Bundle Public Board of Directors 7 May 2025

0 Agenda
- 0.0 - DRAFT Public BoD Agenda May 25 v1.6 - 06.05.25

1 Chair's Welcome, Introductions, Apologies and Declarations of Interest:
Apologies from:
Christopher Brooks-Daw
Paran Govender
Nigel Stevens

2 Written Questions from the Public

3 Minutes of the Board of Directors meeting held in public on 5 March 2025
- 3.0 - DRAFT Public BoD Minutes March v1.1 - 19.03.25

4 Action List and Matters Arising
- 4.0 - Public BoD Action List Mar 25 v1.0 - 21.03.25

5 Governor Log of Assurance Questions and Responses (for information)
- 5.0 - Governor Log of Assurance Questions v1.0 - 02.05.25

6 Items discussed at Private Board

7 Patient Story
- 7.0 - Patient Story cover sheet to Board of Directors 7.5.25

8 CEO, Managing Director, and Chair's Report
- 8.0 - RUH CEO Public BoD Report 07.05.25

9 Integrated Performance Report
- 9.0 - May 2025 Pub BoD - IPR Cover Sheet (Mar 2025 Data) v1
- 9.1 - Pub BoD - May 2025 - IPR slide deck v1

10 Finance Plan 2025/26
- 10.0 - RUH May Public Board cover sheet Planning Document 25-26
- 10.1 - Budget 2025-26 Paper - RUH draft Public Board

11 Staff Survey Results
- 11.0 - Board Cover Paper - Staff Survey Update - March 2025
- 11.1 - Board - Staff Survey - March 2025

12 Joint Committee Terms of Reference and Partnership Agreement
- 12.0 - Cover_Sheet_May25_BSW Hospitals Group_Partnership Agreement TORsV1.0
- 12.1 - Project Sapphire - Draft Partnership Agreement v006.3(71688163.15)

13 Board Assurance Framework Summary Report
- 13.0 - BAF Coversheet - May 2025
- 13.1 - Board Assurance Framework May Board 2025

14 Annual Review of Constitution
- 14.0 - Front Sheet for Constitution Changes v1.1 - 10.10.24
- 14.1 - Foundation Trust Constitution RE-DRAFT - 01.05.25 (v 22)

15 Annual Review of Directors' Fit and Proper Persons Test
- 15.0 - 2025 Annual Review of Directors FPPT v1.1 - 01.05.25

16 Annual Review of Directors' Interest
- 16.0 - 2025 Annual Review of Directors DoI v1.1 - 06.05.25

17 NHSE Self-Certification CoS7 (Continuation of Services) and Training for Governors
- 17.0 - NHSE Licence Self-Certification - CoS7 - 2025-26 - 01.05.25 (002)
- 17.1 - Self-certification_template_CoS 7 V1

18 MIS Combined Maternity and Neonates Report Q3
- 18.0 - Mat-Neo Q3 quality report V3
- 18.1 - PCLP February Board report
- 18.2 - TC and ATAIN Report Q3 2024 V12docx

19 Midwifery and Neonatal Bi-Annual Staffing Report
- 19.0 - Maternity and Neonatal bi-annual staffing review

20 Learning from Deaths Q1, Q2 & Q3
- 20.0 - Learning From Deaths coversheet KB edits
- 20.1 - Quarterly Learning From Deaths Report H1 24 25
- 20.2 - Quarterly Learning From Deaths Report Q3 24 25

21 Delegation of Quality Accounts Sign Off
- 21.0 - Draft Quality Account Coversheet for Board of Directors May 25

22 Quality Assurance Committee Upward Report
- 22.0 - QAC Upward Reporting April 25

23 People Committee Upward Report
- 23.0 - People Committee Upward Report

24 Strategic Priorities Q4
- 24.0 - 202425 Q4 Quarterly Strategy Update Cover Sheet Final
- 24.1 - Q4 202425 strategy review Final

25 Finance and Performance Committee Upward Report
- 25.0 - Finance Upward Reporting 300425

26 Audit and Risk Committee Upward Report
- 26.0 - Upward Report Audit Risk Ctte 130325

27 Non-Clinical Governance Committee Upward Report
- 27.0 - NCGC Upward report to Board 2 May 25

28 Any Other Business

Royal United Hospitals Bath
NHS Foundation Trust

MEETING IN PUBLIC OF THE BOARD OF DIRECTORS
OF THE ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST
WEDNESDAY 7 MAY 2025, 13:00 – 16:00
VENUE: PAVILION FUNCTION ROOM, KINGSWOOD SCHOOL UPPER PLAYING FIELDS, BATH, BA1 9BH

Item	Item	Presenter	Enc.	For
OPENING BUSINESS				
1.	Chair's Welcome, Introductions, Apologies and Declarations of Interest: Christopher Brooks-Daw, Paran Govender, Nigel Stevens	Alison Ryan, Chair	Verbal	-
2.	Written questions from the public		Enc.	I/D
3.	Minutes of the Board of Directors meeting held in public on 5 March 2025		Enc.	A
4.	Action Log		Enc.	A/D
5.	Governor Log of Assurance Questions and Responses (For Information)		Enc.	I
6.	Items discussed at Private Board		Verbal	I
7.	Patient Story	Jason Lugg, Deputy Chief Nursing Officer	Pres.	I/D
8.	CEO, Managing Director, and Chair's Report	Cara Charles-Barks, Chief Executive / Andrew Hollowood, Interim Managing Director / Alison Ryan, Chair	Enc. / Verbal	I
9.	Integrated Performance Report	Simon Truelove, Interim Chief Finance Officer	Enc.	I/D
10.	Finance Plan 2025/26	Simon Truelove, Interim Chief Finance Officer	Enc.	I/D
11.	Staff Survey Results	Alfredo Thompson, Chief People Officer	Enc.	I/D
Governance				
12.	Joint Committee Terms of Reference and Partnership Agreement	Cara Charles-Barks, Chief Executive	Enc.	A
13.	Board Assurance Framework Summary Report	Roxy Milbourne, Interim Head of Corporate Governance	Enc.	I/D
14.	Annual Review of Constitution	Roxy Milbourne, Interim Head of Corporate Governance	Enc.	A
15.	Annual Review of Fit and Proper Persons Test	Roxy Milbourne, Interim Head of Corporate Governance	Enc.	I/D

16.	Annual Review of Director's Interest	Roxy Milbourne, Interim Head of Corporate Governance	Enc.	A
17.	NHSE Self-Certification CoS7 (Continuation of Services) and Training for Governors	Roxy Milbourne, Interim Head of Corporate Governance	Enc.	I
The People We Care For				
18.	MIS Combined Maternity and Neonates Report Q3	Zita Martinez, Director of Midwifery	Enc.	I/D
19.	Midwifery and Neonatal Bi-Annual Staffing Report	Zita Martinez, Director of Midwifery	Enc.	I/D
20.	Learning from Deaths Q1, Q2 & Q3	Kheelna Bavalia, Interim Chief Medical Officer	Enc.	I/D
21.	Quality Accounts Sign Off	Toni Lynch, Chief Nursing Officer	Enc.	A
22.	Quality Assurance Committee Upward Report	Simon Harrod, Non-Executive Director	Enc.	I/D
The People We Work With				
23.	People Committee Upward Report	Paul Fairhurst, Non-Executive Director	Enc.	I/D
The People in Our Community				
24.	Strategic Priorities Q4	Joss Foster, Chief Strategic Officer	Enc.	I/D
25.	Finance and Performance Committee Upward Report	Antony Durbacz, Non-Executive Director	Enc.	I/D
26.	Audit and Risk Committee Upward Report	Sumita Hutchison / Simon Harrod, Non-Executive Directors	Enc.	I/D
27.	Non-Clinical Governance Committee Upward Report	Sumita Hutchison, Non-Executive Director	Enc.	A
CLOSING BUSINESS				
28.	Any Other Business	Alison Ryan, Chair	Verbal	-

Date of Next Meeting: Wednesday 2 July 2025, 13:00 – 16:00
Pavilion Function Room, Kingswood School Upper Playing Fields, Bath, BA1 9BH

Key:

A – Approval	Enc – Paper enclosed with the meeting pack
D – Discussion	Pres– Presentation to be delivered at the meeting
I – Information	Verbal – Verbal update to be given by the presenter at the meeting

Royal United Hospitals Bath
NHS Foundation Trust

ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST
MINUTES OF THE MEETING OF THE PUBLIC BOARD OF DIRECTORS
WEDNESDAY, 5 MARCH 2025, 13:00 – 16:00
VENUE: PAVILION FUNCTION ROOM, KINGSWOOD SCHOOL, UPPER PLAYING FIELDS, LANSDOWN ROAD, BATH, BA1 9BH

Present:

Members

Alison Ryan, Chair
Antony Durbacz, Non-Executive Director
Paul Fox, Non-Executive Director
Paul Fairhurst, Non-Executive Director
Nigel Stevens, Non-Executive Director
Simon Harrod, Non-Executive Director
Sumita Hutchison, Non-Executive Director
Cara Charles-Barks, Chief Executive
Andrew Hollowood, Interim Managing Director
Jocelyn Foster, Chief Strategic Officer
Christopher Brooks-Daw, Chief of Staff
Jon Lund, Interim Chief Finance Officer
Alfredo Thompson, Chief People Officer
Kheelna Bavalia, Interim Chief Medical Officer
Jason Lugg, Deputy Chief Nursing Officer *(deputising for the Chief Nursing Officer)*

In attendance

Roxy Milbourne, Interim Head of Corporate Governance
Juliette Jackson, Senior Sister, TAU *(item 7)*
Sharon Manhi, Lead for Patient and Carer Experience *(item 7)*
Public Governors
Abby Strange, Membership and Governance Administrator *(minute taker)*

Apologies

Toni Lynch, Chief Nursing Officer
Paran Govender, Chief Operating Officer
Hannah Morley, Non-Executive Director

BD/25/03/01 Chair's Welcome, Introductions, Apologies and Declarations of Interest:

The Chair welcomed everyone to the meeting and confirmed that apologies had been received from those listed above. She informed the Board that the Deputy Chief Nursing Officer was in attendance on behalf of the Chief Nursing Officer.

The Board of Directors confirmed that they had no additional interests to declare with the exception of Paul Fox, who declared that he had been appointed as a Non-Executive Director for B&NES, Swindon, and Wiltshire Integrated Care Board and would become Chair of their Finance and Infrastructure Committee. His start date was yet to be determined but he would leave the Trust in the coming months. The Chair advised that she would manage any conflicts of interest throughout the meeting, particularly during discussions around the financial plan.

BD/25/03/02 Written questions from the public

The Chair summarised a number of questions that had been submitted by a member of the public via email on 10th January 2025. She explained that the questions had not been received in time to provide a full and comprehensive response at the Public Board of Directors Meeting in January and therefore a response was provided via email. The full list of questions and responses would be made available on the Trust website.

BD/25/03/03 Minutes of the Board of Directors meeting held in public on 15 January 2025

The minutes of the meeting held on 15 January 2025 were approved as a true and accurate record.

BD/25/03/04 Action List and Matters Arising

The actions presented for closure were approved.

BD/25/03/05 Governor Log of Assurance Questions and Responses

The Governor Log was presented for information. The Board of Directors noted that no further questions had been raised since the last report.

BD/25/03/06 Item Discussed at Private Board

The Chair provided an overview of the items discussed during the Private Board of Directors meeting. The primary focus had been the business plan for 2025/26. The timescales were extremely limited and as such the Board had agreed to hold an extraordinary Board meeting to sign off the business plan at the end of March. There was some discussion around whether these meetings would be held in private or public and the Interim Head of Corporate Governance would work with the Board to determine this.

Action: Interim Head of Corporate Governance

BD/25/03/07 Patient Story

The Deputy Chief Nursing Officer welcomed the Lead for Patient and Carer Experience and the Senior Sister, Trauma Assessment Unit (TAU) to the meeting to present the patient story. They shared a film in which a patient named Eileen spoke about her experience of attending TAU. Eileen felt that the care she received was very professional. She was particularly grateful to the TAU Team for coordinating her appointment with her husband's and for providing a patient initiated follow up which would allow her to attend TAU directly if she had any concerns about her arm in the near future.

The Deputy Chief Nursing Officer highlighted that there were opportunities to develop this pathway further and consideration would be given to how this could be applied to other clinical services. The Board joined him in congratulating the TAU Team on their recent silver accreditation through the Ward and Outpatient Accreditation Programme.

The Chair observed that Eileen's comments had been focused on how she had been treated and taken care of rather than her injury. The Senior Sister, TAU explained that the environment in TAU allowed staff to get to know patients and the team were incredibly good at making people feel relaxed and identifying what was important to them.

Sumita Hutchison sought clarity on the scale of the TAU service. The Senior Sister, TAU explained that the service had been established in 2020 but continued to grow and

evolve. She advised that not every patient would be referred to the service, and this was sometimes due to the time that they presented in ED. If trauma and orthopaedic input was needed outside of TAU hours the ED Team were able to refer to the on call team.

Paul Fairhurst reflected on the ability of the team to make patients feel relaxed and reassured and asked whether this was a specific training objective. The Senior Sister, TAU explained that the team continued to learn from one another as the service evolved and that there were a number of Trauma Sisters who had a wealth of experience to share with their colleagues. The Deputy Chief Nursing Officer added that the Trust was increasingly aware of the importance of soft skills and added that the small footprint of TAU allowed for more personal interaction.

The Chief Strategic Officer asked what the vision was for the future of the service. The Senior Sister, TAU advised that the service could currently only do soft tissue work but could look to increase laminar flow so that metal work could also be done. Space was currently the biggest issue in terms of capacity.

The Interim Managing Director commended the ongoing innovation of the TAU Team in designing a patient focused service. The Chair thanked the Lead for Patient and Carer Experience and the Senior Sister, TAU for attending.

BD/25/03/08 CEO and Chair's Report

The Chief Executive summarised her section of the report and highlighted that there were significant changes within NHS England (NHSE) at a national level with the Chief Executive stepping down from her position at the end of the financial year. Work was progressing to develop the Group model and Managing Director recruitment was ongoing with interviews due to take place in April. Transitional support was due to commence in March and the Council of Governors from each of the 3 Trusts had been working with legal advisors Browne Jacobson to understand how they would function within the Group model and to consider the recruitment process for a Group Chair.

The Interim Managing Director reported that while there had been an increase in Non-Criteria to Reside (NCTR), there had been an improvement in 4 hour performance and ambulance handovers in January with some patients being managed through trolley waits in the corridor to release ambulances. It was likely that the Trust would be the first organisation in the South West to have no patients waiting over 65 weeks but overall referral to treatment (RTT) performance was below where it needed to be and work continued to improve overall Trust performance. Cancer performance had improved but diagnostics remained challenging and the Trust remained in tiering for this. In terms of finance, a reforecast position had been agreed at the end of month 10 and the Trust position could not deteriorate beyond a £9m deficit. Key drivers related to non-pay and operating income budget overspends, clinical supplies and consumables, and a higher number of whole time equivalents (WTE) than the budgeted trajectory, and key actions had been identified to deliver a deficit of £9m.

There were a number of items to celebrate within the report, including the Trust's Safe, Effective, Quality Occupational Health Service Accreditation and particular thanks were extended to Julie Stone, Occupational Health Nurse Manager for her exceptional leadership in achieving this milestone.

The Chair summarised her section of the report and drew attention to her approval of a purchase order related to capital equipment and 7 year maintenance contracts for the replacement of the Trust's endoscopes for gastroenterology and respiratory. She outlined the proposed minor change to the Board cadence to implement 3 'all Board' seminars per year with the 3 Boards within the Group joining together for a seminar in June and October 2025, and February 2026.

The Board of Directors noted the update and approved the changes to the Board meeting and seminar dates and structure in 2025/26.

BD/25/03/09 Integrated Performance Report

The Interim Managing Director presented the report and indicated that he would focus on workforce and quality as he had reported on financial and operational performance during item 8. He highlighted:

Workforce

The Trust continued to reduce WTEs and manage agency costs. The rolling turnover had decreased to 8.36% but appraisal rates remained an issue and work would continue around pay efficiencies, management of sickness absence and improving appraisal compliance. Recruitment controls remained in place but the Chief Executive was working with the system to see if this could be managed within the individual organisations so that they had more control over areas of risk.

Quality

There had been 5 reported pressure ulcers in December and all cases were being reviewed. The Trust continued to perform well in terms of falls but there were issues in relation to infection prevention and control (IPC) in that there had been an increase in both C. diff and E. coli infections in December. Work continued to address this and it was noted the C. diff was a national issue.

Nigel Stevens reflected on the challenges that the Trust was faced with and acknowledged the role of the Non-Executive Directors in acting as a check and balance to the difficult decisions that the Executive Team needed to make. He emphasised that the Non-Executive Directors needed to continue to work effectively with the Executive Directors to ensure that the right decisions were made.

Paul Fox sought clarity on ongoing work around sickness absence. The Chief People Officer explained that work was ongoing to review the Sickness Absence Policy and to upscale managers in terms of how they applied the policy. The aim was to create a more empowered approach for both the line manager and employee, particularly where there was a long term condition. Technological solutions were also being explored and a piece of work was being done to conduct stress risk assessments across the organisation. This work was not yet at a stage where it would impact the sickness absence rate and there was a focus on looking at the impact of sickness absence rather than the number of sickness absences.

Sumita Hutchison asked what the narrative was around the appraisal rate. The Chief People Officer advised that this was cultural in that staff felt they did not have time for appraisals. He felt that creating standard work for managers with clear expectations around appraisals would help to resolve issues around staff burnout. The Interim Managing Director added that the Trust Management Executive (TME) had recently

reviewed a proposal around creating an appraisal window but there were questions around whether this was the right way forward as it would not address staff recognition of the value of appraisals. The Board discussed the value of appraisals in providing a way forward, particularly in terms of development and showing staff that they mattered. They agreed that the Trust needed to be firm around the requirement to complete them.

Paul Fairhurst asked why the overall appraisal rate had improved by 3% but the appraisal rate for global majority staff had improved by 8%. The Chief People Officer confirmed that he would investigate this.

Action: Chief People Officer

Antony Durbacz agreed with taking a supportive approach to staff that were on long term sick leave but felt opportunities needed to be identified to get staff back to work due to the cost associated with this. The Chief People Officer confirmed that the total cost of staff sickness was around £10m but advised that the real area to focus on was short term sickness as this was equivalent to 5182 WTEs. The Chair suggested that this was approached with caution given that the preliminary Staff Survey results had indicated that there was an increase in the number of staff saying that they felt pressured to work when they were unwell.

Paul Fairhurst sought clarity on the section of the report stating that the vacancy rate had increased to 2.83% but that the reserves continued to offset divisional vacancies which would give an appearance of a lower vacancy rate than otherwise reported. The Interim Chief Finance Officer explained that the report should state that savings continued to offset the divisional vacancy rather than reserves.

The Board of Directors noted the update.

BD/25/03/10 Item Withdrawn

BD/25/03/11 Quality Assurance Committee Upward Report

Simon Harrod presented the report and highlighted that there was an ongoing risks and issues around flow, and IPC issues were contributing to this due to the limited number of side rooms. There had been a significant increase in adult safeguarding allegations in Q2 but this thought to be a result of increased training and awareness across the Trust and there was no current evidence of patient harm. Assurance had been received around antibiotic stewardship, radiopharmacy, and changes to the way that the backlog of structured judgement reviews was being managed. Risks had been identified around capacity to rollout the Patient Safety Incident Response Framework, the recent rise in C. diff cases, and the clinical letter typing backlog across specialities. The Committee had also approved the Patient Experience Group Terms of Reference.

The Chair expressed her concern around the clinical letter typing backlog and requested that the Quality Assurance Committee look at this in more detail. The Deputy Chief Nursing Officer confirmed that the Associate Director for Patient Safety and Quality was in the process of investigating the detail around this and would produce a report for the Committee. It was acknowledged that a long term digital solution was required to resolve this issue but the Interim Chief Medical Officer advised that a more urgent solution was needed to clear the existing backlog due to the significant impact on ongoing care.

The Board of Directors noted the update.

BD/25/03/12 People Committee Upward Report

Paul Fairhurst presented the report and highlighted that the Committee continued to scrutinise plans, programmes, and risks to deliver the required pay cost savings. The Committee continued to monitor staff wellbeing and work to reduce discrimination in the organisation and had explored themes coming out of the 2024 Staff Survey Results. Assurance had been received around the performance of the People Directorate and work around sexual safety in the workplace. Risks had been identified around the restrictions on staffing due to the Trust's financial performance and localised industrial action relating to the removal of paid breaks.

The Board of Directors noted the report.

BD/25/03/13 Annual Health and Safety Compliance Report

The Board of Directors noted the report.

BD/25/03/14 Finance and Performance Committee Upward Reports and Terms of Reference for Ratification

Antony Durbacz presented reports from the last two Finance and Performance Committee meetings and the updated Terms of Reference for ratification. The first report raised concerns around the Trusts financial forecast and as a consequence of this, the forecast had been adjusted. It also highlighted concerns around performance, particularly in terms of NCTR, cancer, and diagnostics. The second report related to a joint meeting of the Finance and Performance, Quality Assurance, and People Committees to discuss the first iteration of the business plan. There were currently significant risks in terms of achieving the forecast outturn and the Board would work through this and sign off the plan through an extraordinary meeting.

The Board of Directors noted the report and ratified the updated Committee Terms of Reference.

BD/25/03/15 Charities Committee Upward Report

Sumita Hutchison reported that the Committee discussed risks relating to the Trusts planning obligations to develop the green heart and had also been informed that the general fund monies were constrained. They had noted that funds from RUHX had contributed to some important projects in the last quarter and that the League of Friends had made £400k available to the Trust in 2024/25. They had also approved funding applications for a number of projects, the RUHX spending plan for 2025/26, and the service level agreement for admin services between the Trust and RUHX.

The Chair advised that the green heart planning obligations were a concern and it was likely that this would be discussed by the Board at a future meeting.

The Board of Directors noted the update.

BD/25/03/16 Non-Clinical Governance Committee Terms of Reference for Ratification

Sumita Hutchison presented the Terms of Reference for ratification and provided a summary of the minor amendments that had been made.

Paul Fairhurst asked whether the quorum needed to be amended as the Committee could currently be deemed quorate with more Executive Directors than Non-Executive Directors. The Interim Head of Corporate Governance confirmed that she would update the section on quorum and attendance.

Action: Interim Head of Corporate Governance

The Board of Directors ratified the updated Terms of Reference subject to the discussed amendment.

BD/25/03/17 Mineral Hospital Assets Update

The Interim Head of Corporate Governance presented the report and explained that the Trust had acquired the Royal National Hospital for Rheumatic Diseases (RNHRD) in 2015 and had inherited a number of heritage assets from the building. In 2018 a Loan and Joint Working Agreement was drawn up between the Trust and Bath Medical Museum (BMM) to enable the Trust to provide a long term loan of historic medical artefacts to BMM and a number of items went to Pulteney Practice GP Surgery and the Victoria Art Gallery. In November 2024 the Trust was notified that renovation works had begun at Pulteney Practice and the future use of the site as a GP surgery may change in the near future. As a result, the loan of the items that went to Pulteney Practice was terminated on 31st January 2025 and options for relocation were noted within the report. In particular, the Board was asked to note the Chair's action to gift five paintings and the bust of Dr William Falconer to the Guildhall, Bath with conditions in January 2025.

Antony Durbacz questioned whether it was appropriate for the progression of this work to be overseen by the Finance and Performance Committee. The Board discussed this and agreed that the Audit and Risk Committee should oversee the work.

The Board of Directors noted the report.

BD/25/03/18 Board Sub-Committee Terms of Reference Update

The Interim Head of Corporate Governance reported that a review of the Trust's Corporate Risk Management System had been undertaken by KPMG in 2023/24 and it had been identified that the risk management responsibilities at TME and Board sub-Committee level required an update. It had been agreed that the Terms of Reference for TME and each sub-Committee would be updated to ensure that the roles and responsibilities of risk domains were explicit. The risk domains had now been agreed and the Board was asked to approve the suggested text for TME and each of the sub-Committee' Terms of Reference as outlined in the report.

The Board of Directors approved the updated draft risk objective for TME and each of the sub-Committee's Terms of Reference.

BD/25/03/19 Group Chair Proposal

The Chair left the meeting for the duration of this item.

Nigel Stevens presented the report and explained that the next step in the development of the Group model was to appoint a Group Chair to support Group development and leadership. He reported that the post would be a single role across the three organisations within the Group and was expected to create a number of benefits. The Board of Directors were asked to consider the options for the process to recruit a Group Chair. Option 1 was to proceed with an open external recruitment process and option 2

was to make an interim appointment ringfenced to the current Chairs of the 3 Trusts pending the completion of an external open recruitment process.

The Chief Executive asked the Board to consider the timing of the proposal and the need for consistency and stability given the challenging position that the Group was in. She reflected that the Chair needed to be able to make difficult decisions and while she was supportive of open recruitment, it was also important to consider what the Group needed now from a stability perspective.

The Board had an in depth discussion around the recruitment options and the majority of those present expressed their support for option 2 given that the interim appointment would be ringfenced to the current Chairs of the three Trusts. It was felt that this would provide more support and stability for the Group, particularly in terms of the pre-existing relationships with key stakeholders, and would enable decision making at scale and pace to deliver the objectives of the Group. Appointing an interim would also allow the necessary time for an open recruitment process. The Chief Strategic Officer felt that it would be easier to recruit only once to provide continuity while the 3 organisations were going through this significant change process, she supported option 1.

The Board noted that the suggested term of an interim Chair was 6-8 months and it was felt that this may need to be extended to 12-18 months to allow the Group to move forward in its development. The Chief Executive recommended that the interim term was linked to the planning rounds and 12-18 months would enable this to happen.

The Board of Directors supported the development of a Job Description and Person Specification for a Group Chair in support of the Nominations Committee of the Council of Governors recommendation to the Council of Governors. They recommended that recruitment option 2 was taken forward with the suggestion that the interim period was extended to 12-18 months for stability and that the length of the interim term was determined around the business planning cycle.

The Board noted that section 27.1.8 of the Constitution stated that an Executive Director, Non-Executive Director, or Governor of another Health Service Body may not become or continue as a member of the Board of Directors unless approval was received from no less than 75% of the voting members of the Board of Directors. As the Board was supportive of recruitment option 2 they agreed take a vote and unanimously approved the motion that the Interim Group Chair would become a member of the Board of Directors.

BD/25/03/20 Maternity Incentive Scheme Sign Off / Clinical Negligence Scheme for Trusts

The Deputy Chief Nursing Officer reported that the Trust had achieved full compliance with the Maternity Incentive Scheme year 6 and confirmed that the Board of Directors had given permission to the Chief Executive to sign the Board declaration form prior to submission to NHS Resolution at their meeting in private on 5th February 2025.

BD/25/03/21 Any Other Business

There was no other business.

The Meeting closed at 15.30

Royal United Hospitals Bath
NHS Foundation Trust

Agenda Item: 4

ACTION LIST - BOARD OF DIRECTORS MEETING IN PUBLIC
WEDNESDAY, 5 MARCH 2025

Action No	Details	Agenda Item No	First Raised	Action by	Progress Update & Status	Lead
PB609	**BAF Summary Report** Non-Executive Director to ensure that the sub-Committee reports to Board summarised of what was being done to mitigate the risks in the BAF.	**BD/25/01/19**	**January 2025**	**May 2025**	Non-Executive Directors to include detail within their reports. **To close**	**Non-Executive Director**
PB610	**BAF Summary Report** Interim Head of Corporate Governance to include a summary of what the BAF is and how the organisation uses it in the report going forward.	**BD/25/01/19**	**January 2025**	**May 2025**	Summary included in cover sheet. **To close**	**Chief of Staff**
PB612	**Items Discussed at Private Board** Interim Head of Corporate Governance to work with the Board to determine whether the Extraordinary Board of Directors meeting would be held in private or public.	**BD/25/03/06**	**March 2025**	**May 2025**	The Extraordinary Board of Directors meeting was held in private on 26 March 2025. **To close**	**Interim Head of Corporate Governance**
PB613	**Integrated Performance Report** Chief People Officer to investigate why the overall appraisal rate had improved by 3% but the appraisal rate for global majority staff had improved by 8%.	**BD/25/03/09**	**March 2025**	**May 2025**	Ethnicity is unlikely to be a direct factor in the increase in appraisal rates. It is more likely to be an indirect one reflecting the distribution of roles across the organisation and the emphasis given to appraisal varies by demographic. This would	**Chief People Officer**

Action No	Details	Agenda Item No	First Raised	Action by	Progress Update & Status	Lead
					need a more in depth investigation. There are factors that could mean one sub-set outperforms another i.e. band. Progress is being made at lower bands but less so at higher bands (where Global Majority representation is less, so the group is less affected, therefore compliance growth isn't going to be compromised in the same way). There are many hypotheses around why we are seeing this (e.g. capacity of higher grades to do appraisals, recognition of appraisal importance etc) but there is no data to examine these. **To close**	
PB614	**Non-Clinical Governance Committee Terms of Reference for Ratification** Interim Head of Corporate Governance to update the quorum and attendance to ensure the Committee could not be quorate with more Executive Directors that Non-Executive Directors.	**BD/25/03/16**	**March 2025**	**May 2025**	ToR updated. **To close**	**Interim Head of Corporate Governance**

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**5**
Date of Meeting:	**Wednesday 7 May 2025**		

Title of Report:	**Governor Log of Assurance Questions and Responses**
Status:	**For Information**
Board Sponsor:	**Alison Ryan, Chair**
Author:	**Roxy Milbourne, Interim Head of Corporate Governance**
Appendices	**None**

1. Executive Summary of the Report

This report provides the Board of Directors with an update on all questions on the "Governors' log of assurance questions" and subsequent responses. The Governors' log of assurance questions is a means of tracking the communication between the Governors and the Non-Executive Directors (NEDs). Governors are required to hold the NEDs to account for the performance of the Board and this is one way of demonstrating this.

No new questions have been raised since the January 2025 and there are currently no open questions.

2. Recommendations (Note, Approve, Discuss)

The report is presented for information.

3. Legal / Regulatory Implications

None

4. Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc.)

There are no risks on the risk register.

5. Resources Implications (Financial / staffing)

There are no resource or financial implications.

6. Equality and Diversity

All Governors no matter their background can input into the NED questions.

7. References to previous reports

January 2025.

8. Freedom of Information

Public

9. Sustainability

Governors have asked questions on various topics including sustainability.

10. Digital

Governors have asked questions on various topics including digital.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**7**
Date of Meeting:	**Wednesday 7 May 2025**		

Title of Report:	**Patient story**
Status:	**For discussion**
Board Sponsor:	**Toni Lynch, Chief Nursing Officer**
Author:	**Sharon Manhi, Lead for Patient and Carer Experience** **Dr Jessica Spedding, Emergency Medical Consultant** **Dr Alastair Stanley, Consultant in the Children's Emergency Department**
Appendices	**None**

1. Executive Summary of the Report

Patient stories help to bring patient experiences to life. They help us to understand what we are doing well and where we need to improve. The Trust is committed to listening and acting on what matters most to patients and their families. This supports the Trust vision for '*the people we care for'* making them feel safe, cared about and always welcome.

The purpose of presenting a patient story to the Board members is to:

- Set a patient focussed context to the meeting
- By filming patient stories, making them more accessible to a wider audience
- For Board members to reflect on the impact of the lived experience for the patient and their family and its relevance to the Trust's strategic objectives.

Emily and Remy's experience of the Children's Emergency Department (ED)

Remy attended the Children's ED on 6 February 2025 aged 15 months. He had been unwell for approximately one week. On 5 February, Emily (Remy's mother) called 111 and received a video call with a paediatrician who provided advice. Remy had not improved the next morning and he was brought to the Children's Emergency Department at the RUH.

Remy's care was overseen by Alastair Stanley, Consultant in Children's ED. Alastair could see that Remy was very unwell and started immediate treatment for Sepsis. Emily felt that Alastair's bedside manner was phenomenal. She said he managed to share with them that Remy was very unwell without scaring them.

Remy was investigated for the source of his infection. Alastair was highly suspicious that Remy had orbital cellulitis and therefore requested advice from a Paediatric Radiologist who confirmed the diagnosis of orbital cellulitis.

On the Children's ward Remy was cared for by the paediatric nurses and doctors with the teams in Ear Nose and Throat (ENT) and Ophthalmology providing specialised care and treatment. He was on the High Dependency Unit (HDU) initially and after a few days, his condition started to improve. Remy was discharged home after 7 nights in hospital but attended Ambulatory Care for infusions.

Background and context

We see around 22,000 children in our ED each year.

Sepsis - this is when the body cascades into an overwhelming response to infection, which can be fatal. It is almost always due to an infection with one of a few strains of bacteria, most of which are part of the standard childhood immunisation programme. We encourage anyone who hasn't yet immunised their children to consider booking an appointment with their GP to explore any concerns they may have.

It can be difficult to tell if a child has sepsis in the early stages and there is no specific test for it, so a lot of checks in hospital are tailored towards considering this. We really appreciate understanding the level of concern families have and what it is that is worrying them to guide our approach.

Orbital cellulitis is a serious infection affecting the soft tissue around the eye and can lead to sepsis as well as infection tracking back and causing meningitis. It is very rare so needs the medical team to have a high index of suspicion.

Triage is carried out by a children's ED nurse specifically trained in the nationally approved triage tool "Manchester triage" - this is usually the first encounter a family has after booking in at reception and aims to identify how serious a child's illness or injury might be and allows the taking of vital signs and administration of important medication such as pain killers. The child is then assigned a triage category 1 (most serious) to 5 (least serious) and the clinical team see children in order of priority not always arrival time.

Next steps

- The film will be shared widely with staff across the Trust
- It will also be shown to new staff joining the department

2.	Recommendations (Note, Approve, Discuss)
The patient story is for discussion.	

3.	Legal / Regulatory Implications
The Equality Act 2010 requires organisations to make reasonable adjustments to ensure that people with disabilities or other conditions are not at an advantage. The Care Act 2014 recognising the equal importance of supporting carers and the people they care for. The Health and Care Act 2022 introduced a statutory requirement that regulated service providers ensure that their staff receive training on learning disability and autism which is appropriate to the persons role.	

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc.)
A failure to demonstrate sustained quality improvement could risk the Trust's registration with the Care Quality Commission (CQC) and the reputation of the Trust.	

5.	Resources Implications (Financial / staffing)
A business case has been submitted for the antibiotic hand pump	

6.	Equality and Diversity
Ensures compliance with the Equality Delivery System (EDS).	

7.	References to previous reports
Monthly Quality Reports and Quarterly Patient Experience reports to the Trust's Quality & Safety Group, Quality Governance Committee and the Board of Directors	

8.	Freedom of Information
Public.	

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Public Board of Directors	Agenda item:	8
Date of Meeting:	Wednesday 7 May 2025		
Title of Report:	Chief Executive Officer Report		
Status:	For Information		
Board Sponsor:	Cara Charles-Barks, Chief Executive Officer & Andrew Hollowood, Interim Managing Director		
Author:	Helen Perkins, Senior Executive Assistant to Chair and Chief Executive		
Appendices	None		

1. Executive Summary of the Report

The purpose of the Chief Executive's Report is to provide a summary of key concerns and highlight these to the Board of Directors.

Updates included in this report are:

Chief Executive's Report

- National/System
  - Laying the Foundation for Reform
  - Updated NHS Standard Contract and Payment Scheme 2025/26
  - Board Member Appraisal Guidance
- Group
  - Group Development
  - Leadership Team
  - Transitional Support Partner
  - Partnership Agreement and Joint Committee Establishment
  - Board to Board Development
  - Operating Model/Leadership Structures/Corporate Services
  - Governance and Accountability Framework
  - Group Engine Room
  - Shared Electronic Patient Record (EPR)

Chair's Report

Local (RUH)

- Finance
- Transformational Change for 2025/26
- RUH introduces at-home feeding for premature babies
- Powering through energy-efficiency improvements at the RUH
- New Intensive Care Unit opens
- Tree planting on-site
- National recognition for our kindness and civility work
- Spring Inclusion Week
- Excellence at Every Level Accreditation
- Patient Experience Awards
- International Day of the Midwife
- Membership Engagement Strategy
- Use of Trust Seal

2.	Recommendations (Note, Approve, Discuss)
The Board is asked to note the report.	

3.	Legal / Regulatory Implications
Not achieving financial duties will impact on the ability for the Trust to secure the economy, efficiency, and effectiveness in its use of resources.	

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)
Strategic and environmental risks are considered by the Board on a regular basis and key items are reported through this report.	

5.	Resources Implications (Financial / staffing)
A significant amount of time is being taken by the Improvement Team to support the recovery programme.	

6.	Equality and Diversity
Recovery actions for the financial position are being overseen by the Improvement Programme Steering Group (IPSG) to ensure the impact on clinical services is considered. As part of the development of new Projects, a Quality & Equality Impact Assessment (QEIA) is completed. QEIAs undergo an Executive lead panel review prior to a project being approved to commence. The impact on health inequalities is also considered as part of this process.	

7.	References to previous reports/Next steps
The Chief Executive submits a report to every Board of Directors meeting.	

8.	Freedom of Information
Public	

9.	Sustainability
Further opportunities to improve sustainability should be pursued to contribute towards the Finance Improvement Programme.	

10.	Digital
Several projects within the Improvement Programme and the development of the Quality Management System will be reliant on digital solutions. There will also be elements of the Digital Strategy that will have a direct link into the Improvement Programme.	

CHIEF EXECUTIVE, CHAIRS & MANAGING DIRECTORS REPORT

CHIEF EXECUTIVE'S REPORT

1. National/System

Laying the Foundations for Reform

Sir James Mackey, the new NHS England Chief Executive wrote to Trust and ICB Chairs and Chief Executives on 1st April 2025 setting out priorities for the coming weeks and months. The letter covers an update on 2025/26 planning, next steps on reducing non-patient-facing roles and planned work on the financial regime and NHS operating model.

The governments mandate published in January to reform the NHS lays the foundation for longer-term reform as part of its health mission, focusing on bringing care closer to communities, prioritising prevention over treatment, embracing digital transformation, and embedding financial discipline within the system.

Through the 10 Year Health Plan, the government will focus on 3 strategic shifts, moving care from:

- hospital to community
- sickness to prevention
- analogue to digital

These shifts will help to:

- cut waiting times for care
- reduce the amount of time spent in ill health
- tackle health inequalities
- reduce the lives lost to the biggest killers - cancer, cardiovascular disease and suicide
- make the NHS sustainable in the long term

Among those changes:

We are required to reduce the cost of the current operating model of the NHS.

- 50% reduction in NHSE and DHSE staffing by Q3 – Central oversight of the NHS (which has been the remit of NHS England since 2012) will now be reduced in size and move back into the Department of Health in the following 2 years.
- 50% reduction in ICB running and program costs by start of Q3
- 50% reduction in corporate cost growth in providers
- Plans to reduce costs and streamline governance and non-clinical activities.

I appreciate that these are challenging messages, the reason for these changes is that the NHS and BSW are in deficit and need to make changes to move to a more financially

sustainable model. There are also clear requirements regarding service offering and delivery of core performance and quality metrics.

I appreciate that this is a challenging time for all our teams. For providers such as us, there is a significant change in the oversight regime and the expectation regarding delivery, along with a changed consequence regime for non-delivery.

I understand that these times of transition and uncertainty are by nature unsettling. I also want to reassure you that we are already doing good work in terms of the change that's needed for our future NHS, for example leaders of Corporate Services are taking control of what will be best for us and our patients in terms of future service design. Planning has also been underway for a number of months now responding to the asks of the national Guidance issued in January and consistent with creating a bright and sustainable future for the NHS.

As a group we have a great opportunity to learn together, to tackle inequalities in access to services, to work together to remove barriers to good health and provide improved health outcomes for all our communities. Together I believe we can be at the forefront of the transformation that's needed in the NHS, but most importantly we will achieve this by working together.

Updated NHS Standard Contract and Payment Scheme 2025/26

NHS England recently published the 2025/26 NHS Standard Contract which is mandated for use by commissioners for all contract for healthcare services other than primary care. Following the consultation on the 2025/26 NHS Payment Scheme, NHS England are now consulting on further changes to the 2025/26 Contract. The consultation is scheduled to close on Monday, 28th April 2025.

Board Member Appraisal Guidance

NHS England published new Board member appraisal framework on 1st April 2025 which sets out expectations and recommendations in the completion of board member appraisals to ensure a consistent and standard approach to appraisal.

2. Group

Group Development

March and April saw progress in resourcing and governance supporting the establishment of BSW Hospitals Group.

Leadership Team: Managing Directors and Group Chief Transformation and Innovation Officer (Interim)

The recruitment process for our three Managing Director roles saw stakeholder panels and final interviews held in early April. Later in April, Jonathan Hinchcliffe started with us as interim Group Chief Transformation and Innovation Officer. Jonathan brings a wealth of digital experience as well as years of working in a hospital group at Manchester University Hospitals.

Transitional Support Partner

Following a detailed procurement exercise, we have selected an experienced partner, Teneo, to support us in our Group set-up, design and implementation over the next eighteen months. The Teneo team is led by Lucy Thorp and started working with us in late March. Initially, focus will be on detailed planning for our Group design phase – including work on our operating model, leadership structure, corporate services programme and governance and accountability framework.

Partnership Agreement and Joint Committee Establishment.
The working party leading development of our BSW Hospitals Group Partnership Agreement and Terms of Reference (TOR) for a group Joint Committee held further sessions in March, supported by colleagues from our legal advisors Browne Jacobson. Trust Board review of the draft Partnership Agreement, incorporating TORs for a special purpose Joint Committee is underway. Subject to Board approval, the first meetings will be arranged for 23rd May and 25th June.

Board to Board Development
Following our first Board to Board development day in January, we have agreed to hold three Board to Board development sessions annually, to allow Board members from GWH, RUH and SFT to build and deepen relationships. Sessions are planned in June, October and next February.

Operating Model/ Leadership Structures/ Corporate Services
Work to establish our new operating model began in April, supported by colleagues from Teneo. Corporate services will be an important part of the new operating model. We have re-launched a comprehensive joined-up corporate services programme. A Steering Group with executive leads (Simon Wade & Melanie Whitfield), has been established to oversee the programme, confirming core assumptions and adopting a common framework in response to latest national requirements on NHS provider corporate service workforce.

Governance and Accountability Framework
Trust governance leads and company secretaries meet weekly and, with Teneo's support, are developing our Group Governance and Accountability Framework, identifying opportunities for collaboration, alignment and avoidance of duplication.

Group Engine Room
Improving Together and the engine room rhythm is well-established in the Trust; we will establish something similar for the Group to help us align teams around our biggest problems, connecting Teams across the Group. Improving Together leads, Alex Talbot, Emily Beardshall and Rhiannon Hills are helping shape our approach, aiming to establish our Group Engine Room in May.

Shared Electronic Patient Record (EPR)
We are now in the 'Engage' stage which runs through to March 2026. This includes the build, testing and training for EPR. The team are in the building phase, preparing to show that build for the first time from 30th June onwards at Future State Review. Future State Validation will follow in mid-July. Our EPR Joint Committee met on 21st March. The implementation team is well established and following a tender exercise, St Vincent's has recently joined us as EPR Implementation partner.

CHAIR'S REPORT

During the last two months we had the pleasure of recruiting Joy Luxford as a NED to replace Paul Fox who is moving to the ICB. I also welcomed new Staff Governor, Craig Sanders following his election following the resignation of Baz Harding-Clark. I would like to thank both Paul and Baz for their contributions, always given with goodwill and their unique personal styles.

We strengthened our links with Bath Spa University, exploring ways in which we could work together for mutual benefit.

At the end of March, we said farewell to our colleagues in Wiltshire Health and Care whose services are now being provided by HCRG. I would like to thank Stephen Ladyman, Chair and Shirley-Ann Cavill, Managing Director for their steady hands in exceptionally difficult circumstances bringing these services to a safe and secure handover. Wiltshire Health and Care is in the process of winding down, which I will continue to supervise.

MANAGING DIRECTORS REPORT

1. Finance

The Trust achieved its revised financial target of £4.2m deficit for 24/25 with the RUH delivering a £3.2m deficit and SULIS a £0.95m deficit. Although some of the deficit relates to one off costs the risk of the exit run rate being worse than planned has increased. The finance team are working to fully understand the recurrent exit run rate and how it links to the planning assumptions.

The system achieved its revised financial target, however the utilisation of non-recurrent support and other adjustments was significant and reflects the increased risk of the recurrent run rate.

The recurrent savings delivery was in line with previous reported with the final delivery being reported as £32.7m against a target of £36.6m. Agency expenditure in March was 0.8% of total pay bill which was a significant improvement from the start of the financial year.

Performance against the elective recovery was 19% above the 2019/20 baseline.

The Trust delivered against its capital plan including the over-shoot relating to the purchase of the second surgical robot that was supported by the Region.

The financial environment for 25/26 continues to be challenging with the need to deliver real operational change that is linked to the financial savings. This will include reducing length of stay for non-elective services, increased productivity for electives and the re-organisation of our corporate and support services in line with the Group strategy. The savings programme is heavily linked to the management of demand by the wider health system as well as maximising the flow of clients through the hospital and maximising the core funded capacity for elective services. Work continues throughout the Trust in order to maximise the delivery of the financial plan in 25/26.

The finance committee has approved the revised plan submission in line with NHSE revised planning requirements. This has included the impact of a further £2.4m that the

finance director has secured for the organisation to support the delivery of RTT compliance. The plan also currently assumes a net financial risk of £8.4m which relates to the Group savings target of £4.4m and unidentified savings of £4m. Work continues on the financial risks and mitigations position and will continue to be updated as the financial year progresses.

2. Transformational Change for 2025/26

The business plan for 2025/26 has an overarching risk profile that is significantly higher across all areas than in previous planning years. The delivery of this ambitious plan is predicated on a need to transform the way we provide our services so we can achieve our performance, workforce and financial commitment this year. It will require rapid pacing of high complexity delivery with significant focus, skill, capacity and stakeholder management to deliver successfully and to minimise additional pressures on staff and unintended consequences to quality of care.

To support this, we have revised our governance structure to provide clear Executive sponsorship for the transformation programme, one which is clinical lead and integrated into our Trust's Operational Management System. There will be five Delivery Groups focusing on trust wide and transformational pieces of work, underpinned by continuous improvement work led at specialty and department level. Programme Mandates for each Delivery Groups are in development. These will provide clarity on what each programme will deliver against the asks within the Business Plan, how they will deliver the plan and by when so that we can track delivery and manage risks within the plan. There will be a fortnightly oversight of delivery via our Engine Room to ensure we maintain the pace and focus needed to deliver large-scale transformational changes to the way we provide our services.

The key transformational focus for the delivery groups are:

- Urgent and Emergency Care – Urgent Treatment Centre process changes and workforce redesign, Ward capacity & demand so that our bed base is aligned to demand improving flow and Reduction in Non-Criteria to Reside numbers to 40 in order to reduce our acute bed base
- Theatres – continuation of productivity improvement with a realignment of theatres to priority specialties, supported by a cultural shift so that the productive running of theatres becomes the standard way in which we work
- Outpatients – Digital first such as Ambient AI to release clinical time and remote monitoring and Pathway redesign looking at Community Hub & Spokes, outreach models and PIFUP by default to change the traditional referral pathways and clinic based model in secondary care
- Corporate Services redesign – will focus on continuous improvement at a local level whilst contributing to the transformational ambitions for the group design aiming to reduce duplication and increase standardisation of processes across the three trusts
- Central – providing assurance in a number of BAU areas including Procurement, Commercial and private patients and temporary staffing to sustain benefits into this year

Progress against these plans will be provided via the Integrated Performance Report and assured via our Board Assurance Committees.

3. RUH introduces at-home feeding for premature babies

Since spring 2024, some premature babies being cared for at the Royal United Hospitals Bath NHS Foundation Trust's Neonatal Care Unit can go home earlier thanks to the introduction of at-home tube feeding.
The RUH's Dyson Centre for Neonatal Care is one of only four units in the South West that have introduced the new initiative, which means parents can feed their babies through tubes at home, supported by the hospital's outreach nurses.

4. Powering through energy-efficiency improvements at the RUH

In March, the RUH submitted a second planning permission application as part of its plans to become a more sustainable and energy-efficient organisation by improving its heating system and reducing carbon emissions.

The application compliments a previous application to install Air Source Heat Pumps (ASHPs) on the roof of the hospital's Energy Centre, which the RUH was pleased to receive approval for in February.

These improvements are part of a project to de-steam much of the RUH's 52-acre estate by replacing some of the hospital's ageing heating systems with these newer, greener and more energy-efficient sources of energy.

5. New Intensive Care Unit Opens

The Trust was delighted to open its new Intensive Care Unit in March this year. The modern 16-bed ICU provides care for some of the sickest patients at the RUH, including those recovering from major surgery, heart attacks and strokes or life-threatening infections such as sepsis. The ICU team fed into the design process at every step of the way, to create the best environment for everyone using or working in the new unit. From more natural light and better ventilation through to the very latest equipment and better facilities for visitors, we are very proud of what we have achieved.

The new unit includes ceiling mounted pendants to house equipment used to care for patients. The majority of the pendants were funded by RUHX and Friends of the RUH

.

6. Tree planting on-site

Colleagues from the RUH planted around 120 new saplings across the RUH site in April, to ensure we can all continue to benefit from and enjoy our outdoor space. The native trees will help improve air quality, reduce noise, carbon emissions and pollution and give patients, visitors and staff the welcome opportunity to connect with nature. The new trees will be cared for by our estates team, to ensure they have the best start in life.

7. National recognition for our kindness and civility work

Our Kindness and Civility Handbook was praised at the National Guardian's Office Freedom to Speak Up Conference in March.

The guide and toolkit have been designed to provide individuals and teams with some practical tips and activities to help start conversations around kindness and civility whilst at work. It encourages reflection, learning and insight.

The issue is an important one as evidence shows that when incidents of rudeness or incivility occurs in teams, there is an impact on other team members including a 20% reduction in team performance and a 50% drop in willingness to help others (Riskin and Erez - The Impact of Rudeness on Medical Team Performance).

8. Spring Inclusion Week

The RUH held its first inclusion week in March, where amongst other activities clinical and non-clinical teams shared the work they had been doing to improve the experience of inclusion in their teams. During the week staff were also able to hear staff experiences, share a coffee and a chat around inclusion issues, view a championing exclusion exhibition and find out more about the many RUH staff networks.

9. Excellence at Every Level Accreditation

Excellence at Every Level is an accreditation programme which assesses wards against four levels, Foundation, Bronze, Silver and Gold. Over the last two months William Budd ward and the Neonatal Unit have both achieved Gold Accreditation which is an incredible achievement. The Gold Award signifies a team that consistently delivers the highest levels of patient care for the people we care for whilst also supporting, developing and caring for the people we work with. Members of the Board of Directors attended their respective Portfolio presentation where the multi-professional team provide evidence of achievement, both teams did an incredible job and it is clear to see how, through using the Improving Together methodology, they are making great strides forward. We are very proud of their achievements, congratulations to both teams. In addition to this, the Older Persons Unit Short Stay and the Trauma Assessment Unit both achieved Silver Accreditation, they will now consolidate this achievement before commencing their preparations for the Gold Award.

10. Patient Experience Awards

We held our improving patient experience awards in April, celebrating colleagues who had gone above and beyond to further improve the experience of people they care for. First place went to our Maternity Triage Team. After listening to feedback, the team introduced a single point of access for all enquiries, leading to an immediate urgent care review if required. Feedback from women, families and birthing people describe a responsive and supportive team and positive experiences of the new system and department facilities.

Other award winners included:

- The Pain Clinic nursing team for developing a dedicated pain information session for patients. The new session provides patients who have been referred to the service with additional information and support about what to expect from their treatment and help them to make informed decisions about their treatment plan.
- Art at the Heart - the RUH's in-house art and design team - for their work on children and older patients' wards, introducing a musician in residence and artists in residence along with other ward-based art activities to support a healing environment.
- The Listening Service Introduced by the Patient Support and Complaints Team which provides patients, families and carers with an opportunity to reflect on their or their loved one's care and share their thoughts and feedback on the service they received.

- The Critical Care Outreach team for the development of the Call for Concern service which gives patients and families an additional way to raise concerns if they feel they or their loved one is not getting better or is worsening.

11. International Day of the Midwife

On 5 May we celebrated the International Day of the Midwife. This year it fell on a bank holiday but we still managed to say thank you to our midwives, midwifery support workers and midwifery care workers for all they do to care for women, birthing people and their families. Our midwifery team continue to focus on involving the voice of our local community on our journey of improvement for maternity care. Our team have had many successes over the last 12 months, inclusive of their outstanding rating by the Care Quality Commission in 2024 and it was lovely to be able to celebrate them and say thank you.

12. Membership Engagement Strategy

Engagement with members and the public that they represent, is a key part of the role of the Governor. Our Council of Governors Membership and Outreach group has established a task and finish group to create our membership engagement strategy. This will set out their intentions and will sit alongside our own corporate strategy for ensuring that we hear the voices of the population that we serve. I am delighted that the Governors are using their expertise to develop this and look forward to meeting with them to hear more as it is developed.

13. Use of Trust Seal

The Trust Seal was used on 29th April 2025 to seal the following documents:

- Licence to alter in relation to MRI extension at Sulis Hospital Bath Ltd.
- Licence to alter in relation to the Community Diagnostics Centre (CDC) at Sulis Hospital Bath Ltd.
- Licence to alter in relation to the Sulis Elective Orthopaedic Centre (SEOC) at Sulis Hospital Bath Ltd.
- Licence to alter in relation to Modular theatre at Sulis Hospital Bath Ltd.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**9**
Date of Meeting:	**7 May 2025**		
Title of Report:	**Integrated Performance Report**		
Status:	**For Noting**		
Board Sponsor:	**Paran Govender, Chief Operating Officer** **Simon Truelove, Interim Chief Finance Officer** **Alfredo Thompson, Chief People Officer** **Toni Lynch, Chief Nursing Officer**		
Author:	**Operational Team** **Tom Williams, Head of Financial Management** **Matt Foxon, Associate Director for People** **Jason Lugg, Deputy Chief Nursing Officer / Rob Elliott, Lead for Quality Assurance**		
Appendices	**Appendix 1: Integrated Performance Report slide deck**		

1. Executive Summary of the Report

The report provides an overview of the Trusts Performance for the period up to and covering March 2025, aligned to our True North Pillars and breakthrough objectives agreed for the year.

The slide pack includes an overarching Executive summary with each section providing a more detailed summary on key indicators and measures monitored via the Integrated Performance Report.

This programme drives improvement on the three nationally reported measures: price cap compliance, framework provision and our total spend on agency as a percentage of our total pay bill.

Finance

BSW Integrated Care System

- The organisations in the BSW Integrated Care System must collaborate to develop Revenue and Capital Financial Plans with a view to achieving breakeven against allocations each year. The financial environment is challenging with costs, notably workforce costs, having increased since the pandemic and the NHS funding regime returning to its pre-pandemic levels.
- The BSW System developed a financial plan with a breakeven position for the year, of which the RUH was also planning to achieve breakeven. This plan was accepted by NHS England and non-recurrent revenue support funding of £5.3m had been provided during the year. NHS England amended NHS business rule this year and delivery of the plan meant that this funding will not be repayable in future years.
- At Month 12 the Integrated Care System shows breakeven against plan (see slides 13 & 14 for further details).

RUH Group Financial Plan

- The RUH breakeven plan is underpinned by £32.8m of non-recurrent revenue

support, which was £22.7m revenue financial support from commissioners; and £5.3m of deficit support funding as well as a further £4.8m surge funding from NHSE. For the 25/26 operating plan, only

- The financial plan for the year required full delivery of a £36.6m Savings Programme, which was phased to recognise progressive reduction in costs and increases in income over the year. Delivery of this plan has been supported by an Improvement programme with 3 workstreams focussing on (1) Clinical Operational Service Transformation (2) Paybill Reduction and (3) Cost Control and Commercial Income. Achieving the financial plan was an RUH Breakthrough Objective for 2024/25.

Revenue Financial Performance – Month 12 (see slides 4-12 for further details)

- At Month 12: the Group finished the year at a deficit position of £4.2 million, which is £4.2 million adverse to the breakeven plan
- The key drivers of this variance are:
    - £9.4m net of non-pay and operating income budget overspends, of which c£5m is one off in nature. High-Cost Drugs and Clinical Supplies and Consumables remain a challenge to the budget. Worked WTE continues to reduce but is higher than budgeted trajectory. Pay is overspent by £0.3m, £0.5m relating to underfunding of pay awards.
    - This has been offset by £4.8m additional surge support funding.
- Savings of £32.8m have been delivered (89.5% of annual target), including £17.0m of pay savings against budget, and the benefit of Elective Recovery Fund Income and operating margin of 57%.
- The exit run rate worsened by £1.4m in Month 12 as greater reliance on non-recurrent benefits was required to deliver the £4.2m deficit position.
- The finance team are currently reviewing the 2024/25 financial position against the 2025/26 plan to highlight changes in actuals against the assumptions in the forecast position.

Capital and Balance Sheet Position – Month 12 (see slides 15-17 for further details)

- Total capital expenditure is £64.7m, although this is £1.8m above plan, this was due to an allowable additional spend on a second surgical Robot.
- The closing cash balance for the Group was £37.5m which is 19.5% higher than the plan, however this is anticipated to reduce when the recent capital purchases are paid.

Workforce

Overall, the key workforce performance indicators at the RUH remain positive.

- Staff-in-post in March 2025 was 5708.7 WTE, a slight decrease from the M11 position of 5711.2.
- The pay bill increased to £50.4m in M12 due to predicted £21.6m worth of NHS Pension Contributions.
- The vacancy rate increased from 2.53% in M11 to 3.03% in M12.

- Agency spend as a proportion of the total pay bill decreased from 0.84% (M11) to 0.53% (M12), keeping us well within the local target of 3.5% and the national target of 3.2%.
- Rolling turnover decreased to 8.18% in M12, which is a positive variance against a target of 11.00%.
- The target percentage figure for Appraisal completion is 90%; Appraisal rate increased marginally to 80.43% in M12.
- Mandatory Training compliance continues to meet target at 88.68%.

The priorities within our People agenda will continue the work around pay efficiencies, management of sickness absence and improving appraisal compliance.

A 2025/26 Strategic People, Culture and Leadership Plan 'refresh' has been developed to support stability and change management capability as BSW Hospitals Group develops (presented at April 2025 People Committee)

Summary of ongoing countermeasures are being taken to improve the 5 key standards:

1. Non-attendance due to sickness

Short-Term Sickness:

- Using Allocate reports for real time sickness management, data migrating across to Halo.
- Preventative work with teams and managers around early interventions to manage anxiety, stress and burnout.

Long-Term Sickness:

- The People Hub is supporting managers with 120 long term sickness cases.
- MSK campaign ongoing (Wellbeing Outreach Lead), focusing on Cleaning and Emergency Department.
- Reviewing and developing the staff physiotherapy service.
- Workplace adjustments and Working with Cancer working groups have prepared policies for ratification and resourcing / support tools are launching April / May 2025. Communications plan due April 2025.
- Departmental stress risk assessments to be conducted in ED, Maternity and Radiology in line with the new Wellbeing at Work Policy to address structural issues that increase the risk of stress, burnout, and mental health issues.
- Levels of stress, anxiety and depression are decreasing but still high – tools and resources developed for managers to assess and address issues (including team-based solutions, proactive intervention from Wellbeing Hub).
- Charitable funds used for wellbeing specialist to focus on high pressure areas for worry, stress and burn-out.

2. Appraisal Compliance & Quality:

Despite showing an improvement over the last 12 months, the appraisal rate remains consistently below the target (currently 10% below). A revised Appraisal Policy is now ratified, and Divisional People Partners have started a concerted campaign to support managers to appraise colleagues whose appraisals are out of date and signpost to appraisal training.

3. Agency Spend and Bank Rate

Whilst agency spend is below national target, it is a workstream that continues to have significant focus to support our financial position. Medical and Dental remain the highest spend on agency provision, whilst there was no agency provision in corporate, estates and facilities during Q4. Trust led Workforce Controls continue to support the reduction in temporary staffing usage and spend.

4. Recruitment

Workforce controls remain in operation to support a sustainable workforce for the future. This includes all corporate posts and any clinical post above Band 7 to be subject to additional scrutiny at ICB level to support financial recovery.

5. Mandatory Training

Task and Finish group (with clinical representation) in place to ensure recovery of resus compliance and monitoring of safety outcomes, as well as continuing to raise through Divisional PRM Structure.

Operational Performance

Ambulance Handover

In March, the Trust lost a total of 2,924 hours in ambulance handovers, which was an increase from the previous month (2,849). The percentage of ambulance handovers completed within 30 minutes decreased in March to 27.4% compared to the previous month (29%) against the national standard of 95%. We are working with the team in ED to better utilise our flat bed space capacity (including Resus, Pitstop and High Care) to improve this position.

4 Hour Performance

RUH 4-hour performance in March was 64.48% (58.55% on the RUH footprint unmapped), which was a decrease from February's performance (66.6% and 57.4% respectively). Non-admitted performance was 70.77%, which was a slight increase against the performance for February (70.7%) and admitted performance was slightly improved at 29.06% (February 26.7%).

Non-Criteria to Reside (NC2R)

In March, the Trust had an average of 98 patients without criteria to reside, which was

a decrease of 6.5 patients on the previous month. Additional senior management support on behalf of the Hospital Group, to focus on NC2R, was put in place during the month, which aimed to reduce community waits. Wiltshire P2 and P1 capacity remained the top contributors to adverse performance. The Trust will be supporting the new community-based care partnership provided by HCRG Care Group for the people in Bath and North-East Somerset, Swindon, and Wiltshire from April 2025, seeking opportunities to improve access for our patients who no longer require acute hospital care.

Referral to Treatment (RTT)

In March, the Trust achieved an RTT performance of 60.5%, which was a decrease of 0.4% from February. For waiters > 65 weeks, the Trust saw a decrease from 11 to 8 patients. There was 1 patient waiting > 78 weeks at the end of March (corneal transplant waits further to patient choice) and 7 patients > 65 weeks (further to choice and complexity across a range of specialities).

Cancer 62-Days

Performance in February dropped just below the 70% standard, achieving 69.3%, which followed a deterioration in performance in Breast, Head & Neck, Upper GI and Urology. Despite achieving the target, Breast performance reduced with half of the breaches for patients referred later, on the screening pathway, being received by the RUH over halfway through their pathway. Waiting time across the Breast pathway had lengthened due to long term sickness of key surgical and radiology staff. Upper GI was predominantly impacted by the waiting time for Gastro OPA, but also longer pathways for patients requiring Endoscopic Ultrasound (EUS) at University Hospitals Bristol and Weston (UHBW). Urology was primarily impacted by Magnetic Resonance Imaging (MRI) and Local Anaesthetic Transperineal Prostate (LATP) biopsy waiting times in December 2024 and January 2025. Colorectal remained the most challenged tumour site despite their performance improving in-month to 53.8%.

Diagnostics

In March, 74.37% of patients received their diagnostic within the 6-week target against an in-month target of 94.70% (revised trajectory October 2024). This represented a reduction in breaches of 4.77% compared to the previous month (-645 breaches), despite being off trajectory. March continued to see increased activity levels in-line with ongoing planned recovery action (+1865 diagnostics tests delivered when compared to the previous month). Increased demand for urgent and suspected cancer continued to impact on available capacity for routine diagnostics, despite increased activity levels.

Elective Recovery

Month 12 delivered 116% of 2019/20 ERF activity overall and 109% of the Trust planned activity volumes, which generated an in-month contribution of £1.6m over delivery against plan.

Quality

This report highlights performance against the Trust patient safety, quality and patient experience priorities. These have been identified through the Quality and Patient Experience Improving Together A3s. The Quality A3 describes the harm that could be caused to patients if consistently high quality and safe care is not delivered.

The Quality Report routinely reports on agreed performance measures and patient safety priorities.

Updates:

Pressure Ulcers
The RUH benchmarks performance against other Acute Trusts in the Integrated Care System (ICS) for the number of pressure ulcers per 1,000 bed day and the overall number of pressure ulcers by category.
For February 2025, the RUH reported 0.4 pressure ulcers per 1,000 bed days (7 pressure ulcers). GWH reported 0.89 and Salisbury data was not available.
The RUH investigated two category 3, two category 2 pressure ulcers and three medical device related pressure ulcers, one of which was a category 4 pressure ulcer, across five wards. The category 4 medical device related pressure ulcer was found to have no lapses in care following full review. There were no new emerging themes.

Falls
In February 98.2% of patients admitted to the RUH did not sustain a fall whilst in our care. There was 1 reported fall that resulted in moderate harm to a patient. The incident occurred on a surgical ward and resulted in a hip fracture. A Safety Huddle has been completed for these incidents and any learning noted at this stage. Where appropriate a further investigation will be completed and presented to the investigation panel. Any actions formulated are then included in the falls work plan to ensure improvement work is planned and completed.

Infection Prevention and Control Update
There were 11 cases of Clostridiodes Difficile Infection (CDI), there were 9 Hospital Onset Healthcare Acquired (HOHA) and 2 Community Onset Healthcare Acquired (C)OHA) reported in February 2025. The Trust has reported 94 cases against a threshold of 75. The cases have been widespread across the Trust predominantly in the Medical Division with total of 49 cases due to the patient's demographic. Further investigation into cause and effect relating to the increase of this infection is supported by the CDI Collaborative in the Southwest. The Infection, Prevention and Control Team are reviewing insights and intelligence regarding the rise in CDI which will be presented to the next Quality Assurance Committee.

There were 6 cases of *E. coli* infection (2 HOHA and 4 COHA) reported during January 2025. This means there are 90 cases against a threshold of 82. With the incidence of urinary and hepatobiliary source accounting for 53 (59%) of cases, which is the Trusts predominant contributor in cases of *E. coli*. Improvement work is focussing on completion of fluid charts, to support the patients and improve accuracy of data recorded.

Patient Support and Complaints
In February, the Trust received 32 new formal complaints, this compares to 31 received in January. The number of reopened complaints remains low with the majority of contacts satisfied with the outcome/response. 2 complaints were reopened in February. 74% (target 90%) of complaint responses were closed within the agreed timeframe with the complainant. Early resolution (within 14 days) was achieved in 79% of all complaints and concerns (target 75%). The Listening Service continues to provide helpful support to families in resolving families concerns.

Safe Staffing
The combined shift fill rates for day shifts for Registered Nurses (RNs) across the 25 inpatient wards was 92% and 100% respectively for night shifts. The combined shift fill rate for Health Care Support Workers (HCSWs) was 89% for the day and 102% for the night shift. The 102% represents the additional HCSW shifts for patients requiring 1 to 1 care. Therefore, the Trust as a collective set of wards is within safe limits for February.

Total monthly CHPPD is 8.6 reflecting the same as the previous month. CHPPD continues to remain stable for both registered and unregistered staff over the past 12 months.

When reviewed on Model Hospital (latest data January 2025) we remain in quartile 3 and benchmark in line with the peer median of 8.6.

Perinatal Update

- Birth to Midwife ratio improved since last month
- MDT ward round compliance reduction was an error in recording and this has been addressed
- Inaccurate neonatal shift fill rates are being addressed with rostering team to remove unused tiles on the electronic rostering system and ensure roster requirement are validated for neonatal roster
- There is on-going training and validation of Birthrate+ data on Mary ward to ensure accuracy of percentage of time staffing meets or does not meet acuity, escalation guidance used to mitigate if safe staffing concerns.
- There were two antenatal stillbirths in month, no immediate care concerns were identified
- No neonatal deaths in month
- Review of triangulation of feedback group underway to streamline feedback and ensure robust triangulation, setting and monitoring of actions

2.	Recommendations (Note, Approve, Discuss)
The Board is asked to note the report and discuss current performance, risks and associated mitigations.	

3.	Legal / Regulatory Implications
Trust Single Oversight Framework.	

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)
The Integrated Performance Report is linked to the Board Assurance Framework and Risk Register.	

5.	Resources Implications (Financial / staffing)
Operational, Financial, Workforce, and Quality Assurance risks as set out in the paper.	

6.	Equality and Diversity
NA	

7.	References to previous reports
Standing agenda item.	

8.	Freedom of Information
Public	

9.	Sustainability
None identified.	

10.	Digital
None identified.	

NHS
Royal United Hospitals Bath
NHS Foundation Trust

Integrated Performance Report

April 2025 (March 2025 data)

The RUH, where you matter

Trust Priorities 2024/25

Royal United Hospitals Bath NHS Foundation Trust

The people we care for

The people we work with

The people in our community

Trust goals

- Patient safety incidents (moderate to catastrophic)
- Number of patients over 65 weeks
- Overall patient experience score
- % recommend RUH as a place to work
- % staff say the organisation acts fairly with regard to career progression
- % staff experiencing discrimination at work
- Delivery of breakeven position
- Equity of access to RUH for all
- Carbon emission reduction

Breakthrough goals 24/25

Why not home? Why not now?
Reducing inpatient length of stay top 25% of acute trusts

Discrimination
% of staff reporting they have experienced discrimination at work

Making best use of available resources
Delivery of financial plan

Enabling Breakthrough Goal: We "Improve Together" to make a difference
(measured by the adoption of tools, routines and behaviours of Improving Together via a quarterly maturity assessment)

Trust-wide projects

- **Patient Safety Programme -** Quality Management System, Patient Safety Incident Response Framework, Paperless Inpatients
- **Atrium Redesign**
- **Patient Experience Programme** - DrDoctor Patient Platform, Website
- **Clinical Estate -** One ICU, Maternity DAU, Dyson Cancer Centre Benefits Realisation
- **Community Services Tender**
- **Elective & Cancer -** Community Diagnostic Centre & Sulis Elective Orthopaedic Centre

- **Foundations Programme** – Basics Matter & People Hub
- **Workforce Plan**
- **Employee Experience & Engagement –** Joy at Work, Employee Recognition
- **Restorative, Just & Learning Culture**
- **Equality, Diversity & Inclusion Programme** – Positive Action & Dignity at Work
- **Leadership Development Programme**

- **Health Inequalities Programme** – Preventative services, Anchor Plan
- **Estate Decarbonisation**
- **Financial Improvement Programme** – Clinical productivity, Pay Bill, Income and cost controls
- **Single EPR**
- **Acute Hospital Alliance reset** – Clinical and Corporate Services

Business Rules

	Measure		Suggested Rule	Expectation
Trust Goals, Breakthrough & Key Standards	Driver is **green** for current reporting period		Share success and move on.	No action required.
	Driver is **green** for 6 reporting periods		Retire to tracker measure status.	Standard structured **verbal** update, and retire measure to tracker status.
	Driver is **red** for current reporting period		Share top contributing reason, the amount this contributor impacts the measure, and summary of initial action being taken.	Standard structured **verbal** update.
	Driver is **red** for 2+ reporting periods		Undertake detailed improvement / action planning and produce full structured countermeasure summary.	Present full written **countermeasure** analysis and summary.
	More than **6** countermeasure summaries to present		Discuss with Exec before Meeting which countermeasure summaries should be prioritised for presentation.	Present full written **countermeasure** summary against Exec expectations.

Royal United Hospitals Bath
NHS Foundation Trust

Finance Report

Month 12

The people in our community

The RUH, where you matter

Executive Summary

BSW Integrated Care System

- The organisations in the BSW Integrated Care System must collaborate to develop Revenue and Capital Financial Plans with a view to achieving breakeven against allocations each year. The financial environment is challenging with costs, notably workforce costs, having increased since the pandemic and the NHS funding regime returning to its pre-pandemic levels.
- The BSW System developed a financial plan with a breakeven position for the year, of which the RUH was also planning to achieve breakeven. This plan was accepted by NHS England and non-recurrent revenue support funding of £5.3m had been provided during the year. NHS England amended NHS business rule this year and delivery of the plan meant that this funding will not be repayable in future years.
- At Month 12 the Integrated Care System shows breakeven against plan (see slides 13 & 14 for further details)

RUH Group Financial Plan

- The RUH breakeven plan is underpinned by £32.8m of non recurrent revenue support, which was £22.7m revenue financial support from commissioners; and £5.3m of deficit support funding as well as a further £4.8m surge funding from NHSE. For the 25/26 operating plan, only
- The financial plan for the year required full delivery of a £36.6m Savings Programme, which was phased to recognise progressive reduction in costs and increases in income over the year. Delivery of this plan has been supported by an Improvement programme with 3 workstreams focussing on (1) Clinical Operational Service Transformation (2) Paybill Reduction and (3) Cost Control and Commercial Income. Achieving the financial plan was an RUH Breakthrough Objective for 2024/25.

Revenue Financial Performance – Month 12 (see slides 4-12 for further details)

- At Month 12: the Group finished the year at a deficit position of £4.2 million, which is £4.2 million adverse to the breakeven plan
- The key drivers of this variance are:
    - £9.4m net of non-pay and operating income budget overspends, of which c£5m is one off in nature. High Cost Drugs and Clinical Supplies and Consumables remain a challenge to the budget. Worked WTE continues to reduce but is higher than budgeted trajectory. Pay is overspent by £0.3m, £0.5m relating to underfunding of pay awards.
    - This has been offset by £4.8m additional surge support funding.
- Savings of £32.8m have been delivered (89.5% of annual target), including £17.0m of pay savings against budget, and the benefit of Elective Recovery Fund Income and operating margin of 57%.
- The exit run rate worsened by £1.4m in Month 12 as greater reliance on non-recurrent benefits was required to deliver the £4.2m deficit position.
- The finance team are currently reviewing the 2024/25 financial position against the 2025/26 plan to highlight changes in actuals against the assumptions in the forecast position.

Capital and Balance Sheet Position – Month 12 (see slides 15-17 for further details)

- Total capital expenditure is £64.7m, although this is £1.8m above plan, this was due to an allowable additional spend on a second surgical Robot.
- The closing cash balance for the Group was £37.5m which is 19.5% higher than the plan, however this is anticipated to reduce when the recent capital purchases are paid.

Executive Scorecard

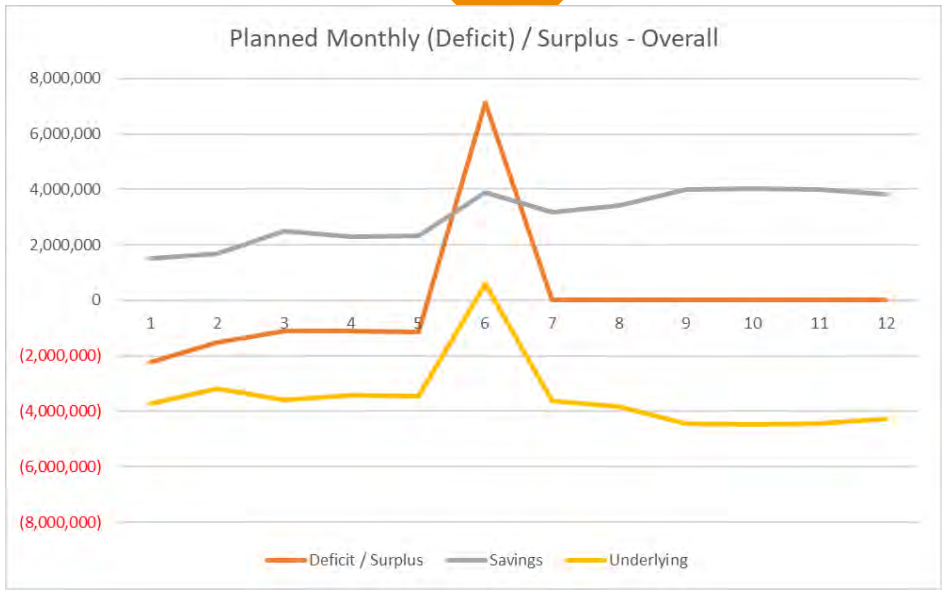
	Performance Indicator	Description	Target		Baseline	Actual 2024/25											
			Performing	Under Performing		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Sustainability Tracker Metrics	Delivery of Group financial plan	Variance from year to date plan	<=0	>0	£0	£0m	(£0.08m)	(£1.50m)	(£0.61m)	(£0.63m)	(£1.88m)	(£2.11m)	(£4.24m)	(£6.27m)	(£8.96m)	(£5.34m)	(£4.2m)
	Forecast delivery of Group financial plan	Forecast variance from year to date plan	<=0	>0	(£5.30m)	£0m	£0m	£0m	£0m	£0m	£0m	£0m	£0m	£0m	(£9.00m)	(£4.2m)	(£4.2m)
	Group delivery of Plan	Total year to date financial performance	<=0	>0	(£5.30m)	(£2.26m)	(£4.06m)	(£6.50m)	(£6.59m)	(£7.76m)	(£1.88m)	(£2.11m)	(£4.24m)	(£6.27m)	(£8.96m)	(£5.34m)	(£4.20m)
	Value of Forecast QIPP Unidentified	Forecast performance against plan	< = £5m	> £5m	£0m	£2.86m	£2.86m	£2.86m	£2.81m	£2.81m	£2.81m	£2.81m	£0.00m	£0.00m	£0.00m	£0.00m	(£3.83m)
	Delivery of QIPP against plan	Performance against plan	<=100%	>100%	100.0%	100.0%	98.0%	96.1%	99.2%	95.2%	89.2%	97.0%	100.5%	93.8%	91.9%	89.4%	89.5%
	Reduction in agency expenditure	Agency costs as a % of total pay costs	<= 3%	> 3%	3.0%	1.2%	1.2%	0.3%	1.0%	1.0%	1.0%	0.8%	1.1%	0.5%	0.8%	0.9%	0.8%
	Sickness against plan	Actual levels of sickness against average pre-pandemic levels	<= 4.1%	> 4.1%	4.5%	4.5%	4.4%	4.4%	4.9%	4.6%	4.4%	4.6%	5.2%	4.6%	5.1%	5.2%	5.1%
	Net impact of high cost drugs and devices	Total expenditure and income against plan for high cost drugs and devices	<=0	>0	£0	(£0.1m)	(£0.6m)	(£0.8m)	(£1.2m)	(£1.1m)	(£1.7m)	(£1.5m)	(£2.2m)	(£2.0m)	(£2.2m)	(£2.4m)	(£2.1m)
	Increase productivity	Implied productivity based on financial and operational performance (Quarterly)	>=3%	3%	-7%	-23%	-23%	-23%	-23%	-23%	-13%	-13%	-13%	-12%	-9%	-9%	-9%
	Elective recovery	In Month Performance against planned levels of activity (Value based)	>= 100%	< 100%	n/a	112%	113%	109%	106%	105%	105%	114%	112%	101%	104%	111%	119%
	Non elective activity	In Month Performance against planned levels of activity (Value Based)	<= 102%	> 102%	n/a	119%	142%	116%	120%	112%	113%	112%	107%	109%	110%	106%	97%
	Delivery of capital programme	Variance from year to date planned capital expenditure (Internally Funded Schemes)	-5%	<5%	n/a	67.3%	51.9%	69.7%	65.7%	61.8%	51.8%	63.7%	66.2%	63.2%	76.9%	78.6%	100.0%
	Forecast delivery of capital programme	Forecast variance from annual planned capital expenditure	+ or - 5%	><5%	n/a	0	0	0	0	0	0	0	0	0	0	0	0
	Delivery of planned cash balance	Variance from year to date planned cash balance	- 10%	<10%	n/a	8.8%	25.6%	24.50%	38.7%	40.0%	17.4%	64.9%	41.6%	30.2%	16.0%	25.8%	19.5%

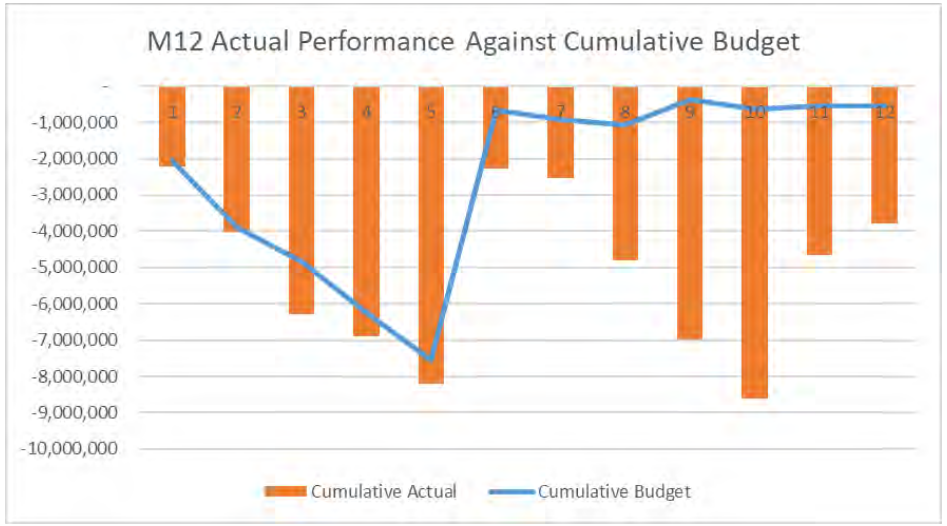
Overall Revenue Position

At Month 12 the Group is at a deficit position of £4.2million which is £4.2million adverse to a breakeven plan.

The Planned Monthly (Deficit) / Surplus graph shows the phased budget over the year. This shows the base case deficit around £3.5 million per month with savings recovering this position and a gradually increasing rate. This graph has been updated to include the £5.3m system recovery funding.

The second graph shows the Cumulative Actuals and Budget. The profile highlights the I&E deficits arising up to Month 6 and highlights the step up in savings delivery in second half of the year to deliver in-month surpluses creating the improvement against the cumulative position.





True North | Breakeven position

Statement of Comprehensive Income Period to 202412	RUH						Sulis						Group Adjustment						Total Group Position					
	202412			YTD			202412			YTD			202412			YTD			202412			YTD		
	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000
Commissioner Income (NHSE/CCG)	39,556	66,818	27,262	482,944	511,456	28,512	3,987	2,901	(1,086)	32,931	29,146	(3,785)	0	0	0	0	0	0	43,544	69,720	26,176	515,875	540,602	24,727
Other Patient Care Income	579	329	(250)	7,358	8,458	1,101	1,362	1,297	(65)	17,090	14,831	(2,259)	0	0	0	0	0	0	1,941	1,626	(315)	24,448	23,289	(1,159)
Other Operating Income	4,405	4,556	152	48,994	60,320	11,326	12	17	5	144	348	204	(201)	(204)	(3)	(2,374)	(2,383)	(9)	4,216	4,370	154	46,763	58,286	11,522
Unallocated	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Income Total	44,540	71,703	27,164	539,296	580,235	40,939	5,361	4,215	(1,146)	50,165	44,325	(5,840)	(201)	(204)	(3)	(2,374)	(2,383)	(9)	49,700	75,715	26,015	587,087	622,177	35,090
Pay	(27,974)	(51,014)	(23,039)	(342,126)	(368,191)	(26,065)	(2,629)	(1,896)	733	(26,154)	(22,655)	3,498	0	0	0	0	0	0	(30,604)	(52,910)	(22,306)	(368,279)	(390,846)	(22,567)
Non Pay	(12,411)	(17,085)	(4,673)	(151,320)	(174,769)	(23,449)	(2,175)	(2,050)	125	(18,940)	(18,230)	710	0	0	0	0	0	0	(14,586)	(19,135)	(4,548)	(170,260)	(192,999)	(22,739)
Depreciation	(1,786)	(1,948)	(162)	(21,431)	(21,035)	396	(386)	(237)	149	(3,367)	(2,748)	619	145	148	3	1,740	1,748	8	(2,027)	(2,037)	(10)	(23,057)	(22,035)	1,023
Impairment	(578)	(1,182)	(604)	(6,941)	(10,400)	(3,459)	0	0	0	0	0	0	0	0	0	0	0	0	(578)	(1,182)	(604)	(6,941)	(10,400)	(3,459)
Expenditure Total	(42,750)	(71,229)	(28,479)	(521,818)	(574,395)	(52,577)	(5,190)	(4,183)	1,007	(48,460)	(43,633)	4,827	145	148	3	1,740	1,748	8	(47,795)	(75,264)	(27,469)	(568,538)	(616,280)	(47,742)
Operating Surplus/(Deficit)	1,790	475	(1,315)	17,478	5,840	(11,638)	171	32	(139)	1,706	692	(1,013)	(56)	(56)	(0)	(634)	(635)	(0)	1,905	451	(1,454)	18,549	5,897	(12,652)
Other Finance Charges	(938)	(483)	455	(11,256)	(7,815)	3,441	(143)	(41)	102	(914)	(524)	390	29	29	0	378	380	1	(1,052)	(494)	558	(11,791)	(7,960)	3,832
Other Gains/Losses	0	(9)	(9)	0	26	26	0	(12)	(12)	0	(12)	(12)	0	0	0	0	0	0	0	(20)	(20)	0	14	14
Finance Charges	(938)	(491)	447	(11,256)	(7,789)	3,467	(143)	(52)	91	(914)	(536)	378	29	29	0	378	380	1	(1,052)	(515)	538	(11,791)	(7,945)	3,846
Surplus/(Deficit)	852	(17)	(868)	6,222	(1,949)	(8,171)	28	(20)	(48)	792	157	(635)	(27)	(27)	0	(256)	(255)	1	853	(64)	(916)	6,758	(2,048)	(8,806)
Adjusted Financial Performance																								
Add back all I&E impairments/ (reversals)	578	1,182	604	6,941	10,400	3,459	0	0	0	0	0	0	0	0	0	0	0	0	578	1,182	604	6,941	10,400	3,459
Remove capital donations/grants I&E impact	(1,429)	(301)	1,128	(13,699)	(12,233)	1,466	0	0	0	0	0	0	0	0	0	0	0	0	(1,429)	(301)	1,128	(13,699)	(12,233)	1,466
System Adjustment	0	0	0	0	(23)	(23)	0	0	0	0	312	312	0	0	0	0	0	0	0	0	0	0	289	289
Adjusted financial performance for the purposes of system achievement	**1**	**865**	**864**	**(536)**	**(3,759)**	**(3,223)**	**28**	**(20)**	**(48)**	**792**	**(155)**	**(947)**	**(27)**	**(27)**	**0**	**(256)**	**(255)**	**1**	**2**	**818**	**816**	**(0)**	**(4,170)**	**(4,169)**

Note. The RUH breakeven plan is underpinned by £32.8m of non recurrent revenue support, which was £22.7m revenue financial support from commissioners; and £5.3m of deficit support funding as well as a further £4.8m surge funding from NHSE.

At Month 12 both Pay expenditure and Income include one off accounting adjustment of c£21.6m in respect of increased rate of employer's pension contributions

For NHSE financial performance the consolidated RUH Foundation Trust and Sulis financial position is taken into account. Adjustments are made for technical accounting entries related to Impairments and Capital Donations

Expenditure Trend Analysis

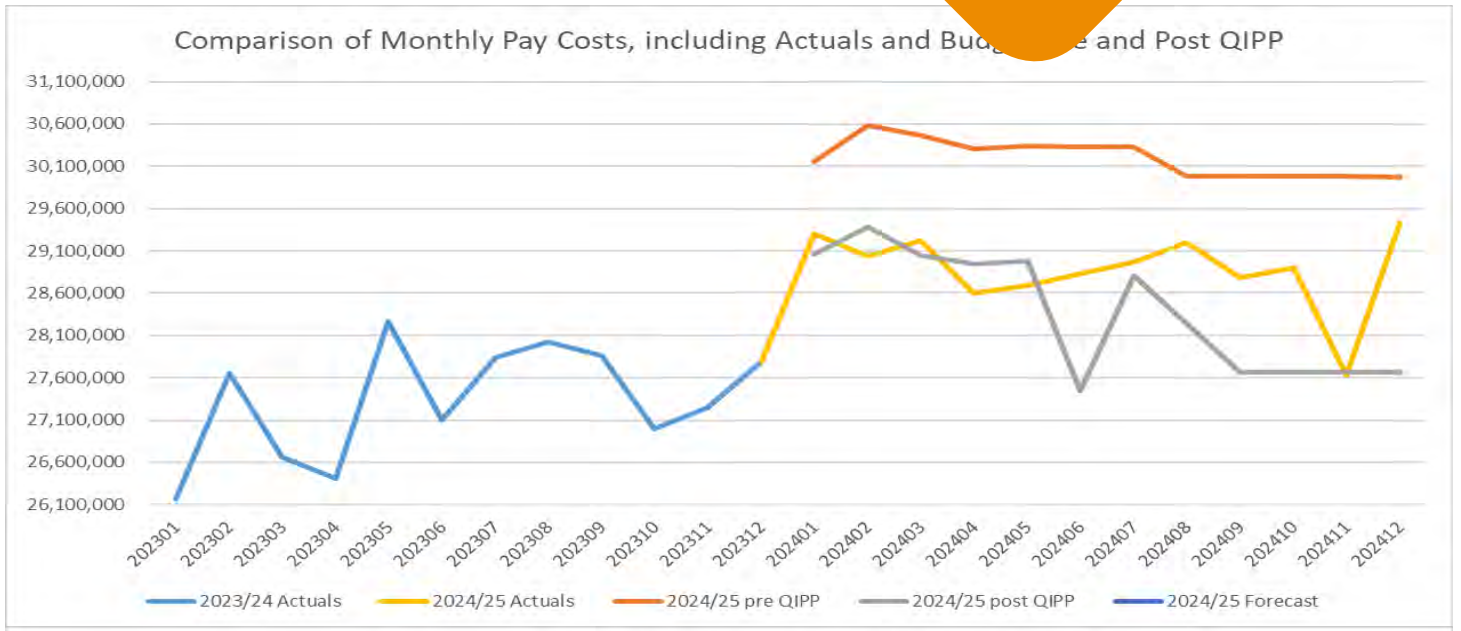
The graphs show the trend of Pay (top graph) and Non-Pay (bottom graph) by Month from April 2023 for the RUH Trust; and how these compare with operating plan assumptions before and after Savings delivery

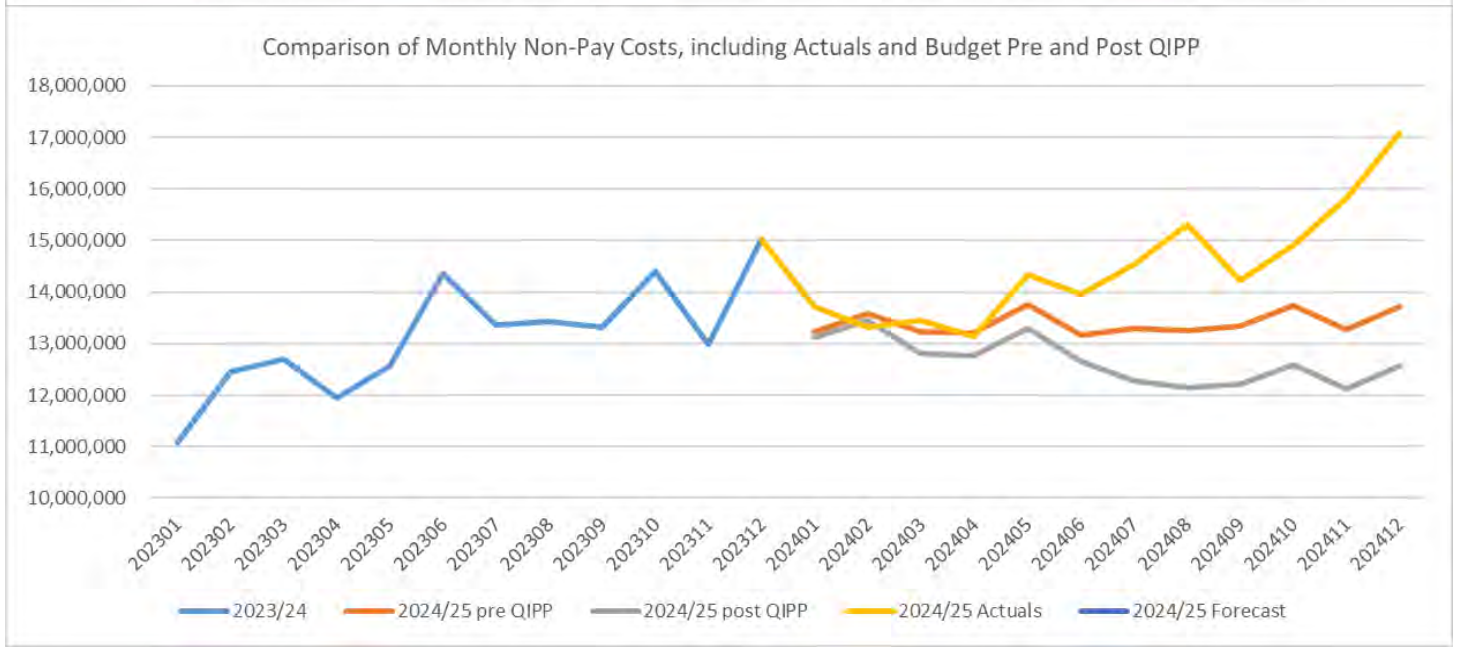
The actual Pay spend in 2023/24 has fluctuated due to backdated pay awards being funded, but there was an overall upward trend in pay costs in 2023/24.

Pay costs in M12 are back in line with trend after year-to-date SEOC costs were moved into non-pay in February.

Non-Pay costs do vary between month, partly related to clinical activity and seasonal variation for utility costs. The increase in M12 reflects increases in spend in clinical supplies and premises.

Both graphs highlight the challenge of savings required during 2024-25.



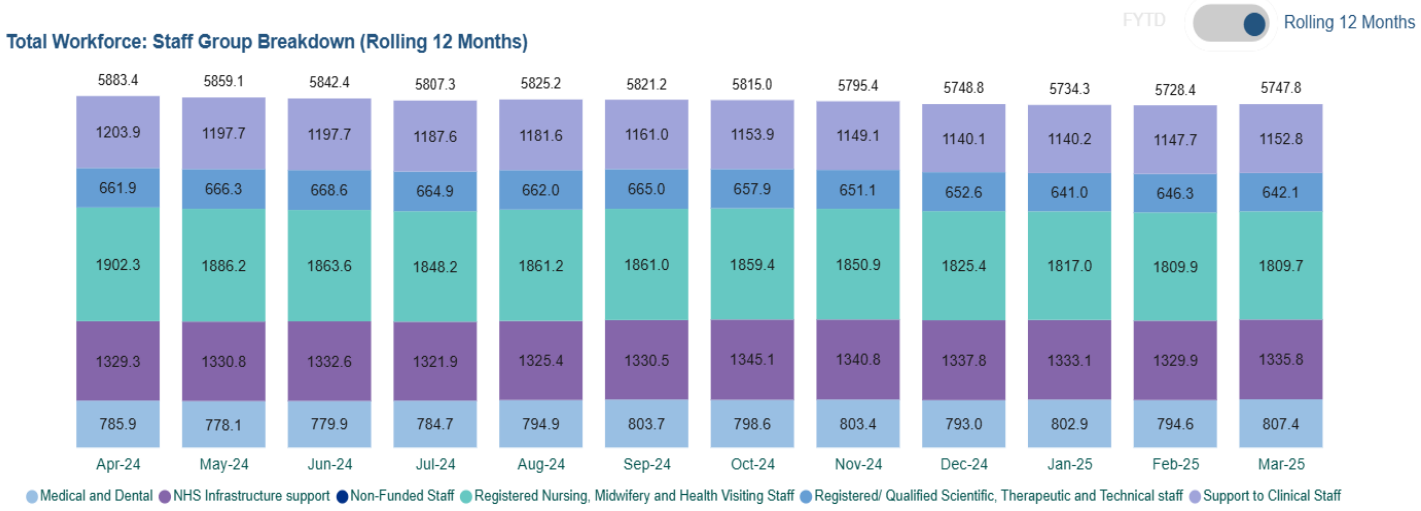


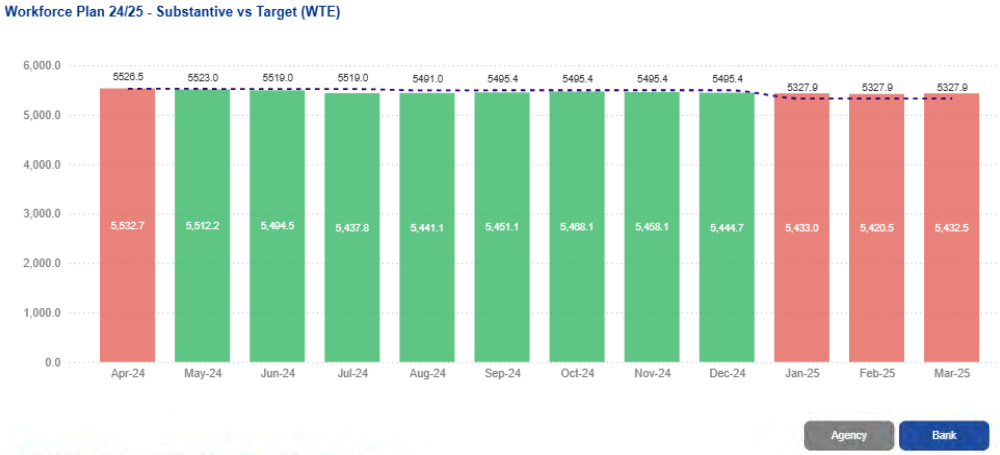
Driver Measure - Workforce Analysis

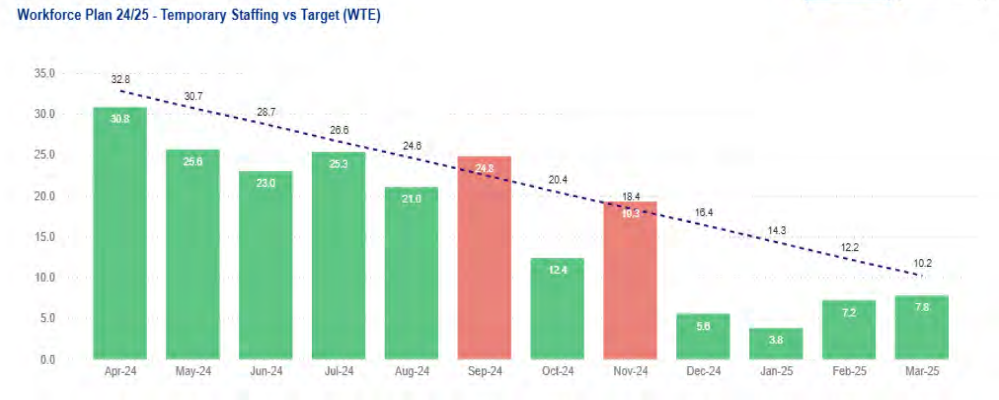
As well as tracking the overall value of Workforce Costs the Trust tracks the Whole Time Equivalent (WTE). The graphs show the Budgeted, Forecast and Actual WTE working per month.

These reports show the actual worked in month. The calculation for Bank has been aligned between Workforce and Finance Reporting.

These graphs highlight the planned reduction of WTE during the year and will measure the performance against that plan. The total WTE has reduced by 166.2 (2.8%) from 5,914.0 in March 23 to 5,747.8 in March 24. Bank usage has increased since February, and agency usage has stayed at a consistent level in month.







QIPP | Financial Progress - overview

Delivery by Month 12 by Improvement Programme Theme

	Year to Date Plan	Year to date Actuals	Variance
	£'000	£'000	£'000
1_Clinical Operation Trans	£9,142	£8,965	-£177
2_Pay Bill reduction	£19,400	£17,033	-£2,367
3_Cost Control/Comm Income	£8,058	£6,777	-£1,280
Total In Year Delivery	**£36,600**	**£32,775**	**-£3,825**

Delivery by Month 12 by Division

DIVISION	PAY	NON-PAY	INCOME	TOTAL
MEDICINE & ED	£4,529	£1,492	£133	£6,154
SURGERY	£3,380	£758	£359	£4,497
FASS	£1,819	£51	£144	£2,014
TOTAL Clinical Divisions	£9,728	£2,301	£636	£12,665
INCOME	£0	£0	£10,836	£10,836
TOTAL Clinical Divisions & Income	£9,728	£2,301	£11,472	£23,501
CORPORATE	£2,396	£252	£81	£2,729
ESTATES & FACILITIES	£2,627	£394	£139	£3,160
Annual Leave Accrual	£2,502	£0	£0	£2,502
Other Drugs		£727		£727
TOTAL Trust	£17,252	£3,674	£11,692	£32,618
SULIS	£0	£0	£157	£157
TOTAL Group	£17,252	£3,674	£11,849	£32,775

Summary

As the end of month 12 delivered £32.8 million against a £36.6 million plan. This meant an under delivery of plan by £3.8 million.

The majority of savings are delivered recurrently and together with a full year effect of £3.8m the full year savings are £36.6m

This was achieved predominantly due to:

- Coding initiatives
- Vacancy Gap savings
- Ward 4 pay & non pay savings
- Paid break pay savings
- Reduction in agency/overtime
- Procurement and medicine savings
- Theatres
- Release of annual leave accrual
- Pay efficiencies from paperless inpatient Project
- Increased elective productivity
- Corporate pay savings

QIPP | Financial Progress – by Division and Programme

Delivered for 24/25

	MEDICINE & ED	SURGERY	FASS	INCOME	ESTATES & FACILITIES	CORPORATE	TRUST CENTRAL	SULIS	Grand Total
1_Clinical Operation Trans	**£368**	**£0**	**£0**	**£7,917**	**£679**	**£0**			**£8,965**
clinical service transformation		£0	£0	£3,710		£0			£3,710
Elective Income				£2,721					£2,721
Estates & Facilties					£679				£679
Outpatients (All Divisions)				£303					£303
Radiology	£222			£87					£309
Theatres				£1,096					£1,096
Patient Flow	£147								£147
2_Pay Bill reduction	**£4,472**	**£3,380**	**£1,907**		**£2,453**	**£2,319**	**£2,502**		**£17,033**
Estates & Facilties					£109				£109
Central HR Initiatives	£2,058	£1,952	£1,845		£2,344	£2,204	£2,502		£12,905
Patient Flow	£554	£1,066							£1,620
Nurse & Therapies Staffing	£1,860	£309	£62			£115			£2,346
Medical Staffing		£53							£53
3_Cost Control/Comm Income	**£1,313**	**£1,117**	**£107**	**£2,919**	**£28**	**£410**	**£727**	**£157**	**£6,777**
Clinical Income (including coding)				£2,716					£2,716
IT improvement programme paperless inpatients						£0			£0
Commercial Opportunites	£78	£198	£144	£0		£71			£491
Pharmacy Services & Medicines Management	£34	£72	-£75	£203			£727		£961
Procurement & Inventory Management	£976	£736	£38		£28	£103			£1,880
FYE 23-24	£0	£0	£0	£0	£0		£0	£0	£0
Divisional Lead	£225	£111				£236			£572
Sulis								£157	£157
Grand Total	**£6,154**	**£4,497**	**£2,014**	**£10,836**	**£3,160**	**£2,729**	**£3,229**	**£157**	**£32,775**

QIPP | ERF – SLAM income performance

SLAM Income Performance

	April £	May £	June £	July £	August £	September £	October £	November £	December £	January £	February £	March £	Total 24/25 £	Total QIPP £
Productivity Performance														
Theatres/Elective Pathway	79,663	32,543	75,867	95,734	71,617	111,876	140,115	117,155	100,328	75,679	96,277	99,546	1,096,400	1,096,400
Outpatients DNA Reduction	57,018	85,859	70,083	36,548	58,181	48,536	23,643	54,591	14,429	30,908	13,970	16,833	510,599	510,599
Outpatients DNA Increases	(8,193)	(8,189)	(22,024)	(16,388)	(11,548)	(7,931)	(19,679)	(8,825)	(34,905)	(18,682)	(25,582)	(26,047)	(207,993)	(207,993)
Elective Other - balance	707,834	130,974					551,037	1,278,487	0	0	53,719	0	2,722,051	2,722,051
Radiology coding												87,007	87,007	87,007
Productivity Over the Plan	330,120	891,623	532,111	(35,126)	180,104	(714,714)	(126,835)	(716,768)	(9,394)	(177,151)	148,368	1,714,607	2,016,945	
Total Productivity Income	1,166,442	1,132,810	656,037	80,768	298,354	(562,233)	568,281	724,640	70,458	(89,246)	286,752	1,891,946	6,225,009	4,208,064
PLICS Savings						927,960	154,667	154,667	154,667	154,667	154,667	154,667	1,855,962	1,855,962
AI Scheme										44,512	277,342	456,990	778,844	778,844
Clinical Coding	0	0	117,522	517,888	118,958	146,558	542,184	175,667	175,667	549,064	208,555	208,455	2,760,516	2,760,516
SLAM Income Performance	**1,166,442**	**1,132,810**	**773,559**	**598,657**	**417,312**	**512,285**	**1,265,132**	**1,054,974**	**400,791**	**658,996**	**927,316**	**2,712,058**	**11,620,331**	**9,603,386**

Performance at Month 12

The performance in March significantly improved from M11, this came from the completion of clinical coding review from the application of AI as well as a full month of additional out of hours work and little interruption of elective inpatient care from urgent and emergency pressures.

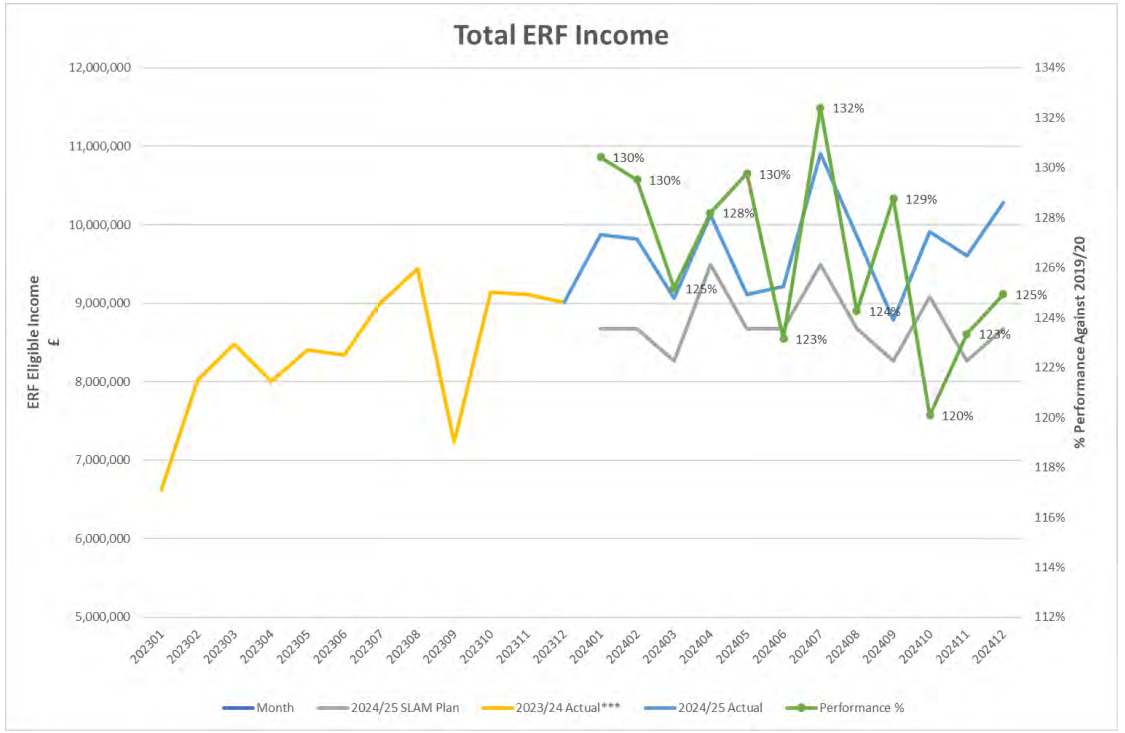
Driver Measure - RUH ESRF Performance

The total value of ERF eligible activity was £10.2 million in month. This is an increase of £1 million from February. Backdated coding was completed in month contributing significantly to the income with underlying performance improving again from M11 delivering against the forecasted value in month and contributing £1.6 million income over the plan.

	Investment Expenditure			Elective Recovery Performance			Metrics		
	Plan	Actual	Variance	Plan	Actual Performance Against 19/20	Variance	Performance Against 19/20	Performance Against Plan	Margin
Division	£'000	£'000	£'000	£'000	£'000	£'000	%	%	%
FASS	1,003	1,401	(398)	4,373	7,820	3,447	84%	116%	82%
Medicine	4,244	4,014	229	7,061	10,008	2,946	139%	109%	60%
Surgery	5,626	5,471	155	2,246	7,473	5,228	122%	110%	27%
Total	**10,873**	**10,887**	(14)	**13,680**	**25,301**	**11,620**	133%	111%	57%

Performance year to date:

- Actual investment costs are £10.9 million coming in on budget. This investment generated additional income of £25.3 million, £11.6 million above plan.
- The margin is 57% compared to a planned margin of 35% and this has contributed £9.6 million to the Savings Programme



Productivity

Productivity is measured as changes in costs, compared to changes in activity levels. Productivity has deteriorated since pre-pandemic, although is now recovering. The reduction in productivity is a key driver of the Trust's adverse financial position and why the Government is expecting higher activity and performance delivery without further uplifts in funding.

Table 1 compares productivity with 19/20 up to Month 7.
On this metric RUH productivity has deteriorated by 9.6%.
However, this is better than Regional and National average.

	Explained change in spend				Explained activity			
System name	Inflation adj. expenditure	Service transfers	Non acute service change (incl	Unexplained expenditure growth	Cost weighted activity	Service transfers	Unexplained Activity Change	Implied productivity growth
GLOUCS	13.7%	6.6%	0.0%	20.2%	2.8%	0.0%	2.8%	(14.5%)
DEVON	29.9%	(6.1%)	0.0%	23.8%	14.3%	0.0%	14.3%	(7.7%)
BNSSG	27.0%	(1.0%)	0.0%	26.0%	10.0%	0.0%	10.0%	(12.7%)
SOMERSET	25.8%	0.0%	(2.0%)	23.8%	6.9%	0.0%	6.9%	(13.6%)
DORSET	22.5%	0.0%	0.0%	22.5%	3.4%	1.2%	4.6%	(14.6%)
BSW	29.1%	(5.5%)	(0.6%)	23.0%	7.5%	0.0%	7.5%	(12.6%)
CORNWALL	22.7%	(0.4%)	0.0%	22.3%	1.9%	0.0%	1.9%	(16.6%)
SW Region	26.0%	(2.1%)	(0.3%)	23.6%	7.7%	0.2%	7.8%	(12.8%)
Salisbury	26.9%	0.0%	0.0%	26.9%	11.7%	0.0%	11.7%	(11.9%)
GWH	25.4%	0.0%	(1.9%)	23.4%	3.8%	0.0%	3.8%	(15.9%)
RUH	34.4%	(14.4%)	0.0%	19.9%	8.5%	0.0%	8.5%	(9.6%)

Table 2 compares productivity with 23/24 up to Month 7.
On this metric RUH productivity has improved by 3.0%,
which is lower than National average.

	Explained cost change			Explained activity change			
System name	Inflation adj. expenditure	Service transfers	Unexplained exp growth	Cost weighted activity	Changes to Activity	Unexplained activity change	Implied productivity growth
DEVON	3.5%	0.0%	3.5%	11.6%	0.0%	11.6%	7.8%
BSW	3.6%	(0.3%)	3.3%	8.1%	0.0%	8.1%	4.6%
GLOUCS	3.1%	0.0%	3.1%	7.3%	0.0%	7.3%	4.0%
SOMERSET	3.1%	0.0%	3.1%	7.4%	0.0%	7.4%	4.2%
CORNWALL	4.2%	0.0%	4.2%	8.2%	0.0%	8.2%	3.8%
DORSET	5.1%	0.0%	5.1%	7.0%	0.5%	7.5%	2.4%
BNSSG	4.8%	0.0%	4.8%	6.4%	0.0%	6.4%	1.5%
SW Region	4.0%	(0.0%)	3.9%	8.3%	0.1%	8.3%	4.3%
Salisbury	2.1%	0.0%	2.1%	11.2%	0.0%	11.2%	9.0%
GWH	4.3%	0.0%	4.3%	8.0%	0.0%	8.0%	3.5%
RUH	4.0%	(0.7%)	3.4%	6.5%	0.0%	6.5%	3.0%

NHS England has paused national data reporting whilst the methodology for 25/26 is refined.
The productivity reporting is also adjusted to exclude the impact of Sulis.

BSW System Position - Finance monthly report

Alert, Assure, Advise	
Alert	• M12 YTD draft position reported as breakeven. This is after the application of both £30m deficit funding and an additional £15m of support funding. • The reported financial outturn reflects a consistent position with the previously reported trajectory. • There remain key cost drivers, including UEC pressures, non pay and slippage against efficiency schemes. • NCTR/Escalation continues to impact financial position. • An additional £1m was required for RUH to hit the year end position. • There are ongoing discussions re spec comm ERF (RUH and SFT).
Assure	• System FY forecast outturn of breakeven (Draft reporting). • The forecast for ERF has also been adjusted to reflect the ceiling and CUF adjustments, £87.5m.
Advise	• All outstanding allocations have been received from NHS England in the financial period. • £25.4m of ERF funding was received in Month 11.

March 2025 (M12) Financial Position

	GWH				RUH				SFT				ICB				System			
	Trajectory	Actual	Variance	RAG	Trajectory	Actual	Variance	RAG	Trajectory	Actual	Variance	RAG	Trajectory	Actual	Variance	RAG	Trajectory	Actual	Variance	RAG
Financial Position (£m)*	1.4	1.4	0.0		(4.2)	(4.2)	0.0		(5.5)	(5.5)	0.0		8.4	8.4	0.0		0.0	0.0	0.0	

Month 12 Adjusted YTD financial trajectory vs Actual:

- The system is reporting a break-even position vs the revised trajectory.

The anticipated financial outturn by organisation is:

- GWH £1.4m surplus
- RUH £(4.2)m deficit
- SFT £(5.5)m deficit
- ICB £8.4m surplus

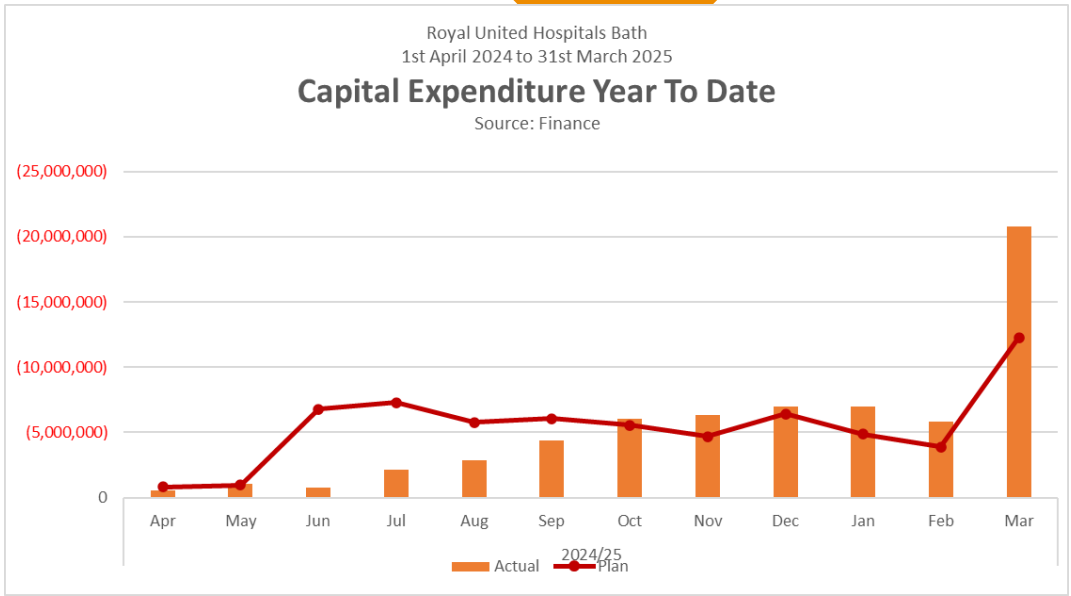
*Forecasts represent the anticipated outturn after the application of £15m ICS deficit support funding (breakeven).

*** Financial values based on draft reporting, as at 9th April**

RAG Ratings	
RED	Over 15% deviation against YTD plan
AMBER	Between 5-15% deviation against YTD plan
GREEN	Between 0-5% deviation against YTD plan

Tracker Measure | Sustainability – Capital (RUH and SULIS)

Capital Position as at 31st March 2025	Annual Plan	Forecast @ M11	Year to Date Plan	Year to Date Actuals	Year to Date Variance
	£000s	£000s	£000s	£000s	£000s
Internally Funded schemes	(13,559)	(13,817)	(13,559)	(13,556)	3
Internally Funded schemes - Robotic Surgery Equipment	0	(1,952)	0	(1,944)	(1,944)
IFRS 16 Lease Schemes	(3,700)	(4,022)	(3,700)	(3,743)	(43)
Disposals - NBV write off - Internally Funded & Lease		6		71	71
External Funded (PDC & Donated):					
SEOC PDC	(18,138)	(18,138)	(18,138)	(18,178)	(40)
BSW EPR PDC	(3,293)	(3,294)	(3,293)	(3,294)	(1)
Digital Diagnostic PDC	(288)	(226)	(288)	(218)	70
Community Diagnostic Centre PDC	(2,165)	(2,165)	(2,165)	(2,165)	0
Cancer Centre PDC	(460)	(460)	(460)	(460)	(0)
UEC PDC	(1,400)	(1,400)	(1,400)	(1,400)	0
Digital Screening PDC	(1,045)	(1,045)	(1,045)	(1,045)	0
Critical Infrastructure Risk PDC	(741)	(741)	(741)	(741)	0
Trowbridge ICC PDC	(389)	(389)	(389)	(389)	0
Endoscopy Equipment PDC	(3,700)	(3,700)	(3,700)	(3,700)	0
Engergy Efficient Fund PDC	(476)	(476)	(476)	(479)	(3)
MRI Acceleration S/W PDC	(136)	(136)	(136)	(162)	(26)
Salix Decarbonisation Grant	(10,819)	(10,819)	(10,819)	(10,819)	(0)
Donated	(2,580)	(2,593)	(2,580)	(2,476)	104
Total	**(62,889)**	**(65,367)**	**(62,889)**	**(64,698)**	**(1,809)**



Is standard being delivered? No
What is the top contributor for under/over-achievement? BSW EPR, Lease schemes and Surgical Robot

Trust funded programme. Excluding the surgical robot, Trust funded capital spend was broadly in line with budget for Trust capital purchases. However, an overspend of £200k had been agreed for the RUH within the BSW system allocation for the EPR forecast outturn, this level of spend was not achieved and there is an underspend against forecast across the 3 trusts for EPR which will needed to be funded from future years CDEL allocation. Additional CDEL cover was obtained in month 11 to purchase a Robot, which has been reflected in the forecast internally funded scheme, The purchase was not cash backed and shows as an agreed overspend.
The IFRS 16 lease scheme budget was underspent by £258k, this relates to the indexation on the MPT lease being lower than budgeted for and the increase in dilapidation provision for the modular theatre not scoring against CDEL

External funded schemes. Full PDC funding was spent in year across the PDC schemes.
The Heat Decarbonisation scheme is grant funded, There is £4 million spend within the position for which Salix agreement for funding is still pending. If funding application is not agreed this is a risk to next year's capital programme.

Countermeasures completed last month

Countermeasure /Action	Owner

Countermeasures for the month ahead

Countermeasure /Action	Owner
CPMG to continue to monitor delivery of projects and schemes Capital leads agreeing further measures to offset known slippages and underspends	Head of Financial Services

Tracker Measure | Sustainability – Balance Sheet (RUH & Sulis)

	31/03/2024 Actual £'000	31/03/2025 Actual £'000	Movement from March 24 £'000
Non current assets			
Intangible assets	7,105	8,070	965
Property, Plant & Equipment	301,392	334,216	32,824
Right of use assets - leased assets for le	51,035	50,584	(451)
Trade and other receivables	1,861	1,947	86
Non current assets total	**361,393**	**394,817**	**33,424**
Current Assets			
Inventories	8,284	8,836	552
Trade and other receivables	29,887	35,142	5,255
Cash and cash equivalents	34,531	37,549	3,018
Current Assets total	**72,702**	**81,527**	**8,825**
Current Liabilities			
Trade and other payables	(54,354)	(67,298)	(12,944)
Other liabilities	(13,298)	(10,857)	2,441
Provisions	(475)	(932)	(457)
Borrowings	(3,070)	(2,662)	408
Current Liabilities total	**(71,197)**	**(81,749)**	**(10,552)**
Total assets less current liabilities	**362,897**	**394,595**	**31,698**
Non current liabilities			
Provisions	(1,370)	(1,315)	55
Borrowings	(54,128)	(55,227)	(1,099)
TOTAL ASSETS EMPLOYED	**307,399**	**338,053**	**30,654**
Financed by:			
Public Dividend Capital	253,535	285,706	32,171
Income and Expenditure Reserve	12,303	11,267	(1,036)
Revaluation reserve	41,562	41,080	(482)
Total Equity	**307,399**	**338,053**	**30,654**

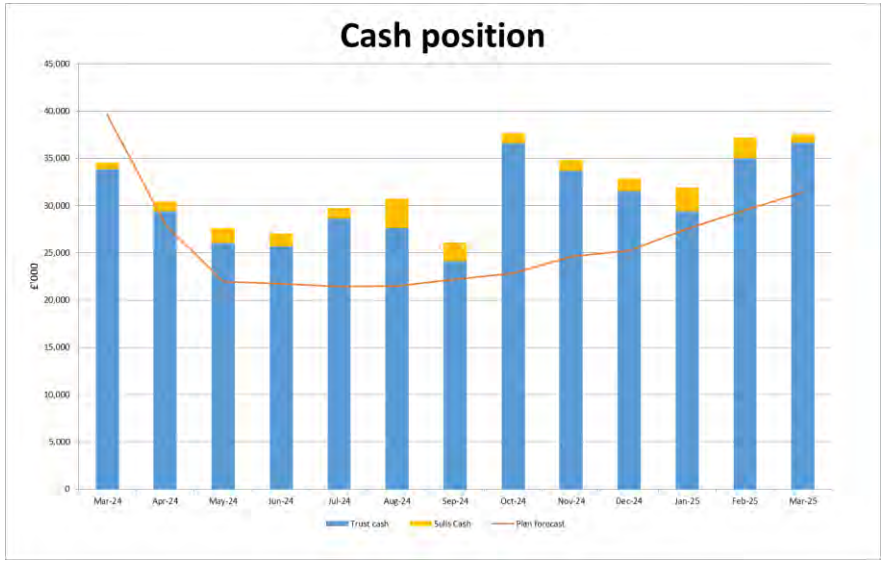
The Group Balance Sheet (RUH and Sulis)

Month 12 against 31/03/24:

- Non-current assets have decreased. The position reflects spend related to capital expenditure, less depreciation and accounting adjustments required following the full valuation that has taken place as 31st March 2025.
- Trust inventories have increased, This relates to drug stock.
- Trust receivables have increased from last year end. This relates to income accrual for donated and grant capital funding, ERF funding and variable elements of NHS funding.
- Cash has increased as set out in the cash slide
- Trust payables have increased. This relates to increases in capital payables, increases in expenditure offset by a reduction in the annual leave accrual.
- Trust other liabilities have decreased. The key movement relates to funding for the pay award.
- Borrowings overall have increased in line with expected payments, offset by lease capital expenditure and technical adjustments in relation to the group consolidation.
- PDC funding has increased for the drawdown of cancer centre funding, SEOC, and CDC. All PDC funding has been spent in year as detailed in the Capital slide.

Tracker Measure | Sustainability – Cash (RUH and SULIS)

Group Cash Month 12



Is standard being delivered for cash? No

The Group cash balance is £6.1 million higher than planned.

What is the top contributor for under/over-achievement?

The variance against plan is driven by capital expenditure accruals for both income and expenditure, interest received, pay award funding, variable NHS income and movements in working capital.

Sulis cash position has decreased by £1.6 million against month 11.

Cashflow statement	
	Actual £'000
Operating Surplus/(deficit)	5,897
Depreciation & Amortisation	22,019
Income recognised in respect of capital donations (cash and non-cash)	(13,296)
Impairments	10,400
Working Capital movement	2,971
Provisions	171
Net cash generated from / (used in) operating activities	**28,163**
Capital Expenditure	(54,360)
Cash receipts from asset sales	2,063
Donated cash for capital assets	44
Interest received	8,251
Net cash generated from / (used in) investing activities	**(44,002)**
Public dividend capital received	32,171
Movement in loans from the DHSC	(313)
Capital element of finance lease rental payments	(2,705)
Interest on loans	(120)
Interest element of finance lease	(1,740)
PDC dividend (paid)/refunded	(8,435)
Net cash generated from/(used in) financing activities	**18,858**
Increase/(decrease) in cash and cash equivalents	**3,019**
Opening Cash balance	**34,531**
Closing cash balance	**37,549**

Royal United Hospitals Bath
NHS Foundation Trust

Operational Performance Report

April 2025 (March 2025 data)

The people we care for

The RUH, where you matter

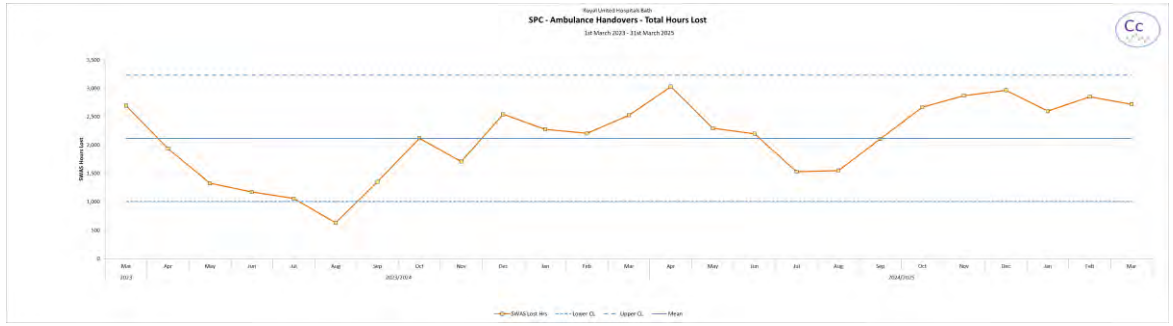
Executive Summary: Performance

Measure	Change	Executive Summary
Ambulance Handover	↓	In March, the Trust lost a total of 2,924 hours in ambulance handovers, an increase from the previous month (2,849). The percentage of ambulance handovers completed within 30 minutes decreased for March to 27.4% compared to the previous month (29%) against the national standard of 95%. We are working with the team in ED to better utilise our flat bed space capacity (including Resus, Pitstop and High Care) to improve this position.
4 Hour Performance	↓	RUH 4-hour performance in March was 64.48% (58.55% on the RUH footprint unmapped), a decrease from February's performance (66.6% and 57.4% respectively). Non-admitted performance was 70.77%, which was a slight increase against the performance for February (70.7%) and admitted performance was slightly improved at 29.06% (February 26.7%).
Non-Criteria to Reside (NC2R)	↑	In March, the Trust had an average of 98 patients without criteria to reside, a decrease of 6.5 patients on the previous month. Additional senior management support on behalf of the Hospital Group, to focus on NCTR, was put in place during the month, aiming to reduce community waits. Wiltshire P2 and P1 capacity remain the top contributors to adverse performance. The Trust will be supporting the new community-based care partnership provided by HCRG for the people in Bath and North-East Somerset, Swindon, and Wiltshire from April 2025, seeking opportunities to improve access for our patients who no longer need acute hospital care.
Referral to Treatment	↑	In March, the Trust achieved an RTT performance of 60.5% which was a decrease of 0.4% from February. For waiters > 65 weeks, the Trust saw a decrease from 11 to 8 patients. There was 1 patient waiting > 78 weeks at the end of March (corneal transplant waits further to patient choice) and 7 patients > 65 weeks (further to choice and complexity across a range of specialities).
Cancer 62 Days	↓	Performance in February dropped just the 70% standard, achieving 69.3% following a deterioration in performance in Breast, Head & Neck, Upper GI and Urology. Despite achieving the target, Breast performance reduced with half of the breaches for patients referred later on the screening pathway, being received by the RUH over halfway through their pathway. Waiting time across the Breast pathway have lengthened due to long term sickness of key surgical and radiology staff. Upper GI was predominantly impacted by the waiting time for Gastro OPA but also longer pathways for patients requiring EUS at UHBW. Urology was most impacted by MRI and LATP waiting times in December and January. Colorectal remained the most challenged tumour site despite their performance improving in month to 53.8%.
Diagnostics	↑	In March 2025, 74.37% of patients received their diagnostic within the 6-week target against an in-month target of 94.70% (revised trajectory October 2024). This represents a reduction in breaches of 4.77% when compared to previous month (-645 breaches), despite being off trajectory. March continued to see increased activity levels in line with ongoing planned recovery action (+1865 diagnostics tests delivered when compared to the previous month). Increased demand for urgent and suspected cancer continues to impact on available capacity for routine diagnostics, despite increased activity levels.
Elective Recovery	↑	M12 delivered 116% of 2019/20 ERF activity overall and 109% of the Trust planned activity volumes, which generated an in-month contribution of £1.6m over delivery against plan.

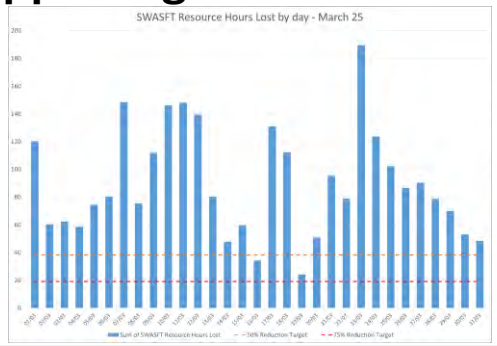
Key Standards | Ambulance Handover Delays:

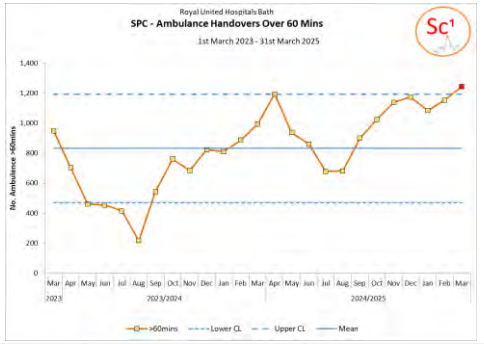
Performance Target:
Lose no more than 500 hours per month.

Historic Data: Hours lost to Ambulance handover



Supporting data





Is the standard being delivered?

- In March, the Trust lost a total of 2,924 hours in ambulance handovers, an increase from the previous month (2,849). The percentage of ambulance handovers completed within 30 minutes decreased for March to 27.4% compared to the previous month (29%) against the national standard of 95%.
- SWASFT have shared some data with RUH, and it does show an overall increase for ambulance handovers in 15-30mins, 30-60mins with a concurrent reduction in those ambulance handovers in 90-120mins, 2-3hrs, 3-4hrs and 4-8hrs, which is positive.

What's the top contributor for under/over achievement?

The Trust saw a worsening position in March, the contributary factors were…

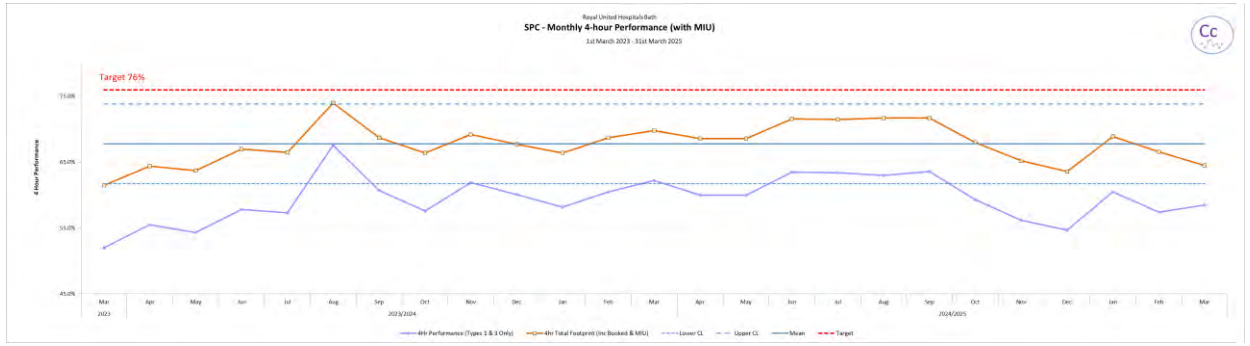
- SDEC units full so expected patients arrive in ED & UTC contributing to overcrowding.
- Challenges with flow out of the ED resulting in more patients being placed in cohort areas.
- IPC challenges limiting flow out of the ED.
- Consultant vacancies contributing to no formal RAT cover, this is covered on an ad-hoc basis.
- Second registrar being pulled into CED / into ED numbers when staffing low.
- SAU pathway for ENT patients not being followed resulting in congested department and patients queuing into Majors waiting area

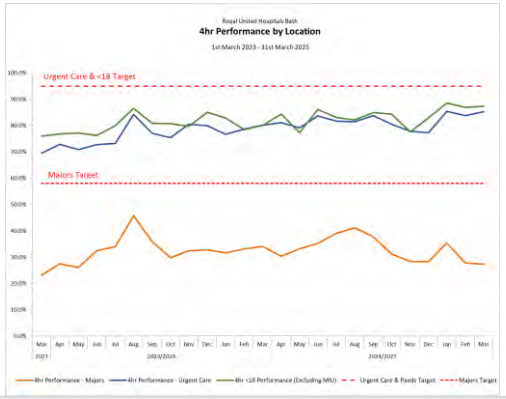
Countermeasures / Actions	Owner	Due Date
Recruit to Consultant posts and ensure that there are 3 Consultants on to allow RAT to occur consistently. - Recruitment in process, expected establishment in July.	M. Price	July 2025
Open fit2sit 08:00 – 00:00 following PDSA.	T. Thorn/ C. Irwin-Porter	COMPLETE
Review Fit to Sit protocol and maximise with patients arriving by ambulance.	M. Price & C. Irwin-Porter	COMPLETE
Works to be done to increase size of SDEC waiting room Q1 2025/2026.	M.Rumble	June 2025
To have a discussion with BSW ICB / SWAST regarding role of HALO and impact on handover / XCAD issues.	C.Macgregor	COMPLETE
Trial of a second SpR overnight to be able to undertake overnight RAT.	M. Price	COMPLETE

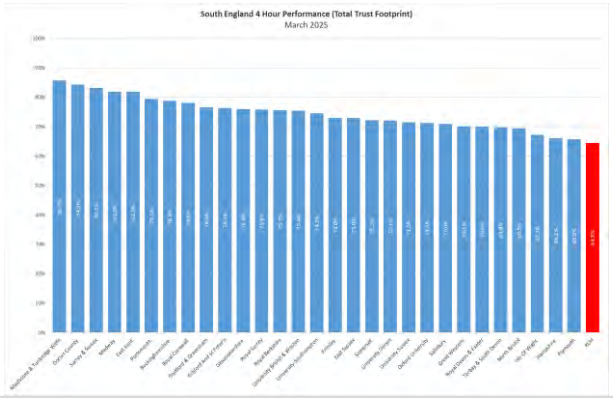
Key Standard | 4-hour Emergency Standard:

Performance Target:
76% of patients discharged or admitted from ED within 4 hours.

Historic Data:







Is the standard being delivered?

- Please note that due to ongoing data issues with MIU, the March performance including MIU of 64.5% does not match the published NHSE data
- RUH 4-hour performance in March was 64.48% (58.55% on the RUH footprint unmapped), a decrease from February's performance (66.6% and 57.4% respectively).

Area	Admitted	Non-admitted	**Total**
Emergency Department	20.65%	33.13%	**26.68%**
Children's Emergency Department	67.97%	90.90%	**87.38%**
Urgent Treatment Centre	58.72%	86.13%	**84.09%**
Urgent & Emergency Care	**29.06%**	**70.77%**	**58.55%**

Root causes	**Jan25**
Initial assessment from arrival <15mins	62.31%
Treatment from arrival <60mins	37.05%
DTA to admit <1hr	29.53%

What's the top contributor for under /over achievement?

- Timely flow-out of the emergency department, delays with beds becoming available.
- IPC restrictions impacted on patient flow out of the ED.
- Identified patients breaching in Fit2Sit (delay to first clinician).
- Difficulty in flipping ACA to Fit2Sit at 08:00 due to the acuity of patients.
- Ongoing long waits for mental health patients to be seen by Mental Health Liaison / AWP, particularly overnight, and in addition long waits for MH beds.
- Vacancy within consultant workforce and urgent care staffing leading to gaps in rota and no consistent RAT cover.
- Overcrowding in ED leading to no assessment space, reducing time to assessment/treatment/referral.
- Inconsistent use of SAU and DAA waiting areas for Surgically and Medically expected patients.

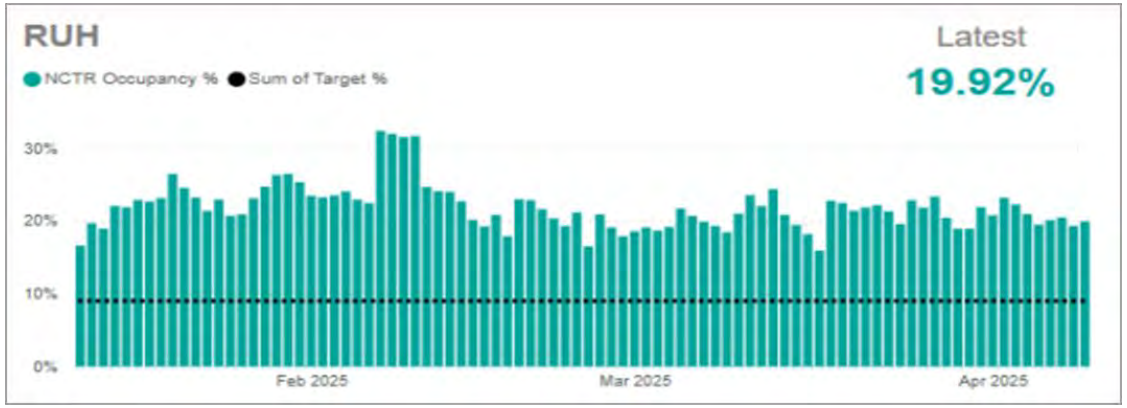
Countermeasures / Actions	Owner	Due Date
(away day action) Plan PDSA of single front-door consultant to reduce wait to be seen/support early plans/streaming.	UEC Tri	31/03/2025
Update ED safety matrix and upload to intranet page.	C. Irwin-Porter/ T. Thorn	COMPLETE
Merge bed management and escalation policies into one document, ratify and upload to intranet.	A. West/ S. Hudson/ D. Allison	June 2025
Link with the Urgent Care Directory of Services to ensure in line with GWH and the national specification.	T. Thorn / J. Rayner	COMPLETE
Complete ECIST staffing review for senior decision makers in ED.	C. MacGregor	ON HOLD
Open fit2sit 08:00 – 00:00 following PDSA.	T. Thorn/ C. Irwin-Porter	COMPLETE
Share learning from practitioner in charge PDSA and monitor impact on 4-hour performance.	J. Rayner / T. Thorn	COMPLETE

Is this a Kev Standard?| Non-criteria To Reside:

Performance Target:
Agreed with commissioners for no more than 55 patients waiting who don't have criteria to reside.

Historic Data: as of: 09/04/2025

Supporting data



Is the standard being delivered?
The daily average target for NCTR patients at the RUH is 55 patients per day across Community (pathways 1-3) and Hospital (most patients are pathway 0) responsibilities. During March, the Trust had an average of 98 patients waiting for discharge, who no longer met criteria to reside, which is 6.5 patients lower than in February 2025, although, remaining above the system refreshed target of 55 patients and the April 2024 position.

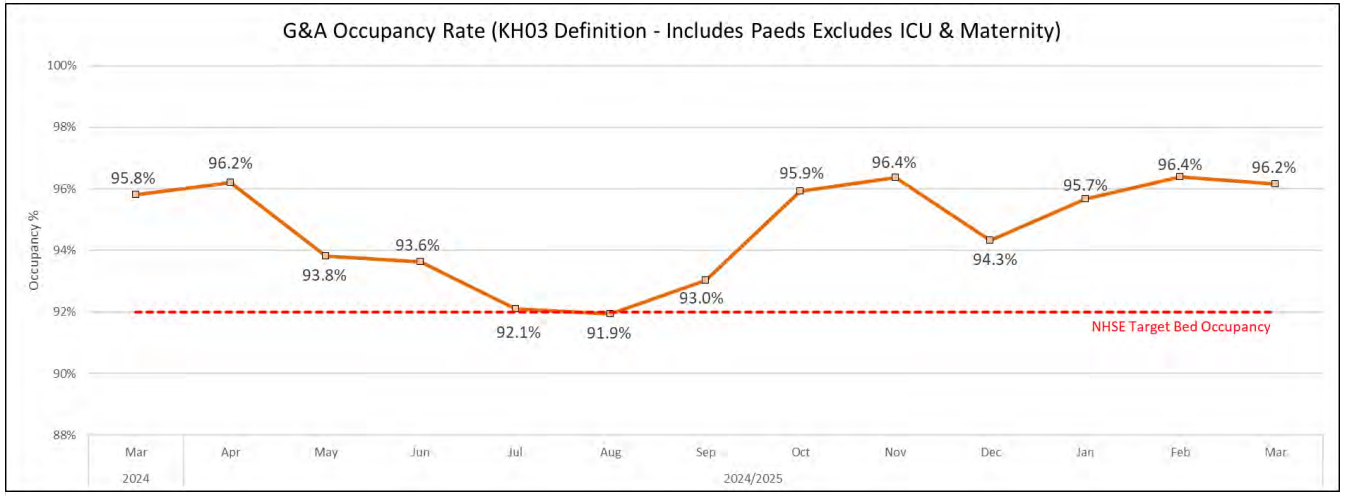
- **What's the top contributor for under/over achievement?**
- In March 2025, the daily average number of patients decreased to 98.0, not achieving target and remaining off course to achieve the trajectory of Decembers average rate at 55 or below (set in April 2024) by the end of March 2025. Wiltshire P1 and P2 capacity remain the top contributors to adverse performance.
- Key challenges remain:
  - Waiting for pathway confirmation – delays through the Wiltshire care transfer hub.
  - P1 home based rehabilitation capacity.
  - Ongoing workforce challenges/gaps for pathway 1 providers reducing capacity.
  - P2 bed-based rehabilitation capacity – top contributor to Wiltshire delays.
  - Challenge in reducing community hospital bed and hub bed pathway 2 beds length of stay, therefore reducing capacity for acute patient transfer.
- The Trust will be supporting the new community-based care partnership provided by HCRG for the people in Bath and North East Somerset, Swindon, and Wiltshire from April 2025, seeking opportunities to improve access for our patients who no longer need acute hospital care.
- Additional senior management support on behalf of the Hospital Group, to focus on NCTR, was put in place during the month, aiming to reduce community waits especially Wiltshire P2 and P1 capacity as the RUH top contributor to adverse performance.

Countermeasures / Actions	Owner	Due Date
BSW led recovery actions with Wiltshire Local Authority and Community partners to address capacity gaps for pathways 1-3 to meet NCTR target for 2025/26.	Emma Crockett Sarah Hudson	Q1 2025/26
Home is Best focus on admission avoidance with system colleagues.	David Allison	Q1 23/24
Further embed P0 therapy referral guidance across all wards – aim for zero P0 therapy delays (Hospital responsibility).	Calum McGregor Fenella Maggs Jo Lloyd-Rees	Q1 2025/26
75% reduction in hospital-related discharge delays (pathways 1-3) and <5 pathway 0 patients 24 hours post NCTR per day.	Calum McGregor Fenella Maggs Jo Lloyd-Rees	Q1 2025/26
Implementation of thresholds for discharge post NCTR for P1-P3 and escalation to a new twice weekly tactical NCTR touchpoint to reduce length of stay post NCTR.	Sarah Hudson Emma Crockett	Q1 2025/26

Key Standards | Bed Occupancy:

Performance Target:
Bed occupancy should be no greater than 92%.

Historic Data:



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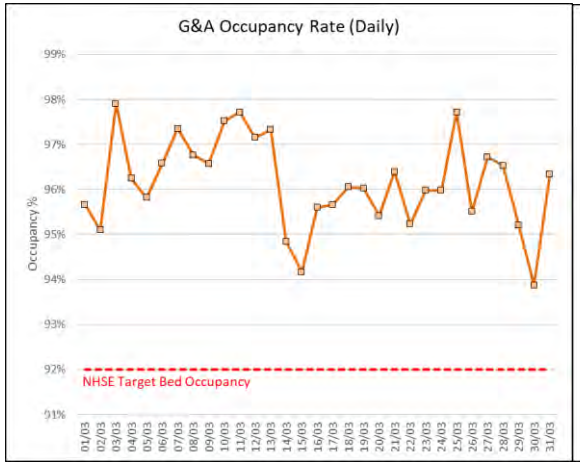
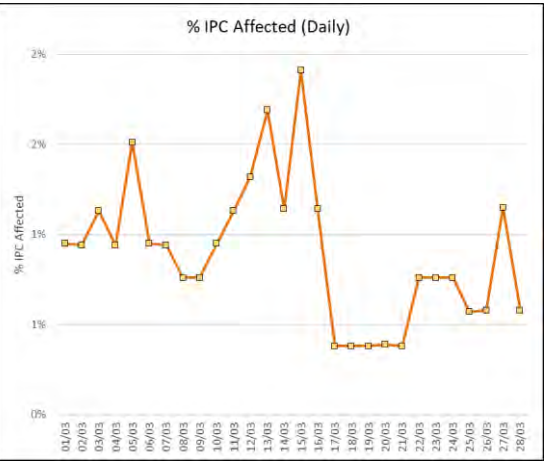




Is the standard being delivered?

NHS England target as described in the Urgent and Emergency Care Recovery Plan indicates that bed occupancy should be at or below **92%**. For March 2025, the Trust's bed occupancy was **96.2%**, a decrease of 0.2% compared to February 2025 and remains above 92%.

What's the top contributor for under/over achievement?.

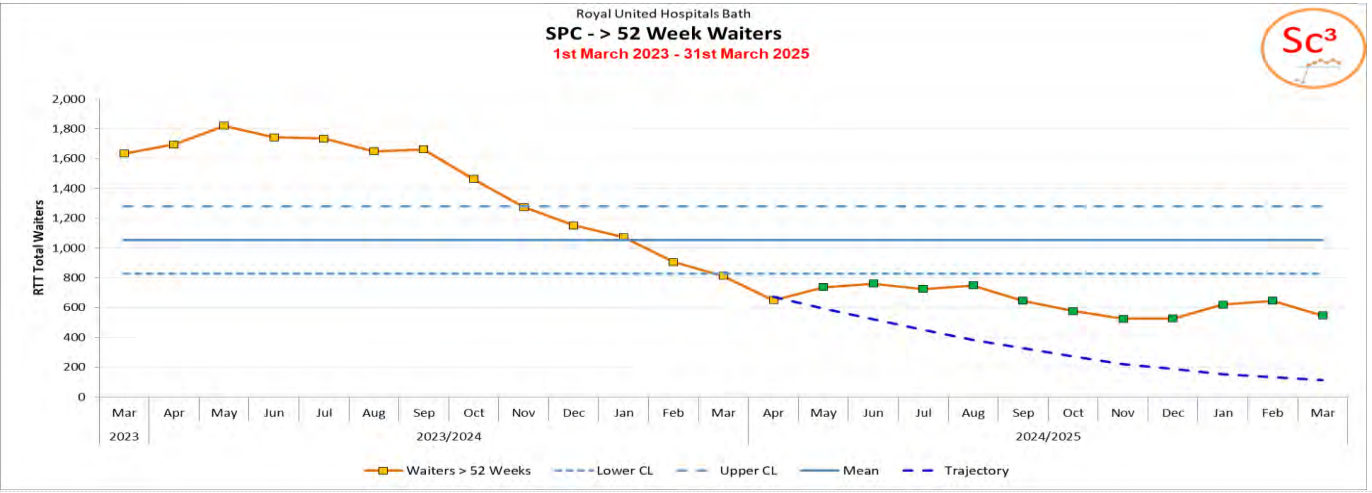
- Discharge lounge underutilised which exacerbates the number of patients that can be discharged by midday.
  - Discharge Lounge daily weekday average has increased and on 4 occasions in the month over 40 patients occupied the Discharge Lounge (maximum achieved 47 patients) which was 32% of all discharges that day,
  - The discharges before midday in March was 24% this increased from 22.9% in February .
  - A decrease in patients being discharged after 1700 supporting earlier flow. In March, 71% of all discharges occurred before 17:00, compared to 67.8% in February.
  - 34.8% of patients seen through an SDEC pathway in March 2025 (increase of 1.2%).

Countermeasures / Actions	Owner	Due Date
Embedding of Discharge lounge SOP to increase utilisation and compliance. Eligibility criteria prominent in ward areas, and compliance supported by the Discharge Lounge Senior Charge Nurse visiting all ward daily to embed the application of the criteria. Aim to sustain 42 patients discharged per day in April 2025	Manny Mabulay	Ongoing
Continued Improvement work on pre-midday discharges and utilisation of discharge lounge.	Clinical Divisions	Ongoing
Embed ward standard work and pm huddles to reduce length of stay and escalation through the daily divisional leadership and flow meetings to unblock delays.	Calum McGregor Fenella Maggs Jo Lloyd-Rees	Ongoing
Relocation of Discharge Lounge to main block to increase capacity and utilisation by being centrally located closer to the wards, enabling efficient transfer and removing barriers such as the incline to the lounge and transfer outside. Proposal to develop C16 which will be empty from 09/06/2025.	Sarah Hudson	Q2 25/26

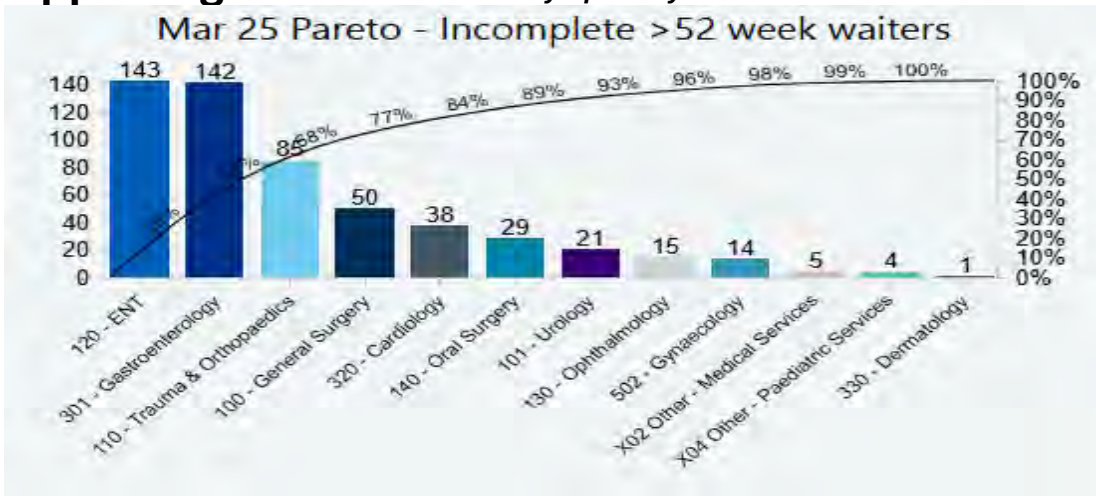
Trust Goal | Referral to Treatment:

Performance Target:
No patients waiting greater than 52 weeks by March 25.

Historic Data:



Supporting Data: - *Pareto 52+ by Specialty*



Is the standard being delivered?

- In March 2025, the Trust had 547 patients waiting **> 52 weeks**, a decrease of 15% on February.
- For waiters **> 65 weeks**, the Trust saw a decrease in March from 11 to 8 patients.
- There was 1 patient waiting **> 78 weeks** at the end of March (Ophthalmology)
- RTT performance was 60.5% in March (-0.4%)
- For waiters over 52 weeks, the three largest specialties combined represent two thirds of the waiters. These are ENT, Gastroenterology and Trauma & Orthopaedics.
- ENT saw an increase from 124 patients waiting >52 weeks in February to 143 patients waiting >52 weeks at the end of March
- Gastroenterology saw a significant decrease in March, from 210 patients to 142
- T&O also decreased with 85 patients waiting >52 weeks, down from 90 in February

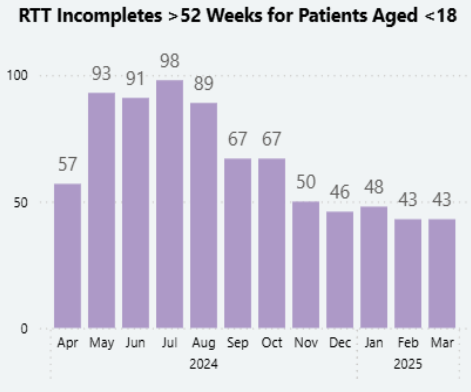
What's the top contributor for under/over achievement?

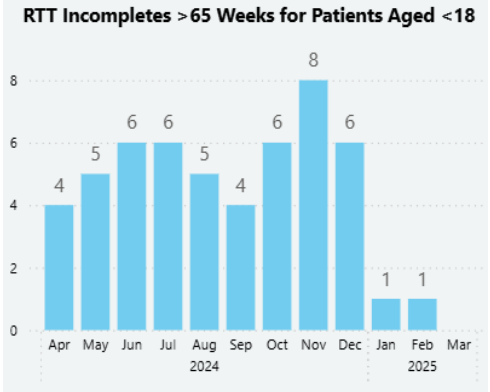
- Gastro – support from independent provider approved – 30 patients per week being transferred
- ENT – potential to utilise SFT locum being scoped. Suitable referrals continue to be transferred to Sulis c. 48 per month
- T&O – long waits for first appointment for spinal patients are contributing to over 52 week waits

Countermeasures / Actions	Owner	Due Date
Capacity review ENT as part of BSW Group – no suitable locum available so expected additional capacity has not been delivered	Division	June 2025
Continue 2 x weekly long waiter PTLs for "challenged" specialties to meet 65 weeks by end of Sept 24 – currently Gastro, T&O, Gen Surg, ENT.	Dando	End of Q3 24/25
Review of spinal outpatient capacity	Prosser	May 25
Trust taking part in NHSE validation sprint – 7 April to 22 June – admin validation with clinical support as appropriate	Dando	End Q1

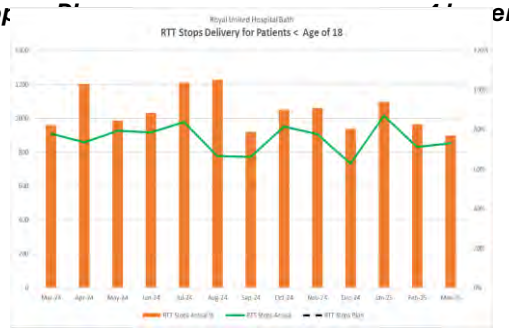
Trust Goal | Paediatrics:

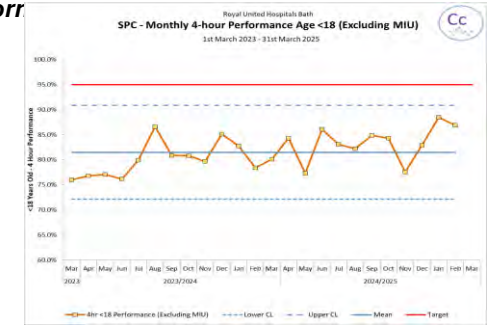
Historic Data:





Supporting Data:





Is the standard being delivered?

- RTT non-compliant – In March we reported 0 patients <age of 18 waiting **>78 weeks and >65 weeks**. The majority of patients waiting over 52 weeks are within ENT.

- Cancer 28 Day Diagnosis compliant – 100.0%

What's the top contributor for under/over achievement?

Long waits to first appointment in ENT

Countermeasures / Actions	Owner	Due Date
Review of overall ENT capacity with new clinical lead	Gillet/ Ashworth	June 25
CED/PAU - working together to improve 4hr performance • Twilight CED nurse established following safer staffing review - Recruitment process underway. Will optimise flow during peak periods. • Currently bank for twilight shift approved for Fri, Sat and Sun • Exploring how this shift will impact 4 hour performance. • Plan for time in motion study for CED high-tide focusing on mitigations/opportunities to improve non-admitted breaches • CED/Paeds huddles set up at 4pm each day – Bringing CED/PAU teams together and improving communication	Potter/Thorn /Lewis Lewis/Improvement Lewis/Goodwin	June 25 May 25 Ongoing
CAMHS pathway – new low risk pathway proposed to expedite CAMHS discharge process, clinical risk under review.	Goodwin	May 25

Key Standards | Elective Recovery:

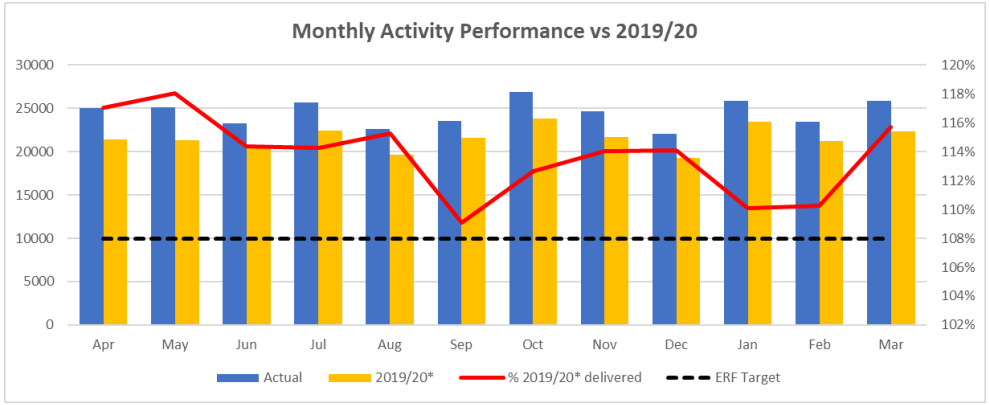
Performance Target:
Deliver 109% of elective activity compared to 2019/20.

ERF Performance:

	Vs 19-20												
Division	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	YTD
FASS	152%	158%	148%	153%	143%	146%	155%	141%	151%	139%	140%	125%	**146%**
Medicine	151%	148%	153%	144%	140%	138%	139%	137%	139%	126%	137%	110%	**141%**
Surgery	125%	114%	105%	114%	124%	110%	122%	113%	117%	112%	114%	117%	**115%**
Total	**137%**	**131%**	**126%**	**129%**	**132%**	**124%**	**133%**	**125%**	**130%**	**121%**	**125%**	**116%**	**128%**

	Vs 24-25												
	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	YTD
FASS	112%	115%	113%	111%	100%	110%	122%	119%	122%	121%	125%	125%	**116%**
Medicine	110%	117%	117%	106%	106%	109%	110%	109%	101%	103%	110%	114%	**109%**
Surgery	117%	110%	104%	105%	107%	103%	115%	114%	103%	108%	117%	119%	**110%**
Total	**114%**	**113%**	**110%**	**107%**	**105%**	**106%**	**115%**	**114%**	**106%**	**109%**	**116%**	**119%**	**111%**

Supporting Data: - ERF Activity Delivery



Key areas of variance this month within each Division is as follows:

- The income performance over plan for the year is £11.6m, the in month contribution is £1.6m, with back dated coding contributing a further £1.1m.
- Every Division improved on their performance against plan, the following areas has significant improvements in month:
- Gynae saw and increase of £96k in month delivering 138% of plan up from 127% in February. The increase came from across all areas, but most significantly in DC where they finished 150% of planned income.
- Oncology and Breast Surgery continued to deliver above plan with Oncology contributing £2.5m over plan, this excludes the increased chemo activity that sits outside of ERF.
- Cardiology improved from February driven by new appointments increasing income performance by £17.5k. Day cases continue to deliver just above plan, with the capture of remote monitoring of patients driving the significant over performance for the specialty.
- Gastro day cases were 9% above plan in month with an increase in income of over £100k
- Rheumatology day case and outpatients continued to over perform, they finished the year £875k over plan
- General Surgery income fell in month by £83k, this was drive by a reduction in elective inpatient activity and not endoscopy, there was also a small reduction of £13k for OP procedures.
- T&O saw an increase of £122k in month, this was most significant in New OP appointments which increased by £76k, with the rest in DC and Elective Inpatients.
- Urology income increased by £91k in month, driven by OP and OP procedures. There was a shift in activity between Elective Inpatients and DC with DC income increasing by £98k, off-set by £49k reduction in Elective Inpatients.
- Overall, with coding and improved performance in month the Trust delivered against its forecast for March.

Is the standard being delivered?

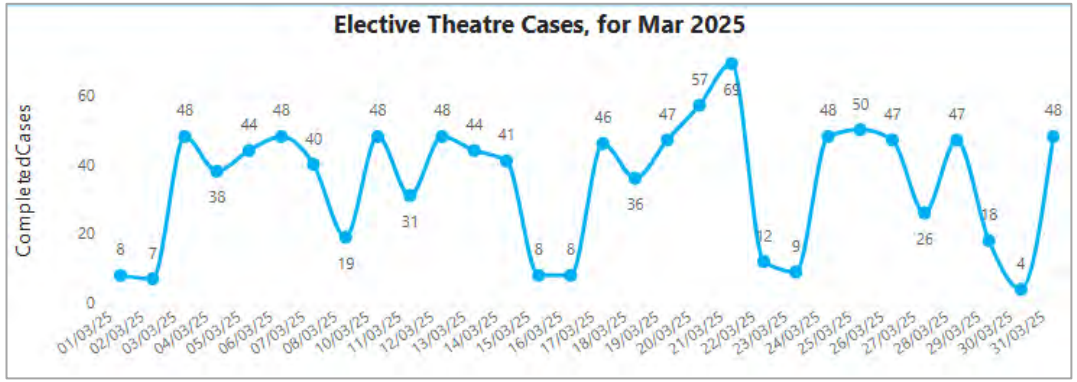
M12 delivered 116% of 2019/20 ERF activity overall and 109% of the Trust planned activity volumes. Year to date we have delivered 114% against 2019/20 and 103% of plan.

The Trust has delivered financial performance year-to-date of 128% of 19/20 and 111% of our 24/25 plan in ERF.

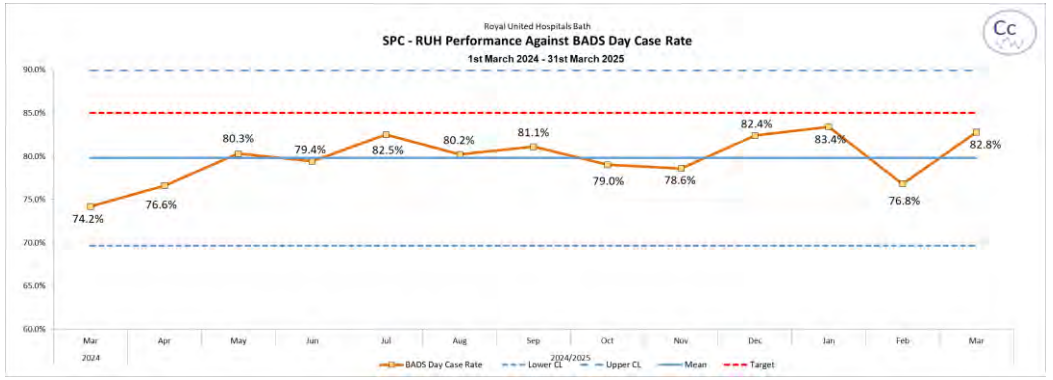
Countermeasures / Actions TO BE UPDATED	Owner	Due Date
Transformation workstreams focused on supporting increased activity within Theatres and Outpatients. Extending to endoscopy/ Cath labs.	Divisions	Through Q1-Q3 24/25
Clinic Templates are being reviewed. In some specialities however there is an ongoing need to balance the NEW patient activity, for which we receive income, with any clinical risks in overdue follow-ups. Clinical Divisions are working to support clinical and administrative validation of follow/ups.	Divisions/ Improvement tea m	Q2-3 24/25
Meeting with Coding to form action plan to catch up on coding backlog. Update: Clinical Coding is improving though there are still some delays in clinical coding.	Wisher-Davies	Q4 24/25

Key Standards | Productivity:

Historic Data:



Supporting Data:



Is the standard being delivered?

- The RUH aims to book to 85% of lists available minutes (to allow for turnaround time), in March theatres were booked to 88% - this is above target and with reduced late changes and increased focus remains a key target
- The Capped utilisation in March was 79%, (target 85%).
- The British Association of Day case Rates (BADs) was 90.3% (validated), against the 85% National Target. The RUH remains amongst top performer in region for day case rates

What's the top contributor for under/over achievement?

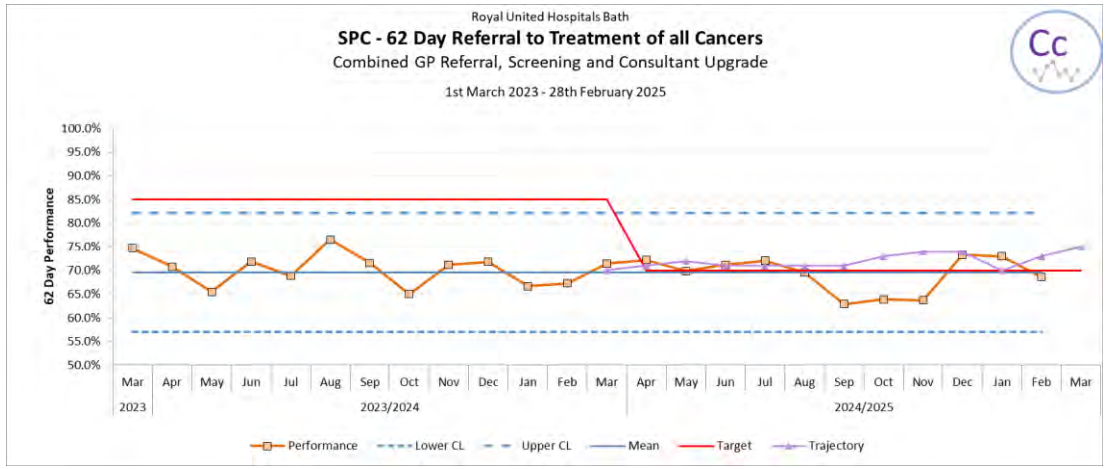
- Elective cancellations on the day were 81, the biggest contributing factors being patients being unfit due to acute illness, list overrun and cases with higher clinical priority.
- The Improvement Team continue to support theatre efficiency projects with focus on elective bookings and wider theatre efficiency measures, including late starts, turnaround time.

Countermeasures / Actions	Owner	Due Date
Theatre productivity is being incorporated into the "Improving Together" work across all theatre locations By reducing downtime and start delays - this will drive Capped utilisation improvements	B Baiju	Q1 25/26
BADs day case rates continue to be good and improvements will continue through 25/26 focusing on reaching 90%	R Edwards	Q1-Q4 25/26
Review/refresh of booking and procedure times to ensure lists booked more accurately. Additional cases being booked regularly to HVLC cataract lists now in place	J Price	Q1 25/26
NHSE Theatre Improvement recommendations being incorporated into List Management and Booking. List booking being targeted to be at least 85% with this being achieved across all theatres	J Price/A Dougherty	Q1-4 25/26

Key Standards | Cancer 62 Days:

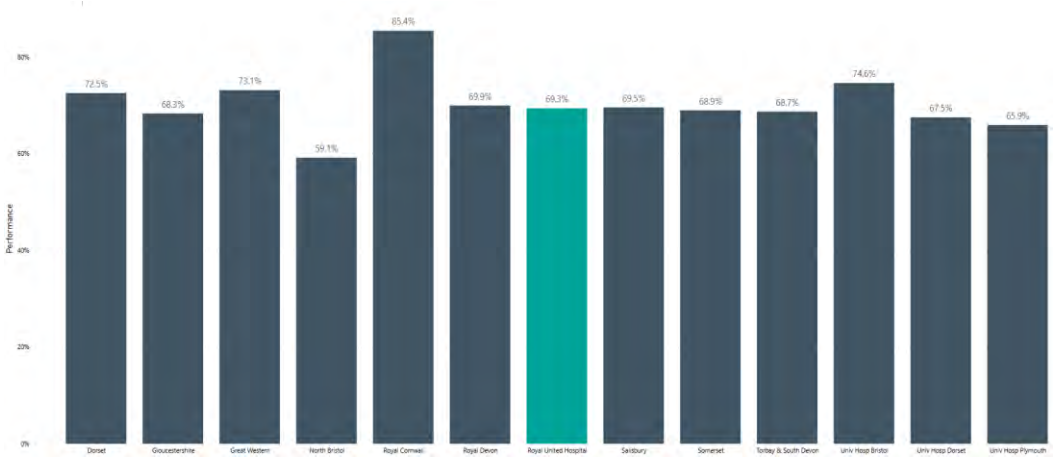
Performance Target: 70% of patients treated within 62 days of referral on a cancer pathway.

Historic Data



Supporting data

Regional 62 Day Combined RTT Comparison



Is the standard being delivered?
February performance deteriorated, delivering performance below target at 69.3%.

What's the top contributor for under/over achievement?
62 Day Treated:

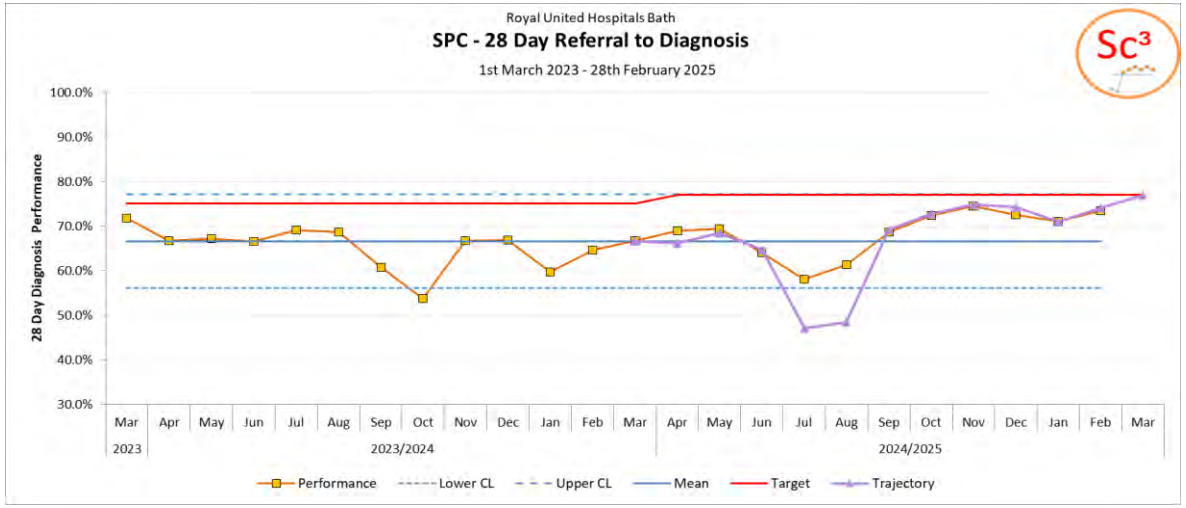
- Whilst improving in month to 53.8%, Colorectal remained the most challenged tumour site.
- Gastro OPA waiting time remained a factor in breaches for patients on the IDA pathway under Colorectal and on the Upper GI pathway. Appointment of a locum consultant in February has reduced the waiting time to two weeks.
- A PDSA is in progress to establish the demand for STT and telephone clinics vs F2F.
- Breast achieved the standard but performance deteriorated due to an increase in demand through the screening pathway, with patients referred across beyond halfway through their pathway.
- Surgical capacity has been challenged due to long term consultant sickness with changes in locum cover. A new locum was appointed in late March with aim for them to operate by the end of April.
- Lung performance improved but below the national standard, impacted by waiting times for OPA and imaging. Additional breaches also for patients transferred from other tumour sites late in pathway.
- Urology performance was impacted by MRI and LATP waiting times in December and January, both improved since through WLIs and insourcing to improve 62 day performance although not delivered in the timeframe required to consistently achieve 28 day pathway.
- Small number of patients waiting longer for HIFU due to consultant sickness.

Countermeasures / Actions	Owner	Due Date
Breast – Replacement agency locum appointed, in March, operating from end of April	H Wheeler	Apr 2025
Colorectal – PDSA for IDA pathway to establish STT and telephone clinic demand	N Lepak E Williams	Apr 2025
Colorectal – Funding bid submitted to SWAG to maintain evening and weekend theatre WLIs	N Lepak	May 2025
Lung – Long term consultant resource – funding requested from SWAG to cover OPA capacity gap	M Warner-Holt	May 2025
Urology – Long term nursing plan to support LATP service. Being raised through business planning. Funding bid also submitted to SWAG to cover WLIs	K Rye	May 2025
Urology – Additional consultants being trained in HIFU	L Simmons	Jul 2025

Key Standards | Cancer 28 Days:

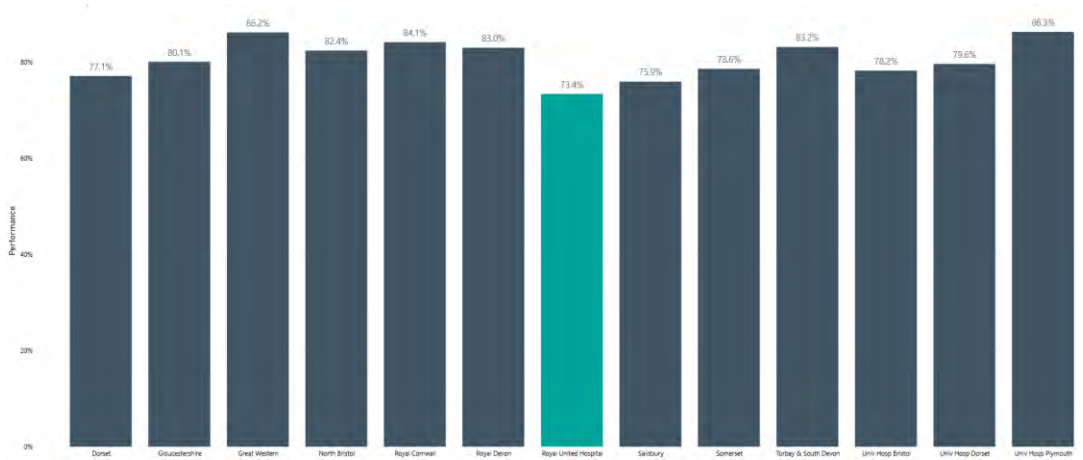
Performance Target: 77% of patients given their diagnosis within 28 days of referral.

Historic Data



Supporting data

28 Day FDS Regional Comparison



Is the standard being delivered?

- February performance improved to 73.4%, above trajectory and above the 72.5% threshold for Tier 2, under which the RUH remains.

What's the top contributor for under/over achievement?

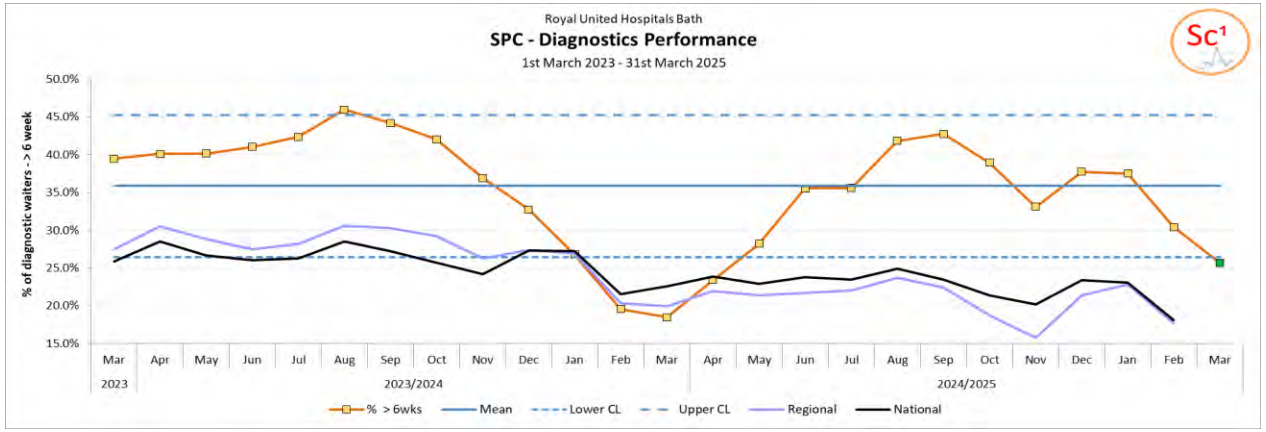
- Breast performance remained just below the national standard. The one-stop clinic went live in March but capacity issues for outpatients and imaging due to demand and staff sickness has necessitated only a partial go-live. A locum consultant has been appointed on a longer term contract and WLIs are being agreed to clear the imaging backlog which will allow for full one-stop from June.
- To support long term demand management a Breast Pain ANP has been recruited, starting in June.
- Colorectal performance improved to 48.4%, helped by go-live of Medilogik in January.
- Gastro OPA waiting time for IDA and Upper GI patients continued to impact performance. A locum appointment has helped reduce the waiting time to two weeks. IDA PDSA to complete by end of April to inform capacity requirements to transfer patients on STT/telephone OPA pathway to Colorectal.
- Haematology breaches due to BMAT reporting in Bristol and patients initially referred to other tumour sites. One-stop pathways for myeloma and lymphoma to mitigate these delays.
- Urology improved due to reduction in LATP waiting time through WLIs and insourcing. Waiting time for MRI and LATP remains over timeframe required to consistently deliver performance.
- Additional demand increase and consultant sickness led to longer OPA waiting time in March/April.

Countermeasures / Actions	Owner	Due Date
Breast – Imaging WLIs to clear backlog and allow for full one-stop go-live	H Wheeler M Jarvis	Jun 2025
Breast – Breast Pain pathway design	H Wheeler R Sutton R Ravi	Jun 2025
Colorectal – Option appraisal for switch of IDA pathway from Gastro to Colorectal	N Lepak E Williams	Apr 2025
Haematology – Lymphoma one-stop implementation	C Frape	Apr 2025
Radiology – SWAG funding bid to maintain WLIs	N Aguiar	May 2025
Urology – Explore options for OPA extra capacity	K Rye E Jefferies	Apr 2025

Key Standards | Diagnostics 6 Weeks:

Performance target: No more than 5% of patients waiting over 6 weeks for their diagnostic test.

Historic Data



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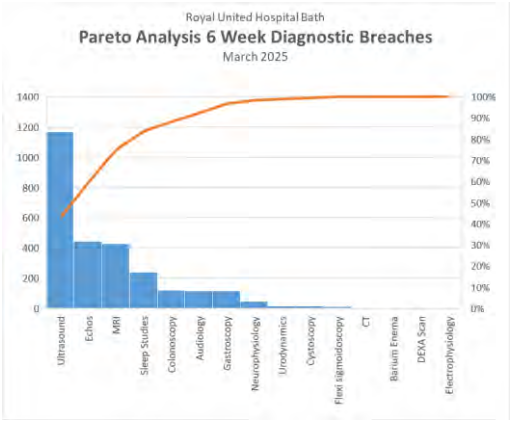
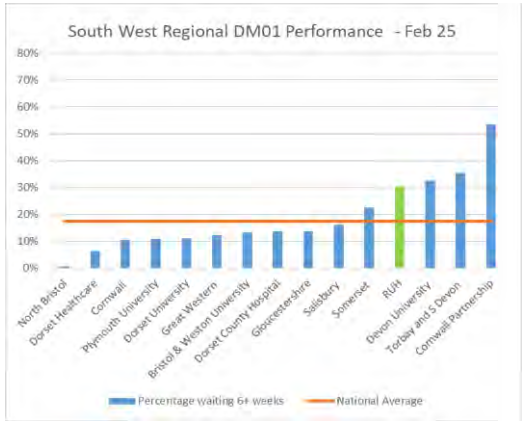




Is the standard being delivered?

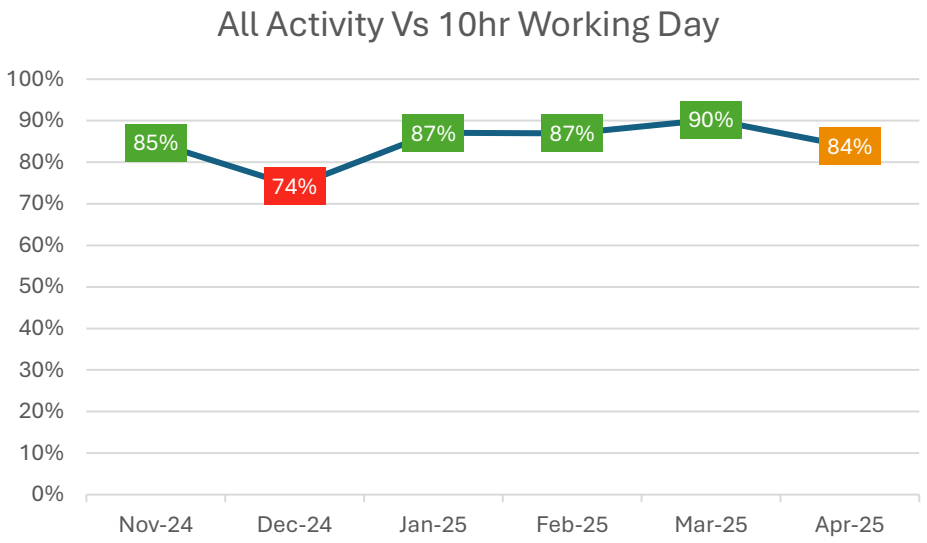
In March 2025, 74.37**%** of patients received their diagnostic within the 6-week target against an in-month target of 94.70% (revised trajectory October 2024). This represents a reduction in breaches of 4.77% when compared to previous month (-645 breaches), despite being off trajectory. March continued to see increased activity levels in line with ongoing planned recovery action (+1865 diagnostics tests delivered when compared to previous month). Increased demand for urgent and suspected cancer continues to impact on available capacity for routine diagnostics, despite increased activity levels.

What's the top contributor for under/over achievement?

- Majority of modalities improved performance, with MRI, Audiology and Urodynamics being the most improved.
- Top contributors for breaches: MRI, USS and Echo.
  - Sustained high demand for MRI and USS diagnostics.
  - Ongoing staffing issues for USS, being mitigated with weekend insourcing and additional WLI's.
  - Echo – additional activity via WLI in place, but ongoing admin staff challenges impacting on waiting list validation.
- Capacity challenges with mobile Endoscopy Unit at CDC continue – mitigation with continued weekend insourcing at RUH.
- Delay in transferring Sleep Studies referrals to Sulis CDC due to clinical reasons and now planned for Q2 25/26 – discussions ongoing re: remaining >6 weeks backlog.

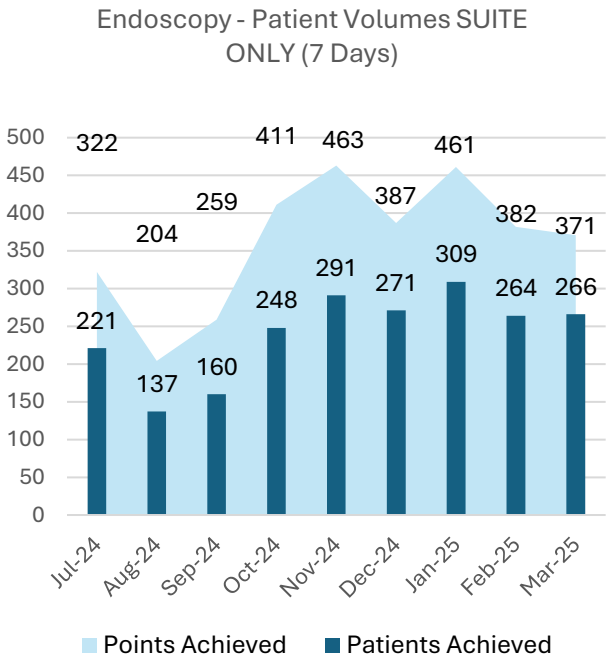
Countermeasures / Actions	Owner	Due Date
Sustain and increase radiology activity at Sulis CDC (additional 150 CT/MRI diagnostics) - monitored weekly. Review of plans for direct access to CDC for GP's and CDC reporting DM01 for activity delivered.	NA / PN / MC	Ongoing
WLI for USS, MRI and Echo.	NA/JLR	Ongoing
USS insourcing at weekends	NA/TB/RF	Ongoing
Additional Endoscopy capacity from mobile unit at Sulis CDC.	SH / VM	Ongoing
Transfer of Sleep Studies service to Sulis CDC.	Sulis CDC	Q2 25/26
Review of DM01 trajectories for 2025/2026	NA / AA	March-25
Weekly review of each modality – performance, demand and activity against trajectory.	NA / JS	ongoing

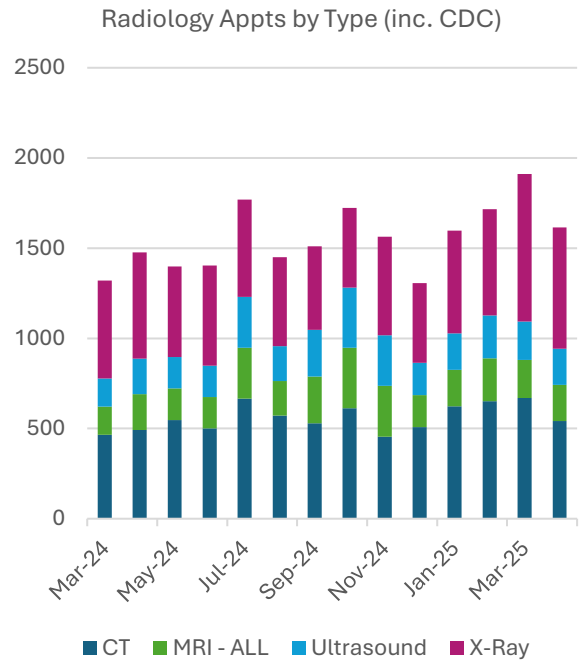
Key Standards | Sulis Hospital



RTT: **76%**

Weeks	PT QTY
78+	1
65+	3
42-65	38
19-42	596
0-18	2081





Is the standard being delivered?

- **Theatre** – Utilisation against staffed time was excellent in March. The challenge was in our session up-take. We lost up-take 28 half day sessions due to impact of a ventilation challenge. The activity utilisation improved as we consolidated and offset with some Sunday sessions.
- **Radiology** volumes up YoY by 38%. All modalities showing great performance. XRAY continues to show large improvements with referrals growing directly from the RUH. Timing is good as we open up a second XRAY room.
- **Endoscopy** volumes within the suite declined due to prioritisation of filling the mobile van. Session up-take also down due to consultant availability (74% against last month's 79%).
- **Endoscopy Van** Ongoing risks with the mobile van capacity limit capacity. Volumes now routinely meeting the 17point limited day. Challenge to book two weeks forward ongoing. New risk is the lack of patients deem suitable for Sulis. Criteria being reviewed.
- **RTT position** at 76%. Those patient over 65+ weeks are patient choice. Huge improvement on RTT p[position between 42+ weeks.

What's the top contributor for under/over achievement?

- XRAY referral volumes increased by RUH. Not limiting postcode catchment area.
- Endoscopy triage and booking process limiting throughput of activity, and technology/process impacting efficient flow of referrals.

Countermeasures / Actions	Owner	Due Date
Maximize utilisation of mobile endoscopy van. Maintain planned figures for van and overall CDC programme.	Milner/ Harrison	Ongoing
Review option to improve session up-take in theatres. With focus on Saturday sessions, due to the increased capacity of SOC	Milner/ Harrison	June
Maintain CDC activity plan against agreed figures to ensure capacity is maximised between RUH and Sulis.	Milner/ MacGregor	Ongoing
Launch substantive CDC Sleep Service at Sulis with RUH support.	Milner/ MacGregor	June

Royal United Hospitals Bath
NHS Foundation Trust

Workforce Report

April 2025 (March 2025 data)

The people we work with

The RUH, where you matter

Executive Summary I

				National Survey				
	Performance Indicator	Performing	Outside Tolerance	2020	2021	2022	2023	2024
Trust Goal	Staff Recommend Trust as Place To Work	>=65.0%	<60.0%	73.43%	65.42%	62.59%	67.97%	63.50%
Breakthrough Goal	Experienced Discrimination from Manager/Colleague	<=5.0%	>5.75%	6.67%	7.13%	8.00%	8.13%	8.25%

				Last 12 Months											
	Performance Indicator	Performing	Outside Tolerance	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Key Standard	Trust Vacancy WTE (Unit 4)			290.2	94.7	50.1	150.5	11.6	139.5	145.9	123.4	83.2	161.4	144.4	172.9
Contextual Information	Trust Establishment WTE (Unit 4)			5888.3	5693.9	5639.3	5699.8	5576.2	5728.4	5737.2	5696.9	5648.8	5709.2	5711.2	5708.7
Contextual Information	Substantive WTE (Unit 4)			5598.1	5598.6	5589.2	5549.3	5564.6	5588.9	5591.3	5573.5	5565.6	5547.9	5566.9	5535.9
Key Standard	Vacancy Rate	<=4.00%	>4.50%	4.93%	1.66%	0.89%	2.64%	0.21%	2.43%	2.54%	2.17%	1.47%	2.83%	2.53%	3.03%
Contextual Information	Total Pay Bill (exc R&D)			£27.5M	£27.2M	£27.3m	£26.7m	£28.1m	£25.7m	£36.1m	£28.6m	£28.2m	£28.3m	£27.1m	£50.4m
Key Standard	In Month Turnover	<=0.92%	>1.00%	0.66%	0.92%	0.69%	0.71%	0.66%	0.89%	0.73%	0.48%	0.73%	0.52%	0.68%	0.52%
Key Standard	Rolling 12 Month Turnover	<=11.00%	>12.00%	8.19%	8.52%	8.46%	8.62%	8.31%	8.20%	8.26%	8.19%	8.42%	8.35%	8.50%	8.18%
Contextual Information	Leavers Inside 1st Year WTE (Permanent Contract Held, All Reasons)			12.8	11.4	7.5	6.3	6.4	8.9	3.2	3.6	3.9	2.9	7.0	0.5
Contextual Information	Bank Use (Staffing Solutions Data)			189.2	199.1	197.3	207.5	222.7	198.0	204.8	182.3	176.7	181.1	164.8	190.3
Contextual Information	Agency Use (Staffing Solutions Data)			19.8	17.2	17.1	13.3	14.0	16.4	11.4	15.0	2.2	0.9	0.4	0.1
Key Standard	Agency Spend as Proportion of Total Pay Bill	<=2.50%	>3.50%	1.14%	1.13%	0.27%	1.02%	0.94%	1.03%	0.81%	1.11%	0.47%	0.81%	0.84%	0.53%
Contextual Information	Agency Spend			£315k	£310k	£73k	£277k	£267k	£268k	£297k	£321k	£135k	£233k	£229k	£
Contextual Information	% of agency usage that are off framework			1.26%	4.89%	9.15%	5.93%	7.07%	1.42%	5.27%	0.33%	12.45%	19.58%	4.07%	12.29%
Contextual Information	% agency shifts that are above price cap			95.58%	88.52%	76.82%	55.67%	34.67%	25.27%	24.71%	23.98%	46.08%	49.54%	68.17%	71.57%
Key Standard	Nurse Agency Spend as Proportion of Registered Nursing Pay Bill	<=3.00%	>4.00%	1.62%	1.71%	-1.71%	0.60%	0.69%	1.20%	1.22%	0.53%	0.09%	0.02%	0.50%	0.00%
Key Standard	In Month Sickness Rate (Actual) - Reported 1 month behind	<=5.13%	>5.63%	4.43%	4.39%	4.87%	4.64%	4.41%	4.64%	5.21%	4.64%	5.09%	5.23%	5.07%	
Contextual Information	In Month Sickness - Estimated Cost (£m)			£758k	£781k	£861k	£876k	£819k	£839k	£1m	£847k	£959k	£975k	£875k	
Key Standard	Rolling 12 Month Sickness Rate - Reported 1 month behind	<=4.30%	>4.80%	4.48%	4.49%	4.54%	4.54%	4.55%	4.61%	4.66%	4.68%	4.72%	4.75%	4.77%	
Contextual Information	Short-Term Sickness Rate			2.33%	2.18%	2.42%	2.30%	2.07%	2.36%	2.80%	2.40%	2.66%	3.09%	2.98%	
Contextual Information	Long-Term Sickness Rate			2.10%	2.21%	2.46%	2.34%	2.34%	2.28%	2.41%	2.23%	2.44%	2.14%	2.03%	
Tracker	Rolling 6 Month Sickness Rate due to Anxiety,Stress of Depression - Reported 1 month behind	<=0.9%	>1.0%	1.20%	1.17%	1.19%	1.21%	1.22%	1.24%	1.26%	1.27%	1.27%	1.24%	1.22%	
Contextual Information	In Month Sickness Rate due to Anxiety,Stress of Depression - Reported 1 month behind	<=0.9%	>1.0%	1.12%	1.14%	1.34%	1.25%	1.33%	1.24%	1.29%	1.16%	1.34%	1.12%	1.18%	

* Colour coding reflects performance against relevant In Month Target, which may differ from latest month target

Measures requiring focus and a countermeasure summary this month are:

Measure	Commentary	Actions being taken to manage / mitigate the workforce risks
Recommend as a Place to Work	Although still within the top quartile nationally for Acute Trusts, the proportion of staff recommending the Trust as a place to work has fallen to 64%.	Intermin People Plan 2025/26 renews focus on value, recognition and staff wellbeing. People Breakthrough Objective changed to "organisation values my work".
Breakthrough Objective: Organisation values my work	NSS 2024 49% of respondents feel organisation values their work. Potential negative impact on workforce engagement and productivity, and colleagues recommending RUH as a place to work.	Intermin People Plan 2025/26 renews focus on value, recognition and staff wellbeing. Actions include developing wellbeing hub, implementing TED tool and establishing leadership and change management office.
Vacancy	The Trust Vacancy Rate has increased to 3.03%.	The Trust and ICB Workforce controls continue to support right-sizing our workforce against our workforce plans. The controls are supporting the Trust financial recovery plans and we anticipate vacancy rates to increase when it's safe to hold a post to support our financial position.

Executive Summary II

				Last 12 Months											
	Performance Indicator	Performing	Outside Tolerance	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Tracker	Global Majority likelihood of being appointed from shortlisting - comparative ratio to 1 White (WRES 2) - Rolling 3 months	0.8 - 1.25	<0.8 or > 1.25	0.56	0.63	0.64	0.59	0.48	0.54	0.64	0.64	0.52	0.52	0.59	0.68
Contextual Information	% of Band 6/7 who are from Global Majority Background (WTE)			15.40%	15.39%	15.48%	15.49%	15.54%	15.66%	15.79%	15.84%	15.97%	15.74%	15.72%	15.76%
Contextual Information	% of Band8A+ who are from Global Majority Background (WTE)			6.54%	6.45%	6.39%	6.11%	6.44%	6.44%	6.43%	6.62%	6.62%	6.90%	6.62%	6.56%

				Last 12 Months											
	Performance Indicator	Latest Month Target	Outside Tolerance	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Key Standard	Appraisal Compliance Rate	>=90.00%	<85.00%	77.66%	77.69%	78.91%	78.53%	82.75%	82.84%	80.19%	80.90%	80.83%	80.75%	79.76%	80.43%
Contextual Information	Global Majority Appraisal Compliance Rate	>=90.00%	<85.00%	76.89%	78.32%	81.24%	80.07%	85.91%	86.00%	83.23%	83.28%	81.98%	83.40%	82.84%	84.55%
Key Standard	Mandatory Training Compliance (exc Bank)	>=85.00%	<80.00%	90.32%	90.03%	90.04%	88.74%	89.01%	88.16%	88.38%	88.61%	88.57%	88.68%	88.68%	88.68%
Key Standard	IG Training Compliance (exc Bank)	<=95.00%	>100.00%	88.51%	86.61%	85.92%	85.24%	87.94%	86.34%	86.23%	88.69%	86.65%	86.44%	86.71%	86.75%
Key Standard	Safeguarding Adults Level 1 Compliance (exc Bank)	>=90.0%	<85.0%	92.79%	92.84%	92.93%	92.56%	91.76%	91.60%	91.33%	91.63%	91.33%	92.10%	92.49%	92.65%
Key Standard	Safeguarding Adults Level 2 Compliance (exc Bank)	>=90.0%	<85.0%	91.69%	91.84%	92.08%	91.96%	92.34%	91.09%	90.81%	90.45%	90.49%	90.48%	90.90%	90.82%
Key Standard	Safeguarding Adults Level 3 Compliance (exc Bank)	>=90.0%	<85.0%	30.43%	36.01%	37.97%	42.16%	47.36%	52.25%	59.00%	67.62%	71.49%	72.13%	75.77%	79.38%
Key Standard	Safeguarding Children Level 1 Compliance (exc Bank)	>=90.0%	<85.0%	92.55%	92.30%	92.11%	91.68%	91.43%	91.48%	91.05%	91.02%	90.91%	91.30%	92.32%	92.16%
Key Standard	Safeguarding Children Level 2 Compliance (exc Bank)	>=90.0%	<85.0%	91.87%	91.51%	91.28%	91.19%	91.85%	90.44%	90.28%	90.57%	90.29%	90.29%	90.65%	90.59%
Key Standard	Safeguarding Children Level 3 Compliance (exc Bank)	>=90.0%	<85.0%	91.32%	90.41%	88.14%	87.32%	89.34%	88.98%	87.90%	88.04%	88.76%	89.53%	87.74%	88.32%

** Training data based on Learning Together from Jun-23; Appraisal and Training information re-stated due to new reporting methodology

Measures requiring focus and a countermeasure summary this month are:

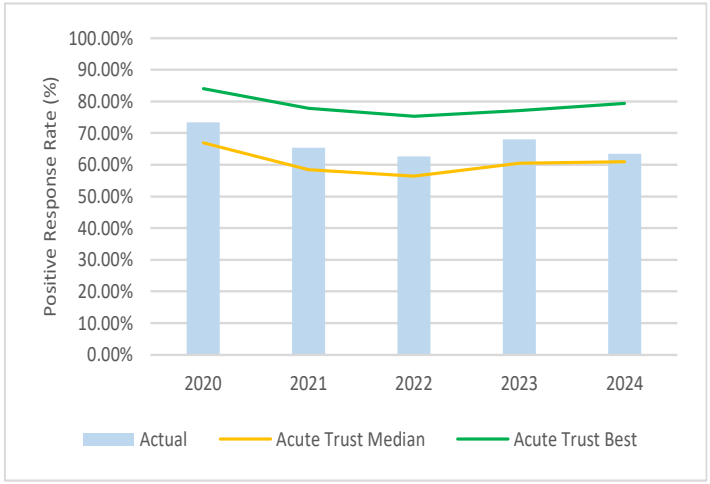
Measure	Commentary	Actions being taken to manage / mitigate the workforce risks
Appraisal	Appraisal compliance continues to fall short of the 90% target at 80.43%.	• Focussed work with specialities with low appraisal compliance led by DPP's. • Increase uptake of appraisal training and support to prioritise (Managers and DPPs) • Developing feasibility options for implementing an appraisal window to focus efforts on quality conversations • Revised Appraisal Policy due ratification • Forging alignment between health and wellbeing interventions and manager engagement with team colleagues • People Function skilling up for improving appraisal quality, which is likely to impact compliance positively

Trust Goal | Staff Recommend the Trust as a Place to Work

Making a Difference Survey Result

Latest Survey	62.6%

National Survey Results



Latest Survey	63.5%

Is standard being delivered?

The Trust has fallen 4.5 percentage points on the position in 2023 to 63.5%, bucking the trend of the best and median results which saw slight upturns. This result nonetheless places the Trust in the top quartile and ranks us 18th nationally for Acute Trusts and 3rd amongst Acute Trusts in the South West.

What is the top contributor for under/over-achievement?

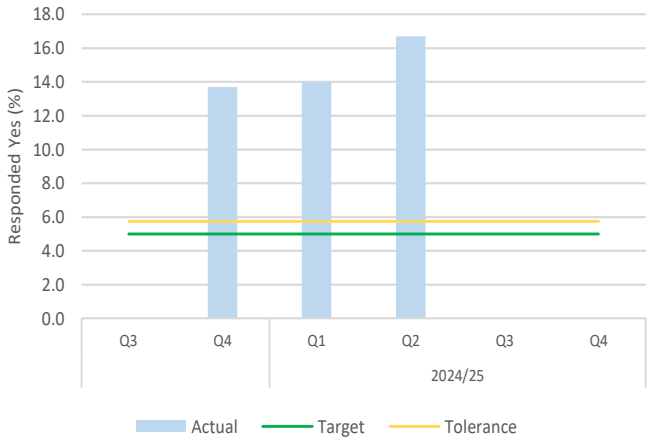
Based on unweighted results, Emergency Medicine (which has since been merged into Medicine) had the lowest positive response rate at 47.6%. Estates and Facilities (56.4%) and Corporate (60.6%) were the next lowest.

Countermeasure Summary

Countermeasure/Action	Owner
• Review of strategic recognition offer aligned to renewed culture communications and engagement plan. • Renewed, targeted wellbeing interventions for areas under most strain. • More focus on inclusion and belongingness throughout people projects and programmes (esp. Leadership Development) • Large-scale review of leadership and management development offer to enhance staff experience • Basics Matter programme identified priorities from staff survey to inform the content of the workstreams • Review Breakthrough Objective to focus on the organisational recognition and appreciation for roles undertaken	People Team for Culture Divisional People Partners/ Divisional Leadership Teams Basics Matter Team
• Focused leadership and team develop interventions ongoing with UEC teams	DPP Medicine Culture Team

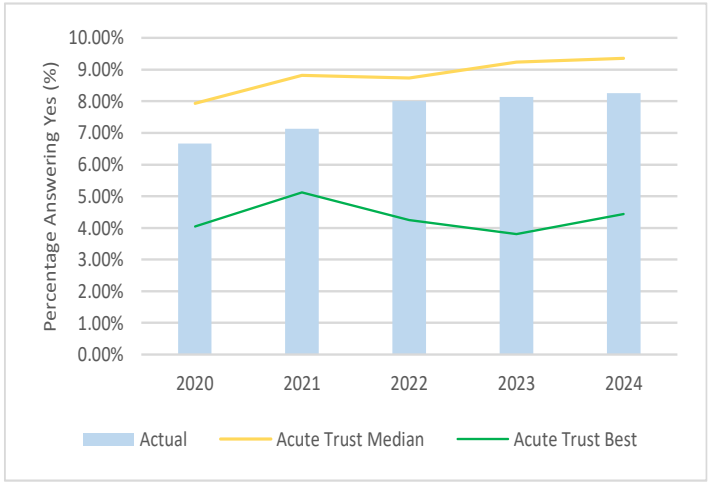
Breakthrough Goal | Reduce Proportion of Staff Reporting Experiencing Discrimination from Line Managers/ Colleagues

Making a Difference Survey Result



Latest Survey	8.00%

National Survey Results



Latest Survey	8.25%

Is standard being delivered?

There was a small, statistically insignificant increase in the number of staff reporting discrimination in 2024 to 8.25%. The Trust now places outside the top quartile of Acute Trusts.

What is the top contributor for under/over-achievement?

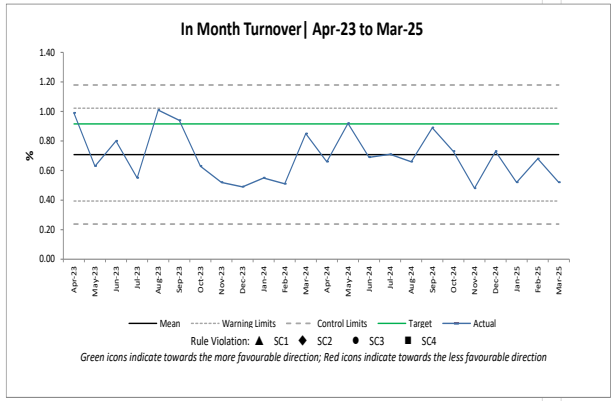
- Based on unweighted results, Estates and Facilities (10.3%), Emergency Medicine (9.9%), Corporate (9.6%) and Surgery (9.2%) had the highest proportion of staff having reported experiencing discrimination from a manager or colleague.
- R&D (4.6%) and FASS (5.9%) had relatively low proportions of staff reporting discrimination.

Countermeasure Summary

Countermeasure/Action	Owner
• Targeted team development interventions (in collaboration with People Team) to address identified issues, including emergency medicine, theatres and cleaning – triangulated process to provide swifter action • Report and Support launched in August 2024, (renewed comms 2025 to support sexual safety work) therefore better, swifter support to areas most affected by discrimination. • Violence Management and Reduction Policy embedding programme ongoing (engagement and communications with Nursing and Midwifery colleagues) • Breakthrough foci from 2023 – 25 consolidation: i.e. race, disability and long-term conditions. • Real-time outliers will be identified using reports through Datix, DPPs and Report + Support – quarterly sample is small, and survey data requires additional balancing to identify specific areas of concern.	People Hub DPPs People Team AD for Culture

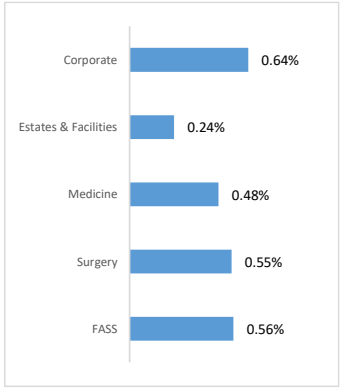
Key Standard| Turnover Rate

In Month Turnover - Trust

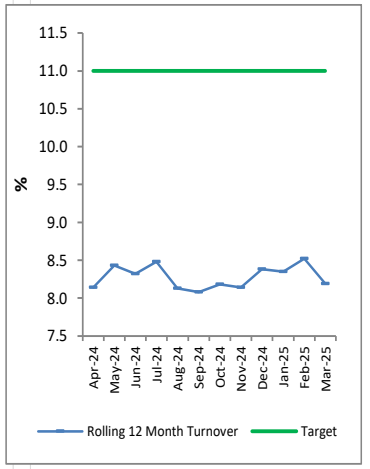


Turnover Rate	0.52%

In Month Divisional Turnover



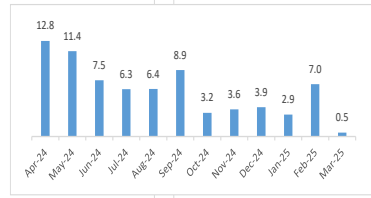
Rolling 12 Months Turnover - Trust



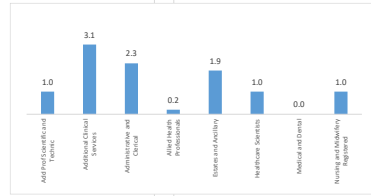
Turnover Rate	8.18%

Leavers Inside 1st Year (Permanent Contract)

Trust Trend



Staff Group - Last 3 Months



Is standard being delivered?

In month turnover continues to be below target at 0.52%.

12 month turnover also remains below target, having fallen to 8.18%.

What is the top contributor for under/over-achievement?

Corporate Division continues to be the only main division to have a 12 month rolling turnover above 11%.

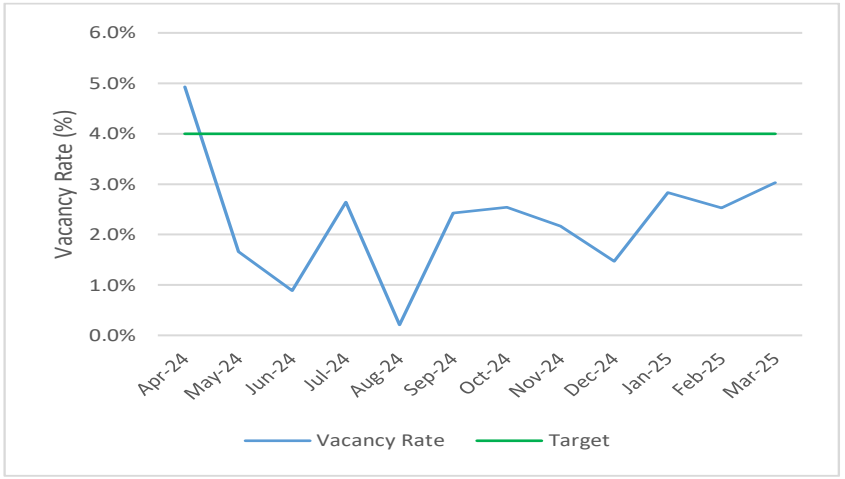
Add Prof Scientific and Technical and Allied Health Professionals both have 12 month turnover rates that are above 11% and are on an upward trend.

Countermeasure Summary

Countermeasure/Action	Owner
Trend is monitored alongside other workforce controls in the context of ongoing sustainability and redesign priorities. Recognition and wellbeing workplans are expected to improve retention.	Workforce Lead Head of Talent

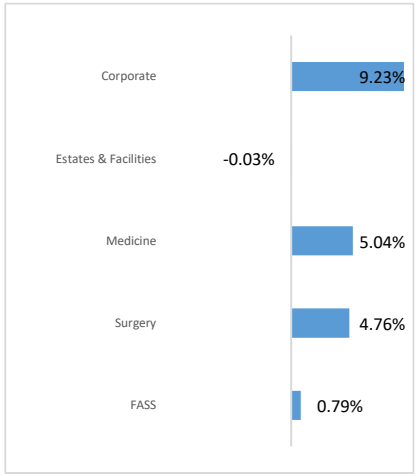
Key Standard| Vacancy Rate

Vacancy Rate - Trust

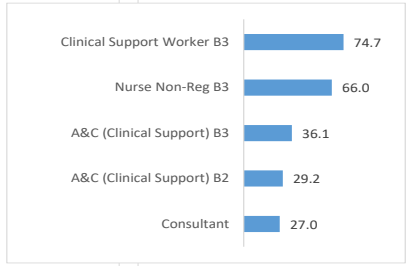


Vacancy Rate	3.03%

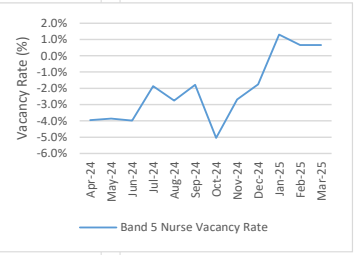
Divisional Vacancy Rates



Top 5 Roles by Vacancy Rate



B5 Nurse Vacancy Rate



Is standard being delivered?

- The vacancy rate increased to 3.03% in M12 from 2.53% in M11 remaining within internal target of 4%
- Divisional vacancy rates may increase as we take the necessary steps to secure a sustainable workforce and slow down the recruitment pipeline where feasibly safe to do so to support our financial position.
- Leavers within the first year fluctuates although secures an overall improved position in comparison to the previous financial year. M12 decreased to 0.5WTE from 7WTe in M11 suggesting ongoing monitoring required in this area to ensure the new joiner experience is making a positive impact on onboarding experience and supporting retention

What is the top contributor for under/over-achievement?

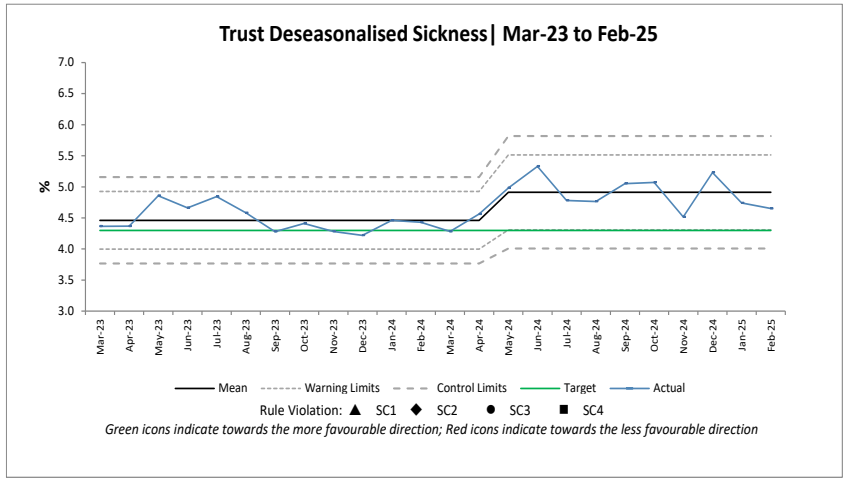
- At staff group level the highest vacancy rate continues to be Band 3 unregistered Nurses. Active campaigns and Career events have enabled us to make 20+ offers during Feb and March.
- During M11 Corporate had the highest vacancy rate at 9.23% supporting our workforce controls of holding vacancies when feasibly safe to do so without impacting on patient safety.
- Medicine had the highest vacancy WTE at 104.3 WTE, equivalent to a vacancy rate of 5.04
-

Countermeasure Summary

Countermeasure/Action	Owner
Trust led Vacancy Control and Agency Reductional Panel continues to support the pay bill reduction and financial recovery plan.	Executive Team
International Recruitment cohorts eligible for Indefinite Leave to Remain will be supported to help the retention of this diverse workforce. Provision includes legal workshops to assist with application process and hardship funds.	AD for People – Capacity and Talent
You Matter app relaunching in April making it easier for staff to access well-being information and all NHS discounts in one place	AD for People – Capacity and Talent
EVP work continues as we get ready to launch new pages on the internet to showcase all the RUH has to offer to support attraction and retention of staff.	AD for People – Capacity and Talent

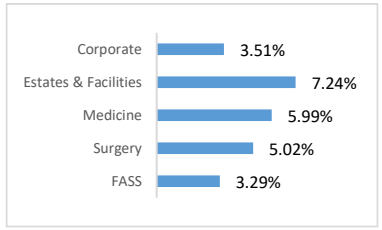
Key Standard| Sickness Absence Rate

Deseasonalised Sickness Absence Rate - Trust

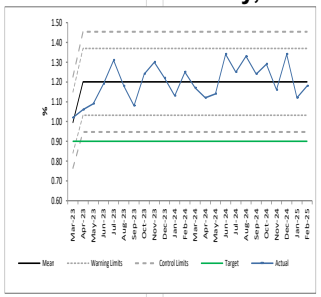


In Month Actual		In Month Deseasonalised		Rolling 12 Months	
	5.07%		4.65%		4.77%

In Month Divisional Sickness Rates



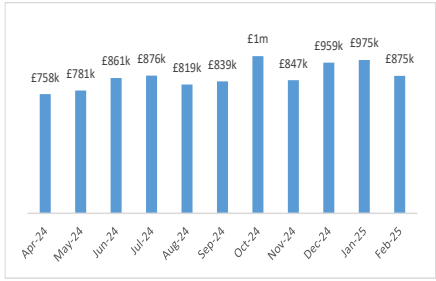
Anxiety, Stress & Depression - Trust



Absence Rate

1.18%

Estimated Absence Cost



RIDDOR Reporting - Employees

	2023/24				2024/25			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Dangerous Occurrence –release or escape of biological agents	-	-	-	-	-	-	-	-
Exposed to harmful substance/ Work acquired Infection	-	-	-	-	-	-	-	-
Lifting and handling injuries	-	1	3	-	1	4	3	-
Physical assault	1	-	-	-	1	-	3	1
Slip, trip, fall same level	-	1	3	1	1	2	1	5
Struck against	-	-	-	-	1	-	-	-
Struck by object	1	-	-	1	-	-	1	-
Fell from height	2	-	1	-	-	-	1	-
Another kind of accident	-	1	1	2	-	1	1	1

Is standard being delivered?

• In month sickness absence stands at 5.07% for February. Although this is slightly below the respective monthly target, there's little to indicate that achieving the seasonally adjusted monthly target is something that will be sustained.

• 12 month sickness rate continues to rise and stands at 4.77%, well above its 4.3% target.

What is the top contributor for under/over-achievement?

• Following a fall last month, Anxiety, Stress and Depression has partially rebound back to an in month rate of at 1.18%. This is likely just natural variation and further evidence to support the notion that there is fair stability within the current control limits. Crucially, to revert back to the historic rates of around 1% signs of disruption would actually be desirable at this time.

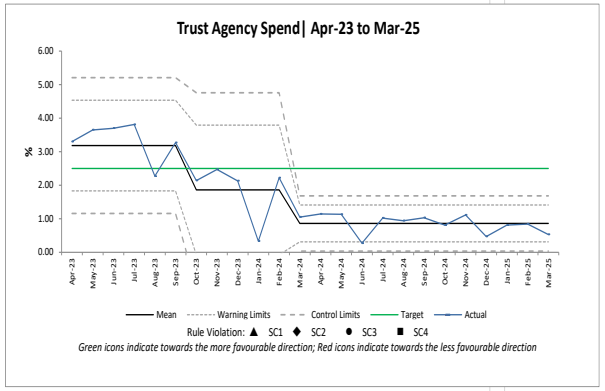
• Cold and Flu remains elevated, but would appear to be a downward trajectory having peaked in January.

Countermeasure Summary

Countermeasure/Action	Owner
Short term absence • Allocate now being used to monitor and support short term absence. Work underway to build this into Halo. • Comm's campaign focussed on 'keeping yourself well this winter' **Long term absence** • People Hub currently supporting managers with 141 long term sickness cases. • Reviewing and developing the staff physiotherapy service • Reasonable adjustments working group developing ways to improve the support for staff with long term health conditions • Departmental stress risk assessments to be conducted in ED, Maternity and Radiology in line with the new Wellbeing at Work Policy	Divisional People Partners/ Nursing Improvement G roup/People Hub Lead Wellbeing Service All – led by DPP for FASS

Key Standard| Agency Spend & Bank

Agency Spend as Proportion of Total Pay Bill

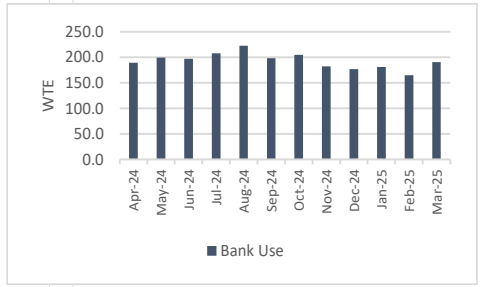


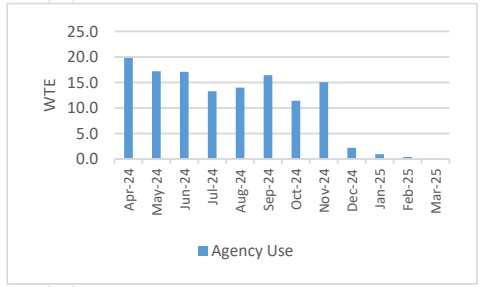
Proportion	0.53%

Agency Spend Breakdown

Agency Spend	In Month	FYTD
Consultants	£253,353	£2,024,170
Junior Medical Staff	£0	£0
Non Medical - Non-Clinical Staff	£3,155	£334,999
Registered Nurses & Midwives	-£392	£589,546
ST&T - Allied Health Professionals	£6,337	£14,089
ST&T - Health Care Scientists	£0	£0
ST&T - Other	£7,066	£32,085

Bank & Agency Use – Staffing Solutions Data





Is standard being delivered?

- Total agency spend decreased in March to 0.53% of the total pay bill supporting us to remain below the national target of 3.2%.
- Off-framework usage accounted for 12.29% of all agency shifts and we're actively sourcing alternative provision to switch out off-framework Locum Consultant in Oncology which is a national shortage/hard to fill post.
- Price cap compliance decreased to 28.49% of all agency shifts secured at cap. The outlier is Medical and Dental as these shifts were outside of price cap and form the majority of our agency use.

What is the top contributor for under/over-achievement?

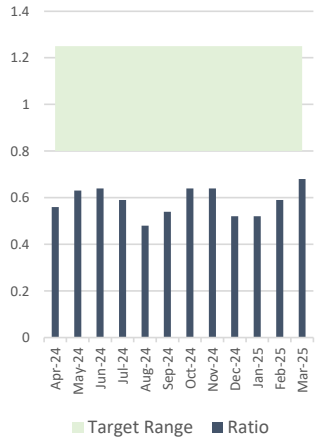
- No agency provision in corporate, estates or facilities during Q4.
- Medical and Dental remain the highest in month and FYTD spend on agency provision with Oncology and Clinical Haematology being the top contributors.
- Bank usage increased from 164.8WTE in M11 to 190.3WTE in M12

Countermeasure Summary

Countermeasure/Action	Owner
SW Agency rate card for Medical & Dental flight paths in place for existing locums to reach rate card by March. Work continues with suppliers to reach compliance and weekly tracker of progress shared with Deputy CMO	Associate Director for People – Capacity
Divisional workforce data tracked prospectively (and retrospectively) and shared with divisional teams to support management of spend	Workforce Lead
Trust led Workforce Controls continue to support the reduction in temporary staffing usage and spend	Executive Team

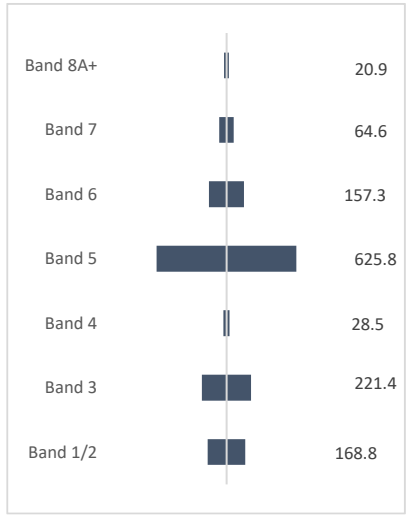
Key Standard| Agency Spend & Bank

Agency Spend as Proportion of Total Pay Bill

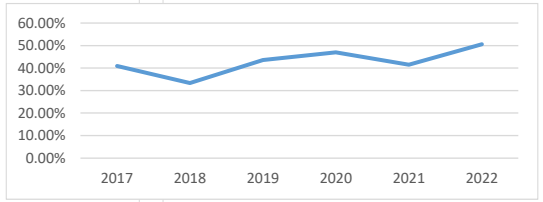


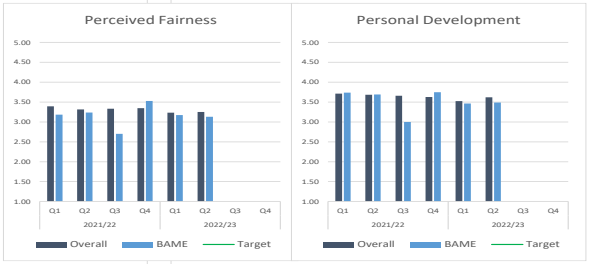
Proportion	0.68

Agency Spend Breakdown



Bank & Agency Use – Staffing Solutions Data





Is standard being delivered?

Based on Trac data, the ratio of the likelihood of appointment from shortlisting comparing Global Majority to White candidates has improved to 0.68. However, this remains below the targeted two-fifths range(0.8-1.25).

What is the top contributor for under/over-achievement?

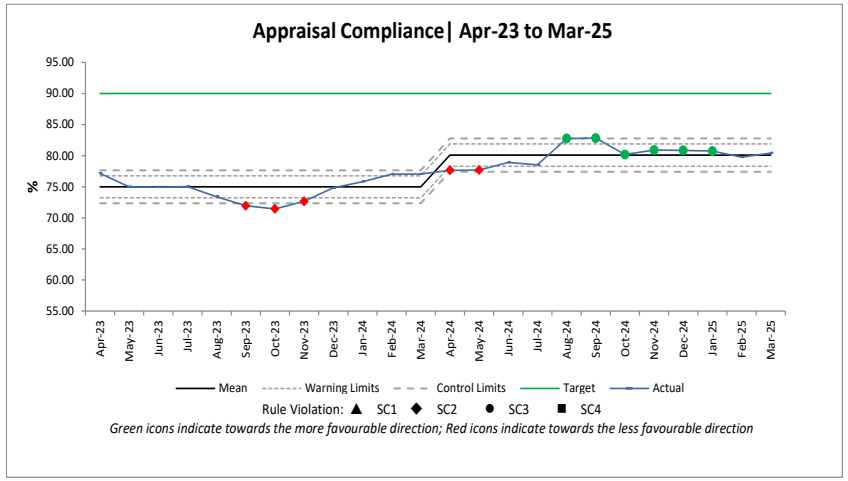
• Candidate distribution across vacancies is masked by the aggregation and this has a significant impact in determining the overall figure.

Countermeasure Summary

Countermeasure/Action	Owner
Work to debias structural barriers to inclusion at interview stage by implementing Independent Inclusion Advisors Programme (RCN Dignity Champions by 2025/26 Q2)	EDI Team / Head of Talent and Resourcing
Extend network of Inclusion Champions to one in every team by 2026/27 Q4	Inclusion Lead
Embed Improving Together leadership behaviour competencies and Core Leadership Programme by 2025/26 Q3	Improving Together Lead and Head of Leadership and Engagement

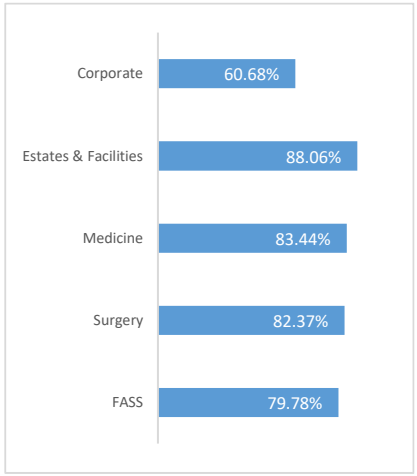
Key Standard| Appraisal Compliance

Appraisal Compliance - Trust



Compliance Rate	80.4%

Divisional Appraisal Compliance



Selected Group Compliance Rates

AfC Staff 81.2%

M&D Staff 72.2%

Consultants 79.4%

White 79.1%

BME 84.6%

Is standard being delivered?

Appraisal compliance has slightly improved to 80.43%, but remains well below the 90% target.

What is the top contributor for under/over-achievement?

• Corporate Division has recovered the 3 percentage points it lost over January and February, but still only has a compliance of 60.68%.

'• Estates and Facilities Division has notably improved its compliance by over 6 percentage points to 88.06%.

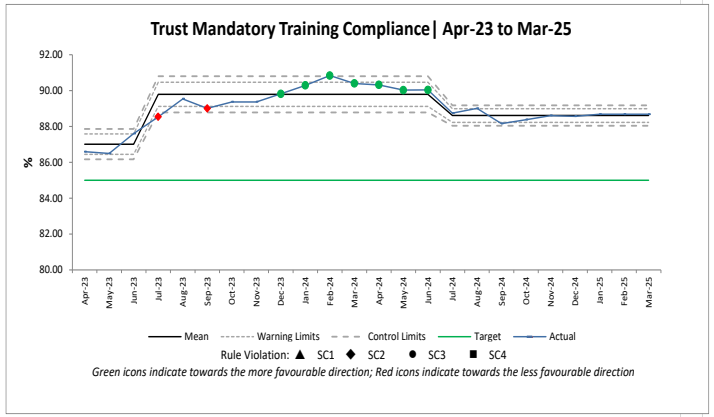
'• All other main divisions are within 1 percentage point of their position last month, reflecting minimal change.

Countermeasure Summary

Countermeasure/Action	Owner
• Focussed work with specialities with low appraisal compliance led by DPP's. • Increase uptake of appraisal training and support to prioritise (Managers and DPPs) • Developing feasibility options for implementing an appraisal window to focus efforts on quality conversations • Revised Appraisal Policy pending ratification • Forging alignment between health and wellbeing interventions and manager engagement with team colleagues.	Divisional People Partners Divisional People Partners Associate Directors for People

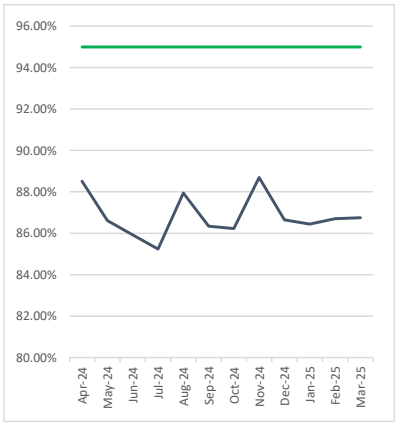
Key Standard| Mandatory Training Compliance

Mandatory Training Compliance Rate - Trust



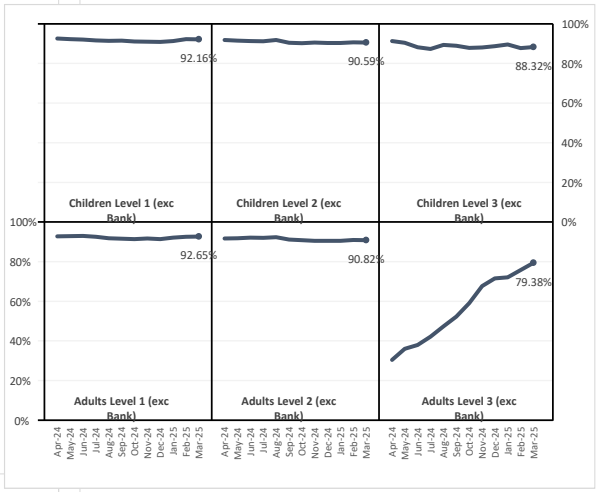
Compliance Rate	88.7%

Information Governance Training Compliance Rate - Trust



Compliance Rate	86.8%

Safeguarding Training Compliance Rates - Trust



Is standard being delivered?

For a second consecutive month Mandatory Training compliance remains static and above target at 88.68%.

What is the top contributor for under/over-achievement?

- All major Divisions are above target for Mandatory Training compliance.
- There has been no significant change in terms of which subjects are not rated green. These remain IG, Manual Handling L2, the Resuscitation subjects and the L3 Safeguarding subjects.

Countermeasure Summary

Countermeasure/Action	Owner
Continues to be pushed through Divisional PRM structure.	Deputy People Partners
Set up MT steering group as required by NHS E, move to measure impact not compliance	Head of Corporate Education
Resus task and finish group in situ (people driver)	Head of Corporate Education

NHS
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Quality Report

April 2025 (February 2025 data)

The RUH, where you matter

Executive Summary | Quality

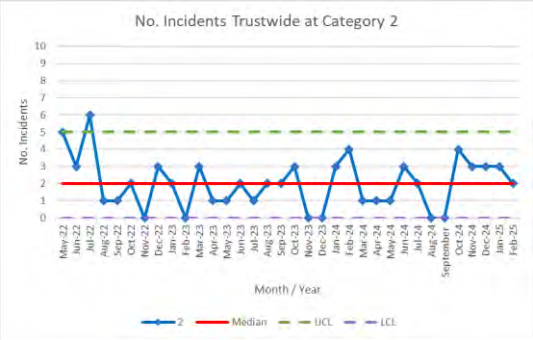
Strategic Goal		Performance Indicator	Description	Target		2023/2024		2024/2025										Trend
				Performing	Under Performing	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	
Other Measures	People we care for	Serious Incidents with Overdue Actions	All non-rejected serious incidents reported on Datix with incomplete actions at month end.	<5	>=5	4	4	2	1	1	2	5	5	9	7	8	5	8	
		Clostridium Difficile Hospital Onset, Healthcare Associated (counted)		<=3	>3	9	6	2	8	3	7	3	5	6	3	4	9	9	
		Clostridium Difficile Community Onset, Healthcare Associated				2	3	5	1	1	4	8	7	0	3	3	1	2	
		E.coli bacteraemia cases Hospital Onset, Healthcare Associated		<=6	>6	4	1	4	4	2	5	2	3	5	5	9	11	2	
		E.coli bacteraemia cases Community Onset, Healthcare Associated				4	4	5	6	2	4	3	0	1	2	7	3	4	
		MRSA Bacteraemias >= 48 hours post admission		0	>=1	0	0	0	0	0	0	0	0	0	0	0	0	0	
		Klebsiella spp Hospital Onset, Healthcare Associated		<=2	>2	4	1	2	2	0	3	1	1	1	0	0	0	0	
		Klebsiella Spp Community Onset Healthcare Associated				0	2	2	2	1	1	1	1	0	1	0	0	1	
		Pseudomonas aeruginosa Hospital Onset, Healthcare Associated		<=1	>1	0	0	1	0	2	0	1	0	0	0	0	1	1	
		MSSA Post 48 Hours				6	5	2	0	1	1	2	2	3	1	0	0	1	
		Flu - Healthcare Onset (+3 days)				-	-	2	1	1	0	0	0	0	6	51	38	49	
		Norovirus Outbreaks				1	2	0	0	1	1	0	0	1	0	3	9	4	
		Number of Hospital Acquired Pressure Ulcers Category 2		<=5	>5	4	1	1	1	3	2	0	0	4	3	3	2	2	
		Number of Hospital Acquired Pressure Ulcers Category 3		<=4	>4	2	0	1	1	1	0	2	3	3	3	1	1	2	
		Hospital Acquired Category 4 Pressure Ulcer		<=0	>0	0	0	0	0	0	0	0	0	0	0	0	0	0	
		Never events		0	>=1	0	0	0	0	0	2	1	0	0	0	1	0	0	
		Mixed Sex Accomodation Breaches				170	182	170	221	191	154	186	160	237	244	246	263	341	

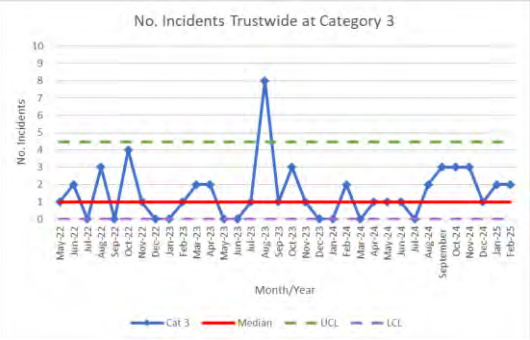
Executive Summary | Patient Experience

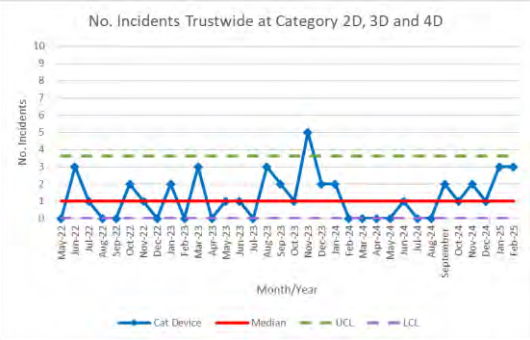
Strategic Goal		Performance Indicator	Description	Target		Baseline	2023/2024		2024/2025										Trend
				Performing	Under Performing		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	
Tracker Measures	People we care for	% of positive responses to friends and family test					94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	
		% of complaints responded to within agreed timescales with complainant		>=90%	<90%	-	90.9%	92.3%	86.7%	64.5%	73.1%	73.1%	87.5%	75.0%	69.0%	85.7%	61.3%	81.1%	73.9%	
		Number of complaints received		<30	>=30		39	33	25	25	26	38	29	32	43	30	27	31	32	
		Number of reopened complaints each month		<=3	>3	-	5	2	1	3	2	8	0	3	1	3	1	1	2	
		Concerns are acknowledged within 2 working days		>90%	<90%		-	-	100.0%	98.0%	99.0%	100.0%	99.0%	97.0%	98.0%	99.0%	98.0%	99.0%	99.0%	

Pressure Ulcers

Tracker measure







We are driving this measure because...

Pressure ulcers are estimated to cost the NHS £1.4m per day. Maintaining a low incidence of pressure ulcers is a Trust priority.

The national acquired prevalence benchmark is 9.6% (2021) and the RUH prevalence was 0.87% in 2024.

Understanding the performance

The RUH benchmarks performance against other Acute Trusts in the ICS for the number of pressure ulcers per 1,000 bed day and the overall number of pressure ulcers by category.

For February 2025, the RUH reported 0.4 pressure ulcers per 1,000 bed days (7 pressure ulcers). GWH reported 0.8 (16 pressure ulcers) and Salisbury data was not available.

The RUH investigated two category 3, two category 2 pressure ulcers and three medical device related pressure ulcers across five wards. There were 3 Medical Device pressure ulcer, one of which was a category 4 which was found to have no lapses in care following full review.

Actions (SMART)

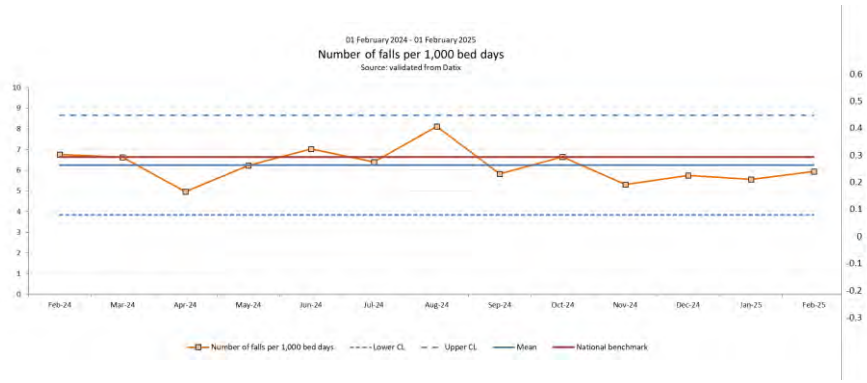
- Improvement plans have been commenced in clinical areas where pressure ulcer performance has deteriorated. These are being monitored by the respective clinical Divisions. Improvements include daily skin care rounds by the band 6 on duty for assurance.
- Divisions are monitoring compliance with skin assessment and will report to the Tissue Viability Improvement Group in May 2025.
- The Tissue Viability Improvement Group continues to monitor all acquired pressure ulcers category 2 - 4 and medical device related to identify trends and opportunities for learning from the Divisions.

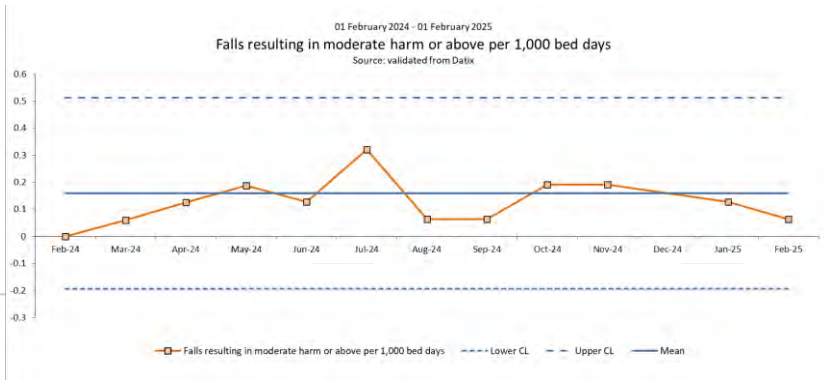
Risks and Mitigations

The Tissue Viability Team continue to work with the digital team to mitigate ongoing risks and following the transition to the full electronic patient record in 2024.

Falls

Tracker measure





We are driving this measure because...

Falls prevention is one of the Trust's 5 safety priorities. The national benchmark from the National Audit for Inpatient Falls is 6.63 falls per 1000 bed days (any reported falls).
The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falls also affect the family members and carers. Falls are estimated to cost the NHS more than £2.3 billion per year and have an impact on quality of life, health and healthcare costs (NICE).

Understanding the performance

Pareto analysis identifies the 5 top contributing inpatient areas are within 3 Older Persons wards,1 Orthopaedic ward and 1 Medical ward. The frailty and complexity of patients on these wards means they have an increased vulnerability to falling whilst they are in hospital. Data shows that during February 98.2% of inpatients did not fall in our care which has remained consistent.

NICE guidance advises all inpatients at risk of falls should have lying and standing blood pressure recorded as part of a multifactorial risk assessment. This is used to diagnose a health condition called Orthostatic hypotension that increases the risk of falls.
Analysis reveals that one of the top contributing factors is patients not receiving the assessment.

Actions (SMART)

1. The Falls Prevention Improvement Group QI project is on increasing compliance with recording lying and standing blood pressure :

- Initial Aim: 50% of patients in 4 wards have a lying and standing blood pressure recorded by February 2025 –
  - Lying and standing BP compliance achieved 48%
  - Correlating to a 12% reduction in the number of falls in the 4 wards
- Next stage of project to spread improvement project to 6 additional wards with the aim to increase compliance to 50% in these areas by July 2025.

Risks and Mitigations

1. Staff are not always capturing when it is not appropriate for a patient to have a lying and standing blood pressure assessment (may not be medically stable or physically well enough to stand). This will affect the data as patients that are not appropriate will not be removed. Mitigations include how to document 'not appropriate' in training sessions.
2. Expanding the project from OPU wards to the 6 additional wards may highlight some limitations owing to differing patient cohorts and specialities. PDSA cycles will be utilised to mitigate this risk and adapt where needed for each clinical setting.

Infection Prevention and Control

Tracker measure

We are driving this measure because...

Infection Prevention is one of the Trust's 5 safety priorities. Good infection prevention and control (IPC), including cleanliness, is essential to ensure that people who use health and adult social care services receive safe and effective care.
The total annual cost of Healthcare associated infections in the UK is estimated to be £774 million. The HAI cost is mainly driven by excess length of stay in hospital (HIS 2021). The impact of an infection can be devastating to both the patient and their families.

Understanding the performance

There were 11 cases of Clostridioides Difficile infection (CDI) (9 HOHA and 2 COHA) reported during February 2025. 94 cases have been reported year to date against an annual threshold of 75. The affecting CDI collaborative is working with the national team to identify any probable causes which is also a national issue. The group is investigating the effects of anti depressants and Glucagon Like Peptide (GLP 1).

There were 6 cases of E. coli infection (2 HOHA and 4 COHA) reported during February 2025. There have been 90 cases reported year to date against the annual threshold of 82.

The Gloves Off campaign will be presenting at the Trust's Sustainability Day in April, which will also aim to recruit new areas to get involved.

Actions (SMART)

To reduce ingestion of environmental bacteria and virus' during a hospital stay, we will enhance hand hygiene opportunities.
Aim: To increase patient hand hygiene pre and post meals within a bay on an older person's unit by 30% within 3 months. Planned wipes trial to support patient hygiene commencing 28 April 2025 until 23 May trialling 2 companies across 4 wards.
Gloves off campaign: To ensure clinical gloves are worn appropriately. Aim: To reduce the inappropriate use of gloves by 30% within 3 months. Launch on OPAU at the beginning of May.
To develop and launch a RUH PPE App to improve the use of correct PPE for all non-high consequence infections/symptoms.
Aim: To empower clinical staff in a department to select the correct PPE plan to roll: as soon as IT can support.

Risks and Mitigations

During February there were 11 COVID cases and 158 Influenza cases, 127 flu A and 31 Flu B, this put considerable pressure on the front door. There were 47 beds days lost due to Flu cases being detected on or during the fist days of admission. The Communication Team are supporting to hand hygiene messaging and Trust information for both visitors and patients on the web pages.

UKHSA have declared a national standard incident in response to increasing detections of Candidozyma auris (*C. auris*), due to worsening outbreaks especially in London and the South-East. Focus on increased screening with augmented care and for patients that have travelled outside of the UK or have been hospitalised.

Development of a quick guide to support correct completion of fluid charts on Millenium is in progress.

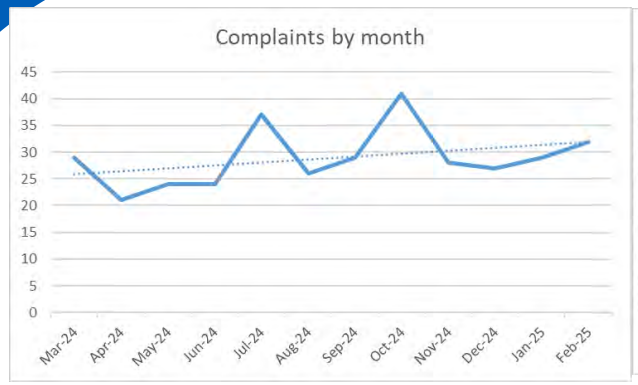
Ward/Unit allocation to IPC team to support nursing process and procedure, allowing for areas to identify with a nurse to sustain IPC practice and improve visibility of the team across the Trust.

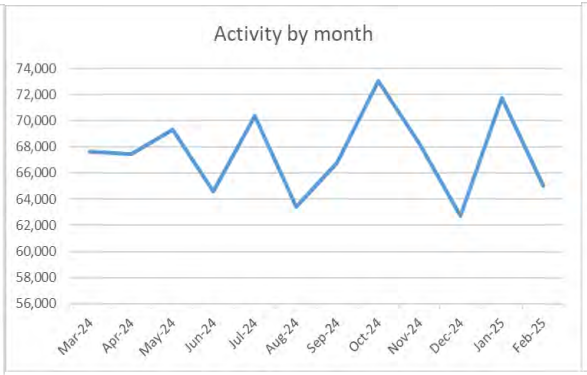
The RUH, where you matter

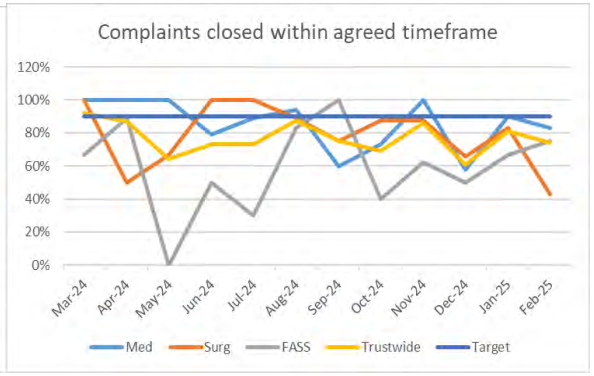
HOHA: Healthcare Onset Hospital Associated Community
COHA: Onset Healthcare Associated
PPE: Personal Protective Equipment

Patient Support & Complaints (PSCT)

Tracker measure







We are driving this measure because…

The Trust values feedback and recognises that complaints and compliments provide a valuable insight into how we can improve our services for patients and families.

The NHS Complaint Standards supports organisations to provide a quicker, simpler and more streamlined complaints handling service. The standards have a strong focus on early resolution.

Month	March 2025
% complaints/concerns resolved with early resolution (14 days)	79% (target 75%)
% of formal complaint responses closed within the timeframe agreed with the complainant	74% (target 90%)

Understanding the performance

In February 2025, the Trust received 32 new complaints. (this compares to 31 in January). The relate to concerns about clinical care (n=20), this is consistent with previous months, there are no themes regarding specific areas. The Medicine Division received the highest number of new complaints (n=19). The number of re-opened complaints remains low. 2 complaints were reopened in February. Complaint rate per 1000 patients in February is 0.49. 79% of all contacts with PSCT were resolved within 14 days in line with NHS Complaints Standards for early resolution. The response times for formal complaints continue to fall short of the target with 74% of complaints responded to within the agreed timeframe.

Actions (SMART)

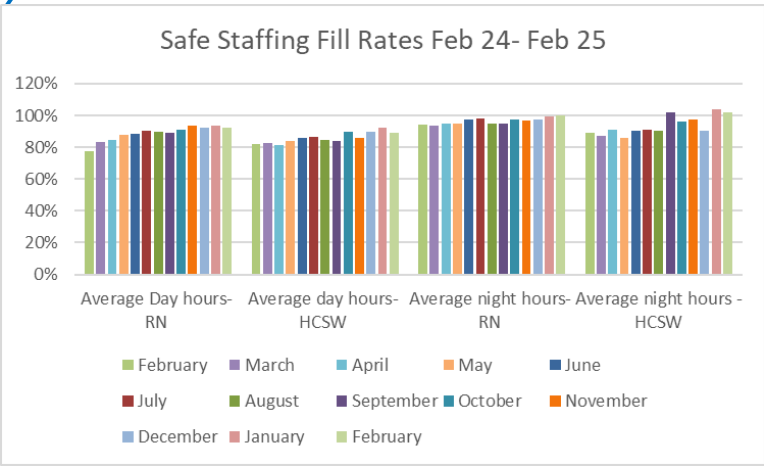
- Month on month improvement in response rates in all Divisions by end of Q2.
- With the DDONs, review process of assurance for the quality of actions and learning/improvements from complaints.
- Continue training for staff on managing concerns and complaints through bespoke sessions and on the Learn Together platform.
- A revised complaints process has now been agreed with the Divisions and an updated Complaints and Concerns policy is being drafted and will be completed by 31 May 2025

Risks and Mitigations

1. The capacity and confidence of ward staff to respond to concerns and complaints and resolve issues at the earliest opportunity. The Head of Complaints is supporting staff with ongoing training.
2. Learning from complaints and completion of actions is not consistently embedded across the Trust together with the assurance that feedback is leading to sustained quality improvement. This is a key element of the Patient Experience priorities and focussed work has commenced.
3. Lack consistency in responding within agreed timeframe could cause reputational harm to the organisation.

Safe Staffing (Nursing Inpatient Areas)

Breakthrough Objective



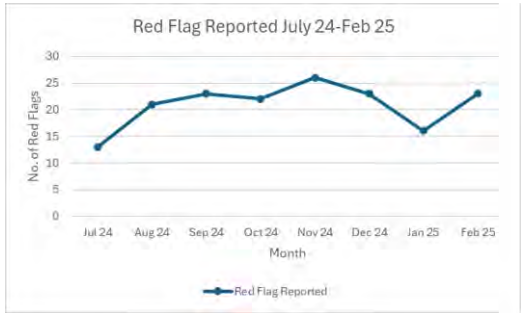
Day Shift Fill Rate		Night Shift Fill Rate	
RN	HCSW	RN	HCSW
92%	89%	100%	102%

<80%
>120
80% -100%

Ward	RN Day	HCSW Day	RN Night	HCSW Night
Charlotte	72%			
Acute Stroke				121%
Childrens		45%		71%
Combe				129%
Waterhouse				150%
Helena	127%	145%	130%	139%
Philip Yeoman		47%		50%
Pulteney	122%			
Robin Smith		77%		139%
Emergency Dept		73%		

We are driving this measure because…

Ward staffing levels are determined as safe, if the shift fill rate falls between 80-120%. This is a National Quality Board (NQB) target.



Understanding the performance

The combined shift fill rates for day shifts for RNs across the 25 inpatient wards was 92% and 100% respectively for nights. The combined shift fill for HCSWs was 89% for the day and 102% for the night shift. The 102% represents the additional HCSW shifts for patients requiring 1:1 care. Therefore, the Trust as a collective set of wards is within safe limits for February.

The table above shows exceptions to the 80-120% fill rate. No wards fell below 80% fill rate for RN staffing at night. One ward (Charlotte) fell below 80% RN dayshift fill rate (72%) because of reduced bed numbers due to essential maintenance. The consistent RN fill rate on all shifts is reflective of the overall continued vacancy improvement.

Helena ward have seen increased acuity during the month of February resulting in an enhanced staffing requirement on day and night shifts.

The decreased HCSW fill rate < 80% on all areas other than Philip Yeoman ward (PY) is due to HCSW vacancy. PY fill rate is <80% is due to elective occupancy levels and planned staffing. HCSW fill rate reflects the current HCSW vacancy.

- The increase HCSW fill rate >120% particularly on night shifts reflects the deployment of additional staff in response to patient acuity.

Actions (SMART)

- To recruit to 5.6wte remaining vacancies by May 2025 following the successful February/March recruitment events. These vacancies are within the Emergency Department/ Medical Assessment Unit and there will be a specialty specific recruitment campaign.
- Align roster templates for Robin Smith Ward and Philip Yeoman HCSW night shift changes on new rota template from June 2025.

Risks and Mitigations

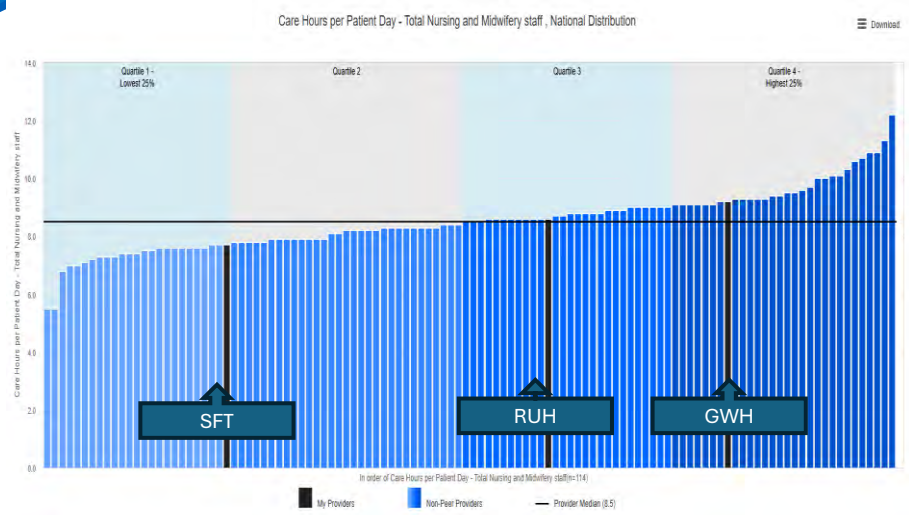
There is a risk that the current HCSW vacancies will remain vacant and decreased fill rate >80% will continue. To mitigate this risk there is a Trust wide recruitment campaign which has successfully recruited 28.02wte who are due to start April-May 2025.

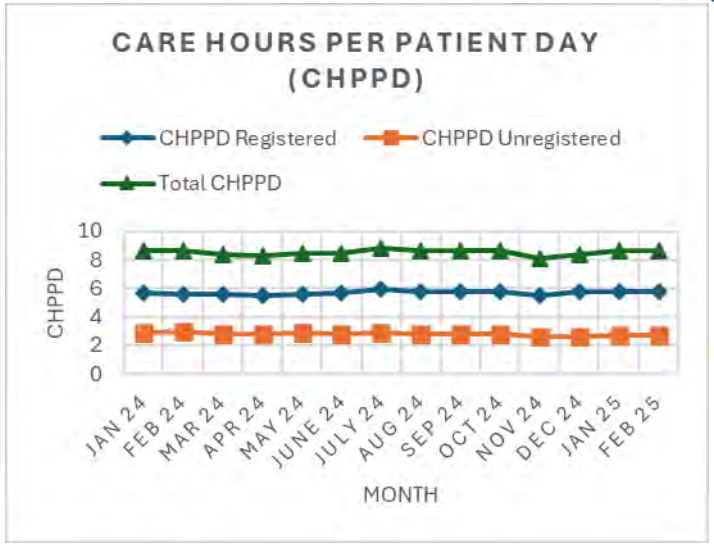
There are twice daily Safer Staffing meetings to review safe staffing and potential risks or red flags with mitigation put in place as appropriate. This will include redeployment of staff.

There were 23 red flags reported by wards in February 2025 an increase from 16 reported in January 2024. The breakdown of the 23 was predominantly a shortfall of 25% RN time due to short notice sickness.
All these were reviewed and appropriate mitigation put in place with staff redeployment as required.

Care Hours (Nursing Inpatient Areas)

Breakthrough Objective





We are driving this measure because…

Care hours per patient day (CHPPD) measures the total hours worked by RNs and HCSWs divided by the average number of patients at midnight.

CHPPD data gives nursing teams a picture of how staff are deployed and how productively.

Understanding the performance

Total monthly CHPPD is 8.6 reflecting the same as the previous month. CHPPD continues to remain stable for both registered and unregistered staff over the past 12 months.

When reviewed on Model Hospital (latest data January 2025) we remain in quartile 3 and benchmark in line with the peer median of 8.6.

Actions (SMART)

- Divisional monthly prospective roster reviews with focus on effective rostering principles and key performance indicators.
  Retrospective reviews to commence May 2025
- Twice daily (minimum) of safe care census completion on all relevant wards by April 2025. Weekly divisional reporting of compliance.
- To commence The bi-annual Safer Nursing Care Tool (SNCT) collection for 30 consecutive days from the 1 April.

Risks and Mitigations

The risks identified in February was increased levels of short-term absence requirement daily review and deployment of nursing staff. As well as additional capacity areas requiring nurse staffing.

Mitigation:

- Twice daily safe staffing meetings reviewing unfilled shifts alongside acuity and dependency of all wards.
- Minimal RN vacancies and over-establishment in some ward areas supporting redeployment.
- Successful HCSW recruitment campaign.
- Focused joint led (Nurse & HR) sickness reduction programme (oversight via NAMIP).

Royal United Hospitals Bath
NHS Foundation Trust

Perinatal Quality Surveillance

April 2025

February 2025 data

The RUH, where you matter

Safe – Maternity& Neonatal Workforce

	Target	Threshold G	Threshold A	Threshold R	Dec 24	Jan 25	Feb 25	Comment
Midwife to birth ratio	1:24	<1:24		>1:26	1:26	1:28	1:26	
Midwife to birth ratio (including bank)	1:24	<1:24		>1:26	1:24	1:27	1:24	
Consultant presence on BBC (hours/week)	98	>97			98	98	98	
Consultant non-attendance when clinically indicated (in line with RCOG guidance)	0	0		>1	0	0	0	
Percentage daily multidisciplinary team ward round	90%	>90%		<80%	97	97	89	See countermeasure
Band 5/6 Midwifery substantive vacancy rate WTEs	7.0 WTE	≤7.0		>10	0.9	0	0	
Percentage Neonatal Nurse QIS rate	70%	≥70%		≤60%	63	60	60	Clarification from SWODN re criteria for QIS calculation. Direct patient facing staff only. Sees adjustment to figure. Forecast 66% June, 77% September
Neonatal Nursing vacancy rate WTES	0				3.12	2.59	1.46	Continue uplift to band 4 to support SNA training
Percentage Neonatal shifts staffed to BAPM standards	100%	>90		<80%	95	100	100	
Percentage medical staffing to BAPM minimal standards	100%	>97%		<80%	98.8	98	98.2	ANNP no longer getting non-clinical time (as per ACP pillars) to cover gaps. ANNP vacancy live
Percentage Maternity 12-Month Turnover rate	≤5%	≤5%		≥7%	3..52	2.94	2.89	
Percentage Neonatal Unit 12-month Turnover rate	≤5%	≤5%		≤7%	6.28	6.33	6.42	
Percentage of TC shifts with staff dedicated to TC care only		>90%		<80%	97	100	100%	

Is the standard of care being delivered?
- **Improved Midwife to Birth ration**

What are the top contributors for under/over-achievement?
- NNU QIS trained – trajectory for compliance >70% in Q2 2025

Countermeasure /Action (completed last month)	Owner
NNU roster finalised	Inpatient matron / Lean NNU nurse

Countermeasure /Action (planned this month)	Owner
MDT ward round compliance – clerical omission addressed	GD

Average Shift Fill Rates

			Dec 24	Jan 25	Feb 25
Maternity	Midwives	Day	98%	93%	96%
		Night	92%	93%	96%
	MCA/MSWs	Day	72%	78%	73%
		Night	84%	88%	79%
Neonates	Registered nurses	Day	N/A	N/A	83%
		Night	N/A	N/A	94%
	Nursing support staffing	Day	N/A	N/A	24%
		Night	N/A	N/A	71%

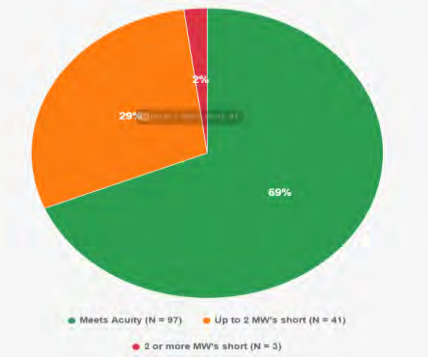
Table 2. Band 5/6 Midwifery Vacancy rate and staffing pipeline projections

Safe – Maternity& Neonatal Acuity Jan 25

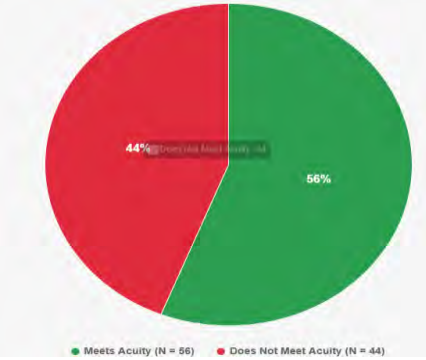
	Target	Threshold			Dec 24	Jan 25	Feb 25	Comment
		G	A	R				
Percentage of 'staff meets acuity'	100%	>90 %		<70%	78	83	69	Trained staff only included in acuity data
Percentage of 'staff meets acuity' Mary Ward (inpatient care)	100%	>90 %		<70%	58	55	56	Care hours required, trained and support staff included in acuity data
Confidence factor in BirthRate+ recording BBC	60%	>60 %		<50%	75	78	84	Percentage of possible episodes for which data recorded
Confidence factor in BirthRate+ recording Mary Ward	60%	>60 %		<50%	85	88	89	Percentage of possible episodes for which data recorded
Maternity 12 month rolling absence rate %	4.5%	<4%		>5%	3.52	3.77	3.77	
Neonatal Unit 12 month rolling absence rate %	4.5%	<4 %		>5%	4.46	4.24	4.24	
1:1 care not provided in labour	0	0		>1	0	0	0	
Labour ward coordinator not supernumerary episodes	0	0		>1	0	0	0	
Nice red flags	NICE 2015				3	2	3	
Birth outside of BAPM L2 place of birth standards	0	0		1	0	0	0	
Number of days in LNU outside of BAPM guidance	0	0		>2	0	0	0	

Countermeasure /Action (completed)	Owner
Reset of red flags and staffing to inform acuity complete with March 25 go live	SLT
Mary ward staffing meets acuity reporting in line with BR+ reporting (meets acuity or does not meet acuity)	SLT

Countermeasure /Action (planned)	Owner
Staffing escalation guideline updated – to be reviewed Trust wide and presented through CEF	Business manager



BBC



Mary ward

Is the standard of care being delivered?

- No episodes of supernumerary Labour Ward coordinator status not maintained
- No episodes where 1-1 care in labour not provided
- NICE red flags – delay between admission and commencing IOL
- Mary ward staff meet acuity compliance to 56%.

What are the top contributors for under/over-achievement?

- No correlation with BBC staffing meet acuity and other metrics. Probable anomaly, will continue to monitor closely
- Mary ward data continues to be based on old staffing versus acuity data with reset due in March 2025.

Incidents

New incidents of moderate harm or above February 25

Case Ref	Date	Category	Incident	Outcome/Learning/Actions	MNSI Reference	PSII?
138093	21/02/25	Unexpected death	31- week antenatal intrauterine death	DOC commenced. Rapid review undertaken; no care concerns identified. Will receive full PMRT		
137696	11/02/25	Unexpected death	37-week antenatal intrauterine death	DOC commenced. Rapid review undertaken; no care concerns identified.		

Ongoing Maternity and Neonatal Reviews

Case Ref (Datix)	Date	Category	Incident	Outcome/Learning/Actions/ Update of progress	MNSI Reference	PSII?
137174	26/01/25	Moderate harm	PPH – urinary retention Epidural catheter tip in situ on removal	Rapid review 31/01/25 - actions to be added to Datix		Discussed at PSERG
133795	12/10/24	Unexpected death	Neonatal death of a 28-week gestation post placental abruption and Prolonged Pre-Labour Rupture Of Membranes from 22 weeks of pregnancy	DOC commenced; Rapid review conducted no care issues identified causal to the outcome		
133490	03/10/24	Moderate harm	Transfer of neonate to tertiary level NICU for active therapeutic cooling- MRI Normal – MNSI progressing at family request	DOC commenced by on call consultant, rapid review undertaken	MI-038594	
127900	04/04/24	Unexpected Death	Neonatal death following elective caesarean birth	DOC commenced by on call consultant Referred to Maternity Independent Advocacy service	Discussed- did not meet criteria	
132682	10/09/24	Unexpected Death	Intrauterine Death at 28 weeks of pregnancy	DOC commenced, PMRT interim report published		
133232	26/09/24	Unexpected Death	Intrauterine Death at an unknown >37-week gestation in an undiagnosed/concealed pregnancy	DOC commenced, discussed with MNSI	Discussed at MNSI regional meet 30/09/24 – does not meet criteria	
133329	28/09/24	Catastrophic harm/ Unexpected Death	Death of 8-day old infant following call to Maternity Triage Line 12 hours prior to presentation	DOC commenced – Patient Safety Investigation commenced		Declared 07/10/24
134753	21/22/23	Moderate Harm	LTFU. Cardiac referral not followed up. Presented 28+4 symptomatic, admitted to tertiary cardiac centre	DOC commenced. Rapid review undertaken; 2nd review required following collection of further information		

Incidents

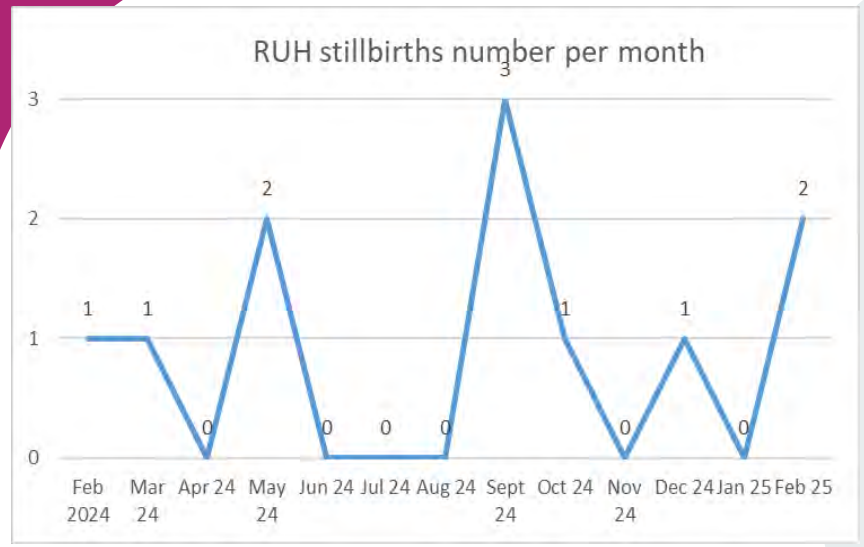
Closed reviews February 2025

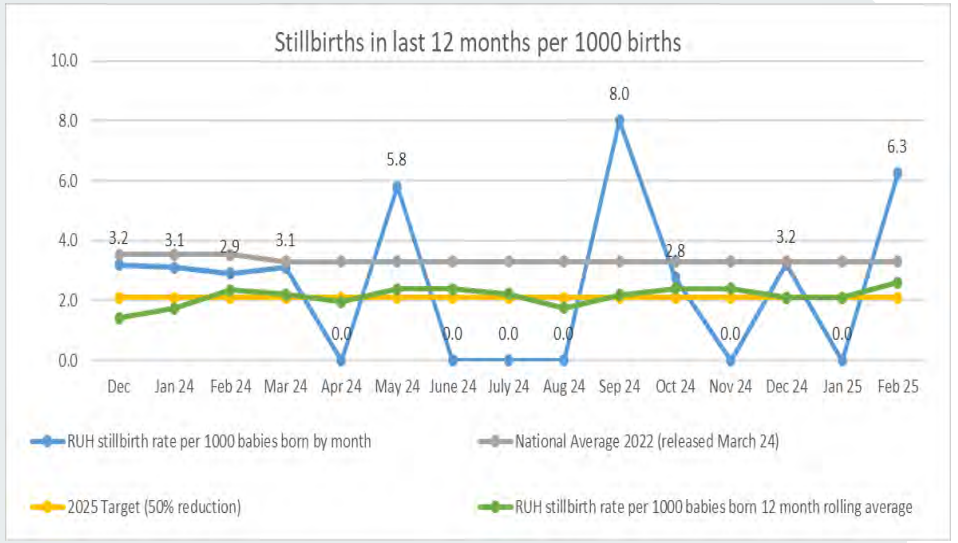
Case Ref (Datix)	Date	Category	Incident	Outcome/Learning/Actions - all monitored via action tracker	MNSI Reference	PSII Reference
134325	31/10/24	Moderate harm	Maternal ICU admission on day 16 post elective caesarean birth with bowel injury	DOC commenced by on call consultant. 5 MDT reviews. Discussed as surgical M&M Actions produced and will be monitored by patient safety team. DOC closure letter sent		
130511	29/06//24	Moderate harm	Transfer of neonate to tertiary level NICU for active therapeutic cooling	DOC commenced. Referral to MNSI- MNSI review in progress at familial request. Final report published Feb 25 and shared with family. Action plan agreed	MI-037619	
135330	29/11/24	Moderate harm	Entrapment of fetal head of 29/40 baby	DOC commenced. Rapid review undertaken, no immediate care concerns		
135577	20/11/24	Unavoidable death	22+5 neonatal death	In utero transfer to Bristol for ongoing care following SRM. No immediate care concerns		
134092	23/10/24	Unexpected death	36-week antenatal stillbirth, cord detached at birth of baby.	DOC commenced ; Rapid review conducted. Action plan to Governance April 2025		

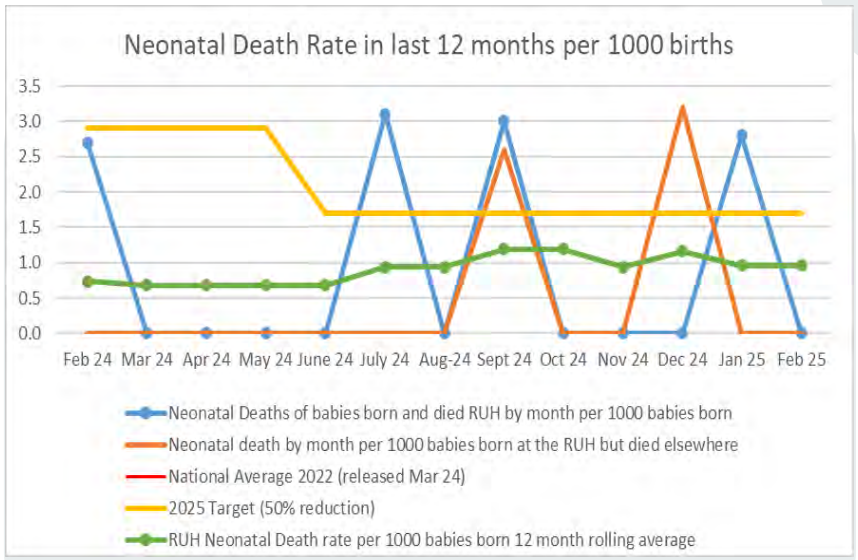
Number of IVH	Nil	**Number of PVL**	Nil

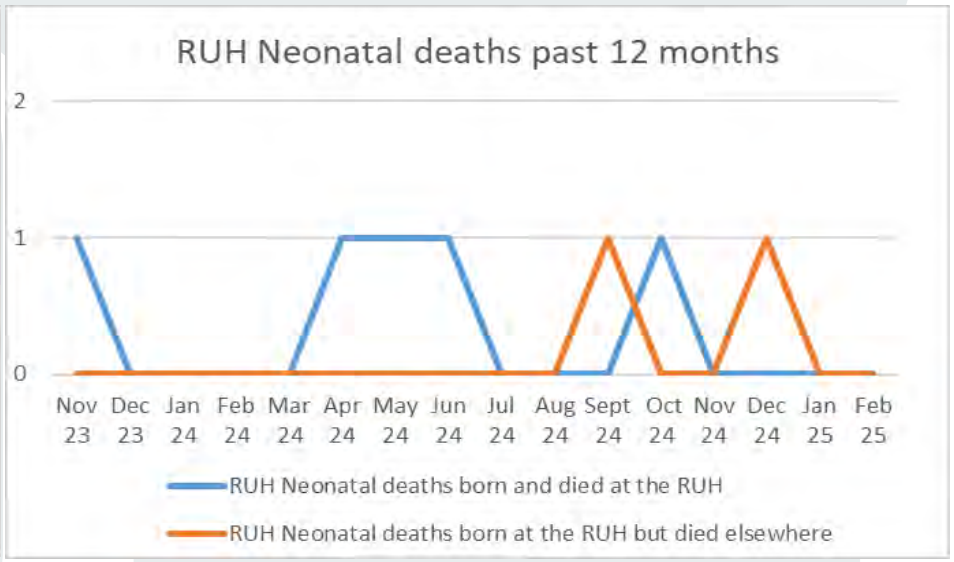
Maternity Safety Support Programme	N/A	**Coroner's regulation 28**	N/A

Safe- Perinatal Mortality Review Tool (PMRT)









Background information

All perinatal deaths have been reported using the Perinatal Mortality Review Tool (PMRT) tool since 2018. PMRT reporting is Safety Standard 1 of the NHSR Maternity Incentive Scheme year 6. A quarterly update paper is shared with the Board.

Perinatal deaths are defined from 22 weeks and include neonatal deaths, but stillbirths are defined from 24 weeks. The rate of stillbirth and perinatal death may therefore be different.

Stillbirth and neonatal death rate is presented as 'rate per 1000 births' for national benchmarking, therefore the numbers per month are presented on separate graphs.

During March 25 we received the MBRRACE-UK report of 2023 deaths at the RUH. Benchmarking will be undertaken.

Monthly update

2 PMRT MDT reviews completed in February:

132682 – Graded A and A

135855 – Graded B and A

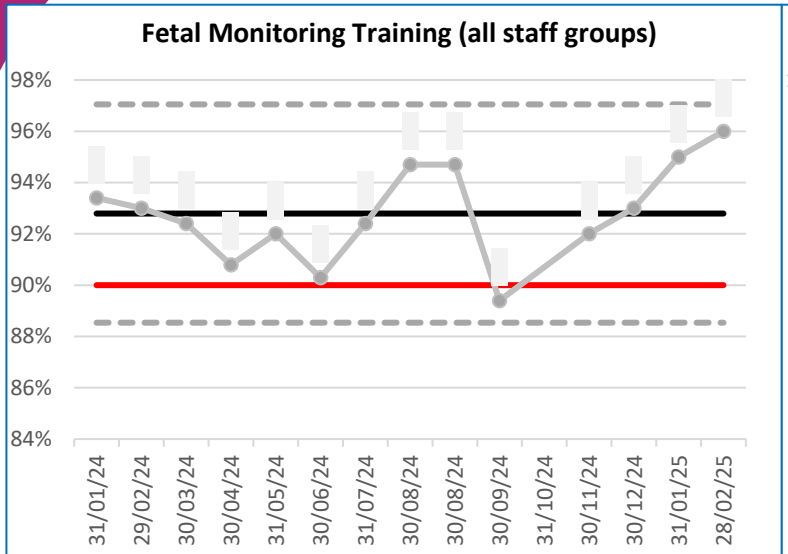
134092 - (October 24) Graded C as triage guidance not followed and C in response to family feedback.

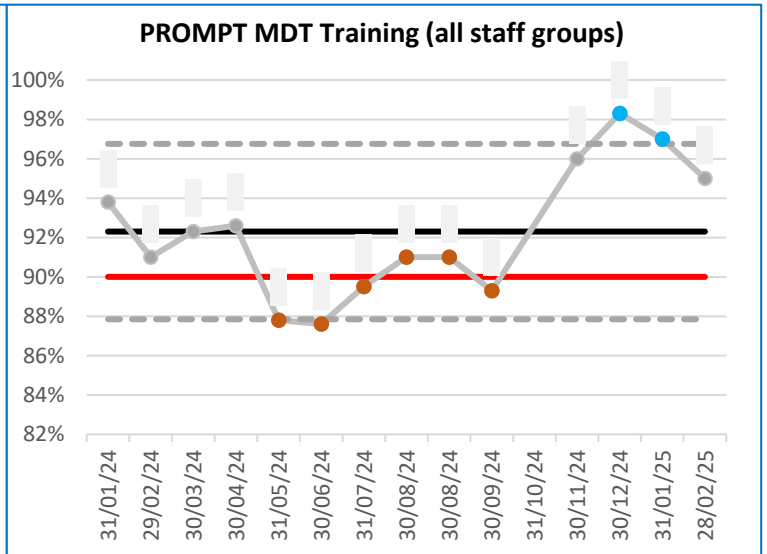
Action plans for any gradings of C or D will be agreed through Governance process and learning shared via monthly quality boards, safety catch and individual learning if needed.

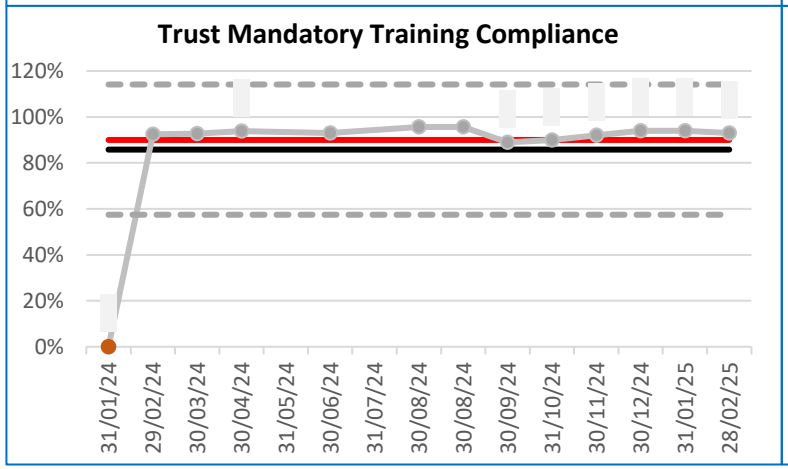
Two antenatal stillbirths in February. No immediate care concerns identified.

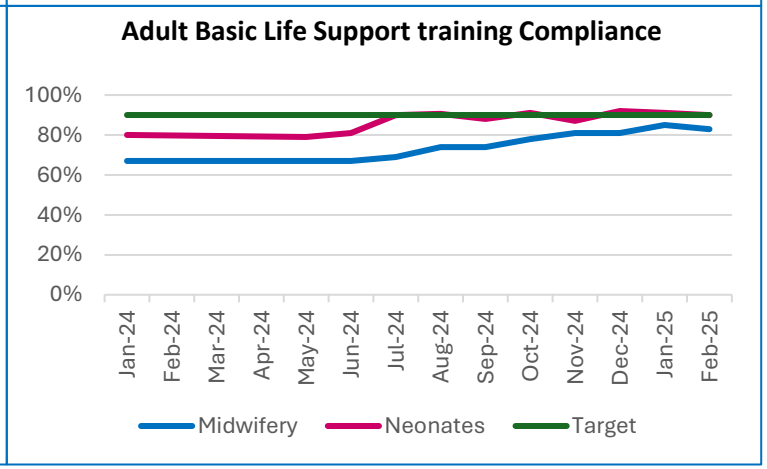
No neonatal deaths in February.

Well-led – Training









Training
Compliance monitoring and booking system now in place supporting future compliance. Updated Training Needs Analysis awaiting formal departmental ratification. Compliance data being sent to all MDT leads monthly to ensure good information sharing between all staff groups.

Countermeasures/action:
- Bespoke refresher skills sessions available for community staff : Skills drills and newborn life support with dates booked for the next year. This is supported by the resuscitation team and advanced neonatal nurse practitioners (ANNPs).
- Additional skills sessions available to newly qualified staff and senior students facilitated by the Retention and Education team.

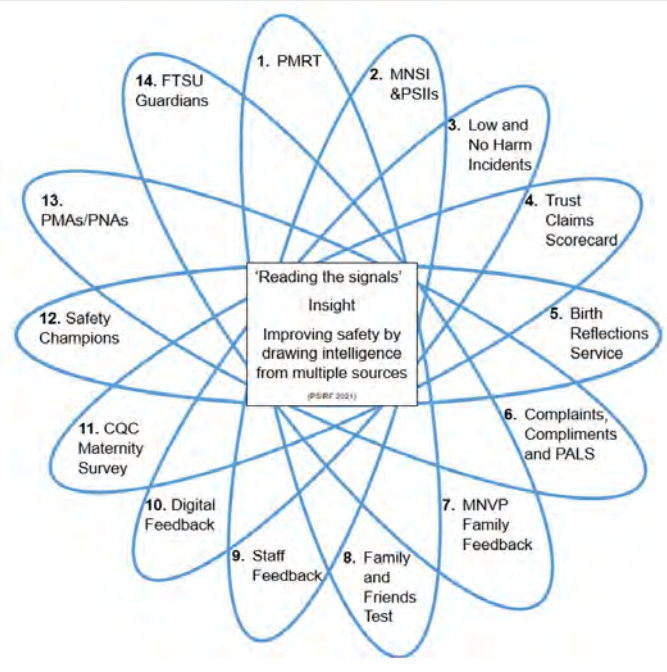
- ABLS managed in specialty moving forwards as part of the PROMPT programme.
- Fetal monitoring 96%.
- PROMPT 95%.
- Trust mandatory training (MAT/NEO) 93%.
- ABLS (MAT/NEO) 88%.

Risks:
- The use of our own compliance tracker as opposed to using ESR data – ESR still reflects theatre teams which impacts on our compliance. Linking in with ESR and Theatres to find a resolution to this for transparency and information sharing.
- Rotation of obstetric & anaesthetic doctors – knock on compliance within this staff group for both fetal monitoring and PROMPT – see countermeasures

Responsive

Family Feedback 'Insights' Triangulation Group 24

Maternity and Neonatal 'Insights' Family Feedback triangulation group meet monthly to discuss 'in month' feedback received across the service via the various sources listed, with an aim to enable any commonalities trends or themes to be identified



Safety Champions Staff Feedback

Maternity:

- Community and Hummingbird teams – feeling positive. Some challenges to facilitate births in community – actioned by community leads
- BP machines – equipment sorted
- Positive feedback about nurture clinics
- Student midwife feedback fantastic experience in Frome
- Hello Baby – concerns flagged about staffing model and high DNA rate

- **Next steps**
- Discuss Hello Baby provision with community lead

Neonates:

- No feedback

Maternity and Neonatal Voices Partnership (MNVP)

Feedback received across various sources including in person conversations and birth workers

None in Month

Compliments & Complaints

Formal Compliments		**PALS Contacts**	**8**
Online Compliments	**--**	**Formal Complaints**	**1**

February 24 Themes

Review of triangulation of feedback group underway to streamline feedback and ensure triangulation, setting and monitoring of actions.

Friends & Family Survey

NNU utilise SWNODN feedback survey. No feedback received from SWNODN survey. Regional issue – explored by SWODN. Positive actions taken to promote locally. SWNODN Parent Engagement and Evaluation lead visiting unit.

Key Achievements: 36 responses with positive feedback, kind and caring theme, environment helpful, professional. Felt concern listened to. **Identified Areas of Improvements:**

2 comments regarding discharge delays on Mary ward

2 comments regarding community sonography, rude and rushed appointment

1 comments regarding better communications , e.g. around the Flat use and rules and Parent room on NICU not very relaxing, let the unit down as everywhere else perfect

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**10**
Date of Meeting:	**Wednesday 7 May 2025**		

Title of Report:	**Financial Plan for 2025-2026**
Status:	**For information and ratification**
Board Sponsor:	**Simon Truelove, Interim Chief Finance Officer**
Author:	**Pippa Ross-Smith, Interim Deputy Chief Finance Officer** **Louise Luke, Head of Financial Services** **Tom Williams, Head of Financial Management** **Sarah Wisher-Davies, Head of Income and Contracting** **Anne-Marie Lewis, Head of Finance Projects**
Appendices	**None**

1. Executive Summary of the Report

The Trust Board is required to agree the revenue and capital budget for the financial year 2025/26 in order that budgets can be formally delegated.

A revenue budget has been produced which takes the recurrent financial outturn for 24/25 and inflates by the national financial planning assumptions for the NHS. The national efficiency ask od 2% has been applied plus a further 2% deficit improvement target, establishing a total savings target of £25.3m on core Trust activities for 25/26. In addition a Group savings target has been applied to the Trust of £4.4m.

Work continues on establishing a delivery plan for the savings target which is profiled in twelfths across the financial year. Given the current status of the savings programme, it is likely that the Trust will be off plan, early in the financial year. Actions to mitigate this position will be sought, including the continuation of vacancy control and other non pay restrictions.

For capital the Trust is compliant with the amount of capital made available by the system. A number of risks have been highlighted which the current capital allocation will not be able to mitigate.

Given the financial challenges for 25/26, the cash position of the Trust could become very challenging following the announcement of changes to the cash loan framework for the NHS. The finance team will be actively monitoring cash to ensure supplier payments are made on a timely basis and the payroll is protected.

2. Recommendations (Note, Approve, Discuss)

This plan has been discussed at the Finance and Performance Committee in March and an Extraordinary Board Meeting at the end of March prior to submitting the details to NHSE on 27 March 2025. Directors are asked to ratify the details contained within the plan, and the associated risks and mitigations discussed in this paper.

3.	Legal / Regulatory Implications
(Hyperlink to) National Planning Guidance was issued on 12th January confirmed the operational priorities for 2025/26.	

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)
Risks associated with the plan and its deliverability are in the paper	

5.	Resources Implications (Financial / staffing)
There is an expectation that provider and system plans must continue to move towards financial balance meaning delivering improved productivity and workforce reductions. The RUH plan includes £29.7m of improvement schemes, which encompasses ambitious productivity and £15.4m workforce cost reduction elements.	

6.	Equality and Diversity
QEIAs are undertaken for all service developments as part of the Improvement Programme. Taking positive action to reduce health inequalities is a Trust goal, which has been reviewed in line with the strategic A3 process for 2024/26.	

7.	References to previous reports/Next steps
An Extraordinary Meeting of the Board signed off the submission on 26 March 2025.	

8.	Freedom of Information
Private. Commercial in confidence.	

9.	Sustainability
The Trust must contribute towards achieving a financially balanced system. The RUH plan submission contributes a breakeven position to the system financial position which includes delivery of £29.7m savings plan (c.5.2% of income). In terms of environmental sustainability, the Trust is working in year two of a £21m Salix towards decarbonisation of the estate. Full revenue impact of this in terms of energy costs continues to be fully evaluated.	

10.	Digital
Digital transformation is likely to form a key part of enabling the actions in the national planning guidance. Digital capacity continues to be reviewed as part of the planning process in light of the shared EPR project.	

Meeting	Public Board of Directors Meeting
Date of meeting	Wednesday 7 May 2025
Agenda item	10

Title of report	2025/26 Financial Plan
Report author	Deputy Director of Finance / Head of Financial Accounts / Head of Financial Management
Report sponsor	Chief Financial Officer

Situation

1. The NHS England Priorities and Operational Planning Guidance for 2025/26 was published on the 30th January 2025. Within this, the key operational priorities for the coming twelve months are outlined, along with high level financial planning principles for the next 12 months.

2. As part of this documentation, the technical financial guidance outlines the approach organisations needed to take with regards to financial planning in 2025/26 as well as reiterating the financial ask being placed upon systems/organisations, given the challenging financial environment that the NHS currently faces.

3. As was the case in 2024/25 and previous financial years, the Trust has a statutory responsibility at both organisational and system level to ensure the delivery of a breakeven financial position.

4. The Trust has a predicted £37.6m underlying deficit exiting 2024/25.

5. An efficiency requirement of £25.3m has been identified for 2025/26 based upon mandated tariff requirements (including the increase to 2% efficiency), planned deficit reduction of 2% and recovering the residual balance of recurrent efficiencies not delivered in 2024/25.

6. A further £4.4m of savings has been aligned to the RUH associated with the establishment of the BSW Group Provider structure.

7. In line with the original parameters of the system medium term financial plan, and at this stage, the originally planned exit deficit for 2025/26 of £18.8m will be funded on a non-recurrent basis through provider deficit support.

8. As part of the Operational Planning process for 2025/26, a finalised budget position was formally approved by the Trust Board in private at the end of March 2025 and ahead of the system submission. There were a number of nationally

specified planning parameters that needed to be followed in order to derive this position, as well as a significant number of locally driven adjustments to deliver a final draft budget position.

9. As part of the submission that was submitted on the 27th March 2025, a single consolidated system financial plan has been produced in order to ensure consistency with each constituent element (individual provider and commissioner plans). Significant work has been undertaken in the BSW system to ensure that draft financial plans were developed in line with these principles and meet the final triangulation checks that will be applied by the NHS England regional teams.

10. Significant work has and continues to be undertaken to ensure that the Trust financial plan aligns with the workforce plan (which is outlined separately in the Operational Plan paper also to be presented to committee) through triangulation and the use of shared consistent underlying assumptions.

11. The Trust will need to continue to comply with the "double lock" financial protocol applied by the ICB as a result of the partial delivery of efficiencies in 2023/24. This lock is now in place system wide and means that organisations cannot commit to any new investment over £50k without the approval of the system if no contractual funding source is in place. Any in-year deviation from plan will likely trigger the application of the "triple lock" process with significant additional restrictions and controls.

12. Unlike previous financial years, the Trust has limited non-recurrent flexibility available that is not already committed that could be utilised to offset slippage on savings schemes or to cover unplanned expenditure.

13. This paper sets out the overarching principles that have been applied to the financial plan for 2025/26, outlines the key financial messages, and identifies the key risks and mitigations that may be required in order to deliver against the breakeven plan proposed.

Background

Principles that support the development of the budget for 2025/26

14. In line with the approach taken in previous financial years, at the start of the budget setting process a number of key principles were identified as core assumptions to be applied as part of the development of the 2025/26 base budget. These are outlined below:

Baseline Budget Rollover

- 2024/25 closing recurrent outturn will be rolled over to form the 2025/26 starting budget.

- All non-recurrent spend will be removed with the budget representing the recurrent rollover before accounting for any overspends

- Budget managers continue to be able to change their skill mix in year if it remains within their recurrent budget, although changes impacting upon Medical staffing budgets will continue to need approval from the Medical Director Budgets cannot be changed if it increases the budget requirement without the appropriate authorisation set out by the scheme of delegation (additional staffing without additional income to fully fund requires Executive Team approval). Furthermore, budgets that fall within the remit of the Safer Staffing review cannot be changed unless agreed by the Nursing & Quality leads responsible for determining Safer Staffing levels. Any investment over £50k will need ICB approval given the "double lock" is in place.

Pay Budgets

- Pay budgets (funded establishment and cost) will be rolled forward from the recurrent closing position for 2024/25. This includes the deliver of savings delivered in 2024/25.

- The mix of the rolled over pay budget can be changed in advance of the new financial year commencing as long as the available recurrent budget is not exceeded.

- Inpatient staff budgets will continue to reflect the agreed safer staffing levels that were last approved by Trust Board. These establishments continue to reflect a 20% uplift for absence. No other adjustments for safer staffing will be applied to ward budgets for 2025/26 unless agreed by the executive team or Board in line with the scheme of delegation.

- Given that there has been no confirmation of the agreed pay award settlement for 2025/26, budgets will be rolled forward at current 2024/25 values updated for the change to employers national insurance and Minimum Wage only and pay inflation applied as a variation in year when the details of the revised award have been released and final planning guidance received. A central pay reserve will be held in the interim period based upon the provisional 2.8% inflationary uplift indicated within the planning guidance issued to date.

- Agency premium budgets have been removed from 2025/26 budgets in order to reflect the significant reduction in agency achieved as part of the 2024/25 efficiency programme to be realised from a budget perspective.

- Budgets will be uplifted where an Executive Team decision has approved a new investment or where the new commitment is supported by commissioning funding. Budgets that have been running over-

establishment in 2024/25 will be expected to move back to budgeted levels in 2025/26 in order to ensure delivery of the efficiency programme.

- Unfunded posts that are not supported by an income stream or Board approval will be removed or need to be offset by funding transfers. As was the case in 2024/25, there will be no unfunded posts unless authorised by an Executive Team decision. Any investment over £50k will need ICB approval given the "double lock" is in place.

- The enhanced vacancy control panel (including medical agency and agency lines of work approval) will continue as a key element of our approach to grip and control. Any request for recruitment that does not have funding will be rejected until there is clear evidence of the funding source or executive team approval has been given.

- No member of staff can be upgraded outside of a formal process without the approval through the VCARP process. Any uplift has to sit within the available funding envelope.

- Additional staffing associated with acuity and complexity will show as an over-establishment against the budget. It is expected that any pay overspend incurred will be recovered by holding vacancies in future months.

- Vacancy factors that were applied to the 2024/25 budgets reflecting the savings for last year will be rolled over into 2025/26 and divisions and corporate departments will be expected to manage within the resources available.

Non Pay Budgets

- Non-pay budgets will be rolled over from the closing recurrent position of 2024/25. Any material inflationary pressures not reflected in the 2024/25 base budget will be adjusted for. Non-Pay is a considerable pressure to the Trust so whilst funded needs clearer management in 2025/26.

- Non pay inflation will be applied to budgets with known contractual uplifts/commitments such as the energy, catering, maintenance contract and Rates.

- The Clinical Negligence (CNST) budget has been reduced in line with the confirmed premium issued by NHS Resolution.

- Inflation will not initially be applied to general supplies budgets on the assumption that budget holders will have to adjust their purchasing commitments in order to mitigate any material inflationary pressures.

Income Budgets

- Income budgets have been uplifted in line with the Revenue and Contracting guidance issued to date.

- Core patient care income budgets have been uplifted for gross inflation including the impact of the change to employers national insurance rates (+4.15%) and adjusted for the revised level of tariff efficiency (-2.0%) in line with national planning parameters. Within the core uplift the following inflationary assumption / weightings have been assumed:

  Table 2: Cost Uplift Factor 2025/26

Cost	Estimate	Cost weight	Weighted estimate
Pay	4.72%	70.45%	3.33%
Drugs	0.83%	2.34%	0.02%
Capital	2.39%	7.35%	0.18%
Unallocated CNST	0.31%	2.09%	0.01%
Other	3.51%	17.76%	0.62%
Total			**4.15%**
Note: calculations are done unrounded – only two decimal places displayed.			

- Income and expenditure budgets relating to Health Education England have been applied at the start of the year in line with the opening contract estimates / forecast uplift factor. Adjustments will be made for any in year changes as they are confirmed. Any non-recurrent funding in this area will not be budgeted for and will be recognised on an actuals basis when received.

- Elective recovery funding (ERF) has been included in the plan to reflect the proportion of income allocated to the Trust from the system plus the additional £2.4m of income to support the delivery of RTT compliance.

- The funding for BSW commissioned high cost drugs and devices has been fixed at the baseline level agreed at the start of 2024/25 with no growth for 2024/25 or 2025/26 included in the income budgets. Drugs expenditure

budgets have been updated to reflect expected growth over the 2 years, this is £3.7m over the anticipated income.

- Other variable income budgets that have a variable element (i.e. diagnostics and inter-system high cost drugs and devices) have been reflected at the anticipated contractual levels. Any over or under delivery will be applied to the budget at a local level and reported on during the financial year.

- Amendments to system funding / other system driven non-recurrent income allocations have been made as per agreements.

- Any in year changes to income budgets will need to align to a known contract variation and go through the existing budget virement approval process.

Efficiencies

- The base level of efficiencies required in 2025/26 has increased from the £20.4m originally forecast in the system medium term financial plan to £29.7m. This movement is partly driven by the impact of the increase in the tariff efficiency requirement from the standard 1.1% to 2%, partly due to inflationary cost pressures seen in year as well as the deterioration in the recurrent cost base.

- The delivery of the £29.7m efficiency programme for 2025/26 will continue to focus on the productivity opportunities:

    - Driving efficiency gains for Planned Care, including Outpatients, Theatres and supporting Clinical Services

    - Restructuring Urgent Care and managing bed demand with patients cared for in the appropriate place for their condition.

    - Continuously improve processes and reduce waste through procurement savings, rostering optimisation for Clinical colleagues.

    - Redesigning the Corporate Services in line with national productivity expectations.

    - Reviewing Estates and Facilities costs to deliver efficiency opportunities.

- In order to provide assurance on the delivery of the savings plan further work is required to develop a detailed delivery plan including profiling the savings against the current plan,

- As noted earlier in this paper, the Trust has very little uncommitted non-recurrent flexibility available that could be utilised to offset slippage on savings schemes, meaning full delivery is essential to bringing the Trust financial position back within the MTFP parameters.

Income and Expenditure Budget for 2025/26

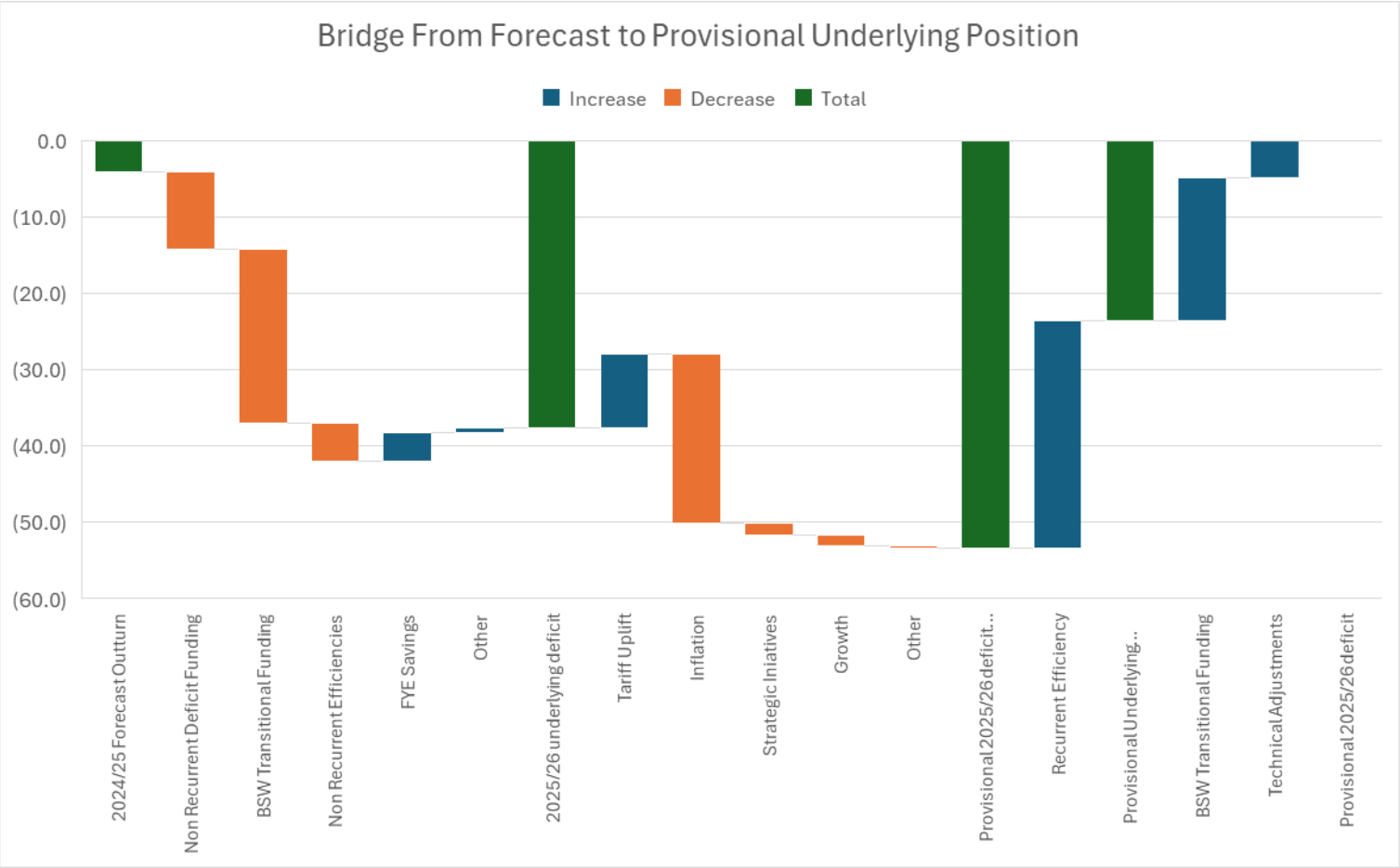
15. The opening 2025/26 budget position is outlined below in table 3 as compared to the 2024/25 closing budget and the 2024/25 month 11 forecast outturn position:

Table 3: Summary Income and Expenditure Budget for 2025/26 compared to the Forecast Outturn and Closing Budgets for 2024/25

	2024/25 M11 Forecast £m	2025/26 Opening Budget £m
Revenue from Patient Care Activities	-452.26	-476.87
Non Recurrent System Funding	-32.8	-18.8
Other Income	-46.59	-43.86
Total Income	**-531.65**	**-539.53**
Pay	338.94	345.59
Other Operating Expenditure	169.82	163.58
Operating Costs	**508.76**	**509.17**
EBITDA	**4.3%**	**5.6%**
Financing Costs	27.69	30.36
Retained Deficit	**4.8**	**0**

16. The high level movement of the budget from the 2024/25 closing budget to the 2025/26 opening budget is shown in the following waterfall diagram:

Table 4: Waterfall diagram outlining the movement from 2024/25 closing budget to 2025/26 opening budget (deficit equals positive value).



17. An indicative view of 2025/26 pay inflation has been included within the position at 2.8% per national planning parameters. This will need to be amended post budget approval when the full impact of the 2025/26 Pay Award offer is known / any impact of other medical pay discussions is clear. It is expected that any impact above the originally identified 2.8% will be nationally funded as has been the case in previous financial years, although this has not been confirmed. The impact of the change in employers national insurance threshold / rates has been factored into budgets on a by pay band basis (as the impact % varies dependent on annual salary point).

18. Non pay inflation has been included either in line with national inflationary assumptions (3.51%) or in line with revised estimates (either in line with or over and above national planning parameters). Areas of significant inflationary uplift are noted below in table 5:

Table 5: Areas of significant inflationary pressure

Inflation Area	% Uplift
Utilities	4.30%
Rates	7.00%
Water	14.40%

19. The inflationary pressure for Utilities has been calculated by the Trust Energy manager and reflects the pricing that we have committed to pay.

20. A summary of gross tariff inflation (excluding the efficiency requirement) / income against inflationary and technical pressures is outlined below in table 6 along with the addition funding received from the system in order to mitigate:

Table 6: Summary of 2025/26 Inflationary / Technical Pressures

		£'000s
Funding through Contract Uplift Factor (CUF)	-	18,518
Funding through Other Areas (e.g. HEE/ Providor to Providor)	-	662
Inflation for Pay		18,683
Inflation for Non-Pay		3,911
Inflation Pressures		**3,414**
Savings Expectation as part of CUF		9,050
Total Inflation Pressure		**12,464**
Change in CNST Premium	-	573
Net Inflation Pressure		**11,891**

21. The Trust has an efficiency requirement of £29.7m for 2025/26 – the construct of this is outlined below in table 7:

Table 7: Breakdown of 2025/26 Efficiency Requirement

Category	£'000s
25/26 Efficiency savings mandated through tariff	9,050
BSW Group Savings Requirement	4,400
Underlying Deficit Recovery	16,250
Inflation Pressures	**29,700**

22. In line with the Trust strategy, the delivery of this saving requirement will continue to focus on areas of significant opportunity (Discharge Ready Patients (Non Criteria to Reside), Outpatient redesign, loss making services whilst maximising the benefits associated with the ongoing transformation programme.

23. For 2025/26 the Trust has planned to deliver £29.7m of which £21.3m has identified opportunities of focus with the remaining £8.4m unidentified. The schemes are still being worked up and a delivery plan is being prepared.

24. Details of the areas of opportunities where the savings will be identified is outlined below in table 8 with the phasing of the currently assumed in 12 monthly instalments.

    In order to deliver both the Trust and System financial plan and in order to prevent a further deterioration in the underlying position of the Trust, it is essential that any recurrent slippage on delivery against this plan be mitigated by further recurrent savings.

Table 8: Opening Trust Efficiency position for 2025/26

Savings Programme Opportunity	Risk	Plan £m	Mth1 £m	Mth2 £m	Mth3 £m	Mth4 £m	Mth5 £m	Mth6 £m	Mth7 £m	Mth8 £m	Mth9 £m	Mth10 £m	Mth11 £m	Mth12 £m	Notes
Non-elective overnight	high	4	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	Reduction in NCR/closure of 30 beds
A&E and SDEC	high	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	length of stay reduction
Elective Opportunity	high	1.4	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	Reduce WLI and improve utilisation
Outpatient Opportunity	high	2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	Reduce WLI , booking and scheduling, PIFU
Other Acute Activity	high	3.5	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	Radiology £0.5m Pathology £0.5m, Long term conditions £1m, mental health £0.8m
Temp Staffing	high	3.1	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	T&Cs, rostering
Corp Services	high	2.5	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	Corporate Services Redesign
Medicines	medium/low	0.8	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	Bi-similiars, IPOC opportunities, drug optimisation
Commercial	medium	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Other Local Opportunities	high/medium	4.1	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	procurement projects/Sulis/Estates and Facilties
Fragile Service Rationalisation	high	3.7	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	speciality reviews
Group Initiatives	high	4.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	unidentified
		29.8	**2.5**	**2.5**	**2.5**	**2.5**	**2.5**	**2.5**	**2.5**	**2.5**	**2.5**	**2.5**	**2.5**	**2.5**	

25. A high level summary of the revised underlying position of the Trust is outlined below in table 9:

Table 9: Underlying Trust Financial Position 2025/26

	Recurrent £m	Non Recurrent £m	Total £'m
2024/25 Forecast Outturn	**(37.0)**	**32.8**	**(4.2)**
Non Recurrent Deficit Funding		(10.1)	(10.1)
BSW Transitional Funding		(22.7)	(22.7)
Non Recurrent Efficiencies	(5.0)		(5.0)
FYE Savings	3.8		3.8
Other	0.6		0.6
2025/26 underlying deficit	**(37.6)**	**0.0**	**(37.6)**
Tariff Uplift	9.7		9.7
Inflation	(22.2)		(22.2)
Strategic Iniatives	(1.5)		(1.5)
Growth	(1.5)		(1.5)
Other	(0.3)		(0.3)
Provisional 2025/26 deficit before savings	**(53.4)**	**0.0**	**(53.4)**
Recurrent Efficiency	29.7		29.7
Provisional Underlying 2025/26 deficit	**(23.6)**		**(23.7)**
BSW Transitional Funding		18.8	18.8
Technical Adjustments		4.8	4.8
Provisional 2025/26 deficit	(23.6)	23.6	(0.0)

Capital Plan 2025/26

26. The NHS capital regime was reformed in 2020/21 as part of the spending review in recognition that the previous model was not supporting the NHS strategy of developing out-of-hospital care. The previous financial regime enabled providers to spend capital from a mix of cash from depreciation and surpluses, though for RUH this was generally limited to depreciation due to the financial and cash balance position.

27. Capital Departmental Expenditure Limit (CDEL) is now allocated to systems in order to evaluate priorities and investments, aiming to minimise risk and support the ongoing strategy. RUH sits within the BSW system from a CDEL perspective.

28. The CDEL allocation for the Trust has been provisionally set at £12.87m. There are ongoing discussions at system level regarding the overall split of the allocation. Additional funding of £16.08m relating to donated assets and grants is available in 2025/06. This is not set by the BSW system.

29. Table 10 presents the capital plan for 2025/26.

Table 10: Capital Plan 2025/26

Area	Project	25/26 £'000s
IT		
	Device refresh, network and maternity EPR	£ 1,500
Medical Equipment		
	Replacement of end of life CT	£ 1,250
Capital operational Funds		
	CRG	£ 250
	Estates	£ 250
	IT	£ 250
	MEC	£ 250
	Sulis	£ 250
	Contingency	£ 93
Precommitted Spend		
	Decarbonisation - to match grant funding	£ 2,995
	EPR	£ 2,882
	Sulis Lease	£ 1,500
	Capital staff	£ 600
	Pre committed Fire	£ 400
	Radio Pharmacy pre commitment	£ 100
	IFRS16 leases	£ 300
Total CDEL allocation		**£ 12,870**
Donated/Grant and PDC	Decarbonisation Grant Funding	£ 10,820
	Donated Medical Equipment	£ 2,300
	EPR PDC	£ 2,955
TOTAL Capital plan		**£ 28,945**
Funding	**Area**	**25/26 £'000s**
Internal		
	CDEL	£ 11,070
	IFRS16 leases	£ 1,800
	Net internal funding	**£ 12,870**
PDC		
	EPR	£ 2,955
Donated	Donated Medical Equipment	£ 2,300
Grant	Decarbonisation Grant Funding	£ 10,820
	TOTAL funding	**£ 28,945**
	Variance	**0**

30. As can be seen from Table 10, there is a significant amount of pre committed spend from decision making in prior years. This includes £3m of match funding against the decarbonisation funding, Electronic Patient Record (EPR) and the additional funding for the Sulis lease.

31. It should be noted that this envelope includes the known PDC allocation for EPR however does not include all future Public Dividend Capital (PDC) schemes.

32. In a change to prior years, three capital funding allocations have been advised ahead of the financial year with some indicative national allocations and an aspiration to confirm individual provider allocations as soon as possible;

    a. Estates Safety Fund - £12m to the BSW system. The Trust has submitted bids to a total value of £6m.

    b. Constitutional Standards - £59m to the BSW system. The Trust has submitted bids to a total value of £11m

    c. Operational Funding - £39 m to the BSW system. The Trust has been provisionally allocated £12m

33. Currently these additional capital schemes have not been included within the current submission. However the plan may be subject to further “presentational” change if it is agreed each organisation has to take a share of the provisional allocation for the purposes of the submission. Should this approach be agreed, this does not mean that the bids have been approved – they will remain subject to the existing approval process and organisation plans will be amended post-agreement.

34. If the Trust is successful with the bids noted above, the expectation is that there will be PDC drawdown available in order to fund the works. The works that take place will need to align to the successful bid lines.

35. The total capital requirements for the Trust and system far outweighs the allocation available in BSW and therefore Trust will need to recognise and manage risks where possible.

36. Table 11 shows the remaining value of capital, and therefore risk that has not been covered by the current capital allocation.

Table 11 : Remaining capital risk

Area	Remaining value of capital requirement not funded by existing plan 25/26 £'s
Estates/CRG	Total Backlog - **£66m** **Of which** 'High and Significant Risk Backlog' - **£22m**
IT	**£4.8m**
MEC	**£3.69m**
Sulis	Information not shared
Total	**£30.49 (excluding Sulis)**

Statement of Cashflow 2025/26

37. Anticipated cash flows for the current financial year outturn and the next financial year are outlined below in table 12 and align to the draft plan submission. The cashflow assumes full delivery of the 2025/26 savings programme.

Table 12: Statement of Cash Flows 2025/26

Statement of Cash Flows	24/25 £'000	25/26 £'000
	FOT	
Operating Surplus/(Deficit)	5,755	8,171
Depreciation and Amortisation	22,449	26,622
Impairments and Reversals	10,995	13,621
Income recognised in respect of capital donations (cash and non-cash)	- 13,634	- 13,120
(Increase)/Decrease in Trade and Other Receivables	- 7,456	5,000
Increase/(Decrease) in Trade and Other Payables	- 7,989	- 6,419
Increase/(decrease) in other liabilities	- 1,490	-
Increase/(Decrease) in Provisions	-	- 798
All other movements in operating cash flows	-	1,160
Net Cash Inflow/(Outflow) from Operating Activities	**8,630**	**34,237**
Cash Flows from Investing Activities		
Interest Received	2,000	480
(Payments) for Property, Plant and Equipment	-53,561	-37,052
Proceeds from sales of property, plant and equipment and investment property	35	0
Receipt of cash donations	14,898	13,116
Net Cash Inflow/(Outflow) form Investing Activities	**-29,142**	**-23,456**
Cash Flows from Financing Activities		
PDC received	32,171	2,955
Loans from Department of Health and Social Care - repaid	-313	-313
Capital element of lease liability repayments	-2,810	-2,214
Interest paid	-121	-113
Interest element of lease liability repayments	-2,798	-1,832
PDC dividend paid	-9,341	-9,342
Cash flows from (used in) other financing activities	**16,787**	**-10,859**
Net Increase/(Decrease) in Cash and Cash Equivalents	-3,724	-78
Cash and Cash Equivalents at start of period	34,531	30,807
Cash and Cash Equivalents at Year end	**30,807**	**30,729**

38. Based upon this, the Trust is not currently forecasting that it will require any additional cash support from the BSW system or DHSC in 2025/26 – this assumes significant recurrent delivery of cash releasing savings from the efficiency programme. As part of the recent national announcements, access to cash for organisations in difficulty is anticipated to become a significant challenge. The minimum cash level requirement required for the Trust that has mandated by DHSC is £1.7m, hence the delivery of the financial position in line with plan is essential to maintain cashflow in order to pay suppliers and staff.

39. The current planned deficit for 2025/26, additional capital works and any further potential efficiency shortfalls will reduce available cash from the levels seen during the past three financial years.

40. The 2025/26 cash balance includes estimates for Sulis, as a cashflow forecast and budget for 2025/26 was not available at the time of submission of the plan. Borrowings, depreciation, capital element of lease liabilities and the associated interest do not reflect Sulis balances accurately. This will result in variances during the 2025/26 financial year when actuals are recorded.

41. The cash balance includes cash related to Health Innovation Network Southwest, the Trust hosts this organisation. Their cash balance fluctuates at around £3m. This means available cash to the Trust at the end of 2025/26 is £27.7m.

Statement of Financial Position 2025/26

42. Table 13 below highlights the forecast Statement of Financial Position for 2024/25 and the planned position for 2025/26:

Table 13: Statement of Financial Position 2025/26

Statement of Financial Position	24/25 £'000	25/26 £'000
	FOT	
ASSETS		
Total Non-Current Assets	395,999	384,701
Total Current Assets	69,684	63,938
Total Non-Current Liabilities	-58,225	-40,907
Total Current Liabilities	-56,659	-55,932
TOTAL ASSETS	**350,799**	**351,799**
TAXPAYERS EQUITY		
Public Dividend Capital	285,706	288,661
Revaluation Reserve	46,646	46,646
Retained Earnings	18,447	16,492
TOTAL EQUITY	**350,799**	**351,799**

43. Unlike prior years, there have not been any significant technical accounting changes during 2024/25 and there are no anticipated adaptations during 2025/26 that would have a material impact on the Trust Statement of Financial Position.

44. The 2025/26 balance sheet includes estimates for Sulis, as the Sulis budget was not available at the time of submission of the plan. IFRS16 assets, borrowings, depreciation, and cash do not reflect Sulis balances accurately. This will result in variances during the 2025/26 financial year when actuals are recorded

Risks and Mitigations

45. Although the budget for 2025/26 has been constructed around a number of core principles (both nationally and locally determined), there is nonetheless still some

significant level of risk that will make delivery challenging, not least the challenging financial environment that the NHS is now in. There is also significantly less non-recurrent flexibility available (as compared to previous financial years) to help mitigate these risks. The most significant risks are:

- Delivery against the efficiency programmes / current level of slippage on efficiencies: At this stage of the budgeting process and based upon operational plans that support the budgeted savings profile, there likely to be significant slippage of the overall efficiency requirement. Although there is further work to be completed in this area, there remains a risk that there is slippage, reflecting the time taken to step delivery up.

- Safer Staffing: Safer Staffing reviews are currently undertaken on an annual basis. As the review recently undertaken has not yet reached a stage of formal recommendation, it has not been possible to reflect any potential recommendations in the 2025/26 budget proposal. Any recommendations will need consideration and approval by the executive team / potentially the system (dependent on value) prior to any budgets being amended.

- Inflation: Although as in previous years realistic inflationary estimates have been included in the proposed budget for 2025/26, the current inflationary environment and external pressures could see inflation rise further above these levels (despite national expectations), creating a further budgetary pressure.

- Capital availability: As identified in the capital section of the paper, there remains significant demands on limited internally generated capital resource, to support equipment replacement and estate compliance.

- Financial constraints across the NHS could lead to potential cost shunting between providers and systems as organisations struggle to manage the financial challenge.

- Usual level of unforeseen cost pressures.

- Availability of cash if the savings does not deliver quickly. Available cash to the Trust is approximately £27m. The monthly run-rate gap if savings are not delivered will be around £2m and £2.5m so cash resources could be quickly depleted.

Assessment

46. As national planning parameters must be adhered to and individual organisation level plans must reconcile to the overarching system plan, there are no alternative budget proposals for 2025/26 to consider – this is the only available option.

47. Given the current financial landscape within the NHS, 2025/26 is likely to be an extremely challenging year, with efficiency delivery and seeing reductions in areas of over-establishment key to ensuring delivery in line with the planned breakeven position.

Recommendation

48. The Board is asked to:

- **NOTE** the proposed revenue budget for 2025/26, the level of savings that are required to be delivered at a Trust and Group level and need to deliver the efficiency programme in full on a recurrent basis.
- **NOTE** the capital and cash plan for 2025/26.
- **NOTE** the identified risks inherent with this budget proposal as things currently stand.
- **APPROVE** the proposed revenue and capital budget for 2025/26 and recommend formal sign off to Trust Board.

Decision

49. The Board is asked to **approve** the Revenue and Capital budget plans for 2025/26,

- Given the level of financial challenge that the NHS is currently subject to, it is essential that the efficiency programme delivers recurrently in full by the end of the financial year, in order to prevent a further deterioration in the underlying financial position of the Trust.
- There are still some significant internal delivery risks and that the overall system position continues to rely upon significant non-recurrent resources being available.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**11**
Date of Meeting:	**Wednesday 7 May 2025**		

Title of Report:	**Staff Survey 2024: Themes, highlights and areas for improvement**
Status:	**For information**
Board Sponsor:	**Alfredo Thompson, Chief People Officer**
Author:	**Ben Padfield, Associate Director for People – Culture Change**
Appendices	**Appendix 1: Staff Survey 2024: early trends, highlights and areas for improvement (slide deck)**

1. Executive Summary of the Report

This report provides a summary of the RUH 2024 NHS Staff Survey, focusing on themes, areas to focus our improvement efforts and positive insights.

Key Findings

The 2024 survey indicates a mixed picture of employee satisfaction and organisational challenges. Despite a 6% dip in response rate, RUH remains 6% above the Picker average for acute trusts. However, there is a 4% decline in colleagues recommending RUH as a place to work. Contributing factors are likely to include the removal of paid breaks and other sustainability measures, and high levels of acuity, which colleagues are finding challenging. A higher percentage of respondents were from the Global Majority (21.5% for the 2024 survey, compared to 19% in 2023) and respondents with a disability (23.6% for the 2024 survey, compared to 22.5% in 2023).

Positive Results

- **Career Development**: Many staff members feel there are ample opportunities for career development and support for improving knowledge and skills.
- **Managerial Support**: Immediate managers are recognised for their encouragement, feedback, and interest in team health and wellbeing.
- **Team Dynamics**: Teams work well together with shared objectives and mutual respect, contributing to a positive environment.
- **Organisational Commitment**: The organisation prioritises patient care and acts on concerns raised by patients and service users.

Challenges/Areas of Focus

- **Work-Life Balance**: Efforts are needed to help staff achieve a better balance between work and home life, including support for flexible working arrangements.
- **Team Effectiveness**: Teams should meet more frequently to discuss effectiveness and handle disagreements constructively.
- **Staffing and Resources**: Addressing concerns about adequate staffing and resources is crucial, as is managing conflicting demands on staff time.
- **Health, Well-being, and Safety**: Strategies to reduce work-related stress and improve reporting and learning from incidents are essential.

2.	Recommendations (Note, Approve, Discuss)
Note/Discuss	

3.	Legal / Regulatory Implications
There is a direct link between colleague experience and operational/clinical effectiveness, therefore the survey results provide an important insight into our organisational culture. This is pertinent to care quality regulation.	

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)
BAF 2.1 **Description of Risk:** Failure to reduce levels and incidences of discrimination by managers against staff, based on race, ethnicity, religion, gender, sexuality or disability could affect the Trust's ability to recruit and retain staff, expose the Trust to unlimited damages following successful litigation and adversely affect the organisation's reputation.	

5.	Resources Implications (Financial / staffing)
Programmes are in place to address/improve experiences around the areas raised in the 2024 survey. The ongoing review of the RUH People Strategy is being shaped and influenced by what colleagues are telling us through the survey.	

6.	Equality and Diversity
The Staff Survey is how compliance with the Workforce Race Equality Standards and the Workforce Disability Equality Standards is assessed – further reports to Board will address those as discrete items.	

7.	References to previous reports/Next steps
Assurance of workstreams related to the People Plan is obtain via the two-monthly People Committee, and it forms part of the regular People Plan update to the Board.	

8.	Freedom of Information
Private – Staff Survey 2024 results are currently subject to embargo.	

9.	Sustainability
BAF risk 2.1 - Failure to provide safe and inclusive working environments has a direct negative impact on effectiveness, productivity, wellbeing and a wide range of staff experience metrics: NHS Confederation (2024) – continued focus on improvement in this area is required for a 'fit for the future' organisation.	

10.	Digital
Use of digital solutions is key to improving staff experience, especially in relation to increasing efficiency, productivity and accessibility for colleagues.	

Royal United Hospitals Bath
NHS Foundation Trust

RUH Staff Survey 2024

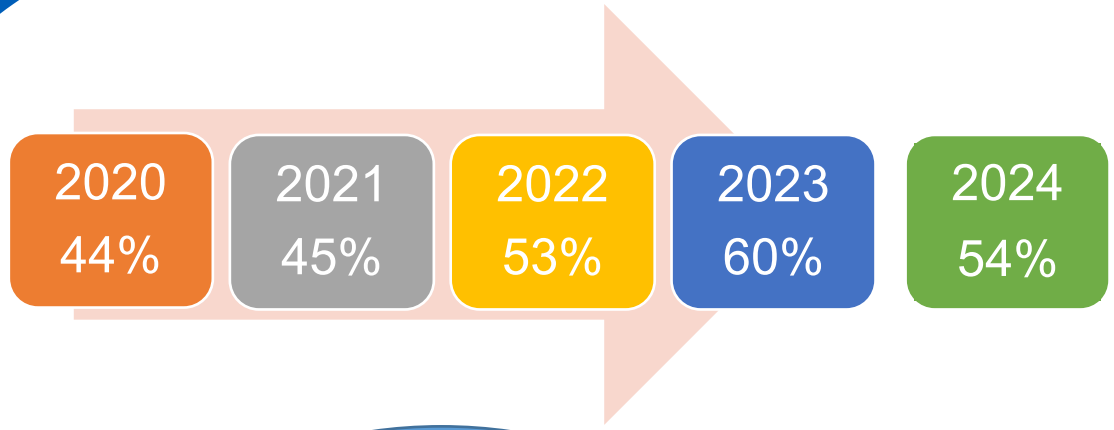
Themes, highlights and areas for improvement

RUH Board of Directors, May 2025

Prepared by People & Culture Directorate

The RUH, where you matter

Engagement and High-Level Themes



64% would recommend RUH as a place to work

High level trend:

- There are some areas in which satisfaction scores have dipped, which accord with our focused organisational sustainability work. The removal of paid breaks was a recurrent theme during the engagement campaign.
- Staff experience has been challenged by high levels of acuity and expectations around flow, coupled with a perception that there are insufficient resources to do the job.
- We remain challenged to improve the safety of reporting, team effectiveness, support to maintain health and wellbeing, and to ensure colleagues have a good work life / homelife balance.

Breakdown of respondents

114 - Add Prof Scientific and Technic = 3.3%

876 - Administrative and Clerical = 25.5%

181 - Estates & Ancillary = 5.2%

284 - Medical and Dental = 8.3%

4 - Students = 0.01%

513 - Additional Clinical Services = 14.9%

225 - Allied Health Professionals = 6.5%

114 - Healthcare Scientists = 3.3%

1123 - NMC Registered = 32.7%

23.6% of respondents have a disability

This is an increase from 22.5% in 2023

21.5% of respondents are Global Majority

This is an increase from 19% in 2023

Areas to celebrate

Career Development Opportunities

- **Opportunities for Career Development**: Many staff members feel there are ample opportunities to develop their careers within the organisation.
- **Knowledge and Skills Improvement**: There is a strong sense of support for improving knowledge and skills, with many staff feeling they have access to the necessary resources.

Managerial Support

- **Encouragement and Feedback**: Immediate managers are recognised for encouraging staff and providing clear feedback on their work.
- **Health and Well-being**: Managers are taking a positive interest in the health and wellbeing of their teams, which is greatly appreciated.

Team Dynamics

- **Shared Objectives**: Teams are working well together with a clear set of shared objectives.
- **Respect and Understanding**: There is a high level of respect and understanding among team members, contributing to a positive working environment.

Organisational Commitment

- **Patient Care Priority**: The organisation continues to prioritize the care of patients and service users, which is a significant source of pride.
- **Acting on Concerns**: There is confidence that the organisation acts on concerns raised by patients and service users.

Areas needing more focus

Work-Life Balance

Balancing Work and Home Life: Efforts should be made to help staff achieve a better balance between work and home life.

Flexible Working: Continue to support flexible working arrangements and ensure staff feel comfortable discussing these options with their managers.

Team Effectiveness

Meeting to Discuss Effectiveness: Encourage teams to meet more frequently to discuss their effectiveness and address any issues collaboratively.

Constructive Disagreements: Focus on improving how teams deal with disagreements to ensure they are handled constructively.

Staffing and Resources

Adequate Staffing: Address concerns about having enough staff to do the job properly and ensure teams have the necessary materials and supplies.

Meeting Demands: Help staff manage conflicting demands on their time more effectively.

Health, Well-being, and Safety

Reducing Work-Related Stress: Implement strategies to reduce work-related stress and ensure staff do not feel pressured to work when unwell.

Reporting and Learning from Incidents: Encourage the reporting of errors and near misses, and ensure feedback is given on changes made to prevent recurrence.

Central support to teams and divisions

Renewed People Plan (due April 2025) will provide a programme of central support projects and delivery timescales shaped by 2024 staff survey data.

Work/life balance:

- Embed reviewed flexible working policy and practices
- Implement Trust recognition strategy (including financial wellbeing programme)
- Support better wellbeing and work/life balance conversations through line manager development

Team Effectiveness

- Review compassionate team working offer to build in structural effectiveness
- Embed self-service leadership and team development toolkit to improve efficiency and effectiveness
- Leadership and management competency framework (align with Improving Together and national NHS E standards and competencies for management and leadership)

Staffing and Resources

- Using Improving Together tools to support teams to manage conflicting demands
- Enhance support to teams (tools and interventions) to help increase efficiencies safely and respectfully

Health, wellbeing and safety

- Further work to enhance reporting culture using reliable platforms (Updated Datix and Report + Support)
- Phase 2 review of wellbeing services to provide up-stream interventions for high-stress / high-acuity teams
- Generate easy-to-use, self-service wellbeing tools for teams and managers

Projects will take into consideration operational demands and capacity. This includes combining events, trainings, expanding self-service for leadership and team development and using the Framework for Joy in Work.

Central support to teams and Divisions continued

Staff survey sessions

To support managers to utilise their local staff survey results we are hosting sessions throughout April for managers to learn how to interpret the staff survey data, how they can engage their teams to reflect and take ownership of actions and improvements at a local level.

Staff from 36 different departments from across all our Divisions have attended these sessions to date, the quotes on this page show some of their feedback comments following these session.

"To have open conversations to help to find out how we can help support staff."

"Talking to the team about the survey and open up for thoughts and feedback"

"Continue the positive culture conversations to understand the true meaning behind the responses."

"Nice relaxed session, easy to take the information on board, not dull, kept everyone interested, given time to ask random questions, certainly worth keeping as a regular session"

RUH EDI Agenda

Routes to Success

Routes to Success is our positive action program for band 5-6 nurses, midwives and AHPS from the global majority. Participants learn interview skills and undertake personal reflection on their career path. The second cohort is underway and we have already seen positive outcomes for last year's cohort.

Workplace Adjustments

A working group of teams from across the Trust has been working on a new flowchart to simplify and better explain the process of organising workplace adjustments.

Working with Cancer

We will soon be launching the 'Cancer at Work' Policy, a vital initiative designed to support employees affected by cancer. This policy reflects our deep commitment to fostering a compassionate, inclusive, and supportive workplace.

RUH Inclusion Weeks

New for 2025 are our very own Inclusion Weeks. These dates give us a chance to have intersectional conversations about inclusion.

Summer Inclusion Week is 16th-20th June. The theme is Active Allyship.

Sexual Safety Charter

We are working towards the ten principles of the Sexual Safety Charter. We commit to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards our workforce.

People Promise Scores

Our NHS Staff Survey Results 2024

NHS
Royal United Hospitals Bath
NHS Foundation Trust

The questions in the NHS Staff Survey are aligned to the People Promise.
This is a promise we must all make to each other – to work together to improve the experience of working in the NHS for everyone. The survey tracks progress towards the seven elements of the People Promise, as well as measuring Morale & Staff Engagement.
Below you can see how we have scored on each element compared to a national average of other organisations within our benchmarking group (Acute and Acute & Community Trusts).

We are compassionate & inclusive

7.4 — 2023 score 7.4 — National avg 7.2

We are recognised and rewarded

6.0 — 2023 score 6.1 — National avg 5.9

We each have a voice that counts

6.7 — 2023 score 6.8 — National avg 6.7

We are safe & healthy

6.0 — 2023 score 6.1 — National avg 6.1

We are always learning

5.6 — 2023 score 5.6 — National avg 5.6

We work flexibly

6.2 — 2023 score 6.4 — National avg 6.2

3434 colleagues from across the RUH took the opportunity to have their say. That's 54% of our workforce.

Key
- Improvement
- Same
- Decline

We are a team

6.8 — 2023 score 6.9 — National avg 6.7

Staff Engagement

6.9 — 2023 score 7.1 — National avg 6.8

Morale

5.9 — 2023 score 6.0 — National avg 5.9

All elements are scored 1-10, with a higher score being more positive.

The RUH, where you matter

Divisional responses

Compared to the organisation's overall results…

Corporate

473 responses

- ↑ Feel more able to make suggestions on improvements in their area, and to make those improvements happen.
- ↑ Are more satisfied with their level of pay and achieving a good balance between work and home life.
- ↓ Are less satisfied with opportunities to develop their career, improve their knowledge and skills and the support to develop their potential.
- ↓ Are more likely to look for a job at another organisation in the next year.

Emergency Medicine

106 responses

- ↑ Where violence occurred, this was reported.
- ↓ Other questions have lower scores compared to the rest of the Trust, most significantly:
  - experiencing harassment, bullying and abuse from patients/service users
  - having felt unwell due to work stress and being exhausted by the thought of another shift at work
  - Feel less able to make suggestions on improvements and less trusted to do their job.

Estates & Facilities

281 responses

- ↑ Higher response for achieving a good balance between work and home life and find work less emotionally exhausting.
- ↑ Experience feeling unwell due to work related stress less.
- ↓ Feel less able to make suggestions on improvements and less trusted to do their job.
- ↓ Are less likely to recommend the organisation as a place to work

Divisional responses

Compared to the organisation's overall results…

FASS

699 responses

- ↑ Said they have access to opportunities to develop their career, improve their knowledge and skills and the support to develop their potential.
- ↑ Say they are encouraged to report errors/near misses/incidents, feel staff involved in those are treated fairly, and feedback is given.
- ↓ A lower response rate for the organisation is committed to helping balancing work and home life, and achieving this balance.
- ↓ More work additional unpaid hours and feel worn out at the end of work

Medicine

1030 responses

- ↑ Said colleagues are polite, treat each other with respect, show appreciation to one another and that that team members have shared objectives.
- ↑ Said they have access to opportunities to develop their career, improve their knowledge and skills and the support to develop their potential.
- ↓ More said they have experienced musculoskeletal problems because of work activities.
- ↓ More work additional unpaid hours and feel worn out at the end of work

Surgery

779 responses

- ↑ Say they are encouraged to report errors/near misses/incidents and feedback is given.
- ↑ Received an appraisal in the last 12 months and said this helped staff to improve how they do their job.
- ↓ More said they have experienced musculoskeletal problems because of work activities.
- ↓ Feel less able to make suggestions on improvements in their area, and to make those improvements happen.

Appendix

Appendix 1: High Level Scores: Top & Bottom / Most improved and declined

Top 5 scores vs Organisation Average	Org	Picker Avg
q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation	70%	61%
q8b. Colleagues are understanding and kind to one another	75%	69%
q8c. Colleagues are polite and treat each other with respect	76%	70%
q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours	70%	64%
q11e. Not felt pressure from manager to come to work when not feeling well enough	84%	78%

Bottom 5 scores vs Organisation Average	Org	Picker Avg
q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	43%	51%
q3g. Able to meet conflicting demands on my time at work	42%	47%
q3i. Enough staff at organisation to do my job properly	28%	33%
q19d. Feedback given on changes made following errors/near misses/incidents	56%	60%
q5a. Have realistic time pressures	22%	26%

Most improved scores	Org 2024	Org 2023
q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours	70%	59%
q23a. Received appraisal in the past 12 months	84%	79%
q13d. Last experience of physical violence reported	69%	65%
q11e. Not felt pressure from manager to come to work when not feeling well enough	84%	81%
q14c. Not experienced harassment, bullying or abuse from other colleagues	82%	80%

Most declined scores	Org 2024	Org 2023
q11a. Organisation takes positive action on health and well-being	53%	59%
q26c. I am not planning on leaving this organisation	59%	64%
q23d. Appraisal left me feeling organisation values my work	31%	36%
q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	43%	47%
q25c. Would recommend organisation as place to work	64%	68%

Picker

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**12**
Date of Meeting:	**Wednesday 7 May 2025**		

Title of Report:	**BSW Hospitals Group Partnership Agreement and Joint Committee Terms of Reference**
Status:	**For approval**
Board Sponsor:	**Cara Charles-Barks, Chief Executive**
Author:	**Ben Irvine, Programme Director, BSW Hospitals Group**
Appendices	**Appendix 1: BSW Hospitals Group Partnership Agreement and Terms of Reference.**

1. Executive Summary of the Report

- In accordance with the Board of Directors' decision in [July/ September 2024] to form a Group, in January 2025 Trusts nominated non-executive and executive directors to join a working party to develop Terms of Reference for our BSW Hospitals Group Joint Committee. The working party has been supported by legal advisors Browne Jacobson, who have helped other groups across the NHS develop their governance arrangements. The team has completed a ***Partnership Agreement***, incorporating ***Terms of Reference for a Joint Committee***.

  The document was reviewed in private Boards in April. In response to those Board discussions a few updates have been made to text:

  - Provision for attendance of deputies has been included, in the event of absence of a member [refer s5.4].
  - The binding nature of decisions of the Joint Committee in relation to Joint Functions is clarified [refer s8.4]
  - Reference is included to duties introduced by the Health and Care Act 2022 on the Trusts to have regard to the wider effects of their decisions and the expenditure limits and use of resources requirements of their system. [refer s10.3]
  - In the event of the Joint Committee establishing a committee to oversee a tranche of work, that committee may include members who are not voting members of the Joint Committee [refer s17.3].
  - Finally, the cycle of business for the Joint Committee will include a review after six months of operation.

  The updated version of the *BSW Hospitals Group Partnership Agreement*, incorporating *Terms of Reference for a Joint Committee* is presented for Board consideration and approval.

2.	Recommendations (Approve)

"In accordance with Board of Directors' decision in [July/ September 2024] to form a Group it recommended that the Board of Directors:

1) *Approve the BSW Hospitals Group Partnership Agreement, agreeing*
    1) *Five Joint Functions - set out in Schedule 3 (Page 22)*
    2) *Terms of Reference of a special purpose Joint Committee – set out in Schedule 5 (Page 58)*
2) *Approve the execution of the Partnership Agreement by 9th May.*
3) *Request that the Chair and Chief Executive nominate members of the Joint Committee.*
4) *Establish the BSW Hospitals Group Joint Committee in May.*

3.	Legal / Regulatory Implications

In policy terms the Partnership Agreement and Joint Committee, are designed to support delivery of greater collaboration between providers, enabling delivery of benefits of working at scale in service of BSW population.

The Partnership Agreement and Joint Committee TORs have been drafted with support of legal advisors Browne Jacobson. The documents are based on model content. The Trusts have developed the Partnership Agreement for the purpose of collaborating as a Group including exercising their powers under s65Z5 and s65Z6 of the NHS Act (2022) to agree and establish joint working and delegation arrangements.

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)

The Partnership Agreement and Terms of Reference are designed to support the Trust and Group to address risks associated with service delivery, performance and financial sustainability, through collaborative activities.

5.	Resources Implications (Financial / staffing)

The Partnership Agreement and Terms of Reference are designed to support delivery of benefits identified in the 2024 Case for Collaboration.

6.	Equality and Diversity

An Equality and Health Inequalities Assessment in relation to BSW Hospitals Group Development Programme was completed in July and August 2024.

7.	References to previous reports/Next steps

This report addresses one of the recommendations approved by the Board of Directors in [July/ September 2024], to establish a Group Joint Committee. The

previous draft of the *Partnership Agreement and Terms of Reference* was considered by the Board of Directors in April 2025.

Next steps

- 1-8th May. SFT, RUH and GWH Board review and consideration of recommendations.
- Nomination by Trust Chairs and Chief Executive of Members of the Joint Committee.
- 9th May. Signing / Execution of Partnership Agreement
- 23rd May. First meeting of Joint Committee.

8.	**Freedom of Information**
The report is Public.	

Date **2025**

Great Western Hospitals NHS Foundation Trust and Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust

Partnership Agreement

for the purpose of establishing Hospital Group Joint Working Arrangements and Appointment of a Joint Committee to Exercise Joint Functions

Version control

Date	Version	Author
18 Feb 2025	001	Browne Jacobson LLP
23 Feb 2025	001B	BSW Programme Team updates
17 Mar 2025	002	Working party updates from 3 March meeting and marked up copies of version 001B
20 Mar 2025	003	Browne Jacobson LLP
26 Mar 2025	004	Feedback incorporated from Board Members re membership, quorum and decision-making.
27 Mar 2025	005	Working party updates from 27 March included: Draft for Board consideration.
14 Apr 2025	006	Updated following review by all three Trust Boards.

Contents

This Agreement is made between the Parties on

PART A – PARTIES

The Parties to this Agreement are

(1) Great Western Hospitals NHS Foundation Trust of Marlborough Road, Swindon, SN36BB (**GWH**)
(2) Royal United Hospitals Bath NHS Foundation Trust of Combe Park, Bath, BA1 3NG (**RUH**) and
(3) Salisbury NHS Foundation Trust of Salisbury District Hospital, Odstock Road, Salisbury, Wiltshire, SP2 8BJ (**SFT**)

Each a Trust and together the Trusts

PART B – BACKGROUND

A. The Background to this Agreement (including acronyms and capitalised words that are used in it) shall be interpreted in accordance with the definitions and rules of interpretation set out in Schedule 1

B. GWH is constituted as an NHSFT in accordance with its constitution dated November 2023

C. RUH is constituted as an NHSFT in accordance with its constitution dated 2022

D. SFT is constituted as an NHSFT in accordance with its constitution dated January 2023

E. Each Trust must exercise its Functions in accordance with its respective Governance and having regard to Guidance.

F. The Trusts have worked together collaboratively since 2018 as the Acute Hospital Alliance (AHA) in Bath and North East Somerset, Swindon and Wiltshire Integrated Care System (BSW ICS). The Trusts have formalised this relationship through Committees in Common made up of the Chief Executive, Managing Directors and Chairs.

G. In May / June 2024 the Boards received the Case for Collaboration report which set out recommendations for the collaborative leadership, governance, and development of the Trusts as a group. In July and September 2024 the Boards formally approved eight recommendations developed in light of the Case for Collaboration report.

H. In October 2024 the Trusts implemented recommendation 1 by appointing Cara Charles-Barks as Joint Chief Executive.

I. The Trusts now wish to work together to deliver high quality care to our population more effectively and efficiently. In a climate with increasing financial constraints and demand, a group structure is seen as an appropriate way to do that and future initiatives will include, but are not limited to, the remaining recommendations set out in Schedule 9.

J. Accordingly, the Trusts intend to exercise their powers under sections 65Z5 and 65Z6 of the NHSA to establish and implement joint working and delegation arrangements as set out in this Agreement and to establish a joint committee to exercise Joint Functions.

K. The Trusts accordingly intend that the arrangements set out in this Agreement will supersede and replace their current committees in common arrangements.

L. The Trusts intend to agree to data sharing, access to records and mutual operation of all Joint Functions including human resources and joint line management arrangements to facilitate the exercise of Joint Functions.

M. The Trusts have agreed that the BSW Hospitals Group Joint Committee should exercise Joint Functions but not Reserved Functions.

PART C – OPERATIVE PROVISIONS

1 Definitions and interpretation

This Agreement (including acronyms and capitalised words that are used in it) shall be interpreted in accordance with the definitions and rules of interpretation set out in Schedule 1.

2 Purpose of this Agreement

The Trusts have entered this Agreement for the purpose of collaborating as a Group including exercising their powers under s65Z5 and s65Z6 of the NHSA to agree and establish joint working and delegation arrangements.

3 **Creating an Environment for Success**

3.1 The Trusts will:

3.1.1 Work as a Group with pace and agility.

3.1.2 Work collectively to enable provision of seamless services to the population, prioritising resources to provide maximum healthcare benefit, ensuring that patient experience and outcomes are reflected in discussions and decisions.

3.1.3 Communicate frequently, comprehensively and with transparency using multiple channels to reach all patients, staff and partners. Staff will be enabled to relay in clear and simple terms why the group matters to patients and staff.

3.1.4 Actively seek to build trust between themselves and all partners.

3.1.5 Adopt the principle of doing together once what can beneficially be done as a group, allowing the Trusts to deliver that which can only be done locally.

3.1.6 Share learning across the Group as a core behaviour.

3.1.7 Agree a timely definition of the Operating Model which provides clarity and certainty and, once agreed, provide strong and consistent support.

3.1.8 Appoint a highest quality leadership team and provide them strong and consistent support to thrive.

3.1.9 Empower the BSW Hospitals Group Joint Committee which will include the Joint Chief Executive, a Chief Nursing Officer, Chief Medical Officer, Chief Finance Officer, Chief People Officer, Chief Operating Officer, and Director of Estates and Facilities, Managing Director of each Trust, agreed joint Executive Director roles (Chief Strategy Officer and Chief Information and Technology Officer), Joint Chair and a majority of voting NEDs

3.1.10 Ensure the demands on capacity of Non-Executive Directors and Executive Directors are practical, so will review frequency, length and remit of Board committee meetings as the BSW Hospitals Group Joint Committee and other group-level fora emerge.

3.1.11 Establish an annual programme of work that provides focus, clear deliverables and quick wins.

3.1.12 Through the BSW Hospitals Group Joint Committee, be responsible for Group strategy development in accordance with the Group Strategy Framework.

4 Commencement and duration

4.1 The Agreement shall take effect from the Commencement Date and will continue in full force and effect until terminated in accordance with the terms of this Agreement and, in particular but without limitation, in accordance with Clause 19.

4.2 No termination of the Agreement by any of the Trusts shall take effect within the period of three years from the Joint Chair Commencement Date.

5 No merger, acquisition or dissolution

5.1 The Trusts shall remain independent, sovereign organisations constituted in accordance with the NHSA and their respective constitutions.

5.2 Nothing in this Agreement commits the Trusts or is intended to commit them to undertake or apply for merger, acquisition or dissolution or any other transaction whose outcome would be the establishment of a single organisation as successor to any of them.

5.3 Each of the Trusts shall continue at all times to maintain its own individual governance, registrations, licences, memberships, committees and other arrangements that it may be required to maintain or hold by Law, Direction or Guidance including:

5.3.1 Standing Orders, Standing Financial Instructions and Scheme of Delegation

5.3.2 CQC registration

5.3.3 NHS provider licence

5.3.4 ICO registration

5.3.5 NHSR Schemes membership

5.3.6 Remuneration Committee

5.3.7 Audit Committee

5.3.8 Meetings that the Trusts' Boards must each hold in accordance with Schedule 7.

6 **Capacity and capability**

6.1 The Trusts shall together use their best endeavours to support their leadership capacity and capability:

6.1.1 To focus not on doing more but doing the things only the Trusts can do.

6.1.2 To work in partnership between the Trusts and with others – collaborating as inter-dependent parts of the BSW Hospitals Group and BSW Integrated Care System.

6.1.3 To focus on what the Trusts can do to deliver improvements in the services they provide to the BSW population.

6.2 The Trusts shall together use their best endeavours to improve their leadership capacity and capability through:

6.2.1 The 'golden thread' of working together, learning together, improving together – cultural change.

6.2.2 Maximising the opportunity to transform and work differently that coming together as a Group gives them.

6.2.3 Listening to and delivering through front-line teams based on clear priorities, using an 'Improving Together' approach.

7 **Trust Board Appointments**

7.1 Voting NEDs of each Trust shall continue to be appointed by its CoG in accordance with its Constitution.

7.2 Voting EDs of each Trust shall continue to be appointed by its Remuneration Committee:

7.3 Each Trust shall (in compliance with its Constitution) continue to maintain a functioning Board comprising Voting NEDs (including the Chair) and Voting EDs whose numbers will be neither less nor more than the number of Voting NEDs and Voting EDs prescribed by its Constitution.

7.4 For the purpose of developing Group Operating Model and Governance arrangements the Trusts including their Councils of Governors shall cooperate to appoint Joint Directors where the BSW Hospitals Group Joint Committee recommends that they should do so.

8 **Appointment of Joint Committee**

8.1 The Trusts shall establish a special purpose Joint Committee to be known as the BSW Hospitals Group Joint Committee.

8.2 The BSW Hospitals Group Joint Committee shall be fully and equally accountable to each Trust.

8.3 The BSW Hospitals Group Joint Committee membership (including the number of members, and balance between EDs and NEDs) shall be agreed by each Trust.

8.4 The BSW Hospitals Group Joint Committee ToR shall be substantially in the form set out in Schedule 5 and shall include the provisions set out in Clause 8.5.

8.5 The provisions referred to in Clause 8.4 are:

8.5.1 All the Voting Directors of each Trust shall be eligible for appointment as voting members of the BSW Hospitals Group Joint Committee during their terms of office

8.5.2 The Trusts may agree in writing to appoint Non-Voting Directors and/or other individuals to be voting members of the BSW Hospitals Group Joint Committee

8.5.3 The Trusts and BSW Hospitals Group Joint Committee shall have Committees in accordance with Clause 12

8.5.4 The BSW Hospitals Group Joint Committee shall exercise the Joint Functions

8.5.5 The proceedings of the BSW Hospitals Group Joint Committee shall not be invalidated by any vacancy in its membership or by any defect in the appointment of a member of the BSW Hospitals Group Joint Committee.

9 Joint Exercise of Functions

9.1 Subject to Clause 9.2 the Trusts agree that:

9.1.1 They shall jointly exercise their Joint Functions

9.1.2 If the BSW Hospitals Group Joint Committee appoints a Committee in accordance with Clause 12, then the BSW Hospitals Group Joint Committee may authorise the Committee to exercise Joint Functions that the BSW Hospitals Group Joint Committee expressly subdelegates to the Committee in its ToR.

9.1.3 The BSW Hospitals Group Joint Committee may authorise one of the Trusts to contract with a third party on behalf of itself alone or the Trusts jointly and/or severally subject to compliance with the Trusts' standing orders and standing financial instructions.

9.2 Subject to Clause 8.5.5, the Trusts agree that they, the BSW Hospitals Group Joint Committee and their Committees, directors and officers shall always comply with each of the Trust's Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation when they are exercising Joint Functions.

10 **Workforce**

10.1 Each Trust shall continue to employ its own workforces

10.2 The Trusts intend that in the exercise of their joint working arrangements, members of one Trust's workforce may be line managed by duly authorised officers of one or more of the Trusts.

11 **Exercise of Reserved Functions**

11.1 The Trusts shall continue to exercise separately their Reserved Functions.

11.2 The Trusts agree that the BSW Hospitals Group Joint Committee shall not at any time exercise their Reserved Functions.

12 **Appointment of Committees and Committees in Common**

12.1 The BSW Hospitals Group Joint Committee shall have the following Committees (sub-committees to the Joint Committee):

- Electronic Patient Record (EPR) Committee
- Financial Sustainability Committee
- Group Development, Strategy & Planning Committee

12.2 For the purpose of assisting the exercise of Joint Functions the BSW Hospitals Group Joint Committee may appoint one or more Committees additional to those set out in Clause 12.1.

12.3 The voting members of a Committee of the BSW Hospitals Group Joint Committee may comprise or include individuals who are or are not voting members of the BSW Hospitals Group Joint Committee.

12.4 For the purpose of assisting the exercise of their Mandatory Reserved Functions the Trusts may appoint Committees in Common.

12.5 Without prejudice to the generality of Clause 12.4, the Boards of each of the Trusts (acting as independent, sovereign bodies) may consider and (if agreed by each Board) arrange for their like for like committees to operate together as Committees in Common.

12.6 For illustrative purposes an organogram of the Trusts' Committees structure as at the Commencement Date is set out in Schedule 6.

13 **Operating Principles**

13.1 The Trusts shall exercise their Functions having regard to best practice in effective collaborative and system leadership, adopting the operating principles set out in Clause 13.2, and further commitments set out in Clause 13.3.

13.2 The operating principles referred to in Clause 13.1 are:

13.2.1 Create value for the population

13.2.2 Create constancy of purpose

13.2.3 Think systematically

13.2.4 Lead with humility

13.2.5 Respect every individual

13.3 In addition, the Trusts together commit to:

13.3.1 Develop a shared purpose and vision for the population we serve

13.3.2 Ensure frequent personal contact to build understanding and trust

13.3.3 Surface and resolve conflicts, not letting them fester

13.3.4 Work collectively for the long-term

13.3.5 Behave altruistically towards partners

13.3.6 An open book approach to information to build understanding and trust.

13.3.7 Be facilitative, enabling and pace setting in their role as System leaders.

14 Benefits

14.1 The Trusts shall exercise their Functions having regard to unlocking benefits set out in Clause 14.2. The benefits of group formation and approach to measurement and evaluation of those benefits will be set out in detail in **BSW Hospitals Group Business Case** and **Return on Investment plan**, which will be developed alongside the **Group Operating Model** and **Governance and Accountability Framework**.

14.2 The benefits referred to in Clause 14.1 are:

14.2.1 Together we will make the best use of collective resources available to us to support the population we serve. Our decisions will be judged by their ability to make best use of resources for Group in BSW, working to deliver the BSW Integrated Care Partnership strategy.

14.2.2 A collective approach will enable enhanced clinical effectiveness – spreading best practice, and responding to inequity, fragile services, improving fairness across BSW.

14.2.3 A collective approach will enable service viability – it will be easier to create high quality resilient services in Group for the BSW population. We will work to avoid creation or emergence of unacceptable levels of fragility to services and individual Trusts.

14.2.4 We need to change how we operate. Individually, Trust sustainability is challenging. A group model offers Trusts opportunity to remain as stand-alone local organisations focused on needs of population within the support structure of a group.

14.2.5 A group model offers a range of benefits for staff, including increased service resilience, enhanced career development and specialization opportunities. It also offers the ability to work within a wider network of professionals, spreading learning, improving training and development provision, freeing-up capacity by reducing duplication.

15 **Organisational development**

The Trusts will develop and adopt a shared organisational development programme.

16 **Resourcing the BSW Hospitals Group Joint Committee**

The Trusts shall be jointly responsible for resourcing the BSW Hospitals Group Joint Committee.

17 **Pooled Fund**

17.1 The Trusts may enter arrangements for the Trusts themselves or the BSW Hospitals Group Joint Committee to establish and maintain a Pooled Fund.

17.2 Arrangements for any Pooled Fund must be on terms set out in a Pooled Fund Agreement.

18 **Variation**

18.1 Except as set out in Clause 18.2 or otherwise in this Agreement, any Variation of this Agreement, including the introduction of any additional terms and conditions, shall only be binding when agreed by written resolutions of each Trust's Board.

18.2 The Scheme for Trust Board Appointments set out in Schedule 8, the Governance Organogram for the Trusts' Appointment of Committees as at the Commencement Date set out in Schedule 6 and the Recommendations set out in Schedule 9 are intended to be illustrative only and may be updated by resolution of the BSW Hospitals Group Joint Committee without the requirement for Variation set out in Clause 18.1.

19 **Termination**

19.1 The Trusts acknowledge and confirm that, save in accordance with this Clause 19, none of them shall be entitled to terminate this Agreement.

19.2 The Trusts acknowledge and confirm that none of them shall be entitled to terminate this Agreement in consequence of any breach (whether material or otherwise) of any provision of this Agreement by the other.

19.3 The Trusts acknowledge and confirm that they have considered and understood the position set out at Clause 19.2 above and that the provisions of Clause 4.2 (and Clause 24 in relation to the Dispute Resolution Procedure) shall apply in the event of any breach of this Agreement.

19.4 Subject to Clause 4.2 , a Trust may only terminate this Agreement by giving Notice of Termination specifying a minimum notice period that expires on the next 31 March which is not less than six months before the third anniversary of

the Joint Chair Commencement Date if it expires on the third anniversary of the Joint Chair Commencement Date or (if it expires on a date after the third anniversary of the Joint Chair Commencement Date) twelve (12) months from the date the notice of termination is served. The notice period may be shorter where agreed in writing by the other Trusts.

20 **Consequences of termination**

20.1 On or pending termination of this Agreement, the Trusts will agree an Exit Plan to ensure that the services provided by any Trust are not destabilised. The Trusts shall use best endeavours to agree the Exit Plan no less than six (6) months prior to termination of this Agreement

20.2 For a reasonable period before and after termination of this Agreement the Trusts shall co-operate fully with one another and ensure that the Exit Plan provides for continuity of services and a smooth transition of Trust Boards whilst avoiding any inconvenience or risk to the health and safety of the Trusts' service users, employees or members of the public.

20.3 This Clause 20 shall continue in full force and effect on or after termination of this Agreement.

21 **Data sharing and confidentiality**

Each Trust undertakes that it shall not at any time during the period for which this Agreement applies, and for a period of five years after termination of this Agreement, disclose to any person any Confidential Information concerning or in connection with the other Trust or this Agreement except as permitted by Schedule 7.

22 **No partnership**

Except as expressly provided in this Agreement, nothing in this Agreement is intended to, or shall be deemed to, establish any partnership between the Trusts, constitute one Trust the agent of another Trust, nor authorise a Trust to make or enter any commitments for or on behalf of another Trust.

23 **Notices**

23.1 A notice given under this Agreement:

23.1.1 Will be in writing in the English language

23.1.2 Will be sent to the intended recipient by email to the following address or such other address as the Party has notified for the purposes of this clause:

(a) For GWH, the Chief Executive Officer of GWH in post at the time of the notice

(b) For RUH, the Chief Executive Officer of RUH in post at the time of the notice

(c) For SFT, the Chief Executive Officer of SFT in post at the time of the notice

23.2 Any notice or other communication given to a Trust under or in connection with the Agreement shall be in writing, addressed to the authorised representatives at the Trust's principal place of business or such other address as that Trust may have specified to the other Trusts in writing in accordance with this Clause, and shall be delivered personally, or sent by pre-paid first class post, recorded delivery, commercial courier or email.

23.3 A notice or other communication shall be deemed to have been received:

23.3.1 If delivered personally, when left at the address referred to in Clause 23.2; if sent by pre-paid first class post or recorded delivery, at 9.00 am on the second Business Day after posting; if delivered by commercial courier, on the date and at the time that the courier's delivery receipt is signed; or, if sent by fax, one (1) Business Day after transmission.

23.3.2 If delivered by email, immediately on sending provided it is correctly addressed or if deemed receipt is not within business hours (meaning prior to 5.30 pm and excluding weekends and public holidays in England), then it will be deemed to have been received at 9.00 am on the next day that is not a weekend or a public holiday in England.

23.4 The provisions of this Clause 23 shall not apply to the service of any proceedings or other documents in any legal action.

24 **Dispute Resolution**

24.1 In accordance with Clauses 4.2 and 19 regarding termination of the Agreement, the Trusts agree to this dispute resolution process.

24.2 In a case where it has not been possible or appropriate to seek to resolve any dispute informally, a Trust shall promptly serve on the other Trusts a Notice (a 'Dispute Notice') of any dispute or claim or any potential dispute or claim in relation to this Agreement or its operation (each a 'Dispute') when it arises.

24.3 A Dispute Notice must contain a particularised account of the Dispute and the resolution sought.

24.4 In the first instance the Chair(s) shall seek to resolve any Dispute to the mutual satisfaction of each of the Trusts.

24.5 If the Dispute cannot be resolved by the Chair(s) within ten (10) Working Days of the Dispute being referred to it, the Dispute shall be referred to the ICB Chair.

24.6 The ICB Chair will consider and reach a position on the Dispute which, in the view of the ICB Chair, is the most consistent with the principles set out in this Agreement.

24.7 If a Trust does not agree with the position reached by the ICB Chair, it may within ten (10) Working Days of receiving notice of the ICB Chair position, refer the Dispute to an independent facilitator.

24.8 Where it has not been possible or appropriate to seek to resolve any dispute informally, if the Trusts consider doing so appropriate before or instead of

making a referral to the ICB under Clause 24.5, they may refer the Dispute to an independent facilitator.

24.9 If the Trusts are unable to agree on an independent facilitator or the terms of their appointment within seven (7) Working Days of any Trust serving details of a suggested independent facilitator on the others, any Trust shall then be entitled to request NHS England to appoint an appropriately experienced and reputable independent facilitator and for NHS England to agree with the terms of appointment.

24.10 The independent facilitator shall act on the following basis:

24.10.1 The independent facilitator shall decide the procedure to be followed in the determination and shall be requested to make their determination within thirty (30) Working Days of their appointment or as soon as reasonably practicable thereafter. The Trusts shall assist and provide the documentation that the independent facilitator requires for the purpose of the determination

24.10.2 The determination process shall be conducted in private and shall be confidential

24.10.3 The independent facilitator shall have its costs and disbursements met by the Trusts.

24.11 The Trusts recognise that any dispute or operation of this procedure will be without prejudice to and will not affect the statutory duties of each Trust.

24.12 In the case of dispute between the Boards leading to consideration of termination, Clauses 3.2 and 3.3 determine the timescale and Clause 18 in respect of notification of termination.

25 **Other general provisions**

25.1 Each Trust shall (at its own expense) promptly execute and deliver such documents, perform such acts and do such things as the other Trust may reasonably require from time to time for the purpose of giving full effect to this Agreement.

25.2 Each Trust will bear its own costs of negotiating and entering into this Agreement.

25.3 This Agreement is personal to each of the Trusts who shall not assign, transfer, mortgage, charge, declare a trust of, or deal in any other manner with any of its rights and obligations under this Agreement without the prior written consent of the other Trusts.

25.4 This Agreement (together with the documents referred to in it) constitutes the entire agreement between the Trusts and supersedes and extinguishes all previous discussions, correspondence, negotiations, drafts, agreements, promises, assurances, warranties, representations and understandings between them, whether written or oral, relating to its subject matter.

25.5 No failure or delay by a Trust to exercise any right or remedy provided under this Agreement or by law shall constitute a waiver of that or any other right or

remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy. No single or partial exercise of such right or remedy shall prevent or restrict the further exercise of that or any other right or remedy. A waiver of any right or remedy under this Agreement or by law is only effective if it is in writing.

25.6 Except as expressly provided in this Agreement, the rights and remedies provided under this Agreement are in addition to, and not exclusive of, any rights or remedies provided by law.

25.7 If any provision or part-provision of this Agreement is or becomes invalid, illegal or unenforceable, it shall be deemed modified to the minimum extent necessary to make it valid, legal and enforceable. If such modification is not possible, the relevant provision or part-provision shall be deemed deleted. Any modification to or deletion of a provision or part-provision under this Clause shall not affect the validity and enforceability of the rest of this Agreement.

25.8 This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute a duplicate original, but all the counterparts shall together constitute the one agreement.

25.9 No one other than a party to this Agreement shall have any right to enforce any of its terms.

25.10 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the law of England and Wales.

25.11 Each Trust irrevocably agrees that the courts of England and Wales shall have exclusive jurisdiction to settle any dispute or claim arising out of or in connection with this Agreement or its subject matter or formation (including non-contractual disputes or claims).

The Trusts have executed this Agreement as set out below on the date stated at the beginning of it.

PART D – SCHEDULES

Schedule 1 – Definitions and Interpretation

1 In this Agreement capitalised words and expressions shall have the meanings given to them as follows:

Word or expression	**Meaning**
Agreement	This partnership agreement (including its Schedules) which sets out arrangements for the purpose the Trusts exercising their Functions jointly
Arrangements for delegation and joint exercise of statutory functions	NHS England Guidance *Arrangements for delegation and joint exercise of statutory functions – Guidance for integrated care boards, NHS trusts and foundation trusts* dated 27 March 2023 (Publication approval reference: PRN00346)
Audit Committee	A Committee that each of the Trusts must appoint in accordance with NHS England's *Code of governance for NHS provider trusts* (2022) to ensure that it operates effectively and meets its statutory and strategic objectives, and to provide it with assurance that this is the case
CEO	A Voting ED who is the Chief Executive Officer of one or more of the Trusts
Chair	A Voting NED who is the Chair of one or more of the Trusts
Commencement Date	[DATE]
Committee	A committee or subcommittee of one of the Trusts or a subcommittee of a joint committee (including the BSW Hospitals Group Joint Committee)
CiC or Committees in Common	Arrangements between the Trusts to appoint like for like Committees with the same or equivalent terms of reference and

Word or expression	**Meaning**
	memberships so that they may meet simultaneously with shared agenda and minutes
Conditions for Success	the conditions for success set out in Clause 3
CoG	Council of Governors
CQC	Care Quality Commission
Constitution	The constitution of an NHSFT that has been approved by its Board of Directors and CoG and is in force at the relevant time of their respective decision-making and exercise of functions
Direction	A direction to a Trust that the Secretary of State or NHS England may issue in the exercise of their respective functions under Legislation
Director	A NED or an ED of one or more of the Trusts
ED or Executive Director	an executive director who may be Voting ED or a Non-Voting ED
Exit Plan	A plan for the transition of any affected services and required changes to the Trust Boards on the termination of this Agreement to include: (i) details of the affected services; (ii) details of service users and/or user groups affected; (iii) the joint working arrangements and jointly exercised functions that will need to continue to ensure continuity of services and how these will be transitioned into separate arrangements for each Trust; (iv) the intended timescales for the Exit Plan
Functions	All the duties and/or powers of the Trusts under the NHSA or their constitutions or any other legislation or otherwise conferred by any other source whatsoever

Word or expression	**Meaning**
Governance	A Trust's Constitution, Standing Orders and Schedule 7
Group	The Trusts jointly working together as a hospitals' group in accordance with this Agreement
Group Strategy Framework	The group strategy framework set out in Schedule 2
Guidance	Any statutory guidance of the Secretary of State or NHS England to NHS bodies comprising or including NHS trusts (for example *Arrangements for delegation and joint exercise of statutory functions*) or other non-statutory guidance that the Trusts must have regard to in accordance with their NHS provider licence
Joint Chair Commencement Date	The date of commencement in post of the Joint Chair
Joint Committee	A joint committee that the Trusts have agreed to establish under section 65Z6 of the NHSA to exercise Joint Functions in accordance with the BSW Hospitals Group Joint Committee ToR
Joint Committee ToR	ToR of the BSW Hospitals Group Joint Committee
Joint Functions	Any Functions which the Trusts agree are jointly exercisable by them in accordance with Schedule 3
Legislation	An Act of Parliament (for example the NHSA) or statutory instrument (for example the NHSM&P Regulations)
Mandatory Reserved Functions	Any Reserved Functions that the Trusts may not delegate and/or exercise jointly under Legislation or Guidance

Word or expression	Meaning
NED or Non-Executive Director	A non-executive director who may be Voting NED or a Non-Voting NED
NHSA	National Health Service Act 2006
NHSFT	NHS foundation trust within the meaning of section 30 of the NHSA
NHSR Schemes	The indemnity schemes known as the Clinical Negligence Scheme for Trusts, Liabilities to Third Parties Scheme and Property Expenses which the Secretary of State has established under the NHSA and which are managed on her behalf by NHS Resolution
Non-Voting ED	An Executive Director who is not a Voting Director
Non-Voting NED	A Non-Executive Director who is not a Voting Director
Notice of Termination	Notice in writing from one Trust to the other Trust to terminate this Agreement in accordance with Clause 19
Pooled Fund	A fund to be made up of payments received in accordance with arrangements between the Trusts that must be set out in a Pooled Fund Agreement and out of which payments may be made in accordance with the arrangements towards expenditure incurred in the exercise of Joint Functions
Pooled Fund Agreement	An agreement in writing between the Trusts for the establishment of a Pooled Fund in accordance with section 65Z6 of the NHSA
Remuneration Committee	A Committee that each Trust must appoint whose responsibilities include functions under paragraphs 17(3), 17(4) and 18(2) of Schedule 7:

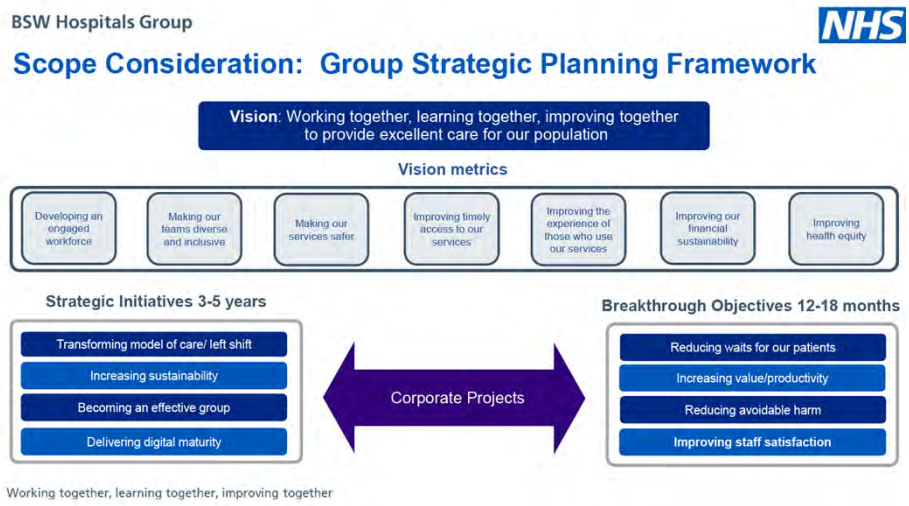
Word or expression	Meaning
	• (The CEO not being a member of it) to appoint the Trust's CEO and to determine the remuneration and terms of service of the CEO and other executive directors and • (The CEO being a member of it) to appoint the other executive directors
Reserved Functions	Any Functions that are not Joint Functions
Schedule 7	Schedule 7 of the NHSA unless it is intended to refer to Schedule 7 of this Agreement
Secretary of State	Secretary of State for Health and Social Care
Standing Orders	The standing orders of each of the Trust's board of directors and/or the standing orders of its CoG that the Trust is required to adopt by its Constitution for the regulation of their proceedings and business
ToR	Terms of reference
UK GDPR	Has the meaning given to it in section 3(10) (as supplemented by section 205(4)) of the Data Protection Act 2018.
Variation	A variation of this Agreement in accordance with Clause 18
Voting Director	A Voting ED or a Voting NED
Voting ED	A Director who is an executive director of one of the Trusts within the meaning of paragraph 16 of Schedule 7 and has been appointed by the NEDs and (except for the CEO's appointment) the CEO in accordance with the NHSFT's Constitution

Word or expression	Meaning
Voting NED	A Director who is a non-executive director of one of the Trusts within the meaning of paragraph 16 of Schedule 7 and has been appointed by the Trust's CoG in accordance with its Constitution
Working Day	A day (other than a Saturday, Sunday or public holiday) when banks in London are open for business.

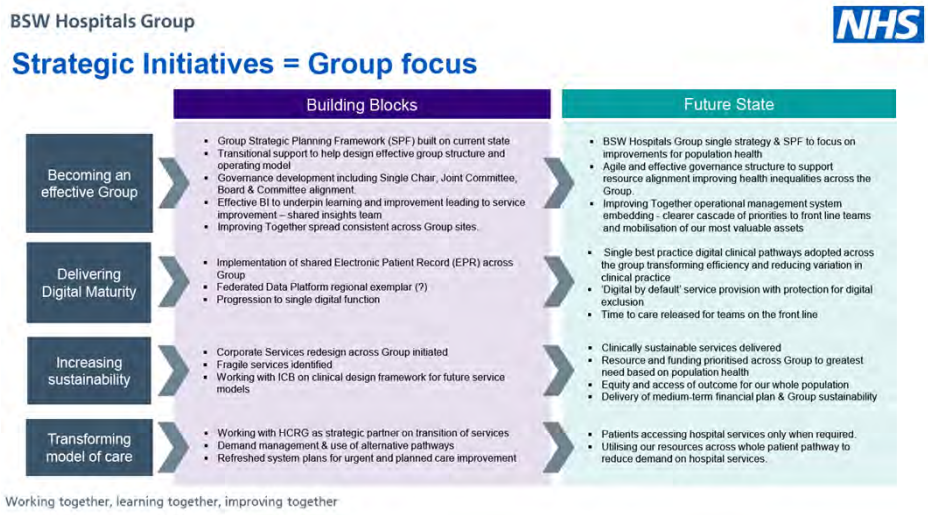
2 Any reference to the exercise by the Trusts of Joint Functions shall be interpreted to include any exercise of Joint Functions by the BSW Hospitals Group Joint Committee or a Committee of it on behalf of the Trusts.

Schedule 2 Group Strategy Framework

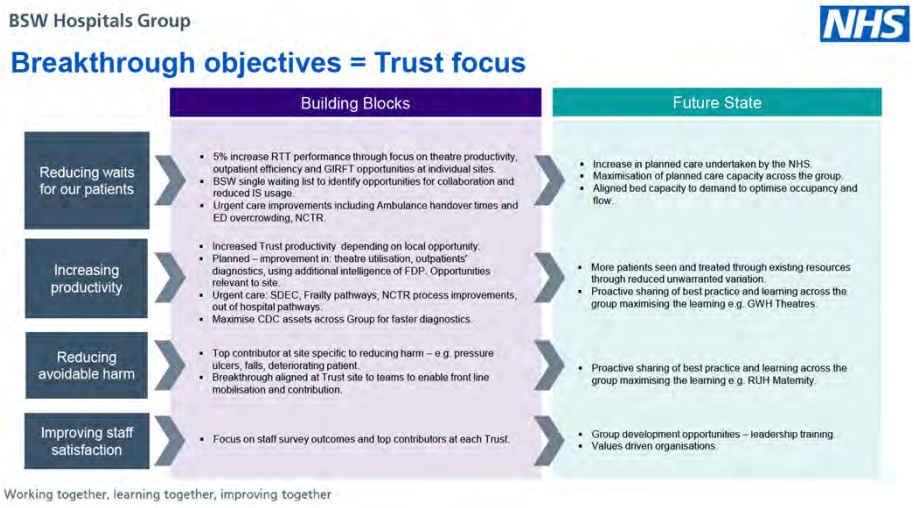
Part 1 - Strategic Planning Framework



Part 2 – Group Focus



Part 3 – Trust Focus



Schedule 3 – Joint Functions

1 Subject to paragraph 2:

1.1 Joint Functions are any Functions relating to any of the matters set out in paragraph 3 below.

1.2 Joint Functions may additionally include any or all Functions that NHS England has categorised as 'Open to Joint Exercise of Functions' in *Arrangements for delegation and joint exercise of statutory functions* as reproduced in the table set out in Paragraph 4 below (excluding references to legislation that is applicable to or in force in Wales only) which the Trusts agree by Variation should be Joint Functions.

2 Joint Functions may not at any time include Mandatory Reserved Functions.

3 The matters referred to in paragraph 1.1 are:

3.1 Group Strategy & Planning Framework

- Development, approval and delivery of overarching Group Strategy and associated specialist development and delivery plans, including Group Clinical, Workforce, Financial Sustainability, Digital, Estates & Facilities, Innovation, Research & Development, Partnership working, and Capital Plans.
- Development, approval and delivery of Group Strategic Planning Framework and Annual Group-wide Plan.
- Oversight of delivery of Group Strategic Initiatives.
- Management of risk to delivery of Group Strategy

3.2 Transforming our Model of Care for the BSW Population we Serve - Clinical Services Organisation/ Pathways/ Design

- Development of Group **clinical services framework for the collective population we serve** with associated decision-making processes.
- **Approval** of service/pathway/treatment configuration changes across the Group.

3.3 Financial Sustainability - Use of Resources

- Setting and delivery of Group Financial Recovery and long-term Group financial sustainability.
- Capital Programme. Development and approval of capital investment programme for the Group ensuring we attract capital into BSW to address priorities.
- Capital Programme. Development and approval of capital limits for each Trust within the group to be delegated.

3.4 Group Mobilisation & Development

- Oversight of Group Mobilisation & Development. Approval of Group Operating Model, including Accountability Framework and associated Integrated Performance Reporting.
- Oversight of delivery of the Case for Collaboration and emerging agreed priorities. Includes programme oversight of 10x workstreams from case for collaboration – with details, phasing and resourcing agreed in Group annual plan.
- Group Development - Corporate Services – Define objectives, shape and structure of Group corporate services transformation. Approve resourcing of programme.

3.5 Achieving Digital Maturity

- EPR Programme – Oversight of Implementation. Approval of new Benefits Profile. Approval of proposals for new Budget.
- Group Digital transformation programme – implementation [x-refer 3.1]

4 The table referred to in paragraph 1.2 is as follows:

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Section 43 NHS Act 2006	(2) An NHS foundation trust may provide goods and services for any purposes related to— (a) the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and (b) the promotion and protection of public health. (2A) An NHS foundation trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes. (3) An NHS foundation trust may also carry on activities other than those mentioned in subsection (2) for the purpose of making additional income available in order better to carry on its principal purpose.	ANCILLARY FUNCTION	Yes
Section 44 NHS Act 2006	(6) According to the nature of its functions, an NHS foundation trust may, in the case of patients being provided with goods and services for the purposes of the health service, make accommodation or further services available for patients who give undertakings (or for whom undertakings are given) to pay any charges imposed by the NHS foundation trust in respect of the accommodation or services. (7) An NHS foundation trust may exercise the power conferred by subsection (6) only to the extent that its exercise does not to any significant extent interfere with the performance by the NHS foundation trust of its functions.	COMMISSIONING	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Section 47 NHS Act 2006	(1) An NHS foundation trust may do anything which appears to it to be necessary or expedient for the purpose of or in connection with its functions. (2) In particular it may– (a) acquire and dispose of property, (b) enter into contracts, (c) accept gifts of property (including property to be held on trust for the purposes of the NHS foundation trust or for any purposes relating to the health service), (d) employ staff. (3) Any power of the NHS foundation trust to pay remuneration and allowances to any person includes power to make arrangements for providing, or securing the provision of, pensions or gratuities (including those payable by way of compensation for loss of employment or loss or reduction of pay). (4) "The purposes of the NHS foundation trust" means the general or any specific purposes of the trust (including the purposes of any specific hospital at or from which services are provided by the trust).	ANCILLARY FUNCTION	Yes
Section 47A NHS Act 2006 as inserted by section 64 of the Health and Care Act 2022	Joint exercise of functions An NHS foundation trust may enter into arrangements for the carrying out, on such terms as the NHS foundation trust considers appropriate, of any of its functions jointly with any other person.	CORPORATE	Yes
Section 56 NHS Act 2006	(1) An application may be made jointly by– (a) an NHS foundation trust, and (b) another NHS foundation trust or an NHS trust	CORPORATE	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	established under section 25, to the regulator for the dissolution of the trusts and the establishment of a new NHS foundation trust. (1A) An application under this section may be made only with the approval of more than half of the members of the council of governors of each applicant (that is an NHS foundation trust). (2) The application must– (a) be supported by the Secretary of State if one of the parties to it is an NHS trust, (b) specify the property and liabilities proposed to be transferred to the new NHS foundation trust, and (d) be accompanied by a copy of the proposed constitution of the new trust (4) The regulator must grant the application if it is satisfied that such steps as are necessary to prepare for the dissolution of the trusts and the establishment of the proposed new trust have been taken. (11) On the grant of the application, the proposed constitution of the NHS foundation trust has effect, but the directors of the applicants may exercise the functions of the trust on its behalf until a board of directors is appointed in accordance with the constitution.		
Section 56A NHS Act 2006	56A Acquisitions (1) An application may be made jointly by— (a) an NHS foundation trust (A), and (b) another NHS foundation trust or an NHS trust established under section 25 (B), to the regulator for the acquisition by A of B.	CORPORATE	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	(2) An application under this section may be made only with the approval of more than half of the members of the council of governors of each applicant (that is an NHS foundation trust). (3) The application must— (a) be supported by the Secretary of State if B is an NHS trust, and (b) be accompanied by a copy of the proposed constitution of A, amended on the assumption that A acquires B. (4) The regulator must grant the application if it is satisfied that such steps as are necessary to prepare for the acquisition have been taken. (4A) Where the regulator proposes to grant the application, it may by order make provision for the transfer of employees of B to A on the grant of the application. (5) On the grant of the application, the proposed constitution has effect, but where a person who is specified as a director of A in the constitution has yet to be appointed as such, the directors of A may exercise that person's functions under the constitution.		
Section 63 NHS Act 2006	An NHS foundation trust must exercise its functions effectively, efficiently and economically.	ANCILLARY FUNCTION	Yes
Section 63A NHS Act 2006	(1) In making a decision about the exercise of its functions, an NHS foundation trust must have regard to all likely effects of the decision in relation to— (a) the health and well-being of the people of England;	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	(b) the quality of services provided to individuals— (i) by relevant bodies, or (ii) in pursuance of arrangements made by relevant bodies, for or in connection with the prevention, diagnosis or treatment of illness, as part of the health service in England; (c) efficiency and sustainability in relation to the use of resources by relevant bodies for the purposes of the health service in England.		
Section 65Z5 NHS Act 2006 as inserted by Section 71 of the Health and Care Act 2022	Joint working and delegation arrangements (1) A relevant body may arrange for any functions exercisable by it to be exercised by or jointly with any one or more of the following— (a) a relevant body (b) a local authority (within the meaning of section 2B); (c) a combined authority. (2) In this section "relevant body" means— (a) NHS England, (b) an integrated care board, (c) an NHS trust established under section 25, (d) an NHS foundation trust, or (e) such other body as may be prescribed.	CORPORATE	Yes
Section 65Z6 NHS Act 2006 as inserted by Section 71 of the Health and Care Act 2022	Joint committees and pooled funds (1) This section applies where a function is exercisable jointly (by virtue of section 65Z5 or otherwise) by a relevant body and any one or more of the following— (a) a relevant body; (b) a local authority (within the meaning of section 2B);	CORPORATE	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	(c) a combined authority. (2) The bodies by whom the function is exercisable jointly may— (a) arrange for the function to be exercised by a joint committee of theirs; (b) arrange for one or more of the bodies, or a joint committee of the bodies, to establish and maintain a pooled fund.		
Section 72 NHS Act 2006	(1) It is the duty of NHS bodies to co-operate with each other in exercising their functions.	ANCILLARY FUNCTION	Yes
Section 82 NHS Act 2006	In exercising their respective functions NHS bodies (on the one hand) and local authorities (on the other) must co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.	ANCILLARY FUNCTION	Yes
Section 223L NHS Act 2006	(1) NHS England may set joint financial objectives for integrated care boards and their partner NHS trusts and NHS foundation trusts. (2) An integrated care board and its partner NHS trusts and NHS foundation trusts must seek to achieve any financial objectives set under this section.	CORPORATE	Yes
Section 223LA NHS Act 2006	(1) An integrated care board and its partner NHS trusts and NHS foundation trusts must exercise their functions with a view to ensuring that their expenditure in a financial year (taken together) does not exceed the aggregate of any sums received by them in the year.	CORPORATE/ ANCILLARY	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Section 223M NHS Act 2006	(1) Each integrated care board and its partner NHS trusts and NHS foundation trusts must exercise their functions with a view to ensuring that, in respect of each financial year— (a) local capital resource use does not exceed the limit specified in a direction by NHS England; (b) local revenue resource use does not exceed the limit specified in a direction by NHS England.	CORPORATE/ ANCILLARY	Yes
Section 242 NHS Act 2006	(1B) Each relevant English body must make arrangements, as respects health services for which it is responsible, which secure that users of those services, whether directly or through representatives, are involved (whether by being consulted or provided with information, or in other ways) in– (a) the planning of the provision of those services, (b) the development and consideration of proposals for changes in the way those services are provided, and (c) decisions to be made by that body affecting the operation of those services.	ANCILLARY FUNCTION	Yes
Section 249 NHS Act 2006	(1) In exercising their respective functions, NHS bodies (on the one hand) and the prison service (on the other) must co-operate with one another with a view to improving the way in which those functions are exercised in relation to securing and maintaining the health of prisoners.	ANCILLARY FUNCTION	Yes
Criminal Justice Act 2003, Section 325(3)	In establishing those arrangements for the purpose of assessing and managing risks posed by relevant sexual	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	and violent offenders &c, the responsible authority i.e. the chief officer of police, the local probation board for that area or (if there is no local probation board for that area) a relevant provider of probation services and the Minister of the Crown exercising functions in relation to prisons, acting jointly must act in co-operation with the persons specified in subsection (6); and it is the duty of those persons to co-operate in the establishment by the responsible authority of those arrangements, to the extent that such co-operation is compatible with the exercise by those persons of their relevant functions. NHS trusts are included among persons in sub-s (6)(h).		
Mental Health (Care and Treatment) (Scotland) Act 2003, Section 31	(1) Where it appears to a local authority that the assistance of a Health Board, a Special Health Board or a National Health Service trust– (a) is necessary to enable the authority to perform any of their duties under section 25 or 26 of this Act i.e. relating to provision of care and support services and services designed to promote well-being and independence; or (b) would help the authority to perform any of those duties, the authority may request the Health Board, Special Health Board or National Health Service trust to co-operate by providing the assistance specified in the request. (2) A Health Board, a Special Health Board or a National Health Service trust receiving a request under subsection (1) above shall, if complying with the request– (a) would be compatible with the discharge of its own	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	functions (whether under any enactment or otherwise); and (b) would not prejudice unduly the discharge by it of any of those functions, comply with the request.		
National Health Service Trust (Scrutiny of Deaths) (England) Order 2021, article 3	(1) An NHS trust in England may scrutinise the death of any person who has died in England where— (a) a senior coroner is not under a duty to investigate the death under section 1 of the Coroners and Justice Act 2009, or (b) it is unclear whether the death is one which a registered medical practitioner would be required to notify to the relevant senior coroner under the Notification of Deaths Regulations 2019.	ANCILLARY FUNCTION	Yes
Social Workers Regulations 2018, reg 7	(1) The persons specified for the purposes of section 53(1)(d) of the Act i.e the Children and Social Work Act 2017, which requires Social Work England ("the regulator") to cooperate with, among others, any person specified in regulations made by the Secretary of State are— (d) any NHS trust established under section 25 of the National Health Service Act 2006,	ANCILLARY FUNCTION	Yes
Children Act 2014, s11(2); (4)	(2) Each person and body to whom this section applies which includes NHS Trusts by ss(1) must make arrangements for ensuring that– (a) their functions are discharged having regard to the need to safeguard and promote the welfare of children; and	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	(b) any services provided by another person pursuant to arrangements made by the person or body in the discharge of their functions are provided having regard to that need. (4) Each person and body to whom this section applies must in discharging their duty under this section have regard to any guidance given to them for the purpose by the Secretary of State.		
Children Act 2014, Section 25(5) [Applicable in Wales only]	(1) Each local authority in Wales must make arrangements to promote co-operation between– (a) the authority; (b) each of the authority's relevant partners which includes NHS Trusts by ss(4)(e); and (c) such other persons or bodies as the authority consider appropriate, being persons or bodies of any nature who exercise functions or are engaged in activities in relation to children in the authority's area. (2) The arrangements under subsections (1) and (1A) not reproduced here are to be made with a view to— (a) improving the well-being of children within the authority's area, in particular those with needs for care and support; (b) improving the quality of care and support for children provided in the authority's area (including the outcomes that are achieved from such provision); (c) protecting children who are experiencing, or are at risk of, abuse, neglect or other kinds of harm (within the meaning of the Children Act 1989). (5) The relevant partners of a local authority in Wales	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	must co-operate with the authority in the making of arrangements under this section.		
Children Act 2014, Section 25(6) [Applicable in Wales only]	(6) A local authority in Wales and any of their relevant partners may for the purposes of arrangements under this section– (a) provide staff, goods, services, accommodation or other resources; (b) establish and maintain a pooled fund as defined by ss(7).	ANCILLARY FUNCTION	Yes
Children Act 2014, Section 25(8) [Applicable in Wales only]	(8) A local authority in Wales and each of their relevant partners must in exercising their functions under this section have regard to any guidance given to them for the purpose by the Welsh Ministers.	ANCILLARY FUNCTION	Yes
Children Act 2014, Section 27(3) [Applicable in Wales only]	(3) An NHS trust to which section 25 see lines above applies must– (a) appoint an executive director, to be known as the trust's "lead executive director for children and young people's services", for the purposes of the trust's functions under that section; and (b) designate one of the trust's non-executive directors as its "lead non-executive director for children and young people's services" to have the discharge of those functions as his special care.	ANCILLARY FUNCTION	Yes
Children Act 2014, Section 28(2) [Applicable in Wales only]	(2) Each person and body to whom this section applies including an NHS trust all or most of whose hospitals, establishments and facilities are situated in Wales, by ss(1)(c) must make arrangements for ensuring that–	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	(a) their functions are discharged having regard to the need to safeguard and promote the welfare of children; and (b) any services provided by another person pursuant to arrangements made by the person or body in the discharge of their functions are provided having regard to that need.		
Children Act 2014, Section 28(4) [Applicable in Wales only]	(4) The persons and bodies referred to in subsection (1)(a) to (c) and (i) must in discharging their duty under this section have regard to any guidance given to them for the purpose by the Assembly.	ANCILLARY FUNCTION	Yes
Domestic Violence, Crime and Victims Act 2004, Section 9(2), (3)	(3) It is the duty of any person or body within subsection (4) establishing or participating in a domestic homicide review (whether or not held pursuant to a direction under subsection (2)) to have regard to any guidance issued by the Secretary of State as to the establishment and conduct of such reviews.	ANCILLARY FUNCTION	Yes
Mental Health Units (Use of Force) Act 2018, s2(1) [Not in force]	(1) A relevant health organisation which includes NHS trusts by s13 that operates a mental health unit must appoint a responsible person for that unit for the purposes of this Act.	ANCILLARY FUNCTION	Yes
Mental Health Units (Use of Force) Act 2018, s3(1) [Not in force]	(1) The responsible person for each mental health unit must publish a policy regarding the use of force by staff who work in that unit.	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Mental Health Units (Use of Force) Act 2018, s11(2) [Not in force]	(2) In exercising functions under this Act, responsible persons and relevant health organisations which includes NHS Trusts by s13 must have regard to guidance published by the SoS by ss(1) under this section.	ANCILLARY FUNCTION	Yes
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s4(3) [In force in Wales only]	(3) The following persons must, when exercising functions under this Part, have regard to any relevant guidance contained in the code on additional learning needs issued by the Welsh Ministers by ss(1)]— (h) an NHS trust;	ANCILLARY FUNCTION	Yes
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s20 [In force in Wales only]	(4) If a matter is referred to an NHS body which includes an NHS Trust by s99(1) under this section, the NHS body must consider whether there is a relevant treatment or service as defined by ss(6) that is likely to be of benefit in addressing the child's or young person's additional learning needs. (5) If the NHS body identifies such a treatment or service, it must— (a) secure the treatment or service for the child or young person, (b) decide whether the treatment or service should be provided to the child or young person in Welsh, and (c) if it decides that the treatment or service should be provided to the child or young person in Welsh, take all reasonable steps to secure that the treatment or service is provided in Welsh.	COMMISSIONING	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s21 [In force in Wales only]	Various duties (not set out in full here) consequent on the NHS body identifying (or not identifying) a relevant treatment or service per s20	COMMISSIONING	Yes
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s64 [In force in Wales only]	(1) This section applies where a health body mentioned in subsection (2) which includes an NHS Trust, in the course of exercising its functions in relation to a child who is under compulsory school age and for whom a local authority is responsible, forms the opinion that the child has, or probably has, additional learning needs. (3) The health body must inform the child's parent of its opinion and of its duty in subsection (4). (4) After giving the parent an opportunity to discuss the health body's opinion with an officer of the body, the health body must bring it to the attention of the local authority that is responsible for the child or, if the child is looked after, to the attention of the local authority that looks after the child, if the health body is satisfied that doing so would be in the best interests of the child. (5) If the health body is of the opinion that a particular voluntary organisation is likely to be able to give the parent advice or other assistance in connection with any additional learning needs that the child may have, it must inform the parent accordingly.	REGULATORY	Yes
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s65 [In force in Wales only]	(1) Subsection (2) applies if a local authority requests a person mentioned in subsection (4) [which includes NHS Trusts] to exercise the person's functions to provide the authority with information or other help, which it requires for the purpose of exercising its functions under this Part.	REGULATORY	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	(2) The person must comply with the request unless the person considers that doing so would— (a) be incompatible with the person's own duties, or (b) otherwise have an adverse effect on the exercise of the person's functions. (3) A person that decides not to comply with a request under subsection (1) must give the local authority that made the request written reasons for the decision.		
Additional Learning Needs and Education Tribunal (Wales) Act 2018, s76 [In force in Wales only]	(1) The Education Tribunal for Wales may, in relation to an appeal under this Part,— (a) exercise its functions to require an NHS body to give evidence about the exercise of the body's functions; (b) make recommendations to an NHS body about the exercise of the body's functions. (3) An NHS body to whom a recommendation has been made by the Tribunal must make a report to the Tribunal before the end of any prescribed period beginning with the date on which the recommendation is made. ss(4) specifies the contents of the report.	REGULATORY	Yes
Regulation and Inspection of Social Care (Wales) Act 2016, s178 [in force in Wales only]	(2) A regulatory body i.e. the Welsh Ministers and SCW, by s176(1) must, in the exercise of its relevant functions, seek to co-operate with a relevant authority which includes, by s177(1)(e) an NHS Trust if the regulatory body thinks such co-operation— (a) will have a positive effect on the manner in which the body exercises its functions, or (b) will assist the body in achieving its general objectives.	REGULATORY	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Regulation and Inspection of Social Care (Wales) Act 2016, s178 [in force in Wales only]	(3) Where a regulatory body requests the co-operation of a relevant authority under subsection (2) the authority must comply with the request unless the authority— (a) is prevented from co-operating in the manner requested by any enactment or other rule of law, (b) thinks that such co-operation would otherwise be incompatible with its own functions, or (c) thinks that such co-operation would have an adverse effect on its functions.	REGULATORY	Yes
Regulation and Inspection of Social Care (Wales) Act 2016, s178 [in force in Wales only]	(4) If a relevant authority requests the co-operation of a regulatory body, the body must comply with that request unless the body— (a) is prevented from co-operating in the manner requested by any enactment (including this Act) or other rule of law, (b) thinks that such co-operation would otherwise be incompatible with the regulatory body's own functions, or (c) thinks that such co-operation would have an adverse effect— (i) on the body's functions, or (ii) on achieving the body's general objectives.	REGULATORY	Yes
Well-being of Future Generations (Wales) Act 2015, Parts 2 and 3	Not reproduced in full here, the Act confers various duties on public bodies to do things in pursuit of the economic, social, environmental and cultural well-being of Wales in a way that accords with the sustainable development principle and to require public bodies to report on such	REGULATORY	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	action. "Public bodies", by section 6, includes NHS Trusts.		
Counter-terrorism and Security Act 2016, s26	(1) A specified authority which includes, by Schedule 6, and NHS Trust must, in the exercise of its functions, have due regard to the need to prevent people from being drawn into terrorism.	ANCILLARY FUNCTION	Yes
Counter-terrorism and Security Act 2016, s38	(1) The partners which include NHS Trusts by Schedule 7 of a panel i.e. a panel established by a LA by s36 must, so far as appropriate and reasonably practicable, act in co-operation with— (a) the panel in the carrying out of its functions; (b) the police and local authorities in the carrying out of their functions in connection with section 36.	CORPORATE	Yes
Counter-terrorism and Security Act 2016, s38	By ss(3) the duty of a partner of a panel to act in co-operation with the panel includes the giving of information (subject to ss(4)) and extends only so far as the co-operation is compatible with the exercise of the partner's functions under any other enactment or rule of law.	CORPORATE	Yes
Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, reg 4(1)	(1) Each public authority listed in Schedule 2 which includes NHS Trusts to these Regulations must publish information to demonstrate its compliance with the duty imposed by section 149(1) of the Act i.e. the public sector equality duty of the Equality Act 2010. See further regs 4(2) onwards and reg 6 for requirements as to publication and exemption for authorities with fewer than 150 employees	REGULATORY	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
National Health Service (Charges for Drugs and Appliances) Regulations 2015, reg 6(1)	(1) Where an NHS trust or an NHS foundation trust supplies a drug or appliance to a patient for the purpose of treatment, the NHS trust or the NHS foundation trust (as the case may be) must, subject to paragraphs (3) to (6), make and recover from the patient for the supply of continues as to charges to be made in respect of particular items See further reg 6 for exemptions	COMMISSIONING	Yes
National Health Service (Charges for Drugs and Appliances) Regulations 2015, reg 7(1)	(1) Where drugs or appliances are supplied to a patient, including during the out of hours period, for the purpose of treating that patient, by a prescriber at a walk-in centre, the NHS trust, NHS foundation trust or other person responsible for the management of the centre, must, subject to paragraphs (3) to (5), make and recover from that patient for the supply of continues as to charges to be made in respect of particular items See further reg 7 for exemptions	COMMISSIONING	Yes
National Health Service (Charges for Drugs and Appliances) Regulations 2015, reg 10(1)	(9) Where a claim to an exemption has been made but is not substantiated, and in consequence of the claim a charge has not been recovered, if— (b) the drugs or appliances were supplied by an NHS trust or an NHS foundation trust as mentioned in regulation 6, then that NHS trust or NHS foundation trust must recover that charge from the person concerned	COMMISSIONING	Yes
National Health Service (Charges to Overseas Visitors) Regulations 2015	The Regulations place various duties (not set out in full here) on "relevant bodies" (which includes NHS Trusts, by reg 2) to make and recover charges for the provision	COMMISSIONING	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	of relevant services to overseas visitors. Further, NHS Trusts, in meeting their obligations to make and recover charges from overseas visitors, must (by reg 3A) enter certain specified information against record against the overseas visitor's consistent identifier.		
National Health Service (Optical Charges and Payments) Regulations 2013, reg 2(2)	(2) Where a charge is payable by virtue of paragraph (1) a charge for such amount for glasses and contact lenses as determined by the SoS, the NHS trust or NHS foundation trust, or other person on its behalf, that supplies or is to supply the glasses or contact lenses must– (a) on arranging to supply the glasses or contact lenses, make the charge, and (b) on supplying the glasses or contact lenses or having them available for supply, recover the charge from the person supplied or to be supplied (if the charge has not previously been paid).	COMMISSIONING	Yes
National Health Service (Optical Charges and Payments) Regulations 2013, reg 10(1)	(1) An NHS trust or NHS foundation trust which, following a sight test, issues a prescription for an optical appliance to a person who— (a) has indicated that they are an eligible person; or (b) is an eligible person by virtue of regulation 8(5), must issue to that person a voucher relating to the optical appliance prescribed. See further reg 10(2) for requirements on issuing a voucher	COMMISSIONING	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013/218, reg 23	This provision imposes consultation duties (not set out in full here) on a "responsible person" ("R") (which may be a "service provider", a definition which by reg 23(14) includes an NHS Trust) where R has under consideration any proposal for a substantial development of the health service. This is subject to reg 23(12) which sets out the circumstances in which the functions in reg 23 are to be carried out by a responsible commissioner in the place of a service provider.	ANCILLARY FUNCTIONS	Yes
NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012, reg 4	(1) This regulation applies where a clinical commissioning group, NHS trust or NHS foundation trust and a local authority propose to designate a body as a Care Trust under section 77(1) of the 2006 Act, or propose to revoke such designation. (2) Where this regulation applies, the body and the local authority must, before designating or revoking the designation, as the case may be, consult jointly such persons as appear to them to be affected by the proposed designation or revocation.	REGULATORY	Yes
Care Act 2014, s6	(1) A local authority must co-operate with each of its relevant partners which, by ss(7) includes each NHS body in the authority's area, defined in turn by ss(8) as NHS trust or NHS foundation trust which provides services in the authority's area, and each relevant partner must co-operate with the authority, in the exercise of— (a) their respective functions relating to adults with needs for care and support, (b) their respective functions relating to carers, and	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	(c) functions of theirs the exercise of which is relevant to functions referred to in paragraph (a) or (b).		
Social Services and Well-being (Wales) Act 2014, s17	(5) A Local Health Board or an NHS Trust providing services in the area of a local authority must, for the purposes of this section which imposes a duty on Welsh LAs to secure the provision of information, advice and assistance, provide that local authority with information about the care and support it provides in the local authority's area.	ANCILLARY FUNCTION	Yes
Social Services and Well-being (Wales) Act 2014, s118	(2) Where a child who is accommodated in Wales— (g) in any accommodation provided by or on behalf of an NHS Trust or by or on behalf of an NHS Foundation Trust, ceases to be so accommodated after reaching the age of 16, the person by whom or on whose behalf the child was accommodated or who carries on or manages the home or hospital (as the case may be) must inform the local authority or local authority in England within whose area the child proposes to live. subject to ss(3) which provides that the duty if the accommodation has been provided for a consecutive period of at least three months.	ANCILLARY FUNCTION	Yes
Social Services and Well-being (Wales) Act 2014, s120	(1) Subsection (2) applies where a child is provided with accommodation in Wales by a Local Health Board, an NHS Trust or a local authority in the exercise of education functions ("the accommodating authority")— (a) for a consecutive period of at least 3 months, or (b) with the intention, on the part of that authority, of	ANCILLARY FUNCTION	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	accommodating the child for such a period. (2) The accommodating authority must notify the appropriate officer as defined by ss(4) of the responsible authority as defined by ss(3)— (a) that it is accommodating the child, and (b) when it ceases to accommodate the child.		
Social Services and Well-being (Wales) Act 2014, s134	Not reproduced in full here, this section makes provision for "Safeguarding Boards" and regulations governing them. By ss(2)(d) an NHS Trust is designated as a partner of a Safeguarding Board.	ANCILLARY FUNCTION	Yes
Social Services and Well-being (Wales) Act 2014, s161B	(1) The Welsh Ministers may require a person falling within subsection (2) which includes an NHS Trust to provide them with— (a) any documents, records (including medical or other personal records) or other information— (i) which relate to the exercise of a social services function of a local authority, and (ii) which the Welsh Ministers consider it necessary or expedient to have for the purposes of a review under section 149A or 149B; (b) an explanation of the content of— (i) any documents, records or other information provided under paragraph (a), or (ii) any documents or records provided to an inspector conducting an inspection of premises under section 161 in connection with a review under section 149B. Subject to ss(3) which provides that a person is not required to provide documents, records or other	REGULATORY	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	information under subsection (1) if the person is prohibited from providing them by any enactment or other rule of law.		
Social Services and Well-being (Wales) Act 2014, s162(6)	(1) A local authority must make arrangements with a view to promoting the matters specified in ss(3) to promote co-operation between— (a) the local authority, (b) each of the authority's relevant partners including, by ss(4)(f) an NHS Trust providing services in the area of the authority in the exercise of— (i) their functions relating to adults (ii) their other functions the exercise of which is relevant to the functions referred to in sub-paragraph (i), and (c) such other persons or bodies as the authority considers appropriate, being persons or bodies of any nature who or which exercise functions or are engaged in activities in relation to— (i) adults within the authority's area with needs for care and support, or (ii) adults within the authority's area who are carers. (6) The relevant partners of a local authority must co-operate with the authority in the making of arrangements under this section.	ANCILLARY FUNCTION	Yes
Social Services and Well-being (Wales) Act 2014, s162(7); (9)	(7) A local authority and any of its relevant partners may for the purposes of arrangements under this section— (a) provide staff, goods, services, accommodation or other resources;	COMMISSIONING	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	(b) establish and maintain a pooled fund defined at ss(7); (c) share information with each other.		
Social Services and Well-being (Wales) Act 2014, s162(7); (9)	(9) A local authority and each of its relevant partners including, by ss(4)(f) an NHS Trust providing services in the area of the authority must, in exercising their functions under this section, have regard to any guidance given to them for the purpose by the Welsh Ministers.	ANCILLARY FUNCTION	Yes
Social Services and Well-being (Wales) Act 2014, s164(1), (3)	(1) If a local authority requests the co-operation of a person mentioned in subsection (4) includes an NHS Trust in the exercise of any of its social services functions, the person must comply with the request unless the person considers that doing so would— (a) be incompatible with the person's own duties, or (b) otherwise have an adverse effect on the exercise of the person's functions. (3) A person who decides not to comply with a request under subsection (1) or (2) must give the local authority which made the request written reasons for the decision.	REGULATORY	Yes
Social Services and Well-being (Wales) Act 2014, s164(2); (3)	(2) If a local authority requests that a person mentioned in subsection (4) includes an NHS Trust provides it with information it requires for the purpose of the exercise of any of its social services functions, the person must comply with the request unless the person considers that doing so would— (a) be incompatible with the person's own duties, or (b) otherwise have an adverse effect on the exercise of the person's functions.	REGULATORY	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	(3) A person who decides not to comply with a request under subsection (1) or (2) must give the local authority which made the request written reasons for the decision.		
Social Services and Well-being (Wales) Act 2014, s164(5)	(5) A local authority and each of those persons mentioned in subsection (4) includes an NHS Trust must in exercising their functions under this section have regard to any guidance given to them for the purpose by the Welsh Ministers.	ANCILLARY FUNCTION	Yes
Social Services and Well-being (Wales) Act 2014, s164A(1), (3)	(1) If a local authority requests the co-operation of a person mentioned in subsection (4) includes NHS Trusts in the exercise of its functions mentioned in subsection (5) relating to functions under Children Act 1989 &c, the person must comply with the request unless the person considers that doing so would— (a) be incompatible with the person's own duties, or (b) otherwise have an adverse effect on the exercise of the person's functions. (3) A person who decides not to comply with a request under subsection (1) or (2) must give the local authority which made the request written reasons for the decision.	REGULATORY	Yes
Social Services and Well-being (Wales) Act 2014, s164A(2), (3)	(2) If a local authority requests that a person mentioned in subsection (4) includes NHS Trusts provides it with information it requires for the purpose of the exercise of any of its functions mentioned in subsection (5) relating to functions under Children Act 1989 &c, the person must comply with the request unless the person considers that doing so would—	REGULATORY	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	(a) be incompatible with the person's own duties, or (b) otherwise have an adverse effect on the exercise of the person's functions. (3) A person who decides not to comply with a request under subsection (1) or (2) must give the local authority which made the request written reasons for the decision.		
Children and Families Act 2014, s28	(1) A local authority in England must co-operate with each of its local partners which includes, by ss(2)(m), an NHS Trust or NHS Foundation Trust which provides services in the authority's area, or which exercises functions in relation to children or young people for whom the authority is responsible, and each local partner must co-operate with the authority, in the exercise of the authority's functions under this Part.	ANCILLARY FUNCTIONS	Yes
Children and Families Act 2014, s31	(1) This section applies where a local authority in England requests the cooperation of any of the following persons and bodies in the exercise of a function under this Part— (g) an NHS trust or NHS foundation trust. (2) The person or body must comply with the request, unless the person or body considers that doing so would— (a) be incompatible with the duties of the person or body, or (b) otherwise have an adverse effect on the exercise of the functions of the person or body. (3) A person or body that decides not to comply with a	ANCILLARY FUNCTIONS	Yes

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
	request under subsection (1) must give the authority that made the request written reasons for the decision.		
Children and Families Act 2014, s77	(4) The persons listed in subsection (1) including at ss(1)(l) NHS Trusts must have regard to the Code of Practice issued by the SoS pursuant to ss(1) in exercising their functions under this Part.	ANCILLARY FUNCTIONS	Yes
Equality Act 2010 c. 15	Refers to all functions under this Act	CORPORATE	Yes
Health Act 2009 c. 21	Refers to entire Act.	REGULATORY	Yes
Health and Social Care Act 2008 c. 14	All duties of an NHS Trust under this Act	REGULATORY	Yes
Local Government and Public Involvement in Health Act 2007 c. 28	All duties of an NHS Trust under this Act	REGULATORY	Yes
Health Act 2006 c. 28	Refers to entire Act.	REGULATORY	Yes
Health and Social Care (Community Health and Standards) Act 2003 c. 43	Refers to entire Act.	REGULATORY	Yes
Mental Capacity Act 2005 c. 9	Refers to entire Act.	REGULATORY	Yes
Health and Social Care Act 2008 c. 14	All functions of a Trust under this Act.	REGULATORY	Yes
Local Audit and Accountability Act 2014 c. 2	Refers to entire Act.	REGULATORY	Yes

Schedule 4 Mandatory Reserved Functions

1 Mandatory Reserved Functions are any Functions of the Trusts that they cannot lawfully delegate or jointly exercise or otherwise are Functions that NHS England has categorised as not 'Open to Joint Exercise of Functions' in *Arrangements for delegation and joint exercise of statutory functions* as reproduced in the table set out in paragraph 2 below.

2 The table referred to in paragraph 1 is as follows:

Section & Act/ Clause & Bill	Wording	Category of function	Open to joint exercise
Section 27A NHS Act 2006	(1) A public benefit corporation must hold an annual meeting of its members. (2) The meeting must be open to members of the public. (3) At least one member of the board of directors of the corporation must attend the meeting and present the following documents to the members at the meeting— (a) the annual accounts, (b) any report of the auditor on them, (c) the annual report. (4) Where an amendment is made to the constitution in relation to the powers or duties of the council of governors of a public benefit corporation (or otherwise with respect to the role that the council has as part of the corporation)— (a) at least one member of the council of governors must attend the next meeting to be held under this paragraph and present the amendment, and (b) the corporation must give the members an opportunity to vote on whether they approve the amendment. (5) If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the corporation must take such steps as are necessary as a result.	CORPORATE	**No**
Section 37 NHS Act 2006	(1) An NHS foundation trust may make amendments of its constitution only if— (a) more than half of the members of the council of governors of the trust voting approve the amendments, and (b) more than half of the members of the board of directors of the trust voting approve the amendments.	CORPORATE	**No**
Section 42B (6) NHS Act 2006 as inserted by section 62 of the Health and Care Act 2022	Limits on capital expenditure (6) A trust that is the subject of an order under this section must not exceed the capital expenditure limit imposed by the order during the financial year to which it relates.	CORPORATE / REGULATORY	**No**

Section 43 NHS Act 2006	(1) The principal purpose of an NHS foundation trust is the provision of goods and services for the purposes of the health service in England.	CORPORATE	**No**
Section 43 NHS Act 2006	(3D) An NHS foundation trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the council of governors of the trust voting approve its implementation.	CORPORATE	**No**
Section 46 NHS Act 2006	(1) An NHS foundation trust may borrow money for the purposes of or in connection with its functions. (4) An NHS foundation trust may invest money (other than money held by it as trustee) for the purposes of or in connection with its functions. (5) The investment may include investment by– (a) forming, or participating in forming, bodies corporate, (b) otherwise acquiring membership of bodies corporate. (6) An NHS foundation trust may give financial assistance (whether by way of loan, guarantee or otherwise) to any person for the purposes of or in connection with its functions.	CORPORATE / ANCILLARY	**No**
Section 50 NHS Act 2006	An NHS foundation trust must pay to the regulator such fee as the regulator may determine in respect of its exercise of functions under— (a) section 39; (b) section 39A.	REGULATORY	**No**
Section 51A NHS Act 2006	(1) An NHS foundation trust may enter into a significant transaction only if more than half of the members of the council of governors of the trust voting approve entering into the transaction. (2) "Significant transaction" means a transaction or arrangement of such description as may be specified in the trust's constitution. (3) If an NHS foundation trust does not wish to specify any descriptions of transaction or arrangement for the purposes of subsection (2), the constitution of the trust must specify that it contains no such descriptions.	CORPORATE	**No**

Section 56B NHS Act 2006	(1) An application may be made to the regulator by an NHS foundation trust for the dissolution of the trust and the establishment of two or more new NHS foundation trusts. (2) An application under this section may be made only with the approval of more than half of the members of the council of governors of the applicant. (3) The application must, by reference to each of the proposed new trusts— (a) specify the property and liabilities proposed to be transferred to it; (b) be accompanied by a copy of its proposed constitution. (4) The regulator must grant the application if it is satisfied that such steps as are necessary to prepare for the dissolution of the trust and the establishment of each of the proposed new trusts have been taken. (5) On the grant of the application, the proposed constitution of each of the new trusts has effect but, in the case of each of the new trusts, the proposed directors may exercise the functions of the trust on its behalf until a board of directors is appointed in accordance with the constitution.	CORPORATE	**No**
Section 57A NHS Act 2006	57A Dissolution (1) An application may be made by an NHS foundation trust to the regulator for dissolution. (2) An application under this section may be made only with the approval of more than half of the members of the council of governors of the applicant.	CORPORATE	**No**
Section 61 NHS Act 2006	(1) An NHS foundation trust must take steps to secure that (taken as a whole) the actual membership of any public constituency and (if there is one) of the patients' constituency is representative of those eligible for such membership.	CORPORATE	**No**
Chapter 5A NHS Act 2006	Trusts Special Administration.	REGULATORY	**No**
Domestic Violence, Crime and Victims Act 2004, Section 9(2), (3)	(2) The Secretary of State may in a particular case direct a specified person or body within subsection (4) including NHS trusts established under section 25 of the National Health Service Act 2006 or section 18 of the National Health Service (Wales) Act 2006 by ss(4)(a) to establish, or to participate in, a domestic homicide review as defined by ss(1).	ANCILLARY FUNCTION	**No**

Charities Act 2011, ss149; 152	Various provisions as to the audit/examination of the accounts of an "English NHS charity" (which would include a charitable trust, the trustees of which are an NHS Trust), including requirements as to the auditor/independent examiner and the giving of guidance by the Charities Commission	REGULATORY	**No**
Policing and Crime Act 2017, s1	(1) A collaboration agreement as defined by ss(3) may be made by— (a) one or more persons within a paragraph of subsection (2), and (b) one or more persons within another paragraph of that subsection. (2) Those persons are— (a) an ambulance trust in England, (b) a fire and rescue body in England, and (c) a police body in England. See further sections 3 and 4 regarding collaboration agreements	CORPORATE	**No**
Investigatory Powers Act 2016, Part 3	Not reproduced in full here, this part of the Act contains provision for applications by "relevant public authorities" to the Investigatory Powers Commissioner for authorisations to obtain communications, and the granting of authorisations by a designated officer in a relevant public authority in specific circumstances. "Relevant public authority" includes (by Schedule 4) ambulance trusts.	REGULATORY	**No**
Immigration Act 1999, s20A	Not reproduced in full here, this provision confers a duty on NHS Trusts to supply a "nationality document" at the direction of the SoS, if the SoS has reasonable grounds for believing is lawfully in the possession of an NHS Trust.	REGULATORY	**No**
Network and Information Systems Regulations 2018	Not reproduced in full here, the regulations make provision for the identification of "operators of essential services" (OES) (where they provide an essential service as specified in Schedule 2 of the regs and where they (a) rely on network and information systems; and (b) satisfy a threshold requirement described for that kind of essential service. NHS Trusts are specified in Schedule 2. An OES is subject to duties relating to notification of their status to a designated competent authority and take appropriate and proportionate technical and organisational measures to manage risks posed to the security of the network and information systems on which their essential service relies.	CORPORATE	**No**

Housing Act 1996, s213B	NHS Trusts are included among the public authorities specified by Homelessness (Review Procedure etc) Regulations 2018 (see reg 10 and Schedule) for the purposes of this provision: (1) This section applies if a specified public authority considers that a person in England in relation to whom the authority exercises functions is or may be homeless or threatened with homelessness. (2) The specified public authority must ask the person to agree to the authority notifying a local housing authority in England of— (a) the opinion mentioned in subsection (1), and (b) how the person may be contacted by the local housing authority. (3) If the person— (a) agrees to the specified public authority making the notification, and (b) identifies a local housing authority in England to which the person would like the notification to be made, the specified public authority must notify that local housing authority of the matters mentioned in subsection (2)(a) and (b).	REGULATORY	**No**
Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, reg 5(1)	(1) Each public authority listed in Schedule 2 which includes NHS Trusts to these Regulations must prepare and publish one or more objectives it thinks it should achieve to do any of the things mentioned in paragraphs (a) to (c) of section 149(1) of the Act. See further regs 5(2) onwards and reg 6 for requirements as to publication.	CORPORATE	**No**
Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017, Schedule 1(2)	Not reproduced in full here, a relevant public authority is subject to a duty to publish annual information relating to gender pay gap information relating to employees.	CORPORATE	**No**
Controlled Drugs (Supervision of Management and Use) Regulations 2013	The Regulations place various duties (not set out in full here) on "designated bodies" (which includes NHS Trusts, by reg 7) in relation to the supervision, management and use of controlled drugs	REGULATORY	**No**

Children and Families Act 2014, s23	(1) This section applies where, in the course of exercising functions in relation to a child who is under compulsory school age, a clinical commissioning group, NHS trust or NHS foundation trust form the opinion that the child has (or probably has) special educational needs or a disability. (2) The group or trust must— (a) inform the child's parent of their opinion and of their duty under subsection (3), and (b) give the child's parent an opportunity to discuss their opinion with an officer of the group or trust. (3) The group or trust must then bring their opinion to the attention of the appropriate local authority in England. (4) If the group or trust think a particular voluntary organisation is likely to be able to give the parent advice or assistance in connection with any special educational needs or disability the child may have, they must inform the parent of that.	ANCILLARY FUNCTIONS	**No**
Mental Health Act 1983	Refers to entire Act.	REGULATORY	**No**
Mental Capacity Act 2005	Refers to entire Act.	REGULATORY	**No**
Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008/1858	Refers to entire Regulations.	REGULATORY	**No**
Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008/1184	Refers to entire Regulations.	REGULATORY	**No**

Schedule 5 BSW Hospitals Group Joint Committee ToR

Terms of Reference for a special purpose joint committee (the BSW Hospitals Group Joint Committee) between Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust

Version control

Date	Version	Author
18 Feb 2025	001	Browne Jacobson LLP
27 Mar 2025	002	Browne Jacobson LLP
14 Apr 2025	003	Browne Jacobson LLP

1 Introduction

1.1 The BSW Hospitals Group Joint Committee is a statutory joint committee of the boards of Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust, and Salisbury Hospital NHS Foundation Trust (the Trusts) who have established it under section 65Z6 of the National Health Service Act 2006 to exercise Joint Functions in accordance with the Partnership Agreement entered into by the Trusts dated [DN: INSERT DATE] (the Partnership Agreement).

1.2 As set out in the Partnership Agreement, the BSW Hospitals Group Joint Committee will oversee the plan for closer collaboration, the subsequent delivery programme, and development of the proposed Group model. The shared narrative for the Group is as follows:

1.2.1 Together we will make the best use of collective resources available to us. Our decisions will be judged by their ability to make best use of resources for the population in BSW.

1.2.2 A collective approach will enable enhanced clinical effectiveness – spreading best practice, and responding to inequity, fragile services, improving fairness across BSW.

1.2.3 A collective approach will enable service viability – it will be easier to create high quality resilient services in Group. We will work to avoid creation or emergence of unacceptable levels of fragility to services and individual Trusts, including with our Place-based, network and tertiary partners.

1.2.4 We need to change how we operate. Individually, Trust sustainability is challenging. A group model offers real opportunity to remain as stand-alone local organisation focused on needs of population within the support structure of a group.

1.2.5 Risk: We will develop collective approach to risk and address differences between local and group risk appetite when they emerge.

1.3 In these terms of reference 'Joint Functions' mean all the Trusts' functions that the Trust Boards have agreed are Joint Functions in accordance with the Partnership Agreement.

2 Authority & Accountabilities

2.1 The BSW Hospitals Group Joint Committee is authorised by the Boards to exercise the Joint Functions.

2.2 The BSW Hospitals Group Joint Committee shall be fully and equally accountable to each Trust Board for the exercise of the Joint Functions and shall at all times comply with the Partnership Agreement and NHS England guidance when exercising Joint Functions.

2.3 The BSW Hospitals Group Joint Committee may authorise one of the Trusts to contract with a third party on behalf of itself alone or each Trust jointly and severally subject to compliance with the Trusts' standing orders and standing financial instructions.

2.4 The BSW Hospitals Group Joint Committee is authorised by the Boards to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

2.5 The BSW Hospitals Group Joint Committee shall transact all business in accordance with the policies of the Trusts on openness and conformity with the Nolan principles and values of the Public Services.

3 Reporting Arrangements

3.1 The minutes of Joint Committee meetings shall be formally recorded and submitted to each Trust's Board.

3.2 The BSW Hospitals Group Joint Committee shall provide regular update reports to each Trust's Board on the activities of the BSW Hospitals Group Joint Committee in accordance with a single reporting schedule agreed by the Trust Boards.

4 Membership

4.1 All the Voting Directors of each Trust shall be eligible for appointment as voting members (Members) of the BSW Hospitals Group Joint Committee during their terms of office.

4.2 Each Trust shall appoint the following Members, who may be Voting Director or Non-Voting Directors:

4.2.1 Chair, Vice Chair and three other Voting NEDs nominated in writing by the Trust's Chair

4.2.2 Chief Executive Officer, Managing Director and two other EDs nominated in writing by the Trust's Chair and Chief Executive Officer.

4.2.3 All joint Executive Director roles created by the Trusts.

4.3 The Trusts shall ensure that in appointing the EDs in accordance with paragraph 4.2.2 the membership of the BSW Hospitals Group Joint Committee shall include a Chief Nursing Officer, a Chief Medical Officer, a Chief Finance Officer, a Chief People Officer, a Chief Operating Officer, and a Director of Estates and Facilities. The role of these EDs shall be to bring their portfolio expertise to the decisions of the BSW Hospitals Group Joint Committee in the interests of the Group.

4.4 It is acknowledged that the role of the Members shall be to make decisions in the interests of the Group rather than to represent the views of their individual Trusts.

Commented [RH1]: Browne Jacobson comment: I have suggested separating this provision out so that it is a standalone provision that applies to all members of the Joint Committee rather than just the EDs.

4.5 The Trusts may agree in writing to vary these Terms of Reference to amend the number of Members of the BSW Hospitals Group Joint Committee provided that:

4.5.1 Each Trust appoints the same number of Members

4.5.2 The Chair and Chief Executive Officer are Members

4.5.3 The Chair and other Voting NED Members outnumber the ED Members.

4.6 Additionally, the Trusts may agree in writing to vary these Terms of Reference to permit them to appoint Non-Voting Directors of the Trusts to be Members of the BSW Hospitals Group Joint Committee.

4.7 The proceedings of the BSW Hospitals Group Joint Committee shall not be invalidated by any vacancy in its membership or by any defect in the appointment of a Member.

4.8 A Member's initial term of appointment to the BSW Hospitals Group Joint Committee shall be up to three years, or the end of their term of appointment as a Director of a Trust, whichever is the earlier. A Member's may be reappointed by their Trust in accordance with paragraph 4.2 for further terms.

5 Attendance

5.1 The Trust Secretary of one of the Trusts will attend as required to ensure that the BSW Hospitals Group Joint Committee business is transacted as per this Terms of Reference, the Partnership Agreement, the Trusts' Standing Orders and documents referred to in them.

5.2 With the consent of the BSW Hospitals Group Joint Committee Chair, other persons may be invited to attend and contribute to meetings of the BSW Hospitals Group Joint Committee but not take part in making decisions.

5.3 In line with the Trusts' Standing Orders, Members must attend at least half the BSW Hospitals Group Joint Committee's meetings annually. Any failure of a Member to meet this attendance requirement shall be considered as part of that individual's Annual Review and Appraisal process.

5.4 Subject to paragraph 5.3 and the prior agreement of the Chair, each Trust may nominate a deputy to attend a meeting of the BSW Hospitals Group Joint Committee in the event of a Member's absence. For Members appointed under paragraph 4.2.1 the deputy shall be a Voting NED nominated by the Chair of the relevant Trust. For Members appointed under paragraph 4.2.2 the deputy shall be an ED or senior director nominated by the Chair and Chief Executive of the relevant Trust. For Members appointed under paragraph 4.2.3 the deputy shall be an ED or senior director nominated by the Chief Executive. A deputy shall be formally nominated with the same rights and privileges as the Member for whom they are deputising.

6 Chair

6.1 The Joint Chair of the Trusts, if present, shall preside at any meeting of the BSW Hospitals Group Joint Committee or, if the Joint Chair is absent, the Deputy Chair of the BSW Hospitals Group Joint Committee shall preside. If the Deputy Chair is presiding at a meeting instead of the Chair, then references in this Terms of Reference to the Joint Chair shall be construed as the Deputy Chair.

6.2 Pending the appointment of a Joint Chair of the Trusts, the current Chairs of the Trusts shall agree between them who shall chair meetings of the BSW Hospitals Group Joint Committee (where possible rotating between them) and any reference in these terms of reference to 'Joint Chair' shall (where the context requires) be construed as the Trust Chair who presides at a meeting.

7 Quorum

7.1 No business shall be transacted at a meeting of the BSW Hospitals Group Joint Committee unless:

7.1.1 At least half the Members of the BSW Hospitals Group Joint Committee are present

7.1.2 At least half of the Members present are Voting NEDs

7.1.3 The Members present include (in addition to the Joint Chair) at least two EDs of each of the Trusts (who in the case of a joint director may be the same person) and at least two Voting NEDs of each of the Trusts (who in the case of a joint director may be the same person).

8 Decision making

8.1 The BSW Hospitals Group Joint Committee will generally operate on the basis of forming a consensus on all issues considered, taking account of the views expressed by all Members. The Joint Chair will seek to ensure that any lack of consensus is resolved amongst Members.

8.2 If the BSW Hospitals Group Joint Committee is unable to reach a consensus on an issue, the Joint Chair may put the issue to a vote. The vote will be carried if:

8.2.1 A special majority of not less than two thirds of the Members present and voting are in favour, and

8.2.2 The Members in favour include more than half of the Members from each Trust.

8.3 Each Member of the BSW Hospitals Group Joint Committee shall have one vote except in the event that prior to the appointment of the Joint Chair an individual is appointed as the Chair of two of the Trusts but not the other, in which case they shall be treated as if they were separate individuals and entitled to cast a vote on behalf of each Trust to which they are appointed.

8.4 The decisions of the BSW Hospitals Group Joint Committee (which for the avoidance of doubt extend only to decisions in respect of the Joint Functions) are binding on each of the Trusts.

9 Admission of the public to meetings

9.1 Meetings of the BSW Hospitals Group Joint Committee shall be held in in private.

9.2 But the BSW Hospitals Group Joint Committee may, by resolution, permit the public to attend a meeting to observe (whether during the whole or part of the proceedings).

10 Managing Conflicts of Interest

10.1 Each Member of the BSW Hospitals Group Joint Committee must abide by all policies of the Trust of which she or he is a director or officer in relation to conflicts of interest.

10.2 At the first meeting of the BSW Hospitals Group Joint Committee, the BSW Hospitals Group Joint Committee will select a chair ("Joint Committee Chair") from amongst the members who are Trust Chairs. A Deputy-Chair will also be selected. Once a joint chair for the Trusts is appointed, he or she shall become the BSW Hospitals Group Joint Committee Chair and the incumbent Joint Committee Chair (if not the joint chair) shall immediately hand over.

10.3 The Trusts acknowledge that sections 63A and 223L to 223N of the NHSA (as introduced by the Health and Care Act 2022) impose duties on the Trusts to have regard to the wider effects of their decisions and the expenditure limits and use of resources requirements of their system. In the light of these duties, there should be few occasions where the interests of the Trusts are not aligned and directors of each Trust must have regard to the wider impact of their decisions on the other Trusts and seek to cooperate with the other Trusts in exercising their functions.

11 Administrative Support

The Chief Executive Officer shall nominate a Trust Secretary to arrange provision of administrative support to the BSW Hospitals Group Joint Committee.

12 Annual Workplan

The BSW Hospitals Group Joint Committee will agree an Annual Workplan and cycle of business prior to the beginning of each financial year. The reporting cycle will then form part of the agenda alongside the standing agenda items.

13 Frequency of Meetings

13.1 Ordinary meetings of the BSW Hospitals Group Joint Committee shall be held not less than six times a year and shall be coordinated with the cycle of Board meeting of the Trusts.

13.2 Notice of all meetings shall comprise venue, time and date of the meeting, together with an agenda of items to be discussed.

13.3 Extraordinary meetings may be called for a specific purpose at the discretion of the Joint Chair. Where possible, a minimum of seven working days' notice will be given when calling any extraordinary meeting.

14 Papers Publication

All papers will be published using the available electronic Board paper system. Publication of papers will be seven working days before meetings. A progress report of outstanding/pending Joint Committee actions will be presented to each meeting of the BSW Hospitals Group Joint Committee.

15 Routines, Behaviours and Standards

15.1 The BSW Hospitals Group Joint Committee will implement the following routines and behaviours, in order to enable a safe, inclusive and trusting environment, where teams build and maintain effective relationships:

15.1.1 Develop a shared purpose and vision for the population we serve

15.1.2 Ensure frequent personal contact to build understanding and trust

15.1.3 Surface and resolve conflicts, not letting them fester

15.1.4 Work collectively for the long-term

15.1.5 Behave altruistically towards partners

15.1.6 An open book approach to information to build understanding and trust.

15.1.7 Be facilitative, enabling and pace setting in their role as System leaders.

15.2 The BSW Hospitals Group Joint Committee shall comply with the following standards:

15.2.1 NHSE Code of Governance for NHS provider trusts

15.2.2 NHSE Risk Assessment Framework

15.2.3 NHSE Annual Planning Guidance

15.2.4 The Health NHS Board – Principles of Good Governance

15.2.5 Corporate Governance – Principles of Public Life (GP01)

15.2.6 King's Fund: The Practice of Collaborative Leadership: across health and care services

15.3 The BSW Hospitals Group Joint Committee shall work to the following principles:

15.3.1 Create value for the population

15.3.2 Create constancy of purpose

15.3.3 Think systematically

15.3.4 Lead with humility

15.3.5 Respect every individual

16 Standard Agenda

16.1 Agendas will be built around the BSW Hospitals Group Joint Committee annual workplan, and most of the following will appear on each agenda, while some will appear only once or twice each year:

16.1.1 Declarations of interest,

16.1.2 Minutes of previous meeting,

16.1.3 Action list

16.1.4 Group Strategy

16.1.5 Performance, Transformation and Benefits Realisation

16.1.6 Reports of committees of the BSW Hospitals Group Joint Committee

16.1.7 Self-assessment of the BSW Hospitals Group Joint Committee's effectiveness

16.1.8 Review of the BSW Joint Hospitals Group Committee's terms of reference

16.1.9 Regular reports to the Trust Boards

16.1.10 Other items as per agreed cycle of business

17 Committees

17.1 The BSW Hospitals Group Joint Committee shall have the following committees (sub-committees to the Joint Committee):

17.1.1 The EPR Committee

17.1.2 Financial Sustainability

17.1.3 Group Development, Strategy & Planning

17.2 For the purpose of assisting the exercise of Joint Functions the BSW Hospitals Group Joint Committee may appoint one or more additional committees.

17.3 The voting members of a committee of the BSW Hospitals Group Joint Committee may may comprise or include individuals who are or are not voting Members of the BSW Hospitals Group Joint Committee.

17.4 The BSW Hospitals Group Joint Committee may authorise a committee to exercise Joint Functions that the BSW Hospitals Group Joint Committee expressly subdelegates to the committee in its ToR.

18 Amendment

These terms of reference may only be amended by variation agreed by resolution of each of the Trust Boards save that the Chair and Chief Executive of each of the Trusts may agree a non-material variation that they may reasonably consider to be necessary for the purpose of remedying any obvious error or omission in the terms of reference.

Date approved:

Date of review:

Annex to BSW Hospitals Group Joint Committee Terms of Reference

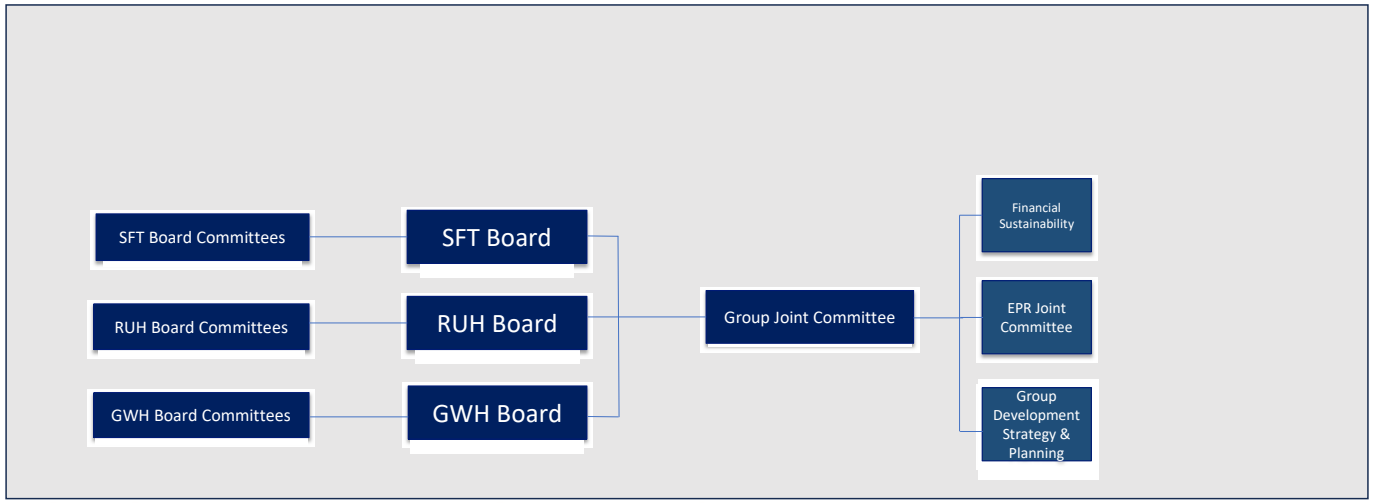
Functions Delegated by each of the Boards of GWH, RUH and SFT – Roles & responsibilities

	Role of the Joint Committee	Role of the Trust Boards
	1. Group Strategy & Planning	
Strategy		
1	Development and approval of BSW Hospitals Group Strategy. The Joint Committee determines the strategic direction, ensuring that collective BSW population interests are paramount.	Responsible for development and delivery of local operational plans aligned to and reinforcing *Group Strategy and Specialist Delivery* Plans.
2	Development and approval of *Specialist Delivery Plans* underpinning Group Strategy; Finance, People, Clinical, Digital, Estates & Facilities, Innovation, Research & Development, Partnership working, and Capital plans, in accordance with relevant system plans or strategies.	
Planning		
1	Development, approval and delivery of *Group Strategic Planning Framework* and *Annual Group-wide Plan*, reflecting planning guidance and Group Strategy. Set strategic goals and key objectives for upcoming year. Oversee budgeting process, reviewing and consolidating budgets at Group level. Oversight of delivery of *Group Strategic Initiatives.*	Development and delivery of the Trust operational plan aligned to Group objectives.
2	Approval of the overall Group Programme Budget - developing a plan that determines the financial contribution, and pooling of resources to meet financial challenges.	Delivery of the Trust operational plan, incorporating Group programme budget requirements.
3	Development of a Group Board Assurance Framework and Risk Management Framework.	Board Assurance Frameworks and risk management processes will remain in place for each Trust. Enable standardisation and consistency in a controlled and managed approach as determined by the Joint Committee.
4	Review and identification of the risks associated with the delivery of *Group Strategy and Group Annual Plan*.	
	2. Transforming Models of Care for the Population we Serve	
1	Development and approval of a *Group Clinical Services Framework* for the collective population we serve and associated decision-making processes.	Actively engage in co-creation and implementation of the Group Clinical Services Framework.

2	Approval of service/pathway/treatment configuration changes across the Group	
	3. Financial Sustainability – Use of Resources	
1	Sets and delivers Group financial recovery and long-term Group financial sustainability.	Responsible for developing and delivering financial plans as determined by the Group Programme Budget. Manage operational budgets.
2	Approval of new capital investment programme for the Group	Responsible for implementing local capital investment plans.
3	Approval of capital limits for each Trust within the Group.	Identifies local priorities for investment within the delegated limit.
	4. Group Mobilisation & Development	
1	Approval of *Group Operating Model*, *Accountability Framework* and associated *Integrated Performance Reporting*.	Works within the Group governance structure and accountability framework to deliver services ensuring that local governance aligns with group governance.
2	Oversight of delivery of the BSW Hospitals Group Case for Collaboration and emerging agreed priorities. Includes programme oversight of workstreams from case for collaboration – with details, phasing and resourcing agreed in *Annual Group-wide Plan*.	Manages day-to-day services delivery, compliance, and patient safety. Local Transformation oversight. Delivery of change locally with Partners. Participates in group mobilisation and development workstreams.
3	Defines objectives, shape and structure of Group Corporate Services transformation. Approval of programme resourcing.	Manages day-to-day services delivery, compliance, and patient safety. Local Transformation oversight.
4	Identification and approval of any further opportunities in support of Group Strategy.	Actively identify further opportunities to maximise economies at scale.
	5. Achieving Digital Maturity	
1	Responsible for the strategic oversight of successful delivery of the EPR Programme [via EPR Joint Committee activity]. Approves proposals for new budget and new benefits profile.	Ensures local delivery plans in place and appropriate relevant engagement for successful implementation.
2	Identifies, approves and implements digital transformation initiatives across the Group structure, as described in *Group Digital Delivery plan* [refer 1,2].	Ensures local IT infrastructure supports Group-wide strategy. Ensures local delivery plans in place and appropriate relevant engagement for successful implementation

Schedule 6 Governance Organogram for the Trusts' Appointment of Committees as at the Commencement Date

BSW Hospitals Group – Organogram



Acute Provider Collaborative in Bath and North East Somerset, Swindon and Wiltshire

Schedule 7 Data sharing and confidentiality

Part A: Confidentiality

1 In this Schedule "Confidential Information" means: all information, whether written or oral (however recorded), provided by one Trust (the Disclosing Trust) to the other Trusts (Receiving Trust(s)) and which (i) is known by the Receiving Trust(s) to be confidential; (ii) is marked as or stated to be confidential; or (iii) ought reasonably to be considered by the Receiving Trust(s) to be confidential.

2 The Trusts may disclose Confidential Information:

2.1 to their employees, agents or consultants who need to know such information for the purpose of discharging their obligations under this Agreement if they ensure that their employees, agents, or consultants to whom they disclose Confidential Information comply with this Schedule 7 and

2.2 as may be required by law, a court of competent jurisdiction or any governmental or regulatory authority.

3 The Trusts will not use each other's Confidential Information for any purpose other than to comply with this Agreement.

4 The Trusts acknowledge that they are subject to legal duties under the FOIA and EIR which may require them to disclose, on request, information relating to this Agreement and that they are also subject to the Code of Practice on Openness in the NHS (4 August 2003).

5 If a Trust receives a Request for Information (as defined in FOIA) or a request under regulation 5(1) of EIR (each, a Request) about their collaboration arrangements or the BSW Hospitals Group Joint Committee, prior to any disclosure of information to which an exemption to FOIA or EIR (as the case may be) may apply (Potentially Exempt Information) and recognising fully that the decision whether and what to disclose is for the Trust receiving the Request:

5.1 Notify the other Trusts of such Request

5.2 Consider any representations made by the other Trusts in relation to the Request and any possible exemptions and

5.3 Consult with the other Trusts in relation to any proposed disclosure as to whether any further explanatory material or advice should also be disclosed with the information in question.

6 Each Trust agrees that it will promptly inform the other Trusts of any media enquiries which it receives in relation to the collaboration arrangements. The Trusts will work co-operatively to agree a joint response to any media enquiries received in relation to the collaboration arrangements.

Part B: Independent Data Controllers

7 The Trusts shall, and shall procure that any of its staff and its other employees, agents and sub-contractors involved in the processing of Relevant Personal Data under this Agreement ("Personnel") shall, in connection with this Agreement and the transactions

and activities contemplated by it, comply with their obligations under Data Protection Legislation and this Schedule 7.

8 For the purposes of the Data Protection Legislation each Trust shall be an independent Data Controller of any Relevant Personal Data created in connection with the conduct or performance of this Agreement.

9 Each Trust shall implement and maintain appropriate technical and organisational measures (including, but not limited to, [encryption and password protection]), when transferring and/or processing Relevant Personal Data, to preserve the confidentiality, integrity, availability and resilience of Relevant Personal Data and prevent any unlawful processing or disclosure or damage, taking into account the state of the art, the costs of implementation, the nature, scope, context and purposes of processing as well as the risk of varying likelihood and severity for the rights and freedoms of the Data Subjects.

10 Each Trust shall notify the other Trusts without undue delay, and in any event within 48 hours of becoming aware of:

10.1 a Personal Data Breach where the breach has affected or could have affected the Relevant Personal Data;

10.2 a breach of technical and organisational security measures or any Data Protection Legislation where the breach has affected or could have affected the Relevant Personal Data;

10.3 an enquiry from the Information Commissioner's Office about the Relevant Personal Data; or

10.4 a request from a Data Subject exercising any of their rights under Chapter III UK GPDR in respect of the Relevant Personal Data (a "Data Subject Rights Request").

Each Trust agrees to keep the other Trusts regularly updated as to how the handling of such breach, enquiry or request.

11 Each Trust shall provide reasonable assistance to the other Trusts in ensuring compliance with its obligations under the Data Protection Legislation with respect of Personal Data Breach notifications and a Trust shall not make such notification without first consulting the other Trusts wherever possible.

12 Each Trust shall, as soon as reasonably practicable taking into account the nature of the processing provide reasonable assistance to the other Trusts, where that Trust has received:

12.1 a Data Subject Rights Request;

12.2 an enquiry from the Information Commissioner's Office about the Relevant Personal Data;

12.3 a complaint or request relating obligations served under the Data Protection Legislation which relates to the processing of Relevant Personal Data by any Trust; or

12.4 any other communication directly relating to the processing of any Relevant Personal Data created in connection with the conduct or performance of this Agreement in relation to such requests.

Wherever possible, no Trust shall not disclose, release, amend, delete or block any Relevant Personal Data in response to a Data Subject Rights Request or respond to such a request, complaint or communication without first consulting the other Trusts. Each Trust will bear their own costs in complying with their respective obligations under this Schedule 7.

13 Each Trust shall:

13.1 ensure that only those Personnel who need to have access to the Relevant Personal Data are granted such access and only for the purposes of performing their respective obligations under this Agreement;

13.2 take all reasonable steps to ensure the reliability of its Personnel;

13.3 ensure that all Personnel have completed training in Data Protection Legislation and in the care and handling of the Relevant Personal Data;

13.4 ensure that all Personnel are informed of the confidential nature of the Relevant Personal Data and are subject to appropriate contractual obligations of confidentiality; and

13.5 ensure that all Personnel comply with the obligations set out in this Schedule 7.

14 During the term and upon the termination of this Agreement, each Trust shall ensure that all Relevant Personal Data held by it shall be up-to-date and accurate.

15 Where transferring the Relevant Personal Data to the other Trusts or to a third party, each Trust shall:

15.1 ensure that such transfer is compliant with all applicable laws;

15.2 make such transfer in a secure manner; and

15.3 take all reasonable steps, at its own cost, to provide the Relevant Personal Data in a usable and compatible format.

16 Where transferring the Personal Data to a third party, each Trust shall enter into appropriate arrangements with all third parties containing written contractual obligations concerning the Relevant Personal Data (including obligations of confidentiality) which are no less onerous than those imposed by this Schedule 7 and where applicable, compliant with Article 26 or 28 UK GDPR.

17 No Trust shall transfer any Relevant Personal Data outside the UK unless the transferor ensures that:

17.1 the transfer is to a country approved under the applicable Data Protection Legislation as providing adequate protection;

17.2 there are appropriate safeguards in place, such as the Standard Contractual Clauses, pursuant to the applicable Data Protection Legislation; or

17.3 one of the derogations for specific situations in the applicable Data Protection Legislation applies to the transfer.

18 Each Trust shall retain Relevant Personal Data in a form which permits identification of Data Subjects for no longer than is necessary for the purposes for which it processes the Personal Data, as per its obligations under the Data Protection Legislation. Each Trust shall securely delete Relevant Personal Data which cannot be lawfully retained in accordance with Data Protection Legislation and good industry practice.

19 In this Schedule 7 the terms "Personal Data", "Processing", "Processor", "Controller", "Personal Data Breach" and "Data Subject" shall have the meanings ascribed to them under Data Protection Legislation, and the terms "Process" "Processes" and "Processed" shall be construed accordingly.

Part C: Joint Controller Status and Allocation of Responsibilities

20 With respect to personal data under Joint Control of the Trusts, as set out in Paragraph Schedule 725 below ("Shared Personal Data"), the Trusts envisage that they shall each be a Data Controller in respect of that Shared Personal Data in accordance with the terms of this Part C of Schedule 7 (Joint Controller Agreement) in replacement of Part B of Schedule 7. Accordingly, the Trusts each undertake to comply with the applicable Data Protection Legislation in respect of their Processing of such Shared Personal Data as Data Controllers.

21 The Trusts agree that the information governance team(s) of each Trust:

21.1 are the exclusive point of contact for Data Subjects and is responsible for using best endeavours to comply with the UK GDPR regarding the exercise by Data Subjects of their rights under the UK GDPR;

21.2 shall direct Data Subjects to the Data Protection Officer(s) or suitable alternative in connection with the exercise of their rights as Data Subjects and for any enquiries concerning their Shared Personal Data or privacy;

21.3 are responsible for the Trusts' compliance with all duties to provide information to Data Subjects under Articles 13 and 14 of the UK GDPR;

21.4 are responsible for ensuring the informed consent of Data Subjects, in accordance with the UK GDPR, for Processing in connection with the Joint Functions where consent is the relevant legal basis for that Processing; and

21.5 shall make available to Data Subjects the essence of this Part C of Schedule 7 (and notify them of any changes to it) concerning the allocation of responsibilities as Joint Controller and its role as exclusive point of contact, the Trusts having used their best endeavours to agree the terms of that essence. This must be outlined relevant privacy policies (which must be readily available by hyperlink or otherwise on all of its public facing services and marketing).

22 Notwithstanding the terms of Paragraph 21, the Trusts acknowledge that a Data Subject has the right to exercise their legal rights under the Data Protection Legislation as against the relevant Trust as Controller.

Undertakings of all Trusts

23 The Trusts each undertake that they shall:

23.1 report to the other Trusts every quarter on:

23.1.1 the volume of Data Subject Access Request (or purported Data Subject Access Requests) from Data Subjects (or third parties on their behalf);

23.1.2 the volume of requests from Data Subjects (or third parties on their behalf) to rectify, block or erase any Shared Personal Data;

23.1.3 any other requests, complaints or communications from Data Subjects (or third parties on their behalf) relating to the other Trusts' obligations under applicable Data Protection Legislation;

23.1.4 any communications from the Information Commissioner or any other regulatory authority in connection with Shared Personal Data; and

23.1.5 any requests from any third-party for disclosure of Shared Personal Data where compliance with such request is required or purported to be required by Law,

that it has received in relation to the exercise of the Joint Functions under this Agreement during that period;

23.2 notify each other immediately if it receives any Data Subject Request, complaint or communication made as referred to in Paragraphs 23.1.1 to 23.1.5. For the avoidance of doubt, this clause 23.2 does not apply to requests, complaints or communications made about the general operations of the Trusts as a whole;

23.3 provide the other Trusts with full cooperation and assistance in relation to any request, complaint or communication made as referred to in Paragraphs 21 and 23.1.1 to 23.1.5 to enable the other Trusts to comply with the relevant timescales set out in the Data Protection Legislation;

23.4 not disclose or transfer the Shared Personal Data to any third-party unless necessary for the provision of the Joint Functions and, for any disclosure or transfer of Shared Personal Data to any third-party, (save where such disclosure or transfer is specifically authorised under this Agreement or is required by Law) that disclosure or transfer of Shared Personal Data is otherwise considered to be lawful processing of that Shared Personal Data in accordance with Article 6 of the UK GDPR. For the avoidance of doubt, the third-party to which Shared Personal Data is transferred must be subject to equivalent obligations which are no less onerous than those set out in this Part C of Schedule 7

23.5 request from the Data Subject only the minimum information necessary to provide the Joint Functions and treat such extracted information as Confidential Information;

23.6 ensure that at all times it has in place appropriate technical and organisational measures to guard against unauthorised or unlawful Processing of the Shared Personal Data and/or accidental loss, destruction or damage to the Shared Personal Data and unauthorised or unlawful disclosure of or access to the Shared Personal Data;

23.7 use best endeavours to ensure the reliability and integrity of any of its Personnel who have access to the Shared Personal Data and ensure that its Personnel:

23.7.1 are aware of and comply with their duties under this Part C of Schedule 7 (Joint Controller Agreement) and those in respect of Confidential Information;

23.7.2 are informed of the confidential nature of the Shared Personal Data, are subject to appropriate obligations of confidentiality and do not publish, disclose or divulge any of the Shared Personal Data to any third-party where that Trust would not be permitted to do so;

23.7.3 have undergone adequate training in the use, care, protection and handling of Shared Personal Data as required by the applicable Data Protection Legislation;

23.8 ensure that it has in place appropriate technical and organisational measures as appropriate to protect against a personal data breach having taken account of the:

23.8.1 nature of the data to be protected;

23.8.2 harm that might result from a personal data breach;

23.8.3 state of technological development; and

23.8.4 cost of implementing any measures;

23.9 ensure that it has the capability (whether technological or otherwise), to the extent required by Data Protection Legislation, to provide or correct or delete at the request of a Data Subject all the Shared Personal Data relating to that Data Subject that the party holds; and

23.10 ensure that it notifies the other Trusts as soon as it becomes aware of a personal data breach.

24 Each Joint Controller shall use best endeavours to assist the other Controllers to comply with any obligations under applicable Data Protection Legislation and shall not perform its obligations under this Part C of Schedule 7 in such a way as to cause the other Joint Controllers to breach any of its obligations under applicable Data Protection Legislation to the extent it is aware, or ought reasonably to have been aware, that the same would be a breach of such obligations.

Shared Personal Data

25 All Trusts shall document and keep a register of types of Shared Personal Data that will be shared between the Trusts during the Term. This register will be coordinated by the Information Governance team(s).

Data Protection Breach

26 Without prejudice to Paragraph 27, each Trust shall notify the other Trusts without undue delay, and in any event within 48 hours, upon becoming aware of any personal

data breach or circumstances that are likely to give rise to a personal data breach, providing the other Trusts and their advisors with:

26.1 sufficient information and in a timescale which allows the other Trusts to meet any obligations to report a personal data breach under the Data Protection Legislation;

26.2 all reasonable assistance, including:

26.2.1 co-operation with the other Trusts and the Information Commissioner investigating the personal data breach and its cause, containing and recovering the compromised Shared Personal Data and compliance with the applicable guidance;

26.2.2 co-operation with the other Trusts including using such best endeavours as are directed by the Trusts to assist in the investigation, mitigation and remediation of a personal data breach;

26.2.3 co-ordination with the other Trusts regarding the management of public relations and public statements relating to the personal data breach; and/or

26.2.4 providing the other Trusts and to the extent instructed by the other Trusts to do so, and/or the Information Commissioner investigating the personal data breach, with complete information relating to the personal data breach, including, without limitation, the information set out in Paragraph 27.

27 Each Trust shall use best endeavours to restore, re-constitute and/or reconstruct any Shared Personal Data where it has lost, damaged, destroyed, altered or corrupted as a result of a personal data breach which is the fault of that Trust as if it was that Trust's own data at its own cost with all possible speed and shall provide the other Trusts with all reasonable assistance in respect of any such personal data breach, including providing the other Trusts, as soon as possible and within 48 hours of the personal data breach relating to the personal data breach, in particular:

27.1 the nature of the personal data breach;

27.2 the nature of Shared Personal Data affected;

27.3 the categories and number of Data Subjects concerned;

27.4 the name and contact details of the joint Data Protection Officer or other relevant contact from whom more information may be obtained;

27.5 measures taken or proposed to be taken to address the personal data breach; and

27.6 describe the likely consequences of the personal data breach.

Impact Assessments

28 The Trusts shall:

28.1 provide all reasonable assistance to each other to prepare any Data Protection Impact Assessment as may be required (including provision of detailed

information and assessments in relation to Processing operations, risks and measures); and

28.2 maintain full and complete records of all Processing carried out in respect of the Shared Personal Data in connection with this Agreement, in accordance with the terms of Article 30 UK GDPR.

Liabilities for Data Protection Breach

29 If financial penalties are imposed by the Information Commissioner on a Trust for a personal data breach ("Financial Penalties") then the following shall occur:

29.1 if in the view of the Information Commissioner, one Trust (Trust A) is responsible for the personal data breach, in that it is caused as a result of the actions or inaction of Trust A, its employees, agents, contractors (other than the other Trust) or systems and procedures controlled by Trust A, then Trust A shall be responsible for the payment of such Financial Penalties. In this case, Trust A will conduct an internal audit and engage at its reasonable cost when necessary, an independent third-party to conduct an audit of any such personal data breach. The other Trusts shall provide to Trust A and its third-party investigators and auditors, on request and at Trust A's reasonable cost, full cooperation and access to conduct a thorough audit of such personal data breach;

29.2 if no view as to responsibility is expressed by the Information Commissioner, then the Trusts shall work together to investigate the relevant personal data breach and allocate responsibility for any Financial Penalties as outlined above, or by agreement to split any financial penalties equally if no responsibility for the personal data breach can be apportioned.

29.3 If a Trust is the defendant in a legal claim brought before a court of competent jurisdiction ("Court") by a third-party in respect of a personal data breach, then unless the Trusts otherwise agree, the Trust that is determined by the final decision of the court to be responsible for the personal data breach shall be liable for the losses arising from such personal data breach. Where one or more Trusts are liable, the liability will be apportioned between the Trusts in accordance with the decision of the Court.

29.4 In respect of any losses, cost claims or expenses incurred by a Trust as a result of a personal data breach (the "Claim Losses"):

29.4.1 if a Trust is responsible for the relevant personal data breach, then that Trust shall be responsible for the Claim Losses;

29.4.2 if responsibility for the relevant personal data breach is unclear, then the Trusts shall be responsible for the Claim Losses equally.

30 Nothing in either Paragraph 28 or Paragraph 29 shall preclude the Trusts reaching any other agreement, including by way of compromise with a third-party complainant or claimant, as to the apportionment of financial responsibility for any Claim Losses as a result of a personal data breach, having regard to all the circumstances of the personal data breach and the legal and financial obligations of the Trusts.

Termination

31 The Trusts acknowledge and confirm that none of them shall be entitled to terminate this Agreement in consequence of any breach, including of this Part C of Schedule 7 in accordance with Clause 19 (Termination).

Sub-Processing

32 In respect of any Processing of Shared Personal Data performed by a third-party on behalf of a Trust, that Trust shall:

32.1 carry out adequate due diligence on such third-party to ensure that it is capable of providing the level of protection for the Shared Personal Data as is required by this Agreement, and provide evidence of such due diligence to the other Trusts where reasonably requested; and

32.2 ensure that a suitable agreement is in place with the third-party as required under applicable Data Protection Legislation.

Data Retention

33 The Trusts agree to erase Shared Personal Data from any computers, storage devices and storage media that are to be retained as soon as practicable after it has ceased to be necessary for them to retain such Shared Personal Data under applicable Data Protection Legislation and their privacy policy (save to the extent (and for the limited period) that such information needs to be retained by the Trust for statutory compliance purposes or as otherwise required by this Agreement), and taking all further actions as may be necessary to ensure its compliance with Data Protection Legislation and its privacy policy.

Part D: Controller to Processor Agreement

Allocation of responsibilities

34 With respect to personal data under Control of one of the Trusts, as set out in Paragraph 37 below ("Personal Data"), the Trusts envisage that for the purpose of the Data Protection Legislation that they shall, at times, each serve as the Controller and the others as the Processors in respect of that Personal Data in accordance with the terms of this Part D of Schedule 7 (Controller to Processer Agreement) in replacement of paragraphs Part B of Schedule 7 (Data Protection).

35 Accordingly, the Trusts each undertake to comply with the applicable Data Protection Legislation in respect of their Processing of such Personal Data in their respective roles as Controller and Processor.

36 The Controller retains control of the Personal Data and remains responsible for its compliance obligations under the Data Protection Legislation, including but not limited to, providing any required notices and obtaining any required consents, and for the written processing instructions it gives to the Processor.

37 A record will be maintained by all Trusts to detail the subject matter, duration, nature and purpose of the processing and the Personal Data categories and Data Subject types in respect of which a Trust will serve as the Processor and may process the Personal Data to fulfil the Joint Functions.

38 The Trusts acknowledge that a Data Subject has the right to exercise their legal rights under the Data Protection Legislation as against the relevant Trust as Controller.

Undertakings of the Trusts

39 The Processor will only process the Personal Data to the extent, and in such a manner, as is necessary for the exercise of the Joint Functions in accordance with the Controller's written instructions. The Processor will not process the Personal Data for any other purpose or in a way that does not comply with this Agreement or the Data Protection Legislation. The Processor must promptly notify the Controller if, in its opinion, the Controller's instructions do not comply with the Data Protection Legislation.

40 The Processor must comply promptly with any Controller written instructions requiring the Processor to amend, transfer, delete or otherwise process the Personal Data, or to stop, mitigate or remedy any unauthorised processing.

41 The Processor will maintain the confidentiality of the Personal Data and will not disclose the Personal Data to third-parties unless the Controller or this Agreement specifically authorises the disclosure, or as required by domestic law, court or regulator (including the Commissioner). If a domestic law, court or regulator (including the Commissioner) requires the Processor to process or disclose the Personal Data to a third-party, the Processor must first inform the Controller of such legal or regulatory requirement and give the Controller an opportunity to object or challenge the requirement, unless the domestic law prohibits the giving of such notice.

42 The Processor will reasonably assist the Controller, at no additional cost to the Controller, with meeting the Controller's compliance obligations under the Data Protection Legislation, taking into account the nature of the Processor's processing and the information available to the Processor, including in relation to Data Subject rights, data protection impact assessments and reporting to and consulting with the Commissioner under the Data Protection Legislation.

43 The Processor (and any subcontractor) must not transfer or otherwise process the Personal Data outside the UK without obtaining the Controller's prior written consent.

44 The Processor may not authorise any third party or subcontractor to process the Personal Data without the agreement of the Controller. The Trusts agree that the Processor will be deemed by them to control legally any Personal Data controlled practically by or in the possession of its subcontractors.

45 The Processor must, at no additional cost to the Controller, take such technical and organisational measures as may be appropriate, and promptly provide such information to the Controller as the Controller may reasonably require, to enable the Controller to comply with:

45.1 the rights of Data Subjects under the Data Protection Legislation, including, but not limited to, subject access rights, the rights to rectify, port and erase personal data, object to the processing and automated processing of personal data, and restrict the processing of personal data; and

45.2 information or assessment notices served on the Controller by the Commissioner under the Data Protection Legislation.

46 The Processor must notify the Controller immediately in writing if it receives any complaint, notice or communication that relates directly or indirectly to the processing of the Personal Data or to either party's compliance with the Data Protection Legislation.

47 The Processor must notify the Controller within 7 days if it receives a request from a Data Subject for access to their Personal Data or to exercise any of their other rights under the Data Protection Legislation.

48 The Processor will give the Controller, at no additional cost to the Controller, its full co-operation and assistance in responding to any complaint, notice, communication or Data Subject request.

49 The Processor must not disclose the Personal Data to any Data Subject or to a third-party other than in accordance with the Controller's written instructions, or as required by domestic law.

50 The Processor must at all times implement appropriate technical and organisational measures against accidental, unauthorised or unlawful processing, access, copying, modification, reproduction, display or distribution of the Personal Data, and against accidental or unlawful loss, destruction, alteration, disclosure or damage of Personal Data.

51 The Processor must implement such measures to ensure a level of security appropriate to the risk involved, including as appropriate:

51.1 the pseudonymisation and encryption of personal data;

51.2 the ability to ensure the ongoing confidentiality, integrity, availability and resilience of processing systems and services;

51.3 the ability to restore the availability and access to personal data in a timely manner in the event of a physical or technical incident; and

51.4 a process for regularly testing, assessing and evaluating the effectiveness of the security measures.

52 The Processor will ensure that all of its employees:

52.1 are informed of the confidential nature of the Personal Data and are bound by written confidentiality obligations and use restrictions in respect of the Personal Data;

52.2 have undertaken training on the Data Protection Legislation and how it relates to their handling of the Personal Data and how it applies to their particular duties; and

52.3 are aware both of the Processor's duties and their personal duties and obligations under the Data Protection Legislation and this Agreement.

Breaches

53 The Processor will within 48 hours and in any event without undue delay notify the Controller in writing if it becomes aware of:

53.1 the loss, unintended destruction or damage, corruption, or unusability of part or all of the Personal Data. The Processor will restore such Personal Data at its own expense as soon as possible.

53.2 any accidental, unauthorised or unlawful processing of the Personal Data; or

53.3 any Personal Data Breach.

54 Where the Processor becomes aware of the matters set out in Paragraph 53 above, it will, without undue delay, also provide the Controller with the following written information:

54.1 description of the nature of the matters set out in Paragraph 53, including the categories of in-scope Personal Data and approximate number of both Data Subjects and the Personal Data records concerned;

54.2 the likely consequences; and

54.3 a description of the measures taken or proposed to be taken to address the matters set out in Paragraph 53, including measures to mitigate its possible adverse effects.

55 Immediately following any accidental, unauthorised or unlawful Personal Data processing or Personal Data Breach, the Trusts will co-ordinate with each other to investigate the matter. Further, the Processor will reasonably co-operate with the Controller at no additional cost to the Controller, in the Controller's handling of the matter, including but not limited to:

55.1 assisting with any investigation;

55.2 providing the Controller with physical access to any facilities and operations affected;

55.3 facilitating interviews with the Processor's employees, former employees and others involved in the matter including, but not limited to, its officers and directors;

55.4 making available all relevant records, logs, files, data reporting and other materials required to comply with all Data Protection Legislation or as otherwise reasonably required by the Controller; and

55.5 taking reasonable and prompt steps to mitigate the effects and to minimise any damage resulting from the Personal Data Breach or accidental, unauthorised or unlawful Personal Data processing.

56 The Processor will not inform any third-party of any accidental, unauthorised or unlawful processing of all or part of the Personal Data and/or a Personal Data Breach without first obtaining the Controller's written consent, except when required to do so by domestic law.

57 The Processor agrees that the Controller has the sole right to determine:

57.1 whether to provide notice of the accidental, unauthorised or unlawful processing and/or the Personal Data Breach to any Data Subjects, the Commissioner, other in-scope regulators, law enforcement agencies or others,

as required by law or regulation or in the Controller's discretion, including the contents and delivery method of the notice; and

57.2 whether to offer any type of remedy to affected Data Subjects, including the nature and extent of such remedy.

58 The Processor will cover all reasonable expenses associated with the performance of the obligations under Paragraphs 53 to 55 unless the matter arose from the Controller's specific written instructions, negligence, wilful default or breach of this Agreement, in which case the Controller will cover all reasonable expenses.

59 The Processor will also reimburse the Controller for actual reasonable expenses that the Controller incurs when responding to an incident of accidental, unauthorised or unlawful processing and/or a Personal Data Breach to the extent that the Processor caused such, including all costs of notice and any remedy as set out in Paragraph 57.

Warranties

60 Each Trust warrants and represents that, in acting as Processor:

60.1 its employees, subcontractors, agents and any other person or persons accessing the Personal Data on its behalf are reliable and trustworthy and have received the required training on the Data Protection Legislation;

60.2 it and anyone operating on its behalf will process the Personal Data in compliance with the Data Protection Legislation and other laws, enactments, regulations, orders, standards and other similar instruments;

60.3 it has no reason to believe that the Data Protection Legislation prevents it from providing any of the Joint Functions; and

60.4 considering the current technology environment and implementation costs, it will take appropriate technical and organisational measures to prevent the accidental, unauthorised or unlawful processing of Personal Data and the loss or damage to, the Personal Data, and ensure a level of security appropriate to:

60.4.1 the harm that might result from such accidental, unauthorised or unlawful processing and loss or damage;

60.4.2 the nature of the Personal Data protected; and

60.4.3 comply with all applicable Data Protection Legislation and its information and security policies.

61 Each Trust warrants and represents that in acting as Controller, the Processor's expected use of the Personal Data for the Joint Functions and as specifically instructed by the Controller will comply with the Data Protection Legislation.

Impact assessment

62 The Trusts shall:

62.1 provide all reasonable assistance to each other to prepare any Data Protection Impact Assessment as may be required (including provision of detailed information and assessments in relation to Processing operations, risks and measures); and

62.2 maintain full and complete records of all Processing carried out in respect of the Personal Data in connection with this Agreement, in accordance with the terms of Article 30 UK GDPR.

Termination

63 The Trusts acknowledge and confirm that none of them shall be entitled to terminate this Agreement in consequence of any breach, including of this Part D of Schedule 7 in accordance with Clause 19 (Termination).

Data retention

64 At the Controller's request, the Processor will give the Controller, or a third-party nominated in writing by the Controller, a copy of or access to all or part of the Personal Data in its possession or control in the format and on the media reasonably specified by the Controller.

65 On termination of this Agreement for any reason, the Processor will securely delete or destroy or, if directed in writing by the Controller, return and not retain, all or any of the Personal Data related to this Agreement in its possession or control, only.

66 If any law, regulation, or government or regulatory body requires the Processor to retain any documents, materials or Personal Data that the Processor would otherwise be required to return or destroy, it will notify the Controller in writing of that retention requirement, giving details of the documents, materials or Personal Data that it must retain, the legal basis for such retention, and establishing a specific timeline for deletion or destruction once the retention requirement ends.

67 The Processor will certify in writing to the Controller that it has deleted or destroyed the Personal Data within 28 days after it completes the deletion or destruction.

Schedule 8 Scheme for Trust Board Appointments

Organisational Development Plan: to develop in Q1 2025-2026

Schedule 9 Recommendations

Recommendations approved by Boards [July/ September 2024].

Report to:	**Public Board of Directors**	**Agenda item:**	**13**
Date of Meeting:	**Wednesday 7 May 2025**		
Title of Report:	**Board Assurance Framework**		
Status:	**Discussion and approval**		
Board Sponsor:	**Christopher Brooks-Daw, Chief of Staff**		
Author:	**Marty McAuley, Corporate Governance and respective Executive Director leads for related risks**		
Appendices	**Appendix 1: Board Assurance Framework**		

1. Executive Summary of the Report

1.1 Board Assurance Framework (BAF):

The BAF is presented to Trust Board today for discussion and approval.

The Board Assurance Framework (BAF) is a live document, subject to update and change. It is also a public document. It should show openly and with transparency the key strategic risks that the organisation faces.

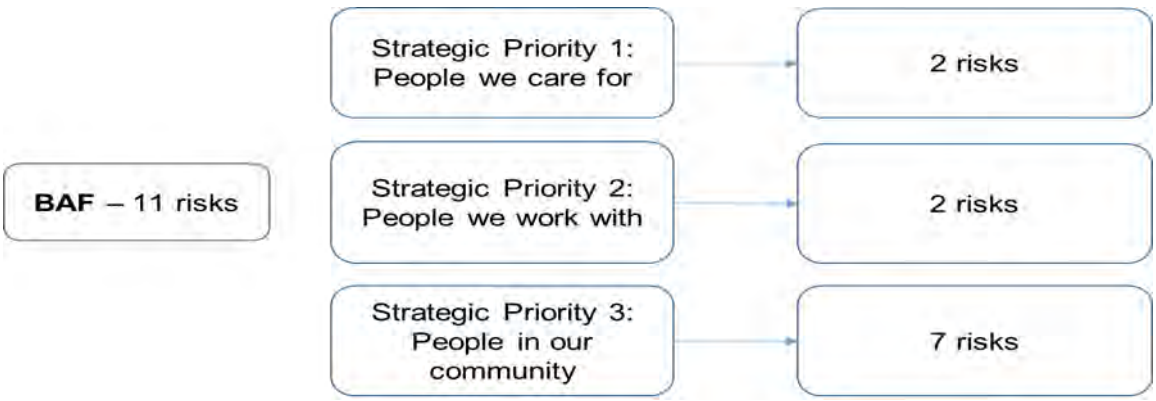
NHS Providers Guide to Good Governance states “The BAF sets out the provider's strategic objectives, the risks to achieving them and the controls and assurance mechanisms that have been put in place to manage risk and deliver the objectives”.

It plays a key role in assuring the Board that risks to the achievement of our strategy are identified, with controls and mitigations noted. As such, a BAF will usually include ≤12 risks.

Due to the nature of risks on a BAF, they will change slowly. This is because they usually need significant actions to develop additional controls and/or mitigations for complex issues. They may also be highly dependent on factors that are outside of the direct control and/or influence of the Trust/Executive Lead.

The BAF should be considered as part of an organisation’s overall risk management framework, with risks on the risk register playing a key role in providing the operational detail of how associated risks are managed on a day-to-day basis.

1.2 Board Assurance Framework – RUH content:



1.3 – Update for Board – May 2025

- Each BAF risk has been reviewed by the Corporate Governance Team and the Executive Lead for each risk. As a result of this review the 11 risks in the BAF presented to Board include:
    - 8 risks that have not been changed
    - 1 risk that has been amended to more accurately reflect the risk
    - 2 risks where management action has meant that the likelihood of the risk occurring has been reduced and therefore the overall risk score.

1.4 Plan for next Board – July 2025

- Further work will continue to refine the risks, ensuring that the description of the risk articulated the actual risk that is being faced.
- Where there are multiple controls listed these will be reduced to the key controls that we know are making a difference.
- We will focus on how assured we are that these controls are effective
- Risk scores will again be evaluated and recommendations made
- Target scores will be agreed for all risks with clear plans on how this will be delivered.
- Risk appetite scores will be reviewed and aligned to current level of risk and actions to address will be provided.
- All Committees will receive risks within their remit for scrutiny and assurance.
- New format and presentation of the BAF to allow easier interpretation and. interrogation. This will focus heavily on the mitigation of risk, the assurance that the controls are working and the overall level of assurance taken.
- Existing assurance reports to the Board from the Committees will be adapted to provide assurance to the Board.

2.	Recommendations (Note, Approve, Discuss)
The Board is asked to approve the Board Assurance Framework.	

3.	Legal / Regulatory Implications
It is best practise the have a Board Assurance Framework in place that provides assurance against the principal risks to the achievement of our Trust Strategy.	

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)
The Board Assurance Framework sets out the principal risks to the achievement of the Trust Strategy. As such, it forms a key part of the wider risk management framework for the Trust.	

5.	Resources Implications (Financial / staffing)
The Board Assurance Framework sets risks related to resources. It also requires significant time and input to ensure that it reflects the position across multiple areas and functions.	

6.	Equality and Diversity
The content of the BAF sets key risks that may impact equality and diversity.	

7.	References to previous reports/Next steps
Board sub-committees routinely receive updates on risks that fall within their areas of responsibility.	

8.	Freedom of Information
Available in public board papers.	

9.	Sustainability
The content of the BAF sets out key risks that may be associated with or impact sustainability.	

10.	Digital
The content of the BAF sets out key risks that may be associated with or impact digital.	

Royal United Hospitals Bath
NHS Foundation Trust
Board Assurance Framework 2025/2026
Board: 7 May 2025

People we care for:

Risk description	Exec Lead	Score	Update since the last Board
1.1 There is a risk that not meeting internally and externally set standards of quality and safety may result in harm to patients and/or experience below expected.	Chief Nursing Officer	15	Risk remains unchanged
1.2 Increasing demand for both emergency and planned care is exceeding our capacity to treat patients promptly, leading to longer wait times for procedures. This could negatively impact patient outcomes and satisfaction.	Chief Operating Officer	16	Risk remains unchanged

People we work with:

Risk description	Exec Lead	Score	Update since the last Board
2.1 Without fostering a culture of inclusion and actively addressing **possible managerial discrimination**, we may hinder staff recruitment and retention, expose the Trust to financial and reputational damage, and undermine our ability to deliver the best possible patient care.	Chief People Officer	16	**Risk amended:** *Possible managerial discrimination* – updated to read *possible discrimination from Managers or Colleagues*.
2.2 Without strong management and leadership development, including succession planning, we risk limiting our ability to transform and innovate, cultivate a positive culture and sustain improvements. This could negatively impact patient care, staff satisfaction, and workforce stability.	Chief People Officer	16	**Risk Reduction:** Development programme has been approved. Risk likelihood to be reduced from 5 to 4. Risk score changed from 20 to 16.

People in our community:

Risk description	Exec Lead	Score	Update since the last Board
3.1 Without delivering the financial plan and ensuring financial accountability across the organisation the Trust may not achieve financial recovery and sustainability, affecting our control to provide safe, appropriate and effective care to our patients.	Chief Finance Officer	16	Risk remains unchanged
3.2 If Sulis Hospital does not deliver its financial target it may have a direct financial impact to RUH financial position	Chief Finance Officer	12	**Risk Reduction:** Sulis has delivered its 2024/25 financial plan. Risk likelihood reduced from 4 to 3 and risk score from 16 to 12.
3.3 Without reducing unwanted variation and addressing inequity of care, people may not receive appropriate levels of care.	Chief Medical Officer	16	Risk remains unchanged
3.4 Our aging estate with increasing backlog maintenance needs could lead to service disruptions, compromised patient safety, failure to meet regulatory requirements in addition to degrading the experience for patients and staff.	Chief Nursing Officer	16	Risk remains unchanged
3.5 Climate change and its accelerating consequences may threaten the health of patients, staff, and the wider community. Failure to achieve net zero goals and adapt to climate-related risks (e.g., overheating, flooding) may jeopardise the Trust's sustainability, its ability to provide care, and its commitment to future generations.	Chief Nursing Officer	15	Risk remains unchanged
3.6 Insufficient digital capabilities may hinder the Trust's potential to enhance patient and staff experiences, optimise efficiency, and improve overall effectiveness and care delivery	Chief Finance Officer	16	Risk remains unchanged
3.7 Cyber-security breaches, caused by deliberate malicious acts or inadvertent actions by staff, could result in an inability to use digital platforms, resulting in loss of services and data across the Trust, and in turn causing risk to patients	Chief Finance Officer	16	Risk remains unchanged

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**14**
Date of Meeting:	**Wednesday 7 May 2025**		

Title of Report:	**Annual Review of Trust Constitution**
Status:	**For approval**
Board Sponsor:	**Cara Charles-Barks, Chief Executive**
Author:	**Roxy Milbourne, Interim Head of Corporate Governance**
Appendices	**Appendix 1: Draft Foundation Trust Constitution 2025 v22**

1. Executive Summary of the Report

As part of a review of the Trust Constitution amendments have been proposed to cover changes since the last review. The proposed key changes reflect:-

- the establishment of Joint Committees/Committees-in-Common
- the revised Health and Care Act 2022
- holding virtual/hybrid meetings
- various 'tidying up' i.e. change of job titles and gender-neutral language.
- Updates to reflect the Fit and Proper Persons (FPPR) regulations.
- Updates to the Board Composition in order to align the Constitution to Great Western Hospitals NHS Foundation Trust and Salisbury NHS Foundation Trust.

For ease of identification of key changes, a summary of the main elements of revision is included within this document. The full constitution is attached as an appendix.

Changes to the Constitution require approval of both the Board of Directors and Council of Governors. The Council of Governors approved this document at their meeting in September 2024.

2. Recommendations (Note, Approve, Discuss)

The Board of Directors and Council of Governors is asked to approve the proposed amendments to the Trust's Constitution.

3. Legal / Regulatory Implications

The Foundation Trust Constitution is the Trust's fundamental governance document

4. Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)

None identified

5. Resources Implications (Financial / staffing)

None identified

6. Equality and Diversity

None identified

7.	References to previous reports
This paper is produced annually provided that potential amendments have been identified.	

8.	Freedom of Information
Public	

9.	Sustainability
N/A	

10.	Digital
N/A	

Royal United Hospitals Bath
NHS Foundation Trust

Constitution – Table of Amendments

Page number	Section	Current version	Amendment	Rationale
4	Preamble	No information regarding group model	Royal United Hospitals Bath NHS Foundation Trust, Salisbury NHS Foundation Trust, and Great Western Hospitals NHS Foundation Trust approved arrangements to establish a group model to support increased joint working and collaboration between the three organisations and wider system, in line with the powers set out in the Health and Care Act 2022 and with approval from NHS England and Bath and North-East Somerset, Swindon and Wiltshire Integrated Care Board (BSW ICB) In line with current legislation all three Trusts remain as individual statutory organisations with individual constitutions. Therefore, for the purposes of this document references to the chief executive will remain singular and not 'joint' or 'group'.	To reference the Trust's move to a group model with GWH and SFT.
5	Interpretation and definitions	Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this	Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this Constitution shall bear the same	To include reference to the Health and Care Act 2022.

Page number	Section	Current version	Amendment	Rationale
		Constitution shall bear the same meaning as in the 2006 Act	meaning as in the 2006 Act as amended by the 2012 Act and the Health and Care Act 2022	
5			**"2022 Act"** means the Health and Care Act 2022	To reference the Health and Care Act 2022.
7			**"Code of Governance for NHS Providers"** means the best practice advice published by NHS England on 27th October 2022, with effect from 1st April 2023.	To reference the latest published best practice advice published by NHS England.
10			**"Integrated Care Partnership"** An Integrated Care Partnership (ICP) is a formal partnership of organisations (commissioners and providers) working together to improve the health and care of the whole population they serve.	To take account of the establishment of the ICP
10			**"Integrated Care System"** In England an Integrated Care System (ICS) us a statutory partnership of organisations who plan, buy and provide health and care services in their geographical area. The organisations involved include the NHS, local authorities,	To take account of the establishment of the ICS

Page number	Section	Current version	Amendment	Rationale
			voluntary and charity groups, and independent care providers	
11			**"NHS England"** The Health and Care Act 2022 has merged "Monitor" and the Trust Development Authority (TDA) into NHS England and removed legal barriers to collaboration and integrated care, making it easier for providers to take on greater responsibility for service planning and putting Integrated Care Systems (ICSs) on a statutory footing.	To take account that Monitor and the Trust Development Authority had been merged into NHS England by the Health and Care Act 2022.
16	Powers		The Trust may arrange for any functions exercisable by it to be exercised by or jointly with any one or more of the bodies set out in section S 65Z5(i) of the 2006 Act. Where such a function is exercisable jointly the bodies may arrange for the functions to be exercised by joint committees as set out in S5 65Z6 of the 2006 Act.	To recognise joint committees and the 2006 Act (revised 2022)
			In exercising its powers, the Trust will have regard to: 4.8.1 S.63B of the 2006 Act (revised 2022) (duty to have regard to the wider effect of discussions), also referred to as the "Triple Aim".	Added as specified in the Health and Care Act 2022

Page number	Section	Current version	Amendment	Rationale
			4.8.2 S.63B of the 2006 Act (revised 2022) (duties in relation to climate change).	
25	Council of Governors – general duties	19A. 1.2 to represent the interests of the Members as a whole and the interests of the public	19A. 1.2 to represent the interest of the Members as a whole and the interest of the public at large	To support collaboration between organisations and the delivery of better, joined-up care, councils of governors are required to form a rounded view of the interests of the 'public at large'. This includes the population of the local system of which the NHS Foundation Trust is part.
26	Board of Directors – composition	20.2 The Board of Directors is to comprise: 20.2.1 a Non-Executive Director Chair; and 20.2.2 up to a maximum of 6 other Non-Executive Directors; and 20.2.3 up to a maximum of 6 Executive Directors.	20.2 The Board of Directors is to comprise: 20.2.1 a Non-Executive Director Chair; and 20.2.2 a minimum of 5 other Non-Executive Directors; and 20.2.3 a minimum of 5 Executive Directors.	Board Composition has been updated and aligns with Great Western Hospitals NHS Foundation Trust and Salisbury NHS Foundation Trust.
26	Board of Directors – composition	20.10.1 any change in the number of Directors is within the range set out in paragraph 20.2 above; and	Remove	No longer required if minimum numbers are documented.
28	Board of Directors – appointment of initial Chair and initial	Remove section 23	Remove	No longer required as the Trust is an established Foundation Trust,

Page number	Section	Current version	Amendment	Rationale
	other Non-Executive Directors			this section was only required for initial appointments.
29	Board of Directors – appointment and removal of initial Chief Executive	**25 Board of Directors – appointment and removal of initial Chief Executive** 25.1 The Non-Executive Directors shall appoint the Chief officer Executive of the Applicant Trust as the initial Chief Executive of the Trust, if he wishes to be appointed. 25.2 The appointment of the chief officer of the Applicant Trust as the initial Chief Executive of the Trust shall not require the approval of the Council of Governors.	**25 Board of Directors – appointment and removal of Chief Executive and other Executive Directors** The Non-Executive Directors shall appoint or remove the Chief Executive. The appointment of the Chief Executive is subject to the approval of a majority of the members of the Council of Governors present and voting at a meeting of the Council of Governors. A committee consisting of the Chair, the Chief Executive and the other Non-Executive Directors shall appoint or remove the other Executive Directors.	Removal of "initial" Chief Executive as the Trust has been a Foundation Trust since 2014. Update to include clarity on the NEDs appointing the CEO and other Directors.
29	24 and 25 (Board and Non-Executive Director appointments)		All appointments must satisfy the requirements of Regulation 5: Fit and Proper Persons: Directors of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014 including all future amendments to the regulation.	Updated to reflect the Fit and Proper Persons (FPPR) regulations.

Page number	Section	Current version	Amendment	Rationale
51	Composition of the Council of Governors	Bath and North East Somerset Integrated Care Partnership may appoint one Partnership Governor by notice in writing signed by the Chief Executive of the Integrated Care Partnership and delivered to the Secretary.	Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board may appoint two Partnership Governor's by notice in writing signed by the Chief Executive of the Integrated Care Board and delivered to the Secretary. One nominee should represent BaNES and the other Wiltshire.	Updated to reflect BSW ICB.
51	Composition of the Council of Governors – partnership Governors	2.2.2.1 University of Bath; 2.2.2.2 University of Bristol; 2.2.2.3 University of the West of England.	2.2.2.1 University of Bath; 2.2.2.2 University of Bristol; 2.2.2.3 University of the West of England. 2.2.2.4 Bath Spa University.	Addition of Bath Spa University to the University Partner Organisations list as the Trust has developed its relationship with the University and is working much closer together.
109	Transitional provisions for the initial Elected Governors	Remove section 5	Remove	No longer required as the Trust is an established Foundation Trust, this section was only required for initial elections.
118	Annex 6 – Standing Orders for the Practice and Procedure of the Council of Governors 4.2 Calling Meetings	4.2.1 Meetings of the Council of Governors shall be held at such times and places as the Council of Governors may determine and there shall be at least four meetings in any year including:	4.2.1 Meetings of the Council of Governors shall be held at such times and places and of such format including in person, by using electronic communication or hybrid as the Council of Governors may determine and there shall be at least four meetings in any year including:	Updated to take account of holding virtual meetings

Page number	Section	Current version	Amendment	Rationale
119	Annex 6 – Standing Orders for the Practice and Procedure of the Council of Governors 4.3 Notice of Meetings and Agenda	4.3.2 Before each meeting of the Council of Governors a public notice of the time and place of the meeting, and if possible the public part of the agenda, shall be displayed at the Trust's Headquarters and shall be advertised on the Trust's website at least 3 Clear Days before the meeting, save in the case of emergencies.	4.3.2 Before each meeting of the Council of Governors a public notice of the time and place of the meeting, and if appropriate remote access/electronic communication arrangements, of the meeting, and if possible the public part of the agenda, shall be displayed at the Trust's Headquarters and shall be advertised on the Trust's website at least 3 Clear Days before the meeting, save in the case of emergencies.	Updated to take account of holding virtual meetings
125/126	Annex 6 – Standing Orders for the Practice and Procedure of the Council of Governors 4.12 Voting	4.12.6 All questions put to the vote shall, at the discretion of the Chair, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Governors present so request. 4.12.9 A Governor may only vote if present at the time of the vote on which the question is to be decided; no Governor may vote by proxy but a Governor is considered to have been present at the meeting if they took part by telephone or video link and so is therefore entitled to vote.	4.12.6 All questions put to the vote shall, at the discretion of the Chair, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Governors present so request. In the event of a meeting held using electronic communication, an electronic voting facility will be made available, including when appropriate, the facility for holding a secret ballot. 4.12.9 A Governor may only vote if present (either in person or by electronic communication) at the time of the vote on which the question is to be decided; no Governor may vote by proxy but a	Updated to take account of holding virtual meetings

Page number	Section	Current version	Amendment	Rationale
			Governor is considered to have been present at the meeting if they took part by telephone or video link and so is therefore entitled to vote.	
143	Annex 7 – Standing Orders of Practice and Procedure of the Board of Directors 13.13 Voting	13.13.2 All questions put to the vote shall, at the discretion of the Chair, be determined by a show of hands. A paper ballot may also be used if a majority of the Directors present so request.	13.13.2 All questions put to the vote shall, at the discretion of the Chair, be determined by a show of hands or by appropriate electronic means. A paper ballot may also be used if a majority of the Directors present so request.	Updated to take account of holding virtual meetings
150	Annex 7 – Standing Orders of Practice and Procedure of the Board of Directors 15.2 Joint Committees		5.2.1 Joint committees may be established by the Trust, by joining together with one or more other trusts, consisting of wholly or partly of the Chair and Directors of the Trust or other health service bodies, or of Directors of the Trust with non-directors of other health bodies in question. 5.2.2 Any Committee-in-Common or Joint Committee established under standing orders may, subject to such directions or guidance as may be given by NHS England or the Trust or any other health bodies in question, appoint sub-committees consisting wholly or partly of directors sitting on the Committee or	Added to reflect the establishment of Joint Committees and Committee-in Common

Page number	Section	Current version	Amendment	Rationale
			Joint Committee (whether or not they are directors of the other health bodies in question) or wholly of persons who are not directors of the other health bodies in question provided that the Trust is always represented by an Executive Director (or deputy nominated by the Executive Director) on such Committees, Joint Committees or sub committees.	
Throughout	Throughout	He/his/him/himself NHSE/I Applicant Trust	They/their/them/themselves NHS England Trust	To update the constitution in terms of gender-neutral language which is inclusive of everyone. Updated name since NHSE/I merged. Updated as no longer an “applicant Trust”

Royal United Hospitals Bath
NHS Foundation Trust

ROYAL UNITED HOSPITALS BATH

NHS FOUNDATION TRUST

(A PUBLIC BENEFIT CORPORATION)

CONSTITUTION

Table of Contents

PREAMBLE

An NHS Foundation Trust is a Public Benefit Corporation which is authorised under the National Health Service Act 2006 to provide goods and services for the purposes of the health service in England. A Public Benefit Corporation is a body corporate which is constituted in accordance with Schedule 7 of the 2006 Act. The Constitution provides, inter alia, for the Foundation Trust to have Members, Governors and Directors, and determines who may be eligible for membership and how Governors and Directors are appointed and defines their respective roles and powers. Further, Members of the Foundation Trust may attend and participate at Members' meetings, vote in elections to, and stand for election for, the Council of Governors, as provided in this Constitution.

Royal United Hospitals Bath NHS Foundation Trust, Salisbury NHS Foundation Trust, and Great Western Hospitals NHS Foundation Trust approved arrangements to establish a group model to support increased joint working and collaboration between the three organisations and wider system, in line with the powers set out in the Health and Care Act 2022 and with approval from NHS England and Bath and North-East Somerset, Swindon and Wiltshire Integrated Care Board (BSW ICB)

In line with current legislation all three Trusts remain as individual statutory organisations with individual constitutions. Therefore, for the purposes of this document references to the chief executive will remain singular and not 'joint' or 'group'.

1. Interpretation and definitions

1.1 Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this Constitution shall bear the same meaning as in the 2006 Act as amended by the 2012 Act and the Health and Social Care Act 2022.~~.~~

~~1.2 Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.~~

~~1.3~~1.2 References in this Constitution to legislation include all amendments, replacements or re-enactments made and include all subordinate legislation made thereunder.

~~1.4~~1.3 Headings are for ease of reference only and are not to affect interpretation.

~~1.5~~1.4 All annexes and appendices referred to in this Constitution form part of it.

~~1.6~~1.5 References to paragraphs are to paragraphs in this Constitution save that where there is a reference to a paragraph in an annex or appendix to this Constitution it shall be a reference to a paragraph in that annex or appendix unless the contrary is expressly stated or the context otherwise so requires.

~~1.7~~1.6 In this Constitution:

"2006 Act"
means the National Health Service Act 2006 (as amended);

"2012 Act"
means the Health and Social Care Act 2012;

"2022 Act"
Means the Health and Social Care Act 2022;

"Accounting Officer"
means the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act;

"Annual Accounts"
means those accounts prepared by the Trust pursuant to paragraph 25 of Schedule 7 to the 2006 Act;

"Annual Governors' Meeting"
has the meaning ascribed to it in paragraph 3.1 of Appendix 2 of Annex 5 of the Constitution;

"Annual Members' Meeting"
has the meaning ascribed to it in paragraph 40.1 of this Constitution;

"Annual Report"

means a report prepared by the Trust pursuant to paragraph 26 of Schedule 7 to the 2006 Act;

~~**"Applicant Trust"**~~
~~means the Royal United Hospital, Bath NHS Trust, established pursuant to the Royal United Hospital, Bath National Health Service Trust (Establishment) Order 1991, SI 1991/2392, which has made the application to become the Trust;~~

"Appointed Governors"
means a Local Authority Governor, or a Partnership Governor;

"Area of the Trust"
means the area, consisting of all the areas, specified in column 2 of Annex 1 of this Constitution, as an area for a Public Constituency;

"Audit and Risk Committee"
means a committee of the Board of Directors as established pursuant to paragraph 36 of this Constitution;

"Auditor"
means the auditor of the Trust appointed by the Council of Governors pursuant to paragraph 35 of this Constitution;

"Authorisation"
means the authorisation issued to the Trust by Monitor under Section 35 of the 2006 Act;

"Bath and North East Somerset Council"
means the local authority of that name established pursuant to the Local Government Act 1972 (as amended) of the Guildhall, High St, Bath, BA1 5AW;

"Board of Directors"
means the Board of Directors of the Trust as constituted in accordance with this Constitution;

"Chair"
means the person appointed in accordance with the Constitution to ensure that the Board of Directors and Council of Governors successfully discharge their overall responsibilities for the Trust as a whole. The expression "the Chair" shall be deemed to include the Vice Chair or any other Non-Executive Director appointed if the Chair and/or Vice Chair is absent from the meeting or is otherwise unavailable;

"Chief Executive"
means the Chief Executive of the Trust;

"Clear Day"
means a day of the week not including a Saturday, Sunday or public holiday;

"Code of Governance for NHS Providers"
means the best practice advice published by NHS England on 27 October 2022, with effect from 1 April 2023;

"Comptroller and Auditor General"
means the individual engaged in the position of Comptroller and Auditor General to the National Audit Office (UK government department) or its statutory successor from time to time;

"Constitution"
means this Constitution together with the annexes and appendices attached hereto;

"Council of Governors"
means the Council of Governors as constituted in this Constitution;

"Deputy Chief Executive"
means an Executive Director appointed pursuant to paragraph 25.5 of this Constitution;

"Director"
means a member of the Board of Directors;

"Directors' Code of Conduct"
means the Code of Conduct for Directors of the Trust, as adopted by the ~~Applicant~~ Trust and as amended from time to time by the Board of Directors, which all Directors must subscribe to;

"Disclosure and Barring Service"
Means the body corporate to whom the Secretary of State has delegated ~~his~~ their functions under Part V of the Police Act 1997 in relation to applications for criminal record certificates and enhanced criminal record certificates as established by section 87(1) of the Protection of Freedoms Act 2012;

"Electronic Communication"
has the meaning ascribed to it in Section 1168 of the Companies Act 2006 and the phrase "electronically" (where the context permits) shall be construed accordingly;

"Elected Governor"
means a Public Governor or a Staff Governor;

"Executive Director"
means an executive member of the Board of Directors of the Trust;

"Finance Director"
means the Finance Director of the Trust;

"Financial Year"
means:
(a) a period beginning with the date on which the Trust is authorised as an NHS foundation trust and ending with the next 31 March; and
(b) each successive period of twelve months beginning with 1 April;

"Forward Plan"
means the document prepared by the Trust pursuant to paragraph 27 of Schedule 7 to the 2006 Act;

"Funds held on Trust"
means those funds which the Trust holds at the date of Authorisation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under Section 47(2)(c) of the 2006 Act. Such funds may or may not be charitable;

"Governor"
means a member of the Council of Governors;

"Governors' Code of Conduct"
means the Code of Conduct for Governors of the Trust, as adopted by the ~~Applicant~~ Trust and as amended from time to time by the Board of Directors, which all Governors must subscribe to;

"Health Overview and Scrutiny Committee"
means a local authority overview and scrutiny committee established pursuant to Section 21 of the Local Government Act 2000;

"Health Service Body"
means an NHS Trustor an NHS Foundation Trust.

"Immediate Family Member"
means either a:

(a) spouse;
(b) person whose status is that of "Civil Partner" as defined in the Civil Partnerships Act 2004;
(c) child, step child or adopted child; or
(d) parent;

~~**"Initial Elected Governors"**~~
~~means those Elected Governors who are elected under the transitional provisions set out in paragraph 5 of Appendix 2 of Annex 5 as Governors at the Initial Elections;~~

~~**"Initial Elections"**~~
~~means the first elections held by the Applicant Trust pursuant to this Constitution, which for the avoidance of doubt includes an election held pursuant to the powers contained in Section 33(4) of the 2006 Act;~~

"Integrated Care Partnership"
An Integrated Care Partnership (ICP) is a formal partnership of organisations (commissioners and providers) working together to improve the health and care of the whole population they serve.

"Integrated Care System"
In England an Integrated Care System (ICS) us a statutory partnership of organisations who plan, buy and provide health and care services in their geographical area. The organisations involved include the NHS, local authorities, voluntary and charity groups, and independent care providers

"Licence"
means the licence granted to the Trust under Section 81 of the 2012 Act;

"Local Authority Governor"
means a member of the Council of Governors appointed by one or more local authorities whose area includes the whole or part of the Area of the Trust;

"Local Authority Partnership Agreement"
means an agreement made under Section 75 of the 2006 Act;

"Member"
means a Member of the Trust and the term "membership" shall be construed accordingly;

"Membership Strategy"
means the document describing the Trust's strategy to set up systems and processes to establish, maintain and develop an active membership;

"Mendip District Council"
means the local authority of that name whose offices are located at Cannards Grave Road, Shepton Mallet, Somerset, BA4 5BT;

"Model Rules for Elections"
means the election rules set out in Annex 4 of this Constitution;

~~**"Monitor"**~~
~~means the corporate body known as Monitor as provided by Section 61 of the 2012 Act, which from 1 April 2016 is part of NHSEI;~~

"NHS Constitution"
means the document of that name published by the Secretary of State for Health on 21 January 2009, or any revised version of that document published under Sections 3 or 4 of the Health Act 2009;

"NHS Foundation Trust Code of Governance"
means the best practice advice published in July 2014, and as may be amended, varied or replaced by NHS England~~I~~ from time to time;

"NHS England"
The Health and Care Act 2022 has merged "Monitor" and the Trust Development Authority (TDA) into NHS England and removed legal barriers to collaboration and integrated care, making it easier for providers to take on greater responsibility for service planning and putting Integrated Care Systems (ICSs) on a statutory footing.

~~**"NHS EnglandI "**~~
~~Means the body corporate known as NHS EnglandI, which became part of NHS England in July 2022;~~

"Nominated Officer"
means an Officer charged with the responsibility for discharging specific tasks within the SOs, the SFIs, or the Scheme of Delegation;

"Non-Executive Director"
means a non-executive member of the Board of Directors of the Trust including the Chair;

"Officer"
means an employee of the Trust or any other person holding a paid appointment or office with the Trust;

"Partnership Governor"
means a member of the Council of Governors other than: a Public Governor; Staff Governor; or Local Authority Governor;

"Partnership Organisation"
means an organisation that may appoint Partnership Governors and which is listed at paragraph 1.3 of Annex 3 of this Constitution;

"Principal Purpose"
means the purpose set out in Section 43(1) of the 2006 Act;

"Public Constituency"
has the meaning ascribed to it in paragraph 8.2 of this Constitution;

"Public Governor"
means a member of the Council of Governors elected by the members of one of the Public Constituencies;

"Registered Dentist"
means a fully registered person within the meaning of the Dentists Act 1984 who holds a license to practice under that Act;

"Registered Medical Practitioner"
means a fully registered person within the meaning of the Medicines Act 1983 who holds a license to practice under that Act;

"Registered Midwife"
means a fully registered person within the meaning of the Nurse and Midwifery Order 2001 (SI 2001/253);

"Registered Nurse"
means a fully registered person within the meaning of the Nurse and Midwifery Order 2001 (SI 2001/253);

"Regulatory Framework"
means the 2006 Act, the Constitution and the Licence;

"Replacement Governor"
has the meaning ascribed to it in paragraph 2.2 of Appendix 2 of Annex 5 of this Constitution;

"RNHRD"
Means the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust ;

"RNHRD Acquisition"
Means the grant of acquisition pursuant to S56A of the 2006 Act to authorise the acquisition of the RNHRD by the Trust

"Scheme of Delegation"
means the Trust's Reservation of Powers to the Board of Directors and Delegation of Powers;

"Secretary"
means the Secretary of the Board of Directors and the Council of Governors or any other person appointed by the Trust to perform the roles and responsibilities as set out in Appendix 5 of Annex 8 of this Constitution;

"Sex Offenders Order"
means either:

(a) a Sexual Offences Prevention Order made under either Section 104 or Section 105 of the Sexual Offences Act 2003; or

(b) an Interim Sexual Offences Prevention Order made under Section 109 of the Sexual Offences Act 2003; or

(c) a Foreign Travel Order made under Section 114 of the Sexual Offences Act 2003; or

(d) Risk of Sexual Harm Order made under Section 123 of the Sexual Offences Act 2003; or

(e) an Interim Risk of Sexual Harm Order made under Section 126 of the Sexual Offences Act 2003;

"Sex Offenders Register"
means the notification requirements set out in Part 2 of the Sexual Offences Act 2003, commonly known as the "Sex Offenders Register";

"SFIs"
means the Trust's Standing Financial Instructions, which regulate the conduct of Directors and Nominated Officers in relation to all financial matters with which they are concerned;

"Significant Transaction"
has the meaning ascribed to it in Annex 9;

"Staff Constituency"
has the meaning ascribed to it in paragraph 9.2 of this Constitution;

"Staff Governor"
means a member of the Council of Governors elected by the members of the Staff Constituency;

"Standing Orders for the Board of Directors" or "SOs"
means the Standing Orders set out in Annex 7 of this Constitution and the term "SO" when used in Annex 7 shall be construed accordingly;

"Standing Orders for the Council of Governors" or "SOs"
means the Standing Orders set out in Annex 6 of this Constitution and the term "SO" when used in Annex 6 shall be construed accordingly;

"Trust"
means the Royal United Hospitals Bath NHS Foundation Trust;

"Trust Headquarters"
means the Royal United Hospital, Combe Park, Bath BA1 3NG;

"University of Bath"
means the chartered corporation of that name established by Royal Charter in 1966 of University of Bath, Bath, BA2 7AY;

"University of Bristol"
means the chartered corporation of that name established by Royal Charter in 1909 of University of Bristol, Senate House, Tyndall Avenue, Bristol, BS8 1TH;

"University of the West of England"
means the higher education corporation of that name established under the Education Reform Act 1988 of University of the West of England, Coldharbour Lane, Bristol, BS16 1QY;

"Voluntary Organisation"
means a body other than a public or local authority, the activities of which are not carried on for profit;

"Volunteer"
means a person who provides goods or services to the Trust, but who is not employed to do so by the Trust;

"Vice Chair"
means the Vice Chair of the Trust appointed pursuant to paragraph 24 of this Constitution; and

"Wiltshire Council"
means the local authority of that name established pursuant to the Local Government Act 1972 (as amended) of County Hall, Bythesea Road, Trowbridge, Wiltshire BA14 8JN.

2. Name

2.1 The name of the Trust is to be "Royal United Hospitals Bath NHS Foundation Trust".

2.2 Pursuant to the RNHRD ~~Acquisition made~~Acquisition made on 28 January 2015 the Trust is the successor body to the Royal National Hospital for Rheumatic Diseases NHS Foundation Trust

3. Principal Purpose

3.1 The Principal Purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

3.2 The Trust may provide goods and services for any purposes related to:

3.2.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness; and

3.2.2 the promotion and protection of public health.

3.3 The Trust may also carry on activities other than those mentioned in paragraph 3.2 above for the purpose of making additional income available in order to better carry on its Principal Purpose.

3.4 The Trust does not fulfil its Principal Purpose unless, in each Financial Year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

4. Powers and functions

4.1 The Trust is to have all the powers of an NHS foundation trust set out in the 2006 Act.

4.2 In the exercise of its powers, the Trust shall have regard to the principles of the NHS and the values of the Trust as set out in Appendix 1 of Annex 8.

4.3 All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

4.4 Subject to any restriction contained in this Constitution or in the 2006 Act and to paragraph 4.5 below, any of these powers may be delegated to a committee of Directors or to an Executive Director.

4.5 Where the Trust is exercising functions of the managers pursuant to Section 23 of the Mental Health Act 1983 (as amended), those functions may be exercised by any three or more persons authorised by the Board of Directors, each of whom must be neither an Executive Director of the Trust, nor an employee of the Trust.

4.6 In performing its NHS functions the Trust shall have regard to the NHS Constitution. For the purposes of this paragraph "NHS functions" means functions under an enactment which is a function concerned with, or connected to, the provision, commissioning or regulation of NHS services and "NHS services" means health services provided in England for the purposes of the health service under Section 1(1) of the 2006 Act.

4.7 ~~.~~The Trust may arrange for any functions exercisable by it to be exercised by or jointly with any one or more of the bodies set out in section S 65Z5(i) of the 2006 Act. Where such a function is exercisable jointly the bodies may arrange for the functions to be exercised by joint committees as set out in S5 65Z6 of the 2006 Act.

4.8 In exercising its powers, the Trust will have regard to:

4.8.1 S.63A of the 2006 Act (revised 2022) (duty to have regard to wider effect of decisions), also referred to as the "Triple Aim"~~.~~

~~4.6~~ 4.8.2 S63B of the 2006 Act (revised 2022) (duties in relation to climate change).

5. Other purposes

5.1 The purpose of the Trust is to provide goods and services, including education, training and research and other facilities for purposes related to the provision of health care, in accordance with its statutory duties.

5.2 The Trust may carry out research in connection with the provision of health care and make facilities and staff available for the purposes of education, training or research carried on by others.

5.3 The Trust may fulfil the social care functions of any local authority as specified by an agreement made under Section 75 of the 2006 Act.

5.4 The Trust may also undertake activities other than those mentioned in paragraphs 5.1 to 5.3 above. These activities must be for the purpose of making additional income available in order to better carry out the Trust's Principal Purpose.

6. Membership and constituencies

The Trust shall have Members, each of whom shall be a Member of one of the following constituencies:

6.1 a Public Constituency; or

6.2 the Staff Constituency.

7. Application for membership

7.1 Subject to paragraphs 8.6, 9.5 and 9.7 below, an individual who is eligible to become a Member of the Trust may do so on application to the Trust as set out in paragraphs 8 and 9 below.

7.2 Subject to paragraphs 8.6, 9.5 and 9.7 below, applicants for membership of the Trust must complete an application in the form prescribed by the Secretary or ~~his~~ their delegated Officer.

8. Public Constituency

8.1 Subject to the provisions of paragraph 10 below and paragraphs 1 to 3 of Appendix 2 to Annex 8, an individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a Member of the Trust.

8.2 Those individuals who live in an area specified for a public constituency are referred to collectively as the "Public Constituency".

8.3 The minimum number of Members in each Public Constituency is specified in Annex 1.

8.4 An eligible individual shall become a Member upon entry to the Trust's register of Members pursuant to an application by them. The Secretary may require any individual to supply supporting evidence to confirm eligibility.

8.5 The Secretary shall, normally within 21 days of receipt of an application for membership, and subject to being satisfied that the applicant is eligible, cause the applicant's name to be entered in the Trust's register of Members.

Members of the RNHRD public or patient constituency, provided that they are eligible to be a member of a public constituency of the Trust were invited to become a member of the Trust. RNHRD members who accepted the Trust's invitation to become members of the Trust were assigned to the relevant public constituency of the Trust by the Secretary.

9. Staff Constituency

9.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a Member of the Trust provided:

9.1.1 ~~he is~~they are employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

9.1.2 ~~he has~~they have been continuously employed by the Trust under a contract of employment for at least 12 months.

9.2 Those individuals who are eligible for membership of the Trust by reason of the provisions of paragraph 9.1 above are referred to collectively as the "Staff Constituency".

9.3 The minimum number of Members of the Staff Constituency is specified in Annex 2.

9.4 For the purposes of paragraph 9.1 above, Chapter 1 of Part 14 of the Employment Rights Act 1996 shall apply for the purposes of determining whether an individual has been continuously employed by the Trust or has continuously exercised functions for the purposes of the Trust, as it applies for the purposes of that Act.

9.5 An individual who is eligible to become a member of the Staff Constituency under paragraph 9.1 above and who is invited by the Trust to become a member of the

Staff Constituency, shall become a Member of the Trust as a member of the Staff Constituency without an application being made unless ~~he~~ they informs the Trust, that ~~he~~ they does not wish to do so.

9.6 Any individual who is eligible to become a member of the Staff Constituency under paragraph 9.1 above shall become a member upon entry to the Trust's register of Members.

9.7 With effect from the date of the RNHRD Acquisition, any member of the RNHRD staff shall, provided that they are eligible to be a member of the staff constituency of the Trust, be deemed to be a member of the Trust. The Secretary shall cause the name of the individual to be entered in the Trust's register of Members.

10. Restriction on membership

10.1 An individual, who is a member of a constituency, or of a class within a constituency, may not while membership of that constituency or class continues, be a member of any other constituency or class.

10.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.

10.3 All membership is individual and there shall be no facility for corporate membership.

10.4 Save as for provided for under paragraph 18.1 below and paragraph 1 of Appendix 2 to Annex 5 of this Constitution, Members are not entitled to receive payments or dividends from the Trust and no Member is entitled to preferential receipt of any goods or services provided by the Trust.

10.5 Save as provided for in this Constitution, no Member may represent ~~himself~~themselves, in writing or verbally, as belonging to any category of membership of the Trust:

10.5.1 in a manner which might associate the Trust with the personal opinions expressed by the Member in question;

10.5.2 where this might be misconstrued as a title unless it applies to a factual statement of any type of membership of the Trust in books of reference or in a curriculum vitae; and

10.5.3 save for members of the Staff Constituency, and subject to the provisions of paragraph 32.2.3 below, no Member shall designate the Trust as his personal or professional postal address in any published work or any communication to the media.

10.6 Further provisions as to the circumstances in which an individual may not become or continue as a Member of the Trust are set out in Appendix 2 of Annex 8.

11. Council of Governors – composition

11.1 The Trust is to have a Council of Governors, which shall comprise both Elected Governors and Appointed Governors.

11.2 The composition of the Council of Governors is specified in Annex 3.

11.3 The members of the Council of Governors, other than the Appointed Governors, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency.

11.4 The number of Governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 3.

12. Council of Governors – election of Governors

12.1 Elections for Elected Governors shall be conducted in accordance with the Model Rules for Elections, as may be varied from time to time, and as are attached at Annex 4. Elections for Elected Governors shall be conducted using the first past the post system. Thus, where appropriate, the alternative rules marked "FPP" (First Past the Post) should be used.

12.2 The Model Rules for Elections, as published from time to time by the Department of Health or the Foundation Trust Network form part of this Constitution.

12.3 A subsequent variation of the Model Rules for Elections by the Department of Health or the Foundation Trust Network shall not constitute an amendment of the terms of this Constitution for the purposes of paragraph 44 of the Constitution.

12.4 An election, if contested, shall be by secret ballot.

12.5 A person may not vote at an election for or stand for election as an Elected Governor unless within the specified period stated in the Model Rules for Elections ~~he~~ they have~~has~~ made a declaration in the forms specified in paragraphs 6.1 and/or 6.2 (as appropriate) of Appendix 2 of Annex 5 of this Constitution. It is an offence (other than in relation to the Staff Constituency) to knowingly or recklessly make such a declaration which is false in a material particular.

13. Council of Governors - tenure

13.1 Elected Governors

13.1.1 Subject to the provisions of paragraph 13.2 below, an Elected Governor may hold office for a period of up to 3 years.

13.1.2 An Elected Governor shall cease to hold office if ~~he~~ they ceases~~s~~ to be a member of the constituency or class by which they were~~he was~~ elected.

13.1.3 Subject to paragraph 13.1.4 below, an Elected Governor shall be eligible for re-election at the end of ~~his~~ their term.

13.1.4 An Elected Governor may hold office for a maximum of 9 years.

~~13.2 The transitional provisions of paragraph 5 of Appendix 2 of Annex 5 relating to the Initial Elections shall apply in relation to the Initial Elected Governors.~~

~~13.3~~13.2 **Appointed Governors**

~~13.3.1~~13.2.1 An Appointed Governor may hold office for a period of up to 3 years.

~~13.3.2~~13.2.2 An Appointed Governor shall cease to hold office if the relevant sponsoring organisation withdraws its sponsorship of ~~him~~ them by notice in writing to the Secretary.

~~13.3.3~~13.2.3 An Appointed Governor shall cease to hold office if ~~he~~ they cease~~s~~ to be employed by or associated with the relevant sponsoring organisation.

~~13.3.4~~13.2.4 Subject to paragraph 13.3.5 below, an Appointed Governor shall be eligible for re-appointment at the end of ~~his~~ their term.

~~13.3.5~~13.2.5 An Appointed Governor may hold office for a maximum of 9 years.

~~13.4~~13.3 For the purposes of the tenure provisions set out in paragraphs 13.1, 13.2 and 13.3 above, a "year" means a period of 12 consecutive months commencing immediately on the date of Authorisation and each successive period of 12 months thereafter.

~~13.5~~13.4 The appointment of Appointed Governors is subject to the veto provisions, in relation to partnership governors, contained in paragraph 2.2.5 of Annex 3.

14. Council of Governors – disqualification and removal

14.1 The following may not become or continue as a member of the Council of Governors:

14.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

14.1.2 a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);

14.1.3 a person who has made a composition or arrangement with, or granted a trust deed for, ~~his~~ their creditors and has not been discharged in respect of it;

14.1.4 a person who within the preceding five years has been convicted of any offence anywhere in the world and a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on ~~him~~them;

14.2 Governors must be at least 16 years of age at the date they are nominated for election or appointment.

14.3 A Governor may resign from that office at any time during the term of that office by giving notice in writing to the Secretary.

14.4 Subject to paragraph 14.5 below, if a Governor fails to attend 2 consecutive meetings of the Council of Governors in any Financial Year, ~~his~~ their tenure of office is to be terminated immediately unless the Council of Governors is satisfied by a 75% majority of those members of the Council of Governors present and voting at a meeting of the Council of Governors that:

14.4.1 the absence was due to a reasonable cause; and

14.4.2 ~~he~~ they will be able to start attending meetings of the Council of Governors again within such a period as the other Governors consider reasonable.

14.5 Notwithstanding the provisions of paragraph 14.4 above, if a Governor fails to attend 2 out of 3 consecutive meetings of the Council of Governors and ~~he has~~they have previously been the subject of a decision in ~~his~~ their favour under paragraph 14.4 above, that Governor's tenure of office is to be terminated immediately.

14.6 If a Governor is considered to have acted in a manner inconsistent with:

14.6.1 the principles of the NHS and/or the values of the Trust, as set out in Appendix 1 of Annex 8, or in a manner detrimental to the interests of the Trust; or

14.6.2 the Standing Orders for the Council of Governors; or

14.6.3 the Governor's Code of Conduct; or

~~14.6.4~~ ~~he has~~they have failed to declare an interest as required by this Constitution or the Standing Orders for the Council of Governors, or ~~he~~ they ha~~s~~ves spoken or voted at a meeting on a matter in which ~~he has~~they have an interest contrary to this Constitution or the Standing Orders for the Council of Governors, and in this paragraph "interest" includes a pecuniary and a non-pecuniary interest and in either case whether direct or indirect, and

~~he is~~they are adjudged to have so acted by a majority of not less than two-thirds of the members of the Council of Governors present and voting at a meeting of the Council of Governors then the Governor shall vacate ~~his~~ their office immediately.

14.7 The Standing Orders for the Council of Governors shall provide for the process to be adopted in cases relating to the termination of a Governor's tenure.

14.8 A Governor who resigns from that office under paragraph 14.3 above, or whose office is terminated under paragraphs 14.5 or 14.6 above, shall not be eligible to stand for re-election or re-appointment to the Council of Governors for a period of 3 years from the date of ~~his~~ their resignation or removal from office or the date upon which any appeal against ~~his~~ their removal from office is disposed of, whichever is later.

14.9 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors are set out in Appendix 1 of Annex 5.

15. Council of Governors – meetings of Governors

15.1 The Chair of the Trust (i.e. the Chair of the Board of Directors, appointed in accordance with the provisions of paragraph 22.1 or 23.1 below) or, in ~~his~~ their absence, the Vice Chair (appointed in accordance with the provisions of paragraph 24 below), shall preside at meetings of the Council of Governors and the person chairing the meeting shall have a casting vote.

15.2 Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons by resolution of the Council of Governors on the grounds that the Council of Governors considers that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of the business or the proceedings.

15.3 For the purpose of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the Trust's or Directors' performance), the Council of Governors may require one more of the Directors to attend a meeting of the Council of Governors.

16. Council of Governors – standing orders

The Standing Orders for the Council of Governors are attached at Annex 6.

17. Council of Governors - conflicts of interest of Governors

17.1 If a Governor has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the Governor must declare the nature and extent of that interest to the other Governors before the Trust enters into the transaction or arrangement.

17.2 If a declaration under paragraph 17.1 above proves to be, or becomes, inaccurate or incomplete, the Governor must make a further declaration before the Trust enters into the transaction or arrangement.

17.3 This paragraph 17.3 does not require a declaration of an interest of which the Governor is not aware or where the Governor is not aware of the transaction or arrangement in question.

17.4 A Governor need not declare an interest:

17.4.1 if, it cannot reasonably be regarded as likely to give rise to a conflict of interest;

17.4.2 if, or to the extent that, the Governors are already aware of it.

17.5 The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a Governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

18. Council of Governors – travel, remuneration and other expenses

18.1 Governors are not to receive remuneration from the Trust, provided that this shall not prevent the remuneration of Governors by their employer.

18.2 Subject to any Trust policy on the payment of expenses, the Trust may pay travelling and other costs and expenses to members of the Council of Governors at such rates as the Board of Directors decides from time to time in its absolute discretion.

19. Council of Governors – further provisions

Further provisions with respect to the Council of Governors are set out in Annex 5. These include:

19.1 Eligibility to be on the Council of Governors;

19.2 Remuneration;

19.3 Vacancies;

19.4 Meetings;

~~19.5 Transitional provisions for the Initial Elected Governors;~~

~~19.6~~19.5 Committees, sub-committees and joint committees; and

~~19.7~~19.6 Council of Governors: declarations.

19A Council of Governors – general duties

19A.1 The general duties of the Council of Governors are:

19A.1.1 to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors; and

19A.1.2 to represent the interests of the Members as a whole and the interests of the public at large.~~.~~

19B Council of Governors – skills and knowledge

The Trust must take steps to secure that the Governors are equipped with the skills and knowledge they require in their capacity as such.

19C Council of Governors – referral to the panel

19C.1 Subject to paragraph 19C.2 below, a Governor of the Trust may refer to the Panel a question as to whether the Trust has failed or is failing to act in accordance with:

19C.1.1 this Constitution; or

19C.1.2 the provisions made by or under Chapter 5 of Part 2 of the 2006 Act.

19C.2 A Governor may refer a question to the Panel only if more than half of the members of the Council of Governors present and voting at a meeting of the Council of Governors approve the referral.

19C.3 In this paragraph 19C, the "Panel" means a panel of persons appointed by ~~NHSEI~~ NHS England to which a governor of an NHS foundation trust may refer a question as to whether the trust has failed or is failing to act in accordance with its Constitution, or to act in accordance with provision made by or under Chapter 5 of the 2006 Act.

20. Board of Directors – composition

20.1 The Trust is to have a Board of Directors, which shall comprise both Executive Directors and Non-Executive Directors.

20.2 The Board of Directors is to comprise:

20.2.1 a Non-Executive Director Chair; and

20.2.2 up to a mi~~nax~~imum of 5~~6~~ other Non-Executive Directors; and

20.2.3 up to a ma~~in~~x~~i~~mum of ~~6~~5 Executive Directors.

20.3 One of the Executive Directors shall be the Chief Executive.

20.4 The Chief Executive shall be the Accounting Officer.

20.5 One of the Executive Directors shall be the ~~Finance Director~~Chief Finance Officer.

20.6 One of the Executive Directors is to be a Registered Medical Practitioner or a Registered Dentist.

20.7 One of the Executive Directors is to be a Registered Nurse or a Registered Midwife.

20.8 There shall be a majority of Non-Executive Directors (including the Chair). In the event that the number of Non-Executive Directors (including the Chair) is equal to the number of voting Executive Directors, the Chair (and in ~~his~~ their absence, the Vice Chair), shall have a casting vote at meetings of the Board of Directors in accordance with the Standing Orders for the Board of Directors.

20.9 The validity of any act of the Trust is not affected by any vacancy among the Directors or by any defect in the appointment of any Director.

~~20.10 Subject to the provisions of paragraphs 20.3 to 20.7 above, the Board of Directors shall determine any change in the number of Directors, provided that:~~

~~20.10.1 any change in the number of Directors is within the range set out in paragraph 20.2 above; and~~

~~20.10.2 there shall be a majority of Non-Executive Directors (including the Chair).~~

~~20.11~~20.10 Additional Executive Directors may be appointed to the Board of Directors from time to time ~~(exceeding the total of 6 referred to in section 20.2.3)~~. These individuals are officers of the Trust appointed in accordance with the Constitution, entitled to full participation in the work of the Board of Directors with the exception of formal voting rights.

21. Board of Directors – qualification for appointment as a Non-Executive Director

Subject to the provisions of paragraph 23.3 below, a person may be appointed as a Non-Executive Director only if:

21.1 ~~he is~~they are a member of the Public Constituency; and

21.2 ~~he is~~they are not disqualified by virtue of paragraphs 2~~6~~7.1 or 2~~7~~6.2 below.

22. Board of Directors – appointment, suspension and removal of Chair and other Non-Executive Directors

22.1 ~~Subject to paragraph 22.2 below and the provisions of paragraph 2 of Appendix 3 of Annex 8~~, ~~t~~The Council of Governors at a general meeting of the Council of Governors shall appoint, suspend (in a case where there may be grounds to remove) or remove the Chair and the other Non-Executive Directors.

22.2 During any general meeting of the Council of Governors at which the Chair may be suspended or removed, the Vice Chair shall preside, or if the Vice Chair is absent from the meeting or is absent temporarily on the grounds of a declared conflict of interest, another Non-Executive Director, as shall be appointed by the Council of Governors, shall preside.

22.3 Suspension or removal of the Chair or another Non-Executive Director shall require a resolution to be submitted by 11 Governors which must be seconded by not less than 3 Governors and requires the resolution in question to be approved by three-quarters of the members of the Council of Governors.

22.4 The Governor sponsoring the resolution mentioned in paragraph 22.3 above shall provide written reasons in support of the resolution to the Chair or other Non-Executive Director in question, who shall be given the opportunity to respond to such reasons at the meeting of the Council of Governors which the resolution is to be considered and voted upon. If the individual in question fails to attend the meeting without due cause, the meeting may proceed in their absence. The decision to proceed in these circumstances will be at the sole discretion of the person chairing the meeting in question.

22.5 In making any decision to remove either the Chair or a Non-Executive Director under paragraph 22.4 above, the Council of Governors shall:

22.5.1.1 take into account the results of any appraisals concerning the Chair (or, as the case may be) the Non-Executive Director in question;

22.5.1.2 have regard to the criteria set out at paragraph 2 of Appendix 3 to Annex 8 of this Constitution; and

22.5.1.3 follow the relevant Trust procedures for investigating and handling concerns and complaints regarding Non-Executive Directors.

22.6 If any resolution to suspend or remove either the Chair or a Non-Executive Director is not approved at a meeting of the Council of Governors in accordance with paragraph 22.3 above, no further resolution can be put forward to suspend or remove such Non-Executive Director, or the Chair which is based on the same reasons within 12 calendar months of the meeting of the Council of Governors at which the resolution mentioned in paragraph 22.3 above was considered.

~~22.7 The initial Chair and the initial Non-Executive Directors are to be appointed in accordance with paragraph 23 below.~~

~~23. Board of Directors – appointment of initial Chair and initial other Non-Executive Directors~~

~~23.1 The Council of Governors shall appoint the Chair of the Applicant Trust as the initial Chair of the Trust, if he wishesthey wish to be appointed.~~

~~23.2 The power of the Council of Governors to appoint the other Non-Executive Directors is to be exercised, so far as possible, by appointing as the initial Non-Executive Directors any of the non-executive directors of the Applicant Trust (other than the Chair) who wish to be appointed.~~

~~23.3 The criteria for qualification for appointment as a Non-Executive Director set out in paragraph 21 above (other than disqualification by virtue of paragraph 27 below) do not apply to the appointment of the initial Chair and the initial other Non-Executive Directors in accordance with the procedures set out in this paragraph 23.~~

~~23.4 An individual appointed as the initial Chair or as an initial Non-Executive Director in accordance with the provisions of this paragraph 23 shall be appointed for the unexpired period of his term of office as Chair or (as the case may be) non-executive director of the Applicant Trust, but if, on appointment, that period is less than 12 months, he shall be appointed for 12 months.~~

~~24.~~23. Board of Directors – appointment of Vice Chair

~~24.1~~23.1 The Council of Governors at a general meeting or otherwise of the Council of Governors shall appoint one of the Non-Executive Directors as a Vice Chair for such period, not exceeding ~~his~~ their term of office as a Non-Executive Director, as the Council of Governors may specify on appointing ~~him~~them.

~~24.2~~23.2 Any Non-Executive Director so appointed under paragraph 2~~3~~4.1 above may at any time resign from the office of Vice Chair by giving notice in writing to the Secretary. The Council of Governors may thereupon appoint another Non-Executive Director as Vice Chair in accordance with paragraph 2~~3~~4.1 above.

~~24.3~~23.3 If the Chair is unable to discharge ~~his~~ their functions as Chair of the Trust, the Vice Chair will be the "acting Chair" of the Trust until such time as the Chair is able to discharge ~~his~~ their functions as Chair, or a new Chair is appointed by the Council of Governors in accordance with paragraph 22 above.

~~25.~~24. Board of Directors - appointment and removal of the Chief Executive, the Deputy Chief Executive and other Executive Directors

24.1 The Non-Executive Directors shall appoint or remove the Chief Executive. All appointments must satisfy the requirements of Regulation 5: Fit and Proper Persons: Directors of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014 including all future amendments to the regulation.

~~25.1~~24.2

~~25.2~~24.3 ~~Subject to the provisions of paragraph 26.2 below, t~~The appointment of the Chief Executive shall require the approval of a majority of the members of the Council of Governors present and voting at a meeting of the Council of Governors.

~~25.3 The initial Chief Executive is to be appointed in accordance with paragraph 26 below.~~

~~25.4~~24.4 A committee consisting of the Chair, the Chief Executive and the other Non-Executive Directors shall appoint or remove the other Executive Directors.

~~25.5~~24.5 The Chief Executive shall from time to time nominate, by way of written resolution, one of the Executive Directors to be the Deputy Chief Executive and the resolution in question is to be approved by a simple majority of members of the Board of Directors present and voting at a meeting of the Board of Directors.

~~26.~~25. Board of Directors – appointment and removal of ~~initial~~ Chief Executive and other Executive Directors

~~26.1~~25.1 The Non-Executive Directors shall appoint or remove the ~~c~~Chief ~~officer~~ Executive ~~of the Applicant Trust as the initial Chief Executive of the Trust, if he wishes to be appointed.~~

25.2 The appointment of the Chief Executive is subject to the approval of a majority of the members of the Council of Governors present and voting at a meeting of the Council of Governors.

25.3 A committee consisting of the Chair, the Chief Executive and the other Non-Executive Directors shall appoint or remove the other Executive Directors.

25.4 All appointments must satisfy the requirements of Regulation 5: Fit and Proper Persons: Directors of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014 including all future amendments to the regulation.

~~26.2 The appointment of the chief officer of the Applicant Trust as the initial Chief Executive of the Trust shall not require the approval of the Council of Governors.~~

~~27.~~26. Board of Directors – disqualification

~~27.1~~26.1 The following may not become or continue as a member of the Board of Directors:

~~27.1.1~~26.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

~~27.1.2~~26.1.2 a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);

~~27.1.3~~26.1.3 a person who has made a composition or arrangement with, or granted a trust deed for, ~~his~~ their creditors and has not been discharged in respect of it;

~~27.1.4~~26.1.4 a person who within the preceding five years has been convicted of an offence anywhere in the world and a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on ~~him~~ them;

~~27.1.5~~26.1.5 a person whose tenure of office as a Chair or member or director of a Health Service Body has been terminated on the grounds that ~~his~~ their appointment is not in the interests of the health service;

~~27.1.6~~26.1.6 a person who has had ~~his~~ their name removed from a list maintained under regulations pursuant to Sections 91, 106, 123, or 146 of the 2006 Act, or the equivalent lists maintained by Local Health Boards in Wales under the National Health Service (Wales) Act 2006, and ~~he has~~they have not subsequently had ~~his~~ their name included in such a list and, due to the reasons(s) for such removal, ~~he is~~they are considered by the Trust to be unsuitable to be a Director;

~~27.1.7~~26.1.7 a person who is a member of the Council of Governors;

~~27.1.8~~26.1.8 an executive director, non-executive director or a governor of another Health Service Body, unless approval is received from no less than 75% of the voting members of the Board of Directors;

~~27.1.9~~26.1.9 a person who is a member of a local authority Health Overview and Scrutiny Committee;

~~27.1.10~~26.1.10 a person who is the subject of a disqualification order made under the Company Directors' Disqualification Act 1986;

~~27.1.11~~26.1.11 a person who has failed without reasonable cause to fulfil any training requirement established by the Board of Directors;

~~27.1.12~~26.1.12 a person who has failed to sign and deliver to the Secretary a statement in the form required by the Board of Directors confirming acceptance of the Directors' Code of Conduct;

~~27.1.13~~26.1.13 a person who is an Immediate Family Member of a Director or a Governor;

~~27.1.14~~26.1.14 a person who is the subject of a Sex Offenders Order and/or ~~his~~ their name in included in the Sex Offenders Register;

~~27.1.15~~26.1.15 a person who, by reference to information revealed in a criminal record certificate or enhanced criminal record certificate issued by the Disclosure and Barring Service under Part V of the Police Act 1997, is considered by the Trust to be inappropriate on the grounds that ~~his~~ their

appointment might adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute;

~~27.1.16~~26.1.16 subject to the provisions of paragraph 2~~56~~7.1.19, a person who is incapable by reason of mental disorder, illness or injury of managing and/or administering ~~his~~ their property and/or ~~his~~ their affairs;

~~27.1.17~~26.1.17 a person who is included in any barred list established under the Safeguarding Vulnerable Groups Act 2006, or who is included in an equivalent list maintained under the law of Scotland or Northern Ireland;

~~27.1.18~~26.1.18 a person who has demonstrated aggressive or violent behaviour (such as verbal assault, physical assault, violence or harassment) at any NHS hospital, NHS premises or other NHS establishment or against any of the Trust's employees, or other persons who exercise functions for the purposes of the Trust, whether or not in circumstances leading to ~~his~~ their removal or exclusion from any NHS hospital, premises or establishment;

~~27.1.19~~26.1.19 a person who has within the preceding 2 years been dismissed, otherwise than by reason of redundancy, from any paid employment with a Health Service Body; or

~~27.1.20~~26.1.20 Where an individual is deemed by the Secretary, in ~~his~~ their absolute discretion, to be incapable by reason of mental disorder, illness or injury of managing and/or administering ~~his~~ their property and/or affairs for the purposes of paragraph 2~~5~~7.1.15 of the Constitution, the Secretary shall either:

~~27.1.20.1~~26.1.20.1 temporarily suspend the individual from office until such time as the Secretary, in ~~his~~ their absolute discretion, considers ~~him~~ them to be capable of managing and/or administering ~~his~~ their property and affairs; or

~~27.1.20.2~~26.1.20.2 (where the Secretary, in ~~his~~ their absolute discretion, considers ~~him~~ them to be permanently incapable of managing and/or administering ~~his~~ their property and affairs), declare that the individual is disqualified from office, in accordance with the individual's terms and conditions of employment, service or engagement (as the case may be); and

~~27.1.20.3~~26.1.20.3 In considering whether an individual is incapable by reason of mental disorder, illness or injury of managing and/or administering ~~his~~ their property and/or affairs, the Secretary shall take into account the provisions of the Mental Capacity Act 2005, or any statutory modification thereof and ~~he~~they shall be entitled to take appropriate professional advice from internal Trust advisors, and/or external advisors, as necessary.

~~27.2~~26.2 Where an individual was a non-executive director of the ~~Applicant~~ Trust, they may not be re-appointed as a Non-Executive Director of the Trust after the expiry of:

~~27.2.1~~26.2.1 in the case of an individual who served two consecutive terms of office as a non-executive director of the ~~Applicant~~ Trust, the period for which they were appointed as a Non-Executive Director of the Trust ~~pursuant to paragraph 23.4 above, but if that period is 12 months (the "**Initial Term**") a further term of office of not more than 12 months following the Initial Term~~; or

~~27.2.2~~26.2.2 in any other case, a further term of not more than 3 years following the period for which they were appointed as a Non-Executive Director of the Trust. ~~pursuant to paragraph 23.4 above.~~

~~28.~~27. Board of Directors – standing orders

The Standing Orders for the Board of Directors are attached at Annex 7.

2~~7~~8A Board of Directors – general duty

2~~7~~8A.1 The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the Members as a whole and for the public.

~~29.~~28. Board of Directors - conflicts of interest of Directors

~~29.1~~28.1 The duties that a Director of the Trust has by virtue of being a Director include in particular:

~~29.1.1~~28.1.1 A duty to avoid a situation in which the Director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust (a "**Conflict**").

~~29.1.2~~28.1.2 A duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity.

~~29.2~~28.2 The duty referred to in sub-paragraph 2~~7~~9.1.1 is not infringed if:

~~29.2.1~~28.2.1 The situation cannot reasonably be regarded as likely to give rise to a Conflict, or

~~29.2.2~~28.2.2 The matter has been authorized in accordance with the Constitution.

~~29.3~~28.3 The duty referred to in sub-paragraph 2~~7~~9.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

~~29.4~~28.4 In sub-paragraph 2~~7~~9.1.2, “third party” means a person other than:

~~29.4.1~~28.4.1 the Trust, or

~~29.4.2~~28.4.2 a person acting on its behalf.

~~29.5~~28.5 If a Director of the Trust has in any way a direct o~~r~~f indirect interest in a proposed transaction or arrangement with the Trust, the Director must declare the nature and extent of that interest to the other Directors.

~~29.6~~28.6 If a declaration under this paragraph 2~~7~~9 proves to be, or becomes, inaccurate or incomplete, the Director must make a further declaration before the Trust enters into the transaction or arrangement.

~~29.7~~28.7 Any declaration required by this paragraph 2~~7~~9 must be made before the Trust enters into the transaction or arrangement.

~~29.8~~28.8 This paragraph 2~~7~~9 does not require a declaration of an interest of which the Director is not aware or where the Director is not aware of the transaction or arrangement in question.

~~29.9~~28.9 A Director need not declare an interest:

~~29.9.1~~28.9.1 if, it cannot reasonably be regarded as likely to give rise to a conflict of interest;

~~29.9.2~~28.9.2 if, or to the extent that, the Directors are already aware of it;

~~29.9.3~~28.9.3 if, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered by:

~~29.9.3.1~~28.9.3.1 a meeting of the Board of Directors: or

~~29.9.3.2~~28.9.3.2 by a committee of the Directors appointed for the purpose under this Constitution.

~~29.10~~28.10 A matter shall have been authorised for the purposes of paragraph 2~~7~~9.2.2 above if:

~~29.10.1~~28.10.1 the Directors, in accordance with the requirements set out in this paragraph 2~~7~~9.10, authorise any matter or situation proposed to them by any Director which would, if not authorised, involve a Director (an "Interested Director") potentially breaching ~~his~~ their duty under paragraph 2~~7~~9.2.1 above to avoid Conflicts:

~~29.10.1.1~~28.10.1.1 the matter in question shall have been proposed by any Director for consideration in the same way that any other matter may be proposed to the Directors under the provisions of this Constitution;

~~29.10.1.2~~28.10.1.2 any requirement as to the quorum for consideration of the relevant matter is met without counting the Interested Director or any other Interest Director; and

the matter was agreed to without the Interested Director voting

~~29.10.2~~28.10.2 Any authorisation of a Conflict under this paragraph 2~~7~~9.10 may (whether at the time of giving the authorisation or subsequently):

~~29.10.2.1~~28.10.2.1 extend to any actual or potential conflict of interest which may reasonably be expected to arise out of the Conflict so authorised;

~~29.10.2.2~~28.10.2.2 provide that the Interested Director be excluded from the receipt of documents and information and the participation in discussions

(whether at meetings of the Directors or otherwise) related to the Conflict;

~~29.10.2.3 provide that the Interested Director be excluded from the receipt of documents and information and the participation in discussions (whether at meetings of the Directors or otherwise) related to the Conflict;~~

~~29.10.2.4~~28.10.2.3 impose upon the Interested Director such other terms for the purposes of dealing with the Conflict as the Directors think fit;

~~29.10.2.5~~28.10.2.4 provide that, where the Interested Director obtains, or has obtained (through ~~his~~ their involvement in the Conflict and otherwise than through ~~his~~ their position as a Director of the Trust) information that is confidential to a third party, ~~he~~ they will not be obliged to disclose that information to the Board of Directors, or to use it in relation to the Trust's affairs where to do so would amount to a breach of that confidence; and

~~29.10.2.6~~28.10.2.5 permit the Interested Director to absent ~~himself~~ themselves from the discussion of matters relating to the Conflict at any meeting of the Directors and be excused from reviewing papers prepared by, or for, the Directors to the extent they relate to such matters.

~~29.11~~28.11 Where the Directors authorise a Conflict, the Interested Director will be obliged to conduct ~~himself~~ themselves in accordance with any terms imposed by the Directors in relation to the Conflict.

~~29.12~~28.12 The Directors may revoke or vary such authorisation at any time, but this will not affect anything done by the Interested Director, prior to such revocation or variation in accordance with the terms of such authorisation.

~~29.13~~28.13 A Director is not required, by reason of being a Director, to account to the Trust for any remuneration, profit or other benefit which ~~he~~ they derive~~s~~ from or in connection with a relationship involving a Conflict which has been authorised by the Directors (subject in each case to any terms, limits or conditions attaching to that authorisation) and no contract shall be liable to be avoided on such grounds.

~~29.14~~28.14 The Standing Orders for the Board of Directors shall make provision for the disclosure of interests and arrangements for the exclusion of a Director declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

~~30.~~29. Board of Directors – remuneration and terms of office

~~30.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other Non-Executive Directors, but pending its decision on these matters, these matters are to continue in accordance with the remuneration and allowances, and the other terms and conditions of office of the respective individuals as engaged by the Applicant Trust.~~

29.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other Non-Executive Directors.

~~30.2~~29.2 The Trust shall establish a committee of Non-Executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other Executive Directors.

30. ~~30A~~ Board of Directors – Meetings

30.1 ~~30A.1~~ Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

30.2 ~~30A.2~~ Before a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

31. Registers

31.1 The Trust shall have:

31.1.1 a register of Members showing, in respect of each Member, the constituency to which ~~he~~ they belong~~s~~ and, where there are classes within it, the class to which ~~he~~ they belong~~s~~;

31.1.2 a register of members of the Council of Governors;

31.1.3 a register of interests of the members of the Council of Governors;

31.1.4 a register of members of the Board of Directors; and

31.1.5 a register of interests of the members of the Board of Directors.

31.2 The Secretary shall be responsible for compiling and maintaining the registers in paragraph 31.1 above and the registers may be kept in either paper or electronic form. Admission to and removal from any register shall be in accordance with the provisions of this Constitution. The Secretary shall update the registers with new or amended information as soon as is practical and in any event within 21 days of receipt.

32. Admission to and removal from the registers

32.1 **Register of Members**

The Secretary shall maintain the register of Members in two parts:

32.1.1 Part one, which shall be the register referred to in the 2006 Act, shall include the name of each Member and the constituency to which they belong and, where there are classes within it, the class to which they belong, and shall be open to inspection by the public in accordance with paragraphs 33 and 34 below.

32.1.2 Part two shall contain all the information from the application referred to in paragraph 7 above and shall not be open to inspection by the public nor may copies or extracts from it be made available to any third party (save to the extent that copies or extracts from it be made available to any third party appointed by the Trust to maintain the register of Members and to conduct elections in accordance with the provisions of paragraph 12 above).

32.1.3 Notwithstanding the provisions of paragraphs 32.1.1 and 32.1.2 above, the Trust shall extract such information as it needs in aggregate to satisfy itself that the actual membership of the Trust is representative of those eligible for membership and for the administration of the provisions of this Constitution.

32.2 **Register of members of the Council of Governors**

The register of members of the Council of Governors shall list:

32.2.1 the name of each Governor;

32.2.2 their category of membership of the Council of Governors (public, staff, local authority, or partnership organisation); and

32.2.3 an address through which they may be contacted, which may be the Secretary.

32.3 **Register of interests of members of the Council of Governors**

The register of interests of the members of the Council of Governors shall contain:

32.3.1 the names of each Governor; and

32.3.2 whether ~~he has~~they have declared any interests and, if so, the interests declared in accordance with this Constitution and the Standing Orders for the Council of Governors.

32.4 **Register of members of the Board of Directors**

The register of members of the Board of Directors shall list:

32.4.1 the name of each Director;

32.4.2 their capacity on the Board of Directors; and

32.4.3 an address through which they may be contacted which may be the Secretary.

32.5 **Register of interests of members of the Board of Directors**

The register of interests of members of the Board of Directors shall contain:

32.5.1 the name of each Director; and

32.5.2 whether ~~he has~~they have declared any interests and, if so, the interests declared in accordance with this Constitution and the Standing Orders for the Board of Directors.

33. Registers – inspection and copies

33.1 The Trust shall make the registers specified in paragraphs 32.1 to 32.5 above available for inspection by members of the public, except in the circumstances set out in paragraph 33.2 below or as otherwise prescribed by regulations including, for the avoidance of doubt, the Public Benefit Corporation (Register of Members) Regulations 2004 (SI 2004/539).

33.2 The Trust shall not make any part of the register of Members available for inspection by members of the public which shows details of any Member of the Trust, if the Member so requests.

33.3 So far as the registers are required to be made available:

33.3.1 they are, subject to paragraph 33.4 below, to be available for inspection free of charge at all reasonable times; and

33.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

33.4 If the person requesting a copy or extract is not a Member of the Trust, the Trust may impose a reasonable charge for doing so.

34. Documents available for public inspection

34.1 Subject to paragraph 34.4 below, the Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times as well as on the Trust's website:

34.1.1 a copy of the current Constitution;

34.1.2 a copy of the latest Annual Accounts and of any report of the Auditor on them;

34.1.3 a copy of the latest Annual Report;

~~34.2~~34.1.4 Subject to paragraph 34.4 below, the Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times:

~~34.2.1~~34.1.5 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L (trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act;

~~34.2.2~~34.1.6 a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act;

~~34.2.3~~34.1.7 a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act;

~~34.2.4~~34.1.8 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act;

~~34.2.5~~34.1.9 a copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act;

~~34.2.6~~34.1.10 a copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J

(power to extend time), 65KA (NHS England's decision), 65KB (Secretary of State's response to NHS England's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act;

34.2.734.1.11 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act;

34.2.834.1.12 a copy of any final report published under section 65I (administrator's final report) of the 2006 Act;

34.2.934.1.13 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act; and

34.2.1034.1.14 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

34.334.2 Subject to paragraph 34.4 below, any person who requests a copy of or extract from any of the documents listed in this paragraph 34 is to be provided with a copy, or extract.

34.434.3 If the person requesting a copy or extract is not a Member of the Trust, the Trust may impose a reasonable charge for doing so.

35. Auditor

35.1 The Trust is to have an Auditor.

35.2 The Council of Governors shall appoint or remove the Auditor at a general meeting of the Council of Governors.

35.3 In appointing the Auditor, the Council of Governors shall have regard to the recommendations (if any) of the Audit Committee. If, in appointing the Auditor, the Council of Governors does not accept the recommendations (if any) of the Audit Committee, it must state, at the time of making the appointment, the reasons why it has taken a different position.

35.4 The Accounting Officer shall ensure that the Auditor carries out ~~his~~ their duties in accordance with Schedule 10 to the 2006 Act and in accordance with any guidance or best practice advice issued by ~~NHSEI~~ NHS England on standards, procedures and techniques to be adopted.

35.5 The Board of Directors may resolve that an "external consultant" be appointed to review and publish a report on any other aspect of the Trust's performance. Any such "external consultant" is to be appointed by the Board of Directors.

36. Audit and Risk Committee

The Board of Directors shall cause the Trust to establish a committee of Non-Executive Directors as an Audit & Risk Committee to perform such monitoring, reviewing and other functions as are appropriate.

37. Accounts and records

37.1 The Trust must keep proper accounts and proper records in relation to the accounts.

37.2 ~~NHSEI~~ NHS England may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

37.3 The accounts are to be audited by the Auditor.

37.4 The following documents will be made available to the Comptroller and Auditor General for examination at his request:

37.4.1 the accounts;

37.4.2 the records in relation to them; and

37.4.3 any report of the Auditor on them.

37.5 The Trust is to prepare in respect of each Annual Accounts in such form as ~~NHSEI~~ NHS England may with the approval of the Secretary of State direct.

37.6 ~~NHSEI~~ NHS England may with the approval of the Secretary of State direct the Trust:

37.6.1 to prepare accounts in respect of such period as may be specified in the direction; and/or

37.6.2 that any accounts prepared by it by virtue of paragraph 3~~5~~7.6.1 above are to be audited in accordance with such requirements as may be specified in the direction.

37.7 In preparing its Annual Accounts or in preparing any accounts by virtue of paragraph 37.6.1 above, the Trust must comply with any directions given by ~~NHSEI~~ NHS England with the approval of the Secretary of State as to:

37.7.1 the methods and principles according to which the Annual Accounts must be prepared; and/or

37.7.2 the content and form of the Annual Accounts.

37.8 The Trust must:

37.8.1 lay a copy of the Annual Accounts, and any report of the Auditor on them, before Parliament: and

37.8.2 send copies of the Annual Accounts, and any report of the Auditor on them to ~~NHSEI~~ NHS England within such a period as ~~NHSEI~~ NHS England may direct.

37.9 The Trust must send a copy of any accounts prepared by virtue of paragraph 3~~5~~7.6.1 above and a copy of any report of the Auditor to ~~NHSEI~~NHS England within such a period as ~~NHSEI~~ NHS England may direct.

37.10 The functions of the Trust referred to in this paragraph 37 shall be delegated to the Accounting Officer.

38. Annual Report, Forward Plans and non-NHS work

38.1 The Trust is to prepare Annual Reports and send them to ~~NHSE~~NHS England.

38.2 Each Annual Report must give:

38.2.1 information on any steps taken by the Trust to secure that (taken as a whole) the actual membership of any Public Constituency is representative of those eligible for such membership;

38.2.2 information on the impact that income received by the Trust otherwise than from the fulfilment of the Principal Purpose has had on the provision by the Trust of goods and services for those purposes; and

38.2.3 such other information as may be prescribed by ~~NHSE~~NHS England.

38.3 The Trust shall give the Forward Plan in respect of each Financial Year to ~~NHSE~~NHS England.

38.4 The Forward Plan shall be prepared by the Board of Directors.

38.5 In preparing the Forward Plan, the Board of Directors shall have regard to the views of the Council of Governors.

38.6 Each Forward Plan must include information about:

38.6.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on; and

38.6.2 the income that it expects to receive from doing so.

38.7 Where an Forward Plan contains a proposal that the Trust carry on an activity of a kind mentioned in paragraph 38.6.1 above, the Council of Governors must:

38.7.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its Principal Purpose or the performance of its other functions; and

38.7.2 notify the Directors of the Trust of its determination.

38.8 The Trust may implement a proposal to increase by 5% or more the proportion of its total income in any Financial Year attributable to activities other than the fulfilment of the Principal Purpose only if more than half of the members of the Council of Governors present and voting at a meeting of the Council of Governors approve the implementation of the proposal.

39. Meeting of Council of Governors to consider Annual Accounts and reports

39.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

39.1.1 the Annual Accounts;

39.1.2 any report of the Auditor on them; and

39.1.3 the Annual Report.

39.2 Nothing in paragraph 39.1 above prevents the Council of Governors from holding a general meeting more than once a year.

40. Annual Members' Meeting

40.1 The Trust must hold an annual meeting of its Members (the "**Annual Members' Meeting**"). The Annual Members' Meeting shall be open to members of the public.

40.2 In addition to the obligations set out in paragraph 40.3 below, the Council of Governors of the Trust shall present to each Annual Members' Meeting:

40.2.1 a report on steps taken to secure that, taken as a whole, the actual membership of the Public Constituency is representative of those eligible for such membership;

40.2.2 the progress of the Membership Strategy; and

40.2.3 any changes to the Membership Strategy.

40.3 At least one member of the Board of Directors must attend each Annual Members' Meeting and present the following documents:

40.3.1 the Annual Accounts;

40.3.2 any report of the Auditor on them;

40.3.3 the Annual Report.

41. Combined meetings of Members and Governors

The Trust may hold a meeting which combines the meetings conducted pursuant to paragraphs 39 and 40 above.

42. Mergers etc. Significant Transactions

42.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

42.2 The Trust may enter into a Significant Transaction only if more than half of the members of the Council of Governors present and voting at a meeting of the Council of Governors approve entering into the transaction.

43. Instruments

43.1 The Trust shall have a seal.

43.2 The seal shall not be affixed except under the authority of the Board of Directors as set out in the Standing Orders for the Board of Directors.

44. Amendment of the Constitution

44.1 Amendments to this Constitution are to be made with the approval of:

44.1.1 more than half of the members of the Council of Governors present and voting at a meeting of the Council of Governors; and

44.1.2 more than half of the members of Board of Directors present and voting at a meeting of the Board of Directors.

44.2 The Trust must inform NHS England~~NHSEI~~ of amendments pursuant to paragraph 44.1 but, for the avoidance of doubt, ~~NHSEI's~~ NHS England's functions do not include a power or duty to determine whether or not the Constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

44.3 Amendments made under paragraph 44.1 above take effect as soon as the conditions in paragraph 44.1.1 and 44.1.2 are satisfied, but the amendment has no effect insofar as the Constitution would, as a result of the amendment, not accord with Schedule 7 of the 2006 Act.

44.4 Where an amendment is made to the Constitution in relation to:

44.4.1 the powers or duties of the Council of Governors of the Trust; or

44.4.2 the role that the Council of Governors has as part of the Trust,

the following requirements must be met:

44.4.3 at least one member of the Council of Governors must attend the next meeting of the Members to be held under paragraph 40 or paragraph 41 and present the amendment to the Members;

44.4.4 the Trust must give Members an opportunity to vote on whether they approve the amendment; and

44.4.5 if more than half of the Members present and voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

45. Effect of the RNHRD Acquisition

45.1 On the Acquisition Date all assets and liabilities of RNHRD (save for criminal liabilities) shall transfer by operation of statute and the RNHRD Acquisition to the Trust.

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ANNEX 1 – THE PUBLIC CONSTITUENCIES

(Paragraph 8)

1 Public Constituencies of the Trust

NAME OF CONSTITUENCY	AREA	MINIMUM NUMBER OF MEMBERS	NUMBER OF GOVERNORS
City of Bath	The following electoral ward areas comprising the area covered by Bath and North East Somerset Council and, for the avoidance of doubt, any successor authority of Bath & North East Somerset Council: • Abbey • Bathwick • Combe Down • Kingsmead • Lambridge • Lansdown • Lyncombe • Newbridge • Odd Down • Oldfield • Southdown • Twerton • Walcot • Westmoreland • Weston • Widcombe	75	2
North East Somerset	The following electoral ward areas comprising the area covered by Bath and North East Somerset Council and, for the avoidance of doubt, any successor authority of Bath & North East Somerset Council: • Bathavon North • Bathavon South • Bathavon West • Chew Valley North • Chew Valley South • Clutton • Farmborough • High Littleton • Keynsham East • Keynsham North	75	2

	• Keynsham South • Mendip • Midsomer Norton North • Midsomer Norton Redfield • Paulton • Peasedown • Publow and Whitchurch • Radstock • Saltford • Timsbury • Westfield		
North Wiltshire	The following electoral ward areas comprising the area covered by Wiltshire Council and, for the avoidance of doubt, any successor authority of Wiltshire Council: • Aldbourne and Ramsbury • Box and Colerne • Brinkworth • Bromham, Rowde and Potterne • Bulford, Allington and Figheldean • Burbage and the Bedwyns • By Brook • Calne • Chippenham • Corsham • Cricklade and Latton • Devizes • Durrington and Larkhill • Kington • Ludgershall and Perham Down • Lyneham • Malmesbury • Marlborough • Minety • Pewsey • Purton • Roundway • Royal Wootton Bassett • Sherston • The Collingbournes and Netheravon • The Lavingtons and Erlestoke • Tidworth • Urchfont and The Cannings • West Selkley	75	2

South Wiltshire	The following electoral ward areas comprising the area covered by Wiltshire Council and, for the avoidance of doubt, any successor authority of Wiltshire Council: • Alderbury and Whiteparish • Amesbury • Bourne and Woodford Valley • Bradford-on-Avon • Downton and Ebble Valley • Ethandune • Fovant and Chalke Valley • Hilperton • Holt and Staverton • Laverstock, Ford and Old Sarum • Melksham • Mere • Nadder and East Knoyle • Redlynch and Landford • Salisbury • Southwick • Summerham and Seend • Till and Wylye Valley • Tisbury • Trowbridge • Warminster • Westbury • Wilton and Lower Wylye Valley • Winsley and Westwood • Winterslow	75	2
Mendip	The electoral wards comprising the area covered by Mendip District Council and, for the avoidance of doubt, any successor authority of Mendip District Council.	50	2
England and Wales	All other electoral wards in England and Wales save those electoral wards that fall within any of the Public Constituencies set out above.	10	1
Totals	**Minimum Membership**	**360**	
	Public Governors		**11**

ANNEX 2 – THE STAFF CONSTITUENCY

(Paragraph 9)

1 Staff Constituency

The minimum number of Members required for the Staff Constituency shall be 200.

ANNEX 3 – COMPOSITION OF COUNCIL OF GOVERNORS

(Paragraph 11)

The composition of the Council of Governors shall be as follows:

1 Composition

1.1 The Council of Governors shall comprise:

1.1.1 11 Public Governors;

1.1.2 5 Staff Governors;

1.1.3 2 Local Authority Governors; and

1.1.4 3 Other Partnership Governors.

1.2 The number of Public Governors is to be more than half of the total membership of the Council of Governors.

1.3 The organisations currently specified as Partnership Organisations that may appoint members of the Council of Governors for the purposes of paragraph 9(7) of the Schedule 7 of the 2006 Act are:

1.3.1 University of Bath;

1.3.2 University of Bristol;

1.3.3 University of the West of England;

1.3.4 Bath and North East Somerset, Swindon and Wiltshire Integrated Care ~~System (Wiltshire area); and~~Board (Wiltshire area (1) and BaNES area(1))

~~1.3.5 Bath and North East Somerset, Swindon and Wiltshire Integrated Care System (BaNES area).~~

2 Appointed Governors

2.1 Local Authority Governors

2.1.1 Wiltshire Council or its successor organisation may appoint one Local Authority Governor by notice in writing signed by the leader/chief executive of the Local Authority and delivered to the Secretary. For the avoidance of doubt, the Local Authority Governor shall be a councillor of Wiltshire Council.

2.1.2 Bath and North East Somerset Council or its successor organisation may appoint one Local Authority Governor by notice in writing signed by the leader/chief executive of the Local Authority and delivered to the Secretary. For the avoidance of doubt, the Local Authority Governor shall be a councillor of Bath and North East Somerset Council.

2.2 Partnership Governors

2.2.1 Subject to the provisions contained at paragraph 2.2.2 and 2.2.5 below, each Partnership Organisation listed at paragraphs 2.2.2.1 – 2.2.2.3 or its successor organisation may appoint one Partnership Governor by notice in writing signed by the Chief Executive (or equivalent) of the Partnership Organisation and delivered to the Secretary on a rotational basis in accordance with the provisions of paragraph 2.2.2 below.

2.2.2 Notwithstanding the provision of paragraph 13.3.1 of the Constitution, each of the following Partnership Organisations or its successor organisations may appoint one Partnership Governor to hold office for a period of two years on a rotational basis in the following order:

2.2.2.1 University of Bath;

2.2.2.2 University of Bristol;

2.2.2.3 University of the West of England.

~~2.2.2.3~~2.2.2.4 Bath Spa University

2.2.3 Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board ~~Wiltshire Integrated Care Partnership~~ may appoint two ~~one~~ Partnership Governor's by notice in writing signed by the Chief E~~e~~xecutive of the Integrated Care ~~Partnership~~ Board and delivered to the Secretary. One nominee should represent BaNES and the other Wiltshire.

~~2.2.4 Bath and North East Somerset Integrated Care Partnership may appoint one Partnership Governor by notice in writing signed by the Chief Executive of the Integrated Care Partnership and delivered to the Secretary.~~

~~2.2.5~~2.2.4 Notwithstanding the provisions of paragraphs 2.2.1 - 2.2.4 above, the Chair may veto the appointment of a Partnership Governor by serving notice in writing to the relevant Partnership Organisation(s) where ~~he~~ they believe~~s~~ that the appointment in question is unreasonable, irrational or otherwise inappropriate.

ANNEX 4 –THE MODEL RULES FOR ELECTIONS

(Paragraph 12)

MODEL ELECTION RULES 2014

PART 1: INTERPRETATION

1. Interpretation

PART 2: TIMETABLE FOR ELECTION

2. Timetable
3. Computation of time

PART 3: RETURNING OFFICER

4. Returning officer
5. Staff
6. Expenditure
7. Duty of co-operation

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election
9. Nomination of candidates
10. Candidate's particulars
11. Declaration of interests
12. Declaration of eligibility
13. Signature of candidate
14. Decisions as to validity of nomination forms
15. Publication of statement of nominated candidates
16. Inspection of statement of nominated candidates and nomination forms
17. Withdrawal of candidates
18. Method of election

PART 5: CONTESTED ELECTIONS

19. Poll to be taken by ballot
20. The ballot paper
21. The declaration of identity (public and patient constituencies)

Action to be taken before the poll

22. List of eligible voters
23. Notice of poll
24. Issue of voting information by returning officer
25. Ballot paper envelope and covering envelope
26. E-voting systems

The poll

27. Eligibility to vote
28. Voting by persons who require assistance
29. Spoilt ballot papers and spoilt text message votes
30. Lost voting information
31. Issue of replacement voting information
32. ID declaration form for replacement ballot papers (public and patient constituencies)
33 Procedure for remote voting by internet
34. Procedure for remote voting by telephone
35. Procedure for remote voting by text message

Procedure for receipt of envelopes, internet votes, telephone vote and text message votes

36. Receipt of voting documents
37. Validity of votes
38. Declaration of identity but no ballot (public and patient constituency)
39. De-duplication of votes
40. Sealing of packets

PART 6: COUNTING THE VOTES

STV41. Interpretation of Part 6
42. Arrangements for counting of the votes
43. The count
STV44. Rejected ballot papers and rejected text voting records
FPP44. Rejected ballot papers and rejected text voting records
STV45. First stage
STV46. The quota
STV47 Transfer of votes
STV48. Supplementary provisions on transfer
STV49. Exclusion of candidates
STV50. Filling of last vacancies
STV51. Order of election of candidates
FPP51. Equality of votes

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections
STV52. Declaration of result for contested elections
53. Declaration of result for uncontested elections

PART 8: DISPOSAL OF DOCUMENTS

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

PART 10: ELECTION EXPENSES AND PUBLICITY

Expenses

Publicity

PART 11: QUESTIONING ELECTIONS AND IRREGULARITIES

PART 12: MISCELLANEOUS

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

"*2006 Act*" means the National Health Service Act 2006;

"*corporation*" means the public benefit corporation subject to this constitution;

"*council of governors*" means the council of governors of the corporation;

"*declaration of identity*" has the meaning set out in rule 21.1;

"*election*" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

"*e-voting*" means voting using either the internet, telephone or text message;

"*e-voting information*" has the meaning set out in rule 24.2;

"*ID declaration form*" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"*lead governor*" means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (December 2013) or any later version of such code.

"*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;

"*method of polling*" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"~~*NHSEI*~~*NHS England*" means the corporate body known as ~~NHSEI~~ NHS England as provided by section 61 of the 2012 Act;

"*numerical voting code*" has the meaning set out in rule 64.2(b)

"*polling website*" has the meaning set out in rule 26.1;

"*postal voting information*" has the meaning set out in rule 24.1;

"*telephone short code"* means a short telephone number used for the purposes of submitting a vote by text message;

"*telephone voting facility*" has the meaning set out in rule 26.2;

"*telephone voting record*" has the meaning set out in rule 26.5 (d);

"*text message voting facility*" has the meaning set out in rule 26.3;

"*text voting record*" has the meaning set out in rule 26.6 (d);

"*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"*voting information*" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

PART 2: TIMETABLE FOR ELECTIONS

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2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	**Time**
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;

(b) Christmas day, Good Friday, or a bank holiday, or

(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, "bank holiday" means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

PART 3: RETURNING OFFICER

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4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as ~~he or she~~they consider~~s~~ necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of ~~his or her~~their functions under these rules,

(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of ~~his or her~~their functions under these rules.

8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held,

(b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(c) the details of any nomination committee that has been established by the corporation,

(d) the address and times at which nomination forms may be obtained;

(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

(f) the date and time by which any notice of withdrawal must be received by the returning officer

(g) the contact details of the returning officer

(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination form, and

(b) is to prepare a nomination form for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name,

(b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and

(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:

(a) any financial interest that the candidate has in the corporation, and

(b) whether the candidate is a member of a political party, and if so, which party,

and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

(a) that ~~he or she is~~they are not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,

(b) for a member of the public or patient constituency, of the particulars of ~~his or her~~their qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,

(b) their declaration of interests as required under rule 11, is true and correct, and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,

(b) decides that the nomination form is invalid,

(c) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,

(b) that the paper does not contain the candidate's particulars, as required by rule 10;

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

(d) that the paper does not include a declaration of eligibility as required by rule 12, or

(e) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after ~~he or she~~they haves received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and

(b) the declared interests of each candidate standing,

as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by ~~him or her~~them in consultation with the corporation.

PART 5: CONTESTED ELECTIONS

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19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate internet voting record in respect of any voter who casts ~~his or he~~their vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate telephone voting record in respect of any voter who casts ~~his or her~~their vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate text voting record in respect of any voter who casts ~~his or her~~their vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts ~~his or her~~their ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that

constituency, or class within that constituency,

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and

(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

(a) that the voter is the person:

(i) to whom the ballot paper was addressed, and/or

(ii) to whom the voter ID number contained within the e-voting information was allocated,

(b) that ~~he or she has~~they have not marked or returned any other voting information in the election, and

(c) the particulars of ~~his or her~~their qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return ~~his or her~~ their declaration of identity with ~~his or her~~their ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) a postal address; and,

(b) the member's e-mail address, if this has been provided

to which ~~his or her~~their voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,

(g) the address for return of the ballot papers,

(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,

(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,

(k) the date and time of the close of the poll,

(l) the address and final dates for applications for replacement voting information, and

(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope,

(b) the ID declaration form (if required),

(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and

(d) a covering envelope;

("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast ~~his or her~~their vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),

(b) the voter's voter ID number,

(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate, (d) contact details of the returning officer,

("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or

(b) only be sent e-voting information; or

(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail

address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and

(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed ID declaration form if required, and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as “the telephone voting facility”).

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:

(i) enter ~~his or her~~their voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast ~~his or her~~their vote;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(v) instructions on how to vote and how to make a declaration of identity,

(vi) the date and time of the close of the poll, and

(vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than ~~he or she is~~they are entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote,

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to

(i) enter ~~his or her~~ their voter ID number in order to be able to cast ~~his or her~~ their vote; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) instructions on how to vote and how to make a declaration of identity,

(v) the date and time of the close of the poll, and

(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than ~~he or she is~~they are entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:

(i) provide ~~his or her~~their voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast ~~his or her~~their vote;

(b) prevent a voter from voting for more candidates than ~~he or she is~~they are entitled to at the election;

(d) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(ii) the candidate or candidates for whom the voter has voted; and

(iii) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as ~~he or she~~they considers necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with ~~his or her~~their ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if ~~he or she~~they can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless ~~he or she~~they:

(a) is satisfied as to the voter's identity; and

(b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with ~~his or her~~their text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if ~~he or she~~ they can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless ~~he or she~~they are ~~is~~ satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(c) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1 Where a voter has not received ~~his or her~~their voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless ~~he or she~~they:

(a) is satisfied as to the voter's identity,

(b) has no reason to doubt that the voter did not receive the original voting information,

(c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter

(b) the details of the unique identifier of the replacement ballot paper, if applicable, and

(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, ~~he or she is~~they are also satisfied that that person

has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter,

(b) the unique identifier of any replacement ballot paper issued under this rule;

(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast ~~his or her~~their vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter ~~his or her~~their voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast ~~his or her~~their vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom ~~he or she~~they wish~~es~~ to cast ~~his or her~~their vote.

33.5 The voter will not be able to access the internet voting system for an election once ~~his or her~~ their vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast ~~his or her~~their vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter ~~his or her~~their voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast ~~his or her~~their vote by keying in the numerical voting code of the candidate or candidates, for whom ~~he or she~~they wish~~es~~ to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once ~~his or her~~their vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast ~~his or her~~their vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain ~~his or her~~their voter ID number and the numerical voting code for the candidate or candidates, for whom ~~he or she~~they wish~~es~~ to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or

(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied

that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, ~~he or she is~~they are to:

(a) put the ID declaration form if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, ~~he or she is~~they are to:

(a) mark the ballot paper "disqualified",

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,

(c) record the unique identifier on the ballot paper in a list of disqualified documents (the "list of disqualified documents"); and

(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, ~~he or she is~~they are to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, ~~he or she is~~they are to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and

(c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public and patient constituency)[1]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

[1] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

(a) mark the ID declaration form “disqualified”,

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and

(c) place the ID declaration form in a separate packet.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election ~~he or she~~they shall:

(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and

(b) mark as "disqualified" all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

(a) mark the ballot paper "disqualified",

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,

(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;

(d) place the document or documents in a separate packet; and

(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;

(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and

(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it,

(b) the ID declaration forms, if required,

(c) the list of spoilt ballot papers and the list of spoilt text message votes,

(d) the list of lost ballot documents,

(e) the list of eligible voters, and

(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

PART 6: COUNTING THE VOTES

STV41. Interpretation of Part 6

STV41.1 In Part 6 of these rules:

"*ballot document*" means a ballot paper, internet voting record, telephone voting record or text voting record.

"*continuing candidate*" means any candidate not deemed to be elected, and not excluded,

"*count*" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"*deemed to be elected*" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"*mark*" means a figure, an identifiable written word, or a mark such as "X",

"*non-transferable vote*" means a ballot document:

(a) on which no second or subsequent preference is recorded for a continuing candidate,

or

(b) which is excluded by the returning officer under rule STV49,

"*preference*" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,

(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"*quota*" means the number calculated in accordance with rule STV46,

"*surplus*" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,
"*stage of the count*" means:

(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"*transferable vote*" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"*transferred vote*" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"*transfer value*" means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:
  (i) the use of such software for the purpose of counting votes in the relevant election, and
  (ii) a policy governing the use of such software, and
(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:

(iii) ballot papers that have been returned; and

(iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44. Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

(a) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word "rejected" on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by ~~him or her~~them under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by ~~him or her~~them under each of the sub-paragraphs (a) to (c) of rule STV44.3.

FPP44. Rejected ballot papers and rejected text voting records

FPP44.1Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which votes are given for more candidates than the voter is entitled to vote,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,

(b) otherwise than by means of a clear mark,

(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that ~~he or she~~they can be identified by it.

FPP44.4The returning officer is to:

(a) endorse the word "rejected" on any ballot paper which under this rule is not to be counted, and

(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words "rejected in part" on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,

(b) voting for more candidates than the voter is entitled to,

(c) writing or mark by which voter could be identified, and

(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,

(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or

(c) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP448 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,

(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that ~~he or she~~they can be identified by it.

FPP44.9The returning officer is to:

(a) endorse the word "rejected" on any text voting record which under this rule is not to be counted, and

(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words "rejected in part" on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,

(b) writing or mark by which voter could be identified, and

(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

STV45. First stage

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46. The quota

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as "the quota").

STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

STV47. Transfer of votes

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value ("the transfer value") which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

(a) a transfer value calculated as set out in rule STV47.4(b), or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

STV48. Supplementary provisions on transfer

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(a) record the total value of the votes transferred to each candidate,

(b) add that value to the previous total of votes recorded for each candidate and record the new total,

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49. Exclusion of candidates

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and

(b) subject to rule STV50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV9.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV9.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value ~~he or she~~they shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until ~~he has~~they have dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:

(i) the total value of votes, or

(ii) the total transfer value of votes transferred to each candidate,

(b) add that total to the previous total of votes recorded for each candidate and record the new total,

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV50. Filling of last vacancies

STV50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51. Order of election of candidates

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which theyhe obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP51. Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who ~~he or she has~~they have declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the Royal United Hospital, Bath NHS Trust by section 33(4) of the 2006 Act, to the Chair of the NHS Trust, or

(ii) in any other case, to the Chair of the corporation; and

(c) give public notice of the name of each candidate whom ~~he or she has~~they have declared elected.

FPP52.2The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and

(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,

(c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

STV52. Declaration of result for contested elections

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who ~~he or she has~~they have declared elected –

(i) where the election is held under a proposed constitution pursuant to powers conferred on the Royal United Hospital, Bath NHS Trust by section 33(4) of the 2006 Act, to the Chair of the NHS Trust, or

(ii) in any other case, to the Chair of the corporation, and

(c) give public notice of the name of each candidate who ~~he or she has~~they have declared elected.

STV52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,

(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule STV44.1,

(f) the number of rejected text voting records under each of the headings in rule STV44.3,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who ~~he or she has~~they have declared elected to the Chair of the corporation, and

(c) give public notice of the name of each candidate who ~~he or she has~~they have declared elected.

PART 8: DISPOSAL OF DOCUMENTS

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54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,

(b) the ballot papers and text voting records endorsed with "rejected in part",

(c) the rejected ballot papers and text voting records, and

(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,

(b) the list of spoilt ballot papers and the list of spoilt text message votes,

(c) the list of lost ballot documents, and

(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the Chair of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –

(i) any rejected ballot papers, including ballot papers rejected in part,

(ii) any rejected text voting records, including text voting records rejected in part,

(iii) any disqualified documents, or the list of disqualified documents,

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that ~~his or her~~their vote was given, and

(ii) that NHS England~~I~~ has declared that the vote was invalid.

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and

(b) order a new election, on a date to be appointed by ~~him or her~~them in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5The returning officer is to:

(a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,

(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6The returning officer is to endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the Chair of the corporation, and rules 57 and 58 are to apply.

STV59. Countermand or abandonment of poll on death of candidate

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

PART 10: ELECTION EXPENSES AND PUBLICITY

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to NHS England~~,~~ under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or ~~his or her~~their family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be

distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

(c) a photograph of the candidate.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of ~~his or her~~their own services voluntarily, on ~~his or her~~their own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

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66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to NHS England~~l~~ for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to NHS England~~l~~ by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of

the election. NHS England~~I~~ will refer the application to the independent election arbitration panel appointed by NHS England~~EI~~.

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 NHS England~~I~~ shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

PART 12: MISCELLANEOUS

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67. Secrecy

67.1 The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the voter ID number allocated to any voter,

(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as they~~he or she~~ think~~s~~ fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68.

Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom ~~he or she has~~they have voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,

(b) an employee of the corporation,

(c) a director of the corporation, or

(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or

(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as ~~he or she~~they consider~~s~~ appropriate.

ANNEX 5 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

(Paragraphs 14 and 19)

Appendix 1:

Eligibility to be on the Council of Governors

1 A person may not become or continue as a Governor of the Trust if:

1.1 in the case of an Elected Governor, ~~he~~ they ceases to be a member of the constituency or (where relevant) the class within the constituency he represents;

1.2 in the case of an Appointed Governor, the sponsoring organisation withdraws their sponsorship of ~~him~~them;

1.3 In the case of an Appointed Governor, ~~his~~ their primary place of residence or (where relevant) ~~his~~ their primary place of business is located in an area other than an area specified in Annex 1 as an area for a public constituency;

1.4 ~~he~~ they are~~is~~ a person whose tenure of office as the Chair or as a member or director of a Health Service Body has been terminated on the grounds that ~~his~~ their appointment is not in the interest of the health service;

1.5 ~~he is~~they are a Director of the Trust, or a governor, executive director, non-executive director, Chair, chief executive officer of another Health Service Body (unless they are appointed by a Partnership Organisation which is a Health Service Body), or a body corporate whose business involves the provision of health care services, including for the avoidance of doubt those who have a commercial interest in the affairs of the Trust;

1.6 ~~he has~~they have been a director of the ~~Applicant~~ Trust or a Director of the Trust in the preceding 3 years prior to the date of ~~his~~ their nomination to stand for election as an Elected Governor, or in the case of an Appointed Governor, the date of ~~his~~ their appointment by a Partnership Organisation;

1.7 ~~he has~~they have had ~~his~~ their name removed from a list maintained under regulations pursuant to Sections 91, 106, 123, or 146 of the 2006 Act, or the equivalent lists maintained by Local Health Boards in Wales under the National Health Service (Wales) Act 2006, and ~~he has~~they have not subsequently had ~~his~~ their name included in such a list and, due to the reason(s) for such removal, ~~he is~~they are considered by the Trust to be unsuitable to be a Governor;

1.8 subject to paragraph 5 below ~~he is~~they are incapable by reason of mental disorder, illness or injury of managing and administering ~~his~~ their property and affairs;

1.9 ~~he has~~they have refused without reasonable cause to undertake any training which the Trust and/or Council of Governors requires all Governors to undertake;

1.10 ~~he is~~they are a member of a local authority Health Overview and Scrutiny Committee;

1.11 ~~he is~~they are the subject of a Sex Offenders Order and /or ~~his~~ their name is included in the Sex Offenders Register;

1.12 ~~he is~~they are an Immediate Family Member of a Governor or Director of the Trust;

1.13 ~~he has~~they have failed to repay (without good cause) any amount of monies properly owed to the ~~Applicant Trust or the~~ Trust;

1.14 ~~he has~~they have failed to sign and deliver to the Secretary a statement in the form required by the Trust confirming acceptance of the Governor's Code of Conduct;

1.15 ~~he is~~they are a person who, by reference to information revealed in a criminal record certificate or enhanced criminal record certificate issued by the Disclosure and Barring Service under Part V of the Police Act 1997, is considered by the Trust to be inappropriate on the grounds that ~~his~~ their appointment might adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute;

1.16 ~~he has~~they have failed to make, or has falsely made, any declaration as required by paragraph 12.5 of the Constitution;

1.17 ~~he is~~they are included in any barred list established under the Safeguarding Vulnerable Groups Act 2006, or who is included in an equivalent list maintained under the law of Scotland or Northern Ireland;

1.18 ~~he is~~they are a person who is the subject of a disqualification order made under the Company Directors' Disqualification Act 1986;

1.19 the relevant Partnership Organisation which ~~he~~ they represent~~s~~ ceases to exist;

1.20 ~~he has~~they have within the preceding 2 years been dismissed, otherwise than by reason of redundancy, from any paid employment with a Health Service Body;

1.21 ~~he has~~they have received a written warning from the Trust for verbal and/or physical abuse towards Trust staff; or

1.22 ~~he has~~they have been expelled from the post of governor of another NHS foundation trust.

2 Where a person has been elected or appointed to be a Governor and they~~he~~ become~~s~~ disqualified or are~~is~~ removed from office under paragraph 14 of the Constitution or paragraph 1 above, they~~he~~ shall notify the Secretary in writing of such disqualification and/or (as the case may be), removal as soon as is practicable and, in any event, within 14 days of first becoming aware of those matters which rendered him disqualified or removed.

3 If it comes to the notice of the Secretary at the time of their~~his~~ taking office or later that the Governor is so disqualified, the Secretary shall immediately declare that the person in question is disqualified and notify them~~him~~ in writing to that effect as soon as is practicable.

4 Upon despatch of any such notification under paragraphs 2 or 3 above, that person's tenure of office, if any, shall be terminated immediately and they~~he~~ shall cease to act as a Governor, and the Secretary shall cause their~~his~~ name to be removed from the register of members of the Council of Governors.

5 Where an individual is deemed by the Secretary, in their~~his~~ absolute discretion, to be incapable by reason of mental disorder, illness or injury of managing and/or administering their~~his~~ property and/or affairs for the purposes of paragraph 1.8 above, the Secretary shall either:

5.1 temporarily suspend the individual from office until such time as the Secretary, in their~~his~~ absolute discretion, considers them~~him~~ to be capable of managing and/or administering their~~his~~ property and affairs; or

5.2 (where the Secretary, in their~~his~~ absolute discretion, considers them~~him~~ to be permanently incapable of managing and/or administering their~~his~~ property and affairs), declare that the individual is disqualified from office in accordance with paragraphs 3 and 4 above; and

5.3 In considering whether an individual is incapable by reason of mental disorder, illness or injury of managing and/or administering their~~his~~ property and/or affairs, the Secretary shall take into account the provisions of the Mental Capacity Act 2005, or any statutory modification thereof and they~~he~~ shall be entitled to take appropriate professional advice from internal Trust advisors, and/or external advisors, as necessary.

ANNEX 5 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

Appendix 2:

Council of Governors: further provisions

1 Remuneration

Governors are not to receive remuneration from the Trust, provided that this shall not prevent the remuneration of Governors by their employer.

2 Vacancies

2.1 Where a vacancy arises amongst the Elected Governors for any reason other than expiry of a term of office, the provisions set out in paragraphs 2.1.1 to 2.1.3 below shall apply:

2.1.1 the Trust shall invite the next highest polling candidate for that seat at the most recent election or (where relevant) by-election, who is willing to take office, to fill the seat until the next annual election, at which time the seat will fall vacant and be subject to election for any unexpired period of the term of office;

2.1.2 where there is no next highest polling candidate willing to take office in accordance with paragraph 2.1.1 above, the Trust shall leave the seat vacant until the next scheduled elections are held if the unexpired period of office is less than six months;

2.1.3 where the unexpired period of office is not less than six months in accordance with paragraph 2.1.2 above, the Trust shall call an election within three months to fill the seat for the remainder of that term of office.

2.2 Where a vacancy arises amongst the Appointed Governors for any reason other than expiry of the term of office, the Secretary will request that the relevant organisation appoint a Replacement Governor within 30 days to hold office for the remainder of the term of office. Appointed Governors shall be replaced in accordance with the processes agreed pursuant to paragraph 2 of Annex 3 of this Constitution.

2.3 The validity of any act of the Council of Governors is not affected by any vacancy among the Governors or by any defect in the appointment of any Governor.

3 Meetings

3.1 The Council of Governors is to meet at least 4 times per year, including an annual meeting no later than 30 September in each Financial Year apart from the first year, when the Council of Governors is to receive and consider the Annual Accounts and any report of the Auditor on them and the Board of Directors is to present to the Council of Governors the Annual Report (the "**Annual Governors' Meeting**") in accordance with paragraph 39 of this Constitution.

3.2 The Secretary shall call meetings in accordance with paragraph 3.1 above.

3.3 Subject to paragraph 3.5 below, any meeting of the Council of Governors requires a quorum of one-third of the total number of Governors to be present, including 3 Public Governors and 2 Staff Governors.

3.4 No business shall be carried out at a meeting which is not quorate.

3.5 If at any meeting of the Council of Governors, there is no quorum present within 60 minutes of the time fixed for the start of the meeting the meeting shall stand adjourned for a minimum period of 5 Clear Days and the Secretary shall give or shall procure the giving of notice to all Governors of the date, time and place of that adjourned meeting. Notwithstanding paragraph 3.3 above, upon reconvening, those present shall constitute a quorum.

4 Committees, sub-committees and joint committees

4.1 The Council of Governors may appoint committees consisting wholly or partly of its members to assist it in carrying out its functions. A committee appointed under this paragraph may appoint a sub-committee.

4.2 The Council of Governors may appoint members to serve on joint committees with the Board of Directors or committees thereof.

4.3 These committees, sub-committees or joint committees may call upon outside advisers to help them in their tasks, provided that the financial and other implications of seeking outside advisers have been discussed and agreed by the Board of Directors. Any conflict arising between the Council of Governors and the Board of Directors under this paragraph will be determined in accordance with paragraph 2.3 of Appendix 4 of Annex 8.

~~5 Transitional provisions for the Initial Elected Governors~~

~~The following provisions shall apply for the Initial Elected Governors of the Trust.~~

~~5.1 The initial Public Governors~~

~~5.1.1 Of those candidates who are declared elected from the following Public Constituencies of the Trust at the Initial Election:~~

~~5.1.1.1 City of Bath;~~
~~5.1.1.2 North East Somerset;~~
~~5.1.1.3 North Wiltshire;~~
~~5.1.1.4 South Wiltshire; and~~
~~5.1.1.5 Mendip,~~

~~the candidate who polls the most votes shall serve a term of office ending 3 (three) years from the date of Authorisation and the remaining candidate shall serve a term of office ending 2 (two) years from the date of Authorisation.~~

~~5.1.2 Candidates elected unopposed shall be deemed to have received 1 (one) vote for the purposes of paragraph 5.1.1 above.~~

~~5.1.3 If after applying the provisions of paragraphs 5.1.1 and 5.1.2 above, it is not possible to determine which candidate or candidates are entitled to~~

~~an initial term of office of 2 years or 3 years, his or their initial term of office shall be determined by the drawing of lots. The drawing of lots shall be conducted by the Chair in the presence of two Non-Executive Directors and the Secretary, who shall report the outcome to the candidates concerned.~~

~~**5.2 The initial Staff Governors**~~

~~5.2.1 Of those candidates who are declared elected at the Initial Election, the three candidates who polled the most votes shall serve a term of office ending 3 (three) years from the date of Authorisation.~~

~~5.2.2 Of those candidates who are declared elected at the Initial Election, the two candidates who polled the least votes shall serve a term of office ending 2 (two) years from the date of Authorisation.~~

~~5.2.3 Candidates elected unopposed shall be deemed to have received 1 (one) vote for the purposes of paragraphs 5.2.1 and 5.2.2 above.~~

~~5.2.4 If, after applying the provisions of paragraphs 5.2.1 to 5.2.3 above it is not possible to determine which candidate or candidates are entitled to an initial term of office of 2 years or 3 years, his or their initial term of office shall be determined by the drawing of lots. The drawing of lots shall be conducted by the Chair in the presence of two Non-Executive Directors and the Secretary, who shall report the outcome to the candidates concerned.~~

~~5.3 For the purposes of the provisions set out in paragraphs 5.1 and 5.2 above, a "year" means a period of 12 consecutive "months" commencing immediately on the date of Authorisation and a "month" means a calendar month.~~

~~6~~5 Council of Governors: declarations

~~6.1~~5.1 The specified form of declaration referred to at paragraph 12.5 of this Constitution regarding the declaration to stand for election as an Elected Governor shall be as set out on the nomination paper referred to in the Model Rules for Elections at Annex 4 and shall state as follows:

"I declare that I am resident at the address detailed in Section 1 of this form. I declare that to the best of my knowledge I am eligible to stand for election to the Council of Governors for the seat named in Section 2 of this form. I declare that to the best of my knowledge I am not de-barred from standing for election by any of the provisions detailed at Section 3 of this form. I declare that I have stated details of any of my political membership and any financial interests I have in the Trust at Section 4 of this form. I understand that if any of these declarations are later found to be false I will if elected lose my seat on the Council of Governors and may also have my membership withdrawn".

~~6.2~~5.2 The specified form of declaration referred to at paragraph 12.5 of this Constitution regarding the declaration to vote in elections for Public Governors will be as set out in Rule 21 of the Model Rules for Elections.

ANNEX 6 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

(Paragraph 16)

1 INTRODUCTION

1.1 The Trust became a Public Benefit Corporation following on [INSERT DATE].

1.2 The Trust's principal place of business is the Trust Headquarters.

1.3 The Trust is governed by the Regulatory Framework. The functions of the Trust are conferred by the Regulatory Framework. The Regulatory Framework requires the Council of Governors to adopt SOs for the regulation of its proceedings and business and to adhere at all times to the Governors' Code of Conduct.

2 INTERPRETATION

2.1 Save as otherwise permitted by law, at any meeting of the Council of Governors, the Chair of the Trust shall be the final authority on the interpretation of the SOs (on which ~~he~~ they should be advised by the Secretary).

2.2 Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in these SOs shall bear the same meaning as in the Constitution.

2.3 The provisions of paragraphs 1.2 to 1.6 of the Constitution apply to these SOs, save that any reference to "Constitution" shall be read as a reference to these "SOs".

3 THE COUNCIL OF GOVERNORS

Further provisions for the Governors are set out in Annex 5 of the Constitution and have effect as if incorporated into the SOs. Certain powers and decisions may only be exercised by the Council of Governors in formal session.

4 MEETINGS OF THE COUNCIL OF GOVERNORS

4.1 Admission of the public

4.1.1 The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Council of Governors except where it resolves by special resolution that members of the public and representatives of the press be excluded from all or part of a meeting on the grounds that:

4.1.1.1 any publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted; or

4.1.1.2 for other reasons stated in the resolution and arising from the nature of the business or the proceedings that the Council of Governors believe are special reasons for excluding the public from the meeting in accordance with the Constitution.

4.1.2 Nothing in these SOs shall require the Council of Governors to allow members of the public and representatives of the press to record proceedings in any manner whatsoever, other than in writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Chair.

4.2 Calling meetings

4.2.1 Meetings of the Council of Governors shall be held at such times and places and of such format including in person, bu ising electronic communication or hybrid as the Council of Governors may determine and there shall be at least four meetings in any year including:

4.2.1.1 the Annual Governors' Meeting; and

4.2.1.2 any other meetings required of the Governors in order to fulfil their functions in accordance with the Constitution.

4.2.2 The Chair may call a meeting of the Council of Governors at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least 7 Governors and specifying the business to be transacted at the meeting, has been presented to ~~him~~them, or if, without so refusing, the Chair does not call a meeting within 14 Clear Days after such requisition has been presented to ~~him~~ them at the Trust's Headquarters, such one-third or more of the Governors may forthwith call a meeting for the purpose of conducting that business.

4.2.3 The Council of Governors may invite the Chief Executive, members of the Board of Directors or a representative of the Auditor or other advisors to attend a meeting of the Council of Governors.

4.2.4 The Council of Governors may agree that Governors can participate in its meetings by telephone or video link. Participation in a meeting in this manner shall be deemed to be exceptional but shall constitute presence in person at the meeting for the purposes of SO 4.18 (Quorum).

4.2.5 Notwithstanding the provisions of SO 4.2.1 above, the Secretary shall publish the dates, times and locations of meetings of the Council of Governors, apart from meetings convened under SO 4.2.2 or those held in the event of an emergency giving rise to the need for an immediate meeting, for each year, six months in advance.

4.3 Notice of meetings and agenda

4.3.1 Before each meeting of the Council of Governors, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair or by an Officer authorised by the Chair to sign on ~~his~~ their behalf, shall be delivered to, or sent by post to the usual place of residence of every Governor or sent electronically, so as to be available to ~~him~~ them at least 3 Clear Days before the meeting save in the case of emergencies.

4.3.2 Before each meeting of the Council of Governors a public notice of the time and place of the meeting, and if appropriate remote access/electronic communication arrangements, of the meeting, and if possible the public part of the agenda, shall be displayed at the Trust's Headquarters and shall be advertised on the Trust's website at least 3 Clear Days before the meeting, save in the case of emergencies.

4.3.3 Want of service of the notice of meeting on any one Governor shall not affect the validity of a meeting but failure to serve such a notice on more than three Governors will invalidate the meeting. A notice of meeting shall be presumed to have been served one day after posting or, in the case of a notice sent electronically, on the date of transmission.

4.3.4 In the case of a meeting called by Governors in default of the Chair in accordance with SO 4.2.2, the notice shall be signed by those Governors and no business shall be transacted at the meeting other than that specified in the requisition.

4.3.5 Agendas will be sent to Governors electronically, by mail or other means before the meeting and supporting papers (including draft minutes of the previous meeting), whenever possible, shall accompany the agenda, but will certainly be despatched no later than 3 Clear Days before the meeting, save in the case of emergencies.

4.3.6 In the event of an emergency giving rise to the need for an immediate meeting failure to comply with the notice periods referred to in SOs 4.3.1, 4.3.2 and 4.3.5 shall not prevent the calling of or invalidate such meeting provided that every effort is made to contact members of the Council of Governors who are not absent from the United Kingdom and the agenda for the meeting is restricted to matters arising in that emergency.

4.4 Annual Governors' Meeting

4.4.1 In accordance with paragraph 3.1 of Appendix 2 to Annex 5 of the Constitution and SO 4.2.1.1, the Council of Governors shall hold an Annual Governors' Meeting in each Financial Year (apart from the first year) and, subject to SO 4.4.2, shall present to that meeting:

4.4.1.1 a report on the proceedings of its meetings held since the last Annual Governors' Meeting;

4.4.1.2 a report on the progress since the last Annual Governors' Meeting in developing the Membership Strategy including the steps taken to ensure that the actual membership of the Public Constituencies is representative of the persons who are eligible to be Members under the Constitution;

4.4.1.3 a report on any change to the Governors which has taken place since the last Annual Governors' Meeting; and

4.4.1.4 a report containing such comments as it wishes to make regarding the performance of the Trust and the accounts of the Trust for the preceding Financial Year and the future service development plans of the Trust.

4.4.2 The reports set out in SOs 4.4.1.1 to 4.4.1.4 for the first Annual Governors' Meeting shall cover the period from the date of Authorisation to the date of that meeting.

4.5 Setting the agenda

4.5.1 The Council of Governors may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted ("Standing Items").

4.5.2 A member of the Council of Governors desiring a matter other than a Standing Item to be included on an agenda, including a formal motion for discussion and voting on at a meeting, shall make ~~his~~ their request in writing to the Secretary at least 15 Clear Days before the meeting. For the purposes of this SO 4.5.2, receipt of any such requests via Electronic Communications is acceptable. A request for a formal motion must be signed or transmitted by at least 2 Governors. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 15 Clear Days before a meeting may be included on the agenda at the discretion of the Chair.

4.5.3 All requests received by the Secretary pursuant to SO 4.5.2 will be acknowledged by the Secretary in writing to the Governors who have signed or transmitted the same.

4.6 Petitions

Where a petition has been received by the Trust, the Chair shall include the petition as an item for the agenda of the next meeting of the Council of Governors.

4.7 Written motions

4.7.1 In urgent situations and with the consent of the Chair, business may be affected by a Governor's written motion to deal with business otherwise required to be conducted at a meeting of the Council of Governors.

4.7.2 If all members of the Council of Governors have been notified of the proposal and three-quarters of Governors entitled to attend and vote at a meeting of the Council of Governors confirms acceptance of the written motion either in writing or electronically to the Secretary within 5 Clear Days of dispatch then the motion will be deemed to have been resolved, notwithstanding that the Governors have not gathered in one place.

4.7.3 The effective date of the resolution shall be the date that the last confirmation is received by the Secretary and, until that date, a Governor who has previously indicated acceptance can withdraw, and the motion shall fail.

4.7.4 Once the resolution has been passed, a copy certified by the Secretary shall be recorded in the minutes of the next ensuing meeting where it shall be signed by the person presiding at it.

4.8 Chair of meeting

4.8.1 At any meeting of the Council of Governors, the Chair, if present, shall preside.

4.8.2 If the Chair is absent from the meeting or is absent temporarily on the grounds of a declared conflict of interest, the Vice Chair shall preside.

4.8.3 If the Vice Chair is absent from the meeting or is absent temporarily on the grounds of a declared conflict of interest, another Non-Executive Director as shall be appointed by the Council of Governors for that Trust meeting shall preside.

4.9 Motions

4.9.1 Where a Governor has requested inclusion of a matter on the agenda in accordance with SO 4.5.2 above as a matter to be formally proposed for discussion and voting on at the meeting, the provisions of this SO 4.9 shall apply in respect of the motion.

4.9.2 The mover of the motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto, or to raise a point of order.

4.9.3 When a motion is under discussion or immediately prior to discussion it shall be open to a Governor to move (without prior notice having been given):

4.9.3.1 that the motion be withdrawn; or

4.9.3.2 an amendment to the motion; or

4.9.3.3 the adjournment of the discussion or the meeting; or

4.9.3.4 that the meeting proceed to the next item of business on the agenda; or

4.9.3.5 the appointment of an ad hoc committee to deal with a specific item of business; or

4.9.3.6 that the motion be now put; or

4.9.3.7 that the public be excluded from the meeting in relation to the discussion concerning the motion under SO 4.1.

4.9.4 In the case of SOs 4.9.3.4 and 4.9.3.6 above, to ensure objectivity these matters may only be put by a Governor who has not previously taken part in the debate and who is eligible to vote.

4.9.5 No amendment to the motion shall be admitted if, in the opinion of the Chair, the amendment negates the substance of the motion.

4.9.6 For the avoidance of doubt, the following motions may be moved at a meeting of the Council of Governors without notice pursuant to SO 4.5.2 above:

4.9.6.1 a motion in relation to the accuracy of the minutes of the previous meeting of the Council of Governors;

4.9.6.2 a motion to change the order of business in the agenda for that meeting;

4.9.6.3 a motion to refer a matter discussed at a meeting to an appropriate body or individual;

4.9.6.4 a motion to appoint an ad hoc committee or a working group to deal with a specific item of business;

4.9.6.5 a motion to receive reports or adopt recommendations made by the Board of Directors;

4.9.6.6 a motion to withdraw a motion;

4.9.6.7 a motion to amend a motion;

4.9.6.8 a motion to proceed to the next item of business on the agenda;

4.9.6.9 a motion that the question be now put;

4.9.6.10 a motion to adjourn a debate;

4.9.6.11 a motion to adjourn a meeting;

4.9.6.12 a motion to suspend a particular SO (subject to SO 4.15 below);

4.9.6.13 a motion to exclude the public and press from the meeting in question pursuant to SO 4.1 above;

4.9.6.14 a motion to not hear further from a Governor, or to exclude them from the meeting in question (if a Governor persistently disregards the ruling of the Chair or behaves improperly or offensively or deliberately obstructs business, the Chair, in ~~his~~ their absolute discretion, may move that the Governor in question be not heard further at the meeting in question. If seconded, the motion will be voted on without discussion. If the Governor continues to behave improperly after such a motion is carried, the Chair may move that either the Governor leaves the meeting room or that the meeting in question is adjourned for a specified period. If seconded, the motion will be voted on without discussion); and

4.9.6.15 a motion to give the consent of the Council of Governors to any matter where its consent is required pursuant to the Constitution.

4.10 Report from the Board of Directors

4.10.1 Unless otherwise agreed in writing between the Council of Governors and the Board of Directors, at each meeting of the Council of Governors,

the Board of Directors through the Chair or an Executive Director (or Nominated Officer) is required to report to the Council of Governors on the Trust's general progress forward and forward planning.

4.10.2 At any meeting a Governor may ask any question through the Chair without notice on any report made pursuant to SO 4.10.1 above after that report has been received by or while such report is under consideration by the Council of Governors at the meeting. Unless the Chair decides otherwise no statements will be made other than those which are strictly necessary to define any question posed. A Governor who has put such a question may also put one supplementary question if the supplementary question arises directly out of the reply given to the initial question. The Chair may, in their~~his~~ absolute discretion, reject any question from any Governor if in their~~his~~ opinion the question is substantially the same and relates to the same subject matter as a question which has already been put to that meeting or a previous meeting. At the absolute discretion of the Chair questions may, at any meeting which is held in public, be asked of the Executive Directors present by Members of the Trust or any other members of the public present at the meeting.

4.11 Chair's ruling

4.11.1 Subject to SO 4.11.2 below, statements of Governors made at meetings of the Council of Governors shall be relevant to the matter under discussion at the material time, and subject to SO 2.1, the decision of the Chair on questions of order, relevancy, regularity and any other matters shall be final.

4.11.2 This SO applies to all forms of speech/debate by Governors in relation to motions or questions under discussion at a meeting of the Council of Governors.

4.11.3 Content and length of speeches

Any approval to speak must be given by the Chair. Speeches must be directed to the matter, motion or question under discussion or to a point of order. In the interests of time the Chair may, in ~~his~~ their absolute discretion, limit the number of replies, questions or speeches which are heard at any one meeting.

4.11.4 When a person may speak again

A person who has already spoken on a matter at a meeting may not speak again at that meeting in respect of the same matter, except:

4.11.4.1 in exercise of a right of reply; or

4.11.4.2 on a point of order.

4.11.5 Identification

All speakers must state their name and role before starting to speak to ensure the accuracy of the minutes

4.12 Voting

4.12.1 A Governor may not vote at a meeting of the Council of Governors unless, within 7 Clear Days prior to the commencement of the meeting ~~he has~~they have:

4.12.1.1 made a declaration in the form specified within Annex A of these SOs, that ~~he is~~they are a member of the constituency which elected ~~him~~them; and

4.12.1.2 that ~~he is~~they are not prevented from being a member of the Council of Governors by paragraph 8 of Schedule 7 to the 2006 Act or under the Constitution.

4.12.2 A Governor shall be deemed to have confirmed the declarations on attending a subsequent meeting of the Council of Governors, unless ~~he~~ they otherwise notify~~ies~~ the Secretary in writing.

4.12.3 Subject to SO 4.12.4 below, every question at a meeting shall be determined by a three-quarters majority of the votes of the Chair and the Governors present and voting at a meeting of the Council of Governors on the question but no resolution may be passed if it is opposed by all of the Public Governors present and voting on the question at the meeting of the Council of Governors.

4.12.4 Whoever is Chair of the meeting of the Council of Governors shall in the case of an equality of votes on any question or proposal have a casting vote.

4.12.5 A resolution for the removal of the Chair or a Non-Executive Director shall be passed only if three-quarters of the total number of Governors vote in favour of it and the provisions of paragraphs 22.2 to 22.6 of the Constitution have been complied with.

4.12.6 All questions put to the vote shall, at the discretion of the Chair, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Governors present so request. In the event of a meeting held using electronic communication, an electronic voting facility will be made available, including when appropriate, the facility for holding a secret ballot.

4.12.7 If at least one-third of the Governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Governor present voted or abstained.

4.12.8 If a Governor so requests, ~~his~~ their vote shall be recorded by name upon any vote (other than by paper ballot).

4.12.9 A Governor may only vote if present (either in person or by electronic communication) at the time of the vote on which the question is to be

decided; no Governor may vote by proxy but a Governor is considered to have been present at the meeting if they took part by telephone or video link and so is therefore entitled to vote.

4.12.10 In certain circumstances, the Chair may specify in a notice of meeting any matter which requires approval by a written resolution and such a matter may be approved in writing provided that at least three-quarters of the Governors, and a majority of Governors who are members of the Staff Constituency and Public Constituency of the Trust, approve the resolution in writing within the timescale imposed in such a notice.

4.12.11 All decisions taken in good faith at the meeting of the Council of Governors or at any meeting of a committee shall be valid even if it is subsequently discovered that there was a defect in the calling of the meeting or the appointment of the Governors attending the meeting.

4.13 Special provisions relating to termination of Governors' tenure:

4.13.1 Where a person has been elected or appointed to be a Governor and ~~he~~ they becomes disqualified from office under paragraph 14, or the provisions of Appendix 1 of Annex 5 of the Constitution, ~~he~~ they shall notify the Secretary in writing of such disqualification as soon as practicable and in any event within 14 days of the first becoming aware of those matters which render ~~him~~ them disqualified. The Secretary shall forthwith remove ~~him~~ them from the register of members of the Council of Governors.

4.13.2 If it comes to the notice of the Secretary that the Governor is disqualified pursuant to SO 4.13.1, whether at the time of the Governor's appointment or (as the case may be) election, or later, the Secretary shall immediately declare that the individual in question is disqualified and give ~~him~~ them notice in writing to that effect as soon as practicable and in any event within 14 days of the date of the said declaration. In the event that the Governor shall dispute that ~~he is~~they are disqualified the Governor may refer the matter to the dispute resolution procedure set out in paragraph 2.2 of Appendix 4 of Annex 8 of the Constitution within 28 days of the date upon which the notice was given to the Governor.

4.13.3 The Chair shall be authorised to take such action as may be immediately required, including but not limited to exclusion of the Governor concerned from the meeting so that any allegation made against a Governor on the grounds set out in paragraph 14.6 of the Constitution can be investigated.

4.13.4 Where any grounds within SO 4.13.3 are alleged, it shall be open to the Council of Governors to decide, by two-thirds majority of those present and voting at a meeting of the Council of Governors, to lay a formal charge of non-compliance or misconduct.

4.13.5 The Governor in question will be notified in writing of the allegations and grounds upon which the charges referred to in SO 4.13.4 are made, inviting and considering his response within a defined, appropriate and reasonable timescale.

4.13.6 The Governor may be invited to address the Council of Governors in person at a meeting of the Council of Governors if the matter cannot be resolved satisfactorily through correspondence.

4.13.7 The Governors, by two-thirds majority of those present and voting at a meeting of the Council of Governors can decide whether to uphold the charge.

4.13.8 Should the Governors uphold the charge in accordance with SO 4.13.7, the Governors can impose such sanctions as shall be deemed appropriate. Such sanctions may range from the issuing of a written warning as to the Governor's future conduct and consequences, to non-payment of expenses, or removal of the Governor from office in accordance with paragraph 14.6 of the Constitution.

4.13.9 Upon disqualification, removal or termination of a Governor's office under this SO, the Secretary shall cause ~~his~~ their name to be removed immediately from the register of members of the Council of Governors.

4.13.10 Any decision of the Council of Governors to terminate a Governor's tenure of office may be referred by the Governor concerned to the dispute resolution procedure set out in paragraph 2.2 of Appendix 4 of Annex 8 of the Constitution within 28 days of the date upon which notice in writing of the Council of Governor's decision made in accordance with SOs 4.13.7 and 4.13.8 is communicated to the Governor concerned.

4.13.11 A Governor may resign from that office at any time during the term of that office by giving notice to the Secretary in writing, upon which ~~he~~ they shall cease to hold office.

4.13.12 A Governor who resigns under SO 4.13.11 above or whose office is terminated under this SO or paragraph 14 of the Constitution shall not be eligible to stand for re-election or re-appointment to the Council of Governors for a period of 3 years from the date of ~~his~~ their resignation or removal from office or the date upon which any appeal against ~~his~~ their removal from office is disposed of whichever is later.

4.13.13 Where a vacancy arises on the Council of Governors, the provisions of paragraph 2 of Appendix 2 of Annex 5 of the Constitution shall apply.

4.14 Minutes

4.14.1 The minutes of the proceedings of a meeting of the Council of Governors shall be drawn up by the Secretary and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

4.14.2 No discussion shall take place upon the minutes except upon their accuracy or where the person chairing the meeting considers discussion appropriate.

4.14.3 Any amendment to the minutes shall be agreed and recorded at the next meeting.

4.15 Suspension of Standing Orders

4.15.1 Except where this would contravene any provision of the Regulatory Framework or any guidance or best practice advice issued by NHS England~~l~~, any one or more of the SOs may be suspended at any meeting, provided that at least three-quarters of the Governors are present, there is a majority of Governors who are members of the Public Constituency, and that a three-quarters majority of those present vote in favour of suspension.

4.15.2 A decision to suspend the SOs shall be recorded in the minutes of the meeting and shall only be suspended for the duration of the meeting in question.

4.15.3 A separate record of matters discussed during the suspension of SOs shall be made and shall be made available to the Chair and Governors.

4.15.4 No formal business may be transacted while the SOs are suspended.

4.16 Record of attendance

The names of the person chairing the meeting and Governors present at the meeting shall be recorded in the minutes.

4.17 Quorum

4.17.1 No business shall be transacted at a meeting unless at least one-third of the total number of Governors is present including 3 Public Governors and 2 Staff Governors.

4.17.2 If at any meeting there is no quorum present within 60 minutes of the time fixed for the start of the meeting, the meeting shall stand adjourned for a minimum period of 5 Clear Days and the Secretary shall give or shall procure the giving of notice to all Governors of the date, time and place of the adjourned meeting. Notwithstanding SO 4.18.1 above, upon reconvening, those present shall constitute a quorum.

4.17.3 If a Governor has been disqualified from participating in the discussion on any matter and/or from other voting on any resolution by reason of the declaration of a conflict of interest as provided in SO 7, ~~he~~ they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

5 COMMITTEES

5.1 Subject to any guidance or best practice advice as may be issued by NHS England~~l~~, the Council of Governors may and, if directed by NHS England~~l~~, shall appoint

committees of the Council of Governors to assist it in the proper performance of its functions under the Regulatory Framework, consisting wholly or partly of the Chair, Governors and others.

5.2 A committee appointed under SO 6 may, subject to such directions as may be given by the Council of Governors, appoint sub-committees consisting wholly or partly of members of the committee.

5.3 These SOs, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Council of Governors with the terms "Chair" to be read as a reference to the Chair of the committee, and the term "Governor" to be read as a reference to a member of the committee as the context permits.

5.4 Each such committee shall have such terms of reference and powers and be subject to such conditions as the Council of Governors shall decide and shall be in accordance with the Regulatory Framework and any guidance or best practice advice issued by NHS England~~I~~, but the Council of Governors shall not delegate to any committee any of the powers or responsibilities which are to be exercised by the Council of Governors at a formal meeting.

5.5 Where committees are authorised to establish sub-committees they may not delegate their powers to the sub-committee unless expressly authorised by the Council of Governors.

5.6 Any committee or sub-committee established under this SO 6 may call upon outside advisers to assist them with their tasks, subject to the advance agreement of the Board of Directors. Any conflict arising between the Council of Governors and the Board of Directors under this paragraph shall be determined in accordance with the dispute resolution procedure set out at paragraph 2.3 of Appendix 4 of Annex 8 of the Constitution.

5.7 The Council of Governors shall approve the appointments to each of the committees which it has formally constituted.

5.8 Where the Council of Governors is required to appoint persons to a committee to undertake statutory functions, and where such appointments are to operate independently of the Council of Governors, such appointments shall be made in accordance with applicable statute and regulations and with guidance or best practice advice issued by ~~NHSEI~~NHS England.

5.9 Where the Council of Governors determines that persons who are neither Governors, nor Directors or Officers of the Trust, shall be appointed to a committee, the terms of such appointment shall be determined by the Council of Governors subject to the payment of travelling expenses and other allowances being in accordance with such sum as may be determined by the Board of Directors.

5.10 The Council of Governors may appoint Governors to serve on joint committees with the Board of Directors on the request of the Chair.

6 DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

6.1 Declaration of interests

6.1.1 The Regulatory Framework requires each Governor to declare to the Secretary (before the Trust enters into the transaction or arrangement):

6.1.1.1 any actual or potential interest, direct or indirect interest in a proposed transaction or arrangement with the Trust, as described in SO 7.2.1; and

6.1.1.2 any actual or potential pecuniary interest, direct or indirect, in any contract, proposed contract or other matter concerning the Trust, as described in SOs 7.2.2 and 7.2.3; and

6.1.1.3 any actual or potential family interest, direct or indirect, of which the Governor is aware, as described in SO 7.2.5.

6.1.2 Such a declaration shall be made either at the time of the Governor's election or appointment or as soon thereafter as the interest arises, and in a form prescribed by the Secretary as attached at Annex B to these SOs.

6.1.3 In addition, if a Governor is present at a meeting of the Council of Governors and has an interest of any sort in any matter which is the subject of consideration, they~~he~~ shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not vote on any question with respect to the matter.

6.1.4 If a declaration under paragraph 7.1.2 above proves to be, or becomes, inaccurate or incomplete, the Governor must make a further declaration before the Trust enters into the transaction or arrangement. This does not require a declaration of an interest of which the Governor is not aware or where the Governor is not aware of the transaction or arrangement in question.

6.1.5 A Governor need not declare an interest:

7.1.5.1 if, it cannot reasonably be regarded as likely to give rise to a conflict of interest;

6.1.5.2 if, or to the extent that, the Governors are already aware of it.

6.1.6 Subject to SO 7.2.4, if a Governor has declared a pecuniary interest (as described in SOs 7.2.2 and 7.2.3) they~~he~~ shall not take part in the consideration or discussion of the matter. At the time the interests are declared, they should be recorded in the Governor's meeting minutes. Any changes in interests should be officially declared at the next relevant meeting following the change occurring.

6.1.7 This SO 7 applies to any committee, sub-committee or joint committee of the Council of Governors and applies to any member of any such committee, sub-committee, or joint committee (whether or not he is also a Governor).

6.1.8 The interests of Governors in companies likely or possibly seeking to do business with the Trust should be published in the Annual Report. The

information should be kept up to date for inclusion in succeeding Annual Reports.

6.2 Nature of interests

6.2.1 Interests which should be regarded as "relevant and material" are as follows and are to be interpreted in accordance with guidance issued by ~~NHSE~~NHS England:

6.2.1.1 directorships, including non-executive directorships held in private companies or public limited companies (with the exception of those of dormant companies); or

6.2.1.2 ownership, part-ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS or the Trust; or

6.2.1.3 significant or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS or the Trust; or

6.2.1.4 a position of authority in a charity or Voluntary Organisation in the field of health and social care; or

6.2.1.5 any connection with a voluntary or other organisation contracting for NHS or Trust services or commissioning NHS or services; or

6.2.1.6 any connection with an organisation, entity or company considering entering into or having entered into a financial agreement with the Trust, including but not limited to, lenders or banks.

6.2.2 A Governor shall be treated as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

6.2.2.1 they~~he~~, or a nominee of theirs~~his~~, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or

6.2.2.2 they are~~he is~~ a partner of, or is in the employment of, a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration.

6.2.3 A Governor shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

6.2.3.1 of their~~his~~ membership of a company or other body, if ~~he has~~they have no beneficial interest in any securities of that company or other body; or

6.2.3.2 of an interest in any company, body or person with which ~~he is~~they are connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Governor in the consideration or discussion of or in voting on, any question with respect to that contract or matter; or

6.2.3.3 of any travelling or other expenses or allowances payable to a Governor in accordance with the Constitution.

6.2.4 Where a Governor:

6.2.4.1 has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

6.2.4.2 the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

6.2.4.3 if the share capital is of more than one class, the total nominal value of shares of any one class in which ~~he has~~they have a beneficial interest does not exceed one-hundredth of the total issued share capital of that class, the Governor shall not be prohibited from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to ~~his~~ their duty to disclose ~~his~~ their interest.

6.2.5 A family interest is an interest of an Immediate Family Member of a Governor which if it were the interest of that Governor would be a personal interest or a pecuniary interest of his.

6.2.6 If Governors have any doubt about the relevance or materiality of an interest, this should be discussed with the Secretary. Influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships should also be considered.

6.3 Register of members of the Council of Governors

The register of members of the Council of Governors shall list the names of Governors, their category of membership of the Council of Governors and an address through which they may be contacted which may be the Secretary.

6.4 Register of interests of members of the Council of Governors

The Secretary shall keep a register of interests of members of the Council of Governors which shall contain the names of each Governor, whether he has declared any interest, and if so, the interest declared.

7 STANDARDS OF BUSINESS CONDUCT

Members of the Council of Governors shall comply with the Governors' Code of Conduct and any guidance or best practice advice issued by ~~NHSE~~NHS England.

8 APPOINTMENTS AND RECOMMENDATIONS

8.1 A Governor shall not solicit for any person any appointment under the Trust or recommend any person for such appointment but this paragraph of this SO shall not

preclude a Governor from giving written testimonial of a candidate's ability, experience or character for submission to the Trust in relation to any appointment.

8.2 Informal discussions outside nominations panels, appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee in question.

8.3 Every Governor shall disclose to the Chief Executive or ~~his~~ their delegated Officer any relationship between ~~himself~~ themselves and a candidate of whose candidature that Governor or Officer is aware. It shall be the duty of the Chief Executive or ~~his~~ their delegated Officer to report to the Council of Governors any such disclosure made.

8.4 On appointment, members of the Council of Governors should disclose to the Council of Governors whether they are related to any other member of the Council of Governors or holder of any office in the Trust.

8.5 Where the relationship to a member of the Council of Governors of the Trust is disclosed, SO 7 shall apply.

9 MISCELLANEOUS

9.1 The Secretary shall provide a copy of these SOs to each Governor and endeavour to ensure that each Governor understands ~~his~~ their responsibilities within these SOs.

9.2 If for any reason these SOs are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Council of Governors for action or ratification. All Governors have a duty to disclose any non-compliance with these SOs to the Chair as soon as possible.

Annex A

Declaration to the Secretary of the Royal United Hospitals Bath NHS Foundation Trust

I hereby declare that I am at the date of this declaration a member of the [Public/Staff][2] Constituency, and I am not prevented from being a member of the Council of Governors by reason of any provision of paragraph 8 of Schedule 7 to the 2006 Act or the Constitution.

Annex B

Prescribed Form of Declaration of Interests

Declaration to the Secretary of **the Royal United Hospitals Bath NHS Foundation Trust**

Date [insert]

To the Secretary of **the Royal United Hospitals Bath NHS Foundation Trust**

Dear [insert]

In fulfilment of the obligations imposed on me by paragraph 17 of the Constitution of the Trust and the provisions of Standing Order 7 of the Standing Orders for the Council of Governors generally, and in particular Standing Order 7.1.2, I hereby give notice to the Trust of my interest in **[**insert details of the nature and extent of the relevant interest(s) (e.g. pecuniary, non-pecuniary, direct, indirect, actual, potential, etc.)**]** as of the date posted above.

I require the nature and extent of my interest(s) to be recorded in the Trust's register of interests of the members of the Council of Governors.

Yours faithfully

[insert name]

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[2]Please delete as appropriate.

ANNEX 7 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

(Paragraph 28)

10 INTRODUCTION

10.1 Statutory framework

10.1.1 The Trust became a Public Benefit Corporation on 1 November 2014.

10.1.2 The Trust's principal place of business is the Trust Headquarters.

10.1.3 The Trust is governed by the Regulatory Framework. The functions of the Trust are conferred by the Regulatory Framework. The Regulatory Framework and in particular paragraph 28 of the Constitution requires the Board of Directors to adopt SOs for the regulation of its proceedings and business.

10.1.4 As a Public Benefit Corporation, the Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable. The Trust also has a common law duty as a bailee for patients' property held by the Trust on behalf of patients.

10.1.5 The SOs, Scheme of Delegation and SFIs provide a comprehensive business framework for the administration of the Trust's affairs, and these need to be read in conjunction with the Regulatory Framework. All Directors and Nominated Officers should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions contained within them.

10.1.6 The Chair, Chief Executive or any other person giving information to the public on behalf of the Trust shall ensure that they follow the principles set out in the Directors' Code of Conduct.

10.2 Delegation of powers – Scheme of Delegation

10.2.1 Under SO 5 (Arrangements for the exercise of functions by delegation) the Board of Directors exercises its power to make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee of the Board of Directors appointed by virtue of SO 6 or by an Executive Director of the Trust, in each case subject to such restrictions and conditions as the Board of Directors thinks fit. Delegated powers are covered in the Scheme of Delegation.

11 INTERPRETATION

11.1 Save as otherwise permitted by law, at any meeting of the Board of Directors, the Chair of the Trust shall be the final authority on the interpretation of the SOs (on which he should be advised by the Chief Executive and Board of Directors' Secretary).

11.2 Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in these SOs shall bear the same meaning as in the Constitution.

11.3 The provisions of paragraphs 1.2 to 1.6 of the Constitution apply to these SOs, save that any reference to "Constitution" shall be read as a reference to these "SOs".

12 THE BOARD OF DIRECTORS

12.1 All business shall be conducted in the name of the Trust.

12.2 All funds received in trust shall be in the name of the Trust as corporate trustee. Directors acting on behalf of the Trust as corporate trustees are acting as quasi-trustees.

12.3 In relation to Funds held on Trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as the Trust. Accountability for charitable Funds held on Trust is to the Charity Commission.

12.4 The Trust has the functions conferred on it by the Regulatory Framework.

12.5 The powers of the Trust shall be exercised by the Board of Directors meeting either in public or private session except as otherwise provided for in SO 4.1.

12.6 The Trust has resolved that certain powers and decisions may only be exercised or made by the Board of Directors. These powers and decisions are set out in the Scheme of Delegation.

12.7 The Board of Directors (in consultation with the Council of Governors) may appoint any Non-Executive Director as the "senior independent director" (as defined in the NHS Foundation Trust Code of Governance), for such period not exceeding the remainder of ~~his/her~~their term as a Non-Executive Director, as they may specify on appointing ~~him/her~~them.

12.8 Any Non-Executive Director appointed under SO 3.7 may at any time resign from the office of "senior independent director" by giving notice in writing to the Chair. The Board of Directors (in consultation with the Council of Governors) may thereupon appoint another Non-Executive Director as "senior independent director" in accordance with the provisions in SO 3.7.

13 MEETINGS OF THE BOARD OF DIRECTORS

13.1 Admission of the public and the press

13.1.1 Meetings of the Board of Directors shall be held in public, unless the Board of Directors determines that any part of a meeting of the Board of Directors shall be held in private in accordance with paragraph 28~~30~~A.1 of the Constitution.

13.1.2 Where a meeting of the Board of Directors is held in public, the public and representatives of the press shall be afforded facilities to attend such meeting of the Board of Directors but shall be required to withdraw upon the Board of Directors resolving as follows:

"…that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest".

13.1.3 The Chair shall give such directions as ~~he/she~~they think~~s~~ fit (including a decision to expel or exclude any member of the public and/or press if the individual in question is interfering with or preventing the proper conduct of the meeting) in regard to the arrangements for meetings of the Board of Directors and (where relevant) accommodation of the public and representatives of the press such as to ensure that the Board of Directors' business shall be conducted without interruption or disruption and, without prejudice to the power to exclude the public and representatives of the press under SO 4.1.2 above, members of the public and representatives of the press) will be required to withdraw upon the Board of Directors resolving as follows:

"…that in the interests of public order the meeting adjourn for [the period to be specified] to enable the Board of Directors to complete business without the presence of the public or press."

13.1.4 Nothing in these SOs shall require the Board of Directors to allow members of the public or representative of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the Chair.

13.1.5 Matters to be dealt with by the Board of Directors following the exclusion of the public and representatives of the press under SOs 4.1.2 or 4.1.3 above shall be confidential to the Directors. Members of the Board of Directors, Nominated Officers, Officers and/or others in attendance at the request of the Chair shall not reveal or disclose the content of papers or reports presented, or any discussion on these generally, which take place while the public and press are excluded, without the express permission of the Chair.

13.1.6 The Directors will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers, advisors and others to attend and address any meeting of the Board of Directors, and may change, alter or vary these terms and conditions as it deems fit.

13.2 Calling meetings

13.2.1 Subject to SO 4.2.2 below, meetings of the Board of Directors shall be held at such times and places as the Board of Directors may, in its absolute discretion, determine.

13.2.2 The Chair may call a meeting of the Board of Directors at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of members of the Board of the Directors and specifying the business to be transacted at the meeting, and this has been presented to ~~him/her~~them, or if, without so refusing,

the Chair does not call a meeting within 7 Clear Days after such requisition has been presented to ~~him/her~~them, at the Trust's Headquarters, such one-third or more members of the Board of Directors may forthwith call a meeting for the purpose of conducting that business.

13.3 Notice of meetings

13.3.1 Before each meeting of the Board of Directors, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair, or by an Officer of the Trust authorised by the Chair to sign on ~~his/her~~their behalf, shall be delivered to every Director, or sent by post to the usual place of residence of every Director or sent electronically so as to be available to ~~him/her~~them at least 5 Clear Days before the meeting, save in the case of emergencies as set out in SO 4.3.5 below.

13.3.2 Before a public meeting of the Board of Directors, a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's Headquarters and shall be advertised on the Trust's website at least 5 Clear Days before the meeting, save in the case of emergencies.

13.3.3 Want of service of the notice on any one member of the Board of Directors shall not affect the validity of a meeting but failure to serve such a notice on more than three Directors will invalidate the meeting. A notice of the meeting shall be presumed to have been served one day after posting or, in the case of a notice sent electronically, on the date of transmission.

13.3.4 In the case of a meeting called by the Directors in default of the Chair in accordance with SO 4.2.2 above, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the requisition.

13.3.5 In the event of an emergency giving rise to the need for an immediate meeting, failure to comply with the notice periods referred to in SO 4.3.1 and (where relevant) SO 4.3.2 above shall not prevent the calling of, or invalidate, such a meeting provided that every effort is made to make personal contact with every Director who is not absent from the United Kingdom and the agenda for the meeting is restricted to matters arising in that emergency.

13.4 Agendas and supporting papers

13.4.1 Agendas will be sent to members of the Board of Directors 5 Clear Days before the meeting and supporting papers (including the minutes of the previous meeting of the Board of Directors), whenever possible, shall accompany the agenda, but will certainly be dispatched no later than 3 Clear Days before the meeting, save in an emergency giving rise to the need for an immediate meeting of the Board of Directors, as set out in SO 4.3.5 above. Failure to serve the agenda and (where relevant) supporting papers on more than three members of the Board of Directors will invalidate the meeting. The agenda and supporting papers shall be

presumed to have been served one day after posting or, in the case of a notice being sent electronically, on the date of transmission.

13.4.2 Before holding a meeting of the Board of Directors, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors.

13.5 Setting the agenda

13.5.1 The Board of Directors may determine that certain matters shall appear on every agenda for a meeting of the Board of Directors and shall be addressed prior to any other business being conducted ("Standing Items").

13.5.2 A Director desiring a matter to be included on an agenda, other than a Standing Item or a motion under SO 4.10 (emergency motions and written motions) below, including a formal proposition for discussion and voting on at a meeting of the Board of Directors, shall make ~~his/her~~their request in writing to the Chair at least 10 Clear Days before the meeting. Requests made less than 10 Clear Days before a meeting may be included on the agenda at the discretion of the Chair.

13.5.3 No business may be transacted at any meeting of the Board of Directors which is not specified in the notice of that meeting unless the Chair, in ~~his/her~~their absolute discretion, agrees that the item and (where relevant) any supporting papers should be considered by the Board of Directors as a matter of urgency. A decision by the Chair to permit consideration of the item in question and (where relevant) the supporting papers shall be recorded in the minutes of that meeting.

13.6 Petitions

Where a petition has been received by the Trust, the Chair shall include the petition as an item for the agenda of the next meeting of the Board of Directors.

13.7 Chair of meeting

13.7.1 At any meeting of the Board of Directors, the Chair, if present, shall preside. If the Chair is absent from the meeting the Vice Chair, if there is one and ~~he/she is~~they are present, shall preside. If the Chair and Vice Chair are absent such Non-Executive Director as the members of the Board of Directors present shall choose, shall preside.

13.7.2 If the Chair is absent temporarily on the grounds of a declared conflict of interest, the Vice Chair, if present, shall preside. If the Chair and Vice Chair are absent, or are disqualified from participating, such Non-Executive Director as the members of the Board of Directors present shall choose shall preside.

13.7.3 If any matter for consideration at a meeting of the Board of Directors relates to the interests of the Chair or the Non-Executive Directors as a class, neither the Chair nor any of the Non-Executive Directors shall preside over the period of the meeting during which the matter is under

discussion. The Directors (excluding the Chair and the Non-Executive Directors) shall elect one of the number to preside during that period and that person shall exercise all the rights and obligations of the Chair, including (for the avoidance of doubt) the right to exercise a casting vote where the numbers of votes for and against a motion is equal.

13.8 Chair's ruling

Statements of Directors made at meetings of the Board of Directors shall be relevant to the matter under discussion at the material time and subject to SO 2.1, the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

13.9 Notices of motion

13.9.1 Notwithstanding the provisions of SO 4.5 above, and subject to the provisions of SO 4.11 (Motions: procedure at and during a meeting) and SO 4.12 (Motion to rescind a resolution) below, a member of the Board of Directors wishing to move or amend a motion shall send a written notice to the Chair.

13.9.2 The notice shall be delivered at least 14 Clear Days before the meeting. The Chair shall include in the agenda for the meeting all notices so received that are in order and permissible under these SOs. Subject to SO 4.3.4, this SO shall not prevent any motion being moved without notice on any business mentioned on the agenda for the meeting.

13.10 Emergency motions and written motions

13.10.1 **Emergency motions**

13.10.1.1 Subject to the agreement of the Chair, and subject also to the provisions of SO 4.11 (Motions: procedure at and during a meeting), a member of the Board of Directors may give the Chair written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared by the Chair to the Board of Directors at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision to include the item shall be final.

13.10.2 Written motions

13.10.2.1 In urgent situations and with the consent of the Chair, business may be effected by a Director's written motion to deal with business otherwise required to be conducted at a meeting of the Board of Directors.

13.10.2.2 If all members of the Board of Directors have been notified of the proposal and three-quarters of Directors entitled to attend and vote at a meeting of the Board of Directors confirms acceptance of the written motion either in writing or electronically to the Board of Directors' Secretary within 5 Clear Days of dispatch then the motion will be deemed

to have been resolved notwithstanding that the Directors have not gathered in one place.

13.10.2.3 The effective date of the resolution shall be the date that the last confirmation is received by the Board of Directors' Secretary and, until that date a Director who has previously indicated acceptance can withdraw and the motion shall fail.

13.10.2.4 Once the resolution is passed, a copy certified by the Board of Directors' Secretary shall be recorded in the minutes of the next ensuing meeting where it shall be signed by the person presiding at it.

13.11 Motions: procedure at and during a meeting

13.11.1 Who may propose

A motion properly notified under SO 4.9 above may be proposed by the Chair of the meeting or any other member of the Board of Directors present at the meeting. All motions so proposed must be seconded by another member of the Board of Directors.

13.11.2 Contents of motions

13.11.2.1 The Chair may exclude from the debate at ~~his/her~~their sole discretion any motion of which notice was not given on the notice summoning the meeting other than a motion relating to:

13.11.2.1.1 the reception of a report;

13.11.2.1.2 consideration of any item of business before the Board of Directors;

13.11.2.1.3 the accuracy of minutes;

13.11.2.1.4 that the Board of Directors proceed to the next item of business on the agenda;

13.11.2.1.5 that the Board of Directors adjourn the discussion or the meeting; or

13.11.2.1.6 that the question be now put.

13.11.3 Amendments to motions

13.11.3.1 A motion for amendment shall not be discussed unless it has been proposed and seconded.

13.11.3.2 Amendments to motions shall be moved relevant to the motion and shall not have the effect of negating the motion before the Board of Directors.

13.11.3.3 If there are a number of amendments proposed and seconded to a motion, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

13.11.4 Rights of reply to motions

13.11.4.1 Amendments

The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

13.11.4.2 Substantive/original motion

The mover who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

13.11.5 Withdrawing a motion

A motion, or an amendment to a motion, once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

13.11.6 Motions once under debate

13.11.6.1 When a motion is under debate, no motion may be moved other than:

13.11.6.1.1 an amendment to the motion; or

13.11.6.1.2 the adjournment of the discussion, or the meeting; or

13.11.6.1.3 that the meeting proceed to the next item of business on the agenda; or

13.11.6.1.4 the appointment of an ad hoc committee to deal with a specific item of business; or

13.11.6.1.5 that the motion be now put; or

13.11.6.1.6 (where relevant), a motion under SO 4.1 above resolving to exclude the public (including the press); or

13.11.6.1.7 that a member of the Board of Directors be not further heard.

In the case of motions under SO 4.11.6.1.3 (proceed to next business) or 4.11.6.1.5 (motion be now put), in the interests of objectivity these motions should only be put forward by a member of the Board of Directors who has not previously taken part in the debate and who is eligible to vote.

13.11.6.2 If a motion to proceed to the next business or that the question be now put, is carried, the Chair should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

13.12 Motion to rescind a resolution

13.12.1 Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding 6 calendar months shall bear the signature of the member of the Board of Directors who gives it and also the signature of four other members of the Board of Directors, and before considering any such motion of which notice shall have been given, the Board of Directors may refer the matter to an appropriate committee of the Board of Directors or the Chief Executive for recommendation.

13.12.2 When any such motion has been dealt with by the Board of Directors, it shall not be competent for any member of the Board of Directors other than the Chair to propose a motion to the same effect within 6 calendar months; however, the Chair may do so if ~~he/she~~they considers it appropriate. This SO shall not apply to motions moved in pursuance of a report or recommendations of a committee of the Board of Directors or the Chief Executive.

13.13 Voting

13.13.1 Subject to SO 4.15 (Suspension of Standing Orders), or as otherwise provided by the SOs, every question at a meeting shall be determined by a three-quarters majority of the votes of the Directors present and voting on the question and, in the case of the number of votes for and against a motion being equal, the Chair shall have a casting vote.

13.13.2 All questions put to the vote shall, at the discretion of the Chair, be determined by a show of hands or by appropriate electronic means. A paper ballot may also be used if a majority of the Directors present so request.

13.13.3 If at least one-third of the members of the Board of Directors present so request, the voting (other than by paper ballot), on any question may be recorded to show how each Director present voted or abstained.

13.13.4 If a Director so requests, ~~his/her~~their vote shall be recorded by name upon any vote (other than by paper ballot).

13.13.5 In no circumstances may:

13.13.5.1 an absent Director vote by proxy (absence is defined as being absent at the time of the vote); or

13.13.5.2 a resolution be passed if it is opposed by all of the Non-Executive Directors present and voting, or by all of the Executive Directors present and voting at a meeting of the Board of Directors.

13.13.6 An Officer who has been appointed formally by the Board of Directors to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director. An Officer attending the Board of Directors to represent an Executive Director during a period

of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An Officer's status when attending a meeting shall be recorded in the minutes.

13.14 Minutes

13.14.1 The minutes of the proceedings of a meeting of the Board of Directors shall be drawn up by the Board of Directors' Secretary and submitted for agreement at the next ensuing meeting, where they will be signed by the person presiding at it.

13.14.2 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate.

13.14.3 Any amendment to the minutes shall be agreed and recorded at the next meeting.

13.14.4 Minutes of the meetings of the Board of Directors shall be retained in the Chief Executive's office.

13.14.5 Subject to paragraph 28~~30~~A.2 of the Constitution, minutes of the Board of Directors' meeting shall be circulated in accordance with Directors' wishes.

13.14.6 The minutes of the meetings of the Board of Directors shall be made available to the public, save for items discussed by the Directors following the exclusion of the public and representatives of the press under SO 4.1.2 and 4.1.3.

13.14.7 As soon as practicable after holding a meeting of the Board of Directors, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

13.15 Suspension of Standing Orders

13.15.1 Except where this would contravene any provision of the Regulatory Framework or any guidance or best practice advice issued by NHS England~~l~~, any one or more of the SOs may be suspended at any meeting, provided that at least three-quarters of the Directors are present, including one Executive Director and one Non-Executive Director, and that a three-quarters majority of those present vote in favour of suspension.

13.15.2 A decision to suspend the SOs shall be recorded in the minutes of the meeting.

13.15.3 A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the Directors.

13.15.4 No formal business may be transacted while the SOs are suspended.

13.15.5 The Audit Committee shall review every decision to suspend the SOs.

13.16 Record of attendance and apologies

13.16.1 The names of the Directors present at the meeting shall be recorded in the minutes, together with the names of any Nominated Officers, Officers and others invited by the Chair to be in attendance, save for members of the public or representatives of the press.

13.16.2 Directors who are unable to attend a meeting of the Board of Directors shall notify the Board of Directors' Secretary in writing in advance of the meeting in question so that their apologies may be submitted.

13.17 Quorum

13.17.1 No business shall be transacted at a meeting of the Board of Directors unless at least one-third of the whole number of the voting Directors are present, including the Chief Executive or Deputy Chief Executive and the Chair or Vice Chair.

13.17.2 An Officer in attendance for an Executive Director but without formal acting up status as described in SO 4.13.6 above may not count towards the quorum.

13.17.3 If a Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest as provided in SO 8 below ~~he~~ they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for either the Chief Executive or Deputy Chief Executive to form part of the quorum shall not apply where the Executive Directors are excluded from a meeting (for example when the Board of Directors considers the recommendations of the Remuneration Committee established under SO 6.1.7.2 below).

13.18 Meetings: Electronic Communication

13.18.1 A Director in Electronic Communication with the Chair and all other parties to a meeting of the Board of Directors or of a committee or sub-committee of the Directors shall be regarded for all purposes as personally attending such a meeting provided that, but only for so long as, at such a meeting ~~he has~~they have the ability to communicate interactively and simultaneously with all other parties attending the meeting including all persons attending by way of Electronic Communication.

13.18.2 A meeting at which one or more of the Directors attends by way of Electronic Communication is deemed to be held at such a place as the Directors shall at the said meeting resolve. In the absence of such a resolution, the meeting shall be deemed to be held at the place (if any) where a majority of the Directors attending the meeting are physically

present, or in default of such a majority, the place at which the Chair of the meeting is physically present.

13.18.3 Meetings held in accordance with this SO are subject to SO 4.18 (Quorum). For such a meeting to be valid, a quorum must be present and maintained throughout the meeting.

13.18.4 The minutes of a meeting held in this way must state that it was held by Electronic Communication and that the Directors were all able to hear each other and were present throughout the meeting.

13.19 Adjournment of meetings

13.19.1 The Board of Directors may, by resolution, adjourn any meeting to some other specified date, place and time and such adjourned meeting shall be deemed a continuation of the original meeting.

13.19.2 No business shall be transacted at any adjourned meeting which was not included in the agenda of the meeting of which it is an adjournment.

13.19.3 When any meeting is adjourned to another day, other than the following day, notice of the adjourned meeting shall be sent to each Director specifying the business to be transacted and the date, time and place of the adjournment.

13.20 Reports from the Executive Directors

At any meeting of the Board of Directors a Director may ask any question through the Chair without notice on any report by an Executive Director, or other Officer of the Trust, after that report has been received by or while such report is under consideration by the Board of Directors at the meeting. The Chair may, in ~~his/her~~their absolute discretion, reject any question from any Director if, in ~~his/her~~their opinion, the question is substantially the same and relates to the same subject matter as a question which has already been put to that meeting or a previous meeting.

14 ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

14.1 Subject to SO 3.6, the Regulatory Framework and such guidance or best practice advice as may be issued by NHS England~~,~~, the Board of Directors may make arrangements for the exercise of any of its functions by a committee or sub-committee appointed by virtue of SO 5.3 below or by an Executive Director subject to such restrictions and conditions as the Board of Directors considers appropriate.

14.2 Emergency powers

The powers which the Board of Directors has retained to itself within these SOs or the Scheme of Delegation may in emergency or for an urgent decision be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board of Directors for ratification.

14.3 Delegation to committees

The Board of Directors shall agree from time to time to the delegation of powers to be exercised by committees of the Board of Directors, which it has formally constituted. The constitution and terms of reference of these committees and their specific powers shall be approved by the Board of Directors.

14.4 Delegation to Nominated Officers

14.4.1 Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to a committee of the Board of Directors shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall determine which functions ~~he~~ they will perform personally and shall nominate Officers to undertake the remaining functions for which ~~he~~ they will still retain accountability to the Board of Directors.

14.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying ~~his/her~~their proposals, which shall be considered and approved by the Board of Directors, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation, which shall be considered and approved by the Board of Directors as indicated above.

14.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of Directors of the Finance Director or other Executive Director to provide information and advise the Board of Directors in accordance with any statutory requirements.

14.4.4 The arrangements made by the Board of Directors as set out in the Scheme of Delegation shall have effect as if incorporated in these SOs, but for the avoidance of doubt, the Scheme of Delegation does not form part of the Constitution.

14.5 Duty to report non-compliance with Standing Orders

If for any reason these SOs are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board of Directors for action or ratification. All members of the Board of Directors and all Officers (including Nominated Officers) have a duty to disclose any non-compliance with these SOs to the Board of Directors' Secretary as soon as possible.

15 COMMITTEES

15.1 Appointment of committees

15.1.1 Subject to SO 3.6, the Regulatory Framework and such guidance or best practice advice issued by NHS England~~l~~, the Board of Directors may and, if directed by NHS England~~l~~, shall appoint committees of the Board of Directors consisting wholly or partly of Directors.

15.1.2 A committee appointed under SO 6.1.1 may, subject to the Regulatory Framework and such guidance and/or best practice advice as may be

issued by ~~NHSEI~~ NHS England or the Board of Directors, appoint sub-committees consisting wholly or partly of Directors.

15.1.3 The SOs, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees (and any sub-committees or joint committees appointed under SO 6.1.2) established by the Board of Directors, in which case the term “Chair” is to be read as a reference to the Chair of the committee (or sub-committee or joint committee) as the context permits, and the term “member" is to be read as a reference to a member of the committee (or sub-committee or joint committee) also as the context permits.

15.1.4 Each such committee, sub-committee or joint committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors), as the Board of Directors shall decide in accordance with any legislation, and/or regulations and/or such guidance or best practice advice issued by NHS England~~l~~. Such terms of reference shall have effect as if incorporated into the SOs, but for the avoidance of doubt, these terms of reference do not form part of the Constitution.

15.1.5 Where committees are authorised to establish sub-committees they may not delegate powers to the sub-committee unless expressly authorised by the Board of Directors.

15.1.6 The Board of Directors shall approve the appointments to each of the committees, which it has formally constituted. Where the Board of Directors determines, and the Regulatory Framework permits, that persons, who are neither Directors nor Officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board of Directors as defined by the Regulatory Framework. The Board of Directors shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses.

15.1.7 The committees established by the Board of Directors are:

15.1.7.1 Audit and Risk Committee;

15.1.7.2 Nominations and Remuneration Committee;

15.1.7.3 Quality ~~Governance~~ Assurance Committee;

15.1.7.4 Non-Clinical Governance Committee;

15.1.7.5 Charities Committee;

15.1.7.6 People Committee;

15.1.7.7 Trust Management ~~Board~~Executive;

15.1.7.8 Finance and Performance Committee

15.1.7.9 Commercial Transactions Steering Group; and

15.1.7.10 Subsidiary Oversight Committee

15.1.8 The Constitution and terms of reference of the committees listed in SOs 6.1.7 above shall be agreed by the Board of Directors.

15.1.9 Notwithstanding the provisions of SO 6.1.7 above, the Board of Directors may establish other committees, sub-committees and joint committees, including ad hoc committees, sub-committees and joint committees from time to time at its discretion.

15.2 Joint Committees

15.2.1 Joint committees may be ~~establilshed~~established by the Trust, by joining together with one or more other trusts, consisting of wholly or partly of the Chair and Directors of the Trust or other health service bodies, or of Directors of the Trust with non-directors of other health bodies in question.

15.2.2 Any Committee-in-Common or Joint Committee established under standing orders may, subject to such directions or guidance as may be given by NHS England or the Trust or any other health bodies in question, appoint sub-committees consisting wholly or partly of directors sitting on the Committee or Joint Committee (whether or not they are directors of the other health bodies in question) or wholly of persons who are not directors of the other health bodies in question provided that the Trust is always represented by an Executive Director (or deputy nominated by the Executive Director) on such Committees, Joint Committees or sub committees.

~~15.2~~15.3 Confidentiality

~~15.2.1~~15.3.1 A member of a committee (including sub-committees or joint committees) shall not disclose any matter dealt with, by, or brought before, the committee, sub-committee or joint committee without its permission until the committee, sub-committee or joint committee (as appropriate) shall have reported to the Board of Directors or shall otherwise have concluded on that matter.

~~15.2.2~~15.3.2 A Director or a member of a committee, sub-committee or joint committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the committee, sub-committee or joint committee, notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or committee, sub-committee or joint committee resolve that it is confidential.

16 INTERFACE BETWEEN THE BOARD OF DIRECTORS AND THE COUNCIL OF GOVERNORS

16.1 The Board of Directors will cooperate with the Council of Governors as far as possible in order to comply with the Regulatory Framework in all respects and in particular in relation to the following matters which are set out specifically within the Constitution:

16.1.1 The Directors, having regard to the views of the Council of Governors, are to prepare the Forward Plan in respect of each Financial Year to be given to NHS England~~l~~;

16.1.2 The Directors are to present to the Council of Governors at a general meeting of the Council of Governors the Annual Accounts, any report of the Auditor on them, and the Annual Report.

16.2 The Annual Report is to give:

16.2.1 information on any steps taken by the Trust to secure that (taken as a whole) the actual membership of its Public Constituency is representative of those eligible for such membership; and

16.2.2 any other information which NHS England~~l~~ requires.

16.3 In order to comply with the Regulatory Framework in all respects and in particular in relation to the matters which are set out in SOs 7.1 and 7.2 above, the Council of Governors may request that a matter which relates to paragraphs 35~~7~~ and 36~~8~~ of the Constitution is included on the agenda for a meeting of the Board of Directors.

16.4 If the Council of Governors so desires such a matter as described within SO 7.3 above to be included on an agenda item, they shall make their request in writing to the Chair at least 15 Clear Days before the meeting of the Board of Directors, subject to SO 4.3. The Chair shall decide whether the matter is appropriate to be included on the agenda. Requests made less than 15 Clear Days before a meeting may be included on the agenda at the discretion of the Chair.

17 DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS OF THE MEMBERS OF THE BOARD OF DIRECTORS

17.1 The Constitution requires members of the Board of Directors to declare (before the Trust enters into the transaction or arrangement):

17.1.1 any direct or indirect interest in a proposed transaction or arrangement with the Trust; and

17.1.1.1 any actual or potential pecuniary interest, direct or indirect, in any contract, proposed contract or other matter concerning the Trust; and

17.1.1.2 any actual or potential family interest, direct or indirect, of which the Director is aware.

17.2 All members of the Board of Directors must declare such interests as soon as the Director in question becomes aware of it. Any members of the Board of Directors appointed subsequently to the date of the Authorisation must do so on appointment.

17.3 Such a declaration shall be made by completing and signing a form, as prescribed by the Board of Directors' Secretary from time to time, setting out any interests required to be declared outside a meeting in accordance with the Constitution or the SOs and delivering it to the Board of Directors' Secretary on appointment or as soon as is practicable thereafter as the interest arises.

17.4 If a declaration under SOs 8.1 or 8.2 above proves to be, or becomes, inaccurate or incomplete, the Director must make a further declaration before the Trust enters into the transaction or arrangement. This does not require a declaration of an interest of which the Director is not aware or where the Director is not aware of the transaction or arrangement in question.

17.5 A Director need not declare an interest:

8.5.1 if, it cannot reasonably be regarded as likely to give rise to a conflict of interest;

8.5.2 if, or to the extent that, the Directors are already aware of it;

8.5.3 if, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered by:

8.5.3.1 a meeting of the Board of Directors: or

8.5.3.2 by a committee of the Directors appointed for the purpose.

17.6 In addition, if a Director is present at a meeting of the Board of Directors and has an interest of any sort in any matter which is the subject of consideration, ~~he~~ they must at the meeting and as soon as practicable after its commencement disclose the fact and ~~he~~ they must then withdraw from the meeting and play no part in the relevant discussion and ~~he~~ they shall not vote on any question with respect to the matter.

17.7 If a Director has declared a pecuniary interest in accordance with SO 8.8 below ~~he~~ they shall not take part in the consideration or discussion of the matter in respect of which an interest has been disclosed and shall be excluded from the meeting whilst that matter is under consideration. At the time the interests are declared, they should be recorded in the Director's meeting minutes. Any changes in interests should be officially declared at the next relevant meeting following the change occurring.

17.8 Subject to any guidance or best practice advice issued by NHS England~~l~~, interests which should be regarded as "relevant and material" for the purposes of these SOs are:

17.8.1 Directorships, including non-executive directorships held in private companies or public listed companies (with the exception of those of dormant companies);

17.8.2 Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS or the Trust;

17.8.3 majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS or the Trust;

17.8.4 a position of authority in a charity or voluntary organisation in the field of health and social care;

17.8.5 any connection with a voluntary or other organisation contracting for NHS or Trust services or commissioning NHS or Trust services;

17.8.6 any connection with an organisation, entity or company considering entering into or having entered into a financial agreement with the Trust, including but not limited to, lenders or banks;

17.8.7 research funding or grants that may be received by an individual or their department; and

17.8.8 interests in pooled funds that are under separate management.

17.9 Members of the Board of Directors who hold directorships in companies likely or possibly seeking to do business with the NHS or the Trust should be published in the Annual Report. The information should be kept up to date for inclusion in succeeding Annual Reports.

17.10 A Director shall be treated as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

17.10.1 ~~He/she~~They, or a nominee of ~~his/her~~theirs, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or

17.10.2 ~~He/she is~~they are a partner or associate of, or is in the employment of, a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration.

17.11 A Director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

17.11.1 of ~~his/her~~their membership of a company or other body, if ~~he/she has~~they have no beneficial interest in any securities of that company or other body; or

17.11.2 of an interest in any company, body or person with which ~~he/she is~~they are connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

17.12 Where a Director:

17.12.1 has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

17.12.2 the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

17.12.3 if the share capital is of more than one class, the total nominal value of shares of any one class in which ~~he has~~they have a beneficial interest

does not exceed one-hundredth of the total issued share capital of that class,

the Director shall not be prohibited from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to ~~his/her~~their duty to disclose ~~his/her~~their interest in accordance with the Constitution and these SOs.

17.13 In the case of Immediate Family Members, the interest of one Immediate Family Member shall, if known to the other, be deemed for the purposes of the Constitution and these SOs to be also an interest of the other.

17.14 If Directors have any doubt about the relevance or materiality of an interest, this should be discussed with the Board of Directors' Secretary. Influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships should also be considered.

17.15 Any remuneration, compensation or allowances payable to a Director by virtue of paragraph 18 to Schedule 7 of the 2006 Act shall not be treated as a pecuniary interest for the purpose of this SO.

17.16 SO 8 applies to any committee, sub-committee or joint committee of the Board of Directors and applies to any member of any such committee, sub-committee or joint committee (whether or not ~~he is~~ they are also a Director).

17.17 Register of interests of the members of the Board of Directors

17.17.1 The register of interests of members of the Board of Directors shall contain the names of each Director, whether ~~he/she has~~they have declared any interests and, if so, the interests declared in accordance with the Constitution or these SOs.

17.17.2 In accordance with SO 8.3 above, it is the obligation of the Director to inform the Board of Directors' Secretary in writing as soon as is practicable of becoming aware of the existence of a relevant or material interest. The Board of Directors' Secretary must then amend the register of interests of members of the Board of Directors upon receipt of new or amended information as soon as is practical and, in any event, within 14 days of receipt.

17.17.3 The register of interests of members of the Board of Directors will be available to the public in accordance with paragraph 33 of the Constitution.

18 STANDARDS OF BUSINESS CONDUCT

18.1 Policy

Directors and (where relevant) Nominated Officers should comply with the Directors' Code of Conduct and any guidance and best practice advice issued by NHS England~~l~~. This section of the SOs should be read in conjunction with these documents.

18.2 Interest of Directors and Officers in contracts

18.2.1 Any Director or Officer who comes to know that the Trust has entered into or proposes to enter into a contract in which ~~he has~~they have any pecuniary interest, direct or indirect, shall give notice in writing of such fact to the Chief Executive or Board of Directors' Secretary as soon as practicable, but in any event within 7 days of first becoming aware of the fact. In the case of Immediate Family Members, the interest of one Immediate Family Member shall, if known to the other, be deemed to be also the interest of that Immediate Family Member.

18.2.2 A Director or Officer must also declare to the Chief Executive or Board of Directors' Secretary any other employment or business or other relationship of ~~his/her~~theirs, or of an Immediate Family Member, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust in accordance with SO 8. The Trust shall require such interests to be recorded in the register of interests of members of the Board of Directors.

18.3 Canvassing of, and recommendations by, Directors in relation to appointments

18.3.1 Canvassing of Directors or members of any committee, sub-committee or joint committee of the Board of Directors directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of these SOs shall be included in application forms or otherwise brought to the attention of candidates.

18.3.2 A Director of the Board of Directors shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this SO shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust in relation to any appointment.

18.3.3 Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee in question.

18.4 Relatives of Directors or Officers

18.4.1 Directors and Officers shall bear in mind that candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any Director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render ~~him/her~~them liable to instant dismissal.

18.4.2 Directors and Officers shall disclose to the Board of Directors' Secretary any relationship between ~~him/herself~~themselves and a candidate of whose candidature that Director or Officer is aware. It shall be the duty of the Board of Directors' Secretary to report to the Board of Directors any such disclosure made.

18.4.3 On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) must disclose to the Board of Directors' Secretary whether they are related to any other member of the Board of Directors, the Council of Governors, or holder of any office in the Trust.

18.4.4 Where the relationship to an Officer, Governor, or another Director is disclosed, SO 8 shall apply.

18.5 External consultants

SO 9 will apply equally to all external consultants or other agents acting on behalf of the Trust.

19 CUSTODY OF SEAL AND SEALING OF DOCUMENTS

19.1 Custody of seal

The common seal of the Trust shall be kept by the Board of Directors' Secretary or ~~his/her~~their Nominated Officer in a secure place.

19.2 Sealing of documents

19.2.1 The common seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board of Directors or of a committee, thereof or where the Board of Directors has delegated its powers in accordance with the Scheme of Delegation.

19.2.2 Where it is necessary that a document shall be sealed, the common seal of the Trust shall be affixed in the presence of two Officers duly authorised by the Chief Executive, and also not from the originating department, and shall be attested by them.

19.3 Register of sealing

The Board of Directors' Secretary shall make an entry of every sealing (numbered consecutively) in a book provided for that purpose, and shall ensure that each entry is signed by the persons who shall have approved and authorised the document and those who attested the seal. The Board of Directors' Secretary shall make a report of all sealings to the Board of Directors at least quarterly. (The report shall contain details of the seal number, the description of the document and date of sealing).

20 SIGNATURE OF DOCUMENTS

20.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board of Directors shall have given the necessary authority to some other person for the purpose of such proceedings.

20.2 The Chief Executive or Nominated Officers shall be authorised, by resolution of the Board of Directors, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by

the Board of Directors or committee of the Board of Directors to which the Board of Directors has delegated appropriate authority.

20.3 Notwithstanding the generality of SOs 11.1 and 11.2 above, in land transactions the signing of certain supporting documents may be delegated to Nominated Officers, as set out in the Scheme of Delegation, but will not include the main of principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works, or main warranty agreements) or any document which is required to be executed as a deed.

21 MISCELLANEOUS

21.1 Standing Orders to be given to Directors and Nominated Officers

21.1.1 It is the duty of the Chief Executive to ensure that existing Directors and Nominated Officers and all new appointees are notified of and understand their responsibilities within these SOs.

21.1.2 Copies of the SOs shall be issued to Directors and Nominated Officers designated by the Board of Directors' Secretary. The Board of Directors' Secretary shall ensure that new Directors and Nominated Officers are informed of these SOs in writing and shall receive copies of these SOs.

21.2 Documents having the standing of Standing Orders

The SFIs and the Scheme of Delegation shall have the effect as if incorporated into these SOs, but for the avoidance of doubt, neither the SFIs nor the Scheme of Delegation form part of this Constitution.

ANNEX 8 - FURTHER PROVISIONS

(Paragraphs 1, 4, 8, 9, 14, and 22)

Appendix 1:

Trust values

1 NHS principles

1.1 The NHS provides a comprehensive service, available to all;

1.2 Access to NHS services is based on clinical need, not an individual's ability to pay;

1.3 The NHS aspires to the highest standards of excellence and professionalism;

1.4 The patient will be at the heart of everything the NHS does;

1.5 The NHS works across organisational boundaries;

1.6 The NHS is committed to providing best value for taxpayer's money;

1.7 The NHS is accountable to the public, communities and patients that it serves.

2 NHS values

2.1 Working together for patients;

2.2 Respect and dignity;

2.3 Commitment to quality of care;

2.4 Compassion;

2.5 Improving lives;

2.6 Everyone counts;

3 Trust values

3.1 Everyone Matters;

3.2 Working Together;

3.3 Making a Difference

4 Representative membership

The Trust shall at all times strive to ensure that, taken as a whole, its actual membership of the Public Constituency is representative of those eligible for membership. To this end:

4.1 The Trust shall at all times have in place and pursue a Membership Strategy which shall be approved by the Board of Directors and prepared and reviewed by the Council of Governors from time to time as set out this Constitution and at least every 3 years.

4.2 The Council of Governors shall present to each Annual Governors' Meeting the reports set out in SO 4.4.2 of Annex 6 of this Constitution.

5 Co-operation with health service and other bodies

5.1 In exercising its functions, the Trust shall co-operate with Health Service Bodies and any local authority with which the Trust has a Local Authority Partnership Agreement.

5.2 Notwithstanding the provisions of paragraph 3.1 above, the Trust shall co-operate with any specific third party body that it has a duty (statutory, contractual, or otherwise) to co-operate with.

6 Respects for rights of people

In conducting its affairs, the Trust shall respect the rights of the members of the community it serves, its employees and people dealing with the Trust as set out in the Human Rights Act 1998.

ANNEX 8 - FURTHER PROVISIONS

Appendix 2:

Membership

1 Disqualification from membership of the Trust

1.1 A person may not become or continue as a Member of the Trust if:

1.1.1 ~~he~~ they are~~is~~ under 16 years of age at the date of ~~his~~ their application or invitation to become a Member (as the case may be);

1.1.2 ~~he has~~they have demonstrated aggressive or violent behaviour (such as verbal assault, physical assault, violence or harassment) at any NHS hospital, NHS premises or NHS establishment against any of the Trust's employees or other persons who exercise functions for the purposes of the Trust whether or not in circumstances leading to their~~his~~ removal or exclusion from any NHS hospital, premises or establishment;

1.1.3 ~~he has~~they have been confirmed as a 'vexatious complainant' in accordance with the relevant

1.1.4 Trust policy for handling complaints;

1.1.5 ~~he has~~they have been removed as a member from another NHS foundation trust;

1.1.6 ~~he has~~they have been deemed to have acted in a manner contrary to the interests of the Trust;

1.1.7 ~~he~~ they fail~~s~~ or cease~~s~~ to fulfil the criteria for membership of the Public Constituency or the Staff Constituency; or

1.1.8 ~~he has~~they have been dismissed (otherwise than by reason of redundancy) from a position of employment with the Trust.

1.2 Where the Trust is on notice that a Member may be disqualified from membership, or may no longer be eligible to be a Member, or it appears to the Secretary that a Member no longer wishes to be a Member, the Secretary shall give the Member 14 days written notice to show cause why ~~his~~ their name should not be removed from the Trust's register of Members. On receipt of any such information supplied by the Member, the Secretary may, if ~~he~~ they consider~~s~~ it appropriate, remove the Member from the Trust's register of Members. In the event of any dispute about entitlement to membership, the dispute shall be resolved in accordance with the procedure set out in paragraph 2.1 of Appendix 4 of this Annex 8.

1.3 All Members of the Trust shall be under a duty to notify the Secretary of any change in their particulars which may affect their entitlement as a Member.

2 Expulsion from membership of the Trust

2.1 A Member may be expelled by a resolution approved by not less than two-thirds of the members of the Council of Governors present and voting at a meeting of the Council of Governors. The following procedure is to be adopted:

2.1.1 Any Member may complain to the Secretary that another Member has acted in a way detrimental to or contrary to the interests of the Trust, or is otherwise disqualified as set out in paragraph 1 above.

2.1.2 Subject to paragraphs 2.2 to 2.6 below, if a complaint is made, the Council of Governors, or a delegated committee, sub-committee or joint committee of the Council of Governors and the Board of Directors, will consider the complaint, having taken such steps as it (or they) consider appropriate, to ensure that each Member's point of view is heard and may either:

2.1.2.1 dismiss the complaint and take no further action; or

2.1.2.2 arrange for a resolution to expel the Member complained of to be considered at the next meeting of the Council of Governors.

2.2 If a resolution to expel a Member is to be considered at a meeting of the Council of Governors pursuant to paragraph 2.1.2.2 above, details of the complaint must be sent to the Member complained of not less than one calendar month before the meeting with an invitation to answer the complaint and to attend the meeting.

2.3 At the meeting referred to in paragraph 2.2 above, the Council of Governors will consider the evidence and any representations made in support of the complaint and such other evidence and any representations made by the Member making the complaint which is placed before them.

2.4 If the Member complained of fails to attend the meeting mentioned in paragraph 2.2 above without due cause, the meeting may proceed in their absence. The decision to proceed in these circumstances will be at the sole discretion of the person chairing the meeting in question.

2.5 A person expelled from membership under the provisions of paragraphs 2.1 to 2.4 above will cease to be a Member upon the declaration by the person chairing the meeting that the resolution to expel them is carried.

2.6 No person who has been expelled from membership pursuant to the provisions of paragraphs 2.1 to 2.5 above is to be re-admitted as a Member except by a resolution of the Council of Governors carried by votes of two-thirds of the members of the Council of Governors present and voting at a general meeting of the Council of Governors.

3 Termination of membership

A Member shall cease to be a Member on:

3.1 death; or

3.2 resignation by notice in writing to the Secretary; or

3.3 ceasing to fulfil the requirements of paragraphs 8 or 9 of this Constitution, as the case may be; or

3.4 being disqualified pursuant to paragraph 1 above, or being expelled pursuant to paragraph 2 above.

ANNEX 8 - FURTHER PROVISIONS

Appendix 3:

Board of Directors – further provisions

1 Criteria for suspension and removal of Non-Executive Directors and the Chair

1.1 General criteria

1.1.1 The Council of Governors, when exercising the powers of suspension or removal in accordance with paragraphs 22.3 to 22.5 of this Constitution, shall have regard to the following criteria (this is not an exhaustive list and each case shall be considered on its own merits taking into account all relevant factors, including any representations made by the Non-Executive Directors or Chair in question):

1.1.1.1 if a Director fails to attend 2 consecutive meetings of the Board of Directors in any Financial Year ~~he~~ they may be removed from office unless the Council of Governors is satisfied by a 75% majority of those members of the Council of Governors present and voting at a meeting of the Council of Governors that:

1.1.1.1.1 the absence was due to a reasonable cause; and

1.1.1.1.2 ~~he~~ they will be able to start attending meetings of the Board of Directors again within such a period as the Council of Governors considers reasonable;

1.1.1.2 failure to disclose an interest in accordance with paragraph 29 of this Constitution and Standing Order 8 of the Standing Orders for the Board of Directors (Annex 7 of this Constitution);

1.1.1.3 if a Director is considered to have acted in a manner inconsistent with:

1.1.1.3.1 the values of the Trust, as set out in Appendix 1 of Annex 8, or in a manner detrimental to the interests of the Trust; or

1.1.1.3.2 the Authorisation; or

1.1.1.3.3 the Standing Orders for the Board of Directors; or

1.1.1.3.4 the Directors' Code of Conduct.

1.2 Further criteria: suspensions

1.2.1 Suspension is a temporary measure which shall be used to prevent a Non-Executive Director from exercising ~~his or her~~their functions pending the completion of an investigation or removal from office under paragraph 22 of the Constitution. The Council of Governors, when exercising the power of suspension in accordance with paragraphs 22.2 to 22.5 of the Constitution, shall have regard to the following criteria (this is not an exhaustive list and each case shall be considered on its own

merits taking into account all relevant factors, including any representations made by the Non-Executive Director or the Chair in question);

1.2.1.1 the criteria referred to in paragraph 2.1.1 above;

1.2.1.2 where the Trust or the Council of Governors is in receipt of information which gives cause for concern about a Non-Executive Director continuing to hold office;

1.2.1.3 where there is sufficient evidence to warrant removal from office under paragraph 22 of the Constitution, but before the removal takes effect; or

1.2.1.4 where there is an allegation of fraud or other impropriety or other alleged misconduct that would require the Non-Executive Director to be suspended in order to protect patients, staff or public funds, or which is likely to impair the work of the Trust.

ANNEX 8 - FURTHER PROVISIONS

Appendix 4:

Further provisions: general

1 Indemnity

1.1 Members of the Council of Governors, the Board of Directors and the Secretary who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their functions save where they have acted recklessly. Any costs arising in this way will be met by the Trust.

1.2 The Trust may purchase and maintain insurance against this liability for its own benefit and for the benefit of members of the Council of Governors, the Board of Directors and the Secretary.

1.3 The Trust may take out insurance either through the NHS Litigation Authority or otherwise in respect of directors and officers liability, including liability arising by reason of the Trust acting as a corporate trustee of an NHS charity.

2 Dispute resolution procedures

Membership disputes

2.1 In the event of any dispute about the entitlement to membership, the dispute shall be referred to the Secretary who shall make a determination on the point in issue. If the Member or applicant (as the case may be) is aggrieved at the decision of the Secretary they~~he~~ may appeal in writing within 14 days of the Secretary's decision to the Council of Governors or a delegated committee or sub-committee of the Council of Governors or a joint committee of the Council of Governors and the Board of Directors, whose decision shall be final.

Other disputes

2.2 In the event of any dispute in relation to this Constitution that concerns anything other than membership, the dispute shall be referred to the Chair who shall make a determination on the point in issue. If the Member or complainant (as the case may be) is aggrieved at the decision of the Chair ~~he~~ they may appeal in writing within 14 days of the Chair's decision to the Board of Directors whose decision shall, subject to the provisions of paragraphs 2.2A and 2.2B below, be final.

2.2A In the event of a dispute being referred to the Chair under SO 4.13.10 of Annex 6 of this Constitution and a determination being made in accordance with the procedure set out in paragraph 2.2 above, if the Governor in question is aggrieved at the decision of the Board of Directors ~~he~~ they may apply in writing within 7 days to the Board of Directors for the decision to be referred to an independent assessor. The independent assessor will then consider the evidence and conclude whether the proposed removal is reasonable or otherwise.

2.2B On receipt of an application under paragraph 2.2A above, the Board of Directors and the applicant Governor will co-operate in good faith to agree on the appointment of the

independent assessor. If the parties fail to agree on an independent assessor within 21 days of the date upon which the application is received by the Board of Directors, the independent assessor will be nominated by the Chair, whose decision shall be final. The independent assessor's decision will be binding and conclusive on the parties.

Disputes between the Council of Governors and the Board of Directors

2.3 Subject to paragraph 19C of the Constitution, in the event of dispute between the Council of Governors and the Board of Directors:

2.3.1 in the first instance the Chair on the advice of the Secretary, and such other advice as the Chair may see fit to obtain, shall seek to resolve the dispute;

2.3.2 if the Chair is unable to resolve the dispute ~~he~~ they shall appoint a committee comprising equal numbers of Directors and Governors to consider the circumstances and to make recommendations to the Council of Governors and the Board of Directors with a view to resolving the dispute (the "Special Committee");

2.3.3 if the recommendations (if any) of the Special Committee are unsuccessful in resolving the dispute, the Chair may refer the dispute back to the Board of Directors who shall make the final decision.

3 Notices

3.1 Save where a specific provision of the Constitution otherwise requires or permits, any notice required by this Constitution to be given shall be given in writing or shall be given using Electronic Communications to an address for the time being notified for that purpose.

3.2 Proof that an envelope containing a notice was properly addressed, prepaid and posted shall be conclusive evidence that the notice was given. A notice served pursuant to paragraph 3.1 above shall be deemed to have been received 48 hours after the envelope containing it was posted, or in the case of a notice contained in an Electronic Communication, 48 hours after it was sent.

ANNEX 8 - FURTHER PROVISIONS

Appendix 5

The role and responsibilities of the Secretary

1 The Trust shall have a Secretary who may be an Officer of the Trust, but may not be a Governor or Director of the Trust.

2 Notwithstanding the specific functions of the Secretary, as set out in this Constitution, the Secretary will be expected inter alia to:

2.1 ensure good information flows within the Board of Directors and its committees and between senior management and the Council of Governors, and Members;

2.2 ensure that the procedures of the Board of Directors (as set out in this Constitution and the Standing Orders for the Board of Directors) are complied with;

2.3 ensure that the procedures of the Council of Governors (as set out in this Constitution and the Standing Orders for the Council of Governors) are complied with;

2.4 advise the Board of Directors and the Council of Governors (through the Chair or the Vice Chair, as the case may be) on all governance matters;

2.5 be available to give advice and support to individual Directors and Governors and assistance with professional development;

2.6 be available to give advice and guidance to Directors and Governors on their respective statutory duties and corporate governance-related matters;

2.7 attend as necessary all meetings of the Board of Directors and Council of Governors including their committees, sub-committees and joint committees, and to keep accurate minutes of these meetings; and

2.8 attend Members' meetings and keep accurate minutes of these meetings.

ANNEX 9 – SIGNIFICANT TRANSACTION

1 A Significant Transaction is a transaction which meets any of the following criteria:

Ratio	Description	Percentage
Assets	The Gross Assets subject to the transaction divided by the gross assets of the Trust.	>25
Income	The income attributable to: • the assets; or • the contract associated with the transaction divided by the income of the Trust.	>25
Consideration to total Trust Capital	The Gross Capital of the company or business being acquired/divested divided by the Total Capital of the Trust following completion, or the effects on the Total Capital of the Trust resulting from a transaction.	>25

2 For the purposes of this Annex 9:

2.1 "Gross Assets" is the total of fixed assets and current assets;

2.2 "Gross Capital" equals the market value of the target's shares and debt securities, plus the excess of current liabilities over current assets; and

2.3 "Total Capital" of the Trust equals taxpayers' equity.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Public Board of Directors	Agenda item:	15
Date of Meeting:	Wednesday 7 May 2025		

Title of Report:	Annual Review of Directors' Fit and Proper Persons Test
Status:	For noting
Board Sponsor:	Alison Ryan, Chair
Author:	Roxy Milbourne, Interim Head of Corporate Governance Abby Strange, Corporate Governance Manager
Appendices	None

1. Executive Summary of the Report

In September 2023, NHS England launched new national Fit and Proper Person Test (FPPT) Framework guidance which takes into account the requirements of the Care Quality Commission (CQC) in relation to directors being fit and proper for their roles. The Framework sits in the wider context of good governance, leadership and Board development, and is intended to strengthen individual accountability for Board members, thus enhancing the quality of leadership within the NHS.

There is an ongoing requirement for individual assessments to be completed on currently serving Board members each year and as such the Board of Directors undertakes an annual review and declaration that Board members continue to meet the requirements of the FPPT framework.

This report provides confirmation to the Board that all necessary individual annual checks have been completed, and the evidence reviewed confirms that all serving members of the Board are fit and proper. All Board members have completed and signed their self-declarations confirming that they continue to meet the requirements of the Test. The requirements for the annual FPPT assessment have therefore been fully satisfied, and an overall summary submitted to the NHSE Team confirming compliance with the framework within the required deadline of 12 June 2025.

It is recommended that the Trust implements a Fit and Proper Person Policy which has been drafted and is going through consultation. It will be presented to the next Board meeting for ratification.

2. Recommendations

The Board of Directors is asked to:

1. Note that the annual FPPT has been conducted for the period 2024/25 and that all current Board members satisfy the requirements.
2. Note that a draft FPPT policy has been developed and will be shared at the next Board meeting.

3.	Legal / Regulatory Implications
The requirements of the Fit and Proper Persons Test for Executive and Non-Executive Directors are set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. NHS England developed the FPPT Framework to strengthen/reinforce individual accountability and transparency for board members, this came into effect in September 2023.	

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)
The CQC has the power to take enforcement action against the Trust if it considers that requirements of FPPR have not been complied with.	

5.	Resources Implications (Financial / staffing)
None	

6.	Equality and Diversity
All Board members, regardless of their voting rights are required to undertake fit and proper persons checks.	

7.	References to previous reports
This is an annual report presented to the Board of Directors.	

8.	Freedom of Information
This is a public Board paper.	

9.	Sustainability
The annual FPPT processes has been digitalised and all records are stored digitally.	

10.	Digital
The annual FPPT processes has been digitalised and all records are stored digitally.	

Annual Fit and Proper Persons Test

1. Introduction

The Fit and Proper Person Regulation (FPPR) came into force for all NHS Trusts in November 2014 and requires all organisations to seek assurance that all Directors are fit to undertake the responsibilities of their role.

In September 2023, NHS England (NHSE) developed a Fit and Proper Person Test (FPPT) Framework in response to the recommendations made by the Kark Review in 2019. This was commissioned to establish why the FPPT was not being applied effectively and consistently and built upon the Francis Report which called for better regulation of NHS Board level Directors.

The FPPT framework came into effect from 30 September 2023, and it is a requirement that FPPT checks are undertaken annually. The next annual submission is required by 12 June 2025. The framework applies to all Executive and Non-Executive Board members, regardless of voting rights or whether an individual is permanent or interim.

2. Fit and Proper Person checks: New Appointment and Annual Assurance Checks

2.1 New Appointments

During the Financial year, new FPPT checks have been undertaken for the following Board members:

- Dr Kheelna Bavalia, Interim Chief Medical Officer
- Mr Simon Truelove, Interim Chief Finance Officer

2.2 Existing Directors Annual Review Process

As part of the annual review process, all current Directors have been subject to the following checks.

- Satisfactory completion of the self-declaration
- Search of insolvency and bankruptcy register.
- Search of Companies House register to ensure that no board member is disqualified as a Director.
- Search of the Charity Commission's Register of Removed Trustees
- Web/social media search.

The Chair is accountable for ensuring the FPPT process is effective and that the desired culture of the Trust is maintained to support an effective regime. The Interim Head of Corporate Governance supports the Chair in ensuring that the appropriate processes are followed.

The annual FPPT process at the Trust are aligned with NHSE recommendations as well as broader HR processes. They are well documented and are completed on an annual basis, however the Trust should implement a Fit and Proper Persons Policy which would make this process more robust.

3. Outcome of the 2025 Annual FPPT checks and submission

All Board members have completed and signed their self-declarations confirming that they continue to meet the requirements of the Test. All necessary individual annual checks have been completed and the outcome of the FPPTs have been saved on each personal file and uploaded onto ESR.

All serving members of the Board continue to meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and Proper Persons Test. An overall summary will be submitted to the regional NHSE Team to confirm compliance with the framework within the required deadline of 12 June 2025.

Between annual checks, each Director is responsible for identifying any issues which may affect their ability to meet the statutory requirements and for bringing these issues to the attention of the Interim Head of Corporate Governance or Chair.

4. FPPT Policy

It is recommended that the Trust implements a Fit and Proper Person Policy which has been drafted and is going through consultation. It will be presented to the next Board meeting for ratification. This would further demonstrate that robust processes are in place to determine whether all new and existing Directors are and continue to be fit and proper.

This will ensure ongoing compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 5: Fit and Proper Persons Requirement and that the conditions of the Trust's Provider Licence continue to be met.

This will also align Trust processes with Great Western Hospitals NHS Foundation Trust and Salisbury NHS Foundation Trust.

5. Recommendations

The Board is asked to:

a) note that the FPPT has been conducted for the period 2024/2025 and that all Board members satisfy the requirements.
b) Note that a draft FPPT policy has been developed and will be shared at the next Board meeting.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Public Board of Directors	Agenda item:	16
Date of Meeting:	Wednesday 7 May 2025		

Title of Report:	Annual Review of Directors' Interests
Status:	For Approval
Board Sponsor:	Alison Ryan, Chair
Author:	Roxy Milbourne, Interim Head of Corporate Governance
Appendices	Appendix 1: Directors Declarations of Interest

1. Executive Summary of the Report

The Trust's Managing Conflicts of Interest Policy requires all staff to declare relevant interests which are recorded on a central register of interest.

All "Decision Making" staff (which includes Directors, all staff at band 8D and above and those with substantial budgetary responsibility) are required to make an annual declaration of interests, which are published on the Trust website.

It is good practice for the Board of Directors to receive and review the interests declared by its members at least once a year for approval, and these are included at appendix 1.

The Board is also reminded of the requirement to declare interests at meetings when matters in which there is an interest are being considered and the requirement to withdraw from the meeting during their consideration.

2. Recommendations

The Board of Directors is asked to approve the Register of Directors' Interests as at 7 May 2025 and highlight any anomalies.

3. Legal / Regulatory Implications

All NHS Directors are legally required to declare their interests. This requirement is outlined in the Code of Governance for NHS Provider Trusts.

4. Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)

The consequences of not dealing with a conflict of interest can be significant. It can result in reputational risk, a failure to act in the best interest of the RUH, and poor governance.

5. Resources Implications (Financial / staffing)

None

6. Equality and Diversity

All Board members are required to declare interests as they arise.

7. References to previous reports

This is an annual report presented to the Board of Directors.

8.	Freedom of Information
This is a public Board paper.	

9.	Sustainability
The Declarations of Interest processes has been digitalised and all records are stored digitally.	

10.	Digital
The Declarations of Interest processes has been digitalised and all records are stored digitally.	

Annual Review of Directors' Interests

Introduction

The Trust's Managing Conflicts of Interest Policy requires all staff to declare relevant interests which are recorded on a central register of interest. Additionally, all "Decision Making" staff (which includes Directors, all staff at band 8D and above and those with substantial budgetary responsibility) are required to make an annual declaration of interests, which are published on the Trust website.

It is good practice for the Board of Directors to receive and review the interests declared by its members at least once a year for approval, and these are presented overleaf.

The Board is also reminded of the requirement to declare interests at meetings when matters in which there is an interest are being considered and the requirement to withdraw from the meeting during their consideration.

Board of Directors Declared Interests

The interests documented overleaf have been declared by the members of the Board of Directors, and they have been approved by the Chief Executive, Interim Managing Director, or Chair, or in the case of the Chair's interests, by the Senior Independent Director.

The interests that have been marked as 'ceased' will remain on the register for 6 months in line with the Managing Conflicts of Interest Policy.

Recommendations

The Board of Directors is asked to approve the Register of Directors' Interests as at 7 May 2025 and highlight any anomalies.

Surname	First Name	Role	Declared Interest
Bavalia	Kheelna	Interim Chief Medical Officer	• Health Foundation Generation Q Fellow • On the Board of Trustees of Shooting Star Children's Hospices.
Brooks-Daw	Christopher	Chief of Staff	• Nil
Charles-Barks	Cara	Chief Executive	• Group CEO for Royal United Hospitals, Great Western Hospitals and Salisbury Foundation Trust. • Visiting Professor in the Faculty of Health and Applied Sciences at the University of the West of England. • Chair of NHS Quest, a leadership/development provider. • Vice Chair of the Health Innovation West of England on Behalf of the RUH (ceased 01/11/24). • Appointed Honorary Colonel of 243 Multi-role Medical Regiment, part of the Army Reserve Medical Services.
Durbacz	Antony	Non-Executive Director	• Independent Governor at Bath Spa University. • Daughter is on rotation as a registrar in Obstetrics and Gynaecology in the Severn region. • Trustee at Wessex Learning Trust.
Fairhurst	Paul	Non-Executive Director	• Trustee of Designability (UK Charity). • Trustee of Back-Up (UK Charity).
Foster	Joss	Chief Strategic Officer	• Complaints Panelist for the Dental Complaints Service. • Investor in Veloscient Ltd (An organisation developing a platform to facilitate structured data capture for a range of markets including healthcare).

Surname	First Name	Role	Declared Interest
Govender	Paran	Chief Operating Officer	• Nil.
Harrod	Simon	Non-Executive Director	• Trustee of Amesbury History Centre.
Hollowood	Andrew	Interim Managing Director	• Wife is a General Practitioner at Hartcliffe Surgery, Bristol.
Hutchison	Sumita	Non-Executive Director	• Volunteer for the Save the Soil movement. • Non-Executive Director at Gloucestershire Health and Care NHS Foundation Trust. • Chair of West of England Nature Partnership. • Trustee of Avon Wildlife Trust. • Governor of Bristol Grammar School. Professional association with Ian Chesham, RUH Charity Investment Manager, who also sits on the school Board of Governors.
Luxford	Joy	Non-Executive Director	• Joy was appointed on 1st May and we are awaiting this information.
Lynch	Antonia	Chief Nursing Officer	• Spouse is a Matron at Great Western Hospitals NHS Foundation Trust.
Morley	Hannah	Non-Executive Director	• Member of the Charter Society of Physiotherapists. • Member of Canadian Alliance Physiotherapy. • Member of College of Physiotherapy, British Columbia. • Employed by Aneurin Bevan University Health Board as a Senior Planning and Service Development Manager. • Member of the Health and Care Professions Council.
Ryan	Alison	Chair	• South West Regional Chair for Organ Donation, part of NHS Blood and Transplant (unremunerated). • Mentor to the CEO of Julian House (unremunerated).

Surname	First Name	Role	Declared Interest
Stevens	Nigel	Non-Executive Director	• Chair, Transport Focus - a public funded watchdog. • Owner and sole-trader, Raybarrow Consulting - management consultancy.
Thompson	Alfredo	Chief People Officer	• Attends Locum's Nest Special Interest Group meetings. Locum's Nest is a private organisation that the Trust uses to book Medical Locums. I have not attended any meetings since January 2024.
Truelove	Simon	Interim Chief Finance Officer	• Married to the Deputy CEO and CFO of BNSSG ICB, commissioner of health services for the BNSSG area. • Trustee of the Independent Living Centre, Semington, a provider of advice for supporting people to live at home in the Trowbridge and Melksham area.
Walters	Libby	Chief Finance Officer	• Daughter is a student midwife and will be undertaking her clinical placements at the RUH.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**17**
Date of Meeting:	**Wednesday 7 May 2025**		

Title of Report:	**NHSE Licence Self-Certification – CoS7**
Status:	**Approval**
Board Sponsor:	**Cara Charles-Barks, Chief Executive**
Author:	**Roxy Milbourne, Interim Head of Corporate Governance**
Appendices	**Appendix 1: Self certification Condition CoS7- Commissioner Requested Services (CRS) Requirements**

1. Executive Summary of the Report

The Trust operates under an NHS Provider Licence and is required to self-certify on an annual basis whether or not it is compliant with the conditions of the NHS Provider Licence.

With the introduction of a refreshed provider licence in 2023 the self-certification for G6 (3) and FT4 has ceased to remove duplication with the annual report. However, the Trust is still required to self-assess against CoS7 which is as follows:

Declaration	Detail
CoS7 (3)	Providers providing Commissioner Requested Services (CRS) have to certify that they have a reasonable expectation that required resources will be available to deliver designated services. (For NHS Foundation Trusts only)

To help with the process NHS England has provided a template (Appendix 1) which Boards can use. To fulfil the requirement to publish the self-certification, the templates, proposed by NHS England, will be completed and signed by the Chair and Chief Executive. These documents will then be added to the Key Publications section of the Trust's website.

This report invites the Board to review and confirm the attached statement in line with its provider licence CoS7.

2. Recommendations (Note, Approve, Discuss)

The Board are requested to approve the self-certification CoS7 for publication on the Trust website.

Signs off declaration B within Condition CoS7 as **Confirmed** based on the evidence highlighted in Appendix 3,

3. Legal / Regulatory Implications

Failure to comply with licence conditions (or failure to mitigate against /repair breaches) will result the Trust breaching its regulatory and statutory obligations.

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc.)
Failure to meet the range of conditions of the NHS Provider Licence for a licensed provider can lead to NHS England imposing compliance and restoration requirements or monetary penalties. This could ultimately lead to revocation of a provider's licence. The greatest impact is most likely to be reputational and the impact that this could have on patients' and stakeholders' confidence in the RUH as a provider of NHS services.	

5.	Resources Implications (Financial / staffing)
Not Applicable	

6.	Equality and Diversity
Not Applicable	

7.	References to previous reports
This is an annual process and forms part of the Board's annual work-plan.	

8.	Freedom of Information
Public.	

Worksheet CoS7

Financial Year to which self-certification relates 2025_26

Declarations required by Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

Confirmed

OR

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

• The 2024/25 annual accounts are prepared on a going concern basis.

• Income and expenditure budgets have been set on robust and agreed principles and divisions should be able to provide high quality healthcare within the resources available, provided the cost improvement plans are achieved.

• The year to date and the annual financial position are detailed in the Monthly Integrated Performance Report and regular Finance update reports presented to the Board of Dircetors and relevant Board sub-committees and Executive Led Groups.

• The Trust is working to achieve the best possible financial position for 2025/26 in agreement with the ICS and NHSE however the emergent nature of the financial settlement for 2025/26 including system wide schemes and the impact of the ERF cap for example mean that the operational plan will be a challenge to meet full delivery across all (financial, operational performance, quality and workforce) domains.

The financial plan for 2025/26 is challenging with a savings plan target of £29.7m (4.7% of turnover) which is not without significant risk, and an overall planned breakeven position. Improvement plans are in place, however, the pace and scale required must be considered in the context of operational pressures and capacity.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Cara Charles-Barks	**Name**	Alison Ryan
Capacity	Chief Executive	**Capacity**	Chair
Date		**Date**	

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item No:**	**18**
Date of Meeting:	**7 May 2025**		

Title of Report:	**Maternity and Neonatal Safety Report Quarter 3**
Board Sponsor:	**Antonia Lynch, Chief Nursing Officer**
Author(s):	**Zita Martinez, Director of Midwifery**
Appendices	**Appendix 1: Perinatal Culture and Leadership Programme Board Report** **Appendix 2: Transitional Care Pathway and ATAIN Audit Q3 2024/2025** **Appendix 3: Bi-annual Midwifery and Neonatal Nursing Staffing Report – attached at agenda item 19**

1. Executive Summary of the Report

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety. The purpose of the report is to inform the Local Maternity and Neonatal System (LMNS) and Board of Directors of present and/or emerging safety concerns.

The Royal United Hospitals Bath NHS Foundation Trust (RUH) Maternity and Neonatal Safety report identifies at the end of Q3, the RUH rolling 12-month average stillbirth rate is 2.1 per 1000 births; this remains below the reported national average of 3.3 per 1000 births (2022) and remains stable from Q2.

The RUH neonatal mortality 12-month rolling average at the end of Q3 24/25 is 0.91 per 1000 births, which remains below the reported national average for 2022 of 1.7 per 1000 births and shows a reduction from Q2.

All stillbirths and neonatal deaths, during Q3 have been reported to Mothers and Babies Reducing Risk through Audit and Confidential Enquiries-UK (MBRRACE-UK), and where applicable, excluding Medical Terminations of Pregnancy (MTOPs), a Perinatal Mortality Review Tool (PMRT) process will be undertaken.

No births met the criteria for referral to the Maternity and Neonatal Safety Investigations (MNSI) team hosted by the Care Quality Commission (CQC) in Q3. The service currently has two ongoing reviews with MNSI, which are proceeding at family request.

The perinatal service has been working with KPMG to provide assurance for Year 6 Safety Actions for the Maternity Incentive Scheme (MIS), the current and projected position at submission is detailed within this report.

This report outlines the current service responses to insights from service users including the Maternity and Neonatal Voices Partnership (MNVP) and Safety Intelligence data. Appendix 1 of this report provides oversight of the Perinatal Leadership and Culture Programme (PCLP) which the RUH commenced in August 2023. This programme was designed in direct response to nationally derived intelligence and aims to support Perinatal Quadrumvirate teams to create and craft positive safety cultures. This report seeks to provide assurance of the service ongoing commitment to continuous improvement.

The Avoiding Term Admissions into the Neonatal Unit (ATAIN) working group identified during Q3 the transitional care (TC) pathway remained open for 100% of the time, with staffing meeting the identified transitional care pathway model on average 98% of the time. On no occasion were there

missed opportunities to have provided TC care or admissions to the neonatal unit (NNU) that would have met current TC admission criteria but were admitted to the neonatal unit due to capacity or staffing issues. No babies were admitted to or remained on Local Neonatal Unit (LNU) because of the need for nasogastric tube feeding, which could have been cared for in TC if nasogastric feeding were supported there. There were two avoidable term admissions in Q3 into the LNU, the same as in Q2. There have been no themes for learning identified (Appendix 2).

The bi-annual staffing report (Appendix 3) provides a summary of the measures in place to ensure safe midwifery and neonatal nurse staffing; including clinical and specialist roles, headroom requirement, fill rates, escalation, recruitment and retention, midwife to birth ratio, Birth Rate Plus® Live Acuity Tool compliance with supernumerary labour ward coordinator status, one to one care in labour, and red flag incidents.

It provides evidence of compliance that obstetric medical workforce is monitored to ensure locum doctors meet MIS criteria, and consultants comply with the attendance requirement set out in the Royal College of Obstetricians and Gynaecologists (RCOG, 2021) workforce document 'Roles and responsibilities on the consultant providing acute care in obstetrics and gynaecology.'

Evidence that a duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should always have clear lines of communication to the supervising anaesthetic consultant is provided in line with MIS requirements. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients to be able to attend immediately to obstetric patients in line with Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1.

It also provides a summary of measures taken to demonstrate working towards compliance with safe staffing for the Local Neonatal Unit (LNU) to include an annual nursing workforce review, including a mid-year review and collaborative working with the Operational Delivery Networks (ODN) to ensure recruitment and retention, skill mix and flexible working. A summary of compliance for neonatal medical workforce meeting British Association of Perinatal Medicine (BAPM) national standards, or actions to mitigate if not compliance are in place and are shared with the Local Maternity & Neonatal System (LMNS) and ODN.

2.	**Recommendations (Note, Approve, Discuss)**
Discuss and approve.	

3.	**Legal / Regulatory Implications**
It is a legal requirement to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).	

4.	**Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc.)**

There were no new risks added to the risk register.
Current open risks in Maternity and Neonates Q3 24/5
All low risks are managed as per the Trust Risk Management Policy

Risk No	Description	Scoring
2950	There is a risk that due to the current compliance of percentage of staff Qualified in Specialty (QIS) trained in the LNU below BAPM standards, the quality of care being delivered to the babies at risk of	12

	being compromised	
2785	There is a risk that the current pharmacist cover for the Neonatal Unit does not meet clinical needs or BAPM standards.	12
2717	Shared Father/Partner information within the multi-agencies	10
2591	There is a risk that the current funded provision of Allied Health Professionals in the Neonatal Unit will not continue following cease of fixed term funding from the neonatal Operational Delivery Network.	9
2681	Mandatory Training room booking availability	9
2724	Risk of loss of Obstetric USS reporting System	9
2359	Maternity Information System IT support/capacity	8
2467	Maternity workforce	8
2649	Delays to commencement of induction of labour	8
2660	Tertiary level neonatal cot capacity in the region	8
2718	Bacillus Calmette-Guerin (BCG) Vaccination programme	8
2949	There is a risk that due to the current estates footprint, and estates availability of Princess Anne Wing (PAW) Maternity services are unable to run optimally.'	8
2948	There is a risk that due to a gap between demand and capacity to process the increasing volume of Maternity Subject Access request the service will be unable to meet the mandated 30-day delivery target	8
1948	Obstetric ultrasound scan capacity	8
2784	Maternity and Neonatal Services Adult Basic Life Support Compliance	6
2679	Service provision of digital blood pressure monitors validated for use in pregnancy and pre-eclampsia	5

5. Resources Implications (Financial / staffing)

Compliance with the Maternity Incentive Scheme for Trusts has financial and safety implications for the Trust. There is a financial commitment required by the Trust to achieve full compliancy.

6. Equality and Diversity

Equality and Diversity legislation is an integral component to registration.

7. References to previous reports

Previous monthly Perinatal Quality Surveillance reporting
CNST Maternity Incentive Scheme – Year 6 declaration of compliance
Q1, 2, and 4 Maternity and Neonatal Safety Reports – Quality Governance Committee & Board of Directors,

8. Publication

Public.

REPORT OVERVIEW

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document '*Implementing a revised perinatal quality surveillance model'* (December 2020). The purpose of the report is to inform the Local Maternity and Neonatal System (LMNS) Board and the Board of Directors of present or emerging safety concerns within Maternity and Neonatal services. The information within the report reflects actions and progress in line with the RUH Maternity Single Delivery Improvement plan encompassing of Ockenden 2022 Immediate and Essential Actions (IEAs) aligned to the three-year delivery plan for Maternity and Neonatal Services of 2023. This report also outlines the current position of compliance with the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS).

1. PERINATAL MORTALITY RATE

Figures 1 and 2 demonstrate RUH performance against the national ambition to reduce stillbirth in the UK by 50%, and the local ambition for continual progression in reducing perinatal mortality. From March 2024, the national averages have been adjusted to reflect the publication of the MBRRACE-UK report of 2022 perinatal mortality revised National averages.

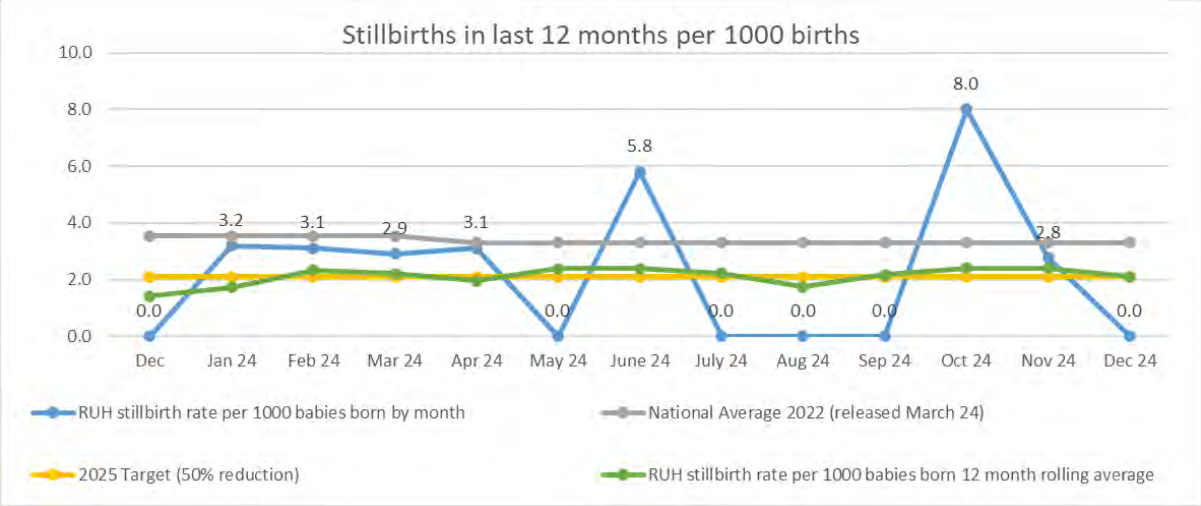


Figure 1: RUH NHS Trust stillbirth rate per 1000 births over last 12 months

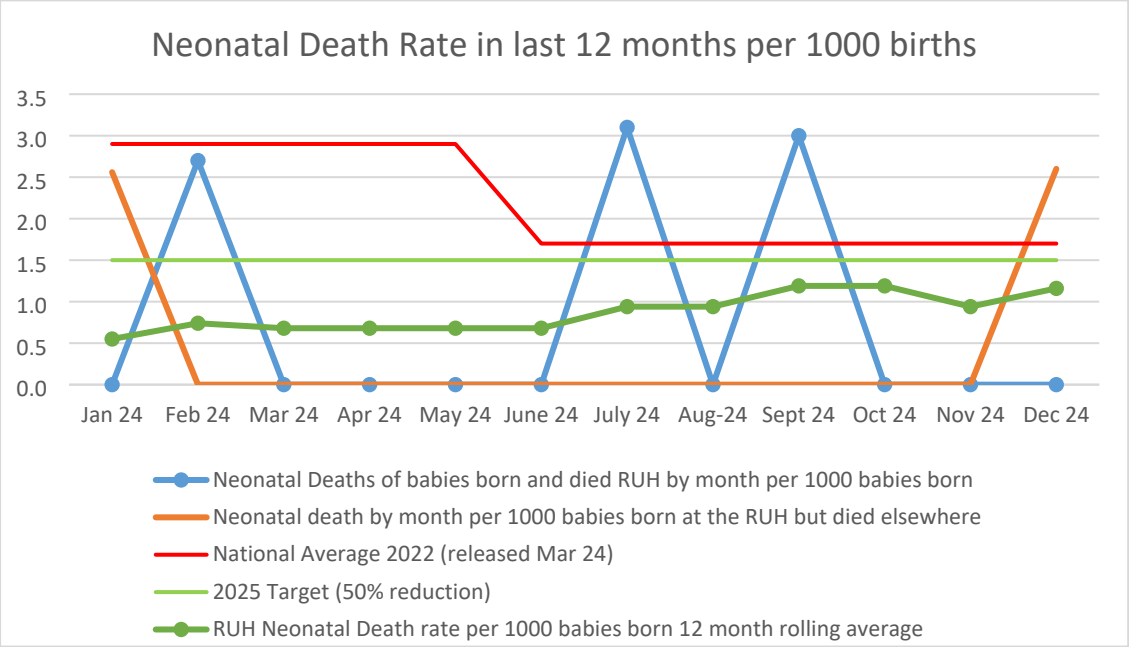


Figure 2: RUH NHS Trust Neonatal Death rate per 1000 births over last 12 months

MBRRACE-UK collects data on perinatal death defined as babies born without signs of life from 22 weeks gestation to term and neonatal deaths at any gestation up to 28 days of age, excluding termination of pregnancy.

The RUH Electronic Patient Record (EPR) records all stillbirths (24 weeks or greater gestation) and neonatal deaths. Neonatal deaths of pre-viability infants (less than 22 weeks gestation) born with signs of life, and births between 22-24 weeks are identified manually and added to the data set submitted to MBRRACE-UK as in figure 1. Perinatal deaths are defined from birth after 22 weeks gestation and include neonatal deaths at any gestation where the baby is born with signs of life, but stillbirths are defined from 24 weeks at diagnosis of death. The rate of stillbirth and perinatal death may therefore be different.

Trusts are provided with initial MBRRACE-UK perinatal mortality rate per 1000 births, results are subsequently stabilised and adjusted to reflect if the RUH statistics were representative of the national socioeconomic demographics. Therefore, MBRRACE crude, and stabilised and adjusted rates for the RUH will be different. MBRRACE-UK collates the data for those babies who were born at the RUH and subsequently died elsewhere. This report has separated these values to ensure alignment of internal mortality data figures ahead of reported and adjusted MBRRACE-UK figures, see figures 1 and 2.

Five perinatal deaths excluding Medical Terminology of Pregnancy (MTOP) were reported in Q3. This consisted of two stillbirths: one at 24 weeks of pregnancy and one at 36 weeks of pregnancy. There was one neonatal death of a baby born at 22+5 weeks of pregnancy with signs of life who subsequently died, one baby born at 28 weeks of pregnancy who died shortly after birth and one baby who died at 4 weeks of age from a metabolic disorder.

2024/25 (excluding terminations for abnormalities)	3 24/25	Annual total 2024 (calendar year)
Stillbirths (>37 weeks)	0	2
Stillbirths(>24weeks-36+6weeks)	1	4
Late miscarriage (22+weeks-23+6weeks)	0	1
Neonatal death at the RUH	2	4
Neonatal death elsewhere following birth at the RUH	1	2
Total	**5**	**13**

Table 1: Perinatal Mortality summary by number of cases, quarter 3 2024/25

2. PERINATAL MORTALITY REVIEW TOOL (PMRT)

All perinatal deaths that occur within the Trust have been reported using the PMRT tool since 2018. PMRT reporting is a requirement of Safety Action 1 of the NHS-R Maternity Incentive Scheme year 6. All Q3 cases have been reported to MBRRACE-UK via PMRT. See figure 3 as confirmation of reporting as per table 1.

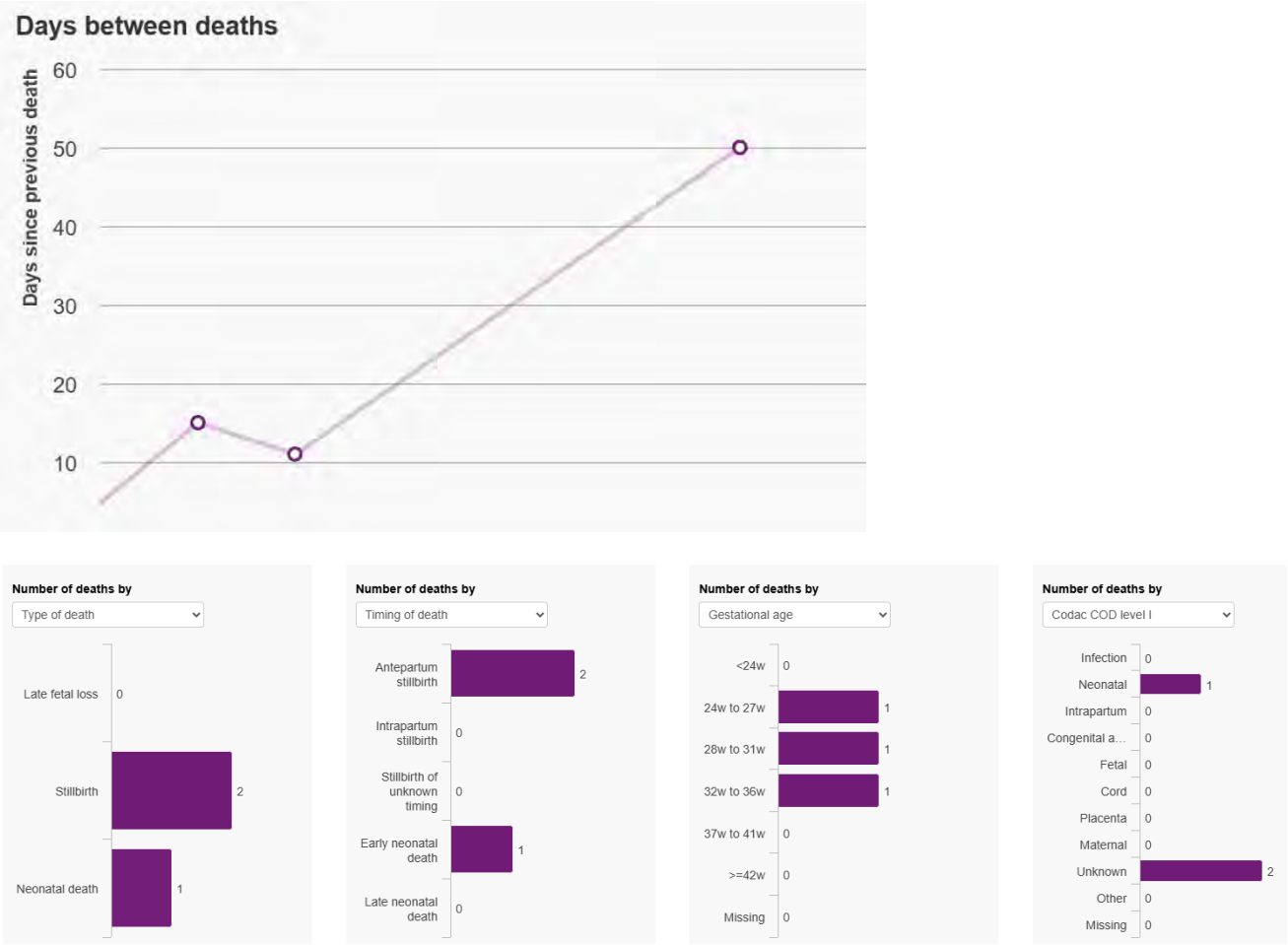


Figure 3: Reporting of RUH NHS Trust Deaths within Organisation for Q3 24/25

2.1 PMRT PROCESS MEASURES

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	Q3 24/25	Annual 24/25	Standard
Notification of all perinatal deaths eligible to notified to MBRRACE-UK to take place within seven working days	100%	100%	95%
Surveillance of all perinatal death's information must be completed within one month of the death. Deaths where the surveillance form needs to be assigned to another Trust for additional information are excluded from the latter	100%	100%	95%
A PMRT review must be commenced within two months following the death of a baby	100%	100%	50%
Percentage of PMRT review meetings which have met quoracy as outlined within the PMRT recommended composition	100%	100%	100%
A draft PMRT report must be completed within four months of a baby's death	75%	75%	50%
A PMRT must be completed within six months of the death of a baby's death	75%	75%	50%
All parents will have been told that a review of their baby's death is taking place and asked for their contribution of questions and/or concerns	100%	100%	95%
Quarterly reports will have been submitted to the Trust Board from 6 May 2022 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions	100%	100%	100%

Table 2: PMRT Process Measures Quarter 3 24/25.

2.2 LEARNING FROM PMRT REVIEWS

In Q3, 1 PMRT review was completed and shared with the family. The PMRT review group concluded that there were no issues with care identified for the mother which would have impacted upon the outcome for the baby. The review group identified co-incidental learning actions to support service quality improvements outlined below identified at Rapid Review:

Issue/area for improvement	Review Response/Action plan	Action target date
1 blood pressure monitoring and actions not in line with guidance	Update guidance following implementation of triage and inform staff of changes to ensure monitoring and referral for obstetric opinion in line with guidance.	Feb 25

Table 3: PMRT Action plan Q3 24/25

Monitoring of action one from Q2 continues, there have been no incidents relating to this action. The planned implementation of Badgernet in June 25 has been delayed to July 25 and will mitigate this risk with a digital solution.

Going forward all learning whether linked or co-incidental will be related to the relevant element of Saving Babies Lives V3 which will be referred to in PMRT reports.

3. MATERNITY AND NEONATAL SAFETY INVESTIGATIONS (FORMERLY THE HEALTHCARE SAFETY INVESTIGATION BRANCH) AND MATERNITY PATIENT SAFETY INCIDENT INVESTIGATIONS

3.1 BACKGROUND

Maternity and Neonatal Safety Investigations (MNSI) undertake maternity investigations in accordance with the Department of Health and Social Care criteria (Maternity Case Directions 2018), taken from Each Baby Counts and MBRRACE-UK. In accordance with these defined criteria, eligible babies include all term babies (at least 37 completed weeks of gestation) born following labour who have one of the following outcomes:

- Maternal Deaths
- Intrapartum stillbirth
- Early neonatal death
- Severe brain injury diagnosed in the first seven days of life.

3.2 INVESTIGATION PROGRESS UPDATE

One new referral was made in Q3. Table 4 summarises the ongoing MNSI reviews into Q3. The findings and recommendations of these reviews, and the actions taken in response, will feature in future quarterly Trust Board reports. No cases in 24/25 have met the criterion for Early Notification Scheme referral to NHS-Resolution.

Ref	Details of Event	Confirmed Investigation	External Notifications and Other Investigations	Duty Of Candour commenced inclusive of information sharing pertaining to MNSI and NHS-R.	Local Learning Identified
Completed in Q3					
None					

Ongoing					
MI-037619	Neonatal transfer to Tertiary Neonatal Unit for ongoing care and active therapeutic cooling, normal MRI post cooling.	June 24 progressing at family request.		Yes 04/07/2024	
New Referrals					
MI-038594	Neonatal transfer to Tertiary Neonatal Unit for ongoing care and active therapeutic cooling, normal MRI post cooling.	Progressing at family request.		Yes 04/10/2024	

Table 4. MNSI referrals and ongoing investigations Q3 2024/2025

3.3 CORONER REGULATION 28 MADE DIRECTLY TO TRUST

Not applicable.

3.4 MATERNITY PATIENT SAFETY INCIDENT INVESTIGATIONS (PSII)

There were no Patient Safety Incident Investigations (PSII) that reached completion in Q3 and no new PSIIs declared, see Section 3.5 for learning and improvement recommendations findings and actions identified in response. See table 5.

Ref	Details of Event	Review Response	External Notifications and Other Investigations	Duty Of Candour commenced
Completed reviews				
None				
Ongoing reviews				
	Neonatal Death on day 8 of life	PSII declared with terms of reference: • To review the current service education provision to parents regarding routes of escalation in response to the signs of an unwell newborn in the early postnatal period. • To review the current Maternity Telephone Triage line 'signs of an unwell newborn' 'action cards' & 'red flags'. • To review the supporting	PMRT/MBRRACE/ Coroners/CDOP	Yes 15/10/2024

		systems and structures in place in managing escalations of clinical concerns from parents regarding signs of an unwell newborn via the Maternity Telephone Triage line. • To review the referral pathways following contact from parents via the Maternity Triage line for neonatal clinical concern. • Draft report in progress.		

Table 5. Maternity and Neonatal Patient Safety Incident Investigations Q3

There were no recurrent incidents during Q3 of moderate harm or above. Ongoing surveillance of 3rd and 4th degree tears continues following the findings in Q2.

3.5 LEARNING AND IMPROVEMENT

One ongoing MNSI draft review was received in Q3 2024/25. Safety recommendations (A safety recommendation is made where alterations in care may have changed the outcome for either the mother or the baby) were made to the Trust within the draft report which had already been identified at local MDT review and actioned, and progress will be monitored via Maternity and Neonatal Specialty Governance. This will contribute to the 'triangulation of feedback' data base to allow for assessment of wider commonalities or trends across the service 'insights.

Learning and Improvement drivers from service insights are fed back to staff in a variety of formats including: the maternity newsletter, staff e-mails, staff safety briefings, patient safety 'Safety Catch' newsletter, Microsoft Teams RUH Maternity Team, case review QR code posters to full reports and quality and safety whiteboards displayed in clinical areas with a 'Safety Hot Spot' of the month. Safety Hotspots are identified from co-incidental learning through service insights such as themes of low and no harm incidents, audit and, or family feedback. Furthermore, local insights for learning are fed into the mandatory training programme for midwives as per the Core Competency Framework version 2 (CcFv2).

4. RUH SINGLE MATERNITY AND NEONATAL IMPROVEMENT PLAN

4.1 THREE YEAR DELIVERY PLAN UPDATE- Q3 2024-2025

RUH Single Improvement plan compliance categorised under the 4 pillars of the 3 year Delivery plan 2023						
Domain	**Blue**	**Green**	**Amber**	**Red**	**Total Actions**	**% of Compliance**
1- Listening to Women	12	1	5	0	18	66.7
2- Workforce	52	10	10	0	72	72.2
3- Culture and Leadership	42	9	4	0	49	85.7
4- Standards	21	7	2	0	29	72.4
Total	**127**	**20**	**21**	**0**	**159**	79.9

Table 6. RUH compliance with open actions towards the 3-year delivery Plan Q3 24/25

Perinatal services continue to work towards full compliance of the Trust single Maternity and Neonatal Improvement Plan for 24/25 in response to the NHSE 3-year Delivery Plan, Ockenden report of 2022 and the RUH NHSE visit of 2022. The plan encompasses all actions

associated with the reports as above, listed under the 4 Domains of the 3-year plan. Next steps include the incorporation of the CQC action plan into the single delivery plan to ensure concurrent review and delivery. Compliance has increased from 73% in Q2 to 79.9% in Q3.

The compliance for the individual report action plans can be extracted from within the plan.

Progress towards full implementation is outlined within table 6 and 7; percentage of compliance is only attributed to those actions within the action plan which have been complete.

- Blue actions - Evidence of implementation assurance can be obtained if required.
- Green actions - Improvement work is on target for completion, and/or the service is developing assurance processes.
- Amber actions - Improvement work in progress however continued work is required, or no assurance of compliance is available at present.
- Red actions - Current non-compliance with no work in progress to address currently.

4.2 OCKENDEN FINAL REPORT UPDATE – Q3 2024-2025

The Trust is no longer required to submit evidence of compliance with the 15 Immediate and Essential Actions outlined within the Ockenden report of 2022. Any remaining open actions have been incorporated into the RUH Single Maternity and Neonatal Improvement Plan and progress monitored at Specialty Governance, Maternity and Neonatal safety champions via the Integrated Performance Review (IPR) presentation every month.

5. TRAINING COMPLIANCE FOR ALL STAFF GROUPS IN MATERNITY RELATED TO THE CORE COMPETENCY FRAMEWORK

5.1 Q3 POSITION

The report provides an update on the local training, including a response to year 6 of MIS, Safety Action 8. The Core Competency Framework version 2 sets out clear expectations for all Trusts, aiming to address known variation in training and competency assessment for midwifery staffing across England. It ensures that training to address significant areas of harm are included as minimum core requirements and standardised for every maternity and

neonatal service. Compliance with attendance and demonstrated competence for fetal monitoring, neonatal resuscitation, and multi-disciplinary training (MDT) Emergency Skills Training (PROMPT) across all staffing groups can be found in Figure 4.

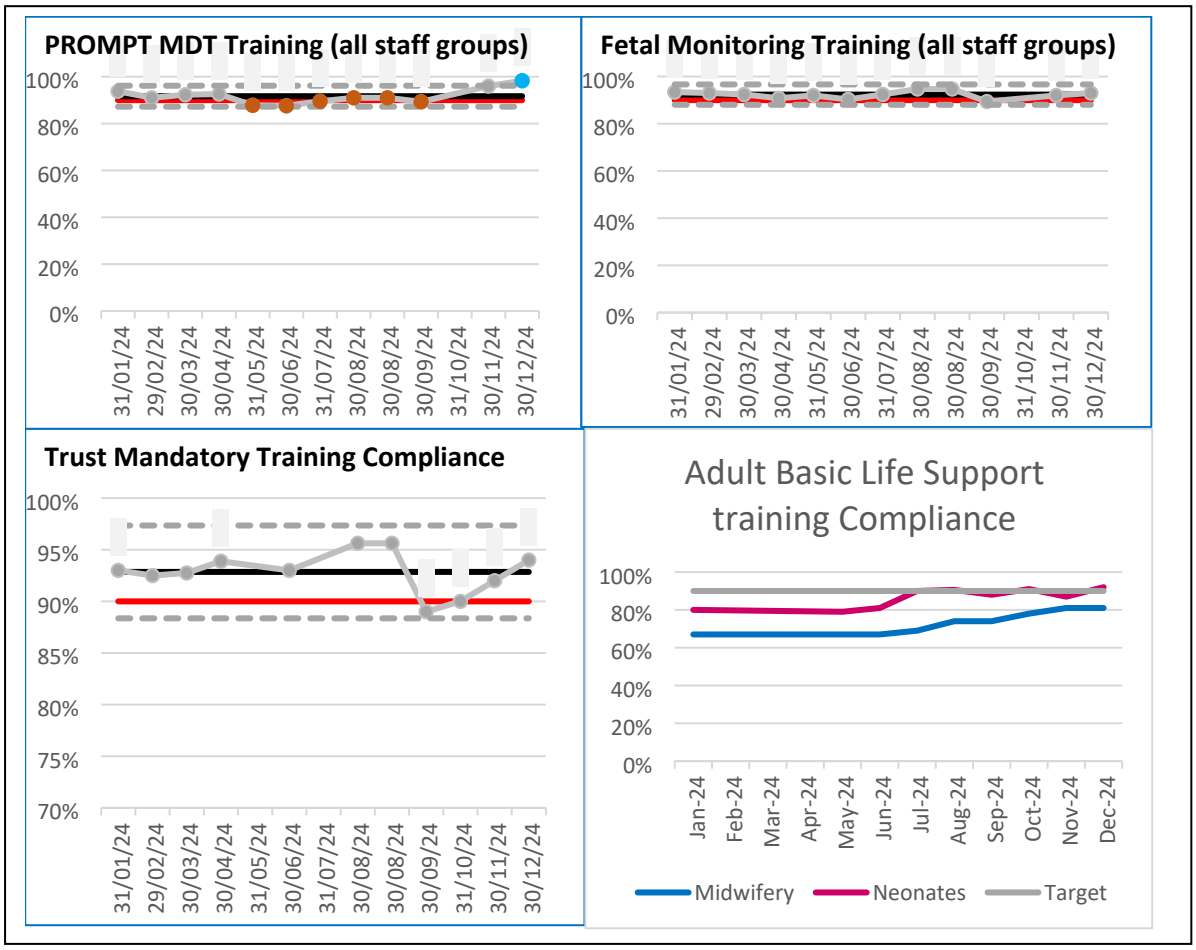


Figure 4. Maternity Training Statistical Process Charts for PROMPT, Fetal Monitoring, Mandatory Training compliance and Adult Basic Life Support compliance, as of 31/12/2024

Specific training standards for all staffing identified within the Saving Babies Lives Version 3 are externally assessed by the Integrated Care Board (ICB) Local Maternity and Neonatal System (LMNS) for both content and compliance. See section 8.

During Q3 the service achieved compliance for PROMPT at 98% and Fetal Wellbeing at 93% (target 90%) detailed as per table 7 with compliance met for MIS.

Staff Group	Training programme			
	PROMPT (NBLS inclusive)		Fetal Wellbeing Study Day	
	Dec Compliance	Projected compliance January	Dec compliance	Projected compliance December
Midwives (n=260)	**96.9%**	**98.4%**	**96.8%**	**97.1%**
Maternity Support Workers (n=75)	**96.3%**	**96.4%**	Not Applicable	
Consultant Obstetricians (n=11)	**100%**	**100%**	**93.9%**	**91.7%**
Obstetric Registrars (n=13)	**100%**	**100%**	**100%**	**93.3%**
Other obstetric doctors (n=12)	**100%**	**100%**	Non applicable	
Other obstetric doctors on the specialty trainee programme for obstetrics (n=4)			**100%**	**97.2%**
Anaesthetists (n=40)	**93.3%**	**97.6%**	Not Applicable	
Overall, across all staff groups	**98.4%**	**98.3%**	**96.3%/93.9%**	**95.7%**

Table 7. RUH compliance with mandatory training requirements and compliance for MIS reporting

6. BOARD LEVEL SAFETY CHAMPIONS

The Maternity and Neonatal Safety Champions are active in their role to listen to the staff voice in maternity services. All staff are invited to attend monthly 'listening event' meetings and interact with Safety Champions during walkabouts with the Chief Nursing Officer, the Non-Executive Director for Maternity and Neonatal services, and the Obstetric, Neonatal and Maternity Safety champions.

Themes raised to the Safety Champions during Q3 were:

- Positive feedback for neonatal unit from families and student midwife
- Positive feedback regarding meal access for neonatal families and the greater knowledge of psychological support available
- Concerns continue regarding the trust-wide paid breaks consultation and outcome, both regarding breaks facilitation on shift, and the impact the unpaid breaks will have on work-life balance due to an increased requirements for 'make-up shifts' if not reducing hours
- Impact of fire wall work on operational planning on Mary ward.

Current work to address the concerns raised:

- Leadership and Culture QI programme in partnership with Korn Ferry, see Appendix 2 for full report and action plan
- Collaborative working with estate and FASS Division to plan around essential building works to limit the impact on patient care.

Identified themes, commonalities and actions from this feedback is monitored via the Maternity and Neonatal Safety Champions meetings and is triangulated with further service insights in the Maternity and Neonatal 'Insights' report to drive our continuous improvement work.

7. NHS RESOLUTION MATERNITY INCENTIVE SCHEME UPDATE Q3 2024/25

The Clinical Negligence Scheme for Trusts (CNST) released the Maternity (and perinatal) Incentive Scheme Year 6 on 31 March 2024. Updates on progress and monitoring towards achievement of the 10 Safety Actions outlined is completed and shared within Maternity and Neonatal Speciality Governance meeting and Board Level Safety Champions monthly. Areas of current non-compliance are in response to the reporting time scales set within MIS not yet reached to be able to achieve the set standards.
The service is on target to submit a full compliance position for each of the ten Safety Actions and their associated sub-requirements within MIS Year 6. The Trust has engaged KPMG to conduct an audit to validate the evidence supporting compliance with MIS Year 6. KPMG assessed the minimum evidence requirements for Safety Actions 3, 4, 5, 7, 8, and 9. Safety Actions 1, 2, 6, and 10 were excluded from the KPMG audit scope, as assurance for these actions will be obtained through external validation processes. The KPMG audit result is planned to be shared in Quarter 4 reporting period prior to MIS self-declaration submission.

8. SAFETY ACTION 6 - MIS SAVING BABIES LIVES CARE BUNDLE V3.

Saving Babies Lives Care Bundle Version 3 (SBLCB V3) implementation is subject to ongoing continuous improvement work. The Service is compliant using the SBL NHSE Implementation Tool and at least quarterly improvement discussions with the ICB have been held. The service received confirmation from the LMNS ICB on 12 December 2024, that compliance with Safety Action 6 has been met. Whilst full implementation of SBLCB V3 is not in place yet, compliance

is still achieved as the ICB have confirmed it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory, moving from 73% to 90%.

Intervention Elements	Description	Element Progress	% of Interventions Fully Implemented
Element 1	Smoking in Pregnancy	Partially Implemented	90%
Element 2	Fetal Growth Restriction	Partially Implemented	80%
Element 3	Reduced Fetal Movement	Fully Implemented	100%
Element 4	Fetal Monitoring in Labour	Fully Implemented	100%
Element 5	Preterm Birth	Partially Implemented	93%
Element 6	Diabetes	Fully Implemented	100%
All Elements	TOTAL	Partially Implemented	90%

Table 8: RUH Maternity position for implementation of Saving Babies Lives Care Bundle v3.

9.0 SAFE MATERNITY AND NEONATAL STAFFING

9.1 MIDWIFERY STAFFING

As of December 2024, the Band 5/6 Midwifery establishment vacancy rate has a gap of 0.49 WTE. Of which 9.16WTE are on secondment, and 9.76WTE are on Maternity leave. Due to the consistent rates of maternity leave cover required within the service, the RUH has agreed an additional 8.0 substantive WTE into budget to minimise impact on clinically available workforce vacancy and maintenance of safe staffing.

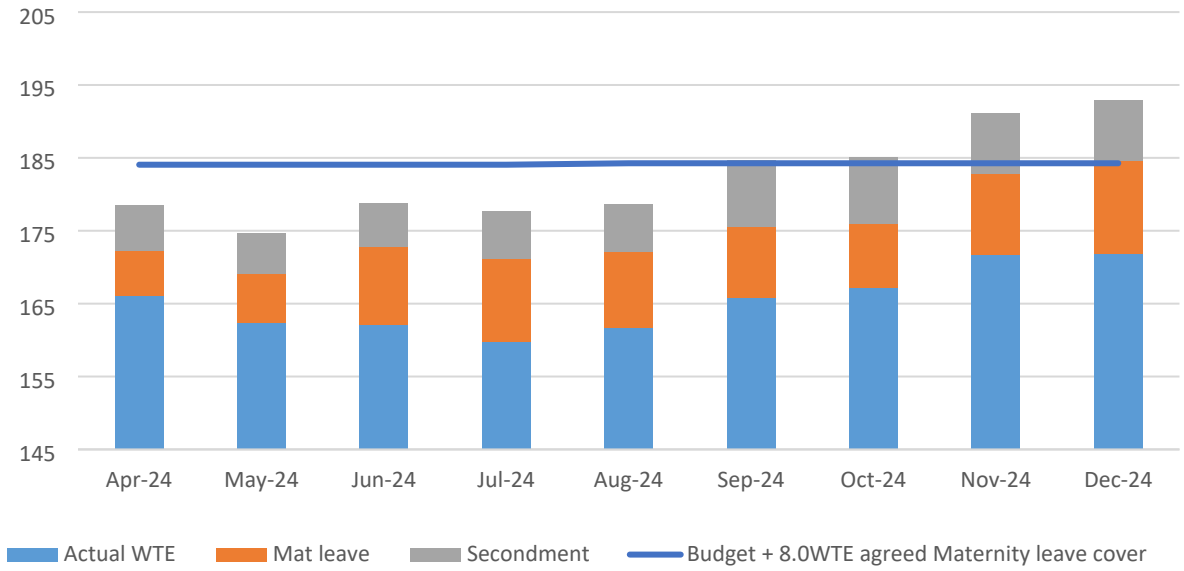


Figure 5. Band 5/6 Midwifery Workforce staffing vacancy and forecast (not including long-term sickness)

Table 9 Outlines some of the key process and outcome measures during Q3 for the provision of safe staffing levels.

Measure	Aim	October	November	December
Midwife to birth ratio	1:24	1:29	1:26	1:26
Midwife to birth ratio including bank	1:24	1:26	1:24	1:24

Episodes of inability to maintain Supernumerary labour ward coordinator status	0	0	0	0
1:1 care not provided	0	0	0	0
Confidence factor in Birth-rate+ recording	60%	82.26	80.00	75.27

Table 9. Midwifery staffing safety measures

The midwife to birth ratio advised in the Birthrate+ report 2021 has been achieved during Q3 other that in October when there was an increased in the number of births and women with complex care needs.

9.2 OBSTETRIC STAFFING

Measure	Aim	October	November	December
Consultant presence on BBC (hours/week)	≥90 hours	98	98	98
Consultant non-attendance (in line with RCOG guidance)	0	0	0	0
Twice daily MDT ward round	90%	94%	97%	97%

Table 10. Obstetric staffing safety measures

The service is compliant with BBC consultant presence and twice daily MDT ward rounds. Improvement work is underway to explore enhancing consultant review and oversight for postnatal readmissions.

9.3 NEONATAL NURSE STAFFING

MIS Safety Action 4 outlines the requirement to demonstrate compliance with meeting BAPM neonatal nursing standards. During 24/25 the service has seen a decrease in the number of staff members within the LNU holding the QIS qualification in neonatal nursing due to staff re-locations and retirements. The substantive vacancies have been filled with new starters however due to the new starters not holding the QIS qualification this has resulted in a drop below BAPM target standard of 70%.

Measure	Aim	October	November	December
Percentage of nursing establishment who hold Qualified in Speciality (QIS) qualification.	>70%	69%	69%	63%
Percentage of Transitional Care (TC) shifts with staff dedicated to TC care only	>90%	97%	97%	100%
Neonatal Nursing Vacancy rate (WTES)		3.5	3.8	3.1

Table 11. Neonatal nursing staff

The high demand for academic QIS training programmes is compounded by the lack of locally available academic courses in the Southwest Region. The Southwest Neonatal Operational Delivery Network (SWNODN) are moving forward with the pilot course in association with Plymouth University. The trust has been offered one fully funded place on this course which in addition to the four currently being undertaken will ensure compliance with BAPM standards by Q2 2025.

QIS is a Continued Professional Development in addition to Bachelor of Science Paediatric Nursing there is no identified funding stream for continued QIS training programmes, resulting in a risk to recurrent funding and pipelines. The risk remains on the Maternity and Neonatal Risk Register, Risk 2950. See section 12.0.

Actions towards mitigation of the risk, and reduction in the likelihood of quality of care being impacted will be monitored via Maternity and Neonatal Specialty Governance and Maternity and Neonatal Performance Review Meetings for financial planning.

	Action Plan towards Risk Mitigation:	Target Completion date
1.	Shifts allocations/rostering overseen by senior sister to ensure stability in the number of QIS members of staff on each shift to meet service need	Ongoing
2.	Shift swap requests/allocations made in response to short-term sickness to preserve QIS staff on each shift	Ongoing
3.	Monthly monitoring of percentage of neonatal shifts staffed to BAPM standards shared at board level as part of monthly internal performance review Perinatal Quality Surveillance Tool to provide assurance of effectiveness of actions 1 and 2	Complete
4.	Four nurses are enrolled on QIS course in Birmingham for 2024/2025 funded via Trust-Wide CPD funding	April 2025
5.	One nurse allocated to funded place on pilot course on behalf of SWODN to commence Jan 25	January 2025
6.	Identification of Risk on Maternity and Neonatal Risk Register to ensure progression of actions towards mitigation	Complete
7.	All new starters to the Neonatal Unit to complete the Southwest Neonatal Foundation programme	Complete/ongoing
8.	Additional skills and simulation training for existing staff	Ongoing

Table 12. QIS action plan

9.4 NEONATAL MEDICAL STAFFING

The service has maintained compliance with the BAPM standards for neonatal medical workforce across Q3 of 24/25 in line with Safety Action 4 of MIS.

Measure	Aim	July	August	September
Tier 1 separate rota compliance 24/7 'At least one resident Tier 1 (ANNP or junior doctor ST1-3) practitioner dedicated the providing emergency care for the neonatal service 24/7'	100%	100%	100%	100%
Tier 2 Separate rota compliance 12h per day 'Resident Tier 2 (ANNP or junior doctor ST4-8) practitioner dedicated solely to the neonatal service 12 hours a day during the busiest times of the day'	100%	100%	100%	100%
Tier 2 compliance: significant geographical separation between neonatal and paediatric units 'The Tier 2 (ANNP or junior doctor ST4-8) practitioner should be immediately available	100%	100%	100%	100%

at all times to the neonatal unit and the labour ward. If the site of the paediatric unit makes this immediate response impossible separate Tier 2 rotas are required'				
Tier 3 daytime compliance All consultants on-call for the unit have regular weekday commitments to the neonatal service only (ideally with a 'consultant of the week' system) and all consultants do a minimum of four 'consultant of the week' service weeks per year	100%	100%	100%	100%
Tier 3 compliance No on-call rota should be more onerous than one in six		compliant		

Table 13. Neonatal medical workforce compliance

10.0 INSIGHTS FROM SERVICE USERS AND MATERNITY VOICES PARTNERSHIP CO-PRODUCTION

10.1 COMPLAINTS/COMPLIMENTS/PATIENT ADVICE AND LIAISON SERVICE/CONTACTS

	October	November	December
Number of formal compliments	5	1	5
Number of Patient Advice and Liaison Service (PALS) contacts/concerns	4	5	4
Complaints	0	0	1

Table 14. Complaints and compliments Q3 24/25

Compliments to the service were received across all areas of Maternity and Neonatal care. A continued theme amongst compliments to the service is the kindness and compassion showed to birthing people and their families from members of staff providing care.

During Q3, one formal complaint was received, all complaints, PALS contacts and informal feedback are assessed for commonalities, trends, or themes within the monthly Maternity and Neonatal 'Insights' Family feedback Triangulation group.

The service identified improving patient experience in the immediate postnatal care period as a safety priority for 2024/2025. See Section 10.2.

Next steps: Implementation of actions from the Leadership and Culture QI project (Appendix 1) including.

- Increase in senior leadership on Mary ward to ensure senior presence 7 days per week
- Implementation of an operational support midwife to support flow through the maternity service, including supporting staff breaks.

10.2 SERVICE 'INSIGHTS' SAFETY PRIORITIES UPDATE

All service feedback 'insights' received 'in month' are reported into a cumulative tracker to allow for thematic assessment of trends or commonalities seeking identification of areas for improvement. Any identified 'in month' themes or trends requiring action are shared via the

Perinatal Quality Surveillance Tool (PQST) shared with Board Level Safety Champions and Trust Quality and Safety Group.

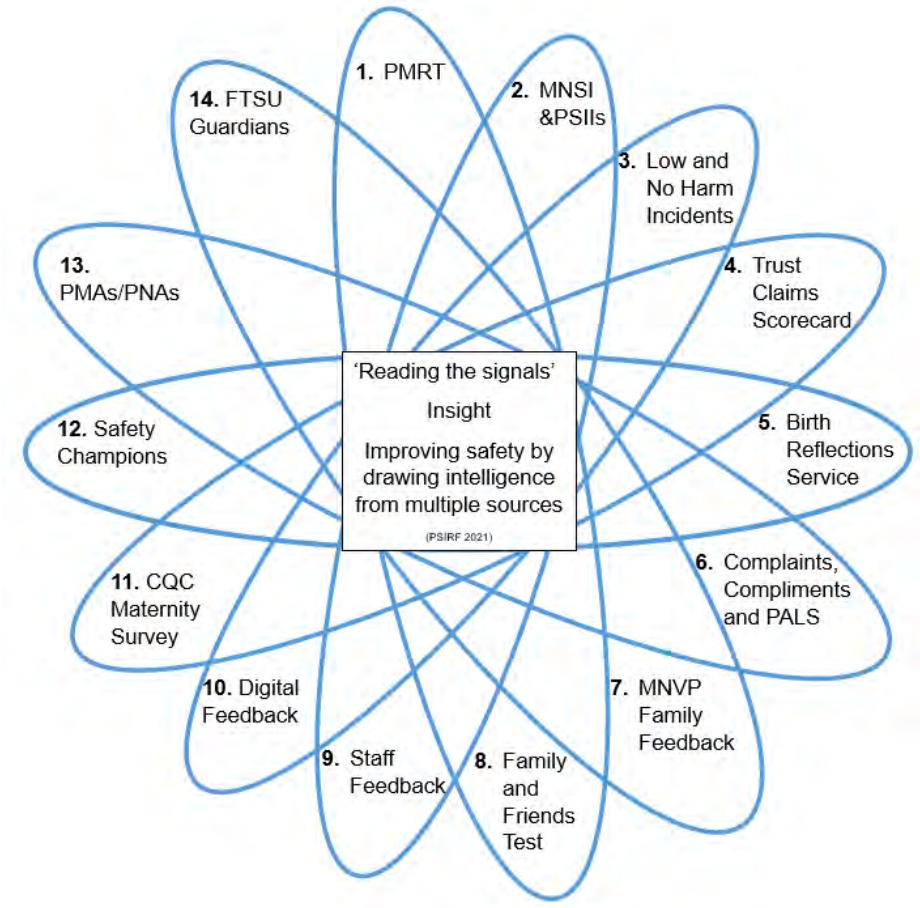


Figure 6. Sources of service 'insight' analysed monthly via the Maternity and Neonatal Triangulation of feedback group.

Annually the service conducts a thematic review of the service 'insights' to generate identified safety priorities to inform quality improvement focus for the upcoming year. There were three identified areas for improvement as 'safety priorities' for 2024/2025.

1) Fetal Monitoring – Intermittent Auscultation
2) Information provision to ensure Informed Consent
3) Improving patient experience in the immediate postnatal care provision.

To further improve insight's triangulation there will be improvement work commencing in Q4 to evaluate feedback from patient safety, families and staff linking with the Trust values.

11.0 RISK REGISTER

There were no new risks added in Q3 however emerging risks are monitored through Maternity

and Neonatal Specialty Governance.

During Q3 2 risks were closed:

Risk No	Title of Risk	Rationale for closure	
2682	Mandatory training room booking availability	No episodes when rooms not available and compliance achieved for MIS SA8	9
2660	Tertiary level neonatal cot capacity	No episodes of babies being born outside of the relevant level neonatal unit	8

Table 15. Closed Risks for the Maternity and Neonatal risk register Q3 2024/25

A full summary of the maternity and neonatal risk register is detailed in table 16. Actions towards closing the gaps identified within the individual risk assessments on Datix, and continued mitigation of risk, will be monitored through Specialty and Divisional Governance with Trust Management Executive, oversight to ensure appropriate actions are taken in accordance with the Trust Risk Framework.

Risk No	Description	Scoring
2950	There is a risk that due to the current compliance percentage of staff QIS trained in the LNU below BAPM standards, the quality of care being delivered to the babies at risk of being compromised	12
2785	There is a risk that the current pharmacist cover for the Neonatal Unit does not meet clinical needs or BAPM standards	12
2717	Shared Father/Partner information within the multi-agencies	10
2591	There is a risk that the current funded provision of Allied Health Professionals in the Neonatal Unit will not continue following cease of fixed term funding from the neonatal Operational Delivery Network.	9
2681	Mandatory Training room booking availability	9
2724	Risk of loss of Obstetric USS reporting System	9
2359	Maternity Information System IT support/capacity	8
2467	Maternity workforce	8
2649	Delays to commencement of induction of labour	8
2660	Tertiary level neonatal cot capacity in the region	8
2718	Bacillus Calmette-Guerin (BCG) Vaccination programme	8
2949	There is a risk that due to the current estates footprint, and estates availability of Princess Anne Wing (PAW) Maternity services are unable to run optimally'	8
2948	There is a risk that due to a gap between demand and capacity to process the increasing volume of Maternity Subject Access Request the service will be unable to meet the mandated 30-day delivery target	8
1948	Obstetric ultrasound scan capacity	8
2784	Maternity and Neonatal Services Adult Basic Life Support Compliance	6

2679	Service provision of digital blood pressure monitors validated for use in pregnancy and pre-eclampsia	5

Table 16. Maternity and Neonatal Risk Register December 2024

Low risks are monitored as per Trust Risk Management policy.

12.0 AVOIDING ADMISSION INTO THE NEONATAL UNIT (ATAIN) & TRANSITIONAL CARE

During Q3 the transitional care pathway remained open for 100% of the time, with staffing meeting the identified transitional care pathway model on average 98% of the time. There were no occasions were missed opportunities to have provided TC care or identified admissions to NNU that would have met current TC admission criteria but were admitted to NNU due to capacity or staffing issues. No babies were admitted to or remained on NNU because of their need for nasogastric tube feeding, which could have been cared for on a TC if nasogastric feeding were supported there.

The ATAIN working group identified two avoidable admissions into the NNU in Q3. There have been no identifiable commonalities between the avoidable admissions reviewed at the ATAIN MDT. Learning from these cases has been actioned by the obstetric consultant and the quality and education midwife with an identified quality hot spot focusing on the Safety Catch and quality boards.

13:0 PERINATAL CULTURE AND LEADERSHIP PROGRAMME

The Perinatal Culture and Leadership Programme (PCLP), funded by NHSE, aims to support the Perinatal Quadrumvirate (Quad) teams to create and craft positive safety cultures within perinatal services. The programme design was in direct response to nationally derived intelligence regarding the intrinsic relationship between a positive workplace culture and continuous quality improvement. It aligned with the response to the Immediate and Essential Actions in the Independent Review of Maternity Services at Shrewsbury and Telford Hospitals and informs the Three-Year Delivery Plan for Maternity and Neonatal Services.

The overarching aim is to support all perinatal teams in England to create and craft the conditions for a positive culture of openness, safety, and continuous improvement. Reviews of perinatal services have highlighted cultural and leadership issues as a theme that contributes to underlying patient safety failures across organisations. Compassionate and positive leadership creates effective teamwork and drives safer, more personalised, and more equitable care. Co-designed by frontline teams and leadership experts, the programme brought together senior leaders from across maternity and neonatal services to assist them in gaining a meaningful understanding of their workforce culture and how to tailor their improvement plan to best impact the quality, safety, and experience of care for women and families.

The RUH perinatal services joined the programme in Autumn 2023 as one of the final cohorts and in conjunction with Korn Ferry Associates analysed existing insights and concluded that prioritising postnatal care with particular emphasis ono the inpatient element. A detailed improvement plan was developed and can be found in appendix 1.

14.0 RECOMMENDATION

The Quality Governance Committee is asked to discuss and approve the content of the report.

APPENDIX 1 PCLP board update report February 2025
APPENDIX 2 Transitional Care Pathway and ATAIN Audit Q3 2024/2025
APPENDIX 3 Bi-annual Midwifery and Neonatal Nursing Staffing Report – attached at agenda item 19

Appendix 1

Royal United Hospitals Bath
NHS Foundation Trust

RUH Perinatal Culture and Leadership Programme

Quality Assurance Committee Update Report

February 2025

Purpose:

To provide the Board of Directors with oversight of the progress, support requirements and improvement plans in relation to the ongoing Perinatal Culture and Leadership Programme which began in November 2023 within Maternity and Neonatal services.

Background:

The Perinatal Culture and Leadership Programme, funded by NHSE, aims to support perinatal Quadrumvirate (Quad) teams to create and craft positive safety cultures within perinatal services. The Programme design was in direct response to nationally derived intelligence regarding the intrinsic relationship between a positive workplace culture and continuous quality improvement. It aligned with the response to the Immediate and Essential Actions in the Independent Review of Maternity Services at Shrewsbury and Telford Hospitals and informs the Three-Year Delivery Plan for Maternity and Neonatal Services.

The overarching aim is to support all perinatal teams in England to create and craft the conditions for a positive culture of openness, safety, and continuous improvement. Reviews of perinatal services have highlighted cultural and leadership issues as a theme that contributes to underlying patient safety failures across organisations. Compassionate and positive leadership creates effective teamwork and drives safer, more personalized, and more equitable care. Co-designed by frontline teams and leadership experts, the Programme brought together senior leaders from across maternity and neonatal services to assist them in gaining a meaningful understanding of their workforce culture and how to tailor their improvement plan to best impact the quality, safety, and experience of care for women and families.

The RUH joined the Programme in Autumn 2023 in one of the final cohorts. The Quad met with an assigned Culture Coach from Korn Ferry

Associates and mapped out initial stages which included consideration of how best to understand the existing perinatal culture. The Programme offered trusts an opportunity to undertake a SCORE culture survey to aid this, but this was a flexible, opt out invite. The RUH Quad demonstrated that they were already completing work to meaningfully understand local culture, and therefore opted out, opting instead to utilise existing intelligence from a broad range of other insights work which was, deemed to be 'suitable alternative' as stated in the Programme specification. This data was shared with Korn Ferry for further analysis and joint consideration of where the RUH improvement plan should focus. The conclusion was to prioritise 'Postnatal Care' as this aligned with other improvement work already underway, but with a particular emphasis on inpatient care. At this stage came the appointment and training of the Culture Coaches who were to continue the next phase of the Programme and begin to formulate and execute a more detailed Improvement Plan. The RUH Culture Coaches include a Doctor, a Midwife, a perinatal Matron, and a Neonatal Nurse (Table 1.0)

PERINATAL QUADRUMVIRATE	PERINATAL CULTURE COACHES
Zita Martinez (Director of Midwifery and Neonates)	**Jo Coggins** (Maternity and Neonatal Matron)
Heidi Green (Neonatal Nurse Consultant)	**Hannah Rossi** (Senior Neonatal Nurse)
Aaron Joyce (Specialty Manager for Maternity)	**Sam Hayward** (Obstetric Consultant)
Claire Park (Lead Consultant for Obstetrics)	**Jessica Murray** (Retention lead Midwife)

Table 1.0: RUH Perinatal Culture and Leadership Team

Formulating The Improvement Plan

Upon completion of the training and with support from Korn Ferry, Culture Coach's held a series of 'Culture Conversations' with a cross section of staff who work on the inpatient ward or whose work is related to the ward area, e.g., the Transitional Care and Advanced Neonatal Nurse Practitioner teams. Attendees represented Agenda for Change (AFC) Bands 2 to 8. Analysis of the data identified key themes and observations which subsequently informed the Improvement Plan (Table 1.2).

Theme	Observation	Staff Feedback
Ward staff feel unheard and unimportant	• Staff feel other areas are prioritized e.g., BBC/Triage • Ward staff are first to be redeployed in escalation which means care relating to feeding support/patient experience/prompt discharge is negatively impacted •	*"a lack of respect generally for midwives and staff allocated to the ward"* *"Often we are left with only 3 midwives but should be on 6, downstairs (BBC) takes priority but then discharges are delayed and it's demoralizing for the staff and the families"* *"band 7's rarely come up to the ward and all decisions are made from BBC"*
Ward is under-led	• Only one Band 7, not enough leadership	*"X is great but can't be there 24 hours a day – it shows a lack of respect that we don't have more Band 7's for us"*
Skill Mix/ Resource needs reviewing and improving	• Skill mix is often poor which can inhibit improvement work and affect safety • MSW's feel they are asked to do things they don't feel sufficiently confident to do	"*Often they will take a Band 6 downstairs but that leaves just one with a team of Band 5's which isn't fair"* *"MSW's are relied upon to do a lot of work in area's we haven't had much training and we aren't given time to have any additional training either"*
Physical Environment is Poor	• Ward can feel loud and the layout is not ideal • Staff break area is not protected • The ventilation and lighting are poor for staff and families	"*The office is cramped and can be loud when everyone is in there – patients can hear"* *"The staff room is busy and you can't have an uninterrupted break – its not relaxing*
Confusion over change to handover process	• Concern that Staff room is too small for handover – was in dining area before • Splitting Antenatal/Postnatal handover might mean missed safeguarding information	"*There isn't a suitable place for handover because the dining area is needed for families, but the staff room should be free for people getting their bags etc."* *"I wouldn't know if someone had a dietary requirement on the PN end because I don't go to both handovers"*

Culture on the ward needs improvement	• Dissatisfied with breaks 'consultation' management • Ward is often loud, and people are rushing around • Not taking a break is 'normal'	"*The consultation was disingenuous to say the very least*" *"It's not an area of calm for mothers and babies to recover – it feels stressful and pressured"* *"We have so much to do and a bell is always ringing so we can never take a break"*
Others interacting with the ward often find it badly organised	• Difficult to determine who's in charge • Don't always know who is caring for who • Escalation processes aren't always followed correctly	"*often get bleeped twice about the same person because they don't communicate effectively"* *"I rarely know who is in charge"* *"It feels like better organization would save time and improve things for families"*

Table 1.2: Themes Emerging from Culture Conversations

Identification of the themes enabled reflection and discussion around a comprehensive, purposeful improvement plan, with the overarching aspiration of creating an ethos whereby staff working in this area feel that a positive safety culture is 'everyone's business' and that not only are their thoughts and opinions 'heard' but that they are valued. Additionally, people feel psychologically safe to innovate and to challenge, contributing constructively to a shift in culture in which inpatient postnatal care is prioritized alongside other service areas, and that the people working in this area feel energized and determined to make care the very best it can be. The Improvement Plan was finalised in collaboration with the assigned Korn Ferry Culture Coach and the Quad in November 2024 and outlines the direction of key workstreams ongoing work streams within the Programme throughout 2025 (Table 1.3).

Action Details	Secondary Action Details
Staffing structure improvements on Mary Ward	1.1 - Recruit 2WTE B7 Sisters to enable 7 days a week management cover
	1.2 - Band 6 Operational Midwife Role to commence (7days/week)
	1.3 - Extra late shift on Mary Ward 2 days a week to assist with high acuity after ELCS days
	1.4 - Improve Data capture of ward acuity vs staffing data via BR+
	1.5 - Review handover on Mary Ward - including deciding which handover the B7 MW and B6 Opps MW will be going to each day
	1.6 - Maternity Department Workforce MATRIX
Staff support and development	2.1 - Support for community staff to feel confident in the acute unit when re-deployed (MSW's and MW's)
	2.2 - Send 'you said, we did' to all staff about the PCLP project
	2.3 - Continue to educate staff around the importance on breaks and improve the breaks culture
Improve escalation and communication processes between medical colleagues and midwifery staff	3.1 - Band 5 SD sessions about escalation processes to ANNP/SHO/Reg
	3.2 - Comms to midwifery staff about escalation process to SHO/Reg
	3.3 - Explore creating an electronic jobs list for non-urgent SHO jobs
	3.4 - Improve midwife attendance at daily ward round
	3.5 - Improve communication processes between primary and secondary care providers
Improve Estates and Facilities on the Ward	4.1 - Refurbishment of staff breaks room
	4.2 - Review whether NIPE room has more room for staff base
	4.3 - Improve lighting/cosmetic appearance on the ward to foster a calmer culture/environment
	4.4 - Discuss/review notes storage
	4.5 - Implementation of BadgerNet
Improve MSW Vacancy/Turnover	5.1 - Review MSW roster (including current FW requirements)
	5.2 - MSW line management to be reviewed
	5.3 - Review current workforce regarding up-to-date skills and competencies and identify knowledge gaps
	5.4 - Retention Survey for MSW's
	5.5 - Improve Infant feeding structure/sign-off
	5.6 - Review competency need for each area
	5.7 - MSW Workforce MATRIX
Improve IOL Process	6.1 - Consider IOL Bay on Mary Ward
	6.2 - Review roles of daily AN Midwives (i.e one taking all IOL's)
	6.3 - Improve FLOW between Mary Ward and BBC when IOL becomes ARMable
	6.4 - RAG rating system for IOL ward round each day
	6.5 - Improve system of booking IOL and streamlining process
	6.6 - Improve AN counselling around IOL
	6.7 - Improve FLOW on Mary Ward to prevent bed blocking on the ward
	6.8 - Improve FLOW from BBC to Mary Ward

1.3: RUH Perinatal Culture and Leadership Improvement Plan

Current Position and Next Steps

Within the full Improvement Plan are details relating to accountability and timelines for each primary and secondary action. The final ‘check in’ with Korn Ferry is scheduled for March 2025 at which point all NHSE touch points will have been utilised and the project will continue to be driven internally by the Perinatal Culture Coaches with Quad oversight. Updates will be provided monthly to the senior maternity and neonatal team and to the Executive and Non-Executive Board Safety Champions. Monitoring progress towards the Improvement Plan includes follow up culture conversations and data analysis alongside assessment of additional watch metrics intrinsically linked to each primary and secondary action, for example, sickness rates, staff turnover, skill mix within shifts and patient feedback. The Action Plan is visible in Sharepoint for approved persons to view real-time progress by virtue of RAG rating of individual elements. Access is via request to the Quad/Culture Coach membership at any time. In addition, any Board member is welcome to approach the team for an in-person update around the project.

Support Requirements

The success of this project relies on the ongoing support of the Perinatal Quad being assured of the time to meet and reflect on its progress and to formulate mid-point interventions with the Culture Coaches where necessary. In addition, the Culture Coaches require Quad support to have protected time to undertake the work necessary to steer the project and ensure its success. This includes, but is not limited to time for collaborative discussion, work planning for future culture conversations and promoting active engagement from all perinatal staff. It is the responsibility of Culture Coaches to monitor progression of the Improvement plan and to escalate concerns to the Quad if progress deviates from agreed timelines or if other concerns emerge.

Appendix 2

Clinical Audit Report

Transitional Care Pathway and ATAIN Audit Q3 2024/2025

Speciality: RUH Local Neonatal Unit

Division: Family & Specialist Services Division

Project team				
Kirstie Flood	Title/grade:	Lead Nurse	Data period:	Q3 October 2024-December 2024
Sarah Goodwin	Title/grade:	Neonatal Governance Lead	Report completion:	January 2025

Transitional Care Pathway and ATAIN Audit Q3 2024

Contents

Background

ATAIN is an acronym for **A**voiding **T**erm **A**dmissions **I**nto **N**eonatal units (ATAIN). It is a national programme of work initiated under patient safety to identify harm leading to term admissions. The current focus is on reducing harm and avoiding an unnecessary separation of mother and baby.

Mothers and babies have a physiological and emotional need to be together, hours and days following birth – this is important for physiological stability of baby and initiation of maternal infant interaction.

There is overwhelming evidence that separation of mother and baby so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding, long-term morbidity for mother and child.

This makes preventing separation, except for compelling medical reason, an essential practice in maternity services and an ethical responsibility for healthcare professionals. As part of the RUH Maternity and Neonatal services, the continued monitoring of admission data and modifiable factors which may have impacted upon the resulting admission allows the continuous evaluation of current systematic care provision and seeks to identify key areas of improvement.

This audit report is demonstrative of the upward reporting from the ATAIN working group's Terms of Reference (TOR) supporting the continued improvement of our services and supplementary evidence of the Maternity Incentive Scheme - year five, Safety Action 3* (MIS).

**Safety Action 3: To demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the avoiding term admissions (ATAIN) into Neonatal units (LNU) programme.*

Objectives

- To assess compliance with the pathways of care into transitional care (TC) which have been jointly approved by maternity and neonatal teams focusing on minimising the separation of mothers and babies. Please see Guidance Neo-100. Neonatal teams are involved in decision making and planning care for all babies in transitional care.

- To monitor that the pathway of care into TC has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, Local Maternity and Neonatal System (LMNS), commissioner and Integrated Care Board (ICB) quality surveillance meeting each quarter
- To evaluate the number of admissions into the neonatal unit that would have met TC admission criteria but were admitted to the neonatal unit due to capacity or staffing issues
- To evaluate the number of babies that were admitted to or remained on LNU because of their need for nasogastric tube feeding but could have been cared for on a TC if nasogastric feeding was supported there. 34+0 - 36+6
- To provide a data record of existing TC activity, (regardless of place - which could be a TC, postnatal ward, virtual outreach pathway etc. The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery, nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered
- To analyse staff/parent data captured via a questionnaire around satisfaction and quality and safety of care
- Outline the key findings and improvements identified by the ATAIN working group activity on a quarterly basis for sharing within Maternity and Neonatal Governance structures and the Board Level Safety Champions
- To provide evidence and assurance of progression with the action plan for sharing with the neonatal maternity safety champion, and Board Level Champions, LMNS and ICS quality surveillance meeting each quarter
- To provide an audit trail of evidence that reviews of all term babies transferred or admitted to the LNU, irrespective of their length of stay.

The ATAIN working group is responsible for completing a thematic review of the primary reasons for all admissions, with a focus on the leading cause/ reason(s) for admission through a deep dive to determine relevant areas of improvement to be addressed. This is in line with the working group's TOR.

Key findings

Standard	Compliance October 2024	Compliance November 2024	Compliance December 2024	Quarter 1,2 and 3 24/25 %
Audit findings shared with neonatal safety champion	**Complete**	**Complete**	**Complete**	**Complete**
The % of babies who received all their care on the TCP pathway – require higher level care (would otherwise require NNU admission)	**44%**	**47%**	**40%**	**44%**
The % of babies who received care on the TCP for part of their admission	**54%**	**64%**	**57%**	**58%**
The number of admissions to the neonatal unit that would have met current TC admission criteria but were admitted to the neonatal unit due to capacity or staffing issues	**0**	**0**	**0**	**0**
The number of babies that were admitted to or remained on NNU because of their need for nasogastric tube feeding but could have been cared for on a TC if nasogastric feeding was supported there. 34+0 -36+6	**0**	**0**	**0**	**0**
% of shifts TCP nurse provided as	**100%**	**100%**	**100%**	**100%**

per TCP staffing model				
% of shifts TCP nurse: baby ratio was above 1:4 as per recommendation.	**3%**	**4%**	**3%**	**Av 3%**
TCP open	**100%**	**100%**	**100%**	**100%**
Number of babies readmitted to neonatal unit from TCP	**0%**	**0%**	**0%**	**0%**
The number of avoidable term admissions 37+0 weeks gestation and above admitted to the neonatal unit	**2**	**1**	**1**	**8**
The number of term babies transferred or admitted to the neonatal unit from other areas – for example Emergency Department, Children's ward.	**3**	**1**	**1**	**19**

Clinical Audit Report

Project title

Transitional Care and ATAIN Audit Q3 2024/2025 October - December 2024

Division

Family & Specialist Services Division

Specialty

Local Neonatal Unit (LNU)

Disciplines involved

Neonatal Nurse Consultant, Neonatal Senior Sister

Obstetric Consultant, Patient Safety Midwives

ATAIN working group

Project leads

Kirstie Flood Lead Nurse

Sarah Goodwin Neonatal Governance Lead

Standards

Maternity Incentive Scheme - year Six. Safety Action 3.

Sample

- All admissions to LNU and TCP from 01/10/2024-31/12/2024 to determine if the correct location of care was achieved.

- All babies born at 37+0 weeks gestation and above from 01/10/2024-31/12/2024 who were admitted to the LNU.

Data source

Badger Net, LNU and TCP admission book and individual medical notes.

Audit type

Retrospective and live data collection.

Transitional Care Audit Findings Q3

Staffing:

- During Q3 the transitional care pathway (TCP) remained open for 100% of the time, with staffing meeting the identified transitional care pathway model on average 100% of the time.
- There were on average 3% of shifts where there were more than 4 babies being cared for on the TCP where there was no additional staffing provided from within the neonatal team and thus the baby nurse ratio was above the BAPM recommendations of 1:4.
- On no occasion were there identified missed opportunities to have provided TC care or identified admissions to the LNU that would have met current TC admission criteria but were admitted to the neonatal unit due to capacity or staffing issues.
- No babies were admitted to or remained on LNU because of their need for nasogastric tube feeding, which could have been cared for on a TC if nasogastric feeding was supported there.
- Staffing TC questionnaire out for circulation to identify themes and triangulate feedback between staff and families.

Admissions:

The leading causes of admission to the TCP (figure 1), remains consistent in Q1, Q2 and Q3

- Requirement for 'Kaiser' observations for a risk of sepsis 32%
- Requirement for intravenous antibiotics 19%

The 3rd leading cause for admission in Q3 was 'Feeding Support', taking up 16% of the admissions . This data will be monitored into Q4 to assess for trends, as the 3rd cause appears to be different from Q1 & Q2.

The increase in admissions is seen as a result of the inclusion of the 2 new locally agreed criteria categories in Q2 (babies below 2nd centile and 34-35+6/40 above 1.8kg) which has reduced from 26% of the total admissions in Q2 to 12% in Q3.

There have been times when there have been up to 7 babies (6%) on the TCP, 3 above the 4 cot capacity. 3% of these were supported by another staff member from neonatal team working on TC, resulting in the correct staffing model for this level of babies.

Capacity and provision for 8 TC cots is supported and recommended by the Getting It Right Frst Time (GIRFT) report for our birth rate. A specialist interest group (SIG) has been formed to support the TC and improve the culture and staff morale.

The Perinatal Culture & Leadership programme (PCLP) also includes TC and has had a focus on getting the culture right between maternity and TC staff groups and working conditions. The expansion of TC cot provision is an ongoing piece of work.

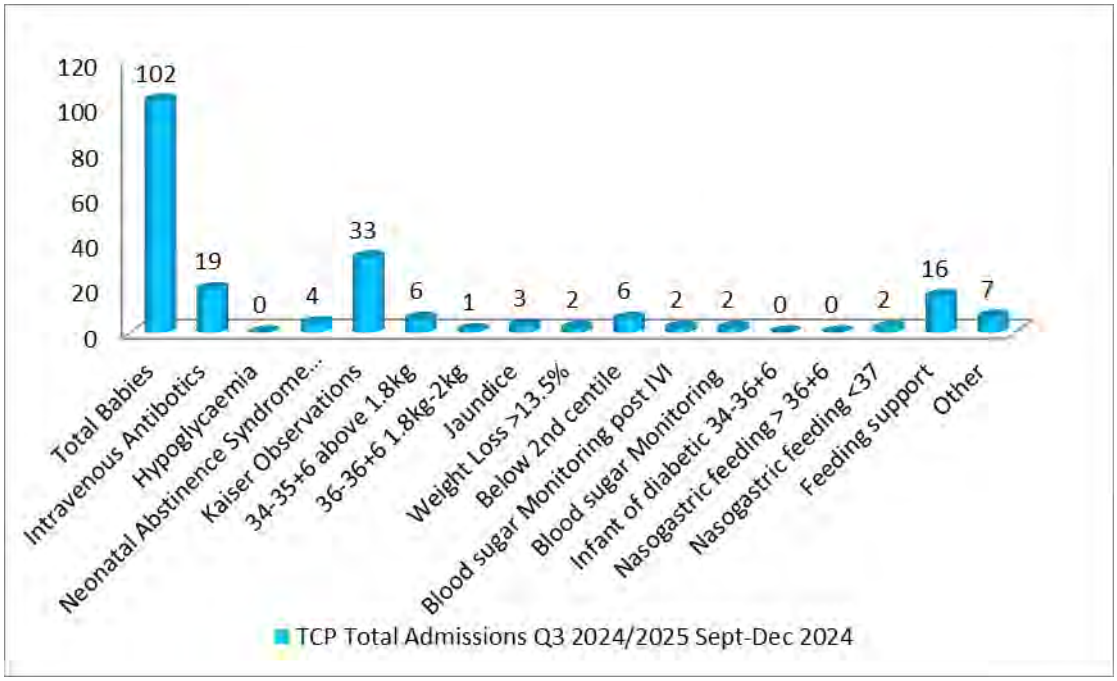


Figure 1: values of admissions to the RUH TCP by causation Q3 24/25

- **Parental TCP feedback**

The transitional care pathway seeks parental feedback via an optional patient/parent survey sent to all families who received TC care via a QR code which is collated by the Trust-wide Patient experience team. The results are provided to service providers for analysis to identify improvements.

During Q3, 12 responses were received to the TCP patient experience survey.

- 100% of people responded identifying that the reason for their baby being on a TCP was clear and easy to understand
- 100% of people responded identifying that the staff caring for their baby were available when needed
- 100% of people responded identifying they felt supported by the neonatal nurse caring for their baby whilst under the TCP
- 100% of people responded identifying they felt their baby was safe
- 100% of people responded identifying they felt their baby was well cared for
- 17% (2 responses) commented on the environment on Mary ward. They expressed that it is a small space that felt overcrowded and loud. They also responded that they felt Mary ward required a more dedicated space for TC. One parent felt their partner had felt like a visitor, whilst staying on TC not a father
- From review of the written comments left by parents and families within the survey a commonality regarding positive feedback for the level of care and support provided by the TC team was identified within 7 out of 12 responses, the other 5 responses left the optional comments box blank.

ATAIN Audit Findings Q3

- The ATAIN working group meets fortnightly to undertake a Multi-Disciplinary Team (MDT) review of all admissions and transfers into the LNU assessing if alterations in care may have provided opportunities to have avoided the admission therefore providing insight into areas of potential service improvements
- Q3 identified 4 possible avoidable admissions to the LNU, this is an increase from both Q1 and Q2, both had 2 avoidable admissions. All the avoidable admissions to the LNU in Q3 were identified at MDT to be because of decisions made during intrapartum care
- In Q3 there was an identifiable commonality in two of the cases where it was considered that expedition of birth may have resulted in both babies not requiring LNU admissions.

October Admissions – There was 1 likely avoidable term admission, currently awaiting final clarification of this with an MNSI investigation and 1 avoidable admission.

The first case had an initial rapid review, which identified obstetric areas for improvement. This case was routinely referred to MNSI however as the baby had a normal MRI did not fall into their criteria. The care is however being reviewed at parental request.

The baby required admission to the LNU initially and subsequently transferred to the local tertiary hospital for therapeutic cooling with a total stay of 9 days following birth. The baby is now home with no anticipated long-term impact.

The second case also identified obstetric areas of improvement; a review of the care considered that the choice of instruments used to deliver the baby was likely to have contributed to a subgaleal haemorrhage. The review group agreed that this case did not meet the criteria for a Patient Safety Incident Investigation however learning from the review was identified and actioned by the maternity service. The baby required initial monitoring on the LNU for 3 days and was relocated to the transitional care pathway for a further 2 days. The baby is now home with no anticipated long-term impact.

November Admission – 1 avoidable term admission

This case identified obstetric areas for improvement, a review of the care considered that the expedition of the birth may have resulted in a difference to the cord gases. The cord gases necessitated an admission to the LNU for cerebral function monitoring. There were no ongoing neurological concerns, and the baby was relocated to transitional care at the earliest opportunity.

December Admission - 1 avoidable term admission

This case identified obstetric areas of improvement in that the cardiotocograph (CTG) interpretation and escalation had potentially resulted in the admission to the LNU. The baby required initial respiratory support for 2 days and was then relocated to the transitional care. The baby is now home with no anticipated long-term impact.

Admissions to the neonatal unit from other areas in the hospital

- In line with standard 3, neonatal unit transfers or admissions regardless of their length of stay, of all term babies transferred or admitted to the LNU from other areas within the RUH, are reviewed. This includes Emergency Department and the Children's ward. In Q3 2024 there were 5 babies admitted, a decrease from Q2 (n=10). Admissions are assessed against current admission guidance seeking to ascertain if the LNU was the appropriate care setting. The review looks for common themes within the source and cause of admission.

- Of the 5 admissions over Q2, 4 were identified as the LNU being the most appropriate care location and in 1 case, the Children's ward was deemed a more appropriate location.

- There is a draft guideline, "Care of community infants less than 3 months admitted to paediatrics needing intensive care" out for consultation prior to ratification. This guideline details current pathways of care for all babies that are readmitted from home into the RUH. This is to improve the efficiency of the service and protect the vulnerable and immunosuppressed babies being cared for in the LNU from a potential risk of introducing community acquired infections into the LNU via re-admissions. It is also imperative to recognise the potential impact on patient experience, with families often appreciating the holistic aspects of the current referral pathways back into care via maternity and neonatal services.

- Where cases have highlighted learning, information is cascaded to the teams on vignette Safety Catches, shift safety briefs, local newsletters, quality board displays and is shared at the Maternity Neonatal Governance meeting.

Detailed analysis of Term admissions by causation to LNU Q3 2024/25

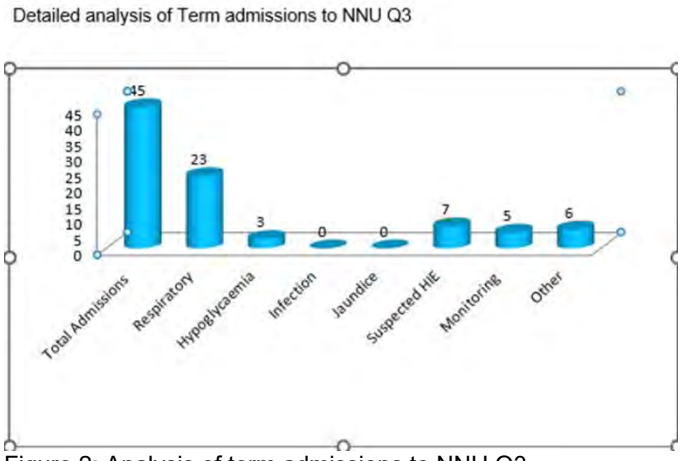


Figure 2: Analysis of term admissions to NNU Q3

When reviewing the leading causes for admission to the LNU during Q3, respiratory symptoms remain the leading cause of term admissions into the LNU, this is in line with national data.

No commonalities or cause for concerns in respiratory management was identified within the MDT review of care, all admissions were deemed as appropriate based on the clinical presentation of the babies.

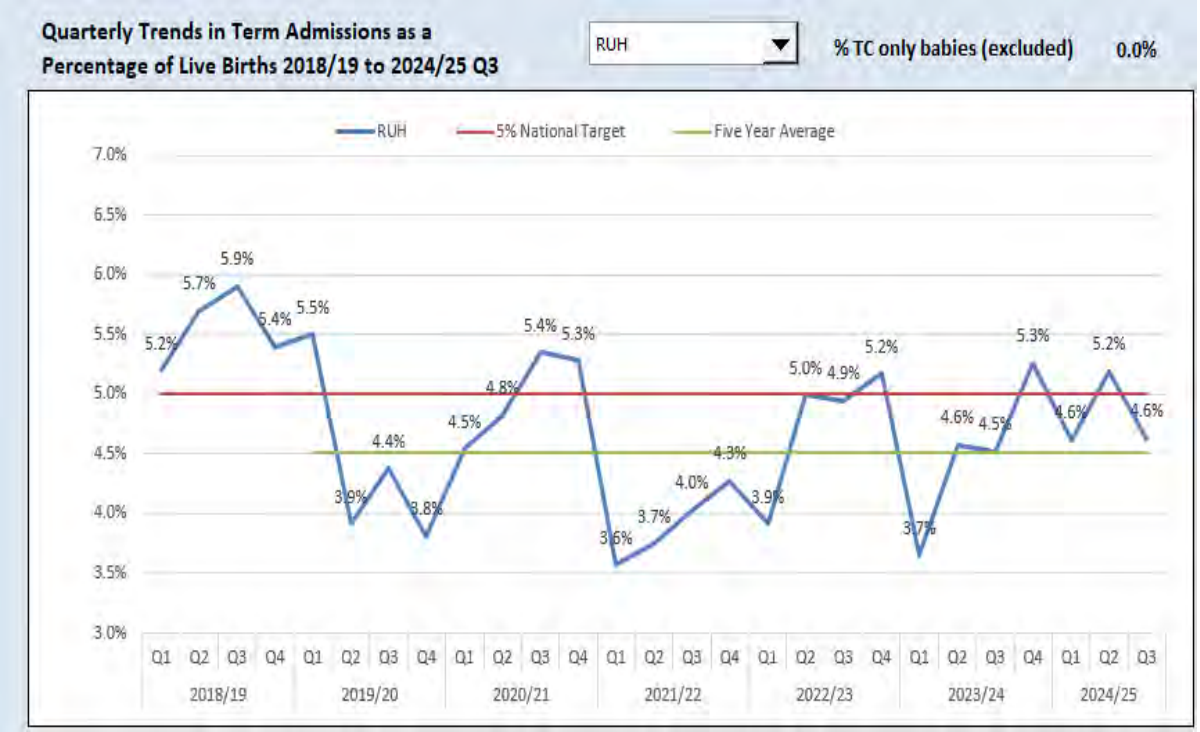


Figure 3: Trended term admissions

Quality Improvement Projects

- The TCP guideline has been updated and recommendations from BAPM included. Criteria for admission has been altered to include all 35/40 babies; babies less than 2nd centile, and clinically stable ≥34-week babies who previously may have been admitted to midwifery care. During Q2 there has been increased overall numbers of babies being cared for on the TCP 26% due to the new recommendations

- The Room G project to offer further facilities for parents to sleep at the baby's bedside will further reduce family separation, due completion February 2025

- A Collaborative meeting between the neonatal team and Mary ward leadership team has taken place to discuss ideas for improvement to the TCP service and discuss plans for midwifery support to provide maternal care to mothers on NNU. An MDT SIG has been formed

- Progression with the implementation of the "CPAP on skin early intervention" (COSEI) Project to reduce the parent-infant separation of term babies with transient tachypnoea of the newborn

- Ongoing analysis of QI project implemented to reduce the number of unnecessary neonatal care interventions in response to a low cord gas result by increasing the

accuracy of neonatal cord pH samples post birth, with an aim for >90% of cord blood samples to be processed within 20 minutes of the baby's birth by December 2024.

Ongoing work streams

- Exploration of Data caption concerning 37+ week gestation babies being readmitted into neonatal services and included within the neonatal ATAIN rates. Benchmark against other neonatal units within the Southwest Neonatal Network
- Implementation of the guideline: Care of community infants less than 3 months admitted to paediatrics needing intensive care
- Formation of MDT Special Interest Group for Transitional Care with monthly meetings arranged.

Action plan

Action	No	Details	Progress	Lead	Due	RAG status	Completion date
1.Ensure the appropriate process is followed in line with NEWTT2 observations within the TCP							
Provide quarterly assurance by audit of 10 sets of notes. This tool is designed to support recognition and escalation of the deterioratin g Newborn	1	NEWTT2 outlines a standardis ed escalation response including: who is responsibl e, time scale of review target, and support informatio n for further escalation .	Quarter 3 2023/24 demonstra ted complianc e by 80% Staff training and awarenes s increased of correct escalation pathway. Quarter 4 was 100% compliant	Neonatal transitiona l care lead	June 30th 2024		June 2024
2.What we need? **A conversion of Room G on the neonatal unit into a 4 bedded parent and baby residential bay**							
Conversio n of clinical room G into a 4 bedded Parent and baby residential bay. , to reduce the length of time babies are cared for on the neonatal unit by being able to room in mothers to establish	2.	To provide additional space for parents to stay alongside their baby, and to offer TCP for 34/40 week babies where postnatal ward may not be correct environme nt	Project due to start in June to install rails to partition off each bed space Convert the Visitor toilet into a shower room.	Neonatal transitiona l care lead and Maternity Matron	Feb 2025		

feeding sooner							

3. Collaborative Working Group to **implement change, improve, and progress TCP service.**							
TCP working group to be established to work together to implement change and improve and progress TCP service	3	This group will have members of staff across all grades from the neonatal unit with a senior maternity representative	To be established	Neonatal transitional care lead and Senior Midwife	Sept 2024		Sept 2024
4. Business Case for provision of 7 day Community Outreach Service							
To increase the community Outreach team to enable a 7 day a week service	4.	To support Naso - gastric tube feeding at home to reduce length of stay and reduce the number of babies that were admitted to, or remained on NNU because of their need for nasogastric tube feeding.	Business case being compiled	Consultant ANNP	August 2025		

5. To ensure verification of ATAIN Data to ensure accuracy and equity of provision across the Network							
To examine the Southwest Operational Network Dashboard ATAIN Data	5	Have a greater understanding and awareness of Data with particular focus on readmission of 37+/40 babies from home or other areas within the RUH and that impact on ATAIN Data	To arrange a meeting with the Network Data Manager and Analyst	Consultant ANNP and Quality and Education Neonatal Sister			

Report to:	**Public Board of Directors**	**Agenda item:**	**19**
Date of Meeting:	**Wednesday 7 May 2025**		

Title of Report:	**Bi-annual Midwifery and Neonatal Nursing Staffing Report**
Status:	**For approval**
Board Sponsor:	**Antonia Lynch, Chief Nursing Officer**
Author:	**Zita Martinez, Director of Midwifery**
Appendices	**None**

1. Executive Summary of the Report

This report provides cover for the period of July to December 2024 inclusive.

Maternity

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that Trusts develop procedures to ensure that a systematic process is used to review staffing establishment, to maintain continuity of maternity and neonatal services, and to always provide safe care to women and babies across all settings.

This report gives a summary of the measures in place to ensure safe midwifery and neonatal staffing; including clinical and specialist workforce planning, headroom requirement, fill rates, escalation, recruitment and retention, midwife to birth ratio, Birth Rate Plus® Live Acuity Tool compliance with supernumerary labour ward coordinator (LWC) status, one to one care in labour and red flag incidents.

Birthrate Plus® (BR+) is the only recognised national tool for calculating midwifery staffing levels. The Trust report was published in April 2023; compliance with the report is a requirement of Safety Action 5 of the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS).

The vacancy in December 2024 (inclusive of maternity leave) was 0.9 whole time equivalent (wte), there have been 12.19wte new starters in this reporting period. The rolling turnover rate at the end of 3.68%. Rolling sickness rate is 3.86%.

Neonatal Services

NHS England – Specialist Commissioning Service Specification for Neonatal Critical Care Review (NCCR, 2024) covers the provision of Neonatal Critical Care, including neonatal intensive care, high dependency care, special care and transitional care.
There are four levels of Neonatal Units, the Dyson Centre of Neonatal Care is a level 2 Local Neonatal Unit (LNU).

Neonatal Critical Care is organised around Operational Delivery Networks (ODN) in close alignment with maternity services and the LMNS. The British Association of Perinatal Medicine (BAPM) and NHS Toolkit for High Quality Neonatal Services provide a framework and calculation tool to determine neonatal nurse staffing depending on cot capacity, acuity and is endorsed by Department of Health (DH) to ensure safe and productive working.

This report provides a summary of measures taken to work towards compliance with BAPM safe staffing for the LNU. The Southwest ODN conducted an annual review using the Safer Nursing Care Tool – Shelford Group (2013) using triangulated data sets, inclusive of an annual workforce review, acuity, recruitment, retention, skill mix and Qualification in Speciality (QIS). In addition, the wider workforce is reviewed inclusive of allied health professionals (AHP) and medical establishment aligned to acuity.

The substantive nursing vacancy for December 2024 in the LNU for band 5 and 6 nurses was 4.84wte following recruitment of 6.18wte during the reporting period. LNU rolling turnover rate has increased from 4.54% to 6.28%. Rolling sickness rate is 4.32%.

2.	Recommendations (Note, Approve, Discuss)
Approve.	

3.	Legal / Regulatory Implications
It is a legal requirement to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). Trust to support Birthrate Plus® report 2023 and meet BAPM Neonatal staffing standards. Maternity Incentive Scheme Year 6 standards.	

4.	Risk related to staffing (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc.)	
2950	There is a risk that neonatal patients may be cared for outside of BAPM guidelines for nursing staff who are not qualified in spec	12
2591	There is a risk that the current funded provision of Allied Health Professionals in the Neonatal Unit will not continue following cease of fixed term funding from neonatal Operational Delivery Network	8

5.	Resources Implications (Financial / staffing)
Nil	

6.	Equality and Diversity
Equality and Diversity legislation is an integral component to registration.	

7.	References to previous reports/Next steps
Maternity Incentive Scheme combined Maternity and Neonatal Safety Quality report Q2, 2024 Birthrate Plus® (BR+) report data from 2022, presented to Trust Board 2023 Perinatal Quality Surveillance Tools (PQST) presented monthly.	

8.	Freedom of Information
Public	

BI-ANNUAL MIDWIFERY AND NEONATAL STAFFING REPORT

1.0 Background

1.1 It is a requirement that NHS providers continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board (NQB, 2016) requirements.

1.2 Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that Trusts develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings.

1.3 The Department of Health (DH 2009) recommended an adequate and appropriate workforce with the leadership, skill mix and competencies to provide excellent care at the point of delivery; organised into managed clinical networks, with hospitals providing neonatal care working together to ensure that babies and their families receive care in the most appropriate setting.

2.0 Executive Summary

2.1 This report provides a summary of the measures in place to ensure safe midwifery and neonatal nurse staffing; including clinical and specialist roles, headroom requirement, fill rates, escalation, recruitment and retention, midwife to birth ratio, Birth Rate Plus® Live Acuity Tool compliance with supernumerary labour ward coordinator status, one to one care in labour, and red flag incidents.

2.2 It provides evidence of compliance that Obstetric medical workforce is monitored to ensure locum doctors meet MIS criteria, and consultants comply with the attendance requirement set out in the Royal College of Obstetricians (RCOG) workforce document 'Roles and responsibilities on the consultant providing acute care in obstetrics and gynaecology'.

2.3 Evidence that a duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should always have clear lines of communication to the supervising anaesthetic consultant is provided. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients to be able to attend immediately to obstetric patients in line with Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1

2.4 It also provides a summary of measures taken to demonstrate working towards compliance with safe staffing for the Local Neonatal Unit (LNU) to include an annual nursing workforce review, including a mid-year review and collaborative working with the Operational Delivery Networks (ODN) to ensure recruitment and retention, skill mix and flexible working. A summary of compliance for neonatal medical workforce meets BAPM national standards, or actions to mitigate if not compliance are in place and are shared with the Local Maternity & Neonatal System (LMNS) and ODN.

3.0 Birth rate Plus® Workforce Planning for Midwifery staffing

3.1 BR+ is the only recognised national tool for calculating midwifery staffing levels, the Trust commissioned and received a new report in April 2023. It is recommended that BR+ assessment is undertaken every three years to ensure planned staffing establishment is in line with changing activity and acuity within Trusts, the next report is due to be completed 2026.

3.2 In addition to clinical midwifery posts, consideration needs to be given to recommendations from national reports such as Ockenden, MIS and the 3-year Maternity and Neonatal Delivery Plan. This will need to be considered within Bath Wiltshire and Sailsbury (BSW) Integrated Care System workforce planning. We continue to explore service needs and long-term funding to make care safer, personalised and equitable.

4.0 Recruitment and retention

4.1 The service is fully staffed to substantive funded establishment. Maternity leave and secondment figures remain relatively stable.

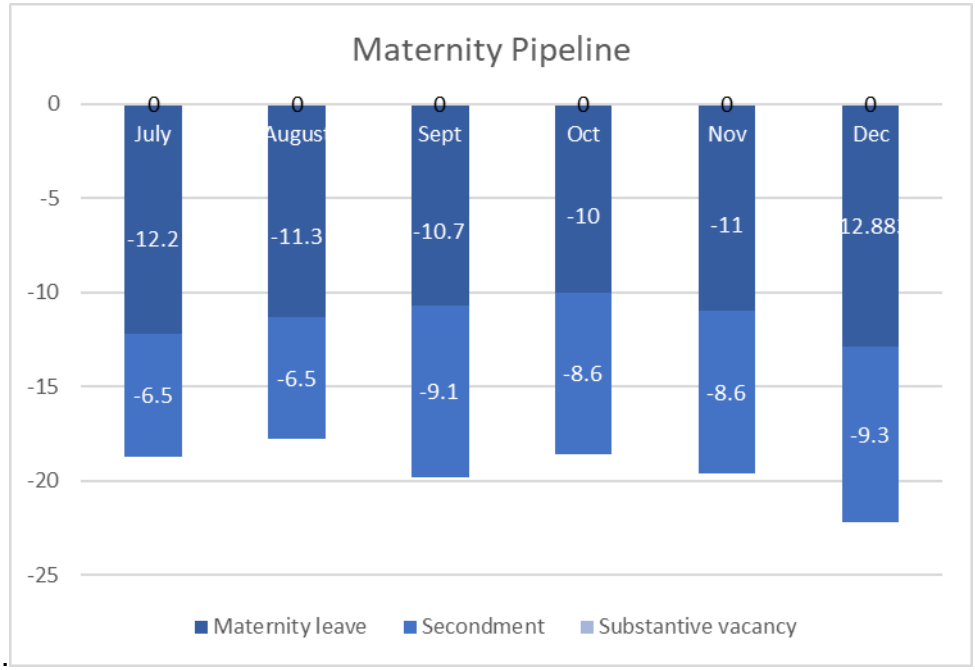


Table 1: midwifery pipeline

4.2 The service saw 3 band 5 midwives leave (following 100% retention for 18 months), 2 due to family relocation and one to train in Health Visiting. A total of five band 5 midwives have achieved their band 6 within this period.

4.3 Rolling turnover rate saw a decrease from 7.39% in June 2023 to 3.86% in December 2024. Flexible working and adjustments are offered to all staff members prior to them leaving along with a conversation with the retention lead midwife. In this period1 band 7 retired, 2 band 7's took a career break/external secondment and one band 8 was seconded internally. No commonalities were identified from exit interviews.

5.0 Sickness rates

5.1 Midwifery sickness rates remain stable with an almost equal split for long-term and short-term sickness. The top contributor for episodes at 52 is cold, cough, flu – influenza, but 165 sickness days (based on 11.5 hours shifts) were lost due to anxiety/depression/other psychiatric disorder, these remain the same top reasons as the previous reporting period. Supporting attendance is managed in line with guidelines with a focus on health and wellbeing. Surgeries have also been established between HR and band 7 line managers to support attendance.

Month	sickness %
July 2024	4.06%
Aug 2024	4.15%
Sept 2024	4.24%
Oct 2024	4.14%
Nov 2024	4.03%
Dec 2024	3.84%

Table 2: 12 month rolling sickness % for midwives

Reason	Sickness days	Episodes
Anxiety/stress/depression/other psychiatric	165	22
Cold, cough, flu – influenza	135	52
Back problems	144	5

Table 3: Top three reasons for sickness (over reporting period)

6.0 Planned vs Actual

6.1 Table 4 highlights the position for midwifery shift fill rates. This remains similar to the previous report with an anticipated improvement in the next reporting period following recruitment to vacancy.

Month	Day qualified %	Night qualified %
July 24	92%	93%
Aug 24	90%	89%
Sept 24	91%	93%
Oct 24	89%	90%
Nov 24	96%	93%
Dec 24	88%	92%

Table 4: Shift fill rates

6.2 Mitigation and Escalation

Mitigations and escalation processes are implemented to manage any shortfalls in planned versus actual midwifery staffing. Staffing and Operational Pressures Escalation Level Midwifery Framework (OPELMF) status is reviewed daily by the senior operational leadership team and mitigated where redeployment is considered based on acuity to ensure safe staffing is maintained. When midwifery staffing does not meet acuity, the following measures are

taken to maximise staffing into critical functions to maintain safe care for the women and their babies in line with the Maternity Escalation Policy:

- Request midwifery staff undertaking specialist roles to work clinically
- Elective workload prioritised to maximise available staffing
- Managers at Band 7 level and above work clinically
- Relocate staffing to ensure one to one care in labour and the labour ward coordinator remains supernumerary
- Activate the on-call midwives from the community to support Bath Birth Centre (BBC)
- Request additional support from the on-call midwifery manager
- Consult closely with maternity services at other sites to manage and move capacity as required (mutual aid).

There continues to be minimal use of on call provision to support acute services with only 2 6-hour occasions when on call support was needed.

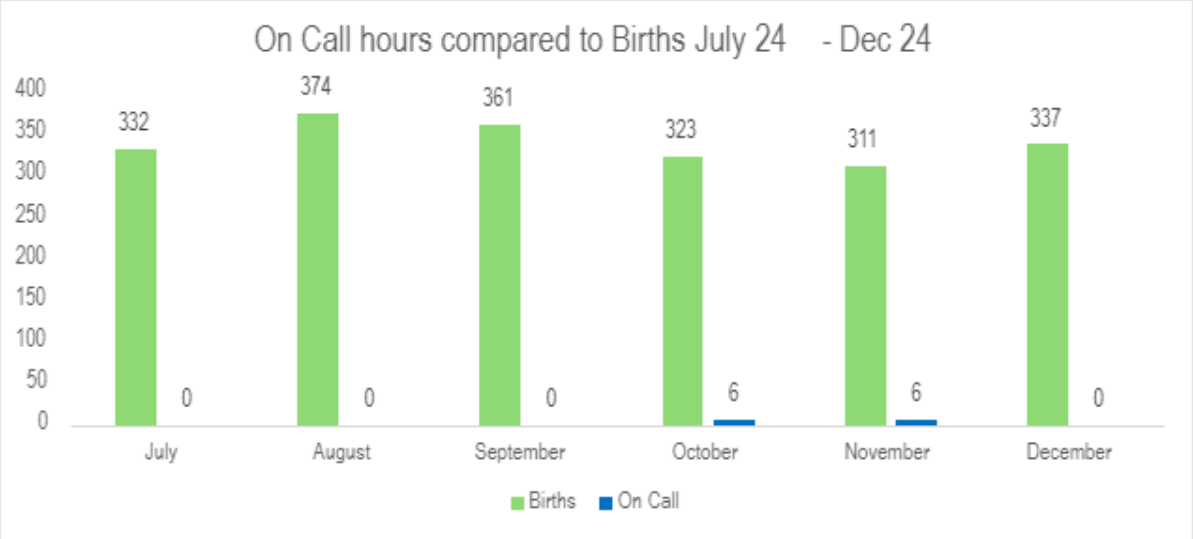


Table 5: On-call hours and birth number comparison per month

6.3 Midwife to birth ratio

The midwife to birth ratio is calculated monthly using BR+ methodology. The BR+ Midwife to birth ratio 1:24 target was introduced in July 2023 to align with the outcome RUH BR+ Report 2023. There were months when the midwife to birth ratio was above the target due to increased activity and acuity and holding vacancy over the summer months however these new starters has resulted in meeting the requirement in November and December. Mitigations explained in 6.3 were enacted during times of escalation to preserve safety.

Midwife to birth ratio	Target	July 2024	Aug 2024	Sept 2024	Oct 2024	Nov 2024	Dec 2024
Substantive only	1.24	1.28	1.28	1.31	1.29	1.26	1.26
Including bank	1.24	1.25	1.25	1.28	1.26	1.24	1.24

Table 6: Midwife to birth ratio

6.4 Supernumerary status

As part of Maternity Incentive Scheme Safety Action 5, Trusts are required to demonstrate supernumerary status of the midwifery coordinator in charge of labour ward. This is to oversee safety on the labour ward and oversight of all birth activity within the service. An internal performance review is conducted monthly to monitor compliance and reported via speciality governance. Table 7 outlines the compliance for the past 6 months.

Month	Days per month	Shifts per month	Compliance
July 2024	31	62	100%
August 2024	31	62	100%
September 2024	30	60	100%
October 2024	31	62	100%
November 2024	30	60	100%
December 2024	31	62	100%

Table 7: Supernumerary status of LWC

6.5 1:1 care in Labour

Women in established labour are required to have 1:1 care and support from an assigned midwife to ensure the safe, high-quality provision of care. As part of Maternity Incentive Scheme Safety Action 5, Trusts are required to demonstrate to provision of 1:1 care in active labour. An internal performance review is conducted monthly to monitor compliance and reported via speciality governance. Table 8 outlines the compliance for the past 6 months.

	July 2024	Aug 2024	Sept 2024	October 2024	Nov 2024	December 2024
1:1 care in established labour	100%	100%	100%	100%	100%	100%

Table 8: 1:1 care in labour – source BR+ live acuity tool

6.6 Inpatient ward acuity

The inpatient ward-based acuity tool data is entered prospectively for the upcoming 6 hours.

Compliance data has evidenced that staffing has consistently not met the acuity, with a data entry compliance consistently around 80% (confidence factor >60%). Actions to include a review of staffing baseline and further training on the ward-based acuity tool hosted by BirthRate+ have been set during the reporting period.

Escalation to the ward manager and LWC ensures that ward safety is maintained in periods of high acuity and actions detailed in section 6.2 are initiated.

6.7 Specialist Midwives

BR+ recommends 18.37wte specialist midwives including management and non-clinical element of specialist roles.

There are currently 17.37wte specialist midwives including those in management positions available to be deployed to mitigate in times of escalation. A number of these roles are externally funded but form part of requirements of Ockenden, MIS and the 3-year Maternity and Neonatal Delivery Plan. These roles are being discussed within BSW and will need to be considered within BSW workforce planning. We continue to explore service needs and long-term funding to make care safer, personalised and equitable.

7.0 NICE Red Flag Events (NG14, published 27/02/2015)

7.1 A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. Actions to reduce red flag events includes operational management actions such as initiation of the Operational Pressures Escalation Level Midwifery Framework (OPELMF). NICE Red Flag events are all recorded on BR+ acuity tool, the reliability of this data is also analysed on the tool via the confidence factor which should be maintained above 75%.

7.2 There are 9 national red flags agreed by NICE. Other midwifery red flags may be agreed locally. The service has agreed 2 local red flags pertaining to induction of labour and patient flow which has been identified as a quality and patient safety risk, (Risk Register Entry 2649) and monitored through the risk register processes. The highest number of red flag events recorded by the service are the locally set red flags for delay in admission to commence and continuation of induction of labour. Actions towards mitigation of the risk are detailed within the risk register and monitored for progress by internal governance processes. This includes increasing band 7 leadership on the inpatient ward and implementation of an operational support midwife to support flow and forms part of the Leadership and Culture QI project.

8.0 Obstetric and Anaesthetic staffing

8.1 The Trust has not employed any locum obstetric staff doing the reporting period.

8.2 Table 9 provides evidence of consultant obstetric presence in line with RCOG guidelines.

	July 2024	Aug 2024	Sept 2024	October 2024	Nov 2024	December 2024
Hours Consultant present	98	98	98	98	98	98

Table 9: Consultant presence in hours

8.3 Table 10 shows consultant attendance when clinically indicated. There was one episode in August when the on-call consultant could not be contacted due technical issues however another consultant was contacted and attended immediately with no negative impact on the clinical care.

	July 2024	Aug 2024	Sept 2024	October 2024	Nov 2024	December 2024
Consultant non-attendance when clinically indicated	0	1	0	0	0	0

Table 10: Consultant presence in hours

8.4 Table 11 provides evidence of dedicated obstetric rostered junior anaesthetic staff and a consultant allowing for clear escalation to a dedicated consultant if required

	July 2024	Aug 2024	Sept 2024	October 2024	Nov 2024	December 2024
Junior Dr rostered	100%	100%	100%	100%	100%	100%
Consultant Rostered	100%	100%	100%	100%	100%	100%

Table 11: Consultant presence in hours

9.0 Neonatal Nurse Staffing

9.1 The Neonatal Nursing Workforce Tool (2020) has been adapted from the Clinical Reference Group (CRG) Workforce Calculator (Dinning) Tool (2013) and provides a consistent method for calculation of nursing establishment requirements; this tool should be used for direct patient care in the LNU only. NHSE (2016) recommends an uplift of 25%, headroom is currently built into budget at 23%.

9.2 As recommended by NHSE, Transitional Care and Community Outreach should be delineated from the inpatient neonatal budget. Based on service cot occupancy and activity calculations in 2023/24, safe staffing levels were maintained from the inpatient establishment and budget. Consideration for redefining the inpatient budget is being explored by service leads.

9.3 Overall vacancy in December is 4.84wte. There remains a national shortage of paediatric and neonatal nurses which continues to cause challenges in recruitment.

9.4 Nurse rolling turnover rate remains stable and below the Trust rolling KPI of 11% at 6.28%.

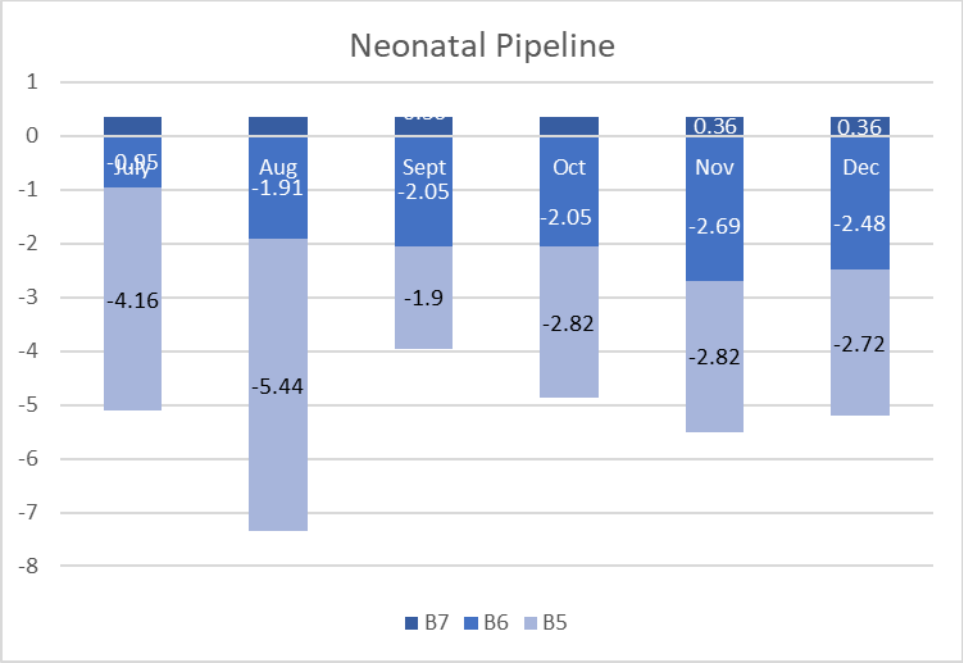


Table 12: Nurse vacancy pipeline

10.0 Sickness

10.1 Rolling sickness absence rates remain just above the Trust target of 4% except in September. The top episode and sickness days lost for NNU absence is cold, cough, flu – influenza at 33 episodes resulting in 75 lost days (based on 11.5-hour shifts). Supporting attendance is a priority for line manager as per trust guidelines with a focus on staff health and wellbeing.

Month	Sickness %
July 24	4.35%
Aug 24	4.06%
Sept 24	3.84%
Oct 24	4.05%
Nov 24	4.23%
Dec 24	4.32%

Table 13: 12 month rolling sickness % for registered nurses

Reason	Sickness days	Episodes
Cold, cough, flu – influenza	75	33
Anxiety/stress/depression/other psychiatric	55	4
Genitourinary & gynaecological disorders	17	9

Table 14: Top three reasons for sickness (over reporting period)

11.0 Transitional Care

11.1 All LNUs should offer a transitional care service (BAPM, 2017). TC is staffed from the LNU patient facing budget, with 100% of shifts assigned with one neonatal nurse/associate.

The Trust currently provide a 4-bed service with ratio of 1:4 nurse to patient care as per BAPM standard. Getting it Right First Time (GIRFT) report recommends the Trust should increase the TC service to at least 8-beds based on the current birth rate. The neonatal service is often caring for more than 4 babies within TC, a review of current staffing is in progress to consider expansion of TC cot provision. All eligible babies have received transitional care in the given period. Where 2 nurses were required due to higher TC acuity, 98% shifts were covered in the reporting period. Quarterly reports are maintained and presented to Trust Board.

12.0 Neonatal Community Outreach Workforce

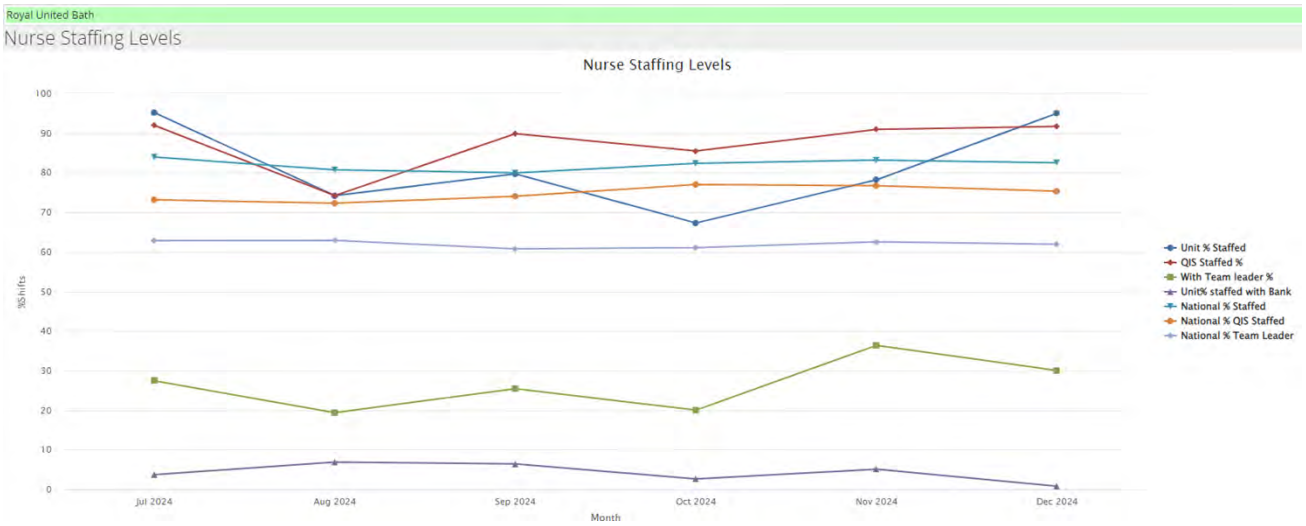
12.1 Neonatal Community Outreach remains at 1.8wte nurses offering a 6-day service for families, as per GIRFT recommendations (2022). We have been successful in expanding the offer of care for babies in the community to include home tube feeding, this will reduce length of stay for the preterm population and enhance parental experience. BAPM have released a draft Neonatal Outreach Framework (2024), when finalised further service delivery and staffing recommendations will be included.

13.0 Qualified in Speciality (QIS)

13.1 The British Association of Perinatal Medicine (BAPM) recommends all ITU and HDU patients should be cared for by a nurse who is qualified in specialty (QIS) trained. QIS is a post registration education pathway, combined with clinical competency which allows registered nurses working in neonatal units to become equipped with the specific knowledge and skills to practice safely and effectively in neonatal critical care. It is best practice for special care babies to also be cared for by a QIS trained nurse although national standards can still be met if they are supervised by a QIS nurse. The supervisory nurse in charge and nurse overseeing TC must also be QIS trained. The national standard for neonatal LNU establishment in QIS training is 70% of the nursing patient facing workforce.

13.2 There are national, regional and local challenges in achieving the 70% QIS compliance rate. Currently RUH QIS is 69% of the qualified workforce. Graph 1 represents QIS trained neonatal nurse staffing provision over the review period. During the reporting period 81.87% of shifts were staffed to BAPM recommendations, with 87.25% of shifts QIS to toolkit. QIS compliance is monitored via the Maternity and Neonatal Specialty Governance. Non-compliance to the standard has instigated this being added to the Risk Register with an action plan in place to achieve the national BAPM recommendation of 70%. It is anticipated that RUH will be complaint at 70% by Q1 2025.

13.3 During periods of high acuity staff are redeployed and rosters changed to ensure adequate QIS trained nurses are available for baby's needing intensive or high dependency care. There is mitigation in place as all nurses complete the Southwest Neonatal Foundation programme and local induction programme, and all are supported with gaining experience in intensive and high dependency care.



Graph 1: QIS shift fill rates

14.0 Medical Staffing

14.1 BAPM Optimal arrangements for Local Neonatal Units and Special Care baby units in the UK including guidance on their staffing; a Framework for Practice (2018) provides guidance on optimal activity levels and additional guidance on medical staffing for LNUs in the UK. Medical staffing comprises roles traditionally undertaken by medical practitioners now also undertaken by appropriately trained and experienced Advanced Neonatal Nurse Practitioners (ANNPs). ANNP's provide a high standard of practical skills and experience, continuity of care and empathy for families providing a solid foundation for neonatal services which strengthens medical trainee experience and service progression. We have an established ANNP workforce working on both tier 1 and tier 2 level, which ensures our compliance with BAPM medical staffing requirements.

14.2 The following standards are set by BAPM (2018)

- At least one resident Tier 1 (ANNP or junior doctor ST1-3) practitioner dedicated the providing emergency care for the neonatal service 24/7
- Resident Tier 2 (ANNP or junior doctor ST4-8) practitioner dedicated solely to the neonatal service 12 hours a day during the busiest times of the day
- The Tier 2 (ANNP or junior doctor ST4-8) practitioner should be immediately available at all times to the neonatal unit and the labour ward. If the site of the paediatric unit makes this immediate response impossible separate Tier 2 rotas are required
- Tier 3 compliance requires all consultants on-call for the unit to have regular weekday commitments to the neonatal service only (ideally with a 'consultant of the week' system) and all consultants do a minimum of four 'consultant of the week' service weeks per year.
- No on-call rota should be more onerous than one in six.

BAPM Standard	RUH
Tier 1 separate rota compliance 24/7	Compliant
Tier 2 separate rota compliance 12h per day	Compliant
Tier 2 compliance: significant geographical separation between neonatal and paediatric units	N/A
Tier 3 daytime compliance	Compliant
Tier 3 compliance on-call rota	Compliant

Table 15: Medical workforce

Consultant additional Roles; Funded PA's	RUH
Clinical Lead	1 neonates/paeds
Governance	0.5
Perinatal Mortality Review (PMRT)	0
Educational +/- college tutor	0.75 neonates/paeds
NNU lead Doctor	0.5

Table 16: Consultant additional roles

15.0 Allied Health Professionals (AHP) staffing

15.1 In addition to nursing staff, neonatal services require key contributions from an essential group of AHPs to enhance service provision and optimise short and long-term neurodevelopment and mental health of infants and their families; this is advocated in the NCCR report.

Each AHP specialty has developed staffing recommendations and competencies which provide a model for embedded service provision as part of the wider neonatal team (BAPM 2022). The National standards for acute AHP provision are based on unit cot allocation and presented in table 17, in addition each AHP should have 0.15wte allocated for neurodevelopmental follow up clinic. Here at RUH we provide neurodevelopmental clinics with physiotherapy and occupational therapy input and refer to other AHP as required.

National standards for SCBUs, LNUs and Medical NICUs					
	OT	Physio	Dietitian	S&LT*	Clinical Psychologist
IT cot	0.05	0.05	0.1	0.05	0.055
HD cot	0.05	0.05	0.05	0.05	0.055
SC cot	0.05	0.05	0.033	0.05	0.055
TC cot	0.02	0.05	0.033	0.02	0.055
1/2 day clinic	0.15	0.15	0.15	0.15	

Table 17: National standards for AHP WTE provision (BAPM 2022)

15.2 The service recognises a gap in our provision to recommended BAPM standards and is reflected in the Risk Register entry 2591 and is monitored via Maternity and Neonatal Safety Governance. The provision of Ockenden funds has supported recruitment of AHPs within our LNU however this does not fully meet the BAPM recommendations, the current provision and deficit are identified in table 19 and now inclusive of recommended follow up provision. Focussed work for AHP's is on inpatient babies with support provided by a named Consultant and Advanced Neonatal Nurse Practitioner (ANNP). To mitigate this, MDT specialist interest groups have also been implemented such as a Family Integrated Care (FiCare) and Nutrition. This position is reflective of all neonatal units within the southwest region.

AHP	Current provision (WTE)	Deficit against BAPM (WTE)
Physio	0.2	1.15
OT	0.35	0.93
SALT	0.2	1.08
Dietician	0.2	1.09
Psychologist	0.3	0.86
Pharmacist	0.08	1.24

Table 18: AHP wte comparison

15.3 Pharmacy cover was not included within the Ockendon review and funding provision. The Neonatal and Paediatric Pharmacists Group (NPPG) have Pharmacy Staffing Standards for Neonatal Services that support the BAPM standards. BAPM standards state the pharmacist must have sufficient time allocated to fulfil their specialist role, with a minimum of 0.12 whole time equivalent (WTE) pharmacist for a 5 day service (and 0.168 WTE for a 7 day service) for each funded Intensive Care cot, for every two funded High Dependency cots and for every four funded Special Care cots.

In recognition of the limitation of service provision and potential impact to safety and enhanced practice the RUH have lack of pharmacy cover on their risk register.

16.0 Specialist roles

16.1 BAPM Service specification states additional provision should be implemented for staff delivering quality, management and other non-direct patient-facing roles which are additional to the direct patient care ratios. Every provider of neonatal care should ensure that non-direct patient-facing roles include provision for a designated lead nurse, clinical nurse educator, supernumerary shift co-ordinator, discharge planning / outreach co-ordinator, bereavement lead, patient safety and governance nursing lead and infant feeding lead are in addition to other roles outlined in the Toolkit for High Quality Neonatal Services (2009).

16.2 We continue to have four such roles in place; 0.4wte Neonatal Education and Quality Lead, 0.4wte Safety Governance lead and 0.5wte Family Integrated Care Lead. Remaining specialist roles, in line with BAPM recommendations, are allocated to individuals from the clinical nurse budget and subject to being redeployed during times of staffing escalation.

17.0 Recommendations

1. Review the need to increase headroom required to support the BR+ 2023 report and findings from BSW Academy review for maternity staff, including new mandated training

2. Undertake review of externally funded posts and agree workforce planning strategy to mitigate risk of removal of national funding

3. Review of inpatient acuity and staffing model to support expansion of TC

4. Work with SWODN to ensure access to funding/education for QIS training.

18.0 Conclusion

Maternity services are a high-risk specialism, the impact of poor care can be life changing for women and their families. Investment in safe maternity staffing not only safeguards the provision of high-quality care and best outcomes but also mitigates the reputational and litigious risk for the organisation.

Neonatal services offer the best start in life to babies who have care needs which will have a lifelong impact if not provided in line with National standards. Having a baby in neonatal care has a significant impact to parental mental health which is long standing if they do not receive the care and support as per national requirements.

The Trust Board is asked to discuss the report and note the position of staffing in maternity and neonatal services.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**20**
Date of Meeting:	**Wednesday 7 May 2025**		

Title of Report:	**Learning from Deaths Q1, Q2 & Q3**
Status:	**To note and discuss**
Board Sponsor:	**Kheelna Bavalia, Interim Chief Medical Officer**
Author:	**Reston Smith, Deputy Chief Medical Officer**
Appendices	**Appendix 1: Learning from Deaths H1** **Appendix 2: Learning from Deaths Q3**

1. Executive Summary of the Report

Conducting and learning from a review of the care provided to patients who die should be an integral part of every Trust's clinical governance and quality improvement processes. This requirement is reinforced by the National Quality Board's National Guidance on Learning from Deaths, which sets out a framework for Trusts to identify, report, investigate and learn from deaths that occur in their care. This aim of this report is to assure the Board of the Trust's compliance with this requirement, but also that it is actively taking the opportunities to improve the quality and safety of the care that it provides because of the work that it does in this area.

Between April and September 2024 (Q1 & Q2):

- Hospital mortality remains within expected ranges for both weekday and weekend admissions.
- 78% of Structured Judgment Review's (SJRs) completed in Q2 rated care as either good or very good. This is an increase from 65% in Q1.
- None of the SJRs completed in the first half of the year rated overall care as very poor but there were four findings of poor care (2 in Q1 and 2 in Q2). The findings of poor care have been reviewed through divisional governance.
- There are no new or emerging themes in patient safety or quality from the mortality review process. Issues relating to delays, end of life care, and falls align with our current patient safety priorities.
- There has been a small decrease in the number of outstanding SJRs.

Between October and December 2024 (Q3):

- Standardised hospital mortality remains within expected ranges for both weekday and weekend admissions and benchmarks favourably against system and regional peers
- 88% of SJRs completed in Q3 rated care as either good or very good
- A single case (0.3% of deaths) was judged to have received poor care overall in Q3 this was reviewed through divisional governance processes
- There are no new or emerging themes in patient safety or quality from the mortality review process. Issues align with our current patient safety priorities
- There has been a small decrease in the number of outstanding SJRs

A focused piece of work for trust over this period has been to address the growing

backlog of cases awaiting review and to complete SJRs in a timelier way. To support this, the criteria for undertaking a SJR was reviewed and revised to bring in line with benchmarked practice and underpinned by the principle that cases that had undergone scrutiny through a different process would yield less opportunity to learn by an additional SJR process. By streamlining and reprioritising the list, we are working through outstanding cases, with the ambition to complete 95% within 2 months. We are yet to meet this target, performance at Q3 was at 33%, but recognising we are now completing more reviews than those being requested.

2.	Recommendations (Note, Approve, Discuss)

The report is presented for noting and discussing.

3.	Legal / Regulatory Implications

The Care Quality Commission (CQC) report *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England* found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements/learning are being missed. The Trust is required, by national guidance, to have a process in place to ensure that it identifies, reports, investigates and learns from deaths in its care.

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)

The risk of failing to deliver an effective learning from deaths process is that there will be missed opportunities to learn and improve the quality and safety of care delivered at the Royal United Hospitals Bath.

We are taking steps to improve our approach to learning from deaths by:

- looking at better joining up the insights that come from work with specific patient groups, such as though safeguarding, end of life care, vulnerable adults, maternity and perinatal
- address gaps in coding to support the integrity of our data
- linking with BSW ICB to improve and better understand our SHMI (Summary Hospital-level Mortality Indicator) data and wider work across the BSW footprint in this space

There is a risk that due to gaps in the collation of demographic data in relation to ethnicity, religion and learning disability the Trusts ability to have oversight in the quality of services for patients with protected characteristics.

5.	Resources Implications (Financial / staffing)

No specific resource implications identified.

6.	Equality and Diversity

The report demonstrates a signal of inequity in mortality related to index of multiple deprivation and ethnicity and highlights gaps in the collation of data in relation to

ethnicity, religion and learning disability. This is aligned with the overall national picture. We are not surfacing any insights or intelligence from our SJRs that suggest specific reasons for this.

7.	References to previous reports/Next steps
These reports were considered by the Quality Assurance Committee in February and April 2025.	

8.	Freedom of Information
The information included is public	

9.	Sustainability
The report has no impact on sustainability	

10.	Digital
The report does not identify or highlight issues related to the Trust's digital strategy	

Royal United Hospitals Bath
NHS Foundation Trust

Appendix 1: Learning From Deaths H1

April 2024 to September 2024

This report considers the learning from deaths process, mortality trends and the learning from deaths that has occurred.

This report considers how effectively and efficiently the Mortality Review Process is operating, and reviews what lessons have been learnt as a result of the data generated by that process.

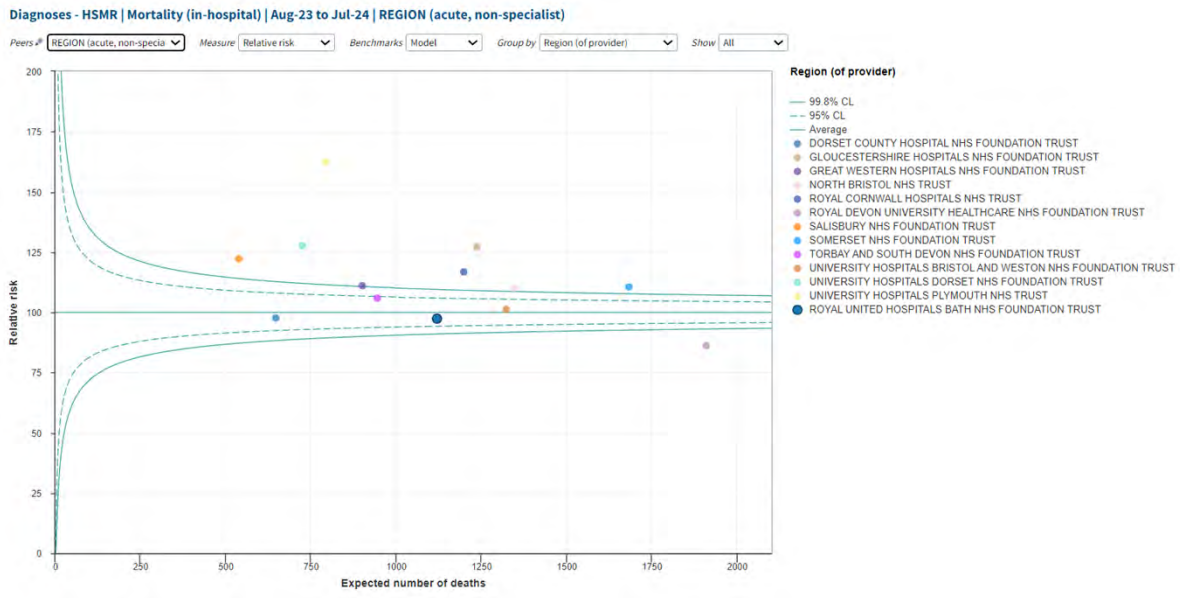
1.0 Overview

The number of in-patient deaths were;

- Q1 361
- Q2, 309

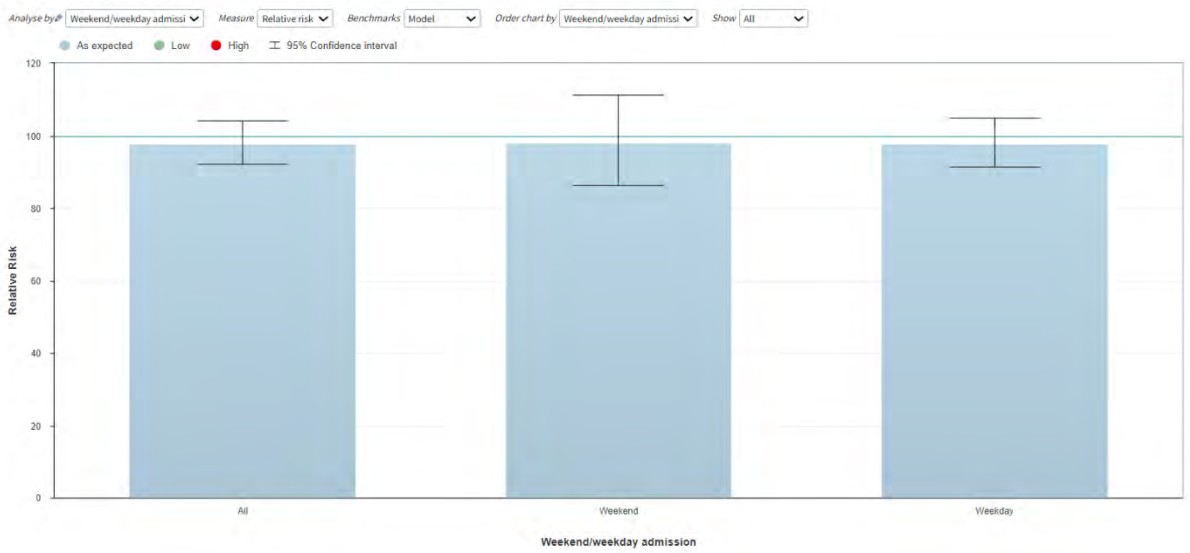
The December Telstra report demonstrates the following mortality rates for August 2023 – July 2024:

- Overall HSMR+ 97.4 - within expected range
- Weekday HSMR+ 97.9 - within expected
- Weekend HSMR+ 98.2 - within expected
- SMR+ 93.9 - statistically lower than expected



Diagnoses - HSMR | Mortality (in-hospital) | Aug-23 to Jul-24 | Weekend/weekday admission

Admission method (group): Emergency



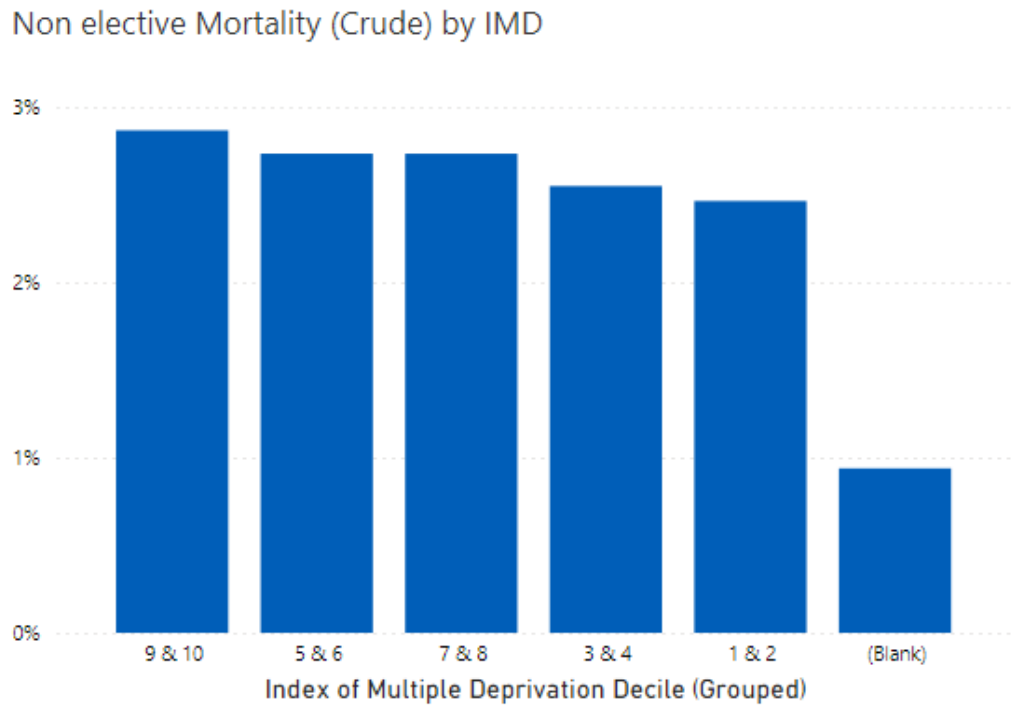
Diagnoses - HSMR | Mortality (in-hospital) | Aug-21 to Jul-24 | Trend (rolling 12 months) by Weekend/weekday admission

Admission method (group): Emergency

1.1 Health Inequalities:

Data on health inequalities has been collated using the business intelligence dashboard. The data displayed below is for non-elective admissions between 1st April 2024 and 4th January 2025

1.1.1 CORE 20 - Indices of multiple deprivation

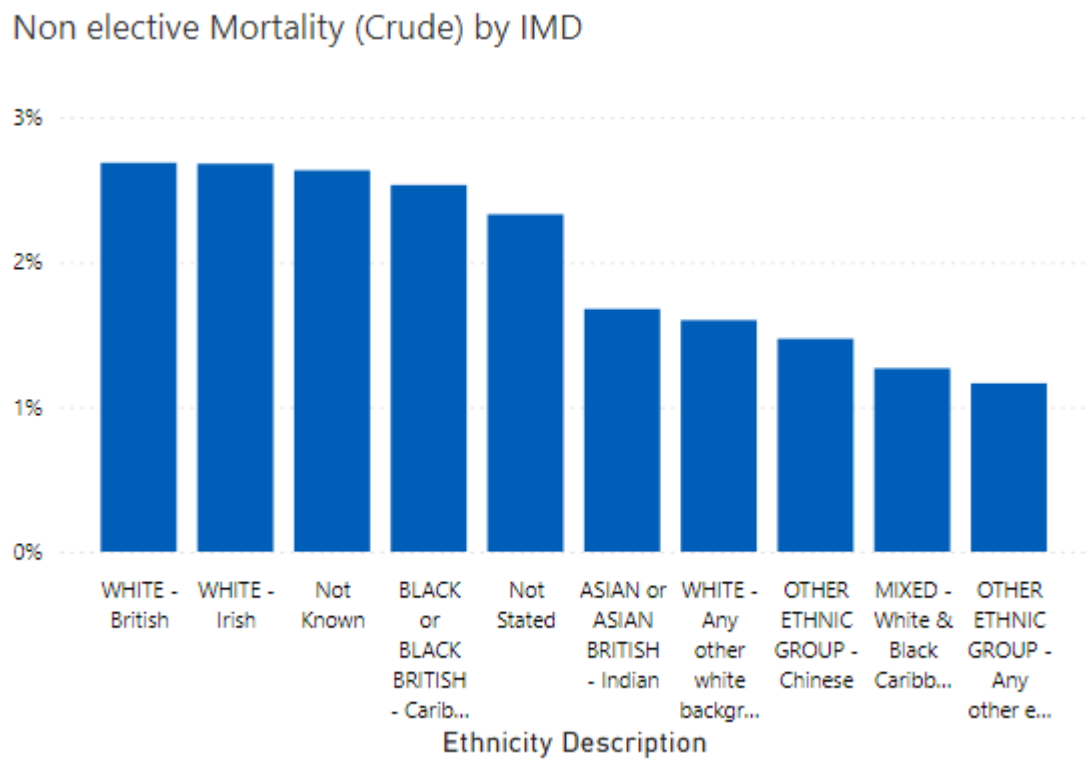


The data suggests that the crude mortality for the CORE 20 most deprived members of our community is in line with the rest of the community. However, when broken down by age band there is signal in the data that suggests the CORE 20 most deprived population have a higher crude mortality in the 30th and 70th decades than peers. We are undertaking work to understand and benchmark this finding locally and nationally.

Non Elective Mortality by Age Band (10 years) and IMD

Index of Multiple Deprivation Decile (Grouped)	10	20	30	40	50	60	70	80	90	100	Total
(Blank)		0.4%			0.9%	1.0%	1.6%	6.7%	8.3%		**1.1%**
1 & 2			0.4%		0.5%	2.6%	5.2%	4.5%	6.1%		**2.1%**
3 & 4				0.2%	0.6%	2.8%	3.5%	6.7%	7.5%		**2.5%**
5 & 6			0.1%	0.6%	1.1%	1.8%	3.3%	6.6%	8.0%		**2.7%**
7 & 8	0.4%		0.1%	0.5%	1.3%	2.2%	3.1%	4.7%	8.4%		**2.5%**
9 & 10	0.4%	0.1%	0.1%	0.3%	1.3%	2.0%	3.2%	5.0%	8.1%	23.5%	**2.8%**
Total	**0.2%**	**0.1%**	**0.1%**	**0.4%**	**1.1%**	**2.1%**	**3.3%**	**5.5%**	**8.0%**	**14.3%**	**2.6%**

1.1.2 PLUS - Ethnicity



The data suggests that the crude mortality is consistent across the ethnic groups represented in our community. However, when broken down by age band there is signal in the data that suggests that in specific age bands certain ethnic groups have a higher crude mortality. We are undertaking work to understand and benchmark this finding locally and nationally.

Crude mortality by Ethnicity:

Ethnicity Description	10	20	30	40	50	60	70	80	90	100	Total
ASIAN or ASIAN BRITISH - Indian											1.7%
BLACK or BLACK BRITISH - Caribbean								5.9%			2.5%
MIXED - White & Black Caribbean											1.3%
Not Known	0.9%	0.4%	0.3%	0.3%	1.0%	1.9%	4.3%	4.1%	8.2%		2.6%
Not Stated						1.0%	2.3%	4.2%	9.8%		2.3%
OTHER ETHNIC GROUP - Any other ethnic group						3.6%		4.5%			1.2%
OTHER ETHNIC GROUP - Chinese								14.3%			1.5%
WHITE - Any other white background		0.5%		0.6%	0.7%	3.1%	3.1%	7.1%	2.3%		1.6%
WHITE - British	0.1%		0.1%	0.4%	1.1%	2.1%	3.2%	5.7%	8.1%	16.0%	2.7%
WHITE - Irish								7.1%			2.7%
Total	**0.2%**	**0.1%**	**0.1%**	**0.4%**	**1.1%**	**2.1%**	**3.3%**	**5.5%**	**8.0%**	**14.3%**	**2.6%**

2.0 Performance of the Mortality Review Process

It is essential that the Mortality Review process occurs in a timely manner. Delays reduce the opportunity for learning from deaths and the risk that timely improvement does not occur resulting in ongoing risks to patient safety and quality.

The performance of the Medical Examiners is considered in greater detail in the quarterly Medical Examiner Office Reports.

2.1 Checklists

At the time of writing this report, there are two outstanding checklists from patients who died in April and June 2024. All others had been completed.

2.2 Screening

The Medical Examiners screen all deaths and a standard proforma is used to ensure consistency in the cases that are selected for SJR. The Medical Examiner Office Report details the performance of the screening process.

2.3 Structured Judgement Reviews

In Q1 19% (n=69) of cases were selected for SJR and in Q2 16% (n=51). Figure 1 demonstrates the selection criteria for Q1 and Figure 2 for Q2.

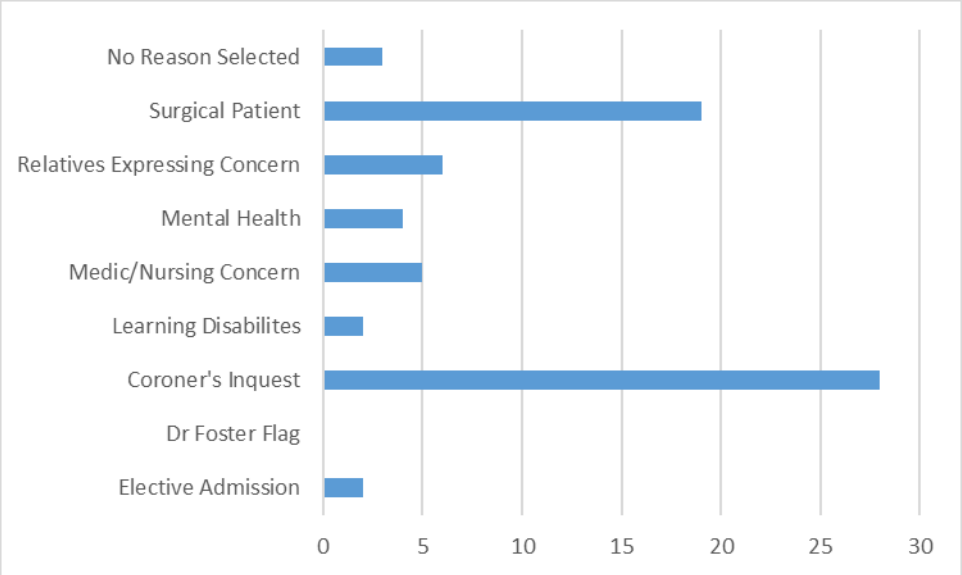


Figure 1: Q1 number of deaths selected for SJR by selection criteria

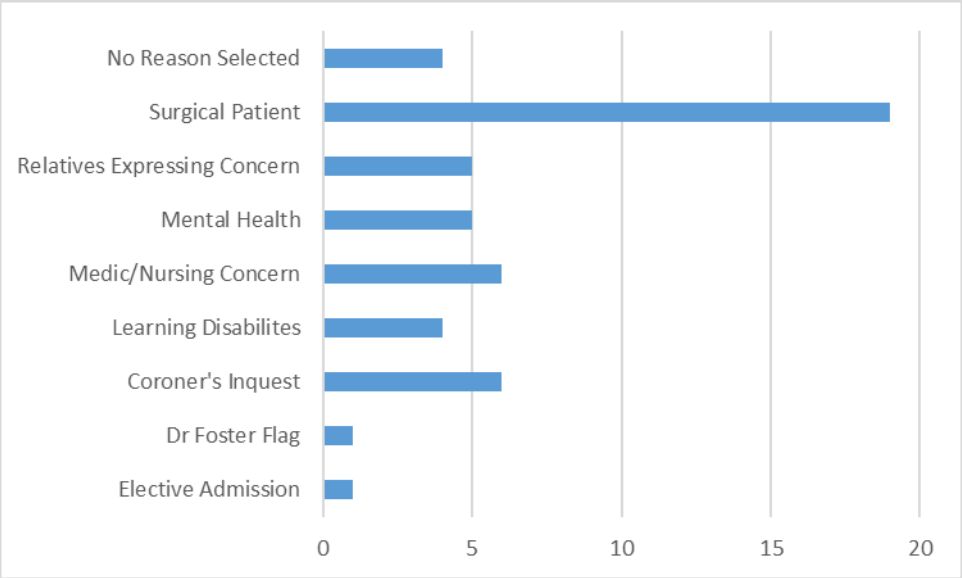


Figure 2: Q2 number of deaths selected for SJR by selection criteria

Figure 3 illustrates the number of SJRs requested per quarter, compared to the number completed and the percentage of SJRs that are completed within two months of the patient's death. The Trust target is to complete 95% of SJRs within 2 months of the death.

Over three of the last four quarters, the number of SJRs completed has exceeded the number requested, a review of the selection criteria has been undertaken and proposals are currently being considered the likely impact will be to narrow the selection criteria for SJR. The result of this will be to ensure that the SJR process is focused on the greatest opportunity to learn in a timely manner.

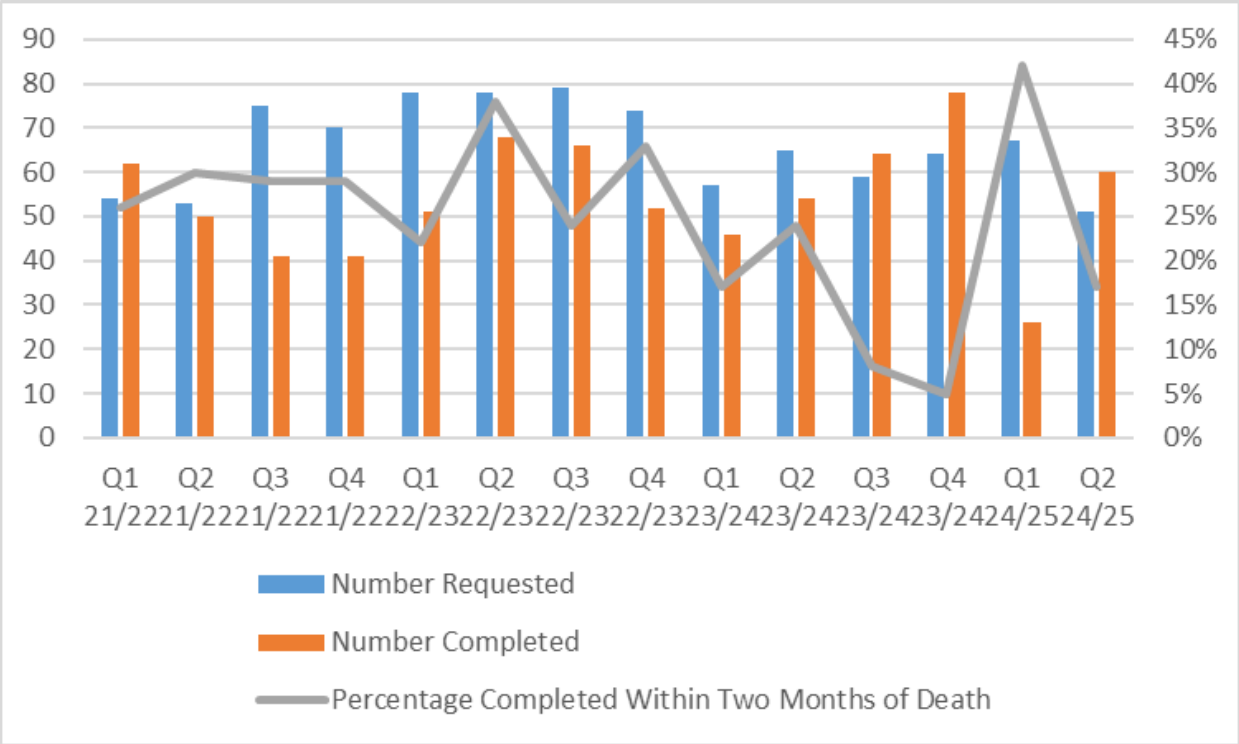


Figure 3: Number of completed SJRs v Number Requested and % completed within two months of the death

Figure 4 shows the number of outstanding SJRs relating to patients who have died since January 2021. Reflecting that the completion rate has begun to exceed the selection rate, a small reduction in the back-log has been seen.

A review of the back-log has been completed and it has been identified that a significant proportion of cases have already been the subject of a detailed view, via another process such as a formal complaint, incident investigation or inquest. It has proposed that these SJRs can be closed as the risk of losing additional learning is small. It has also been recommended that SJRs pre-dating 2024 where the selection criteria is Coroner's Inquest, could also be closed. The proposals were supported by the Trust Quality and Safety Group (November 2024).

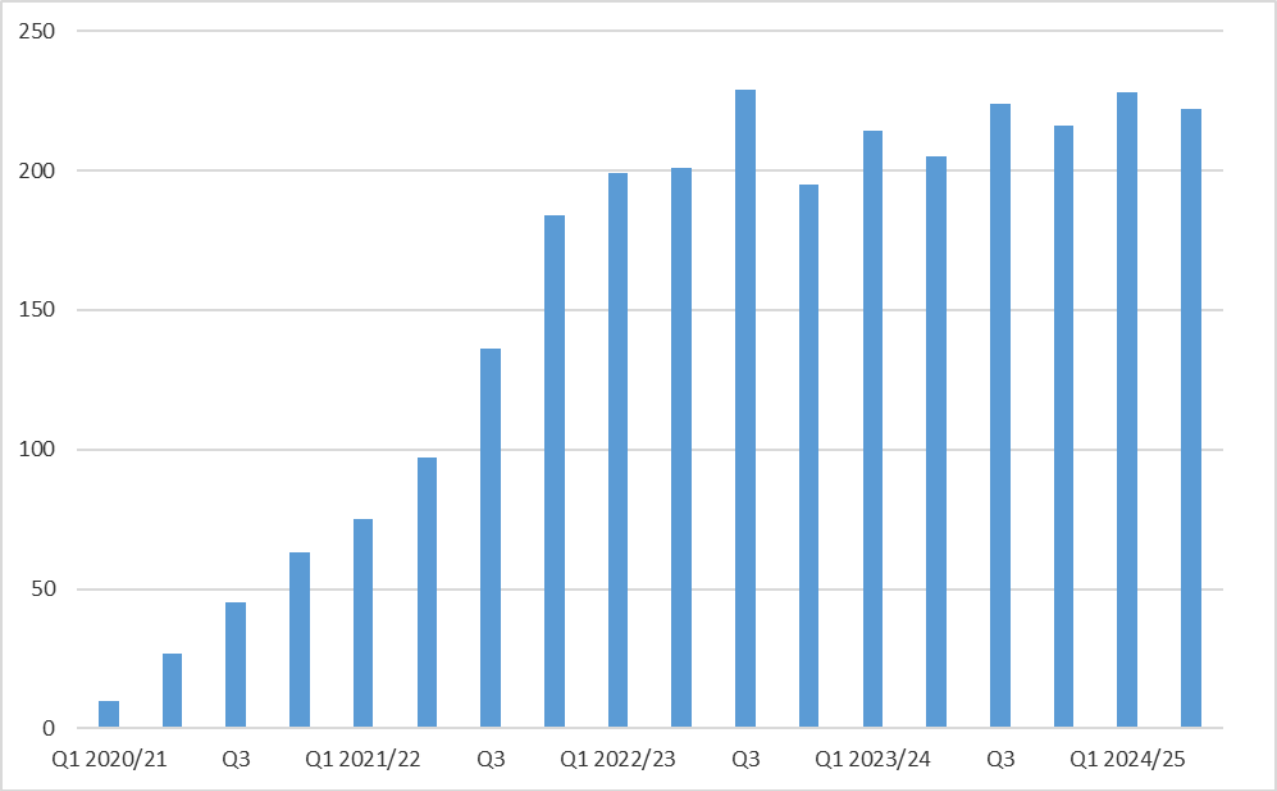


Figure 4: Number of outstanding SJRs

Generally (this is not always possible in FASS due to the smaller nature of the division) SJRs are allocated to a speciality that was not involved in the patient's care. However, surgical patients are reviewed by Surgery; medical patients are reviewed by Medicine etc. Figure 5 below shows the number of deaths within each division, the number of patients screened for an SJR within the division, the number completed and the number outstanding. The number of SJRs completed includes those completed during the quarter, regardless of when the patient died. The total number of outstanding SJRs is a rolling total i.e. the number allocated but not completed since January 2021.

The data within the Mortality database shows the speciality the patient was under when they died. It is not possible to differentiate between medical and FASS patients who died on ICU, and surgical patients. In the chart below, these patients have been allocated to Surgery, leading to a probable inflation of their numbers.

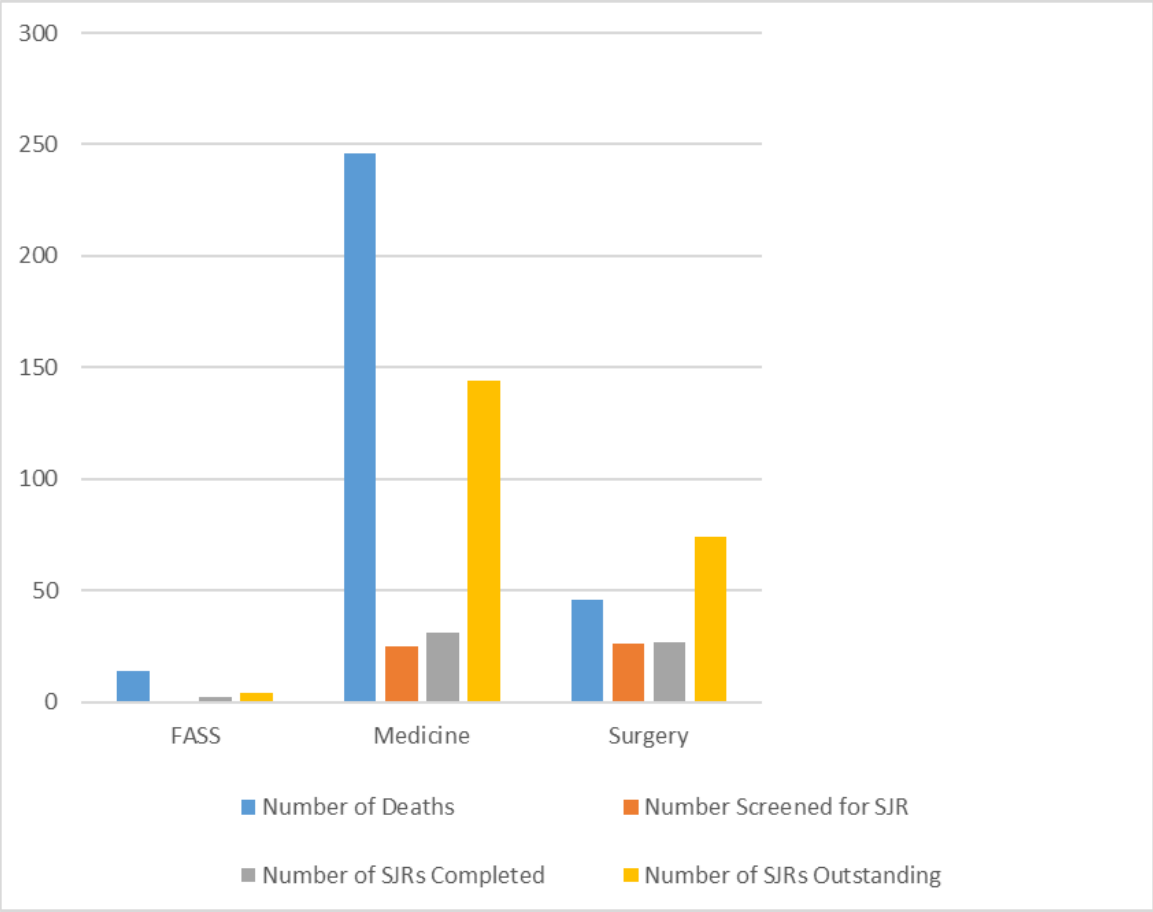


Figure 5: SJR activity by Division

3.0 Learning from Mortality Reviews

3.1 Overall Quality of Care

The table below sets out the ratings of care for each element of an inpatient admission.

Of the SJRs completed during quarter 1, 17 (65%, a decrease from 77%, in Q3 and Q4) assessed the overall care to be either Good (a score of 4) or Very Good (a score of 5).

Rating Type	Average	Number of	Number Of 1s	Number Of 2s	Number Of 3s	Number Of 4s	Number Of 5s
Initial Admission	4.08	26	0	1	5	11	9
Ongoing Care	3.83	23	0	4	3	9	7
Care During	3.83	6	0	0	2	3	1
Return To Theatre		0					
Perioperative Care	3.00	3	0	1	1	1	0
End Of Life	4.09	23	0	1	2	14	6
Overall	3.85	26	0	2	7	10	7
Patient Record	3.76	25	0	1	8	12	4

Table 1: Phase of Care Ratings Quarter 1

Of the SJRs completed during quarter 2, 46 (78%, an increase from 65% in Q1 and 77% in Q3 and Q4 of the previous financial year) assessed the overall care to be either Good (a score of 4) or Very Good (a score of 5).

Rating Type	Average	Number of	Number Of 1s	Number Of 2s	Number Of 3s	Number Of 4s	Number Of 5s
Initial Admission	4.20	59	0	1	8	28	22
Ongoing Care	4.00	49	1	2	11	17	18
Care During	4.05	21	0	0	2	16	3
Return To Theatre	4.00	4	0	0	0	4	0
Perioperative Care	4.06	17	0	0	2	12	3
End Of Life	4.21	43	0	0	7	20	16
Overall	4.03	59	0	2	11	29	17
Patient Record	3.75	59	1	2	25	14	17

Table 2: Phase of Care Ratings in Q2

In both Q1 and Q2 no patients were assessed as having received very poor care overall but there were two findings of poor care. These were the fall, and omission of dalteparin, mentioned in 3.2 below.

The figure below shows the rating of overall care by quarter. The SJRs completed in Q1 recorded a reduction in the overall quality of care but, reassuringly, an improvement has been seen in Q2.

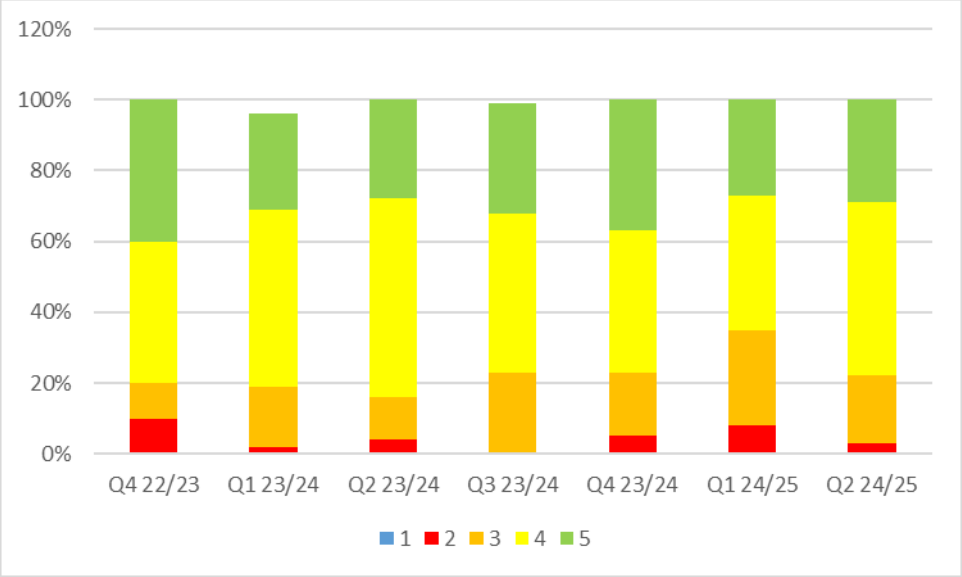


Figure 5: Score Allocated to Overall Care by Quarter

Any specialty receiving a 1 or a 2 will receive a copy of the SJR, even if the patient did not die whilst under their care, or the overall standard of the care during admission was good. This is to ensure that lessons are learnt from every element of care that appears to be substandard, even if it did not ultimately affect the outcome.

3.2 SJRs and Patient Safety Events

Two SJRs completed during Q1 raised queries about the quality of the care the patient received. One to a deteriorating patient and one to a delay in diagnosis. Neither matter had previously been reported on Datix. Both are subject to review by the Surgical Division.

Three SJRs completed during Q2 raised queries about the quality of the care the patient received. Two cases identified concerns related to the quality of care that had already been reported through our normal governance processes. One identified a previously unidentified concern that was reported via datix and is being investigated.

3.3 Emerging Themes

The below shows the most commonly occurring themes arising from completed SJRs. It is important to recognise that in most cases, either no additional learning was identified, or it was recognised that the care delivered was of a good or excellent standard.

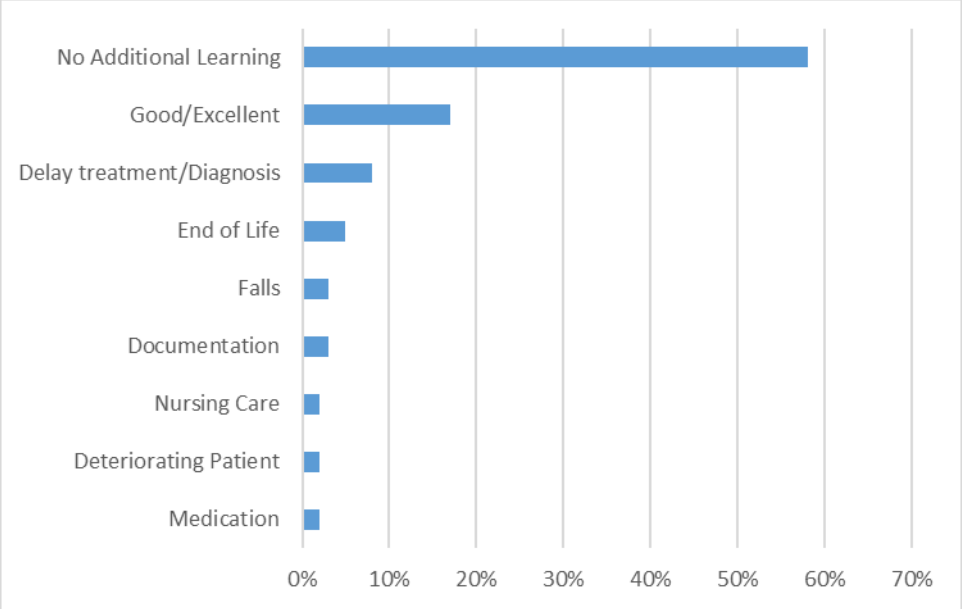


Figure 6: SJR themes

3.3.1 Delay in Treatment/Diagnosis

Five SJRs comment upon delays in treatment or diagnosis. The first comments that greater consideration should have been given to the assessment of other injuries in a patient who was unable to provide a history. A fracture was missed as a result but did not contribute to death. The second that there was an opportunity to surgically intervene at an earlier point although the outcome may not have been changed.

However, the most significant theme is three SJRs state there were delays in securing scans and imaging due to pressures in Radiology

3.3.2 End of Life

Three SJRs comment upon end-of-life care. The first states the community ReSPECT form made it clear that the patient was not for further hospital admissions. The second states an earlier discharge would have allowed the patient's wishes to not die in hospital to be fulfilled. The third states there could have earlier discussions with the family in terms of goals of care and the guarded prognosis.

4.0 Inquests

11 inquests were opened and seven were concluded during Q2, two following an in-person hearing. The Trust did not receive any Regulation 28 Reports.

5.0 Summary

- Hospital mortality remains within expected ranges for both weekday and weekend admissions.
- 78% of SJRs completed in Q2 rated care as either good or very good. This is an increase from 65% in Q1.
- None of the SJRs completed in the first half of the year rated overall care as very poor but there were four findings of poor care (2 in Q1 and 2 in Q2). The findings of poor care have been reviewed through divisional governance.
- There are no new or emerging themes in patient safety or quality from the mortality review process. Issues relating to delays, end of life care, and falls were align with our current patient safety priorities
- There has been a small decrease in the number of outstanding SJRs

Royal United Hospitals Bath
NHS Foundation Trust

Appendix 2: Learning From Deaths

October 2024 to December 2024

This report considers the learning from deaths process, mortality trends and the learning from deaths that has occurred.

1.0 Overview

The number of in-patient deaths in Q3 was 331.

The December Telstra report demonstrates that for July 2023 – September 2024 standardised mortality rates are within the expected range for both weekday and weekend admissions and they benchmark favourably across both BSW system and regional peers.

- Overall HSMR+ 95.6 - within expected range
- Weekday HSMR+ 96.0 - within expected
- Weekend HSMR+ 96.7 - within expected
- SMR+ 92.6 - statistically lower than expected

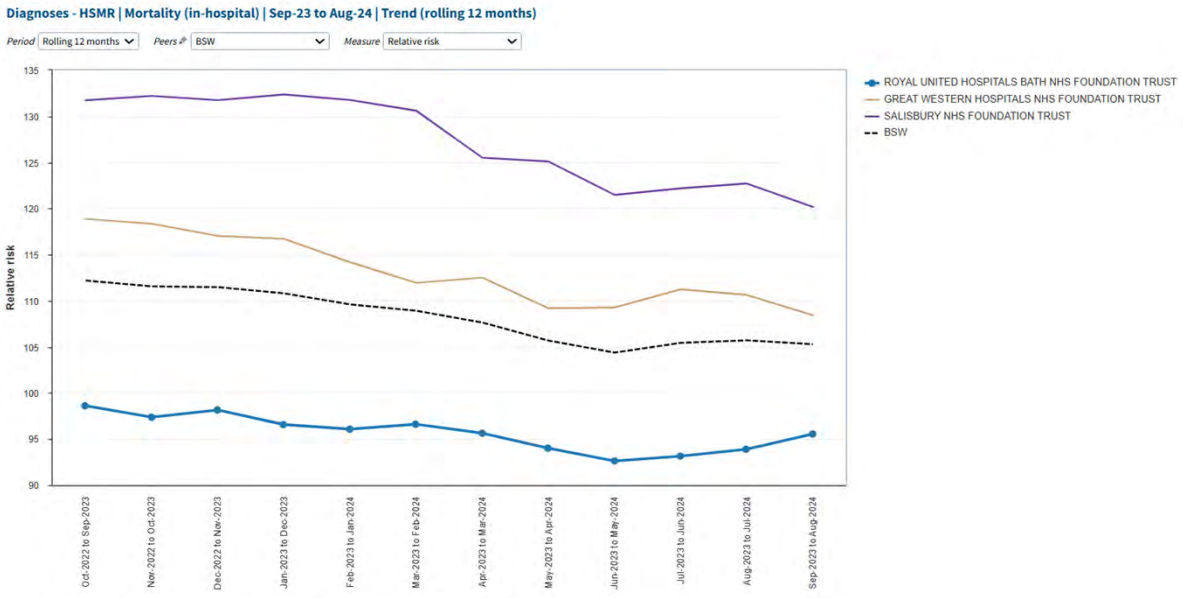


Figure 1: HSMR over time for BSW acute hospitals

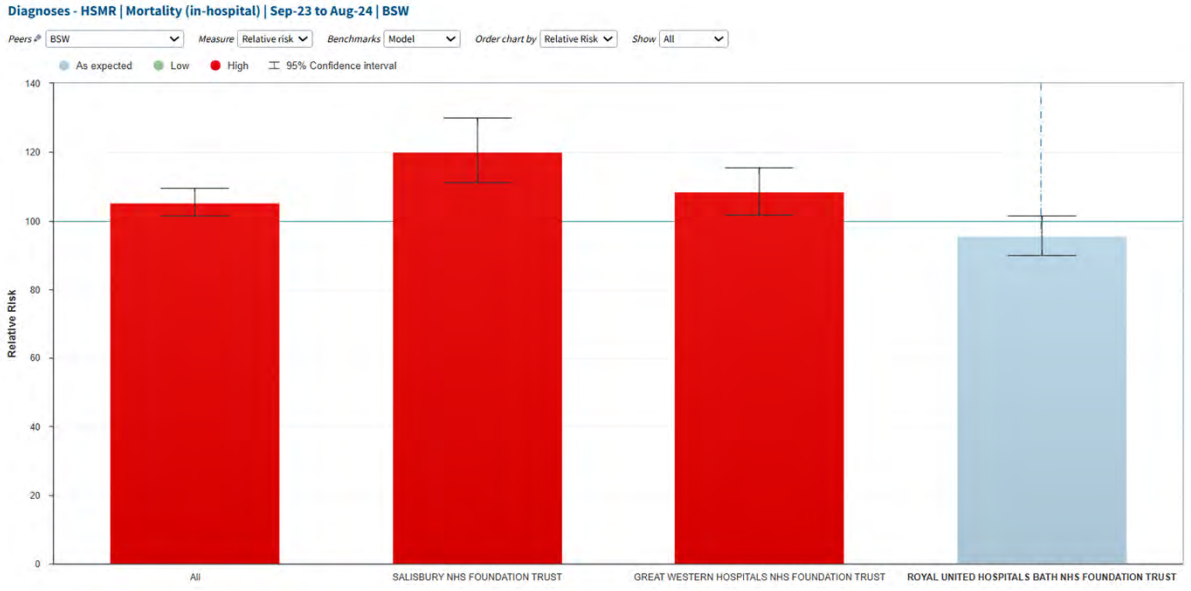


Figure 2: HSMR+ for BSW acute hospitals for period August 23 - September 24

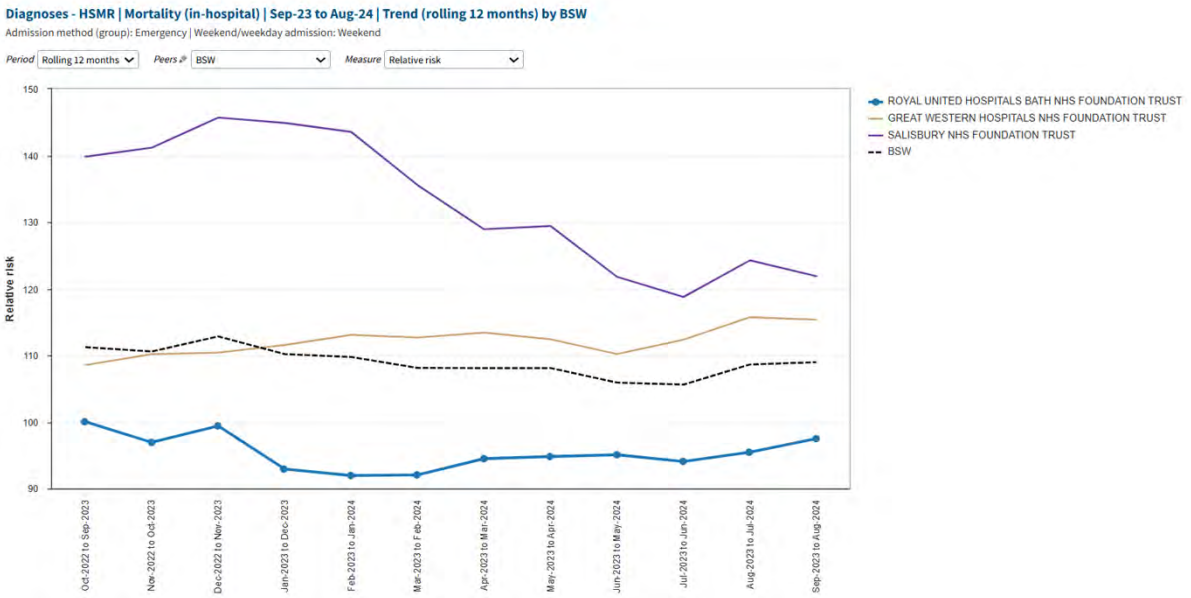


Figure 3: Weekend admission HSMR+ over time for BSW acute hospitals

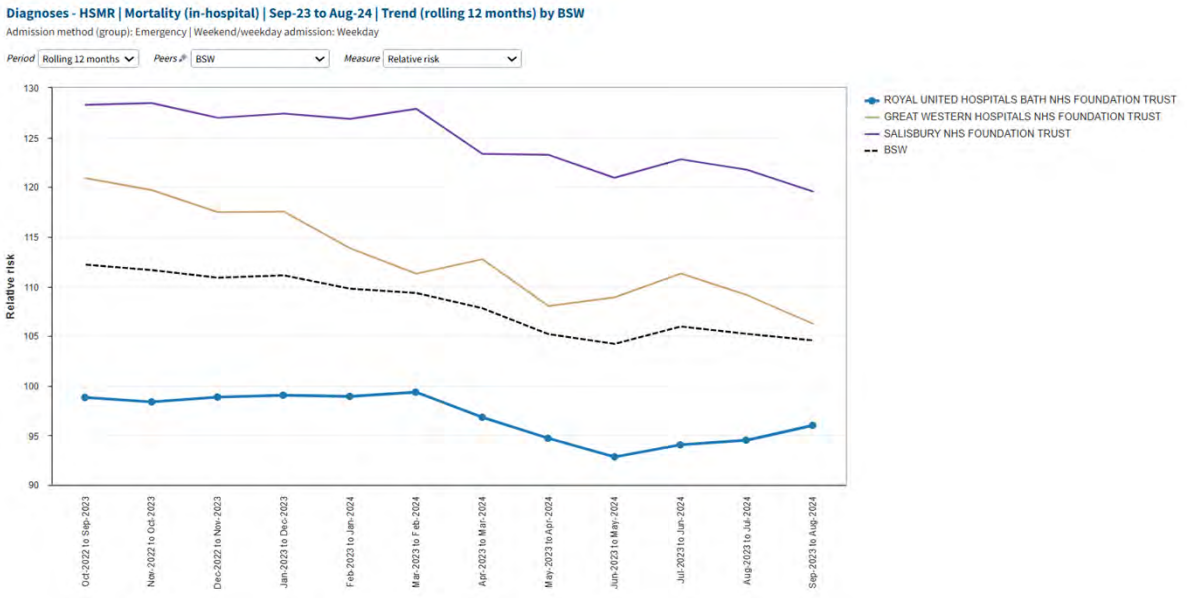


Figure 4: Weekday admission HSMR over time for BSW acute hospitals

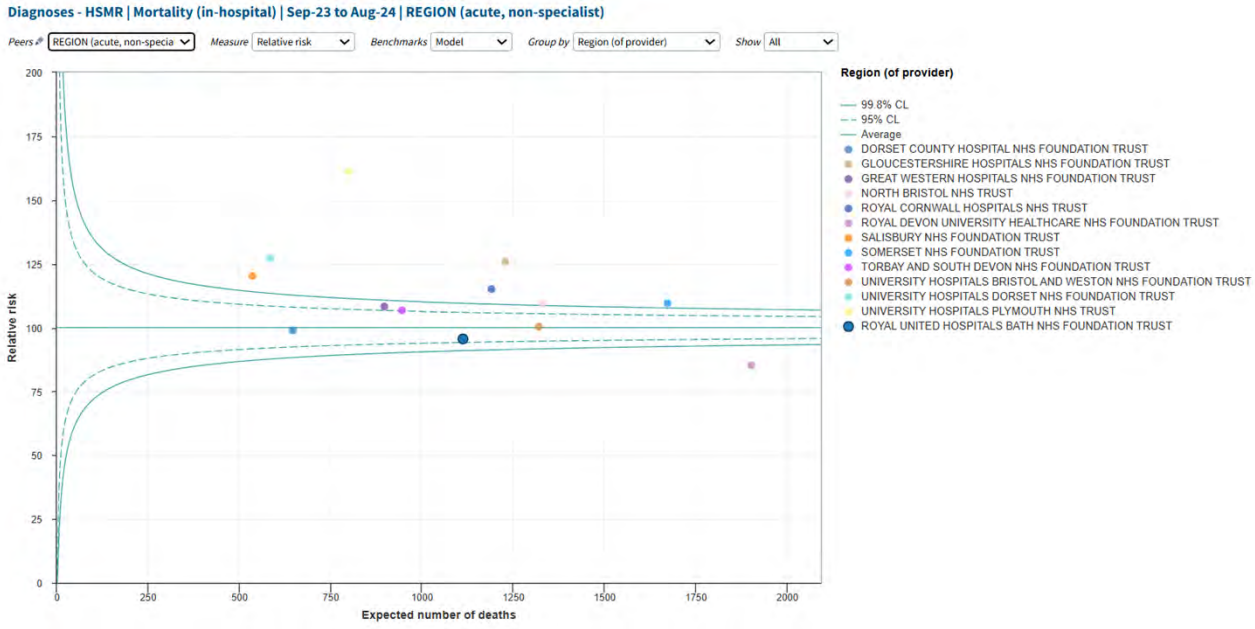


Figure 5: Regional HSMR+ benchmarking for period August 23 - September 24

1.1 Health Inequalities:

Data on health inequalities has been collated using the business intelligence dashboard. The data displayed below is for non-elective admissions between October 2024 and March 2025

1.1.1 CORE 20 - Indices of multiple deprivation

The data suggests that the crude mortality for the CORE 20 most deprived members of our community is greater than the rest of the community (figure 6). This trend is replicated, when broken down by age band; there is signal in the data that suggests the CORE 20 most deprived population have a higher crude mortality in all decades of life than those from less deprived areas (figure 7). The data is replicated regionally and nationally.

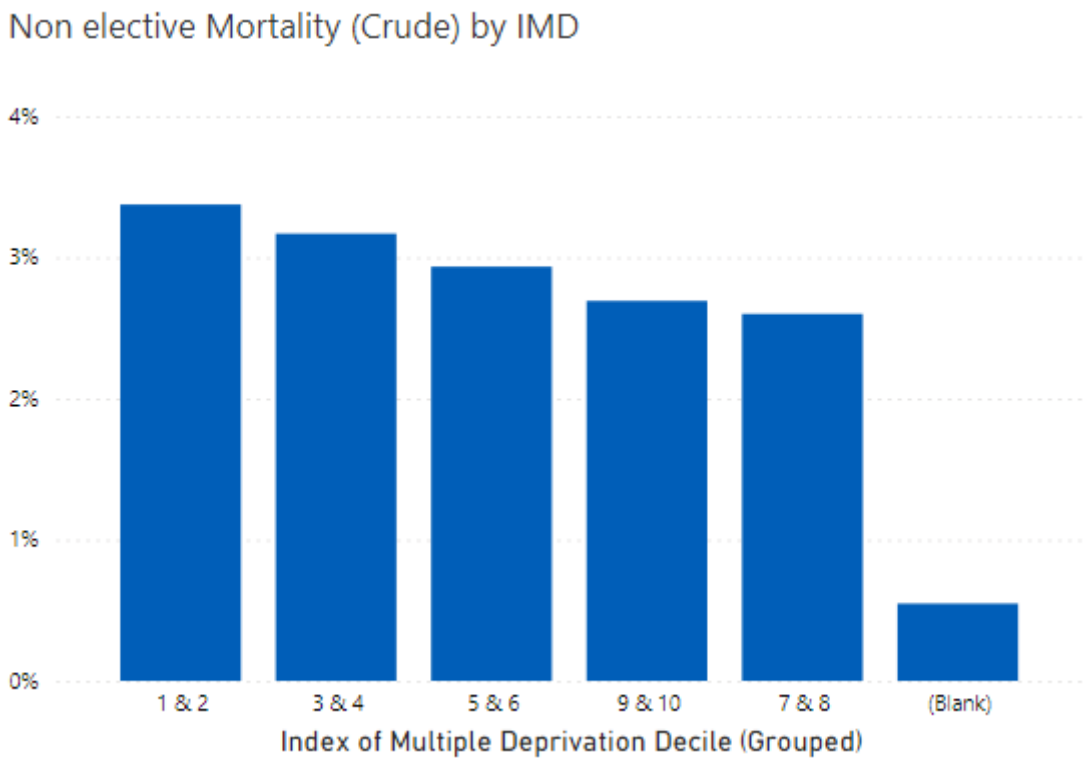


Figure 6: Crude mortality by index of multiple deprivation

Index of Multiple Deprivation Decile (Grouped)	20	30	40	50	60	70	80	90	100	Total
(Blank)					2.0%		2.8%	20.0%		**0.5%**
1 & 2		0.7%		3.1%	2.7%	4.7%	8.7%	10.0%		**3.4%**
3 & 4		0.3%	0.5%	1.1%	2.9%	5.2%	7.7%	9.3%		**3.2%**
5 & 6		0.1%	1.2%	1.8%	1.7%	3.0%	6.8%	8.3%		**2.9%**
7 & 8	0.2%	0.3%	0.6%	1.0%	2.2%	3.2%	4.8%	8.5%		**2.6%**
9 & 10	0.2%			2.2%	1.4%	2.7%	4.9%	8.8%	25.0%	**2.7%**
Total	**0.1%**	**0.2%**	**0.5%**	**1.7%**	**2.0%**	**3.2%**	**5.8%**	**8.8%**	**9.1%**	**2.8%**

Figure 7: Crude mortality by IMD and age band

1.1.2 PLUS - Ethnicity

The data suggests that the crude mortality is consistent across the ethnic groups represented in our community (figure 8). However, when broken down by age band (figure 9) there is signal in the data that suggests that in specific age bands certain ethnic groups have a higher crude mortality. We are undertaking work to understand and benchmark this finding locally and nationally.

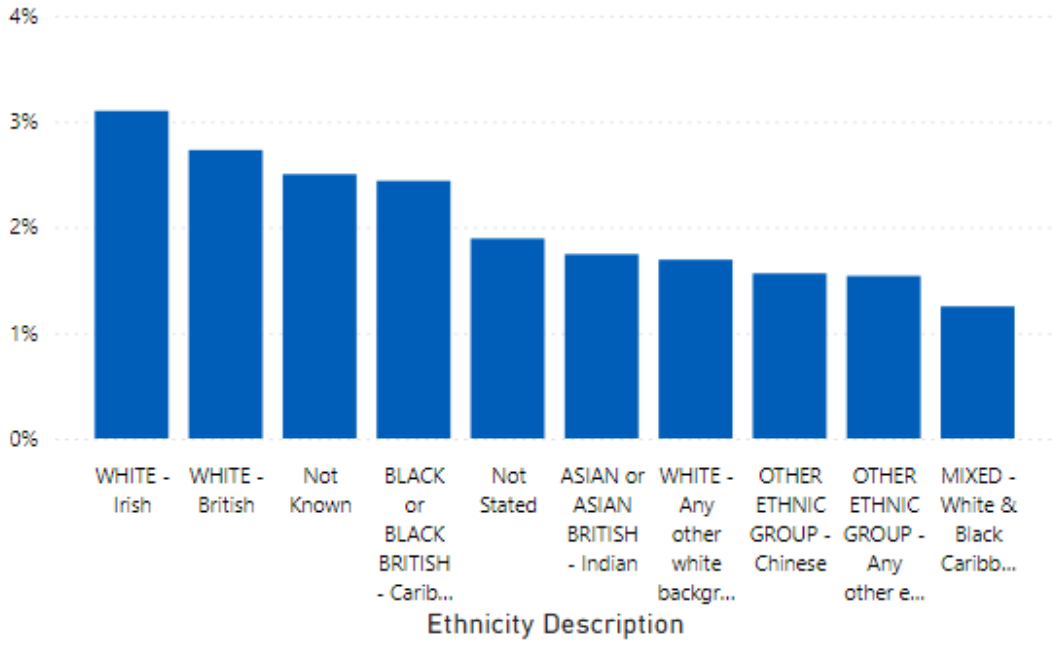


Figure 8: Crude mortality by ethnicity

Ethnicity Description	10	20	30	40	50	60	70	80	90	100	Total
ASIAN or ASIAN BRITISH - Indian						9.1%	6.7%		33.3%		**1.7%**
BLACK or BLACK BRITISH - Caribbean							6.7%	5.9%			**2.4%**
MIXED - White & Black Caribbean					10.0%						**1.3%**
Not Known		1.0%	0.3%	0.9%	1.5%	1.8%	3.3%	3.8%	8.6%		**2.5%**
Not Stated						0.9%		3.7%	12.0%		**1.9%**
OTHER ETHNIC GROUP - Any other ethnic group						4.2%	3.1%	8.3%			**1.5%**
OTHER ETHNIC GROUP - Chinese							33.3%				**1.6%**
WHITE - Any other white background		0.5%		0.6%	1.4%	3.0%	4.5%	5.9%	4.5%		**1.7%**
WHITE - British	0.1%		0.2%	0.4%	1.3%	2.3%	3.1%	5.5%	8.4%	17.4%	**2.7%**
WHITE - Irish						5.6%		6.9%	33.3%		**3.1%**
Total	**0.1%**	**0.1%**	**0.1%**	**0.4%**	**1.3%**	**2.2%**	**3.1%**	**5.3%**	**8.4%**	**15.4%**	**2.6%**

Figure 9: Crude mortality by ethnicity broken down by age band

2.0 Performance of the Mortality Review Process

It is essential that the Mortality Review process occurs in a timely manner. Delays reduce the opportunity for learning from deaths and the risk that timely improvement does not occur resulting in ongoing risks to patient safety and quality.

The performance of the Medical Examiners is considered in greater detail in the quarterly Medical Examiner Office Reports.

2.1 Checklists

At the time of writing this report, there are two outstanding checklists from patients who died in November and December 2024. All others had been completed.

2.2 Screening

The Medical Examiners screen all deaths and a standard proforma is used to ensure consistency in the cases that are selected for SJR. The Medical Examiner Office Report details the performance of the screening process.

2.3 Structured Judgement Reviews

In Q3 13% (n=44) of patients who died during Q3 were selected for SJR, plus 13 patients whose death had occurred during an earlier quarter. Figure 10 demonstrates the selection criteria for those patients who died during Q3. The selection criteria used most frequently was that the patient was a surgical patient (all surgical patients have an SJR) and that the patient's death had been referred to the Coroner.

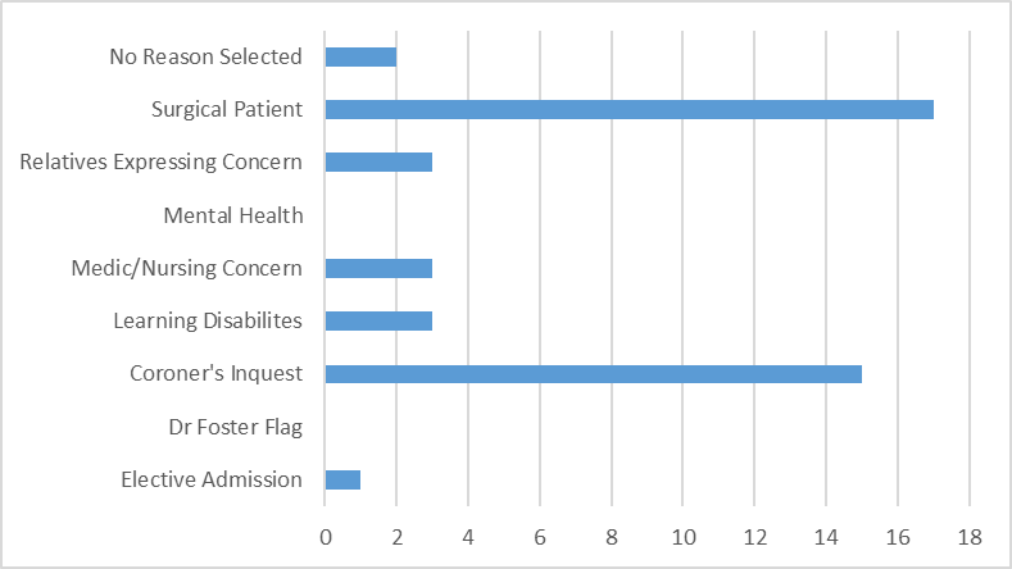


Figure 10: Number of deaths selected for SJR by selection criteria

Figure 11 illustrates the number of SJRs requested per quarter, compared to the number completed and the percentage of SJRs that are completed within two months of the patient's death. The Trust target is to complete 95% of SJRs within 2 months of the death.

Over four of the last five quarters, the number of SJRs completed has exceeded the number requested. A review of the selection criteria has been undertaken and proposals are currently being considered; the likely impact will be to narrow the selection criteria for SJR. The result of this will be to ensure that the SJR process is focused on the greatest opportunity to learn in a timely manner.

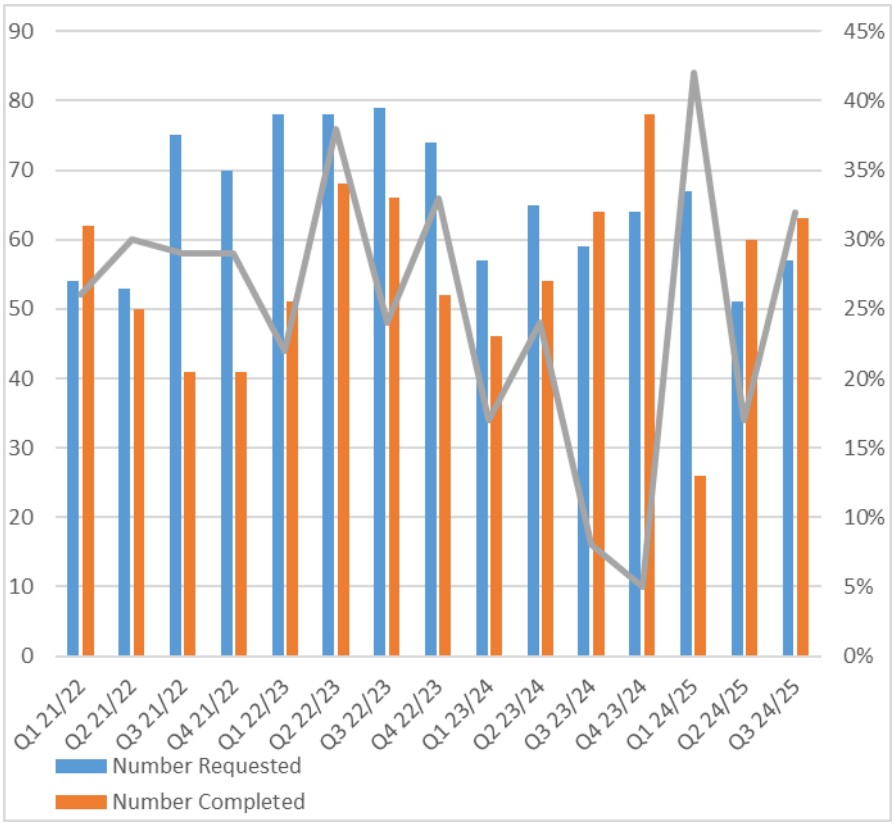


Figure 11: Number of completed SJRs v Number Requested and % completed within two months of the death

Figure 12 shows the number of outstanding SJRs relating to patients who have died since January 2021. Reflecting that the completion rate has begun to exceed the selection rate, a small reduction in the back-log has been seen.

A review of the back-log has been completed and it has been identified that a significant proportion of cases have already been the subject of a detailed view, via another process such as a formal complaint, incident investigation or inquest. It has proposed that these SJRs can be closed as the risk of losing additional learning is small. It has also been recommended that SJRs pre-dating 2024 where the selection criteria is Coroner's Inquest, could also be closed. These proposals were supported by the Quality Assurance Committee (February 2025) and will be enacted prior to the Q4 reporting period concludes.

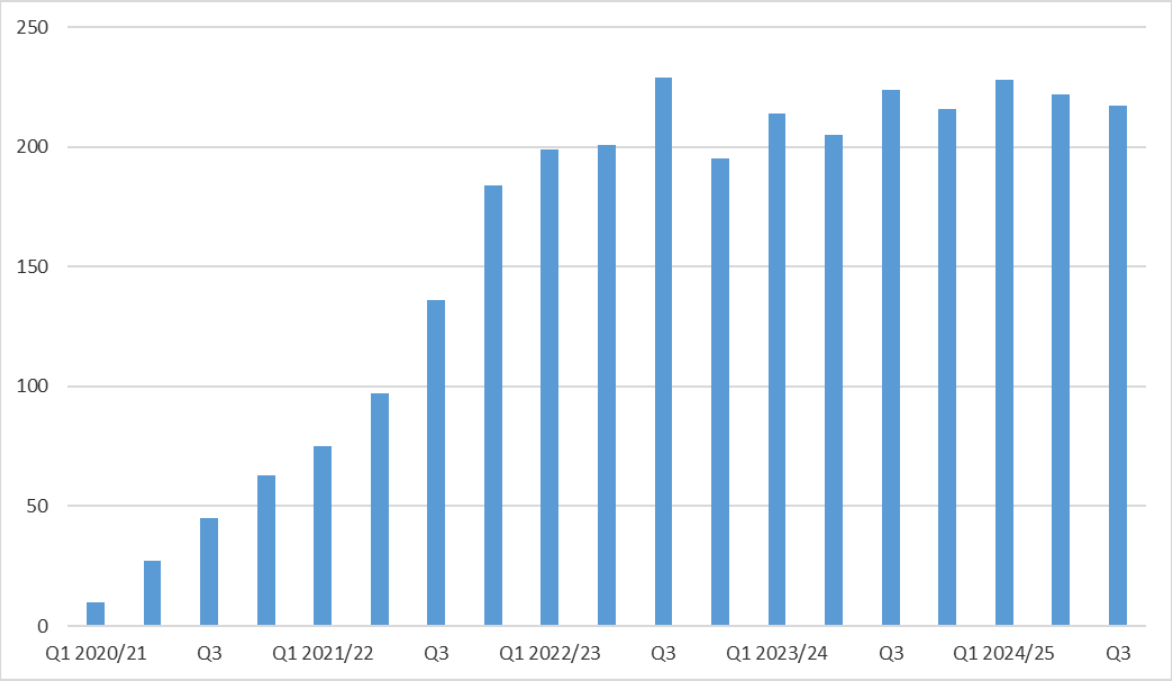


Figure 12: Number of outstanding SJRs

Generally (this is not always possible in FASS due to the smaller nature of the division) SJRs are allocated to a speciality that was not involved in the patient's care. However, surgical patients are reviewed by Surgery; medical patients are reviewed by Medicine etc. Figure 13 below shows the number of deaths within each division during Q3, the number of those patients screened for an SJR within the division, the number completed and the total number of SJRs that remain outstanding. The number of SJRs completed includes those completed during the quarter, regardless of when the patient died. The total number of outstanding SJRs is a rolling total i.e. the number allocated but not completed since January 2021.

The data within the Mortality database shows the speciality the patient was under when they died. It is not possible to differentiate between medical and FASS patients who died on ICU, and surgical patients. In the chart below, these patients have been allocated to Surgery, leading to a probable inflation of their numbers as the number of patients who have died should be the same as the number who have been selected for an SJR.

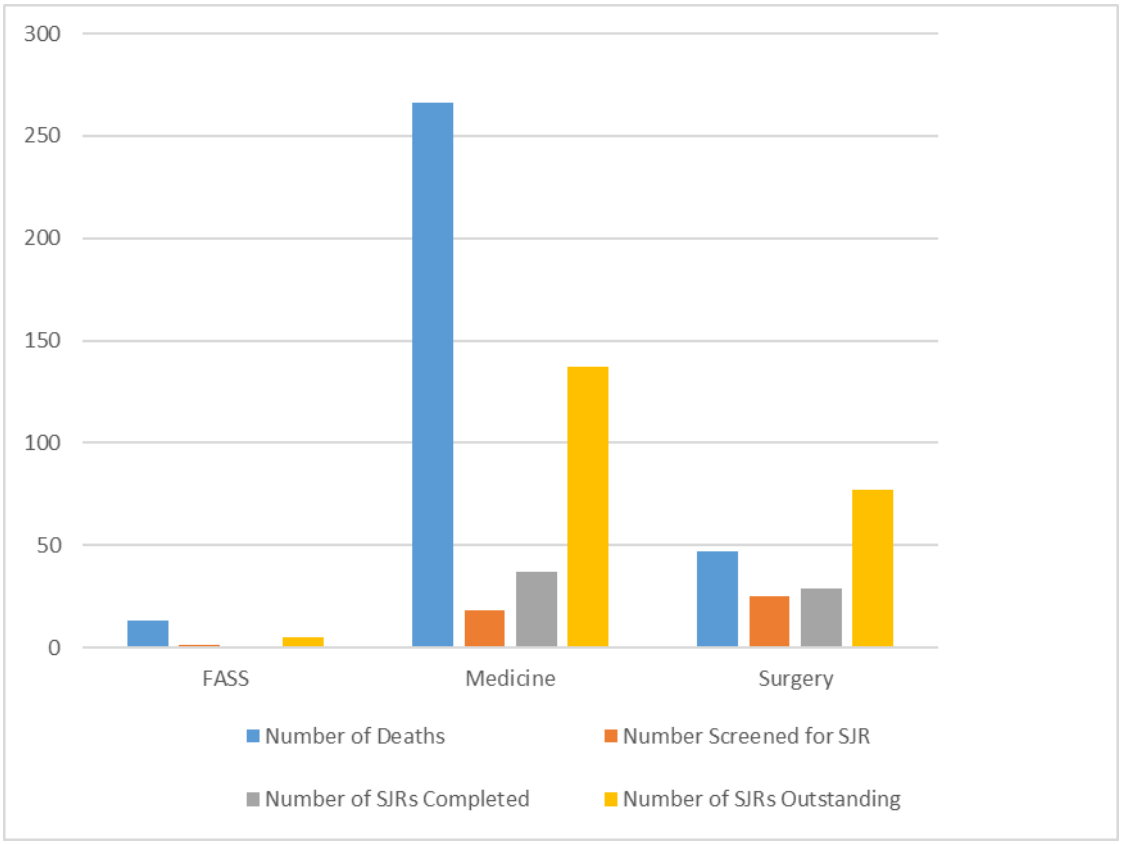


Figure 13: SJR activity by Division

3.0 Learning from Mortality Reviews

3.1 Overall Quality of Care

The table below sets out the ratings of care for each element of an inpatient admission.

Of the SJRs completed during quarter 3, 58 (88%, an increase from 78% in Q2 and 65% in Q1) assessed the overall care to be either Good (a score of 4) or Very Good (a score of 5).

Table 1: Phases of care ratings in Q3

Rating Type	Average	Number of	Number Of 1s	Number Of 2s	Number Of 3s	Number Of 4s	Number Of 5s
Initial Admission	4.24	66	0	2	7	30	27
Ongoing Care	4.31	55	0	1	6	23	25
Care During	4.43	7	0	0	0	4	3
Return To Theatre		0					
Perioperative Care	4.33	3	0	0	0	2	1
End Of Life	4.39	51	0	0	4	23	24
Overall	4.23	66	0	1	7	34	24
Patient Record	4.17	66	0	1	9	34	22

In Q3, no patients were assessed as having received very poor care overall but there was one finding of poor care. This related to a patient who was re-patriated from

another hospital overnight and a decision made to clerk her the following morning. Unfortunately she died before that could take place. The SJR concludes the delay in clerking and review is unlikely to have changed the sad outcome but poor practice on the part of the repatriating and receiving hospital.

Figure 14 below shows the rating of overall care by quarter. The SJRs completed in Q1 recorded a reduction in the overall quality of care but, reassuringly, an improvement has been seen in Q2 and Q3.

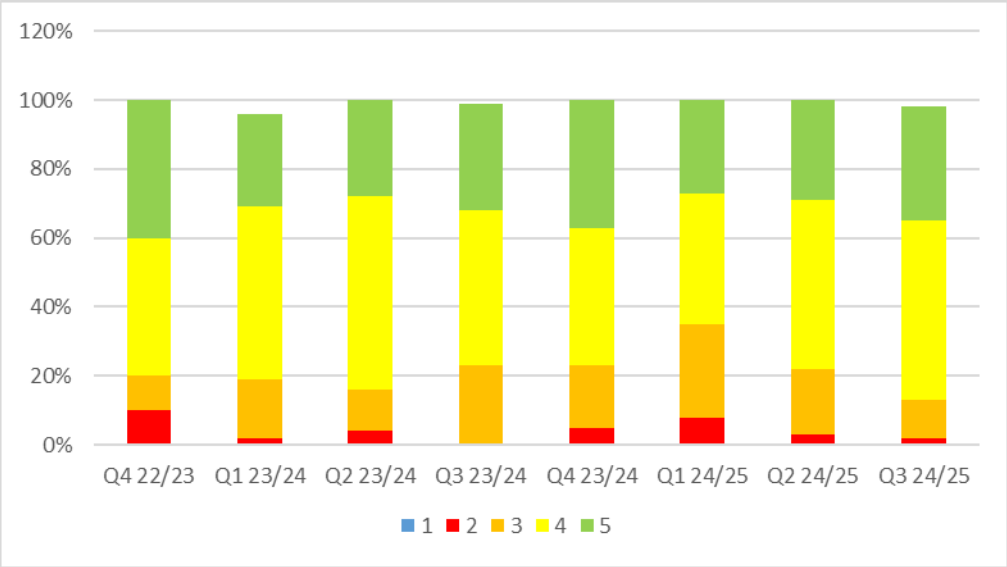


Figure 14: Score allocated to overall care by quarter

Any specialty receiving a 1 or a 2 will receive a copy of the SJR, even if the patient did not die whilst under their care, or the overall standard of the care during admission was good. This is to ensure that lessons are learnt from every element of care that appears to be substandard, even if it did not ultimately affect the outcome.

3.2 SJRs and Patient Safety Events

Two SJRs completed during Q3 raised queries about the quality of the care the patient received. One was the repatriated patient discussed above. The other was a patient who suffered an inpatient fall and died in 2022. The death has been subject of an inquest and a claim; it remains unclear the extent to which the fall contributed to the patient's death.

3.3 Emerging Themes

Figure 15 shows the most commonly occurring themes arising from completed SJRs. It is important to recognise that in most cases, either no additional learning was identified, or it was recognised that the care delivered was of a good or excellent standard.

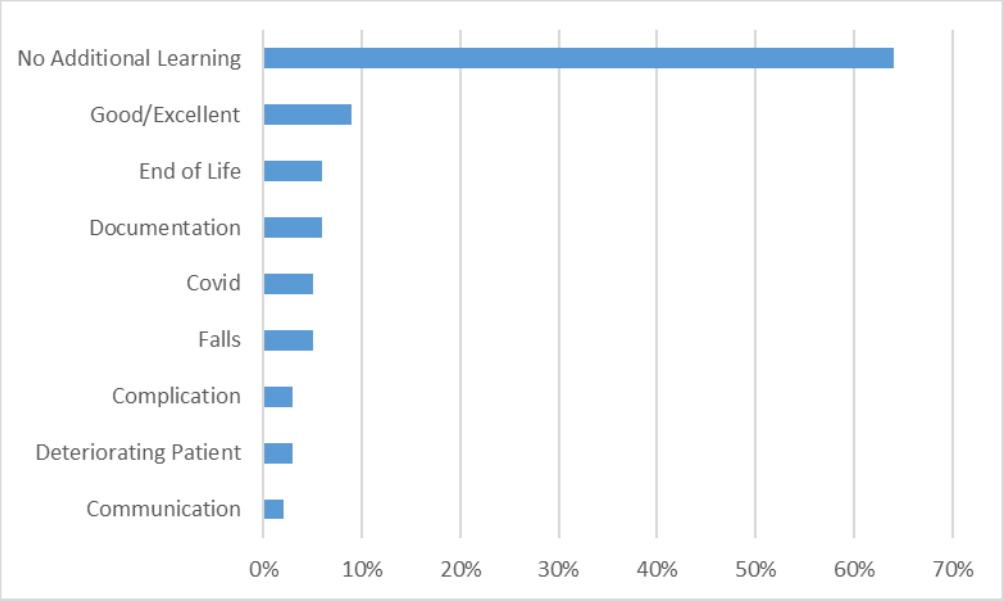


Figure 15: SJR themes

3.3.1 End of Life

Four SJRs make reference to end of life care. Two state that it remains difficult to facilitate patients dying at home or in a hospice setting, rather than in hospital. One states that asking for an ITU opinion when the patient is not suitable for life saving surgery is unnecessary and risks raising false hope. The fourth raises concerns about the lack of a ReSPECT form and that analgesia was inadequate.

3.3.2 Documentation

Four SJRs raised concerns about the quality of documentation; two specifically reference paperless notes. One states that understanding the timeline of the admission was made more difficult by the paperless record and it appeared that some

documentation might be missing (a record of a face to face consultation with the Orthopaedic Surgeon). The second states that the details of who the most senior person on ward rounds was, were missing.

The third states that a lack of documentation by doctors gave the impression (uncertain whether it is a correct or incorrect impression) that a patient had not been medically reviewed for two days. The final SJR comments on the lack of a frailty score being recorded.

3.3.3. Covid
Three patients died as a result of hospital-acquired Covid infection.

4.0 Inquests

15 inquests were opened and one was concluded during Q3. The Trust was not required to attend the in-person hearing. The Trust did not receive any Regulation 28 Reports.

5.0 Summary

Hospital mortality remains within expected ranges for both weekday and weekend admissions.

88% of SJRs completed in Q3 rated care as either good or very good. This is an increase from 78% in Q2.

None of the SJRs completed in the first half of the year rated overall care as very poor but there was one finding of poor care.

Issues relating to end of life, documentation and nosocomial Covid were themes identified resulting in reduced quality care.

There has been a small decrease in the number of outstanding SJRs.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Public Board of Directors	Agenda item:	21
Date of Meeting:	Wednesday 7 May 2025		

Title of Report:	Quality Account 2024/25
Status:	For noting and approval
Board Sponsor:	Antonia Lynch, Chief Nursing Officer
Author:	Jason Lugg, Deputy Chief Nursing Officer
Appendices	None

1. Report

All NHS providers are required by law under the National Health Service (Quality Accounts) Regulations 2010 to produce a Quality Account annually. NHS England no longer publishes guidance for the preparation of the Quality Account and the production of the document has been based on the most recent template in 2019/20.

The Regulations state that Quality Accounts must be published by 30 June each year following the end of the reporting period. By publishing our Quality Account on our website and forwarding the link to NHS England, we fulfil our statutory obligation to submit to the Secretary of State.

Work is underway coordinated by a small task and finish group to produce this year's Quality Account. The working deadline for the first draft of the document is the 28 April. The draft Quality Account will be shared externally with the following partner organisations who will be invited to provide a statement by Friday 30 May:

- Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board
- Bath and North East Somerset (BaNES) Council Overview and Scrutiny Committee
- Wiltshire Council Overview and Scrutiny Committee
- Healthwatch Bath and North East Somerset
- Healthwatch Wiltshire

The proposed timescales for completion and approval of the document are as follows:

- Review and approval at Trust Quality & Safety Group - 26.05.25
- Review and approval at Quality Assurance Committee - 9.06.25
- Presented to Board of Directors - 2.07.25

The Board of Directors are asked to delegate the approval of the publishing of the Quality Accounts 2024/25 to the Quality Assurance Committee.

2. Recommendations (Note, Approve, Discuss)

The Board of Directors asked to note the content of the paper and delegate the approval of the publishing of the Quality Accounts 2024/25 to the Quality Assurance Committee.

3. Legal / Regulatory Implications

The Trust is required to produce an annual quality account by virtue of the National

Health Service (Quality Accounts) Regulations 2010.

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)
None identified.	

5.	Resources Implications (Financial / staffing)
Preparation of the quality account is a joint responsibility between the Corporate and Quality Governance teams.	

6.	Equality and Diversity
There are no identified impact on equality and diversity in this paper.	

7.	References to previous reports
N/A	

8.	Freedom of Information
Private – subject to future publication.	

9.	Sustainability
N/A	

10.	Digital
N/A	

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**22**
Date of Meeting:	**Wednesday 7 May 2025**		
Title of Report:	**Alert, advise and assure report -Quality Assurance Committee**		
Status	**For Information**		
Author	**Simon Harrod, Non-Executive Director**		

Key discussion points and matters to be escalated from the meeting on 15 April 2025

ALERT: Alert to matters that require the Board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy

- There is a potential that a number of patients may have been lost to follow up. Two areas of concern were described:
  - Following a previous incident in surgery were an 'admin pool' or inbox of requests with no completed outcome was found, a recent investigation suggests there is still no robust system in all specialities to triage pools, also not all actions from the incident have been actioned.
  - To be scheduled lists – these are patients who have yet to be added to a waiting list. Again, a concern described that there is no robust triage system in place to monitor. Chris Lafferty, Associate Director of Patient Safety and Quality is seeking further assurance from the divisions.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance

- Mandatory Audits – four are rated red secondary to lack of a clinical lead.
- Limited resource to manage the Patient Safety Incident Response Framework across the Trust.
- Operational issues around flow continue.

ASSURE: Inform the Board where positive assurance has been achieved

- The Committee received assurance around the following areas:
  - Safer staffing across all wards in January.
  - Volunteer recruitment.
  - Q3 Maternal and Neonatal Safety and Quality Report.

RISK: Advise the Board which risks were discussed and if any new risks were identified

- The Committee received an update on the Trust's patient safety and quality risks.14 risks are rated above 15 and there are no new risks. There are many old, tolerated risks with updated mitigations e.g. infection prevention and control risk secondary to the small number of side rooms.

CELEBRATING OUTSTANDING: Share any practice innovation or action that the committee considers to be outstanding

- The Committee celebrated:
  - The development of a paediatric staffing model to support child and adolescent mental health.
  - The personal protective equipment (PPE) App that has been developed.

APPROVALS: Decisions and Approvals made by the Committee

- The Committee approved the terms of reference for the Quality Insight and Improvement Committee.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**23**
Date of Meeting:	**Wednesday 7 May 2025**		
Title of Report:	**Alert, Advise and Assure Report – People Committee**		
Status:	**For discussion**		
Author:	**Paul Fairhurst, Chair of the People Committee**		

Key Discussion Points and Matters to be escalated from the meeting held on 14 April 2025 (postponed from March due to business plan finalisation)

ALERT: Alert to matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy

Pay cost reduction and formation of Group: the Committee met with only Members and Associate Directors present and with a shortened agenda focussed on a number of highly sensitive and confidential matters that remain very fluid. The Committee noted that there is a great deal of work in development across several key areas that are core to the development and delivery of the strategy and delivery of the benefits of Group and the Business Plan.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance

- **Staff Survey (ongoing monitoring):** the Committee discussed the principal and emerging issues including burnout, health and wellbeing, the experience of colleagues in the Emergency Department and the impact on the survey response rates and scores of the removal of paid breaks. The Staff Survey is on the agenda for the May Public Board Meeting.
- **People Plan Refresh (ongoing monitoring):** The Committee discussed a draft of the revised plan, which will be built on three core areas:
    - Change Management: establishing an RUH Change Management Office to build change management capability and resilience; support teams and business lines to adapt to (and seek opportunity within) change; and partner Improving Together and programme management functions to support effective change.
    - Organisational Design: removing barriers to productivity; building sustainable workforce models across Group with friction-free alignment and optimal team / role design.
    - Organisational Effectiveness: development of Leadership and Teams; ensuring safe and inclusive working environments; delivering programmes to ensure staff feel valued, recognised and engaged.

  A workplan will be developed and monitored by the Committee.

ASSURE: Inform the board where positive assurance has been achieved

No items to report.

RISK: Advise the board which risks where discussed and if any new risks were identified.

The Committee discussed several emerging risks related to the formation of Group and the 2025/26 pay bill reduction requirements. These risks will be discussed

between the Chief People Officer and the Corporate Governance Specialist as part of the overall refresh of the Board Assurance Framework.
CELEBRATING OUTSTANDING: Share any practice, innovation or action that the committee considers to be outstanding
No items to report.
APPROVALS: Decisions and Approvals made by the Committee
No approvals or decisions to report.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**24**
Date of Meeting:	**Wednesday 7 May 2025**		

Title of Report:	**You Matter Strategy Quarterly Update Q4 2024/25**
Status:	**For information**
Board Sponsor:	**Joss Foster, Chief Strategic Officer**
Author:	**Fi Abbey, Head of Strategic Projects**
Appendices	**Appendix 1: Q4 2024/25 Strategy Review - final**

1. Executive Summary of the Report

This paper sets out progress made in quarter 4 towards delivery of our You Matter Trust Strategy, including new risks/context and progress against breakthrough goals. The priorities reflect the critical areas of delivery in 2024/25 and are aligned to reflect the Trust's focus on the people we work with, the people we care for and the people in our community.

Overall, good progress continues to be made towards delivery of the strategy in quarter 4 against a context of significant external change including National ambitions for the NHS and our move to a more aligned Group model locally. Where progress has been delayed, this has largely been due to interdependencies with Group planning and capacity constraints.

People we care for

- Reductions in length of stay seen in a number of wards/areas (Forrester Brown, Philip Yeoman, Pierce Ward, Cardiology)
- Significant step change in progress of strategic projects, including the single Intensive Care Unit fully operational and key programmes of work underway (e.g. outpatients and theatres transformation)
- Some areas of work continue to be delayed due to capacity or resource challenges, including identification of funding for some estates work
- Some areas of work are paused to ensure they are fully aligned with Group plans, for example the innovation and communications strategies.

People we work with

- A small percentage improvement in staff not experiencing bullying, harassment or abuse
- Strides have been made in improving experiences for staff with disabilities and long-term conditions, through improved processes, new policies and enhanced support infrastructure
- Positive work continues to support equality, diversity and inclusions with tangible outputs including an expansion in staff network membership
- A small number of programmes including the Basics Matter programme, are delayed due to capacity pressures

People in our community

- Savings of £32.8m were delivered in 2024/25
- Good progress is being made in partnership working with other organisation and in key projects across estates, digital, finance and strategy
- Progress against some of the sustainability projects has been delayed due to vacancy constraints.

The Board is asked to review the emergent risks, context and considerations for each people group in more detail, as well as assessing current performance against our goals.

Progress for each strategic priority will be reviewed as part of the Engine Room process in the Trust Management Executive and, in line with strategic and operational plans for 2025/26, the sunrays will be updated for the coming year. Through this process, projects to continue through 2025/26 will be aligned to the Trust's planning delivery structure and governance.

2.	**Recommendations (Note, Approve, Discuss)**
Board is asked to note the updates against the You Matter Strategy and discuss the emergent risks/context for the three people groups.	

3.	**Legal / Regulatory Implications**
A number of the 2024/25 strategic priorities reflect the Trust's response to national planning guidance such as meeting regulatory performance targets, particularly the timeliness of urgent and emergency care and the continued delivery of our elective recovery plan to reduce waiting times for elective, cancer and diagnostic care. A new ten year health plan has been indicated for release by the Government in Spring as a result of Lord Darzi's report into the NHS. The Financial Improvement Programme priority also reflects the Trust's response to the long-term need to return to financial balance and contribute to the BSW system control total for 2024/25.	

4.	**Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)**
Priorities are indicated as delivered, on track, or off track. Where relevant, key risks to future delivery have also been outlined. Significant context during Q4 include: • **Lord Darzi report** – published in September, the report highlights the major challenges the NHS currently faces and identifies themes expected within the new governments ten year health plan including shifting care closer to home, improving productivity, and unleashing potential of AI. • **Financial balance** – Medium term financial planning to deliver system-wide recovery programme	

- **Group model** – Establishment of a collaborative group operating model between Great Western Hospitals NHS Foundation Trust, Salisbury NHS Foundation Trust and Royal United Hospitals NHS Foundation Trust including Joint Chief Executive and a shared Chair. Transformation and change management will be required to ensure that benefits from the case for collaboration will be realised.

5.	Resources Implications (Financial / staffing)

Scale of ongoing transformation has significant capacity implications to deliver at pace.

6.	Equality and Diversity

The EDI (Equality, Diversity & Inclusion) and Health Inequalities Programmes underpin the Trust's current focus on equality and diversity, for the people we care for, the people we work with and the people in our community.

Key EDI related progress for Q4:

- 30% growth in staff networks
- New EDI newsletter launched
- Celebration of Spring Inclusion week in March
- Neurodiversity Support Group launched
- 150% increase in number of inclusion champions

Risks

- Continued capacity and resource constraints across teams risks delays in progress in this area

7.	References to previous reports/Next steps

Updates presented to Public Board as follows:
Q1 – July 2024, Q2 – November 2024, Q3 – January 2025, Q4 – May 2025

8.	Freedom of Information

Public

9.	Sustainability

Key sustainability related progress for Q3:

- Green Team competition complete, showcasing five projects beneficial for sustainability
- Heat decarbonisation project on track
- National Green Plan guidance published in Feb 2025

Risks:

- Significant capacity constraints in the sustainability team leading to delays in progress; we are working with partner organisations to scope any opportunity for collaborative working to mitigate this risk

10.	Digital
A number of priorities (including Paperless Inpatients Project (PIP), Single Electronic Patient Record (Single EPR) and Recruitment Transformation), aim to embed digital solutions to aid transformation in line with the Trust's Digital Strategy. RUH, SFT and GWH digital leads are working together to progress the adoption and roll out of Artificial Intelligence (AI) technologies.	

Trust Priorities 2024/25

Royal United Hospitals Bath NHS Foundation Trust

The people we care for

The people we work with

The people in our community

Trust goals

- Patient safety incidents (moderate to catastrophic)
- Number of patients over 65 weeks
- Overall patient experience score
- % recommend RUH as a place to work
- % staff say the organisation acts fairly with regard to career progression
- % staff experiencing discrimination at work
- Delivery of breakeven position
- Equity of access to RUH for all
- Carbon emission reduction

Breakthrough goals 24/25

Why not home? Why not now?
Reducing inpatient length of stay top 10% of acute trusts

Discrimination
% of staff reporting they have experienced discrimination at work

Making best use of available resources
Delivery of financial plan

Enabling Breakthrough Goal: We "Improve Together" to make a difference
(measured by the adoption of tools, routines and behaviours of Improving Together via a quarterly maturity assessment)

Trust-wide projects

- **Atrium Redesign**
- **Community Diagnostics Centre (Sulis)**
- **Paperless Inpatients**
- **Quality Governance**
- **Sulis Elective Orthopaedic Centre (SEOC)**
- **Single Intensive Care Unit (ICU)**
- **Basics Matter**
- **Improving Access to Workplace Adjustments**
- **Leadership and Management Framework (and development offer)**
- **Building Change Readiness and Change Management Capability**
- **Restorative, Just and Learning Culture**
- **Violence Prevention and Reduction (VPR) Programme**
- **Health Inequalities Programme**
- **Community Services Tender**
- **Heat Decarbonisation**
- **Financial Improvement Programme** – Clinical productivity, Pay Bill, Income and cost controls
- **Single Electronic Patient Record (EPR)**

2024/25 Highlights

The people we care for

- Increased surgical capacity through Modular Theatre, SEOC and Frome Theatre
- Dyson Cancer Centre, Maternity Day Assessment Unit and one ICU open.
- Paperless inpatients go-live
- Vulnerable People Strategy launched
- CQC 2024 UEC Survey – RUH ED only 1 of 9 Trusts rated 'better than expected in England. Maternity services in top 3% of maternity departments in England

The people we work with

- Basics Matter: Halo launched – vacancies and change of conditions now managed through the system
- External turnover is low across the Trust continuing to be better than the target of 1%
- Introduction of Independent Equality, Diversity and Inclusion Advisors
- Violence, Prevention and Reduction policy launched
- 125 teams (95%) are now running regular Improvement Huddles, enabling staff to raise improvement ideas

The people in our community

- First RUH Community Day and first RUH Sustainability Day
- Decarbonisation of the estate project has commenced to help achieve carbon net zero by 2030
- Health inequalities: new digital inclusion service for patients
- Formation of BSW Hospitals Group
- On track to deliver £36.6m Cost Improvement Programme through driving productivity and reducing costs

Trust Priorities 2024/25

Royal United Hospitals Bath NHS Foundation Trust

The people we care for

The people we work with

The people in our community

Strategic Risks (summarised from the BAF)

Ref	Description	Score
1.1	There is a risk that not meeting internally and externally set standards of quality and safety may result in harm to patients and/or experience below expected.	15
1.2	Increasing demand for both emergency and planned care is exceeding our capacity to treat patients promptly, leading to longer wait times for procedures. This could negatively impact patient outcomes and satisfaction.	16

Ref	Description	Score
2.1	Without fostering a culture of inclusion and actively addressing possible managerial discrimination, we may hinder staff recruitment and retention, expose the Trust to financial and reputational damage, and undermine our ability to deliver the best possible patient care.	16
2.2	Without strong management and leadership development, including succession planning, we risk limiting our ability to transform and innovate, cultivate a positive culture and sustain improvements. This could negatively impact patient care, staff satisfaction, and workforce stability.	20

Ref	Description	Score
3.1	Without delivering the financial plan and ensuring financial accountability across the organisation the Trust may not achieve financial recovery and sustainability, affecting our control to provide safe, appropriate and effective care to our patients.	16
3.2	If Sulis Hospital does not deliver its financial target it may have a direct financial impact to RUH financial position.	16
3.3	Without reducing unwanted variation and addressing inequity of care, people may not receive appropriate levels of care.	16
3.4	Our aging estate with increasing backlog maintenance needs could lead to service disruptions, compromised patient safety, failure to meet regulatory requirements in addition to degrading the experience for patients and staff.	16
3.5	Climate change and its accelerating consequences may threaten the health of patients, staff, and the wider community. Failure to achieve net zero goals and adapt to climate-related risks (e.g., overheating, flooding) may jeopardise the Trust's sustainability, its ability to provide care, and its commitment to future generations.	15
3.6	Insufficient digital capabilities may hinder the Trust's potential to enhance patient and staff experiences, optimise efficiency, and improve overall effectiveness and care delivery	16
3.7	Cyber-security breaches, caused by deliberate malicious acts or inadvertent actions by staff, could result in an inability to use digital platforms, resulting in loss of services and data across the Trust, and in turn causing risk to patients.	16

Emergent risks/context/considerations

Significant changes in NHS England and DHSC, affecting wider picture of how health services will be delivered

Lord Darzi rapid review findings and impact of resultant 10-year Government plan for the NHS

Opportunities and implications of community services procurement to be mobilised in Q3/Q4

Group model opportunities for corporate and clinical services

GP sector disputes creating additional demands on secondary care services and potential for patient impacts

Impact of Trust financial position and changes to staff payment rates impacting elective recovery

NHS financial recovery necessitating actions such as workforce efficiencies, organisational change (including reviewing ways of working), and integrated trust models affecting staff experience and pace of delivery.

Impact of current financial climate, in particular cost of living on the people we work with.

Increased controls and centralisation of approval of recruitment activity and changes to existing contracts increasing. Impacting on ability to adopt user-friendly processes and increased admin pressures across the Trust to deliver this.

Increasing focus of work on change preparedness to ensure we can effectively adapt to the emerging context that we operate in. Resuscitation and clinical skills remains an organisational risk (2791 on risk register). Active work ongoing to skill mix and recruit into posts to address this

RUH financial recovery plan requiring £36.3m efficiency target

The key risks and enablers to achieving this are:

- Any QIPP delivered non-recurrently
- Run rates above budget
- Group model implications on clinical and corporate services
- Capacity to progress partnership and strategic work at pace is limited

Trust Priorities 2024/25

The people we care for

Trust goals

- Patient safety incidents (moderate to catastrophic)
- Number of patients over 65 weeks
- Overall patient experience score

Breakthrough goals 24/25

Why not home? Why not now?
Reducing inpatient length of stay top 10% of acute trusts

Trust-wide projects

- **Atrium Redesign**
- **Community Diagnostics Centre (Sulis)**
- **Paperless Inpatients**
- **Quality Governance**
- **Sulis Elective Orthopaedic Centre (SEOC)**
- **Single Intensive Care Unit (ICU)**

2024/25 deliverables – breakthrough objectives

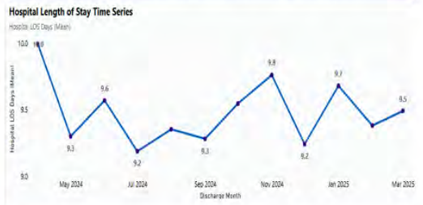
Breakthrough Objective 2024/25 | Reducing Non-Elective Length of Stay | Key Highlights

Why was this a breakthrough objective in 2024/25?

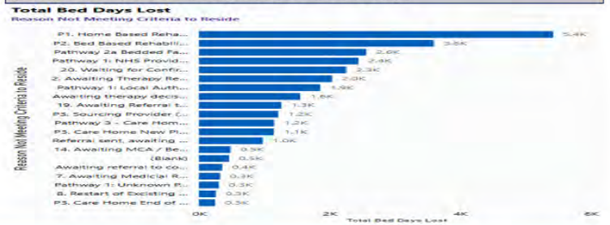
The RUH is currently ranked in the top quartile nationally for LOS but can achieve greater capacity for our patients if we are able to deliver a 7.8% reduction in LOS (top 10 nationally). In practice using model hospital data, we need to reduce our non-elective LOS for adults from 9.34 days (Feb 25) to 8.4 days by the end of March 25. Out two areas of focus needs to be on patients admitted between 7-13 days (we are in third quartile) and weekend discharges (currently 19% of total discharges – unchanged since Dec 24).

Performance in 2024/25

Our total NEL average for 24/25 is 9.48 days (lowest 9.2) [2+ days] and we needed to reduce to 8.4 days.



Non-Criteria to Reside: Patients with a LOS of 7-13 days and not meeting C2R, top 3 hospital-related bed days have been lost due to waits for Therapy Review, CTH decision delays (likely poor quality ref's) or ward discharge referral submission delays.



Outcomes achieved

2024 focused on new co-developed in-hospital flow and discharge standard work:
- ✓ Deployment & education on tools, SOPs/Policies to support Flow, and ultimately improve LOS.
- ✓ Rapid and intensive 121 deployment on tools and processes across all wards, supported by UEC improvement team until Nov 24.
- ✓ Flow & Discharge Co-ordinators and IDS rapidly trained in all new standard work.

By end of March 2025:
- ✓ Restarted revised UEC Improvement Programme ('6 Pillar workstreams') to drive required areas of focused improvement (achieve > Q3 2024 perf.)
- ✓ Further work commenced to ensure wards are optimally supported to make timely (within 24 hrs of need to do so) and accurate discharge referrals using latest BSW form (V5 Jan 25).
- ✓ Ensure CTH metrics are being manually reported and met - % referrals responded to within 2 hrs of receipt/Number of validated (agreed) referrals per day by pathway - RUH_SOP_Management_of_the_Care_Transfer_Hub.pdf
- ✓ Continue to embed whiteboard standardization, afternoon huddles and therapy pathway 0 referral criteria across all wards to proactively identify and reduce hospital-related discharge delays (Aim for <5 end of each day).

Benefits realised

- ✓ % discharge by midday – April 24 was 19%, lowest in August at 16%, and March 25 increased to 23% (further early discharge 'push' with wards March 25)
- ✓ Discharge Lounge daily activity 25-35 M-F in April-June 24; >40 for last 2 weeks March 25 (Discharge lounge push with wards, including mandating suitability question in Millenium, and identification of KPI/new report to indicate afternoon huddle conducted on wards
- ✓ Cardiology LOS 9.8 July 24; reduced to 6.6 March 25
- ✓ Respiratory LOS largely unchanged (6.7 April 24 and March 25)
- ✓ Neuro (Helena ward) LOS 12.4 April 24; increased to 14.3 March 25
- ✓ T&O (Forrester Brown, Phillip Yeoman and Pierce ward) LOS 9.4 June 24, 10.0 Feb 25 and reduced to 8.6 March 25

Trust Priorities 2024/25

The people we care for

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2024/25 deliverables – strategic objectives

Delivered

Paperless Inpatients
- Continuing in benefits realisation

Single Intensive Care Unit
- Now open and fully operational

Vulnerable People Strategy
- Internal launch complete

Community Diagnostics Centre
- In use, currently in handover period

On track

Sulis Elective Orthopaedic Centre
- Works ongoing with completion planned for May 2025

Website
- Work to complete new website in Q1 25/26 underway

Outpatients
- Key themes identified: demand and referral management, scheduling, specialty specific plans, AI coding
- Deep dives for scheduling complete for each specialty
- Moving specialties to electronic triage using ERS (referral management system)

Theatres and elective productivity
- On track to deliver income forecasts for Month 12
- Main focus is on maximizing efficiency and productivity

Off track/Paused

Quality Governance
- Delays with some milestones (process mapping and training for risk management, quality data,)
- These should recover in Q1 25/26 and not negatively impact overall project timescales

PAW Fire Improvement Works
- Underway but initially delayed with plans for work to continue in Spring/Summer 2025

Infection Prevention and Control Programme
- On hold pending availability of funding

Improved signage
- On hold pending availability of capacity and funding

UEC Programme
- Complexity of interdependent factors affecting delivery

Comms strategy
- Updated strategy to be signed off pending Group alignment.

Atrium Redesign
- Planning for redesign in progress but off track due to resource constraints
- Small improvements completed (e.g. new café chairs and information screen)
- Other improvements ongoing (e.g. updating maps and signposting).

Innovation Strategy
- Paused pending group alignment

The people we care for

Together, we will support you as and when you need us most

2024-25

- Paperless Inpatients
- Vulnerable people strategy
- Atrium improvement
- Quality Governance
- Infection control programme including estates plan
- Patient Experience: Customer Care standards, patient representation, and improved signage

2025-26

- Patient safety programme – year 3
- Integrated digital and health and social care systems
- Training and skills to work with different patient groups
- Infection control programme including estates plan
- Integrated digital and health and social care systems

- Care closer to home model established
- Alongside Midwifery Unit complete
- Collaborative relationship with primary care creating integrated models
- Integrated nursing home model with ART+
- Lower GI hub

- Patient portal with digital bookings

- Dyson Cancer Centre & DAU completion
- One ICU
- Research strategy

- Outpatient & theatre transformation
- Service integration with key community services
- Further development of CDC
- Elective productivity
- Urgent emergency care improvement
- Sulis Elective Orthopaedic Centre

- Innovation strategy
- Critical infrastructure risk reduction (fire safety)

- Further development of DrDoctor
- New website
- Communication strategy

Connecting with you, helping you feel safe, cared about and always welcome

Consistently delivering the highest quality healthcare and outcomes

Communicating well, listening and acting on what matters most to you

Trust Priorities 2024/25

The people we work with

Trust goals

- % recommend RUH as a place to work
- % staff say the organisation acts fairly with regard to career progression
- % staff experiencing discrimination at work

Breakthrough goals 24/25

Discrimination
% of staff reporting they have experienced discrimination at work

Trust-wide projects

- **Basics Matter**
- **Improving Access to Workplace Adjustments**
- **Leadership and Management Framework (and development offer)**
- **Building Change Readiness and Change Management Capability**
- **Restorative, Just and Learning Culture**
- **Violence Prevention and Reduction (VPR) Programme**

2024/25 deliverables – breakthrough objectives

How are we reducing instances of bullying, harassment, abuse and discrimination?

Report + Support

#YOUR VOICE WILL BE HEARD

Freedom to Speak Up

Freedom to Speak Up

Staff networks and support groups

Inclusion Champions

Learn Together

Plus…

- Violence Prevention and Reduction Policy
- Anti-racism commitments
- Development programmes for global majority colleagues

There has been a small increase in % of staff not experiencing bullying, harassment or abuse since 2024

NHS Staff Survey results 2025

Percentage not experiencing bullying, harassment and abuse

- From patients and public – 74% compared to 73% in 2024, and 72% in 2021
- From colleagues – 82%, up from 80% in 2024.
- From managers – 92% up from 90% in 2024.

Percentage not experiencing discrimination

- From patients and public – 89% steadily declining over the last 4 years
- From manager, team leader or other colleagues - 92% (fairly stable)

Our 2024/25 focus was on improving experiences for people with disabilities and long-term conditions, which has included:

- commissioning an internal estates accessibility audit,
- making significant improvements to our workplace adjustments process,
- amending our attendance/ sickness support infrastructure , and
- Designing a new support package and policy for colleagues working with cancer

Trust Priorities 2024/25

The people we work with

Trust goals

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Breakthrough goals 24/25

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% of staff reporting they have experienced discrimination at work

Trust-wide projects

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- **Violence Prevention and Reduction (VPR) Programme**

2024/25 deliverables – strategic objectives

Delivered

Violence Prevention and Reduction (VPR) Programme

- Since policy launched in August 2024, over 125 staff members across 10 wards have been trained

Halo self service portal

- Launched in February 2025 to deliver more efficient processes for responding to staff queries in relation to Digital and People
- Further staged implementation will continue with increasing functionality throughout 2025/2026.

Improving Together

- Deployed in 100% of targeted frontline teams

Pay cost reduction

- £17m savings made in 24/25 through vacancy savings and reduction in agency spend

On track

Equality, Diversity and Inclusion

- Continuing to grow staff networks (30% expansion on 24/25)
- New EDI newsletter published
- Celebrated Spring Inclusion Week in March
- Neurodiversity Support Group launched
- 150% increase in number of inclusion champions

Policies

- Working with Cancer policy and Workplace Adjustments Policy to be launched

Off track/Paused

Calderdale workforce planning

- Calderdale workforce planning is constrained by capacity pressures

Basics Matter

- Delayed due to resourcing
- Market engagement underway for the gym tender
- Atrium improvements underway
- Funding secured for parasols for onsite picnic tables

The people we work with

Together, we will create the conditions to perform at our best

Demonstrating our shared values with kindness, civility and respect

2024/25

- People Plan – Programme 2 (Restorative Just and Learning Culture),
- Programme 3 (Employee Experience, incorporating Violence against Staff),
- Programme 6 – Wellbeing (incorporating burnout)
- Programme 10 – Talent Acquisition (incorporating new staff programme and employee value proposition)

- People Plan – Programme 1 (Basics Matter year 2) Digital People Hub – easy to use, reduce pay errors, improved food offer, improved employee rest areas, residential accommodation gym/health/wellbeing campus offer)
- Programme 5 – (Leadership development, change management training)
- Programme 7 (Learning and Development – competency frameworks and clinical skills).
- Programme 8 – Workforce Planning (apprenticeships and role definition / skill mix / career pathways, scope for growth).

Taking care of and investing in teams, training and facilities to maximise potential

2025/26

- Refresh RUH People Plan staff engagement programmes
- Sexual safety policy and programme
- Review Recognition Protocols
- Restorative, Just and Learning Culture

- Self-service team engagement and development platform
- Renewed Management and Leadership Programme
- Embedding Improving Together into People Functions

- People Plan Programme 4 – EDI
- Introduce cultural intelligence module,
- Continue positive action programme
- Race, Disability, Equality board development
- Develop and roll out ally-ship programme
- Improve reach and impact of Staff Networks
- Anti-Racist Organisation
- Flexible/Agile Working programme
- Commence Disability inclusive programme
- Race and disability pay gap analysis and actions

- Consolidate, review and enhance interventions under Programme 4 (EDI)
- Focus on high-impact accessibility projects (disability and LTC, workplace adjustments)

Celebrating our diversity and passion to make a difference

Trust Priorities 2024/25

The people in our community

Trust goals

- Delivery of breakeven position
- Equity of access to RUH for all
- Carbon emission reduction

Breakthrough goals 24/25

Making best use of available resources
Delivery of financial plan

Trust-wide projects

- **Health Inequalities Programme**
- **Community Services Tender**
- **Heat Decarbonisation**
- **Financial Improvement Programme** – Clinical productivity, Pay Bill, Income and cost controls
- **Single Electronic Patient Record (EPR)**

2024/25 deliverables – breakthrough objectives

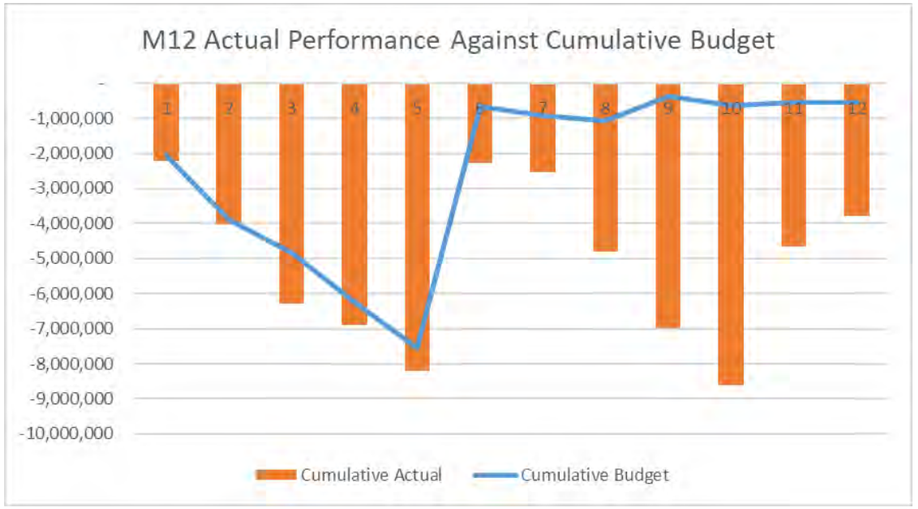
The financial environment is challenging with costs, notably workforce costs, having increased since the pandemic and the NHS funding regime returning to its pre-pandemic levels.

The financial plan for the year required full delivery of a £36.6m Savings Programme, which was phased to recognise progressive reduction in costs and increases in income over the year. Delivery of this plan has been supported by an Improvement Programme with 3 workstreams focussing on (1) Clinical Operational Service Transformation (2) Paybill Reduction and (3) Cost Control and Commercial Income

- At Month 12: the Group finished the year at a deficit position of £4.2 million, which is £4.2 million adverse to the breakeven plan
- Savings of £32.8m have been delivered (89.5% of annual target), including £17.0m of pay savings against budget, and the benefit of Elective Recovery Fund Income and operating margin of 57%.

Savings were achieved predominantly through:

- Coding initiatives
- Vacancy Gap savings
- Ward 4 pay & non pay savings
- Paid break pay savings
- Reduction in agency/overtime
- Procurement and medicine savings
- Theatres
- Release of annual leave accrual
- Pay efficiencies from Paperless Inpatient Project
- Increased elective productivity
- Corporate pay savings



Trust Priorities 2024/25

The people in our community

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Breakthrough goals 24/25

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Delivery of financial plan

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- **Financial Improvement Programme** – Clinical productivity, Pay Bill, Income and cost controls
- **Single Electronic Patient Record (EPR)**

2024/25 deliverables – strategic objectives

Delivered

Sustainability Green Team Competition
- Competition complete with five beneficial projects showcased

Financial Improvement Programme
- £35.8m delivered (M11) out of £36m efficiency target

On track

Heat decarbonisation
- Project remains on track for completion by March 2026

Community site review
- Underway to look at opportunities to maximise use of community sites

Community and Anchor
- Working with Civic Partners to scope and deliver joint schemes

Single EPR
- Continued work towards go-live date

AI Programme
- Planning underway to launch Copilot across three Group Trusts

Corporate Service Review
- RUH plans to review corporate functions underway as part of the Group Corporate Redesign Programme

Community Day
- Planning for 25/26 Community Day commenced after success of the first RUH Community Day in 2024

Off track/Paused

Green Plan
- Greener NHS published Green Plan guidance in Feb 2025
- Vacancy constraints affecting capacity to refresh RUH Green Plan in line with national guidance

Sustainability Steering Group
- Launch delayed due to capacity constraints

Working with partners to make the most of shared resources to plan wisely for future needs

2024/25

- Maximise utilisation of Frome asset
- Productivity improvements
- Increased recurrent QIPP delivery
- Shared EPR
- Group transformation and joint planning
- Standard work
- Efficient Corporate services

2025/26

- Innovative ideas shared across the Trust & TME
- Clinical services plan delivering savings
- Embedded opportunities to projects approach
- Deficit reduction

The people in our community

Together, we will create one of the healthiest places to live and work

- Health inequalities programme – year 3
- Population health data integrated digital H&SC
- RUH as an anchor organisation
- Target areas for promoting careers

- De-carbonisation of buildings project – LED lighting, de-steam & fabric improvements
- Sustainability risk assessment embedded in decision-making
- Climate adaptation planning workstream established
- New provider for community services in place

- Health inequalities programme – year 2
- Bespoke access of care
- Support vulnerable community members Core20plus5, smoking and digital programmes
- Anchor organisation strategy & delivery plan

- Decarbonisation of buildings project
- Carbon awareness & competency training programme & stakeholder engagement plan
- Sustainability risk assessment created
- Sustainability network established
- Community services mobilisation
- Continue to develop services off site/ Frome

Taking positive action to reduce health inequalities

Creating a community that promotes the wellbeing of our people and environment

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**25**
Date of Meeting:	**Wednesday 7 May 2025**		
Title of Report:	**Alert, Advise and Assure Report – Joint Finance and Performance Committee**		
Status:	**For information**		
Author:	**Antony Durbacz, Non-Executive Director**		

Key Discussion Points and Matters to be escalated from the meeting held on 30/04/25

ALERT: Alert to matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy

- The plans to support the 2025/26 Cost Improvement Programme (CIP) remains very much work in progress. So much so that they have not been incorporated into the relevant divisional budgets. In the absence of defined budgets, the largest part of the CIP program must be considered to be at significant risk. Notwithstanding the considerable effort in this area this formalising of the plans needs immediate action
- Given the change in policy of the NHS in supporting cashflow deficits at trusts there is a significant risk that the trust may run out of cash. This mitigation of this risk is dependent on realising the CIP savings.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance

- The procurement plan for 2025/26 was shared with the committee, and a discussion on the effectiveness of procurement as a vanguard in group working. There is significant learning that should be shared as other group functions are established.
- As the board will be aware the performance in A&E was very disappointing which led to significant debate on the forward remedies. Clearly this will be kept under review.
- The committee recommends that the Busi plan for summary document "the plan in numbers "is adopted by the board as the primary monitoring tool for performance

ASSURE: Inform the board where positive assurance has been achieved

- The draft 2024/25 were presented and it was confirmed they reconciled to the underlying management accounts. The Audit committee will undertake further work.
- Given the importance of non-criteria to reside in the 25/26, the committee were cheered by the positive feedback in the developing relationship with HCRG. Although its early days this was encouraging.

RISK: Advise the board which risks where discussed and if any new risks were identified.

- There were no new risks identified.

CELEBRATING OUTSTANDING: Share any practice, innovation or action that the committee considers to be outstanding
• No items to report.
APPROVALS: Decisions and Approvals made by the Committee
• The interventional cardiology consumables purchasing proposal was approved. • Acting on delegated authority the committee approved the resubmission of the Trusts annual business plan which included amendments to referral to treatment targets (with some additional funding), and ambulance handover target times

The Board is asked to NOTE the content of the report.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**26**
Date of Meeting:	**Wednesday 7 May 2025**		
Title of Report:	**Alert, Advise and Assure Report – Audit & Risk Committee**		
Status:	**For information**		
Author:	**Paul Fox, Non-Executive Director**		

Key Discussion Points and Matters to be escalated from the meeting held on 13 March 2025

ALERT: Alert to matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy

- The Committee was informed by the Internal Auditor that they were minded to give a 'Partial Assurance' opinion which would need to be referenced in the published Annual Report (Annual Governance Statement), on account of their understanding that insufficient of the key actions had been implemented. The Chief of Staff has been tasked with following up on these actions. A verbal update in relation to this will be given at the Board meeting.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance

- The above alert relates to the need to urgently close the key Internal Audit Actions arising from the following reports:
  - Health and Safety Incident Management
  - Sustainability Reporting
  - Financial Controls (Pay Controls)

ASSURE: Inform the board where positive assurance has been achieved

- The Internal Audit report on Patient Consent was given an assurance rating of 'Significant Assurance with minor improvement opportunities', or amber / green.
- The Local Counter-Fraud Service report on Reporting Culture identified that the Trust has high levels of reporting for freedom to speak up when compared to comparable Trusts, showing staff are aware of how to speak up and feel empowered to do so. It also identified a timely incident reporting and a relatively high level of fraud referrals.
- The Committee was satisfied with progress in relation to the annual accounts on the part of both the External Auditors and the internal finance function.

RISK: Advise the board which risks where discussed and if any new risks were identified.

- No new risks were identified

CELEBRATING OUTSTANDING: Share any practice, innovation or action that the committee considers to be outstanding

- The Committee was pleased that the Counter Fraud advice to staff included advice in relation to their own circumstances as well as that of the Trust.

APPROVALS: Decisions and Approvals made by the Committee
• The Committee approved the recommended accounting policies and in particular the basis on which management would make judgements, estimates and assumptions as set out in the paper. • The Committee approved the Internal Audit Plan for 2025/26, welcoming the inclusion of joint reviews across the 3 hospitals in the Group.

The Board is asked to NOTE the content of the report.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**27**
Date of Meeting:	**Wednesday 7 May 2025**		
Title of Report:	**Alert, Advise, and Assure Report - Non-Clinical Governance Committee (NCGC)**		
Status	**For information**		
Author	**Sumita Hutchison, Non-Executive Director**		

Key discussion points and matters to be escalated from the meeting

ALERT: Alert to matters that require the Board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy

Electronic Patient Record (EPR): NCGC received a report from EPR Joint Committee highlighting multiple delays and issues resulting in the programme status being Red (from Amber in January). The reason for this is six clinical and technical work streams are now rated red due to significant delays, data collection workbooks are behind schedule, procurement of third-party support is still incomplete, and a new national requirement could also cause delays. It is recommended by the Committee that this project has close monitoring by Boards, and it is given resource prioritisation given its strategic importance.

Emergency Preparedness Resilience and Response (EPRR): NCGC have requested assurance on EPRR systems and structures to include incorporation of new Green Plan guidance.

Health and Safety: The Committee were alerted to 2 risks –
1. Lack of radiation safety training to support staff due to the capacity of subject matter experts, the Health and Safety Committee would continue to monitor this and manage and mitigate the risk through the division.

2. Ageing surgical instruments - 38% of equipment required replacement. The Trust did not currently have a replacement programme and equipment was repaired where possible, but the situation would continue to be monitored through the Decontamination Committee.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance

Digital: This is a fast-moving, complex area with huge opportunities (e.g. Halo, Artificial Intelligence) and risks (e.g. Cyber, Information Governance). The Committee established that clarity was needed regarding budget, optimisation, and interoperability. NCGC suggested that a paper come to Board with clarity on this.

ASSURE: Inform the Board where positive assurance has been achieved

Cyber and Data Security Protection Toolkit (DSPT): The Committee received assurance on cyber and DSPT; both have been aligned with the cyber assessment framework to strengthen resilience against cyber threats and improve data governance. The RUH is not currently expected to meet the new standards and NHS

England has released a statement in recognition that the significant change in standards would be a considerable challenge. However, an improvement plan will be submitted by 30th of June 2026.

RISK: Advise the Board which risks were discussed and if any new risks were identified

Cleaning: The Committee congratulated the Chief Nursing Officer and her team for improvements made in cleaning to date. However, in order to meet financial targets a reduction in cleaning staff would be required resulting in the Trust's failure to meet the cleaning standards. A mitigation would be for Estates and Facilities to manage their savings across all areas as they are considering digital solutions in some areas.

CELEBRATING OUTSTANDING: Share any practice innovation or action that the committee considers to be outstanding

Patient Led Assessment of the Care Environment: The Committee celebrated the improvements around cleanliness, environment, and food in the hospital.

APPROVALS: Decisions and Approvals made by the Committee

Sustainability: The Committee received an update on the progress of the Salix Project and strategic plans for the sustainability agenda. The Sustainability Development Management Plan (SDMP) would expire at the end of the year and a green plan would be developed to outline the next 5 years. Key staff have left the RUH. Consideration to be given to maximising connections to drive the sustainability agenda forward with the development of a Group green plan. It was acknowledged that leadership at Group level could enable the RUH to meet its objectives.

Achievement of 2030 net zero target was in jeopardy due to resource implications from capital, pay, and infrastructure issues. BANES Council had indicated that they may be able to offset the Trust, but going forward it was recommended that the Trust align to the 2040 NHS net zero target. To be approved by Board.