

Public Board - 23 September 2026

MEETING
23 September 2026 09:00 BST

PUBLISHED
21 September 2026

Agenda

Location
Seminar Room, Trust Education Centre, Royal Berkshire Hospital

Date
23 Sep 2026

Time
09:00 BST

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1	Apologies for Absence and Declarations of Interest (Verbal)	Helen Mackenzie		-
2	Star Cards (Verbal)	Oke Eleazu	09:00	-
3	Patient Story (Verbal)	Dom Hardy	09:05	-
4	Staff Story (Verbal)	Dom Hardy	09:35	-
5	Minutes for Approval: 29 July 2026	Caroline Lynch	10:05	3
6	Minutes of Board Committee Meetings and Committee Updates:		10:10	-
6.1	Finance & Investment Committee: 15 July 2026 & 16 September (Verbal)	Mike O'Donovan		8
6.2	Charity Committee: 5 August 2026	Catherine McLaughlin		13
6.3	Quality Committee: 3 September 2026 (Verbal)	Minoo Irani		19
6.4	Audit & Risk Committee: 10 September 2026 (Verbal)	Mike McEnaney		21
6.5	Innovation & Transformation Committee: 16 September 2026 (Verbal)	Umesh Jetha		-
7	Chief Executive's Report	James Blythe	10:35	22
8	Integrated Performance Report	Dom Hardy	10:55	26
9	Maternity & Neonatal 10 Point Plan Assurance Process - Baseline Assessment	Katie Prichard-Thomas	11:20	55
10	Maternity Triage Specification: Gap Analysis	Katie Prichard-Thomas	11:30	58
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12	Work Plan	Caroline Lynch		75
13	Date of Next Meeting: Wednesday 25 November 2026 at 09.00am			-

Minutes

Board of Directors

Wednesday 29 July 2026

09.00 – 11.45

Seminar Room, Trust Education Centre, Royal Berkshire Hospital

Present

Mrs. Helen Mackenzie	(Non-Executive Director) (Chair)
Mr. James Blythe	(Chief Executive)
Ms. Suzanne Byrne	(Non-Executive Director)
Mr. Paul da Gama	(Chief People Officer)
Mr. Dom Hardy	(Chief Operating Officer)
Dr. Minoo Irani	(Non-Executive Director)
Mr. Umesh Jetha	(Non-Executive Director)
Mrs. Frances Khatcherian	(Chief Finance Officer)
Dr. Janet Lippett	(Chief Medical Officer)
Ms. Catherine McLaughlin	(Non-Executive Director)
Mr. Mike O'Donovan	(Non-Executive Director)
Mrs. Katie Prichard-Thomas	(Chief Nursing Officer)
Mr. Andrew Statham	(Chief Strategy Officer)

In attendance

Mrs. Caroline Lynch	(Trust Secretary)
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Apologies

Mr. Oke Eleazu	(Chair)
Mr. Mike McEnaney	(Non-Executive Director)

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

101/26 Staff Story

The Chief Medical Officer introduced Libby, Resident Doctor Peer Lead. Libby advised that this was her second year at the Trust and had applied for the role as Peer Lead as she was passionate about wellbeing and work/life balance. Libby explained that the role of the Peer Lead was to provide a link between Resident Doctors and the Board. She collaborated with the Chief Medical Officer, the Chief People Officer and the Guardian of Safe Working. The Trust was covering most of the 10 Point Plan for Resident Doctors although the Resident Doctors' themselves were not aware of this. Libby advised that she had allocated time for her role as Peer Lead and balance this with her clinical work.

The highlights of her role were a feeling of belonging and connecting with the organisation, professional growth including developing a leadership package for which she received an email of thanks from the NHS England (NHSE) Medical Director as well as being able to deliver practical impact initiatives.

The Board noted that Libby was working with the communications team to raise awareness for Resident Doctors' using the Trust's Workvivo platform to create a sense of belonging as well as providing useful information.

102/26 Patient Story

The Chief Nursing Officer introduced Louise, Consultant Midwife and Yasmine with baby Penelope and brother Henry. Yasmine's story highlighted the importance of listening to patients and provision of personalised care.

Yasmine explained that Henry had been born at another trust and her experience had not been good. Yasmine had been induced at 37 weeks and was upset as she wanted a natural birth. Yasmine explained that she felt she could not advocate for herself during the experience. As a result of her first birth Yasmine had requested a homebirth for her second pregnancy. She presented to the Trust at 27 weeks and had researched the risks involved with a homebirth. Yasmine advised that Lead Consultant Obstetrician had been engaged to ensure that Yasmine had all the information she needed. Yasmine's request for a homebirth had been discussed a multidisciplinary team meeting. When Yasmine was 41 weeks, she wanted minimal involvement and was supported by the Homebirth team. This meant that Yasmine saw the same staff throughout her pregnancy and was able to build a relationship with her midwife. Yasmine advised that she felt empowered by the Trust during the birth despite needing to come into hospital for treatment afterwards. Yasmine stated that it was important for all first time mothers to educate themselves about pregnancy and birth.

The Board thanked Yasmine for her story.

103/26 Minutes for approval: 27 May 2026 and Matters Arising Schedule

The minutes of the meeting held on 27 May 2026 were agreed as a correct record and signed by the Chair.

The Board received the matters arising schedule. All actions were completed or scheduled for completion.

104/26 Minutes of Board Committee Meetings and Committee Updates

Audit & Risk Committee: 13 May and 8 July 2026

The Committee noted that the Audit & Risk Committee had received the Healthcare Facilities Management (HFMS) Ltd governance review and the substantial refresh of the Standing Financial Instructions (SFIs). The Committee had also received the year end audit and the finance and procurement improvement plan. The Committee had also reviewed the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) and recommended that a risk on cash should be developed. The Committee had also received good assurance from the Fit & Proper Persons Test (FPPT) internal audit review.

Finance & Investment Committee: 20 May, 17 June and 15 July 2026

The Chair of the Finance & Investment Committee advised that the Trust was on plan in the first quarter of 2026/27. Although the Trust had delivered its savings programme and plan in 2025/26 there was a need to identify further recurrent savings in 2026/27. Cash was £23m at the end of Quarter 1 2026/27 although the Trust could require cash support in Quarter 3. The capital programme for 2026/27 was £66m although this was dependent on the Trust's cash position. Therefore cash management would be important. The Committee had also discussed the financial impact of the 17% increase year on year in Emergency Department (ED) attendances. This created a challenge on ED staff maintaining their budget despite the significant increase in the number of patients presenting. The Chief Operating Officer advised that the Trust had raised awareness with Primary Care colleagues of the Urgent Care Centre and there had been a slight reduction in attendances during Quarter 2. However, there had been a slight increase in the number of patients admitted and an increase in length of stay. The

Chief Executive highlighted the need to balance quality and patient experience set against the financial position as the Winter period approached. In addition, opportunities to deliver further cost savings remained a challenge.

Quality Committee: 15 June, 25 June and 1 July 2026

The Chair of the Quality Committee advised that, at the July meeting, the Committee received substantial assurance on the learning from deaths report. The Committee also received the Patient Experience Annual Report noting the significant amount of work undertaken by the Trust. The Committee also received an update on the collaborative work with Berkshire Healthcare Foundation Trust (BHFT) in relation to mental health patients presenting at the Emergency Department (ED). In addition, results of the national inpatient survey report and the improvement work impact on the national cancer standards were noted. The Committee also supported the proposed actions following the Board seminar on patient safety. The Chair of the Quality Committee advised that there were improvements and ongoing monitoring on Maternity data quality. There had been an increase in major obstetric haemorrhage and surgical site infections and as a result additional scrutiny had been put in place.

People Committee: 7 May 2026

The Board received the minutes of the meeting held on 7 May 2026.

Charity Committee: 21 May 2026

The Chair of the Charity Committee advised that the Committee had approved a grant application for the refurbishment of the Cardiology Outpatients waiting area at a cost of £82k including VAT.

105/26 Chief Executive's Report

The Chief Executive highlighted that the new Secretary of State for Health & Social Care visited the Trust in the previous week and met the Same Day Emergency Care (SDEC) and Maternity teams. The visit provided a valuable insight into our work as well as being able to discuss with staff their challenges as well as innovation work. The Chief Executive thanked all teams involved for facilitating the visit at short notice.

The Chief Executive advised that the Executive Management Committee (EMC) had been amended to enable the forum to dedicate one meeting each month to focus on the Trust's strategic programmes. This was in preparation to align with the new Board Innovation & Transformation Committee (ITC) in September 2026. The Board discussed the resource and capacity for the strategic programmes. The Chief Strategy Officer advised that each programme had an Executive lead, a Senior Responsible Officer (SRO) and support from the transformation team although programme management was a constraint. It was important to ensure that each programme was clearly defined prior to any programme management resource being put in place.

The Board discussed the recent hot weather period and noted that the Executive had been to visit teams across the organisations as some areas of the estates were challenged in relation to temperatures. Temporary air conditioning was in place where possible.

The Board discussed the NHS Staff Standards. The Chief Strategy Officer advised that the NHS Staff Standards would result three additional metrics being added to the National Oversight Framework (NOF).

106/26 Integrated Performance Report (IPR)

The Chief People Officer introduced the IPR highlighted two key themes; the increase in non-elective and number of patients presented at the ED and the need for partnership working to address this. The Trust had maintained a strong elective performance as well as a focus on productivity. 76% of patients had been seen within four hours. Type 1 ED performance was higher in June 2026 in comparison with the previous year. The average ambulance handover time was 20 minutes. Length of stay had increased with patients waiting for either a community bed or social care pathway discharge.

The Board queried response from system partners in relation to the increase in ED attendances. The Chief Operating Officer advised that the Trust had been working with partners as well as raising awareness with General Practice in relation to the capacity available in the Urgent Care Centre. Primary Care colleagues were also challenged and any collective decisions would need to consider their challenges as well as the Trust's.

62-day cancer performance was ahead of plan at 78% although below the national standard of 80%. Most patients over 62 days were gynaecology, urology and lower gastrointestinal. Referral to Treatment (RTT) standard performance was ahead of trajectory at 84.3% and the number of patients waiting more than 52 week was 30.

The Chief People Officer highlighted that the Friends & Family Test (FFT) demonstrated that 93% of patients listened to, well informed and involved in decisions about their care and the number of complaints responded to within 25 days had improved to 72%. The number of patient safety incidents per 1000 bed days was 54.34% although the majority were low harm and this demonstrated a good safety culture in the Trust.

The Board noted that, as discussed with the Quality Committee, there had been a general increase in complaints and, particularly, Artificial Intelligence (AI) generated complaints, and, as a result, these complaints were long and complex. The Chief Nursing Officer advised that response times for complaints had improved because of stability in the complaints team as well as aligned working with the Care Group teams.

The Chief People Officer highlighted the workforce metrics and whilst total absence rates were lower in June 2026 in comparison to May 2026 there had been an increase in absence related to stress, anxiety and depression although this was lower than in the same period in the previous year.

107/26 Ensuring Safe and Effective Perinatal Care at the Trust

The Chief Nursing Officer introduced the report that provided an overview of the learning from the national maternity investigations and set out the Trust's response to the 10 urgent actions. The Chief Nursing Officer highlighted that it was important to be clear on the current national position on maternity and neonatal services.

The Board noted that of the 10 urgent actions, six were either in progress or had been implemented although some actions were awaiting further national guidance being issued. The Chief Nursing Officer advised that a perinatal service review had been commissioned and the Maternity & Neonatal Voices Partnership (MNVP) Lead had been engaged as part of this. The Chief Nursing Officer confirmed that improvements would be achieved from the 10 urgent actions although the Trust had a number of these in place already. The MNVP provided valuable feedback to the Trust as well as supporting messaging with groups of women.

The Trust's Maternity Unit had been inspected by the Care Quality Commission (CQC) 2 years previous and had received a 'Good' rating. An NHS England (NHSE) insights visit had taken place in the previous year and a repeat visit was planned for September 2026.

The Board noted that the perinatal service review included key areas such as capacity across services, pathways, staffing according to acuity, digital support, estates and culture, and would incorporate feedback from women, families and staff. The review would also consider what future maternity care would need to be.

The Chief Executive highlighted that the national demand for maternity services had changed significantly and acknowledged the impact on Trust staff from the national reviews. The national reports provided learning and it was important to empower teams to make changes for future service provision. The Board noted that the perinatal review had been planned prior to national reports being issued although they review would be developed taking these into account.

108/26 Masterplan

The Chief Strategy Officer introduced the Masterplan that had been produced as a result of the delays to the New Hospital Programme (NHP) and the need to remain on the current Reading site for a number of years. The Masterplan provided a strategic framework for planning and decision making and would assist in prioritising any development on the current site. Extensive engagement had been undertaken with operational and clinical teams on the development of the Masterplan.

The focus for the Reading site was on high acuity care and the relevant adjacent services required with ambulatory care provided elsewhere. There were six strategic priorities for investment:

- Emergency Care (Emergency Care Village)
- Elective Surgery (Cold Surgical Hub)
- Ambulatory Care (Combined Day Unit)
- Trauma capacity
- Maternity and Neonates
- Pharmacy (including aseptics and stores)

The Chief Executive advised that the Executive Management Committee had reviewed the Masterplan plan and were very supportive. The Chief Strategy Officer advised that the business cases would raise the focus with the NHP team and this would set out the funding required for building on the current site. The Trust would need to bid for any funding available as currently no funding was currently available for the Masterplan.

The Board approved the Masterplan.

109/26 Work Plan

The Board received the work plan.

110/26 Date of Next Meeting

It was agreed that the next meeting would be held on Wednesday 23 September 2026 at 09.00

Mike O'Donovan, on behalf of the Board, thanked Helen Mackenzie for her significant contribution to the Trust Board, during her tenure as Non-Executive Director, in particular, her role as Chair of Quality Committee and member of the Audit & Risk Committee.

SIGNED:

DATE:

Minutes

Finance & Investment Committee Part I

Wednesday 15 July 2026

9.30 – 10.25

Boardroom, Level 4, Royal Berkshire Hospital

Members

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

In Attendance

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

Apologies

Mr. Dom Hardy	(Chief Operating Officer)
Dr. Janet Lippett	(Chief Medical Officer)
Ms. Katie Prichard-Thomas	(Chief Nursing Officer)

92/26 Declarations of Interest

There were no declarations of interest.

93/26 Minutes for Approval: 17 June 2026 & Matters Arising Schedule

The minutes of the meeting held on 17 June 2026 were approved as a correct record and signed by the Chair.

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

94/26 Month 3 Finance Report including Financial Improvement Plan 2026/27

The Chief Finance Officer introduced the report and advised that Month 3 financial performance was broadly on plan with a £3.59m deficit. However, the underlying position with the exclusion of one-off funding support, non-recurrent savings and depreciation was £2.83m worse than plan. The Committee noted that, the run rate continuing this would result in a year-end deficit of £26m and emphasised the need to achieve the £43.7m savings plan.

[s43, FOI Act] Capital was behind plan at Month 3 although this was anticipated during Quarter 1.

The Committee discussed key risks including the need to deliver efficiency savings, the cash position and the increase in workforce in month. The Committee noted that the

increase in workforce in Quarter 1 2025/26/27 was planned as part of the additional funding received to increase elective work. A significant element of the increase in workforce related to temporary labour in clinical areas. Therefore, this would be a challenge to reduce. The Committee noted that the Chief Executive's team Go and See visits were focused on those areas with an increase in workforce relative to their plan.

The Chief Finance Officer advised that the Financial Improvement Programme would strengthen governance on efficiency savings. Work was on-going to consolidate the number of schemes, and these would be risk adjusted.

The Chief Executive highlighted the importance of the Trust being able to demonstrate a lower cost base as part of the planning process for 2027/28. The Committee requested that a schedule should be developed and submitted to next meeting setting out the risk profile to the year-end including activity and income assumptions. **Action: F Khatcherian**

The Committee noted that non-pay spend on clinical supplies was £400k adverse to plan. It was agreed that the Chief Finance Officer would provide further detail in relation to this in the next update. **Action: F Khatcherian**

The Chief Executive highlighted that the first Financial Improvement Committee had been held and provided an overview of the discussion that included the focus on efficiency delivery alongside the challenge of the Trust's risk appetite.

95/26 Key Messages for the Board

Key messages for the Board included:

- Work was on-going to align income and activity
- The need to increase CIP delivery
- Workforce WTE on plan although there was a need to reduce WTE
- Cash balance on plan although expected claw back of income expected and cash support could be required later in the year

96/26 Date of Next Meeting

It was agreed that the next meeting would take place on Wednesday 16 September 2026 at 9.30am.

SIGNED:

DATE:

Finance & Investment Committee Chair's Report

Committee Chair: Mike O'Donovan

15 July 2026

Agenda Item 3 Month 3 Finance Report	Partial assurance
Agenda Item 6 Capital Programme 2026/27	Substantial Assurance
Agenda Item 7 Estates Masterplan	Substantial Assurance

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE (ALERT)

- Although on budget at Month 3, the underlying financial position is adverse to plan. Need to deliver a higher run rate of savings in the coming months with a greater recurrent component that can be carried into future years.

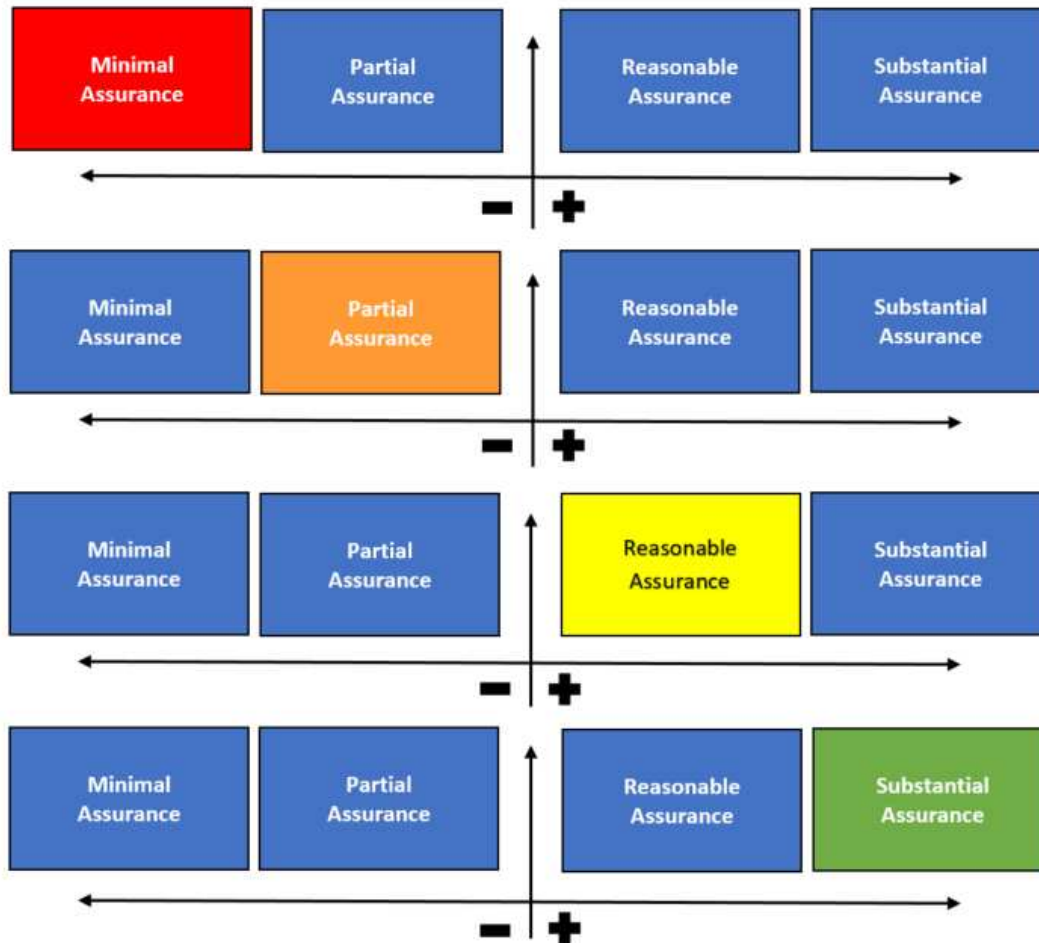
MAJOR ACTIONS AGREED (ADVISE)

- Recommend 2026/27 Capital Plan to the Board

POSITIVE ASSURANCES TO PROVIDE (ASSURE)

- On Budget at end of Month 3
- Clear direction for future development of our Estate shown in the Masterplan

DECISIONS MADE (APPROVE)



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

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

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

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

Finance & Investment Committee Chair’s Report

Committee Chair: Mike O’Donovan, Non-Executive Director

16 September 2026

Agenda Item 3 - Month 5 Finance Report	Partial Assurance
Agenda Item 4 – Long Term Resourcing Model	Partial Assurance

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE (ALERT) - Although we are on budget at Month 5, we need to address an increasing underlying deficit with emphasis on increasing the run rate of efficiency savings delivery, with a greater proportion of recurrent savings. - Although the Long Term Resourcing Model has given a clear indication of what we need to do to deliver medium term financial sustainability, the challenge is substantial and will require new initiatives both in optimising income and become more productive	MAJOR ACTIONS AGREED (ADVISE) To update and refine the Long Term Resourcing Model in the next 3 months
POSITIVE ASSURANCES TO PROVIDE (ASSURE) - On Budget at Month 5 - First clear indications from the Long Term Resourcing Model of the challenge we face to deliver medium term financial sustainability.	DECISIONS MADE (APPROVE)

Minutes

Charity Committee

Wednesday 5 August 2026

14.00 – 15.30

Boardroom, Level 4

Present

Ms. Catherine McLaughlin	(Non-Executive Director) (Chair)
Mr. Jonathan Barker	(Public Governor, Reading)
Dr. Minoo Irani	(Non-Executive Director)
Dr. Janet Lippett	(Chief Medical Officer)
Ms. Jo Warrior	(Charity Director)

In attendance

Mr. Johnson Adeleye	(Group Financial Controller)
Mr. Andrew Barrett	(Head of Commercial)
Mr. James Blythe	(Chief Executive)
Miss. Kerrie Brent	(Corporate Governance Manager)

Apologies

Mr. Mike Clements	(Director of Finance)
Mr. Umesh Jetha	(Non-Executive Director)
Mrs. Caroline Lynch	(Trust Secretary)
Mr. John Stannard	(Patient Representative)
Rev. Josh Wilson	(Governor Representative)

23/26 Declarations of Interest

There were no declarations of interest.

24/26 Minutes for Approval: 6 May 2026 & Matters Arising Schedule

The minutes of the meeting held on 6 May 2026 and 21 May 2026 were approved as correct and signed.

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

Minute: 18/26: Committee Terms of Reference: The Committee agreed that the Terms of Reference should be updated to include the rotation of patient and staff representative, in line with the arrangements for Governor representatives. **Action: C Lynch**

25/26 Charity Director's Report

The Charity Director presented the Quarter 1 report and highlighted positive progress across fundraising and charity development activities.

The Committee noted the continued success of major donor fundraising and grateful patient giving, including significant donations received during the quarter. It was recognised that a small number of donors had generated substantial income and continued investment in relationship building and donor stewardship would be important to maximise future opportunities. The Chief Executive confirmed his support for donor engagement activities including personally thanking donors where appropriate.

The Committee received an update on corporate fundraising and sponsorship activity. Interest from organisations wishing to support the Charity through fundraising, volunteering and sponsorship continued to increase. The Committee discussed the need to manage any actual or perceived conflicts of interest appropriately, particularly where relationships existed with Trust suppliers or contractors.

An update was provided on legacy fundraising. Whilst legacy materials and processes had been refreshed, the Committee noted that dedicated resource would be required to further develop a comprehensive legacy giving programme. This would be considered as part of the planned Charity team review.

The Committee noted that grant income in Quarter 1 was lower than anticipated due to the timing of awards, although over £100k of grants had already been secured early in Quarter 2. The Committee congratulated the Charity team on this achievement and recognised the value of maintaining strong relationships with grant-making organisations.

The Committee received an update on community fundraising activity and noted the success of the Charity's 30th Anniversary Garden Party. Whilst the event generated approximately £6k net income, its wider benefits included raising the Charity's profile, strengthening stakeholder relationships and providing engagement opportunities with supporters, donors and community representatives. A calendar of future events would be circulated to enable Board members to support attendance where possible.

Action: J Warrior

The Committee discussed the proposed major fundraising appeal linked to the Charity Strategy ambitions. It was noted that external specialist support would be sought to undertake donor analysis, market testing, governance development and fundraising planning for a potential appeal in the region of £5m to £10m. The Committee supported the proposed procurement exercise and agreed delegated authority for the Charity Director to progress the appointment process within approved financial limits, recognising that this represented an investment in the Charity's future fundraising capability.

The Charity Director advised that the planned donor "Thankathon" had been postponed from July 2026 to November 2026 due to staff sickness. The Committee supported plans to broaden participation in donor thank-you calls and the importance of Executive involvement in donor stewardship activities.

26/26 Customer Relationship Management (CRM) System Replacement

The Charity Director presented a proposal to replace the Charity's current CRM system. It was noted that the existing system no longer met operational requirements, relied heavily on manual processes and offered limited automation. **[s43(2) FOI Act]**

The Committee noted that the investment represented an opportunity to improve the Charity's infrastructure and support future development, rather than simply replacing like-for-like functionality.

[s43(2) FOI Act]

[s43(2) FOI Act]

The Committee also noted that the preferred supplier and system would not interface directly with the finance system, reflecting a common limitation in the CRM solutions reviewed.

[s43(2) FOI Act]**27/26 Grant application: High Dose Rate (HDR) Brachytherapy Machine**

The Charity Director presented an application from Berkshire Cancer Centre seeking charitable funding of £450k from an existing legacy donation towards the replacement of the Trust's High Dose Rate (HDR) Brachytherapy Machine.

The existing machine was approaching end of life and replacement would enable the Trust to continue providing the treatment locally and without replacement of the equipment, patients may be required to travel elsewhere to access treatment.

The Charity Director confirmed that Estates & Facilities had been involved in developing the proposal and that associated infrastructure requirements had been included within the business case. A Capital Investment Group (CIG) application was progressing.

The Committee discussed the potential for additional infrastructure requirements to emerge through the CIG process and noted that any significant changes to project costs or scope would need to be considered further.

The Committee approved the application in principle, subject to completion of the Trust's CIG approval process. It was agreed that, should the final project costs or requirements differ materially from those presented, the application would be returned to the Committee for further consideration and approval.

Action: J Warrior

28/26 Finance Report

The Group Financial Controller presented the Quarter 1 financial position and reported that the Charity remained financially stable, with fund balance reduced by £154k during the quarter in line with the planned utilisation of reserves to maximise charitable impact.

Income for the quarter totalled £168k, below both plan and the equivalent period in 2025/26, primarily reflecting lower legacy income and the timing of charitable income. Expenditure was also below plan at £321k, reflecting the timing of planned charitable projects, with expenditure expected to increase during the remainder of 2026/27. The Committee noted that grant funding activity remained strong, with more than £100k of grant income already secured in Quarter 2.

The Committee noted that 109 grant applications had been approved totalling £246k, including support for Cardiology and chemotherapy-related projects. Of that, approximately £186k of planned charitable expenditure was expected to be delivered during Quarter 2 and 4. Debtors had reduced significantly following receipt of a legacy payment accrued in the previous financial year. Cash balance had increased during the quarter and reflected positive operating and investment cash flows. The Group Financial Controller provided assurance that the Charity had sufficient resources to support planned charitable activities throughout 2026/27.

The Committee discussed the Charity's cost-to-income ratio and was advised that administration and governance costs remained broadly in line with expectations. The

Committee received assurance that income levels were expected to increase during the remainder of the year.

An update was provided on the procurement exercise to appoint an investment house. It was noted that the tender process would close on 11 August 2026, with seven applications received to date. A panel comprising the Chair of the Charity Committee, Chief Finance Officer, Director of Finance and the Charity Director would undertake the initial assessment, supported by an independent representative from another charity. The Committee requested that a shortlist of approximately three to four preferred providers, together with information and scoring outcomes, be presented to a future meeting for consideration. **Action: J Warrior**

29/26 Fundraising on Trust Premises Protocol

The Committee received the updated protocol. The Charity Director confirmed that minor changes had been made to titles. It was confirmed that the protocol also covered charitable activities on Trust premises.

The Committee approved the updated protocol.

30/26 Work Plan

The Committee received the work plan.

31/26 Key Messages for the Board

The Committee agreed the following key messages for the Board:

- Approved implementation of a new CRM system to strengthen the Charity's fundraising infrastructure
- Approved funding for the High Dose Rate (HDR) Brachytherapy Machine, subject to Capital Investment Group approval.
- Approved procurement of specialist consultancy support to develop the Charity's major appeal strategy
- Approved the updated Fundraising on Trust Premises Protocol
- Noted strong grants and foundations performance, with over £100k secured early in Quarter 2
- Noted the attendance of the Head of Commercial at the Committee to strengthen collaboration between Trust and Charity commercial activity
- Agreed to review arrangements for rotating patient and staff representatives on the Committee
- Noted the rescheduling of the donor Thankathon to November 2026 and the request for Executive support with donor stewardship activities

32/26 Reflections of the Meeting:

Jonathan Barker led a discussion.

The Committee agreed that in future clinical representation would be invited to the meeting where grants were submitted for approval. In addition, an annual impact report would be considered on the work plan. **Action: J Warrior**

33/26 Date of the Next Meeting:

It was agreed that the next meeting would be held on Wednesday 18 November 2026 at 14.00.

SIGNED:

DATE:

Charity Committee Chairs Report

Committee Chair: Catherine McLaughlin, Non-Executive Director

5 August 2026	
Agenda Item 3: Charity Director's Report	Substantial Assurance
Agenda Item 4: Customer Relationship Management System Replacement	Partial Assurance
Agenda Item 5: Grant Application: High Dose Rate (HDR) Brachytherapy Machine	Partial Assurance
Agenda Item 6: Finance Report	Substantial Assurance
Agenda Item 7: Fundraising on Trust Premises Policy	Substantial Assurance

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE (ALERT) N/A	MAJOR ACTIONS AGREED (ADVISE) - Approved the updated Fundraising on Trust Premises Protocol - Noted the rescheduling of the donor Thankathon to November 2026 and the request for Executive support with donor stewardship activities
POSITIVE ASSURANCES TO PROVIDE (ASSURE) Noted strong grants and foundations performance, with over £100k secured early in Quarter 2	DECISIONS MADE (APPROVE) - Approved implementation of a new CRM system to strengthen the Charity's fundraising infrastructure - Approved funding for the High Dose Rate (HDR) Brachytherapy Machine, subject to Capital Investment Group approval. - Approved procurement of specialist consultancy support to develop the Charity's major appeal strategy

Quality Committee Chairs Report

Committee Chair: Minoo Irani

Committee Date: 3 September 2026

Agenda Item 5: Learning from deaths report	Substantial Assurance
Agenda Item 3: Maternity Quality Assurance report including perinatal mortality & MIS year 8 midpoint review	Partial Assurance
Agenda Item 4: Patient safety Q1 report	Reasonable Assurance
Agenda Item 9: clinical audit programme update	Reasonable Assurance
Agenda item 10: patient relations report	

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE (ALERT)

1. Moderate or above incidents in maternity have recurring themes which also triangulate with wider safety pressures (theatre capacity, induction of labour delays). Delays in Category 2 emergency caesarean sections due to theatre capacity pressures.
2. Partial assurance at midpoint review; assurance that the trust will be able to submit full compliance for year 8 of MIS on 2/3/2027.
3. Patient safety incidents in Q1 show upward trend. Of 58 moderate harm incidents, majority were related to maternity, falls, treatment/ procedure. Recurring themes include unendorsed clinical results, NEWS2 implementation delays, breast screening follow-up.
4. Patient safety training (NPSS) levels vary from 1% to 47.5% in groups of staff. PSIRF training for medical staff is a focus.
5. HTA unannounced inspection (10/6/26): RBFT suitable to be licensed subject to corrective and preventative actions implemented for shortfalls (4 major, 1 minor) identified during the inspection.

MAJOR ACTIONS AGREED (ADVISE)

1. Baseline assessment submission for NHSE 10-point action plan (maternity) will come for approval to Public Trust Board on 24/9/2026.
2. Rollout of Martha's Rule (NHS Standard Contract) requires full implementation by April 2027 and plans for mitigation of workforce risk for implementation are being addressed.

POSITIVE ASSURANCES TO PROVIDE (ASSURE)

1. Clinical accreditation scheme (internal) has resulted in 8 gold and 4 silver awards for 12 clinical services.
2. Majority of actions arising from the internal audit of patient safety (25/26) have been completed.
3. Reassurance that the trust records an increase in expected mortality rate and a decrease in observed mortality rate. Case note review of deaths suggest good to very good care provided.
4. C.Difficile infection rates remain below threshold. On-going work to

DECISIONS MADE (APPROVE)

1. Seasonal influenza staff and patient vaccination plan (2026/27) approved.
2. Winter Plan for 26/27 provides reasonable assurance of mitigation in part of the risks and 'assurance checklist assessment supported to go to Board.
3. BAF & CRR reviewed

reduce surgical site infections.

5. formal complaints rose by 65% compared with the same period last year. Number of complaints closed increased by 81%.

Audit & Risk Committee Chairs Report

Committee Chair: Mike McEnaney

9 September 2026

Agenda Item 5 Internal Audit Reports	Substantial Assurance
Agenda Item 6 Internal Audit Recommendations	Substantial Assurance
Agenda Item 7 Finance & Procurement Improvement Plan	Reasonable Assurance

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE (ALERT)

MAJOR ACTIONS AGREED (ADVISE)

- Received two internal audit reports on Mortality and Care Group Risk Management – both significant assurance
- Received an update on the Finance & procurement function improvement plan and were reassured as to progress.

POSITIVE ASSURANCES TO PROVIDE (ASSURE)

- Noted only one overdue internal audit recommendation

DECISIONS MADE (APPROVE)

- Approved the Treasury Policy

Title:	Chief Executive's Report
Agenda item no:	7
Meeting:	Board of Directors
Date:	23 September 2026
Presented by:	James Blythe, Chief Executive
Prepared by:	Caroline Lynch, Trust Secretary

Purpose of the Report	- To update the Board with an overview of key issues since the previous Board meeting. - To update the Board with an overview of key national and local strategic environmental and planning developments - This includes items that may impact on policy, quality and financial risks to the Trust.
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Report History	None
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What action is required?	
Assurance	
Information	For information and discussion: The Board is asked to note the report
Discussion/input	
Decision/approval	

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

Strategic objectives This report impacts on			
Delivering the highest quality care for all			✓
Supporting our people to thrive			✓
Partnering for impact			✓
Driving improvement and enabling innovation			✓
Building a sustainable future together			✓
Well Led Framework applicability:			Not applicable ☐
1. Leadership ☐	2. Vision & Strategy ☐	3. Culture ☐	4. Governance ☐
5. Risks, Issues & Performance ☐	6. Information Management ☐	7. Engagement ☐	8. Learning & Innovation ✓
Publication			
Published on website		Confidentiality (Fol)	Private
			Public
			✓

Strategic Objective 1: Delivering the highest quality care for all

National Oversight Framework (NOF) Quarter 1 2026/27

- 1.1 The National Outcome Framework has been published since September 2025 as a league table of all NHS Providers against a number of quality and efficiency domains. For 2026/27, this framework has been refreshed with new metrics and slightly changed domains. The Quarter 1 2026/27 data have just been published with the Trust's overall position remaining stable despite the changes made. The Trust's average score is 1.89 which would rank 17 of 134 and place in segment 1 (top 25% of providers in the country). However, as the Trust continues to forecast a financial deficit, the segment score is capped at segment 3.
- 1.2 The Trust is in segment 1 for 4 out of 6 domains: Access to Services, Patient Safety, People and Experience of Care. The Trust scores in segment 2 for Finance, Productivity and Innovation segment, with lower scoring metrics for the Data Quality Maturity Index Score (rank = 41) (new metric), Planned Surplus/ Deficit (rank = 79), and Percentage of Clinical Trials set up with 90 days (rank 104) (new metric). The Trust scores in segment 4 for Effectiveness of Care and Population Health. This is impacted by the metrics: Delayed Inductions Rate (rank = 116) and Percentage of Acute Inpatients making a Supported Quit Attempt with an Inhouse Dependence Treatment Service (rank = 97), both newly scoring metrics.
- 1.3 We will review the opportunities for improvement highlighted by the new metrics over the following quarter.

NHSE South East Regional Insights Visit

- 1.4 The NHSE South East regional team undertook a Maternity and Neonatal Insights Visit on Wednesday 9 September 2026 led by Kaye Wilson, Regional Chief Midwife. The regional team recognised the substantial progress made since their previous visit and commended the strong culture of continuous improvement across maternity and neonatal services. Strengths highlighted included strong leadership and governance arrangements, clear organisational oversight and accountability through the perinatal service review, a positive and responsive culture that places women, babies and families at the centre of care, and demonstrable progress against key improvement priorities.
- 1.5 The review also recognised the Trust's effective learning from national investigations, its commitment to coproduction with women and families, positive staff engagement initiatives, and its work to address health inequalities. Ongoing challenges relating to sonography workforce sustainability, timely induction of labour (as highlighted in the NOF) and digital infrastructure were acknowledged. The regional team encouraged continued focus on a manageable programme of improvement priorities to maximise delivery and impact and offered ongoing support to the Trust. A formal feedback letter is expected in October, with further review discussions scheduled over the next six months. Overall, the visit provides strong external assurance regarding the quality, safety and leadership of the Trust's maternity and neonatal services.

Human Tissue Authority (HTA) Evidential Compliance Assessment Retrospective Incident Review

- 1.6 As part of our response to the National Maternity reviews and the subsequent 10 point plan we are required to conduct a 10 year retrospective review of all Mortuary, Histology and Human Tissue Authority (HTA) related incidents and consider whether, with the benefit of hindsight, they met the criteria for HTA reported incidents (HTARIs). We reviewed a total of 1,455 incidents over the 10 year period. We have reported the outcome of our review to the HTA in line with their requirements.

Strategic Objective 2: Supporting our people to thrive

NHS Staff Standards

- 2.1 The new NHS Staff Standards, introduced nationally in July 2026, set clear minimum expectations for NHS employers across six areas: line management, health and wellbeing, violence prevention and reduction, tackling racism, sexual safety and flexible working. Importantly, the standards are not simply aspirational; compliance will form part of the NHS Oversight Framework and wider assurance arrangements, increasing the prominence of staff experience and employment practice within organisational oversight.
- 2.2 The Trust is currently assessing its position against each of the standards to identify areas of good practice and any gaps requiring further action. Initial assessment indicates good levels of activity across most areas, with greater focus required on strengthening governance, data collection and the evidence needed to demonstrate compliance. Further work will now be undertaken to address identified gaps, strengthen assurance and embed the standards within our wider people and workforce arrangements.

Strategic Objective 4 – Driving improvement and enabling innovation

University Hospital Application update

- 3.1 This month we submitted our application to the University Hospital Association (UHA) for consideration of University Hospital status. This accolade is awarded to those Trusts/Hospitals that meet the highest standards of Research and Education. The benefits of achieving this would be felt in organisational reputation, access to research opportunities and recruitment and retention of staff.
- 3.2 The application process required submission of a portfolio of evidence across a number of domains exploring our research credentials, academic achievements and educational standing. As part of the application, we obtained letters of support from the Universities that we currently partner with and provide student placements for; they all gave their support unreservedly.
- 3.3 The application will now be considered by the UHA board at their next meeting in November 2026 although it is likely the outcome will not be available until the New Year.

Strategic Objective 5: Building a sustainable future together

Financial Position – Month 5

- 4.1 The Trust remains close to its year-to-date financial plan at Month 5, reporting a deficit of £2.93m against a planned £2.96m. This headline position relies on non-recurrent support, including Deficit Support Funding and one-off savings, and the underlying deficit (once these are excluded) is £16.45m, £13.49m adverse to plan. Closing this gap depends on recurrent efficiency delivery over the remainder of the year.
- 4.2 Efficiency savings are not yet fully identified, with £37.4m identified against the £43.69m annual target. Income performance is positive but carries risk, as a material part depends on commissioner agreement to pay for activity delivered outside the fully variable contract terms and this is not yet secured. Pay costs remain under pressure, driven by medical staffing and bank usage, and continue to require close management.
- 4.3 The Executive team is maintaining tight focus on these areas, and the Board will continue to receive detailed updates through the Finance & Investment Committee.

Strategic Programmes

- 4.4 The Trust has made positive progress in developing its five Strategic Programmes, with initial key performance indicators, benefits profiles and high-level quarterly mobilisation plans now in place. The 'Care Where I Am' and RoyalBerks@Home' Programmes are currently recruiting for Transformation Programme Directors to build on the work completed so far and drive progress forward at pace.
- 4.5 Further work is underway to strengthen the detail behind each programme before consideration by the Board. This includes validating financial assumptions, confirming the scale of expected benefits, developing clearer delivery milestones, and identifying interdependencies or shared resource pressures across programmes. The Perinatal Service Review will also be brought into the strategic programme portfolio from the next reporting cycle."

Title:	Integrated Performance Report (IPR)
Agenda item no:	8
Meeting:	Board of Directors
Date:	23 September 2026
Presented by:	Dom Hardy, Chief Operating Officer
Prepared by:	Executive Team

Purpose of the Report	The purpose of this report is to provide an analysis of quality performance to the end of August 2026
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Report History	
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What action is required?	
Assurance	
Information	The Board is asked to note the report
Discussion/input	
Decision/approval	

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

Strategic objectives This report impacts on (tick all that apply)::						
Delivering the highest quality care for all						✓
Supporting our people to thrive						✓
Partnering for impact						✓
Driving improvement and enabling innovation						✓
Building a sustainable future together						
Well Led Framework applicability:					Not applicable ☐	
1. Leadership ☐		2. Vision & Strategy ☐		3. Culture ☐		4. Governance ☐
5. Risks, Issues & Performance ☐		6. Information Management ☐		7. Engagement ☐		8. Learning & Innovation ☐
Publication						
Published on website			Confidentiality (FoI)		Private	
					Public	✓

Integrated Performance Report

August 2026

Improving together to deliver
outstanding care for our community



Guide to statistical process control (SPC)

Introduction to SPC:

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

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

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

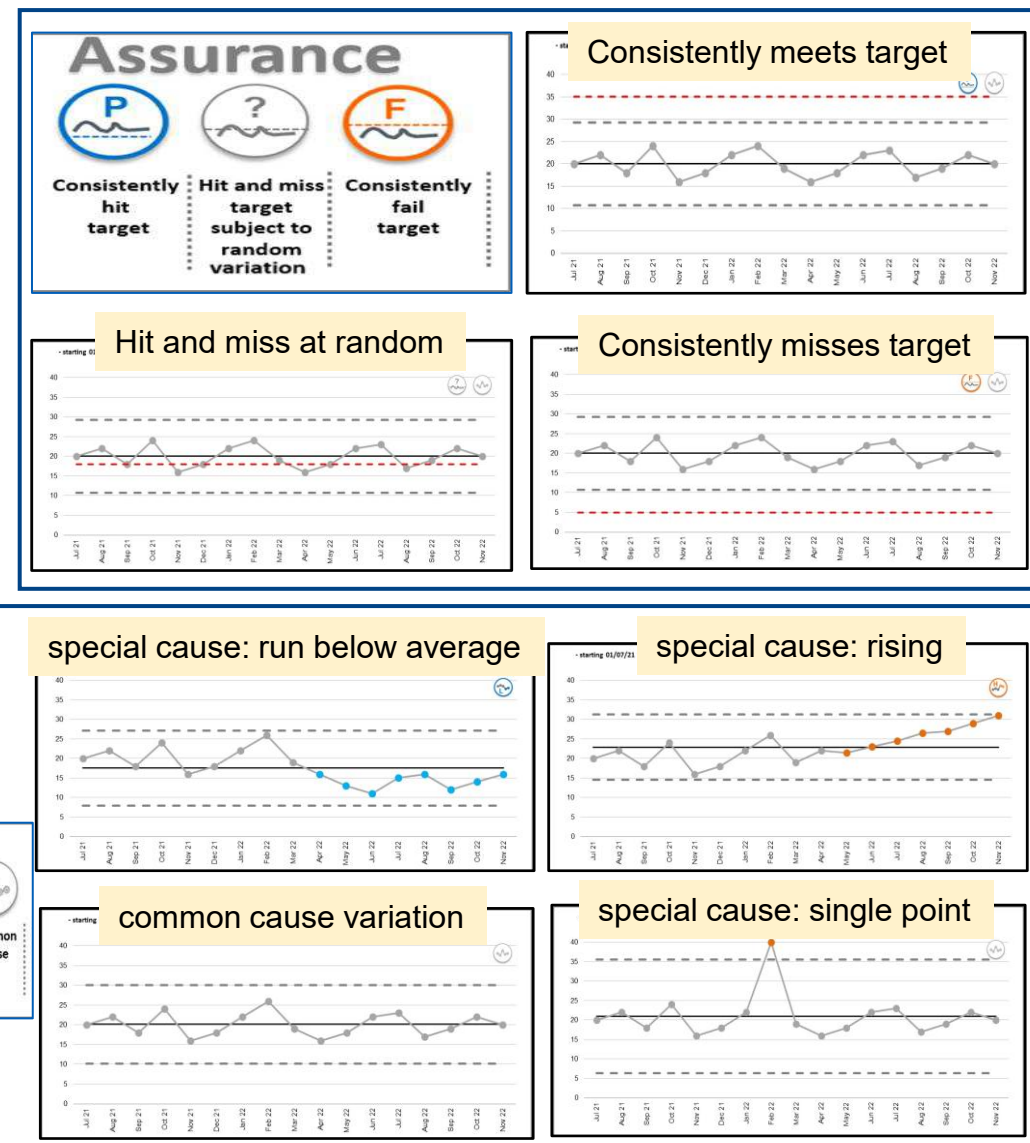
- The variation is routine, expected and stable within a range. We call this '*common cause*' variation, or
- The variation is irregular, unexpected and unstable. We call this '*special cause*' variation and indicates an irregularity or that something significant has changed in the process

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

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

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

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



August 2026 performance summary

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

The key messages from the report are:

- ED Performance:** Despite sustained demand and operational pressures, the Emergency Department maintained a strong focus on improving patient flow and minimising delays throughout August 2026. Overall, 75.37% of patients were seen within four hours, with Type 1 Emergency Department performance reaching 64.27%, a 3.35% decline, although in line with planned trajectory. Type 1 attendances increased by 6% compared with August 2025, while ambulance conveyances remained broadly consistent with seasonal trends. This performance was achieved against significant national and regional pressures, including record summer A&E demand and periods of extreme heat, highlighting the continued pressure across urgent and emergency care services.
- Cancer performance:** July performance (month arrears) shows all cancer access standards ahead of the Trust's planned trajectory. Improvement actions continue, with the most challenged pathways reviewed weekly Cancer Action Group meetings.
- Financial performance:** YTD M05 position, the Trust delivered its plan deficit of £(2.96)m. The financial improvement plan delivered £13.67m YTD of the £43.69m. Work continues to deliver the balance of that target.
- Cash:** The Trust entered 2026/27 with a cash position significantly ahead of plan, demonstrating strong liquidity performance in the first five months of the year. However, the forecast indicates a marked reduction in cash balances during the remainder of the financial year, with cash expected to remain below planned levels. The current position remains manageable, but the forecast deterioration highlights the need for continued focus on cash preservation, income recovery and cost improvement delivery to protect financial sustainability through the remainder of 2026/27.
- This month we have seen 13 of the 115 **watch metrics** measure outside of statistical control.

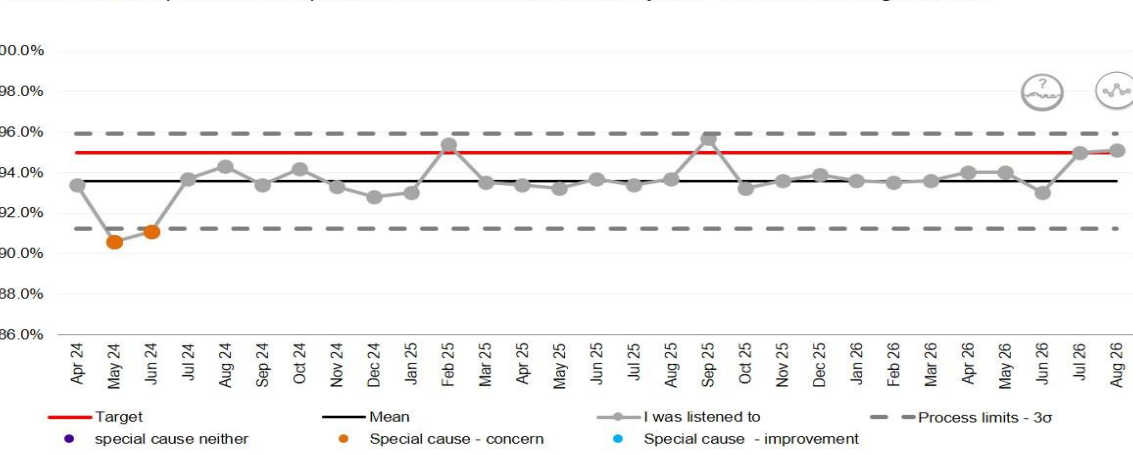
		Assurance			
					No Target
Variance				Emergency Department (ED) performance against 4hr target Page 8	Total WTE worked Page 18
				Productivity % Growth Page 14	Avoidable absence in days lost per month Page 7
			I was listened to (FFT) Page 5 62 day cancer standard (%) Page 9 Cash Performance Page 13 Ave LOS for non-elective patients (inc zero LOS) Page 16 Total Volume of first OP activity Page 17	18wks RTT (%) Page 10 % of eligible patients using portal or NHS app within month Page 11	Patient Safety incidents/1000 bed days Page 6 % total inpatients cared for in virtual hospital Page 12
					
					

Strategic Metrics

Strategic objective: Delivering the highest quality care for all

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

I was listened to, well informed, and involved in decisions about my care - Trustwide starting 01/04/24



Insight Metrics	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
I was listened to, well informed & involved in decisions about my care (FFT) Q2	93.6%	94.0%	94.0%	93.0%	95.0%	95.1%
FFT Overall satisfaction rate	93.3%	94.0%	93.5%	92.8%	93.0%	93.6%
FFT Overall response rate	9.0%	8.1%	6.9%	6.90%	9.20%	7.7%
Number of complaints	64	54	70	87	79	63
Complaints turnaround in 25 days	55%	75%	60%	72%	78%	73%
Percentage of complaints acknowledged within 3 days	72%	81%	71%	80%	70%	70%

* Denotes metric is part of the NHS Oversight Framework dataset

Board Committee: Quality committee

SRO: Chief Nursing Officer

Assurance



Variation



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

How we are performing:

- This month we met the target with a score of 95.1% on Q2 of the FFT. The overall FFT response rate remains stable at 7.7%.
- Trust wide overall FFT satisfaction score was 93.6% which remains stable although below the 95% target.
- Complaints turnaround in 25 days has reduced slightly since last month, however we have seen a reduction in the number of complaints.

Actions and next steps:

- The Experience First strategic programme includes a workstream on utilising patient feedback and aims to increase response rate, improve analysis and changes in practise.
- A trial in 3 wards is planned to pilot a new system (Medalia) to help use their FFT data to support changes in practice in a more timely way.
- The Patient Experience team are planning a deep dive into FFT scores and comments for Q2 as part of the work around shared decision making.
- Collaboration with a National expert in Patient Experience due to commence early October.

Risks:

- Delayed analytics tool awaiting 'Go-live' date to monitor and theme complaints and PALS data.
- Limited FFT information on staff intranet to support specialty queries. Patient Experience team working with Communications to address this issue.

Strategic objective: Delivering the highest quality care for all

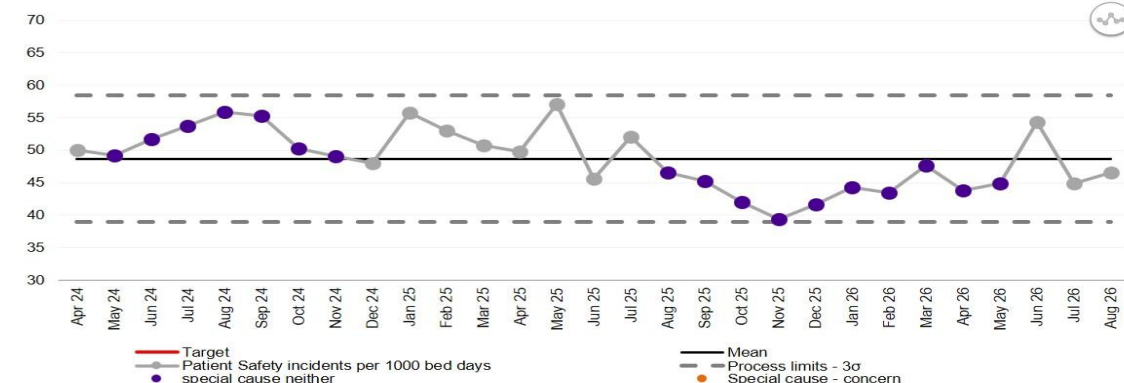
Strategic metric: Learning from incidents to reduce harm

Board Committee: Quality committee

SRO: Chief Nursing Officer

Assurance	Variation
N/A	

Patient Safety incidents per 1000 bed days - Trustwide starting 01/04/24



Insight Metrics	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Patient Safety incidents per 1000 bed days	47.62	43.76	44.85	54.34	44.84	46.50
*% of patient safety incidents that are low/no harm	95.63%	96.26%	95.31%	95.47%	95.31%	95.77%
No. of Deteriorating patient incidents	7	8	5	6	7	5
FFT question: I felt safe during my visit to the hospital (%)	90.29%	91.00%	89.00%	91.00%	97.00%	90.54%
Total Calls for Concern from patient and family	17	22	37	45	33	38
National Patient Safety Syllabus training compliance: Level 1	33.8%	41.0%	47.4%	52.9%	56.7%	60.6%
National Patient Safety Syllabus training compliance: Level 2	-	24.0%	40.3%	45.6%	49.2%	51.1 %

* Denotes metric is part of the NHS Oversight Framework dataset

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

How are we performing:

- There was an increase in the number of incidents per 1000 bed days, this remains above the minimum threshold of 40 and within control limits.
- There is an upward trend on compliance with the National Patient Safety Syllabus for Level 1 and Level 2 training. Compliance rates continue to be shared with care groups and through speciality governance and training meetings to encourage further progress.
- Sustaining number of total calls for concern.

Actions and next steps:

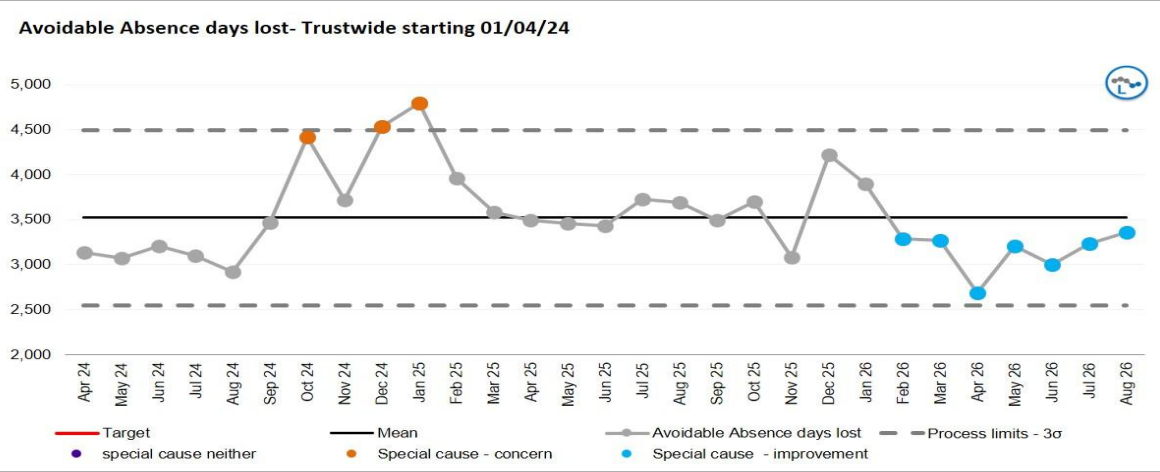
- Replacement/upgrade of the Datix Incident Management system is currently under review. Plan to draft new specification.
- Current PSIRF plan is under review and out to consultation with the Care Groups. Aim for Quality Governance Committee approval in November.
- New Associate Director of Nursing for Patient Safety appointed.
- Plans in place to celebrate World Patient Safety Day, 17th September.
- Chief Nursing Informatics Officer working with Digital, Data and Technology (DDaT) to develop digital oversight governance process.

Risks:

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

Strategic objective: Supporting our people to thrive

Strategic metric: Reducing avoidable absence



Insight Metrics	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Avoidable absence in days lost per month	3267	2686	3203	3003	3235	3355
Stress, anxiety & depression absence (no. of days lost)	1395	1233	1345	1410	1736	1493
Incidents of violence and aggression (patients, relatives, visitors to staff)	64	58	88	91	90	70
Total number of freedom to speak up referrals	11	8	8	15	15	12
Number staff accessing health prevention offer	136	81	111	54	21	87
Statutory and mandatory training compliance	92.76%	92.89%	93.07%	93.42%	93.32%	93.62%

* Denotes metric is part of the NHS Oversight Framework dataset

Board Committee: People Committee

SRO: Chief People Officer

Assurance

Variation

N/A



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

How are we performing:

- Total Avoidable absence YTD is currently 11.5% lower than the previous year while Stress/Anxiety & Depression is 8.5% lower than 2024/25 against a target of delivering a 5% reduction in 2026/27.
- Total absence rates were below target in August 3.35% in month against a target of 3.5% and 3.5% (rolling year) against a 3.7% target.
- Trust absence rates remain lower than the NHS average and generally benchmark amongst the best in the region.

Actions and next steps:

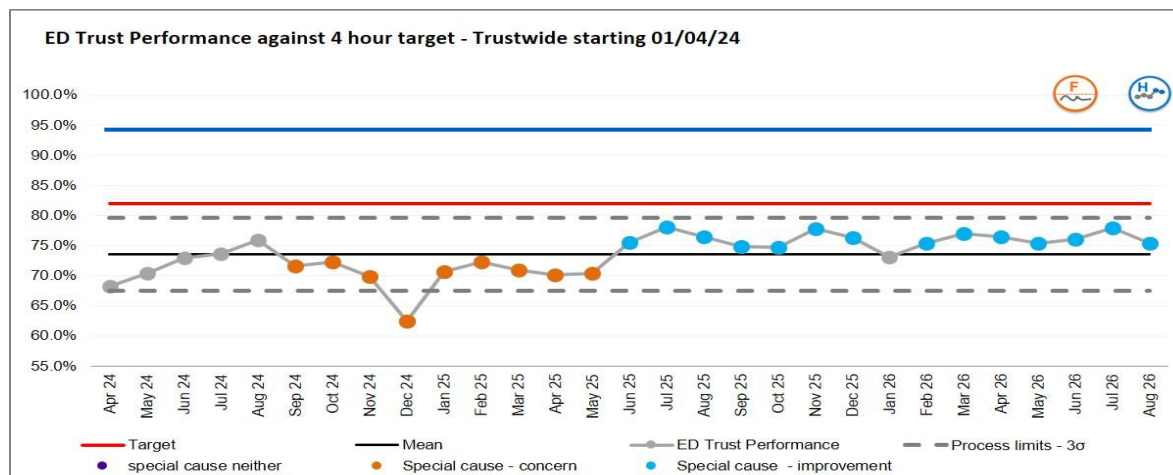
- Staff Survey 2025 Action Plans are now operational, with many departments committed to reducing burnout in their areas.
- Information webinars from the E-Rostering and Occupational Health teams were held in May 2026, to help managers manage sickness absence in their teams. Webinars for leaders in Facilities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

Risks:

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

Strategic objective: Partnering for Impact

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



Insight Metrics	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
*Performance against 4 hour std (%)	76.49%	76.49%	75.42%	76.06%	77.99%	75.37%
Average time to Clinician - all arrivals (minutes)	74	74	80	85	75	81
Number of redirects from ED to Urgent Care Centre (UCC)	1208	1009	1061	1034	1000	1029
Average Handover time (SCAS)	17:54	18:49	18:27	20:26	18:59	18:09
*Number of >12hr LOS from arrival in ED (% of total volume)	5.0%	5.5%	4.9%	6.10%	4.70%	4.1%
Number of >12hr Decision To Admit (DTA) LOS in ED	28	16	17	47	17	0
*Number patients who received corridor care >45 minutes within the previous 24-hour period	-	-	-	0	0	0

* Denotes metric is part of the NHS Oversight Framework dataset

Board Committee:
Quality Committee

SRO: Chief Operating Officer

Assurance

Variation



This measures: The number of patients experiencing excess waiting times (>4hr) for emergency service. While the constitutional standard remains at 95%, NHS England has set the target of consistently seeing 82% of patients within 4 hours by the end of March 2027.

How are we performing:

- There has been a month-on-month improvement in the 4hr standard with 75.37% all types of patients seen within 4 hours, a slight decline but in line with seasonal trends and planned trajectory.
- There has been an increase of 6% in attendances to ED when comparing August 2025 to August 2026.
- There was also a reduction in average LOS for both admitted (-26mins for admitted).
- There were no patients who waited more than 12hrs from decision to admit to be transferred to a ward.

Actions and next steps:

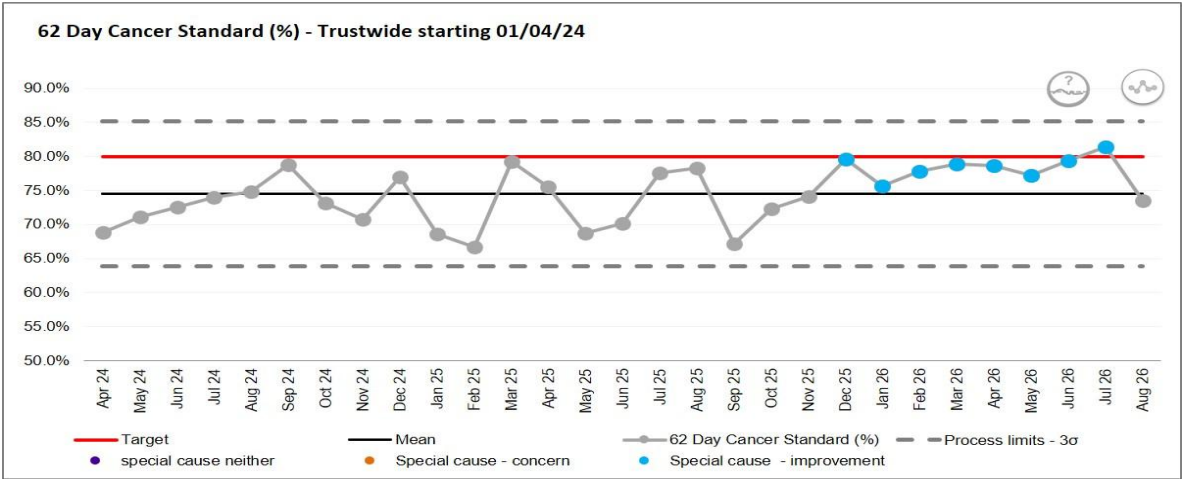
- Progressing the front door optimisation programme, aligned to key deliverables for Winter 2026/27. Key focus on developing attendance and admission alternatives to help support admission capacity.
- Working with regional colleagues to assess how to implement the NHS streaming solution into ED, to support patient redirection to available services.

Risks: Corporate Risk 4172

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

Strategic objective: Partnering for Impact

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



Insight Metrics	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
*Cancer 62 day %	78.9%	78.7%	77.2%	79.4%	81.4%	73.5%
Cancer 62 day % Trajectory	75.0%	75.0%	75.2%	75.3%	76.2%	76.0%
*Performance against 28 day faster diagnostic standard (FDS) (%)	87.1%	84.0%	86.0%	84.7%	84.4%	83.3%
31-day cancer standard performance (combined)	90.9%	89.1%	92.9%	94.8%	93.0%	87.1%
31-day cancer standard trajectory	-	89.9%	90.0%	90.0%	91.1%	91.0%
Percentages of cancers diagnosed at stages 1 & 2	46.5%	52.3%	44.0%	50.2%	Arrears	Arrears

* Denotes metric is part of the NHS Oversight Framework dataset

Board Committee:
Quality Committee

SRO: Chief Operating Officer

Assurance



Variation



Royal Berkshire
NHS Foundation Trust

This measures: The percentage of patients with confirmed cancer receiving first definitive treatment within 62 days of referral to the Trust. The national target is 85%. Trusts are expected to achieve 80% performance by March 2027

How are we performing:

- In July 81.4% of patients were treated within 62 days. August's unvalidated performance is 73.5%. This will likely improve post-validation.
- The total number of patients on the Patient Tracking List (PTL) waiting over 62 days at the end of August was 215, down from 227 in July. The tumour sites with the most patients on the PTL over 62 days are Gynaecology, Lower Gastrointestinal (LGI) and Urology.

Actions and next steps:

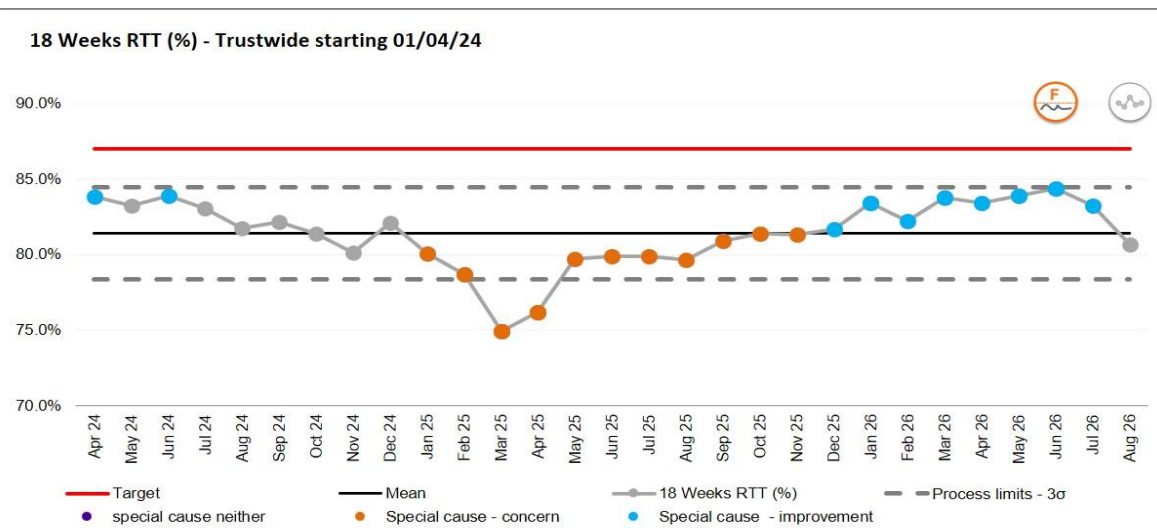
- Gynaecology are exploring additional theatre lists in order to increase inpatient hysteroscopy and surgical capacity, as well as introducing a Triage Assessment Clinic model.
- LGI are focusing on reducing length of wait for endoscopy to be able to see patients within 10 days of referral.
- Urology are focusing on implementing a one-stop clinic to speed up diagnostics for suspected bladder cancer, as well as introducing additional CNS results clinics for prostate.

Risks: Corporate Risk 4241

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

Strategic objective: Partnering for Impact

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



Insight Metrics	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
*18 Weeks RTT (%)	83.78%	83.40%	83.09%	84.38%	83.27%	80.65%
% referrals returned with advice to referrer	14.9%	14.6%	13.3%	13.5%	14.1%	14.3%
% plan for first outpatients	-	31.28%	31.18%	32.45%	31.97%	35.01%
% plan for combined daycase and inpatients (cumulative)	96.14%	95.84%	97.99%	97.83%	96.69%	90.39%
*% patients waiting less than 6 weeks for diagnostics (DM01)	86.8%	77.1%	81.50%	82.90%	82.90%	89.90%
*Number of patients waiting more than 52 weeks for treatment (RTT)	40	38	39	30	37	41

* Denotes metric is part of the NHS Oversight Framework dataset

Board Committee:
Quality Committee

SRO: Chief Operating Officer

Assurance	Variation

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

How are we performing:

- Performance in August has dipped as expected as we continue to reduce over all PTL size through increased first outpatient activity and targeted data quality improvement. We remain above plan/trajectory.
- 2026/27 core focus of recovery actions remain on maximising first assessment activity and driving down first assessment waiting times as well as chronological booking for individual stage of treatment.
- We expect performance to continue to reduce slightly through Q2 and Q3 as triage, validation and data quality enhancement continue to affect the profile, before improving in the second half of the year. This is in line with the submitted trajectory.

Actions and next steps:

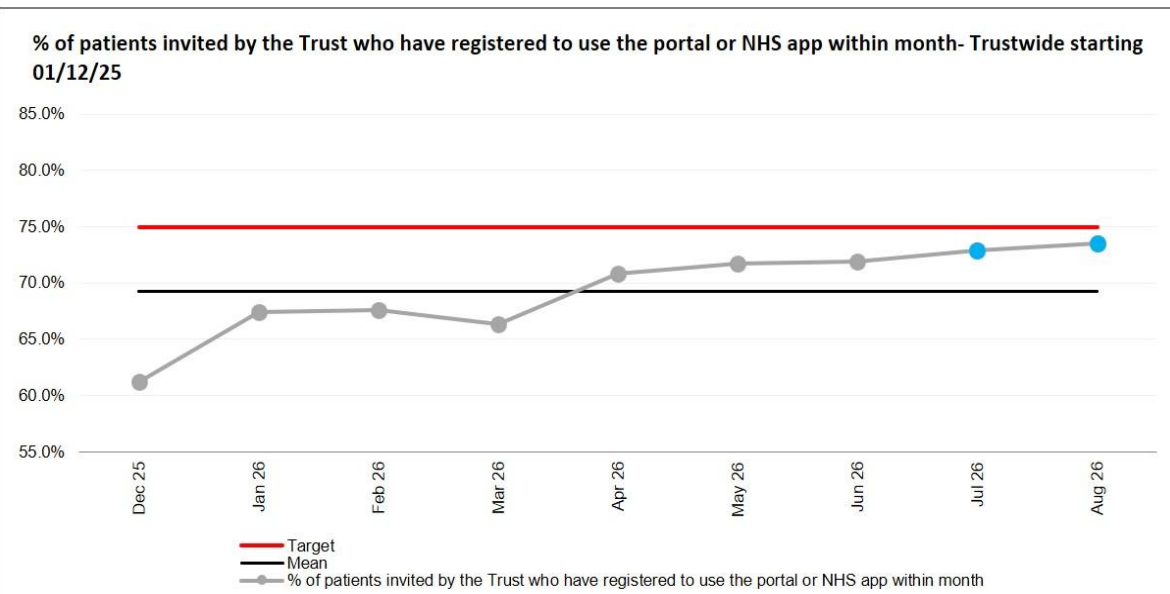
- Continue to drive improvement in the 1st OPA waiting times.
- Continue to focus on reducing tip-over demand whilst driving down volume of long wait pathways.
- Large Language Model Development and Pathways Insight & Coordination Solution (PICS) is well underway. With early results looking promising. Parallel running of PICs is delayed (resourcing) but work has commenced during Aug 26.
- Allocation of TV Innovation Funds to maximise stage of treatment backlog reduction.

Risks: Corporate Risk 5995

- Capacity to sustain performance against standard.

Strategic objective: Driving improvement and enabling innovation

Strategic metric: Digitally enabling our patients



Insight Metrics	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Cumulative % of patients eligible who are registered	66.3%	70.8%	71.7%	71.9%	72.9%	73.5%
Number of logins via NHS App or patient portal	242,385	223,636	240,901	268,972	306,958	295,745
Total number of letters viewed in the portal / NHS app in month	-	-	127,753	149,287	162,971	141,817
Advice and guidance (A&G) activity	3043	2634	2706	2907	3098	2588

* Denotes metric is part of the NHS Oversight Framework dataset

Board Committee
Quality Committee

SRO: Chief Strategy Officer

Assurance



Variation



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

How are we performing:

- We saw another climb in adoption rate in August, representing a significant positive trend.
- We ran additional analysis during August to examine adoption by demographics and found good adoption across most groups (including 65+) with lower adoption in 0-19.

Actions and next steps:

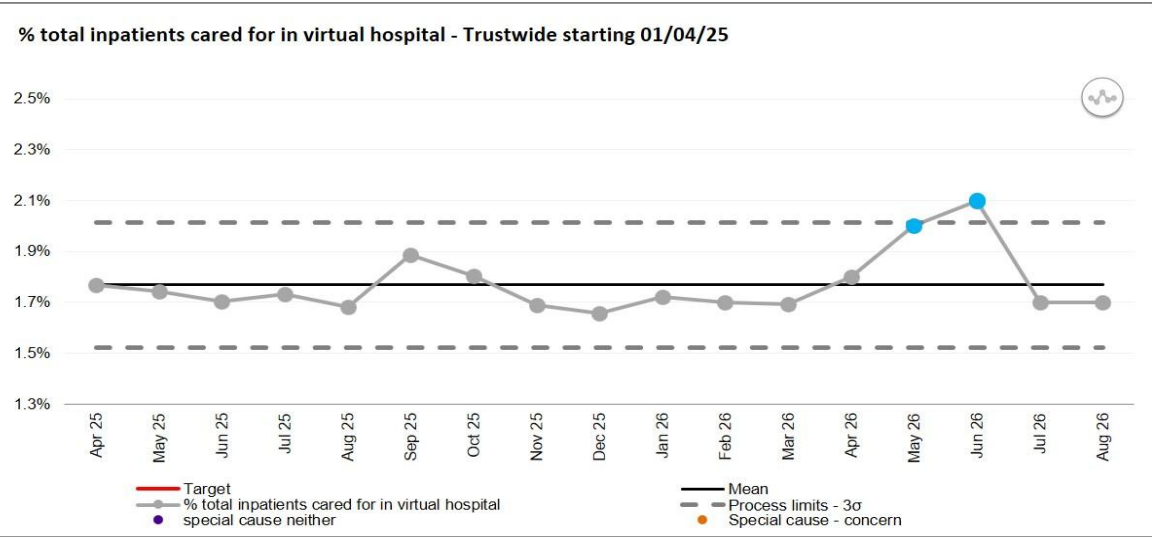
- Launched a new feature in August where all patients are messaged automatically on referral to let them know we have received it.
- Set up a Paediatrics Working Group to examine the adoption rate and policy towards 0-19 patients on the portal (currently permitted) given some issues experienced by the department.
- Examining message content and determining if we need to redesign them to increase adoption further and make the portal easier to use.
- We reached a final draft of the roadmap for next 2-5 years features in Patient Portal.
- Make discharge summaries available in a paperless format in addition to clinic and appointment letters which already are for those not opted out.

Risks:

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

Strategic objective: Driving improvement and enabling innovation

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



Insight Metrics	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
% total inpatients cared for in virtual hospital	1.7%	1.8%	2.0%	2.1%	1.7%	1.7%
Daily Average Virtual Hospital Activity	99	85	96	85	100	97
Daily Average Virtual Hospital Performance against plan (%)	124%	106%	120%	106%	125%	121%
Number of Virtual attendances	11,799	10,658	9490	11,790	10,941	9128
Distance travelled by our patients (average miles) (Outpatients including Virtual Attendances and Advice & Guidance)	5.3	5.1	5.1	5.0	Arrears	Arrears

* Denotes metric is part of the NHS Oversight Framework dataset

Board Committee
Quality Committee

SRO: Chief Strategy Officer

Assurance

Variation

N/A



Royal Berkshire
NHS Foundation Trust

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

How are we performing:

- In August, 1.7% of all inpatients were cared for in our virtual hospital.
- We are no longer seeing an upward trend in the proportion of inpatients cared for in our virtual hospital.

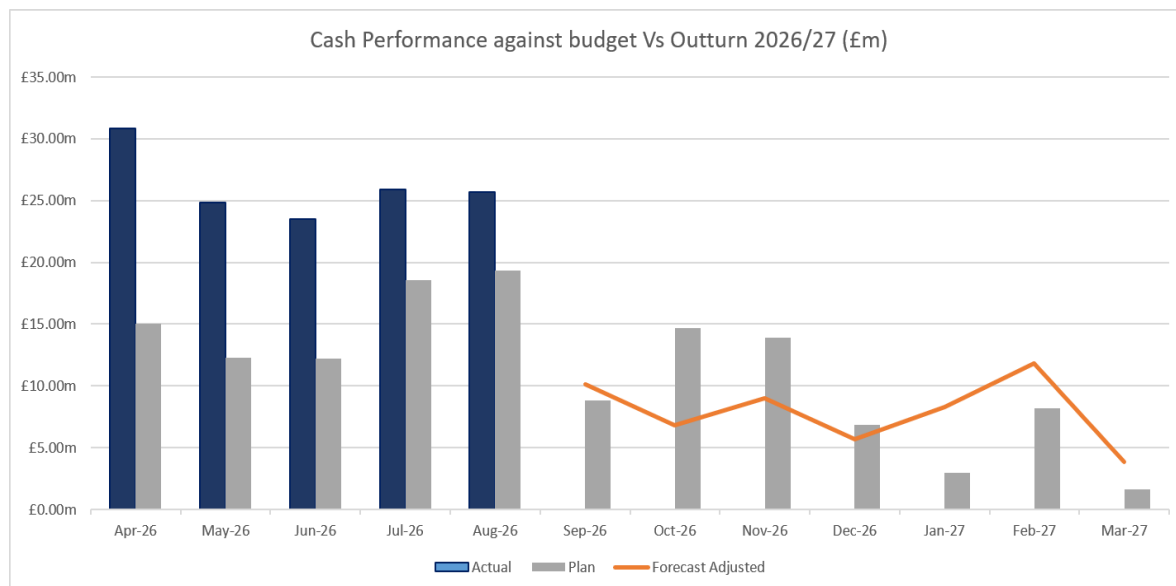
Actions and next steps:

- The 'Royal Berks @ Home' strategic programme is a multi-year transformation programme that is currently in the scoping phase, therefore the metrics on this page are subject to change once KPIs are confirmed.
- Beyond the above, further actions, risks, and next steps will be identified once the scope is agreed.

Risks:

Strategic objective: Building a sustainable future together

Strategic metric: Cash performance (£)



Insight Metrics	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Cash Performance (£m)	£27.04m	£30.85m	£24.82m	£23.51m	£25.92m	£25.67m
Underlying financial position (£m)	£(3.86)m	£(2.60)m	£(3.35)m	£(4.15)m	£(2.54)m	£(3.81)m
In-month variance to plan: Pay (£m)	£(1.39)m	£(0.18)m	£0.26m	£(0.19)m	£(0.9)m	£(1.21)m
In-month variance to plan: Non-Pay (£m)	£(2.82)m	£0.72m	£0.59m	£(0.64)m	£(0.65)m	£0.51m
In-month WTE (incl bank and agency)	6469	6388	6366	6421	6433	6485

* Denotes metric is part of the NHS Oversight Framework dataset

Board Committee
Finance & Investment

SRO: Chief Finance Officer

Assurance



Variation



This measures: RBFT's cash position at M05 £25.67m is ahead of plan. The graph shows in-month performance against adjusted plan, with a straight-line projection to year-end. The forecast deteriorates later in the year, although the cash position remains positive (above zero) in Q4.

How are we performing:

Cash Performance: The Trust cash position £25.67m is significantly ahead of plan, £6.35m above plan, due to ICB clawback (due end of Q2).

Forecast: The current forecasts suggest the Trust will maintain positive cash balances throughout the year, assuming the delivery of financial recovery actions, including commissioner income plans, and CIP programmes will be critical to maintaining cash resilience and mitigating liquidity risk.

Actions and next steps:

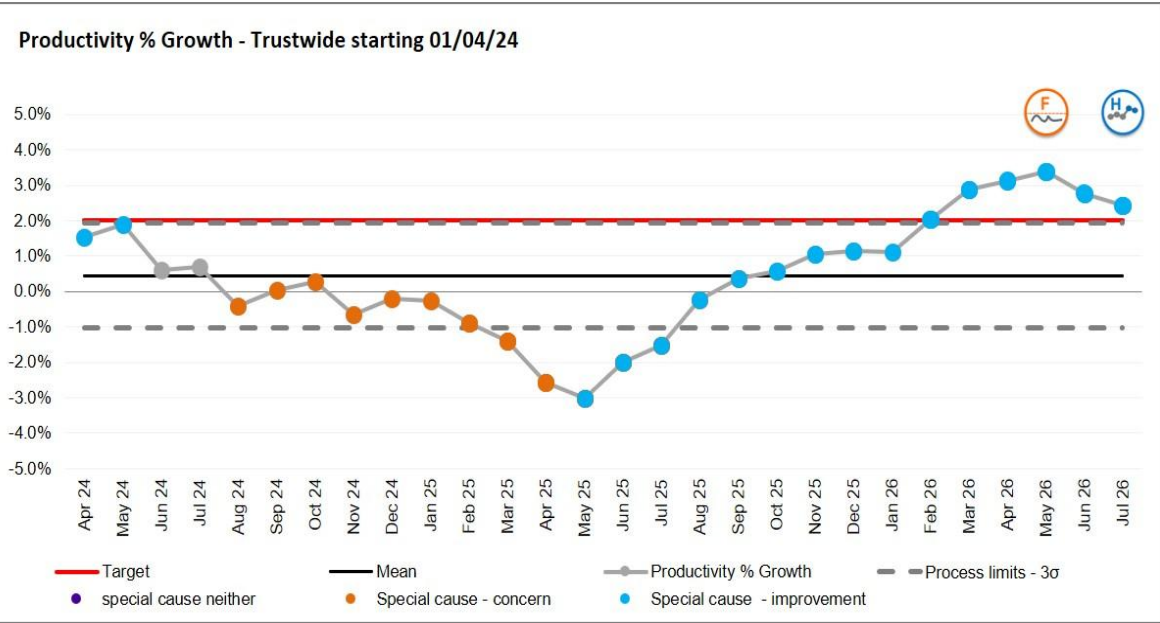
- Prioritise the cash releasing schemes.
- Q4 ICB clawback impact actively managed within liquidity plan.
- Manage supplier payments carefully.
- Capital payment profile kept under review; any acceleration assessed for cash impact before commitment.

Risks:

- FIP non-delivery - direct cash shortage risk with limited Q3/Q4 headroom.
- Liquidity risk if capital payment or ICB receipt timing cannot be managed.
- £0.47m unfunded industrial action cost remains unresolved at M02
- Inability to pay suppliers on time.
- National capital risk: if NHS England require in-year capitalisation (as in 2025/26), cash position will require capital programme re-profiling.
- Increase in WTE at the current run rate.

Strategic objective: Building a sustainable future together

Strategic metric: Productivity Growth



Insight Metrics	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
*Year-on-year Productivity % Growth (activity/WTE)	2.9%	3.1%	3.4%	2.8%	2.4%	Arrears
Cost Weighted Activity (CWA) % Growth	2.9%	3.1%	3.5%	3.0%	3.0%	Arrears
Whole Time Equivalent (WTE) % Growth	0.0%	0.0%	0.1%	0.2%	0.5%	Arrears

* Denotes metric is part of the NHS Oversight Framework dataset

Board Committee
Finance & Investment

SRO: Chief Strategy Officer

Assurance



Variation



This measures: Productivity, here measured by 'output per worker' in the Trust as approximated by the value of all wholtime equivalent (WTE) growth against activity growth year on year. The measure is reported on a 12-month moving average basis to account for seasonal variation.

How are we performing:

- In July, the Trusts productivity was 2.4% higher than the 12 months previously this was driven by continued growth in activity delivered by a fixed workforce base. The rate of improvement has slowed due to the WTE growth.
- The National outcomes framework indicates RBFT productivity improvement in the last 12 months is in the top quartile of acute trusts with a year-on-year productivity improvement of 6% on the NHSE metric.

Actions and next steps:

- Teams are working on the identification of their cost improvement plans for 26/27, with around 85% of the total plan identified to date, supported by the financial improvement programme.
- Business planning for 28/29 will be a focus of activity in Q3. The framework under development with teams continues to emphasise productivity improvement supported by both continuous and step change programmes.

Risks:

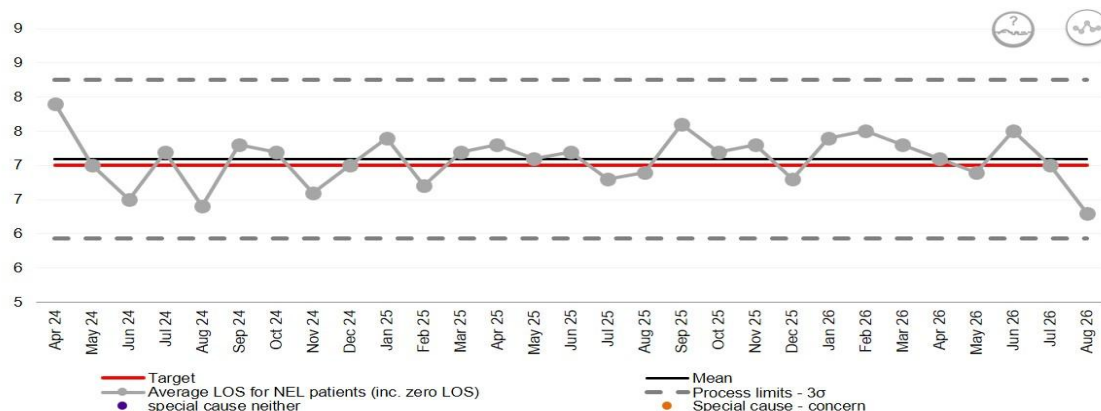
- There remains the risk that the Trust will not be able to recover the income from activity growth in Non-elective pathways.

Breakthrough Priorities

Breakthrough priority metric: Safest place

Average Length of Stay (LOS) for non-elective patients

Average LOS for NEL patients (inc. zero LOS) - Trustwide starting 01/04/24



Insight Metrics	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Ave LOS for NEL patients (inc. zero LOS)	7.3	7.1	6.9	7.5	7.0	6.3
Wait time (days) for a community hospital bed in Berkshire West	2.8	3.1	3.1	3.8	2.9	3.0
% of core inpatients who are ready for discharge but require support	10.7	9.8	11.1	10.1	10.7	11.7
Average number of Community Hospital empty beds overnight	8	6	7	8	6	10
Average number of days patients wait for Social Care packages at home in Berkshire West	3.9	4.4	3.2	4.2	3.1	4.4
Average number of days patients wait for a Health Care(reablement) package of care at home in Berkshire West	1.6	1.8	2.0	1.9	1.4	1.8

* Denotes metric is part of the NHS Oversight Framework dataset

Board Committee: Quality Committee

SRO: Chief Operating Officer

Assurance



Variation



NHS

Royal Berkshire
NHS Foundation Trust

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

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

How are we performing:

- The average LOS in August was below target at 6.3 days. (6.8 Excl SDDC)

Actions and next steps:

- A targeted drive has commenced for wards not meeting target for expected accuracy of predicting a day of discharge for all patients the day before they go home.
- Refining new process to highlight community bed demand and capacity, with new targets anticipated for winter.
- Resilience meetings along with improved communication with Local Authorities to commence to ensure visibility and improvement of Domiciliary and Car Home Pathways.

Risks:

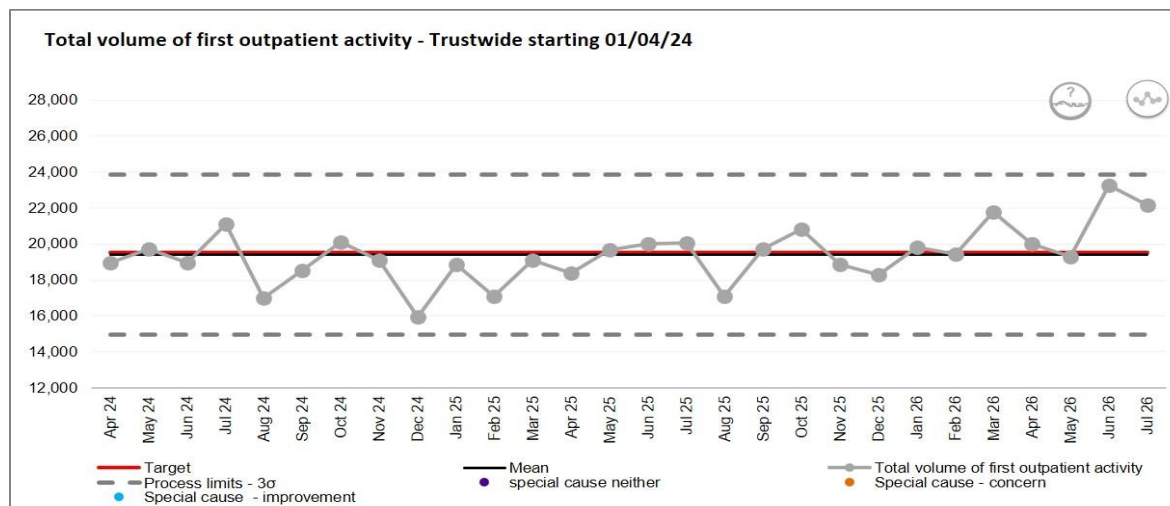
- Enhanced therapeutic observations and care patients needing Care at Home or Care Homes take longer to find appropriate care.
- Bed capacity pressures, increased patient moves / discharge to non-optimal ward.
- Ward closures and delays for patients needing isolation period Community Hospital ward closures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

Breakthrough priority metric: Improving elective performance

Total Volume of first Outpatient (OP) Activity

Board Committee: Quality Committee
SRO: Chief Strategy Officer

Assurance	Variation



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

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

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

How are we performing:

- Completed data for July shows that we delivered over 22k 1st OPA, and remains above plan for the year.
- August data is not yet available due to data processing delays. There is no indication that we will not be meeting plan.

Insight Metrics	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Total Volume of first outpatient activity	21,792	20,020	19,277	23,259	22,188	Arrears
First outpatient activity Plan	19,499	17,055	16,203	18,760	19,612	Arrears
Average wait for first outpatient appointment	64.5	60.3	57.6	64.2	58.5	60.9
% patients waiting over 12 weeks for first assessment	68.75	69.82%	70.20%	69.52%	65.80%	68.93%
% OP that did not attend/were not brought (1 st OP Appt)	7.0%	7.4%	7.5%	7.4%	8.5%	7.5%
% triage within 2 working days for all GP referrals (including 2 week wait, urgent and routine)	57.10%	55.20%	50.90%	65.30%	49.82%	56.40%

* Denotes metric is part of the NHS Oversight Framework dataset

Actions and next steps

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

Risks: Corporate Risk 5698

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

Breakthrough priority metric: Future workforce

Future fit workforce (total wholetime equivalent worked)

Board Committee: Finance & Investment Committee

SRO: Chief People Officer

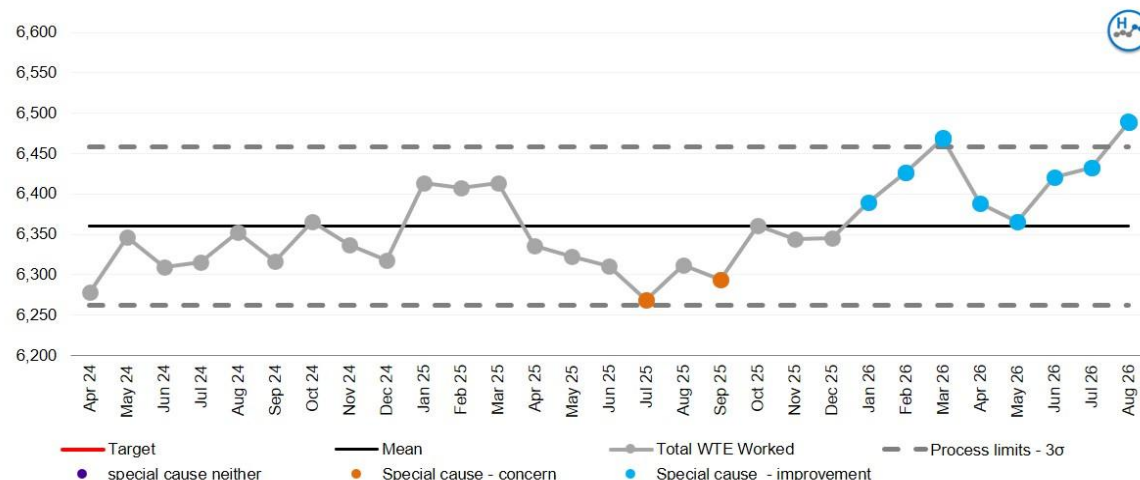
Assurance

Variation

N/A



Total WTE Worked- Trustwide starting 01/04/24



Insight Metrics	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Total WTE worked	6469	6388	6366	6421	6433	6489
Contracted worked WTE	6111	6127	6130	6152	6121	6154
*Bank WTE	346	254	228	262	308	331
*Agency WTE	11	7	7	8	4	4
Internal promotion (all bands) proportion vacancies filled with internal applicants (%)	-	-	42%	41%	38%	51%

* Denotes metric is part of the NHS Oversight Framework dataset

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

How are we performing:

- In August, Worked WTE was 6,485 WTE, 52 WTE higher than the previous month and also higher than the workforce plan for Month 5 (+150 WTE). This was driven by higher than planned for substantive numbers as well as increases in Bank workers. Work is ongoing to identify actions to improve performance against plan focussing on CIP delivery across the Trust.
- Agency WTE was 60% lower than plan in August and is on course to exceed the nationally mandated target of a 30% reduction on 25/26.

Actions and next steps:

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

Risks:

- Balancing rightsized workforce with patient safety & experience, activity levels and income and maintaining cancer standards. Ongoing need to develop CIP schemes to deliver workforce plans which will need to be delivered by March 2027.

Watch Metrics

Summary of alerting watch metrics

Introduction:

Across our five strategic objectives we have identified 115 metrics that we routinely monitor, we subject these to the same statistical tests as our strategic metrics and report on performance to our Board committees.

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

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

Alerting Metrics August 2026:

In the last month 13 of the 115 metrics exceeded their process controls. These are set out in the table opposite.

There are 4 new alerting watch metrics this month:

- E.coli (Trust acquired) Bloodstream Infections (Cumulative)
- Medication incidents per 1000 bed days
- FFT Satisfaction Rates ED
- Complaints response Rate - Maternity

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

Delivering the highest quality of care for all

- Perinatal Mortality Rate (rolling year per 1000 births)
- E.coli (Trust acquired) Bloodstream Infections (Cumulative)
- Medication incidents per 1000 bed days
- FFT Satisfaction Rates ED
- Complaints response Rate - Maternity

Supporting our people to thrive

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

Partnering for Impact

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

Driving improvement and enabling innovation

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

Building a sustainable future together

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

Strategic Objective: Delivering the highest quality care for all

Watch metrics

SROs: Katie Prichard-Thomas
Janet Lippett

Metric	Variation	Assurance	Target	Jun-26	Jul-26	Aug-26	Aug-25
Pressure ulcer incidence per 1000 bed days			1.00	0.21	0.15	0.11	0.56
Category 2 avoidable pressure ulcers			5	0	0	0	0
* Category 3 avoidable pressure ulcers			0	0	0	1	1
* Category 4 avoidable pressure ulcers			0	0	0	0	0
Unstageable avoidable pressure ulcers			0	0	0	0	0
* Patient Falls per 1 000 bed days			5.00	3.13	3.40	4.28	4.37
* Patient falls resulting in harm (PSIRF methodology applied)			-	3	0	1	1
No. of DOLS applications applied for			-	28	32	19	20
No. of detentions under the MH act to RBH			-	2	5	1	2
% of staff: Safeguarding children L1 training			90.00%	95.80%	95.90%	96.90%	96.50%
No. of child safeguarding concerns by the Trust			-	138	144	135	153
No. of adult safeguarding concerns by the Trust			-	54	79	66	30
No. of safeguarding concerns against the Trust			-	4	2	5	9
Unborn babies on child protection (CP) / child in need plans (CIP)			-	42	22	47	44
* C.Diff (Cumulative – Trust Apportioned)			39	7	9	10	29
C.Diff lapses in care			-	1	2	1	3
* MRSA Bacteraemia (avoidable)			0	0	0	0	0
E.coli (Trust Apportioned) Bloodstream Infections			-	8	12	9	4
* E.coli (Trust Apportioned) Bloodstream Infections (Cumulative)			77	26	38	47	43
MSSA surveillance (trust acquired)			-	5	5	3	4
Hand Hygiene			95.00%	94.67%	95.36%	94.57%	97.28%
VTE inpatient (excluding short stay/maternity) risk assessment / prescription compliance			95.00%	96.80%	Arrears	Arrears	93.30%
Hospital Acquired Thrombosis (HAT) rate / 1000 inpatient admissions			0.00	1.37	Arrears	Arrears	0.50
Medication incidents per 1000 bed days			-	8.10	7.11	9.45	7.44
* % of inpatients making a supported quit attempt with an in-house tobacco dependence treatment service			-	2.33%	5.84%	Arrears	1.32%

* Denotes metric is part of the NHS Oversight Framework dataset

Strategic Objective: Delivering the highest quality care for all

Watch metrics

SROs: Katie Prichard-Thomas
Janet Lippett

Metric	Variation	Assurance	Target	Jun-26	Jul-26	Aug-26	Aug-25
FFT Satisfaction Rates Inpatients			95.0%	94.7%	95.0%	94.2%	93.8%
FFT Satisfaction Rates ED			95.0%	80.0%	80.0%	80.2%	80.8%
FFT Satisfaction Rates Outpatients			95.0%	95.0%	95.0%	95.6%	96.6%
FFT Satisfaction Rates Daycases			95.0%	97.5%	98.0%	99.2%	97.6%
FFT Satisfaction Rates Children and Young People			95.0%	100.0%	82.0%	92.0%	93.3%
Mixed sex accommodation - breaches			0	100	56	17	192
Myocardial Ischaemia National Audit Project (MINAP): Door-to-Balloon target of less than 90 minutes			97.0%	88.9%	90.0%	Arrears	78.6%
Myocardial Ischaemia National Audit Project (MINAP): Call-to-Balloon target of less than 120 minutes			86.0%	75.0%	75.0%	Arrears	72.7%
Myocardial Ischaemia National Audit Project (MINAP): Call to Balloon target less of than 150 minutes			82.0%	87.5%	100.0%	Arrears	90.9%
Never Events			0	0	0	0	1
PSIRF: No. of Patient Safety Incident Investigations (PSII)			-	0	0	1	2
PSIRF: No. of After Action reviews			0	1	1	0	6
PSIRF: No. of Multidisciplinary Team (MDT) reviews			-	0	1	0	5
PSIRF: No. of Thematic reviews			-	0	1	0	0
No. of compliments			-	56	51	42	48

Metric	Variation	Assurance	Target	Dec-25	Jan-26	Feb-26	Feb-25
Crude mortality			-	1.80	1.80	1.20	1.30
HSMR			100.00	112.20	111.70	111.30	106.00
SMR			100.00	112.20	111.70	112.20	104.50
* SHMI			1.00	1.14	1.15	1.15	1.08

* Denotes metric is part of the NHS Oversight Framework dataset

Strategic Objective: Delivering the highest quality care for all

Maternity Watch metrics

SROs: Katie Prichard-Thomas
Janet Lippett

Metric	Variation	Assurance	Target	Jun-26	Jul-26	Aug-26	Aug-25
Deliveries			-	399	403	390	385
Bookings			-	462	509	400	512
* % of Inductions of labour			-	29.7%	27.8%	29.7%	30.9%
Perinatal mortality rate (rolling year per 1000 births)			4.77	5.80	5.81	4.96	2.48
Number of occasions MLU service suspended for 4 hours or more			4	0	0	0	14
Midwifery staffing vacancy rate			-	0.0%	0.0%	0.0%	5.3%
Midwifery staffing turnover			14.0%	9.8%	9.7%	Arrears	11.7%
Midwife : birth ratio (utilised workforce)			1.22	1.22	1.22	0.00	1.23
FFT Satisfaction Rates Maternity			95.00%	93.00%	93.00%	95.71%	98.10%
No. of complaints - Maternity			3	10	7	5	2
Complaints response Rate			80.00%	57.00%	50.00%	25.00%	-
Number of Patient Advice and Liaison Service (PALS)			-	10	7	9	-
Number of Rapid Reviews			-	10	14	5	-
PSIRF: No. of Patient Safety Incident Investigations (PSII)			-	0	2	3	-
PSIRF: No. of After Action reviews			-	0	1	1	-
PSIRF: Number of MDT reviews			-	0	3	3	-
PSIRF: Number of thematic reviews			-	0	2	2	-
Babies born with features associated with potential hypoxia			1.50%	0.00%	0.00%	0.00%	1.54%

* Denotes metric is part of the NHS Oversight Framework dataset

Strategic Objective: Supporting our people to thrive

Watch metrics:

SRO: Paul da Gama

Metric	Variation	Assurance	Target	Jun-26	Jul-26	Aug-26	Aug-25
% of staff from global majority backgrounds in senior AFC Bands 8a and above			25.00%	24.83%	25.28%	25.00%	21.48%
* Rolling 12 month Sickness absence			3.3%	3.5%	3.5%	Arrears	3.9%
% Fill rate of Registered Nurse Shifts (RN)			90.0%	96.2%	93.9%	91.5%	93.0%
% Fill rate of Care Support Worker Shifts (CSW)			90.0%	99.6%	98.4%	95.2%	94.1%
Appraisals			90.0%	90.4%	90.9%	87.4%	89.9%
Nurse Staffing Red Flags			-	32	40	40	49
Stability Rate (%)			90.0%	92.2%	91.9%	92.7%	90.6%
Turnover rate % (excluding fixed term temps and non-execs)			13.0%	8.6%	8.3%	8.1%	9.9%
Vacancy rate			7.0%	4.1%	3.7%	1.4%	2.6%

* Denotes metric is part of the NHS Oversight Framework dataset

Strategic Objective: Supporting our people to thrive

Watch metrics:

SRO: Paul da Gama

Metric	Variation	Assurance	Target	Jun-26	Jul-26	Aug-26	Aug-25
RIDDOR reportable Incidents			-	6	3	2	3
Body fluid exposure/needle stick injury			-	18	22	19	20
Environment Related Incidents			-	28	20	15	19
Conflict Resolution			90%	95%	95%	95%	90%
Fire (Annual)			90%	93%	92%	92%	92%
Moving and Handling Level 1			90%	95%	95%	95%	94%
Moving and Handling Level 2			90%	88%	88%	88%	90%
Health and Safety Training			-	96%	96%	96%	95%
Slips and Trips			-	4	1	1	2
Musculoskeletal - Inanimate object			-	2	6	4	7
Total non clinical incidents reported			-	299	273	232	217
Incidents of violence and aggression (patients, relatives, visitors to staff) - other			-	-	72	59	-

* Denotes metric is part of the NHS Oversight Framework dataset

Strategic Objective: Partnering for Impact

Watch metrics

SRO: Dom Hardy

Metric	Variation	Assurance	Target	Jun-26	Jul-26	Aug-26	Aug-25
Fractured Neck of Femur: Surg in 36 hours			60.0%	64.9%	52.0%	Arrears	52.0%
Proportion of patients admitted directly to an acute stroke unit within 4 hours of hospital arrival			90.0%	72.0%	63.0%	75.0%	73.0%
Proportion of patients spending 90% of their inpatient stay on a specialist stroke unit (national target)			80.0%	93.0%	88.0%	93.0%	88.0%
Proportion of people with high risk TIA fully investigated and treated within 24hrs			90.0%	91.0%	84.0%	92.0%	90.0%
Cancer Incomplete 104 days			0	56	54	50	83
Average waiting times in diagnostic (DM01) services			6	2	3	4	4
* 30 day readmissions			-	499	541	492	613

* Denotes metric is part of the NHS Oversight Framework dataset

Strategic Objective: Driving improvement and enabling innovation

Watch metrics

SRO: Andrew Statham

Metric	Variation	Assurance	Target	Jun-26	Jul-26	Aug-26	Aug-25
% OP appointments done virtually			-	20.5%	19.4%	19.0%	19.4%
Number of OPPROC			-	17505	17568	Arrears	13288
Number of MDT OP			-	907	806	Arrears	709
Number of PIs			-	175	175	178	137
Number of active research trials			-	371	373	376	179
Total Number of projects supported by Health Innovation Partnership (HIP)			-	66	66	66	63
Percentage of Commercial Studies opened < 60 days(from site selection to opening of studies)			-	-	100.0%	50.0%	-
* Data Quality Maturity Index			95.0%	Arrears	Arrears	Arrears	-
Cyber Risk average (out of 25) on Datix Level 1, 2, & 3 includes Security, Infrastructure, application cyber risk			6	11	12	12	-
Windows 11 across End User Device (EUD) Operating System (%)			95.0%	44.8%	61.1%	77.6%	-

* Denotes metric is part of the NHS Oversight Framework dataset

Strategic Objective: Building a sustainable future together

Watch metrics

SRO: Frances Khatcherian

Metric	Variation	Assurance	Target	Jun-26	Jul-26	Aug-26	Aug-25
Pay cost vs Budget (£m)			-	-0.19	-0.79	-1.21	0.96
Non pay cost vs Budget (£m)			-	-0.64	-0.61	0.51	-0.53
Income vs Plan (£m)			-	0.93	1.56	0.78	-0.48
Daycase actual vs Plan (£m)			-	0.40	-0.05	0.84	0.32
Elective actual vs Plan (£m)			-	0.64	-0.75	0.27	-0.04
Outpatients actual vs Plan (£m)			-	0.40	-0.05	0.84	2.62
Non-elective actual vs plan (£m)			-	11.20	-0.35	0.74	-0.40
A&E actual vs plan (£m)			-	2.75	0.75	0.69	0.92
Drugs & devices actual vs plan (£m)			-	0.59	0.31	-0.17	0.82
Other patient income (£m)			-	0.16	0.37	-0.53	-0.10
Delivery of capital programme (£m)			-	1.84	1.72	3.54	2.58
Agency spend % of total staff cost (%)			-	3.7%	3.9%	4.1%	0.4%
Creditors (£m)			-	-87.26	-99.82	-98.36	-97.55
Debtors (£m)			-	40.15	47.67	46.17	45.85
Better Payment Practice Code (BPPC) *paying supplier invoices within 30 days of date of invoice (%) YTD			95.00%	87.50%	87.10%	87.60%	81.10%
Better Payment Practice Code (BPPC) *paying supplier invoices within 30 days of date of invoice (%) In Month			95.00%	89.30%	85.60%	89.80%	50.20%

* Denotes metric is part of the NHS Oversight Framework dataset

Title:	Perinatal service NHSE 10 point plan baseline assessment
Agenda item no:	9
Meeting:	Public Board
Date:	23 September 2026
Presented by:	Katie Prichard-Thomas Chief Nursing Officer Janet Lippett Chief Medical Officer
Prepared by:	Sarah Bailey, Interim Director of Midwifery Elizabeth Williams Interim Head of Midwifery Bryn Kemp Obstetric Clinical Director

Purpose of the Report	- To provide Trust Board with the baseline assessment against the NHS England 10-Point Plan for Maternity and Neonatal Services, prior to regional submission by 25 September 2026. - To seek oversight, scrutiny sign-off on the baseline compliance position, supporting evidence, identified gaps in assurance and improvement actions. - To confirm continued use of existing governance routes to monitor delivery of improvement actions ahead of the December 2026 progress return.
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Report History	Executive Management Committee 14/09/2026 Urgent Care Board 14/09/2026
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What action is required?	
Assurance	Board assurance from the baseline assessment and oversight of further development work.
Information	To note the Trust's 10-Point Plan current position and next steps.
Discussion/input	
Decision/approval	Board approval of the baseline submission for regional return by deadline

Resource Impact:	n/a
Relationship to Risk in BAF:	SO1 - Delivering the highest quality of care
Corporate Risk Register (CRR) Reference /score	n/a
Title of CRR	n/a

Strategic objectives This report impacts on (tick all that apply)::			
Delivering the highest quality care for all			x
Supporting our people to thrive			x
Partnering for impact			x
Driving improvement and enabling innovation			x
Building a sustainable future together			x
Well Led Framework applicability:			Not applicable ☐
1. Leadership x ☐	2. Vision & Strategy x ☐	3. Culture x ☐	4. Governance x ☐
5. Risks, Issues & Performance x ☐	6. Information Management x ☐	7. Engagement x ☐	8. Learning & Innovation x ☐

Publication			
Published on website		Confidentiality (Fol)	Private
			Public
			x

1 Executive Summary

- The NHSE 10-point plan sets out the most urgent actions arising from recent national maternity and neonatal investigations. These should be the focus of local leadership, improvement activity and board oversight whilst the national Maternity and Neonatal Taskforce develop a comprehensive national action plan by the end of the year.
- NHSE requires trust boards to complete a baseline assessment against the 10-Point Plan for Maternity and Neonatal Services and return the submission to regional teams by 25 September 2026. The baseline assessment has been completed for the Trust across 26 key deliverable areas within the 10-point plan.
- The assessment identifies areas of established compliance, as well as areas where further assurance, evidence strengthening or implementation work is required. The strongest areas of assurance relate to clear executive joint accountability, homebirth review, post death care, elements of 24/7 safety and responsiveness, midwifery establishment, anaesthetic cover and Board reporting associated with specific evidence submissions.
- Key gaps requiring Board oversight include improved ethnicity and deprivation analysis, neonatal medical workforce planning, escalation arrangements, Patient Safety Incident Response Framework (PSIRF) embedding, compassionate debriefing and triage performance oversight.
- The Board is asked to approve the baseline submission, note the evidence log and support continued monitoring of improvement actions through existing governance structures ahead of the 31 December 2026 progress return.

2. Key Issues

Overall baseline position:

The baseline assessment covers 26 deliverables. The summary indicates 13 deliverables assessed as fully compliant. 3 points of the 10-point action plan are compliant overall, these being Martha's Rule, homebirth services and post death care. With the remaining 7 points showing a mixed position across the 10-point plan, including compliant, partially compliant, non-compliant and not applicable ratings.

Listening to women and families, Patient experience, outcomes and audit:

Call for Concern is embedded Trust-wide, including maternity, and 40 maternity Call for Concern contacts were recorded between January and August 2026. A maternity and neonatal Call for Concern standard operating procedure is under development, with plans to embed patient (women) wellness questions into perinatal services. Existing intelligence sources include Friends and Family Test feedback, the National Maternity Survey, Maternity and Neonatal Voice Partnership 15 Steps reviews, complaints, compliments, clinical outcome dashboards and audit programmes. Reported to Quality Committee through the Perinatal Quality Oversight Report and through the Committees Chair Assurance report to Trust Board. The service receive multiple sources of feedback and to support deeper analysis, insight and improvement further investment into technology is being led through the Experience First Strategic Programme and a pilot is currently in progress.

There is further work to analyse the ethnicity and deprivation data for outcomes. This is currently reported for perinatal mortality and attain, with development dashboard work underway for perinatal morbidity in relation to ethnicity and deprivation.

Assurance is in place for consultant presence in acute care situations, midwifery establishment, anaesthetic cover and homebirth review.

Remaining risks relate to neonatal medical establishment planning, escalation guidance to ensure alignment with new national guidance, strengthening regional sitrep compliance, safety

huddles, internal resource deployment in time for escalation, and contingency arrangements for specialist roles and non-frontline staff deployment.

Governance, learning and candour:

There continues to be focus on embedding PSIRF across perinatal services, supported by recruitment to the perinatal patient safety team. Further assurance is required on compassionate debriefing, early duty of candour by senior clinicians or managers. The triage audit has been completed and reported with plans to further develop digital data collection and oversight of waiting times, review times, delays, redeployment and inequalities. Good progress has been made in relation to the appointment of the new clinical director for women services; the focus now is on embedding this role.

3. Recommendation

The baseline assessment provides a clear starting position against the NHS England 10 Point Plan and enables the Trust Board to demonstrate visible ownership, scrutiny and assurance of maternity and neonatal safety priorities. The Board is requested to approve the baseline submission to enable regional return by the deadline of 25th September 2026. Focused work will continue to improve the position of the remaining 13 ratings. The next progress report will be presented at November Public Board to achieve the 31 December 2026 deadline for reporting progress to NHSE.

Title:	Perinatal Triage Review
Agenda item no:	10
Meeting:	Board of Directors
Date:	23 September 2026
Presented by:	Katie Prichard-Thomas Chief Nursing Officer Janet Lippett Chief Medical Officer
Prepared by:	Sarah Bailey Interim Director of Midwifery Kirsty Koroma Perinatal Review Lead Kate Rowley Transformation Lead

Purpose of the Report	To note the findings from the Trust's Maternity Assessment Unit gap analysis and approve the implementation plan new Maternity Triage Specification
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Report History	Urgent Care Board 14 September 2026 Executive Management Committee 14 September 2026
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What action is required?	
Assurance	
Information	To note gap analysis findings and share actions required to improve compliance
Discussion/input	
Decision/approval	To approve proposed actions and provide executive support in evaluating costs

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

Strategic objectives This report impacts on (tick all that apply)::							
Delivering the highest quality care for all				X			
Supporting our people to thrive							
Partnering for impact							
Driving improvement and enabling innovation				X			
Building a sustainable future together							
Well Led Framework applicability:				Not applicable ☐			
1. Leadership	X	2. Vision & Strategy	X	3. Culture	X	4. Governance	X
5. Risks, Issues & Performance	X	6. Information Management	X	7. Engagement	X	8. Learning & Innovation	X

Publication						
Published on website		Confidentiality (Fol)	Private		Public	

1 Executive Summary

- 1.1 As outlined in NHS England's 10 Point Plan for maternity and neonatal services, all trusts must commit to delivering safe and effective maternity triage.
- 1.2 The National Maternity Triage Specification was published on the 7 July 2026.
- 1.3 Trusts are required to complete a gap analysis against this specification and develop an implementation plan, report progress through Public Board and submit to regional NHS England teams by 7 October 2026.
- 1.4 The Trust has completed the NHSE gap analysis template and current compliance against the 10 principles is summarised in Figure 1 below.

Click below to link through to each principle		Fully in place	Partially in place	Not in place	Not relevant	Data not complete
Principle 1: Access and integration	Clear, local 24/7 pathways so women know where to go and are supported between services.	45%	55%	0%	0%	0%
Principle 2: Recognition as urgent care	Maternity triage is the safety-critical emergency front door for urgent and unscheduled care and must be recognised and treated as such.	20%	60%	20%	0%	0%
Principle 3: Assessment and care of women	Every woman receives timely assessment, prioritisation and a clear plan of care.	40%	40%	0%	20%	0%
Principle 4: Clear information for women	Information and messaging must be clear, welcoming and unambiguous: contact triage if you are worried.	33%	67%	0%	0%	0%
Principle 5: Telephone maternity triage	A dedicated 24/7 maternity helpline must be answered promptly and not diverted to labour ward.	50%	50%	0%	0%	0%
Principle 6: Service user voice and experience	Women's feedback must shape service design, improvement and experience.	20%	60%	20%	0%	0%
Principle 7: Facilities and estates	Triage needs safe, visible, fit-for-purpose space designed for urgent care.	60%	30%	10%	0%	0%
Principle 8: Staffing	Staffing must support timely assessment and prompt midwifery and medical review when escalation is needed.	50%	42%	0%	8%	0%
Principle 9: Equity and equality	Services must use data and targeted action to identify and reduce inequalities.	60%	40%	0%	0%	0%
Principle 10: Data and measurement	Data must drive oversight, learning from incidents and continuous improvement.	0%	29%	71%	0%	0%

Figure 1: Summary of current compliance against the 10 maternity triage principles.

Across the 10 principles there are 60 standards: 23 are fully in place (38%), 28 are partially in place (47%), 7 are not in place (12%) and 2 were not relevant.

2 Key Issues

2.1 Data and Measurement

The biggest gap was identified in the data and measurement principle with 5/7 standards not met. Digital, Data & Technology (DDaT) support is required to ensure the metrics outlined in the measurement strategy are captured and reported, with a Maternity Same Day Emergency Care (SDEC) TIPS report in development. Review of this data will need to be embedded into maternity governance. There is also a requirement that women are informed of why data is collected.

2.2 Digital Integration

Maternity triage should be supported with interoperable digital solutions. Currently Birmingham Symptom Specific Obstetric Triage System (BSOTS) does not integrate with the Trust's Electronic Patient Record (EPR) and neither do the Dawes Redman Cardiotocograph (CTG) machines.

2.3 Estates

Signage improvements are required to strengthen wayfinding to maternity triage and waiting room modifications are needed to increase capacity and provide staff visibility of patients to support safety.

2.4 BSOTS compliance

Adoption of obstetric review timings is required to comply with the BSOTS guidance. This will likely require additional obstetric cover overnight and at weekends.

2.5 Service User Voice

Embed Martha's rule and Patient (Woman) Worry and Questionnaire component, with enhanced training on listening to women and families' concerns and providing reassurance.

Strengthen feedback mechanisms and centralise the review of all patient feedback, ensuring actions and improvements are clearly captured, regularly reviewed through governance processes, and shared with patients. A pilot of analysing patient feedback to support theming and improvement is underway and there is a plan to add a feedback option to the end of the triage call for women, families to use and further support the development of the service.

2.6 Access

Address delays in interpretation services, provide easy read information materials and develop a neurodiverse pathway to support inclusive and equitable access.

2.7 Training

Implement formal telephone-triage assessment and establish robust monitoring of training compliance

2.8 Documentation

Across various principles there is need to update policies and protocols to evidence existing processes and compliance, the service will update accordingly as Business As Usual.

All actions identified from the gap analysis are summarised in Table 2 below.

3 Resource requirements

The submission to NHS England requires the Trust to include anticipated costs associated with implementing the actions required to reach full compliance. Further work is underway to provide these cost estimates and an overview has been provided in Table 1 below:

Area	Comment
DDAT	A significant number of actions require DDAT support, to improve data capture and reporting to align to the measurement strategy, improve digital integration with EPR and optimize triage call-handling. There is planned DDAT resource allocation for the Perinatal Service Review programme, next steps to confirm the time allocated to this specifically.
Estates	Waiting room modifications and signage updates. Assurance required that this is included in the future Maternity estate plan
Staffing	Adoption of the BSOTS obstetric review time standards will require review of obstetric staffing, which may indicate the need for further weekend and night cover. Next steps report will be presented at Urgent Care Board.
Additional admin time	Whilst it is anticipated that a large volume of the actions will be conducted as part of BAU. There will be the need for dedicated time for clinical and midwifery leads to conduct audits and develop pathways to ensure full compliance of the specification.

4 Key dependencies

4.1 Key dependencies include:

- Estates future planning for Maternity
- Planned option paper from DDAT regarding EPR provider
- Integrated Care Board (ICB)-wide telephone-triage model – awaiting further update from Thames Valley ICB in regard to the implementation plan. Interim Director of Midwifery escalating through ICB Directors of Midwifery network and update expected early October 2026.

5 Next steps

- 5.1 Perinatal Service Review Team to estimate costs ahead of submission (DDAT, estates and staffing).
- 5.2 Develop implementation plan and submit to NHS England by 7 October 2026 with ongoing oversight from Executive Management Committee and Trust Board oversight.
- 5.3 Achieve full implementation of the maternity triage specification within 12 months of publication (7 July 2027).

Table 2: Action Summary

Principle	Key actions
Principle 1: Access and integration	• Address delays in interpretation services • Create easy read information materials • Develop a neurodiverse pathway • Update documentation for all access routes • Embed Martha's Rule (PWQ)
Principle 2: Recognition as urgent care	• Improve signage and virtual orientation. • Reinforce staff reassurance training • Monitor inappropriate attendances • Add feedback option to triage line
Principle 3: Assessment and care of women	• Adopt BSOTS obstetric review timings, which may require additional obstetric cover overnight/weekends • Establish robust monitoring of training compliance
Principle 4: Clear information for women	• Review patient information and website content • Communicate free interpreting service • Share EDL with patients
Principle 5: Telephone maternity triage	• Develop call-diversion options (admin/advise) • Seek clarity on plans for an ICB-wide telephone-triage model.
Principle 6: Service user voice and experience	• Formalise feedback review and capture, ensuring you said we did is shared with patients • pilot Medallia to support collation and theming of feedback • Broaden feedback from diverse groups • Provide patients with clear information on how to raise concerns
Principle 7: Facilities and estates	• Expand waiting room and improve staff visibility of those waiting for safety. • Integrate BSOTS with EPR. • Integrate Dawes Redman CTGs with EPR
Principle 8: Staffing	• Review staffing requirements to meet obstetric review time standards • Implement formal telephone-triage assessment • Include triage information and acuity in huddles/IQVIA • Digitalise redeployment activity capture
Principle 9: Equity and equality	• Improve IMDS heatmap data quality and review frequency. • Include demographic filters on dashboard
Principle 10: Data and measurement	• Develop Maternity SDEC TIPs report and refine the Maternity dashboard to align with the measurement strategy. • Embed the measurement strategy review and action planning into Maternity governance • Communicate why data is collected to women.

Title:	Winter Plan 26/27
Agenda item no:	11
Meeting:	Public Board
Date:	23 September 2026
Presented by:	Dom Hardy, COO
Prepared by:	Hannah Berrington, UCG DoO

Purpose of the Report	Present Winter 26/27 initiatives to Board Gain Board endorsement of Assurance Framework, for final submission to NHSE
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Report History	OMT 17 August 2026 EMC 24 August 2026 Quality Committee 3 September 2026
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What action is required?	
Assurance	x
Information	x
Discussion/input	
Decision/approval	x

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

Strategic objectives This report impacts on (tick all that apply)::			
Delivering the highest quality care for all			
Supporting our people to thrive			
Partnering for impact			
Driving improvement and enabling innovation			
Building a sustainable future together			
Well Led Framework applicability:			Not applicable ☐
1. Leadership ☐	2. Vision & Strategy ☐	3. Culture ☐	4. Governance ☐
5. Risks, Issues & Performance ☐	6. Information Management ☐	7. Engagement ☐	8. Learning & Innovation ☐
Publication			
Published on website		Confidentiality (FoI)	Private
Is the report confidential and includes patient data of commercial interests or can the public view the report?			

1. Executive Summary

- The Trust has completed its annual Board Assurance Statement (BAS) Self-Assessment, as required by NHSE. This requires endorsement by Trust Board to submit to NHSE by 30 September 2026.
- To support the completion of the BAS Self-Assessment, the Trust has developed a full and comprehensive Winter Plan for 2026/27 and Seasonal Vaccination Plan. These detailed plans have been endorsed by OMT, EMC and Quality Committee, throughout August and September 2026, prior to presentation to Board.
- The BAS Self-Assessment demonstrates full compliance across all specified areas. The Board can take assurance that the required actions and essential improvements necessary for winter preparedness, as identified by NHSE, are either in place or progressing as planned, with implementation and embedding on track ahead of Winter 2026/27.
- Work on the Winter Plan continues and incorporates further works than those set out by NHSE. Over 70 actions and work streams are identified and tracked via the Winter Plan. The Plan brings together many programmes of work whilst encouraging continued use of established Improving Together governance, as opposed to duplicative reporting structures.
- Representatives from the Trust engaged in the South East Winter Testing Event on 14 September. Additionally, we are coming together locally with system partners at the Winter Demand Reduction and Management Group 30th September to continue to test the Winter Plan. Feedback from both events will feed into further actions and continue to evolve the Trust's detailed Winter Plan.
- Delivery of all actions of the Trust's detailed Winter Plan will be monitored monthly through OMT.

2. Objectives

RBFT's objective is to continue to deliver safe, timely care in the right place for our patients, throughout winter and in the face of huge anticipated winter demand challenges. Throughout Winter, the Trust aims to :

- Mitigate the anticipated seasonal increase in non-elective demand while maintaining safe, effective and compassionate care.
- Improve front-door flow and reduce avoidable waiting, including ambulance handover delay, long waits following decision to admit and 12-hour breaches.
- Maximise admission avoidance through SDEC, PSDEC, SAU, SPOA, VACU, UCC, frailty and other ambulatory pathways.
- Reduce length of stay and improve discharge through criteria-led discharge, improved TDD accuracy, discharge lounge utilisation, community transfers and closer system working.
- Maintain safe capacity, workforce resilience, infection prevention and control, vaccination, escalation and business continuity arrangements.

- Provide clear ownership, measurable delivery milestones and an escalation route for under delivering workstreams

3. Learning From Last Year

Learnings from last winter have discussed at previous OMTs and informed the 26/27 Winter Plan.

What worked well :

- Improving Together activity supported focused improvement in Zone B, paediatrics, ambulance handovers, Fit to Sit and UCC pathways.
- SPOA referrals and redirection increased, same-day pathways expanded, and the Clinical Directory of Services improved visibility of alternatives to ED. Utilisation of alternative pathways to admission saw a decreased proportion of ED patients waiting >12 hours within the department.
- Additional senior decision-maker presence at the front door supported an average improvement of approximately 30 minutes in wait to be seen compared with the previous winter.
- Earlier flow to the discharge lounge improved, criteria-led discharge was successfully introduced on two wards, and IPC reviews supported risk-assessed reopening of capacity.
- System partner calls, the community bed sitrep and stronger operational review of DTA, 12-hour breaches and longest waits improved shared oversight.

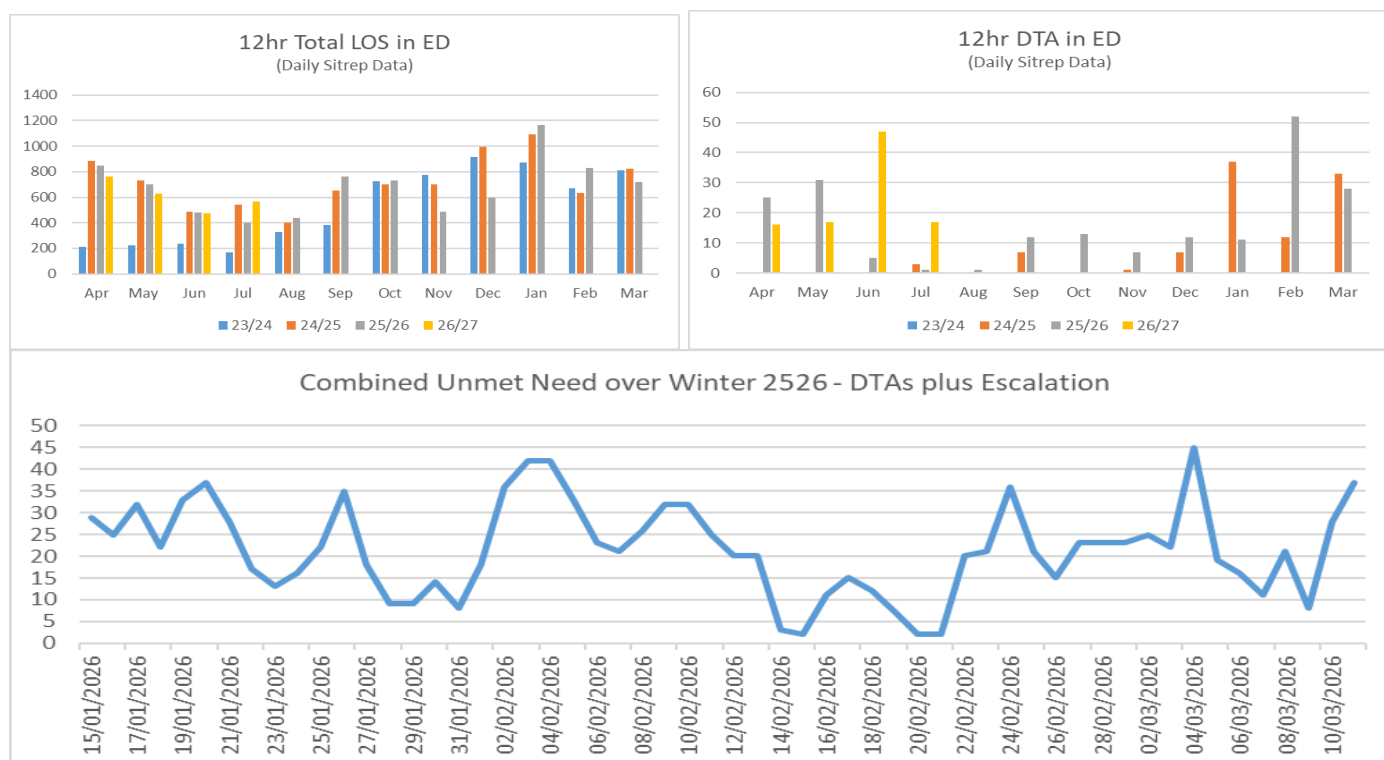
Areas of challenge last year :

- Improvement programmes did not fully mitigate demand and prolonged escalation. SDEC and SAU escalation reduced their ability to deliver admission avoidance, due to frequency of having to bed assessment areas.
- TDD completion remained high, but accuracy did not exceed 52%, limiting timely allocation and effective use of transfer and discharge processes.
- Temporary escalation space was under-used, additional viable escalation areas were not identified, and pressure could not be rapidly de-escalated following prolonged periods of surge.
- Live zonal performance and pathway compliance data were not consistently available, reducing operational visibility.

4. Scale of Challenge

Winter 2026/27 is expected to be challenging. It is estimated that the Trust has experienced a 24-bed reduction over the previous 24 months (NRU, respiratory, paediatrics, SSU, stroke). Over the same period, ED attendance increased by 10%, ED admissions by 2%, and other admissions (including SDEC and hot-clinic routes) by 10%.

Last winter demonstrated the quality and safety consequences of insufficient NEL capacity: longer ambulance and ED waits, increasing waits for DTAs, prolonged use of assessment units and elective areas as escalation space, delayed discharge, deconditioning and additional pressure on staff.



A review of unallocated DTAs each morning, added with those in temporarily bedded escalation areas, indicates last winter's NEL bed deficit reached as high as 35-40 beds.

5. Key Interventions

Over 70 actions and work streams have been captured in the 26/27 Winter Plan. The Winter Plan is a live document which will continue to evolve as opportunities are identified and/or mitigations required as appropriate.

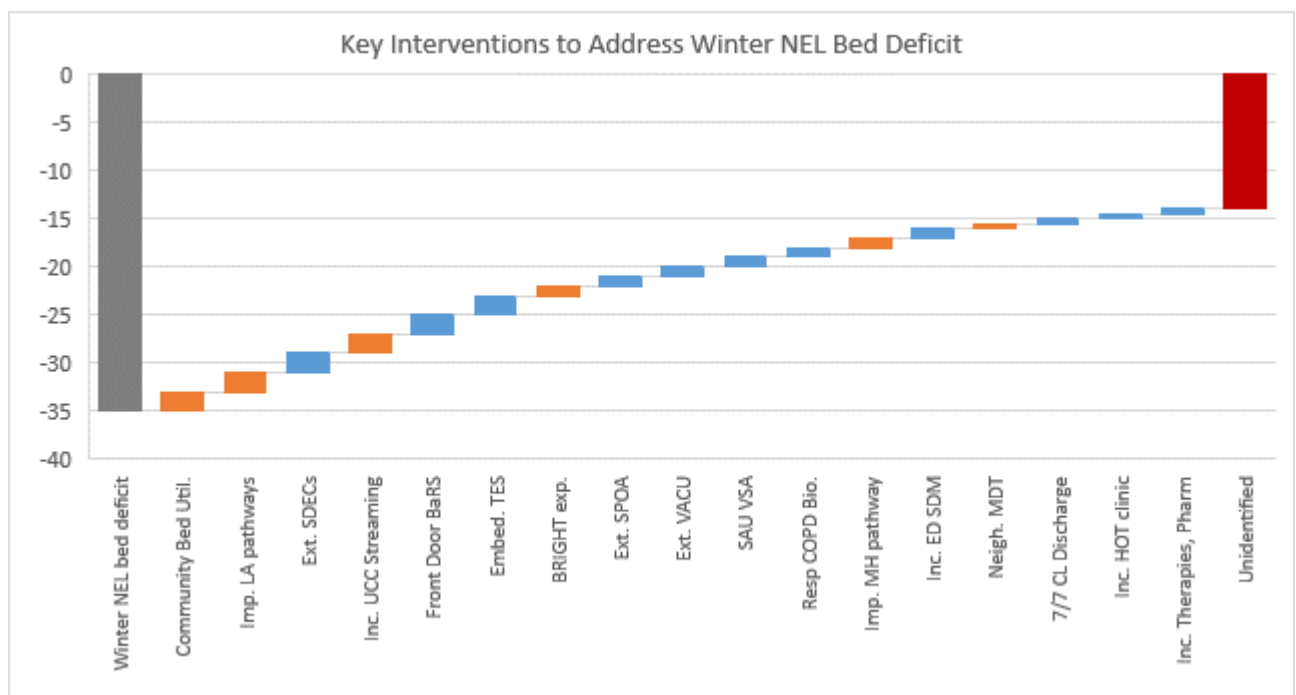
The programmes of work reach across Care Groups, Corporate functions and across organisations through essential works with system partners.

In Summary, the 26/27 Winter Plan captures eight strategic priorities :

1. Improve front door flow
2. Strengthen admission avoidance
3. Reduce LOS and improve discharge processes
4. Maximise available bed capacity
5. Improve operational productivity and visibility
6. Sustain our workforce
7. Eliminate cross-organisational barriers and work cohesively with system partners
8. Protect service quality and patient safety



Work is ongoing to quantify the expected impact of each of the 70+ actions captured. Those known and expected to have direct positive impact against NEL bed deficit are shown below.



- Collaboration with system partners, and delivery of shared benefits (orange in graph) is absolutely essential to achieve significant mitigation against expected NEL bed base deficit in winter.

- Despite all identified efforts, it is expected demand will continue to outstrip capacity, resulting in remaining circa 15 bed base deficit. Work continues to quantify remaining schemes and identify further actions required to further mitigate expected pressures.
- The £4.4m Non-Elective Growth Support Funding, received April 2026, is being used across care groups to support above investments. System partners are known to receive similar investments through NEL Growth Support Funding or Innovation Fund allocations. These provide a mechanism to see real, tangible improvements across all identified areas.

6. Ownership and Governance

- The Winter Plan, Vaccination Plan and Assurance Statement have been endorsed at OMT, EMC and Quality Committee.
- All Winter Plan actions have clear leads identified and work is ongoing to finalise benefits quantification fully, ahead of winter.
- At Trust level, the winter plan has been broken down into care group and corporate action logs with updates due regularly through NEL OMT monthly meetings. Escalations may be brought to EMC as required and appropriate.
- System partner meetings are already in place at local level, with escalation routes to fortnightly executive bilateral, NHS partners and unified executive meetings.

7. Engagement Plan

- The Winter Plan is due to be shared in detail with all system partners, following Board endorsement
- Winter Plan testing events continue, with feedback incorporated (14/9, 30/9)
- Building on learning from last year, the Trust will host another open session Winter Briefing, due to take place in October.
- Winter Plan action leads will be expected to deliver monthly updates throughout autumn and winter itself, via OMT. Escalation routes prior to OMT are well known and established.

Equality and Quality Impact Assessment (CQIA) - Winter Plan 2026/27	
Project Title	Winter Plan 2026/27
Project Owner	Exec Lead: Don Hardy, Chief Operating Officer and Executive Winter Sponsor Director Lead: Hannah Berrington, Director of Operations, Urgent Care Group Project Owner: Hannah Berrington, Director of Operations, Urgent Care Group

Guidance	Please read this prior to filling out the CQIA assessment below
The CQIA form requires a judgement to be made against 8 quality risk categories. Each project will need to be assessed against each category to identify potential positive and adverse impacts that the project may have on our patients, staff or the organisation. Answer positive or adverse in each category. If an adverse impact is identified, please complete the likelihood and impact columns using the guidance in the risks and issues section. Adverse impacts with scores greater than or equal to 8 indicate there is a potential risk that the project can have a negative impact on our patients, staff or the organisation. For these categories, the remaining columns will automatically be opened (highlight removed) to allow you to enter further detail on how the risk can be mitigated to an acceptable level. It is important that you complete these sections with sufficient detail to give the CQIA panel the information it requires to assess this project's impact. It is also important that early warning indicators are developed to enable the organisation to monitor these and mitigate these risks before they become significant.	

Quality/risk area	Impact: Positive/Negative	Describe the clinical or quality impact (Both Positive and Negative)	Likelihood (If negative)	Impact (If negative)	Risk Score	Summarise the mitigation actions required and monitoring arrangements for managing the impacts	Early warning indicators	Post-mitigation Likelihood	Post-mitigation Impact	Final Risk Score
Duty of quality Could this project impact on compliance with the NHS Constitution, partnerships, safeguarding children or adults and the duty to promote equality?	Negative	The Winter Plan is intended to support delivery of safe, effective and equitable care during seasonal pressure. If actions are not delivered, or do not have desired improvement effect, constrained non-elective capacity, bed deficits, and overworking could affect timely access, dignity, safeguarding oversight, partnership working and the Trust's duty to promote equality.	3	4	12	Maintain normal overnight and monthly CMT, overnight of all actions, escalate amber/red delivery risks, complete winter exercise testing (commenced Sept); review OPEL actions, escalation processes & outstanding business continuity plans; circulate winter plans to system partners & complete local system winter exercises	Rising ambulance and ED waits; growth in 12-hour waits or OTA breaches; prolonged use of escalation areas; safeguarding or equality concerns; red/overdue actions in the Winter Plan tracker.	3		9
Patient experience Could this project impact on positive survey results from patients, patient choice, personalised and compassionate care?	Negative	The winter plan aims to maintain patient experience through winter as much as possible, through maintaining wait times, better communication, appropriate alternatives to admission and earlier discharge. Residual risk remains if crowding, delayed transfer, repeated moves, use of escalation areas or inconsistent access to alternative pathways affects privacy, dignity, choice and compassionate care.	4	3	12	Continue patient-experience monitoring through existing patient safety governance, PFT, PALS, complaints and Datax, maintain focus on ambulance handover, front door flow, discharge lounge use and long waits, apply clear communication and reasonable adjustments; escalate adverse themes through established quality governance.	Deterioration in FTT feedback; increased complaints, PALS contacts or Datax incidents relating to waits, communication, privacy, dignity, discharge or access; increasing longest waits and OTA breaches.	2	3	6
Patient safety & Harms Prevention Could this project impact on safety, systems in place to safeguard patients to prevent harm, including infections?	Negative	Failure to deliver the plan could increase harm associated with crowding, long waits, delayed admission or discharge, deconditioning, infection transmission, deterioration and care in temporary escalation areas. Successful delivery of the plan has positive safety impacts through admission avoidance, senior decision-maker cover, IPC controls, vaccination, fit testing and strengthened escalation.	4	4	36	Use OPEL triggers, director-led bed meetings and on-call escalation; maintain IPC cohorting risk assessment; PPE and fit-testing arrangements; monitor 12-hour waits, OTA delay, ambulance handover and winter waits; relaunch the twelve-hour action group; undertake daily and weekly stranded-patient reviews.	Increase in 12-hour waits; OTA breaches; ambulance handover delay or safety incidents; prolonged assessment-in-ED escalation; infection outbreaks; delayed reviews; deterioration, falls, pressure damage, medication delay or deconditioning themes.	2	4	8
Quality, clinical effectiveness and outcomes Could this project impact on evidence based practice, clinical leadership, clinical engagement, patient outcomes and/or high quality standards?	Negative	The programme supports evidence-based urgent and emergency care, clinical leadership and improved outcomes through Model pathways reviews and GFT recommendations, SDEC ambulatory pathway, earlier senior decision-making and data-led improvement. Benefits may be reduced if pathway standards, clinical criteria, action ownership or measurement are inconsistent.	3	3	9	Reassess services against national model pathway standards; standardise SDEC eligibility and OPEL flex criteria; maintain clinical governance through PRM, SMA and Care Group routes; quantify direct benefits using agreed methodology and track delivery evidence monthly via OMT	Variation in pathway compliance; reduced SDEC or ambulatory utilisation; assessment areas used for beds; missed-opportunity reviews identifying avoided admission; actions without evidence, metrics or accountable owners.	2	2	4
Prevention Could this project impact on promotion of self-care and health inequality?	Negative	The plan has positive prevention impacts through vaccination, respiratory-virus measures, risk stratification, utilisation of Protected Care and preventative health pathways. There is a risk that people at greater clinical or socioeconomic risk may not benefit equally if information, vaccination or admission-avoidance pathways are not accessible or targeted effectively.	3	3	9	Use population-health intelligence and risk stratification with system partners to identify vulnerable and high-risk cohorts (PCA proactive, MGT Neighbourhood works); provide accessible staff and targeted vaccination offers; maintain primary care, community, frailty virtual and remote-monitoring work; review uptake and access by relevant population groups where data are available.	Low or unequal vaccination uptake; increased respiratory outbreaks; repeat acute care attendance; low referral or acceptance into preventative pathways; insufficient prevention, gaps identified through Connected Care or partner review.	2	2	4
Patient Flow and Access Could this project impact on patient flow and access to services?	Negative	The plan is designed to maintain and/or improve access and flow through front-door optimisation, admission avoidance, reduced length of day, discharge improvement and better use of community capacity. If delivery is delayed, patients may experience unequal or prolonged access to assessment, diagnostics, admission, transfer and discharge, particularly during peak demand.	4	4	36	Deliver and monitor the eight Winter Plan priorities; extend SDEC, PSDEC, SPOA and VACU pathways; improve diagnostics, TDO accuracy, criteria-led discharge, discharge lounge use and community transfers; review OPEL actions and temporary escalation capacity; use monthly accountability via OMT and escalation in DoC / CC boards	ED attendance and admission pressure; increased WTBs, OTA and 12-hour waits; high occupancy; delayed diagnostics; low SDEC/SPOA/VACU use; reduced discharge lounge use; delayed community transfer; rising stranded and super-stranded patients.	3	3	9
Health economy impact Will your project impact other areas of RoB in terms of service provision, patient demand, or cost?	Negative	The plan relies on coordinated delivery across the Trust, primary care, SCAs, local authorities, Berkshire Healthcare NHS Foundation Trust, the CMA and community partners. Delay or inconsistent escalation across organisations could shift demand, reduce community capacity utilisation and delay transfers of care.	4	3	12	Share and test the Winter Plan with system partners; maintain local and executive escalation routes; progress UEC service mapping, Connected Care, call before-conveyance, local authorities' end-user and aligned discharge/community capacity metrics; Escalate via unified exec and NHS partners	Delayed transfers of care; empty community beds alongside acute demand; reduced call-before-conveyance; repeated manual handover delay; uninvolved system dependencies; escalation actions not closed.	3	2	6
Productivity, Innovation & Performance Could this project impact on - the best setting to deliver best clinical and cost effective care; eliminating any resource inefficiencies; low carbon pathway; improved care pathway?	Negative	The programme should improve productivity through digital dashboards, Connected Care, the Federated Data Platform, pathway redesign, discharge processes and better use of existing capacity. Benefits may not be realised if data quality, informatics capacity, metrics definition, recruitment or implementation delays persist.	3	3	9	Prioritise critical data and informatics dependencies; define meaningful operational and benefit metrics; require evidence-based progress updates; monitor delivery M&M and quantified impact; escalate blocked actions through OMT/EMC, embed successful flow activity as business as usual.	Unavailable or unreliable dashboards; missing or inconsistent strip data; actions without quantified impact; red/blackout DQAT dependencies; low pathway utilisation; failure to improve TDO accuracy, transfer times or discharge performance.	3	2	6
Workforce Effectiveness Could this project impact on staff satisfaction, staff willingness to recommend hospital to friends and family?	Negative	Winter pressure, prolonged escalation and vacancies can increase workload, fatigue, sickness, stress and reliance on temporary staffing. The plan includes positive mitigations through rota review, senior clinical cover, recruitment and retention, reduced agency reliance, vaccination, fit testing, security and staff wellbeing oversight.	4	4	36	Complete safe staffing and rota reviews; maintain medical and nursing leadership and on-call support; monitor sickness, return to-work timelines, vacancies, agency use and wellbeing; implement vaccination and fit testing, use redeployment and escalation processes with appropriate supervision. Uplift rota as B&U over winter to increase front door support offering (ambulo, nap, geriatrics, PSDEC, SDEC, AMA)	Rising sickness or stress-related absence, gaps in safe staffing or senior decision-maker cover; increased agency use; delayed return-to-work; low vaccination or fit testing completion; workforce safety incidents or sustained high OPEL pressure.	3	3	9
Equality, Inclusion and Diversity Impact Is there evidence that the proposal will affect different population groups differently (staff and patients), including unintended discrimination against certain groups? Does it compromise our ability to advance quality of opportunity for staff/patients who share protected characteristics?	Negative	Seasonal pressure and pathway changes may affect groups differently. Potentially greater impacts include people with disabilities or communication needs, older or frail people, children, pregnant people, people with mental health needs, people from minority ethnic communities, people with limited English, carers, people experiencing deprivation or digital exclusion, and staff with protected characteristics. Risks include unequal access, communication barriers, reduced privacy and dignity, and indirect disadvantage from digital or location-based pathways.	3	2	6			2	2	4
Total Score					117					65
Additional Panel FAQs: - Current team vacancy position? - What are the cover opportunities across the department? - Is the role currently vacant? - Can this role be put on hold for 3 months? - How many people fulfil this role?										

Review and approval note

Table 1 - Consequence

	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Business Objectives OR Projects	- Insignificant cost increase - and or schedule slippage	< 5% over budget - and or schedule slippage	5-10% over budget - and or schedule slippage	10-25% over project budget - Noncompliance with national target - key objectives not met	- Incident leading > 25% over budget - Schedule slippage - Key objectives not met
Injury / harm to patient, staff and others	- Minimal injury / illness requiring no or minimal intervention or treatment - No time off work	- Minor injury/illness requiring minor intervention - Less than 7 days off work - Increase in hospital stay by 1-3 days	- Moderate injury requiring professional intervention - Requiring 7-14 days off work - Reportable to CQC / HSE or other Regulator - An event which impacts on small numbers of patients up to 10	- Major injury leading to long term incapacity or disability - Requiring over 14 days off work - Mismanagement of patient care with long term effects - Event impacting on, < 50 patients	- Incident leading to death - Multiple permanent injuries or irreversible health effects - An event which impacts on large numbers (50+)
Quality & Audit	Peripheral element of treatment or service suboptimal	- Overall treatment or service suboptimal - Single failure to meet internal standards - Minor implications for patient safety if left unresolved - Reduced performance rating if unresolved	- Treatment or service has significantly reduced effectiveness - Repeated failure to meet internal standards - Major patient safety implications if findings are not acted on	- Non-compliance with national standards with significant risk to patients if unresolved - Low performance rating - Critical report	- Totally unacceptable level or quality of service - Gross failing of patient safety if findings are not acted upon - Gross failure to meet national standards
Complaints	Locally resolved complaint	Formal complaint	Formal complaint with the potential to go to review	Multiple complaints / independent review	Inquest/ombudsman inquiry
Service / business interruption	Interruption of > 1 hour	Loss / interruption of > 8 hours	Loss / interruption > 1 day	Loss / interruption > 1 week	Permanent loss of service or facility
Environmental impact	No or minimal impact on environment	Minor impact on environment	Moderate impact on environment	Major impact on environment	Catastrophic impact on environment
Staffing / workforce	- Short term low staffing level - temporarily reduces service quality (<1 day)	Low staffing level that reduces the service quality	- Late delivery of key objective or service due to the lack of staff - Poor attendance at mandatory training - Unsafe staffing level > 1 day - Low staff morale	- Uncertain delivery of key objective/service due to lack of staff - Loss of key staff - No staff attending mandatory training - Very low staff morale - Unsafe staffing level or competence (>5 days)	- Non delivery of key objective / service due to lack of staff - Loss of several key staff - No staff attending mandatory training on an on-going basis - On-going unsafe staffing levels or competence
Finance	Small loss of budget < £10,000	Loss of less than 0.25% of budget	Loss of 0.25 - 0.5% of Trust budget	Loss of 0.5 - 1.0% of Trust budget	- Loss of > 1% of budget - Loss of contract
Claim	Remote risk of claim	Claim < £10,000	Claim between £10 - £100,000	Claim between £100,000 - £1M	Claim > £1M
Statutory duty Inspection	Minimal impact or breach of guidance or statutory duty	- Breach of statutory duty - Reduced performance rating if unresolved	- Single breach in statutory duty - Challenging external recommendations or improvement notice	- Enforcement Action - Low performance rating or critical report - Multiple breaches in statutory duties - Improvement Notice	- Multiple breaches - Prosecution - Zero performance rating and or severely critical report - Complete systems change required
Adverse Publicity / Reputation	- Rumours - Potential for public concern	- Local media coverage - Short term reduction in public concern - Elements of public expectation not being met	- Local media coverage - Long term reduction in public confidence	- National Media coverage < than 3 days - Service well below reasonable public expectation	- National media coverage > 3 days - MP Concern (Questions in House) - Total loss of public confidence

Table 2 - Likelihood

	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Certain
General	Probably never happen or recur	Do not expect harm at level indicated to happen or recur but it is possible	Harm at the level indicated might happen or recur occasionally	Harm at the level indicated will probably happen or recur	Harm at the level indicated will undoubtedly happen or recur possibly frequently
Time period	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected	Expected to occur at least daily
Probability	Less than 1% chance it will happen	1 to 5% chance of occurring	5-10% chance of occurring	10 - 50% chance of occurring	>50% chance of occurring

Table 3 - Risk Grading Matrix

		Consequence				
		1 - Negligible	2 - Minor	3 - Moderate	4 - Major	5 - Catastrophic
Likelihood	5 - Certain	5	10	15	20	25
	4 - Likely	4	8	12	16	20
	3 - Possible	3	6	9	12	15
	2 - Unlikely	2	4	6	8	10
	1 - Rare	1	2	3	4	5

Winter Planning 26/27

Board Assurance Statement (BAS)



1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust Boards has oversight that all key considerations have been met. It should be signed off by both the Trust / Provider's Accountable Officer and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please include the Trust / Provider name at the top of the tab.

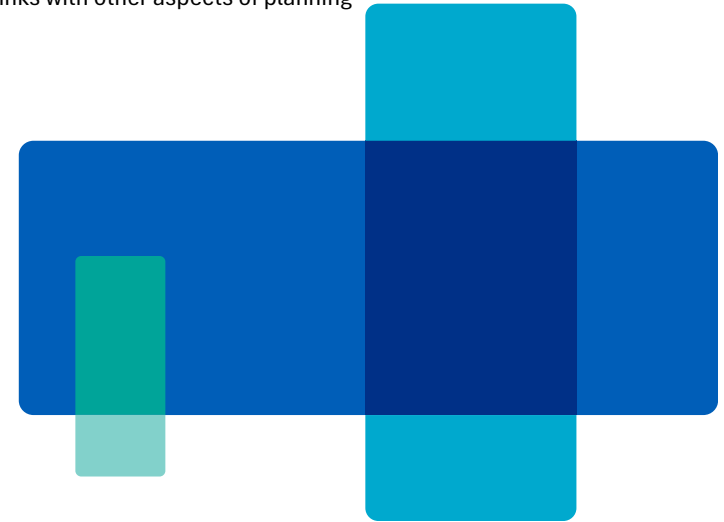
This section gives Trust the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 26/27 Winter Plan checklist

This section provides a checklist of what Boards should ensure is covered in their 2026/27 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2026**.



Winter Planning 26/27

Section A: Board Assurance Statement (BAS)

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

Provider/Trust Name (drop down):

Royal Berkshire Foundation Trust

If Other, write Provider/Trust Name:

Contact details (email, phone number):

Dom Hardy, COO, Dom.Hardy@royalberkshire.nhs.uk

Date:

7/1/2026

Please complete these sections

Assurance statement			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Governance and executive leadership					
1	1.1	The Board has assured the Trust Winter Plan for 2026/27.	Yes	A comprehensive Winter Plan has been created to address and mitigate upcoming winter demand. This has recieved approval at OMT, EMC,	NA
	1.2	The Board is assured that a robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	EQIA completed and to be signed off at OMT 21 September and Board 26 September	NA
	1.3	The Board is assured that the Trust's plan was developed with appropriate input from and engagement with all system partners, including primary care and social care.	Yes	Plan includes system working with PCA/primary care, SCAS, local authorities, Berkshire Healthcare NHS Foundation Trust, ICB and community partners. The Winter Plan will be tested in collaboration with system partners at local and regional events held in September.	NA
	1.4	The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	Tested during South East Winter Test Event 14 September and local system partner event 30 September. Feedback from both events incorporated. Further Trustwide Winter briefing due early October - further	NA
	1.5	The Board has identified a named Executive Winter Sponsor with accountability for winter preparedness (including vaccinations), escalation and operational delivery.	Yes	Dom Hardy, COO, is the identified executive winter sponsor.	NA
	1.6	The Board is assured that clear governance arrangements, escalation processes and operational leadership arrangements are in place throughout the winter period.	Yes	Clear governance arrangements and escalation processes are embedded. OPEL status action cards are under re-review to ensure accurate and adhered, as part of comprehensive winter plan. ICB and system partner escalations to be retested as part of collaborative september winter plan	NA

Winter Planning 26/27 Section B: 26/27 Winter Plan checklist	This section provides a checklist on what Boards should assure themselves is covered by 26/27 Winter plans. Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.
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Section B: 26/27 Winter Plan checklist			Please complete these sections		
			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Prevention					
1	1.1	The Board is assured there are plans in place to deliver a frontline healthcare worker (FHCW) flu vaccination programme that achieves the trust level uptake ambitions and demonstrates: •the offer is accessible to all frontline staff between 1 October – 31 March with the majority of vaccinations completed by 30 November; •that both walk-in and bookable appointments are available; •that all FHCW vaccination activity will be recorded on Record a Vaccination Service (RAVS); and •the FHCW flag has been applied to the ESR records of all clinical and non-clinical staff who are in direct contact with patients to ensure accurate reporting on FDP.	Yes	A full and comprehensive Seasonal Influenza (Flu) Staff and Patient Vaccination Plan has been completed for Winter 26/27. This plan has been endorsed at OMT, EMC, Quality Governance and Trust Board. The plan complies with all aspects of the Winter Plan checklist	NA
	1.2	The Board is assured that frontline staff vaccination, respiratory virus prevention, and staff health measures are supported by targeted operational plans.	Yes	Assurance provided via Trust Seasonal Influenza (Flu) Staff and Patient Vaccination Plan	NA
	1.3	The Board is assured that plans are in place to offer vaccinations (flu and COVID-19) to long stay inpatients (21 days and above) and inpatients who are being discharged into a care home.	Yes	Assurance provided via Trust Seasonal Influenza (Flu) Staff and Patient Vaccination Plan	NA
	1.4	The Board is assured that population health intelligence and risk stratification information are used in partnership with system colleagues to identify and support vulnerable patients and high-risk cohorts ahead of and during periods of winter pressure.	Yes	Connected Care data is used in collaboration with system partners to identify preventative programmes of work. This data has been utilised to identify vulnerable patients and high-risk cohorts ahead of winter, including PCA-led frailty/preventative pathways and Berkshire 1000/BRIGHT expansion	NA
Occupancy and discharge					
2	2.1	The Board is assured that a review of discharges across each pathway required to manage bed demand and occupancy has taken place ahead of winter with system partners. These have been developed jointly with local authority, Community Health Service Providers and system partners, including holiday-period arrangements.	Yes	Reviews of discharges by pathway are embedded and monitored through daily sitreps. Work continues with BHFT and LA system partners to utilise capacity and improve efficiencies. Driver metrics have been developed collaboratively with system partners and form respective winter plans	NA
	2.2	The Board is assured that model discharge pathway requirements are in place to optimise discharge seven days a week across acute, community and social care services. This should include: • coordinated escalation, surge and extreme surge response arrangements, including bed escalation capacity, which have been tested and capable of safe activation to maintain patient flow, create additional capacity and support operational resilience during periods of increased demand. •executive-led governance arrangements to provide oversight of occupancy, the number of discharges required and delivered each day to support safe bed availability and flow, along with the number of patients who are NCTR by pathways 1 to 3 with monitoring of patients with long discharge delays. •targeted operational actions to reduce long discharge delays. •Discharge to Assess pathways that operate effectively with home first as the default and assessment taking place outside hospital wherever possible. These should be supported by integrated escalation arrangements with community and social care partners to maintain patient flow	Yes	A full and comprehensive Trust Winter plan has been developed which addressed all recommendations. This plan includes further roll out of criteria-led discharge for weekend flow, increased utilisation of discharge lounge, community transfer actions, NCTR pathway works with LAs, DTA reduction, TDD accuracy and weekly stranded/super-stranded patient reviews. Operational Bed meetings continue to be chair at director level with executive-led governance, sighting and support.	NA
	2.3	The Board is assured that pre-Christmas and holiday-period occupancy reduction plans will be implemented.	Yes	Trust Winter Plan ensures robust rotas and sufficient and targeted senior decision maker cover is in place to ensure essential organisational flow is maintained over holiday periods.	NA
	2.4	The Board is assured that Same Day Emergency Care (SDEC) and ambulatory emergency care pathways have been optimised to support admission avoidance.	Yes	Trust Winter Plan includes actions on further SDEC expansion ahead of winter. Other assessment units, and ambulatory Trust services have seen equal investment, through NEL programme.	NA
	2.5	The Board is assured that frailty pathways have been reviewed and are operating effectively to support avoidance of unnecessary admission.	Yes	Work continues with system partners utilising Connected Care to identify vulnerable/high-risk cohorts for PCA-led frailty/preventative pathways. NEL investments have been made with SPOA, SDECs and Virtual teams to	NA
Capacity					
3	3.1	The Board is assured that workforce resilience assumptions are evidenced and include safe staffing levels, appropriate skill mix, redeployment models and staff wellbeing support, with clear mitigations in place for sustained periods of increased demand.	Yes	Workforce resilience actions include rota review ahead of winter, staff wellbeing oversight, reduced agency reliance, recruitment/retention work, increased security measures, vaccination programme and fit testing.	NA
	3.2	The Board is assured that rotas have been reviewed to ensure consistent senior clinical decision-making capacity at times of peak pressure, including weekends, supported by clear escalation and supervision arrangements.	Yes	Centralised Rota team allow for continued robust oversight and scrutiny of SDM cover. As per Trust Winter Plan, additional SDM shifts will be implemented, building on learnings from last winter.	NA
	3.3	The Board is assured that elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes	Plans are in place to maintain elective RTT and cancer performance. Ongoing programmes (Reforming Elective Care, Cancer Action Group) remain in place to ensure continuous improvements.	NA
	3.4	The Board has reviewed its 4-hour and 12-hour, and RTT trajectories, and is assured that the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off for 2026/27.	Yes	Winter trajectories continue to be accurate, with sufficient mitigations in place as part of full and comprehensive local Trust Winter Plan 26/27.	NA
	3.5	The Board is assured that there are effective operational actions in place to ensure urgent community capacity is prioritised for the sickest patients.	Yes	As per Trust Winter Plan, programmes of work are ongoing with system partners to maximise use of community capacity.	NA
Flow					
4	4.1	The Board is assured that emergency department crowding mitigations have been reviewed and implemented to actively eliminate corridor care as a patient safety priority. This should include implementation of relevant GIRFT recommendations, and with defined safety thresholds, clear escalation triggers, and routine Board level oversight of associated risks, including dignity, privacy and clinical harm.	Yes	BHFT does not provide corridor care A multitude of actions are captured within the Trust Winter Plan to mitigate department crowding, including actions on UCC utilisation, BARS implementation, increased SDM presence. Clear triggers are defined within individual departmental OPEL status with clear escalation processes embedded	NA
	4.2	The Board is assured that ambulance handover plans are deliverable and supported by appropriate operational arrangements and escalation processes.	Yes	Handover performance continues to be a ED driver metric with continued focus and Improving Together support.	NA
	4.3	The Board is assured that escalation arrangements with system partners support timely transfer of care and patient flow.	Yes	Clear escalation processes are in place and well relieved by system partners. Further works are ongoing with partners to improve efficiency and best utilise all organisations full capacity.	NA
	4.4	The Board is assured that plans are in place to implement the Model ED, Model Acute Pathway and Model Discharge requirements ahead of winter.	Yes	Individualised assessments and have been completed in relevant areas to ensure compliance against all Model ED, Model Acute and Model Discharge standards.	NA
Infection Prevention and Control (IPC)					
5	5.1	The Board is assured that plans, infrastructure, estates arrangements, IPC governance and operational capability are in place to enable the safe rapid reconfiguration of physical space, creation of additional clinical capacity and implementation of patient cohorting arrangements during periods of increased demand or infectious disease transmission, supported by appropriate environmental risk assessments and compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections.	Yes	Firm IPC processes in place including cohorting plan. Risk assessments as standard, with collaborative reviews to ensure best outcomes for patients whilst operational flow maintained.	NA
	5.2	The Board is assured that IPC colleagues, including the Director of Infection Prevention and Control or nominated IPC Lead, have been engaged in the development of the winter plan, and are confident in the planned mitigations and actions.	Yes	IPC colleagues have been involved in the development of the Winter plan	NA
	5.3	The Board is assured that fit testing arrangements are in place for relevant staff, are appropriately recorded and monitored, and can be rapidly expanded during periods of increased respiratory disease and gastrointestinal viral transmission. Appropriate PPE supply, stock management and escalation arrangements are in place to support periods of increased demand.	Yes	Clear plans are in place to complete all relevant Fit testing requirements	NA
	5.4	The Board is assured, as encompassed by criterion 5 of the Health and Social Care Act 2008: code of practice on the prevention and control of infections, that a patient cohorting plan, including risk-based escalation, is in place that is understood by all staff and is ready to be activated by site management teams.	Yes	IPC Cohorting Plan to be recirculated as reminder to teams	NA
Leadership and operational grip					
6	6.1	The Board is assured that on-call arrangements are in place and have been tested, and those on-call have access to medical and nursing leaders for urgent advice, and effective operational oversight to ensure urgent community capacity is prioritised for the sickest patients, where needed.	Yes	Effective on call arrangements are in place and well embedded. Effective SOPs, guidance and documentation is readily available to support individuals on call.	NA
	6.2	The Board is assured that plans are in place to monitor and report real-time pressures utilising the OPEL framework, with clear triggers for escalation and timely operational response.	Yes	The Trust Winter Plan includes review of all OPEL status action cards. OPEL is captured by department as well as at organisational level, monitored throughout the day through bed meetings, with clear escalation processes in place	NA
	6.3	The Board is assured that mutual aid arrangements have been reviewed and are capable of activation, if required.	Yes	Escalation processes and methods of requesting mutual aid are well known, tried and tested	NA
	6.4	The Board is assured that business continuity plans have been reviewed and tested where appropriate.	Yes	BCPs have been reviewed. All due to be in date by end of Sept apart from Paediatrics (due to be completed November post ward move)	Ward moves delay 1 BCP from being in date, at time report is due
	6.5	The Board is assured that severe weather and infrastructure disruption contingencies have been reviewed.	Yes	Trust BCP for severe weather and infrastructure disruptions are in place	NA
	6.6	The Board is assured that industrial action contingencies have been reviewed where relevant.	Yes	Processes for IA are robust within the Trust	NA
	6.7	The Board is assured that plans are in place to support staff welfare through periods of high demand.	Yes	Multitude of actions to support staff welfare are included in the Trust Winter Plan.	NA
Specific actions for Mental Health Trusts					
7	7.1	The Board is assured that a plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via NHS 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.		NA - action for MH Trust only	NA
	7.2	The Board is assured that any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.		NA - action for MH Trust only	NA
	7.3	The Board is assured that liaison psychiatry pathways and Section 136 arrangements remain resilient during periods of peak demand.		NA - action for MH Trust only	NA

Executive Approval

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the Trust / Provider's Accountable Officer and Chair.

Trust / Provider Name: Royal Berkshire NHS Foundation Trust

Provider CEO name: James Blythe

Date reviewed:

Provider Chair name: Oke Eleazu

Date reviewed:

Please update following completion of the BAS template

Please provide name and contact details of designated Senior Responsible Officer (Executive Level)

Dom Hardy
Chief Operating Officer
Dom.Hardy@royalberkshire.nhs.uk

Please provide confirmation that the SRO has reviewed and approved the responses within this document, confirming they are correct and complete.

Hannah Berrington
Director of Operations, Urgent Care Group
Hannah.Berrington@royalberkshire.nhs.uk

Please confirm date reviewed

BAS Self-Assessment Dashboard

Trust

Overall Assessment Rating: 5 - Full assurance



Section B

Prevention
Flow, occupancy and discharge
Capacity and community
UEC Flow
Infection Prevention and Control (IPC)
Leadership and operational grip
Specific actions for Mental Health Trusts

Rating

5 - Full assurance
5 - Full assurance
5 - Full assurance
5 - Full assurance
5 - Full assurance
5 - Full assurance

Awaiting assessment

Board Work Plan 2026

Focus	Item	Lead	Freq	Nov-25	Jan-26	Mar-26	May-26	Jul-26	Sep-26	Nov-26
Delivering the highest quality of care for all	Winter Plan	DH	Annually							
Supporting our people to thrive	Patient Story	Exec	Every							
	Staff Story	Exec	Every							
Building a sustainable future together	Quarterly Forecast	FK	Quarterly							
	2026/27 Capital Plan	FK	Annually							
	Operating Plan/ Business Plan 2027/28	AS	Annually							
	The Green Plan	AS	Annually							
Driving improvement and enabling innovation	Standing Financial Instructions	FK	Annually							
	Trust Strategy Refresh	AS	Nov-25							
Other / Governance	Chief Executive Report	JB	Every							
	Board Assurance Framework	CL	Bi-Annually							
	Corporate Risk Register	KP-T	Bi-Annually							
	Integrated Performance Report (IPR)	Exec	Every							
	NHSE Annual Self-Certification	FK/CL	Annually							
	Standing Orders Review	CL	Annually							
	Board Work Plan	CL	Every							