Royal Berkshire
NHS Foundation Trust

Public Board - 25 March 2026

MEETING

25 March 2026 09:00 GMT

PUBLISHED
23 March 2026

Agenda

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

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1	Apologies for Absence and Declarations of Interest (Minoo Irani, Katie Prichard-Thomas)	Oke Eleazu		-
2	Staff Story (Verbal)	Andrew Statham	09:00	-
3	Patient Story (Verbal)	Janet Lippett	09:30	-
4	Minutes for Approval: 28 January 2026 & Matters Arising Schedule	Caroline Lynch	10:00	3
5	Minutes of Board Committee Meetings and Committee Updates:		10:05	-
5.1	Audit & Risk Committee: 14 January 2026 & 11 March 2026 (Verbal)	Mike McEnaney		11
5.1.1	Committee Review of Effectiveness and Terms of Reference			18
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6	Chief Executive's Report	Steve McManus	10:35	70
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9	2025 Staff Survey Results	Paul da Gama	11:35	116
10	Work Plan	Caroline Lynch	11:45	124
11	Date of Next Meeting: Wednesday 27 May 2026 at 09.00am			-

Board of Directors

Wednesday 28 January 2026
09.00 – 11.45
Seminar Room, Trust Education Centre, Royal Berkshire Hospital

Present

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

In attendance

Mrs. Caroline Lynch	(Trust Secretary)

Apologies

Mr. Paul da Gama	(Chief People Officer)
Mr. Umesh Jetha	(Non-Executive Director)
Mr. Mike McEnaney	(Non-Executive Director)

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

01/26 Patient Story and Staff Story

The Chief Nursing Officer and Chief Operating Officer introduced Sheila, Jody, Roslyn and Ange. Sheila was a Staff Nurse in the Acute Medical Unit (AMU) and her daughter Maka had been a patient at the Trust.

Jody explained that she was passionate about patient safety and the need to reflect when things went well as well as when things went wrong. Patient safety issues were recorded on the Datix system and a Datix had been raised in relation to Maka's care

Sheila advised that it was important for the Trust to learn from what happened with her daughter's care in order to make improvements for patients. Sheila explained that Maka had been treated for a Urinary Tract Infection (UTI) for 3 days which transpired to be pyelonephritis. They had waited a long time in the Emergency Department (ED) and her daughter was in severe pain. Sheila had indicated to the doctor that it could be pyelonephritis and could a scan be carried out. A scan was not carried out and discharge was planned for her daughter. However, her pain continued and her stomach was swollen. Sheila highlighted the importance of listening to patients and their family. Maka was eventually taken to theatre and the operation went well. Sheila had discussed her concerns with doctors in the Intensive Care Unit (ICU). When Maka was discharged from the ICU she was taken to a side room on the surgical

unit. Sheila visited her daughter and who was coughing severely and had Flu. During this visit Sheila took her daughter's observations and considered that she was not well enough to be in a side room so she contacted the Critical Care outreach team. The member of the Critical Care outreach team visited her daughter daily and her wound from the surgery had become infected. Maka spent a total of 14 days as an inpatient. When her daughter was discharged home Sheila cared for her directly and had significant support from her managers so that she could continue to care her for daughter at home. Sheila thanked Jody for raising the Datix and stated that she herself educated all staff, including resident doctors on the importance of calling the Critical Care outreach team when they had any concerns. Sheila also highlighted that she and her daughter had received post discharge counselling from the ICU team and they felt heard and supported by them.

Roslyn explained her role as patient safety lead and highlighted that Maka's story had been an emotional journey for everyone involved. She explained the importance of the multi-disciplinary team reviews that ensured everyone involved met together to discuss patient safety cases. Staff often had to be reassured when things went wrong and Roslyn explained that she was an advocate for the Patient Safety Incident Response Framework (PSIRF). The Board noted that families were informed as soon as possible and the patient safety team spoke to them to include them in the development of the terms of reference for the investigation as well as encouraging them to raise any concerns. Roslyn highlighted that she continued to support some families often 3 or 4 years after the patient safety incident.

Ange explained that the learning from incidents was presented to clinical governance meetings and the 15-step patient safety review was used to speak to staff about incidents. Ange advised that the deteriorating patient was a driver metric for the Urgent Care Group and this was a learning journey that ensured that staff reflected, communication and learned from patients and their relatives and/or carer. In response to a question as to who learning was sustained for new member of staff the Board noted that a central repository would be developed to including all PSIRF learning. Monthly reviews were carried out to identify themes and the patient safety team ensured that cases were discussed. The open culture in the Trust ensured that learning was shared across the organisation. Work also continued to encourage staff to report incidents or speak directly to the patient safety team.

The Board noted that Call 4 Concern cases were discussed at weekly Mortality and Morbidity meetings and any harm identified would be discussed and recorded on the Datix system. The patient safety team also reviewed complaints. Complaints were also discussed at huddles. The Chief Executive highlighted that the induction process for new staff incorporated Freedom To Speak Up, CARE values and the improvement programme.

The Board thanked the group for their presentation.

02/26 Minutes for approval: 26 November 2025 and Matters Arising Schedule

The minutes of the meeting held on 26 November 2025 were agreed as a correct record and signed by the Chair.

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

03/26 Minutes of Board Committee Meetings and Committee Updates

<u>People Committee: 1 December 2025</u>

The Board noted that the People Committee had received an update on the Resident Doctors 10 point plan implementation and discussed that Executive presence at the Resident Doctors' forum would be beneficial. The Committee had also noted good progress in relation to the Sexual Safety Charter including range of training and the Trust's Behaviours Framework being updated accordingly. The Board noted that the Committee had received a comprehensive update on Equality, Diversity & Inclusion (EDI) that enabled a broader discussion at the

meeting. The Committee had discussed the issue of the need to focus on broader EDI issues in addition to the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). The Committee had also noted that the Trust had the highest proportion of Global Majority staff in leadership positions to date.

The Committee had also approved the recommendation from the Nursing & Midwifery Safer Staffing review. In addition, there had been a discussion on the high numbers of Resident Doctor's at the Trust undertaking Industrial Action that demonstrated a positive culture in the Trust.

Audit & Risk Committee: 12 and 18 November 2025

The Board noted that the Audit & Risk Committee had received two internal audit reports: Board Assurance Framework (BAF) and Patient Safety Incident Review Framework (PSIRF); both of which had been rated as 'significant assurance with minor improvement opportunities' in addition to an Artificial Intelligence (AI) benchmarking report. The Committee had noted that PSIRF implementation was ongoing and a number of the issues highlighted by the internal audit report were already being addressed. The Chief Nursing Officer advised that PSIRF training had been discussed at the Executive Management Committee (EMC) and it had been agreed that training would be added to local training profiles.

The Committee had also received a Freedom to Speak Up report that had highlighted the 13% improvement of staff feeling safe and able to speak up in the Staff Survey results. The Committee had also reviewed and recommended the HFMS Ltd and Royal Berks Charity annual report and accounts for approval.

Finance & Investment Committee: 19 November 2025

The Chair of the Finance & Investment Committee advised that the Committee had discussed financial performance and had received strong assurance that the Trust would meet its target deficit for 2025/26. The business plan had been discussed that there was a significant gap in relation to the returns received from teams and the income offer from the Integrated Care Board (ICB). The plan was based on data and the Trust was relatively efficient in comparison with other organisations in the system. In the January meeting the Committee had noted that discussions with the ICB was on-going and the Trust was due to formally submit the business plan in February 2026 and an additional Board meeting had been scheduled to review the plan ahead of submission. The Committee had continued to be briefed on the Trust's cash position and a cash application for deficit support had been submitted in December 2025 for £18.93m with the first payment being received in January 2026. The Board discussed the impact on staff of the Trust's financial position and the need to achieve its cost improvement programme (CIP) both in the current year and the year ahead. The Chief Operating Officer advised that there had been a robust discussion at the EMC and clinical leadership teams had raised concerns in relation to the achievement of CIP and the on-going requests to teams to review their processes to achieve efficiencies as well as focus on the significant transformation programmes. However, it had been noted that the Trust had made significant progress in comparison to the previous year in relation to identification of CIPs. The Board noted that the Trust had submitted bids for innovation funding from ICB and had highlighted that the delivery of efficiencies and delivery of performance standards was dependent on the receipt of this funding. The Board noted that the ICB had received circa 200 bids for innovation funding.

Charity Committee: 2 December 2025

The Chair of the Charity Committee advised that the Committee approved the Charity Annual Report and Accounts at its meeting in December 2025 and this had since been successfully submitted to the Charity Commission.

Quality Committee: 3 December 2025

The Chair of the Quality Committee advised that the Committee had been advised that C.Diff. threshold for 2025/26 had been met as referenced in the watch metrics in the Integrated Performance Report (IPR) and there was a significant focus on this by the Executives.

The Committee had also received a detailed review into the management of complaints and recommendations were being implemented. The overarching themes were communication and clinical care.

The Chair of the Quality Committee advised that the Patient Safety Incident Response Framework (PSIRF) meant that not all incidents leading to moderate or serious harm required investigation via a rapid review, for example, a fall. However, they were noted at the Patient Safety Incident Response Group along with confirmation that learning was already capture on the overarching improvement plan. The Committee had noted the seven action areas for patient safety were deteriorating patients, falls, pressure ulcers, medicine safety, discharge and flow, diabetes and insulin safety and venous thromboembolism (VTE) working group.

The Committee had also noted that there were seven patient safety incident investigations commissions during Quarter 2 2025/26, four of these involved deteriorating patients, one related to medicine safety and two related to maternity. Identified learning from incidents included:

- Gentamicin prescription and administration issues
- Insulin administration and monitoring
- Nasogastric tube insertion and feeding
- Preventing use of contaminated instruments
- Managing treatment delays
- Preventing bathroom falls

The Board noted that the Quality Committee was seeking further assurance in relation to completion of actions in response to investigations, reviews etc.

The Chair of the Quality Committee had also received an update on the Fuller 2 report from the independent inquiry on whether procedures and practices in hospitals and other settings safeguard the security and dignity of deceased people. The Committee had received good assurance that recommendations were progressing. The Trust provided mortuary services on behalf of the Coroner who was content with the Trust's plans and progress. The new mortuary expansion was opened at the end of September 2026.

The Quality Committee had also approved a proposal to reduce the target of % of patients receiving surgery for hip fracture within 36 hours to 60%. This was a locally agreed target and amended target was in response to the changing complexity of patients both in stabilising their condition and the types of fracture sustained.

04/26 Chief Executive's Report

The Chief Executive introduced the report and expressed his thanks to all teams for their work over the Winter period. The Trust had achieved the best performance and elective standards as well as maintaining a focus on cancer standards. The Emergency Department (ED) had been operating at OPEL 4, the highest level, for the first two weeks of January 2026. Currently it was OPEL 3 although the challenges remained for the teams and this pressure could present in the Integrated Performance Report (IPR) at the next meeting.

The Chief Executive highlighted the significant focus on maternity and neonatal services and the Trust's maternity team were working on implementation of recommendations from the national investigation as well as provided assurance to patients. The Chief Nursing Officer

advised that communications had been issued to the public and work was on-going by the maternity leadership team and the communications team to develop a communications plan, co-produced with the Maternity and Neonatal Voice Partnership (MNVP). This would include the community midwifery teams and social media platform to engage certain groups. Overall, feedback had been positive and where negative feedback had been received, women had been encouraged to engage with the Trust. A survey was also being developed and work was on-going to engage with Black African women in relation to reduced foetal movements.

The Board noted that the Trust had achieved its highest response rate in the 2024 Staff Survey. A further update would be provided to the Board in March 2026.

The Chief Executive highlighted that nominations for the annual CARE awards had opened on 12 January 2026. Over 700 nominations had been received in the previous year and communications had been launched encouraging teams to nominate their colleagues. The award ceremony would take place in May 2026.

The Board noted that Anna Horwood, Emeritus Professor of Orthoptics had been awarded an MBE in the King's New Years Honours list in recognition of her services to Orthoptics and Research in visual development, specialising in children's vision.

The Chief Executive expressed his thanks to the Royal Berks Charity, volunteers and the community for the success of both the Christmas Carol Concert that raised over £8,000 for the Christmas appeal supporting the Elderly Care wards Trust's Christmas appeal as well as the Christmas appeal resulting in the receipt of over 900 presents to ensure that every patient received a gift.

The Chief Executive highlighted the significant media engagement undertaken over the last year and expressed his thanks to the communications team. This included industrial action, the Winter period as well as showcasing the work of the Trust.

A major study published in the Lancet has shown that the introduction of artificial intelligence (AI) imaging software across NHS stroke networks significantly increased access to lifesaving treatment for patients with severe stroke in England. The study was authored by colleagues from the Trust in collaboration with Health Innovation Network Oxford and Thames Valley, and Brainomix 360. The study was the largest global evaluation to date of AI in stroke care.

The Chief Executive highlighted the work of the Thames Valley Fracture Liaison Service as part of the Acute Provider Collaborative (APC) clinical services programme noting the benefits for patients of this large scale collaboration between organisations. The Chief Medical Officer advised that the APC continued to review clinical services as part of the programme and some did not provide any benefits at system level, some required collaboration due to workforce challenges and others where there were opportunities for learning. One example included the Trust's urology service that had short waiting times and this provided a learning opportunity for Oxford University Hospitals (OUH).

The Board noted that, following the National Audit Office (NAO) had released a report on the New Hospital Programme that had indicated that the timeline for the new Royal Berkshire Hospital was 2045/46. The Chief Executive advised that work on land acquisition for the new hospital was on-going.

The Board discussed the Trust's business plan for 2026/27. The Chief Strategy Officer provided an overview of the current status including the gap between the income offer from the Integrated Care Board (ICB) despite a challenging cost improvement programme. The Trust was engaged in discussions with the ICB, for example, in relation to funding for first outpatient appointments. However, there was a need to focus on transforming pathways.

05/26 Integrated Performance Report (IPR)

The interim Chief Finance Officer introduced the IPR and highlighted that there had been a strong performance in ED during December, however, it was anticipated that performance would reduce in January 2026 although this was in line with trajectory. The interim Chief Finance Officer highlighted that strong performance in ED was also reliant on internal performance as well as support from partners in the system. The Board noted that whilst the media had reported on 'corridor care' being provided in EDs, the Trust's policy was not to do this, and, during extremely busy periods, there had been a need to escalate spaces in ED with appropriate staffing. The Trust had also developed a policy in relation to the use of temporary escalation spaces. The Chief Operating Officer confirmed that, as part of the Winter planning process, meetings had been held with Care Group colleagues, and wards had identified areas where patients could wait in order to support patient flow. The Chief Operating Officer highlighted that improvements had been achieved using the Improving Together methodology including ambulance handover delays. These had been significantly reduced over the Winter period in comparison with the previous year. The Chief Executive advised that the National Quality Board was due to report on the issue of 'corridor care' in the NHS.

The Board noted that 62-day cancer performance data for December 2025 was currently unvalidated at 75.5% although it was anticipated that this would increase post-validation. Funding had been made available for Quarter 4 2025/26. The Chief Operating Officer advised that the Trust was working with a local company to develop a Large Language Model (LLM) to support the referral process. This had been discussed and supported by the Executive Management Committee (EMC). The LLM would enable referrals to be automatically read. This was currently being tested outside the Electronic Patient Record (EPR) and, so far had been extremely positive. The Board discussed its risk appetite in relation to transformation and the issue of patients consent to their data being used in this way.

The interim Chief Finance Officer highlighted the productivity metric and the improvement seen over the year as the staff profile had remained flat although more activity had been completed.

The interim Chief Finance Officer highlighted the Friends & Family Test (FFT) response rate of 6.8% in December 2025. The Chief Nursing Officer advised that trusts were being asked to focus on satisfaction rates and, as part of the strategic programme on experience of care, the FFT metric would be considered as this was currently under national review. The Board noted that the implementation of PPUK had impacted on the FFT response rate and there was a need to generally consider how to obtain increased patient feedback.

The interim Chief Finance Officer provided an overview of the focus on finance including increased assurance on income and expenditure. Following the 10-point action plan being agreed there had been improvement seen during October to December 2025. During Quarter 4 2025/26 there would be an increase in interventions although there was a level of confidence that budget holders would deliver their financial plan for the year.

The Chief Executive highlighted that the positive performance seen in the IPR overall and, in particular, the Trust's achievement in the Referral To Treatment (RTT) performance and recognised the contribution of staff and volunteers in this.

06/26 Standing Orders

The Trust Secretary introduced the Standing Orders as part of the annual review cycle. These had been reviewed by the Audit & Risk Committee. No changes were proposed. The Board approved the Standing Orders.

07/26 Work Plan

The Trust Secretary introduced the work plan that had been updated for 2026. It was agreed that an update on the Green Plan would need to be scheduled. **Action: C Lynch**

08/26 Date of Next Meeting

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

SIGNED:

DATE:

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

Date	Minute Ref	Subject	Matter Arising	Owner	Update
28 January 2026	07/26	Work Plan	The Trust Secretary introduced the work plan that had been updated for 2026. It was agreed that an update on the Green Plan would need to be scheduled.	C Lynch	Completed. An update on the Green Plan is scheduled for April private Board.

Audit & Risk Committee Chairs Report

Royal Berkshire NHS Foundation Trust

Committee Chair: Mike McEnaney

14 January 2026	
Agenda Item 4: Local Counter Fraud Specialist Report	**Substantial Assurance**
Agenda Item 6: Internal Audit Report	**Partial Assurance**
Agenda Item 7: Estates Project Management Review	**Partial Assurance**
Agenda Item 8: Internal Audit Recommendations	**Partial Assurance**
Agenda Item 9: Annual Report Timetable 2025/26	**Substantial Assurance**

14 January 2026	
Agenda Item 5: External Audit Progress Report	**Substantial Assurance**
Agenda Item 10: Cyber Security Update	**Partial Assurance**
Agenda Item 13: Standing Orders	**Substantial Assurance**
Agenda Item 15.1: Internal Audit Annual Review of Effectiveness	**Substantial Assurance**
Agenda Item 15.2: External Audit Annual Review of Effectiveness	**Substantial Assurance**
Agenda Item 15.3: Counter Fraud Annual Review of Effectiveness	**Substantial Assurance**

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE (ALERT)

- Internal Audit Report – Patient Safety Incident Response Framework (PSIRF) rated "partial assurance, improvements required.

MAJOR ACTIONS AGREED (ADVISE)

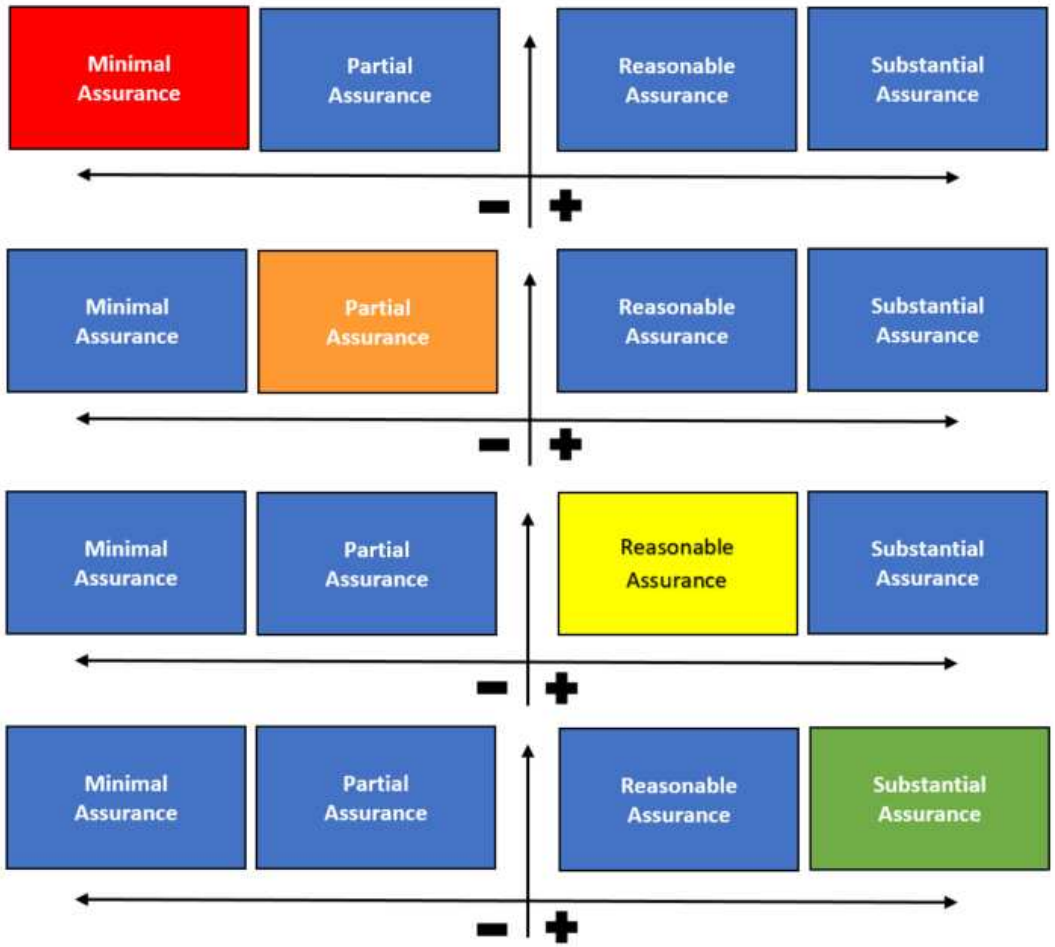
- The revised and reviewed Trust Standing Orders were recommended to for approval by the Board.

POSITIVE ASSURANCES TO PROVIDE (ASSURE)

- Internal Audit Report – Board Assurance Framework (BAF) rated as "significant assurance with minor improvement opportunities.

DECISIONS MADE (APPROVE)

- Annual reviews of effectiveness for Internal Audit, External Audit and Counter Fraud were reviewed and accepted as providing assurance.



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)

Audit & Risk Committee

Wednesday 14 January 2026
9.30 – 11.35
Video Conference Call

Members

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

In attendance

Advisors

Mr. John Oladimeji	(Senior Manager, Deloitte) (up to minute 18/26)
Mr. James Shortall	(Local Counter Fraud Specialist) (LCFS) (up to minute 18/26)
Mr. Neil Thomas	(Partner, KPMG) (up to minute 18/26)
Mr. Sam Williams	(Manager, Deloitte) (up to minute 18/26)

Trust Staff

Mr. Mike Clements	(Director of Finance)
Mr. Stuart Cooney	(Chief Technology Information Officer) (for minute 09/26)
Mr. Dom Hardy	(Chief Operating Officer) (up to minute 09/26)
Mr. Guy Keiser	(Associate Director of Estates & Facilities) (for minute 05/26)
Mrs. Caroline Lynch	(Trust Secretary)
Ms. Katie Prichard-Thomas	(Chief Nursing Officer)
Mr. Andrew Statham	(Chief Strategy Officer) (for minute 05/26)
Ms. Helen Troalen	(interim Chief Financial Officer)

Ms. Marthy Milhavy	(KPMG) (Observer) (up to minute 18/26)

01/26 Declarations of Interests

There were no declarations of interest.

02/26 Minutes for approval: 12 and 18 November 2025 and Matters Arising Schedule

The minutes of the meetings held on 12 and 18 November 2025 were agreed as a correct record and signed by the Chair.

The Committee received the matters arising schedule.

Minute 105/25 (83/25, 25/25, 02/25, 113/24): Minutes for approval: 21 November 2024: HFMS Ltd Annual Report & Accounts 2023/24: The Chair highlighted that the terms of reference for the HFMS Governance review had been circulated to members of the Committee. The review would be submitted to the March meeting. **Action: N Thomas**

Minute 124/25: Local Counter Fraud Progress Report: The interim Chief Finance Officer advised that the finance team would undertake a review of high earners. However, this

would need to be completed after year-end. Therefore, an update would be provided to the July meeting. **Action: H Troalen**

Minute 125/25: Internal Audit Progress Report: Workforce Planning Review: The Partner, Deloitte, confirmed that actions and owners had been updated following a meeting with the Chief Nursing Officer.

Minute 129/25: Corporate Risk Register (CRR): The Chief Nursing Officer confirmed that a review of the maternity risk register was now scheduled as part of the Integrated Risk Management Committee (IRMC) work plan.

Minute 131/25: Use of Single Tenders: A further discussion on the single tenders report would be scheduled with the Chair of the Committee. **Action: H Troalen**

03/26 Local Counter Fraud Progress Report

The Local Counter Fraud Specialist (LCFS) advised that work was on-going in relation to the Local Proactive Exercise on anomalies and outliers within overtime claims. A top 10 list had been provided and this would be reviewed against overtime sessions booked on the Patchwork system. The LCFS highlighted that 126 staff had received bespoke Fraud Awareness training as part of the National Fraud Awareness week. The Committee noted that one fraud referral had been recently received and a further update would be provided to the Committee in due course. **Action: J Shortall**

The interim Chief Finance Officer highlighted that the recent referral had highlighted a further group of staff that would benefit from bespoke training.

04/26 Internal Audit Progress Report

The Partner, KPMG, introduced the report and advised that those reviews not yet completed would be concluded by year-end. The Committee discussed the Access and Activity Data, Outpatients that was issued in October 2025 and remained outstanding. The Chief Operating Officer advised that he anticipated that this would be complete by year-end.

The Partner, KPMG, introduced the review of the Board Assurance Framework (BAF) that had been rated as 'significant assurance with minor improvement opportunities'. The Committee discussed the recommendation to introduce risk scoring and setting target implementation and risk score dates for all improvement actions that had not been accepted by management as it was considered that the current approach was fit for purpose. The Trust Secretary advised that this request had been previously considered by the Executive team and rejected as it was considered that the current approach of reviewing the BAF at each of the Board Committees as well as outcomes and delivery against the Trust Strategy refresh were being developed by the Chief Strategy Officer could result in duplication of work. The interim Chief Finance Officer advised that whilst risk scoring was used in other trusts, this did prove a difficult exercise and it was the Corporate Risk Register (CRR) identified individual risks, scoring and the mitigations. The Partner, KPMG, advised that it was good practice rather than best practice to include risk scoring on the BAF as this could demonstrate movement in each of the risks.

The Committee considered the review provided good assurance and it was agreed that the outcome of the Trust Strategy refresh outcomes would be awaited.

The Partner, KPMG, introduced the review of the Patient Safety Incident Response Framework (PSIRF) that had been rated as 'partial assurance with improvements required'. The Chief Nursing Officer advised that she was aware of the areas of focus and priority and

confident that the recommendations would be achieved. This included the action related to training as this was discussed and agreed by the Executive Management Committee earlier in the week. In addition, the work related to policy was on-going and due to be submitted to the Policy Approval Group in February 2026. The Chief Nursing Officer confirmed that the policy updates related to clarification of the roles and responsibilities in relation to the Duty of Candour including who provided the evidence, sent the letter and ensured that learning was shared.

The Committee noted that when the audit review had been received a further review by the team had been undertaken and it was established that the Duty of Candour discussion was being recorded in different places. Therefore, each of the cases review by internal audit had been further reviewed and Duty of Candour had been undertaken. The improvement therefore was related to the administrative processes and ensuring that the PSIRF policy was aligned to all other policies. A random monthly audit would be undertaken by the patient safety team going forward. The Chief Nursing Officer advised that a new incident management system was being procured. However, a supplier had not yet been agreed. Further updates on this would be included in the quarterly patient safety reports to the Quality Committee. **Action: K Prichard-Thomas**

The Committee noted that the Quality Committee would continue to oversee PSIRF being embedded into the organisation.

The Partner, KPMG, introduced the Care Group Financials review that had been rated as 'significant assurance with minor improvement opportunities'. The Committee noted that controls were well designed and working effectively and the recommendations related to best practice.

05/26 Estates Project Management Review

The Chief Strategy Officer introduced the report and highlighted that work was on target to complete all actions by the end of January 2026. The Associate Director of Estates & Facilities advised that some actions had been completed prior to the audit being carried out and standard methods of operating had been put in place, for example, a standardised template for Senior Responsible Owners (SROs) to report to the Capital Programme Committee on all major projects not just those within the remit of the estates team. The Chief Strategy Officer advised that the availability of financial information did not pose a financial risk, this related specifically to the formal financial reporting that was fixed in the month and SROs were being encouraged to provide a written report with a more detailed financial update at the meeting itself.

06/26 Internal Audit Recommendations

The Director of Finance introduced the report and highlighted that 14 overdue recommendations, 12 relating to the estates review.

The Committee noted one request to extend the target date: Integrated Board Reporting – Use of ESR data with a proposed completion date of May 2026. This was to further demonstrate that the process was embedded in addition to reconciliation with the 2026/27 budget. The Committee approved the extension.

The Committee discussed the actions from the previous finance function and working capital and cash reviews. The interim Chief Finance Officer advised that a previous update had been submitted to the Committee in July 2025. Currently other work remained a priority for

the finance team. However, an update would be provided to the Committee to set out those actions that had been completed in addition to evidence of improvement achieved.

Action: H Troalen

The interim Chief Finance Officer highlighted that NHS England (NHSE) had approved the Trust's cash application and this would have only been the case if NHSE considered that the Trust had good cash management.

07/26 Annual Report Timetable 2025/26

The Trust Secretary introduced the timetable for the production of the Annual Report for 2025/26. The request for content had been issued to authors the previous day and the timetable was being submitted to the Executive Management Committee on 26 January 2026.

08/26 External Audit Progress Report

The Senior Manager, Deloitte, advised that the Royal Berks Charity and HFMS Ltd audits had been completed and planning had begun for the year-end audit. The timetable for the audit had been agreed and an update on progress would be provided to the next meeting.

Action: S Turner

11/26 Use of Single Tenders

The Committee noted that 13 single tender waiver contracts had been awarded from 17 November 2025 to 22 December 2025. The interim Chief Finance Officer advised that the procurement team continued to work closely with both the estates and Digital Data & Technology (DDaT) teams. Overall, very few single tender waivers were rejected.

13/26 Bank Account Authorisations

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

14/26 Standing Orders

The Trust Secretary introduced the Standing Orders as part of the annual review cycle. The Committee agreed that a recommendation should be submitted to the Board to approve the Standing Orders subject to minor typographical amendments and standardisation of the reference to Board Committees. **Action: M McEnaney**

16/26 Internal Audit (IA) Annual Review of Effectiveness

The Trust Secretary introduced the annual effectiveness review and highlighted that whilst there were a low number of respondents, overall, a strong performance had been highlighted and no areas were identified as requiring improvement.

17/26 External Audit (EA) Annual Review of Effectiveness

The Trust Secretary introduced the annual effectiveness review and highlighted that overall, a strong performance had been highlighted.

18/26 Counter Fraud Annual Review of Effectiveness

The Trust Secretary introduced the annual effectiveness review and highlighted that overall, a strong performance had been highlighted.

19/26 Appointment of External Auditors

The Chair highlighted concerns in relation to the lack of involvement of the Committee in the process in addition to Governor oversight. The interim Chief Finance Officer advised that the Healthcare Financial Management Association (HFMA) handbook would be reviewed to ensure that the procurement process undertaken would not be invalidated.

It was agreed that the evaluation paperwork would be shared with the Chair of the Committee and the interim Chief Finance Officer would confirm the next stage of the process as soon as possible. **Action: H Troalen**

The interim Chief Finance Officer highlighted that receipt of two bids from the procurement process was a positive outcome.

20/26 Work Plan

The Committee received the work plan for 2026.

21/26 Key Messages to the Board

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

- Year-end processes were on-going
- Internal audit on BAF and PSIRF received
- Assurance received on estates management review and actions being progressed
- Assurance received on Cyber Security
- Effectiveness reviews of IA, EA and Counter Fraud received

22/26 Reflections of the Meeting

Mike McEnaney led the discussion.

23/26 Date of Next Meeting

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

24/26 Private Meeting with Internal Audit

A private meeting with KPMG was not held.

25/26 Private Meeting with External Audit

A private meeting with Deloitte was not held.

26/26 Private Meeting of the Committee

A private meeting of the Committee was not held.

Chair:

Date:

Royal Berkshire
NHS Foundation Trust

March 2026

Audit and Risk Committee Annual Report 2025/26

Mike McEnaney
Chair, Audit and Risk Committee

Caroline Lynch
Secretary to Audit and Risk Committee

1. Governance

1.1. The Committee met formally on eight occasions during the year:

- 14 May 2025
- 19 June 2025 (Special Meeting)
- 9 July 2025
- 10 September 2025
- 12 November 2025
- 18 November 2025
- 14 January 2026
- 11 March 2026

1.2. The attendance record of members of the Committee is as follows:

Member	Maximum Number of Meetings	Number Attended
Mike McEnaney	8	8
Mike O'Donovan	8	8
Helen Mackenzie	8	8
Umesh Jetha	5	3

1.3. The Chief Finance Officer or equivalent has attended all meetings. The Trust Secretary or a nominated deputy has attended all meetings. The Deputy Director of Finance and Chief Executive or equivalent were regular attendees at meetings. The Chair of the Trust attended four meetings as an observer. Other Directors and staff have attended the meeting during the course of the year to advise and respond to questions from the Committee. These have included the Chief Operating Officer, Chief Strategy Officer, Chief Nursing Officer, Deputy Director of Finance – Financial Control, Associate Director of Estates & Facilities.

1.4. The Committee reviewed the Corporate Risk Register in detail at two meetings. The Chief Nursing Officer provides a report that incorporates decisions from the Integrated Risk Management Committee. The Committee received updates on the Board Assurance Framework at two meetings. The Committee received a detailed overview on Cyber Security at the January meeting and reviewed the Digital, Data and Technology risk register at the March meeting.

1.6. The Committee has received updates in respect of Freedom to Speak Up. The Committee also received an update on the Charity Annual Report and Accounts for the financial year 2025/26.

1.7. The Committee reviewed the Health & Safety Annual Report 2025/26 at the 9 July 2025 meeting.

1.8. The Committee followed a scheduled programme of work over the course of the year. This was developed with our Internal Audit team to ensure that the Committee gives the appropriate level of consideration to all areas within its terms of reference.

2. Internal Audit

2.1. KPMG were appointed Internal Auditor from 1 April 2022 and have continued in the role throughout 2025/26.

2.2. The Committee has continued to oversee the delivery of a robust internal audit programme during 2025/26.

2.3. The Internal Audit plan has been delivered within an overall budget of £114,900. As of the date of this report the following reports have been issued in final:

KPMG

- Data Protection & Security Toolkit, Assignment Report May 2025
- Rostering Report, July 2025
- Estates Project Management Report, September 2025
- Workforce Planning, November 2025
- Research Finance Management, November 2025
- Board Assurance Framework, January 2026
- Patient Safety Incident Response Framework (PSIRF), January 2026
- Core Financial Controls, January 2026

2.4. The following report is in progress:

- DDAT Operations

2.5. check when I receive the IA plan – still awaiting

2.6. KPMG commissioned for external Well Led

2.7. The Committee received the Internal Audit plan for 2025/26 at its meeting on 11 March 2026.

2.8. The annual effectiveness review of the performance of Internal Audit was submitted for review by the Committee at its meeting on 14 January 2026.

3. Counter Fraud

3.1. The Committee has continued to receive a progress report from the Local Counter Fraud Service at each meeting. The reports have provided a comprehensive briefing to the Committee on the actions being taken to develop a counter fraud culture within the Trust and progress with any investigations.

3.2. The Counter Fraud plan for 2025/26 was submitted to the Audit & Risk Committee on 11 March 2026.

3.3. The annual effectiveness review of the performance of Counter Fraud was submitted for review by the Committee at its meeting on 14 January 2026.

4. External Audit

4.1. Deloitte LLP were appointed as External Auditor in 2016 and were re-appointed for a further three years from April 2022.

4.2. The work of the External Auditors and the Committee has been carried out within a framework set by NHS Improvement and the requirements of the National Audit Office's Code of Audit Practice 2020. The work of the external audit has been focussed on the Financial Statements, the Trust's Value for Money arrangements, and considering the consistency of the Annual Report (including the Annual Governance Statement) with information obtained in the audit.

4.3. Over the course of the year, Deloitte LLP delivered a range of assurance reports to the Committee including:

- the ISA260 report outlining the findings of the 2024/25 audit of the Trust's Group 2024/25 financial statements
- regular progress updates on the delivery of the audit and technical updates to members of the Audit Committee.
- the ISA260 report outlining the findings of the 2024/25 audit of the Royal Berkshire NHS Foundation Trust Charity
- the ISA260 report outlining the findings of the 2024/25 audit of Healthcare Facilities Management Services Limited.

4.4. Deloitte LLP have provided the External Audit work plan, technical updates highlighting NHS FT and health sector issues of relevance and contributed to the 2024/25 Annual Report and Financial Statements reporting process.

4.5. Private meetings with External Audit are scheduled on each agenda and held as required.

4.6. The annual effectiveness review of the performance of External Audit was submitted for review by the Committee in January 2026.

5. Monitoring of Processes

5.1. The Committee has, at each meeting, kept under review

- Losses and special payments
- The use of single tenders
- Significant contracts entered into by the Trust
- Levels of non-NHS debt
- New bank account authorisations

5.2. The Committee has reviewed a number of Trust policy and procedural documents, including:

- review of the Trust Standing Orders
- review of the Trust's Freedom to Speak Up arrangements

5.3. The Committee received technical updates as part of its continuing development. Updates received during the year have included:-

- Declarations of Interest Update
- NHS Code of Governance review
- Trust Seal Update

5.4. The Committee Terms of Reference will be submitted to the meeting on 11 March 2026 for review.

6. Other Items

6.1. The Committee agreed the 2024/25 financial statements.

6.2. The Committee approved the Annual Report and Accounts for 2024/25 for submission to the Board.

6.3. The Committee agreed the Charity Annual Report and Accounts for 2024/25 for submission to the Charity Committee.

6.4. The Committee agreed the HFMS Ltd Annual Report and Financial Statements for 2024/25 for submission to the HFMS Board.

Audit and Risk Committee
Terms of Reference

Constitution and Membership

The Committee will be appointed by the Board to oversee risk and audit issues within the Trust.

The Committee is authorised by the Board of Directors to investigate any activity necessary to gain assurance. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board of Directors to obtain outside independent professional advice and to secure the attendance of individuals with relevant experience and expertise if it considers this necessary whilst still complying with the Trust budget management process.

The Committee is non-executive in nature and will review and scrutinise papers and recommend to the Board and advise as necessary.

The Committee shall be appointed by the Board from amongst the Non-Executive directors of the Trust and shall consist of not less than three members. A quorum shall be two members. One of the members will be appointed Chair of the Committee by the Board of Directors. The Chair of the Trust shall not be a member of the Committee. Substitutes are not permitted.

Members are expected to attend three quarters of meetings in any one financial year.

Attendance

The Chief Finance Officer and representatives from Internal and External Audit shall normally attend meetings. At least once a year the Committee should meet privately with the External Auditors and the Internal Auditors.

Other directors and staff will be invited to attend as appropriate depending on the topics being discussed.

The Chair and the Chief Executive would attend three meetings annually. The Chief Executive should be invited to attend to discuss with the Committee the process for assurance that supports the Annual Governance Statement. Executive leads will be invited to attend the meeting when a high risk rated report has been submitted to the Committee

The Trust Secretary (or their nominee) will act as secretary to the Committee.

Frequency of meetings

The Committee will meet at least six times a year and one meeting must coincide with the financial year end timetable. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

Monitoring

The Committee will conduct an annual review of its effectiveness with its terms of reference and submit any findings and proposals for changes to the Board of Directors for

consideration. The Committee shall also once a year prepare an annual report. Both reports shall be presented to the Board.

The Committee will review its terms of reference annually and submit them for approval to the Board together with any recommendations for change.

Risk Management Duties

The Committee will co-ordinate and prioritise non-clinical governance and non clinical risk issues. The Committee will ensure development and implementation of the Risk Management Strategy and Policy and risk management systems to:

- Ensure that the risk management system meets the Trust's statutory obligations and other relevant standards
- Ensure risk management systems and policies are effective and are appropriately implemented
- Ensure the Trust Board, staff and other appropriate stakeholders are advised of significant risks.

In fulfilling these functions the Committee will:

1. Provide assurance to the Board in respect of arrangements to ensure data quality in the Trust, including oversight of the data quality policy. To approve, monitor progress and review projects to develop data quality within the Trust.

2. Review the Corporate Risk Register and Board Assurance Framework at every meeting. Thereby reviewing the risk analysis of the Annual Plan through the corporate risk register. Advise on proposed treatment and prioritising, for review and agreement by the Board.

3. Review and respond to information from the Executive Integrated Risk Management Committee on risk concerns and issues escalated from its work, including regular reviews of departmental risk registers. The Risk Manager will provide a report on the work of the Integrated Risk Management Committee to every meeting of the Committee.

4. Recommend the approval of Trust Health and Safety and Risk Management policies to the Board and receive updates at each meeting on the work of the Health & Safety Committee.

Audit Duties

The Committee shall review the effectiveness of financial systems for internal control and reporting and report to the Board of Directors on the levels of assurance.

The Committee will satisfy itself that reporting to the Board of Directors is consistent and subject to audit review, especially as to completeness and accuracy which may include reviewing the performance of the other Board Committees and satisfying itself that the outcomes are adequate.

The Committee will review for the Trust and its subsidiaries:

- The Annual Report and Financial Statements of the Trust
- Associated audit reports to the Annual Financial Statements
- The Annual Financial Statements of the Trust Charitable Funds
- All associated audit reports to the Trust Charitable Funds Annual Financial Statements

- The annual statement of internal control
- External Audit Plan
- Internal Audit Plan
- Corporate Risk Register and Board Assurance Framework (at every meeting)
- Receive updates from the Quality Committee on their review of the clinical risks in the Corporate Risk Register
- Risk and control related disclosure statements (in particular the Statement on Internal Control and declarations of compliance with the CQC Standards), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors
- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements
- the work of local Counter Fraud
- all work related to fraud and corruption
- Freedom to Speak Up reports

Additional Issues

In carrying out its work the Committee will consider the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

Relationship with Internal Audit

The Committee shall ensure that management establishes an effective internal audit function that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Board of Directors. This will be achieved by:

- an annual review of the effectiveness of internal audit
- review of any resignation and dismissal of internal audit
- approval of the appointment of the Internal Auditor and if internal audit is outsourced to participate in the process for and approval of the selection of internal auditors
- review of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organization
- consideration of the reports of internal audit work (including management's responses), and promoting co-ordination between the Internal and External Auditors.
- satisfying itself that the Internal Audit function has appropriate standing within the organisation.
- reporting to the Board of Directors any issues on the adequacy of Internal Audit resources

The Internal Auditor shall have direct access to the Chairman of the Committee and of the Board.

Management of Internal Audit is the responsibility of the Chief Finance Officer.

Relationship with External Audit

The Committee shall review the work and findings of the External Auditor.

This will include:

- Participating in the process for and the approval of the selection of the External Auditor.
- Submitting the recommendation to the Council of Governors for the appointment of the External Auditors.
- Consideration of the skills, experience and independence of the External Auditor
- Consideration of the performance of the External Auditor,
- Satisfying itself that management has discussed and agreed with the External Auditor, before the audit commences, the nature and scope of the audit as set out in the Annual Plan,
- Discussion with the External Auditors of their evaluation of audit risks and assessment of the Trust
- The review of all External Audit reports, including the annual audit letter before submission to the Board of Directors and any audit work carried outside the annual audit plan.
- The Committee shall review and approve the scope of non-audit services provided by external auditors to ensure there is no impairment of independence

Non audit services will not exceed 40% of the Audit Fee unless specifically authorised by the Committee

Management of External Audit is the responsibility of the Chief Finance Officer.

The Committee will recommend the audit fee to the Board of Directors.

Relationship with Counter Fraud Service

The Committee shall satisfy itself that management establishes an effective counter fraud function that provides appropriate independent assurance to the Board of Directors.

This will be achieved by:

- Reviewing the systems, plans and actions taken to develop an anti-fraud culture
- Reviewing the detailed operational plan
- Consideration of reports produced by the counter fraud service
- Ensuring that the counter fraud function has appropriate standing within the organisation.
- Conducting the annual review of the effectiveness of the counter fraud function.

Management of the Counter Fraud Service is the responsibility of the Chief Finance Officer.

Other Sources of Assurance

The Audit Committee shall satisfy itself that the findings of other assurance reports and studies relating to the Trust, is drawn to its attention by the Board or management, are reviewed and the implications to the governance of the organisation considered. These reports may be instigated by, for example Department of Health bodies, Regulators/Inspectors (e.g. NHS Improvement/ NHS England, Care Quality Commission, NHS Litigation Authority, etc.), and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

The Committee may request and review reports and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

Annual Financial Reporting

The Audit Committee shall review the Annual Report and Financial Statements before submission to the Board of Directors focusing particularly on:

- The wording in the Statement on Internal Control and other disclosures
- Any changes in, and compliance with, accounting policies and practices
- Any unadjusted mis-statements in the financial statements
- Major judgemental areas
- Any significant adjustments resulting from the audit.

Reporting

The minutes of meetings will be formally recorded and submitted to the Board after each meeting.

The Committee will review these terms of reference on an annual basis and report to the Board accordingly.

Reviewed by the Committee: 11 March 2026

Approved by the Board:

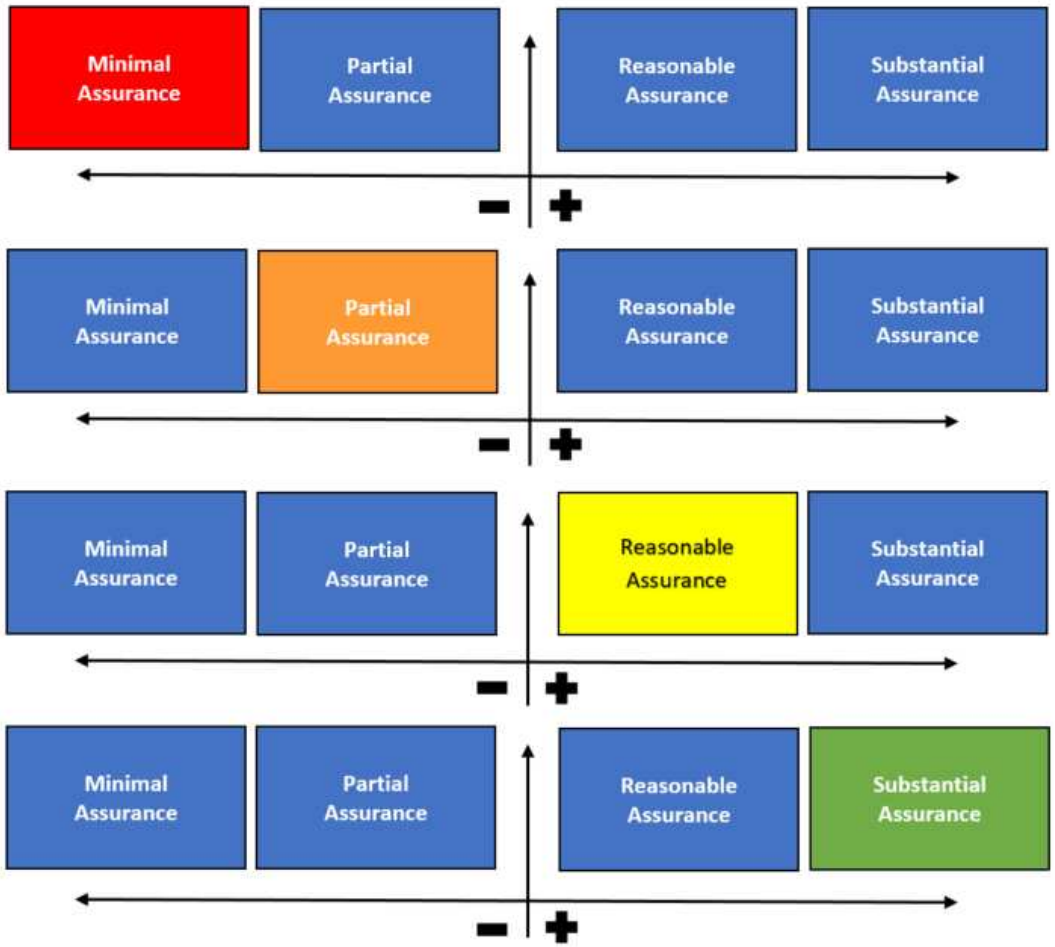
Finance & Investment Committee Chairs Report

Royal Berkshire NHS Foundation Trust

Committee Chair: Mike O'Donovan

21January 2026	
Agenda Item 3: Month 9 Finance Report	**Substantial Assurance**
Agenda Item 3.1: Capital Programme Update	**Partial Assurance**
Agenda Item 4: Business Planning 2026/27	**Partial Assurance**
Agenda Item 5: Financial Improvement 2026/27	**Partial Assurance**

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE (ALERT)	MAJOR ACTIONS AGREED (ADVISE)
• None	• Recommendation to the Board that £3.9m of 'CDEL', own capital funds, be used to ensure continuation of the Emergency Dept extension, in anticipation that this would be funded from Public Dividend Capital (PDC), for which a business case had been submitted
POSITIVE ASSURANCES TO PROVIDE (ASSURE)	**DECISIONS MADE (APPROVE)**
• Deficit, at £9.33m, was on plan. • c.£6m of cash support had been received, with further drawdowns anticipated for March and April • The Business Planning Process for 2026/27 was on track though delivering a compliant plan was a challenge. • The Financial Improvement Plan for 2026/27 had so far identified c.£16m of savings. The need to deliver a greater level of recurrent savings and ensure capacity to deliver transformation programmes was noted.	• None



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)

Royal Berkshire
NHS Foundation Trust

Minutes

Finance & Investment Committee Part I

Wednesday 21 January 2026
9.30 – 10.55
Boardroom, Level 4, Royal Berkshire Hospital

Members

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

In Attendance

Mr. Oke Eleazu	(Chair of the Trust)
Mr. Paul da Gama	(Chief People Officer) (up to minute 05/26)
Mrs. Caroline Lynch	(Trust Secretary)
Mr. Steve McManus	(Chief Executive)
Mr. Tom Tandy	(KPMG) (Observer)

01/26 Declarations of Interest

There were no declarations of interest.

02/26 Minutes for Approval: 19 November 2025 & Matters Arising Schedule

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

The Committee received the matters arising schedule.

Minute 155/25 (138/25): Minutes for Approval: 22 October 2025 & Matters Arising Schedule: Month 6 Finance Report including Financial Improvement Plan & Capital Programme 2025/26: The interim Chief Finance Officer advised that it was planned to devolve income to the Care Groups during 2026. However, there was currently limited capacity in the finance year and the substantive Chief Finance Officer would need to progress this work.

03/26 Month 9 Finance Report

The interim Chief finance Officer advised that Care Groups Month 9 financial performance was in line with plan: £34.74m actual versus the forecast of £34.78m. This demonstrated that performance was in line with the actions set out in the ten point plan.

Overall Month 9 was a deficit of £9.33m which was in line with budget.

The interim Chief Finance Officer highlighted the worst case, most likely and best case scenarios in relation to income and expenditure. The worst case was a deficit of £5.58m and included release of a central contingency of £1.62m being held and a risk on underperformance of £6.8m materialising. Income had been discussed with the Integrated Care Board (ICB) versus their forecast and that the forecast showed an additional £700k would be paid to the Trust. The best case was a break even position and included an offset on underperformance of £2.28m to reflect the already agreed clawback as well £1.61m achieved by delivery of the ten point plan.

The Committee noted that the Trust had also received notification of an allocation to support industrial action costs. The interim Chief Finance Officer advised that reserves had been released to cover these costs and the allocation would enable this to be added back to the reserves.

The Committee noted that financial performance had been discussed at Performance Review Meetings (PRMs) and no risks or concerns had been raised. The Chief Strategy Officer advised that there had been a discussion at the recent Executive Management Committee on finance recognising the work undertaken by the teams to date in addition to the need for all areas to delivery their planned position. The Chief Executive added that 'town hall sessions' had been scheduled for the organisation to discuss the financial challenges as well as thanking staff. These had been held twice previously in the previous year and had been well received.

The interim Chief Finance Officer confirmed that the underperformance on activity was not a continuation of previous issues, there were some capacity issues in the finance team resulting in delayed forecasting. However, there was a need to review end to end processes in relation to activity being captured and ensuring that information was provided to management in a timely fashion. The Chief Executive confirmed that this work had been discussed at the Chief Executive team meeting and an update would be provided in March setting out the activity plan versus income.

The interim Chief Finance Officer confirmed that the overspend on drugs related to an increase in overspend on high cost drugs.

The Committee noted that following the cash application of £18.93m one third of this had been received with further draw down planned for March and April. The interim Chief Finance Officer highlighted that a cash committee would need to be scheduled for February 2026 although a full reapplication for cash would not be required.

04/26 Capital Programme Update 2025/26

The interim Chief Finance Officer introduced the report and highlighted that Board approval was required to release Capital Departmental Expenditure Limit (CDEL) of £3.5m in order to continue the on-going work for the Emergency Department (ED) expansion. The Trust had submitted a business case for Public Dividend Capital (PDC) funding and although approval had not yet been received there was confidence that this would be forthcoming. The Committee agreed that a recommendation should be submitted to the Board to approve the use of CDEL for the ED expansion. **Action: M O'Donovan**

05/26 Business Planning 2026/27

The Chief Strategy Officer introduced the report and advised that the draft business plan had been submitted in December 2025 as planned. The draft plan had a gap of circa £27m versus the target deficit The Committee noted that the Trust had submitted bids for the Thames Valley Integrated Care Board (ICB) innovation funds. The Chief Executive highlighted the Trust's productivity position and the challenge of increasing the CIP for

2026/27. However, the Trust was in an improved position in relation to cash management. The Chief Executive highlighted the requirement for the Trust to deliver its constitutional standards.

The Committee discussed the need to ensure that data was correct as well as the need to demonstrated understanding of the position of system colleagues. The Chief Operating Officer advised that the Trust could evidence data to support the business plan including CIP. In addition, work with other partners in the system was key in relation to delivery of the plan. A further update on the business plan narrative would be submitted to the private Board on 5 February 2026. **Action: A Statham**

06/26 Financial Improvement Plan 2026/27

The Chief Operating Officer advised that £16.27m of cost improvement programmes had been identified for 20262/27 and there was good assurance that this would be delivered. The Chief Operating Officer highlighted that the Trust was in an improved position in comparison with the previous year and financial improvement was now embedded into the organisational culture. Financial controls would be maintained. There was a need to realise a greater level of recurrent savings as well as the need to deliver some of the larger transformation programmes. Scoping work was on-going for the transformation programmes, for example, the resource required to deliver these.

07/26 Key Messages to the Board

Key messages for the Board included:

- Month 9 financial performance reviewed with substantial assurance that the year-end plan for 2025/26 would be achieved
- Recommendation to approve the use of CDEL for the ED expansion.
- £16m of cost improvement programmes identified 2026/27 with a focus on identifying a great level of recurrent savings and delivery of transformation programmes ensuring capacity of the teams to deliver these.

08/26 Date of Next Meeting

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

SIGNED:

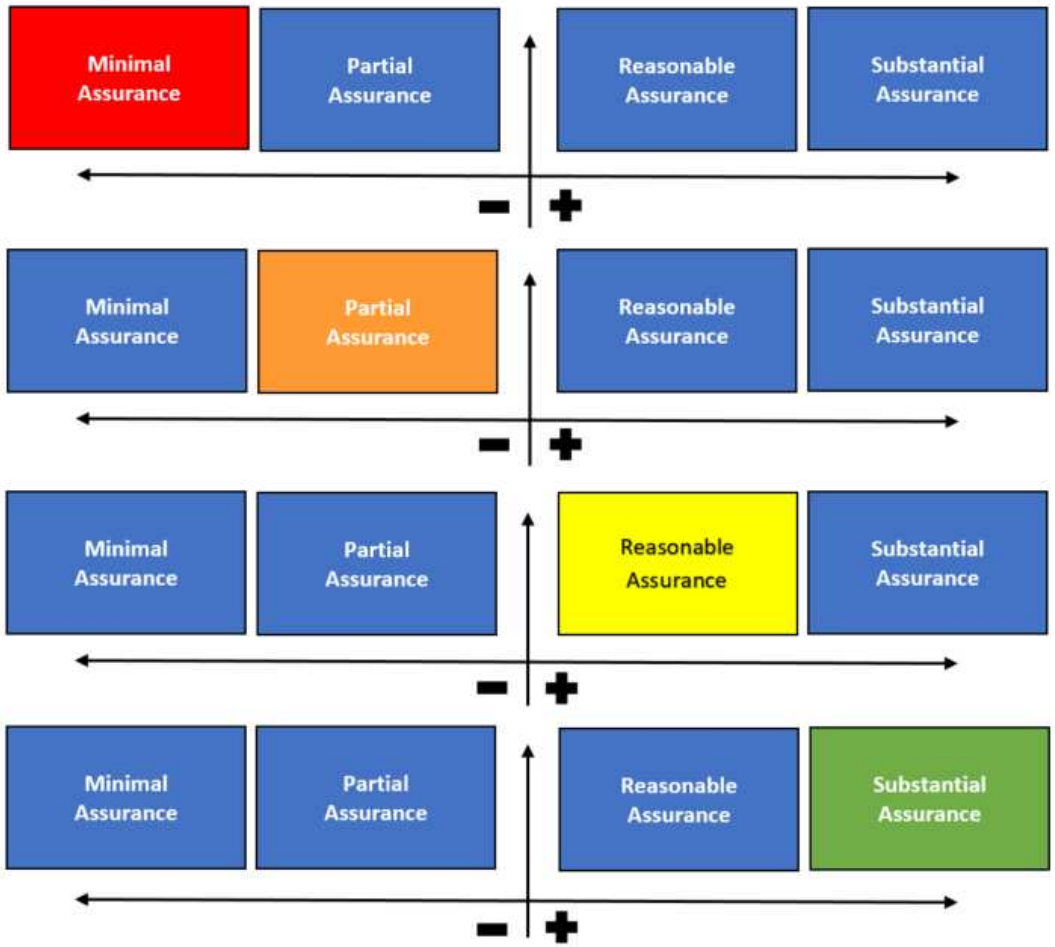
DATE:

Finance and Investment Committee Chairs Report

Committee Chair: Mike O'Donovan

18 February 2026	
Agenda Item 3: Month 10 Finance Report	**Partial Assurance**
Agenda Item 4: Draft Capital Programme Update 2026/27	**Partial Assurance**
Agenda Item 10: Cash Planning 2026//27	**Partial Assurance**

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE (ALERT)	MAJOR ACTIONS AGREED (ADVISE)
• There was a high level of confidence that the planned budget deficit for 2025/26 would be delivered, but this would need further improvement, notably around workforce management, in months 11and 12.	• The full capital programme for 2026/27 would be reviewed at the March meeting and, following discussion, would be recommended to the Board
POSITIVE ASSURANCES TO PROVIDE	**DECISIONS MADE (APPROVE)**
Month 10 deficit on budget Noted application for cash support for delivery in April Reviewed and noted the draft cash plan through to March 2027	NONE



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)

Royal Berkshire NHS Foundation Trust

Minutes

Finance & Investment Committee Part I

Wednesday 18 February 2026
9.35 – 10.20
Boardroom, Level 4, Royal Berkshire Hospital

Members

Mr. Mike O'Donovan	(Non-Executive Director) (Chair)
Dr. Janet Lippett	(Chief Medical Officer)
Mr. Mike McEnaney	(Non-Executive Director)
Ms. Catherine McLaughlin	(Non-Executive Director)
Mr. Andrew Statham	(Chief Strategy Officer)
Ms. Helen Troalen	(interim Chief Finance Officer)

In Attendance

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

Apologies

Mr. Dom Hardy	(Chief Operating Officer)

18/26 Declarations of Interest

There were no declarations of interest.

19/26 Minutes for Approval: 21 January 2026 & Matters Arising Schedule

The minutes of the meeting held on 21 January 2026 were approved as a correct record and signed by the Chair subject to a minor typographical error in Minute 07/26.

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

20/26 Month 10 Finance Report

The interim Chief finance Officer introduced the report and highlighted that the Month 10 position had been achieved and key variances remained the same as the previous month. Cash support had been received in January 2026 and the second application for cash support in March had been submitted. The underlying financial position continued to deteriorate. The run rate was trending upwards and the Whole Time Equivalent (WTE) continued to trend upwards. The Chief People Officer was reviewing options in relation to workforce and an options report would be submitted to the Executive Management Committee (EMC) for review. For example, the introduction of recruitment freeze as well as strengthening governance and controls. The Chief Executive highlighted that, during January 2026, the use of bank and agency in maternity was 18 WTE.

The interim Chief Finance Officer advised that the 10 point plan actions were being maintained. The Committee discussed the on-going planning process and the need to deliver performance standards for 2026/27 and whilst applications had been made for elective and non-elective funding the Trust would need the capacity to deliver this activity.

The Committee discussed the need for budgets to be correct including WTE. The Chief Strategy Officer advised that the Trust's final business planning submission included revised WTE numbers although there still remained a need to revise processes. The Trust's productivity was increasing although WTE was not reducing due to the increased demand. A further example was the workforce changes to increase value, for example, the increase in WTE for the Digital, Data and Technology (DDaT) team. The Committee noted that Care Groups were underspent on pay as part of their delivery of efficiency savings.

The interim Chief Finance Officer advised that the next stage was to understand the use of temporary labour during Month 10, a review of short term measures, the need to ensure teams were provided with information to manage their financial position as well as the need to then focus on more transformational changes. The Committee noted that based on the Month 10 position it was most likely that the year-end position could be £0.5m off target although there were some opportunities possible in Month 11 and Month 12 to mitigate this

The interim Chief Finance Officer advised that, whilst cost improvement programme delivery was currently behind plan, the delivery of the full programme was not required to achieve the year-end position. The forecast was £41.20m with some element of risk.

The Committee queried whether the budgets were correct in relation to drugs and clinical supplies for 2026/27. The interim Chief Finance Officer advised that the drugs income and contract for 2025/26 had not been aligned with budget there was a focus on this for 2026/27.

21/26 Draft Capital Programme Update 2026/27

The interim Chief Finance Officer advised that the draft capital programme for 2026/27 had been discussed at the Capital Programme Committee. However, there was further work required and the capital programme and budget for 2026/27 would be submitted to EMC, the Committee and Board in March 2026. **Action: H Troalen**

22/26 Key Messages to the Board

Key messages for the Board included:

- Advise the Board that the full capital programme for 2026/27 would be reviewed at the March meeting
- The Month 10 financial position had been achieved

23/26 Date of Next Meeting

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

SIGNED:

DATE:

Royal Berkshire
NHS Foundation Trust

March 2026

Finance & Investment Committee

Annual Review of Effectiveness 2025/26

Mike O'Donovan
Chair, Finance & Investment Committee

Caroline Lynch
Secretary to Finance & Investment Committee

1 Summary

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

2 Governance

2.1 The role of the Committee is to give detailed consideration to finance, estates, investments and Digital, Data & Technology (DDaT) and to recommend to the Board, for approval, any business cases and contracts that fall beyond the delegated approval limits of the Executive team.

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

2.3 Mike O'Donovan was appointed Chair of the Finance & Investment Committee from 1 November 2023 and remains as Chair. Nicky Lloyd left her post as Chief Finance Officer at the end of June 2025. Helen Troalen commenced her role as Interim Chief Finance Officer in July 2025. Frances Khatcherian commenced her role as Chief Finance Officer in March 2026.

2.4 The Committee's terms of reference are to be reviewed for recommendation to the Board at the meeting on 18 March 2026. The Committee also maintains an annual work plan.

3 Meetings and Membership

3.1 The Committee met formally on 10 occasions between April 2025 and February 2026 as follows:

• 23 April 2025 • 21 May 2025 • 18 June 2025 • 23 July 2025 • 17 September 2025	• 22 October 2025 • 19 November 2025 • 11 December 2025 • 21 January 2026 • 18 February 2026

The March 2026 meeting, at which this report is presented, is not included.

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

Member	Maximum Number of Meetings	Number Attended
Mike O'Donovan	10	10
Mike McEnaney	10	9
Catherine McLaughlin	10	9
Chief Finance Officer	10	8
Chief Strategy Officer	10	9
Chief Nursing Officer*	10	5
Chief Medical Officer*	10	5
Chief Operating Officer	10	9

Chair of the Trust**	10	9
Chief Executive**	10	9

*Either Chief Medical Officer or Chief Nursing Officer required to attend.
** The Chief Executive/Chair of the Trust are only required to attend 6 meetings a year.

3.3 The Trust Secretary or their nominee has attended all meetings. Other Directors and staff have attended meetings during the course of the year to advise and to respond to questions from the Committee. These have included the Director of Finance, Deputy Director of Financial Turnaround, Director of Estates and Facilities and Chief People Officer.

4 Assurance

4.1 The Committee reviewed financial performance at each meeting.

4.2 During 2025/26, the Committee received regular updates at each meeting or regular intervals that included Board Assurance Framework, budget updates, capital plan updates, transformation projects, business plans, quarterly forecasts, acute and non-acute contracts updates and contract approvals.

4.3 Other items received throughout the year included:

- Cash Flow Forecasting & Working Capital Optimisation
- Building Berkshire Together (BBT)
- LINAC Business Case
- Mechanical, Electrical, and Plumbing Services
- Use of Resources Action Plan
- West Berkshire Community Hospital Project
- NHS England Self Certification Scheme
- Digital Strategy Update
- Long Term Resourcing Model (LTRM)
- Corporate Risk Register
- Equality and Quality Impact Assessments (EQIA) Tracker
- Constituting a Cash Committee
- NHS Oversight Framework Benchmarking
- 2025 National Cost Collection Assurance
- Land Purchase
- Application for Cash Support
- District Heat Network Update

5 Attachments

5.1 The following are attached to this report:

Appendix 1 – Terms of Reference

Finance & Investment Committee

Terms of Reference

Constitution and Membership

The Committee will be appointed by the Board to give detailed consideration to finance estates, investment and IT, and to recommend to the Board any business cases and contracts that fall beyond the delegated approval limits of the Executive. The Committee will also oversee cash management, ensuring the Trust maintain liquidity.

It will advise the Executive and Board on issues to achieve the best value for money and use of resources. It will seek to ensure that agreed strategies for finance, estates and IT are developed, implemented, monitored and reviewed.

The Committee will review and scrutinise papers and recommend to the Board and advise as necessary. Meetings will consist of three parts and will be minuted separately. Part 2 of the meeting will consider investment items and the Outline Business Case (OBC) as part of the Estate Redevelopment. Part 3 will consider the cash position of the organisation and seek assurance on short-term and longer-term cash management strategies.

The Committee will be chaired by a Non-Executive Director. The membership will include at least two further Non-Executive Directors, Chief Finance Officer, Chief Strategy Officer, Chief Operating Officer, the Chief Medical Officer or the Chief Nursing Officer. Substitutes are not permitted.

The quorum of the Committee will be five members and will include at least three Non-Executive Directors.

Members are expected to attend three quarters of meetings in any one financial year.

Attendance

The Director of Estates and Facilities, and Chief Digital Information Officer will be invited to attend part 2 of meetings as required. The Chief Executive and the Chair will attend five meetings annually.

The Trust Secretary (or their nominee) will act as secretary to the Committee.

The Committee may invite other staff and external advisors to attend for all or part of any meeting.

Frequency of Meetings

The Committee will meet monthly with the exception of August and December.

Monitoring

The work of the Committee will be kept under review by the Board.

The Committee will conduct an annual review of its effectiveness with its terms of reference and submit any findings and proposals for changes to the Board of Directors for consideration.

Duties

The main duties of the Committee will be:

a) To confirm a broad and long-term Financial Strategy is developed in support of the wider integrated business plan and to review the overall financial performance of the Trust.

b) To monitor the performance of the Trust in respect of its key Financial Performance targets, delivery of the NHS Improvement Single Oversight Framework and the overall cost improvement programme.

c) To confirm the Trust manages its asset base efficiently and effectively and to confirm projects of significant value, whether related to property or other assets, are properly identified, managed and controlled and that business cases are robust.

d) To review the Trust's cash balances, its daily cash floor limits, operational management of surplus cash invested within risk profile parameters, monitor committed funds to cover existing business cash flows while providing flexibility for seasonal and capital expenditure.

e) To review the Trust's Estates Strategy, its formulation, development and implementation, its links to other related strategies and thus ensure that the Trust's capital assets are properly and effectively utilised.

f) To review the Trust's IT Strategy, its formulation, development and implementation, its links to service and financial strategies.

g) To review the negotiation of contracts with the organisation's commissioners and to review and recommend the approval of any procurement contracts beyond the delegated authority of the Executive to the Board.

h) To review and make recommendations to the Board in respect of any business cases that fall beyond the delegated authority of the Executive.

i) To review post implementation investment appraisals and to advise the Board on the level of benefits realised from such investments.

j) To make recommendations to the Board and to the Chief Executive as to appropriate actions required in respect of finance, estates and IT to ensure the Trust is operating effectively, efficiently and economically.

k) To consider and approve all business cases, clinical and or commercial in line with the delegated limits of authorisation as stipulated in the Trust's Standing Financial Instructions in relation to the Estates Redevelopment Programme.

l) To review in detail any other relevant issue referred to it by the Board for more detailed consideration.

Estates

For the period that the Trust is preparing and submitting business cases in relation to the Estates redevelopment (including the Outline Business Case (OBC) and Full Business Case (FBC)) the Committee will take on additional governance responsibilities for oversight and review and to make recommendations to the Trust Board.

The recommendations would include financial and economic elements which underpin the various stages of the business cases ahead of submission to approval to NHS England (NHSE) / Treasury. The Director of Estates and Facilities and Director of Strategy will attend for this part of the meeting.

Cash

For the period that the Trust is in receipt of, or anticipating the need for cash support, the Committee will meet on a quarterly basis in part 3 as the Cash Committee. To gain assurance that the Trust has sufficient liquidity, the Cash Committee will scrutinise the following cash reports:

12 month rolling cash forecast
13 week rolling forecast

The Committee may be convened on an ad-hoc basis to provide NED oversight of short-term cash management strategies such as delaying payment to suppliers or choosing to pay certain suppliers over others.

The Committee will meet to review any revenue cash support applications and recommend the application to the Board for approval.

The Cash Committee will also seek assurance that:

Processes are in place to accurately manage and forecast cash
Sufficient non-pay controls are in place
Sufficient work force controls are in place
Efficiency plans are robust and cash releasing (to the degree required in the annual operating plan)

In line with the annual/ medium term planning cycle the Cash Committee will also oversee the development of medium-term cash planning i.e. for a period longer than 12 months,

Reporting

The minutes of meetings will be formally recorded and submitted to the Board after each meeting. The investment section of the meeting will be minuted as a private meeting and submitted to the private Board.

The Committee will review these terms of reference on an annual basis and report to the Board accordingly.

Reviewed by the Committee: 18 March 2026

Approved by the Board:

Quality Committee Chairs Report

Royal Berkshire NHS Foundation Trust

Committee Chair: Helen Mackenzie

Committee Date 2 February 2026	
Agenda Item 9: Watch metrics	**Substantial Assurance**
Agenda Item 12: Quality Governance Committee Report	**Substantial Assurance**

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE (ALERT)

- Alert to one potential high risk inquest related to trauma and orthopaedics/care of the elderly.
- Alert two never events were declared
- Alert that the C.Diff. target was breached although the Committee was assured on actions being taken

MAJOR ACTIONS AGREED (ADVISE)

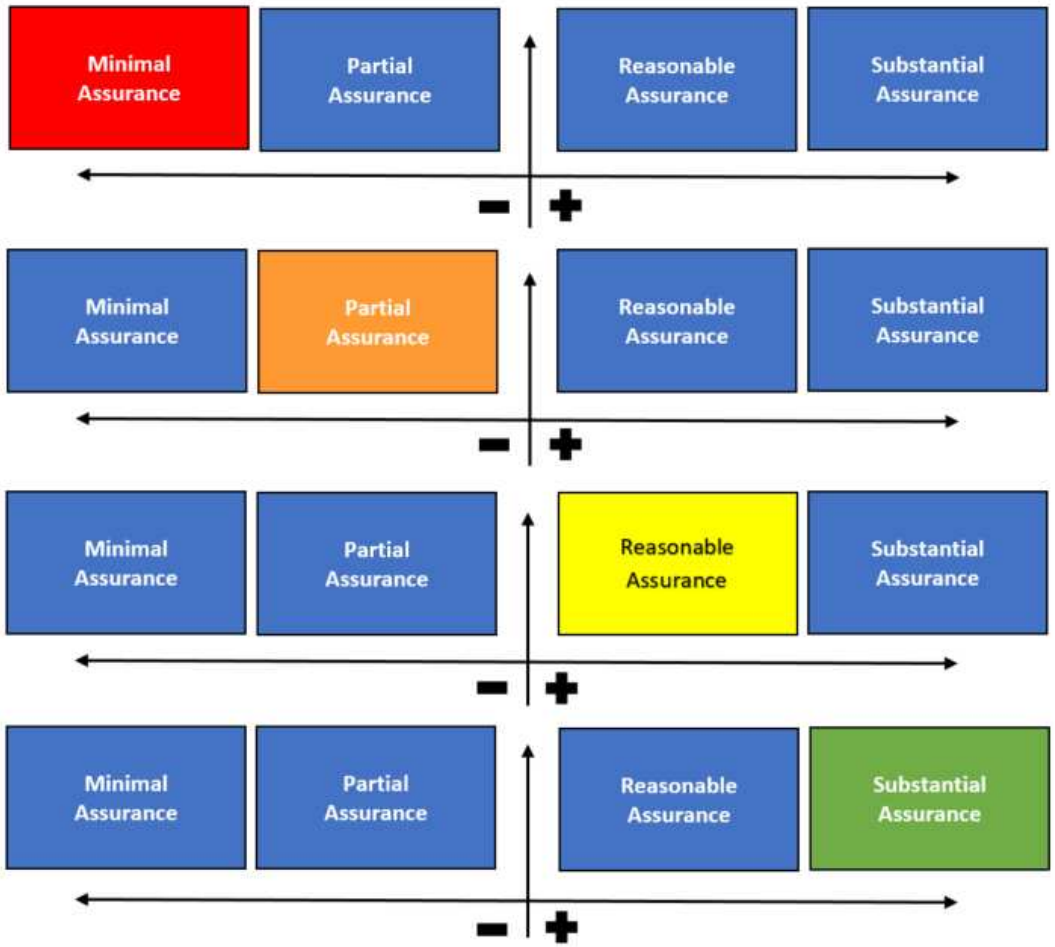
- Advise of the increase in perinatal mortality in Quarter 3 and that a review was in progress with the outcome being submitted to the next meeting.
- Advise of the reporting changes on maternity and neonatal services following the latest updates on maternity and neonatal services from NHSE including the Maternity Oversight Signal System (MOSS).
- Advise that Call 4 Concern implementation was progressing and the number of calls were increasing.
- Advise that there were three patient safety investigations in Quarter 3 including two Never Events and one maternity case. 58 rapid reviews, 5 after action reviews and 7 multidisciplinary reviews had also been undertaken.
- Advise that the complaints review had been completed and actions in response were in progress.
- Advise incident reporting deep dive had been completed and that incident reporting levels were returning to previous levels

POSITIVE ASSURANCES TO PROVIDE (ASSURE)

- Advise that the Committee had received the Home Birth report that provided assurance that the Trust met the required standards.
- Assurance that the watch metrics were being monitored and actions taken where required.
- Assurance of care following strong performance on several national audits including the National Emergency Audit and the National Hip Fracture Database

DECISIONS MADE (APPROVE)

- Approve the Chief Executive to sign the Board declaration form for MIS ahead of the submission on 3 March 2026.



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)

Royal Berkshire NHS Foundation Trust

Minutes

Quality Committee

Monday 2 February 2026
10.00 – 12.00
Boardroom, Level 4

Members

Mrs. Helen Mackenzie	(Non-Executive Director) (Chair)
Mr. Dom Hardy	(Chief Operating Officer)
Dr. Minoo Irani	(Non-Executive Director)
Mr. Umesh Jetha	(Non-Executive Director) (up to minute 09/26)
Dr. Janet Lippett	(Chief Medical Officer)
Mr. Mike O'Donovan	(Non-Executive Director) from minute 10/26)

In Attendance

Ms. Sarah Bailey	(Interim Director of Midwifery) (up to minute 06/26)
Ms. Jess Higson	(Deputy Chief Nursing Officer)
Mrs. Caroline Lynch	(Trust Secretary)
Mr. Steve McManus	(Chief Executive)

Apologies

Mrs. Katie Prichard-Thomas	(Chief Nursing Officer)
Prof. Parveen Yaqoob	(Non-Executive Director)

01/26 Declarations of Interest

There were no declarations of interest.

02/26 Minutes for Approval: 3 December 2025 and Matters Arising Schedule

The minutes of the meeting held on 3 December 2025 were approved as a correct record and signed by the Chair.

The Committee noted the matters arising schedule.

Minute 75/25 (57/25): Minutes for Approval: 1 September 2025 and Matters Arising Schedule: Prevention of Future Deaths (PFD) Report Response: The Chief Medical Officer advised that the Coroner did not yet have access to the Trust's Electronic Patient Record (EPR) as a Digital Data and Technology issue had not yet been resolved.

Action: J Lippett

03/26 Maternity Quality Assurance Report including Perinatal Mortality (PNM)

The interim Director of Midwifery introduced the report and highlighted that there had been an increase in perinatal mortality in Quarter 3 2025/26 that was above the national percentage expectation. Weekly multidisciplinary team meets were held to review all cases and to identify any themes and/or learning. On initial review there had been no themes identified. However, an update would be provided to the next meeting.

Action: K Prichard-Thomas

The Committee discussed the ethnicity and perinatal mortality data in the report and the supporting narrative provided. The interim Director of Midwifery agreed to clarify whether the data was correct. **Action: K Prichard-Thomas**

The Committee noted that, in relation to the Prevention of Future Deaths (PFD) notice issued to the Trust, all training had now been completed and the Coroner had been advised of this as part of the official response from the Trust. The interim Director of Midwifery advised that there had been one inquest held in January 2026 related to a baby that had sadly died at home and the death had been recorded as natural causes with no recommendations or learning for the Trust.

There had been an increase in the number of complaints and themes were communication, behaviour and attitudes. The maternity team were working in collaboration with the Maternity & Neonatal Voices Partnership (MNVP) to review customer service.

The interim Director of Midwifery confirmed that all actions related to the screening incident had been completed and a follow up meeting with NHS England had been scheduled for March 2026.

The Committee discussed the long waits for the Maternity Assessment Unit (MAU) and queried whether this was an increasing risk. The interim Director of Midwifery advised that the risk had been included on the maternity risk register due to the number of women presenting to the service and the 15 minute triage metric not being met. Obstetric cover on a 24/7 basis was required. The risk was being mitigated although the workforce number would need to be reviewed.

The Committee advised that the Board would be advised of the increase in perinatal mortality in Quarter 3 and a review was in progress with the outcome being submitted to the next meeting.

04/26 Maternity Incentive Scheme (MIS)

The interim Director of Midwifery highlighted that full compliance had been achieved for all 10 safety actions in the Maternity Incentive Scheme (MIS). The Chair confirmed that evidence for the MIS had been reviewed in detail with the Chief Nursing Officer and interim Director of Midwifery. It was agreed that the Board would be advised that the Committee had approved the Chief Executive to sign the Board declaration form ahead of the submission on 3 March 2026.

05/26 Community Home Birth Service

The interim Director of Midwifery highlighted that following the death of a mother and baby in Manchester and a PFD being issued by the Senior Coroner, all maternity services had been requested to review operational, care planning and risk assessment, governance and oversight of homebirth services. The Committee noted that the Manchester case had highlighted an internet connection problem. However, the Trust had a number of mitigations in place in relation to this such as policies being available in hard copy as well as blood tests being ordered via telephone. In addition, midwives attending home births had contact at all times with a senior midwife and obstetrician.

It was agreed that the Board would be advised that the Committee had received the report that provided assurance that the Trust met the required standards.

The interim Director of Midwifery highlighted that the work was on-going to benchmark community midwifery services in relation to the need for continuous care.The Continuity of

Care team was due to be launched shortly. The Committee recommended that the Chief Nursing Officer should consider whether an internal audit on maternity would be useful.

Action: K Prichard-Thomas

06/26 Maternity Neonates NHS England Change Overview

The Committee received the report that set out the latest maternity and neonatal updates from NHSE. This included an additional report to the Board on maternity and neonatal services.

It was agreed that the Board would be advised of the reporting changes on maternity and neonatal services.

07/26 Quarter 3 Patient Safety Report

The Deputy Chief Nursing Officer introduced the report and highlighted that the award status for cohort 2 of the ward accreditation scheme was currently being finalised and cohort 3 was due to begin shortly.

The Committee noted that Call 4 Concern/Martha's rule would be piloted in Loddon Ward followed by Marsh Ward. The Committee queried the purpose of the standard operating procedure/triage tool. It was agreed that clarity should be provided in the next update.

Action: K Prichard-Thomas

The Committee noted that some of the calls received by Call 4 Concern were not always related to patient safety.

The Deputy Chief Nursing Officer advised that the National Patient Safety Syllabus (NPSS) training would now be added to core compliance training following approval by the Executive Management Committee.

08/26 Complaints Detailed Review

The Deputy Chief Nurse Officer introduced the report and advised that complaints were discussed at Quality Governance Committee and performance review meetings and Care Groups were engaged in the process. The Committee noted that improvement actions arising from complaints were recorded on the Datix system.

The Committee noted the increase in complaints and agreed it was important to respond to these in a timely fashion. It was noted that both the volume and complexity of complaints were increasing and the Committee discussed whether interventions would be effective. The introduction of an 'artificial intelligence' tool would enable in depth analysis of complaints. Further updates on complaints would be provided via the Patient Relations reports to the Committee.

It was agreed that the Board would be advised that the complaints review had been completed.

09/26 Patient Safety Incidents Detailed Review

The Deputy Chief Nursing Officer introduced the report. The Committee noted that Care Groups did review and monitor all incident reporting levels. The Deputy Chief Nursing Officer advised that a tender process was on-going for a new risk management system.

The Committee noted the increase in complaints for rheumatology. The Chief Medical Officer advised that this could be in part due to the speciality having more patients with a medically unexplained diagnosis.

It was agreed that the Board would be advised that the Committee had reviewed patient safety incident reporting and reporting levels were returning to previous levels.

10/26 Learning From Deaths Report

The Chief Medical Officer introduced the report and advised that this had previously been reported as part of the Quality Governance Committee update, now, at the request of the Quality Committee, the stand alone report would be submitted direct to the Committee.

The Committee noted that during Quarter 2 and 3 of 2025/26, there were 686 deaths at the Trust, of which 113 had triggered an SJR. Timely completion of SJRs continued to improve, with none exceeding the 12 week timeframe.

The Chief Medical Officer advised that Structured Judgement Reviews (SJRs) undertaken over this period had highlighted an overarching theme of effective multidisciplinary team (MDT) collaboration and communication. Bereavement meetings with families had highlighted an ongoing issue of 'listening versus being listened to' and this had persisted from Quarter 2 into Quarter 3. This was being reviewed by the End of Life Steering Group. The Committee noted that, overall, the SJRs had highlighted a mixture of both good and poor feedback.

The Committee noted that cases were assigned an avoidability grade of 1 or 2. The Chief Medical Officer advised that although there were more Grade 2s in the last quarter this was not part of a trend. The SJRs in their entirety were not routinely shared with families as this was dependent upon the families wishes. However, the bereavement nursing staff were engaged in providing significant feedback to families.

The Committee noted that when the Medical Examiners contacted families, concerns could also be raised that were not directly related to the death. These type of concerns would be managed via the complaints route.

The Committee noted that a target had been set for providing feedback to Next of Kin. This was 80% within a 12 weeks. During Quarter 2 2025/26, 77% of feedback had been provided within the 12-week deadline.

The Chief Medical Officer highlighted that Andrew Jacques had recently been appointed as Associate Medical Director and would be invited to a future meeting to present the report.

Action: J Lippett

11/26 Integrated Performance Report (IPR) Quality Watch Metrics

The Committee received the watch metrics. The Chief Medical Officer highlighted that the same watch metrics were alerting. The C.Diff. target had been breached and an action group had been set up to review this. The Committee noted that each Care Group had focused patient level learning and the issue of C.Diff. cases was not related to any estates issues. The Trust's target was low in comparison to other trusts and whilst rates had slowed down there had been a national rise across the South East region.

The Committee discussed mixed sex accommodation breaches and noted that these related to patient flow issues. However, there had been no complaints received related to these breaches.

The number of Deprivation of Liberty (DOLs) had increased due to a high volume of complex patients.

It was agreed that the Board would be alerted to the C.Diff target being breached although the Committee was assured on actions being taken and assured that the watch metrics were being monitored and actions taken where required.

12/26 Quality Governance Committee Report

The Chief Medical Officer introduced the report that set out issues discussed at the November meeting. However, the Committee had also met again recently.

The Committee discussed the issue of PPUK, the new patient portal, and the perceived impact on Do Not Attends (DNAs). The Chief Medical Officer advised that there had been issues with the implementation and the Chief Operating Officer had chaired two escalation meetings on issues related to deployment of the portal and how it was used by the various Clinical Admin Teams (CATs). The Chief Executive team had undertaken a number of Go & See visits to numerous CATs and, following feedback, this had been escalated to an end-to-end review of the processes. The Digital, Data & Technology (DDaT) teams were working through issues with the CAT teams. The Committee requested that an update should be provided to a future meeting. **Action: D Hardy**

The Committee discussed the review of gynaecology multidisciplinary (MDT) working practices. The Chief Operating Officer advised that the Care Group Director for Urgent Care had set up a Rapid Process Improvement Workshop (RPIW) and there had been an improvement in the gynaecology pathway.

The Chief Medical Officer highlighted the Committee had discussed sepsis monitoring compliance and further analysis would be undertaken. It was agreed that an update would be provided at the next meeting. **Action: J Lippett**

The Committee agreed that the Board should be assured of the strong performance on several national audits including the National Emergency Audit and the National Hip Fracture Database.

13/26 Learning Disabilities Report

The Committee received the report and noted that any deaths of people with a Learning Disability and/or Autism were reviewed under the Learning from Lives and Deaths (LeDeR) national programme. The LeDeR process was led by the Integrated Care Board (ICB). The Committee noted that the ICB had over 200 cases to review and the Trust was providing supporting on this.

14/26 Autism Report

The Deputy Chief Nursing Officer advised that a total of 204 staff had completed the Tier 2 Oliver McGowan Mandatory training. The Neurodiversity Patient Group had held its first meeting recently and this group would review complaints. The Committee requested that future reports would include feedback on complaints for this patient group.
Action: K Prichard-Thomas

The Committee noted that non-compliance with Oliver McGowan Tier 2 mandatory training was recorded on the Chief Nursing Officer risk register. However, the target for compliance

had not yet been confirmed. The Committee noted that Tier 2 training was a full days training to be undertaken every 3 years.

15/26 Work Plan

The work plan for 2026 was noted.

16/26 Key Messages for the Board

The Committee agreed the following key messages for the Board:

- Advise of the increase in perinatal mortality in Quarter 3 and a review was in progress with the outcome being submitted to the next meeting.
- Advise that the Committee had received the Home Birth report that provided assurance that the Trust met the required standards.
- Advise that the Committee had approved the Chief Executive to sign the Board declaration form for MIS ahead of the submission on 3 March 2026.
- Advise of the reporting changes on maternity and neonatal services following the latest updates on maternity and neonatal services from NHSE.
- Advise that Call 4 Concern implementation was progressing and the number of calls were increasing.
- Advise that there were three patient safety investigations in Quarter 3 including two Never Events and one maternity case. 58 rapid reviews, 5 after action reviews and 7 multidisciplinary reviews had also been undertaken.
- Alert to one potential high risk inquest related to trauma and orthopaedics/care of the elderly.
- Advise that the complaints review had been completed.
- Advise that incident reporting levels were returning to previous levels
- Alert that the C.Diff. target was breached although the Committee was assured on actions being taken
- Assure that the watch metrics were being monitored and actions taken where required.
- Assure of the strong performance on several national audits including the National Emergency Audit and the National Hip Fracture Database.

16/26 Reflections of the Meeting

Minoo Irani led a discussion.

17/26 Date of Next Meeting

It was agreed that the next meeting would be held on Wednesday 22 April 26 at 10.00.

SIGNED:

DATE:

People Committee Chairs Report

Royal Berkshire NHS Foundation Trust

Committee Chair: Prof. Parveen Yaqoob

20 February 2026	
Agenda item 4: Workforce information and KPIs	**Substantial Assurance**
Agenda item 5: Staff survey results	**Substantial Assurance**
Agenda item 6: Gender pay gap report	**Partial Assurance**
Agenda item 7: 10-point plan to improve Resident Doctors' working lives	**Substantial Assurance**
Agenda item 8: Guardian of safe working report	**Substantial Assurance**
Agenda item 9: Review of committee's effectiveness and Terms of Reference	**Substantial Assurance**

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE (ALERT)

- None

MAJOR ACTIONS AGREED (ADVISE)

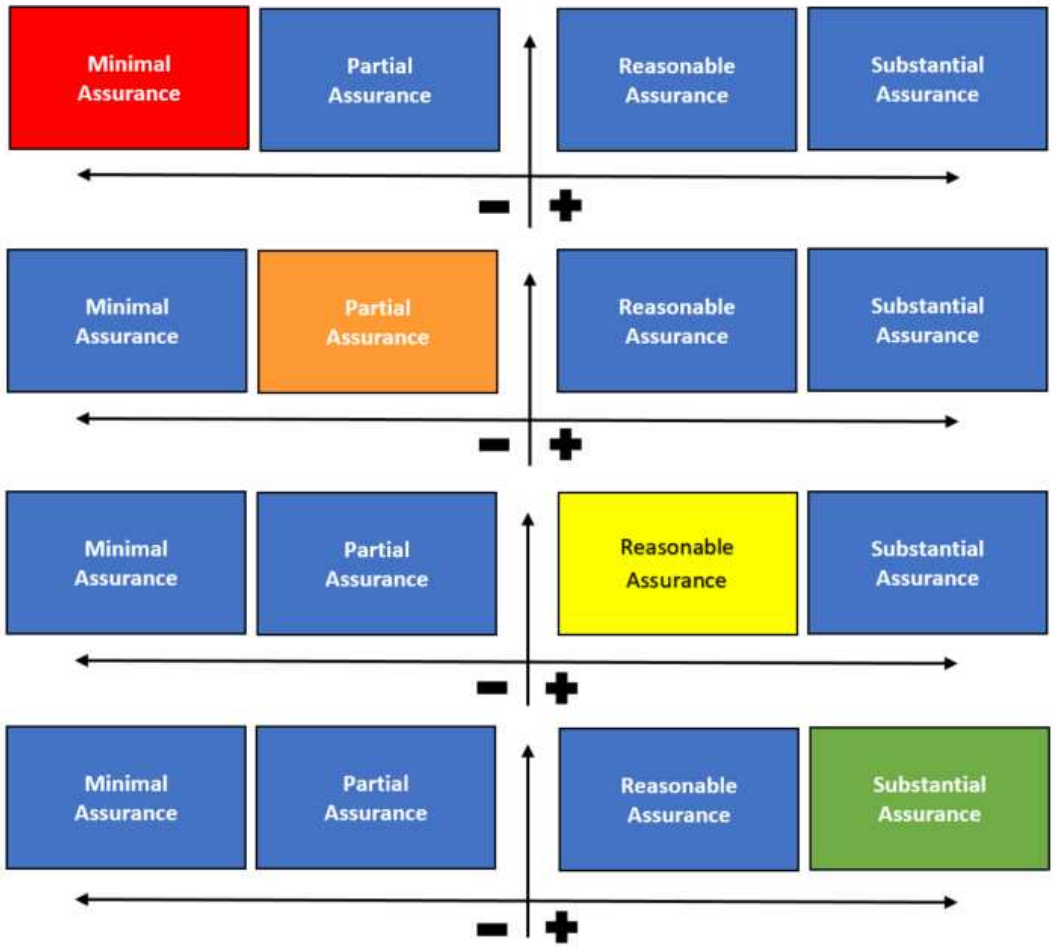
- Deep-dive report and discussion on outcomes relating to global majority staff.
- Consideration of occupational segregation in gender pay gap reporting and exploration of the value of segmented analysis, accompanied by targeted action.

POSITIVE ASSURANCES TO PROVIDE (ASSURE)

- Alongside a forthcoming national review aiming to make statutory and mandatory training more outcome-focussed, the Trust is already laying the groundwork for this.
- Processes are in place to support compliance with national changes to exception reporting by Resident Doctors, whereby up to 2 hours of additional work will automatically be approved through the system, which might result in some shifts in the data.
- Strong staff survey results.
- Good progress again the 10-point plan to improve Resident Doctors' working lives.

DECISIONS MADE (APPROVE)

- Recommendation to approve the Effectiveness Review and Terms of Reference.



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)

Royal Berkshire NHS Foundation Trust

Minutes

People Committee

Friday 20 February 2026
14.00 – 16.00
Boardroom, Level 4

Members

Prof. Parveen Yaqoob	(Non-Executive Director) (Chair)
Mr. Paul da Gama	(Chief People Officer)
Dr. Minoo Irani	(Non-Executive Director)
Dr. Janet Lippett	(Chief Medical Officer)
Ms. Catherine McLaughlin	(Non-Executive Director)
Ms. Katie Prichard-Thomas	(Chief Nursing Officer)

In Attendance

Mr. Oke Eleazu	(Trust Chair)
Ms. Suzanne Emerson-Dam	(Deputy Chief People Officer)
Dr. Libby Halford	(Resident Doctor Peer Lead) (for minute 07/26)
Mrs Caroline Lynch	(Trust Secretary)
Dr. Jess Palmer	(Guardian of Safe Working) (for minute 08/26)
Mr Pete Sandham	(Associate Director for Staff Experience and Inclusion)
Mr. Thomas Tandy	(KPMG) (Observer)
Mrs Tara Whittington	(Head of Corporate Governance)

01/26 Declarations of Interest

There were no declarations of interest.

02/26 Minutes for Approval: 4 September 2025 & Matters arising Schedule

The minutes of the meeting held on 1 December 2025 were approved as a correct record subject to one typographical amendment and were signed by the Chair.

The Committee received the matters arising schedule.

Minute 45/25: People Strategy 2023/27 Progress Report: The Chief Medical advised that the Leng review would be rescheduled for a future meeting following completion of the on-going judicial review. **Action J Lippett**

Minute 47/25: Workforce Information & Key Performance Indicators Quarter 3 2025/26: The Deputy Chief People Officer confirmed that the stability index was tracked on a monthly basis. The Chief People Officer report submitted to the previous meeting had included inconsistent terminology and this had been addressed.

03/26 Chief People Officer Report

The Chief People Officer introduced the report and provided an overview of national, regional and local issues.

The Chief People Officer reported that Agenda for Change (AfC) pay award had been approved and would be implemented in April 2026.

Mandatory and Statutory Training (MAST) was undergoing a significant review to align this with other local MAST programmes and remove duplications. The aim of the review was to ensure that MAST was more effective. The Chief People Officer highlighted that there would be a competency framework review in April 2026 with the aim to launch the new MAST by March 2027. The Chief People Officer reported that, internally, the Trust would be comparing MAST with other local providers to ensure national alignment. **Action: P da Gama**

The Committee discussed Nursing Pay noting engagement between the Government and the Royal College of Nursing (RCN) and noting that there would be a greater focus on graduate pay. Band 5 nursing roles would be re-evaluated to ensure that job descriptions and banding were aligned correctly when compared to Band 5 roles across the wider NHS. The Chief Nursing Officer advised that further assurance was being sought nationally on this, particularly in relation to timelines for implementation.

The Chief People Officer provided an overview of the People Scaling Services programme led by the Acute Provider Collaborative (APC). Workshops had taken place at the end of Quarter 3 2025/26 and Frimley Health would also be collaborating with the programme. The intention was to assess 10 areas for the organisation to lead on with Oxford University Hospitals (OUH) leading the work. The Chief People Officer reported that progress to date was appropriate and aligned with funding allocations. The full scope of the work would require time for completion.

The Committee discussed the need for the Trust to prepare for the Lead Employer Model for Resident Doctors. Currently 34% of Resident Doctors were already working under this model with the intention that all would transition to the new model by February 2027. Funding would be a key challenge. However, financial modelling could not yet be undertaken.

The Committee discussed the increase of national controls on temporary staffing. The Deputy Chief People Officer confirmed that monthly reports were being produced. It was anticipated that would be a further minimum 30% reduction in agency spend in addition to a 10% reduction in bank expenditure. The programme of work included Allied Health Professionals (AHPs) and Scientists.

The Chief People Officer provided an update on the Trust's Workforce Plan submission for 2026 to 2029. It had been calculated that there would need to be a reduction of 364 Whole Time Equivalents (WTEs) and this had been discussed with the Executive Management Committee (EMC). It was anticipated that this reduction would be achieved through transformation programmes, a recruitment freeze and a Mutually Agreed Resignation Scheme (MARS) that would be launched following approval by EMC. The MARS would be available for two months to enable time for Expressions of Interest.

The Committee discussed the risk to the quality of service provided with education in headcount. It was agreed this would need to be considered and monitored.
The Chief People Officer reported that an Appraisal window would be piloted from April to July 2026.

The Flu Staff Vaccination Programme had an uptake of 55% and compared favourably with the national average of 48%. The Committee noted that this was a good achievement for the Trust and positive assurance received on vaccination rates.

The Committee noted that the Financial Wellbeing Service had been introduced by the Trust in addition to Money First Aid being commissioned to train a selection of staff as Money First Aiders.

The Chief Nursing Officer reported that the Trust undertook the Safe Staffing Review on a biannual basis with the next review scheduled for May 2026.

The Committee agreed that the Board would be assured that positive assurance had been received on MAST training. In addition, a key risk for escalation was workforce planning.

04/26 Workforce Information & Key Performance Indicators (KPIs) 2025/26

The Chief People Officer introduced the driver metrics for Quarter 3 that demonstrated a strong position in all areas with the exception of staff costs. Sickness absence was 3.76% although this was only marginally above the national average of 3.7%. Work was ongoing to conduct an audit of Return To Work interviews as well has ensuring all managers were following short term absence management guidance.

The Chief People Officer proposed a review of refining the metrics of sickness absence into categories with particular focus on avoidable absence.

The Chief Medical Officer reported that the data provided in relation staff taking sickness absence due to coughs and colds enabled teams to make informed decisions about wearing face masks in order to reduce other staff members from becoming sick. The Chief Medical Officer requested that this data should still be provided for this use.

The Chief People Officer highlighted that the Trust was in a good position regarding the use of temporary staff as this had significantly reduced by 25,000 hours less than Quarter 3 in the previous year.

The Committee discussed the Global Majority Aspiring Leaders programme and noted that further work was required to increase representation of the local community considering that the Global Majority made up 46% of the Reading community. It was agreed that the programme should be targeted to the right people and here should be a greater degree of operational alignment. It was agreed that there should be a greater focus on the programme and its outcomes, as well as other relevant activity; more detailed information to be included in the next report. **Action: P da Gama**

The Chief Nursing Officer reported that there was a risk to workforce stability within Nursing and Midwifery and Health Care Assistants with more staff leaving than joining. This presented a concern in light of the current freeze on overseas recruitment and the reduction of agency staff.

Assurance: substantial.

05/26 2025 Staff Survey Results

The Chief People Officer introduced the initial Staff Survey Results highlighting that the Trust had achieved its highest ever response rate of 62%. Overall, results were positive although it was important not to be complacent and the Trust should strive to do more.

The Chair of the Trust suggested that, as the Trust benchmarked at the high end of NHS acute trusts, could the Trust benchmark itself again other industries in order to improve further. The Chief People Officer agreed that, whilst the Trust could review this option, the NHS itself was a unique workplace and comparison against organisations in other industries would be difficult.

Assurance: substantial.

06/26 Gender Pay Gap Report

The Chief People Officer introduced the report and highlighted an inaccuracy in relation to bonus pay. The Committee agreed to approve the report subject to the amendment being made.

Action: P da Gama

The Committee noted that the mean gap was the narrowest since 2017. In year improvement was modest in the mean gap but more significant in the median gap. There continued to be a 'representation gap' in female representation in the top pay quartile relative to female representation overall in the Trust. The Chief People Officer advised that work was required in collaboration with the Women's + Network to drive further drive improvements in representation. **Action: P da Gama**

The Committee considered that a wider ranging report on equality issues would be beneficial.

Action: P da Gama

The Chief Medical Officer advised that overall good progress had been made in relation to the gender pay gap. The most recent national data indicated that the Trust's position was not an outlier and was approximately 20% lower than the figures reported for Hospital Doctors nationally.

Assurance: Partial

07/26 10-Point Plan to Improve Resident Doctors' Working Lives

The Chief Medical Officer introduced the 10-Point Plan report and highlighted that the Chief Registrar had approved the data. The Trust's data submission to NHS England demonstrated an 8% improvement in 12 weeks, from 76% at the start and 84% in December 2025. A communications package would be developed for the new Resident Doctors.

Action: J Lippett

It was agreed that some Resident Doctors' Peer Lead Survey questions would be updated to ensure that the Trust had full assurance that new Resident Doctors' were aware of all the new joiner information. The survey would be issued at the most effective times of the year, for example, at the start and end of rotations. **Action: J Lippett**

The Committee discussed the issue of low attendance at the Resident Doctors Forum. It was noted that this was often due to shift patterns. However, the Peer Resident Doctor had attempted various times of the day and the Forum was available as a hybrid option to enable attendance.

It was agreed that the Board would be advised that positive assurance had been received on the 10 Point Plan and the Resident Doctor Peer Lead had provided a valuable contribution to the work by producing a survey.

08/26 Guardian of Safe Working Report

The Guardian of Safe Working introduced the report and highlighted that new reforms were now in place and this provided further opportunity for Resident Doctors to report confidentially. Therefore, it was anticipated that there would be an increased level of reporting in the future. There had been 146 exception reports submitted in Quarter 3, a reduction of 25% from Quarter 2 although, overall this was a 39% increase year-on-year.

The Committee noted there were a higher number of reports raised in General Surgery and Ophthalmology. However, General Surgery now had a full Resident Doctor rota that would assist to in issues being resolved going forward.

The Committee noted that another member of staff would be undertaking the role of Guardian of Safe Working whilst the incumbent was on maternity leave.

The Committee agreed that the Board would be assured that substantial assurance had been received on the Guardian of Safe Working report.

09/26 Review of Committee's Effectiveness & Terms of Reference

The Trust Secretary introduced the Annual Effectiveness Review and Terms of Reference for review and recommendation to the Board.

The Committee agreed that a recommendation would be submitted to the Board to approve the Effectiveness Review and Terms of Reference. **Action: P Yaqoob**

10/26 Work Plan

The Committee received the work plan for 2026. It was agreed that the 10-Point Plan would be added to each meeting and the Safer Staffing review update to a biannual basis. In addition, the work plan would be reviewed with Chief People Officer and updated ahead of the next meeting. **Action: C Lynch**

11/26 Reflections of the Meeting

Parveen Yaqoob led a discussion.

The Chair of the Trust expressed thanks to Parveen for her valuable work with the Committee during her tenure as this was her last meeting.

12/26 Date of the Next Meeting

It was agreed that the next meeting would be held on Thursday 7 May 2026.

Chair:

Date:

People Committee Annual Report 2025/26

Parveen Yaqoob
Chair, People Committee

Caroline Lynch
Trust Secretary, People Committee

1 Summary

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

2 Governance

2.1 The role of the Committee is to keep abreast of the external environment and the workforce consequences and implications and support the development of the people strategy and ensure strategic priorities are being addressed.

2.2 The Committee capture and review the views of staff via relevant staff engagement mechanisms and develop effective strategies to respond to feedback.

2.3 The People Committee monitor workforce metrics; review areas of concern and report issues and plans to address them to the Board. The Committee requests and reviews reports and positive assurances from executives on the overall arrangement for Human Resources, workforce planning and learning and development.

2.4 Parveen Yaqoob was appointed Chair from September 2024.

2.5 The Committee's terms of reference were approved by the Board in March 2025. The Committee maintains an annual work plan.

3 Meetings and Membership

3.1 The Committee met formally on four occasions between February 2024 and December 2024.

- 6 February 2025
- 7 July 2025
- 4 September 2025
- 1 December 2025

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

Member	Maximum Number of Meetings	Number Attended
Parveen Yaqoob	4	3
Don Fairley	3	3
Katie Prichard-Thomas	4	3
Janet Lippett	4	3
Catherine McLaughlin	4	3
Minocher Irani	4	4
Suzanne Emerson-Dam	1	1

3.3 The Trust Secretary or a nominated deputy has attended all meetings. The Chair of the Trust and the Chief Executive attend two meetings a year. Other Non-Executive Directors have also attended the meetings. Other Directors and staff have attended meetings during the course of the year to advise and to respond to questions from the Committee. These have included the Deputy Chief People Officer, Guardian of Safe Working, Associate Director for Staff Experience and Inclusion, Staff Inclusion and Experience Manager,

Director of Midwifery, Head of Learning and Engagement Services and Co-Chair of Women's+ Network, Associate Director of Occupational Health & Wellbeing and the Associate Chief Nurse, Workforce, Improvement & Standards

4 Assurance

4.1 The Committee has received the following annual reports and strategies during the year:

- People Strategy Progress Report
- NHS Staff Survey Results
- Nursing & Midwifery Safer Staffing Review
- Occupational Health Annual Report
- Workforce Race Standard Equality Annual Report
- Workforce Disability Standard Equality Annual Report
- Medical Revalidation Annual Report
- Gender Pay Gap Report
- Library and Knowledge Services Annual Report

4.2 The Committee also received regular reports including:

- Guardian of Safe Working
- Workforce Key Performance Indicators
- Occupational Health
- Board Assurance Framework
- Corporate Risk Register

4.3 The Chief People Officer provided a report on a quarterly basis to provide assurance on key issues that included:

- NHS England statutory and mandatory learning (StatMand)
- National Living Wage and Impact on AfC Staff
- What Matters 2024
- Global Majority Aspiring Leaders Programme
- Medical E-rostering
- Scaling People Services
- Health & Wellbeing
- Nursing and Midwifery National Profiles
- Organisational Development updates
- Vaccinations
- National Sexual Safety At Work Charter
- Up the Anti Programme
- Staff Survey

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

- Gender Pay Gap
- Talent Management and Succession Planning
- National Sexual Safety At Work Charter and Action Plan
- Equality, Diversity and Inclusion Update
- Mandatory and Statutory Training (MAST)
- Appraisal Compliance Rates
- Recruitment & Retention
- Violence & Aggression

People Committee

Terms of Reference

Constitution and Membership

The Committee will be appointed by the Board to develop and oversee delivery of the People strategy.

The Committee is non-executive in nature and will review and scrutinise papers and recommend to the Board and advise as necessary.

The Committee will be chaired by a Non-Executive Director. The membership will include at least two further Non-Executive Directors, the Chief People Officer and the Chief Medical Officer or Chief Nursing Officer.

The quorum will be four members and will include at least two Non-Executive Directors and two executive directors.

Members are expected to attend three quarters of meetings in any one financial year.

Attendance

The Chief People Officer will be expected to attend all meetings. The Chief Executive and the Chair will attend two meetings annually.

The Trust Secretary (or their nominee) will act as secretary to the Committee.

The Committee may invite other staff or external advisors to attend for all or part of any meeting.

Frequency of Meetings

The Committee will meet at least four times a year and at such other times as may be required.

Monitoring

The work of the Committee will be kept under review by the Board.

The Committee will conduct an annual review of its effectiveness with its terms of reference and submit any findings and proposals for changes to the Board of Directors for consideration.

Duties

The main duties of the group will be:

To keep abreast of the external environment and the workforce consequences and implications.

To capture and review the views of staff via relevant staff engagement mechanisms and develop effective strategies to respond to feedback.

To support the development of the OD strategy to include recruitment and retention, education and training and employee wellbeing, prior to approval by the Board.

To support the development of the People strategy, develop and monitor key measures to ensure strategic priorities are being addressed.

To identify and monitor key workforce risks and ensure risks are appropriately included in the Board Assurance Framework.

To monitor workforce metrics, review areas of concern and report issues and plans to address them to the Board. The Committee shall request and review reports and positive assurances from executives (directors and managers) on the overall arrangement for Human Resources, workforce planning and learning and development.

To scrutinise systems and controls to ensure statutory and regulatory standards regarding workforce are met.

To monitor workforce and data and review issues in relation to the development and implementation of relevant HR policies.

Reporting

The minutes of meetings will be formally recorded and submitted to the Board after each meeting.

The Committee will review these terms of reference on an annual basis and report to the Board accordingly.

Reviewed by the Committee: 20 February 2026

Approved by the Board:

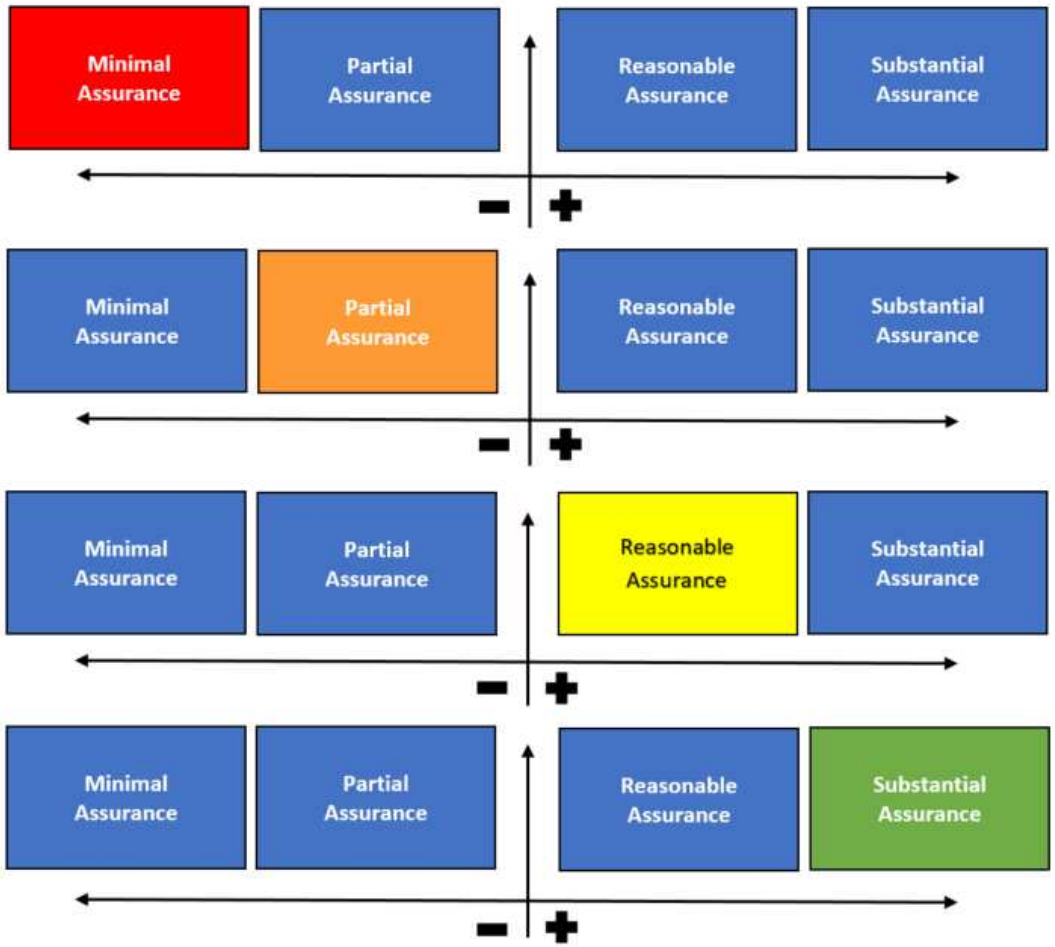
Charity Committee Chairs Report

Royal Berkshire NHS Foundation Trust

Committee Chair: Catherine McLaughlin

Committee Date	
Agenda Item 3: Charity Director's Report	**Substantial Assurance**
Agenda Item 4: Finance Update	**Reasonable Assurance**
Agenda Item 5: Draft Budget 2026/27	**Reasonable Assurance**

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE (ALERT)	MAJOR ACTIONS AGREED (ADVISE)
• E.g. None	• Advise that there is an action to scope out the options for an internal post or external provider to support corporate volunteering and link this work into building corporate partnerships. • Advise that there is a Charity Workshop scheduled for 24 March 2026 to discuss the direction for the Charity in terms of strategic goals and expenditure on operating costs
POSITIVE ASSURANCES TO PROVIDE (ASSURE)	**DECISIONS MADE (APPROVE)**
• Assurance on the budget with the final budget being submitted at the next meeting • Assurance on the procurement process for an investment house • Assurance on the Charity activities update	• None



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)

Royal Berkshire NHS Foundation Trust

Minutes

Charity Committee

Wednesday 4 March 2026
14.00 – 16.00
Boardroom, Level 4

Present

Ms. Catherine McLaughlin	(Non-Executive Director) (Chair)
Mr. Jonathan Barker	(Public Governor, Reading)
Mr. Mike Clements	(Director of Finance)
Dr. Minoo Irani	(Non-Executive Director)
Mr. Umesh Jetha	(Non-Executive Director)
Dr. Janet Lippett	(Chief Medical Officer)
Dr. Sunila Lobo	(Public Governor, Reading)
Ms. Adenike Omogbehin	(Staff Representative)
Ms. Jo Warrior	(Charity Director)

In attendance

Mrs. Tara Whittington	(Head of Corporate Governance)
Ms. Martha Milhavy	(KPMG) (Observer)

Apologies

Mrs. Caroline Lynch	(Trust Secretary)
Mr. John Stannard	(Patient Representative)

01/26 Declarations of Interest

There were no declarations of interest.

02/26 Minutes for Approval: 5 November 2025 & 2 December 2026 & Matters Arising Schedule

The minutes of the meeting held on 5 November 2025 & 2 December 2025 were approved as correct and signed.

03/26 Charity Director's Report

The Charity Director reported that activities over the Christmas period had raised circa £18k, with the Christmas concert being particularly successful, raising £8.5k.

The Committee discussed the next major donor event that would be held in May 2026.

The Charity Director reported that a legacy payment of £336k had recently been received. The Committee agreed that legacy payments should be included in any future reports.

Action: J Warrior

The Committee discussed upcoming fundraising events including the Reading Half Marathon on Sunday 22 March 2026 that had raised £22k to date.

The Charity Director reported that work was progressing in relation to the Charity's 30-year anniversary campaign. The refreshed branding had been completed and had been launched in January 2026. The refreshed branding would support visibility throughout the year and align with the Equipment Appeal that aimed to raise £300k.

The Charity Director reported that the website refresh was being progressed. A working group would be established to include members of the Communications Team as well as the Lead Governor, one Non-Executive Director and the Chair of the Committee. **Action: J Warrior**

The Committee noted that a workshop would be held on 24 March 2026 with a broader group across the Trust to review the Charity's five year plan and to consider the priorities for fundraising. It was agreed that a Governor would be invited to attend. **Action: J Warrior**

The Committee discussed the Charity's use of corporate volunteers and the value they provided. The Charity Director confirmed that a review would be undertaken to evaluate whether corporate volunteers should be managed through an internal post or external provider. It was agreed that an options report would be submitted to the next meeting.
Action: J Warrior

04/26 Finance Update

The Director of Finance reported that, as at Quarter 3, income was ahead of plan. Donations had reduced and highlighted the low rate of expenditure. The purchase of medical equipment was particularly below target by circa £300k.

The Committee discussed how teams could be encouraged to utilise their charitable funds. The Chief Medical Officer advised that some departments were reluctant to spend and preferred to accumulate funds for the purchase of larger items.

The Charity Director advised that there had been some duplication in the process for spending allocated funds that had created difficulty and discouraged teams from utilising them. The Director of Finance agreed to propose a solution to streamline the process.
Action: M Clements

The Committee noted that there was an error within the report where 'Corporate' was included within the unrestricted and restricted funds balances. The Charity Director would amend the report. **Action: J Warrior**

The Committee agreed that, in order to encourage expenditure, the Trust would implement a biannual period for teams to apply for larger funds along with matched funding from the General Fund. The Charity Director would develop a proposal for this plan.
Action: J Warrior

The Committee noted that the work to collaborate with the procurement team on the selection of an investment house was progressing. An update would be provided at the next meeting.
Action: M Clements

05/26 Draft Budget 2026/27

The Committee received the draft budget for 2026/27. It was noted that the workshop on 24 March 2026 would inform the fundraising section of the budget. The Committee agreed that the workshop would need to consider the continuation of Charity events as a number of these only generated a small amount of revenue. **Action: J Warrior**

The Charity Director reported that pay costs for 2025/26 were below plan due to a number of vacancies during the year, and the re-banding of two roles following a Mutually Agreed Redundancy Scheme.

The Charity Director reported that the 2026/27 non-pay budget had increased. One reason for this was to support the implementation of a new customer relationship management system. The Committee supported this implementation.

The Charity Director reported that the Charity was below target for charitable activities expenditure, particularly the spend on medical equipment. However, the new breast imaging scanner had now arrived and this had increased expenditure from £310k to £440k.

The Charity Director advised that work was on-going with the Accounts Payable team to review outstanding purchase orders to the value of £200k that remained unpaid due to invoice queries.

The Committee agreed that the draft budget should be re-submitted to the next meeting following completion of the agreed actions. **Action: J Warrior**

06/26 Work Plan

It was agreed that an update on investment house should be added to the work plan on a bi-annual basis from May 2026 onwards. **Action: C Lynch**

The Committee agreed that the governors who were members of the Committee should be refreshed either biannually or annually. The Trust Secretary would seek expressions of interest to join the Committee from governors. **Action: C Lynch**

07/26 Key Messages for the Board

The Committee noted the following key messages:

- No matters of risk to be escalated
- Major action agreed to scope out corporate volunteering and link this work into building corporate partnerships
- Reasonable Assurance received on the budget with the final budget being submitted at the next meeting
- Reasonable Assurance received on the procurement process for an investment house
- Positive Assurance received on the Charity activities update
- Charity Workshop scheduled for 24 March 2026 to discuss the direction for the Charity in terms of strategic goals and expenditure on operating costs

08/26 Reflections of the Meeting:

Jonathan Barker led the discussion.

09/26 Date of the Next Meeting

It was agreed that the next meeting would be held on Wednesday 6 May 2026 at 14.00.

SIGNED:

DATE:

NHS
Royal Berkshire
NHS Foundation Trust

Title:	**Chief Executive Report**
Agenda item no:	6
Meeting:	Board of Directors
Date:	25 March 2026
Presented by:	Steve McManus, Chief Executive
Prepared by:	Caroline Lynch, Trust Secretary

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

Report History	None

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

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

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

Strategic Objective 1: Delivering the highest quality care for all

Quarter 3 National Oversight Framework

1.1 The Trust has been advised that NOF Quarter 3 position for 2025/26 has now been validated and the Trust has been placed in segment 3. The underlying score has improved slightly so our position in the acute league table is 28/134.

Care Quality Commission (CQC) IR[ME]R Return inspection

1.2 Following an announced inspection on 16 July 2025 of the Nuclear Medicine Department, the Trust was issued an Improvement Notice under the Health and Safety at Work Act 1974 (Section 19) and the Ionising Radiation (Medical Exposure) Regulations 2017 ('IR[ME]R') Regulation 6 Employer's duties: establishment of general procedures, protocols and quality assurance programmes. The Trust submitted an action plan to the Care Quality Commission (CQC) in September 2025.

1.3 A return inspection was undertaken on Monday 2 March 2026 and the improvement noticed has now been lifted. The Nuclear Medicine team from Planned Care Group and the Trust were commended for the significant amount of work undertaken to achieve this outcome.

1.4 The CQC's file has now been closed and the next inspection will form part of the routine cycle. Everyone who contributed to this important work has been thanked for their efforts and contribution.

Maternity Block

1.5 At the start of the year we received a report that indicated that the fire compartmentalisation in our maternity building had been compromised as a result of historic works over the past couple of decades.

1.6 The impact of this means that the normal approach to managing and evacuating patients and staff in the event of a fire (phased horizontal evacuation – PHE) was judged by advisors and the Royal Berkshire Fire and Rescue Service (RBFRS) to pose a significant risk and resulted in RBFRS issuing the Trust with two enforcement notices, one in relation to revising our approach to evacuation and the second relating to developing a plan to rectify the building such that PHE could be resumed.

1.7 To ensure we comply with our Fire Risk Assessment and guidance from RBFRS, we have changed our evacuation procedures and updated the Local Emergency Evacuation Plans (LEEPs) for each floor of the block and staff based in the block undergoing essential training in the new evacuation procedures which covers the use of new evacuation equipment we have procured. This has resulted in RBFRS lifting the first of our enforcement notices.

1.8 We have also undertaken an extensive set of fire safety precaution work including:

- Testing and updating fire alarms in all 40 zones of the block.
- Repairing and replacing fire doors.
- Replacing fluorescent lights with LEDs.
- Remedial structural work around how we stop a fire spreading through the building.
- Revising staffing and patient ratios in some parts of the building.
- Decluttering wards and corridors removing unnecessary items and improving storage.
- Procuring additional evacuation equipment for clinical areas
- Removing wall posters and signage and removing other items that could pose a fire risk

1.9 We are also working up a programme of works to remedy the building that will take place in Spring 2026. These works and the wider risk we have identified require moves of services around the Royal Berkshire estate and reductions in capacity. Rushey ward (our midwifery led unit) has already moved to be co-located with delivery suite. Buscot ward (our neonatology ward) will integrate with our paediatric unit on lion and dolphin wards, and Hurley ward (our trauma ward) will move into the spaces currently occupied by short stay and Dorrell wards.

1.10 Throughout this period the safety of our staff, patients and visitors is our priority, and we have committed to keeping them informed and updated on a regular basis. Patients are being informed at face to face appointments, via our website and, following the recent relocation of the Rushey Midwifery-Led birthing service, a video posted on our social media channels and website. We have also engaged widely and regularly with key stakeholders including Maternity Voices Partnership, Healthwatch, BiBs (Babies in Buscot) and partners across the Berkshire West health and care footprint including local authorities and the Integrated Care Board.

1.11 We have posted regular communications on our staff intranet; the issue has been included in a number of exec team led messages and staff were able to discuss the situation with members of the Board who visited the block last week.

Strategic Objective 2: Supporting our people to thrive

2025 Staff Survey

2.1 The 2025 NHS Staff Survey results were officially released on 12 March 2026. We achieved our best ever response rate with 4165 completing the survey providing an overall response rate of 62%. The 2025 Acute Trust median response rate was 47%. The full report is later on the agenda.

2026 CARE awards

2.2 During March 226 we received circa 600 nominations from across the Trust for our annual CARE awards. Care group leaders and members of the Board will be reviewing the nominations over the next few weeks ahead of our awards evening on 15 May 2026.

Executive Appointments

Chief Finance Officer

2.3 As advised previously Frances Khatcherian was appointed to the role of Chief Finance Officer taking up the role March 2026. Frances joins us from Hertfordshire Community NHS Trust, where she has been serving as Chief Financial Officer with responsibility for Finance, Estates, and Systems.

Chief Executive

2.4 Following interviews held on 29 and 30 January 2026, James Blythe's appointment at Chief Executive was approved by the Council of Governors on 10 February 2026. James will join the organisation on 18 May 2026. In his current role, James is the current interim Chief Executive at one of the largest NHS health groups in the country; St George's, Epsom and St Helier Hospitals (GESH), which includes community services teams in Surrey and South West London. James has more than 20 years' experience in the health service and has worked in operational management, system management and policy roles.

Strategic Objective 3: Partnering for impact

Renaming of the Health Innovation Partnership (HIP) with the University of Reading

3.1 The 2025 partnership evaluation report made 26 recommendations, one of which was to revisit the naming of the Partnership and consider whether the name conveyed a clear remit and identity. As part of the process for choosing a new name, we looked at other examples of NHS-University partnerships and engaged with stakeholders across both organisations, at various time points to ensure coverage.

3.2 As part of the new phase of the partnership, and the partnerships vision and mission indicating '*the health of Berkshire and beyond'* we opted to include our place names i.e. Berkshire, Thames Valley etc. This provides longevity to our partnership with opportunities to have other partners within our region join in the future and would reflect the work delivered across three of our local authorities (Wokingham, Reading and West Berkshire). The voting with our stakeholders presented a significant voting majority for Reading & Thames Valley Health Innovation Partnership**,** and this decision was ratified by the Strategic Partnership Board on the 18 February 2026. A light touch process of rebranding and communication will ensue.

University of Reading Court – Receival of Centenary Community Pledge

3.3 On the 17 March 1926 the University of Reading received a Charter of Incorporation from King George the fifth and became a University in its own right: able to issue its own degrees. To mark one hundred years of this special event me and Janet Lippett were invited to a special University Court. As part of the auspicious occasion, I received a Community Pledge on behalf of the Trust from the Chancellor of the University. As anchor institutions in the community, we share many common ambitions and aspirations – not least the work we are doing together through the Reading and Thames Valley Health Innovation Partnership where we aim to inform policy and shape the healthcare practice of tomorrow. Being physically based alongside each other at Harborne and Dingley on the Whiteknights campus as well as the shared clinical skills facility only serves to underline the importance of our relationship with the University. It was no co-incidence that we featured in the Universities publicity for the centenary year; reporting on a combined AI project that we co-developed to identify patients more likely to miss hospital appointments, due to factors such as language needs or travel difficulties. Through targeted support the risk of not attending can be reduced.

3.4 From the University's perspective, the aim of the pledge was to make it clear that while it pursues global ambitions, it remains deeply rooted in and committed to the community. And by accepting the pledge, I was also able to visibly reaffirm our commitment to the partnership with the University, nurturing our existing connections, and looking for opportunity to build on them into the future.

Strategic Objective 4 – Driving improvement and enabling innovation

Emergency Department (ED)

4.1 The former Urology clinical area has been stripped out and reconfigured to expand the Emergency Department, providing additional assessment rooms, trolley and recliner bays, and supporting facilities including a new reception to improve capacity and patient flow. Construction remains on target for practical completion on 24 April 2026.

4.2 Associated ED Observation Bays breakthrough works were completed as planned (w/c 09 March 2026), including medical gas connections, demolition works, and creation of new fire door access. The area was handed back to the ED team on 15 March 2026.

Royal Berkshire Hospital and Bracknell Linac replacement

4.3 The LA04 LINAC bunker and control room within the Radiotherapy Department at Royal Berkshire Hospital have been refurbished, including electrical and ventilation upgrades, layout improvements, and installation of new radiotherapy and dosimetry equipment to support commissioning and ongoing service delivery.

4.4 The Royal Berkshire Hospital Linac installation has been completed successfully and removal of the Bracknell LINAC is scheduled for the weekend of 28 March 2026 as part of enabling works for the new LINAC at that location.

Strategic Objective 5: Building a sustainable future together

Financial Position

5.1 The Trust has worked hard throughout the year to deliver against all aspects of its financial plan, including a deficit of no more than £7.8m. As we approach the year end, we remain confident that underlying performance is in line with plan.

5.2 However, the Trust has recently identified a significant income issue, primarily relating to the treatment of prior year accruals, which is currently being discussed with NHS England. The impact of this could impact the 2025/26 position.

5.3 The Trust has engaged closely with regional and national colleagues on this matter. This issue is non-recurrent in nature and does not reflect a deterioration in the Trust's underlying financial performance.

Operational Planning 2026 – 2029

5.2 The Trust submitted its financial and operating plans to NHS England on 12 February 2026. The Trust's submissions are compliant with expectations from NHS England in relation to delivery of elective, cancer and urgent care performance standards. The plan is also complaint against financial targets, but at the point of submission there was a £23.7m difference in income expectations between the Trust and its commissioners. Over the past month there has been progress in closing this misalignment. At Finance & Investment Committee on 18 March 2026 the residual gap was £11.2m with operational standards remaining compliant. Achieving the plan is dependent on delivery of an efficiency programme of £43.7m.

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Title:	**Integrated Performance Report (IPR)**
Agenda item no:	7
Meeting:	Board of Directors
Date:	25 March 2026
Presented by:	Janet Lippett, Chief Medical Officer
Prepared by:	Executive Team

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

Report History	Executive Management Committee 23 March 2026

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

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

Strategic objectives This report impacts on (tick all that apply)**:**	
Delivering the highest quality care for all	✓
Supporting our people to thrive	✓
Partnering for impact	✓
Driving improvement and enabling innovation	✓
Building a sustainable future together	

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

Publication						
Published on website		Confidentiality (FoI)	Private		Public	✓

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Integrated Performance Report

February 2026

Improving together to deliver
outstanding care for our community

Improving Together

Guide to statistical process control (SPC)

NHS Royal Berkshire NHS Foundation Trust

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

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

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

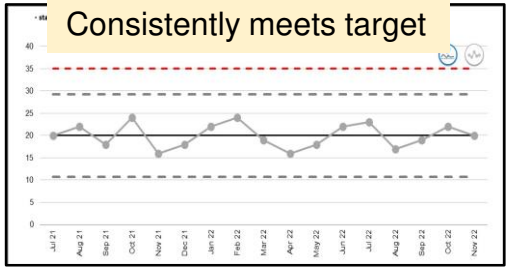
- The variation is routine, expected and stable within a range. We call this '*common cause*' variation, or
- The variation is irregular, unexpected and unstable. We call this '*special cause*' variation and indicates an irregularity or that something significant has changed in the process

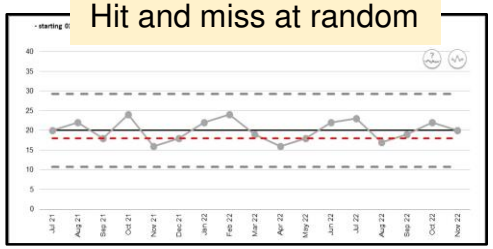
Each chart shows a VARIATION icon to identify either common cause or special cause variation. If special cause variation is detected the icon can also indicate if it is improving (blue) or worsening (orange).

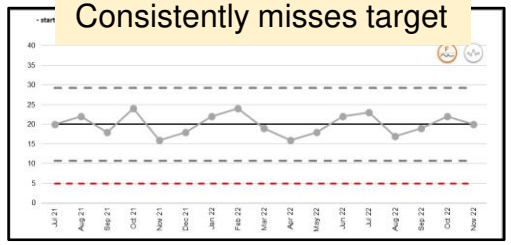
Where we have set a target, the chart also provides an ASSURANCE icon indicating:

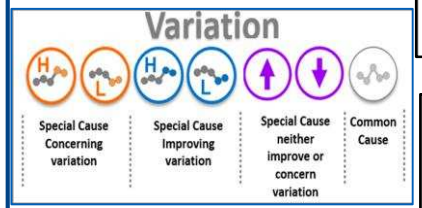
- If we have consistently met that target (blue icon),
- If we hit and miss randomly over time (grey icon), or
- If we consistently fail the target (orange icon)

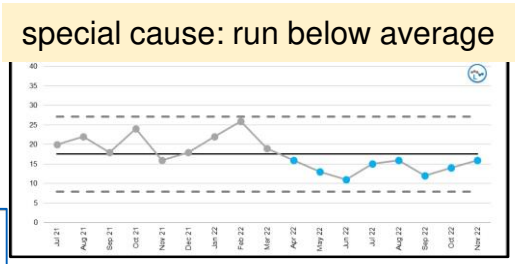
For each of our strategic metrics and breakthrough priorities we will provide a SPC chart and detailed performance report. We apply the same Variation and Assurance rules to watch metrics but display just the icon(s) in a table highlighting those that need further discussion or investigation.

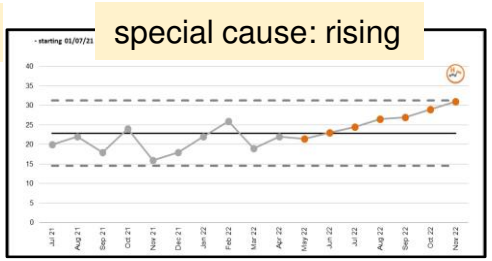


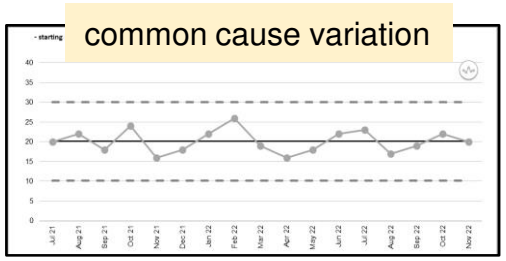


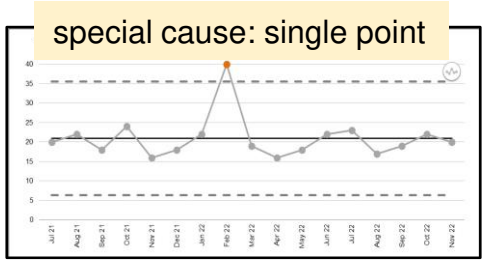










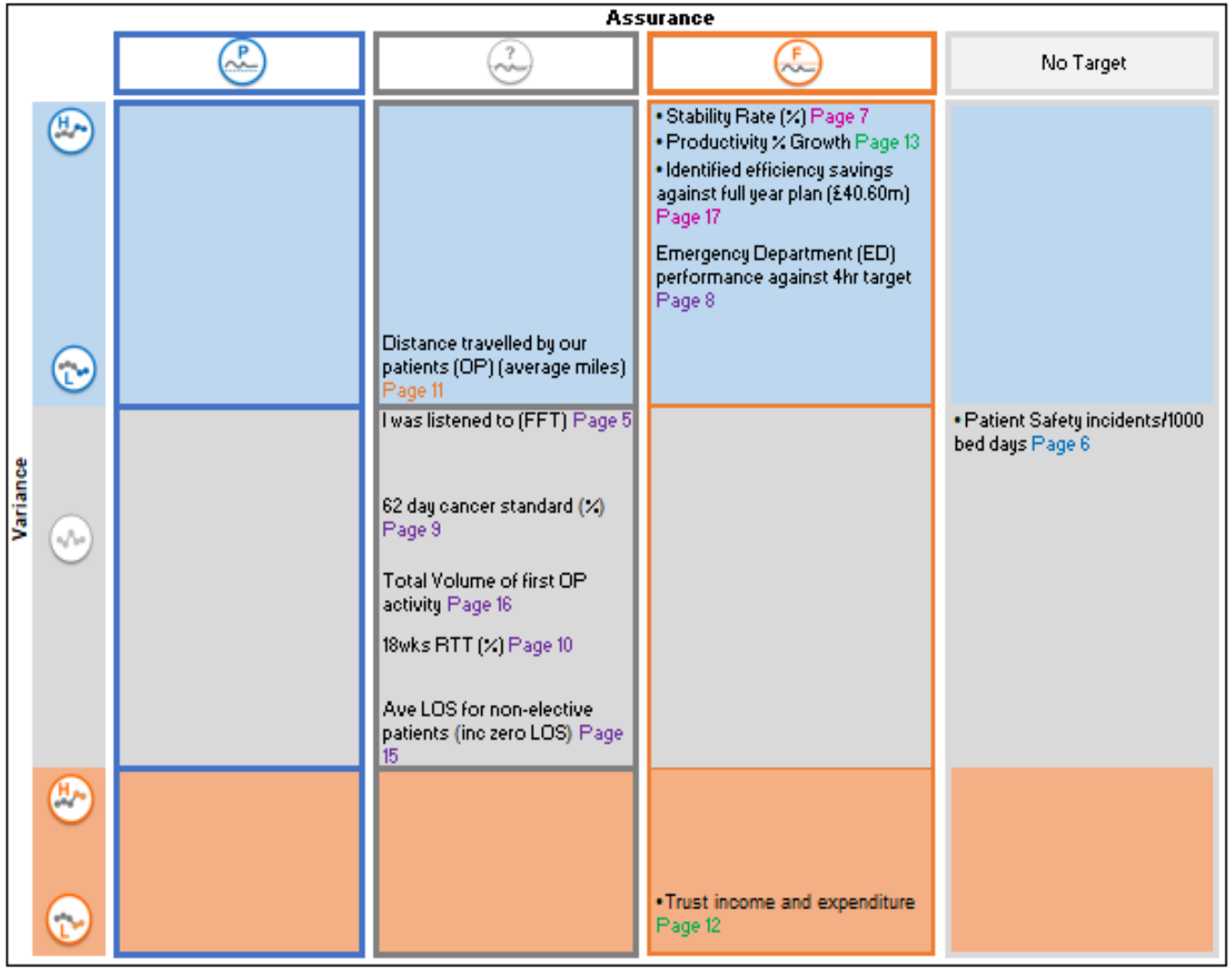


February 2026 performance summary

Royal Berkshire NHS Foundation Trust

The data in this report relates to the period up to 28th February The key messages from the report are:

- **ED Performance:** All types Performance for the period met plan. The national planning assumption was based on 0% activity growth; however, locally we experienced a 10% increase in activity (T1). This growth has placed additional strain on service delivery, workforce capacity, departmental resources and increases waits for admission from ED.
- **Cancer performance:** performance against the 28-day faster diagnosis standard remains compliant with the Trust's planned trajectory for 2025-26. Performance against the 62-day standard met the Trust's planned trajectory as well as the national ambition in December and is forecast to do so in January as well. Improvement actions continue to be worked on for the most challenged pathways through weekly Cancer Action Group meetings.
- **Financial performance:** at the end of February the income and expenditure deficit of £(8.15)m YTD is within the agreed plan. We have now delivered £32.36m of the £40.60m efficiency savings plan. We are delivering the action plan required to deliver our full year plan and are focused on embedding recurrent actions going into 2026/27.
- **Cash** balance of £22.51m, driven by timing of capital payments and receipt of education funding. We have confirmation of a further cash drawdown in March.
- This month we have seen 14 of the 110 **watch metrics** measure outside of statistical control.



Royal Berkshire
NHS Foundation Trust

Strategic Metrics

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

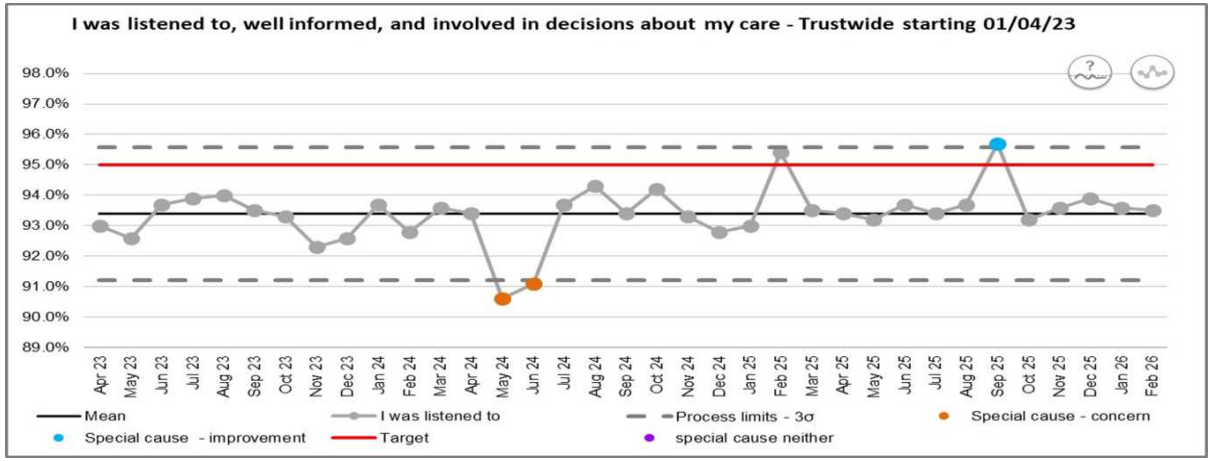
Strategic metric: I was listened to, well informed & involved in decisions about my care

Board Committee: Quality committee

SRO: Katie Prichard-Thomas

Assurance	Variation
	

Royal Berkshire NHS Foundation Trust



Insight Metrics	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
I was listened to, well informed & involved in decisions about my care (FFT) Q2	95.7%	93.2%	93.60%	93.9%	93.6%	93.5%
Inpatient FFT satisfaction rate	96%	95%	96%	94%	94.2%	94.5%
Outpatient FFT satisfaction rate	95%	95%	96%	96%	95.7%	95.1%
Maternity FFT satisfaction rate	97%	95%	98%	97%	95.8%	96.2%
Emergency Departments FFT satisfaction rate	78%	78%	83%	83%	78%	81%
Day Case FFT satisfaction rate	97%	99%	99%	98%	98.3%	99.6%
Paediatrics (IP only) FFT satisfaction rate (%)	77%	96%	100%	89%	95.6%	100%
Overall Trust FFT satisfaction rate	93.7%	93.3%	94.2%	94%	93.4%	93.5%

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

How are we performing:

- This metric now includes the Trustwide overall FFT Satisfaction score, currently 93.5% for February (93.4% in Jan) with a target of 95%.
- Satisfaction score for FFT Question 2 for February is 93.5%;overall stable although below the Trust target of 95%.
- Trust response rate remains at 9.4% for Feb.

Actions and next steps

- Audit of clinic names against FFT records underway.
- Satellite clinics and Outpatient clinics confirmed, and display boards being identified for results.
- FFT trial dashboards now live in IQVIA for review.
- Developing auto-reports to be sent to leads on a weekly/monthly basis.
- Process for extracting themes and safety/safeguarding risks from FFT and National feedback to be disseminated through Care Groups.
- Updated You Said…We Did poster now available.

Risks

- Changes to location for several wards (Buscot/Hurley) and restrictions on displaying results .
- KPIs for FFT awaiting review, to ensure data is useful
- Communication team have limited capacity to train Patient Experience team leads to update Workvivo team pages, to provide staff with information re FFT, You Said…We Did, Interpreting, Patient Information.

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

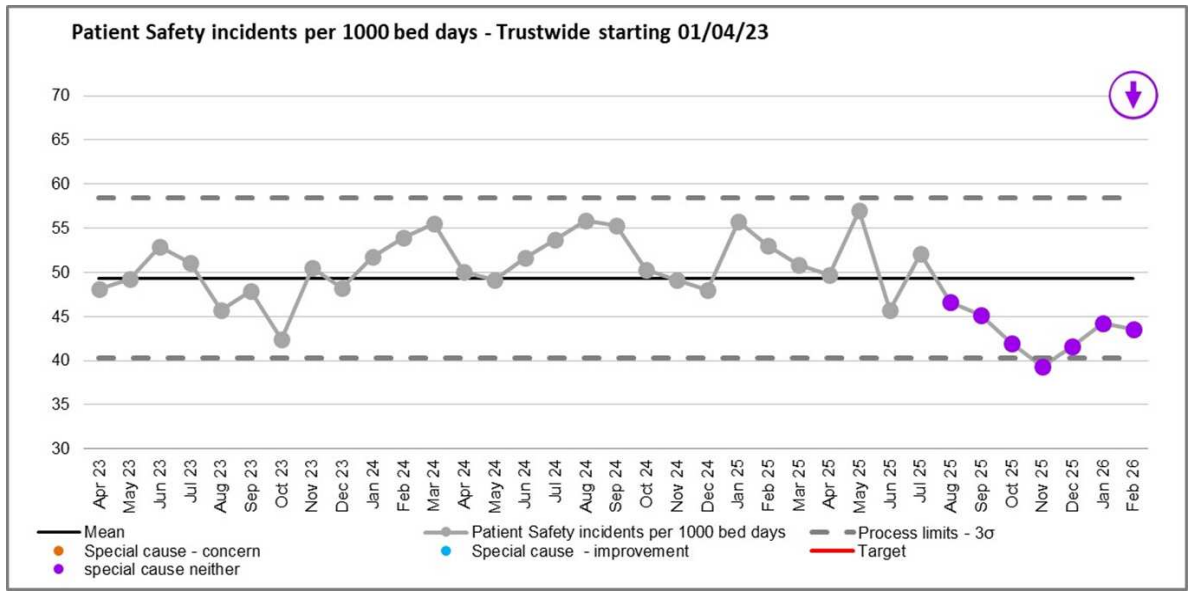
Strategic metric: Learning from incidents to reduce harm

Board Committee: Quality committee

SRO: Katie Prichard-Thomas

Assurance	Variation
N/A	↓

Royal Berkshire NHS Foundation Trust



Insight Metrics	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Patient Safety incidents per 1000 bed days	45.29	41.98	39.34	41.98	44.27	43.50
Patient Safety incidents/100 admissions	9.08	7.84	6.55	8.75	9.26	8.9
No. of Deteriorating patient incidents	7	7	10	9	9	5
FFT question: I felt safe during my visit to the hospital (%)	93.1%	91.2%	92.8%	92.1%	90.8%	91.2%
Total Calls for Concern from patient and family	34	27	23	20	30	31

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:

- The number of incidents per 1000 bed days remain above the minimum threshold of 40 and within to control limits .
- PSIRF policy out for consultation with sign off through Policy Approval Group planned for March 2026.
- National Patient Safety Syllabus (NPSS) training has increased from 16% to 28% and is now on local compliance for all staff.

Actions and next steps

- Replacement/upgrade of the datix system for managing incidents, risk and complaints currently out to tender during February/March 2026. Demonstration sessions booked for April 14 and clinical and corporate staff included.
- Comms for the changes to local compliance for NPSS training planned for March 2026.
- PSIRF priorities and plan have been developed with the care groups and will be presented at Patient Safety Committee in April for approval.

Risks:

- Number of total staff who have completed NPSS e-learning remains low (28% of Trust staff). This is increasing with changes to learning matters.

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

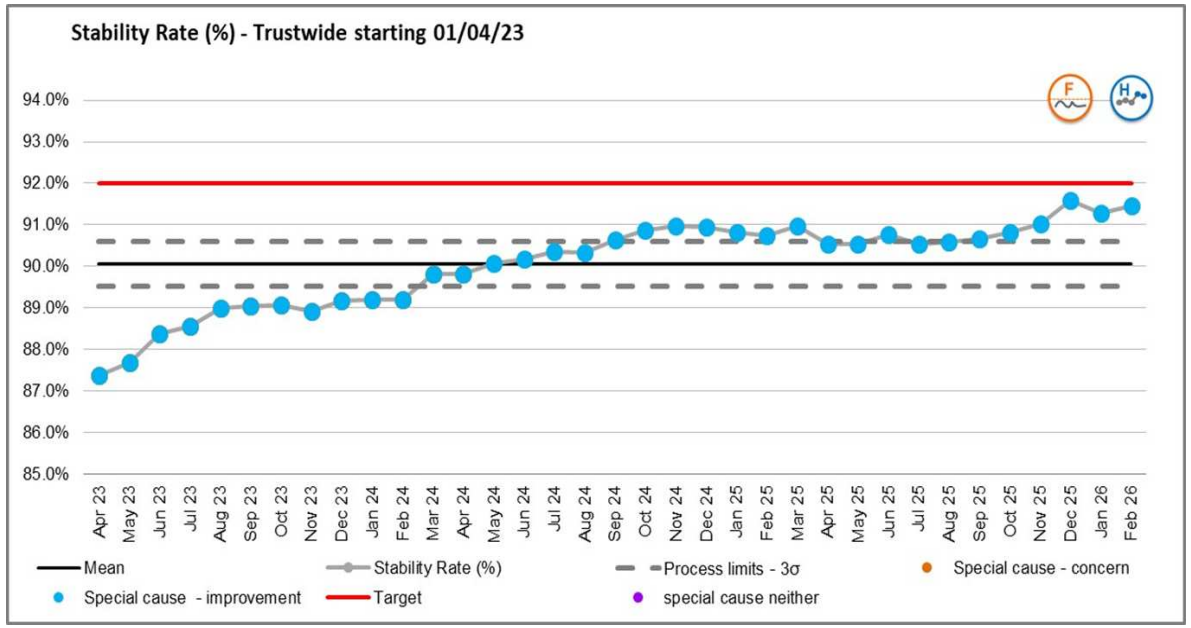
Strategic metric: Improve retention

Board Committee: People Committee

SRO: Paul Dagama

Assurance	Variation
F	H

Royal Berkshire NHS Foundation Trust



Insight Metrics	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Stability Rate (%)	90.67%	90.81%	91.03%	91.60%	91.28%	91.47%
Turnover rate %	9.99%	9.85%	9.60%	9.36%	9.17%	9.15%
Vacancy rate	3.92%	2.05%	2.17%	2.25%	1.38%	1.25%
Sickness absence (rolling 12 month)	3.85%	3.79%	3.77%	3.76%	3.73%	Arrears

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

How are we performing:

- In February, our stability rate was 91.47%. We are yet to hit the 92% target but the trend continues to improve.

Actions and next steps:

- Departments are currently working on their local Staff Survey improvement plans that will tackle local concerns and celebrate areas of good practice. These will be operational as of the 1 April.
- The People Directorate teams continue to work with the Care Groups to focus on preventative measures around avoidable sickness absence rather than taking a reactive stance.
- Departments are encouraged to complete risk assessments related to health and wellbeing issues, and return to work forms following periods of sickness absence.
- The People Directorate is working on culture improvement interventions with the teams that need it most via the People Matrix.
- People and Change Partners continue to work with their Care Groups to develop this year's Staff Survey improvement plans, and their strategic People Plans for the next few years.
- Talent Review Boards are expected to be booked in for April.
- Corporate and Care Group Performance Review Meetings in March will set new driver metrics for the year, with each area having a People-related metric.

Risks:

- Winter pressures and financial constraints are putting pressure on teams. Indicators suggest that there may be a risk of burnout in some teams.

Strategic objective: **Partnering for Impact**

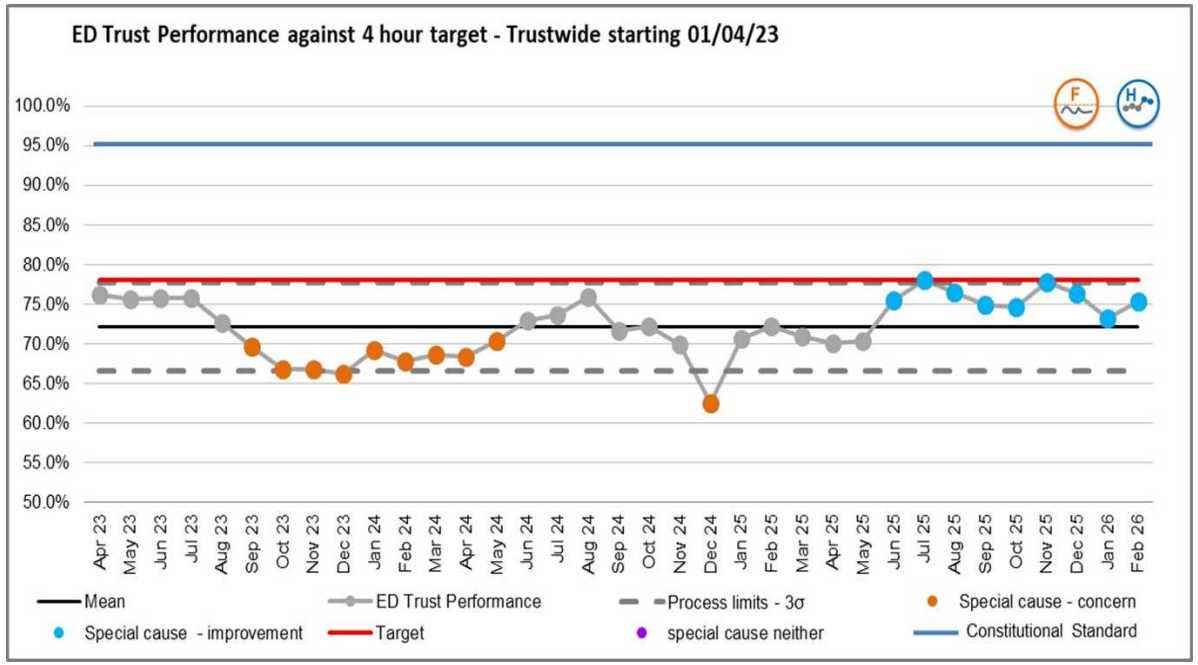
Strategic metric: Performance against 4hr Emergency Pathway target

Board Committee: Quality Committee

SRO: Dom Hardy

Assurance	Variation
F	H

Royal Berkshire NHS Foundation Trust



Insight Metrics	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
4hour Performance (%)	74.87%	74.69%	77.77%	76.36%	73.2%	75.40%
4hr Performance (%) Trajectory	74%	75%	73%	74%	73.5%	78%
Average daily Type 1 attendance	403	418	410	397	404	402
Total Breaches	4385	4640	3866	4093	4737	3949
Ambulance Handover: 30 Minutes	165	246	193	246	272	227
12 hours from arrival in ED (%)	2.68%	2.85%	2.10%	2.32%	2.69%	2.46%

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

How are we performing:

- 75.4% all types of patients were seen within 4 hours.
- Despite all the efforts across Berkshire West UEC pathways, ED has seen more patients than the same time last year.
- There was a slight increase in Ambulance handovers >30 minutes and >60 mins, although the overall demand remains consistent with seasonal pattern, and flat against least years conveyances.
- RBFT ED T1 performance 65.68%, which is improved. ED team continue to monitor compliance by individual areas.
- Exit block and downstream capacity/flow limitations – Work continues to address early discharge and improve flow earlier in the day.

Actions and next steps:

- Working with ICB/Urgent Care Centre (UCC), to refine UCC Model of delivery
- Further refining the application of the Temporary Escalation Space Standard Operating Procedure on wards
- Maximising attendance and admission alternatives

Risks: Corporate Risk 4172

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

Strategic objective: **Partnering for Impact**

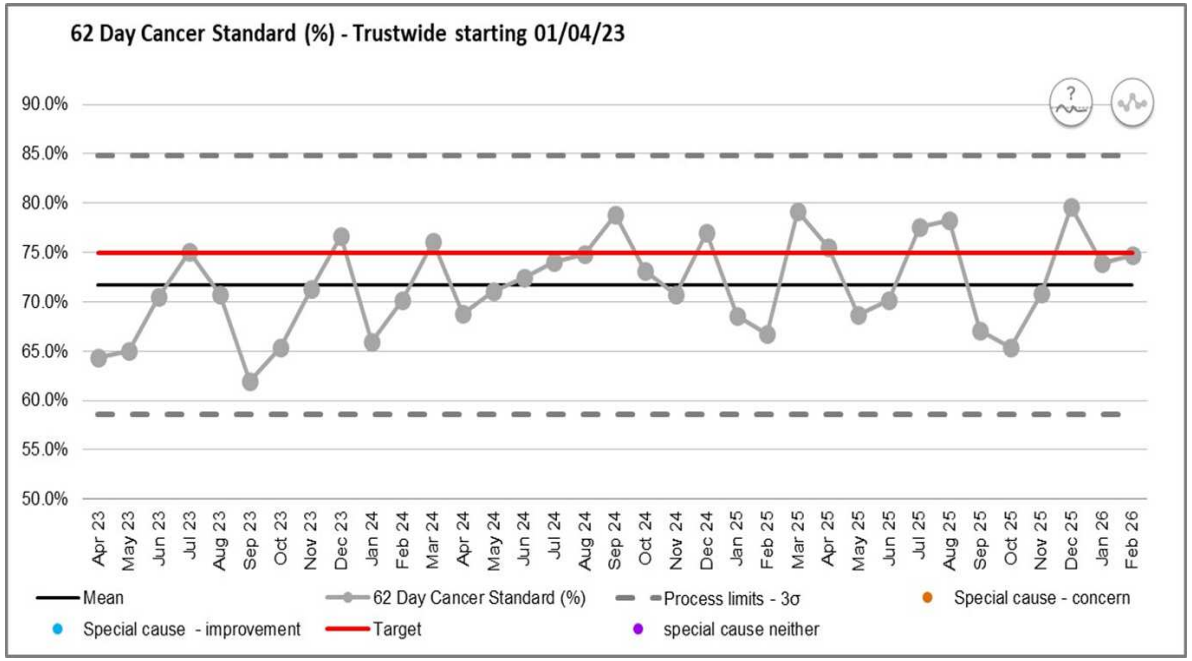
Strategic metric: Reduce waits of over 62 days for Cancer patients

Board Committee: Quality Committee

SRO: Dom Hardy

Assurance	Variation
	

Royal Berkshire NHS Foundation Trust



Insight Metrics	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Cancer 62 day %	67.1%	72.3%	74.1%	79.6%	75.7%	74.7%
Cancer 62 day % Trajectory	73.0%	73.0%	73.0%	74.0%	74.0%	74.0%
No. on PTL over 62 days	366	263	207	202	217	218
% on PTL over 62 days	12.2%	9.6%	7.6%	8.4%	9.1%	9.1%
Cancer 28 day Faster Diagnosis (80% standard)	77.1%	81.7%	80.7%	85.1%	80.0%	85.6%

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

How are we performing:

- In January 75.7% of patients were treated within 62 days. February's unvalidated performance is 74.7%. This will likely improve post-validation.
- The total number of patients on the Patient Tracking List waiting over 62 days at the end of February was 218, up from marginally from 217 in January. Predominantly within Urology, Gynaecology & Lower Gastrointestinal (LGI)

Actions and next steps:

- Gynaecology are focusing on reducing length of wait for patients requiring an inpatient hysteroscopy (IPH) by redesigning the pre-op pathway
- LGI are focusing on increasing the % of patients who are triaged straight to test and developing a protocol for same day CT scanning post endoscopy
- Urology are reviewing demand & capacity for prostate biopsies and nurse led results clinics
- Radiology are trialing navigator admin roles dedicated to supporting the Urgent Suspected Cancer Pathway, which has led to faster booking of CT & MRI scans

Risks: Corporate Risk 4241

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

Strategic objective: **Partnering for Impact**

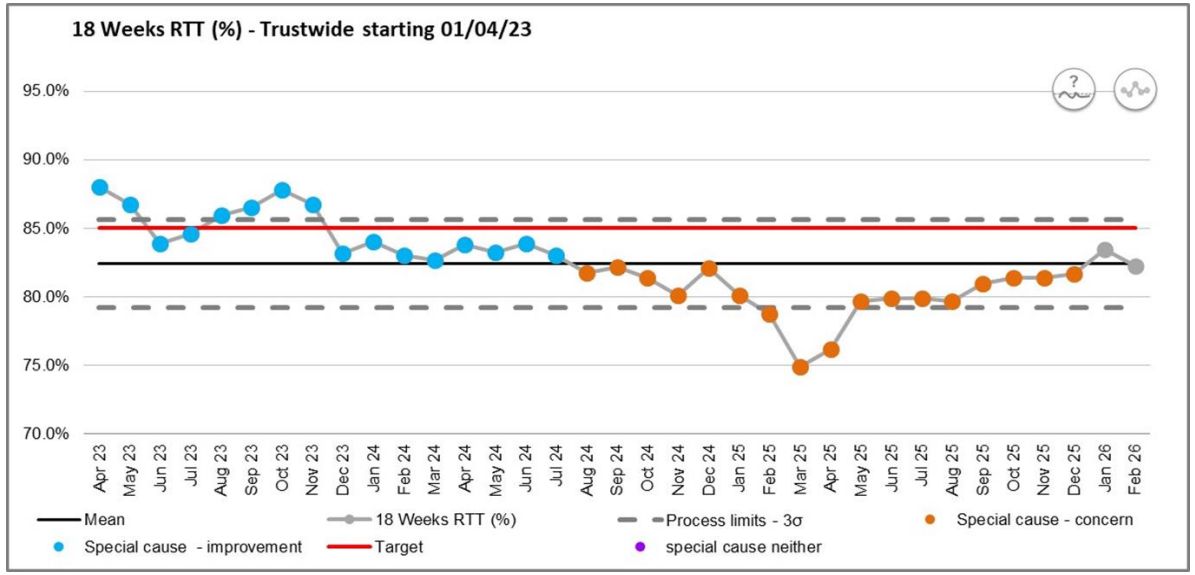
Strategic metric: Maximising Elective Activity: Achievement of the <18 week Referral to Treatment (RTT) standard

Board Committee: Quality Committee

SRO: Dom Hardy

Assurance	Variation
?	

Royal Berkshire NHS Foundation Trust



Insight Metrics	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
18 Weeks RTT (%)	80.93%	81.38%	81.36%	81.69%	83.45%	82.21%
18 Wks RTT (%) Trajectory	80%	80%	80%	80%	80%	80%
Total Elective Activity (No.) (provisional)	4920	4982	4,302	4,287	4,576	4,436
% of plan for Daycases (cumulative)	98.26%	97.73%	97.41%	96.61%	97.17%	96.89%
% of plan for Inpatients (cumulative)	94.39%	95.30%	97.39%	96.12%	95.65%	95.79%
% of plan for Outpatient Attendances (News & Follow Ups (cumulative)	110.53%	109.51%	110.81%	109.51%	109.78%	110.12%

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

How are we performing:

- Performance against the headline RTT standard remains in line with trajectory as a combined result of RTT-specific validation, Master waiting list data cleansing actions and sprint activity.
- The Trust expects to meet the year end expectations.
- However a number of specialties continue to have extended waits for first outpatient appointment. Without intervention over the remainder of the year, this will adversely impact on 26/27 performance.

Actions and next steps:

- Continue to drive improvement in the diagnostic waiting times
- Q4 drive to undertake significant additional first OPA activity to reduce waiting times. This is an NHSE funded initiative. We have recorded c. 1200 additional OPAs so far (noting that we believe this is closer to 2000 OPAs but there is a catch up required for reporting)
- LLM Development and Pathways Insight and Coordination Solution (PICS) is well underway. With early results looking promising. Parallel running of PICs is delayed as a result of resourcing challenges making data feeds available.

Risks: Corporate Risk 5995

- Capacity to sustain performance against standard

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

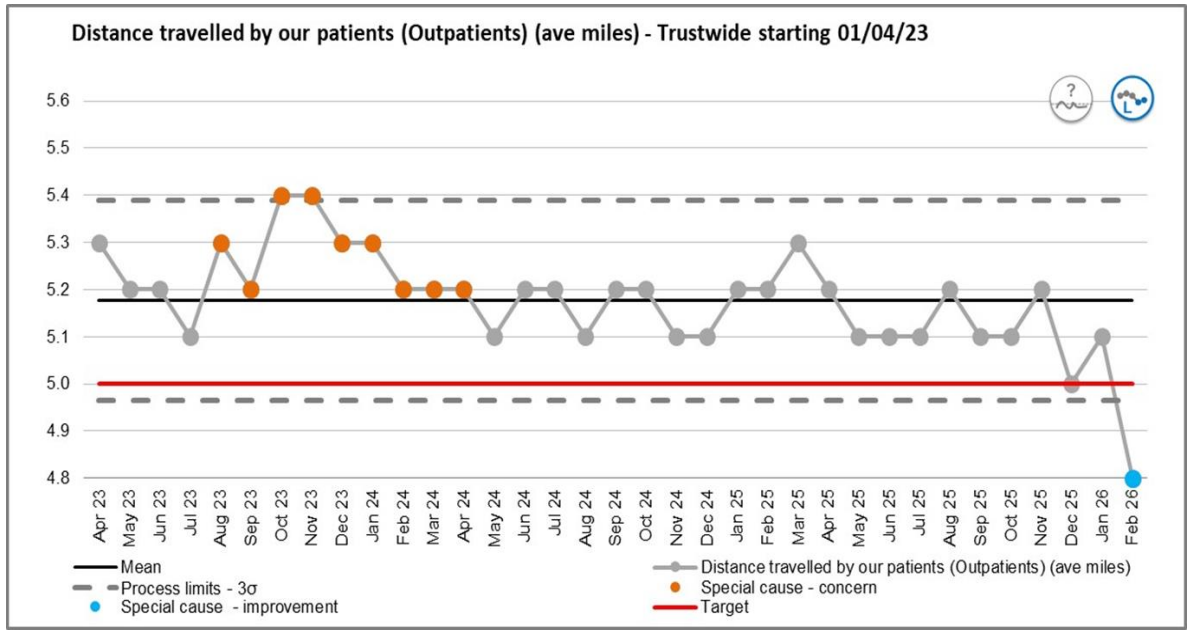
Strategic metric: Distance travelled by our patients (outpatients)

Board Committee
Quality Committee

SRO: Andrew Statham

Assurance	Variation
?	L

Royal Berkshire NHS Foundation Trust



Insight Metrics	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Distance travelled by our patients (average miles) (Outpatients including Virtual Attendances and Advice & Guidance\)	5.1	5.1	5.2	5	5.1	4.8
Number of Virtual attendances	10709	11189	9713	9922	10173	9919
Advice & Guidance (A&G) activity	2592	2875	2521	2715	2728	2757
Face to face (FTF) activity at non RBH sites	9592	10169	9703	8471	9564	9381

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

How are we performing:

- In February, the average distance travelled by our patients for outpatients was 4.8 miles. We are not routinely hitting our target of 5 miles.
- Use of non-RBH sites remains variable over the last 6 months with no positive or negative trend.

Actions and next steps

- One workstream within the Transformation Outpatient Programme aims to implement four new remote monitoring models across ENT, Urology, IBD and Obstetrics, with ENT as the initial priority and a planned go-live by April 2026.
- The 6-4-2 planning meetings continue to be held weekly, and the monthly utilisation report continues to be shared with management teams for review of percentage booking against use.

Risks:

- Activity plan risks (see Partnering for Impact)
- Ongoing inability to deliver some activity from non-RBH sites and additional costs of multisite delivery e.g. equipment and staff travel

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

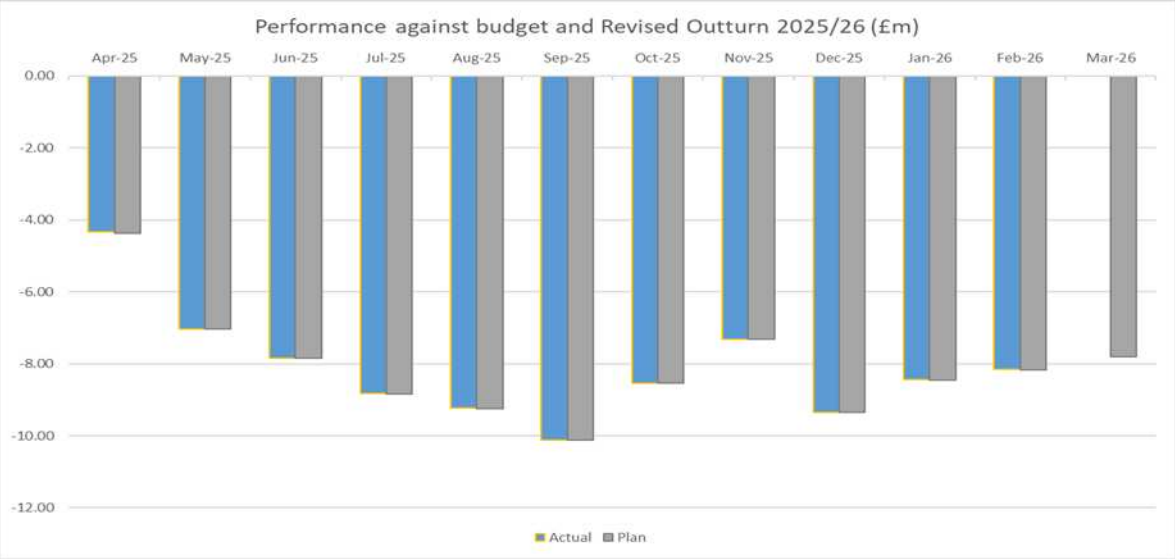
Strategic metric: Trust income & expenditure performance

Board Committee
Finance & Investment

SRO: Frances Khatcherian

Assurance	Variation
F	L

Royal Berkshire NHS Foundation Trust



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

How are we performing:

- At YTD M11, February 2025, the deficit of £(8.15)m is in line with plan
- Income is £12.36m better than plan mainly driven from non-patient care, grant income, sales of goods and education income.
- Pay is £(7.61)m adverse to plan, largely due to non-delivery of corporate and care group savings targets. The current position includes premium rate payments for additional activity as we run through the winter months.
- Non-pay is £(2.60)m worse than budget mainly due to both high-cost drugs and clinical supplies.

Insight Metrics	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Income as % of plan	101.99%	103.57%	102.14%	103.64%	104.21%	100.84%
Pay as a % of plan	100.94%	102.17%	101.71%	103.39%	102.95%	104.10%
Non-Pay as a % of plan	103.51%	106.30%	103.34%	103.49%	104.16%	87.18%
Cost Improvement Plans (CIP) delivered (cumulative) (£)	£17.16m	£20.27m	£22.94m	£25.55m	£29.32m	£32.36m
Value weighted activity actual in month (£m)	£38.39m	£44.89m	£38.56m	£37.79m	£35.90m	£37.90m
Bank and Agency Spend actual (cumulative) (£m)	£8.74m	£10.34m	£11.85m	£13.34m	£14.97m	£16.65m
Cash Position (£m)	£18.81m	£21.96m	£19.76m	£5.35m	£8.01m	£22.52m

Actions and next steps

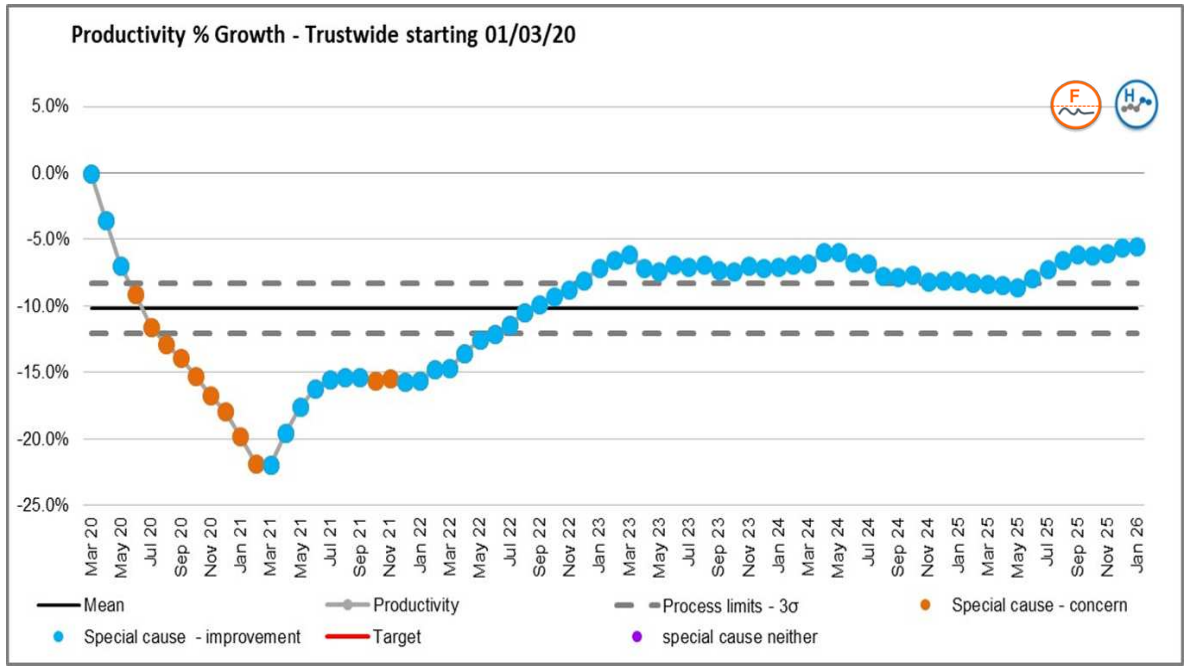
- Delivery of the agreed ten-point action plan to ensure the Trust meets its financial plan.
- A continued focus on the reduction of WTE in line with plan

Risks:

- Risk - non delivery of efficiency plans due to winter pressure (Corporate Risk 4182) and increase on monthly target.
- Risk – further industrial action planned for the winter period

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

Strategic metric: Productivity (Activity/Wholetime Equivalent)



Insight Metrics	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Productivity % Growth	-6.1	-6.2	-6.0	-5.6	-5.5	Arrears
Cost Weighted Activity (CWA) % Growth	15.6%	15.6%	15.8%	16.4%	16.4%	Arrears
Whole Time Equivalent (WTE) % Growth	23.1%	23.1%	23.1%	23.2%	23.1%	Arrears

Board Committee
Finance & Investment

SRO: Frances Khatcherian / Andrew Statham

Assurance	Variation
F	H

Royal Berkshire NHS Foundation Trust

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

How are we performing:

- Since 2021, productivity has continued to improve as the Trust's activity levels returned to and then exceeded 19/20 levels. This trend has returned in 25/26
- In January, the Trust performs 5.5% below 2019/20 levels of productivity as workforce growth (23.1%) exceeds activity growth (16.4%), but maintains continued improvement in this metric.
- 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%.

Actions and next steps:

- EMC has reviewed the latest productivity data from NHSE and Model Hospital and is in the process of using this to develop the 26-27 plans
- We are targeting 75% recurrent savings and have asked teams to identify workforce savings.
- In addition to savings the operating framework requires the Trust to improve our output on both the elective and non-elective pathway

Risks:

- The Trust is now in the second half of the financial year where we typically use more labour so do not expect the WTE % growth to decrease.

Breakthrough Priorities

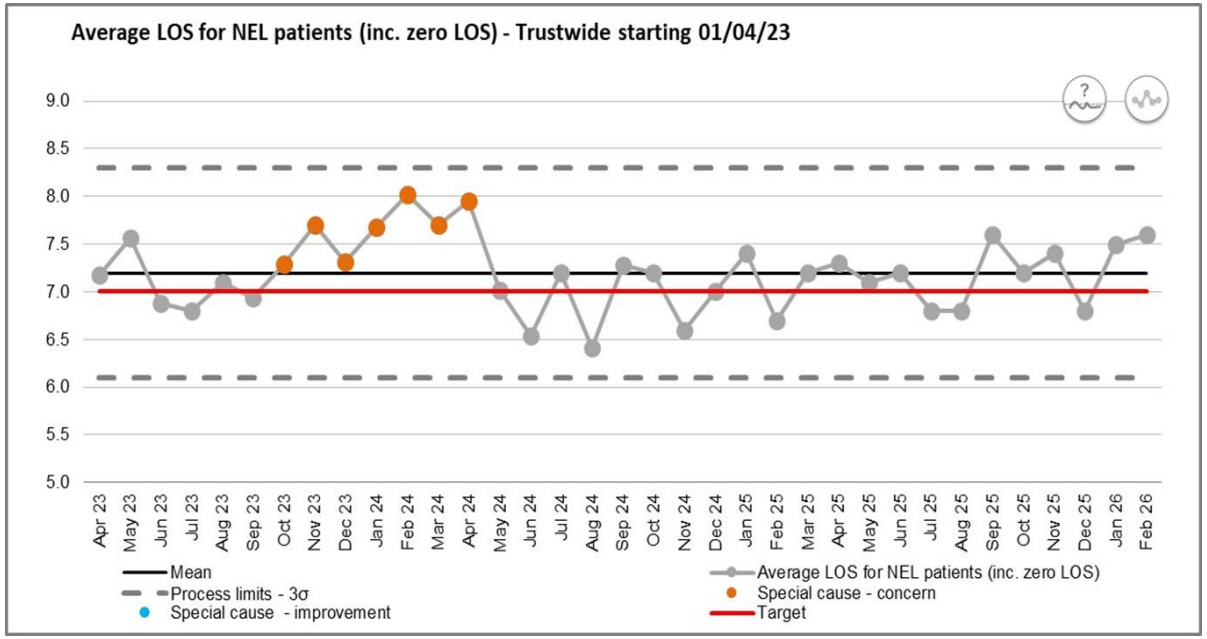
Breakthrough priority metric: Average Length of Stay (LOS) for non-elective patients (inc. zero LOS)

Board Committee: Quality Committee

SRO: Dom Hardy

Assurance	Variation
?	~

Royal Berkshire NHS Foundation Trust



Insight Metrics	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Ave LOS for NEL patients (inc. zero LOS	7.10	7.40	6.8	7.5	7.4	7.9
Bed Occupancy (%)	86%	85%	81%	87%	87%	91%
No. of patients with zero day LoS	677	555	677	570	570	476
Ave number patients > 7 days	248	250	236	273	273	253
Ave number patients > 21 days	85	80	80	90	90	87
Ave no. of patients through discharge lounge per day	19	19	15	15	15	16

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

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

How are we performing:

- LOS increased (0.7 days) in Feb to 7.9 days
- Excluding same day admissions this is 7.6 days against a target of 7.3 days
- This is a worsened position compared to Feb 24

Actions and next steps

- Continued drive for improved accuracy of targeted day of discharge, Jan improved to 55% vs the target of 60%
- Continued focus on early use of Discharge Lounge. Feb saw 46% of patients discharged via the DCL DCd before midday (target = 50%).
- Usage of the discharge lounge was down at 415 patients in Feb (target = 500) with 247 patients before 12pm. Reduction was primarily due to transport uncertainty. This is being addressed with the provider.
- Refining the new process to highlight community bed capacity and demand and identifying patients 1 working day in advance is underway.
- Winter resilience meetings continue with CH

Risks:

- Winter pressure and increased patient moves / discharge to non-optimal ward

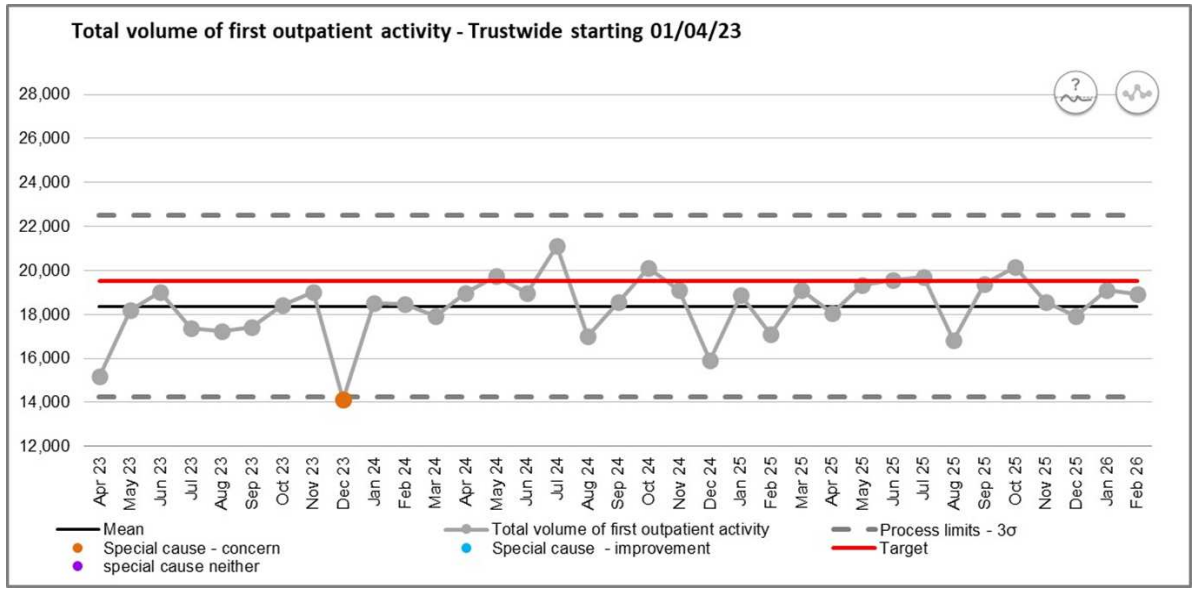
Breakthrough priority metric: Total Volume of first Outpatient (OP) Activity

Board Committee: Quality Committee

SRO: Andrew Statham

Assurance	Variation
	

Royal Berkshire NHS Foundation Trust



Insight Metrics	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Total Volume of first outpatient activity	19,396	20,161	18,577	17,942	19,097	18,902
First outpatient activity Plan	20,390	21,317	18,536	19,463	19,463	18,536
% of patients waiting over 12 weeks All patients, wait to first assessment	77.48%	73.73%	71.50%	75.55%	70.27%	69.39%
No. of patients waiting >52wks RTT national standard	40	34	37	45	32	43
% OP that did not attend/were not brought (1st OP Appt)	8.0%	8.1%	8.5%	8.5%	7.9%	7.6%
% triage within 2 working days for all GP referrals (including 2 week wait, urgent and routine)	47.46%	40.5%	46.4%	48.5%	54.3%	56.3%

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 February shows that we delivered 18.9k 1st OPA which is higher than our plan in-month. This data is provisional and may increase as the data is refreshed in coming weeks.

Actions and next steps

- Q4 intervention focused on increased 1st OPA and OPPROC activity. Focus will be targeted on challenged services, but open to all services.
- The opt-in process for booking MSK Physiotherapy appointments has been extended to the entirety of Physiotherapy for routine appointments. Patients can now use the Royal Berkshire Connect platform to opt in for their appointment.
- The go-live date for ENT remote monitoring is by 30 April-26. Work will start after for the Antenatal obstetrics remote dashboard.
- The go-live date for patient initiated follow up through both EPR and Royal Berkshire Connect integration is by 30 April 26.

Risks: Corporate Risk 5698

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

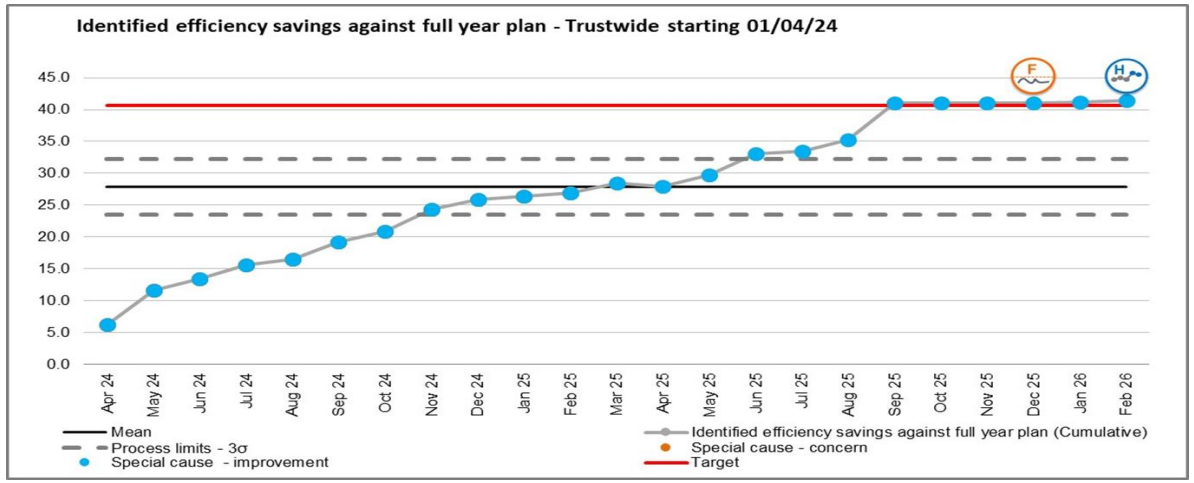
Breakthrough priority metric:
Identified efficiency savings against full year plan (£40.60m)

Board Committee: Finance & Investment Committee

SRO: Dom Hardy

Assurance	Variation
F	H

Royal Berkshire NHS Foundation Trust



Insight Metrics	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26
Cumulative identified efficiency savings against full year plan (£40.60m)	£41.05m	£41.05m	£41.05m	£41.05m	£41.20m	£41.36m
Total Delivery against identified efficiency savings (%)	41.8%	49.4%	55.88%	62.22%	72.21%	78.24%
Delivery against identified efficiency savings: Corporate Services (%)	33.09%	38.88%	48.17%	50.61%	63.00%	69.13%
Delivery against identified efficiency savings: Commercial (Procurement & Income) %	47.90%	56.08%	60.69%	64.41%	78.45%	84.38%
Delivery against identified efficiency savings: Other local opportunities (%)	40.37%	50.99%	58.35%	68.13%	80.44%	89.79%
Identified efficiency savings %: Recurrent	49.89%	43.99%	43.72%	39.8%	42.6%	42.8%
Identified efficiency savings %: Non-recurrent savings	50.11%	56.01%	56.28%	60.2%	57.4%	57.2%

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

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

How are we performing

- Our efficiency savings target is £40.60m for the 2025/26 financial year
- At year-to-date M11 February 2026, we delivered £32.36m of £41.36m efficiency savings identified.

Actions and next steps:

- Fully track the progress of care groups and corporate directorates to ensure the ten-point action plan continue to be delivered.
- Urgent care is £(0.13)m behind forecast, the requirement is to remain on budget for the rest of the year.
- Planned care holding vacancies to deliver the WTE efficiencies
- Networked Care is within trajectory YTD, however urgent focus should remain in all areas.

Risks: - Corporate Risk 4182

The non delivery of identified efficiency savings

Royal Berkshire
NHS Foundation Trust

Watch Metrics

Summary of alerting watch metrics

Royal Berkshire NHS Foundation Trust

Introduction:

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

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

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

Alerting Metrics February 2026:

In the last month 14 of the 110 metrics exceeded their process controls, two more than last month. These are set out in the table opposite.

There are no new alerting watch metrics this month.

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

Provide the highest quality of care for all

- C.diff (Cumulative – Trust Apportioned) 48 cases against a threshold of 39.
- Number of unborn babies on child protection plan remains high.
- Complaints turnaround time within 25 days 67%% Trustwide

Invest in our staff and live out or values

- % of staff from global majority backgrounds in senior AFC Bands 8a and above, currently sitting at 22.65%, with a target of 25.00%
- Rolling 12 month Sickness Absence data is in arrears but unlikely to meet target based on previous months and winter pressures
- Violence, Aggression and Abuse from patients towards staff has increased

Deliver in Partnership

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

Achieve long term sustainability

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

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

Watch metrics

SROs: Katie Prichard-Thomas

Janet Lippett

NHS Royal Berkshire NHS Foundation Trust

Metric	Variati	Assura	Target	Dec-25	Jan-26	Feb-26	Feb-25
Never Events			0	1	1	0	0
Pressure ulcer incidence per 1000 bed days			1.00	0.15	0.30	0.28	0.06
Category 2 avoidable pressure ulcers			5	2	1	1	1
Category 3 avoidable pressure ulcers			0	1	0	2	0
Category 4 avoidable pressure ulcers			0	0	0	0	0
Unstageable avoidable pressure ulcers			0	0	0	0	0
Patient Falls per 1000 bed days			5.00	3.94	3.74	3.42	3.44
Patient falls resulting in harm (PSIRF methodology applied)			-	2	2	0	0
No. of DOLS applications applied for			-	37	27	22	19
No. of detentions under the MH act to RBH			-	5	2	0	2
% of staff: Safeguarding children L1 training			90.00%	97.10%	96.70%	96.80%	96.80%
No. of child safeguarding concerns by the Trust			-	136	172	102	135
No. of adult safeguarding concerns by the Trust			-	83	62	76	34
No. of safeguarding concerns against the Trust			-	5	7	9	6
Unborn babies on child protection (CP) / child in need plans (CIP)			-	43	38	45	44
C.Diff (Cumulative - Trust Apportioned)			39	39	46	48	51
C.Diff lapses in care			-	3	6	2	2
MRSA Bacteraemia (avoidable)			0	0	1	0	0
E.coli (Trust Apportioned) Bloodstream Infections			-	8	5	4	10
E.coli (Trust Apportioned) Bloodstream Infections (Cumulative)			92	72	77	81	91
MSSA surveillance (trust acquired)			-	3	0	6	3
Hand Hygiene			95.00%	96.06%	97.27%	98.64%	96.85%
VTE inpatient (excluding short stay/maternity) risk assessment / prescription compliance			95.00%	97.10%	Arrears	Arrears	97.10%
Hospital Acquired Thrombosis (HAT) rate / 1000 inpatient admissions			0.00	2.32	Arrears	Arrears	0.82
Medication incidents per 1000 bed days			0.00	7.09	6.43	7.45	5.59

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

Watch metrics

SROs: Katie Prichard-Thomas

Janet Lippett

NHS Royal Berkshire NHS Foundation Trust

Metric	Variation	Assurance	Target	Dec-25	Jan-26	Feb-26	Feb-25
No. of compliments			-	52	27	40	49
FFT Satisfaction Rates Inpatients: i.Inpatients			95%	94%	94%	95%	97%
FFT Satisfaction Rates Inpatients: ii.ED			95%	83%	78%	81%	80%
FFT Satisfaction Rates Inpatients: iii.OPA			95%	96%	96%	95%	96%
FFT Satisfaction Rates Inpatients: iv.Daycases			95%	98%	98%	100%	96%
FFT Satisfaction Rates Inpatients: v.Children and Young People			95%	89%	96%	100%	96%
Mixed sex accommodation - breaches			0	264	615	283	264
Myocardial Ischaemia National Audit Project (MINAP): Door-to-Balloon target of less than 90 minutes			97%	93%	80%	Arrears	100%
Myocardial Ischaemia National Audit Project (MINAP): Call-to-Balloon target of less than 120 minutes			86%	77%	50%	Arrears	45%
Myocardial Ischaemia National Audit Project (MINAP): Call to Balloon target less of than 150 minutes			82%	85%	75%	Arrears	100%
No. of Patient Safety Incident Investigations (PSII)			-	4	1	1	2
Number of Rapid Reviews			-	0	0	0	4
No. of After Action reviews			-	0	1	0	1
No. of Multidisciplinary Team (MDT) reviews			-	2	2	1	1
No. of Thematic reviews			-	0	0	0	3
Number of Complaints			-	54	90	71	27
Complaints turnaround time within 25 days (%)			80%	63%	59%	67%	43%
Mortality Metrics	**Variation**	**Assurance**	**Target**	**Oct-24**	**Nov-24**	**Dec-24**	**Dec-23**
Crude mortality			-	1.20	1.40	1.40	1.60
HSMR			100.0	97.0	98.1	101.0	82.9
SMR			100.0	97.5	98.3	100.2	83.0
SHMI			1.00	1.04	1.04	1.05	1.00

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

Maternity Watch metrics

SROs: Katie Prichard-Thomas

Janet Lippett

NHS
Royal Berkshire
NHS Foundation Trust

Metric	Variation	Assurance	Target	Dec-25	Jan-26	Feb-26	Feb-25
Deliveries			-	409	373	375	344
Bookings			-	442	527	429	445
% of Inductions of labour			-	22.7%	28.7%	24.8%	27.5%
Perinatal mortality rate (rolling year per 1000 births)			4.84	5.43	6.16	6.31	3.83
Number of occassions MLU service suspended for 4 hours or more			4	8	Arrears	Arrears	4
Midwifery staffing vacancy rate			-	0.0%	0.0%	0.0%	0.0%
Midwifery staffing turnover			14.0%	11.7%	11.3%	10.4%	11.1%
Midwife : birth ratio (utilised workforce)			1.22	1.22	1.21	Arrears	01:19
FFT Satisfaction Rates Maternity			95.00%	97.40%	95.80%	96.20%	97.50%
No. of complaints - Maternity			3	5	5	1	4
Complaints response Rate			80.00%	0.00%	30.00%	0.00%	-
Number of Rapid Reviews			-	5	5	8	0
No. of After Action reviews			-	0	0	0	4
No. of Patient Safety Incident Investigations (PSII)			-	1	0	1	0
Percentage of babies born with features associated with potential hypoxia			0.00%	0.23%	0.00%	0.26%	0.85%

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

Watch metrics:

SRO: Paul Dagama

Royal Berkshire NHS Foundation Trust

Metric	Variation	Assurance	Target	Dec-25	Jan-26	Feb-26	Feb-25
% of staff from global majority backgrounds in senior AFC Bands 8a and above	H	F	25.00%	22.65%	23.28%	23.82%	19.95%
Rolling 12 month Sickness absence	H	F	3.3%	3.8%	3.7%	Arrears	3.9%
% Fill rate of Registered Nurse Shifts (RN)	L	P	90.0%	93.2%	95.6%	95.2%	96.6%
% Fill rate of Care Support Worker Shifts (CSW)	L	P	90.0%	95.6%	98.2%	96.7%	105.1%
Completed Mandatory Training		P	90.0%	92.8%	92.8%	92.2%	92.9%
Appraisals	H	F	90.0%	90.3%	89.7%	88.0%	87.6%
Nurse Staffing Red Flags			-	54	55	52	33

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

Watch metrics:

SRO: Paul Dagama

NHS Royal Berkshire NHS Foundation Trust

Metric	Variation	Assurance	Target	Dec-25	Jan-26	Feb-26	Feb-25
RIDDOR reportable Incidents			-	0	2	2	0
Abuse/V&A (Patient to staff)			-	75	77	54	55
Body fluid exposure/needle stick injury			-	16	34	21	18
Environment Related Incidents			-	13	26	15	19
Conflict Resolution		?	90%	90%	90%	90%	89%
Fire (Annual)	H	?	90%	93%	93%	92%	91%
Moving and Handling Level 1	H	?	90%	95%	95%	95%	91%
Moving and Handling Level 2		?	90%	89%	90%	90%	91%
Health and Safety Training			-	96%	96%	96%	96%
Slips and Trips			-	5	8	2	1
Musculoskeletal - Inanimate object			-	1	4	2	3
Total non clinical incidents reported			-	234	313	242	223

Strategic Objective: **Partnering for Impact**

Watch metrics

SRO: Dom Hardy

Royal Berkshire NHS Foundation Trust

Metric	Variation	Assurance	Target	Dec-25	Jan-26	Feb-26	Feb-25
Fractured Neck of Femur: Surg in 36 hours			60.0%	57.0%	57.0%	48.0%	59.4%
Proportion of patients admitted directly to an acute stroke unit within 4 hours of hospital arrival		F	90.0%	69.0%	63.0%	72.0%	59.0%
Proportion of patients spending 90% of their inpatient stay on a specialist stroke unit (national target)	H	?	80.0%	94.0%	86.0%	89.0%	78.0%
Proportion of people with high risk TIA fully investigated and treated within 24hrs (IPM national target)	H	F	90.0%	87.0%	93.0%	95.0%	90.0%
Cancer 31 day wait: to first treatment		?	96.0%	95.1%	91.5%	97.7%	97.2%
62 Day screen Ref		?	85.0%	93.8%	86.2%	92.3%	64.3%
Cancer Incomplete 104 days	L	F	0	48	57	51	55
Average waiting times in diagnostic (DM01) services	L	?	6	3	3	1	5
Diagnostics Waiting < 6 weeks (DM01) (%)		F	99.0%	78.0%	78.7%	86.0%	90.4%

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

Watch metrics

SRO: Andrew Statham

NHS Royal Berkshire NHS Foundation Trust

Metric	Variation	Assurance	Target	Dec-25	Jan-26	Feb-26	Feb-25
% OP appointments done virtually			-	19.1%	19.3%	19.5%	20.0%
Number of OPPROC			-	13653	14214	13338	12715
Number of MDT OP			-	764	809	813	736
Number of PIs			-	142	142	143	129
Number of active research trials			-	199	200	202	161
Number of projects supported by HIP			-	64	64	64	63

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

Watch metrics

SRO: Frances Khatcherian

NHS Royal Berkshire NHS Foundation Trust

Metric	Variation	Assurance	Target	Dec-25	Jan-26	Feb-26	Feb-25
Pay cost vs Budget (£m)			-	-1.15	-1.01	-1.40	-0.82
Non pay cost vs Budget (£m)			-	-0.73	-0.85	2.62	-2.88
Income vs Plan (£m)			-	1.95	2.38	0.47	2.81
Daycase actual vs Plan (£m)			-	-1.22	0.52	-0.13	0.68
Elective actual vs Plan (£m)			-	-0.58	-0.12	-0.30	0.33
Outpatients actual vs Plan (£m)			-	0.28	-6.87	0.89	-0.16
Non-elective actual vs plan (£m)			-	-0.36	1.20	-0.14	-0.07
A&E actual vs plan (£m)			-	-0.03	1.34	0.41	0.04
Drugs & devices actual vs plan (£m)			-	1.02	-5.05	-0.75	1.06
Other patient income (£m)			-	-0.14	-0.07	-0.07	-0.17
Delivery of capital programme (£m)			-	2.67	4.33	6.03	6.25
Cash position (£m)			-	5.35	8.01	22.52	13.00
Agency spend % of total staff cost (%)			-	0.4%	0.4%	0.4%	1.0%
Creditors (£m)			-	-82.79	-91.15	-85.43	-75.38
Debtors (£m)			-	52.77	62.71	43.93	45.11
Better Payment Practice Code (BPPC) *paying supplier invoices within 30 days of date of invoice (%) YTD			95.00%	88.80%	88.40%	88.20%	76.40%
Better Payment Practice Code (BPPC) *paying supplier invoices within 30 days of date of invoice (%) In Month			95.00%	85.30%	84.70%	85.50%	74.20%

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Title:	Integrated Performance Report (IPR) Refresh final recommendations
Agenda item no:	8
Meeting:	Board of Directors
Date:	25 March 2026
Presented by:	Dom Hardy, Chief Operating Officer
Prepared by:	Rebecca Cullen, Associate Director of Strategy and Performance

Purpose of the Report	Provide the committee the final recommendations for the IPR refresh

Report History	Operational Management Committee 16 March 2026 Executive Management Committee 23 March 2026 Private Board 25 February 2026

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

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

Strategic objectives. This report impacts on (tick all that apply)**:**	
Delivering the highest quality of 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:			
1. Leadership ✓	2. Vision & Strategy ✓	3. Culture ✓	4. Governance ✓
5. Risks, Issues & Performance ✓	6. Information Management ✓	7. Engagement ✓	8. Learning & Innovation ✓

Publication						
Published on website		Confidentiality (FoI)	Private		Public	✓

1. Executive summary

1.1. The metrics within the Integrated Performance Report (IPR) should be reviewed, and subsequently refreshed if areas are identified, at least annually, aligned to financial year end.

1.2. In November 2025, our refreshed strategy, Our Trust Strategy 2025-2030, was published. It sets out our priorities and ambitions for the next five years. These will need to be reflected in the IPR refresh for 2026/2027.

1.3. And in June 2025, NHS England published the first NHS Oversight Framework (NOF). The NOF is a transparent approach to assessing ICBs and Trusts and is also used as a public platform for performance accountability. The NOF metrics are reflected throughout the IPR, which allows us a 'real-time' view of how we are performing against these measures and where we are likely to land in the NOF assessments. Appendix 1 sets out where the NOF measures are currently nested in the IPR.

1.4. This paper sets out the final proposals following the Senior Responsible Officer (SRO), Operational Management Team (OMT), Executive Management Committee (EMC) and Board engagement for each metric. A summary of the changes suggested in light of this engagement is set out in Appendix 2.

1.5. The Board are asked to approve the final recommendations.

2. Background to the Integrated Performance Report (IPR)

2.1. The Integrated Performance Report is a key part of the Trustwide Performance Oversight Architecture which shows alignment through all governance levels of the Trust – from Ward to Board. It tracks progress on the key performance indicators aligned to our strategy, as well as reporting on significant assurance metrics.

2.2. The current IPR presents our 5 Strategic Objectives, with 8 Strategic Metrics identified to track progress against them.

2.3. Alongside the priority indicators, the IPR also reports on a wider set of 115 watch metrics, highlighting any indicators requiring extra attention. A series of statistical measures and qualitative insight is used to guide decision making where additional focus is required.

2.4. Alerting watch metrics are monitored and explored by the Quality committee. Any issues are then escalated to the Board as required via the Committee Chair template.

3. Reviewing and refreshing the IPR –process and timelines

3.1. The IPR should be reviewed, and subsequently refreshed if areas are identified, at least annually, aligned to financial year end.

3.2. This year, we may expect to see a more significant change in some of our strategic metrics with the refresh of the Trust strategy, published in November 2025.

3.3. As per the previous refreshes, it has been agreed that the strategic metrics and breakthrough priorities would be reviewed against the following 6 criteria:

Clarity – is movement in the metric definitively clear and understandable? E.g. is an increase or decrease unarguably good or bad? *Note: for some metrics such as patient safety incidents this is not possible and accepted as part of our business rules*.
Influenceable – is the metric amenable to intervention over the course of the reporting cycle? i.e. will the metric demonstrate whether changes are making improvements in the monthly cycle of the IPR
Outcome-driven – does the metric/priority measure outcomes and not inputs?
Effective - Is the metric the best measure of success/failure for the strategic objective? Or is it a surrogate or proxy measure?
Comprehensive –is this metric/priority inclusive and representative of the staff, patients and communities we serve? And is this metric representative of all/multiple specialties?
Accurate – is the data used for this metric accurate, reliable and up-to-date?

4. Watch Metrics, the NHS Oversight Framework (NOF) and the 'Neighbourhood Health Framework'

4.1. In June 2025, NHS England published the first NHS Oversight Framework (NOF). The NOF is a transparent approach to assessing ICBs and Trusts and is also used as a public platform for performance accountability.

4.2. Most of the NOF metrics (that meet the criteria set out in 3.3) are reflected throughout the IPR, which allows us a 'real-time' view of how we are performing against these measures and where we are likely to land in the NOF assessments. Appendix 1 sets out where the NOF measures are currently nested in the IPR.

4.3. The Board and OMT have recommended that the three indicated (yellow highlighted) metrics in Appendix 1 from the NOF that are not currently reflected in our IPR be added to the watch metrics.

4.4. The watch metrics have also been reviewed to streamline where possible, fall in line with new national guidance around maternity, and to include additional watch metrics in digital and estates. The full suite of watch metrics will be finalised and agreed with SROs ready for the refreshed IPR.

4.5. Last week, on 17 March 2026, the UK Government also published the 'Neighbourhood Health Framework' which set out 5 core goals and associated objectives over the medium and long term. A summary of these goals can be found in Appendix 3. Some of the acute-related metrics identified are already reflected in the IPR, and the remaining ones will be reviewed and added into the watch metrics as required.

5. Ask of the Board

5.1. The tables overleaf show the final recommendations for the strategic metrics and breakthrough priorities following engagement with the SROs, OMT, EMC and Trust Board. A summary of the feedback and rationale from the engagement can be found in Appendix 2.

5.2. **The Board are asked to approve the final recommendations for the IPR.**

New Strategic Objective and underpinning priorities	Current Strategic Metric	Strategic Metric proposal (bold) and Insight Metrics
Delivering the highest quality of care for all • Person-centred and personalised care • Communication that works for everyone • Increasing accessibility of all our services • Addressing health inequalities • Improving patient experience and comfort • Listening, learning, and acting on feedback transparently	I was listened to, well informed & involved in decisions about my care (FFT response) SRO: CNO	• **Person-centred care: I was listened to, well informed & involved in decisions about my care (FFT response)** • Number of complaints • Complaints turnaround in 25 days • Percentage complaints acknowledged within 3 days • Overall Trustwide FFT satisfaction rate • Overall Trustwide FFT response rate
	Learning from incidents to reduce harm: Patient safety incidents per 1,000 bed days SRO: CNO	• **Learning from incidents to reduce harm: Patient safety incidents per 1000 bed days** • % total incidents that are low/no harm • Number of deteriorating patient incidents • I felt safe during my visit to the hospital (FFT question) • Total calls for concern from patients and family • National Patient Safety Syllabus training compliance
Supporting our people to thrive • Health and Wellbeing • Growing and supporting talent • Education, development, and training • Preparing our workforce for tomorrow • Strengthening our role as a community anchor	Improve retention: Stability rate (%) SRO: CPO	• **Prioritising staff safety: Avoidable absence in days per month** • Incidents of violence and aggression • Statutory and mandatory compliance (e.g. manual handling – data to be reviewed) • Total number of freedom to speak up referrals • Number staff accessing health prevention offer (health checks plus new pathways)
Partnering for Impact • Partnering for prevention • Neighbourhood healthcare, closer to home • Patients as partners, both in their care and in health service design • Unlocking commercial, academic, and industry partnerships	Improve waiting times: ED performance against 4-hour Emergency Pathway target SRO: COO	• **Working together: Performance against 4-hour Emergency Pathway target** • Average time to first review • Number of redirects to Urgent Care Centre • Average handover time • Percentage of those waiting more than 12 hours from arrival in ED • Number of Decision to Admit (DTA)
	Improve waiting times: Reduce waits of over 62 days for cancer patients SRO: COO	• **Improve waiting times: 62-day cancer standard performance** • 62-day cancer standard trajectory • Performance against 28 day faster diagnostic standard (FDS) (%) • 31-day cancer standard performance • 31-day cancer standard trajectory • Stage cancer presentation

	Maximising elective activity: <18 week RTT standard achievement SRO: COO	• **Maximising elective activity: <18 week RTT standard achievement** • Percentage referrals returned with advice to referrer • % plan for first outpatients • % plan for combined daycase and inpatients • DM01 (diagnostics) performance • Number of patients waiting more than 52 weeks for treatment (RTT)
Driving improvement and enabling innovation • Strengthening the foundations for a smarter, and more connected future • Leveraging data and insights to drive excellence • Building on our Improving Together success • Making innovation easier and more accessible for all our staff • Innovating to improve patient experience before, during and after our care • Expanding research for all and keeping our eyes on the horizon	Increase care closer to home: Distance travelled by patients (outpatients) SRO: CSO	• **Digitally enabling our patients: % of patients accessing patient portal / NHS app** • % services live on patient portal / NHS App • Number of patient portal logins • Advice and guidance (A&G) activity
	New metric SRO: CSO	• **Royal Berks @ Home: Percentage of total inpatients cared for in virtual hospital** • % patients accessing patient portal / NHS app • Number of virtual attendances • Number of patients using remote monitoring • Distance travelled by our patients for outpatient appointments (average miles)
Building a sustainable future together • Planning for the long-term to achieve financial sustainability • Maximising our current estates, whilst getting ready for our new hospital • Evolving future-forward clinical support services • Collaborating across our Thames Valley Acute Provider Collaborative • Protecting our environment	Live within our means: Trust income and expenditure performance SRO: CFO	• **Living within our means: Cash position (£)** • Underlying financial position • In-month variance to plan: Pay • In-month variance to plan: Non-pay • In-month WTE (incl bank and agency)
	Productivity (activity / whole time equivalent) SRO: CFO/CSO	• **Increasing efficiency: Productivity growth (activity/whole time equivalent)** • Cost weighted activity (CWA) % growth • Whole Time Equivalent (WTE) % growth • NHSE Productivity growth estimate

Current Breakthrough Priority Metric	Emerging Breakthrough Priority proposal and Insight Metrics
Average Length of Stay for non-elective patients (including zero length of stay) SRO: COO	• **Caring for our patients in the safest place: average length of stay for non-elective patients** • No. patients with zero-day length of stay • Waiting time for community hospital bed • % inpatients with no criteria to reside/medically optimized for discharge • Community bed utilisation • Delays to social care packages
Total volume of first outpatient activity SRO: CSO	• **Total volume of first outpatient activity** • Average wait for first outpatient appointment • First outpatient activity plan • % patients waiting over 12 weeks for first assessment • % first outpatients that did not attend/were not brought • % triage within 2 working days for all GP referrals
Identified efficiency savings against full year plan (£40.6m) SRO: COO	• **Sustainable and future focused workforce: Total WTE worked** • Contracted worked • Bank and agency • Safe skill mix • Internal promotion (all bands) – proportion vacancies filled with internal applicants • Stress, anxiety and depression absence (number of days lost)

Appendices

Appendix 1: NHS Oversight Framework metrics and our IPR

NOF Metric	In IPR?	Where?
Access domain metrics		
Percentage of cases where a patient is waiting 18 weeks or less for elective treatment (absolute performance and performance compared to plan)	Yes	Strategic Metric
Percentage of cases where a patient is waiting more than 52 weeks for elective treatment	Yes	Strategic Metric
Percentage of patients diagnosed with cancer or ruled out within 28 days of an urgent referral	Yes	Insight Metric (and proposal to move to Strategic Metric)
Percentage of patients treated for cancer within 62 days of referral	Yes	Strategic Metric (proposed to move to Insight)
Percentage of emergency department attendances admitted, transferred or discharged within 4 hours	Yes	Strategic Metric
Percentage of emergency department attendances spending over 12 hours in the department	Yes	Insight Metric
Effectiveness and experience of care domain metrics		
Summary Hospital Level Mortality Indicator	Yes	Watch Metric
Readmission rate band	No	Not currently represented in the IPR, opportunity to add to watch metrics or insight
CQC inpatient survey satisfaction rate	No	Good Proxy - FFT
National maternity survey score	No	Only measured once per year and reported to Board separately from the IPR
Patient safety domain metrics		
NHS Staff Survey – raising concerns sub-score	No	Only measured once per year and reported to Board separately from the IPR
CQC safe inspection score (if awarded within the preceding 2 years)	No	Not amendable to intervention within one month
Rates of Healthcare Associated Infection (MRSA, C-Difficile and E-Coli)	Yes	Watch Metrics
Percentage of inpatients acquiring a new pressure ulcer	Yes	Watch Metric
People and workforce domain metrics		
Sickness absence rate	Yes	Watch Metric
NHS staff survey engagement theme score	No	Only measured once per year and reported to Board separately from the IPR
National Education and Training Survey overall satisfaction score	No	Annual reporting of this metric
Finance and productivity domain metrics		
Planned surplus/deficit	No	Reported separately to the Board via Finance Reporting

Variance year-to-date to financial plan	Yes	Breakthrough Metric
Implied productivity level	Yes	Strategic Metric
Percentage of inpatients referred to in-house tobacco treatment services who make a supported attempt to quit stop smoking	No	Not currently represented in the IPR, opportunity to add to watch metrics or insight
Percentage of people waiting over 6 weeks for a diagnostic procedure or test	Yes	Watch Metric
Under 18s elective waiting list growth	No	Not currently represented in the IPR, opportunity to add to watch metrics or insight

Appendix 2 IPR Refresh Engagement feedback

New Strategic Objective and underpinning priorities	Engagement feedback and rationale
Delivering the highest quality of care for all • Person-centred and personalised care • Communication that works for everyone • Increasing accessibility of all our services • Addressing health inequalities • Improving patient experience and comfort • Listening, learning, and acting on feedback transparently	**Proposal: Person-centred care: I was listened to, well informed & involved in decisions about my care (FFT response)** Desire to maintain current Strategic Metric but may wish to change this in-year as scoping for 'Experience First' Strategic Programme is completed. Insights changed to reflect performance around complaints and further detail on complaints breakdown may be added to watch metrics in year with roll out of Quail digital system.
	Proposal: **Learning from incidents to reduce harm: Patient safety incidents per 1000 bed days** Maintaining the current metric to reflect QSIRF approach with additional insight reflecting challenge in compliance with national training.
Supporting our people to thrive • Health and Wellbeing • Growing and supporting talent • Education, development, and training • Preparing our workforce for tomorrow • Strengthening our role as a community anchor	**Proposal: Prioritising staff safety: Avoidable absence in days per month** Staff safety was a subject in our Staff Survey results and this proposal reflects several facets (with metrics that meet our criteria) of staff safety performance. This metric should include, but not be limited to, workplace trips or fall, work related stress, MSK related to work.
Partnering for Impact • Partnering for prevention • Neighbourhood healthcare, closer to home • Patients as partners, both in their care and in health service design • Unlocking commercial, academic, and industry partnerships	**Proposal: Working together: Performance against 4-hour Emergency Pathway target** Suggested maintenance of current strategic metric but changes to insight metrics to reflect partnership aspects of the pathway.
	Proposal: Improve waiting times: 62-day cancer standard performance Suggested maintenance of current strategic metric to remain aligned with national direction and inclusion of new insight metric to reflect stage presentation.

	Proposal: Maximising elective activity: <18 week RTT standard achievement Strategic metric maintained but again insights amended to reflect partnership working, demand and diagnostics capacity. As part of our elective recovery work we are exploring a whole patient administration system approach to waitlist management that would encompass both RTT and non-RTT activity, this could be reflected in the IPR once completed.
Driving improvement and enabling innovation • Strengthening the foundations for a smarter, and more connected future • Leveraging data and insights to drive excellence • Building on our Improving Together success • Making innovation easier and more accessible for all our staff • Innovating to improve patient experience before, during and after our care • Expanding research for all and keeping our eyes on the horizon	**Proposal: Digitally enabling our patients: % of patients accessing patient portal / NHS app** Digital is a key catalysis to unlocking benefits in both access and quality and this metric was recommended to reflect that.
	Proposal: Royal Berks @ Home: Percentage of total inpatients cared for in virtual hospital New metric suggested to reflect caring for patients in their homes linked to the Royal Berks @ Home Strategic Programme. The proposed insight metrics were amended based on OMT feedback and the emerging A3 thinking on the strategic programme. This metric should be shaped in-year if required once full strategic scoping is concluded.
Building a sustainable future together • Planning for the long-term to achieve financial sustainability • Maximising our current estates, whilst getting ready for our new hospital • Evolving future-forward clinical support services • Collaborating across our Thames Valley Acute Provider Collaborative • Protecting our environment	**Proposal: Living within our means: Cash position (£)** Cash position a good indicator of current financial health and robustness, insight metrics also recommended to better reflect current position.
	Proposal: **Increasing efficiency: Productivity growth (activity/whole time equivalent)** A move to 12 month moving average vs previous comparison to 2019/2020 as per NHS England guidance with an additional insight of the new monthly NHSE Productivity growth estimate.

Current Breakthrough Priority Metric	Engagement feedback and rationale
Average Length of Stay for non-elective patients (including zero length of stay) SRO: COO	**Proposal**: **Caring for our patients in the safest place: average length of stay for non-elective patients** Insight metrics updated to reflect wider pathway and focus of programme. Alternatively, this could have been switched with the SO3 metric on 4 hour urgent and emergency care performance, with insight metrics reflecting other key indicators of safest place across an inpatient journey such as length of stay, medically optimised for discharge, and outliers but the SRO has made this recommendation.
Total volume of first outpatient activity SRO: CSO	**Proposal: Total volume of first outpatient activity** Engagement showed a strong preference to maintaining a first outpatient breakthrough priority, with some discussion around the desired metrics. The SRO has recommended to remain as is, with first outpatient activity a good indicator for elective/RTT performance and an area of pressure for the Trust, and inclusion of the average wait time as an insight metric.
Identified efficiency savings against full year plan (£40.6m) SRO: COO / CPO	**Proposal: Sustainable and future focused workforce: Total WTE worked** Pay is the biggest driver of our position and the insight metrics suggested give a wider view on the future workforce (alongside a counterbalance with stress, anxiety and depression-related absence).

Appendix 3: Goals and objectives set out in the UK Government Neighbourhood Health Framework

Goal	Details and objectives
Goal 1: Improve health outcomes	Focus on high-priority cohorts (frailty, care homes, housebound, end of life, long-term conditions, mental health, dementia, children and young people) and other cohorts identified by local areas. Key objectives by March 2029: • 10% reduction in nonelective admissions/bed days for frailty and housebound cohorts. • 10% increase in identification of people approaching end of life and a 10 per cent reduction in their non-elective admissions/bed days. • 10% improvement in clinical outcomes for major long-term conditions where warranted, and 10 per cent increase in diabetes patients receiving all eight care processes. • 10% reduction in outpatient appointments for under16s and significant progress on reducing community waits.
Goal 2: Improve access to general practice	• 90% of clinically urgent patients seen the same day by March 2027. • Routine GP access and satisfaction baselined in 2026–27 with local goals set by ICBs in the interim.
Goal 3: Improve experience of planned care	• 25% diversion of referrals via single points of access for ten high volume specialties by March 2027, supporting RTT recovery. • 10% reduction in follow-up outpatient activity by March 2027, with neighbourhood-based follow-up for priority cohorts and cancer metrics aligned with the National Cancer Plan.
Goal 4: Improve urgent and emergency care performance	Objectives by March 2029: • Reduce non-elective admissions and emergency department (ED) attendances for high-priority cohorts (defined as severe frailty, in a care home or housebound and end of life). • Contribute towards 82% ED four-hour performance by March 2027, moving to 85% in the longer term. • Reduce category 3/4 ambulance conveyances for high-priority cohorts by expanding urgent care response. • Improve discharge efficiency (more patients discharged on their ready date; quicker discharge where delays occur).
Goal 5: Improve patient and staff satisfaction	From 2026–27: • Introduce new patient experience and outcome measures with year-on-year improvement. • 95% of people with complex needs to have a care plan by 2027. • New staff experience measures introduced in neighbourhoods with annual improvement trajectories.

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Title:	**2025 NHS Staff Survey Results**
Agenda item no:	9
Meeting:	Board of Directors
Date:	25 March 2026
Presented by:	Paul Da Gama, Chief People Officer
Prepared by:	Pete Sandham, Associate Director – Staff Experience and Inclusion

Purpose of the Report	To provide a high level Trust overview of the RBFT results from the 2024 NHS Staff Survey following the publication of the full National Data set on 12 March 2026.

Report History	Executive Management Committee 23 March 2026 Preliminary survey insights report also shared with Executive Management Committee, 26 Jan 2026 and People Committee, 20 Feb 2026

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

Resource Impact:	None
Relationship to Risk in BAF:	BAF Risk 2.2 -If we fail to uphold our Values (CARE and Diversity & Inclusion) the Trust will not be an employer of choice or considered an exemplar organisation for staff
Corporate Risk Register (CRR) Reference /score	None
Title of CRR	None

Strategic objectives This report impacts on (tick all that apply)**:**	
Delivering the highest quality care for all	
Supporting our people to thrive	✓
Partnering for impact	
Driving improvement and enabling innovation	
Building a sustainable future together	

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

Publication						
Published on website	✓	Confidentiality (FoI)	Private		Public	

1 Executive Summary

1.1 The 2025 NHS Staff Survey results were officially released on the 12th March 2026.

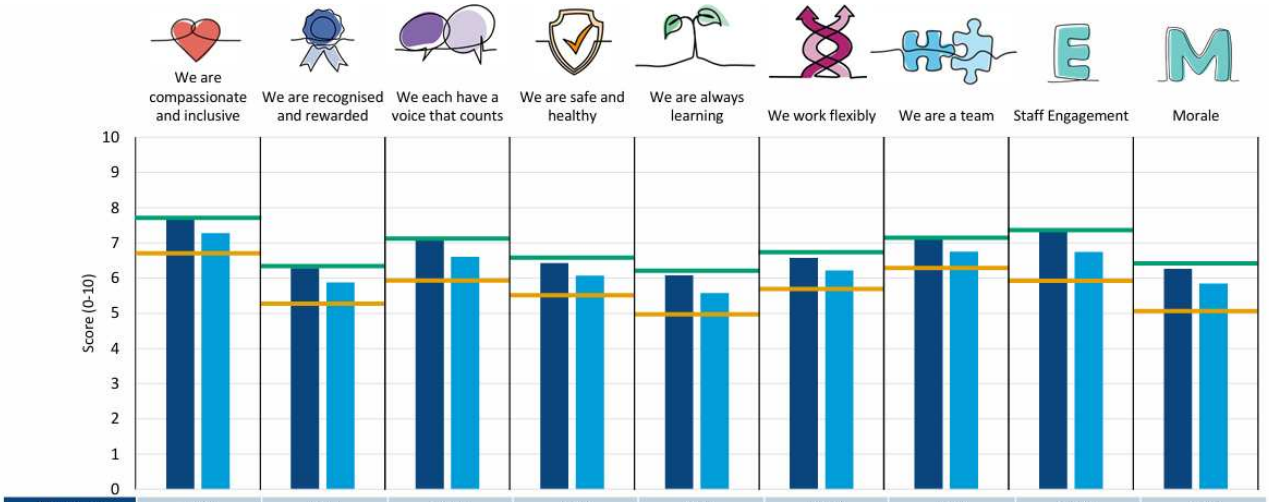
1.2 4165 staff engaged with the survey at the RBFT, delivering an overall response rate of 62% - our best ever. The 2025 Acute Trust median response rate was 47%.

1.3 The in-year performance trend at the RBFT is one of continuous improvement – further building on our excellent results from 2024. Benchmarked performance places the Trust as one of the very top performers nationally.

1.4 The 2025 survey was once more aligned to the 9 Primary People Promise Themes and 21 constituent sub themes set out in the National People Plan.

1.5 In year, Trust performance in 8 of the 9 primary themes and 19 of the 21 sub themes has once again improved.

1.6 This positive Trust Trend runs counter to the 2025 National Average Trend, which evidences overall deterioration in staff experience across the NHS. Summary of our performance across the 9 Primary People Promise Themes is set out in the graphic below.



Your org	7.68	6.29	7.12	6.43	6.08	6.57	7.14	7.34	6.26
Best result	7.71	6.34	7.12	6.58	6.21	6.74	7.14	7.36	6.42
Average result	7.28	5.87	6.60	6.07	5.57	6.22	6.75	6.74	5.84
Worst result	6.71	5.27	5.93	5.51	4.98	5.69	6.29	5.92	5.06
Responses	4151	4150	4108	4119	3890	4116	4143	4149	4155

1.6 In terms of Nationally Benchmarked Performance, the Trust is the top National Performer in two primary themes - '**We each have a voice that counts' and 'We are a Team'**. The Trust is a 'Top Five' performer in 8 out of 9 themes and 'Top Ten' in all themes.

1.7 The Trust has the 3rd highest staff recommendation rate as a place to work Nationally. Satisfaction with standard of care provided by this organisation is ranked as 8th best Nationally (but does evidence a 0.3% decrease in year)

1.8 Where marginal thematic deterioration is evident, this is reported in the Primary Theme of Staff Engagement (down 0.01, but maintaining a 2nd Best ranking Nationally). The two deteriorating sub themes are: 'Development' (down 0.02 but ranked 2nd best Nationally) and Motivation (down 0.05, but ranked 3rd best Nationally). No deteriorations are regarded statistically significant.

1.9 Full breakdown of Primary Theme and Sub them performance, trends and ranking is provided in Appendix 1.

1.10 Our most notable in year improvements are evident in the following themes/Sub themes (1) Diversity and Equality (2) Appraisals (Quality) (3) Intention to Stay (4) Compassion and Inclusion.

1.11 Underpinning primary themes and subthemes is the question level granular data. Based on 2025 performance, the Trust is the best National Acute performer on 16 specific staff experience markers, including (full list provided in Appendix 2):

- I feel my role makes a different to patients/service users
- I look forward to going to work
- I am able to make improvements happen in my area of work
- My organisation takes positive action on health and wellbeing
- My organisation acts on concerns raised by patients/service users
- Satisfaction with the extent to which my organisation values my work
- Confident that my organisation would address my concerns about unsafe clinical practice.

1.12 The 2025 survey results provide positive assurance on the cultural health of the organisation as reported by over 4000 Trust colleagues. The five year data trend evidences significant improvement in staff experience at the Trust.

1.13 Continuous improvement requires a relentless focus. Our stratified staff experience data insights by directorate/speciality provide insight into specific areas of focus drive forward experience and local, service level improvement plans are being developed and readied to be operational by the 1 April 2026.

1.14 From a Trust perspective, it remains important to continue to look underneath the headlines to identify granular Trust level trends requiring ongoing focus. In this regard, three key themes are identified:

(a) Negative experiences from patients (including violence, discrimination and bullying)

(b) Opportunities to grow and develop within the organisation

(c) Motivation and Morale in a challenging operating context

1.15 A high-level summary Trust thematic improvement plan is attached *(Appendix 3).*

2. Key Issues

2.1 The following section extracts key headlines, focussing on the Trust level position, whilst also picking up granular question level trends of note that risk being masked by a sole focus on high level thematic performance**.**

<u>We are compassionate and inclusive</u>

2.2 This People Promise theme evidences our biggest in year improvement, driven by ever improving experience of '*compassionate leadership*' and '*diversity and inclusion*' in the Trust.

2.3 Consistent and strong improvements in immediate managers supporting, listening, caring and taking action to support staff is again noted. Strong improvement in staff thinking the '*organisation values individual differences (e.g cultures, backgrounds etc')* is recorded and on this measure the Trust is the 2nd best National Performer. Experience of discrimination from colleagues, team leaders/managers is down in year.

2.4 Increase in staff experiencing discrimination from patients, relatives or members of the public is of concern and at 10.9% ranks as the 30th highest prevalence of such behaviour experience in the acute sector. Where discrimination is experienced, it is most commonly experienced on the grounds of race.

We each have a voice that counts

2.5 The RBFT is the top National Trust in this theme. The primary theme is made up of two sub themes – (i)Autonomy and Control (ii) Raising Concerns.

2.6 The continuing impact of our Improving Together Culture drives a staff experience where people feel they are '*able to make improvements happen in their work'*, which – for a 4th successive year - ranks as the very best in the country

2.7 Staff feeling both (i) *secure in raising concerns and (ii) confident that the organisation would address concerns* both improve in year and on the latter measure the Trust is the best National performer. Both findings continue to provide strong assurance on our safety culture.

We are safe and healthy

2.8 General improvements are noted across the theme. Burnout measures show an improving (decreasing) trend as does incidence of work related stress and experience of bullying from other colleagues/managers (10th lowest prevalence Nationally). The Trust maintains its position as the top National Performer in staff believing the Trust '*takes positive action on Health and Wellbeing'*. Sexual Safety at work indicators trend favourably in year and on experience of unwanted behaviour of a sexual nature from other colleagues – the Trust reports the 6th lowest prevalence Nationally.

2.9 Some clustered trends beneath the headline are noted of concern. Firstly, colleagues experience of physical violence from patients, relatives or other members of the public has increased in year (up to 14%). Secondly, 26% of colleagues experienced bullying, harassment or abuse from patients, relatives or members of the public (41st highest prevalence Nationally).'Thirdly, the number of colleagues reporting incidents of physical violence experience has dropped 5% in year to 74%.

We are Always Learning

2.10 Staff feeling '*supported to develop their potential* improves and ranks 2nd best Nationally. Conversely however, staff belief that '*there are opportunities to develop their careers in the organisation*' have deteriorated slightly. Measures of appraisal quality improve in year and continue to benchmark well above National average.

We are a Team

2.11 This theme, comprising measures of both *'team working'* and *'line management'* is a top performing theme Nationally. Covering areas such as respect from colleagues; shared objectives, discussing team effectiveness; understanding of roles; freedom to operate – it provides strong assurance of a culture of collaboration.

Morale

2.12 Morale at the Trust, as reported through the survey improves in year and benchmarks at the 4th highest levels in the sector. '*Likelihood of Leaving'* measures continue to trend and benchmark favourably providing positive assurance for onwards retention. In staff believing '*there are enough staff in the organisation to enable them to do their job'*, the Trust benchmarks as 5th best Nationally

3. Conclusion

3.1 The 2025 survey results provide an overall very positive assurance on the quality of staff experience and the cultural health of the organisation as reported by over 4000 Trust colleagues.

3.2 The survey results provide evidence of strong and consistent in year improvement; the continuation of our very strong benchmarked position Nationally and in many areas of staff experience – the very best National Performer/Number 1.

3.3 Our in year and benchmarked position is extremely strong and driven by a focus that it is crucial is maintained as we continue to deliver on our People Strategy Vision to be 'the best and most inclusive place to work in the NHS'.

3.4 Beneath the headline trends it is important to note specific areas where continued elevated focus is required in the year ahead to further drive improvements in the experience for our staff. Specifically, these areas include:

- Negative experiences from patients (including violence, discrimination and bullying)
- Continued opportunities to grow and develop within the organisation
- Motivation and Morale in a challenging operating environment

3.5 A focussed high level Trust thematic improvement plan has been developed ***(Appendix 3),*** with headline priorities for action.

3.6 Local results and analysis by Care Group, Corporate, E&F, Directorate and Speciality have already been cascaded, and results have been communicated across the organisation. Local development plans - developed and delivered by local leaders through engagement with their staff - are being shaped with expectation that they are fully operational by the end of April 2025. Local plans are key to address local variation in service performance beneath the Trust wide headline performance.

4 Attachments: The following are attached to this report:

(a) Appendix 1 **- Summary Performance and Ranking across People Promise Sub Themes**

(b) Appendix 2 ***– Summary of areas where RBFT is Top National Performer in 2025***

(c) *Appendix 3* ***- Trust Level Thematic Improvement (Plan on a Page 2026/27)***

Appendix 1:

Summary ranked benchmarked performance on each Survey primary theme and Sub Theme relative to all Acute providers at Nationally. Note: The National benchmark ranking is out of 121 Acute Trusts. A ranking of 1 is always best. With some sub themes the measure is the 'absence' not the 'presence' of element

People Promise Primary Themes and Headline Recommendation Rates	2025 RBFT Scores* and 24/25 Trend (Bracketed)	2025 RBFT Ranked National position and 24/25 Trend (Bracketed)	5 Year Trend in Ranked National position
We are compassionate and inclusive	7.68 (+0.1)	4th (▲3)	▲13
We are recognised and rewarded	6.29 (+0.07)	4th (▲4)	▲21
We each have a voice that counts	7.12 (+0.03)	1st (▲1)	▲12
We are safe and healthy	6.43 (+0.07)	2nd (▲3)	▲5
We are always learning	6.08 (+0.06)	3rd (▲4)	▲8
We work flexibly	6.57(+0.06)	8th (▲6)	▲6
We are a team	7.14 (+0.06)	1st (▲2)	▲2
Staff Engagement	7.34 (-0.01)	2nd (-)	▲5
Morale	6.26 (+0.06)	4th (▲8)	▲10
Headline Recommendation Rates			
I would recommend my organisation as a place to work (Agree/Strongly Agree)	74.5% (+1.6%)	3rd (▲3)	▲14
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation (Agree/Strongly Agree)	78.5% (-0.3%)	8th (▲1)	▲13

People Promise Sub Themes	People Promise Sub Themes	2025 Performance and 24/25 Trend	2025 RBFT Ranking and 24/25 Trend	5 Year trend in Ranking
We are Compassionate and Inclusive	Compassionate Culture	7.71 (+0.02)	3rd ▲1	▲6
	Compassionate Leadership	7.36 (+0.05)	4th ▲2	▲28
	Diversity and Equality	8.54 (+0.30)	22nd ▲8	▲35
	Inclusion	7.12 (+0.02)	6th ▲1	▲26
We each have a voice that counts	Autonomy and Control	7.31 (+0.03)	1st ▲2	▲11
	Raising Concerns	6.94 (+0.03)	2nd ▲2	▲11
We are Safe and healthy	Health and Safety Climate	5.87 (+0.01)	3rd ▲4	▲8
	Burnout	5.29 (+0.03)	2nd ▲3	▲4
	Negative Experiences	8.11 (+0.13)	7th ▲9	▲4
We are always learning	Development	6.74 (-0.02)	2nd ▲3	▲10
	Appraisals	5.4 (+0.15)	12th ▲8	▲5
We work flexibly	Support for Work life Balance	6.72 (+0.07)	2nd ▲3	▲21
	Flexible Working	6.42 (+0.05)	19th ▲5	▲5
We are a Team	Team Working	7.07 (+0.06)	1st ▲1	▲10
	Line Management	7.22 (+0.07)	4th (-)	▲27
Staff Engagement	Motivation	7.24 (-0.05)	3rd (-)	▲16
	Involvement	7.24 (+0.01)	1st ▲1	▲9
	Advocacy	7.54 (+0.02)	4th ▲2	▲7
Morale	Thinking about leaving	6.41 (+0.10)	9th ▲11	▲22
	Work Pressure	5.71 (+0.02)	7th ▲6	▲3
	Stressors	6.68 (+0.09)	1st ▲7	▲15

Appendix 2:

Themes, Sub themes and specific questions where the RBFT is the top National Performer in the 2025 NHS Staff Survey

People Promise Themes	We each have a voice that counts
	We are a Team

People Promise Sub Themes	Autonomy and Control
	Team Working
	Involvement
	Stressors

Specific Survey Question
I feel that my role makes a difference to patients/service users
My organisation acts on concerns raised by patients service users
Satisfaction with recognition I get for good work
Satisfaction with the extent which my organisation values my work
I always know what my work responsibilities are
I am able to make improvements happen in my area of work
Confident that my organisation would address my concerns about unsafe clinical practice
My organisation takes appositive action on health and wellbeing
In the last three months have you ever come to work despite not feeling well enough to perform your duties
The team I work in has a set of shared objectives
The team I work in often meets to discuss the teams effectiveness
My Team has enough freedom in how to do its work
In my team disagreements are dealt with constructively
Teams within this organisation work well together to achieve their objectives
My immediate manager gives me clear feedback on my work
I look forward to going to work

Appendix 3: 2025 NHS Staff Survey Trust Level Thematic Improvement (Plan on a Page)				
Priority Sub Theme	**Improvement Opportunities**	**Headline Programmes of Work**	**When**	**Who**
Negative Experience	Colleagues continue to experience unacceptable levels of bullying, abuse, discrimination and violence from patients, relatives or members of the public. Fewer colleagues are formally reporting incidents of physical violence. 7.5% of colleagues report experiencing unwanted conduct of a sexual nature from patients (38th lowest prevalence Nationally)	Enhanced integration of our internal 'Up the Anti' campaign into external and public facing spaces Promotion and operationalisation of Operation Cavell and 'No Excuse for Abuse' programmes Trust wide visibility and communication around application of Yellow, Amber, Red scheme application Priortised communication and focus on fundamental importance of reporting incidents	Ongoing throughout the year	Various
Growth and Development	Views around opportunities to *'develop careers'* in the Trust have declined slightly in year. View on fairness of opportunities for career progression/promotion benchmark as 13th best Nationally. Retention indicators (colleagues indicating they intend to stay with the Trust) are improving.	Focus on RISE talent management pathways as springboards for onward progression Enhanced utilisation of internal secondment opportunities Specific focus on non-clinical career pathways and attraction strategies	Various	Learning and OD and Recruitment Teams
Motivation and Morale	Whilst benchmarked performance in 'motivation' and 'morale' remains very high, small deteriorations in '*enthusiasm about work*' and *'looking forward to going to work'* are reported. Satisfaction with standard of care provided by this organisation is ranked as 8th best Nationally (but does evidence a 0.3% decrease in year)	Continued strong senior communications focus on recognition and the ongoing contribution of our people. 'What Matters' staff engagement programme for 2026/27 Technological enablement's to ensure colleagues can realise maximum 'value' and 'purpose' from their work – benefiting both staff experience and patient focus.	Ongoing	Various

NHS
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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 2026/27	AS	Annually	■	■					■
	Standing Financial Instructions	FK	Annually			■				
Driving improvement and enabling innovation	Trust Strategy Refresh	AS	Nov-25	■						
	Chief Executive Report	SM	Every	■	■	■	■	■	■	■
Other / Governance	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	■	■	■	■	■	■	■