Bundle Public Board of Directors 2 July 2025

0 Agenda
- 0.0 - Draft Public BoD Agenda July 25 v3.2 - 24.06.25

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Paran Govender
Liam Coleman

2 Written questions from the public

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- 3.0 - DRAFT Public BoD Minutes May v1.1 - 19.06.25

4 Action List and Matters Arising
- 4.0 - Public BoD Action List May 25 v1.1 - 19.06.25

5 Governor Log of Assurance Questions and Responses (for information)
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- 5.1 - NED Assurance 2025 v1.1 - 25.06.25

6 Items discussed at Private Board

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- 7.0 - Colleague Story June 2025 Formatted

8 CEO, Managing Director, and Chair's Report
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9 Board Assurance Framework Summary Report
- 9.0 - BAF - July Board.doc

10 Integrated Performance Report
- 10.0 - July 2025 Board - IPR Cover Sheet (May 2025 Data) v2
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11 Transformation Programmes
- 11.0 - Cover Sheet - BOD Transformation Update - 2nd July 2025
- 11.1 - Appendix 1 - PDFTransformation Programme BOD 02.07.25
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12 Business Plan 2025/26
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- 12.1 - Appendix 1 - PDFPublic Board - Business Plan 2025-26 final v1

13 TME Terms of Reference Approval
- 13.0 - Changes to TME Cover sheet July 2025
- 13.1 - Appendix 1 - Management Executive Committee TOR V1.3 230625
- 13.2 - Appendix 2 - Strategic Executive Forum TOR V3.1 230625

14 MIS Combined Maternity and Neonates Quarterly Report
- 14.0 - Mat-Neo Q4 quarterly report_
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15 Six Monthly Nurse and Allied Health Staffing Report
- 15.0 - Six Monthly Nursing and Allied Health staffing report July 23-Dec 24 v3_

16 Quality Assurance Committee Upward Report
- 16.0 - QAC Upward Report June 2025

17 People Committee Upward Report
- 17.0 - PC Upward Report June 25

18 Finance and Performance Committee Upward Report
- 18.0 - FPC May 2025

19 Audit and Risk Committee Upward Report
19.0 - Upward Report Audit Risk Ctte 190625

20 Charities Committee Upward Report
20.0 - Charities Committee Upward Report June 25

21 Non-Clinical Governance Committee Upward Report
21.0 - NCGC Upward Report June 25

22 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 2 JULY 2025, 13:00 – 16:00
VENUE: WHARF ROOM, WIDCOMBE SOCIAL CLUB,
WIDCOMBE HILL, BATH, BA2 6AA

Item	Item	Presenter	Enc.	For
OPENING BUSINESS				
1.	Chair's Welcome, Introductions, Apologies and Declarations of Interest: Paran Govender, Liam Coleman, Kheelna Bavalia, Cara Charles-Barks	Sumita Hutchison, Interim Vice-Chair	Verbal	-
2.	Written questions from the public		Enc.	I/D
3.	Minutes of the Board of Directors meeting held in public on 7 May 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.	Colleague Story	Toni Lynch, Chief Nursing Officer	Pres.	I/D
8.	CEO, Managing Director, and Chair's Report	Andrew Hollowood, Interim Managing Director / Sumita Hutchison, Interim Vice-Chair	To follow	I
Governance				
9.	Board Assurance Framework Summary Report	Roxy Milbourne, Interim Head of Corporate Governance	Enc.	I/D
10.	Integrated Performance Report	Executive Leads	Enc.	I/D
11.	Transformation Programmes	Executive Leads	Enc.	I/D
12.	Business Plan 2025/26	Joss Foster, Chief Strategic Officer	Enc.	I/D
13.	TME Terms of Reference Approval	Andrew Hollowood, Interim Managing Director	Enc.	A
The People We Care For				
14.	MIS Combined Maternity and Neonates Quarterly Report	Zita Martinez, Director of Midwifery / Claire Park, Obstetric Lead	Enc.	I/D
15.	Six Monthly Nurse and Allied Health Staffing Report	Toni Lynch, Chief Nursing Officer	Enc.	I/D
16.	Quality Assurance Committee Upward Report	Simon Harrod, Non-Executive Director	Enc.	I/D

The People We Work With				
17.	People Committee Upward Report	Paul Fairhurst, Non-Executive Director	Enc.	I/D
The People in Our Community				
18.	Finance and Performance Committee Upward Report	Antony Durbacz, Non-Executive Director	Enc. / Verbal	I/D
19.	Audit and Risk Committee Upward Report	Joy Luxford, Non-Executive Director	Enc.	I/D
20.	Charities Committee Upward Report	Sumita Hutchison, Non-Executive Director	To follow	I/D
21.	Non-Clinical Governance Committee Upward Report	Sumita Hutchison, Non-Executive Director	To follow	I/D
CLOSING BUSINESS				
22.	Any Other Business	Liam Coleman, Chair	Verbal	-
Date of Next Meeting: Wednesday 3 September 2025, 13:00 – 16:00 Venue: Room C, Education Centre (E7), Royal United Hospital, Combe Park, Bath, BA1 3NG				

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
MINUTES OF THE MEETING OF THE PUBLIC BOARD OF DIRECTORS
WEDNESDAY, 7 MAY 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
Joy Luxford, Non-Executive Director
Paul Fairhurst, Non-Executive Director
Simon Harrod, Non-Executive Director
Sumita Hutchison, Non-Executive Director
Hannah Morley, Non-Executive Director
Cara Charles-Barks, Chief Executive
Andrew Hollowood, Interim Managing Director
Jocelyn Foster, Chief Strategic Officer
Toni Lynch, Chief Nursing Officer
Simon Truelove, Interim Chief Finance Officer
Alfredo Thompson, Chief People Officer
Kheelna Bavalia, Interim Chief Medical Officer

In attendance

Roxy Milbourne, Interim Head of Corporate Governance
Jonathan Hinchliffe, Interim Group Transformation and Innovation Officer
Jason Lugg, Deputy Chief Nursing Officer *(item 7)*
Dr Jessica Spedding, Emergency Medical Consultant *(item 7)*
Kerry Perkins, Interim Quality Improvement and Patient Safety Lead Midwife *(items 8 & 9)*
Public Governors
Abby Strange, Corporate Governance Manager *(minute taker)*

Apologies

Christopher Brooks-Daw, Chief of Staff
Paran Govender, Chief Operating Officer
Nigel Stevens, Non-Executive Director

BD/25/05/01 Chair's Welcome, Introductions, Apologies and Declarations of Interest:

The Chair welcomed everyone to the meeting and introduced Joy Luxford, Non-Executive Director and Jonathan Hinchliffe, Interim Group Transformation and Innovation Officer. She confirmed that apologies had been received from those listed above. The Board of Directors confirmed that they had no additional interests to declare.

BD/25/05/02 Written questions from the public

The Chair confirmed that no written questions had been received.

BD/25/05/03 Minutes of the Board of Directors meeting held in public on 5 March 2025

The minutes of the meeting held on 5 March 2025 were approved as a true and accurate record.

BD/25/05/04 Action List and Matters Arising
The actions presented for closure were approved. The following actions were discussed in further detail:

PB612 – The Chair confirmed that the business plan for 25/26 would be presented in public at the Board of Directors meeting in July.

BD/25/05/05 Governor Log of Assurance Questions and Responses
The Governor Log was presented for information. The Board of Directors noted that there were no open questions and no new questions had been raised since January 2025.

BD/25/05/06 Item Discussed at Private Board
The Chair provided an overview of the items discussed during the Private Board of Directors meeting and reported that the Board had agreed that the following Non-Executive Directors (NEDs) would represent the Trust on the B&NES, Swindon, and Wiltshire (BSW) Hospitals Group Joint Committee: Antony Durbacz, Sumita Hutchison, Paul Fairhurst, and Simon Harrod. This was subject to change over time.

The Board had a focused discussion on the risks around the business plan for 25/26 and how it was going to track progress against this. There had also been an interesting discussion around fire safety risks and the need for effective communication.

BD/25/05/07 Patient Story
The Chair welcomed the Deputy Chief Nursing Officer and the Emergency Medical Consultant to the meeting who presented the patient story. The story focused on Emily and her 15 month old son Remy's experience of the Children's Emergency Department (ED). Remy's care was overseen by Alastair Stanley, Consultant in Children's ED who started immediate treatment for Sepsis and suspected orbital cellulitis. Once the diagnosis was confirmed, Remy was cared for on the Children's Ward and was discharged home after 7 nights in hospital.

The Deputy Chief Nursing Officer reported that there were a number of members of the ED Team who had identified the seriousness of Remy's condition and had ensured that he was seen quickly. He indicated that going forward patient stories would be used more broadly across the organisation as part of improvement work. This work was linked to the Carers Strategy in terms of how the organisation recognised, valued and collaborated with carers. The Trust had also begun to compare its work with Salisbury Foundation Trust (SFT) and Great Western Hospitals (GWH) and this would provide opportunities to align work and learning between the 3 organisations.

The Board discussed the need to ensure there was robust governance and oversight around paediatric services and the Chair confirmed that she had discussed appointing an associate or shared Non-Executive Director with the Chair of GWH. A Children and Young Persons Committee was also in the process of being established and would report into the Quality Assurance Committee (QAC).

The Interim Managing Director acknowledged that the Emergency Medical Consultant had worked in both adult and paediatric environments and asked how the 2 differed. The Emergency Medical Consultant explained that Children's ED was a much more pleasant environment because there were no issues with flow. Flow issues made it difficult for staff

to provide the care that they wanted to and this was the primary reason why she had left adult practice.

Simon Harrod asked whether the patient story would be shared publicly. The Chief Nursing Officer confirmed that all patient stories should be available with the Board papers on the website. The Corporate Governance Manager agreed to check that the patient stories were available.

Action: Corporate Governance Manager

The Chair asked where in the pathway described was the most risk of failure. The Emergency Medical Consultant indicated that if the patient had not been greeted by a senior member of the team there could have been a delay in the administration of antibiotics. She added that more senior support was making a difference to the quality and safety of the department.

Sumita Hutchison asked what type of scenario was most likely to result in Children's ED receiving a complaint, and whether poor mental health amongst patients had impacted the department. The Emergency Medical Consultant indicated that most complaints were around the perception that some patients were being seen sooner than others. The sickest patients were prioritised and work was in progress to ensure this was better communicated within the waiting room. Not many complaints were received around poor mental health, but these patients did not currently receive the level of care that staff wanted to deliver.

The Board of Directors noted the patient story and the Chair thanked the Deputy Chief Nursing Officer and Emergency Medical Consultant for attending.

BD/25/05/08 CEO, Managing Director, and Chair's Report

The Chief Executive reported that the NHS was undergoing a significant period of transformation and the Government was using the framework of the NHS in 2009 as a platform for the new 10 year plan with updated digital and staffing opportunities. The Trust's priority continued to be caring for the population and delivering the best possible services and outcomes, but there were patients that could be cared for differently. The new 10 year plan would become the framework for planning and a process was due to begin to review data across BSW to form the basis of the Group strategy. The substantive Managing Directors for each Trust would be announced imminently and the Interim Group Transformation and Innovation Officer was now in post, bringing a wealth of digital experience. The establishment of the BSW Hospitals Group Joint Committee was also progressing and this would enable to Group to move forward.

The Interim Managing Director reported that the Trust was focusing on service redevelopment and change to become financially sustainable moving forward. Transformational change would centre around urgent and emergency care, theatres, outpatients, corporate services redesign, and a number of central functions. Each workstream had been assigned an executive lead, senior responsible officer, and a lead clinician. Work was ongoing to ensure that the metrics around this were available in one place so that the organisation could monitor progress in terms of financial and operational performance. Despite the level of challenge that the organisation was facing, there were a number of items to celebrate including the introduction of at home feeding for premature babies, the opening of the new intensive care unit, national recognition for

the Trust's kindness and civility work, and the ongoing success of the Excellence at Every Level Accreditation Programme.

The Chair presented her section of the report and highlighted that she had met with the Vice-Chancellor of Bath Spa University to explore ways in which the organisations could work together for their mutual benefit.

The Board discussed the transformation programmes and how improving together methodology would be used to encourage staff innovation. They acknowledged that this would be useful in terms of the work around patient initiated follow ups and particularly to empower staff and reset the way that patients interacted with the Trust.

Sumita Hutchison sought clarity on the intention to link sustainability with the cost improvement programme (CIP). The Interim Managing Director indicated that sustainability projects often had cost savings associated with them and many more simple steps could be taken to generate sustainability improvement.

The Board of Directors noted the report.

BD/25/05/09 Integrated Performance Report

Finance
The Interim Chief Finance Officer reported that the RUH Group had achieved its target £4.2m deficit at month 12 but the position had been offset by £4.8m additional surge support funding and this would impact the 25/26 position. Savings of £32.8m were delivered but the exit run rate had worsened by £1.4m in month 12 as greater reliance on non-recurrent benefits was required to deliver the deficit position. The capital plan had been achieved and the closing cash balance for the RUH Group was £37m. £27m related to the Trust but this would not provide significant protection against deficit in 25/26 and work was required to ensure that the Trust would deliver its financial plan.

The Board reflected on the cash risk and acknowledged the challenge in terms of the changes in the cash regime. The key mitigation was the CIP and clarity was needed around the delivery of this and the scale of the risk that the Trust was trying to manage. The Interim Chief Finance Officer indicated that there would be a maximum of 10 months before the Trust reached a chronic cash position and the organisation ultimately needed to protect the payroll. As such the Trust would need to deploy cash management processes, review non-pay, and prioritise which suppliers to pay first. The most extreme circumstance would require the Trust to delay the capital programme. It was also possible that compliance with the better payment practice code would be impacted and this metric would be monitored by the Finance and Performance Committee.

The Chair asked what the Directors' responsibilities were in terms of producing a letter of going concern. The Interim Chief Finance Officer explained that while NHS England (NHSE) continued to produce a letter of going concern, this would support the Trust's position. It was rare that an individual NHS organisation would need to identify its own position as going concern.

Workforce
The Chief People Officer reported that the vacancy rate had increased to 3% in month 12 and this was driven by the corporate and medicine divisions. There had been a further

reduction in agency spend and while sickness absence was increasing, this was significantly lower than the national average. Work around appraisal rates continued but they had increased marginally in month 12.

Quality
The Chief Nursing Officer reported that 7 pressure ulcers had been reported for January 2025, and while the Trust continued to benchmark well, improvement plans were in place to minimise harm. Falls continued to sit at the national average and the improvement workstream was being reviewed to continue to reduce them. The Trust continued to see significant cases of c. diff and work continued with the system and the region to better understand the causation around this. Ward staffing levels had been determined as safe but the midwife to birthrate ratio was marginally lower than the required level due to an increase in short term sickness. There had been 2 antenatal stillbirths in month with no immediate care concerns identified and there had been no neonatal deaths.

Antony Durbacz asked whether the Trust was aiming to move to quartile 1 in terms of where it benchmarked for safe staffing. The Chief Nursing Officer explained that the Trust benchmarked well against other similar Trusts in terms of its safe staffing and cost effectiveness. The aim was to maintain the current position and this was reassessed on a bi-yearly basis.

Operational Performance
The Interim Managing Director reported that ambulance handovers and 4 hour performance remained static, non-criteria to reside (NCTR) was around 98, and there had been improvements in length of stay. The Trust remained in tiering for cancer and diagnostics and there was a focus on long waiters in terms of referral to treatment (RTT). The Trust had been unable to achieve its RTT performance target due to significant growth in certain areas and work was needed to realign the trajectory with this. 62 day cancer performance had deteriorated in some areas and the Group Director for Planned Care was providing assistance with this and RTT. The Interim Urgent and Elective Care (UEC) Director was focusing on the UEC pathway with the Chief Nursing Officer.

The Chief Executive sought clarity on what needed to change in terms of diagnostics and the improvement trajectory. The Interim Managing Director indicated that he had requested that the trajectory was mapped to performance to improve understanding of the diagnostic position for all services. Work was also ongoing around the Community Diagnostic Centre pathways and to ensure that staff were following best practice guidelines to order diagnostics.

The Board of Directors noted the update.

BD/25/05/10 Finance Plan 2025/26
The Board of Directors noted the report and confirmed that the 25/26 Financial Plan had been discussed at length during their meeting in private. They ratified the details contained within the plan and the associated risks and mitigations.

BD/25/05/11 Staff Survey Results
The Chief People Officer presented the report and highlighted that there had been a small decline in the response rate because the survey had only been circulated electronically and this would be rectified going forward. There had been a 4% decline in colleagues recommending the Trust as a place to work and contributing factors were

likely to include the removal of paid breaks, other sustainability measures, and high levels of acuity. Positive results centred around career development, managerial support, team dynamics, and organisational commitment. Areas of focus were work-life balance, team effectiveness, staffing and resources, and health and wellbeing and safety.

The Board discussed the challenges that the organisation was experiencing and acknowledged the impact that this was having on staff. They recognised the need to provide leadership and to encourage staff to become more innovative and engage in the identification of solutions. The Chief Executive suggested that a comprehensive engagement programme would help to increase staff energy and ambition around the changes that were taking place and to encourage the organisation to lead.

Paul Fairhurst reflected on the breakthrough objective around reducing discrimination and felt that the results indicated that other areas may need more focus. The Chief People Officer confirmed that the breakthrough objective would now be around valuing staff as a result of the staff survey.

Sumita Hutchison asked whether the Trust's anti-racist statement had positively impacted the number of global majority staff in leadership positions. The Chief People Officer indicated that numbers remained relatively low and work around inclusion needed to continue. The appointment of the Interim Chief Medical Officer was a milestone for the organisation because it had not previously had a global majority medical leader.

The Board of Directors noted the update.

BD/25/05/12 Joint Committee Terms of Reference and Partnership Agreement

The Chief Executive presented the Joint Committee Terms of Reference and Partnership Agreement for approval. She reported that a number of areas would be approached at Group level including strategy development, financial recovery, alignment of corporate services, and the delivery of the electronic patient record (EPR) programme.

The Board of Directors approved the BSW Hospitals Group Partnership Agreement for execution by 9 May 2025 and the establishment of the BSW Hospitals Group Joint Committee in May 2025.

BD/25/05/13 Board Assurance Framework Summary Report

The Interim Head of Corporate Governance reported that the Board Assurance Framework (BAF) was presented for information and approval. She explained that the report documented the work that the Corporate Governance Specialist and Chief of Staff had undertaken since the BAF was last presented in January, as well as the work that would take place ahead of the July Board meeting. Changes presented for approval included the reduction of risks 2.2 and 3.2, and the amended description of risk 2.1.

The Board discussed the BAF and whether a further update to risk 3.2 was required to reflect that the key risk around Sulis was operational rather than financial. They also considered the need to be clear around timelines for mitigation and where risks related to system partners.

The Board of Directors approved the BAF.

BD/25/05/14 Annual Review of Constitution

The Interim Head of Corporate Governance reported that as part of a review of the Trust Constitution, amendments had been proposed to reflect key changes since the last review. These included the establishment of Joint Committees and Committees in Common, the revised Health and Care Act 2022, updated job titles, gender neutral language, updates to Fit and Proper Persons regulations, and updates to the Board composition. The Council of Governors had approved the changes at their meeting in September 2024.

The Board of Directors approved the proposed amendments to the Trust's Constitution.

BD/25/05/15 Annual Review of Fit and Proper Persons Test (FPPT)

The Interim Head of Corporate Governance reported that the Trust was required to undertake annual FPPT checks in line with the FPPT framework. New FPPT checks had been undertaken for the Interim Chief Medical and Interim Chief Finance Officers and all other Board members had been subject to annual checks with nothing untoward returned. 3 Board members were yet to complete their self-declarations and this would be followed up ahead of the submission deadline on 12 June 2025. An FPPT Policy had been drafted to further demonstrate that robust processes were in place and this would be presented at the next Board meeting for ratification.

The Board of Directors noted the update.

BD/25/05/16 Annual Review of Directors' Interest

The Interim Head of Corporate Governance advised that it was good practice for the Board to receive and review the interests declared by its members once a year for approval. The Board was also reminded of the requirement to declare interests at meetings when matters in which there was an interest were being considered and to withdraw from the meeting during their consideration.

The Board of Directors approved the Register of Directors' Interests as at 7 May 2025.

BD/25/05/17 NHSE Self-Certification CoS7 (Continuation of Services)

The Interim Head of Corporate Governance reported that the Trust was required to self-certify that it was compliant with CoS7 on an annual basis as part of the conditions of the NHS Provider License. The Board was asked to review and confirm the statement in appendix 1 in line with its provider license CoS7.

The Board of Directors approved the self-certification CoS7 for publication on the Trust website.

BD/25/05/18 MIS Combined Maternity and Neonates Report Q3

The Chair welcomed the Interim Quality Improvement and Patient Safety Lead Midwife who presented the report and highlighted that mortality was stable with the Trust below the national average for stillbirths and neonatal deaths. She provided an overview of the Perinatal Culture and Leadership Programme and reported that the culture on the maternity ward was much improved. Staffing had met the identified transitional care pathway model on average 98% of the time and all eligible babies had been cared for on the pathway. Sickness had been stable, and the turnover rate was low. 69% of the qualified workforce were currently qualified in specialty against a standard of 70% and it was anticipated that the Trust would be compliant by Q2 of 25/26. The Trust had been

unsuccessful in recruiting to the Advanced Neonatal Nurse Practitioner vacancy and an experienced neonatal nurse would not be supported to undertake a 12 month fast track training course to close the gap.

The Chief Executive asked what the Interim Quality Improvement and Patient Safety Lead Midwife was proud of and what she was most concerned about. The Interim Quality Improvement and Patient Safety Lead Midwife indicated that she was proud of the team's dedication to improvement and was most concerned about the impact of financial pressures on staff. The Chief Executive acknowledged that staff needed to be supported and stated that the right environment needed to be created to encourage innovation and transformation so that the Trust could move to a more sustainable financial position.

The Board of Directors noted the report and thanked the Interim Quality Improvement and Patient Safety Lead Midwife for attending.

BD/25/05/19 Midwifery and Neonatal Bi-Annual Staffing Report
This item was taken during item 18.

BD/25/05/20 Learning from Deaths Q1, Q2 & Q3
The Interim Chief Medical Officer presented the report and highlighted that the hospital standardised mortality ratio remained within the expected range for both weekday and weekend. Crude mortality was slightly higher for the most deprived communities but this was consistent with regional and national data. The majority of structured judgement reviews (SJR) rated care as good or very good but there were 5 cases of poor care and each of these cases had been reviewed in more detail through divisional governance. Work was ongoing around the Trust's backlog of SJRs and while more were now being completed than were coming in, further action was required to reduce this at pace. Work had also commenced to better link data together to identify themes from SJRs.

Antony Durbacz asked what further action would be taken around the SJR backlog and whether the Board should be concerned that no themes had been identified. The Interim Chief Medical Officer advised that actions would centre around working with the divisional leads to ensure each division had the right capacity. The failure to identify themes was not concerning, but a dialogue needed to be facilitated around this.

The Board of Directors noted the report.

BD/25/05/21 Quality Accounts Sign Off
The Chief Nursing Officer reported that the Trust was mandated to publish the Quality Accounts by 30 June each year and provided a summary of the process. The Board of Directors was asked to delegate the approval to publish the document to QAC.

The Board of Directors agreed to delegate the approval to publish the 24/25 Quality Accounts to QAC.

BD/25/05/22 Quality Assurance Committee Upward Report
Simon Harrod reported that a number of patients may have been lost to follow up as there was no robust system across specialties to triage requests and some patients were yet to be added to waiting lists. The Associate Director of Patient Safety and Quality was seeking further assurance around this and the Committee would receive more detail once this had been through divisional governance. The Committee had discussed issues

around clinical audits due to a lack of clinical lead and the continuation of operational issues around flow. They had received assurance around safe staffing, volunteer recruitment, and maternity and neonatal safety, and had celebrated the development of a paediatric staffing model to support child and adolescent mental health. The Quality Insight and Improvement Committee terms of reference had been approved and a review of the Trust's older patient safety and quality risks had been suggested to ensure that they were still relevant.

The Chair asked whether internal auditors should be looking at issues around patient follow ups. The Chief Nursing Officer advised that this was a new risk that had been identified through the Patient Safety Incident Response Framework and the Committee had received this information as part of initial insight work. She confirmed that an action plan had been developed to take this forward.

The Board of Directors noted the report.

BD/25/05/23 People Committee Upward Report

Paul Fairhurst reported that plans were in a state of flux across many key areas from a people strategy perspective and there were concerns around staff capacity, capability and distraction due to the complicated and sensitive nature of the situation. Responsibility and accountability had not yet been defined in terms of how the Committee would work with the BSW Hospitals Group Joint Committee but this would improve over time. There had been a discussion around several emerging risks related to the formation of the Group and the 25/26 pay bill reduction requirements and this would be incorporated into the BAF.

The Chief Executive advised that a Group strategy would be developed within the next 12 months and this would include a people plan to detail the aspiration for staff. Local delivery plans would sit underneath this and in the interim, each Trust would need to continue to work towards delivering what it had committed to at a local level.

The Board of Directors noted the report.

BD/25/05/24 Strategic Priorities Q4

The Chief Strategic Officer presented the report and summarised the progress made towards delivery of the Trust's You Matter Strategy in Q4. She highlighted the significant amount of work that had taken place throughout 24/25 and advised that where progress had been delayed, this was largely due to interdependencies with Group planning and capacity constraints. Work around the breakthrough objectives would continue into 25/26 and the Board would receive updates on the strategic priorities through the Integrated Performance Report going forward.

The Chair reflected on the Trust's achievements throughout 24/25 and acknowledged that the organisation was focused on continually improving. It was suggested that the Governors were invited to the Board of Directors Seminar to reflect on progress and challenges across the executive portfolios in 24/25.

The Board of Directors noted the report.

BD/25/05/25 Finance and Performance Committee Upward Report

Antony Durbacz presented the report and indicated that the Committee had received positive assurance from the Director of Site Operations around NCTR and the Trust's developing relationship with HCRG Care Group. There had been a discussion around the redesign of corporate services and it was suggested that procurement could provide valuable reflections on this, having already been through a redesign. The Committee had approved a contract award for interventional cardiology consumables and had approved the resubmission of the Trust's annual business plan on delegated authority.

The Board discussed the value of getting feedback from procurement in terms of redesigning the corporate services model. It was agreed that the Interim Chief Finance Officer would take this forward.

Action: Interim Chief Finance Officer

The Board of Directors noted the report.

BD/25/05/26 Audit and Risk Committee Upward Report

Sumita Hutchison presented the report and explained that the Committee had been informed that the internal auditor was minded to give a 'partial assurance' opinion on account of their understanding that key actions had not been sufficiently implemented. Assurance had been received around the internal audit report on patient consent, the counter fraud service report on the freedom to speak up reporting culture, and progress in relation to the annual accounts. The Committee had approved the recommended accounting policies and the internal audit plan for 25/26.

The Board had an in depth discussion around work that the Chief of Staff had undertaken to close a number of recommendations and it was agreed that clarity was needed around actions that remained open.

Action: Chief of Staff

The Chief Executive asked that the Executive Team provide a report on what the Trust was going to do differently in terms of the management of audit going forward. They would need to consider the deliverability of recommendations and the robustness of the process around closing off audits.

Action: Interim Chief Finance Officer

The Board of Directors noted the report.

BD/25/05/27 Non-Clinical Governance Committee Upward Report

Sumita Hutchison presented the report and highlighted that the Committee had discussed issues around the EPR, emergency preparedness resilience and response (EPRR), and two health and safety risks that had been identified. She reported that the EPR was being closely monitored by the Board due to its strategic importance and the Committee would receive assurance around EPRR at their next meeting. The health and safety risks were detailed within the report and there would be ongoing monitoring through the Health and Safety and Decontamination Committees. Clarity had been sought on the role of digital within the Trust's transformation programmes and there was an update on changes to the cyber and data security protection toolkit. A risk had been identified around the impact of the CIP on cleaning standards and an update was provided on the progress of the Salix Project. Achievement of the 2030 net zero target

was in jeopardy due to resource implications around capital, pay, and infrastructure. Going forward it was recommended that the Trust align to the NHS 2040 net zero target.

The Board of Directors noted the report. They discussed the recommendation to align to the NHS 2040 net zero target and advised that further evidence was required to indicate that the 2030 target was not feasible.

BD/25/05/28 Any Other Business

The Board of Directors acknowledged that it was the Chair's last meeting and they thanked her for her leadership and contribution to the Trust. The Chair thanked the Board and Governors for their support during her time at the Trust.

The Meeting closed at 16:10

DRAFT

Royal United Hospitals Bath
NHS Foundation Trust

Agenda Item: 4

ACTION LIST - BOARD OF DIRECTORS MEETING IN PUBLIC
WEDNESDAY, 7 MAY 2025

Action No	Details	Agenda Item No	First Raised	Action by	Progress Update & Status	Lead
PB615	**Patient Story** Corporate Governance Manager to ensure that patient story videos are available on the website.	**BD/25/05/07**	**May 2025**	**July 2025**	Following consideration of consent of the patients and potential reputational risks, the Chief Nursing Officer agreed that patient story videos would continue to be utilised internally only for staff learning purposes. Members of the public are welcome to attend Public Board of Directors meetings to hear and see patient stories. Written summaries are available to view as part of the Board papers on the Trust website. **To close.**	**Corporate Governance Manager**
PB616	**Finance and Performance Committee Upward Report** Interim Chief Finance Officer to seek feedback from procurement to inform the redesign of corporate services.	**BD/25/05/25**	**May 2025**	**July 2025**	The Director of Procurement will provide the Finance and Performance Committee with a report on the learnings from the delivery of the group procurement services. **To close**	**Interim Chief Finance Officer**
PB617	**Audit and Risk Committee Upward Report** Chief of Staff to provide clarity around the number of open internal audit actions.	**BD/25/05/26**	**May 2025**	**July 2025**	• Nearly 70 management actions were raised from	**Chief of Staff**

Action No	Details	Agenda Item No	First Raised	Action by	Progress Update & Status	Lead
					the 2024/25 audit programme. • At year-end 2024, 24 actions were open and overdue. • Remedial action was taken and 18 actions were closed, leaving 6 open. • At Audit and Risk Committee on 19 June 2025, it was reported that the current position was 10 overdue actions. 4 were low and 6 were medium.	
PB618	**Audit and Risk Committee Upward Report** Interim Chief Finance Officer to provide a report on what the Trust was going to do differently in terms of the management of audit going forward.	**BD/25/05/26**	**May 2025**		Internal audit progress reports will now come to the Executive Team on a monthly basis following a monthly Chief Finance Officer / internal audit meeting in order that actions are being delivered. **To close**	**Interim Chief Finance Officer**

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**5**
Date of Meeting:	**2 July 2025**		

Title of Report:	**Governor Log of Assurance Questions and Responses**
Status:	**For Information**
Board Sponsor:	**Liam Coleman, Chair**
Author:	**Roxy Milbourne, Interim Head of Corporate Governance**
Appendices	**Appendix 1: Governor Log of questions June 2025**

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.

Two new questions, JUNE25A and JUNE25B were raised since the last report was presented in May 2025. JUNE25A sought clarity on endoscopy capacity at Sulis following the cessation of the temporary mobile endoscopy unit. 25B was submitted to seek assurance on plans to sustainably and significantly reduce ambulance handover waiting times.

The questions were sent to the relevant Trust colleagues for response and Victoria MacFarlane, Sulis and Elective Recovery System Lead has provided a response to 25A which is detailed in appendix 1. The Interim Urgent and Emergency Care Director and the Deputy Chief Operating Officer are in the process of formulating a response to the remaining question and this will be circulated to the Council of Governors in due course.

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

May 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

Appendix 1: Governor Log of Assurance Questions

Date:	**11th June 2025**
Source Channel	**Email from Public Governor after the Council of Governors meeting on 11 June 2025.**
Date Sent & Responder	Sent to Victoria MacFarlane, Sulis and Elective Recovery System Lead
Question and ID	**JUNE25A** I understand the mobile Colonoscopy/Gastroscopy unit at Sulis Hospital is to cease operating from its present site and is moving to a new unknown location as of 6th June. What measures are being taken to compensate for this loss?
Process / Action	Sent to Victoria MacFarlane, Sulis and Elective Recovery System Lead. Response shared via email on 17/06/25.
Answer	The purpose of the mobile endoscopy van was to provide additional capacity to clear the specific surveillance backlog. This has now happened, and the backlog has reduced from more than 500 lists to just 5. The totality of the van capacity is therefore not required. Sulis hospital will continue to provide endoscopy services to NHS patients referred on ERS plus CDC patients referred from the RUH. The RUH provides 50 lists per week in existing capacity and will continue insourcing solutions at the weekend to keep pace with demand. We have seen a significant improvement in DM01 performance over this period, and we expect this to continue.
Closed?	Open, shared with the Council of Governors via email and no further questions received. To be closed at the next Council of Governors meeting in September 2025.

Date:	**11th June 2025**
Source Channel	**Email from Public Governor after the Council of Governors meeting on 11 June 2025.**
Date Sent & Responder	Sent to Bernie Bluhm, Interim Urgent and Emergency Care Director, and Sufi Husain, Deputy Chief Operating Officer for response on 19/06/25.
Question and ID	**JUNE25B** Governors seek assurance from the RUH Board that a fully resourced work plan is being implemented, monitored, reviewed and reported to sustainably and significantly reduce Ambulance Handover waiting times across the RUH site. In seeking this assurance, the Governors would look for detail on; current trends, the impact and effectiveness of actions taken so far, insights and learning from such actions and gained from other Trusts, and proposed innovative solutions for mutual benefit of RUH and ambulance service providers.
Process / Action	Sent to Bernie Bluhm, Interim Urgent and Emergency Care Director and Sufi Husain, Deputy Chief Operating Officer who are in the process of formulating a response.
Answer	The question has been shared with colleagues and a response will be provided alongside further updates via the Quality Working Group.
Closed?	Open.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**7**
Date of Meeting:	**2 July 2025**		

Title of Report:	**Colleague Story – Enhanced Care and Support Team**
Status:	**For discussion and noting**
Board Sponsor:	**Toni Lynch, Chief Nursing Officer**
Author:	**Jo Baker, Associate Director for Vulnerable People**
Appendices	**Enoch Doe, Enhanced Care Specialist Practitioner / Team Lead**

1. Executive Summary of the Report

The colleague story provides an overview of the development of the Enhanced Care and Support Team at the RUH. It includes the team's activity and achievements, challenges and opportunities. The aim is to demonstrate a typical day in practice for the team, the impact of the team in terms of patient experience and outcomes, and to highlight and raise awareness of the role of a Registered Mental Health Nurse in a general acute hospital. Further, it invites Board members to reflect on our model of least restrictive, strengths based, person-centred care.

2. Recommendations (Note, Approve, Discuss)

The Board is requested to discuss and note the story.

3. Legal / Regulatory Implications

Under the Equality Act (2010), all disabled people have the right to reasonable adjustments when using public services, including healthcare. The Act places a requirement on public services to anticipate and prevent discrimination against disabled people.

Under section 6 of the Human Rights Act (1998) the Trust has a responsibility to uphold and promote the human rights of people using Trust services and its staff.

The Health and Care Act 2022 introduced a requirement that regulated service providers must ensure their staff receive learning disability and autism training appropriate to their role.

Everyone working with, or providing care and support for, a person over 16 years of age, who may lack capacity to make decisions for themselves, is required by law to understand and use the MCA. They must also have regard to the MCA Code of Practice (the Code), [2] and the Deprivation of Liberty Safeguards (DoLS), an amendment to the MCA introduced in 2009 via the Mental Health Act 2007. [3]

When making decisions about the appropriate use of physical intervention, practitioners must give due regard and consideration to the Mental Health Act Code of Practice 2015.

The development of the Enhanced Care Team is underpinned by the above legal requirements and aims to improve the care standards for vulnerable people accessing the Trust's healthcare services

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

An opportunity arising from the Vulnerable People Committee (VPC) is the proposal for robust strategic oversight and governance for the use of the Mental Health Act in the Trust. This will include the creation of a 'Least restrictive practice' group chaired by the Lead Nurse for Mental Health / Enhanced Care ensuring robust oversight and scrutiny, reporting upwards to VPC in relation to restrictive intervention.

5.	Resources Implications (Financial / staffing)

There are no resource implications.

6.	Equality and Diversity

Legislation in relation to equality, diversity and human rights should be applied when implementing procedures and processes in respect of vulnerable people. 'Respecting diversity, promoting equality and ensuring human rights will help to ensure that everyone using health and social care services receives safe and good quality care.' (Care Quality Commission). The Vulnerable People Strategy key priority is to improve the care standards for our most vulnerable patients. The development of the Enhanced Care and Support Team is underpinned by this.

7.	References to previous reports/Next steps

The Vulnerable People Strategy underpins the development of the Enhanced Care and Support Team. The Vulnerable People Strategy was discussed and approved at the Board meeting on 4 September 2024.

8.	Freedom of Information

Public.

9.	Sustainability

The development of the Enhanced Care and Support Team, underpinned by the Vulnerable People Strategy, aligns to the objectives and values of the Trust Strategy ensuring environmental and financial sustainability are central.

10.	Digital

Digital capability is a key enabler of success in delivering the Vulnerable People Strategy vision and key priorities and, thus, the continued development of the Enhanced Care and Support Team.

Enhanced Care and Support Team

The Enhanced Care and Support Team model is built on the vision and ambitions of the Trust's Vulnerable People Strategy. The principles and values of the RUH Strategy - Everyone Matters, Working Together, and Making a Difference – underpin the work of the team.

The Enhanced Care and Support Team provide a 24/7 multidisciplinary service. The team comprises of highly skilled professionals who are Registered Mental Health Nurses and Enhanced Care Support Workers. The team bring extensive experience from diverse mental health settings, healthcare settings and social care settings: such as dementia care, eating disorder care, acute mental health settings, low secure mental health settings, forensic locked rehabilitation service, psychiatric intensive care unit, children and young people's services.

Close working relationships with specialist roles, such as the Lead Nurse for Learning Disability and Autism and the Dementia Nurse Specialists, provide essential leadership and guidance, ensuring that the delivery of care meets the diverse needs of the people we care for.

The team provides trauma informed person-centred care for people who require an enhanced level of care and support. Guided by the Enhanced Observation Standard Operating Procedure, care is delivered through structure interventions. This may include therapeutic conversation, activities, supportive observation, clinical holding, restrictive intervention to keep a person/people safe, close monitoring of mental well-being. All with the aim of promoting independence and minimising risk.

The team aim to deliver safe, effective, and least restrictive support that aligns with legal frameworks, national guidelines and the Trust's commitment to holistic and compassionate care.

Direct Patient Support
Support is tailored according to the needs and requirement of the patient. All care and support are person-centred.

Where there is a mental health and wellbeing need the person is offered therapeutic engagement with a Registered Mental Health Nurse to reflect on their care and identify any additional needs. All interventions are designed to be least restrictive and recovery focused.

Staff Training and Development
The team provide education, coaching and role modelling to ward staff to improve understanding and delivery of trauma informed and evidence-based care. The team ensure a collaborative approach to help upskill and manage situations that might be deemed challenging to staff.

The Team Leads provide support in the provision of professional, clinical advice and leadership, ensuring person-centred individualised care. This includes raising awareness and understanding about enhanced observation at an appropriate level for the individual, thus not always resulting in extra staff and the use of RMNs. This is an area for continued development.

Patients and Family/Carer Engagement

The team work closely with patients and their families/carers to ensure clarity, compassion, and confidence in the care provided. The team have received very positive user feedback.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**8**
Date of Meeting:	**2 July 2025**		
Title of Report:	**Chief Executive Officer Report**		
Status:	**For Information**		
Board Sponsor:	**Cara Charles-Barks, Group 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
  - Urgent & Emergency Care Plan 2025/26
  - National Maternity investigation launched to drive improvements
  - NHS Oversight Framework 2025/26

- Group
  - Group EPR Senior Responsible Officer
  - Leadership Team – Confirmation of Managing Director Appointments
  - Interim Chair & Vice Chair Appointments
  - Partnership Agreement and Joint Committee Establishment
  - Board to Board Development
  - Operating Model/Leadership Structures/Corporate Services
  - Group Engine Room
  - Mutually Agreed Resignation Scheme (MARS) across GWH, RUH, and SFT

MD's Report

- Local (RUH)
  - Operational
  - Finance
  - Workforce
  - Closure of the Special Care Baby Unit at Yeovil Hospital
  - Sustainability Week
  - RUH staff celebrated for award-winning achievements
  - RUH sets up new support group for heart failure patients
  - Radiology Department anniversary
  - New Sulis Orthopaedic Centre to cut surgical waiting times for NHS patients
  - Hospital at Home team celebrates supporting 5,000 patients
  - Service to remember special babies
  - New mouth care boxes support patients' oral health
  - Award winning Dyson Cancer Centre

- Membership
- Consultant Appointments

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.	

GROUP CHIEF EXECUTIVE AND MANAGING DIRECTOR REPORT

GROUP CHIEF EXECUTIVE'S REPORT

National

Urgent & Emergency Care Plan 2025/26

The Urgent and Emergency Care Plan 2025/26 was published on 6th June 2025 and outlines how patients will receive better, faster and more appropriate emergency care as the Government sets out reforms to shorten waiting times and tackle persistently failing Trusts.

The new package of investment and reforms will improve patients' experiences this year, including caring for more patients in the community, rather than in hospital which is often worse for patients and more expensive for taxpayers.

Backed with a total of nearly £450 million, the Urgent and Emergency Care Plan 2025 to 2026 will deliver:

- around 40 new same day emergency care and urgent treatment centres - which treat and discharge patients in the same day, avoiding unnecessary admissions to hospital;
- up to 15 mental health crisis assessment centres to provide care in the right place for patients and avoid them waiting in A&E for hours for care, which is not the most appropriate setting for people who are experiencing a crisis. These centres will offer people timely access to specialist support and ensure they are directed to the right care;
- almost 500 new ambulances will also be rolled out across the country by March 2026.

The plan's emphasis will be on shifting more patient care into more appropriate care settings as part of the move from hospital to community under the government's Plan for Change to rebuild the NHS, while tackling ambulance handover delays and corridor care.

Further information on the Urgent & Emergency Care Plan 2025/26 can be found via https://www.england.nhs.uk/publication/urgent-and-emergency-care-plan-2025-26/

An overview of the current Urgent and Emergency Care performance across the Trust is shown below:

Urgent and Emergency Care at performance continues to be challenging at the Trust, with type 1 weekly performance remaining stubbornly around 59%.

Admitted performance was 29.32% and non-admitted performance 70.77%. Exit block and flow continue to be the most significant cause of the delays and Non Criteria to Reside fluctuates daily, but is on average between 80-90 per day.

A new Medical Same Day Emergency Care (SDEC) opened on Monday, 23rd June 2025 and has been well received. Patients have been actively pulled from the ED and on Tuesday, 24th June, 82% of the medical take was managed through the SDEC which gives confidence that the trajectory to achieving a reduction of between 15-20 patients per day in ED is achievable.

For Ambulance off load performance, the Trust achieved ahead of trajectory for May, with 60.9 minutes against the trajectory of 69 minutes.

The priority improvement actions in the immediate and short term to improve performance are to bring forward the UTC/Streaming changes, Trauma and Orthopaedic assessment capacity and direct access pathways.

National Maternity Investigation Launched to Drive Improvements
On 23 June 2025 the Health and Social Care Secretary announced that there will be a rapid national investigation into NHS maternity and neonatal services. It is believed that the investigation will have two phases, the first will investigate up to 10 maternity and neonatal services, NHS England has yet to confirm which trusts will be involved. The second phase will undertake a system-wide review of maternity and neonatal care, bringing together lessons learned from past inquiries to create one clear plan; the terms of reference for this review are being developed by NHSE.

An overview of the current Maternity and Neonatal services across the Trust is shown below:

The RUH was rated outstanding for Maternity care by the Care Quality Commission in March 2024. In 2025, the Trust reported compliance with the 10 Safety Actions for year 6 of the Maternity Incentive Scheme. The Maternity and Neonatal Quarterly report is included in the Board papers which provides a comprehensive briefing on maternity and neonatal services at RUH.

NHS Oversight Framework 2025/26
The new NHS Oversight Framework 2025/26 was published on 26th June 2025 and describes a consistent and transparent approach to assessing Integrated Care Boards (ICBs) and NHS Trusts and Foundation Trusts, ensuring public accountability for performance and providing a foundation for how NHS England works with systems and providers to support improvement.

It has been developed with the engagement and contributions from the NHS leadership and staff, representative bodies and think tanks, including through two public consultations.

This 1-year framework sets out how NHS England will assess providers and ICBs, alongside a range of agreed metrics, promoting improvement while helping us identify quickly where organisations need support.

Further information about the NHS Oversight Framework 2025/26 can be found via: https://www.england.nhs.uk/long-read/nhs-oversight-framework-2025-26/

Group Update

Group Electronic Patient Records (EPR) Programme Senior Responsible Officer (SRO)
The Board is formally asked to note the transfer of the SRO for the Group EPR from the interim Managing Director at the RUH to the interim Chief Transformation & Innovation

Officer with effect from 28th May 2025. This change will optimise the programme leadership and governance approach to mitigate the risks associated with the EPR Programme. Thanks go to the RUH interim Managing Director for providing SRO support up to the transfer.

Updates on the EPR Programme will be provided to the Board on a regular basis.

Leadership Team – Confirmation of Managing Director Appointments
In May we confirmed the appointment of three new substantive Managing Directors across BSW Hospitals Group, each bringing a wealth of experience in leadership and a strong track record of delivering high-quality, patient-centred services. As Managing Directors, they will be responsible for the overall operational leadership of our hospitals. They will work closely with each other, their Boards and senior leadership team, and together as part of our Group leadership. The appointments are:

- Great Western Hospitals Swindon - Lisa Thomas. Lisa joins from Salisbury NHS Foundation Trust where she is currently the Interim Managing Director.

- Royal United Hospitals Bath - John Palmer. John joins from Royal Devon University Healthcare NHS Foundation Trust where he is the Chief Operating Officer.

- Salisbury NHS Trust - Nick Johnson. Nick joins from a joint role with Dorset County Hospital NHS Foundation Trust and Dorset Healthcare University NHS Foundation Trust where he is Joint Chief Strategy, Transformation and Partnerships Officer and Deputy Chief Executive at Dorset County Hospital.

Interim Chair & Vice Chair Appointments
In May and June, the Trusts also held successful appointment processes for an interim Joint Chair for RUH & GWH (Liam Coleman), an interim Chair in SFT (Eiri Jones) and Vice Chairs in GWH (Faried Chopdat) and RUH (Sumita Hutchison). In coming weeks, the Councils of Governors, company secretaries and governance leads will support the establishment of a joint Nominations Committee to coordinate recruitment of a substantive Joint Chair by April 2026.

Partnership Agreement and Joint Committee Establishment
In May, Trust Boards approved our BSW Hospitals Group Partnership Agreement, including Joint Committee Terms of Reference. The Partnership Agreement was executed on 22nd May, and on 23rd May, Salisbury NHS Foundation Trust hosted the inaugural BSW Hospitals Group Joint Committee meeting. A full committee report to Boards from the Group Joint Committee will be issued with minutes in the 4th week of July.

The next Joint Committee meeting will be held on 16th July in Swindon and will focus on discussion and approval of the proposed Group Operating Model and Leadership Model. A new Group Integrated Performance Report (IPR) will be shared and detailed corporate services model plans will be introduced for priority services – Finance, People, Digital, Estates & Facilities and Capital Planning - plus Corporate Governance and Communications.

Board to Board Development
The 4th of June saw RUH host the latest of our Board-to-Board development days. Discussion generated a series of areas for focused work – including on potential Target Operating Model and development of our Governance and Accountability Framework. A report on proposed next steps is included in July Board papers. Further Board-to-Board sessions are planned in October and next February.

Operating Model/Leadership Structures/Corporate Services
Work to establish our new operating model has continued in May and June, supported by colleagues from Teneo. Corporate services will be an important element of the new operating model. A comprehensive joined-up corporate services programme is now in place. A Project Director funded by NHS England has recently joined, and a Steering Group has been established to oversee the programme.

Group Engine Room
In June, Improving Together Leads confirmed plans with the Managing Directors to establish a Group Engine Room meeting monthly from July, to help us align teams across the Group around our biggest problems and priority programmes.

Mutually Agreed Resignation Scheme (MARS) across GWH, RUH, and SFT
Following agreement in the Joint Committee on 23rd May, BSW Hospitals Group introduced a MARS scheme. MARS enables our Trusts to support staff to leave their organisation on a voluntary basis support Trust corporate service savings. The scheme ran between 2nd and 20th June 2025. An update on the take-up rate and impact of the MARS scheme will be shared in August.

MANAGING DIRECTOR'S REPORT

1. Operational

The average ambulance handover delay for May was 60.9 minutes, a reduction of 10.3 minutes compared to April 2025. Achieving the national target for ambulance handover times is one of the Trusts breakthrough objectives, and work is underway to reach an average handover target time of 33 minutes. One of the key areas to achieve the target is to optimise the newly expanded Medical Same Day Emergency Care (SDEC) unit, which opened on the 23rd of June 2025.

In April 28-day faster diagnosis cancer performance declined to 67.2%, and 31-day cancer performance improved slightly to 90.4%, however this remained below the 96% target. The Trust achieved above trajectory on the 62-day standard, delivering 72.3%. The key contributors for underperformance on the cancer standards are in Breast and Colorectal cancers. To improve the performance in Breast, a locum consultant has been appointed, and a 1-stop clinic is now operational.

In May, the number of patients waiting less than 18-weeks for their first outpatient appointment was 62.3% against the target of 72%. There is work underway within the 3 specialties to clear the backlog of long waiters, review capacity, and to redesign clinical pathways to reduce waits.

2. Finance

The RUH Group is £7.2m adverse to plan at the end of May, of which £6.6m arising in RUH Trust and £0.8m in Sulis. This is significantly adverse to plan and has triggered regulatory intervention through the Recovery Director and immediate enhanced expenditure controls.

The key driver is £4.5m variance arising from under delivery of the £29.7m savings programme and acceleration of delivery plan and scoping of further areas to close the unidentified gap must be top priorities for the organisation. £9.1m remains unidentified at his time and there are significant delivery risks within planned schemes.

Further adverse variances arise from deterioration in the exit run rate (£1.0m), and operational pressures arising from increased spend on high cost drugs and devices (£0.2m), Corporate cost pressure (£0.2m) and Estates and Facilities Maintenance Costs (£0.5m), and Sulis profitability levels (£0.8m) which require recovery or further mitigation.

Cash balances for the Trust are £29.2m, which was £4.0m lower than forecast. Further work is ongoing on updating the metric for the breakthrough objective of 6.7% improvement in implied productivity by the end of Quarter 1.

The Trust operates within BSW Integrated Care System which has reported a £13.4m adverse variance to plan year to date, of which BSW Hospitals Group is £16.6m adverse to plan.

3. Workforce

Twenty four colleagues from the People profession across the BSW Hospitals Group have completed the AlignOrg methodology to support with organisational design work. It is key to capability building to enable us to be more successful with the Corporate Redesign Transformation programme.

4. Closure of the Special Care Baby Unit at Yeovil Hospital

On 19th May 2025 Somerset Foundation Trust made the difficult decision to temporarily close their Special Care Baby Unit at Yeovil Hospital, as a result, the Trust is also unable to safely provide care during labour and birth at the Yeovil Maternity Unit for an initial period of six months. Outpatient services continue as usual including antenatal clinics, consultant clinics, scanning and community midwife service, including the homebirth service.

As of 25 June 2025:

- 29 women/birthing people have remained with Yeovil community team and have booked to birth at RUH
- 22 women have transferred all their care and rebooked with RUH community services
- 3 women have birthed at RUH who previously intended to birth at Yeovil Hospital
- We are also supporting staff to join the RUH team to support the additional referrals and activity which includes midwives, neonatal nurses and student midwives.

The RUH Maternity and Neonatal leadership team continue to work with the team at Yeovil to support a seamless transition of care and the impact of the additional activity is being monitored and will feature in future Board reports.

5. Sustainability Week

In June the RUH held a Big Green Week – celebrating the RUH's commitment to sustainability and the NHS goal of achieving Net Zero. Activities included an active travel roadshow, information on volunteering and environmental activities to take part in, waste and recycling stands to support the RUH's new food segregation system and advice on small steps that we can all take to improve sustainability. Staff were also able to find out more about options for cycling to work and buying a bike through the cycle scheme.

6. RUH staff celebrated for award-winning achievements

The highest quality of care, compassion and innovation was recognised in May at the RUH's annual staff awards ceremony. Winners of the You Matter Awards were selected from over 200 nominations in seventeen categories, thanking staff for their exceptional dedication to people they care for, the people they work with and people in the wider community.

Staff were also recognised for 25, 35 and 45 years of service.

Award winners:

- **Volunteer of the Year Award winner** - Emergency Department Volunteer Andrew Edwards
- **Student of the Year Award winners** - Lead Pharmacy Technician for Operations Sarah Thompson and Electrical Apprentice Reece Paginton
- **Working With Our Community Award winner, sponsored by apetito** - midwife Emily Williamson in the Lotus midwifery team
- **Sustainability Award winner** - Speciality Doctor Liz Brown
- **Patient Safey Award winner** – Pain Clinic sister Roisin Davis
- **Corporate Services Improvement Award joint winners** - People Programme Partner Hannah McCoid and Business Intelligence Unit team - Charlie Gale, Shaun Lomax, Annika Atkins and Frances Cathcart-Burn.
- **Research and Innovation Award winner, sponsored by Health Innovation West of England** - Breast Cancer Genes and Me, Digital Patient Empowerment Project team.
- **Personal Achievement Award winner, sponsored by J4 Projects** - Research Database Manager Charlotte Cavill
- **Wellbeing at Work Award winner** - Clinical Practice Facilitator Ruby Sejas
- **Kindness and Civility Award winner** - Senior Clinical Practice Facilitator Ruel Donaire
- **Equality, Diversity and Inclusion Award winner** - Clinical Practice Facilitator JJ Estose
- **Rising Star Award winner** - People Advisor Kerrie Baker
- **Leader of the Year Award winner, sponsored by Linea** - Senior Sister Sam Rye
- **Lifetime Achievement Award winner, sponsored by Electrio** - Consultant in Anaesthesia and Intensive Care Kim Gupta
- **Everyone Matters Annual Award winner** - Cardiac ward Senior Sister Katie James

- **Making a Difference Annual Award winner** - Paediatric Diabetes Administrator Molly Priestley
- **Working Together Annual Award winner** - Hospital at Home team

7. RUH sets up new support group for heart failure patients

In May the Trust launched a new support group to bring together patients with heart failure to share their experiences of the illness. The group also gives patients the opportunity to ask clinical staff any questions they may have about heart failure and to get advice. This has been positively received by patients.

8. Radiology Department Anniversary

Our Radiology Department celebrated its 50th anniversary in May. Our radiology department is a key part of our hospital, with over 90% of patients being seen by the department for X-rays, CT scans and MRIs. During the last 50 years the department has been transformed to ensure it continues to provide the best service including introducing modern MRI and CT scanners as well as X-Ray and ultrasound facilities.

9. New Sulis Orthopaedic Centre to cut surgical waiting times for NHS patients

Our new Sulis Orthopaedic Centre (SOC) opened in late May to NHS patients from Bath and North-East Somerset, Swindon and Wiltshire (BSW). The state-of-the-art new specialist surgical centre located just outside of Bath will perform an additional 3,000 planned orthopaedic operations on suitable NHS patients in BSW every year. This will help to significantly reduce waiting times for many patients awaiting such operations, which include life-changing hip and knee replacements.

10. Hospital at Home team celebrates supporting 5,000 patients

In May our Hospital at Home team marked a significant milestone, having helped 5000 patients to leave hospital, supporting them to have an earlier discharge and receive the care they need at home. Patients are safely looked after in the comfort of their own home, and remain under the care of their RUH consultant, until they have safely completed their programme of treatment. Being in a familiar environment can lead to faster and more effective recovery at home.

11. Service to remember special babies

In June the RUH held a special remembrance service for families who have lost a baby through miscarriage, stillbirth or neonatal death. Organised by the Spiritual Care team and the charity Bath Sands, the service is an opportunity for families to come together and remember those lives that were lost too soon.

12. New mouth care boxes support patients' oral health

In June the RUH highlighted an initiative to support oral hygiene for our inpatients. Mouth care is an integral part of a person's health and wellbeing. Often staff are required to support patients with their oral hygiene and need the right equipment to do this. Each ward has now been provided with a mouth care box which includes items such as toothbrushes and toothpaste.

13. Award winning Dyson Cancer Centre

In June the RUH's Art at the Heart team and the interior design team from Arcadis were awarded a European Healthcare Award for the use of interior design, art and sculpture in the Dyson Cancer Centre,

The prestigious award recognises projects that demonstrate exceptional skill in creating a compassionate healthcare environment, using interior design and art. The team was up against projects from as far afield as Singapore and the USA.

As part of the work to develop the Dyson Cancer Centre, Art at the Heart and Arcadis worked with patients and staff and the wider community to develop a 'Land Water Sky' theme, used throughout the building. Thoughtful interior design, the use of natural light and over 100 artworks and art installations, many of which are influenced by the local environment, create a soothing and welcoming space, to balance the high-tech facilities housed in the centre.

Most of the art works in the centre have been funded by the RUH's official charity, RUHX and their donors.

14. RUH Membership

We are always actively seeking new members to help us shape the future of the hospital and as a member of the Trust you can influence many aspects of the healthcare we provide.

By becoming a Member, our staff, patients and local community are given the opportunity to influence how the hospital is run and the services that it provides. Membership is completely free and offers three different levels of involvement. Through the Council of Governors, Members are given a greater say in the development of the hospital and can have a direct influence in the development of services. Simply sign up here: https://secure.membra.co.uk/RoyalBathApplicationForm/

15. Consultant Appointments

The following Consultant appointments were made since the last report to Board of Directors:

Mr Peter Glen was appointed as Consultant in Oral and Maxillofacial Surgery and commenced his new role on 1st June 2025.

Mr James Berwin was appointed as Consultant in Trauma and Orthopaedics on 15th May 2025. Mr Berwin is currently a Consultant in Trauma and Orthopaedics and North Bristol NHS Trust and will commence his new role on 1st August 2025.

Report to:	**Public Board of Directors**	**Agenda item:**	**9**
Date of Meeting:	**2 July 2025**		
Title of Report:	**Board Assurance Framework**		
Status:	**Assurance**		
Board Sponsor:	**Andy Hollowood, Interim Managing Director**		
Author:	**Marty McAuley, Corporate Governance Specialist** **All Executive Directors**		
Appendices	**None**		

1. Executive Summary of the Report

Purpose of report:

This report provides an update on the strategic risks that are part of the Board Assurance Framework. This Board is receiving the summary only.

What is a Board Assurance Framework (BAF):

The BAF sets out our strategic objectives, and the risks to achieving them, alongside the controls and assurance mechanisms that have been put in place to manage risk and deliver the objectives.
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.

Format of the paper

The BAF paper has three parts to it:

- Part 1: Board Assurance Framework – Scorecard.
- Part 2: Board Assurance Framework - Summary of changes.
- Part 3: new look template for the BAF reporting.

Part I: Board Assurance Framework – Scorecard

The scorecard shows:

- A single page document mapping the risks to the objectives.
- Shows where as risk score has increased, decreased or remained static based on its score for this board meeting compared to last time.
- BAF risks mapped to Committees and Executive Leads as well as the objectives.

Part 2: Board Assurance Framework - Summary of changes

The summary of changes shows:

- Each BAF Risk has a risk status which shows if there have been changes to how the risk is articulated or if the risk score has increased, decreased or remained static.
- All Executive Leads have reviewed their risks in detail.
- Key changes are also noted for each BAF risk.

Part 3: Board Assurance Framework – New template

The new template shows:

- The detail behind each BAF risk.
- How key risk indicators are being incorporated.
- Clearer focus on controls and assurances.
- This will be presented one risk per page at the next Board.

Next steps:

1) At the next meeting the Board will receive (i) the BAF scorecard, (ii) the BAF summary of changes and (iii) the BAF summary template for each risk.
2) Each BAF risk will continue to be presented to its respective committee for oversight.

Recommendation:

The Board of Directors is asked to note the changes made by the Executive Team and take assurance from the information provided.

2.	Recommendations (Note, Approve, Discuss)
The Board of Directors is asked to take note the changes made by the Executive Team and take assurance from the information provided.	

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. There is one risk in particular that has sustainability context.	

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: JULY 2025

Part I: Board Assurance Framework – Scorecard

BAF	DESCRIPTION OF THE RISK	OBJECTIVE	SCORE MAY BOARD	SCORE JULY BOARD	DIRECTION	EXEC LEAD	COMMITTEE
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.	The people we care for	15	**20**	INCREASE	Chief Nursing Officer	Quality
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.	The people we care for	16	**16**	STATIC	Chief Operating Officer	Quality

BAF	DESCRIPTION OF THE RISK	OBJECTIVE	SCORE MAY BOARD	SCORE JULY BOARD	DIRECTION	EXEC LEAD	COMMITTEE
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.	The people we work with	16	**16**	STATIC	Chief People Officer	People
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.	The people we work with:	20	**16**	REDUCTION	Chief People Officer	People

BAF	DESCRIPTION OF THE RISK	OBJECTIVE	SCORE MAY BOARD	SCORE JULY BOARD	DIRECTION	EXEC LEAD	COMMITTEE
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.	The people in our community	20	**25**	INCREASE	Chief Finance Officer	Finance
3.2	If Sulis Hospital does not deliver its financial target it may have a direct financial impact to RUH financial position.	The people in our community	16	**12**	REDUCTION	Chief Finance Officer	Subsidiary
3.3	Without reducing unwanted variation and addressing inequity of care, people may not receive appropriate levels of care.	The people in our community	16	**20**	INCREASE	Chief Medical Officer	Quality
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.	The people in our community	16	**16**	STATIC	Chief Nursing Officer	Non-Clinical Governance
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.	The people in our community	15	**15**	STATIC	Chief Nursing Officer	Non-Clinical Governance
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.	The people in our community	16	**20**	INCREASE	Chief Transformation & Innovation Officer	Non-Clinical Governance
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.	The people in our community	16	**20**	INCREASE	Chief Transformation and Innovation	Non-Clinical Governance

Part II: Board Assurance Framework - Summary of changes

People we care for:

	Risk description	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.	**Risk Status: Risk description updated** **Risk Status: Risk score increased** • Reworded the risk to more accurately define the risk. It is shorter and less wordy. The new wording is as follows: There is a risk that we may not deliver the quality and safety standards resulting in harm to patients • There are 3 key risks in the risk register (key risk indicators) that are all at 16. As such we have changed the BAF risk score from 15 to 20. The previous score was Impact 5 and Likelihood 3 which was 15. The impact remains the same at 5 but the likelihood score has been increased to 4. • The target score has been set at 16 (Impact 4 and Likelihood 4). This is a realistic target score for March 2026. There will be scope to reduce the score further in the future, but it is unrealistic to reduce any further at this point, especially noting that we have just increased the risk score. • Actions have been completed and become controls. • Sources of assurance have been strengthened.
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.	**Risk Status: Risk description updated** • Reworded the risk to more accurately define the risk. It is shorter and less wordy. The new wording is as follows: There is a risk that patients may be dissatisfied with the care they receive or the time they had to wait for it, as increasing demands on emergency and planned care is exceeding our capacity to treat patients promptly. • The target score has been set at 16 (Impact 4 and Likelihood 4). This is a realistic target score for March 2026. There will be scope to reduce the score further in the future, but it is unrealistic to reduce any further at this point. • Reviewed controls ensuring all controls are active and relate directly to the risk.

People we work with:

	Risk description	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.	**Risk Status: Risk description updated** • Reworded the risk to more accurately define the risk. The risk title was updated from possible managerial discrimination to possible discrimination from Managers or Colleagues. • Key controls were updated. • The target score has been set at 12 (Impact 4 and Likelihood 3). • This is a realistic target score for March 2026. • Risk to be further reviewed and updated to more accurately reflect the risk, around creating the right culture for people to thrive.
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.	**Risk Status: Risk reduced** • The risk has been reduced from 20 to 16. This is due to a reduction in the likelihood of the risk. • The key control for the risk has been added as the leadership programme has now been approved. • 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	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.	**Risk Status: Risk score increased** • Key source of assurance is the Audit Opinion. Following the significant weakness identified the score was updated. • Key controls and actions have been agreed. • Clear plan in place that will cover four key areas have been added to the risk.
3.2	If Sulis Hospital does not deliver its financial target it may have a direct financial impact to RUH financial position.	**Risk Status: Risk score reduced** • This risk is currently scored as a 16 but the original score is 20. It is proposed to reduce the current score to 12. • Whilst the impact of the risk remains the same (4) the likelihood of it occurring has been reduced (3). • There are strong controls and processes for assurance in place, and these have been reviewed.
3.3	Without reducing unwanted variation and addressing inequity of care, people may not receive appropriate levels of care.	**Risk Status: Risk score increased** **Risk Status: Risk description updated** • Reworded the risk to more accurately define the risk. The new wording is as follows: There is a risk that we will not provide equitable care to patients, if we do not recognise their individual needs and provide the right care pathways. • Key controls to manage the risk have been identified and implemented • Increased the risk score as it was previously underscored. The likelihood of this risk is a 5 and not a 4. The consequence remains at 4.
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.	**Risk Status: Risk description updated** • Reworded the risk to more accurately define the risk. It is shorter and less wordy. The new wording is as follows: There is a risk that without sufficient money to manage our ageing estate and maintenance backlog, we could fail to meet regulatory requirements. • The target score has been set at 16 (Impact 4 and Likelihood 4). This is a realistic target score for March 2026. • Actions and assurances have been reviewed and updated.
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.	**Risk Status: Risk description updated** • Reworded the risk to more accurately define the risk. It is shorter and less wordy. The new wording is as follows: **There is a risk that if we are not able to achieve net zero, we may Impact on future generations' health and undermine our role as a community anchor.** • The target score has been set at 15 (Impact 3 and Likelihood 5). This is a realistic target score for March 2026. • Risks in the risk register have been mapped to the BAF as key risk indicators with strengthened controls.
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	**Risk Status: Risk owner updated** • The Executive Lead for this risk is Jonathan Hinchliffe, Chief Transformation and Innovation Officer. Full risk review completed. • Increased the risk score as it was previously underscored. The new score is 20. The impact of this risk is a 5 and the Likelihood is a 4. • Target score has been set at 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	**Risk Status: Risk owner updated** • The Executive Lead for this risk is Jonathan Hinchliffe, Chief Transformation and Innovation Officer • Increased the risk score as it was previously underscored. The new score is 20. The impact of this risk is a 5 and the Likelihood is a 4. • Target score has been set at 16. • Full review of the risk, controls and assurance has been completed.

Part III: New look template for BAF – Example risk only

Risk Lead:	The people we care for	**RISK**	There is a risk that xxxxxx

CAUSE	Things that drive the risk and can make it happen
CONSEQUENCE	If the risk materialises what we are going to do

Risk Lead:		**Accountable Exec:**		**Directorate:**		**Committee:**	Name of
Risk Domain:		**Risk Appetite:**		**Is it within appetite**			

Score without Controls						**Score with controls**						**Score when risk fully managed**					
Likelihood:	5	**Impact:**	4	**Score:**	**20**	**Likelihood:**	5	**Impact:**	3	**Score:**	**15**	**Likelihood:**	5	**Impact:**	2	**Score:**	**10**

KEY RISK INDICATORS		
ID	**RISK**	**SCORE**
2074	There is a risk that patient safetyxxxxxx	**16**
		16

KEY RISK INDICATORS		
ID	**RISK**	**SCORE**
2557	There is a risk that due to the lack of xxxxx	**16**

KEY CONTROLS OF THIS RISK	
1	Monthly IPR produced and scrutinised across division, executive, committee, council of governors identifying areas of non-delivery and so what…xxxxxxxx
2	Trust Quality and Safety Group xxxxxxx
3	Complaints and compliments xxx

KEY SOURCES OF ASSURANCE THAT THE RISK IS BEING MANAGED	
1	Quality Accounts xxxxx
2	Learning from Deaths & Mortality Reviews xxxxx
3	Go & See xxxxxxx

ACTIONS TO BE TAKEN	**Who**	**When**	**Control or Assurance**
• A Clinical Effectiveness Committee xxxxx	Manager	Date	Control
• Standardise and enhance Divisional Governance processes under review xxxxx	Manager	Date	Control
• Paperless in Patients went live in August 2024 – optimise data reporting to improve insight sxxx	Manager	Date	Assurance

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**10**
Date of Meeting:	**2 July 2025**		
Title of Report:	**Integrated Performance Report**		
Status:	**For Noting**		
Board Sponsor:	**Andy Hollowood, Interim Managing Director (on behalf of Chief Operating Officer)** **Toni Lynch, Chief Nursing Officer** **Alfredo Thompson, Chief People Officer** **Simon Truelove, Interim Chief Finance Officer**		
Author:	**Operational Team** **Rob Elliott, Lead for Quality Assurance** **Matt Foxon, Deputy Chief People Officer** **Tom Williams, Head of Financial Management**		
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 April 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.

Operational Performance

The average ambulance handover delay for May 2025 was 60.9 minutes, a reduction to 10.3 minutes on average compared to April 2025. Through May 2025 the total hours lost was 2,144. This is a 154-hour decrease compared to last month's lost hours of 2,298.

RUH 4-hour performance in May was 58.2% on the RUH footprint a slight decrease from April's performance (58.6%) this is not inclusive of Minor Injury Unit (MIU) performance which is operated by HCRG Care Group. RUH non-admitted performance was 70.3%, which was a the same as April performance, and admitted performance was slightly improved at 29.4% compared to April.

The number of patients going through our Medical Same Day Emergency Care (MSDEC) and Frailty Same Day Emergency Care (FSDEC) continues to increase, with a parallel increase in our performance at 36% for May 2025 (April 35.1%).

In May 2025, 71.72% of patients received their diagnostic within the 6-week target against an in-month target of 84.25%. Increased demand for urgent and suspected cancer continues to impact on available capacity for routine diagnostics, despite increased activity levels. Total breaches reduced by 68 and 465 additional diagnostic

tests delivered in May 2025 when compared to April 2025.

In April (cancer performance reported one month in arrears) the RUH achieved 67.2% against the 28-Day standard, a decrease from March due to a continued gap in Breast due to locum availability, and additional demand for outpatients in Colorectal and an increase in waiting times due to high rates of referral. 31-Day performance improved slightly to 90.4% but remained under target due to the Breast locum gap. Skin and Urology surgical capacity breaches also impacted performance. Against the 62-Day standard the RUH achieved above trajectory, delivering 72.3%. Alongside the Breast capacity, increased waiting times for Lung outpatients and diagnostics at RUH and UHBW resulted in the Trust not achieving the new 75% national target.

In May, Referral to Treatment (RTT) saw an increase in total patients waiting over 18-weeks by 1.6%, but a static performance of 60.6%. The number of patients waiting less than 18-weeks for their first outpatient appointment was 62.3% (0.2% improvement from April). Total over 52-week waiters increased from 614 to 872 (+36%).

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.

Pressure Ulcers

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

For April 2025, the RUH reported 0.6 pressure ulcers per 1,000 bed days (10 pressure ulcers). GWH reported 0.34 and Salisbury data was not available.
The RUH investigated one category 3 pressure ulcer, six category 2 pressure ulcers and three medical device related pressure ulcers across seven wards.
Locations on the body were feet and sacrum, nostril and ear. The themes were variance in skin checks and pressure relieving. The Divisions are working closely with the wards on action plans for improvement.

Falls

There were 3 reported falls that resulted in moderate harm to patients. Huddles were completed for these incidents to explore if there was any new learning to be noted. As a result of several falls across the 3 divisions, the Trust has commenced a trust wide Patient Safety Incident Investigation (PSII) which is due to be completed in 3-6 months.

Infection Prevention and Control Update

There were 5 Hospital Onset, Healthcare Acquired (HOHA) cases of Clostridioides

Difficile infection (CDI) reported during April 2025. The IPC team are working with the Southwest CDI collaborative and as of, yet no specific contributor has been linked to the cases identified at RUH.

There were 10 cases of E. coli infection reported during April 2025 (3 HOHA and 7 Community Onset, Healthcare Acquired). Five cases that were identified as having a urinary source, there is an improvement plan focussed on hydration.

Patient Support and Complaints
In April 2025, the Trust received 32 new complaints (this compares to 40 in March). The majority of complaints were about clinical care (n=14) consistent with previous months. The Medicine Division received the highest number of new complaints (n=14).

3 complaints were reopened in April; this is higher than the previous month.
The complaint rate per 1000 patients in April was 0.47 which is down from 0.54 in March. In April 98% of all concerns were acknowledged within 2 working days.

The response times for formal complaints continues to fall below the target of 90% with 78% of complaints responded to within the agreed timeframe. This varies by Division, however in April the Surgery Division responded to 100% of complaints within the agreed timeframe. 78% of all contacts with PSCT were resolved within 14 days.

Safe Staffing
The combined shift fill rates for days for RNs across the 25 inpatient wards was 92% and 97% respectively for nights. The combined shift fill for HCSWs was 89% for the day and 99% for the night shift. Therefore, the Trust as a collective set of wards is within safe limits for April.

Average monthly CHPPD is 8.4. CHPPD continues to remain stable for both registered and unregistered staff over the past 12 months.

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

Perinatal Update

- Decrease in MW:BR due to in month due to high level of short-term sickness
- 3 moderate harm incidents all reviewed under PSIRF – see PQST slide deck
- ANNP workforce – going to advert for a trainee post
- Obstetric Doctor maternity training compliance currently 55.6% expected to return to 77% in June and 100% in July 2025, additional sessions generated
- MBRRACE 2023 report received and presented. Stillbirth and neonatal death rate within 2025 reduction target. To continue with full implementation of PMRT, see appendix. Received Ockenden Integration and Three-Year Delivery Plan Progress Report.

Workforce

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

- Actual Total WTE in May 2025 was 5741.3 a slight increase from the M1 position of 5739.6 Total WTE. This was due to an increase in bank usage
- Year to date budget was £58.024m. The actual spend was £60.562m. An overspend of £2.538m
- The vacancy rate reduced from 3.68% in M1 to 3.30% in M2.
- Agency spend as a proportion of the total pay bill decreased from 0.44% in M2 when compared to 0.63% in M1, within the local target of 2.5% and the national target of 3.2%
- Rolling turnover decreased further to 7.57% in M2, which is a positive variance against a target of 11.00%.
- The target percentage figure for Appraisal completion is 90%; Appraisal rate decreased marginally to 80.08% in M2
- Mandatory Training compliance continues to meet target at 88.7% in M2

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.

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

1. Non-attendance due to sickness

Short-Term Sickness:

- Preventative work with teams and managers around early interventions to manage anxiety, stress and burnout.
- Focus has been on Estates and Facilities, via targeted interventions for those on long term sickness, resulting in the Estates and Facilities 12-month absence rate trending down and is the best figure for over 2 years.

Long-Term Sickness:

- MSK campaign ongoing (Wellbeing Outreach Lead), focusing on Emergency Department.
- Reviewing and developing the staff physiotherapy service across the group model to establish the most effective model.
- Following extensive consultation both the Working with Cancer and Wellbeing and Supporting Attendance policies have now been ratified and will be launched in July 2025.

EAP sessions held with multiple departments (particularly Theatres and ED where sickness is high). Along with Health and Wellbeing sessions to support staff with feeling well at work.

2. Appraisal Compliance & Quality:

The appraisal rate remains consistently below the target (currently 9% below). A

revised Appraisal Policy is now ratified, and Divisional People Partners are continuing to support managers to identify colleagues whose appraisals are out of date and signpost to appraisal training. Multiple workstreams have been set up to support this within each division, including FASS piloting a group-appraisal approach with one of the community birthing teams.

3. Agency Spend and Bank Rate

Agency spend is below national target of 3.2%, 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 (98% of agency spend), whilst there continues to be no agency provision in corporate, estates and facilities. Recruitment campaigns are live to recruit Oncology Consultants (4 posts) to support an exit strategy for long-term locums.

In May, bank usage was 11.6% above plan. 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 a recruitment freeze for non-clinical roles with any exceptions requiring regional to support.

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.

Finance

The RUH Group is £7.2m adverse to plan at the end of May, of which £6.6m arising in RUH Trust and £0.8m in Sulis. This is significantly adverse to plan and has triggered regulatory intervention through the Recovery Director and immediate enhanced expenditure controls.

The key driver is £4.5m variance arising from under delivery of the £29.7m savings programme and acceleration of delivery plan and scoping of further areas to close the unidentified gap must be top priorities for the organisation. £9.1m remains unidentified at his time and there are significant delivery risks within planned schemes.

Further adverse variances arise from deterioration in the exit run rate (£1.0m), and operational pressures arising from increased spend on high-cost drugs and devices (£0.2m), Corporate cost pressure (£0.2m) and Estates and Facilities Maintenance Costs (£0.5m), and Sulis profitability levels (£0.8m) which require recovery or further mitigation.

Cash balances for the Trust are £29.2m, which was £4.0m lower than forecast. Further work is ongoing on updating the metric for the breakthrough objective of 6.7% improvement in implied productivity by the end of Quarter 1.

The Trust operates within BSW Integrated Care System which has reported a £13.4m

adverse variance to plan year to date, of which BSW Hospitals Group is £16.6m adverse to plan.

2.	Recommendations (Note, Approve, Discuss)
The Trust Management Executive team 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

June 2025 (May data)

The RUH, where you matter

Executive Summary

Performance

The average ambulance handover delay for May 2025 was 60.9 minutes, a reduction to 10.3 minutes on average compared to April 2025. Through May 2025 the total hours lost was 2,144. This is a 154-hour decrease compared to last month's lost hours of 2,298.

RUH 4-hour performance in May was 58.2% on the RUH footprint a slight decrease from April's performance (58.6%) this is not inclusive of Minor Injury Unit (MIU) performance which is operated by HCRG Care Group. RUH Non-admitted performance was 70.3%, which was a the same as April performance, and admitted performance was slightly improved at 29.4% compared to April.

The number of patients going through our Medical Same Day Emergency Care (MSDEC) and Frailty Same Day Emergency Care (FSDEC) continues to increase, with a parallel increase in our performance at 36% for May 2025 (April 35.1%).

In May 2025, 71.72% of patients received their diagnostic within the 6-week target against an in-month target of 84.25%. Increased demand for urgent and suspected cancer continues to impact on available capacity for routine diagnostics, despite increased activity levels. Total breaches reduced by 68 and 465 additional diagnostic tests delivered in May 2025 when compared to April 2025.

In April (cancer performance reported one month in arrears) the RUH achieved 67.2% against the 28-Day standard, a decrease from March due to a continued gap in Breast due to locum availability, and additional demand for outpatients in Colorectal and an increase in waiting times due to high rates of referral. 31-Day performance improved slightly to 90.4% but remained under target due to the Breast locum gap. Skin and Urology surgical capacity breaches also impacted performance. Against the 62-Day standard the RUH achieved above trajectory, delivering 72.3%. Alongside the Breast capacity, increased waiting times for Lung outpatients and diagnostics at RUH and UHBW resulted in the Trust not achieving the new 75% national target.

In May, Referral to Treatment (RTT) saw an increase in total patients waiting over 18-weeks by 1.6%, but a static performance of 60.6%. The number of patients waiting less than 18-weeks for their first outpatient appointment was 62.3% (0.2% improvement from April). Total over 52-week waiters increased from 614 to 872 (+36%).

Executive Summary

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.

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

For April 2025, the RUH reported 0.6 pressure ulcers per 1,000 bed days (10 pressure ulcers). GWH reported 0.34 and Salisbury data was not available.
The RUH investigated one category 3 pressure ulcer, six category 2 pressure ulcers and three medical device related pressure ulcers across seven wards.
Locations on the body were feet and sacrum, nostril and ear. The themes were variance in skin checks and pressure relieving. The Divisions are working closely with the wards on action plans for improvement.

Falls
There were 3 reported falls that resulted in moderate harm to patients. Huddles were completed for these incidents to explore if there was any new learning to be noted. As a result of several falls across the 3 divisions, the Trust has commenced a trust wide Patient Safety Incident Investigation (PSII) which is due to be completed in 3-6 months.

Infection Prevention and Control Update
There were 5 Hospital Onset, Healthcare Acquired (HOHA) cases of Clostridioides Difficile infection (CDI) reported during April 2025. The IPC team are working with the Southwest CDI collaborative and as of, yet no specific contributor has been linked to the cases identified at RUH.

There were 10 cases of E. coli infection reported during April 2025 (3 HOHA and 7 Community Onset, Healthcare Acquired). Five cases that were identified as having a urinary source, there is an improvement plan focussed on hydration.

Executive Summary

Quality continued

Patient Support and Complaints
In April 2025, the Trust received 32 new complaints (this compares to 40 in March).
The majority of complaints were about clinical care (n=14) consistent with previous months. The Medicine Division received the highest number of new complaints (n=14).

3 complaints were reopened in April; this is higher than the previous month.
The complaint rate per 1000 patients in April was 0.47 which is down from 0.54 in March. In April 98% of all concerns were acknowledged within 2 working days.

The response times for formal complaints continues to fall below the target of 90% with 78% of complaints responded to within the agreed timeframe. This varies by Division, however in April the Surgery Division responded to 100% of complaints within the agreed timeframe. 78% of all contacts with PSCT were resolved within 14 days.

Safe Staffing
The combined shift fill rates for days for RNs across the 25 inpatient wards was 92% and 97% respectively for nights. The combined shift fill for HCSWs was 89% for the day and 99% for the night shift. Therefore, the Trust as a collective set of wards is within safe limits for April.

Average monthly CHPPD is 8.4. CHPPD continues to remain stable for both registered and unregistered staff over the past 12 months.

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

Perinatal Update
- Decrease in MW:BR due to in month due to high level of short term sickness
- 3 moderate harm incidents all reviewed under PSIRF – see PQST slide deck
- ANNP workforce – going to advert for a trainee post
- Obstetric Doctor maternity training compliance currently 55.6% expected to return to 77% in June and 100% in July 2025, additional sessions generated
- MBRRACE 2023 report received and presented. Stillbirth and neonatal death rate within 2025 reduction target. To continue with full implementation of PMRT, see appendix. Received Ockenden Integration and Three-Year Delivery Plan Progress Report.

Executive Summary

Workforce

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

- Actual Total WTE in May 2025 was 5741.3 a slight increase from the M1 position of 5739.6 Total WTE. This was due to an increase in bank usage
- Year to date budget was £58.024m. The actual spend was £60.562m. An overspend of £2.538m
- The vacancy rate reduced from 3.68% in M1 to 3.30% in M2.
- Agency spend as a proportion of the total pay bill decreased from 0.44% in M2 when compared to 0.63% in M1, within the local target of 2.5% and the national target of 3.2%
- Rolling turnover decreased further to 7.57% in M2, which is a positive variance against a target of 11.00%.
- The target percentage figure for Appraisal completion is 90%; Appraisal rate decreased marginally to 80.08% in M2
- Mandatory Training compliance continues to meet target at 88.7% in M2

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.

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

1. Non-attendance due to sickness

Short-Term Sickness:

- Preventative work with teams and managers around early interventions to manage anxiety, stress and burnout.
- Focus has been on Estates and Facilities, via targeted interventions for those on long term sickness, resulting in the Estates and Facilities 12-month absence rate trending down and is the best figure for over 2 years.

Long-Term Sickness:

- MSK campaign ongoing (Wellbeing Outreach Lead), focusing on Emergency Department.
- Reviewing and developing the staff physiotherapy service across the group model to establish the most effective model.
- Following extensive consultation both the Working with Cancer and Wellbeing and Supporting Attendance policies have now been ratified and will be launched in July 2025.
- EAP sessions held with multiple departments (particularly Theatres and ED where sickness is high). Along with Health and Wellbeing sessions to support staff with feeling well at work.

Executive Summary

Workforce continued

2. Appraisal Compliance & Quality:

The appraisal rate remains consistently below the target (currently 9% below). A revised Appraisal Policy is now ratified, and Divisional People Partners are continuing to support managers to identify colleagues whose appraisals are out of date and signpost to appraisal training. Multiple workstreams have been set up to support this within each division, including FASS piloting a group-appraisal approach with one of the community birthing teams.

3. Agency Spend and Bank Rate

Agency spend is below national target of 3.2%, 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 (98% of agency spend), whilst there continues to be no agency provision in corporate, estates and facilities. Recruitment campaigns are live to recruit Oncology Consultants (4 posts) to support an exit strategy for long-term locums.

In May, bank usage was 11.6% above plan. 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 a recruitment freeze for non-clinical roles with any exceptions requiring regional to support.

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.

Executive Summary

Finance

The RUH Group is £7.2m adverse to plan at the end of May, of which £6.6m arising in RUH Trust and £0.8m in Sulis. This is significantly adverse to plan and has triggered regulatory intervention through the Recovery Director and immediate enhanced expenditure controls.

The key driver is £4.5m variance arising from under delivery of the £29.7m savings programme and acceleration of delivery plan and scoping of further areas to close the unidentified gap must be top priorities for the organisation. £9.1m remains unidentified at his time and there are significant delivery risks within planned schemes.

Further adverse variances arise from deterioration in the exit run rate (£1.0m), and operational pressures arising from increased spend on high cost drugs and devices (£0.2m), Corporate cost pressure (£0.2m) and Estates and Facilities Maintenance Costs (£0.5m), and Sulis profitability levels (£0.8m) which require recovery or further mitigation.

Cash balances for the Trust are £29.2m, which was £4.0m lower than forecast

Further work is ongoing on updating the metric for the breakthrough objective of 6.7% improvement in implied productivity by the end of Quarter 1.

The Trust operates within BSW Integrated Care System which has reported a £13.4m adverse variance to plan year to date, of which BSW Hospitals Group is £16.6m adverse to plan.

Trust Priorities 2025/26

Royal United Hospitals Bath NHS Foundation Trust

The people we care for | **The people we work with** | **The people in our community**

Vision Metrics (7-10 Years)

- Providing safe and effective care
- Right care, right time, right place
- Improve the experience of those who use our services
- Recommending RUH as a place to work
- Fair career progression and development
- Reducing discrimination from managers, colleagues and others
- Deliver a sustainable financial position
- Equity of access to RUH for all
- Carbon emission reduction

Breakthrough Objectives 2025/26 (12-18 months)

Valuing Patient & Staff time
Achieving ambulance offload times

Recognising and valuing colleagues' work
Increase percentage of staff feeling valued

Productivity
Maximising value, eliminating waste

Corporate Projects 2025/26

- **Urgent and Emergency Care**
- **Corporate Services Redesign**
- **Theatres Transformation**
- **Outpatient Transformation**
- **Central (efficiency and income)**

Enabling Projects – Clinical Value Review, Demand & Capacity, Digital Transformation, Leadership Development, Embedding Improving Together, Group Design

Strategic Initiatives (3-5 Years)

- **Integrated front door**
- **Patient Safety Incident Response Framework (PSIRF)**
- **Sustaining Improving Together Operational Management System (OMS)**
- **Collaboration as and at Group**
- **Shared Electronic Patient Record (EPR) Benefits**
- **Community Transformation Year 2 - 5**
- **Artificial Intelligence / Automation Programme**
- **Deliver Medium Term Financial Plan**
- **Reduction in Carbon Emissions**

What is an Integrated Performance Report (IPR)

Our IPR is a summary view of how our Trust is performing against various strategic and operational objectives. It is divided into three sections aligned to our People Groups. **The People We Care For** section includes information on performance against key access targets, quality of care and patient experience. **The People We Work With** with section includes information around our workforce and the **People In Our Community** section includes information on our Finances. Within these sections the following terms are used;

Key Term	Definition
Breakthrough Objective	Trust wide area of focus for the next 12-18 months. We are striving for an improvement of more than 20-30% in the metrics over this period.
Key Performance Indicator (KPI)	Key metric that is monitored as part of the NHS National Operating Framework and relates to improving patient care and increasing positive outcomes
Alerting Watch Metric	A metric that has triggered one or more business rules and should be monitored more closely to address worsening performance or celebrate achievement if improving.
Non-Alerting Watch Metric	A metric that we are monitoring but is not a current cause for concern as it is within expected range.

Part 1 | People We Care For

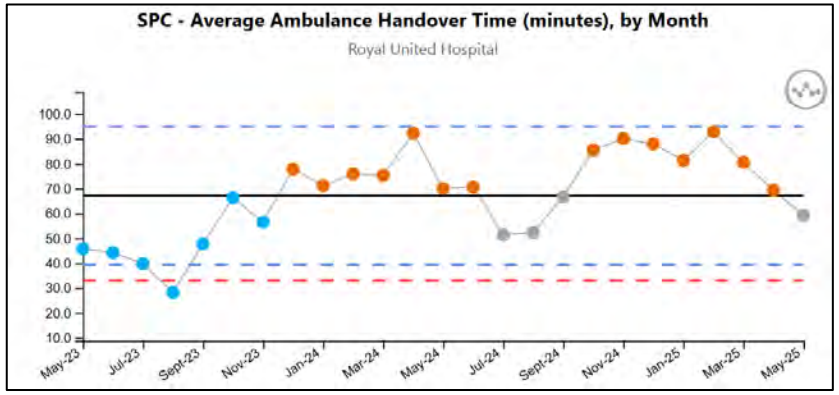
- Providing safe and effective care
- Right care, right time, right place
- Improve the experience of those who use our services

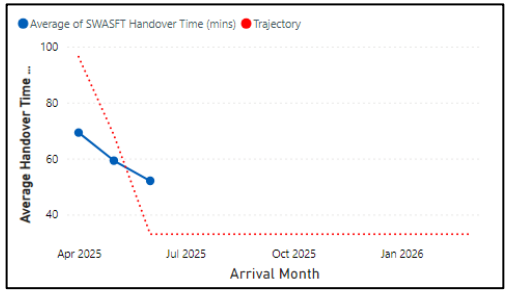
Ambulance Handover Times

Royal United Hospitals Bath NHS Foundation Trust

Breakthrough Objective

We are driving this metric because.. Performance Target:	*The Trust is not meeting the national standard of offloading ambulances into our Emergency Department within 15 minutes. The average offload time in Q1 2025 was 80 minutes. Ambulance offload delays reduce emergency response capacity, delay critical care, and strain hospital resources, putting patient safety and community health at risk.* *Average ambulance handover = 33mins (30th June 2025)*





The average ambulance handover delay for May 2025 was 60.9 minutes, a reduction to 10.3 minutes on average compared to April 2025.
Through May 2025 the total hours lost was 2,144.. This is a 154-hour decrease compared to last month's lost hours of 2,298.

62.2% of handovers were completed within 30 minutes, an improvement of 26.5% since last month. Additionally, handovers taking place in less than 15 minutes improved from 15.7% to 17.8%, giving additional confidence that total handover time is reducing.

May 2025 performance is 9.17 minutes ahead of trajectory; however, June is currently (11/06/2025) 24.93 minutes behind trajectory.

Understanding Performance

Blockers to achievement:
ED overcrowding due to.
- Exit block due to lack of flow into downstream wards
- ED used as default capacity when assessment areas are full
- Delays in ED senior decision making particularly overnight
- Current pit stop being used for extended assessments

ED Footprint:
- Limited physical space to accommodate additional stretchers
- Overcrowding in shared UTC waiting room
- Stretchers being over-used by ambulance colleagues and RUH staff

Countermeasures	Owner	Due Date
Implement a standard procedure for the use of a resus bay to be used as additional off load capacity when not in use – *launched, monitoring compliance.*	TT	28/05/2025 Launched, improving process
ED team to run 2 x PDSA's that will require changing the function of current physical capacity. • Create 2 separate waiting areas • Exchange Pit stop for a larger Rapid assessment area ** both actions also apply to slide 7	MP	30/06/2025 4 – 6 week PDSA's
Increased focus on early escalation proactive rather than reactive) joint working with clinical site team - Liaison role	SH	Ongoing
Work with ambulance colleagues to implement "straight to waiting room" and reduce stretcher usage as per clinical need – TT attending BSW meetings, reviewing SOP.	TT	19/06/2025 and ongoing

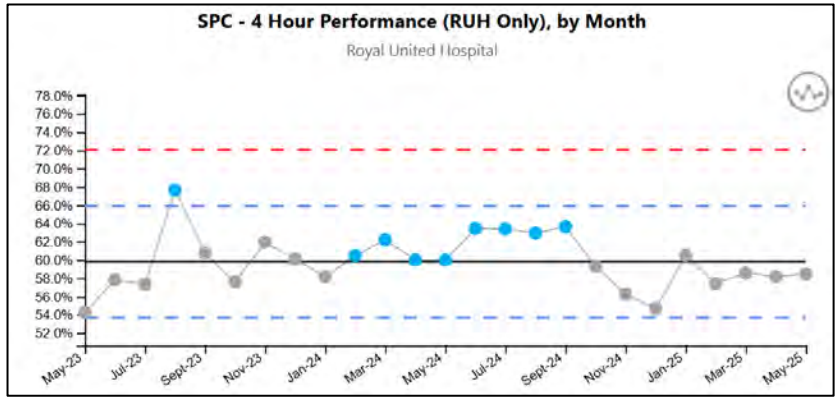
Risks and Mitigation

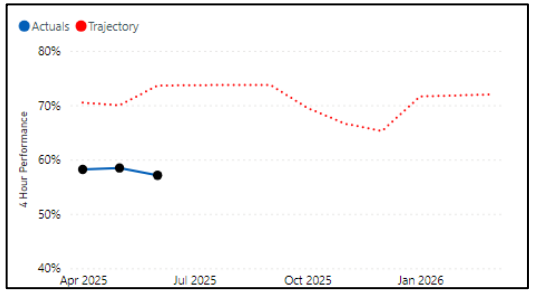
- Risk of >45min handover duration.
  - Site/ED extended handover process in place.
- Risk of patient deterioration in an ambulance not offloaded.
  - RUH ED review of deteriorating pts, QI project in progress.

4 Hour Performance

Royal United Hospitals Bath NHS Foundation Trust

We are driving this metric because..	*The Trust is not meeting the national target for 4hr performance, there is a known negative effect on mortality against extended wait times within an emergency department setting.*
Performance Target:	*78% by March 2026 (72% excl. MIU)*





	Admit	Non-admit	Total	Target
ED	22.34%	36.42%	**29.21%**	**56%**
CED	67.82%	88.74%	**85.70%**	**95%**
UC	59.27%	85.77%	**83.16%**	**95%**
Total	**29.41%**	**70.26%**	**58.45%**	**78%**

*72% target excl. MIU

Understanding Performance

Blockers to achievement:
ED overcrowding due to.

- Exit block due to lack of flow into downstream wards
- ED used as default when assessment areas are full
- Delays in ED senior decision making particularly overnight
- Delays in speciality response times

UTC

- Streaming and redirection is not consistently applied
- UTC is not closing at mid-night as model intended
- UTC clinicians assessing and treating non - UTC activity
- UTC assessment capacity being used by admitting specialties
- Inconsistent GP cover
- Insufficient segregation of UTC and Majors activity

Countermeasures	Owner	Due Date
Open new MSDEC 23rd June 2025, providing 42 chairs and 3 consulting rooms. Surgical SDEC capacity and pathways will be addressed in the wider UEC improvement programme	CY	23/06/2025
1. Undertake medical workforce modelling and address shortfalls / opportunities. 2.Outcome to be shared and discussed with divisional Tri ahead of recommendations to Execs	MP/BI	1.07/06/2025 2. 23/06/2025
Review UTC footprint to consider changes to support internal UTC flow -	UEC TRI	30/05/2025
Streaming PDSA for UTC starting 16/06/2025 for one week, opening 4 MSDEC spaces to test processes.	JR	16/06/2025

Risks and Mitigation

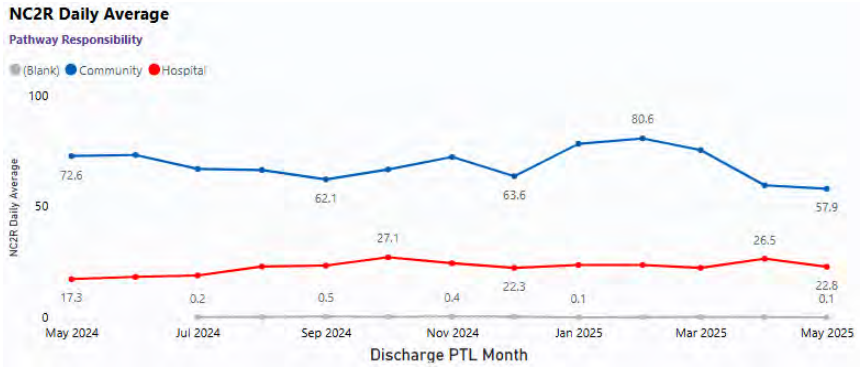
- Risk of increase mortality due to extended wait times in ED/UC.
- Risk of staff burnout and disengagement due to overcrowding.
    - UEC improvement programme to reduce overcrowding.

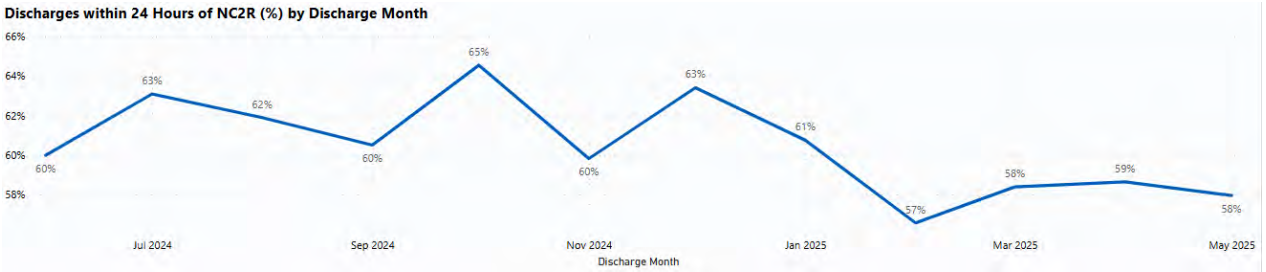
Non-Criteria to Reside

Royal United Hospitals Bath NHS Foundation Trust

We are driving this metric because.. Performance Target:	*The Trust is not meeting the national standard for the number of patients, community and hospital responsibility, who no longer have criteria to reside. In May 2025, the average number of NCTR patients per day was 80.8 a reduction of 5.3 patients compared to April 2025. Discharges within 24 hours of NCTR decreased by 1% in May (58%)* Total of 40 patients per day (community and hospital responsibility) to be delivered in line with the BSW trajectory.

UEC Delivery Group Driver Metric





Understanding Performance

Blockers to achievement:

Community capacity for pathway 1 and 2 patients, more specifically in the Wiltshire locality; RUH referral demand exceeds available capacity.

Countermeasures	Owner	Due Date
Home is Best focus on admission avoidance with system colleagues.	Heather Cooper	Q1 23/24
Further embed P0 therapy referral guidance across all wards – aim for zero P0 therapy delays (Hospital responsibility).	Medicine DMT	Q1 2025/26
75% reduction in hospital-related discharge delays (pathways 1-3) and <5 pathway 0 patients 24 hours post NCTR per day.	Medicine DMT	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	Q1 2025/26
Implementation of the NHS Federated Data Platform Optimised Patient Tracking and Intelligent Choices Application (OPTICA) to establish an accurate and reliable data system to identify and track patients without criteria to reside. Platform implemented successfully 20/05/2025, two weeks of parallel working with the previous process and week commencing 02/06/2025 OPTICA used exclusively with no shadow monitoring.	Sarah Hudson	22/06/2025

Risks and Mitigation

- Non-delivery of the BSW community responsibility NCTR reduction trajectory to deliver the equivalent of 40 patient per day (or 9-10% of the non-elective bed base).

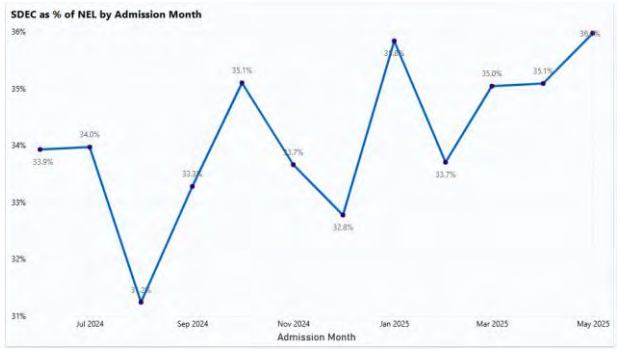
SDEC

Royal United Hospitals Bath NHS Foundation Trust

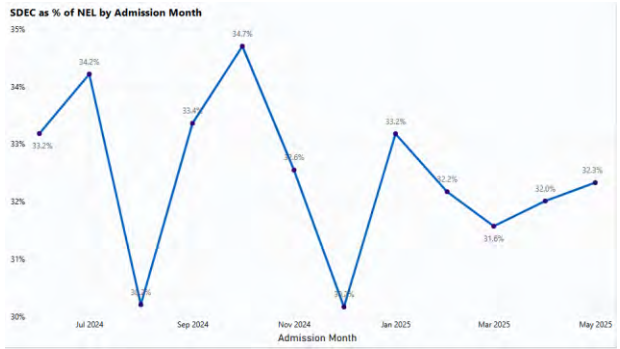
UEC Delivery Group Driver Metric

We are driving this metric because.. Performance Target:	*SDEC models are a credible alternative to admission which are known to improve exit block and flow from ED. They support UEC recovery by reducing long waits in ED which are associated with worse patient outcomes and increased mortality. They can support in reducing LOS for medical and frail patients by facilitating rapid investigation and management.* *40% of non-elective medical patients have a zero-day length of stay.*

Trust Wide SDEC Performance May 2025:
36% against a target of 40%



Medicine Division SDEC Performance May 2025:
32.3% against a target of 40%



Medical Division are responsible for two SDEC services:

Service / Monthly Activity	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25
Medical SDEC (Amb Care and DAA)	462	572	517	495	474	487
Frailty SDEC (OPRAA and OPU)	21	14	13	25	22	32
Other Measures:						
Number of GP Admissions through ED	5	14	11	8	6	5

Understanding Performance

Blockers to achievement:

- Reduced Medical and Frailty SDEC capacity.
  - Limited physical space
  - Reduced Consultant/Medical workforce (vacancies)
  - Reduced Therapy workforce (frailty)
- Expected patients arriving to ED/UC inappropriately when Amb Care/DAA/OPRAA is full
- Lack of accurate frailty scoring at front door – needed for the patient to go to the right SDEC service first time
- Unanswered Cinapsis (primary care referral) calls – could be creating more demand on ED/use of suboptimal patient pathways
- Unclear pathways and service criteria causes some confusion/delays
- Time of arrival of patient limits the time available to treat and discharge by midnight

Countermeasures	Owner	Due Date
Open new MSDEC 23rd June 2025, providing 42 chairs and 3 consulting rooms.	CY	11/06/2025
Increase cover on Cinapsis phone to improve admission avoidance, streaming to other services and use of appropriate patient pathways	CY	1/10/25
BSW SDEC Oversight and Working Group - to ensure a consistent BSW delivery against the national requirements	CY and RK	Ongoing
Training for front door clinicians on Clinical Frailty Scoring (CFS)	RK	30/7/25
Development of Integrated Front Door (IFD) Lead and IFD working	FM, BI, CY, RK	30/8/25

Risks and Mitigation

<u>Consultant recruitment (acute med)</u>
High risk of impact
Interviewing IFD Lead mid-July
Using consultant funding differently (ST3+)

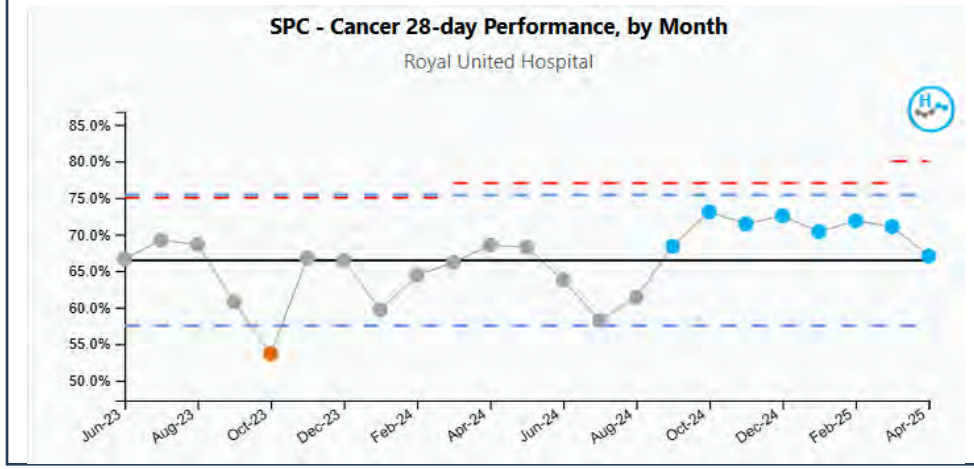
<u>Flow from SDECs to specialty beds</u>
High risk of impact
Site aware
SOPs to be followed

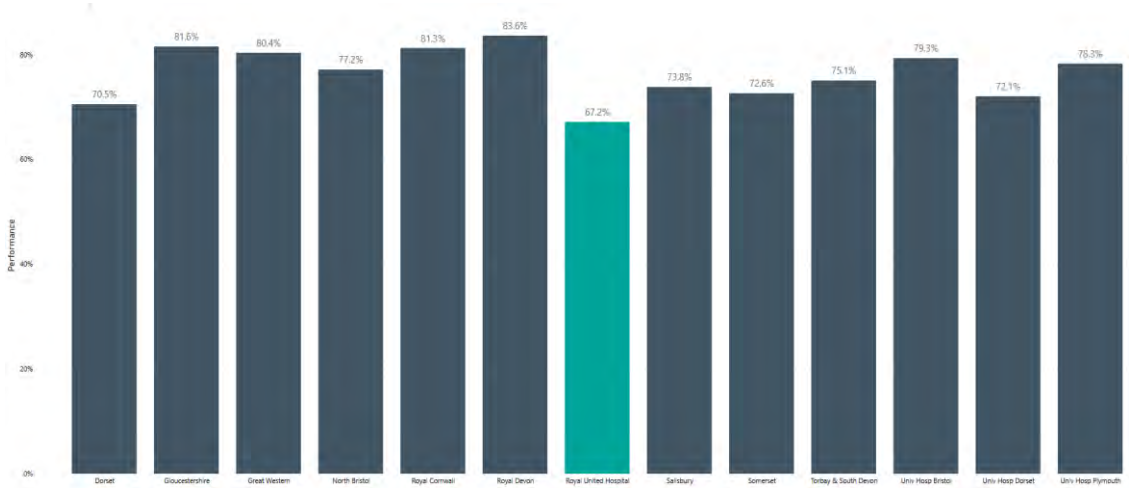
28 Day Cancer Performance

Royal United Hospitals Bath NHS Foundation Trust

We are driving this metric because..	*The Trust is not meeting the national 28 Day Faster Diagnosis Standard target. There is a known link between delayed diagnosis of cancer and poorer outcomes for patients. The Trust is currently in NHSE Tier 2 for cancer performance.*
Performance Target:	*80% by March 2026 (increase from 77% in 2024/25)*

SPC & supporting data if required





Understanding Performance

Performance declined further in April to 67.2%, the lowest since August 2024.

Top contributors:
Breast, Colorectal, Urology

In month challenges:
- Continued Breast locum gap leading to reduced one-stop capacity and longer OPA waiting times
- Colorectal high demand in February leading to increased OPA and endoscopy waiting times
- Long term Gastro consultant vacancies – OPA wait for IDA
- Urology Prostate demand increase and consultant sickness – longer OPA and MRI scan and reporting waiting time
- LATP waiting time reduced with WLIs but long term substantive capacity deficit remains

Countermeasures	Owner	Due Date
Breast Locum consultant appointed	HW	May 2025
Breast one-stop service full implementation	HW	June 2025
Breast pain pathway – ANP recruited	RR/RS	June 2025
IDA service from Gastro to Colorectal – tri-divisional meeting with MD 11/06	NL	June 2025
Change Colorectal consultant list from operating to OPA	NL	June 2025
Urology reduced PSA clinic polling range and WLIs – waiting time now below four days	KR / Exec Team	February 2025
LATP nursing staffing investment case (3.8 WTE)	KR	May 2025

Risks and Mitigation

Risks:
- Financial position
- Recruitment
- Sickness
- Agency locums – availability / leave role at short notice
- Skin insourcing dependency
- Increases in demand
- Pressures on resources from RTT, 4 hours, DM01

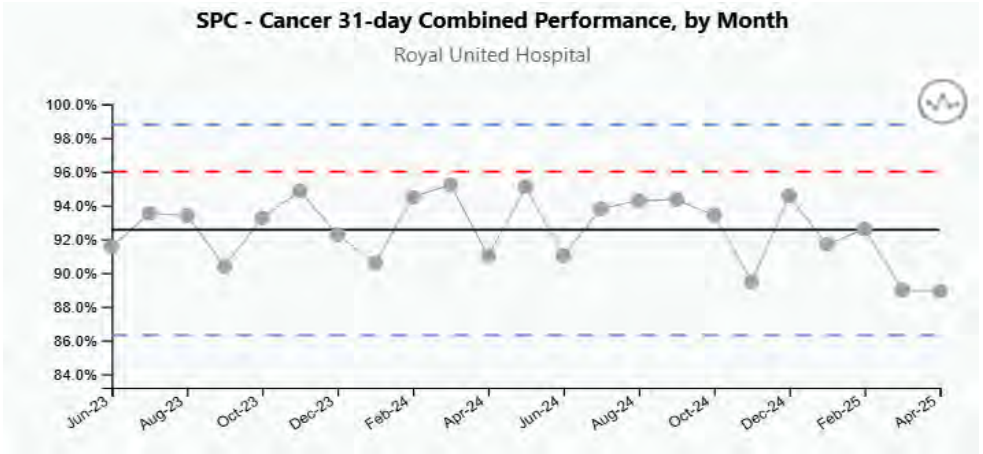
Mitigation:
- SWAG funding for WLI
- Clinic rooms being created in Gastro footprint
- IDA pathway transfer

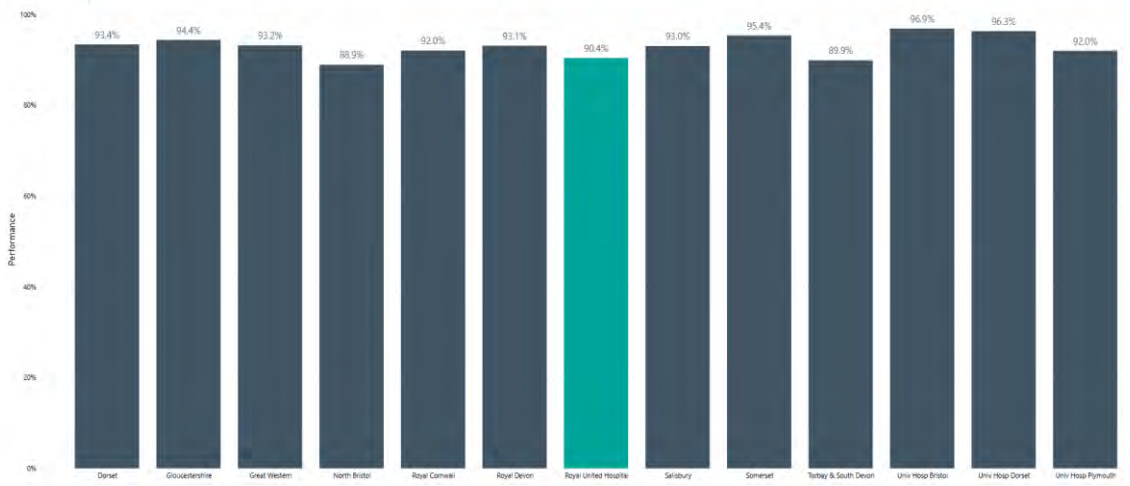
31 Day Cancer Performance

Royal United Hospitals Bath NHS Foundation Trust

We are driving this metric because..	*The Trust is not meeting the 31 Day DTT to Treatment combined standard with patients experiencing longer waits to commence first and subsequent treatments for cancer.*
Performance Target:	*96%*

SPC & supporting data if required





Understanding Performance

Performance improved by 1%, achieving 90.4%.

Top contributors:
Breast, Skin, Urology

In month challenges:
- Breast surgeon sickness and locum gap – previous locum left but new locum appointed end of May – delay in operating
- Dermatology MOPs capacity
- Uptake of WLIs in June reduced following pay rate change
- Urology consultant sickness in March/April
- Urology surgical backlog due to LATPs being done in theatres in late 2024, creating surgical backlog
- Increased waiting time for non-prostate surgery due to booking process

Countermeasures	Owner	Due Date
Breast Locum consultant appointed – operating from 03/07	HW	July 2025
Theatre WLIs – covering all bar one vacated list in June	HW	June 2025
OMFS and Dermatology MOPs WLIs – SWAG funded	NG / GJ	July 2025
Teledermatology 'see and treat' clinics	GJ	June 2025
Urology theatre WLIs – SWAG funded	KR	June 2025
New theatre booking/case prioritisation process	KR/EJ	June 2025

Risks and Mitigation

Risks:
- Sickness
- Agency locums – availability / leave role at short notice
- Reduction in Skin MOPs WLI uptake following change in pay structure
- Increases in demand
- Pressures on resources from RTT
- Ability to provide robotic WLIs at weekends

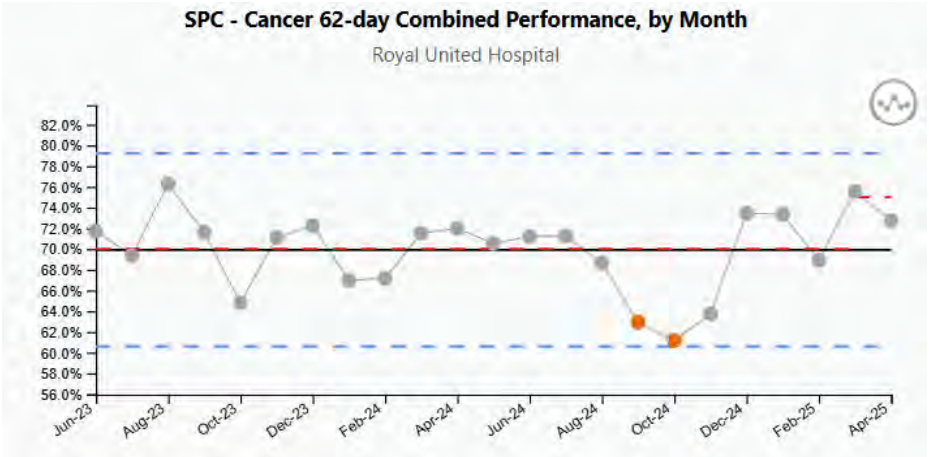
Mitigation:
- SWAG funding for WLI

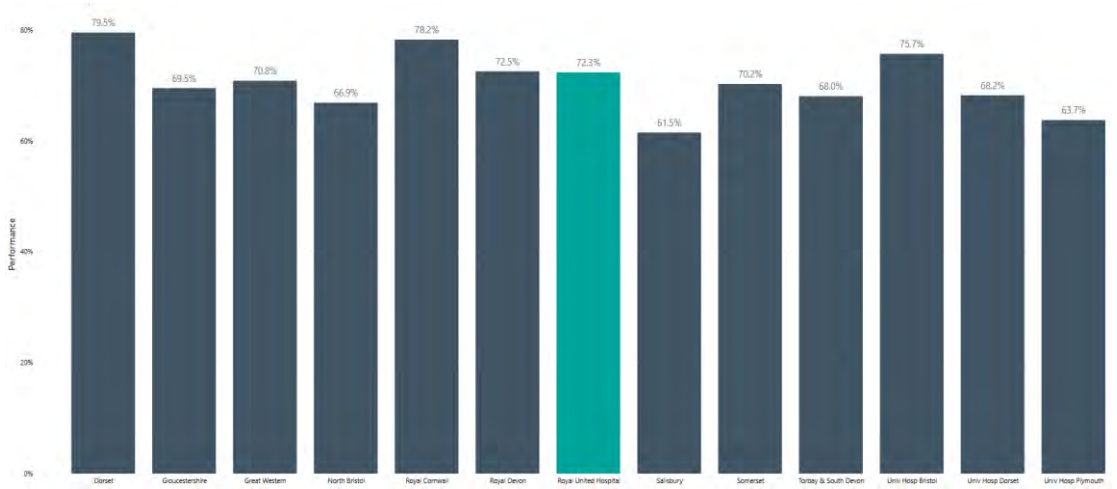
62 Day Cancer Performance

Royal United Hospitals Bath NHS Foundation Trust

We are driving this metric because..	*The 62 Day Referral to Treatment combined standard remains a focus for the Trust as a core access standard. The national target is increasing in 2025/26 to a level which the Trust is not yet achieving.*
Performance Target:	*75% by March 2026 (increase from 70% in 2024/25)*

SPC & supporting data if required





Understanding Performance

Performance reduced to 72.3%, under the new national target for 2025/26 of 75%.

Top contributors:
Breast, Colorectal, Lung, Urology

In month challenges:
- Breast locum gap led to increased waits for surgery
- High demand from Breast screening services
- Colorectal performance improvement but breaches due to Gastro OPA waiting time for IDA pathway patients
- Lung increased demand through screening
- OPA, PET, image-guided biopsies and Oncology waits
- Longer PSA OPA waits due to increased demand and consultant sickness
- Prostate MRI reporting waiting times

Countermeasures	Owner	Due Date
Breast Locum consultant appointed operating from 03/07	HW	July 2025
IDA service from Gastro to Colorectal – tri-divisional meeting with MD 11/06	NL	June 2025
Colorectal theatre WLIs – SWAG funded	NL	June 2025
Additional respiratory physician business case	MW-H	June 2025
PSA OPA WLIs and reduced eRS polling range	KR	May 2025
Radiology WLIs to reduce Prostate MRI reporting	NA	June 2025

Risks and Mitigation

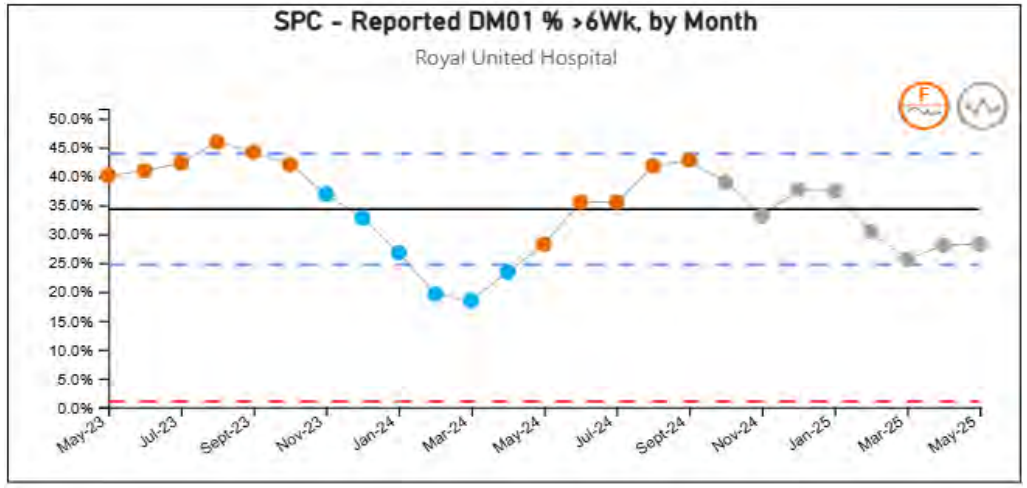
Risks:
- Sickness
- Recruitment
- Agency locums – availability / leave role at short notice
- Reduction in Skin MOPs WLI uptake following change in pay structure
- Increases in demand
- Pressures on resources from RTT, 4 hours, DM01

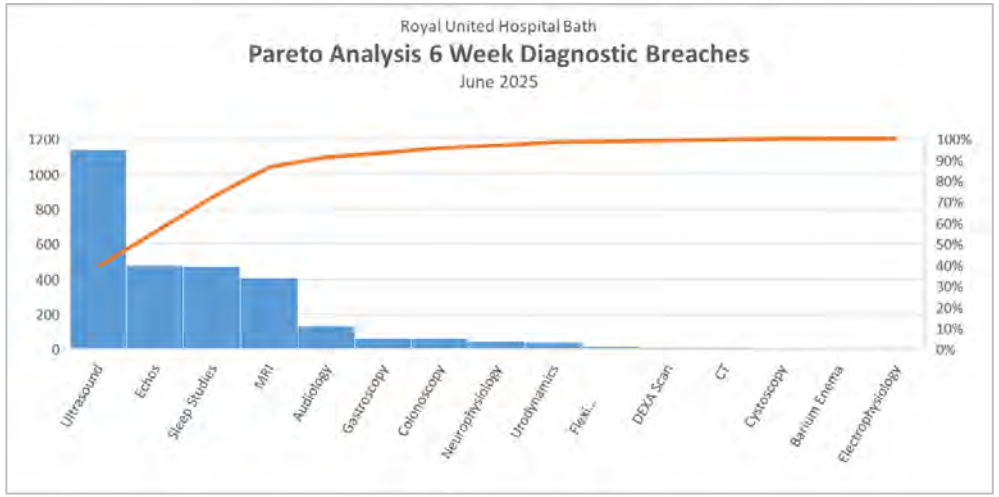
Mitigation:
SWAG funding for WLI

Diagnostic waits

Royal United Hospitals Bath NHS Foundation Trust

Performance Target: 95% compliance (<5% breaches)	*Patients are waiting longer than 6 weeks for their routine diagnostic test (DM01). The Trust is not meeting the national target for DM01 performance, which is ≤5% breaches for 2025/2026.*





Understanding Performance

- *In May 2025, 71.72% of patients received their diagnostic within the 6-weeks against the 84.25% target.*
- *Whilst performance has not changed, there was a reduction of 68 breaches and Diagnostic activity increased by and 465 tests.*
- *The **top contributors** to 6 week breaches were USS, Echo and Sleep Studies*
- *Key drivers of underperformance were:*
  - *Surge in demand during March-April*
  - *USS staffing issues (sickness)*
  - *Reduction of WLI activity due to school holidays*
  - *Delay in transferring Sleep Studies to Sulis CDC*

Countermeasures	Owner	Due Date
Continuation of WLIs for USS, MRI and Echo.	NA/BI	In place
USS insourcing at weekends	PN/NA	In place
Transfer of Sleep Studies activity to Sulis CDC.	Sulis CDC	Q2 25/26
Weekly review of each modality – performance, demand and activity against trajectory. (~3% performance gain)	NA/JS	In place

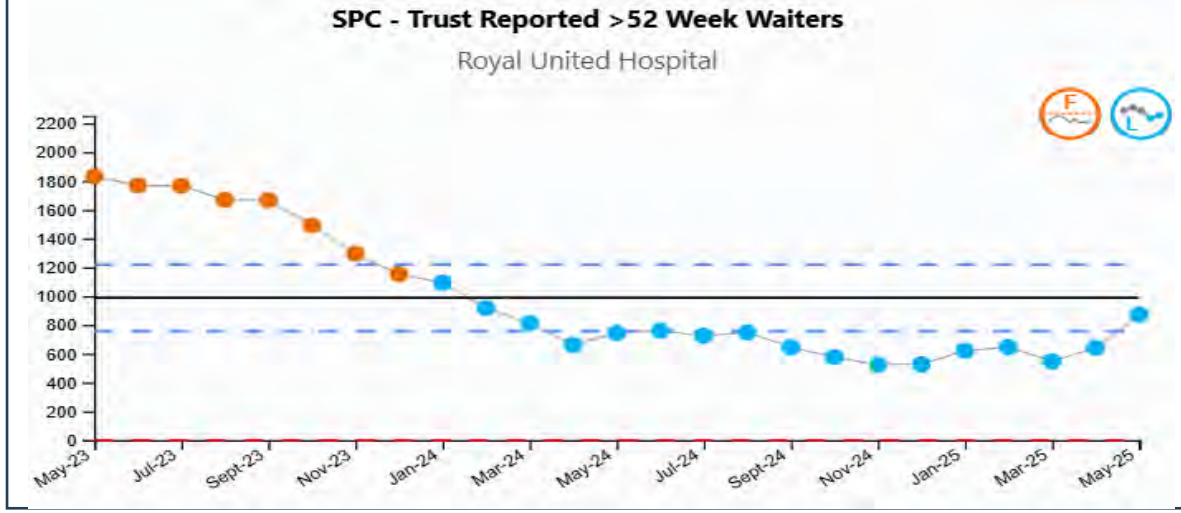
Risks and Mitigation

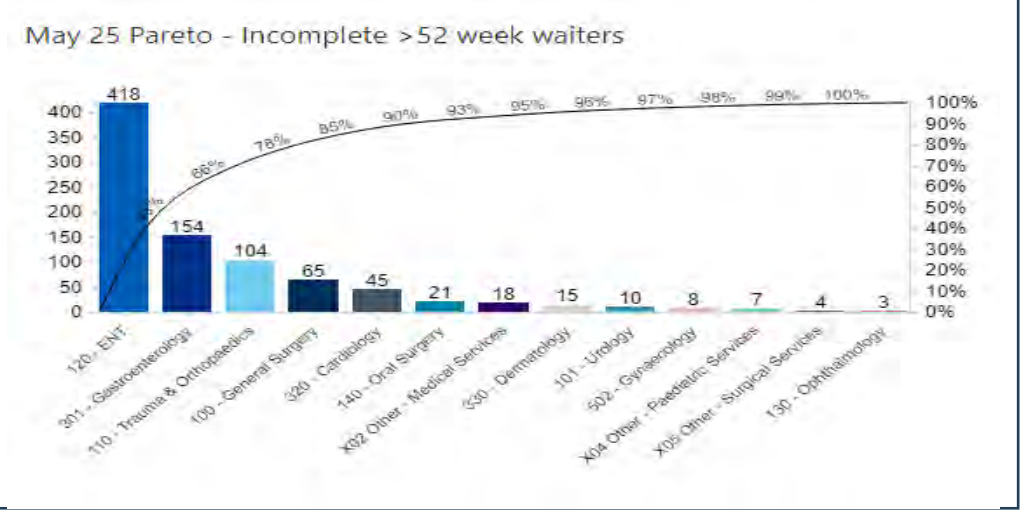
- **Risks:**
  - Sickness
  - Funding for additional activity (WLI's, insourcing)
- **Mitigations:**
  - Productivity improvement (MRI acceleration)

Referral To Treatment (RTT) over 52 weeks

Royal United Hospitals Bath NHS Foundation Trust

We are driving this metric because.. Performance Target: <1% total waiters >52weeks by March 2026	*Too many patients are waiting over 52 weeks for their definitive treatment.*





Understanding Performance

- The number of >52 week patients increased from 614 to 872 (+36%).
- 2.08% of total RTT patients have waited >52 weeks vs target of <1%
- The top contributors to >52 week breaches (78%) are ENT, Gastroenterology and Trauma & Orthopaedics:
  - ENT increased in May from 250 to 418 patients waiting >52weeks (+67%)
  - Gastroenterology increased in May from 103 to 154 patients waiting >52weeks (+50%)
  - T&O increased in May from 84 to 104 patients waiting >52weeks (+24%)

Countermeasures	Owner	Due Date
T&O - Review of spinal pathway – imaging requests and support from Sulis Spinal outpatient template review and increase by 2 new patients per clinic	Prosser/Price	June 25
Gastro - Move IDA patients to General Surgery STT pathway freeing up cancer appointments for routine RTT patients	Shaw/Wilson	July 25
ENT - Escalation of MRI/CT capacity @ Sulis to support long waiting patients in ENT	Gillett/Macfarlane	June 25
Continue 3 x weekly meetings for all patients waiting over 52 weeks in challenged specialties	Dando	Ongoing

Risks and Mitigation

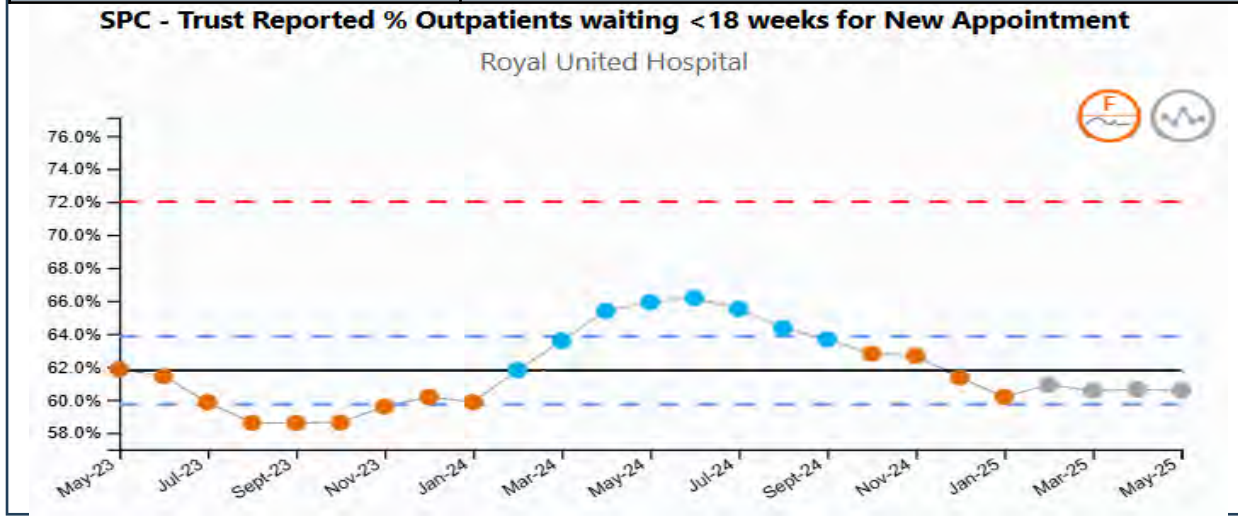
Risks:
- Radiology guided spinal injection capacity remains a risk
- Routine radiology capacity
- Greater patient choice delays increases during spring/summer
- ENT outpatient capacity

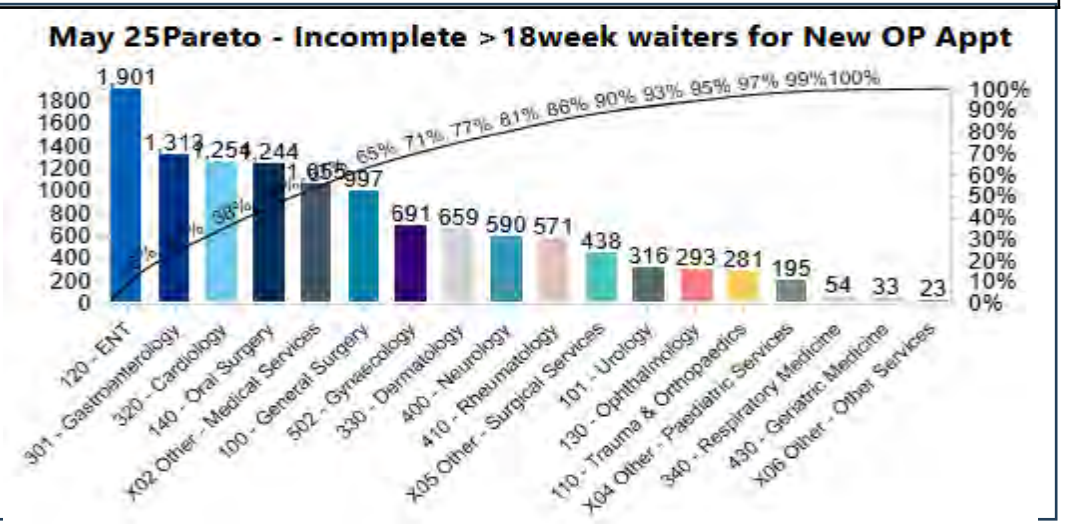
Mitigations:
- Gastro recovery plan refresh
- Super Saturdays for spinal patients @ Sulis

Referral To Treatment (RTT) Wait to 1st Outpatient Appointment

Royal United Hospitals Bath NHS Foundation Trust

We are driving this metric because..Performance Target: 72% of patients waiting for New OP Appt >18w by March 2026	*Describe the problem and why it's important* 72% of patients waiting for a new OP Appt must be >18weeks by March 2026





Understanding Performance

- 62.3% of patients were waiting <18 weeks for a 1st outpatient appointment vs a target of 72%. This is an increase of +0.2% on the previous month
- The top contributors of over 18 week breaches for 1st appointments were
  - ENT 1,901 (48.6%)
  - Gastroenterology 1,313 (48.9%)
  - Cardiology 1,254 (59.6%)
  - Oral Surgery 1,244 (53.3%)

Countermeasures	Owner	Due Date
WLI in Cardiology – delivering 1,000 new appts per year – currently agreed 8 weeks in advance through VCARP	Frape	Ongoing
Short term capacity to recover backlog in Cardiology approved through RTT funding – current gap is 34 patients per week	Frape	August 25
Oral Surgery – RTT funding approved for Specialty Dr and 2 Dental nurses to support LA lists in week	Gillett/Brown	Oct 25
Enhanced clinical triage starting 1/6/25 for ENT to ensure that patients are streamlined to the most suitable clinical setting including Sulis	Gillett/Ashworth	June 25

Risks and Mitigation

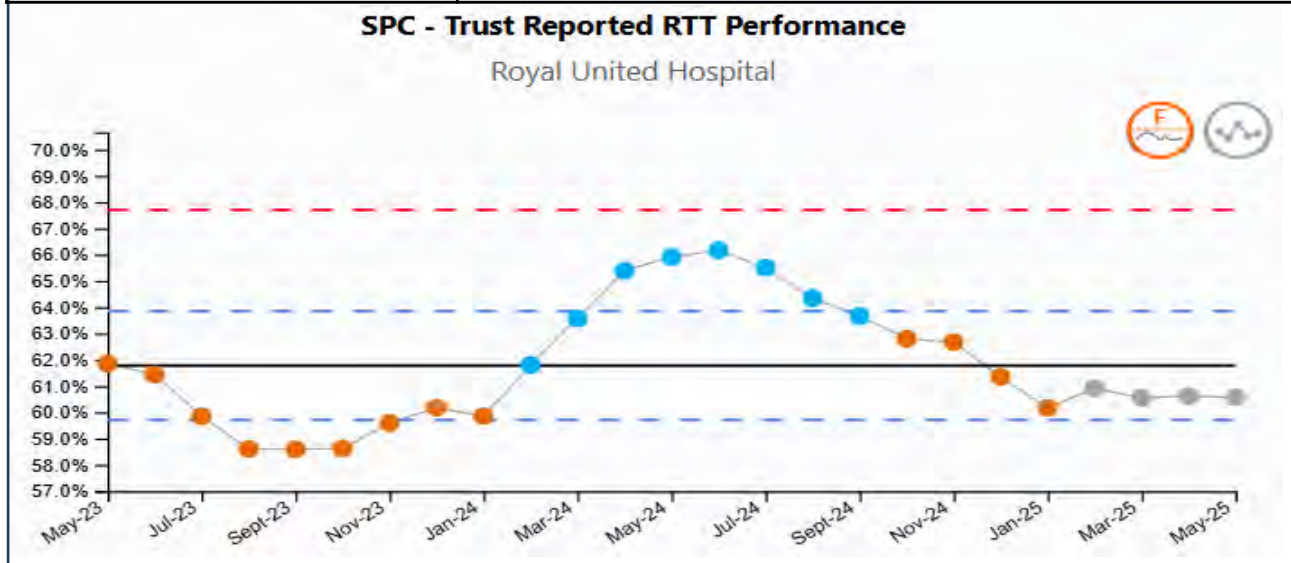
Risks:
- ENT physical space
- Recruitment timelines

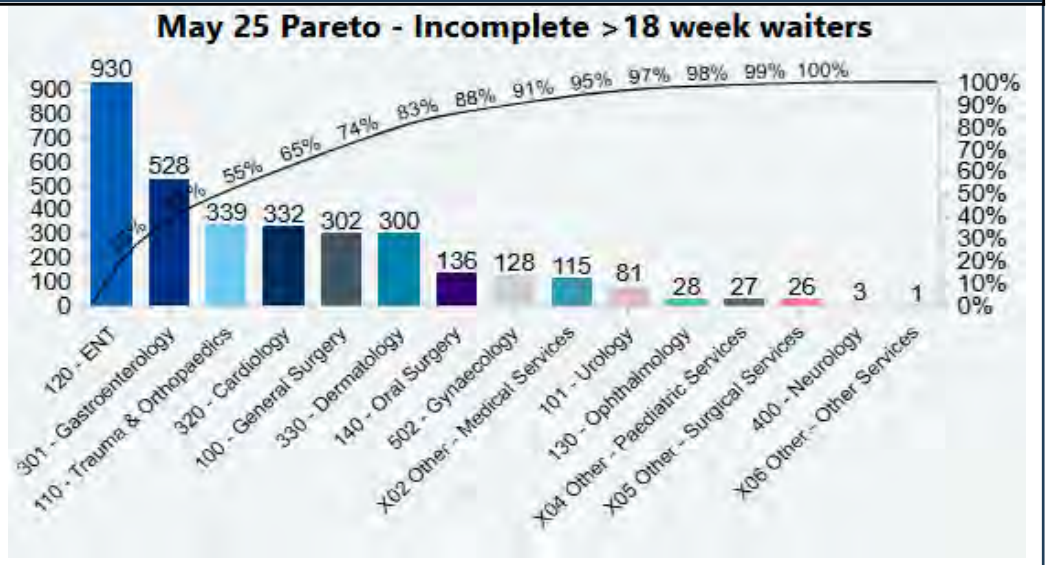
Mitigations:
- Cardiology Recovery Action Plan being developed including capacity and demand review
- Gastro recovery plan being refreshed
- SBAR for additional specialty Dr in Oral Surgery

Referral To Treatment (RTT) 18 weeks

Royal United Hospitals Bath NHS Foundation Trust

We are driving this metric because.. Performance Target: 67.7% by March 2026	*The Trust is not meeting the national Referral to Treatment target and patients are experiencing long waits for their definitive treatment. The national target is for the overall RTT performance to improve by 5% to 67.7% by end of March 26.*





Understanding Performance

• RTT performance in may was 60.6% vs a target of 67.7%. There was no change from the previous month.
• The top Contributors to over 18 week breaches were in the following 5 specialties.
  • ENT 2228 (48.6%)
  • Cardiology 1996 (53.1%)
  • Gastroenterology 1619 (48.9%)
  • Oral Surgery 1572 (53%)
  • General Surgery 1494 (57.8%)

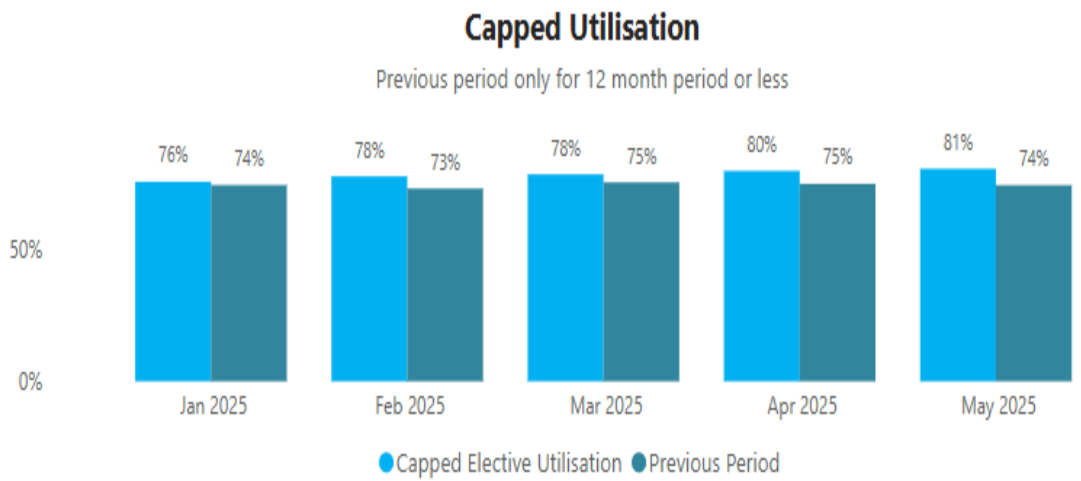
Countermeasures	Owner	Due Date
Capacity review ENT as part of BSW Group – no suitable locum available so expected additional capacity has not been delivered	Division	June 2025
General Surgery – biliary week 16/6 to treat longest waiting patients requiring lap chole c.50 pts	Lepak	June 2025
Review of spinal outpatient capacity including GIRFT visit – template change to ensure capacity is maximised	Prosser	June 25
Trust taking part in NHSE validation sprint – 7 April to 22 June – admin validation with clinical support as appropriate	Dando	End Q1

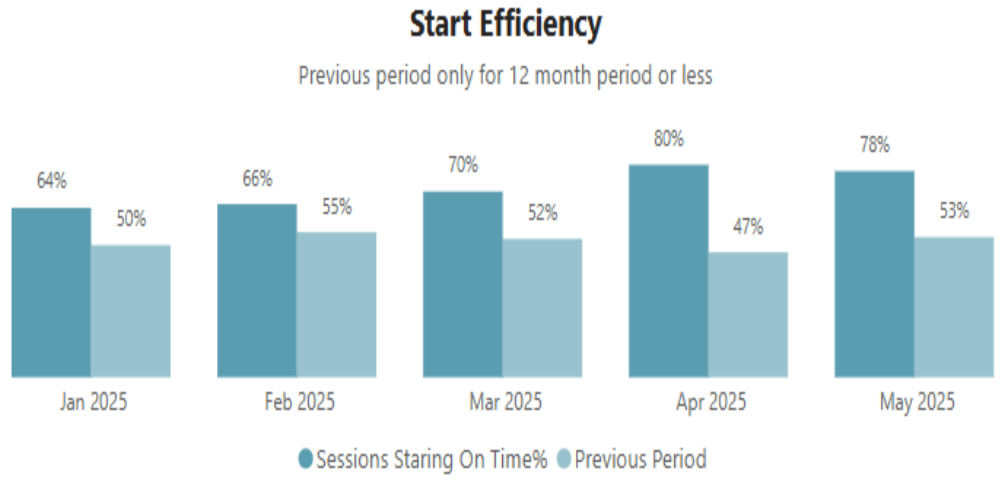
Risks and Mitigation
Risks: • Radiology capacity for routine patients • Specialist radiology capacity for Guided injections (T&O but spines in particular) • Physical space for gastro, ENT and general surgery Mitigation: • 2 additional clinic rooms being created in Gastro footprint

Theatre Utilisation

Royal United Hospitals Bath NHS Foundation Trust

We are driving this metric because.. Performance Target: capped utilisation 85-90%	*Theatre utilisation is a key metric to drive a reduction in waiting lists and reduce costs and year to date utilisation is steadily improving but remains below the 85%–90% target, indicating a clear opportunity to optimise capacity, reduce delays, and enhance efficiency.*





Understanding Performance

- Capped theatre utilisation was 81% vs a target of 85%
- This is an improvement of 1% from the previous month and represents the 5th month of improvement. This compares to 74% in the previous year.
- Top contributors to underperformance
  - Delays in list start times
  - Variable list fill rates and
  - Avoidable cancellations on the day
- Theatre starts times have been a key area of focus. 78% of lists started on time in May. This is a 2% reduction from the previous month but is a 25% improvement on the previous year.

Countermeasures	Owner	Due Date
Refresh 6-4-2 scheduling process for theatres and all specialties. Embed best practice from peer top performers e.g. list fill audits and mandatory booking review checkpoints.	Adam Dougherty	Q3
Reduction of cancellations on the day: - A new theatre cancellation SOP was signed off and implemented. - Thematic review of cancellation data to identify further opportunities.	Adam Dougherty	Ongoing
Standardise pre-op assessment to ensure that patients are optimised for surgery and that there is sufficient pre-op capacity to ensure that there is a sufficient pool patients available to undergo surgery.	Jonny Price	Q2

Risks and Mitigation

Risk: Theatre Staff morale due to increased pressure to deliver targets

Mitigation: Continuous engagement with theatre staff. Workstream being set up to review culture in theatres.

Alerting
Watch Metrics

Royal United Hospitals Bath
NHS Foundation Trust

Watch Metrics - Performance - Alerting

Strategic Goal	Measure	Measure Description	Local Year-End Target	National Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
People we care for	% Discharged by Midday		45.0%		May-25	25.3%	X			Special Cause Improving - Above Upper Control Limit
People we care for	% No criteria to reside Adult G&A occupied beds		10.0%		May-25	17.2%	X			Common Cause Variation
People we care for	% No criteria to reside pathway 0 discharges				May-25	82.3%				Special Cause Concerning - Run Below Mean
People we care for	% of patients waiting >12hrs in ED		0.0%		May-25	7.5%	X			Special Cause Concerning - Run Above Mean
People we care for	Adult % G&A bed occupancy		92.0%		May-25	95.6%	X			Common Cause Variation
People we care for	Mean time in ED - >75y				May-25	448				Special Cause Concerning - Run Above Mean
People we care for	Mean time in ED - Not Admitted (mins)				May-25	238				Special Cause Concerning - Two Out of Three High
People we care for	Non Elective Length of Stay		8.4		May-25	9.1	X			Common Cause Variation
People we care for	Number of 65 week waiters incomplete pathways			0	May-25	23	X			Special Cause Improving - Below Lower Control Limit
People we care for	RUH hospital at home team occupancy	Average occupancy	62.0		Apr-25	56.8	X			Special Cause Improving - Above Upper Control Limit

Alerting Watch Metric Commentary

Royal United Hospitals Bath
NHS Foundation Trust

Understanding Performance and Countermeasures

Provisional alerting watch metrics (flagged in April)

- Adult % G&A Bed occupancy, Non Elective Length of Stay, % Discharged by Midday, % of patients waiting >12hrs in ED, Mean time in ED – not admitted, Mean time in ED >75y, % of ED admissions <60mins from CRTP

Understanding Performance and countermeasures

We have continued to improve our ambulance handovers (60.9 minutes); however, we are still a fair way off our 33-minute target (by end June 2025). We have seen a plateau in our 4-hour performance; however, we have several actions to help improve this including PDSAs focussed on streaming and waiting room separation. We have made some slight improvement in the percentage of people going through our same day emergency care (SDEC) services; however, we anticipate further improvements once we open our new medical SDEC on 23rd June 2025. Our no criteria to reside numbers remain high at 80.8 and alongside high bed occupancy (95.6%) this is impacting on flow within the organisation. We continue to work with our community partners to address this.

Non-Alerting
Watch Metrics

Royal United Hospitals Bath
NHS Foundation Trust

Watch Metrics - Performance - Non-Alerting

Strategic Goal	Measure	Measure Description	Local Year-End Target	National Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
People we care for	% with Discharge Summaries Completed within 24 Hours				May-25	89.0%				Common Cause Variation
People we care for	A&E Arrivals - Ambulance (av per day)				May-25	80				Common Cause Variation
People we care for	A&E Arrivals - Walk ins (av per day)				May-25	218				Common Cause Variation
People we care for	Mean time in ED - Admitted (mins)				May-25	466				Common Cause Variation
People we care for	Mean time in ED - Mental health				May-25	385				Common Cause Variation
People we care for	Number of 52 Week Waiters Incomplete Pathways				May-25	872				Special Cause Improving - Run Below Mean
People we care for	Weekend discharge %				May-25	20.7%				Common Cause Variation

Trust Scorecard - Quality Metrics (April 2025 Data)

Strategic Goal	Measure	Measure Description	Local Year-End Target	National Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
People we care for	% complaints responded to within agreed timescales with the complainant		90.0%		Apr-25	77.8%	X			Common Cause Variation
People we care for	% Discharged by Midday		45.0%		Apr-25	23.3%	X			Special Cause Improving - Run Above Mean
People we care for	% Key national standards met in the month		100.0%		Apr-25	11.1%	X			
People we care for	% No criteria to reside Adult G&A occupied beds				Apr-25	18.1%				Common Cause Variation
People we care for	% No criteria to reside pathway 0 discharges				Apr-25	76.5%				Special Cause Concerning - Below Lower Control Limit
People we care for	% of ED admissions <60mins from CRtP		80.0%	80.0%	Apr-25	48.7%	X			Special Cause Concerning - Run Below Mean
People we care for	% of ED patients assessed <15mins				Apr-25	58.4%				Common Cause Variation
People we care for	% of patients waiting >12hrs in ED		0.0%		Apr-25	7.9%	X			Special Cause Concerning - Run Above Mean
People we care for	% of positive responses to friends and family test	Improve the experience of those who use our service			Apr-25	94.5%				Common Cause Variation
People we care for	% treated and admitted or discharged within four hours (To ensure 78% of patients can be treated within 4 hours of arrival at ED)		72.0%	95.0%	Apr-25	58.2%	X			Common Cause Variation
People we care for	% Virtual ward bed occupancy				Mar-25	137.0%				Special Cause Improving - Above Upper Control Limit
People we care for	% with Discharge Summaries Completed within 24 Hours				Apr-25	88.9%				Common Cause Variation
People we care for	28 day referral to informed of diagnosis of all cancers		80.0%	80.0%	Mar-25	71.0%	X			Special Cause Improving - Run Above Mean
People we care for	A&E Arrivals - Ambulance (av per day)				Apr-25	80				Common Cause Variation
People we care for	A&E Arrivals - Walk ins (av per day)				Apr-25	209				Common Cause Variation
People we care for	Adult % G&A bed occupancy		93.0%		Apr-25	96.2%	X			Common Cause Variation
People we care for	Average Handover Time for All Arrivals (mins)	Average ambulance handover time (mins)	30		Apr-25	69	X			Special Cause Concerning - Run Above Mean
People we care for	Clostridium Difficile Community Onset, Healthcare Associated				Apr-25	0				Common Cause Variation
People we care for	Clostridium Difficile Hospital Onset, Healthcare Associated				Apr-25	5				Common Cause Variation
People we care for	Combined 31 day cancer targets for first treatment, subsequent surgery, subsequent drug, subsequent radiotherapy and subsequent other treatments; excludes subsequent active monitoring and subsequent palliative care		90.0%	90.0%	Mar-25	88.9%	X			Common Cause Variation
People we care for	Combined 62 day cancer targets for GP referral, screening and consultant upgrade		75.0%	75.0%	Mar-25	75.6%	✓			Common Cause Variation
People we care for	Concerns are acknowledged within 2 working days		90.0%		Mar-25	98.0%	✓			
People we care for	COVID 8+ Days				Apr-25	2				Common Cause Variation

People we care for	Diagnostic tests maximum wait of 6 weeks		95.0%	95.0%	Apr-25	71.9%	✗			Special Cause Improving - Two Out of Three High
People we care for	E.coli bacteraemia cases Community Onset, Healthcare Associated				Apr-25	7				Common Cause Variation
People we care for	E.coli bacteraemia cases Hospital Onset, Healthcare Associated		6		Apr-25	3	✓			Common Cause Variation
People we care for	Early Identification of Deteriorating Patient	NEWS 5+ Screening Completed in 30 - Trust (%)			Apr-25	33.5%				Special Cause Improving - Above Upper Control Limit
People we care for	Flu - Healthcare Onset (+3 days)				Apr-25	0				Common Cause Variation
People we care for	HSMR - Total		100	100	Jan-25	98	✓			Common Cause Variation
People we care for	HSMR - Weekday		100	100	Jan-25	97	✓			Common Cause Variation
People we care for	HSMR - Weekend		100	100	Jan-25	105	✗			Common Cause Variation
People we care for	Klebsiella Spp Community Onset Healthcare Associated				Apr-25	0				Common Cause Variation
People we care for	Klebsiella Spp Hospital Onset, Healthcare Associated		2		Apr-25	0	✓			Special Cause Improving - Run Below Mean
People we care for	Mean time in ED - >75y				Apr-25	450				Special Cause Concerning - Run Above Mean
People we care for	Mean time in ED - Admitted (mins)				Apr-25	484				Common Cause Variation
People we care for	Mean time in ED - Mental health				Apr-25	354				Common Cause Variation
People we care for	Mean time in ED - Not Admitted (mins)				Apr-25	236				Special Cause Concerning - Run Above Mean
People we care for	Medication incidents per 1000 bed days		7.0		Apr-25	9.0	✗			Special Cause Concerning - Run Above Mean
People we care for	Mixed Sex Accommodation Breaches				Apr-25	256				Special Cause Concerning - Run Above Mean
People we care for	MRSA Bacteraemias >= 48 hours post admission		0		Apr-25	0	✓			Special Cause Improving - Run Below Mean
People we care for	MSSA Post 48 Hours				Apr-25	1				Common Cause Variation
People we care for	Never events		0		Apr-25	0	✓			Common Cause Variation
People we care for	Non Elective Length of Stay		8.4		Apr-25	8.9	✗			Common Cause Variation
People we care for	Number of 52 Week Waiters Incomplete Pathways				Apr-25	641				Special Cause Improving - Below Lower Control Limit
People we care for	Number of 65 week waiters incomplete pathways			0	Apr-25	20	✗			Special Cause Improving - Below Lower Control Limit
People we care for	Number of complaints received		30		Apr-25	30	✓			Common Cause Variation
People we care for	Number of Hospital Acquired Pressure Ulcers Category 2		5		Apr-25	5	✓			Common Cause Variation

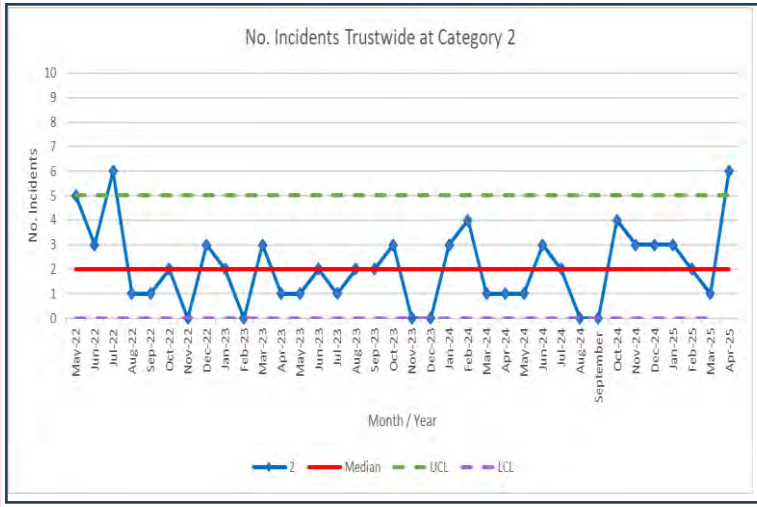
People we care for	Number of Hospital Acquired Pressure Ulcers Category 3		4		Apr-25	2	✓			Common Cause Variation
People we care for	Number of Hospital Acquired Pressure Ulcers Category 4				Apr-25	0				Special Cause Concerning - Above Upper Control Limit
People we care for	Number of reopened complaints each month		3		Apr-25	3	✓			Common Cause Variation
People we care for	Pseudomonas aeruginosa Community Onset, Healthcare Associated				Apr-25	0				Common Cause Variation
People we care for	Pseudomonas aeruginosa Hospital Onset, Healthcare Associated		1		Apr-25	0	✓			Common Cause Variation
People we care for	Readmissions - Total		10.5%		Mar-25	8.7%	✓			Special Cause Concerning - Two Out of Three High
People we care for	RTT - Incomplete Pathways in 18 weeks		63.1%	95.0%	Apr-25	60.6%	X			Common Cause Variation
People we care for	RTT - Incomplete Pathways over 52 weeks		1.0%		Apr-25	1.5%	X			Special Cause Improving - Below Lower Control Limit
People we care for	RTT – wait to 1st OP appointment	% patients waiting <18 weeks for their first OP appt	72.0%	72.0%	Apr-25	62.1%	X			Special Cause Concerning - Below Lower Control Limit
People we care for	Scanning Compliance for patients being given medication				Apr-25	54.3%				Special Cause Improving - Above Upper Control Limit
People we care for	Serious incidents with overdue actions		5		Apr-25	16	X			Special Cause Concerning - Above Upper Control Limit
People we care for	SHMI				Dec-24	100.0%				Special Cause Concerning - Above Upper Control Limit
People we care for	Total monthly fill rate, day hours, HCA		90.0%		Apr-25	87.7%	X			Special Cause Improving - Above Upper Control Limit
People we care for	Total monthly fill rate, day hours, RN		90.0%		Apr-25	90.5%	✓			Special Cause Improving - Above Upper Control Limit
People we care for	Total monthly fill rate, night hours, HCA		90.0%		Apr-25	100.6%	✓			Special Cause Improving - Above Upper Control Limit
People we care for	Total monthly fill rate, night hours, RN		90.0%		Apr-25	94.0%	✓			Special Cause Improving - Run Above Mean
People we care for	Weekend discharge %				Apr-25	17.2%				Common Cause Variation

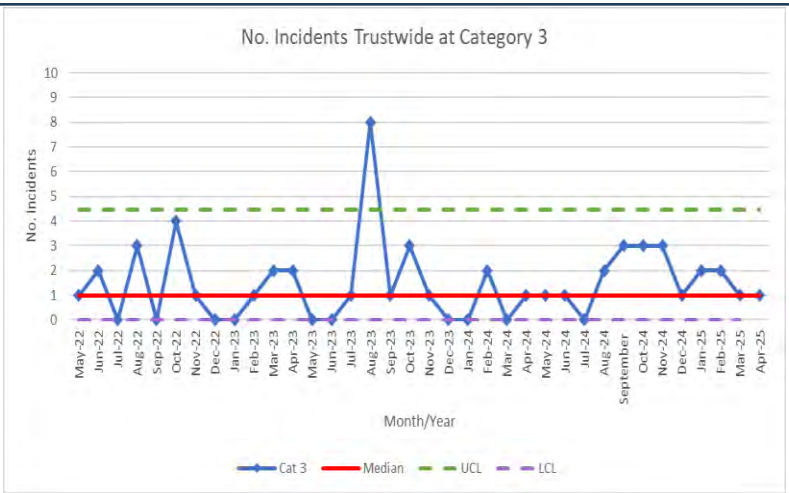
Pressure Ulcers

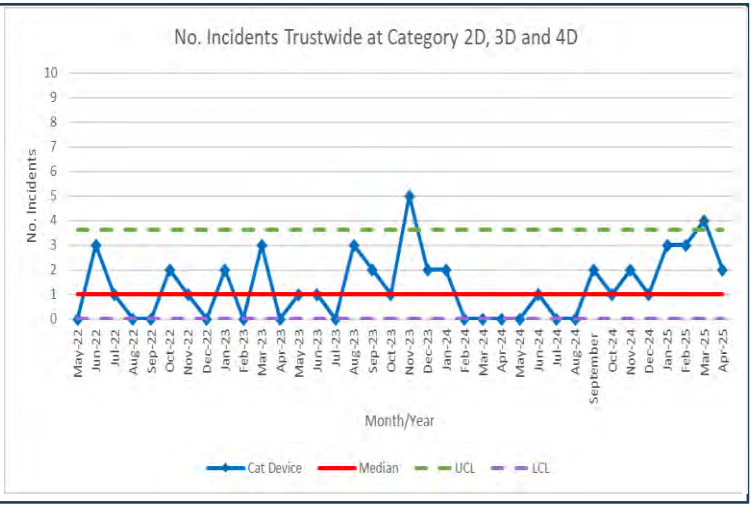
Royal United Hospitals Bath NHS Foundation Trust

We are driving this metric 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.

Improving the experience of those who use our service







Understanding Performance

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

For April 2025, the RUH reported 0.6 pressure ulcers per 1,000 bed days (10 pressure ulcers). GWH reported 0.34 and Salisbury data was not available.

The RUH investigated one category 3, six category 2 pressure ulcers* and three medical device related pressure ulcers across seven wards.

The category 2 pressure ulcers were identified on a number of different areas, of which 2 were in ED and MAU. The ED patient spent a prolonged period on trolley between ambulance and the department.

*this data on the scorecard was produced on 16th April, since then further data has been validated

Countermeasures	Owner	Due Date
Band 6 nursing staff to undertake daily skin care rounds in clinical areas where pressure ulcer performance has deteriorated starting April 2025. The aim is to improve accuracy of skin assessments and timely escalation of concerns to the Senior Sister.	Specialty Matrons	Ongoing
Divisions to start monitoring compliance with skin assessment and report monthly to the Tissue Viability Improvement Group from May 2025.	Specialty Matrons	June 2025
Following the yearly prevalence audit in May, that was carried out to review all pressure areas of all inpatients, the results will be shared with the TVIG and QSIG in June 2025.	Tissue Viability Lead Nurse	June 2025

Risks and Mitigation

There is a risk that the lack of timely skin bundle assessments will impact on the ability to reduce avoidable pressure ulcers.

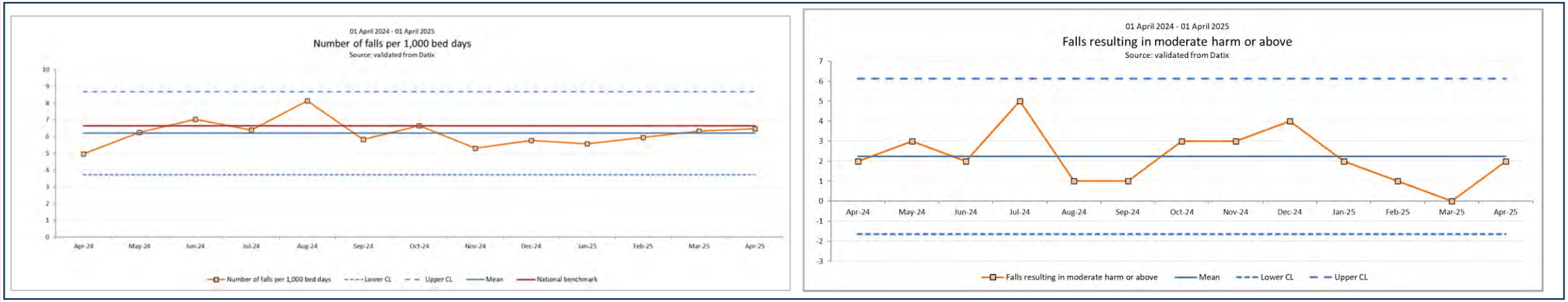
The mitigation is that the Tissue Viability Improvement Group monitors compliance with the Matron who will work with the clinical area to implement improvements.

Falls

Providing Safe and Effective Care

We are driving this metric 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).

SPC & supporting data if required



Understanding Performance

Analysis shows 77% of patients who fall as an inpatient were 65 years or older.

Falls are multifactorial, meaning they are caused by a combination of factors and all patients over 65 should have a multifactorial risk assessment. These factors include frailty, comorbidities and deconditioning which causes a decrease in muscle strength as a result of inactivity.

NICE guidance advises all inpatients at risk of falls should have lying and standing blood pressure (BP) recorded as part of the 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.

Countermeasures	Owner	Due Date
Increase compliance in lying and standing blood pressure in 6 general medical wards to 50% by July 2025	Ward Manager	July 2025
Work with the top contributor Older Persons ward to increase compliance to 50% by August 2025	Ward Manager	August 2025

Data shows that during April 98.21% of inpatients did not fall in our care which has remained consistent.

Risks and Mitigation

1. Differing patient cohorts and specialities when expanding from OPU wards to 6 additional wards. PDSA cycles to mitigate risk and adapt where needed for each clinical setting.
2. Post falls investigations to be aligned with PSIRF focusing on completing differing levels of investigations relating to insights and themes from all falls.
3. The new investigation/huddle process is at divisional sign off.

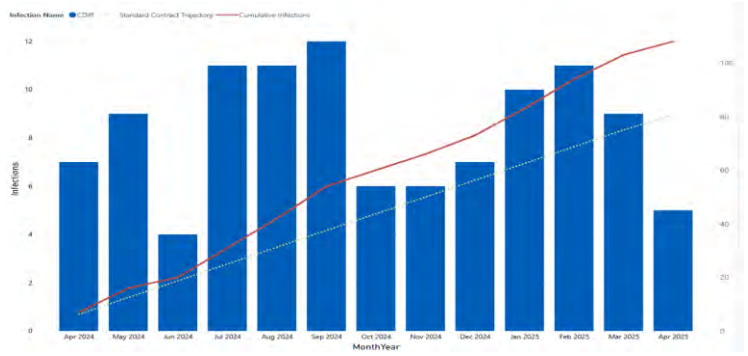
Infection Prevention and Control

Royal United Hospitals Bath NHS Foundation Trust

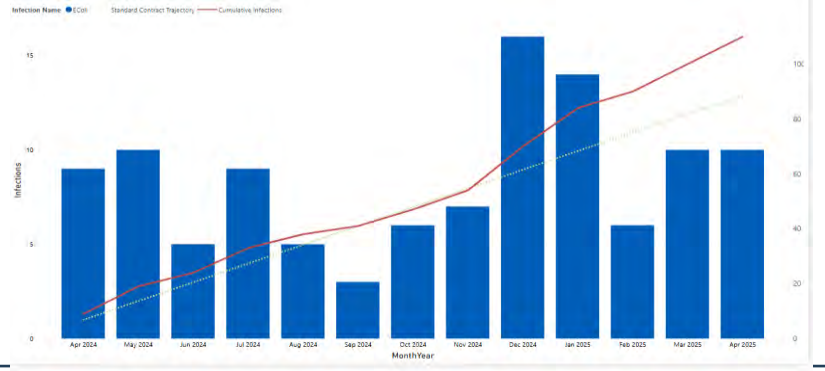
Providing Safe and Effective Care

We are driving this metric 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.

CDI Healthcare Associated Standard Contact Threshold



E. coli Healthcare Associated Standard Contact Threshold



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

Understanding Performance

There were 5 HOHA cases of Clostridioides Difficile infection (CDI) reported during April 2025. There is no obvious links to prescribing or cleaning standards. There is no specific contributor identified/linked to the RUH at present

There were 10 cases of *E. coli* infection (3 HOHA and 7 COHA) reported during April 2025. 5 cases have been attributed to a urinary primary source.

There was one MRSA bacteraemia against a zero tolerance, no known history of MRSA colonisation, there was a missed opportunity for MRSA screening on admission.

Countermeasures	Owner	Due Date
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 – delayed due to logistical issues. Plan to commence for June 2025	Infection Prevention and Control	Sept 2025
Gloves off campaign: To ensure clinical gloves are worn appropriately. **Aim:** To reduce the inappropriate use of gloves by 30% within 3 months. Implemented on ASU, Vascular Studies and theatre recovery. OPAU commenced at the beginning May 25	Infection Prevention and Control	August 2025
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 meetings continue with IT to support launch due to NHS Digital requirements.	Infection Prevention and Control	Sept 2025

Risks and Mitigation

There is a risk that the CDI threshold will be exceeded due to increasing infection being detected.
Mitigations: External review request from ICB. Maintaining surveillance, hand hygiene, and environmental cleaning and adherence antimicrobial policies. Working with Southwest CDI collaborative to identify any probable causes, such as obesity and other comorbidities.

MRSA Bacteraemia's have a zero tolerance
Mitigations: Following up with MRSA screening for high-risk patients following the completion of the safety assessment. Review the electronic risk assessment to add screening prompts.

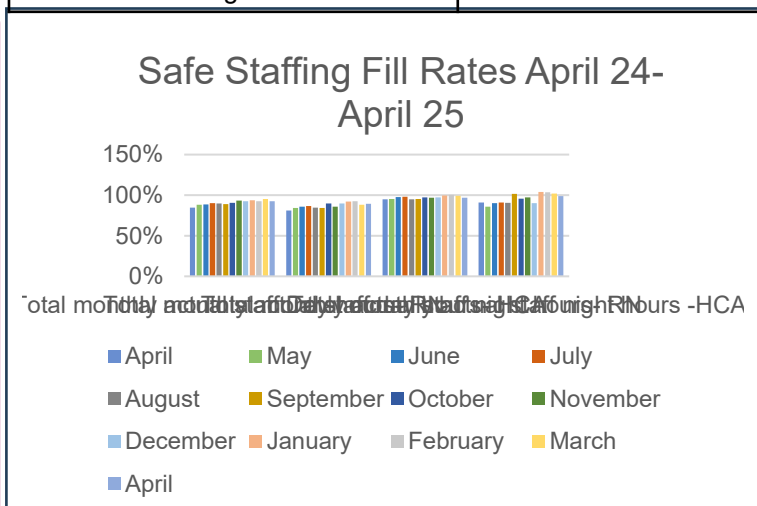
There is a risk *E coli* numbers continue to rise due to a urinary and hepatobiliary primary source.
Mitigations: Well hydrated patients and a completion of A3 into the hepatobiliary increase

Safe Staffing (Nursing Inpatient Areas)

Royal United Hospitals Bath NHS Foundation Trust

We are driving this metric because..	Nurse staffing fill rate is a measure of wards being sufficiently staffed.
Performance Target:	*For staffing fill rates to remain >80%*

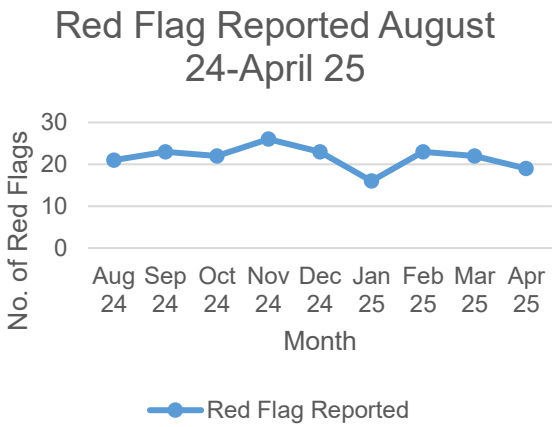
Breakthrough Objective



Day Shift Fill Rate		Night Shift Fill Rate	
RN	HCSW	RN	HCSW
92%	89%	97%	99%

<80%
>120
80% -100%

Ward	RN Day	HCSW Day	RN Night	HCSW Night
Pulteney			124%	
Medical Assessment Unit		73%		
Charlotte Ward	76%	53%		
Childrens	121%	60%	75%	74%
Combe				127%
Waterhouse				132%
Helena		162%		147%
Philip Yeoman		57%		30%
Medical Short Stay		60%		
Respiratory		74%		74%



Understanding Performance

The combined shift fill rates for days for RNs across the 25 inpatient wards was 92% and 97% respectively for nights. The combined shift fill for HCSWs was 89% for the day and 99% for the night shift. Therefore, the Trust as a collective set of wards is within safe limits for April.

The table above shows exceptions to the 80-120% fill rate. Charlotte ward fell below 80% fill rate for RN staffing on day shifts due to temporary ward relocation and a reduced bed base resulting in a reduced nurse staffing requirement. The consistent RN fill rate on all shifts is reflective of the overall continued vacancy improvement. The >120% RN fill rate on Children's and Pulteney ward is due to increased acuity of patients.

Helena ward have seen increased acuity during the month of April resulting in an enhanced HCSW 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% due to elective occupancy levels and planned staffing, staffing establishment has now been substantively changed to reflect activity.

The increase HCSW fill rate >120% particularly on night shifts reflects the deployment of additional staff in response to increased dependency and enhanced care patients.

Countermeasures	Owner	Due Date
To recruit to remaining HCSW vacancies by July 2025 following the successful March recruitment events. There will be specialty specific recruitment events to recruit to the remaining vacancies/ alongside staff redeployment.	Senior Sister/ Matron	July 2025
Align the new paediatric inpatient skill mix to the rostering template from August 2025 rota.	Paediatric Matron	August 2025
To recruit mental health care support worker staff as part of the paediatric establishment by July 2025.	Paediatric Matron/ Senior Sister	July 2025
To recruit into Emergency Department band 5 registered nurse vacancies	Emergency Department Matron	September 2025

Risks and Mitigation

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 27.02wte who are due to start April-July2025.

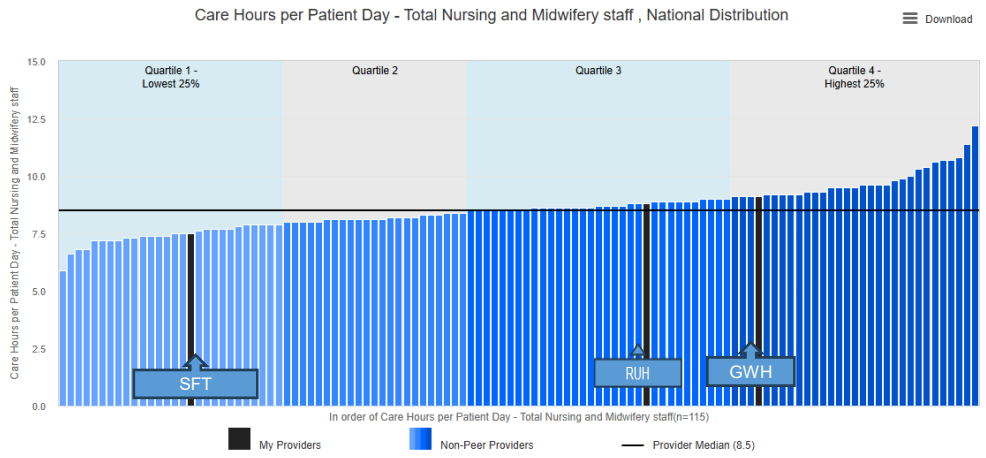
There are twice daily safer staffing meetings to review safe staffing and potential risks or red flags with mitigation put in place as appropriate. This will include redeployment of staff.

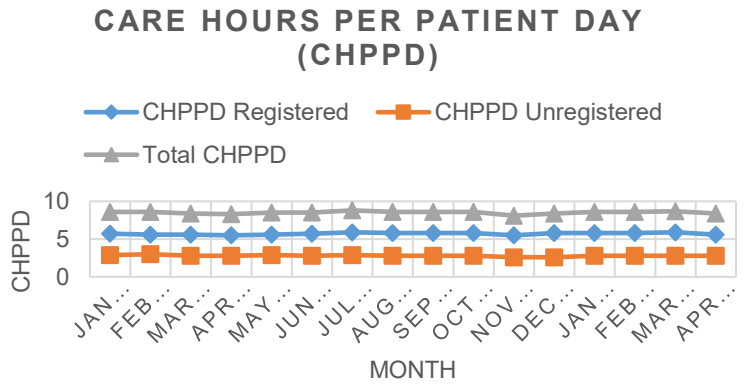
There were 19 red flags reported by wards in April 2025 a decrease from 22 reported in March 2025. The breakdown of the 19 was predominantly a shortfall of 25% RN time due to short notice sickness.

Care Hours (Nursing Inpatient Areas)

Royal United Hospitals Bath NHS Foundation Trust

We are driving this metric 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 Performance

Average monthly CHPPD is 8.4. CHPPD continues to remain stable for both registered and unregistered staff over the past 12 months.

When reviewed on Model Hospital (latest data available March 2025) we remain in quartile 3 and benchmark in line with the provider/ peer median 8.5.

Countermeasures	Owner	Due Date
Twice daily (minimum) of safe care census completion on all relevant wards by July 2025. Weekly divisional reporting of compliance.	Deputy DDoNs	July 2025
Review completion times of safe care census completion to correlate with nurse in charge handover by July 2025	Associate Chief Nurse Workforce & Education	July 2025
To review the outcome of the bi-annual Safer Nursing Care Tool (SNCT) April 2025 collection. Provisional results due July 2025.	Associate Chief Nurse Workforce & Education	July 2025

Risks and Mitigation

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

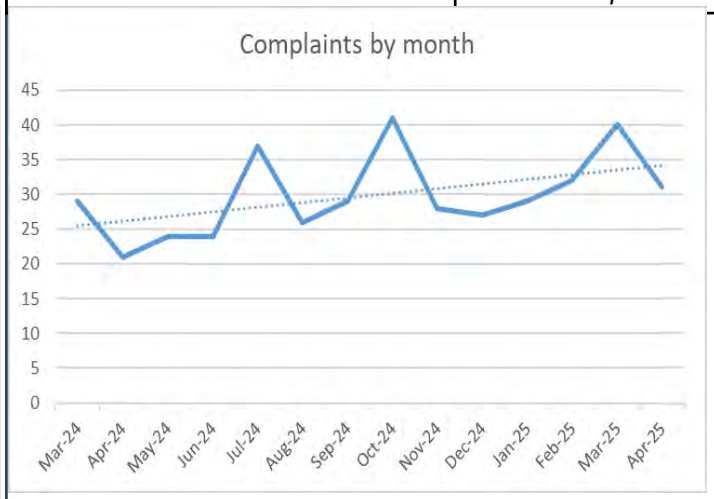
•Mitigation:
•Twice daily safe staffing meetings reviewing unfilled shifts alongside acuity and dependency of all wards.
•Minimal RN vacancies and over-establishment in some ward areas supporting redeployment.
•Successful HCSW recruitment campaign.
•Focused joint led (Nurse & HR) sickness reduction programme
•Review of safe staffing levels at all clinical site meetings

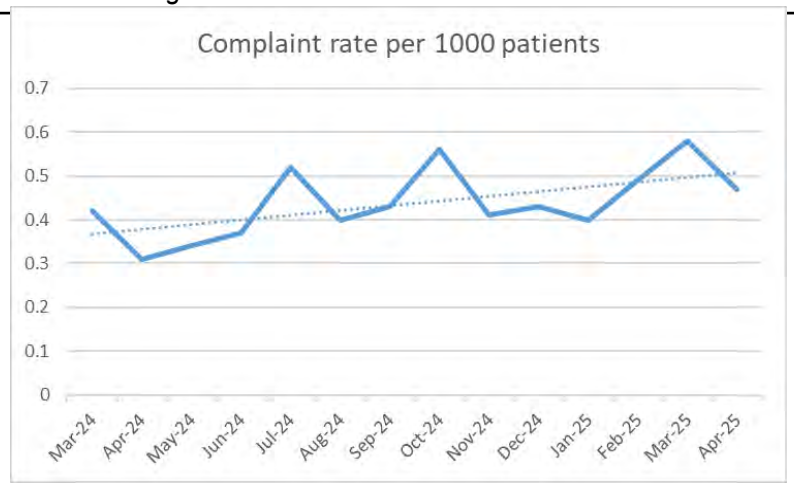
Patient Support & Complaints (PSCT)

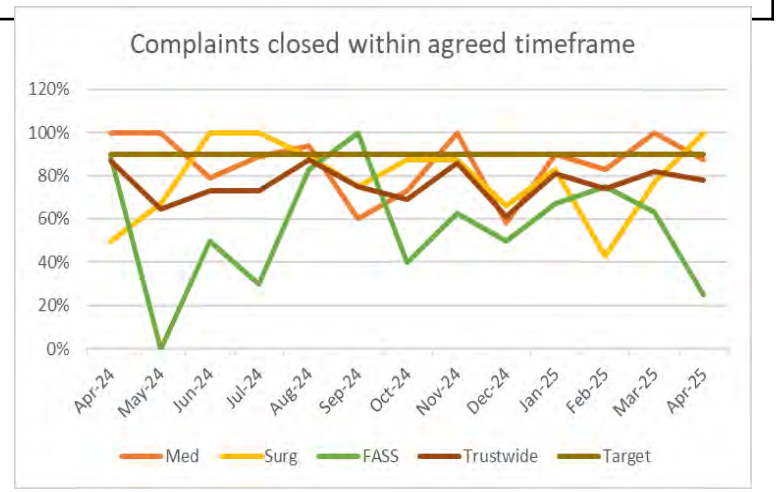
Royal United Hospitals Bath NHS Foundation Trust

We are driving this metric 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. *90% of complaints responded to within agreed timeframe.*

Improving the experience of those who use our service







Understanding Performance

In April 2025, the Trust received 32 new complaints.
(this compares to 40 in March) The number of complaints continue to be on an upward trajectory although no new themes have been identified. Complaints were evenly distributed across several departments. The Medicine Division received the highest number of new complaints (n=14). 3 complaints were reopened in April, this is higher than the previous month. The complaint rate per 1000 patients in April was 0.47 which is down from 0.54 in March.
In April 98% of all concerns were acknowledged within 2 working days.
The response times for formal complaints continues to fall below the target of 90% with 78% of complaints responded to within the agreed timeframe. This varies by Division, however in April the Surgery Division responded to 100% of complaints within the agreed timeframe. 78% of all contacts with PSCT were resolved within 14 days.

Countermeasures	Owner	Due Date
Further investigation into the complaint themes in older persons services will be undertaken to support improvement work.	Head of PSCT/Division	1 July 2025
A revised complaints process has now been agreed with the Divisions and an updated Complaints and Concerns policy is being drafted to reflect the new process. • Share process with divisional teams	Head of PSCT	1 September 2025
Focus on achieving compliance with agreed complaint response times in FASS and monitor for improved performance	Head of PSCT/Division	1 August 2025

Risks and Mitigation

The capacity and confidence of ward staff to respond to concerns and complaints – ongoing support and training available.

Lack of Complaints manager/ coordinator in FASS and Surgery – interim process in place to support complaints

Lack of consistency in responding within agreed timeframe is distressing for patients/families and could cause reputational harm to the organisation

Royal United Hospitals Bath
NHS Foundation Trust

Perinatal Quality Surveillance

May 2025

April 2025 data

The RUH, where you matter

Safe – Maternity Workforce

	Target	Threshold G	Threshold A	Threshold R	Feb 25	Mar 25	April 25	Comment
Midwife to birth ratio	1:24	<1:24		>1:26	1:26	1:26	1:27	Trained staff only included in acuity data Increase in sickness in April 2025
Midwife to birth ratio (including bank)	1:24	<1:24		>1:26	1:24	1:24	1:25	Care hours required, trained and support staff included in acuity data
Percentage of 'staff meets Acuity' BBC	100%	>90%		<70%	69	83	80	Percentage of episodes for which data recorded
Percentage of 'staff meets Acuity' Mary Ward (inpatient care)	100%	>90%		<70%	55	65	62	Percentage of episodes for which data recorded Continued MSW vacancy effecting compliance
Confidence factor in BirthRate+ recording BBC	60%	>60%		<50%	84	77	82	
Confidence factor in BirthRate+ recording Mary Ward	60%	>60%		<50%	89	74	78	
Percentage maternity sickness rolling 12 months	<4%	<4%		>5%	3.77	3.64	3.49	
Percentage Maternity turnover rolling 12 months	≤5%	≤5%		≥7%	2.89	2.46	2.77	
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	
Number of NICE red flags on Birth Rate +	NICE 2015				3	2	0	A 'red flag' event is a warning indicator that something may be wrong with midwifery staffing

Countermeasure /Action (completed last month)	Owner

Countermeasure /Action (planned this month)	Owner
Review of maternity dashboard to include reflecting national dashboard	HOM/PS Lead
Explore temporary fixed term increasing hours for substantive staff and long line bank until Sept 25	Matrons

Pipeline actuals in month

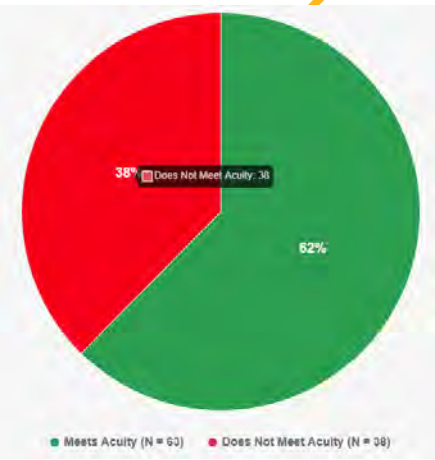
Substantive MW vacancy	Secondment	Mat leave	Fixed term in post	Budget V actual
+4.36 (can go 8.0wte over)	7.68	12.08	8.50	-6.90

Substantive MSW vacancy	Secondment	Maternity leave	Budget V actual
5.34	2.0	1.61	-7.95

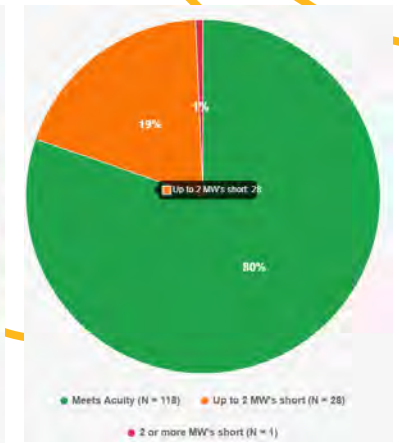
Summary of clinical actions relating to staffing V acuity

Action	Times occurred	Percentage
Internal redeployment	3	30%
Community redeployment	2	20%
Ops support mw in BBC numbers	3	30%
Escalate to MOC/matron	2	20%

Mary ward



BBC



Safe – Neonatal Workforce

	Target	Threshold G	Threshold A	Threshold R	Feb 25	Mar 25	Apr 25	Comment
Neonatal nurse vacancy					1.46	1.46	1.36	Continue uplift to band 4 to support SNA training
Percentage neonatal sickness rolling 12 months	100%	<4%		>4%	4.24	4.06	3.7	
Percentage neonatal turnover rolling 12 months	<5%	<5%		>7%	6.42	4.99	4.99	0% for 5 months in row
Percentage neonatal nursing shifts filled to BAPM standard	100%	>90%		<80 %	100	91.84	98.31	
Percentage medical shifts filled to BAPM minimal standard	100%	>90		<80	98.2	97.98	99.16	• Note minimal standards. • ANNP no longer getting non-clinical time (as per ACP pillars). ANNP Tier 2 Vacancy – not recruited to. Trainee ANNP post approved and progressing to advert.
Percentage neonatal QIS trained	70%	<70 %		<60 %	60	60	60	Expected compliance >70% Q2 2025
Percentage of TC shifts with staff dedicated to TC care only	100%	>90%		<80 %	100	100	100	

Countermeasure /Action (completed)	Owner
JD complete and funding identified for ANNP training	H Green

Countermeasure /Action (planned)	Owner
Awaiting ANNP training job to be uploaded to Trac	H Green

Is the standard of care being delivered?

- Reduction in nurse turnover
- Rolling sickness within Trust target

Budget v Actual

Maternity leave B5 0.64 and uplift in Band 4 SNA's 0.46
Forecast: Maternity Leave from June: B5 0.92 + B6 0.64
Action Plan: Fixed term hours for B6 agreed for internal interest. Band 5 awaiting final approval.
Currently Budget 46.12 wte v Actual 43.5 wte

Incidents

New Cases for March 25

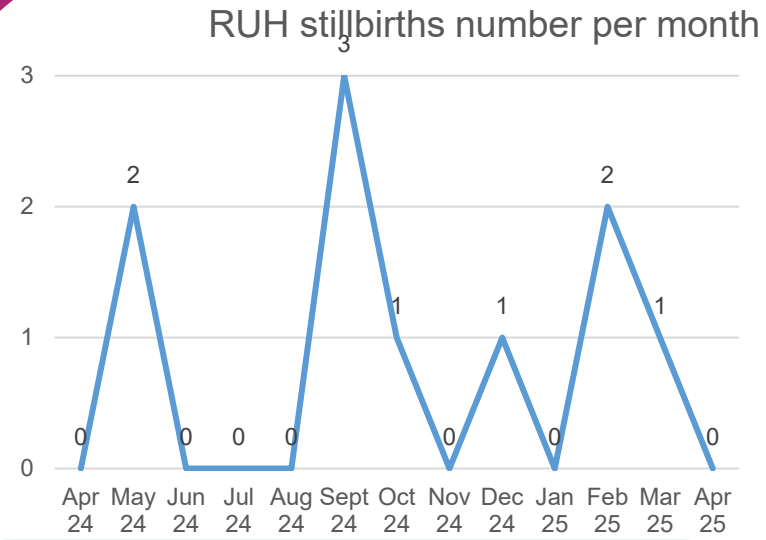
Case Ref	Date	Category	Incident	Outcome/Learning/Actions	MNSI Ref	PSII
139757	19/04/25	Moderate	Readmission for sepsis	DOC commenced. Learning identified and actions set. DOC closure letter sent		
140021	22/04/25	Moderate harm	34+5 low Apgar's, transferred to tertiary unit	DOC not required. Rapid review undertaken awaiting further information, local learning identified.		
140204	26/04/25	Moderate harm	Subgalea haemorrhage, admission to NNU	DOC commenced. Rapid review undertaken. Immediate learning and action identified.		

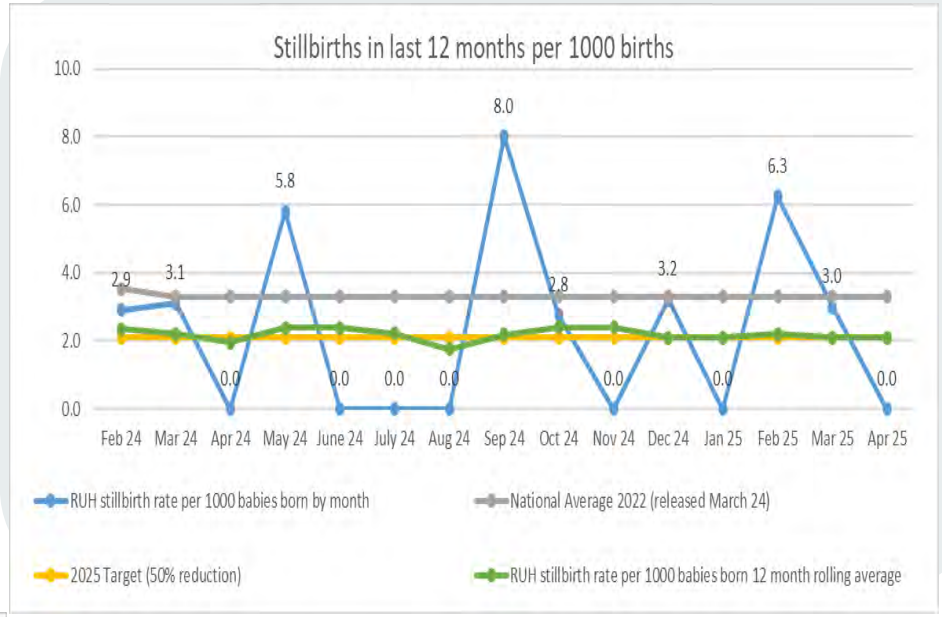
Ongoing Maternity and Neonatal Reviews

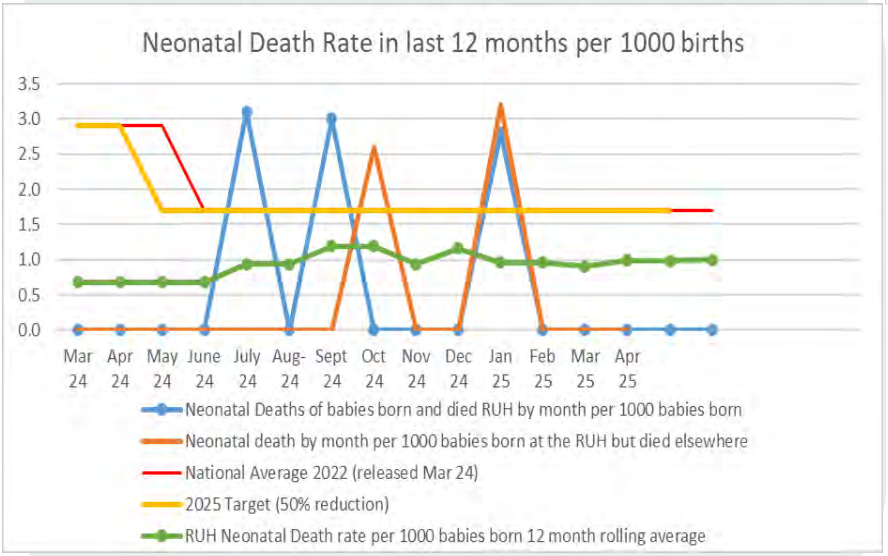
Case Ref	Date	Category	Incident	Outcome/Learning/Actions/ Update of progress	MNSI Ref	PSII Ref
133232	26/09/2024	Unexpected Death	Intrauterine Death at an unknown >37-week gestation in an undiagnosed/concealed pregnancy.	DOC commenced, discussed with MNSI, discussed with coroner, rapid review undertaken, plan for Systems Engineering In Patient Safety (SEIPS) Analysis to support full exploration of learning. PMRT report complete	Discussed at MNSI regional meet 30/09/24 – does not meet criteria	
133329	28/09/2024	Catastrophic harm/ Unexpected Death	Death of 8-day old infant following call to Maternity Triage Line 12 hours prior to presentation	DOC commenced – PSII declared, Terms of Reference looking at the systems and processes supporting the Maternity Triage line advice and referral pathways when contacted regarding a parental neonatal clinical concern. PSII report in draft		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. Trust risk identified for lack of integration of EPR with Tomcat DOC closure letter completed by Cons and sent to family as a hard copy at their request.		

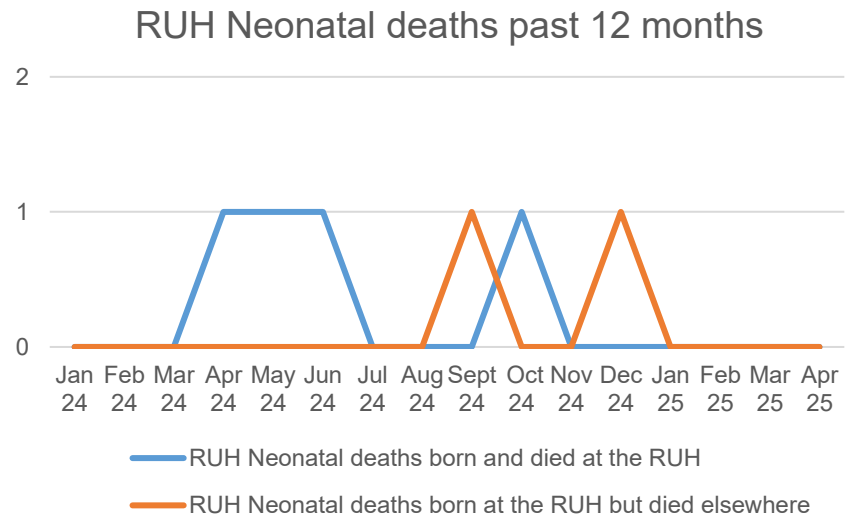
Number of IVH	Nil	**Number of PVL**	Nil
Maternity Safety Support Programme	N/A	**Coroner's regulation 28**	N/A

Safe- Perinatal Mortality Review Tool (PMRT)









Background information

All perinatal deaths have been reported using the Perinatal Mortality Review Tool (PMRT) tool. PMRT reporting is mandated by MIS Safety Action 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 24 we received the MBRRACE-UK report of 2022 deaths at the RUH. This identified new national averages for both stillbirth and neonatal deaths therefore the charts on this slide have been adjusted to reflect the new national averages for accurate benchmarking.

Monthly update

No stillbirths in the month of April

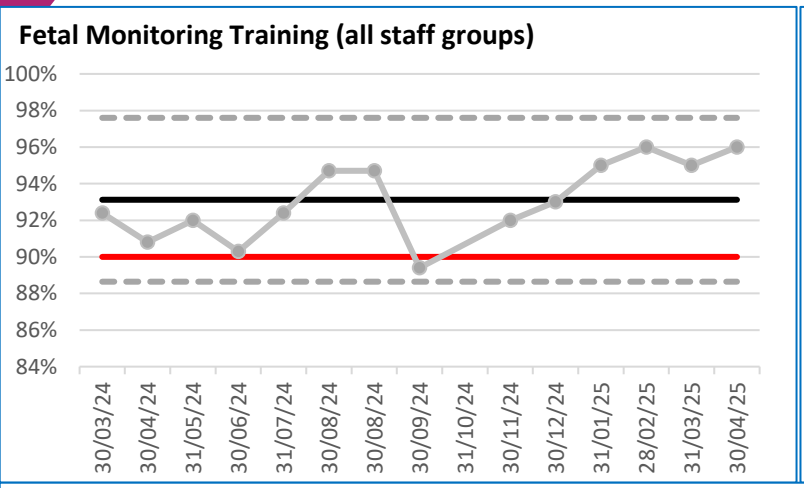
No neonatal death in the month of April.

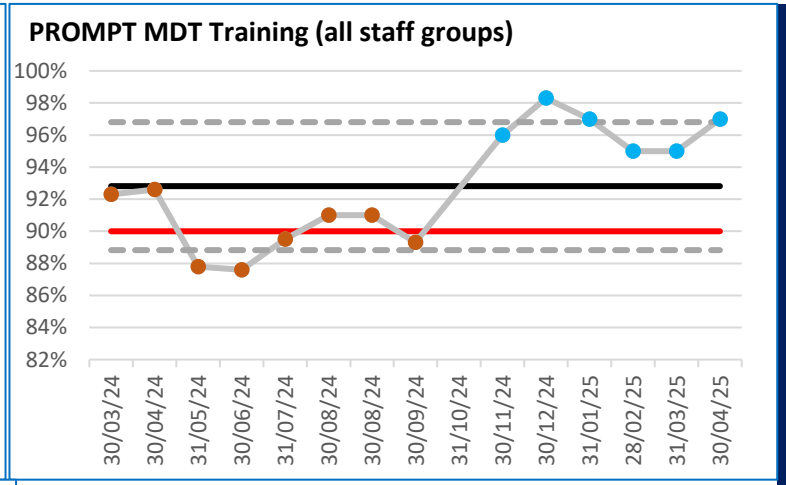
Identified learning

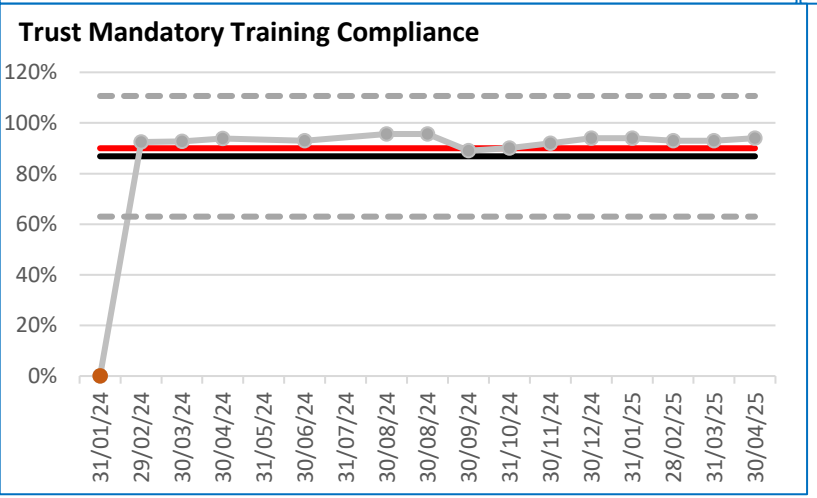
No PMRT reports were published in April.

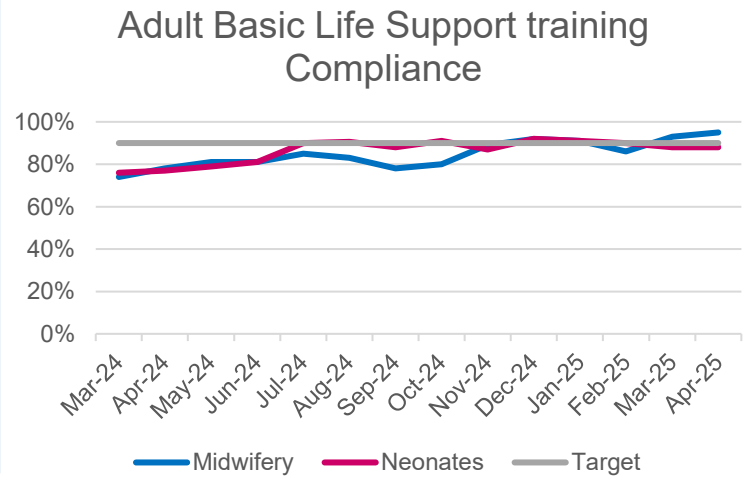
Improvement actions & timescales

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.

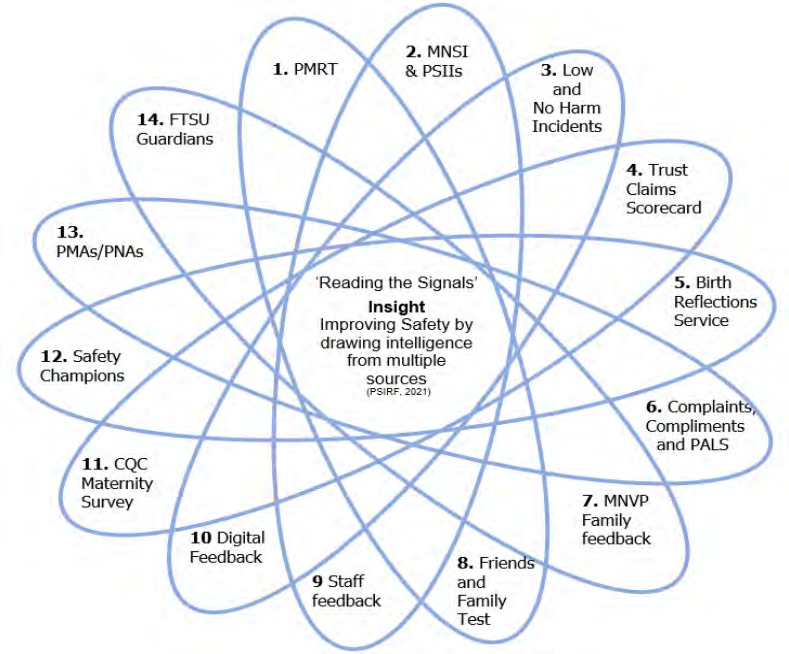
- ABLS managed in specialty moving forwards as part of the PROMPT programme.
- Fetal monitoring 96%
- PROMPT 97%
- Trust mandatory training (MAT/NEO) 94%
- ABLS (MAT/NEO) 93%

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

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:
•Good student feedback, welcome and supportive team
•Benefits of increased leadership on Mary ward and flow role evident
•More reclining chairs – matron aware
•Ward clerk and medical staffing enjoying job

Neonates :
•No feedback received

Maternity and Neonatal Voices Partnership (MNVP)

- **Key points raised -**
- **Next Steps: -**

Compliments & Complaints

Formal Compliments	**0**	**PALS Contacts**	**La g**
Concerns	**1**	**Formal Complaints**	**2**

March 25 Themes

- Positive feedback from staff including students, welcome and supportive teams
- Positive feedback for student midwife kindness and knowledge

Friends & Family Survey

Key Achievements:
- 53 very good/good pieces of feedback received
- 5 neutral

Identified Areas of Improvements:
- Inpatient ward discharge communication/process
- Medical review – waiting times

Part 2 | People We Work With

- Recommending RUH as a place to work
- Fair career progression and development
- Reducing discrimination from managers, colleagues and others

Breakthrough and Vision Metrics Summary

Royal United Hospitals Bath
NHS Foundation Trust

Strategic Goal	Measure Group	Measure	Measure Category	Latest Survey	Latest Performance	Trend
People we work with	Employee Experience	% Satisfied with extent organisation values their work	Breakthrough	2024	42.7%	
People we work with	Employee Experience	% Agreeing that immediate manager values work	Context	2024	74.7%	
People we work with	Employee Experience	% Agreeing that feel valued by team	Context	2024	72.1%	
People we work with	Employee Experience	% Recommend Trust as place to work (National)	Vision	2024	63.5%	
People we work with	Employee Experience	% Recommend Trust as place to work (Pulse)	Watch	25-26 Q1	57.6%	
People we work with	Employee Experience	% Agreeing that organisation acts fairly regarding career progression (National)	Vision	2024	56.1%	
People we work with	Employee Experience	% Experienced discrimination from public (National)	Vision	2024	10.5%	
People we work with	Employee Experience	% Experienced discrimination from managers/colleagues (National)	Vision	2024	8.2%	

Metrics where the Latest Survey shown is a year are derived from the National Staff Survey and are updated annually., after formal publication by the National Team.
Those where the Latest Survey references a specific quarter are derived from the Pulse survey and are updated 3 times a year., in Quarters 1, 2 and 4. No Quarter 3 survey is run to avoid a clash with the National Survey.

Metric Summary I

Royal United Hospitals Bath
NHS Foundation Trust

Strategic Goal	Measure Group	Measure	Measure Category	Latest Month	Latest Performance	Trend	Target	Target Met	Months Since Last Met	Target Feasibility Assurance	Variation	Variation Detail
People we work with	Workforce Plan	Total WTE	Watch	May-25	5744.4		<=5721.4	✗	Not in FY			SPC not appropriate
People we work with	Workforce Plan	Substantive WTE	Context	May-25	5409.6		<=5418.7	✓	0			SPC not appropriate
People we work with	Workforce Plan	Bank WTE	Context	May-25	331.0		<=296.7	✗	Not in FY	F		Common Cause
People we work with	Workforce Plan	Agency WTE	Context	May-25	3.8		<=6.0	✓	0	?	L	Special Cause Improving - Run Below Mean
People we work with	Vacancy	Vacancy Rate	Key Standard	May-25	3.30%		<=4.00%	✓	0			SPC not appropriate
People in our community	Pay	Pay Bill % on Agency	Watch	May-25	0.44%		<=2.50%	✓	0	P		Common Cause
People we work with	Turnover & Leavers	In Month Turnover	Key Standard	May-25	0.41%		<=0.92%	✓	0	?		Common Cause
People we work with	Turnover & Leavers	12 Month Turnover	Key Standard	May-25	7.57%		<=11.0%	✓	0	P		Common Cause
People we work with	Turnover & Leavers	Leavers Inside 1st Year	Context	May-25	2.60		N/A					

Metric Summary II

Royal United Hospitals Bath
NHS Foundation Trust

Strategic Goal	Measure Group	Measure	Measure Category	Latest Month	Latest Performance	Trend	Target	Target Met	Months Since Last Met	Target Feasibility Assurance	Variation	Variation Detail
People we work with	Sickness Absence	In Month Sickness	Key Standard	Apr-25	4.56%		<=4.61%	✓	0	F		Common Cause
People we work with	Sickness Absence	Short Term Sickness	Context	Apr-25	2.14%		N/A					
People we work with	Sickness Absence	Long Term Sickness	Context	Apr-25	2.42%		N/A					
People we work with	Sickness Absence	12 Month Sickness	Key Standard	Apr-25	4.79%		<=4.70%	✗	5	F	H	Special Cause Concerning - Trending up
People we work with	Sickness Absence	In Month ASD Sickness	Driver	Apr-25	1.25%		TBC			F		Common Cause
People we work with	Appraisal	Appraisal Compliance	Key Standard	May-25	80.08%		>=90.0%	✗	Pre-2021	F		Common Cause
People we work with	Appraisal	AfC Appraisal Compliance	Context	May-25	80.69%		>=90.0%	✗	Pre-2021	F		Common Cause
People we work with	Appraisal	M&D Appraisal Compliance	Context	May-25	73.52%		>=90.0%	✗	Pre-2021	F		Common Cause
People we work with	Training	Mandatory Training Compliance (Core)	Key Standard	May-25	88.67%		>=85.0%	✓	0	P		Common Cause

Only ESR data since 2021 has been uploaded to the warehouse for PBI reporting. Training data and appraisal data is only available from October 2022.
Safeguarding Adults required audience changed in April 2024.

Sickness

Royal United Hospitals Bath NHS Foundation Trust

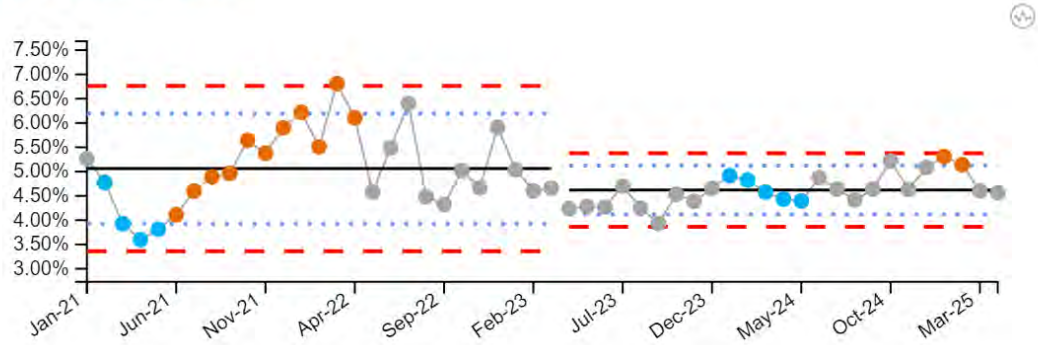
DRIVING

Key Standard

We are driving this metric because

Sickness absence remains generally higher than pre-pandemic levels, with in month rates above 4.5% now common place. High sickness levels impact the Trust in terms of staff availability, productivity and cost, but could also indicate staff ill-health and potentially a lack of engagement. Reducing sickness absence would have benefits for performance, as well as employee well-being.

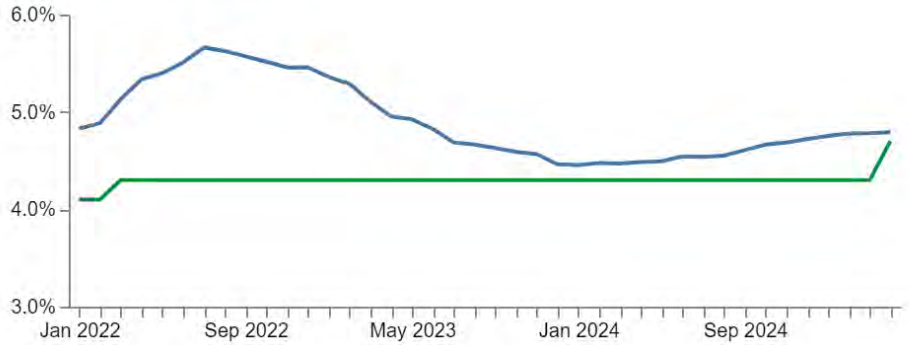
Trust In Month Trend



4.56% Latest In Month Sickness

4.61% Target

Trust 12 Month Trend



4.79% Latest 12 Month Sickness

4.70% Target

Understanding Performance

- The 12-month sickness rate in April was 4.79%, exceeding the revised target of 4.7%.Based on known data and typical patterns, the earliest this revised 12-month target may be achieved potentially is August.
- In month sickness rate in April (4.56%) was below the revised seasonally adjusted target.
- Estates and Facilities has the highest 12-month rate at 6.59%. However, this is trending down and is the best figure for over 2 years.
- Medicine has the next highest 12-month rate at 5.19% and has been trending up consistently over the past year.
- Surgery have the highest in month rate 5.22 and their 12-month rate has jumped 0.12 percentage points in 2 months.

Countermeasures	Owner	Due Date
Wellbeing Hub offering in-reach skilling to managers and targeted support to teams most impacted by increasing sickness rates.	Wellbeing Hub Manager	Review 2025/26 Q3
Project to understand factors influencing sickness absence in areas of most concern due for completion in late June 2025	DPP FASS	Due for July People Committee
Estates and Facilities: Continued HR Drop ins / Increased Focus on H&W meetings to support LTS back into work. A3's on Departmental Sickness being completed in Facilities.	DPP E+F	July 2025
Medicine: Action plans re violence and aggression , civility, skill mix and wellbeing interventions in ED, Parry and Haygarth ward.	DPP Med	Aug 25

Risks and Mitigation

Estates and Facilities - Increased sickness management in Cleaning in line with current policy has led to staff feeling that the trigger system is "punitive" and not supportive. This will change with the new policy implementation.

Anxiety, Stress and Depression Sickness

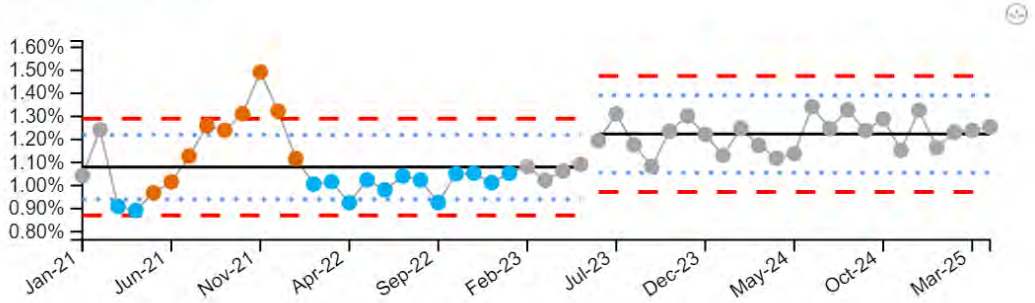
Royal United Hospitals Bath
NHS Foundation Trust

Driver

We are driving this metric because

Compared to historical performance, the in-month Anxiety, Stress and Depression sickness rate has been consistently elevated for the past two years and is a key driver of the high in month sickness rates. To reduce the overall sickness rate, ASD rates would need to return to the previous norm. That reduction would have benefits for the Trust in terms of staff availability, productivity and cost; but would also represent that we are improving staff well-being by addressing any work-related factors and providing support for any personal challenges.

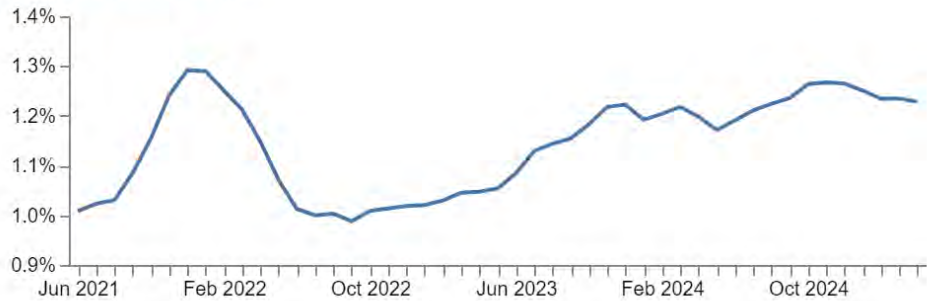
Trust In Month Rate



1.25%

Latest In Month Rate

Trust 6 Month Trend



1.23%

Latest 6 Month Rate

Understanding Performance

- In month Anxiety, Stress and Depression sickness rate in April was 1.25%
- 158 unique employees were absent for at least one day across April. Whilst not the highest value recorded, it is some way above the 100-120 range that would likely be required to return rates back to the historic norm.
- Surgery has the highest in month rate at 1.51%. Its 12 month rate is, however, relatively low at 1.10%; though there is an emerging upward trend .
- Although Estates and Facilities and Medicine both have 12-month rates of 1.35%, Medicine is on an upward trend whereas Estates and Facilities are trending down.

Countermeasures	Owner	Due Date
Stress and burnout workshops (alongside team manager-based skills interventions) being delivered to areas most in need of support. 17 workshops over the last 2 months (areas include: ED, Theatres, Parry, NICU, Anaesthetics & Children's Ward)	Wellbeing Hub Manager	Review 2025/ 26 Q3
Emergency Medicine - • Stress/burnout action plan being with assistance from EAP • Health and wellbeing sessions as part of ED away days • Cultural work surrounding civility	Divisional People Partner	June 2025
Theatres - • Theatre recovery had their burnout session with EAP • Listening events held • Monthly HR / Clinical lead meetings discussing health and wellbeing. • A3 to be completed in June 2025	Divisional People Partner	Review in July 2025

Risks and Mitigation

Corporate Service - Review/ Hold on recruitment may cause additional stress/burn out of current teams.

Appraisal

Royal United Hospitals Bath NHS Foundation Trust

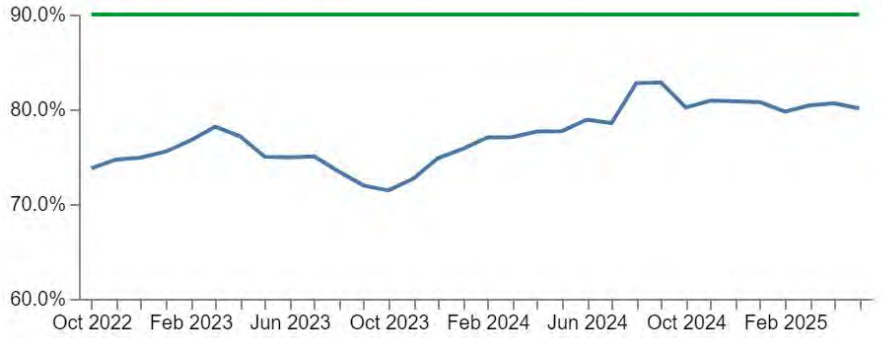
DRIVING

Key Standard

We are driving this metric because

Timely, high-quality appraisals improve performance, engagement and productivity, reducing sickness and burnout. All colleagues should have access to a meaningful programme of interaction with their managers, including an annual appraisal. The organisation has set a 90% compliance target for the annual appraisal. Concerted effort is needed to ensure the organisation's approach to appraisal is both meaningful and fully embedded.

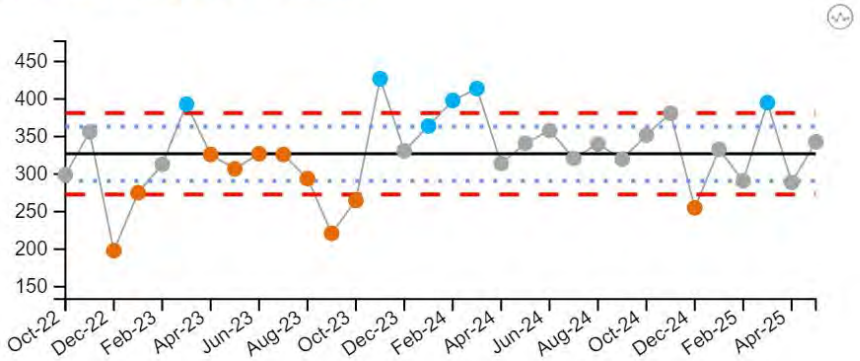
Trust Appraisal Compliance



80.1%
Latest Appraisal Compliance

90.0%
Target

Appraisals Completed in Month



343
Appraisals Completed in Month

Understanding Performance

- Overall appraisal compliance has slightly fallen to 80.08%, with no individual Division achieving the 90% target.
- Corporate continues to improve its compliance, but at 64.2% it remains by some way the poorest performing major division.
- Medicine and Surgery continue to trend down from the most recent peak seen in August 24.

Countermeasures	Owner	Due Date
Project to improve appraisal quality and compliance initiated – this supports the embedding of the one to one and appraisal policy refresh	DPPs and ADP Culture Change	September 2025
FASS: • Developing a pilot for a team-style appraisal with one of the community birthing teams.	DPP	August 2025

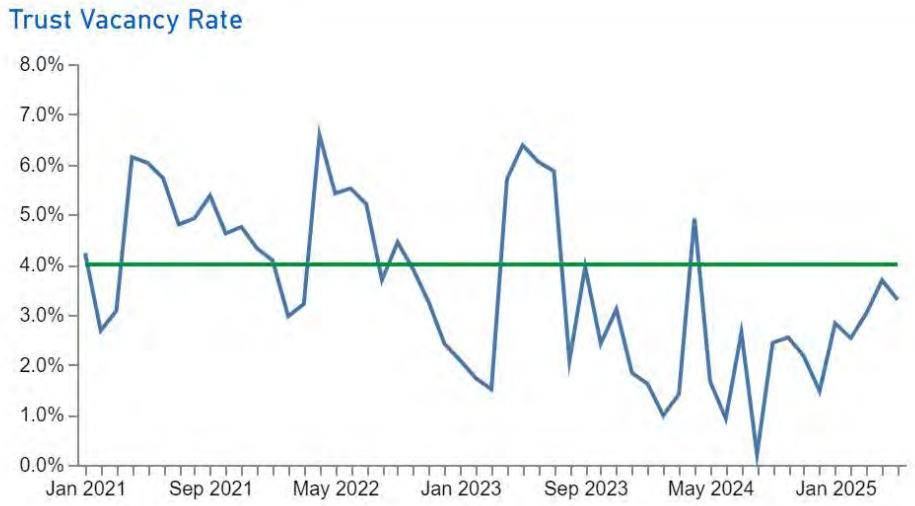
Risks and Mitigation

Risk: Too fixed a focus on achieving appraisal compliance risks a dip in the quality of the appraisal conversation.
Mitigation: New one-to-ones and appraisal approach aims to embed a rhythm of purposeful interactions between managers and colleagues, making compliance more attainable.
Priority: Improving interactions between managers and direct reports is central to the breakthrough objective: increasing perceptions that the organisation values my work.

Vacancy

Royal United Hospitals Bath NHS Foundation Trust

Key Standard



3.30% Latest Vacancy Rate

4.00% Target

5704.6 Latest Budget

5516.6 Latest Contracted

188.0 Latest Vacancy

Understanding Performance

- Unit 4 data shows a slight drop in the vacancy rate to 3.30%, reflecting a slightly lower Budget WTE and a higher contracted WTE.
- Medicine continues to have the highest vacancy WTE at 94.3 WTE, with approximately half of this pertaining to the Emergency Medicine Directorate.
- Pharmacy (18.9 WTE) and Nursing and Patient Care (15.8 WTE) are the only other Directorates with a vacancy above 15 WTE, though 3 (Medicine Management, Oncology and Cardiology) have a vacancy above 10 WTE.
- Across the Trust, unregistered Band 3 support staff is the main vacancy hotspot.

Countermeasures	Owner	Due Date
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.	Head of Talent	July 2025
Trust led Vacancy Control Panel continues to support financial recovery plans	Executive Team	Open
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 Talent & Capacity	Open
Medicine – ED recruitment campaign in place, with pipeline of people appointed.	Senior Matron ED	Sept 25

Risks and Mitigation

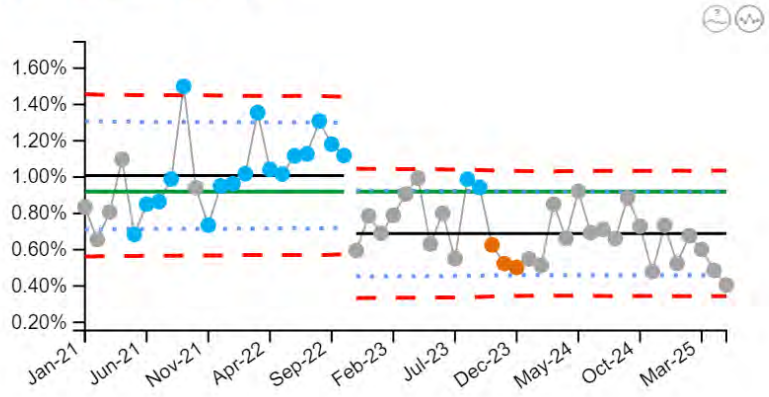
Divisional vacancy rates may increase as we take the necessary steps to secure a sustainable workforce and slow down the recruitment pipeline where feasibly safe to do so to support our financial position.

Changes to the immigration system outlined in the White paper may impact on workforce supply.

Turnover

Key Standard

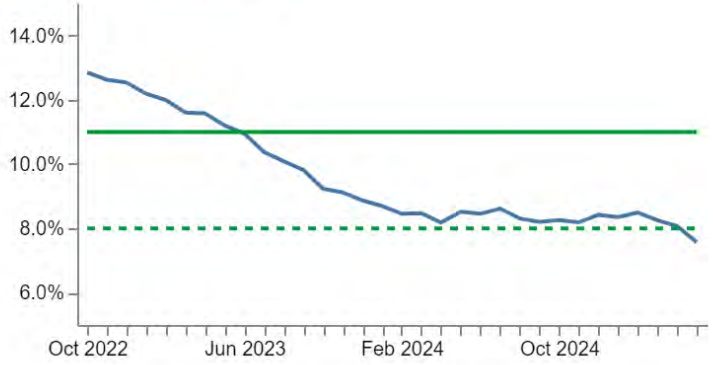
Trust In Month Turnover



0.41%
Latest In Month Turnover

0.92%
Target

Trust 12 Month Turnover



7.57%
Latest 12 Month Turnover

11.00%
Target

Division	In Month	12 Month
Capital Summary [Division]	2.40%	12.44%
Charity Summary [Division]	8.19%	29.18%
Corporate Division	0.20%	9.74%
Estates and Facilities Division	0.68%	6.68%
Family and Specialist Service Division	0.42%	8.07%
Medical Division	0.40%	6.93%
Research & Development [Division]	1.86%	8.94%
Surgical Division	0.33%	7.38%

Main Staff Group	In Month	12 Month
Add Prof Scientific and Technic	1.52%	17.47%
Additional Clinical Services	0.66%	9.28%
Administrative and Clerical	0.53%	10.10%
Allied Health Professionals	1.19%	13.48%
Estates and Ancillary	1.06%	7.49%
Healthcare Scientists	0.60%	8.57%
Medical and Dental	0.12%	2.49%
Nursing and Midwifery Registered	0.02%	4.29%

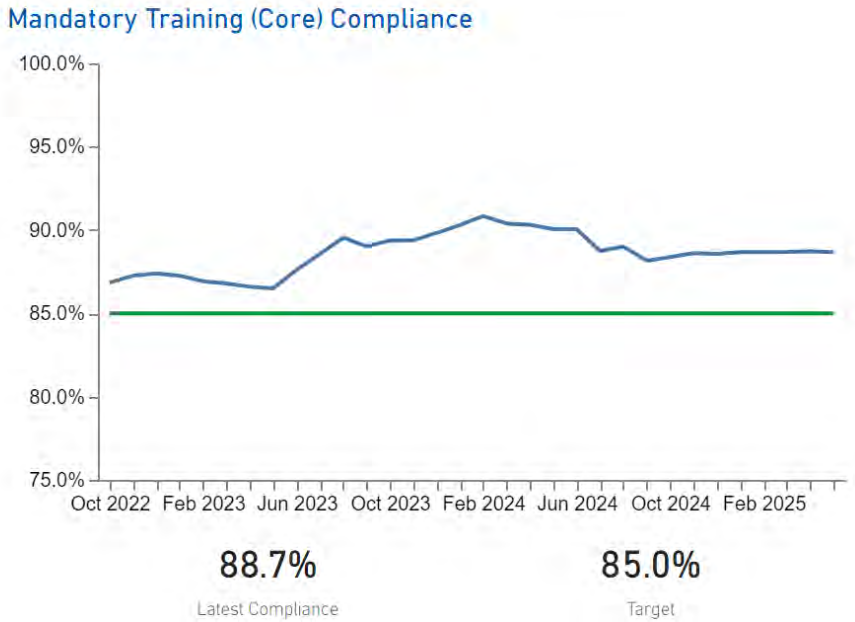
Understanding Performance
Overall, in month turnover was 0.41% in May. No SPC rule has yet been triggered; but the recent frequency of low turnover months - which has led to 12-month turnover falling below 8%.

Countermeasures	Owner	Due Date
No counter measures in place due to 12-month turnover below target.		

Risks and Mitigation
Turnover is currently lower than 8%. This may be considered unhealthy for the organisation and problematic to achieving the savings plan through natural loss.

Mandatory Training

Key Standard



Understanding Performance
• Overall mandatory training compliance remains relatively stable, above target at 88.67%. • All main Divisions exceed the 85% target; however, only non-clinical Divisions exceed 90% compliance. • Three subjects are more than 5 percentage points below their respective targets: Safeguarding Adults Level 3 and Adult and Paediatric Resuscitation. • A further four subjects are below target, but within 5 percentage points: Moving & Handling Level 2, Infection Prevention & Control Level 2, Newborn Resuscitation and Safeguarding Children Level 3.

Countermeasures	Owner	Due Date
IPC compliance 86.06% and MH 90.49%. IPC Lead nurse and Manual Handling Lead working with Mandatory Learning Oversight Group to evaluate training content and compliance against current risk.	IPC Lead &Manual Handling Lead & Corporate Head Education	31st July
Reviewing mandatory training frequency as part of NHSE National Programme- Present at MLOG June. Aim to move frequency from 1 to 2 yearly, based on clinical outcome data.	Corporate Head Education	Oct 25

Risks and Mitigation
Rise in ECOLI and CDIFF. National project reviewing training content and Trust asked to show evidence of behaviour change and competence . Mandatory Learning Oversight group Established to carry out work. Led by Corporate Head of Education. **Trust Risk ID 2791** Resus Staffing. Vacancies and sickness. Team have been delivering to a compliance of 50%. 2 wte now started and Resus driver to start in July.

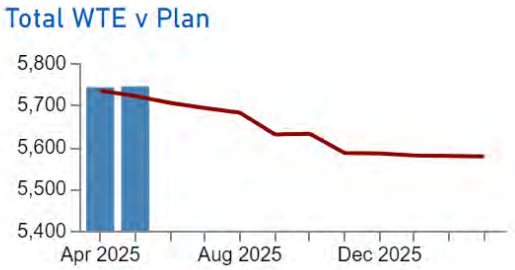
Performance vs Workforce Plan

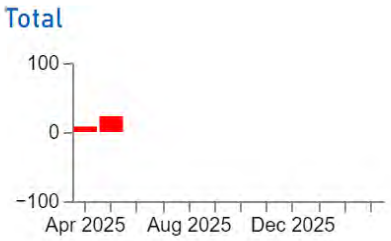
Royal United Hospitals Bath NHS Foundation Trust

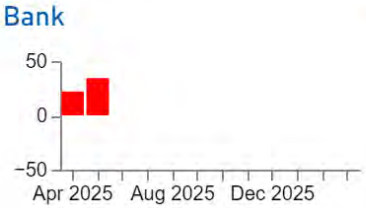
Driver

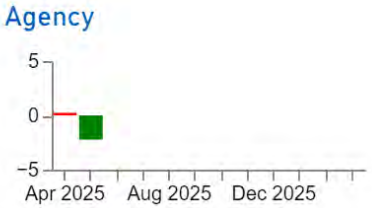
We are driving this metric because

Achieving the Workforce Plan will be a key factor in achieving the financial savings required. Affording regular attention to progress against the plan will enable more timely intervention should deviation become apparent.









Plan

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Total	5,733.87	5,721.37	5,704.87	5,692.37	5,681.38	5,629.68	5,631.28	5,585.28	5,584.28	5,579.28	5,578.28	5,577.28
Substantive	5,423.21	5,418.71	5,410.21	5,399.71	5,401.81	5,360.11	5,362.71	5,322.71	5,322.71	5,322.71	5,322.71	5,322.71
Bank	304.66	296.66	288.66	286.66	273.57	264.57	263.57	257.57	256.57	251.57	250.57	249.57
Agency	6	6	6	6	6	5	5	5	5	5	5	5

Actual

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Total	5,741.71	5,744.37										
Substantive	5,408.81	5,409.60										
Bank	326.67	331.01										
Agency	6.23	3.76										

Understanding Performance
• For a second consecutive month the Trust has not achieved its overall plan. In the financial year to date, over 30 WTE more has been used than expected, with excess bank use the driver. • In May, bank usage was 11.6% above plan, up from 7.2% in April.

Countermeasures	Owner	Due Date
A Nursing and Support to Clinical Temp staffing specific workforce plan inc narrative) is being developed with the Deputy Chief Nurse, DDONS, DPPs and FMs. This will allow a better understanding and an opportunity to change the future of temp staffing usage.	Workforce, Finance, Nursing	EOM July 2025
A weekly spend/usage report has been developed in Power BI from HealthRoster and Locum's Nest. The report is future focused and shows the current week and the next five weeks.	Rostering and Workforce	Weekly
Fortnightly and monthly monitoring meetings with the DPPS, Head of Temporary Staffing and adhoc meetings (when necessary with DDOs and Clinical Staff).	Trust Wide	Monthly / Fortnightly

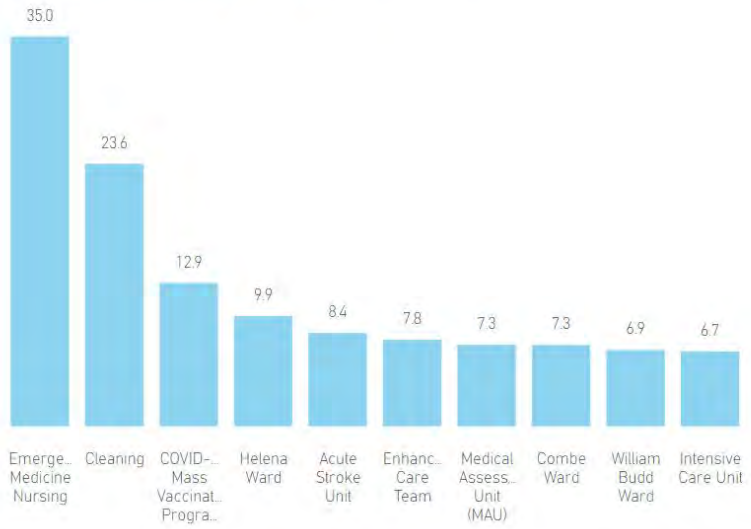
Risks and Mitigation
• The main risk is the over usage of bank wte at the start of the year where the plan was for there to be a reduction. • After M2 the RUH have used 30wte more than expected, this leads to the need to now reduce by a further 30wte on top of what was planned in future months.

Bank & Agency Use

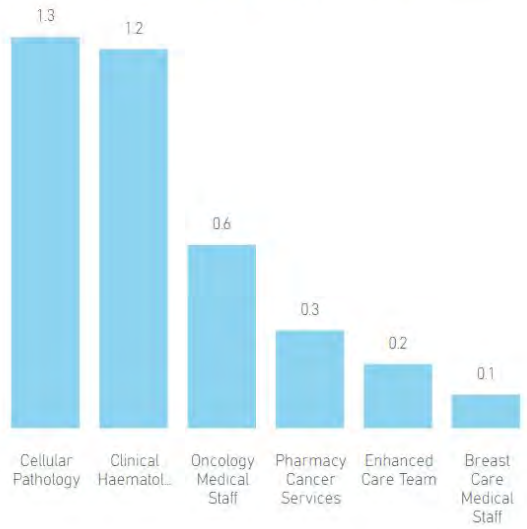
Royal United Hospitals Bath NHS Foundation Trust

Key Standard

Top Departments for Bank Use In Month



Top Departments for Agency Use In Month



PWR Staff Group Breakdown

PWR Staff Group	Bank WTE	Agency WTE
Medical and Dental	19.3	3.2
Registered/ Qualified Scientific, Therapeutic and Technical staff	14.4	0.3
Registered Nursing, Midwifery and Health Visiting Staff	111.4	0.2
NHS Infrastructure support	62.4	0.0
Support to Clinical Staff	123.5	

Understanding Performance

- Emergency Medicine Nursing is the biggest user of bank, with their main use in the registered nurse (18.6 WTE) and support to clinical staff (15 WTE) staff groups.
- Whilst MAU, William Budd and ICU also had a greater requirement for registered nurses, Helena Ward, Acute Stroke Unit, Enhanced Care Team and Combe all sought more support to clinical staff. This reflects that a wider mix of need in general which saw 37.3% of bank use being associated with support to clinical and 33.7% with registered nursing.
- Cleaning accounts for over a third of infrastructure support bank
- Agency is primarily being used to cover hard to fill consultant roles in fragile services.

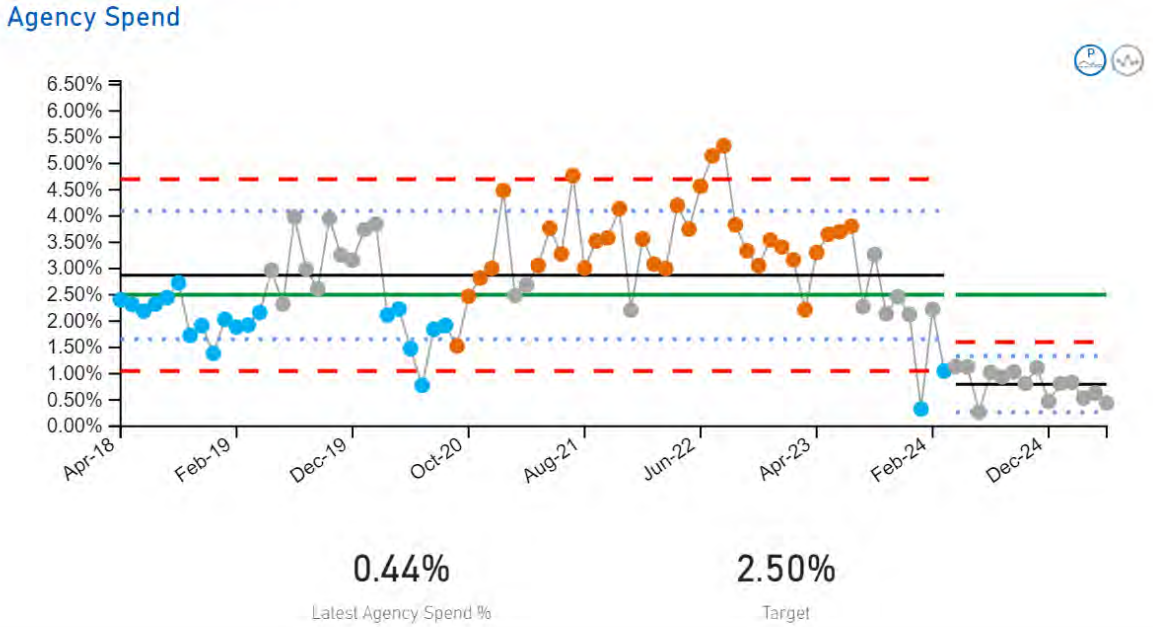
Countermeasures	Owner	Due Date
A weekly spend/usage report has been developed in Power BI from HealthRoster and Locum's Nest. The report is future focused and shows the current week and the next five weeks.	Rostering Workforce	Weekly
South West Regional rate card for Bank Nursing is being developed to align rates across the patch. The approach creates equity and aims to remove competition in rates and incentives to attract and fill bank shifts	AD for Talent	September 25

Risks and Mitigation

The ICB Covid Mass Vaccination are running summer programme closing end of June. Demand for support should decrease from July.

Agency Spend as % of Total Pay Bill

Key Standard



Understanding Performance
• Agency spend remains tightly controlled at 0.44% of the total pay bill against a local target of 2.5% and national target of 3.2% • 98% of spend in May was on Consultants, with Oncology Medical Staff and Cellular Pathology continuing to be the higher spending departments. • Off framework agency continues to be used for the Oncology Consultant role (a national shortage/hard to fill post) with alternatives options being pursued.

Countermeasures	Owner	Due Date
Recruitment campaign live to recruit Oncology Consultants (4 posts) to support exit strategy for long-term locums.	AD for Talent & Capacity	July 2025
SW Agency rate card for Medical & Dental in place . Work continues with suppliers to reach compliance or source alternative workers. Weekly tracker of progress shared with Deputy CMO	AD for Talent & Capacity	On-going
Preferred Supplier Lists and Master Vend having regular review meeting to manage contract and demonstrate best value provision and compliance.	AD for Talent & Capacity	On-going

Risks and Mitigation
South West price cap compliant rate card in place for Nursing and Allied Health Professionals.

Part 3 | People In Our Community

Deliver a sustainable financial position

Equity of access to RUH for all

Carbon emission reduction

Year to date % change in productivity compared to 24/25

Royal United Hospitals Bath
NHS Foundation Trust

Breakthrough Objective

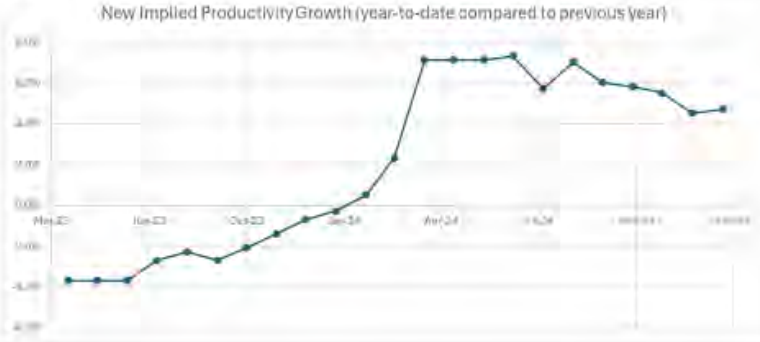
We are driving this metric because…	*Productivity, measured as changes in real-terms costs compared to activity has deteriorated since 2019/20 pre-pandemic. NHSE has committed to improving Productivity has part of funding settlement with Central Government. NHSE have developed a metric 'Change in Implied Productivity' that enables benchmarking against other NHS organisations* *Productivity is a helpful metric to consider changes in activity and demand and alongside changes in costs and budgetary performance, particularly in a financial framework where income isn't solely driven by activity.* *It is important to note that changes in Implied Productivity, only relate to real terms costs and activity, and do not measure Value or Outcomes.*
Performance Target: Improve Implied Productivity by 6.7% compared to 24/25	

M11 2024/25	23/24 Comparison, unadjusted			Movement from M10, unadjusted		
	Inflation adj. expenditure growth	Cost weighted activity growth	Implied productivity growth	Inflation adj. expenditure growth	Cost weighted activity growth	Implied productivity growth
RUH	2.5%	7.4%	**4.7%**	-0.4%	-0.1%	**0.3%**
BSW	2.9%	8.3%	**5.2%**	0.0%	-0.2%	**-0.1%**

Data are only updated to M11 (February) 2024/25. RUH data still includes Sulis costs but not activity.

Understanding Performance

Data for Feb 25 show an implied productivity growth of 4.7% compared to M11 23/24, this ranks as the eighth largest productivity increase in the South West Region (of 13 providers). This is driven by cost weighted activity growth of 7.4% with an inflation adjusted expenditure growth of 2.5%. Compared to M10 23/24 implied productivity growth was 0.3%. Cost weighted activity reduced by 0.1% and expenditure reduced by 0.4%.



Countermeasures	Owner	Due Date
Delivery of Productivity improvements and cash releasing savings target set out in Operational Plan for 25/26	Savings programme SRO	Ongoing
Develop metric to be based on real-time data	Head of Financial Projects	31 July
Develop metric to be calculated at Division level	Head of Financial Projects	31 July
Establish single KPI for each Specialty to focus on during 25/26	Divisional/ Specialty Tris	30 June

Risks and Mitigation

- Ensure understanding of the metric and calculations
- If Productivity improvements are not sufficiently cash releasing this could lead to achievement of the metric but failure to delivery financial performance targets

Income & Expenditure Year to Date (NHSE Performance)

Royal United Hospitals Bath NHS Foundation Trust

I&E to May 2025	YTD											
	RUH			Sulis			Inter-Group			Total Group Position		
	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Actual £'m	Variance £'m
Commissioning Income	79.751	79.315	(0.436)	6.133	5.400	(0.733)	0.000	0.000	0.000	85.884	84.715	(1.169)
Clinical Education Income	3.121	3.097	(0.024)	0.000	0.000	0.000	0.000	0.000	0.000	3.121	3.097	(0.024)
Other Income	8.887	8.851	(0.036)	2.434	2.320	(0.114)	(0.666)	(0.407)	0.258	10.656	10.764	0.108
Pay	(58.024)	(60.562)	(2.538)	(3.969)	(4.079)	(0.110)	0.000	0.000	0.000	(61.993)	(64.641)	(2.648)
Non Pay	(26.205)	(29.848)	(3.644)	(3.900)	(3.760)	0.140	0.000	0.000	0.000	(30.105)	(33.608)	(3.504)
EBITDA	**7.531**	**0.853**	**(6.678)**	**0.698**	**(0.119)**	**(0.817)**	**(0.666)**	**(0.407)**	**0.258**	**7.563**	**0.327**	**(7.237)**
Depreciation & Amortisation	(3.918)	(3.918)	0.000	(0.542)	(0.539)	0.003	0.364	0.296	(0.068)	(4.097)	(4.162)	(0.065)
Impairments	(13.621)	0.000	13.621	0.000	0.000	0.000	0.000	0.000	0.000	(13.621)	0.000	13.621
Net Finance Charges	(1.522)	(1.335)	0.187	(0.093)	(0.093)	0.000	0.093	0.057	(0.036)	(1.523)	(1.371)	0.151
Surplus/(Deficit)	**(11.530)**	**(4.400)**	**7.131**	**0.063**	**(0.752)**	**(0.814)**	**(0.209)**	**(0.055)**	**0.154**	**(11.677)**	**(5.206)**	**6.470**
Donated/Grant Income	(11.677)	2.041	13.718	0.000	0.000	0.000	0.000	0.000	0.000	(11.677)	2.041	13.718
Adjusted Financial Performance	**0.146**	**(6.441)**	**(6.587)**	**0.063**	**(0.752)**	**(0.814)**	**(0.209)**	**(0.055)**	**0.154**	**(0.000)**	**(7.247)**	**(7.247)**
Deficit Support Funding	0.067	0.067	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.067	0.067	0.000
Underlying Financial Performance	**0.080**	**(6.507)**	**(6.587)**	**0.063**	**(0.752)**	**(0.814)**	**(0.209)**	**(0.055)**	**0.154**	**(0.067)**	**(7.314)**	**(7.247)**

The RUH submitted a balanced plan for 2025/26. This included £29.7m of savings profiled equally throughout the year. To deliver a balanced plan the Trust is receiving £19.2m of Deficit Support funding in the form of ICB Transitional Funding. The Trust is also required to deliver £4.8m of non recurrent improvement in addition to the Savings Programme. The deficit support funding is phased to set a breakeven budget each month.

NHSE Financial Performance is measured including fully consolidated financial position of the wholly owned subsidiary, Sulis. NHSE Financial performance is measured excluding the accounting impact of donated/grant income for capital assets and the impact of asset revaluations

The Trust secured £2.4m of ICB funding to deliver an improved Referral to Treatment (RTT) performance and budgeted £1.5m of pump priming funding to deliver the savings programme. Business cases against RTT have been developed and for month 2 the income and costs are reported based on current delivery, whilst the pump priming activities have been paused.

Understanding Performance

The RUH is adverse to plan by £6.6m. This is resulting from delays to delivery against the savings programme (£4.5m), deterioration in the exit run rate (£1.0m), and operational pressures arising from increased spend on high cost drugs and devices (£0.2m), Corporate cost pressures (£0.2m) and Estates and Facilities Maintenance costs (£0.5m).

Sulis is adverse to plan by £0.8m. This is principally driven by under performance on CDC activity based income without corresponding reduction to pay and non pay marginal cost.

The underlying exit run rate has been assessed as £6.0m worse than originally planned, £3.3m deterioration from 2024/25, plus a further £2.7m cost that was not reflected in the original financial plan for 2025/26.

Countermeasures	Owner	Due Date
Acceleration of our saving plans that have been scoped for UEC, theatres, outpatients and corporate restructuring; as well as scoping of the un-identified savings requirement at Trust and BSW Hospitals Group level	Delivery Group SROs; Trust Management Executive, BSW Hospitals Group Joint Committee and BSW ICS Recovery Board	30 June
Capital expenditure that has not been contractually committed or is mandated has been stopped. All discretionary spend, such as room hire, has been cancelled A vacancy freeze for corporate areas has started	Trust Management Executive and Budget Holders	Monitoring Impact
Devolution of the savings targets to local budgets	Finance Department and Divisional Tris	30 June
Rapid improvement in the transfer of activity that flows to Sulis to maximise the use of capacity	System Delivery Director for Planned Care and Sulis Director	30 June
Deep dive into the drug expenditure and to understand the gap in reimbursement by Spec Comm and ICB	Chief Pharmacist, Divisional Tris and Chief Financial Officer	30 June

Income & Expenditure – Risks and Mitigations

Royal United Hospitals Bath NHS Foundation Trust

Pending detailed Saving Delivery Plans and forecast outturn calculation the table below sets out the key risks and potential mitigations to the delivery of the annual financial plan; as well as the progression since the initial development of the plan.
Total net unmitigated risk is currently calculated as £25.2m, which will not be acceptable to ICS and NHSE and will require further corrective action.
The Trust is also carrying contingent liabilities relating to accounting treatments and legal disputes that cannot be financially quantified at this time.

Category	Gross Risk £'m	Gross Mitigation £'m	Net Risk £'m
Exit Run Rate	(6.000)	0.000	(6.000)
Savings	(21.742)	2.500	(19.242)
Budget Management	(2.800)	2.800	0.000
Technical or Funding	(11.930)	11.930	0.000
Sulis	(0.750)	0.750	0.000
(Risk)/Mitigation	**(42.472)**	**17.230**	**(25.242)**

Risks and Mitigation

Should financial risks crystallise there is a risk to the RUH Group maintaining sufficient cash flow to pay suppliers in a timely basis and finance Capital Programme

The Trust will receive regulatory intervention from NHSE

Immediate actions to stop all discretionary expenditure set out in the previous slide, together with close collaboration at BSW Hospitals Group and BSW Integrated Care System on financial improvement are the main further mitigations.

	Plan Submision - FPC Feb £m	Draft Operating Plan submission £m	Final Plan £m	Month 1 £m	Month 2 £m		Change from Final Plan £m
Risks							
Exit Run Rate & Plan Risks	(3.000)	(3.000)	(2.500)	(6.000)	(6.000)		(3.500)
Group Savings - unidentified	0.000	(4.400)	(4.400)	(4.400)	(4.400)		0.000
Trust Savings - unidentified	(4.600)	(4.000)	(5.500)	(5.500)	(4.715)		0.785
Trust Savings - Delivery Maturity Status	(10.000)	(12.200)	(16.000)	(16.000)	(11.127)		4.873
Costs of Change	0.000	0.000	(1.500)	(1.500)	(1.500)		0.000
Revenue impact of reduced cash balances	0.000	0.000	0.000	0.000	(1.000)		(1.000)
Demand growth - ICB commissioned High Cost Drugs & Devices	(2.000)	(2.000)	(2.000)	(3.000)	(0.930)		1.070
Demand growth - Weight Management NICE guidelines	(3.000)	(3.000)	(3.000)	(1.000)	(1.000)		2.000
Demand growth - Urgent Care demand	(10.000)	(10.000)	0.000	(1.200)	(1.200)		(1.200)
Demand growth - RTT Delivery / referral growth	(10.000)	(10.400)	(5.600)	(5.600)	(2.500)		3.100
Armed Forces commissioning contract value	0.000	0.000	0.000	(0.700)	(0.700)		(0.700)
Ambulance Handover Fines	0.000	0.000	(2.000)	0.000	0.000		2.000
Operational pressures	0.000	0.000	0.000	0.000	(1.600)		(1.600)
Sulis Income plan incl CDC	0.000	0.000	0.000	(1.500)	(0.350)		(0.350)
CDC Endoscopy Van productvity	0.000	0.000	0.000	0.000	(0.400)		(0.400)
Pay Inflation higher than budgeted	0.000	0.000	(0.625)	(0.625)	(3.300)		(2.675)
SEOC Elective Income cap	(6.500)	(6.500)	0.000	0.000	0.000		0.000
Accounting judgement for Annual Leave accrual	0.000	0.000	0.000	0.000	(2.500)		(2.500)
Gross Risk	(49.100)	(55.500)	(43.125)	(47.025)	(43.222)		(0.097)
Mitigations							
Commissioner funding or Activity Mangement Plans							
High Cost Drugs & Devices	2.000	2.000	2.000	3.000	0.930		(1.070)
Weight Management	3.000	3.000	3.000	1.000	1.000		(2.000)
RTT Delivery	10.000	10.000	5.600	5.100	2.500		(3.100)
UEC demand management	10.000	10.400	0.000	0.000	0.000		0.000
Additional transitional support	4.600	5.500	0.000	0.000	0.000		0.000
Armed Forces contract negotiation	0.000	0.000	0.000	0.700	0.700		0.700
Pay inflation	0.000	0.000	0.625	0.625	3.300		2.675
Cost of Change	0.000	0.000	1.500	1.500	1.500		0.000
Ambulance Handover funding	0.000	0.000	2.000	0.000	0.000		(2.000)
SEOC funding	4.000	4.000	0.000	0.000	0.000		0.000
CDC Endoscopy Van funding	0.000	0.000	0.000	0.000	0.400		0.400
Internal Recovery							
Sulis income recovery	0.000	0.000	0.000	1.500	0.350		0.350
Operational budget management	0.000	0.000	0.000	0.000	2.800		2.800
Savings maturity	4.000	12.200	20.000	8.000	0.000		(20.000)
Discretionary spend freeze	0.000	0.000	0.000	0.000	1.000		1.000
Cash management	0.000	0.000	0.000	0.000	1.000		1.000
Annual leave management	0.000	0.000	0.000	0.000	2.500		2.500
Gross Mitigation	37.600	47.100	34.725	21.425	17.980		(16.745)
Net unmitigated Risk	(11.500)	(8.400)	(8.400)	(25.600)	(25.242)		(16.842)

Drivers of M2 Deficit

BSW System - M2 YTD

Summary heading	GWH £'m	RUH £'m	SFT £'m	**Group £'m**	ICB * £'m	**System £'m**
M2 Position	(5.6)	(7.2)	(3.8)	**(16.6)**	3.2	**(13.4)**
M2 Plan	0.0	0.0	0.0	**0.0**	0.0	**0.0**
M2 Variance (+ve = favourable)	**(5.6)**	**(7.2)**	**(3.8)**	**(16.6)**	**3.2**	**(13.4)**
Drugs	(0.3)	(0.2)	(0.2)	**(0.7)**	1.5	**0.8**
Unidentified Group savings	(0.6)	(0.7)	0.0	**(1.3)**		**(1.3)**
Non delivery of Identified local efficiencies	(2.6)	(3.8)		**(6.4)**	0.0	**(6.4)**
Sulis		(0.8)		**(0.8)**		**(0.8)**
Non Pay - Facilities Management		(0.5)	(0.6)	**(1.1)**		**(1.1)**
Temporary staffing reductions	(0.4)		(0.1)	**(0.5)**		**(0.5)**
Utilities			(0.2)	**(0.2)**		**(0.2)**
PY Outturn impact		(0.5)		**(0.5)**		**(0.5)**
Deficit support funding	(1.6)		(2.3)	**(3.9)**		**(3.9)**
Other	(0.1)	(0.8)	(0.4)	**(1.3)**	1.7	**0.4**

Notes:

- Drugs adverse variance has come down month on month (particularly at RUH)
- SFT group savings back-ended phased
- No deficit support funding in plan for RUH
- ICB drugs benefit of £1.5m relates to prior year and already factored into supporting position

Budget – by Division

Royal United Hospitals Bath NHS Foundation Trust

Budget by Division		In Month RUH			Year to Date RUH		
	Yearly Budget £'m	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Actual £'m	Variance Excl HCDD £'m
Commissioning Income	468.990	39.226	38.099	(1.127)	78.627	78.191	(1.482)
Clinical Education Income	18.725	1.560	1.549	(0.012)	3.121	3.097	(0.024)
Deficit Support Funding	19.198	1.124	1.124	0.000	1.124	1.124	0.000
Surgery	(139.219)	(11.365)	(10.938)	0.427	(22.853)	(22.144)	0.787
Medicine	(166.548)	(13.735)	(13.393)	0.342	(27.138)	(26.846)	0.561
FASS	(102.465)	(8.411)	(7.914)	0.497	(16.389)	(16.486)	0.796
E&F	(34.115)	(2.777)	(2.711)	0.065	(5.706)	(5.981)	(0.275)
Corporate	(65.930)	(5.422)	(5.503)	(0.081)	(10.947)	(11.068)	(0.121)
HIWE	0.000	0.000	(0.000)	(0.000)	0.000	(0.000)	(0.000)
R&D	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Unallocated Savings	29.070	2.335	0.000	(2.335)	4.810	0.000	(4.810)
Reserves	(0.728)	(0.267)	(0.676)	(0.409)	0.005	(1.750)	(1.755)
Finance Charges	(29.008)	(14.820)	(0.633)	14.187	(16.186)	(2.538)	13.647
Donated/Grant Income	(1.955)	(12.649)	1.593	14.242	(11.677)	2.041	13.718
Adjusted Financial Performance	**(0.076)**	**0.098**	**(2.589)**	**(2.687)**	**0.146**	**(6.441)**	**(6.394)**
Sulis	0.500	0.007	(0.257)	(0.265)	0.063	(0.752)	(0.814)
Inter Group	0.000	(0.105)	(0.028)	0.077	(0.209)	(0.055)	0.154
Financial Performance	**0.425**	**0.000**	**(2.875)**	**(2.875)**	**(0.000)**	**(7.247)**	**(7.054)**

Understanding Performance

This table shows the spend against current budgets. Note that annual savings target have not yet been fully devolved to Divisional budgets, and also £0.3m of year to date savings delivery has not been transacted into Divisional budgets.

Surgery are £0.7m underspent, of which £0.4m relates to reduced costs for SOC as the budget assumed it would be fully operational; this is fully offset in income under delivery. There are also underspends on WLI payments and general consumables which are part of the savings programme.

Estates and Facilities are overspent by £0.3m, which includes a one-off benefit of £0.2m. Their underlying pressure is £0.5m. . Significant maintenance work was undertaken in April and May driving part of the overspend as well as continual pressure from the patient kitchens not being fully operational. It is not anticipated that these costs will continue throughout the year.

Countermeasures	Owner	Due Date
Devolution of the savings targets to local budgets including the potential further top slicing across all budgets of the un-identified savings target	Finance Department and Divisional Tris	30 June
Corrective action required to reverse or mitigate operational cost pressures	Estates & Facilities Management Team & Corporate Teams	31 July

Budget – Pay

Royal United Hospitals Bath NHS Foundation Trust

Pay by Staffing Type	In Month RUH			Year to Date RUH		
	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Actual £'m	Variance £'m
Senior Medical	(5.425)	(5.259)	0.166	(10.751)	(10.533)	0.218
Junior Medical	(3.451)	(3.794)	(0.343)	(6.919)	(7.405)	(0.486)
Registered Nursing and Midwifery	(9.300)	(8.897)	0.403	(18.606)	(17.804)	0.802
Registered ST&T	(3.425)	(3.413)	0.012	(6.866)	(6.792)	0.074
Other Clinical Support	(4.784)	(4.845)	(0.061)	(9.697)	(9.878)	(0.181)
NHS Infrastructure Support	(3.727)	(3.985)	(0.258)	(7.421)	(7.842)	(0.420)
Other	(0.129)	(0.154)	(0.024)	(0.259)	(0.308)	(0.050)
Unallocated Savings	1.185	0.000	(1.185)	2.495	0.000	(2.495)
Surplus/(Deficit)	**(29.057)**	**(30.347)**	**(1.289)**	**(58.024)**	**(60.562)**	**(2.538)**
Pay Vacancy Factor Included Above	0.969	0.000	(0.969)	2.063	0.000	(2.063)

Pay by Spend Type	In Month RUH			Year to Date RUH		
	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Actual £'m	Variance £'m
Substantive	(29.755)	(28.393)	1.362	(59.513)	(56.632)	2.882
Pay Vacancy Factor	0.969	0.000	(0.969)	2.063	0.000	(2.063)
Net Budget	**(28.786)**	**(28.393)**	**0.393**	**(57.450)**	**(56.632)**	**0.819**
Bank	(0.048)	(1.557)	(1.509)	(0.091)	(3.087)	(2.997)
Agency	(0.025)	(0.141)	(0.115)	(0.050)	(0.338)	(0.287)
WLI	(0.083)	(0.138)	(0.055)	(0.203)	(0.266)	(0.064)
Other	(0.115)	(0.118)	(0.003)	(0.230)	(0.239)	(0.009)
Surplus/(Deficit)	**(29.057)**	**(30.347)**	**(1.289)**	**(58.024)**	**(60.562)**	**(2.538)**

Understanding Performance

Pay budgets are overspent by £2.5m. The Pay vacancy factor (£2.1m) has been delivered but further Pay savings (£2.5m) have not yet been achieved.

Registered Nursing and Midwifery has a significant underspend in outpatient and theatre areas but there are areas, such as Medical Wards, that are overspent due to escalation capacity and UEC pressure.

Finance team are undertaking work to ensure Junior Medical costs are funded from additional recharge income, where applicable.

Corporate Division overspends arise from senior management posts above establishment; and additional costs in discharge and site management teams

Agency costs are currently less than 1% of the total pay costs, well below the 3% expectation. Bank costs are currently 5.1% of the total pay costs, and have remained high for the last 2 months.

Countermeasures	Owner	Due Date
Devolution of the savings targets to local budgets including the potential further top slicing across all budgets of the un-identified savings target	Finance Department and Divisional Tris	30 June
Corrective action required to reverse or mitigate operational cost pressures	Budget Holders	31 July
Ensuring offsetting income is applied for recharged or externally funded posts, where applicable	Finance Team	30 June

Risks and Mitigation

The 2.8% pay awards have been accrued into this position matching to budget, if pay awards and staff in post are different this will cause a financial variation

If overall vacancy levels are not sustained this will lead to an unaffordable increase in expenditure run rate

Budget – Pay by Division

Royal United Hospitals Bath NHS Foundation Trust

Pay by Division	In Month			Year to Date		
	RUH			RUH		
	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Actual £'m	Variance £'m
Surgery	(7.990)	(7.861)	0.129	(16.000)	(15.773)	0.227
Medicine	(10.628)	(10.662)	(0.034)	(21.245)	(21.210)	0.035
FASS	(5.500)	(5.510)	(0.011)	(11.003)	(11.019)	(0.016)
E&F	(1.713)	(1.795)	(0.082)	(3.420)	(3.533)	(0.113)
Corporate	(3.029)	(3.261)	(0.232)	(6.145)	(6.528)	(0.382)
HIWE	(0.291)	(0.294)	(0.003)	(0.581)	(0.594)	(0.013)
R&D	(0.284)	(0.284)	(0.000)	(0.569)	(0.574)	(0.006)
Reserves	(0.807)	(0.680)	0.128	(1.556)	(1.330)	0.226
Unallocated Savings	1.185	0.000	(1.185)	2.495	0.000	(2.495)
Surplus/(Deficit)	**(29.057)**	**(30.347)**	**(1.289)**	**(58.024)**	**(60.562)**	**(2.538)**
Pay Vacancy Factor Included Above	0.969	0.000	(0.969)	2.063	0.000	(2.063)

Budget – Pay – WTE

Royal United Hospitals Bath NHS Foundation Trust

WTE by Staffing Type	In Month RUH		
	Budget WTE	Actual WTE	Variance WTE
Senior Medical	(325.2)	(313.6)	11.6
Junior Medical	(449.3)	(480.1)	(30.8)
Registered Nursing and Midwifery	(1,822.4)	(1,800.9)	21.5
Registered ST&T	(652.5)	(643.4)	9.1
Other Clinical Support	(1,624.0)	(1,580.8)	43.3
NHS Infrastructure Support	(888.0)	(879.4)	8.6
Other	(1.4)	(3.2)	(1.8)
Unallocated Savings	(7.1)	0.0	7.1
Surplus/(Deficit)	**(5,769.8)**	**(5,701.3)**	**68.6**
Pay Vacancy Factor Included Above	216.7	0.0	(216.7)

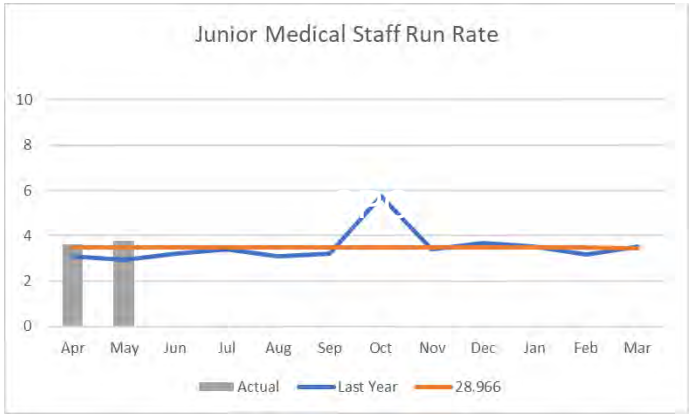
WTE by Spend Type	In Month RUH		
	Budget WTE	Actual WTE	Variance WTE
Substantive	(5,971.0)	(5,417.3)	553.7
Pay Vacancy Factor	216.7	0.0	(216.7)
Net Budget	**(5,754.3)**	**(5,417.3)**	**337.0**
Bank	(17.4)	(280.2)	(262.8)
Agency	0.0	(3.8)	(3.8)
WLI	1.9	0.0	(1.9)
Other	0.0	0.0	0.0
Surplus/(Deficit)	**(5,769.8)**	**(5,701.3)**	**68.6**

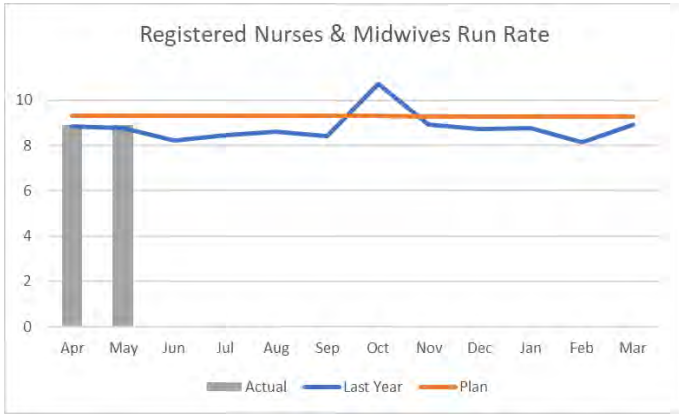
WTE by Division	In Month RUH		
	Budget WTE	Actual WTE	Variance WTE
Surgery	(1,448.8)	(1,454.2)	(5.4)
Medicine	(2,047.3)	(2,028.5)	18.8
FASS	(1,051.8)	(1,016.5)	35.3
E&F	(532.8)	(529.9)	2.9
Corporate	(586.3)	(567.2)	19.1
HIWE	(47.8)	(41.0)	6.9
R&D	(62.3)	(60.5)	1.9
Reserves	14.4	(3.5)	(17.9)
Unallocated Savings	(7.1)	0.0	7.1
Surplus/(Deficit)	**(5,769.8)**	**(5,701.3)**	**68.6**
Pay Vacancy Factor Included Above	216.7	0.0	(216.7)

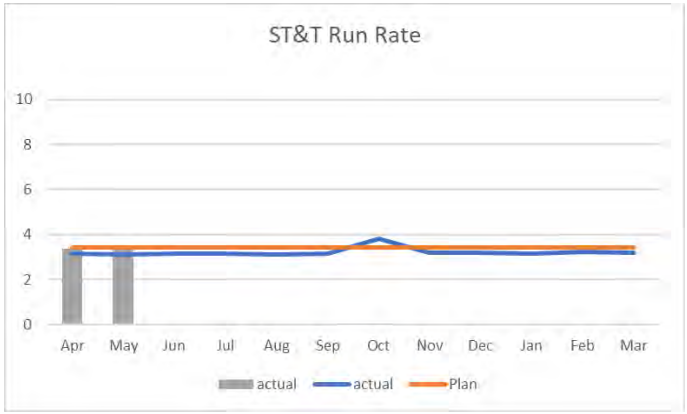
NB. There is no WTE target applied to Pay Savings and therefore pay variances and WTE variances to not always correlate

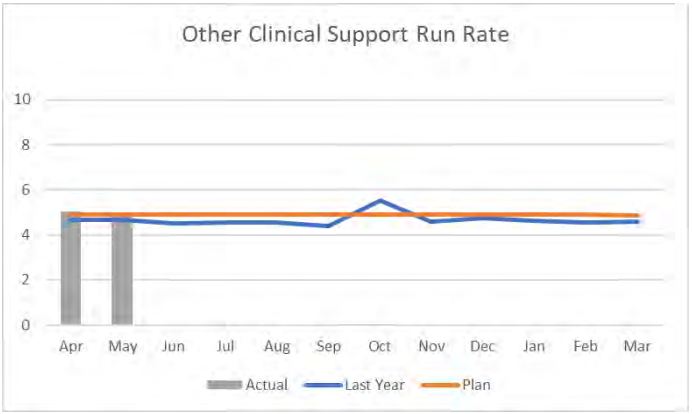
Pay Run Rate Graphs

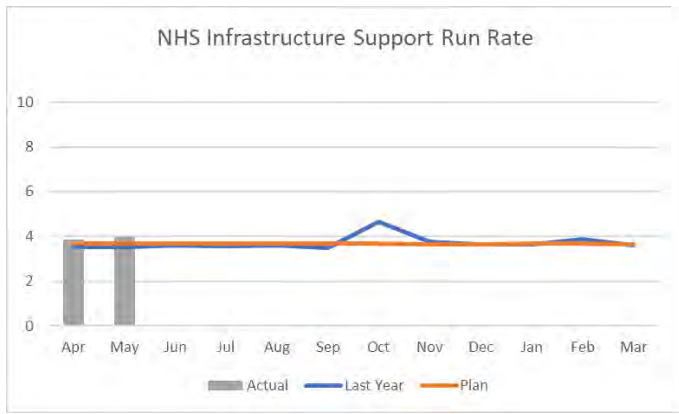
Royal United Hospitals Bath
NHS Foundation Trust











Budget – Non-Pay

Royal United Hospitals Bath NHS Foundation Trust

I&E to May 2025	In Month RUH			Year to Date RUH		
	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Actual £'m	Variance £'m
High Cost Drugs and Devices	(4.588)	(4.789)	(0.201)	(8.431)	(9.671)	(1.240)
In Tariff Drugs	(0.745)	(0.817)	(0.072)	(1.370)	(1.600)	(0.231)
Clinical Supplies and Services	(4.005)	(4.169)	(0.163)	(7.880)	(8.169)	(0.290)
Other Non Pay	(5.366)	(4.729)	0.637	(10.611)	(10.408)	0.202
Unallocated Savings	1.036	0.000	(1.036)	2.086	0.000	(2.086)
Surplus/(Deficit)	**(13.670)**	**(14.505)**	**(0.835)**	**(26.205)**	**(29.848)**	**(3.644)**

Budget by Division	In Month RUH			Year to Date RUH		
	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Actual £'m	Variance £'m
Surgery	(3.288)	(3.077)	0.211	(6.622)	(6.151)	0.471
Medicine	(1.984)	(1.799)	0.184	(3.902)	(3.566)	0.336
FASS	(0.709)	(0.705)	0.004	(1.395)	(1.403)	(0.008)
E&F	(1.555)	(1.424)	0.131	(3.257)	(3.371)	(0.114)
Corporate	(2.727)	(2.663)	0.064	(5.471)	(5.380)	0.091
HIWE	(0.103)	(0.041)	0.062	(0.206)	(0.103)	0.103
R&D	(0.054)	(0.007)	0.047	(0.108)	0.220	0.328
Capital Charges	0.010	0.011	0.000	0.021	0.021	0.001
High Cost Drugs and Devices	(4.588)	(4.789)	(0.201)	(8.431)	(9.671)	(1.240)
Unallocated Savings	1.036	0.000	(1.036)	2.086	0.000	(2.086)
Reserves	0.293	(0.009)	(0.302)	1.081	(0.445)	(1.526)
Surplus/(Deficit)	**(13.670)**	**(14.505)**	**(0.835)**	**(26.205)**	**(29.848)**	**(3.644)**

Understanding Performance

Non-pay spend is £3.6m overspent against budget. £2.1m of this relates to undelivered savings and £1.0m relates to the deterioration in underlying position shown in Reserves.

High-cost drugs and devices are overspent by £1.2m, £1.0m of which is funded as through a pass-through arrangement. This leaves a net £0.2m pressure, as growth in ICB-funded high-cost drugs are at the Trust's risk

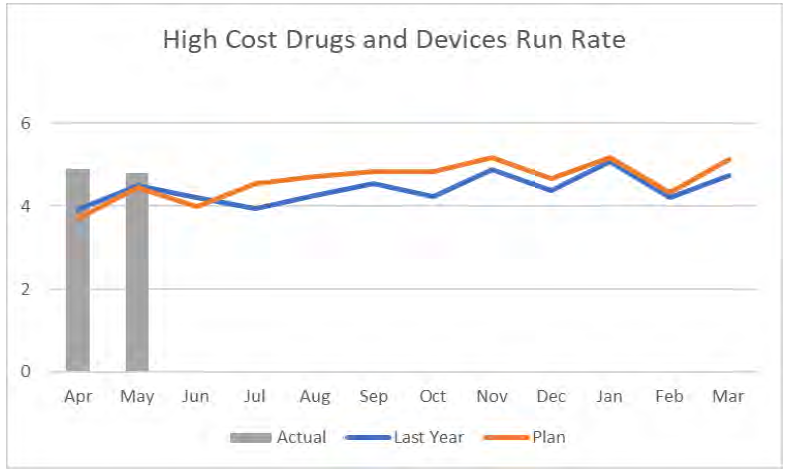
Other non-pay includes costs in Estates and Facilities such as maintenance, and the cook-freeze food option that has been used whilst the main kitchens have been renovated.

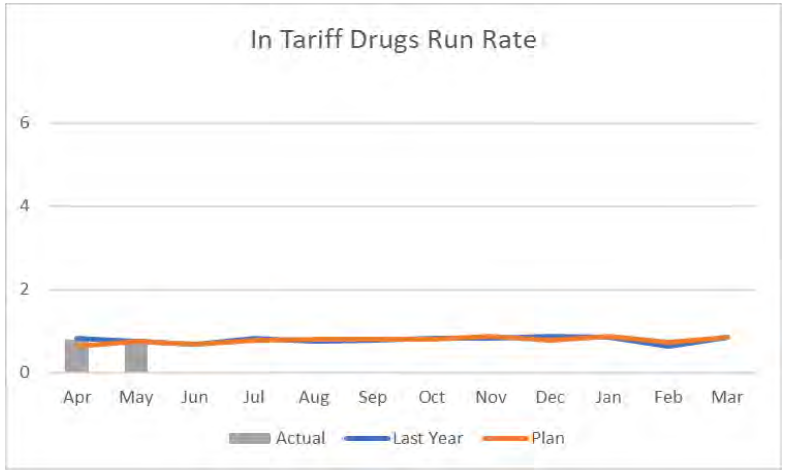
Excluding high-cost drugs and devices the 3 clinical areas have a combined underspend but with a similar message as pay this is before savings have been assigned and these budgets remain unaffordable.

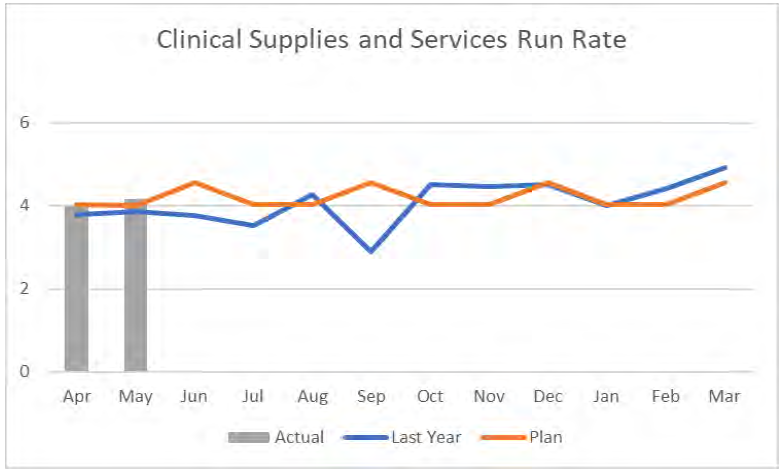
Countermeasures	Owner	Due Date
Devolution of the savings targets to local budgets including the potential further top slicing across all budgets of the un-identified savings target	Finance Department and Divisional Tris	30 June
Estates and Facilities to review profile of Maintenance spend to ensure that it is spent in line with budget.	E&F management team	30 June
High-cost drugs and devices position is clarified with BSW to move to a pass-through arrangement in line with guidance.	Chief Finance Officer	30 June
Pharmacy supporting the review of high-cost drugs to determine spend profile and opportunities to reduce spend.	Pharmacy and Specialty Tris	30 June

Risks and Mitigation

Non Pay – Run Rate Graphs

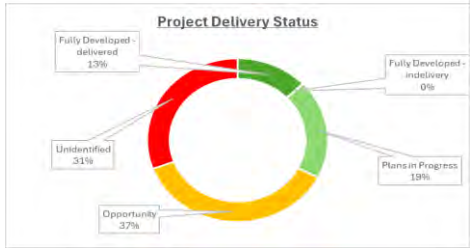


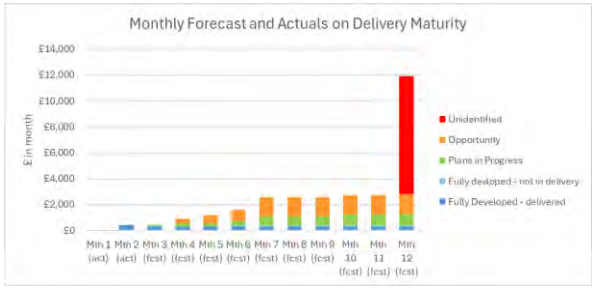


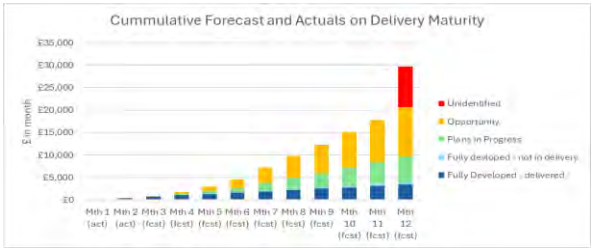


Savings Delivery Against Plan

Royal United Hospitals Bath NHS Foundation Trust







NB System reporting will also include an additional £4.9m to reflect FYE carried into 25/26 – these are reported as fully delivered and has already been removed from base budgets.

	In Month			YTD			Programme Status					
	Month 2 Acts	Plan Mth 2	Month Variance to Plan	Month 2 YTD	Plan YTD	YTD Variance to Plan	Fully Developed - in delivery	Fully Developed - not in delivery	plans in progress	opportunity	unidentified	Grand Total
UEC Delivery Group	**0**	**333**	**(333)**	**0**	**667**	**(667)**	**0**	**0**	**1,012**	**2,988**	**0**	**4,000**
Non Pay	0	30	(30)	0	60	(60)	0	0	280	0	0	280
Pay	0	303	(303)	0	607	(607)	0	0	732	2,988	0	3,720
Outpatients Delivery Group	**15**	**250**	**(235)**	**15**	**500**	**(485)**	**0**	**0**	**1,005**	**1,995**	**0**	**3,000**
Non Pay	16	42	(26)	16	83	(68)	0	0	500	0	0	500
Pay	(1)	208	(209)	(1)	417	(417)	0	0	505	1,995	0	2,500
Elective Delivery Group	**70**	**117**	**(47)**	**70**	**233**	**(163)**	**420**	**0**	**0**	**980**	**0**	**1,400**
Non Pay	0	0	0	0	0	0	0	0	0	204	0	204
Pay	70	117	(47)	70	233	(163)	420	0	0	776	0	1,196
Corporate Services	**60**	**208**	**(149)**	**60**	**417**	**(357)**	**831**	**26**	**723**	**920**	**0**	**2,500**
Income	0	0	0	0	0	0	30	0	0	0	0	30
Non Pay	60	63	(3)	60	125	(65)	358	0	0	920	0	1,278
Pay	0	146	(146)	0	292	(292)	443	26	723	0	0	1,192
Central Delivery Group	**254**	**634**	**(379)**	**254**	**1,268**	**(1,013)**	**2,063**	**0**	**3,091**	**2,451**	**0**	**7,605**
Income	100	50	50	100	100	0	1,000	0	300	0	0	1,300
Non Pay	70	275	(205)	70	550	(480)	558	0	1,689	453	0	2,700
Pay	84	309	(224)	84	618	(533)	505	0	1,102	1,998	0	3,605
Estates & Facilities	**0**	**132**	**(132)**	**0**	**263**	**(263)**	**0**	**0**	**0**	**1,580**	**0**	**1,580**
Income	0	23	(23)	0	46	(46)	0	0	0	346	0	346
Non Pay	0	71	(71)	0	142	(142)	0	0	0	850	0	850
Pay	0	38	(38)	0	76	(76)	0	0	0	384	0	384
Unidentified	**0**	**393**	**(393)**	**0**	**786**	**(786)**	**0**	**0**	**0**	**0**	**4,715**	**4,715**
Income		0	0		0	0					0	0
Non Pay	0	204	(204)	0	409	(409)					2,969	2,969
Pay	0	189	(189)	0	377	(377)					1,746	1,746
Total RUH Savings	**399**	**2,067**	**(1,668)**	**399**	**4,133**	**(3,734)**	**3,314**	**26**	**5,831**	**10,914**	**4,715**	**24,800**
SULIS	**31**	**42**	**(11)**	**31**	**83**	**(53)**	**500**	**0**	**0**	**0**	**0**	**500**
Income	31	42	(11)	31	83	(53)	500	0	0	0	0	500
Total RUH + SULIS savings	**430**	**2,108**	**(1,679)**	**430**	**4,217**	**(3,787)**	**3,814**	**26**	**5,831**	**10,914**	**4,715**	**25,300**
Group	**0**	**367**	**(367)**	**0**	**733**	**(733)**	**0**	**0**	**0**	**0**	**4,400**	**4,400**
Non Pay	0	367	(367)	0	733	(733)	0	0	0	0	4,400	4,400
Grand Total	**430**	**2,475**	**(2,045)**	**430**	**4,950**	**(4,520)**	**3,814**	**26**	**5,831**	**10,914**	**9,115**	**29,700**

Understanding Performance

£0.4m savings have been delivered year to date. The Trust now has a £4.5m shortfall against plan year to date, a major contributor to the Trust overall adverse variance to plan.

£4m annual savings are now in delivery and the amount unidentified has been reduced by £0.7m. However, of the programme target of £29.7m there is still an unidentified gap of £9.1m, and £10.9m assessed as an opportunity without firm delivery plan in place.

Countermeasures	Owner	Due Date
Devolution of the savings targets to local budgets including the potential further top slicing across all budgets of the un-identified savings target	Finance Department and Divisional Tris	30 June
Acceleration of our saving plans that have been scoped for UEC, theatres, outpatients and corporate restructuring, re-forecasting weekly and consistent reporting to fortnightly Engine room to build momentum	Delivery Group SROs, Finance team and Recovery Director	30 June
Enhancing controls on discretionary spending to mitigate savings shortfall	Trust Management Executive and Budget Holders	Monitoring Impact
Business Cases for Invest to Saves for ring fenced £1.5m investments fund are being worked up for approval to facilitate pace of delivery.	Delivery Group SROs	30 June
Delivery Groups to collaborate with BSW ICS Delivery Groups to ensure out of hospital delivery plans are clear and are supporting Savings delivery e.g. reduction in NCTR & attendance avoidance plans	Delivery Group SROs	30 June

Risks and Mitigation

Delivery Programme maturity however pace has increased to support delivery

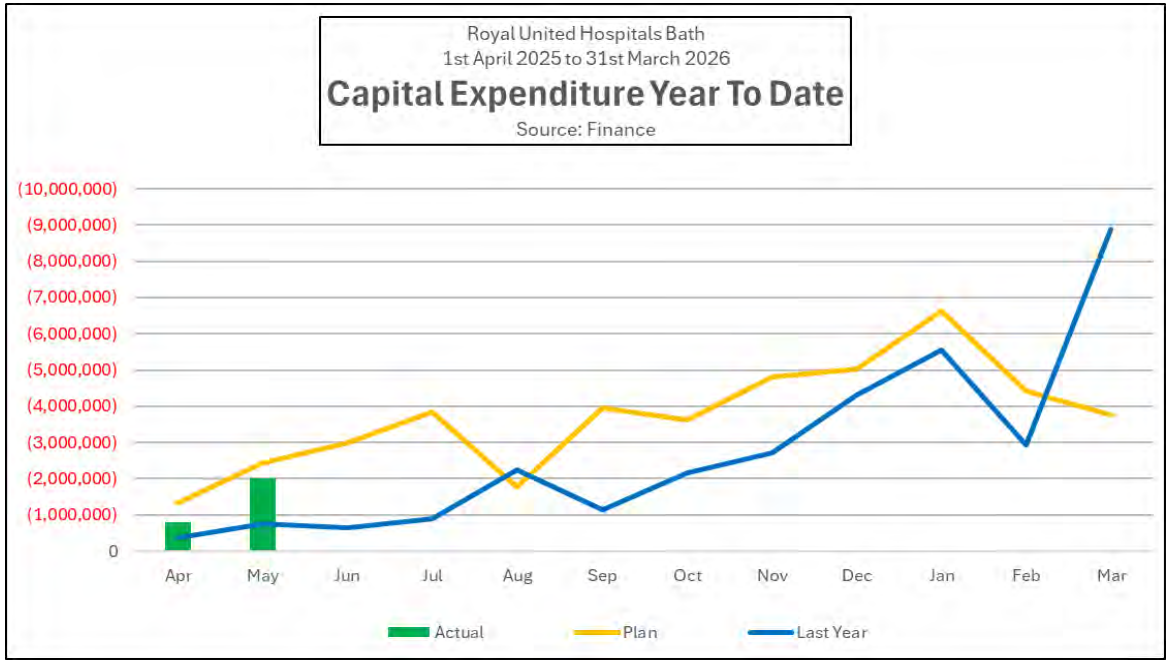
Lack of clear funding approach to any Costs of Change requirement

Defer investment against Spend to Save to directly mitigate unidentified savings gap

Capital – Operational, Grant & Donated

Royal United Hospitals Bath NHS Foundation Trust

Position as at 31st May 2025	Annual Plan £'m	Forecast Outturn £'m	YTD Plan £'m	YTD Actuals £'m	YTD Variance £'m
Decarbonisation	(2.985)	(2.985)	(0.200)	(0.008)	0.192
BSW EPR	(2.865)	(2.865)	0.000	0.000	0.000
Sulis Lease	(0.953)	(0.953)	0.000	0.000	0.000
Strategic Schemes Total	**(6.803)**	**(6.803)**	**(0.200)**	**(0.008)**	**0.192**
IT	(1.750)	(1.750)	(0.224)	(0.072)	0.152
Medical Equipment (MEC)	(1.610)	(1.610)	(0.026)	(0.031)	(0.005)
Estates, CRG & Projects	(1.500)	(1.500)	(0.285)	(0.243)	0.042
Sulis	(0.250)	(0.250)	(0.026)	(0.013)	0.013
Right of Use Leases	(0.300)	(0.300)	0.000	0.000	0.000
Minor	(0.107)	(0.107)	(0.010)	(0.159)	(0.149)
Lease Provision release (Modular Theatre)	(0.547)	(0.547)	0.000	0.000	0.000
Other Schemes Total	**(6.064)**	**(6.064)**	**(0.571)**	**(0.519)**	**0.053**
TOTAL : Operational Capital	**(12.867)**	**(12.867)**	**(0.771)**	**(0.527)**	**0.245**
Decarbonisation (Salix)	(10.820)	(10.820)	(2.220)	(2.198)	0.022
PET-CT	(2.000)	(2.000)	0.000	0.000	0.000
Minor donated schemes	(0.300)	(0.300)	(0.050)	(0.092)	(0.042)
TOTAL : Donated & Grant Funded	**(13.120)**	**(13.120)**	**(2.270)**	**(2.290)**	**(0.020)**
OVERALL TOTAL	**(25.987)**	**(25.987)**	**(3.041)**	**(2.817)**	**0.224**



Understanding Performance

Operational capital behind plan due to late confirmation of operational capital allocation and the decision to hold non-committed capital spend due to adverse revenue position.

Committed capital is being reviewed and discussed with capital leads, a paper will be presented at the June CPMG and shared with the Board to confirm the expected spend. The forecast will be updated once this has been formally agreed as at month 2 the forecast remains at planned levels.

EPR forecast for year is provided by the EPR project board and EPR project accountant. EPR is currently for a £0.4 million overspend against allocation in year

Countermeasures	Owner	Due Date
EPR project accountant and Manager have been asked attend CPMG and provide an update paper on EPR cost pressure to Trust Board. A decision on committing future CDEL funding or reduction in scheme will need to be taken or additional PDC funding obtained.	EPR Board	30 Sept
In response to the adverse revenue position capital expenditure that has not been contractually committed or is mandated has been stopped.	CPMG	Immediate
CPMG to provide update paper to Trust Management Executive outlining risks, benefits and revenue consequences of not taken forward non-committed schemes for review and decision	CPMG	30 June

Risks and Mitigation

Overall EPR forecast outturn end of project is £1.500 million overspend against approved FBC. This could increase further and is being reviewed by the EPR project accountant.
EPR project accountant and Manager have been asked to provide an update paper on EPR cost pressure to Trust Board.

Trust contribution to the decarbonisation (£2.985m) must be spent alongside the grant funding by 31st March to meet conditions of grant. This is being monitored by the Capital Project Team.

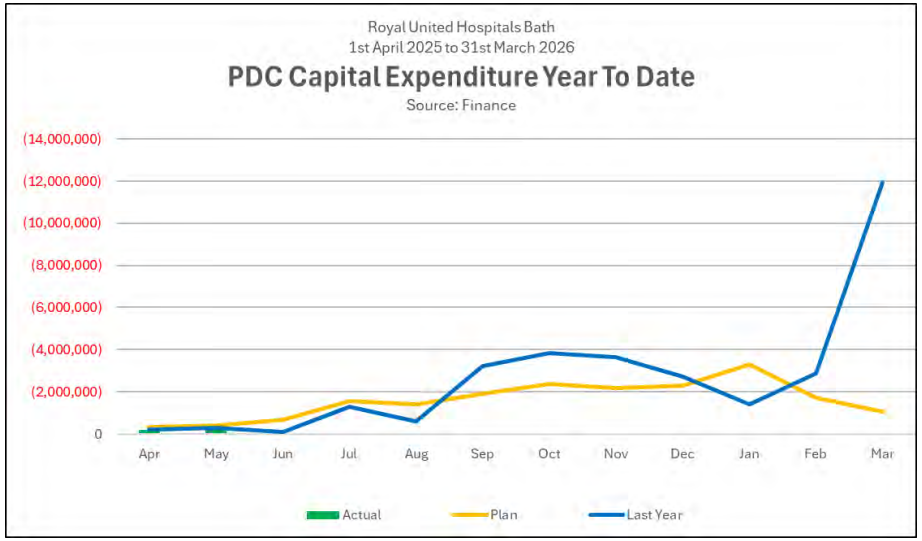
Salix grant funding must be utilised by 31st March, the Project Team is working with contractor to manage the risk of Salix not approving funding applications, Capital project team are working with Salix to ensure the Trust meet all grant criteria

Cash is a risk to capital programme.

Capital – PDC Funded

Royal United Hospitals Bath NHS Foundation Trust

PDC Funded Capital Position as at 31st May 2025		Annual Plan £'m	Forecast Outturn £'m	YTD Plan £'m	YTD Actuals £'m	YTD Variance £'m	Approval status
BSW EPR		(2.955)	(2.955)	(0.718)	(0.399)	0.319	FBC approved, MOU not yet received
Solar Energy (Net Zero)		(0.295)	(0.295)	0.000	0.000	0.000	Approved, MOU signed
Total Other		**(3.250)**	**(3.250)**	**(0.718)**	**(0.399)**	**0.319**	
Estates:	Fire Safety Programme	(1.890)	(1.890)	0.000	0.000	0.000	
	Fire Evacuation Risk - Cardiac Fire Lift	(0.385)	(0.385)	0.000	0.000	0.000	
	Life critical UPS Replacement	(0.270)	(0.270)	0.000	0.000	0.000	
	Sterile Services Autoclave/Steriliser Replacement	(0.900)	(0.900)	0.000	0.000	0.000	Estates strategy funding has been approved by national panel. Awaiting MOUs
	Nurse Call Replacement	(0.072)	(0.072)	0.000	0.000	0.000	
	Asbestos / roof Works Block 37	(0.135)	(0.135)	0.000	0.000	0.000	
	Staff Attack SystemReplacement	(0.054)	(0.054)	0.000	0.000	0.000	
	Chiller Replacement (Pathology)	(0.720)	(0.720)	0.000	0.000	0.000	
	Maternity AHU Replacement	(0.630)	(0.630)	0.000	0.000	0.000	
Total Estates Safety		**(5.056)**	**(5.056)**	**0.000**	**0.000**	**0.000**	
Diagnostics:	MRI replacement	(1.448)	(2.180)	0.000	0.000	0.000	
	MRI Acceleration software	(0.143)	(0.143)	0.000	0.000	0.000	
	ECHO Equipment for Phyiological Scieinces	(0.120)	(0.120)	0.000	0.000	0.000	Constitional Standards schemes are not fully approved, business cases have been submitted to regional team at the end of May, for review and submission to national team. Decision by national team expected by end of June. (Two schemes not taken forward for Integrated Front Door seed funding & SDEC Digital)
	CDC Expansion- Design works to RIBA stage 4	(0.750)	(0.750)	0.000	0.000	0.000	
Elective:	Gastroenterology / General Surgery Out Patient clinic rooms	(0.250)	(0.250)	0.000	0.000	0.000	
	Gynae Theatre Clinical Pathway Redesign	(1.600)	(1.600)	0.000	0.000	0.000	
UEC:	Admisson & Transfer Lounge	(1.700)	(1.700)	0.000	0.000	0.000	
	Medical Short Stay expansion	(0.850)	(0.850)	0.000	0.000	0.000	
	Integrated front Door / SDEC (Seed Funding)	(0.300)	0.000	0.000	0.000	0.000	
	Neurology Ward reconfiguration and relocation	(3.100)	(3.100)	0.000	0.000	0.000	
	IPC Programme	(1.350)	(1.350)	0.000	0.000	0.000	
	SDEC digital enabling	(0.400)	0.000	0.000	0.000	0.000	
Total Constitutional Standards		**(12.010)**	**(12.043)**	**0.000**	**0.000**	**0.000**	
TOTAL : PDC Funded		**(20.316)**	**(20.349)**	**(0.718)**	**(0.399)**	**0.319**	



Understanding Performance	Countermeasures	Owner	Due Date
EPR scheme is behind plan for the PDC funded element, the current forecast from EPR Board is for full allocation to be spent in year.	In response to the adverse revenue position capital expenditure that has not been contractually committed or is mandated has been stopped. This will include PDC financed schemes where there is an ongoing revenue consequence that has not been agreed by CPMG or Board.	CPMG	Immediate

Risks and Mitigation

Constitutional schemes are not yet approved, Business cases were submitted at the end of May. Outcome expected by end of June. Risk to deliverability if approval delayed. When funding confirmed a decision will need as to whether schemes can meet this criteria before accepting funding and there is adequate revenue funding to cover the scheme.

There is a risk of revenue impact relating to seed funding and business cases developed using capital. Should the project not continue the capital will get written off to the revenue.

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Statement of Financial Position

Royal United Hospitals Bath NHS Foundation Trust

Statement of financial position As at April 2025	M2 FY 2025-26 31/05/2025 £'m	M1 FY 2025-26 30/04/2025 £'m	Variance £'m	% Variance
Non current assets				
Intangible assets	6.868	6.929	(0.061)	(0.880)%
Property, Plant & Equipment	330.329	329.898	0.431	0.131%
Right of use assets - leased assets for lessee	49.162	49.446	(0.284)	(0.574)%
Investments in associates and joint ventures	3.941	3.941	0.000	0.000%
Trade and other receivables	4.996	5.110	(0.114)	(2.231)%
Total non current assets	**395.296**	**395.324**	**(0.028)**	**(0.007)%**
Current Assets				
Inventories	6.809	6.598	0.211	3.198%
Trade and other receivables	27.665	28.408	(0.743)	(2.615)%
Cash and cash equivalents	29.210	26.705	2.505	9.380%
Total current assets	**63.684**	**61.711**	**1.973**	**3.197%**
Current Liabilities				
Trade and other payables	(55.018)	(50.836)	(4.182)	8.226%
Other liabilities	(8.579)	(9.565)	0.986	(10.308)%
Provisions	(0.924)	(1.014)	0.090	(8.876)%
Borrowings	(2.562)	(2.547)	(0.015)	0.589%
Total current liabilities	**(67.083)**	**(63.962)**	**(3.121)**	**4.879%**
Total assets less current liabilities	**391.897**	**393.073**	**(1.176)**	**(0.299)%**
Non current liabilities				
Provisions	(1.315)	(1.315)	0.000	0.000%
Borrowings	(54.539)	(54.718)	0.179	(0.327)%
Total assets employed	**336.043**	**337.040**	**(0.997)**	**(0.296)%**
Financed by:				
Public Dividend Capital	285.705	285.705	0.000	0.000%
Income and Expenditure Reserve	9.258	10.255	(0.997)	(9.722)%
Revaluation reserve	41.080	41.080	0.000	0.000%
Total equity	**336.043**	**337.040**	**(0.997)**	**(0.296)%**

Understanding Performance

Non-current assets – There was an increase in capital assets purchased in month 2 of £3.2m compared to £1.0m in month 1. Other net movement variance relates to depreciation and amortisation charged in the month.

Current assets – Cash was the top contributor to the variance, which has been set out within the cash slide. Also, there was a 3.2% increase in inventory in the month which is related to an increase in drugs stock.

Current liabilities – Top contributor is trade and other payables with a slight increase of £4.2m in month 2 compared to month1. Increase was due to invoices not being paid timely as expected.

Total equity – The decline in reserves was due to the net loss of £1.0m in month 2.

Risks and Mitigation

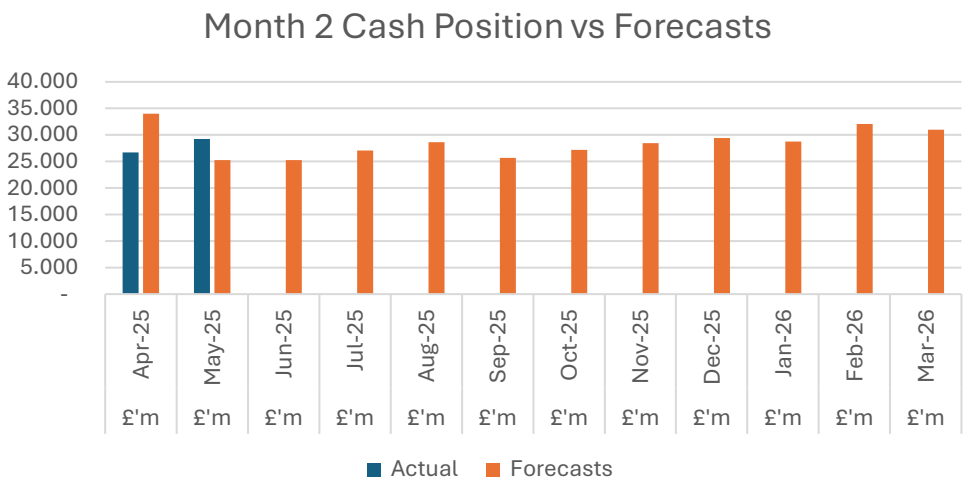
Risks include:
- Slippage in capital spend. Mitigated through monthly CPMG meetings and monthly reporting to ICB and NHSE.
- Risks relating to receivables, payables, BPPC and cash have been set out in their respective slides.

Countermeasures	Owner	Due Date
Capital – Monitored through CPMG and monthly reporting to ICB and NHSE.	Head of financial services	Monthly monitoring
Cash – the saving plan has a direct impact on the level of cash the Trust will have available. Cash releasing savings will need to be realised to maintain the cash balance.	Trust Management Executive and Recovery Director	Monthly monitoring
Payables – This will continue to be monitored, however, there are close links to non pay saving plans.	Head of Financial services	Monthly Monitoring
Equity – Monthly position will be monitored by the finance team; however, equity will be impacted by the level of the saving plan that is achieved.	Interim Chief Finance Officer & Andy Hollywood	Monthly Monitoring

Cash

Royal United Hospitals Bath NHS Foundation Trust

Trust Only Cashflow Statement	Actual £'m
EBITDA surplus	0.853
Income recognised in respect of capital donations (cash and non-cash)	(2.191)
Impairments	0.000
Working capital movement	(1.494)
Provisions	(0.008)
Net cash used in operating activities	**(2.840)**
Capital Expenditure	(3.203)
Cash receipts from asset sales	0.001
Donated cash for capital assets	2.191
Interest received	0.354
Net cash used in investing activities	**(0.657)**
Capital element of finance lease rental payments	(2.223)
Interest element of finance lease	(1.717)
Net cash used in financing activities	**(3.941)**
Decrease in cash and cash equivalents	**(7.438)**
Opening cash balance	36.648
Closing cash balance	**29.210**
Adjusted for petty cash	(0.004)
Adjusted closing cash balance	**29.206**



The orange bars represents the latest cash forecast. This forecast has been developed since the submission of annual operating plan. Importantly the current forecast assumes full delivery of the savings programme in line with budget.

Understanding Performance

There was a £4.0m variance between month 2 cash balance and the forecast. The forecast shown assumes all savings are delivered.

The main drivers are:
- Non-NHS income received was £3.1m higher than forecast.
- Patient care income was £0.8m higher than forecast.
- Payments relating to non pay were £0.9m lower than forecast, with the main driver being savings.

Countermeasures	Owner	Due Date
Acceleration of our saving plans that have been scoped for UEC, theatres, outpatients and corporate restructuring.	Delivery Group SROs	30 June
Adherence to Better Payment Practise Code including adherence to No PO No Pay policy will support more accurate cash forecasting.	All budget holders	31 March

Risks and Mitigation

Should the Trust not meet its saving plan, there is a risk that the Trust will have insufficient cash to cover all payroll and capital and revenue suppliers in a timely manner.

The cash will be continuously monitored and reforecast based on the latest information. Mitigations include;
- Withdrawal of operational capital funding
- Aged debt monitoring
- Withholding payments to suppliers.

Better Payment Practice Code

Royal United Hospitals Bath NHS Foundation Trust

	May-25		Apr-25		% Variance	
	Volume ('m)	£'m	Volume ('m)	£'m	Volume ('m)	£'m
Non NHS						
Total bills paid in the year	11.998	77.582	6.432	51.276	87%	51%
Total bills paid within target	11.409	61.213	6.171	38.153	85%	60%
Percentage of bills paid within target	**95%**	**79%**	**96%**	**74%**	**-1%**	**6%**
NHS						
Total bills paid in the year	0.156	2.278	0.109	1.723	43%	32%
Total bills paid within target	0.118	1.166	0.085	0.809	39%	44%
Percentage of bills paid within target	**76%**	**51%**	**78%**	**47%**	**-3%**	**9%**
Total						
Total bills paid in the year	12.154	79.86	6.541	52.999	86%	51%
Total bills paid within target	11.527	62.379	6.256	38.962	84%	60%
Percentage of bills paid within target	**95%**	**78%**	**96%**	**74%**	**-1%**	**6%**

Understanding Performance

Better payment practice code compliance is within the statutory tolerance of 95% for volume, however, this has not been met in terms of the £'s.

Countermeasures	Owner	Due Date
Active management by Accounts Payable team	Head of Financial services	Continuous
Adherence to Better Payment Practise Code including adherence to No PO No Pay policy will support more accurate cash forecasting.	All budget holders & Procurement Team	31 March

Risks and Mitigation

The payment of amounts due will have an impact on the cash position and will have to be closely monitored in relation to the available cash balance.

Purchase Order Compliance

Royal United Hospitals Bath NHS Foundation Trust

Division	May Invoice Totals Off Purchase Order £'m	On Purchase Order £'m	Total £'m	% on PO
Capital Summary	0.332	1.075	1.407	76%
Total capital PO compliance	**0.332**	**1.075**	**1.407**	**76%**
Corporate Division	0.999	0.358	1.357	26%
Estates And Facilities Division	0.090	0.467	0.557	84%
Family And Specialist Service Division	2.692	0.230	2.922	8%
Health Innovation West Of England	0.000	0.025	0.025	99%
Medical Division	0.379	0.949	1.328	71%
Research & Development	0.001	0.022	0.023	94%
Surgical Division	0.197	1.187	1.384	86%
Total revenue PO compliance	**4.359**	**3.238**	**7.597**	**43%**
Total compliance in April	**4.691**	**4.313**	**9.004**	**48%**

Understanding Performance

The most significant contributor for each division are below:

- Capital division; Decarbonisation contract not on PO
- Corporate division; IT Applications not on PO
- Estates and facilities; Utilities contracts and rates not on PO
- Family and Specialist Services; Managed Service for Pharmacy contract not on PO
- Medical Division; Endocrinology centre
- Research and Development; £0.001 not significant
- Surgical Division; Cellular pathology not on PO

Countermeasures	Owner	Due Date
The Interim Chief Finance Officer has requested that PO compliance is 95% compliance by the end of Qtr1 25/26.	Divisional Finance Managers and Procurement	30 June
PO compliance is monitored through the non pay group. The group has been tasked with forming a No PO No Pay subgroup by the end of May.	Divisional Finance Managers, Financial Services and Procurement Teams	31 May

Risks and Mitigation

Risks include:
The Trust pays for goods, services and works which have not been properly ordered and authorised.

Invoices paid that are not on PO can impact on the achievement of the better payment practice guide.

Risks are being mitigated through the monthly non pay and sub-groups meeting with oversight from the interim Chief Finance Officer.

Sulis

Royal United Hospitals Bath NHS Foundation Trust

Month Performance against Budget P02

Statement of Comprehensive Income	SULIS Budget	SULIS Actual	SULIS Variance	CDC Budget	CDC Actual	CDC Variance	SOC Budget	SOC Actual	SOC Variance	TOTAL Budget	TOTAL Actual	TOTAL Variance
Commissioner Income (NHSE/CCG)	1,955	2,051	96	623	412	(212)	534	535	2	3,112	2,998	(114)
Other Patient Care Income	1,049	1,058	9							1,049	1,058	9
Other Operating Income	32	44	12							32	44	12
Income Total	3,036	3,153	117	623	412	(212)	534	535	2	4,193	4,100	(93)
Pay	(1,447)	(1,511)	(64)	(225)	(282)	(57)	(288)	(288)	(0)	(1,960)	(2,081)	(121)
Non Pay	(1,216)	(1,198)	18	(447)	(515)	(69)	(246)	(248)	(2)	(1,908)	(1,961)	(53)
Depreciation	(238)	(236)	2	(34)	(34)					(272)	(269)	2
Expenditure Total	(2,901)	(2,945)	(44)	(705)	(831)	(126)	(534)	(535)	(2)	(4,139)	(4,311)	(172)
Operating Surplus/(Deficit)	135	208	73	(82)	(419)	(337)	0	0	0	54	(211)	(265)
Other Finance Charges	(40)	(40)	0	(7)	(7)	(0)				(46)	(46)	0
Other Gains/Losses		(0)	(0)								(0)	(0)
Finance Charges	(40)	(40)	0	(7)	(7)	(0)				(46)	(46)	0
Surplus/(Deficit)	96	169	73	(89)	(426)	(337)	0	0	0	7	(257)	(265)

Balance Sheet
Cash Balance £2.078m
Average of prior year £1.615m

Understanding Performance

NHS Income:
Activity levels for Sulis were strong and above Budgeted activity levels at +105% of Budget, with strong performances from Spinal Surgery, Gynaecology & Ophthalmology.
CDC was below Budget at 66% of Budgeted activity levels. Of the £212k variance, Endoscopy was -£119k, sleep studies -£52k

Private Income:
Other Patient Care Income was £9k over Budget in P2 – Self pay +£40k, PMI -£31k

Countermeasures	Owner	Due Date
Better understanding of pipeline and booking lead times	Sam Harrison	ongoing
Working closer with the RUH, GWH & Salisbury to unlock new patient streams	Sam Harrison	ongoing
Opening Sundays across May (*2) and June	Sam Harrison	TBC
Focus on higher revenue bookings – MRI/CT over X-ray	Sam Harrison	Ongoing
Collaborate with ICB, NHSE and In health on mitigations to higher cost premium of temporary Endoscopy Van	Victoria MacFarlane	31 July

Risks and Mitigation

Risks
- Don't make income target

Mitigation:
Per table to left

Appendix

Business Rules

SPC Guidance

Business Rules - Driver metrics

Rule No	Rule	What It means	Suggested Action for Metric Owner	Rationale
1	Driver does not meet target for a single month	Performance outside of expected range for a single month	Give Structured Verbal Update	Understanding required as to whether adverse performance will be due to a consistent issue or a one-off event.
2	Driver does not meet target for 2 or more months in a row	Performance outside of expected for multiple months in a row	Prepare Countermeasure Summary	Showing signs of continued difficulty meeting the target and need understanding of root cause.
3	Driver meets or exceeds target	Performance outside of expected range for a single month	Share top contributing reason	Showing early signs of improvement but not yet sustained
4	Driver meets or exceeds target for 2 – 4 months in a row	Performing above target for multiple months in a row	Share and celebrate success and move on	Showing signs of continued improvement but not yet assured that the target will always be met
5	Driver meets or exceeds target for 5 or more months in a row	Performing above target for a sustained length of time	Consider swapping out for a Concerning Watch metric	Assess Watch metrics and consider switching out this high performing Driver metric for an underperforming Watch metric
6	**Driver is orange**	Performance outside of expected range in a negative/deteriorating direction	Refer to rules 1-3 above and act accordingly	Driver metrics are being deliberately targeted and therefore SPC rules are not strict enough for monthly performance assurance purposes
7	Driver is grey	Performance is in line with expectations (no special cause)	Refer to rules 1-3 above and act accordingly	Driver metrics are being deliberately targeted and therefore SPC rules are not strict enough for monthly performance assurance purposes
8	**Driver is blue**	Performance outside of expected range in a positive /improving direction	Refer to rules 1-3 above and act accordingly	Driver metrics are being deliberately targeted and therefore SPC rules are not strict enough for monthly performance assurance purposes

Business rules updated on 23/04/25 to reflect the move to SPC charts in PowerBI

Business Rules – Watch metrics

Rule No	Rule	What It means	Suggested Action	Rationale
9	Watch has one point out of control limits – **orange**	Adverse performance outside of normal variation	Share top contributors and move on	**SPC logic** – Orange means special cause variation causing adverse performance.
10	Watch has 2 out of 3 points low **– orange**	Worsening performance	Give Structured Verbal Update (includes top contributors)	**SPC logic** – Orange means special cause variation causing adverse performance. Understanding required as to whether adverse performance will be due to a consistent issue or a one off event
11	Watch has 6 points below mean or 6 points deteriorating - **orange**	Worsening performance	Consider: - Upgrading to a driver and which driver to downgrade to a watch (include on Slide 4)	**SPC logic** – Row of orange dots means special cause variation causing adverse performance. Discussion required around whether this requires promotion to driver and replace current focus.
12	Watch has one point out of control limits - **blue**	Strong performance outside of normal variation	Do not discuss	**SPC logic** – achieving our stretch target. Sustained improvement, not natural variation. Blue dots = showing sustained improvement
13	Watch has 2 out of 3 points high **- blue**	Improving performance	Do not discuss	**SPC logic** – achieving our stretch target. Sustained improvement, not natural variation. Blue dots = showing sustained improvement
14	Watch has 6 points above mean or 6 points increasing - **blue**	Improving performance	Do not discuss	**SPC logic** – achieving our stretch target. Sustained improvement, not natural variation. Blue dots = showing sustained improvement
15	Watch is **grey** (no special cause)	Performance is as expected	Do not discuss	**SPC logic** – nothing special is going on, performance is within normal variation

Business rules updated on 23/04/25 to reflect the move to SPC charts in PowerBI

Business Rules – Standard/Mandatory Metrics

These are additional rules only applied to certain metrics that are statutory or mandatory to be monitored at Trust level. Whether or not a metric has met its target each month will be iindicated by a tick or cross icon in the 'target met this month?' column. The number to the right indicated how many months the metric has NOT met its target. Any metric that has met the target in the current reporting month will therefore show a 0 in this column. Different actions are suggested depending on how many months the target has not been met. These metrics are assessed against their improving target.

Rule No	Rule	What It means	Suggested Action for Metric Owner	Rationale
16	Mandatory does not meet target for a single month	Performance outside of expected range for a single month	Note performance. Give structured verbal update by exception.	
17	Mandatory does not meet target for 2 or more months in a row	Performance outside of expected for multiple months in a row	Give structured verbal update, agree if countermeasure summary required.	Showing signs of continued difficulty meeting the target and need understanding of root case.
18	Mandatory does notmeet target for 4 or more months in a row	Performance below improvement target for a sustained length of time	Consider applying improvement target.	Showing signs of continued difficulty meeting the target despite understanding root cause. Current performance known and acknowledged.
19	Mandatory with improvement target meets or exceeds target for 4 or more months in a row	Performing above improvement target for a sustained length of time	Consider increase target of mandatory.	
520	Mandatory is orange	Performance outside of expected range in a negative/deteriorating direction	Refer to rules 16-17 above and act accordingly.	

Business rules updated on 23/04/25 to reflect the move to SPC charts in PowerBI

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**11**
Date of Meeting:	**2 July 2025**		
Title of Report:	**Transformation Plan Update**		
Status:	**For information / discussion**		
Board Sponsor:	**Andrew Hollowood, Interim Managing Director**		
Author:	**Rhiannon Hills, Director of Transformation** **Delivery Group Clinical and Senior Responsible Officers**		
Appendices	**Appendix 1: Transformation Programme** **Appendix 2: Delivery Group Update**		

1. Executive Summary of the Report

This report provides the Board of Directors with an update on the development of transformation programmme to support delivery of the business plan for 2025-26. The report provides progress on these plans including;

1. Month 2 position against our business plan key metrics
2. Governance Structure
3. Delivery Group updates
4. Next steps in developing our transformation programme

Further details are provided below and in ***Appendix 1***.

1.1 Business plan key metrics – Month 2

A summary of our position against the key metrics as set out in our business plan is provided in ***Appendix 1***. This will be used to track performance throughout the year.

RTT performance
At month 2 we are off trajectory for RTT less than 18 weeks by 0.5% and 2.8% off trajectory for Time to 1st appointment however, it should be noted that many of the key changes to support improvements for outpatient waiting times, including the additional 10,000 activities, are not yet due for implementation.

The first tranche of RTT business cases against the £2.4m additional funding were approved by ICB on 12th June 2025. Divisions are now working through implementation timescales so that we can track the impact on outpatient waiting times from these additional schemes.

Referral Growth
Referral growth has dropped to -7.9% this month against the planning assumption of zero growth. BIU are reviewing the reduction in referrals by specialty to understand the impact although the Referral Support Service (RSS) implemented A&G changes from April 2025. It is likely that we will see an increase in referral levels over the next few months so will be tracking referral levels closely and will use this intelligence to model the likely impact on the waiting list over the year.

Elective Activity
Overall, activity against plan for month 2 remained within tolerance with Day cases slightly above plan and Inpatients 7 cases behind plan.

Outpatient Activity
Outpatients are behind plan for both First and Follow up appointments although the largest variance is within Follow ups which are 900 below plan. The overall ambition is to reduce follow up activity through the implementation of patient initiated follow ups and remote monitoring so the reduction in follow ups will be beneficial to support increases in new appointment capacity to support waiting time reductions.

Non-Elective Activity
ED attendances are above plan in month and we have seen a 3.2% growth against the plan of 2.6%, although NEL admissions are lower than plan at 0.6% against a plan of 3.4%.

No Criteria to Reside (NC2R) is at 81 at the end of May, which is lower than the trajectory of 85. We continue to work with system colleagues on plans to further reduce NC2R to 40 to inform our bed capacity for the remainder of the year.

Financial position
Financial metrics remain off plan in month 2 with the Trust financial position reported at - £7.2m and cash releasing savings adverse to plan by £4.5m. Further details are provided in the Finance Report to the Board.

1.2 Governance Structure

To support delivery of the annual business plan, there is a recognition of the need to shift our focus to larger scale transformational. To support this, a revised governance structure has been developed to ensure;

- Executive sponsorship of delivery groups
- Clinically led approach to prioritisation
- Clear accountability and responsibilities so that everyone is clear of role and expectations
- Integrated into the Trust's Operational Management System so it forms part of our standard oversight and delivery function
- Meeting structure rhythm that supports the pace of change required
- Corporate resource allocation so that the right capacity and capability is aligned to our prioritised Corporate projects
- Clear measurement of what we expect to change and the impact / benefits, including system partner deliverables which are dependencies for our plan
- Effective EQIA process including impact monitoring

We have created five new delivery groups; Urgent & Emergency Care, Theatres, Outpatients, Corporate Services redesign and Central Delivery. Each group has an Executive Sponsor, Clinical and / or Senior Responsible Officers as well as a Programme team to support the activities of each group.

To provide greater oversight of the programme and link in support across the senior leadership of the organisation, we have established a new weekly rhythm of meetings including fortnightly Engine Rooms to oversee delivery of the plan, supported by fortnightly Delivery Group meetings and weekly sub-groups for each of the five programmes.

Assurance of the transformation programme will be provided via the Board Sub-Committees with reporting to Board of Directors via the Integrated Performance Report, Finance report and Transformation Programme updates.

1.3 Delivery Group Updates

Delivery Group progress updates are provided in ***Appendix 2***. The slides provide details on:

1. Programme Outcome Measures
2. Financial forecast
3. Highlight report including key milestones and risks
4. Key Programme Milestones

Work continues to map the anticipated financial impact to inform the profile of financial savings across the year. It should be noted that due to the nature of transformational change, there is a mismatch between the savings plan which has been modelled in 12ths and the delivery profile of the step changes planned.

The savings target for the delivery groups equates to just under 75% of the £29.7m target at 18.5m. To date, schemes have been quantified for £9.2m, which is 50% of the total. Each delivery group has been tasked with quantifying the financial benefits for the remaining transformation schemes to ensure the final profiles are confirmed.

Delivery Group	Target	Fully Developed - delivered	Fully Developed - not in delivery	Plans in progress	Opportunity
UEC	4.0			1.0	3.0
Theatres	1.4	0.42			0.98
Outpatients	3.0			1.0	2.0
Corporate Services Redesign	2.5	0.39	0.47	0.72	0.92
Central	7.6	2.0		3.1	2.45
Delivery Groups (sub-total)	**18.5**	**2.87**	**0.47**	**5.8**	**10.9**
% of overall savings	73%	16%	3%	32%	50%

Due to the difference in planned and actual profile of savings, we are continuing to assess and implementing short term measures to address the mismatch of the delivery profile across the financial year and identify further opportunities to move into the delivery phase.

1.4 Next steps

Delivery Groups are now working on detailed project planning for each of the transformation areas identified and quantifying the financial benefits for the remaining transformation opportunities. Until plans are fully formulated, there remains a high financial risk for the delivery of the savings plan for this year

Key milestones to note for the next three months;

- Sulis Orthopedic Center opened on 27th May 2025
- Expanded Medical SDEC opened on 23rd June 2025

- Electronic triage in place for all outpatient specialties by end of June 2025
- Ambient AI pilot planned for July 2025
- Business cases for waiting times improvement being implemented during quarter 2

2. Recommendations (Note, Approve, Discuss)

The Board is asked;

- **To note** the update on the Transformation Programme including details of the priority areas for change, key programme milestones and next steps to quantify the financial impact of these projects to inform the profile of financial savings across the year.

- **To note** the financial risk associated with the mismatch of the delivery profile for transformation change and the unidentified savings which is impacting the financial savings plan for this year.

3. Legal / Regulatory Implications

As a Trust, we must work to support the achievement of the system control total and address our underlying deficit to meet our organisational obligations to financial sustainability and liquidity.

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

There are a number of delivery risks resulting from the financial and operational context within which we are planning and it should be noted that the overarching risk profile of the plan is significantly higher across all areas than in previous planning years. We have identified delivery of RTT / Financial balance and UEC targets as highlighted areas of risk due to heavy reliance on productivity improvements, demand management and capital availability assumptions.

Due to the nature of transformational change, there is a mismatch between the savings plan which has been modelled in 12ths and the delivery profile of the step changes that form part of the transformation plan. To mitigate this, we are assessing and implementing short term measures to address the mismatch in the delivery profile. This will also include a need to make up the gap in the non-delivery year to date.

Additional areas of risk include capacity & demand profiling, external factor reliance e.g. demand management and NC2R reductions, staff engagement and availability due to requirement to improve productivity and remove financial incentivisation through pay spend reductions, capability to deliver rapid pacing of high complexity transformation, continued cost pressures and the ability to remove costs without impacting performance trajectories.

5. Resources Implications (Financial / staffing)

The financial and workforce requirements for 2025-26 are a significant ask in addition to the savings delivered during 2024/25. Current savings opportunities are at the higher end of available opportunities identified in benchmarking.

To achieve these opportunities, it is expected that substantive WTE would be reduced, capacity would be reduced and all service delivery requires review.

6.	Equality and Diversity

Equality and Diversity is a critical lens through which we must consider all our Trust plans. Quality and equality impact assessments (QEIA) will be undertaken as part of all transformational changes delivered in year.

In addition, taking positive action to reduce health inequalities is a key area, for which the trust will be continuing a focus on digital inclusion and working with AWP to secure improved services for patients requiring mental health support at the front door.

7.	References to previous reports/ Next Steps

Headline plan submitted to NHSE Feb 27th 2025
Extraordinary Board Meetings – 18th and 26th March 2025
FPC Business Planning Update – 25th March 2025
Final plan to be submitted to NHSE March 27th 2025
Revised plan submitted to NHSE April 30th 2025

8.	Freedom of Information

Public Board

9.	Sustainability

The Trust is required to contribute to delivery of the BSW Medium Term Financial Plan (MTFP) which sets out the requirement of all organisations in the system to support a route back to financial breakeven. Our planning framework will help us to consider how we can make the best use of our shared resources with the system for the year ahead.

Considering our impact on environmental sustainability as well as our local population is an important part of planning. The decarbonisation project will continue in 2025 with some capital contribution from the Trust to enable ongoing progress towards carbon net zero.

10.	Digital

Digital transformation is a key enabler to support the transformation changes identified as part of our business planning and is in line with the Government drive from analogue to digital. There is a challenge to accessing digital capacity to support transformation in this financial year in light of the shared EPR project which is due to go live for the RUH during Quarter 4, 2025/26.

Appendix 1: Transformation Programme

Executive Summary

Performance update

- RTT performance is below trajectory for May but the first tranche of RTT business cases have been approved by ICB for implementation. These will need to focus on non-recurrent investment cases.
- Referral growth has dropped by -7.9% but it is believed this may be linked to changes relating to A&G so we may see return of referrals over future months. The impact will be tracked closely.
- ED attendances remain above plan whilst Non-elective admissions and NC2R are tracking below trajectory.

Finance update

- £0.4m of savings have been delivered year to date with a shortall of £4.5m against plan year to date
- £4m of saving are now in delivery and the amount of unidentified has been reduced by £0.7m
- There remains an unidentified gap of £9.2m including the £4.4m allocated to Group savings and £11m assessed as an opportunity requiring firm plans to be developed.
- Delivery Groups are assessing further opportunities to meet the savings gap.

Governance update

- Delivery group resources have been fully allocated and the Delivery Group and Engine Room meeting rhythm is in place.
- We will move to the new format of meetings from July 2025.
- Reporting and programme documentation is being further developed with the aim to move to Smartsheet over next couple of months, in order to automate the process.

The Plan in numbers

Business Plan Delivery May 2025

Plan in Numbers

	YTD Plan	YTD Actual	Variance	Change per Day Plan	Change per Day Actual
OP News	32,000	31,686	-314	+6	-8
OP Follow Ups	69,356	68,453	-903	-11	-23
Daycases	6,126	6,268	142	+4	+4
EL Inpatients	724	717	-7	+2	+0
ED Attendances	17,797	17,893	96	+9	+2
NEL Admissions	10,561	10,573	12	+7	+0
Diagnostic tests	27,012	27,087	75	+46	+2

What needs to be true?

	Plan	YTD Actual
GP Referral Growth	0.0%	-7.9%
ED Atts Growth	2.6%	3.2%
NEL Admit Growth	3.4%	0.6%
NCTR	85	81
NEL Length of Stay	6.4	6.5

Performance

		Year End Target	Current Month Plan	Actual
RTT	<18 1st app	71.7%	65.1%	62.3%
	<18 weeks	67.7%	61.1%	60.6%
	>52 weeks	1.0%	1.3%	2.1%
Cancer 62 days*		75.0%	70.5%	72.3%
	28 days*	80.0%	77.2%	62.7%
ED	4 hrs type 1	72.0%	70.0%	64.4%
	12 hours	reduction	4.1%	7.6%
DM01	< 6 weeks	5.0%	15.7%	28.3%

* 1 month reporting lag

Finance

	YTD Plan	YTD Actual	Variance
Cash Releasing Saving	£4.950M	£0.430m	-£4.520m
Financial Position	£0	-£7.247m	-£7.247m
Productivity	+6.7%	+4.7%	-2.0%

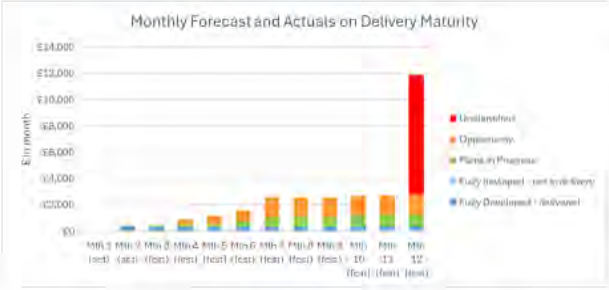
Lag - Feb 25 productivity

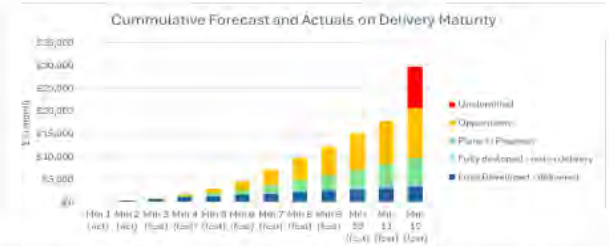
Workforce

	YTD Planned	YTD Actual	Variance
Pay Savings (£m)	58.024	60.562	2.538
WTE Reduction	5,721.4	5,742.0	20.6
Sickness (1 mth la	4.43%	4.56%	0.1%

Savings Delivery Against Plan

Royal United Hospitals Bath
NHS Foundation Trust





NB System reporting will also include an additional £4.9m to reflect FYE carried into 25/26 – these are reported as fully delivered and has already been removed from base budgets.

	In Month			YTD			Programme Status				
	Month 2 Acts	Plan Mth 2	Month Variance to Plan	Month 2 YTD	Plan YTD	YTD Variance to Plan	Fully Developed - in delivery	Fully Developed - not in delivery	plans in progress	opportunity	unidentified	Grand Total
UEC Delivery Group	**0**	**333**	**(333)**	**0**	**667**	**(667)**	**0**	**0**	**1,012**	**2,988**	**0**	**4,000**
Non Pay	0	30	(30)	0	60	(60)	0	0	280	0	0	280
Pay	0	303	(303)	0	607	(607)	0	0	732	2,988	0	3,720
Outpatients Delivery Group	**15**	**250**	**(235)**	**15**	**500**	**(485)**	**0**	**0**	**1,005**	**1,995**	**0**	**3,000**
Non Pay	16	42	(26)	16	83	(68)	0	0	500	0	0	500
Pay	(1)	208	(209)	(1)	417	(417)	0	0	505	1,995	0	2,500
Elective Delivery Group	**70**	**117**	**(47)**	**70**	**233**	**(163)**	**420**	**0**	**0**	**980**	**0**	**1,400**
Non Pay	0	0	0	0	0	0	0	0	0	204	0	204
Pay	70	117	(47)	70	233	(163)	420	0	0	776	0	1,196
Corporate Services	**60**	**208**	**(148)**	**60**	**417**	**(357)**	**831**	**26**	**723**	**920**	**0**	**2,500**
Income	0	0	0	0	0	0	30	0	0	0	0	30
Non Pay	60	63	(3)	60	125	(65)	358	0	0	920	0	1,278
Pay	0	146	(146)	0	292	(292)	443	26	723	0	0	1,192
Central Delivery Group	**254**	**634**	**(379)**	**254**	**1,268**	**(1,013)**	**2,063**	**0**	**3,091**	**2,451**	**0**	**7,605**
Income	100	50	50	100	100	0	1,000	0	300	0	0	1,300
Non Pay	70	275	(205)	70	550	(480)	558	0	1,689	453	0	2,700
Pay	84	309	(224)	84	618	(533)	505	0	1,102	1,998	0	3,605
Estates & Facilities	**0**	**132**	**(132)**	**0**	**263**	**(263)**	**0**	**0**	**0**	**1,580**	**0**	**1,580**
Income	0	23	(23)	0	46	(46)	0	0	0	346	0	346
Non Pay	0	71	(71)	0	142	(142)	0	0	0	850	0	850
Pay	0	38	(38)	0	76	(76)	0	0	0	384	0	384
Unidentified	**0**	**393**	**(393)**	**0**	**786**	**(786)**	**0**	**0**	**0**	**0**	**4,715**	**4,715**
Income		0	0		0	0					0	0
Non Pay	0	204	(204)	0	409	(409)					2,969	2,969
Pay	0	189	(189)	0	377	(377)					1,746	1,746
Total RUH Savings	**399**	**2,067**	**(1,668)**	**399**	**4,133**	**(3,734)**	**3,314**	**26**	**5,831**	**10,914**	**4,715**	**24,800**
SULIS	**31**	**42**	**(11)**	**31**	**83**	**(53)**	**500**	**0**	**0**	**0**	**0**	**500**
Income	31	42	(11)	31	83	(53)	500	0	0	0	0	500
Total RUH + SULIS savings	**430**	**2,108**	**(1,679)**	**430**	**4,217**	**(3,787)**	**3,814**	**26**	**5,831**	**10,914**	**4,715**	**25,300**
Group	**0**	**367**	**(367)**	**0**	**733**	**(733)**	**0**	**0**	**0**	**0**	**4,400**	**4,400**
Non Pay	0	367	(367)	0	733	(733)	0	0	0	0	4,400	4,400
Grand Total	**430**	**2,475**	**(2,045)**	**430**	**4,950**	**(4,520)**	**3,814**	**26**	**5,831**	**10,914**	**9,115**	**29,700**

Understanding Performance

£0.4m savings have been delivered year to date. The Trust now has a £4.5m shortfall against plan year to date, a major contributor to the Trust overall adverse variance to plan.

£4m annual savings are now in delivery and the amount unidentified has been reduced by £0.7m.. However, of the programme target of £29.7m there is still an unidentified gap of £9.2m, and £11m assessed as an opportunity without firm delivery plan in place.

Countermeasures	Owner	Due Date
Devolution of the savings targets to local budgets including the potential further top slicing across all budgets of the un-identified savings target	Finance Department and Divisional Tris	30 June
Acceleration of our saving plans that have been scoped for UEC, theatres, outpatients and corporate restructuring, re-forecasting weekly and consistent reporting to fortnightly Engine room to build momentum	Delivery Group SROs, Finance team and Recovery Director	30 June
Enhancing controls on discretionary spending to mitigate savings shortfall	Trust Management Executive and Budget Holders	Monitoring Impact
Business Cases for Invest to Saves for ring fenced £1.5m investments fund are being worked up for approval to facilitate pace of delivery.	Delivery Group SROs	30 June
Delivery Groups to collaborate with BSW ICS Delivery Groups to ensure out of hospital delivery plans are clear and are supporting Savings delivery e.g. reduction in NCTR & attendance avoidance plans	Delivery Group SROs	30 June

Risks and Mitigation

Delivery Programme maturity however pace has increased to support delivery

Lack of clear funding approach to any redundancy requirement

Defer investment against Spend to Save to directly mitigate unidentified savings gap

Key Risks and Mitigations

- There are a number of delivery risks resulting from the financial and operational context within which we are planning and it should be noted that the overarching risk profile of the plan is significantly higher across all areas than in previous planning years.

- We have identified delivery of RTT / Financial balance and UEC targets as highlighted areas of risk due to heavy reliance on productivity improvements, demand management and capital availability assumptions.

- Duse to the nature of transformational change, there is a mismatch between the savings plan which has been modelled in 12ths and the delivery profile of the step changes that form part of the transformation plan. To mitigate this, we are assessing and implementing short term measures to address the mismatch in the delivery profile. This will also include a need to makee up the gap in the non-delivery year to date.

- Additional areas of risk include capacity & demand profiling, external factor reliance e.g. demand management and NC2R reductions, staff engagement and availability due to requirement to improve productivity and remove financial incentivisation through pay spend reductions, capability to deliver rapid pacing of high complexity transformation, continued cost pressures and the ability to remove costs without impacting performance trajectories.

- The weekly governance rhythm and delivery group structure has been developed to create increased momentum to work up and deliver transformation change to support the asks set out in the trust’s annual plan

Governance & Oversight

Delivery Approach

To support delivery of the annual business plan, a revised governance structure has been developed to ensure;

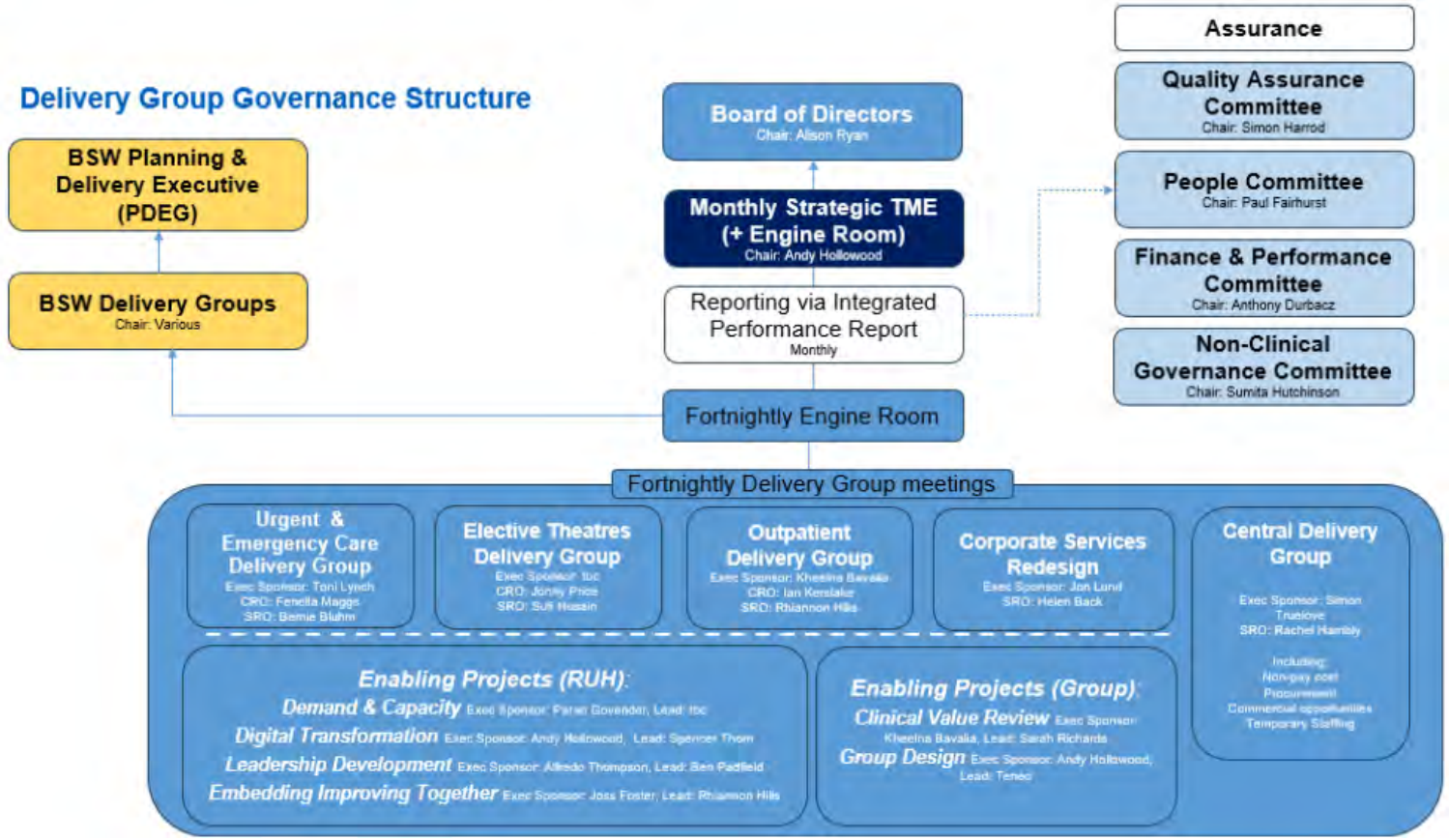
- Executive sponsorship of delivery groups
- Clinically led approach to prioritisation
- Clear accountability and responsibilities so that everyone is clear of role and expectations
- Integrated into the Trust's Operational Management System so it forms part of our standard oversight and delivery function
- Meeting structure rhythm that supports the pace of change required
- Corporate resource allocation so that the right capacity and capability is aligned to our prioritised Corporate projects
- Clear measurement of what we expect to change and the impact / benefits, including system partner deliverables which are dependencies for our plan
- Effective EQIA process including impact monitoring

Governance Structure

In recognition of the need to shift our focus to larger scale transformational schemes to deliver the annual business plan, we have created five new delivery groups; Urgent & Emergency Care, Theatres, Outpatients, Corporate Services redesign and Central Delivery.

Each group has an Executive Sponsor, Clinical and / or Senior Responsible Officers as well as a Programme team to support the activities of each groups.

There are also a number of enabling projects which will feed outputs into the delivery groups.



The RUH, where you matter

Delivery Oversight Rhythm

Delivery Groups

SRO Lead Led

- UEC
- Elective
- Outpatients
- Corporate Services
- Pay & Non-Pay

Week 1

Week 2

Strategic Engine Room

Executive Led

Progress updates across the programme

Strategic Executive Forum (Thurs)

Events e.g. Strategy planning, Winter planning, business planning, future planning, leadership development

Delivery Groups

SRO Lead Led

- UEC
- Elective
- Outpatients
- Corporate Services
- Pay & Non-pay

Week 3

PRMs

Division Led

Countermeasure summary for each Driver metric

Week 4

Delivery Group Engine Room

Executive Led

Progress updates across the programme

Management Executive Committee (Wed)

Integrated Performance Report (IPR), Risk Management, Business decisions

Supported by Weekly Driver Meetings under each Delivery Group (as appropriate)

Assurance

Quality Assurance Committee
Chair: Simon Harrod

People Committee
Chair: Paul Fairhurst

Finance & Performance Committee
Chair: Anthony Durbacz

Non-Clinical Governance Committee
Chair: Sumita Hutchinson

Appendix 2: Delivery Group Updates

Urgent and Emergency Care

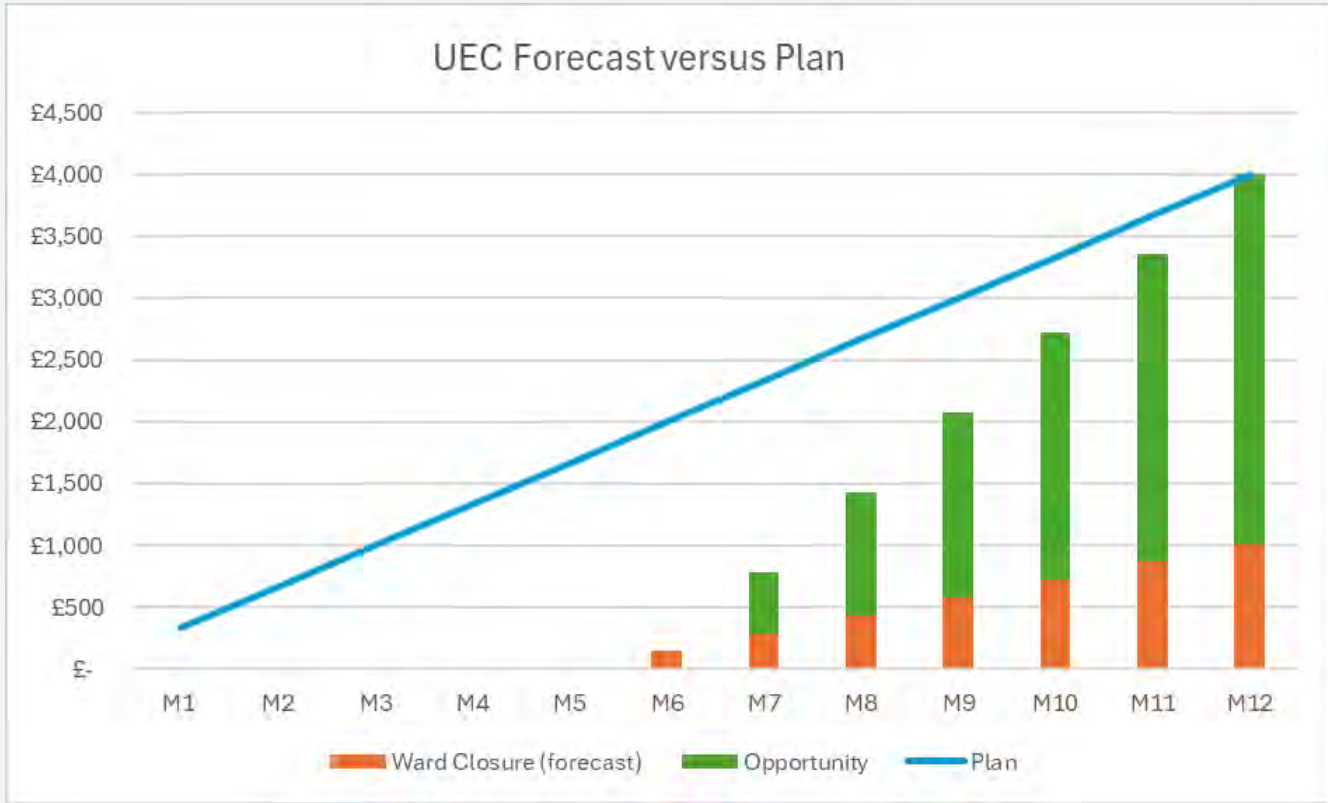
The RUH, where you matter

UEC Programme Outcome Measures

Workstream	Metric	Target March 2026	Current Performance (June)	Current reporting
UEC programme	4-hour performance – Type 1	72% 78% (stretch)	56.14%	Trust IPR (monthly) Medicine Driver (monthly PRM)
UEC programme	Ambulance handover times (average)	33 mins	58.74 mins	Trust IPR (monthly) Medicine Driver (monthly PRM)
UEC programme	Reduction in non-elective length of stay	0.5 days reduction	3.93 days	Surgery Driver (monthly PRM)
UEC programme	Financial contribution	£1m (at M3)	£0	Finance and Performance Committee
UEC programme	Non-Criteria to Reside	40	81	Trust IPR (monthly)

Urgent and Emergency Care

Urgent and Emergency Care Toni Lynch **£4m**	Urgent Treatment Centre Bernie Bluhm	**TBC**	SDEC Sarah Richards	**TBC**
	Capacity Management Bernie Bluhm	**TBC**	Home is Best Heather Cooper	**£1m**



2025/26 UEC Delivery Group | June week 4 Highlight Report

Date: 25th June 2025

Delivery Group Overview

- To oversee, monitor and drive improvements in UEC focusing on 4 key workstreams: UTC Redesign, SDEC, Capacity Management and Home is Best.
- To recover and improve UEC performance against national KPIs for 4-hour, 12-hour and ambulance handover indicators.
- To contribute £4m savings for 2025/26.

Celebrations

- Average ambulance handover delays continue to reduce
- Medical SDEC opened on Monday 23rd June
- Surgical SDEC SOP to close overnight relaunched 16th June

Escalations from Delivery Group

- Requirement to phase bed reduction plan in line with non-criteria to reside position will impact financial contribution.
- Gap in cash releasing savings identified circa £3m

Workstream	Metric	Target	June Actuals (up to and including 23/6)	Actions for next two weeks / plans to get back on track
UTC Redesign	UTC 4-hour performance (adults)	90%	82.59%	• Streaming PDSA review • Rat PDSA to start early July
SDEC	% of non-elective admissions	40% surg 45% med	34.3%	• Reviewing impact of medical SDEC including modelling performance impact • Agree surgical SDEC metrics and specialities of focus
Capacity Management	Majors admitted 4-hour performance (adults)	TBC	20.36%	• Review of admitted breach data and complete A3 • Use of benchmarking data for cardiology, T&O and gastroenterology to support LoS reduction plan
Home is Best	Reduce number of NCTR to 9% of bed base	40	81.4	• Planning for bed blitz • Ongoing work regarding deconditioning support tool for ward nurses and implementation of ward standards.

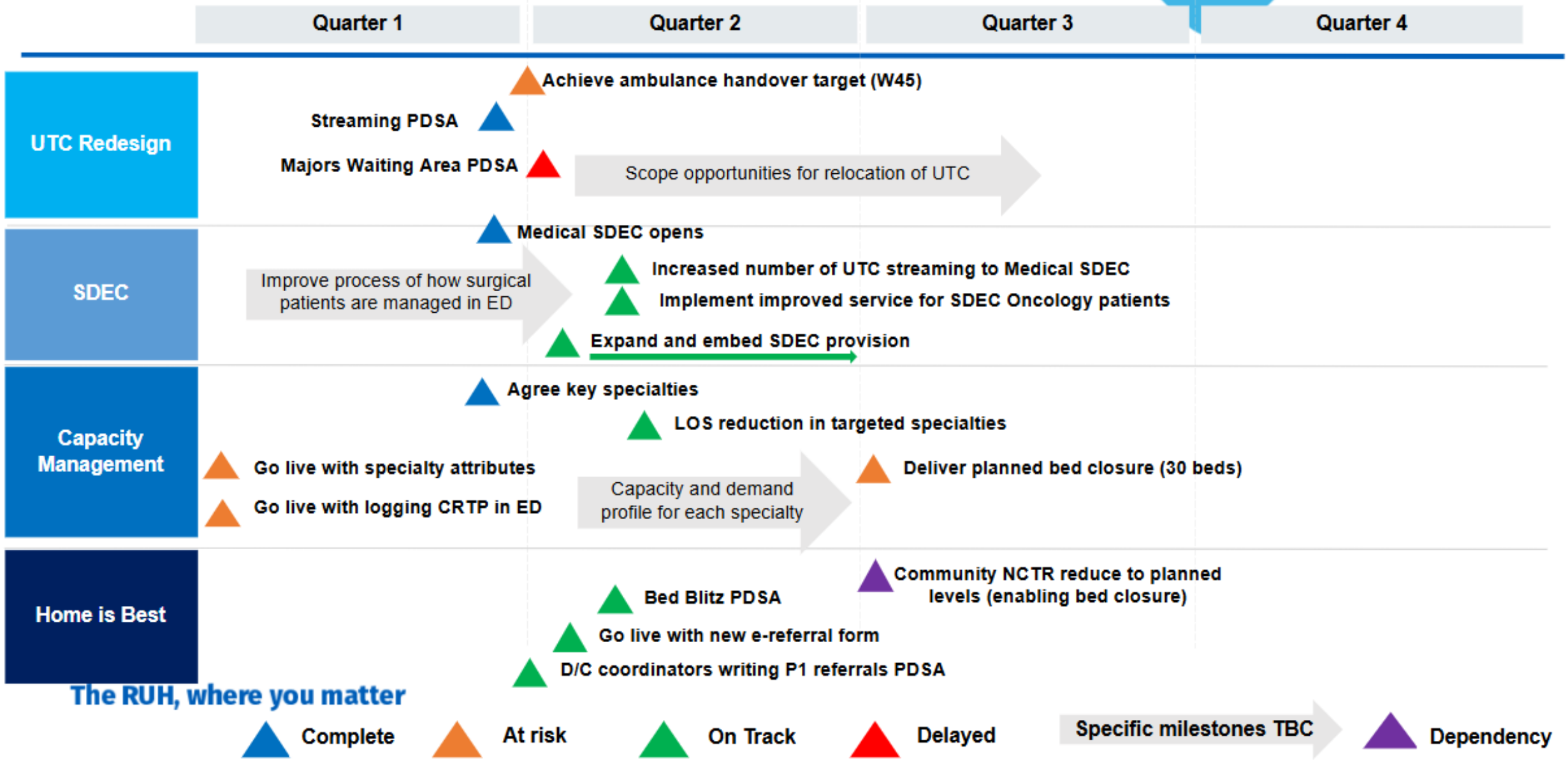
Programme Risks (over 16)	Current score	Mitigation	Mitigated score
NCTR position does not reduce to planned levels resulting in inability to close escalation or core beds impacting UEC performance and financial delivery	16	Collaborative working with all community providers and Local Authorities, internal actions to reduce delays across the interface	12
Risk to patient safety if beds are closed before sufficient improvements have been made to patient flow (reduction in LoS and NCTR)	16	Continue to monitor performance across the programme and ensure performance has met improvement targets before bed closures.	12
Risk to delivery of £4m savings target due to lack of identified schemes and increased trajectories for Q2-4	16	Review of model hospital data Continue to work with teams to identify further opportunities	12

Dependencies

- SDEC estates work and C16 capital works need to be complete (complete)
- SDEC funding being identified (high risk)
- System plans delivering i.e. demand (high risk)
- Revised AWP contract in place
- Adequate community capacity & improvements in processes to reduce interface delays (high risk)
- Workforce readiness for change
- Reduction in length of stay and NC2R to deliver bed closure target (high risk)

Date: 25th June 2025

Key Programme Milestones



Outpatients

Outpatient Programme Outcome Measures

Section	Measure	Mar-26 Target	Ytd Target	Ytd Actual	Commentary
Performance Targets	RTT 1st Appointment	71.7%	65.1%	62.3%	
	RTT 18 weeks	67.7%	61.1%	60.6%	
Activity	New appointments	202,197	32,000	31,686	-314 below plan
	FUP appointments	429,181	69,356	68,453	-903 below plan
	Total activity	631,378	101,356	100,139	-1,217 below plan
Assumptions	Referral growth	0%	0%	-7.9%	
Productivity ~ £4m benefit	**Measure**	**Top decile**	**Median**	**Current**	
	FUP:First ratio	1.6	2.1	2.13	
	PIFUP rate	6.0%	3.6%	3.8%	
	DNA rate	4.2%	6.5%	4.6%	
	Remote consultations	25.2%	18.4%	19.5%	
	Pre referral specialist advice	16.0%	-	18.2%	
Finances	Cash releasing savings	£2m	-	£1m	£1m of £2m identified to date

Productivity Metrics Key Top Quartile Second Quartile Third Quartile Bottom Quartile

Outpatients Delivery

Outpatients

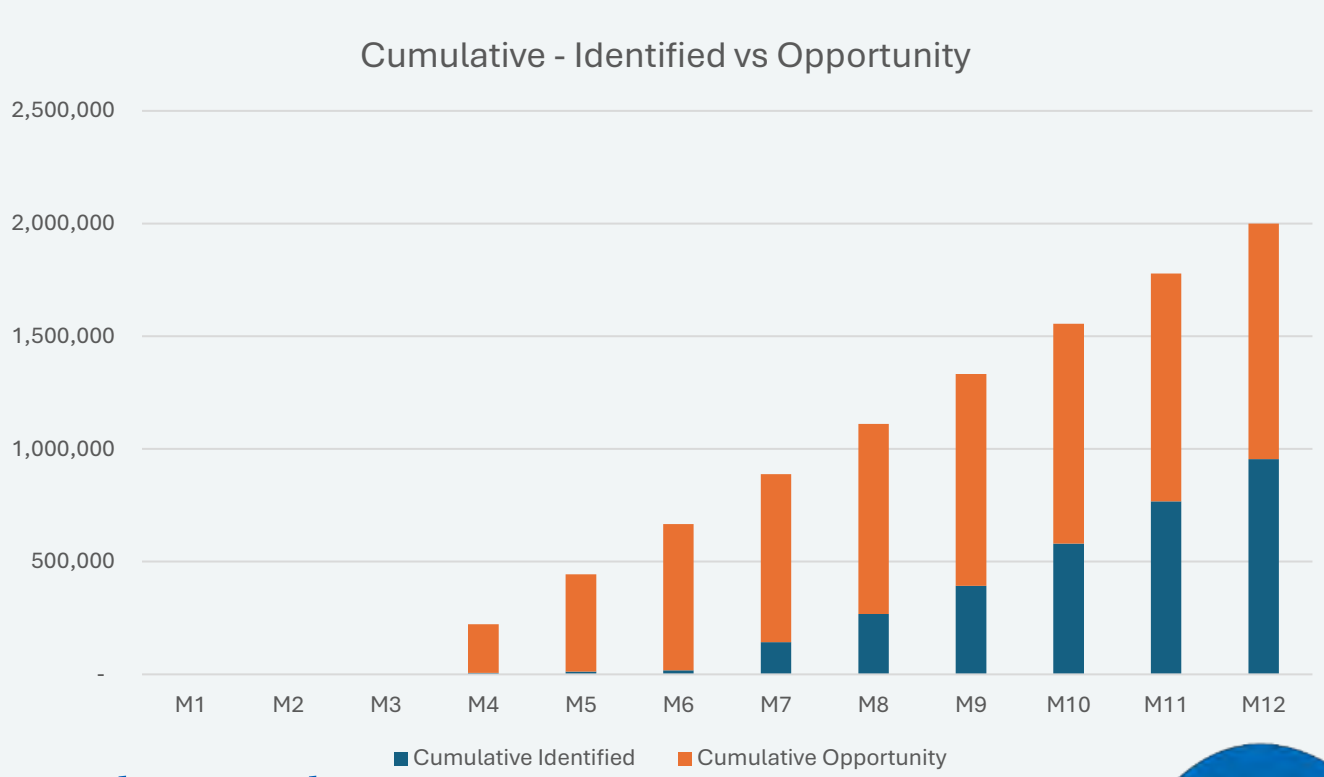
Cash releasing savings of £2.0m

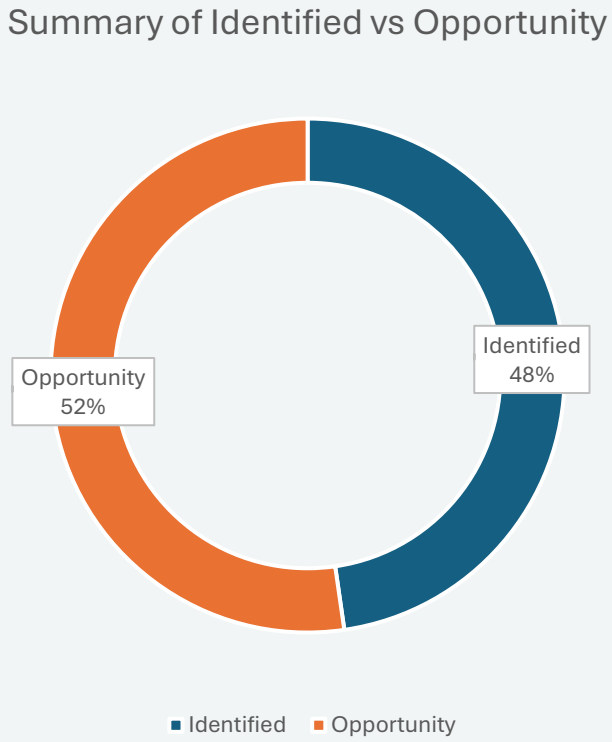
Identified Savings

1	Empowering Patients Ian Kerslake	£ tbc m
2	Optimised Models of Care Louise Pisani	£ 0.78 m
3	Care Closer to Home Chris Dyer	£ 0.16 m

Additional Information

- Initial savings has been identified for Hub & Spoke models, E-prescription (2) & Clinical Admin Redesign (incl. Electronic Triage) (3).
- Exploring further cash releasing opportunities in the three biggest high-cost OP areas: non pay, staff costs & prescribing, analysis is currently underway. Deep dive by specialty into OP costs and opportunities now to end of July, starting with Cardiology





1.1 2025/26 Outpatients Delivery Group | June week 4 Highlight Report

Date: 25th June 2025

Delivery Group Overview

- To oversee, monitor and drive improvements in Outpatients focusing on 3 key areas: Empowering Patients, Care Closer to Home and Optimised models of care underpinned with 6 supporting workstreams.
- To Improve % of patients waiting <18 weeks for treatment (67.7%) & for first appointment (71.7%), increase news by 6 per day & follow ups by 11 per day.
- To achieve productivity benefits of circa £4.1m, including £2.0m cash releasing savings for outpatients including clinical admin review.

Celebrations

- Agreement: X2 ENT Virtual Clinics to launch at Frome & Mendip from September
- Heidi AI meets NHSE compliance standards
- Go & Sees: Ophthalmology & Urology deploying staff differently to deliver care (CNS/Support Staff)

Escalations from Delivery Group (DG)

- RTT recurrent Business Cases not approved impacting speciality RTT plans
- Approval granted: E-Prescribing case approved by DG, requesting TME approval to proceed

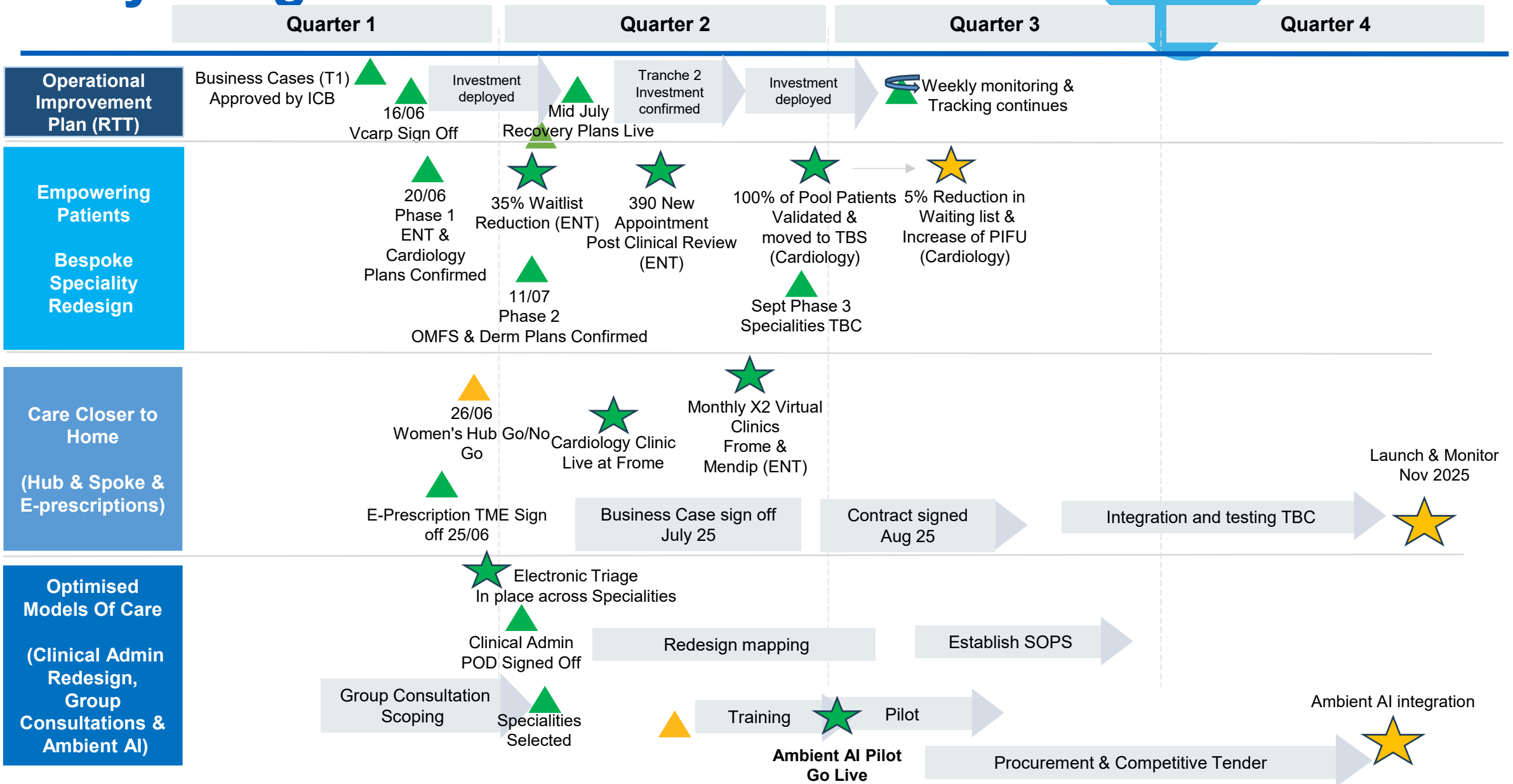
Workstream	Key OP Metrics	Target	YTD Target	June Actuals	Actions for next two weeks / plans to get back on track
Empowering Patients Bespoke Speciality Redesign ENT / Cardiology	RTT 1st Appointment	71.7%	65.1%	62.3%	• Intense validation & triage expedited by DrDoctor, 35% waitlist reduction expected from July (ENT) & October (Cardiology) • Clinical Template review to add circa 390 new appointments from August (ENT) • Phase 2 support to commence mid-July with OMFS & Dermatology • PIFU increase expected from Oct
Care Closer to Home Hub & Spoke E-Prescribing	RTT 18 Weeks	67.7%	61.1%	60.6%	• Women's Hub Go/No GO (Year 2) 26/06 • X2 ENT Virtual clinics (PM) established for ENT at Frome & Mendip from Sept. Cardiology committed to monthly Frome Clinic • E-Prescribing TME Outline Business Case sign off 25/06. Targeting Nov go live
Optimised Models of Care Ambient AI, Clinical Admin Redesign & Group Clinics	New Appointments	202,197	32,000	31,686	• Targeting contract signage for Hedi AI, backlog reduction expected Sept • Clinical Admin Redesign scope agreed, targeting form of centralised delivery. • Cohorts identified for group clinics (Cardiology)
	Follow Ups	429,181	69,356	68,453	

Programme Risks (over 16)	Current score	Mitigation	Mitigated score
There is a risk to **delivery of £2.0 cash releasing savings** due to lack of fully identified plans and cash releasing opportunities for OP this year.	16	• £1m identified against £3m target • Cost analysis underway at speciality level, key opportunities noted in Staff Costs, Pharmacy & Non-Pay • Specialty level roll out plan to redesign operating models through year • Scoping Radiology and Pathology opportunities	12
There is a risk **EPR Change Freeze** & implementation limits both Digital innovation and tech & Digital support to enable Outpatient transformation.	16	• Focusing on digital improvements that do not rely on integration with the PAS • Digital backlog areas shared with Simon S and Johnathan Hincliffe to consider as group priorities.	12
There is a risk that **teams are not ready to change at the pace required** due to longstanding customs & practices	16	• Now a strategic priority. Performance will be reviewed as part of the business planning process to drive change at pace. • Transformation plan focused on unlocking high impact, high reward pieces that could change hearts & Minds • Governance in place to monitor and track progress underpinned by regular and robust communication & Engagement.	12

Dependencies

- Commissioning models to support care closer to home agenda in discussion for ENT with ICB.
- Electronic Triage implementation (July) & Ambient AI positively impacts Clinical Admin Redesign scope/interventions.
- Awaiting contract signage of Heidi AI following completion of assurance documentation.

Key Programme Milestones



Theatres

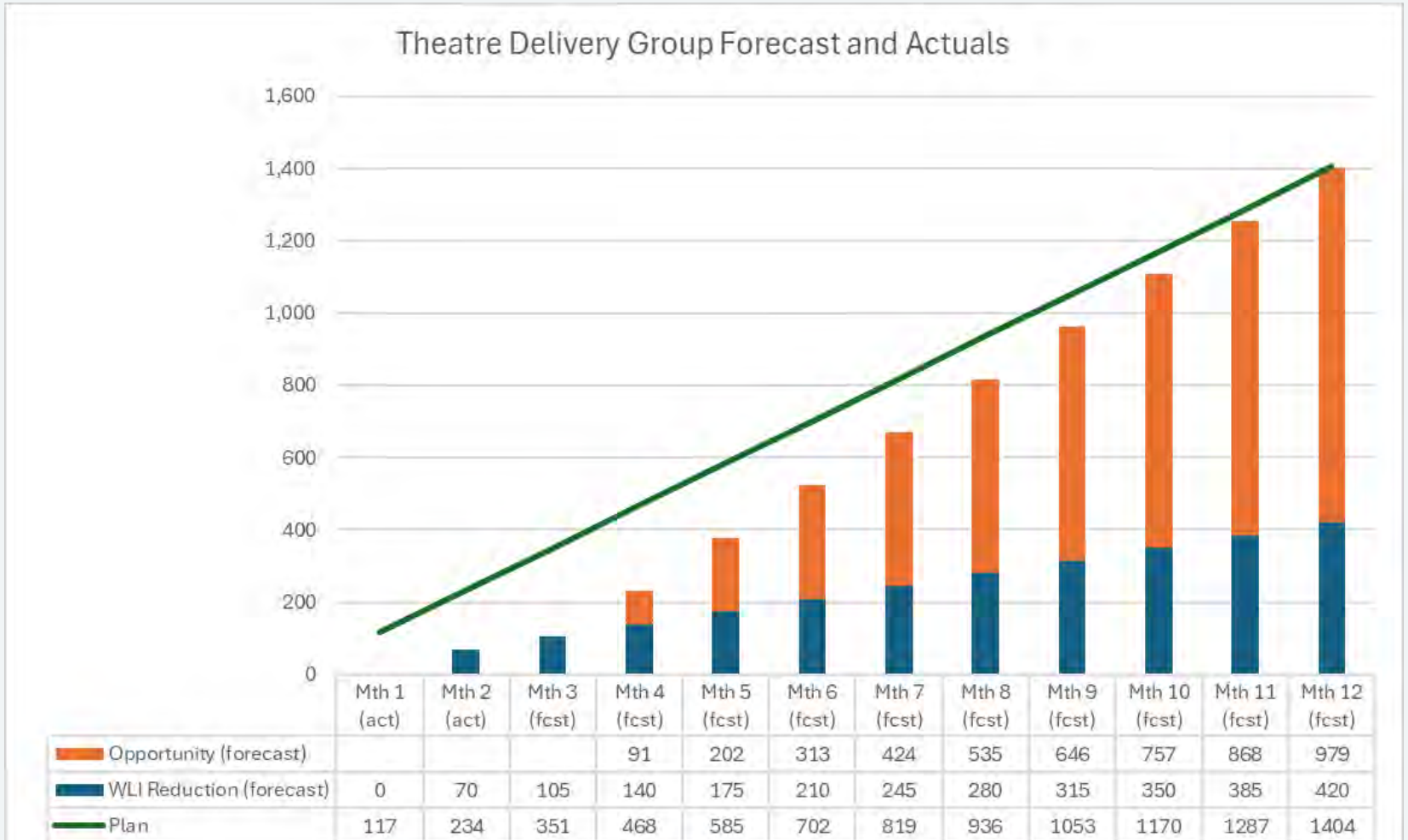
Theatre/Peri Op Outcome Measures

Metric	Frequency	Target	Baseline performance	Current reporting
Elective Activity	Monthly	YTD Plan 724 (+2 per day)	YTD Actual 717	Finance and Performance Committee
Day Case Activity	Monthly	YTD Plan 6,126 (+4 a day)	YTD Actual 6,268	Finance and Performance Committee
RTT <18 weeks	Monthly	67.7%	60.6%	Trust IPR (monthly)
Financial contribution	monthly	£1.4m	£70k	Engine Room

Theatres Delivery Group

Theatres Delivery Group
(Executive Sponsor)
£1.4m

Non-pay Sufi Husain	**£ opportunity tbd**
Peri Operative Optimisation Adam Dougherty	**£400k *(WLI reduction)***
Targeted Transformation Dr Jonny Price	**£ opportunity tbd**
Capacity and Demand Sufi Husain	**Enablers**
People and Culture Lilly Cohen	**Enablers**



	Mth 1 (act)	Mth 2 (act)	Mth 3 (fcst)	Mth 4 (fcst)	Mth 5 (fcst)	Mth 6 (fcst)	Mth 7 (fcst)	Mth 8 (fcst)	Mth 9 (fcst)	Mth 10 (fcst)	Mth 11 (fcst)	Mth 12 (fcst)
Opportunity (forecast)				91	202	313	424	535	646	757	868	979
WLI Reduction (forecast)	0	70	105	140	175	210	245	280	315	350	385	420
Plan	117	234	351	468	585	702	819	936	1053	1170	1287	1404

2025/26 Theatre Delivery Group

Date: 24th June 2025

Delivery Group Overview	To oversee, monitor and drive improvements across Theatres focusing on five key sub-groups; non pay, perioperative optimisation, targeted transformation, demand and capacity supported by an engaged and motivated workforce.

Celebrations	Escalations from Delivery Group
Theatre turnaround time reduced from 24 mins in Feb to 16 mins in June	Will an interim Exec be supporting the Theatre delivery group?

Workstream	Metric	Target	May/June actuals	Plans to get back on track/planned for next 2 weeks
Non-pay	Non pay spend	?500k (tbd with procurement)	Xx (May)	Meeting with SRO for central workstream to identify what opportunity sits with procurement and what's within Theatre delivery group.
Peri-operative optimisation & Targeted Transformation	Theatre Cancellations (Cancellation Rate)	Tbd	6.3% cancellation rate (50 patients up to 20th June)	Common cause variation. A3 to commence w/c 23/06 and bi-weekly meetings with pre-op to review on the day cancellations (clinical and non-clinical)
	Theatre Turnaround Times	15 mins	16 mins (up to 20th June)	Positive downward trend, A3 to be started and bi-weekly meetings to review speciality-specific turnaround times and targeted transformation.
	WLI spend	£35k saving a month	£35k (May)	Communication with Speciality teams to ensure WLI's keep within the agreed budget and scope
	Bank Spend	tbd	£36,994 (May) (50k less than month 2, 2024)	Targeted transformation for specialities that regularly overrun and incur overtime.

Programme Risks (over 16)	Current score	Mitigation	Mitigated score
Not updating the procurement catalogue once the decision has been made to standardise products will mean that products can still be ordered, and therefore, savings will not be realised.	16	The Divisional Finance lead keeps track of decisions made and follows up with the procurement team to update the catalogue.	12

Dependencies
Sulis Orthopaedic Centre is open and meeting activity plans (Low risk)
Capacity of the BIU and workforce team to support modelling (Low risk)
Clinical engagement and ownership in targeted transformation areas (High risk)
Being able to recruit, retain and develop staff (Medium risk)

Key Programme Milestones

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Capacity and Demand	Open SOC	Capacity and Demand modelling Revised theatre schedule >>>Job plan reviews		
Theatre Planning	On the day cancellations policy	>>>A3 on cancellations on the day >>> Monitor and track theatre productivity		

Targeted Transformation	Refresh theatre planning meetings
	Self-assessment against GIRFT recommendations
	Model hospital benchmarking
		>>> Implement cataract operations
		>>> Implement robotic surgery opportunities
		Clinical engagement
			>>> Implement, review and refine	

Non-Pay	Identify procurement lead
	Non-pay spend reviews
		>>> Orthopaedic loan kit opportunities
		>>> Hearing aid devices opportunities
		>>> Hernia mesh opportunities
			>>> Further non-pay cost improvements	

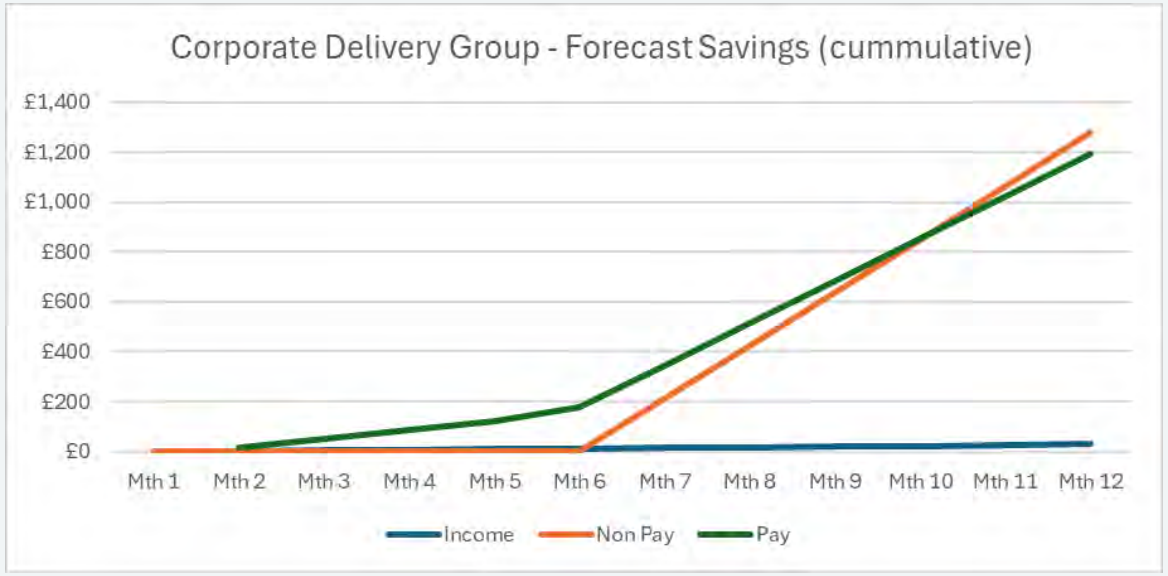
Corporate

The RUH, where you matter

2025/26 Corporate Services Delivery Group | Month 2 Delivery Status

Date: 12th June 2025

Plan Cash Savings Targets	Income	Non Pay	Pay	Grand Total
Corporate Services Delivery Group				
corporate Services Delivery Group	£0	£750	£1,750	£2,500
Sub Total	**£0**	**£750**	**£1,750**	**£2,500**



Scheme	Risk of delivery	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Total
1	amber							200,000.00						200,000.00
2	green		41,667.00	20,833.00	20,833.00	20,833.00	20,833.00	20,833.00	20,833.00	20,833.00	20,833.00	20,833.00	20,833.00	249,997.00
3	red		15,540.00	15,439.00	15,339.00	15,239.00	15,410.00	15,042.00	14,944.00	14,847.00	14,750.00	14,655.00	14,560.00	165,765.00
4	green		17,700.00	8,800.00	8,800.00	8,800.00	8,800.00	8,800.00	8,800.00	8,800.00	8,800.00	8,800.00	8,800.00	106,250.00
5	green			8,108.00	8,108.00	8,108.00	8,108.00	8,108.00	8,108.00	8,108.00	8,108.00	8,108.00	8,108.00	81,080.00
6	remove - group													-
7	remove - group													-
8	amber										200,000.00			200,000.00
9	red													-
10	red													-
11	remove - group													
12	amber												30,000.00	30,000.00
13	green				13,520.00	13,520.00	13,520.00	13,520.00	13,520.00	13,520.00	13,520.00	13,520.00	13,520.00	121,680.00
Gap	no plans													1,345,228.00
Monthly total			74,907.00	53,180.00	66,600.00	66,500.00	66,671.00	266,303.00	66,205.00	66,108.00	266,011.00	65,916.00	95,821.00	**1,154,222.00**
Actuals			60,000.00											

re you matter

2025/26 Corporate Services Delivery Group | Month 2 Highlight Report

Date: 12th June 2025

Delivery Group Overview

- A reduction of £2.5m on budget spend which equates to around 36.7 WTE.
- Since the original plan was developed, there has been a national request to reduce Corporate Growth between 2018/19 and 2023/24 by 50% by quarter 3 which for the RUH is £3.7m of cost. This is against the annual corporate benchmarking submission which differs from the RUH definition of corporate.

Workstream	Updates
Long Term Vacancies	▪ Budgets have been mapped ▪ Savings and vacancies are in the process of being removed from budgets. ▪ £250,000 removed from budgets
RUH Service Redesign	▪ Quick wins scoped (no viable options). Paper being drafted to formally consider options for a Trust Decision. For Board in July 2025 ▪ Group Joint Committee decision on team structures on 16/07/2025
MARS	▪ Scheme live ▪ Closes on 20/06/2025 with Trust decisions due to be made on 30/06/2025. ▪ Financial impact estimated July 2025
Systems	▪ Quick wins scoped. ▪ Contracts, cost and capability of systems being identified and developed to be considered for options.

Key Milestones

Dependencies

- Workforce readiness for change
- Group Corporate Services Review
- Central Programme
- VCARP Processes
- Available resource to deliver programme

Risk	Potential Impact	Mitigation
Opportunity to make £2.5m from corp services reduced as a result of transformation at group level.	Unable to successfully deliver project and achieve savings target	Escalate risk to exec and establish clearer timeframe for group
Difficulty in moving at pace in some workstreams as executives are working within group space and also desire to be involved is impacted.	Unable to successfully deliver project and achieve savings target	Engage execs early on in project, deputies to keep execs informed of plans
Risk that the pace at which the project is expected to be implemented is too quick to ensure true and effective transformation	Unable to successfully deliver project and achieve savings target. Or project is delivered but not done well - staff morale is affected and structure and skillmix of corporate teams is not well designed	Provide execs with realistic timeframes of delivery and impact if project not delivered at correct pace
Corporate vacancy freezes will impact the capacity of corporate teams to deliver current services/programmes of work and any future intiatives.	Potential risk to patient safety and performance.	Any proposals relating to reducing WTE with have a thorough impact assessment completed
Unable to deliver target because we don't have enough schemes to deliver £2.5 million	Failure of RUH to deliver savings required of £30million.	Articulate risk to engine room view Exec Sponsor.
MARS programme won't deliver savings within this financial year	will not reach £2.5m saving target.	nil - risk acknowledged in project plan
Duplication of savings captured as part of other programmes. Assumptions/dependencies built in may cause overlap with other programmes	Double counting and assumption of savings	Involvement of finance, clear scope of programmes agreed.
Non-patient facing nurses colleagues may be asked to review their workfroce outside of this programme of work as detailed in National corporate reduction letter on 01.04.25	Unknown	
National corporate target of £3.7m reduction by Q3 does not align with internal timeframes	Unknown	Initial submission suggestd £400k of target.
Corporate overspend at M1 when forecasted forward show over £2m overspend	overspends will negate any savings made	Share data through engine room, group work should reduce costs (but not in year)

The RUH, where you matter

Key Programme Milestones

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Long Term Vacancies	Budgets Mapped and savings removed			
RUH Service Redesign	Quick Wins Scoped	Structures Released & Change Processes begin	Structures in place	
MARS	Joint Committee; Scheme Live (June 2025)		Exits take place	
Systems	Quick Wins Scoped; Present Options		Continual milestones on going as contracts end	

The RUH, where you matter

Milestones; Interim Milestones; Dependencies; Complete

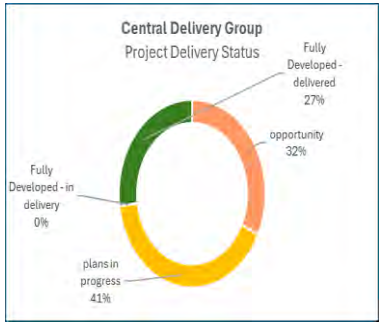
Central

The RUH, where you matter

Central Delivery Group – Month 2 Status

Royal United Hospitals Bath NHS Foundation Trust

Plan Cash Savings Targets	Income	Non Pay	Pay	Grand Total
Central Delivery Group				
Commercial income	£300			£300
Procurement		£1,900		£1,900
Temp Staff - Bank Outsourcing			£902	£902
Temp Staff - E Sourcing			£200	£200
Temp Staff - Other			£1,998	£1,998
Sub Total	**£300**	**£1,900**	**£3,100**	**£5,300**
Other				
Medicine Management		£800		£800
Frome Chemo	£1,000			£1,000
Divisional Led Budget Savings			£505	£505
SubTotal	**£1,000**	**£800**	**£505**	**£2,305**
Total	**£1,300**	**£2,700**	**£3,605**	**£7,605**



Project	Project Status	Risk	Sum of Actuals Mth 1	Sum of Actuals Mth 2	Sum of Fcst Mth 3	Sum of Fcst Mth 4	Sum of Fcst Mth 5	Sum of Fcst Mth 6	Sum of Fcst Mth 7	Sum of Fcst Mth 8	Sum of Fcst Mth 9	Sum of Fcst Mth 10	Sum of Fcst Mth 11	Sum of Fcst Mth 12
Biosimiliars and drug optimisation 1	plans in progress	medium			£12.17	£6.08	£6.08	£6.08	£10.08	£13.33	£13.33	£93.33	£93.33	£93.33
Biosimiliars and drug optimisation 2	opportunity	medium				£50.31	£50.31	£50.31	£50.31	£50.31	£50.31	£50.31	£50.31	£50.31
Chemo at Frome	Fully Developed - delivered	medium		£100.00	£90.00	£90.00	£90.00	£90.00	£90.00	£90.00	£90.00	£90.00	£90.00	£90.00
Commercial income	plans in progress	medium				£33.33	£33.33	£33.33	£33.33	£33.33	£33.33	£33.33	£33.33	£33.33
Divisional led budget savings - surgery	Fully Developed - delivered	Low		£61.11	£30.55	£30.55	£30.55	£30.55	£30.55	£30.55	£30.55	£30.55	£30.55	£30.55
Divisional led budget savings - surgery (Anesthetics)	Fully Developed - delivered	Low		£23.17	£11.57	£11.57	£11.57	£11.57	£11.57	£11.57	£11.57	£11.57	£11.57	£11.57
Procurement - delivered corporate	Fully Developed - delivered	Low		£22.11	£11.06	£11.06	£11.06	£11.06	£11.06	£11.06	£11.06	£10.41	£10.41	£10.41
Procurement - delivered Estates & Facilities	Fully Developed - delivered	Low		£0.53	£3.64	£3.64	£3.64	£3.64	£3.64	£3.64	£3.64	£3.64	£3.64	£3.64
Procurement - delivered FASS	Fully Developed - delivered	Low		£20.56	£10.28	£10.28	£10.28	£10.28	£10.28	£10.28	£10.28	£10.28	£10.28	£10.28
Procurement - delivered Surgery	Fully Developed - delivered	Low		£26.82	£13.41	£13.41	£13.41	£13.41	£13.41	£13.41	£13.41	£13.41	£13.41	£13.41
Procurement - in delivery FASS	Fully Developed - delivered	Low			£10.81	£3.60	£3.60	£3.60	£3.60	£3.60	£3.60	£3.60	£3.60	£3.60
Procurement - in delivery Medicine	Fully Developed - delivered	Low			£10.81	£3.60	£3.60	£3.60	£3.60	£3.60	£3.60	£3.60	£3.60	£3.60
Procurement - in delivery Surgery	Fully Developed - delivered	Low			£4.99	£1.66	£1.66	£1.66	£1.66	£1.66	£1.66	£1.66	£1.66	£1.66
Procurement - plans - surgery	plans in progress	medium			£20.23	£36.82	£35.51	£38.31	£38.31	£38.31	£38.31	£38.31	£38.31	£38.31
Procurement - plans corporate	plans in progress	medium												£15.24
Procurement - plans Estates & Facilties	plans in progress	medium			£10.12	£4.43	£5.68	£7.22	£8.47	£9.05	£9.05	£13.22	£13.22	£17.39
Procurement - plans medicine	plans in progress	medium			£44.42	£57.76	£94.25	£95.92	£95.92	£95.92	£95.92	£95.92	£95.92	£95.92
Temp Staff - bank outsourcing	plans in progress	Low							£150.33	£150.33	£150.33	£150.33	£150.33	£150.33
Temp Staff - E-sourcing	plans in progress	medium										£66.67	£66.67	£66.67
Temp Staff - other	opportunity	medium					£250.00	£250.00	£250.00	£250.00	£250.00	£250.00	£250.00	£248.00
Grand Total				**£254.30**	**£284.05**	**£368.12**	**£654.54**	**£660.55**	**£816.13**	**£819.97**	**£819.97**	**£970.15**	**£970.15**	**£987.56**

Understanding Performance

Procurement - £309k delivered and £133k sign off for year opportunities have been identified and plans in place to deliver full £1.9m target.
Temp Staffing – Opportunities have been identified, e-rostering for medics business case awaiting approval at TME on 25/6/25 Temporary staffing workstream group being set up.
Commercial Income – Plans in place and being presented for review and approval. Agreement around splitting the target no complete.
Non-Pay – 4 workstreams in place: No PO No Pay, catalogue management, stock control and management and contract and SLA management.
Biosimilar and Drug Optimisation – Drugs have been identified, and full schedule of savings being drawn up based on funding stream.
Chemo at Frome – £1m of income opportunity to be confirmed. Meeting week of 23/6/25 to work through the detail and timelines for this.

Countermeasures	Owner	Due Date
PODs, ToR and EQIAs in the process of being approved for non pay and non pay subgroups.	Rachel Hambly	ongoing
Detailed work being undertaken to bottom out exactly what the specific projects will be, and targets and key milestones being identified across the Central Delivery Group.	Rachel Hambly	30 June 25
Procurement plan being managed tightly with divisions to ensure that savings can be released as quickly as possible and that the appropriate catalogue changes are made.	Rob Webb	Ongoing
Discretionary spend Task and Finish group now in place to deliver £480k target.	Rachel Hambly	End Sept 25

Risks and Mitigation

+ Commercial Income – schemes may not deliver this year. However, opportunity with moving private patients to Sulis to grow income.

+ e rostering for medics – savings dependant on funding of business case. Being considered at TME on 25/6/25.

+ Temporary staffing – there is a risk that we may not be able to reduce bank staffing by the anticipated amount. Plans being worked through with clinical areas by 27/6/25

2025/26 Improvement Programme | Central Delivery Group Highlight Report

Date: 24/6/025

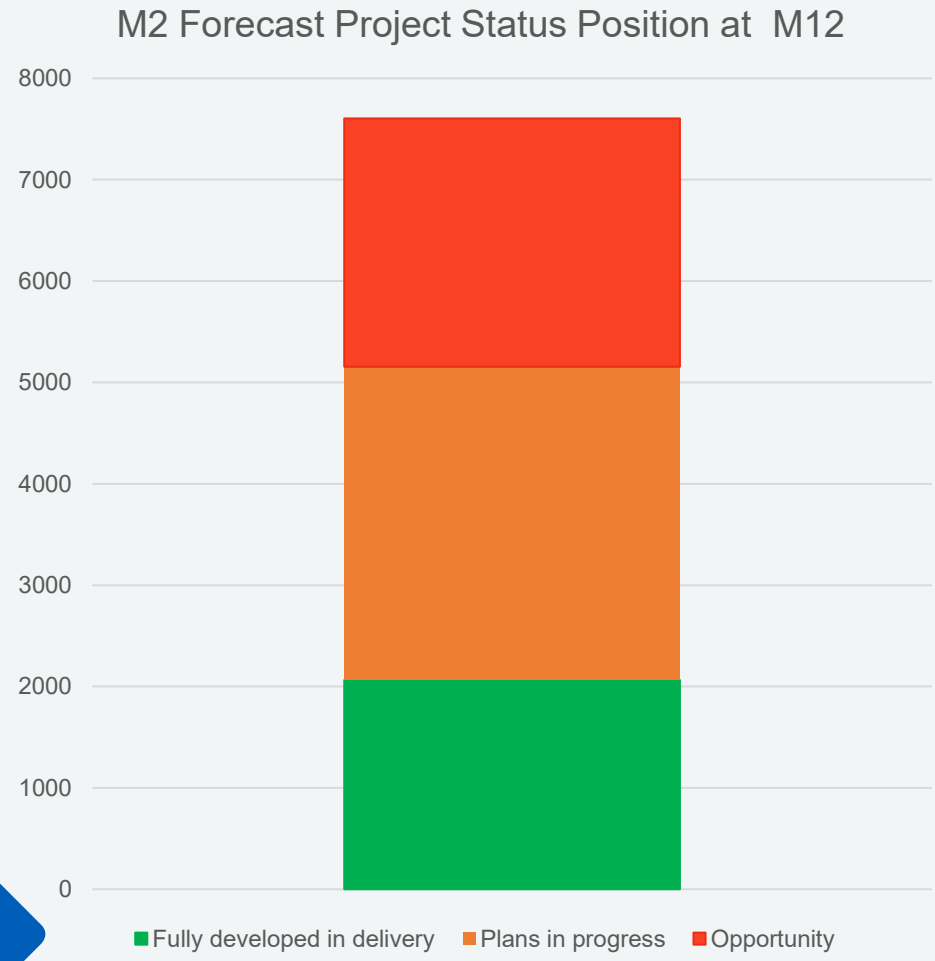
Central Delivery Group

Procurement | Commercial | Temp Staffing – Medical eRostering | Temp staffing - Nursing, Midwifery and AHP | Temp staffing – Senior Management | Non-pay | Medicines Management | Chemo - Frome | Online Portal

Delivery Group Overview

The Central Delivery Group oversees workstreams that sit outside of the core 4 Delivery Groups and are organisationally cross cutting. The target for 2025/26 is to deliver £7.6m. The target each month is £634k. YTD £253k has been delivered at M2 against a target of £1.268m.

Workstream	Updates
Procurement	M2 savings submitted YTD from procurement was £562k split across the divisions £494k has been signed off by finance and £67k is still with finance for approval. Current forecast increased to over £1.9m following work over the past few weeks – up £400k from month 1. Risk to delivery due to reduced resource because procurement now has 14 vacancies
Commercial and Private Patients Overseas	2025/26 projects have been identified but need further development and pprioritisation needed to focus on a key projects. There are risks associated with capacity, unknown income from projects across the trust, and the loss of overseas income. Broader work underway to understand totality of commercial opportunity across the Trust.
Medical eRostering	Deputy CMO & CMO in discussion to confirm if Business Case needs to go TME or System first. There is a risk that the ICB do not approve the business case for eRostering leading to the project not being progressed and closed and as a result the anticipated staff savings and efficiencies will not be met.
Nursing, Midwifery and AHP	The DDons, HRBP and Finance BPs are working with Matt Evans to create workforce - finance and WTE forecast up to M12 by 27/6/25.
Senior Management	Project being taken forward by Simon Truelove via the Senior Management Reorganisation Outside Group Construct.
Non-Pay	Subgroups are making good progress and have clear TOR, PODs and EQIAs going through the sign off process. A ask as Finish Group for discretionary spend has been set up. Contract savings identified at £400k against the £500k target – money will be released in M3 and phased through the year. Further work ongoing to identify gap.
Medicines Management	No savings were realized in M1 and M2 as most biosimilar drugs are not expected to be on the market before M4 due to ongoing patent restrictions Project phasing has been altered to reflect this.
Chemo - Frome	Meeting in the diary week of 23/6/25 to confirm Chemo Frome delivery and timing of the release of savings.
Online Portal	Clarity is being sought on the procedures for taking private patient payments. A Receiving Card Payments Over the Phone policy is being developed to mitigate the Payment Card Industry Data Security Standard (PCI



Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**12**
Date of Meeting:	**2 July 2025**		
Title of Report:	**Annual Business Plan 2025/26**		
Status:	**For Information**		
Board Sponsor:	**Andrew Hollowood, Interim Managing Director**		
Author:	**Rhiannon Hills, Director of Transformation** **Business Planning Leads**		
Appendices	**Appendix 1: Annual Business Plan 2025/26**		

1. Executive Summary of the Report

This report provides the Board of Directors with a summary of the Trust's Annual Business Plan for 2025-26.

Annual Plan approval process

The annual plan was submitted to NHS England as part of the ICB submission of the system plan on 27th March 2025.

Following the submission of the plan on the 27th March 2025, the regional executive team assessed the BSW plan and it was rated as "*Category 2 – some areas of the plan need review and change*".

These areas were addressed and the final plan was approved on behalf of the Board of Directors, via delegated authority, by the Finance and Performance Committee on 30th April 2025 ahead of submission to NHS England on the 30th April 2025.

Following this revised submission, BSW received a response from that NHSE to sign off the plan and close the planning round. We have now move into monitoring delivery against the operational plan.

Annual Business Plan 2025/26

Appendix 1 provides an overview of the Annual Business Plan 2025/26 including;

- **Review of last year's** delivery against our Strategic ambitions for 2024/25
- **Breakthrough Objectives and Corporate Projects** agreed for 2025/26
- **Performance plan** with ensures we can support delivery of all of the key headline access targets by March 2026
- **Financial plan** that outlines our ambition to achieve a break even position supported by £29.7m recurrent savings in year. This includes £25.3m of RUH specific productivity/efficiency improvement and £4.4m of savings anticipated to be delivered via the Group Transition programme.
- **Workforce Plan** with continued expectation to maintain the WTE equivalent reductions we have seen in the last year, 2024/25 and reduce the trust pay bill by a further £15.2m in 2025/26 to ensure we achieve our financial plan. This includes a particular focus on corporate services reduction as per national planning requirements

- **Productivity opportunities** to support our performance improvements and achievement of our financial plan including cash releasing savings

- **Quality & Safety** priorities for the year that aim to improve patient safety and quality, develop a framework for carers and improve patient experience through effective communication

2. Recommendations (Note, Approve, Discuss)

The Board of Directors is asked;

- **To Note** the summary of the Annual Business Plan 2025/26, approved on behalf of the Board of Directors, via delegated authority, by the Finance and Performance Committee on 30th April 2025.

- **To Note** the key risks to the plan and actions required to mitigate these to ensure delivery of this plan.

3. Legal / Regulatory Implications

As a Trust, we must work to support the achievement of the system control total and address our underlying deficit to meet our organisational obligations to financial sustainability and liquidity.

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

There are a number of delivery risks resulting from the financial and operational context within which we are planning. We have identified delivery of RTT / Financial balance and UEC targets as highlighted areas of risk due to heavy reliance on productivity improvements, demand management and capital availability assumptions. It should be noted that the overarching risk profile of the plan is significantly higher across all areas than in previous planning years.

Additional areas of risk include capacity & demand profiling, external factor reliance e.g. demand management and NC2R reductions, staff engagement and availability due to requirement to improve productivity and remove financial incentivisation through pay spend reductions, capability to deliver rapid pacing of high complexity transformation, continued cost pressures and the ability to remove costs without impacting performance trajectories.

5. Resources Implications (Financial / staffing)

The financial and workforce requirements for 2025-26 are a significant ask in addition to the savings delivered during 2024/25. Current savings opportunities are at the higher end of available opportunities identified in benchmarking.

To achieve these opportunities, it is expected that substantive WTE would be reduced, capacity would be reduced and all service delivery requires review.

6. Equality and Diversity

Equality and Diversity is a critical lens through which we must consider all our Trust plans. Quality and equality impact assessments (QEIA) will be undertaken as part of all transformational changes delivered in year.

In addition, taking positive action to reduce health inequalities is a key area, for which the trust will be continuing a focus on digital inclusion and working with AWP to secure improved services for patients requiring mental health support at the front door.

7.	References to previous reports/ Next Steps

BSW Medium Term Financial Plan – FPC October 2024
25/26 Financial Plan – FPC November 2024
25/26 Business Planning Approach – TME December 2024
25/026 Business Planning Update – TME and FPC, January 2025
Headline plan submitted to NHSE Feb 27th 2025
Extraordinary Board Meetings – 18th and 26th March 2025
FPC Business Planning Update – 25th March 2025
Final plan to be submitted to NHSE March 27th 2025
Revised plan to be submitted to NHSE April 30th 2025

8.	Freedom of Information

Public Board

9.	Sustainability

The Trust is required to contribute to delivery of the BSW Medium Term Financial Plan (MTFP) which sets out the requirement of all organisations in the system to support a route back to financial breakeven. Our planning framework will help us to consider how we can make the best use of our shared resources with the system for the year ahead.

Considering our impact on environmental sustainability as well as our local population is an important part of planning. The decarbonisation project will continue in 2025 with some capital contribution from the Trust to enable ongoing progress towards carbon net zero.

10.	Digital

Digital transformation is a key enabler to support the transformation changes identified as part of our business planning and is in line with the Government drive from analogue to digital. There is a challenge to accessing digital capacity to support transformation in this financial year in light of the shared EPR project which is due to go live for the RUH during Quarter 4, 2025/26.

Royal United Hospitals Bath
NHS Foundation Trust

Annual Business Plan 2025/26

Public Board, July 2025

The RUH, where you matter

Executive Summary

Our plan builds on the work undertaken during 2024/25, in which the Trust delivered significant improvements; retaining Outstanding in Maternity Services, reducing agency spend by 89% since Mar-24 and delivering £36m of efficiency savings during the year.

This has been delivered through;

- a continued focus on using Improving Together to drive local performance and change
- a focus on productivity within the hospital, with successes such as being top quartile for day cases and Did Not Attend rates
- ongoing development of our clinical services including the opening of the new Dyson Cancer Centre, Maternity Day Assessment Unit and Intensive Care Unit
- a strong focus on quality standards and developing our workforce

The Plan for 2025/26 focuses on further productivity benefits, delivery of national performance targets and further stepped improvements through transformational change.

Our plan contains a number of delivery risks resulting from the financial and operational context within which we are planning and the overarching risk profile of the plan is significantly higher than in previous planning years. These risks will be mitigated through collaborative working across the BSW Hospital Group and our system partners.

Business planning process

- Planning for the future is a standard activity for most organisations. Nationally, NHS organisations submit their annual plans by ‘system’ (our system being Bath, North East Somerset, Swindon and Wiltshire (BSW))
- All systems are required to deliver an overall ‘balanced’ plan (delivering a range of operational and quality standards within the funding envelope provided). Within systems each partner has its own part to play in delivering that final plan and makes a commitment to that.
- A National oversight framework of the plan includes a range of mechanisms to hold organisations and systems to account for delivery to plan. Mechanisms may include different levels of external intervention/support/resource.
- Our plan must demonstrate how we are continuing to address key challenges in order to deliver against national and system requirements including a positive trajectory towards our Vision: The RUH where You Matter.

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Review of 2024/25

The RUH, where you matter

Achievements in 2024/25

As part of our priorities for 2024/25, we identified three Breakthrough Objectives for the year;

- Reducing length of stay
- Reducing number of stay reporting experience of discrimination at work
- Delivering financial balance

We also had a fourth enabling Breakthrough Objective, which was

- Embedding Improving Together focusing on ensuring trust wide adoption of the tools, routines and behaviours of Improving together to support improvements

In addition, we supported a number of trust wide projects delivering improvements across our three of our People Groups and Trust Goals.

Through this collective focus on improvement across the organisation we have seen a significant number of benefits including;

- 125 teams (95%) now running regular Improvement Huddles, enabling staff to raise improvement ideas,
- Low external turnover across the Trust continuing to be better than 1%
- £36.6m of cost savings 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

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, Surgical Orthopaedic Centre 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
- Delivered £36.6m Cost Improvement Programme through driving productivity and reducing costs

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Trust Business Plan 2024/25

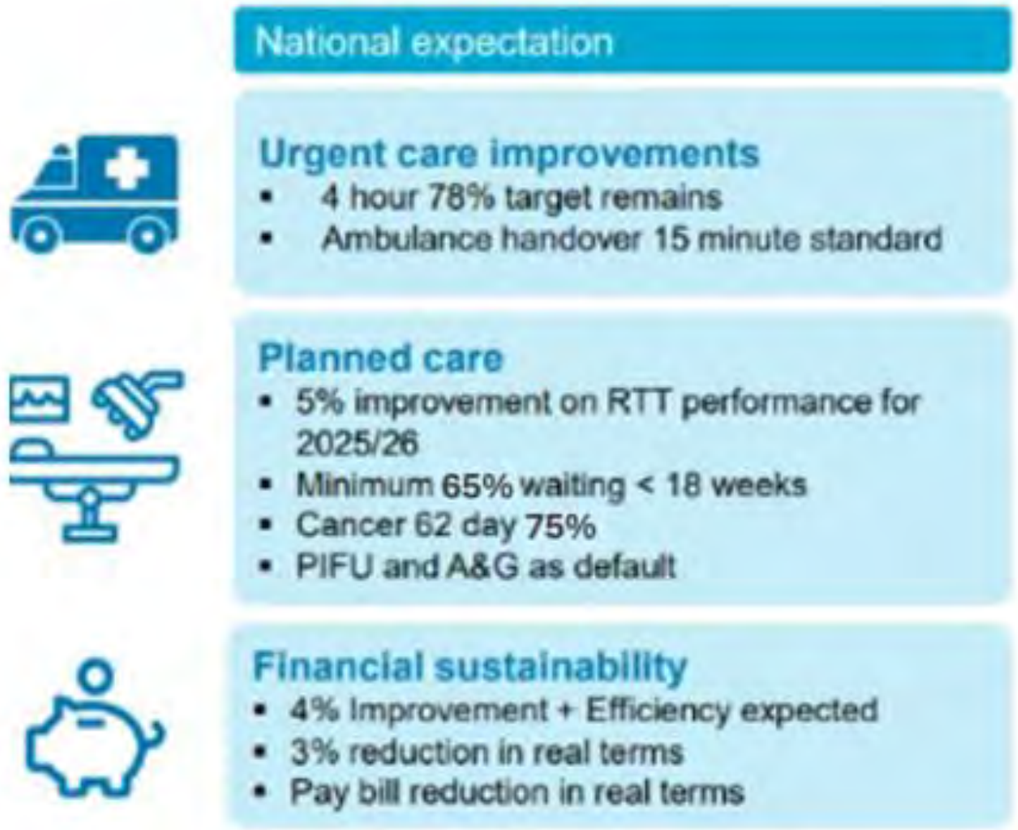
The RUH, where you matter

National Planning Context

The national planning guidance was published on 30 January 2025

Key messages;

- NHS is facing major challenges in meeting growing needs of an ageing population
- The NHS must live within their means, ensuring taxpayers money is spent wisely
- Improve services for patients, focusing on three shifts:
  - hospital to community
  - analogue to digital
  - sickness to prevention
- Maintaining quality and safety of our services
- Planning guidance is more focused with a small set of headline ambitions and key enablers
- Focus needs to be improving productivity, tackling unwarranted variation, reducing delays and waste



Annual Business Plan 2025/26

- As part of planning for 2025/26, we have undertaken a review of our strategic ambitions and used data insights to identify the most pressing operational, performance, safety and workforce issues we need to address.
- Through this process we have identified three Breakthrough Objectives for the coming year;
    - Achieving Ambulance off load times
    - Increase the percentage of staff feeling valued
    - Maximise value, eliminate waste
- Breakthrough objectives are our annual focus on a small number of measures that we believe will significantly help us in achieving our Trust Vision. We want every member staff to support with these and as a result, expect to see a 20-30% improvement within 12-18 months as we are all working on the same problem together.
- In support of these Breakthrough Objectives, we have also identified five Corporate Projects which we feel are the areas where we can make larger scale transformational change to deliver the annual business plan. These are:
    - Urgent and Emergency Care
    - Elective Theatres
    - Outpatients
    - Corporate Services Redesign
    - Central Programme including Non-pay, Procurement, Commercial Opportunities and Temporary staffing
- A summary of our Trust Priorities for 2025/26 are shown on the next page.

Trust Priorities 2025/26

Royal United Hospitals Bath NHS Foundation Trust

The people we care for | **The people we work with** | **The people in our community**

Vision Metrics (7-10 Years)

- *Providing safe and effective care*
- *Right care, right time, right place*
- *Improve the experience of those who use our services*
- Recommending RUH as a place to work
- Fair career progression and development
- Reducing discrimination from managers, colleagues and others
- Deliver a sustainable financial position
- Equity of access to RUH for all
- Carbon emission reduction

Breakthrough Objectives 2025/26

Valuing Patient & Staff time
Achieving ambulance offload times

Recognising and valuing colleagues' work
Increase percentage of staff feeling valued

Productivity
Maximising value, eliminating waste

Corporate Projects 2025/26

- **Urgent and Emergency Care**
- **Corporate Services Redesign**
- **Theatres Transformation**
- **Outpatient Transformation**
- **Central Projects**

Enabling Projects – Clinical Value Review, Demand & Capacity, Digital Transformation, Leadership Development, Embedding Improving Together, Group Design

Strategic Initiatives (3-5 Years)

- **Integrated front door**
- **Patient Safety Incident Response Framework (PSIRF)**
- **Sustaining Improving Together Operational Management System (OMS)**
- **Collaboration as and at Group**
- **Shared Electronic Patient Record (EPR) Benefits**
- **Community Transformation Year 2 - 5**
- **Artificial Intelligence / Automation Programme**
- **Deliver Medium Term Financial Plan**
- **Reduction in Carbon Emissions**

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Performance Plan

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Performance Improvement

The plan for 2025/26 includes ambitions to improve performance across all key national performance standards and achieve the national targets set for this year.

Referral to Treatment (RTT) times

- Increase RTT % within 18 weeks to minimum 67.7%
- Less than 1% of waiting list waiting over 52 weeks
- Increase % of patients waiting over 18 weeks for First OPA to minimum 71.7%

Access to Cancer Care

- Achieve 80.2% of patients receiving a cancer diagnosis within 28 days
- 75.3% of patients receiving treatment within 62 day

Urgent and Emergency Care

- Increase performance against the 4 hour standard to 78%
- Reduce the proportion of patients spending longer than 12 hours in the ED to 4.9%

Diagnostic waiting times

- Reduce patient waiting more than 6 weeks to 5%

Planning Assumptions

Delivery of the plan is predicated on a number of planning assumptions, some of which are reliant on system partners and collaboration across health, social care and primary care.

Elective Care	Non-elective Care
Delivery of Elective care performance improvements is reliant on; - System reduction in referrals and an increase in levels of Advice and Guidance to mitigate the current referral growth of 4.1% - Increased capacity through expansion of the Community Diagnostic Centre (CDC) and opening of the Sulis Orthopaedic Centre - Further improvements in productivity of around 6.7% - Improved validation of waiting lists	Delivery of the Non-elective plan is reliant on system responses to reduce; - ED attendances by 15,000 - No Criteria to Reside numbers by 60 patients to maximum of 40 Plus RUH absorbing; - 2.6% ED attendances through streaming and process redesign - 3.4% NEL growth through improved ward productivity and reduced LOS

What the plan delivers

Activity Plan

	Plan 25/26	Change to FOT
Outpatients	632,378	+58 per day
Day cases	39,865	+5 per day
Elective	4,738	+2 per day
A&E	104,665	+6 per day
Non-Elective	55,545	+9 per day
Diagnostics	173,036	+27 per day

Planning Assumptions

0.0% Elective Demand (currently 4.1%) System referral reduction & A&G at 5%

+2.6% ED Demand reduction -15,000 atts

+3.4% Demand NC2R 40 & LOS reduction ~ 0.4 days

Performance Plan

RTT 1st Appt	71.7%
RTT 18 weeks	67.7%
RTT 52 weeks	1.0%
Cancer 62 days	75.3%
Cancer 28 days	80.2%
4 hour	72% Type 1 / 78% Inc MIUs
12 hour	4.9%
Diagnostics	5.0%

Cash releasing savings

£29.7m
£25.3m + £4.4m Group

Financial position

Balanced plan

Pay savings

15.2m

Productivity

32.7m

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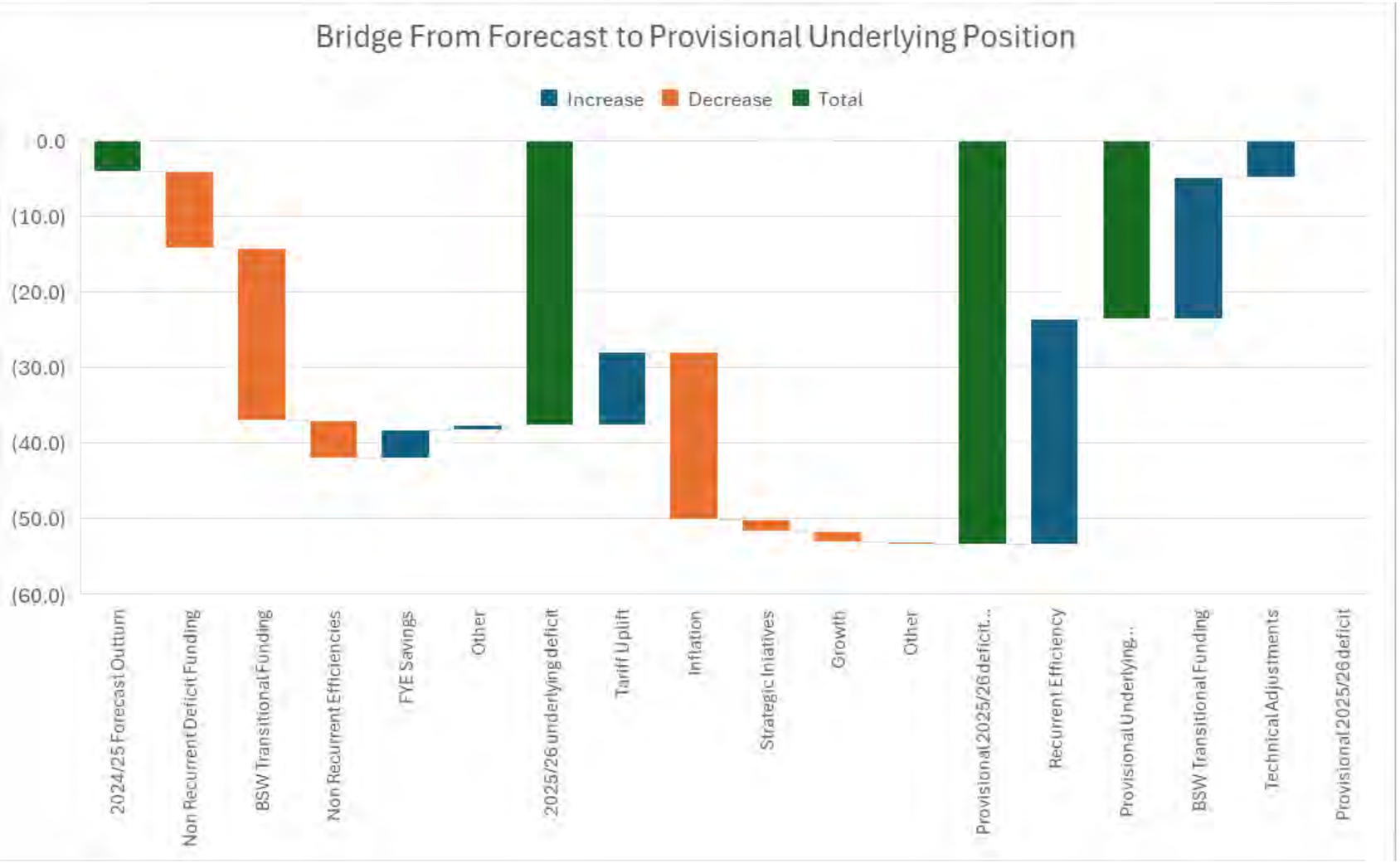
Financial Plan

The RUH, where you matter

2025/26 Bottom up bridge



- The graph outlines the key movements from the updated **£4.2m forecast** deficit position at March 2025 to the breakeven position.
- This is partly driven by increased requirements on non-recurrent deficit funding and the impact of the National Insurance change shown in inflation.

Financial Plan

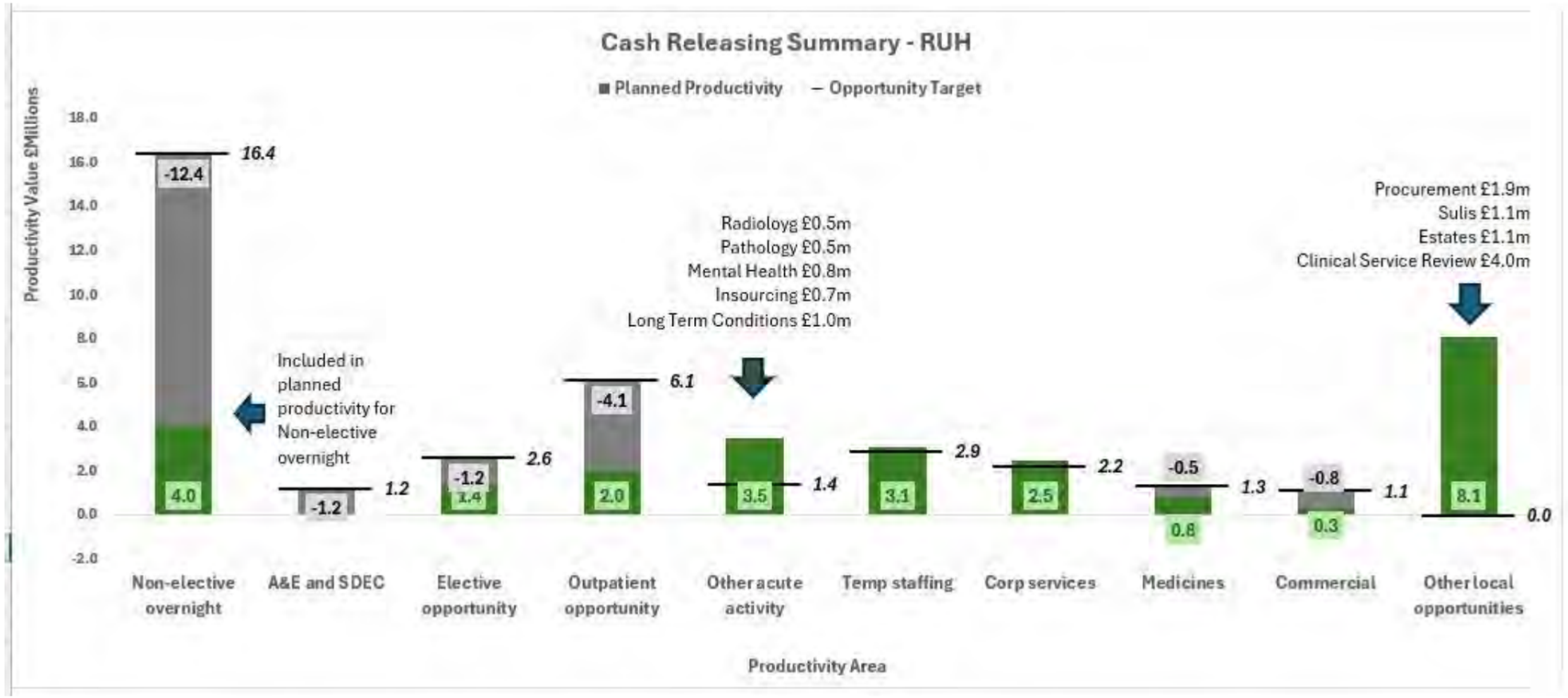
The RUH plan has a breakeven plan for 2025/26, of which £23.6m is a recurrent deficit. This is an improvement of the 2024/25 underlying recurrent deficit of £37.6m.

To support the breakeven position the Trust has received £18.8m of transitional funding and need to make £4.8m of technical adjustments.

£4.4m of the total savings target relate to the Groups savings target.

	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)

Savings Plan 2025/26



The national modelling indicates that there ia significant opportunity for **Non-cash releasing p**roductivity.

As part of our plan to deliver 6.7% productivity improvement, we have identified an opportunity of around £32.7m against the £35.2m total opportunity.

Of this figure, £25.3m is cash releasing plus £4.4m of opportunity at Group taking our total savings ask to £29.7m

Financial Plan – Risk Assessment

When assessing 2025/26, £49.5m of risks have been identified.

This Includes:

- Risk to financial delivery of 2024/25 and the recurrent impact in 2025/26
- Maintaining the delivery of ERF and changes to funding arrangements
- Non-elective and Emergency care being above plan
- Slippage on savings delivery, including the unidentified savings
- Ensuring utilisation of the Sulis Orthopaedic Centre (SOC)
- Growth of High-Cost Drugs and Devices
- Unfunded use of Weight Loss drugs

The mitigation of these risks relies on additional savings / funding.

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Workforce Plan

The RUH, where you matter

Workforce Plan

The plan requires a reduction in pay spend and associated workforce reductions will be achieved through a combination of:

- Corporate Services review (including admin and clerical review) and vacancy management.
- A 16.5% reduction of Bank staffing, aligned with corporate and divisional reviews, a reduction of bank shifts for non-clinical areas and improved absence management.
- A 28% reduction of Agency staffing achieved through a reduction in Medical Agency spend through recruitment of hard to recruit posts specialist medical posts, and increased efficiency of the use of specialist agency staff.
- Optimising the use of existing resources across the Organisation.

In support of this, we will continue to utilise workforce control measures through the Vacancy Control and Review VCARP) process. We will continue to collaborate closely with divisions and staff group leads to conduct regular forecasting enabling proactive planning and positive future outcomes.

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Productivity Opportunities

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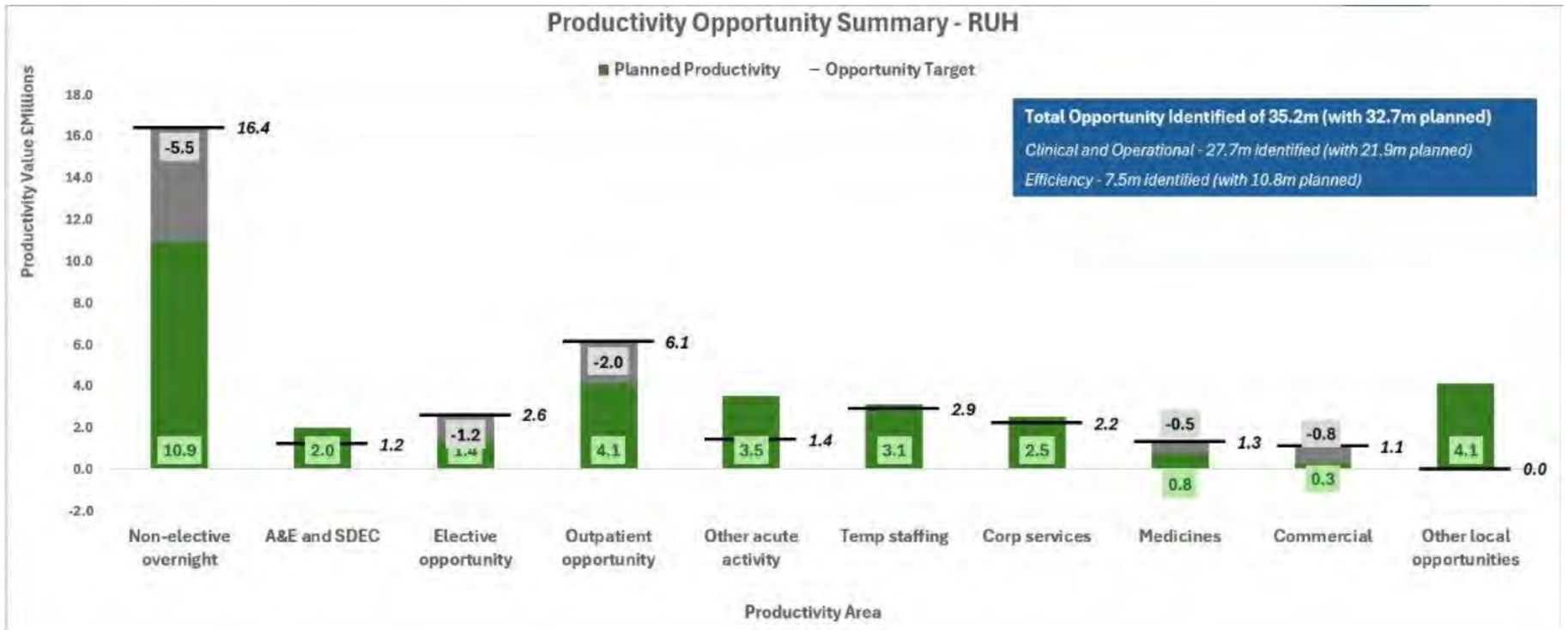
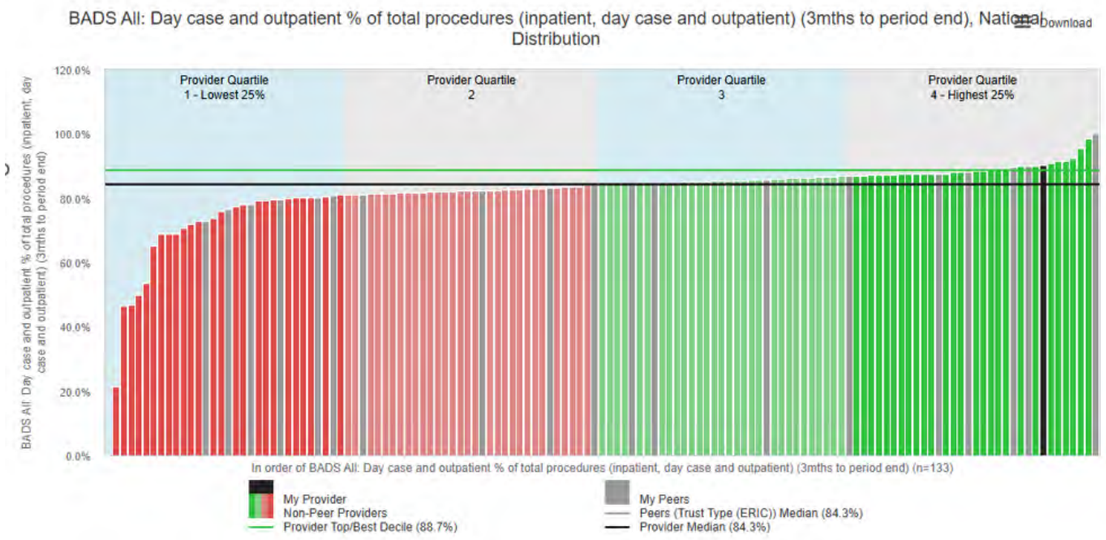
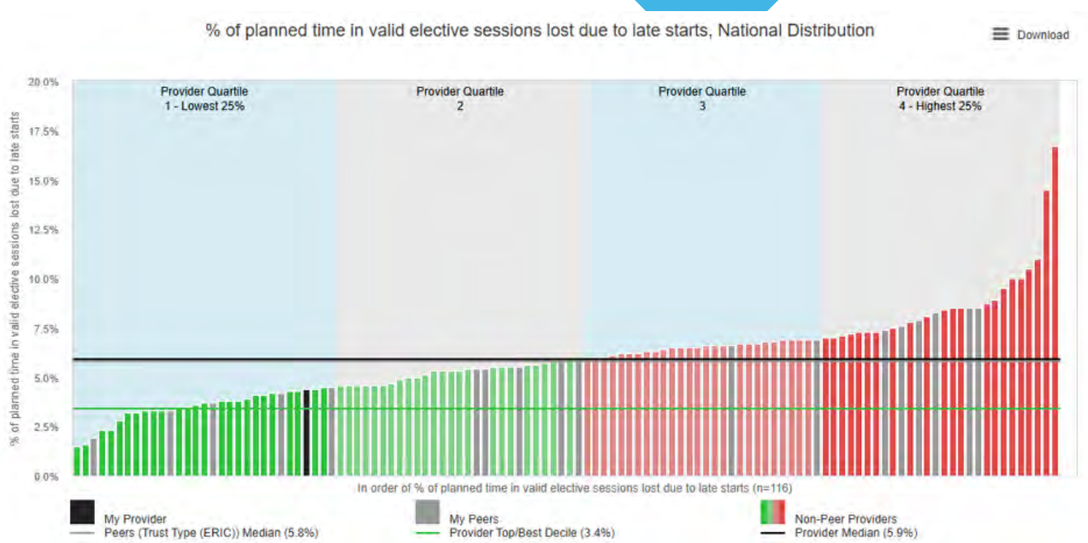
Productivity Benchmarking

- NHS England published a Productivity & Efficiencies Tool to support identification of areas for productivity opportunity.
- The tool identified £35m of opportunity (comprising cash and non-cash releasing opportunities).
- We have assumed a high level of success in realising these to underpin both our performance trajectory and £29.7m cash releasing savings plan.

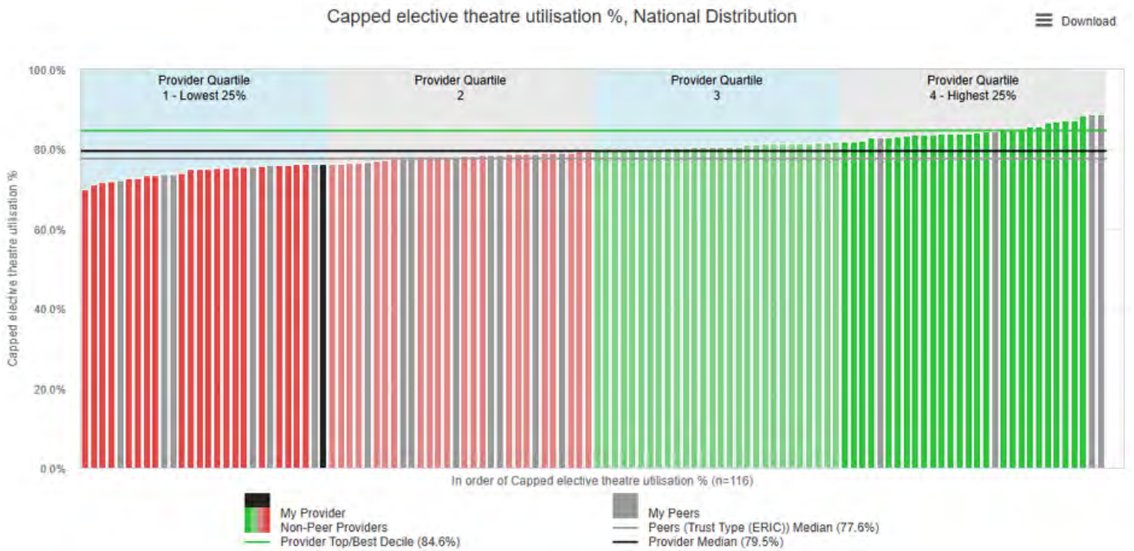


Theatre Productivity





The RUH performs in the top quartile for Day case and Outpatient procedure rates and Percentage of time lost due to late starts but is currently in the lowest quartile for Capped elective theatre utilisation indicating that this a potential opportunity for productivity improvements in the coming year.



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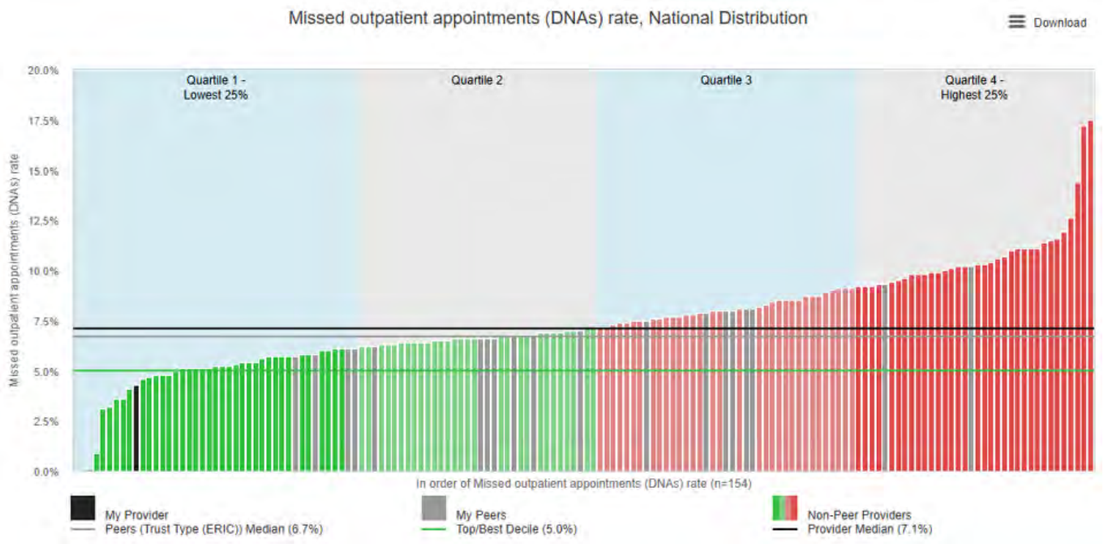
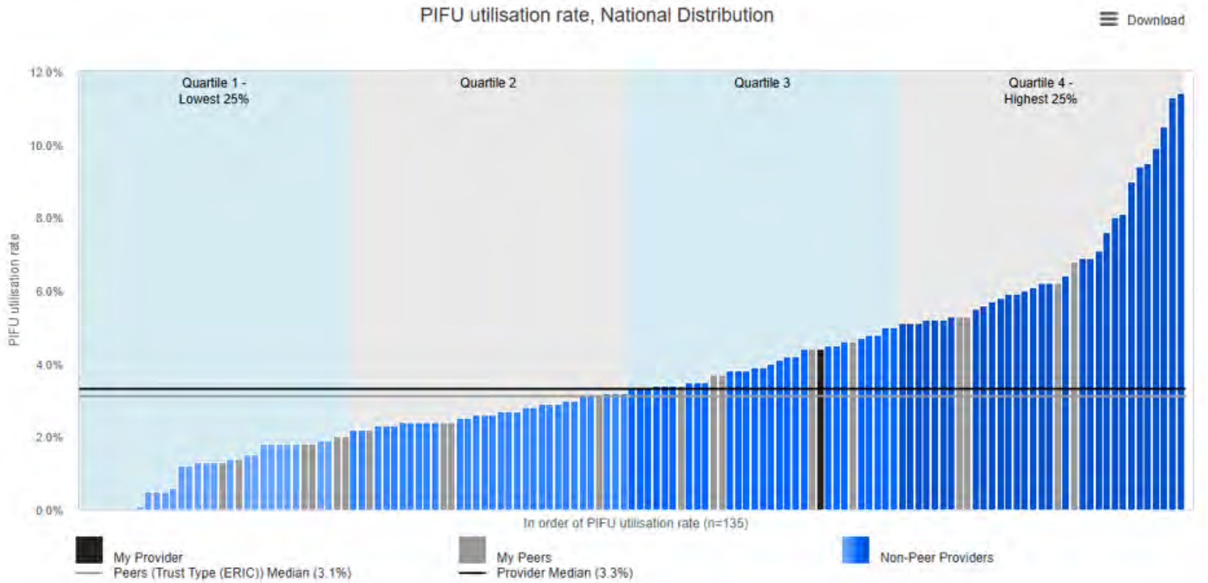
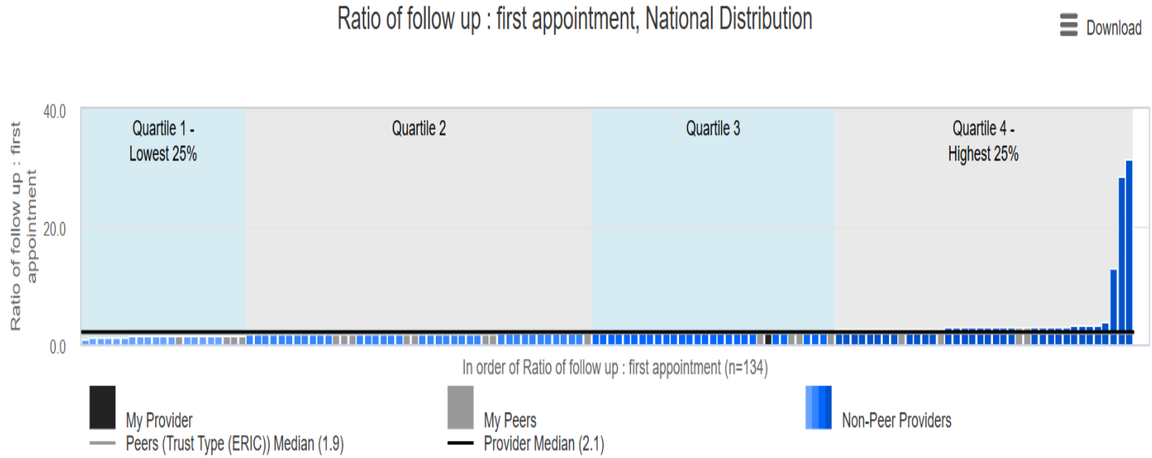
Outpatient Productivity



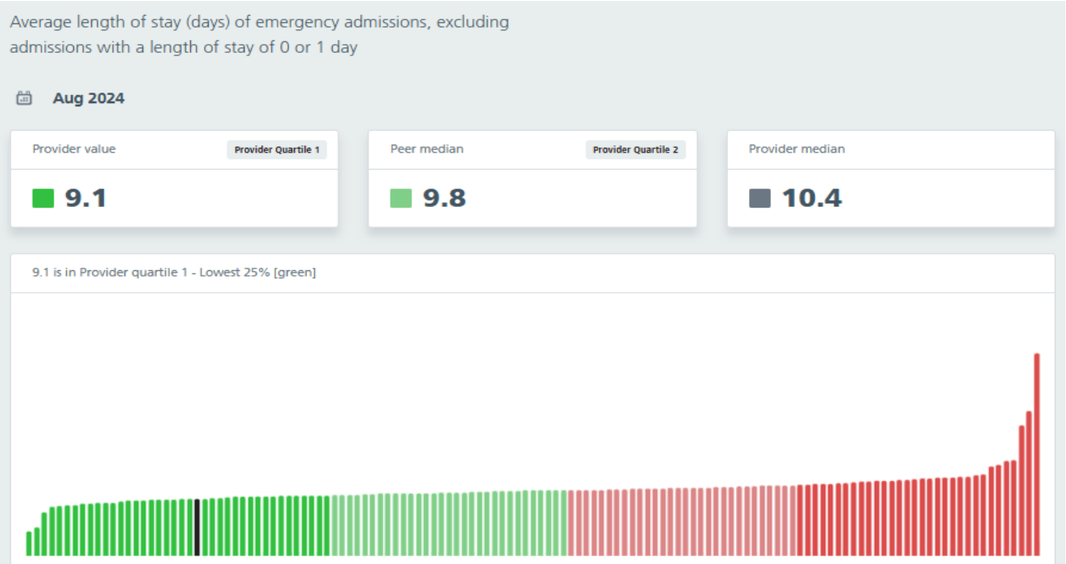


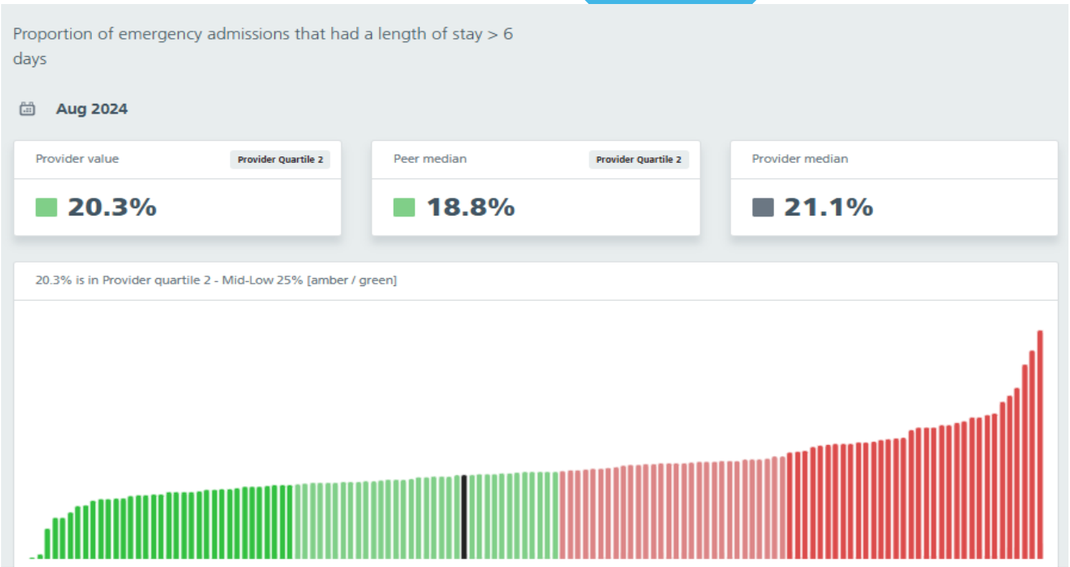
The RUH is in the top quartile for Missed outpatient Appointments (Did not attend rates) but in Quartile 3 for Patient Initiated Follow Up (PIFU) rates and Ratio of first appointments to follow up.

Both are areas of potential opportunity for productivity improvements in the coming year.



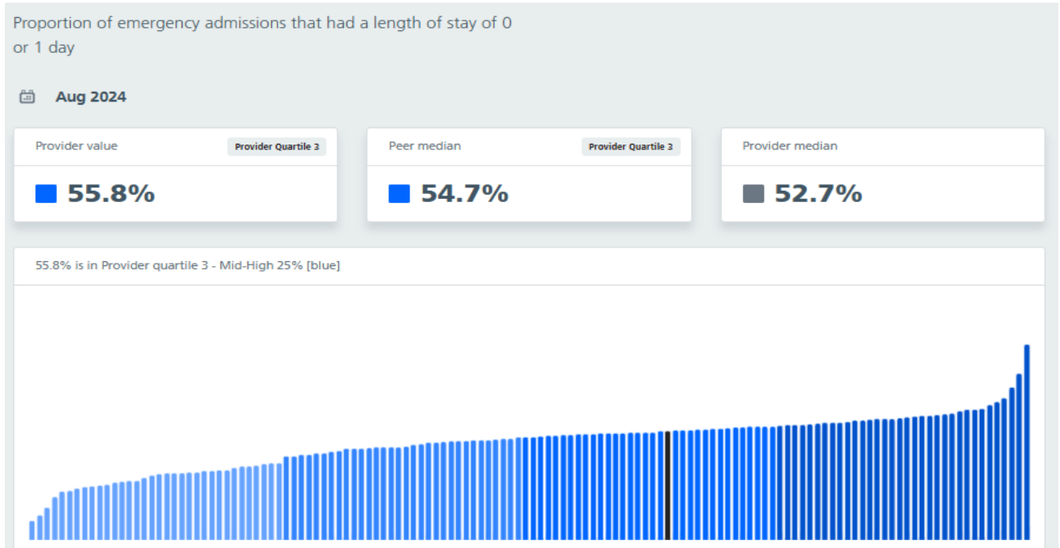
Non-Elective Productivity





Although the RUH performs in the top quartile for average length of stay of emergency admissions (excluding admissions with a length of stay of 0 or 1 day), the proportion of emergency admissions that had a length of stay of 0 or 1 day is in the third quartile, indicating a potential improvement is available in this area.

Additionally, the proportion of emergency admissions with a LoS greater than six days is in the second quartile, highlighting a further potential opportunity.



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Quality & Safety

The RUH, where you matter

Quality & Safety Focus

The quality and safety of care provided to our patients remains a key focus throughout the business plan. Priority areas for improvement this year include;

Improving Patient Safety and Quality	• Patient safety culture improvement work plan developed • Streamlined event report, triaging of all patient safety incidents and feedback to those involved • Demonstrating improvement to staff as a result of reporting events ensuring every learning response has an agreed quality improvement measure where indicated which is clearly linked to the relevant QI workstream • Ensuring the involvement of clinical teams across the Trust in developing learning and improvement, ensuring a restorative approach • Compassionate engagement and involvement by staff with patients, their families and carers in our response to patient safety events
Developing our Framework for Carers	• We will undertake a review of how we currently support our carers • Design a series of actions to improve the experience that carers have at the RUH • We will revise our Carer website for our patients, carers and staff and raise the profile of carer experience in the Trust
Improve Patient Experience through Effective Communication	• Provide more support to help staff communicate with people who need help with communication • Work to improve how quickly we respond to patients, their families and carers • Improve the provision of information to patients, their families and carers

Strategic Initiatives (3-5 years)

Implementation and Embedding the Patient Safety Incident Response Framework

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Planning Risks

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Business Plan Risks

Workforce

- Requirement to maintain vacancies held this year and deliver further cost reduction of £15.2m on top of this
- Further decrease in the percentage of staff recommending RUH as a place to work and impact on staff feeling valued by the organisation
- Negatively impact our sickness levels along with other KPIs (appraisals, turnover, vacancy etc)

Performance

- 3% reduction in NEL growth is reliant on admission avoidance and NC2R reductions by community partners
- 0% growth vs 4.1% referral growth, reliant on reduction in GP referrals and increased use of Advice & Guidance
- Waiting times will increase with risk to delivery of performance targets
- Non-elective improvements require partner support for a significant reduction in demand and NCTR – clarity on detailed plans required to provide confidence of delivery

Quality

- Impact on patient experience if waiting list grows
- Impact on clinical care if decision taken to reduce or stop spending on some services and functions
- Increase in staff sickness and decrease is staff morale may impact quality of service provided

Finance

- £29.7m cash releasing savings for 2025/26 over and above this year plus £19.4m underlying deficit
- Plans rely on productivity at the top end of opportunities, demand management support from partners and changes to the way we provide services to enable cost reduction as well as maintain activity and performance
- Insufficient capital allocation to cover predicted costs for the year

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Public Board of Directors	Agenda item:	13
Date of Meeting:	2 July 2025		

Title of Report:	Revision to the structure of Trust Management Executive
Status:	For Approval
Board Sponsor:	Andy Hollowood, Interim Managing Director
Author(s):	Rhiannon Hills, Director of Transformation Roxy Milbourne, Interim Head of Corporate Governance Lisa Lewis, Head of Coach House
Appendices	Appendix 1: Management Executive Committee (MEC) Terms of Reference Appendix 2: Strategy Executive Forum (SEF) Terms of Reference, including draft work plan

1. Executive Summary of the Report

This paper sets out a proposal to separate the current Trust Management Executive (TME) responsibilities into two meetings, a Committee focusing on the Operational and Business aspects of the committee's remit and the other a Forum focusing on the Strategic elements of the committee's work programme.

It is also proposed to amend the membership of these two Committees to ensure we are making the most appropriate use of staff time whilst broaden participation to a wider cross section of the Trust's Senior Leadership into Strategic decision making.

Rationale for the proposed change

A key driver for this proposed change in governance structure is in response to feedback that the current TME has an overloaded agenda with minimal time to have meaningful discussion on the pertinent topics and very little space for any longer term strategic discussion. This is coupled with the fact that the current structure does not provide an opportunity for Deputy directors and other members of the senior leadership team who are not members of TME to input into strategic discussions.

It is anticipated that by separating out the functions of TME into Business / Operational and Strategic focus, that this will;

- allow greater time for focussed and meaningful discussion for both operational and strategic business
- broaden participation for strategic discussion to more of the senior leadership team of the trust, thereby increase valuable contribution to our longer term planning
- improved communication across the Trust's senior leadership team.

The separation of functions will also provide a space to provide leadership and professional development so as to equip our senior leaders with the skills and mindset they need to lead in a complex and changing environment.

It is proposed to change the name these committees to the "Management Executive Committee (MEC)" and "Strategic Executive Forum (SEF)".

There is a risk that this new structure will increases the number of management hours committed to corporate meetings but it is proposed that whilst the membership of SEF will be expended, the membership of MEC will be reduced to a much smaller, core membership to support timely business decision making.

The expectation is that over time, this new format will speed up the business / operational function and enrich the strategic conversations thereby reducing the overall duplication of work and / or miscommunication across the organisation.

As this is a significant change to the current management structure, the change will be formally evaluated after six months to ensure that the changes have realised the benefits and met the objectives as set out above.

The weekly Executive Team Meeting (ETM) will return to its purpose as a team meeting and will therefore not have any executive powers delegated down from Board of Directors as these will sit with MEC and SEF. Any executive decisions would be directed via the Management Executive Committee or Strategic Executive Forum as set out in the Terms of reference of each.

The draft terms of reference are included in:
Appendix 1 – Management Executive Committee (**MEC)**
Appendix 2 – **Strategic Executive Forum** (**SEF)**.

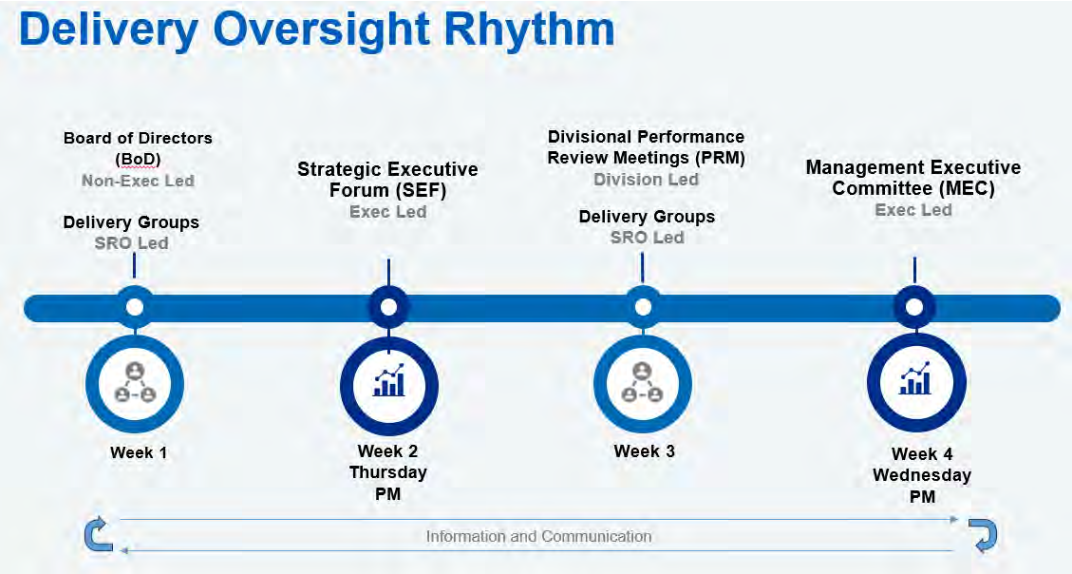
Appendix 2 also includes a draft annual work plan for SEF to provide an example of the topic areas that would be covered via this Committee. It will also provide a regular space to support leadership and professional development that promotes reflection, trust, strategic and creative thinking across the senior management level of the organisation.

To note: the decision making powers of MEC referred to in the TOR reflect our Standing Financial Instructions. As the Trust is currently in Special Measures, there are additional approval levels in place for any investment decision (Triple lock) which will need to be adhered to over and above the approval levels as set out in the TORs.

Meeting Rhythm
To align with the monthly reporting cycle of the Trust, it is proposed that MEC will remain on Wednesday PM in Week 4 of the month so that the Committee can make any required business and operational decisions on the most recent and up to date data available ahead of Board of Directors which takes place in Week 1.

It is proposed that SEF is held in Week 2 and moved to a Thursday PM to ensure that the Divisional Clinical Directors are able to attend as this aligns with their regular management day.

The illustration of the proposed new meeting rhythm and how the Committees link with the Delivery Groups, PRMs and Board of Directors for 2025-26 is shown below:



The TOR for the Committee & Forum and the work plan for the Strategic Executive Forum have been reviewed and signed off by Trust Management Executive (TME) for submission to Board of Directors for final approval.

2. Recommendations (Note, Approve, Discuss)

Board of Directors is asked to:

- **Approve** the recommendation from TME to separate the responsibilities of the Board sub-committee into two meetings, a Committee focusing on the Operational and Business aspects of the committee's remit and the other a Forum focusing on the Strategic elements of the committee's work programme.
- **Approve** the Terms of Reference for the Management Executive Committee and Strategic Executive Forum.

3. Legal / Regulatory Implications

The Committees are the most senior decision-making and operational committees of the Trust, its purpose being to develop Trust strategy and make management decisions on issues within the remit of the executive directors and to support individual executive directors to deliver their delegated responsibilities by providing a forum for briefing, exchange of information and resolution of issues.

The proposal to separate out strategic and operational oversight is intended to enhance and improve the remit of these Committees.

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

There is a risk that this new structure will increases the number of management hours committed to corporate meetings however, it is anticipated that any increase in management hours will be outweighed by the richness and focus of discussions to improve our longer term planning as well as to streamline the approval process for business and operational decisions.

5.	Resources Implications (Financial / staffing)

The proposal is that Strategic Executive Forum will not be formally minuted but any key decisions, recommendations and actions will be recorded whilst Management Executive Committee will continue to have formal minutes and actions recorded. This will reduce the administrative burden but retain oversight of the decision making remit of MEC.

6.	Equality and Diversity

None identified.

7.	References to previous reports / Next Steps

The Terms of Reference were last discussed at the Trust Management Executive meeting on 12 November 2020.

The proposal is that we would move to this new meeting structure from July 2025 and undertaken a formal evaluation in January / February 2026.

8.	Freedom of Information

Public Board

9.	Sustainability

The Trust is required to contribute to delivery of the BSW Medium Term Financial Plan (MTFP) which sets out the requirement of all organisations in the system to support a route back to financial breakeven. Considering our impact on environmental sustainability as well as our local population is an important part of our future plans.

By creating greater time and space for more of the senior leadership team of the trust to participate in strategic discussions and provide leadership and professional development to equip our senior leaders with the skills and mindset they need to lead in a complex and changing environment will enhance our contribution to our longer term planning.

10.	Digital

Digital transformation is a key enabler to support the transformational changes identified as part of our Trust Strategy. It is anticipated that digital transformation will form a key part of the strategic discussions and workplan for the Strategic Executive Forum.

Royal United Hospitals Bath
NHS Foundation Trust

DRAFT FOR APPROVAL

Management Executive Committee (MEC)
Terms of Reference

1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the **Management Executive Committee** (the Committee). The Committee is the executive and operational decision-making committee of the Trust. It has the powers specifically delegated in these Terms of Reference.

The **Management Executive Committee** is accountable to the Board of Directors through the Managing Director for the operational management of the Trust and delivery of objectives agreed by the Board.

2. Terms of Reference

a. Purpose

The Committee is the decision-making committee of the Trust, its purpose being to make management decisions on issues within the remit of the executive directors and to support individual executive directors to deliver their delegated responsibilities by providing a forum for briefing, exchange of information and resolution of issues.

It will ensure timely clinical and operational decision making and risk mitigation processes in delivering the Trust's objectives through the operating plans and strategy.

The Committee will promote and embed the Trust's You Matter Strategy, with Improving Together as a key enabler.

The Management Executive Committee is accountable to the Board of Directors through the Managing Director for the coordination and operational management of the system of internal control and for the delivery of the objectives set by the Board of Directors.

It is the formal mechanism for supporting the Managing Director in effectively discharging their responsibilities as Accounting Officer. The Managing Director holds Trust level responsibility for the daily management of the Trust.

The Management Executive Committee will set appropriate frameworks, policies and procedures to support delivery of the organisational objectives. The Management Executive Committee will continually monitor and review all aspects of the operational performance of the Trust, including in relation to the quality of its services, workforce, finance, clinical and corporate governance and the management of risk, and it will put in place corrective measures where necessary.

The Management Executive Committee will champion the Improving Together methodology as the principal tool for embedding quality and service improvement across the Trust and will work in ways that reflect and embody the Trust's values.

The Management Executive Committee, in conjunction with the Strategic Executive Forum, will ensure that there is alignment between Strategic planning and Operational delivery with the ultimate aim of delivering the Trust's You Matter Strategy.

b. Objectives

The Management Executive Committee will be in two parts:

Part 1 – Engine Room

(i) Oversee the Trust's performance against breakthrough objectives
(ii) Oversee the Trust's Project Wall, ensuring that large-scale Corporate projects are delivered according to plan and enabling delivery of the breakthrough objectives

Part 2 – Management Executive Committee

The Management Executive Committee has delegated powers from the Board of Directors, via the Managing Director, to oversee the day-to-day management of all systems and functions across the whole organisation's activities (both clinical and non-clinical), which also supports the achievement of the organisation's objectives.

In particular the Management Executive Committee will:

Monitor Performance

(i) monitor the Trust's performance against key targets, quality and safety measures, business plans, actions arising from recommendations by CQC and other external bodies;

(ii) monitor performance against agreed operational priorities and other activities;

(iii) oversee actions arising from the integrated performance report and performance manage the delivery of those action plans;

(iv) oversee the delivery of QIPP within the Trust;

Approve Business Cases for new investments

(v) approve business cases for the filling of additional clinical posts over and above existing complements, taking account of the delegated resource responsibilities

and the Trust's corporate objectives ; (replacement of consultant posts with a like for like consultant on the same or fewer PA's, undertaking predominantly the same caseload will be approved via the Executive Performance Review Meetings);

(vi) approve business cases and service developments which require investment of £75,000 or above; (business cases of less than £75,000 will be approved by the Executive Performance Review Meetings);

(vii) scrutinise the capital programme ahead of Board of Directors' approval;

Monitor Risks

(viii) monitor the effectiveness of the management of significant risks as per the Strategic Framework for Risk Management, namely the Committee is responsible for;

- the final approval of all risks added to the Risk Register with a score of ≥ 16, to assess whether the scoring and proposed action plans are appropriate;
- the monthly review of all current risks on the Risk Register with a current score of ≥ 16, monitoring progress against the action plan agreed to mitigate the risk, or identifying actions necessary to achieve completion of the action plan;
- the monthly notification of all Risk Register entries that remain unapproved after two months;

(ix) oversee the structures, processes and responsibilities for identifying and managing key risks facing the organisation, prior to discussion at the Board of Directors;

(x) scrutinise all risk-related disclosure statements, in particular the Annual Governance Statement, prior to approval by the Board of Directors;

Assess Policies and Procedures

(xi) assess the operational effectiveness of policies and procedures and provide final approval for updates to Trust policies and procedures;

(xii) scrutinise and comment on key performance and governance reports prior to submission to the Board of Directors to ensure their accuracy and quality;

Support our People

(xiii) ensure effective coordination and collaboration across the Trust's clinical and corporate divisions;

(xiv) ensure that the Trust meets both the letter and spirit of its obligations around equality, diversity and inclusion, and that these are central to its work;

General Duties

The Management Executive Committee will ensure that governance and assurance systems operate effectively and thereby underpin clinical care.

The Management Executive Committee will put in place and maintain effective systems to ensure safe, effective and timely care for all patients.

3. Membership

The Committee will meet monthly, with no less than ten meetings per year.
The Management Executive Committee will be in two parts, with different membership for each part, comprised as follows:

Part 1 – Engine Room (Week 4)

- Managing Director (Chair)
- Chief Medical Officer
- Chief Operating Officer
- Chief Strategic Officer
- Chief Financial Officer
- Chief Nursing Officer
- Chief People Officer
- Chief of Staff
- Clinical Responsible Officers (CROs) of Delivery Groups
- Senior Responsible Officers (SROs) of Delivery Groups
- Divisional Representation *
    - Divisional Directors
    - Divisional Directors of Operations
    - Divisional Directors of Nursing

    - Director of Midwifery
- Engine Room Facilitators

Part 2 – Management Executive Committee

- Managing Director (Chair)
- Chief Medical Officer
- Chief Operating Officer
- Chief Strategic Officer
- Chief Financial Officer
- Chief Nursing Officer
- Chief People Officer
- Chief of Staff
- Divisional Representation *
    - Divisional Directors
    - Divisional Directors of Operations
    - Divisional Directors of Nursing
    - Director of Midwifery

* To ensure the best use of Divisional Leadership time, a minimum of one (1) representative from each Division can attend, providing there is representation from each function within the triumvirate e.g. one Divisional Director, one (1) Divisional Director of Operations and one Divisional Director for Nursing / Midwifery as a minimum.

The Head of Communications will be invited to attend meetings as an observer.

Whilst the Group Chief Executive is not a substantive member of the Committee, they may attend any/all meetings as they decide.

3.1 Quorum

Monthly: A quorum is one third of the members which must include at least two (2) Executive Directors and at least one (1) representative from each Division & at least one (1) representative from each Triumvirate role (see above).

In the absence of the Managing Director, another nominated Executive Director will Chair.

3.2 Attendance by Members

If an Executive Director member is unable to attend a meeting, they can nominate a deputy (if an appropriate deputy is available) to attend the meeting in their place.

This will not be necessary in the case of Divisional members, provided that at least one member from that Division is in attendance.

3.3 Attendance by Officers

The Executive Management Committee may call upon any employee to attend the Committee.

4. Frequency

The Management Executive Committee will normally meet monthly on the last Wednesday of each month. Other senior managers within the organisation may be called on to attend part of the meeting to present papers as the subject matter expert.

Papers for each meeting will be circulated no later than the Friday of the week before the next meeting.

5. Accountability and Reporting Arrangements

The Management Executive Committee will be accountable to the Board of Directors through the Managing Director. The Board of Directors will be informed of the Executive Management Committee's work through a no less-than-quarterly upward report to the Board of Directors.

The sub-committees and groups of the Management Executive Committee will provide regular reports of their activities to the Management Executive Committee using the Committee and Group Upward Reporting template. The Management Executive Committee will receive a report on current risks, as specified in the Strategic Framework for Risk Management, at each meeting.

There will be clear lines of communication between Management Executive Committee and Strategy Executive Forum to ensure information, discussion and decisions are shared between the two meetings.

6. Authority

The Management Executive Committee is authorised by the Board of Directors, through the Managing Director, to pursue/investigate any activity within its terms of Reference.

The Management Executive Committee has been established to oversee, coordinate, review and assess the effectiveness of operational activities within the Trust.

The Management Executive Committee is authorised to create sub-groups or working groups, as are necessary to fulfil its responsibilities within its terms of reference. However, the Management Executive Committee may not delegate executive powers and remains accountable for the work of any such group.

Any sub-groups or working groups will report directly and to an agreed schedule to the Management Executive Committee who will oversee their work.

7. Monitoring Effectiveness

The Management Executive Committee will undertake an annual review of its performance against its work plan and the Trust's Annual Plan in order to evaluate the achievement of its duties. This review will be received by the Board of Directors.

8. Other Matters

The Head of Corporate Governance is responsible for arranging the provision of administrative support to the Management Executive Committee including:

a. Agreement of the agenda with the Chair and attendees;
b. Collation of the papers;
c. Taking the minutes and keeping a record of the matters arising and issues to be carried forward; and
d. Advising the Management Executive Committee on pertinent issues around governance and procedure.

9. Review

These terms of reference will be reviewed at least annually as part of the monitoring effectiveness process.

Approved by the Board of Directors on TBC

Royal United Hospitals Bath
NHS Foundation Trust

DRAFT FOR APPROVAL

Strategic Executive Forum (SEF)

Terms of Reference

1. Constitution

The Board hereby resolves to establish a Sub-group of the Board to be known as the **Strategic Executive Forum** (the Forum). The Forum is the executive and strategic decision-making committee of the Trust. It has the powers specifically delegated in these Terms of Reference.

The **Strategic Executive Forum** is accountable to the Board of Directors through the Managing Director for the ongoing development of the Trust's Strategic Planning Framework and supporting strategies that contribute to the delivery of the Trust's You Matter Strategy.

2. Terms of Reference

a. Purpose

The Forum's purpose is to undertake strategic planning and strategic decision making on issues within the remit of the executive directors and to support individual executive directors in delivering their delegated responsibilities by providing a forum for briefing, exchange of information, development of strategic responses and contributing to the strategic direction of the organisation.

The Forum will promote and embed the Trust's You Matter Strategy, with Improving Together as a key enabler.

It will oversee the ongoing development of the Trust's Strategic Planning Framework (SPF), creating the space and time to discuss and debate areas of strategy development to ensure we are making informed and considered decisions on the direction of our Trust's strategy.

The Forum will oversee the development of the Strategic A3's and future priorities, development of the Annual Plan and support activities that form part of the annual planning cycle so that when proposals are presented to the Board of Directors for approval, they are robust in terms of meeting strategic and operational objectives, performance measures, investment priorities and affordability.

The Forum will champion the Improving Together methodology as the principal tool for embedding quality and service improvement across the Trust and will work in ways that reflect and embody the Trust's values.

The Strategic Executive Forum, in conjunction with the Management Executive Committee, will ensure that there is alignment between Strategic planning and Operational delivery with the ultimate aim of delivering the Trust's You Matter Strategy.

b. Objectives

The agenda for Strategic Executive Forum meetings will be structured to allow time for strategic thinking, discussion and debate of both current and future issues affecting the Trust and the wider local health and care economy. It will ensure a good balance between oversight of the Trust Strategy and annual plan and longer-term strategic development.

The Forum will also create a space to support leadership and professional development for the Trust's senior leadership team that promotes reflection, trust, strategic and creative thinking.

The Forum will be in two parts:

Part 1 – Engine Room

(i) oversee the Trust's Vision and Strategic Initiatives Wall within the Engine Room, ensuring visibility of progress against objectives.

(ii) monitor performance against agreed strategic priorities and other activities;

(iii) oversee the dependencies and risks that impact the delivery of the annual plan across the projects as specified on the Trust Project Wall.

(iv) oversee the Trust's Breakthrough Objectives and Project Wall, ensuring that large-scale corporate projects are filtered to prioritise them, have sufficient resource available and that progress towards delivery is monitored;

Part 2 – Strategy & Leadership section of the SEF

The Strategic Executive Forum will support:

Strategic Development

(v) participate in the annual refresh of the Strategic A3s across our three people groups; the people we care for, the people we work with and people in our community and make recommendations to the Board on our Breakthrough Objectives.

(vi) oversee the Trust's business planning cycle, ensuring key stakeholders are involved and activity plans across the workforce, finance, and activity are well coordinated and risks mitigated.

(vii) consider changes to the strategy's context and whether the strategy or delivery of the strategy needs to be adapted, including national developments and links to system groups.

(viii) horizon scan to proactively identify emerging trends, risks and opportunities.

(ix) take a key role in the development of the BSW Hospitals Group Strategy and related activities

Strategy Implementation

(x) ensure the maintenance of effective internal and external two-way communication flows, and that staff, patients, governors and all of the Trust stakeholders are kept up to date on all aspects its work, future developments and performance against its strategy and key objectives

(xi) Sign off the quarterly strategic updates before submission to the Board of Directors

Monitor Strategic Risks

(xii) Regularly review associated strategic risks identified on the Trust's Board Assurance Framework

Leadership and Professional Development

(xiii) Leadership and professional development that promotes reflection, trust, strategic and creative thinking across the senior management level of the organisation to equip our senior leaders with the skills and mindset they need to lead in a complex and changing environment.

3. Membership and Frequency

The Forum will meet monthly, with no less than ten meetings per year.
Membership will be the same for Part 1 – Engine Room and Part 2 – Strategy and Leadership and is as follows:

- Managing Director (Chair)
- Chief Medical Officer
- Chief Operating Officer
- Chief Strategic Officer
- Chief Financial Officer
- Chief Nursing Officer
- Chief People Officer
- Chief of Staff
- Clinical Responsible Officers (CROs) of Delivery Groups
- Senior Responsible Officers (SROs) of Delivery Groups
- Divisional Directors
- Divisional Directors of Operations
- Divisional Directors of Nursing
- Director of Midwifery
- Director of Transformation
- Director of Research & Innovation
- Deputy Chief Medical Officers
- Deputy Chief Operating Officer
- Deputy Chief Strategic Officer
- Deputy Chief Finance Officer
- Deputy Chief Nursing Officers
- Deputy Chief People Officer
- Deputy Director of Estates & Facilities
- Director of Site Operations
- Programme Director, Financial Improvement
- Chief Digital Officer
- Director of Pharmacy
- Hospital Director, Sulis Hospital
- Associate Director, Capability and Planning
- Associate Director, Culture Change
- Head of Strategy and Development
- Head of Strategic Projects
- Head of Communications
- Head of Corporate Governance
- Head of the Coach House
- Deputy Head of Corporate Governance
- Engine Room Facilitators

Commented [HT1]: question from Christopher - why are ADs members and not others?

Whilst the Group Chief Executive is not a substantive member of the Forum, they may attend any/all meetings as they decide.

Quorum

A quorum is one third of the members (minimum of 14 attendees) which must include at least three (3) Executive Directors, at least one (1) representative from each Division.

In the absence of the Managing Director, another nominated Executive Director will Chair.

Attendance by Members

The membership of the Strategic Executive Forum represents the senior leadership team of the Trust therefore, if a member is unable to attend a meeting, it will not be necessary to nominate a deputy providing the meeting is quorate.

Attendance by Officers

The Strategic Executive Forum may call upon any employee to attend the Forum.

4. Accountability and Reporting Arrangements

The Strategic Executive Forum will be accountable to the Board of Directors through the Managing Director. The Board of Directors will be informed of the Forum's work through a no-less-than-quarterly upward report to the Board of Directors. The sub-committees and groups of the Strategic Executive Forum will provide regular reports of their activities to the Forum using the reporting template.

There will be clear lines of communication between Strategic Executive Forum and Management Executive Committee to ensure information, discussion and decisions are shared between the two meetings.

5. Authority

The Strategic Executive Forum is authorised by the Board of Directors, through the Managing Director, to pursue/investigate any activity within its terms of Reference.

The Strategic Executive Forum has been established to oversee, coordinate, review and assess the effectiveness of strategic activities within the Trust.

The Strategic Executive Forum is authorised to create sub-groups or working groups, as are necessary to fulfil its responsibilities within its terms of reference. However, the Strategic Executive Committee may not delegate executive powers and remains accountable for the work of any such group.

Any sub-groups or working groups will report directly and to an agreed schedule to the Strategic Executive Forum who will oversee their work.

6. Monitoring Effectiveness

The Strategic Executive Forum will undertake an annual review of its performance against the strategic objectives in order to evaluate the achievement of its duties. This review will be received by the Board of Directors.

7. Other Matters

The Head of Strategy and Development and Associate Director, Culture Change are responsible for arranging the provision of administrative support to the Strategic Executive Forum including:

a. Agreement of the agenda with the Chair and attendees;
b. Collation of the materials to inform debate and discussion;
c. Record all key decisions, recommendations and actions and matters arising to inform future topics; and
d. Advising the Strategic Executive Forum on pertinent issues around governance and procedure.

8. Review

These terms of reference will be reviewed at least annually as part of the monitoring effectiveness process.

Approved by the Board of Directors on TBC

Royal United Hospitals Bath NHS Foundation Trust

Strategy Executive Forum Annual Work Plan (*draft*)

			July 2025	August 2025	September 2025	October 2025	November 2025	December 2025	January 2026	February 2026	March 2026	April 2026	May 2026	June 2026
	Dates 2025/26	Timings	10th	14th	11th									
Standing items	Engine Room - Breakthrough and Corporate Projects	13:00 – 14:00	√	√	√	√	√	√	No meeting	√	√	√	√	√
	Engine Room - Strategic Priorities Boards	2 slots 14:15 – 15:00	-	√ Q1	-	-	-	√ Q2		√ Q3	-	-	√ Q4	-
	Operational Planning		Winter Planning		Business Planning		Business Planning			Delivery Planning	Annual Plan			
	Strategic Planning		-		Strategic A3 refresh		Breakthrough objectives	Sunray Refresh		Objective Dialogue	-			
	Leadership Development	15:15 – 16:00	Leading through complex change		-		-			-	-			
	Topic Discussions		-		-	Digital - Art of the possible	-			-	Staff Survey Results		Freedom to Speak up report	R&D update

Report to:	Public Board of Directors	Agenda item No:	14
Date of Meeting:	2 July 2025		

Title of Report:	Maternity and Neonatal Safety Report Quarter 4
Board Sponsor:	Antonia Lynch, Chief Nursing Officer
Author(s):	Zita Martinez, Director of Midwifery Kerry Perkins, Patient Safety Lead Midwife
Appendices	Appendix 1: Transitional Care Pathway and ATAIN Audit Q4 2024/2025

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.

All stillbirths and neonatal deaths, during Q4 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.

The Royal United Hospitals Bath NHS Foundation Trust (RUH) Q4 rolling 12-month average stillbirth rate is 2.2 per 1000 births remaining below the reported national average of 3.3 per 1000 births (2022). The neonatal mortality 12-month rolling average is 0.98 per 1000 births, remaining below the reported national average for 2022 of 1.7 per 1000 births.

No births met criteria for referral to the Maternity and Neonatal Safety Investigations (MNSI) team hosted by the Care Quality Commission (CQC) in Q4. The service currently has one ongoing review with MNSI, which is proceeding at family request.

The service declared full compliance with Year 6 Safety Actions for the Maternity Incentive Scheme (MIS) with confirmation received that compliance has been met. Saving Babies Lives Care Bundle version 3 (SBL) forms Safety Action 6 of MIS and ongoing compliance is monitored via quarterly meetings with the Local Maternity & Neonatal System (LMNS).

The service remains compliant with the Avoiding Term Admissions into the Neonatal Unit (ATAIN) and transitional (TC) care pathway during Q4 (Appendix 1).

This report outlines the current service responses to insights from service users including the Maternity and Neonatal Voices partnership (MNVP) and Safety Intelligence data. Bladder care has been identified as a theme from incidents and family feedback; a quality improvement project is currently underway.

2. Recommendations (Note, Approve, Discuss)

The Board of Directors is asked to discuss and note the report.

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.)

In Q4 there was one new risk assessment presented, which were approved for the risk register:

Risk No	Domain of Risk	The Risk	
3013	Patient Safety Quality	There is a risk that maternity services are unable to deliver timely USS pathways because of USS capacity, demand, and workforce issues, which is likely to impact on patient care such as avoidable maternal and neonatal harm	12

Table 1. New risk, Q4 2024/25

Current open risks scoring >12 in Maternity and Neonates Q4 202/5 scoring:

Risk No	Domain of Risk	The Risk	
3013	Patient Safety & Quality	There is a risk that maternity services are unable to deliver timely USS pathways because of USS capacity, demand, and workforce issues, which is likely to impact on patient care such as avoidable maternal and neonatal harm	12
2950	Patient Safety & Quality	There is a risk neonatal patients will be cared for outside of BAPM guidelines by nursing staff who are not qualified in specialty (QIS)	12
2785	Patient Safety & Quality	As a result of the level of clinical pharmacist provision to the NNU, BAPM service quality standards are not being met	12
2717	Patient Safety & Quality	There is a risk that information sharing of father's information is not facilitated resulting in a safeguarding incident with potential harm to unborn/newborn babies	12

Table 2. Ongoing risks scoring >12 Q4 2024/25

All risks are managed as per the Trust Risk Management Policy

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 3 Maternity and Neonatal Safety Reports – Quality Assurance 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) including Saving Babies Liver Care Bundle V3 (SBL).

1. PERINATAL MORTALITY RATE

The following graphs 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.

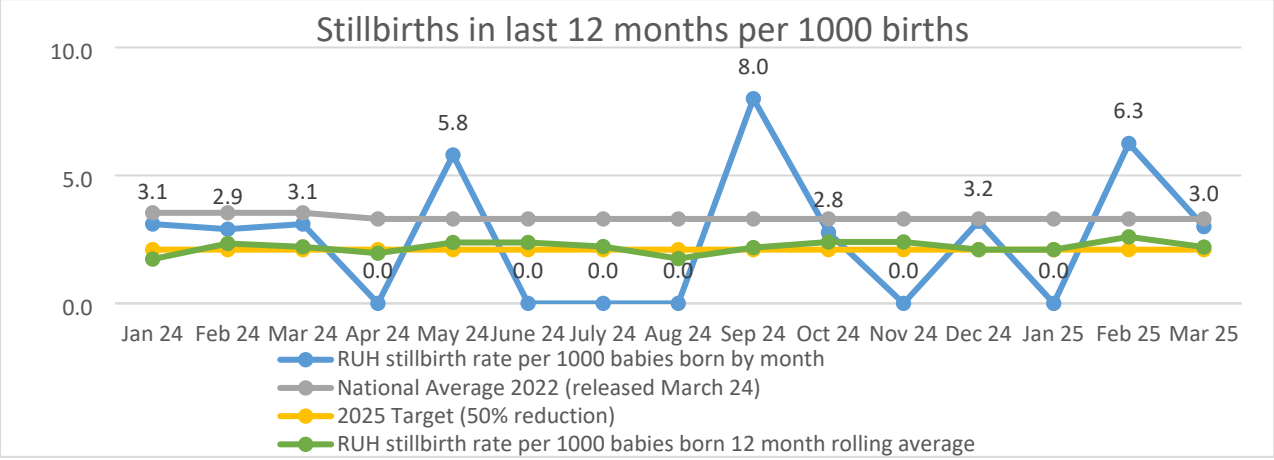


Figure 1. RUH NHS Trust stillbirth rate per 1000 births over last 12 months

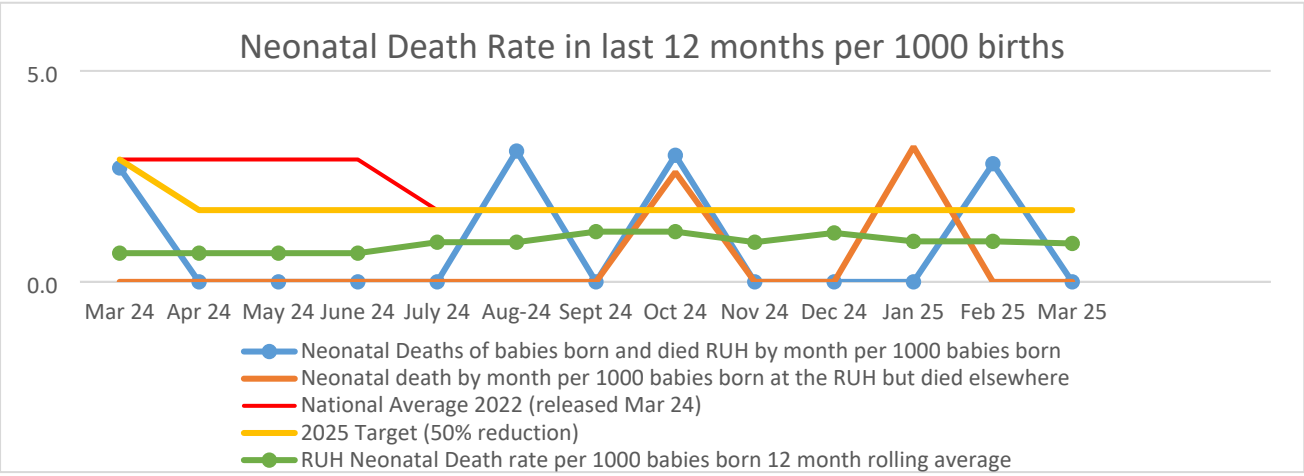


Figure 2. RUH NHS Trust Neonatal Death rate per 1000 births over last 12 months

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.

Three antenatal deaths were reported in Q4. This consisted of two stillbirths: one at 31 weeks of pregnancy and one at 37 weeks of pregnancy, and one late miscarriage at 23+5 weeks gestation. There were no neonatal deaths.

2024/25 (excluding terminations for abnormalities)	**Q4 24/25**	**Annual total 24/25**	**Annual total 2024 (calendar year)**
Stillbirths (>37 weeks)	1	5	5
Stillbirths(>24weeks-36+6weeks)	1	10	7
Late miscarriage (22+weeks-23+6weeks)	1	1	2
Neonatal death at the RUH	0	4	4
Neonatal death elsewhere following birth at the RUH	0	3	2
Total	**3**	**23**	**20**

Table 3. Perinatal Mortality summary by number of cases, quarter 4 2024/25

2. PERINATAL MORTALITY REVIEW TOOL (PMRT)

PMRT reporting is a requirement of Safety Action 1 of the NHS-R Maternity Incentive Scheme. All perinatal mortality incidents will be subject to an MDT team rapid review within 1 week of the incident to identify any immediate safety concerns or learning using the Patient Safety Incident Response Framework (PSIRF). All perinatal mortality incidents are then reviewed using the PMRT process during monthly MDT meetings. If the PMRT process identifies further concerns or learning opportunities, this is escalated to the patient safety team.

Initial findings during the PMRT process are subject to change following receipt of investigations such as placental histology or postmortem report. Family concerns/questions are discussed at the monthly PMRT meeting, and all families are offered support through a single point of contact during the review process. Families may choose to receive a draft

report pending further investigation results such as postmortem which can take considerable time to receive.

Standards for quarterly and annual PMRT compliance for MIS can be found in table 4.

2.1 PMRT PROCESS MEASURES

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	Q4 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 4. PMRT Process Measures Quarter 4 24/25.

2.2 Q4 2024/25 PMRT BIRTH DATA

Birth Data	
Cases for full PMRT review	2
Antenatal Stillbirth	2
Intrapartum stillbirth	0

Late fetal losses	0
Early neonatal death	0
Late neonatal death	0

Table 5. PMRT birth data Q4 24/25.

2.3 Q4 2024/25 PMRT REVIEWS PROVISIONAL GRADING

Case	Grading of care at provisional MDT review (pending further clinical investigation results)	
AN SB 37+1	Care of mother and baby up to point baby was confirmed as having died	A
	Care of mother following the confirmation of death of baby	A
AN SB 31+1	Care of mother and baby up to point of baby was confirmed as having died	A
	Care of mother following the confirmation of death of baby	B

Table 6. Q4 2024/25 provisional grading of care pending further clinical investigation results.

PMRT	Grading of care key
Grade A	No issues with care identified that would have impacted on the outcome
Grade B	Care issues which would have made no difference to the outcome
Grade C	Care issues which may have made a difference to the outcome
Grade D	Care issues which were likely to have made a difference to the outcome

Table 7. PMRT grading of care key

2.4 Q4 2024/25 PMRT INITIAL REVIEW LEARNING OPPORTUNITIES

No themes or commonalities have been identified from initial PMRT reviews in Q4 however one area for improvement has been identified with the following action.

Issue/area for improvement	Review Response/Action plan	Action target date
2 To review Baby View SOP's	To review Trust Baby View SOPs for private maternity scanning to ensure in line with national guidance	May 25

Table 8. Q4 2024/25 provisional review improvement plan.

2.5 Q4 2024/25 LEARNING FROM COMPLETED PMRT REVIEWS

One PMRT report was completed in Q4. Actions and learning opportunities were identified as follows.

Issue/area for improvement	Review Response/Action plan	Action target date
1. Triage advice line	Individual learning and reflection	May 25
2. Forget me not suite	User guides to be produced in relation to environment, specifically lighting	May 25
3. Communication	Individual learning and reflection and wider training	May 25
4. Communication and documentation	Include in learning meaningful individualised care following pregnancy loss	May 25

Table 9. Q4 2024/25 PMRT completed reviews improvement plan.

2.6 2024/25 OUTSTANDING REVIEWS AWAITING FINAL GRADING (EXCLUDING Q4)

Case	Provisional grading of care pending further clinical investigation results	
AN SB 37+1 Awaiting coronial PM	Care of mother and baby up to point of birth of baby	A
	Care of the baby from birth up to death of baby	A
	Care of mother following the death of baby	A
NND 28+6	Care of mother and baby up to point of birth of baby	B
	Care of the baby from birth up to death of baby	A
	Care of mother following the death of baby	A

Table 10. 2024/25 ongoing reviews pending further clinical results.

2.7 SAVING BABIES LIVES CARE BUNDLE 3

The Saving Babies Lives Care Bundle V3 (SBL) provides evidence-based best practice to achieve the national ambition to halve the rate of perinatal mortality by 2025 by driving innovation and quality improvement in key areas in maternity care. As part of the three-year delivery plan, providers are responsible for fully implementing all interventions for all 6 elements of SBL. All PMRT reviews are triangulated against SBL and improvements identified. Table 11 provides triangulation of care concerns against each element of SBL.

January	February	March
Number of perinatal mortality cases where smoking in pregnancy was a relevant issue (Element 1)		
0	0	0
Number of perinatal mortality cases where fetal growth: risk assessment, surveillance or management was an issue (Element 2)		
0	0	0
Number of perinatal mortality cases where raising awareness of reduced fetal movements was an issue (Element 3)		
0	1	1
Number of perinatal mortality cases where effective fetal monitoring during labour was an issue (Element 4)		

0	0	0
Number of perinatal mortality cases annually where the prevention, prediction, preparation, or perinatal optimisation of preterm birth was relevant issue (Element 5)		
0	0	0
Number of perinatal mortality cases annually where the management of diabetes was an issue (Element 6)		
0	0	0

Table 11: Q4 2024/25 PMRT care concerns triangulated against SBL elements.

Although there were two stillbirths in Q4 where reduced fetal movements was a factor (SBL element 3), there were no care concerns identified that would have changed the outcomes.

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

3.1 INVESTIGATION PROGRESS UPDATE

No referrals were made in Q4. Table 12 summarises the ongoing MNSI review into Q4. The findings and recommendations of this review, 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 Q4					
MI-037619	Neonatal transfer to Tertiary Neonatal Unit for ongoing care and active therapeutic cooling, Normal	June 24 progressing at family request.	N/A	Yes 04/07/2024	Trust guidance in relation to antepartum haemorrhage in labour to be recognised as a risk factor and

	MRI post cooling.				escalated. CTG categorisation to align with NICE guidance. Support senior staff to complete contemporaneous records. Monitoring of maternal pulse and recognition of alarms. Placenta to be sent for histology.
Ongoing					
MI-038594	Neonatal transfer to Tertiary Neonatal Unit for ongoing care and active therapeutic cooling, Normal MRI post cooling.	Progressing at family request.	N/A	Yes 04/10/2024	
New Referrals					
None					

Table 12. MNSI referrals and ongoing investigations Q4 2024/2025

The completed MNSI report received in Q4 2024/25 made two safety recommendations pertaining to aligning Trust guidance with national guidance for the identification of antepartum haemorrhage in labour and concurrent obstetric review, and that the Trust CTG categorisation tool aligns with NICE to support staff with CTG assessment (a safety recommendation is made when the evidence indicates a change is needed to make care safer). Both recommendations had been identified at local MDT review and actioned, and progress on actions will be monitored via Maternity and Neonatal Specialty Governance.

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 Q4 and no new PSII's declared. One PSII is currently in draft with immediate learning from rapid review identified.

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 including Adherence to Neonatal Transitional Care Pathway, Use of Birmingham Symptom-specific Obstetric Triage System (BSOTS), Continuity of Care and Maternal Health and Impact on Neonatal Outcome.	PMRT/MBRRACE/ Coroners/CDOP	Yes 15/10/2024

Table 13. Maternity and Neonatal Patient Safety Incident Investigations Q4

There were no recurrent incidents during Q4 of moderate harm or above.

4. TRUST CLAIMS SCORECARD – OBSTETRICS

The Trust's latest scorecard correlates open and closed claims managed by the Trust legal team during 2024. The legal claims span a time frame from 2014-2024. The latest trust claim incident was in 2022. Obstetrics accounts for around 16% of claims made to the Trust but represents 65% of the value of Trust claims. The scorecard (tables 14 to 17), outlines the top five injuries and top five causes resulting in legal claims because of care.

Claims by value:

Top 5 causes by value for Obstetrics

					% of Specialty	
	Causes	Volume	Value	Ave Claim Value	Volume	Value
1	Fail / Delay Treatment	9	33,138,931	3,682,103	20%	30%
2	Fail To Monitor 2nd Stg Labour	3	28,645,682	9,548,561	7%	26%
3	Failure/Delay Diagnosis	7	15,312,439	2,187,491	15%	14%
4	Other	3	15,042,712	5,014,237	7%	14%
5	Fail To Monitor 1st Stg Labour	2	14,578,000	7,289,000	4%	13%
Total Top 5 causes by Volume for Obstetrics		**24**	**106,717,765**	**4,446,574**	**52%**	**96%**

Table 14. Claim by cause

Top 5 injuries by value for Obstetrics

					% of Specialty	
	Injury	Volume	Value	Ave Claim Value	Volume	Value
1	Cerebral Palsy	3	57,510,450	19,170,150	7%	52%
2	Brain Damage	2	28,940,000	14,470,000	4%	26%
3	Hypoxia	2	14,479,089	7,239,544	4%	13%
4	Meningitis	1	3,230,000	3,230,000	2%	3%
5	Erb's Palsy	1	1,350,000	1,350,000	2%	1%
Total Top 5 injuries by Volume for Obstetrics		**9**	**105,509,539**	**11,723,282**	**20%**	**95%**

Table 15. Claims by injury

Top 5 injuries by volume for Obstetrics

	Injury	Volume	Value	Ave Claim Value	% of Specialty Volume	% of Specialty Value
1	Unnecessary Pain	8	767,661	95,958	17%	1%
2	Psychiatric/Psychological Dmge	7	638,280	91,183	15%	1%
3	Adtnl/unnecessary Operation(s)	5	514,116	102,823	11%	0%
4	Stillborn	4	212,785	53,196	9%	0%
5	Cerebral Palsy	3	57,510,450	19,170,150	7%	52%
Total Top 5 injuries by Volume for Obstetrics		**27**	**59,643,292**	**2,209,011**	**59%**	**54%**

Table 16. Injuries by volume

Top 5 causes by volume for Obstetrics

	Causes	Volume	Value	Ave Claim Value	% of Specialty Volume	% of Specialty Value
1	Fail / Delay Treatment	9	33,138,931	3,682,103	20%	30%
2	Failure/Delay Diagnosis	7	15,312,439	2,187,491	15%	14%
3	Fail To Recog. Complication Of	3	241,630	80,543	7%	0%
4	Intra-Op Problems	3	755,284	251,761	7%	1%
5	Fail To Monitor 2nd Stg Labour	3	28,645,682	9,548,561	7%	26%
Total Top 5 causes by Volume for Obstetrics		**25**	**78,093,967**	**3,123,759**	**54%**	**71%**

Table 17. Claims by volume

Table 18 outlines the current position of completed claims during 2014-2024, including distribution of closed cases for which no damages were paid (40%) and those where damages were paid (60%) and total monies paid.

Claim Outcomes (Incidents Excluded)

	Volume	Value	Ave Total Value	%
Closed - Nil Damages	10	358,770	35,877	40%
Settled - Damages Paid	14	1,919,521	137,109	56%
Periodical Payments	1	28,570,450	28,570,450	4%
Total	**25**	**30,848,742**	**1,233,950**	

Table 18. Claim outcomes

Of the damages paid identifying issues with care and areas for improvement the leading causes for claims by volume were:

- Retained products of Conception +/- Major Obstetric Hemorrhage (n=5)
  (unnecessary pain, unnecessary operation, fail/delay treatment, psychological damage)
- Bladder Injury - all at CS births (n=4)
  (Fail/delay treatment, psychological damage)
- Traumatic birth (n=3)
  (Bowel damage/dysfunction, fail/delay treatment)
- Baby born in poor condition (n=3)
  (Cerebral palsy, Fail/delay treatment, brain damage, psychological/physiological damage).

5. LEARNING AND IMPROVEMENT FROM PMRT, FEEDBACK, MNSI & CLAIMS

Triangulation of feedback has identified the following themes:

- Bladder care
- Informed consent
- Guideline management
- Medicine management (VTE)

Bladder care and informed consent are priorities that were set in 2024/25 following the annual Insights report with ongoing QI projects that are monitored through governance. A thematic review of medicine management relegating to venous thromboembolism is underway and guideline updates are monitored through governance.

There are several ongoing quality improvement projects relating to themes identified which are monitored through Governance quarterly.

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).

6. RUH SINGLE MATERNITY AND NEONATAL IMPROVEMENT PLAN

6.1 THREE YEAR DELIVERY PLAN UPDATE- Q4 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	11	2	5	0	18	61.1
2- Workforce	52	12	8	0	72	72.2
3- Culture and Leadership	45	5	5	0	49	91.8
4- Standards	20	7	2	0	29	69.0
Total	**128**	**19**	**20**	**0**	**159**	**80.5**

Table 19. RUH compliance with open actions towards the 3-year delivery Plan Q4 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 79.9% in Q3 to 80.5% in Q4.

The compliance for the individual report action plans can be extracted from within the plan.

Progress towards full implementation is outlined within Table 19; 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.

7. OCKENDEN FINAL REPORT UPDATE – Q4 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 Internal Performance Review (IPR) presentation every month. The service is currently reviewing this and will present a close report in Q1 to governance.

8. TRAINING COMPLIANCE FOR ALL STAFF GROUPS IN MATERNITY RELATED TO THE CORE COMPETENCY FRAMEWORK

8.1 Q4 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 3.

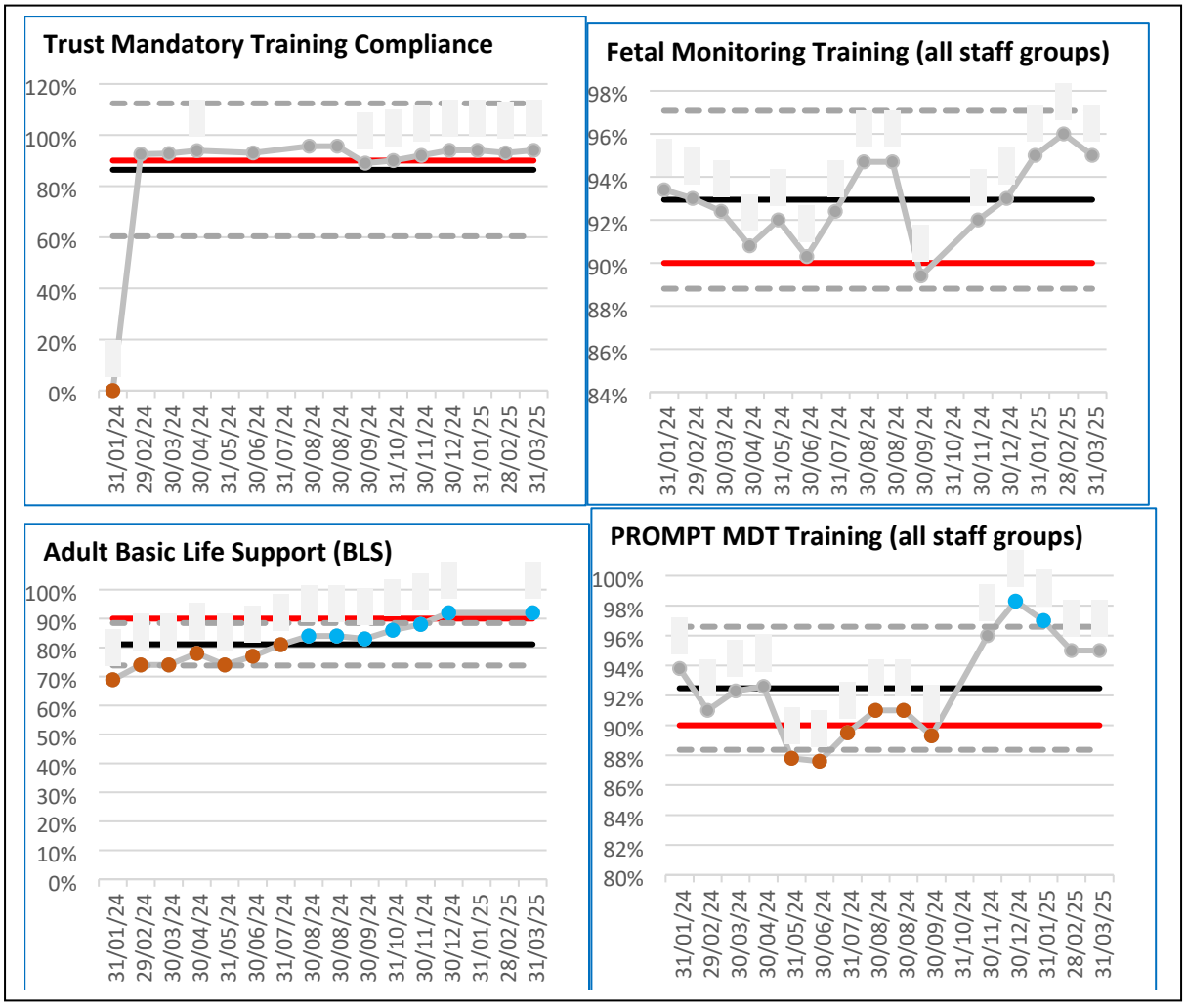


Figure 3. Maternity Training Statistical Process Charts for PROMPT, Fetal Monitoring, Mandatory Training compliance and Adult Basic Life Support compliance, as of 31/03/2025

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 Q4 the service achieved compliance for PROMPT at 96% and Fetal Wellbeing at 96% (target 90%) detailed as per table 20 with compliance met for MIS.

Staff Group	Training programme			
	PROMPT (NBLS inclusive)		Saving Babies Lives Study Day	
	March Compliance	Projected Compliance April	March Compliance	Projected Compliance April
Midwives (N=260)	96.5%	98.1%	97.2%	97.6%
Maternity Support Workers (N=75)	96.4%	97.6%	Not Applicable	
Consultant Obstetricians (N=11)	100%	100%	75%	100%
Obstetric Registrars (N=13)	93.8%	93.8%	87.5%	81.3%
Other obstetric doctors (N=12)	66.7%	75%	Non applicable	
Other obstetric doctors on the specialty trainee programme for obstetrics (N=4)			100%	100%
Anaesthetists (N=40)	97%	100%	Not Applicable	
Overall, across all staff groups	95.7%	97.1%	95.7%	96.1%

Table 20. RUH compliance with mandatory training requirements and compliance for MIS reporting

The compliance with obstetric doctors is a result or a change in rota and is a known issue. This is mitigated by doctors being booked onto the next available training with compliance relying on attendance on the booked training day.

9. BOARD LEVEL SAFETY CHAMPIONS

The Maternity and Neonatal Safety Champions are active in their role to listen to the staff and gain service user feedback in maternity and neonatal services. All staff are invited to attend monthly 'listening event' meetings and interact with Safety Champions during their monthly 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 Q4 were:

- Positive feedback for nurture clinics

- Lack of available car parking, particularly for late shift workers
- Unavailability of blood pressure (BP) machines in community that are validated for use in pregnancy
- Concerns around the staffing model for Hello Baby sessions and high DNA rates.

Current work to address the concerns raised:

- Business manager expediting order of BP machines
- Director of Midwifery to discuss Hello Baby sessions
- Deputy Director of Estates reviewing car parking Trust wide.

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.

10. NHS RESOLUTION MATERNITY INCENTIVE SCHEME UPDATE Q4 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 is completed and shared within Maternity and Neonatal Speciality Governance meeting and Board Level Safety Champions monthly.

The service submitted a full compliance position for each of the 10 Safety Actions and their associated sub-requirements within MIS Year 6. Confirmation that compliance was achieved in Q4.

11. 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. Further review of the audit schedule is underway with an aim to meet stretch targets.

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 21. RUH Maternity position for implementation of Saving Babies Lives Care Bundle v3.

12. SAFE MATERNITY AND NEONATAL STAFFING

12.1 MIDWIFERY STAFFING

As of March 2025, the Band 5/6 Midwifery establishment vacancy rate has no substantive

vacancy however there are 8.16wte are on secondment, and 12.72wte 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. This means there is a fixed term vacancy of 11.6wte which is being held to allow for recruitment to existing students.

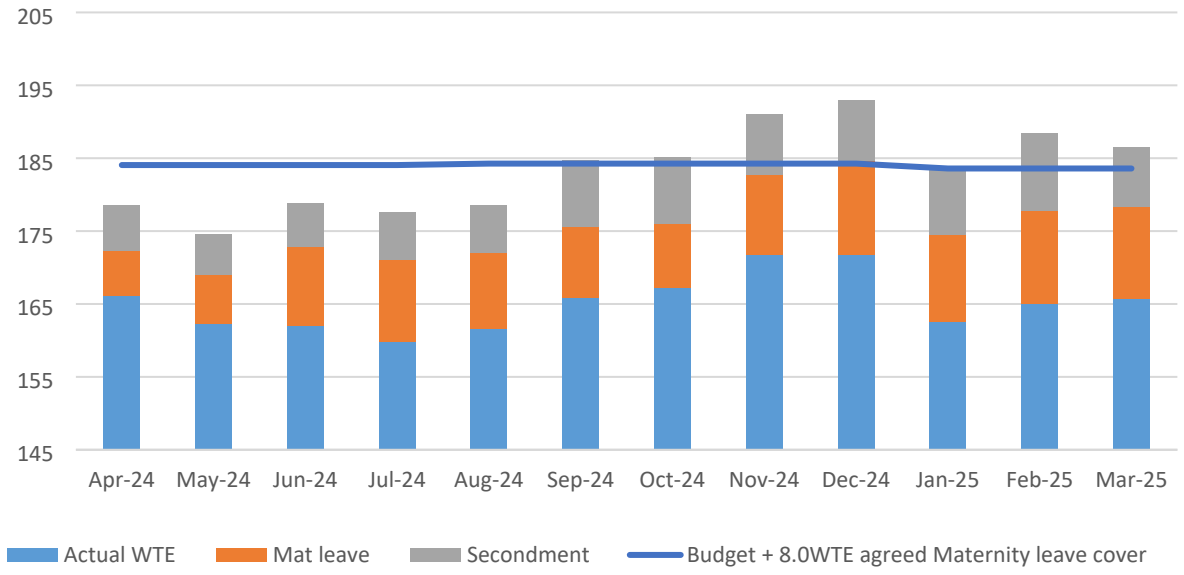


Figure 4. Band 5/6 Midwifery Workforce staffing vacancy and forecast (not including long-term sickness)

Table 22 outlines some of the key process and outcome measures during Q4 for the provision of safe staffing levels.

Measure	Aim	January	February	March
Midwife to birth ratio	1:24	1:28	1:26	1:26
Midwife to birth ratio including bank	1:24	1:27	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%	78	84	77

Table 22. Midwifery staffing safety measures

The midwife to birth ratio advised in the Birthrate+ report 2021 has been achieved during Q4 other than in January. Metrics that may influence this result were reviewed, however no reason could be identified, and the ratio has been stable in February and March 2025.

In March 2025 Birthrate Plus was reset to include updated staffing metrics and Red Flags to align with NICE following review with the maternity and Birthrate Plus teams.

13. OBSTETRIC STAFFING

Measure	Aim	January	February	March
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%
Anaesthetic staffing	<70%	100%	100%	100%

Table 23. Obstetric staffing safety measures

The service is compliant with BBC consultant presence and twice daily MDT ward rounds and has moved to exception reporting. This is monitored daily and if no ward round is completed due to activity and acuity an MS Teams forms is completed which initiates immediate escalation. Improvement work continues exploring enhancing consultant review and oversight for postnatal readmissions with planning underway to launch a quality improvement project to review all readmissions to postnatal ward. Compliance with anaesthetic staffing remains within the acceptable range.

14. NEONATAL NURSING STAFFING

MIS Safety Action 4 outlines the requirement to demonstrate compliance with meeting BAPM neonatal nursing standards. During 2024/25 the service has seen a decrease in the number of staff members within the Neonatal Unit (NNU) holding the qualified in speciality (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 there has resulted in a drop below BAPM target standard of 70%. In addition, the Southwest Operational Delivery Network (SWODN) contacted all providers to advise that only those nurses qualified in QIS who contributed to clinical shifts should be included in calculation resulting in a further drop in compliance. As a result, we are now confident that the figures in table 24 are a true reflection of compliance with BAPM and recommendations from the SWODN.

Measure	Aim	January	February	March
Percentage of nursing establishment who hold Qualified in Speciality (QIS) qualification.	>70%	60%	60%	60%
Percentage of Transitional care (TC) shifts with staff dedicated to TC care only	>90%	100%	100%	100%
Neonatal Nursing Vacancy rate (WTES)		2.59	1.46	1.86

Table 24. 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) have commenced a pilot course in association with Plymouth University with one nurse undertaking the course, in addition to four currently undertaking the qualification with the service expecting compliance >70% in 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 (Section 18). Ongoing funding for this is being discussed with the SWODN and considering available CPD monies.

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.	Complete
5.	One nurse allocated to funded place on pilot course on behalf of SWODN to commence Jan 25	Complete
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
8.	Additional skills and simulation training for existing staff	Ongoing

Table 25. QIS action plan

15. NEONATAL MEDICAL STAFFING

The service has maintained compliance with the BAPM standards for neonatal medical workforce across Q4 of 24/25 in line with Safety Action 4 of MIS.

Measure	Aim	January	February	March
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 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'	100%	100%	100%	100%
Tier 3 daytime compliance All consultants on-call for the unit have	100%	100%	100%	100%

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				
Tier 3 compliance No on-call rota should be more onerous than one in six		Compliant		

Table 26. Neonatal medical workforce compliance

Despite repeated advertising the ANNP vacancy, the Trust has not received any applicants. There is a shortage of qualified ANNPs and to mitigate this the service is planning to advertise for a trainee ANNP post using the fast track 12-month programme. Currently rota gaps are being prioritised negatively impacting on the ability for ANNPs to fulfil all four pillars of advance practice.

16. INSIGHTS FROM SERVICE USERS AND MATERNITY VOICES PARTNERSHIP CO-PRODUCTION

16.1 COMPLAINTS/COMPLIMENTS/PATIENT ADVICE AND LIAISON SERVICE/CONTACTS

	January	February	March
Number of formal compliments	3	3	4
Number of Patient Advice and Liaison Service (PALS) contacts/concerns	9	9	12
Number of formal complaints	1	1	2

Table 27. Complaints and compliments Q4 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 Q4, three formal complaints were 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 and is a focus for the Perinatal Leadership and Culture Programme (PCLP). This included an increase in senior leadership on Mary ward and implementation of an operational support midwife to support flow through the maternity service, including supporting staff breaks. Progress on the PCLP Quality Improvement project is monitored quarterly through speciality governance.

17. SERVICE ‘INSIGHTS’ SAFETY PRIORITIES UPDATE

All service feedback ‘insights’ received ‘in month’ are reviewed 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.

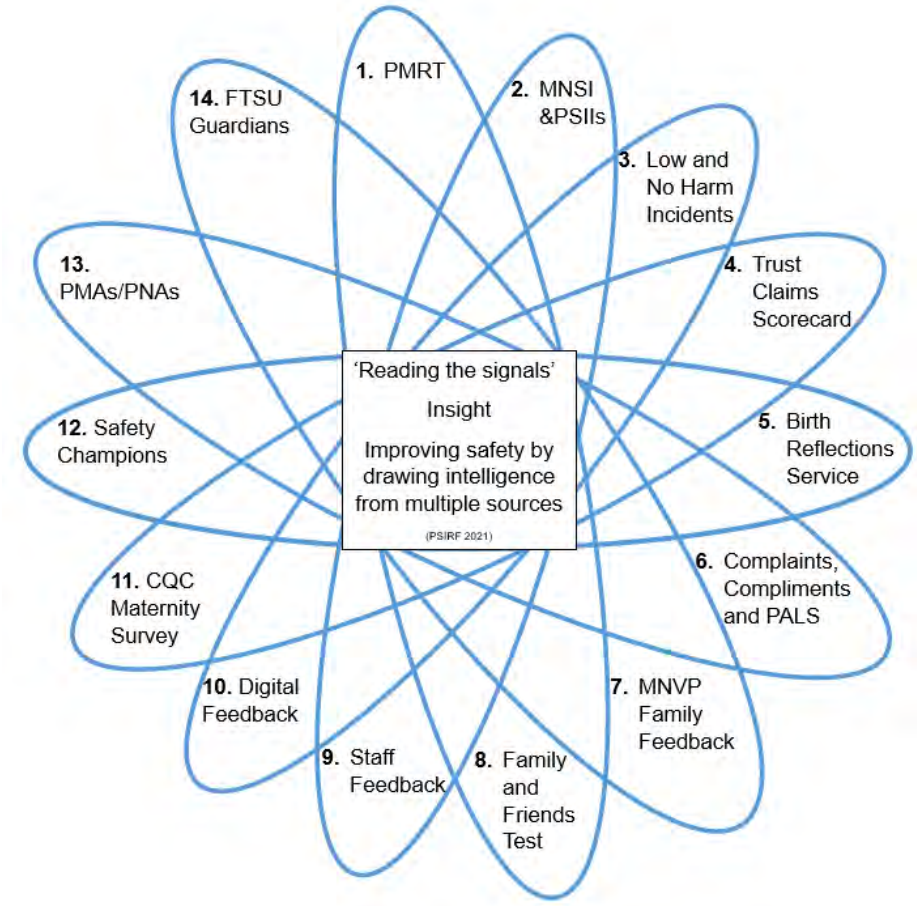


Figure 5. Sources of service 'Insight' analysed monthly via the Maternity and Neonatal Triangulation of feedback group.

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 2023/24.

1) Fetal Monitoring – Intermittent Auscultation

A national quality improvement project is underway called Listen2Baby of which the fetal monitoring lead midwife is involved alongside undertaking the RUH Quality, Service Improvement and Redesign (QSIR) course leading on a quality improvement project looking at how to improve the way intermittent auscultation is delivered. This will be monitored through Speciality and Divisional Governance and PRM with progress updates.

2) Information provision to ensure Informed Consent

A quality improvement project is being undertaken to improve information for families in the antenatal period. Focus groups and a social media survey have been undertaken and key positive themes and areas for improvement identified. An information leaflet is being coproduced with the maternity and neonatal voices partnership (MNVP) aimed at promoting conversations and providing information on areas for improvement. Virtual tours have been available for many years and are being updated to include interactive platforms and QR codes links to videos and additional resources are underway.

3) Improving patient experience in the immediate postnatal care provision

The RUH joined the Perinatal Culture and Leadership Programme (PCLP) in Autumn 2023 and with support from the quadrumvirate and perinatal culture coaches produced an improvement plan following culture conversations with a wide range of staff who work in the inpatient areas. 6 themes were identified and actions derived from further conversations which are monitored through governance (Appendix 2).

Improvement work into insight's triangulation to evaluate feedback from patient safety, families and staff linking with the Trust values is currently underway.

18. RISK REGISTER

There was one new risk added in Q4, all risks and emerging risks are monitored through Maternity and Neonatal Specialty Governance

Risk No	Title of Risk	
3013	There is a risk that USS service, provided jointly by maternity and radiology, does not have enough capacity	12

Table 28. New risk for the Maternity and Neonatal risk register Q4 2024/25

During Q3 2 risks were closed:

Risk No	Title of Risk	Rationale for closure	
2467	Maternity Workforce	Fully established to midwifery workforce	8
2681	Mandatory training room bookings	No episodes when mandatory training could not be facilitated	4

Table 29. Closed Risks for the Maternity and Neonatal risk register Q4 2024/25

Risk is monitored by the patient safety lead midwife and all risks rating >12 is reported monthly via Speciality 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
3013	There is a risk that USS service, provided jointly by maternity and radiology, does not have enough capacity	12
2950	There is a risk that due to the current compliance of 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	12

Table 30. Maternity and Neonatal Risk Register rating >12 March 2025

Moderate and low risks are monitored as per Trust Risk Management policy.

19. AVOIDING ADMISSION INTO THE NEONATAL UNIT (ATAIN) & TRANSITIONAL CARE

During Q4 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 transitional (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 possible avoidable admissions into the NNU in Q4, a reduction from four in Q3. Both cases identified decisions made during intrapartum care that may have impacted on the admission to NNU. Discharge home was facilitated on day two with no anticipated long-term impact for either baby. There were no commonalities identified between the two cases, individual learning and support was facilitated and wider learning shared via quality boards.

The leading causes for admission to TC remain the same as in Q3:

- Requirement for intravenous antibiotics 31%
- Requirement for 'Kaiser' observations for a risk of sepsis 25%
- Requirement for feeding support 11%

Q4 saw four babies admitted to the NNU from other areas within the RUH such as ED or Children's ward, a decrease of one from Q3. All admissions were appropriate although it is important to recognise that protection of vulnerable and immunosuppressed babies in the NNU must be a priority when readmitting babies from community settings. To mitigate there is a consultant-to-consultant decision and a draft guideline to support decision making which is being reviewed through governance.

20. PERINATAL CULTURE AND LEADERSHIP PROGRAMME

The Perinatal Culture and Leadership Programme (PCLP), 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 with 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.

Following training of four culture coaches and multidisciplinary culture conversations, and through triangulation of feedback and insights, the inpatient ward including antenatal, postnatal, and transitional care was chosen as the focus for the programme. An extensive action plan was derived from the themes identified which has previously been reported to the Board. A closure report will be featured in the Q1 report.

Progress on actions is monitored through speciality and divisional governance and includes an increase in senior leadership, implementation of operational midwife role, increase in midwifery staff to assist in high elective caesarean lists all of which has received positive feedback.

21. EQUITY AND EQUALITY

Better Births was released by NHSEI in 2021 with a priority to provide safer, more personalised, and more equitable care. This was followed by the Department of Health (DH) Core20plus5 Safer Maternity Care document. In response BSW published their Equity & Equality Strategy 2021/24 outlining areas of focus, Health Inequalities Quality Account Priority in 2023/24 and the Three-Year Delivery Plan in 2023/26 followed. The RUH benchmarked against the Core20Plus5, relaunching the Equity and Quality Group in November 2024. 4 key priorities were identified.

- Improving data quality and response
- Language and communication
- Access to both physical and digital care
- Staff Equity

The group identified the following aims.

- Align RUH workstream to LMNS Equity and Equality plan
- Greater focus on Equity and Equality improvements for staff
- Increased engagement and awareness from clinical leads in all areas
- MNVP involvement and co-production in all workstream
- Regular review and oversight of actions

Actions against each priority were set and are monitored through quarterly Governance updates. A risk assessment to facilitate entry to the risk register in line with the CQC action plan is also underway.

22. MATERNITY TRIAGE

The National review of maternity services in 2022 by the Care Quality Commission (CQC) identified significant variation for maternity triage with no national targets or standards. The Royal College of Obstetricians and Gynaecologist (RCOG) published the Good Practice paper on Maternity Triage in 2023 which recommended operational structure and pathways to support safe care of pregnant and newly postnatal women and people outside of scheduled appointments.

In response the RUH commenced a journey to implement the Birmingham Symptom specific Obstetric Triage System (BSOTS), a Trust wide quality improvement project requiring investment in estates and staffing culminating in the opening of the maternity triage unit in May 2024.

The service has commenced a review of the service to include call waiting times and abandonment, phone call quality, risk assessment, in person activity and BSOTS compliance including feedback from staff and families. Initial results have identified wait times for women who are triaged as green or amber who require a medical review. RCOG Triage guidance (2023) recommends all maternity triage services have a resident doctor in the maternity triage area ‘in hours’ which the RUH is not compliant with. Although there have been no safety issues identified, the quality of patient experience is an emerging theme due to wait times. In response an improvement plan has been produced which will be monitored quarterly via governance including completing a risk assessment to add to the risk register.

23. RECOMMENDATION

The Board of Directors is asked to discuss and approve the content of the report.

APPENDIX 1 Transitional Care Pathway and ATAIN Audit Q4 2024/2025

Clinical Audit Report

Appendix 1: Transitional Care Pathway and ATAIN Audit Q4 2024/2025

Speciality: RUH Local Neonatal Unit

Division: Family & Specialist Services Division

Project team				
Kirstie Flood	Title/grade:	Lead Nurse	Data period:	Q4 January 2025-March 2025
Sarah Goodwin	Title/grade:	Neonatal Governance Lead	Report completion:	April 2025

Royal United Hospitals Bath
NHS Foundation Trust

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. 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*.

**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 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 transitional care 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 transitional care activity, (regardless of place - which could be a Transitional Care (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's activity on a quarterly basis for sharing within Maternity and Neonatal Governance structures and the Board Level Safety Champion.
- To provide evidence and assurance of progression with the action plan for sharing with the neonatal maternity safety champion, and Board Level Champion, LMNS and ICB 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 January 2025	Compliance February 2025	Compliance March 2025	Year Totals average 2024/25
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 per TCP staffing model	**100%**	**100%**	**100%**	**100%**

% of shifts TCP nurse: baby ratio was above 1:4 as per recommendation.	**0%**	**0%**	**5%**	**1.5%**
% of days between 4-8 babies cared for on TCP	**23%**	**25%**	**45%**	**31%**
TCP open	**100%**	**100%**	**100%**	**100%**
Number of babies readmitted to neonatal unit from TCP	**0**	**0**	**2**	**2**
The number of avoidable term admissions 37+0 weeks gestation and above admitted to the neonatal unit	**0**	**0**	**2**	**10**
The number of term babies transferred or admitted to the neonatal unit from other areas – for example Emergency Department, Children's ward.	**3**	**1**	**0**	**23**

Clinical Audit Report

Project title

Transitional Care and ATAIN Audit Q4 2024/2025 January - March 2025

Division

Family & Specialist Services Division

Specialty

Local Neonatal Unit

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 01/01/2025-31/03/2025 to determine if the correct location of care was achieved.
- All babies born at 37+0 weeks gestation and above from 01/01/2025-31/03/2025 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 Q4.

Staffing:

- During Q4 the transitional care pathway 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 1.5% 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 neonatal unit 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 NNU 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, (see figure 1), remains consistent in Q4 from Q3.

- Requirement for intravenous antibiotics 31%
- Requirement for 'Kaiser' observations for a risk of sepsis 25%
- Requirement for feeding support 11%

The inclusion of the 2 new locally agreed criteria categories in Q2 (Babies below 2nd centile and 34-35+6/40 above 1.8kg) combined, are consistant at 12% of the total admissions to the TCP with Q3.

More accurate data collection methods are now being used to monitor maximum number of babies cared for on TCP per day at any one given time, rather than only at the beginning of a shift. This is due to the transient nature of admissions and discharges throughtout the day and is a more accurate reflection of babies being cared for under TC. On average 31% of days saw between 4 and 7 babies being cared for on the TCP. Average 1.5% of these not supported by an extra staff member resulting in the incorrect staffing model for this level of babies.

Q4 saw twin babies readmitted to NNU and a further 3 were transferred to NNU where parents stayed with baby on the unit, remaining on the transitional care pathway in the NNU as a preferred location to Mary ward due to enviornmental factors.

The Perinatal, Culture & Leadership programme (PCLP) also includes TC with a focus on improving communication and collaborative working between maternity and TC staff groups.

This QI project is monitored quarterly through governance. The expansion of TC cot provision is an ongoing piece of work looking at acuity demands and workforce, led by Matron and Senior Sister.

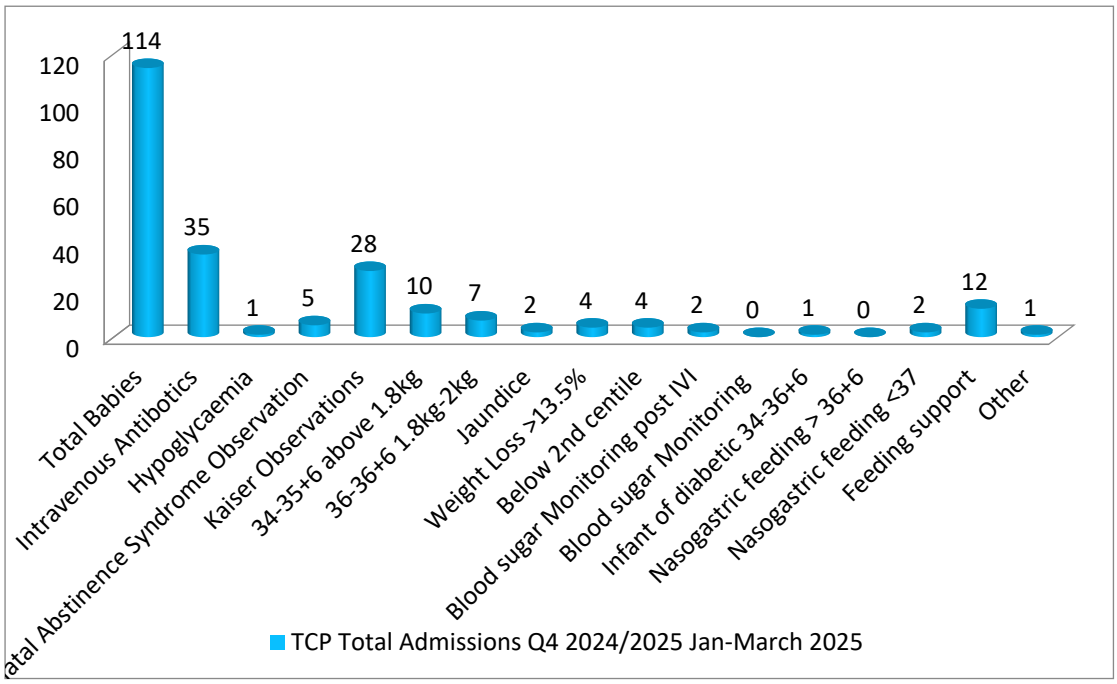


Figure 1: The number of admissions to the RUH Transitional Care Pathway (TCP) by causation Q4 24/25

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 Q4, 8 responses were received to the TCP patient experience survey:

- From review of the written comments provided by parents and families a commonality regarding positive feedback for the level of care and support provided by the TC team was identified within 7 out of the 8 responses.
- 1 mother discussed how she would have liked quicker support for latching advice with feeding as she and her baby became distressed and the lack of consistency of staff caring for her and her baby was a little overwhelming.
- A parent of a baby that was re located on request to NNU where she could continue to stay by the bedside left feedback that it was very beneficial to her.

Staff TCP feedback

- Only 1 staff response to staff survey for staff working on TCP. Mostly positive. Staff confident to work on TCP. But state's ability to provide best level of care dependant on number of babies on TCP. Feels supported by neonatal colleagues,

ATAIN Audit Findings Q4

- The ATAIN working group meets fortnightly to undertake a Multi-Disciplinary Team (MDT) review of all admissions and transfers into the neonatal unit assessing if alterations in care may have provided opportunities to have avoided the admission into the Local Neonatal Unit (LNU), therefore providing insight into areas of potential service improvements.

- Q4 identified 2 possible avoidable admissions to the LNU, this is a decrease from 4 in Q3. All avoidable admissions to the LNU in Q4 were identified at MDT to have an element of decisions made during intrapartum care and there were identifiable commonalities around CTG interpretation and escalation.

No Avoidable admissions in January and February

March admissions - There were 2 avoidable term admission.

The first case identified that a deteriorating CTG (pathological) should have been escalated to the obstetric team, resulting in the birth of the baby being expediated. The baby required admission to the LNU and received some respiratory support initially and Cerebral Function Monitoring (CFM) which was normal. The baby was on the LNU for 2 days and then discharged home with no anticipated long-term impact.

The second case also identified as a potential area for obstetric improvement; a review of the care considered that there was a lack of recognition of hypoxia in second stage which should have prompted intrauterine resuscitation – the Oxytocin switched off and pushing discouraged. The baby required initial monitoring on the LNU for 2 days for suspected poor transition to extrauterine life. The baby was discharged home with no anticipated long-term impact.

Going forward all learning from ATAIN will be shared quarterly via the quality and safety boards. The Maternity Fetal Monitoring Lead uses the CTGs discussed in this report to share examples across the LMNS to see if there is any input/learning that can be gained from them and to see if we have any local themes. These cases are also added to a learning portfolio of CTGs that are used as part of MDT discussions on the Fetal Monitoring Training. At present there is a 45-minute section that is dedicated to human factors and escalation. These cases will be used as part of this to aid teaching and the importance of escalating concerns. We know this is identified as a national issue by many reports. This includes midwives, registrars and obstetricians so that we explore these themes. Part of the study day also talks about intrauterine resuscitation and fetal physiology. With specific focus on the 2nd stage of labour and how hypoxia can rapidly evolve. These cases will be taken and used as part of these teaching sessions. The current fetal monitoring guideline supports this. The escalation in labour SOP is also in the process of being updated.

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 neonatal unit from other areas within the RUH, are reviewed. This includes Emergency Department and the Children's ward. In Q4 2025 there were 4 babies that were admitted, a decrease by 1 from Q3. 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 4 admissions over Q4, all 4 were identified as the neonatal unit being the most appropriate care location with a consultant-to-consultant decision about location of care.

- There is a draft guideline, "Care of community infants less than 3 months admitted to paediatrics needing intensive care" and "Location of care for Infants < 10 days of age" awaiting ratification. These guidelines detail 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 Q4 2024/25

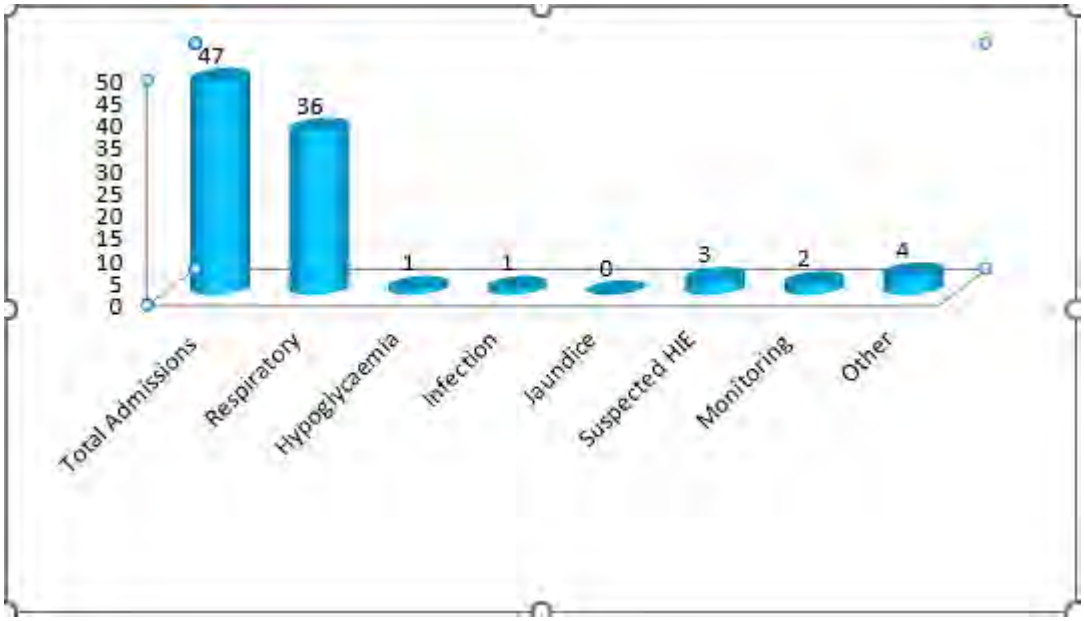


Figure 2: Analysis of term admissions by causation

When reviewing the leading causes for admission to the LNU during Q4, respiratory symptoms remain the leading cause of term admissions, 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.

In 2023/2024 there were 17 avoidable admissions, however this has reduced to 10 in 2024/2025. With the dissemination of learning and ongoing training and education it is recognised that progress has been made in the last year which has resulted in less separation of mothers and babies. The overall total of babies admitted to the LNU from other areas in the hospital has brought our total annual community admission to LNU number to 23, which is an increase of 4 from previous quarter. With ongoing plans to implement new guidelines relating to appropriate location of care, it is anticipated that this figure should reduce in the next year.

Quality Improvement Projects

- 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. Simulation training in progress.

- 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. We continue to monitor the numbers of low cord gases reported via Datix, analysis of the results is continuing to identify if there are trends.

- The RUH joined the Perinatal Culture and Leadership Programme (PCLP) in Autumn 2023 and with support from the quadrumvirate and perinatal culture coaches produced an improvement plan following culture conversations with a wide range of staff who work in the inpatient areas. 6 themes were identified and actions derived from further conversations which are monitored through governance (Appendix 3).

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.

- Ratification and implementation of the Guidelines – "Care of community infants less than 3 months admitted to paediatrics needing intensive care" and "Location of care for Infants < 10 days of age".

- A collaborative Special Interest Group (SIG) between the neonatal team and maternity has been formed. Discussion for improvement to the TCP service and cultural conversations ongoing. Monthly meetings in progress.

Transitional Care and ATAIN Action plan Q4 2024/2025

	Description	Objective	Current Status	Lead/Responsible	Next Steps
CPAP on Skin Early Intervention (COSEI)	Reduce parent-infant separation for term babies with transient tachypnoea of the newborn.	Implement early CPAP on skin to support bonding and reduce admissions.	Simulation training in progress.	Neonatal Team	Complete training and evaluate early outcomes.
Cord Gas Accuracy QI Project	Improve accuracy and timeliness of neonatal cord pH samples.	Achieve >90% of cord blood samples processed within 20 minutes post-birth.	Ongoing analysis of Datix reports and trends.	Neonatal Governance Team	Continue monitoring and identify improvement opportunities.
Perinatal Culture and Leadership Programme (PCLP)	Improve perinatal culture through staff engagement and leadership.	Implement improvement plan based on 6 identified themes.	Ongoing work streams monitored through governance.	Quadrumvirate and Perinatal Culture Coaches	Continue governance monitoring and implement actions.
Readmission Data Analysis	Explore readmissions of 37+ week babies into neonatal services.	Benchmark against other units in the Southwest Neonatal Network.	Data exploration ongoing.	ATAIN Working Group	Complete benchmarking and identify trends.
Guideline Implementation	Implement guidelines for care of community infants and location of care.	Improve care efficiency and reduce infection risk in LNU.	Guidelines ratified and implementation underway.	Neonatal and Paediatric Teams	Monitor adherence and evaluate impact.
Neonatal-Maternity Special	Collaborative group to improve TCP	Enhance communication	Monthly meetings in progress.	Neonatal and Maternity Teams	Continue discussions and implement

Interest Group (SIG)	service and culture.	and service delivery.			agreed improvements.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Public Board of Directors	Agenda item:	15
Date of Meeting:	2 July 2025		

Title of Report:	Mid-Year review of Nursing Staffing levels
Status:	For approval
Board Sponsor:	Toni Lynch, Chief Nursing Officer
Author:	Simon Andrews, Associate Chief Nurse for Workforce Olivia Ratcliffe, Deputy Chief Nursing Officer
Appendices	Appendix 1: National Quality Board Recommendations Appendix 2: Developing Workforce Standards Recommendations

1. Executive Summary of the Report

The purpose of this paper is to provide assurance to the Board of Directors by assessing nursing staffing levels and the associated challenges for both nursing and Allied Health Professionals (AHPs). This assessment covers the six-month period from July 2024 to December 2024, specifically reviewing nursing workforce levels within inpatient areas, including the Intensive Care Unit (ICU), Theatres, and the Emergency Department (ED).

This paper evaluates compliance with the Developing Workforce Safeguards (NHSI, 2018), which build upon the standards set by the National Quality Board (NQB) and guidance from the National Institute for Health and Care Excellence (NICE, 2014).

The workforce requirements for safe Maternity services and the Neonatal Unit (NNU) have been reviewed separately, and the paper was reported to the Board of Directors May 2025.

The planned establishment review for Registered and Health Care Support Workers was completed in September 2024. This review provided an opportunity to align roster templates with the safe staffing establishments agreed in the annual safe staffing review (June 2024), thus improving roster efficiency and ensuring deployment of the right staff with appropriate skills.

The Chief Nursing Officer and Chief Medical Officer confirm in response to the bi-annual safe staffing review that the nurse staffing levels are safe, effective and sustainable.

The skill mix review considered the establishment changes referenced in the paid break consultation for staff working shifts of 12 hours or more. This had no impact on staffing ratios or skill mix within the nursing establishments.

Key headlines include:

- Nursing vacancy and turnover remains low which contributes to safe staffing
- Introduction of live nursing vacancy tracker within clinical Divisions
- Inpatient fill rate for Registered Nurses and Health Care Support Workers have continued to improve during the period of this report
- Reduced Registered Nurse and Operating Department Practitioner vacancies and turnover within theatres has resulted in a reduced bank and agency spend
- Substantive recruitment to the Enhanced Care Team, has contributed to a significant reduction in bank and agency spend as well as, improved personalised care and support
- There is no correlation between quality metrics and safe staffing levels in this period.

2. Recommendations (Note, Approve, Discuss)

The Board of Directors are asked to **approve** the paper for onward submission to the Board of Directors.

3. Legal / Regulatory Implications

The National Quality Board (NQB) guidance (2013) requires trusts to undertake a full nursing and midwifery safe staffing review annually, and at least every six months to review nursing, midwifery and care staffing capacity and report this to a public Board meeting. The midwifery staffing report has been submitted separately as part of the standard midwifery reporting schedule.

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

The contents of this report links directly to the risk register and are shown in this table below:

Risk ID	Division	Description	Current Risk Score	Action
2075	Medicine	Emergency Department / Urgent Treatment Centre vacancy	**16**	22 actions 18 completed
2748	Medicine	Reduced capacity of Occupational Therapist provision for Acute Stroke Unit	**12**	6 actions 5 completed

2725	Medicine	Reduced capacity of Physiotherapists with respiratory skills to provide on-call service	**12**	6 actions 5 completed

5.	Resources Implications (Financial / staffing)
There is no resource implications related to this paper.	

6.	Equality and Diversity
There are no issues raised in this paper relating to equality and diversity.	

7.	References to previous reports/Next steps
• Bi-annual Nursing Safe Staffing Report, Public Board of Directors, March 2024 • Annual Nursing Safe Staffing Report, Public Board of Directors, January 2025 • Bi-annual, Maternity and Neonatal Staffing Report, Public Board of Directors, May 2025	

8.	Freedom of Information
This paper is a public document.	

9.	Sustainability
This paper does not impact the Trust's sustainability strategy.	

10.	Digital
There are no issues raised in this report that impact the Trust's Digital Strategy	

1. Purpose of Paper

1.1. The purpose of this paper is to provide assurance to the Board of Directors by assessing nursing staffing levels and presenting an overview of the workforce and associated challenges for Allied Health Professionals (AHPs) at the Royal United Hospitals Bath. This assessment covers the six-month period from July 2024 to December 2024.

1.2. This is evaluated against compliance with the Developing Workforce Safeguards (NHSI, 2018). The latest DWS self-assessment (Appendix 2) shows compliance with 11 out of the 14 recommendations. Compliance is also evaluated against the National Quality Board (NQB 2016). The NQB self-assessment (Appendix 1) shows an improvement in compliance from 19 (July 2024) to 30 (May 2025) out of the 37 recommendations.

1.3. This review builds on the standards set by the NQB and guidance from the National Institute for Health and Care Excellence (NICE, 2014).

1.4. This paper specifically reviews nursing workforce data from the mid-year reviews. The inpatient areas include Intensive Care Unit (ICU), Theatres, and the Emergency Department (ED), during the period of July 2024 to December 2024.

1.5. The workforce requirements for safe Maternity services and the Neonatal Unit (NNU) have been reviewed separately, and the paper was reported to the Board of Directors in May 2025.

2. Nursing Staffing Overview

2.1. The planned skill mix review for Registered Nurses (RNs) and Health Care Support Workers (HCSWs) was completed in September 2024 and integrated within the bi-annual establishment review. This review provided an opportunity to align roster templates with the safe staffing establishments agreed in the annual safe staffing review (June 2024), thus improving roster efficiency and ensuring deployment of the right staff with appropriate skills.

2.2. The skill mix review considered the establishment changes referenced in the paid break consultation for staff working shifts of 12 hours or more. Previously, in 2016, the RUH agreed that a thirty-minute break during for shifts >12 hours would be paid. At that time, the rationale for paid breaks was the high number of vacancies, which prevented staff from taking adequate breaks.

2.3. The Nursing workforce turnover rate is consistently low, having successfully increased its nursing workforce and significantly reduced vacancies. This stability has enhanced ward leaders' ability to allocate breaks effectively. The removal of the 30-

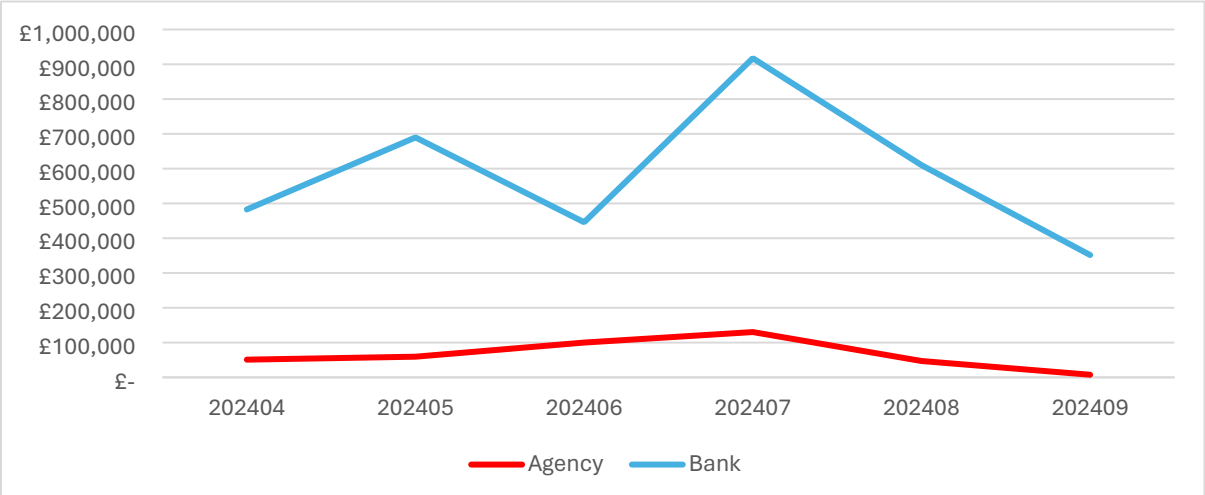
minute paid break has not affected staffing ratios or staffing levels in clinical areas. The change was benchmarked against neighbouring NHS Trusts, ensuring an equitable approach to rest breaks for RUH staff on shorter shifts who were previously not eligible for the 30-minute paid break. This adjustment will contribute to ongoing financial stability.

2.4. To date, the changes regarding paid breaks have not impacted vacancy or turnover rates; however, qualitative data and insights into staff morale will be closely monitored for the full year as part of the annual safe staffing review.

2.5. The previously agreed skill mix investment within inpatient ward budgets ensured the presence of senior nursing leadership 24/7. A Sister/Charge Nurse (Band 6) both in and out of hours is now aligned with the 2025/26 budgets. This investment aims to foster a supportive work environment that reflects the complexity and demands of care, especially during night-time hours. It is anticipated that this will lead to improved patient and staff experience and outcomes.

2.6. The Nursing and AHP teams continue to prioritise efficient resource utilisation, balancing clinical risk, maintaining safe staffing levels, and ensuring financial sustainability. Agency Nurse and AHP expenditure significantly reduced during this period, down to a low of £7,576 a month. Similarly, bank Nurse and AHP expenditure decreased to £351,656 in December 2024.

2.7. Graph 1 illustrates the declining trend in agency, bank Nurse, and AHP spend since the beginning of the 2024/25 financial year. There are three key reasons for agency and bank spend reduction.



Graph 1: Bank & Agency Nursing and AHP Spend July – December 2024.

2.7.1. The Theatre workforce (specifically Operating Department Practitioners and Anaesthetic trained Nurses) have completed a focussed recruitment and training programme for all 15 vacant positions over this time period. Workforce strategies

such as apprenticeships supported four staff members, in addition to enabling six scrub, and recovery staff to undertake the anaesthetic course. These actions have improved the skill mix and operational efficiency within theatres. Table 1 illustrates the significant reduction in temporary staff usage within theatres. All long-line agency contracts in theatres ceased entirely in January 2025.

Theatres/Recovery				
	Theatres & Recovery Bank hours	Tier 4 Agency	RN/ODP Agency hours	Overtime (including Recovery)
July 24	1872	0	895	0
Aug 24	1761	0	620	0
Sept 24	2388	0	572	0
Oct 24	2700	0	1334	0
Nov 24	2055	0	1025	0
Dec 24	1879	0	421	0
Jan 25	1334	0	0	0

Table 1: Bank and Agency usage in Theatres

2.7.2. The significant enhanced care and support demand has been addressed by the establishment of a specialist Enhanced Care Team, which has involved recruiting a Lead Mental Health Nurse and a Lead Learning Disability & Autism Nurse, alongside additional recruitment of Registered Mental Health Nurses (RMN) and Mental Health Clinical Support Workers (MHCSW). This has shifted the delivery of care from agency and bank staff to predominantly highly trained substantive staff. Temporary staffing usage is expected to reduce further as recruitment, workforce training and standardised practice continues.

2.7.3. In December, the team required 130 hours of registered mental health nurse agency support, a significant reduction from the 1597 hours required in July 2024. This reduction aligns with the recruitment of two permanent Band 7 Specialist Enhanced Care Practitioners, who assess enhanced care requests and ensure patients and staff receive support from the most suitable professionals, whether RMNs or MHCSWs.

2.8. All inpatient rosters have been reviewed in line with agreed safe staffing establishments as part of the mid-year establishment review. This has ensured effective rostering, with accurate roster templates which has enabled appropriate temporary staffing requests and accurate reporting in terms of fill rate and care hours per patient per day.

2.9. Headroom is the percentage financial uplift applied when calculating inpatient establishments from band 3 HCSW to the band 6 sister post. The Shelford Group

recommends 22%, however the headroom at the RUH is 20%. (15.8% annual leave, 1.2% study leave and 3% sickness). 20% has been applied to all nursing inpatient establishments other than the Emergency Department (ED) and the paediatric inpatient ward. The ED review includes 27% as recommended by the Royal College of Emergency Medicine and similarly the paediatric ward including the Paediatric Assessment Unit includes a headroom of 25% as per the Royal College of Nursing recommendation. This enables staff to undertake considerable levels of training and clinical supervision to ensure they possess the right knowledge and skills to deliver care.

2.10. Between July and December 2024, a total of 68 escalations were reported from the RUH workforce through the Freedom to Speak Up (FTSU) process. Of the 68, 26.5% (n=18) were submitted by Allied Health Professionals, Nurses, and Midwives.

2.11. The main themes raised via FTSU, in descending order of prevalence, was staff well-being, inappropriate attitudes and behaviours, bullying and harassment, and patient safety. Key concerns related to micro-aggressive and discriminatory behaviours, burn out and patient waiting times. These issues are being addressed within Divisions.

3. Nursing Staff Planned Versus Actual (Inpatient areas)

3.1. The Trust submits monthly staffing returns to the Department of Health via the NHS national staffing return system (Unify2). This submission outlines the Trust's overall position, comparing actual hours worked with expected hours across all inpatient areas. It includes percentage fill rates for RNs and HCSWs for both day and night shifts, as well as the overall Trust-wide fill rate. Additionally, the return includes data on Care Hours per Patient Day (CHpPD).

3.2. Inpatient fill rates for RNs and HCSWs have continued to improve during the reporting period. It is anticipated that these rates will increase further, reflecting improvements in recruitment across nursing teams. Nonetheless, some fluctuations remain due to changes in operational activity and the need to provide enhanced care for vulnerable patients.

3.3. Table 2 demonstrates consistently high night-time fill rates for both RNs and HCSWs, with the majority exceeding 95%. Average day shift fill rates have been above 90% for RNs and above 85% for HCSWs. This reflects a notable improvement compared to the same period in 2023, when the average HCSW day fill rates were below 75% and RN day fill rates were below 82%.

Total Average	July	August	September	October	November	December
Total monthly actual staff Day hours- RN	90%	90%	89%	91%	93%	93%
Total monthly actual staff day hours- HCA	86%	85%	84%	90%	86%	90%
Total monthly actual staff night hours- RN	98%	95%	95%	97%	97%	97%
Total monthly actual staff night hours -HCA	91%	91%	102%	96%	97%	90%

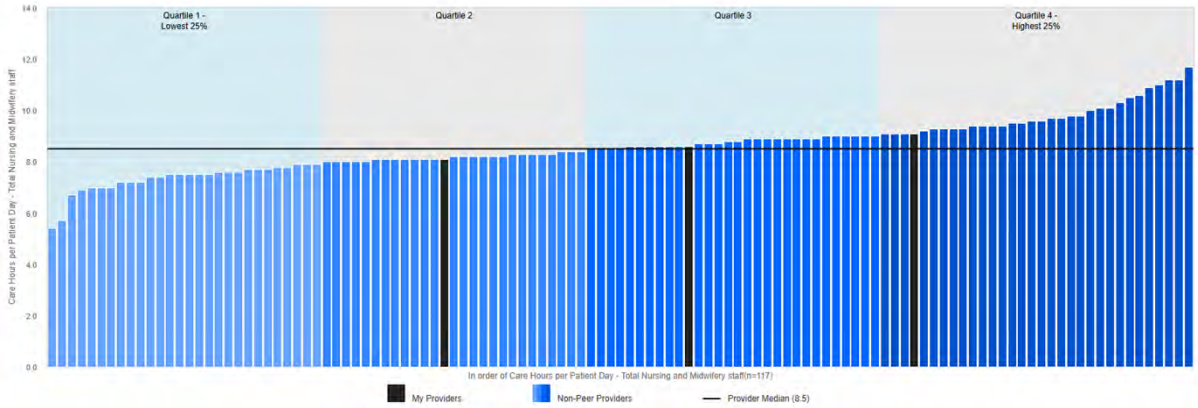
Table 2: RN and HCSW fill rates July – December 2024

3.4. Any variations or risks related to safe staffing is operationalised by a minimum of twice-daily staffing meetings, seven days a week, to review clinical acuity, patient dependency, staffing levels and skill mix. This supports a dynamic, risk-based approach to staff deployment, led by a senior nurse. Oversight of out-of-hours staffing is provided by Clinical Site Managers and Senior Patient Flow Leads.

3.5. CHpPD as recommended in the Carter Review (2015), is reported via the Model Hospital dashboard. This provides a standardised method for NHS Trusts to benchmark their staffing levels and productivity.

3.6. Each month, the total hours worked during day and night shifts by RNs, Midwives, and HCSWs are calculated. Alongside this, the number of patients occupying beds at midnight is recorded daily, then added across the month and divided by the number of days to obtain a daily average for the month. The total hours worked are then divided by this daily average to calculate the CHpPD figure.

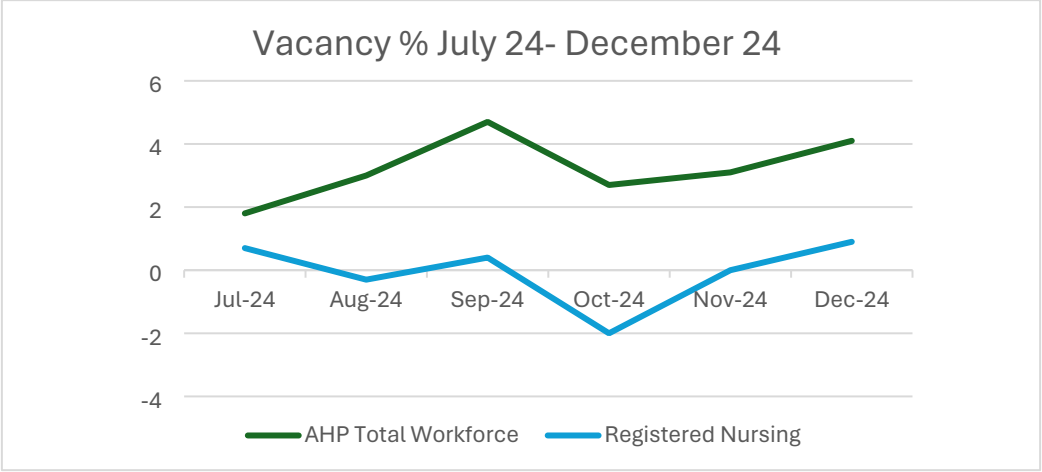
3.7. The Nursing workforce CHpPD is broadly in line with both the provider median and that of Trusts of a similar size (Graph 2). Encouragingly, the Trust is positioned in Quartile 3 with a CHpPD median of 8.5, which closely aligns with both the peer and national median of 8.6. When comparing against BSW peers (Great Western Hospital and Salisbury Foundation Trust) the RUH is consistently resourcing the appropriate level of staff for the levels and acuity of patients.



Graph 2: CHpPD Total for Nursing and Midwifery Staff – National Distribution benchmarked against peer hospitals.

4. Vacancy and Turnover

4.1. This has led to sustained low levels of vacancies and turnover within these staff groups. Graph 3 illustrates the low percentage of vacancies across RNs and AHPs. There is some caution with this data – the data is workforce (Electronic Staff Register) information and may differ from finance information due to the way vacancy savings are captured.

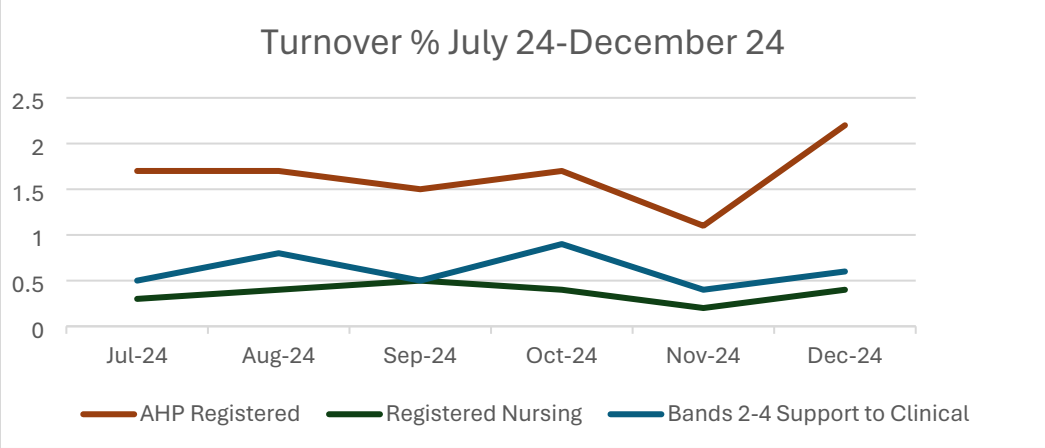


Graph 3: Vacancy Percentage AHP/ Registered Nursing July – December 2024

4.2. The above data has been validated with the live Divisional recruitment trackers. The hot spots within this current time period were vacancies for RNs within the Paediatric (21.78 WTE) and Emergency departments (27.57 WTE). The practitioners' gaps (4 WTE) were within the Urgent Treatment Centre. Active recruitment into these posts is ongoing, with the aim of reaching full establishment by May 2025.

4.3. As of December 2024, there were 29.8 whole-time equivalent (WTE) vacancies for Health Care Support Workers. Accurately reporting on HCSW data remains a challenge due to the aggregation of all clinical support roles across Bands 2 to 4. Work is currently underway with the corporate workforce team to address and rectify this issue. A targeted recruitment campaign for Health Care Support Workers was conducted between January and March 2025. This included both internal and external advertising, with the overarching aim of reducing HCSW vacancies to zero.

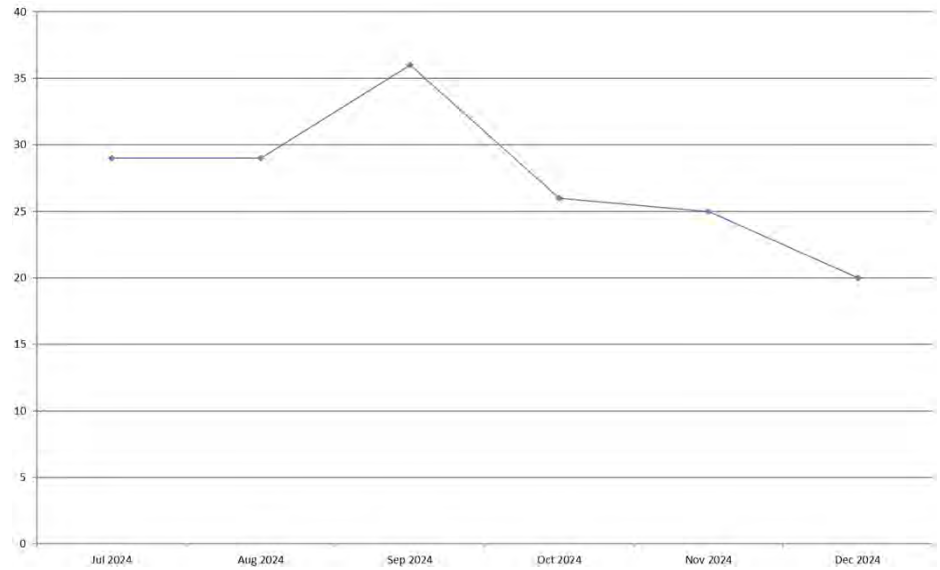
4.4. There continues to be low levels of turnover within the nursing and AHP workforce (Graph 4). AHP workforce turnover rates remained relatively stable for most of the time period, peaking at 2.2% in December 2024. In February 2025, a dedicated AHP workforce lead started in post, to focus on professionally led recruitment and retention programmes for all AHP professions.



Graph 4: AHP/Registered Nursing/ Support to Clinical Turnover Percentage, July – December 2024

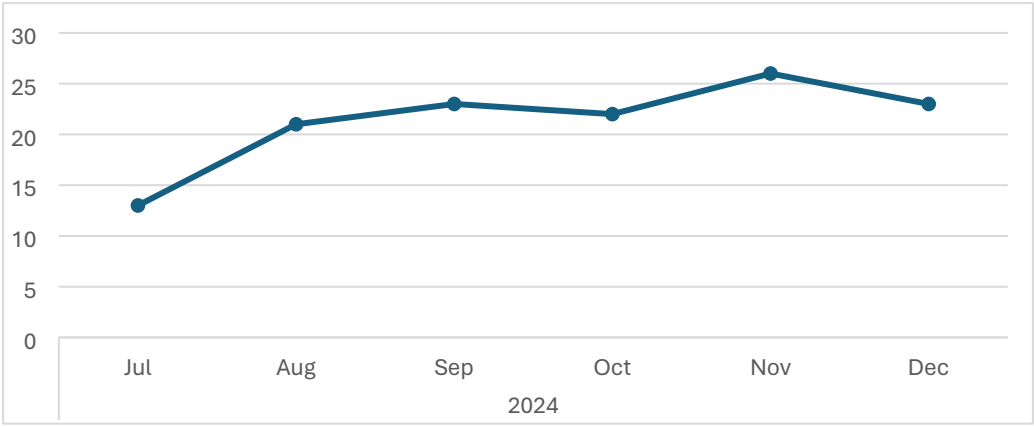
5. Nursing Staffing Incidents (including rostering red flags)

5.1. The 163 incidents (Datix) across the time period were reviewed by the appropriate line managers, senior nurses, or Allied Health Professionals (AHPs). Graph 5 demonstrates workforce incident reporting has taken a downward trend. The significant themes when reporting was lack of suitably trained staff, and low staffing levels due to sickness. The improvement reflects the implementation of the enhanced care team, better roster utilisation practices, and lower turnover and vacancy rates.



Graph 5: Nursing & AHP workforce incidents reporting trend July – December 2024

5.2. The Nurse in Charge raises a red flag on the roster if, in their professional assessment, nursing staffing levels are insufficient to meet care requirements. This action notifies the Matron, and the red flag must then be addressed or mitigated to close the escalation. Red flag reporting, as outlined in national safe staffing guidance, provides a consistent framework for reporting shortages in RN time or when patient acuity or dependency exceeds the agreed establishment levels.

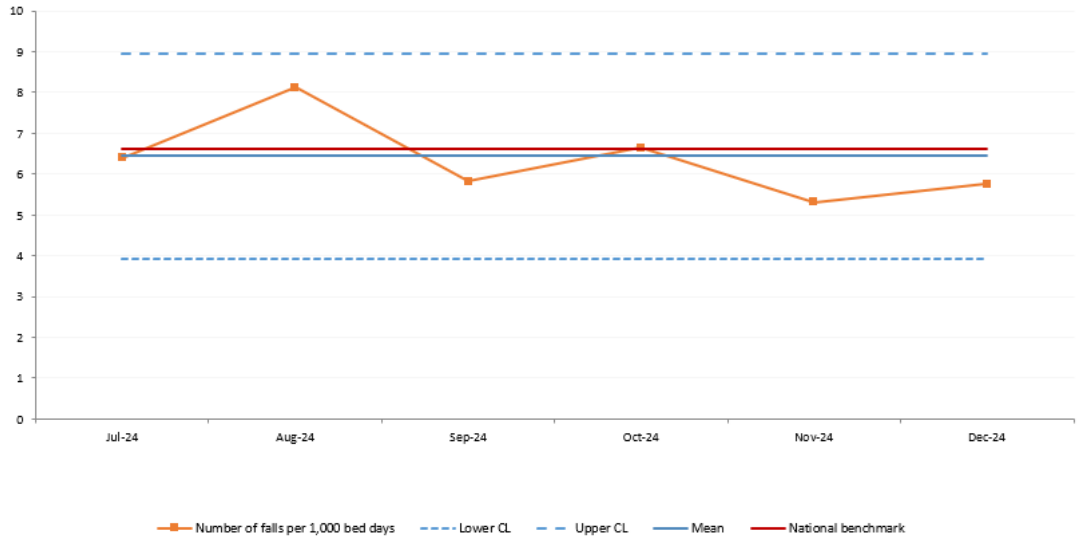


Graph 6: Number of Nursing in-patient roster red flags, July – December 2024.

5.3. The trend of red flag reporting has stabilised between July and December 2024 (Graph 6). The primary reason for red flag reporting during this period was a 25% shortfall in RNs, followed by omissions in comfort rounds. At present, there is no national guidance for AHP roster red flags, and therefore this system has not been adopted. Monitoring of red flags continues through the monthly Nursing, Allied Health Professionals, and Midwifery Workforce Group (NAMWG), chaired by the Chief Nursing Officer.

6. Performance against key quality metrics

6.1. The inpatient falls rate has continued to decrease since July 2024 (Graph 7) and remained on or below the national benchmark. The main contributing factor for falls at the RUH relate to patients with delirium and dementia. This patient cohort has a consistent demand for 1:1 care provision. The Enhanced Care Support workers are supporting the demand for this group of patients. The Enhanced Care Support Workers commenced in post in August 2024.



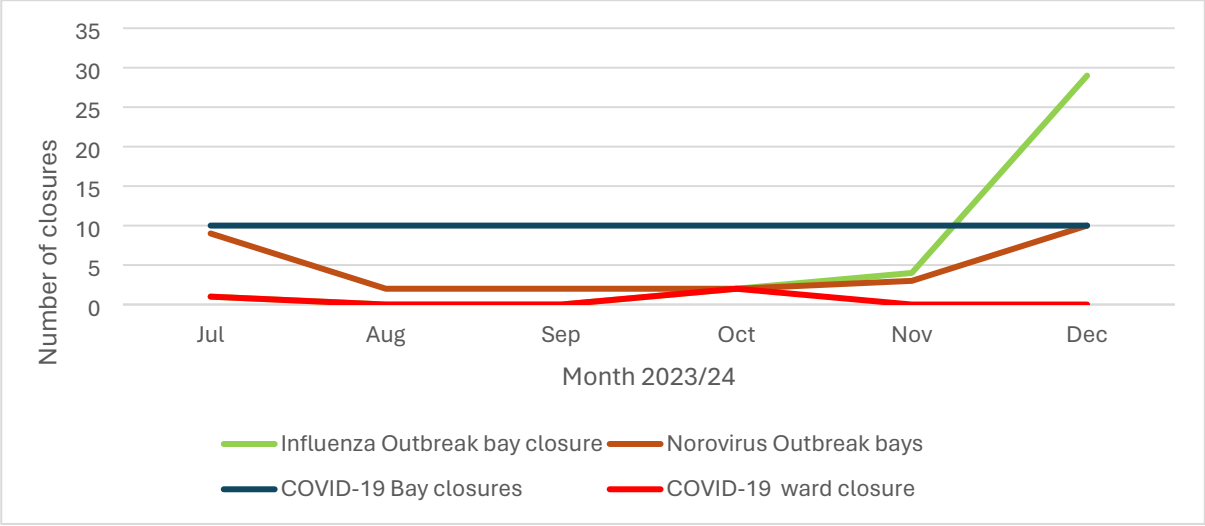
Graph 7: Number of falls per 1,000 bed days, July – December 2024

6.2. There were 31 pressure ulcers reported from July – December 2024 (Graph 8). 9 pressure ulcers were deemed unavoidable with no lapses in care. Respiratory Ward had the highest incidence at 8 cases. All pressure ulcers were investigated and identified learning was met with appropriate action plans. The key themes related to the incidents was gaps in knowledge rather than safe staffing levels, as observed in the Respiratory Ward, the fill rate of 85% and above.

	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
RUH	0.1	0.1	0.3	0.4	0.5	0.3
Swindon	1.32	1.42	0.78	0.63	0.97	0.55
Salisbury	2.52	4.4	3.1	2.2	2.9	

Graph 8: Number of pressure ulcers per 1,000 bed days, July – December 2024

6.3. The incidence of infection outbreaks (consisting of two or more symptomatic patients within 24 hours) remained consistent until November 2024. Graph 9 shows the expected upward trend in the winter months, pertaining both to Influenza and Norovirus. There was no correlation between safe staffing and infection outbreaks, the monthly ward staffing fill rates remained greater than 90% in this period.



Graph 9: Number of infection outbreaks July – December 2024 by infection type

7. Nursing and AHP Workforce Risks above 12 (High/Moderate)

7.1. There were three approved risks on the risk register for Nursing and AHPs. The highest risk relates to UTC practitioner vacancies, which has an action plan with a focus on a recruitment trajectory to be realised by May 2025. The other two risks are rated moderate.

Risk ID	Division	Description	Current Risk Score	Action
2075	Medicine	Emergency Department / Urgent Treatment Centre vacancy	**16**	22 actions 18 completed
2748	Medicine	Reduced capacity of Occupational Therapist provision for Acute Stroke Unit	**12**	6 actions 5 completed
2725	Medicine	Reduced capacity of Physiotherapists with respiratory skills to provide on-call service	**12**	6 actions 5 completed

Table 3: Risk register entries with a risk score > 12 relating to nursing and AHP staffing levels.

8. Annual Staffing Review (ASR)

8.1. The next ASRs are being undertaken through January to March 2025 to inform the 2025/26 workforce plans. The key outcomes of this review will be included in the next 6 monthly report on safe staffing to the Board of Directors in December 2025.

9. Conclusion

9.1. This report on nursing and AHP safe staffing provides a range of data and information that provides assurance to the Board of Directors that there are no current safety themes relating to nursing or AHP staffing during the period of July 2024- December 2024.

9.2. The establishment review has identified the need for no further investment during this review period in nursing establishments for inpatient wards, Paediatrics and the Emergency department.

9.3. During the period of the report there continues to be ongoing improvement in supporting our patients requiring enhanced care, highlighting the substantial work being undertaken to support vulnerable people.

9.4. The nursing and AHP workforce require continued focus on recruitment into outstanding vacancies within the Emergency Department alongside focused work on retention. This will be monitored alongside the overall reliance on temporary staffing.

9.5. In accordance with the Developing Workforce Safeguards Recommendations (2018) The Chief Nursing Officer and Chief Medical Officer confirm in response to the bi-annual safe staffing review that the nurse staffing levels are safe, effective and sustainable.

Appendix 1: National Quality Board (2016) Recommendations Self-Assessment (Completed May 2025)

Expectation	Descriptor	No.	Recommendation	Current measures in place	RUH Assessment	Identified actions required	Timescale	Lead
	Boards should ensure there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients at all times, across all care settings in NHS provider organisations. Boards should ensure there is an annual strategic staffing review, with evidence that this is developed using a triangulated approach (i.e. the use of evidence-based tools, professional judgement, and comparison with peers), which takes account of all healthcare professional groups and is in line with financial plans. This should be followed with a comprehensive staffing report to the board after six months to ensure workforce plans are still appropriate. There should also be a review following any service change or where quality or workforce concerns are identified. Safe staffing is a fundamental part of good quality care, and CQC will therefore always include a focus on staffing in the inspection frameworks for NHS provider organisations. Commissioners should actively seek to assure themselves that providers have sufficient care staffing capacity and capability, and to monitor outcomes and quality standards, using information that providers supply under the NHS Standard Contract	**1.1 Evidence-based workforce planning**						
1: Right staff		1.1.1	The organisation uses evidence-based guidance such as that produced by NICE, Royal Colleges and other national bodies to inform workforce planning, within the wider triangulated approach in this NQB resource	Triangulated approach to staffing establishments well embedded. Shelford SNCT used. Embedded 'safecare' as part of eRostering. Emergency Department workforce RCEM/RCN standards implemented. Royal college/ national guidance utilised to support workforce planning. Introduced assessment area SNCT; MAU, SAU, OPAU.	**Complete**		NA	
		1.1.2	The organisation uses workforce tools in accordance with their guidance and does not permit local modifications, to maintain the reliability and validity of the tool and allow benchmarking with peers.	All tools used as recommended.	**Complete**	Monitor the impact on the inclusion of 'enhanced care' scoring.	NA	
		1.1.3	Workforce plans contain sufficient provision for planned and unplanned leave, e.g. sickness, parental leave, annual leave, training, and supervision requirements.	20% included in all direct care in-patient areas. Compliance monitored as part of Healthroster reporting suite. Moved monitoring from ESR to healthroster reporting to aid prompt oversight and action. Created monthly divisional healthroster KPI meeting. Reviewed headroom for inpatient and non-ward-based areas.	**Action Required**	Parental leave is still outstanding and incurs a significant cost-pressure. Working ongoing to support a sustainable solution	04/26	SA
		1.2 Professional judgement						
		1.2.1	Clinical and managerial professional judgement and scrutiny are a crucial element of workforce planning and are used to interpret the results from evidence-based tools, taking account of the local context and patient needs. This element of a triangulated approach is key to bringing together the outcomes from evidence-based tools alongside comparisons with peers in a meaningful way.	6 monthly staffing reviews include face to face meetings with Corporate Nursing Team/Divisional Directors of Nursing/Matron/Senior Sister/Charge Nurses as well as workforce systems and finance. Professional judgement key part of the reviews	**Complete**		NA	
		1.2.2	Professional judgement and knowledge are used to inform the skill mix of staff. They are also used at all levels to inform real-time decisions about staffing taken to	As above. Professional judgement also used as part of the twice daily staffing review meetings.	**Action Required**	Revision of safe staffing SOP to include clear guidance and process of documented professional judgement.	07/25	SA

			reflect changes in case mix, acuity/dependency, and activity					
		1.3 Compare staffing with peers						
		1.3.1	The organisation compares local staffing with staffing provided by peers, where appropriate peer groups exist, taking account of any underlying differences.	Previous benchmarking included through establishment reviews and targeted at specific services under development. Need to strengthen and formalise BSW benchmarking through model hospital monthly at the integrated performance review and bi-annual safe staffing report.	**Complete**		NA	
		1.3.2	The organisation reviews comparative data on actual staffing alongside data that provides context for differences in staffing requirements, such as case mix (e.g. length of stay, occupancy rates, caseload), patient movement (admissions, discharges, and transfers), ward design, and patient acuity and dependency.	All considered as part of the systematic staffing reviews Strengthen the use of this data as part of the bi-annual establishment review process	**complete**		NA	
		1.3.3	The organisation has an agreed local quality dashboard that triangulates comparative data on staffing and skill mix with other efficiency and quality metrics: e.g. for acute inpatients, the model hospital dashboard will include CHPPD.	Integrated performance report includes all staffing and quality metrics.	**Complete**		NA	
		2.1 Mandatory training, development, and education						
2: Right Skills	Boards should ensure clinical leaders and managers are appropriately developed and supported to deliver high quality, efficient services, and there is a staffing resource that reflects a multiprofessional team approach. Decisions about staffing should be based on delivering safe, sustainable, and productive services. Clinical leaders should use the competencies of the existing workforce to the full, further developing and introducing new roles as appropriate to their skills and	2.1.1	Frontline clinical leaders and managers are empowered and have the necessary skills to make judgements about staffing and assess their impact, using the triangulated approach outlined in this document.	Senior Sister/Charge Nurse leadership education programme including workforce training. Focused training with the e-roster lead and senior nurse leads for safe-staffing and rostering practice.B6-B7.	**Action Required**	Roll-out Band 6 sister/charge Nurse training to maintain competence, skills and knowledge through education sessions and staffing/ establishment review meetings. Introduction of Band 6 Leadership and development programme to include workforce education.	12/25	SA
		2.1.2	Staffing establishments take account of the need to allow clinical staff the time to undertake mandatory training and continuous professional development, meet revalidation requirements, and fulfil teaching, mentorship, and supervision roles, including the support of preregistration and undergraduate students.	20% headroom allowance and provision of supervisory Senior Sister/Charge Nurse. Funded allocation for study leave is 1.5% Introduction of revised Clinical Practice Facilitator (CPF) model for all areas to support in areas training and supervision. Nursing and AHP learner dashboard to monitor learner numbers.	**Action Required**	Review headroom for inpatient and non-ward-based areas when considering apprenticeships Monitor impact of new CPF structure.	01/26	SA

	expertise, where there is an identified need or skills gap.	2.1.3	Those with line management responsibilities ensure that staff are managed effectively, with clear objectives, constructive appraisals, and support to revalidate and maintain professional registration.	All expectations clearly included in JD and annual objectives for line managers	**Complete**	Monitored as part of ongoing HR key performance metrics	NA	
		2.1.4	The organisation analyses training needs and uses this analysis to help identify, build, and maximise the skills of staff. This forms part of the organisation's training and development strategy, which also aligns with Health Education England's quality framework.	Mandatory and essential training analysis in place per role.	**Action Required**	Review of current department training needs analysis baseline Implementation of training needs analysis for departments and align to CPD arrangements.	01/26	
		2.1.5	The organisation develops its staff's skills, underpinned by knowledge and understanding of public health and prevention, and supports behavioural change work with patients, including selfcare, wellbeing and an ethos of patients as partners in their care.	Comprehensive training programmes in place to equip staff with required Skills. Wellbeing hubs Health determinant leads in place Professional Nurse advocates	**Complete**		NA	
		2.1.6	The workforce has the right competencies to support new models of care. Staff receive appropriate education and training to enable them to work more effectively in different care settings and in different ways. The organisation makes realistic assessments of the time commitment required to undertake the necessary education and training to support changes in models of care.	Comprehensive training programmes in place to equip staff with required Skills.	**Action required**	TNA as above.	01/26	SA
		2.1.7	The organisation recognises that delivery of high-quality care depends upon strong and clear clinical leadership and well-led and motivated staff. The organisation allocates significant time for team leaders, professional leads, and lead sisters/charge nurses/ward managers to discharge their supervisory responsibilities and have sufficient time to coordinate activity in the care environment, manage and support staff, and ensure standards are maintained.	100% Supervisory ward leader time established in all inpatient direct care areas. Roster report analyses the supervisory levels monthly at the roster KPI meetings.	**Complete**		NA	
		2.2 Working as a multiprofessional team						

		2.2.1	The organisation demonstrates a commitment to investing in new roles and skill mix that will enable nursing staff to spend more time using their specialist training to focus on clinical duties and decisions about patient care.	Range of new roles developed to meet service needs have been implemented within divisional workforce and patient pathways. Successful nurse associate and registered nurse apprenticeship pathways and roles. Introduction of enhanced care team.	**Complete**		NA	
		2.2.2	The organisation recognises the unique contribution of nurses, in the wider workforce. Professional judgement is used to ensure that the team has the skills and knowledge required to provide high-quality care to patients. This stronger multiprofessional approach avoids placing demands solely on any one profession and supports Improvements in quality and productivity, as shown in the literature	Multiprofessional approach to all aspects of workforce development and training delivered within an integrated Training, Development and Workforce department. Appointed an AHP Lead and AHP workforce lead. Increased collaboration with Midwifery colleagues eg joint T-levels work-stream.	**Complete**		NA	
		2.2.3	The organisation works collaboratively with others in the local health and care system. It supports the development of future care models by developing an adaptable and flexible workforce (including AHPs and others), which is responsive to changing demand and able to work across care settings, care teams and care boundaries.	Strong record of working with other providers both in provider and HEI/FE sector. Continue with current approach and strengthen partnership working with local colleges to maximise T-levels and apprenticeships.	**Complete**		NA	
		2.3 Recruitment and retention						
		2.3.1	Leadership that closely resembles the communities it serves. The research outlined in the NHS provider roadmap42 demonstrates the scale and persistence of discrimination at a time when the evidence demonstrates the links between staff satisfaction and patient outcomes.	RUH plan to address equality and diversity within trust linked to WRES data Supporting equity – DALS and Routes to success programme. Detailed in separate ED&I action plan. Ensuring any N&M specific actions are also incorporated into the retention toolkit and action plan Band 6 leadership programme. RCN cultural ambassadors	**Complete**		NA	
		2.3.2	The organisation has effective strategies to recruit, retain and develop their staff, as well as managing and planning for predicted	Retention and recruitment of Paediatrics and Theatres established maintains the Focus. Continue to monitor monthly.	**Complete**		NA	

			loss of staff to avoid over-reliance on temporary staff.					
		2.3.3	In planning the future workforce, the organisation is mindful of the differing generational needs of the workforce. Clinical leaders ensure workforce plans address how to support staff from a range of generations, through developing flexible approaches to recruitment, retention, and career development	Generational work starting to be incorporated into projects for retention and recruitment and specifically, around preceptorship, return to practice, rotations, flexible working, early careers engagement and T-levels.	**Complete**		NA	
		3.1 Productive working and eliminating waste						
3: Right Place and Time	Boards should ensure staff are deployed in ways that ensure patients receive the right care, first time, in the right setting. This will include effective management and rostering of staff with clear escalation policies, from local service delivery to reporting at board if concerns arise. Directors of nursing, Directors of operations, Directors of finance and Directors of workforce should take a collective leadership role in ensuring clinical workforce planning forecasts reflect the organisation's service vision and plan, while supporting the development of a flexible workforce able to respond effectively to future patient care needs and expectations.	3.1.1	The organisation uses 'lean' working principles, such as the as a way of eliminating waste.	Transformation work is underpinned by the 'improving together methodology.' The techniques applied as appropriate including reviews of care hours, SNCT, Quality metrics, and model hospital productivity data.	**Complete**		NA	
		3.1.2	The organisation designs pathways to optimise patient flow and improve outcomes and efficiency e.g. by reducing queuing.	Incorporated in service Redesign. SDECS, fit-to-sit area, DAA, the discharge lounge, and H@H.	**Complete**		NA	
		3.1.3	Systems are in place for managing and deploying staff across a range of care settings, ensuring flexible working to meet patient needs and making best use of available resources.	Staff are employed to be fully flexible (skills and competence allowing). Continued review as part of daily staffing meetings to maximise flexibility of staff	**Complete**		NA	
		3.1.4	The organisation focuses on improving productivity, providing the appropriate care to patients, safely, effectively and with compassion, using the most appropriate staff.	Staff are employed to be fully flexible (skills and competence allowing). The workforce and quality meetings review productivity. The enhanced care team addressed the areas for further skills.	**Complete**		NA	
		3.1.5	The organisation supports staff to use their time to care in a meaningful way, providing direct or relevant care or care support. Reducing time wasted is a key priority.	Included as part of methodology of reviews of staffing. Direct care time monitored. Other roles utilised to maximise direct Care. Assurance through SafeCare.	**Complete**		NA	
		3.1.6	Systems for managing staff use responsive risk management processes, from frontline services through to board level, which clearly demonstrate how staffing risks are identified and managed.	Clear escalation processes in place and risk register, daily staffing meeting. PSIRF roll-out will inform the new way to review and learn from any staffing issues. Monthly divisional dashboard support governance to the board.	**Complete**		NA	

		3.2 Efficient deployment and flexibility							
		3.2.1	Organisational processes ensure that local clinical leaders have a clear role in determining flexible approaches to staffing with a line of professional oversight, that staffing decisions are supported and understood by the wider organisation, and that they are implemented with fairness and equity for staff.	Involvement of clinical leaders at all levels in setting establishment levels and rostering workforce. This is systematically reviewed through 6 monthly staffing reviews reported to board	**Complete**		NA	
		3.2.2	Clinical capacity and skill mix are aligned to the needs of patients as they progress on individual pathways and to patterns of demand, thus making the best use of staffing resource and facilitating effective patient flow.	Clinical speciality, acuity, dependency and pathways included as part of the systematic review of staffing Levels. Where the skill falls out of an area- the Enhanced care team has been created.	**Complete**		NA	
		3.2.3	Throughout the day, clinical and managerial leaders compare the actual staff available with planned and required staffing levels, and take appropriate action to ensure staff are available to meet patients' needs.	Twice daily reviews of staffing levels planned and actual undertaken at care group, Division and trust wide level through daily staffing meetings linked to site.	**Complete**		NA	
		3.2.4	Escalation policies and contingency plans are in place for when staffing capacity and capability fall short of what is needed for safe, effective, and compassionate care, and staff are aware of the steps to take where capacity problems cannot be resolved.	Escalation policies in place into site for unresolved staffing issues. Temporary staffing escalation in place and resource shared Trust-wide when required	**Action Required**	Finalise the Safe staffing SOP with the newly recruited Enhanced care team.	07/25	SA
		3.2.5	Meaningful application of effective e-rostering policies is evident, and the organisation uses available best practice from NHS Employers and the Carter Review Rostering Good Practice Guidance (2016).	Use of eRoster systematically reviewed and managed through the management team structure. Divisional monthly roster reviews. KPIs reviewed at the monthly workforce committee. Roster policy is being published by HR.	**Complete**		NA	
		3.3 Efficient employment, minimising agency use							
		3.3.1	The annual strategic staffing assessment gives boards a clear medium-term view of the likely temporary staffing requirements. It also ensures discussions take place with service leaders and temporary workforce suppliers to give best value for money in	Currently undertake 6 monthly staffing reviews that take account of all the recommendations. Staffing reviews closely aligned to the Retention & Recruitment and temporary staffing strategies and clear actions in place to	**Complete**		NA	

			deploying this option. This includes an assessment to maximise flexibility of the existing workforce and use of bank staff (rather than agency), as reflected by NHS Improvement guidance.	maximise bank use and reduce agency A programme of work NAMIP provide assurance of 10 active drivers to create efficiencies for bank and agency usage.				
		3.3.2	The organisation is actively working to reduce significantly and, in time, eradicate the use of agency staff in line with NHS Improvement's nursing agency rules, supplementary guidance and timescales.	Plan in place to reduce agency usage in line with NHSI guidance Only exception is NICU which is minimal. Enhanced care team for RMN no further reliance on agency.	**Complete**		NA	
		3.3.3	The organisation's workforce plan is based on the local Sustainability and Transformation Plan (STP), the place-based, multi-year plan built around the needs of the local population.	The Nursing workforce teams is very much engaged in the business cycle and local process provided. The sustainability focus is on addressing appropriate headroom and standardised Job plans.	**Complete**		NA	
		3.3.4	The organisation works closely with commissioners and with Health Education England, and submits the workforce plans, using the defined process, to inform supply and demand modelling.	RUH is fully engaged in development of Workforce planning aspects and matching the establishments to commissioned work.	**Complete**		NA	
		3.3.5	The organisation supports Health Education England by ensuring that high quality clinical placements are available within the organisation and across patient pathways, and actively seeks and acts on feedback from trainees/students, involving them wherever possible in developing safe, sustainable, and productive services.	Strong systems in place to identifying placement capacity and monitor student allocation and quality across all staff groups. The NETS survey is monitored with an action plan is in place.	**Complete**		NA	

Appendix 2: Developing Workforce Safeguards Recommendations (2018) Self-Assessment (Completed May 2025)

Recommendation	Evidence	Compliance	Action plan
1. Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance	-Monthly Nursing & Midwifery Safe Staffing/ workforce meeting and reports set out as per expectations of the NQB (2016). -Safer Nursing Care Tool data collection April & Oct -Bi-annual establishment review Dec-Feb & Aug-Sep -CHPPD reported monthly in comparison with peers to the integrated performance review	Compliant	NA
2. Trusts must ensure the three components are used in their safe staffing processes: – evidence-based tools (where they exist) – professional judgement – outcomes	Evident within the Bi-annual establishment review presentation reports	Compliant	NA
3. We will base our assessment on the annual governance statement, in which trusts will be required to confirm their staffing governance processes are safe and sustainable	Confirmation included in annual governance statement that our staffing governance processes are safe and sustainable	Compliant	NA
4. We will review the annual governance statement through our usual regulatory arrangements and performance management processes, which complement quality outcomes, operational and finance performance measures	-Confirmation included in annual governance statement that our staffing governance processes are safe and sustainable. -All outcomes are triangulated in the bi-annual safe staffing report.	Compliant	NA
5. As part of this yearly assessment we will also seek assurance through the SOF, in which a provider's performance is monitored against five themes	-Quality dashboards developed for nursing (e-rostering performance metrics, fill-rates, and finance within the monthly Nursing workforce group reports and included in the integrated performance review. -Electronic rostering and KPIs reported monthly, and areas of improvement acknowledged	Compliant	NA
6. As part of the safe staffing review, the director of nursing and medical director must confirm in a statement to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable	-The Chief Nurse Officer signs-off the annual establishment review meetings -The CNO is positioned as responsible director for monthly Nursing & Midwifery safer staffing metrics -The CNO plays an active leadership role for Safe Staffing evolvement and aspirations -The CNO chairs the monthly Nursing workforce group -Statement CMO/CNO as part of the bi-annual board report	Compliant	NA
7. Trusts must have an effective workforce plan that is updated annually and signed off by the chief executive and executive leaders. The board should discuss the workforce plan in a public meeting	-Evident in the bi-annual Nursing Safe Staffing Report.	Compliant	NA

8. They must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their board every month	-Quality dashboards developed for nursing vacancies, fill rates, CHPPD, rostering red flags, performance metrics, monthly clinical dashboard e.g. falls are presented monthly at the Integrated performance report to board. -Electronic rostering reported and areas of improvement acknowledged	Compliant	NA
9. An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the board by ward or service area twice a year, in accordance with NQB guidance and NHS Improvement resources. This must also be linked to professional judgement and outcomes	-Evident in the Bi-annual safe staffing nursing report -Bi-annual establishment review cycle -SNCT assessment April and October	Compliant	NA
10. There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool	- Evident and continuously reviewed by the Associate Chief Nurse for Workforce & Education. -Any changes are presented at the Nursing Workforce Group chaired by the CNO – and reflected in the bi-annual reports as well as a supporting EQIA. The budgets and establishments are set annually. -The Associate Chief Nurse for Workforce and Education is responsible for the training of the Safer Nursing Care Tool (SNCT) and ensuring staff are aware that adaptions to the tool are not condoned	Compliant	NA
11. As stated in CQC's well-led framework guidance (2018)6 and NQB's guidance7 any service changes, including skill-mix changes, must have a full quality impact assessment (QIA) review	EQIA evident (most recent is the Paediatric inpatient establishment) reviewed at the Monthly Nursing workforce group and applied to the bi-annual Nursing safe staffing reports as an appendix.	Compliant	NA
12. Any redesign or introduction of new roles (including but not limited to physician associate, nursing associates and advanced clinical practitioners – ACPs) would be considered a service change and must have a full QIA	EQIA assessment is embedded within the business case and annual business planning processes. For specifically, a change within the Nurse Associates a EQIA will be completed by the Associate Chief Nurse of Workforce and Education as per the Nursing processes	Compliant	NA
13. Given day-to-day operational challenges, we expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments	-Dynamic risk assessments undertaken at twice daily Trust wide daily operational oversight and leadership for staffing led by allocated Senior Nurse (Divisional Director of Nursing or Deputy)	Compliant	NA
14. Should risks associated with staffing continue or increase and mitigations prove insufficient, trusts must escalate the issue (and where appropriate, implement business continuity	-Twice-daily operational oversight of safe-staffing and site management. Senior Nurse leadership chairs the meetings. -Business continuity plans in place to support.	Compliant	NA

plans) to the board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example, wards, beds and teams, realignment, or a return to the original skill mix.	Escalation process and professional judgement guidance included in the safe staffing standard operating procedure for nursing and midwifery.		

Royal United Hospitals Bath
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Report to:	**Public Board of Directors**	**Agenda item:**	**16**
Date of Meeting:	**2 July 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 9 June 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

- Overall flow through the hospital including Non-Criteria to Reside patients remains serious issue.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance

- C Diff rates at the RUH are some of the highest in the South West, risen from 77 cases in 23/24 to 101 cases in 24/25. This reflects the national picture and the declaration of an NHS incident in December. This is not obviously associated with any poor infection, prevention, and control (IPC) practice locally, however RUH struggles with lack of isolation side rooms. Salisbury has a low rate possibly associated with a different sampling process. Group work in progress with IPC teams.

- Cancer performance worsened in April/May but there is now some improvement reflecting a new locum and one stop service within breast oncology.

- Work within urology with Swindon to provide additional capacity.

ASSURE: Inform the Board where positive assurance has been achieved

- Radio pharmacy removed from compliance oversight.

- Operational report describing robust plans to improve emergency flows, expansion of Same Day Emergency Care services and work on earlier discharge.

RISK: Advise the Board which risks were discussed and if any new risks were identified

- New college recommendations presented to have dedicated SHO cover in maternity triage areas to reduce risk. Options being discussed within maternity as to how to achieve this.

- Further increase in patient complaints, especially in medicine. Planned deep dive to look at themes (20 in April 24, 40 in March 25).

- Delays in clinic letters described as a digital risk but more work needed on quality of responses.

CELEBRATING OUTSTANDING: Share any practice innovation or action that the committee considers to be outstanding

- Enhanced care team for mental health enabled a reduction in agency hours from 1500 in July 24 to 130 hrs in Dec 24 also providing improved continuity of care for these vulnerable patients.

- Reduction in agency hours in theatres from 1000 hrs in November 24 to 0 in January secondary to recruitment to vacancies.

- Formation of a Children's and Young People Committee.

APPROVALS: Decisions and Approvals made by the Committee

- The Committee approved the 2024/25 Annual Quality Account.

- The Committee approved the Annual Pharmacy Assurance Report.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**17**
Date of Meeting:	**2 July 2025**		
Title of Report:	**People Committee Upward Report**		
Status	**For discussion**		
Author	**Paul Fairhurst, Chair of the People Committee**		

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

- **Governance:** The Committee discussed its role and purpose in the complex and dynamic current environment (transitioning to Group whilst simultaneously delivering the five Transformation Programmes alongside business-as-usual). The Committee agreed that during the transitional period its key focus should be to seek assurance that:
  - a robust change management methodology is in place to bring people with us through change;
  - staff related issues are a key element of the five Transformation Programmes;
  - governance remains effective for business-as-usual staffing issues.
- **Risk**:
  - Risk Register: The Committee discussed the five high scoring risks related to workforce changes and staffing levels: industrial action; adverse impact on employee engagement; adverse impact on patient safety in the Emergency Department and Urgent Treatment Centre; adverse impact on safe care in Haematology and Oncology; staffing of Resus and Simulation team. Three new risks are being assessed: impact of Executive and Divisional leadership team changes; impact of Group on workforce issues; tension between delivering £15m pay bill reduction and making staff feel valued. Future People Committee meetings will be updated on management of the high scoring risks. These risks are being assessed for addition to the Board Assurance Framework (BAF).
- **BAF:** two emerging strategic level risks were discussed: getting the culture right so that people thrive, feel valued and empowered; and capacity to resource, lead and respond to organisational change. The BAF will remain tailored to the RUH but reviewed for commonality with the Great Western Hospitals and Salisbury Foundation Trust BAFs. The refreshed BAF will be presented to the July Board.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance

- **Change Management - establishing the RUH Leadership and Change Management Office (LCMO) (ongoing monitoring):** The Committee was

updated on work across the Group to manage the “people side” of complex change. Guiding aims include to reduce disruption and stress, enhance staff engagement and morale and improve communication and collaboration to help drive adoption of new initiatives. The Group has adopted the Prosci Methodology. In April the RUH established the LCMO. The LCMO will be a central hub of expertise, tools, and coaching resources, advising on change strategies, facilitating team transitions and educating leaders on effective change practices. It will lead the internal leadership programme and expand coaching capabilities. It will operate through a matrix model, drawing on talent across the RUH. The Committee discussed preliminary Assessment Dashboards for each of five Transformation Programmes. The Dashboards will track and measure progress based on programme milestones, financial savings and Prosci Change Triangle success assessments. Updated Dashboards will be presented to future People Committee meetings. The Committee discussed the need for consistency across the Group (given the many interdependencies) and noted that it is not yet certain whether LCMO functionality will be established across the Group. The Committee also noted the finite bandwidth of the People Function and the discussions amongst the leadership team as to what the Function should stop doing in order to support the transformation.

ASSURE: Inform the Board where positive assurance has been achieved

- **Mutually Agreed Resignation Scheme (MARS):** The Committee was advised that national guidance on MARS has been adhered to; that there is a consistent approach across Group; that TCNC Consultation subgroup has discussed the proposal; and that the proposal is in line with section 20 of the Agenda for Change (AFC) NHS Terms and Conditions of Service Handbook. On the basis of that advice, the Committee was assured on those matters.

RISK: Advise the Board which risks were discussed and if any new risks were identified

- Please see the alert section of the report.
- UK visa and settlement rules: the Committee noted the changes introduced by the Government in April 2025 (including changes to the Skilled Worker visa salary threshold; English language requirements for visa applicants and dependants; and increases to the standard period for qualifying for permanent settlement from five to ten years). The Committee discussed support to affected staff, which includes a factsheet that explains the Immigration White Paper (but some key issues are yet to be established) and provides information on support available (such as the hardship fund and webinars on immigration law). RUH regards itself as a leader in terms of the support we were offering affected staff. The Committee discussed the potential impact on recruitment and the talent pipeline, given the increase to the salary threshold. The Committee also expressed concerns that the changing political climate and national sentiment towards immigration could bring about an upturn in our level of discrimination. The Committee will monitor that risk.

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 item to report.

Royal United Hospitals Bath
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Report to:	**Public Board of Directors**	**Agenda item:**	**18**
Date of Meeting:	**2 July 2025**		
Title of Report:	**Finance and Performance Committee Upward Report – 27 May 2025**		
Status	**For information**		
Author	**Nigel Stevens, Non-Executive Director**		

Key discussion points and matters to be escalated from the meeting on 27 May 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

- Operational Performance continues to struggle, notably 4 hour and Cancer.
- Financial Performance in P1 significantly off budget due to costs on staff and drugs being above budget, the improvement plan was not delivered in period, and the original budget had no phasing of improvements.
- Capital controls following NHS England intervention will impact on projects, the impact is being assessed but this is critical for the Board to consider.
- Speed of delivery of change remains a concern and reductions in admin support staff is seen as a significant risk.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance

- Debrief from the new Deputy Chief Operating Officer indicates areas of the Emergency Department, notably the Urgent Treatment Centre, offer opportunities for improvement.
- Similarly, opportunities exist on other referral and elective targets.
- Small transformation budgets and effective empowerment are key to quick progress.
- Update on the transformation plan continues to raise concerns over deliverability, pace, and prioritisation.

ASSURE: Inform the Board where positive assurance has been achieved

- Executives were asked to review caveats included in the budget submission.
- Key assumptions for financial and operational recovery require monthly review – executives agreed to produce this assessment.

RISK: Advise the Board which risks were discussed and if any new risks were identified

- The overall financial and operational performance of the Trust remains very fragile and will need careful and strong management to navigate the current challenges.

CELEBRATING OUTSTANDING: Share any practice innovation or action that the committee considers to be outstanding

• Nil
APPROVALS: Decisions and Approvals made by the Committee
• The decarbonisation project was reviewed, and it was agreed that the submission of the next stage in the process should go ahead, as a zero resource commitment. It was agreed that no further steps should be taken without a full review of the capital and people resource commitment.

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RZ2.Report to:	**Public Board of Directors**	**Agenda item:**	**19**
Date of Meeting:	**2 July 2025**		
Title of Report:	**Alert, Advise and Assure Report – Audit & Risk Committee**		
Status:	**For information**		
Author:	**Joy Luxford, Non-Executive Director**		

Key Discussion Points and Matters to be escalated from the meeting held on 19th June 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

- As previously reported, the Internal Auditor have concluded their Annual Report 24/25 with a 'Partial Assurance with improvements required' opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. This will be referenced in the published Annual Report (Annual Governance Statement), due to insufficient key actions being implemented during the required timescales. A new process has been implemented by the Chief Finance Officer (CFO) and Chair of Audit and Risk Committee designed to prevent this issue reoccurring next year.
- The External Auditor shared their ISA260 statement including Audit Opinion and Value for Money statement with an unmodified audit opinion ('true and fair view') but with reference to material weaknesses in internal control (as per Internal Audit's Report above) and Financial Sustainability (the need for a robust financial sustainable plan). They also highlighted some negative movements in quality indicators indicating a need to improve processes and controls around the external audit reporting going forward. This will be taken forward by the CFO.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance

- The alerts above relate to the need to maintain close oversight of key Internal Audit Actions arising throughout the year and to implement lessons learnt from the FY24/25 audit processes.

ASSURE: Inform the board where positive assurance has been achieved

- The Internal Audit report on Improvement Programme Governance 24/25 was given an assurance rating of Partial Assurance with improvement required', or amber / red.
- The Internal Audit report on the electronic patient record (EPR) implementation 24/25 was given an assurance rating of 'Significant Assurance with minor improvement opportunities', or amber / green.

- The Internal Audit report on Consultant Absence Management report was given an assurance rating of 'Partial Assurance with improvement required', or amber / red.
- The Local Counter-Fraud Service Annual Report 24/25 was given an overall rating of green (11 green and 1 amber).
- The Committee noted progress in relation to the Annual Accounts on the part of both the External Auditors and the internal finance function and approved the Annual Report. It also agreed that any further changes (typos, minor adjustments) need to be authorised by the CFO and Chair of the Audit and Risk Committee.

RISK: Advise the board which risks were discussed and if any new risks were identified.

- As previously reported and discussed at Board, there is a need for clarity around our financial sustainability plans and ensure internal control gaps and recommendations are addressed quickly and maintained.

CELEBRATING OUTSTANDING: Share any practice, innovation or action that the committee considers to be outstanding

- None noted this meeting.

APPROVALS: Decisions and Approvals made by the Committee

- The Committee approved the draft Annual Governance Statement and Financial Statements FY2024/25 presented and delegated approval for any last-minute changes to the Chair of Audit and CFO. This was because the external audit fieldwork had not quite finished at the time of the committee meeting. No material changes are expected. The final version should be shared with NHSE by the national 30 June deadline.
- The Committee noted the Internal Audit Annual Report, 3 internal audit reports and Local Counter Fraud Annual Report mentioned above.

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:**	**20**
Date of Meeting:	**2 July 2025**		
Title of Report:	**Charities Committee Upward Report**		
Status	**For discussion**		
Author	**Sumita Hutchison, Vice-Chair**		

Key discussion points and matters to be escalated from the meeting on 15 May 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

- No items to report.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance

- Income £3.15m.
- Return on investment 3.92%.
- PET CT to be launched in July 2025.
- Agree revised service level agreement for admin services between Trust and Charity.

ASSURE: Inform the Board where positive assurance has been achieved

- The Committee noted progress on several funded investments and associated workstreams. These demonstrate alignment with strategic goals and offer positive impact for staff, patients, and the wider RUH community.
- Ongoing work to encourage staff and Board member participation in upcoming events and engagement initiatives is well underway and being positively received.
- The funds were being managed effectively by the charity's Investment Fund manager.

RISK: Advise the Board which risks were discussed and if any new risks were identified

- Recruitment Challenges and Vacancy Control limited recruitment into key roles that is needed for the charity to run effectively and raise target funds. Recruitment & Workforce Pipeline: The committee flagged a risk regarding constrained capacity to recruit due to headcount limits, which could impact delivery in priority areas. A lack of clear guidance on internal recruitment routes adds to the uncertainty. The Chair has agreed to escalate this risk to Board.

CELEBRATING OUTSTANDING: Share any practice innovation or action that the committee considers to be outstanding

- Successes in Funded Initiatives: The Committee celebrated the successful delivery and positive impact of recent investments and associated initiatives. Special recognition was given to Associate Director, RUHX and her team for their leadership.

• Friends of the RUH Activity: The contribution and momentum of the Friends of the RUH was warmly acknowledged. Their continued support and engagement are highly valued. Had set aside £400,000 for grant applications. Further 215 people volunteering for a total of 22,404 hours of unpaid work.
APPROVALS: Decisions and Approvals made by the Committee
• No items to report.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**21**
Date of Meeting:	**2 July 2025**		
Title of Report:	**Non-Clinical Governance Committee Upward Report**		
Status	**For discussion**		
Author	**Sumita Hutchison, Vice-Chair**		

Key discussion points and matters to be escalated from the meeting on 19 June 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

- Radiopharmacy Isolator Screen Risk - Visibility through isolator screens is significantly reduced due to material degradation, creating risks of needlestick injury, radiation exposure, and production errors. Interim mitigations (polishing, senior oversight) are in place but not sustainable. Replacement is delayed due to bespoke manufacture requirements. Impact on operational performance and staff safety.
- Digital Interface Risk (Mirth): The current system underpinning clinical message exchange is outdated and vulnerable. Replacement via Health Connect is planned, but resource challenges could delay implementation.
- Radiation Protection Compliance: The Trust is currently non-compliant with radiation protection supervision requirements. Immediate assessment of Board exposure/liability is required if services continue under current conditions.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance

- Cleaning Risk: Despite improvements, variability in cleanliness remains a concern partly due to workforce issues and the need for better implementation of new standards. Leadership changes and better implementation of the standards are expected to improve standards. Risk score held at 16.
- Electronic patient record (EPR) Programme: New Senior Responsible Owner (SRO) and revised governance in place. Staff engagement remains critical.
- Artificial Intelligence (AI) Strategy and Governance: Early work underway to develop group-wide digital strategy including AI use. Strong emphasis on governance, safety, and national compliance. Policies and engagement with board and divisions to follow and discussed the urgency of this given the likely early adoption of AI.
- Sterile Services Capacity: Concerns raised over impact on productivity and clinical services. Follow-up required.

ASSURE: Inform the Board where positive assurance has been achieved

- The Committee reviewed the Annual Emergency Preparedness, Resilience and Response (EPRR) Annual Report and risk register. The report provided an annual summary of EPRR activity and assurance for the Trust for the 2024–2025 period. It outlined current compliance, progress made, challenges identified, and risk areas under management. The RUH achieved **Full**

Compliance in the NHS England EPRR Core Standards assessment for 2024. The Trust is on track to maintain this status in 2025, with preparatory work underway ahead of the next review in September.
RISK: Advise the Board which risks were discussed and if any new risks were identified
• Resource Limitations: Migration to new digital systems (Health Connect) risks delay due to internal and third-party resource capacity. • Divisional Business Continuity Plans: Visibility remains partial. System-wide collaboration needed to ensure oversight. • HAZMAT Training and Kit: Identified as a gap. Update and provision of suitable equipment ongoing.
CELEBRATING OUTSTANDING: Share any practice innovation or action that the committee considers to be outstanding
• Health and Safety: Patient kitchen has reopened serving fresh meals which are cost effective and of higher quality. • EPRR Full Compliance: A significant milestone achieved with the Trust reaching full EPRR compliance for the first time.
APPROVALS: Decisions and Approvals made by the Committee
• No items to report.