Public Board - 29 May 2024

MEETING
29 May 2024 09:00 BST

PUBLISHED
24 May 2024

Agenda

Location	Date	Time
Seminar Room, Trust Education Centre, Royal Berkshire Hospital	29 May 2024	09:00 BST

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2	Health and Safety Moment (Verbal)	Don Fairley	09:00	-
3	Patient Story (Verbal)	Katie Prichard-Thomas	09:20	-
4	Staff Story (Verbal)	Andrew Statham	09:40	-
5	Minutes for Approval: 27 March 2024 and Matters Arising Schedule	Graham Sims	10:00	3
6	Minutes of Board Committee Meetings and Committee Updates:	Graham Sims		-
6.1	Charity Committee: 17 January 2024 & 1 May 2024	Bal Bahia	10:05	10
6.2	Finance & Investment Committee: 20 March 2024 & 17 April 2024	Mike O'Donovan	10:10	16
6.3	Quality Committee: 10 April 2024	Helen Mackenzie	10:15	22
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9	Operational Plan Trajectories 2024-25	Dom Hardy	11:20	65
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13	Date of Next Meeting: Wednesday 31 July 2024 at 9:00am			-

Minutes

Board of Directors

Wednesday 27 March 2024
09.00 – 12.00
Seminar Room, Trust Education Centre, Royal Berkshire Hospital

Present

Mr. Graham Sims	(Chair)
Mr. Steve McManus	(Chief Executive)
Dr. Bal Bahia	(Non-Executive Director)
Mr. Don Fairley	(Chief People Officer)
Mr. Dom Hardy	(Chief Operating Officer)
Mrs. Priya Hunt	(Non-Executive Director)
Dr. Janet Lippett	(Chief Medical Officer)
Mrs. Nicky Lloyd	(Chief Finance Officer)
Mrs. Helen Mackenzie	(Non-Executive Director)
Mr. Mike McEnaney	(Non-Executive Director)
Mr. Mike O'Donovan	(Non-Executive Director)
Mrs. Katie Prichard-Thomas	(Chief Nursing Officer)
Prof. Parveen Yaqoob	(Non-Executive Director)

In attendance

Dr. Bannin De Witt Jansen	(Head of Corporate Governance)
Mrs. Caroline Lynch	(Trust Secretary)
Mr. Andrew Statham	(Director of Strategy)

Apologies

There were seven Governors and nine members of staff present.

37/24 Health & Safety Moment

The Chief People Officer introduced the team from the Prince Charles Eye Unit (PECU). Gemma Dix provided an overview of a Health &Safety incident involving the replacement of the air handling unit at the PECU in which replacement works had started without prior notice to staff in the unit. The dust and debris caused by the works compromised the sterile environments required for the intravitreal injection and Age-related Macular Degeneration (AMD) services and resulted in their closure. Gemma highlighted the coordinated efforts of Estates & Facilities, Clinical Engineering and Digital, Data and Technology (DDaT) that facilitated the move of the service to alternative sites over the course of a weekend. Travel and transport solutions were implemented to support staff access to sites. A full incident review was completed and key external stakeholders were engaged in the process. The works had been incorrectly categorised as a 'non-theatres' project and subcontractors were not aware that the unit included sterile environments. The Trust has since established strong relationships with these stakeholders and amended processes to ensure future works within the Trust would be clearly communicated to clinical teams ahead of time. Although services were impacted for three months, activity levels for patient services were largely maintained with only a small backlog accrued in the AMD service.

The Board thanked the team for their presentation.

38/24 Patient Story

The Chief Medical Officer introduced the Associate Chief Nurse, Sharon Herring. A short video was played of a 16-year old patient's experience of recovering from a hip replacement surgery on an adult ward. The patient, Kaitlyn, explained that she had autism and found the quieter environment of an adult ward beneficial but had experienced challenges with other aspects of her care. These included not having her mother with her to assist her with her morning routine and anxiety in relation to not understanding her medication regimen. On occasion, delays in receiving her medication had resulted in pain. The video was part of a series of short films developed for training and development purposes as part of a wider programme of work across the Trust in relation to reasonable adjustments. The Trust had commissioned the Carer's Network to assist with this work and they were actively working with teams across the Trust, including the ward that provided care for Kaitlyn, to identify initiatives and best practice approaches to ensuring reasonable adjustments for neurodivergent patients and people with disabilities.

The Board queried why a young patient had been placed in an adult ward. The Chief Medical Officer advised that since hip replacement surgery was extremely rare in the paediatric population, Kaitlyn had been placed with a clinical team who routinely managed recovery from this specific type of surgery. However, in this instance, additional reasonable adjustments had been required.

The Board thanked the Associate Chief Nurse for her presentation.

39/24 Staff Story

The Chief Medical Officer introduced Kiruba, a Trust Consultant and Arjan, a representative from Smoke-Free Life Berkshire. Kiruba provided an overview of the Trust's Smoking Cessation initiative and pledge to become a smoke-free site. Kiruba highlighted that as an organisation committed to supporting health-seeking behaviour in staff, the Trust had engaged Smoke-Free Life, a Berkshire-based service, to provide structured support to staff who wished to stop smoking. Arjan highlighted that Smoke-Free Life aimed to support people to become smoke-free by the end of week four of a twelve-week programme. Smoke-Free Life provided advisers as well as other support including an app, patches and lozenges. A member of Trust staff provided an overview of their experience of giving up smoking with Smoke-Free Life.
The Board supported the pledge to become a smoke-free site and asked whether Smoke-Free Life would attend the Trust's other sites. Arjan confirmed that Smoke-Free Life would provide on-site support across sites.

The Board thanked Kiruba and Arjan for their presentation.

40/24 Minutes for approval: 24 January 2024 and Matters Arising Schedule

The minutes of the meeting held on 24 January 2024 were agreed as a correct record and signed by the Chair.

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

41/24 Minutes of Board Committee Meetings and Committee updates

<u>Audit & Risk Committee: 10 January 2024 and 6 March 2024</u>

Three internal audit reports had been completed. The audit outcome for violence & aggression had resulted in partial assurance; however, work was progressing to address this. The Committee received assurance from the external auditor on progress made in the year-end audit. The Committee identified health and safety and information governance as areas for future focus. The Committee received its annual effectiveness review.

<u>Finance & Investment Committee: 17 January 2024 and 21 February 2024</u>

The Committee had reviewed the Trust's budget forecast. The Trust's deficit position at year-end was £8.0m. The Committee had agreed an initial flash submission to NHS England (NHSE) for the Trust's 2024/25 budget and capital plan in February 2024 and this would be reviewed again ahead of final submission in May. The Committee also approved the NHS Resolution Insurance Contribution and received its annual review of effectiveness report. The Committee had reviewed its Terms of Reference.

Charity Committee: 14 March 2024

The Committee had reviewed and approved the Charity's budget and income for 2024/25. A reduction in income was noted but good progress had been made in relation to the major donors strategy. Work was ongoing to identify opportunities to fundraise for 'big ticket' items including estates and facilities projects and medical equipment. The Committee had approved an application for the purchase of ventilators for the Buscot Ward. The Committee had reviewed its Terms of Reference.

Quality Committee: 5 February 2024

The Quality Committee had heard a very powerful, first-hand account from a patient of her experience of losing her first baby. A comprehensive response was provided by the Head of Midwifery describing the ongoing programme of work aimed at preventing future occurrences. The Committee noted that the Trust was participating in a trial on Strep B testing in pregnant women. The Committee had received the final outcome report from the CQC in relation to the maternity inspection. The Committee had reviewed its Terms of Reference.

People Committee: 15 February 2024

The Chair of the People Committee advised that staff appraisals and Mandatory and Statutory Training (MAST) had been added as a driver metric for all care groups. The Committee had reviewed the Gender Pay Gap report and recognised that further work was required in relation to clinical staff. The Committee noted an update on the launch of the Womens+ Network. The Committee received their annual review of effectiveness report which demonstrated that a good balance of strategic and operational items had been reviewed over the year. The Committee had reviewed and approved its Terms of Reference.

42/24 Chief Executive's Report

The Chief Executive advised that Phase Two of the national Independent Inquiry into the David Fuller case was underway. The Trust had completed its review of all aspects of mortuary care and a formal response was submitted to the Inquiry on 8 March 2024.

The Chief Executive highlighted the positive outcomes of the 2023 Staff Survey and the launch of the Trust's What Matters 2024 programme. The Board noted that What Matters 24 intended to provide opportunities for staff to feedback on the Trust's organisational values and identify additional ways to support staff.

The Chief Executive advised that the Trust continued to work closely with its key partners. The Chief Medical Officer of the Buckinghamshire, Oxfordshire & Berkshire Integrated Care Board (BOB ICB) had attended the Trust's Council of Governors to engage Governors on the recently launched BOB ICB Primary Care Strategy. The Chair of the Trust, Non-Executive Directors, the Trust Secretary and the Lead Governor had attended a BOB ICB workshop on Governing in a System that explored ways in which well-led trusts could ensure robust and responsive governance systems which integrated system-wide working.

The Improving Together programme continued to progress with wave seven scheduled to start in April 2024. This work was aligned with the Value Stream Analysis being carried out across

the Trust which focused on improvements to patient flow, patient care, Emergency Department (ED) performance and the efficient use of resources.

The Chief Executive advised that development of the Health Data Institute (HDI) was ongoing with a soft internal launch planned for April 2024. The Trust had entered a partnership with the Thames Valley and Surrey Secure Data Environment (TVS SDE) and secured £200,000 in funding to support part of this work.

The Trust's financial performance remained slightly behind the year-to-date forecast revenue position, with a year to date deficit of £8.6m. However, various mitigations were in place to support the Trust to achieve the adjusted forecast position of £7.55m. The Chief Executive advised that the recovery of the waiting lists in the Trust's cancer and elective activity pathways and repeated rounds of industrial action had contributed to this position. The Trust continued to work closely with system partners. The Chief Executive advised the financial challenges had enhanced system working as leadership teams across BOB ICB Trusts were aligned in their values and on the importance of system working, the strength of the partnerships and the efficient use of resources. The Trust was facing similar financial and operational challenges to other Trusts within the BOB ICB. The ICB were evaluating how it delegated responsibilities to PLACE, Berkshire West and Berkshire Healthcare Foundation Trust and considering what was required to enable system partners to work collaboratively and cost effectively with each other The ICB workshop on Governing in a System had been an important preliminary stage in that process.

The Chief Executive highlighted that Building Berkshire Together (BBT) report on site viability had identified significant challenges in relation to the major redevelopment of the existing site. Revised options were being costed and compared to the option of building a new hospital on a new site.

The Board thanked all staff who had attended a tragic fatal incident in the Trust's car park in the previous week. All staff involved had been offered support through the Trauma Risk Management (TRiM) service.

43/24 Staff Survey

The Chief People Officer provided an overview of the results of the Staff Survey. The Trust was the top performing acute trust in the South East of England with improved performance across all 21 people themes. The Chief People Officer highlighted that the Trust was ranked highest on the theme of staff feeling empowered to make changes in their area. The What Matters 24 programme would build on the results of the survey through staff engagement via a combination of short discussions and detailed reviews.

Areas requiring improvement included flexible working provisions, Equality, Diversity and Inclusion indicators, incidents of violence and aggression and staff burnout. The Trust was looking at provisions for flexible working in line with operational requirements. The Chief People highlighted that the Trust was part of a regional EDI network in which trusts shared their learning and best practice approaches and actions to mitigate against violence and aggression were being implemented. Oversight of progress would be provided by the People Committee.

The Board queried the root causes of incidents of bullying and harassment and violence and aggression. The Chief People Officer advised that the root causes were multifactorial and included societal pressures such as the cost of living crisis. Trust staff were actively encouraged to use the various staff forums and the Freedom to Speak Up Guardian to report these incidents and further feedback would be sought through the What Matters 24 programme.

The Board queried progress in relation to meeting the target for appraisals. The Chief People Officer advised that the Trust had moved from a rolling programme to a 'window' system whereby an appraisal required completion by a set date. A new online system had been launched and it was anticipated that these initiatives would help support compliance.

44/24 Integrated Performance Report (IPR)

The Chief People Officer introduced the IPR and advised that the Trust's retention and vacancy metrics remained on an upwards trend. The Chief People Officer highlighted some improvements made in the DM01 and cancer waiting time metrics as a result of additional resource allocation and capital investment. Further improvement in ED waiting times was required. The Trust was on target to meet the forecast deficit position of £7.0m and was focused on operational planning to inform the final submission to NHS England (NHSE) on the 2 May 2024.

The Board requested further detail on the ED waiting times. The Chief Operating Officer advised that the ED had experienced significantly increased rates of attendance over a period of time which had increased wait times. There had been significant collaborative effort across Trust departments to reduce this. The Trust was working with system partners to identify ways to improve performance.

The Board queried whether the 62-day wait times included patients who had received a cancer diagnosis and those who were waiting for treatment. The Chief Operating Officer advised that this only applied to people who were placed on a cancer pathway but who had not yet received a diagnosis. The Chief Operating Officer highlighted that patients who had received a diagnosis and were waiting for treatment were placed on a 31-day waiting list. The Trust routinely achieved the 31-day target for over 91% of patients. The Board agreed that good assurance had been received in relation to the 31-day wait and recognised that the delays occurred in the diagnostic pathways.

The Board discussed whether a new approach was required to enable the Trust to meet the DM01 standard. The Chief Operating Officer advised that there were too few data points available to ensure robust decision-making and the metrics would continue to be monitored over the new few months. It was anticipated that improvement would be seen as a result of the additional activity and continued insourcing engaged by the Trust.

45/24 Integrated Performance Report (IPR) Refresh

The Board received the report. It was agreed that further review of the cancer metrics would be discussed at the Quality Committee. **Action: D Hardy**

46/24 Standing Financial Instructions (SFIs)

The Chief Finance Officer provided an overview of the report. The Board approved the Standing Financial Instructions.

47/24 Board Assurance Framework (BAF)

The Trust Secretary introduced the Board Assurance Framework and advised that it was progressing through its review cycle and would be subject to further update.

48/24 Corporate Risk Register

The Board received the Corporate Risk Register. The Chief Executive Officer advised that the risks associated with the North Block East Wing (NBEW) were being reviewed by the Chief Executive's team on a weekly basis.

49/24 Work Plan

The Board received the work plan.

50/24 Date of the Next Meeting

It was agreed that the next meeting would be held on Wednesday 29 May 2024 at 09.00am

SIGNED:

DATE:

Public Board of Directors Matters Arising Schedule **Agenda Item 5**

Date	Minute Ref	Subject	Matter Arising	Owner	Update
27 March 2024	45/24	Integrated Performance Report (IPR)	The Board received the report. It was agreed that further review of the cancer metrics would be discussed at the Quality Committee.	D Hardy	Completed. Item was discussed at the Quality Committee on 10 April 2024.

Minutes

Charity Committee

Wednesday 17 January 2024
Meeting by Email

Present

Dr. Bal Bahia	(Non-Executive Director) (Chair)
Mr. Jonathan Barker	(Public Governor, Reading)
Mr. Mike Clements	(Director of Finance)
Mr. Don Fairley	(Chief People Officer)
Dr. Sunila Lobo	(Public Governor, Reading)
Mrs. Caroline Lynch	(Trust Secretary)
Ms. Adenike Omogbehin	(Staff Representative)
Mr. John Stannard	(Patient Representative)
Ms. Jo Warrior	(Charity Director)

01/24 Grant Application

The Committee received a request to approve a grant application for the purchase of 36 renal dialysis chairs. The grant had already been previously approved by the Charity Grants Panel in November 2023 and the Capital Investment Group in December 2023. The supplier required a purchase order to be raised by 31 January in order for the quote to be held.

The Committee approved the request.

SIGNED:

DATE:

Charity Committee Notes

Wednesday 1 May 2024
10.00 – 12.00
Video Conference Call

Present

Dr. Bal Bahia	(Non-Executive Director) (Chair)
Mr. Jonathan Barker	(Public Governor, Reading)
Mr. Mike Clements	(Director of Finance)
Dr. Sunila Lobo	(Public Governor, Reading)
Mrs. Caroline Lynch	(Trust Secretary)
Ms. Jo Warrior	(Charity Director)

In attendance

Miss. Kerrie Brent	(Corporate Governance Officer)
Ms. Kate Martin	(Philanthropy Manager) (for minute 16/24)
Mr. Graham Sims	(Chair of the Trust)
Ms. Monica Srivastava	(Charity Grants Manager) (for minute 16/24)

Apologies

Mr. Don Fairley	(Chief People Officer)
Ms. Adenike Omogbehin	(Staff Representative)
Mr. John Stannard	(Patient Representative)

[The Committee was not quorate.]

It was agreed that a review of the terms of reference was required in relation to the quorum of the Committee. **Action: C Lynch**

13/24 Declarations of Interest

There were no declarations of interest.

14/24 Minutes for Approval: 14 March 2024 and Matters Arising Schedule

The minutes of the meeting held on the 14 March 2024 were noted.

The Committee noted the matters arising schedule.

Minute 08/24: Terms of Reference: The Director of Finance noted that the review of approval limits in line with the Standing Financial Instructions (SFI) was on-going. A recommendation would be submitted to the next meeting. **Action: M Clements**

Minute 03/24: Charity Director's Report: The Committee agreed that the final letter to retailers would be circulated to the Committee for information. **Action: J Warrior**

15/24 Charity Director's Report

The Charity Director provided an overview of the report. The Committee noted that, despite efforts, income had not achieved financial plan for 2023/24. It was anticipated that factors including economic conditions had contributed to this. The team continued to review alternative streams of income.

The Committee discussed the need to review the legacy income target as well as the associated accounting protocols in accruing expected legacy in advance of receiving funding. It was agreed that the Director of Finance would review the target and provide clarification on the accounting protocol. **Action: M Clements**

The Committee noted a positive increase in the number of major donors due to active engagement and events. Work was on-going to develop relationships further and continue growth moving forward including the identification and scope of projects.

Partnership and engagement with Thames Valley Chamber of Commerce (TVCC) continued including a number of key networking events and business alliance dinners enabling the Charity to showcase work and connect with potential beneficial partners.

The Charity Director advised that the events for 2025 would be reviewed in order to maximise opportunities for return on investment. This included further presence at pre-established community events. It was agreed that there would need to be a balance to ensure the Charity continued to raise its community profile by holding its own events.

The Committee noted the chart that detailed the percentage of expenditure in relation to patients compared to staff in 2023/24. Feedback was provided to include the total cost rather than the percentage as well as clarification on the reporting period. In addition, the inclusion of a comparison of income received versus funds spend was suggested. **Action: J Warrior**

The Committee noted the total value of approved grant applications for 2023/24 was now £1.94m following focused effort to expedite the processing of grant applications. However, a few of the projects expenditure would not be realised until 2024/25.

The Committee received the '2023 at a glance' infographic that had been designed and published across all sites to highlight a summary of 2023 and the projects completed. Feedback was provided in relation to the use of acronyms.

The Charity Director advised that the funding provided by NHS Charities Together for a Charity Grants Assistant for one year was due to expire in July 2024; and following extended sick leave and resignation the post would remain unfilled due to the recruitment process timescales and the Trust-wide recruitment restrictions.

The Chair of the Trust highlighted that, following a number of cancelled events, the need for further support and sustainable commitment from the Board including attendance at fundraising activities, introductions and donor events to promote the Charity. It was agreed that an agenda item would be added to the next Charity Board. **Action: C Lynch**

The Committee discussed the request from the Charity for links to commercial companies in the area. It was agreed that any suggestions should be provided to the Charity Director.

The Trust Secretary provided an update on the plan to invite and host major donors as part of the Trust's Annual General Meeting in September 2024 along with a Royal Berks Charity stand.

16/24 Royal Berks Charity Strategy 2024/28

The Committee received an overview of the draft strategy that set out the priorities for the next four years. The following was suggested for consideration:

- The development of a visionary strapline that was aspirational and highlighted the overall vision statement.
- A revised summary that was reduced in length but highlighted the key aims that the strategy would deliver.
- Further inclusion of strengthening trust wide relationships between departments specifically Corporate Governance in relation to Membership and Council of Governors.
- Additional emphasis on the wider geographical community that the Trust serves.
- The Charity Director would liaise with the Director of Strategy for review.

The Charity Grants Manager would review whether the Charity would qualify for the criteria of The National Lottery and BBC Children in Need.

Proposal for Developing a Community Lottery

The Charity Director provided an overview of the proposal to establish a community lottery to support generating unrestricted income and engage supporters. The Committee noted examples of hospices and charities that had already implemented this and their success. It was anticipated that profits of circa £500k would be achievable within five years, contingent on the initial investment and appetite for growth. However, this was not expected until year three or four.

Members of the public would be asked to sign up for a minimum of £1 a week and a maximum of £5 a week via subscription; that they would be able to cancel at any time. The management of the weekly draws and prizes would be provided by an External Lottery Manager (ELM).

The Committee discussed the recommendation of an upfront cost and collaboration with a canvassing agency and to assess the appetite canvassers would be based across the Trust sites in the main reception to raise awareness as well as sign people up. It was discussed whether this would be inappropriate for the main reception considering the recent improvement works commissioned by the Chief Executive.

The Committee discussed whether this would promote gambling and therefore affect the reputation of the Trust. It was noted that the structure of a community lottery was not considered as encouraging gambling by the Gambling Commission and was considered low-risk and did not offer immediate rewards. Circa 55% of society and community lottery players were motivated primarily by supporting the cause.

The Committee queried whether there was the option for a pilot period. The Charity Director confirmed that although there was not a pilot period although there would be a 3-month break clause.

The Committee considered the proposal and agreed that further clarification was required that provided assurance and evidence from other charities including written testimonials, lessons

learned and potential challenges, as well as a financial modelling review carried out by the Director of Finance. In addition, further socialisation was required including with the Chief Executive team. **Action: J Warrior/M Clements**

17/24 Finance Update

The Director of Finance introduced the report that included the full year-end of the management accounts. The accounts had not yet been audited. The Director of Finance highlighted that the year-end position of donations and investment income of £939k with grants and other associated costs of £1.94m. Total spend for the year was £1.2k.

The Committee noted that deployment of reserves had been more effective, and further work was required in relation to grants compared to operating costs.

The Committee noted that discussions were on-going with fund advisors on spend.

The Committee queried what the Charity was doing to reduce operating costs to reflect its lower income. The Charity Director advised that the team would not recruit to establishment until greater income could be generated and that if income did not improve further reductions in the team would be required. It was considered whether a review of effectiveness was required. It was agreed that an update would be provided at the next meeting that included a review of the return on investments from posts, the trend of income and a trajectory.

Action: J Warrior

The Committee recommended that the Director of Finance should provide a balance of transactions and rental arrangements in relation to Melrose House at the next meeting.

Action: M Clements

The Committee noted that the donation of £650k made by Healthcare Facilities Management Services (HFMS) in 2022/23 was not repeated in 2023/24.

18/24 Knowledge & Development Fund Update

The Charity Director highlighted that 30 applications had been received for the fund in 2023/24; of that 23 applications were approved totalling circa £118k. The Committee recognised the increase and improvement to previous year reporting.

The team continued to promote and raise awareness of the fund to all members of staff and to encourage applications where appropriate to support the wider development needs across the Trust. The Committee reviewed the projects funded and agreed that going forward further assurance was required that the fund was reaching staff at all levels across the Trust. Additional promotion would be considered that included hard to reach areas and junior members of staff.

The Committee noted the reasons for rejecting applications were mainly due to lack of meeting criteria that included insufficient benefits to the Trust or patients.

19/24 Charity Risk Register

The Committee received the risk register. It was agreed that although expenditure had increased over a four year period, resulting in a decrease of funds the current risk rating in relation to high levels of reserves held would not change at this time.

The Committee noted that work was on-going as part of the capital plan 2024/25 to identify a large scale project as part of the medical equipment programme that could be funded by the Charity and therefore would provide sufficient evidence to reduce the risk rating. The Director of Finance would provide an update at the next meeting. **Action: M Clements**

The Committee discussed whether a risk entry on staffing resources should be considered. It was agreed that this was a low risk and would not be added.

The Committee discussed the on-going work to fund and locate the two donated MRI scanners at West Berkshire Community Hospital where a charity contribution would be considered. It was noted that a review would be required with the Charity Director. An updated proposal was due to be submitted to the Board in May 2024.

20/24 Work Plan

The Committee noted the work plan.

21/24 Reflections of the Meeting

The Director of Finance led the discussion.

22/24 Date of the Next Meeting

It was agreed that the next meeting would be held on Wednesday 7 August 2024 at 10.00am.

SIGNED:

DATE:

Minutes

Finance & Investment Committee Part I

Wednesday 20 March 2024
12.25 - 13.25
Boardroom, Level 4, Royal Berkshire Hospital

Members

Mr. Mike O'Donovan	(Non-Executive Director) (Chair)
Ms. Priya Hunt	(Non-Executive Director)
Dr. Janet Lippett	(Chief Medical Officer)
Mrs. Nicky Lloyd	(Chief Finance Officer)
Mr. Mike McEnaney	(Non-Executive Director)

In Attendance

Mrs. Caroline Lynch	(Trust Secretary)
Mr. Steve McManus	(Chief Executive)
Mr. Graham Sims	(Chair of the Trust)
Mr. Andrew Statham	(Director of Strategy)

Apologies

Mr. Dom Hardy	(Chief Operating Officer)

50/24 Declarations of Interest

There were no declarations of interest.

51/24 February 2024 Finance Update

The Chief Finance Officer advised that Month 11 year to date financial position was a deficit of £8.60m, this was £5.75m behind the revised planned year to date deficit of £2.85m and £1.78m adverse to the year-to-date forecast outturn of £6.8m. The Trust had received additional deficit funding of £6.4m during February 2024 towards betterment of the Trust's original plan, and 11/12, £5.87m of this was reflected in the February year to date M11 position, as well as £1.17m of industrial action funding. The combined effect of this additional funding meant that the revised full year forecast outturn had changed from a deficit £15.12m to a deficit £7.55m

It was agreed that a note would be circulated to the Committee to set out the actions being taken by the Executive team to secure the year-end forecast position with indicative ranges.

Action: N Lloyd

The Committee noted that capital spend was significantly behind plan, with £17.36m spent year to date against a full year plan of £37.02m. The Chief Finance Officer advised that several vesting certificates would need to be sought and highlighted the fact that significant sums of external capital funding (PDC) had been allocated to the Trust during Quarter 4, that had added to the challenge of delivering the programme in such a compressed period of time. The Chief Executive confirmed that the Executive team was confident the full capital plan by year-end.

52/24 Business Plan & Budget 2024/25

The Chief Executive provided an overview of the meeting with NHS England (NHSE) in relation to their concerns of the Trust's movement in year in relation to its financial position. The Trust's labour cost growth was being scrutinised as there had been a month-on-month increase of 2.4%. As part of the Integrated Care Board's (ICB's) response to NHSE, it was proposed that there would be a freeze on non-clinical vacancies. The Trust was required to re-submit its plan for 2024/25 on 21 March 2024, with further work anticipated to secure costs, savings and income, leading to the final 2024/25 plan submission on 2 May 2024. The Chief Executive highlighted that an external peer review of pay may be required.

The Chief Executive advised that meetings with budget holders had been held during the week in relation to the forecasted £29.09m deficit position for 2024/25. Additional meetings would also be scheduled on a weekly basis.

The Committee noted that national planning guidance for 2024/25 had not yet been issued and that there was, as yet no confirmed income position for the Trust. There was a need to correlate activity growth in relation to activity. The Committee agreed that a recommendation would be submitted to the Board for the 2024/25 plan submission on 21 March 2024 noting that this was not the final position. **Action: M O'Donovan**

53/24 Capital Plan 2024/25

The Chief Executive highlighted that the capital plan for 2024/25 was dependent upon the Trust's year-end position. A capital plan of £22m was proposed based on a £10m revenue deficit plan. The Committee noted that £5.3m was already pre-committed from 2023/24 and it was proposed that estates, medical equipment and Digital, Data and Technology (DDaT) would be allocated £3m each in the first instance. The Committee discussed the impact on the Trust's cash floor in relation to this proposal. It was agreed that a recommendation would be submitted to the Board to approve the capital plan of £22m, with confirmation that £15m would be released immediately to enable orders continuation of 2023/24 projects and new capital schemes up to the £3m allocation for each of the areas noted above from 1 April 2024. **Action: M O'Donovan**

54/24 Minutes for Approval: 20 March 2024 & Matters Arising Schedule

The minutes of the meeting held on 20 March 2024 were approved as a correct record and signed by the Chair.

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

Minute 20/24: Standing Financial Instructions (SFIs): The Chief Finance Officer confirmed that levels of authority did include VAT. The Committee noted that the NHS could reclaim VAT but not in all cases.

55/24 Key Messages for the Board

Key messages for the Board included:

- February 2024 finance update discussed noting a £1m adverse variance at Month11 to the £7.55m adjusted full year deficit.
- Approval of the draft business plan and budget for 2024/25 noting that this was not the final position, with the need to implement expenditure and other mandates from NHSE.
- Capital plan for 2024/25 agreed with £15m agreed for release immediately to enable new orders to be placed from 1 April 2024, as well as the continuation of pre-committed spend for 2024/25

56/24 Reflections of the Meeting

Mike McEnaney led a discussion.

57/24 Date of Next Meeting

It was agreed that the next meeting would be held on Wednesday 17 April 2024 at 11.00am.

SIGNED:

DATE:

Minutes

Finance & Investment Committee Part I

Wednesday 17 April 2024
11.00 – 12.25
Boardroom, Level 4, Royal Berkshire Hospital

Members

Mr. Mike O'Donovan	(Non-Executive Director) (Chair)
Mr. Dom Hardy	(Chief Operating Officer)
Ms. Priya Hunt	(Non-Executive Director)
Dr. Janet Lippett	(Chief Medical Officer)
Mrs. Nicky Lloyd	(Chief Finance Officer)
Mr. Mike McEnaney	(Non-Executive Director)
Ms. Katie Prichard-Thomas	(Chief Nursing Officer)

In Attendance

Mr. Mike Clements	(Director of Finance)
Mrs. Caroline Lynch	(Trust Secretary)
Mr. Steve McManus	(Chief Executive)
Mr. Andrew Statham	(Director of Strategy)

Apologies

58/24 Declarations of Interest

There were no declarations of interest.

59/24 Minutes for Approval: 20 March 2024 & Matters Arising Schedule

The minutes of the meeting held on 20 March 2024 were approved as a correct record and signed by the Chair subject to the amendment of a minor typographical error.

The Committee received the matters arising schedule.

60/24 March 2024 Finance Update

The Director of Finance advised that Month 12 year to date (YTD) the Trust had reported a deficit of £7.5m and delivered a savings programme of £16.03m, exceeding the original target by £1.03m. A total of £16.03m efficiency savings had been delivered for 2023/24 against the original target of £15m; £6m of which was recurrent.

The Committee noted that £40.52m capital programme had been delivered for 2023/24 against a plan of £40.51m. A significant amount of work had been undertaken by the estates, finance and procurement teams to achieve this during Month 12, noting that only £17.36m had been delivered up to the end of February year to date. A full schedule of vesting certificates would be available to auditors. The Chair thanked the teams for their efforts.

Cash was £38.81m at the end of Month 12. The Committee recommended that a profile of controllable spend was included in the next update. **Action: N Lloyd**

The Committee noted that pay spend was £29.81m adverse to plan year to date at Month 12. The Chief Finance Officer advised that the whole time equivalent (WTE) profile at Month 12 for all staff groups was included in the report. The Committee noted that whilst the retention and vacancy rate had improved the reliance on bank and agency spend had remained at broadly the same level throughout recent months. As part of the savings programme for 2024/25, whole time equivalent reductions would need to be achieved.

The Chief Executive advised that the budget setting process for 2024/25 had started early in the financial year and it was considered whether this process should be started even earlier. For 2024/25, the Executive team would need to set expectations that budget holders would need to work within their budgets and, whilst there were variations in activity and acuity, workforce controls would need to be maintained unless there was a sustained increase in activity and acuity. Workforce and vacancy controls were in place.

[Section exempt under s.43 of the FOI Act]

The Committee queried the process for capitalisation of assets and revaluation. The Chief Finance Officer confirmed that a peer review was undertaken in the finance team and the exercise of re-lifing of assets that were fully life expired and remained in use over the coming periods was considered routinely as part of year-end processes.

The Committee recommended that the Public Dividend Capital (PDC), reserves and revaluation reserves should continue to be clearly identified in future reports.

Action: N Lloyd

61/24 Budget & Capital Plan 2024/25

The Chief Finance Officer introduced the report and advised that, following the original flash submission of a £29.09m deficit on 21 March 2024 to NHS England (NHSE), a series of meetings had been held with budget holders and it was now proposed that a revised budget of a £15.50m deficit would be submitted to NHSE on 2 May 2024. The revised budget included an efficiency programme of £15m of new schemes with an additional £6.20m of full year effect from recurrent schemes from 2023/24; a total of £21.20m. The Chief Finance Officer advised that £10m of the £21.20m savings had already been identified. There was also a further £3m of efficiency savings that would need to be identified through system opportunities.

The Chief Executive advised that review meetings held with individual budget holders had successfully resulted in the revised budget for 2024/25. In addition, cost controls would be in place from Quarter 1 2024/25 and regular oversight of budget performance for all areas would be in place. The Chief Medical Officer and Chief Nursing Officer would ensure messaging was clear that areas would not be able to spend beyond their budgets in particular regarding agency and bank spend. However, there would be strong leadership at every level to ensure safe patient care.

The Chief Operating Officer advised that the Trust expected to achieve all national performance targets for 2024/25 except for ED performance. It was anticipated that the ED target of 71% would be achieved by March 2025. However, given the lack of confirmation by commissioners of their intention to establish an Urgent Care Centre on the Reading Hospital site, the Trust could not confirm that the ED target would be met. The Trust's performance in relation to all national trajectories for 2024/225 would be submitted to the Board on 24 May 2024. **Action: D Hardy**

[Section exempt under s.24 of FOI Act]
It was agreed that an update on the Digital Strategy would be scheduled for a future meeting. **Action: D Hardy**

The Committee discussed the need to focus on the delivery of planned activity levels, pay costs/WTEs and being able to demonstrate improved productivity and efficiency. The Chief Executive advised that the monthly finance report would need to be refreshed to focus on organisational efficiency particularly considering the system view of the Trust's actual increase in headcount over the last few years. The Chief Operating Officer advised that the Integrated Performance Report (IPR) headline metrics would include productivity and that efficiency would be a breakthrough priority. The Chief Finance Officer advised that a working draft of the revised finance report would be available by June 2024 and would be in use from July 2024 onwards. **Action: N Lloyd**

The Committee discussed the income risk for 2024/25 and considered that it would be useful for the Board to see the risks and opportunities as part of the budget for 2024/25. It was agreed that a recommendation would be submitted to the Board to approve the revised budget of £15.50m deficit for 2024/25 nothing that there was a significant savings programme requirement and the need to address the underlying run rate element and the cash flow would be maintained and monitored through the year. **Action: M O'Donovan**

62/24 Key Messages for the Board

Key messages for the Board included:

- 2023/24 final position of a £7.55m deficit, £16.03m efficiency savings and £40.52m capital programme delivered.
- Recommendation to approve the budget of £15.50m deficit for 2024/25 with a formal schedule of risks and opportunities as requested.
- Draft refreshed finance report that would focus on measures of productivity and efficiency being developed for use late in Quarter 1

63/24 Date of Next Meeting

It was agreed that the next meeting would be held on Wednesday 22 May 2024 at 11.00am.

SIGNED:

DATE:

Minutes

Quality Committee

Wednesday 10 April 2024
10.00 – 12.00
Boardroom, Level 4

Members

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

In Attendance

Miss. Kerrie Brent	(Corporate Governance Officer)
Mrs. Christine Harding	(Director of Midwifery) (from minute 20/24 to 23/24)
Mrs. Caroline Lynch	(Trust Secretary)

17/24 Declarations of Interest

There were no declarations of interest.

18/24 Minutes from the previous meeting: 5 February 2024 and Matters Arising Schedule

The minutes of the meeting held on 5 February 2024 were approved as a correct record and signed by the Chair.

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

19/24 Serious Incidents including Maternity (SIs)

The Chief Nursing Officer introduced the report and advised that a Never Event was reported in late February 2024. No harm had been caused to the patient and immediate actions and learning had been implemented. The investigation was ongoing through the Patient Safety Incident Review Group (PSIRG) meetings. The Committee noted the thematic analysis of Never Events in 2023/24; that detailed five of the six Never Events. The report would be updated and submitted to the next meeting.

Action: K Prichard-Thomas

The Trust had noticed similar figures during 2023/24 in comparison to those reported in 2021/22 that were recorded as a high number due to Covid-19. However, of those reported it was noted that five had resulted in no harm; and one in moderate harm. The Trust was trending comparatively across the Buckinghamshire, Oxfordshire & Berkshire, Integrated Care System (BOB ICS). However, nationally, there had been a reported downward trend. A national consultation on Never Events was open to review the list of criteria and the Trust had contributed to this. The Committee also noted the BOB ICB delays in approval process.

The Chief Nursing Officer advised that Trust had identified a recent increase in pressure ulcers that resulted in a detailed review. Learning would be identified and a Trust-wide improvement plan would be developed. **Action: K Prichard-Thomas**

Patient Safety Incident Response Framework: The Committee noted that, from April 2024, the Trust would be transitioning to the Patient Safety Incident Response Framework (PSIRF). The PSIRF would replace the current Serious Incident Response Framework (SIF) (2015). The Trust's PSIRF Policy had been approved by the Policy Approval Group as well as the BOB ICB System Quality Group.

The Chief Nursing Officer advised that incident reporting through Datix remained the same as well as internal processes around scoping and monitoring reporting levels. However, the tools and methodology used to investigate the learning had changed that would enable more time to focus on improvement. The Committee discussed the multiple learning response methodologies including swarm-based huddles immediately after an incident. The framework was aligned to the patient safety and improvement agenda as well as the Trust's Improving Together programme.

The Committee noted that work was ongoing to further develop the programme plan that included; Trust-wide communications and engagement in readiness of the launch as well as the staff training programme and updates to the Trust incident reporting system Datix. It was noted that challenges in staff turnover and vacancies in the patient safety team had slightly delayed implementation.

The Chief Nursing Officer confirmed that the PSIRG meetings would continue to monitor the completion of reports and would approve them. Swarm-based huddles and other methodologies would enable the involvement of patients and families to ensure we listened to their experiences and views. However, under the new framework there was a potential risk to patient expectation that meant that not all incidents would be investigated with a formal written report.

The Committee noted the five identified initial Trust priorities that were aligned with BOB ICB and national priorities and consultation with circa 250 staff members. These included:

- Treatment delay within the two week wait pathway
- Communication and or handover between departments
- Recognition of the deteriorating patient
- Patient flow from the Emergency Department
- Medication errors in prescribing and administering

The Committee discussed including treatment delay within the two week wait pathway priority and it was suggested that delayed discharges would be more suitable due to the Trust recognising that this was a breakthrough priority as well as a potential patient safety issue. The Chief Nursing Officer advised that a six-month review would be scheduled that would incorporate the review of priorities. The Chief Medical Officer and Chief Nursing Officer would review and scope the suggestion for consideration.

Action: K Prichard-Thomas

20/24 Integrated Performance Review (IPR) Watch Metrics

The Chief Medical Officer introduced the watch metrics. The Committee welcomed the improved report that highlighted the metrics that required specific focus of this Committee. The following was noted:

- The challenges and ongoing work to recruit to vacancies in Stroke and Neurology affecting the proportion of people with high risk Transient Ischaemic Attack (TIA) being fully investigated and treated within 24 hours. It was noted that this would be considered by the Acute Provider Collaborative (APC) as a speciality for consideration.
- The Director of Midwifery would review the Maternity watch metrics in line with the clinical dashboard review as it was noted the percentage of pre-term live births receiving a full course of antenatal corticosteroids within seven days of birth was no longer a safe metric standard and should be removed.

The Chief Operating Officer introduced the IPR refresh final recommendations report. The Committee discussed the recommendations. It was agreed that a recommendation would be submitted to the Board to approve the inclusion of 62-day Cancer metric as a strategic metric and DM01 removed and monitored as a watch metric. However, as DM01 was integral to achieving the 62-day target details would be included in the cancer metric to some extent. **Action: D Hardy**

It was noted that a detailed review on DM01 was scheduled on the work plan for September 2024.

21/24 Maternity Quality Assurance Report including Maternity Incentive Scheme (MIS)

The Director of Midwifery introduced the report and advised that an investigation was on-going following a recent moderate to high incident of community acquired Venous Thromboembolism (VTE). Discussions with the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care Board (ICB) to find a solution due to a change in general practice prescribing.

The Trust-wide mandatory training in relation to the MIS was 91.3% against a target of 90% for all staff groups in Maternity. However, it was noted that this was separate to the Mandatory and Statutory Training (MAST) training compliance.

The Committee noted that a gap analysis was in progress following the publication of the MIS Year 6 as well as the reporting requirements. The amalgamation of reports would be considered in future reporting to reduce duplication.

It was noted that the action plan in relation to the six ‘should do’ actions following the Care Quality Commission Maternity inspection would be submitted to the next meeting.
Action: K Prichard-Thomas

22/24 Perinatal Mortality Report Quarter 3 2023/24

The Director of Midwifery introduced the report and advised that in Quarter 3 the perinatal death rate was 3.25 per 1000 births; lower than the national figures available. Four perinatal deaths were noted in Quarter 3. Details of deaths and detailed reviews had been carried out including a detailed review of symphysis fundal height (SFH) measuring.

The Committee acknowledged the positive MBRACE-UK report that indicated that the Trust’s perinatal mortality was below the national average.

It was noted that the work carried out to improve the soundproofing of bereavement rooms had helped to reduce the noise and as a result, no further complaints had been received.

The Committee acknowledged that there was no evidence at this stage in relation to ethnicity outcomes. However, work was ongoing to improve this. It was noted that a

review would be carried out at the end of the year where it was anticipated that trends and data would be available over a greater period of time. It was noted that a dashboard would also be developed to review and monitor outcomes for these women.

23/24 Perinatal Quality Surveillance Model Report (PQSM) Q3 2023 – 2024

The Committee received and noted the report.

24/24 Quality Governance Committee Exception Report

The Chief Nursing Officer highlighted that the Committee had met for the first time on 28 March 2024 following its restructure. Good engagement and assurance was noted. The Committee acknowledged the new format of the report. However, agreed that improvement could be made on key messages for escalation to provide sufficient assurance to this Committee. **Action: K Prichard-Thomas**

25/24 Board Assurance Framework (BAF)

The Committee received the BAF. It was agreed that The Trust Secretary would meet with the Chief Operating Officer, Chief Medical Officer and Chief Nursing Officer to review the specific sections in relation to the gaps in assurance and improvement and action plans. It was agreed that an updated report would be submitted to the next meeting.
Action: C Lynch

26/24 Corporate Risk Register

The Committee received the Corporate Risk Register and noted that it was due to be reviewed in detail at the upcoming Integrated Risk Management Committee scheduled for 18 April 2024.

27/24 Committee Annual Review & Effectiveness Report

The Trust Secretary introduced the Committee's annual effectiveness review as part of the annual review cycle. The Committee agreed that the review provided assurance that the Committee had carried out its obligations in accordance with its terms of reference over the past year.

It was agreed that a recommendation would be submitted to the Board to approve the report. **Action: H Mackenzie**

28/24 Work Plan

The Committee received the work plan.

29/23 Key Messages for the Board

The Committee agreed the following key messages for the Board:

- Assurance received in relation to the implementation of PSIRF and Trust priorities.
- Noted the delays in SI sign off caused by the ICB.
- Noted the Watch Metrics and actions taken on alerting metrics
- Agreed to recommend that 62-day cancer metric be added as a strategic metric and DM01 removed and monitored as a watch metric.
- Good assurance received in the positive MBRACE-UK report that indicated that perinatal mortality was below the national average.

- Received the Board Assurance Framework and Corporate Risk Register.
- Recommendation to approve the Effectiveness Review

30/24 Reflections of the Meeting

Parveen Yaqoob led the discussion.

31/24 Date of Next Meeting

It was agreed that the next meeting would be held on Monday 3 June 2024 at 10.00am.

SIGNED:

DATE:

April 2024

Quality Committee Annual Review of Effectiveness 2023/24

Helen Mackenzie
Chair, Quality Committee

Caroline Lynch
Secretary, Quality Committee

1. Summary

1.1. The purpose of this report is to give an update on the work on the Quality Committee over the past year, and to provide assurance to the Board that the Committee has carried out its obligations in accordance with its terms of reference.

2. Governance

2.1. The role of the Committee is to give detailed consideration to all components of the quality of care provided by the Trust including clinical effectiveness, patient safety and patient experience.

2.2. The Committee receives an exception report from the Quality Governance Committee at each meeting that sets out the key issues, risks and themes identified by that Committee.

2.3. The Quality Committee is a sub-committee of the Board. The Chair is responsible for escalating matters that the Committee considers need to be drawn to the attention of the Board when presenting the minutes of the Committee to the next meeting of the Board.

2.4. Helen Mackenzie was appointed Chair of the Quality Committee in January 2019.

2.5. The Committee's terms of reference were approved by the Board in February 2024. The Committee also maintains an annual work plan.

3. Meetings and Membership

3.1. The Committee met formally on five occasions between April 2023 and March 2024.

- 12 April 2023
- 15 June 2023
- 14 September 2023
- 6 December 2023
- 5 February 2024

3.2. The attendance record of members of the Committee is as follows

Member	Maximum Number of Meetings	Number Attended
Helen Mackenzie	4	5
Bal Bahia	4	5
Prof. Parveen Yaqoob	4	5
Chief Nursing Officer	5	5
Chief Medical Officer	5	5
Chief Operating Officer	4	5
Chief Executive	2	3
Chair	1	5

3.3. The Trust Secretary or their nominee has attended all meetings. Other Non-Executive Directors have attended meetings to observe. Other Directors and staff have attended meetings during the course of the year to advise and to respond to questions from the

Committee. These have included the Deputy Chief Nursing Officer, Head of Safeguarding, Director of Midwifery, the Associate Director of Nursing, Associate Chief Nurse Patient Experience, Workforce and Education, Matron - Acute Medicine.

3.4. A patient of the Trust attended the meeting on the 5 February 2024 to discuss their experience in the Trust's maternity service.

4. Assurance

4.1. Items that were reviewed at each meeting or regular intervals include; updates on Serious Incident themes including Maternity, CQC Maternity Assessment Update, Quality Governance Committee (formerly Quality Assurance and Learning Committee) exception reports, Maternity Action Plan including Ockendon Response, Perinatal Mortality Surveillance Report and Perinatal Mortality Quarterly reports, Corporate Risk Register, Board Assurance Framework, Legal Services/Claims Update.

4.2. The Committee received regular updates on Maternity that included Serious Incidents, Maternity Incentive Scheme, Maternity Safety Rounds, Ockenden Action Plan, Maternity Strategy, Maternity Internal Audit Action Plan.

4.3. The following annual reports were received during the year:

- Protecting Elective Activity: NHSE Self-Assessment
- Improving Together: NHS Impact Self-Assessment
- Learning Disabilities and Autism Update
- Safer Staffing Review
- Winter Plan
- Complaints & Patient Relations Annual Report
- National Patient Survey 2022/23 Updates
- Quality Impact Assessment Policy
- Safeguarding Annual Report
- Single Delivery Plan
- Infection Prevention & Control Annual Report
- Patient Experience Annual Report
- Mixed Sex Accommodation Update
- Clinical Audit Programme Update
- Integrated Performance Report Annual Refresh
- Research & Innovation Report
- Annual Clinical Governance review
- Quality Account 2022/23
- Legal Claims

4.4. The Quality Strategy was also received during the year.

4.5. In addition to the regular assurance received from items on the work plan, the Committee has sought and received assurance on the following specific issues:

- Newborn Life Support Instructors Training

- Letby Case Board Assurance
- Cancer Performance 62-day wait
- Surgical Site Infection & A3 Improvement Work
- Venous Thromboembolism
- Mixed Sex Accommodation
- Elective Care 2023/24 Priorities
- Excellence in End-of-Life Care

Minutes

People Committee

Thursday 2 May 2024
10.00 – 12.00
Video Conference Call

Members

Mrs. Priya Hunt	(Non-Executive Director) (Chair)
Mr. Bal Bahia	(Non-Executive Director)
Mr. Don Fairley	(Chief People Officer)
Dr. Janet Lippett	(Chief Medical Officer)
Prof. Parveen Yaqoob	(Non-Executive Director)
Ms. Katie Prichard-Thomas	(Chief Nursing Officer)

In Attendance

Ms. Bernice Boore	(Lead Nurse for Integrated Medicine A) (from minute 22/24 to 23/24)
Miss. Kerrie Brent	(Corporate Governance Officer)
Ms. Val Davis	(Associate Director for Resourcing and Relations)
Mr. Dwayne Gillane	(Associate Director Occupational Health and Wellbeing)
Ms. Jackie Lunn	(Research Nurse, Berkshire Cancer Centre) (from minute 22/24 to 23/24)
Mrs. Caroline Lynch	(Trust Secretary)
Mr. Steve McManus	(Chief Executive Officer) (up to minute 24/24)
Ms. Aisha Mohamed	(HR Graduate Scheme Trainee)
Mr. Pete Sandham	(Associate Director for Staff Experience and Inclusion)
Ms. Sim Scavazza	(Acting Chair, Berkshire, Oxfordshire and Berkshire West Integrated Care Board)
Mr. Graham Sims	(Chair of the Trust) (up to minute 24/24)

Apologies

Mrs. Helen Mackenzie	(Non-Executive Director)

17/24 Declarations of Interest

There were no declarations of interest.

18/24 Minutes: 15 February 2024 and Matters Arising Schedule

The minutes of the meeting held on 15 February 2024 were approved as a correct and would be signed by the Chair.

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

Minute 09/24: Womens+ Network: It was agreed that a list of all staff networks at the Trust would be circulated to the Committee. **Action: D Fairley**

19/24 Chief People Officer Report

The Chief People Officer introduced the report. The Committee noted the Buckinghamshire, Oxfordshire and Berkshire Integrated Care Board (BOB ICB) System People Board progress update that included the progression of a number of system-wide work streams as well as an overview of the South East Temporary Staffing Collaborative region-wide projects for delivery in 2024/25. The Committee sought clarification on the governance, alignment and purpose of each board and sub-group. It was noted that work was on-going to align all groups as well as ensure that there was no duplication specifically in relation to system-level and trust-level programmes of work. The Chief Executive advised that development was on-going in relation to the Acute Provider Collaborative (APC) Board including governance arrangements. There were three programmes of work and, in addition, work was on-going to ascertain whether opportunities that could be extended, for example, developing other areas of people efficiencies in a benchmarking approach.

The Committee discussed industrial action including consultants' acceptance of the latest pay offer from the Government. However, it was noted that no further announcements had been made since 20 March 2024 and the mandate for Junior Doctors was extended from 3 April 2024 to 19 September 2024.

The Committee received the comparative data in relation to gender pay gap across the BOB ICB. The Trust had the lowest pay gap across acute providers and compared consistently across the ICB. The Committee recognised that the reported position remained an area of focus with a number of actions being progressed including improvements recommended as part of the national Mend the Gap report publication. The Trust did not currently publish its ethnicity pay gap in the public domain due to a recent review of reporting. However, it was agreed that this would be a focus for improvement. **Action: D Fairley**

The Committee received an update on the 'What Matters 2024' staff engagement programme following its launch in March 2024 with over circa 1000 engagements made in the initial stage. The programme would continue over the coming months until August 2024 with a trajectory to achieve 4500 engagements.

The Chief People Officer advised that he had recently presented the Trust's continued focus on Health and Wellbeing and engagement to the NHS England South East Region meeting. Positive feedback had been received as well as suggested interest in visits to the Oasis Health and Wellbeing Centre.

The Committee queried the baseline of the Leadership Behaviours Framework and how the Trust measured the impact. The Chief People Officer confirmed that the framework formed an integral part of the appraisal and talent management framework that was being cascaded throughout the organisation. The framework was planned to be phased in tiers of staff that would eventually be applicable across the organisation for Band 6 and above. However, due to the early stages of the framework cascade a baseline position could not yet be established. There was a plan to revisit this in 12 to 18 months' time to identify a baseline position that could be benchmarked over time. The annual 'Staff Survey' questions could also be reviewed and updated to include a question related to this if required.

20/24 Chief People Officer Metrics

The Chief People Officer introduced the Driver Metrics and highlighted that turnover rate continued to reduce, a downward trend since April 2023. There would a continued focus on stability and turnover of staff within the first 12 months during 2024/25.

The Chief People Officer highlighted the implementation of ‘stay conversations’ in the first 12 months and probationary period of employees. These conversations would be after four and nine months in post and would highlight areas the Trust could improve on as well as what further support employees required.

Additionally, good progress had been made in relation to vacancy rates since April 2023. However, this could be impacted due to the Trust’s financial position and the vacancy freeze. The Chief People Officer advised that work was on-going to compare data held on Human Resources (HR) systems compared to Finance systems to aid better planning and understanding of the vacancy position going into 2024/25.

The Committee noted the progress made in relation to non-clinical time to hire; and the need to further improve clinical time to hire. There were several concerns to be addressed in clinical areas and that this would be a focus for 2024/25. Next steps related to process improvements and impact of Occupational Health processes on individual staff groups.

The Committee discussed the turnover metric. The Chief People Officer advised that currently the Trust was performing just below target. However, this was higher than preferred.

The Chief People Officer advised that a review was carried out to not provide ‘gold’ and ‘green’ appraisal pathways to those who had not appraised 100% of staff within their remit. It was also noted that the Trust had reintroduced a claw back for senior manager’s band 8c and above that had not carried out their appraisals; circa 10% of their salary.

Appraisal rates continued to be reviewed on a regular basis including at management boards and performance review meetings.

21/24 Guardian of Safe Working

The Chief Medical Officer provided a verbal update. The Trust had formally opened out of hours food provision service including a seating area as well as hot food meal dispensing meals, drinks and snacks for staff working out of hours. This had been well received by staff. The Acting Chair, BOB ICB suggested that the project be shared with other providers in the ICB.

Action: D Fairley

22/24 Workforce Race Equality Standard (WRES) Annual Report

The Associate Director for Staff Experience and Inclusion provided a summary of WRES performance across the relevant metrics for 2023/24. The Trust continued to report positive improvements that were better than the NHS average on all measures based on 2022/23 data. A positive trajectory in senior level positions was noted. However, the Committee recognised that further improvements were required overall in senior roles in the organisation. By maintaining its current growth trajectory the Trust would be on target to deliver the People Strategy aspiration of 25% representation in most senior roles by 2027.

The Committee noted that the staff experience metrics were all on a positive trajectory. However, recognising the low national targets, The Trust strived to go beyond the satisfaction average. It was suggested that the report was shared more broadly to acknowledge the overall improvements made.

It was agreed that a more detailed review would be provided in relation to bullying and harassment of ethnic minority staff compared to white staff.

Action: P Sandham

The Lead Nurse for Integrated Medicine A noted the Trust's improvement in this area had been acknowledged by ethnic minority staff who had stated they considered they were part of the RBFT family. However, they required support to be able to apply for senior appointments specifically at Band 8A level and above. The need to further expand reverse mentoring at Board level was suggested. An update would be provided at the next meeting. **Action: D Fairley**

The Committee noted the eight key recommendations approved by the Executive Management Committee in October 2023 to further enhance and embed inclusion at the Trust. One of the recommendations included a specific Equality, Diversity and Inclusion objective for all managers band 8a and above as part of their appraisal process.

The Committee approved the Workforce Race Equality Standard (WRES) Annual Report.

23/24 Workforce Disability Equality Standard (WDES) Annual Report

The Associate Director for Staff Experience and Inclusion provided a summary of WDES performance across the relevant metrics for 2023/24. The Trust reported an improving trajectory that was better than the national average based on 2022/23 data. Although, it was recognised that the national average was low.

Good improvements had been reported in likelihood of appointment following shortlisting, reflecting the work on ensuring recruitment and selection processes were more inclusive. Continued focus was required to deliver the equity positon. The Committee noted that declaration rates from staff continued to improve although this metric remained adverse to the national average.

The Committee noted that levels of bullying and harassment and abuse from patients, although reducing in year, remained an area of concern.

The Research Nurse, Berkshire Cancer Centre highlighted the on-going work to raise the profile of the Disability and Wellness Network (DAWN) and promote education more widely. Alternative ways of communication and promotion would be explored for staff that did not have regular access to Workvivo.

The Associate Director for Resourcing and Relations advised that the recruitment team had recently engaged with Differing Minds who had reviewed the Trust's end to end recruitment processes to support the further developing recruitment of neurodiverse candidates. The outcome had been positive and suggested learning was provided. The recruitment team were in the process of collating data to produce an action plan. A summary would be submitted to the next meeting. **Action: V Davis**

The Committee approved the Workforce Disability Equality Standard (WDES) Annual Report.

24/24 Care Group Appraisal Compliance Rate

The Chief People Officer introduced the report. It was noted that in line with the Trust-wide Improving Together methodology, Care Groups had identified appraisal compliance rates as a driver metric with a target of 95%. The driver metric was monitored through the monthly Performance Review meetings. The Committee noted the positive focus to improve this metric and conduct detailed reviews of specific challenging areas and departments as well as identifying the variation in detail.

The Committee noted the significant improvement made by Corporate Services and, in particular the Finance directorate. However, recognised that further work at pace was required with specific focus on the Care Groups.

The Committee noted the high-level root causes for low compliance that were; system challenges, time pressures driven by the operating environment, data inaccuracies driven by users as well as an element of sickness. As Care Groups were using appraisals as a driver metric, a focus on these would be reflected in their Improving Together plans.

25/24 Nursing and Midwifery Inpatients Workforce Benchmarking with BOB ICB

The Chief Nursing Officer introduced the report that presented the outcomes of the BOB ICB Workforce benchmarking exercise for nursing. The Workforce Group was implemented in response to a letter received from Nick Broughton, Chief Executive and Julian Kelly, Chief Financial Officer, BOB ICB.

The data provided an overview of safer registered nurse staffing levels across the three acute trusts in BOB ICB. A review of the right staff, right skills and right place and time was considered partially in line with the National Quality Board (NQB 2016) and the Developing Workforce Standards (DWS 2018) guidance in relation to workforce planning.

The benchmarking exercise provided data that enabled the Trust to identify possible opportunities to further evaluate registered nurse staffing levels. The limitations of this benchmarking include the challenges in comparing services within a system where the acute trusts delivered services in slightly different ways, as well as, a lack of triangulation with other workforce methodologies or care quality indicators. It was noted that further benchmarking would need to consider how these variables could be recognised and mitigated in future reviews. It was important to acknowledge the elements of the triangulated process as advocated in the national publications (National Quality Board 2016 & Developing Workforce Safeguards 2018).

26/24 Exit Interviews and Surveys

The Chief People Officer introduced the report that highlighted a sample overview of exit interviews and leaver surveys from Networked Care for the period October to December 2023. The Committee noted that, although the data was from a low database, the data provided was useful and reinforced theories that education, career progression, work life balance and satisfaction with pay were common themes of resignations. Further work was required to improve processes and data in relation to exit interviews and surveys and this would be a significant area of focus for the appointed People Promise Manager recruited as part of the national programme.

The Committee noted that work was on-going to update the process of advertising secondments internally. Previously secondments were recruited to by expression of interests. However, the policy had recently been updated to reflect that all secondments were required to be advertised via the TRAC system for two weeks to enable all staff members to apply. It was suggested that staff that were on the 'gold' appraisal pathway should be considered first.

The Committee noted the implementation of 'stay conversations' as part of the on-going work to improve turnover specifically within the first 12 months of employment and probationary period. It was noted that the conversations would be conducted by either the Retention team, People Promise Manager or People Change Partners.

Significant focus would be allocated to how the Trust could improve its response rate for exit interviews and surveys to ensure that 100% of employees are invited to participate, including internal movers. It was anticipated that not all employees that transferred between departments were currently contacted at this stage. It was agreed that an update would be provided at the next meeting. **Action: D Fairley**

27/24 Board Assurance Framework (BAF)

The Trust Secretary introduced the report that had recently been updated. It was noted that the addition of the National Sexual Safety Charter signatory that the Trust had signed up to had been added and included ten actions for implementation by July 2024. It was agreed that a report would be submitted to the next meeting. **Action: D Fairley**

The Acting Chair, BOB ICB queried whether the Committee focussed on productivity and workforce numbers considering the current financial situation. The Trust Secretary advised that the Finance & Investment Committee reviewed workforce data as part of the monthly finance report that was currently being refreshed to include a focus on efficiency and productivity.

28/24 Corporate Risk Register

The Committee noted the risk register and the two associated risks.

29/24 Work Plan

The Committee received the work plan.

30/24 Key Messages for the Board

The Committee agreed the following key messages for the Board:

- Approval of the Workforce Race Equality Standard (WRES) Annual Report and noted the positive improvement in senior management recruitment.
- Approval of the Workforce Disability Equality Standard (WDES) Annual Report and noted the engagement with Differing Minds to improve the recruitment processes for Neurodiverse applicants.
- Formal opening of the Trust's out of hours hot food provision.
- The on-going work to identify the variation related to appraisals and the focus within the Care Groups.
- Initial findings in relation to the Nursing and Midwifery Inpatients Workforce Benchmarking with BOB ICB did not indicate any immediate opportunities. However, medium term opportunities to learn from each of the acute trusts were noted.

31/24 Reflections of the Meeting

The Associate Director for Staff Experience and Inclusion led a discussion.

32/24 Date of the Next Meeting

It was agreed that the next meeting would be held on Monday 30 September 2024 at 10.00am

Chair:

Date:

Audit & Risk Committee

Wednesday 8 May 2024
9.35 – 11.30
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. Ben Sherriff	(Associate Partner, Deloitte) (up to minute 60/24)
Mr. James Shortall	(Local Counter Fraud Specialist) (LCFS)
Mr. Neil Thomas	(Partner, KPMG)

Trust Staff

Mr. Mike Clements	(Director of Finance)
Mrs. Caroline Lynch	(Trust Secretary)
Mr. Steve McManus	(Chief Executive)
Ms. Katie Prichard-Thomas	(Chief Nursing Officer)
Mr. Graham Sims	(Chair of the Trust)

Apologies

48/24 Declarations of Interests

There were no declarations of interest.

49/24 Minutes for approval: 6 March 2024 and Matters Arising Schedule

The minutes of the meeting held on 6 March 2024 were agreed as a correct record and signed by the Chair.

The Committee received the matters arising schedule.

50/24 Local Counter Fraud Progress Report

[Section Exempt under s.40 FOI Act]

The LCFS highlighted that work was ongoing in relation to raising staff awareness of counter fraud. This include the launch of a staff awareness survey in May, the provision of additional training and development sessions for individual departments and online content that was being developed in collaboration with the Trust's Communications Team and Counter Fraud Champion.

The LCFS presented a NHS Counter Fraud Authority (NHSCFA) study which involved Artificial Intelligence (AI) 'deepfake' technology. The LCFS advised that work was ongoing

with the Trust's Human Resources and Recruitment teams to ensure that pre-employment and other checks included robust identification verification checks.

The Committee noted that the National CFA team was in attendance in the Trust on an engagement visit. The purpose of the visit was to review referral levels and examples included in LCFS reports.

51/24 External Audit Progress Report

The Associate Partner, Deloitte, advised that there had been a slight delay in receipt of the draft Annual Report and a further draft was due to be submitted on 14 May 2024. In relation to the year-end audit progress on key areas of standard year-end testing including valuations, capital expenditure, accruals and IFRS16 reporting was ongoing. The Associate Partner, Deloitte, advised that reports on revenue and IFRS16 were yet to be received. A briefing note on accruals had been received and comments returned. However, progress on the year-end audit was better compared to last year. There would be a focus on the modular build in relation to the basis for recognition that this was a significant expenditure.

The Director of Finance advised that the finance and audit teams had met regularly, and the finance team was working through a large number of requests on Connect with deadlines set for next week.

The Trust Secretary advised that the Annual Report would include a joint statement from the Chief Executive and Trust Chair. Some items remained outstanding. However, the second draft of the Annual Report would be submitted on 14 May 2024.

The Committee agreed that the Chief Finance Officer and the Chief Executive would meet with Deloitte in the next two weeks to discuss the delays and ensure progress continued. The Committee agreed that it should be informed as soon as possible if it was unlikely that the final Annual Report and Accounts would be submitted by the 12 June 2024 deadline.

Action: N Lloyd

52/24 Internal Audit Progress Report

The Partner, KPMG, advised that the cyber scoping review had been delayed and the final report would be issued in two weeks' time.

The Committee discussed progress on management actions and it was reported that there were in the region of 30 overdue actions. The Committee requested that these were progressed over the coming months. The Committee requested that a status report was submitted for review to each meeting to ensure progress was maintained. It was agreed that an update on any extensions to deadlines should be submitted to the Committee for review at the July meeting. **Action: N Lloyd**

53/24 Draft Internal Audit Annual Report 2023/24 and Head of Internal Audit Opinion

The Committee received the draft Annual Report 2023/24 and the Head of Internal Audit Opinion. Nine reviews had been completed in the 2023/24 reporting period and 48 management actions were raised. None of the actions were rated high priority. The overall opinion of the Head of Internal Audit was 'significant assurance with minor improvement opportunities'.

The Committee noted that a significant volume of non-audit work had been undertaken by the internal auditor and queried whether this impacted on their ability to remain independent.

The Partner, KPMG, advised that as part of their bid for the non-audit work, evidence had been submitted to demonstrate the firm's independence. Two separate teams within KPMG carried out the work and appropriate procurement processes were followed. The Committee noted that KPMG had invoiced for £290k in non-audit fees. It was agreed that the Director of Finance would confirm the procurement process for non-audit work by internal auditors.
Action: M Clements

[Section exempt under s.24 FOI Act]

54/24 Board Assurance Framework

The Committee agreed that it was useful to review the BAF on a regular basis. The Committee recommended that the capital expenditure and finance sections were updated to reflect the Trust's revised financial position. **Action: N Lloyd**

The Chief Nursing Officer highlighted that the Integrated Performance Report (IPR) included the Patient Safety Incident Response Framework (PSIRF) reporting. Work was ongoing with the informatics team in relation to recording metrics and the narrative in the IPR would set out the methodology being used.

The Trust Secretary advised that Strategic Objective 4 in relation to Improving Together would be reviewed with the Chief Medical Officer. **Action: C Lynch**

The Chair highlighted that, in other organisations, a risk score was included in the BAF. The Trust Secretary advised that this would need to be a Board decision. It was agreed that the Chair would raise this for discussion at the Board. **Action: M McEnaney**

55/24 Corporate Risk Register

The Chief Nursing Officer introduced the report and highlighted that 23 risks had ratings of between 9 and 25. All risks were mapped to the relevant Board Committee. A number of finance risks were rated between 20 and 25. The North Block East Wing had been downgraded from 25 to 20 and this was likely to be reduced further.

[Section Exempt under s.43 FOI Act]

The Committee agreed that a significant amount of work had been put into the estates, DDaT and Pathology risk registers. Further work was required in relation to mitigations for patient experience, demand and capacity, environment and complaints.

The Committee requested that the word 'avoid' was replaced with the word 'manage' in relation to risks in the Trust Risk Appetite. **Action: K Prichard-Thomas**

The Committee agreed that the fire safety risk score would be reviewed in light of the mitigating actions. **Action: K Prichard-Thomas**

It was agreed that all controls and mitigating actions would be amended to stipulate the capital allocation for 2024/25. **Action: K Prichard-Thomas**

56/24 Losses & Special Payments

The Committee noted that there had been one payment for loss of property to the value of £1,675 and seven cases of other losses totalling £57,578.30 had been made since the last

meeting. There had been four special payments to the value of £28.563.30. The Committee requested that additional information to provide the context of losses and special payments over a longer period was included in future reports. **Action: N Lloyd**

57/24 Use of Single Tenders

The Committee noted that eight single tender waiver contracts had been awarded since the last Committee meeting.

58/24 Schedule of Significant Contracts

The Committee noted that four significant contracts had been awarded since the last meeting.

59/24 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.

60/24 Freedom to Speak Up Guardian Update

The Committee received the Freedom to Speak Up Guardian (FTSUG) update that included data submitted to the National FTSUG Office for Quarter 3 of 2023/24. 34 concerns had been raised to FTSUGs between 1 October 2023 and 31 March 2024. Fourteen reports were in relation to inappropriate or poor attitudes and behaviours, difficulties with inter-colleague relationships and management relationships. The Committee noted that this was slightly higher than the national benchmark. The Chief Nursing Officer advised that monthly meetings with the FTSUG were held to review each case in detail and learning from these cases would inform wider work streams on the Staff Survey results and What Matters 24 programme. The Committee noted that there was a need to increase the number of FTSU ambassadors in the Trust.

The Committee noted the FTSUG action plan and the proposal to increase FSTUG's hours from November 2024. It was agreed the FSTUG post would be added to a workforce controls meeting. **Action: K Prichard-Thomas**

It was agreed that the three areas that had not yet been allocated a Red, Amber and Green (RAG) rating would be assessed and rated accordingly. **Action: K Prichard-Thomas**

61/24 Declarations of Interest, Gifts & Hospitality Update

The Committee noted the report. The Trust had achieved 87% compliance for 2023/24. The Committee requested further clarification for non-compliance among the remaining 13%. **Action: C Lynch**

62/24 Non-NHS Debt Report

The Committee noted that non-NHS debt was £8.6m as at 31 January 2024. The Committee noted the additional detail included in the report in relation to the percentage of overseas debt. The Director of Finance advised that whilst the Overseas Team had been successful in identifying overseas patients with unpaid invoices, in practice, recovery of the debt was challenging once the patient had left the country. The Trust had collected 50% of debt from overseas visitors. The Director of Finance advised that NHS organisations had strong links with the UK Borders Agency and individuals with debts owing to the NHS were notified to the

Agency. The Trust was treating a high volume of patients. However, clinicians were aware of the need to inform the overseas team when treating overseas patients.

The Director of Finance advised that the Trust planned to raise awareness of the overseas visitors' process across the community. **Action: N Lloyd**

The Director of Finance advised that the collection rate of private patient debt required improvement and work was ongoing with the various insurance companies.

It was agreed that information on the Trust's benchmarked performance in collection of debt would be circulated to the Committee. **Action: N Lloyd**

63/24 Work Plan

The Committee requested that the Healthcare Facilities Management Services (HFMS) Limited year-end audit was scheduled on the work plan. **Action: C Lynch**

63/24 Key Messages for the Board

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

- Counter Fraud activity remained stable
- The Committee received an update on the progress of the external year-end audit and noted that current progress had improved compared to last year. Some issues had been identified but would be resolved.
- The Committee received good assurance from the internal audits on the DSPT toolkit and Cerner modules.
- The Committee noted that there were around 30 overdue actions on the Internal Audit Recommendations and requested that these be progressed. A status report on the progress of management actions to address internal audit recommendations would be submitted for review to each meeting.
- The Committee received the Head of Internal Audit's final opinion for 2023/24.
- A concern was raised in relation to delays in addressing the internal audit recommendations and the number of overdue items.
- The Committee reviewed the BAF and requested that capital expenditure was included in the Corporate Risk Register mitigations and actions.
- The Committee received the Freedom to Speak Up Guardian report for Quarter 3 of 2023/24 and noted the action plan.
- The Committee noted the high profile nature of the Trust's Non-NHS debt.

64/24 Reflections of the Meeting

Helen Mackenzie led a discussion.

65/24 Date of Next Meeting

It was agreed that the next meeting would be held on Thursday 20 June 2024 at 9.30am

Chair:

Date:

Title:	**Chief Executive Report**
Agenda item no:	7
Meeting:	Board of Directors
Date:	29 May 2024
Presented by:	Steve McManus, Chief Executive
Prepared by:	Caroline Lynch, Trust Secretary

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

Report History	None

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

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

Strategic objectives This report impacts on (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	✓

Introduction

With the recent announcement of the General Election being called for 4 July 2024 we will shortly be entering into the period of Purdah for public bodies ahead of the election. This report is set out with that consideration in mind.

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

Operational Status

1.1 The Trust has remained operationally busy through April and May. Despite an increasing demand for complex diagnostics, radiology have been successful in delivering their diagnostic waiting times. The elective recovery programme is gaining momentum with teams agreeing operational trajectories to achieve the productivity targets. At the end of April the Trust had slightly more patients waiting over 62 days on cancer pathways than planned due to extremely high unpredicted demand in dermatology. Additional work is being undertaken to address this.

1.2 Emergency Department (ED) performance continues to be a challenge with increased demand and complexity resulting in a longer length of stay across the hospital and higher occupancy in both ICU and Paediatrics. Work is being undertaken to improve both the length of stay internally and the Berkshire West Primary and Urgent Care teams are co-designing a new Primary Care Service to be co-located with ED for the winter.

Industrial Action

1.3 Currently no dates for further industrial action have been announced and talks are ongoing with the various bodies. Consultants have agreed the offer that was made, and as such no further action is expected.

1.4 The Specialty and Specialist (SAS) doctors committee have negotiated a new and improved offer after an earlier one was rejected. This is being put to members with the vote due to close on the 14 June. The junior doctors remain in discussion with the government and have a current mandate to strike which runs until the 19 September. These talks continue and no strike dates have as yet been announced.

1.5 GPs are in dispute over the imposing of the new 2024/25 primary care contract. An indicative vote indicated 99% of GPs would be prepared to take strike action and a ballot is due to take place between 17 June and 29 July. Although not directly involved with this, we would undoubtedly be impacted by industrial action in primary care. We are following the discussion with interest and will make plans accordingly.

Audiology IQIPS accreditation

1.5 Failings in Paediatric Audiology (children's hearing services) have been identified in Scotland and England leading to a NHSE Improvement Programme and a review of service provision. The CQC has asked trust boards to provide two specific assurances by the 30 June 2024. These are in relation to whether a trust has achieved Improving Quality in Physiological Services (IQIPS) accreditation and whether any major recommendations or findings have been made since that time and the number of incidents resulting in harm or detriment to children in the service as a result of delayed or missed diagnosis.

1.6 Our submission will confirm the assertion that our paediatric audiology service has maintained its Improving Quality in Physiological Services (IQIPS) accreditation without any major recommendations or findings since 2014. The Trust has received minor findings in line with the ethos of continuous quality improvement.

1.7 There have been no incidents within our paediatric audiology service where detriment or harm has been caused to a child due to delayed or missed diagnosis or where timely follow up care and support has not been received.

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

RBFT Staff Care Awards

2.1 On Friday 17 May 2024 we held our annual staff CARE awards that celebrate the outstanding work of our staff and volunteers. There were 13 winners across 12 categories with 61 shortlisted individuals and teams represented on the night.

2.2 We had over 600 nominations in total for the 12 categories and over 1,500 votes for our new award for 2024 - the People's Choice Award.

2.3 We were joined by colleagues from a number of partner organisations who co-presented on a number of awards. We were also joined by Beth Huff who presented the 2024 Richard Huff Patient Safety Award in memory of her late father who was a Patient Leader and passionate supporter of patient safety at the Trust.

What Matters 2024

2.4 What Matters is our large scale staff engagement programme which launched in March 2024. The initiative aims to connect with colleagues about our organisational values and the behaviours underpinning them. As of 20 May 2024, 2115 colleagues have engaged in our What Matters 2024 programme. The first module which focused on the value of Compassion received nearly 1800 contributions. Some Trust Governors attended a What Matters session on Compassion on the 14 May 2024 which was well received.

2.5 The programme is currently in module two, which explores the value of Aspirational. Conversations in this module will focus particularly on themes of inclusion, belonging and development.

2.6 The Learning and Organisational Development (OD) team are processing the qualitative outputs from the first module focus on Compassion, in readiness to reflect back into the organisation in early June 2024.

Staff experience of violence and aggression

2.7 The most recent NHS Staff Survey results showed an increase in staff reporting on experienced discrimination, physical violence or harassment from patients and visitors. A staff listening event in October also highlighted these themes including staff expressing feelings of vulnerability and experiencing challenging/violent/aggressive behaviour from patients and families. We are committed to ensuring the safety of our staff, patients and visitors and continue to work on a number of areas to improve this.

2.8 Personal alarms will be available to staff in the Emergency Department (ED), Sidmouth and Whitley Wards from June with a direct connection to the security team. In ED there will be an increased security presence and some staff will be equipped with body worn cameras. A full training needs analysis has been undertaken and a new programme of conflict resolution training to equip staff with de-escalation and breakaway techniques will begin to roll out before the Autumn. A review of CCTV cameras and lighting is being carried out to ensure site security at all time. A full communications programme is in development including a "No Excuse for Abuse" campaign specifically focussed at violence, aggressive and abusive behaviour which will run alongside ongoing work including "Up the Anti" for anti-discriminatory behaviour and the Trust Sexual Safety Charter.

3. Strategic Objective 3: Deliver in Partnership

Strengthening the acute provider collaborative

3.1 The Trust has been working as part of an acute provider collaborative with our partners at Buckinghamshire Healthcare Trust (BHT) and Oxford University Hospitals (OUH) over the past 2 years. We have recently strengthened this relationship with the formation of an APC Board chaired by David Highton (Chair BHT), with membership including the 3 CEOs and other 2 chairs as well as a further non-executive director from each organisation.

3.2 The work programme covers reducing the number of patients with the longest elective waiting times across our geography, configuration of clinical services, financial sustainability and maximising the opportunity of scale across the 3 organisations regarding corporate services, procurement etc. The programme of work is led by executive directors from across the 3 organisations and will report consistently on the work of the APC to the 3 constituent boards.

4. Strategic Objective 4: Cultivate Innovation and Improvement

Global Clinical Site Accreditation

4.1 The Trust's clinical research has been recognised as 'world-class' after we became the first NHS trust to achieve full Global Clinical Site Accreditation by the International Accrediting Organisation for Clinical Research (IAOCR). This accreditation demonstrates that the Trust has met the global quality standard for Clinical Research Sites and is recognised for providing innovative new treatment opportunities for patients, conducting research safely and offering opportunities for commercial clinical research.

4.2 The accreditation was awarded following a comprehensive, evidence-based assessment of the Trust's clinical research processes including governance, workforce quality, site business strategy, patient engagement, feasibility, study start-up and initiation, study management and close down.

5. Strategic Objective 5: Achieve Long Term Sustainability

Financial Position

5.1 We are continuing to work alongside system partners to arrive at an acceptable budget position for 2024/25, with the extensive negotiations of earlier months continuing through May 2024 to arrive at plans which are deliverable and which help to reduce the system gap towards a breakeven position.

5.2 This continues to be challenging and is requiring focus across the organisation to balance cost reduction with sustaining the right level of resources to deliver, at the right level of quality, the volume of activity needed to restore access standards. The Trust's revenue plan position is for a deficit of circa £15m, which will support an internally funded capital programme of £22m.

5.3 Given these challenges, we have opted to put ourselves in a turnaround position and our Chief People Officer will be stepping into the role of executive turnaround director to ensure that we remain focused on the most efficient use of our resources and that we achieve that in a way which fully considers the quality of service we provide.

Building Berkshire Together (BBT)

5.4 In the last few weeks Andrew Statham and I were able to meet with parliamentary candidates for Berkshire and South Oxfordshire, to give them an introduction to the Trust and an overview of our case for a new hospital, and our asks of the New Hospital Programme (NHP) at this point. This proved very timely as the sessions concluded on the day of the general election announcement.

5.5 As set out in the paper later in the agenda we are awaiting an engagement with the NHP team following the submission of our site viability review. This meeting is critical to gaining clarity for the Trust and our patients on the scope of options for the new hospital and the timescales we should expect to be working to.

Integrated Performance Report

April 2024

Improving together to deliver outstanding care for our community

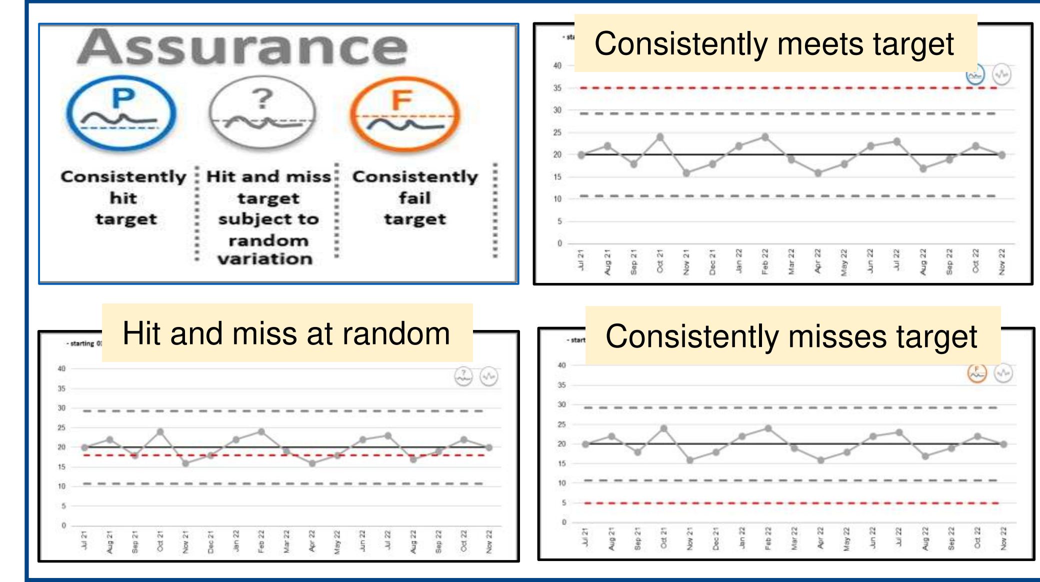
Guide to statistical process control (SPC)

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

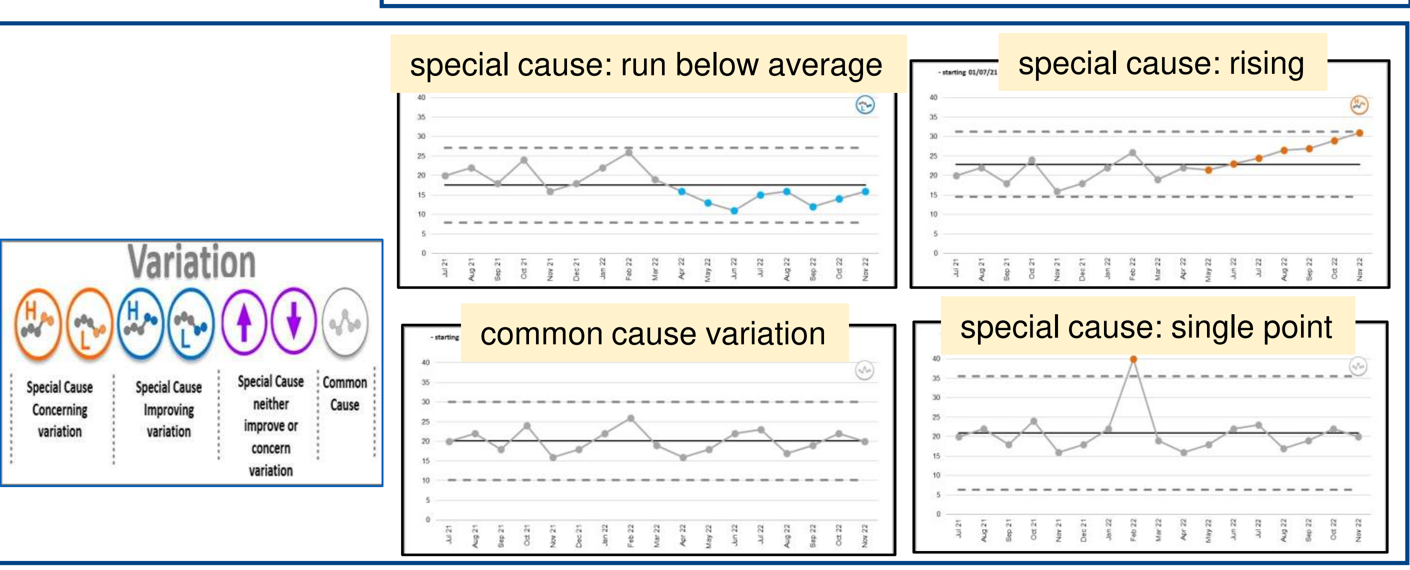


Each chart shows a VARIATION icon to identify either common cause or special cause variation. If special cause variation is detected the icon can also indicate if it is improving (blue) or worsening (orange).

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.

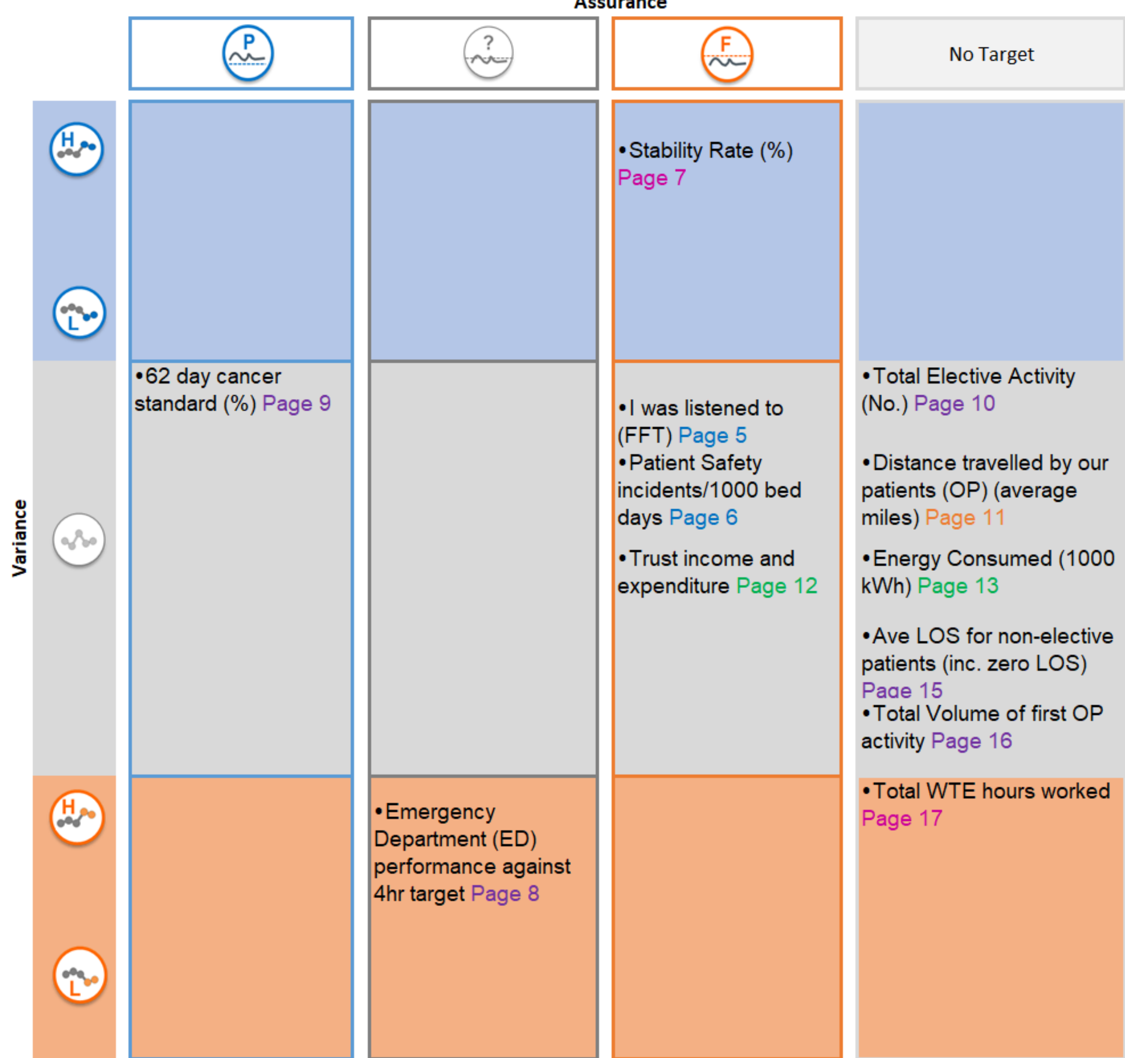


April 2024 performance summary

The data in this report relates to the period up to 30th April and is the first iteration of the refreshed Integrated Performance Report.

Key messages from the report are included below

- **Accident & Emergency performance** remains under significant pressure resulting from ongoing patient flow challenges across the Trust. As a result, we have struggled to make improvement to the 4 hour standard.
- **Cancer performance** continue to fall below national standards.
- Despite these pressures, the Trust currently continues to maintain a low number of long wait (>52) patients on the RTT **elective care standard.**
- Staff retention stability rate will be monitored to focus attention on the number of staff leaving the Trust and the Total Whole Time Equivalent in hours in order to monitor bank and agency usage.
- **Financial performance** as at Month 01 is a deficit of £1.96m which is £(0.45)m worse than the plan deficit of £(1.52)m. The Trust has enacted internal financial turnaround, in order to deliver our full year plan, and to seek routes for transformational change at scale.
- As in previous months, several **watch metrics** are outside of statistical control. Most relate to the operational pressures experienced in the Trust and are expected to improve in line with strategic metrics and there are two new alerting watch metrics related to Percentage of term babies admitted to neonatal unit and Non pay cost vs Budget (£m).



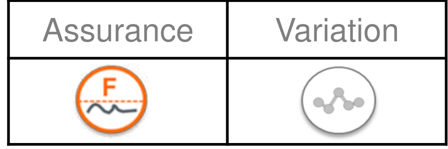
Strategic Metrics

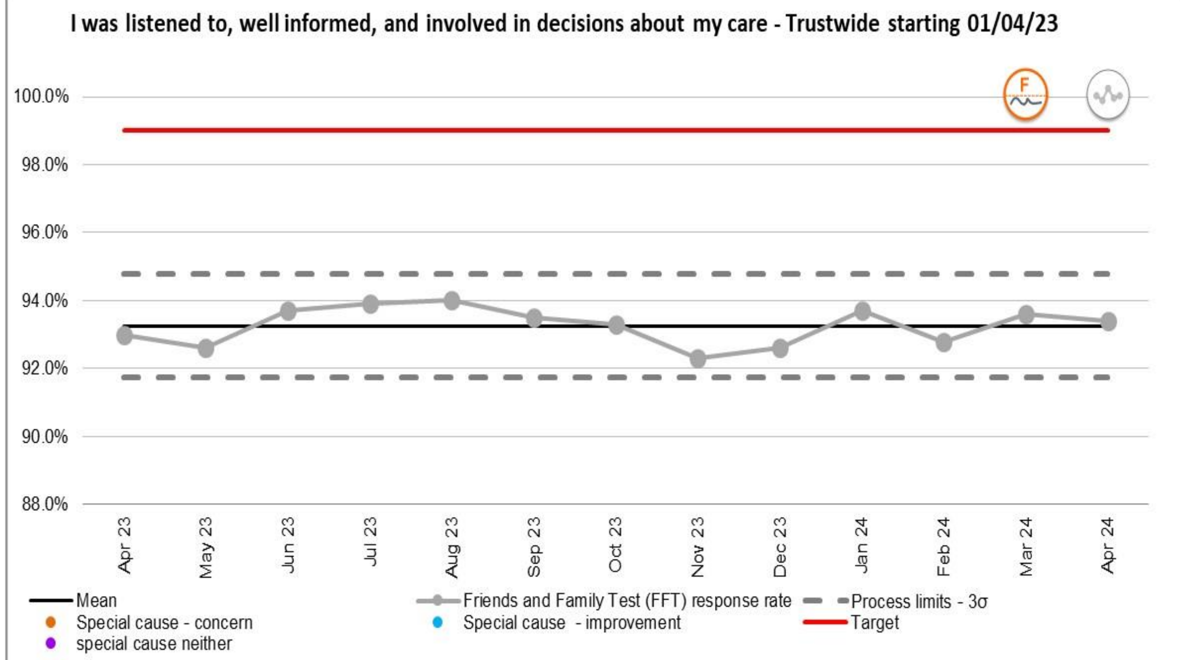
Strategic objective: **Provide the highest quality care for all**

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

Board Committee: Quality committee

SRO: Katie Prichard-Thomas





	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
I was listened to, well informed & involved in decisions about my care (FFT)	92.30%	92.60%	93.70%	92.80%	93.60%	93.40%
Inpatient FFT response rate (%)	38.7%	35.0%	40.0%	50.0%	34.5%	44.0%
Outpatient FFT response rate (%)	8.3%	9.5%	9.0%	9.8%	9.4%	9.8%
Maternity FFT response rate (%)	6.00%	4.00%	9.60%	13.00%	10.00%	5.00%

This metric 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:

- Average of 93% of patients Trust-wide feel they have been listened to and involved in decisions about their care
- Highest percentages for this question are in OP and IP
- Lowest percentage in the Emergency Department (ED)
- Response rates increasing in Inpatients since digitalisation

Actions and next steps

- Extend online survey to all Maternity areas to improve response rate
- Review Outpatients denominator to make sure it is giving accurate response rates
- Digitalise Day Case FFT

Risks:

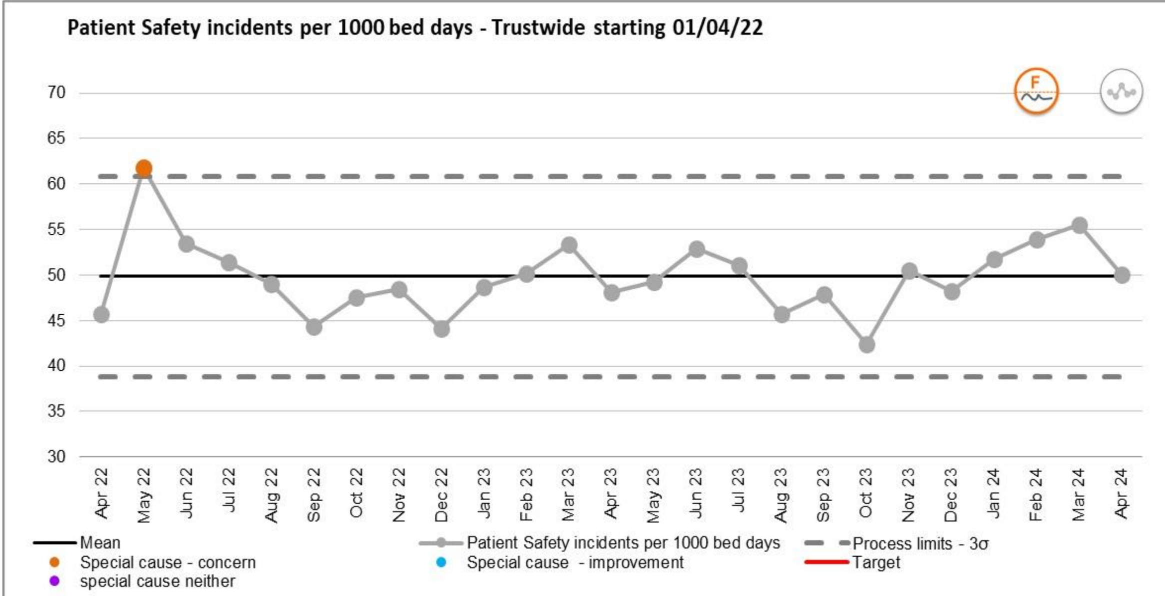
- Limited use of FFT in our top 5 languages – increase awareness to provide more diversity in our responses (Aug 2024)
- Poor response rates in key areas, review access to survey (June 24)
- Real time feedback not always actioned - improve notification of concerns and improve ('You said, we did') via data capture platform (IQVIA) trial

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



	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Patient Safety incidents per 1000 bed days	50.52	48.22	51.72	53.95	55.51	50.07
Patient Safety incidents/100 admissions	10.82	11.59	11.48	11.38	11.22	10.97
No. of Deteriorating patient incidents	20	12	17	16	24	14
FFT question: I felt safe during my visit to the hospital (%)	90.4%	90.2%	91.0%	90.5%	92.9%	94.6%
No. of medication incidents (affecting patients)	115	116	119	101	120	117

This metric 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:

- Levels of incident reporting appear consistent reflecting a good safety culture
- Patient's perception of their safety remains positive
- Additional new insight metrics have been selected to provide monitoring and assurance of the current trust PSIRF priorities
- Further PSIRF metrics can be found in the watch metrics

Actions and next steps

- To continue to monitor new metrics and understand trends
- Continue to implement PSIRF methodology

Risks:

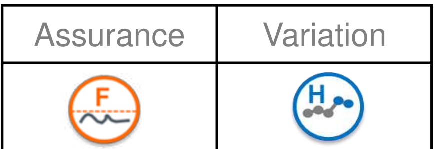
- Patient safety team resource constraints – additional workload created by PSIRF implementation
- Transition from Serious Incidents framework to PSIRF- changes in processes, reporting and closure remain a work in progress
- Risk of more qualitative data than quantitative for analysis purposes with the new methodology

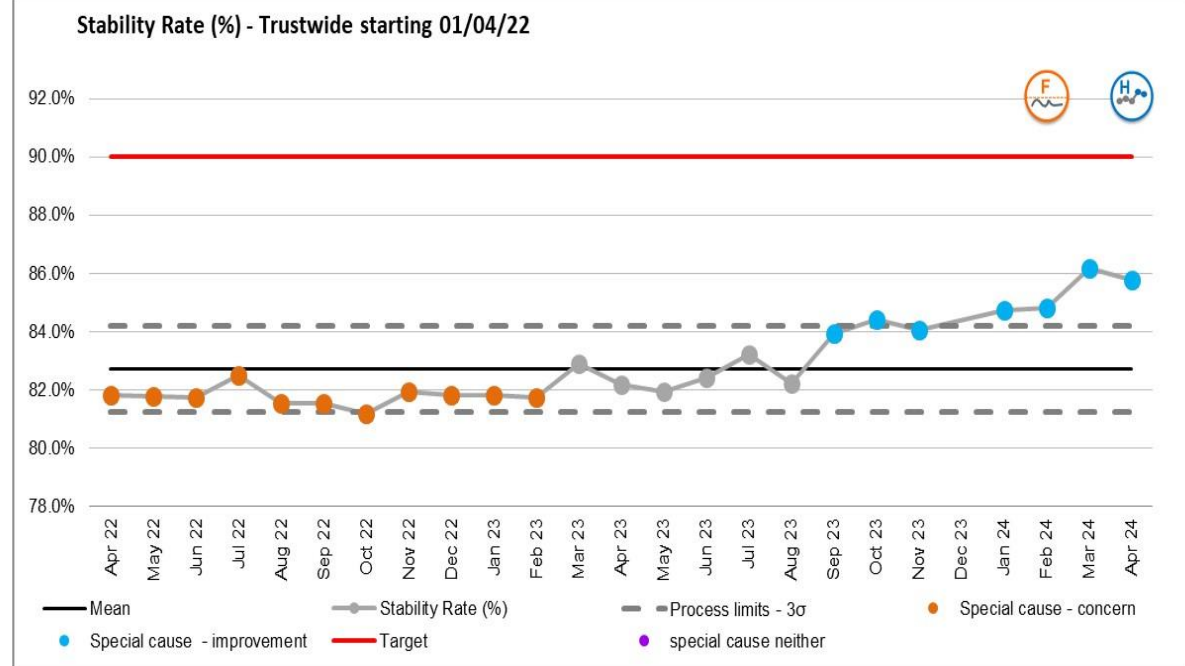
Strategic objective: **Invest in our people and live out our values**

Strategic metric: Improve retention

Board Committee: People Committee

SRO: Don Fairley





	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Stability Rate (%)	84.06%	N/A	84.75%	84.82%	86.16%	85.78%
Turnover rate %	11.67%	11.50%	11.15%	11.06%	10.77%	10.34%
Vacancy rate	7.67%	7.91%	7.03%	7.02%	6.82%	7.03%
Sickness absence (rolling 12 month)	3.53%	3.59%	3.56%	3.45%	3.48%	Arrears

This metric measures:

The Staff Stability Index, which is the percentage of permanent staff (headcount) who are still in post 12 months after appointment – giving an indication of how stable our new workforce is.

How are we performing:

- Despite not achieving the 90% target we are seeing an improvement in the stability trend over the previous 7 months
- We are exploring the data quality for Dec 2023
- Turnover continues in a downward trend

Actions and next steps

- Networked Care Group (NCG) Board and Head of Therapies working through Attraction and Retention scheme proposal for Occupational Therapists
- Widescale operationalisation of National Staff Survey Improvement plans across all services
- Realignment work on stay survey at 4 and 8 months to include onboarding, induction and probation
- Career Conversation training under development to ensure a shorter online offering and to link with career pathways resources

Risks:

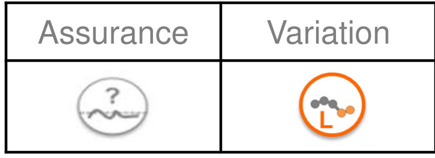
- Impact on our ability to decrease Bank and Agency costs
- System wide workforce control and oversight may be a risk to our ability to recruit substantively

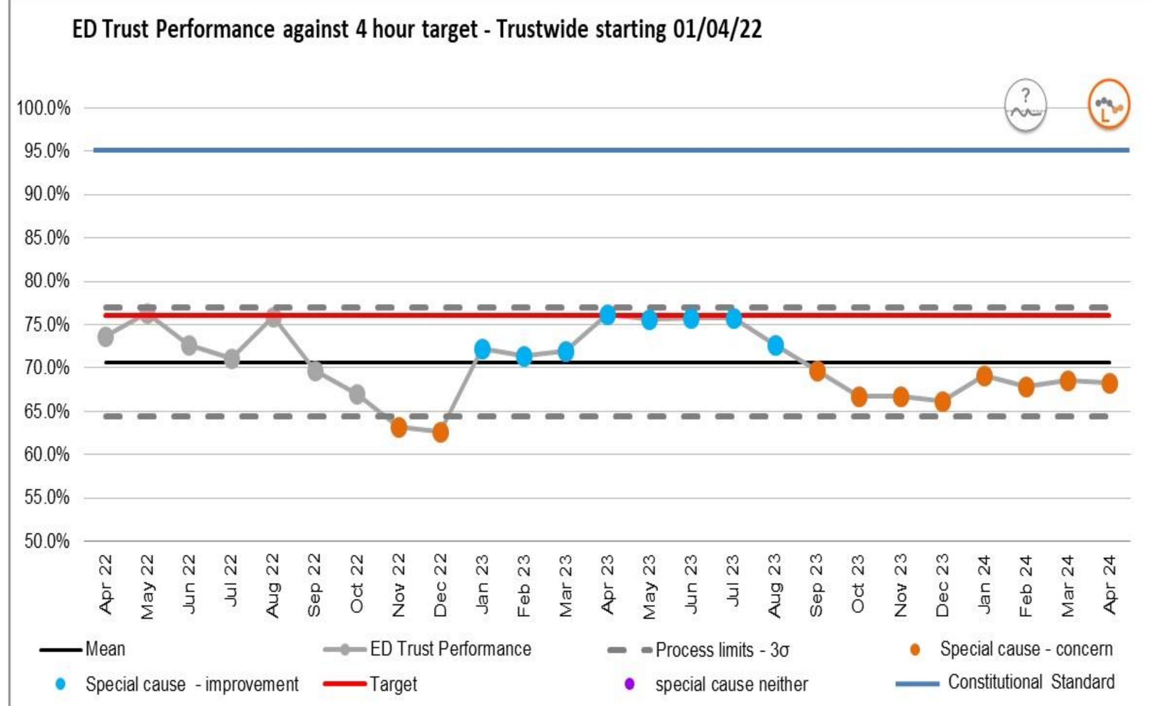
Strategic objective: **Deliver in partnership**

Strategic metric: Performance against 4hr A&E target

Board Committee: Quality Committee

SRO: Dom Hardy





	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
4hour Performance (%)	66.80%	66.21%	69.16%	67.83%	68.62%	68.29%
Total Attendances	14832	14411	14574	14416	15636	14531
Total Breaches	4924	4869	4494	4637	4906	4462
Ambulance Handover: 30 Minutes	372	376	375	318	369	343
12 hours from arrival in ED (%)	5.3%	5.9%	6.0%	4.9%	5.3%	6.4%

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 25.

How are we performing:

- 68.29% of patients were seen within 4 hours.
- High daily attendances continue, average 406 per day, 15 days >400
- ED Minors Unit activity decreased to an ave of 95 patients per day
- >60 & >30 minutes ambulance handover have improved. Further improvement challenged with decision to admit (DTA) capacity issues

Actions and next steps

- Reading Urgent Care Centre - Average utilisation of 14 slots per day.
- 12 o'clock huddle embedded with a focus on improving daily performance.
- Westcall usage saw an average of 8 patients referred per day
- Focus on reducing the number of queuing ambulances

Risks:

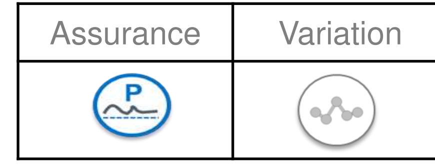
- Significant increase in Mental Health demand as well as incidences of Violence & aggression towards staff
- Significant space constraints of the current ED facility
- Dependence on specialties to see referred patients in a timely manner

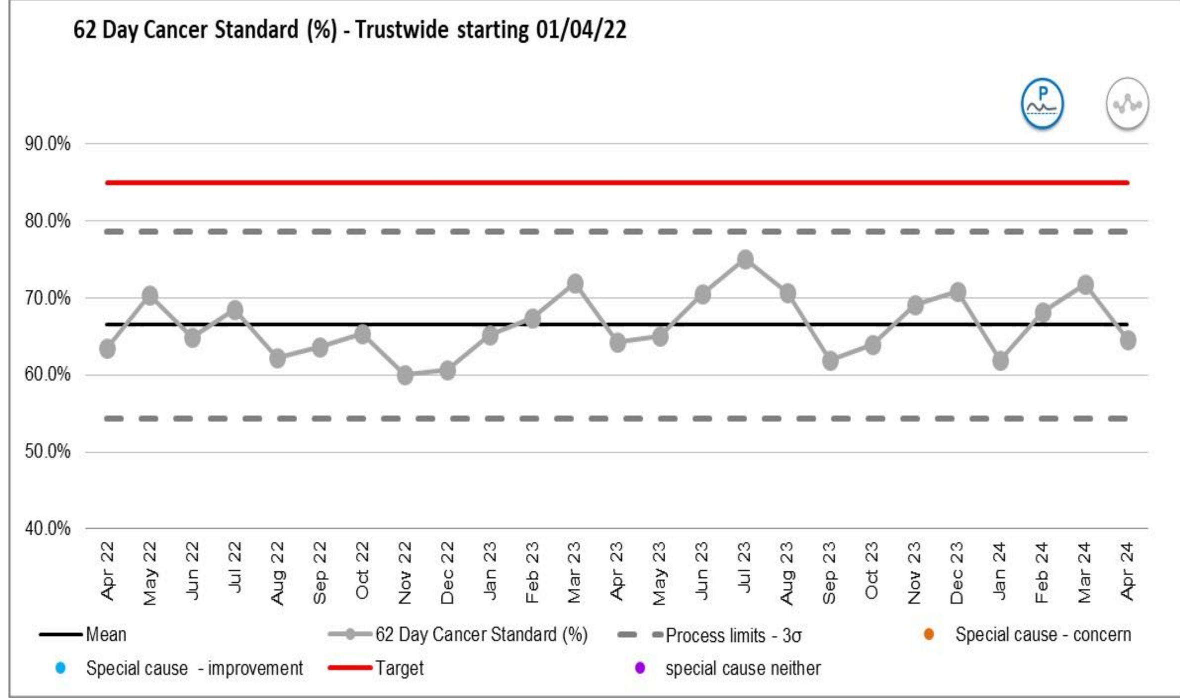
Strategic objective: **Deliver in partnership**

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

Board Committee: Quality Committee

SRO: Dom Hardy





	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Cancer 62 day %	69.10%	70.90%	61.90%	68.20%	71.80%	64.60%
No. on PTL over 62 days	294	327	302	248	226	224
% on PTL over 62 days	13.2	14.8	13.0	9.8	9.4	9.3
Cancer 28 day Faster Diagnosis	75.7	77.5	71.8	75.8	69.9	78.7

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%.

How are we performing:

- In March 71.8% of treated within 62 days. April's unvaliadated performance is was 64.6%
- The total number of patients on the PTL >62 days has fallen to 224. Still predominantly within skin, gynae and gastro.
- 31 day and 62 day is unlikely to pass / improve in the short term whilst backlog is cleared via additional capacity (Risk Assessed Targeted Initiatives (RATI) / Vitalis.

Actions and next steps

- Continue to work with TVCA and through internal services teams to provide additional capacity initiatives (RATI/Insource/Outsource)
  - Ongoing discussions re: utilisation of Community Diagnostic Centre (CDC) to support recovery across Skin, Gynaecology and Gastro.
  - Super Saturday plan (Dermatology) for May w/c 12/05

Risks:

- Not recovering sufficiently in skin, gynae and gastro
- High reliance on insourcing/outsourcing
- Service level agreement for delivery of plastics capacity from Oxford University Hospitals (OUH)

Strategic objective: **Deliver in partnership**

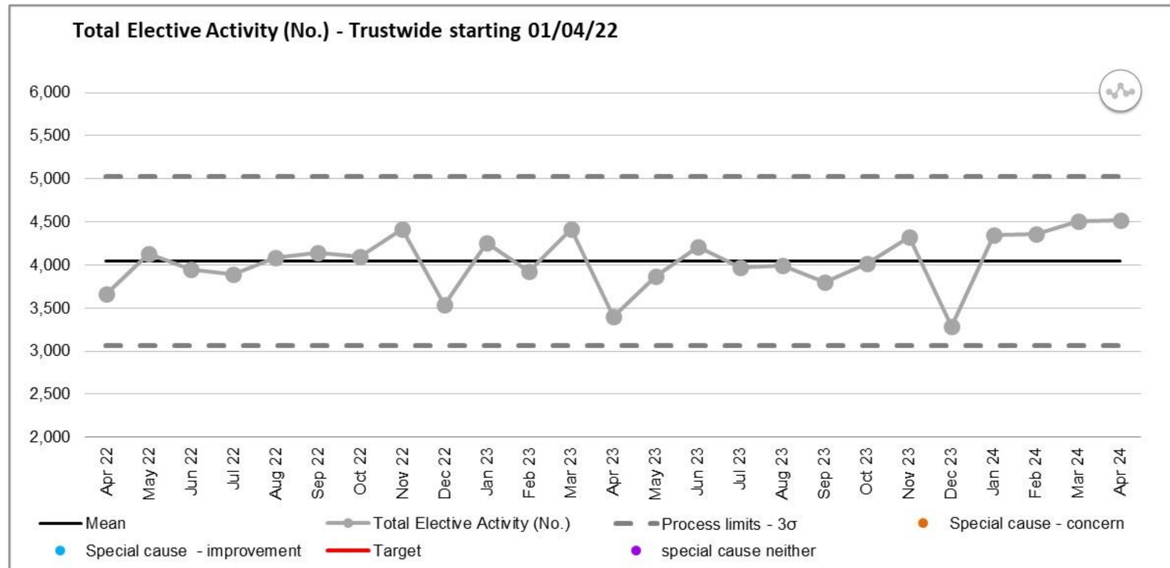
Strategic metric: Maximising Elective Activity

Board Committee: Quality Committee

SRO: Dom Hardy

Assurance	Variation
N/A	

NHS Royal Berkshire NHS Foundation Trust



	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Total Elective Activity (No.) (provisional)	4328	3286	4347	4361	4512	4514
% of plan for Daycases (cumulative)						
% of plan for Inpatients (cumulative)						
% of plan for Outpatient Attendances (News & Follow Ups (cumulative)						
Patients waiting > 65wks	0	1	2	3	0	1

This metric measures: The volume of elective activity taking place within the Trust. Targets will be aligned to submitted plans and Elective Recovery Fund (ERF) expectations.

How are we performing:

- Performance is monitored via SUS freeze reporting and is therefore 6 weeks behind. Crude M1 figures have been included as indicative only
- M1 Activity is above 22/23 and 23/24 levels but below plan.

Actions and next steps:

- Weekly activity performance meeting has been put in place to review outturn against plans and budgets, to define the gap and actions required to close the gap.
- Rapid analysis underway to assess current state vs risk adjusted expectations vs ERF expectations.
- Focus remains on delivering more activity across the board but with a particular focus on first outpatient.

Risks:

- Calculation of VWA – the exact method of calculation is difficult to replicate and there is no national solution for this. Current national data is at M10 23/24. This makes monitoring very challenging
- Inclusion/exclusion of Advice and Guidance and Follow Up activity
- Submitted activity plans include a level of risk associated to staff being in post to deliver activity at this level.

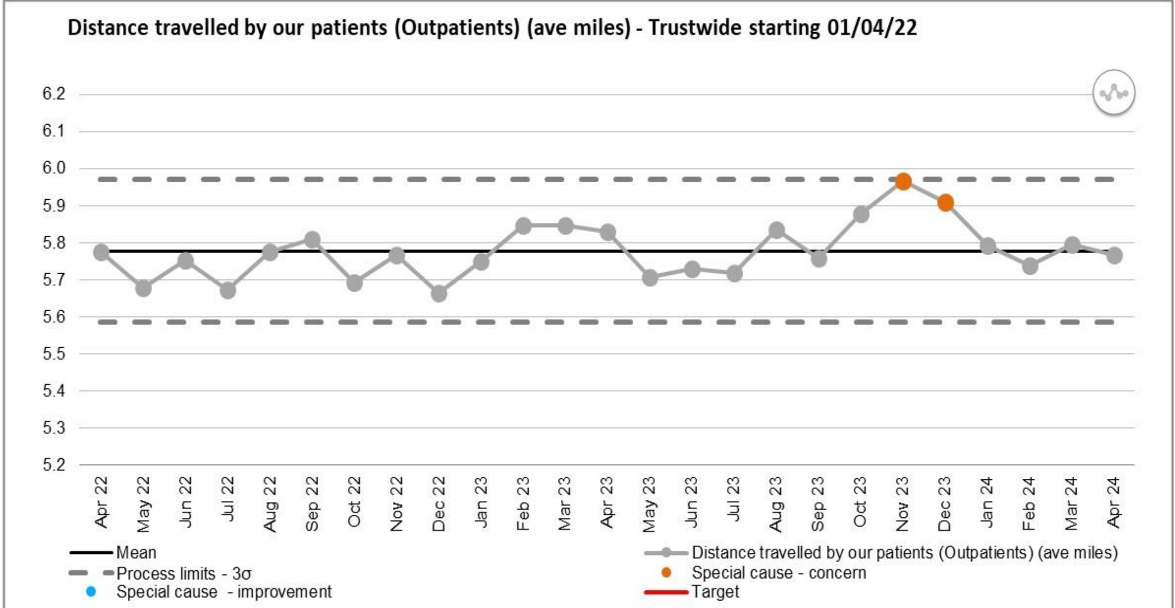
Strategic objective: **Cultivate Innovation and Improvement**

Strategic metric: Distance travelled by our patients (Outpatients)

Board Committee
Quality Committee

SRO: Andrew Statham

Assurance	Variation
N/A	



	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Distance travelled by our patients (average miles) (Outpatients including Virtual Attendances)	6.0	5.9	5.8	5.7	5.8	5.8
Number of Virtual attendances	11193	8434	10689	10346	10245	10286
Advice & Guidance (A&G) activity	2134	1709	2119	2187	2066	1983
Face to face (FTF) activity at non RBH sites	10240	7137	8847	8291	7916	8394

This metric measures:

We are tracking the **average miles travelled** for patients that attended an OP appointment, including virtual appointments and advice and guidance.

Delivering our strategy would result in this metric falling over time.

How are we performing:

- In April the average distance travelled was 5.8miles. Performance has been static over the past two years
- The number of virtual appointments, and A&G has remained constant over the time period
- Use of non RBH sites has remained constant over the period

Actions and next steps

- Delivery of 24/25 activity plan at specialty level including A&G increase
- Completion of the space review programme for Bracknell, Townlands and West Berkshire and identification of teams to occupy additional space at those sites
- Review of use of virtual OP as part of Digital Hospital programme

Risks:

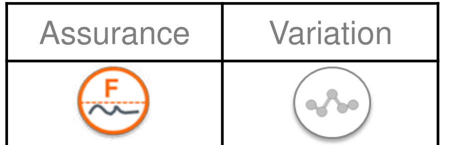
- Activity plan risks (see deliver in partnership)
- Ability to deliver some activity from non-RBH sites
- Additional costs of multisite delivery

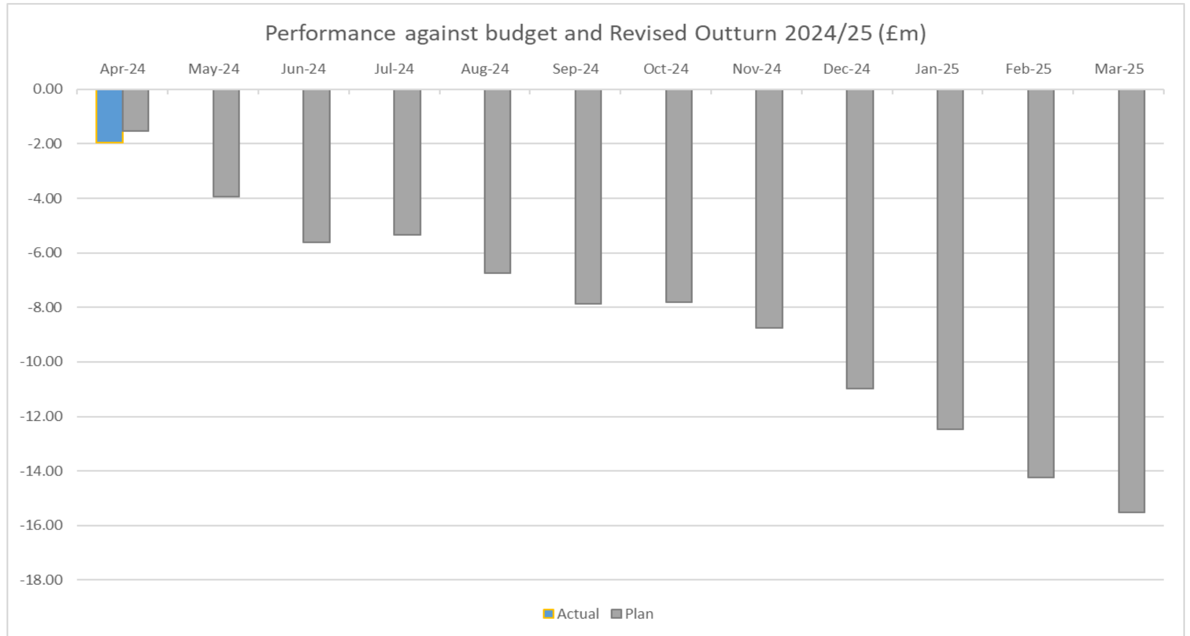
Strategic objective: **Achieve long-term sustainability**

Strategic metric: Trust income & expenditure performance

Board Committee
Finance & Investment

SRO: Nicky Lloyd





Metric Description	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Income as % of plan						105.20%
Pay as a % of plan						101.58%
Non Pay as a % of plan						113.47%
Cost Improvement Plans (CIP) (cumulative) (£)						£0.00
Value weighted activity £m)						£32.90m
Bank and Agency Spend (cumulative) (£m)						£2.03m

This metric measures:

Our performance against our financial plan for the year.

As part of our return to financial sustainability we submitted a plan on the 2nd of May 24 for a £15.50m deficit for the year.

How are we performing:

- We are £(0.45)m behind plan at April, M01 2024/25
- Income is ahead of plan, £2.58m
- Pay is higher than plan, £(0.49)m
- Non-pay is higher than plan, £(2.61)m

Actions and next steps

- Identification of recovery actions to ensure activity levels are in line with plan throughout the year
- Identification of £24.2m savings programme, (£15m internal, £6.2m full effect of 23/24 programme and £3m of systems)
- Align with newly convened Turnaround team to maximise delivery of efficiency programme in the first quarter
- Work across the ICS to develop system level savings, £3m

Risks:

- Expectation of further savings to support the wider system financial plan
- Under-delivery of agreed activity plans
- Delivery of system efficiencies

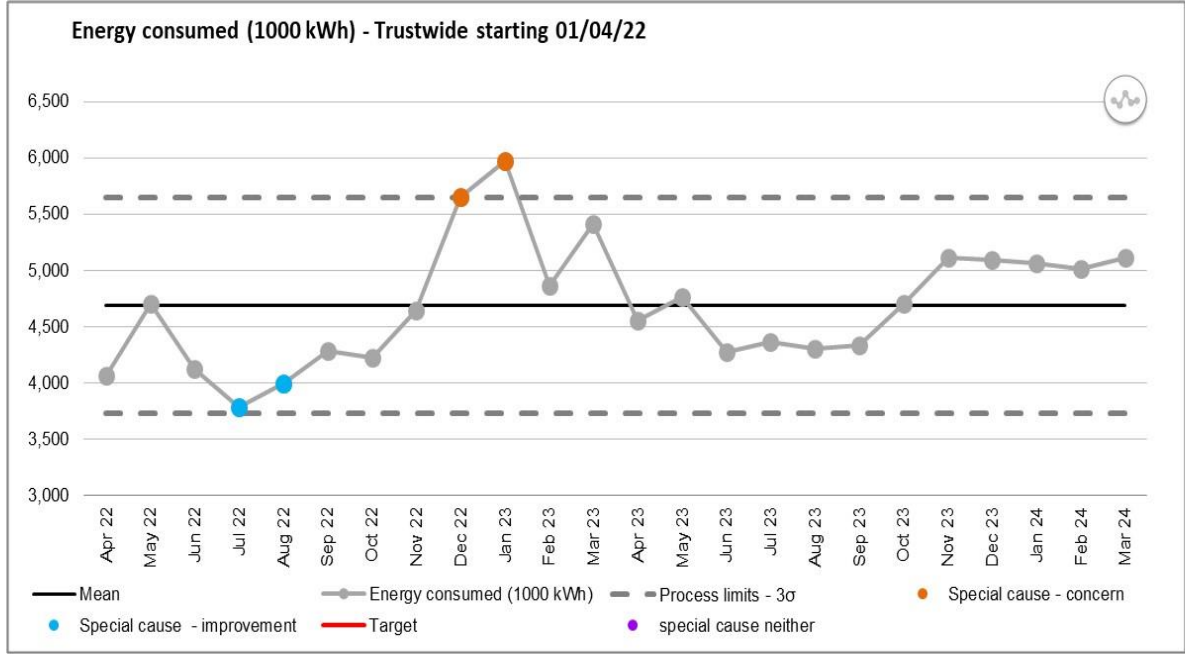
Strategic objective: **Achieve long-term sustainability**

Strategic metric: Energy consumed (1000 kWh)

Board Committee
Finance & Investment

SRO: Nicky Lloyd

Assurance	Variation
N/A	



Total electricity and gas consumption in kWh by month for all sites

	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Energy used (1000 kWh)	5117	5090	5059	5013	5113	Arrears
Electricity (1000 kWh)	185	213	183	141	223	Arrears
Gas (1000 kWh)	4931	4877	4876	4872	4890	Arrears

This metric measures:

We are monitoring our progress on carbon emissions by tracking our energy consumption in kWh in the month.

How are we performing:

- Our total energy consumption in April was higher than in the two previous years but within the statistical controls
- The RBH Combined Heat & Power plant is continuing to perform well, generating 1,341,414 kWh of electricity in March.
- This reduced our monthly imported electrical consumption to 223,000 kWh.

Actions and next steps

- Continue site review regarding future low Carbon skills funding and Public Sector Decarbonisation Scheme opportunities
- Continued reduction of energy consumption by refining Building Energy Management System controls
- Delivery of energy saving Back Log Maintenance Projects during 2024/25.

Risks:

- Aging RBH plant and infrastructure limitations.

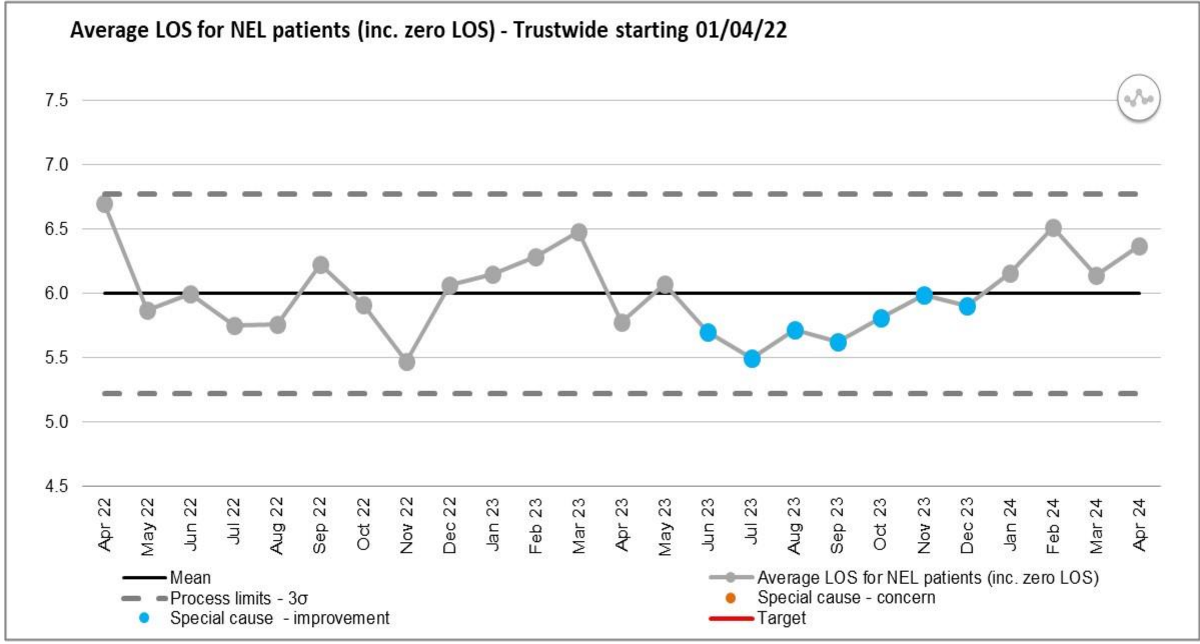
Breakthrough Priorities

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

Board Committee: Quality Committee

SRO: Dom Hardy

Assurance	Variation
N/A	



	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Ave LOS for NEL patients (inc. zero LOS	6.0	5.9	6.2	6.5	6.1	6.4
Bed Occupancy (%)	88%	86%	89%	87%	89%	90%
No. of patients with zero day LoS	1128	997	1082	1038	1103	1091
Ave number patients > 7 days	257	236	267	262	276	276
Ave number patients > 21 days	92	83	98	91	97	105
Ave no. of patients through discharge lounge per day	10	9	9	8	8	11

This metric 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 trust has taken longer to emerge from winter than hoped, and following some improvement in March, the average LOS rose in April
- Whilst this remains within normal fluctuations there is room to significantly improve on this performance in the coming months
- There are early indications of improvement for May

Actions and next steps

- Focus on Target Discharge Date accuracy and use of the discharge lounge
- Processes around TTOs and system working for complex discharges are also being addressed

Risks:

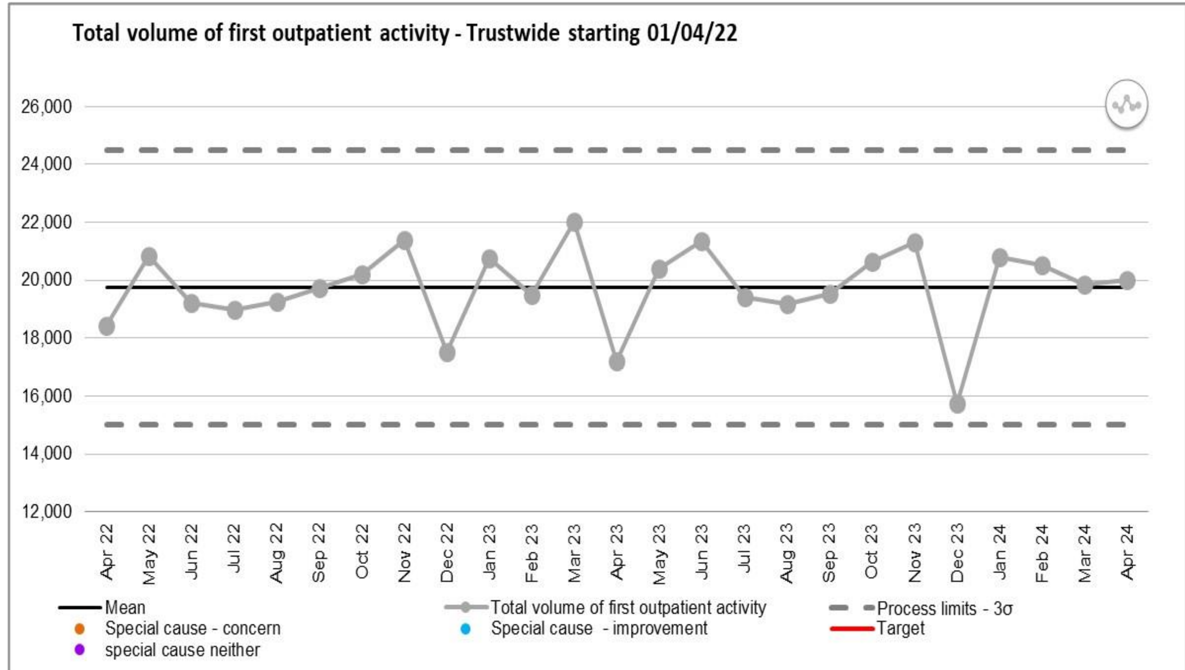
- Cultural norms prove harder to change than we hope
- Complexity across the Trust and externally makes success hard to identify
- Key staff groups more stretched and less able to engage in actions

Breakthrough priority metric:
Total volume of first outpatient (OP) activity

Board Committee: Quality Committee

SRO: Andrew Statham

Assurance	Variation
N/A	



	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Total Volume of first outpatient activity	21307	15745	20798	20507	19847	20007
% OP 1st + OPPROC vs. Total OP Activity (46% target)	42.8%	41.5%	42.0%	43.8%	43.2%	43.0%
1st OP DNA rate	7.50%	8.10%	8.10%	7.20%	7.00%	8.30%
1st OP cancellations (%)	8.70%	9.00%	8.80%	8.00%	8.00%	7.40%
First / Follow up rate	1.9	2.1	2.0	1.9	1.9	2.0

This metric measures:

The volume of first outpatient appointment (OPA) 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 by 33%

How are we performing:

- The volume of first 1st OPA, based upon the data that has been used to provide this chart, remains flat, despite the focus of operational teams
- As a developing breakthrough priority, a review of the data and business rules harnessed to support a meaningful (so what, what next) will take place over the coming weeks to refine this metric

Actions and next steps

- Refinement of the data utilised to support this metric to take place over the coming weeks (include both chart and table metrics)
- Planned Care leading work to improve the collection of OP Procedures (OPPROC) within the outpatient setting
- Trust wide rollout of eTriage, Phase 1 to commence in June 24, to support with optimisation of 1st OPA pathway

Risks:

- As a new metric current risk is associated with the need to refine the information to insight and the identification of high risk areas

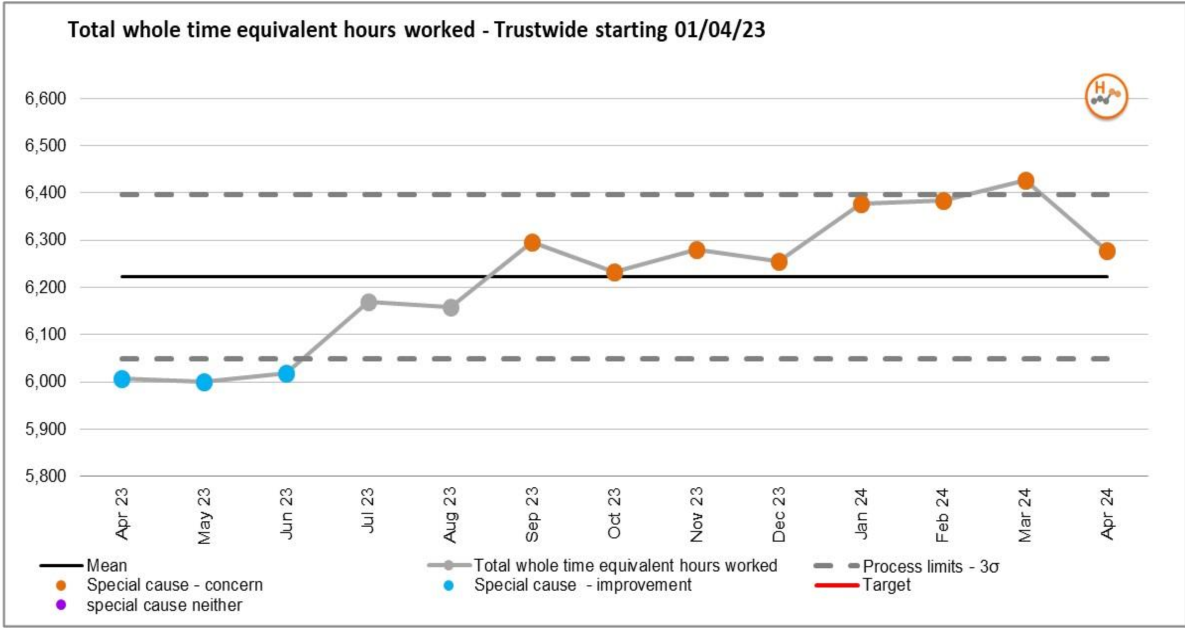
Breakthrough priority metric:
Total whole time equivalent (wte) hours worked

Board Committee: People Committee

SROs: Nicky Lloyd/ Don Fairley

Assurance	Variation
N/A	

Royal Berkshire NHS Foundation Trust



This metric measures:
The total WTE hours worked within the Trust, broken down by bank, agency, and substantive workforce. Delivery of our financial plan requires us to make inroads into our total pay costs with a key focus on managing the contingent labour position.

How are we performing:

- The total WTE worked fell in April relative to March but remained c.250 higher than this time last year
- Agency reduced month on month (MoM) by 16 WTE, total cost reduced by 200k year on year (YoY)
- Bank usage reduced by 141 WTE, total cost reduced by 185k YoY
- Overall WTE hours have reduced MoM by 150 WTE or 2.3%

	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24
Total WTE hours worked	6280	6255	6376	6385	6428	6278
Substantive WTE	5840	5872	5902	5921	5954	5962
Bank WTE	362	319	407	398	416	275
Agency WTE	78	64	67	66	58	42
Vacancy rate	7.67%	7.91%	7.03%	7.02%	6.82%	7.03%
Ave time to hire (clinical) (days)	63	62	66	62	52	57
Ave time to hire (non-clinical)	57	48	50	49	52	53

Actions and next steps:

- Full review of bank usage and control measures to be put in place
- Continued reduction of agency usage and controls
- Current pause of Internationally Education Nurses (IEN) onboarding
- Continue review of non-clinical roles through Workforce Control Panels

Risks:

- Reduction in the use of Agency staff may result in niche roles not being filled

Summary of alerting watch metrics

Introduction:

Across our five strategic objectives we have identified 111 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 April 2024:

In the last month 10 of the 111 metrics exceeded their process controls. These are set out in the table opposite.

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 mixed sex accommodation

For this month there are 2 new alerting metric:
- Non pay cost vs Budget (£m)
- Percentage of term babies admitted to neonatal unit

Better Payment Practice Code achievement of 88.9% by volume and 93.5% by value for April 2024, a significant improvement. On track to return to national standard of 95%.

Provide the highest quality of care for all
- Mixed sex accommodation breaches
- FFT Response – Maternity
- Percentage of term babies admitted to neonatal unit

Invest in our staff and live out or values
- Ethnicity progression disparity ratio
- Appraisal rates

Deliver in Partnership
- Proportion of patients with high risk TIA fully investigated and treated within 24 hours
- Cancer 31 day drug treatments

Cultivate innovation and improvement
- % OP treated virtually

Achieve long term sustainability
- Pay cost vs Budget (£m)
- Non pay cost vs Budget (£m)

Title:	Royal Berkshire Foundation Trust (RBFT) Operational Performance Trajectories: 2024-25
Agenda item no:	10
Meeting:	Board of Directors
Date:	29 May 2024
Presented by:	Dom Hardy, Chief Operating Officer
Prepared by:	Dom Hardy, Chief Operating Officer

Purpose of the report	The purpose of this report is to: • present the current planned forecast delivery trajectories through 2024-25 against key national standards; • summarise the assumptions, outstanding issues, risks and mitigations for these trajectories; • ensure the Board has fully discussed and supported these trajectories.

Report History	Operational Management Team: 15 April 2024 Executive Management Committee: 22 April 2024

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

Resource Impact:	Links to earning Elective Recovery Fund income for 24-25 and therefore delivery of the Trust's financial position
Relationship to Risk in BAF:	Links to BAF risks 1.1 (if we allow material lapses in the quality of care, including access to care…) and 1.2 (if we do not deliver our clinical and quality opportunities at the intended pace…)
Corporate Risk Register (CRR) Reference /score	4172, 4241, 5698, 5995
Title of CRR	ED capacity and compliance; compliance with cancer standards; compliance with DM01; failure to achieve elective targets

Strategic objectives This report impacts on (tick all that apply)::	
Provide the highest quality care	X
Invest in our staff and live out our values	X
Drive the development of integrated services	X
Cultivate innovation and transformation	X
Achieve long-term financial sustainability	X

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	X	Public	

1 Executive Summary

1.1 NHS England's 2024-25 priorities and operational planning guidance[i] sets out performance expectations for ICBs, Trusts and primary care providers for this financial year.

1.2 The guidance makes clear that "the overall priority in 2024-25 remains the recovery of our core services and productivity following the COVID-19 pandemic". 4 of the 6 headline priority areas stated in the guidance directly relate to RBFT's services:

- Maintain our collective focus on the overall quality and safety of our services, particularly maternity and neo-natal services, and reduce inequalities in line with the CORE20PLUS5 approach;
- Improve ambulance response and A&E waiting times by supporting admissions avoidance and hospital discharge, and maintaining acute bed and ambulance service capacity that systems and individual providers committed to put in place for the final quarter of 2023-24;
- Reduce elective long waits and improve performance against the core cancer and diagnostic standards;
- Improve staff experience, retention and attendance.

1.3 The remaining 2 headline priority areas – improving access to primary care, and to mental health services – also support delivery of the 4 areas that RBFT will focus on.

1.4 The specific objectives against performance standards are set out in the table at paragraph 2.1 below; the paper then provides the current planned trajectory in each case together with a summary of delivery assumptions, risks and mitigations.

1.5 In summary, the Trust is currently planning to be compliant with all but 2 objectives at this stage; the non-compliant areas are for ED performance against the 4-hour standard and for the new outpatient standard. Work continues in both cases to reach compliance.

2 National NHS objectives for 2024-25

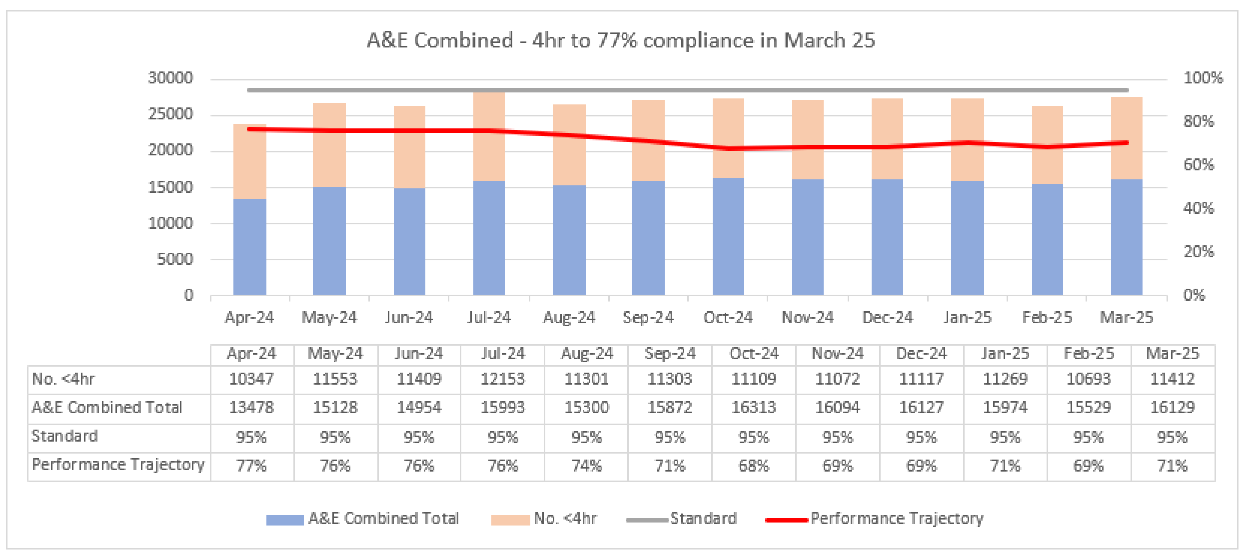
2.1 The table below sets out the NHS England performance objectives for 2024-25 that relate to RBFT, together a current status assessment as part of the Trust's operating plan:

Performance area	New / existing	Specific objective and metric	Current status of RBFT plan
Urgent and Emergency Care	Existing	Improve A&E waiting times, compared to 2023-24, with a minimum of 78% of patients seen within 4 hours in March 2025	Non-compliant
Elective care	Existing	Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest	Compliant
	Existing	Deliver (or exceed) the system-specific activity targets, consistent with the national value-weighted activity target of 107%	Compliant
	New	Increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46% across 2024-25	Non-compliant at this stage – baseline and improvement trajectory not yet established
Cancer	Existing	Improve performance against the headline 62-day standard to 70% by March 2025	Compliant
	Existing	Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025	Complaint
Diagnostics	Existing	Increase the percentage of patients that receive a diagnostic test within 6 weeks in line with the March 2025 ambition of 95%	Compliant

[i] NHS England » Priorities and operational planning guidance 2024/25

2.2 The national targets we are able to forecast against at this time are presented in the charts below with accompanying assumptions/risks.

ED 4 hr standard

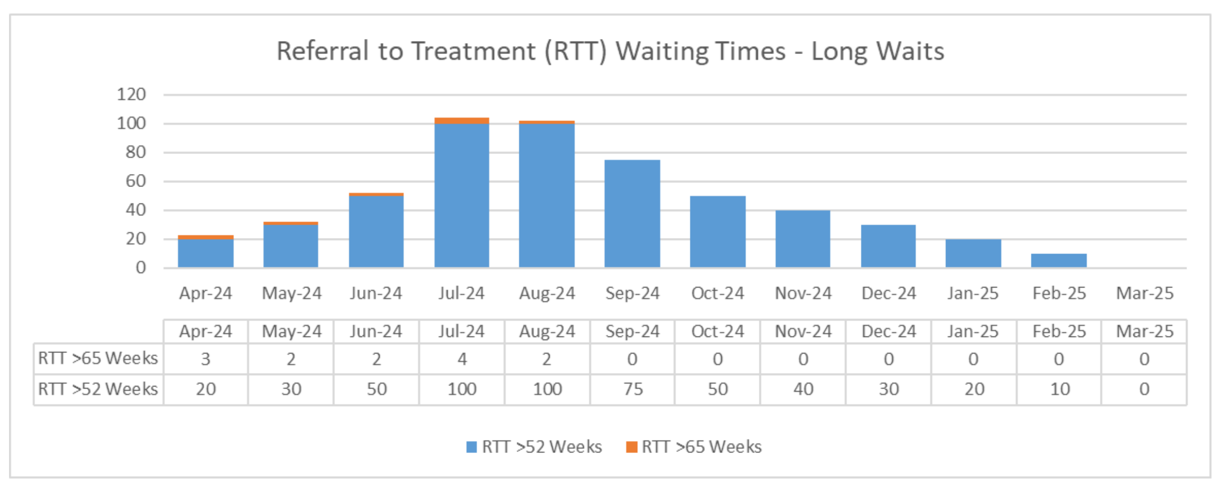


	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
No. <4hr	10347	11553	11409	12153	11301	11303	11109	11072	11117	11269	10693	11412
A&E Combined Total	13478	15128	14954	15993	15300	15872	16313	16094	16127	15974	15529	16129
Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Performance Trajectory	77%	76%	76%	76%	74%	71%	68%	69%	69%	71%	69%	71%

- Demand is not expected to reduce from high levels last year and in 2022-23.
- Current monthly all-types performance has plateaued at c70% for the second half of 2023-24 so, even allowing for some possible seasonal improvement during Q1 and Q2, nd a continued focus on the improvement actions that are within RBFT's control, delivery of 78% will not be possible without further significant intervention.
- RBFT is working with the ICB to understand what options exist once the current town-centre UCC facility contract ends in June.

Elective Activity

Long Waits (65, 52)



	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
RTT >65 Weeks	3	2	2	4	2	0	0	0	0	0	0	0
RTT >52 Weeks	20	30	50	100	100	75	50	40	30	20	10	0

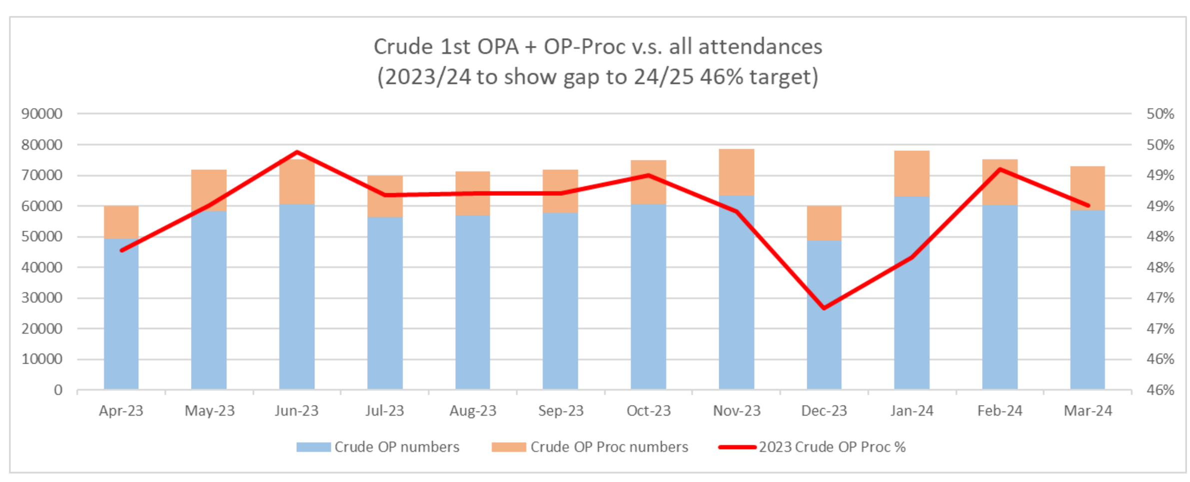
- The expectation is that the Trust complies with this objective
- The core assumptions here are that:
  - Activity is focused particularly on waits to 1st outpatient appointments (and subsequent diagnostics)
  - No industrial action impact to 1st OPA activity. MWL and the e-triage app are deployed in April 24

Value-weighted activity

- The expectation is that the Trust will deliver 107% of value-weighted activity (VWA) compared with 2019-20 levels

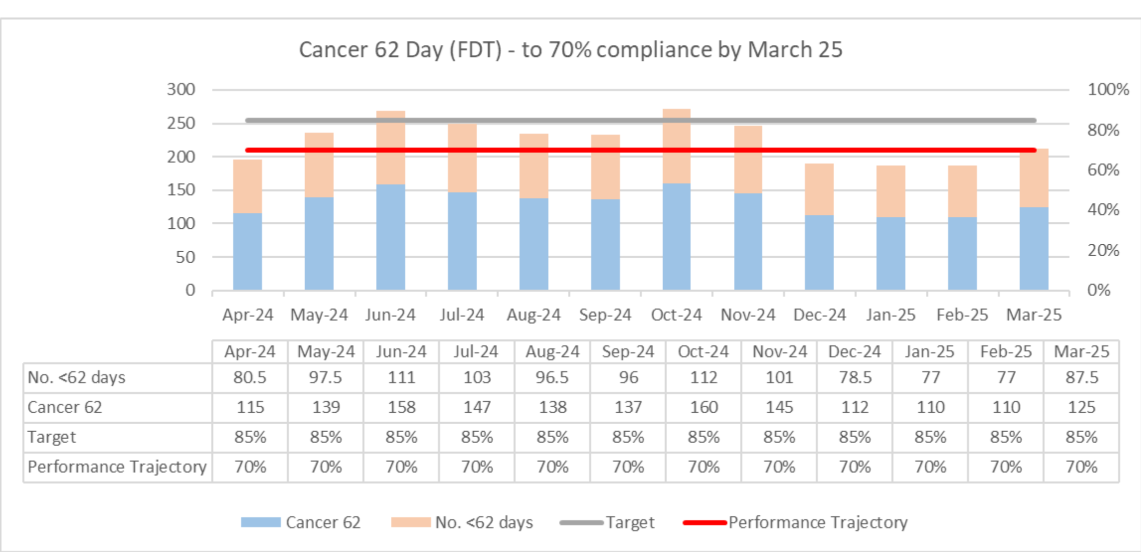
- The key assumption is that teams can do additional activity above baseline capacity by recruiting, through insourcing and via premium-rate work. The costs of this work have been built into budgets for 2024-25
- Teams need to be able to record, count, code and attract income for all activity.
- The Trust is reliant either on no further industrial action or adequate recompense for lost working days should it happen.

1st Outpatient appointments and Outpatient procedures as a % of all Outpatient activity



- 2023/24 crude outpatient activity provided to inform discussion. This signals that we should expect to be compliant with this measure.
- However, further work is required for this new metric to better understand the RBFT baseline position and to develop a trajectory for delivery as required, underpinned by activity
- Additional clarity is also required to understand any national inclusion/exclusion criteria that may be applied centrally.

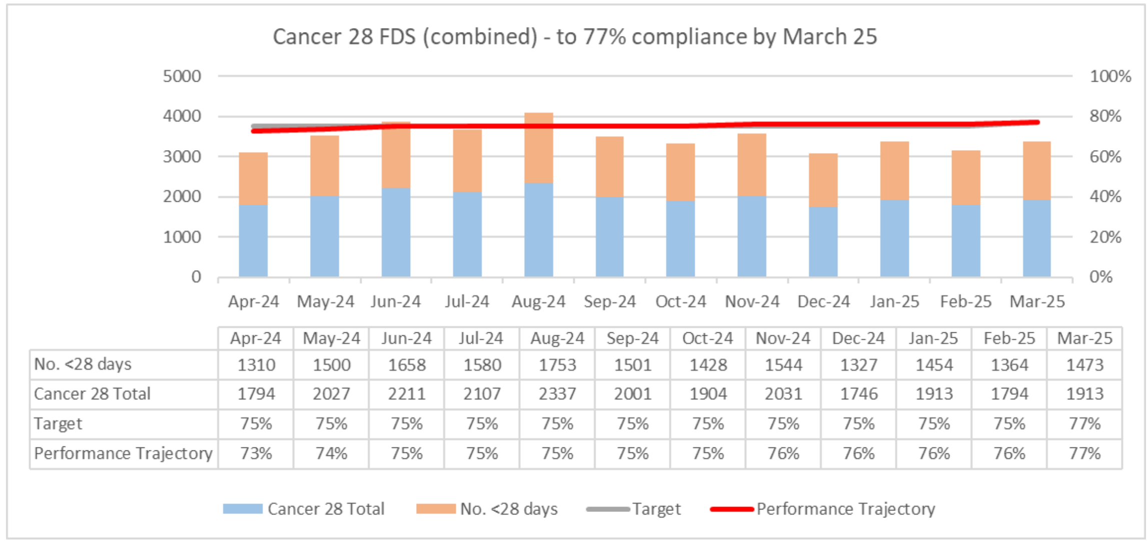
62 Day standard



	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
No. <62 days	80.5	97.5	111	103	96.5	96	112	101	78.5	77	77	87.5
Cancer 62	115	139	158	147	138	137	160	145	112	110	110	125
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Performance Trajectory	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%

- The expectation is compliance with the national objective for this standard;
- That is dependent on continuing to address known capacity issues in key high-volume pathways (skin, gynae, GI, urology) – which in turn is dependent on RATI and insourcing;
- It is also dependent on TVCA funding some of this capacity.

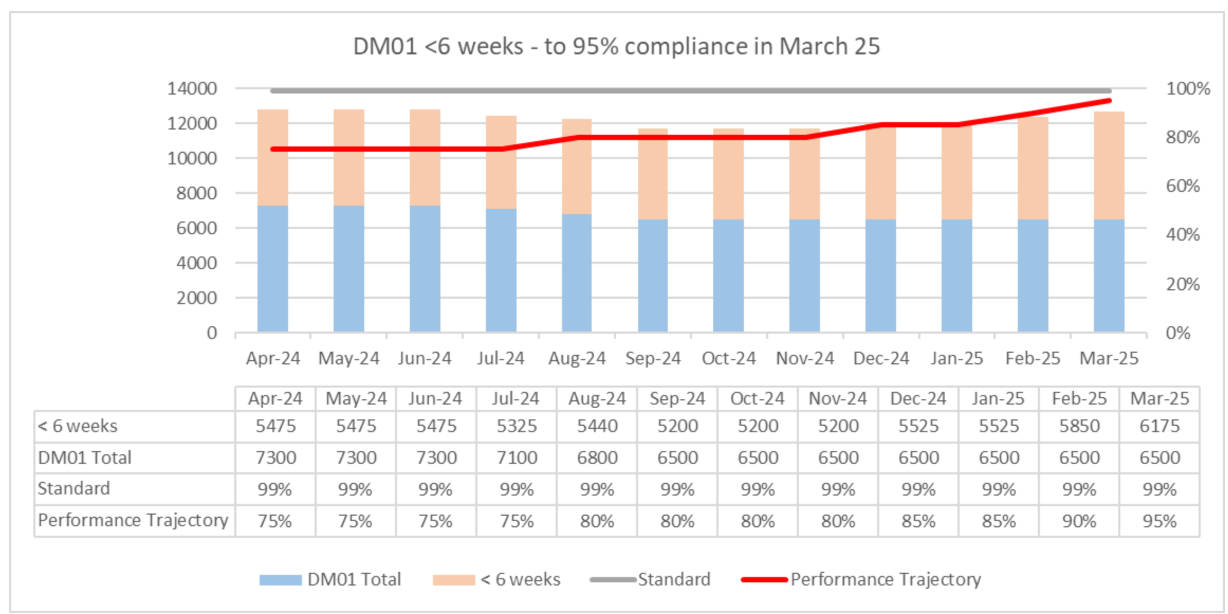
28 Day Faster Diagnosis



	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
No. <28 days	1310	1500	1658	1580	1753	1501	1428	1544	1327	1454	1364	1473
Cancer 28 Total	1794	2027	2211	2107	2337	2001	1904	2031	1746	1913	1794	1913
Target	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	77%
Performance Trajectory	73%	74%	75%	75%	75%	75%	75%	76%	76%	76%	76%	77%

- Expectation is compliance;
- However the dependencies are the same as for the 62-day standard above.

DM01 (>1% patients waiting 6 wks or more for diagnostic test)



	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
< 6 weeks	5475	5475	5475	5325	5440	5200	5200	5200	5525	5525	5850	6175
DM01 Total	7300	7300	7300	7100	6800	6500	6500	6500	6500	6500	6500	6500
Standard	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
Performance Trajectory	75%	75%	75%	75%	80%	80%	80%	80%	85%	85%	90%	95%

- Current performance is just under 75%
- assumes maintained performance in MRI and recovery of CT, Endoscopy and Cardiology – which in turn are dependent on a combination of RATI and insourcing work

3. Next Steps

3.1 Work will continue not only to refine trajectories and their presentation but to provide final confirmation that, especially in the case of elective standards, plans are in place to lay on the capacity and activity required. We expect this to be complete by the end of the month for the final national planning return on 2 May.

3.2 Assurance for delivery against these standards will be provided through the usual reporting routes i.e. monthly Care Group Performance Review Meetings, Executive Management Committee and ultimately Board of Directors.

3.3 The Board is invited to support this paper.

Title:	**Building Berkshire Together (BBT) Update**
Agenda item	11
Meeting:	Board of Directors
Date:	29 May 2024
Presented by:	Steve McManus, Chief Executive
Prepared by:	Andrew Statham, Director of Strategy Alison Foster, Programme Director, BBT

Purpose of the Report	To update the Board of Directors on key developments relating to the replacement of the Royal Berkshire Hospital

Report History	Content discussed at Finance and Investment Committee May 2024

What action is required?	
Assurance	
Information	The Board is asked to NOTE the submission of reports to the New Hospital programme team and the forward looking work programme
Discussion/input	
Decision/approval	

Resource Impact:	
Relationship to Risk in BAF:	
Corporate Risk Register (CRR) Reference /score	4183 Management of Estates Infrastructure/Backlog Maintenance/20 4182 Risk to achieving strategic objective of financial sustainability/20 4459 Staff welfare and support to ensure workforce resilience/9 4177 Staff Retention/9
Title of CRR	See above

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	x
Achieve long-term sustainability	x

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

Publication							
Published on website			Confidentiality (FoI)	Private	x	Public	

1. Purpose

1.1. The purpose of this report is to update the Board on two reports that the Trust has completed (site viability review, and site criteria engagement) and provide an overview on the work we will be doing over the next few months (impact assessment).

1.2. The Board is asked to note the conclusions of reports completed and the plans for the impact assessment.

2. Site viability and options report:

Background

2.1. In December 2023, the Trust met with NHP to discuss the gap between the NHPs funding earmark for the Trust and the Board's preferred way forward.

2.2. At that meeting the NHP requested that an independent team (Mott MacDonald) conduct a technical study covering the value of investing the current site:

- The factors affecting the viability of the current site (should RBH move?)
- The timescales affecting when a relocation is required (when should RBH move?)
- The issues preventing a timely relocation (when could RBH move?)

2.3. The Report has now been completed and submitted to the NHP for consideration. A summary of the report is provided at appendix 1.

2.4. The Board will note that the report only considers the economic and technical case for relocation and its intent is to seek alignment of the funding expectations between the Trust and NHP. It is not a substitute for formal business cases and consultation which the Trust is committed to working through with patients, staff and partners.

Key messages

2.5. The report makes value for money case for relocation due to the additional costs and timescales of developing on the current site. Key factors influencing this conclusion are:

- The landlocked nature of the site that has few clear areas for development
- The restrictions on development due to surrounding residential and conservation areas
- Underlying geology, especially areas to the North of the site.
- The challenges of developing while operating clinical services 24/7.
- Additional requirements of the Hospital 2.0 relative to traditional methods of construction.
- The need for future expansion and reconfiguration potential.

2.6. In reaching its conclusion the report explored the merits of a number of options, a high-level summary of each is set out below:

- **Redeveloped existing site:** This option involves the redevelopment of the existing hospital site over 14 years and 26 stages to deliver a mix of new build and remodelled/refurbished existing buildings that together deliver a new hospital. indicates the complexity of stages and the level of new build/retained estate.
- **New build site:** The new build hospital on a new site option consists of a new build acute hospital on a new site location with all the services of the existing Royal

Berkshire Hospital relocated to a new site, but delivering a hospital that meets the new schedules of accommodation generated through the new clinical model.

- **Hybrid Option:** This is an option where the required RBH hospital services are part located on a new site and part retained (in remodelled and refurbished existing building stock) on the existing site. The split of services would be on the basis of a "hot site" and a "cold site".
- **New Site – 1st phase (hot site):** The phased new hospital on a new site (split over 2 funding rounds) would deliver phase 1 within the current funding round which would be a "hot site" (Urgent/Critical) on a new site with on this site and the "cold site" (Elective) remaining on the existing site within existing accommodation (with some level of refurbishment / remodelling) until further funding is obtained to complete the cold site on the new site.

2.7. The Viability report was submitted to NHP, on 29 April 2024. We have requested a meeting with the SRO for the New Hospital Programme to discuss this further.

2.8. <u>The Board is asked to Note the findings of the independent Mott MacDonald report.</u>

3. Site criteria engagement:

3.1. In January 2024 in anticipation of the NHP supporting the Trust to explore the benefits of relocation the Trust launched a site evaluation criteria survey. The aim of the engagement was to collect a wide range of views on how to best evaluate potential sites, whether the identified criteria required further refinement and if anything was missing from them.

3.2. A total of 2301 responses were received. Respondents from all areas said that access by car (57%) and access by public transport (54%) was most important to them when considering site location. The full findings of the report are available on the Building Berkshire Together website. The results will support the Trust in appraising potential sites for relocation should this be supported.

3.3. <u>The Board is asked to note the findings of the site criteria engagement</u>

4. Impact assessment:

4.1. The Trust has begun work on an Integrated Impact Assessment (IIA) to evaluate and communicate the potential effects of relocating the hospital on patients, staff, and the broader community. After a competitive bidding process, KPMG was selected to conduct the IIA, with significant engagement activities scheduled for May, June, and July 2024. The work is expected to conclude by August 2024.

4.2. Stakeholder input will be gathered during the data collection phase (May-July 2024), starting with staff engagement. The communication and engagement strategy for the IIA is based on key principles such as transparency, accessibility, fairness, collaboration, two-way feedback, and proportional engagement. The IIA aims to ensure thorough engagement, representing the diverse communities potentially impacted by the hospital relocation.

4.3. The IIA will examine the effects on Trust healthcare services and will analyse the broader impacts on population health/inequalities, the wider community, and nearby trusts and sectors. The analysis will focus on the patients/population assessment to address health disparities.

4.4. The process will be consolidated, assessing risks and benefits, and key outputs will be communicated through a final IIA report that itself will inform future consultation and decision making business cases (DMBC).

4.5. <u>The Board is asked to note the future work on the Impact Assessment.</u>

Title:	**NHS England Self-Certification 2023/24**
Agenda item no:	12
Meeting:	Board of Directors
Date:	24 May 2024
Presented by:	Nicky Lloyd, Chief Finance Officer Caroline Lynch, Trust Secretary
Prepared by:	Caroline Lynch, Trust Secretary

Purpose of the Report	To approve the self-certification statements for 2023/24

Report History	N/A

What action is required?	The Board is asked to approve the self-certification statements for 2023/24
Assurance	
Information	
Discussion/input	
Decision/approval	✓

Resource Impact:	None
Relationship to Risk in BAF:	Not applicable
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 Background

1.1 The Compliance Framework published by NHS England requires foundation trusts to submit an Annual Plan each year. The Plan is used by NHS England primarily to assess the risk that a foundation trust may breach its Licence in relation to finance and governance. NHS England will also assess the quality of the underlying planning processes.

1.2 As part of the submission the Board is required to self-certify against a number of prescribed statements as either 'confirmed' or 'not confirmed'.

1.3 If the Board feels it is unable to fully certify a particular statement, the guidance states that the Board

'….should make an alternative declaration by amending the self-certification as necessary and including any significant prospective risks and concerns the FT has in respect of delivering quality services and effective quality governance and

…must provide a commentary explaining the reasons for the absence of a full self-certification and the actions it proposes to take to address it.'

NHS England may adjust the relevant risk rating if there are significant issues arising and this may increase the frequency and intensity of monitoring for the Trust.'

1.4 The Board of Directors is required to confirm self-certification against the requirements of General Condition G6 and Continuity of services 7 of the NHS Provider Licence and to confirm the self-certification against FT4 and the Training of Governors, as appropriate.

2 Comment

2.1 The Board statements are listed in the appendices to this report, together with a commentary, supporting the following declarations:

- *General Condition 6 – Systems for compliance with license conditions* – 'confirmed'
- *Continuity of services 7 – Availability of resources* – 'confirmed'
- *FT4 Declaration – Corporate Governance Statement* – *'*confirmed'
- *Training of Governors* – *'*confirmed'

2.2 The Board is invited to consider whether it is able to certify each statement or whether further evidence is required. Should the Board be unable to fully certify then amendments to the appropriate statement and supporting commentary should be considered.

3 Recommendation

3.1 The Board is recommended to self-certify that the four board statements for 2023/24 can be marked as 'confirmed'.

4 Attachments

4.1 The following is attached to this report:

- Self-Certification Statement for May 2024

Annual Plan Board Statements 2023/24 **Appendix 1**

Declarations required by General Condition 6 (GC6) and Continuity of Services 7 (CoS7) of the NHS Provider Licence

Statement		Lead	Commentary
1 & 2	**General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)** Conditions G6(2): NHS providers must have processes and systems that: a) identify risks to compliance with the licence, NHS acts and the NHS Constitution b) guard against those risks occurring Providers must complete a self-certification after reviewing whether their processes and systems were implemented in the previous financial year and were effective (condition G6(3)).	Nicky Lloyd, Chief Finance Officer	Confirmed
3	**Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)** (a) After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.		
	(b) After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the	Nicky Lloyd, Chief Finance Officer	Confirmed Matters to draw to the attention of NHSE: *The Trust Board is assured that it will have the necessary Required Resources assuming it is able to deliver the underlying budgeted performance and hence will have access to the incremental ERF monies available. However, should performance deteriorate then it is assumed action will be taken, including a re-phasing of the capital programme, to mitigate the adverse impact*

Statement		Lead	Commentary
	text box in section 3 below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.		*on available resources.* Evidence: i. <u>Management resources:</u> *Executive roles all held by substantive appointments during 2023/24 and currently (May 2024).* *Appointments in place for all Non-Exec roles* *Workforce plan prepared as part of NHSI annual plan, based on budget built specialty by specialty* ii. <u>Financial resources and financial facilities:</u> *2023/24 Financial forecast delivered. HFMA Financial Sustainability checklist self-assessment originally completed by CFO and independently verified by Internal Audit as part of national benchmarking exercise of financial controls and effectiveness in 2021/22 subsequently revisited by CFO in 2023/24 and ratings improved in some areas* iii. <u>Personnel:</u> *Workforce plan prepared as part of NHSI annual plan, based on budget built specialty by specialty* iv. <u>Physical and other assets including rights, licences and consents relating to their use</u> *Principal facilities used by the Trust are owned by the Trust. Lease / licence agreements in place for the other facilities* v. <u>Working capital</u> *Downside cash forecast for 2024/25 and associated mitigating actions prepared and will be reviewed by Audit and Risk Committee as part of the 2023/24 accounts preparation and review. The Trust Board has set a plan which requires cash holdings to stay above £23m.*
Cont'd	(c) In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.	Nicky Lloyd, Chief Finance Officer	

NHS England Self-Certification 2023/24 **Appendix 2**

Corporate Governance Statement (FTs and NHS trusts)

1 – Corporate Governance

Statement		Lead	Commentary
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Caroline Lynch, Trust Secretary	Governance arrangements follow best practice and are reviewed against the NHSE Code of Governance and other guidance. The system of governance is subject to review by internal and external audit on an annual basis.
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS England from time to time.	Caroline Lynch, Trust Secretary	The Audit & Risk Committee receives an update at every meeting from internal or external auditors which includes NHSE advice issued. The Chief Executive's report to the Board also covers national reports, advice and topics.
3	**The Board is satisfied that the Licensee has established and implements:** (a) Effective board and committee structures;	Caroline Lynch, Trust Secretary	(a) A Board and Committee structure is in place and terms of reference for each of the committees is reviewed on an annual basis and submitted to the Board for approval.
	(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and		(b) Terms of reference are set for all committees. Matters reserved for the Board, as well as its role in general have been agreed. All directors reporting to the Board have responsibilities set out in job descriptions.
	(c) Clear reporting lines and accountabilities throughout its organisation.		(c) Organisational charts are in place for all corporate and care group directorates which set out reporting lines and accountabilities.
4	**The Board is satisfied that the Licensee has established and effectively implements systems and/or processes:** (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;	Nicky Lloyd, Chief Finance Officer	a) The Trust's internal control mechanisms and reporting regime to NHS England ensure that this is closely monitored. The Trust is subject to internal and external audit which also

Statement		Lead	Commentary
			monitors performance in this area. Actions to improve compliance identified in previous years have been implemented. Consequently, the External Auditors are in the process of completing their work in the year-end report compliance with regards to this matter. The Trust received a rating of 'good', in its Use of Resources report from NHS England, carried out during 2019/20.
	(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;	Katie Prichard-Thomas, Chief Nursing Officer / Dom Hardy, Chief Operating Officer	b) The Trust Board receives a monthly Integrated Performance Report. This is in addition to specific exception reports on operational issues.
Cont'd	(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;	Katie Prichard-Thomas, Chief Nursing Officer	c) The Trust has a governance structure linking the Board, key committees charged with responsibility for oversight of operations (the Quality Committee, Finance & Investment Committee, Audit & Risk Committee and People Committee, Restructuring Oversight Committee), through to the Executive Structure (the Executive, the Executive Management Committee and the Quality Governance Committee, Executive performance meetings with Care Group Clinical Governance and performance meetings). There are clearly defined reporting lines and accountabilities between the Board, its Committees and the Executive Management Team within the overall governance structures of the Trust.
	(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);	Nicky Lloyd, Chief Finance Officer	d) The Trust's Standard Financial Instructions, Business Case Policy annual planning process (including quarterly forecasting) and cash management processes ensure the ability of the Trust to continue as a going concern. These were updated in March

Statement		Lead	Commentary
			2024. In addition, a specific paper to confirm going concern is provided to the Audit & Risk Committee and Board as part of adopting the year end accounts.
	(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;	Nicky Lloyd, Chief Finance Officer	e) A monthly Integrated Board Performance Report including quality, access, operational performance, staffing information, exception reports and a Chief Finance Officer report is produced for Board which outlines performance at Board level. Prior to the Board, performance is monitored through a monthly performance meeting with the Executive team and care groups. However, the Trust acknowledges that improvements are needed to assure itself as to data quality and has instigated a programmatic approach to doing this which has been routinely monitored by the Audit and Risk Committee of the Board.
	(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;	Katie Prichard-Thomas, Chief Nursing Officer	f) The Trust identifies key risks through the Board Assurance Framework and the Corporate Risk Register. This identifies any risk to compliance with the conditions of the license. The Operational Plan sets out key risks.
Cont'd	(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and	Nicky Lloyd, Chief Finance Officer	g) The Board monitors delivery against financial plans through its Finance & Investment Committee and through the Board with particular focus on those areas identified of greatest risk. In addition, the Trust undertakes a quarterly forecast as part of our quarterly financial process to assess delivery against Business Plans supported by monthly performance reviews of Care Groups and Corporate Departments. Several iterations of the annual financial plan have been submitted in line with national timetables. The latest submission was made on 2nd May 2024, for a deficit plan of £15.5m.
	(h) To ensure compliance with all applicable legal requirements.	Katie Prichard-Thomas, Chief Nursing Officer	h) Legal obligations on the Trust are brought to the attention of Directors.

Statement		Lead	Commentary
5	**The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure:** (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;	Caroline Lynch, Trust Secretary	a) The Nominations and Remuneration Committee has responsibility for overseeing the competence and capability of the management team. The Trust has an appraisal system for all individuals.
	(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;	Katie Prichard-Thomas, Chief Nursing Officer / Janet Lippett, Chief Medical Officer	b) The Board of Directors' leadership of the Operational and Strategic Planning processes includes a focus on quality strategy and plans. The Board Quality Committee regularly monitors delivery of the Quality Strategy and Quality priorities.
	(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;	Katie Prichard-Thomas, Chief Nursing Officer	c) Quality information is produced by Informatics prior to analysis by the Care Groups, Committees and by the Executive. This is triangulated through a collective meeting with all three care groups and the Executive to discuss quality, finance and workforce performance.
Cont'd	(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;	Katie Prichard-Thomas, Chief Nursing Officer	d) A monthly Integrated Board Performance Report including quality, access, operational performance and staffing information and a Finance report is produced for Board which outlines performance at Board level and includes KPIs and scorecard. Metrics are at granular level by theme and by month with a commentary. Prior to the Board, performance is monitored through a monthly performance meeting with the Executive Team and Care Groups to discuss finance, quality performance and workforce to discuss quality performance. Ward to Board has been developed and the Trust has a ward accreditation scheme. Exception reports are published for consideration of the Board.

Statement		Lead	Commentary
	(e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and	Katie Prichard-Thomas, Chief Nursing Officer	e) The Trust drives engagement with key stakeholders through the patient experience committees. Appropriate channels are in place including: Patient Leadership Programme, Patient Standing Conferences, Patient Groups, local and national surveys, Friends & Family Test, PALS, patient stories reported to Board and to our Commissioners. Regular meetings are in place with local Healthwatch and maternity & neonatal voices partnership leads. A stakeholder engagement plan ensures all interested parties are actively involved in the identification and selection of the Trust's quality priorities.
	(f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Katie Prichard-Thomas, Chief Nursing Officer	f) At Board level, the Chief Medical Officer and Chief Nursing Officer have joint responsibility for quality issues to the Board, including assurance on quality governance. The monthly Integrated Performance Report identifies and escalates key quality performance issues to the Board. Within the organisation, an incident reporting system is in place, with a structure for the escalation of incidents to speciality Care Group Clinical Governance meetings, the Quality Governance Committee and to the Executive and Board Quality Committee.
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Don Fairley, Chief People Officer	The Trust Board is compliant with the NHS England Code of Governance in respect of appropriate numbers of Non Executives/Executives. The Trust is working to improve workforce planning capability to ensure it has optimal staffing moving forward. Regular skill mix reviews take place and adjustments made where required. The Trust also ensures that robust pre-employment checks on all new staff are carried out.

2 – Training of Governors

Statement		Lead	Commentary
1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Caroline Lynch, Trust Secretary	A comprehensive induction session is provided for all new governors and for existing governors to refresh their knowledge. In 2023-24, Governors undertook training and development in the following areas: CQC Well-led session, consultation and engagement session on the Primary Care Strategy and tours of the hospital to raise understanding and knowledge of Trust services. This included guided tours with the Building Berkshire Together team. The Chair & Trust Secretary meet with governors on a monthly video call. As part of this, additional presenters are invited to provide updates to governors. All governors are also given the opportunity to attend NHS Providers and Governwell programmes where relevant.

Board Work Plan 2024

Focus	Item	Lead	Freq	Jan-24	Mar-24	May-24	Jul-24	Sep-24	Nov-24
Provide the Highest Quality Care to all	Winter Plan	DH	Annually						
	Ockendon Action Plan Update	KP-T	By Exception						
	Children & Young People Update	KP-T	Bi-Annually						
	Health & Safety Story	NL	Every						
	Quality & Improvement Strategy	KP-T/JL	Once						
Invest in our People and live out our Values	Patient Story	Exec	Every						
	Staff Story	Exec	Every						
	Health & Safety Annual Report	NL	Annually						
	People Strategy	DF	Once						
	Annual Revalidation Report	JL	Annually						
Achieve Long-Term Sustainability	Quarterly Forecast	NL	Quarterly						
	2023/24 Budget	NL	Annually						
	2023/24 Capital Plan	NL	Annually						
	Operating Plan/ Business Plan 2023/24	AS	Annually						
	Estates Strategy	NL	Once						
Cultivate Innovation & Improvement	Standing Financial Instructions	NL	Annually						
	ICP/ICS Update	AS	By Exception						
	Building Berkshire Together	NL	Every						
Deliver in Partnership	Communications & Engagement Strategy	AS	Once						
Other / Governance	Chief Executive Report	SMC	Every						
	Board Assurance Framework	CL	Bi-Annually						
	Corporate Risk Register	KP-T	Bi-Annually						
	Integrated Performance Report (IPR)	Exec	Every						
	IPR Metrics Review	DH/AS	By Exception						
	NHSI Annual Self-Certification	NL/CL	Annually						
	Standing Orders Review	CL	Annually						
	Fit & Proper Persons Update	DF	Once						
	Board Work Plan	CL	Every						