Bundle Public Board of Directors 3 September 2025

0 Agenda
- 0.0 - Draft Public BoD Agenda Sept 25 v1.7 - 28.08.25

1 Chair's Welcome, Introductions, Apologies and Declarations of Interest

2 Written Questions from the Public

3 Minutes of the Board of Directors meeting held in public on 2 July 2025
- 3.0 - DRAFT Public BoD Minutes July v1.0 - 17.07.25

4 Action List and Matters Arising
- 4.0 - Public BoD Action List July 25 v1.0 - 26.08.25

5 Governor Log of Assurance Questions and Responses (for information)
- 5.0 - Governor Log of Assurance Questions v1.0 - 26.08.25
- 5.1 - Appendix 1 - NED Assurance 2025 - 24.06.25

7 Patient Story
- 7.0 - Patient Story cover sheet to Board of Directors v2 3.9.25

8 CEO, Managing Director, and Chair's Report
- 8.0 - RUH MD & CEO Public BoD Report 03.09.25

9 Withdrawn

10 BSW Hospitals Group - Resolution to Update Partnership Agreement, Schedule 3 Joint Functions and Schedule 5, Joint Committee Terms of Reference
- 10.0 - Cover BSW Joint Committee_Update to Joint Functions and Joint Cee TORs_Aug-SeptV0.1
- 10.1 - Appendix A BSW Hospitals Group Joint Functions - July 2025 V1.2 (1)
- 10.2 - Appendix B BSW Hospitals Group Joint Cee TORs July 2025 - V1.2

11 Integrated Performance Report
- 11.0 - September 2025 Public Board - IPR Cover Sheet (July 2025 Data) v1
- 11.1 - Integrated Performance Report - September 2025 (July Data) v1

13 Quality Assurance Committee Upward Report
- 13.0 - QAC Upward Report August 25

14 Q4 Learning from Deaths Report
- 14.0 - Learning From Deaths coversheet for BoD
- 14.1 - Quarterly Learning from Deaths Report Q4

15 Children's Safeguarding Annual Report
- 15.0 - Safeguarding Children and Maternity Annual Report 2024-25

16 Adult's Safeguarding Annual Report
- 16.0 - Adult Safeguarding Annual Report BoD 2024-25

17 Infection Prevention and Control Annual Report
- 17.0 - Cover Board of Directers IPC Annual Report Sept 2025
- 17.1 - 2024-25 DIPC Annual Report - BoD

18 People Committee Upward Report
- 18.0 - Sept 25 PC Upward Report v1.1

19 Finance and Performance Committee Upward Report
- 19.0 - Finance Upward Reporting 280725
- 19.1 - Finance Upward Reporting 2860825ver2

20 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 3 SEPTEMBER 2025, 13:00 – 16:00 VENUE: ROOM 2.55 (INCEPTA), SCHOOL OF MANAGEMENT, UNIVERSITY OF BATH, CONVOCATION AVE, CLAVERTON DOWN, BATH BA2 7AZ

Item	Item	Presenter	Enc.	For
OPENING BUSINESS				
1.	Chair's Welcome, Introductions, Apologies and Declarations of Interest: Joy Luxford	Liam Coleman, Interim Chair	Verbal	-
2.	Written questions from the public		To follow.	I/D
3.	Minutes of the Board of Directors meeting held in public on 2 July 2025		Enc.	A
4.	Action Log		Enc.	A/D
5.	Governor Log of Assurance Questions and Responses (For Information)		Enc.	I
6.	Items discussed at Private Board		Verbal	I
7.	Patient Story	Toni Lynch, Chief Nursing Officer	Pres.	I/D
8.	CEO, Managing Director, and Chair's Report	Cara Charles-Barks, Chief Executive / Andrew Hollowood, Interim Managing Director / Liam Coleman, Interim Chair	Enc.	I
Governance				
9.	Item withdrawn			
10.	BSW Hospitals Group – Resolution to Update Partnership Agreement, Schedule 3 Joint Functions and Schedule 5, Joint Committee Terms of Reference	Cara Charles-Barks, Chief Executive	Enc.	A
11.	Integrated Performance Report	Executive Leads	Enc.	I/D
12.	Item withdrawn			
The People We Care For				
13.	Quality Assurance Committee Upward Report	Hannah Morley, Non-Executive Director	Enc.	I/D
14.	Q4 Learning from Deaths Report	Kheelna Bavalia, Interim Chief Medical Officer	Enc.	I/D
15.	Children's Safeguarding Annual Report	Toni Lynch, Chief Nursing Officer	Enc.	I/D
16.	Adult's Safeguarding Annual Report	Toni Lynch, Chief Nursing Officer	Enc.	I/D

17.	Infection Prevention and Control Annual Report	Toni Lynch, Chief Nursing Officer	Enc.	I/D
The People We Work With				
18.	People Committee Upward Report	Paul Fairhurst, Non-Executive Director	Enc.	I/D
The People in Our Community				
19.	Finance and Performance Committee Upward Report	Antony Durbacz, Non-Executive Director	Enc. / Verbal	I/D
CLOSING BUSINESS				
20.	Any Other Business	Liam Coleman, Interim Chair	Verbal	-
Date of Next Meeting: Wednesday 5 November 2025, 13:00 – 16:00 Venue: Room T0.24, Bath Spa University Sion Hill Campus, Sion Hill, Bath, BA1 5SF				

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

Present:

Members

Sumita Hutchison, Interim Vice-Chair *(Chair)*
Antony Durbacz, Non-Executive Director
Joy Luxford, Non-Executive Director
Paul Fairhurst, Non-Executive Director
Simon Harrod, Non-Executive Director
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
Jonathan Hinchliffe, Interim Group Transformation and Innovation Officer
Sarah Richards, Deputy Chief Medical Officer *(deputising for the Chief Medical Officer)*

In attendance

Roxy Milbourne, Interim Head of Corporate Governance
Enoch Doe, Enhanced Care Specialist Practitioner *(item 7)*
Jo Baker, Associate Director for Vulnerable People *(item 7)*
Sharon Manhi, Head of Patient Experience *(item 7)*
Zita Martinez, Director of Midwifery *(item 14)*
Public Governors
Management Trainees
Abby Strange, Corporate Governance Manager *(minute taker)*

Apologies

Paran Govender, Chief Operating Officer
Liam Coleman, Chair
Kheelna Bavalia, Interim Chief Medical Officer
Cara Charles-Barks, Chief Executive
Hannah Morley, Non-Executive Director

BD/25/07/01 Chair's Welcome, Introductions, Apologies and Declarations of Interest:

The Interim Vice-Chair welcomed everyone to the meeting and confirmed that apologies had been received from those listed above. The Board of Directors confirmed that they had no additional interests to declare.

BD/25/07/02 Written questions from the public

The Interim Vice-Chair summarised a number of questions that had been submitted by a member of the public via email on 25th June 2025. She explained that the questions had arisen from evidence given by witnesses at a public employment tribunal in March 2025, for which a judgement had now been published. The Board had not been able to answer all of the questions within 5 working days and a full and comprehensive response would be provided to the remaining questions via email. The outstanding questions and

responses would also be read out at the Public Board of Directors meeting in September 2025 and the full list of questions and responses would be made available on the Trust website.

BD/25/07/03 Minutes of the Board of Directors meeting held in public on 7 May 2025

The minutes of the meeting held on 7 May 2025 were approved as a true and accurate record.

BD/25/07/04 Action List and Matters Arising

The actions presented for closure were approved and it was agreed that PB617 could be closed.

BD/25/07/05 Governor Log of Assurance Questions and Responses

The Governor Log was presented for information and the Board noted that 2 new questions had been asked. The first question related to endoscopy capacity at Sulis and the response was detailed in appendix 1. The second related to ambulance handovers and a response would be circulated to the Governors in the next week. Both questions would be presented for closure at the Council of Governors meeting in September.

BD/25/07/06 Item Discussed at Private Board

The Interim Vice-Chair explained that the Board had had a lengthy discussion around the Trust's financial position, the savings that would be generated by the 5 transformation programmes, and additional steps that needed to be taken to close the remaining gap.

BD/25/07/07 Colleague Story

The Interim Vice-Chair welcomed the Enhanced Care Specialist Practitioner and the Associate Director for Vulnerable People to the meeting to present the Colleague Story. The Chief Nursing Officer introduced the story and reported that there had been an increase in the number of patients with mental health conditions requiring acute care and staff were not always equipped with the right knowledge, skills and confidence. Consequentially, the Trust had become reliant on agency staff to care for patients with mental health conditions but had now repurposed money to create its own Enhanced Care Team which had been in place for the last year. The team provided a 24/7 multidisciplinary service and was comprised of highly skilled professionals who were Registered Mental Health Nurses (RMN) and Enhanced Care Support Workers.

The Enhanced Care Specialist Practitioner explained that he had a background in mental health nursing and was passionate about giving back to the UK as his second home. He advised that he had worked as an agency worker at the Trust before applying for a substantive post when the Enhanced Care Team was established. The role of the Enhanced Care Team was to provide high quality care for the Trust's vulnerable patients and to make a difference to patients with primary mental health diagnoses. Patients were individually reviewed so that an informed approach could be taken in terms of their nursing support and the long term goal was to educate colleagues to improve understanding and delivery of trauma informed and evidence-based care. The Associate Director for Vulnerable People added that the team had received very positive feedback and there was a positive financial variance of £1.2m.

Antony Durbacz asked how the Trust ensured that patients received ongoing support once they had been discharged. The Enhanced Care Specialist Practitioner and

Associate Director for Vulnerable People advised that the Enhanced Care Team had good networking skills and worked closely with colleagues at Avon and Wiltshire Mental Health Partnership (AWP) to progress referrals for community support. They also worked closely with the Emergency Department (ED) in terms of admission avoidance.

The Board discussed whether this model of care was being utilised in other hospitals. They were informed that this model was unique to the Trust but a growing number of organisations were interested and the model was being shared across the Group. The organisation had also been recognised and contacted by the regional team. The purpose of implementing this model of care was to make both patients and the organisation safer and to reduce costs and it was proving to be a sustainable workforce model. The service continued to evolve to support patients who were at high risk of falls or had dementia or delirium to improve safety and meaningful intervention.

The Interim Chief Finance Officer sought clarity on the interaction between the Trust and AWP and noted the importance of professional supervision and support. The Enhanced Care Specialist Practitioner and Associate Director for Vulnerable People explained that weekly meetings were held with AWP to review Trust patients. Professional supervision was provided by both the Lead Nurse and the Associate Director for Vulnerable People.

The Board of Directors noted the story and the Interim Vice-Chair thanked the Enhanced Care Specialist Practitioner and Associate Director for Vulnerable People for attending.

BD/25/07/08 CEO, Managing Director, and Chair's Report

The Interim Managing Director reported that the Urgent and Emergency Care (UEC) Plan 25/26 and the new NHS Oversight Framework 25/26 had been published and the Trust was expecting a report as to where it would sit within this imminently. UEC remained a big focus for the Trust and a new Same Day Emergency Care (SDEC) unit had recently opened to support this. Operational performance remained challenged with a deterioration in Referral to Treatment and cancer and diagnostic performance and the financial position was £7.2m adverse to plan due to unidentified savings and the need to accelerate transformational opportunities within the organisation. A rapid national investigation into NHS maternity and neonatal services had been launched and advice and support was being sought from the Trust as an organisation that was rated outstanding for maternity care. The Trust was likely to see a significant number of mothers choosing to give birth at the RUH following the temporary closure of Yeovil Hospital Maternity Unit, and the team were working hard to transition patients.

The Board noted the transfer of Senior Responsible Officer for the Group Electronic Patient Record (EPR) Programme to the Interim Chief Transformation and Innovation Officer. It was also noted that Liam Coleman had been appointed as the Trust's Interim Chair, Sumita Hutchison had been appointed as Interim Vice-Chair, and John Palmer had been appointed as the substantive Managing Director. The BSW Hospitals Group Joint Committee was due to consider the proposed Group Operating and Leadership models at their next meeting and a Mutually Agreed Resignation Scheme (MARS) had been opened across the Group as part of the organisational redesign work. It was recognised that specialist skills were required to deliver the transformation and 24 colleagues from the People Directorates across the Group had completed AlignOrg methodology training to support with organisational redesign work.

The Board of Directors noted the report. They acknowledged that this was the Interim Managing Director's last meeting in his interim role and they thanked him for his leadership.

BD/25/07/09 Board Assurance Framework Summary Report

The Interim Vice-Chair welcomed the Corporate Governance Specialist to the meeting who provided an update on the Board Assurance Framework (BAF). He reported that there were 11 risks in total and 5 risk scores had increased, 4 remained the same, and 2 had been reduced. Key changes for each BAF risk were noted within the report and the increased risk scores were a result of reviews that had taken place to produce more realistic scores. A new template was included within part 3 of the report and this had been developed to show the detail behind each BAF risk, how key risk indicators were being incorporated, and to provide a clearer focus on controls and assurances.

Antony Durbacz noted that risk 1.2 had previously been within the remit of the Finance and Performance Committee (FPC) but was now the responsibility of the Quality Assurance Committee. He asked whether reporting around operational performance and constitutional standards needed to be realigned. It was agreed that a discussion would take place following the meeting.

Action: Chief Operating Officer

The Board discussed the BAF and it was suggested that clarity was needed around how the Executive Team collectively assessed risks and discussed changes before they flowed through to the BAF. The detail around the changes that had been made and the direction of each risk was welcomed and it was agreed that the BAF needed to be maintained as an agile document that met the needs of the organisation.

The Board of Directors noted the report and the Interim Vice-Chair thanked the Corporate Governance Specialist for attending.

BD/25/07/10 Integrated Performance Report

Quality

The Chief Nursing Officer reported 0.6 pressure ulcers per 1000 bed days in April 2025. The divisions were working closely with a small number of wards on action plans for improvement and patient safety investigations had been launched to review pressure ulcers and falls more broadly. There were 5 cases of hospital onset healthcare acquired Clostridioides Difficile infection (CDI) reported and the Infection Prevention and Control (IPC) Team continued to work closely with the Southwest CDI Collaborative. The combined shift fill rate for registered nurses across the 25 inpatient wards was 92% for days and 97% for nights, and the Trust remained stable in quartile 3. In terms of maternity, 3 moderate harm incidents were being investigated and there had been 33 additional births in May 2025. This was not related to the closure of Yeovil Hospital Maternity Unit but it had contributed to a slight reduction in the midwife the birth ratio.

The Interim Vice Chair asked whether the Trust should be looking to move to a less costly quartile in terms of safe staffing. The Chief Nursing Officer advised that quartile 3 was the right position in terms of how the Trust benchmarked with other organisations of a similar size. She added that the Trust's nursing establishment and staffing models were underpinned by evidence and benchmarked against National Quality Board Standards.

Workforce
The Chief People Officer reported that the vacancy rate had reduced to 3.30% in month 2 but bank usage had exceeded plan and work was ongoing to reduce this. Agency spend had decreased to 0.44% and rolling turnover had decreased to 7.57% against a target of 11%. Work continued to improve sickness absence and a new policy had been developed to support staff with long term conditions.

Finance
The Interim Chief Finance Officer reported that the RUH Group was £7.2m adverse to plan at the end of May, of which £6.6m related to the Trust, and £0.8m related to Sulis. This had triggered regulatory intervention and immediate enhanced expenditure controls. The key driver in terms of the Trust was the under delivery of the savings programme and the net adjusted risk financially was a £25m deficit based on month 2 trends. Work continued to improve the position and a review was taking place to determine whether it was possible to accelerate the savings plans given the level of operational risk. The Trust's cash balance continued to reduce and while the forecast was ok, further deterioration would require instigation of cash management activities.

Operational Performance
Operational performance was discussed within item 8.

The Board of Directors noted the update.

BD/25/07/11 Transformation Programmes
The Interim Managing Director provided an update on the development of the transformation programme including the month 2 position against business plan key metrics, the governance structure, delivery group updates, and next steps in developing the transformation programme. The delivery groups were working on detailed project planning for each of the transformation areas and quantifying the financial benefits for the remaining transformation opportunities. Until the plans were fully formulated, there would be a significant financial risk in terms of delivering the savings plan for 25/26. Key milestones to note were the opening of the Sulis Orthopaedic Centre and the implementation of electronic triage for all outpatient specialties. An ambient Artificial Intelligence (AI) pilot was also planned for July 2025 and a business case around improving waiting times was due to be implemented in Q2.

Antony Durbacz recognised the extent of the additional work that had been done in terms of transformation but commented that the Trust needed to deliver financial and operational metrics at a greater pace and the trajectories needed to be rephased.

Paul Fairhurst reflected on the change management office function and the appraisal dashboard that was being developed and noted that there was limited reference to this within the report. He was concerned that the initiatives were not yet embedded within the delivery groups which could pose a risk to successful delivery. The Chief People Officer advised that the organisation was in the early stages of building its change management capability but acknowledged the need to ensure that adequate attention was given to this. The Executive Team needed to work with the Organisational Development Team and the Change Management Office to understand the methodology and the Transformation Team needed to make sure that the people implications were considered at every milestone. It was agreed that this would be overseen by the People Committee.

Action: People Committee

The Board of Directors noted the update on the Transformation Programme and the financial risks associated with the delivery profile for transformational change and the unidentified savings.

BD/25/07/12 Business Plan 2025/26

The Chief Strategic Officer provided a summary of the Trust's Annual Business Plan for 25/26 including breakthrough objectives and corporate projects, performance, financial and workforce plans, productivity opportunities, and quality and safety priorities. She reported that the plan had been scrutinised via the governance process and had been approved on behalf of the Board of Directors, via delegated authority, by the Finance and Performance Committee on 30th April 2025. The plan had been signed off by NHS England (NHSE) following submission on 30th April 2025 but it was important to note that there was a significant level of complexity in terms of delivering the plan.

The Board of Directors noted the summary of the Annual Business Plan 25/26, the key risks, and the mitigations required to ensure delivery of the plan.

BD/25/07/13 TME Terms of Reference Approval

The Interim Managing Director presented the proposal to separate the Trust Management Executive (TME) responsibilities into 2 meetings, a Management Executive Committee (MEC) focusing on the operational and business aspects of the work plan and a Strategic Executive Forum (SEF) focusing on the strategic elements of the work plan. This had been developed to allow greater time for focussed and meaningful discussion and to broaden participation for strategic discussion to more of the Senior Leadership Team. It was thought that this would increase valuable contribution to the Trust's longer term planning and would improve communication across the Senior Leadership Team.

The Board of Directors approved the recommendation to separate the responsibilities of TME into MEC and SEF and ratified the MEC and SEF Terms of Reference.

BD/25/07/14 MIS Combined Maternity and Neonates Quarterly Report

The Interim Vice-Chair welcomed the Director of Midwifery to the meeting who reported that the stillbirth and neonatal death rate remained stable and below the national average. No births met the criteria for referral to the Maternity and Neonatal Safety Investigations Team and but one ongoing review was proceeding at family request. The service had declared full compliance with the Year 6 Safety Actions for the Maternity Incentive Scheme and also remained compliant with the Avoiding Term Admissions into the Neonatal Unit and transitional care pathway during Q4. Maternity triage was an area of focus for the Care Quality Commission and the Trust had commenced a review of it's Maternity Triage Unit. While there had been no safety issues identified, the quality of patient experience was an emerging theme due to wait times. The Trust was also non-compliant with the recommendation to have a resident doctor in the Maternity Triage Unit. An improvement plan had been developed in response to this and a risk would be added to the risk register in Q1. In terms of staffing, there was ongoing qualified in speciality training for neonatal staff and the Trust was on trajectory to be compliant in Q2. There was a risk around ultrasound capacity and demand and a workforce group had been formed to devise a more sustainable model for the future.

The Board of Directors noted the report and thanked the Director of Midwifery and her team for all they had done to support women from Yeovil Hospital Maternity Unit.

BD/25/07/15 Six Monthly Nurse and Allied Health Staffing Report

The Chief Nursing Officer presented the report which assessed the nursing staffing levels and the associated challenges for both nursing and Allied Health Professionals from July – December 2024. She reported that compliance had been evaluated with the Developing Workforce Safeguards and the evaluation had been submitted to the National Chief Nursing Officer. Nursing vacancy and turnover remained low and a live nursing vacancy tracker had been introduced within clinical divisions. The inpatient fill rate continued to improve and there had been a reduction in bank and agency spend due to reduced vacancies and turnover within theatres and substantive recruitment to the Enhanced Care Team. No correlation between quality metrics and safe staffing levels had been identified.

The Board of Directors noted the report.

BD/25/07/16 Quality Assurance Committee Upward Report

Simon Harrod presented the report and highlighted that flow through the hospital remained an issue and work continued to expand SDEC Services. CDI rates continued to be a concern but there was no indication that this related to poor IPC practice. The Committee discussed risks around recommendations to have dedicated Senior House Officer cover in maternity triage areas, complaints, and the quality of clinical letters. They also approved the 24/25 Annual Quality Account and the Annual Pharmacy Assurance Report.

The Board of Directors noted the report.

BD/25/07/17 People Committee Upward Report

Paul Fairhurst presented the report and highlighted that changes to the UK visa and settlement rules that were introduced by the Government in April 2025 could potentially impact international colleagues. The Committee had discussed support for the effected colleagues and would continue to monitor this risk.

The Board of Directors noted the report.

BD/25/07/18 Finance and Performance Committee Upward Report

Antony Durbacz presented the report and explained that there was concern around the Trust's financial performance and the momentum in addressing the phasing of savings. Performance metrics continued to fall below trajectories and these would be revised going forward. Significant momentum was required to address opportunities around outpatients and the approval of a number of constitutional standards business cases would support the delivery of this.

The Board of Directors noted the report.

BD/25/07/19 Audit and Risk Committee Upward Report

Joy Luxford presented the report and highlighted that the Internal Auditor had concluded their 24/25 Annual Report with a 'partial assurance with improvements required' opinion due to a lack of progress on actions within the required timeframe. The External Auditor signed off their ISA260 statement with an unmodified audit opinion but referenced material weaknesses in internal control and financial sustainability. The Committee had

signed off the Annual Accounts and had noted 3 internal audit reports, and the Local Counter Fraud Annual Report.

The Board of Directors noted the report.

BD/25/07/20 Charities Committee Upward Report

The Interim Vice-Chair reported an income of £3.15m and a return on investment of 3.92%. She highlighted that a PET CT initiative would be launched in July 2025 and a revised service level agreement for administrative services between the Trust and Charity had been agreed. Recruitment challenges and vacancy control had been identified as a risk to RUHX and it had been agreed that this would be escalated to the Board. Thanks were extended to the Associate Director, RUHX and her team for their leadership around recent funded initiatives and to the Friends of the RUH for their continued support.

The Board of Directors noted the report.

BD/25/07/21 Non-Clinical Governance Committee Upward Report

The Interim Vice-Chair presented the report and advised that variability in cleanliness remained a concern due to workforce issues and the need for better implementation of new standards. The Committee had received assurance that new governance structures and plans were in place to address overspend and time slippage around the EPR Programme and noted that early governance work was underway in terms of the adoption of AI. The Committee had celebrated full compliance with the NHSE Emergency Preparedness, Resilience and Response core standards and the reopening of the patient kitchen.

The Board of Directors noted the report.

BD/25/07/22 Any Other Business

No other business was discussed.

The Meeting closed at 15:00

Royal United Hospitals Bath
NHS Foundation Trust

Agenda Item: 4

ACTION LIST - BOARD OF DIRECTORS MEETING IN PUBLIC
WEDNESDAY, 2 JULY 2025

Action No	Details	Agenda Item No	First Raised	Action by	Progress Update & Status	Lead
PB619	**Board Assurance Framework** Acting Chief Operating Officer to discuss BAF risk 1.2 and which Committee should be responsible for this with the Corporate Governance Specialist.	**BD/25/07/09**	**July 2025**	**Sept 2025**	BAF risk 1.2 was incorrectly presented as being within the remit of QAC at the last Board of Directors meeting and has since been reallocated to the Finance and Performance Committee. **To close**	**Acting Chief Operating Officer**
PB620	**Transformation Programmes** People Committee to oversee the building of the organisation's change management capabilities.	**BD/25/07/11**	**July 2025**	**Sept 2025**	The People Committee will review status updates for each transformation programme and project, evidencing embedding of change management methodology (use of PROSCI and impact of the Leadership and Change Management Office). **To close**	**People Committee**

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**5**
Date of Meeting:	**3 September 2025**		

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

No new questions have been raised since the last report was presented in July 2025. Questions JUNE 25A and JUNE 25B remain open and are due to be closed at the Council of Governors meeting on 8th September 2025. Both questions and their subsequent responses are detailed at appendix 1 for information.

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

July 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.

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. Response shared via email on 11/07/25.
Answer	A full response was shared with the Governors on the 11/07/25. The response provided an overview of work to improve ambulance handover performance through the Urgent and Emergency Care Improvement Programme which consisted of 4 workstreams designed to reduce length of stay. Details were also shared around the Trust's current performance position, the performance metrics that were being measured, and the trajectory to acheive the expectations set by NHS England.
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.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**7**
Date of Meeting:	**3 September 2025**		

Title of Report:	**Patient story**
Status:	**For discussion**
Board Sponsor:	**Toni Lynch, Chief Nursing Officer**
Author:	**Sharon Manhi, Lead for Patient and Carer Experience** **Zita Martinez, Director of Midwifery** **Linda Webb, Ocean Midwife**
Appendices	**None**

1. Executive Summary of the Report

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

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

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

Louise's maternity experience

This story outlines the maternity and mental health journey of Louise, who experienced previous complex and traumatic pregnancies. Following a difficult first birth in 2022, which involved induction, forceps delivery, and ongoing complications from an episiotomy, Louise developed mastitis and suspected sepsis, requiring a prolonged hospital stay. This experience, compounded by a miscarriage in 2021 and a COVID-19 infection postpartum, had a significant impact on her mental health and led to treatment for Post Traumatic Stress Disorder (PTSD).

In 2023, Louise experienced a late miscarriage and received support from the Ocean midwifery team and therapy services. An open referral was given to Louise to ensure continuity of care should she become pregnant again.

During her most recent pregnancy in 2024, she was very anxious about the pregnancy and birth. She received ongoing support from the Ocean team, community midwives, and the Perinatal Mental Health Team. Exposure visits to the hospital were arranged to help manage trauma-related triggers, and a planned caesarean section was offered to avoid further physical and emotional distress.

Her second child was born via caesarean section in February 2025. She reported feeling safe and supported throughout the birth and postnatal period. Louise managed

to breastfeed receiving help from the infant feeding team, and her mastitis was managed early. The baby's tongue tie was identified and treated promptly.

This case highlights the importance of integrated perinatal mental health and midwifery support, continuity of care, and trauma-informed practice in improving outcomes for patients with complex maternity histories.

Background and context

The Ocean service is a specialist perinatal mental health provision comprising a small, multidisciplinary team of psychological therapists, specialist midwives, and nurses operating across Bath and North East Somerset (BaNES), Swindon, and Wiltshire (BSW).

The team delivers psychological assessment and therapy for individuals experiencing moderate to severe mental health difficulties resulting from trauma and loss associated with pregnancy, baby loss, or childbirth. The service is accessible to women and birthing people registered with a GP in BaNES, Swindon, or Wiltshire who are experiencing significant distress related to:

- Trauma following perinatal loss (including early miscarriage, recurrent miscarriage, stillbirth, and neonatal death)
- Psychological distress following a traumatic birth
- Termination of pregnancy for any reason
- Tokophobia (severe fear of childbirth) during or prior to pregnancy
- Support and signposting for partners.

Ocean provides expert assessment to determine appropriate care pathways and develops individualised treatment plans. Therapeutic interventions include Eye Movement Desensitisation and Reprocessing (EMDR) and trauma-focused Cognitive Behavioural Therapy (CBT), both evidence-based approaches for trauma recovery.
Referrals to the service are made via GPs, midwives, health visitors, and mental health professionals.

The Royal United Hospitals Bath NHS Foundation Trust (RUH) is committed to delivering personalised perinatal mental health care and ensuring equitable access to these specialist services. The Ocean service has been embedded within the BSW system since October 2021 and continues to evolve in response to local population needs. Future development plans also align with the Three-Year Delivery Plan for Maternity and Neonatal Services and the forthcoming NHS Long Term Plan (2025–2035).

Next Steps

Louise's maternity story showcasing the Ocean service will be shared widely with staff across the Trust to raise awareness and understanding.

The film will also be incorporated into local induction programmes for new staff joining

the Trust to support early engagement with the service.

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

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

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

5.	Resources Implications (Financial / staffing)
None	

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

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

8.	Freedom of Information
Public.	

Report to:	**Public Board of Directors**	**Agenda item:**	**8**
Date of Meeting:	**3 September 2025**		
Title of Report:	**Group Chief Executive & Managing Directors 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 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
  - Approach to Assessing Provider Capability
  - Lead Appointed for National Maternity Investigation
  - NHS Publishes Strike Impact Data
  - Tiering Approach for RUH

- Group
  - Joint Committee & Partnerships Agreement
  - Leadership Team
  - Group Strategy & 26/27 Planning
  - Group Governance & Assurance Arrangements & Transition Roadmap
  - Council of Governors Workshop
  - Board to Board development

MD's Report

- Local (RUH)
  - Operational
  - Finance
  - Workforce
  - Update on Industrial Action By Residential Doctors
  - The National Cancer Patient Experience Survey 2024
  - Decarbonisation of the Site
  - Use of Trust Seal
  - Membership
  - 2025 Governor Elections
  - 2025 Annual General Meeting
  - 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

Approach to Assessing Provider Capability

NHS England wrote to Provider Chief Executive's on 13th August 2025 providing an update on the approach to assessing Provider capability.

As set out in the recently published NHS Oversight Framework (NOF), NHS England will consider not only an organisation's delivery, as evidenced by its NOF segment, but also its capability. The rating of provider capability will help NHS England inform their response to NOF segmentation and may also inform any decisions about entry into the National Provider Improvement Program (NPIP), as well as Trusts being considered for new FT status.

The aim is to ensure that NHS England has a holistic view of providers, not just focussed on delivery of national programmes but also capturing wider information relevant to grip and governance. It is also intended to be a development tool, helping Boards to reflect on their competencies, develop robust approaches to internal assurance, and encourage continuous improvement.

The capability rating will be based on:

- an annual self-assessment by provider Boards and submission to NHS England, with supporting evidence. The assessment will be based on themes from last year's publication of 'The Insightful Board' (https://www.england.nhs.uk/publication/the-insightful-provider-board/)
- a review of the self-assessment, triangulated with the provider's track record to date and any third-party information (including CQC), to provide an overall view on the Board's capability. Whilst ICBs remain jointly responsible and involved in provider oversight we would also seek their views on the provider capability self-assessments for the providers in their systems.
- across the year, NHS England will use the capability rating and self-assessment to inform the relationship with the provider, revising the capability rating should events merit it e.g. if an issue emerges that was not foreseen in the self-assessment.

It is intended that the capability rating will be published alongside the NOF segmentation.

NHS England confirmed on 26th August 2025 that the first stage of this assessment involves Trust Boards assessing their organisation's capability against a range of criteria derived from last year's Insightful Provider Board document and submitting these self-assessments to regions. Oversight teams in each region will then review these, triangulating with their own views of the provider, its track record of delivery and any relevant information from third parties before assigning a capability rating.

Provider self-assessments are to be completed by 22nd October 2025.

Lead Appointed for National Maternity Investigation
It has been announced that Baroness Amos has been selected to lead the independent investigation into NHS Maternity and Neonatal Care.
The investigation was announced by the Secretary of State in June 2025 and will look at up to ten services in the country. It will also review the maternity and neonatal system, bringing together the findings of past reviews into one clear national set of actions to ensure every woman and baby receives safe, high-quality and compassionate care.

It will begin its work this Summer and produce an initial set of national recommendations by December 2025.

NHS Publishes Strike Impact Data
NHS England published data earlier in the month which outlined the impact of last month's industrial action by Resident Doctors, which showed the results of a more robust approach by NHS leaders with staff working around the clock to keep services open for patients.

The data showed that more care was delivered during the July 2025 Resident Doctors' strike than in the 5-day June 2024 walkout, with NHS analysis estimating that an additional 11,071 appointments and procedures went ahead. Staff absence due to industrial action was lower during this latest round, with around 1,243 fewer staff absent each day on average compared to last June – a 7.5% drop – helping Trusts to maintain more services and protect patient care.

An overview of the industrial action by Resident Doctors across RUH is outlined below:

<u>RUH</u>
We entered a new period of resident doctor industrial action beginning at 7am on Friday 25th July, until Wednesday 30th July 7am. As in previous years, the RUH declared a Business Continuity Incident for the entirety of the strike period and put plans in place to respond. Once again, our focus was to maintain safe care for our patients. Our Deputy Chief Medical Officer chaired our tactical group and through our divisional teams we ensured we prioritised urgent and emergency front door, inpatient cover, and time critical care. Planned and routine care were maintained as much as possible. We did not need to seek any Patient Safety Mitigation ('derogation') requests.

Our data suggests that overall, 46.1% resident doctors that would have been working across the five affected days took strike action. This is fewer than in previous episodes, although we saw variation across different days, grades, and specialties. Our UEC pathway was pressured for the tail end of the strike period, with no fall in demand and challenge with flow even with senior decision makers across the trust.

More planned care activities were maintained than we have for previous periods of strikes. Overall, we postponed 6 Inpatient procedures, 11 Day Case procedures, 26 new outpatient and 58 follow up outpatient appointments. The main driver for cancellation was where consultant rotas were changed to cover on-call or in-patient care.

There has been no notice of further planned industrial action periods. The BMA's current mandate is until Jan 2026. Talks will resume between the BMA and government to negotiate a position, with 'Improving Resident Doctors Lives' remaining a key component of resolution, and we will continue to work on this area.

Tiering Approach for Royal United Hospitals Bath NHS Foundation Trust
NHS England (NHSE) confirmed on 5th August 2025 that following a review of the Royal United Hospitals Bath NHS Foundation Trust performance, that the Trust would move to Tier 1 for Elective, Cancer, Diagnostics and Urgent and Emergency Care (UEC) for quarter two of 2025/26.

Being in Tier 1 will involve regular meetings with attendance from both Regional and National colleagues to discuss delivery progress and any required support from NHS England, including through the new national improvement offers. This may include a diagnostic or onboarding visit, on-site operational support from the National Improvement Support Team (IST) and/or GIRFT as well as clinical expertise (through National Clinical Directors and GIRFT Clinical Advisors). Trusts in UEC Tier 1 will also receive a further offer of direct improvement support for a period of up to six months

RUH Recovery Plan Update
At the end of July, the Trust remains behind trajectory for the Emergency Department (ED), Cancer, Referral to Treatment (RTT) and Diagnostics. Recovery plans have been developed for all four disciplines.

In Tier 1 the Trust can expect a heightened scrutiny from NHSE and the requirement for additional reporting on performance trajectories and improvement plans.

It will be important that the organisation manages this sensibly with our South West NHSE colleagues to avoid any distraction from delivery as a result of duplication of meetings and or reports. It is important that we remain focussed on delivery of our agreed plans and that we use our operational management capacity carefully.

UEC
On 30th June 2025 the Trust commenced a 4-week challenge in the Urgent Treatment Centre to accelerate priority actions which has resulted in an improvement in July across all key UEC metrics. 4-hour performance (type 1) improved from 57.6% to 62.8% against our recovery plan trajectory of 64% and Ambulance handover time reduced by 11 minutes to 45 minutes due to focused collaborative efforts with ED and South Western Ambulance Service NHS Foundation Trust (SWASFT) teams.

On 23rd June 2025, the new Medical Same Day Emergency Care (SDEC) opened its doors to patients, combining the work that was previously done in Ambulatory Care and on Direct Assessment Area (DAA) trolleys. In July 2025, 40.5% of patients admitted as an emergency went via our SDEC pathways. This is over 5% higher than in April. Further work is ongoing to embed the Medical SDEC and review capacity and processes for other SDEC pathways across the Trust.

The UEC Delivery Group is overseeing improvement actions across three key workstreams: UTC, Capacity Management (including SDEC) and Home is Best.

Cancer

For Cancer, 28-day performance is expected to remain consistent until September, whereas performance for 31-day and 62-days is expected to decline until Q3 at which point recovery actions implemented in August and September will take effect. Some key mitigations for Cancer performance include Cancer Alliance/national funding for short term capacity, demand management for priority cancer sites, expansion of Straight to Test (STT) pathways and timed pathway performance monitoring to rapidly identify issues and act accordingly.

RTT

For RTT performance, detailed trajectories have been drafted for all specialties with dedicated action plans that are reviewed weekly. The Trust expects performance recovery to start from September due to the timescales required to mobilise the recovery schemes. These plans include the assumed impact of the 12-week challenge and validation of waiting lists based on sample validation data.

On 18th August the RUH launched a 12-week challenge which will focus on validating and cleansing waiting lists, improving scheduling and booking processes and standardising the Patient Tracking List (PTL) governance structure. Additional managerial and administrative support is being sought from NHSE and Commissioning Support Unit (CSU) with this 12-week challenge.

Diagnostics

The Trust's position year to date is significantly off plan for diagnostics with those waiting over 6 weeks increasing to 32% in July compared to initial trajectory. The ultrasound position remains a key risk, but additional Sulis capacity has been confirmed increasing to a 5-day service, which will support recovery from September. A review is underway to review options to increase reporting capacity, and an agreement has been reached with University Hospitals Bristol and Weston NHS Foundation Trust for Continuous Positive Airway Pressure (treatment for sleep apnea) (CPAP) capacity which will support sleep recovery.

Group Update

Joint Committee & Partnership Agreement

Our second BSW Hospitals Group Joint Committee meeting was held on 16th July in Swindon with focus being on discussion and approval of the proposed Group Operating Model and Leadership Model. Initial corporate services plans were introduced for priority services – Finance, People, Digital, Estates & Facilities and

Capital Planning. Proposed clarifications to the Group Partnership Agreement Joint Functions and Joint Committee Terms of Reference were approved pending ratification by Boards. The establishment of a Group Strategy and Planning working Group was approved. A report from the July Group Joint Committee has been included with September Trust Board papers.

Leadership Team

September and October will see developments in the Group leadership team. Our three Managing Directors (Lisa Thomas – GWH, John Palmer – RUH, Nick Johnson – SFT), will start in-post on 1st September. Following approval of proposed leadership model by the Remuneration Committees in Common at the end of July a consultation exercise is now underway. The post-consultation report will be considered by the Joint Committee on 29th September. In the short-term we have progressed recruitment to:

- Strategic Clinical Transformation Director. Advertised. Interviews 27th August. Target in-post September.

Group Strategy & 26-27 Planning

The development of our Group Strategy has begun, led by SRO Joss Foster and coordinated by Trust strategy leads. Our Transitional support partner Teneo is supporting this work. The strategy will be developed in close coordination with the 26-27 planning round.

Group Governance and Assurance Arrangements and Transition Roadmap

To support safe and effective mobilisation of our new Operating Model by April 2026, the programme team is focused on developing a detailed governance and assurance roadmap in readiness for consideration by the 29th September Joint Committee. The development of our group risk approach and assurance arrangements will form an important part of this roadmap.

Councils of Governors Workshop

On 5th August the three Councils of Governors came together in Devizes, to start the conversation about opportunities for BSW Hospitals and the 10-Year Plan, to discuss the emerging Operating Model and Council of Governors role. It was agreed that a follow-up meeting would be arranged, so Governors can continue the conversation on Group Development and our response to the 10-Year Plan; this next session will be held on 1st October.

Board to Board Development

We have begun planning for our next Board-to-Board sessions planned on 2nd October and 12th February. Further details will be circulated in early September.

MANAGING DIRECTOR'S REPORT

1. Operational

Ambulance Handover

In July, and in partnership with ambulance colleagues, we commenced the 45-minute "drop and go", a focused collaborative effort with ED (Emergency Department) and SWASFT (South Western Ambulance Service Foundation Trust) teams, and have seen a significantly improved performance, achieving an average handover time of 45 minutes in July. This is a reduction of 10.7 minutes compared to June. July 2025 also saw a reduction of 332 hours in lost hours.
Overall, we remain behind the 33-minute trajectory. However, this financial year we have been making month on month improvements despite increased demand.

Tier 1 Performance

The RUH has been placed into Tier 1 for RTT (Referral to Treatment), Diagnostics, Cancer and UEC (Urgent and Emergency Care) performance. Recovery plans have been developed for all four disciplines.
There was improvement seen across all key UEC metrics in July, driven by a 4-week challenge to expedite priority actions. The UEC Delivery Group is overseeing improvement actions across three key workstreams: UTC (Urgent Treatment Centre), Capacity Management (including SDEC – Same Day Emergency Care) and Home is Best.
When looking at the progress that has been made in UEC performance, it should be noted that this has been achieved despite the closure of 15 escalation beds, a steady increase in ambulance activity and an increase of non – elective admissions of circa 8%.
Our top risks for UEC remain to be the deficit of senior decision makers based on modelled demand, NCTR (No criteria to reside) remains well above recovery trajectory, with a daily average of 76.5 in July, resulting in exit block and delays in the admitted pathway.
For cancer, 28-day performance is expected to remain consistent until September, whereas performance for 62-days is expected to decline until Q3 at which point recovery actions and additional capacity mobilised in August and September will begin to deliver improvement.

DMO1 (Diagnostics Waiting Times and Activity)

The Trust's position YTD (year to date) is significantly off plan for diagnostics with those waiting over 6 weeks increasing to 32% in July compared to initial trajectory. Key issues are in Ultrasound, Echo, Sleep and MRI. Significant progress has been made to correct capacity and demand mismatch, with the Sulis ultrasound service increasing to a 5-day service, and an agreement being reached with UHBW (University Hospitals Bristol and Weston) for CPAP (Continuous Positive Airway Pressure) capacity.

Additional risk to achieving the DMO1 standard will come as a result of the work being undertaken to improve the Trust's RTT performance. As we work through the back of delays to first appointment, we will drive up demand for diagnostic tests.

It is imperative that we understand at a granular level the demand and capacity gaps to support effective planning for short-, medium and long-term interventions. We will carry out on a diagnostic deep dive through September and October.
For RTT performance, detailed trajectories have been drafted for all specialties with dedicated action plans that are reviewed weekly. We expect performance recovery to start from September due to the timescales required to mobilise the recovery schemes. These plans include the assumed impact of the 12-week challenge and validation of waiting lists based on sample validation data. The 12-week challenge was launched on 18th August and is looking at how we manage and govern our waiting lists.

2. Finance

The Trust delivered a deficit of £1.3m for month 4, increasing the year to date deficit to £10.1m. This was an improvement on previous months but was supported by one off benefits of £0.75m.

The key driver of the RUH financial position continues to be the slippage on the delivery of the annual savings target which is £8.4m off plan against a year to date target of £10m. With many of the savings linked to service change, the ability of the Trust to manage demand, deliver performance targets and reduce cost is becoming very challenging. A financial recovery plan for the RUH has been developed that aims to achieve a £10m deficit by the end of the financial year. This would require a £22m improvement against the 'Do Nothing' run rate. The plan has been reviewed and signed off by the management executive and the finance and performance committee.

It will be essential that this financial recovery plan is delivered in order to safeguard the cash position of the Trust. Without a significant improvement in the income and expenditure position for the Trust the cash position for the Trust will become very challenging in the last quarter of the financial year and will require the cash management framework to be implemented.

The delivery of the capital plan continues to be limited, in part driven by decisions to hold back on some capital expenditure in order to support the cash position of the Trust.

3. Update on Industrial Action by Residential Doctors

We entered a new period of resident doctor industrial action beginning at 07:00 on Friday 25th July, until Wednesday 30th July 07:00. As in previous years, the RUH declared a Business Continuity Incident for the entirety of the strike period and put plans in place to respond. Once again, our focus was to maintain safe care for our patients. Our Deputy Chief Medical Officer chaired our tactical group and through our divisional teams we ensured we prioritised urgent and emergency front door, inpatient cover, and time critical care. Planned and routine care were maintained as much as possible. We did not need to seek any Patient Safety Mitigation ('derogation') requests.

Our data suggests that overall, 46.1% resident doctors that would have been working across the five affected days took strike action. This is fewer than in previous episodes, although we saw variation across different days, grades, and specialties. Our Urgent and Emergency Care pathway was pressured for the tail end of the strike period, with no fall in demand and challenge with flow even with senior decision makers across the trust. More planned care activities were maintained than we have before. This is in keeping with national trends.

There has been no notice of further planned industrial action periods. The British Medical Association's current mandate is until Jan 2026. Talks will resume between the British Medical Association's and government to negotiate a position, with 'Improving Resident Doctors Lives' remaining a key component of resolution, and we will continue to work on this area.

4. The National Cancer Patient Experience Survey 2024

The results of the National Cancer Patient Experience Survey 2024 show a continued year-on-year improvement at the RUH, with the Trust's overall 'experience of care' rising to 9.1 - above the top 'upper expected' range, reflecting the RUHs commitment to supporting the people we care for every step of the way.

For 18 questions in the survey, the Trust scored above the 'expected' (average) range and there were no questions where the score was below the expected range.

We were delighted to hear that patients said that staff provided them with relevant information on available support and that their family or carer was involved as much as they wanted them to be in decisions about treatment options. In addition to receiving a high score for treating patients with privacy and dignity and for team working the patients provided positive feedback about pain control, and the support available to patients to manage side effects from treatment.

We are committed to improving and we will analyse the results further, triangulate them with other insights to make improvements for the people we care for and the people we work with. You can find more information and a breakdown of results for each Trust on the National Cancer Patient Experience Survey website - https://www.ncpes.co.uk/

5. Decarbonisation of the Site

We have previously shared that the Trust received a grant of £21.6million from the Department of Energy Security and Net Zero to enable the Trust to deliver 'Project Clean Heat', with the aim to make RUH a greener, healthier cleaner environment for all those who use it. We are thankful to our partner organisations who are supporting us to achieve our ambition, notably the Carbon Energy Fund, Salix, and Veolia.

The grant is enabling the Trust to install new air and water source heat pumps in addition to funding other important building improvements such as additional solar panelling, better insulation, high-quality LED lighting, and more efficient heating and cooling. controls.

Over the last two weeks the water and air source heat pumps have arrived on site and the installation phase has commenced. As such, there are cranes and large pieces of equipment on the Combe Park site. To install the new equipment there will be some disruption to our parking and internal roads. All changes will be shared via our communication channels, and we will ensure our wayfinding is updated during the disruption to the site. If you are visiting for appointments, we advise that you leave a little extra time to get to your appointments.

6. Use of Trust Seal

The Trust seal was used on 23rd July 2025 to seal the licence to alter in relation to Sulis Elective Orthopaedic Centre (SEOC) works at Sulis Hospital Bath Ltd. The seal number is 537.

7. 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/

8. 2025 Governor Elections

Throughout September, our members will have the opportunity to nominate themselves for election to the RUH Council of Governors. The nominations stage opens on Monday 8th September and will close on Tuesday 23rd September. We are looking for interested, energetic and committed members of the local community to represent the following constituencies:

- City of Bath
- North East Somerset
- Mendip
- North Wiltshire
- South Wiltshire
- Rest of England and Wales

Please contact the Membership Office via email at RUHmembership@nhs.net to arrange an informal discussion to find out more about the role.

9. 2025 Annual General Meeting

The Trust will be holding its Annual General Meeting combined with Annual Members' Meeting on Thursday 25th September 2025 from 16:00. To ensure accessibility and to make the most of our available resources, this year's event will be hosted virtually.

Details of the Annual General Meeting will be shared over the coming weeks on our Trust website and directly with members. The event will be a fantastic opportunity to hear about the work that the Trust has been doing over the past year and to ask questions to the Board. If you would like to submit a question in advance of the event or to register your interest in attending, please contact the Membership Office using the details provided in the 'Governor Elections' section of this report.

10. Consultant Appointments

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

Dr Nathalie Webber was appointed as Consultant Clinical Oncologist (Colorectal & Gynaecology) and commenced his new role on 13th November 2025.

Dr Georgina Gullick was appointed as Consultant Medical Oncologist (Breast & HPB) and commenced his new role on 2nd February 2026.

Dr Charles Crocker was appointed as Consultant Clinical Oncologist (Breast & Skin)and commenced his new role on 24th November 2025.

Dr Emma Tenison was appointed as Consultant in Geriatrics and commenced his new role on 29th November 2025.

BSW Hospitals Group

Report to:	Royal United Hospitals Bath NHS Foundation Trust Public Board of Directors	Agenda item:	10
Date of meeting:	3rd September 2025		

Report title:	BSW Hospitals Group – Resolution to Update Partnership Agreement, Schedule 3 Joint Functions and Schedule 5, Joint Committee Terms of Reference			
Status:	Information	Discussion	Assurance	Approval
				X
Approval Process: (where has this paper been reviewed and approved):	N/A			
Prepared by:	Ben Irvine, Programme Director, BSW Hospitals Group			
Executive Sponsor:	Cara Charles-Barks, CEO, BSW Hospitals Group			
Appendices	• Appendix A: Schedule 3: Group Joint Functions. • Appendix B: Schedule 5: Joint Committee Terms of Reference			
BAF Risk Link	N/A			

Recommendation:

Following Trust Board agreement in principle (July 2025) to changes intended to provide further clarity regarding delegated functions and Joint Committee Terms of Reference, the Trust Board is asked to **approve** the proposed variations to the May 2025 Partnership Agreement, Schedule 3 - Group Joint Functions, and Schedule 5 - Joint Committee Terms of Reference, of the BSW Hospitals Partnership Agreement.

Executive Summary:

In July 2025, Private Boards of Great Western Hospitals NHSFT (GWH), Royal United Hospitals Bath NHSFT (RUH), and Salisbury NHSFT (SFT) received and approved a proposal to move to a Joint Chair and a General-Purpose Joint Committee (Group Board) by 01 April 2026.

The Boards approved an immediate first step to strengthen the formal delegations of the existing Special Purpose Joint Committee giving it the specific and delegated remit to:

- Develop and approve the roadmap from now to 01 April 26 implementation of the Group Board and Joint Chair
- Develop and approve the Group Board membership (subject to relevant approvals from the Remuneration committees in common and Councils of Governors with respect to NEDs)
- Develop and approve the Target Operating Model for the Group
- Develop and approve the Group's governance and assurance framework
- Develop and approve the Group's OD and engagement plan, including the approach to engagement with the Councils of Governors
- Develop and approve a single financial plan for the Group
- Oversee the development of the Group Strategy (for approval by the Group Board in April 2026)

Two Schedules in the BSW Hospitals Group Partnership Agreement have been updated in response, incorporating these strengthened delegations. **Appendix A** comprises an update to Schedule 3: Group Joint Functions. **Appendix B** comprises a revision to Schedule 5, the Joint Committee Terms of Reference. Revisions in Schedules 3 and 5 are highlighted in red text.

On 16th July the BSW Hospitals Group Joint Committee approved these changes in principle, noting that Clause 18 of the BSW Hospitals Group Partnership Agreement requires:

- *18.1 Except as set out in Clause 18.2 or otherwise in this Agreement, any Variation of this Agreement, including the introduction of any additional terms and conditions, shall only be binding when agreed by written resolutions of each Trust's Board.*

Accordingly, the Trust Board is asked to confirm approval of the proposed variations to Schedule 3 and Schedule 5.

Group Vision Metrics	Select as applicable:
Developing an engaged workforce	x
Making our teams diverse and inclusive	x
Making our services safer	x
Improving timely access to our services	x
Improving the experience of those who use our services	x
Improving our financial sustainability	x
Improving health equity	x

Date **[INSERT DATE WHEN APPROVED]** **2025**

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

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

Version control

[Once approved , Version 2.0]

Schedule 3– Joint Functions

1 Subject to paragraph 2:

1.1 Joint Functions are any Functions relating to any of the matters set out in paragraph 3 below.

1.2 Joint Functions may additionally include any or all Functions that NHS England has categorised as 'Open to Joint Exercise of Functions' in *Arrangements for delegation and joint exercise of statutory functions* as reproduced in the table set out in Paragraph 4 below (excluding references to legislation that is applicable to or in force in Wales only) which the Trusts agree by Variation should be Joint Functions.

2 Joint Functions may not at any time include Mandatory Reserved Functions.

3 The matters referred to in paragraph 1.1 are:

3.1 Group Strategy & Planning Framework

- Development, approval and delivery of overarching Group Strategy (by April 2026) and associated specialist development and delivery plans, including Group Clinical, Workforce, Financial Sustainability, Digital, Estates & Facilities, Innovation, Research & Development, Partnership working, and Capital Plans.
- Development, approval and delivery of Group Strategic Planning Framework and Annual Group-wide Plan.
- Oversight of delivery of Group Strategic Initiatives.
- Management of risk to delivery of Group Strategy

3.2 Transforming our Model of Care for the BSW Population we Serve - Clinical Services Organisation/ Pathways/ Design

- Development and approval of Group **clinical services framework for the collective population we serve** with associated decision-making processes.
- **Approval** of service/pathway/treatment configuration changes across the Group.

3.3 Financial Sustainability - Use of Resources

- Development and approval of a single financial plan for the Group.
- Setting and delivery of Group Financial Recovery and long-term Group financial sustainability plans.
- Capital Programme. Development and approval of capital investment programme for the Group ensuring we attract capital into BSW to address priorities.
- Capital Programme. Development and approval of capital limits for each Trust within the group to be delegated.

3.4 Group Mobilisation & Development

- Oversight of Group Mobilisation & Development. Development and approval of Group Roadmap [June 2025-April 2026] to implementation of a Group Board [by April 2026] and Joint Chair [by April 2026].
- Development and approval of Group Target Operating Model,
- Development and approval of the Group Governance, assurance and accountability framework (including development and approval of Group Board - General Purpose Joint Committee Terms of Reference), and associated Integrated Performance Reporting.
- Development and approval of Group Board membership.
- Oversight of delivery of the Case for Collaboration and emerging agreed priorities. Includes programme oversight of 10x workstreams from case for collaboration – with details, phasing and resourcing agreed in Group annual plan.
- Group Development - Corporate Services – Define objectives, shape and structure of Group corporate services transformation. Approve resourcing of programme.
- Group Development - Develop and approve the Group's Organisational Development and engagement plan, including the approach to engagement with the Councils of Governors

3.5 Achieving Digital Maturity

- EPR Programme – Oversight of Implementation. Approval of new Benefits Profile. Approval of proposals for new Budget.
- Group Digital transformation programme – implementation [x-refer 3.1]

4 The table referred to in paragraph 1.2 is as follows: [Note: Not changed. Refer to original Partnership Agreement]

Browne Jacobson

Date: 22nd May [INSERT NEW DATE WHEN APPROVED] 2025

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

Partnership Agreement

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

Schedule 5. BSW Hospitals Group Joint Committee ToR

Terms of Reference for a special purpose joint committee (the BSW Hospitals Group Joint Committee) between Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust

Version control

Date	Version	Author
18 Feb 2025	001	Browne Jacobson LLP
27 Mar 2025	002	Browne Jacobson LLP
14 Apr 2025	003	Browne Jacobson LLP
12 June 2025	004	Ben Irvine, BSW Hospitals Programme Director [added Partnership Agreement execution date]
26th June	July 001	Ben Irvine.

1 Introduction

1.1 The BSW Hospitals Group Joint Committee is a statutory joint committee of the boards of Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust, and Salisbury Hospital NHS Foundation Trust (the Trusts) who have established it under section 65Z6 of the National Health Service Act 2006 to exercise Joint Functions in accordance with the Partnership Agreement entered into by the Trusts dated 22nd May 2025 (the Partnership Agreement).

1.2 As set out in the Partnership Agreement, the BSW Hospitals Group Joint Committee will oversee the plan for closer collaboration, the subsequent delivery programme, and development of the proposed Group model. The shared narrative for the Group is as follows:

1.2.1 Together we will make the best use of collective resources available to us. Our decisions will be judged by their ability to make best use of resources for the population in BSW.

1.2.2 A collective approach will enable enhanced clinical effectiveness – spreading best practice, and responding to inequity, fragile services, improving fairness across BSW.

1.2.3 A collective approach will enable service viability – it will be easier to create high quality resilient services in Group. We will work to avoid creation or emergence of unacceptable levels of fragility to services and individual Trusts, including with our Place-based, network and tertiary partners.

1.2.4 We need to change how we operate. Individually, Trust sustainability is challenging. A group model offers real opportunity to remain as stand-alone local organisation focused on needs of population within the support structure of a group.

1.2.5 Risk: We will develop collective approach to risk and address differences between local and group risk appetite when they emerge.

1.3 In these terms of reference 'Joint Functions' mean all the Trusts' functions that the Trust Boards have agreed are Joint Functions in accordance with the Partnership Agreement.

2 Authority & Accountabilities

2.1 The BSW Hospitals Group Joint Committee is authorised by the Boards to exercise the Joint Functions.

2.2 The BSW Hospitals Group Joint Committee shall be fully and equally accountable to each Trust Board for the exercise of the Joint Functions and shall at all times comply with the Partnership Agreement and NHS England guidance when exercising Joint Functions.

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

2.4 The BSW Hospitals Group Joint Committee is authorised by the Boards to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

2.5 The BSW Hospitals Group Joint Committee shall transact all business in accordance with the policies of the Trusts on openness and conformity with the Nolan principles and values of the Public Services.

3 Reporting Arrangements

3.1 The minutes of Joint Committee meetings shall be formally recorded and submitted to each Trust's Board.

3.2 The BSW Hospitals Group Joint Committee shall provide regular update reports to each Trust's Board on the activities of the BSW Hospitals Group Joint Committee in accordance with a single reporting schedule agreed by the Trust Boards.

4 Membership

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

4.2 Each Trust shall appoint the following Members, who may be Voting Director or Non-Voting Directors:

4.2.1 Chair, Vice Chair and three other Voting NEDs nominated in writing by the Trust's Chair

4.2.2 Chief Executive Officer, Managing Director and two other EDs nominated in writing by the Trust's Chair and Chief Executive Officer.

4.2.3 All joint Executive Director roles created by the Trusts.

4.3 The Trusts shall ensure that in appointing the EDs in accordance with paragraph 4.2.2 the membership of the BSW Hospitals Group Joint Committee shall include a Chief Nursing Officer, a Chief Medical Officer, a Chief Finance Officer, a Chief People Officer, a Chief Operating Officer, and a Director of Estates and Facilities. The role of these EDs shall be to bring their portfolio expertise to the decisions of the BSW Hospitals Group Joint Committee in the interests of the Group.

4.4 It is acknowledged that the role of the Members shall be to make decisions in the interests of the Group rather than to represent the views of their individual Trusts.

Commented [RH1]: Browne Jacobson comment: I have suggested separating this provision out so that it is a standalone provision that applies to all members of the Joint Committee rather than just the EDs.

4.5 The Trusts may agree in writing to vary these Terms of Reference to amend the number of Members of the BSW Hospitals Group Joint Committee provided that:

4.5.1 Each Trust appoints the same number of Members

4.5.2 The Chair and Chief Executive Officer are Members

4.5.3 The Chair and other Voting NED Members outnumber the ED Members.

4.6 Additionally, the Trusts may agree in writing to vary these Terms of Reference to permit them to appoint Non-Voting Directors of the Trusts to be Members of the BSW Hospitals Group Joint Committee.

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

4.8 A Member's initial term of appointment to the BSW Hospitals Group Joint Committee shall be up to three years, or the end of their term of appointment as a Director of a Trust, whichever is the earlier. A Member's may be reappointed by their Trust in accordance with paragraph 4.2 for further terms.

5 Attendance

5.1 The Trust Secretary of one of the Trusts will attend as required to ensure that the BSW Hospitals Group Joint Committee business is transacted as per this Terms of Reference, the Partnership Agreement, the Trusts' Standing Orders and documents referred to in them.

5.2 With the consent of the BSW Hospitals Group Joint Committee Chair, other persons may be invited to attend and contribute to meetings of the BSW Hospitals Group Joint Committee but not take part in making decisions.

5.3 In line with the Trusts' Standing Orders, Members must attend at least half the BSW Hospitals Group Joint Committee's meetings annually. Any failure of a Member to meet this attendance requirement shall be considered as part of that individual's Annual Review and Appraisal process.

5.4 Subject to paragraph 5.3 and the prior agreement of the Chair, each Trust may nominate a deputy to attend a meeting of the BSW Hospitals Group Joint Committee in the event of a Member's absence. For Members appointed under paragraph 4.2.1 the deputy shall be a Voting NED nominated by the Chair of the relevant Trust. For Members appointed under paragraph 4.2.2 the deputy shall be an ED or senior director nominated by the Chair and Chief Executive of the relevant Trust. For Members appointed under paragraph 4.2.3 the deputy shall be an ED or senior director nominated by the Chief Executive. A deputy shall be formally nominated with the same rights and privileges as the Member for whom they are deputising.

6 Chair

6.1 The Joint Chair of the Trusts, if present, shall preside at any meeting of the BSW Hospitals Group Joint Committee or, if the Joint Chair is absent, the Deputy Chair of the BSW Hospitals Group Joint Committee shall preside. If the Deputy Chair is presiding at a meeting instead of the Chair, then references in this Terms of Reference to the Joint Chair shall be construed as the Deputy Chair.

6.2 Pending the appointment of a Joint Chair of the Trusts, the current Chairs of the Trusts shall agree between them who shall chair meetings of the BSW Hospitals Group Joint Committee (where possible rotating between them) and any reference in these terms of reference to 'Joint Chair' shall (where the context requires) be construed as the Trust Chair who presides at a meeting.

7 Quorum

7.1 No business shall be transacted at a meeting of the BSW Hospitals Group Joint Committee unless:

7.1.1 At least half the Members of the BSW Hospitals Group Joint Committee are present

7.1.2 At least half of the Members present are Voting NEDs

7.1.3 The Members present include (in addition to the Joint Chair) at least two EDs of each of the Trusts (who in the case of a joint director may be the same person) and at least two Voting NEDs of each of the Trusts (who in the case of a joint director may be the same person).

8 Decision making

8.1 The BSW Hospitals Group Joint Committee will generally operate on the basis of forming a consensus on all issues considered, taking account of the views expressed by all Members. The Joint Chair will seek to ensure that any lack of consensus is resolved amongst Members.

8.2 If the BSW Hospitals Group Joint Committee is unable to reach a consensus on an issue, the Joint Chair may put the issue to a vote. The vote will be carried if:

8.2.1 A special majority of not less than two thirds of the Members present and voting are in favour, and

8.2.2 The Members in favour include more than half of the Members from each Trust.

8.3 Each Member of the BSW Hospitals Group Joint Committee shall have one vote except in the event that prior to the appointment of the Joint Chair an individual is appointed as the Chair of two of the Trusts but not the other, in which case they shall be treated as if they were separate individuals and entitled to cast a vote on behalf of each Trust to which they are appointed.

8.4 The decisions of the BSW Hospitals Group Joint Committee (which for the avoidance of doubt extend only to decisions in respect of the Joint Functions) are binding on each of the Trusts.

9 Admission of the public to meetings

9.1 Meetings of the BSW Hospitals Group Joint Committee shall be held in in private.

9.2 But the BSW Hospitals Group Joint Committee may, by resolution, permit the public to attend a meeting to observe (whether during the whole or part of the proceedings).

10 Managing Conflicts of Interest

10.1 Each Member of the BSW Hospitals Group Joint Committee must abide by all policies of the Trust of which she or he is a director or officer in relation to conflicts of interest.

10.2 At the first meeting of the BSW Hospitals Group Joint Committee, the BSW Hospitals Group Joint Committee will select a chair ("Joint Committee Chair") from amongst the members who are Trust Chairs. A Deputy-Chair will also be selected. Once a joint chair for the Trusts is appointed, he or she shall become the BSW Hospitals Group Joint Committee Chair and the incumbent Joint Committee Chair (if not the joint chair) shall immediately hand over.

10.3 The Trusts acknowledge that sections 63A and 223L to 223N of the NHSA (as introduced by the Health and Care Act 2022) impose duties on the Trusts to have regard to the wider effects of their decisions and the expenditure limits and use of resources requirements of their system. In the light of these duties, there should be few occasions where the interests of the Trusts are not aligned and directors of each Trust must have regard to the wider impact of their decisions on the other Trusts and seek to cooperate with the other Trusts in exercising their functions.

11 Administrative Support

The Chief Executive Officer shall nominate a Trust Secretary to arrange provision of administrative support to the BSW Hospitals Group Joint Committee.

12 Annual Workplan

The BSW Hospitals Group Joint Committee will agree an Annual Workplan and cycle of business prior to the beginning of each financial year. The reporting cycle will then form part of the agenda alongside the standing agenda items.

13 Frequency of Meetings

13.1 Ordinary meetings of the BSW Hospitals Group Joint Committee shall be held not less than six times a year and shall be coordinated with the cycle of Board meeting of the Trusts.

13.2 Notice of all meetings shall comprise venue, time and date of the meeting, together with an agenda of items to be discussed.

13.3 Extraordinary meetings may be called for a specific purpose at the discretion of the Joint Chair. Where possible, a minimum of seven working days' notice will be given when calling any extraordinary meeting.

14 Papers Publication

All papers will be published using the available electronic Board paper system. Publication of papers will be seven working days before meetings. A progress report of outstanding/pending Joint Committee actions will be presented to each meeting of the BSW Hospitals Group Joint Committee.

15 Routines, Behaviours and Standards

15.1 The BSW Hospitals Group Joint Committee will implement the following routines and behaviours, in order to enable a safe, inclusive and trusting environment, where teams build and maintain effective relationships:

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

15.1.2 Ensure frequent personal contact to build understanding and trust

15.1.3 Surface and resolve conflicts, not letting them fester

15.1.4 Work collectively for the long-term

15.1.5 Behave altruistically towards partners

15.1.6 An open book approach to information to build understanding and trust.

15.1.7 Be facilitative, enabling and pace setting in their role as System leaders.

15.2 The BSW Hospitals Group Joint Committee shall comply with the following standards:

15.2.1 NHSE Code of Governance for NHS provider trusts

15.2.2 NHSE Risk Assessment Framework

15.2.3 NHSE Annual Planning Guidance

15.2.4 The Health NHS Board – Principles of Good Governance

15.2.5 Corporate Governance – Principles of Public Life (GP01)

15.2.6 King's Fund: The Practice of Collaborative Leadership: across health and care services

15.3 The BSW Hospitals Group Joint Committee shall work to the following principles:

15.3.1 Create value for the population

15.3.2 Create constancy of purpose

15.3.3 Think systematically

15.3.4 Lead with humility

15.3.5 Respect every individual

16 Standard Agenda

16.1 Agendas will be built around the BSW Hospitals Group Joint Committee annual workplan, and most of the following will appear on each agenda, while some will appear only once or twice each year:

16.1.1 Declarations of interest,

16.1.2 Minutes of previous meeting,

16.1.3 Action list

16.1.4 Group Strategy

16.1.5 Performance, Transformation and Benefits Realisation

16.1.6 Reports of committees of the BSW Hospitals Group Joint Committee

16.1.7 Self-assessment of the BSW Hospitals Group Joint Committee's effectiveness

16.1.8 Review of the BSW Joint Hospitals Group Committee's terms of reference

16.1.9 Regular reports to the Trust Boards

16.1.10 Other items as per agreed cycle of business

17 Committees

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

17.1.1 The EPR Committee

17.1.2 Financial Sustainability

17.1.3 Group Development, Strategy & Planning

17.2 For the purpose of assisting the exercise of Joint Functions the BSW Hospitals Group Joint Committee may appoint one or more additional committees.

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

17.4 The BSW Hospitals Group Joint Committee may authorise a committee to exercise Joint Functions that the BSW Hospitals Group Joint Committee expressly subdelegates to the committee in its ToR.

18 Amendment

These terms of reference may only be amended by variation agreed by resolution of each of the Trust Boards save that the Chair and Chief Executive of each of the Trusts may agree a non-material variation that they may reasonably consider to be necessary for the purpose of remedying any obvious error or omission in the terms of reference.

Date approved:

Date of review:

Annex to BSW Hospitals Group Joint Committee Terms of Reference

Functions Delegated by each of the Boards of GWH, RUH and SFT – Roles & responsibilities

Role of the Joint Committee		Role of the Trust Boards
1. Group Strategy & Planning		
Strategy		
1	Development of BSW Hospitals Group Strategy (for approval by the Group Board in April 2026). The Joint Committee determines the strategic direction, ensuring that collective BSW population interests are paramount.	Responsible for development and delivery of local operational plans aligned to and reinforcing *Group Strategy and Specialist Delivery* Plans.
2	Development and approval of *Specialist Delivery Plans* underpinning Group Strategy; Finance, People, Clinical, Digital, Estates & Facilities, Innovation, Research & Development, Partnership working, and Capital plans, in accordance with relevant system plans or strategies.	
Planning		
1	Development, approval and delivery of *Group Strategic Planning Framework* and *Annual Group-wide Plan*, reflecting planning guidance and Group Strategy. Set strategic goals and key objectives for upcoming year. Oversee budgeting process, reviewing and consolidating budgets at Group level. Oversight of delivery of *Group Strategic Initiatives.*	Development and delivery of the Trust operational plan aligned to Group objectives.
2	Approval of the overall Group Programme Budget - developing a plan that determines the financial contribution, and pooling of resources to meet financial challenges.	Delivery of the Trust operational plan, incorporating Group programme budget requirements.
3	Development of a Group Board Assurance Framework and Risk Management Framework.	Board Assurance Frameworks and risk management processes will remain in place for each Trust. Enable standardisation and consistency in a controlled and managed approach as determined by the Joint Committee.
4	Review and identification of the risks associated with the delivery of *Group Strategy and Group Annual Plan*.	
2. Transforming Models of Care for the Population we Serve		

1	Development and approval of a *Group Clinical Services Framework* for the collective population we serve and associated decision-making processes.	Actively engage in co-creation and implementation of the Group Clinical Services Framework.
2	Approval of service/pathway/treatment configuration changes across the Group	
	3. Financial Sustainability – Use of Resources	
1	Development and approval of a single financial plan for the Group.	Responsible for developing and delivering financial plans as determined by the Group. Manage operational budgets.
2	Sets and delivers Group financial recovery and long-term Group financial sustainability.	Responsible for developing and delivering financial plans as determined by the Group. Manage operational budgets.
3	Approval of new capital investment programme for the Group	Responsible for implementing local capital investment plans.
4	Approval of capital limits for each Trust within the Group.	Identifies local priorities for investment within the delegated limit.
	4. Group Mobilisation & Development	
1	Develop and approve the roadmap from June/July 2025 to 01-April-26 implementation of the Group Board and Joint Chair. *Develop and approve the Target Operating Model for the Group, including the Accountability Framework* and associated *Integrated Performance Reporting*. Develop and approve the Group and Trust leadership structures in line with the Target Operating Model (subject to relevant approvals from the Remuneration committees in common). Develop and approve the Group governance and assurance framework (including development and approval of Group Board (General Purpose Joint Committee TORs) and Board committee structure and ToR. Develop and approve the Group Board membership (subject to relevant approvals from the Remuneration committees in common and Councils of Governors with respect to NEDs)	Works within the Group governance structure, assurance and accountability framework to deliver services ensuring that local governance aligns with group governance.

2	Oversight of delivery of the BSW Hospitals Group Case for Collaboration and emerging agreed priorities. Includes programme oversight of workstreams from case for collaboration – with details, phasing and resourcing agreed in *Annual Group-wide Plan*.	Manages day-to-day services delivery, compliance, and patient safety. Local Transformation oversight. Delivery of change locally with Partners. Participates in group mobilisation and development workstreams.
3	Defines objectives, shape and structure of Group Corporate Services transformation. Approval of programme resourcing.	Manages day-to-day services delivery, compliance, and patient safety. Local Transformation oversight.
4	Develop and approve the Group's Organisational Development and engagement plan, including the approach to engagement with the Councils of Governors	
5	Develop and approve the Group's communications strategy, including key communication tools/ artifacts.	Engagement in and contribution to the development of the Group narrative.
6	Identification and approval of any further opportunities in support of Group Strategy.	Actively identify further opportunities to maximise economies at scale.
	5. Achieving Digital Maturity	
1	Responsible for the strategic oversight of successful delivery of the EPR Programme [via EPR Joint Committee activity]. Approves proposals for new budget and new benefits profile.	Ensures local delivery plans in place and appropriate relevant engagement for successful implementation.
2	Identifies, approves and implements digital transformation initiatives across the Group structure, as described in *Group Digital Delivery plan* [refer 1,2].	Ensures local IT infrastructure supports Group-wide strategy. Ensures local delivery plans in place and appropriate relevant engagement for successful implementation

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**11.0**
Date of Meeting:	**3 September 2025**		
Title of Report:	**Integrated Performance Report**		
Status:	**For Noting**		
Board Sponsor:	**Bernie Bluhm, Chief Operating Officer (Acting)** **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 July 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 July 2025 was 45.0minutes, a reduction of 10.7 minutes on average compared to June 2025. Through July 2025 the total hours lost was 1,377. This is a 332-hour decrease compared to last month's lost hours of 1,709. 56.2% of handovers were completed within 30 minutes, an improvement of 16.1% since last month. Additionally, handovers taking place in less than 15 minutes improved from 16.4% to 28.0%

RUH 4-hour performance in July was 62.79% on the RUH footprint (unmapped; we are not currently receiving Minor Injury Unit (MIU) data from HCRG), an increase of more than 5% from June's performance (57.57%). Non-admitted performance was 73.36%, which was an increase against the performance for June (68.94%) and admitted performance was also improved at 37.58% (June 30.07%). Both metrics have seen a marked improvement.

The numbers of patients going through our Medical Same Day Emergency Care (MSDEC) (777) and Frailty Same Day Emergency Care (FSDEC) (30) continue to increase, with an associated increase in our performance at 40.5% for July 2025 (June 36.8%). This has met the national target of 40% of patients going through Same Day Emergency Care (SDEC) pathway.

In July, 67.80% of patients received their diagnostic within the 6-weeks against the 71.94% target. Performance was 4.14% below trajectory. Total breaches increased by 750, with –261 diagnostics delivered in month when compared to June 2025.

In June (Cancer performance is reported one month in arrears) performance against all three cancer standards improved with 28-day improving over 7% to 70.0%, 31-day improving 6% to 95.1% and 62-day performance increasing by 3%, to 68.1%. 28-day performance is expected to remain consistent until September, whereas performance for 31-day and 62-days is expected to decline until Q3 at which point recovery actions implemented in August and September will take effect.

In July, Referral to Treatment (RTT) saw a decrease in overall performance of 1.7% to 57.7%. The percentage of patients waiting less than 18 weeks for their first outpatient appointment was 59% (-1.91% from June). Total over 52-week waiters decreased from 1017 to 939 (-8%). For patients over 65 weeks, the Trust saw a decrease from 18 to 13 patients.

Quality

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 June 2025, the RUH reported 0.4 pressure ulcers per 1,000 bed days (5 pressure ulcers). GWH reported 0.29 (5 pressure ulcers) and Salisbury is unknown. The RUH reported two category 3 pressure ulcers, two category 2 medical device related pressure ulcers, one category 3 medical device related pressure ulcer and no category 2 or 4 pressure ulcers.

Locations on the body sacrum, heel, toe, penis and ear. The themes were inadequate skin checks and off-loading of pressure particularly under the medical device. The Divisions are working closely with the wards on action plans for improvement.

Falls

In June 2025 there were 3 reported inpatient falls that resulted in moderate harm to patients. Huddles were completed for these incidents to explore if there was any learning to be noted. Any new actions or areas of learning agreed was then included in the falls work plan to ensure improvement work is planned and completed. As a result of several falls across the 3 divisions a trust wide PSII (Patient safety incident investigation) has been commissioned and is aimed to be completed in 3-6 months.

Infection Prevention and Control Update

There were 5 HOHA cases of Clostridioides Difficile infection (CDI) reported during April 2025. There were three mortalities from the cases identified. 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 COHA). With five cases that were identified as having a urinary source work on

alternative hydration is being supported around the Trust.

There was 1 COHA MRSA Bacteraemia, for June 2025 related to an IV cannula that became infected. Further surveillance and teaching will be addressed to support the importance of timely documentation.

Patient Support and Complaints

In June 2025, the Trust received 39 new complaints (this compares to the same number in May). The trend for complaints received each month continues to be on an upward trajectory.

Complaints were evenly distributed across several departments with ED (n=9) receiving the highest number. The majority of complaints were about clinical care (n=29) consistent with previous months with concerns about the quality of medical care and inappropriate care and treatment the most prominent themes. The Medicine Division received the highest number of new complaints (n=25). 2 complaints were reopened in June. The complaint rate per 1000 patients in June was 0.55 which is down from 0.58 in May. 99% of all concerns were acknowledged within 2 working days.

The response times for formal complaints continues to fall below the target of 90% with 71.4% (30) of the 42 closed complaints responded to within the agreed timeframe. This varies by Division, the FASS Division responded to 55% of complaints within the agreed timeframe, the Surgical Division improved from 25% to 71% and Medicine was 84%.

Safe Staffing

The combined shift fill rates for days for RNs across the 25 inpatient wards was 88% and 89% respectively for nights. The combined shift fill for HCSWs was 86% for the day and 97% for the night shift. Therefore, the Trust as a collective set of wards is within safe limits for June.

Average monthly CHPPD is 8.5. CHPPD continues to remain stable for both registered and unregistered staff over the past 12 months.

When reviewed on Model Hospital (latest data available April 2025) the RUH is in high quartile 2, this is a change from low quartile 3 in March 2025, however we continue to benchmark in line with the peer median.

Maternity and Neonatal

- Maternity Inpatient acuity tool affected by support worker vacancy MSW vacancy. On going improvement work to support validity of tool and alignment to BSW maternity provider workforce reporting.
- 1 episode of Labour ward Co-ordinator not being supernumerary in month, recommendation for 100% supernumerary status. Episode incorrectly captured within the acuity tool following review.
- 5 moderate harm incidents all reviewed under PSIRF.
- Maternity incentive scheme year 7 predicted 100% compliance.
- NHSE Maternity and Neonatal voices Partnership ICB statutory obligation to ensure adequate infrastructure to commission and fund MNVP, current model

required escalation to Local Maternity and Neonatal System for action.

Workforce

Overall, the key workforce performance indicators at the RUH remain positive – a summary of key points are below:

- Actual Total WTE in July 2025 was 5735.38 a slight decrease from the M3 position of 5747.91 Total WTE. Substantive decreased by 8 WTE, bank reduced by 6.91 WTE and agency increased by 2.43 WTE.
- The vacancy rate has reduced to - 0.43% in M4, meaning that the Trust is over-established by 23 WTE.
- Agency spend as a proportion of the pay bill has slightly increased to 0.74% but remains well within the control parameters and below the 2.5% target.
- Rolling sickness absence is 4.79% against a target of 4.70%.
- Rolling turnover was 7.34% in M4, 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 78.6% in M4.
- Mandatory Training compliance continues to meet target at 89.4% in M2.

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

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

Non-attendance due to sickness
Training is ongoing for the new Wellbeing and Supporting Attendance Policy and the People Hub are working through the top 50 absences ensuring appropriate support and advice to line managers.

Appraisal Compliance and Quality:
The appraisal rate remains approximately 11% below our compliance target, with divisions citing increased operational pressures as the cause.

Divisional People Partners are undertaking a range of interventions to support managers to demonstrate increased compliance through their divisional PRMS (including piloting new approaches such as group appraisals in FASS). Improvement focus remains on the quality of the appraisal conversation and the rhythms of engagement in the work setting as well as pure compliance.

Agency Spend and Bank Rate
Agency WTE is 2.6 WTE over plan but remains one of the lowest levels of agency usage nationally. Agency costs are currently 0.74%, well below the 3.2% national target.

Agency remains a workstream that continues to have significant focus to support our financial position. Medical and Dental remains the highest spend on agency provision (90% of agency spend), although we're actively recruiting to 4 Oncology Consultants -

3 Offers made and 1 post remains out to advert supporting our agency exit strategy. There continues to be no agency provision in corporate, estates and facilities.

Bank WTE stands at 11.2 WTE over plan. The biggest demand for support is Bank clinical workers although it has decreased slightly as newly appointed substantive HCSWs arrive and complete their training. We continue to recruit to vacancies to reduce reliance on bank particularly in Emergency Medicine.

Trust led Workforce Controls continue to support the reduction in temporary staffing usage and spend.

Recruitment

Workforce controls remain in operation to support a sustainable workforce for the future. This includes a recruitment freeze for non-clinical roles although business critical roles have an escalation route to maintain the safety and performance of services.

The Government White Paper outlining Immigration changes may impact workforce supply and create uncertainty for our international workforce whilst we await transitional plans and key dates for changes. Support in place for Managers and staff impacted by change.

Finance

Year to date RUH is a £10.1m deficit including a surplus in Sulis of £1.2m. The £10.1m is explained by the following: shortfall in savings of £8.4m, exit run rate deterioration £2.0m, high-cost drugs and devices £0.7m, impact of industrial action £0.25m and pay award funding shortfall £0.2m.

£1.6m of savings have been delivered year to date (0.7m M3) with a shortall of £8.4m (£6.7m M3) against plan year to date £6m of saving are now in delivery (£6m M3) and the amount of unidentified has been reduced by £1.5m.

There remains an unidentified gap of £11.4m including the £4.4m allocated to Group savings and £6.1m assessed as an opportunity requiring firm plans to be developed.

Deliverability of in year cash releasing savings remains a significant risk due to the need to address performance issues and deviation to planning assumptions.

There is a need to identify additional financial recovery actions to mitigate the delay in transformational benefits.

The RUH Group underlying deficit, in additional to recurrent delivery of 25/26 plan is assessed at £39.4m

The Trust operates within BSW Integrated Care System which has reported a £18.1m adverse variance to plan year to date, of which BSW Hospitals Group is £24.6m adverse to plan, partially offset by ICB favourable variance to plan of £6.5m.

2.	Recommendations (Note, Approve, Discuss)
The Public Board of Directors 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.	

Royal United Hospitals Bath
NHS Foundation Trust

Integrated Performance Report

September 2025 (July data)

The RUH, where you matter

Executive Summary

Performance

The average ambulance handover delay for July 2025 was 45.0minutes, a reduction of 10.7 minutes on average compared to June 2025. Through July 2025 the total hours lost was 1,377. This is a 332-hour decrease compared to last month's lost hours of 1,709. 56.2% of handovers were completed within 30 minutes, an improvement of 16.1% since last month. Additionally, handovers taking place in less than 15 minutes improved from 16.4% to 28.0%

RUH 4-hour performance in July was 62.79% on the RUH footprint (unmapped; we are not currently receiving Minor Injury Unit (MIU) data from HCRG), an increase of more than 5% from June's performance (57.57%). Non-admitted performance was 73.36%, which was an increase against the performance for June (68.94%) and admitted performance was also improved at 37.58% (June 30.07%). Both metrics have seen a marked improvement.

The numbers of patients going through our Medical Same Day Emergency Care (MSDEC) (777) and Frailty Same Day Emergency Care (FSDEC) (30) continue to increase, with an associated increase in our performance at 40.5% for July 2025 (June 36.8%). This has met the national target of 40% of patients going through Same Day Emergency Care (SDEC) pathway.

In July, 67.80% of patients received their diagnostic within the 6-weeks against the 71.94% target. Performance was 4.14% below trajectory. Total breaches increased by 750, with –261 diagnostics delivered in month when compared to June 2025.

In June (Cancer performance is reported one month in arrears) performance against all three cancer standards improved with 28-day improving over 7% to 70.0%, 31-day improving 6% to 95.1% and 62-day performance increasing by 3%, to 68.1%. 28-day performance is expected to remain consistent until September, whereas performance for 31-day and 62-days is expected to decline until Q3 at which point recovery actions implemented in August and September will take effect.

In July, Referral To Treatment (RTT) saw a decrease in overall performance of 1.7% to 57.7%. The percentage of patients waiting less than 18 weeks for their first outpatient appointment was 59% (-1.91% from June). Total over 52-week waiters decreased from 1017 to 939 (-8%). For patients over 65 weeks, the Trust saw a decrease from 18 to 13 patients.

Executive Summary

Quality

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 June 2025, the RUH reported 0.4 pressure ulcers per 1,000 bed days (5 pressure ulcers). GWH reported 0.29 (5 pressure ulcers) and Salisbury is unknown. The RUH reported two category 3 pressure ulcers, two category 2 medical device related pressure ulcers, one category 3 medical device related pressure ulcer and no category 2 or 4 pressure ulcers.

Locations on the body sacrum, heel, toe, penis and ear. The themes were inadequate skin checks and off-loading of pressure particularly under the medical device. The Divisions are working closely with the wards on action plans for improvement.

Falls
In June 2025 there were 3 reported inpatient falls that resulted in moderate harm to patients. Huddles were completed for these incidents to explore if there was any learning to be noted. Any new actions or areas of learning agreed was then included in the falls work plan to ensure improvement work is planned and completed. As a result of several falls across the 3 divisions a trust wide PSII (Patient safety incident investigation) has been commissioned and is aimed to be completed in 3-6 months.

Infection Prevention and Control Update
There were 5 HOHA cases of Clostridioides Difficile infection (CDI) reported during April 2025. There were three mortalities from the cases identified. 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 COHA). With five cases that were identified as having a urinary source work on alternative hydration is being supported around the Trust.

There was 1 COHA MRSA Bacteraemia, for June 2025 related to an IV cannula that became infected. Further surveillance and teaching will be addressed to support the importance of timely documentation.

Patient Support and Complaints
In June 2025, the Trust received 39 new complaints (this compares to the same number in May). The trend for complaints received each month continues to be on an upward trajectory.

Complaints were evenly distributed across several departments with ED (n=9) receiving the highest number. The majority of complaints were about clinical care (n=29) consistent with previous months with concerns about the quality of medical care and inappropriate care and treatment the most prominent themes. The Medicine Division received the highest number of new complaints (n=25). 2 complaints were reopened in June. The complaint rate per 1000 patients in June was 0.55 which is down from 0.58 in May. 99% of all concerns were acknowledged within 2 working days.

Executive Summary

Quality cont…

The response times for formal complaints continues to fall below the target of 90% with 71.4% (30) of the 42 closed complaints responded to within the agreed timeframe. This varies by Division, the FASS Division responded to 55% of complaints within the agreed timeframe, the Surgical Division improved from 25% to 71% and Medicine was 84%.

Safe Staffing

The combined shift fill rates for days for RNs across the 25 inpatient wards was 88% and 89% respectively for nights. The combined shift fill for HCSWs was 86% for the day and 97% for the night shift. Therefore, the Trust as a collective set of wards is within safe limits for June.

Average monthly CHPPD is 8.5. CHPPD continues to remain stable for both registered and unregistered staff over the past 12 months.

When reviewed on Model Hospital (latest data available April 2025) the RUH is in high quartile 2, this is a change from low quartile 3 in March 2025, however we continue to benchmark in line with the peer median.

Maternity and Neonatal

- Maternity Inpatient acuity tool affected by support worker vacancy MSW vacancy. On going improvement work to support validity of tool and alignment to BSW maternity provider workforce reporting.
- 1 episode of Labour ward Co-ordinator not being supernumerary in month, recommendation for 100% supernumerary status. Episode incorrectly captured within the acuity tool following review.
- 5 moderate harm incidents all reviewed under PSIRF.
- Maternity incentive scheme year 7 predicted 100% compliance.
- NHSE Maternity and Neonatal voices Partnership ICB statutory obligation to ensure adequate infrastructure to commission and fund MNVP, current model required escalation to Local Maternity and Neonatal System for action.

Executive Summary

Workforce

Overall, the key workforce performance indicators at the RUH remain positive – a summary of key points are below:

Actual Total WTE in July 2025 was 5735.38 a slight decrease from the M3 position of 5747.91 Total WTE. Substantive decreased by 8 WTE, bank reduced by 6.91 WTE and agency increased by 2.43 WTE.
The vacancy rate has reduced to - 0.43% in M4, meaning that the Trust is over-established by 23 WTE.
Agency spend as a proportion of the pay bill has slightly increased to 0.74% but remains well within the control parameters and below the 2.5% target.
Rolling sickness absence is 4.79% against a target of 4.70%.
Rolling turnover was 7.34% in M4, 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 78.6% in M4.
Mandatory Training compliance continues to meet target at 89.4% in M2.

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

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

Non-attendance due to sickness
Training is ongoing for the new Wellbeing and Supporting Attendance Policy and the People Hub are working through the top 50 absences ensuring appropriate support and advice to line managers.

Appraisal Compliance and Quality:
The appraisal rate remains approximately 11% below our compliance target, with divisions citing increased operational pressures as the cause.

Divisional People Partners are undertaking a range of interventions to support managers to demonstrate increased compliance through their divisional PRMS (including piloting new approaches such as group appraisals in FASS). Improvement focus remains on the quality of the appraisal conversation and the rhythms of engagement in the work setting as well as pure compliance.

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Executive Summary

Workforce cont…

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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

The Plan in numbers

Business Plan Delivery **July 2025**

Activity Plan

	YTD Plan	YTD Actual	Variance	Change per Day Plan	Change per Day Actual
OP News	67,817	67,156	-661	+6	-8
OP Follow Ups	103,577	104,315	738	-11	+9
Daycases	13,293	12,565	-728	+4	-9
EL Inpatients	1,538	1,266	-272	+2	-3
ED Attendances	35,006	35,022	16	+9	+0
NEL Admissions	20,952	21,568	616	+7	+7
Diagnostic tests	57,102	52,072	-5,030	+46	-60

Planning Assumptions

	Plan	YTD Actual
GP Referral Growth	0.0%	-1.4%
ED Atts Growth	2.6%	2.7%
NEL Admit Growth excludes maternity	3.4%	8.3%
NCTR	72	77
NEL Length of Stay for 1+ days	6.4	5.6

Performance

		Year End Target	Current Month Plan	Actual
RTT	<18 1st app	71.7%	66.8%	59.0%
	<18 weeks	67.7%	62.8%	57.6%
	>52 weeks	1.0%	1.3%	2.4%
Cancer	62 days*	75.0%	70.4%	67.7%
	28 days*	80.0%	77.2%	70.0%
ED	4hr type 1	72.0%	73.7%	62.8%
	12 hours	reduction	3.7%	6.5%
DM01	< 6 weeks	5.0%	14.2%	32.2%

* 1 month reporting lag

Finance

	YTD Plan	YTD Actual	Variance
Cash Releasing Savings	£9.9m	£1.6m	-£8.3m
Financial Position	£0m	-£10.1m	-£10.1m
Productivity	+6.7%	+4.0%	-2.7%

Lag - March 25 productivity

Workforce

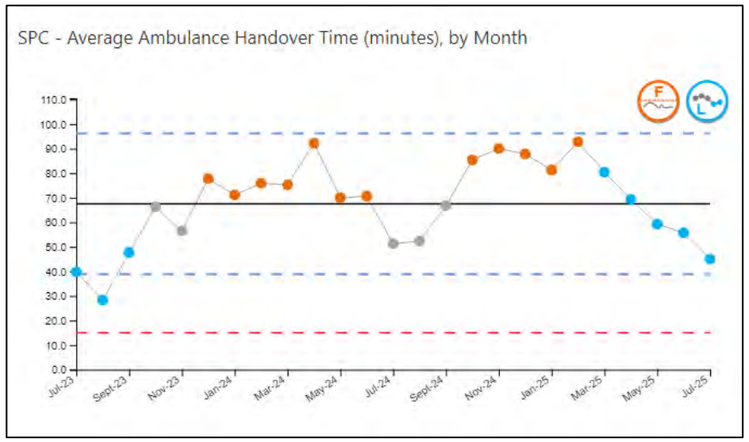
	YTD Planned	YTD Actual	Variance
Pay Savings (£m)	£5.4m	£0.5m	-£4.9m
WTE Reduction	5692.3	5731.9	39.6
Sickness (1 mth lag)	4.42%	4.70%	1 month lag

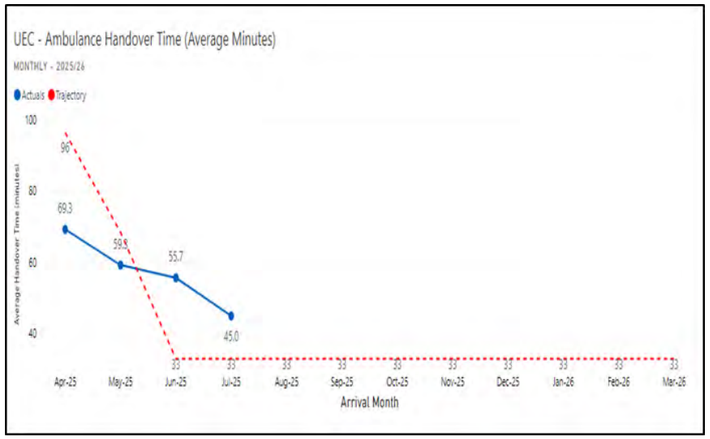
Ambulance Handover Times

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 July 2025 was 45.0 minutes, a reduction of 10.7 minutes on average compared to June 2025. Through July 2025 the total hours lost was 1,377. This is a 332-hour decrease compared to last month's lost hours of 1,709.

56.2% of handovers were completed within 30 minutes, an improvement of 16.1% since last month. Additionally, handovers taking place in less than 15 minutes improved from 16.4% to 28%. This tells us that the average handover time is confidently decreasing.

July 2025 performance is 12.03 minutes behind trajectory; August so far is currently showing a worsened position, at 14 minutes behind trajectory (11/08/2025).

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
Repurpose Fit2Sit as 'Ambulatory ED', with a reviewed SOP to support flexible use for ambulatory patients pre/post treatment and awaiting inpatient beds.	Leadership team	04/08/2025 Ongoing improvement.
Attend BSW meetings, engage with change, support the socialisation of process to meet average 33min handover.	TT/BI	Complete, ongoing
Ensure all RUH receiving units are trained in the use of XCAD to prevent ~107.5 breaches (average 56hrs) monthly, excludes ED.	Improvement Team	22/08/2025
Increased focus on early escalation proactive rather than reactive) joint working with clinical site team - liaison role attending regular ED huddles.	SH	Ongoing
Ensure ongoing adherence to standard procedure of the use of resus and high care spaces to offload ambulances.	TT	Ongoing

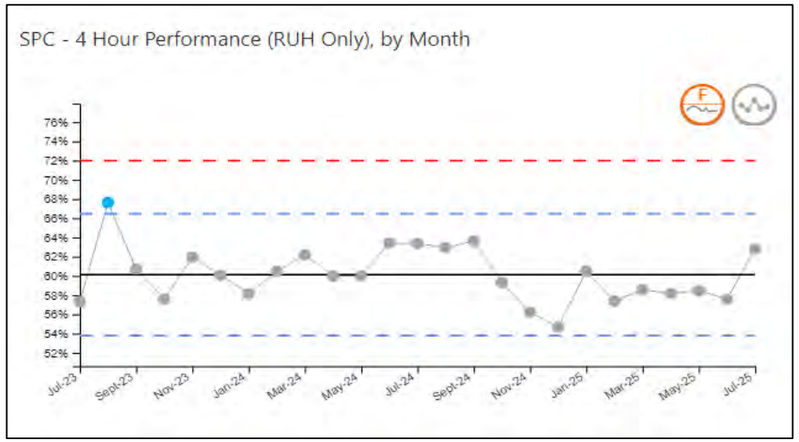
Risks and Mitigation

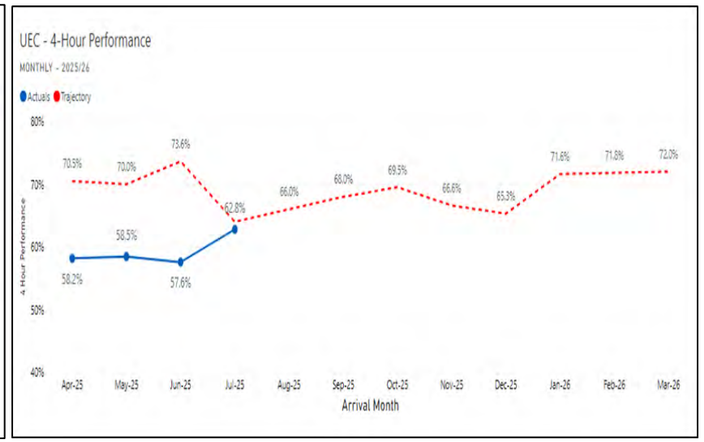
- Risk of >45min handover duration.
  - Site/ED extended handover process in place.
- Risk of patient deterioration in an ambulance not offloaded.
  - RUH ED review of deteriorating pts, QI project in progress.

4 Hour Performance

Royal United Hospitals Bath NHS Foundation Trust

We are driving this metric because.. Performance Target:	*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.* *78% by March 2026 (72% excl. MIU)*





	Admit	Non-admit	Total	Target
ED	30.65%	42.58%	**36.48%**	**42%**
CED	74.89%	88.74%	**86.76%**	**95%**
UTC	66.22%	88.51%	**86.86%**	**95%**
Total	**37.58%**	**73.36%**	**62.79%**	**72%**

*78% target incl. 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 midnight 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
Provide draft business case for ED medical staffing to mitigate gaps identified within ECIST demand vs capacity modelling.	MP/BI/CJ	15/08/2025
Redefine what is a UTC patient criteria, supporting right patient in the right place, at the right time.	JR	18/07/2025 Complete
Implement front-door streaming in UTC following the launch of UTC patient criteria.	JR/TT	14/08/2025
Repurpose Fit2Sit as 'Ambulatory ED', with a reviewed SOP to support flexible use for ambulatory patients pre/post treatment and awaiting inpatient beds.	Leadership team	04/08/2025 Ongoing improvement.

Risks and Mitigation

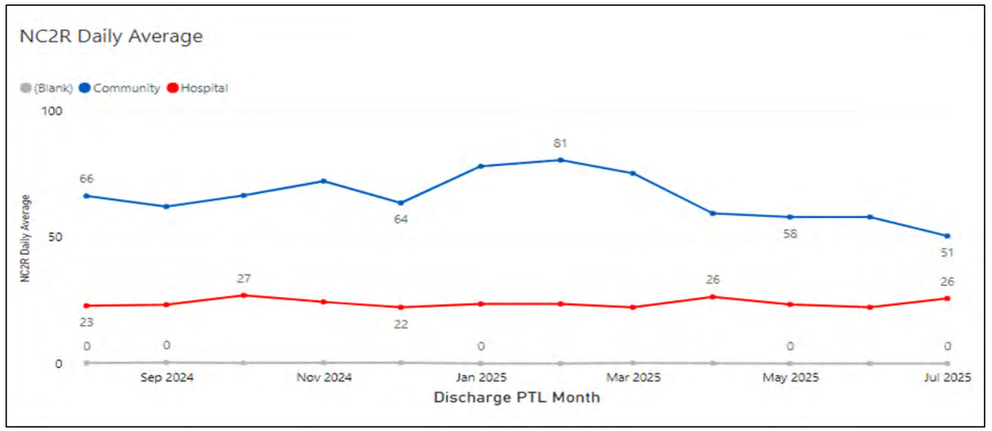
- Risk of increase mortality due to extended wait times in ED/UC.
- Risk of staff burnout and disengagement due to overcrowding.
    - UEC improvement programme to reduce overcrowding.

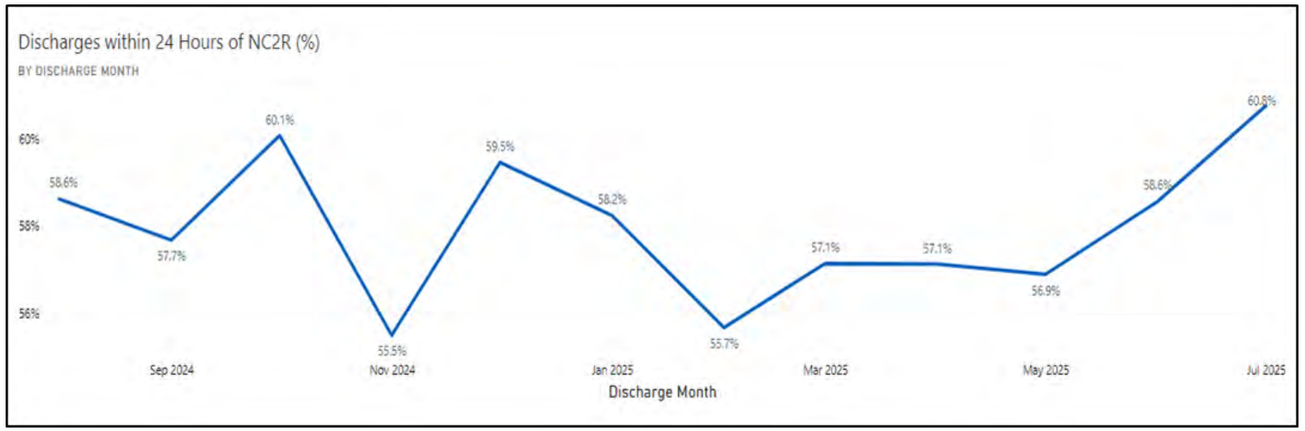
Non-Criteria to Reside

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 July 2025, the average number of NCTR patients per day was 76.5, a reduction of 4 patients compared to June 2025. Discharges within 24 hours of NCTR increased by 2.2% in July to 60.8%. A total of 40 patients per day (community and hospital responsibility) is to be delivered in line with the BSW trajectory, in July this number was a daily average of 51 patients.*

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.

Hospital responsibility NCTR has not significantly reduced compared to April 2025 baseline (26.5 patients), in July reported a daily average of 25.9 patients.

Countermeasures	Owner	Due Date
Home is Best focus on admission avoidance with system colleagues.	Heather Cooper	Q2 25/26
Further embed P0 therapy referral guidance across all wards – aim for zero P0 therapy delays (Hospital responsibility).	Medicine DMT	Q2 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
Monitoring 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. In place and monitored daily through the BSW Touchpoint call and includes the reporting of P0-P3 discharges against the BSW daily trajectory.	Sarah Hudson	Achieved
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. Next steps to embed processes and develop output reports to support action completion to increase discharges within threshold.	Sarah Hudson	Achieved

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). The impact of which will be the non-closure of escalation and core bed capacity in line with the bed reduction plan.

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 ("SDEC Performance")*

Trust Wide SDEC Performance July 2025:
40.5% against a target of 40%

Medicine Division SDEC Performance July 2025:
40.1% against a target of 40%

Medical Division are responsible for two SDEC services:

Service / Monthly Activity	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25
Medical SDEC (Amb Care and DAA)	514	494	473	487	581	777
Frailty SDEC (OPRAA and OPU)	13	24	22	31	24	30

Medical SDEC opened 23rd June. July data has the first full month's impact.
Both trust performance and medical division performance exceeds 40%.

Understanding Performance

SDEC performance has maintained the initial improvement in June, throughout July. The monthly activity through Medical SDEC has increased by more than 50%.
Average activity in 12 months before SDEC opened was 492 patients per month, equivalent to 16 patients per day. July saw on average 25 patients per day. This is an increase of 9 patients per day.

Improvement blockers:

Reduced SDEC capacity due to Consultant vacancies

- Reduced Frailty SDEC capacity due to:
  - Limited physical space
  - Reduced Therapy workforce (frailty)
- 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

Countermeasures	Owner	Due Date
Open new MSDEC 23rd June 2025, providing 42 chairs and 4 consulting rooms.	CY	11/06/2025 ACHIEVED
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 Score (CFS)	RK	DONE 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
IFD Lead Consultant no longer planned
Using consultant funding differently (ST3+ / ?MNP)

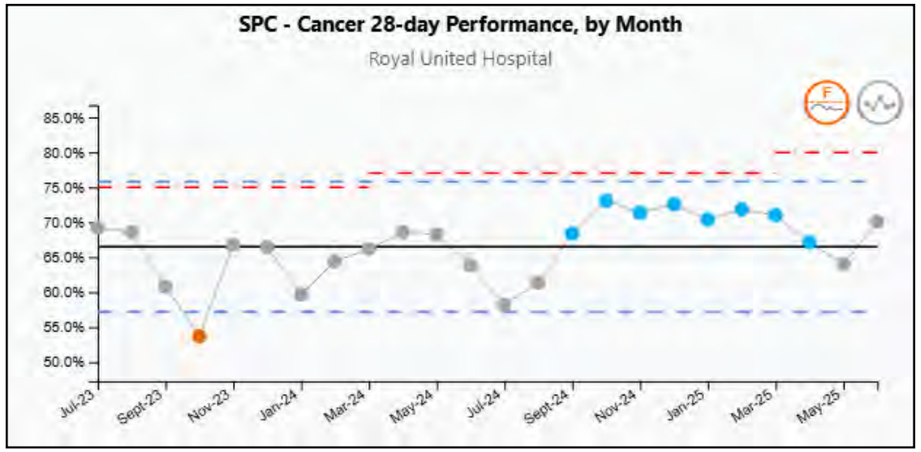
<u>Flow from SDECs to specialty beds</u>
High risk of impact
Site aware
SOPs to be followed
B6 Coordinator training

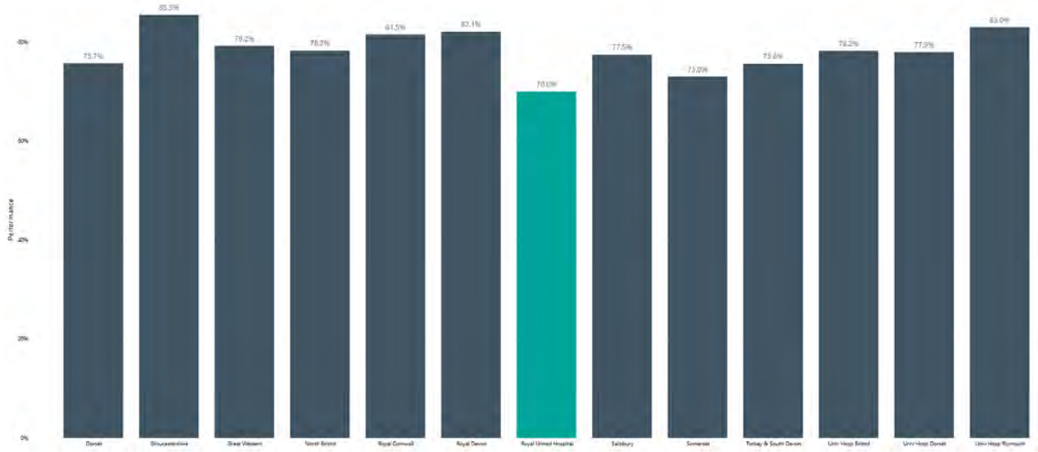
28 Day Cancer Performance

Royal United Hospitals Bath NHS Foundation Trust

We are driving this metric because.. Performance Target:	*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 Tiering for cancer performance.* *80% by March 2026 (increase from 77% in 2024/25)*

SPC & supporting data if required





Understanding Performance

Performance improved in June to 70.0%.

Performance remain consistent in July and August. Recovery initiatives delivering improvement from September-November.

Top contributors: Breast, Colorectal, Gynaecology, Urology
In month challenges:

- Breast improved 14% to 80% with one-stop increasing to full capacity from the beginning of June with locum cover
- Colorectal breaches due to Gastro OPA waits for IDA decreased slightly to 25% of total breaches, but Colorectal F2F breaches increased from 36% to 40%
- Imaging/report and endoscopy at approximately 3 weeks
- Gynaecology improved to 65% - PMB OPA wait and outsourced histology at 3 weeks
- Urology improved 16% - prostate MRI report wait increased

Countermeasures	Owner	Due Date
Breast 2nd locum - to reduce one-stop waiting time	HW	September 2025
IDA service – Gastro OPA WLIs	TS	September 2025
Increase endoscopy weekend insourcing	TS	August 2025
Gynae PMB WLIs	AJ	August 2025
Hysteroscopy clinical guideline change	LA	August 2025
Histology outsourcing – 100 cases per week	EW	August 2025
Prostate pathway STT	EJ	October 2025
Radiology resource directed to prostate MRI reporting	NA	August 2025
Revised biopsy protocol	EJ	September 2025

Risks and Mitigation

Risks:

- Financial position
- Recruitment
- Sickness
- Agency locums – availability / leave role at short notice
- Skin insourcing dependency
- Spikes in demand
- Pressures from RTT, DM01
- Junior doctor rotation

Mitigation:

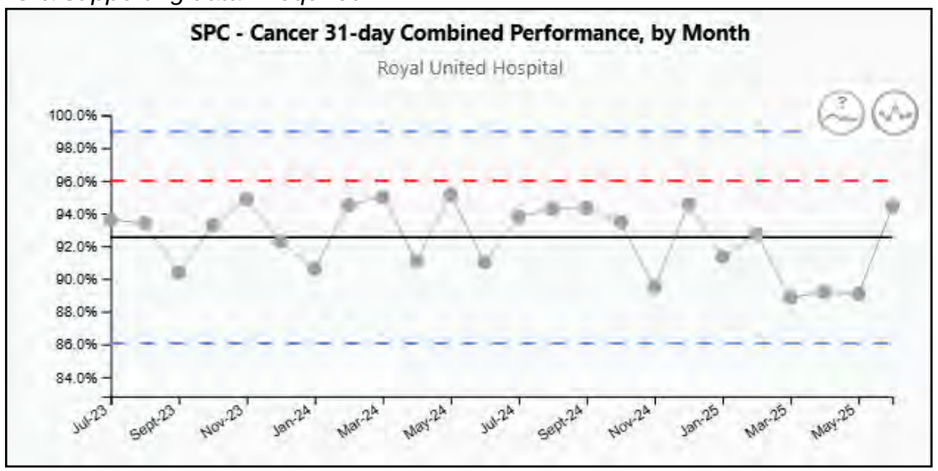
- SWAG/NHSE funding for WLI and in/outsourcing
- Telederm
- Pathway change (Gynaecology / Prostate)

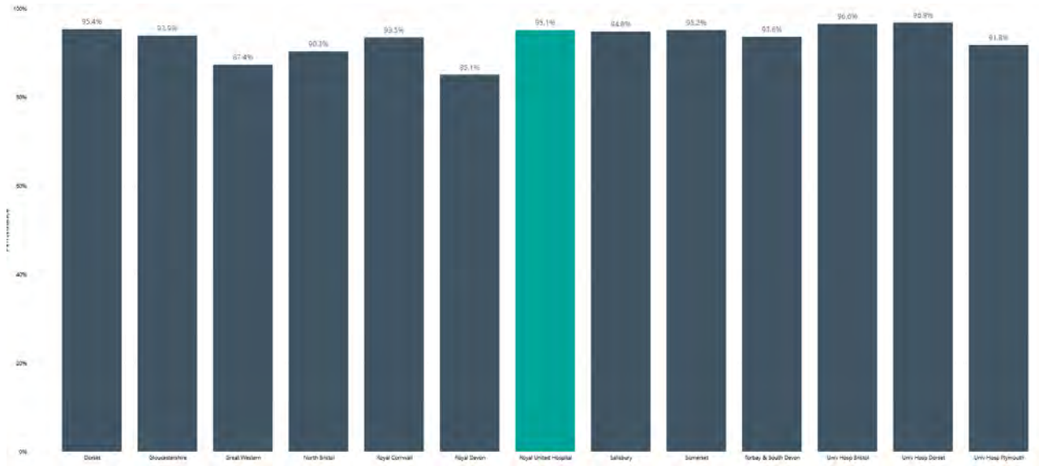
31 Day Cancer Performance

Royal United Hospitals Bath NHS Foundation Trust

We are driving this metric because.. Performance Target:	*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.* *96%*

SPC & supporting data if required





Understanding Performance

Performance improved in June by 6% to 95.1%.

Risk to performance in Q2 due to derm MOPS capacity

Top contributors: Breast, Skin

In month challenges:

- Breast surgeon sickness and locum gap – new locum recruitment, commenced operating 03/07
- WLIs being agreed for August/September
- Full theatre allocation utilised in July
- Dermatology MOPs capacity worsening due to reduced clinical capacity and no uptake of WLIs following pay rate change
- Urology improvement by 7% in month to 96% – remaining breaches due to non-urgent subsequent treatments

Countermeasures	Owner	Due Date
Breast theatre WLIs	HW	August 2025
Dermatology locum consultant request - approved	GJ	September 2025
MOPS insourcing	GJ	September 2025

Risks and Mitigation

Risks:

- Sickness
- Agency locums – availability / leave role at short notice
- Reduction in WLI uptake following pay change (Skin)
- Increases in clinical demand from locums
- Pressures from RTT
- Junior doctor strikes
- Junior doctor August rotation

Mitigation:

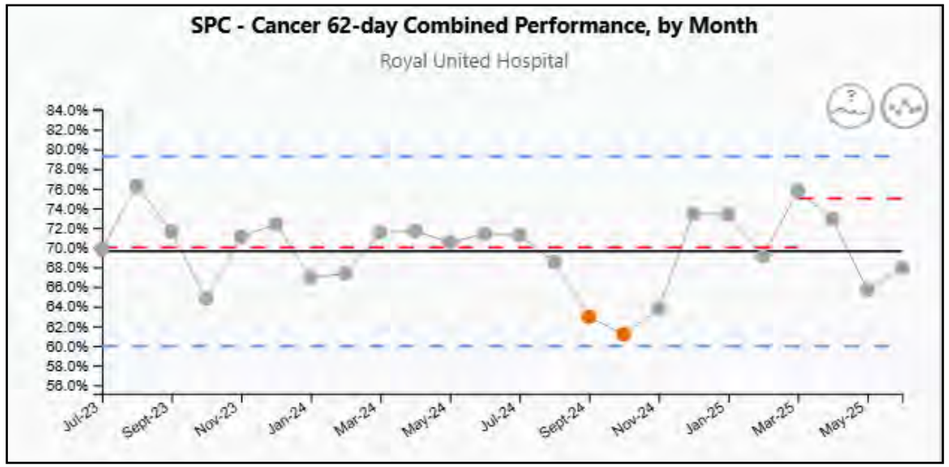
- SWAG funding for WLI, outsourcing and locums

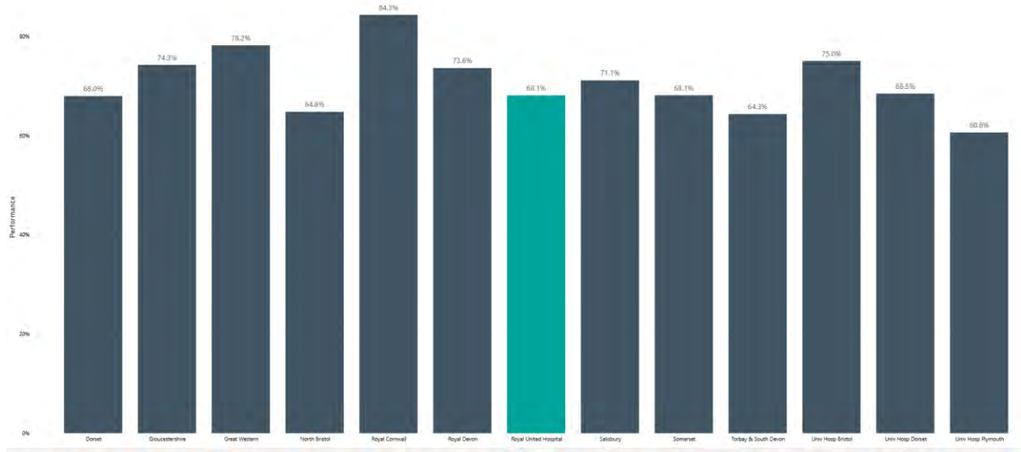
62 Day Cancer Performance

Royal United Hospitals Bath NHS Foundation Trust

We are driving this metric because.. Performance Target:	*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.* *75% by March 2026 (increase from 70% in 2024/25)*

SPC & supporting data if required





Understanding Performance

Performance improved by 3% to 68.1% - Expected to deteriorate August/September before recovering from October

Top contributors: Breast, Colorectal, Lung, Urology

In month challenges:

- Breast surgeon sickness/locum gap – increased waits for surgery and first appointments
- Colorectal delivered best performance (65%)
- Lung waiting times for CT, CT bx, PET, OPA (resp and onc) resulting in breaches
- Urology breaches due to OPA and prostate MRI reporting
- LATP still dependent on WLI – nursing capacity deficit
- Patient choice breaches impacting several tumour sites
- Reduction in Skin performance in July/August due to MOPS capacity – annual leave and junior doctor rotation

Countermeasures	Owner	Due Date
Breast theatre WLIs	HW	August 2025
IDA service – Gastro OPA WLIs	TS	August 2025
Endoscopy weekend insourcing increase	TS	August 2025
Radiology WLIs for initial CT	NA	September 2025
Dermatology locum	GJ	September 2025
MOPS insourcing	GJ	September 2025
Prostate pathway review – reduced OPA demand through STT and reduced LATP demand (GIRFT guidelines)	KR	September 2025
Radiology reporting options review	NA/RW	August 2025

Risks and Mitigation

Risks:

- Sickness
- Recruitment/retirement (Skin)
- Agency locums – availability / leave role at short notice
- Reduction in WLI uptake – change in pay (Skin) and annual leave over summer
- Junior doctor strikes/rotation
- Increases in demand
- Pressures on resources from RTT, 4 hours, DM01

Mitigation:

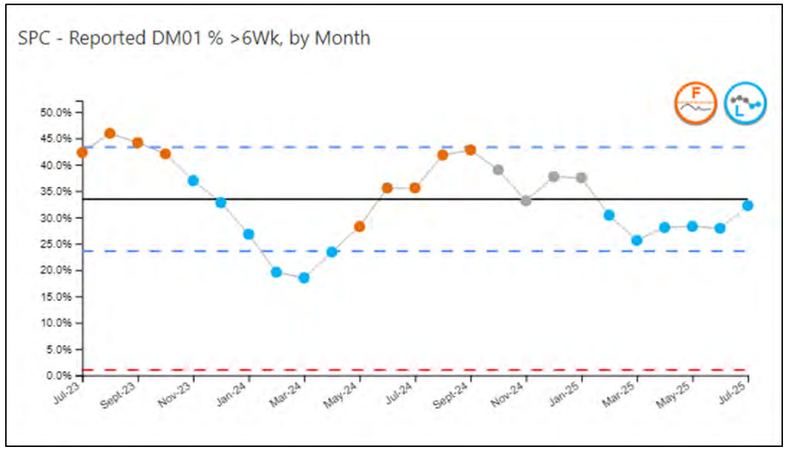
- SWAG funding for WLI

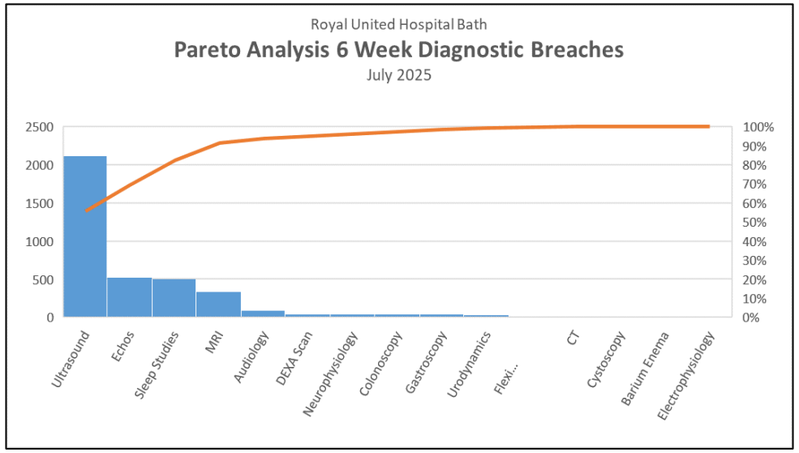
Diagnostic waits

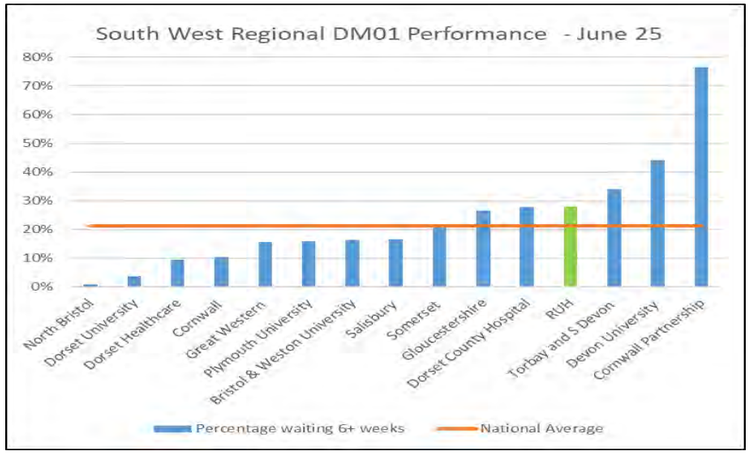
Royal United Hospitals Bath NHS Foundation Trust

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.*

SPC & supporting data if required







Understanding Performance

- *In July, 67.80% of patients received their diagnostic within the 6-weeks against the 71.94% target.*
- *Performance was 4.14% below trajectory. Total breaches increased by 750, with –261 diagnostics delivered in month when compared to June 25.*
- *August performance is forecasted at 72.5%.*
- *The **top contributors** to 6-week breaches were USS, Echo and Sleep Studies.*
- *Key drivers of underperformance were:*
  - *Increased demand for routine, urgent and cancer referrals.*
  - *Impact of Resident Doctor strikes (unplanned), especially on USS activity.*
  - *USS staffing issues (ongoing sickness/vacancies)*
  - *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 *Additional USS activity at Sulis CDC in-week (insourcing)*	PN/NA SH/NA	In place August 2025
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

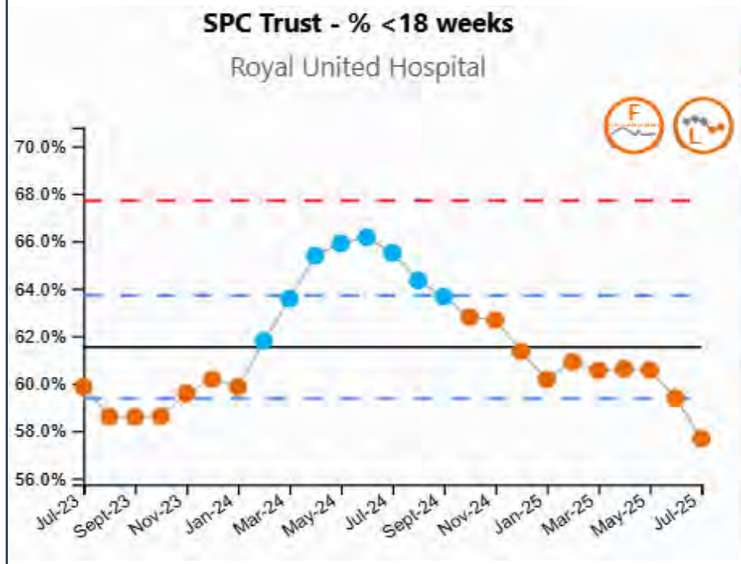
Risks and Mitigation

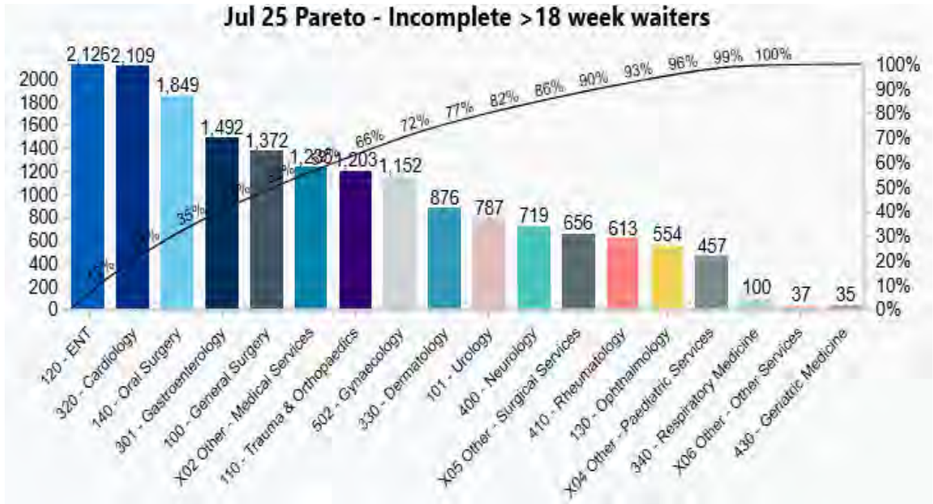
- **Risks:**
  - Sickness
  - Funding for additional activity (WLI's, insourcing)
  - USS staffing
  - Additional strikes
- **Mitigations:**
  - Productivity improvement (MRI acceleration)
  - Exploring additional sonographer insourcing (RUH and Sulis)

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 July was 57.7% vs a target of 67.7%, trajectory 62.8% for July. This is 1.7% reduction on the previous month
- The top Contributors to over 18 week breaches were in the following 5 specialties.
  - ENT 2126 (39.7%)
  - Cardiology 2109 (49.5%)
  - Oral Surgery 1849 (48.9%)
  - Gastroenterology 1492 (48.9%)
  - General Surgery 1372 (58.9%)

Countermeasures	Owner	Due Date
ENT – insourcing plan being worked through utilising RTT funding	Division	Sept 2025
Oral Surgery – additional WLI clinics to carry out LA extractions being scoped	Division	July 2025
Gastro – review of insourcing outpatient clinics for 400 pts to clear routine over 52 week patients	Wilson/Shaw	Aug 2025
Trust taking part in 2nd NHSE validation sprint – 7 July to end of September – admin validation with clinical support as appropriate	Dando	Sep 2025

Risks and Mitigation

Risks:

- Radiology capacity for routine patients v. cancer pts
- Specialist radiology capacity for Guided injections (T&O but spines in particular)
- Physical space for gastro, ENT and general surgery

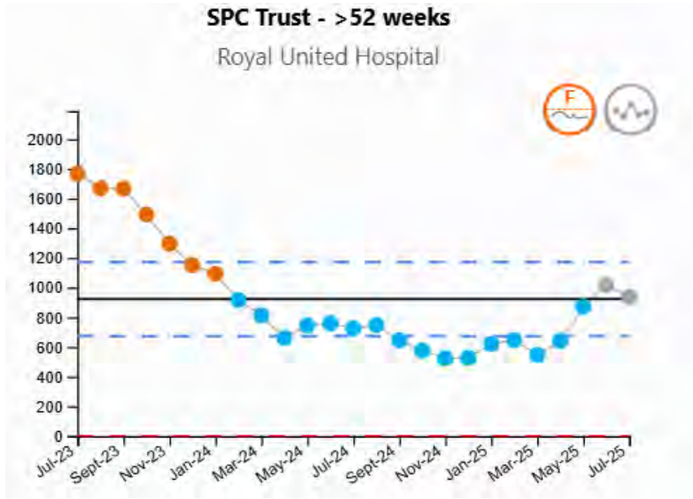
Mitigation:

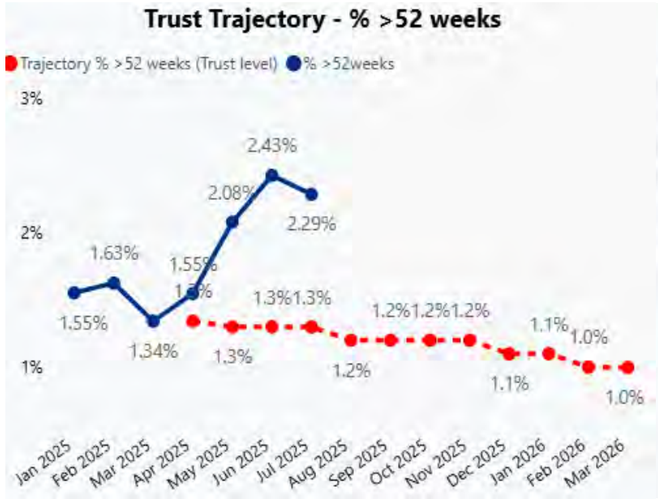
- 2 additional clinic rooms being created in Gastro footprint

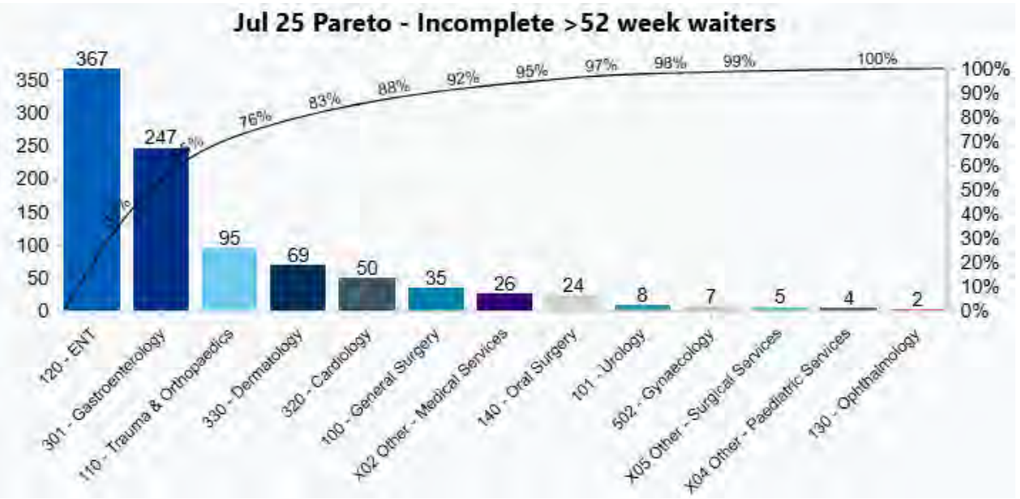
Referral To Treatment (RTT) over 52 weeks

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 decreased from 1017 to 939 (-8%).
• 2.3% of total RTT patients have waited >52 weeks vs target of <1%, trajectory of 1.3% for July
• The top contributors to >52-week breaches (65%) are ENT and Gastroenterology:
  • ENT decreased in July from 501 to 367 patients waiting >52weeks (-27%)
  • Gastroenterology increased in July from 205 to 247 patients waiting >52weeks (+20%)

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 - complete	Prosser/Price	June 25
Gastro – IDA pathway change to nurse led freeing up 34 consultant appts for long waiters per week	Shaw/Wilson	July 25
Increase ENT referrals to Sulis to 160 per month including longest waiting patients	Gillett/Schram	July 25
Continue 3 x weekly meetings for all patients waiting over 52 weeks in challenged specialties	Dando	Ongoing

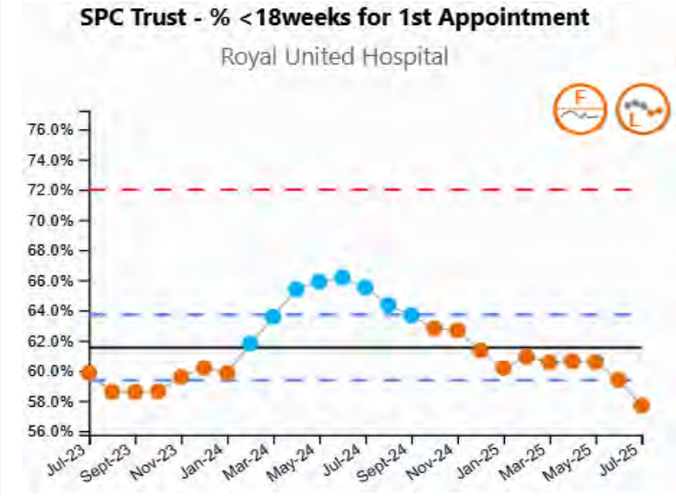
Risks and Mitigation
Risks: • Radiology guided spinal injection capacity remains a risk – review of pathway • Routine radiology capacity • Greater patient choice delays increases during spring/summer • ENT outpatient capacity **Mitigations:** • Gastro recovery plan refresh • Super Saturdays for spinal patients planned for August @ RUH

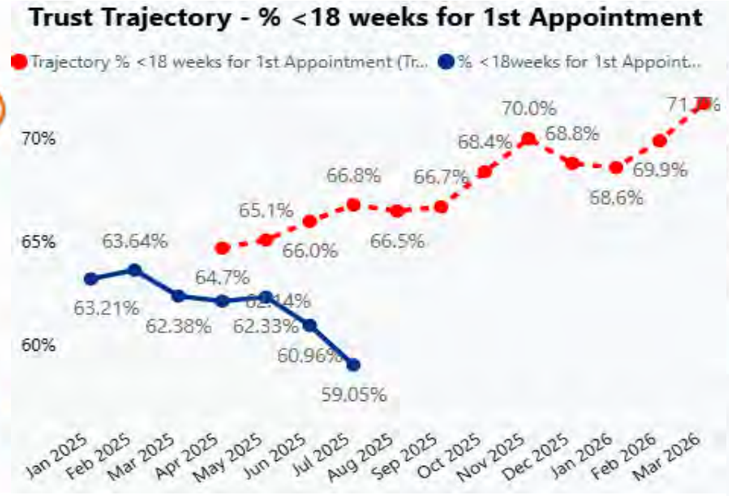
Referral To Treatment (RTT) Wait to 1st Outpatient Appointment

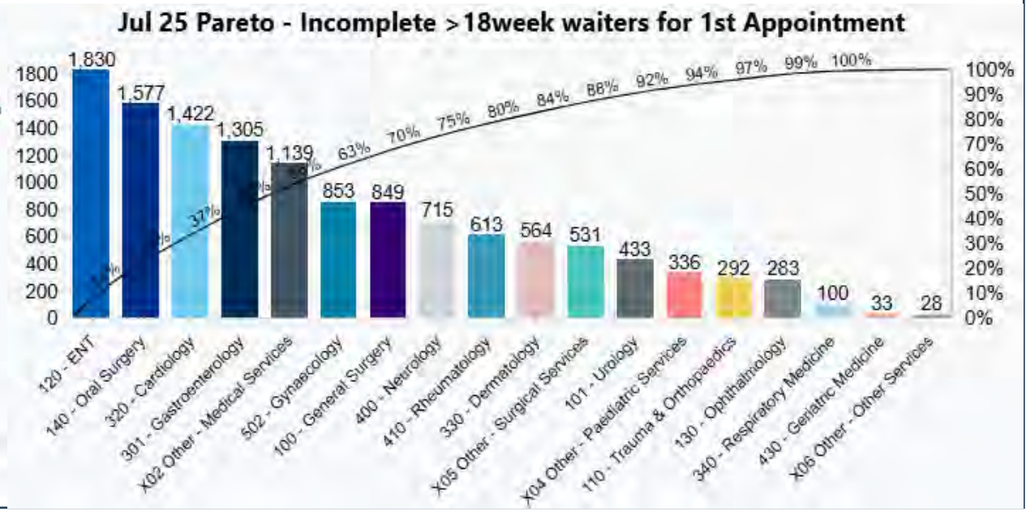
Royal United Hospitals Bath NHS Foundation Trust

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

Outpatient Delivery Group Driver Metric







Understanding Performance

- 59% of patients were waiting <18 weeks for a 1st outpatient appointment vs a target of 72%, trajectory of 66.8% for July. This is –1.91% on the previous month
- The top contributors of over 18-week breaches for 1st appointments were
  - ENT 1,830 (37.69%)
  - Oral Surgery 1,577 (47.52%)
  - Cardiology 1,422 (54.63%)
  - Gastroenterology 1,305 (47.86%)

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
Insourcing plan agreed for ENT – start date September	Gillett/Ashworth	Sept 25

Risks and Mitigation

Risks:
- ENT physical space
- Recruitment timelines

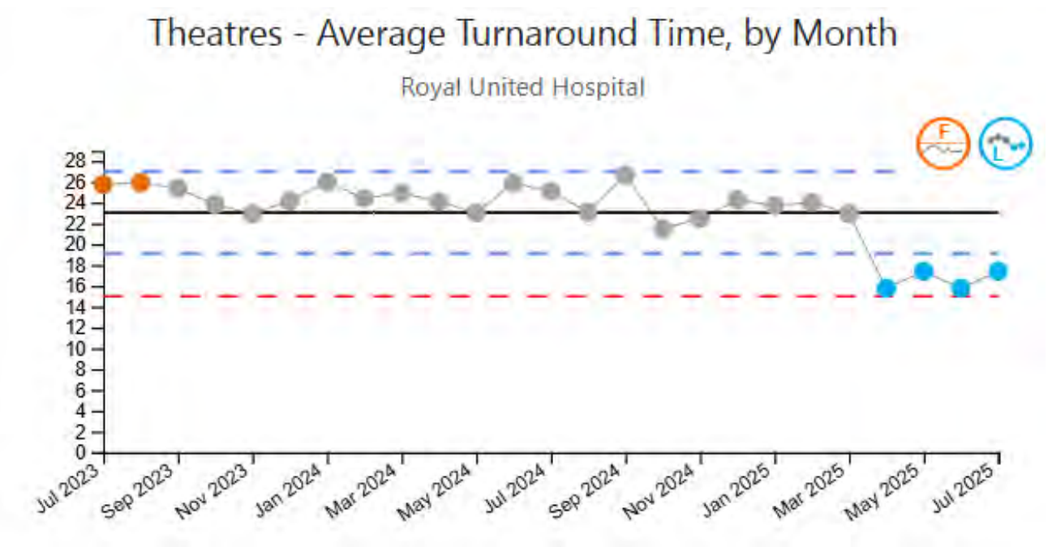
Mitigations:
- Cardiology Recovery Action Plan being developed including capacity and demand review
- Gastro recovery plan being refreshed
- SBAR for additional specialty Dr in Oral Surgery

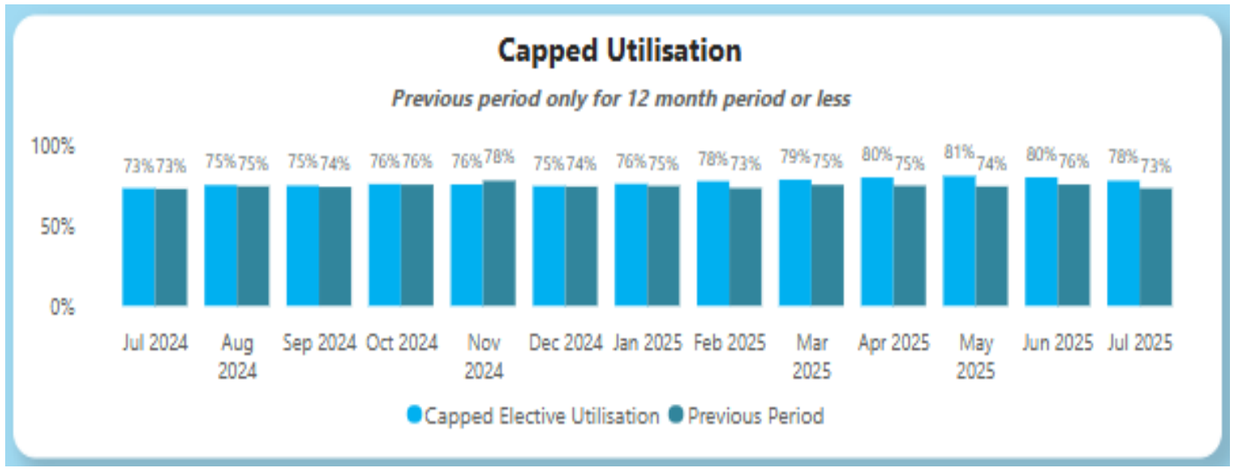
Theatre Utilisation

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.*

Theatres Delivery Group Driver Metric





Understanding Performance

- Capped utilisation was 78.0% vs a target of 85.0%.
- This was a deterioration from the previous month 80.1%, and compares to 73.1% in the previous year.
- Turnaround time between cases increased to 17mins compared to 16 mins in June but the reduction from an average 24 minutes in 2024-25 is sustained.
- Top contributors to underperformance were:
  - Avoidable cancellations on the day; this is a key focus of improvement actions this year.
  - Routine patients booked less than 6 weeks ahead which is in part constrained by pre-op assessment capacity.

Countermeasures	Owner	Due Date
Refresh 6-4-2 scheduling standards for theatres and all specialties with a focus on ensuring booking P3/P4 patients out to 6 weeks.	Adam Dougherty	Oct 25
Reduction of cancellations on the day: - Implement Theatre cancellation SOP - Thematic review of cancellation data to identify further opportunities.	Adam Dougherty / Chris Marsh	Complete Aug 2025
Standardise pre-op assessment to ensure that patients are optimised for surgery and that there is a sufficient pool patients available and clinically fit to undergo surgery.	Adam Dougherty	Oct 2025

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%		Jul-25	23.1%	✗			Special Cause Improving - Run Above Mean
People we care for	% No criteria to reside Adult G&A occupied beds		10.0%		Jul-25	16.4%	✗			Special Cause Improving - Decreasing Run
People we care for	% No criteria to reside pathway 0 discharges				Jul-25	82.8%				Special Cause Concerning - Run Below Mean
People we care for	% of patients waiting >12hrs in ED		0.0%		Jul-25	6.5%	✗			Special Cause Improving - Decreasing Run
People we care for	Adult % G&A bed occupancy		92.0%		Jul-25	93.8%	✗			Special Cause Improving - Decreasing Run
People we care for	Mean time in ED - Not Admitted (mins)				Jul-25	230				Special Cause Concerning - Run Above Mean
People we care for	Non Elective Length of Stay		8.4		Jul-25	8.5	✗			Common Cause Variation
People we care for	Number of 65 week waiters incomplete pathways			0	Jul-25	13	✗			Special Cause Improving - Below Lower Control Limit
People we care for	RUH hospital at home team occupancy	Average occupancy	62.0		Jul-25	55.9	✗			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
- % 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 *The average ambulance handover delay for July 2025 was 45.0minutes, a reduction of 10.7 minutes on average compared toJune 2025. Through July 2025 the total hours lost was 1,377. This is a332-hour decrease compared to last month's lost hours of 1,709.*

- We are continuing to work with our SWASFT colleagues to improve this further to meet our target as soon as possible.

- We have seen a good improvement in our 4-hour performance in July that we need to continue to sustain and improve to hit our target. We have made further improvements in the percentage of people going through our same day emergency care (SDEC) services (2% improvement to 40.5% in July 2025) since the opening of our new medical SDEC on 23rd June 2025.

- Our no criteria to reside numbers remain high at 80.4 daily average and alongside high bed occupancy (95.2%) this is impacting on flow within the organisation. We continue to work with our community partners to address this and bring in line with BSW trajectory for reduction.

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				Jul-25	87.0%				Common Cause Variation
People we care for	A&E Arrivals - Ambulance (av per day)				Jul-25	81				Common Cause Variation
People we care for	A&E Arrivals - Walk ins (av per day)				Jul-25	204				Common Cause Variation
People we care for	Mean time in ED - >75y				Jul-25	395				Special Cause Improving - Decreasing Run
People we care for	Mean time in ED - Admitted (mins)				Jul-25	418				Special Cause Improving - Decreasing Run
People we care for	Mean time in ED - Mental health				Jul-25	343				Common Cause Variation
People we care for	Number of 52 Week Waiters Incomplete Pathways				Jul-25	939				Common Cause Variation
People we care for	Weekend discharge %				Jul-25	16.6%				Common Cause Variation

Watch Metrics - Quality - 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	% complaints responded to within agreed timescales with the complainant		90.0%		Jun-25	71.4%	✗			Common Cause Variation
People we care for	% of ED admissions <60mins from CRtP		80.0%	80.0%	Jun-25	77.8%	✗	F	H	Special Cause Improving - Above Upper Control Limit
People we care for	HSMR – Total		100	100	Mar-25	110	✗		H	Special Cause Concerning - Above Upper Control Limit
People we care for	HSMR – Weekday		100	100	Mar-25	109	✗		H	Special Cause Concerning - Above Upper Control Limit
People we care for	HSMR – Weekend		100	100	Mar-25	115	✗		H	Special Cause Concerning - Above Upper Control Limit
People we care for	Medication Incidents per 1000 bed days		7.0		Jun-25	7.7	✗		H	Special Cause Concerning - Run Above Mean
People we care for	Mixed Sex Accommodation Breaches				Jun-25	187			H	Special Cause Concerning - Run Above Mean
People we care for	Number of complaints received		30		Jun-25	39	✗		H	Special Cause Concerning - Run Above Mean
People we care for	Readmissions - Total		10.5%		May-25	8.9%	✓	P	H	Special Cause Concerning - Above Upper Control Limit
People we care for	Serious incidents with overdue actions		5		Jun-25	13	✗		H	Special Cause Concerning - Above Upper Control Limit
People we care for	SHMI				Feb-25	104.5%			H	Special Cause Concerning - Increasing Run
People we care for	Total monthly fill rate, day hours, HCA		90.0%		Jun-25	87.4%	✗	F	H	Special Cause Improving - Above Upper Control Limit
People we care for	Total monthly fill rate, day hours, RN		90.0%		Jun-25	86.2%	✗		H	Special Cause Improving - Run Above Mean
People we care for	Total monthly fill rate, night hours, RN		90.0%		Jun-25	84.5%	✗	P	L	Special Cause Concerning - Decreasing Run
People in our community	% Difference in DNA rates between IMD1-2 and IMD 9-10		0.0%		Jun-25	4.2%	✗	F		Common Cause Variation

Watch Metrics - Quality - 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	% of ED patients assessed <15mins				Jun-25	59.2%				Common Cause Variation
People we care for	Clostridium Difficile Community Onset, Healthcare Associated				Jun-25	1				Common Cause Variation
People we care for	Clostridium Difficile Hospital Onset, Healthcare Associated				Jun-25	2				Common Cause Variation
People we care for	Concerns are acknowledged within 2 working days		90.0%		Jun-25	99.0%	✓			Common Cause Variation
People we care for	COVID 8+ Days				Jun-25	3				Common Cause Variation
People we care for	E.coli bacteraemia cases Community Onset, Healthcare Associated				Jun-25	6				Common Cause Variation
People we care for	E.coli bacteraemia cases Hospital Onset, Healthcare Associated		6		Jun-25	5	✓			Common Cause Variation
People we care for	Early Identification of Deteriorating Patient	NEWS 5+ Screening Completed in 30 - Trust (%)			Jun-25	32.4%				Special Cause Improving - Two Out of Three High
People we care for	Flu - Healthcare Onset (+3 days)				Jun-25	0				Special Cause Improving - Two Out of Three Low
People we care for	Klebsiella Spp Community Onset Healthcare Associated				Jun-25	0				Common Cause Variation
People we care for	Klebsiella Spp Hospital Onset, Healthcare Associated		2		Jun-25	1	✓			Common Cause Variation
People we care for	MRSA Bacteraemias >= 48 hours post admission		0		Jun-25	0	✓			Special Cause Improving - Below Lower Control Limit
People we care for	MSSA Post 48 Hours				Jun-25	3				Common Cause Variation
People we care for	Never events		0		Jun-25	0	✓			Special Cause Improving - Run Below Mean
People we care for	Number of Hospital Acquired Pressure Ulcers Category 2		5		Jun-25	0	✓			Common Cause Variation
People we care for	Number of Hospital Acquired Pressure Ulcers Category 3		4		Jun-25	2	✓			Common Cause Variation
People we care for	Number of Hospital Acquired Pressure Ulcers Category 4				Jun-25	0				Special Cause Improving - Below Lower Control Limit
People we care for	Number of reopened complaints each month		3		Jun-25	2	✓			Common Cause Variation
People we care for	Pseudomonas aeruginosa Community Onset, Healthcare Associated				Jun-25	0				Common Cause Variation
People we care for	Pseudomonas aeruginosa Hospital Onset, Healthcare Associated		1		Jun-25	0	✓			Common Cause Variation
People we care for	Scanning Compliance for patients being given medication				Jun-25	57.2%				Special Cause Improving - Above Upper Control Limit
People we care for	Total monthly fill rate, night hours, HCA		90.0%		Jun-25	99.6%	✓			Special Cause Improving - Above Upper Control Limit
People in our community	% Difference in 28 Day Diagnosis Performance between IMD 1-2 vs IMD 9-10		0.0%		May-25	9.4%	✓			Common Cause Variation
People in our community	Delivery of Financial Control Total	Variance from Revised Plan		0	Jun-25	-7981	✓			
People in our community	Reduction in Agency Expenditure	Agency as % of Total Pay			Jun-25	0.6%				Special Cause Improving - Below Lower Control Limit

The RUH, where y

Trust Scorecard - Quality Board Metrics (June 2025 Data)

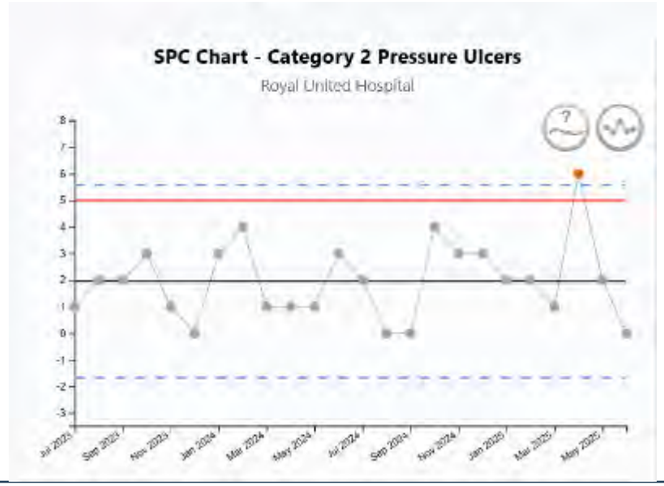
Section Of Scorecard	Strategic Goal	Measure	Measure Description	Local Year-End Target	National Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
National KPI	People we care for	% treated and admitted or discharged within four hours (To ensure 78% of patients can be treated within 4 hours of arrival at ED)		72.0%	95.0%	Jun-25	57.6%	✗			Common Cause Variation
National KPI	People we care for	28 day referral to informed of diagnosis of all cancers		80.0%	80.0%	May-25	63.1%	✗			Common Cause Variation
National KPI	People we care for	Average Handover Time for All Arrivals (mins)	Average ambulance handover time (mins)	30		Jun-25	56	✗			Common Cause Variation
National KPI	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%	May-25	89.0%	✗			Common Cause Variation
National KPI	People we care for	Combined 62 day cancer targets for GP referral, screening and consultant upgrade		75.0%	75.0%	May-25	65.3%	✗			Common Cause Variation
National KPI	People we care for	Diagnostic tests maximum wait of 6 weeks		95.0%	95.0%	Jun-25	72.1%	✗			Common Cause Variation
National KPI	People we care for	RTT - Incomplete Pathways over 52 weeks		1.0%		Jun-25	2.4%	✗			Special Cause Improving - Run Below Mean
National KPI	People we care for	RTT – wait to 1st OP appointment	% patients waiting <18 weeks for their first OP appt	72.0%	72.0%	Jun-25	61.0%	✗			Special Cause Concerning - Below Lower Control Limit
Vision	People we care for	% Key national standards met in the month		100.0%		Jun-25	0.0%	✗			
Vision	People we care for	% of positive responses to friends and family test	Improve the experience of those who use our service			Jun-25	93.3%				Common Cause Variation
Vision	People in our community	Delivery of Breakeven Position	Variance from Plan YTD	£0k	£0k	Jun-25	£2452k	✓			

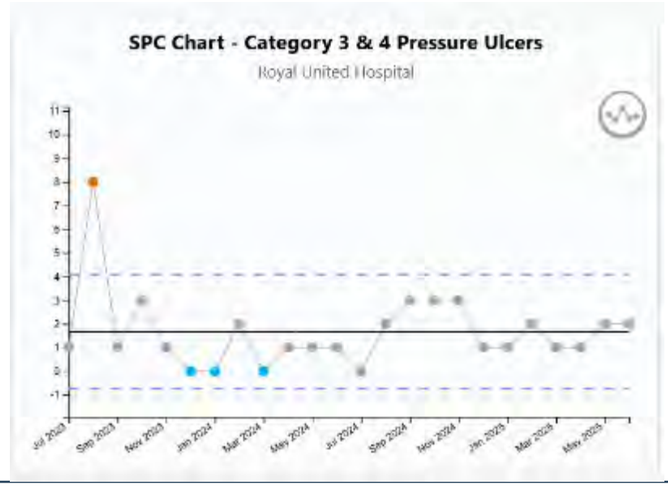
Pressure Ulcers

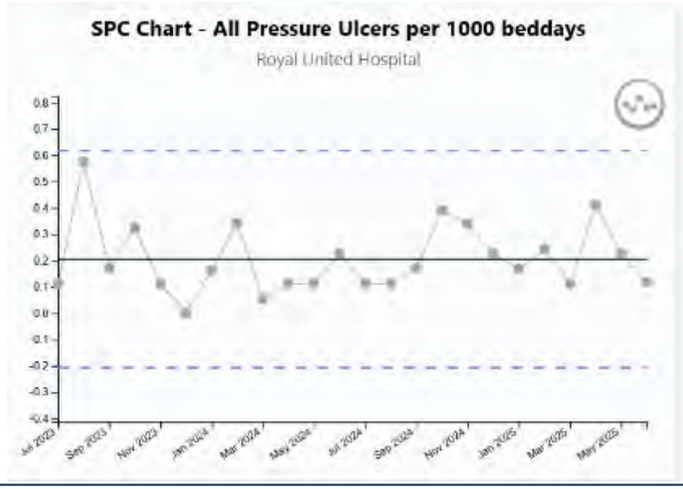
Royal United Hospitals Bath NHS Foundation Trust

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 1.3% in May 2025.

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 June 2025, the RUH reported 0.4 pressure ulcers per 1,000 bed days (5 pressure ulcers). GWH reported 0.29 (5 pressure ulcers) and the Salisbury data was unavailable.
The RUH reported two category 3 pressure ulcers, two category 2 medical device related pressure ulcers, one category 3 medical device related pressure ulcer and no category 2 or 4 pressure ulcers.
The Divisions are working closely with the wards on action plans for improvement.

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 risk assessment (Braden) and report monthly to the Tissue Viability Improvement Group from May 2025.	Specialty Matrons	Ongoing
Respiratory ward are to present their action plan to the Tissue Viability Improvement group in August	Senior nursing respiratory ward	August

Risks and Mitigation

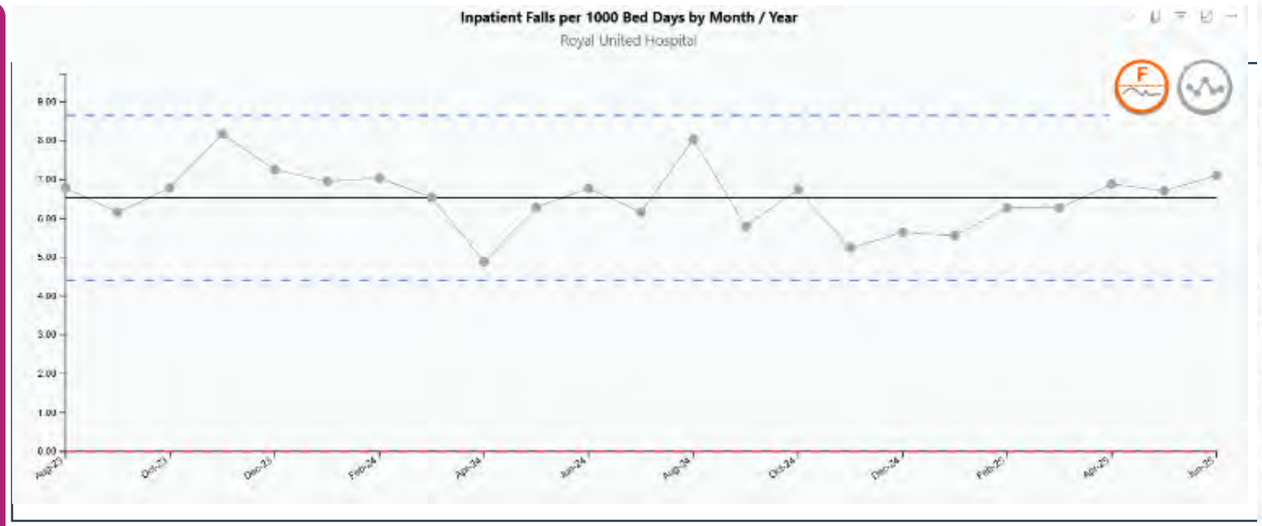
There is a risk that the lack of timely skin bundle assessments will impact on the ability to reduce avoidable pressure ulcers.

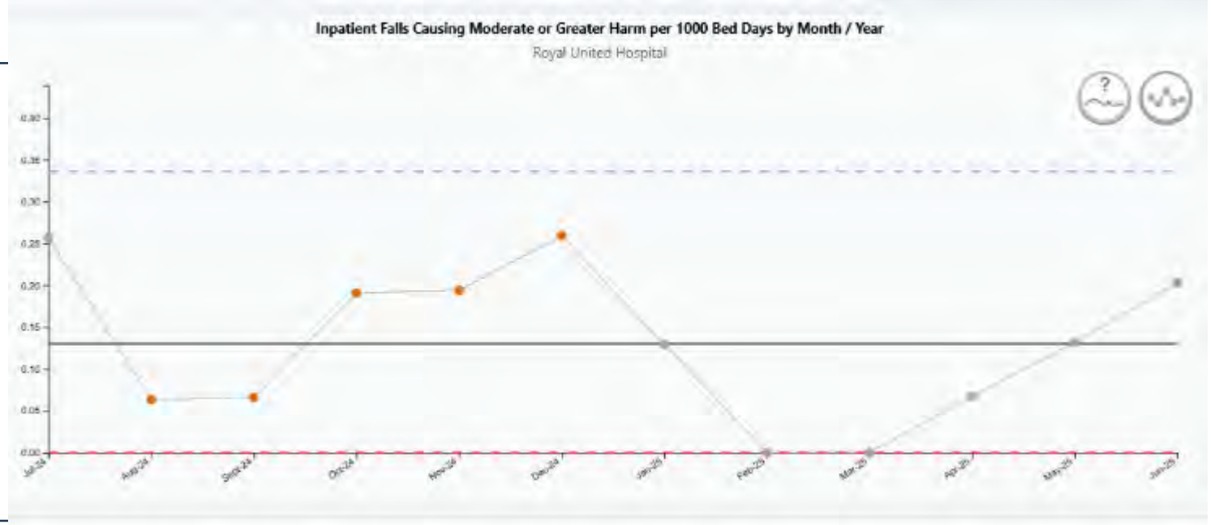
The mitigation is that the Tissue Viability Improvement Group monitors compliance with the Matron who will work with the clinical area to implement improvements.

Falls

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).

Providing Safe and Effective Care





Understanding Performance

Data shows that during June 98.18% of inpatients did not fall in our care which has remained consistent. There were 3 reported inpatient falls that resulted in moderate harm to patients.

Analysis shows 84% of patients who fell as an inpatient in June were 65 years or older.

Falls are multifactorial, meaning they are caused by a combination of factors and all inpatients 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 August 2025	Ward Manager	August 2025
Work with the top contributor Older Persons ward to increase compliance to 50% by August 2025	Ward Manager	August 2025
Trust-wide falls PSII commissioned in May 2025 to thematically review falls cases.	Associate Director of Patient Safety and Quality	October 2025

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 <u>all</u> falls.
3. Launch of Falls Insight and Improvement huddles in Medicine 14th August 2025 .

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 3 cases of Clostridioides Difficile infection (CDI) (2 HOHA and 1 COHA) reported during June 2025. There have been 19 cases against a threshold of 75 reported to date for 2025/26. There are no obvious links to prescribing or cleaning standards and all divisions were impacted during this period, with no specific contributor.

There were 11 cases of *E. coli* infection (5 HOHA and 6 COHA) reported during June 2025. There have been 31 cases reported for 2025/26 against a threshold of 77. There were some consistencies identified during this month, with 6 cases were lower UTI (none of these had a catheter) and the other five had different contributory factors.

There was 1 COHA MRSA Bacteraemia, this was in relation to an IV cannula that became infected. Documentation has been highlighted as a factor that could have changed the outcome and further teaching and surveillance will be completed to support the team and other areas across the Trust.

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 - delayed due to logistical issues. Plan to commence further into the Autumn months.	Infection Prevention and Control	September 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 have been finalised, TAU have commenced work	Infection Prevention and Control	September 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 departments to select the correct PPE, awaiting further updates from the digital team reference the desktop version.	Infection Prevention and Control	October 2025

Risks and Mitigation

There is a risk that the CDI threshold will be exceeded due to increasing infections being detected.
Mitigations: Maintaining surveillance, hand hygiene, stool chart compliance and environmental cleaning and adherence antimicrobial policies. Working with Southwest CDI collaborative to identify any probable causes, such as obesity, diabetes and other comorbidities.

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

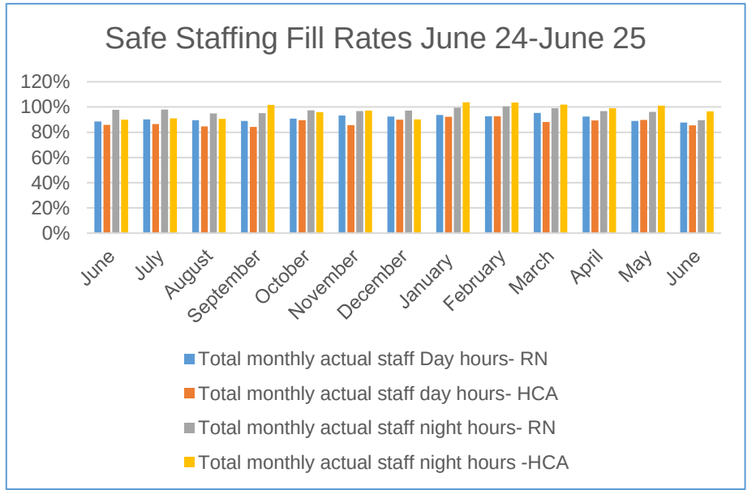
There is a risk *E coli* numbers continue to rise due to a urinary and hepatobiliary primary source.
Mitigations: Well hydrated patients and completion of an A3 into the hepatobiliary increase. The launch of the quick guide for Medication, IV Fluid and fluid balance launched. Review of Laparoscopic Cholecystectomy waiting list, to reduce the at-risk patient list due to these sources being consistently the primary source, this will support *E. coli infection* reduction

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%*

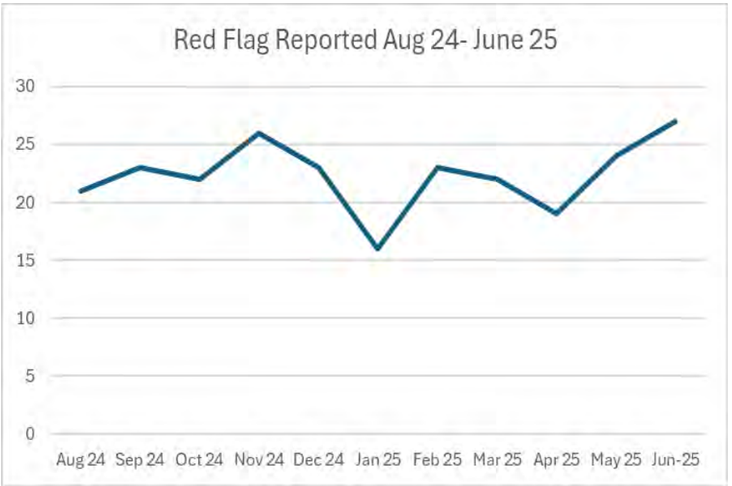
Breakthrough Objective



Day Shift Average Fill Rate		Night Shift Average Fill Rate	
RN	HCSW	RN	HCSW
88%	86%	89%	97%

<80%
>120
80% -120%

Ward	RN Day	HCSW Day	RN Night	HCSW Night
Childrens		55%		
Combe				144%
Cheselden	74%			
waterhouse				125%
Philip Yeoman		54%		0%
Charlotte	66%			
Respiratory		78%		
William Budd	78%		74%	
Emergency Department		52%		



Understanding Performance

The combined shift fill rates for days for RNs across the 25 inpatient wards was 88% and 89% respectively for nights. The combined shift fill for HCSWs was 86% for the day and 97% for the night shift. Therefore, the Trust as a collective set of wards is within safe limits for June.

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. Cheselden ward fell below the 80% due to reduced escalation capacity within the ward. William Budd ward fell below the 80% due to vacancy which is currently being recruited to.

The decreased HCSW fill rate < 80% in all areas other than Philip Yeoman ward (PY) is due to HCSW vacancy. The fill rate continues to improve as HCSW commence in post. PY fill rate is <80% due to varying elective occupancy levels and planned staffing levels.

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 August 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	August 2025
To recruit into William Budd RN vacancies	Senior Sister/Matron	September 2025
To recruit mental health care support worker staff as part of the paediatric establishment and commence in post.	Paediatric Matron/ Senior Sister	September 2025
To recruit into Emergency Department band 5/6/7 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-August 2025.

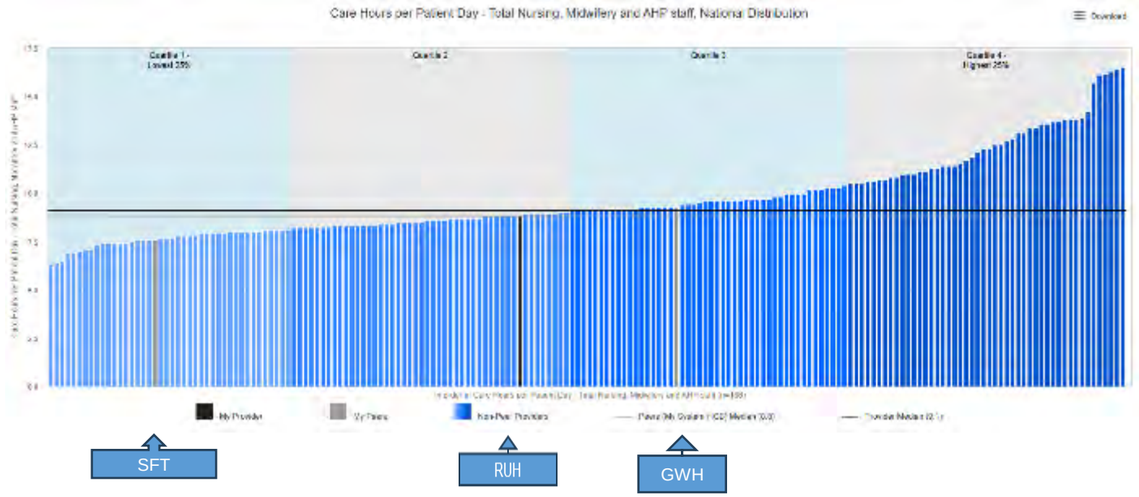
There are twice daily safer staffing meetings to review safe staffing and potential risks or red flags with mitigation put in place as appropriate. This will include redeployment of staff.

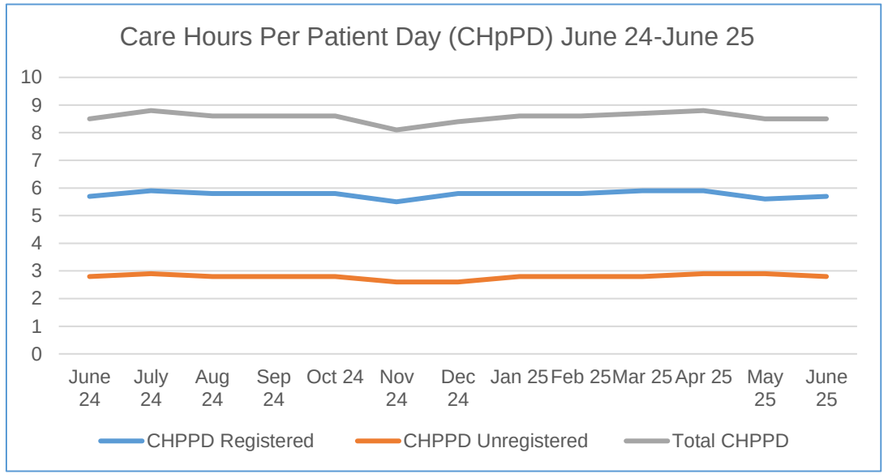
There were 27 red flags reported by wards in May 2025 an increase from 24 reported in May 2025. The breakdown of the 24 was predominantly a shortfall of 25% RN time due to short notice sickness and vacancy. All these were reviewed and appropriate mitigation put in place with staff redeployment as required.

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 8.5. CHPPD continues to remain stable for both registered and unregistered staff over the past 12 months.

When reviewed on Model Hospital (latest data available April 2025) we are in high quartile 2 from low quartile 3 compared to March data, however we continue to benchmark in line with the peer median.

Countermeasures	Owner	Due Date
Review completion times of safe care census completion to correlate with nurse in charge handover by August 2025	Associate Chief Nurse Workforce & Education	August 2025
To review the outcome of the bi-annual Safer Nursing Care Tool (SNCT) April 2025 collection. Provisional results due August 2025.	Associate Chief Nurse Workforce & Education	August 2025

Risks and Mitigation

The risks identified in June 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:

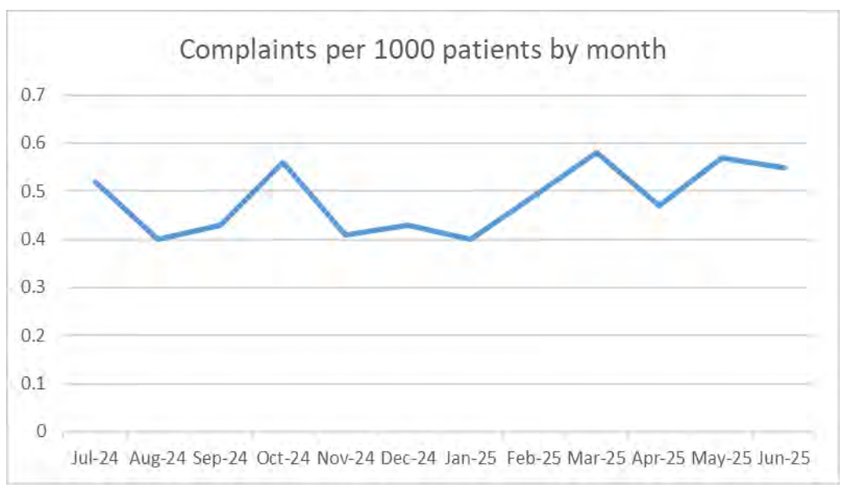
- Twice daily safe staffing meetings reviewing unfilled shifts alongside acuity and dependency of all wards.
- Minimal RN vacancies and over-establishment in some ward areas supporting redeployment.
- Successful HCSW recruitment campaign.
- Focused joint led (Nurse & HR) sickness reduction programme
- Prospective and Retrospective roster reviews with divisional senior nurse, people business partner, finance and roster team
- Review of safe staffing levels at all clinical site meetings

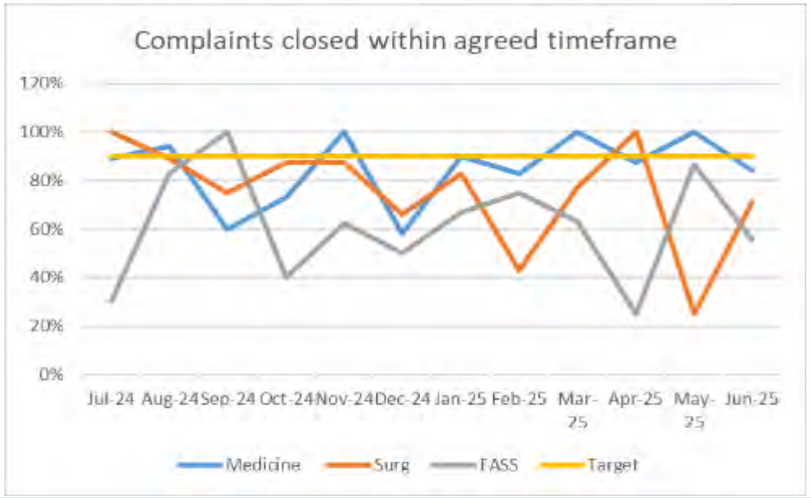
Patient Support & Complaints (PSCT)

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 June 2025, the Trust received 39 new complaints (this compares to the same number in May). Complaints were evenly distributed across several departments with ED (n=9) receiving the highest number.

The majority of complaints were about clinical care (n=29) consistent with previous months with concerns about the quality of medical care. 2 complaints were reopened in June.
The complaint rate per 1000 patients in June was 0.55 which is down from 0.58 in May. 99% of all concerns were acknowledged within 2 working days.

The response times for formal complaints continues to fall below the target of 90% with 71.4% (30) of the 42 closed complaints responded to within the agreed timeframe.

Countermeasures	Owner	Due Date
Further exploration of complaints will be undertaken through thematic coding to support understanding of complaint themes and inform improvement work.	Patient Experience Team	1 July 2025 - ongoing
Revised complaints process has now been agreed with the Divisions and an updated Complaints and Concerns policy will go out for consultation in August and to Patient Experience Committee on 12 August 2025	Head of PSCT	12 August 2025
Continue to monitor compliance with agreed complaint response times in FASS. Complaint team will attend weekly FASS governance meetings to provide progress updates and highlight outstanding/overdue complaints	PSCT/Division	1 September 2025

Risks and Mitigation

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

The new governance structures within the 3 Divisions will support greater oversight of the management and ownership of 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

July 2025

May 2025 data

The RUH, where you matter

Safe – Maternity Workforce

	Target	Threshold G	Threshold A	Threshold R	Apr 25	May 25	June 25	Comment
Midwife to birth ratio	1:24	<1:24		≥1:26	1:27	1:30	1:26	Trained staff only included in acuity data
Midwife to birth ratio (including bank)	1:24	<1:24		≥1:26	1:24	1:25	1:24	Care hours required, trained and support staff included in acuity data.
Percentage of 'staff meets Acuity' BBC	100%	>90%		<70%	80	63	79	
Percentage of 'staff meets Acuity' Mary Ward (inpatient care)	100%	>90%		<70%	65	62	56	MSW vacancy increased and in month MSW sickness 4.87%
Confidence factor in BirthRate+ recording BBC	60%	>60%		<50%	82	86	87	Percentage of episodes for which data recorded
Confidence factor in BirthRate+ recording Mary Ward	60%	>60%		<50%	78	92	92	Percentage of episodes for which data recorded
Percentage maternity sickness rolling 12 months	<4%	<4%		>5%	3.49	3.40	3.39	One month behind
Percentage Maternity turnover rolling 12 months	≤5%	≤5%		≥7%	2.77	1.10	1.04	
1:1 care not provided in labour	0	0		>1	0	0	0	
Labour ward coordinator not supernumerary episodes	0	0		≥1	0	0	1	LWC named caregiver (alongside MSW) for PN woman de-escalated from HDU care - whilst awaiting transfer to ward. Escalated and resolved within 15 minutes but occurred at time of BR submission.
Number of NICE red flags on Birth Rate +	NICE 2015				0	3	2	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
MSW engagement events planned for Sept with HR support	LP/JC

Pipeline actuals in month

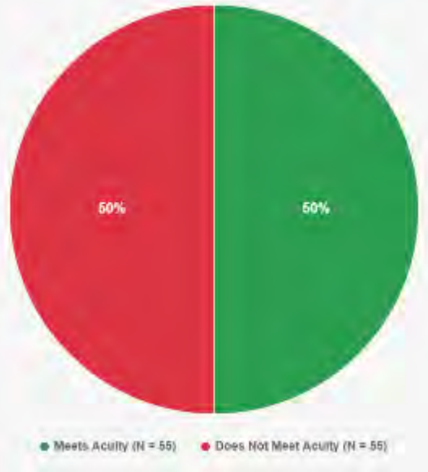
Substantive MW vacancy	Secondment	Mat leave	Fixed term in post	Budget V actual
+7.43 (can go 8.0wte over)	7.08	7.48	5.50	-1.63

Substantive MSW vacancy	Secondment	Maternity leave	Budget V actual
-2.16	2.0	1.61	-5.77

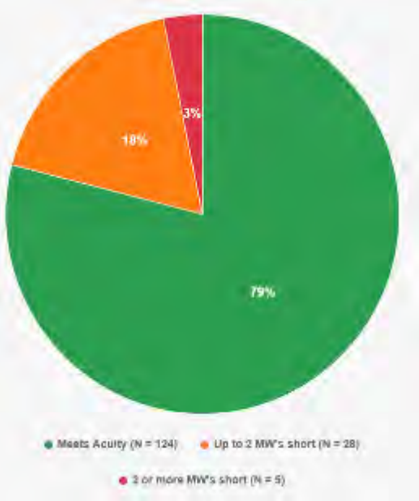
Summary of clinical actions relating to staffing V acuity

Action (top 5)	Times occurred	Percentage
Internal redeployment	3	75%
Staff unable to take allocated break	1	25%

Mary ward



BBC



Safe – Neonatal Workforce

	Target	Threshold			Apr 25	May 25	June 25	Comment
		G	A	R				
Neonatal nurse vacancy					1.36	2.11	2.09	Continue uplift to band 4 to support SNA training. 1 student completes August
Percentage neonatal sickness rolling 12 months	100%	<4%		>5%	3.70	3.48	3.21	One month behind. 2 LTS
Percentage neonatal turnover rolling 12 months	<5%	<5%		<7%	4.99	4.95	5.04	B5 Retirement
Percentage neonatal nursing shifts filled to BAPM standard	100%	>90%		<80 %	98.31	80.3	89.47	
Percentage medical shifts filled to BAPM minimal standard	100%	>90		<80	99	97	98	• Note minimal standards. • Trainee ANNP post recruited. 12 month full time training until able to work on rota.
Percentage neonatal QIS trained	70%	<70 %		<60 %	60	65	65	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
Honorary contact for Yeovil midwife underway Starting July 2025 Appointment to 0.9 wte B5 maternity cover	KF
Live advert for B5 1.5 wte 1 SNA student completes end July	KF

Countermeasure /Action (planned)	Owner
Interview for B6 maternity cover next week B6 appointed but on maternity leave. Due to start End September 2025	KF

Is the standard of care being delivered?

- **Sickness remains under Trust Target**
- **Improvement in BAPM nursing shift fill**
- **TC staffed 100% with dedicated TC nurse 100% though 50% of days between 4-8 babies cared for on TCP. 30% of shifts not supported by correct nurse :baby ratio on TCP when between 4-8**

Safe – Acuity

	Target	Threshold			Apr 25	May 25	June 25	Comment
		G	A	R				
Obstetric consultant presence on BBC	60 hours	>60 hours		<60 hours	98	98	98	
Obstetric consultant non-attendance to clinical situation	100%	100%		<100 %	100	100	100	
Obstetric percentage daily MDT ward round	100%	100%		<100 %				Reviewed by LWC daily, MS forms completed if no ward round completed with immediate escalation.
Birth outside of BAPM L2 place of birth standards	100%	100%		<100 %	100	100	100	100% births in the right unit
Number of days in LNU outside of BAPM guidance	90%	≥90%		<90%	0	0	0	No days in LNU outside of BAPM guidance
Anaesthetic rota compliance	70%	≥70%		<70%	100	100	100	

Countermeasure /Action (completed)	Owner

Countermeasure /Action (planned)	Owner

Is the standard of care being delivered?

- **Obstetric percentage daily MDT ward round reporting by exception**

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

Incidents

New Cases for June 25

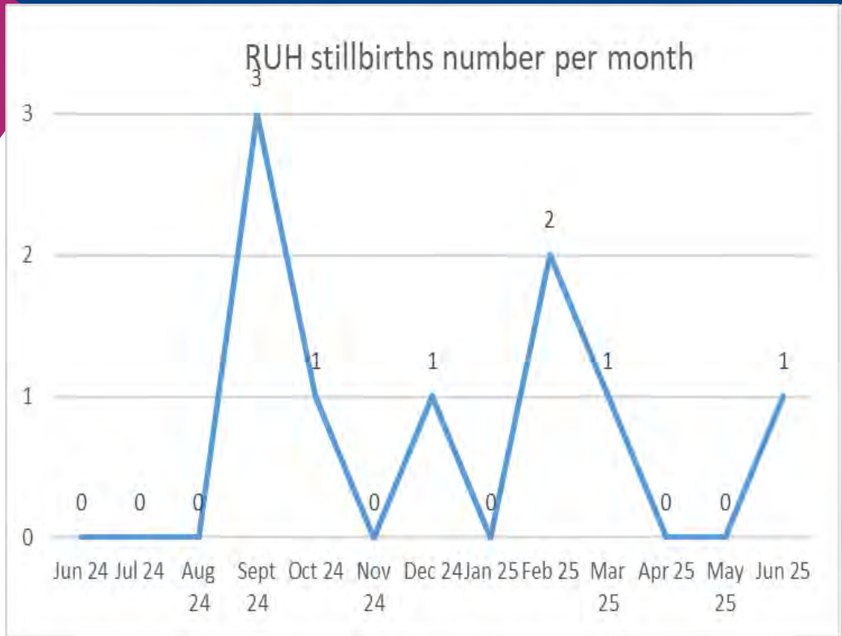
Case Ref	Date	Category	Incident	Outcome/Learning/Actions	MNSI Ref	PSII
141630	08/06/25	Moderate harm	Transfer for therapeutic hypothermia	DOC commenced. Collapse 2 hours post birth. MNSI proceeding at family request	MI-042892	
141606	07/06/25	Moderate harm	Transfer for therapeutic hypothermia	DOC commenced. Intrapartum transfer from community. MNSI proceeding at family request and service concerns	MI-042893	
142057	20/06/25	Moderate harm	Transfer to tertiary unit 34/40	DOC commenced. Fetal distress EM CS. Local learning identified		
142067	20/06/25	Moderate harm	Antenatal stillbirth	DOC not required. Will receive full PMRT		
142238	26/06/25	Moderate harm	Neonatal death	Abnormal AN CTG. Transferred to tertiary unit. Died at 4 days old. DOC not required. Will receive full PMRT		

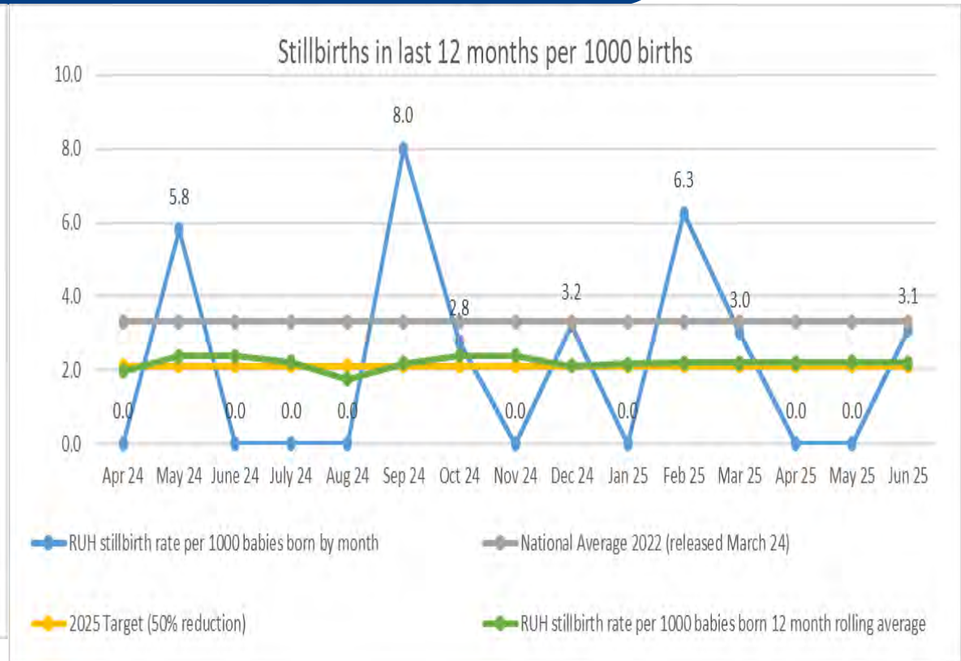
Ongoing Maternity and Neonatal Reviews

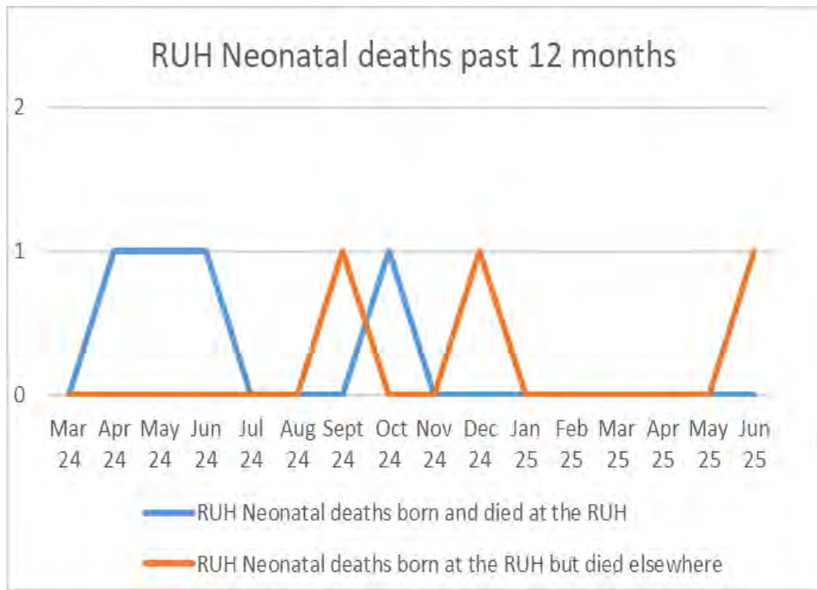
Case Ref	Date	Category	Incident	Outcome/Learning/Actions/ Update of progress	MNSI Ref	PSII Ref
133232	26/09/2024	Unexpected Death	Intrauterine Death at an unknown >37-week gestation in an undiagnosed/concealed pregnancy.	Escalated through governance and safety champions. Datix manager changed	Discussed 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 to be presented at PSEOG . Presented at PSEOG further review needed		Declared 07/10/24

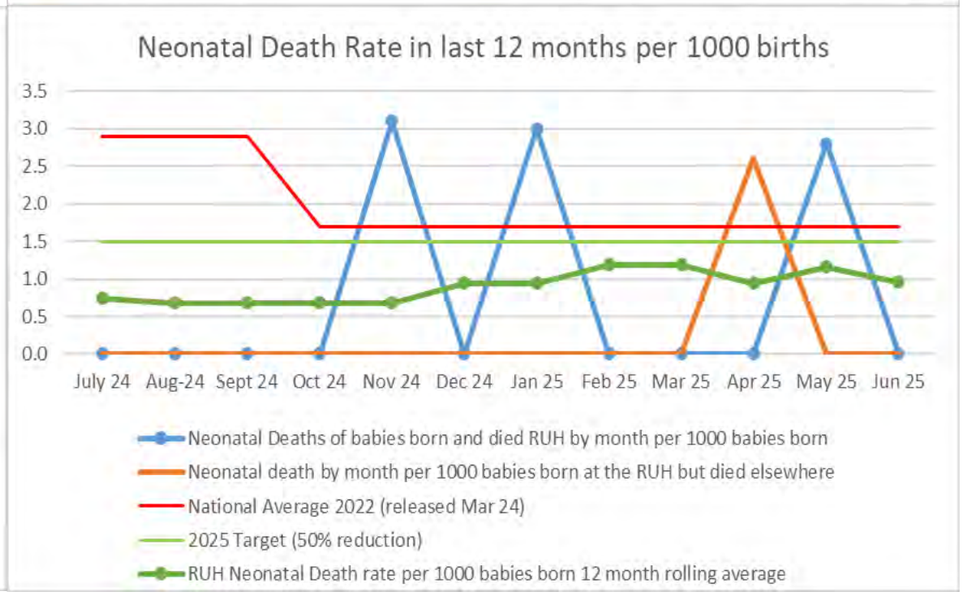
Number of IVH	Nil	**Number of PVL**	Nil
Maternity Safety Support Programme	N/A	**Coroner's regulation 28**	N/A

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 25 we received the MBRRACE-UK report of 2023 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

One stillbirth in the month of June

One neonatal death born at the RUH but died elsewhere in the month of June

Identified learning

No PMRT reports were published in June

Improvement actions & timescales

PMRT grading of care - Key

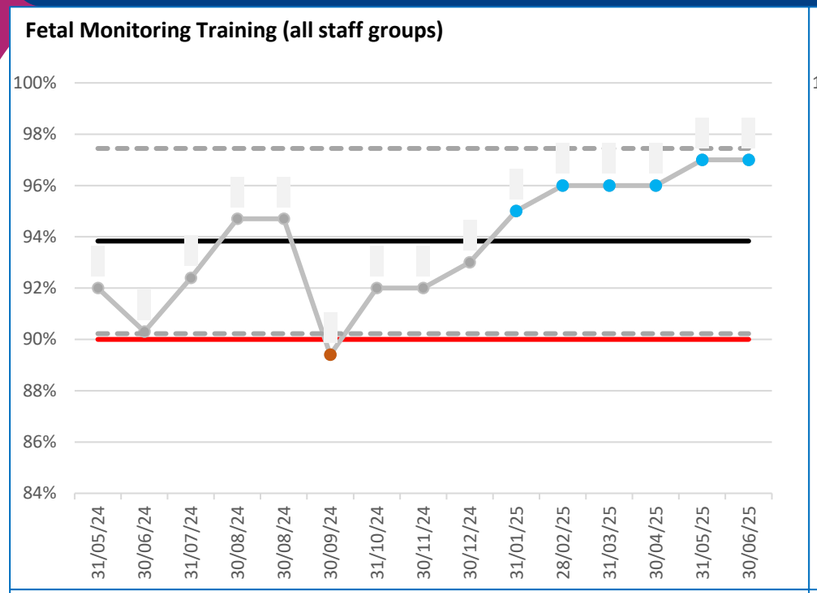
A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

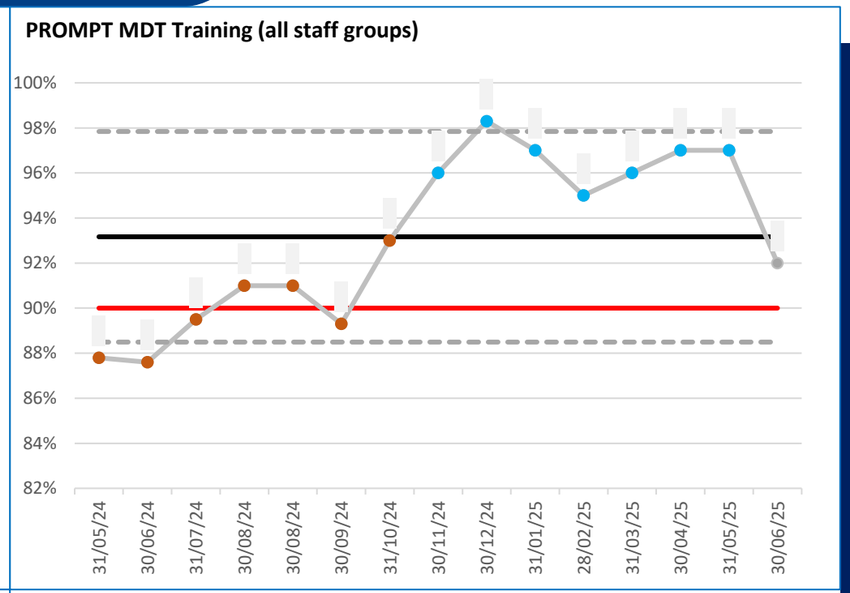
A- The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother

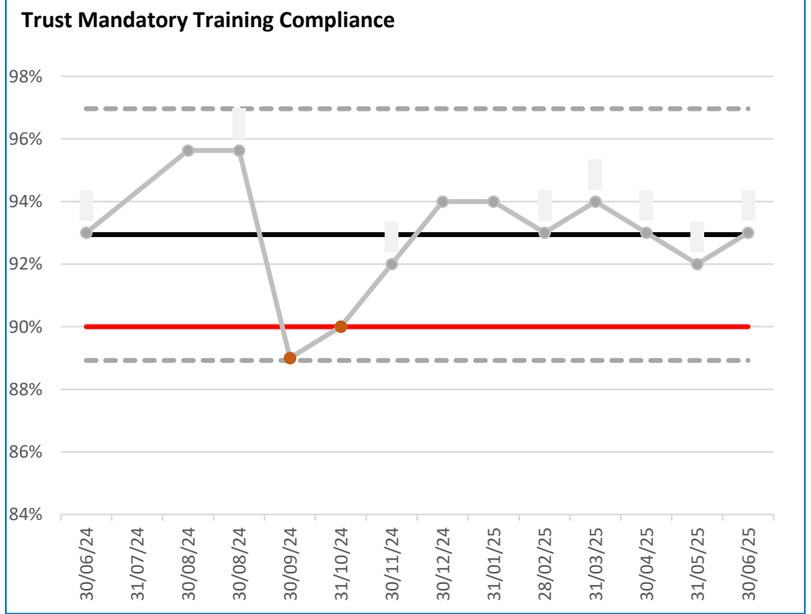
No PMRT grading of care C or D in June

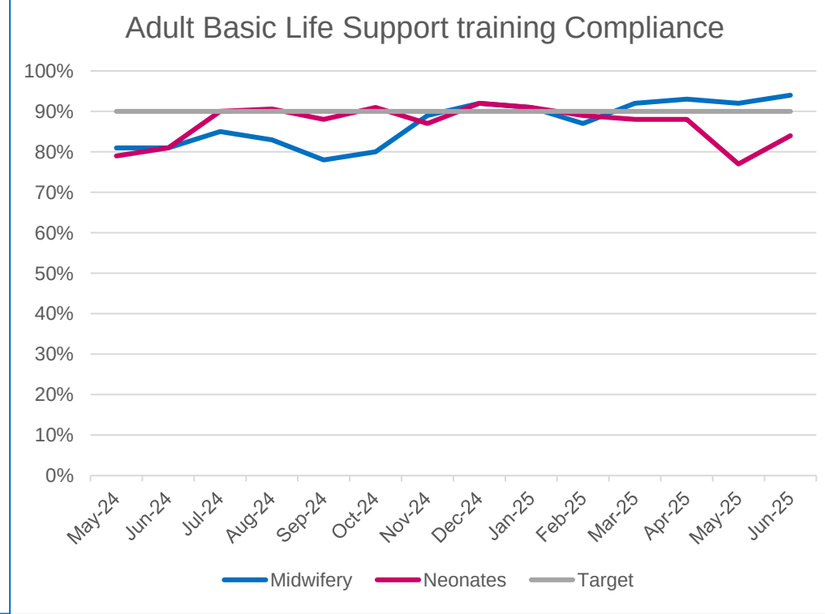
Case Ref	Date	Category	Incident	Outcome/Learning/Actions	MNSI Reference	PSI Reference

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 97%
- PROMPT 92%
- Trust mandatory training (MAT/NEO) 93%
- ABLS (MAT/NEO) Increase from 77% to 84% following cancellation due to period of high acuity in May

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

Compliance to National Guidance – MIS year 7

	Maternity Incentive Scheme Y6 - Safety Action Detail	Current position	Anticipated submission position March 26
1	Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths that occurred from 1 December 2024 to 30 November 2025 to the required standard?		
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?		
3	Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?		
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?		
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?		
6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?		
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users		
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?		
9	Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal safety and quality issues?		
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB)(known as Maternity and Newborn Safety Investigations Special Health authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?		

Maternity Incentive Scheme (CNST) Year 7

- **Key Achievements:**

- **Band 8 or above sponsor for each MIS element**
- Continued compliance with PMRT
- DOC/MNSI/ENS referrals remain 100%
- Continued non requirement for use of Locum obstetricians
- Planning and agreements in place with LMNS to progress/demonstrate compliance with SA6.
- Q4 SBLv3 evidence submission completed – continued 90% compliance from Q3

Next Steps for Progressions:

- Bi-monthly Quad leadership meets at safety champions
- Bi-monthly culture slide to continue in safety champions PQST
- MSDS submission data for July 25
- MNVP statutory obligation escalation to Trust board
- Training compliance across all staff groups fluctuates per month however overall compliance remains strong- continued challenge of small numbers resulting in large impact on overall compliance.

NHSE MNVP statutory obligation

Problem

- Not fulfilling statutory NHSE obligation regarding employment status
- MNVP renumerated as volunteers

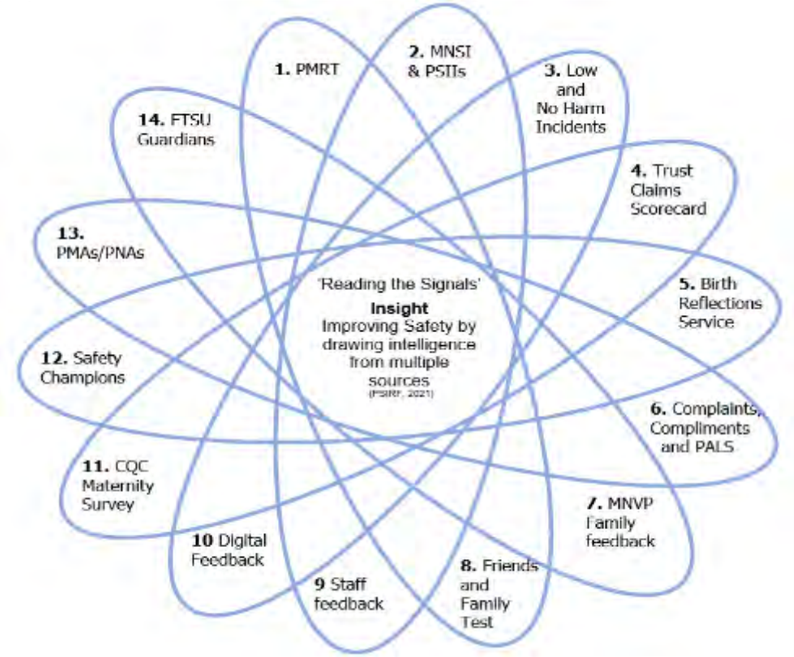
Action required

- ICB to consider appropriate remuneration through:
  - Employing the lead directly
  - Self-employment and being contracted in
  - Contracting a third party who employs the lead
- Escalation as per NHSE escalation guidance
- Trust & ICB to produce action plan to mitigate

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 identif



Safety Champions Staff Feedback

Maternity:

- No feedback received

Neonates :

- No feedback received

Maternity and Neonatal Voices Partnership (MNVP)

- **Key points raised -**
- Different communication styles between nursing/midwifery and medical staff, and the difference between male & female medics communication
- Lack of joined up PN care for women in NNU. PN care of mother's whose baby transferred to Bristol and communication that maternal PN care will still be by RUH team
- Infant feeding support – praise for NNU infant feeding lead across the board
- **Next Steps:** -
- Feedback to obstetric lead
- Review of PN care for women whose baby is transferred to tertiary unit
- Feedback to NNU infant feeding lead

Compliments & Complaints

Formal Compliments	**2**	**PALS Contacts**	**14**
Concerns		**Formal Complaints**	**1**

June 25 Themes

- Friendly attentive staff
- Day 5 screeners, informative and listened to concerns
- Environment for partners – more reclining chairs, bathroom facilities

Friends & Family Survey

Key Achievements:

- 78 pieces of positive feedback
- 1 constructive feedback regarding noise on inpatient ward

- **Identified Areas of Improvements:**

Teddy Bear’s Picnic: A health promotion and engagement event for ex-neonatal families

- In June our FICare Group organised our annual Neonatal Teddy Bear's Picnic for babies and families that have been discharged from the unit within the past 2 years. Thank you to the MNVP who funded the venue hire.
- AIM: The event provides a space for families to receive invaluable health promotional information and support from our Allied Health Professionals, weigh and measure their babies to monitor development, catch up with staff who cared for their baby and meet other parents from the unit for essential peer support.
- Families could also provide feedback to the MNVP to help us to improve the service provided within our neonatal unit.
- Parents could learn about how they can become more involved in neonatal parent engagement work across the southwest and BSW region.
- Parent feedback:

"Seeing the neonatal team again and meeting other families."
"Seeing all the NICU staff"
It was great, thank you to everyone who organised and attended the event!
Such a lovely idea to get NICU parents together to share experiences and seeing the NICU staff again was so lovely. Baby classes such as baby massage or baby sensory would be amazing if ran by OT and NICU staff. I’m sure parents who’ve had babies within NICU would benefit from these - being NICU specific

27 Families

The RUH, where you matter

Bath & North East Somerset, Swindon and Wiltshire
Maternity & Neonatal Voices
Working in partnership to improve maternity services

Alerting Watch Metric Commentary – Serious Incidents Overdue Actions

Royal United Hospitals Bath NHS Foundation Trust

Understanding Performance
Measure dependant on when the report is run, dedicated patient safety facilitator now has ownership of tracking and monitoring actions with a plan to ensure full ownership transfers to the patient safety nurses. We should see less actions agreed as part of future learning responses and PSII's in line with the PSIRF approach so overtime monitoring 'numbers' will be more manageable but additional time will be needed to for longer term follow up around action impact and sustainability. *A report in September will be prepared for divisional governance to assess open actions, timeframes and viability with an assurance report to IIC by the end of the year.* *Currently in progress, actions for incidents without a learning response/PSII or Huddle will no longer be individually entered and tracked on the datix specific module but will be noted as part of the investigation outcome summary text.*

Countermeasures	Owner	Due Date
Dedicated recourse for the follow up of outstanding actions	L Wilkie	Complete
Transition of action monitoring and follow up to patient safety nurses	Patient Safety Nurses	30/11/2025
Report to divisional governance to assess *open actions, timeframes and viability with an assurance report to IIC by the end of the year.*	L Wilkie	01/09/2025
Actions for incidents without a learning response/PSII or Huddle will no longer be individually entered and tracked on the datix specific module.	H Butler	30/09/2025

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 (National)	Breakthrough	2024	42.7%	
People we work with	Employee Experience	% Agreeing organisation values work (Pulse)	Context	25-26 Q2	46.1%	
People we work with	Employee Experience	% Agreeing that immediate manager values work (National)	Context	2024	74.7%	
People we work with	Employee Experience	% Agreeing that immediate manager values work (Pulse)	Context	25-26 Q2	71.7%	
People we work with	Employee Experience	% Agreeing that feel valued by team (National)	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 Q2	52.4%	
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.
Pulse survey questions pertaining to feeling valued first asked in 25026 Q2.

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	Jul-25	5735.4		<=5692.4	✗	Not in FY			SPC not appropriate
People we work with	Workforce Plan	Substantive WTE	Context	Jul-25	5428.9		<=5399.7	✗	2			SPC not appropriate
People we work with	Workforce Plan	Bank WTE	Context	Jul-25	297.9		<=286.7	✗	Not in FY	F		Common Cause
People we work with	Workforce Plan	Agency WTE	Context	Jul-25	8.6		<=6.0	✗	2	?	L	Special Cause Improving - Run Below Mean
People we work with	Vacancy	Vacancy Rate	Key Standard	Jul-25	-0.43%		<=4.00%	✓	0			SPC not appropriate
People in our community	Pay	Pay Bill % on Agency	Watch	Jul-25	0.74%		<=2.50%	✓	0	P		Common Cause
People we work with	Turnover & Leavers	In Month Turnover	Key Standard	Jul-25	0.67%		<=0.92%	✓	0	?	L	Special Cause Improving - Shift
People we work with	Turnover & Leavers	12 Month Turnover	Key Standard	Jul-25	7.38%		<=11.0%	✓	0	P	L	Special Cause Improving - Two out of Three Low
People we work with	Turnover & Leavers	Leavers Inside 1st Year	Context	Jul-25	5.72		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	Jun-25	4.70%		<=4.42%	⊗	1	?		Common Cause
People we work with	Sickness Absence	Short Term Sickness	Context	Jun-25	2.25%		N/A					
People we work with	Sickness Absence	Long Term Sickness	Context	Jun-25	2.45%		N/A					
People we work with	Sickness Absence	12 Month Sickness	Key Standard	Jun-25	4.79%		<=4.70%	⊗	7	F	H	Special Cause Concerning - Two out of Three High
People we work with	Sickness Absence	In Month ASD Sickness	Driver	Jun-25	1.28%		TBC			F		Common Cause
People we work with	Appraisal	Appraisal Compliance	Key Standard	Jul-25	78.63%		>=90.0%	⊗	Pre-2021	F	L	Special Cause Concerning - Below Lower Control Limit
People we work with	Appraisal	AfC Appraisal Compliance	Context	Jul-25	79.10%		>=90.0%	⊗	Pre-2021	F	L	Special Cause Concerning - Below Lower Control Limit
People we work with	Appraisal	M&D Appraisal Compliance	Context	Jul-25	73.66%		>=90.0%	⊗	Pre-2021	F	L	Special Cause Concerning - Shift
People we work with	Training	Mandatory Training Compliance (Core)	Key Standard	Jul-25	89.40%		>=85.0%	✓	0	P	H	Special Cause Improving - Two out of Three High

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

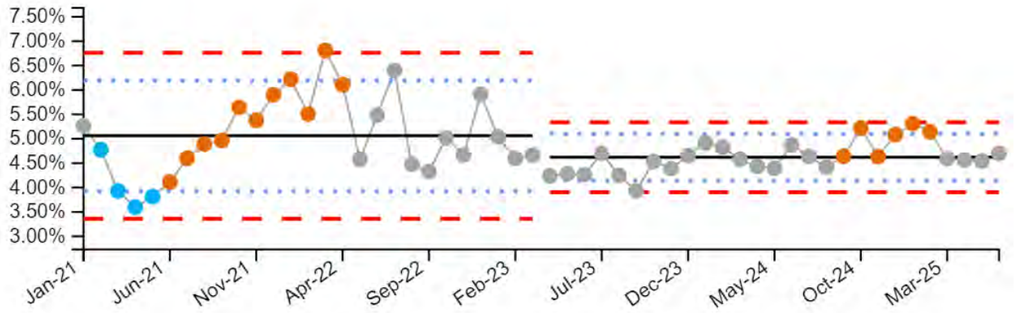
DRIVING

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 and employee well-being.

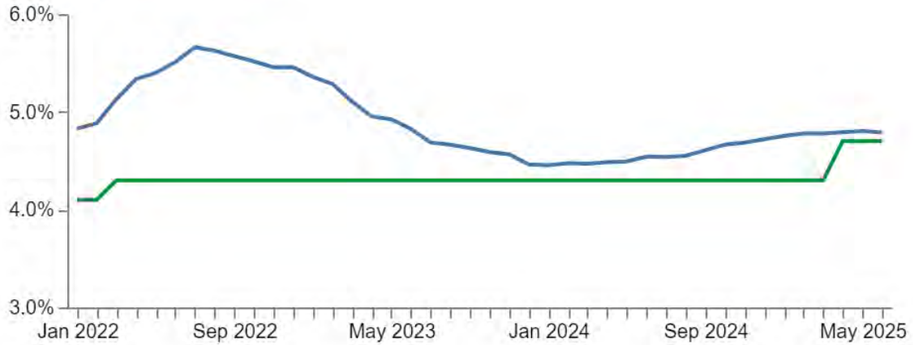
Trust In Month Trend



4.70% Latest In Month Sickness

4.42% Target

Trust 12 Month Trend



4.79% Latest 12 Month Sickness

4.70% Target

Understanding Performance

- The in-month sickness rate in June was 4.70%, which is above the seasonally adjusted target. On average c.260 WTE were lost per day due to sickness in June, which is up slightly (c. 5-9 WTE/day) on the previous 3 months.
- The in-month rate is, however, down on 12 months ago, which is why the 12-month turnover rate has seen a negligible drop to 4.79%.
- Other musculoskeletal problems was the second most common reason for sickness behind anxiety, stress and depression. In the past 5 months, the absence rate for this reason has been elevated in the range of 0.45-0.55%, compared to previously being in the range of 0.30-0.40%
- Estates and Facilities has the highest sickness rates; however, its 12-month rate continues to be on a downward trend.
- Medicine has the second highest rates. Its 12-month rate is again 5.27%, but it is too early to draw conclusions on whether a peak has been reached.

Countermeasures	Owner	Due Date
Estates and Facilities: Additional Manager Q&A's to support and training around new sickness policy. A3's on Departmental Sickness being completed in Facilities. Sickness remains Driver in Estates.	DPP/Hub	August/Sept 2025
Medicine: Action plans re violence and aggression, civility, skill mix and wellbeing interventions in ED, Parry and Haygarth ward to address root causes of sickness absence.	DPP Med	August/Sept 2025
New Wellbeing and Supporting Attendance policy – training and upskilling of line managers.	Hub	2025/2026 Driver
Surgery: have Anxiety, Stress and depression as a Driver linking into ensuring people feel valued at work .	DPP	2025/2026 Driver
Top 50 Long term sickness cases have been reviewed to ensure we are supporting staff.	Hub	September 2025

Risks and Mitigation

Risk
Risk that high sickness (short/long term) in impact areas is resulting in poor staff wellbeing and higher costs linked to increased bank spend.

Mitigation
People hub working with line managers to undertake case reviews on long and short-term sickness. DPP's review options for well-being interventions.

Anxiety, Stress and Depression Sickness

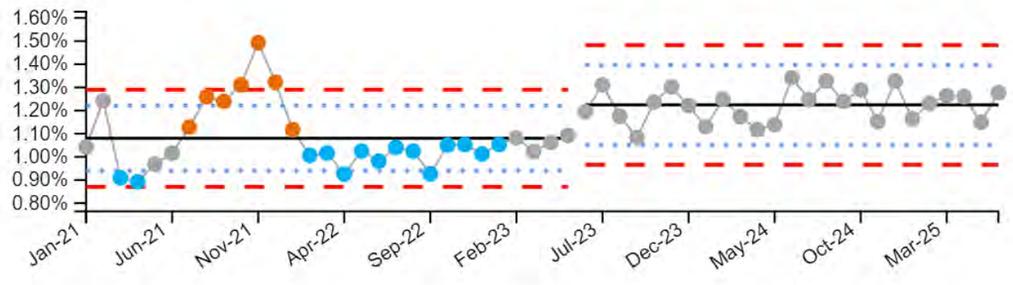
Royal United Hospitals Bath NHS Foundation Trust

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.

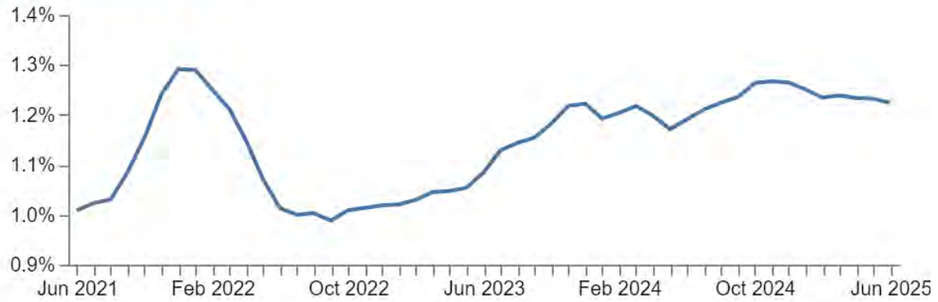
Trust In Month Rate



1.28%

Latest In Month Rate

Trust 6 Month Trend



1.22%

Latest 6 Month Rate

Understanding Performance
• The in-month anxiety, stress and depression sickness rate has increased to 1.28%. Although this increase on last month is likely not a concern and just natural variation, the fact that performance consistently remains stable within the current parameters is arguably a concern as it shows no improvement. • Medicine has the highest 12-month anxiety, stress and depression sickness rate at 1.37%; however, June did represent a slight fall after month on month increases over the preceding year.

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
Medicine • Stress/burnout analysis and action planning in areas of high burnout – ED, Haygath, Parry, Radiology. • Additional Health and wellbeing sessions as part of ED away days. • Cultural work surrounding civility in ED linked to patient outcomes • Focussed actions surrounding violence and aggression through use of Trust policy and support mechanisms within areas of high prevalence.	DPP Med Wellbeing Hub team DPP Med with enhanced care	August 2025 Sept 2025
Theatres • Theatre recovery had their burnout session with EAP • Listening events held to listen to staff feedback • Monthly HR/Clinical lead meetings discussing health and wellbeing. • A3 to be completed in August 2025 to analyse sickness trends	Divisional People Partner	Review in Sept 2025

Risks and Mitigation
Risks - Increased sickness absence - Impaired productivity, quality and safety - Decreased value attributions from colleagues **Mitigations** - Effective inreach/ preventative work from culture team and Wellbeing Hub - People Breakthrough Objective driven at PRMs - Leadership and change management interventions to enhance quality of engagement (early assessment and prevention of stress)

Appraisal

Royal United Hospitals Bath NHS Foundation Trust

DRIVING

Key Standard

We are driving this metric because

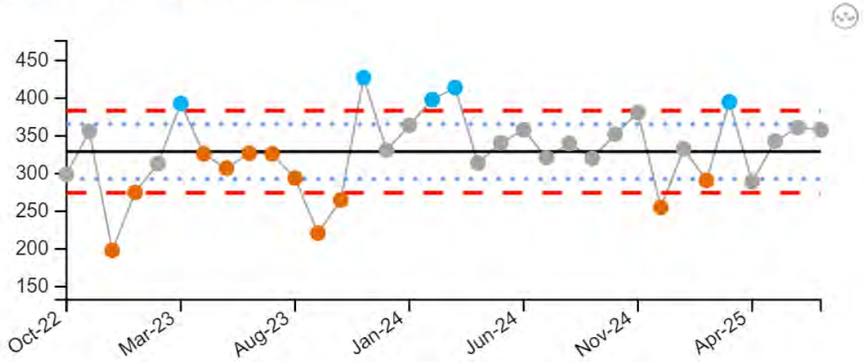
Timely, high-quality appraisals improve performance, engagement and productivity, reducing sickness and burnout. All colleagues should have access to a meaningful programme of interaction with their managers, including an annual appraisal. The organisation has set a 90% compliance target for the annual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

Trust Appraisal Compliance

78.6%
Latest Appraisal Compliance

90.0%
Target

Appraisals Completed in Month



358
Appraisals Completed in Month

Understanding Performance

- Appraisal compliance has fallen for a third consecutive month and now stands at 78.63%.
- Corporate continues to have the poorest compliance of the main divisions, though its latest figure of 64.54% is its best since September and performance is trending up.
- Medicine continues a long-term downward trend, with compliance falling below 80% for the first time since May 2024. FASS also has fallen below 80%.
- Having made a concerted effort to improve compliance in March, over half the gain has now been eroded as Estates and Facilities' compliance falls month on month. It does remain the best performing division, albeit over 5 percentage points below target.

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	Sept 2025
Focus on 8c/Consultant appraisal completion.		Sept 2025
E&F focusing on lowest compliance departments with aim to hit 90% in next 2 months.	E&F Board/ PP	October 2025
FASS: Developing a pilot for a team-style appraisal with one of the community birthing teams & developing bitesize training for line managers.	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.

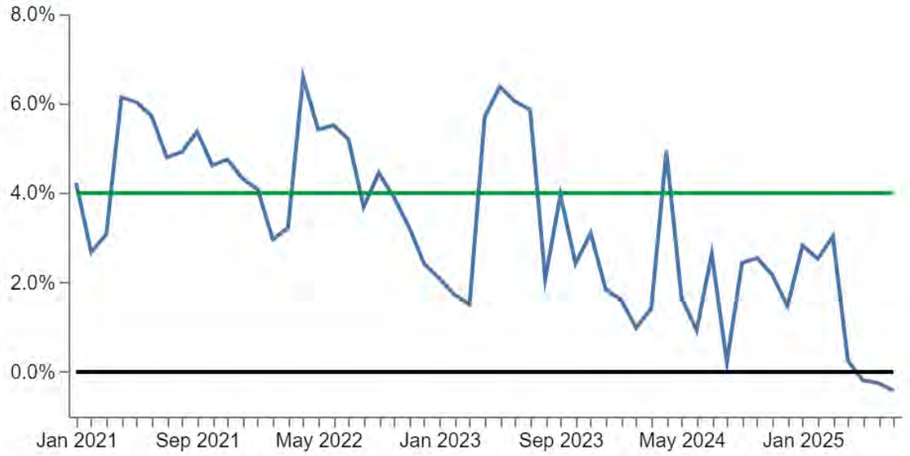
Priority: Improving interactions between managers and direct reports is central to the breakthrough objective: increasing perceptions that the organisation values my work.

Vacancy

Royal United Hospitals Bath NHS Foundation Trust

Key Standard

Trust Vacancy Rate



-0.43% Latest Vacancy Rate

4.00% Target

Budget v Contracted

5516.1 Latest Budget

5539.5 Latest Contracted

-23.5 Latest Vacancy

Understanding Performance

- Finance data held in Unit 4 indicates the Trust being over-established by 23.5 WTE. This equates to a vacancy rate of -0.43%.
- According to Unit 4, Surgery is 30.2 WTE over-established. Combined with Medicine (2.9 WTE over-established) and Reserves (11 WTE offset), this offsets the small vacancies (<10 WTE) in other divisions.
- Most of the negative vacancy for Surgery sits within their unidentified pay savings.

Countermeasures	Owner	Due Date
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
EVP work to showcase all the RUH has to offer to support the attraction and retention of our staff continues. The Recruitment Team are actively supporting community career events to fill current vacancies and work underway to develop new webpages on the internet.	Head of Talent	Open

Risks and Mitigation

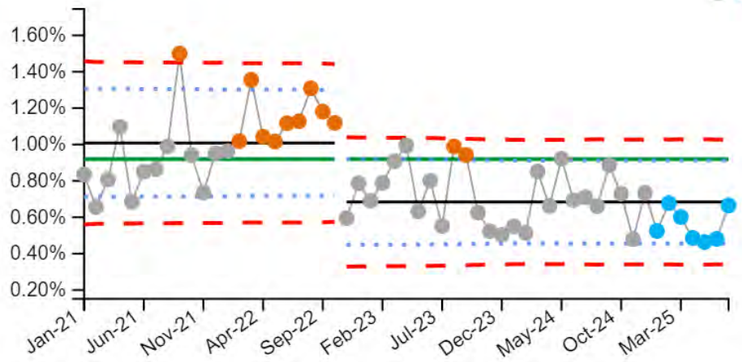
Risk: Government White Paper outlining immigration changes may impact workforce supply and create uncertainty for our international workforce whilst we await transitional plans and key dates for changes. The risk is logged on our Trust Risk Register.

Mitigation: Commitment to communicate what we know and signpost services and support for Managers and staff impacted by change.

Turnover

Key Standard

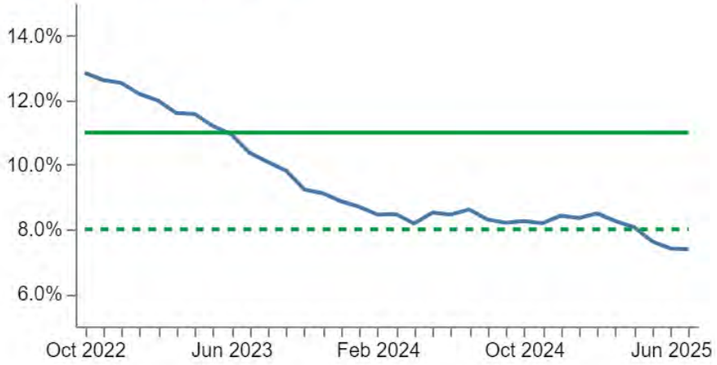
Trust In Month Turnover



0.67% Latest In Month Turnover

0.92% Target

Trust 12 Month Turnover



7.38% Latest 12 Month Turnover

11.00% Target

Division	In Month	12 Month
Capital Summary [Division]	2.75%	12.53%
Charity Summary [Division]	8.19%	29.18%
Corporate Division	0.15%	8.99%
Estates and Facilities Division	0.51%	6.77%
Family and Specialist Service Division	1.60%	9.10%
Medical Division	0.55%	6.72%
Research & Development [Division]	1.15%	6.58%
Surgical Division	0.41%	6.54%

Main Staff Group	In Month	12 Month
Add Prof Scientific and Technic	2.44%	18.87%
Additional Clinical Services	1.65%	9.92%
Administrative and Clerical	0.55%	8.85%
Allied Health Professionals	0.31%	11.92%
Estates and Ancillary	0.63%	7.12%
Healthcare Scientists	1.82%	10.38%
Medical and Dental	0.00%	1.96%
Nursing and Midwifery Registered	0.22%	4.36%

Understanding Performance

• In month turnover in July was 0.67%. Although higher than recent months, in historical terms this would still be considered low and indeed was enough to slightly undercut the figure rolling off, resulting in 12-month turnover falling to 7.38%.

• The 12-month turnover rate may be considered unhealthily low and could fall further in the next three months if we continue to experience in-month turnover that is in line with recent months.

• 12-month turnover for Admin and Clerical continues to fall, which may be considered problematic if natural turnover is seen as a key strategy for re-sizing the Corporate Workforce.

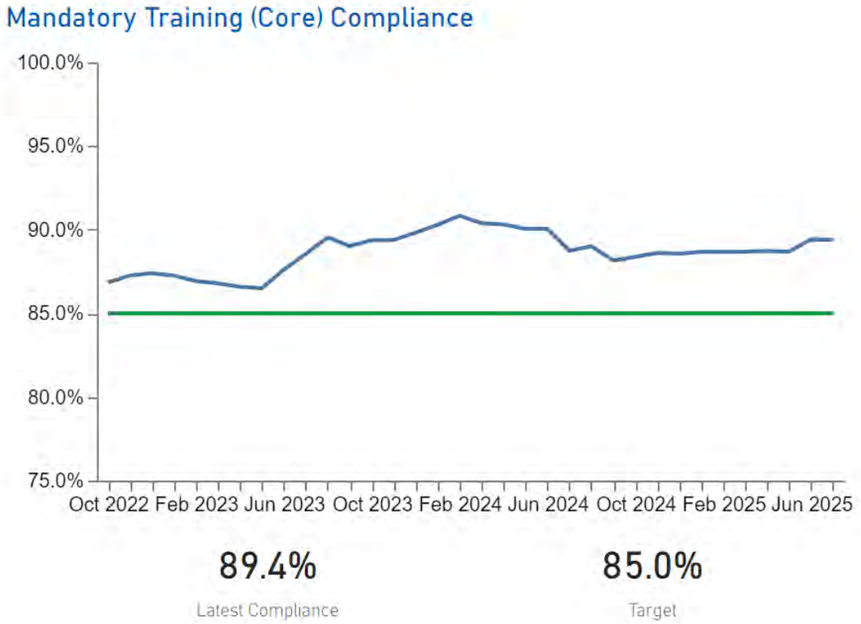
Countermeasures	Owner	Due Date
No counter measures in place due to 12-month turnover below target.		

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 remains comfortably above target at 89.4%. All Divisions are also continuing to achieve the 85% target. • The Resuscitation subjects and the Level 3 Safeguarding subjects, continue to be the main areas below target. The data fails to demonstrate any significant improvement that would give confidence that the respective targets would be imminently achieved.

Countermeasures	Owner	Due Date
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. This includes resus training.	Head of Corp Education	Oct 25
Resus Driver measure as part of People PRM	Head of Corp Education	On-going

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** **ID2791** Resus Staffing. Vacancies and sickness. Team have been delivering to a compliance of 50%. 2 wte now started and Resus driver to started in July 2025

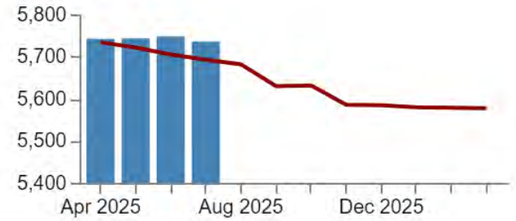
Performance vs Workforce Plan

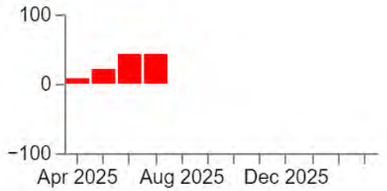
Royal United Hospitals Bath NHS Foundation Trust

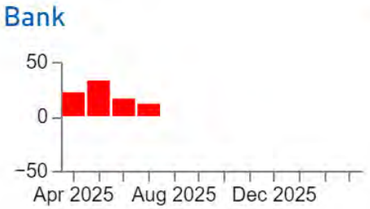
Driver

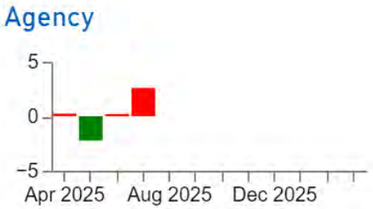
We are driving this metric because

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	5,742.75	5,747.91	5,735.38								
Substantive	5,408.81	5,409.60	5,436.89	5,428.87								
Bank	326.67	329.39	304.82	297.91								
Agency	6.23	3.76	6.20	8.60								

Understanding Performance

- For a second consecutive month, total actual WTE has exceeded the plan. Cumulatively, plan has been missed by 115 monthly WTE in the Financial Year to date.
- Substantive WTE remains above even the April target despite a drop on the numbers last month. To achieve just the September in-month substantive target, almost 70 WTE would need to be lost in 2 months. The likelihood of this appears very low.
- Actual Bank WTE has fallen but is still 7 WTE above the in-month target. The reduction of under 7 WTE may be a concern given target is being missed and the plan has identified further reductions of around 13 and then 11 WTE in next two months. This arguably highlights the progressive difficulty in cutting numbers.
- Actual agency use has increased slightly and is 2.6 WTE above the in-month target. Whilst it is increasingly clear that the targeted 6 WTE falls within the control limits, it is not close to the upper limit and thus will not be achieved consistently.

Countermeasures	Owner	Due Date
RUH Recovery Plan being developed	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
Increased reporting and assurance documentation is being monitored and reviewed in more detail and more regularly	Workforce	On going
Mutually Agreed Resignation Scheme - 14 applications being processed.	People Hub	September 2025

Risks and Mitigation

Risk
The RUH is currently under-delivering on both its wte reduction and its paybill reduction.

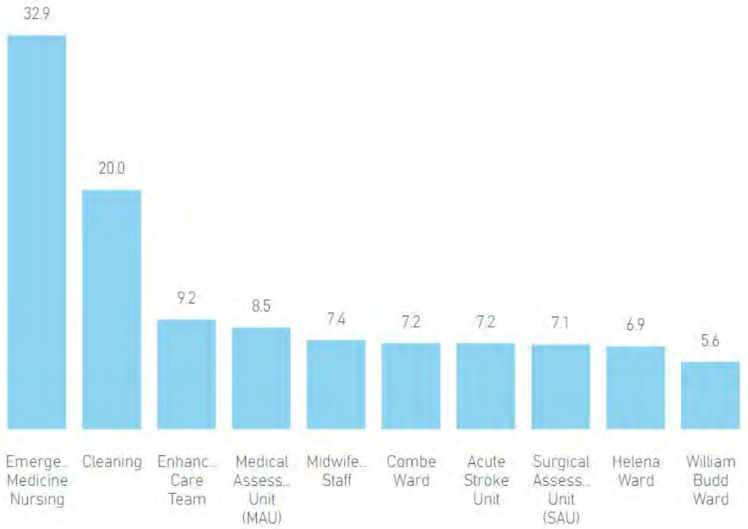
Mitigation
Recovery Plan being developed.

Bank & Agency Use

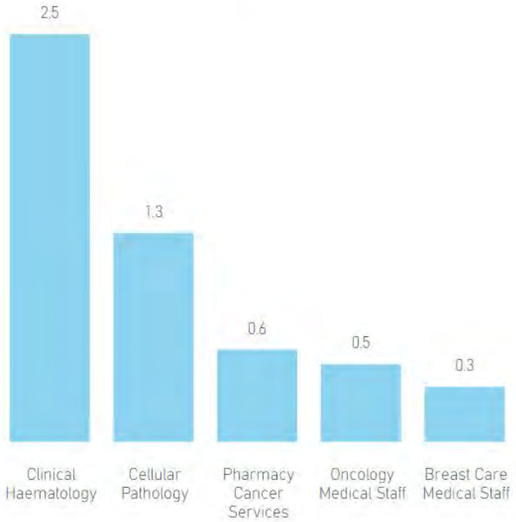
Royal United Hospitals Bath NHS Foundation Trust

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	18.6	4.6
Registered/ Qualified Scientific, Therapeutic and Technical staff	14.0	0.6
NHS Infrastructure support	60.1	0.0
Registered Nursing, Midwifery and Health Visiting Staff	97.6	0.0
Support to Clinical Staff	114.5	

Understanding Performance

- Support to Clinical remains the main staff group for bank use, accounting for 111.9 WTE although a slight reduction can be seen in the financial year for this staff group.
- Registered Nursing has the next highest bank use at 91.4 WTE. Although this is the lowest monthly figure since the 22/23 financial year, it is too early to conclude that this is a lasting sustained change.
- Agency is primarily being used to cover hard to fill consultant roles in fragile services.
- The supply of bank workers to the Covid vaccination programme led by the ICB and PCN's comes to an end 31st August 2025.

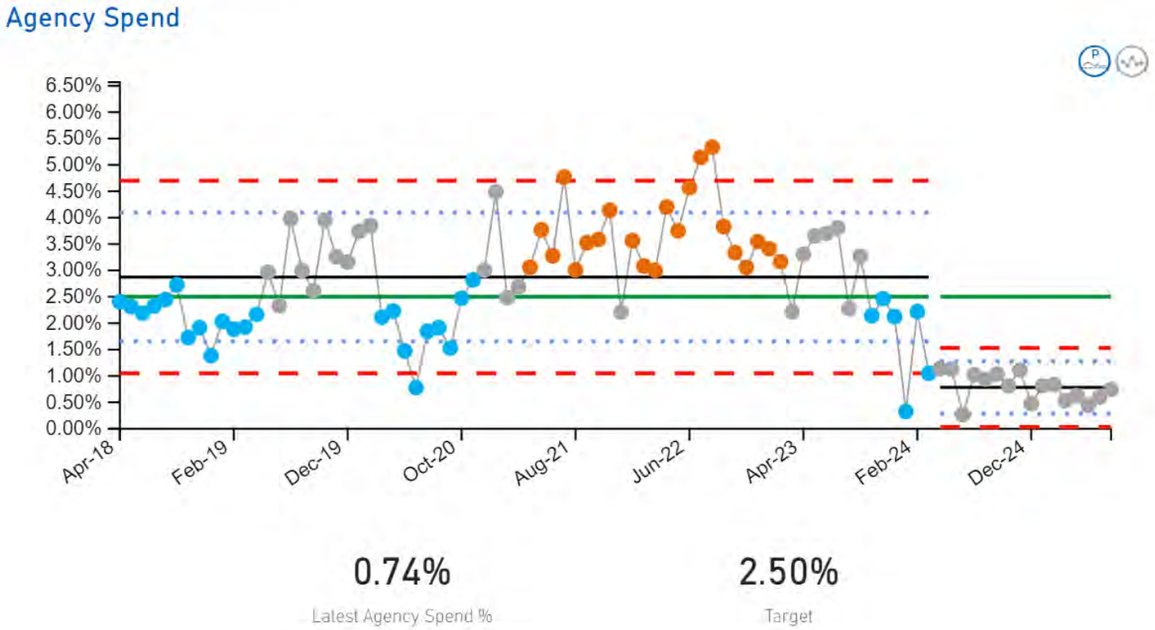
Countermeasures	Owner	Due Date
A weekly spend/usage report has been developed in Power BI from Health Roster and Locum's Nest. The report is future focused and shows the current week and the next five weeks.	Rostering Workforce	Weekly
South West Regional rate card for Bank Nursing is being developed 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
ED recruitment campaign in place and trajectory set to reduce use of bank based on recruitment pipeline (-8 WTE by Sept 25). Further interviews planned for July/August 2025 at Band 3 and Band 5 will provide updated and improved trajectory and reduced bank usage.	ED Senior Matron	October 25

Month

Jun-25

Agency Spend as % of Total Pay Bill

Key Standard



Understanding Performance
• Agency spend as a proportion of the pay bill has slightly increased to 0.74%, but remains well within the control parameters and below the 2.5% target. • Agency spend totalled £232k in month, with over £210k spent on Consultants. • Oncology Medical Staffing and Cellular Pathology are the top contributors for Consultant Agency spend. Combined they account for over 80% of the consultant total. • NHSE recently commended the Trust on the work on agency reduction as we are one of the lowest users nationally. • South West price cap compliant rate card in place for Nursing and Allied Health Professionals.

Countermeasures	Owner	Due Date
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
Risk: Locum Oncology Medical Consultants are the top contributor for agency spend. **Mitigation:** Actively recruiting to 4 Oncology Consultants. 3 Offers made and 1 post remains out to advert supporting our exit strategy.

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	

M12 2024/25	23/24 Comparison, unadjusted			Movement from M11, unadjusted		
	Inflation adj. expenditure growth	Cost weighted activity growth	Implied productivity growth	Inflation adj. expenditure growth	Cost weighted activity growth	Implied productivity growth
RUH	3.4%	7.5%	**4.0%**	0.9%	0.2%	**-0.8%**
BSW	4.0%	8.2%	**4.0%**	1.1%	0.0%	**-1.1%**

Data are only updated to M12 (March) 2024/25. RUH data still includes Sulis costs but not activity.

Understanding Performance

Data for March 25 show an implied productivity growth of 4.0% compared to M12 23/24, this ranks as the ninth largest productivity increase in the South-West Region (of 13 providers). This is driven by cost weighted activity growth of 7.5% with an inflation adjusted expenditure growth of 3.4%. Compared to M11 24/25 implied productivity reduced by 0.8%. Cost weighted activity increased by 0.2% and expenditure increased by 0.9%.

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 August
Develop metric to be calculated at Division level	Head of Financial Projects	31 August
Establish single KPI for each Specialty to focus on during 25/26	Divisional/ Specialty Tris	31 August

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

Underlying Financial Position (BAF Reference)

Royal United Hospitals Bath NHS Foundation Trust

I&E to July 2025	Annual Budget RUH Budget £'m	Year to Date RUH Budget £'m	Actual £'m	Variance £'m
Income	561.074	184.766	182.451	(2.315)
Pay	(348.980)	(116.355)	(122.163)	(5.807)
Non Pay	(167.600)	(53.399)	(59.624)	(6.225)
Finance Charges	(46.500)	(24.581)	(24.252)	0.329
EBITDA	**(2.005)**	**(9.569)**	**(23.587)**	**(14.018)**
Donated/Grant Income	(1.955)	(9.732)	(13.273)	(3.541)
Adjusted Financial Performance	**(0.050)**	**0.163**	**(10.314)**	**(10.477)**
Transitional Funding	(19.200)			
Technical Adjustments	(4.800)			
Underlying Financial Performance	**(24.050)**			
Underlying Surplus	(6.000)			
Vacancy Factor	(9.283)			
Underlying Changes Required	**(39.333)**			

The underlying run rate shows the scale of the challenge for the organisation beyond the current year; and in addition to delivering the £29.7m recurrent savings challenge in 2025/26 and clearing the £6.0m additional deficit arising from the Exit Run rate bought forward into 25/26

- The 2025/26 Financial Plan includes elements of non-recurrent funding, such as the £19.2m transitional funding and the £4.8m technical adjustments
- To deliver a sustainable level of cash, allowing for capital investments, the medium term plan is should aim for a £6.0m surplus level
- A 1% vacancy factor is a reasonable level to aim for on a recurrent basis to allow for reasonable turnover and recruitment delays. Changing this from the current ~4% would equate to £9.3m further savings requirement

Currently the plan would therefore require additional £24.0m improvement to reach a breakeven point, and a further £15.3m improvement to achieve a sustainable position in 2026/27. This may be through making transitional funding recurrent or through increased efficiencies.

This position is stated before the impact of 26/27 & Medium Term funding settlement that would be expected to delivery a further 2% efficiency each year

Income & Expenditure Year to Date (NHSE Performance)

Royal United Hospitals Bath NHS Foundation Trust

I&E to July 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	160.832	160.717	(0.114)	12.720	12.496	(0.224)	0.000	0.000	0.000	173.551	173.213	(0.338)
Clinical Education Income	6.219	6.065	(0.154)	0.000	0.000	0.000	0.000	0.000	0.000	6.219	6.065	(0.154)
Other Income	17.715	15.669	(2.046)	4.789	5.013	0.224	(1.331)	(1.013)	0.318	21.173	19.669	(1.504)
Pay	(116.355)	(122.163)	(5.807)	(8.102)	(8.411)	(0.309)	0.000	0.000	0.000	(124.457)	(130.574)	(6.116)
Non Pay	(53.399)	(59.624)	(6.225)	(8.018)	(7.496)	0.522	0.198	0.198	0.000	(61.218)	(66.921)	(5.703)
EBITDA	**15.012**	**0.665**	**(14.347)**	**1.389**	**1.602**	**0.213**	**(1.133)**	**(0.815)**	**0.318**	**15.268**	**1.452**	**(13.816)**
Depreciation & Amortisation	(7.836)	(7.743)	0.093	(1.091)	(1.077)	0.014	0.727	0.591	(0.136)	(8.200)	(8.229)	(0.029)
Impairments	(13.621)	(13.489)	0.132	0.000	0.000	0.000	0.000	0.000	0.000	(13.621)	(13.489)	0.132
Net Finance Charges	(3.124)	(3.019)	0.105	(0.183)	(0.183)	0.000	0.128	0.112	(0.016)	(3.179)	(3.091)	0.089
Surplus/(Deficit)	**(9.569)**	**(23.587)**	**(14.018)**	**0.115**	**0.342**	**0.227**	**(0.278)**	**(0.112)**	**0.166**	**(9.732)**	**(23.357)**	**(13.624)**
Donated/Grant Income	(9.732)	(13.273)	(3.541)	0.000	0.000	0.000	0.000	0.000	0.000	(9.732)	(13.273)	(3.541)
Adjusted Financial Performance	**0.163**	**(10.314)**	**(10.477)**	**0.115**	**0.342**	**0.227**	**(0.278)**	**(0.112)**	**0.166**	**(0.000)**	**(10.084)**	**(10.084)**

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 stopped, and funding reallocated to offset existing cost pressures.

Understanding Performance

The RUH is adverse to plan by £10.3m. This is resulting from delays to delivery against the savings programme (£8.4m), deterioration in the exit run rate (£2m), and operational pressures arising from increased spend on high cost drugs and devices (£0.7m),Strike Costs (£0.25m) and pressures from pay awards (£0.2m) . This is partly offset by increased cost controls (£0.7m) and utilities underspends of (£0.25m).

Sulis is favourable to plan by £0.2m. This includes an accrual of £0.4m income for reimbursement for the overspend on Mobile Endoscopy Van. CDC continues to make a loss, but is now offset by favourable variance in Sulis core business

Countermeasures	Owner	Due Date
On-going: Acceleration of our saving plans that have been scoped for UEC, theatres, outpatients and corporate restructuring; converting plans into deliverables, opportunities into plans; 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	31 July
On-going: Maximising profit margin at Sulis CDC and Sulis Orthopaedic Centre, including the transfer of activity that flows to Sulis to maximise the use of capacity	System Delivery Director for Planned Care and Sulis Director	31 July
On-going: 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	31 July

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 £25.1m, which will not be acceptable to ICS and NHSE and will require further corrective action.
The Trust is also carrying contingent liabilities relating legal disputes and strikes 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	(20.884)	1.845	(19.039)
Budget Management	(0.500)	0.500	0.000
Technical or Funding	(9.217)	8.804	(0.413)
Sulis	(0.430)	0.930	0.500
(Risk)/Mitigation before ICS support	**(37.031)**	**12.079**	**(24.952)**
ICS Deficit Support	0.000	10.000	10.000
(Risk)/Mitigation after ICS support	**(37.031)**	**22.079**	**(14.952)**
% of Comparable Operating Expenditure	*-6.2%*	*3.7%*	*-2.5%*

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.

Continue to develop a Financial Recovery Plan consider actions to go further, faster on savings delivery

Description	Final Plan	Month 1	Month 2	Month 3	FRP 31 July 25	Month 4	Change from Final Plan	Change from latest Month	Change from FRP
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Risks									
Exit Run Rate & Plan Risks	(2.500)	(6.000)	(6.000)	(6.000)	(6.000)	(6.000)	(3.500)	0.000	0.000
Group Savings - unidentified	(4.400)	(4.400)	(4.400)	(4.400)	(4.400)	(4.400)	0.000	0.000	0.000
Trust Savings - unidentified	(5.500)	(5.500)	(4.715)	(3.100)	(3.200)	(6.948)	(1.448)	(3.848)	(3.748)
Trust Savings - Delivery Maturity Status	(16.000)	(16.000)	(11.127)	(11.084)	(10.400)	(7.691)	8.309	3.393	2.709
Costs of Change	(1.500)	(1.500)	(1.500)	(1.845)	(1.845)	(1.845)	(0.345)	0.000	0.000
Demand growth - Urgent Care demand	0.000	(1.200)	(1.200)	0.000	0.000	0.000	0.000	0.000	0.000
Benefits of Constitutional Standards Business Cases not delivered	0.000	0.000	0.000	(0.500)	(0.500)	(0.500)	(0.500)	0.000	0.000
Operational pressures incl Vacancy Factor & Winter	0.000	0.000	(1.600)	(1.000)	0.000	0.000	0.000	1.000	0.000
Revenue impact of reduced cash balances	0.000	0.000	(1.000)	(0.500)	(0.500)	(0.500)	(0.500)	0.000	0.000
Demand growth - ICB commissioned High Cost Drugs & Devices	(2.000)	(3.000)	(0.930)	(1.896)	(1.896)	(2.088)	(0.088)	(0.192)	(0.192)
Demand growth - Weight Management NICE guidelines	(3.000)	(1.000)	(1.000)	0.000	0.000	0.000	3.000	0.000	0.000
Demand growth - RTT Delivery / referral growth unfunded	(5.600)	(5.600)	(2.500)	(2.500)	(2.500)	(2.400)	3.200	0.100	0.100
Somerset ICB Advice & Guidance payment 25/26 and prior years	0.000	0.000	0.000	(0.600)	(0.600)	0.000	0.000	0.600	0.600
Armed Forces commissioning contract value	0.000	(0.700)	(0.700)	(0.700)	(0.700)	0.000	0.000	0.700	0.700
Ambulance Handover Fines	(2.000)	0.000	0.000	0.000	0.000	0.000	2.000	0.000	0.000
Pay Inflation higher than budgeted	(0.625)	(0.625)	(3.300)	(0.500)	(0.500)	(0.500)	0.125	0.000	0.000
Resident Doctors July only	0.000	0.000	0.000	0.000	0.000	(0.254)	(0.254)	(0.254)	(0.254)
SEOC Elective Income cap	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
NHSE 24/25 ERF	0.000	0.000	0.000	0.000	0.000	(0.825)	(0.825)	(0.825)	(0.825)
Technical adjustments shortfall	0.000	0.000	0.000	0.000	0.000	(0.150)	(0.150)	(0.150)	(0.150)
Accounting judgement for Annual Leave accrual	0.000	0.000	(2.500)	(2.500)	(2.500)	(2.500)	(2.500)	0.000	0.000
Sulis Income plan incl CDC	0.000	(1.500)	(0.350)	(0.350)	(0.350)	0.000	0.000	0.350	0.350
CDC Endoscopy Van productvity	0.000	0.000	(0.400)	(0.430)	(0.430)	(0.430)	(0.430)	0.000	0.000
Gross Risk	(43.125)	(47.025)	(43.222)	(37.905)	(36.321)	(37.031)	6.094	0.874	(0.710)
% of Comparable Operating Expenditure	*-7.2%*	*-7.9%*	*-7.2%*	*-6.4%*	*-6.1%*	*-6.2%*			
Mitigations									
Commissioner funding or Activity Mangement Plans									
High Cost Drugs & Devices	2.000	3.000	0.930	1.896	1.896	2.088	0.088	0.192	0.192
Weight Management	3.000	1.000	1.000	0.000	0.000	0.000	(3.000)	0.000	0.000
RTT Activity Management Plans incl deferral of £2.4m investment	5.600	5.100	2.500	2.500	2.500	2.400	(3.200)	(0.100)	(0.100)
UEC demand management	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Somerset contract negotiation	0.000	0.000	0.000	0.600	0.600	0.000	0.000	(0.600)	(0.600)
Armed Forces contract negotiation	0.000	0.700	0.700	0.700	0.700	0.000	0.000	(0.700)	(0.700)
Pay inflation	0.625	0.625	3.300	0.000	0.000	0.000	(0.625)	0.000	0.000
Ambulance Handover funding	2.000	0.000	0.000	0.000	0.000	0.000	(2.000)	0.000	0.000
SEOC funding	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
NHE 24/25 ERF overperformance	0.000	0.000	0.000	0.000	0.000	0.825	0.825	0.825	0.825
CDC Endoscopy Van funding	0.000	0.000	0.400	0.430	0.430	0.430	0.430	0.000	0.000
Internal Recovery									
Sulis Core business further profit margin	0.000	1.500	0.350	0.350	0.350	0.500	0.500	0.150	0.150
Cost of Change national funding or deferral	1.500	1.500	1.500	1.845	1.845	1.845	0.345	0.000	0.000
Savings maturity	20.000	8.000	0.000	0.000	0.000	0.000	(20.000)	0.000	0.000
Discretionary spend freeze	0.000	0.000	1.000	0.000	0.000	0.000	0.000	0.000	0.000
Operational budget management	0.000	0.000	2.800	1.000	2.800	0.000	0.000	(1.000)	(2.800)
Delivery of Constitutional standards business case benefits	0.000	0.000	2.800	0.500	0.500	0.500	0.500	0.000	0.000
Ongoing balance sheet reviews	0.000	0.000	0.000	0.000	0.000	0.491	0.491	0.491	0.491
Cash management	0.000	0.000	1.000	0.500	0.500	0.500	0.500	0.000	0.000
Annual leave management	0.000	0.000	2.500	2.500	2.500	2.500	2.500	0.000	0.000
Gross Mitigation	34.725	21.425	20.780	12.821	14.621	12.079	(22.646)	(0.742)	(2.542)
% of Comparable Operating Expenditure	*5.8%*	*3.6%*	*3.5%*	*2.1%*	*2.5%*	*2.0%*			
Net unmitigated Risk before ICS Deficit Support	(8.400)	(25.600)	(22.442)	(25.084)	(21.700)	(24.952)	(16.552)	0.132	(3.252)
% of Comparable Operating Expenditure	*-1.4%*	*-4.3%*	*-3.8%*	*-4.2%*	*-3.6%*	*-4.2%*			
Additional transitional support - BSW Hospitals Group	0.000	0.000	0.000	2.800	0.000	0.000	0.000	(2.800)	0.000
Additional transitional support - BSW ICB	0.000	0.000	0.000	6.300	10.000	10.000	10.000	3.700	0.000
Additional transitional support - NHSE SW	0.000	0.000	0.000	10.000	0.000	0.000	0.000	(10.000)	0.000
	0.000	0.000	0.000	19.100	10.000	10.000	10.000	(9.100)	0.000
Net unmitigated Risk after ICS Deficit Support	(8.400)	(25.600)	(22.442)	(5.984)	(11.700)	(14.952)	(6.552)	(8.968)	(3.252)
% of Comparable Operating Expenditure	*-1.4%*	*-4.3%*	*-3.8%*	*-1.0%*	*-2.0%*	*-2.5%*			

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	Variance %	Budget £'m	Actual £'m	Variance £'m	Variance £'m
Commissioning Income	470.329	39.548	39.007	(0.541)		155.334	155.220	(0.114)	
Clinical Education Income	18.596	1.555	1.454	(0.101)		6.219	6.065	(0.154)	
Deficit Support Funding	19.198	1.134	1.134	0.000		5.498	5.498	0.000	
Surgery	(131.486)	(10.843)	(10.900)	(0.057)	-0.5%	(43.493)	(44.420)	(0.927)	-2.1%
Medicine	(157.552)	(13.046)	(13.389)	(0.343)	-2.6%	(51.617)	(53.909)	(2.292)	-4.4%
FASS	(99.346)	(8.218)	(8.495)	(0.277)	-3.4%	(32.026)	(33.116)	(1.089)	-3.4%
E&F	(32.535)	(2.557)	(2.461)	0.096	3.8%	(10.702)	(10.941)	(0.240)	-2.2%
Corporate	(63.852)	(5.511)	(5.497)	0.014	0.3%	(21.293)	(22.012)	(0.720)	-3.4%
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	4.400	0.242	0.000	(0.242)		1.467	0.000	(1.467)	
Reserves	(0.511)	0.108	(1.136)	(1.244)		(0.127)	(3.397)	(3.270)	
Finance Charges	(27.291)	(2.383)	(2.185)	0.198		(9.097)	(9.302)	(0.205)	
Adjusted Financial Performance - RUH	**(0.050)**	**0.028**	**(2.468)**	**(2.496)**		**0.163**	**(10.314)**	**(10.477)**	
Sulis	0.500	0.020	1.204	1.184		0.115	0.342	0.227	
Inter Group	(0.450)	(0.048)	(0.029)	0.019		(0.278)	(0.112)	0.166	
Adjusted Financial Performance - Group	**0.000**	**(0.000)**	**(1.292)**	**(1.292)**		**(0.000)**	**(10.084)**	**(10.084)**	
Impairment	*(13.621)*	*0.000*	*(13.489)*	*(13.489)*		*(13.621)*	*(13.489)*	*0.132*	
Donated/Grant Income	*11.666*	*0.972*	*0.487*	*(0.485)*		*3.889*	*0.216*	*(3.672)*	
Unadjusted Financial Performance	***(1.955)***	***0.972***	***(14.294)***	***(15.266)***		***(9.732)***	***(23.357)***	***(13.624)***	

Understanding Performance

This table shows the spend against current budgets. Note that annual savings target **have** now been devolved to Divisional budgets. The YTD negative variances highlight the lack of delivery of savings.

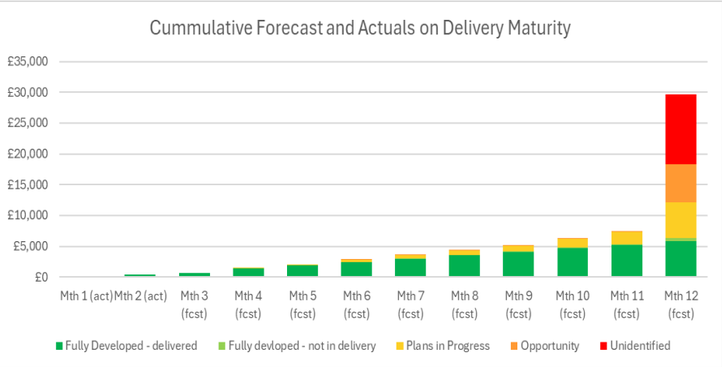
Whilst Clinical Areas, Estates and Facilities and Corporate all have a YTD adverse position there are differences in their relative position. The Surgery position includes underspends against SOC, where spend will increase as the usage of the facility increases. There has also been progress against savings plans for Surgery.

Estates and Facilities has again improved in month, with increased revenue through planned savings programmes such as car parking and catering, as well as further reduced spend against maintenance.

Countermeasures	Owner	Due Date
Completed: Corrective action required to reverse or mitigate operational cost pressures	Corporate Teams	31 July

Savings Delivery Against Plan

Royal United Hospitals Bath NHS Foundation Trust



	In Month						Programme Status					
Delivery Group	Month 4 Actuals	Month 4 Plan	Month Variance to Plan	YTD Actuals	YTD Plan	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	1,333	(1,333)	0	0	617	0	3,383	4,000
Outpatients Delivery Group	7	250	(243)	30	1,000	(970)	141	0	644	2,215	0	3,000
Elective Delivery Group	0	158	(158)	70	633	(563)	420	0	0	1,480	0	1,900
Corporate Services	179	208	(30)	306	833	(528)	1,050	546	34	870	0	2,500
Central Delivery Group	564	629	(64)	873	2,515	(1,642)	3,243	0	4,559	454	0	8,256
Estates & Facilities	8	132	(124)	105	527	(422)	427	0	3	1,150	0	1,580
SULIS	106	42	64	167	167	0	500	0	0	0	0	500
Group	0	367	(367)	0	1,467	(1,467)	0	0	0	0	4,400	4,400
Unidentified		356	(356)	0	1,424	(1,424)	0	0	0	0	3,565	3,565
	864	**2,475**	**(1,611)**	**1,550**	**9,900**	**(8,350)**	**5,782**	**546**	**5,856**	**6,169**	**11,348**	**29,700**
Income	314	131	182	555	525	30	2,376	0	300	76	0	2,752
Non Pay	269	997	(728)	455	3,988	(3,532)	1,981	375	1,196	3,335	4,463	11,350
Pay	282	1,347	(1,065)	539	5,387	(4,848)	1,425	171	4,359	2,758	6,885	15,598
Total	**864**	**2,475**	**(1,611)**	**1,550**	**9,900**	**(8,350)**	**5,782**	**546**	**5,856**	**6,169**	**11,348**	**29,700**

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.

Understanding Performance

£1.6m savings have been delivered year to date. The increase is P2P contracts, temp staffing, procurement savings and an improved Sulis position. The Trust now has a £8.4m shortfall against plan year to date, a major contributor to the Trust overall adverse variance to plan.

Of the programme target of £29.7m there is an unidentified gap of £11.3m,(UEC moving from opportunity to unidentified) and £6.1m assessed as an opportunity has still not translated into firm delivery plans.

Countermeasures	Owner	Due Date
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. Meetings set over the next month to expedite plans.	Delivery Group SROs, Finance team and Recovery Director	On Going
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	On Going
Enhancing controls on discretionary spending to mitigate savings shortfall & No PO no Pay controls	Trust Management Executive and Budget Holders	Monitoring Impact
With Savings now devolved out to Divisional Budget further engagement at Divisional and Specialities level to identify opportunities for savings initiatives.	Delivery Group SRO and DOOs.	31st August

Risks and Mitigation

Significant value of the programme still unidentified or opportunity only with no clear plans.

Savings have been devolved out to divisional budgets to facilitate clarity on delivery against budgets (including savings) and support divisional engagement.

Meetings with recovery Director & Finance Teams & SRO's to expedite plans over the next month.

Key Cost Drivers

Royal United Hospitals Bath NHS Foundation Trust

Business Plan Delivery July 2025

Activity Plan

	YTD Plan	YTD Actual	Variance	Change per Day Plan	Change per Day Actual
OP News	67,817	67,156	-661	+6	-8
OP Follow Ups	103,577	104,315	738	-11	+9
Daycases	13,293	12,565	-728	+4	-9
EL Inpatients	1,538	1,266	-272	+2	-3
ED Attendances	35,006	35,022	16	+9	+0
NEL Admissions	20,952	21,568	616	+7	+7
Diagnostic tests	57,102	52,072	-5,030	+46	-60

Planning Assumptions

	Plan	YTD Actual
GP Referral Growth	0.0%	-1.4%
ED Atts Growth	2.6%	2.7%
NEL Admit Growth excludes maternity	3.4%	8.3%
NCTR	72	77
NEL Length of Stay for 1+ days	6.4	5.6

Performance

		Year End Target	Current Month Plan	Actual
RTT	<18 1st app	71.7%	66.8%	59.0%
	<18 weeks	67.7%	62.8%	57.6%
	>52 weeks	1.0%	1.3%	2.4%
Cancer	62 days*	75.0%	70.4%	67.7%
	28 days*	80.0%	77.2%	70.0%
ED	4hr type 1	72.0%	73.7%	62.8%
	12 hours	reduction	3.7%	6.5%
DM01	< 6 weeks	5.0%	14.2%	32.2%

* 1 month reporting lag

Finance

	YTD Plan	YTD Actual	Variance
Cash Releasing Savings	£9.9m	£1.6m	-£8.3m
Financial Position	£0m	-£10.1m	-£10.1m
Productivity	+6.7%	+4.0%	-2.7%

Lag - March 25 productivity

Workforce

	YTD Planned	YTD Actual	Variance
Pay Savings (£m)	£5.4m	£0.5m	-£4.9m
WTE Reduction	5692.3	5731.9	39.6
Sickness (1 mth lag)	4.42%	4.70%	1 month lag

Commissioning Income & Activity (by POD)

Royal United Hospitals Bath NHS Foundation Trust

POD Grp Code	24-25 Actual Activity	24-25 Actual Price	25-26 Plan Activity	25-26 Plan Price	25-26 Plan Activity YTD	25-26 Actual Activity YTD	25-26 Variance Activity YTD	25-26 Plan Price YTD	25-26 Actual Price YTD	25-26 Variance Price YTD
AE	100,553	25,226,500	103,480	25,846,807	35,006	35,022	16	8,743,685	8,672,102	-71,583
DC	38,591	41,536,702	40,091	44,023,216	13,293	12,565	-728	14,721,654	14,638,455	-83,199
EL	3,681	20,417,028	4,889	27,342,343	1,538	1,266	-272	8,636,776	6,854,947	-1,781,829
HCD	189,019	54,025,019	0	59,871,909	0	68,537	68,537	18,230,815	19,927,237	1,696,422
NE	59,967		62,038		20,952	21,568	616			
OP	780,450	116,004,322	758,359	113,843,275	254,287	265,857	11,570	38,088,982	37,902,334	-186,648
OT	3,374,979	18,045,872	2,978,127	17,723,909	988,791	1,107,782	118,991	5,868,443	5,972,932	104,489

Excluding Critical Care, Excess Bed Days

Understanding Performance

Planned day case and elective inpatient activity and income includes the increases anticipated for Sulis Orthopaedic Centre (SOC) and the additional RTT improvement investments.

As at the end of July, SOC is under plan by £0.7m, this is due to delays in getting access to the second theatre and undertaking 137 fewer surgeries YTD as a result impacting on performance in DC and EL.

RTT investments continue to be limited to date, with some small WLI increases where posts are being recruited, the planned activity to date is £0.8 million.

The high-cost drugs and devices performance is £1.7m over plan, of which £1.2m is eligible for pass-through funding and £0.5m represents a cost pressure due to the fixed contract envelope.

Countermeasures	Owner	Due Date
Resolve casemix issue affecting NEL price plan in 25/26	Income Team	31 August
Finalise contract resolution with Somerset ICB and Armed Forces commissioners, we anticipate this will lead to reimbursement in line with our expectations	Income Team	31 August
Undertake rebasing exercise to compare funding under National Tariff compared to current Block payments	Income team	30 September
Continue progress on implementing the investments to deliver the activity required to improve RTT performance	Divisional Tris	31 October
Work with Pharmacy and Commissioners to mitigate HCDD growth risk, either through additional funding or change in practice	Income Team	31 October

Risks and Mitigation

- Stranded fixed costs where variable income is not reimbursed due to Activity Management Plan process
- Adverse settlement in contract dispute with Somerset ICB regarding Advice & Guidance reimbursement.

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	(5.395)	(5.803)	(0.408)	(21.524)	(21.735)	(0.211)
Junior Medical	(3.447)	(4.087)	(0.640)	(13.820)	(15.016)	(1.195)
Registered Nursing and Midwifery	(9.380)	(9.032)	0.348	(37.281)	(35.647)	1.634
Registered ST&T	(3.365)	(3.517)	(0.152)	(13.667)	(13.675)	(0.008)
Other Clinical Support	(4.891)	(5.068)	(0.177)	(19.451)	(19.846)	(0.395)
NHS Infrastructure Support	(3.679)	(3.887)	(0.208)	(14.720)	(15.641)	(0.921)
Other	(0.129)	(0.142)	(0.013)	(0.518)	(0.603)	(0.085)
Unallocated Savings	1.021	0.000	(1.021)	4.626	0.000	(4.626)
Surplus/(Deficit)	**(29.265)**	**(31.536)**	**(2.271)**	**(116.355)**	**(122.163)**	**(5.807)**
Pay Vacancy Factor Included Above	1.008	0.000	(1.008)	4.102	0.000	(4.102)

Pay by Spend Type	In Month RUH			Year to Date RUH		
	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Actual £'m	Variance £'m
Substantive	(29.911)	(29.567)	0.344	(119.238)	(114.394)	4.844
Pay Vacancy Factor	1.008	0.000	(1.008)	4.102	0.000	(4.102)
Net Budget	**(28.903)**	**(29.567)**	**(0.664)**	**(115.136)**	**(114.394)**	**0.742**
Bank	(0.127)	(1.510)	(1.383)	(0.266)	(5.976)	(5.710)
Agency	(0.025)	(0.232)	(0.207)	(0.100)	(0.763)	(0.663)
WLI	(0.096)	(0.107)	(0.011)	(0.394)	(0.556)	(0.162)
Other	(0.115)	(0.120)	(0.005)	(0.459)	(0.474)	(0.015)
Surplus/(Deficit)	**(29.265)**	**(31.536)**	**(2.271)**	**(116.355)**	**(122.163)**	**(5.807)**

Understanding Performance

Pay budgets are overspent by £5.8m. The Pay vacancy factor (£4.1m) has been delivered but further Pay savings (£4.6m) have not yet been achieved. The Pay awards have generated a net £0.2m pressure, with £1.2m of pay costs being offset by £1m of income. Pay budgets have not yet been adjusted and this variance arises in Pay Reserves. Pay costs also included the estimated impact of industrial action of £0.3m.

Registered Nursing and Midwifery has a significant underspend in outpatient and theatre areas and further control has brought ward spend to within budget.

Junior Medical staff costs are partly driven from covering absences on rotas as well as non-recurrent funding for less than full time (LTFT) doctors. Income has been received for LTFT staffing and allocated to divisions.

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%

Countermeasures	Owner	Due Date
Completed: Corrective action required to reverse or mitigate operational cost pressures	Budget Holders	31st July
Enact budget changes to reflect pay award funding in Month 5 onwards	Finance	31st August

Risks and Mitigation

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	(7.657)	(7.886)	(0.228)	(30.595)	(31.535)	(0.939)
Medicine	(10.054)	(10.748)	(0.694)	(40.210)	(42.421)	(2.210)
FASS	(5.376)	(5.576)	(0.200)	(21.520)	(22.035)	(0.515)
E&F	(1.664)	(1.760)	(0.096)	(6.651)	(7.001)	(0.350)
Corporate	(3.334)	(3.217)	0.117	(12.209)	(12.980)	(0.770)
HIWE	(0.291)	(0.280)	0.011	(1.162)	(1.173)	(0.010)
R&D	(0.284)	(0.303)	(0.018)	(1.137)	(1.158)	(0.021)
Reserves	(0.461)	(1.768)	(1.306)	(2.795)	(3.862)	(1.066)
Unallocated Savings	(0.144)	0.000	0.144	(0.076)	0.000	0.076
Surplus/(Deficit)	**(29.265)**	**(31.536)**	**(2.271)**	**(116.355)**	**(122.163)**	**(5.807)**
Pay Vacancy Factor Included Above	1.008	0.000	(1.008)	4.102	0.000	(4.102)

NB. Pay budgets have not been adjusted for impact of updated pay ward costs. The adverse variance arising of c£1.2m is reported against 'Reserves'. A budget adjustment will be transacted in Month 5

Variance by Functional Area	In Month						
	Medical Staff	Ward	ED	Maternity	Other	Savings	Total
Substantive	(0.499)	0.658	0.205	0.120	(0.117)	(1.042)	(0.676)
Bank	(0.346)	(0.497)	(0.213)	(0.092)	(0.235)	0.000	(1.383)
Agency	(0.211)	(0.001)	0.000	0.000	0.005	0.000	(0.207)
Other	0.000	0.000	0.000	0.000	(0.005)	0.000	(0.005)
Surplus/(Deficit)	**(1.056)**	**0.160**	**(0.008)**	**0.028**	**(0.352)**	**(1.042)**	**(2.271)**

Variance by Functional Area	Year to Date						
	Medical Staff	Ward	ED	Maternity	Other	Savings	Total
Substantive	0.226	2.379	0.894	0.357	1.433	(4.710)	0.580
Bank	(1.042)	(1.984)	(0.858)	(0.351)	(1.475)	0.000	(5.710)
Agency	(0.660)	(0.023)	0.000	0.000	0.020	0.000	(0.663)
Other	0.000	0.000	0.000	0.000	(0.015)	0.000	(0.015)
Surplus/(Deficit)	**(1.475)**	**0.372**	**0.037**	**0.006**	**(0.037)**	**(4.710)**	**(5.807)**

NB. Ward budgets include Enhanced Care and Discharge Lounge costs
Medical Staff, Ward & ED do not include vacancy factor which is offset in 'Other' pay variance

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	(327.4)	(329.3)	(1.9)
Junior Medical	(446.9)	(481.7)	(34.8)
Registered Nursing and Midwifery	(1,825.1)	(1,797.4)	27.7
Registered ST&T	(649.1)	(649.9)	(0.8)
Other Clinical Support	(1,628.6)	(1,630.8)	(2.2)
NHS Infrastructure Support	(886.5)	(892.3)	(5.8)
Other	(1.4)	(3.2)	(1.8)
Unallocated Savings	183.3	0.0	(183.3)
Surplus/(Deficit)	**(5,581.6)**	**(5,784.5)**	**(202.9)**
Pay Vacancy Factor Included Above	216.5	0.0	(216.5)

WTE by Spend Type	In Month RUH		
	Budget WTE	Actual WTE	Variance WTE
Substantive	(5,782.4)	(5,431.9)	350.5
Pay Vacancy Factor	216.5	0.0	(216.5)
Net Budget	**(5,565.8)**	**(5,431.9)**	**133.9**
Bank	(17.7)	(344.0)	(326.3)
Agency	0.0	(8.6)	(8.6)
WLI	1.9	0.0	(1.9)
Other	0.0	0.0	0.0
Surplus/(Deficit)	**(5,581.6)**	**(5,784.5)**	**(202.9)**

WTE by Division	In Month RUH		
	Budget WTE	Actual WTE	Variance WTE
Surgery	(1,396.4)	(1,465.0)	(68.6)
Medicine	(1,962.6)	(2,058.2)	(95.6)
FASS	(1,035.8)	(1,034.8)	1.0
E&F	(521.1)	(546.7)	(25.6)
Corporate	(566.0)	(571.6)	(5.6)
HIWE	(47.8)	(41.9)	5.9
R&D	(62.3)	(59.9)	2.5
Reserves	17.4	(6.5)	(24.0)
Unallocated Savings	(7.1)	0.0	7.1
Surplus/(Deficit)	**(5,581.7)**	**(5,784.5)**	**(202.8)**
Pay Vacancy Factor Included Above	216.5	0.0	(216.5)

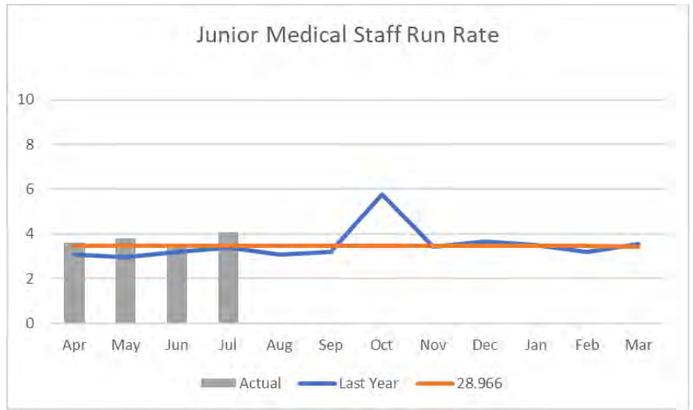
WTE Variance by Functional Area	In Month						
	Medical Staff	Ward	ED	Maternity	Other	Savings	Total
Substantive	-9.52	129.06	40.56	14.02	148.27	-190.37	132.02
Bank	-21.32	-128.51	-48.18	-19.97	-108.30	0.00	(326.28)
Agency	-7.60	0.00	0.00	0.00	-1.00	0.00	(8.60)
Other	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Surplus/(Deficit)	**-38.44**	**0.55**	**-7.62**	**-5.95**	**38.97**	**-190.37**	**(202.86)**

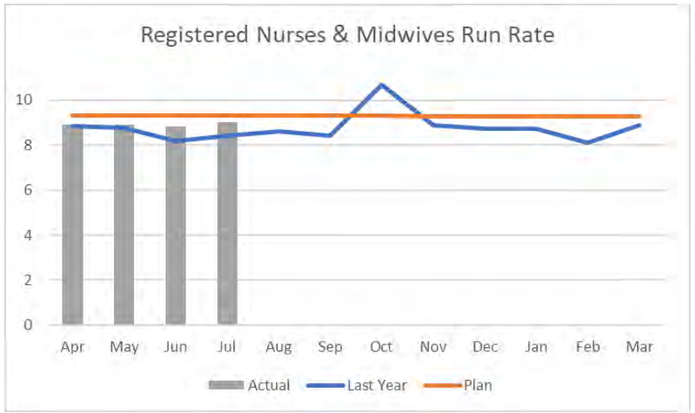
NB. We have applied a WTE target to Pay Savings from Month 3 to more closely align pay variances and WTE variances

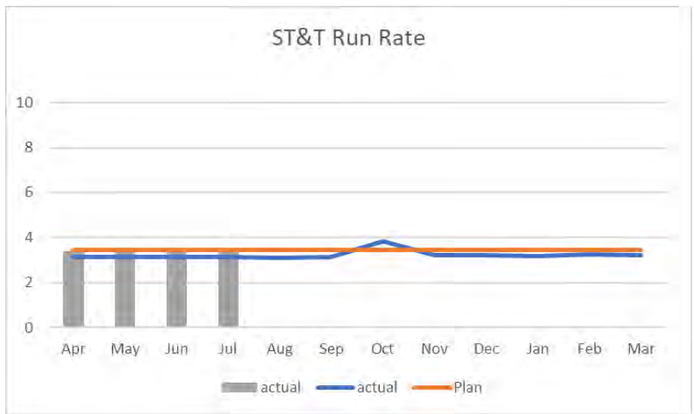
Actual WTE reporting will be marginally different between Workforce reporting and Finance reporting due to technical differences in the datasets for PWR and PFR in respect of Bank Hours worked per week, and small variations in classification of substantive staff. Finance and Workforce teams undertake regular reconciliation and validation to improve alignment

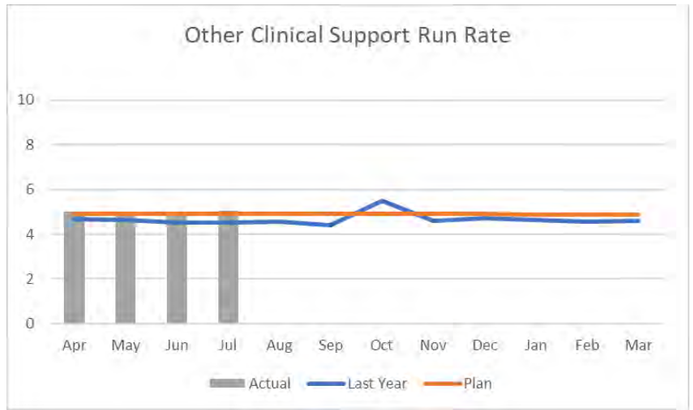
Pay Run Rate Graphs

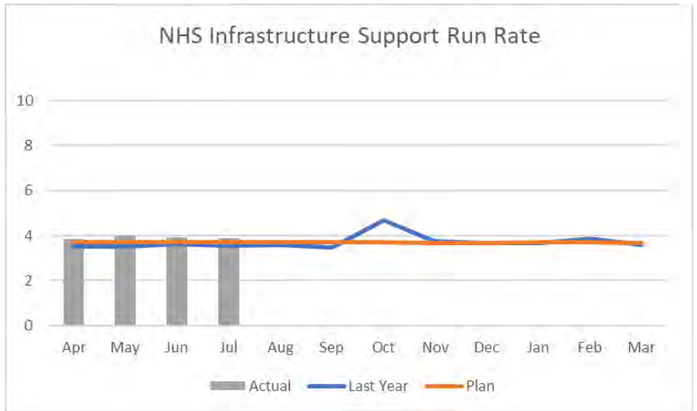
Royal United Hospitals Bath
NHS Foundation Trust











Budget – Non-Pay

Royal United Hospitals Bath
NHS Foundation Trust

Non-Pay by Type	In Month RUH			Year to Date RUH		
	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Actual £'m	Variance £'m
High Cost Drugs and Devices	(4.703)	(4.721)	(0.018)	(17.264)	(18.838)	(1.574)
In Tariff Drugs	(0.764)	(0.759)	0.005	(2.804)	(3.072)	(0.267)
Clinical Supplies and Services	(4.260)	(3.493)	0.767	(16.768)	(15.998)	0.770
Other Non Pay	(5.338)	(5.529)	(0.190)	(22.672)	(21.715)	0.956
Unallocated Savings	1.550	0.000	(1.550)	6.109	0.000	(6.109)
Surplus/(Deficit)	**(13.516)**	**(14.501)**	**(0.985)**	**(53.399)**	**(59.624)**	**(6.225)**

Budget by Division	In Month RUH			Year to Date RUH		
	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Actual £'m	Variance £'m
Surgery	(3.068)	(3.093)	(0.026)	(12.514)	(12.770)	(0.255)
Medicine	(1.800)	(1.747)	0.052	(7.332)	(7.643)	(0.311)
FASS	(0.647)	(0.740)	(0.093)	(2.586)	(2.849)	(0.263)
E&F	(1.389)	(1.281)	0.108	(6.142)	(6.006)	0.136
Corporate	(2.660)	(3.308)	(0.649)	(10.571)	(11.296)	(0.726)
HIWE	(0.103)	(0.060)	0.043	(0.411)	(0.269)	0.142
R&D	(0.054)	(0.043)	0.011	(0.216)	(0.085)	0.131
Capital Charges	0.010	0.011	0.000	0.041	(0.043)	(0.084)
High Cost Drugs and Devices	(4.703)	(4.721)	(0.018)	(17.264)	(18.838)	(1.574)
Unallocated Savings	0.439	0.000	(0.439)	1.756	0.000	(1.756)
Reserves	0.457	0.482	0.025	1.841	0.176	(1.665)
Surplus/(Deficit)	**(13.516)**	**(14.501)**	**(0.985)**	**(53.399)**	**(59.624)**	**(6.225)**

Understanding Performance

Non-pay spend is £6.2m overspent against budget. £4.1m of this relates to undelivered savings and £2.0m as the exit run rate, shown together as unallocated savings in the Non-Pay by Type table.

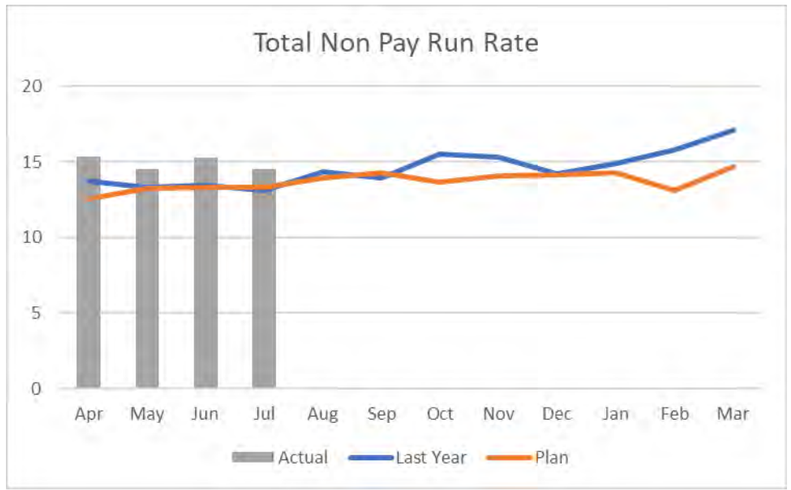
High-cost drugs and devices are overspent by £1.6m, £0.9m of which is funded as through a pass-through arrangement. This leaves a net £0.7m pressure, as growth in ICB-funded high-cost drugs are at the Trust's risk

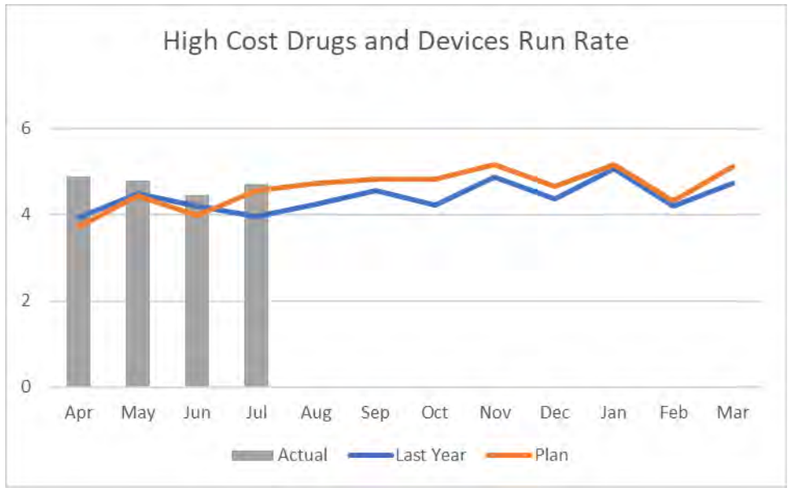
Estates and Facilities are currently underspent, delaying some maintenance projects and reduced utilities costs.

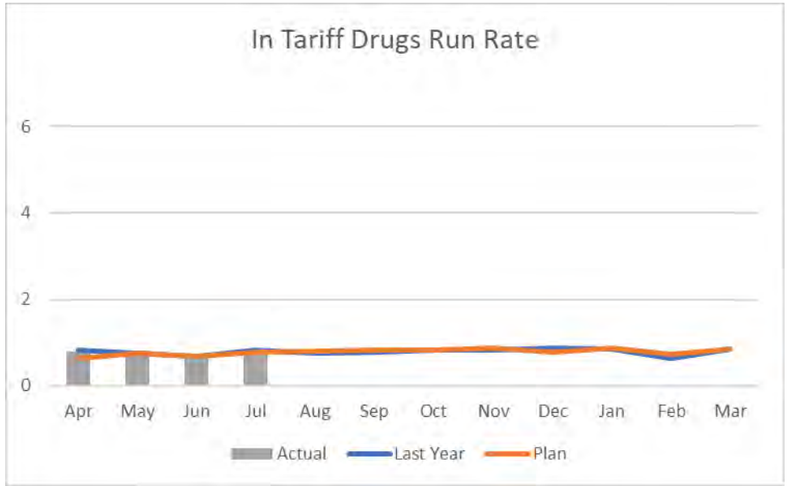
Countermeasures	Owner	Due Date
Completed but with no change: High-cost drugs and devices position is clarified with BSW to move to a pass-through arrangement in line with guidance.	Chief Finance Officer	31 August
On-going: Pharmacy supporting the review of high-cost drugs to determine spend profile and opportunities to reduce spend.	Pharmacy and Specialty Tris	31 August

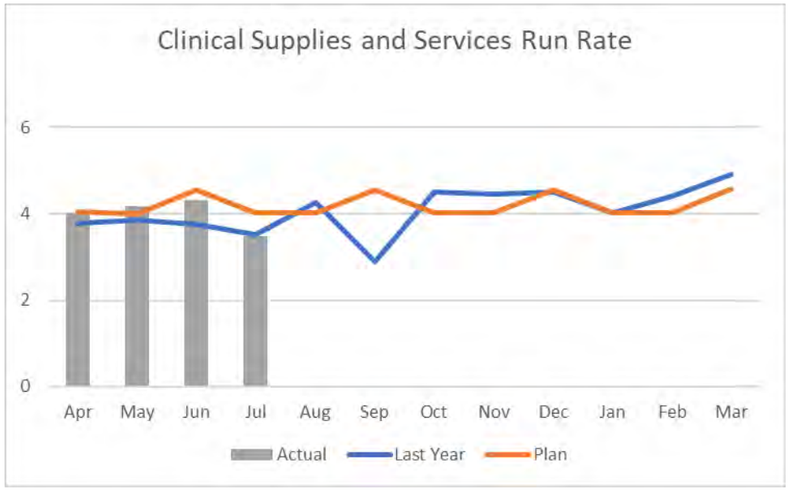
Risks and Mitigation

Non Pay – Run Rate Graphs





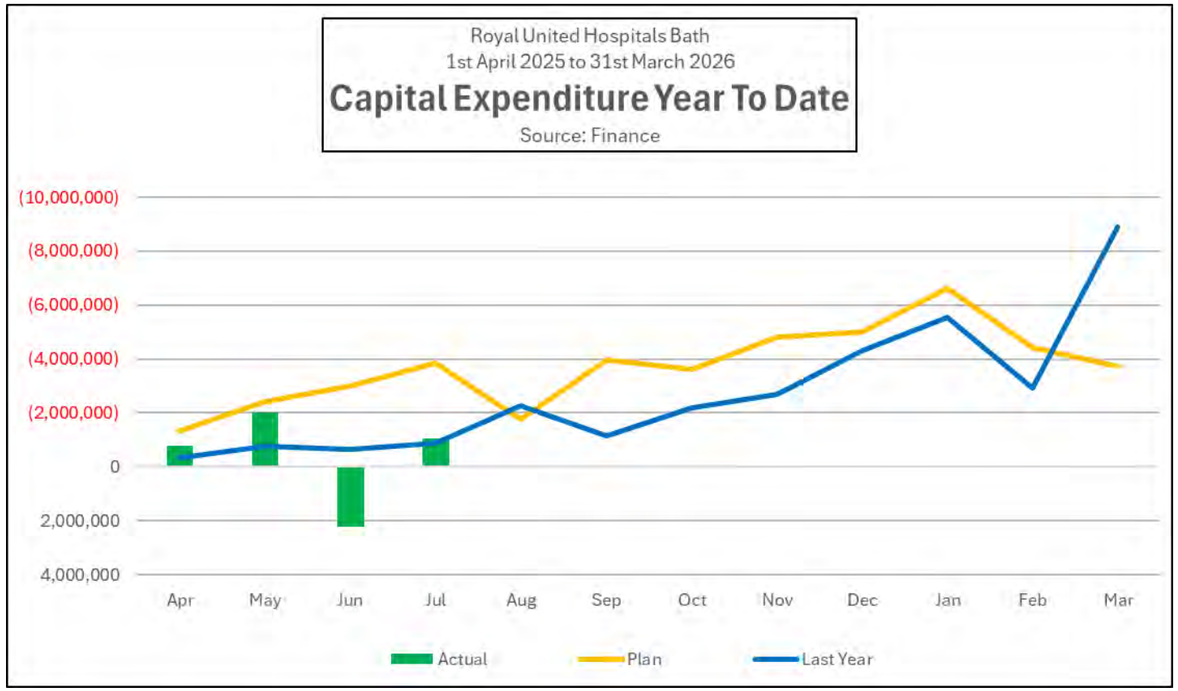




Capital – Operational, Grant & Donated

Royal United Hospitals Bath NHS Foundation Trust

Position as at 31st July 2025	Annual Plan £'m	Forecast Outturn £'m	YTD Plan £'m	YTD Actuals £'m	YTD Variance £'m
Decarbonisation	(2.985)	(2.985)	(0.400)	(0.047)	0.353
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)**	**(0.400)**	**(0.047)**	**0.353**
IT	(1.750)	(1.650)	(0.448)	(0.482)	(0.034)
Medical Equipment (MEC)	(1.610)	(0.380)	(0.062)	0.010	0.073
Estates, CRG & Projects	(1.500)	(1.192)	(0.571)	(0.307)	0.264
Sulis	(0.250)	(0.143)	(0.052)	(0.010)	0.042
Right of Use Leases	(0.300)	(0.300)	(0.075)	0.000	0.075
Minor	(0.107)	(0.107)	(0.010)	(0.080)	(0.070)
Lease Provision release (Modular Theatre)	(0.547)	(0.547)	0.000	0.000	0.000
Other Schemes Total	**(6.064)**	**(4.319)**	**(1.218)**	**(0.868)**	**0.349**
TOTAL : Operational Capital	**(12.867)**	**(11.122)**	**(1.618)**	**(0.915)**	**0.702**
Decarbonisation (Salix)	(10.820)	(10.820)	(5.933)	(0.601)	5.332
PET-CT	(2.000)	(2.000)	0.000	0.000	0.000
Minor donated schemes	(0.300)	(0.300)	(0.100)	(0.100)	0.000
TOTAL : Donated & Grant Funded	**(13.120)**	**(13.120)**	**(6.033)**	**(0.701)**	**5.332**
PFR Adjustment (per NHSE)	0.000	(1.745)	0.000	0.000	0.000
OVERALL TOTAL	**(25.987)**	**(25.987)**	**(7.651)**	**(1.616)**	**6.035**



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 has been reviewed with capital leads, a paper presented at the June TME, agreed to hold back £1.745 million of uncommitted spend, the largest of this is the CT replacement.

An updated cashflow has been received from contractor for the Decarbonisation scheme, this shows spend starting in July and running into next financial year. This shows as negative costs in June due to reversal of accrual based on previous cashflow.

EPR forecast for year is provided by the EPR project board and EPR project accountant. Latest forecast is £0.3 million underspend against allocation in year, underspends will impact CDEL available to the Trust in 2026/27.

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	June 2025
In response to the adverse revenue position capital expenditure that has not been contractually committed or is mandated has been held.	CPMG	Immediate

Risks and Mitigation

Overall EPR forecast outturn at end of project is a £1.4 million overspend against approved FBC. This could increase further and is being reviewed by the EPR project accountant.
EPR project accountant and Manager were asked to provide an update paper on EPR cost pressure to Trust Board in June 25.

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.

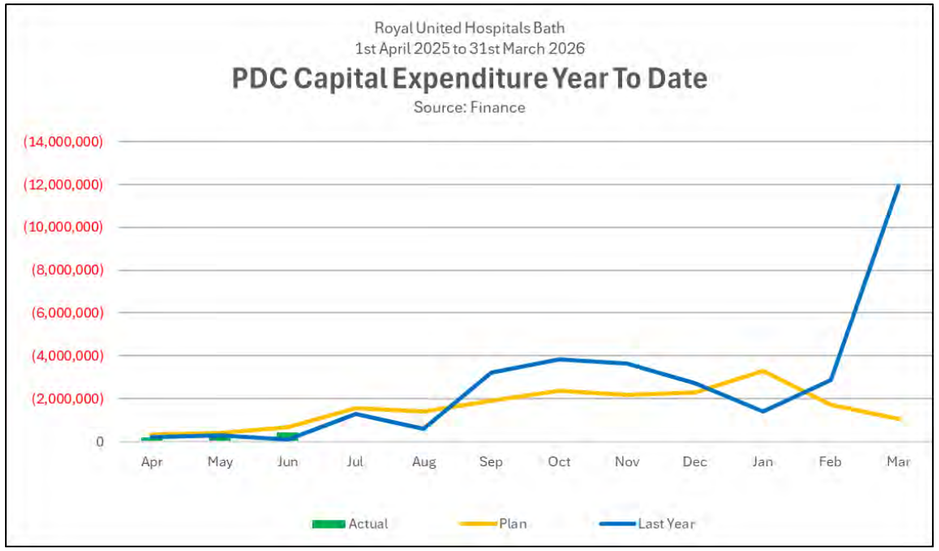
Salix grant funding agreement states it is to utilised by 31st March. Due to delay in programme notified by the contractor, the project team are in discussions with Salix to defer the commission funding to next year. If this is not agreed this will be a pressure to next year's trust funding, which is already strained due to the EPR commitment.

Cash is a risk to capital programme,

Capital – PDC Funded

Royal United Hospitals Bath
NHS Foundation Trust

PDC Funded Capital Position as at 31st July 2025		Annual Plan £'m	Forecast Outturn £'m	YTD Plan £'m	YTD Actuals £'m	YTD Variance £'m	Approval status
BSW EPR		(2.955)	(2.955)	(2.072)	(1.001)	1.071	FBC approved, MOU not yet received
Solar Energy (Net Zero)		(0.295)	(0.295)	(0.050)	0.000	0.050	Approved, MOU signed
Total Other		**(3.250)**	**(3.250)**	**(2.122)**	**(1.001)**	**1.121**	
Estates:	Fire Safety Programme	(1.890)	(1.890)	(0.277)	0.000	0.277	Estates strategy funding has been approved by national panel. MOUs received and signed
	Fire Evacuation Risk - Cardiac Fire Lift	(0.385)	(0.385)	(0.059)	0.000	0.059	
	Life critical UPS Replacement	(0.270)	(0.270)	(0.042)	0.000	0.042	
	Sterile Services Autoclave/Steriliser Replacement	(0.900)	(0.900)	0.000	0.000	0.000	
	Nurse Call Replacement	(0.072)	(0.072)	(0.011)	0.000	0.011	
	Asbestos / roof Works Block 37	(0.135)	(0.135)	(0.021)	0.000	0.021	
	Staff Attack SystemReplacement	(0.054)	(0.054)	(0.008)	0.000	0.008	
	Chiller Replacement (Pathology)	(0.720)	(0.720)	(0.085)	0.000	0.085	
	Maternity AHU Replacement	(0.630)	(0.630)	(0.097)	0.000	0.097	
Total Estates Safety		**(5.056)**	**(5.056)**	**(0.600)**	**0.000**	**0.600**	
Diagnostics:	MRI replacement	(1.448)	(2.323)	0.000	0.000	0.000	Constitional Standards schemes are not fully approved, business cases were submitted to regional team at the end of May, for review and submission to national team. All schemes are still under review by the Regional team and are yet to be submitted to the National Team. There is a delay to the expected approval date
	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	
	CDC Expansion- Design works to RIBA stage 4	(0.750)	(0.750)	(0.150)	0.000	0.150	
Elective:	Gastroenterology / General Surgery Out Patient clinic rooms	(0.250)	(0.250)	(0.025)	0.000	0.025	
	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	(0.060)	0.000	0.060	
	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)**	**(12.185)**	**(0.235)**	**0.000**	**0.235**	
TOTAL : PDC Funded		**(20.316)**	**(20.491)**	**(2.957)**	**(1.001)**	**1.956**	



Understanding Performance

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.

The Return to Constitutional Standards schemes are yet to be approved, which is why there is no committed spend YTD.

Countermeasures	Owner	Due Date
In response to the adverse revenue position capital expenditure that has not been contractually committed or is mandated has been held. 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

The Return to Constitutional Standards Schemes are not yet approved. Business cases were submitted at the end of May. Outcome was expected by end of June but not yet received. Risk to deliverability if approval delayed. When funding is 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 investment will get written off to the revenue.

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Trust - Statement of Financial Position

Royal United Hospitals Bath NHS Foundation Trust

Statement of financial position As at April 2025	M4 FY 2025-26 31/07/2025 £'m	FY 2024-25 31/03/2025 £'m	Variance £'m	% Variance
Non current assets				
Intangible assets	6.708	7.096	(0.388)	(5.468)%
Property, Plant & Equipment	313.048	330.248	(17.200)	(5.208)%
Right of use assets - leased assets for lessee	48.020	49.730	(1.710)	(3.439)%
Investments in associates and joint ventures	3.941	3.941	0.000	0.000%
Trade and other receivables	4.923	5.184	(0.261)	(5.035)%
Total non current assets	**376.640**	**396.199**	**(19.559)**	**(4.937)%**
Current Assets				
Inventories	6.782	6.782	0.000	0.000%
Trade and other receivables	33.162	30.746	2.416	7.858%
Cash and cash equivalents	32.962	36.648	(3.686)	(10.058)%
Total current assets	**72.906**	**74.176**	**(1.270)**	**(1.712)%**
Current Liabilities				
Trade and other payables	(49.397)	(61.625)	12.228	(19.843)%
Other liabilities	(25.031)	(8.634)	(16.397)	189.912%
Provisions	(0.975)	(0.932)	(0.043)	4.614%
Borrowings	(2.206)	(2.530)	0.324	(12.806)%
Total current liabilities	**(77.609)**	**(73.721)**	**(3.888)**	**5.274%**
Total assets less current liabilities	**371.937**	**396.654**	**(24.717)**	**(6.231)%**
Non current liabilities				
Provisions	(1.315)	(1.315)	0.000	0.000%
Borrowings	(53.767)	(54.896)	1.129	(2.057)%
Total assets employed	**316.855**	**340.443**	**(23.588)**	**(6.929)%**
Financed by:				
Public Dividend Capital	285.705	285.705	0.000	0.000%
Income and Expenditure Reserve	(9.930)	13.658	(23.588)	(172.705)%
Revaluation reserve	41.080	41.080	0.000	0.000%
Total equity	**316.855**	**340.443**	**(23.588)**	**(6.929)%**

Understanding Performance

Non-current assets – Top contributor is capital assets. Capital assets decreased by 5% as at month 4. The variance relates to depreciation and amortisation charged year to date and planned capital spend being put on hold as detailed in the capital slides.

Current assets – Cash was the top contributor to the variance, as set out within the cash slide.
The key contributor to the increase in trade and other receivables is slight deterioration in collections of outstanding debt.

Current liabilities – Top contributor is trade and other payables; the key movement is the payment of capital creditors relating to 2024/25 and increased drive in paying invoices in line with the better payment practice code.

Total equity – The decline in reserves was due to the net loss year to date.

Risks and Mitigation

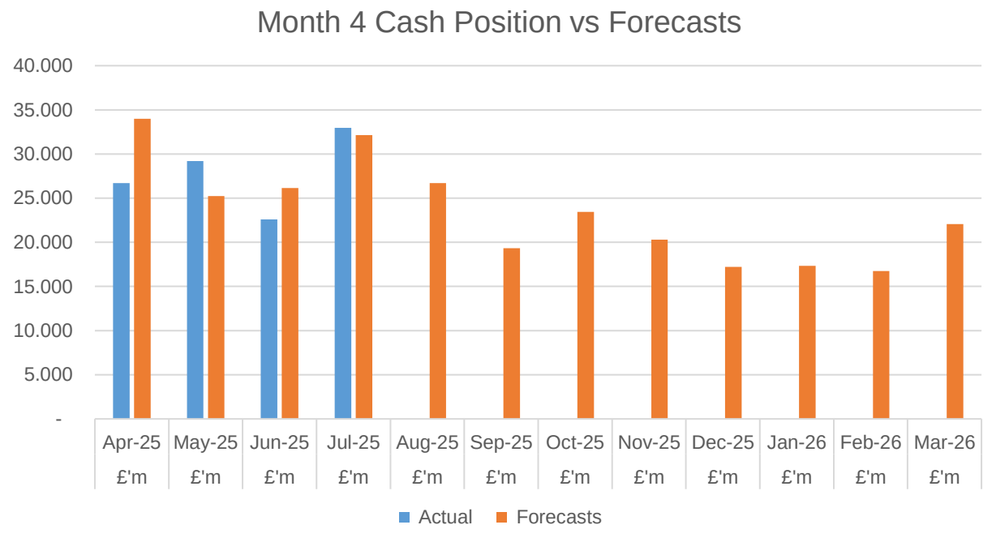
Risks include:
- Slippage in capital spend. Mitigated through monthly CPMG meetings and monthly reporting to ICB and NHSE.
- Risks relating to receivables, payables, BPPC and cash have been set out in their respective slides.

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

Statements of Cash Flows	Actual £'m
EBITDA deficit	(12.825)
Income recognised in respect of capital donations (cash and non-cash)	(0.701)
Impairments	13.489
Working capital movement	(1.602)
Provisions	0.043
Net cash used in operating activities	**(1.595)**
Capital Expenditure	(2.607)
Cash receipts from asset sales	0.016
Donated cash for capital assets	0.701
Interest received	0.609
Net cash used in investing activities	**(1.281)**
Capital element of finance lease rental payments	(0.270)
Interest on loans	0.057
Interest element of finance lease	(0.597)
Net cash used in financing activities	**(0.810)**
Decrease in cash and cash equivalents	**(3.686)**
Opening cash balance	36.648
Closing cash balance	**32.962**
Adjusted for petty cash	0.003
Adjusted closing cash balance	**32.965**



The orange bars represent 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

From the graph above, actual cash balance was slightly higher than the forecasted balance by £0.815m.

The main drivers are:
- Inflow of system revenue support of £14.465m as against the forecasted inflow of £7.233m.
- Increased fixed income of £1.069m against forecast.
- Non-NHS income and non-invoiced income lower than forecasted.
- BACs payment higher than forecast by £4.429m.

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

Risks and Mitigation

If savings plans are not met there is a risk that the Trust will have insufficient cash to cover all payroll, capital and revenue suppliers.

The cash will be monitored and reforecast based on the latest information. Mitigations include;
- Withdrawal of operational capital funding
- Aged debt monitoring
- Withholding payments to suppliers through the No PO No Pay Policy.

Trust Top Ten Debtors

Royal United Hospitals Bath NHS Foundation Trust

Top Ten Aged Debtors	Total	Not due	1 - 30 days	31-60 days	61-90 days	>91 days	Comments
	£'m	£'m	£'m	£'m	£'m	£'m	
Sulis Hospital Bath Ltd	**1.451**	0.890	0.379	0.182	0.000	0.000	Reminders sent as per the debt chasing policy.
HCRG Care Services Ltd	**0.663**	0.500	0.163	0.000	0.000	0.000	Reminders sent as per the debt chasing policy.
NHS England	**0.539**	0.513	0.003	0.000	0.022	0.000	£0.020m invoice was disputed by NHS England, information has been sent to resolve this for payment. £0.04m invoices have been approved, and awaiting payment.
Banes Council	**0.370**	0.370	0.000	0.000	0.000	0.000	Not due for payment
Great Western Hospitals NHS F/T	**0.340**	0.136	0.125	0.013	0.000	0.066	The £0.066m further detailed backing has been sent to GWH. Reminders sent as per the debt chasing policy.
University Hospitals Bristol and Weston NHS Foundation Trust	**0.244**	0.193	0.050	0.002	0.000	0.000	Statement of account has been shared with UBH and all invoices /queries are being chased.
Sundry Customers - Overseas Patient	**0.239**	0.001	0.028	0.005	0.008	0.197	All outstanding debt prior to 1 April 2025 has been provided for in the bad debt provision or have an installment plan agreed.
NHS Bath and North East Somerset Swindon and Wiltshire Integrated Care Board	**0.204**	0.160	0.014	0.030	0.000	0.000	Financial Management are in discussion with the ICB to resolve the debt. Backing data has been sent.
Sailsbury NHS F/T (RNZ)	**0.189**	0.129	0.051	0.000	0.009	0.000	Invoices for Salisbury have been chased.
Gloucestershire Hospitals NHS F/T	**0.171**	0.017	0.024	0.030	0.000	0.100	The debts relates to locums nest shift payments. Ongoing discussions with Financial Management and Gloucester on the overdue debts.
Total	**4.410**	**2.909**	**0.837**	**0.262**	**0.039**	**0.363**	

Understanding Performance	Countermeasures	Owner	Due Date	Risks and Mitigation
The total amount of invoiced receivables as at 31st July is £6.8m. From the table above, out of the total £4.4m balance, £2.9m is not yet due for collections while the remaining balance are being chased for payment in line with the Trust bad debt policy with some provided for as bad debt.	Active management via Accounts Receivable Team	Head of Financial Services	Continuous	Collectability of receivables which will have an impact on the financial performance of the Trust if they are required to be written off. Late collection of receivables will affect the cash position of the Trust. Risks are being mitigated through the application of the Trust debt policy.

Trust Top Ten Creditors

Royal United Hospitals Bath NHS Foundation Trust

Top Ten Aged Creditors	Total	Not due	1 - 30 days	31-60 days	61-90 days	>91 days	Comments
		£'m	£'m	£'m	£'m	£'m	
Sulis Hospital Bath Ltd	**(0.888)**	(0.500)	(0.388)	0.000	0.000	0.000	£0.390m has been approved for payment and £0.498m awaiting approval.
Oracle Corporation Uk Ltd	**(0.623)**	(0.043)	(0.195)	(0.204)	(0.181)	0.000	£0.579m awaiting approval and £0.043m not yet due
Veolia Energy & Utility Services UK LTD	**(0.605)**	(0.605)	0.000	0.000	0.000	0.000	Payment not due.
Telemedicine Clinic Ltd	**(0.454)**	0.000	(0.334)	(0.120)	0.000	0.000	Invoices were parked due to No PO No Pay Policy
Teneo Strategy Ltd	**(0.448)**	(0.448)	0.000	0.000	0.000	0.000	Payment not due.
Moduleco Healthcare Ltd	**(0.388)**	0.000	(0.388)	0.000	0.000	0.000	PO has not been receipted yet. Budget holder has been chased.
University Hospitals Bristol and Wston NHS Foundation Trust	**(0.356)**	(0.098)	(0.069)	0.000	0.000	(0.189)	£0.098m not due for payment and £0.069m awaiting budget holder approval while £0.189 is being queried.
UK Health Security Agency	**(0.284)**	(0.278)	0.000	0.000	(0.001)	(0.004)	£0.278m not due for payment and £0.005 awaiting backing data before budget holder can approve.
NHS Supply Chain (consumables)	**(0.281)**	(0.281)	0.000	0.000	0.000	0.000	All invoices has been approved for payment.
Pentax Uk Ltd	**(2.437)**	(2.437)	0.000	0.000	0.000	0.000	Payment not due.
Total	**(6.765)**	(4.691)	(1.374)	(0.324)	(0.182)	(0.194)	

Understanding Performance	Countermeasures	Owner	Due Date	Risks and Mitigation
From the table above, out of the total £6.8m balance, £4,7m is not yet due for payment while the remaining balances are being chased for approval with budget holders. Total invoices due for creditors as at 31st July 25 is £14.8m.	Active management by Accounts Payable team	Head of Financial Services	Continuous	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.

Better Payment Practice Code

Royal United Hospitals Bath NHS Foundation Trust

	Jul-25		Jun-25		% Variance	
	Volume ('m)	£'m	Volume ('m)	£'m	Volume ('m)	£'m
Non NHS						
Total bills paid in the year	24.663	138.72	17.645	109.151	40%	27%
Total bills paid within target	23.402	114.398	16.659	85.949	40%	33%
Percentage of bills paid within target	**95%**	**82%**	**94%**	**79%**	**1%**	**5%**
NHS						
Total bills paid in the year	0.41	6.449	0.257	4.207	60%	53%
Total bills paid within target	0.298	3.167	0.182	2.162	64%	46%
Percentage of bills paid within target	**73%**	**49%**	**71%**	**51%**	**3%**	**-4%**
Total						
Total bills paid in the year	25.073	145.169	17.902	113.358	40%	28%
Total bills paid within target	23.7	117.565	16.841	88.111	41%	33%
Percentage of bills paid within target	**95%**	**81%**	**94%**	**78%**	**0.5%**	**4%**

Understanding Performance	Countermeasures	Owner	Due Date	Risks and Mitigation
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. There is a slight improvement of 4% in volume as at July 2025.	Active management by Accounts Payable team	Head of Financial services	Continuous	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.
	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	

Trust Purchase Order Compliance

Royal United Hospitals Bath NHS Foundation Trust

Division	Invoice Totals 202504 Off Purchase Order £'m	On Purchase Order £'m	Total £'m	% on PO
Capital Summary	-0.110	0.704	0.593	119%
Total capital PO compliance	**-0.110**	**0.704**	**0.593**	**119%**
Corporate Division	0.228	0.946	1.175	81%
Estates And Facilities Division	1.080	0.567	1.647	34%
Family And Specialist Service Division	2.741	0.317	3.058	10%
Health Innovation West Of England	0.001	0.034	0.035	97%
Medical Division	0.237	1.241	1.479	84%
Research & Development	0.004	0.055	0.060	93%
Surgical Division	1.997	1.432	3.430	42%
Total revenue PO compliance	**6.290**	**4.593**	**10.883**	**42%**
Total compliance in July	**6.180**	**5.297**	**11.476**	**46%**

Understanding Performance	Countermeasures	Owner	Due Date	Risks and Mitigation
The most significant contributor for each division are below: - Corporate division; Finance - procurement recharges, and site management team invoices were not on PO. - Estates and facilities; Utilities contracts, retail catering, general rates and waste management were not on PO. - Family and Specialist Services; Pharmaceutical invoices were off PO. - Medical Division; Urgent treatment centre, neurology medical staff, and adult therapies outpatient were off PO. - Research and Development; not material. - Surgical Division; SEOC, microbiology, and outpatients' bookings were off PO.	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	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.
	PO compliance is monitored through the non pay group. Invoices over £2,500 without a PO are being held and will only be released for payment through the non pay group.	Divisional Finance Managers, Financial Services and Procurement Teams	31 May	

Sulis

Royal United Hospitals Bath
NHS Foundation Trust

Month Performance against Budget P04

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)	2,001	2,676	675	458	779	321	848	677	(171)	3,307	4,132	825
Other Patient Care Income	1,190	1,281	91							1,190	1,281	91
Other Operating Income	34	33	(1)							34	33	(1)
Income Total	3,225	3,990	765	458	779	321	848	677	(171)	4,531	5,446	915
Pay	(1,485)	(1,608)	(123)	(228)	(288)	(60)	(372)	(303)	69	(2,085)	(2,200)	(115)
Non Pay	(1,434)	(1,123)	310	(196)	(232)	(36)	(575)	(473)	102	(2,205)	(1,828)	377
Depreciation	(240)	(234)	5	(36)	(34)	2	83	83		(192)	(185)	7
Expenditure Total	(3,158)	(2,966)	192	(460)	(554)	(94)	(864)	(693)	171	(4,482)	(4,213)	269
Operating Surplus/(Deficit)	67	1,024	957	(2)	225	227	(16)	(16)	0	48	1,233	1,184
Other Finance Charges	(38)	(38)	0	(6)	(6)	(0)	16	16		(28)	(28)	0
Other Gains/Losses												
Finance Charges	(38)	(38)	0	(6)	(6)	(0)	16	16		(28)	(28)	0
Surplus/(Deficit)	29	986	957	(9)	218	227	(0)	(0)	0	20	1,204	1,184

Balance Sheet
Cash Balance £1.426m
Average of prior year £1.615m
Cash currently forecast to run out in Sept

NHS Income: Activity levels for Sulis were at 118% of Budgeted activity levels – strong performances T&O, Spinal & Gynaecology. CDC levels were at 76% of Budget. With the van now gone the intention is to overfill the Endoscopy suite and claw back YTD deficit. Main shortfall in July against Sleep Studies, Cardiology and Radiology, with a strong performance from Endoscopy at +£16k to Budget. Note late income accrual of £430k added.
SOC is well below Budgeted activity levels, with GWH having no activity in July, and have not recruited so will be no activity in next few months.
Other patient Care Income is at +107% or £91k over Budget in P4. Self pay +£53k, PMI +£38k.

Countermeasures	Owner	Due Date
Getting bookings in earlier – has worked in P4, to continue	Sam Harrison	ongoing
Working closer with the RUH, GWH & Salisbury to unlock new patient streams	Sam Harrison	ongoing
Opening Super Sundays for Radiology & Endscopy – to start in September.	Sam Harrison	TBC
With Endscopy van now gone, focus on overfilling suite to claw back YTD losses.	Sam Harrison	ongoing

Risks and Mitigation

Risks
- Don't make income target
- CDC Income accrual £430k – may not receive income.

Mitigation:
Per table to left

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**13**
Date of Meeting:	**3 September 2025**		
Title of Report:	**Quality Assurance Committee Upward Report**		
Status	**For information**		
Author	**Hannah Morley, Non-Executive Director**		

Key discussion points and matters to be escalated from the meeting on 11 August 2025

ALERT: Alert to matters that require the Board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy

There are notable gaps in the current quality and safety infrastructure. Efforts to address these gaps have been hindered by an inability to secure the necessary funding for a comprehensive quality structure. This has subsequently impacted the organisation's ability to fully engage in learning processes under the Patient Safety Incident Response Framework (PSIRF). Funding at divisional level in particular is required to address this but it was acknowledged by the committee that this is unlikely to be received, although a proposal is being drafted.

The limited availability of resources within the clinical coding function continues to have an adverse impact on the accuracy and reliability of mortality data. This presents a risk to effective mortality surveillance and performance reporting.

Mortality data is a piece of data that is used to assess quality and patient safety. There are 2 types, and they are used to detect unusually high death rates in specific departments or specialties, benchmark performance against other Trusts and sometimes to identify areas requiring clinical review or investigation. The Q4 learning from deaths report shows a significant upward trend in mortality data. This trend resulted in a detailed discussion and concerns were raised at the committee because if there were no alternative explanations for this trend, we could be looking at a significant patient safety issue.

However, the committee was reassured that the downward trend can be explained by errors in clinical coding. Clinical coding is done by admin staff. Recruitment into coding posts has been under scrutiny due to the head count reduction requirement but this has led to a skill and personnel gap in clinical coding teams which has resulted in this error.

A Mortality Group has been stood up to fully investigate this upward trend to ensure that it is because of this staffing issue and is not masking a patient safety issue.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance

Since the implementation of the Paperless Inpatients system, it has become increasingly difficult to generate new insights. This challenge is largely attributed to the significant allocation of resources towards the Electronic Patient Record (EPR), which has limited capacity for additional analytical or evaluative work. We are at a stalemate

with this work until EPR is up and running, at which point the benefits of the new system will lead to significant progress in capturing new insights from the data.
ASSURE: Inform the Board where positive assurance has been achieved
Development work is actively underway to establish a comprehensive mental health risk framework. This aims to provide a more cohesive understanding of mental health-related risks across the organisation. The safeguarding reports received have provided substantial assurance regarding the robustness of current safeguarding practices and procedures across the organisation.
RISK: Advise the Board which risks were discussed and if any new risks were identified
Concerns have been raised regarding risks associated with non-reportable waiting lists. These lists require thorough validation to ensure patient safety and to mitigate potential risks stemming from delayed care. This was discussed briefly at the August Board and there is work ongoing to understand the waiting lists in more detail, but this is challenging as validation requires a level of clinical involvement or very experienced clinical admin of which both are a limited resource. There also remains an overarching risk related to outpatient services, with specific concern around the potential for patient harm due to delays or and long waiting lists.
CELEBRATING OUTSTANDING: Share any practice innovation or action that the committee considers to be outstanding
There has been a positive improvement in compliance with Infection Prevention and Control (IPC) mandatory training requirements, reflecting enhanced staff engagement and awareness. A significant improvement has also been observed in the number of current Patient Group Directions (PGDs), which supports safer and more effective clinical practice.
APPROVALS: Decisions and Approvals made by the Committee
No approvals to report.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**14**
Date of Meeting:	**3 September 2025**		

Title of Report:	**Q4 2024/25 Learning from Deaths**
Status:	**For approval**
Board Sponsor:	**Kheelna Bavalia, Interim Chief Medical Officer**
Author:	**Kheelna Bavalia, Interim Chief Medical Officer**
Appendices	**None**

1. Executive Summary of the Report

Conducting and learning from a review of the care provided to patients who die should be an integral part of every Trust's clinical governance and quality improvement processes. This requirement is reinforced by the National Quality Board's National Guidance on Learning from Deaths, which sets out a framework for Trusts to identify, report, investigate and learn from deaths that occur in their care. This aim of this report is to assure the Board of the Trust's compliance with this requirement, and also that it is actively taking the opportunities to improve the quality and safety of the care that it provides because of the work that it does in this area.

For Q4

- We are delayed in receiving our Telstra Mortality report; this is due to incomplete data sets and should be with us for discussion later this month.
- Our SHMI data remains within expected ranges for both weekday and weekend admissions. However, we see a significant upward trend through Q4, that correlates with a high proportion of incomplete data coding.
- Whilst there is a clear recognised rationale for the change of data trend, we need to be vigilant and confident that this data is not masking other changes or concerns that warrant further exploration in order to maintain our quality and safety standards. A mortality group will be convened for this for discussion.
- In conjunction with GHW and SFT, we will no longer be commissioning Telstra for our morality reports. Instead, we are shifting focus to SHMI data, as used by NHSE England, and collaborating around a single Power BI dashboard to give us visibility over BSW group, and better shared insights. This work has commenced.
- 80% of SJRs completed in Q4 rated care as either good or very good. Issues relating to delays and documentation were themes identified as resulting in reduced quality care.
- There has been an increase in the number of outstanding SJRs but the timeliness of those SJRs completed has improved.

2.	Recommendations (Note, Approve, Discuss)
The report is for approval.	

3.	Legal / Regulatory Implications
The Trust is required, by national guidance, to have a process in place to ensure that it identifies, reports, investigates and learns from deaths in its care.	

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)
Data Issues. Gaps in coding have impacted our SHMI mortality Data Quality, resulting in what appears as an upward trend in mortality trend. Whilst we remain within expected range, the marked trend change is a flag for concern, and has required discussion with the ICB and Regional Mortality Leads. Although we can explain this by the coding gaps, we will need to remain vigilant that this trend change is not masking a feature of other quality issues.	

5.	Resources Implications (Financial / staffing)
We need to ensure we do not worsen our data quality issues with ongoing gaps in coding resource and need to consider if the retrospective coding needs to be completed. In light of above, we will re-stand up our mortality group and identify a new clinical mortality lead.	

6.	Equality and Diversity
The report highlights gaps in the collation of data in relation to ethnicity, religion and learning disability. This will require attention for us to fully understand health inequalities impact.	

7.	References to previous reports/Next steps
The report is part of a regular update to QAC on Learning from Deaths.	

8.	Freedom of Information
The information included is public	

9.	Sustainability
The report has no impact on sustainability	

10.	Digital
The report does not identify or highlight issues related to the trust's digital strategy	

Royal United Hospitals Bath
NHS Foundation Trust

Learning from Deaths

January to March 2025 (Q4)

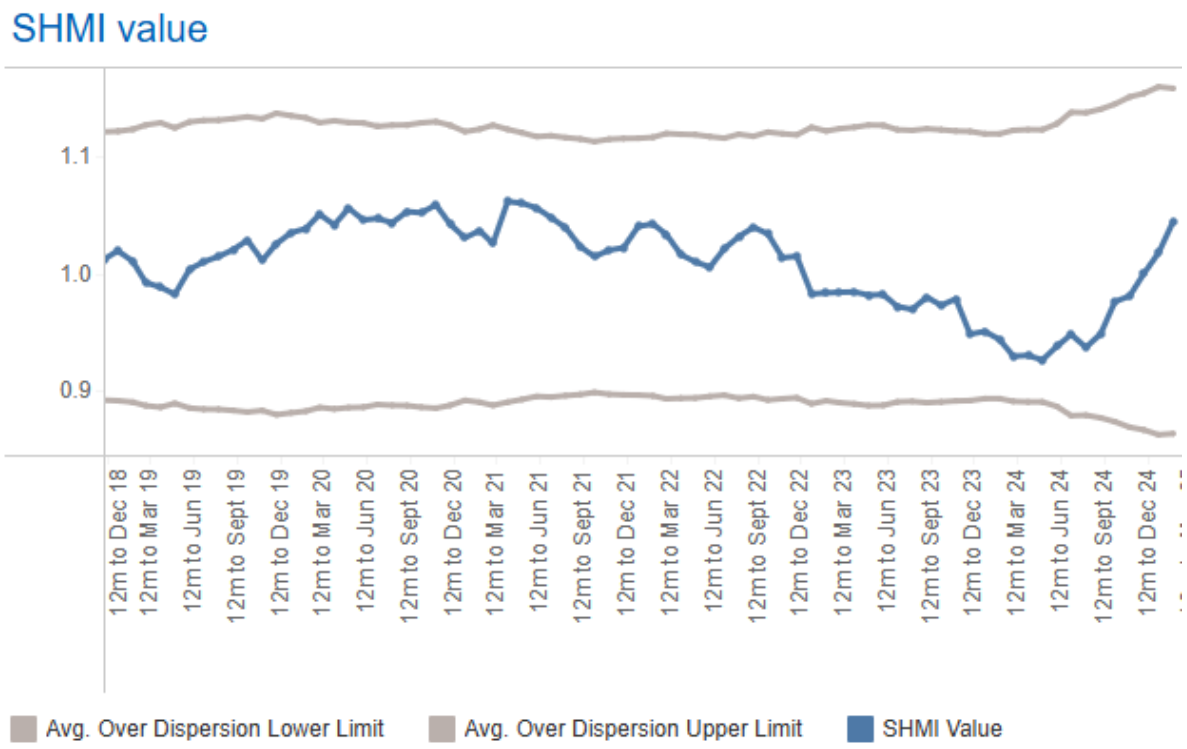
This report considers our mortality trends, learning from deaths, and the processes and approach in place to effectively support this.

1.0 Summary Data

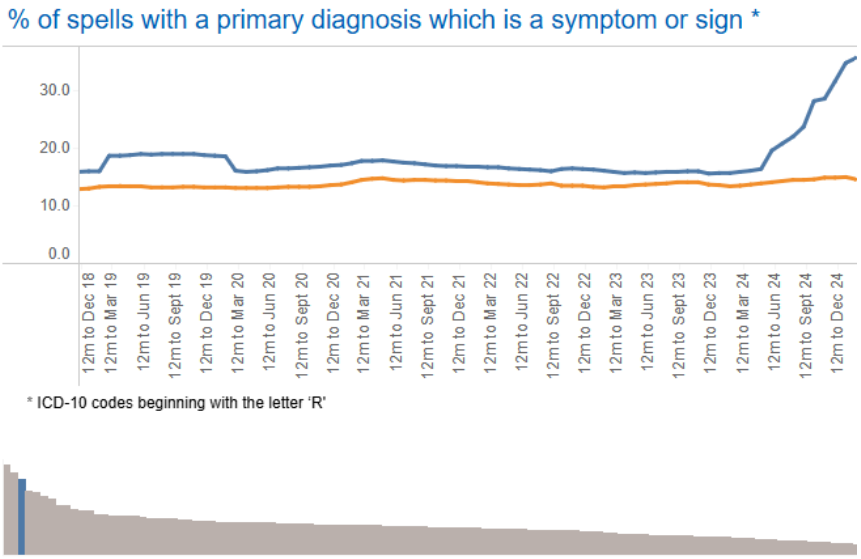
1.1 The number of in-patient deaths in Q4 was 347.

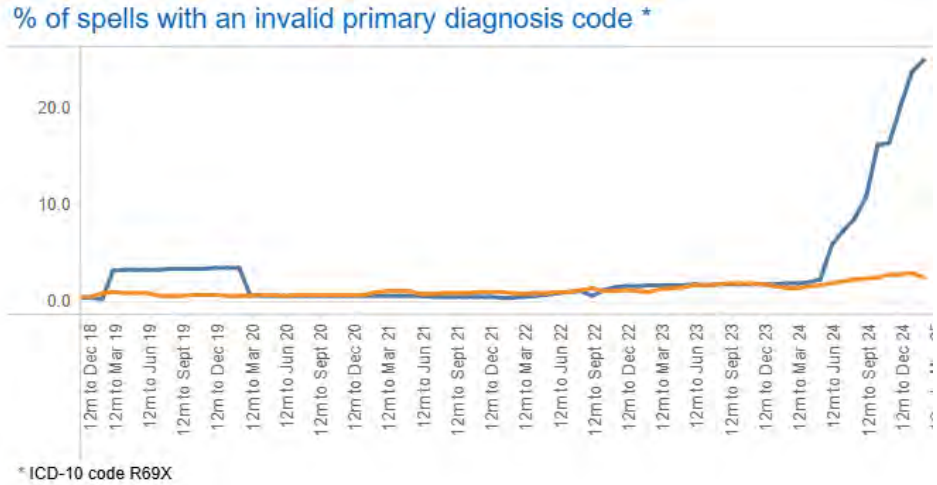
1.2 Due to gaps in coding resulting in incomplete data sets, we do not have a report from Telstra for this period yet. This is being collated and a meeting with Telstra has been arranged for this month. Our trends through the year, up until this point, have consistently demonstrated our overall HSMR falls within expected range, as does weekday and weekend ranges.

1.3 Our Summary Hospital-level Mortality Indicator (SHMI) data for Q4 continues to sit within the expected range, but is showing an upward trend, beginning in Q3 and continuing through Q4:



1.5 Further investigation points to coding issues as during Q4 we have a high percentage of invalid diagnosis codes, specifically with *primary diagnosis as a sign or symptom* (R codes), where we are 3rd highest in the country, and *an invalid primary diagnosis code*, where we are 2nd highest.





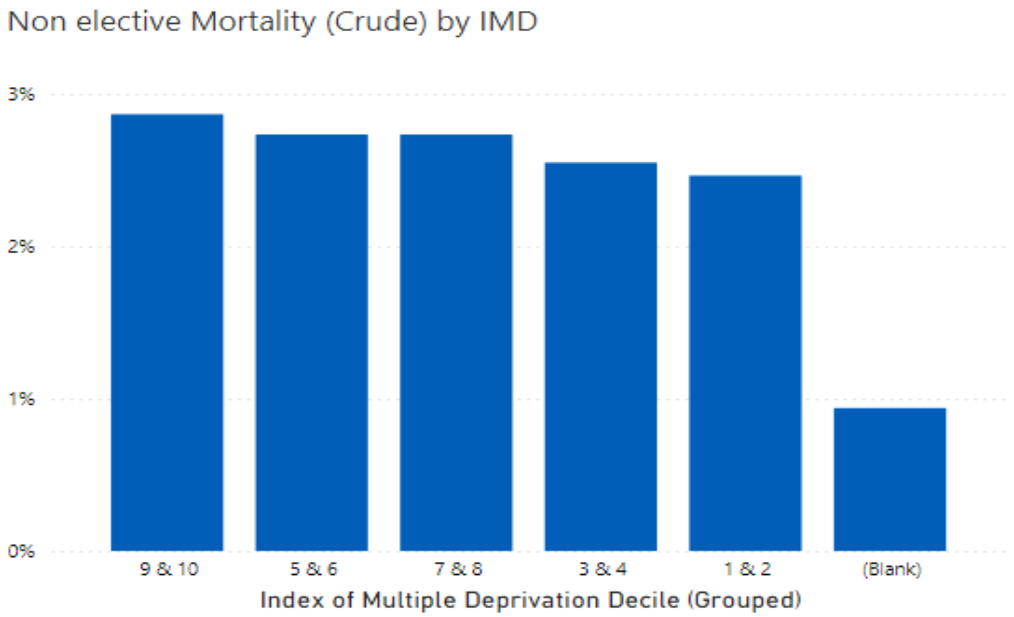
1.6 This change in trend correlates with periods where coding was unable to be undertaken due to workforce gaps in our coding team, with recruitment delayed by held vacancies and limitations on use of temporary staffing in order to meet our financial recovery plan.

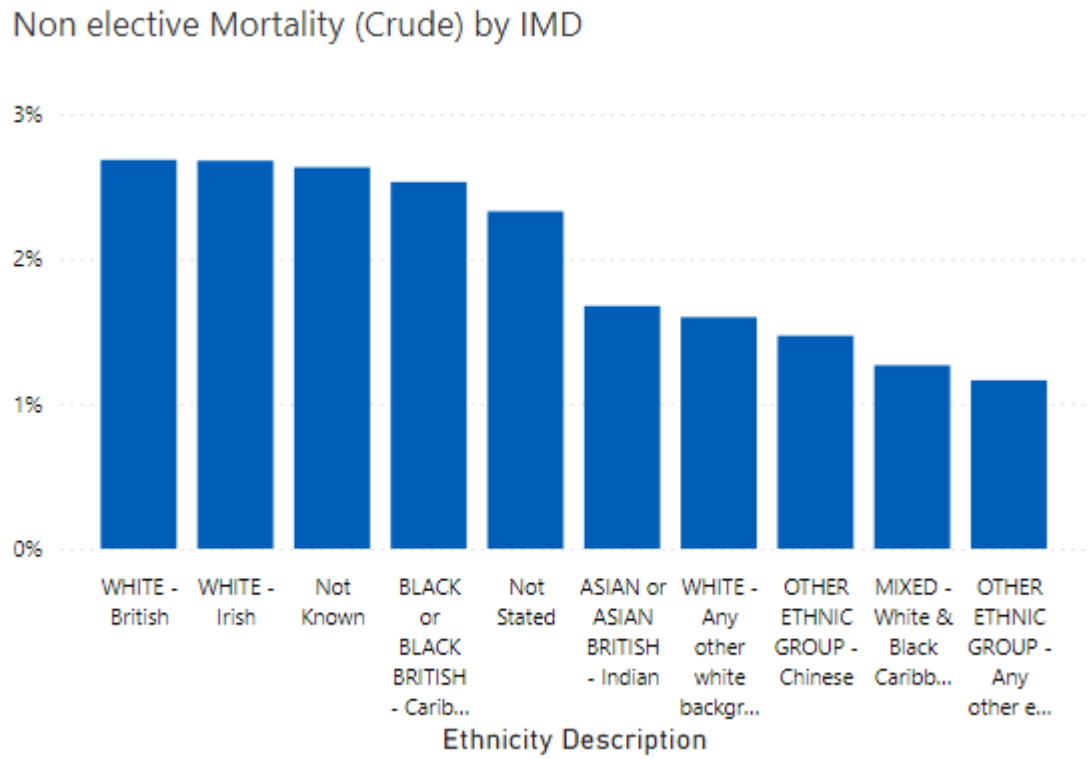
1.7 Whilst there is a clear rationale for the change of data trend, we need to be vigilant and confident that this data is not masking other changes or concerns that warrant further exploration in order to maintain our quality and safety standards. A mortality group will be convened for this for discussion.

2.0 Health Inequalities:

2.1 Health Inequalities data has been collated using the business intelligence dashboard. The data displayed below is for non-elective admissions between 1st April 2024 and 4th January 2025

2.2 The data suggests that slight variation in crude mortality for the most deprived members of our community and across certain ethnic groups. This is consistent with national data trends.





2.3 When broken down by age band, the data suggests the most deprived population have a higher crude mortality in the 30th and 70th decades when compared to least deprived populations. It also suggests that in specific age bands certain ethnic groups have a higher crude mortality.

Non Elective Mortality by Age Band (10 years) and IMD

Index of Multiple Deprivation Decile (Grouped)	10	20	30	40	50	60	70	80	90	100	**Total**
(Blank)		0.4%			0.9%	1.0%	1.6%	6.7%	8.3%		**1.1%**
1 & 2			0.4%		0.5%	2.6%	5.2%	4.5%	6.1%		**2.1%**
3 & 4				0.2%	0.6%	2.8%	3.5%	6.7%	7.5%		**2.5%**
5 & 6			0.1%	0.6%	1.1%	1.8%	3.3%	6.6%	8.0%		**2.7%**
7 & 8	0.4%		0.1%	0.5%	1.3%	2.2%	3.1%	4.7%	8.4%		**2.5%**
9 & 10	0.4%	0.1%	0.1%	0.3%	1.3%	2.0%	3.2%	5.0%	8.1%	23.5%	**2.8%**
Total	**0.2%**	**0.1%**	**0.1%**	**0.4%**	**1.1%**	**2.1%**	**3.3%**	**5.5%**	**8.0%**	**14.3%**	**2.6%**

Ethnicity Description	10	20	30	40	50	60	70	80	90	100	Total
ASIAN or ASIAN BRITISH - Indian											1.7%
BLACK or BLACK BRITISH - Caribbean								5.9%			2.5%
MIXED - White & Black Caribbean											1.3%
Not Known	0.9%	0.4%	0.3%	0.3%	1.0%	1.9%	4.3%	4.1%	8.2%		2.6%
Not Stated						1.0%	2.3%	4.2%	9.8%		2.3%
OTHER ETHNIC GROUP - Any other ethnic group						3.6%		4.5%			1.2%
OTHER ETHNIC GROUP - Chinese								14.3%			1.5%
WHITE - Any other white background		0.5%		0.6%	0.7%	3.1%	3.1%	7.1%	2.3%		1.6%
WHITE - British	0.1%		0.1%	0.4%	1.1%	2.1%	3.2%	5.7%	8.1%	16.0%	2.7%
WHITE - Irish								7.1%			2.7%
Total	**0.2%**	**0.1%**	**0.1%**	**0.4%**	**1.1%**	**2.1%**	**3.3%**	**5.5%**	**8.0%**	**14.3%**	**2.6%**

2.4 We need to undertake further work to understand and benchmark this finding locally and nationally. This will begin with working with GWH and SFT colleagues to help explore possible drivers.

3.0 Mortality Review Process

3.1 It is essential that the Mortality Review process occurs in a timely manner. Delays reduce the opportunity for learning from deaths and the risk that timely improvement does not occur resulting in ongoing risks to patient safety and quality.

3.2 The performance of the Medical Examiners is considered in greater detail in the quarterly Medical Examiner Office Reports. The Medical Examiners screen all deaths and a standard proforma is used to ensure consistency in the cases that are selected for SJR. The Medical Examiner Office Report details the performance of the screening process.

3.3 Regarding Structured Judgement Reviews (SJRs), in Q4 15% (n=53) of patients who died during Q4 were selected for SJR, plus an additional 14 patients whose death had occurred during an earlier quarter.

3.4 Figure 1 demonstrates the selection criteria for those patients who died during Q4. The selection criteria used most frequently was that the patient was a surgical patient (all surgical patients have an SJR), followed by the patient's death had been referred to the Coroner.

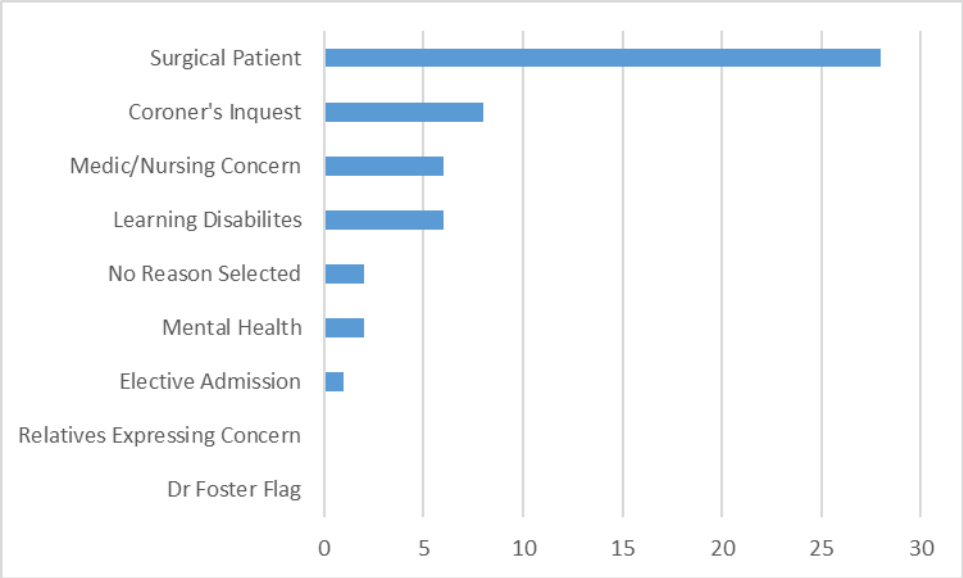


Figure 1: Number of deaths selected for SJR by selection criteria

3.5 The Trust target is to complete 95% of SJRs within 2 months of the death. Our latest achievement is 50%. Figure 2 illustrates the number of SJRs requested per quarter, compared to the number completed and the percentage of SJRs that are completed within two months of the patient's death, showing an improving trend.

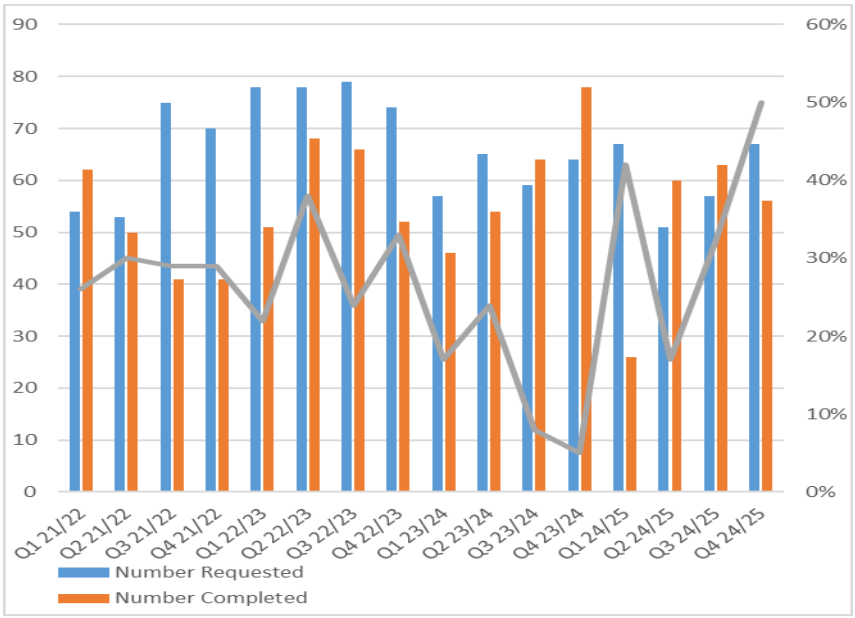


Figure 2: Number of completed SJRs v Number Requested and % completed within two months of the death

3.6 Following completion of review of the backlog of SJR's, it has been agreed historic cases that have already been the subject of a detailed view, via another process such as a formal complaint, incident investigation or inquest, will be removed from the case list, on the basis that the opportunity for additional learning is limited. There remains a reconciliation for our baseline numbers to be checked in order to accurately reflect the total number of SJRs awaiting completion in each division.

4.0 Learning from Mortality Reviews

4.1 Of the SJRs completed during Q4, 45 (80%), assessed the overall care to be either Good (a score of 4) or Very Good (a score of 5). This is decrease from 88% in Q3 but an increase from 78% in Q2.

4.2 No patients were assessed as having received very poor care overall but there were two findings of poor care. The first related to a surgical patient who developed a significant hypokalaemia and there was a concern this was inadequately addressed. The matter was reviewed at the time of the patient's death, and again once the SJR findings were available. Learning was identified via a local review and the division had concluded that this had not contributed to death.

4.3 The second patient experienced two inpatient falls and sustained a fractured hip. At the point of the first fall, there was a query as to whether bed rails were in use. At the time of the second fall, there was a query are to whether the patient's withdrawal from alcohol was being appropriately managed. Falls Huddles were completed at the time and the patient's care has been scrutinised via the inquest preparation process. The clinical view is that the patient died due to factors other than the fall and fracture.

4.4 The figure below shows the rating of overall care by quarter has remained largely consistent.

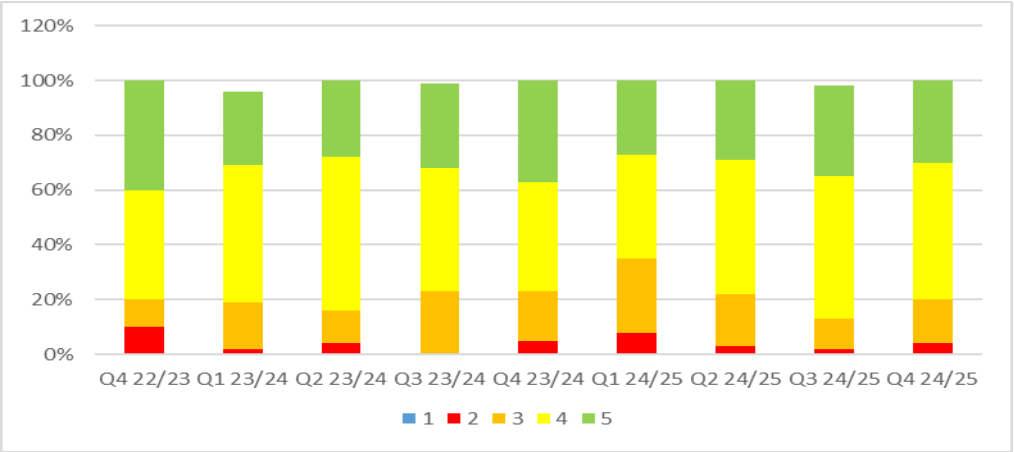


Figure 5: Score Allocated to Overall Care by Quarter

4.5 Where a rating score of 1 or 2 is given, the specialty will receive a copy of the SJR, even if the patient did not die whilst under their care, or the overall standard of the care during admission was good. This is to ensure that lessons are learnt from every element of care that appears to be substandard, even if it did not ultimately affect the outcome.

4.6 The below shows the most commonly occurring themes arising from completed SJRs. It is important to recognise that in 61% of cases, either no additional learning was identified, or it was recognised that the care delivered was of a good or excellent standard.

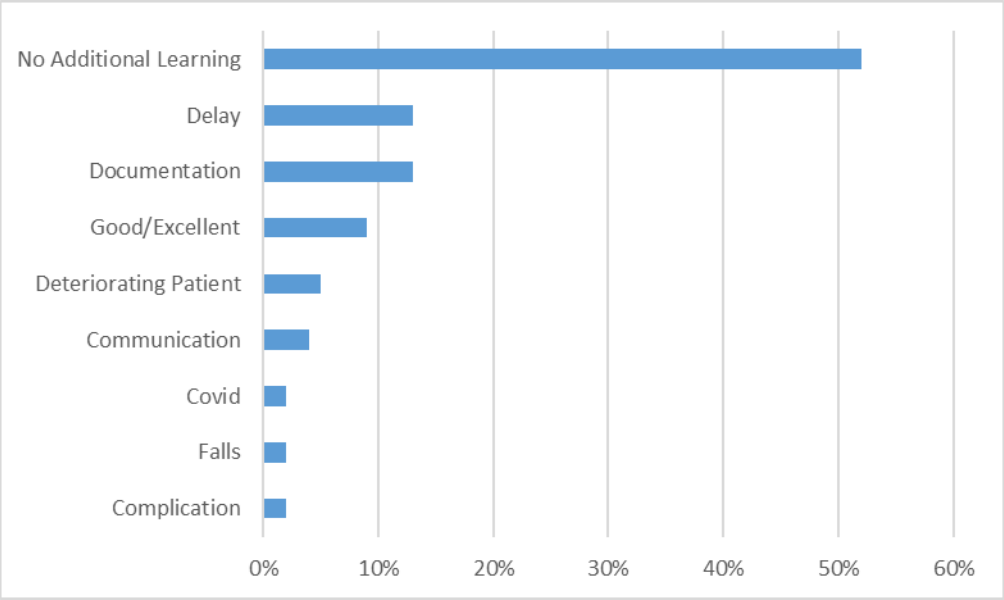


Figure 6: SJR themes

4.7 We found that 7 SJRs reference delays in the patient's treatment pathway. In 4 instances, the delay is not thought to have impacted on the patient's overall outcome. Of the remaining, one raises queries as to whether there was a delay in diagnosing the patient's cancer, 13 months prior to their death. The SJR was unable to look at this in detail as only the final admission is considered, however this was investigated through a formal complaint investigation.

4.8 The second highlights that there appears to have been a delay in acting upon advice to commence hormone treatment in relation to prostate cancer. Upon review, the delay appears to have occurred within the community.

4.9 The third relates to a delay in reporting a barium swallow which demonstrated aspiration and it not being clear the family were involved in the decision to feed at risk.

4.10 We found 7 SJRs raise concerns in relation to documentation. Four instances relate to the fact that anaesthetic charts are not available on EPR. Two instances state the records do not specify the identity of the most senior clinician on the ward round. The final SJR refers to the Medical Examiner Report not being available and the fact the patient's x-ray was not reported because the patient died prior to it being reviewed. It was commented that a radiology report would still be helpful in the context of completing an SJR.

5.0 Inquests

5.1 18 inquests were opened and five were concluded during Q4. The Trust was required to attend one in-person hearing; it was a good example of how good communication with the family can re-establish trust, even in difficult circumstances. HM Coroner was informed of improvements implemented to improve safety regarding instructions to re-starting post-op anticoagulation.

5.2 The Trust did not receive any Regulation 28 Reports.

6.0 Next Phase

6.1. Going forward, we will now shift our reporting to focus on SHMI trends rather than HSMR, as this is the benchmarked data reported on and reviewed by NHS England.

6.2 In conjunction with GWH & SFT, we will not extend our contract with Telstra to provide our data reports from September 2025.

6.3 Instead, we are working with GWH& SFT to build a single Power BI dashboard to share more timely data and insights into mortality data. GWH have already commenced this work for us to collectively build on.

6.4 Following a steer from Clinical Effectiveness Committee, we will stand up a mortality group again, to lead our mortality review work and steer this work and share timely insights and learning for discussion at clinical effectiveness group.

Report to:	**Public Board of Directors**	**Agenda item:**	**15**
Date of Meeting:	**3 September 2025**		

Title of Report:	**Children and Young People, and Maternity/Neonatal Safeguarding Annual Report**
Status:	**Approval**
Committee Sponsor:	**Antonia Lynch Chief Nursing Officer**
Author:	**Mike Menzies, Named Nurse Safeguarding Children and Young People** **Paula Lockyer, Named Midwife for Safeguarding**
Appendices	**Appendix 1: Safeguarding Children Monitoring Form**

1. Executive Summary of the Report

This report provides the Board of Directors with an overview of Safeguarding Children and Maternity Safeguarding activity in the Trust between 1 April 2024 and 31 March 2025.

The Safeguarding Children and Young People Team and the Maternity Safeguarding Team wish to highlight the following achievements to the Board:

- Development of the Maternity, Children and Adults Safeguarding Strategy underpinned by the Trust Vulnerable Peoples Strategy.
- Completion of the new Prevent training plan achieving the > 85% national compliance threshold.
- Quarterly meetings with Child and Adolescent Mental Health Service (CAMHS) participation group to ensure the voice and lived experiences of young people attending the Trust is understood to help shape our services.
  Delivery of 17 Level 3 safeguarding face to face sessions to 189 staff during 2024/25.
- Embedding of the use of the HOPE Boxes to support women and babies separated by the family courts.
- The RUH Maternity Service successfully submitted the required data for phase 2 of the Graded Care Antenatal assessment tool (GCP2A) pilot for the National Society for the Prevention of Cruelty to Children (NSPCC).
- The Named Midwife for Safeguarding has been successful in getting agreement from the Trust Information Governance (IG) and Data Protection Leads to start a pilot of the Sharing Safeguarding Information Regarding Fathers (SIRS) process in the BaNES area.
- Completion of the Annual Audit of Compliance with Safeguarding Standards for BaNES, Swindon and Wiltshire Integrated Care Board (BSW ICB) with no risks identified.

Going forward the Safeguarding Children and Young People Team and the Maternity Safeguarding Team's key priorities for 2025/26 are to:

- Publish and launch the Maternity, Children and Young People, and Adult Safeguarding Strategy, and associated 3-year delivery plan.
- Complete the pilot of the Sharing Safeguarding Information regarding Fathers' Project.

- Support the implementation of the national programme to help people who care for babies cope with crying (ICON) across the BSW area (including Maternity, Neonatal and Paediatric workforce).
- Create a data dashboard for children and young people's safeguarding, and maternity safeguarding. The dashboards will include a suite of local key performance indicators (KPI) to measure and evidence impact and outcomes.
- Re-focus on the quality assurance safeguarding walkabouts in children facing and maternity areas and align these with the BSW ICB quality assurance visit. To ensure the finding of quality assurance activity informs SMART outcome focused action plans which will be reported to the Vulnerable Persons Committee.
- Analyse the impact of learning from audit, reviews, feedback from children/young people, families/carers and partner organisations. Cross-referencing safeguarding data will allow us to assess the influence on outcome measures.

2.	**Recommendations (Note, Approve, Discuss)**
The Board of Directors is requested to approve this report.	

3.	**Legal / Regulatory Implications**

Our safeguarding activity encompasses key legislation, guidance including local and national themes and recommendations. As an NHS provider the Trust is required to comply with legislation and statutory guidance, this includes:

- The Children Act 1989
- The Children Act 2004
- Working Together to Safeguard Children 2023
- Care Quality Commission Fundamental Standard 13: Safeguarding Service Users from Abuse and Improper Treatment - Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13
- Safeguarding Children & Young People: Roles and Competences for Health Care 2019. The Intercollegiate Document.

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

The safeguarding team wish to highlight and update on the following main risks on the Risk Register:

- **Safeguarding Children Training Level 3**
  Level 3 training compliance has increased from 88.14% in Q1 to 88.20% in Q4 and 87.6% in Q1 to 90.42% in Q4 in Maternity Services only. 17 Level 3 safeguarding children and maternity sessions were delivered to 187 staff, and enough training sessions are available to sustain compliance over the 90% threshold. This has been removed from the risk register and will continue to be monitored through the safeguarding governance routes.

  The safeguarding team have focused on the implementation of additional competences at Level 3 for specialist groups outlined in the Intercollegiate Document (an increase from 8 to 12-16 hours every 3 years and initial

starters having 16 hours of training in the first year instead of 8). A proposal was presented to the Trust Management Executive in Q3, defining the processes and systems that need to be updated on the Learn Together platform. This was agreed and the safeguarding team will finalise this process in 2025/26. The risk has reduced to low.

- **Safeguarding Information Sharing (SIRS) with GPs**
  The delay in being able to share information about safeguarding and risks regarding fathers with their GPs. Once started, the risk will be removed from the risk register.

5.	Resources Implications (Financial / Staffing)
None of note.	

6.	Equality and Diversity
Legislation in relation to equality, diversity and human rights should be applied when implementing safeguarding unborn babies, children and young people procedures and processes. '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 Trust safeguarding arrangements reflect the above.	

7.	References to previous reports
Annual Safeguarding Children Report 2023/24.	

8.	Freedom of Information
Public.	

9.	Sustainability
The development of the Safeguarding Strategy aligns to the objectives and values of the Trust Strategy ensuring environmental and financial sustainability are central to safeguarding activity.	

10.	Digital
Digital capability will be a key enabler of success in delivering our Safeguarding Strategy vision and key priorities.	

Royal United Hospitals Bath
NHS Foundation Trust

Safeguarding Children and Young People, and Maternity/Neonatal Annual Report

1 April 2024 - 31 March 2025

Mike Menzies, Named Nurse Safeguarding Children and Young People
Paula Lockyer, Named Midwife Safeguarding

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1. Introduction

This report provides an overview of safeguarding unborn babies, children and young people activity undertaken within the Trust between 1 April 2024 and the 31 March 2025.

The aim of this report is to provide assurance that safeguarding unborn babies, children and young people activity:

- meets national and local safeguarding standards.
- demonstrates a model of continual improvement.
- highlights existing or potential risk in relation to statutory responsibilities.

The structure of this report incorporates all safeguarding children standards and performance indicators for key providers of health services 2023-26.

2. Governance and Commitment to Safeguarding Children and Young People

The local safeguarding partnerships are Bath and North East Somerset (BaNES) Community Safety and Safeguarding Partnership (BCSSP) and Wiltshire Safeguarding Vulnerable People's Partnership (SVPP).

The Chief Nursing Officer is the Executive Lead responsible for safeguarding within the Trust and the nominated Non-Executive Director is a safeguarding champion. The Deputy Chief Nursing Officer is the nominated deputy Lead for safeguarding children and young people. The Associate Director for Vulnerable People leads on the wider safeguarding and vulnerability agenda within the Trust. The Associate Director for Vulnerable People represents the Trust at the SVPP Senior Partners forum.

The Trust has met the statutory responsibilities to the safeguarding partnership and have representation at relevant partnership meetings, and sub-groups.

Further monitoring against the Safeguarding Children Standards and Performance Indicators for Providers of Health Services occur through the Clinical Outcomes and Quality Assurance reports that are submitted to BaNES Swindon and Wiltshire Integrated Care Board (BSW ICB) on a quarterly basis. The BSW ICB (BaNES locality) Designated Nurse for Children provides supervision and oversight to the Named Nurse for Children and Young People, and the Named Midwife for Safeguarding. The Designated Doctor for Safeguarding in BSW ICB provides quarterly supervision to the Named Doctor for Safeguarding.

Vulnerable People Committee (VPC)

There are quarterly internal Joint Safeguarding and Prevent Operational Group (JSPOG) meetings, chaired by the Named Nurse for Safeguarding Children and Young People, and the Named Professional for Safeguarding Adults. There is representation across each division and appropriate safeguarding leads attend these meetings. Key highlights and reports are taken to the Vulnerable People Committee (VPC). This is chaired by the Chief Nursing Officer and there is

representation at this meeting from the Non-Executive Director for Safeguarding, Designated Nurse for Safeguarding in BaNES Locality ICB, Associate Director for Vulnerable People, Divisional Directors of Nursing and other senior leaders across the Trust. A highlight report from VPC is presented to the Quality Assurance Committee and then to the Trust Board via the upward report.

Care Quality Commission (CQC)
The safeguarding children and maternity team continue to support ongoing work with the CQC lead for the Trust.

BSW ICB Peer Review visit
BSW ICB undertook a Quality Assurance visit to the Trust in Q4, following the RUH Safeguarding Team completing a self-assessment (mapped against CQC standards). These visits are intended to be a supportive and valuable learning opportunity for all involved and a safe collaborative environment to explore questions developed from themes identified from the organisation's own self-assessment. The audit results and action plan were presented to the Quality Assurance Committee in August 2025.

Section 11 (S11) Audit
The action plan from the 2023 S11 Audit (BCSSP) has continued with no significant risk to the Trust noted and this is reported through the Joint Safeguarding and Prevent Operational Group (JSPOG), and the VPC.

The Trust also responded to a request for statement of compliance with S11 standards in Q2 2024/25 from Wiltshire SVPP. The standards were assessed as 'mature' with no associated actions identified. This was reported through the JSPOG and VPC.

Safeguarding Children and Young People Audits
Safeguarding children and young people audits are included in the Trust Clinical Audit Programme. During the reporting period, the following audits were undertaken (for maternity specific audits see maternity report):

- Maternity audit of Women with Complex Social Factors.
- Multi-Agency Early Help Assessment Audit with BaNES Community Safety and Safeguarding Partnership.
- Maternity Spot Check Safeguarding Audit with a Focus on Domestic Abuse Routine Enquiry.
- Referral to Childrens Social Care Audit with a Focus on Children's Mental Health.

Each of the audits has an action plan defined and these are monitored and reported through the internal governance processes and ratified at the VPC.

Emergency Department Safeguarding Reviewing Processes (ED)
There are 2 safeguarding specialist nurses in the ED who review every child/young person under the age of 18 attending and continue to support the safeguarding processes, information sharing with partner agencies, training and supervision for their workforce. The number of children and young people presenting to ED has

remained at an average of 1700 per month (higher than the 1250 pre-COVID-19 levels). The use of the safeguarding screening tool remains consistent at 87%-91% for all children presenting to ED. The specialist nurses review 40% of all children within 72 hours with the rest completed within one week.

Paediatric Mental Health Working Group
The group meet quarterly to discuss and share current issues between the ED, paediatric ward, children's safeguarding team and Children and Adolescent Mental Health service partners. A highlight report is discussed at the JSPOG with key messages shared at the VPC.

Safeguarding Supervisors Network
The safeguarding team meet quarterly with named supervisors in the Trust to support consistent learning and practice development across the organisation. Updates continue to be discussed at the JSPOG and the VPC.

Lead Practitioners Network
The safeguarding team meet quarterly with the identified lead safeguarding practitioners across the Trust to share training opportunities, key messages and learning for disseminating to staff in their areas. Updates continue to be discussed at the JSPOG and the VPC.

Prevent Processes.
The Named Nurse for Safeguarding Children and Young People is the Prevent Lead for the Trust, supported by the Named Professional Adult Safeguarding, and overseen by the Associate Director for Vulnerable People. The safeguarding team have reviewed the current training needs analysis reflecting the changes to Prevent training in line with national training competences and Core Skills Training Framework. A new programme was started in Q1 2024/25 across the Trust and by Q3 the training compliance for Level 1/2 (basic awareness) and Level 3 WRAP training were above the 85% threshold in line with expected trajectory. This continues to be monitored and reported through the JSPOG and the VPC.

Emergency Department Children's Safeguarding Group
Reflecting the increasing number of children presenting to ED and the complexity of safeguarding issues, the senior paediatric and leadership staff in ED (medical and nursing) and the safeguarding team have been meeting 4-6 weekly to examine the current issues in the paediatric ED, including reviewing guidelines, sharing learning and key messages and themes. This is reported through the JSPOG and the VPC.

3. Policies, Procedures and Guidelines

During 2024/25 several policies have been written or revised to meet local and national requirements. The following policies and protocols have been written or updated within the reporting period:

- Safeguarding Children and Young People Supervision Policy
- Children and Adults Escalation policy
- Chronology Guidelines
- Discharge Processes where there are Safeguarding Concerns

- Female Genital Mutilation (FGM) Guidelines updated to include the FGM risk assessment tools.

4. Appropriate Training, Skills and Competences

Table 1 shows compliance figures for all levels of training during 2024/25 for all staff including maternity.

Subject	Compliance Requirement	Q1 2024/25	Q2 2024/25	Q3 2024/25	Q4 2024/25
Safeguarding Children Level 1	90%	92.11%	91.41%	90.81%	92.16%
Safeguarding Children Level 2	90%	91.28%	90.44%	90.23%	90.57%
Safeguarding Children Level 3	90%	88.14%	88.29%	88.86%	88.20%

Table 1: Training Compliance Figures (Including Maternity)

The current Level 3 Safeguarding Children compliance ranged from 88.14% in Q1 to 88.20% in Q4 Trust-wide. Levels 1 and 2 Children's Safeguarding training have met the 90% compliance as well. The safeguarding team continues to support training compliance with a mixture of internal and external training opportunities to sustain the compliance at 90%.

The safeguarding team have focused on the implementation of additional competences at Level 3 for specialist groups outlined in the Intercollegiate Document (an increase from 8 to 12-16 hours every 3 years and initial starters having 16 hours of training in the first year instead of 8). A proposal was presented to the Trust Management Executive in Q3, defining the processes and systems that need to be updated on the Learn Together platform. This was agreed and the safeguarding team will finalise this process in 2025/26.

The safeguarding children and maternity team delivered 17 full day, face to face sessions to 189 staff during 2024/25. Each of the sessions were evaluated, including a self-reported knowledge base pre and post session. There was a consistent increase in practitioners' knowledge and understanding across the 8 domains evaluated, before and after the training.

5. Effective Supervision and Reflective Practice

The safeguarding team provided quarterly one to one supervision with 32 identified leads across the Trust in 2024/25: 22 in Maternity and 14 across other children's facing workforce. Current compliance is:

- Children's facing leads supervision: 94.15% (14 leads)
- Maternity leads: 98,37% (22 leads)

Group supervision is embedded across the children's facing workforce with regular supervision being facilitated for the paediatric medical team, Chronic Fatigue team,

Bath Centre for Pain Services, ED nursing staff, Sexual Health staff, community maternity teams, children's therapies teams, paediatric diabetes team and paediatric ward nursing staff. Supervision is now facilitated regularly by the Named Doctor for Safeguarding Children for ED paediatric medical staff and regular monthly supervision is now embedded for Bath Birthing Centre (BBC).

The Named Nurse for Safeguarding Children and Young People and the Named Professional for Adult Safeguarding have co-facilitated 'Think Family' joint sessions with the Rheumatology team and are planning sessions with the Trust Patient Experience and Complaints team.

6. Effective Multi Agency Working

The Trust actively engages in supporting our external partners in the following:

- Domestic Abuse Multi-Agency Risk Assessment Conference (MARAC) in both BaNES and Wiltshire.
- Domestic Violence Safeguarding Partnership sub-groups.
- BaNES Operational Exploitation meeting which highlights those most vulnerable to the Trust.
- Drug and Alcohol Working Group with local partners.
- Paediatric Mental Health Group.
- CAMHS Participation Group re young peoples lived experiences to share learning across the acute hospitals.
- Safeguarding partner agency meetings in both BaNES and Wiltshire.
- Planning for Joint Targeted Area Inspections (JTAI) working group.
- Multi-Agency Sexual Health Risk Assessment Working Group.
- BSW Under 1s Assurance Group.
- BSW/BaNES and Wiltshire Safeguarding Specialist Network.
- National Named Professionals Network.
- South West Prevent Network meetings
- Wiltshire SVPP Senior Partners Forum.

7. Reporting Serious Incidents

There have been no Serious Incidents reported or investigated by the Safeguarding Children and Young People team in 2024/25.

8. Engaging in Child Safeguarding Practice Reviews (CSPRs)

Rapid Review Requests

The safeguarding children team have responded to 2 Rapid Review requests for information from BCSSP with no practice issues or learning identified related to one and no information to share in the second. The safeguarding children team also received one request from Wiltshire SVPP; no concerns related to practice in the Trust or risks were identified. (For maternity requests see maternity report.) These were reported through the JSPOG and the VPC.

9. Safer Recruitment and Retention of Staff

The Disclosure and Barring Policy has been ratified and published; the policy sets out the requirements of the Trust on checks of criminal records obtained through the Disclosure and Barring Service (DBS).

10. Managing Safeguarding Children Allegations Against Members of Staff

There have been no allegations against staff investigated or supported by the Children Safeguarding team in 2024/25.

11. Engaging Children and Young People, and their Families and Carers

Young people aged 16 plus are encouraged to complete Family and Friends' feedback independently. Specialist nurses in the diabetes team run parent evenings to engage families in sharing experiences and feedback. The safeguarding team work closely with the Patient Advisory Liaison Service within the Trust to support ongoing issues of a safeguarding nature with young people, families and carers. The CAMHS participation group share their experiences and learning with the Trust.

Feedback is considered and, as relevant, informs learning and/or development that may be required in specific areas, and practice and policy development.

12. Organisational Risks

The following risk in relation to safeguarding children and young people is on the Trust risk register, clearly defined with controls and action plans in place to reduce the risk:

- **Safeguarding Children Level 3 Training Compliance**
  There are action plans for Level 3 training, to support the Level 3 training needs in the Trust with a particular focus on the additional competences in the Intercollegiate Document increasing from 8 hours to 12-16 hours every 3 years (see Section 4 Executive Summary). The risk remains low to the Trust.

13. Achievements 2024/25

- Children's Safeguarding Strategy completed alongside 3-year plan.
- Completion of Prevent training changes and all levels have achieved the 85% threshold.
- Quarterly meetings with CAMHS Participation Group to ensure the voice of and lived experiences of young people attending the Trust is understood.
- Continued embedding of the supervision model across the Trust including joint 'think family' supervision sessions with the adult safeguarding team.
- The safeguarding children and maternity team delivered seventeen full day face to face sessions to 189 staff during 2024/25.

- Team support for BCSSP changes and ensuring attendance at relevant subgroups. Named Nurse for safeguarding children is chairing the Practice Improvement Group.
- Learning from audits, and local/national reviews has been shared through training, supervision, local policy and key message updates. Associated action plans are discussed at the VPC.
- The Safeguarding team supported the BSW Quality Assurance Peer Review visit.

14. Objectives for 2025/26

- To continue our work with CAMHS Participation Group and other platforms to ensure we capture the voice of the children and young people to help inform learning and service development.
- Attend Trauma Awareness training in the children's safeguarding team and support roll-out amongst appropriate members of the children's facing workforce.
- To ratify and share the Safeguarding Maternity, Children and Adults Safeguarding Strategy.
- To develop and embed the 3-year work plan underlying the Safeguarding Strategy using the Trust Sunray processes.
- To share the report, learning and action plans from the BSW ICB Quality Assurance Peer Review visit.
- To re-focus on the quality assurance safeguarding walkabouts in both children's facing and maternity areas and align these with the BSW ICB quality assurance visit above. To ensure the finding of quality assurance activity informs SMART outcomes focused action plans which will be reported to the VPC.
- Integrate with the Trust Audit Management and Tracking (AMaT) processes to demonstrate learning from audits and reviews.
- Develop a joined-up safeguarding dashboard with BSW ICB partners to ensure robust collection of quantitative data.
- To analyse the impact of learning from audit, reviews, feedback from children/Young people, families/carers and partner organisations. Cross-referencing with safeguarding data will allow us to assess the influence on outcome measures.

Maternity Safeguarding Annual Report 2024/25

1. Governance and Commitment to Safeguarding Children

Maternity and Neonatal Safeguarding Committee (MNSC)

These meetings are held quarterly and chaired by the Head of Midwifery and Neonates, with representation across relevant maternity and neonatal services. Key highlights and reports from this are taken to the Vulnerable People Committee (VPC), where key messages from reports, audits and policies shared at the MNSC are ratified.

The Community Lotus Team

The Lotus team continue to caseload the women with complex social factors managed by the Specialist Perinatal Mental Health Midwife and community midwifery sisters. These midwives received quarterly safeguarding 1-1 supervision from the safeguarding midwives. There is a monthly Lotus team meeting that is chaired by the Named Midwife for Safeguarding.

Perinatal Mental Health

The Named Midwife for Safeguarding continues to work closely with the Specialist Perinatal Mental Health midwife to support the ongoing development of the Perinatal Mental Health service. Two Band 6 midwives have been recruited as a 1 WTE job share to support the perinatal mental health midwife in running new community clinics for women with moderate mental health concerns. There is also a dedicated mental health service for women who have experienced birth trauma and/or loss of a baby. This is called the Ocean Service. The Ocean service will also support women who have been separated from their baby through the family court process on an individual basis.

Safeguarding Children Audits (Maternity)

Safeguarding children and maternity audits are included in the Trust Clinical Audit Programme. During the period the following audits were undertaken:

- Multi-agency Early Help Assessment Audit with BaNES Community Safety and Safeguarding Partnership
- Maternity Spot Check Safeguarding Audit with a Focus on Domestic Abuse Routine Enquiry
- Audit of Women with Complex Social Factors

Audit reports and action plans were submitted to the MNSC and VPC. These are monitored through the audit action tracker and forward plan.

2. Policies, Procedures and Guidelines

The following policies and guidelines have been written, updated or supported by the maternity safeguarding team during this period, having been ratified via the maternity and VPC governance processes:

- Guideline for Professionals Working with Pregnant Women who Misuse Substances
- Female Genital Mutilation Guidelines updated to include the FGM risk assessment tools
- One Minute Guide for Maternity Staff Supporting Pregnant Women with a Learning Disability has been updated to include women with autism and current contact details for the Learning disability teams in the hospital and community.

3. Appropriate Training, Skills and Competences

Maternity Services safeguarding mandatory training compliance is detailed in Table 1.

Subject	Compliance Requirement	Q1 2024/25	Q2 2024/25	Q3 2024/25	Q4 2024/25
Safeguarding Children Level 1	90%	92.88%	83.87%	90.91%	90.91%
Safeguarding Children Level 2	90%	92.88%	87.50 %	100%	100%
Safeguarding Children Level 3	90%	87.6%	86.87%	87.36%	90.42%

Table 1: Maternity Services mandatory training compliance

Compliance with Level 3 safeguarding children training dropped just below 90% for the first 3 quarters, but in Q4 reached the required compliance level of 90%.

In Q2 the process for reporting compliance changed with the numbers reported being just those groups that needed to complete each level. This meant there were very small numbers of staff that needed to complete Level 1 or Level 2 (5 and 2 respectively). The staff were emailed and the numbers improved to the required level.

Regular face to face Level 3 training sessions are booked in the Education Centre into 2026. These are Children's and Maternity specific.

The maternity safeguarding team continue to support the additional competences requirement as outlined in the children's report above.

The maternity safeguarding team have delivered 6 maternity specific Level 3 sessions to 80 maternity and neonatal staff in 2024/25. Each of the sessions were evaluated, including a self-reported knowledge base pre and post session. There was a consistent increase in practitioners' knowledge and understanding across the 8 domains evaluated, before and after the training.

4. Effective Supervision and Reflective Practice

Maternity compliance for the quarterly 1:1 safeguarding supervision with the 20 identified leads has been consistently above the 90% compliance target and has been achieved with the support of the whole safeguarding team.

Group supervision is now well embedded across the community maternity teams. The recruitment and retention midwives have been supporting group safeguarding supervision within the acute maternity setting by covering once a month for midwives on Mary ward to allow them to be released to attend sessions. This has, however, still been challenging as they are only able to cover for one member of staff and are often needed to cover clinical work in times of high workload. There is a plan going forward for safeguarding supervision to be included on the yearly Maternity Professional Development training day, which is mandatory for all midwives. This will commence in September 2025.

5. Multi-Agency Working

The Trust and Maternity Safeguarding team actively engages in supporting our external partners in:

- Attendance at the quarterly Best Start in Life Sub-Group in BCSSP.
- Attendance at the monthly pre-birth tracking meetings in Somerset and Wiltshire.
- Attendance at the quarterly Southwest Safeguarding Midwives Network meetings and National Maternity Safeguarding Network.
- Implementation of Sharing Information Regarding Safeguarding (SIRS) process requesting father's information at maternity booking from GPs.
- Weekly meetings with the BaNES Family Nurse Partnership lead.
- Bi-monthly liaison meetings with the Keynsham area community midwifery team who are employed by University Hospitals Bristol NHS Foundation Trust.
- Participating in the second phase of the pilot of the Graded Care Profile 2 Antenatal version (GCP2A).
- Task and finish group led by NHS England, developing a compassionate pathway for the South West area to support mothers and babies who are separated by the family court following the birth.
- BSW under 1s Assurance Group.
- Involvement in quarterly multi-agency audits of Early Help Assessments in BaNES.

6. Reporting Serious Incidents

There have been no Serious Incidents reported or investigated by the Maternity Safeguarding team children team in 2024/25.

7. Engaging in Child Safeguarding Practice Reviews (CSPR)

There have been two Rapid Review requests involving babies under the age of 1 in 2024/25. Both were in the BaNES local authority and neither met the threshold for a Child Safeguarding Practice Review (CSPR) as there were no current operational or safeguarding practice concerns identified. It was recognised that all expected processes and systems were followed from a safeguarding perspective in relation to the care of unborn babies by the RUH maternity service.

Several recommendations to improve safeguarding practice from both Rapid Reviews were agreed by the BCSSP Practice Review Group and sent out to the agencies involved in the cases. Action plans for the RUH Maternity Service were created and shared/monitored via the MNSC.

8. Organisational Risks

Not being able to share information about safeguarding regarding fathers with their GPs (SIRS) remains on the Trust risk register. This is related to challenges with information governance and data protection barriers. Multiple CSPRs have identified that a lack of safeguarding risk assessment of fathers poses a significant risk to under 1s and have recommended that Maternity services explore how to implement the SIRS process as part of their information sharing and risk assessment. A Data Protection Impact Assessment relating to the SIRS process has now been signed off by the Trust Data Protection Lead and a pilot of the process with the BaNES area Lotus team caseload is to start in Q2 2025/26. Once started, the risk will be reviewed.

Managing Safeguarding Children Allegations Against Members of Staff

There have been no allegations against maternity staff working for the Trust in 2024-25.

9. Maternity Safeguarding Achievements 2024/25

- Compliance with Routine Domestic Abuse Enquiry by midwives continues to improve.
- Embedding of the use of the HOPE Boxes to support women and babies separated by the family courts.
- The RUH Maternity Service successfully submitted the required data for phase 2 of the GCP2A pilot for the NSPCC.
- The Named Midwife for Safeguarding has made robust proposals, informed by analysis of risk, and has been successful obtaining agreement from the Trust Information Governance and Data Protection Leads to start a pilot of the SIRS process in the BaNES area.
- Level 3 safeguarding children training compliance is now above 90%.

10. Maternity Safeguarding Objectives 2025/26

- To continue to embed safeguarding supervision across maternity and neonatal services in both the community and acute settings.
- To continue to work with the IT lead midwife to improve the recording and storage of maternity safeguarding information on the new BadgerNet electronic patient record.
- To continue to attend the pre-birth tracking meetings and to support these meetings in the BaNES area so that babies on Child in Need (CiN) and Child Protection (CP) plans are effectively safeguarded.
- To continue to work with the Named GP from the BSW ICB to ensure that the Trust can implement the sharing of safeguarding information about fathers with GPs.

- To continue to attend the Graded Care Profile Meetings in Wiltshire, to support the full implementation of the GCP2A across maternity and health visiting.
- To be involved as part of the ongoing implementation of the national programme to help people who care for babies cope with crying (ICON) across the BSW area.
- To complete the Trust Safeguarding Strategy with the adult and children and young people safeguarding leads and publish and promote this once the final version is signed off via the Trust governance process.
- To elevate the Band 6 Specialist Support Midwives to Band 7 in line with other Trusts' maternity safeguarding team structure nationally and locally.
- Embed the use of the new cannabis screening tool across maternity.
- Attend trauma awareness training and roll-out across the maternity and neonatal workforce.
- Work with maternity staff around registered sex offenders and balancing risk/not being judgemental and working to individualised safety plans.
- Seek feedback from women/birthing people with complex social factors accessing maternity services at the RUH, to further develop the service provided to them.

Concluding Comments

This report has concentrated on the key safeguarding activity improvements and risks within the organisation. Whilst it has provided an opportunity to capture key activity, it is by no means a full report of achievements of the safeguarding children and young people team and others in the organisation. It is appropriate to acknowledge the achievements of the Maternity Safeguarding team, the Safeguarding Children and Young People team, the support of the Executive Lead for Safeguarding, the Associate Director for Vulnerable People, the safeguarding activities of staff and the very positive direction of travel and making a difference to patient experience and patient outcomes.

References

Intercollegiate Document*: Safeguarding Children and Young People, Roles and Competences for Health Care Staff* , London RCPCH, 2019

Working Together to Safeguard Children, London, DSCF, 2023

Appendix 1

NHS funded service Safeguarding adult and children Monitoring Form 2024-25

Effective
Well Led
Safe
Responsive
Caring

NHS Funded Service Name | **Royal United Hospitals NHS Foundation Trust**

		Quarter 1 April / May / June	Quarter 2 July / Aug / Sept	Quarter 3 Oct / Nov / Dec	Quarter 4 Jan / Feb / March	Total/ Average
Appropriate Training, Skills, and Competencies - Standard 3 - The minimum training compliance target is 90%.						
New staff joining the organisation and have received Level 1 awareness training - adults and children within 3 months	***Number***	Not collected at present	Not collected at present	Not collected at present	Not collected at present	
	Percentage	Not applicable	Not applicable	Not applicable	Not applicable	#DIV/0!
Safeguarding adult training level 1 uptake	***Number***	N/A	N/A	N/A	N/A	
	Percentage	N/A	N/A	N/A	N/A	#DIV/0!

Safeguarding adult training level 2 uptake	***Number***	N/A	N/A	N/A	N/A	
	Percentage	N/A	N/A	N/A	N/A	#DIV/0!
Safeguarding adult training level 3 uptake	***Number***	N/A	N/A	N/A	N/A	
	Percentage	N/A	N/A	N/A	N/A	#DIV/0!
Safeguarding adult training level 4 uptake	***Number***	N/A	N/A	N/A	N/A	
	Percentage	N/A	N/A	N/A	N/A	#DIV/0!
Comments on training						
Safeguarding children training level 1 uptake	***Number***	5522	1691	1729	1739	
	Percentage	92.1%	91.4%	90.8%	92.2%	91.6%
Safeguarding children training level 2 uptake	***Number***	3780	3010	2991	2957	
	Percentage	91.3%	90.4%	90.2%	90.6%	90.6%

Safeguarding children training level 3 uptake	***Number***	676	671	686	695	
	Percentage	88.1%	88.3%	88.9%	88.2%	88.4%
Safeguarding children training level 4 uptake	***Number***	3	3	3	3	
	Percentage	100.0%	100.0%	100.0%	100.0%	100.0%
Comments on training	Please use this section to add any extra information. For eg: please provide details, if able to, on the number and percentage of Safeguarding Children training update at Core and Specialist level.					
Domestic Violence/ FGM / CSE / Modern Traficking and Slavery training uptake. Not currently collected but would be obtained through Level 3 (or at earlier levels) records.	***Number***	676	671	686	695	
	Percentage	88.1%	88.3%	88.9%	88.2%	88.4%
Prevent Level 2 training uptake	***Number***	5792	4463	4473	4458	
	Percentage	96.6%	92.4%	91.7%	92.7%	93.3%
Prevent Level 3 training uptake	***Number***	3867	872	1018	1070	
	Percentage	94.3%	74.2%	86.2%	90.0%	86.2%

MCA DoLS training for all relevant staff	***Number***	N/A	N/A	N/A	N/A	
	Percentage	N/A	N/A	N/A	N/A	#DIV/0!
Effective Supervision, Reflective Practice & Case Consultation - Standard 4						
Supervision sessions received by Safeguarding Specialist Practitioner (level 3 Practitioners) Record Adult, Maternity and Children Supervision separately and by specialist group where appropriate	***Number***	**Children's = 13 Maternity = 22**	**Children's = 13 Maternity = 22**	**Children's = 11 Maternity = 20**	**Children's = 11 Maternity = 18**	
	Percentage	**Children's = 92% Maternity = 100%**	**Children's = 100% Maternity = 100%**	**Children's = 90% Maternity = 100%**	**Children's = 100% Maternity = 100%**	#DIV/0!
Safeguarding supervision received by Sexual Health Only complete if you employ Sexual Health staff	***Number***	1	1	1	1	
	Percentage	Not collected	Not collected	Not collected	Not collected	#DIV/0!
Comments on implementing this standard						
Effective Multi-Agency Working - Standard 5 - only complete if applicable; otherwise submit a nil return						
Initial Adult S42 Meetings invited to	***Number***	N/A	N/A	N/A	N/A	0
Initial Adult S42 Meetings attended	***Number***	N/A	N/A	N/A	N/A	0
	Percentage	N/A	N/A	N/A	N/A	#DIV/0!

Adult Protection reports requested by Local Authority	***Number***	N/A	N/A	N/A	N/A	0
Adult Protection reports submitted to the Local authority	***Number***	N/A	N/A	N/A	N/A	0
	Percentage	N/A	N/A	N/A	N/A	#DIV/0!
Review Meetings invited to	***Number***	N/A	N/A	N/A	N/A	0
Review Meetings attended	***Number***	N/A	N/A	N/A	N/A	0
	Percentage	N/A	N/A	N/A	N/A	#DIV/0!
Review Meeting reports requested	***Number***	N/A	N/A	N/A	N/A	0
Review Meeting reports completed / provided	***Number***	N/A	N/A	N/A	N/A	0
	Percentage	N/A	N/A	N/A	N/A	0
Safeguarding Adult referrals made using section 42(1) (a) & (b) of the Care Act 2014	***Number***	N/A	N/A	N/A	N/A	0
Comments on implementing this standard						

Complete children section if you attend any						
CP Strategy Meetings invited to all data available	***Number***	4	9	15	13	41
CP Strategy Meetings attended	***Number***	4	9	15	13	41
	Percentage	100.0%	100.0%	100.0%	100.0%	100.0%
ICPCs / RCPCs invited to	***Number***	25	31	24	26	106
ICPCs / RCPCs attended	***Number***	0	2	2	2	6
	Percentage	0.0%	6.5%	8.3%	7.7%	5.6%
ICPC / RCPC reports requested	***Number***	0	2	2	2	6
ICPC / RCPC reports submitted to the Local Authority	***Number***	0	2	2	2	6
	Percentage	0.0%	100.0%	100.0%	100.0%	75.0%
CP Core Groups Invited to	***Number***	0	2	4	3	9

CP Core Groups attended	***Number***	0	2	4	3	9
	Percentage	0.0%	100.0%	100.0%	100.0%	75.0%
Referrals to Children's Social Care or / triage or / MASH (depending on locality)	***Number***	291	247	268	324	1130
Referrals for Early Help, CAF	***Number***	0	0	0	0	0
Comments on implementing this standard						
Complete midwifery section if you attend any						
Referrals to social care for unborn infants - child protection	***Number***	55	47	42	35	179
Referrals to social care for unborn infants - Early Help	***Number***	4	0	0	2	6
Referrals to the children's social care for pregnant women under 18 years old	***Number***	0	1	0	0	1
Midwifery referrals to the Family Nurse Partnership, (by Local Authority Area)	***Number***	BaNES = 5 Wiltshire = 12 Somerset = 4	BaNES = 9 Wiltshire = 12 Somerset = 2	BaNES = 1 Wiltshire = 12 Somerset = 0	BaNES = 2 Wiltshire = 8 Somerset = 1	63
Unborn infants subject to a child protection plan	***Number***	31	31	32	32	126

Pregnant women under 18 years subject to a child protection plan	***Number***	0	0	0	0	0
CP Strategy Meetings attended	***Number***	17	11	19	14	61
ICPCs / RCPCs invited to	***Number***	24	23	24	29	100
ICPCs / RCPCs attended	***Number***	24	23	24	29	100
	Percentage	100.0%	100.0%	100.0%	100.0%	100.0%
ICPC / RCPC reports requested	***Number***	24	23	24	29	100
ICPC / RCPC reports submitted to the Local Authority	***Number***	24	23	24	29	100
	Percentage	100.0%	100.0%	100.0%	100.0%	100.0%
CP Core Groups Invited to	***Number***	48	46	53	40	187
CP Core Groups attended	***Number***	48	46	53	40	187
	Percentage	100.0%	100.0%	100.0%	100.0%	100.0%

CIN meetings invited to	***Number***	29	21	28	31	78
CIN meetings attended	***Number***	29	20	28	31	108
	Percentage	100.0%	95.2%	100.0%	100.0%	97.1%
Comments on implementing this standard						
Children not brought to appointments	***Number***	Not collected at present	Not collected at present	Not collected at present	Not collected at present	0
	Percentage	Not collected at present	Not collected at present	Not collected at present	Not collected at present	#DIV/0!
Number of adults presenting that are subject to FGM (only complete if you have actioned this)	***Number***	2	1	2	2	7

Reporting Incidents - Standard 6						
How many incidents were reported as safeguarding concerns? Report by Local Authority area	***BANES Number***	0	0	0	0	0
	SWINDON Number	0	0	0	0	0
	WILTSHIRE Number	0	0	0	0	0
	outside BSW	0	0	0	0	0
Engaging in Statutory Reviews and Multi-Agency Working - Standard 7						
Attendance at Partnership Board Meetings (only complete if you attend or are a member of any sub groups)	***Number***					0
Active SARs (under investigation) (that you are involved in)	***BANES Number***	N/A	N/A	N/A	N/A	0
	SWINDON Number	N/A	N/A	N/A	N/A	0
	WILTSHIRE Number	N/A	N/A	N/A	N/A	0
	outside BSW	N/A	N/A	N/A	N/A	0

Active CSPRs / Rapid Reviews (under investigation) (that you are involved in)	***BANES Number***	N/A	N/A	N/A	N/A	0
	SWINDON Number	N/A	N/A	N/A	N/A	0
	WILTSHIRE Number	N/A	N/A	N/A	N/A	0
	outside BSW	N/A	N/A	N/A	N/A	0
Active DHRs (under investigation) (that you are involved in) Number of cases escalated using the Partnership's escalation policy (submit nil returns if no escalation during this period)	***BANES Number***	N/A	N/A	N/A	N/A	0
	SWINDON Number	N/A	N/A	N/A	N/A	0
	WILTSHIRE Number	N/A	N/A	N/A	N/A	0
	outside BSW	N/A	N/A	N/A	N/A	0

Use of the Safeguarding Partnership Escalation Policy (submit nil returns if no escalation during this period)	***BANES Number***	0	0	0	0	0
	SWINDON Number	0	0	0	0	0
	WILTSHIRE Number	0	0	0	0	0
	outside BSW	0	0	0	0	0
Managing Safeguarding Allegations Against Staff - Standard 9 and 12						
The number of referrals made to LADO/ DOFA/ PIPOT/Prevent related reported by Local Authority area	***BANES Number***	**0**	**0**	**0**	0	0
	SWINDON Number	**0**	**0**	**0**	**0**	0
	WILTSHIRE Number	0	0	0	0	0
From the number of referrals reported above, how many triggered a section 42 (2) enquiry? Reported by Local Authority area	***BANES Number***					0
	SWINDON Number					0
	WILTSHIRE Number					0

Safeguarding Adults criteria are applied to all new category 3 and 4 pressure ulcers - Standard 14						
Pressure ulcers assessed against adult safeguarding criteria, screening tool applied & a safeguarding referral made	***BANES Number***					0
	SWINDON Number					0
	WILTSHIRE Number					0
Looked After Children (CLA)						
For those providing specific CLA Health services						
Health Assessments carried out - Initial 0-5 years old	***BANES Number***	N/A	N/A	N/A	N/A	N/A
	SWINDON Number	N/A	N/A	N/A	N/A	N/A
	WILTSHIRE Number	N/A	N/A	N/A	N/A	N/A
Health Assessments carried out - Review 0-5 years old	***BANES Number***	N/A	N/A	N/A	N/A	N/A
	SWINDON Number	N/A	N/A	N/A	N/A	N/A
	WILTSHIRE Number	N/A	N/A	N/A	N/A	N/A

Health Assessments carried out - Initial 5+ years old	***BANES Number***	N/A	N/A	N/A	N/A	N/A
	SWINDON Number	N/A	N/A	N/A	N/A	N/A
	WILTSHIRE Number	N/A	N/A	N/A	N/A	N/A
Health Assessments carried out - Review 5+ years old	***BANES Number***	N/A	N/A	N/A	N/A	N/A
	SWINDON Number	N/A	N/A	N/A	N/A	N/A
	WILTSHIRE Number	N/A	N/A	N/A	N/A	N/A
Initial Health Assessments - Total to be completed	***Number***	N/A	N/A	N/A	N/A	N/A
Initial Health Assessments completed within 28 days of going into care	***Number***	N/A	N/A	N/A	N/A	N/A
Initial Health Assessments completed within 28 days of notification	***Number***	N/A	N/A	N/A	N/A	N/A
Initial Health Assessment Appointments offered within 28 days of notification	***Number***	N/A	N/A	N/A	N/A	N/A
Number of those children who have declined assessment/ where not brought	***Number***	N/A	N/A	N/A	N/A	N/A
Onward referrals for health services	***Number***	N/A	N/A	N/A	N/A	N/A

Annually provide a breakdown of servces referred onto i.e., CAMHS, Smoking cessation, SALT, other	***CAMHS Number***	N/A	N/A	N/A	N/A	N/A
	Smoking cessation Number	N/A	N/A	N/A	N/A	N/A
	SALT Number	N/A	N/A	N/A	N/A	N/A
	Other Number	N/A	N/A	N/A	N/A	N/A
Total CLA open to service	***BANES Number***	N/A	N/A	N/A	N/A	N/A
	SWINDON Number	N/A	N/A	N/A	N/A	N/A
	WILTSHIRE Number	N/A	N/A	N/A	N/A	N/A
CLA: Out of Area with overdue Assessments	***IHAS Number***	N/A	N/A	N/A	N/A	N/A
	RHAS Number	N/A	N/A	N/A	N/A	N/A
Adoption Medicals- Initial	***Number***	N/A	N/A	N/A	N/A	N/A
Adoption Medicals- Follow up/update	***Number***	N/A	N/A	N/A	N/A	N/A
Requests for Initial Health Assessments from other areas for children placed in Local Authority area.	***Number***	N/A	N/A	N/A	N/A	N/A
Requests for Review Health Assessments from other areas for children placed in Local Authority area: 0-5 years	***Number***	N/A	N/A	N/A	N/A	N/A

All other Provider Services who have contact with Children		N/A	N/A	N/A	N/A	N/A
Identified CLA referrals to your service	***Number***	N/A	N/A	N/A	N/A	N/A
Number of CLA accepted into your service	***Number***	N/A	N/A	N/A	N/A	N/A
Number of those who Decline/ Where not brought	***Number***	N/A	N/A	N/A	N/A	N/A
Feedback from CLA users and their carers to your service	***Number***	N/A	N/A	N/A	N/A	N/A

Report to:	Public Board of Directors	Agenda item:	16
Date of Meeting:	3 September 2025		

Title of Report:	Safeguarding Adults Annual Report
Status:	Approval
Committee Sponsor:	Antonia Lynch Chief Nursing Officer
Author:	Rachel Burns, Named Professional Adult Safeguarding
Appendices	Appendix 1: Safeguarding Adults Monitoring Form

1. Executive Summary of the Report

This report provides an overview of Adult Safeguarding activity in the Trust between 1 April 2024 and 31 March 2025.

The Safeguarding Adult Team wish to highlight the following achievements to the Committee:

- Independent Domestic Abuse and Sexual Violence Advisor (IDSVA) started in the Trust in December 2024.
  The post holder is raising the profile of the Trust IDSVA service and ensuring all staff know how to refer accurately into the service and increasing signposting across the Trust for community Domestic Abuse/Sexual Violence services for staff and patients.
- Development of the Maternity, Children and Adults Safeguarding Strategy unpinned by the Trust Vulnerable Peoples Strategy.
- The Safeguarding Adult Team delivered 25 full day, Level 3 safeguarding face-to-face sessions to 539 staff during 2024/25. We remain on trajectory to reach 90% compliance in the Autumn.
- Reduction of Hospital Acquired Pressure Ulcers that meet the criteria for safeguarding.
- Completion of the Annual Audit of Compliance with Safeguarding Standards for BaNES, Swindon and Wiltshire Integrated Care Board (BSW ICB) with no risks identified.

The Safeguarding Adult Team will be focusing on the following areas in 2025/26:

- To ratify, publish, launch and embed the Safeguarding Maternity, Children and Adult Safeguarding Strategy and associated 3-year delivery plan.
- Quarterly review, audit and quality assurance of adult safeguarding practices.
- Patient involvement and the principles of Making Safeguarding Personal (MSP) embedded in safeguarding activities.
- Introduce and embed adult safeguarding supervision across relevant areas of the Trust.
- Continual promotion of safer culture, maintain and foster open communication about safeguarding concerns and promote continuous improvement in safeguarding practices.

2. Recommendations (Note, Approve, Discuss)

Approve.

3.	Legal / Regulatory Implications

Our safeguarding activity encompasses key legislation, guidance including local and national themes and recommendations. As a NHS provider the Trust is required to comply with legislation and statutory guidance, this includes:

- Care Quality Commission, Fundamental Standard 13, Safeguarding Service users from abuse and improper treatment - Health and Social Care Act (2008) (Regulated activities)
- Mental Capacity Act 2005 including Deprivation of Liberty Safeguards 2007.
- The Care Act 2014
- Serious Crimes Act 2015 (Controlling and coercive behaviour)
- Counter Terrorism and Borders Act 2019 (Prevent)
- Modern Slavery Act (2015)
- Criminal Justice and Courts Act (2015)
- Victims and Prisoners Act 2024
- Clinical Commissioning Groups Quality Schedule 2021-2022

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

The safeguarding team wish to highlight and update on the following risk on the Risk Register:

- **Delivery of Safeguarding Adult Training Level 3**

  The roll out of the new programme in April 2024 resulted in a significant increase of staff numbers required to complete Level 3 mandatory training. This dramatically dropped compliance rates.

  This is noted as a low risk as compliance of core staff had been reached and the new changes will be further strengthening and embedding safeguarding to a wider audience.

  This risk with be reviewed against compliance rates.

5.	Resources Implications (Financial / staffing)

The number of staff now required to complete Level 3 Adult Safeguarding has significantly increased. It is a full day training and no backfill available to release staff to complete.

6.	Equality and Diversity

The Trust safeguarding arrangements reflect the ethnic, social, religious and sexual diversity of patients and families.

Legislation in relation to equality, diversity and human rights should be applied when implementing safeguarding adults' procedures and processes. '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).

7.	References to previous reports

Annual Safeguarding Adult Report 2023/24.

8.	Freedom of Information
Public.	

9.	Sustainability
The development of the Safeguarding Strategy aligns to the objectives and values of the Trust Strategy ensuring environmental and financial sustainability are central.	

10.	Digital
Digital capability will be a key enabler of success in delivering our Safeguarding Strategy vision and key priorities.	

Adult Safeguarding Annual Report

1 April 2024 – 31 March 2025

Rachel Burns
Named Professional Adult Safeguarding

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1. Introduction

This report highlights the work undertaken by the Royal United Hospitals Bath NHS Foundation Trust (RUH) in respect to its commitment and responsibilities in maintaining the safety and protection of adults at risk of abuse and neglect.

The RUH is required under statute and regulation to have effective arrangements in place to safeguard and promote the welfare of adults at risk of harm and abuse in every service that they deliver.

This report covers the period from 1 April 2024 to 31 March 2025 and provides assurance that systems are in place to ensure that patients using Trust services are effectively protected, and that staff are supported to respond appropriately where safeguarding concerns arise.

2. Governance Arrangements

The Bath and Northeast Somerset (B&NES) Community Safety and Safeguarding Partnership (BCSSP) and Wiltshire Safeguarding Vulnerable People Partnership (SVPP) are the key statutory mechanisms for agreeing how relevant organisations in each local area will cooperate to promote the welfare of adults at risk and safeguard them from the risk of being abused. Senior representation is held at relevant subgroups for both partnerships.

The Chief Nursing Officer is the Executive Lead for safeguarding and has responsibility to ensure that the Trust contribution towards safeguarding is discharged effectively throughout the organisation.

We have a nominated Non-Executive Director on the Board who is a safeguarding champion.

The Trust has an Associate Director for Vulnerable People who leads on the wider safeguarding and vulnerability agenda within the Trust.

The BANES, Swindon and Wiltshire Integrated Care Board (BSW ICB) Designated Nurse for Adults (BANES locality) provides supervision oversight to the Lead Professional Adult Safeguarding and has standing invitations to the safeguarding committee ensuring oversight of the Trust's safeguarding work.

2.1 Vulnerable People Committee (VPC)

Clinical Outcomes and Quality Assurance reports are produced quarterly and submitted to BaNES, Swindon and Wiltshire Integrated Care Board (BSW ICB). These reports monitor adult safeguarding activity against the Quality Schedule Key Performance Indicators. Performance and key messages are reported to VPC quarterly.

The Joint Operational Adult and Children's Safeguarding Prevent Group meet quarterly and seek assurance that all safeguarding commitments and responsibilities for adults and children are met. It oversees the work of the Safeguarding Team and safeguarding activity across the Trust and seeks assurance that there are suitable processes in

place to ensure that safeguarding arrangements are reviewed and updated on a regular basis. This group reports to VPC.

VPC is the focal point of Safeguarding governance and assurance and is chaired by the Chief Nursing Officer. The purpose of this is to provide a Trust overview of the safeguarding systems and processes and ensure that this agenda remains core to the Trust's values and that the Trust remains compliant with all statutory and regulatory requirements. Summary highlights are reported to the Quality Assurance Committee and Trust Board.

2.2 Care Quality Commission (CQC)

Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect, as well as promoting good practice for responding to concerns and partnership working.

The Care Quality Commission (CQC) role is to monitor, inspect and regulate services to make sure they meet the fundamental standards of quality and safety.

The Adult Safeguarding Team provide updates to CQC through the RUH engagement sessions.

3. Learning Development and Training

The Adult Safeguarding: Roles and Competencies for Health Care Staff Second Edition (2024) was published on 29th July 2024.

All Adult Safeguarding training is aligned to this document, training is provided by eLearning (Level 1 and Level 2), and Level 3 is a full day classroom-based training. The Level of training is commensurate to your role and required competencies.

All training outline key principles, roles, and competencies necessary for identifying, preventing, and responding to adult abuse and neglect.

Adult Safeguarding training ensures healthcare staff have the appropriate knowledge and skills to safeguard vulnerable adults.

Table 2: Mandatory Training Compliance 2024-25

Subject	Target Compliance %	Q1 %	Q2 %	Q3 %	Q4 %
Level 1 Adult Safeguarding	90%	92.93%	91.58%	91.28%	92.65%
Level 2 Adult Safeguarding	90%	92.08%	91.08%	90.39%	90.80%
Level 3 Adult Safeguarding	90%	37.97%	52.41%	71.58%	79.38%
Prevent awareness	90%	96.61%	92.36%	91.68%	92.53%
Prevent WRAP 3	85%	94.27%	74.15%	86.20%	89.99%

Training evaluations are demonstrating that staff feel more confident on how to raise safeguarding concerns and the importance of culture 'the way we think and do things' has a huge part to play in whether all people are safe.

An acute hospital that encourages open conversations about safeguarding, and where suspected or alleged abuse and neglect can be readily reported, will be well placed to prevent incidents and respond effectively.

4. Supervision and Reflective Practice

All staff have access to informal support and advice from the adult safeguarding team. This is commonly accessed by phone, email and face to face within wards and departments. Advice focuses on assessment of safeguarding risk supporting referral processes as well as reviewing care options in response to safeguarding risk.

The adult safeguarding team have line management supervision meetings to share learning and concerns around complex cases.

The Associate Director for Vulnerable People provides monthly and ad hoc supervision for the Named Professional for Adult Safeguarding.

The Named Professional Adult Safeguarding Lead provides supervision to the Director of Nursing at the Sulis Hospital.

5. Polices and Guidance

The policies are all up to date and reviewed at least 3 yearly or when there are changes in legislation.

The Adult Safeguarding Policy also refers to the SVPP or BCSSP policy and procedure guidance.

6. Safeguarding Activity

6.1 Harm Events

The Safeguarding Adults team received a total 1013 referrals from clinical services across the Trust in 2024/25. This is an increase of 8% from last year.

Staff are being professionally curious and whilst many referrals do not meet the criteria for formal safeguarding, it enables the team to review through a safeguarding lens and respond and signpost appropriately.

Activity	Q1	Q2	Q3	Q4	TOTAL
Advice	12	12	16	23	63
Complaint	0	0	0	0	0
Discriminatory	0	0	1	0	0
Domestic Abuse	58	61	52	92	263
Financial	14	12	15	10	51
Honour-based Violence	0	0	0	0	0

Activity	Q1	Q2	Q3	Q4	TOTAL
Modern Slavery	3	2	1	1	7
Neglect	32	32	45	32	141
Organisational	4	1	3	2	10
Physical	9	16	17	9	51
Prevent	0	0	0	0	0
Psychological	7	7	13	5	32
Public Protection	0	0	0	0	0
Self-Neglect	93	75	104	109	381
Sexual	2	3	3	5	13
TOTAL	**234**	**221**	**270**	**288**	**1013**

Self-neglect, domestic abuse and neglect continue to form the highest percentage of referrals made.

An ongoing theme identified in relation to the categories in the above table is the high degree of complexity and risk which involves multiple agencies and the time taken by the team to scrutinise and assess each concern.

Allegations against the Trust
Section 42 of The Care Act (2014) establishes the process of local authority led Safeguarding Adults Enquiry, which may be in relation to concerns about abuse or neglect within a health or care setting.

The Trust received 96 allegations (compared to 84 in 2023/2024). These concerns were raised about care services delivered by the RUH. The Adult Safeguarding team works closely with B&NES Local Authority to ensure that we respond effectively to identify areas that need further investigation.

To this end, regular face-to-face meetings take place to review progress on all such reports with the local authority.

Of the 96 allegations: 54 were referred to B&NES Local Authority (The Care Act 2014)

A central part of the review process for these cases is to ensure transparency and consistency between any Trust Governance processes and to avoid duplication and possible miscommunication when managing parallel processes. For example, if a case has been raised involving pressure related skin damage, it is important that the response undertaken within the Datix incident management process is clearly integrated into any Section 42 Enquiry.

In relation to the allegations which did not meet the threshold for further safeguarding enquiries, it was considered that the actions and learning already implemented by the Trust following initial internal investigations was appropriate and no further investigations were required.

7. Key Risks and themes arising from allegations

7.1 Discharge Related Concerns

- Individual discharged too early (before medically optimised).
- Lack of involvement and engagement of relevant others (i.e. professionals, care providers, family and friends)
- Failure to consider and apply MCA and appropriate Best Interests (with a specific focus on self-neglect)
- Poor sharing of information (including failure to provide appropriate documentation
- Failure to supply correct prescription and medication
- Inaccurate and/or delayed discharge summaries.

How have these been addressed?

To further address allegations and themes around Discharges, the safeguarding team will be involved in Home is Best strategy. A standing agenda item for the Community Subgroup is 'Safeguarding'. The Lead Professional for Safeguarding Adults will sit on the subgroup and will provide a summary of key themes in relation to allegations against the Trust around discharge. The group will examine the themes and issues to ensure robust analysis of risk and action required. The group will identify learning and ensure oversight of embedding learning into practice through the relevant governance structures, including the Safeguarding Joint Operational Group.

8. Effective Multi Agency Working

The overarching purpose of the Safeguarding Partnerships is to ensure that adults with care and support needs are safeguarded from abuse and neglect.

As part of the Trust's adult safeguarding responsibilities, we participate in multi-agency reviews and have Trust representation on the Safeguarding Partnerships subgroups as below:

- Domestic Abuse Multi-Agency Risk Assessment Conference (MARAC) in both BaNES and Wiltshire
- Member of Safeguarding Vulnerable People Partnership (SVPP) Domestic Abuse Local Partnership Board
- Member of BaNES Operational Exploitation Meeting
- Safeguarding partner agency meetings in both BaNES and Wiltshire.
- National Named Professionals Network.
- Southwest Prevent Network Meetings.
- Community in Practice Mental Capacity Forum
- SVPP Senior Partners Forum

9. Statutory Reviews

All NHS organisations that are asked to participate in a statutory review must do so.

Statutory reviews are processes for learning and improvement and all health providers are required to provide and share information relevant to any statutory

review process. Safeguarding Adult Reviews (SAR) and Domestic Abuse Related Death Reviews (DARDRs) formerly known as Domestic Homicide Reviews (DHR) form an essential part of the multi-agency partnerships safeguarding strategies

The extent of RUH involvement in the statutory review process will depend on the Trust's involvement in the case. This most commonly includes providing a comprehensive chronology and practitioners involved in the case participate in practice review workshops. A representative for the Trust will also be a member of the oversight panel for the review.

Learning from local and national enquiries, SAR and DARDRs, alongside case learning reviews is incorporated into training.

9.1 Safeguarding Adult Reviews (SARs)

During 2024-2025 the adult safeguarding team has completed Agency Involvement Summaries and Chronologies for 10 notifications for consideration of Safeguarding Adult Reviews (SARs), 1 for BaNES Community Safety and Safeguarding Partnership (BCSSP) and 8 for Wiltshire Safeguarding Vulnerable People Partnership (SVPP) ad 1 for South Gloucestershire.

9.2 Domestic Abuse Related Death Reviews (DARDRs) formerly known as Domestic Homicide Reviews (DHRs)

Domestic Homicide Reviews (DHRs) have been renamed to Domestic Abuse Related Death Reviews (DARDRs). This change reflects a broader scope of review to include deaths from domestic abuse, including suspected suicides, not just homicides. The name change was confirmed in the Victims and Prisoners Act 2024.

The team is currently part of the panel for 1 DARDR in BANES and 1 DARDR in Wiltshire.

10. Applications for Deprivation of Liberty Safeguards (DoLS)

Local authorities, as supervisory bodies, continue to hold overarching responsibility for DoLS authorisations. Therefore, they continue to hold most of the legal risk. The RUH, as a managing authority, should be mindful of ensuring compliance with the Human Rights Act (1998) as a key component of these safeguards. Although managing authorities cannot lawfully authorise a deprivation of liberty, they are not exempt from legal challenge if the Mental Capacity Act (2005), and particularly its interaction with the Human Rights Act, is not applied appropriately during a patient's stay in hospital.

There were 997 DoLS applications made during the year (2024/2025), an increase of 24 applications from the previous year (2023/2024).

The number of Standard DoLS authorisations continues to be very low. This reflects the adoption of the 'SWADASS prioritisation tool' amongst local authorities which assigns a lower priority to most people in hospital who are considered deprived of their liberty. A lower priority for allocation is reflective of the relatively short time that patients stay in hospital in comparison to those people who reside in care homes and local authorities assigning their limited resources accordingly.

11. Safer Recruitment

The Disclosure and Barring Policy is published. The policy sets out the requirements of the Trust to check for criminal records obtained through the Disclosure and Barring Service (DBS).

12. Organisational Risks

The following risk in relation to safeguarding adults training is on the Trust Risk Register, with clear trajectories. The current risk level is low.

Safeguarding Adult Level 3 Training Compliance dropped to 30% in April 2024. The key staff initially identified are compliant, widening the audience will only strengthen and further embed Adult Safeguarding. Trajectories indicate we will reach 90% compliance in the Autumn (2025).

13. Achievements 2024-2025

- Independent Domestic Abuse and Sexual Violence Advisor (IDSVA) started in the Trust on Monday 2nd December 2024.
  The post holder is raising the profile of the Trust's IDSVA service and ensuring all staff know how to refer accurately into the service and increasing signposting across the Trust for community Domestic Abuse/Sexual Violence services for both staff and patients.
- Development of the Maternity, Children and Adults Safeguarding Strategy unpinned by the Trust Vulnerable Peoples Strategy.
- The safeguarding adult team delivered 25 full day Level 3 safeguarding face to face sessions to 539 staff during 2024/25. We remain on trajectory to have reached 90% compliance in the Autumn.
- Reduction of Hospital Acquired Pressure Ulcers that meet the criteria for safeguarding.
- Continue to align the adult and child agenda to focus on the 'Think Family' agenda.
- Reestablished representation and participation in BANES and Wiltshire Multi Agency Risk Assessment Conference (MARAC)
- Representation for the Trust on the BaNES Community Safety and Safeguarding Partnership Quality and Performance subgroup.
- Representation of the Trust on the Wiltshire SVPP Senior Partners Forum

14. Safeguarding Priorities for 2025–2026

- To develop an Adult Safeguarding Supervision Policy and an action plan in relation to the delivery of supervision for adult facing care provision within the Trust.
- Explore the introduction of Safeguarding Adults Champions to help to share learning and embed safeguarding principles.
- Achieve level 3 adult safeguarding and Prevent training compliance.
- Continue to develop quality assurance mechanism through thematic auditing to ensure assurance of the effectiveness of safeguarding activity and that practice is continuously improving patient experience and outcomes.

- To address allegations and themes around Discharges, the safeguarding team will be involved in Home is Best. A standing agenda item for the Community Subgroup is 'Safeguarding'. The Lead Professional for Safeguarding Adults will sit on the subgroup. She will provide a summary of key themes in relation to allegations against the Trust around discharge. The group will examine the themes and issues to ensure robust analysis of risk and action required. The group will identify learning and ensure oversight of embedding learning into practice through the relevant governance structures, including the Safeguarding Joint Operational Group**.**
- The dedicated role of Professional Lead for MCA/DoLS has been appointed and starting in June 2025. Part of their role will be to support improvements in compliance with CQC Regulation 13 (5) across inpatient services. As such, we should expect the number of DoLS applications made to local authorities to rise in subsequent quarters as the new role becomes more embedded (which would be a positive improvement). The Professional Lead for MCA/DoLS will provide separate regular assurance reports associated with their role to Vulnerable People Committee (VPC) once key metrics and priorities have been established**.**
- IDSVA role to build professional connection with MARACs, community DA services and other relevant outside agencies (including BCSSP and DALPB).
- Embedding role of Named Medic for Safeguarding Adults

15. Concluding Comments

The Adult Safeguarding Team are committed to ensuring that the Trust effectively executes its duties and responsibilities in adult safeguarding. The Team adopts a whole systems approach to its work with community partners as well as those within the Trust, to ensure that a multi perspective 'Think Family' approach is adopted.

This report demonstrates safe and effective practice in relation to our statutory and regulatory agenda, with good compliance to internal and external safeguarding standards. The team will continue to build on existing work to ensure Trust culture around safeguarding processes are robust and effective and remain aligned with core Trust values.

References: *Adult Safeguarding: Roles and Competencies for Health Care Staff* London RCPCH, *Second edition: July 2024*

Appendix 1

Effective

Well Led

Safe

Responsive

Caring

Safeguarding Adults Monitoring Form 2024-2025

NHS Funded Service Name | **Royal United Hospitals Bath NHS Foundation Trust**

		Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total/ Average
		April / May / June	**July / Aug / Sept**	**Oct / Nov / Dec**	**Jan / Feb / March**	
Appropriate Training, Skills, and Competencies - Standard 3 - The minimum training compliance target is 90%.						
New staff joining the organisation and have received Level 1 awareness training - adults and children within 3 months	***Number***	Not collected at present	Not collected at present	Not collected at present	Not collected at present	
	Percentage	Not collected at present	Not collected at present	Not collected at present	Not collected at present	Not collected at present

Safeguarding adult training level 1 uptake	***Number***	5571	1729	1768	1764	
	Percentage	92.93%	91.58%	91.28%	92.65%	92.11%
Safeguarding adult training level 2 uptake	***Number***	3769	3064	3056	3048	
	Percentage	92.08%	91.08%	90.39%	90.80%	91.09%
Safeguarding adult training level 3 uptake	***Number***	243	359	481	539	
	Percentage	37.97%	52.41%	71.58%	79.38%	60.34%
Safeguarding adult training level 4 uptake	***Number***	1	1	1	1	
	Percentage	100%	100%	100%	100%	100%
Comments on training						
Safeguarding children training level 1 uptake	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	

	Percentage	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	
Safeguarding children training level 2 uptake	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	
	Percentage	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	
Safeguarding children training level 3 uptake	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	
	Percentage	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	
Safeguarding children training level 4 uptake	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	
	Percentage	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	
Comments on training	Please use this section to add any extra information. For eg: please provide details, if able to, on the number and percentage of Safeguarding Children training update at Core and Specialist level.					

Domestic Violence/ FGM / CSE / Modern Trafficking **and Slavery training uptake. Not currently collected but would be obtained through Level 3 (or at earlier levels) records.**	***Number***	243	359	481	539	
	Percentage	37.97%	52.41%	71.58%	79.38%	60.34%
Prevent Level 2 training uptake	***Number***	5792	4463	4473	4458	
	Percentage	96.61%	92.36%	91.68%	92.53%	93.30%
Prevent Level 3 training uptake	***Number***	3867	872	1018	1070	
	Percentage	94.3%	74.2%	86.2%	90.0%	86.2%
MCA DoLS training for all relevant staff	***Number***	243	359	481	539	
	Percentage	37.97%	52.41%	71.58%	79.38%	60.34%
Effective Supervision, Reflective Practice & Case Consultation - Standard 4						
Supervision sessions received by Safeguarding Specialist Practitioner (level 3 Practitioners) Record Adult, Maternity and Children Supervision separately and by	***Number***	2	2	2	2	
	Percentage	100%	100%	100%	100%	

specialist group where appropriate						
Safeguarding supervision received by Sexual Health Only complete if you employ Sexual Health staff	***Number***	Not applicable	Not applicable	Not applicable	Not applicable	
	Percentage	Not applicable	Not applicable	Not applicable	Not applicable	
Comments on implementing this standard						
Effective Multi-Agency Working - Standard 5 - only complete if applicable; otherwise submit a nil return						
Initial Adult S42 Meetings invited to	***Number***	3	7	5	6	21
Initial Adult S42 Meetings attended	***Number***	3	7	5	6	21
	Percentage	100%	100%	100%	100%	100%
Adult Protection reports requested by Local Authority	***Number***	Section 42 Enquiry reports 2	Section 42 Enquiry reports 0	Section 42 Enquiry reports 2	Section 42 Enquiry Reports 4	8
Adult Protection reports submitted to the Local authority	***Number***	Section 42 Enquiry reports 2	Section 42 Enquiry reports 0	Section 42 Enquiry reports 2	Section 42 Enquiry Reports 4	8

	Percentage	100%	100%	100%	100%	100%
Review Meetings invited to	***Number***	7	2	5	4	18
Review Meetings attended	***Number***	7	2	5	4	18
	Percentage	100%	100%	100%	100%	100%
Review Meeting reports requested	***Number***	7	0	5	4	16
Review Meeting reports completed / provided	***Number***	7	0	5	4	16
	Percentage	100%	100%	100%	100%	100%
Safeguarding Adult referrals made using section 42(1) (a) & (b) of the Care Act 2014	***Number***	24	17	19	9	69
Comments on implementing this standard						

CP Strategy Meetings invited to all data available	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
CP Strategy Meetings attended	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
	Percentage					
ICPCs / RCPCs invited to	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
ICPCs / RCPCs attended	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
	Percentage					
ICPC / RCPC reports requested	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
ICPC / RCPC reports submitted to the Local Authority	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
	Percentage					
CP Core Groups Invited to	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team

CP Core Groups attended	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
	Percentage					
Referrals to Children's Social Care or / triage or / MASH (depending on locality)	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
Referrals for Early Help, CAF	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
Comments on implementing this standard						
Complete midwifery section if you attend any						
Referrals to social care for unborn infants - child protection	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
Referrals to social care for unborn infants - Early Help	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
Referrals to the children's social care for pregnant women under 18 years old	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team

Midwifery referrals to the Family Nurse Partnership, (by Local Authority Area)	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
Unborn infants subject to a child protection plan	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
Pregnant women under 18 years subject to a child protection plan	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
CP Strategy Meetings attended	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
ICPCs / RCPCs invited to	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
ICPCs / RCPCs attended	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
	Percentage	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
ICPC / RCPC reports requested	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
ICPC / RCPC reports submitted to the Local Authority	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
	Percentage	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team

CP Core Groups Invited to	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
CP Core Groups attended	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
	Percentage	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
CIN meetings invited to	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
CIN meetings attended	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
	Percentage	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
Comments on implementing this standard						
Children not brought to appointments	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
	Percentage	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
Number of adults presenting that are subject to FGM (only complete if you have actioned this)	***Number***	0	0	0	0	0

Reporting Incidents - Standard 6						
How many incidents were reported as safeguarding concerns? Report by Local Authority area	***BANES Number***	4	4	3	3	14
	SWINDON Number	0	0	0	0	0
	WILTSHIRE Number	11	10	10	8	39
	outside BSW	4	3	4	0	11
Engaging in Statutory Reviews and Multi-Agency Working - Standard 7						
Attendance at Partnership Board Meetings (only complete if you attend or are a member of any subgroups)	***Number***					
Active SARs (under investigation) (that you are involved in)	***BANES Number***	3	0	0	1	4
	SWINDON Number	0	0	0	0	0
	WILTSHIRE Number	0	0	0	2	2

	outside BSW	0	0	0	0	0
Active CSPRs / Rapid Reviews (under investigation) (that you are involved in)	***BANES Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
	SWINDON Number	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
	WILTSHIRE Number	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
	outside BSW	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
Active DHRs (under investigation) (that you are involved in) Number of cases escalated using the Partnership's escalation policy (submit nil returns if no escalation during this period)	***BANES Number***	0	1	1	1	3
	SWINDON Number	0	0	0	0	0
	WILTSHIRE Number	0	0	0	0	0
	outside BSW	1	1	1	1	4

Use of the Safeguarding Partnership Escalation Policy (submit nil returns if no escalation during this period)	***BANES Number***	0	0	0	0	0
	SWINDON Number	0	0	0	0	0
	WILTSHIRE Number	0	0	0	0	0
	outside BSW	0	0	0	0	0
Managing Safeguarding Allegations Against Staff - Standard 9 and 12						
The number of referrals made to LADO/ DOFA/ PIPOT/Prevent related reported by Local Authority area	***BANES Number***	1	0	0	1	2
	SWINDON Number	0	0	0	0	0
	WILTSHIRE Number	0	0	0	0	0
From the number of referrals reported above, how many triggered a section 42 (2) enquiry? Reported by Local Authority area	***BANES Number***	1	0	0	1	2
	SWINDON Number	0	0	0	0	0

	WILTSHIRE Number	0	0	0	0	0
Safeguarding Adults criteria are applied to all new category 3 and 4 pressure ulcers - Standard 14						
Pressure ulcers assessed against adult safeguarding criteria, screening tool applied & a safeguarding referral made	***BANES Number***	0	0	0	0	0
	SWINDON Number	0	0	0	0	0
	WILTSHIRE Number	1	0	0	0	1
Looked After Children (CLA)						
For those providing specific CLA Health services						
Health Assessments carried out - Initial 0-5 years old	***BANES Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
	SWINDON Number	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
	WILTSHIRE Number	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
Health Assessments carried out - Review 0-5 years old	***BANES Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
	SWINDON Number	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team

	WILTSHIRE Number	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
Health Assessments carried out - Initial 5+ years old	***BANES Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
	SWINDON Number	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
	WILTSHIRE Number	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
Health Assessments carried out - Review 5+ years old	***BANES Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
	SWINDON Number	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
	WILTSHIRE Number	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
Initial Health Assessments - Total to be completed	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
Initial Health Assessments completed within 28 days of going into care	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
Initial Health Assessments completed within 28 days of notification	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team

Initial Health Assessment Appointments offered within 28 days of notification	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
Number of those children who have declined assessment/ where not brought	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
Onward referrals for health services	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
Annually provide a breakdown of servces referred onto i.e., CAMHS, Smoking cessation, SALT, other	***CAMHS Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
	Smoking cessation Number	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
	SALT Number	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
	Other Number	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
Total CLA open to service	***BANES Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
	SWINDON Number	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
	WILTSHIRE Number	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team

CLA: Out of Area with overdue Assessments	***IHAS Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
	RHAS Number	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
Adoption Medicals- Initial	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
Adoption Medicals- Follow up/update	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
Requests for Initial Health Assessments from other areas for children placed in Local Authority area.	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
Requests for Review Health Assessments from other areas for children placed in Local Authority area: 0-5 years	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
All other Provider Services who have contact with Children						
Identified CLA referrals to your service	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
Number of CLA accepted into your service	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team
Number of those who Decline/ Where not brought	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team

Feedback from CLA users and their carers to your service	***Number***	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team	Not reported by Adult Team

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**17**
Date of Meeting:	**3 September 2025**		

Title of Report:	**Infection, Prevention and Control (IPC) Annual Report 2024/25**
Status:	**For information and discussion**
Board Sponsor:	**Toni Lynch, Chief Nursing Officer and Director of Infection, Prevention and Control (DIPC)**
Author:	**Lisa Hocking, Deputy DIPC / Suzanne Jordan, IPC lead Nurse**
Appendices	**None**

1. Executive Summary of the Report

The Director of Infection Prevention and Control (DIPC) Annual Report includes infection prevention and control activities within the Royal United Hospitals (RUH) NHS Foundation Trust for April 2024 to March 2025. This report follows the format of the Health and Social Act, reporting on each of the 10 criteria outlined in the Act.

The IPC Board Assurance Framework was published in September 2023. This framework is aligned to the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance. The identified gaps within this framework are all identified as risks on the Trust risk register.

During 2024/25 there was one Methicillin Resistant *Staphylococcus Aureus* (MRSA) Bacteraemia against a threshold of zero tolerance. This one case was a Community-Onset Healthcare-Associated (COHA) MRSA bacteraemia.

The Trust reported 31 cases of Methicillin-sensitive Staphylococcus aureus (MSSA), of those, there were 16 Hospital-Onset, Healthcare Associated (HOHA) and 15 COHA cases in 2024/25, compared to 22 reported cases in 2023/24.

The Trust reported 100 Escherichia Coli (E.coli) Bacteraemia, against a threshold of 82. This was an increase of 10 cases from 2024/25 data. The RUH has seen an upward trend in E. coli bacteraemia infections over the last year, which has placed the Trust near the top of the benchmarking table for the South West. Hepatobiliary and urinary tract infections are the leading causative factors.

15 Pseudomonas Bacteraemia were reported against the threshold of 15. This was an increase of three cases from the previous year.

There were 14 cases of Pseudomonas aeruginosa bacteraemia reported for 2024/25 against a threshold of 14. Of these cases the gender mix is predominantly 79% male with nine different infection sources attributed.

There were 21 cases of Klebsiella bacteraemia reported against a threshold of 25. This was a reduction of four cases from 2023/2024. The Trust has benchmarked 4th best in the South West.

The Trust reported a total of 103 Clostridioides difficile (C. difficile) cases, 28 cases above the threshold of 75 cases. There were 62 Hospital Onset Healthcare Associated (HOHA) cases and 41 Community Onset Healthcare Associated cases (COHA). This equates to a 32.1% increase in cases compared to 2023/24.

United Kingdom Health and Security Agency (UKHSA) have stated that since 2021, the C. difficile infection (CDI) incidence rate has been climbing. As of 2023/24, the rate was 35% higher than in 2018/19, when the rate was at its lowest. Approximately 17,000 cases were identified in the financial year 2023/24 and cases in quarter 2 (July to September 2024) were 13% higher than the preceding quarter. UKHSA have launched a national response to further investigate the rising cases which appear to have multiple, yet unidentified causes relating to both microbiological and epidemiological factors.

Norovirus had a particularly prolonged season and appeared more virulent during 2024/25. There were six ward closures throughout the year. There were 161 lost bed days during this period, with bays being closed for a total of 52 days. In addition, there were 14 outbreaks resulting in bay closures with totalling 115 lost bed. Closures of the bays varied between two and 11 days, with an average of 8 days per bay.

COVID-19 activity was broadly stable across 2024/25, and numbers were lower than similar times for the previous year. Admissions to the Intensive Care Unit and High Dependency Unit admission rates decreased. The pressures on isolation and cohort capacity remained and impacted patient flow similarly to previous years; with 183 days of bay closures in 23/24 against 187 days closed in 24/25.

The RUH detected 729 cases of influenza (flu) for the year of 2024/25. These numbers were predominately over a three-month period, with a notable increase in children presenting this season. December 2024 saw the first rise in influenza cases, with 280 cases of influenza A and 5 cases of influenza B (37 were children). January 2025 saw a further 195 cases of Influenza A and 19 cases of Influenza B (28 were children). During February 2025 there was 127 cases of influenza A and 31 influenza B (20 cases were children).

Level 1 IPC mandatory training has maintained at 85% or above throughout the year. Compliance with infection prevention and control Level 2 training has not met the 85% target Trust wide. The compliance was impacted by bank staff compliance which has been proactively addressed during the year.

The Surgical Site Infection (SSI) surveillance categories for 2024/25 have included the following orthopaedic surgeries: Total Hip Replacement (THR), Total Knee Replacement (TKR) fractured Neck of Femur (NOF) at the RUH and THR/TKR surgeries caried out at the RUH modular theatre, sited at The Sulis Hospital. Data is submitted for colorectal which includes large and small bowel surgery.

The annual report also includes an annual summary from all Committees that report

into the Infection Prevention and Control Committee.

2.	Recommendations (Note, Approve, Discuss)
This report is for approval. This report will be published on the Trust internet page for public access as per the Health and Social Care Act 2008 requirements.	

3.	Legal / Regulatory Implications
Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance. CQC regulation.	

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)
2398: Not achieving cleanliness standards in clinical and non-clinical areas. Rated 16. 2557: Single room an ensuite capacity. Rated 14. 2558: Single room capacity and bariatric room capacity, which at present has no funding to address. Rated 16.	

5.	Resources Implications (Financial / staffing)
Nil	

6.	Equality and Diversity
NA	

7.	References to previous reports/Next steps
All data included in this report has been discussed at Infection, Prevention and Control Committee.	

8.	Freedom of Information
This report can be made public.	

9.	Sustainability
Positive impact.	

10.	Digital
NA	

Royal United Hospitals Bath
NHS Foundation Trust

Royal United Hospitals Bath Infection Prevention and Control Annual Report 2024/25

Toni Lynch, Chief Nursing Officer and Director of Infection Prevention and Control

Lisa Hocking, Deputy Director of Infection Prevention and Control, Associate Chief Nurse

Julia Vasant and Sabrina Fudge, Consultant Microbiologist and Infection Control Doctor

Suzanne Jordan, Lead Infection Prevention and Control Specialist Nurse

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Infection Prevention and Control Annual Report 2024-2025

Purpose

This report provides the Trust Board of Directors with an annual review of the mandatory reporting and activities undertaken by the Infection, Prevention and Control Team between April 2024 and March 2025. The publication of the Infection, Prevention and Control (IPC) Annual Report is a requirement to demonstrate good governance, adherence to Trust values and public accountability in line with the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infection and related guidance.

This report follows the format of the Health and Social Act, reporting on each of the 10 criteria outlined in the Act.

Infection Prevention and Control Board Assurance Framework (BAF)

The adoption and implementation of the National Infection, Prevention and Control Board Assurance Framework (2023) remains the responsibility of the organisation and all registered care providers must demonstrate compliance with the Health and Social Care Act 2008. This requires demonstration of compliance with the ten criteria outlined in the Act.

Of the fifty key lines of enquiry, there are thirteen gaps in the assurance process which have been reported as partially compliant. There are no non-compliant key lines of enquiry.

The partial compliance relates to existing identified risks which are on the risk register, which includes the identification of patients with infections, cleaning standards and the impact of an aging estate in clinical areas. A programme of planned refurbishments is in place for our wards and all maintenance projects in staff or patient areas are supported by IPC, such as the Intensive Care Unit (ICU) refurbishment (undertaken in the reporting year), which was a large-scale project for the Trust.

Background

The Director of Infection, Prevention and Control (DIPC) Annual Report includes infection prevention and control activities within the Royal United Hospitals (RUH) Bath NHS Foundation Trust from April 2024 to March 2025. The report includes the Infection, Prevention and Control (IPC) practice on the RUH Combe Park site, the NHS activity undertaken in the modular theatre and the Sulis Orthopaedic Centre (SOC), located at the Sulis Hospital Bath and any activity where services are run from community sites, such as midwifery services.

Our zero-tolerance approach ensures the Trust maintains a strict policy to prevent avoidable Healthcare Associated Infections. We prioritise infection prevention and

control, ensuring patients receive safe and effective healthcare when using RUH services. Consistent application of high-quality IPC practice protects everyone who uses the healthcare services effectively. Clinical staff members are trained annually to uphold an elevated level of infection prevention and control.

This report highlights the hard work and dedication of all staff, clinical and non-clinical, in improving the quality of patient care. Through open communication and collaboration, infection prevention and control measures effectively reduce risks for patients and stakeholders across the Trust and associated healthcare services. The Trust continues to work collaboratively with several stakeholders as part of the IPC governance arrangements including:

- NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (ICB)
- NHS Bath and North East Somerset Public Health team
- South West UK Health and Security Agency (UKHSA)
- South West NHSE IPC team

The Infection Prevention and Control Committee (IPCC) meets monthly and is chaired by the Chief Nursing Officer and Director of Infection Prevention and Control (DIPC). The IPCC reports to the Trust Quality and Safety Group (TQSG) monthly and then the Quality Assurance Committee (QAC) quarterly.

Committees and services reporting to the IPCC are:

- Antimicrobial Stewardship (AMS)
- Clinical Divisions
- Decontamination Committee
- Estates and Facilities
- Occupational Health & Wellbeing (OHWB)
- Soft Facilities Management
- Surgical Site Infection Surveillance

Criterion 1

Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.

Infection Prevention and Control Staffing

To ensure a safe service is delivered, we foster a strong collaborative working relationship among all teams within the Trust, including the Clinical Site Team, Ward leaders, Microbiology Laboratory services, the Estates and Facilities team, Health and Safety Team, Procurement, Occupational Health and Wellbeing and the Communications Team.

Figure 1 shows the organisational chart for the prevention of as of March 2025.

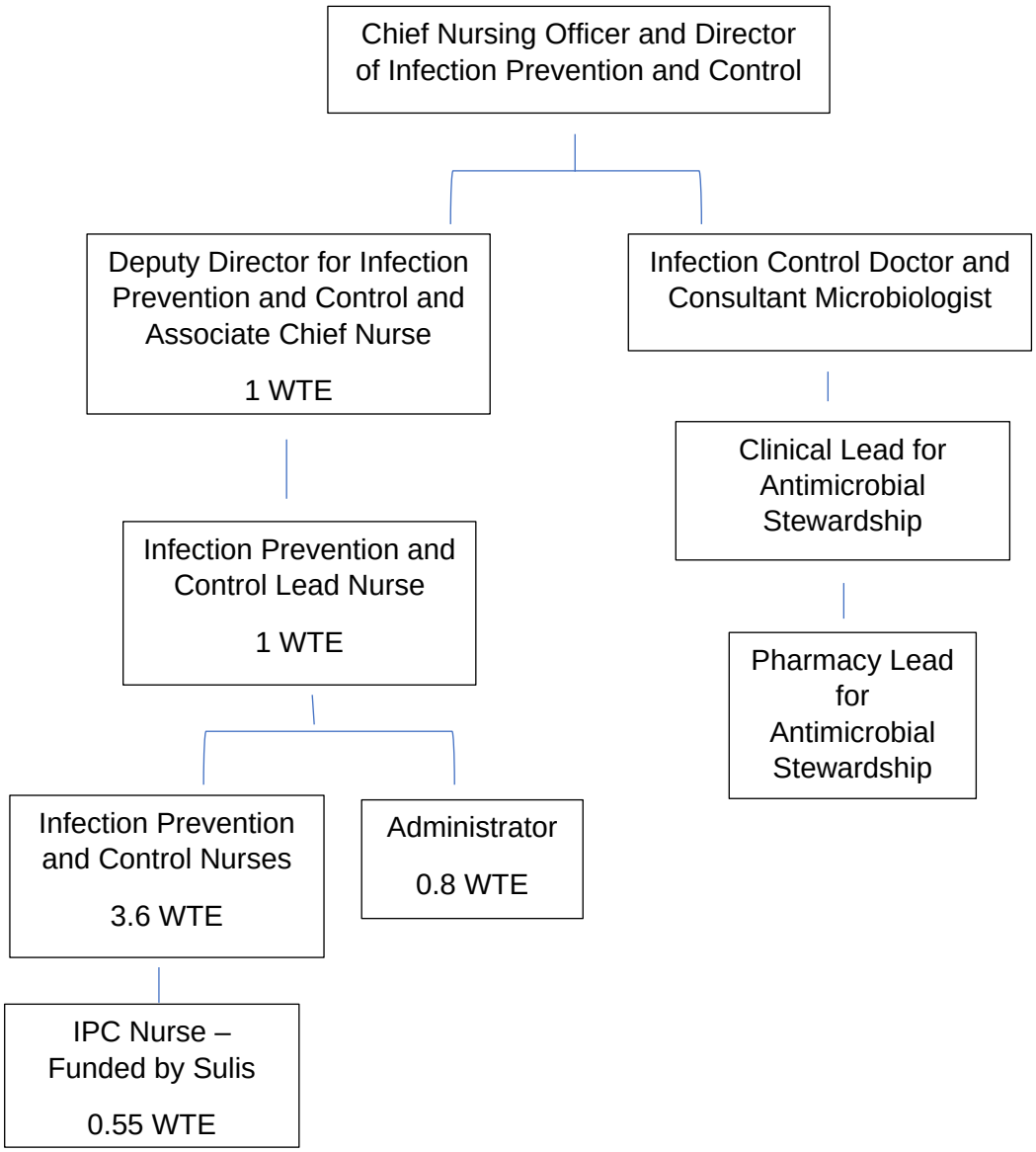

Figure 1: Organisational Structure of Infection Prevention Service

Organisms subject to mandatory reporting

The RUH is required to report to UKHSA on the following organisms:

- Methicillin-resistant Staphylococcus aureus (MRSA) bloodstream infections
- Methicillin-sensitive Staphylococcus aureus (MSSA) bloodstream infections
- Gram negative bloodstream infections - *E. coli*, Klebsiella *spp*. and Pseudomonas Aeruginosa
- Clostridioides difficile (*C. difficile*)

Bacteraemia Trust exposure categories (2020)

The two categories of reporting cover:

Hospital-Onset, Healthcare Associated (HOHA) Any NHS patient specimens taken on the third day of admission onwards (i.e., ≥ day 3 when day of admission is day 1) at an acute trust.

Community-Onset Healthcare-Associated (COHA)
Any case reported by an NHS acute trust not determined to be Hospital-Onset Healthcare Associated and where the patient was discharged within 28 days prior to the current specimen date (where date of discharge is day 1)

Reporting and Investigation

The IPC team reports all HOHA and COHA cases of Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia and Clostridioides difficile (C. *difficile*) onto the Trust incident reporting system Datix. Upon the identification of cases the incident report is the responsibility of the division in collaboration with the IPC team. Divisions report by exception to IPCC with any learning and improvement plans. The Patient Safety Incident Response Framework (PSIRF) principles were adopted during 2024, which is now being used to help identify any themes and trends.

Methicillin-resistant Staphylococcus aureus (MRSA)

There was 1 COHA case of a MRSA bacteraemia during the reporting period of 2024-25. The patient was suffering from multiple-comorbidities and had been admitted previously to the Trust in the last 28 days. The case has undergone a patient safety investigation, and the divisional teams have met to review the case along with the outcomes and the learning from the event. There were no lapses in care identified and screening protocols were adhered to as the patient did not meet the criteria on their previous admission and there was no previous history of MRSA. There was no new learning from this single case to change practice.

Figure 2. shows the MRSA bacteraemia rates for the South West Trusts alongside the National rates per 100,000 bed days. The reported case at RUH is the first since June 2023.

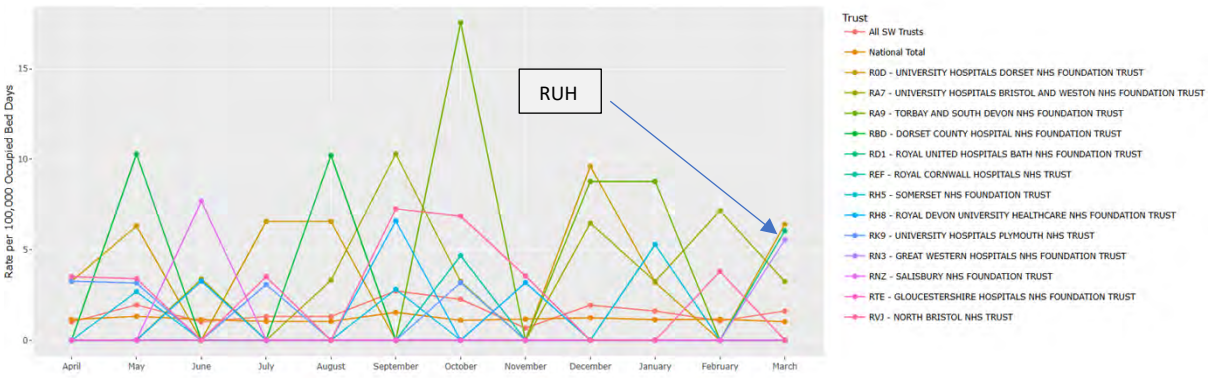

Figure 2: UKHSA MRSA data plot 100,000 bed days 2024/25

Methicillin-sensitive Staphylococcus aureus (MSSA) Bacteraemia

The Trust reported 31 cases of MSSA during 2024/25. There were 16 HOHA and 15 COHA cases, compared to 22 reported cases in 2023/24. The primary recorded infection sources for the Trust are documented below.

Source	Number of cases
Bone and joint	2
Endocarditis	1
Hepatobiliary	1
Lower Respiratory Tract	2
Lower Urinary Tract & Catheter	1
Other	2
Peripheral Venous Catheter	2
PICC	3
Pneumonia	1
Skin & Soft Tissue	3
Tunnelled IV line	1
Unknown	10
Upper Respiratory Tract	1
Wound infection	1

Table 1: MSSA Bacteraemia 2024-2025

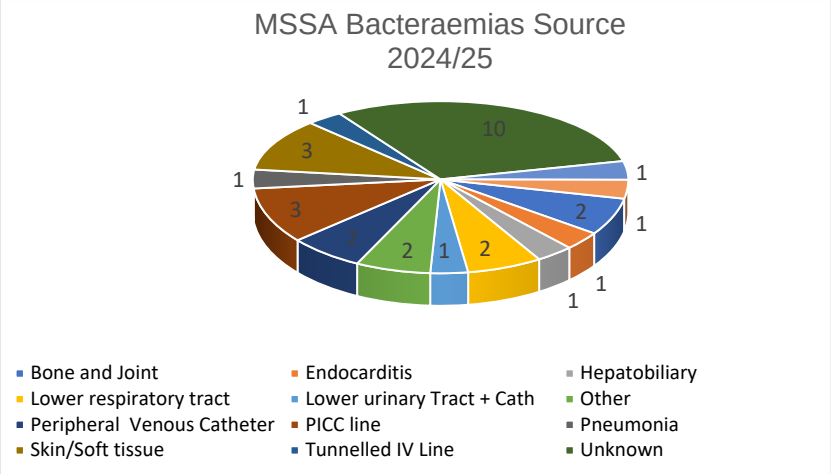

Figure 3: MSSA Bacteraemia Source 2024/25

Reporting has shown that six of the 12 monthly totals were on or below the median line which is comparable to the data collated for 2022/24. A non-statistically significant increase was observed in March 2025 that was comparable to the previous year but exceeded the upper control limit in this instance.

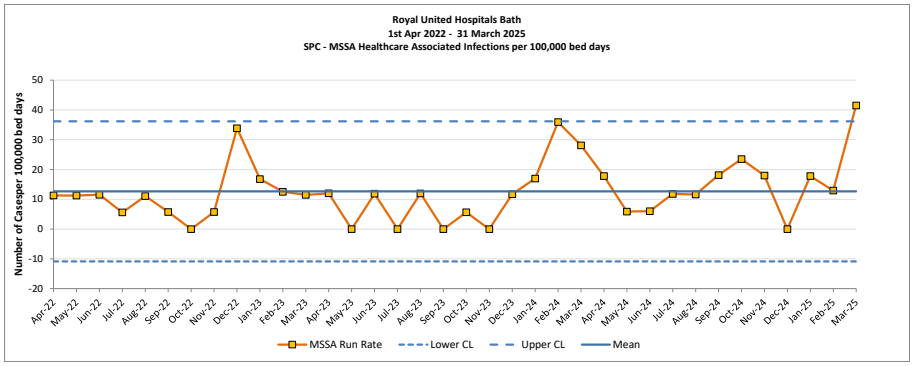

Figure 4: SPC Healthcare associated MSSA bacteraemia data 2022 – 2025 per 100,000 bed days

The RUH benchmarked mid-table throughout the year against the South West Trusts, with a total of 31 cases across 2024/25, with 16 HOHA and 15 COHA cases.

The rates peaked in October 2024 with four cases, one attributed to a PICC line and the other three were of unknown origin which gave a rate of 24.15 per 100,000 bed days. The rate then returned to a lower level until a spike in March 2025 (figure 4) with seven new cases. The source of the cases was: one peripheral venous cannula (PVC), one skin soft tissue, one tunnelled line, one pneumonia and four other cases had an unknown source.

The cases of unknown origin have been difficult to establish with ten cases across 2024/25 showing at least two probable sources for the infection, therefore a source of unknown had to be documented. Overall, the Trust rated well across the South West for 2024/25 with the fifth lowest rate. Although MSSA is reported there is no threshold for this infection.

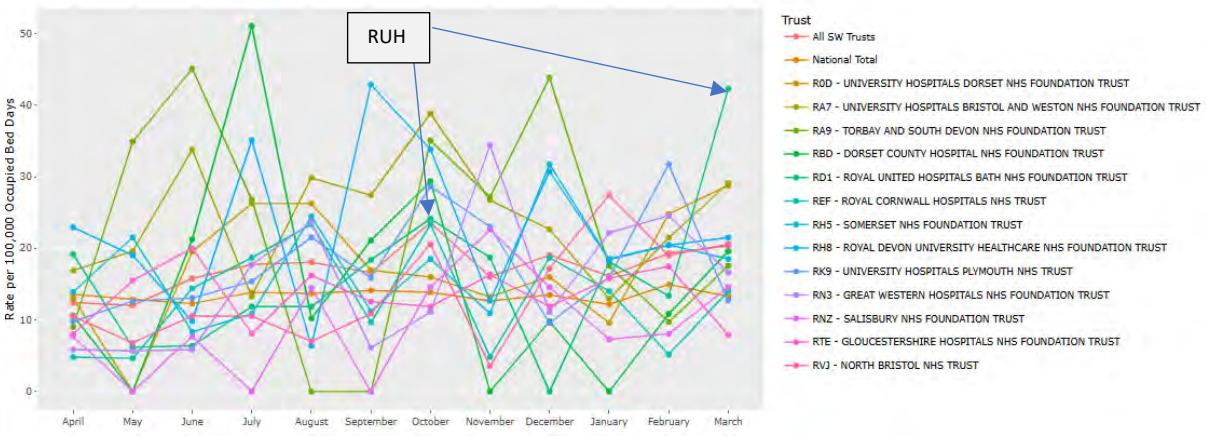

Figure 5: UKHSA MSSA data plot 100,000 bed days 2024/25

Line Care

BD Posi-flush pre filled saline syringes has been trialled successfully and is in the process of being rolled out across the three Trusts in Bath, Swindon and Salisbury. This product will be used for the flushing of newly inserted cannulas and flushing following the administration intravenous medication. The product is cost effective, environmentally sustainable, saves clinical time and decreases the risk of contamination.

Gram Negative Bloodstream Infections

In 2019 the UK agencies published its 20-year vision for antimicrobial resistance (AMR). This set the ambitious goal of ensuring Antimicrobial Resistance (AMR) will be controlled and contained by 2040. To deliver on this vision, the government agencies committed to producing a series of 5-year national action plans across the United Kingdom.

The first 5-year national action plan for antimicrobial resistance, 'Tackling antimicrobial resistance 2019 to 2024', was a crucial step towards achieving this vision. The work conducted by Government, led to progressive action towards reducing the negative impact of AMR in the UK and globally. Successes of that plan included:

- further reductions in the use of antibiotics in food-producing animals
- **the development of improved surveillance systems**
- the piloting of new payment schemes for antibiotics on the NHS

The plans will provide sustained and ongoing progress towards achieving the vision and ambition for change.

In 2024 'Confronting antimicrobial resistance 2024-2029', was introduced by the Government, building on the achievements and lessons learnt in previous years. The work has been seen across the Integrated Care Board and within the Trust highlighting

the negative impact of AMR. This has continued to show how working as a multi-disciplinary team (MDT) can improve performance relating to the switching from intravenous antibiotics to oral antibiotics and improving clinician knowledge to ensure the appropriate use of antimicrobials.

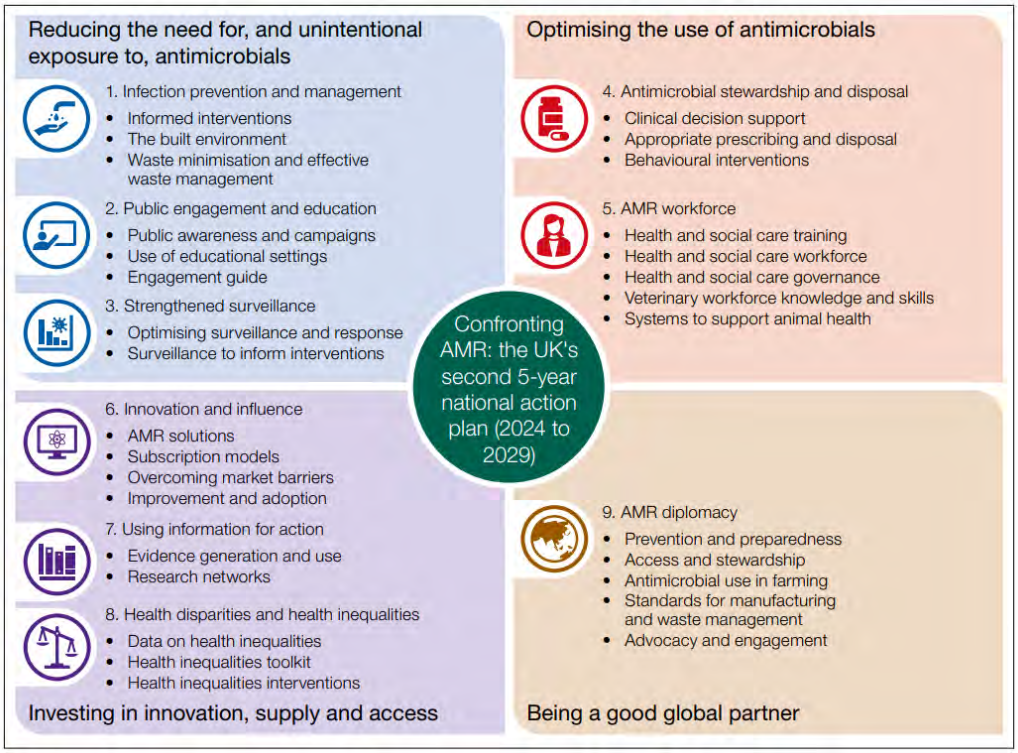

Table 2: Summary of the 2024-2029 National Action Plan

There was an increase of 10 cases for E.coli to 100 for 2024-25. There has been a reduction in Klebsiella (n=4) and Pseudomonas (stayed the same) cases both staying within the threshold given by NHSE and performing well against other Trusts in the region.

Infection	Threshold for 23/24	Final Numbers 23/24	Threshold for 24/25	Final Numbers 24/25	Difference in final Numbers 23/24 and 24/25
E. coli	72	90	82	100	**+10**
Pseudomonas	12	15	14	14	**0**
Klebsiella	25	26	25	21	**-4**

Table 3: Thresholds for 2023/234 and 2024/2025

Escherichia coli Bacteraemia (*E. coli*)

The NHSE threshold was exceeded during 2024/25 by 18 cases. The RUH has seen an upward trend in E. coli bacteraemia infections over the last year which positioned

the Trust near the top of the table in the South West. This was due to an unmatched level of bacteraemia's in both December 2024 (n=16) and January 2025 (n=14).

Of the cases in December and January, nine cases were found to have a Hepatobiliary primary source, this result accounted for 25% of cases in December and 35% in January.

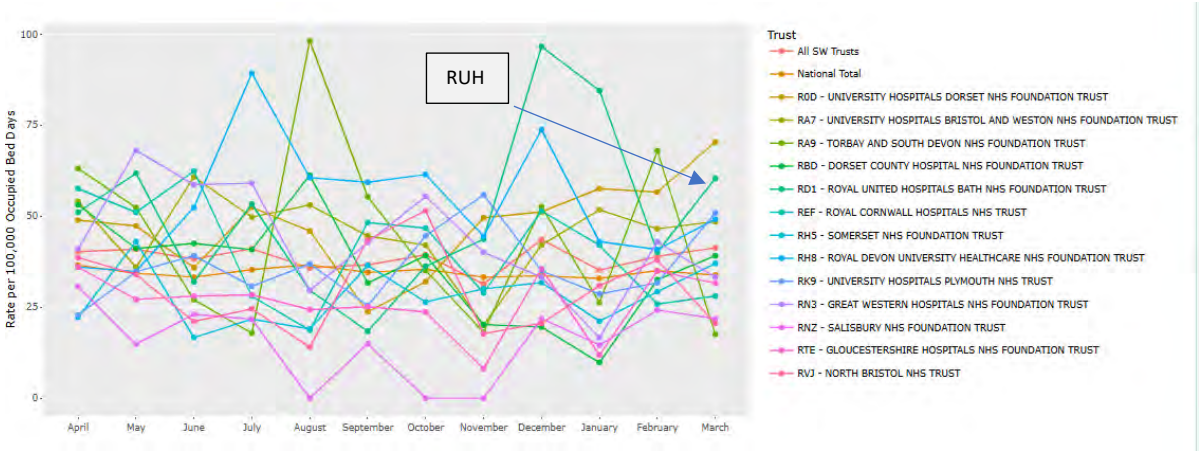

Figure 6: *E. coli* Bacteraemia 100,000 bed days 2024/25

There is a noticeable trend involving a urinary source for *E. coli* infections within the Trust attributing 40% of the documented cases. These cases fall between Upper (n-12) and Lower (n-28) urinary tract and with (n-14) and without (n-26) catheters, this is a significant area for workstream development. The current promotion in the National Action Plan involves AMR and the importance of understanding the negative impact of antimicrobials highlighting the importance of resistance and multiple antibiotics needed to resolve a simple infection.

The current picture is of an ageing population, the Office of National Statistics (ONS) estimates the population will reach 70 million by 2026, with the over 65s increasing to 12.7 million or 19%, this is a significant increase in the over 65-year-old demographic. This group is inherently known to be at a substantial risk due to the probability of having comorbidities, complex health needs or the requirement to access a combination of treatments/medications. This group is therefore identified as a high contributor and will impact the number of Gram-Negative Bloodstream Infections (GNBSI) that are identified.

All GNBSI have a short case review completed by the ward leader and the IPC team to identify the source, any potential risk factors, whether the infection was a healthcare associated infection (HCAI), and any treatment needed. The reviews help focus on effective learning and compassionate, meaningful engagement with the clinical divisions working with staff to support improvement.

Figure 7 demonstrates the Trust associated cases per month of each GNBSI, between April 2024 and March 2025. The cases are plotted against the annual threshold set by NHSE for 2024/25.

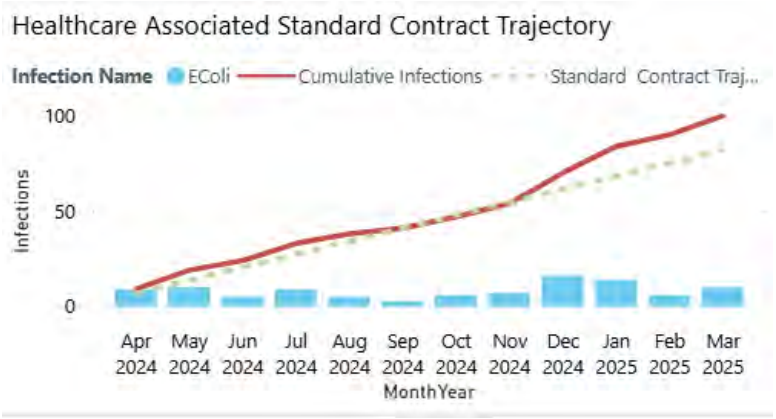

Figure 7: All *E. coli* infections against threshold for 2024/25

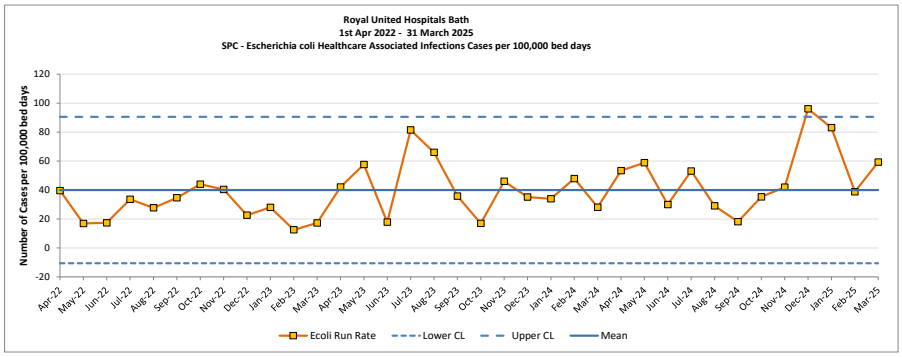

Figure 8: *E. coli* Bacteraemia rates per 100,000 bed days 2022/25

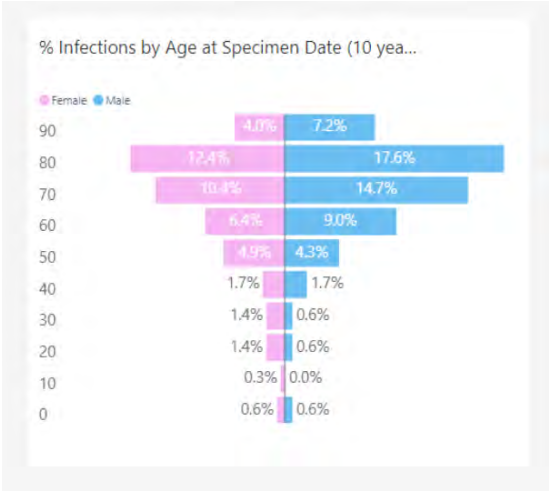

Figure 9: *E. coli* Infection % by age and gender for 2024/25

Figure 9 highlights the current age group and gender of patients who have been seen in RUH, totalling 348 cases of *E. coli* bacteraemia' that have been reported in the Trust (this includes 244 community onset community acquired COCA and 4 community onset indeterminate association (COIA)).

There is a gender split of 43% female and 57% males, the same split that has been associated with both HOHA and COHA (43% females and 57% males) cases. Further analysis has shown that 48.5% of males are > 60 years of age and 38.1% of females in the same age group. The most prevalent range is > 80 years of age relating to 12.4% female and 17.6% males. This can be seen in the RUH with 78% cases reported in the 65 years plus category and 32% are above 85 years alone.

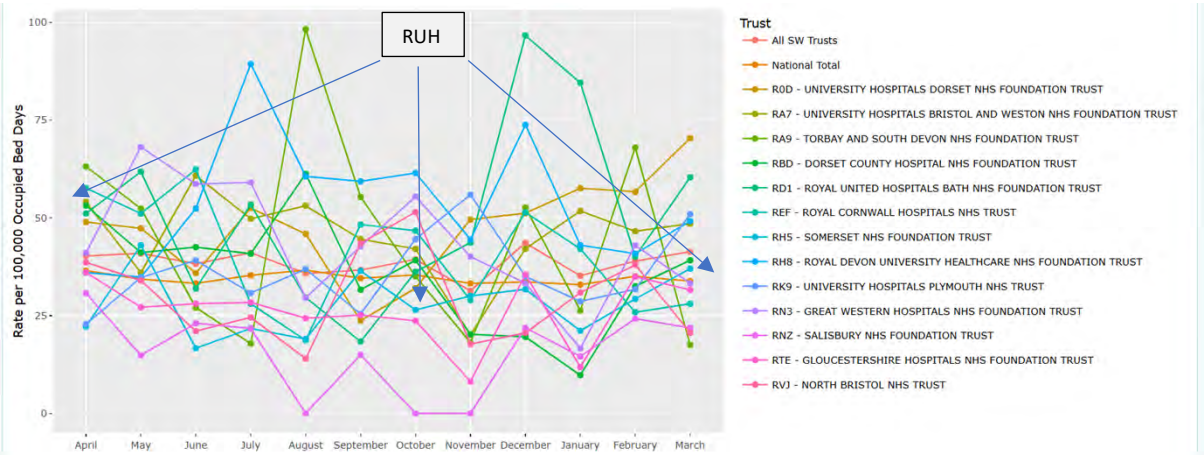

Figure 10: UKHSA *E. coli* data plot 100,000 bed days 2024/25

Pseudomonas aeruginosa

Pseudomonas infections are sometimes associated with contact with contaminated water. In hospitals, the organism can contaminate devices that are left inside the body, such as respiratory equipment and urinary catheters.

Overall, the Trust has stayed within the threshold set by the NHSE for 2024/25 of 14. The rate for the trust was 7.19, positioning RUH 11th in the South West. The rates of Pseudomonas are low, and the smallest change can make an organisation an outlier (figure 11).

Figure 11: All Pseudomonas infections against threshold for 2024/25

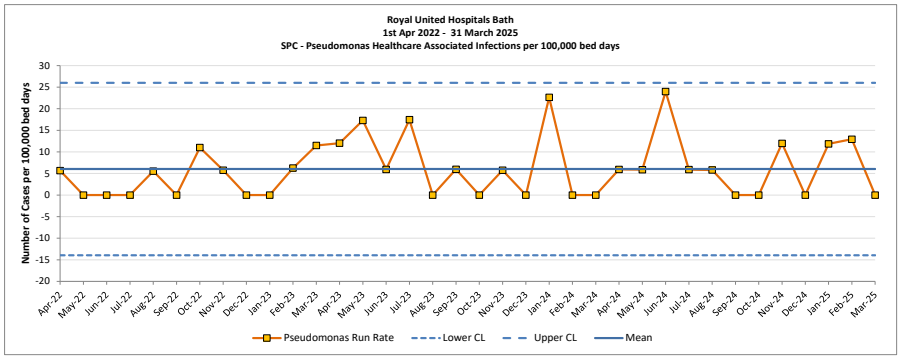

Figure 12: SPC Chart Pseudomonas Aeruginosa 100,000 bed days 2022/25

Of the 14 cases identified there were nine different sources attributed, and one ward has seen more than one case (n=4) in 2024/25. This relates to the susceptibility of certain groups of patients against and the probability of contracting a hospital acquired infection (HAI). There are fluctuations in rates, per 100,000 beds days across all organisations throughout the year, and this can be a result of just one extra case (figure 12).

The gender of Pseudomonas cases is shown to be predominantly 79 % male (n-11) and 21 % female (n-3) cases. Patients that were over the age of 65 at the time of their sample accounted for 93% of cases reported and 57% were over 75 years of age. The total positive samples taken in 2024/25 were 38, these included 24 community onset community acquired (COCA).

Figure 13 demonstrates the age and gender split of the total positive samples, male accounted for 76% of cases over 60 and 13.2% were female.

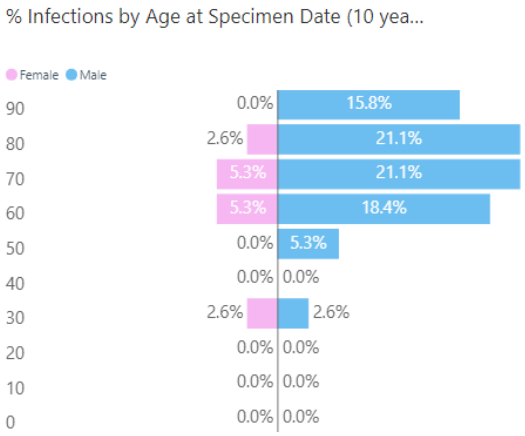

Figure 13: Pseudomonas bacteraemia by age and gender (total samples taken) 2024/25

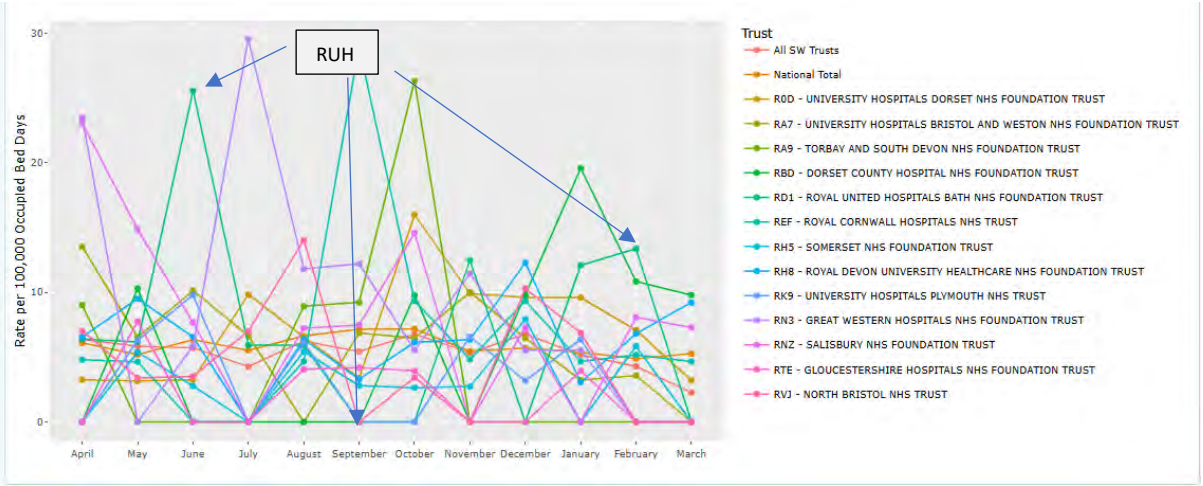

Figure 14: UKHSA Pseudomonas data plot 100,000 bed days 2024/25

Klebsiella

Klebsiella species are commonly found in the environment and in the human intestinal tract and are frequently spread through contaminated hands.

Projects have been commenced with reference to patients' hand hygiene. Reviews of the catheter care pathway have been completed, and the discharge pathway has been strengthened. This will improve the patient journey for those who have both long and short-term catheters. The Nutrition and Hydration Group have supported the access to alternative beverages for patients including the introduction of caffeine-free drinks in clinical areas.

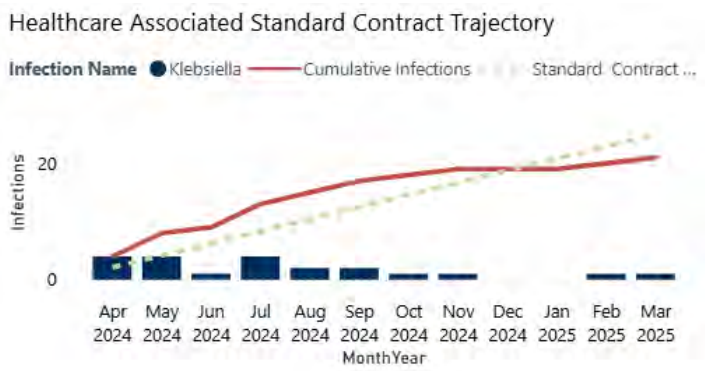

Figure 15: All Klebsiella infections against threshold for 2024/25

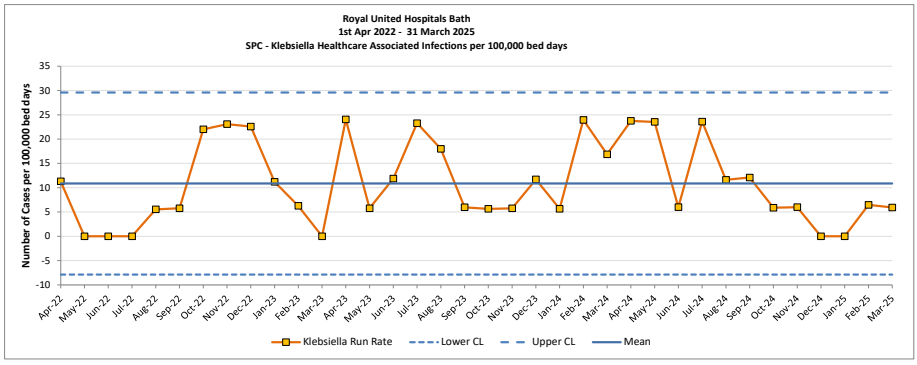

Figure 16: Klebsiella SPC chart 100,000 bed days for 2022/25

There were predominantly more cases in men (62%) than in females (38%) with the overs 65s accounting for 62% of reported cases.

Figure 17 highlights the split of gender and age across all Klebsiella cases reported from samples taken in the Trust including community onset cases (n-87). The highest proportion of positive results occurred in patients aged > 60 years of age (n-73) and predominantly male. Hydration programmes have been set up in the community to support this group of patients and to reduce the number of admissions to acute care, the continued promotion of this work will move forward over 2025/26.

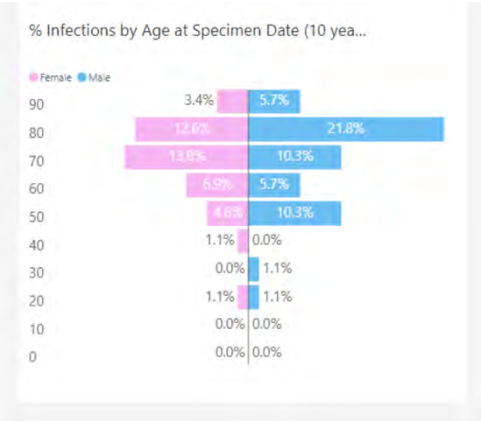

Figure 17: Klebsiella infection by age and gender 2024/25

Figure 18 demonstrates how variable the rates have been across the South West Trusts during 2024/25. Initial high rates between April-July increased the mean rate for the Trust, however performance placed RUH under threshold with 21 cases out of a potential 25. Benchmarking the Trust 4th best in the South West with a year-to-date rate of 10.78 per 100,000 bed days.

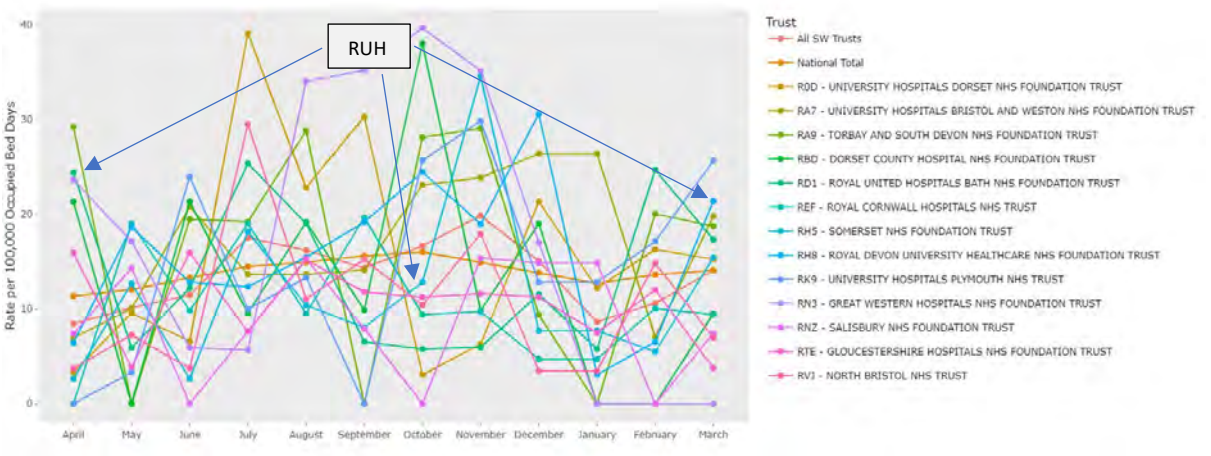

Figure 18: UKHSA Klebsiella data plot 100,000 bed days for 2024/25

Key improvements required for 2025/26

The increase in *E. coli* infections has been notable across the region however, there has been a marked increase in the number of cases identified in the Trust. Increasing from 90 cases in 2023/24 to 100 cases this year.

The usability of the Trusts electronic fluid balance charts has been reviewed and refined using quality improvement methodology. Knowing the fluid intake and output of a patient is a fundamental part of their care, especially when managing deteriorating patients and the capacity to accurately document these details on a fluid balance chart is vital. Work has competed to develop a reference tool to support patient facing staff complete accurate fluid charts, enabling them to keep timely records that will highlight any decline in health status.

The next step during 2025/26 will ensure we can evidence patients within the Trust are adequately hydrated during their stay. This links to the South West hydration message, and aims to prevent urinary tract infections, constipation, improve cognitive ability, improve skin integrity, improve mobility, and prevent falls.

Improvement work has been commenced with the matron lead, to assist in promotion of core skills for staff completing patient care to promote continence management and catheter care, which aims to reduce to reduce the risk of infections developing.

Clostridioides difficile (*C. difficile*)

The threshold for RUH apportioned cases of *C. difficile* for 2024/25 was set at 75 cases, with 103 being reported at the end of March 2025. Of the 103 cases, 62 were Hospital Onset Healthcare Associated (HOHA) cases and 41 Community Onset Healthcare Associated cases (COHA). This was 28 cases over the threshold set by

NHSE and 26 more cases than in 2023/24. This equates to a 32.1% increase in cases compared to 2024/25. The additional burden on the Trusts isolation facilities, means that there is often competing priorities with other infections which also require isolation.

United Kingdom Health and Security Agency (UKHSA) have stated that since 2021, the C. difficile infection (CDI) incidence rate has been climbing. As of 2023/24, the rate was 35% higher than in 2018/19, when the rate was at its lowest point. Approximately 17,000 cases were identified in the financial year 2023/24 and cases in Quarter 2 (July to September 2024) were 13% higher than the preceding quarter.

UKHSA have launched a national response to further investigate the rising cases which appear to have multiple, yet unidentified causes relating to both microbiological and epidemiological factors. These investigations will help provide a better understanding of the recent increases and help target control measures and mitigations. UKHSA have stated that the current increases have been seen in all ages and regions, placing increasing burden on NHS services. To date there has been no new solutions recommended by any agency to help decrease the rates of *C. difficile* infections amongst the population, despite the work being undertaken. The causes of this increase are likely multifactorial but have not yet been established.

Further analyses by IPC teams, AMR Pharmacists and Microbiologists across the regions are continuing to look at the impact of diabetes, obesity and the impact of other medications that are used to treat depression and diabetes (GLP-2). The use of penicillin allergy flags, and the opportunity to de-label patients, and therefore open the use of penicillin derived antibiotics are also being reviewed. All these actions aim to understand any wider risk factors impacting the current increase in cases, where other areas have already been exhausted.

The work that is being generated through the resulting *C. difficile* cases has resulted in the IPC Team re-allocating, resources to allow time to investigate these infections. All Trust associated cases have undergone a multidisciplinary case review, including anti-microbial pharmacy, microbiology, senior ward review from the attributed ward and infection prevention and control. The thematic analysis concluded there are themes pertaining to age and comorbidities. Antibiotic prescribing throughout the Trust is well managed and patients do not remain on broad spectrum antibiotics for excessive time periods. There are gaps in staff adherence to practice standards, adherence to IPC mandatory training at a service level and documentation to ensure changes in bowel motions can be quickly identified. Whilst cleaning scores have significantly improved, there are times when cleaning audit scores are not reflective of the standards IPC expect. There is also a significant usage of laxatives in the patient cohort who go on the develop a *C. difficile* infection, often linked to predisposing medical conditions.

NHSE thresholds since 2023 – 2024/5

Infection	Threshold for 23/24	Final Numbers 23/24	Threshold for 24/25	Final Numbers 24/25	Difference in final Numbers 23/24 & 24/25
C. difficile	41	77	75	103	**+26**

Table 4: *C. difficile* Thresholds for 23/24 and 24/25 and final totals for RUH

Risks factors that hinder the RUH and identified on the risk register

- Suboptimal ventilation in some of our clinical areas, including windows that open (with restrictors) or are unable to be opened for safety reasons.
- Insufficient isolation capacity, 18% side room capacity across all adult services (excluding maternity services).
- Limited bariatric side room capacity.
- Vacancies within the cleaning team.
- No access to hydrogen peroxide for deep cleaning services or any other enhanced cleaning services.
- An aging population accessing medical services and staying an inpatient for extended periods of time, due to limited access to continuing health care (CHC).

Investigations into all HOHA cases and when COHA cases *C. difficile* cases are now completed using the Datix system with ward areas.

Of the 103 Trust reported cases, 98 had no new learning, in two of the cases learning was taken forward (both cases were HOHAs), and three were considered as inconclusive.

Of the 103 Trust reported cases, there have been 10 cases with repeated positive tests and 16 cases of a continuing infection that were taken after the 28-day window. This status is required by the clinical teams, to enable them to administer the correct treatment protocols for the patient. This can occur without consultation with the microbiology team who may have opted to treat the patient instead of taking another sample, especially when the patient remains/is symptomatic and the result of the sample would not have altered the decision-making process. The repeat/continuing samples amount to 26 cases that are included within the 103 Trust total.

Trust Annual *C. difficile* data, by month against threshold

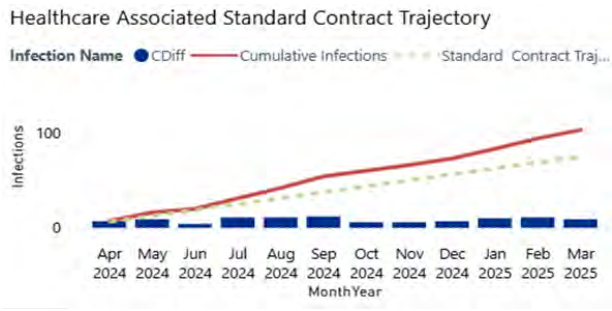

Figure 19: Total number of *C. difficile* cases 2024/25

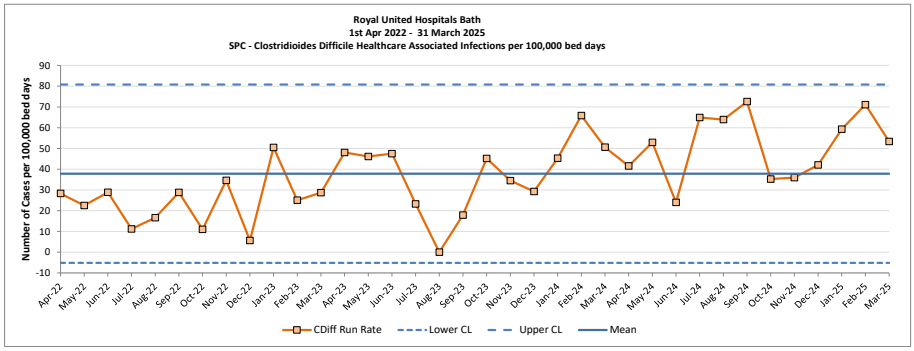

Figure 20: Trust SPC *C. difficile* data100,000 bed days, by month 2022-2025

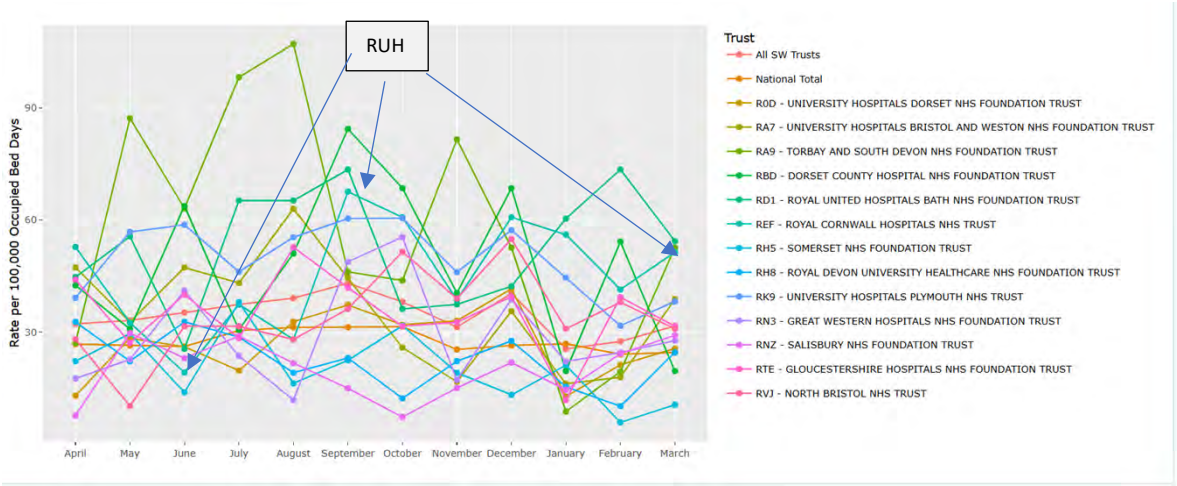

Figure 21: UKHSA *C. difficile* picture data plot 2024/25

Emerging strain of virulent CDI in UK

Cases of CDI due to ribotype 955 (RT955) emerged in 2021 with alerts going to NHS organisations during 2023. This emerging ribotype is closely related to the historic hypervirulent ribotype 027 (RT027). The new ribotype has recently caused two large hospital outbreaks in the Midlands. Appearing to transmit readily; gastroenterology patients were particularly affected at this time. UKHSA reported most cases (78%) have been HOHA. The overall 30-day case-fatality rate of those with *C. difficile* RT955 is 24.6%, compared to an overall CDI 30-day case-fatality rate of 13.8% and an overall hospital-onset CDI case-fatality rate of 20.2%. Management of these outbreaks has been very focused on ventilation and cleaning during their stay, followed by the use of

hydrogen peroxide (HPV) cleans to fully decontaminate after a patient has been discharge.

Since the emergence of RT955, the RUH has identified one community acquired case, in January 2025,which was detected on our testing platform as an 027 and sent for onward typing as per guidance.

Period of Increased Incidence (PII)

As per the national C. difficile guidance (2013), periods of increased incidence (PII) are identified when two or more cases of C. difficile are reported on a ward within a 28-day period.

These have been identified on six areas throughout the year where the team have responded by conducting ward visits and reviews to ascertain the current ward status and need for refurbishments. Enhanced audits look at practice and adherence to protocols of all staff on the ward including their proficiency with decontamination of equipment and hand hygiene/bare below the elbow compliance. Further monitoring of anti-microbial prescribing looking at the 'watch' categories including broad spectrum antimicrobials, this is presented back to the team who collate this in a report back to division.

Review of CDI periods of increased incidence actions:

The areas that have experienced a PII have action plans in place that are being addressed by the ward leaders and are reported back to division. The Antimicrobial pharmacy team has a plan of action across 2024/25 which includes intravenous to oral switch (IVOS). Patient and staff hand hygiene will be focused on as an improvement drive, which will include bare below the elbows for clinical staff. There has been an increased emphasis on the importance of clean nursing equipment and environmental cleaning scores.

Ribotyping results and evidence for cross-infection

Typing results for 2024/25 cases are included in table 5, which demonstrates the wide variation of strains being detected. Typing can only be requested when there are two or more linked cases, so cannot be completed for all positive samples. Figure 23 shows the data from the previous reporting year, and the variation of types detected. The only commonality being CE002 and CE014 these are considered the common strain within acute healthcare services. These cases have not been linked to any direct patient to patient transmission within our services as part of the period of increased incidence (PII) investigations.

Table 5 identifies the areas as having two or more cases of *C. difficile* within 28 days throughout the year.

Month of 24/25	Ward	Ribotype	Ribotype	Ribotype	Ribotype
April	William Budd	002	014		
May/June/July	Waterhouse	050	015	002	014
September	Cheseldon	076			
September	Haygarth	Unable to type			
January/February 2025 (both PII's)	OPUSS	001	005	126	107
	Haygarth	001	062	202	014
January 2025	Respiratory	002	002	MLVA demonstrated **no match**	
January/February 2025	Helena	106	106	MLVA match likely to show incidence of cross infection	
February/March 2025	OPAU	002	023		
March 2025	Pulteney	015	021		

Table 5: Ribotyping results for Periods of Increased Incidence (PII) 2024/25

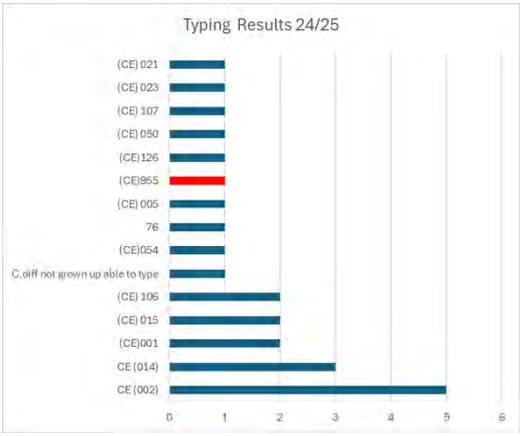

Figure 22: RUH ribotyping 2024/25 (up to Q4)

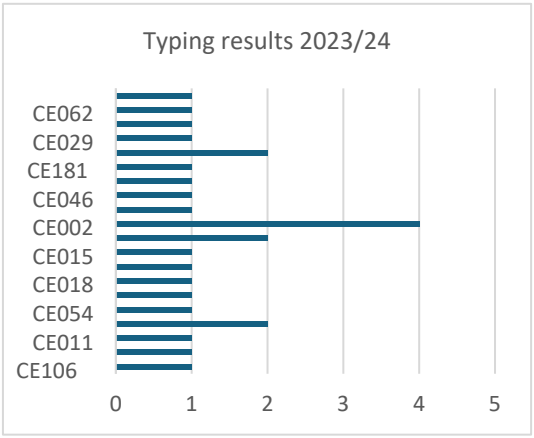

Figure 23: RUH ribotyping 2023/24

In eight of the areas where a PII was declared, epidemiological analysis and ribotyping of each case revealed cross infection in these ward areas was unlikely.

In two ward areas (Respiratory ward and Helena ward) ribotyping revealed the two cases in each PII were caused by the same ribotype and linked in time and/or place. More discriminatory strain typing (MVLA fingerprinting) is available from the Leeds reference laboratory to determine if isolates of *C. difficile* that share the same ribotype, are similar enough to likely represent the same strain and therefore cross-infection.

The MVLA fingerprinting results for Respiratory ward demonstrated they were not a match, and therefore there was no cross infection.

The Ribotyping for Pulteney were all different types, however the lapses in the standards of practice observed by clinical staff was addressed.

The fingerprinting results from the cases attributed to Helena ward have revealed they are identical strains and therefore cross-infection was highly likely. It is unclear how this occurred. The patients had never been in the same bed space and were likely nursed in the main by different nurses on each shift due to nature of their clinical needs. Larger items of patient care equipment cannot be rule out as a source of transmission. Audit scores relating to hand hygiene, equipment cleaning and environmental cleanliness leading up to the PII were good. Since these linked cases no further cases of *C. difficile* have occurred and there is no evidence of ongoing transmission. Furthermore, Helena ward has now been physically relocated and therefore patients are now in a different environment.

Findings and Outcomes of periods of increased incidence 2024/25

The evidence that has been identified through the periods of PII are:

- Inconsistent compliance to bare below the elbow from clinicians.
- Lack of continuity of cleaners on the wards, resulting cleaning scores being lower than expected. Some of the cleaning scores were between 84-94% at the time of the PII.
- Stool charts are not being consistently completed to monitor changes in bowel actions between shifts.
- IPC mandatory training compliance at ward level has not always been at the accepted Trust standard of 85%.
- Compliance with hand hygiene has not been up to expected standards and there is a high incidence of glove usage when not appropriate.
- Antibiotic prescribing throughout the Trust is well managed and patients do not remain on broad spectrum antibiotics for excessive time periods. There is an opportunity to improve the IVOS.

Review of CDI HOHA cases

Of the 62 CDI HOHA cases in 24/25, the average age of patients was 74.6 years with an age range of 31-96 years. 53% of cases were female and 47% male. On average the time to onset of CDI post admission was 15 days, although this ranged from as short as 3 days to as long as 97 days. 45% of patients developed CDI within the first week of admission, although nearly half of these cases had an admission within the previous 3 months.

77% of cases were deemed mild or moderate in severity. 18% of cases were classed as moderate/severe or severe. In 3 cases, severity could not be assessed as the patient was at the end of life. Of the 62 HOHA cases, 9 patients sadly died within 28 days of the CDI diagnosis. However, in none of these patients was CDI assessed to be the primary cause of death. All cases were treated appropriately with antibiotics active against *C. difficile*, and where cases met the NICE criteria patients were also offered Faecal Microbiota Transplantation (FMT).

The 62 *C. difficile* HOHA cases were reviewed in detail looking specifically at rates of recurrence, antibiotic usage and risk factors for diarrhoea, to identify learning themes.

Key findings from this analysis were:

- 27% of HOHA cases had prior *C. difficile* infection or carriage (up from 20% last year).
- 42% of HOHA were on laxatives at the time of sampling (similar to the figure of 41% last year).
- 77% of HOHA cases were on a proton pump inhibitor (medications that have a known association with the development of CDI). This has increased from 70% from last year.
- 95% of HOHA cases had received antibiotics in the past 3 months (increased from last year when it was 88%).

Of these, there was only a single case where significant deviation from guidance/microbiology advice for hospital antibiotic prescribing occurred that likely significantly increased *C. difficile* risk. The overwhelming majority of prescribing was adherent to Trust guidance and justified clinically.

Of the HOHA cases, two cases were likely to have been avoidable. The first case was the case of likely cross-transmission that occurred on Helena ward (see above). The second case was the case where there was a significant deviation in antibiotics prescribed from guidance/microbiology advice.

IPC audit scores are also reviewed as part of every CDI Trust associated case. Although it is difficult to directly link a one-off suboptimal audit score on a ward area to a case of CDI (especially where there is no evidence from epidemiological and ribotyping to suggest cross-infection), it is important to gather this data to look for overall trends and identify potentially areas for improvement and learning.

Overall, this data shows that there is no clear preventable cause to explain the majority of our HOHA cases. Evidence for cross infection is minimal, and we are performing well in terms of antibiotic stewardship and adherence to guidance. However, there are areas of improvement identified regarding hand hygiene and cleaning and also further investigation may be required into the high rate of prescription of PPIs.

It has been noted that during the PII that the cleaning scores have been lower, and RAG rated between amber and red. The percentage scores were between 88.50% and 94.38, which is between a 2 and 4-star rating, with 5 stars being the most that can be achieved. The cleaning service has been concentrating on keeping a consistent team of cleaners on all wards, to create ownership and pride in their work environment. To support this, there has been a focus on recruitment within cleaning services to ensure the workforce is available to consistently achieve the standards required.

This pattern of increasing numbers of Trust associated CDI cases is not isolated to the RUH and has also been reflected in increasing community CDI rates regionally. Overall, the national rates of CDI are also increasing without obvious explanation and data from our HOHA cases at the RUH mirrors this.

Key improvements for 25/26

- Working closer with the ward staff in relation to patient's hand hygiene during an admission to prevent ingestion of *C. difficile* spores, and other pathogens.
- Focus on staff hand hygiene and bare below the elbows and encourage all staff to challenge colleagues who are not compliant.
- Promote the importance of timely sample taking and consultation with microbiology/IPC if in doubt of when to send a sample.
- Proton Pump Inhibitor (PPI) usage review.
- Working with the AMR Pharmacist attending surgical ward rounds to support team learning and development.
- Continue to closely monitor the Trusts usage of antimicrobials and ensure we are using them appropriately based on current best practice and guidelines.
- Continue to work with partners regionally to better understand CDI risk factors locally and analyse data to determine current drivers causing increased rates of infection.

Criterion 2

The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

Environmental IPC and decontamination

The IPCC receives reports from the operational teams on decontamination, water, ventilation, and cleaning throughout the year. IPC are also active members of these operational meetings. A summary of each working group is detailed in this section.

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Water Safety Group (WSG)

Overview: The Water Safety Group (WSG) of the Trust, which includes active participation from the Infection Prevention and Control (IPC) team, meets quarterly to discuss and manage water safety issues. Over the past year, we have taken numerous proactive measures to ensure water safety. This includes conducting all necessary

testing, monitoring, and remedials under Health Technical Memorandum (HTM) 04-01, Approved Code of Practice (ACoP) L8, and Health and Safety Guidance (HSG) 274, which have not highlighted any major concerns. We also reviewed the Trust's Water Sampling Plan and Legionella Risk Assessments to ensure their relevance and thoroughness. Staff training was implemented to reinforce aseptic sampling techniques and consider staff competency levels.

A noteworthy achievement was the successful annual Authorising Engineer (AE) audit. All areas for improvement highlighted in the audit were collated into an Action Plan, and all shortcomings are currently being addressed.

Key Improvements for 2024/25:

- Monitoring and Compliance: Continue planned and reactive monitoring, sampling, testing, and remedial activities.
- Planned Preventive Maintenance (PPM) Review: Overhaul water PPM tasks and associated contracts.
- Water Safety Plan Update: Enhance the Water Safety Plan and local risk assessment template.
- Improved Response Protocols: Refine protocols for escalation, remedial action, and stakeholder notification.
- Legionella Sampling: Conduct a detailed review of the Legionella sampling plan and locations.
- Training: Complete water hygiene training for all Estates Maintenance Workers (EMWs) and schedule further training.
- Authorising Engineer (AE) Audit Actions: Develop and implement a detailed action plan based on the AE audit.
- Record Management: Migrate records to SharePoint and create water safety trackers.
- Asset Mapping: Undertake an asset mapping project to improve management and record-keeping.
- Remote Monitoring: Explore remote monitoring of monthly water temperatures.
- As-Built Drawings: Commission site-wide as-built drawings of water systems.
- In-Sourcing Maintenance: Assess the potential to in-source water cooler servicing and maintenance.
- Rolling Audits: Conduct ongoing audits and reviews of water quality data and testing outcomes.

Ventilation Safety Group (VSG)

Overview: Throughout the past year, the Ventilation Safety Group (VSG) of the Trust, with active members from the Infection Prevention and Control (IP&C) team, microbiology, and other relevant stakeholders, has completed all necessary monitoring, verifications, testing, and inspections. We have seen many noticeable improvements, including the successful design, build, and validation of the new

Intensive Care Unit air handling system. This system ensures compliance with the Health Technical Memorandums (HTM) and future-proofs the department's ventilation strategy by allowing for rebalancing and expansion in case of a national emergency in infection outbreaks, having learnt our lessons from COVID-19.

Policy Review and Updates: We reviewed and updated the policy to align with new HTM guidance, incorporating new sections on contractor competency verification, Local Exhaust Ventilation (LEV), and Chilled Beams. Planned Preventative Maintenance (PPM) schedules have been implemented to meet these requirements in 2025/2026. Additionally, we created Standard Operating Procedures (SOP) for policy implementation, including SOP 28 for air purifier deployment and SOP 69 for handling failed verifications.

Audit and Staffing Challenges: An Authorising Engineer (AE) audit was conducted, and we are actively working on all actions with quarterly reviews by the VSG. We faced challenges with Authorised Person (AP) cover and staffing due to long-term illnesses of the Lead AP and the secondment of mechanical estates staff to the cleaning department. To alleviate the strain, the Estates department created a mechanical role to cover other disciplines and saw the seconded estates officer return to the department.

Risk Management:

- **DATIX 1273:** The air handling units serving critical areas, such as the main theatres, are approximately 40 years old and were deemed end-of-life 20 years ago. With an initial risk score of 12, a current risk score of 6, and a target risk score of 6, this risk is adequately controlled and reviewed quarterly by the VSG.
- **DATIX 2314:** There is an increased risk of nosocomial transmission of COVID-19 and other airborne infections due to the lack of mechanical ventilation in some inpatient areas. This risk, reviewed with IP&C, Deputy Head of Estates, and the AP for ventilation, is accepted as a tolerated risk with yearly reviews. Its initial risk score was 12, current risk score is 9, and target risk score is 6.

Key Improvements for 2025/26:

- Continue monitoring, testing, and inspecting ventilation systems through PPM maintenance and external verifications.
- Respond promptly to verification remedials and inform departments of any failures.
- Increase resilience for ventilation systems by renewing AP appointments and considering the assignment of a third AP on-site as per AE recommendations.
- Work on AE audit actions, including building an "Air Handling Unit Logbook."
- Improve record-keeping by formally assigning contractors deemed as Competent Persons (CP) on the RUH site.

- Enhance governance on LEVs and Chilled Beams by assigning PPM schedules that satisfy HTMs.
- Align the current permit-to-work system for critical ventilation with the estates permit-to-work system, transitioning from paper copies to the SharePoint site and using the Estates Permit numbering system for unified record-keeping.

Decontamination of Medical Devices

Central Decontamination

Sterile Services (SSD) is accredited to BS EN ISO 13485:2016 and registered with the Medicines and Healthcare products Regulatory Agency (MHRA) for the assembly, supply and distribution of sterile packs and instrument sets for hospitals and other health care related establishments. SSD re-manufactures procedure packs, single instruments and theatre sets using the items which are mutually compatible and used in accordance with manufacturer's instructions and users requirements – to meet the provisions of Regulation 14, clause 1 (points a & b) of the Statutory Instrument 2002 No. 618, Medical Device Regulations 2002, as amended and are in conformity with the UK designated standards BS EN ISO 13485:2016, BS EN ISO 14971:2019, BS EN ISO 14644-1:2015. The items are thermally disinfected and will be sterilised in accordance with Health Technical Memorandum (HTM) 01-01 guidelines.

Currently SSD supplies to 80 locations – internal & external to RUH. During 2024/25 SSD process 268,504 items which includes 2,686,440 instruments.

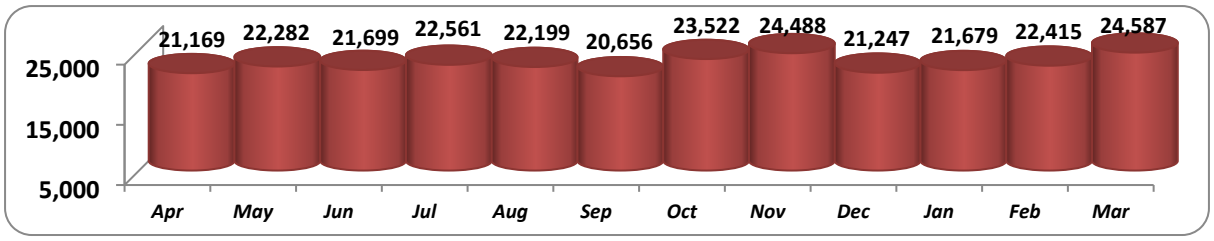

Figure 24: Surgical instrument sets processed per month 2024/25

SSD also provides a comprehensive decontamination services to various Service Users for re-useable heat sensitive flexible endoscopes. High level disinfection service for flexible endoscopes is managed by SSD in accordance with the BSG Guidelines for Gastrointestinal Endoscopy and HTM 01-06.

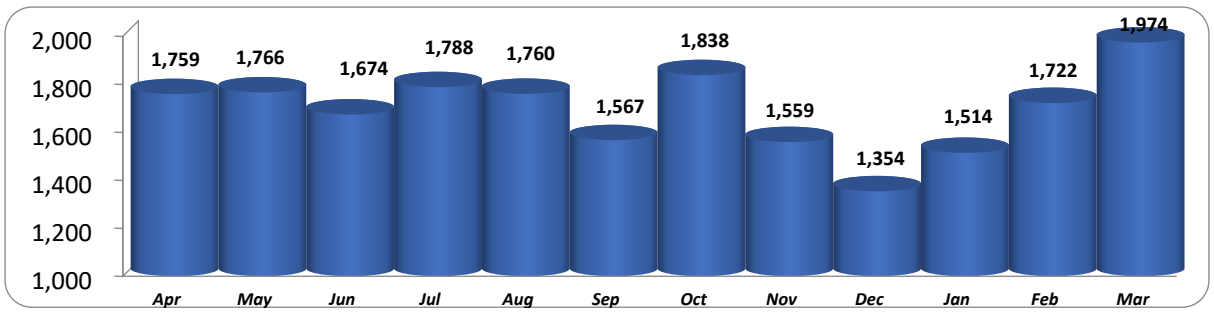

Figure 25: Endoscope processed per Month 2024/25

Trust Decontamination Manager attends and provides quarterly update reports to the IPCC regarding overall Trust compliance with decontamination requirements. The Decontamination Committee meets quarterly and provides assurance to the Health & Safety Committee and the IPCC and report key messages and risks.

Local Decontamination

SSD & IPC team are working with rest of the clinical colleagues to improve the local decontamination standards. Maintaining policies, SOPs, risk assessments & training records is very important to give assurance relating to patient safety. Ear Nose and Throat (ENT) outpatient department (OPD) is using Tristel Trio to disinfect non-lumened nasendoscopes between the procedures. Eye OPD is following Moorfields Eye Hospital NHS Foundation Trust SOP to decontaminate contact lenses; as per the SOP, the lenses are being cleaned with detergent wipes. This is being done by the consultants after they have seen the patient in the individual clinic rooms. Transoesophageal Echocardiography Probes (TOE) are cleaned with Tristel Trio system and traceability records are in use and stored in dedicated storage cabinets. Gynae OPD and Antenatal are using Tristel Duo to decontaminate their TV probes.

Cleaning

The Cleaning Standards Group (CSG) at the RUH was replaced by a rapid improvement intervention in early 2025, it is due to recommence in summer 2025 to ensure compliance with the National Standards of Healthcare Cleanliness 2025.

This commitment aligns with Criterion 2 of the Health and Social Care Act, which emphasises the maintenance of a clean and suitable environment throughout the RUH premises. The CSG will conduct meetings to evaluate cleaning standards, manage action plans, and review cleanliness-related incidents. Operating under an approved term of reference, the group reports to the Infection Prevention and Control Committee (IPCC) and the Safer Environment Group (SEG). These meetings involve participation from multidisciplinary stakeholders across the RUH.

Challenges

As with recent years, the team has been met with considerable challenges. Staff turnover within the cleaning team, absence rates and vacancy rates within the cleaning team, have hindered the team's ability to continually improve and build upon.

The leadership of Facilities, inclusive of cleaning, was transferred to the Chief Nursing Officer (CNO) in March 2024, a Matron role was integrated into the department with the intention of improving moral, standards of cleanliness and working relationship

between staff and department supervisors. The CNO restructured the Facilities and cleaning functions to improve performance outcomes.

Risk Management Measures

In response to the challenges, the team recorded this as a risk on Datix (the RUH risk register), scored at 16 - Datix ID 2398 – Cleaning standards in clinical and non-clinical areas – Infection Risk. This risk has an associated action plan is reviewed at the monthly Estates and Facilities (E&F) risk meeting and the E&F Board to ensure it is current and progress is maintained.

The Chief Nursing Officer requested that an external Director of Facilities undertake a review of Facilities. On completion of this, an improvement plan will be developed, reporting to the Non-Clinical Governance Committee. These challenges remain as a risk and therefore the existing Datix on the Trusts risk register remains and is scored at 16. This will remain until variance is reduced.

Datix ID 2398 – Cleaning standards in clinical and non-clinical areas – Infection Risk. This risk is due to be reviewed in the summer of 2025 with most elements of the risk improving, although some remain a challenge.

Progress and Achievements

Despite the challenges, progress has been made in addressing these issues. The team has successfully completed 90% of the listening events with the cleaning team aimed at identifying areas for improvement to enhance, staff engagement, staff morale and performance. A dedicated cleaning team has also been assembled and mobilised for the Dyson Cancer Centre Building (DCC). A new cleaning product, supported by IPC, has been introduced for use on the linoleum floors in the DCC to maintain cleanliness without causing damage. With assistance from the e-rostering team, new rosters have been built to support the cleaning team in managing such a large team. In addition to a Matron role, a new Cleaning Manager has been recruited.

Key improvements for 2025/26

Continual staff engagement is planned for 2025/26 with more communication methods being introduced, including an electronic staff notice board being developed and further digital assistance for staff with the intention to vastly improve on the 2025 Staff Survey.

A realignment of the National Standards of Healthcare Cleanliness has been proposed, which the potential launch of in summer 2025, which will move away from the current ‘focussed’ approach to a ‘blended’ approach for the intention of improving the frequency of cleans in appropriate areas and allocating staff correctly in priority areas.

Driver measures for absences and vacancies remain in place whilst an on-going recruitment program to hire cleaners remain a high priority.

The primary goal for 2025/26 is to stabilise the team, boost morale and cleanliness standards, and professionalise the service with operational standards being introduced.

Criterion 3

Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.

Antimicrobial stewardship (AMS)

Antimicrobial resistance is a global public health threat. The UK has responded to this with a series of national action plans and by carrying out national surveillance of antimicrobial resistance. There are key aims around reduction of inappropriate antibiotic use, specifically broad-spectrum antibiotics. AMS activities within the Trust are briefly outlined below.

Staff update

The Trust has a clinical lead position for AMS which is currently held by a consultant microbiologist. There is also a Trust lead antimicrobial pharmacist (1.0 WTE), who has support from a rotational clinical medicines' optimisation pharmacy technician (0.2 WTE).

Antimicrobial Stewardship Activities

AMS Activities	Description	Issues
Committee	Quarterly meetings, report to IPCC and Medicine Assurance Committee. Membership has been expanded to include representation from areas of high consumption including: • Respiratory • Acute medicine • General Surgery • Older Persons Unit (OPU) • Trauma and Orthopaedics There is a ratified and updated Antimicrobial Stewardship Policy in place which sets out the	Early in the reporting period, the Committee was chaired by the Deputy Chief Medical Officer. The appointed Interim Chief Medical Officer now chairs the Committee

	governance structure for AMS and defines roles and responsibilities. Standing items on the agenda discussed quarterly include: trust antimicrobial compliance audits, the Trust's consumption of antimicrobials, patient safety incidents related to their use, quality improvement and research initiatives and new additions to the drug formulary.	
AMS Rounds	Microbiology rounds occur on a regular basis. These include: • ICU – daily visit weekdays • Cardiology/Infective Endocarditis MDT – weekly • Staphylococcus aureus bacteraemia weekly reviews • Complex patient review – weekly • Outpatient antibiotic therapy (OPAT) virtual round – weekly • Carbapenem reviews – weekly • Monthly prosthetic joint infection meetings • Medical Assessment Unit (MAU) MDT – weekly • AMS rounds on Parry and Pulteney ward based on antimicrobial compliance audit data and complexity of patients on these wards. • Robin Smith ward – reviewed weekly	
C. difficile	Weekly reviews by Consultant Microbiologist. Contribution to investigations, data on potential causitive antibiotic trends, primary care feedback of non-guideline use of antibiotics.	
CQUIN/ MOP/Standard contract	No CQUIN this year.	
Regional	ICB AMS network South West antimicrobial pharmacist network HCAI collaborative workshops BSW CDI task group.	
Training	Full programme of face to face/hybrid teaching by AMS team underway since Summer 2021 including updates to: - • Acute medical team • Pharmacy team • Emergency Medicine medical team • Surgical junior doctors • Stroke team • Respiratory team • Primary Care teaching • Medical Nurse practitioner teaching.	
Audit	Trustwide compliance audit performed quarterly by AMS pharmacist and fed back to divisional and governance leads and antimicrobial stewardship group members. The data is also discussed	

	quarterly at the IPCC meetings. Areas of good performance are ranked in top 3 and celebrated. Carbapenem review – 1x per week . Antimicrobials missed doses audit now carried out quarterly. Antimicrobials IVOS/plastic waste audit carried out in December 2024. Datix review of antimicrobial incidents carried out quarterly.	
Guidelines	There are comprehensive antimicrobial guidelines available on the Trust intranet and on Eolas. These are updated regularly to try and achieve the correct balance between offering appropriate treatment of infections and maintaining AMS goals. They are designed to ensure they are in line with new national guidance and take into consideration local *C. difficile* infections and resistance patterns. Within the past 2 years many of these guidelines have been updated to ensure they are current and offering the best guidance to our clinicians. Several other guidelines are also currently undergoing review, and this is an ongoing process which will continue going forwards. Paediatric guidelines – for full review and update in 2025, including paediatric IVOS. Adult guidelines – updated in 2023/24. New line infection guideline in adults currently under consultation.	
Safety	Review of OPAT prescribing processes, clinical governance and structure ongoing.	
Comms	World Antibiotic Awareness Week Nov 2024 Antimicrobial Stewardship Newsletter quarterly Updated guidelines highlighted on Workplace and Staff Brief.	

Table 6: Activities of the Antibiotic Stewardship Team

Antibiotic Consumption – Defined Daily Dose - DDD

The AMS team continuously monitor total antibiotic consumption within the Trust. Antibiotic consumption is presented as defined daily doses (DDDs) which is an internationally recognised measure of antimicrobial consumption. A DDD is the assumed average maintenance dose per day for a drug used for its main indication in adults. The amount of antibiotics used by the Trust are reported quarterly and this looks at total usage and usage of specific groups of antimicrobials. Within the past few

years, we have seen the overall usage of antibiotics at the Trust increase, the reasons for this include: we are treating larger numbers of elderly patients whose presenting conditions require more antibiotics. The Trust performs well in the usage of narrow spectrum 'access' antibiotics and are also below the national average for England in our overall usage of carbapenems (very broad-spectrum antibiotics). We will continue to monitor and report on this usage going forwards.

There is also a quarterly antibiotic compliance audit conducted by the AMS pharmacist and reviewed by the antimicrobial stewardship group (ASG) which looks at the Trusts use of antibiotics. Compliance to guidelines is monitored through this audit and is reported both to the ASG and the Infection Prevention and Control Committee via their respective group meetings. Results from the compliance audits are disseminated to clinical governance leads who are expected to cascade and discuss this data with their respective clinical bodies. Any relevant feedback from this should then be discussed at the ASG meetings.

(a) Total Antibiotic Consumption

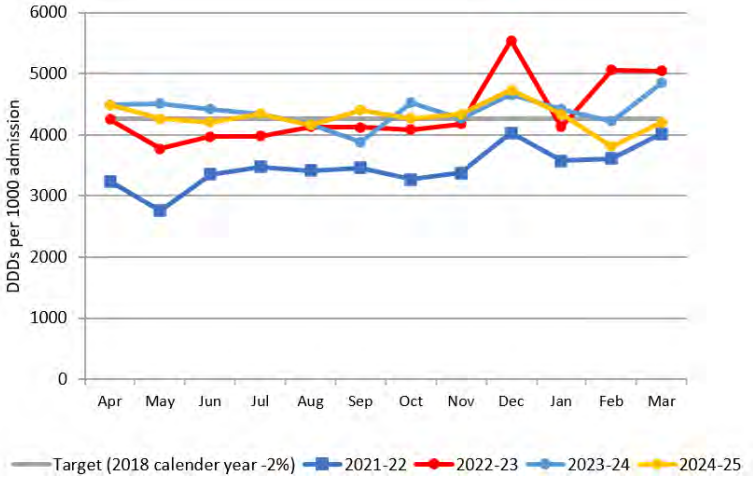

Figure 26: Total antibiotic consumption 2024/25

(b) Carbapenem Consumption

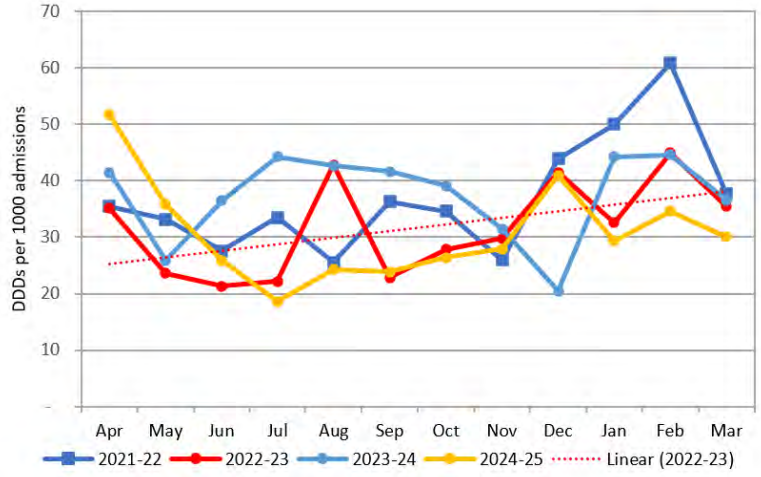

Figure 27: Total Carbapenem consumption 2024/25

(c) Access Group

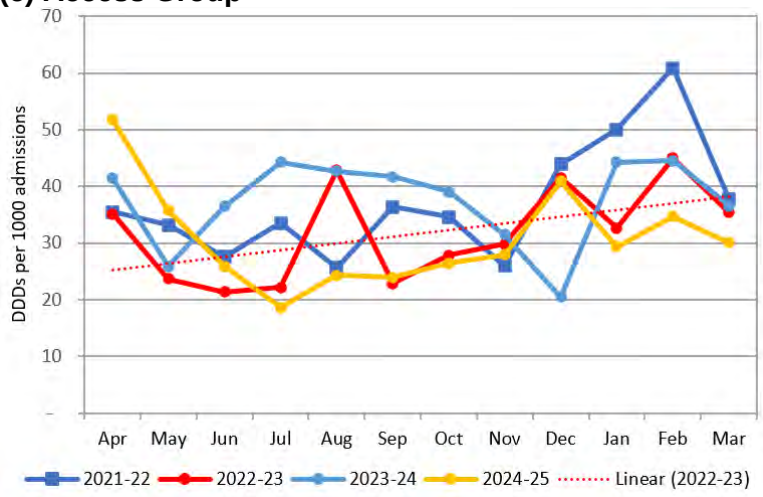

Figure 28: Access group antibiotic consumption 2024/25

(d) Broad Spectrum prescribing from Watch and Reserve

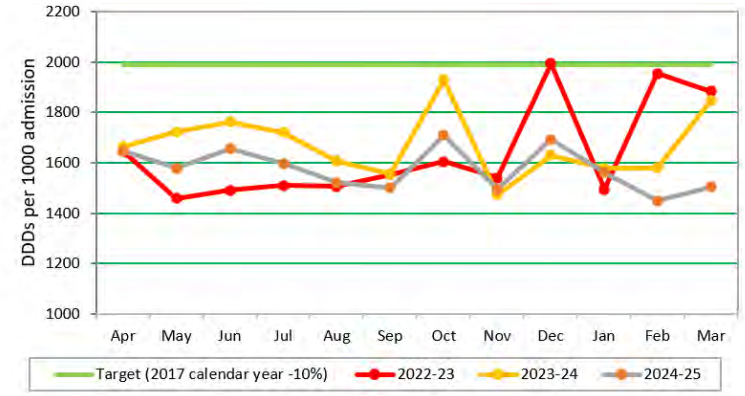

Figure 29: Watch and Reserve group antibiotic consumption 2024/25

Broad Spectrum Prescribing

Although there is no official target, there has been a further reduction in broad spectrum prescribing in 2024/25 in comparison to the previous year.

In 2023/24 there was an average of 1671 DDDs/1000 admissions vs. 1575 DDDs/1000 admission in 2024/25. The RUH is also the lowest user of broad-spectrum antibiotics in the BSW region.

We continue to monitor broad spectrum prescribing and educate prescribers and pharmacists and carry out AMS ward rounds to ensure all antimicrobial prescribing is appropriate and course lengths are kept to a minimum.

Education and Training

Education on AMS within the Trust is mandated via the AMS level 1 and level 2 modules and the ARK toolkit which form part of the Trusts mandatory training. In addition, the AMS pharmacist and microbiology consultants also regularly deliver teaching sessions which cover core AMS themes to various groups of clinical staff within the Trust.

The microbiology consultants and specialist pharmacists also carry out regular stewardship ward rounds in areas of high antibiotic use within the trust, such as daily ICU rounds and weekly rounds on Pulteney and Parry ward. They also contribute to a weekly OPAT antimicrobial review meeting and the monthly orthopaedic prosthetic joint infection MDT. This ensures clinicians have regular direct support to aid the appropriate clinical use of antibiotics.

- **AMS Level 1 = 98.9% (target 85%)**
- **AMS Level 2 = 78.53% which includes ARK as a pre-requisite**

Antimicrobial Stewardship at the RUH is important to improve antibiotic prescribing, protect individual patients and the local population from unintended harm from antibiotic overuse including HCAIs, and contribute to slowing antibiotic resistance.

The Trust is committed to following the principles outlined in the Department of Health (DH) guidance “Antimicrobial Stewardship: Start Smart then Focus” and follow the guidance and processes set out in NICE NG15 and the Public Health England 5 and 20 year action plans on AMR https://www.gov.uk/government/collections/antimicrobial-resistance-amr-information-and-resources#strategic-publications and will follow any upcoming national action plan/ guidance in 2025.

The microbiology consultants also contribute to AMS within the Trust through the clinical queries they receive asking for advice on managing infections involving patients within the Trust and in Primary Care via calls from local GPs. Any advice given will always consider AMS principles. This is also true of the reports that are released on positive microbiology clinical samples where any antibiotics advised will always adhere to AMS requirements.

Going forward, we aim to continue to closely monitor the Trusts usage of antimicrobials and ensure we are using them appropriately based on current best practice and guidelines. This will be done by continuing the work as outlined above. The main threats to this would revolve around staffing levels and ensuring relevant staff

members have the time to review antimicrobial use and attend relevant group meetings to discuss AMS issues.

Criterion 5

That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.

Infection Prevention and Control Surveillance Software

The RUH uses the ICNET system supported by Baxter, which is currently the only product on the market that provides fully supported services for infection alerts for the future.

The IPC team review the reports each day and add any alert flags to the electronic patient records (EPR). This allows for appropriate management of infectious or potentially infectious patients in real time. To reduce the risk to staff, patients and service users as part of the admission risk assessment.

Infection Prevention and Control Incidents and Learning

Measles

Measles is a highly contagious vaccine-preventable notifiable infectious disease and is one of the most infectious diseases, with one patient able to infect 15-20 people. Transmission is mostly airborne by droplet spread or by direct contact with nasal or throat secretions of an infected person. This illness can be particularly severe in individuals with weakened immune systems and in young infants. Additionally, it poses greater risks during pregnancy, increasing the likelihood of miscarriage, still birth, or pre-term delivery. The most effective method of controlling measles is to ensure a high uptake of a vaccine (herd immunity), two doses of the measles, mumps and rubella (MMR) vaccination.

There have five cases of measles identified when attending and using the Trust services, all were aged under the age of 21 and had either not been eligible (due to age) or had only had partial vaccinations (MMR). All cases were reported to the UKHSA, processes were followed around staff and patient safety, contact tracing and treatment. Of the three patients admitted all were well enough to be discharged within 24 hours.

Measles continues to be one of the most common reasons for contacting the Health Protection teams at UKHSA as the presentation can be attributed to other childhood illnesses. The importance of early recognition, diagnosis, and reporting enables staff

the ability to stay safe and prepare. Admission areas and front door services have been informed, and posters have been re-issued to ensure this important message and staff awareness is always paramount.

Carbapenemase-producing Enterobacterales (CPE)

CPE are a large family of bacteria that usually live harmlessly in the gut. People are unaware that they are colonised until they are tested and then identified as a carrier. CPE does not cause a problem until the bacteria get into the wrong place such as the bladder or blood stream, these can then cause an infection, particularly in patient with an impaired immune system. CPE organisms can spread rapidly in healthcare settings and lead to poor clinical outcomes because of limited therapeutic options.

CPE presents considerable financial and operational challenges for the healthcare sector. However, there remains substantial uncertainty about the most effective strategies to reduce the transmission of CPE. As CPE resides in the gut the patient is then classed as colonised indefinitely. Even though evidence has shown that on subsequent admissions patients are found to have negative screens it is difficult to be confident that this represents clearance.

Practices that are currently in place within the Trust are to undertake active patient admission screening of high risk groups, have appropriate surveillance systems in place to monitor rates, have consistent adherence to infection prevention and control practices and standard infection control precautions (SICP) contact precautions, minimise CPE reservoirs by effective environmental cleaning and decontamination, and effective antimicrobial stewardship programmes to minimise inappropriate use of broad-spectrum antibiotics, including carbapenems.

There have been seven new diagnoses of colonisation during admission, and several patients who continue to be readmitted and are known to have CPE.

Learning

Identification of CPE patients as soon as they are at the ‘front door’ and timely isolation on the ward is essential to reduce the spread of infection. The IPC team continue to promote the use of standard work in the admission phase to reduce unwarranted variation.

Norovirus Outbreaks

Norovirus is a highly transmissible virus. Individuals are most infectious when symptomatic but remain infectious before developing symptoms and after symptoms have stopped. Norovirus can be transmitted person to and to any surfaces or via objects or food, especially within a healthcare environment. Diarrhoea, abdominal pain and projectile vomiting typically begin 12-48 hours after exposure to the Norovirus

infection and often comes with other common viral symptoms such as high-temperature and joint pain.

The RUH completes Norovirus testing on all stool samples taken from inpatients (in line with best practice), hence there are cases detected throughout the year. It should be noted that isolated cases do not necessary develop into outbreaks of infection on our wards.

The IPC estates work has continued to increase the number of isolation facilities during 2024/25 this has enabled the Trust to isolate an increasing number of patients with infections and reduce the incidence of ward closures due to infections such as Norovirus. This work will continue across 2025/26 if funding allows.

The community rates of Norovirus were significant during the winter, the activity generated by Norovirus in the acute Trust during 2024/25 was contained by closing bays and complete wards when required.

Ward Closures

There were six ward closures throughout the year, that was required to manage the risk to patients. There were 161 lost bed days during this period, with bays being closed for a total of 52 days, which impacts new admissions and patient flow.

The longest ward closures were for nine consecutive days, which was effectively managed by IPC, supported by the ward teams and Site Management to resolve the situation without major complications or issues. The swift response by all concerned helped to contain the virus ensuring minimal spread outside the affected bays, allowing the wards to return to normal operations within a feasible period of time.

The areas affected were older persons wards. Patients with a cognitive impairment may be likely to wander, therefore the IPC team endeavour to safety limit further spread and protect this vulnerable group of patients by closing when two or more patients are identified.

Due to the increased rates this year, the number of closures in 2024/25 was above 2023/24 with five closures and 2022/23 with four closures.

Month	Area	Days closed	Bed days lost
June 24	Parry Ward	8	51
December 24	Combe Ward	3	10
January 25	Combe Ward	8	26
	Haygarth	14	21
February 25	Combe	8	23
	ASU	11	4
		52	**161**

Table 7: Ward closures 2024/25

Outbreaks with bay closures

There were 14 outbreaks resulting in 51 bay closures with totalling 115 lost bed. Closures of the bays varied between two and 11 days, with an average of eight days per bay.

Some of the bay closures were used to cohort patients with Norovirus and created capacity along with safer flow across the site, this was to prevent whole ward closures. This helps to explain why some prolonged bay closures, which were not seen in the whole ward closures.

In addition to the 51 bays closed due to the increased number of cases, there were 80 bay closures due to exposure of a positive patient, the peak times were between June and July; and January and February where 166 bed days were lost out of a total of 216. There is the requirement to ensure patients are isolated/cohorted until they are 48 hours symptom free, to ensure they do not shed the virus if they have further symptoms or expose new admissions/anyone sharing the facilities to the virus.

Table 8 outlines the impact of the number of days bays were closed and bed days lost as a total, this is broken down into outbreaks in bold and cumulative figure for cohort and contact, exposed but not symptomatic patient bays.

Month	Area	Days closed	Bed days lost
April	Combe, Haygarth, Respiratory (x2). OPRAA (Assessment area on the Older Persons Assessment Unit), Cardiac, Medical Short Stay (MSS) (7 contact bays)	16	25
May	Haygarth, Parry, Waterhouse, Cardiac William Budd and Forrester Brown (FB) (6 contact bays)	19	15
June	Respiratory, Acute Stroke Unit (ASU) Combe (3), Waterhouse, MAU, Ward 4 , FB, Pulteney, and Parry (11 contact bays)	18	30
July	ASU, Cardiac (2), MSS (2), OPAU, Older Persons Unit Short Stay (OPUSS), Respiratory, (7 contact bays) **Cardiac**	19 **3**	30 **9**
August	Pulteney and Respiratory	4	8
September	Cardiac and Respiratory	5	8

October	**OPUSS** Respiratory	**2** 2	**16** 6
November	Waterhouse (x2) OPUSS (3 contact bays)	4	4
December	**Cardiac**	**1**	**2**
	OPUSS	**5**	**7**
	Parry, Combe, Forrester Brown, OPRAA, and Robin Smith (5 contact bays)	13	10
January	**Combe**	**2**	**15**
	Haygarth	**6**	**11**
	OPAU	**3**	**8**
	OPRAA	**1**	**4**
	ASU, Cardiac, Combe Forrester Brown (x3), Haygarth (x3), MAU (x3) OPAU, OPRAA,OPUSS Parry and Philip Yeoman (21 bays of Contacts)	69	69
February	**ASU** **Combe** **OPAU** **OPRAA**	**11** **8** **2** **1**	**4** **21** **5** **7**
	ASU,OPAU, OPRAA, Charlotte, Cheseldon, Combe, Haygarth, Helena, OPUSS and Pierce (10 contact bays)	41	37
March	**Parry**	**3**	**5**
	Waterhouse	**3**	**1**
	Forester Brown, Combe and MAU (x2) (4 contact bays)	6	7
		51 (216)	**115** (249)

Table 8: Outbreaks and exposed bays 2024/25

COVID-19

COVID-19 activity was broadly stable across 2024/25, and numbers were lower than similar times the previous year but continued to place considerable pressure on the available isolation facilities. ICU/HDU admission rates decreased and circulating at baseline levels in the surrounding community. There were minimal increases seen in concurrent weeks across the year and the figures had stabilised. Figure 30 shows clearly how the levels of COVID have reduced locally and nationally and not reached the heights of 2023/24 at 25 cases per 100,000 days in week 52.

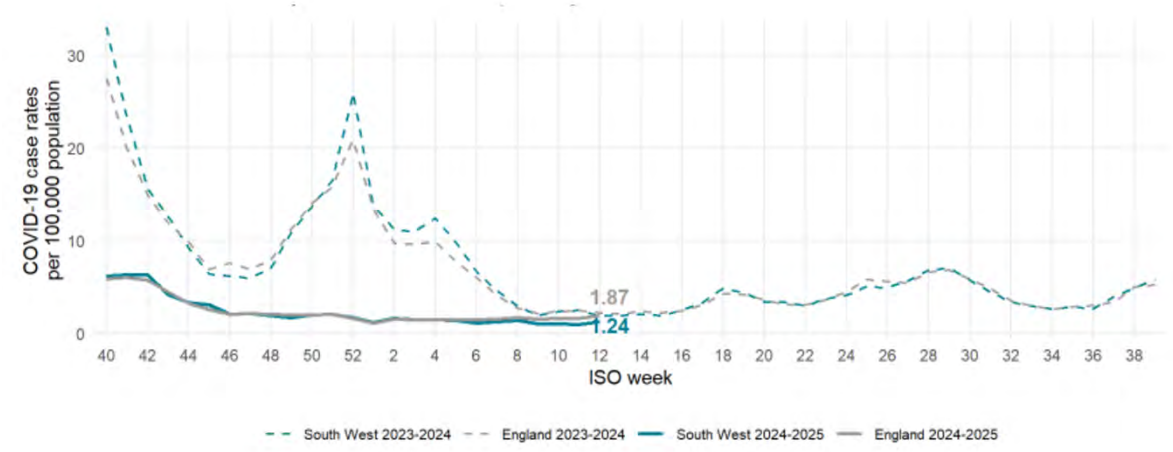

Figure 30: Weekly COVID-19 case rates, data updated as of 22 May 2025

The vaccination programme was delivered in spring and autumn for the elderly and vulnerable population, with healthcare workers were given boosters in the autumn. The Trust continued to provide vaccinations to inpatients.

Testing remains relatively unchanged, only symptomatic and those using Haematology and Oncology services, including staff members when at work are tested.

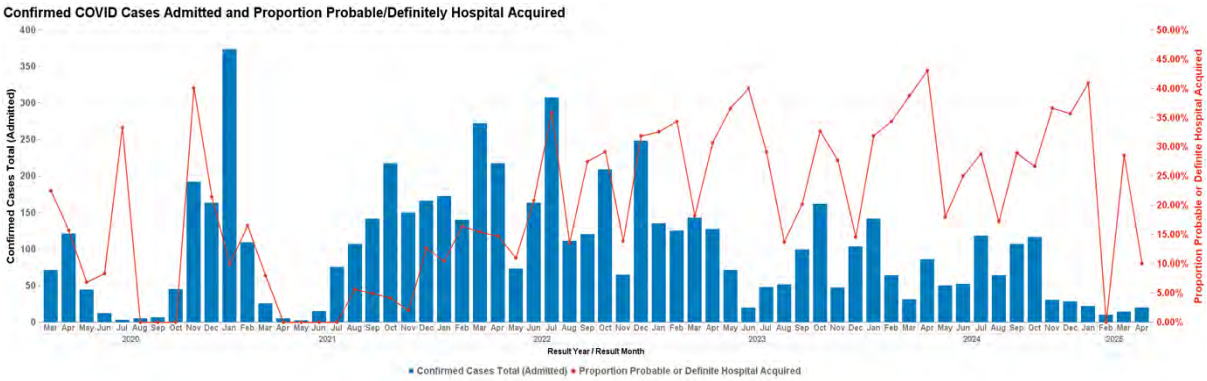

Figure 31: COVID-19 positive case numbers 2020-2025

COVID-19 Outbreaks 2024/25

The impact of COVID across the Trust

Month	Area	Days closed	Bed days lost
April	3 wards with bay closures	6	22
May	3 wards with bay closures	7	29
July	1 ward with bay closures	14	16
August	1 ward with bay closures	4	5
September	7 wards with bay closures	46	34
October	11 wards with bay closures	74	71
November	3 wards with bay closures	10	2

December	3 wards with bay closure	9	7
January	3 wards with bay closures	12	6
March	1 ward with bay closures	5	13
		187	**205**

Table 9: COVID-19 bay and ward closures due to outbreaks 2024/25

The pressures of bay closures have remained the same and have impacted as much as previous years; with 183 days of bay closures in 2023/24 against 187 days closed in 2024/25. Also, there is a comparable link with lost bed days being 211 in 2023/24 and then 205 in 2024/25. There was a seasonal trend emerging that has shown that higher rates of COVID are being seen in September and October in both years.

Influenza

The RUH has detected 729 cases of influenza (flu) for the year of 2024/25.

2024/25	April-Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Total
Influenza A	10	1	5	8	280	195	127	20	**646**
Influenza B	7	0	0	0	5	19	31	22	**84**
Total	17	1	5	8	285	214	158	42	**730**

Table 10: Recorded Influenza numbers 2024/25

December 2024 saw the first rise in influenza cases, when 280 cases of influenza A and five cases of influenza B were detected (37 were children). This high influx of patients put excessive pressure on the front door and the wards with six ward outbreaks, six cohort bays and 23 contact bays that meant the Trust lost 67 bed days.

Transmission showed a different pattern than previous years, and patients were becoming positive more than 5 days after contact with a positive case and symptoms lasted 7 days plus. This delayed bay opening and changes in practice to control the spread within the Trust. The ability to react to change is necessary within outbreak situations and this meant that senior support from division and Site Management were necessary to safeguard the patients.

January 2025 saw a further increase of 195 detected cases (table 10) of Influenza A and 19 cases of Influenza B (28 were children) with 86 admissions.

There was a total of 98 lost bed days that resulted in six outbreaks, with seven cohort bays and 21 contact bays. Of the lost bed days, 42 were in the designated influenza wards.

February 2025 saw a further 127 cases of influenza A and 31 influenza B (20 cases were children) there was a noticeable decrease in cases in March (figure 32) seeing a reduction to 20 influenza A cases and 22 influenza B (6 children).

Of the 42 cases identified 30 of these patients were not vaccinated and 21 were reported as influenza B.

Being able to isolate patients rapidly continues to be a challenge across the Trust and the capacity to do so is restricting containment of communicable diseases. This is especially apparent at the peak times of the year when seasonal viruses are more likely to be prevalent. Initiatives to increase side rooms with ensuite facilities across the Trust are needed to promote a safe environment for all patients.

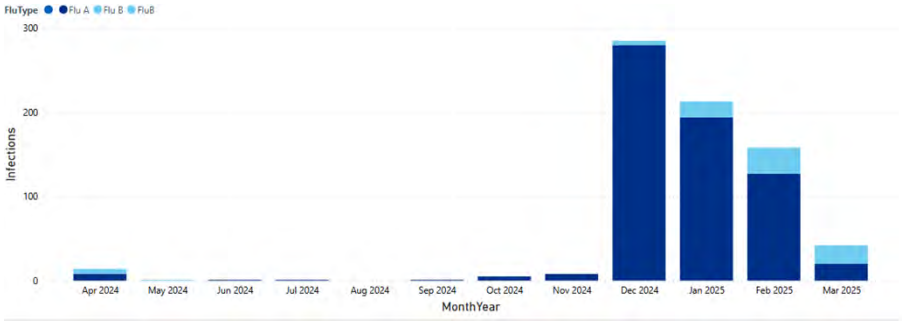

Figure 32: RUH Influenza positive case data 2024-25

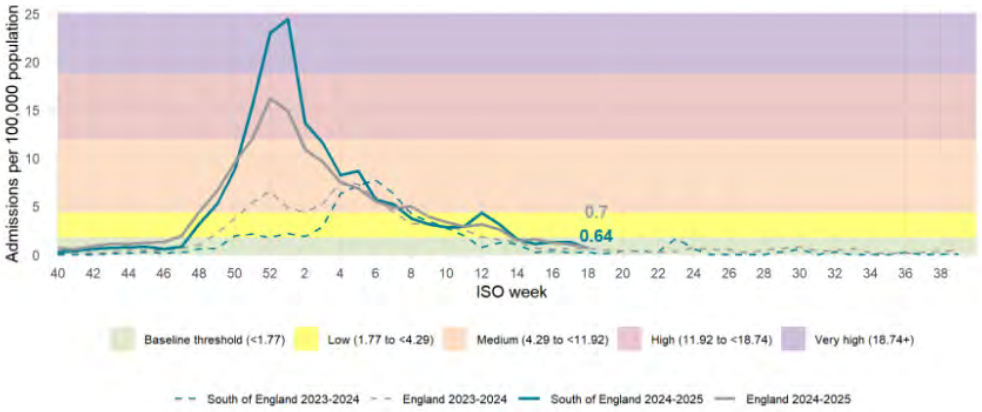

Figure 33: Hospital admission up to week 18, week 13 being the end of 2024/25

Figure 33 shows the peak of influenza within the South West at week 52 that continues until a decline is noted at week 2 until it reaches expected levels at around weeks 6-8, these statistics support the results that have been seen in the Trust and has shown the admissions of positive cases were well above the baseline threshold for that time of year and were a large increase on the levels seen in 2023/24.

Candidozyma auris – *C. auris*

C. auris is a fungal pathogen and is now considered an emerging pathogen that is proving problematic to eradicate throughout the healthcare system. The main challenge with *C. auris* is resistance to key antifungal agents, meaning that treatment options for infections are increasingly limited.

There is recent evidence that *C. auris* is emerging rapidly in the USA, UK, and in other parts of Europe. This has affected some hospitals within the UK with lasting impact. Policies and testing processes are being developed for the Trust in collaboration with the UKHSA laboratory in Bristol.

Information to note about *C. auris*:

- Candida auris has recently had its name changed to Candidozyma auris, this is the same pathogen.
- *C. auris* is a fungal opportunistic pathogen. That can most commonly colonise humans but can cause infections. *C. auris* candidemia and invasive candidiasis can be life-threatening, with a crude mortality in the 30-60% bracket but it's difficult to determine attributable mortality.
- Risk factors for colonisation or infection with *C. auris* are similar to antibiotic resistant bacteria such as CPE: age, devices/ventilation, underlying medical conditions, surgical interventions, medicines (including antimicrobial agents and steroids).
- *C. auris* is extremely capable of colonising human skin, medical devices and other surfaces within a healthcare environment. Most strains of *C. auris* are resistant to fluconazole (first line treatment for Candida), and some strains are resistant to all available classes of antifungal drugs.
- A recent study tracked the emergence of *C. auris* and found it has become the predominant cause of HCAI outbreaks in recent years.
- From an IPC viewpoint, rapid identification combined with timely application of IPC measures is the cornerstone of prevention.

Gloves Off Campaign

In response to the ongoing increased use of non-sterile glove use in the organisation, the "Gloves Off Campaign' Quality improvement work has been successfully implemented on the Acute Stroke Unit, vascular studies, recovery and OPAU.

The non sterile nitrile glove usage puts considerable pressure on the environment and the planets resources. Some of this use is driven by fear of contracting infections, and fear of not getting it right and being a safe default. This behaviour is being addressed in a proactive way, which increases knowledge and reinforces confidence in the workforce about when and where it is necessary to wear non sterile gloves.

There has been great enthusiasm shown within in the Trust to understand the rationale for wearing gloves and the message is passing through all channels, especially after the successful stand and representation at the Sustainability Days in 2024 and 2025.

Understanding the impact of glove reduction on the environment and on people that produce them has highlighted the importance of this initiative. Using the Improving Together methodology this initiative will be spreading across the Trust during 2025/26.

Surgical Site Infection Surveillance (SSI)

Trauma and Orthopaedic SSI Surveillance

Surveillance of infections in these procedures originally started in April 2004. Each Trust was expected to conduct surveillance for at least one orthopaedic category for one period in the financial year. The surveillance categories are hip replacements (THR), knee replacements (TKR), repair of neck of femur (NOF) at the RUH and THR/TKR surgeries conducted at the RUH Modular theatre and will now be followed up in the Sulis Orthopaedic Centre. Data is also submitted for colorectal which includes large and small bowel surgery.

RUH Fractured Neck of Femur Repair (NOF) data

The rates surrounding SSI for fractured neck of femur repair during October-December 2024 were recorded as one incidence that proceeded to be within a deep incisional case and where the patient was readmitted. The primary indicator for surgery in over 99% of cases was trauma/fracture, due to the nature of the injury.

Rates of inpatient, readmission and all SSIs have been stratified using the US National Nosocomial Infections Surveillance System risk index and combines three major risk factors, including the American Society Anaesthesiologists (ASA) score which outlines the patient's health prior to surgery, the duration of surgery and degree of microbial contamination.

The infection rate was 0.8% for the selected period (Oct-Dec 24) and was the only incidence identified within the 4 quarters of 2024. Of the patients who took part in the surveillance for that year 101 cases were risk category 1; 11 cases were a risk index of 2 and all other patients had no identified risk (n-13). Therefore, the patients that were seen by the Trust were classified as completely healthy and low risk.

Year and Period	No. operations	Surgical Site Infection					
		Inpatient & readmission		Post discharge confirmed		All SSI*	
		No.	%	No.	%	No.	%
2024 Q1	123	0	0.0%	0	0.0%	0	0.0%
2024 Q2	127	0	0.0%	0	0.0%	0	0.0%
2024 Q3	109	0	0.0%	0	0.0%	0	0.0%
2024 Q4	125	1	0.8%	0	0.0%	1	0.8%

*All SSI = Inpatient & readmission, post-discharge confirmed and patient reported

Table 11: Trends in rates of SSI by surveillance period Q1-Q4 2024 repair of NOF

RUH Total Hip Replacement data

During the surveillance period of October-December 2024 there were two cases that were reported as inpatient/readmission SSIs. Of these surgeries, there was an

average ASA score of 3 and in over 72% of cases the patients were above the age of 70.

The primary indicator for surgery was due to osteoarthritis at 71% which is lower than the national average at 88%. The Trusts incidence of revision-other and trauma fracture was reported higher at 12.7% and 7.6%, whereas the national picture was below 3% in both incidences. Therefore, the Trust was supporting higher risk patients through their surgical pathway and has improved performance within the last two Quarters with no SSIs.

Year and Period	No. operations	Surgical Site Infection					
		Inpatient & readmission		Post discharge confirmed		All SSI*	
		No.	%	No.	%	No.	%
2024 Q1	76	1	1.3%	0	0.0%	2	2.6%
2024 Q2	67	1	1.5%	0	0.0%	2	3.0%
2024 Q3	67	0	0.0%	0	0.0%	1	1.5%
2024 Q4	79	0	0.0%	0	0.0%	0	0.0%

*All SSI = Inpatient & readmission, post-discharge confirmed and patient reported

Table 12: RUH SSI trend data for Total Hip Replacement Q1-Q4 2024

RUH Sulis Modular Theatre - Total Hip Replacement data

The Sulis Hospital is commissioned to conduct non-emergency NHS orthopaedic surgery. At the start of the surveillance period the infection rate reported at Sulis Hospital was 0.0% for THR and 0.8% for TKR in Quarter 1 2024.

Nothing of note was reported in relation to the SSI report during this period. An increase in SSI was noted in Q1 with two patients reporting an infection post discharge with a rate of 3.6% out of 56 patients, a similar percentage was seen again in July-Sept 24 Q3 at 3.2% this relates to a single patient as lower attendance (n-31) affected the percentage outcome. Awareness on the impact of low numbers on percentage outcomes must be recorded openly, as to not deviate from the importance of valid high infection rates that demonstrate an extreme problem.

Year and Period	No. operations	Surgical Site Infection					
		Inpatient & readmission		Post discharge confirmed		All SSI*	
		No.	%	No.	%	No.	%
2023 Q4	20	0	0.0%	0	0.0%	0	0.0%
2024 Q1	56	0	0.0%	1	1.8%	2	3.6%
2024 Q2	23	0	0.0%	0	0.0%	0	0.0%
2024 Q3	31	1	3.2%	0	0.0%	1	3.2%

*All SSI = Inpatient & readmission, post-discharge confirmed and patient reported

Table 13: Sulis SSI trend data for Total Hip Replacement Q4 -Q3 2023/24

There have been some concerns relating than higher than average reported infections at Sulis Hospital in 2024. Recommendations were devised and listed below:

- IPC training for all clinical staff and relevant support staff. To be monitored through the training matrix.
- Aseptic non-touch technique (ANTT) competencies for staff that are involved in relevant procedures.
- Audits to be completed monthly, including hand hygiene and environmental audits.
- Attendance monthly at RUH IPCC to report compliance and learning.
- Further research into changes in dressing and antimicrobial sutures in line with best practice.
- IPC nurse to attend Sulis weekly to complete audits and Band 7 to support with training needs as required by the clinical teams.
- SSI spreadsheet is to be maintained as an ongoing thematic review of infections and reviewed for trends at the Sulis IPC meeting monthly.

RUH Total Knee Replacement data

Outcomes from TKR at RUH have been positive, with one infection in 2024. The rate in Q1 was 1.7% which accounts for one patient who reported an infection, there was no confirmation of the level of infection identified. Q2 & Q3 experienced no reported infections and completed 38 TKR during that period. The only comment of note was that patients had been suffering with reactions to the dressings that were being used.

Year and Period	No. operations	Surgical Site Infection					
		Inpatient & readmission		Post discharge confirmed		All SSI*	
		No.	%	No.	%	No.	%
2023 Q4	49	0	0.0%	0	0.0%	1	2.0%
2024 Q1	59	0	0.0%	0	0.0%	1	1.7%
2024 Q2	38	0	0.0%	0	0.0%	0	0.0%
2024 Q3	38	0	0.0%	0	0.0%	0	0.0%

*All SSI = Inpatient & readmission, post-discharge confirmed and patient reported

Table 14: RUH SSI trend data for Total Knee Replacement Q4 -Q3 2023/24

RUH Sulis Modular Theatre - Total Knee Replacement data

At the start of the surveillance period at Sulis the infection rate was reported as 0%, for Q1. Q2 rate was reported as 2.6%, this was attributed to a single reported infection and Q3 had a similar rate of 2.7 again for a single case. The previous year 2023 Q4 had shown a rate of 6.5% for three patients therefore the interventions that have been instigated within Sulis have had an impact, although deviation can be seen quite readily when the number of patients is lower. There was one noted joint space infection in July from a patient who had a higher body mass index (BMI), further

evaluation of the surgical pathway is necessary to support better outcomes for this group.

Year and Period	No. operations	Surgical Site Infection					
		Inpatient & readmission		Post discharge confirmed		All SSI*	
		No.	%	No.	%	No.	%
2023 Q4	46	0	0.0%	0	0.0%	3	6.5%
2024 Q1	47	0	0.0%	0	0.0%	0	0.0%
2024 Q2	39	0	0.0%	0	0.0%	1	2.6%
2024 Q3	37	0	0.0%	0	0.0%	1	2.7%

*All SSI = Inpatient & readmission, post-discharge confirmed and patient reported

Table 15: Sulis SSI trend data for Total Knee Replacement Q4 -Q3 2023/24

Colorectal SSI Data

Since the start of the colorectal SSI improvement initiative at the RUH in 2019, there has been a marked and sustained reduction in surgical site infections for elective colorectal procedures. The baseline SSI rate in 2019 was 22%, and by Q4 2024, this has fallen consistently to below 10%.

Figures 34 and 35 demonstrate the sustained SSI reduction elective colorectal surgery at the RUH (2019 - March 2024).

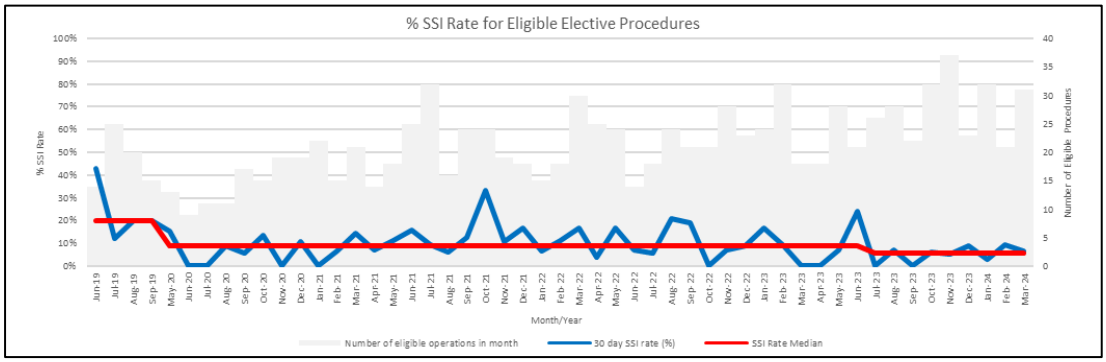

Figure 34: Percentage of infections for eligible elective procedures (low is good) 2019-25

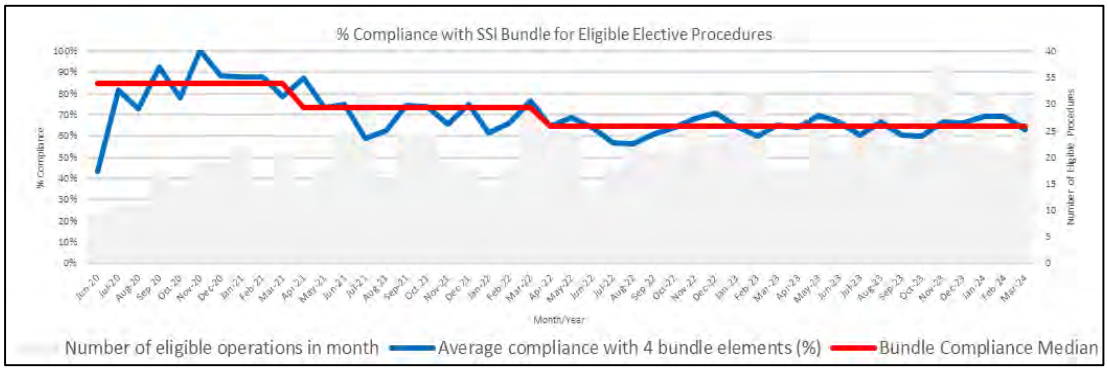

Figure 35: Percentage compliance with SSI bundle for eligible elective procedures (high is good) 2019-25

National Benchmarking – UKHSA and GIRFT Comparison

According to UK Health Security Agency surveillance data, national average SSI rates for elective colorectal procedures range between 8–11%, whilst Get it Right First Time (GIRFT) 2021 National General Surgery Report identifies a national mean of 11.7%, with significant variation across sites.

RUH performance in 2024:

- Q2: 9.5%
- Q3: 7.5%
- Q4: 8.8%
- This demonstrates that RUH is now performing within or below national and GIRFT averages, reflecting the impact of sustained quality improvement efforts.

Bundle Compliance – Current Performance

Compliance with the colorectal SSI bundle has decreased slightly to a median of 65%, with the following current performance by component:

Bundle Element	RUH Compliance	GIRFT/Best Practice
Chlorhexidine skin prep	97%	≥90%
2nd antibiotic dose (>4hr procedures)	87%	≥95%
Wound protector use	39%	Routine use recommended
Antibacterial sutures	29%	Target ≥80%

Table 16: Overall PreSSIion bundle compliance - skin, antibiotics, sutures and wound protector

The main areas for improvement remain the uptake of antibacterial sutures and wound protectors. Under-documentation may partly account for the wound protector data.

Monocryl+ Use:

- Used: 894 cases 64 SSIs **7.2% SSI rate**
- Not Used: 388 cases 56 SSIs **14.4% SSI rate**

Use of Monocryl+ was associated with a significantly lower SSI rate (**$p < 0.01$**), with rates approximately halved compared to cases where it was not used.

PDS+ Use:

- Used: 603 cases 53 SSIs **8.8% SSI rate**
- Not Used: 679 cases 67 SSIs **9.9% SSI rate**

Use of PDS+ was associated with a modest reduction in SSI rate This is not statistically significant. There is no current data supporting an increased risk of wound failure with PDS+.

Wound Protector Use and SSI:

Wound Protector Use	Total Cases	SSI Cases	SSI Rate (%)
Not Used (N)	547	53	9.7%
Used (Y)	699	64	9.2%

Table 17: Wound protector Use and associated SSI

P-value: 0.770 No significant difference in SSI rates based on wound protector use.

Antibiotic Use and SSI:

Antibiotic Use	Total Cases	SSI Cases	SSI Rate (%)
Appropriate (Y)	897	82	9.1%
Not Appropriate (N)	131	17	13.0%

Table 18: Antibiotic use in relation to SSI cases Colorectal

P-value: 0.203 Higher SSI rate with inappropriate antibiotic use, but not statistically significant.

Cost Analysis – Financial Impact of SSI Reduction

Surgical site infections are costly. NHS Improvement and GIRFT estimate that each colorectal SSI costs around £10,000–£15,000, due to extended hospital stays, readmissions, reoperations, and antibiotic use.

Assumptions:

- 320 elective colorectal cases/year
- Initial SSI rate (2019): 22% → ~70 infections/year
- Current SSI rate (2024): 8% → ~26 infections/year
- Reduction: 44 fewer infections/year
- Estimated cost per SSI avoided: £12,500

Annual Cost Saving:

44 infections avoided × £12,500 = £550,000 saved per year

This does not include indirect savings such as bed capacity release, reduced complications, or improvements in patient experience.

Looking Ahead: Introducing Antibiotic Bowel Preparation (ABP)

Strategic priority for 2025–26: Implementation of combined oral antibiotic and mechanical bowel preparation (OABP + MBP) for elective colorectal cases.

Supporting Evidence:

- McSorley et al., 2019 (Ann Surg): Meta-analysis of 38,000+ patients showed significantly lower rates of SSI and anastomotic leak with combined OABP + MBP versus MBP alone or no prep.
- GIRFT and ACPGBI guidance both recommend consideration of OABP as part of enhanced recovery.
- NICE (NG125): Supports OABP in appropriate elective colorectal patients.

Implementation will be supported by protocol development, perioperative team training, pharmacy involvement, and patient education.

Colorectal PreSSIon Study Summary

Elective colorectal SSI rates at RUH have reduced from 22% to under 10%, delivering estimated cost savings of £550,000 per year. RUH is now performing above national benchmarks, with further improvement planned through increased bundle compliance and adoption of evidence-based antibiotic bowel preparation.

Large Bowel Surgery Data

The rate for Q3 was the highest recorded for the year at 9.8% this comprised of 10 patients being re-admitted. Q1 saw the lowest rate of infections with seven patients, six who were readmitted and a further case that was patient reported. The rates were comparable to previous years. Although Q2 and Q3 were both above 9% for all SSI's reported with an extra two patients and three in the latter quarter.

Trend for the selected period

Year and Period	No. operations	Patient questionnaire		Inpatient & readmissions		Post discharge confirmed		Patient reported		All SSI *	
		No. Given	% complete	No.	%	No.	%	No.	%	No.	%
2024 Q1	96	91	94.8	6	6.3	0	0.0	1	1.0	7	7.3
2024 Q2	100	95	95.0	8	8.0	0	0.0	1	1.0	9	9.0
2024 Q3	102	96	94.1	10	9.8	0	0.0	0	0.0	10	9.8
2024 Q4	95	85	89.5	5	5.3	1	1.1	1	1.1	7	7.4

*All SSI = Inpatient & readmission, post discharge confirmed and patient reported

Table 19: RUH SSI trend data for Large Bowel Surgery Q1-Q4 2024

Small Bowel Data

The rate for small bowel surgery is lower with a total of 120 operations recorded for 2024. The overall picture for this surgery has shown a rate of infections which equated to between 2-3 cases per quarter. Although Q4 has shown an increase from the norm, at 11.1% the increase relates to one additional patient. The rates seen during 2024 are higher than 2023, apart from Q2 that had an anomaly at 16% for four patients, this can be seen during 2024 when three cases increased the percentage by more than 5% this aligns with a single patient.

Year and Period	No. operations	Patient questionnaire		Inpatient & readmissions		Post discharge confirmed		Patient reported		All SSI *	
		No. Given	% complete	No.	%	No.	%	No.	%	No.	%
2024 Q1	38	33	86.8	2	5.3	0	0.0	0	0.0	2	5.3
2024 Q2	29	24	82.8	2	6.9	0	0.0	0	0.0	2	6.9
2024 Q3	26	23	88.5	1	3.8	0	0.0	1	3.8	2	7.7
2024 Q4	27	21	77.8	2	7.4	0	0.0	1	3.7	3	11.1

*All SSI = Inpatient & readmission, post discharge confirmed and patient reported

Table 20: RUH SSI trend data for Small Bowel Surgery Q1-Q4 2024

Criterion 6

Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

Training

All new staff to the Trust including contractors complete IPC induction. IPC eLearning meets the statutory and mandatory training requirements and learning outcomes for Infection Control Level 1 and 2 in the UK Core Skills Training Framework (UK CSFT). This is completed 3 yearly for level 1 and annually for level 2 which is designed to be completed by all healthcare staff groups involved in direct patient care or services.

All Trust job descriptions have IPC roles and responsibilities written into them. The IPC team support clinical areas where practice needs to be improved on case-by-case basis. Bank staff training rates have been addressed, and a steady improvement is being made in the compliance rates.

Compliance is to be reported via Divisions to IPCC. Tables 21 and 22 demonstrate the Trust wide monthly compliance for levels 1 & 2 of IPC mandatory training.

Division	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Bank [Division]	77.69%	78.14%	78.72%	77.70%	83.21%	84.73%	77.00%	76.92%	77.94%	79.02%	84.94%	86.23%
Capital Summary [Division]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	95.65%	92.00%
Charity Summary [Division]	92.86%	92.31%	100.00%	91.67%	92.31%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Corporate Division	91.72%	92.19%	91.86%	91.33%	92.63%	93.10%	93.99%	94.18%	94.41%	95.53%	93.96%	94.31%
Estates and Facilities Division	87.23%	85.32%	86.05%	87.45%	95.10%	95.88%	90.30%	90.24%	90.04%	90.39%	92.56%	93.28%
Family and Specialist Service Division	95.05%	94.92%	94.68%	94.41%	92.27%	93.30%	93.37%	93.00%	93.69%	93.30%	95.05%	94.00%
Medical Division	96.55%	96.78%	96.52%	96.96%	95.56%	96.10%	96.45%	97.12%	97.81%	96.90%	96.86%	96.45%
Research & Development [Division]	95.71%	97.26%	98.57%	97.01%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Surgical Division	95.77%	95.49%	95.37%	95.57%	97.14%	96.22%	97.06%	96.78%	97.06%	96.78%	97.08%	97.02%
Total	**92.57%**	**92.67%**	**92.67%**	**92.68%**	**93.79%**	**94.25%**	**92.42%**	**92.52%**	**92.80%**	**93.02%**	**94.12%**	**94.22%**

Table 21: Divisional compliance IPC Level 1 Training 2024/25

Division	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Bank [Division]	51.17%	48.18%	50.51%	50.86%	50.74%	49.74%	51.13%	50.53%	52.69%	54.64%	64.48%	69.28%
Capital Summary [Division]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Corporate Division	81.25%	72.36%	76.67%	78.81%	85.45%	81.75%	74.05%	78.29%	80.30%	83.33%	86.43%	88.11%
Estates and Facilities Division	58.82%	51.10%	42.07%	53.85%	70.29%	59.57%	100.00%	100.00%	100.00%	98.04%	96.23%	96.15%
Family and Specialist Service Division	86.84%	81.19%	82.99%	84.90%	88.86%	88.82%	87.47%	86.28%	87.37%	87.74%	88.35%	87.61%
Medical Division	86.82%	82.89%	83.90%	84.96%	88.52%	85.51%	85.41%	85.00%	84.91%	84.16%	84.33%	84.89%
Research & Development [Division]	87.80%	86.36%	82.93%	90.00%	90.48%	88.10%	93.18%	86.96%	86.96%	91.30%	86.96%	91.30%
Surgical Division	86.45%	82.43%	85.18%	86.05%	88.58%	87.78%	88.58%	87.25%	86.57%	86.73%	86.67%	85.68%
Total	**79.89%**	**75.76%**	**77.08%**	**78.73%**	**81.96%**	**79.71%**	**81.19%**	**80.48%**	**80.92%**	**81.23%**	**83.29%**	**83.89%**

Table 22: Divisional compliance IPC Level 2 Training 2024/25

Fit Testing

All identified staff are trained in the selection and use of personal protective equipment and respiratory protective equipment (RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE.

Staff who present for a Fit Test are instructed by the fit tester on how to safely put on the face masks as per manufacturer's instructions. Staff who are only able to use reusable masks are shown how to clean masks and how to attach filters within the fit test appointment. Each reusable mask comes with manufacturers guidance. All staff that are fit-tested have a training record kept by the fit test team. Future provision of this service is under consultation and there will be a restricted service moving forward. This is a risk to the workforce and our ability to respond to infectious diseases.

There is further extended training on donning and doffing provided by IPC for the High Consequence Infectious Disease (HCID) session that supports the Emergency Department Team to have a more practical experience of PPE and the importance of working together.

Criterion 7

The provision or ability to secure adequate isolation facilities.

Building works

The RUH have undertaken extensive building work during 2024/25 with the new and improved Intensive Care Unit. The option to change a room into an isolation area (via a partition) and the installation of positive and negative pressure enables (in specified areas) the environment to support the needs of the Trust and protect the unit and the people who work there. Having a purpose-built environment enabled the staff to identify the gaps in their previous environment and use their learning from COVID and other Trusts to ensure the unit is able to future proof their surroundings and be ready if another pandemic should/when it occurs.

There has been an increase in the size of Same Day Emergency Care (SDEC) that will allow patients to be appropriately separated and be supported in a more appropriate environment.

Colonoscopy has been expanded to treat more patients.

Major works have been completed at Sulis Hospital and has been named the Sulis Orthopaedic Centre. The centre will include two additional modular theatres, additional inpatient beds, additional day surgery pods and the conversion of two existing theatres to laminar flow. There are now four theatres within the hospital that have laminar air flow that will enable a safer patient pathway, especially when completing higher risk orthopaedic surgery.

Isolation facilities and premises

The RUH is aware there are limited isolation facilities despite the investment in the past three years. The number of single rooms with ensuite capacity is significantly lower than the demand on the organisation. Phase 2 of the IPC works plans to continue to install en-suites on wards which lack facilities. This continues to be subject to funding and access and remains on the risk register.

For patients with known infections, alert flags are used to flag patients that require isolation or assessment. The clinical site team have a constant visual on all clinical flags to influence patient placement. Clinical handover processes are in place between clinical areas. Enhancement of the current process is being addressed in divisions to ensure patients safety is paramount during their admission.

Staff are encouraged to use Datix to report these delays or when and option to isolate is overridden by an alternative service. This will enable the Trust to understand the incidences that occur, that without completion of a Datix would not happen. Escalation plans are in place; this is led by the medical division for winter pressures, and staff are supported by the IPC team. These plans are there to ensure there are affective pathways in place in the event of increased influenza or COVID patients being admitted through the front door. Two wards have been allocated that can be changed into cohort wards in light of increased pressure from respiratory like illness (RLI).

Criterion 8

The ability to secure adequate access to laboratory support as appropriate

Laboratory support

Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.

The RUH Laboratory operates within United Kingdom Accreditation Service (UKAS) accreditation covers all aspects of the laboratory service including standard operating procedures and competencies as part of a yearly external assessment, as well as internal review through the Quality Management System. The RUH has access to an adequate repertoire of UKAS accredited microbiological diagnostic testing through a contract with the UKHSA Bristol Regional Laboratory (routine tests off-site, on-site 'hot lab' for time-critical testing).

The Trust pathology laboratory also provide on-site UKAS accredited testing for pathogens of IPC concern (e.g. Norovirus, C. difficile, COVID, Influenza). Laboratory performance is monitored through a Quality and Clinical Governance infrastructure. A clinical microbiology service is provided by Consultant Microbiologists for diagnostic support both in-hours, and out-of-hours through a collaborative service with University Hospitals Bristol and Weston. IPC monitor test results for patients awaiting screening results.

Point of care testing has been supported by the laboratory team for Influenza and COVID in the Emergency department, using the Abbott ID Now platform. Continuing to support out of hours testing all year round by lab trained ED staff, which has enabled ‘informed’ patient placement and flow.

Criterion 9

That they have and adhere to policies designed for the individual’s care, and provider organisations that will help to prevent and control infections

Policies and Infections

The National Infection Prevention Control (NIPC) manual is used by the Trust and the IPC team. The document is linked via the staff intranet. All IPC related polices are being reviewed within Trust time scales, and Standard Operating Procedures are being introduced where considered necessary replacing some existing policies that were in place.

Outbreak meetings are held as necessary at times of significant ward and bay closures that are affecting site operations. These are supported throughout the day by the team and site managers via regular contact, with senior attendance at the morning site meeting and as deemed necessary across the day.

The continued collaboration with the Integrated Care Board and Public Health teams provided the IPC team insight into the local risks in relation to outbreaks, especially the impact of primary care that can restrict discharges from the Trust. Development

of local protocols are in place to assist with digression from current practice when the impact of outbreaks outweighs the service need. This enables the team to consider the need to bring certain patients out of isolation, when the balance of infections is significantly challenged.

Criterion 10

That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.

Staff Health and Wellbeing

The Chief Nursing Officer and Director of Infection, Prevention and Control (DIPC) and Associate Chief Nurse (Deputy DIPC) work in collaboration with Occupational Health and specific questions/enquiries are responded to or advice given in a timely manner.

Occupational Health needs are managed by OPAS-G2 supplied by Civica. The system specifically designed for Occupational Health purposes, is on the framework, paperless, independent of other systems (for confidentiality), is easy to use and information is stored in a secure cloud hosted by Civica that meets all data protection requirements. G2 also interfaces with Trac our recruitment and on boarding system.

At the offer of employment, the recruitment Trac system will send a link to the appointed candidate to fill in a pre-placement questionnaire (PPQ) and this includes requirement from the candidate to upload any vaccination evidence as well as their exposure prone procedure (EPP) clearance evidence. This, along with other health questions is triaged by an experienced nurse and any issues identified are escalated to a more senior nurse. Skin assessments are also available through management referrals, at new starter or at any time via self-referral.

Any staff who are unable to provide evidence of their vaccination status (as required for their job role) are sent a link to self-book an appointment into the vaccination clinic OR to send in any evidence they may now have found. These clinics are available most days of the week excluding bank holidays. Staff who DNA their appointment are sent an email asking them to phone in to reschedule and their manager is also informed. Further DNA and the staff and their manager receive notification that they are now at risk and should complete a risk assessment or phone in and book an appointment.

Staff who move roles within the Trust must complete an ‘internal transfer’ questionnaire which identifies the new role. This is triaged in the same way as a new starter and any change in category of role which requires further vaccinations the

same process is repeated as for new starters e.g. staff nurse moving from a ward environment to Emergency Department will require further vaccination potentially or serology.

Staff who sustain a sharps injury follow the flow chart procedure which is available in every department and on the intranet. This includes calling in to the OH sharps line. Monday – Friday these calls are picked up by the electronic system and an experienced nurse will answer the call and take any necessary action. These staff are always prioritised for boosters/serology etc. Flow charts are provided to staff to follow.

Health surveillance for a range of tests is available for staff whose job roles require it. For example, plaster room staff will require annual spirometry and audiometry as well as hand/arm vibration tests. Currently our infection control health surveillance covers staff who live with ‘blood borne virus’ (BBV).

In the case of outbreak, the G2 system can report accurately both individually and Trust wide vaccination status as recorded within it. Annual flu vaccinations are provided in house via the occupational health team.

The efficacy of staff vaccination campaigns for Flu and COVID-19 were reported Trust wide via a dashboard accessible by all managers. Progress is charted weekly, and a separate bespoke system (Vaccination Trac) enables us to do this in a granular fashion in order that hot spot areas can be targeted using a different delivery model where necessary.

Trust vaccination status, in general, is an ongoing dynamic situation and currently it is necessary to build and run specific reports at time of request. However, we are constantly developing ways to get our system to work better for the Trust assurances whilst responding to the ever-changing infection status that is nationwide.

Infection Prevention and Control Quality Improvement Plans for 2025/26

1. Addressing sustainability options in relation to IPC practices, this includes the introduction of reusable cleaning tags and highlighting the areas and items that need them.
2. Working with ED to reduce the number of cannulas that are used first line in patients that attend the front door. With an aim to reduce the number of devices used and reduce the risk of peripheral line infections.
3. Address the care and maintenance of IV cannulas within the Trust, promote the importance of recording peripheral damage to address infiltration and extravasation.
4. Reduction and understanding of the necessity of skin decontamination when completing venepuncture, commencing with Phlebotomy to gain a large cross section of data as a base line.
5. Reinvigoration of the patient hand hygiene pre and post meal project to support elderly care wards with patients that are not mobile and unable to decontaminate their hands independently. Baseline data has been gathered of current practice IPC to work with OPUSS to improve practice.
6. Waste water initiative to understand what is being drained from the Trust to realise the pathogens within the supply, working with the University of Bath.
7. Review the urinary catheter care pathways to ensure practice is in line with preventing gram negative urinary tract infections.

Improving Together methodology will be used along with collaborative working with key stakeholders. The work plans for these projects will be overseen by the Patient Quality and Safety Improvement Group.

Acknowledgements:

Thank you to the leads who have provided information for this report. These individuals are:

Dr Juia Vasant, Dr Alan Cordey, Dr Stephen Dalton, Jamie Caulfield, Soby Joseph, Kevin Warlock, Susan logan, Cathy Goss.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**18**
Date of Meeting:	**3 September 2025**		
Title of Report:	**Alert, Advise and Assure Report – People Committee**		
Status:	**For discussion**		
Author:	**Paul Fairhurst, Chair of the People Committee**		

Key Discussion Points and Matters to be escalated from the meeting held 23 July 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

Change Management (ongoing monitoring): key focus areas for the Committee are to seek assurance that a robust change management methodology is in place to bring staff with us through complex change; and that staff related issues are a key element of the five Transformation Programmes.

- PROSCI methodology becoming embedded; Change Partners engaging with the Leadership & Change Office.
- Mixed progress at project level due to resistance, operational pressures, interdependencies.
- Committee will now review project level (as well as programme level) updates for better insight of people-related change blockers and interventions to remove them.
- Group People Function design reflects this approach to supporting change management. Scaling to Group requires £60k PROSCI licence (Integrated Care Board (ICB) unlikely to approve) – Chief People Officer (CPO) to discuss with RUH Executive.

Equality, Diversity and Inclusion (EDI) (ongoing monitoring):

- EDI Annual Report delayed from July to October Committee (due to temporary staffing constraints). To be presented to November public Board for approval in advance of 31 January 2026 publication deadline.
- Workforce Race Equality Standard and Workforce Disability Equality Standard components of EDI Annual Report to be published by 31st October. On track. Committee will provide assurance to the Board.
- Risks being monitored: rise in discrimination / internationally recruited staff not feeling wanted due to the changing political climate around immigration. Proposed that the Board should refresh anti-racism commitments.
- Working with Cancer Policy: well received internally; best practice is being shared across Group and region; mixed external views - questioning additional support (on top of existing generous sickness benefits) in the current financial climate; and why other long-term conditions were not included.

UK visa and settlement rules (ongoing monitoring): Monitoring April 2025 changes; support to RUH staff includes clinics and hardship funds.

Employment Rights Bill (development):

- Likely to have significant impact on temporary staffing (in particular in-house bank) due to changes to unfair dismissal rights, probation periods, zero hours contracts ban.

- Next steps being developed. Government consulting on implementation timelines (proposed from April 2026 through to 2027).

Breakthrough objective – staff feeling valued (ongoing monitoring):

- Feedback suggests staff feel recognised by their managers but undervalued by the Trust (which has other priorities - saving money, national rankings etc).
- Appraisal completion is a key factor. Rates remain below target (despite processes, policies (including a new Appraisal and One to One Policy) and digital solutions put in place). Challenge is cultural, requiring Board leadership.
- Leaders Band 8C+ to complete all appraisals by end August (or explain at PRM).

Innovation – Staff Story (development):

- Andrew Scales, AHP Workforce Lead, presented his MBA assignment investigating RUH organisational readiness to innovate. Andrew surveyed a clinical group (Adult Therapies Staff) and some Executives.
- Key findings include lack of consensus on meaning of "innovation" (Andrew defined three types: efficiency, sustainability and transformation); gap in perception between clinicians and Executives regarding effectiveness of our processes and our readiness.
- Proposal: survey wider group (all Executives, top 40 leaders); co-develop Group innovation strategy (learning from Trusts with an Innovation Strategy); seize opportunities for transformation arising from the Ten Year Plan and move to Group.
- New Group Chief Transformation and Innovation Officer will lead on transformation innovation.

ASSURE: Inform the board where positive assurance has been achieved

Mutually Agreed Resignation Scheme (MARS): status update presented (including Salisbury Foundation Trust (SFT) / Great Western Hospitals (GWH) benchmarking). Closure report due.

24/25 Pay Bill Reduction Closure Report: £19.1m savings delivered vs £19.4m target (significant achievement). Strong programme management and project infrastructure noted amongst things that worked well; areas to improve include pace of decision-making. Change management methodology expected to support 25/26 delivery.

RISK: Advise the board which risks where discussed and if any new risks were identified.

The Committee agreed the approach to three new risks being considered.

- Executive and Divisional leadership changes and transition to Group model to be incorporated within organisational change Board Assurance Framework (BAF) risk.
- Balancing £15m pay bill reduction and making staff feel valued to be incorporated into industrial action risk on the Risk Register and organisational change BAF risk.
- Industrial action risk mitigations include new organisational change policy consistent across RUH, GWH and SFT; and stronger Group level trade union relationships.
- Ownership of risks lies with operational teams; systematic review between People Directorate and Operations under consideration.
- Risks to quality & patient safety from workforce changes discussed – Board to define appetite/tolerance. All BAF risks reviewed, revisions proposed.

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 items to report.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**19**
Date of Meeting:	**3 September 2025**		
Title of Report:	**Alert, Advise and Assure Report – Finance and Performance Committee**		
Status:	**For information**		
Author:	**Antony Durbacz, Non-Executive Director**		

Key Discussion Points and Matters to be escalated from the meeting held on 28/07/25

ALERT: Alert to matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy

- Considerable progress has been made on the plans to support the 2025/26 Cost Improvement Programme (CIP). They have now been incorporated into the relevant divisional and corporate and support service budgets. There remains gaps in terms of achieving the overall ambition and work continues to address this. A pragmatic view has been taken on the realistic realisation of the schemes, with substitution where appropriate. The phasing is considered achievable but is skewed towards the latter part of the year which leaves the first half of the year exposed to budget variances. Pace continues to be a key driver for success. The current forecast based on month 3 financial performance is a £21.7m deficit which assumes £9.9m of savings delivery. Work continues to achieve a minimum of £19.1m
- As a consequence of our performance against our constitutional standards in Referral to Treatment (RTT), diagnostics, cancer and Urgent and Emergency Care (UEC) we have moved into tier 1, which means higher levels of scrutiny
- With the publishing of the NHS 10 year plan, providers are required to produce a medium term plan for the next 3 years to be completed by the end of December. Detail NHS England (NHSE) guidance will not be provided so systems are expected to get on with planning. Phase 1 will support the agreement of a clinical strategy, the rebasing of the block contracts and agreeing the underlying deficit (to be completed by September). A medium term financial plan to be completed by December with a supporting delivery plan for the financial year 2026/27.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance

- A key focus in the revised recovery plan is lower utilisation of bank staff and not consuming escalation beds. The board will need to consider carefully its risk appetite in these areas
- The financial recovery at Sulis is a significant part of the revised plan which requires more efficient use of the additional surgical capacity and the Community Diagnostic Centre (CDC).

• Overall activity levels are favourable to the plan (OP, diagnostics, EL inpatients) but this is not converting into improved operational performance. Focus is increasing on the determinants of this mismatch.
ASSURE: Inform the board where positive assurance has been achieved
• The trust has completed the NHSE "grip and control" self-assessment tool which provides positive assurance that most opportunities and processes are well embedded within the trust. Work continues to ensure that the areas that require further work or greater emphasis are completed. • Key operational and clinical productivity measures benchmark well within the NHS framework.
RISK: Advise the board which risks where discussed and if any new risks were identified.
• No new risks to report.
CELEBRATING OUTSTANDING: Share any practice, innovation or action that the committee considers to be outstanding
• No items to report.
APPROVALS: Decisions and Approvals made by the Committee
• No approvals to report.

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:**	**19.1**
Date of Meeting:	**3 September 2025**		
Title of Report:	**Alert, Advise and Assure Report - FPC Committee**		
Status:	**For information**		
Author:	**Antony Durbacz, Non-Executive Director**		

Key Discussion Points and Matters to be escalated from the meeting held on 26/08/25

ALERT: Alert to matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy

- RUH has been challenged to significantly improve its forecast financial performance. The existing financial improvement plan includes improvements that capture both income/run rate improvements (principally Sulis) and identified cost savings. Although not straightforward, there is reasonable confidence in delivering the existing plan to achieve a £19m deficit.
  The original plan is now supplemented by the need for additional improvements in order to achieve a £10m deficit. The detail on this is considered work in process and at this stage key elements could be at risk. The single biggest challenge being the need to reduce the use of bank across all staff groups by 50% from the 1st October which is in addition to reductions already planned in the existing improvement plan
- RUH must remain diligent to ensure the cost improvement plans do not impact the risk profile on patient care. In addition, there may be impacts on our constitutional standards trajectories as a consequence of unfilled vacancies and reduced bank usage
- There has been no material change in our performance against constitutional standards in Referral to Treatment (RTT), diagnostics, cancer and Urgent and Emergency Care (UEC) so we remain in tier 1. The outlook for future compliance good with diagnostic performance being the principle concern currently.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance

- The application of National tariff to the 25/26 activity has identified that at present there is a gap between our current income and the recalculated income. This may offer an opportunity forward.
- Work is underway to ensure clear line of sight reporting on the committed actions in the financial recovery plan and its impact on the financial reporting.

ASSURE: Inform the board where positive assurance has been achieved

- The 12-week RTT challenge has identified some additional risks identified below, but the Chief Operating Officer gave a reassuring description of the plans to recover the RTT information gap.

RISK: Advise the board which risks where discussed and if any new risks were identified.
• The preliminary work for the 12-week RTT challenge has identified a number of risks that are being evaluated as to their impact on the quality of care, clinical risk and impact on trajectories.
CELEBRATING OUTSTANDING: Share any practice, innovation or action that the committee considers to be outstanding
• It should be recognised that the operational performance has shown improvement month on month against the constitutional standards. Although they still fall sort of the requirements there is evidence that the efforts of the whole team is reflected in this improvement.
APPROVALS: Decisions and Approvals made by the Committee
• The committee approved that RUH should move forward with its proposal on the community solar project, but should revert to the committee for further review on contract terms specifically pricing and termination clauses

The Board is asked to NOTE the content of the report.