuary Expansion

4.5 The works to expand the Mortuary on the Reading site are due to be completed by the end of this month. The expansion has created greater capacity as well as improved changing facilities for the Mortuary team.

5. Strategic Objective 5: Achieve Long Term Sustainability

Financial Position

5.1 The Trust has reported delivery of the planned financial position at the end of month five which is a deficit of £9.24m.

5.2 Whilst we continue to deliver our financial plan each month, we also need to be mindful that the financial challenge does increase as the year goes on. However, we recognise the work of our teams to get us to this position this year and we met with colleagues from across the care group this month to thank them for their efforts.

Annual General Meeting

5.3 Last week we held our Annual General Meeting showcasing the work the Trust achieved together over the past year and looking ahead to the next 12 months. It was the perfect opportunity to recognise the incredible work that our 7,500 colleagues and volunteers do each day, and the challenges they overcome to provide outstanding care to our community.

5.4 We had a total of 95 attendees including virtual attendees, Board members, Governors, Staff and members of the public.

NHS
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Title:	**Acute Provider Collaborative Update**
Agenda item no:	7
Meeting:	Board of Directors
Date:	24 September 2025
Presented by:	Steve McManus, Chief Executive
Prepared by:	Naomi Radcliffe, Director, BOB Acute Provider Collaborative

Purpose of the Report	The purpose of this report is to provide an update to the Board on the current positions of the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Acute Provider Collaborative (APC).

Report History	New report

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

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

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

1. Purpose

1.1. The purpose of this paper is to provide an update to the Board on the current positions of the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Acute Provider Collaborative (APC).

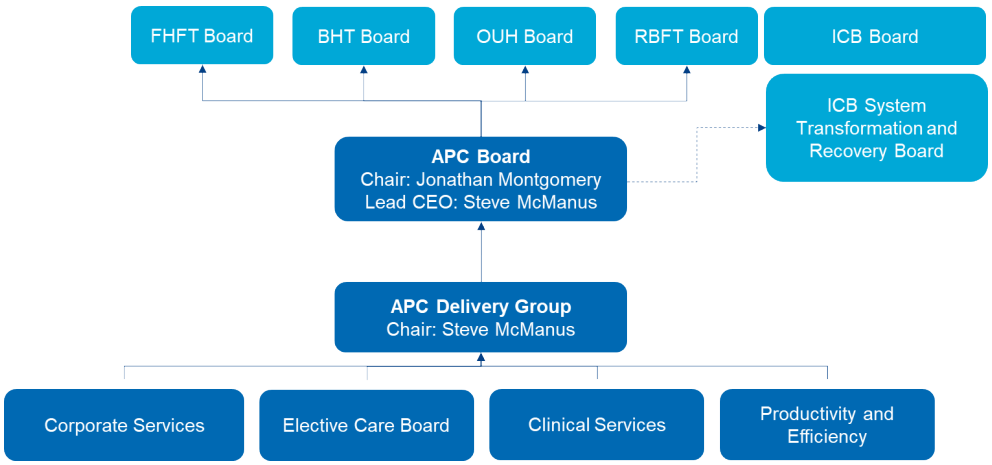
2. Programme Update

2.1. The APC Board met on Tuesday 26 August. The Board confirmed that Frimley Health NHS Foundation Trust (FHFT) will formally join the APC from September 2025. The name of the collaborative is now the **Thames Valley Acute Provider Collaborative** (TVAPC) to reflect this change.

2.2. A new APC Delivery Group has been established, which sits every other month to the APC Board, and is responsible for managing performance, quality, and risks/issues relating to APC programmes. It receives first sight of business cases and proposals prior to consideration by the Board. The Executive SROs and the ICB Chief Delivery Officer sit on the Group, and it is chaired by the Lead CEO, Steve McManus.

2.3. The APC currently updates BOB ICB on its work programmes at the monthly System Transformation and Recovery Board. This will need to be reviewed and updated in line with changes to the Thames Valley ICB operating model.

Figure 1: Revised APC governance structure



2.4. Executive SROs from the APC met with their FHFT counterparts over the summer to review the current programme of work and ensure that deliverables meet the needs of FHFT. Expected changes to the current programme of work will need to be confirmed, but are likely to include:

2.5. **Making best use of elective care capacity across the system**. There is frequently a mismatch between the availability of resources (e.g. staffing and estate) with the demand for elective services. The Elective Care Board is tackling this issue by supporting patients who are willing to travel to other providers for their treatment, staff passporting, a streamlined approach to perioperative care, and implementing the

GIRFT model for High Volume Low Complexity (HVLC) procedures. There are clear opportunities for FHFT to participate in this approach, including making best use of capacity at the Heatherwood Elective Surgical Hub, and Tina Benson (COO, FHFT) will become the Executive Lead for the programme from October this year.

2.6. Improving the quality of clinical services. The APC works with clinical and operational teams to conduct 'deep dives' into clinical services and identify opportunities to reduce unwarranted variation and improve resilience. The following three areas have been identified as of interest to FHFT:

2.6.1.1. The joint **Fracture Liaison Service** is already enhancing patient outcomes by streamlining care pathways, facilitating shared multidisciplinary team meetings, and strengthening collaboration with primary care. The FHFT Clinical Lead has joined this established working group and is benefiting from the progress and foundations already in place.

2.6.1.2. Scoping is underway with the **Neurology** teams to agree a set of common challenges and solutions that could benefit from a joint approach e.g. developing a portfolio pathway for Neurology to attract and grow a highly skilled workforce.

2.6.1.3. **Dermatology** has been flagged as an area of interest for FHFT and the BOB acute providers, so would be a likely candidate for the next 'deep dive' that is identified and scoped.

2.7. **Driving value for money through economies of scale**. FHFT will be invited to join the current procurement working group, which brings together the leads of the five providers in BOB (including MH and Community) to share best practice and facilitate joint contracts where it makes sense to do so and drives value for money.

3. Recommendations

3.1. The Trust Board is asked to receive this report for information.

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Title:	**Integrated Performance Report (IPR)**
Agenda item no:	8
Meeting:	Board of Directors
Date:	24 September 2025
Presented by:	Katie Prichard-Thomas, Chief Nursing Officer
Prepared by:	Executive Team

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

Report History	New report

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

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

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

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Integrated Performance Report

August 2025

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:

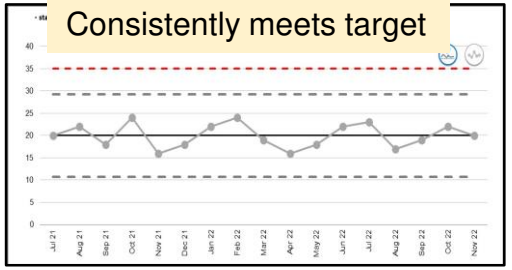
- The variation is routine, expected and stable within a range. We call this '*common cause*' variation, or
- The variation is irregular, unexpected and unstable. We call this '*special cause*' variation and indicates an irregularity or that something significant has changed in the process

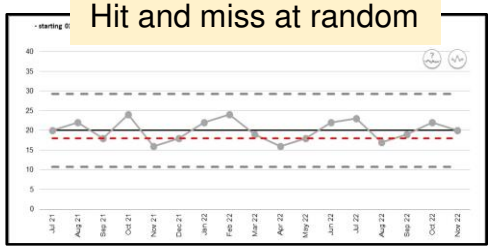
Each chart shows a VARIATION icon to identify either common cause or special cause variation. If special cause variation is detected the icon can also indicate if it is improving (blue) or worsening (orange).

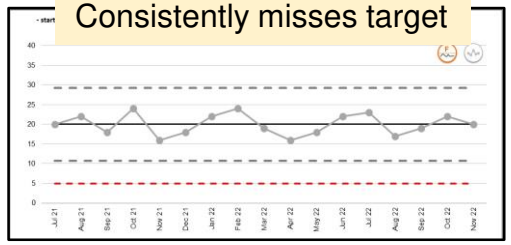
Where we have set a target, the chart also provides an ASSURANCE icon indicating:

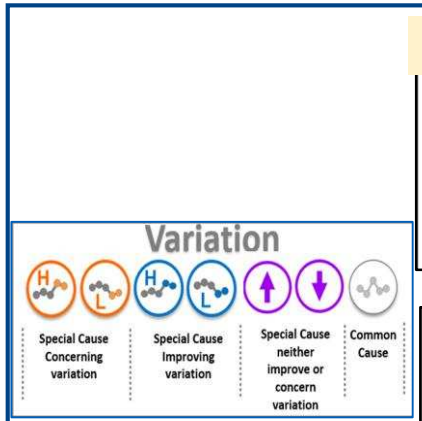
- If we have consistently met that target (blue icon),
- If we hit and miss randomly over time (grey icon), or
- If we consistently fail the target (orange icon)

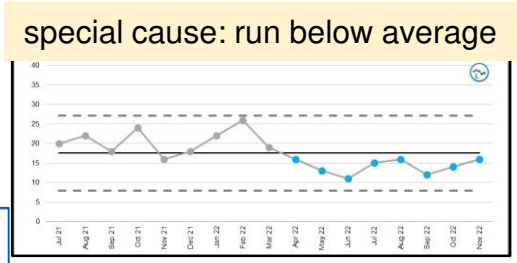
For each of our strategic metrics and breakthrough priorities we will provide a SPC chart and detailed performance report. We apply the same Variation and Assurance rules to watch metrics but display just the icon(s) in a table highlighting those that need further discussion or investigation.

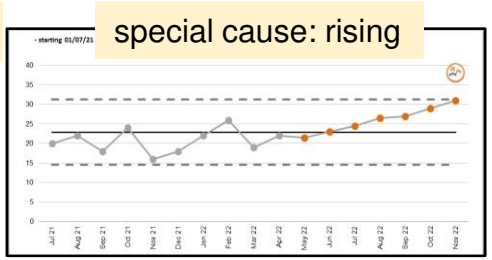


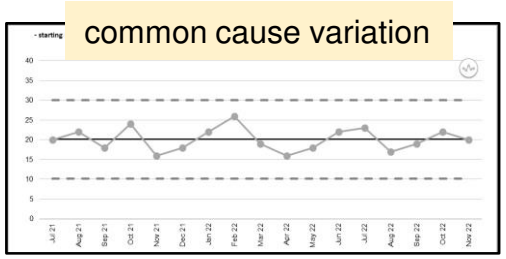


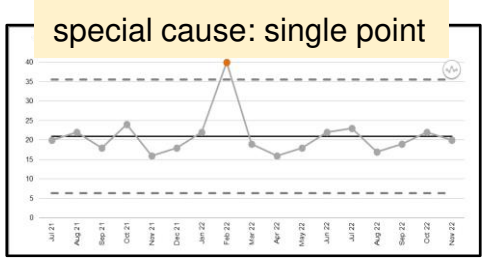












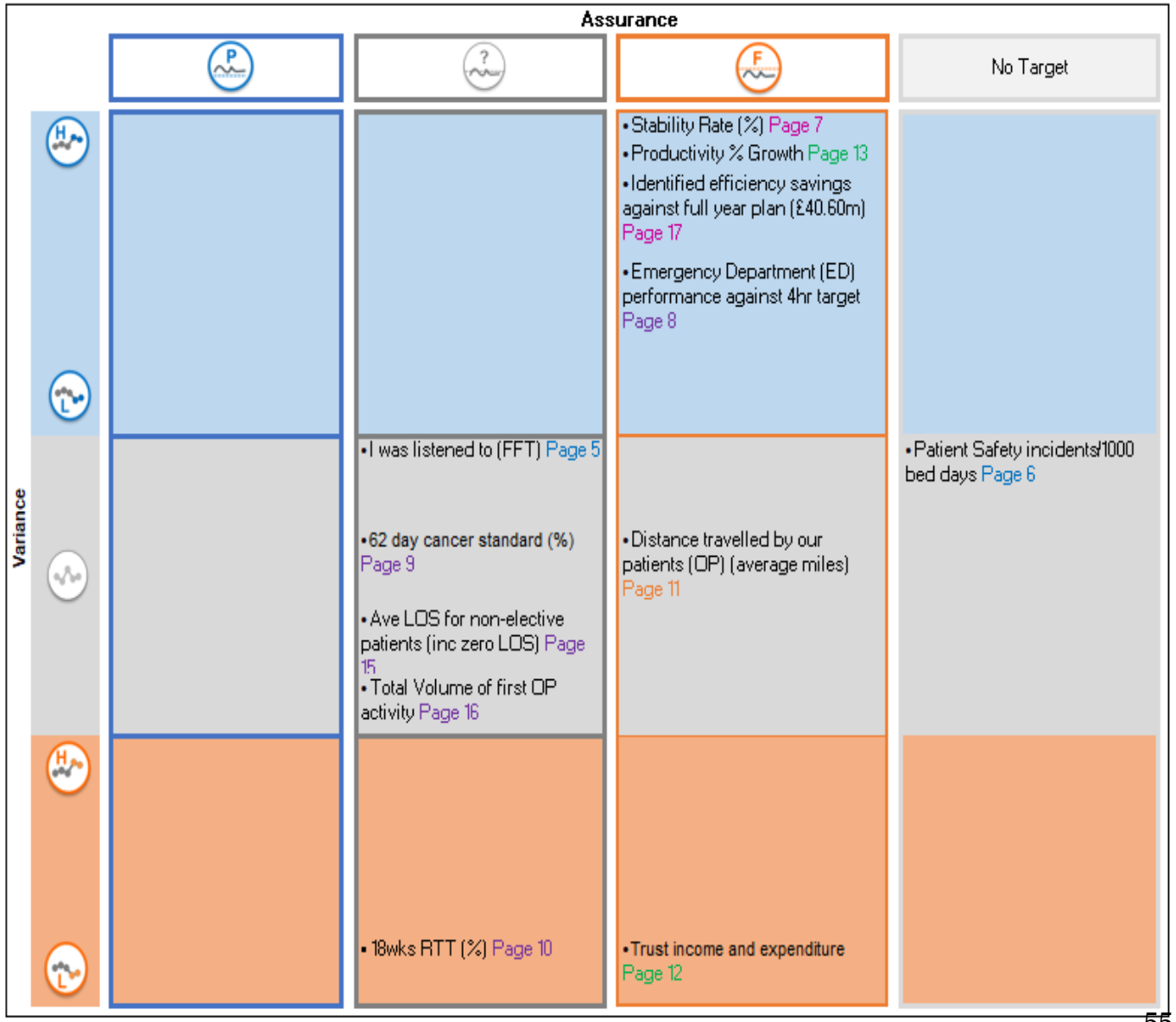
August 2025 performance summary

Royal Berkshire NHS Foundation Trust

The data in this report relates to the period up to 31st August

The key messages from the report are:

- **Accident & Emergency performance;** 76.4% of patients were seen within four hours, performing 1.5% above plan. However, the number of patients remaining in the department for more than 12 hours has increased and remains a concern.
- **Cancer performance** against the 28-day standard remains above the Trust's planned trajectory for 2025-26 (reporting 6 weeks behind). The 62 day performance is now back on plan for the year and actions are being progressed to improve this position further.
- **Financial performance** at the end of August the income and expenditure deficit of £(9.23)m YTD is within agreed plan. In the YTD position we have delivered £12.57m of the £40.60m efficiency savings plan. We continue to work with BOB ICB and other system partners as we implement further actions to improve our financial performance for the financial year 2025/26. We are also focusing on the 2025/26 CIP plan in a view to convert a greater proportion into cash releasing to support the trust financial position.
- **Cash** is a closely watched item and actions taken have resulted in a higher cash balance at the end of August, £25.92m. The identification and delivery of cash releasing efficiencies continue to be a high priority alongside ongoing work with the ICB and NHSE on the recently published cash support regime.
- This month we have seen 15 of the 110 **watch metrics** measure outside of statistical control.



Royal Berkshire
NHS Foundation Trust

Strategic Metrics

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

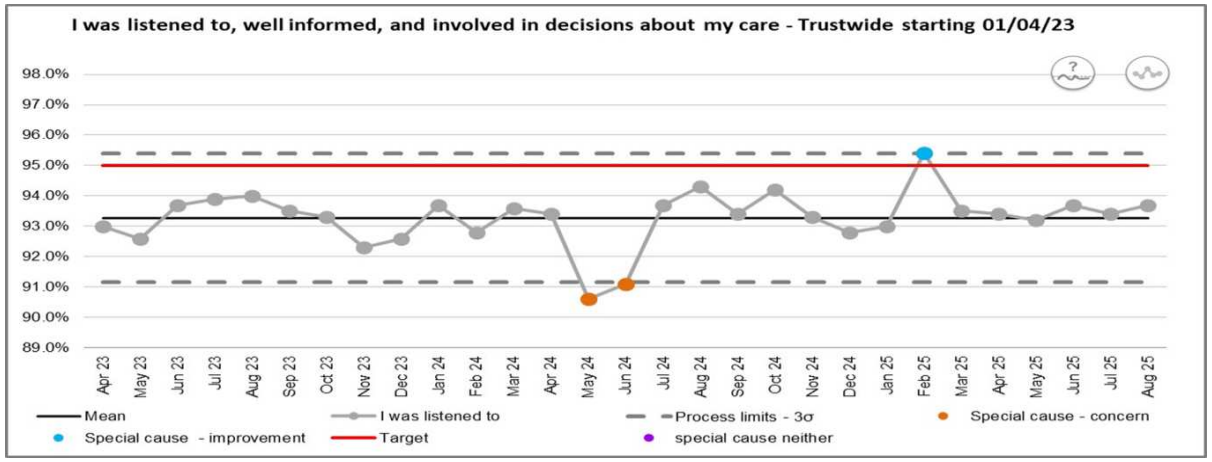
Strategic metric: I was listened to, well informed & involved in decisions about my care

Board Committee: Quality committee

SRO: Katie Prichard-Thomas

Assurance	Variation
?	

Royal Berkshire NHS Foundation Trust



	Mar-25	Apr-25	May-25	June-25	July-25	Aug-25
I was listened to, well informed & involved in decisions about my care (FFT) Q2	93.5%	93.4%	93.2%	93.7%	93.4%	93.7%
Inpatient FFT satisfaction rate	95%	94%	94%	95%	93%	94%
Outpatient FFT satisfaction rate	96%	95%	95%	95%	95%	96%
Maternity FFT satisfaction rate	97%	97%	97%	95%	99%	98%
Emergency Departments FFT satisfaction rate	80%	81%	81%	81%	83%	81%
Paediatric Inpatient FFT satisfaction rate	100%	77%	94%	100%	94%	93%
Day Case FFT satisfaction rate	96%	96%	98%	98%	99%	98%
Overall Trust FFT satisfaction rate	93%	93%	93%	94%	93%	94%

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

How are we performing:

- This metric now includes the Trustwide overall FFT Satisfaction score, currently **94%** with a target of **95%.**
- Satisfaction score for FFT Question 2 for August is at **93.7%**, which remains within the process limits and at mean, but under our trust target of **95%**.
- Emergency Department and Paediatric services are areas with consistently low results for overall satisfaction. Themes highlighted to improve in addition to Q2 are waiting times and conditions while waiting.

Actions and next steps

- FFT digital rolled out to all remaining areas from **1st September 2025**
- Frequent user services on hold pending suitable timed text message (renal/chemo/maternity).
- All departments encouraged to engage in text message process and to reduce the use of paper surveys which can be used where required.
- 'Model' departments/wards selected across all sites, to receive further training on utilising IQVIA (FFT database), reviewing results and identifying improvement opportunities. Learning from this pilot will be rolled out across the Trust.
- Triangulation underway with the Inpatient national survey and FFT to identify recurrent themes to drive departmental improvement plans.

Risks

- Overall capacity limitations in patient experience team and lack of digital capability to analyse high volume feedback in timely way.

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

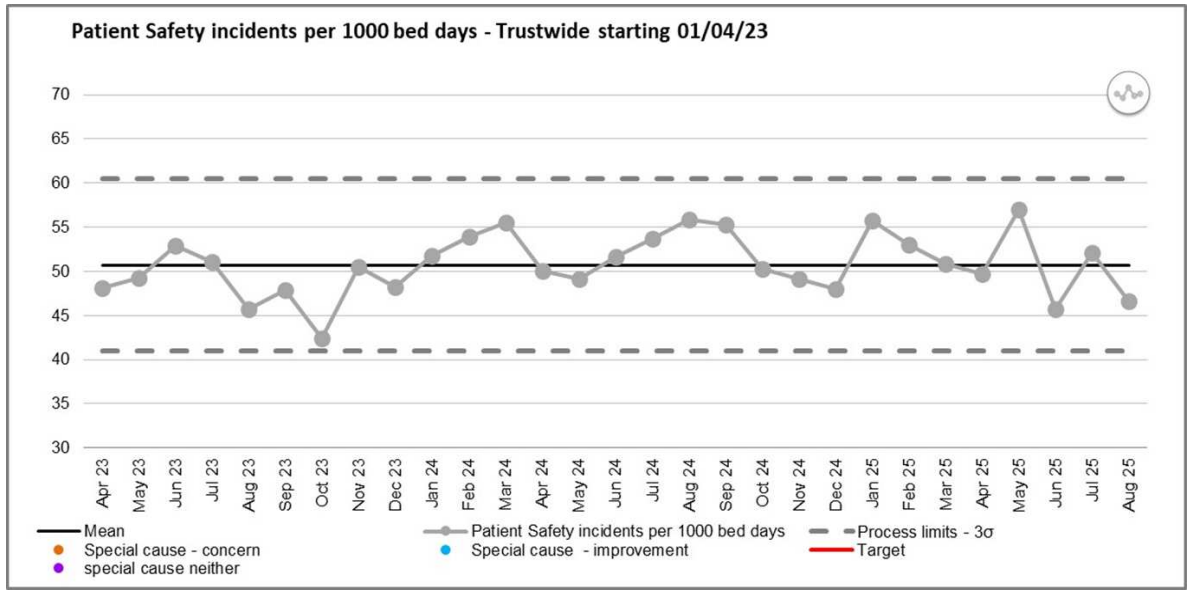
Strategic metric: Learning from incidents to reduce harm

Board Committee: Quality committee

SRO: Katie Prichard-Thomas

Assurance	Variation
N/A	

Royal Berkshire NHS Foundation Trust



	Mar-25	Apr-25	May-25	June-25	July-25	Aug-25
Patient Safety incidents per 1000 bed days	50.80	49.74	57.05	45.66	52.06	46.58
Patient Safety incidents/100 admissions	10.43	10.80	11.45	9.43	10.24	9.41
No. of Deteriorating patient incidents	4	4	11	5	10	8
FFT question: I felt safe during my visit to the hospital (%)	91.70%	98.5%	91.9%	92.4%	92.3%	89.8%
Total Calls for Concern from patient and family	34	26	24	28	23	24

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:

- In month, the level of incidents reported remains stable within the process limits.
- "Total Calls for Concern from patient and family" remains consistent.
- The % completion rate for the National Patient Safety Syllabus training for execs and senior leaders (level 1) is 82%. This is 2 Board members and 3 EMC members.

Actions and next steps

- PSIRF training for "oversight" and "systems approach" have been booked for Autumn 2025 with 40 places at each. These are being allocated via the care groups and corporate teams.
- New Head of Patient Safety has been appointed substantively. Awaiting start date.
- World Patient Safety Day will be celebrated on 17 September 2025 with a conference. The theme is "Safe care for every newborn and every child".

Risks:

- Number of total staff who have completed Patient Safety e-learning remains low (10% of Trust staff).
- Implementation of Ulysses (the replacement for Datix) is significantly delayed (and may be cancelled) due to IT and capital prioritisation.

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

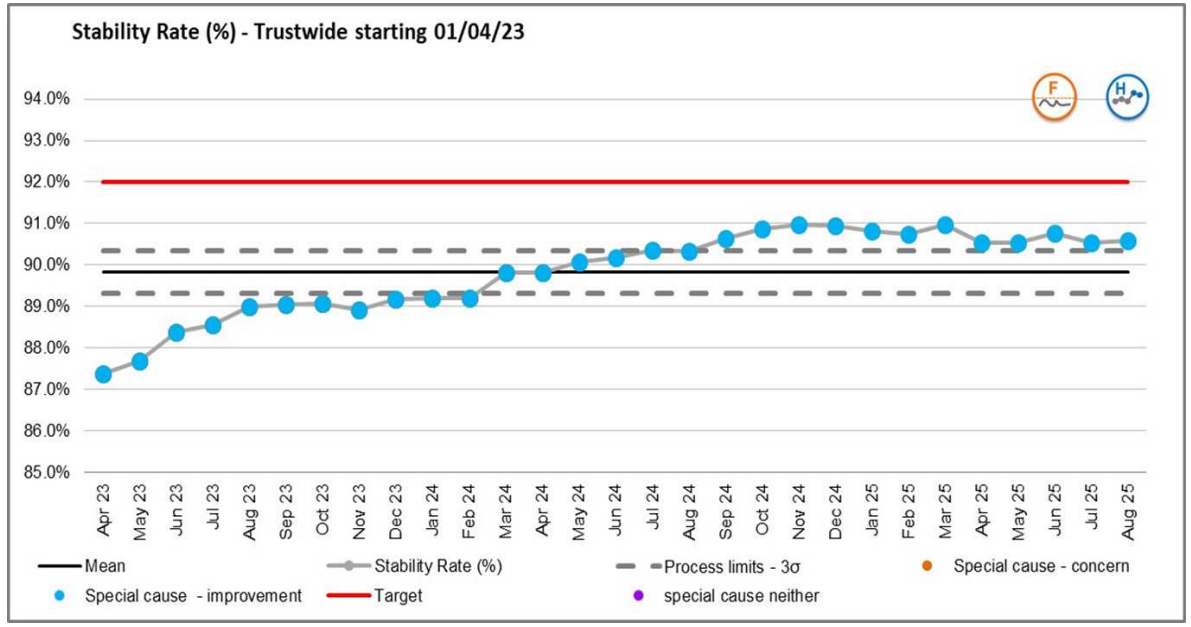
Strategic metric: Improve retention

Board Committee: People Committee

SRO: Don Fairley

Assurance	Variation
F	H

Royal Berkshire NHS Foundation Trust



	Mar-25	Apr-25	May-25	June-25	July-25	Aug-25
Stability Rate (%)	90.97%	90.53%	90.54%	90.76%	90.53%	90.59%
Turnover rate %	9.27%	9.30%	9.16%	8.92%	9.72%	9.93%
Vacancy rate	6.72%	5.01%	4.90%	4.83%	1.79%	2.58%
Sickness absence (rolling 12 month)	3.85%	3.84%	3.83%	3.81%	3.81%	Arrears

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

How are we performing:

- Stability rate trend continues to improve but we are yet to achieve our 92% target (which would place us in the top decile Nationally).

Actions and next steps:

- Continued granular focus on the stability of directorates in Care Groups.
- Preparation for 2025 Staff Survey with the roll out 'Because we care' Communications programme highlighting developments from 2024 Action Plans. Focal points are Appraisal, Health and Wellbeing, Diversity and Inclusion and Violence and Aggression.
- Renewed emphasis on RISE Talent Management programme with Care Groups to support talent review boards operational throughout the Trust.
- Research Programmes with Henley Business School and University of Reading continue into (a) staff retention trends in younger staff groups and (2) predictive forecasting models of staff retention
- Ongoing recruitment into flagship Leadership Development programmes provide (a) a soft 'lock in' retention period for current and aspiring talent during programme completions ranging from 12-36 months dependent on programme (b) high onward promotion rates (70% for Henley Business School Chartered Management Degree Graduates)
- Review communication pathways with Care Groups to inform staff Wellbeing Strategy and services delivered.

Risks:

- Low uptake of talent management reviews after appraisal and Recognising Individuals Success and Excellence (RISE) pathways identified

Strategic objective: **Deliver in partnership**

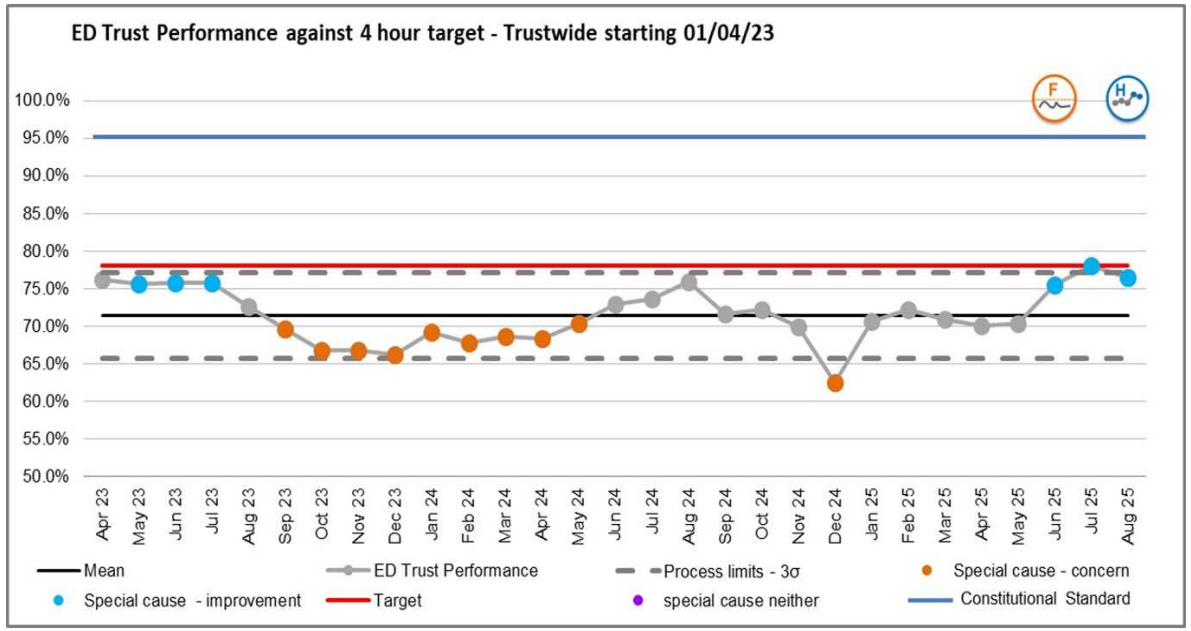
Strategic metric: Performance against 4hr Emergency Pathway target

Board Committee: Quality Committee

SRO: Dom Hardy

Assurance	Variation
F	H

Royal Berkshire NHS Foundation Trust



	Mar-25	Apr-25	May-25	June-25	July-25	Aug-25
4hour Performance (%)	70.97%	70.07%	70.34%	75.47%	78.09%	76.44%
4hr Performance (%) Trajectory	-	69.5%	71.6%	70.6%	75%	74%
Average daily Type 1 attendance	392	348	389	395	398	368
Total Breaches	4894	4617	4626	4000	3951	3508
Ambulance Handover: 30 Minutes	350	313	280	205	156	139
12 hours from arrival in ED (%)	6.04%	6.19%	5.06%	4.21%	2.73%	3.43%

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

How are we performing:

- 76.44% all types of patients were seen within 4 hours – increase in patients remaining the department >12hrs
- Daily attendances have reduced by approx. 30 per day on average in Aug, compared to Q1 – in line with seasonal trends
- Daily average of 89 attendees at the UCC. Approx 10% are primary redirects, 10% 111 redirects, with the remainder ED redirects
- Significant improvements in ambulance handovers >1hr
- ED Trust performance against the 76.44% trajectory, above plan by 1.5%
- ED team are monitoring compliance to the 4hr standard by individual areas - Adult Main department remains the area of focus

Actions and next steps:

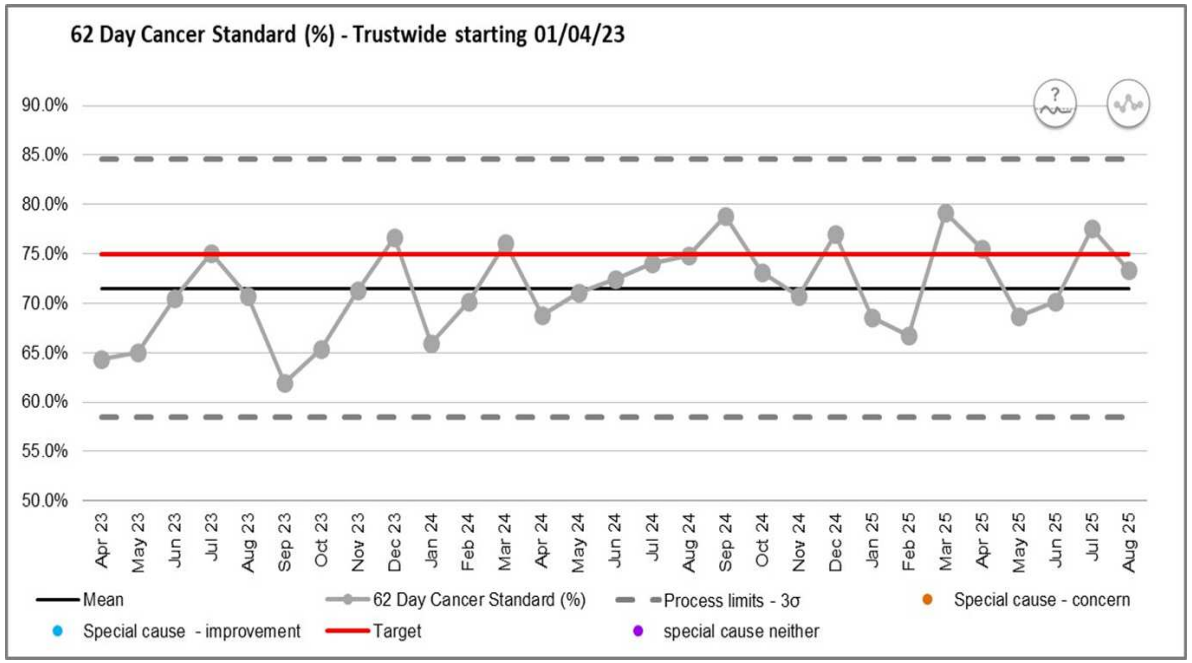
- Increased focus on patients remaining in ED>12hr
- Focusing on Adult main department performance and zone 'B' processes
- Focus on reducing the number of queuing ambulances continues with a trial to support swift handover of patients using Improving Together

Risks: Corporate Risk 4172

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

Strategic objective: **Deliver in partnership**

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



	Mar-25	Apr-25	May-25	June-25	July-25	Aug-25
Cancer 62 day %	79.2%	75.5%	68.7%	70.2%	77.6%	73.4%
Cancer 62 day% Trajectory	68.0%	70.0%	70.0%	72.0%	72.0%	72.0%
No. on PTL over 62 days	197	233	272	213	262	345
% on PTL over 62 days	6.7%	8.4%	9.9%	7.5%	8.5%	11.3%
Cancer 28 day Faster Diagnosis (80% standard)	81.6%	78.1%	79.5%	78.9%	80.4%	76.1%

Board Committee: Quality Committee

SRO: Dom Hardy

Assurance	Variation
	

NHS Royal Berkshire NHS Foundation Trust

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

How are we performing:

- In July 77.6% of patients were treated within 62 days. August's unvalidated performance is 73.4%. This will likely improve post-validation.
- The total number of patients on the Patient Tracking List waiting over 62 days at the end of August was 345, up from 262 in July. Predominantly within Gynaecology, Lower Gastrointestinal (LGI) & Urology
- July's performance was above the 72.0% trajectory for the month
- RBFT is now part of NHSE's tiering process along with the OUH and BHT

Actions and next steps:

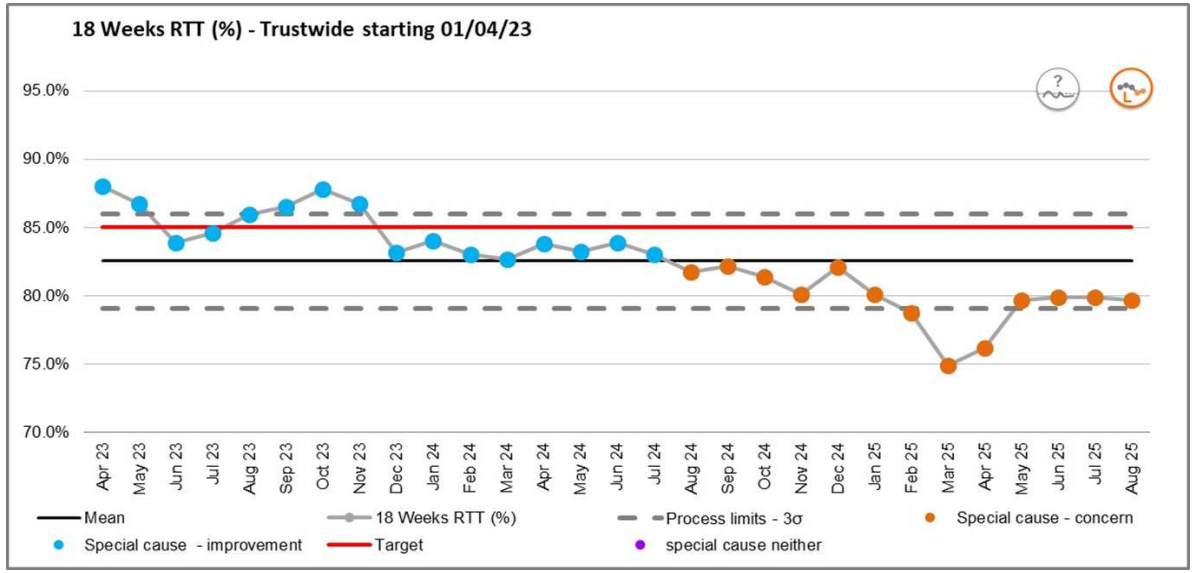
- Cancer Action Group (CAG) meetings for Gynae, Lower GI & Urology have been changed from monthly to weekly
- Gynae to complete a review of demand & capacity for hysteroscopy and ensuring all patients have their scope within 7 days
- Focus for LGI is expanding nurse-led triage capacity to ensure all patients are triaged within 1 day of referral and have their 1st OP appointment or endoscopy within 7 days

Risks: Corporate Risk 4241

- Continued delays to some parts of pathways in Gynaecology, Gastroenterology and Urology
- High reliance on insourcing/outsourcing
- Service Level Agreement for delivery of plastics capacity from OUH (affecting the skin pathway)

Strategic objective: **Deliver in partnership**

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



	Mar-25	Apr-25	May-25	June-25	July-25	Aug-25
18 Weeks RTT (%)	74.91%	76.18%	79.7%	79.92%	79.91%	79.65%
18 Wks RTT (%) Trajectory	-	80%	80%	80%	80%	80%
Total Elective Activity (No.) (provisional)	4697	4469	4679	4630	4933	4423
% of plan for Daycases (cumulative)	103.65%	100.00%	102.19%	100.38%	98.80%	98.33%
% of plan for Inpatients (cumulative)	95.81%	99.50%	103.20%	100.01%	97.71%	97.01%
% of plan for Outpatient Attendances (News & Follow Ups (cumulative)	103.00%	109.97%	109.71%	114.38%	112.63%	110.92%

Board Committee: Quality Committee

SRO: Dom Hardy

Assurance	Variation
?	L

Royal Berkshire NHS Foundation Trust

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

How are we performing:

- The Trust continue to report high performance when compared nationally and has been meeting its plan since May
- Through Q2 the overall PTL size has continued to reduce as a result of sprint validation and Master Waiting List cleansing actions. However there remains a significant data quality burden within RTT which is expected to disproportionately affect the <18. We will aim to balance DQ improvement with performance improvement throughout the year as reflected by our flat trajectory.
- Activity continues to track above 100% of plan

Actions and next steps:

- Continue to drive improvement in the diagnostic waiting times (currently 85% <6 weeks)
- Continue to drive increase first OPA activity to reduce waiting times to first seen where capacity allows.
- Commence development (Jul 25) of Discharge and RTT Large Language Model (LLM). This is expected to reduce RTT validation by c. 75%. This is in addition to MasterWL EPR data cleansing

Risks: Corporate Risk 5995

- Capacity and funding to deliver additional first OPA . Currently in discussion with ICB / NHSE

Strategic objective: **Cultivate Innovation and Improvement**

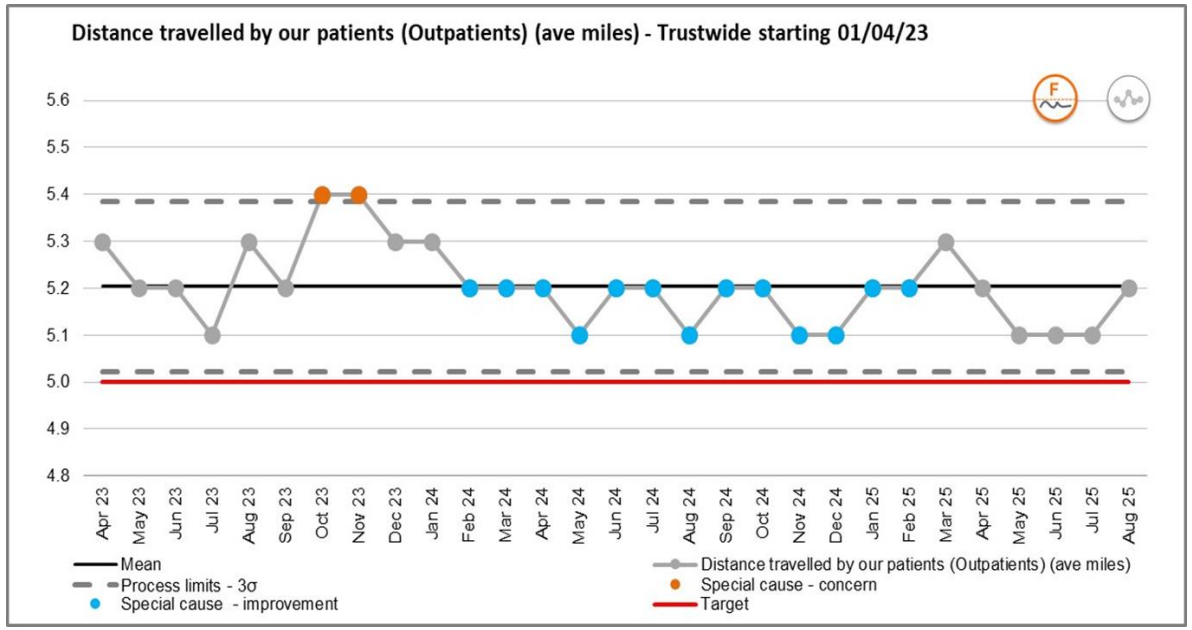
Strategic metric: Distance travelled by our patients (outpatients)

Board Committee
Quality Committee

SRO: Andrew Statham

Assurance	Variation
F	

Royal Berkshire NHS Foundation Trust



	Mar-25	Apr-25	May-25	June-25	July-25	Aug-25
Distance travelled by our patients (average miles) (Outpatients including Virtual Attendances and Advice & Guidance\)	5.3	5.2	5.1	5.1	5.1	5.2
Number of Virtual attendances	9457	9991	9910	10508	11107	8833
Advice & Guidance (A&G) activity	1705	1700	1817	1899	2008	1795
Face to face (FTF) activity at non RBH sites	9141	8947	9368	9909	10148	8536

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

How are we performing:

- In August, the average distance travelled was 5.2 miles. While this remains in the standard range, we are still not achieving our target of 5 miles or less
- Use of non-RBH sites remains variable over the last 6 months with no positive or negative trend

Actions and next steps

- The 6-4-2 planning meetings continue to be held weekly, and the monthly utilisation report continues to be shared with DMs for review of percentage booking against use.
- Scoping for Phase 3 of the Outpatients programme is underway.

Risks:

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

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

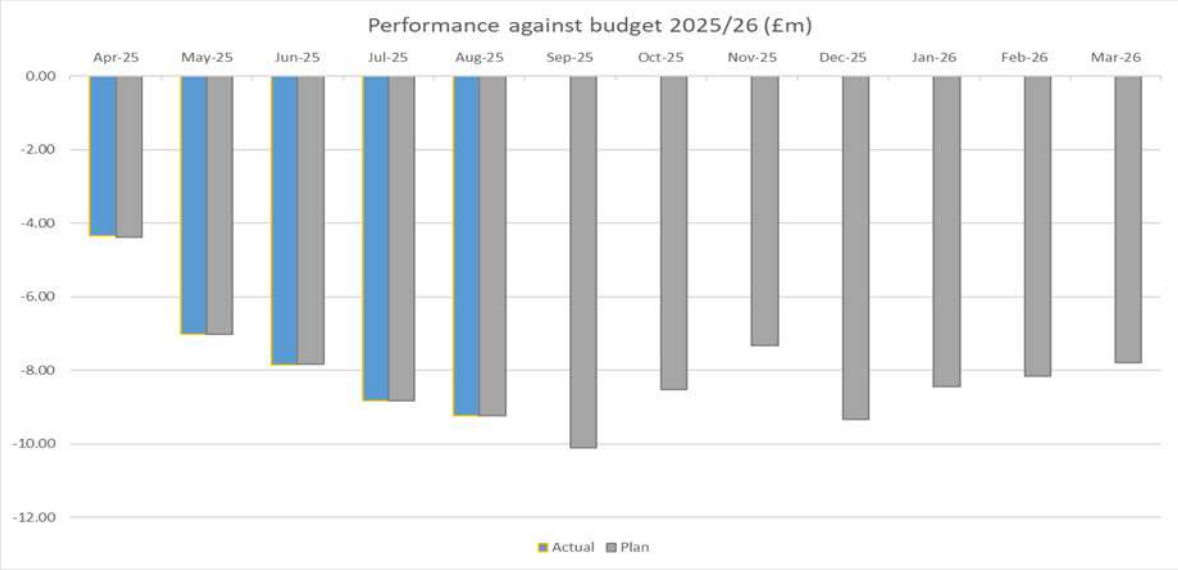
Strategic metric: Trust income & expenditure performance

Board Committee
Finance & Investment

SRO: Helen Troalen

Assurance	Variation
F	L

Royal Berkshire NHS Foundation Trust



Metric Description	Mar-25	Apr-25	May-25	June-25	July-25	Aug-25
Income as % of plan	157.08%	99.91%	100.72%	100.87%	105.17%	99.15%
Pay as a % of plan	171.96%	100.91%	100.66%	100.85	107.64%	97.26%
Non-Pay as a % of plan	192.46%	97.81%	101.76%	101.02%	100.84%	102.42%
Cost Improvement Plans (CIP) delivered (cumulative) (£)	£27.87m	£1.71m	£4.20m	£6.89m	£9.53m	£12.57m
Value weighted activity actual in month (£m)	£35.74m	£34.45m	£37.71m	£41.02m	£42.79m	£39.76m
Bank and Agency Spend actual (cumulative) (£m)	£22.36m	£1.73m	£3.17m	£4.52m	£5.88m	£7.34m
Cash Position (£m)	£9.79m	£7.86m	£5.34m	£7.43m	£17.15m	£25.92m

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

How are we performing:

- YTD M05 August 2025 deficit is £(9.23)m which is in line with agreed plan
- Income is at £280.12m, £3.20m ahead of plan, driven by Other Operating Income – both Urgent and Emergency Care Unit funding and long-term covid funding.
- Pay adverse to plan by £(2.42)m, driven by corporate and care group savings targets, costs of industrial action and premium rate payments for additional activity.
- Non-pay is £(0.85)m adverse to plan driven by high-cost drugs variance. This is a pass-through cost to commissioners and mechanisms are being finalised to recognise this income.

Actions and next steps

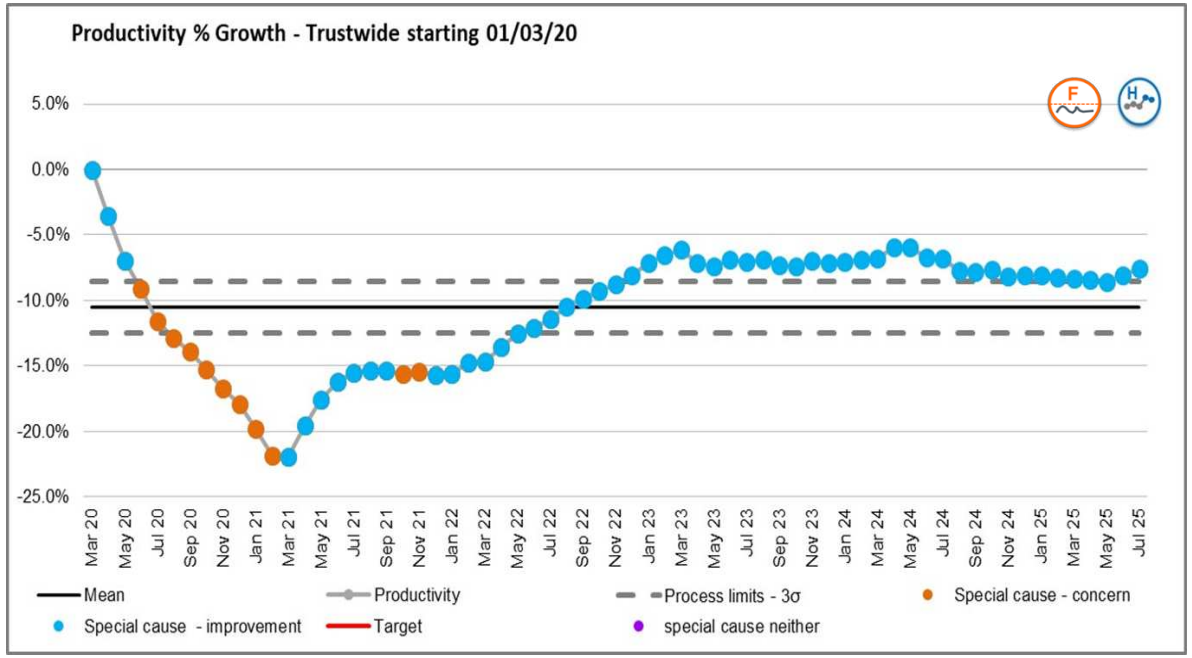
- Finalise contracts with BOB ICB and Specialised Commissioning including the Indicative Activity Plan, High-Cost Drugs and Devices and Aligned Payment Incentive variable payments.
- Continue to drive the focus on the CIP target, to achieve plan for 2025/26.
- Review key contracts for further opportunities to mitigate inflationary increases and ensure volume-based opportunities are maximised on non-pay

Risks: Corporate Risk 4182

- CIP delivery given the current level of identified savings
- Expenditure run rates given the phasing of the plan for efficiencies

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

Strategic metric: Productivity (Activity/Wholetime Equivalent)



	Mar-25	Apr-25	May-25	June-25	July-25	Aug-25
Productivity % Growth	-8.3%	-8.1%	-8.1%	-8.1%	-7.6	Arrears
Cost Weighted Activity (CWA) % Growth	13.0%	13.4%	13.4%	13.4%	13.9%	Arrears
Whole Time Equivalent (WTE) % Growth	23.3%	23.3%	23.3%	23.3%	23.3%	Arrears

Board Committee
Finance & Investment

SRO: Helen Troalen / Andrew Statham

Assurance	Variation
F	H

Royal Berkshire NHS Foundation Trust

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

How are we performing:

- Output per worker' fell significantly during COVID-19 as activity reduced and the Trust employed more people to support the pandemic effort. Since 2021, productivity has continued to improve as the Trust's activity levels returned to and then exceeded 2019/20 levels. This trend continues for August.
- In the last year, productivity improved as workforce stabilised and activity growth continued. The Trust remains 7.6% below 2019/20 levels of productivity as workforce growth (23.3%) exceeds activity growth (13.9%).

Actions and next steps:

- The 2025/26 plan involves a number of actions including specialty by specialty specificity that will support recovery
- A breakdown of productivity by care group and service line has been shared with teams in order to seek a greater understanding of where opportunities might lie and how they can be realised.

Risks:

- Delivery of the 2025/26 plan is challenging as it represents a step change in efficiency asks from all teams, and may require reshaping of teams and services across clinical and corporate areas

Royal Berkshire
NHS Foundation Trust

Breakthrough Priorities

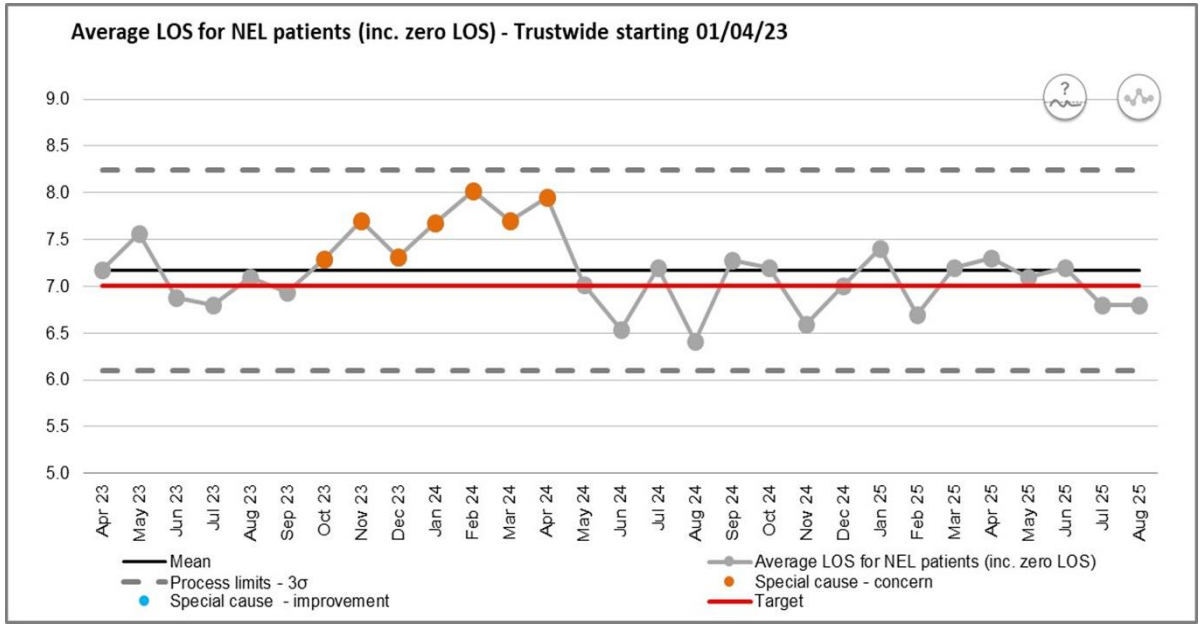
Breakthrough priority metric: Average Length of Stay (LOS) for non-elective patients (inc. zero LOS)

Board Committee: Quality Committee

SRO: Dom Hardy

Assurance	Variation
?	

Royal Berkshire NHS Foundation Trust



	Mar-25	Apr-25	May-25	June-25	July-25	Aug-25
Ave LOS for NEL patients (inc. zero LOS	7.2	7.3	7.1	7.2	6.8	6.8
Bed Occupancy (%)	88%	87%	87%	84%	84%	83%
No. of patients with zero day LoS	590	543	507	607	591	539
Ave number patients > 7 days	259	260	268	246	242	244
Ave number patients > 21 days	84	90	96	94	79	95
Ave no. of patients through discharge lounge per day	16	18	19	19	20	19

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

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

How are we performing:

- The average LOS in recent months has remained around 7+ days within the process limits and mean range (7.1 days in a rolling 6 month average)
- The average LOS for the last 6 months, has been lower than last year by c.0.5 days which equates to c.25 beds/day

Actions and next steps

- Continued drive for improved accuracy of targeted day of discharge (60% target)
- Implemented a new process focused on early use of Discharge Lounge. Over 500 patients per month for the last 3 months and 43% were discharged by midday – great work by all teams. Sept is currently 48%
- Joint focus on Community beds using Continuous Quality Improvement methodology. Priority workstream for elderly care patients and diamond escalation for complicated, long waiters.
- Improved pharmacy support over winter agreed and being modelled (c. 0.6 bed days currently)
- Improved visibility of HDT at morning board rounds with in-person attendance

Risks:

- Cultural norms around ward practice prove harder to change than we hope with key staff groups stretched and less able to engage in actions
- Complexity across the Trust and externally hides successful improvement

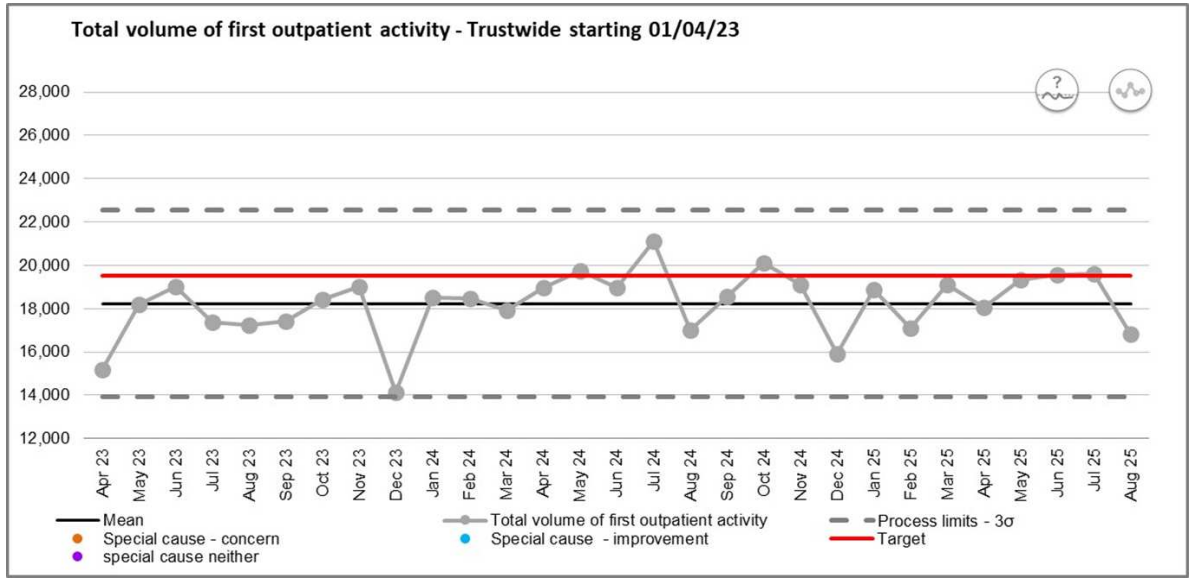
Breakthrough priority metric: Total Volume of first Outpatient (OP) Activity

Board Committee: Quality Committee

SRO: Andrew Statham

Assurance	Variation
?	

Royal Berkshire NHS Foundation Trust



	Mar-25	Apr-25	May-25	June-25	July-25	Aug-25
Total Volume of first outpatient activity	19,112	18,062	19,342	19,561	19,631	16,827
First outpatient activity Plan	19,296	18,536	18,536	19,463	18,536	18,536
% of patients waiting over 12 weeks All patients, wait to first assessment	85.23%	85.29%	85.30%	86.37%	86.37%	79.79%
No. of patients waiting >52wks RTT national standard	62	53	19	37	37	32
% OP that did not attend/were not brought (1st OP Appt)	6.7%	5.7%	6.1%	7.0%	7.8%	7.7%
% triage within 2 working days for all GP referrals (including 2 week wait, urgent and routine)	49%	62%	44%	44.5%	44.50%	32.6%

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 August shows that we delivered 16.8k 1st OPA which is lower than our plan in-month and does not hit our target. This data is provisional and may increase as the data is refreshed in coming weeks.
- Wait to first OPA continues to improve. We are continuing to drive actions in this area.

Actions and next steps

- Work continues to increase the number of first Outpatient Appointments and reduce waiting times.
- The focus is on DNA/WNB reduction, clinic utilisation, improving first to follow up ratios, coding and implementation of patient initiated follow up
- Data on the above focus areas has been shared with all specialties and the expectation is that teams identify opportunities for improvement and act on them

Risks: Corporate Risk 5698

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

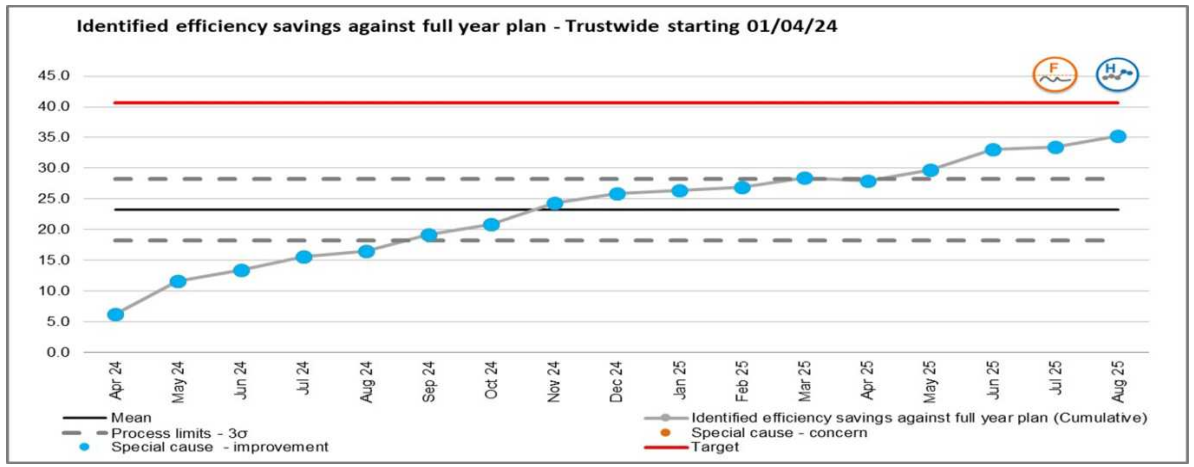
Breakthrough priority metric:
Identified efficiency savings against full year plan (£40.60m)

Board Committee: Finance & Investment Committee

SRO: Dom Hardy

Assurance	Variation
F	H

Royal Berkshire NHS Foundation Trust



	Mar-25	Apr-25	May-25	June-25	July-25	Aug-25
Cumulative identified efficiency savings against full year plan (£40.60m)	£28.45m	£27.92m	£29.70m	£33.04m	£33.44m	£35.26m
Total Delivery against identified efficiency savings (%)	97.96%	6.12%	14.76%	20.85%	28.50%	35.64%
Delivery against identified efficiency savings: Corporate Services (%)		4.75%	9.79%	17.53%	24.67%	29.98%
Delivery against identified efficiency savings: Commercial (Procurement & Income) %		3.97%	13.55%	22.87%	32.62%	38.4%
Delivery against identified efficiency savings: Other local opportunities (%)		9.94%	16.21%	22.13%	27.44%	36.07%
Identified efficiency savings %: Recurrent	42.00%	42.60%	43.30%	43.99%	47.30%	49.24%
Identified efficiency savings %: Non-recurrent savings	58.00%	57.40%	56.70%	56.01%	52.70%	50.86%

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

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

How are we performing:

- Our efficiency savings target is £40.60m for the 2025/26 financial year
- At year-to-date M05 August 2025, we have identified all our efficiency savings although £5.34m has project plans under development.
- We delivered £12.57m

Actions and next steps:

- Continue with tight control on the use of RATI,Vitalis and outsourcing
- Continue reviewing possible opportunities across nursing, midwifery, and AHPs.
- All care groups and directorate to continue to hit their budget
- Work continues with the Acute Provide Collaborative to identify system savings
- Medicines business case implementation
- The work to convert non-recurrent to recurrent schemes has started and is now ongoing in a view to develop the 2026/27 CIP plan.

Risks: - Corporate Risk 4182

- The deliver of the full year plan of £40.60m.

Royal Berkshire
NHS Foundation Trust

Watch Metrics

Summary of alerting watch metrics

Royal Berkshire NHS Foundation Trust

Introduction:

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

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

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

Alerting Metrics August 2025:

In the last month 15 of the 110 metrics exceeded their process controls, two more than last month. These are set out in the table opposite.

There are no new alerting watch metrics this month.

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

Provide the highest quality of care for all

- C.diff (Cumulative – Trust Apportioned)
- Complaints turnaround time within 25 days (%)
- Never Event declared in August 25
- Hospital standardised mortality ratio and standardised mortality ratio(Arrears)

Invest in our staff and live out or values

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

Deliver in Partnership

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

Achieve long term sustainability

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

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

Watch metrics

SROs: Katie Prichard-Thomas

Janet Lippett

NHS Royal Berkshire NHS Foundation Trust

Metric	Variation	Assurance	Target	Jun-25	Jul-25	Aug-25	Aug-24
Never Events			0	0	0	1	0
Pressure ulcer incidence per 1000 bed days			1.00	0.41	0.42	0.56	0.00
Category 2 avoidable pressure ulcers			5	0	1	0	0
Category 3 avoidable pressure ulcers			0	0	1	1	0
Category 4 avoidable pressure ulcers			0	0	0	0	0
Unstageable avoidable pressure ulcers			0	0	0	0	1
Patient Falls per 1 000 bed days			5.00	3.46	3.52	4.37	3.73
Patient falls resulting in harm (PSIRF methodology applied)			-	1	0	1	1
No. of DOLS applications applied for			-	27	33	20	21
No. of detentions under the MH act to RBH			-	2	0	2	4
% of staff: Safeguarding children L1 training			90.00%	96.00%	95.70%	96.50%	96.60%
No. of child safeguarding concerns by the Trust			-	165	221	153	165
No. of adult safeguarding concerns by the Trust			-	53	76	30	24
No. of safeguarding concerns against the Trust			-	8	7	9	1
Unborn babies on child protection (CP) / child in need plans (CIP)			-	41	47	44	40
C.Diff (Cumulative – Trust Apportioned)			39	16	24	27	25
C.Diff lapses in care			-	5	8	3	3
MRSA Bacteraemia (avoidable)			0	0	0	0	0
E.coli (Trust Apportioned) Bloodstream Infections			-	6	12	4	6
E.coli (Trust Apportioned) Bloodstream Infections (Cumulative)			92	27	39	43	45
MSSA surveillance (trust acquired)			-	5	6	4	7
Hand Hygiene			95.00%	95.93%	96.70%	97.28%	97.45%
VTE inpatient (excluding short stay/maternity) risk assessment / prescription compliance			95.00%	93.80%	94.30%	93.30%	95.60%
Hospital Acquired Thrombosis (HAT) rate / 1000 inpatient admissions			0.00	1.34	0.50	0.50	2.13
Medication incidents per 1000 bed days			0.00	7.20	7.51	7.44	6.59

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

Watch metrics

SROs: Katie Prichard-Thomas

Janet Lippett

NHS Royal Berkshire NHS Foundation Trust

Metric	Variation	Assurance	Target	Jun-25	Jul-25	Aug-25	Aug-24
No. of compliments			-	23	0	18	70
FFT Response Rates Inpatients: i.Inpatients			50%	28%	31%	41%	34%
FFT Satisfaction Rates Inpatients: ii.ED			95%	81%	83%	81%	85%
FFT Response Rates Inpatients: iii.OPA			50%	5%	6%	7%	8%
FFT Satisfaction Rates Inpatients: iv.Daycases			95%	-	99%	98%	8%
FFT Satisfaction Rates Inpatients: v.Children and Young People			95%	100%	94%	93%	8%
Mixed sex accommodation - breaches			0	208	168	192	79
Myocardial Ischaemia National Audit Project (MINAP): Door-to-Balloon target of less than 90 minutes			97%	90%	100%	Arrears	100%
Myocardial Ischaemia National Audit Project (MINAP): Call-to-Balloon target of less than 120 minutes			86%	67%	67%	Arrears	88%
Myocardial Ischaemia National Audit Project (MINAP): Call to Balloon target less of than 150 minutes			82%	100%	78%	Arrears	88%
No. of Patient Safety Incident Investigations (PSII)			-	4	2	2	2
No. of SWARM huddles			-	0	0	1	4
No. of After Action reviews			-	5	3	6	1
No. of Multidisciplinary Team (MDT) reviews			-	4	6	5	1
No. of Thematic reviews			-	0	0	0	3
Number of Complaints			-	50	49	48	27
Complaints turnaround time within 25 days (%)			80%	62%	52%	70%	45%

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

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

Maternity Watch metrics

SROs: Katie Prichard-Thomas

Janet Lippett

NHS Royal Berkshire NHS Foundation Trust

Metric	Variation	Assurance	Target	Jun-25	Jul-25	Aug-25	Aug-24
Deliveries			-	405	417	385	356
Bookings			-	498	505	512	467
% of Inductions of labour			-	34.0%	32.9%	30.9%	34.5%
Perinatal mortality rate (rolling year per 1000 births)			5.03	2.40	3.60	0.02	0.34
Number of occassions MLU service suspended for 4 hours or more			4	11	17	14	1
Midwifery staffing vacancy rate			-	2.8%	0.0%	5.3%	8.3%
Midwifery staffing turnover			14.0%	13.8%	12.6%	11.7%	10.6%
Midwife : birth ratio (utilised workforce)			1.22	1:22	1:23	1:23	1:21
FFT Satisfaction Rates Maternity			95.00%	95.60%	99.00%	98.10%	93.80%
No. of complaints - Maternity			3	4	7	2	4
Number of Rapid Reviews			-	90	40	12	0
No. of After Action reviews			-	5	3	6	4
Percentage of babies born with features associated with potential hypoxia			1.50%	1.20%	0.23%	1.54%	1.67%
No. of Patient Safety Incident Investigations (PSII)			-	0	1	0	0

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

Watch metrics:

SRO: Don Fairley

NHS Royal Berkshire NHS Foundation Trust

Metric	Variation	Assurance	Target	Jun-25	Jul-25	Aug-25	Aug-24
% of staff from global majority backgrounds in senior AFC Bands 8a and above	H	F	25.00%	20.71%	21.30%	21.48%	19.95%
Rolling 12 month Sickness absence	H	F	3.3%	3.8%	3.8%	Arrears	3.6%
% Fill rate of Registered Nurse Shifts (RN)	L	P	90.0%	94.6%	94.9%	93.0%	98.1%
% Fill rate of Care Support Worker Shifts (CSW)	L	P	90.0%	101.2%	98.5%	94.1%	109.3%
Completed Mandatory Training		P	90.0%	92.0%	90.7%	91.9%	94.0%
Appraisals	H	F	90.0%	88.5%	86.5%	89.9%	87.9%
Nurse Staffing Red Flags			-	26	21	49	31

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

Watch metrics:

SRO: Don Fairley

NHS Royal Berkshire NHS Foundation Trust

Metric	Variation	Assurance	Target	Jun-25	Jul-25	Aug-25	Aug-24
RIDDOR reportable Incidents			-	1	2	3	0
Abuse/V&A (Patient to staff)			-	74	69	60	82
Body fluid exposure/needle stick injury			-	19	24	20	26
Environment Related Incidents			-	19	33	19	16
Conflict Resolution		?	90%	89%	89%	90%	93%
Fire (Annual)		?	90%	92%	89%	92%	93%
Moving and Handling Level 1	H	?	90%	95%	94%	94%	93%
Moving and Handling Level 2		?	90%	89%	87%	90%	95%
Health and Safety Training			-	94%	94%	95%	97%
Slips and Trips			-	4	3	2	4
Musculoskeletal - Inanimate object	H		-	1	1	7	3
Total non clinical incidents reported			-	257	307	217	151

Strategic Objective: **Delivering in partnership**

Watch metrics

SRO: Dom Hardy

Royal Berkshire NHS Foundation Trust

Metric	Variation	Assurance	Target	Jun-25	Jul-25	Aug-25	Aug-24
Fractured Neck of Femur: Surg in 36 hours			75.0%	-	51.0%	51.0%	54.5%
Proportion of patients admitted directly to an acute stroke unit within 4 hours of hospital arrival		F	90.0%	77%	60.0%	73.0%	76.0%
Proportion of patients spending 90% of their inpatient stay on a specialist stroke unit (national target)		?	80.0%	93%	87.0%	88.0%	94.0%
Proportion of people with high risk TIA fully investigated and treated within 24hrs (IPM national target)	H	F	90.0%	89.0%	90.0%	90.0%	38.0%
Cancer 31 day wait: to first treatment		?	96.0%	95.6%	95.9%	94.2%	95.2%
62 Day screen Ref		?	85.0%	64.5%	78.9%	100.0%	57.1%
Cancer Incomplete 104 days		F	0	56	60	83	75
Average waiting times in diagnostic (DM01) services	L	?	6	4	3	4	9
Diagnostics Waiting < 6 weeks (DM01) (%)		F	99.0%	89.7%	84.7%	78.5%	80.4%

Strategic Objective: Cultivate Innovation and Improvement

Watch metrics

SRO: Andrew Statham

Royal Berkshire NHS Foundation Trust

Metric	Variation	Assurance	Target	Jun-25	Jul-25	Aug-25	Aug-24
% OP appointments done virtually			-	19.8%	20.1%	19.4%	20.2%
Number of OPPROC			-	15348	16002	13288	11865
Number of MDT OP			-	817	890	709	748
Number of PIs			-	132	134	137	121
Number of active research trials			-	169	174	179	141
Number of projects supported by HIP			-	63	63	63	53

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

Watch metrics

SRO: Helen Troalen

NHS Royal Berkshire NHS Foundation Trust

Metric	Variation	Assurance	Target	Jun-25	Jul-25	Aug-25	Aug-24
Pay cost vs Budget (£m)			-	-0.29	-2.55	0.96	-0.46
Non pay cost vs Budget (£m)			-	-0.23	-0.19	-0.53	-2.44
Income vs Plan (£m)			-	0.49	2.85	-0.48	4.57
Daycase actual vs Plan (£m)	H		-	0.32	0.71	0.32	0.50
Elective actual vs Plan (£m)			-	-0.04	0.53	-0.04	0.40
Outpatients actual vs Plan (£m)	H		-	2.62	2.62	2.62	-0.47
Non-elective actual vs plan (£m)	H		-	-0.40	1.59	-0.40	-0.98
A&E actual vs plan (£m)			-	0.92	0.81	0.92	0.05
Drugs & devices actual vs plan (£m)			-	0.82	0.90	0.82	0.96
Other patient income (£m)			-	-0.10	0.19	-0.10	0.14
Delivery of capital programme (£m)			-	0.05	2.94	2.58	1.80
Cash position (£m)			-	7.43	17.15	25.92	18.92
Agency spend % of total staff cost (%)	L		-	0.4%	0.4%	0.4%	1.3%
Creditors (£m)	↓		-	-81.20	-89.17	-97.55	-84.45
Debtors (£m)	↑		-	47.59	47.35	45.85	52.46
Better Payment Practice Code (BPPC) *paying supplier invoices within 30 days of date of invoice (%) YTD	H	F	95.00%	81.20%	75.20%	81.10%	78.80%
Better Payment Practice Code (BPPC) *paying supplier invoices within 30 days of date of invoice (%) In Month	H	F	95.00%	80.60%	59.20%	50.20%	81.20%

Royal Berkshire
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Title:	**Winter Plan 2025/26**
Agenda item no:	9
Meeting:	Board of Directors
Date:	24 September 2025
Presented by:	Dom Hardy, Chief Operating Officer
Prepared by:	Dom Hardy, Chief Operating Officer

Purpose of the Report	To set out the RBFT Winter Plan for 2025/26, provide assurance that appropriate action is being taken to prepare for winter, and to commit to further work to mitigate identified risk.

Report History	Quality Committee 1 September 2025 Executive Management Committee 8 September 2025

What action is required?	
Assurance	
Information	
Discussion/input	
Decision/approval	The Board is asked to approve the winter plan and the proposed Board Assurance Statement

Resource Impact:	None directly
Relationship to Risk in BAF:	
Corporate Risk Register (CRR) Reference /score	4172
Title of CRR	ED capacity and compliance

Strategic objectives This report impacts on (tick all that apply)**:**	
Provide the highest quality care for all	**X**
Invest in our people and live out our values	**X**
Deliver in partnership	**X**
Cultivate innovation and improvement	
Achieve long-term sustainability	

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

Publication						
Published on website		Confidentiality (FoI)	Private		Public	**X**

1 Winter Plan 2025/26

1. NHS Trusts are required to develop a Winter Plan for 2025-26 and submit an associated Board Assurance Statement to NHS England by 30 September 2025. The timetable for preparing these documents has been brought forward compared with previous years to allow as much time as possible to develop and implement plans and mitigate risks.

2. The RBFT winter plan (attached at appendix 1) has been developed over the summer, building on learning, feedback and data from prior years. The objectives are to:

    1. maximise capacity in non-elective and elective pathways
    2. provide alternatives to the Emergency Department
    3. only admit those who benefit from admission
    4. maximise flow and facilitate timely discharge
    5. enable staff to deliver patient-centred care
    6. protect our staff and the resilience of our teams

3. Importantly – as in prior years – our focus has been on enhancing existing work to improve non-elective care for patients, rather than short-term, reactive responses. Data from previous years indicates the likely increase in non-elective bed capacity that will be required over this period to accommodate all patients requiring admission; our winter plan therefore specifically aims to address this issue, through 4 key themes:

    1. alternatives to ED and optimisation of ED processes
    2. reducing admissions
    3. improving flow
    4. effective planning and management processes

4. The plan has been presented to and discussed at OMT, EMC and Quality Committee in the last month and feedback and comments reflected. In addition, it has been tested as part of a South East regional exercise earlier this month, ensuring we have been able to discuss with system partners our collective response to various scenarios. Learning derived from this workshop included the need to agree how to act together when adopting infection prevention and control measures (such as deciding to wear masks when in contact with patients), how to maximise use of available bed capacity across our system, and how to collaborate to increase levels of seasonal vaccination. These issues and others will be the focus of a specific Berkshire West table-top exercise on 13 October 2025.

5. While these meetings have acknowledged good progress in developing the plan, given approval for the focus of the plan as a whole, and noted the significant risk mitigation, data suggests at this point that there remains a high likelihood of +/-25 patients awaiting admission from the Emergency Department on any given day, creating a higher than usual risk of harm. We have therefore committed not only to implementing the plan as it stands but also to an intensification of work to increase the pace of flow across the RBH site and further mitigate this risk. This work will take the form of a series of large-scale engagement events over the autumn with clinical and operational leaders across the organisation with the aim of increasing understanding, ownership and level of response to this risk across the organisation.

6. For this reason, while the attached Board Assurance statement offers full assurance in most areas, at this stage it only offers partial assurance against the requirement to provide assurance that “appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures”. It also means that work to finalise the EQIA is not yet complete.

7 Recommendations

The Board is therefore invited to:

1. Approve the winter plan

2. Approve the Board assurance statement

3. Agree that Quality Committee will receive a further update on winter plan implementation and risk mitigation at its December 2025 meeting.

8 Attachments

The following are attached to this report:

- Appendix 1: Winter Plan 2025/26

- Appendix 2: Board Assurance Statement

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NHS Foundation Trust

Winter Preparedness- 25/26

- ✓ Maximise capacity in non elective and elective pathways
- ✓ Provide alternatives to the Emergency Department
- ✓ Only admit those who benefit from admission
- ✓ Maximise flow and facilitate timely discharge
- ✓ Enable staff to deliver patient-centred care
- ✓ Protect our staff and the resilience of our teams

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Problem Statement

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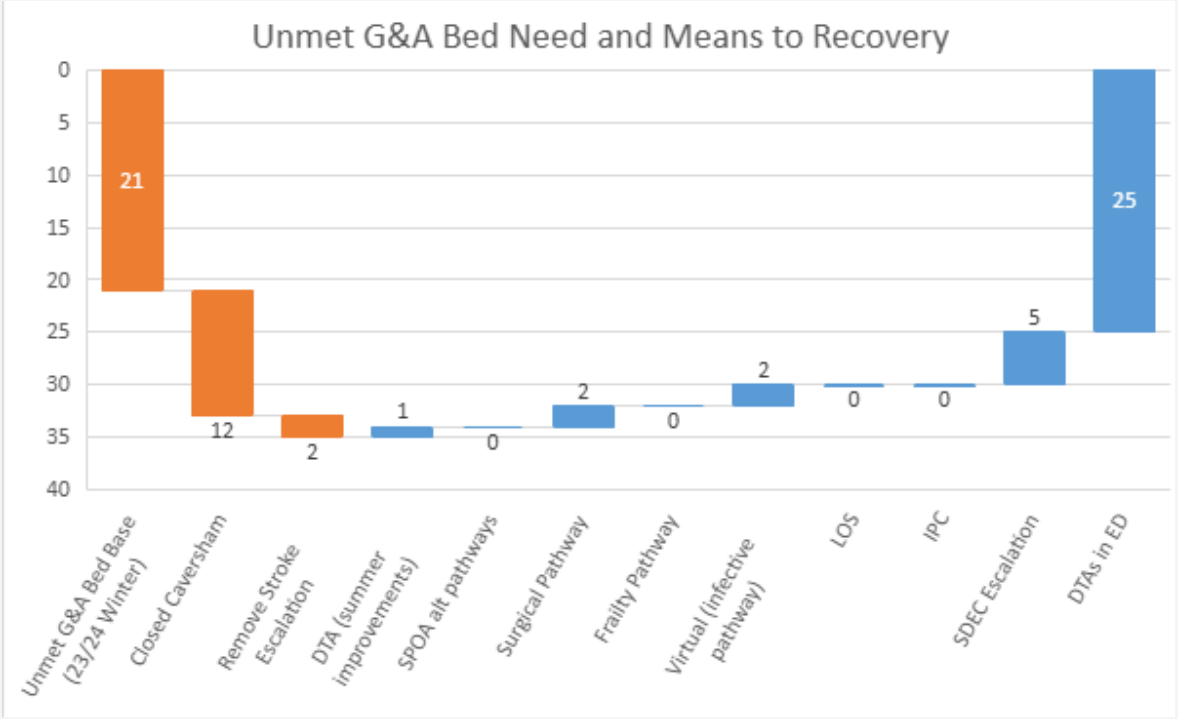
- **There is insufficient non elective bed capacity to accommodate all patients in an appropriate bed, which results in patients experiencing poor care (long waits in ambulances, ED, and being cared for in 'non – ward' escalation areas) worse clinical outcomes and increased pressure on staff**

- In winter 23/24 we identified a gap (@ 06:00) of 23 beds (average) between NEL demand and capacity. Through various improvement workstreams we made a modest improvement which resulted in average of 21 patients being cared for in an inappropriate area during winter 24/25.

- Since then, the NRU at WBCH was relocated to Caversham ward and 2 SAU escalation beds have been taken out of bed base, resulting in additional bed base pressures and a new potential total gap of 35 beds.



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Learnings from Last Winter

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- Leading into winter 24/25 we worked to close this gap through 6 workstreams;
    - Opening on onsite UCC and redirecting 80 low acuity patients per day away from ED ✓
    - Developing and expanding the SPOA and SDEC services by 50% ✓
    - Increasing admissions to the Virtual ward by 13% ✓
    - Reducing ward LOS by 0.5 day ✓
    - IPC improved risk-based decision making to keep beds open, but didn't match testing and other actions to peak of flu prevalence
    - Working with community hospitals to improve bed utilisation was able to make only limited progress
- These workstreams made a modest improvement and resulted in average of 21 patients being cared for in an inappropriate area during winter 24/25.
- This reduction was achieved despite an overall increase in non elective presentations to the trust of 8%.
- When comparing to our peers, the Trust has lower admission rates
- Our review of winter 24/25 clearly identified areas of success to build on and areas that we had made limited progress. Work has been continuing to build on these

Opportunity & Next Steps

Royal Berkshire NHS Foundation Trust

- Our winter preparedness this year is focused on maximising our capacity throughout the Emergency pathways and to offer alternatives to ED and admission.
- Flow remains a strong focus within the organisation, whilst working with partners to facilitate timely discharge
- The national UEC plan clearly outlines areas for ongoing focus

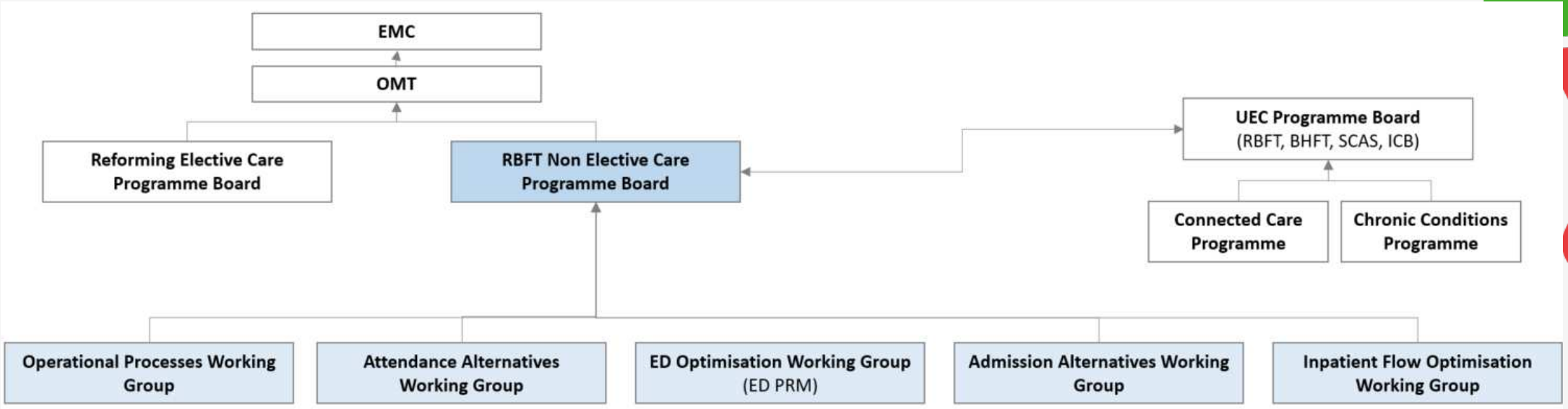
- Established Non elective programme to drive continual improvements, utilising the improving together methodology
- We now have access to population health data through connected care and can compare our population, pathways and bed utilisation with our peers (Bucks and Frimley)
- A recent NHSE visit reviewing our non elective pathways has outlined several opportunities across all care groups / areas to focus on as well as some areas of exemplar models of care

What is the Trusts approach?

Royal Berkshire NHS Foundation Trust

Accountable Executive: Dom Hardy

- Building upon the launch of the Non Elective Programme the winter plan aims to utilise the existing governance arrangements and workstreams.
- Ensure cross section of Care Groups and corporate services are engaged in the development of the plan, including IPC colleagues



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Monitoring

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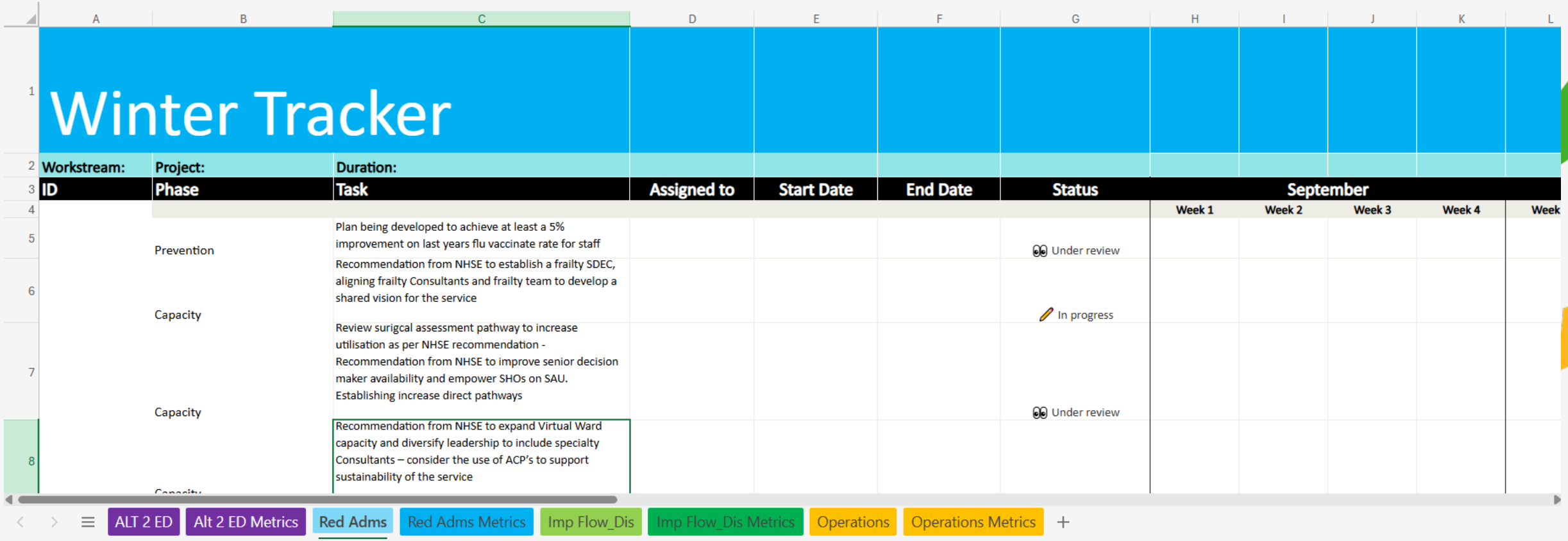
- Monitoring tracker created to ensure a single repository for progress updates
- Each theme is split to allow easy tracking and metric monitoring
- Key action: to agree driver/watch metrics for each theme



Winter Tracker

Workstream:	Project:	Duration:										
ID	Phase	Task	Assigned to	Start Date	End Date	Status	September					
							Week 1	Week 2	Week 3	Week 4	Week	
	Prevention	Plan being developed to achieve at least a 5% improvement on last years flu vaccinate rate for staff				Under review						
	Capacity	Recommendation from NHSE to establish a frailty SDEC, aligning frailty Consultants and frailty team to develop a shared vision for the service				In progress						
	Capacity	Review surigcal assessment pathway to increase utilisation as per NHSE recommendation - Recommendation from NHSE to improve senior decision maker availability and empower SHOs on SAU. Establishing increase direct pathways				Under review						
		Recommendation from NHSE to expand Virtual Ward capacity and diversify leadership to include specialty Consultants – consider the use of ACP's to support sustainability of the service										

ALT 2 ED | Alt 2 ED Metrics | Red Adms | Red Adms Metrics | Imp Flow_Dis | Imp Flow_Dis Metrics | Operations | Operations Metrics

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Our winter preparedness has four key themes

1. **1a. Alternatives to ED & 1b. ED optimisation –** We will ensure the public is well-informed about safe and appropriate alternatives to the Emergency Department for accessing urgent care services. Referrers will also be supported with alternative pathways to ED

2. **Reducing admission levels –** We aim to reduce hospital admissions through increased and better-coordinated admission avoidance services across acute care and into the community

3. **Improving flow through the system** – We will enhance patient outcomes and flow through the Trust with effective discharge planning and improved collaboration with system partners, including managing IPC surges.

4. **Effective planning for and management of surges** – We will build on past successes and ensure that appropriate escalation triggers are regularly reviewed and understood by teams to allow swift enactment.

1a Alternatives to ED & 1b. ED Optimisation

Why focus on this?

- There is significant complexity and challenge in navigating NHS services, which often leads to a large number of patients attending our Emergency Department rather than accessing the most appropriate service for their needs.
- We also recognise that day-to-day system pressures can contribute to overcrowding of the department, heightening the risk of patient harm

What we have already done?

- ED Medic rota's reviewed with clear shift pattern agreed across staffing groups to better meet demand pressures through the week
- Utilising the Improving Together methodology focusing on Ambulance Handovers initially has seen an improvement in times, focus now is to reduce the variability.
- Increased focus on the performance of the 'zones' within ED (Adults, Paediatric and Minor Unit) to identify barriers to performance which are specific to each zone.
- Regional visit held in June to walk UEC Pathway and identify areas of improvement

What we will do?

- **Recommendation from NHSE** to develop an Ambulatory Clinical Decision Unit to ensure continued flow or cubicles in main ED
- **RPIW:** Paediatric pathways focus – SDEC model
- **Improving together;** Support the 'mini ops centre' within ED to support action driven huddles and surge management actions
- **Improving together;** Expand ED improving together huddles (current focus Ambulance Handovers). Confirm next areas of focus and increase viability of ED improving together plan
- Improve pull to SDEC at weekends utilising RBFT Single Point of Access (SPoA) Team
- **Recommendation from NHSE** to review the Surgical Assessment Pathway
- **Recommendation from NHSE** to review the O&G PV Bleed pathway
- **Improving Together:** Deliver the performance trajectories for ED Adults, Paediatrics and Minors Unit
- Visibility of existing and development of 'hot' clinics as an alternative to ED/Admission
- Maximise UCC/EDMU (UTC) Pathway to 40%
- **NHSE Recommendation;** ED Consultant rota review to maximize cover including further recruitment

Reducing admission levels – through increased and better co-ordinated admission avoidance services across acute and community.

Royal Berkshire NHS Foundation Trust

Why focus on this?

- Regional data shows we have high levels of admissions for our population size in a few key demographics – patients over 90, patients with higher needs (PNG groups 10, 11) and patients under 10 years old.
- We have successfully reduced admissions during the day but there is more to do in the evening and overnight
- Our acute and community services could be better joined up

What we have already done?

- Introduced a Single Point of Access for GPs and SCAS for all admission avoidance services with senior clinical triage – 7 days per week 7am-7pm
- Pathways have been developed as alternatives to admission through SPOA (10), further pathways identified (4)
- Virtual wards have increased pathways to provide more alternatives to admission and have focused on more complex patient groups that would otherwise have required inpatient care

What we will do?

- ***RPIW:*** *Paediatric SDEC / ED (combined RPIW (Sep 25)) focused on reducing LOS in ED and providing alternatives to admission*
- **Recommendation from NHSE** to establish a frailty SDEC, aligning frailty Consultants and frailty team to develop a shared vision for the service.
- **Recommendation from NHSE** improvements to emergency surgical pathway through increased senior decision maker availability and empowering SHOs. Establishing increase direct pathways and improved patient flow.
- Review of "Bouncer" patient pathways (assessment unit patients subsequently admitted) with view to reduce proportion admitted
- **Recommendation from NHSE** to continue to support Virtual Ward team, enhance capacity and diversify leadership to include specialty Consultants – consider the use of ACP's to support sustainability of the service. Opportunity within Infective pathways
- Continue developing pathways for alternatives to admission – ENT (currently writing triage), Gynae (confirming live date), Chest pain, metastatic cord compression / Acute Oncology.
- Consider Cardiology/Respiratory winter operating model as per 24/25 (SDEC, HOT clinic, SDM at front door)
- Utilise existing Reforming Elective Care Programme to ensure maintenance of elective activity in order to meet IAP and RTT.

Improving flow– through more effective discharge planning and working with system partners

Royal Berkshire NHS Foundation Trust

Why focus on this?

- At any one time there are c.40-60 patients across our acute beds who are medically fit to leave the hospital
- Our discharges often happen later in the day which can drive up overcrowding in our Emergency Department / delays in moving patients off AMU

What we have already done?

- Focus on TDD's
- Utilising bed meeting to identify tomorrow discharges to move to discharge lounge earlier in the day
- Discharge lounge use and focus of DoD increasing awareness and utilisation
- E-Handovers moved onto Alertive

What we will do?

- Further increase of Discharge Lounge utilisation
- Improve TDD's accuracy
- Improved production of TTO's pharmacy
- **Board Assurance:** Rotas across the Trust to be reviewed to maximize decision making capacity – including AHP's
- Review of 'Right Care, Right Bed' and senior decision maker
- **Board Assurance:** IPC part of the winter plan development to ensure plans are co-developed, including a cohorting escalation plan
- Plan for IPC testing service over winter triggered by community prevalence
- **Board Assurance:** FIT testing completed for all relevant staffing groups and recorded on EPR
- **Board Assurance**: Plan being developed to achieve at least a 5% improvement on last years flu vaccinate rate for staff
- Add in plans for Community beds and staffing models and align with BHFT winter planning
- Add in plans for Social Services and align with Local Authority winter planning
- Review options for increased Therapy support or extended hours to support flow (particularly in AMU)
- Ensure smaller but pivotal teams have resilience going into winter (potentially increase SPOA support)

Effective planning for and management of surges – building on what has been effective in the past

Royal Berkshire NHS Foundation Trust

Why focus on this?

- There will be times when the pressures on the Trust are at their highest, and it is during these moments that we must strengthen our response to ensure patient safety is never compromised.
- We've learned valuable lessons from past experiences—insights that have made a real difference—and we will continue to apply these learnings as we move forward.

What we have already done?

- Agreed escalation process with system partners
- On call arrangements are in place, site team starting to utilize SHREWD platform to be aware of the wider UEC Pathways
- On call forum established to share good practice
- Renewed focus on TDD, and early use of DL, supported by Director of the Day focus at Operational Bed Meetings
- Local OPEL action cards embedded which are specific and relevant to individual clinical areas

What we will do?

- Re-review all OPEL action cards; ensure these are visible and easily accessible. Agree prospective Opel 4 plan with Care Groups and clinical teams, agree escalation process with system partners.
- Weekend planning for on-call teams to enact as required
- Develop a Trust wide escalation plan that demonstrates shared risk and pressure across the whole pathway. This is in recognition that last winter the majority of risk was held at the front door.
- Build on existing wellbeing support to provide specific sessions to support colleagues during times of significant pressure
- Wider review of rotas across the Trust to ensure maximum decision making capacity at peak times
- Equip teams with the right information - increase data sharing, visibility and ownership (IPS, Connected Care and Alertive). Utilize Improving Together methodology and existing PRM structures to increase priority of NEL pathway work
- **NHSE recommendation;** Review input into the operational flow meetings to include Clinicians
- Review of the Director of the Day (DoD) role, aiming to maximize impact, standardize and ensure continuity between DoD changeovers

ceful

Excellent

Winter Planning 25/26

Board Assurance Statement (BAS)

NHS Trust

Provider:	Royal Berkshire Hospital NHS Foundation Trust

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the Trust Winter Plan for 2025/26.	Yes	Winter Plan presented at Board 26th September (following prior presentation at OMT, Quality Committee and EMC)
A robust quality and equality impact assessment (EQIA) informed development of the Trust's plan and has been reviewed by the Board.	In progress	Ongoing
The Trust's plan was developed with appropriate input from and engagement with all system partners.	Yes	Presented at Berkshire West UEC programme board 18th September – further exercise planned for 13th October
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	Winter Plan to be tested in regional event 8th September
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Yes	Dom Hardy, COO
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.	Yes	All actions have been incorporated into the Winter Plan and associated tracker
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	Partial	Ongoing
The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against	Yes	Metrics are routinely reviewed against operating plan

Provider:	Royal Berkshire Hospital NHS Foundation Trust

the trajectories already signed off and returned to NHS England in April 2025.		trajectories and sufficient governing structures in place to ensure timely mitigation if required

Provider CEO name	Date	Provider Chair name	Date
Steve McManus	24/09/25	Oke Eleazu	24/09/25

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.	Yes	Increased peer vaccinators identified to support uptake, communications plan being worked up
Capacity		
2. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.	Partially	Work is ongoing to fully mitigate capacity risks
3. Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	In progress	Ongoing – many areas already completed
4. Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.	Yes	Ongoing – and will be a focus of discussion with partners on 13th October
5. Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes	Sufficient resource remains in place to maintain cancer and elective performance. Continually monitored through PRM and Reforming Elective Care Programme
Infection Prevention and Control (IPC)		
6. IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	Yes	Incorporated into Winter Plan, ongoing works to incorporate into capacity and surge policy (2nd September review).

7.	Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand. Dawn	In progress	Ongoing
8.	A patient cohorting plan including risk-based escalation is in place and understood by site management teams, ready to be activated as needed.	Yes	Ongoing as part of Safety and Capacity Policy review
Leadership			
9.	On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Yes	
10.	Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Yes	
Specific actions for Mental Health Trusts			
11.	A plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	NA	
12.	Any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	NA	

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Board Work Plan 2025

Focus	Item	Lead	Freq	Jan-25	Mar-25	May-25	Jul-25	Sep-25	Nov-25
Provide the Highest Quality Care to all	Winter Plan	DH	Annually					■	
	Health Equalities	KP-T	Jul-25				■		
Invest in our People and live out our Values	Patient Story	Exec	Every	■	■	■	■	■	■
	Staff Story	Exec	Every	■	■	■	■	■	■
Achieve Long-Term Sustainability	Quarterly Forecast	HT	Quarterly	■			■		
	2026/27 Budget	HT	Annually		■				
	2026/27 Capital Plan	HT	Annually		■				
	Operating Plan/ Business Plan 2026/27	AS	Annually	■					■
	The Green Plan	HT	Annually						■
Cultivate Innovation & Improvement	Standing Financial Instructions	HT	Annually	■					
	Trust Strategy Refresh	AS	November	■					■
Other / Governance	Chief Executive Report	SM	Every	■	■	■	■	■	■
	Board Assurance Framework	CL	Bi-Annually			■			■
	Corporate Risk Register	KP-T	Bi-Annually		■				■
	Integrated Performance Report (IPR)	Exec	Every	■	■	■	■	■	■
	NHSE Annual Self-Certification	HT/CL	Annually			■			
	Standing Orders Review	CL	Annually						■
	Board Work Plan	CL	Every	■	■	■	■	■	■