# Quality Report

2025 -26

# Contents

# Glossary of Technical Terms/Acronyms

| | |
|---|---|
| ACM | Aggregate Contract Monitoring |
| ACP | Advanced Care Planning |
| AI | Artificial Intelligence |
| AMU | Acute Medical Unit |
| BOB | Buckinghamshire, Oxfordshire and Berkshire |
| CC | Compassionate Companions |
| CCG | Clinical Commissioning Group |
| COHA | Community Onset Healthcare Associated |
| CQC | Care Quality Commission |
| CQUIN | Commissioning for Quality and Innovation |
| DSP | Data Security and Protection |
| DQ | Data Quality |
| DQSG | Data Quality Surveillance Group |
| ED | Emergency Department |
| EPR | Electronic Patient Record |
| FFT | Friends and Family Test |
| FICM | Faculty of Intensive Care Medicine |
| FTSU | Freedom To Speak Up |
| FY3 | Foundation Year 3 |
| GOSW | Guardian of Safe Working Hours |
| HAP | Hospital Acquired Pneumonia |
| ICB | Integrated Care Board |
| ICS | Integrated Care System |
| ICU | Intensive Care Unit |
| IPC | Infection, Prevention and Control |
| LD | Learning Disabilities |
| LFT | Liver Function Test |
| ME | Medical Examiner |
| MEO | Medical Examiner Officer |
| MSG | Mortality Surveillance Group |
| NEWS2 | National Early Warning Score |
| NIHR | National Institute for Health & Care Research |
| NHS | National Health Service |
| NHSD DQAF | NHS Digital's Data Quality Assessment Framework |
| NICE | National Institute for Health & Care Excellence |
| HOHA | Hospital Onset Healthcare Associated |
| NOK | Next of Kin |
| PPE | Personal Protective Equipment |
| POD | Point of Delivery |
| PROMS | Patient Reported Outcomes Measures |
| RBFT | Royal Berkshire Foundation Trust |
| ReSPECT | Recommended Summary Plan for Emergency Care and Treatment |
| RRT | Referral to Treatment |
| SDEC | Same Day Emergency Care |
| SEND | Special Educational Needs and Disability |
| SHMI | Standardised Hospital Level Mortality Indicator |
| SJR | Structured Judgement Review |
| SSU | Short Stay Unit |
| TRiM | Trauma Risk Management |
| VTE | Venous Thromboembolism |
| WTE | Whole Time Equivalent |

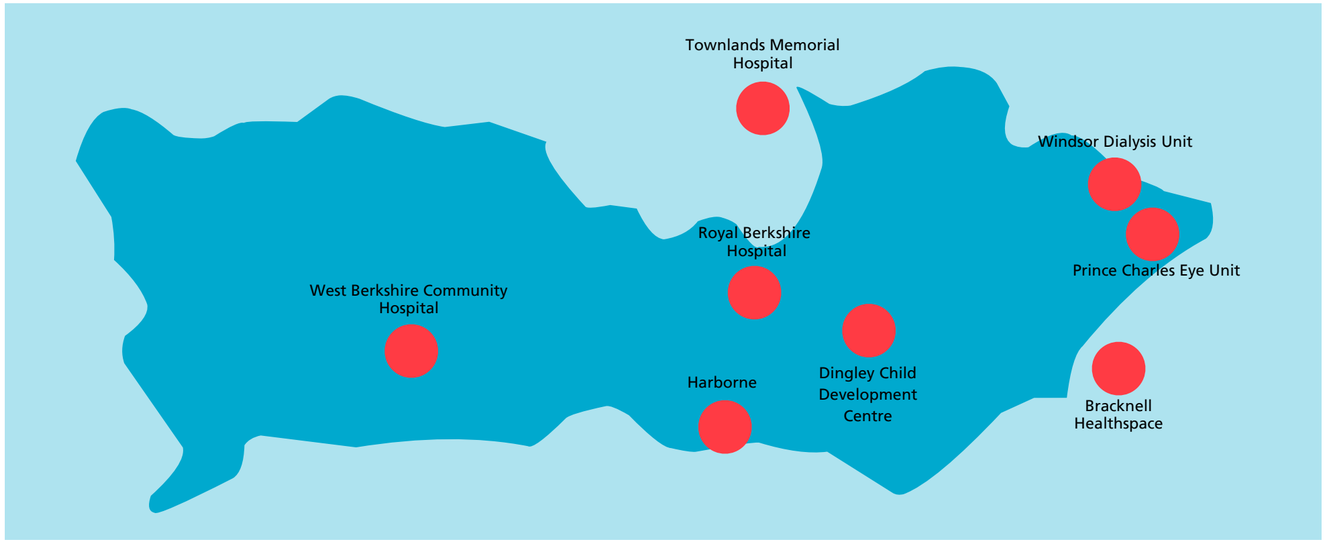
# Introduction

## Our community we serve

The Royal Berkshire NHS Foundation Trust is the main provider of secondary care services for the population of West Berkshire, and also serves people in East Berkshire and bordering areas.

Our specialist centre is the Royal Berkshire Hospital in Reading, a large district general hospital with the expertise to treat patients requiring urgent or hyper-acute care. Additionally, we have a number of community sites in Windsor, Bracknell, Henley-on-Thames and Thatcham where we deliver ambulatory care and diagnostics.

We are a designated specialist centre in renal, cancer, bariatric care, heart attack and stroke.  We also provide specialist care as part of a care network through a local neonatal unit, maternity unit, an interventional radiology unit and a trauma unit. We are part of the critical care and vascular care networks. We employ more than 6000 staff from over 80 different nationalities. Each year we are responsible for efficiently and effectively spending more than £400m of NHS resources on the services we provide. As a founder member of the Berkshire West Integrated Care System (ICS), we are one of NHS England's demonstrator sites for integration between primary, community, mental health and acute healthcare services.




**We serve more than 1 million residents through Berkshire and South Oxfordshire**

# Chief Executive Statement on Quality

As we approach our 200th year at the heart of the community, delivering high-quality, compassionate care remains our central purpose. We look after people at some of their most fragile and vulnerable moments, and we take the responsibility that comes with that seriously. That responsibility means not only must we provide safe and high-quality clinical care, but we must also make sure our patients continue to feel listened to, respected, and supported throughout their time with us. There is a person at the centre of every appointment, procedure, or interaction with us – and by keeping that in mind, we work hard to deliver care with kindness, dignity, and professionalism – giving patients and their families confidence in the care they receive and agency to make their voice heard.

The last 12 months has continued to challenge health and care services both locally and nationally. Ever rising demand, workforce pressures, and constraints across the system have meant that services have had to adapt and look for ways to work differently. To enable us to progress and continue to evolve, we have refreshed our Trust strategy – with input from colleagues at the Trust, patients, partners, and our community - making sure we can respond to needs locally alongside the ambitions of the NHS 10 Year Plan. This strategy aims to more comprehensively connect the services we provide with patients out of the hospital setting, and with community and primary care services.

Over the last year, we have continued to concentrate on patient experience – most fundamentally how we improve access to the right care first time, and how we move patients through the healthcare journey - from the front door to leaving our acute hospital setting. Teams across the organisation have come together to minimise corridor care, improve ambulance handovers, expand Same Day Emergency Care, and support patient-centred discharge through our Discharge Lounge.

And at sites across the Trust we have continued to expand on the services we offer, for example enhancing the diagnostic facilities at our West Berkshire Community Hospital, and new LINAC and x-ray capabilities coming online in Bracknell. By our collective efforts we work to reduce waits, maintain the dignity of our patients, and make sure we can care for each patient in the right place, first time. And our continued strong results in the latest Adult Inpatient Survey, including 94% of patient sharing that they had been treated with respect and dignity during their hospital stay, point towards the high quality of care we provide.

# Chief Executive Statement on Quality

High-quality patient care depends on supported colleagues who feel valued for the work they do. The latest NHS Staff Survey results place us among the very top acute trusts nationally. And in in 16 areas we are the highest ranked trust including: feeling like a team, being able to make improvements, and the believing that concerns raised will be acted upon. Patient feedback reinforces this strong picture. For example, the latest CQC National Maternity Survey shows that 96% of respondents felt they were involved in decisions about their care, and 95% of respondents felt we treated them with respect and dignity during labour and birth.

As a learning organisation, we are always looking for ways to improve the overall quality of the care we provide. Our Improving Together approach to continuous quality improvement underpins transformation across the organisation – for example the introduction of our Cleo e-prescribing system in the autumn of 2025, meaning patients often no longer need to wait or come back to the Trust for their medication, collecting them locally instead. And by listening to patient's first hand, including hearing from them directly at public Board meetings – we identify ways to strengthen how we respond to concerns and involve patients and carers in decisions. Initiatives such as Martha's Rule, evolving in large part from our Call 4 Concern approach, further demonstrate our commitment to empowering patients and families to speak up, ensuring safety and quality remain everyone's responsibility.

Research continues to play a vital role in how we improve the quality of patient care and experience. Over the past year, we have recruited more than 3,000 participants into NIHR-supported research studies, contributing to the treatments and approaches of the future. Our teams are contributing to internationally recognised research, including the use of artificial intelligence to reduce time to diagnosis and treatment after a stroke - delivering real-world benefits for patients. And we continue to build research links with our partners at the University of Reading with 5 consultant colleagues holding Professorships and driving forward progress in areas including Rheumatology, Interventional Radiology, and Cardiology.

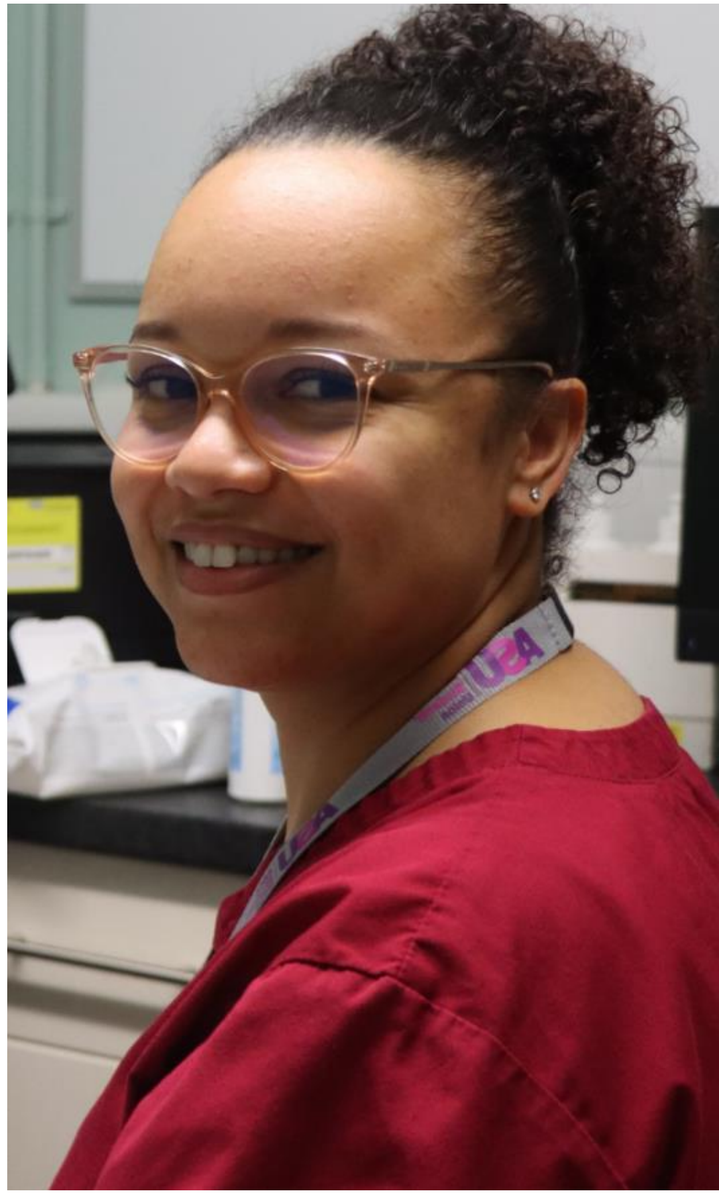
Looking ahead, we are acutely aware of the challenges of delivering modern care in an ageing estate. While longer-term we work towards a new hospital, we continue to invest in our existing estate to improve patient experience and service delivery. This includes a new urgent care centre, our new Frederick Potts elective unit, new radiotherapy equipment for cancer treatment and upgraded diagnostic equipment at the Royal Berkshire Hospital and in our Henley, Bracknell, and West Berkshire sites. These developments, alongside our ongoing commitment to improvement, will help ensure we continue to provide safe, compassionate, and high-quality care for our community now and in the future.

Having recently joined the organization, I am enormously impressed with the focus colleagues display day in, day out on delivering high quality care to our patients. And I am confident the organisation will meet the ask of us in the year ahead with dedication, ingenuity, and a fundamental commitment to the community we serve.

James Blythe, Chief Executive Officer

# Part 1: Our Vision and Quality Priorities 2026/27

## Our vision: Working together to provide outstanding care for our community



Ensuring safety and quality of care for every patient is our top priority. We are ambitious about the quality of care we provide. We want all our services to be outstanding every day of the week. We also strive to be one of the safest and most caring NHS organisations in the country. With this aim the trust is committed to fostering a culture of continuous quality improvement and have implemented the Improving Together programme which builds on the agility, innovation and transformation shown by our staff, during the challenging times following the pandemic. Building on our CARE values, our long history of improvement and our commitment to developing our people, the Improving Together programme is our approach to embedding continuous quality improvement across the trust.

By using the Improving Together approach we are enabling and equipping staff in every area of the trust to manage and improve the quality of care to patients and deliver patient experiences and outcomes that are "outstanding every day, everywhere". Using simple processes that can be built into everyone's working day means staff can drive small improvements to quality and cost that collectively make a large difference. It is important to acknowledge that performance and quality are inextricably linked and as such strategic priorities, and other key improvement metrics are monitored through our Integrated Performance Report. The importance of monitoring the delivery of quality care to our patients and families cannot be understated and therefore alongside the Improving Together programme, the trust have identified 6 key improvement priorities which are linked to our strategic objectives and driver metrics, for the coming year, details of which are outlined in the following pages.

Progress against these priorities will be tracked through bi-monthly performance meetings with the Quality Priority leads and monitored on a quarterly basis through a quality dashboard presented to the Quality Governance Committee, chaired by the Chief Medical Officer/ Chief Nurse; and the Quality Committee, a Board sub-committee chaired by one of our Non-Executive Directors. This will allow appropriate scrutiny against the progress being made with these quality improvement initiatives and also provides an opportunity for escalation of issues. This will ensure that improvement against each priority remains a focus for the year and will give us the best chance of achievement.

# Part 1: Our Vision and Quality Priorities 2026/27

This year our Quality Priorities are directly aligned to Trust strategic objectives or breakthrough metrics identified in consultation with teams across the Trust, through the Improving Together programme. All have an executive Lead and an active work programme behind it and are also aligned to the Quality Strategy. The table below shows how the priority projects are aligned to Trust priorities and to core elements of quality.

| **Strategic/ Breakthrough metric** | **Strategic metric** | **Project** | Metric | **Quality Priority Domain** |
|---|---|---|---|---|
| Strategic Objective | Delivering highest quality care for all | Learning from incidents to reduce harm | 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 | **Patient Safety** |
| Strategic Objective | Partnering for Impact | Improve waiting times: Reduce waits of over 62 days for Cancer patients | The percentage of patients with confirmed cancer receiving first definitive treatment within 62 days of referral to the Trust. The national target is 85%. Trusts are expected to achieve 80% performance by March 2027 | |
| Breakthrough priority metric | Safest place | Average Length of Stay (LOS) for non-elective patients | Our objective is to reduce the average Length of Stay (LOS) for non-elective (NEL) patients to:<br>•Maximise use of our limited bed base for patients that need it most<br>•Reduce harm from unwarranted longer stays in hospital<br>•Positively impact ambulance handover times and ED performance | **Clinical Effectiveness** |
| Breakthrough priority metric | Improving elective performance | Total Volume of first Outpatient (OP) Activity | The volume of first outpatient activity (OPA), including outpatient procedures, being undertaken.<br>First OPA is the largest and most modifiable aspect of the elective pathway and is the biggest contributor to waiting times delays. | |
| Strategic Objective | Delivering the highest quality of care for all | I was listened to, well informed & involved in decisions about my care | 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' | **Patient Experience** |
| Strategic Objective | Partnering for Impact | Performance against 4-hour Emergency Pathway target | Increasing the proportion of patients seen within 4 hours | |

Further detail on each of the projects is provided over the following pages

# Part 1: Our Vision and Quality Priorities 2026/27

## Patient Safety

**Learning from incidents to reduce harm: Patient safety incidents per 1000 bed days**

The introduction and embedding of the Patient Safety Incident Response Framework (PSIRF) into the Organisation over the last couple of years has transformed how we investigate and learn from patient safety incidents, but alongside this, it is important that our incident reporting rate remains stable.  Higher reporting is associated with a positive safety culture. The Trust will aim to keep the rate above the minimum threshold rate of 40.

*Performance Measure: Patient Safety Incidents per 1000 bed days*

**Improve waiting times: 62-day cancer standard**

Ensuring timely, equitable access to care when cancer is suspected is essential as it ensures effective treatment can be initiated. This project continues the progress made in 2025/26. Improving access continues to be a key priority for our organisation and there are a number of initiatives planned to improve performance in this metric.

*Performance Measure*: *Percentage of cancer patients seen within 62 days*

## Clinical Effectiveness

**Reduce the average Length of Stay (LOS) for non-elective (NEL) patients**

Reducing the length of time patients spend in hospital  is key to enhance patient experience, reduce the risk of hospital acquired harm and ensure we have adequate flow within the organisation. This project will build on the progress achieved in 2025. We aim 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

*Performance measure: LOS target of <7 days*

# Part 1: Our Vision and Quality Priorities 2026/27

**Total Volume of first Outpatient (OP) Activity**

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

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

*Performance measure: Average wait for first outpatient appointment, % patients waiting over 12 weeks for first assessment, % OP that did not attend/were not brought (1st OP Appt), % triage within 2 working days for all GP referrals (including 2 week wait, urgent and routine)*

## Patient Experience

**Person-centred care: I was listened to, well informed & involved in decisions about my care (FFT response)**

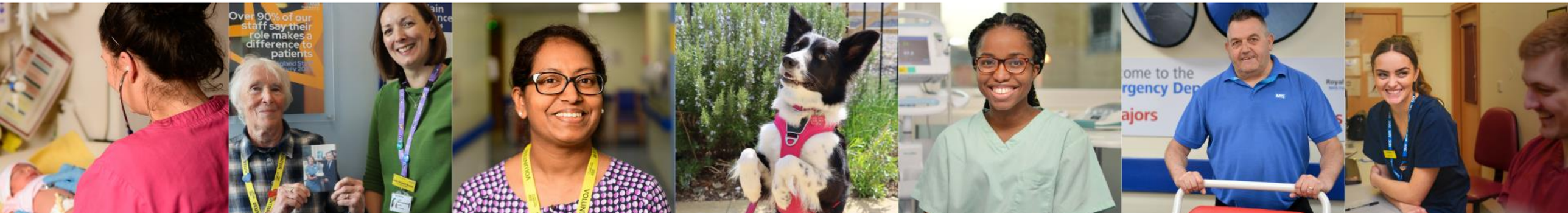
Shared decision making ensures that patients are supported to make the decisions that are right for them, so it is vital that patients feel confident that decisions about their care are done in a collaborative process with their healthcare professional. This approach enables patients to make informed decisions about their health care. A work programme, including using data from other national surveys will underpin this project.

*Performance measure: Achieve 95% target 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'*

**Performance against the 4-hour Emergency Pathway target**

The Emergency Department is the gateway to many of our services so, ensuring that patients can be seen in a timely manner has many benefits - it's beneficial for experience and ensures that patients can commence on the appropriate treatment pathway as soon as possible. It also ensures the department can be run in as an efficient way as possible and maintains the flow of patients throughout the Organisation. NHS England has set a target of 78% of patients to be admitted, transferred or discharged within 4 hours.

*Performance measure: Increasing the proportion of patients seen within 4 hours*




# Part 2: Statements of Assurance from the Board

## CQUIN payment framework and Contracts/Services

During 2025-26 the Royal Berkshire NHS Foundation Trust provided and/or sub-contracted 34 relevant health services.
The Royal Berkshire NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these relevant health services.
The income generated by the relevant health services reviewed in 2025-26 represents 100% of the total income generated from the provision of relevant health services by the Royal Berkshire NHS Foundation Trust for 2025-26.

**CQUIN payment framework**

For the 2024/25 contract year, the CQUIN programme was paused nationally. There continues to be a ‘pause' in place to the Commissioning for Quality and Innovation scheme (CQUIN) (which forms part of the Aligned Payment and Incentives Rules for Trusts within the NHS Payment Scheme).

In terms of the implications for the Contract, SC38.1 requires a CQUIN Scheme to be implemented “where and as required by the Aligned Payment and Incentive Rules and by CQUIN Guidance”. As the pause to CQUINs is continuing, the Rules and Guidance will not require CQUINs to be implemented for the duration of that pause, and so the rest of SC38 will simply be redundant for as long as the pause continues, pending the outcome of the broader review of incentives. But those provisions could become “live” again if and when the pause is terminated. We have therefore not proposed any specific changes to the Contract wording at this stage as a result of the CQUIN pause.
References to CQUINs in the Guidance should be read in this context.

# Part 2: Statements of Assurance from the Board

## Participation in national clinical audits and national confidential enquiries

National clinical audit provides assurance that the care being delivered by our services is of the highest quality in terms of clinical effectiveness, patient outcomes and patient experience, compared to both national best practice standards and other service providers nation-wide. Where the care being delivered does not meet these standards, it provides a stimulus for improvement in the quality of treatment and care. In addition, national clinical audit provides a measure for organisations to be compared with other care providers across the country. National confidential enquiries are national reviews of high-risk medical or surgical conditions, which produce recommendations to be implemented to improve the quality of care being delivered to patients.

During 2025-26, 60  national clinical audits and registries and 3 national confidential enquiries covered relevant health services that the Royal Berkshire NHS Foundation Trust provides. During 2025-26 the Trust participated in 93% national clinical audits (56/60) and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits, registries and national confidential enquiries that the Royal Berkshire NHS Foundation Trust participated in and for which data collection was completed during 2025-26 are listed in Annex 2, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

## Results of National Clinical Audits and National Confidential Enquiries

The reports of 24 National Clinical Audits and National Confidential Enquiries were reviewed by the provider in 2025-26 and the Royal Berkshire NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

### National Hip Fracture Database (*published September 2025 based on 2024 data*)

This is an audit of hip fracture care and secondary prevention with care audited against standards defined by the British Orthopaedic Association (BOA) and British Geriatrics Society (BGS).  Participation in this audit identified the following actions which will be monitored through the appropriate specialty clinical governance meeting:

- Examine and address theatre and surgeon capacity issues.
- Continued promotion of existing fast track policy for hip fracture patients
- Audit/quality documentation checks

# Part 2: Statements of Assurance from the Board

### National Paediatric Diabetes Audit (*published March 2026 based on April 2024 – April 2025 data*)

This is an audit that collects data relating to the care processes provided to, and diabetes outcomes achieved by, all children and young people under the age of 25. Generally, the results from this audit were very good and the Trust performed better than national averages in a number of metrics. Of note :

- The proportion of children & young people in receipt of both key and recommended health checks were all higher than the national average, some significantly so
- Median HbA1c in line with national average
- Emergency hospital admission rate significantly lower than the national average

The audit enabled the clinical team to identify key areas for improvement which they will prioritse over the next year:

- Continuing to strive to reduce median hba1c especially those patients with levels higher than target range
- Aim for > 90% children and young people with type 1 diabetes using diabetes-related technologies especially those in the most deprived quartile
- Screening for auto immune diseases within 90 days diagnosis

In addition to being a driver for quality improvement work, national audit also provides assurance about the quality of care being delivered where the Trust is already performing to the highest standard, or where significant improvements have been made year on year. In some cases, the Trust is one of the highest performers in the country. Some of the highlights of our national audit performance are given below:

### Myocardial Ischaemia National Audit Project (MINAP) *(published December 2025 based on 2024/25 data)*

The  latest findings from this audit, which aims to support quality assurance and the improvement of services for people suffering a heart attack, were published late last year. The Trust performed very well in this audit and was placed as one of the top performing Trusts for a number of different measures:

- All NSTEMI patients underwent an angiogram before discharge, resulting in the Trust being the top ranked Trust in the country for this metric.
- All eligible Heart Attack patients received aldosterone antagonists, resulting in the Trust being the third ranked nationally for this metric
- STEMI patients who underwent an echocardiography
- NSTEMI patients undergoing an angiogram within 72 hours

### National Clinical Audit of Seizures and Epilepsies for Children and Young People (Epilepsy 12) (published July 2025 based on data from December 2022 – November 2023)

Latest findings from this audit, which aims to help epilepsy services, to measure and improve the quality of care for children and young people with seizures and epilepsies. Results showed the Trust performed well in this audit and the team were recognised as outstanding by the national audit body for the metric related to access to Epilepsy Specialist Nurse, a great achievement by the team.

# Part 2: Statements of Assurance from the Board

## Results of Local Clinical Audits and Quality Improvement Projects

Local-level clinical audit and quality improvement projects tend to be more specialised and smaller in scope than the national audit projects. These have the advantage of rapid cycles of data collection and quality improvement work; this means patients can promptly experience the benefits of the change.

The reports of 35 local clinical audit and quality improvement projects were reviewed by the provider in 2025-26 and the Royal Berkshire NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

### Discharge Advice following Hypertension in Pregnancy

This audit, carried out by the Maternity team, looked at the postnatal care, discharge communication and instructions for patients who had experienced hypertension. The actions that were identified in this audit were:

- To liaise with General Practitioners (GP's) and provide education regarding medication titration for postnatal HTN
- To introduce standardised EPR Auto-text and highlight at both induction & weekly Journal Club meetings with junior doctors
- Provide printed instructions for Post Natal Hypertension patients and exhibit in Post Natal Ward

### Compliance with the Chaperone Policy

Patients have a right to request that a trusted adult is present during any consultation, examination or treatment whether that be an informal chaperone or family member/friend or formal chaperone in the case of an intimate examination or procedure. The Urology team carried out an audit to see if key elements of the Chaperoning Policy were being followed and identified the following actions:

- Introduction of Trust-approved laminated posters regarding chaperones will be placed in the Urology Outpatient clinics and reception.
- Emphasise the importance of chaperone offering and documentation with clinical team

## Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by the trust in 2025-26 that were recruited during that period to participate in research approved by a research ethics committee was 1531 participants into 96 National Institute for Health (NIHR) research studies.

# Part 2: Statements of Assurance from the Board

## CQC registration compliance

The Royal Berkshire NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is “Good”. The Royal Berkshire Hospital location is currently rated as “Good”.

The Royal Berkshire NHS Foundation Trust has no conditions on its registration. The Care Quality Commission did issue an improvement notice following its CQC IR(ME)R inspection of the Nuclear Medicine Department at the Royal Berkshire Hospital site in July 2025. The conditions of the improvement notice were met and the CQC closed the improvement notice in November 2025.

During 2025-26 the Trust had one Care Quality Commission (CQC) inspection - the Nuclear Medicine Department at the Royal Berkshire Hospital had a CQC Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspection on 5 July 2025. This was on the basis that the Nuclear Medicine Department’s Employer’s Procedure was out-of-date and did not include a statutory IR(ME)R update. An Improvement Notice was issued by the CQC.

On 18 November 2025 the CQC informed the Trust that the evidence it had submitted had led to the CQC concluding that it had complied with the conditions of the Improvement Notice and that the Improvement Notice would be closed. An on-site visit to the Nuclear Medicine Department took place on 2 March 2026 resulting in notification by the CQC that the inspection process was closed.  IR(ME)R inspections are not given ratings and the report is not published.

In terms of the Trust’s engagement with CQC inspections of local authority partners, in March 2025, the Trust participated in a Joint Targeted Area Inspection focusing on unborn and children’s experience who are victims of domestic abuse. The local authority was Reading Borough Children’s services and included police, probation and all health services.  In January 2026 the Trust took part in the Wokingham, Joint Local Area SEND Ofsted/CQC inspection of its services.  We await the final report and continue to work with the partnership on improvements to our services.

The Trust continues to participate in quarterly engagement meetings with the CQC. The engagement meeting in February 2026 included focussed visit to departments within the children and young people’s service at the Royal Berkshire Hospital site resulting in positive feed-back about the service.

# Part 2: Statements of Assurance from the Board

The Royal Berkshire NHS Foundation Trust continues to respond to enquiries raised by the CQC from additional intelligence streams such as Learning from Patient Safety Events (LFPSE) portals, the CQC public enquiry function and general CQC enquires. In the period 1 April 2025 – 31 March 2026, the Royal Berkshire NHS Foundation Trust received 27 enquiries from the CQC.  Within the same period it proactively reported CQC notifications and issues of importance to the CQC.

## NHS number and general medical practice code validity

The Royal Berkshire NHS Foundation Trust submitted records during 2025 - 26 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

- 99.88% for admitted patient care
- 99.95% for outpatient care and
- 98.86% for accident and emergency care

which included the patient's valid General Medical Practice Code was:

- 100% for admitted patient care
- 100% for outpatient care and
- 100% for accident and emergency care

## Data security & protection (DSP) toolkit attainment levels (previously information governance toolkit)

Following national guidance from NHS Digital the Data Security and Protection toolkit is due to be submitted on the 30 June 2026.
The Trust attained the *Standards Met* classification for the year ending June 2025.

## Clinical coding error rate

The Royal Berkshire NHS Foundation Trust was not subject to a Payment by Results clinical coding audit during 2025 - 26.

# Part 2: Statements of Assurance from the Board

## Data Quality and Assurance

In 2025- 2026 the Royal Berkshire NHS Foundation Trust took the following actions to improve data quality:

- Supported service users with data clean-up processes for operational, reporting, and information functions. The service saw an average of 255 Data Quality tickets per month, consistently achieving the team's target Service Level Agreement (SLA).
- Overseeing and escalating compliance concerns related to the DQMI (Data Quality Maturity Index) national assessment.
- Monitoring and escalating compliance concerns on the Commissioning Data Sets Data Quality Dashboards.
- Collaborating with the Performance team to clean up waitlists. Ongoing monitoring and maintenance are in place, with user support and feedback ensuring improved waitlist data.
- Enhancing the visibility of DQ indicators and standards among senior management and the executive team by regularly presenting the Trust-level Data Assurance Framework dashboard at meetings for ongoing review, monitoring, and action.
- Overseeing and monitoring a suite of 40 Data Quality KPIs, proactively escalating issues, formulating corrective actions, and developing new KPIs as necessary.
- Carrying out audits, which were reviewed by the DQSG (Data Quality Steering Group) and DQAG (Data Quality and Assurance Group) with recommendations made for areas of particular data quality concern.
- Performing monthly data quality audits including Oracle's non-elective inpatient audit, Radiology Day Case capture, reviews of patients without NHS numbers, and inpatient length of stay assessments.
- Collaborating with the Information team to maintain high data quality SUS (Secondary Uses Service) returns.
- Providing continuous support and improvement of Maternity Services Data Set (MSDS) in line with developments in national requirements throughout the year as well as working with the Maternity team to resolve data-related issues with booking assessments.
- Maintaining DQA Risks and Issues log, reviewed and actioned by DQSG/DQAG.
- ISNs (Information Standard Notices) received from NHSE/Digital collated, reported and monitored by DQSG/DQAG and escalated if necessary to DSG.
- Supported the Income Recovery Programme, with a focus on correct reporting of National Interim Clinical Imaging Procedures and activity capture for Interventional Radiology procedures.
- Reviewing and updating of Outpatient Outcomes M-pages in partnership with relevant services.
- Supported transition from Medisoft to Medisight in Ophthalmology including data catch-up initiatives.
- Conducted monitoring, analysis, and reporting of ethnicity data capture and Outpatient outcomes usage to services.
- Monitored, evaluated, and implemented actions based on the Hospital Episode Statistics (HES) Data Quality Report.

# Part 2: Statements of Assurance from the Board

## Learning from deaths

The Royal Berkshire Hospital NHS Trust continues to see a sustained increase in demand for medical services. The majority of patients who access care receive appropriate treatment, recover, and are discharged either to their own homes or to alternative care settings. Regrettably, and unavoidably within an acute healthcare setting, a proportion of patients will die during their admission. Most of these deaths are anticipated and reflect the severity of illness or frailty of the patient population. However, a small number of cases may involve aspects of care that were sub-optimal, may have contributed to the outcome, or offer important opportunities for learning and improvement.

The Trust remains committed to the continuous monitoring and improvement of the quality and safety of care through a robust, structured mortality review programme. This programme is designed to identify recurrent themes, areas requiring improvement, and examples of good practice. Reviews range from case note scrutiny to more in-depth patient safety investigations where indicated. These processes both support the identification learning and enable this to be disseminated both within the organisation and, where appropriate, across the wider healthcare system.

All adult in-hospital deaths, and since September 2024 the majority of community deaths, undergo initial independent scrutiny by a Trust-appointed Medical Examiner (ME). The ME reviews the patient's medical records, discusses the care provided with the responsible clinician, and engages with the patient's next of kin to address any questions or concerns. The ME then agrees the cause of death with the Qualified Authorised Practitioner (QAP), determines whether referral to the Coroner is required, and considers whether further review or investigation is warranted.

Where additional scrutiny is indicated, a Structured Judgement Review (SJR) may be undertaken to provide an objective assessment of the quality of care delivered. The Mortality Team oversees the SJR process, although alternative investigative approaches may be used where appropriate. Each SJR concludes with a formal grading of the overall standard of care. All SJRs are reviewed at specialty-level mortality and morbidity or clinical governance meetings. Cases graded 2 or above are additionally discussed at the Case Review and Triangulation (CRaT) meeting to determine whether further investigation is required.

Where care is assessed as "possibly" contributing to the patient's death or where the care has been assessed as poor, a further SJR is undertaken and both are presented at the Mortality Surveillance Committee (MSC) for final grading and care assessment.

Where care is assessed as "more likely than not" to have contributed to the patient's death, a comprehensive investigation is initiated by the Patient Safety Team in line with the Patient Safety Incident Response Framework (PSIRF). The outcome and final grading of a Patient safety review is formally ratified at the Patient Safety Incident Review Group (PSIRG).

# Part 2: Statements of Assurance from the Board

## Learning from deaths

Emerging themes, learning points, and identified areas for improvement are reported to the MSC on a monthly basis. In addition, as part of the Trust's quality assurance arrangements, a random sample of deaths not initially selected for SJR is reviewed to provide assurance regarding the consistency and robustness of the mortality review process. Learning and examples of good practice are shared across the Trust to support continuous improvement in patient care.

During 2025/26, 1393 of the Trust's adult patients died, along with 3 neonatal or paediatric deaths. The total deaths by quarter are given in Annex 3.

In 2025/26 226 case record reviews and  4 investigations in relation to the 1396 deaths have been undertaken. Out of the 4 investigations, 2 of these mortality cases were subjected to both a case record review and an appropriate level of investigation under PSIRF. The number of deaths in each quarter for which a case record review and/or a Patient Safety (PS) investigation were carried out are given in Annex 1. There were no deaths in 2025/26 that were graded as a grade 3, whereby there was suboptimal care and different care would have reasonably expected to have changed the outcome.

**Learning and Actions**

Over the last year, mortality reviews have highlighted the need to improve the quality and ownership of clinical documentation. Whilst most cases demonstrate good practice, some continue to show challenges, including outdated or irrelevant information being carried forward in the EPR, leading to potential misrepresentation of the clinical picture. Clear documentation of clinical reasoning and decision-making, supported by the use of BRAN, a structured decision-making framework, remains essential. The Trust is also promoting greater specialty engagement in healthcare records audits.

Timely recognition and escalation of the deteriorating patient, particularly in sepsis and earlier identification of the dying patient with appropriate palliative care involvement remain key themes. Although many cases reflect good care, targeted actions have been implemented where learning is identified, including improvements in observation frequency, trend recognition (particularly lactate), and early escalation to Critical Care Outreach. Clear documentation is encouraged to support decision-making at end of life, with patient comfort prioritised.

A further theme identified in some cases is that families do not always feel listened to. Compassionate, timely communication is therefore recognised as a key priority for the Trust. This requires ongoing attention across all specialties, including addressing the "listening/listened to" gap through care group action plans. There is continued emphasis on clear, compassionate communication, with documentation that demonstrates meaningful engagement with patients and their families.

Sharing learning Trust-wide continues to support a culture of reflection and continuous improvement.

# Part 3: Our Quality Performance 2025/26

## Quality Priorities 2025/26

We have made good progress with all our quality priorities for 2025/26. The trust remains challenged with operational pressures and elective recovery. The continuing roll out of the "Improving Together" continuous quality improvement programme the trust has adopted has provided a platform for ensuring all staff are involved in quality improvement projects which are aligned to the trust strategic priorities. The priorities that have been achieved will continue as business as usual. Those priorities where the required level of compliance has not been achieved will follow through into the 2025/26 priorities or form one of the work streams for improving together.

## Summary of performance

| | Priority | Quality Targets | Achievement/ Overall Achievement | |
|---|---|---|---|---|
| Patient Safety | **Prevention, recognition and escalation of the deteriorating patient** | Completion of sepsis, VTE risk and vital signs assessments (target range 95 – 100%) | Partially Achieved | |
| | **Reduction of waiting times for treatment for cancer patients** | The percentage of patients with confirmed cancer receiving first definitive treatment within 62 days of referral to the Trust. | Achieved | |
| Clinical Effectiveness | **Reduce the average Length of Stay (LOS) for non-elective (NEL) patients** | Reduction in average length of stay for non elective patients (including those with a length of stay of 0 days) | Not Achieved | |
| | **Increasing outpatient activity** | Increasing the volume of first outpatient activity (OPA), including outpatient procedures, being undertaken | Achieved | |
| | **Deconditioning (#EndPJParalysis)** | Increasing the proportion of patients on Networked care wards who were dressed | Achieved | |
| Patient Experience | **Shared Decision Making** | Achieve 95% target 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' | Partially Achieved | |
| | **Clinical Accreditation Scheme** | Plan for a further 6 in-patient areas to be accredited 2025/26 | Achieved | Achieved |
| | | Pilot the out-patient and specialist team accreditation with 3 areas 2025/26 | Partially Achieved | |

# Part 3: Our Quality Performance 2025/26

## Patient Safety

### 1. Prevention, recognition and escalation of the deteriorating patient

Timely recognition and escalation of patient deterioration is essential for ensuring patient safety and improving patient outcomes. This project continued the work carried out in the previous year but with a specific focus on patients within the emergency and elective care pathways. The aim was to ensure timely completion of essential patient safety assessments - sepsis, VTE risk and vital signs  when a patient is admitted to the ward in order to identify and prevent patient deterioration.  Whilst significant improvement, particularly in sepsis screening rates, was seen in the completion rates the target levels were not all fully reached.

### 2. Reduction of waiting times for treatment for cancer patients

Ensuring timely, equitable access to care when cancer is suspected is essential as it ensures effective treatment can be initiated. Improving access is a key priority for our organisation and there were a number of initiatives introduced to improve performance including redesigning patient pathways and introducing nurse led clinics. Strong performance in the areas of Skin, Breast and Urology as well as a significant improvement in Lower Gastrointestinal tumour sites has meant that the Trust has met it's performance target with the ambition to increase to 80% for March 2027.

## Clinical Effectiveness

### 1. Reduce the average Length of Stay (LOS) for non-elective (NEL) patients

Reducing the length of time patients spend in hospital has several benefits including maximising the use of our limited bed base for those patients that need it most, whilst also reducing patient harm and improving ambulance handover times and ED performance.  A number of initiatives have been implemented over the last year including
- Additional pharmacy support in AMU and ED to support faster prescribing, screening and dispensing of medication (almost achieving the 3hr target)
- Mon, Wed, Fri meetings every week with community hospital provider - Temporary escalation space policy agreed and implemented during winter
- Priority pathway for patients deemed fit for a Community Hospital bed by a geriatrician reducing the delay in referral, review, acceptance and logistics

Length of stay was an ambitious project involving many complex issues and unfortunately, the actions outlined above have not reduced the length of stay overall. However,  it has reduced the variability/stabilised rates and the work will continue and it is envisaged that improvements will be seen over the next year.

# Part 3: Our Quality Performance 2025/26

## 2. Increasing outpatient activity

The first outpatient appointment is the largest and most modifiable aspect of the elective pathway and is the biggest contributor to waiting times delays. Increasing appointments ensures patients can embark on their treatment pathway earlier.

The Outpatient Transformation Project has made good progress across the several workstreams aimed at increasing first outpatient appointments. We introduced an opt-in approach for physiotherapy patients to help reduce DNAs and strengthened the focus on e-triage so that every patient is reviewed within seven days. We also updated patient letters and leaflets to improve how we communicate and ensure information is clearer. Alongside this, we reviewed Patient Initiated Follow Up (PIFU) pathways on EPR and launched an Ear, Nose & Throat (ENT) remote monitoring service to reduce unnecessary follow-up visits, freeing up clinic capacity for patients waiting for first appointments. The data demonstrates that we have delivered more appointments than were planned over the 25/26 period, therefore this project is classed as achieved.

## 3. Deconditioning (#EndPJParalysis)

Inactivity in inpatients can lead to deconditioning, which causes loss of fitness and muscle tone. Getting patients up and dressed is one way to help ensure patients are able to mobilise and avoid the problems associated with deconditioning. The main focus was to support patients to be up, dressed, and out of bed in a chair before lunch, where clinically appropriate. A target was set for ≥50% of patients to meet this standard, supported by clearly defined clinical exclusion criteria to ensure patient safety. This initiative was implemented across all Networked Care wards, supported by multidisciplinary teams including nursing, therapies, doctors and ward leadership teams. Through consistent monitoring and local ownership, the programme achieved and sustained the 50% target for six consecutive months.

Several wards adopted the Improving Together methodology to embed this as sustained practice change. A dedicated action group continues to oversee progress, maintain focus, and address emerging challenges.  Work is now underway to systematically capture patient experience and feedback to further understand the impact of early mobilisation from the patient perspective.
The Deconditioning Action Group has been opened to other Care Groups, enabling the sharing of learning and best practice across the organisation.

# Part 3: Our Quality Performance 2025/26

## Patient Experience

### 1. Shared Decision Making

Shared decision making ensures that patients are supported to make the decisions that are right for them so it is vital that patients feel confident that they are involved in all decisions about their care. This metric for this project, 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' achieved 93.7%. Whilst the ambitious target level of 95% was not achieved Shared Decision Making continues to be a focus for the Trust, and it is now one of the actions from the National Inpatient Survey and is being incorporated into teaching and induction sessions. Teams from across the Trust have formed a working group to review the future delivery of SDM training including reviewing a national e-learning package and exploring the value of targeting training. A number of teams across the Trust have successfully incorporated SDM into their practice, it is well embedded within the Respect process and within the Renal service and will become "business as usual" for others.

### 2. Clinical Accreditation Scheme (CAS)

A Clinical Accreditation Scheme uses a set of standards to assure the quality of services and promote a sense of pride and promoting a positive quality improvement culture. The CAS has continued to grow in 2025/26, building on the foundations laid in 2024. The programme ran continuously over the year with 6 inpatient wards completing the accreditation process resulting in the awarding of 4 Gold and 2 Silver awards, a great achievement by all the wards demonstrating the high standards that the Trust aspires to. This has meant that the target for this measure was *achieved*.

The piloting of the outpatient and specialist team started this year with 2 areas accredited. Although this is less than the 3 originally outlined this is still positive progress. This measure was therefore classed as *partially achieved*

The scheme will continue to be rolled out across the Trust

# Part 3: Our Quality Performance 2025/26

The following pages outline projects and initiatives from our Continuous Improvement programme, Improving Together before some other examples of other quality initiatives  across the Trust.

## Improving Together

Improving Together continues to focus on investing in our staff and ensuring all colleagues have access to quality improvement training and development. The programme is built on the principle that the people delivering services every day are best placed to identify opportunities for improvement and lead meaningful change. By empowering teams to develop improvements aligned to our Trust priorities, we continue to strengthen both staff engagement and patient outcomes.

The rollout of Improving Together has continued at pace during 2025/26, with 42% of the organisation's teams now trained in Continuous Quality Improvement (CQI), this rollout sits separately to eLearning. This continued expansion is helping to embed a culture of continuous improvement across both clinical and corporate services.

The impact of this approach is increasingly being reflected in staff experience and organisational culture. For four consecutive years since the launch of Improving Together, the Trust has achieved the highest benchmarking results in the NHS Staff Survey for the question: *"I am able to make improvements happen in my area of work."* This demonstrates the growing confidence of staff to identify opportunities, lead change, and contribute to continuous improvement across the organisation.

## Live Lab

Live Lab is an innovative consultancy and collaboration service developed by the Trust to support partner organisations in strengthening their own improvement capability. Through sharing the Trust's Improving Together methodology and practical experience of continuous improvement, Live Lab promotes learning, partnership working, and the spread of best practice across NHS organisations.

The programme creates opportunities for organisations to work together on shared challenges, fostering collaboration and collective learning across systems. It also provides valuable development opportunities for Trust staff, enabling colleagues to contribute their expertise, build improvement capability, and gain wider experience through supporting improvement work beyond the organisation.

In addition to these collaborative benefits, Live Lab also provides an opportunity to generate income to support the sustainability and future development of improvement work within the Trust.

# Part 3: Our Quality Performance 2025/26

## Improvement Events: RPIWs and VSA

During 2025/26, the Trust continued to utilise Rapid Process Improvement Workshops (RPIWs) to support operational and pathway improvements across a range of services. These workshops bring multidisciplinary teams together to review processes, identify inefficiencies, and implement practical improvements that enhance patient care, safety, and operational performance.

RPIWs completed during the year included:

1. **Trauma / Theatre Pathway** – focused on reducing time to theatre for emergency trauma patients and improving theatre list utilisation.
2. **Maternity Delivery Suite** – focused on improving the post-procedure care of women and babies on the delivery suite, ensuring appropriate clinical care is delivered consistently to improve patient safety and outcomes.
3. **Paediatric ED / SDEC** – focused on increasing the number of patients appropriately streamed to Paediatric Same Day Emergency Care (SDEC) and improving the efficiency of the patient pathway.
4. **RACI ICU Pathway** – focused on the "Recovery After Critical Illness" pathway, ensuring the service is equitable, accessible to all patients who require it, and delivered as efficiently as possible.

Building on this work, plans for 2026/27 include the introduction of a Value Stream Analysis (VSA) approach focused on the Emergency Surgical Pathway. This large-scale improvement initiative will involve teams from across the organisation working collaboratively to review the entire patient pathway, identify opportunities for improvement, and reduce inefficiencies.

The VSA programme is expected to generate a range of improvement initiatives, including RPIWs, targeted projects, and ongoing Improving Together activity to embed and sustain identified improvements across the pathway.

# Part 3: Our Quality Performance 2025/26

## Transformation Projects 2025/26

During 2025/26, the Trust continued to deliver a wide range of transformation projects aligned to the Trust's strategic priorities of delivering high quality care, supporting our people, and building a sustainable future together. These projects are focused on improving patient outcomes and experience, increasing efficiency and capacity, supporting staff, and ensuring long-term sustainability of services. Key transformation projects during the year included:

### Outpatients Transformation

- A range of initiatives have been introduced to transform outpatient services, with a focus on reducing waiting lists, increasing the number of first outpatient appointments, and reducing low-value follow-up activity. This work aims to improve patient access, maximise clinical capacity, and ensure patients receive timely care in the most appropriate setting.

### Lung Health Service

- The Trust developed and launched a new Lung Health Service aimed at identifying and screening patients at risk of developing lung disease. The service supports earlier intervention, improves clinical outcomes, and promotes preventative healthcare through earlier diagnosis and treatment.

### Frederick Potts Building

- Investment of approximately £16 million has supported the development of a new elective Urology procedures unit within the Frederick Potts Building. The expansion will increase capacity for outpatient appointments and procedures, helping to reduce waiting times and improve access to elective care for patients.

### Alertive Bleep Replacement

- The Trust introduced a new Alertive communication system to replace the previous bleep infrastructure. The new system represents a significant improvement in patient safety by enabling faster and more reliable communication during emergency situations, while also improving day-to-day communication and operational efficiency across teams.

### 6S Stock Improvement Programme

- The rollout of the 6S Lean methodology has supported ward teams to review stock management processes, improve organisation, reduce waste, and make stock more accessible and efficient for staff. This work is helping to create safer and more sustainable working environments across clinical areas.

### Private Patient Service Improvements

- Improvements to the Trust's Private Patient service have focused on enhancing operational processes and increasing revenue generation, supporting the sustainability of services across the organisation.

### Diagnostic Demand Management

- Work has been undertaken to reduce unnecessary pathology testing, improving patient experience by reducing avoidable investigations while also improving efficiency, reducing staff time, and lowering costs.

### Health Rota

- A new health rota system for medical staff has been introduced to improve staff experience and streamline HR and workforce processes. The new system supports more effective rota management and contributes to operational efficiencies across the organisation.

# Part 3: Our Quality Performance 2025/26

## Improving Together eLearning

The launch of the Improving Together eLearning course in July 2025 marked a significant milestone in strengthening improvement capability across the Trust. As the first programme within the wider eLearning Strategy, it provides an accessible and scalable approach to improvement education for all staff groups.
To date, over 60% of staff have engaged with the programme, gaining an understanding of the principles, tools, and methodologies that underpin Continuous Quality Improvement (CQI) and change management within the Trust.

The programme is supporting staff at all levels to build confidence and consistency in improvement practice and represents a significant investment in workforce development. Further modules and courses are currently in development to continue expanding the Trust's improvement capability.

## Emergency Department (ED) Approach to Improvement

During 2025/26, the Emergency Department further adapted the Improving Together methodology to support the fast-paced and dynamic nature of the service. This has included the introduction of a sustained five-week cyclical improvement approach, combining elements of Rapid Process Improvement Workshops (RPIWs) with the rhythms and routines of Improving Together.

Each cycle focuses on a specific area of the Emergency Department pathway or operational process, such as Zone B or Paediatrics, enabling frontline teams to lead targeted improvements within their area of practice. The approach has strengthened multidisciplinary team engagement and empowered staff to identify and implement practical changes quickly and effectively.

The work has also involved collaboration with enabling services and external partners where appropriate, including the Urgent Care Centre during work to improve referral pathways, and South Central Ambulance Service (SCAS) during improvement activity focused on ambulance handover times.

## Reduction in Neurology wait-times

The aim of this project was to bring down routine face-to-face Neurology wait times, which had risen to around 80 weeks and were causing real delays for patients getting seen and treated. It was a joint effort between a private provider, Neurology consultants, and the CAT 10 admin team, all working together to increase capacity and make the booking and clinic processes run more smoothly. As a result, wait times were reduced to 11 weeks. This has made a big difference for patients, helping them get seen much sooner, and has taken pressure off the service, making it more manageable going forward".

# Part 3: Our Quality Performance 2025/26

## Introducing micro-enemas and reducing wasted appointment slots in Radiotherapy

A radiographer ran a quality improvement project earlier this year to reduce missed appointment slots and improve patient experience for those patients who needed to attend for radiotherapy treatment and required bladder and bowel preparation prior to their CT/planning scan. Due to a number of factors including demographic of patients, age, compliance, co morbidities and medication, problems such as dehydration and irregular bowel habits meant that achieving satisfactory bladder and bowel prep was difficult and often resulted in CT/planning scan failure and thus cancelled appointments.

Specific group sessions were introduced for prostate patients which covered in depth bowel preparation and education as well as the introduction of micro-enemas to ensure successful bowel preparation. Alongside these sessions radiographers were trained in and gained competency in micro-enema provision.

This initiative proved very successful with a  91% reduction in wasted appointment slots.

## Dementia Focus Project

The aim of this project was to improve the consistent use of dementia identifiers (e.g. '8 Things About Me' poster, EPR documentation, utilisation of risk bands (blue wristbands), and forget-me-not flower) across involved wards, in line with person-centred care standards. A process was agreed is outlined below:

- Matrons / Clinical Leads give the list of all patients with dementia and probable dementia to the Nurse-in-Charge of the day every weekday of the month assigned to the area where the Dementia Focus project is taking place
- Nurse-in-Charge facilitates the audit and gives back the list to the Matron / Clinical Lead
- All teams in the area support the patient, utilising the '8 Things About Me' as a starting point for more tailored care
- Nurse and HCA assigned to the patient ensure completion within 24 hours of admission
- Practice Educators and Dementia CNS act as a support system for further education as needed
- Nurse-in-Charge facilitates the audit and gives back the list to the Matron / Clinical Lead
- Reinstated and strengthened monthly dementia audits (IQVIA Meridian Data Input)

To date, a notable improvement in compliance has been seen across supported wards, with some areas achieving ≥90%. Alongside this there has been increased staff awareness of dementia identifiers and their importance in care delivery, improved ward ownership of dementia care standards.

# Part 3: Our Quality Performance 2025/26

## Patient Experience

Patient experience is a cornerstone of quality and reflects every interaction a patient has with the Trust. Positive experiences can directly influence health outcomes and patient safety. The Trust is committed to continually improving patient experience, and the following pages outline how we monitor, learn from, and support this work, along with examples of current projects.
Our strategic programme, *Experience First*, will guide how we collect, analyse, and act on patient experience feedback going forward. During 2026/27 we will develop a metric to enable us to monitor patient experience within this programme. This will inform the Quality Priorities from 2027/28 onwards.

## CQC Inpatient Survey

In September the CQC published their annual national Inpatient Survey results. The annual national Inpatient Survey asks people to give their opinions on the care they received, including quality of information and communication with staff, whether they were given enough privacy, the amount of support given to help them eat and drink, and on their discharge arrangements.
Based on responses from patients at the Royal Berkshire NHS Foundation Trust, 87% of them rated their overall experience a 7 out of 10 or higher – reflecting the dedication of our colleagues in delivering high quality care. Patients also reported consistently being treated with respect and dignity during their hospital stay, with the Trust receiving a 94% satisfaction rating, above the national average of 82%.
Of the 45 questions where a direct comparison could be drawn from last year's results, we built on our ranking of most improved Trust in the 2023 survey, maintaining our positive scores. Areas of particular strength include:

- Being treated with dignity and respect while in hospital
- Being treated with kindness and compassion while in hospital
- The quality of information given while on a waiting list to be admitted.
- Not having to wait too long to get a bed on a ward.
- Getting help from staff to wash and keep clean.
- Having enough nurses on duty.
- Feeling able to discuss worries or fears with staff.
- Knowing what would happen next with care before leaving hospital.
- Discussions around further health or social care support after discharge.

Patients did tell us that there was more we could do to improve their experience of sleeping at night during their stay, and we are continuing to build on our 'Shh, sleep helps health' campaign. This campaign encourages colleagues to take some simple steps to improve the environment for patients at night, and it also encourages patients to let us know if there's something we could do to help them get better sleep during their stay.

# Part 3: Our Quality Performance 2025/26

## Friends and Family Test

The Friends and Family Test (FFT) is a nationally available feedback tool for people who use NHS services and is their opportunity to provide feedback on their experience. Listening to the views of patients and staff helps identify what is working well and what can be improved.  The FFT asks people about their overall experience of services they have used and offers a range of responses to assign.

A core element of the Patient Experience Team's (PET) work is managing, delivering and reporting on numerous national and internal Trust surveys, particularly the Friends and Family Test (FFT).

During 2025/26 the Trust received 75,850 FFT responses (a slight reduction on 80,261 in 24/25).  The overall Trust satisfaction score for this period has remained at 93.5% (based on total ratings of 'good/very good' for overall experience). Work has continued on theming and analysing adverse (negative) FFT comments. This has developed significantly in the last two years, as the team continue exploring the use of the AI tool 'CoPilot'.

The process of theming FFT data and identifying areas for improvement (including measurable data to evidence the effects of improvements) has been shared with Care Group leadership at their meetings in order for them to discuss appropriate actions. The PET is also working with their software provider to set up automated monthly reporting to specific leads, and a more visible dashboard within the portal.

The PET has worked with the Communications Team to develop new 'You said…We did' and FFT QR code posters, which will enable patients and staff to see what improvements have been made in response to their feedback. The focus in the coming year will be around working with Care Groups and individual departments to ensure feedback is being utilised and to record improvements, and support teams with promoting these Trust-wide and publicly.

## Patient Advice and Liaison Service (PALS)

PALS is a confidential service that patients and carers can contact it they need information  or have concerns or problems related to their care. In 2025/26 3,021 PALS contacts were received, a reduction of 4% compared to the previous year.

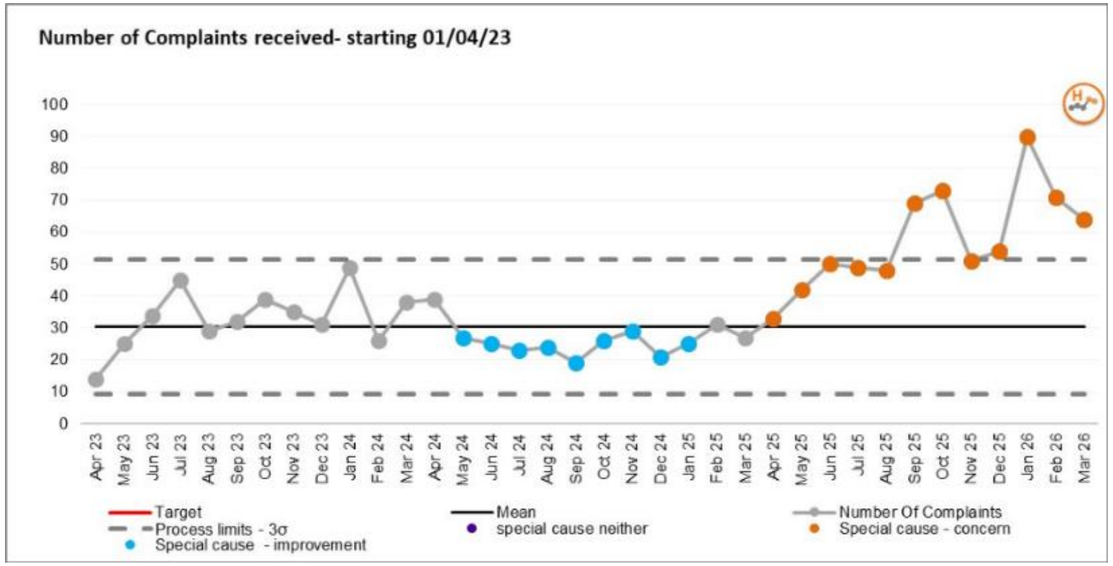
# Part 3: Our Quality Performance 2025/26

## Complaints

There was a significant increase in complaints in 2025/26, echoing the national trend, increasing from 306 in 2024/25 to 688 this year. There remains a seasonal variation in the number of complaints received across the year, with no discernible pattern to the busy months. However, a persistent elevation in the number of complaints received has been seen since December 2024. The three top theme categories used when logging complaints remain Clinical Treatment (57%), Communication and Consultation (21%) and Administration (15%). These may be subject to individual interpretation bias or subjective judgement.

All complaints are risk-rated at closure. Of the complaints closed this year, 41% were partially well-founded, 20% well-founded and 20% unfounded. Overall, 63% were categorised as low or very low risk. There were five high-risk cases that were well-founded; three related to Clinical Treatment, one to Communication and Consultation and one to Administration.

The introduction of a Complaints AI module in 2026 will enable the Trust to identify themes underpinning patient safety, complaints and PALS across the Organisation and facilitate targeted improvement.




# Part 3: Our Quality Performance 2025/26

## Chaplaincy/Spiritual Healthcare

The Chaplaincy/Spiritual Healthcare team continued to provide inclusive, person-centred spiritual, pastoral and religious care to patients, families and staff. Using Improving Together approaches, they extended reach and supported 2,283 patients, 978 visitors, 952 staff and 293 volunteers. Much of this work takes place at significant, often unquantifiable moments such as end-of-life, challenging diagnoses, distress and spiritual searching.

The team supported major patient life events including baby blessings, funerals, baptisms and marriage celebrations. They also led or supported services marking key events such as the VJ Day opening of the Frederick Potts Building, VE and Remembrance Day, Christmas and Easter, Staff and ICU Memorial services, and Baby Loss Services
Weekly provision included Ecumenical communion, Muslim Friday prayers, weekly hospital prayer, a monthly vigil for world events, hospital radio chaplaincy talks and the Iftar celebration. Improvements were also made to Sanctuary washing facilities to better support Muslim staff.

The team contributed to Palliative Care MDT meetings, incident debriefs and ward huddles, helping identify staff requiring additional support. They provided one to one staff support, contributed to the TRiM trauma programme, and delivered Spiritual Healthcare sessions at Trust inductions and study days across multiple specialties, including ED, Elderly Care, Dementia and Junior Doctors.

The team coordinated 27 Patient Companion volunteers supporting patients across the hospital, including those at end-of-life, receiving cancer care, dialysis and veterans' services. The volunteers supported an average of 47 patients a month, including urgent end-of-life requests. Monthly Reflective Practice sessions with a Staff Clinical Psychologist supports volunteer wellbeing. In addition, six Voluntary Assistant Chaplains supported pastoral and religious care, visiting over 300 patients in the past six months.

> "A massive thank you to the Patient Companion – they provided an exceptional amount of empathy, patience and friendship in his last hours." (AMU staff)

# Part 3: Our Quality Performance 2025/26

## Voluntary Services

Volunteer demand remained high, with over 320 active volunteers supporting the Trust. During 2025, 100 volunteers were recruited and 135 exited, reflecting the ongoing recruitment cycle. Volunteers contributed approximately 32,000 hours across established roles such as buggy driving, Emergency Department (ED) tea trolley and pharmacy runners, alongside new roles including ward-based support Ultrasound support, volunteer chaplaincy, Bracknell services and Dress for Dignity audits.

The team also coordinated short-notice and ad-hoc volunteer support, including emergency blood running in ED, communications support, library leaflet corrections and PLACE surveys (NHS environmental surveys). The Pets As Therapy service has expanded over the last year, with seven dogs now visiting staff and patients in over 25 areas of the Royal Berkshire Hospital site.

Volunteer engagement and recognition remained strong, with 150 volunteers attending the annual Volunteers' Supper, supported by corporate donations providing gifts and prizes.

> **"Knowing someone can support him (patient) with companionship and visits is really helpful & reassuring."**
> **(Staff Member)**

## Carers identification and support

Carer identification remained a core priority in 2025/26. A Protocol for the Identification and Support of Carers was developed and published, providing staff with a clear and consistent framework. Training was delivered to ensure carers' details were recorded within the Electronic Patient Record, embedding identification into routine practice and improving data capture.

Targeted training and awareness initiatives were expanded, including bespoke ward sessions, training with Patient Companions and Discharge Co-ordinators, and two Managers' Seminars focused on carers' rights and supporting staff with caring responsibilities. Presentations to the Public Board and Care Group Boards strengthened organisational awareness and accountability.

Partnership working continued with local authorities across Reading, Wokingham and West Berkshire, supporting alignment with local carers' strategies. Collaboration with Age UK Berkshire enabled direct advice, signposting and the visibility of carers' support within the hospital setting.

Community outreach events, alongside promotion of Carers Week and Carers Rights Day, further strengthened engagement. The monthly Carers Café continued to support early identification and engagement, identifying around 20 previously unknown carers last year.

# Part 3: Our Quality Performance 2025/26

## Health Inequalities

The Trust is committed to ensuring that all patients have access to the same great care and treatment and so it runs a number of projects for those who may have difficulty accessing services, often with partners in the Community, to break down barriers and make services more accessible. Below are just a few examples of the work carried out this year:

**Equity of care for Armed Forces and veterans**

This year the Trust has been reaccredited with its Veteran Aware status for the third year in a row, recognising the work the Trust does to support patients, staff and visitors who are part of the Armed Forces community and who may experience health inequalities. In June, the Trust also re-signed its Armed Forces Covenant in a special ceremony at Brock Barracks. Since then, the Trust has received recognition for the work it does to support Armed Forces staff and their families by being awarded Gold in the Armed Forces Employer Recognition Scheme.

The Veterans Covenant Healthcare Alliance (VCHA) has also just launched a new National Training programme to help healthcare staff understand the importance of supporting those in the Armed Forces and how they can help. The VCHA regional representative shared the training launch at the recent Forces Forum. This generated several further opportunities to share the training more widely, in specialities such as Audiology, Maternity and Palliative Care.

**Deaf awareness Course**

The Trust has partnered with Total Communications (who provide our British Sign Language interpreters) to provide staff with information about communicating with people who are Deaf. This training includes topics such as communication methods, terminology, technology, fingerspelling, some basic signs and links to British Sign Language information. The training is suitable for anyone who has regular face to face contact with patients.

Feedback from staff who attended the course has been very positive "I *learnt loads from this session. Well worth attending if you haven't already*"; *"I have had the pleasure of going to this and I thoroughly loved every minute of it*" and *"This is a really good workshop and a great way to improve our patient and carer experience if they have any hearing impairments*".

# Part 3: Our Quality Performance 2025/26

## Sexual Health

The Sexual Health Service are active in the Community to reduce the barriers and stigma associated with sexual health. The team ensure they provide an accessible service using a variety of approaches:

- Main Clinic – opening hours that include early mornings, late evenings and Saturdays.
- Satellite clinics – at least one walk-in clinic in each Local Authority area during the week.
- Seen same day service for vulnerable patients and those with an urgent and/or time sensitive sexual health need.
- Online testing service for people aged over 16 who do not want/cannot access the clinics and have no symptoms.
- Specialist Outreach Service – offers sexual health and contraception services for vulnerable patients unable to access mainstream services. They can be seen in a location of their choosing (usually their home) with supported fast track appointments in the main clinic for those requiring a clinical environment examination and/or procedure.

As well as one-to-one patient consultations the Specialist Outreach Service also attends other health care facilities where patients are deemed too ill to attend the main clinic (Prospect Park Hospital, a mental health facility, for example). In addition, they work with partners from a wide variety of statutory and third sector organisations across the community.

Sexual health also have the use of a van on loan, which has enabled the team to get out to local events and provide a presence at various community events whilst it is still on loan. It has visited a variety of locations including town centres, community fun days, PRIDE events and educational facilities. For World AIDS Day on 1st December 2025, the mobile van was located at various places across the week including sports venues, town centres and libraries to promote sexual health screening to communities and populations that might otherwise find access to services challenging.

The Sexual Health Service social media pages have been utilised and have reached 76,000 followers with 268,000 content views and over 200 link clicks

# Part 3: Our Quality Performance 2025/26

## Meet PEET - Community Wellness Outreach programme

Addressing health inequalities is a key priority within the Trust's refreshed Strategy under the pillar *Delivering the highest quality of care for all*, with a focus on working with communities to understand need and co-create solutions. Meet PEET (Patient Experience Engagement Team) is a core programme supporting this ambition.

Over the last year, Meet PEET jointly delivered a regionally funded initiative aimed at reducing health inequalities among the most vulnerable communities across the region. Working in partnership with Reading Voluntary Action (RVA), the team delivered community-based health checks and social prescribing. Since January 2024, nurses have completed over 4,600 full health checks, identifying and supporting the management or prevention of a wide range of current and future health conditions.

A key improvement this year is that the majority of results are now shared with patients' GPs on the same day via an electronic platform, strengthening continuity of care. Health checks identified significant unmet need, including 69% who underwent checks with very high/high BMI, 21% with high blood pressure, 21% with raised blood glucose (pre-diabetes indicator) and 6% with a high QRisk score, indicating cardiovascular risk.

The programme continued to reach priority groups, with 60% of participants from ethnically diverse backgrounds, including 40% from Asian and Black communities, who are at increased risk of cardiovascular disease and diabetes. The age range was expanded beyond the standard GP cohort of 40–74 years, resulting in 9% aged 75+ and 37% of participants under 40 enabling earlier intervention and prevention.

Health checks were widely promoted, including coverage on BBC South Today and That's TV in January 2026, supported by Reading Borough Council's Media and Communications Team, highlighting both patient impact and programme benefits.
A delay in funding confirmation for 2025/26 temporarily reduced momentum, impacting venue booking and promotion. Once funding was confirmed, additional venues were secured and strengthened community partnerships to ensure continued access for priority cohorts. In addition to the venues identified by RVA, this included outreach to junior carers and their families, food bank users, people accessing substance misuse services, and those who are homeless or insecurely housed.
As the programme concludes, Meet PEET will build on these partnerships to ensure ongoing community engagement and presence beyond the end of the CWO health check initiative.

# Part 3: Our Quality Performance 2025/26

## Patient Safety

The Trust remains committed to delivering consistently safe, high-quality care every day of the year. A strong, open incident reporting culture is actively promoted, supporting continuous learning and improvement and enabling early identification and mitigation of risk. Incident reporting levels throughout the year remained stable, with a small overall increase, which is indicative of a positive safety culture rather than deteriorating patient safety. When patient safety incidents occur, the Trust works openly with patients and their families to understand what happened, listen to their experiences, and ensure that learning leads to tangible improvement. This approach supports patient trust, improves safety outcomes, and aligns with regulatory expectations.

During 2025/26, the Trust has continued to strengthen its approach to patient safety through robust incident reporting, effective learning, and targeted improvement activities. This following pages provide an overview of patient safety incidents, Never Events, National and Local Patient Safety Alerts, together with learning and improvement activity delivered under the Patient Safety Incident Response Framework (PSIRF), a national initiative designed to improve  how healthcare organisations in England respond to patient safety incidents.

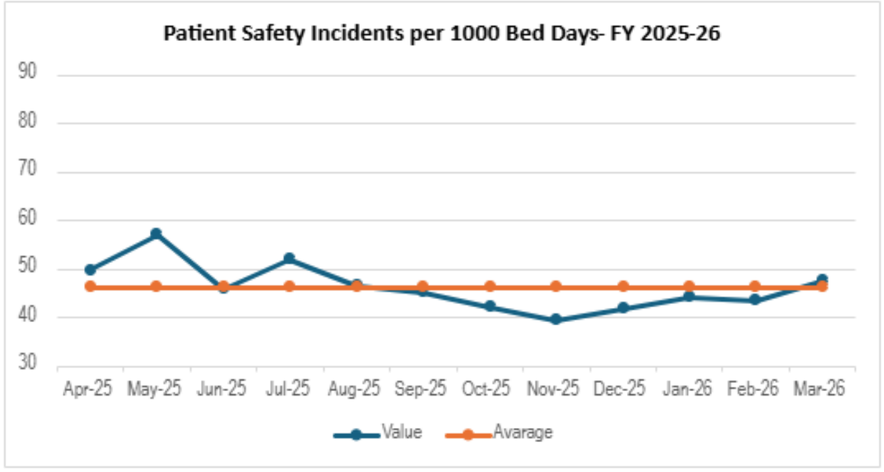
### Duty of Candour

The Duty of Candour is a legal, regulatory, and contractual requirement and is fundamental to the Trust's commitment to openness and transparency. It requires the Trust to be open with patients and/or their next of kin when a patient safety incident has resulted in harm, including providing a timely apology, a clear explanation, and ongoing communication.

This process represents the start of a restorative approach, ensuring the patient voice is central to learning and improvement. During 2025/26, 403 patient safety incidents met the statutory criteria for Duty of Candour. Incidents reported with moderate or above physical or psychological harm. Compliance with the Duty of Candour process was monitored through Trust governance arrangements to ensure completion of all required actions, timely communication, and appropriate learning.

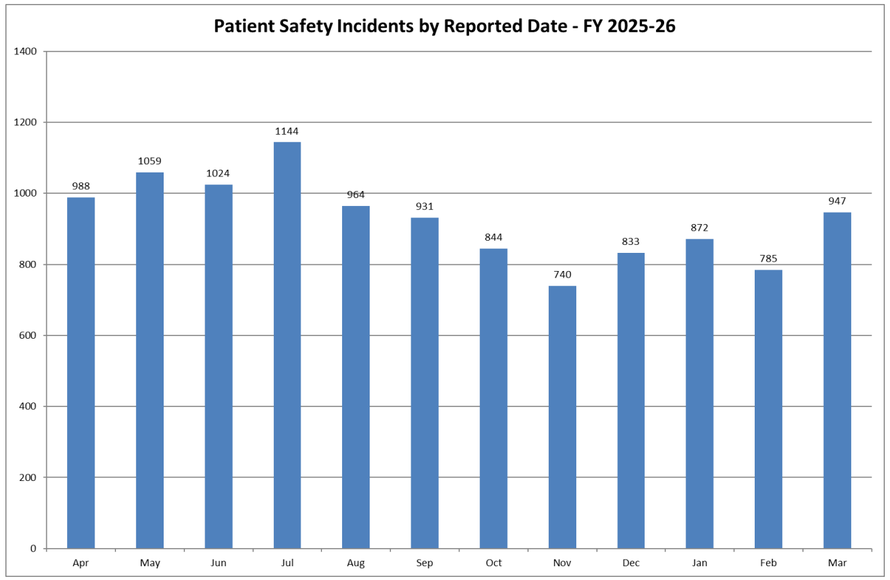
### Patient Safety Incident Reporting and Trends

Patient safety incident rates per 1,000 bed days remained within statistical control limits throughout 2025/26. Early year variation was followed by a sustained period of improvement, with reporting rates remaining at or below the Trust average for much of the year. A modest increase towards year end did not indicate any sustained or systemic deterioration.



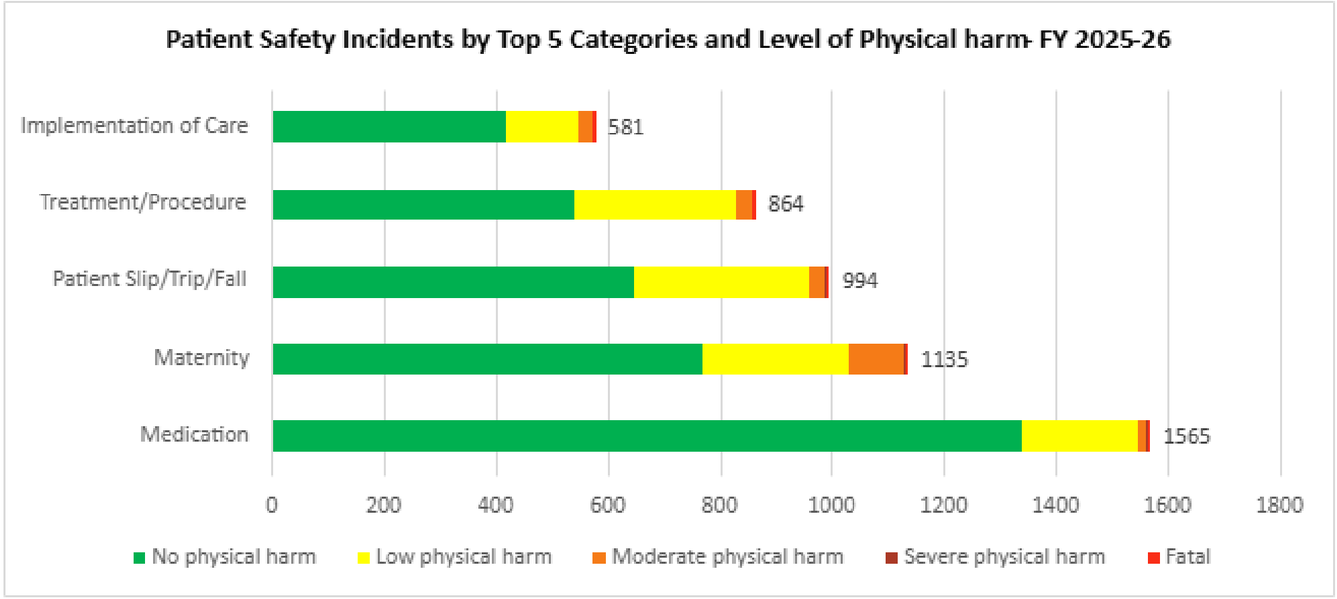
# Part 3: Our Quality Performance 2025/26

## Patient Safety




The Trust continues to encourage reporting of incidents, near misses, and safety concerns as a core mechanism for learning and improvement. Periods of reduced reporting were reviewed and followed by recovery providing assurance that changes reflected reporting behaviour rather than reduced safety.

Overall trends indicate a stable and controlled safety system, supported by a mature reporting culture focused on learning rather than blame.




**Incident Profile and Harm**

The chart on the right demonstrates that across the five highest-reporting patient safety categories, many incidents resulted in no physical harm, with a smaller but consistent proportion causing low harm and only a limited number associated with moderate, severe, or fatal outcomes. Medication incidents account for the highest overall volume and are predominantly no-harm events, reflecting both the complexity of medicines management and a well-embedded reporting culture.

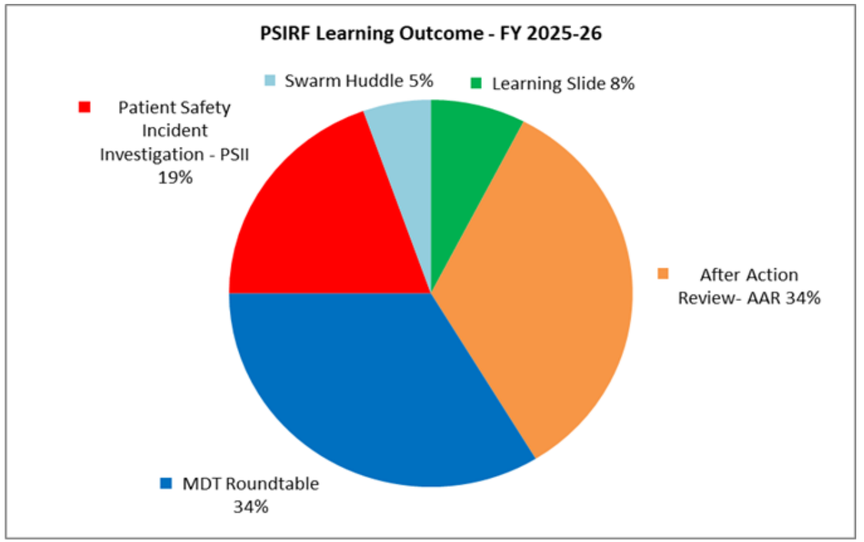
Maternity incidents, while fewer in number, show a relatively higher proportion of moderate harm, largely attributable to third- and fourth-degree vaginal tears, which are recognised complications of childbirth. All five priority themes have been subject to targeted improvement activity during the year, with demonstrable improvements achieved across each area. This harm profile demonstrates effective early identification of risk while reinforcing the need for continued targeted improvement in high risk areas.

# Part 3: Our Quality Performance 2025/26

## Patient Safety - Learning and Improvement under PSIRF

**Patient Safety Incident Response Framework (PSIRF) Learning Responses**

The Trust has further embedded PSIRF during 2025/26, with learning responses proportionately matched to the nature and impact of incidents.
During the year, the Trust applied the Patient Safety Incident Response Framework (PSIRF) to ensure learning responses were **proportionate, timely, and focused on improving systems of care** rather than assigning blame. A range of learning response methods were used, matched to the nature, impact, and learning potential of incidents, as outlined below.




**MDT Roundtables (34%)**
Multidisciplinary team (MDT) roundtables are structured discussions bringing together clinicians and staff from different professional backgrounds to review incidents collectively, identify shared learning, and agree improvement actions and were the joint most frequently used learning response. This approach supports system-wide learning, strengthens teamwork, and enables quicker implementation of changes close to the point of care.

**After Action Reviews (AARs) (34%)**
After Action Reviews are structured facilitated group discussion of an event and are widely used to support reflective, team-based learning soon after an incident. AARs focus on understanding what was expected to happen, what actually happened, why there was a difference, and what can be learned. This method promotes psychological safety, enhances team performance, and supports continuous improvement in everyday practice.

**Learning Slides (8%)**
Learning slides were used to support rapid dissemination of key safety messages and lessons identified from incidents. These concise learning products are shared across teams to raise awareness, support education, and encourage consistent practice, contributing to wider organisational learning.

**Swarm Huddles (5%)**
Swarm huddles provided an immediate, informal learning response following incidents or near misses. These short, focused discussions enabled frontline teams to identify early actions, reduce risk quickly, and support staff wellbeing, particularly following stressful events.

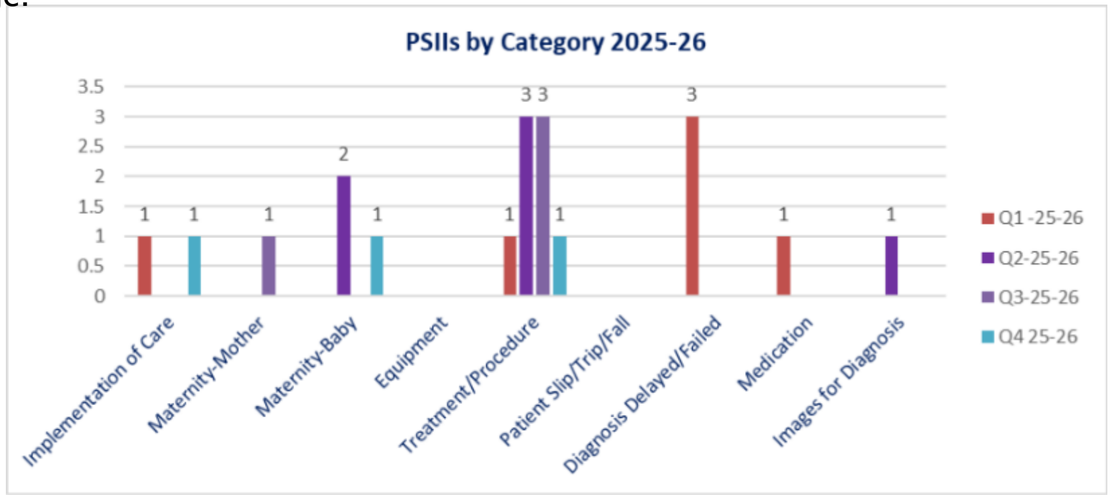
# Part 3: Our Quality Performance 2025/26

## Patient Safety

**Patient Safety Incident Investigations (PSIIs) (19)**

A PSII is an in-depth review to understand how and why a single patient incident happened, carried out by an investigator. Formal Patient Safety Incident Investigations were undertaken selectively for incidents with the greatest potential for harm or system learning. The reduction in PSIIs compared with previous years (28 in 2024/25) reflects increasing PSIRF maturity, with learning being addressed earlier through local, proportionate responses. PSIIs remain an important tool where deeper analysis is required to inform system-level change.

During the last year, 19 Patient Safety Incident Investigations (PSIIs) were commissioned, representing a reduction from 28 PSIIs in the previous year. This reduction is consistent with PSIRF expectations, reflecting increasing maturity in the Trust's approach to learning from patient safety incidents. As proportionate, team-based learning responses become more embedded at a local level, safety learning is being addressed earlier and closer to the point of care, strengthening safety culture and reducing the need for formal investigations requiring system-wide change




**National Patient Safety Alerts**

The Trust has effective systems in place to manage National Patient Safety Alerts (NatPSAs), with executive oversight and compliance recorded through the Central Alerting System (CAS). All relevant alerts were actioned within required timescales, ensuring learning and required actions were implemented across the organisation.

The Trust introduced internal Patient Safety Alert system for themes that are local to the Trust. 9 internal patient safety alerts of various themes were raised and disseminated.

# Part 3: Our Quality Performance 2025/26

## Patient Safety

### Never Events

Never Events are a subset of patient safety incidents defined as being preventable because guidance or safety recommendations should be in place to prevent them.

| | Apr 25 | May 25 | Jun 25 | Jul 25 | Aug 25 | Sep 25 | Oct 25 | Nov 25 | Dec 25 | Jan 26 | Feb 26 | Mar 26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Never Events | 0 | 1 | 0 | 0 | 1 | 1 | 0 | 0 | 2 | 1 | 0 | 0 |

Never Events occurred during FY 2025/26, primarily relating to: wrong-site or near-miss procedures, Patient misidentification or Medication-related errors

All Never Events were managed in accordance with PSIRF and national guidance, with structured learning shared through Trust governance arrangements and improvement actions implemented.

### Patient Safety training

It is important that that staff are equipped with the right skills and tools to investigate patient safety incidents effectively, therefore patient National Patient Safety Syllabus training is provided at the Trust. The compliance for National Patient Safety Syllabus training completion has improved from 8% in Q1 to 29% for Level 1 and 15% for Level 2 Training since moving to “local compliance” in Quarter 4. This is a steady increase, and we will continue to monitor, raise awareness and share reports with Care groups.

### Learning from Patient Safety Events (LfPSE)

All patient safety events are recorded and uploaded to the national Learn from Patient Safety Events (LfPSE) system via the Trust’s incident reporting platform. This supports national learning, identification of emerging risks, and development of preventative strategies, while also strengthening local analysis and improvement.

### Dissemination of Learning from Patient Safety Incidents

Learning from patient safety incidents is shared across the Trust using a range of structured and accessible mechanisms. These approaches support consistent learning, promote engagement across services, and ensure that improvements are embedded into everyday practice.  The main dissemination methods are outlined on the next page. Together, these dissemination routes ensure that learning from patient safety incidents is shared consistently, acted upon locally, and embedded across the organisation, supporting continuous improvement and safer care for patients.

# Part 3: Our Quality Performance 2025/26

## Patient Safety

**Monthly Big 4 Patient Safety Themes**

The Monthly Big 4 (Chief Nursing Officer, Chief Medical Officer, Chief People Officer and Chief Pharmacist) messages bring together four organisational patient safety priorities and is used to highlight recurring risks, key learning points, and required actions. This ensures consistent focus on the Trust's most significant safety issues and supports alignment of improvement activity across clinical teams.

**Internal Patient Safety Alerts**

Internal patient safety alerts are issued to raise immediate awareness of significant risks or emerging safety concerns. These alerts provide clear guidance and, where required, specify actions for teams to implement promptly, helping to reduce the risk of recurrence and improve patient safety in real time.

**Monthly Patient Safety Newsletter**

The Patient Safety Newsletter supports shared learning by summarising key incidents, themes, and improvement initiatives from across the Trust. It also highlights best practice and learning points to reinforce safe care and encourage reflection within teams. Many services use the newsletter to inform discussion at local governance meetings.

**Clinical Governance Meetings**

Learning from patient safety incidents is discussed as a standing agenda item within Clinical Governance meetings. This enables teams to review incidents in context, monitor progress against improvement actions, and ensure local ownership of safety learning and risk management.

**Trust-wide Online Learning Zone**

The Trust is developing a central online Learning Zone to bring together patient safety insights, alerts, newsletters, and learning outputs in one accessible location. This platform supports cross-disciplinary learning, improves visibility of shared themes, and enables staff to engage with learning beyond their immediate service area.

**Progress with Patient Safety Partners (PSPs) and involvement of patients and families**

PSPs are patients, carers, and members of the public who play an active role in enhancing patient safety within healthcare organisations. Work is underway to ensure that there is a job description that will align with the Volunteers recruitment and training scheme.

# Part 3: Our Quality Performance 2025/26

## Patient Safety

### Infection Prevention and Control

The Royal Berkshire NHS Foundation Trust (RBFT) takes a zero-tolerance approach to avoidable infections and puts Infection Prevention and Control at the heart of good patient care and clinical practice with a dedicated team. The Infection Prevention and Control Team (IPCT) provide expert knowledge, direction and education in relation to infection prevention and control across the Trust as well as ensuring adherence to national guidance and best practice. The Trust is committed to ensuring that appropriate resources are allocated for effective protection of patients, their relatives, staff and visiting members of the public. Emphasis is placed on the prevention of healthcare associated infection, the reduction of antibiotic resistance and the maintenance of high standards of cleanliness.

### Infection Rates/Reporting

Hospital Associated Infections (HAI) are those infections acquired by patients during their hospital stay that were not present at time of admission. Causes can be complex and multifactorial. The Trust monitors and reports on HAI levels related to several different healthcare associated infections, with some also assigned target or threshold levels set by our commissioners. Performance data can be seen in the table below. Post Infective Reviews were carried out on all Trust apportioned MRSA, Clostridioides infections to identify possible lapses in care delivery and resultant actions.

| Trust apportioned infections | 2023/24 | 2024/25 | 2025/26 | 2025/26 Objective/Threshold |
|---|---|---|---|---|
| Meticillin Resistant Staphylococcus aureus (MRSA) | 0 | 2 | 6 (4 avoidable) | 0 (avoidable) |
| Meticillin Sensitive Staphylococcus aureus (MSSA) | 39 | 44 | 45 | No threshold |
| Escherichia coli (E. coli) Bacteraemia | 129 | 100 | 87 | 94 |
| Klebsiella Bacteraemia | 45 | 35 | 34 | 36 |
| Pseudomonas Aeruginosa | 17 | 18 | 16 | 16 |
| Clostridioides (prev known as) Clostridium difficile | 44 | 55 | 53 | 39 |

# Part 3: Our Quality Performance 2025/26

## Patient Safety

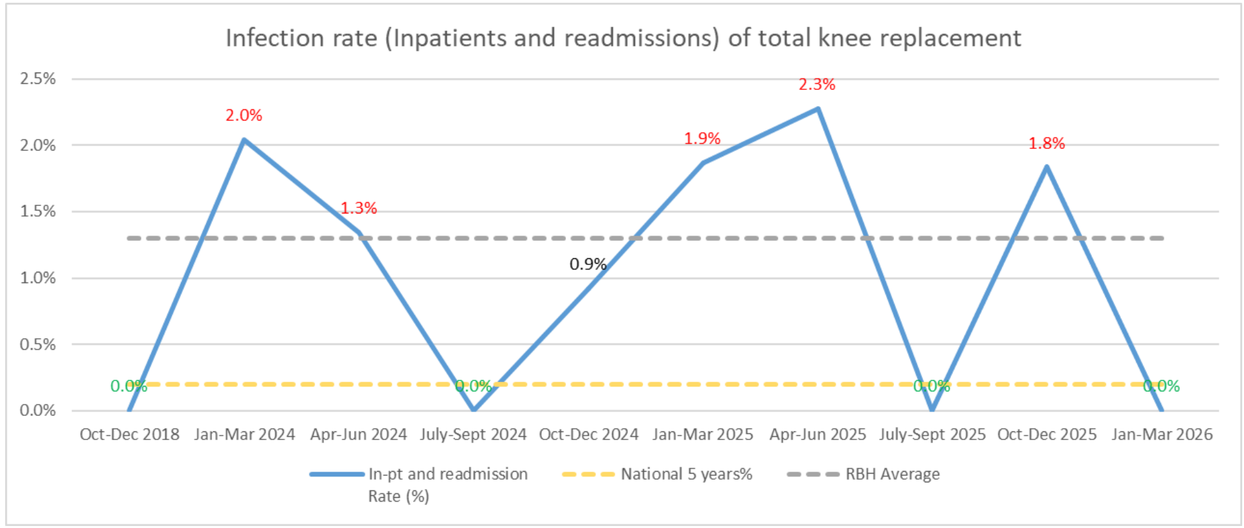
### Infection Prevention and Control (cont'd)

The Trust met or achieved lower than most of the upper threshold levels, apart from Clostridioides. In response to this, a Trust wide C. diff Improvement Group was established, led by the Chief Nursing Officer, to deliver focused improvement using Trust Quality Improvement methodology.

Reducing the numbers for all HAI remains a primary focus for the Infection Prevention and Control Team.

### Surgical Site Infection Surveillance (SSIS)

As per national mandatory guidance, NHS Trusts undertaking orthopaedic surgical procedures are required to undertake a minimum of three months (total 90-day surveillance period) for each individual patient in at least one of four orthopaedic categories, one of which is Total Knee Replacement. SSIS for Total Knee Replacement (TKR) surgery has been undertaken consecutively since January 2024. During the year (UKHSA SSIS surveillance period Q2 2025 – Q1 2026), the Trust continued to be notified as a national high outlier across two surveillance periods. Specialist support was sought and an external review identified that the Trust has a patient cohort with a higher risk profile. Adjusting for this still left the Trust at an elevated rate. SSIS was undertaken for Large Bowel Surgery in Q1, where a sustained reduction in the SSI rate was observed.




All cases of SSI undergo a Post Infective Review by the IPCT, and the learning and any recommended actions are fed back to the respective Surgical Teams. A summary of actions to reduce SSI rates within T&O and other Surgical specialities include:

- Continued active surveillance for Knee Replacement surgery and reactive surveillance, including post-infective reviews, for other Orthopaedics and surgical specialties represented at the SSIS Committee (i.e. Large Bowel Surgery, Urology, Maternity)
- Ongoing representation at the Trust Surgical Site Infection Surveillance (SSIS) Committee, reporting into the Infection Prevention and Control Committee (IPCC)
- Continued representation at specialty-specific SSIS working groups and support for the establishment of new groups, including Theatre & Anaesthetic and Maternity SSI working groups formed during this financial year.

# Part 3: Our Quality Performance 2025/26

## Patient Safety

### Trust Hand Hygiene Compliance

Audits of hand hygiene are undertaken at least monthly in all clinical areas as well as spot checks undertaken by Matrons. These audits are structured observational assessments to monitor staff compliance with hand hygiene policies at key moments of providing patient care. Data is uploaded onto a web based auditing system and the reports generated by the system are widely available to facilitate timely rectification actions to be taken by those areas/staff groups when compliance fails to meet the required standard. Trust level results can be seen in the table below.

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Compliance | 99.08% | 95.10% | 95.93% | 95.79% | 97.19% | 96.23% | 94.13% | 94.71% | 96.06% | 97.27% | 98.64% | 94.70% |

### Antimicrobial Stewardship

Antimicrobial stewardship (AMS) is crucial as it aims to optimize the use of antimicrobials, particularly antibiotics, to preserve their efficacy and reduce the risk of antimicrobial resistance (AMR). The Trust delivered a comprehensive programme of work throughout the year including:

- The review and development of anti-microbial prescribing guidelines and patient group directions.
- Review of patient group directions for the vaccination centre and Florey Sexual health unit
- Completion of 7 ward based audits to improve antibiotic prescribing in the trust
- Completion of 3 trust wide point prevalence audits
- Education and training (trust wide)
- AMS ward rounds

Average Trust consumption of Watch antibiotics (those with higher toxicity or resistance potential) and Reserve antibiotics (newer agents reserved for complex or multi-drug-resistant infections) remained above the 2017 baseline in Quarter 1 and Quarter 2 of 2025/26. However, consumption in Quarter 2 showed a reduction compared to Quarter 1.

Despite this, the Trust had the highest proportion of “Access” antibiotics (first and second-line choices for common infections) across the BOB ICB at 62%, compared with a national target of 70% (national average 53%).

Work continues with AMS Pharmacy and DDaT teams to launch a functioning AMD Dashboard that will enable the provision of “real-time” AMS Data reporting of performance against the contractual and incentive AMS schemes or on relevant key performance indicators (KPIs).

# Part 3: Our Quality Performance 2025/26

## Awards, visits, and external recognition

Over and above our core work, we have had much to celebrate, with colleagues noted for their achievements externally. Our Renal team were recognised by the Health Service Journal for their Kidney Essentials web-based hub, providing information to patients with chronic kidney disease in multiple languages. The Trust as a whole was also recognised by the Thames Valley Chamber of Commerce as their ‘Employer of the Year’.

We’ve also played host to a number of stakeholders including the Secretary of State for Health and Social Care, NHS England’s Chief Pharmacist, and international partners including clinicians from Nigeria visiting to learn more about the work we do in our Stroke Pathway.

In the world of research, colleagues in our Stroke team continue to be at the forefront into the potential of AI, recently co-authoring the largest global study of its kind which showed it can reduce the time to access treatment by more than an hour. And we are proactively sharing our learning outside of the Trust, with Gastroenterology and Hepatology colleagues publishing a research study looking back on 700 patients over a 10-year period to shows clear benefits of taking a proactive approach to identifying people living with chronic Hepatitis B.

# Part 3: Our Quality Performance 2025/26

## Staff Survey

In the latest NHS Staff Survey results, published in March 2026, the Trust was proud to be identified as the top acute trust nationally across 16 areas, putting us up there with the best in terms of working experience.

The NHS Staff Survey is one of the largest workforce surveys in the world – collecting feedback on staff experience across a variety key areas including inclusivity, reward and recognition, staff safety, engagement, and morale. With over 4,000 responses, more colleagues than ever took the time to make their voice heard. From the feedback received, we saw some of our best scores and have been ranked as the top acute Trust in England in 16 areas, alongside two People Promise themes. This builds on and beats the 13 areas we topped the list for last time around. These latest results include top scores for:

- We each have a voice that counts
- My organisation acts on concerns raised by patients.
- I look forward to going to work
- We are a team
- I feel my role makes a difference to patients
- My organisation takes positive action to support health and wellbeing
- I am able to make improvements happen in my area of work

These positive results show that supporting people to thrive - one of our key strategic aims – is feeding through to the experience colleagues have in their day-to-day work as they deliver compassionate care to the community.

Over the past several years, the Trust has built on its wellbeing offer for staff with support including preventative health checks, and on-site support from Citizens Advice. It has also built upon its recognition offering, provided greater leadership and development training, and provided a variety of new benefits including out-of-hours food, and in-house psychological support and more.

Steve McManus, Chief Executive at the time of publication, said: “I am incredibly proud of these latest staff survey results. As a team of thousands, we all contribute in different ways to make the Trust the best place it can be, both to work as part of, and as a place to receive care. “Our staff and volunteers are what make the organisation such a special place, and it’s brilliant to see that we are continuing to build on the positive culture we have, despite a challenging environment we operate within. “We know there’s always more we can do, and these results allow us to go further still and identify where we can make the Trust an even better place to work.”

# Part 3: Our Quality Performance 2025/26

## Staff Wellbeing

The Trust continues to provide a comprehensive health and wellbeing (H&WB) offering to staff. The positive action taken to promote and support Staff Health and Wellbeing was reflected in the 2025 NHS Staff Survey results, mentioned above, which highlighted 70% of staff feel that RBFT take "positive action on Health and Wellbeing." A number of initiatives ensure that staff feel supported and that their health and wellbeing is important to the Trust. Examples of the initiatives/programmes include:

- NHS staff health check+ programme
- Trust Employee Assistance Programme
- Trauma Risk Management (TRiM) network
- Staff Psychological Support service

## Freedom to Speak Up (FTSU)

Freedom to Speak Up is an initiative in the NHS which is designed to support patient safety and create a positive culture where staff feel empowered to speak up about concerns related to patient care and workplace concerns without fear of repercussions. Our 2025 NHS Staff Survey results provide strong assurance on the overall cultural health of the organisation and our experience at work, which is regarded as one of the very best in the country. The ongoing strong performance in speaking up, and confidence in the organisation taking action questions within the survey, demonstrate we continue to drive a culture of openness and feedback, engaging staff voices in our organisational direction.

148 concerns were raised in 2025-26, an increase of 33 cases on the previous year. This is positive as high reporting can lead to low harm. Concerns were raised face-to-face, at FTSU Awareness sessions, listening events, telephone calls, emails, MS Teams, and anonymously by letter.

There is a diverse network of 33 FTSU Ambassadors that meet monthly with the FTSU Guardian, they promote a speaking up culture and signpost people to appropriate support.

'Follow Up in Action' was the theme for October Speaking Up Week. A variety of activities took place supported by the FTSU Ambassadors. South Central Ambulance Service FTSU Guardians visited RBH with the Speakupulance, which is an old ambulance converted into an interactive space for FTSU and staff wellbeing.

The FTSU Guardians deliver FTSU Awareness sessions to teams and departments, and attend the monthly Trust Core Induction. They also maintain visibility across the whole organisation and visit the satellite sites three times a year. The FTSUGs work proactively to support people to raise concerns and help identify barriers, promoting the importance and benefits of people being able to speak up. Managers must listen and act upon concerns when they are raised and ensure that people do not experience detriment for having spoken up.

Following the publication of Dr Penny Dash's Review of patient safety across the health and care landscape in July 2025, the National Guardian's Office (NGO) will close on 30th June 2026. NHS England will assume delivery of the revised FTSU responsibilities from 1st July 2026 NHS England » The future of Freedom to Speak Up.

# Annex 1: Core Performance Indicators 2025/26

The latest data periods given are the latest available data for each indicator. The national averages, NHS best and NHS worst figures are all given where available and for the latest available time periods unless otherwise stated.

## 1. Standardised Hospital-Level Mortality Indicator (SHMI)

| Indicator | Jan– Dec 2018 | Jan-Dec 2019 | Jan – Dec 2020 | Jan-Dec 2021 | Jan – Dec 2022 | Jan – Dec 2023 | Jan – Dec 2024 | Jan – Dec 2025 | Nat Average | NHS Best | NHS Worst |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Summary of SHMI (Value)** | 1.07 | 1.1184 | 1.023 | 1.0268 | 0.973 | 1.0015 | 1.0484 | 1.1394 | 1.0 | 0.7118 | 1.3308 |
| **Banding** | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 1 | 3 |
| **Deaths coded with palliative care** | 51% | 51% | 50% | 59% | 59% | 63% | 62% | 64% | 45% | N/A | N/A |

The Royal Berkshire NHS Foundation Trust considers that this data is as described for the following reasons: The trust mortality data is subject to significant data quality checks and coding review before being submitted nationally for publication.
SHMI, as well as other National Mortality Benchmarking metrics are regularly monitored, with clinical review completed as required. Data is triangulated with other data sources including the Learning from Deaths programme.

## 2. Patient Reported Outcome Measures (PROMS)

The Royal Berkshire NHS Foundation Trust considers that this data is as described for the following reasons: data is collected by a contracted external organisation and then provided to NHS Digital.

| Indicator | 2017-18 | 2018-19 | 2019-20 | 2020-21 | 2021-22 | 2022-23 | 2023-24 | 2024-25 | Nat Average | NHS Best | NHS Worst |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Hip Replacement (Primary) EQ-5D Adjusted Av Health Gain** | 0.494 | 0.452 | 0.473 | * | - | - | 0.416 | 0.420 | 0.451 | 0.544 | 0.267 |
| **Knee Replacement (Primary) EQ-5D Adjusted Av Health Gain** | 0.343 | 0.286 | 0.343 | * | - | - | 0.317 | 0.268 | 0.320 | 0.497 | 0.231 |

In order to respond to the challenges posed by the coronavirus pandemic NHS hospitals in England were instructed to suspend all non-urgent elective surgery for patients for parts of the 2020-21 reporting period. This has directly impacted upon reported volumes of activity pertaining to Hip & Knee replacements reported in PROMS. Data for 2021 – 23 could not be provided as reporting numbers were too low.

# Annex 1: Core Performance Indicators 2025/26

## 3. Readmissions with 30 Days

| Indicator | 2017-18 | 2018-19 | 2019-20 | 2020-21 | 2021-22 | 2022-23 | 2023-24 | 2024-25 |
|---|---|---|---|---|---|---|---|---|
| **Paediatrics (0-15)** | 9.6% | 10.5% | 10.3% | 9.7% | 10.0% | 10.4% | 9.5% | 8.9% |
| **National** | 11.9% | 12.5% | 12.5% | 11.9% | 12.5% | 12.8% | 13.2% | 13.0% |
| **Adults (16+)** | 14.9% | 15.2% | 14.6% | 16.7% | 16.8% | 15.5% | 14.8% | 13.4% |
| **National** | 14.1% | 14.6% | 14.7% | 15.9% | 14.7% | 14.4% | 15.1% | 14.9% |

NHS Digital data are not available for this indicator for 2022-23 and onwards therefore national comparator data are not available.
Data are subject to change post-year end due to the publication timescales for the Quality Report, therefore figures may be slightly different to those reported in the previous year.
The figures above are based on 30 Days rather than 28 Days and are taken from the latest published Compendium of Population Health Indicators provided by NHS Digital.
The figures exclude activity where:

- The provider has submitted data to the Mental Health Services Dataset (MHSDS) and no longer submits to HES.
- The specialised service within which the patient is treated includes mental health services.
- The specialised service within which the patient is treated includes Obstetrics (501), Midwifery Service (560) or Maternity Function (610) and the primary diagnosis is Obstetrics.
- There is a diagnosis of cancer or chemotherapy for cancer during the stay in hospital or within the last year.

The Royal Berkshire NHS Foundation Trust considers that this data is as described for the following reasons: the trust has completed readmission activity reconciliations with both the ICS and national Secondary Uses Services readmission data extracts and has found its data to be in line with these external readmission sources.

## 4. The Trust's Responsiveness to the Personal Needs of Patients

Historically this indicator was based on a composite score of 5 questions from the national inpatient survey. As NHS Digital data was not available similar results for the following questions are included, with a score out of 10:

| Indicator | 2021 | 2022 | 2023 | 2024 | Nat Average | NHS Highest | NHS Lowest |
|---|---|---|---|---|---|---|---|
| To what extent did staff looking after you involve you in decisions about your care and treatment? | 6.9 | 7.0 | 7.4 | 7.2 | 7.2 | 8.5 | 6.3 |
| Did you feel able to talk to members of hospital staff about your worries and fears? | 7.5 | 7.6 | 7.7 | 8.2 | 7.7 | 9.2 | 6.6 |
| Were you given enough privacy when being examined or treated? | 9.4 | 9.6 | 9.5 | 9.6 | 9.4 | 9.9 | 9.0 |
| Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital? | 8.2 | 7.3 | 7.6 | 8.0 | 7.6 | 9.6 | 5.6 |

# Annex 1: Core Performance Indicators 2025/26

## 5. Staff Recommendation Rate (as a provider of care)

The trust participated in the annual staff survey again this year, the survey being a valuable tool in helping us understand the experience of staff here at Royal Berkshire NHS Foundation Trust. The survey covered topics including inclusivity, reward and recognition, staff safety, engagement and morale. With over 4,000 responses, more colleagues than ever answered the survey.

The trust has been ranked as the top acute trust to work for in England in 16 areas, with top scores for:

- My organisation acts on concerns raised by patients
- I feel my role makes a difference to patients
- My organisation takes positive action to support health and wellbeing
- I am able to make improvements happen in my area of work

| Indicator | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | Nat Average | NHS Best | NHS Worst |
|---|---|---|---|---|---|---|---|---|---|---|
| **Staff recommendation rate/If a friend or relative needed treatment I would be happy with the standard of care** | 83.9% | 83.6% | 79.41% | 77.86% | 77.48% | 79.21% | 78.47% | 60.83* | 88.41%* | 34.73%* |

** Acute and Acute & Community Trusts*

The Royal Berkshire NHS Foundation Trust considers that this data is as described for the following reasons: the data is collected by a contracted external organisation and provided to NHS Digital.

The Royal Berkshire NHS Foundation Trust has taken the following actions to improve this proportion, and so the quality of its services, by: implementing action plans to improve the quality of our care and services outlined in this report.

# Annex 1: Core Performance Indicators 2025/26

## 6. Trust Satisfaction Score

| Indicator | 2017-18 | 2018-19 | 2019-20 | 2021-22 | 2022-23 | 2023-24 | 2024-25 | 2025-26 | Nat Average | NHS Best | NHS Worst |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Inpatient FFT Satisfaction score | 100% | 99.7% | 99.6% | 95% | 99.0% | 97.6% | 93.9% | 94.5% | 95% | 100% | 77% |
| ED FFT Satisfaction score | 98% | 97.8% | 98% | 87% | 82.4% | 82.7% | 81.9% | 80.7% | 78% | 100% | 55% |

*Data submission and publication for the Friends and Family Test (FFT) were paused for acute and community providers during the response to COVID-19 from March 2020 therefore data for the 2019-20 year includes April 19 – Feb 20 data only. * NHS average, best and worst are based on data for January 2026*

In 2021/22 Trust Recommendation rate changed to a satisfaction score.

The Royal Berkshire NHS Foundation Trust considers that this data is as described for the following reasons: the data are collected by a contracted external organisation and provided to NHS Digital.

The Royal Berkshire NHS Foundation Trust has taken the following actions to improve this proportion, and so the quality of its services, by: encouraging patients to complete the FFT.

## 7. Venous Thromboembolism (VTE) Risk Assessment

| Indicator | 2017-18 | 2018-19 | 2019-20 | 2020-21 | 2021-22 | 2022-23 | 2023-24 | 2024-25 | 2025-26* | Nat Average** | NHS Best** | NHS Worst** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Patients risk assessed for VTE | 96.1% | 96.6% | 96.3% | - | - | - | - | 95.6% | 94.8% | 91.4% | 100% | 14.7% |

Based on Q1 – 2 data ** Based on Q3 data for NHS acute providers

Data may differ from previous publications due to data reporting dates

National data submission and publication for VTE Risk Assessment figures were paused in March 2020 for acute and community providers during the response to COVID-19 and was not reinstated until 2024 so there is no nationally published data for this indicator for the years 2020 - 2024.

The Royal Berkshire NHS Foundation Trust considers that the data are as described for the following reason: data is subject to periodic checks and auditing to ensure accuracy.

The Royal Berkshire NHS Foundation Trust has taken the following actions to improve this proportion, and so the quality of its services, maintaining the VTE specialist nurse role and regular staff training including on-line training for all resident doctors and face to face training of medical staff in key clinical areas. The Trust screens all diagnosed venous thromboses and investigates these to identify and implement learning. In the last year this has resulted in changes to guidance around suspending VTE prophylaxis before procedures and a significant update to procedures in maternity, which also implement the VTE component of the 2026 NHS England Maternal care bundle.

# Annex 1: Core Performance Indicators 2025/26

## 8. Clostridioides difficile (C.diff)

| Indicator | 2018-19 | 2019-20 | 2020-21 | 2021-22 | 2022-23 | 2023-24 | 2024-25 | 2025-26 | Nat Average | NHS Best | NHS Worst |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Rate of Healthcare associated C.diff per 100000 bed days | 14.7 | 25.7 | 24.01 | 20.02 | 22.94 | 17.89 | 22.52 | Not available | Not available | Not available | Not available |

*Data are subject to change post-year end due to the publication timescales for the Quality Report. Therefore, figures may be slightly different to those reported in the previous year.*
Data for 2025-26 has not yet been published by the UK Health Security Agency.

Refer to the Infection Prevention & Control section for further data and information related to Infection Control.

## 9. Patient Safety Incidents (PSIs)

| Indicator | 2022-23 | 2023-24 | 2024-25 | 2025-26 |
|---|---|---|---|---|
| No of PSIs reported | 12052 | 12108 | 12242 | 11134 |
| Rate per 1000 bed days | 55.7 | 51.7 | 52.4 | 47.7 |
| No of PSIs resulting in severe harm / death | 5 | 25 | 40 | 49 |
| % of PSIs resulting in severe harm or death | 0.04% | 0.21% | 0.33% | 0.44% |

*The data reported here has been revised to ensure consistency and alignment of definitions, therefore may be different to that previously reported*

The reported increase in severe harm and death incidents from 5 cases in 2022/23 to 49 in 2025/26 is primarily attributable to improved identification and reporting rather than a deterioration in care. The step-change from 2023/24 aligns with changes in harm classification and the introduction of more structured physical harm coding under LFPSE, alongside strengthened governance processes such as PSIRG, Case Review and Triangulation (CRaT), Medical Examiner scrutiny and Learning from Deaths reviews. These processes are now capturing incidents that would previously have gone unreported or been managed outside Datix.
Retrospective case finding, batch uploads during the LFPSE transition, and harms identified through complaints or mortality reviews have also contributed to increases in later years. The data highlights consistent underlying safety themes, including delayed diagnosis, failure to recognise and escalate deterioration, follow-up failures and pathway delays. While the rise largely reflects a more mature and transparent reporting system, it also provides clearer visibility of systemic risks requiring ongoing targeted improvement.
NHS England previously published official data through the National Reporting and Learning System (NRLS), which was replaced by the Learn from Patient Safety Events (LFPSE) service in 2024. Official statistics are still in development, so comparator data is not currently available.
The Royal Berkshire NHS Foundation Trust considers this data to be accurate for the following reasons: the Trust promotes an open reporting culture, and all incidents are reviewed and validated by the Quality Governance Team.

# Annex 1: Core Performance Indicators 2025/26

## Single oversight framework

| Indicator for disclosure | 2023-24 performance | 2024-25 performance | 2025-26 performance |
|---|---|---|---|
| Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway | 82.7% | 75% | 84% |
| A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge Type 1 attendances only | 65.7% | 64% | 65.3% |
| All cancers: 62-day wait for first treatment from: | | | |
| • Urgent GP referral for suspected cancer | 67.9% | 71.6% | 74.6% |
| • NHS Cancer Screening Service referral | 73.3% | 74.7% | 76.3% |
| C. difficile: variance from plan | -1 | +16 | +14 |
| Summary Hospital-level Mortality Indicator | See table 1 | See table 1 | See table 1 |
| Maximum 6-week wait for diagnostic procedures | 80.2% | 92% | 86.8% |

# Annex 2: National Clinical Audits and Confidential Enquiries

| Project | Workstream | Participation Rate |
|---|---|---|
| BAUS Data & Audit Programme | British audit Of the investigatiOn and referral of woMen with rEcurrent uRinary trAct infectioN using recent Guidance (BOOMERANG) | 100% |
| | Evaluating the Management Pathway for Suspected Testicular Cancer Referrals (EMPAST) | 100% |
| Breast & Cosmetic Implant Registry | | Continuous data collection |
| British Spine Registry | | Continuous data collection |
| Case Mix Programme (ICNARC) | | 100% |
| Emergency Medicine QIP | Adolescent Mental Health | Data collection ongoing – Deadline Jan 2027 |
| Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People | | Continuous data collection |
| Falls and Fragility Fracture Audit Programme (FFFAP) | Fracture Liaison Service Database (FLS-DB) | Continuous data collection |
| | National Audit of Inpatient Falls (NAIF) | 100% |
| | National Hip Fracture Database (NHFD) | 100% |
| Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) | | Continuous data collection |
| National Adult Diabetes Audit (NDA) | National Diabetes Core Audit | 99% (estimate) |
| | National Diabetes Inpatient Safety Audit | 24 records – Data collection suspended October 2025 |
| | National Pregnancy in Diabetes Audit (NPID) | 100% |
| | Transition (Adolescents and Young Adults) and Young Type 2 Audit | 100% |
| National Audit of Cardiac Rehabilitation | | Data collection ongoing – End May 2026 |
| National Audit of Care at the End of Life (NACEL) | | 100% |
| National Bariatric Surgery Registry | | Continuous data collection |
| National Cancer Audit Collaborating Centre | National Audit of Metastatic Breast Cancer (NA0Me) | 100% |
| | National Audit of Primary Breast Cancer (NA0Pri) | 100% |
| | National Bowel Cancer Audit (NBOCA) | 100% |
| | National Kidney Cancer Audit (NKCA) | 100% |
| | National Lung Cancer Audit (NLCA) | 100% |
| | National Non-Hodgkin Lymphoma Audit (NNHLA) | 100% |
| | National Oesophago-Gastric Cancer Audit (NOGCA) | 100% |

# Annex 2: National Clinical Audits and Confidential Enquiries

| Project | Workstream | Participation Rate |
|---|---|---|
| National Cancer Audit Collaborating Centre (NATCAN) | National Ovarian Cancer Audit (NOCA) | 100% |
| | National Pancreatic Cancer Audit (NPaCA) | 100% |
| | National Prostate Cancer Audit (NPCA) | 100% |
| National Cardiac Arrest Audit (NCAA) | | 100% |
| National Cardiac Audit Programme | National Heart Failure Audit (NHFA) | 100% |
| | National Audit of Cardiac Rhythm Management (CRM) | Data collection ongoing – Deadline 31st May |
| | Myocardial Ischaemia National Audit project (MINAP) | 100% |
| | National Audit of Percutaneous Coronary Interventions (PCI) | Continuous data collection |
| National Child Mortality Database | | 100% |
| National Comparative Audit of Blood Transfusion | 2025 Major Haemorrhage Audit | 100% |
| National Early Inflammatory Arthritis Audit (NEIAA) | | Continuous data collection |
| National Emergency Laparotomy Audit (NELA) | Laparotomy | Continuous data collection |
| National Joint Registry (NJR) | | Continuous data collection |
| National Major Trauma Registry | | 66% |
| National Maternity & Perinatal Audit (NMPA) | | 100% |
| National Neonatal Audit Programme (NNAP) | | 100% |
| National Obesity Audit (NOA) | | 100% |
| National Ophthalmology Database (NOD): | Age-related Macular Degeneration Audit | 100% |
| | Cataract Audit | 100% |
| National Paediatric Diabetes Audit (NPDA) | | 100% |
| National Perinatal Mortality Review Tool | | 100% |
| National Respiratory Audit Programme (NRAP) | COPD Secondary care | 65% (estimate) |
| | Pulmonary Rehabilitation | 100% |
| | Adult Asthma Secondary Care | 80% (estimate) |
| | Children and Young People's Asthma Secondary Care | 74% (estimate) |
| Perioperative Quality Improvement Programme | | Continuous data collection |
| Sentinel Stroke National Audit programme (SSNAP) | | 100% |
| Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme | | 100% |
| UK Parkinsons Audit | | 100% |
| UK Renal Registry | Chronic Kidney Disease audit | 100% |
| | National Acute Kidney Injury Audit | 100% |

# Annex 2: National Clinical Audits and Confidential Enquiries

| Title | Participation Rate |
|---|---|
| **National Confidential Enquiries:** | |
| 1. Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) | 100% |
| 2. Child Health Clinical Outcome Review Programme (NCEPOD) | 100% |
| 3. Medical & Surgical Clinical Outcome Review Programme (NCEPOD) | 100% |

| | |
|---|---|
| **National Clinical Audits and Confidential Enquiries not participated in:** | |
| National Emergency Laparotomy Audit – No Lap | No data submitted due to lack of resource |
| Emergency Medicine QIP's - Care of Older People | No data submitted due to access issues with external platform |
| Emergency Medicine QIP's - Mental Health Self Harm | No data submitted due to access issues with external platform |
| Emergency Medicine QIP's - Time Critical Medications | No data submitted due to access issues with external platform |
| **National Clinical Audits and Confidential Enquiries listed in 2025/26 Quality accounts list subsequently postponed/delayed by the audit bodies** | |
| National Audit of Dementia | |
| National Gestational Diabetes Audit | |

# Annex 3: Learning from deaths

| | Q1 2025-26 (Apr-Jun) | Q2 2025-26 (Jul-Sep) | Q3 2025-26 (Oct-Dec) | Q4 2025-26 (Jan-Mar) | Total 2025-26 | Reported in Quality Accounts 2024-25 | Additional reviews completed in 2025-26 for deaths in 2024-25 | Revised Total 2024-25 |
|---|---|---|---|---|---|---|---|---|
| Total inpatient/ ED deaths | 352 | 306 | 377 | 361 | 1396 | 1522 | - | **1522** |
| Total case note reviews completed * | 72 | 63 | 61 | 30 | **226** | 295 | 37 | **332** |
| Total investigations completed | 4 | 0 | 0 | 0 | 4 | 7 | 26 | **33** |
| Casenote review or investigation completed | 74 | 63 | 61 | 30 | **228** | 299 | 60 | **359** |
| Deaths assessed to be more likely than to be due to problems in care | 0 | 0 | 0 | 0 | **0** | 0 | 1 | **1** |
| % deaths assessed more likely than not due to problems in care | - | - | - | - | **-** | 0% | - | **0.07%** |

**These figures include all reviews that were carried out – regardless of whether one was required*

# Annex 4: Statement from Commissioners

Statement from Thames Valley Integrated Care Board (TV ICB): Royal Berkshire Hospital Foundation Trust Quality Account 2025/26

NHS Thames Valley Integrated Care Board (TV ICB) has reviewed RBFT's Quality Account and believes that it is accurate and meets the requirements of a Quality Account as published in the NHS England Quality Account List for 2025-26.

The Trust wide commitment to quality is evident with the Improving Together approach to continuous quality improvement underpinning transformation across the organisation – for example the introduction of the Cleo e-prescribing system in the autumn of 2025, meaning patients no longer need to wait or return to the Trust for their medication, collecting medications locally instead. This alongside improvement events as described within Rapid Process Improvement workshops, Trauma/theatre pathway, Maternity Delivery Suite, Paediatric ED/SDEC, RACI ICU pathways. RPIW alongside value stream analysis which will be sustained through 2026/27.

The progress against the priorities set for 2025/26 is clearly set out with evidence on whether these are fully or partially met. There has been good progress made on many of the Quality Priorities however the Trust recognises that the ongoing operational pressures impacted the ability to clinical services to complete these. It is positive to note that where the priorities that have been achieved will continue as business as usual. Those priorities where the required level of compliance has not been achieved will follow through into the 2025/26 priorities or form one of the work streams for Improving Together.

The Trust is to be commended on the significant and wide ranging transformation projects which are aligned to the strategic objectives of delivering high quality care, supporting people and a sustainable future. We support the Quality Priorities chosen for 2026/27 and are pleased to see the continued focus at a care group and Trust level.

Over the past year RBFT has worked closely with the ICB and wider system partners, with RBFT attending multiple ICB Steering Groups, System Quality Group, Programme Boards and Committees, System Audit Group, Clinical Governance meetings as well as Patient Safety Improvement Groups.

Key developments across the patient safety space driven by the ongoing implementation of the NHS Patient Safety Strategy, with a focus on system-wide digital, cultural, and operational reforms. A key part of this is the building on the Trusts Call 4 Concern and encompassing the principles of Martha's Rule – giving patients, families, and staff a way to request a rapid review if they are worried about patient deterioration.

The Patient Safety Incident Response Framework (PSIRF) is a system-based learning and continuous improvement approach to incidents. RBFT has had 2 full years since the implementation of PSIRF, and there is evidence of a positive reporting culture with sustained increase in reporting. There is a notable breakdown in the methodologies the Trust have utilised to structure conversations, action and the cascade of learning through the Trust.

# Annex 4: Statement from Commissioners (Cont.)

It is clear from this Quality Account that RBFT has a comprehensive governance process in place for the implementation and auditing of NICE Guidelines, Quality Standards, Baseline Assessments, and Technology Appraisals. The Trust continues to perform strongly in national audit with notable achievements across programmes.

Reducing health inequalities is a national priority and a key focus for the TV system. The ICB are encouraged to see the various strategies detailed such as the "Meet PEET" a community outreach programme. There are also several projects detailed initiatives to assist with access to services including partnering with British Sign Language interpreters to provide staff with information about how to communicate with deaf patients.

The focus is clear from this Quality Account that RBFT has a comprehensive governance process in place for the implementation and auditing of NICE Guidelines, Quality Standards, Baseline Assessments, and Technology Appraisals. The Trust continues to perform strongly in national audit with notable achievements across programmes.

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Patient Experience is evident in the Quality Priorities. The Quality Account details the CQC inpatient survey 87% rated their experience 7 out of 10 and 94% of consistently being treated with dignity and respect. The account further details improving experience initiatives eg; "Shh, Sleep helps health" which is an initiative actioned because of feedback. The handling of complaints is a notable challenge, however its is positive to note that actions taken to facilitate targeted improvement across the themes.

TV ICB is delighted that RBFT continues with the aim of providing high quality care to the population of Reading and beyond within the community sites. The Trusts commitment to continuously learn and improve is evidenced by the breadth of work underway within the Trust to develop, sustain and innovate.

We would like to recognise improvements and achievements in the following areas:
· The rollout of Improving Together during 2025/26, with 42% of the organisation's teams trained in Continuous Quality Improvement (CQI), sitting separately to eLearning. This continued expansion helping to embed a culture of continuous improvement across both clinical and corporate services
· Live Lab promotes learning, partnership working, and the spread of best practice across NHS organisations.
· Various transformation projects aimed at increasing outcomes, experience and efficiencies across the Trust.

# Annex 4: Statement from Commissioners (Cont.)

2025/26 has been yet another challenging year for health and social care with significant challenges across our geography in both the Health, Social Care, and VCSE landscapes. TV ICB is looking forward to collaborating with its system partners to develop the national direction of travel for healthcare to future proof the NHS for future generations by continuing to work on the following 3 key shifts at the core of the government's health mission:

· From hospital to community – providing better care close to or in people's own homes, helping them to maintain their independence for as long as possible, only using hospitals when it is clinically necessary for their care

· From treatment to prevention – promoting health literacy, supporting early intervention and reducing health deterioration or avoidable exacerbations of ill health

· From analogue to digital – greater use of digital infrastructure and solutions to improve care

Yours sincerely
Chief Nursing Officer
Thames Valley ICB

# Annex 5: Statement of Directors Responsibility for Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2018/19 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2025 to March 2026
    - papers relating to quality reported to the board over the period April 2025 to March 2026
    - the 2024 national inpatient survey published September 2025
    - the 2025 national staff survey published March 2026
    - the Head of Internal Audit's annual opinion of the trust's control environment dated N/A (not subject to Audit this year)
    - CQC inspection report dated 07 January 2020
- the Quality Report presents a balanced picture of the Royal Berkshire NHS foundation Trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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# Annex 5: Statement of Directors Responsibility for Quality Report

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

**By order of the Board:**

**Chair:**

**Date: 29 June 2026**

**Chief Executive:**

**Date: 29 June 2026**

NHS

Royal Berkshire

NHS Foundation Trust