Bundle Public Board of Directors 5 November 2025

0 Agenda
- 0.0 - Draft Public BoD Agenda Nov 25 v1.6 - 31.10.25

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

2 Written Questions from the Public
Verbal

3 Minutes of the Board of Directors meeting held in public on
- 3.0 - DRAFT Public BoD Minutes Sept v1.0 - 10.09.25

4 Action List and Matters Arising
- 4.0 - Public BoD Action List Sept 25 v1.0 - 10.09.25

5 Governor Log of Assurance Questions and Responses (for information)
- 5.0 - Governor Log of Assurance Questions v1.0 - 31.10.25

6 Items discussed at Private Board
Verbal

7 Patient Story
- 7.0 - Patient Story cover sheet to Board of Directors Audiology November Board

8 CEO and Chair's Report
- 8.0 - RUH MD_CEO Public BoD Report 05.11.25 - v3

9 Annual Report and Accounts
Verbal

10 Management Executive Committee Upward Report
- 10.0 - MEC Upward Report Sept & Oct 25 v1.0 - 30.10.25

11 Integrated Performance Report
- 11.0 - Integrated Performance Report - October 2025 (Sept Data) v2
- 11.1 - Integrated Performance Report - October 2025 (Sept Data) v2

12 Seasonal Plan
- 12.0 - 251010 RUH Winter Plan for Urgent and Emergency Care 2025 26 coversheet v1 (002)
- 12.1 - 251010 RUH Winter Plan for Urgent and Emergency Care 2025 26 v4
- 12.2 - 251010 RUH Quality Impact Assessment BSW Template Winter Assurance v1

13 MIS Combined Maternity and Neonates Quarterly Report Q1
- 13.0 - Mat-Neo Q1 2025-26 quality report V2
- 13.1 - MBRRACE report 2024 (2023 data)
- 13.2 - Appendix 2 - TC and ATAIN Report Q1 2025.26 V2
- 13.3 - Appendix 3 - RUH_3YDP_Ockenden.v2

14 Midwifery and Neonatal Bi-Annual Staffing Report
- 14.0 - Bi-annual staffing paper Jan-June 2025

15 Annual Mortality Review
- 15.0 - Annual Mortality Review 2024-25 (007) (004)

16 Medical Revalidation Annual Statement
- 16.0 - RUH_Board_cover_sheet Responsible Officer Professional Standards Annual Report Nov25
- 16.1 - Annex-A-FQAI 2025 RO Board

17 Quality Assurance Committee Upward Report
- 17.0 - QAC Upward Report Oct 25

18 People Committee Upward Report
- 18.0 - Nov 25 PC Upward Report
- 18.1 - EDI Annual Report RUH 2025

19 Non-Clinical Governance Committee Upward Report
- 19.0 - NCGC Upward Report Sept 25 v1.0

20 Charities Committee Upward Report
- 20.0 - Charities Upward Report Sept 25 v1.0

21 Audit and Risk Committee Upward Report
- 21.0 - Upward Report Audit & Risk Ctte 300925

22 Finance and Performance Committee Upward Report
- 22.0 - Upward Report FPC Ctte 230925
- 22.1 - Finance Upward Reporting Private 301025

23 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 5 NOVEMBER 2025, 13:00 – 16:00
VENUE: ROOM T0.24, BATH SPA UNIVERSITY, SION HILL, BATH, BA1 5SF

Item	Item	Presenter	Enc.	For
OPENING BUSINESS				
1.	Chair's Welcome, Introductions, Apologies and Declarations of Interest:	Liam Coleman, Interim Chair	Verbal	-
2.	Written questions from the public		Verbal	I/D
3.	Minutes of the Board of Directors meeting held in public on 3 September 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 / John Palmer, Managing Director / Liam Coleman, Interim Chair	Enc.	I
Governance				
9.	Annual Report and Accounts	Roxy Milbourne, Interim Head of Corporate Governance	Verbal	I
10.	Management Executive Committee Upward Report	John Palmer, Managing Director	Enc.	I/D
11.	Integrated Performance Report	Executive Leads	Enc.	I/D
The People We Care For				
12.	Seasonal Plan	Bernie Bluhm, Acting Chief Operating Officer	Enc.	A
13.	MIS Combined Maternity and Neonates Quarterly Report Q1	Jane Farey, Obstetric Lead / Jodie da Rosa, Head of Midwifery and Neonates	Enc.	I/D
14.	Midwifery and Neonatal Bi-Annual Staffing Report	Jane Farey, Obstetric Lead / Jodie da Rosa, Head of Midwifery and Neonates	Enc.	I/D
15.	Annual Mortality Review	Kheelna Bavalia, Interim Chief Medical Officer	Enc.	I/D
16.	Medical Revalidation Annual Statement	Kheelna Bavalia, Interim Chief Medical Officer	Enc.	I/D

17.	Quality Assurance Committee Upward Report	Simon Harrod, Non-Executive Director	Enc.	I/D
The People We Work With				
18.	People Committee Upward Report • Equality, Diversity and Inclusion Annual Report	Hannah Morley Non-Executive Director	Enc.	I/D
The People in Our Community				
19.	Non-Clinical Governance Committee Upward Report	Sumita Hutchison, Vice-Chair	Enc.	I/D
20.	Charities Committee Upward Report	Sumita Hutchison, Vice-Chair	Enc.	I/D
21.	Audit and Risk Committee Upward Report	Joy Luxford, Non-Executive Director	Enc.	I/D
22.	Finance and Performance Committee Upward Report	Antony Durbacz, Non-Executive Director	Enc. / Verbal	I/D
CLOSING BUSINESS				
23.	Any Other Business	Liam Coleman, Interim Chair	Verbal	-
Date of Next Meeting: Wednesday 14 January 2026, 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

ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST
MINUTES OF THE MEETING OF THE PUBLIC BOARD OF DIRECTORS
WEDNESDAY, 3 SEPTEMBER 2025, 13:00 – 16:00
VENUE: ROOM 2.55 (INCEPTA), SCHOOL OF MANAGEMENT, UNIVERSITY OF BATH, CONVOCATION AVENUE, CLAVERTON DOWN, BATH, BA2 7AZ

Present:

Members

Liam Coleman, Interim Chair *(Chair)*
Sumita Hutchison, Interim Vice-Chair
Paul Fairhurst, Non-Executive Director
Simon Harrod, Non-Executive Director
Cara Charles-Barks, Chief Executive
Andrew Hollowood, Interim Managing Director
Jocelyn Foster, Chief Strategic Officer
Toni Lynch, Chief Nursing Officer
Simon Truelove, Interim Chief Finance Officer
Alfredo Thompson, Chief People Officer
Kheelna Bavalia, Interim Chief Medical Officer
Jonathan Hinchliffe, Interim Group Transformation and Innovation Officer

In attendance

Zita Martinez, Director of Midwifery *(item 7)*
Linda Webb, Ocean Midwife *(item 7)*
Louise, Patient *(item 7)*
Public Governors
Stakeholder Governor *(until 14:00)*
Abby Strange, Corporate Governance Manager *(minute taker)*

Apologies

Roxy Milbourne, Interim Head of Corporate Governance
Joy Luxford, Non-Executive Director
Hannah Morley, Non-Executive Director
Antony Durbacz, Non-Executive Director
John Palmer, Managing Director
Bernie Bluhm, Acting Chief Operating Officer

BD/25/09/01 Chair's Welcome, Introductions, Apologies and Declarations of Interest:

The Interim Chair welcomed everyone to the meeting and confirmed that apologies had been received from those listed above. He took the opportunity to thank the outgoing Interim Managing Director and Interim Chief Finance Officer for the hard work, skill and commitment that they had demonstrated during their time in their respective roles.

The Board of Directors confirmed that they had no additional interests to declare.

BD/25/09/02 Written questions from the public

The Interim Chair summarised two questions that had been submitted by a Public Governor via email on 26th August 2025. He provided some context around the role of the Governors within the Group model and highlighted that each Trust would continue to have its own separate Council of Governors. The first question related to how the Non-

Executive Directors and Governors could seek assurance under the new structure. It was confirmed that this would remain largely unchanged and there would continue to be multiple channels through which to seek assurance. The second question related to how the Governors would continue to satisfy themselves that the Non-Executive Directors were adequately fulfilling their assurance function. It was confirmed that that Governors would continue to have access to the Non-Executive Directors and would be able to question them around the content of key reports and to share concerns. It was explained that going forward, Non-Executive Directors would increasingly be focusing on scrutinising and maintaining oversight of the main risks and threats facing the Group, alongside their other roles in accounting for the performance of the Board, promoting good governance and developing long term plans. The next Governor workshop was scheduled to take place on 1st October 2025 and this would be an opportunity for the Councils of Governors across the Group to discuss and agree the design for Governor interaction with the BSW Hospitals Group Joint Committee.

It was reported that 3 questions that were raised by a member of the public in June 2025 were outstanding and a response would be provided at the next Public Board of Directors meeting in November 2025. The questions related to a public employment tribunal that had taken place in March 2025.

BD/25/09/03 Minutes of the Board of Directors meeting held in public on 2 July 2025

The minutes of the meeting held on 2nd July 2025 were approved as a true and accurate record.

BD/25/09/04 Action List and Matters Arising

The actions presented for closure were approved.

BD/25/09/05 Governor Log of Assurance Questions and Responses

The Governor Log was presented for information.

BD/25/09/06 Item Discussed at Private Board

The Interim Vice-Chair explained that the Board's discussions in private had focused on the operational and financial challenges that the Trust continued to experience and the actions that were being worked through to address this. There was particular demand on the Urgent and Emergency Care (UEC) pathway and the position was expected to remain challenging for the next few months with the Trust being closely scrutinised by NHS England (NHSE). The Board had also considered the importance of open and transparent communication with staff during what was a period of significant change for the organisation and had received an update on the work that the Chief People Officer was undertaking to enhance and develop engagement.

There had been considerable discussion around the organisational risk register with a focus on the cyber risk to the public sector and the resilience work that the Interim Chief Transformation and Innovation Officer was undertaking across the Group. An update had also been provided on the steps that would be taken to design and implement the Group governance model and there was likely to be traction on this from October onwards.

BD/25/09/07 Patient Story

The Chief Nursing Officer welcomed the Director of Midwifery, Ocean Midwife, Louise, and baby Sammy to the meeting. She introduced the patient story which outlined the

maternity and mental health journey of Louise and highlighted 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. Louise had experienced previous complex and traumatic pregnancies including a difficult first birth and postnatal period in 2022 which had resulted in treatment for Post Traumatic Stress Disorder (PTSD). Louise then experienced a late miscarriage in 2023 and received support from the Ocean Midwifery Team and Therapy Services who provided an open referral to ensure continuity of care should Louise become pregnant again. During her most recent pregnancy in 2024, Louise was very anxious and received ongoing support from the Ocean Team, community midwives, and the Perinatal Mental Health Team. Her second child, Sammy, was born via caesarean section in February 2025 and Louise had reported feeling safe and supported throughout the birth and postnatal period.

Louise explained that her first birthing and postnatal experience had had a significant effect on her ability to bond with her baby, Rex, and reported that the support she had received during her most recent pregnancy had made a measurable difference.

The Board discussed the level of demand for peri and postnatal mental health support and plans for the future. It was reported that Avon and Wiltshire Mental Health Partnership (AWP) had secured more midwifery hours and this would allow for a slightly bigger caseload. Despite this, demand continued to increase and without further funding the thresholds for care were likely to increase. The Ocean Team currently provided care for women requiring mild to moderate mental health support but was likely to need to move to provision of moderate to severe support over time and it was unclear who would fill the gap in services.

Simon Harrod sought clarity on how the service was communicated with mothers. The Ocean Midwife confirmed that this was advertised on the Trust, Great Western Hospitals (GWH) and AWP websites and by the Maternity Voices Partnership. Pregnant women could self-refer but women who were not pregnant needed to be referred by a General Practitioner (GP), Health Visitor, or by the Neonatal Intensive Care Unit (NICU). Efforts had been made to avoid over-advertising the service but referrals had tripled within the last 3 years.

The Interim Vice-Chair asked whether there was anything that could be done to better inform services. The Ocean Midwife confirmed that there needed to be more trauma informed care across the Trust, with efforts being made to understand the history of patients, their worries and concerns, and how clinicians could provide help and support. This was supported by a ‘How to Help me Plan’ communication tool that had been embedded, and feedback had been positive from both patients and staff. The Director of Midwifery added that there needed to be an emphasis on providing early access to tools and materials in the public health space.

The Chief Nursing Officer thanked the Director of Midwifery, the Ocean Midwife and Louise for attending the meeting. She recognised the hard work of the Maternity Team and Louise’s courage in sharing her story. The Board of Directors noted the patient story.

BD/25/09/08 CEO, Managing Director, and Chair’s Report

The Chief Executive reported that the individual Trusts within the Group were in the process of undertaking a self-assessment around their provider capabilities as part of the recently published NHS Oversight Framework (NOF). The self-assessments would be

submitted to the regional team and reviewed with the 3 Managing Directors to identify areas of focus and development. An initial set of recommendations from the independent investigation into NHS Maternity and Neonatal Care was due to be published by December 2025 and a National Maternity Taskforce was in the process of being selected. The Trust had been placed in tier 1 for elective, cancer, diagnostic and UEC and this would involve regular meetings with attendance from both regional and national colleagues to discuss delivery progress and any required support from NHSE. Recovery plans were in place in all areas but UEC and diagnostics were key priorities. The Group Strategy was now in development in close coordination with the 26-27 planning round and a Council of Governors workshop had taken place on 5th August 2025, during which the 3 Councils had discussed opportunities for the Group and the 10-year plan.

The Interim Managing Director reported that while UEC performance had deteriorated in August due to increased demand, the Trust had been making month on month improvements and this had enabled it to better cope with the surge in demand. There had been an increase in patients going through the expanded Same Day Emergency Care (SDEC) Service and this had significantly impacted offloading of patients through the Emergency Department (ED) and the number of direct admissions by GPs. Diagnostics and Referral to Treatment (RTT) were areas of concern and the Trust was working closely with Sulis to fully utilise Community Diagnostic Centre capacity alongside other insourcing and outsourcing activities. In terms of the financial position, there had been an improvement in the savings plan in month 4 but the Trust remained in a deficit of £10.1m year to date. A financial recovery plan had been developed that would aim to achieve a £10m deficit by the end of the financial year and it was essential that this was delivered to safeguard the cash position of the Trust.

The Interim Managing Director thanked his colleagues for the amount of work that they had done to plan for the recent period of industrial action by resident doctors and confirmed that while there had been significant pressure on the UEC pathway towards the end of this period, no derogation had been requested and there had been minimal elective cancellations.

The Interim Chair highlighted that the 2025 Council of Governors Elections were due to commence on Monday 8th September and the 2025 Annual General Meeting was due to take place on Thursday 25th September from 4pm.

The Board of Directors noted the report.

BD/25/09/09 Item withdrawn

BD/25/09/10 BSW Hospitals Group – Resolution to Update Partnership Agreement, Schedule 3 Joint Functions and Schedule 5, Joint Committee Terms of Reference

The Chief Executive reported that in July 2025 the Private Boards of the RUH, GWH, and Salisbury Foundation Trust (SFT) approved a proposal to move to a Joint Chair and General Purpose Joint Committee (Group Board) by 1st April 2026. They approved an immediate first step to strengthen the formal delegations of the existing Special Purpose Joint Committee giving it a specific and delegated remit, and schedules 3 and 5 of the BSW Hospitals Group Partnership Agreement had subsequently been updated to incorporated these strengthened delegations. The Board of Directors were asked to approve the proposed variations.

The Board of Directors approved the proposed variations to the BSW Hospital Group Partnership Agreement, Schedule 3: Group Joint Functions and Schedule 5: Joint Committee Terms of Reference.

BD/25/09/11 Integrated Performance Report

Operational Performance
Operational performance was discussed during item 8.

Quality
The Chief Nursing Officer reported that the Trust continued to benchmark well in terms of pressure ulcers but there was a continued focus on the standard work. While the Trust benchmarked in line with the national average in terms of falls, there had been an increase in falls resulting in moderate harm, and a Patient Safety Incident Investigation (PSII) had commenced to re-evaluate improvement work with a focus on blood pressure and deconditioning. There had been 5 healthcare associated cases of C. diff reported in April 2025 and learning continued around this. There were 39 new complaints in month and work had identified that many of these related to people waiting for appointments and access to elective care. The Trust was within safe nursing staffing limits in June but had moved into quartile 2. In terms of maternity and neonates, there were there were 5 moderate harm events being investigated and the Trust was predicted to achieve 100% compliance with the Maternity Incentive Scheme (MIS) year 7.

Sumita Hutchison sought clarity on the risks and opportunities around safe staffing. The Chief Nursing Officer explained that patient needs and acuity across the hospital was changeable and resources were moved to meet patient needs. She provided assurance that staffing levels had been safe but advised that ED was an area of concern due to vacancy and sickness rates. Roster compliance indicated that the Trust used resources well and this was constantly assessed by the matrons and the Site Team to make sure that staff were moved from other areas to mitigate risk. It was important to note that the Trust had experienced nurse leaders who were very capable of escalating concerns where risks could not be mitigated and that issues around staffing were being discussed at safety huddles to ensure that there was an awareness of this.

Paul Fairhurst reflected on the impact of financial recovery measures on quality and safety and recognised the effort that was being made to manage the risks. The Chief Nursing Officer emphasised the need to balance financial recovery with maintaining patient safety and advised that the focus was on delivering a safe service that was financially sustainable and met the needs of the community.

Workforce
The Chief People Officer reported that the Trust was the best in the South West for vacancy rates and had been commended for its work to reduce agency usage. He advised that sickness absence was 4.7% and the organisation was focusing on stress and anxiety with bespoke work due to take place via People Committee. Appraisal rates continued to be a source of challenge and this was directly linked to burnout.

Sumita Hutchison sought clarity on work to improve appraisal rates. The Chief People Officer confirmed that the Trust was focusing on ensuring that staff who were band 8c and above had an appraisal and work was also ongoing to simplify the process. A

strategic A3 had been developed to aid this and a toolkit for line managers was also being developed.

The Board discussed the vacancy factor and noted that to maintain deflation following the financial recovery in 24/25, a 3.88% vacancy factor had been applied across the organisation, excluding Estates and Facilities which was holding a 12% vacancy factor. Most organisations operated with a 1% vacancy factor and the Trust would need to remove the vacant posts it was holding and reduce the recurrent funded establishment to a natural level to achieve a vacancy factor of 1%.

The Interim Chair asked whether there had been any impact to date following the government white paper outlining immigration changes. The Chief People Officer advised that about 20% of the Trust's workforce was from the international market and there was anecdotal evidence that other developed countries were actively targeting the workforce. Coupled with the societal challenge around immigration in the UK, the Board needed to be conscious of this issue and to support the international workforce as much as possible. The impact of the change in threshold on the Trust was likely to be minimal but there would be a considerable impact on a national level in the longer term, with graduates being unable to build a career in the healthcare system.

Finance
The Interim Chief Finance Officer reported a year to date deficit of £10.1m at month 4. This was better than forecast and had been driven by financial improvement at Sulis which had helped to mitigate some of the pressure within the Trust position. The drivers of the deficit were the shortfall in savings, exit run rate deterioration, high cost drugs and devices, impact of industrial action and the pay award funding shortfall. The level of financial challenge had been discussed at length during the Private Board of Directors meeting and it had been confirmed that strong plans were in place to deliver a year end deficit of £19.1m. The Trust's target deficit was £10m and work continued to develop firm plans to deliver this. The Trust continued to hold back on its capital programme in line with the directive from NHSE due to the risk to cash and a monthly forecast was in place to monitor cash. Work was taking place to model the different scenarios around cash and robust cash management practices would be implemented to protect payroll if necessary.

The Board discussed the decision to delay the capital programme and whether this was likely to have impacted the Trust's tiering position. They were informed that the Trust was not holding back equipment or maintenance that would impact RTT or UEC performance. It was confirmed that the organisation was following the directive of the national team in prioritising its capital programme and holding back 25% to support cash management requirements.

The Board of Directors noted the report.

BD/25/09/12 Item withdrawn

BD/25/09/13 Quality Assurance Committee Upward Report
Simon Harrod reported that there were notable gaps in the quality and safety structure which was limiting the organisation's ability to fully engage in learning processes under the Patient Safety Incident Response Framework (PSIRF). Issues had also been identified around the availability of resources within the clinical coding function and this was highlighted within agenda item 14. The significant allocation of resources towards

the Electronic Patient Record (EPR) had limited the generation of new insights following the implementation of Paperless Inpatients. Concerns had also been raised around the risks associated with non-reportable waiting lists and the Acting Chief Operating Officer was leading on the significant amount of work that was required to validate waiting lists. The Committee had been assured by work to establish a comprehensive mental health risk framework and had celebrated the improvement in compliance with Infection Prevention and Control (IPC) mandatory training requirements.

The Board discussed mental health as a comorbidity and the need for staff to have skill sets around both physical and mental health conditions. They acknowledged that an Enhanced Care Team had been developed and was made up of registered mental health nurses from a range of backgrounds. The team was proving to be invaluable in improving outcomes and de-escalating reliance on temporary staffing and a programme of teaching and education had also been implemented. The Trust had recruited healthcare support workers who were dedicated to caring for patients with mental illnesses and challenging behaviours and had also changed the establishment in the Children's Unit to increase healthcare support workers with training in mental health. It was recognised that areas such as neuropsychology needed to be considered and that undergraduate education needed to be developed to be inclusive of both mental and physical health.

Sumita Hutchison sought clarity on the next steps around implementing PSIRF. The Chief Nursing Officer advised that the next step would be to leverage opportunities across the Group and confirmed that the Chief Nursing Officers had agreed a number of programmes to analyse and transform the way that the organisations worked. This would be influenced and enabled by the digital agenda and the delivery of the Group EPR.

Paul Fairhurst reflected on the issues around mortality data and asked whether this related to staffing or systems, tools and processes. He suggested that it may be necessary to review Vacancy Review Panel criteria to ensure there was robust risk assessment and decision making. It was confirmed that there were a range of issues and the Trust needed to map out its mission critical roles which would be done over the next 3 months. Coding would be automated through the Group EPR and it was likely that digital and artificial intelligence (AI) would provide solutions in the longer term.

The Board of Directors noted the report.

BD/25/09/14 Q4 Learning from Deaths Report

The Interim Chief Medical Officer provided an overview of the report. She advised that the Trust had been delayed in receiving its Telstra mortality report at the time of writing the report and it had been agreed that Telstra would no longer be commissioned across the Group. The focus would shift to Summary Hospital-level Mortality Indicator (SHMI) and collaborating around a single Power Business Intelligence dashboard to provide better visibility and shared insights across the Group. While the Trust's SHMI data remained within the expected range, there had been a significant upward trend through Q4 which correlated to a high proportion of incomplete data coding. This meant that the Trust needed to interpret mortality data with caution to ensure that issues were not being masked by the incomplete data coding. A Mortality Group would be convened to ensure that the Trust maintained quality and safety standards.

Simon Harrod sought clarity on the timescale for resolving the backlog of Structured Judgement Reviews (SJRs). The Interim Chief Medical Officer confirmed that she had

not yet reconciled the baseline numbers since changing the criteria and would bring this information back through the Quality Assurance Committee.

Action: Interim Chief Medical Officer

The Interim Managing Director asked whether the Trust had the right infrastructure to analyse and provide insights into data in the absence of a contract with Telstra. The Interim Chief Medical Officer advised that feedback had indicated that the insights from Telstra had not been helpful in delivering change. The Board was mindful of the need to develop the workforce and move to a self service approach. It was acknowledged that this would require a digital literacy programme across the Group.

The Board acknowledged that it would take time to recover the gaps in coding and that the Mortality Group would be focusing on the live triangulation of information as a way of monitoring mortality. They recognised that there was also a risk in that the Trust could be under coding activity which would impact its income. It was noted that the Board would receive a further update on this in the next quarter.

The Board of Directors noted the report.

BD/25/09/15 Children's Safeguarding Annual Report

The Chief Nursing Officer provided an overview of safeguarding children and safeguarding maternity activity in the Trust in 24/25 and the key priorities for 25/26. She highlighted that there had been no serious incidents pertaining to care from a child safeguarding perspective and no allegations against staff. The Safeguarding Team had been developing the relationship with Oxford Health to integrate the lived experience of children into safeguarding to better meet their needs. A Maternity, Children and Adults Safeguarding Strategy had been developed and was underpinned by the Trust's Vulnerable People's Strategy and this would be published and launched with an associated 3-year delivery plan in 25/26. Level 3 safeguarding compliance had been maintained at 90% with a new Prevent training plan also having been completed with all levels above national compliance.

The Board of Directors approved the Children and Young People, Maternity and Neonatal Safeguarding Annual Report.

BD/25/09/16 Adult's Safeguarding Annual Report

The Chief Nursing Officer provided an overview of adult safeguarding activity in the Trust in 24/25 and the areas for focus in 25/26. She highlighted that an Independent Domestic and Sexual Violence Advisor had joined the Trust in December 2024 to support patients and staff internally and with onward support. This had strengthened community links with partners and Trust attendance at Multi-Agency Risk Management Conferences. The Safeguarding Adult Team had also delivered 25 full days of training to 539 people which had ensured that training followed the agreed trajectory to achieve 90% compliance in Autumn 2025. 96 allegations had been made against the Trust in 24/25, of which 54 were upheld, and the key themes related to discharge related concerns.

The Board of Directors approved the Safeguarding Adults Annual Report.

BD/25/09/17 Infection Prevention and Control Annual Report

The Chief Nursing Officer provided an overview of infection rates in 24/25. She reported that the organisation benchmarked high in the South West for E. coli and the Trust was

focusing on urinary tract infections in the absence of clear thresholds and themes. The Trust was an outlier in terms of C. diff and while work was ongoing with Integrated Care Board (ICB) partners to review practices, causation remained unidentified. Winter had been challenging in terms of the combined prevalence of norovirus, flu and Covid-19 but staff had managed this well by adhering to best practice. There was no non-compliance with the IPC Board Assurance Framework but there was some partial compliance and the gaps had been identified as risks on the Trust risk register.

The Board of Directors approved the IPC Annual Report for publication on the Trust website.

BD/25/09/18 People Committee Upward Report

Paul Fairhurst summarised the report and highlighted that the Equality Diversity and Inclusion (EDI) Annual Report had been delayed due to temporary staffing constraints and would be presented to the Board in November for approval. The Workforce Race Equality Standard and Workforce Disability Equality Standard components of the EDI Annual Report would be published by 31st October 2025 and the Committee would provide assurance to the Board around this. The change to the UK's immigration rules had been discussed and it was suggested that the anti-racism statement was refreshed and the individual and collective responsibilities around this renewed.

The Chief Executive advised that there was variation across the 3 Trusts in terms of the anti-racism statement and it was agreed that the Chief People Officer would raise this challenge with his equivalents at GWH and SFT.

Action: Chief People Officer

The Board of Directors noted the report.

BD/25/09/19 Finance and Performance Committee Upward Report

The Board of Directors noted the report.

BD/25/09/20 Any Other Business

No other business was discussed.

The Meeting closed at 16:05

DRAFT

Royal United Hospitals Bath
NHS Foundation Trust

Agenda Item: 4

ACTION LIST - BOARD OF DIRECTORS MEETING IN PUBLIC
WEDNESDAY, 3 SEPTEMBER 2025

Action No	Details	Agenda Item No	First Raised	Action by	Progress Update & Status	Lead
PB621	**Q4 Learning from Deaths Report** Interim Chief Medical Officer to provide the Quality Assurance Committee with a timescale for resolving the backlog of Structured Judgement Reviews.	**BD/25/09/14**	**Sept 2025**	**Nov 2025**	This was further raised at the Octobers Improvement and Insight Committee, where ongoing challenges where discussed. A focused piece of work has been stood up for a mortality group, led by the deputy chief medical officer, and a report including updated position and recovery approach will be presented to trust executives and QAC. **To close.**	**Interim Chief Medical Officer**
PB622	**People Committee Upward Report** Chief People Officer to raise the suggestion to refresh and renew the anti-racism statement with his colleagues at GWH and SFT.	**BD/25/09/18**	**Sept 2025**	**Nov 2025**	Group EDI leads collaborating on the design/delivery of a co-produced BSW Group Anti-Racism Statement, working towards publication to align with launch of Group People Function.	**Chief People Officer**

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**5**
Date of Meeting:	**5 November 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	**None**

1. Executive Summary of the Report

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

No new questions have been raised since June 2025. The questions that were raised in June 2025 were responded to and closed at the Council of Governors meeting on 8th September 2025. The questions and subsequent responses were detailed in the report to the Public Board of Directors in September 2025. There are currently no open questions.

2. Recommendations (Note, Approve, Discuss)

The report is presented for information.

3. Legal / Regulatory Implications

None

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

There are no risks on the risk register.

5. Resources Implications (Financial / staffing)

There are no resource or financial implications.

6. Equality and Diversity

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

7. References to previous reports

September 2025.

8. Freedom of Information

Public

9. Sustainability

Governors have asked questions on various topics including sustainability.

10.	Digital
Governors have asked questions on various topics including digital.	

Royal United Hospitals Bath NHS
NHS Foundation Trust

Report to:	Board of Directors	Agenda item:	7.0
Date of Meeting:	5 November 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 David French, Head of Audiology
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.

Background to the Audiology waiting list

As a result of focusing on reducing time from referral to diagnosis (the first part of the Audiology patient pathway), the waiting time for hearing aid fittings (the second part of the pathway) had increased to approximately 14 months in April 2024. The number of people waiting increased from 1,150 to 3,449 people in approximately 12 months), as an average of 40-45 people per week were being added to the list, which equated to the same number being seen. Additionally, staffing levels reduced through absence (vacancies/sickness/maternity leave). During this period over 50% of the calls to the administration team related to the long waiting times.

Once it became clear the waiting time had plateaued at 14 months, the team discussed and implemented options to reduce waits and improve patient experience.

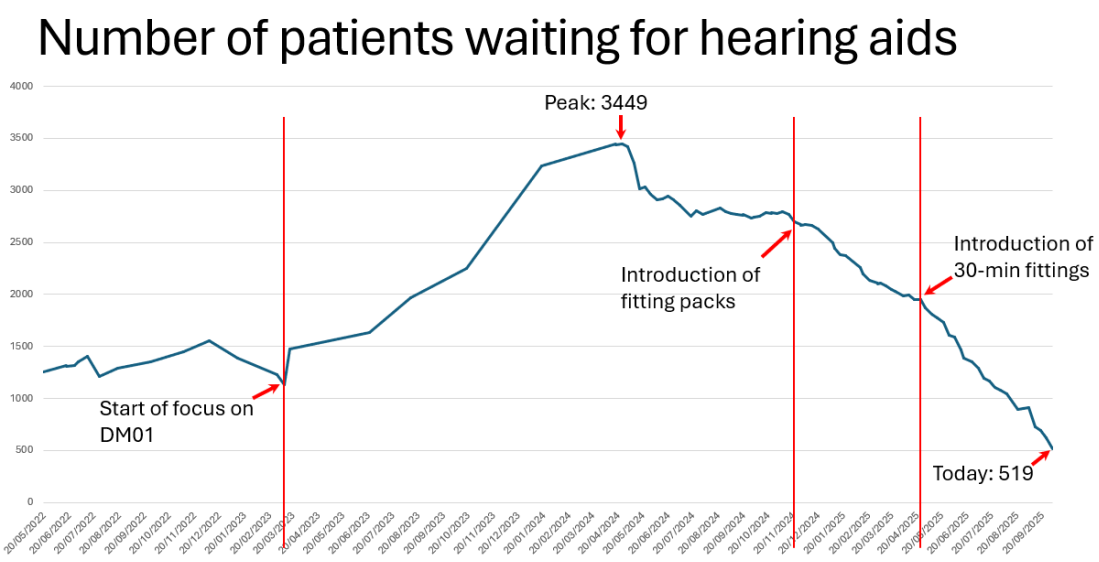
1) Patients waiting for hearing aids who were considered suitable were offered the option to have their aids posted to them (from December 2024), and the Audiology website was completely redesigned to provide the information needed to fit aids at home.

2) Some hearing aid fitting appointments were reduced temporarily from 45 to 30

minutes (May-November 2025).

Now the service is fully recruited, the service sees approximately 50 patients per week for hearing aid fittings. This has reduced current wait time to approximately 10 months and this is estimated to reach 6 weeks by April/May 2026.

The significant decrease comes from a single clinician being able to send out 20 fitting packs each day, while the same clinician would have seen 4-5 fittings a day in person. In terms of number of patients waiting, there are currently around 500 patients on the waiting list, which has reduced from over 3,449 in April 2024, 17 months ago.



Patient feedback on the postal hearing aid service

“Thank you very much for my hearing aids, they are changing my life. You are heroes”

“Brilliant staff and service. Put them in, switched them on and all the S's Th's came to life. Very grateful. Thanks”

“Very happy with my hearing aids”

“The service is excellent, and I find the instructions and guide included in the package easy to follow and understand”

“I can’t think of any improvements as your service has been first class”

“I am so happy with my hearing aids, it has changed by life, that is no exaggeration!”

“Having my hearing aids delivered by post as opposed to waiting possibly as long as 12 months to have them fitted was definitely an advantage and they are very simple to programme aided by simple to follow instructions”

Patients scored the service 4.63/5 for quality of information provided, and 85% would

recommend the service to friends/family.

Future plans

Once the waiting list has reduced, the service is planning to launch a 'self-referral' service for patients who already have hearing aids which will avoid them having to go back to their GP, saving over 50% of the requirement for GP referrals. The service are also starting a hearing aid repairs clinic for simple repairs run by volunteers in the RUH Atrium, alongside volunteer services already in Trowbridge, Frome, Warminster and Malmesbury.

Support for other specialties

The Audiology service have run a number of sessions on hearing aid basics as part of the Deaf Awareness Champions network and are also involved with the Dementia Awareness network.

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)
Temporary overspend on hearing aids, which will return to budget levels once the waiting list stabilises at six weeks (agreed with Division)	

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:**	**8.0**
Date of Meeting:	**5 November 2025**		
Title of Report:	**Chief Executive & Managing Directors Report**		
Status:	**For Information**		
Board Sponsor:	**Cara Charles-Barks, Chief Executive Officer & John Palmer, Managing Director**		
Author:	**Helen Perkins, Senior Executive Assistant to Chief Executive and Roxy Milbourne, Interim Head of Corporate Governance**		
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

- Risks including financial position and performance pressures

- Group
  - Joint Committee update
  - Leadership Team
  - Group Strategy & 26/27 Planning
  - Council of Governors Workshop
  - Board to Board development

- Local Update
  - Care Quality Commission Unannounced Inspection

- National/System
- NHS Trust Performance League Tables
- NHS Online
- 10 Year Workforce Plan
- Implementation of Jess's Rule – Three Strikes and we rethink
- Government to Tackle Antisemitism and Other Racism in the NHS
- Provider Capability Assessment
- Resident Doctors Industrial Action
- Medium Term Planning Framework

MD's Report

- Local (RUH)
  - Operational
  - Finance
  - Quality including perinatal mortality update
  - Staff Survey

- Governor election results
- Consultant Appointments
- RUH In the News – a selection of news stories from the past two months

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

6.	Equality and Diversity
The government announced the immediate rollout of strengthened mandatory antisemitism and antiracism training across the health service. BSW Hospitals Group are already looking at how to develop consistent communication materials across the three organisations ahead of the new mandatory training implementation	

7.	References to previous reports/Next steps
The Chief Executive and Managing Director submit 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
Further opportunities to improve digital sustainability and solutions should be pursued to contribute towards the future developments across all Trusts.	

Group Chief Executive and Managing Director Report

GROUP CHIEF EXECUTIVE'S REPORT

Risks

Financial Position

The financial position across the BSW Hospitals Group has been extremely challenged during the first half of the year, resulting in a £35.5m deficit at month 6. The key drivers of the overspend have consistently been the inability to deliver planned savings due to operational pressures, high cost drugs costs and temporary staffing requirements in excess of planned levels. Following the completion of the first quarter of the year a series of recovery measures were implemented from July onwards, which have demonstrated positive improvements across both the operational and financial positions.

The run rate position at M6 indicated an outturn deficit position in excess of £68m which has been partially mitigated through a comprehensive recovery plan reducing the projected outturn to £10m. Plans have been developed to support this, though there remains a significant element of risk associated with delivering plans at each of the sites. The planned impact of the recovery actions across the sites involve a mix of higher and lower risk schemes, with the high-level RAG categorisation in the table below:

Programme	Value £'m	RAG classification
Optimisation of Temporary staffing usage	8.2	
Elective and Outpatient Productivity (incl Sulis)	9.0	
Non Pay and Drugs	3.2	
Beds/Capacity	1.0	
Commercial and Group opportunities	5.9	
Technical and Other measures	7.7	
Deficit Support Funding	23.4	
TOTAL	**58.1**	

In order to deliver its contribution to the overall system financial position the Hospitals Group has also needed to find an additional £7.4m, along with the planned ICB surplus this would deliver a breakeven position for the BSW system as a whole. Measures identified to address this gap are being fully worked up to ensure there is no impact on the delivery of performance targets. A key element of delivering the operational and financial improvement programme will be through the deployment of a Turnaround team who are due to start at the RUH in early November (subject to NHSE approval and sign off). The knowledge gained from this programme will be shared and implementation across both the Salisbury and Great Western sites to enhance delivery of the recovery programme.

Performance Pressures

Elective Performance

Performance across the BSW Hospitals Group is varied in elective care with the greatest challenges at RUH due to growth in the waiting list over the last 18 months

– although since recovery plans were initiated in Q2, waiting list size has reduced and 18 and 52 week performance improved. Salisbury and Great Western Hospitals have started the year with strong performance in RTT and diagnostics although the summer has seen a reduced rate of improvement due to demand pressures.

Key challenges to be aware of from a BSW Hospitals Group perspective are:

- Demand growth in a number of specialties such as Gynaecology and Dermatology for both cancer and elective referrals. The ICB are conducting a review of data to understand drivers of growth and mitigations. Women's Health Hubs closure and reduced scope of service in the Referral Support Service may be contributing to this and further information and mitigations have been requested. The Elective Care Board has developed a proposed transformation programme for dermatology in BSW to manage rising demand and workforce constraints.

- Diagnostic capacity remains challenged particularly in ultrasound across the group where pathway changes in 25/26 have led to increased demand. Plans are in place in all Trusts to deliver increased capacity to sustain 6 week performance. The BSW Diagnostics Group oversees CDC capacity plans and has commissioned a diagnostic workforce plan to understand key constraints and opportunities across the BSW Hospitals Group.

The planning guidance for 26/27 will require ambitious plans across BSW Hospitals Group as we aim to increase performance and productivity further over the 25/26 position. A Group capacity/demand tool has now been developed and is in use across all three Trusts to ensure a rigorous understanding of the capacity required to deliver this. Effective planning will reduce system reliance on short-term and more expensive means of delivering capacity.

Urgent Care

Urgent Care performance remains challenged across the Hospitals Group although the summer saw improvements in Emergency Department performance and ambulance offloads for BSW. Winter plans have now been developed across the Group and tested via NHSE's Regional team although significant risk remains over winter if demand is higher than plan or Non-Criteria to Reside does not reduce as planned. We are working closely with our system partners particularly Local Authorities, HCRG and the ICB to ensure we can discharge patients promptly when they are ready to leave and that we increasingly manage patients in the community rather than hospital.

Finally, I particularly wanted to thank all our teams involved in managing the impact of the new SWAST 45 minute offload approach – this has been a significant change across BSW but teams have pulled together to help keep patients safe.

Group Update

Joint Committee update

Our latest BSW Hospitals Group Joint Committee meeting was held on 29th September 2025 in Salisbury with focus being on discussion of the Group Leadership Model, Financial Sustainability & Recovery, Care Organisation Risks, and our Group Governance Roadmap. Reports on our Corporate Services Programme, and Group Strategy Development were also introduced. A report from the September Group Joint Committee has been included with November Trust Board papers.

Leadership Team

Quarter three sees a few developments in the Group leadership team. The three Group Managing Directors joined on 1st September 2025 (Lisa Thomas - GWH, John Palmer – RUH, Nick Johnson - SFT). Andrew Hollowood has been appointed as our Group Strategic Clinical Transformation Director has been appointed. Following approval of the proposed leadership model post-consultation report by the Joint Committee on 29th September 2025, interviews for Group Chief Finance Officer and Group Chief People Officer roles were held in October; it is anticipated appointed candidates will be in-post in November. Announcements regarding these appointments will be made in early November.

Group Strategy & 26-27 Planning

The development of our Group Strategy has continued, led by Senior Responsible Officer, Joss Foster and coordinated by Trust strategy leads, overseen by our Strategy, Partnership & Planning executive working group. Our Transitional support partner Teneo is also supporting this work. The strategy will create a high-level, long-term vision aligned with the NHS 10-Year Health Plan, acting as a call to action and a clear narrative for staff, partners, and communities. Development is ongoing and will be managed in close coordination with the 26-27 planning round. The draft Strategy will be produced by December 2025, with final publication targeted for April 2026.

Group Governance and Assurance Arrangements and Transition Roadmap

To support safe and effective mobilisation of our new Operating Model by April 2026, a Governance Working Group led by Managing Director, Lisa Thomas, has been established to develop a detailed governance and assurance roadmap. The proposed roadmap was introduced at the Joint Committee on 29th September 2025. The development of BSW Hospitals Group risk approach and assurance arrangements will be integral to this roadmap.

Councils of Governors Workshop

On the afternoon of 2nd October 2025, the three Councils of Governors came together, to discuss the emerging Operating Model, Group Strategy and our developing Group narrative and vision. It was agreed that a series of follow-up meetings would be arranged, so Governors can continue the conversation on Group Governance arrangements and Group Strategy development; the next session will be held on 2nd December 2025.

Board to Board Development

We held the latest of our Board-to-Board development sessions on the morning of 2nd October 2025. The session focused on our Group Development Roadmap, Strategy and planned Governance and Risk Framework. Our next Board-to-Board session is planned for 12th February 2026. In the meantime, November, December and January will see a series of development workshops focused on our Group operating model, governance and assurance. Further details will be circulated in early November.

Local Update

Care Quality Commission Unannounced Inspection

The Care Quality Commission (CQC) undertook an unannounced inspection of the Emergency Department (ED) and Urgent Treatment Centre (UTC) on 21st October 2025. The onsite inspection lasted 2 days. The inspection continues and the Trust is responding to the additional data requests from the CQC and following this the Trust awaits the draft report.

National Update

NHS Trust Performance League Tables

In November 2024, the Secretary of State announced that NHS England would assess NHS Trusts against a range of performance criteria and publish the results. This assessment would allow NHS England to determine the support individual NHS Trusts would need to improve: those in the middle of the pack would be supported by NHS England to improve and those demonstrating persistently low performance would receive prompt intervention, while those performing at the top may be rewarded with additional freedoms.

The first league tables were published on 9th September 2025. The rating for the Royal United Hospitals Bath NHS Foundation Trust is outlined below:

The Trust was rated 112th of 132 Trusts across the country.

The RUH is behind plan for performance against Urgent and Emergency Care (UEC), Referral to Treatment (RTT), Cancer and Diagnostic Waiting Time and Activity (DM01) standards and as a result are in Tier 1 on these four domains. The RUH has programmes of recovery actions in place for all areas. Revised trajectories forecast a return to plan for RTT and Cancer standards.

UEC: Performance remains challenged and off trajectory. This is in the context of significant increase in attendances (+12%) and ambulance conveyances (+25%) from previous year. A UEC reset programme will commence in November to enhance focus on Internal Professional Standards, Boards/Ward rounds, and Emergency Department medical model. There is ongoing work with system partners to progress delivery of system actions to reduce No Criteria to Reside (NCTR) patients.

RTT: A revised trajectory has been submitted and accepted by NHSE which forecasts a return to plan by December 2025 and achievement of year end targets for 18 weeks and 52 weeks. The 12-week challenge started on 18th August and has made strong progress in strengthening RTT management. This combined with recovery actions including insourcing, waiting list initiatives to tackle backlogs, and transformation actions to improve productivity and utilisation including the implementation of GIRFT Further Faster recommendations.

Cancer: The RUH is achieving the 31-day standard. A revised trajectory has been submitted and accepted by NHSE which forecasts a deterioration in performance on 28 days and 62 days between October-November followed by a return to plan by January 2026. Recovery actions are in place across Breast, Colorectal and Dermatology which are our top contributors to underperformance.

Diagnostics: A revised trajectory has been submitted and accepted by NHSE which forecasts year end achievement of 16.1%. This would improve performance to better than the England and Wales average but below the original plan to achieve 5%,

The financial position at the RUH over the first half of the year has been extremely challenged, but there have been signs of improvement over the last two months. The key drivers of the overspend include the inability to deliver planned savings due to operational pressures, pressures linked to the exit run rate and high cost drugs costs.

The run rate position at M4 indicated an outturn deficit position in excess of £30m which has now been partially mitigated through a comprehensive recovery plan which has reduced the projected outturn to £26m. In order to deliver its contribution to the overall system financial position the Trust needs to deliver a minimum of £17m outturn deficit position, with plans developed to support this. The table below indicates the planned impact of the recovery actions and the risk designation associated with them:

Programme	Value £'m	RAG classification
Optimisation of Temporary staffing usage	2.3	
Elective and Outpatient Productivity	1.4	
Sulis productivity recovery and stretch	2.0	
Technical measures	1.7	
High Cost Drugs	2.0	
Other	2.2	
TOTAL	11.6	

Further information on the leagues tables can be found via https://www.england.nhs.uk/long-read/nhs-oversight-framework-nhs-trust-performance-league-tables-process-and-results/

NHS Online

The NHS is setting up an 'online hospital' – NHS Online – in a significant reform to the way healthcare is delivered in England.

The innovative new model of care will not have a physical site, instead digitally connecting patients to expert clinicians anywhere in England. The first patients will be able to use the service from 2027.

This will mean that patients can be seen faster, as teams triage them quickly through the NHS App and let them book in scans at times that suit them at Community Diagnostic Centres closer to home.

NHS Online will provide a huge boost to patient waiting times, delivering the equivalent of up to 8.5 million appointments and assessments in its first three years – four times more than an average Trust – while enhancing patient choice and control over their care.

Initially the focus will be on a small number of planned treatment areas with the longest waits but over time this will be expanded to more treatment areas. Treatment areas will only be offered if the NHS knows it is it is clinically safe to do so remotely.

10 Year Workforce Plan

The government announced that it is seeking evidence and views primarily from healthcare organisations and those with expertise in workforce planning to inform the development of the 10 Year Workforce Plan.

As part of the 10 Year Health Plan for England: fit for the future, the government conducted the biggest ever public and staff engagement exercise on the future of the NHS. In the 10 Year Health Plan they set out how they will reinvent the healthcare model from:

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

The 10 Year Workforce Plan will build on the 10 Year Health Plan to set out how the government will deliver a new workforce model with staff who are aligned with the future direction of reform and have real hope for the future.

Rather than a formal consultation on specific proposals, this call for evidence is an opportunity to provide views on the government's plans for the next decade and to share examples and case studies that will support its delivery. The call for evidence closes on 7th November 2025.

Further information regarding the 10 Year Workforce plan can be found via https://www.gov.uk/government/calls-for-evidence/10-year-workforce-plan

Implementation of Jess's Rule – Three Strikes and we rethink

On 23rd September 2025 Jess's Rule: Three Strikes and we rethink was implemented. This initiative is led by the Department of Health and Social Care (DHSC) and NHS England and is supported by the Royal College of General Practitioners.

Jess's Rule is a primary care initiative to encourage GPs teams to rethink a diagnosis if a patient presents three times with the same symptoms or concerns, particularly if symptoms unexpectedly persist, escalate, or remain unexplained.

Jess's Rule asks GP teams to 'reflect, review and rethink' if a patient presents three times with the same or escalating symptoms.

Jess's Rule is named in memory of Jessica Brady who passed away due to cancer in December 2020 at the age of 27. In the 5 months leading up to her death, Jess had 20 consultations with her GP practice, and her cancer had not been diagnosed. Jess was then admitted to hospital with stage 4 adenocarcinoma and passed shortly afterwards. Since then, Jess's family have campaigned for primary care staff to elevate a patient's case for review after their third appointment with their practice about a condition or symptom.

Further information about Jess's Rule can be found via https://www.england.nhs.uk/long-read/jesss-rule-three-strikes-and-we-rethink/

Government to Tackle Antisemitism and Other Racism in the NHS

The Prime Minister has ordered an urgent review of antisemitism and all forms of racism in the NHS, as part of wider efforts to tackle discrimination in the health service. Lord John Mann will lead the review, looking at how to protect patients and staff from racism and hold perpetrators to account.

At the same time, the government announced the immediate rollout of strengthened mandatory antisemitism and antiracism training across the health service, and NHS England will review its uniform guidance so patients and staff always feel respected in NHS settings.

BSW Hospitals Group are already looking at how to develop consistent communication materials across the three organisations ahead of the new mandatory training implementation.

Provider Capability Assessment

As part of the NHS Oversight Framework (NOF), NHS England required all NHS Trusts to complete an annual self-assessment of their organisations capability against the following six areas, derived from the Insightful Provider Board:

1. strategy, leadership and planning
2. quality of care
3. people and culture
4. access and delivery of services

5. productivity and value for money
6. financial performance and oversight

These areas will inform a self-assessment which is intended to strengthen board assurance and help oversight teams take a view of NHS trust capability based on boards' awareness of the challenges their organisations face and subsequent actions to address them. NHS England regional teams will then use the assessment and evidence behind it, along with other information, to derive a view of the organisation's capability.

Each organisation within BSW Hospitals Group - Great Western Hospitals, Royal United Hospitals Bath and Salisbury NHS Foundation Trusts submitted their self-assessment and associated evidence by the deadline of Wednesday, 22nd October 2025.

Resident Doctors Industrial Action

The British Medical Association have announced that Resident doctors in England are set to strike from 7am on 14th November 2025 for five days.

The Trust's within BSW Hospitals Group – Great Western Hospitals, Royal United Hospitals Bath and Salisbury NHS Foundation Trusts will start to look to plan and prepare for the industrial action should it go ahead, adopting similar approaches to previous episodes of strike action.

Medium Term Planning Framework

On 24th October 2025 NHS England published the Medium Term Planning Framework – delivering change together 2026/27 to 2028/29. This framework is designed to return the NHS to much better health over the next three years with reduced waiting times and access to local care restored to the level patients and communities expect.

Further information on the Medium Term Planning Framework can be found via https://www.england.nhs.uk/publication/medium-term-planning-framework-delivering-change-together-2026-27-to-2028-29/

MANAGING DIRECTOR'S REPORT

The RUH has been placed into Tier 1 for Urgent and Emergency Care (UEC), Referral to Treat, Diagnostics and Cancer performance.

The organization continues to be held to account in weekly tiering meetings for each of its performance domains by NHSE regional and national; which are then triangulated with NOF4 Financial Recovery and all performance domains once a month. Fortnightly meetings are also taking place with GIRFT (Getting It Right First Time) to support both UEC and planned care.

Broadly, the organization is conducting itself professionally in these engagements with well prepared positions beforehand and good interactions with the regional and national teams. We are beginning to see good indications about RTT, Diagnostics and Cancer performance with some positive messaging coming from national leads in month. However, UEC is genuinely under severe and novel demand pressure and hence we have had in short order during the last month a national UEC visit from Sarah-Jane Marsh on the 2nd October (national COO for UEC) and an ED focused visit from Sue Doherty and Trevor Smith on the 29th October (regional Chair and CMO).

Alongside these important discussions there have been multiple iterations of financial recovery planning for both the Group and RUHB which are culminating in H2 meetings for the System (3/11) and RUHB only (13/11) – the latter of which will be an oversight discussion with Jim Mackey, Chief Executive of NHSE.

I launched a "Call to Action" to all staff on 1st October. The call to action continues to be socialised through in-person meetings focusing on each of the priority areas.

The first face to face session took place on 29th October and all staff were invited to attend and have a discussion with myself and some of the executive team about how we get to grips with the current challenges the NHS is facing. We focused on urgent and emergency care as we head further into the Winter months and stage a reset throughout November.

The second session is taking place on 5th November and will focus on our financial position. The sessions will continue throughout November.

1. Operational

Urgent and Emergency Care

In September, 4-hour performance decreased marginally to 57.56% in the face of 11% month on month increases for ambulance and emergency department attendances (and 25% and 12% increases on October '24). The average ambulance handover was 81 minutes however this has reduced significantly in October since the introduction of the 45-minute ambulance handover policy. This is currently at 39 minutes with full October achievement to be reported in next month's data. A UEC reset will begin in November.

RUH Bath Call to Action

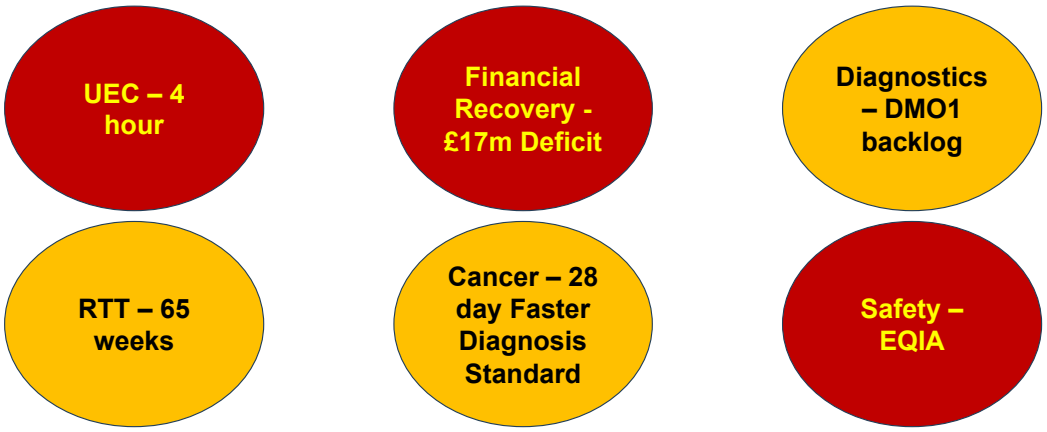


Figure 2: Call to Action

Referral to Treat
In September, RTT saw an increase in overall performance to 60.1% (+ of 1.9%). The percentage of patients waiting less than 18 weeks for their first outpatient appointment improved to 62.9% and total over 52-week waiters decreased from 761 to 565. A revised trajectory has been submitted and accepted by NHSE which forecasts a return to plan by December 2025 and achievement of year end targets for 18 weeks and 52 weeks. We expect to clear all 65-week waiters by 21st December 2025 and 52 weeks to 1% by end of the financial year.

Diagnostics
In September, 66.41% of patients received their diagnostic within the 6-weeks, against the 70.90% target, a slight improvement from August with 1,776 additional diagnostic tests being delivered. A revised trajectory has been submitted and accepted by NHSE which forecasts year end achievement of 16.1%.

Cancer
In August, performance deteriorated against the 28 and 62-day standards but 31-day performance improved, achieving the national standard. A revised trajectory has been submitted and accepted by NHSE which forecasts a deterioration in performance on 28 days and 62 days between October-November followed by a return to plan by January 2026. Recovery actions are in place across Breast, Colorectal and Dermatology which are our top contributors to underperformance.

Winter Plan
We continue to implement the Winter Plan with the following RUHB activities in hand:

- ED overnight workforce resourced (c. £1m) – agreed through Board and about to go through the triple lock retrospectively;
- Reset Programme to run in November (see **figure 4** below);
- 12 PY beds given over to UEC and Trauma and Orthopaedics offset through SULIS; and
- c. £500k of Winter funding.

And we continue to work with the ICB to achieve:

- An additional 5 beds per day access to Virtual Ward through Winter;
- Operationalising of St Martins (20 beds) as P2 step down from November to March;
- An accelerated plan to meet 9% NCTR as soon as possible.

All of this activity is geared to close our worst case Winter bed deficit of c. 94 beds.

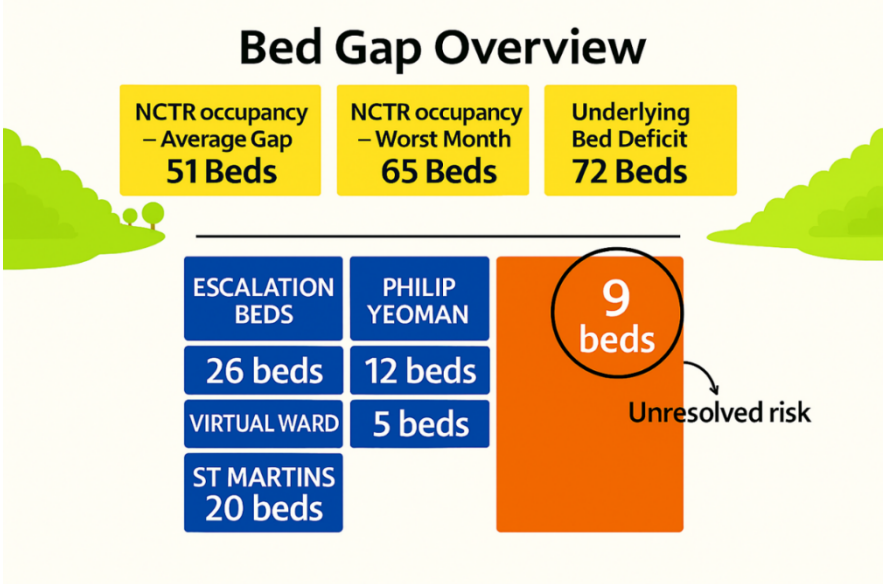


Figure 3: Winter Plan bed gap

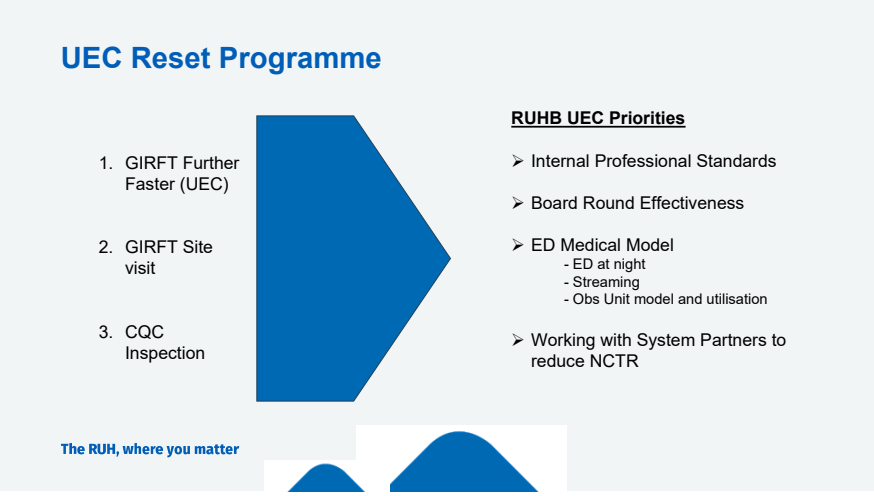


Figure 4: UEC Reset Programme (November)

2. Finance

The RUH developed a breakeven operating plan, with no NHSE Deficit Support Funding allocation. Plan phased in 12ths across year. The Trust has committed to forecast outturn of £17m, as part of BSW Hospitals Group £22m; partly offset by £14.6m ICB surplus; leaving BSW System residual gap of £7.4m.

The RUH has so far identified a further stretch contribution of £1.6m to support closing remaining gap and support System receipt of 23.7m Deficit Support Funding

The current performance at Month 6 Year to Date - £13.0m adverse to plan, however this is overachievement against forecast trajectory by £0.5m in month.

Key Drivers for this are:

- £10.5m - Savings, of which Urgent care demand £1.6m, Group stretch £2.2m
- £3.0m underlying prior year
- £0.6m ICB commissioned high cost drugs
- £0.1m Sulis subsidiary
- £0.9m Resident doctors
- £0.3m Pay Award
- £0.3m Resident Doctors Strike July

Actions completed so far are:

- A review of Investments has been completed.
- The Grip & Control checklist reviewed by NHSE and ongoing governance and oversight through the Trust's Finance and Performance Committee and Audit and Risk Committee approved, with dedicated team resource.
- Workforce controls further escalated to weekly all Executive team face to face process, and enhanced medical staff controls. Line by Line review of Recruitment pipeline underway.
- Activity & Income forecast triangulated with Sulis and with ICB.
- A proposal to commission a Turnaround team to support delivery of our plans is underway.

In terms of the key underpinning conditions for RUHB delivery:

- Some system contribution for contracting the Turnaround Team.
- Achievement of 9% NCTR in order to maintain UEC flow and therefore elective ringfences.
- Assessment of safety.
- Maintenance of RTT investment of £2.4m.

Next Steps:
Further, Faster opportunities of £1.6m identified via £1.35m further pay and cost reduction aligned to Turnaround team impact; and £0.3m further balance sheet review

Risks:

- Risks of £6.1m identified against £17m trajectory
- New Risks arising of £0.25m Industrial action; £0.4m ED Workforce following CQC inspection and stretch savings of £1.6m
- Total risks requiring ongoing mitigation of £8.35m

3. Quality

Excellent Care at Every Level

The Excellent Care at Every Level Accreditation Programme is the most significant quality improvement programme across the Trust. Since the last public Board of Directors, the Discharge Lounge achieved Bronze Accreditation, and the Intensive Care Unit were awarded Gold Accreditation. Gold Accreditation is a wonderful achievement and testament to the standards they set themselves for the people we care for and the people we work with. We are enormously thankful and proud of the work they do.

4. NHS Staff Survey 2025

The NHS Staff Survey is one of the largest workforce surveys in the world and is carried out every year to improve staff experiences across the NHS. Over 1.4 million NHS staff can take part in the 2025 survey. It is run independently and provides an opportunity for every member of staff to share, anonymously and in confidence, what it is like for them working in the NHS. The survey closes on 28th November with the Trust closing in on a 50% response rate currently.

5. Use of Trust Seal

There has been no use of the Trust seal for the execution of any documents within the preceding two-month period.

6. 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/

7. 2025 Governor Elections

We are delighted to confirm that the following candidates have been chosen by our members to represent your constituencies:

- Rachel Walker, City of Bath
- Ming Keng Teoh, City of Bath
- Anna Beria, North East Somerset (re-elected)
- Nick Craw, Somerset (Mendip)
- Christopher Leadbeater, North Wiltshire
- Adam Cooksey, South Wiltshire
- Fi Abbey, Staff
- Anthony Green, Staff

It was a close run election across all of the contested constituencies and we are grateful to all of our members who put themselves forward for election. You can read the full election report on our website: https://www.ruh.nhs.uk/membership/elections/

8. 2025 Annual General Meeting

The Trust's Annual General Meeting combined with Annual Members' Meeting took place on Thursday 25th September 2025. At this year's meeting the Trust reflected on its activities, challenges and achievements over the last financial year. There was presentation of the Annual Report and Accounts, and the Trust outlined its plans for the year ahead.

A video of the AGM, all presentations along with the Trusts Annual Report and Accounts, and the Trust Year in Review can be found on our website: https://www.ruh.nhs.uk/about/agm/

9. Consultant Appointments

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

Dr Pamala Kanagasabapathy was appointed as Consultant Haematologist. Dr Kanagasabapathy will join us in March 2026 and is currently a Haematology Consultant at St. Georges University Hospital.

Dr Hugh Jones was appointed as Consultant Neurologist. Dr Jones is currently an ST7 at University Hospitals Plymouth and will join the Trust on 17th November 2025.

10. RUH In the News – a selection of news stories from the past two months

Organ Donation Week

In September the RUH encouraged people to register their decision to be an organ donor after new figures showed that that more than 12,000 people in the UK have died or been removed from the transplant waiting list over the past 10 years before receiving the lifesaving organs they desperately needed. Confirming a decision to donate on the NHS Organ Donor Register makes it clear to family that you want to be an organ donor, leaving them certain of your decision at what is a difficult and emotional time.

The RUH works in partnership with NHS Blood and Transplant, Tissue and Eye Services as a key donation site, aiming to offer the option of tissue donation to bereaved families as part of normal end of life practice

Patients praise newly opened surgical centre near Bath

In September, Sulis Hospital and the BSW Hospitals Group celebrated the official opening of the Sulis Orthopaedic Centre (SOC), a new facility that will see thousands of NHS patients in the south west receive life-changing surgery much sooner than before.

Based just south of Bath at Sulis Hospital, the SOC is a state-of-the-art surgical centre that delivers planned, ring-fenced, year-round orthopaedic operations – such as hip and knee replacements – to NHS patients from Bath and North East Somerset, Swindon and Wiltshire. The initiative will mean that patients receiving care at BSW Hospitals Group will be able to choose to have their operation at the SOC, providing they are considered suitable during their pre-operative assessment.

Standing beside staff: RUH launches compassionate cancer support policy

The RUH teamed up with Working With Cancer (WWC) to develop a new policy to support RUH colleagues who are affected by cancer. Launched in September, the pilot initiative that lays out how the RUH stand beside our staff when they need us most, focusing on compassion, flexibility and dignity.

The new policy is intended to support team members who receive a cancer diagnosis whether they are in treatment, remission or managing recurrence, someone caring for a loved one with cancer, or anyone working alongside colleagues affected by cancer and wondering how best to help.

RUH patient calls on women to check for signs of gynaecological cancer

In September, Gynaecological Cancer Awareness Month, a patient treated for the cancer at the RUH called on women to get themselves checked out if they have any unusual symptoms. She emphasised that women who are having unusual symptoms is shouldn’t be embarrassed. If anything just doesn't feel right get to your GP straight away. The earlier you can get diagnosed and treated, the better things will be for you.

New fruit and veg stall at the RUH
In October the RUH teamed up with local grocer Dean Cooper, from Wild About Fruit and Veg, to provide a fresh produce stall at the hospital's Weston site.
The stall is on the main RUH site Monday- Thursday and is already proving popular with staff and visitors. The fruit and vegetable stall was introduced in response to staff feedback and is the latest addition to the RUH to provide patients, visitors and staff with more food and drink choices when they are at the hospital.

RUH researchers launch new stroke study
Researchers at the RUH launched a new recruitment drive in October for a study looking at how two different medications might help people who have suffered a particular type of stroke. The national LACunar Intervention (LACI) Trial-3 is investigating whether two types of medication may help patients who have had a cerebral small vessel disease (lacunar) ischaemic stroke.
As there are no treatments for small vessel disease, this study is looking at the use of two drugs that are used for other diseases to see if they help to prevent the small vessel disease from causing another stroke or negatively impacting cognitive function.

RUH welcomed Greg Davies and Time is Precious
In October the RUH was delighted to welcome local charity, Time is Precious, along with one of its patrons, comedian, actor and TV host, Greg Davies, for a visit.
Founders of Time is Precious, Nicky and Neil Halford, set up the charity in memory of their son Ben, who sadly died following a cancer diagnosis. Ben spent a lot of time at the RUH during his illness and this experience inspired Nicky and Neil's vision: to help create a more comfortable and relaxed atmosphere for children and their families in hospital or at home.

Greg popped by during a break from his sell out tour and several nights at The Forum in Bath to see the amazing contribution that Time is Precious has made to the RUH in person as well as meet some of our staff and patients.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**10**
Date of Meeting:	**5 November 2025**		
Title of Report:	**Management Executive Committee Upward Report**		
Status	**For information**		
Author	**Abby Strange, Corporate Governance Manager**		

Key discussion points and matters to be escalated from the meetings on 24th September and 29th October 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

Integrated Performance Report, Tiering and Recovery Plan
Progress against the Recovery Plan and ongoing efforts to improve performance in Urgent and Emergency Care (UEC), diagnostic, cancer, and Referral to Treatment (RTT) continues to be reviewed. The Committee discussed the September position and acknowledged evidence that performance metrics were moving in the right direction. They recognised the need to remain cognisant of emerging risks and noted that a proactive approach was being taken to this.

Financial Position
The financial position remains challenging, and some capital works have been postponed to manage this. The Committee continues to monitor this and discussed the possibility of accelerating service redesign and transformation to accelerate the financial recovery at the October meeting. Further work is required to determine whether the organisation is in a position to do this.

Emergency Department (ED) Overnight Business Case
The Committee discussed a business case proposing to uplift staffing in the Emergency Department to address risks to patient safety and staff wellbeing. This was developed further and was approved retrospectively at the October meeting for submission to the BSW Integrated Care System Triple Lock Investment Panel. The Trust is awaiting formal approval from the panel.

2026/27 Business Planning
The business planning approach for 2026/27 was discussed and the shift to a multi-year rolling five year model was acknowledged. National planning guidance was published on 24th October 2025, and the new approach will require more granular, phased planning and a stronger strategic narrative than in previous years. The Committee has reviewed high level division plans and will maintain oversight of this as it progresses.

Unannounced Care Quality Commission (CQC) visit to the Emergency Department (ED) and Urgent Treatment Centre (UTC)
The Committee received initial feedback following an unannounced CQC visit to ED and UTC. A draft report will be shared with the Trust in 6 weeks.

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

Alert Metrics
An increase in medication safety events has been identified, and work is ongoing to understand the drivers of this trend. Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) metrics will also be monitored through the Integrated Performance Report going forward.

iRefer
The Committee discussed the expiry of the iRefer license in Radiology. Funding options are due to be explored.

BSW Hospitals Group
The Committee received an update on the development of BSW Hospitals Group, including ongoing work around the new governance structure. The new Group governance structure will focus on a risk based approach.

ASSURE: Inform the Board where positive assurance has been achieved

Winter Plan
The Committee provided feedback on the Winter Plan for 2025/26. The feedback was incorporated, and the final iteration was approved via Chair's Action prior to Board and Group level approval.

BSW Hospitals Group Organisational Change Policy
The Committee noted the approval and implementation of the BSW Hospitals Group Organisational Change Policy and endorsed it as the agreed framework for managing organisational change at the Trust.

RISK: Advise the Board which risks were discussed and if any new risks were identified

Salix Decarbonisation Programme
Delays to the Salix Decarbonisation Programme were noted. This will extend the construction and commissioning phase beyond the approved funding window and mitigation planning is in progress.

Equality and Quality Impact Assessment (EQIA Policy)
The Committee received the draft EQIA and noted that there is a risk in terms of resourcing the EQIA process.

Staff Sickness
Concerns were raised around the levels of sickness in the organisation and an intervention plan is being developed in response to this.

CELEBRATING OUTSTANDING: Share any practice innovation or action that the committee considers to be outstanding

The Committee celebrated a number of achievements including:

September 2025

- The success of the RUH Community Day on Saturday 13th September 2025
- RUHX approval of 13 grant applications within the Medicine Division.
- Regional approval of capital schemes in emergency care.

October 2025

- The Critical Care Team's achievement of gold level accreditation through the ExCEL Accreditation Programme.
- Capital funding had been secured for work around UEC, the MRI scanner replacement at Sulis, and other small scale diagnostic improvements.
- There had been some improvement in the performance metrics in the context of an exponential growth in demand.

APPROVALS: Decisions and Approvals made by the Committee

September 2025

- The Committee was appraised of the risks around the backlog in clinical coding and agreed an interim solution to resolve this.
- The Committee agreed a proposed change to Medical Short Stay to address staff shortages and to better align inpatient care with specialty pathways, subject to assurance that there would be no financial impact.
- The Committee approved a proposal to use C16 as a temporary storage and viewing area during refurbishment works in the mortuary.
- The Committee agreed to progress a business case around e-Rostering to ensure consistency, transparency, and planning and demand modelling.
- The Committee received the Risk Register Summary Report and approved the new and upgraded risks outlined in the report.
- The Committee approved the replacement of the Winscribe digital dictation system subject to assurance that this could be funded via the Trust's capital allocation.

October 2025

- The Committee approved the use of 3 Whole Time Equivalent (WTE) Preferred Supplier List (PSL) band 6 agency nurse to support staffing in the Neonatal Unit until the end of December 2025. This is a financially viable option, and the proposed timeline aligns with several anticipated improvements.

- The Committee approved a proposal to change the scope of the Sulis Community Diagnostic Centre (CDC) BaNES Hub capital design from endoscopy expansion to CT and MRI expansion. This is subject to final Board-level approval.

- The Committee retrospectively approved a business case to provide a permanent and sustainable workforce model in ED for submission to the BSW Integrated Care System Triple Lock Investment Panel. The Trust is awaiting formal approval from the panel.

- The Committee received the Risk Register Summary Report and approved the new and upgraded risks outlined in the report.

Report to:	**Public Board of Directors**	**Agenda item:**	**11.0**
Date of Meeting:	**5 November 2025**		
Title of Report:	**Integrated Performance Report**		
Status:	**For Noting**		
Board Sponsor:	**Bernie Bluhm, Acting Chief Operating Officer** **Toni Lynch, Chief Nursing Officer** **Alfredo Thompson, Chief People Officer** **Simon Wade, Chief Finance Officer**		
Author:	**Operational Team** **Rob Elliott, Lead for Quality Assurance** **Matt Foxon, Deputy Chief People Officer** **Jon Lund, Director of Operational Finance**		
Appendices	**Appendix 1: Integrated Performance Report slide deck** **Appendix 2: Trust Scorecard**		

1. Executive Summary of the Report

The report provides an overview of the Trusts Performance for the period up to and covering September 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 September 2025 was 80.89 minutes, an increase of 22.19 minutes on average compared to August 2025. Through September 2025 the total hours lost was 2,860. This is an 898-hour increase compared to last month's lost hours of 1,962. 38% of handovers were completed within 30 minutes, a decrease of 8.4% since last month. Additionally, handovers taking place in less than 15 minutes decreased from 20.4% to 16.4%.

RUH 4-hour performance in September was 57.56% on the RUH footprint (unmapped; we are not currently receiving MIU data from HCRG), a decrease of 1.5% from August's performance (59.05%). Non-admitted performance was 70.35%, which was a decrease against the performance for August (71.30%) and admitted performance also decreased at 28.66% (August 30.50%). Both metrics have seen a similar decrease in performance.

The numbers of patients going through our MSDEC (720) and FSDEC (39) has increased significantly since August 2025, with our performance for MSDEC remaining elevated at 38.2% for August 2025 (July 38.3%). This is just below the national target of 40% of patients going through an SDEC pathway.

In September, 66.41% of patients received their diagnostic within the 6-weeks against

the 70.90% target. Performance improved 1.21% when compared to previous month. In month, 1776 additional diagnostic tests were delivered when compared to August.

In August (Cancer performance is reported one month in arrears) performance deteriorated against the 28- and 62-Days targets, but 31 Days improved, achieving the national standard. 28 Days reduced by 6.5% to 65.7% with further deterioration expected in September-October due to capacity deficits and long first appointment waiting times in Breast and Skin, before recovery from November. 62 Days reduced by 6% to 65.1%, with higher breaches in Colorectal and Urology and further deterioration anticipated in September and October with Skin the top contributor. 31 Days achieved 96.0% but is also expected to reduce September-November due to Skin treatment breaches.

In September, RTT saw an increase in overall performance of 1.9% to 60.1%. The percentage of patients waiting less than 18 weeks for their first outpatient appointment was 62.9% (+2.7% from August). Total over 52-week waiters decreased from 761 to 565 (-25.76%). For patients over 65 weeks, the Trust saw a decrease from 56 to 44 patients. Theatre performance was maintained at 82% capped utilisation.

Quality

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

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

Pressure Ulcers

For August 2025, the RUH reported 0.3 pressure ulcers per 1,000 bed days (5 pressure ulcers). The RUH reported one category 3 pressure ulcer, one category 3 medical device related pressure ulcer, two category 2 pressure ulcers and one category 2 medical device related pressure ulcer.

The themes were inadequate skin checks and off-loading of pressure particularly under a medical device. The Divisions are working closely with the wards on action plans for improvement.

Falls

In August 2025 there were 4 reported inpatient falls that resulted in moderate harm to patients. 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. The PSII is ongoing.

Infection Prevention and Control Update

There have been 4 cases of Clostridioides Difficile infection (CDI) (2 HOHA and 2 COHA) reported during August 2025. There have been 29 cases against a threshold of 75 for 2025/26. There continues to be no specific contributor identified or linked to

the RUH CDI cases.

There have been 8 cases of E. coli infection reported during August 2025 (3 HOHA and 5 COHA), of these cases the consistent themes were urinary (n=7) with 2 of those related to a catheter in situ.

There has been an increase in MSSA seen from April to August 2025 in comparison to the same period in 2024, with the major contributor being skin soft tissue injuries.

Patient Support and Complaints
In August the Trust received 23 new formal complaints, this compares to 38 received in July. The complaint rate per 1000 contacts is 0.40. 78% (target 90%) of complaint responses were closed within the agreed timeframe, which is slightly lower than July.

Safe Staffing
The combined shift fill rates for days for RNs across the 24 inpatient wards was 84% and 92% respectively for nights. The combined shift fill rates for Healthcare Support Workers was 82% for the day and 95% for the night shift.

Perinatal Update
The Perinatal Quality Surveillance Report reflects continued operational pressures across maternity and neonatal services, particularly in relation to staffing and acuity. Despite Midwife-to-birth ratios exceeding the recommended threshold, safe staffing has been maintained in high-risk areas, ensuring 1:1 care in labour and full coverage in transitional care. There was one episode when the Labour Ward Coordinator was not supernummary, this last for 5 minutes until a member of staff was redeployed to take over the role. The Neonatal services have experienced increased demand, but mitigation measures, including recruitment activity and redeployments of specialist roles including paediatric nursing support underway to support safe care delivery. Compliance with national safety standards, PMRT reporting, and training remains strong. There were no neonatal deaths or stillbirths reported in August. Patient feedback remains positive, with targeted improvements in antenatal education and postnatal discharge support being progressed.

Workforce
The following outline the key RUH workforce metrics:

- Actual Total WTE in September 2025 was 5749.9 an increase on the August position of 5738 and around 120 WTE over its planned position. The increase is in substantive staff, with a slight decrease in bank use.
- The vacancy rate has reduced to – 0.44% in M6, meaning that the Trust is over-established by 27.4 WTE an increase from 14 WTE.
- Bank usage has decreased in September, primarily due to reduction in use by Registered Nursing and Midwifery and Support to Nursing staff groups.
- Agency spend as a proportion of the pay bill has slightly decreased from 0.86% to 0.38% and is well within the control parameters and below the 2.5% target.
- Rolling sickness absence is 4.88% in August (M5) against a target of 4.70%, this is the highest it has been in two years.

- Rolling turnover has dropped to 7.31% in M6, with all divisions having a turnover of under 10%.
- The target percentage figure for Appraisal completion is 90%; Appraisal rate increased marginally again to 77.9% in M6.
- Mandatory Training compliance continues to meet target at 89.35% in M6, though has fallen fractionally.

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 continues for the new Wellbeing and Supporting Attendance Policy and the People Hub are working through the top 50 absences ensuring long term sickness cases are appropriately managed.

Appraisal Compliance and Quality:
The appraisal rate remains approximately 12% below our compliance target of 90%. Increasing compliance has had especial focus over Q2, but the impact is not yet being realised.

Divisional People Partners are implementing a suite of targeted interventions aimed at supporting managers in improving compliance. The work continues to keep pressure on increasing compliance, whilst encouraging a more rigorous focus on quality improvement. Appraisal and line manager engagement is central to effecting meaningful workforce changes whilst keeping colleagues engaged and healthy.

Agency Spend and Bank Rate
Agency costs increased slightly in M6 to 0.83% from 0.75% in M5 although we remain below the 3.2% national target.

Agency staffing remains a key focus area in supporting our financial sustainability. Medical and Dental roles continue to account for most of the agency expenditure, representing 96% of total agency spend. Currently, 11 WTE Consultant posts in Oncology, Haematology, and Cellular Pathology are supporting patient services. These specialties are recognised nationally as hard-to-recruit areas.
We are actively pursuing best-value agency provision and implementing exit strategies to reduce reliance on agency workers wherever possible

Bank WTE reduced in M6 by 26.9WTE in comparison to M5. The biggest demand was the Emergency Department which we are actively recruiting to vacant posts to support the reduction in temporary staffing as we onboard new joiners. The second area is cleaning which we are actively recruiting too by attending local job fairs, hosting career events and working in partnership with the Job Centre.

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.

Finance
The RUH Group is £12.796m adverse to plan at the end of September, of which £12.997m arising in RUH Trust and £0.108m in Sulis. This is significantly averse to plan and has triggered regulatory intervention, immediate enhanced expenditure controls & a Call to Action across the organisation. The Trust is subject to Finance Override in National Oversight Framework (NOF) and taken together with UEC and Elective performance delivery places the Trust is Level 4.

The key driver is £10.5m variance arising from under delivery of the £29.7m savings programme and acceleration of delivery plan and scoping of further areas to close the unidentified gap must be top priorities for the organisation. £12.2m remains unidentified at his time and there are delivery risks within planned schemes. £1.6m arises from UEC savings where demand growth and higher than planned NCTR are the key contributors.

Operational budget pressures have reduced in the month, however cumulative pressures arise from increased spend on high-cost drugs and devices (£0.6m), Pay Award (£0.3m) Resident Doctors budget pressures (£0.9m), and Resident Doctor Strike (£0.3m). This is partly offset by increased cost controls and non-recurrent benefits (£1.7m) and reduced utility costs (£0.55m). Sulis is averse to plan by £0.1m. This is principally driven by underperformance on CDC activity-based income. Further adverse variances arise from deterioration in the exit run rate from 24/25 (£3.0m)

Cash balances for the Trust are £30.5m, this includes cash received in advance. Robust cashflow forecasts have been undertaken which show cash balances reducing to £12.5m by April on a do-nothing scenario and c£19m in line with Recovery trajectory. £19m is judged to be the minimum working cash limit to enable contractual obligations to be met in time.

For June 2025 the Trust had an implied productivity improvement of 2.8% against the breakthrough objective of 6.7%. Cost weighted activity grew by 6% compared to inflation adjusted cost growth of 3.1%. Given that some of the activity growth is in non-elective activity we do not see a direct financial benefit from this productivity. The RUH Group underlying deficit has been re-assessed at £47.2m, to align with 25/26 Recovery Actions; and becomes the baseline for 26/27 planning.

The Trust operates within BSW Integrated Care System which has reported a £23.3m adverse variance to plan year to date, of which BSW Hospitals Group is £31.6m adverse to plan, partially offset by ICB favourable variance to plan of £8.3m.
The ICS is still being challenged to deliver a breakeven plan for the year, the initial

stage is for RUH to deliver a £17m deficit, even this position would still leave a £10m gap to be closed through further actions across the ICS.

2.	Recommendations (Note, Approve, Discuss)
The Management Executive Committee 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
Private	

9.	Sustainability
None identified.	

10.	Digital
None identified.	

Royal United Hospitals Bath
NHS Foundation Trust

Integrated Performance Report

October 2025
(September data)

The RUH, where you matter

Executive Summary

Performance

The average ambulance handover delay for September 2025 was 80.89 minutes, an increase of 22.19 minutes on average compared to August 2025. Through September 2025 the total hours lost was 2,860. This is an 898-hour increase compared to last month's lost hours of 1,962. 38% of handovers were completed within 30 minutes, a decrease of 8.4% since last month. Additionally, handovers taking place in less than 15 minutes decreased from 20.4% to 16.4%.

RUH 4-hour performance in September was 57.56% on the RUH footprint (unmapped; we are not currently receiving MIU data from HCRG), a decrease of 1.5% from August's performance (59.05%). Non-admitted performance was 70.35%, which was a decrease against the performance for August (71.30%) and admitted performance also decreased at 28.66% (August 30.50%). Both metrics have seen a similar decrease in performance.

The numbers of patients going through our MSDEC (720) and FSDEC (39) has increased significantly since August 2025, with our performance for MSDEC remaining elevated at 38.2% for August 2025 (July 38.3%). This is just below the national target of 40% of patients going through an SDEC pathway.

In September, 66.41% of patients received their diagnostic within the 6-weeks against the 70.90% target. Performance improved 1.21% when compared to previous month. In month, 1776 additional diagnostic tests were delivered when compared to August.

In August (Cancer performance is reported one month in arrears) performance deteriorated against the 28- and 62-Days targets, but 31 Days improved, achieving the national standard. 28 Days reduced by 6.5% to 65.7% with further deterioration expected in September-October due to capacity deficits and long first appointment waiting times in Breast and Skin, before recovery from November. 62 Days reduced by 6% to 65.1%, with higher breaches in Colorectal and Urology and further deterioration anticipated in September and October with Skin the top contributor. 31 Days achieved 96.0% but is also expected to reduce September-November due to Skin treatment breaches.

In September, RTT saw an increase in overall performance of 1.9% to 60.1%. The percentage of patients waiting less than 18 weeks for their first outpatient appointment was 62.9% (+2.7% from August). Total over 52-week waiters decreased from 761 to 565 (-25.76%). For patients over 65 weeks, the Trust saw a decrease from 56 to 44 patients. Theatre performance was maintained at 82% capped utilisation.

Executive Summary

Quality

Pressure Ulcers

For August 2025, the RUH reported 0.3 pressure ulcers per 1,000 bed days (5 pressure ulcers). The RUH reported one category 3 pressure ulcer, one category 3 medical device related pressure ulcer, two category 2 pressure ulcers and one category 2 medical device related pressure ulcer.

Locations were on the heel, sacrum, spine and ear. The themes were inadequate skin checks and off-loading of pressure particularly under the medical device. A specialist cast was provided for a patient with a heel ulcer that had not been used before so the staff were unsure as to how to proceed, this was reported for July but was an incident that occurred in August. The respiratory ward presented the action plan for recovery in September to the Tissue Viability Improvement group and the medical division has oversight of these improvements. The Divisions are working closely with the wards on action plans for improvement.

Falls

In August 2025 there were 4 reported inpatient falls that resulted in moderate harm to patients. Any new actions or areas of learning from these incidents were agreed and 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. The PSII is ongoing.

Infection Prevention and Control Update

There have been 4 cases of Clostridioides Difficile infection (CDI) (2 HOHA and 2 COHA) reported during August 2025. There have been 29 cases against a threshold of 75 for 2025/26. There continues to be no specific contributor identified or linked to the RUH CDI cases.

Patient Support and Complaints

In August the Trust received 23 new formal complaints, this compares to 38 received in July. The complaint rate per 1000 contacts is 0.40. 78% (target 90%) of complaint responses were closed within the agreed timeframe, which is slightly lower than July and remains fluctuates across the divisions.

Safe Staffing

The combined shift fill rates for days for RNs across the 24 inpatient wards was 84% and 92% respectively for nights. The combined shift fill for HCSWs was 82% for the day and 95% for the night shift.

Perinatal Update

The October 2025 Perinatal Quality Surveillance Report update reflects continued operational pressures across maternity and neonatal services, particularly in relation to staffing and acuity. Despite midwife-to-birth ratios exceeding the recommended threshold, safe staffing has been maintained in high-risk areas, ensuring 1:1 care in labour and full coverage in transitional care. Neonatal services have experienced increased demand, but mitigation measures, including recruitment activity and redeployments of specialist roles including paediatric nursing support underway to support safe care delivery. Compliance with national safety standards, PMRT reporting, and training remains strong. There were no neonatal deaths or stillbirths were reported in August. Patient feedback remains positive, with targeted improvements in antenatal education and postnatal discharge support being progressed.

Executive Summary

Workforce

The following outline the key RUH workforce metrics:

- Actual Total WTE in September 2025 was 5749.9 an increase on the August position of 5738 and around 120 WTE over its planned position. The increase is in substantive staff, with a slight decrease in bank use.
- The vacancy rate has reduced to – 0.44% in M6, meaning that the Trust is over-established by 27.4 WTE an increase from 14 WTE.
- Bank usage has decreased in September, primarily due to reduction in use by Registered Nursing and Midwifery and Support to Nursing staff groups. Agency
- spend as a proportion of the pay bill has slightly decreased from 0.86% to 0.38% and is well within the control parameters and below the 2.5% target. Rolling
- sickness absence is 4.88% in August (M5) against a target of 4.70%, this is the highest it has been in two years.
- Rolling turnover has dropped to 7.31% in M6, with all divisions having a turnover of under 10%.
- The target percentage figure for Appraisal completion is 90%; Appraisal rate increased marginally again to 77.9% in M6.
- Mandatory Training compliance continues to meet target at 89.35% in M6, though has fallen fractionally.

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 continues for the new Wellbeing and Supporting Attendance Policy and the People Hub are working through the top 50 absences ensuring long term sickness cases are appropriately managed.

Appraisal Compliance and Quality:
The appraisal rate remains approximately 12% below our compliance target of 90%. Increasing compliance has had especial focus over Q2, but the impact is not yet being realised.

Divisional People Partners are implementing a suite of targeted interventions aimed at supporting managers in improving compliance. The work continues to keep pressure on increasing compliance, whilst encouraging a more rigorous focus on quality improvement. Appraisal and line manager engagement is central to effecting meaningful workforce changes whilst keeping colleagues engaged and healthy.

Workforce continued

Agency Spend and Bank Rate :

Agency costs increased slightly in M6 to 0.83% from 0.75% in M5 although we remain below the 3.2% national target.

Agency staffing remains a key focus area in supporting our financialsustainability.

Medical and Dental roles continue to account for most of the agency expenditure, representing 96% of total agency spend. Currently, 11 WTE Consultant posts in Oncology, Haematology, and Cellular Pathology are supporting patient services. These specialties are recognised nationally as hard-to-recruit areas.
We are actively pursuing best-value agency provision and implementing exit strategies to reduce reliance on agency workers wherever possible

Bank WTE reduced in M6 by 26.9WTE in comparison to M5. The biggest demand was the Emergency Department which we are actively recruiting to vacant posts to support the reduction in temporary staffing as we onboard new joiners. The second area is cleaning which we are actively recruiting too by attending local job fairs, hosting career events and working in partnership with the Job Centre.

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 anescalation route to maintain the safety and performance ofservices.

Executive Summary

Finance

The RUH Group is £12.796m adverse to plan at the end of September, of which £12.997m arising in RUH Trust and £0.108m in Sulis. This is significantly adverse to plan and has triggered regulatory intervention, immediate enhanced expenditure controls & a Call to Action across the organisation. The Trust is subject to Finance Override in National Oversight Framework (NOF) and taken together with UEC and Elective performance delivery places the Trust is Level 4.

The key driver is £10.5m variance arising from under delivery of the £29.7m savings programme and acceleration of delivery plan and scoping of further areas to close the unidentified gap must be top priorities for the organisation. £12.2m remains unidentified at his time and there are delivery risks within planned schemes. £1.6m arises from UEC savings where demand growth and higher than planned NCTR are the key contributors.

Operational budget pressures have reduced in the month, however cumulative pressures arise from increased spend on high cost drugs and devices (£0.6m), Pay Award (£0.3m) Resident Doctors budget pressures (£0.9m), and Resident Doctor Strike (£0.3m). This is partly offset by increased cost controls and non-recurrent benefits (£1.7m) and reduced utility costs (£0.55m). Sulis is adverse to plan by £0.1m. This is principally driven by under performance on CDC activity based income. Further adverse variances arise from deterioration in the exit run rate from 24/25 (£3.0m)

Cash balances for the Trust are £30.5m, this includes cash received in advance. Robust cashflow forecasts have been undertaken which show cash balances reducing to £12.5m by April on a do nothing scenario and c£19m in line with Recovery trajectory. £19m is judged to be the minimum working cash limit to enable contractual obligations to be met in time.

For June 2025 the Trust had an implied productivity improvement of 2.8% against the breakthrough objective of 6.7%. Cost weighted activity grew by 6% compared to inflation adjusted cost growth of 3.1%. Given that some of the activity growth is in non-elective activity we do not see a direct financial benefit from this productivity.

The RUH Group underlying deficit has been re-assessed at £47.2m, to align with 25/26 Recovery Actions; and becomes the baseline for 26/27 planning.

The Trust operates within BSW Integrated Care System which has reported a £23.3m adverse variance to plan year to date, of which BSW Hospitals Group is £31.6m adverse to plan, partially offset by ICB favourable variance to plan of £8.3m.

The ICS is still being challenged to deliver a breakeven plan for the year, the initial stage is for RUH to deliver a £17m deficit, Even this position would still leave a £10m gap to be closed through further actions across the ICS.

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

Royal United Hospitals Bath
NHS Foundation Trust

Operational Performance

October 2025 (September Data)

The RUH, where you matter

Business Plan Delivery **September 2025**

Activity Plan

	YTD Plan	YTD Actual	Variance	Change per Day Actual
OP News	99,834	101,593	1,759	+21
OP Follow Ups	152,478	154,798	2,320	+28
Daycases	19,452	18,469	-983	-12
EL Inpatients	2,355	2,086	-269	-3
ED Attendances	52,001	52,308	307	+4
NEL Admissions	30,899	32,073	1,174	+14
Diagnostic tests	85,939	83,058	-2,881	-34

Planning Assumptions

	Plan	YTD Actual
GP Referral Growth	0.0%	1.7%
ED Atts Growth	2.6%	3.3%
NEL Admit Growth excludes maternity	3.4%	9.5%
NCTR	61	83
NEL Length of Stay for 1+ days	6.2	6.8

Performance

		Year End Target	Current Month Plan	Actual
RTT	<18 1st app	71.7%	66.7%	62.2%
	<18 weeks	67.7%	62.7%	60.1%
	>52 weeks	1.0%	1.2%	1.5%
Cancer	62 days*	75.0%	70.6%	64.8%
	31 days*	96.0%	89.5%	96.1%
	28 days*	80.0%	74.5%	65.9%
ED	4hr type 1	72.0%	73.7%	57.6%
	4hr All Types	78.0%	79.4%	67.6%
	12 hours	reduction	4.6%	9.0%
DM01	> 6 weeks	5.0%	11.9%	33.6%

* 1 month reporting lag

Finance

	YTD Plan	YTD Actual	Variance
Cash Releasing Savings	£17,301	£6,812	-£10,489
Financial Position	£0	-£12,956	-£12,956
Productivity	+6.7%	+2.8%	-3.9%

Figs to June 25

Workforce

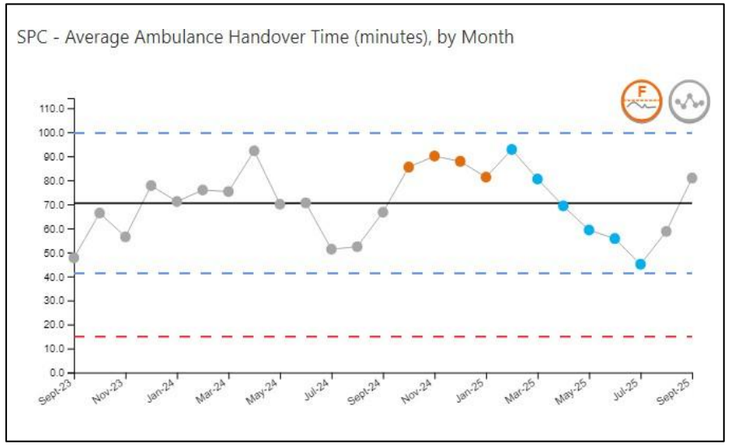
	YTD Planned	YTD Actual	Variance
Pay Savings (£000s)	£6,027	£4,011	-£2,016
WTE Reduction	5629	5748	119.0
Sickness (1 mth lag)		5.11%	

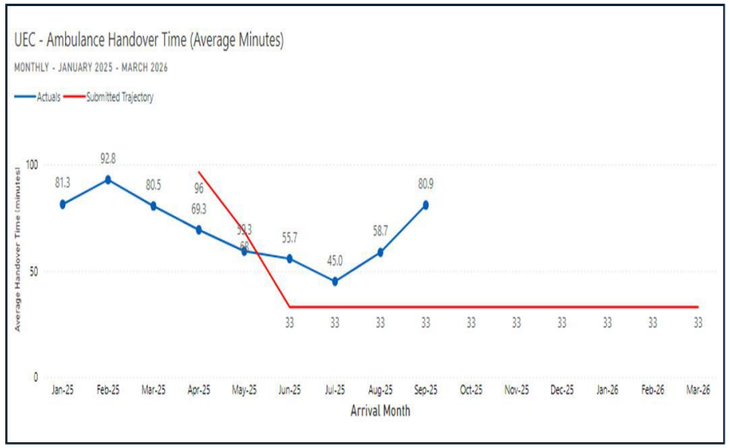
Ambulance Handover Times

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 September 2025 was 80.89 minutes, an increase of 22.19 minutes on average compared to August 2025. Through September 2025 the total hours lost was 2,860. This is a 898-hour increase compared to last month's lost hours of 1,962.

38% of handovers were completed within 30 minutes, a decrease of 8.4% since last month. Additionally, handovers taking place in less than 15 minutes decreased from 20.4% to 16.4%.

September 2025 performance is 48 minutes behind trajectory; October so far is currently showing an improved position, at 29 minutes behind trajectory (10/10/2025).

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**
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**
Provide an ED escalation process to support W45 timely handover protocol.	TT/BI	31/10/2025

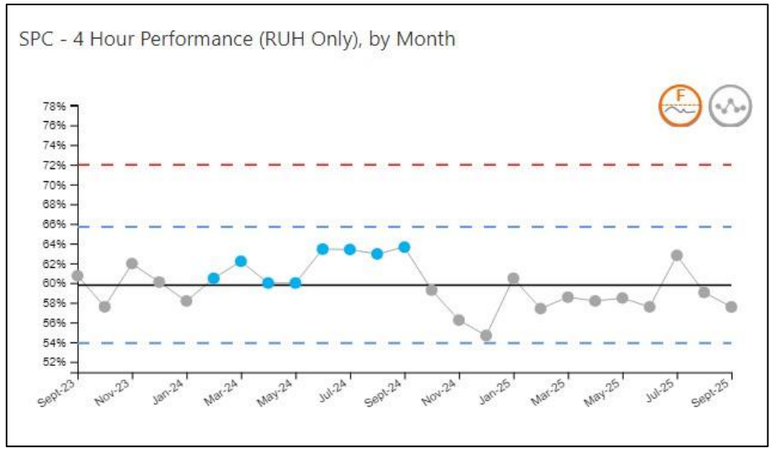
Risks and Mitigation

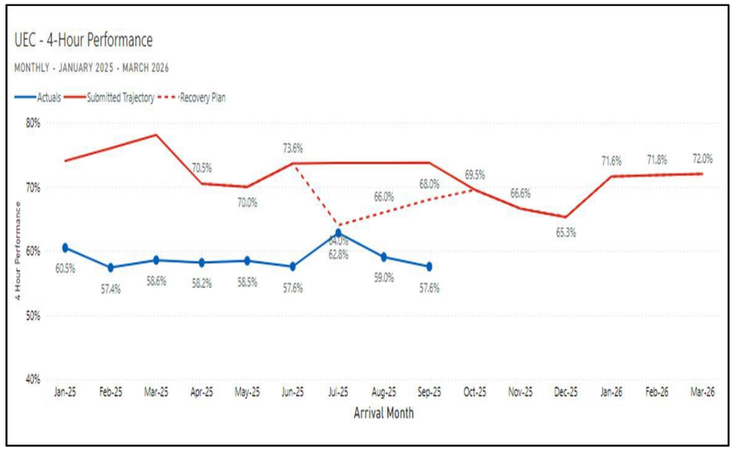
- Risk of >45min handover duration.
  - Site/ED extended handover process in place.
- Risk of patient deterioration in an ambulance not offloaded.
  - RUH ED review of deteriorating pts, QI project in progress.

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	18.54%	35.31%	**26.87%**	**42%**
CED	69.60%	88.13%	**85.09%**	**95%**
UTC	67.02%	89.55%	**87.37%**	**95%**
Total	**28.66%**	**70.35%**	**57.56%**	**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 **Complete**
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	Plan: 17/09/2025 Start: 01/10/2025 **Complete**
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

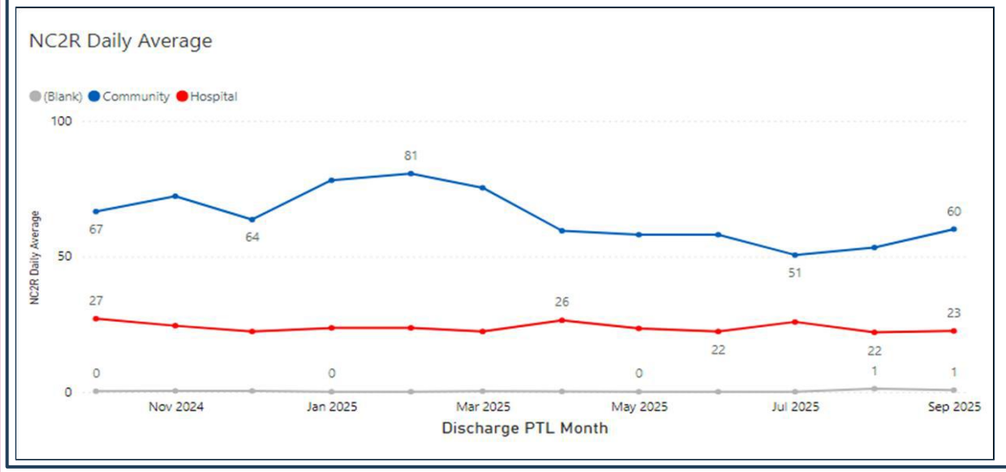
- Risk of increase mortality due to extended wait times in ED/UC.
- Risk of staff burnout and disengagement due to overcrowding.
    - UEC improvement programme to reduce overcrowding.

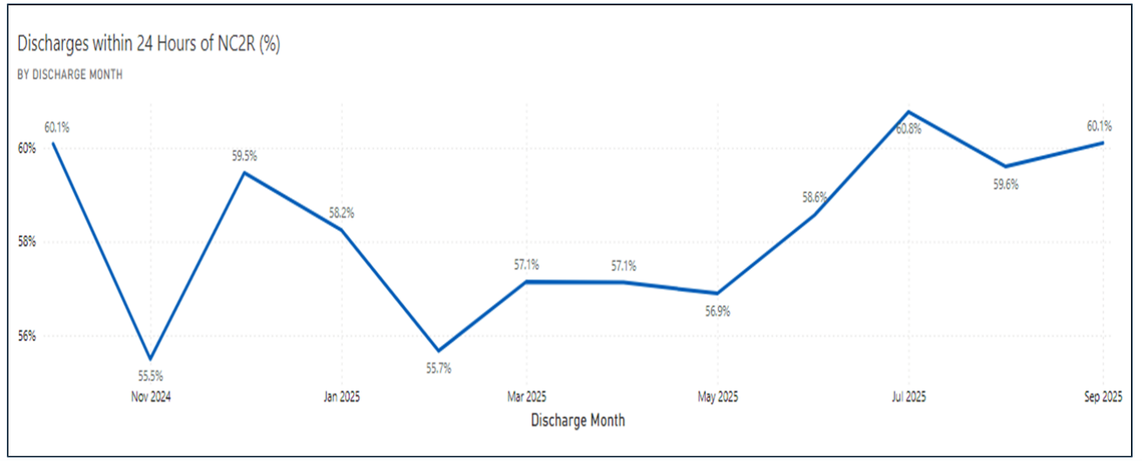
Non-Criteria to Reside

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 September 2025, the average number of NCTR patients per day was 83.3, an increase of 6.8 patients compared to August 2025. Discharges within 24 hours of NCTR (all pathways) increased by 0.5.% in September to 60.1%, back to the July positon. A total of 40 patients per day (community and hospital responsibility) is to be delivered in line with the BSW trajectory; in September the daily average for community responsibility patients was 60 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.

Improved performance:
Hospital responsibility NCTR has remained at a daily average of 22.5 patients, compared to the April 2025 baseline of 26.5 patients. In addition, in September, 84.2% of the hospital responsibility patients were discharge within 24-hour hours of non-criteria, 92.9% within 48 hours and 98.5% within 7 days.

Countermeasures	Owner	Due Date
Desktop exercise led by the RUH with system partners 16/10/2025, aims; 1) To come to a shared understanding of the RUH community NCTR position and how this will be presented. 2) To collaboratively identify opportunities to improve flow through and from the RUH for patients who will discharge under a P1, 2, 3 pathway. 3) To inform strategic demand and capacity decisions. 4) To identify countermeasures to support sufficient flow for our patients and their families.	Sarah Hudson	Immediate actions agreed for w/c 20/10/25. Follow up session w/c 03/11/25
Daily escalation for P1-P3 patients who are delayed > 48 hours for P1, P2 and seven days for P3 and escalation through the daily through the BSW Touchpoint call for escalation to tactical and strategic. Aim to increase P1-P3 discharges,	Sarah Hudson	w/c 20/10/2025
To reduce the number of Hospital Responsibility NCTR patients embed a change in the daily review process to support next step delivery by increasing the responsibility for each delay codes (site team, discharge team and therapies).	Sarah Hudson	w/c 27/10/25
Roll out of the NHS Federated Data Platform Optimised Patient Tracking and Intelligent Choices Application (OPTICA) which has been implemented at the RUH, to all locality partners to establish an accurate and reliable data system to identify and track patients without criteria to reside. Providing a single source of the NCTR position.	Sarah Hudson	01/12/2025

Risks and Mitigation

- Non-delivery of the BSW community responsibility NCTR reduction trajectory to deliver the equivalent of 40 patient per day (or 9-10% of the non-elective bed base). The impact of which will be the non-closure of escalation and core bed capacity in line with the bed reduction plan which also forms part of the RUH winter plan 2025/26.

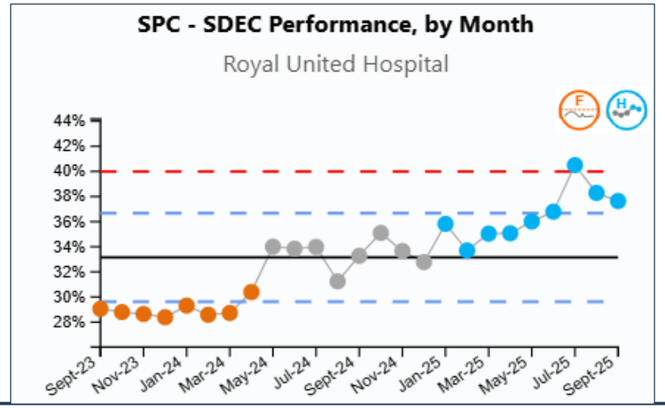
SDEC

Royal United Hospitals Bath NHS Foundation Trust

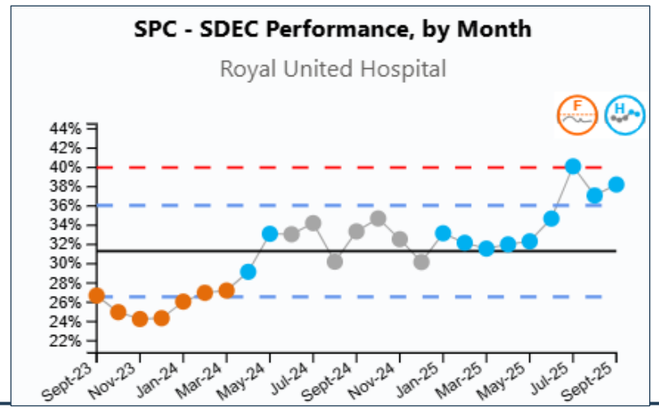
UEC Delivery Group Driver Metric

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 September 2025: **37.6%** against a target of 40%



Medicine Division SDEC Performance September 2025: **38.2%** against a target of 40%



Medical Division are responsible for two SDEC services:

Service / Monthly Activity	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25
Medical SDEC (previously Amb Care/DAA)	473	487	581	777	642	720
Frailty SDEC (OPRAA and OPU)	22	31	24	30	30	39

Understanding Performance

- In September, the SDEC performance in Medical Division was higher than the overall Trust performance.
- Frailty SDEC activity continues to rise and is considerably higher than usual with 39 patients in September.

Improvement blockers:

- Reduced Medical SDEC capacity due to Consultant vacancies – this situation has worsened due to staff sickness
- Reduced Frailty SDEC capacity due to:
  - Limited physical space
  - Reduced Therapy workforce (frailty)
- Unanswered Cinapsis (primary care referral) calls – could be creating more demand on ED/use of suboptimal patient pathways

Countermeasures	Owner	Due Date
Acute Medicine consultant posts out to ad, and locum secured from November 25	CY	30/11/25
Immediate Release Protocol launches 6/10/25: increases the demand on SDECs, including changes to 'queuing in' processes and zero tolerance to medically expected patients going to ED. SOPs and escalation processes under rapid development and PDSA.	FM AW	31/10/25
Change in MSS SBAR approved by Execs – due to start 3/11/25 – to release Acute Medical Consultants to focus on SDEC and MAU.	FM	03/11/25
Continued Integrated Front Door (IFD) working including Joint Winter Planning	BI, CY, RK	30/11/25
BSW SDEC Oversight and Working Group - to ensure a consistent BSW delivery against the national requirements	CY and RK	Ongoing

Risks and Mitigation

<u>Consultant recruitment (acute med)</u>
High risk of impact
Using consultant funding differently (0.4 ST3+ recruited)

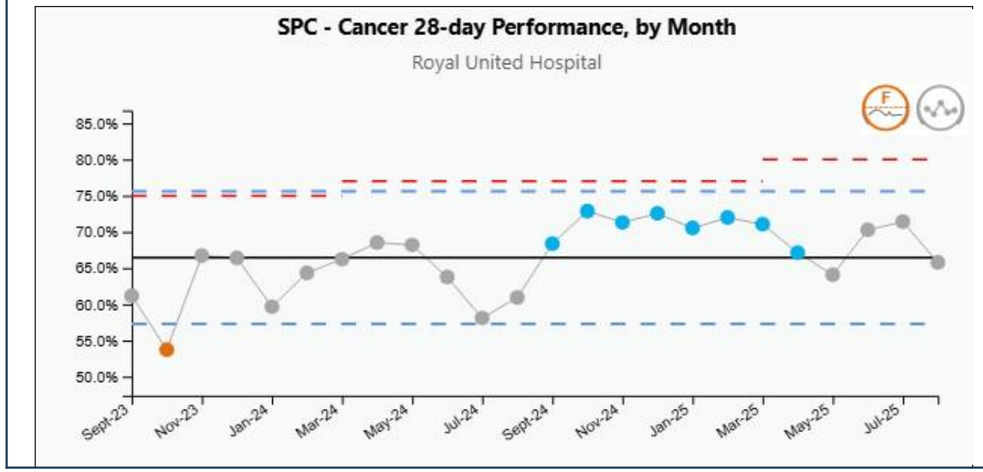
<u>Flow from SDECs to specialty beds</u>
High risk of impact
Site aware
SOPs to be followed
B6 Coordinator training

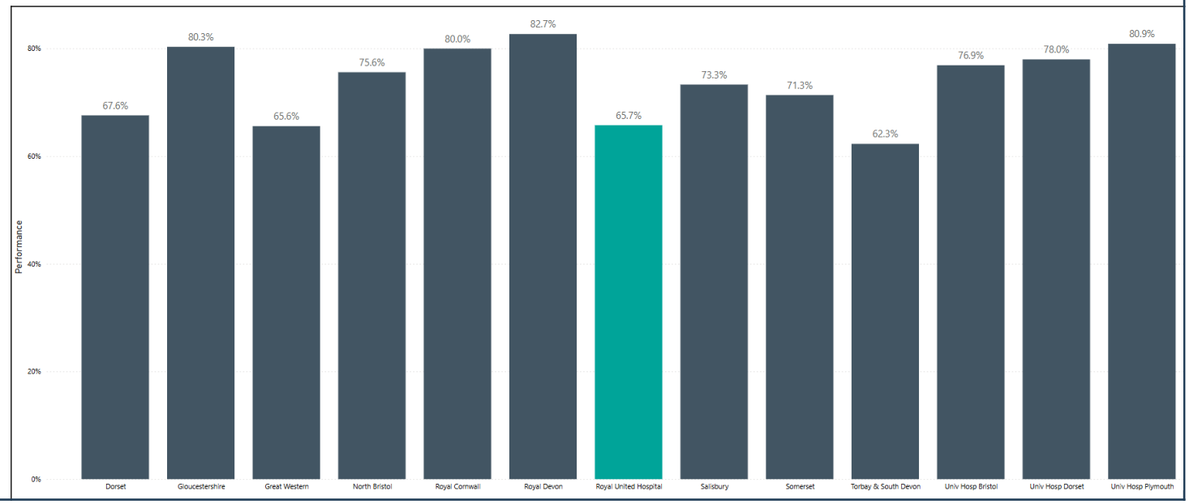
28 Day Cancer Performance

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

August performance deteriorated to 65.7%, below recovery trajectory. Further deterioration expected September-October

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

- Breast >80%. Locum A/L and registrar/clinical fellow gaps (filled from October) leading to 30 day wait for one-stop – now reduced to 21 days. Recovery from November.
- Colorectal remains 42% – all OPAs now under seven days. Colonoscopy at 18 days – action plan in place. CT/CTC at 14-16 days. Long term Sulis capacity plan and improved utilisation of RUH capacity – lost slot reduction pilot
- Gynae PMB at seven days, improvement from September.
- Skin OPA now at 28 days, performance below trajectory in September but earlier improvement in October
- Urology OPA and MRI waits reduced but LATP at 3 weeks.

Countermeasures	Owner	Due Date
Breast locum move to fixed term contract	HW	November 2025
CTC patient contact pilot	KD	October 2025
Electronic triage – Gastro	TS	November 2025
Endoscopy booking process mapping / improvement work	TS	November 2025
Endoscopy and Gastro consultant recruitment	TS	Dec 25 / Apr 26
LATP weekend and evening additional capacity	KR/EJ	October 2025
STT pathway – awaiting group IT approval for Cinapsis	EN/EJ	November 2025
Dermatology locum consultant / insourcing extension	GJ	October 2025
Long term staffing plan / skill-mix review	GJ	December 2025

Risks and Mitigation

Risks:

- Demand increase
- Financial position
- Recruitment
- Sickness
- In/outsourcing, locum, WLI dependency
- Pressures from RTT, DM01
- IT capacity – group model

Mitigation:

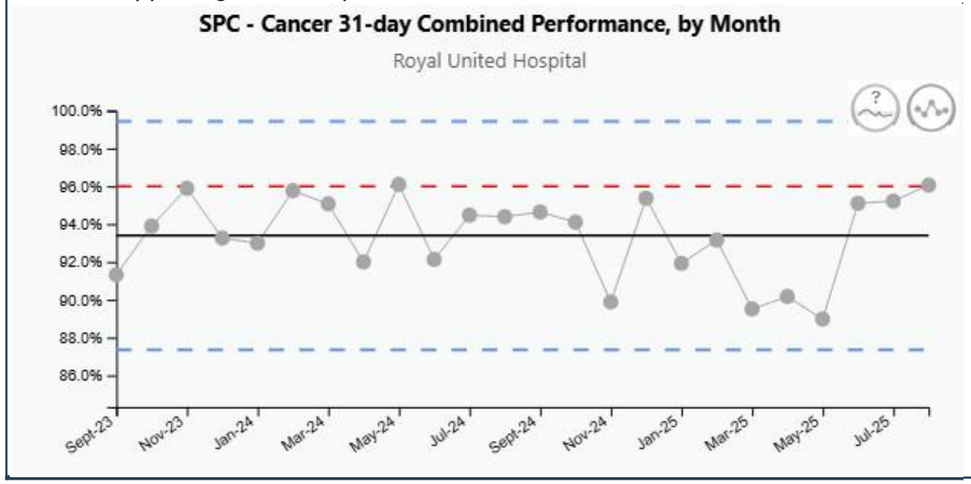
- SWAG/NHSE funding for WLI and in/outsourcing
- Telederm
- Pathway change (Breast / Gynaecology / Prostate / Colorectal)

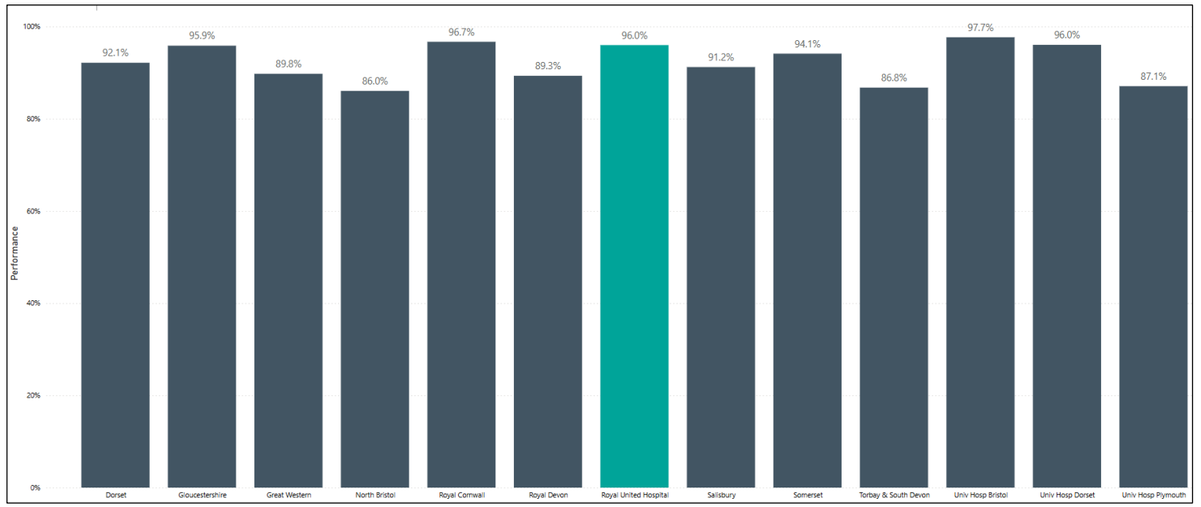
31 Day Cancer Performance

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

National target achieved – performance 96.0%

Top contributors:
Breast, Skin, Urology

In month challenges:
- Breast delays to surgery. Radiotherapy breaches to be validated.
- Dermatology MOPs waiting time further increase to 42 days. Insourcing to commence in October. Performance reduction expected in November as breach patients are treated.
- Urology breaches due to waiting time for HIFU and surgery.
- Urology reviewing consultant capacity to train third HIFU practitioner.
- Urology breaches expected in September for robotic prostate surgery following active monitoring.

Countermeasures	Owner	Due Date
MOPS insourcing	GJ	October 2025
Dermatology long term staffing plan / skill-mix review	GJ	December 2025
Urology third HIFU practitioner	KR/EJ	December 2025
Robotic prostatectomy capacity/demand review – for subsequent treatments	KR	November 2025

Risks and Mitigation

Risks:
- Demand increase
- Sickness
- In/outsourcing, locum, WLI dependency
- Increases in referral for procedures from locums
- Pressures from RTT
- Chemo/RT demand increase

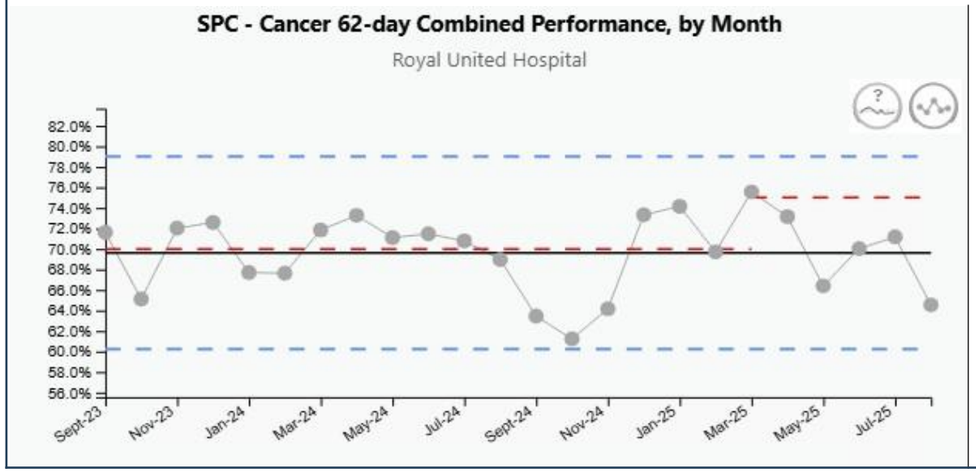
Mitigation:
- WLI, in/outsourcing and locums
- Long term workforce planning
- Telederm

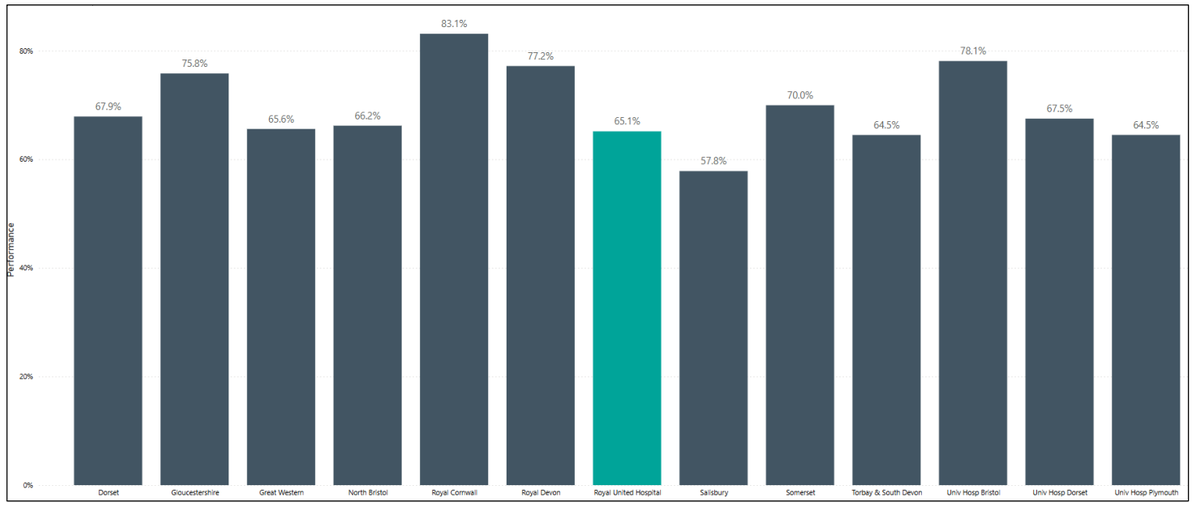
62 Day Cancer Performance

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 deterioration to 65.1%. Further impact expected September-October

Top contributors:
Breast, Colorectal, Skin, Upper GI, Urology

In month challenges:
- Breast one-stop waits, patients requiring multiple biopsies.
- Colorectal deterioration – high number of long waiting patients treated. Diagnostic pathway and additional investigations, waits for outpatients and surgery.
- Skin first OPA and MOPS waiting time.
- Upper GI patients requiring care across RUH/UHBW, Gastro OPA and endoscopy waiting times.
- Urology scan reports (backlog now cleared), LATP, outpatients post-MDT and surgery.

Countermeasures	Owner	Due Date
Breast locum move to fixed term contract	HW	November 2025
CTC patient contact pilot	KD	October 2025
Endoscopy booking process mapping / improvement work	TS	November 2025
Endoscopy and Gastro consultant recruitment	TS	Dec 25 / Apr 26
MOPS insourcing	GJ	October 2025
Dermatology long term staffing plan / skill-mix review	GJ	December 2025
LATP weekend and evening additional capacity	KR	October 2025
Robotic prostatectomy capacity/demand review – for subsequent treatments	KR/EJ	November 2025

Risks and Mitigation

Risks:
- Demand increase
- Sickness
- Consultant recruitment
- In/outsourcing, locum, WLI dependency
- Reduction in WLI uptake
- Pressures on resources from RTT, 4 hours, DM01

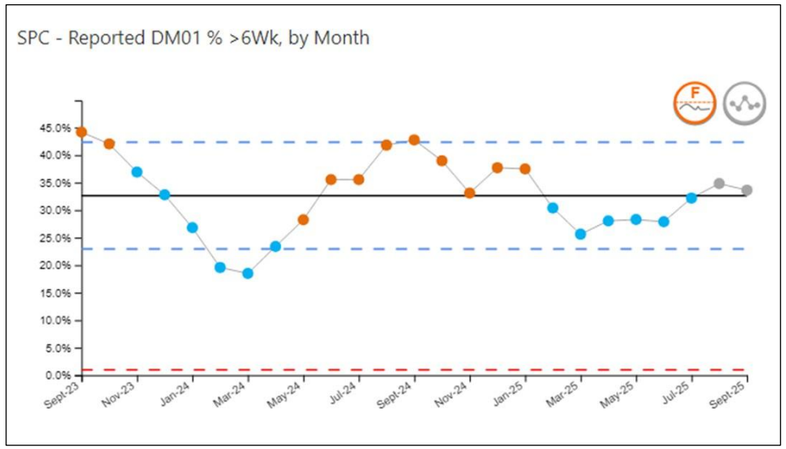
Mitigation:
- WLI, in/outsourcing, locums
- Workforce planning
- Pathway change (Breast / Gynaecology / Prostate / Colorectal)

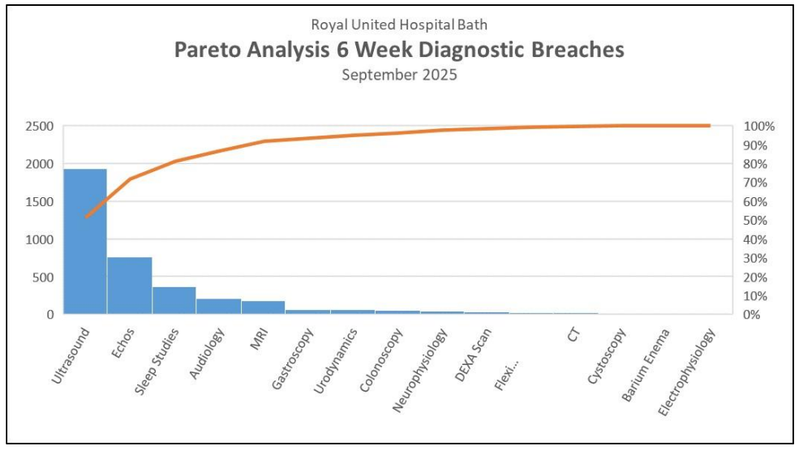
Diagnostic waits

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 September, 66.41% of patients received their diagnostic within the 6-weeks against the 70.90% target.*
- *Performance improved 1.21% when compared to previous month. In month, 1776 additional diagnostic tests were delivered when compared to August.*
- *DM01 trajectory being reviewed to account for additional demand (RTT schemes) and mitigation (additional capacity).*
- *The **top contributors** to 6-week breaches were USS, Echo and Sleep Studies.*
- *Key drivers of underperformance were:*
  - *Increased demand for routine diagnostics, following RTT recover insourcing schemes.*
  - *Increased demand for urgent and cancer referrals.*
  - *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/CF	In place
USS insourcing at weekends *Additional USS activity at Sulis CDC in-week (insourcing)*	PN/NA SH/NA	In place From 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

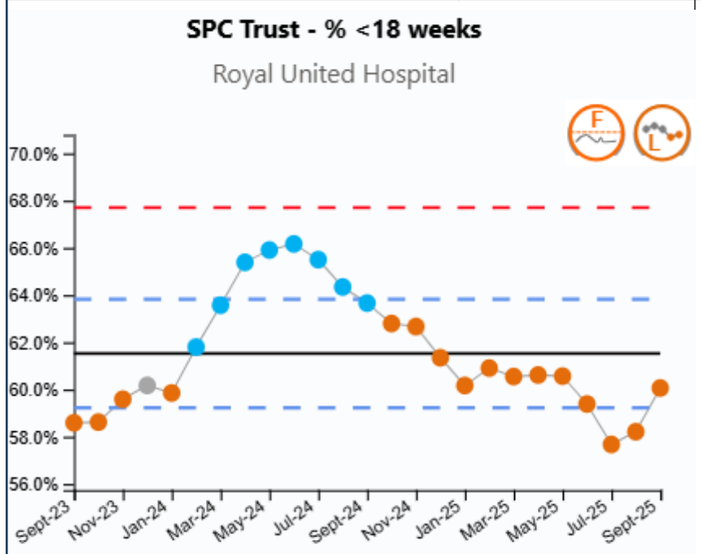
Risks and Mitigation

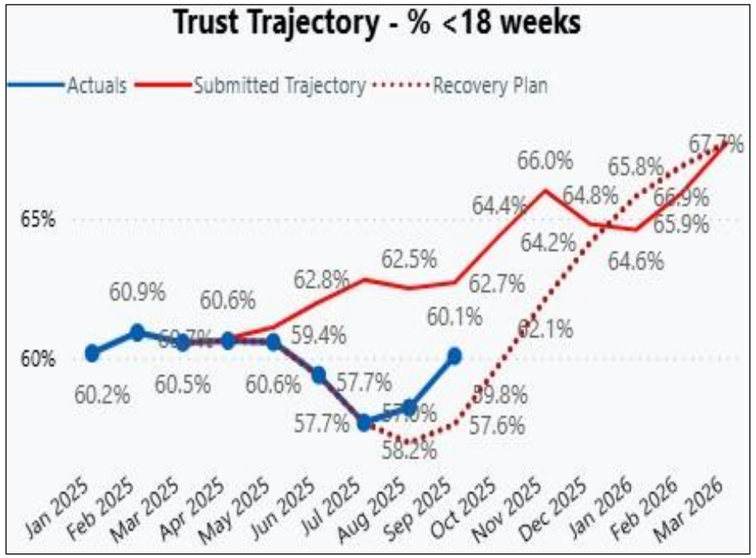
- **Risks:**
  - Sickness
  - Increased demand from RTT insourcing initiatives
  - USS staffing
  - Additional strikes
- **Mitigations:**
  - Productivity improvement (MRI acceleration)
  - Exploring additional capacity at Sulis (USS, CT, MRI and Echo)

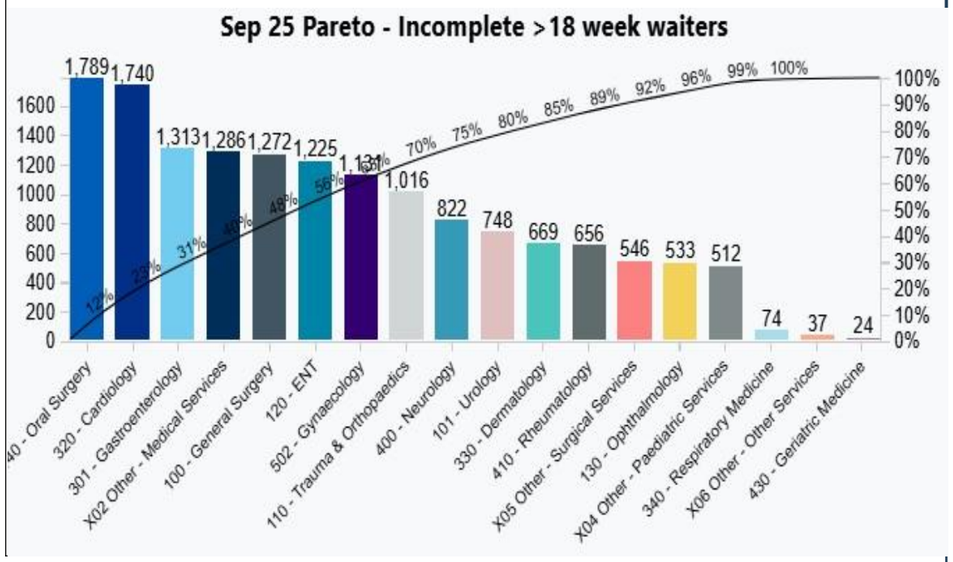
Referral To Treatment (RTT) 18 weeks

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 September was 60.1% vs a target of 67.7%, Trajectory 62.7% for September. This is 1.9% Improvement on the previous month
- The top Contributors to over 18 week breaches were in the following 5 specialties.
  - Oral Surgery 1789
  - Cardiology 1740
  - Gastroenterology 1313
  - Pain 1286
  - General Surgery 1272

Countermeasures	Owner	Due Date
ENT – insourcing plan being worked through utilising RTT funding	Division	Oct 25
Oral Surgery – additional WLI clinics including LAs	Division	Ongoing
12 week Challenge started Aug 25	Bluhm	Nov 2025
Trust taking part in 3rd NHSE validation sprint – Nov to and December – admin validation with clinical support as appropriate	Dando	Dec 25

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

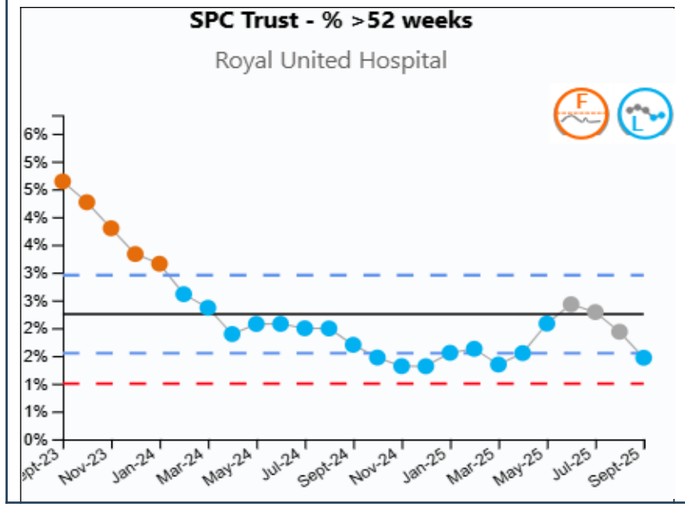
Mitigation:

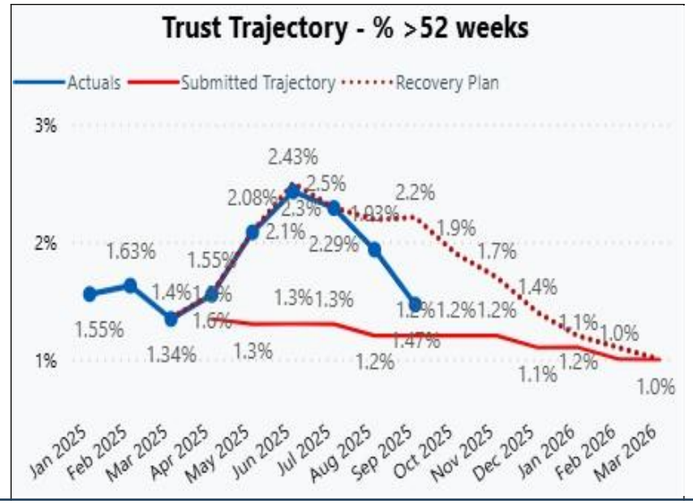
- Sulis support for guided injections

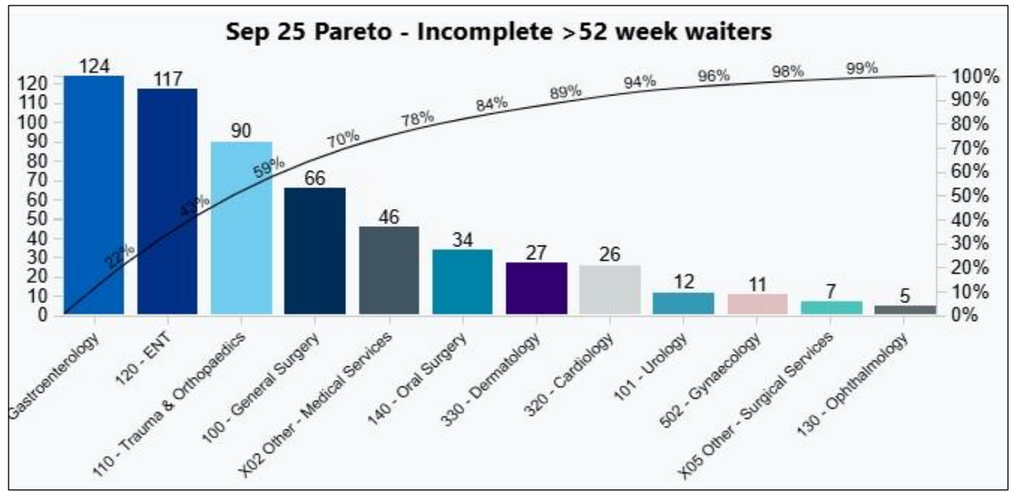
Referral To Treatment (RTT) over 52 weeks

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 761 to 565 (-25.76%).
- 1.47% of total RTT patients have waited >52 weeks vs target of <1%, trajectory of 1.2% for September
- The top contributors to >52-week breaches Gastroenterology and ENT:
  - ENT decreased in September from 252 to 117 patients waiting >52weeks (-53.57%)
  - Gastroenterology decreased in September from 202 to 124 patients waiting >52weeks (-38.61%)

Countermeasures	Owner	Due Date
Spines – review of pathways and support from Sulis for fluoroscopic injections	Prosser	Oct 25
Gastro – insourcing to see longest waiting patients	Shaw	Nov 25
CSU support to call patients in cohort for 52 weeks to ensure patients are waiting well and available to attend. Start date 29th September	Dando	Oct 25
Insourcing ENT starting w/c 6/9	Gillett	Oct 25

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

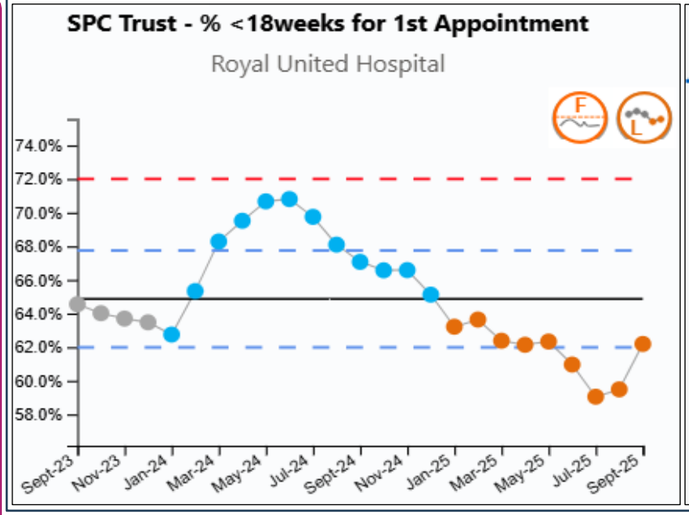
Mitigations:
- Gastro recovery plan refresh

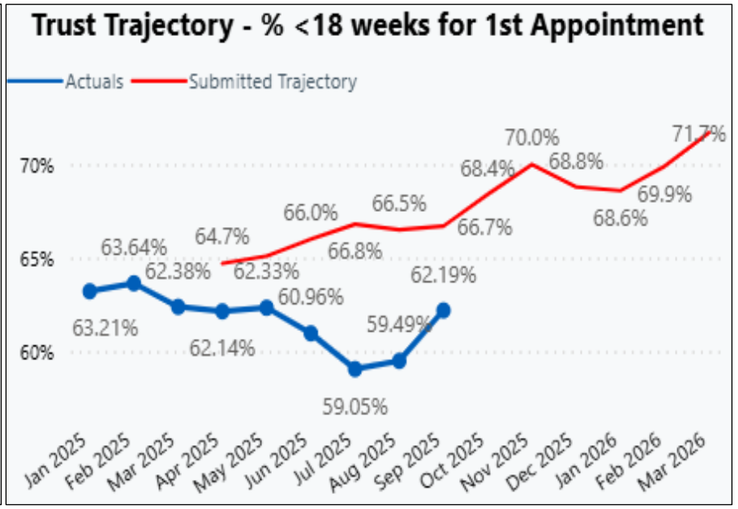
Referral To Treatment (RTT) Wait to 1st Outpatient Appointment

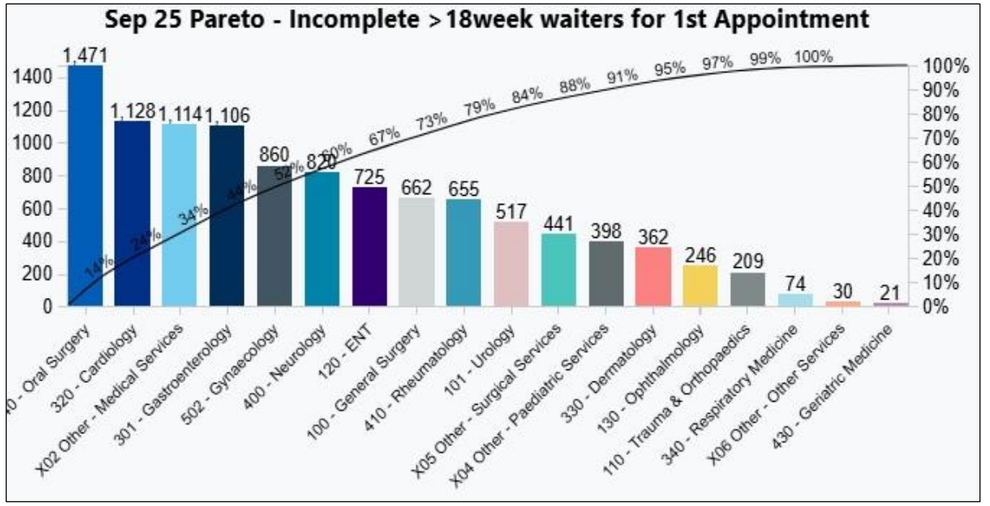
Royal United Hospitals Bath NHS Foundation Trust

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 OPAppt must be <18weeks by March 2026

Outpatient Delivery Group Driver Metric







Understanding Performance

- 62.9% of patients were waiting <18 weeks for a 1st outpatient appointment vs a target of 72%, trajectory of 66.7% for September. This is +2.7% on the previous month
- The top contributors of over 18-week breaches for 1st appointments were
  - Oral Surgery 1.471
  - Cardiology 1,128
  - Pain 1,114
  - Gastroenterology 1,106
  - Gynaecology 860

Countermeasures	Owner	Due Date
WLI in Cardiology – delivering 1,000 new appts per year – currently agreed 8 weeks in advance through VCARP	Frape	Ongoing
Pain – intensive support from NHSE including demand and capacity review; support from Sulis for procedures; increase capacity for PMP from 12 to 18 pts	Stopp	Ongoing
Oral Surgery – WLI clinics	Gillett	Oct 25
WLIs for general Gynae 1st appt and request for Locum in progress	Jarvis	Oct 25

Risks and Mitigation

Risks:
- Uptake of WLI in Gynae
- No suitable locum in Gynae
- Suitable capacity elsewhere for Pain

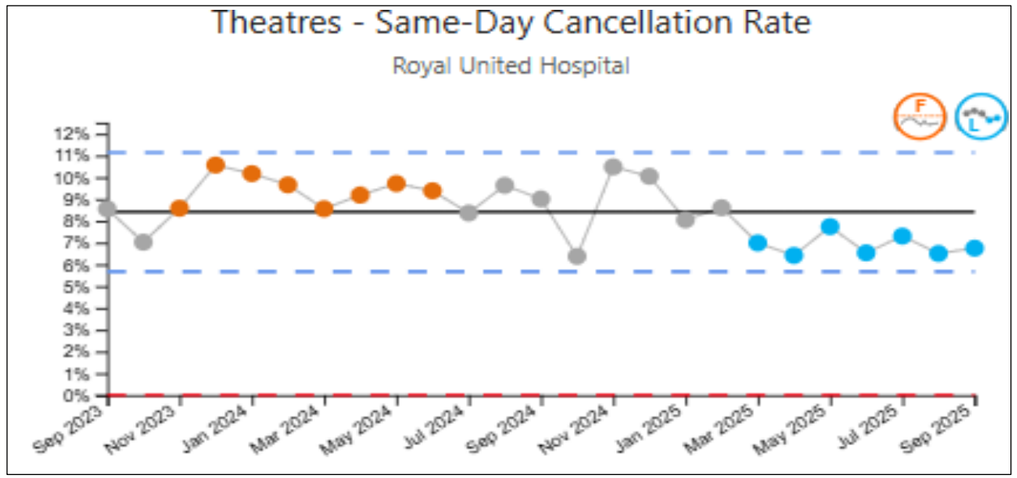
Mitigations:
- Gastro recovery plan being refreshed
- SBAR for additional specialty Dr in Oral Surgery
- Scoping insourcing for Gynae if no suitable locum available

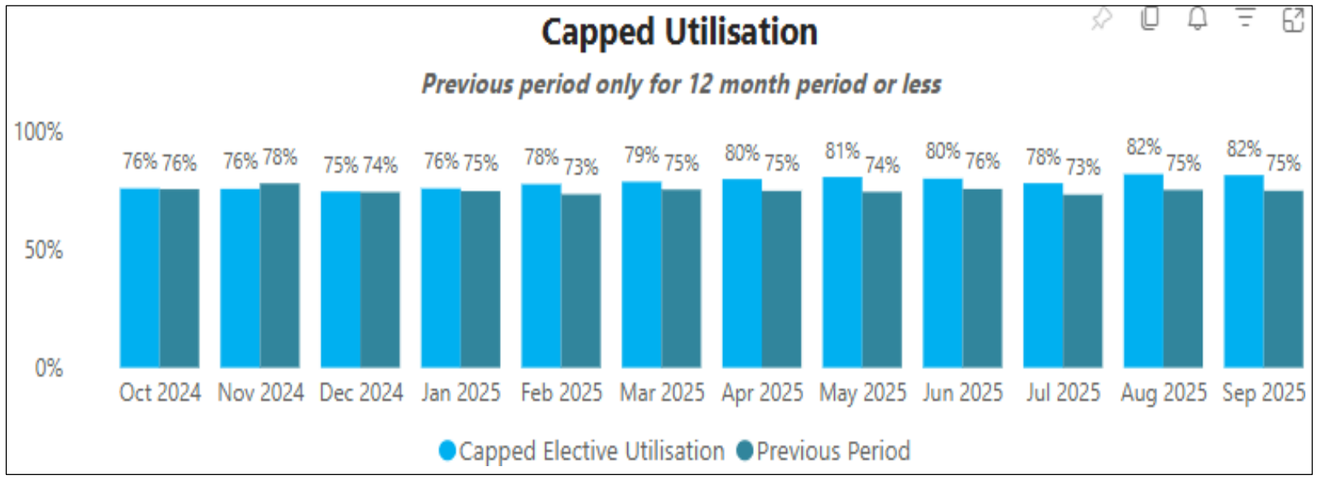
Theatre Utilisation

Royal United Hospitals Bath NHS Foundation Trust

Theatres Delivery Group Driver Metric

We are driving this metric because.. Performance Target: capped utilisation 85 %	*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% target, this remains an opportunity to optimise capacity, reduce delays, and enhance efficiency.*





Understanding Performance
• Capped utilisation remains at 82.0% in Month - this is upper quartile in Model Hospital • Cancelations remain below the national and GIRFT target, the opportunities to make further use of DrDoctor within areas is being explored to support / maintain performance • There has been significant vacancy/sickness within the Inpatient Booking office. Whilst capped utilisation has been maintained, this has limited our ability to book in chronological order which may adversely impact admitted RTT performance.

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
Areas of focus are within Ophthalmology and Gynaecology – review of practice and HVLC process adoption	Duncan Leadbeater, Karen Rye	March 26
Full recruitment into Inpatient booking team and mutual aid from Corporate teams and Sulis.	Adam Dougherty, Lynne Presley	Nov 26

Risks and Mitigation
Risk: Elective Booking team staff vacancies / recruitment are a concern **Mitigation:** Some additional support is being provided during recruit phase

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%		Sep-25	23.2%	X	F		Common Cause Variation
People we care for	% No criteria to reside Adult G&A occupied beds		10.0%		Sep-25	17.3%	X	F		Common Cause Variation
People we care for	% No criteria to reside pathway 0 discharges				Sep-25	82.1%			L	Special Cause Concerning - Run Below Mean
People we care for	% of patients waiting >12hrs in ED		0.0%		Sep-25	9.0%	X	F		Common Cause Variation
People we care for	% with Discharge Summaries Completed within 24 Hours				Sep-25	82.5%			L	Special Cause Concerning - Below Lower Control Limit
People we care for	Adult % G&A bed occupancy		92.0%		Sep-25	96.5%	X	F		Common Cause Variation
People we care for	Mean time in ED - Not Admitted (mins)				Sep-25	235			H	Special Cause Concerning - Run Above Mean
People we care for	Non Elective Length of Stay		8.4		Sep-25	8.6	X	?		Common Cause Variation
People we care for	Number of 65 week waiters incomplete pathways			0	Sep-25	44	X		L	Special Cause Improving - Two Out of Three Low
People we care for	RUH hospital at home team occupancy	Average occupancy	62.0		Sep-25	60.0	X	F	H	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 August)

- % Discharged by Midday
- % No criteria to reside pathway 0 discharges
- % of patients waiting >12hrs in ED
- % with Discharge Summaries Completed within 24 Hours
- Adult % G&A bed occupancy
- Mean time in ED - Not Admitted (mins)
- RUH hospital at home team occupancy – Average occupancy
- Number of 65 week waiters incomplete pathways

Understanding Performance and countermeasures

- Initiatives to improve discharges by midday are being led by the Clinical Divisions and supported through the daily performance and flow meeting to improve on the September position of 23.5% of discharges before midday and continued focus on P0 no criteria patients with wards, therapy and discharge liaison team that are hospital responsibility daily to improve upon 84.2% of discharges within 24 hours of NCTR.

- The average ambulance handover delay for September 2025 was 80.89 minutes, an increase of 22.19 minutes on average compared to August 2025. Through September 2025 the total hours lost was 2,860. This is an 898-hour increase compared to last month's lost hours of 1,962.

- We are continuing to work with our SWASFT and site colleagues to achieve our target as soon as possible and with the introduction of W45 (immediate release of a patient at 45mins) we have already seen significant improvements at the beginning of October 2025.

- Our 4-hour performance in September (57.56%) has decreased slightly however plans are in place to address this, with nursing recruitment and adaptable working patterns in shift for the medics aiming to support this. We continue to see a positive impact on our same day emergency care (SDEC) services (38.2% in September 2025) since the opening of our new medical SDEC on 23rd June 2025.

- Whilst the number of >52week waiters has continued to decrease through RTT recovery actions, there is a residual tail of >65 week waiters which is driven by capacity constraints in specific pathways/sub-specialties e.g. Gastroenterology Spines and paediatric ENT. Additional capacity is being provided by insourcing and mutual aid.

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	A&E Arrivals - Ambulance (av per day)				Sep-25	83				Common Cause Variation
People we care for	A&E Arrivals - Walk ins (av per day)				Sep-25	214				Common Cause Variation
People we care for	Mean time in ED - >75y				Sep-25	487				Common Cause Variation
People we care for	Mean time in ED - Admitted (mins)				Sep-25	503				Common Cause Variation
People we care for	Mean time in ED - Mental health				Sep-25	316				Common Cause Variation
People we care for	Number of 52 Week Waiters Incomplete Pathways				Sep-25	565				Common Cause Variation
People we care for	Weekend discharge %				Sep-25	17.3%				Common Cause Variation

Royal United Hospitals Bath
NHS Foundation Trust

Tier 1

Royal United Hospitals Bath
NHS Foundation Trust

UEC Recovery Plan

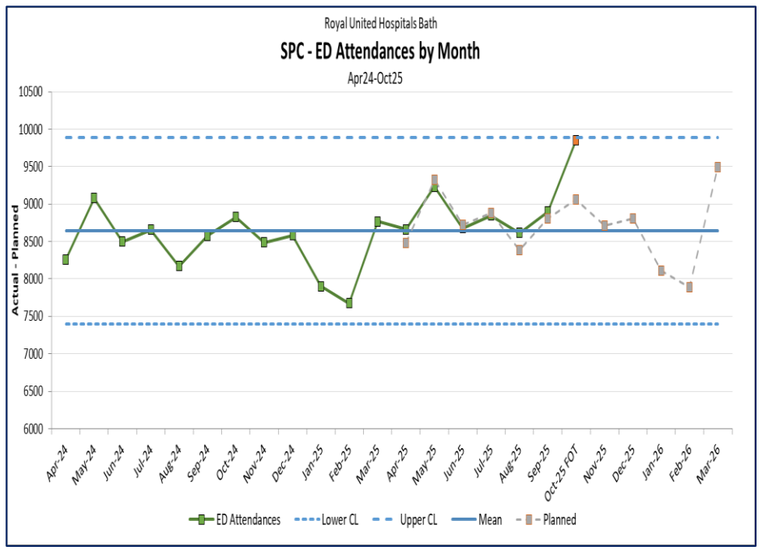
Updated 13/10/25

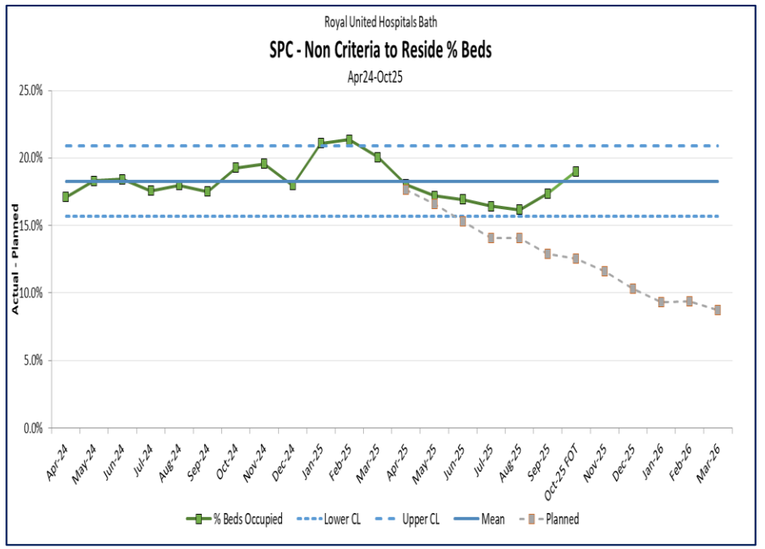
Highlights

- Average ambulance handover time decreased from 89 to 39 minutes.
- 12 Hour Performance has improved from 9% to 8.7%.
- RUH ranking on 4hour standard has improved from 123rd to 103rd of 124.

Key Messages

- UEC Reset programme as part of RUH Call to Action.
- RUH Financial Plan included reduction in beds which was predicated on reduction of NCTR volumes which have not been realised.
- This is in the context of rising attendances, and 19% of beds being occupied by NCTR patients vs a system plan for 12.6% in October.
- RUH has been in internal critical incident on 5 days in the previous 3 weeks.
- RUH is proceeding with recruitment of ED middle grade medical workforce to mitigate safety and improve performance overnight.
- RUH has been visited by GIRFT and CQC, the recommendations of these visits will inform RUH UEC Reset plan.





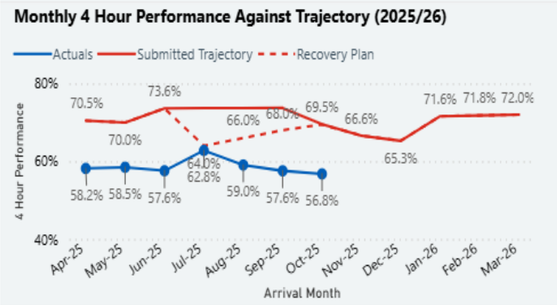
UEC

Current Position (as at 23/10/25)

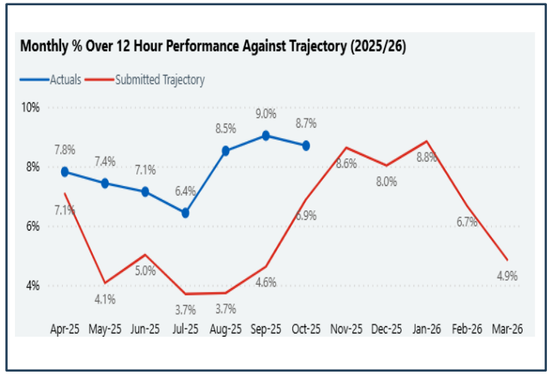
- **4-Hour Performance**: 56.8%, decreased from 57.6% in September. Trajectory for October is 69.5% current position is 12.7% below target.
- **Average Ambulance Handover time:** 39 minutes, a decrease from 81 minutes in September. Target is 33 minutes; current position is 6 minutes above target.
- **% over 12 hours in ED:** 9.7%, increase from 9.0% in September. Target for October is 6.9%; current position is 2.8% above target.
- **NCTR performance**: 90.7 patients, increased from 83.3 patients in August, 34.7 patients above the 56 targeted trajectory.

Performance Overview

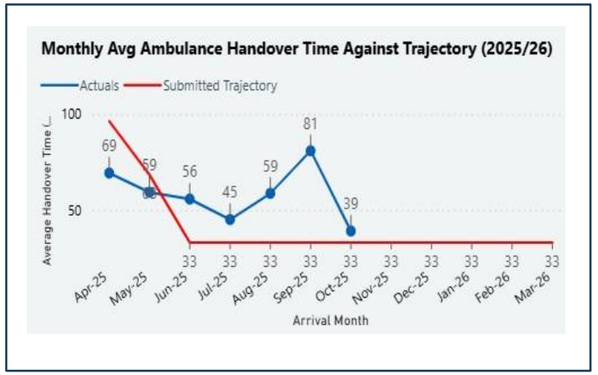
4-Hour performance dipped in October to 56.8%, below the submitted plan of 69.5%.



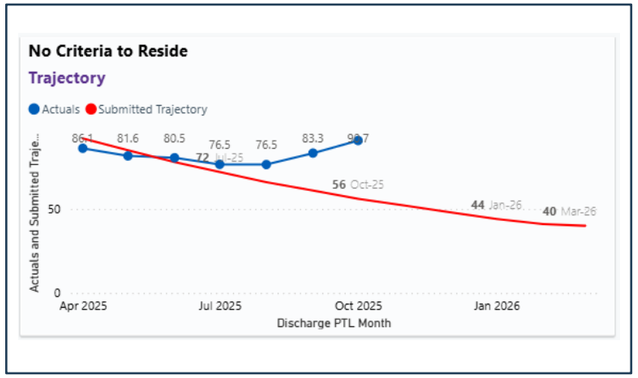
Over 12 hours in ED reduced slightly in October to 8.7%, above the submitted plan of 6.9%



Average ambulance handover time decreased to 39 minutes in October, 6 mins above the submitted plan of 33 minutes.



NCTR is at 90.7 patients, 34.7 patients above target



Recovery Actions

UEC Workstream	Countermeasures	Due Date	RAG	Comments 23/10/25
ED & UTC	Update proposal for ED staffing (capacity and demand) to improve financial balance	Sep 25		Business case in review – subject to triple lock process
ED & UTC	Consider UTC staffing patterns to create efficiencies (nursing/AHP/GP)	Jan 26		Staffing does align to demand; however, we are looking to consolidate the number of shifts currently to further improve this.
ED & UTC	UTC streaming go live	Oct 25		Go live on 06/10/25. Risks related to staff sickness have prevented completely consistent running during opening hours.
ED & UTC	Revised clinical operational standards for Doctors including expectations on ED response times	Dec 25		Clinical engagement event to be planned to socialise standards. Implementation from 1st December
ED & UTC	Scope further development of Ambulatory ED	Nov 25		Reviewing ED footprint and options appraisal
Capacity Management	Review Surgical SDEC model including demand and capacity	Nov 25		Under reporting of activity being addressed. Workforce model review to meet demand profile next action.
Capacity Management	Bed modelling and reconfiguration in line with speciality demand	Nov 25		ECIST model updated. Next step to match to existing ward footprint to propose reconfiguration. BSW capacity management model also be undertaken in parallel (date pending).
Capacity Management	Orthopaedic bed base review (12 elective T@O beds)	Mar 26		Modelling indicates requirement for 6 beds. Proposal supported by Consultants. Next step estates to design current space, and link to opportunities with wider remodelling to relocate. Ward identified to be used as part of winter planning, implementation will be March 2026.

UEC Workstream	Countermeasures	Due Date	RAG	Comments 23/10/25
Capacity Management	Assigning patient attributes and zoning to support bed management	Ongoing rollout		Attribute assignment and update process in place. Next steps to launch BI dashboard with all specialties to provide near real time view of specialty demand outside of specialty bed base.
Home is Best	Process mapping discharge pathways to highlight inefficiencies	Nov 25		Tabletop exercise on 16th October with follow up session to be planned to review root causes and countermeasures and plan for future state.
Home is Best	Reduction in therapies delays	Ongoing rollout		Work is ongoing with consistent performance from August to date
Home is Best	Effective whiteboard rounds	Ongoing rollout		Ward dashboards requested with agreed measures to be sent to ward managers weekly
Home is Best	Site processes and implementation of FOCUSSED framework	Oct 25		Engagement remains challenged – face-to-face meeting with key stakeholders planned to progress

Key issues/contributory factors

- Increased demand for UEC services – ED attendances increased significantly in October, higher than average ambulance conveyances in 25/26 so far, increased non-elective demand through SDEC
- Reduction in NCTR not happening at pace required to mitigate demand increase, includes challenges with engagement and capacity internally

UEC Reset Programme

1. GIRFT Further Faster (UEC)
2. GIRFT Site visit
3. CQC Inspection

RUHB UEC Priorities

- Internal Professional Standards
- Board Round Effectiveness
- ED Medical Model
  - ED at night
  - Streaming
  - Obs Unit model and utilisation
- Working with System Partners to reduce NCTR

Royal United Hospitals Bath
NHS Foundation Trust

RTT Recovery Plan

Updated 6th October

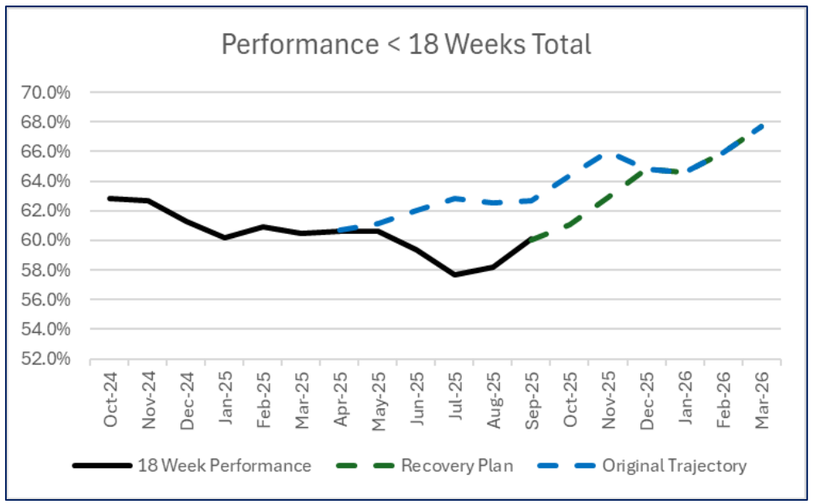
RTT: RUH projects delivery of original plan by Dec 2025 including removal of 65-week breaches

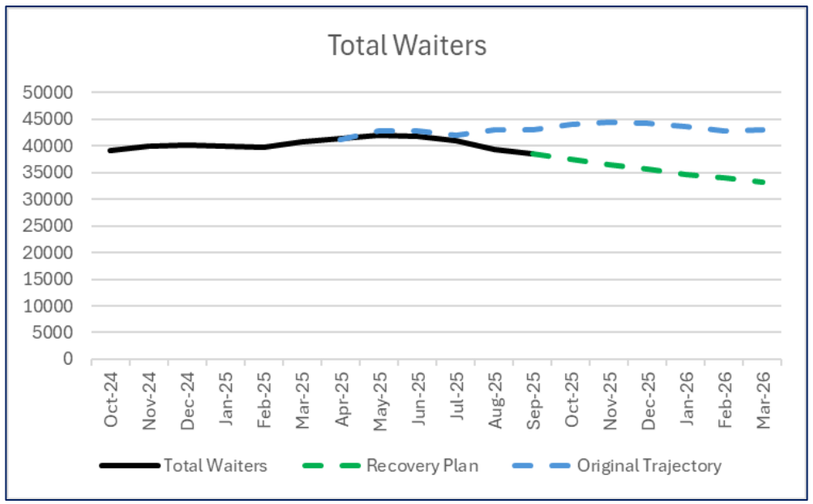
Highlights

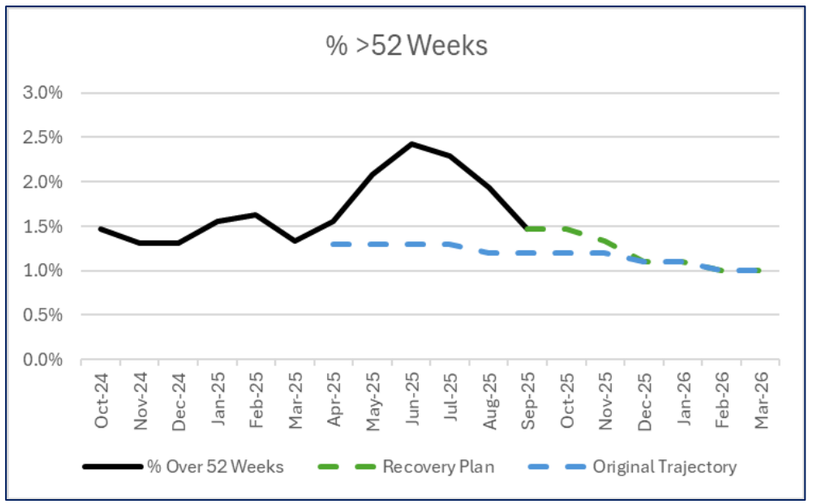
- RUH Sept position moving back towards trajectory for 18 weeks and 52 weeks.
- Trajectory forecasts clearance of 65-week breaches by 21st December. The cohort has reduced to **379** from **2,170** in August. (excluding pain services).
- 40+ week outpatient waits have reduced to **472** from **1,611** in August
- Patient contact validation by SCW has commenced. Further opportunity in “to be scheduled” lists.

Key Messages

- **Revised Trajectory Modelling:** forecasts underlying growth rate pre-recovery actions and bottom-up specialty action plans and impact of validation.
- **Methodology** tested with NHSE. Key assumptions include 6% improvement through 12-week challenge, growth remains as at Q1.
- **Pain Services**: Remains a risk due to incorrectly tracked RTT clocks. These have been validated and recovery actions are in progress







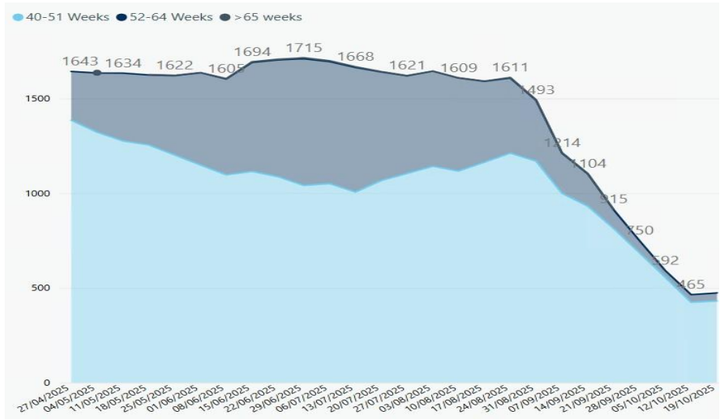
RTT *(n.b. data is not inclusive of incorrectly tracked pain service pathways)*

Current Position

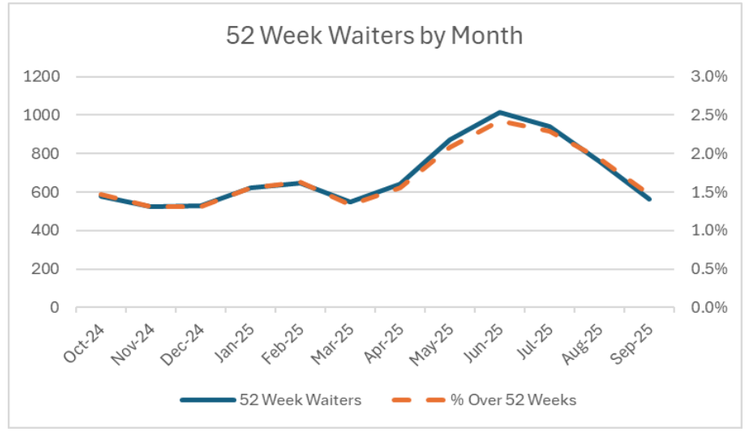
- **RTT Validated Month 6 Performance: 60.1% in September, an improvement** from 58.2% in August.
- **September Position**: **40-week outpatients reduced by 53% in September to 700,** a key driver in lowering future 52- and 65-week risks.
- **52-week waits fell by 25.8% (-196) to 565 strengthening future 65- week sustainability.**
- **65+ weeks reduced to 44 with focused recovery actions in place to minimise breaches from end of October.**

Monthly Progress

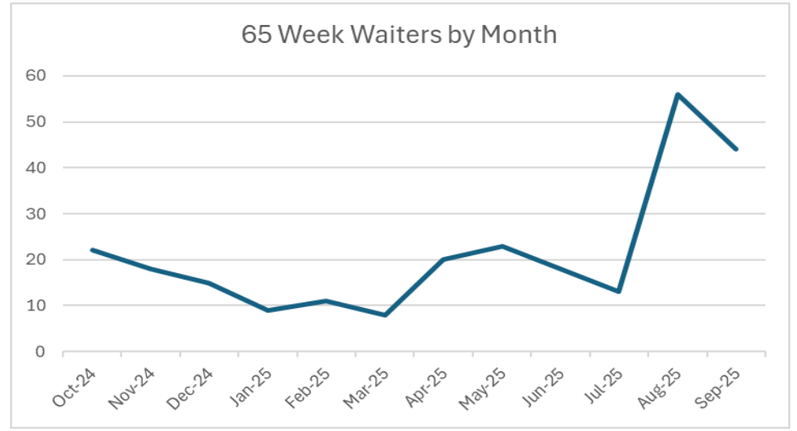
40+ week outpatient waits have reduced consistently over the last four weeks**, with a reduction of 441.**



52 Week Waits have reduced by 26% month on month (-196), clear improvement trend.

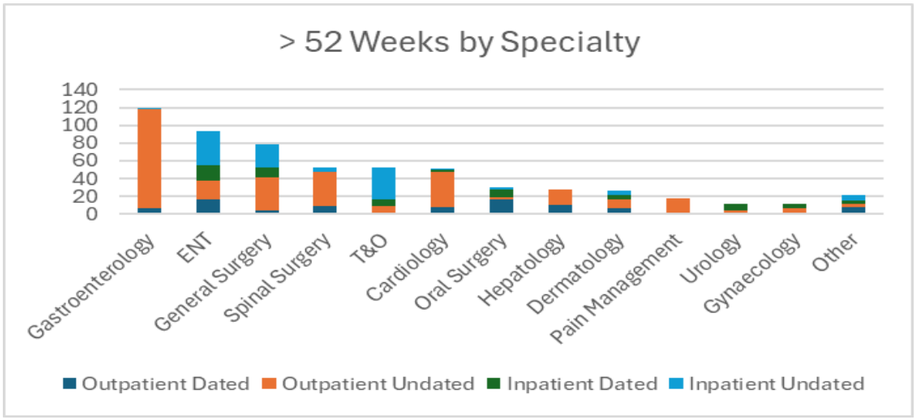


65+ Week waits spiked to 56 in August, **have now rapidly reduced to 44** on a downward trajectory through focused recovery actions.



Key Contributors & Recovery Plans

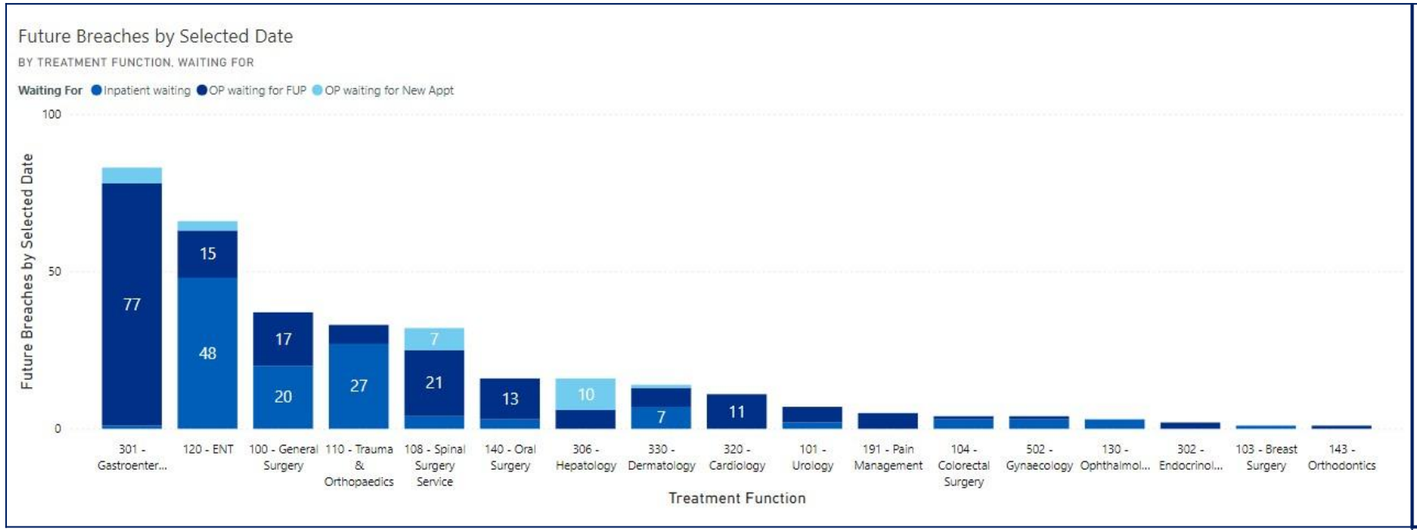
Key contributors to RTT performance include Gastro, ENT, General Surgery, Spines & Cardiology

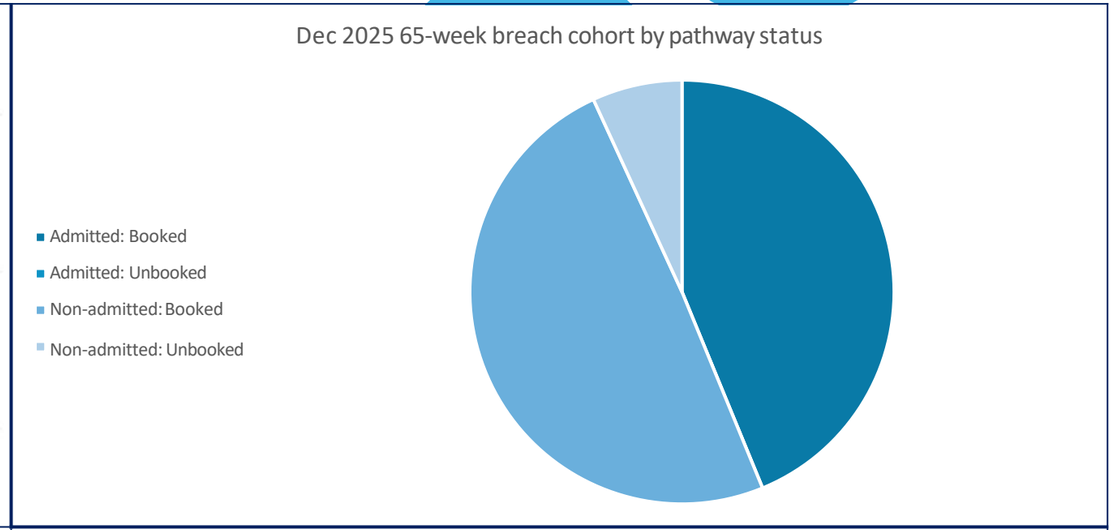


	Focused recovery plans: Are now driving improvements		Actions Delivered (Last 4 Weeks)
Gastro	• Clinical validation • Admin validation incl. DrDr	• Extra clinics for cancer waiters • In-sourcing capacity	• Recovery plan in place for endoscopy + job planning • Insourcing live: 200 patients seen
ENT	• Clinical validation of patients • Sulis transfers	• Salisbury mutual aid • In-sourcing capacity	• IPT Sulis & SFT live since Aug • Revision to approach to triage in place
General Surgery	• Additional Clinics • Sulis transfers (Hernias)	• Smart Theatre booking of Long Waiters • Sulis support for MRI capacity	• Additional Outpatient capacity (Upper GI/Colorectal) +40 • Additional Pelvic floor clinics live from November
T&O Spines	• Super clinics at RUH • Grip to avoid breaches	• Additional clinics	• Sulis has mobilised spinal capacity • Extra clinics delivering through October.
			• Insourcing clinic live.

65-Week Cohort continues to reduce

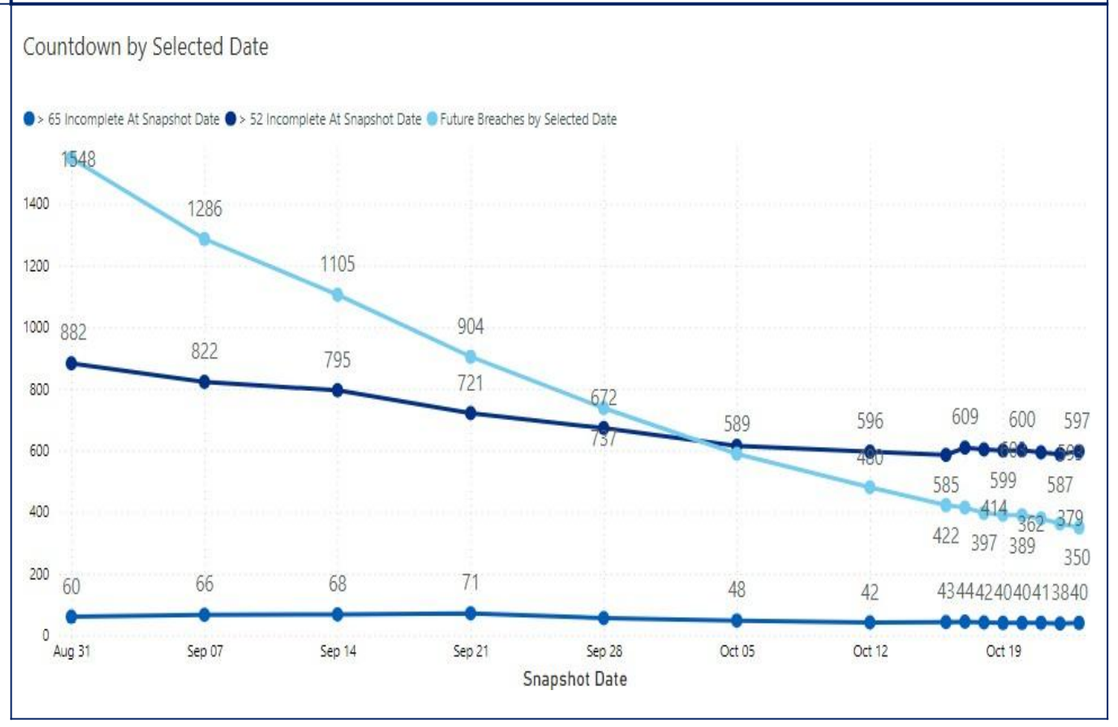
(n.b. data is not inclusive of incorrectly tracked pain service pathways)





- There are **379** patients as of the 25th October that, if not treated by 31 December 2025, will be over 65 weeks.
- This has reduced from **2,170** on 10th August.
- 39% of this cohort is within Gastroenterology and ENT.
- Of these, **13** patients have yet to be seen for their first appointment.
  - **8** have a 1st appointment scheduled before 31st Oct
  - **5** have a 1st appointment scheduled in November of which **4** were due to patient choice and **1** due to capacity
- The Trust is focussed on clearance of 65-week waiters by 20th December 2026. Projections are positive for all specialties.

- **N.B.** There are a further 54 patients in Pain Services in cohort to breach 65 weeks by 20th December. Of these, 22 do not have their next episode booked. Plans are in place to schedule additional activity through Sulis and locum staff to ensure patients are treated in time.



Validation

Overview

- Technical validation (clinical record review) is performed every 12 weeks (100% completion rate).
- Specialty level validation has been strengthened through RTT 12-week challenge.
- Telephone contact validation of 6k pts will be completed by SCW Clinical Support Unit. SCW validation commenced in October.
- **Additional validation opportunity**
  - ~20k overdue follow-up patients on the “to be scheduled” list.

Proposal

i. Initial DrDoctor (text contact) validation which is estimated to result in 10% reduction in list

ii. Telephone contact validation of remaining patients (Patient unsure / non responders).

iii. Estimated £40k based on 60% non-response rate using SCW CSU

Benefits

- Reduction in follow-up demand
- Safety netting for clinical harm due to delays in receiving care
- Preserve clinical administrative capacity to support existing recovery actions

Risks

- Correction of historic data quality issues may adversely affect RTT performance

12 Week RTT Challenge Overview: Kick off 18/08 - 10/11

Strategic Goal	1. Reduce 18 WW 2. Reduce Wait to First 3. Reduce 52WW	**Exec Oversight**	Bernie Bluhm: A/COO Sufi Husain: D/COO Sarah Richards: C/Champion	**Ops Oversight**	Divisions & Speciality Tris	**Programme Support**	Louise Pisani Olivia Lynch Sarah Hudson Karen Driscoll Vicki Cruze Amelia Price

Focus Areas

5 Must-Dos

Non-Negotiables All Specialties

1 Referral & Triage Management
Leads: Helen Mcabe & Specialities

- **Timely, Consistent & Reliable Triage**
- **Standardised & Electronic (by end of Sept)**

2 Booking & Scheduling
Leads: Specialities

- **Time Order Scheduling: Right Patient, Right Priority**
- **Chronological & Correctly Classified, Clinics Rostered 6 Weeks in Advance**

3 Tracking & Validation
Leads: Jenny Dando & Specialities

- **Enhanced Validation of patients > 40 weeks Standardise escalation process**
- **Daily Action: CCS Task Lists, Clinical Letters & Uncached**

Enablers

4 Build & Standardise a PTL that reaches from appointment & Scheduling > Exec oversight & assurance (Via Divisions)

5 Articulate, follow & apply RTT guidelines, rules & internal policies

Opportunities

Potential Enhancements Specialty Specific

- **SPECIALITY INPUT**
- **FEEDBACK FROM IST AND GIRFT**

- Potential theatre session swaps between specialities
- Optimise 6-4-2 scheduling meetings
- Flex Clinic templates: Shift News to Follow Ups
- DRDoctor
- Release time to focus on PTL
- Consultant weekly updates on individual PTL size and waits

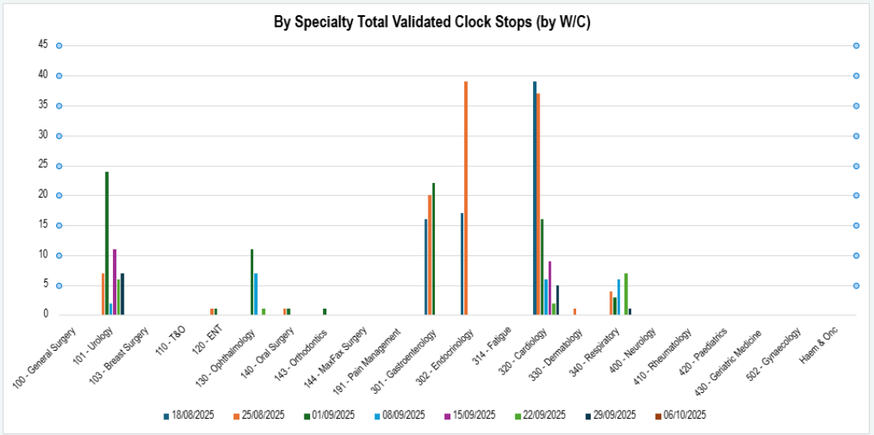
High Level Plan

	Aug			Sep					Oct				Nov
	11	18	25	01	08	15	22	29	06	13	20	27	3
Activity	**Mobilisation**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	12
Programme	18/08: Kick Off	Support in Place				Progress & Look Forward							Close & Consolidate
Teams			Speciality Plans Confirmed			Implementation			100% Specialities On Electronic Triage			Final Push	

12-Week Challenge Progress Since Launch

Since launching the 12-week challenge on 18th August, we have made strong progress:

- **Total waiting list size reduced** from 40,337 to 39,212 (-1,125)
  - ENT alone has reduced from 3417 to 2,731 (-686)
  - Oral Surgery -170
  - General Surgery -85
  - Cardiology -31
- **Outpatient waiters for a new appointment decreased** from 31,089 to 28,987 (-2,102)
- **Speciality RTT Performance Improved,** with ENT increasing from 38.1% to 50.93% (+12.83, Cardiology increasing from 46.98% to 51.59% (+4.61%) & Dermatology increasing from 65.1% to 70.26% (+5.16%).
- Patient contact Validation has delivered in the region of +331 clock stops



The RUH, where you matter

**YTD figures used to compare with challenge start date figures*

NHS
Royal United Hospitals Bath
NHS Foundation Trust

Cancer Recovery Plan

Updated 17/10/25

The RUH, where you matter

Cancer

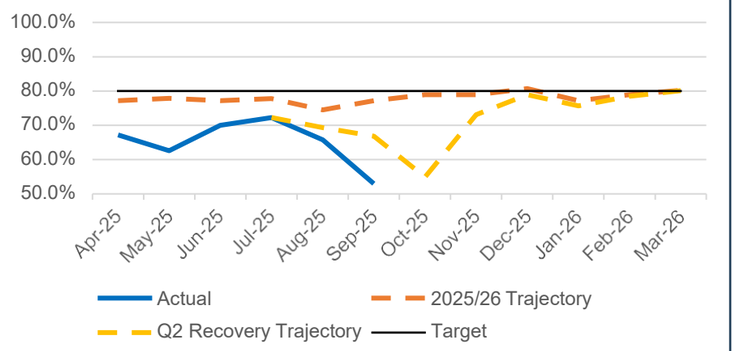
Current Position

September (provisional):

- 28-day deterioration below trajectory due to expediting of Skin recovery through increased OPA capacity.
- 31-day reduction in line with trajectory due to Skin MOPs waiting time – expected further impact in October/November as MOPS insourcing commences and breach patients are treated.
- 62-day deterioration due to Skin OPA and MOPS but improvement expected through validation.
- Additional outpatient capacity in Breast and Skin through September and October to deliver improvements from November.

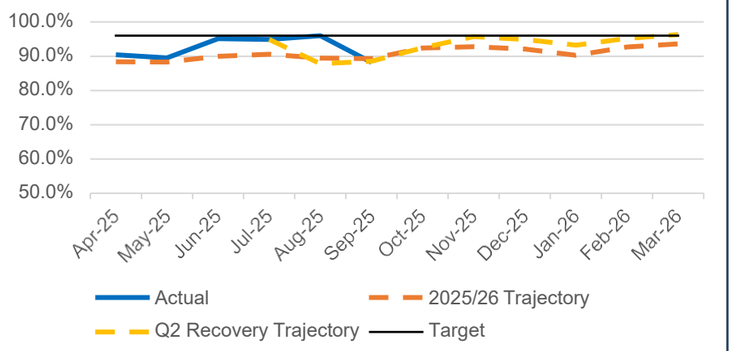
Performance

28 Day FDS



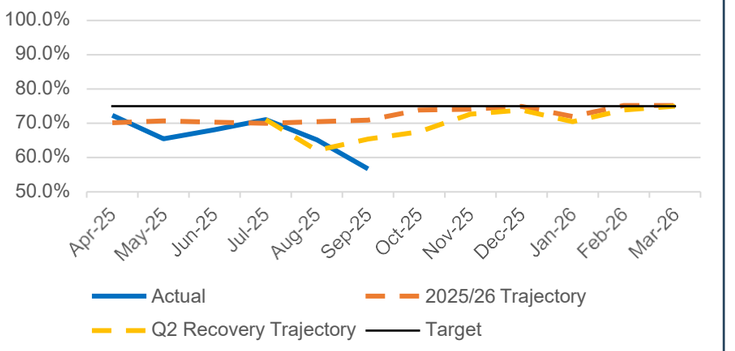
28 Day Performance Trajectory	Jun-25	Jul-25	Aug-25	Sep-25
Actual	70.0%	72.2%	65.7%	53.0%
Q2 Recovery Trajectory		72.2%	69.3%	66.8%
Target	80.0%	80.0%	80.0%	80.0%

31 Day Combined



31 Day Performance Trajectory	Jun-25	Jul-25	Aug-25	Sep-25
Actual	95.1%	94.9%	96.0%	88.2%
Q2 Recovery Trajectory		94.9%	87.8%	88.5%
Target	96.0%	96.0%	96.0%	96.0%

62 Day Combined



62 Day Performance Trajectory	Jun-25	Jul-25	Aug-25	Sep-25
Actual	68.1%	71.1%	65.1%	56.7%
Q2 Recovery Trajectory		71.1%	62.1%	65.4%
Target	75.0%	75.0%	75.0%	75.0%

Issues & Plans

- 28-day performance deterioration against trajectory in September but expectation October performance will be ahead of trajectory, with more significant improvement from November.
- Breast one-stop reduced to 21 days (30 day wait at end of September) with expectation to be booking below 21 days within October.
- Colorectal/IDA OPA reduced to five days. Endoscopy increased to 18 days. Substantive medical and nursing recruitment planned to increase capacity and reduce reliance on insourcing.
- Endoscopy booking process mapping identified opportunity delays in request to offer timeframe. Work in progress with administrative team.
- Reported CTC at 15 days. Capacity increased planned from December at Sulis following staff competencies sign-off.
- Gynae performance improvement with PMB OPA waiting time reduced to seven days – expected performance improvement in October of >5%.
- Skin OPA wait now 28 days. Locums and insourcing remain in place to cover consultant vacancies. OPA waiting time reduction expedited through additional capacity in September, leading to worsening performance as longer waiting patients seen, but with improvement expected in October performance.
- Urology – Reported prostate MRI reduced to nine days. LATP remains sole issue within pathway – additional evening and weekend capacity planned in October and November. Substantive nursing resource requirement being reviewed through business planning.

Cancer

Key Contributors & Recovery Plans					
Issue	**Owner**	**Specialty Update**	**Resource Required**	**Timeframe**	**RAG**
• **Breast one-stop capacity**	HW	• Locum consultant surgeons in place to cover long term consultant sickness • Substantive Radiology capacity in place • Locum moving to **fixed term contract** to provide service stability – role being approved through Trust process	• Trust approval for 12 month post	Nov-25	
• **Gastro OPA wait**	TS	• Gastro IDA nurse clinics delivering further waiting time reduction (currently five days) • Electronic triage in Gastroenterology by November – pathway reduction 1-2 days • Training scheduled for end of October • Median first appointment waiting time reduced from 12 days in June and July to 8 days in September and October – FDS performance benefits expected from October	• System training	Nov-25	
• **Endoscopy booking**	TS	• Endoscopy booking process mapping completed • Review identified half of patients waited longer waiting three days from endoscopy request to appointment being offered • Service reviewing root causes – actions reported through weekly performance meeting	• None	Oct-25	
• **Endoscopy capacity**	TS	• Waiting time for colonoscopy at RUH remaining at 16-18 days. • Consultant Gastroenterologist recruitment – endoscopy capacity increase of 15% • Endoscopy nurse recruitment – to deliver 100 additional endoscopy appointments per week	• Recruitment to vacancies	Apr-26 Jan-26	
• **CTC utilisation**	NA	• CTC increased patient contact pilot commencing 22/10 - to reduce slots lots to DNAs/late notice cancellations – current 15% lost slots, target 8% (10 slots per month) • CTCs planned to commence at Sulis in February following completion of course (commences December) and sign-off of staff competencies • Agreement with Radiology for failed colonoscopy patients to have same-day CTC (on the day availability review)	• None	Oct-25 Feb-26 Oct-25	
• **Skin OPA and MOPs capacity**	GJ	• Locum consultants and insourcing in place to cover substantive consultant vacancies • MOPs insourcing ready to commence – awaiting identification of suitable clinicians by insourcing company. RUH service ready to support insourcing clinics within one week • Long term staff model being developed – budget review undertaken, opportunities for skill-mixing being reviewed, including critical mass of consultants	• NHSE funding for MOPs secured	Oct-25 Oct-25 Dec-25	

Royal United Hospitals Bath
NHS Foundation Trust

DM01 Recovery Plan

Updated 17/10/25

The RUH, where you matter

DM01 Recovery Trajectory – Modelling Approach

Rigorous review of DM01 trajectory and assumptions for RUH. Reflecting increased demand in year, current position at M6, and likely recovery actions that can be delivered through Q3 and Q4.

Modelling assumptions

Starting point:

Updated actuals up to end of September DM01 submission – starting point for M7-12 trajectory

Demand:

- Baseline demand updated to reflect April – June net change in waiting list size for MRI, CT, Non-Obs Ultrasound and Echo. Biggest impact is the increased demand for US from Gynae
- Sleep Studies updated to reflect the updated service transfer timescales to Sulis
- Additional diagnostic demand built in to reflect conversion from additional RTT work carried out

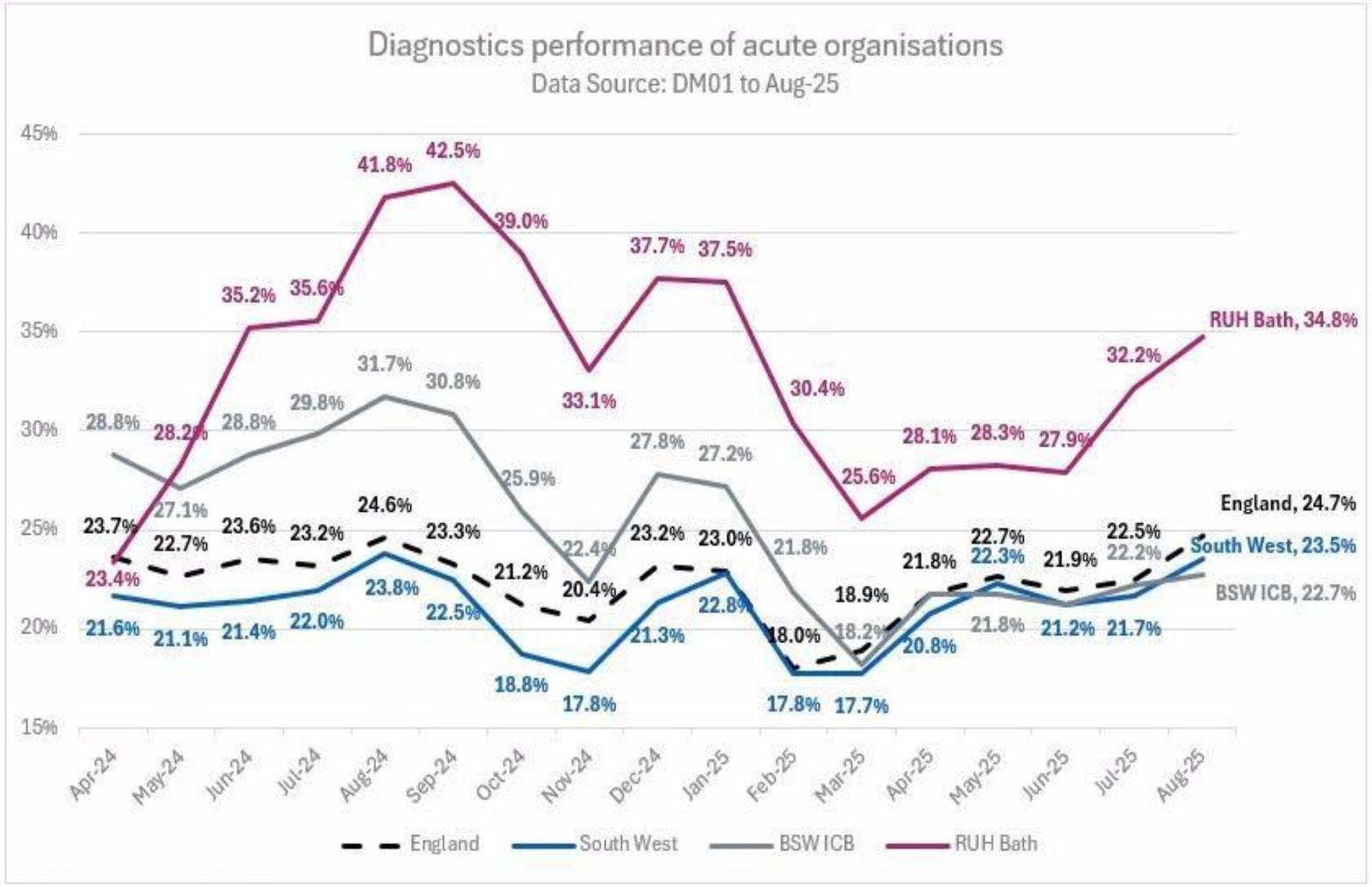
Capacity

- Additional capacity built in to reflect specialty plan to reduce long waiters

Our approach to recovery

Short-term	Deep dive	Long term sustainability
• Utilisation of Sulis CDC capacity • Productivity opportunities maximised • Recovery plans for ultrasound particularly linked to gynae	• Understand ongoing capacity required at RUH • Develop sustainable capacity plans that reduce boom/bust approach and improve cost-effectiveness • Understand drivers of demand and work with GIRFT on mitigations	• Implement long term diagnostic plan for RUH/Sulis • Linked to mobilisation of CDC fully integrated to RUH strategy • Combines clear productivity actions and removal of vans/outsourced activity

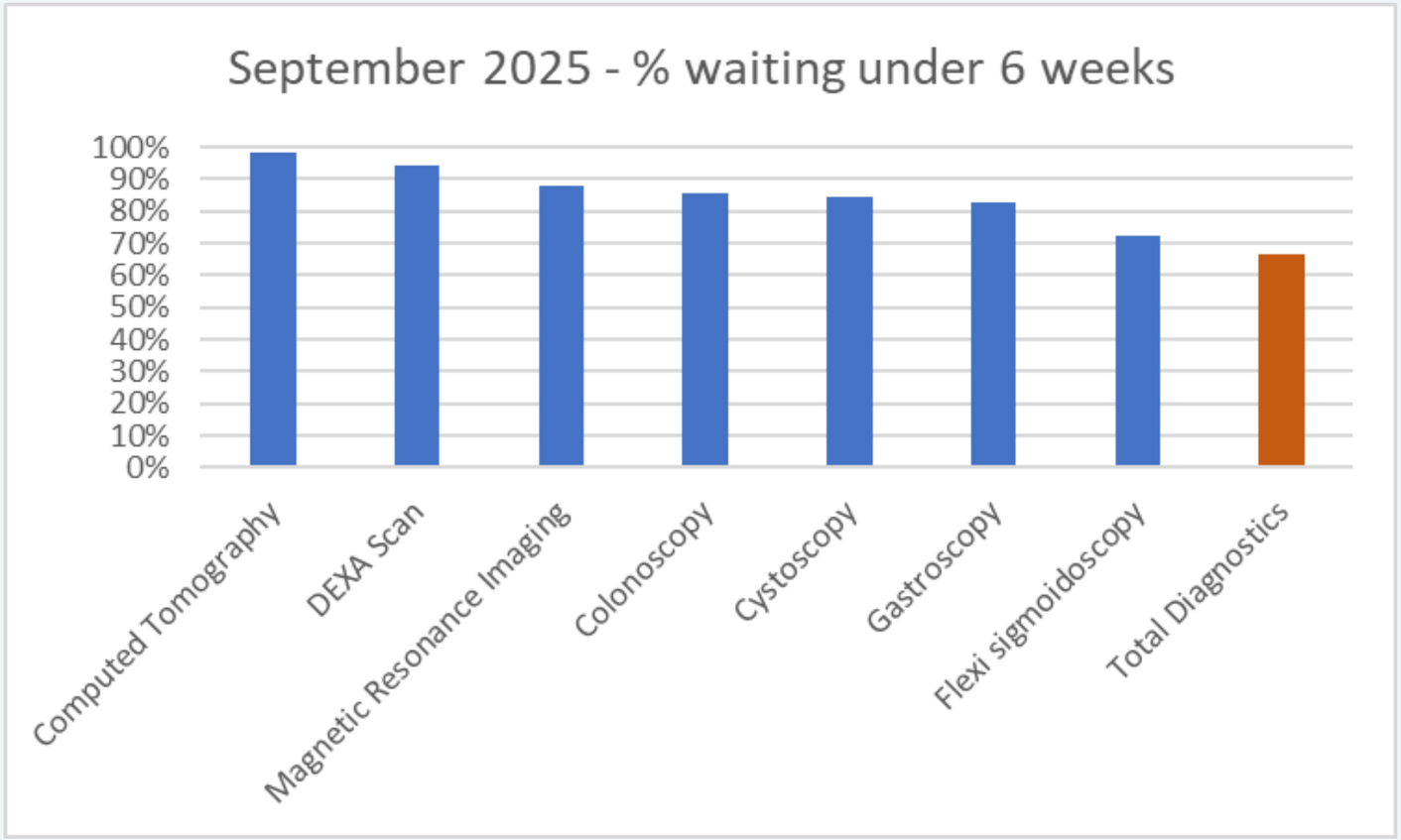
Diagnostics performance has deteriorated from 25.6% in Mar-25 to 34.8% in Aug-25



- CDC mobilisation delays have caused some issues with performance recovery
- Cessation of additional capacity at RUH that services are reliant on led to steep increase in waits
- High growth in demand especially in ultrasound have caused significant performance and capacity issues

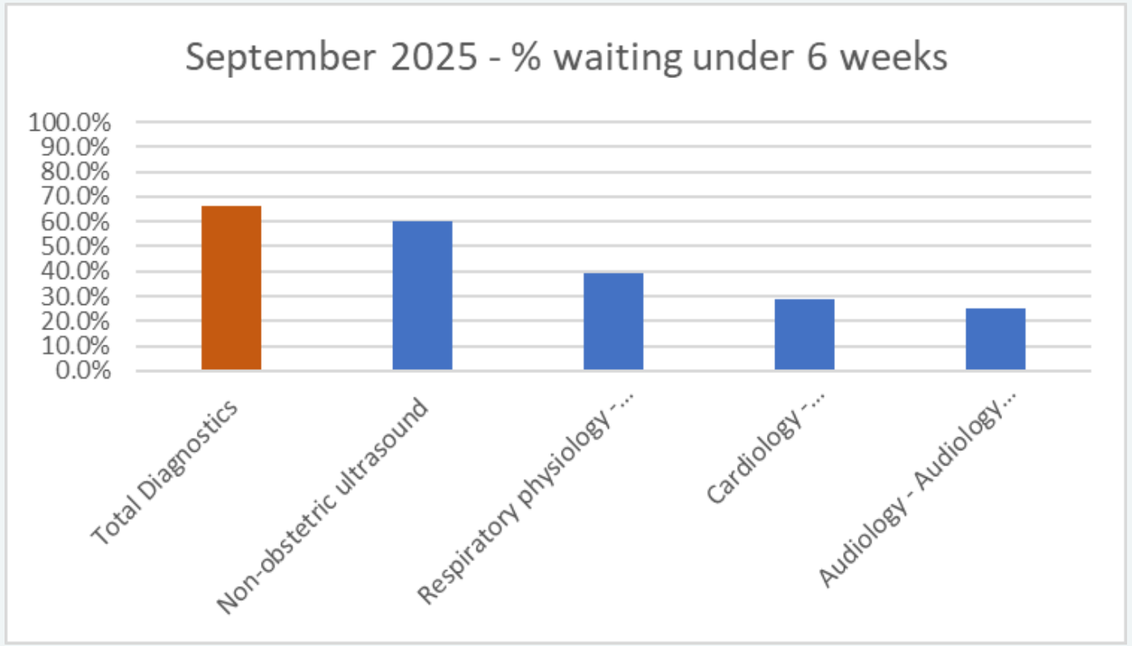
SW Diagnostics dashboard: https://tabanalytics.data.england.nhs.uk/#/views/SouthWestDiagnosticsDashboard/SouthWestOverview?:iid=1

Some areas of strong performance – CT, MRI, Endoscopy particularly



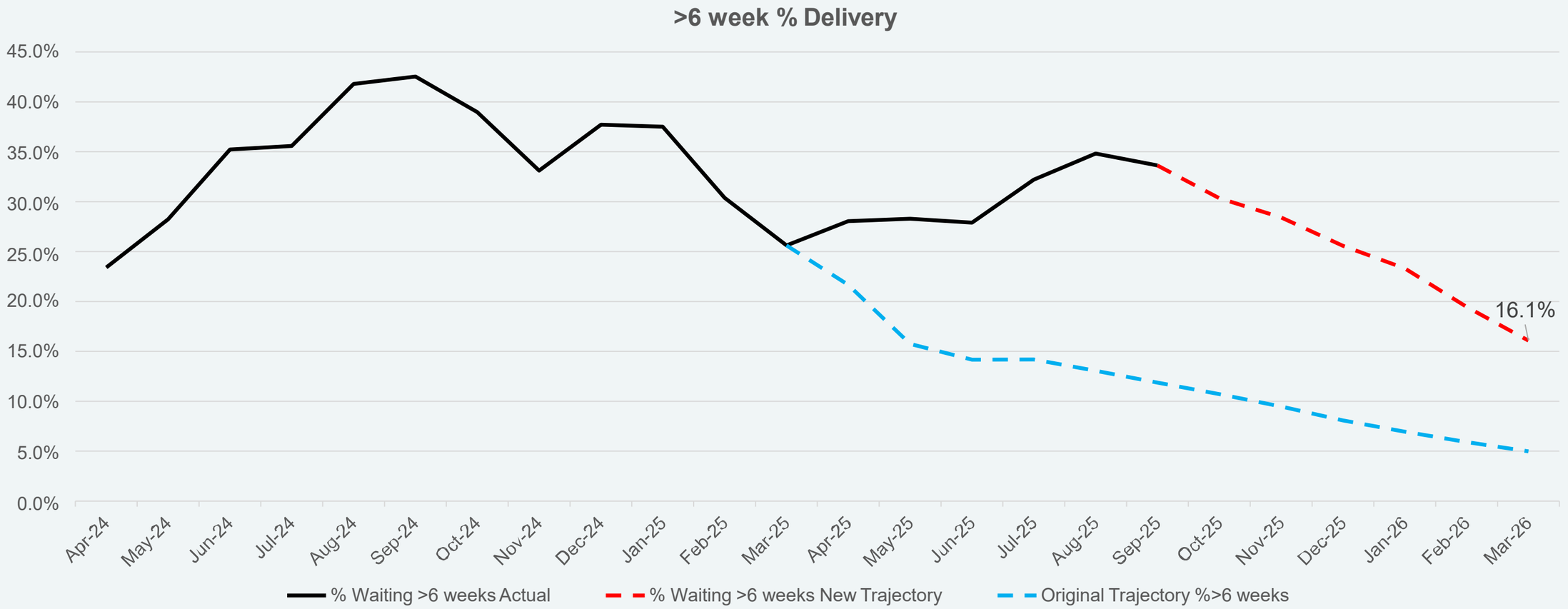
- CT access strong and Sulis CDC will enable this to be sustained despite diagnostic demand from RTT recovery
- MRI performance strong despite high cancer workload. Longer-term plans aim to remove mobile from RUH site by expanding radiology at Sulis.
- Endoscopy recovery of DM01 and surveillance has been strong supported by CDC. Work now focussed on improving productivity and reducing waits for cancer pathways.

RUH challenged diagnostic areas focussed in ultrasound, sleep, echo, and audiology



- Mobilisation of CDC capacity will be instrumental to delivering recovery in these areas
- **Ultrasound** – gynae pathway change has created significantly increased demand for TV ultrasound as seen nationally. Sulis CDC expanding ultrasound capacity to meet this demand. Clinical review underway in FASS division to ensure appropriate demand.
- **Sleep** - issues relating to commissioning of CPAP from Bristol delayed capacity for months. Agreement now reached and plan to recover backlog by March 2026.
- **Echo** – improved capacity at RUH and Sulis are supporting recovery trajectory through 25/26.
- **Audiology** - limited CDC capacity linked to pathway concerns. Further support needed to fully mobilise this area to reduce waits.

Ambitious but realistic plans forecast achievement of 16.1% at year end



Forecast March position

	Total Waiters	>6 week breaches	% over 6 weeks
Magnetic Resonance Imaging	1415	70	4.9%
Computed Tomography	1655	96	5.8%
Non-obstetric ultrasound	3099	853	27.5%
Barium Enema	0	0	0.0%
DEXA Scan	447	32	7.2%
Audiology - Audiology Assessments	436	118	27.1%
Cardiology - echocardiography	1404	229	16.3%
Cardiology - electrophysiology	0	0	0.0%
Neurophysiology - peripheral neurophysiology	81	19	23.5%
Respiratory physiology - sleep studies	32	0	0.0%
Urodynamics - pressures & flows	75	5	6.7%
Colonoscopy	277	29	10.5%
Flexi sigmoidoscopy	68	3	4.4%
Cystoscopy	263	43	16.3%
Gastroscopy	219	26	11.9%
Total Diagnostics	9471	1523	16.1%

Conclusion

- Significant recovery required to reverse current deterioration
- Clear actions outlined that are deliverable to get to 16.1% over 6 weeks
- Risks do exist principally in two areas but these have been modelled more rigorously than before and will be monitored at weekly DM01 meetings
    - Demand being higher than we have modelled – particular risks in ultrasound demand exceeding capacity
    - Capacity mobilisation being delayed
- RUH is undertaking a deep-dive exercise to understand and inform a sustainable diagnostic strategy and capacity plan for the longer-term

Royal United Hospitals Bath
NHS Foundation Trust

Finance

Finance

Context: Breakeven plan, with no NHSE Deficit Support Funding allocation. Plan phased in 12ths across year.

Current Performance:
Month 6 Year to Date - £13.0m adverse to plan. Over delivery against forecast trajectory by £0.5m in month

Key Drivers:
- £10.5m - Savings, of which Urgent care demand £1.6m, Group stretch £2.2m
- £3.0m underlying prior year
- £0.6m ICB commissioned high cost drugs
- £0.1m Sulis subsidiary
- £0.9m Resident doctors
- £0.3m Pay Award
- £0.3m Resident Doctors Strike July

Review of Investments completed

Grip & Control checklist reviewed by NHE and ongoing governance and oversight through Finance Ctte and Audit Ctte approved, with dedicated team resource
Workforce controls further escalated to weekly all Executive team face to face process, and enhanced medical staff controls. Line by Line review of Recruitment pipeline underway
Activity & Income forecast triangulated with Sulis and with ICB

In terms of the key underpinning conditions for RUHB delivery:

- Some system contribution for contracting the Turnaround Team.
- Achievement of 9% NCTR in order to maintain UEC flow and therefore elective ringfences.
- Assessment of safety.
- Maintenance of RTT investment of £2.4m.

Next Steps:
Appoint Turnaround team, Interviews undertaken, funding secured, NHSE business case approval underway
Quantification of further, faster opportunities and Board level EQIA in preparation for Mid Year Review

Finance

Financial Recovery Plan progress

Corrective actions	Current Run Rate	FRP actions	Risk adjustment	Funding / ICB Support	Most likely	Previous week 3 Oct	Latest assessment 10 Oct	Latest assessment 17 Oct	Comments
	£'m	£'m	£'m	£'m	£m				
Straight-line Forecast	28.2				28.2				
Divisional Prudence	2.0	-2.0			0.0				Month 6 run rate v Divisional FOT assumptions
Energy		0.9			0.9				
SulisRecover		-1.2			-1.2				Month 6 run rate
Beds/capacity (excludes overnight ED Drs)		0.5			0.5				Critical Incident in October
Temporary staffing pressures		-2.6			-2.6				Risk assessment and deep dive into Nursing & Midwifery. Consultant job planning now 90%
SULIS Saving		-1.0			-1.0				de-risking due to ICB income offset
ERF & clinical income (RUH recovery)		-1.0			-1.0				Month 6 run rate
Outpatient Delivery		-0.5			-0.5				de-risking due to ICB income offset
Group intervention					0.0				
In/out sourcing					0.0				
Continuous Improvement of Central Delivery Schemes		-2.8			-2.8				Everolimus slippage
Non recurrent		-1.0			-1.0				Provisions & Accruals
Drugs & Devices				3.0	-3.0				Month 6 actuals lower than forecast
Unidentified					0.0				
Sub-Total excl DSF &phasing	**30.2**	**-10.7**	**0.0**	**-3.0**	**16.5**				
Pay award				0.5	-0.5				Month 6 actuals lower than forecast
Resident Doctors Industrial Action				0.3	-0.3				Confirmation no national funding
ICB data Recording challenges				2.0	2.0				EY11Z - over 12 months old
Total excl DSF &phasing					17.8				
Gap to close					0.7				
Further stretch									
ICB triangulation - complete - should be some underspend									
Performance / activity triangulation complete									
Workforce triangulation - nearly complete									
Recurrent / Underlying position reconciliation complete									
Savings Plan triangulation - complete, for review with Delivery Groups									
Balance sheet audit risk									
Costing Unpalatables list									

RUH forecasts achievement plan against OP and DC and will be below plan for EL and OT by year end.

Overview:

- RUH forecasts achievement plan against OP and DC and will be below plan for EL and OT by year end.
- This equates to financial underperformance of £1.01m by year end.

Outpatients:

- Activity is 1.5% above plan and is forecast to remain above plan.
- OP activity has been prioritised as will have greatest impact on RTT recovery.

Other

- Is 2.1% behind plan and forecast to be 3.0% behind plan in M12. The primary driver is Radiology but overall financial impact is low.

Daycase

- Is 3.9% below plan YTD driven primarily by underperformance in Gastro, ENT and T&O
- Recovery plans in gastro and overperformance in other specialties will return to plan by M09 and be sustained to year end.

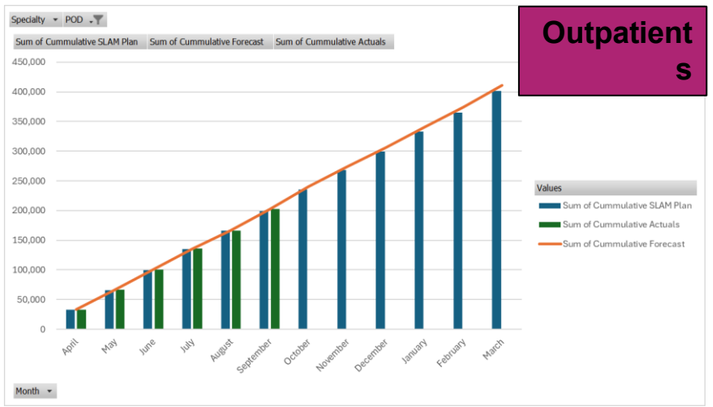
Elective

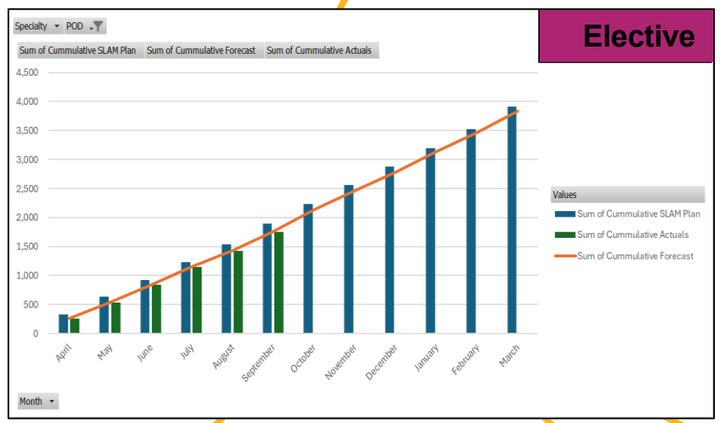
- Is 7.3% behind plan and forecast to be 2.1% behind plan in M12.
- Key drivers are coding changes in maternity activity (EL>NEL) and underperformance in SOC theatres.

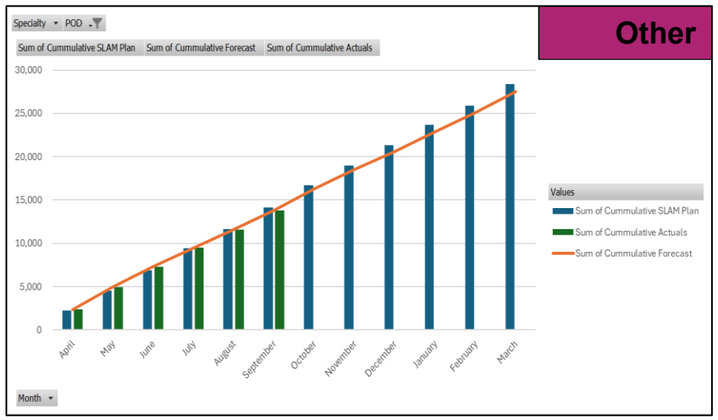
Conclusion:

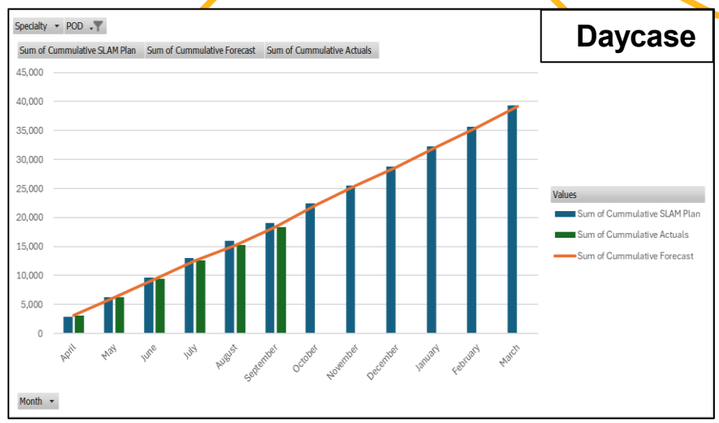
- Improve Utilisation of theatre capacity at SOC and work with ICB to reconcile overall picture across RUH/Sulis
- Ensure impact of coding changes due to revised clinical pathways are accurately reflected (e.g. EL > DC > OP).

	Activity									Income		
	YTD			M09			M12			M12		
POD	Plan	Actual	Actual	Plan	Forecast	Variance	Plan	Forecast	Variance	Plan	Forecast	Variance
OP	199,341	202,416	1.5%	299,553	305,898	2.1%	401,297	410,961	2.4%	72,318,951	73,689,995	1.9%
OT	14,108	13,812	-2.1%	21,289	20,608	-3.2%	28,377	27,514	-3.0%	3,188,050	3,099,459	-2.8%
DC	19,081	18,344	-3.9%	28,738	28,737	0.0%	39,306	39,223	-0.2%	44,009,042	44,061,577	0.1%
EL	1,894	1,756	-7.3%	2,881	2,786	-3.3%	3,916	3,834	-2.1%	23,107,371	20,762,378	-10.1%









Royal United Hospitals Bath
NHS Foundation Trust

Quality Performance

October 2025 (August data)

The RUH, where you matter

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%		Aug-25	78.6%	✗	?		Common Cause Variation
People we care for	HSMR – Total		100	100	May-25	112	✗	?	H	Special Cause Concerning - Increasing Run
People we care for	HSMR – Weekday		100	100	May-25	112	✗	?	H	Special Cause Concerning - Increasing Run
People we care for	HSMR – Weekend		100	100	May-25	115	✗	?	H	Special Cause Concerning - Above Upper Control Limit
People we care for	Klebsiella Spp Community Onset Healthcare Associated				Aug-25	3			H	Special Cause Concerning - Above Upper Control Limit
People we care for	Readmissions - Total		10.5%		Jul-25	9.9%	✓	P	H	Special Cause Concerning - Above Upper Control Limit
People we care for	Serious incidents with overdue actions		5		Aug-25	16	✗	?	H	Special Cause Concerning - Above Upper Control Limit
People we care for	SHMI				Apr-25	110.3%			H	Special Cause Concerning - Above Upper Control Limit
People we care for	Total monthly fill rate, day hours, HCA		90.0%		Aug-25	82.9%	✗	F	H	Special Cause Improving - Run Above Mean
People we care for	Total monthly fill rate, day hours, RN		90.0%		Aug-25	83.2%	✗	?		Common Cause Variation
People we care for	Total monthly fill rate, night hours, RN		90.0%		Aug-25	90.5%	✓	P	L	Special Cause Concerning - Below Lower Control Limit
People in our community	% Difference in 28 Day Diagnosis Performance between IMD 1-2 vs IMD 9-10		0.0%		Jul-25	-4.1%	✗	?		Common Cause Variation
People in our community	% Difference in DNA rates between IMD1-2 and IMD 9-10		0.0%		Aug-25	4.0%	✗	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 admissions <60mins from CRtP		80.0%	80.0%	Aug-25	81.5%	✓	F	H	Special Cause Improving - Above Upper Control Limit
People we care for	% of ED patients assessed <15mins				Aug-25	57.0%			H	Special Cause Improving - Run Above Mean
People we care for	Clostridium Difficile Community Onset, Healthcare Associated				Aug-25	2				Common Cause Variation
People we care for	Clostridium Difficile Hospital Onset, Healthcare Associated				Aug-25	2				Common Cause Variation
People we care for	Concerns are acknowledged within 2 working days		90.0%		Jul-25	99.0%	✓	P		Common Cause Variation
People we care for	COVID 8+ Days				Aug-25	8			L	Special Cause Improving - Run Below Mean
People we care for	E.coli bacteraemia cases Community Onset, Healthcare Associated				Aug-25	5				Common Cause Variation
People we care for	E.coli bacteraemia cases Hospital Onset, Healthcare Associated		6		Aug-25	3	✓	?		Common Cause Variation
People we care for	Early Identification of Deteriorating Patient	NEWS 5+ Screening Completed in 30 - Trust (%)			Aug-25	26.9%				Common Cause Variation
People we care for	Flu - Healthcare Onset (+3 days)				Aug-25	0			L	Special Cause Improving - Two Out of Three Low
People we care for	Klebsiella Spp Hospital Onset, Healthcare Associated		2		Aug-25	0	✓	?		Common Cause Variation
People we care for	Medication Incidents per 1000 bed days		7.0		Aug-25	6.9	✓	?		Common Cause Variation
People we care for	Mixed Sex Accommodation Breaches				Aug-25	103			L	Special Cause Improving - Decreasing Run
People we care for	MRSA Bacteraemias >= 48 hours post admission		0		Aug-25	0	✓	F	L	Special Cause Improving - Below Lower Control Limit
People we care for	MSSA Post 48 Hours				Aug-25	3				Common Cause Variation
People we care for	Never events		0		Aug-25	0	✓	F	L	Special Cause Improving - Below Lower Control Limit
People we care for	Number of complaints received		30		Aug-25	23	✓	?		Common Cause Variation
People we care for	Number of Hospital Acquired Pressure Ulcers Category 2		5		Aug-25	2	✓	?		Common Cause Variation
People we care for	Number of Hospital Acquired Pressure Ulcers Category 3		4		Aug-25	1	✓	?		Common Cause Variation
People we care for	Number of Hospital Acquired Pressure Ulcers Category 4				Aug-25	0			L	Special Cause Improving - Below Lower Control Limit
People we care for	Number of reopened complaints each month		3		Aug-25	3	✓	?		Common Cause Variation
People we care for	Pseudomonas aeruginosa Community Onset, Healthcare Associated				Aug-25	1				Common Cause Variation
People we care for	Pseudomonas aeruginosa Hospital Onset, Healthcare Associated		1		Aug-25	0	✓	?		Common Cause Variation
People we care for	Scanning Compliance for patients being given medication				Aug-25	62.4%			H	Special Cause Improving - Above Upper Control Limit
People we care for	Total monthly fill rate, night hours, HCA		90.0%		Aug-25	97.7%	✓	?	H	Special Cause Improving - Run Above Mean
People in our community	Delivery of Financial Control Total	Variance from Revised Plan		0	Aug-25	-11592	✓			
People in our	Reduction in Agency Expenditure	Agency as % of Total Pay			Aug-25	0.7%			L	Special Cause Improving -

Trust Scorecard - Quality Board Metrics (August 2025 Data)

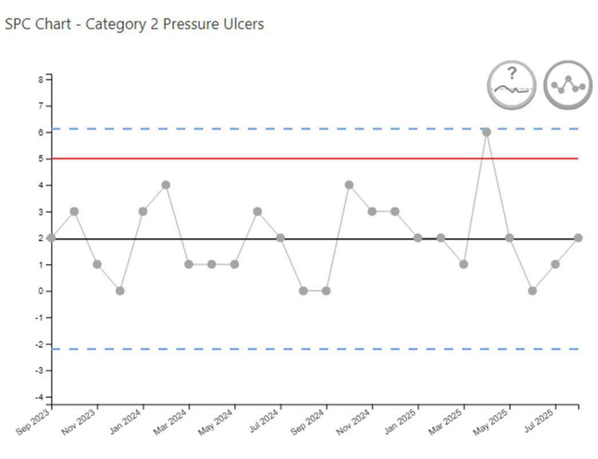
Section Of Scorecard	Strategic Goal	Measure	Measure Description	Local Year-End Target	National Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
National KPI	People we care for	% treated and admitted or discharged within four hours (To ensure 78% of patients can be treated within 4 hours of arrival at ED)		72.0%	95.0%	Aug-25	59.0%	✗	F		Common Cause Variation
National KPI	People we care for	28 day referral to informed of diagnosis of all cancers		80.0%	80.0%	Jul-25	72.5%	✗	F		Common Cause Variation
National KPI	People we care for	Average Handover Time for All Arrivals (mins)	Average ambulance handover time (mins)	30		Aug-25	59	✗	F		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%	Jul-25	94.7%	✓	?		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%	Jul-25	70.6%	✗	?		Common Cause Variation
National KPI	People we care for	Diagnostic tests maximum wait of 6 weeks		95.0%	95.0%	Aug-25	65.2%	✗	F		Common Cause Variation
National KPI	People we care for	RTT - Incomplete Pathways over 52 weeks		1.0%		Aug-25	1.9%	✗	F		Common Cause Variation
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%	Aug-25	59.5%	✗	F	L	Special Cause Concerning - Below Lower Control Limit
Vision	People we care for	% Key national standards met in the month		100.0%		Aug-25	11.1%	✗			
Vision	People we care for	% of positive responses to friends and family test	Improve the experience of those who use our service			Aug-25	93.8%				Common Cause Variation
Vision	People in our community	Delivery of Breakeven Position	Variance from Plan YTD	£0k	£0k	Aug-25	-£15589k	✗			

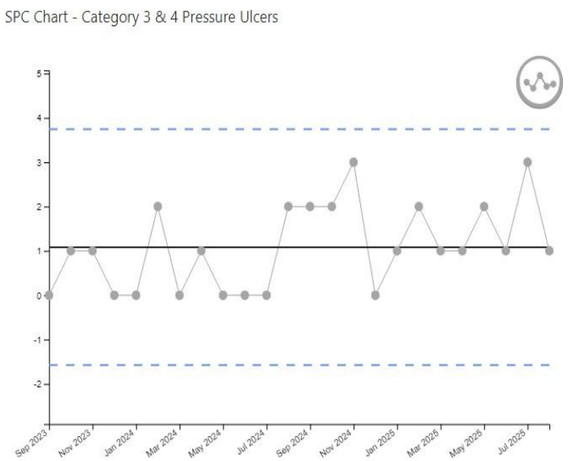
Pressure Ulcers

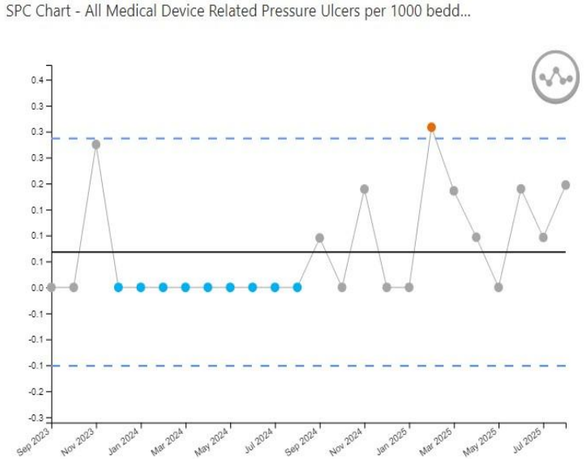
Royal United Hospitals Bath NHS Foundation Trust

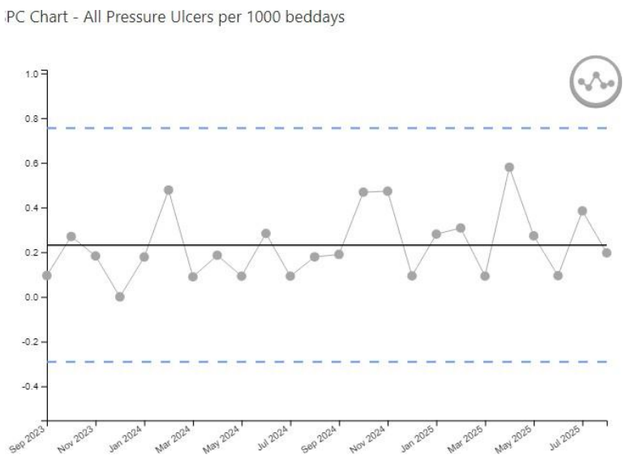
We are driving this metric because..	Pressure ulcers are related to poor patient outcomes, increased length of hospital stay and mortality. The estimated to cost the NHS £1.4m per day and the national acquired prevalence benchmark is 9.6% (2021). Maintaining a low incidence of pressure ulcers is a Trust priority.

Improving the experience of those who use our service









Understanding Performance

In August, the RUH reported 0.3 pressure ulcers per 1,000 bed days and 5 pressure ulcers;

- one category 3 pressure ulcer
- one category 3 medical device related pressure ulcer
- two category 2 pressure ulcers
- one category 2 medical device related pressure ulcer

Locations were on the heel, sacrum, spine and ear. The themes were inadequate skin checking and off-loading of pressure particularly with the use of medical devices. A deep-dive shows a specialist cast was provided to a heel ulcer that had not been used before, and so training need has been identified.

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
Podiatry team to lead training for teams using specialist casts to improve competence	Podiatry Team	Jan 26
Respiratory ward are to present their action plan to the Tissue Viability Improvement group in September	Senior nursing staff respiratory ward	Oct-25
Improve patient compliance with pressure ulcer prevention	Tissue Viability Improvement Group	Jan-26

Risks and Mitigation

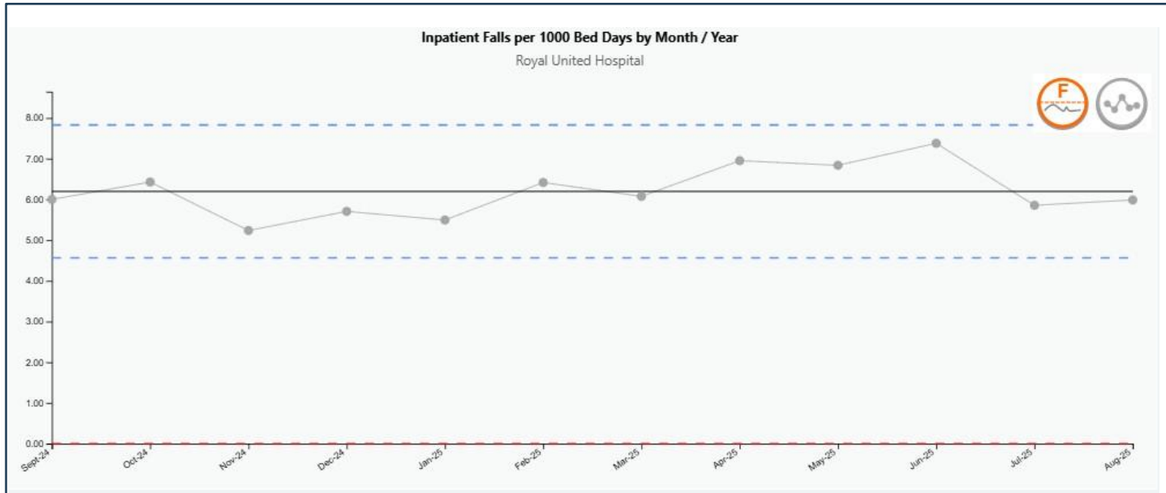
There is a risk that the lack of timely skin bundle assessments will impact on the ability to reduce avoidable pressure ulcers.

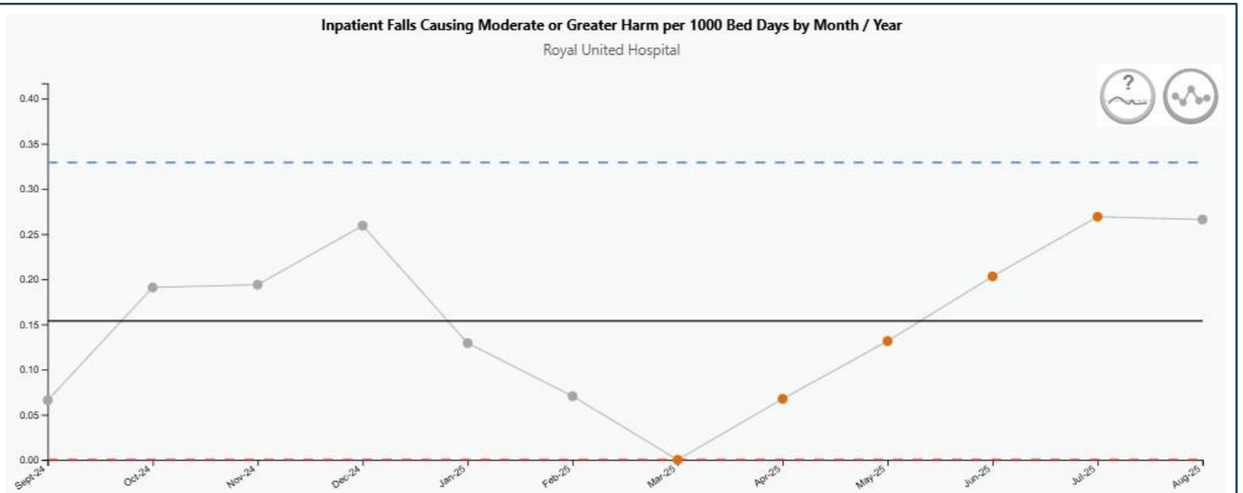
The mitigation is that the Tissue Viability Improvement Group monitors compliance with the Matrons who will work with the clinical area to implement improvements.

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 increased length of hospital stay 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

During August 98.21% of inpatients did not fall in our care which has remained consistent. There were 4 reported inpatient falls resulting in moderate harm to patients.

The falls were multifactorial, meaning they were caused by a combination of factors. As standard clinical practice all inpatients over 65 years old should have a multifactorial risk assessment. These factors include frailty, comorbidities and deconditioning which causes a decrease in muscle strength because 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 – Compliance end of August 34% - project extended due to compliance	Ward Manager	Nov-25
Work with the top contributor - Older Persons ward to increase compliance to 50% by August 2025. Compliance end of August 41% project extended due to compliance	Ward Manager	Nov-25
Trust-wide falls PSII commissioned May 2025 (as a result of several falls across the 3 divisions)	Associate Director of Patient Safety and Quality	Oct-25

Risks and Mitigation

1. Lying and standing blood pressure compliance has reduced in the last 2 months-data available via the BIU portal at ward level. QI Falls Lead to investigate barriers to completion.
2. Launch of Falls Insight and Improvement huddles trustwide September 2025 . Clinical representation limited due to acuity in the clinical areas and understanding of new process. Mitigation of risk is to raise awareness through senior sister forum.

Infection Prevention and Control

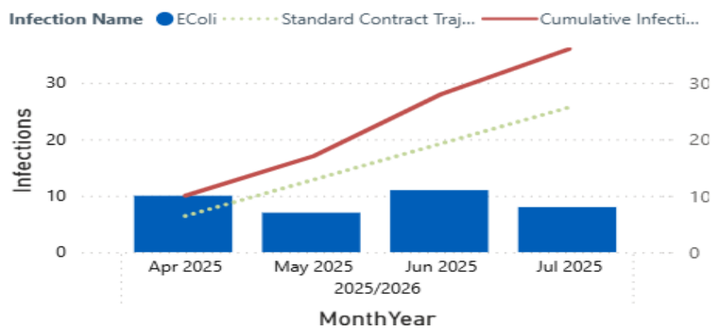
Royal United Hospitals Bath NHS Foundation Trust

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

Providing Safe and Effective Care

CDI Healthcare Associated Standard Contact Threshold

E. coli Healthcare Associated Standard Contact Threshold



Terms of reference:

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

Understanding performance	Countermeasures	Owner	Due Date
There were 4 cases of Clostridioides Difficile infection (CDI) (2 HOHA and 2 COHA) reported during August 2025. There have been 29 cases against a threshold of 75 reported to date for 2025/26. A deep-dive shows are no specific contributor identified for the RUH at present. There were 8 cases of *E. coli* infection (3 HOHA and 5 COHA) reported during August 2025. There have been 45 cases reported for 2025/26 against a threshold of 77. There are consistent themes with 7 cases reporting a urinary source, 2 of those had a catheter inserted. A further 3 cases were hepatobiliary. There has been an increase in the amount of MSSA cases seen in comparison to 2024/25. There were 12 cases until the end of August 2024. Whereas there have been 22 cases of MSSA up until the end of August 2025 with an increase in skin and soft tissue as a top contributory factor (n=7 cases).	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.	Infection Prevention and Control	Nov-25
	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 many areas around the Trust with good rates of implementation.	Infection Prevention and Control	Ongoing Q3 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	Ongoing development 2025

Risks and Mitigation
There is a risk that the CDI threshold will be exceeded due to the increasing number of 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, the research continues. There is a risk *E coli* numbers continue to rise due to a urinary sourced infections in over 65% of cases. **Mitigations**: Completed A3 for 'Well hydrated patients' Quick guide for Medication, IV Fluid and fluid balance launched, this will support *E. coli* infection reduction through good hydration MSSA Bacteraemia's are increasing. **Mitigations** deep dive into the skin soft tissue and line infections to identify probable cause, point prevalence to be completed to ascertain a baseline and further Aseptic technique

Safe Staffing (Nursing Inpatient Areas)

Royal United Hospitals Bath NHS Foundation Trust

We are driving this metric because..	Nurse staffing fill rates is a measure of wards being sufficiently and safely staffed.
Performance Target:	For staffing fill rates to remain >90%

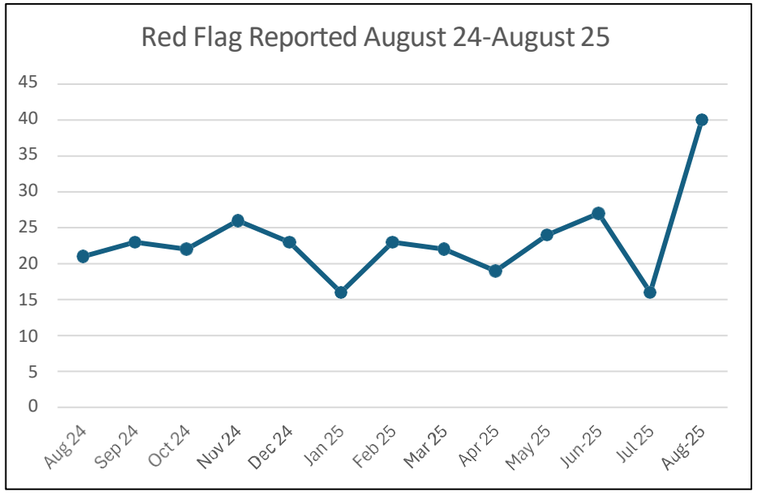
Breakthrough Objective

Location name	Fill rate day RN %	Fill rate day HCSW %	Fill rate night RN %	Fill rate night HCSW %
Acute Stroke	79%	87%	87%	117%
C30 SAU	95%	84%	100%	91%
Cardiology	83%	86%	98%	95%
CCU	96%	81%	98%	76%
Charlotte	69%	100%	98%	102%
Cheselden	71%	92%	88%	118%
Children's ward	84%	41%	72%	95%
Combe	86%	87%	84%	129%
ED	68%	88%	85%	92%
Forrester Brown	84%	100%	94%	99%
Haygarth	67%	91%	78%	97%
Helena	77%	94%	71%	103%
MAU	108%	65%	98%	98%
MSS	86%	99%	100%	103%

LocationName	Fill rate day RN %	Fill rate day HCSW %	Fill rate night RN %	Fill rate night HCSW %
OPAU	61%	78%	98%	97%
OPUSS	88%	90%	90%	89%
Parry	87%	85%	98%	103%
Philip Yeoman C32	100%	56%	100%	0%
Pierce Ward	73%	97%	100%	98%
Pulteney	98%	87%	99%	96%
Respiratory	82%	80%	86%	78%
Robin Smith	96%	81%	100%	94%
Waterhouse	71%	84%	86%	90%
William Budd	71%	84%	86%	90%

Day Shift Average Fill Rate		Night Shift Average Fill Rate	
RN	HCSW	RN	HCSW
84%	82%	92%	95%

KEY
< 89.99 %
90-94.99
95-100.99
>101%



Understanding Performance

The combined day shift fill rates for RNs across the 24 inpatient wards was 84% and 92% respectively for nights. The combined day shift fill for HCSWs was 82% and 95% for the night shift.
The table above shows the monthly fill rate for the inpatient wards and emergency department. The RAG rating (as per Key above) was reviewed in August 2025 across BSW 3 acute Trusts to align with the Trust scorecard quality metric.

Charlotte, Cheselden and Helena wards fell below 80% fill rate for RN staffing on day shifts, the main contributing factors was due to temporary ward relocation and a reduced bed base resulting in a reduced nurse staffing requirement. William Budd, paediatrics and Emergency Department ward fell below the 80% primarily due to current vacancy which is actively being recruited into.

The decreased HCSW fill rate < 80% in all areas other than Philip Yeoman ward (PY) is primarily 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 >101% particularly on night shifts reflects the deployment of additional staff in response to increased dependency and enhanced care patients.

Sickness rates for RN and HCSW remains significantly above the 3% funded headroom and this in turn impacts the fill rates across most wards. Sickness absence is being actively managed across the clinical divisions.

Countermeasures	Owner	Due Date
To recruit to remaining HCSW vacancies by November 2025. Recruitment events x3 planned in September 2025. Interviews planned 20-24th October 2025. (91 applicants)	Senior Sister/ Charge Nurse & Matrons	Nov-25
To recruit into William Budd RN vacancies (3 x new starters in September 2025)	Senior Sister/ Charge Nurse & Matrons	Oct-25
To recruit into Paediatric ward RN vacancies (interviews planned September 2025)	Paediatric Matron & Senior Sister/ Charge Nurse	Jan-25
To recruit into Emergency Department band 5/6/7 registered nurse vacancies	Emergency Department Matron	Feb-25

Risks and Mitigations

There is a risk that the current HCSW vacancies will remain vacant and decreased fill rate <80% will continue. To mitigate this risk there is a Trust wide interviews planned 20-24th October following successful recruitment events.

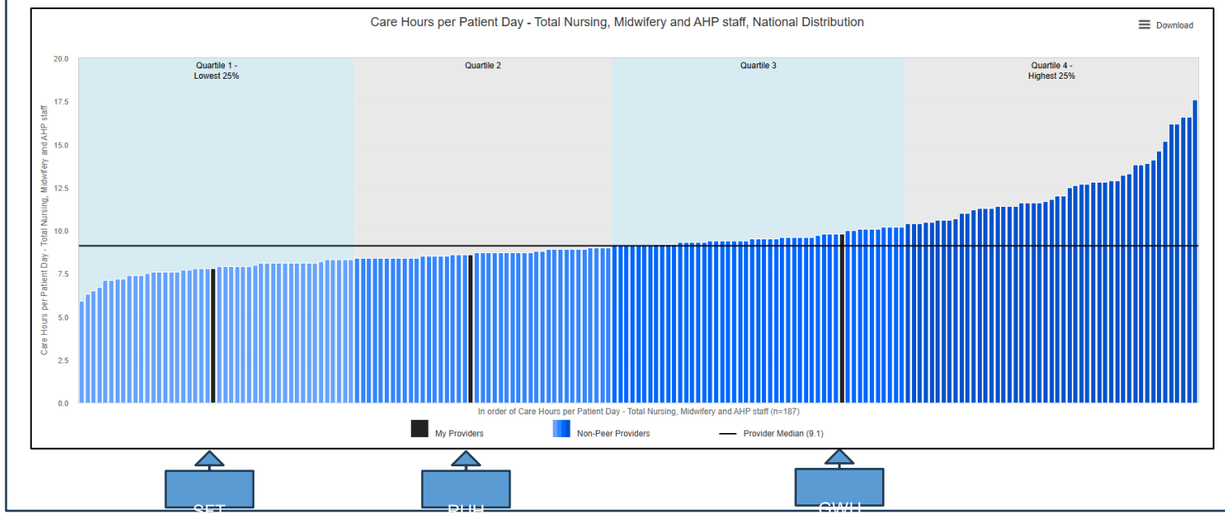
There are twice daily safer staffing meetings to review safe staffing and potential risks or red flags with mitigation put in place as appropriate. This will include redeployment of staff.

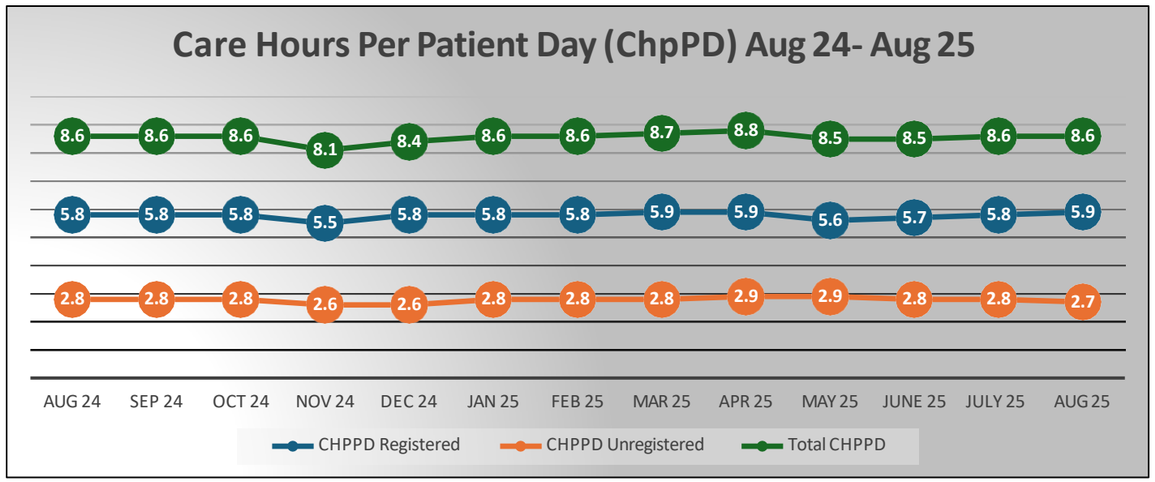
There were 40 red flags reported by wards in August, a significant increase from 16 reported in July. The breakdown of the 40 red flags was predominantly (75%) due to a shortfall of 25% RN time due to short notice sickness and vacancy. All these were reviewed and appropriate mitigation put in place including 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 Registrants (Nurses and Nurse Associates) and Healthcare Support Workers divided by the average number of patients at midnight. CHPPD data provides information on how the Nursing workforce is deployed and how productively.





Understanding Performance

The average monthly CHPPD is 8.6. CHPPD continues to remain stable for both registered and unregistered staff over the past 12 months.

When reviewed on Model Hospital (latest data available July 2025) we remain in quartile 2 and continue to benchmark in line with the peer median 8.6.

Countermeasures	Owner	Due Date
Undertake Safer Nursing Care Tool data collection (bi-annual)	Associate Chief Nurse Workforce & Education	Oct-25
Active recruitment to HCSW and Registrant vacancies	Divisional Directors of Nursing / Matrons	Ongoing

Risks and Mitigations

The risks identified from HealthRoster in August show an increase in levels of short-term absence requiring daily review and deployment of nursing staff.

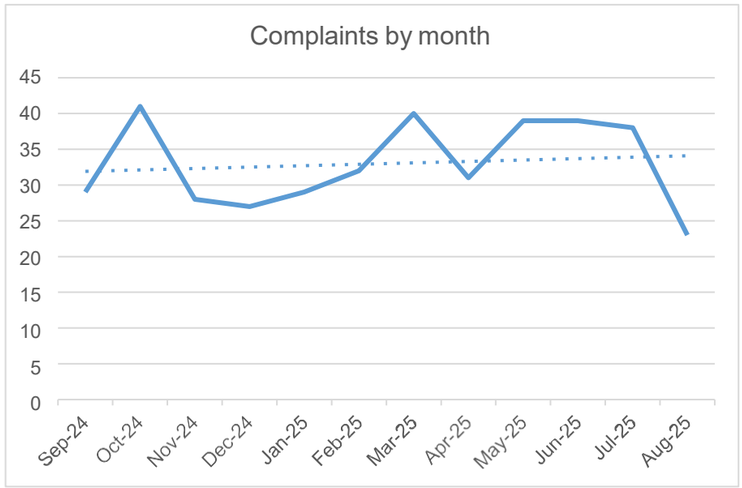
Mitigations:
- Twice daily safe staffing meetings, reviewing both unfilled shifts alongside acuity and dependency of all wards.
- HCSW recruitment campaign, interviews planned for October 20-24th 2025
- Focused joint led (Nurse & HR) sickness reduction programme
- Prospective and retrospective roster reviews
- Safe staffing levels are highlighted within the clinical site meetings

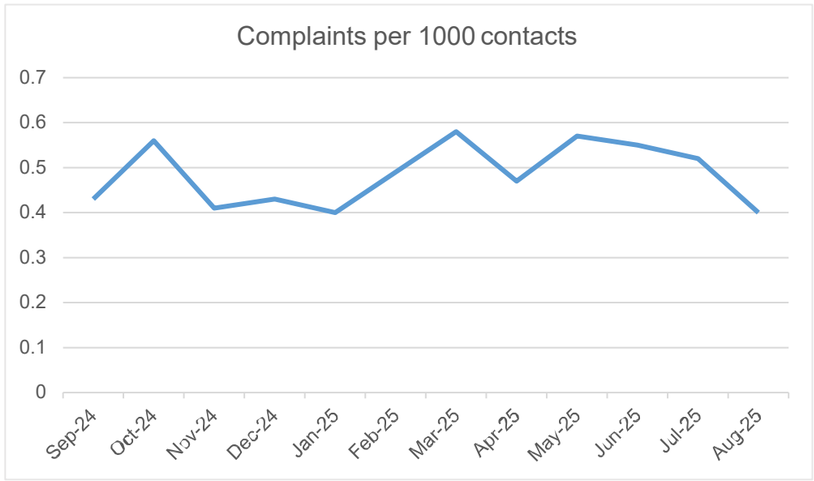
Patient Support & Complaints (PSCT)

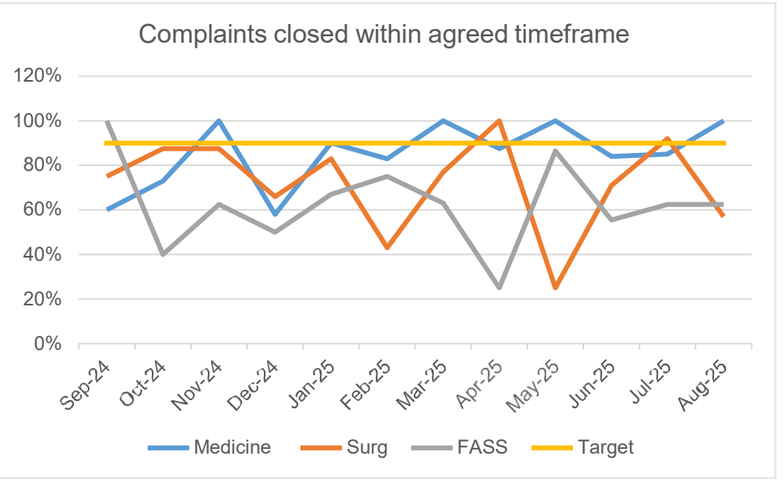
Royal United Hospitals Bath NHS Foundation Trust

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.
Performance Target:	90% of complaints responded to within agreed timeframe.

Improving the experience of those who use our service







Understanding Performance

In August 2025, the Trust received 23 new complaints, this was a significant decrease from July at 38. The complaints were evenly distributed across several departments with Cardiology (n=4) and Maternity (n=3) receiving the highest number. The main theme was clinical care (n=15) consistent with previous months. The Medicine Division received the highest number of new complaints (n=10). The complaint rate per 1000 patients in August was 0.40 which is down from 0.52 in July. 100% of all concerns were acknowledged within 2 working days.

The response times for formal complaints continues to fall below the target of 90% with 78.6% of the 28 complaints closed in August responded to within the agreed timeframe. This varies by Division, the FASS Division remained consistent with the previous month of 62.5% of complaints closed within the agreed timeframe, the Surgical Division decreased from the previous month to 57% and Medicine closed 100% within timeframe.

Countermeasures	Owner	Due Date
Thematic coding of a closed complaint and the response will be undertaken and presented to the Insights and Improvement Committee in January 2026.	Patient Experience Team	Jan-26
Complaints and concerns policy has been updated following a review by the Patient Safety Nurses. The policy has been circulated to members of the Patient Experience Committee for final sign off.	Deputy Head of Patient Experience & Engagement	Oct-25
Continue to monitor compliance with agreed complaint response times in the Divisions. Corporate complaints team will attend weekly meetings to provide progress updates and highlight outstanding/overdue complaints and concerns where responses have not been received.	PSCT/Patient Safety Lead Nurses	Ongoing

Risks and Mitigation

There are ongoing concerns about the responsiveness of staff to patient/family concerns requiring resolution. This relates to outpatient/test results queries.

The new governance structures within the 3 Divisions will support greater oversight of the management and ownership of complaints. However, the lack of resource in F&SS may have an impact on performance metrics.

Need to ensure a more realistic timeframe for responding to some complaints which are more complex.

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

Alerting Watch Metric Commentary: Safe Staffing

Royal United Hospitals Bath NHS Foundation Trust

Understanding Performance

Registrant day shift fill rate was 84% (target 90%).
Healthcare Support Worker (HCSW) day shift fill rate was 82% (target 90%).

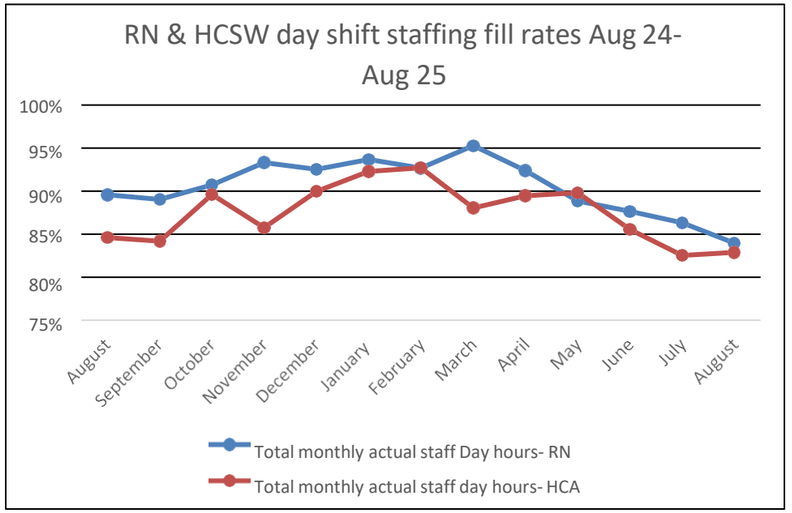
RN and HCSW day fill rates are below 90% performance target since June 2025. The current fill rate for night shifts remain above 90%.

The top contributor for HCSW day fill rate is HCSW vacancy, this has been impacted by the national change in visa and sponsorship rules.

The top contributors for low RN fill rates is vacancy within Paediatrics, William Budd and Emergency Department (ED). New nursing staff are due to commence in September in all areas. Recruitment continues for remaining RN vacancies in paediatrics and ED.

Recent relocation of wards due to planned estates work has impacted fill rates due to reduced bed base and ward layouts requiring less nursing staff than originally planned (Charlotte, Cheselden and Helena wards).

Philip Yeoman ward is staffed proactively aligned to orthopaedic activity and this results in reduced HCSW requirements impacting planned fill rates. Staff are redeployed to support HCSW vacancies within other wards and departments.



Sickness absence rates remain above the funded headroom of 3% and this in turn impacts fill rates. Twice daily safe staffing meetings support the redeployment of staff and allocation of temporary staff.

Safer staffing fill rates, care hours per patient day and quality metrics are monitored monthly through the CNO chaired Nursing, Midwifery and Allied Health Professional Workforce Group.

Countermeasures	Owner	Due Date
Active recruitment to all HCSW vacancies Trust wide. Recruitment events planned locally and regionally September 2025, HCSW interviews planned 20-24th October (91 applicants).	Divisional Directors of Nursing / Associate Chief Nurse Workforce	Oct-25
Redeployment of staff reflected on health roster to improve accurate fill rates.	Divisional Directors of Nursing	ongoing
HCSW retention event aligned to national HCSW day, review opportunities for HCSW forum.	Divisional Director of Nursing (FaSS)	Nov-25
Recruitment to band 5 RN vacancies within Paediatrics and ED.	Matron for Paediatrics and ED	Dec-25

Alerting Watch Metric Commentary: Serious Incidents with 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	Patient Safety Nurses	Complete
Transition of action monitoring and follow up to patient safety nurses	Patient Safety Nurses	Nov-25
Report to divisional governance to assess *open actions, timeframes and viability with an assurance report to IIC by the end of the year:* • *Summary of overdue actions to next Divisional Governance* • *Review of each overdue action with the divisions to determine if action is still relevant or needs to be revised and update on Datix*	Patient Safety Nurses	Dec-25
Actions for incidents without a learning response/PSII or Huddle will no longer be individually entered and tracked on the datix specific module.	Patient Safety Nurses	Oct-25

Royal United Hospitals Bath
NHS Foundation Trust

Perinatal Quality Surveillance

October 2025

August 2025 data

The RUH, where you matter

Safe – Maternity Workforce

	Target	Threshold G	Threshold A	Threshold R	June 25	July 25	Aug 25	Comment
Midwife to birth ratio	1:24	<1:24		≥1:26	1:26	1:27	1:27	Trained staff only included in acuity data
Midwife to birth ratio (including bank)	1:24	<1:24		≥1:26	1:24	1:25	1:26	Care hours required, trained and support staff included in acuity data
Percentage of 'staff meets Acuity' BBC	100%	>90%		<70%	79	76	82	
Percentage of 'staff meets Acuity' Mary Ward (inpatient care)	100%	>90%		<70%	56	89	60	19 occasions – no housekeeper or MSW Redeployment of RM – 13 occasions 26 occasions – no ward clerk
Confidence factor in BirthRate+ recording BBC	60%	>60%		<50%	87	80	80	Percentage of episodes for which data recorded
Confidence factor in BirthRate+ recording Mary Ward	60%	>60%		<50%	92	82	88	Percentage of episodes for which data recorded
Percentage maternity sickness rolling 12 months	<4%	<4%		>5%	3.39	3.34	3.20	
Percentage Maternity turnover rolling 12 months	≤5%	≤5%		≥7%	1.04	1.53	2.33	
1:1 care not provided in labour	0	0		>1	0	0	0	
Labour ward coordinator not supernumerary episodes	0	0		≥1	1	0	1	13/8 8pm – Redeployed from ward to resolve – Lasted 5 minutes. Undertaking CTG observation of IOL therefore had oversight of labour ward.
Number of NICE red flags on Birth Rate +	NICE 2015				2	13	7	A 'red flag' event is a warning indicator that something may be wrong with midwifery staffing BBC- 2 delay in care, 1 delay in pain relief, 1 LWC SN status Mary – 3 – 2 delay/cancel activity, 1 delay IOL commencement.

Countermeasure /Action (completed last month)	Owner
Investigate scorecard discrepancies in MW:BR different data for June sent with July scorecard	GD/KP/KT
Investigate increase in red flags	GD/KP

Countermeasure /Action (planned this month)	Owner
MSW engagement events planned for Sept with HR support	LP/JC
MSW recruitment – 14 candidates (Sep 22nd-24th)	DB/Matrons

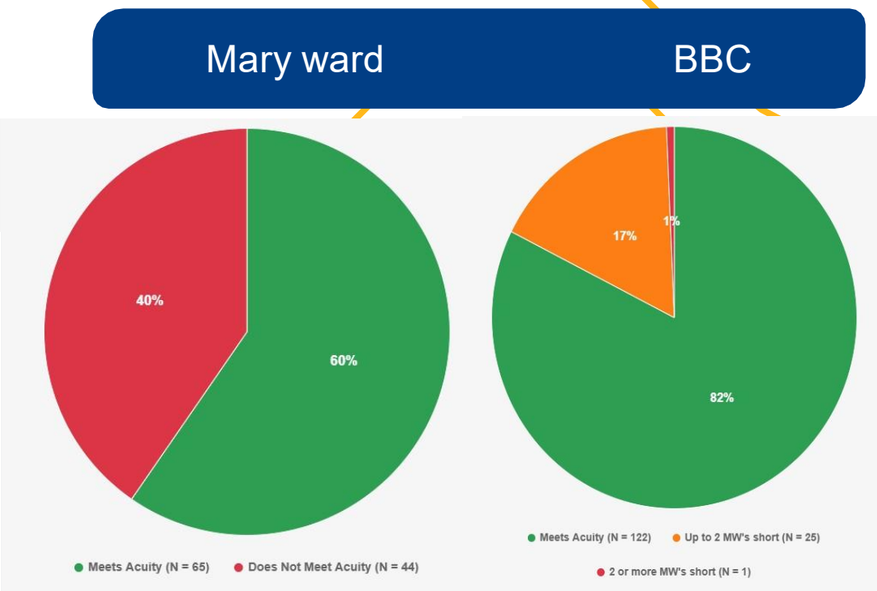
Pipeline actuals in month

Substantive MW vacancy	Secondment	Mat leave	Fixed term in post	Budget V actual
3.64 (can go 8.0wte over)	5.84	7.68	3.56	-6.32

Substantive MSW vacancy	Secondment	Maternity leave	Fixed term in post	Budget V actual
-1.99	2.40	1.25	0.00	-5.64

Summary of management actions relating to staffing V acuity

Action (top 5)	Times occurred	Percentage
Internal redeployment	18	35%
Flow RM in BBC no.	15	29%
Escalate to Matron/MOC	5	10%
Unable to take breaks	4	8%
Redeploy from community	4	8%



Safe – Neonatal Workforce

	Target	Threshold			June 25	July 25	Aug 25	Comment
		G	A	R				
Neonatal nurse vacancy					2.09	2.19	2.41	Continue uplift to band 4 to support SNA training x 1
Percentage neonatal sickness rolling 12 months	100%	<4%		>5%	3.21	3.29	3.63	
Percentage neonatal turnover rolling 12 months	<5%	<5%		<7%	5.04	4.96	3.05	
Percentage neonatal nursing shifts filled to BAPM standard	100%	>90%		<80 %	89.47	98.36	90.16	High acuity, vacancy, maternity leave LTS
Percentage medical shifts filled to BAPM minimal standard	100%	>90		<80	98	93.65	95.16	• Note minimal standards. • Trainee ANNP in post started Sept 2025. 12-month full time training until able to work on rota
Percentage neonatal QIS trained	70%	<70 %		<60 %	65	65%	70.8	
Percentage of TC shifts with staff dedicated to TC care only	100%	>90%		<80 %	100	100	100	

Countermeasure /Action (planned)	Owner
1. 2 WTE Band 6 appointed. Start date October 2. 3 WTE Band 5 appointed. Start date October 3. 2 WTE B5 12 months start November	KF

Is the standard of care being delivered?

- **Sickness rates remains under Trust target**
- **Decrease in BAPM nursing shift fill rates, due to high acuity, maternity leave and long-term sickness**
- **Transitional care staffed 100% with dedicated transitional care nurse.**
- **27% of shifts between 5-8 babies cared for on transitional care and 14% of these shifts were not supported by correct Nurse: baby ratio**

New Cases for August 25

Patient Safety Events

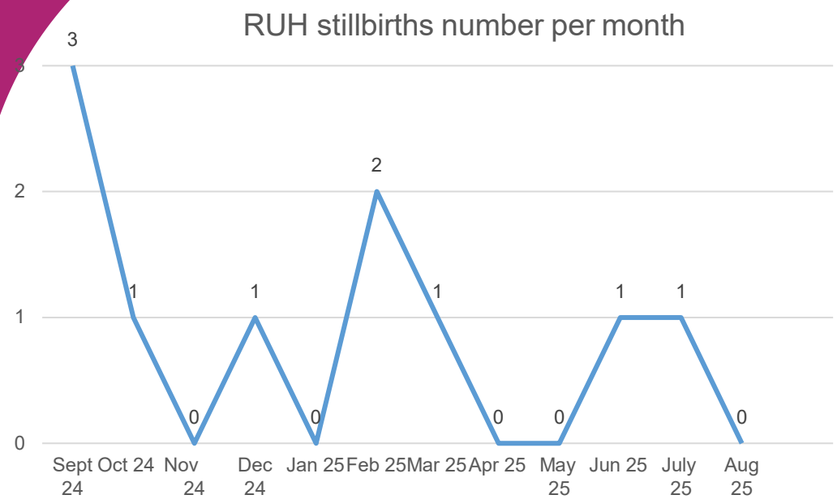
Case Ref	Date	Category	Patient Safety Event	Outcome/Learning/Actions	MNSI Ref	PSII
144324	26/08/25	Moderate	Fractured Clavicle following breech Em LSCS	Awaiting MPSR.		
144016	25/08/25	Moderate	Em LSCS, Meconium asp	Initial Neonatal review. Awaiting MPSR.		
143978	25/08/25	Moderate	4th degree tear	29/08/25 MDT Learning response completed.		
143919	22/08/25	Moderate	Transfer for therapeutic hypothermia	Awaiting MPSR 05/09/25.		
143683	14/08/25	Moderate	Fractured clavicle following ventouse	22/08/25 MDT Review. DOC not required. For family letter.		
143636	02/08/25	Moderate	Missed Fractured clavicle – trial of forceps - ventouse	Safeguarding leading on this. MDT completed.		
143678	11/08/25	Moderate	a left sided parietal bone fracture with subdural haemorrhage on day three of life	After Action Review 08/09/25 . DOC not required. Positive family feedback. For family letter		
143463	05/08/25	Moderate	Perineal haematoma	MDT 20/08/25 . Verbal DOC given, written not required, For family letter		

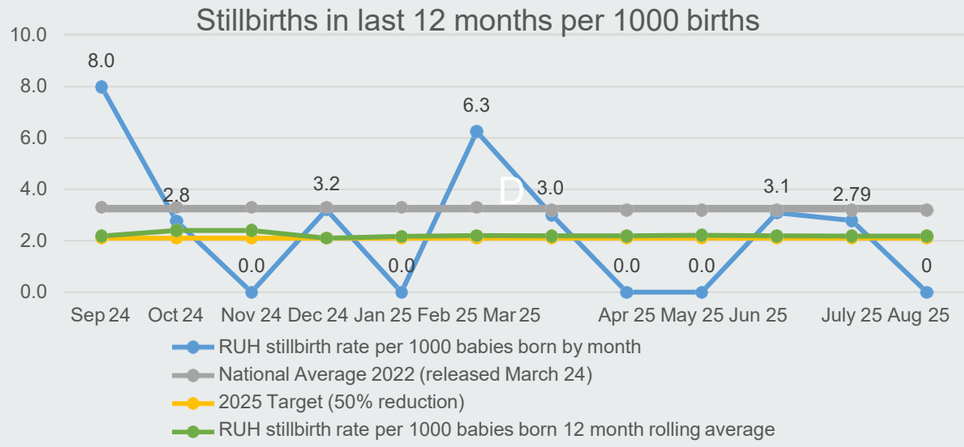
Ongoing Maternity and Neonatal Reviews

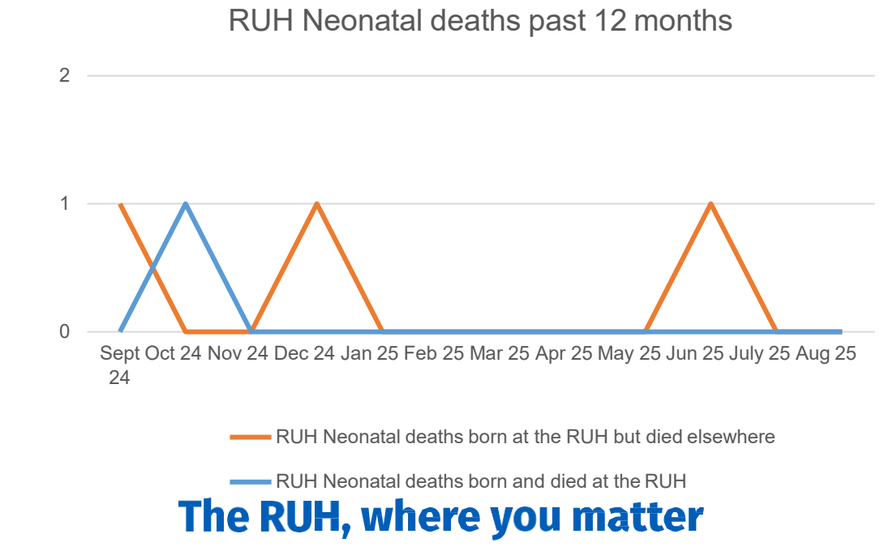
Case Ref	Date	Category	Incident	Outcome/Learning/Actions/ Update of progress	MNSI Ref	PSII Ref
133232	26/09/2024	Unexpected Death	Intrauterine Death at an unknown >37-week gestation in an undiagnosed/concealed pregnancy.	Escalated through governance and safety champions. Datix manager changed. With Associate Director for Patient Safety.	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.		Declared 07/10/24

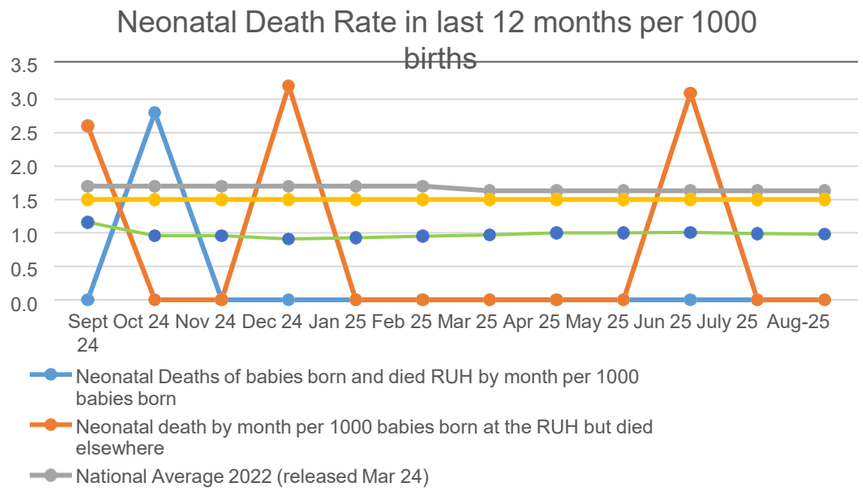
Number of IVH	Nil	**Number of PVL**	Nil
Maternity Safety Support Programme	N/A	**Coroner's regulation 28**	N/A

Safe- Perinatal Mortality Review Tool (PMRT)









The RUH, where you matter

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. Aquarterly 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:

No stillbirths in August 2025

No neonatal deaths in August 2025

Identified learning:

3 PMRT reports were published in August

PMRT grading of care - Key

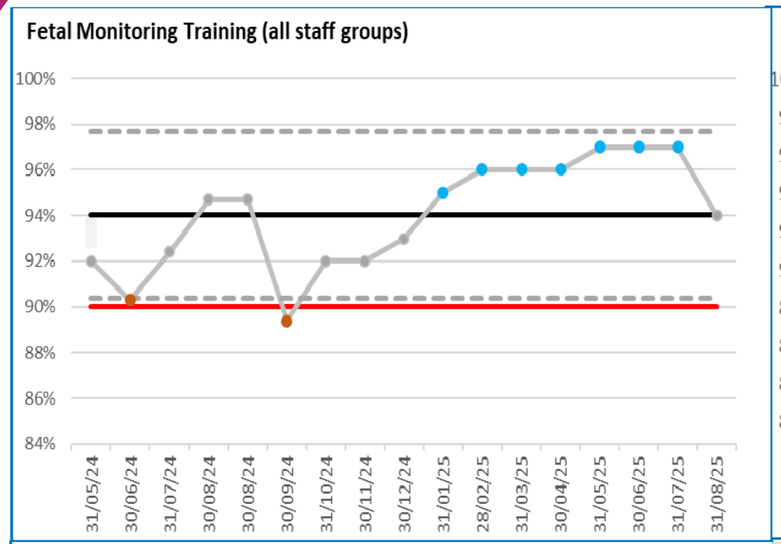
A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby C - The review group identified care issues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

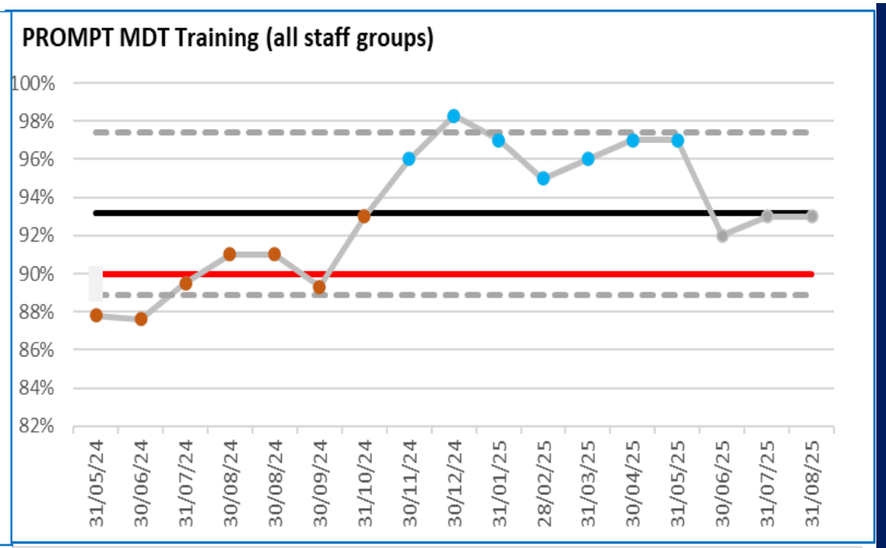
A- The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother
C - The review group identified care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

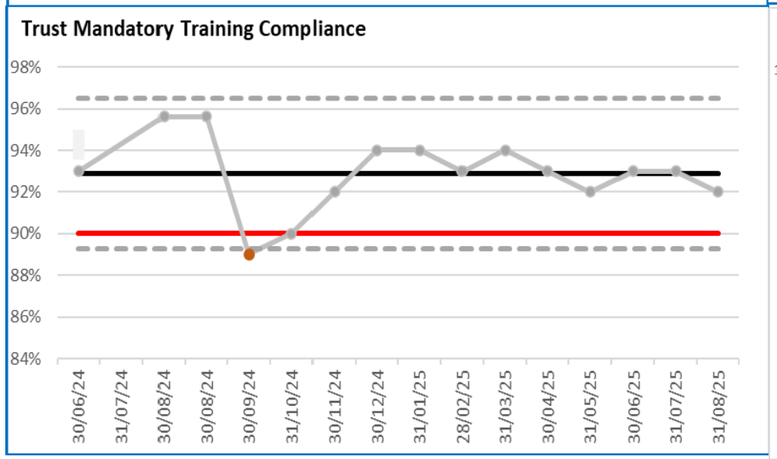
No PMRT grading of care C or D in August

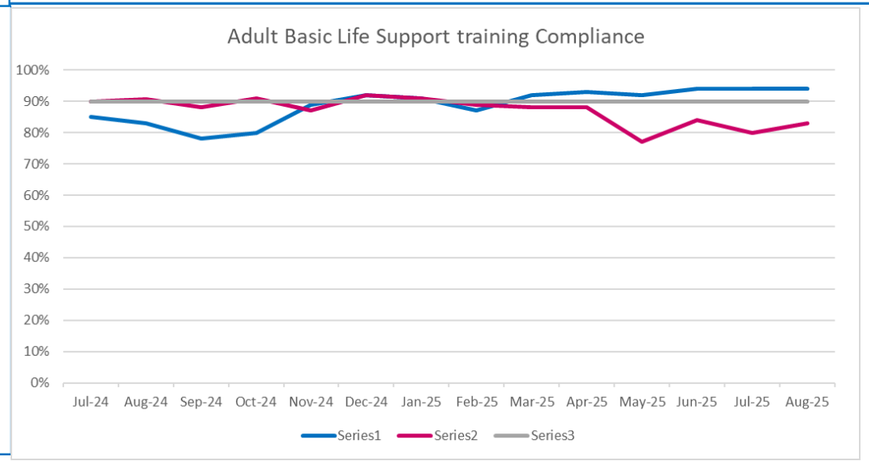
Case Ref	Date	Category	Incident	Outcome/Learning/Actions	MNSI Reference	PSI Reference

Well-led – Training









Training
Compliance data being sent to all 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.

- Adult Basic Life Support (ABLS) managed in specialty moving forwards as part of the PROMPT programme.
- Fetal monitoring 94%
- PROMPT 93%
- Trust mandatory training (MAT/NEO) 92%
- ABLS (MAT/NEO) Increase from 77% to 83% following cancellation due to period of high acuity in May and June

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 impact on compliance within this staff group for both fetal monitoring and PROMPT – see countermeasures
- Clinical activity and acuity impacting staff availability

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:

- Continued compliance with PMRT
- DOC/MNSI/ENS referrals remain 100%
- Continued non-requirement for use of locum Ostetricians
- Planning and agreements in place with LMNS to progress/demonstrate compliance with SA6.
- Q4 SBLv3 evidence submission completed and assessed 84% compliance

Next Steps for Progressions:

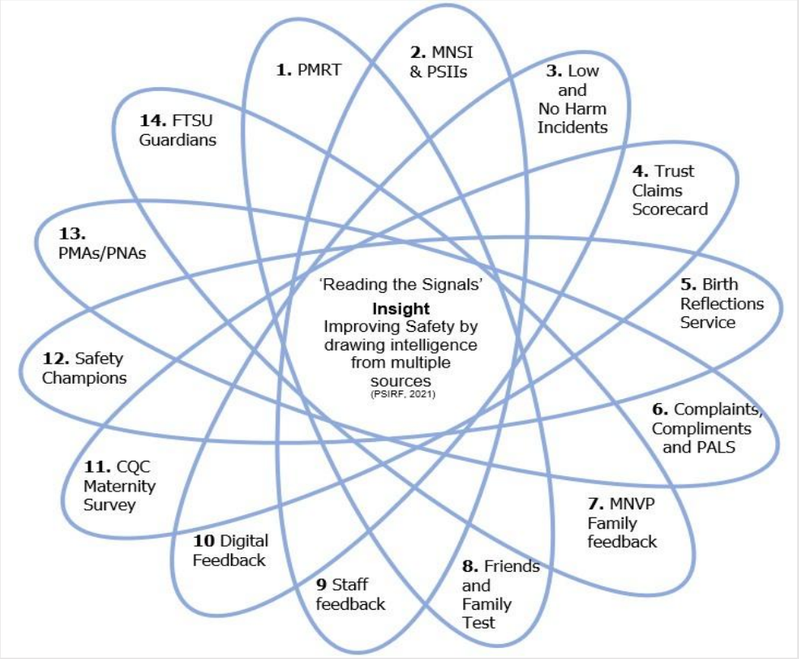
- Bi-monthly Quad leadership meets at safety champions
- Bi-monthly culture slide to continue in safety champions PQST
- MSDS submission data for July 25 ongoing data validation
- MNVP statutory obligation escalation to Trust board, risk register entry
- Training compliance across all staff groups fluctuates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

RISKS:

- Training compliance, impacted by acuity

Responsive

Family Feedback 'Insights' Triangulation Group



Insights and Quality Improvement – Next meeting October 6th

August 25 Themes

- Caring supportive staff
- Information sharing – Antenatal education
- Enhanced comms regarding 'you said we did'
- Improved visibility of feedback opportunities

Safety Champions Staff Feedback

Maternity:

- The embedding of BadgerNet is going well in the community sites although it would be good to get feedback from women about their experience of using the app.
- The new Trowbridge Integrated Care Centre is a couple of days behind building schedule; staff can look around before official opening
- New monthly Perinatal Newsletter has been circulated to all staff
- Newly qualified midwifery/nursing students and anxiety of not being offered employment. SLT will be happy to help and support where concerns raised
- Safety Champion walk around on Mary Ward had positive feedback form 2 cleaners, MCA and 2 B5 midwives (kind staff, positive leadership, improved 'culture'). Updates include break room upgrade with funding from Time is Precious.

Neonates :

- No concerns overall.
- Safety Champions walk around on Mary ward had positive feedback from 2 new F2 doctors.

Maternity and Neonatal Voices Partnership (MNVP)

Key points raised

- Information sharing with parents regarding importance of antenatal education of 'feeding your baby'.
- Breastfeeding support on Mary Ward has been really good.
- Caesarean recovery – more information is needed on what to expect.
- Hello Baby antenatal classes - more information on the practicalities of life with a baby & information regarding postnatal coitus.

- **Next Steps:**
- Improved information sharing during antenatal period.
- Hello baby information review.
- You tube video review for bath baby & birth directory.

Compliments & Complaints July

Formal Compliments	**8**	**PALS Contacts**	**11**
		Formal Complaints	**0**

Friends & Family Survey

Key Achievements:

- 30 pieces of positive feedback
- 2 pieces of feedback with learning opportunities

Identified Areas of Improvements:

- Regular support & analgesia post LSCS on Mary ward

Royal United Hospitals Bath
NHS Foundation Trust

Workforce Report

October 2025
(September Data)

The RUH, where you matter

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	Sep-25	5749.9		<=5629.7	✗	Not in FY			SPC not appropriate
People we work with	Workforce Plan	Substantive WTE	Context	Sep-25	5462.5		<=5360.1	✗	4			SPC not appropriate
People we work with	Workforce Plan	Bank WTE	Context	Sep-25	276.2		<=264.6	✗	Not in FY			Special Cause Improving - Below Lower Control Limit
People we work with	Workforce Plan	Agency WTE	Context	Sep-25	11.2		<=5.0	✗	4			Special Cause Concerning - Two out of Three High
People we work with	Vacancy	Vacancy Rate	Key Standard	Sep-25	-0.44%		<=4.00%	✓	0			SPC not appropriate
People in our community	Pay	Pay Bill % on Agency	Watch	Sep-25	0.38%		<=2.50%	✓	0			Common Cause
People we work with	Turnover & Leavers	In Month Turnover	Key Standard	Sep-25	0.59%		<=0.92%	✓	0			Common Cause
People we work with	Turnover & Leavers	12 Month Turnover	Key Standard	Sep-25	7.31%		<=11.0%	✓	0			Special Cause Improving - Two out of Three Low
People we work with	Turnover & Leavers	Leavers Inside 1st Year	Context	Sep-25	8.60		N/A					

Metric Summary II

Royal United Hospitals Bath
NHS Foundation Trust

Strategic Goal	Measure Group	Measure	Measure Category	Latest Month	Latest Performance	Trend	Target	Target Met	Months Since Last Met	Target Feasibility Assurance	Variation	Variation Detail
People we work with	Sickness Absence	In Month Sickness	Key Standard	Aug-25	5.12%		<=4.42%	✗	3	?		Common Cause
People we work with	Sickness Absence	Short Term Sickness	Context	Aug-25	2.15%		N/A					
People we work with	Sickness Absence	Long Term Sickness	Context	Aug-25	2.96%		N/A					
People we work with	Sickness Absence	12 Month Sickness	Key Standard	Aug-25	4.88%		<=4.70%	✗	9	F	H	Special Cause Concerning - Two out of Three High
People we work with	Sickness Absence	In Month ASD Sickness	Driver	Aug-25	1.35%		TBC			F		Common Cause
People we work with	Appraisal	Appraisal Compliance	Key Standard	Sep-25	77.91%		>=90.0%	✗	Pre-2021	F	L	Special Cause Concerning - Two out of Three Low
People we work with	Appraisal	AfC Appraisal Compliance	Context	Sep-25	78.47%		>=90.0%	✗	Pre-2021	F	L	Special Cause Concerning - Two out of Three Low
People we work with	Appraisal	M&D Appraisal Compliance	Context	Sep-25	71.85%		>=90.0%	✗	Pre-2021	F	L	Special Cause Concerning - Run Below Mean
People we work with	Training	Mandatory Training Compliance (Core)	Key Standard	Sep-25	89.35%		>=85.0%	✓	0	P	H	Special Cause Improving - Two out of Three High

Month

Sep-25

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

Sickness

Royal United Hospitals Bath NHS Foundation Trust

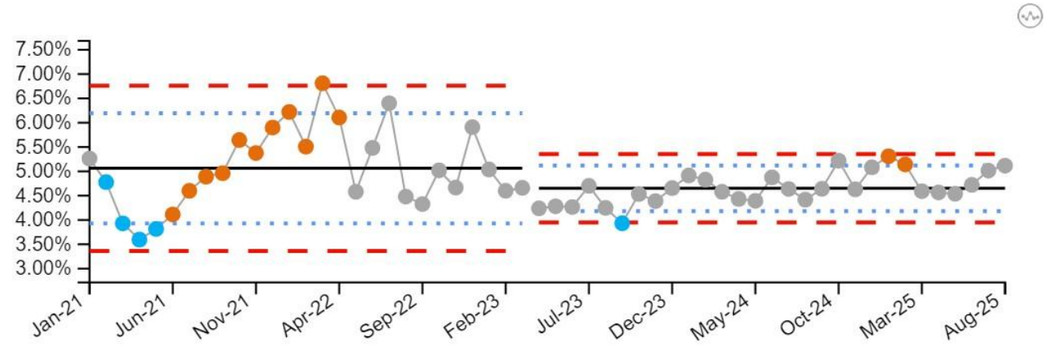
DRIVING

Key Standard

We are driving this metric because

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

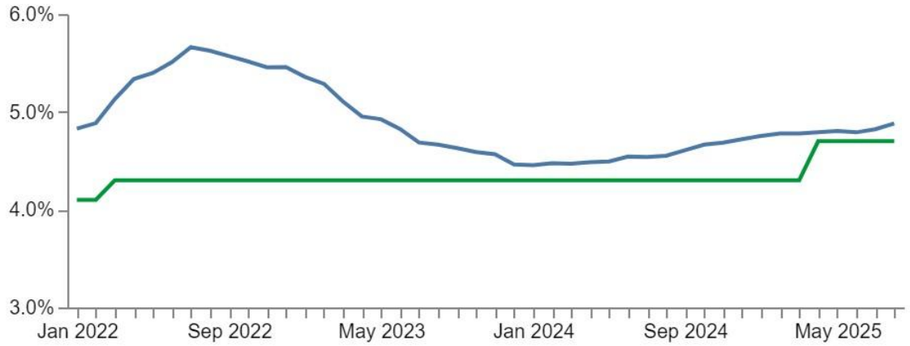
Trust In Month Trend



5.12% Latest In Month Sickness

4.42% Target

Trust 12 Month Trend



4.88% Latest 12 Month Sickness

4.70% Target

Understanding Performance

- The in-month sickness rate of 5.11% recorded in August is significantly higher than the rates recorded for the same month in 2024 (4.41%) and 2023 (4.24%), reflecting that again sickness was unseasonably high.
- Almost 170 FTE days extra were lost in August compared to July, with a c.145 FTE days increase in Anxiety, Stress and Depression sickness.
- At 4.88%, the 12-month sickness rate is the highest it has been in over two years.
- Estates and Facilities has the highest in-month (7.30%). Having previously seen its 12-month rate trending down for some time, this increased in August to 6.42%.
- Corporate Division's in month sickness rate has risen month-on-month since the start of the Financial Year.

Countermeasures	Owner	Due Date
Estates and Facilities: Driver in Estates. Additional Manager Q&A's to support embedding of new sickness policy. Focus on LTS and supporting staff back to work.	DPP – E&F People Hub Manager	Dec 2025
Surgery: have Anxiety, Stress and depression as a Driver linking into ensuring people feel valued at work.	DPP - Surgery	2025/26 driver
Medicine: October 2025 away day with Sisters and Matrons with discussion and actions surrounding violence and aggression and staffing availability – two key drivers to sickness within nursing areas.	DDON and DPP - Medicine	Oct 25
Central: Wholescale review of Staff Wellbeing, reward and recognition approaches for BSW Hospitals Group	ADP Culture Change	April 2026

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

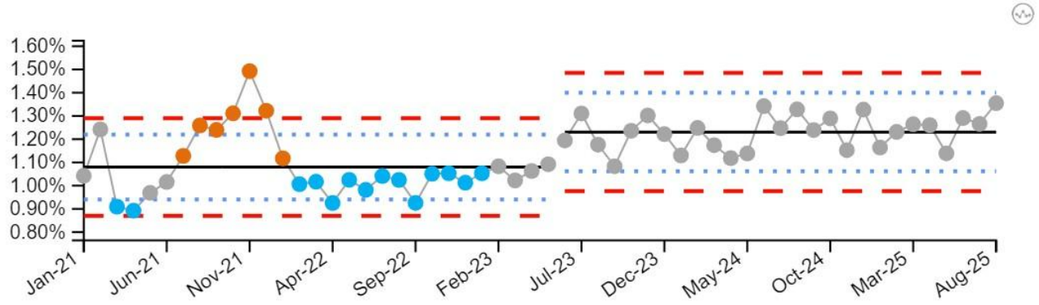
Royal United Hospitals Bath NHS Foundation Trust

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.

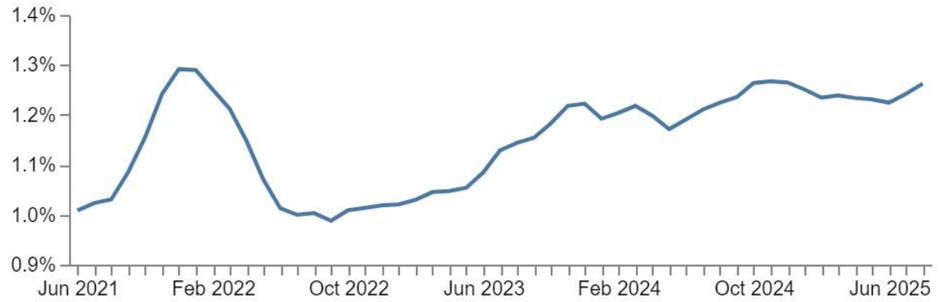
Trust In Month Rate



1.35%

Latest In Month Rate

Trust 6 Month Trend



1.26%

Latest 6 Month Rate

Understanding Performance

- The overall in-month Anxiety, Stress and Depression sickness rate was notably high in August at 1.35%. The 12-month rate remains stubbornly around 1.25%.
- Emergency Medicine Directorate has an in-month rate of 3%, contributing significantly to Medicine Divisions rate of 1.48%.
- Corporate's in-month rate was elevated at 1.58%, having been close to 1% at the start of the Financial Year.
- Surgery deviates from other Divisions, seeing a downward mini trend in recent months and having a comparatively low in month rate of 1.05%.

Countermeasures	Owner	Due Date
People Hub team linking in with divisional teams to ensure all LTS cases are being supported	People Hub Manager	March 26- on trac
Surgery - People hub linking in with those areas who have high sickness absence rate to anxiety, stress to understand themes and develop counter measures	People Hub Manager	December 26
Medicine • Stress/burnout analysis and action planning in areas of high burnout – ED, Haygarth, 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	October 25

Risks and Mitigation

- 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

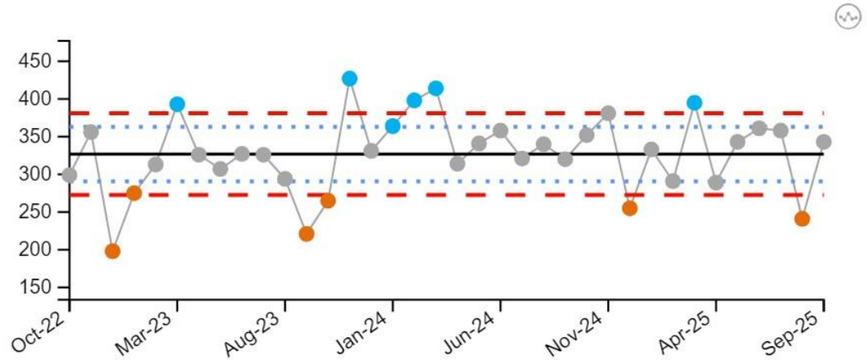
Timely, high-quality appraisals improve performance, engagement and productivity, reducing sickness and burnout. All colleagues should have access to a meaningful programme of interaction with their managers, including an annual appraisal. The organisation has set a 90% compliance target for the annual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

Trust Appraisal Compliance

77.9%
Latest Appraisal Compliance

90.0%
Target

Appraisals Completed in Month



343
Appraisals Completed in Month

Understanding Performance

- Appraisal compliance has fractionally improved to 77.91%, remaining significantly below the 90% target.
- No Division is achieving the target and only R&D are within the 5% tolerance.
- Despite incremental improvement month on month, Corporate continues to have the lowest compliance at 65.43%
- FASS has the second lowest compliance (74.37%) and has been trending down since April.
- Estates and Facilities have also been trending down since the start of the Financial Year, though Medicine's long-term downward trend has ceased.

Countermeasures	Owner	Due Date
Estates and Facilities: A3's being carried out on departments which are failing to hit 90% compliance.	E&F Board/ People Partner	Dec 25
Surgery – HR have sent a list of all those out of date to managers in October asking for recovery plans to be submitted by the end of October which will then be reviewed at speciality performance reviews	DPP - Surgery	October 25
Central: Review of appraisal development, policy and recording process pending release of KPMG 'Appraisal and Wellbeing' Report	ADP – Culture Change	End of 2025/26 Q3
FaSS – Launched a pilot of Group appraisals in Q3 to improve completion and engagement.	DPP – FaSS	Mar 26

Risks and Mitigation

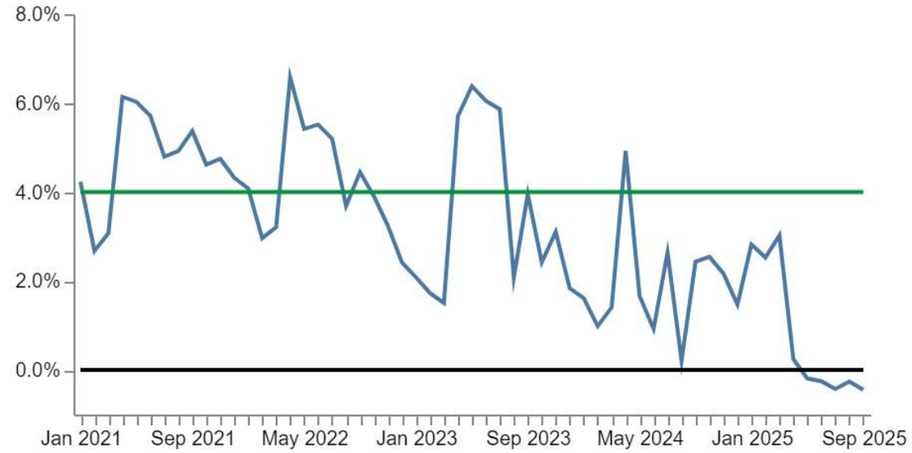
Risk: Too fixed a focus on achieving appraisal compliance risks a dip in the quality of the appraisal conversation.
Mitigation: New one-to-ones and appraisal approach aims to embed a rhythm of purposeful interactions between managers and colleagues, making compliance more attainable.
Priority: Improving 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

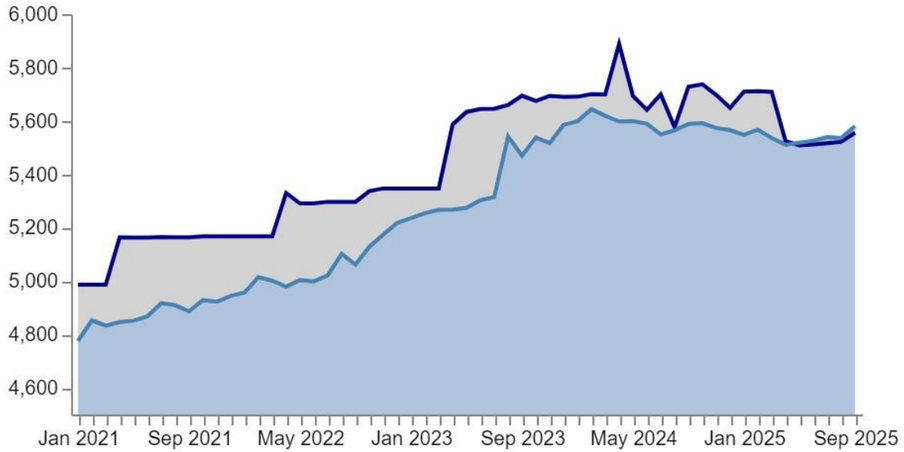
Trust Vacancy Rate



-0.44% Latest Vacancy Rate

4.00% Target

Budget v Contracted



5555.5 Latest Budget

5580.2 Latest Contracted

-24.7 Latest Vacancy

Understanding Performance
Finance data held in Unit 4 indicates the Trust being over-established by 27.4 WTE. This equates to a vacancy rate of -0.44%. The highest vacancies are within Estates and Facilities and primarily cleaning posts accounting for 15.7WTE. The second highest is corporate at 9.7WTE

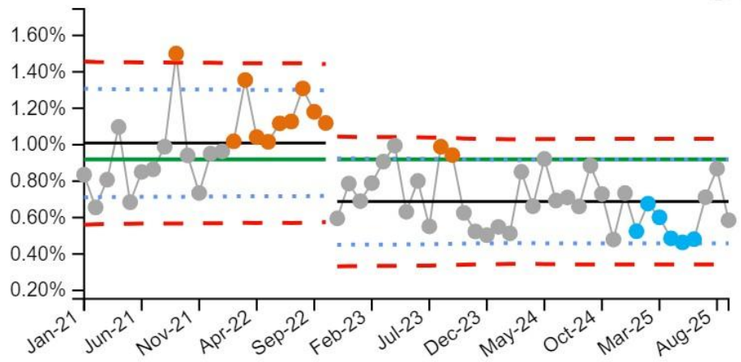
Countermeasures	Owner	Due Date
Trust led Vacancy Control Panel continues to support financial recovery plans.	Executive Team	Open
International Recruitment cohorts eligible for Indefinite Leave to Remain will be supported to help the retention of this diverse workforce. Provision includes legal workshops to assist with application process and hardship funds	AD for Talent & Capacity	Open

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

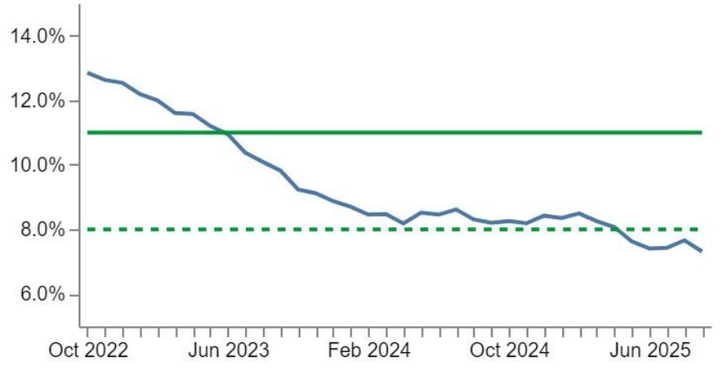
Trust In Month Turnover



0.59% Latest In Month Turnover

0.92% Target

Trust 12 Month Turnover



7.31% 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	1.58%	9.11%
Estates and Facilities Division	0.56%	7.25%
Family and Specialist Service Division	0.57%	8.73%
Medical Division	0.41%	6.40%
Research & Development [Division]	1.97%	9.80%
Surgical Division	0.42%	6.69%

Main Staff Group	In Month	12 Month
Add Prof Scientific and Technic	0.73%	15.69%
Additional Clinical Services	0.69%	9.78%
Administrative and Clerical	1.16%	9.40%
Allied Health Professionals	0.38%	9.76%
Estates and Ancillary	0.68%	7.56%
Healthcare Scientists	0.89%	12.11%
Medical and Dental	0.00%	1.80%
Nursing and Midwifery Registered	0.30%	4.30%

Understanding Performance

- After experiencing slightly higher turnover in August, September's in-month turnover rate of 0.59% represents a return to the recent norm.
- 12-month turnover has also slightly dropped to 7.31%, which may be considered somewhat unhealthy.
- All main Divisions have 12-month turnover rates below 10%.
- Despite overall rate of turnover being below target, People Partners continue to monitor variation across staff groups or specialities and take actions to improve retention in specific areas as needed.

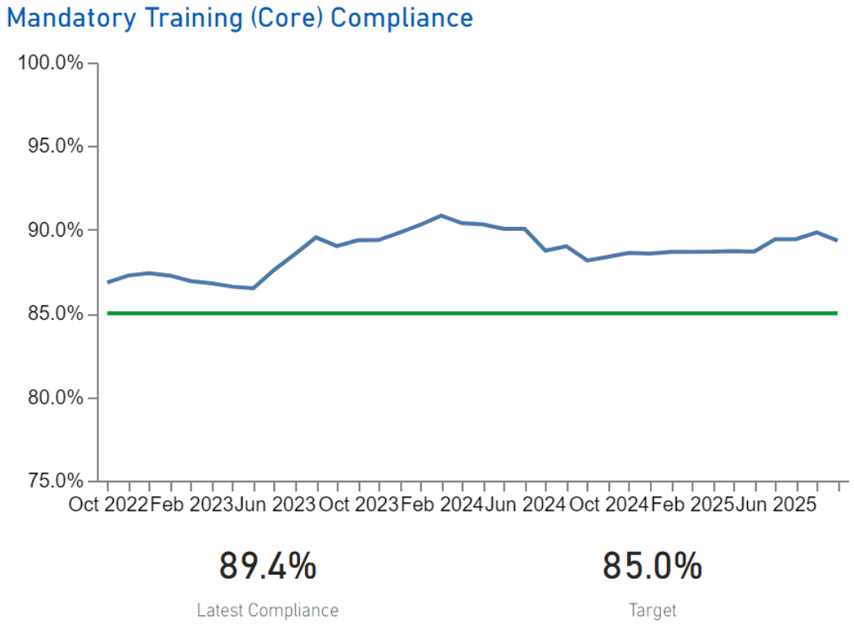
Countermeasures	Owner	Due Date
No counter measures in place due to 12-month turnover below target.		

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
• Mandatory Training compliance has fallen by half a percentage point to 89.35% but remains comfortably above the 85% target. • All main Divisions continue to better the target. •As has been the case for some time, the three resuscitation subjects, the two Level 3 safeguarding subjects and Moving and Handling Level 2 are the courses where compliance is below target.

Countermeasures	Owner	Due Date
Subjects proposed to move from annual to two yearly following review by MLOG – to be reviewed by Improvement and Insight committee (will impact on compliance levels)	Head of Corp Education	November 2025
All Mandatory training being reviews as per NHS E National programme, to ensure outcome focused rather than compliance. Ensuring best use of clinical time	Head of Corp Education	On-going
Review as group, to learn and understand efficiencies.	Head of Corp Education	November 18th 2025

Risks and Mitigation

Trust
Risk ID2791 Resus staffing, vacancies and sickness. Team have been delivering to a compliance of 50%.

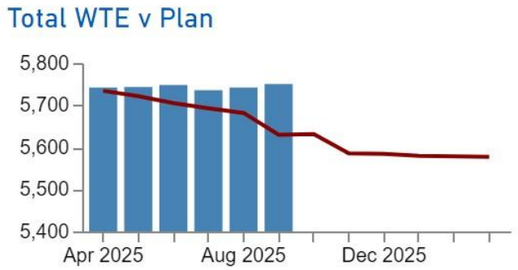
Mitigations:
- 2.0 wte recruited and started in July 2025
- Resus risk established as PRM Driver Measure
- Group level scoping ongoing to mitigate short term risks and seek sustainable long-term solution.

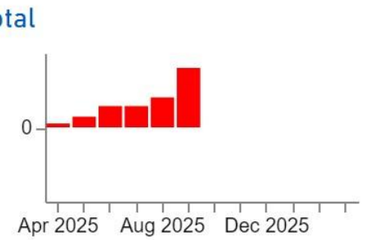
Performance vs Workforce Plan

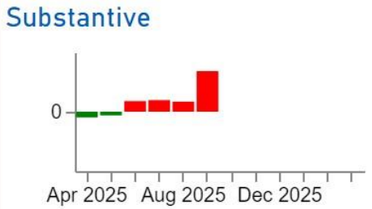
Royal United Hospitals Bath NHS Foundation Trust

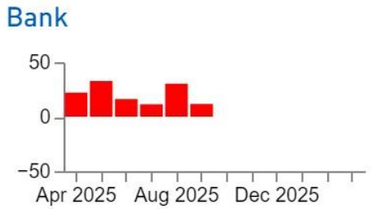
Driver

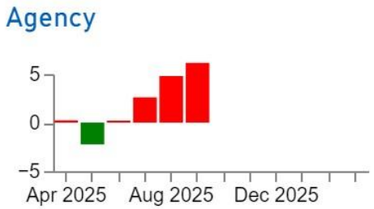
We are driving this metric because: Achieving the Workforce Plan will be a key factor in achieving the financial savings required. Affording regular attention to progress against the plan will enable more timely intervention should deviation become apparent











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	5,741.74	5,749.86						
Substantive	5,408.81	5,409.60	5,436.89	5,428.87	5,427.04	5,462.50						
Bank	326.67	329.39	304.82	297.91	303.90	276.21						
Agency	6.23	3.76	6.20	8.60	10.80	11.15						

Understanding Performance

- At the end of September, the Trust was c.120 WTE above its planned position as actual WTE use in month increased.
- Substantive WTE exceeds plan by c.102 WTE – a significant increase on the month before. This reflects that contrary to the planned reduction of c.40WTE, numbers grew by c.35 WTE. Any growth in the context of trying to reduce numbers is a concern, but the fact that this has occurred in the substantive numbers is arguably more problematic given the relative ease of reducing that number. Additionally, when the plan calls for a further c.40 WTE reduction in substantive numbers in November, growth at this stage makes getting back on the planned course even more challenging.
- Bank use reduced in September; however, the plan for bank again continues to be missed.
- Agency use is more than double its ambitious target and there is little evidence current that the planned limit of 5 WTE will be consistently met

Countermeasures	Owner	Due Date
Increased scrutiny over the growth in wte via the executive team	Executive team	On-going
Changes in the VCARP process, including monitoring bank usage in month against the workforce plan		On-going (first time will be Tuesday 29th)
Revised workforce recovery plan has been developed and signed off to redistribute how the RUH will reach its financial pay saving target	Trust-wide	Complete
Fully calculating the 25/26 target by Division, Speciality & WorkGroup – report this to VCARP Exec Team each week to guide decision-making & dynamic risk assessment; and monthly reporting via PRMS.	Finance, Workforce, Exec Team	TBC

Risks and Mitigation

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

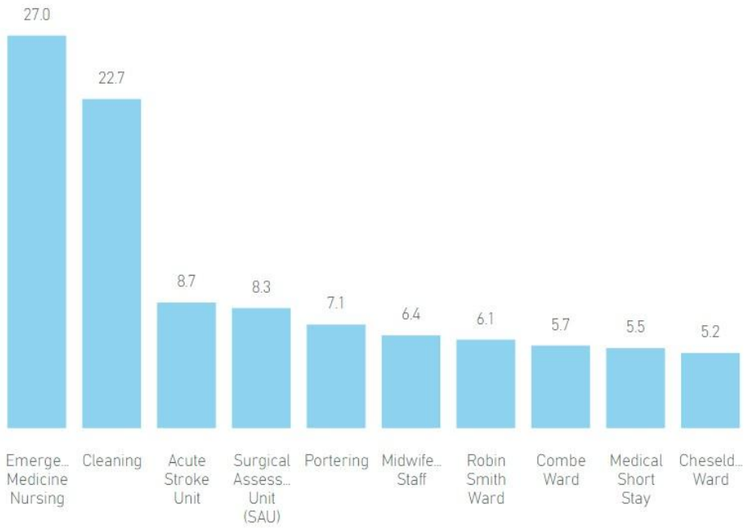
Mitigation
Recovery Plan has been developed to redistribute where and when the wte and pay reductions will take place

Bank & Agency Use

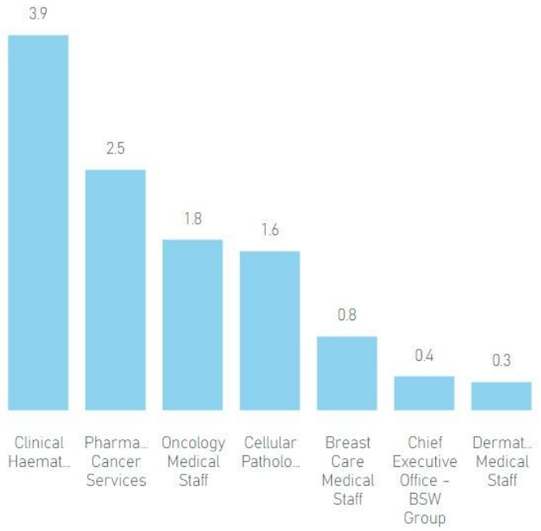
Royal United Hospitals Bath NHS Foundation Trust

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	13.3	8.3
Registered/ Qualified Scientific, Therapeutic and Technical staff	11.4	2.5
NHS Infrastructure support	54.2	0.4
Registered Nursing, Midwifery and Health Visiting Staff	89.4	0.0
Support to Clinical Staff	107.9	

Understanding Performance

- Bank use reduced in September, primarily driven by a reduction in use by the Registered Nursing and Midwifery and Support to Nursing staff groups.
- Despite having its lowest in month bank use in the Financial Year to date, Emergency Medicine Nursing continues to use bank the most.
- Cleaning is the next highest user of bank, with its use continuing to persist around the 22-24 WTE mark as it has for much of the Financial Year.
- Agency use remains primarily driven by the need to cover hard to fill Medical and Dental roles.

Countermeasures	Owner	Due Date
ED recruitment campaigns in place and trajectory set to reduce use of bank based on recruitment pipeline. The Recruitment team are prioritising onboarding new joiners to support service delivery.	Head of Talent	Nov 25
Recruitment Team actively participating in community Career events alongside roadshows to local Job Centre and hosting open days in the Career Zone within the hospital to attract and recruit to vacant posts.	Head of Talent	Open
Temporary Staffing Team continues to try and source best value provision for hard to fill Medical and Dental roles whilst working with suppliers to ratchet down rates to reach compliance with South West Agency rate card	Temporary Staffing Team	Open
Oncology Consultant recruitment campaign secured 3 Consultants. Two will onboard during Q3 and 1 in Q4	Head of Talent	Q4

Risks and Mitigation

Risk: Locum Oncology Medical Consultants are the top contributor for agency spend.

Mitigation: Recruited **3** Oncology Consultants with start dates ranging from October 2025 to February 2026 supporting our exit strategy. Further work on capacity and demand via business planning.

Month

Sep-25

Royal United Hospitals Bath
NHS Foundation Trust

Finance Report

October 2025
(September data)

The RUH, where you matter

Executive Summary

The RUH Group is £12.796m adverse to plan at the end of September, of which £12.997m arising in RUH Trust and £0.108m in Sulis. This is significantly adverse to plan and has triggered regulatory intervention, immediate enhanced expenditure controls & a Call to Action across the organisation. The Trust is subject to Finance Override in National Oversight Framework (NOF) and taken together with UEC and Elective performance delivery places the Trust is Level 4.

The key driver is £10.5m variance arising from under delivery of the £29.7m savings programme and acceleration of delivery plan and scoping of further areas to close the unidentified gap must be top priorities for the organisation. £12.2m remains unidentified at his time and there are delivery risks within planned schemes. £1.6m arises from UEC savings where demand growth and higher than planned NCTR are the key contributors.

Operational budget pressures have reduced in the month, however cumulative pressures arise from increased spend on high cost drugs and devices (£0.6m), Pay Award (£0.3m) Resident Doctors budget pressures (£0.9m), and Resident Doctor Strike (£0.3m). This is partly offset by increased cost controls and non-recurrent benefits (£1.7m) and reduced utility costs (£0.55m). Sulis is adverse to plan by £0.1m. This is principally driven by under performance on CDC activity based income. Further adverse variances arise from deterioration in the exit run rate from 24/25 (£3.0m)

Cash balances for the Trust are £30.5m, this includes cash received in advance. Robust cashflow forecasts have been undertaken which show cash balances reducing to £12.5m by April on a do nothing scenario and c£19m in line with Recovery trajectory. £19m is judged to be the minimum working cash limit to enable contractual obligations to be met in time.

For June 2025 the Trust had an implied productivity improvement of 2.8% against the breakthrough objective of 6.7%. Cost weighted activity grew by 6% compared to inflation adjusted cost growth of 3.1%. Given that some of the activity growth is in non-elective activity we do not see a direct financial benefit from this productivity.

The RUH Group underlying deficit has been re-assessed at £47.2m, to align with 25/26 Recovery Actions; and becomes the baseline for 26/27 planning.

The Trust operates within BSW Integrated Care System which has reported a £23.3m adverse variance to plan year to date, of which BSW Hospitals Group is £31.6m adverse to plan, partially offset by ICB favourable variance to plan of £8.3m.

The ICS is still being challenged to deliver a breakeven plan for the year, the initial stage is for RUH to deliver a £17m deficit, Even this position would still leave a £10m gap to be closed through further actions across the ICS.

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
NHSf.Oundation Trust

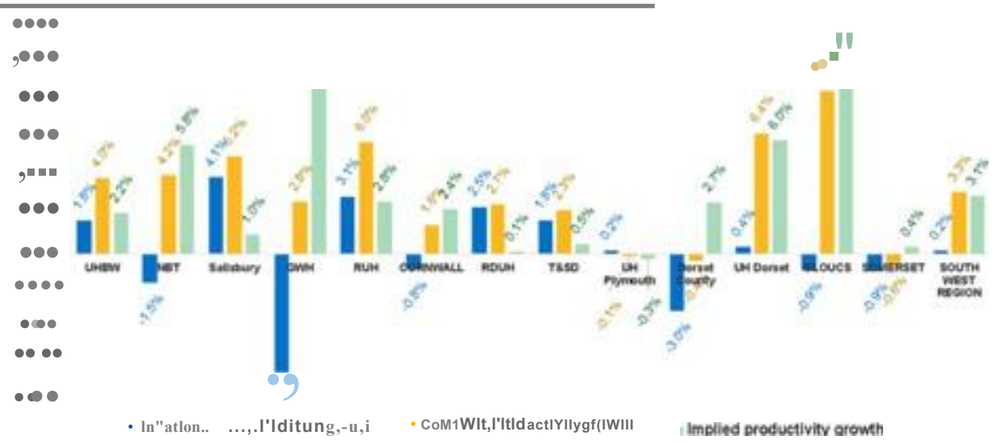
We are driving this metric be<;ause...

Performance Target:ImproveImplied Productivity by 6.7%compared to 24125

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 withCentral Government. NHSE have developed* a *metric 'Change in Implied Productivity·that enables benchmarl<ing against other NHS* ***organlsations***
Productivity is a *helpful metric to consider* changes *in activity and demand and alongside changes in* costs *and budgetary performance, particularly in* a *financial framewor*l *where income isn'*l *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.*

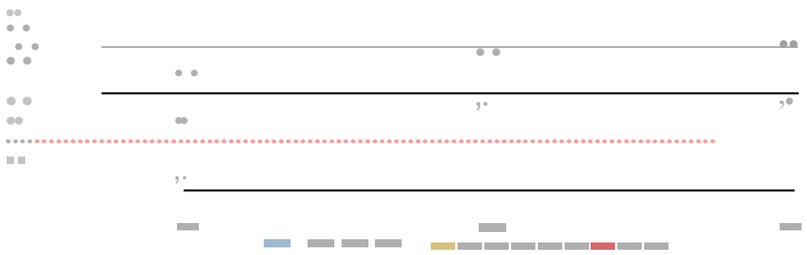
	24125 Comparison, unadjusted			Movement from M2, unadjusted		
M3 2025/26	Inflation adj. expenditure growth	Cost weighted activity growth	Implied productivity growth	Inflation adj. expenditure growth	Cost weighted activity growth	Implied productivity growth
RUH	3.1%	6.0%	**2.8%**	0.7%	0.7%	0.0%
BSW	0.0%	4.7%	**4.7%**	0.6%	·0.6%	·1.2%

Data are published by NHS England several months behind, M3 is the latest available figure.



Understanding Performance

Data for June 25 show an implied productivity growth of 2.8% compared to M3 24125, this ranks as the fifth largest productivity increase in the South-West Region (of 13 providers.) This is driven by cost weighted activity growth of 6.0% with an inflation adjusted expenditure growth or 3.1%. Compared to M2 25/26 implied productivity was unchanged. Cost weighted activity increased by 0.7% 1De-velopmehc-tb_eba_sdeonrea_l-1-ande pen diture increased by 0.7%.



Countermeasures	Owner	Due Date	Risks and Mitigation
Delivery of Productivity improvements andcash releasni g savings target set out in Operationla Plan for 25/26	Savings programme SRO	Ongoing	• Ensure understanding of the metric and calculations
De-velopmehc-tb_eba_sdeonrea_l-1-time data Develop metric to be calculated at Divisionlevel	H-e_da of Financial Projects	-1-0ng_oin_g	-1- The c_otisg-tea_mh-av_e_____ -t developed a productivity calculation one month in arrears for the whole trust and by division. This is currently being tested to ensure reliability and understanding prior to being used for reporting.	• If Productivity improvemen ts are not sufficienUycash re leasing this could lead to achieveme ort he metric but failure to delivery financial performance targets
Establish singleKPI for each Specialtyto focus on during 25/26	**Divisional/** Speciatty Tris	Ongoing	

Underlying Financial Position (BAF Reference)

Royal United Hospitals Bath NHS Foundation Trust

I&E to July 2025	Annual Budget RUH Budget £'m	Forecast RUH Forecast £'m
Income	565.156	565.156
Pay	(353.922)	(364.078)
Non Pay	(166.740)	(174.133)
Finance Charges	(46.500)	(46.500)
EBITDA	**(2.005)**	**(19.555)**
Donated/Grant Income	(1.955)	(1.955)
Adjusted Financial Performance	**(0.050)**	**(17.600)**
Transitional Funding	(19.200)	(19.200)
Technical Adjustments	(4.800)	(4.800)
Non-Recurrent Benefits		(5.625)
Underlying Financial Performance	**(24.050)**	**(47.225)**

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
- 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, £12.0m

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.

<u>Update to latest Recovery Plan</u>

An initial update to reflect the latest 25/26 financial recovery plan has been undertaken, based on a scenario with a £17.6m in year deficit. Taken together, with the non-recurrent transitional funding and technical adjustments as well as non-recurrent elements of the recovery plan would suggest an underlying deficit of £47.2m heading into 26/27.

Income & Expenditure Year to Date (NHSE Performance)

Royal United Hospitals Bath NHS Foundation Trust

I&E to August 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	245.684	244.763	(0.921)	14.776	14.587	(0.189)	0.000	0.000	0.000	260.460	259.350	(1.110)
Clinical Education Income	9.926	9.251	(0.675)	0.000	0.000	0.000	0.000	0.000	0.000	9.926	9.251	(0.675)
Other Income	25.891	24.752	(1.139)	11.629	11.223	(0.406)	(1.997)	(1.722)	0.275	35.523	34.254	(1.270)
Pay	(176.964)	(183.439)	(6.475)	(12.209)	(12.642)	(0.433)	0.000	0.000	0.000	(189.172)	(196.081)	(6.909)
Non Pay	(82.064)	(90.625)	(8.560)	(12.167)	(11.274)	0.893	0.395	0.500	0.104	(93.836)	(101.399)	(7.563)
EBITDA	**22.473**	**4.702**	**(17.771)**	**2.029**	**1.894**	**(0.136)**	**(1.602)**	**(1.222)**	**0.379**	**22.901**	**5.374**	**(17.527)**
Depreciation & Amortisation	(11.753)	(11.614)	0.139	(1.640)	(1.613)	0.028	1.090	0.887	(0.204)	(12.303)	(12.340)	(0.037)
Impairments	(13.621)	(13.482)	0.139	0.000	0.000	0.000	0.000	0.000	0.000	(13.621)	(13.482)	0.139
Net Finance Charges	(4.686)	(4.528)	0.158	(0.271)	(0.270)	0.000	0.192	0.165	(0.027)	(4.765)	(4.634)	0.131
Surplus/(Deficit)	**(7.588)**	**(24.923)**	**(17.335)**	**0.119**	**0.011**	**(0.108)**	**(0.319)**	**(0.171)**	**0.148**	**(7.788)**	**(25.083)**	**(17.295)**
Donated/Grant Income	(7.788)	(12.126)	(4.338)	0.000	0.000	0.000	0.000	0.000	0.000	(7.788)	(12.126)	(4.338)
Adjusted Financial Performance	**0.201**	**(12.796)**	**(12.997)**	**0.119**	**0.011**	**(0.108)**	**(0.319)**	**(0.171)**	**0.148**	**0.000**	**(12.956)**	**(12.956)**

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 £13.0m. This is resulting from delays to delivery against the savings programme (£10.5m), deterioration in the exit run rate (£3.0m), and operational pressures arising from increased spend on high cost drugs and devices (£0.6m), Resident Doctors budget pressures (£0.9m), pressures from pay awards (£0.3m) and July Strike Costs (£0.25m). This is partly offset by increased cost controls (£2.7m) and utilities underspends of (£0.6m).

Sulis is adverse to plan by £0.1m. CDC continues to make a loss with activity 80% of budget.

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	On-going
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. **New target set at £1.5m surplus.**	System Delivery Director for Planned Care and Sulis Director	On-going
Minimising cost pressures arising from Winter Pressures and impact of Tiering Recovery Plans for Elective and Urgent Care	Chief Operating Officer	On-going
Delivery of activity based income and productivity margin on RTT Investment	Divisional Tris	On-going
Reducing bank spend across all staff groups, by 91wte compared to current usage	Divisional Tris & Corporate Departments	On-going

Key Drivers

NHS
Bath and North East Somerset,
Swindon and Wiltshire
Integrated Care Board

	GWH	RUH	SFT	Group	ICB	System
	£'m	£'m	£'m	£'m	£'m	£'m
M6 YTD Variance	**(10.1)**	**(13.0)**	**(12.4)**	**(35.5)**	**10.0**	**(25.5)**
Driven by:						
Deficit support funding	(4.8)		(6.9)	(11.7)		(11.7)
Efficiency schemes	(7.0)	(10.5)	(3.9)	(21.4)	8.0	(13.4)
Pay / Workforce	(4.2)	(1.6)		(5.7)		(5.7)
Income/activity	3.9		(1.0)	3.0		3.0
Drugs	(0.4)		(0.5)	(1.0)	1.5	0.5
Sulis / Subsidiary		(0.1)		(0.1)		(0.1)
PY Outturn impact		(2.5)		(2.5)		(2.5)
Other items	2.4	1.6	(0.1)	4.0	0.5	4.5

Main drivers of the M6 YTD variance:

- Loss of £11.7m deficit support funding
- Group CIP under-delivery & unidentified/non delivery £21.4m
- Pay/Workforce drivers £5.7m
- Group drugs adverse variance of £1m

Income & Expenditure – Forecast and route to £17m

Royal United Hospitals Bath NHS Foundation Trust

In Month 5 the Trust has identified a route to £23.25m year end deficit against a straight-line forecast of £28.2m. The required recovery forecast includes an addition £4m of savings that are unidentified. The bulk of this improvement is through delivering the savings programmes.

Further work has been done against the target to achieve £17m.The cumulative position is shown in the “Run rate vs £17m Target” graph with the monthly position for the other graphs.

Income will deliver above the run rate through increased activity to deliver RTT performance improvements and to fund the Increased costs of High Cost Drugs and Devices.

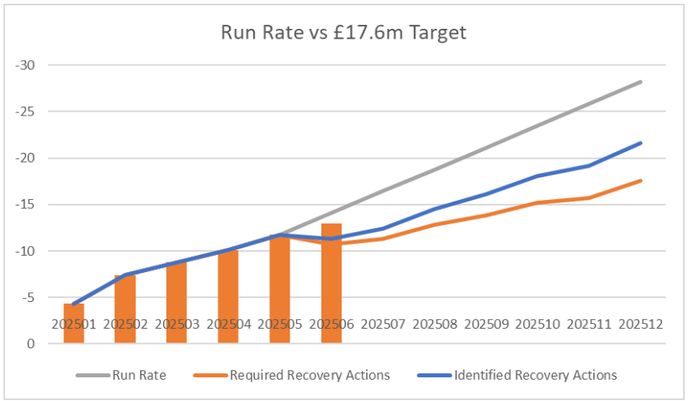
Non-Pay costs are above run rate. This relates to increased utility costs over colder months, increased insourcing to deliver RTT performance improvements and increased High Cost Drug and Devices.

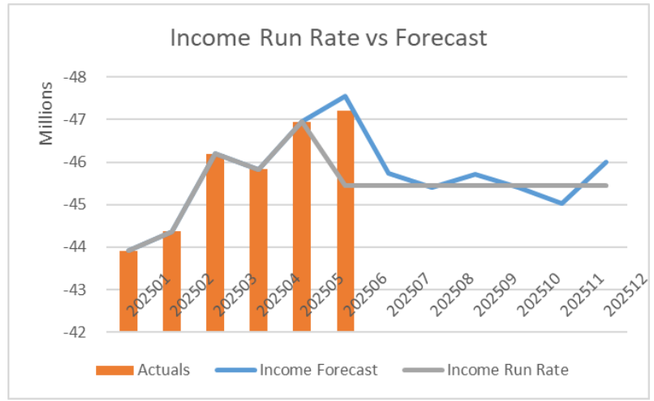
Pay shows the most notable requirement for increased savings, reducing the run rate through temporary staffing reductions and further redesign of services to reduce costs. The improvement has been phased across to increase by £0.2m per month.

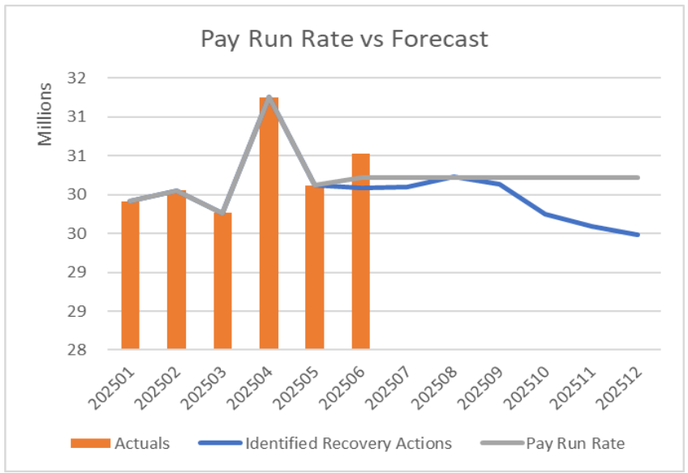
As well as sustaining pay and non pay controls. The key contributors of financial recovery are:

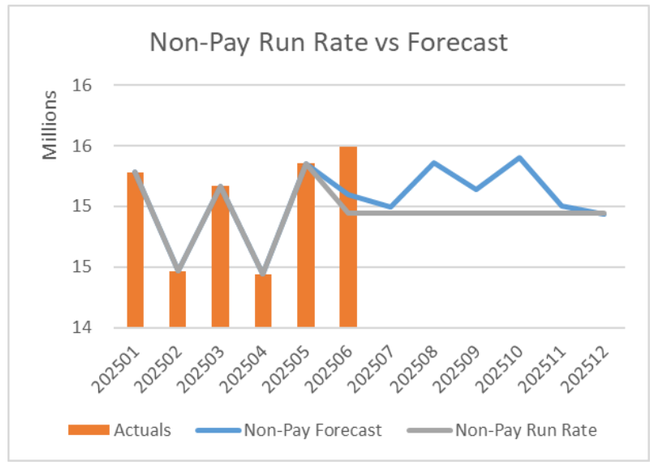
- £2.6m Workforce - Reduction in bank expenditure across all staff groups
- £1.5m Elective & Outpatient Productivity at RUH and Sulis
- £0.5m UEC and Outpatient Delivery Group Savings
- £2.8m Continuous Improvement in Central Delivery Group Savings such as Procurement, Non Pay and Stock controls, Medicines Optimisation and Private Patient & Commercial Income

- Minimise additional spending ensuring the Winter period, and arising from any requirements to exit UEC and Elective tiering
- £1m Review of Capital Charges and other balance sheet movements
- £2m ICB support to reduce expenditure on high cost drugs

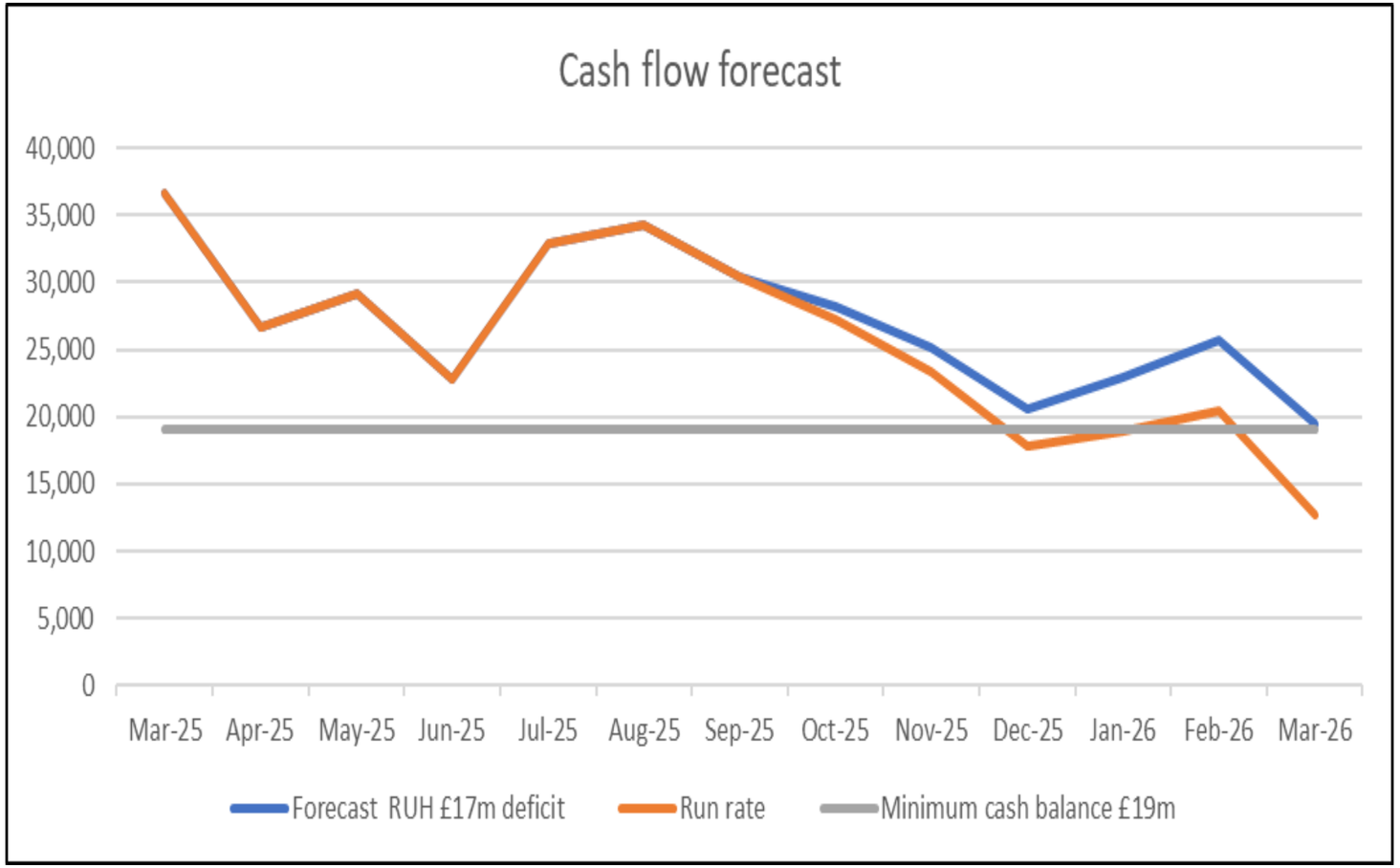








Income & Expenditure – Forecast cash flow



The blue line represent the forecast of £17m deficit (£19.5m deficit RUH and £1.5m surplus Sulis).

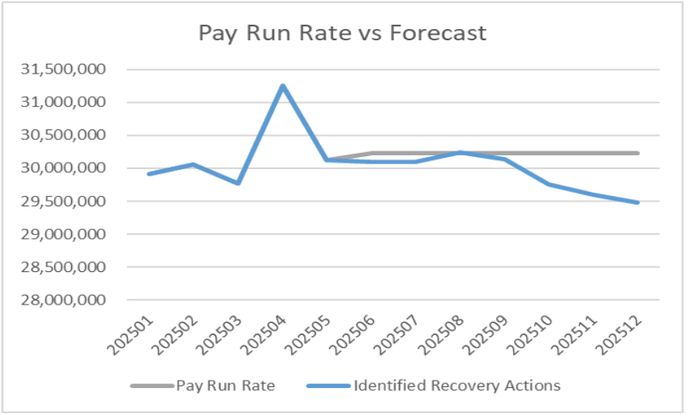
The orange line represents the run rate forecast, this is made up of actual cash flow to date and assumes these savings year to date continue at the same rate.

The grey line is the minimum cash balance required for the Trust.

Income & Expenditure – Forecast WTE trajectory

Royal United Hospitals Bath NHS Foundation Trust

The key Workforce Recovery Actions to support the Pay forecast are set out below:



Recovery Plan additional actions

This plan includes the following additional actions taken.

- Nursing, Midwifery & AHP – further 20wte reduction in bank by M12. Achievement of 180 by M5 (original target for M12). EQIAs complete. Risks remain regarding potential NMC industrial action and winter planning.
- Estates & Facilities – bank reduction plan in place to reduce by 21.9wte from 8% of workforce to 2.7%. Additional actions being taken include recruitment into unfilled cleaning positions, reduction in length of bank shifts advertised, do not backfill first instance of sickness where appropriate
- Medical – deliver against workforce plan with further work ongoing to reduce WLIs (see next slide).
- Clinical admin – additional actions include buddying models across appointment centre and specialities to increase cross cover and reduce requests and assessing any role functions that could be centralised e.g. uncashed appointments or validation
- Corporate - Covid Mass Vaccination Stopping, resulting in a reduction of 2.5wte 31st August
- A further reduction of 61wte of bank staff would be required to be delivered to support a further cost reduction of £2.2m to support the achievement of the £10m deficit

Tables below show the total WTE trajectory and specific Bank WTE trajectory by Staff Group

	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Original Workforce Plan	5730.5	5733.9	5721.4	5704.9	5692.4	5681.4	5629.7	5631.3	5585.3	5584.3	5579.3	5578.3	5577.3
Revised Workforce Plan (Recovery)	5747.8	5739.6	5740.4	5745.2	5732.0	5738.4	5668.6	5660.9	5639.5	5621.7	5610.2	5601.2	5579.6
OWFP vs RWFP	17.3	5.7	19.0	40.3	39.6	57.0	38.9	29.6	54.2	37.4	30.9	22.9	2.3
WTE savings vs previous month		-8.2	0.8	5.6	-14.1	6.4	-69.8	-7.7	-21.4	-17.8	-11.5	-9.0	-21.6
Financial savings in month		134,750.00	134,750.00	134,750.00	134,750.00	232,000.00	156,794.11	39,326.21	109,296.22	90,909.94	58,733.95	45,965.70	110,317.68
In month Total throughout year		1,617,000.00	1,482,250.00	1,347,500.00	1,212,750.00	1,856,000.00	1,097,558.77	235,957.26	546,481.10	363,639.76	176,201.85	91,931.40	110,317.68

	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Bank Total	307.5	324.5	327	302.9	294.5	300.5	249.1	245.2	243.7	242.1	234.6	233	215.5
Medical and Dental	22.6	19.4	19.6	18.6	21.7	21.1	20.1	19.2	18.4	17.6	16.8	15.9	15.1
Registered nursing, midwifery and health visiting staff	101.3	114	109.4	97.2	90.4	94	79	79	79	79	79	79	74
Registered scientific, therapeutic and technical staff	12.5	12.8	13.8	14	13.6	13.3	12.2	11.5	10.8	10	9.3	8.6	7.9
Support to clinical staff	114.4	120.9	123.7	114.5	111.9	118	91	91	91	91	91	91	86
Total NHS infrastructure support	56.7	57.4	60.5	58.6	56.9	53.9	46.8	44.5	44.5	44.5	38.5	38.5	32.5

Income & Expenditure – Risks & Mitigations

Royal United Hospitals Bath NHS Foundation Trust

The Risk and Mitigation log has been re-structured and re-calibrated to align with £17m forecast outturn, there many risks previously reported in previous months have now been crystallised in the Forecast Outturn.

Risk	Value £000	Mitigation	Value of Mitigation £000	Unmitigated Risk £000
ICB High Cost Drugs and Devices	2,000	Reduced demand	1,100	900
Pay Award unfunded on Transitional Funding	500	Other income sources	250	250
Specialised Commissioing Data Contract Challenges	2,000	Contract negotiation	2,000	0
Recovery Actions Delivery Risk	2,500	Call to Action and Further, Faster	0	2,500
Winter Pressures higher than planned	800		0	800
Auditor Balance Sheet assurance	2,500	Annual Leave planning	800	1,700
TOTAL	**10,300**		**4,150**	**6,150**

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 further regulatory intervention from NHSE

Income & Expenditure – Detailed Risk & Mitigation Log up to Month 5

Royal United Hospitals Bath NHS Foundation Trust

Provider	Summary	Description	Plan Submision - FPC Feb	Draft Operating Plan submissi	Final Pla	Month 1	Month 2	Month 3	FRP 31 July 25	Month 4	Month 5	Change from Final Plan	Change from latest Month	Change from FRP
			£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
		Risks												
RUH	Exit Run Rate	Exit Run Rate & Plan Risks	(3.000)	(3.000)	(2.500)	(6.000)	(6.000)	(6.000)	(6.000)	(6.000)	(6.000)	(3.500)	0.000	0.000
RUH	Savings	Group Savings - unidentified	0.000	(4.400)	(4.400)	(4.400)	(4.400)	(4.400)	(4.400)	(4.400)	(4.400)	0.000	0.000	0.000
RUH	Savings	Trust Savings - unidentified	(4.600)	(4.000)	(5.500)	(5.500)	(4.715)	(3.100)	(3.200)	(6.948)	(8.100)	(1.448)	(1.152)	(4.900)
RUH	Savings	Trust Savings - Delivery Maturity Status	(10.000)	(12.200)	(16.000)	(16.000)	(11.127)	(11.084)	(10.400)	(7.691)	(3.000)	8.309	4.691	7.400
RUH	Savings	Costs of Change	0.000	0.000	(1.500)	(1.500)	(1.500)	(1.845)	(1.845)	(1.845)	0.000	(0.345)	1.845	1.845
RUH	Budget management	Demand growth - Urgent Care demand	(10.000)	(10.000)	0.000	(1.200)	(1.200)	0.000	0.000	0.000	0.000	0.000	0.000	0.000
RUH	Budget management	Benefits of Constitutional Standards Business Cases not delivered	0.000	0.000	0.000	0.000	0.000	(0.500)	(0.500)	(0.500)	(0.500)	(0.500)	0.000	0.000
RUH	Budget management	Operational pressures incl Vacancy Factor & Winter	0.000	0.000	0.000	0.000	(1.600)	(1.000)	0.000	0.000	(0.800)	0.000	(0.800)	(0.800)
RUH	Technical or Funding	Tiering Recovery Plans incl Validation & Management Support	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	(0.500)	0.000	(0.500)	(0.500)
RUH	Technical or Funding	Revenue impact of reduced cash balances	0.000	0.000	0.000	0.000	(1.000)	(0.500)	(0.500)	(0.500)	(0.500)	(0.500)	0.000	0.000
RUH	Technical or Funding	Demand growth - ICB commissioned High Cost Drugs & Devices	(2.000)	(2.000)	(2.000)	(3.000)	(0.930)	(1.896)	(1.896)	(2.088)	(2.088)	(0.088)	0.000	(0.192)
RUH	Technical or Funding	Demand growth - Weight Management NICE guidelines	(3.000)	(3.000)	(3.000)	(1.000)	(1.000)	0.000	0.000	0.000	0.000	3.000	0.000	0.000
RUH	Technical or Funding	Demand growth - RTT Delivery / referral growth unfunded	(10.000)	(10.400)	(5.600)	(5.600)	(2.500)	(2.500)	(2.500)	(2.400)	(1.000)	3.200	1.400	1.500
RUH	Technical or Funding	Somerset ICB Advice & Guidance payment 25/26 and prior years	0.000	0.000	0.000	0.000	0.000	(0.600)	(0.600)	0.000	0.000	0.000	0.000	0.600
RUH	Technical or Funding	Armed Forces commissioning contract value	0.000	0.000	0.000	(0.700)	(0.700)	(0.700)	(0.700)	0.000	0.000	0.000	0.000	0.700
RUH	Technical or Funding	Ambulance Handover Fines	0.000	0.000	(2.000)	0.000	0.000	0.000	0.000	0.000	0.000	2.000	0.000	0.000
RUH	Technical or Funding	Pay Inflation higher than budgeted	0.000	0.000	(0.625)	(0.625)	(3.300)	(0.500)	(0.500)	(0.500)	(0.500)	0.125	0.000	0.000
RUH	Budget management	Resident Doctors LTFP contracts			0.000	0.000	0.000	0.000	0.000	0.000	(1.500)	0.000	(1.500)	(1.500)
RUH	Industrial Action	Resident Doctors July only	0.000	0.000	0.000	0.000	0.000	0.000	0.000	(0.254)	(0.254)	(0.254)	0.000	(0.254)
RUH	Technical or Funding	SEOC Elective Income cap	(6.500)	(6.500)	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
RUH	Technical or Funding	NHSE 24/25 ERF	0.000	0.000	0.000	0.000	0.000	0.000	0.000	(0.825)	(0.825)	(0.825)	0.000	(0.825)
RUH	Technical or Funding	Technical adjustments shortfall	0.000	0.000	0.000	0.000	0.000	0.000	0.000	(0.150)	(0.150)	(0.150)	0.000	(0.150)
RUH	Technical or Funding	Accounting judgement for Annual Leave accrual	0.000	0.000	0.000	0.000	(2.500)	(2.500)	(2.500)	(2.500)	(2.500)	(2.500)	0.000	0.000
Sulis	Sulis (excl Savings)	Sulis Income plan incl CDC	0.000	0.000	0.000	(1.500)	(0.350)	(0.350)	(0.350)	0.000	0.000	0.000	0.000	0.350
Sulis	Sulis (excl Savings)	CDC Endoscopy Van productvity	0.000	0.000	0.000	0.000	(0.400)	(0.430)	(0.430)	(0.430)	(0.430)	(0.430)	0.000	0.000
		Gross Risk	(49.100)	(55.500)	(43.125)	(47.025)	(43.222)	(37.905)	(36.321)	(37.031)	(33.047)	6.094	3.984	3.274
		% of Comparable Operating Expenditure	*-8.2%*	*-9.3%*	*-7.2%*	*-7.9%*	*-7.2%*	*-6.4%*	*-6.1%*	*-6.2%*	*-5.5%*			
		Mitigations												
		Commissioner funding or Activity Mangement Plans												
RUH	Technical or Funding	High Cost Drugs & Devices	2.000	2.000	2.000	3.000	0.930	1.896	1.896	2.088	2.088	0.088	0.000	0.192
RUH	Technical or Funding	Weight Management	3.000	3.000	3.000	1.000	1.000	0.000	0.000	0.000	0.000	(3.000)	0.000	0.000
RUH	Technical or Funding	RTT Activity Management Plans incl deferral of £2.4m investment	10.000	10.000	5.600	5.100	2.500	2.500	2.500	2.400	1.000	(3.200)	(1.400)	(1.500)
RUH	Technical or Funding	UEC demand management	10.000	10.400	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
RUH	Technical or Funding	Somerset contract negotiation	0.000	0.000	0.000	0.000	0.000	0.600	0.600	0.000	0.000	0.000	0.000	(0.600)
RUH	Technical or Funding	Armed Forces contract negotiation	0.000	0.000	0.000	0.700	0.700	0.700	0.700	0.000	0.000	0.000	0.000	(0.700)
RUH	Technical or Funding	Pay inflation	0.000	0.000	0.625	0.625	3.300	0.000	0.000	0.000	0.000	(0.625)	0.000	0.000
RUH	Technical or Funding	Tiering Support funding - RTT	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.500	0.000	0.500	0.500
RUH	Budget management	Tiering Support funding - UEC	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.800	0.000	0.800	0.800
RUH	Technical or Funding	Ambulance Handover funding	0.000	0.000	2.000	0.000	0.000	0.000	0.000	0.000	0.000	(2.000)	0.000	0.000
RUH	Technical or Funding	SEOC funding	4.000	4.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
RUH	Technical or Funding	NHE 24/25 ERF overperformance	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.825	0.825	0.825	0.000	0.825
Sulis	Sulis (excl Savings)	CDC Endoscopy Van funding	0.000	0.000	0.000	0.000	0.400	0.430	0.430	0.430	0.430	0.430	0.000	0.000
		Internal Recovery												
Sulis	Sulis (excl Savings)	Sulis Core business further profit margin	0.000	0.000	0.000	1.500	0.350	0.350	0.350	0.500	0.000	0.500	(0.500)	(0.350)
RUH	Savings	Cost of Change national funding or deferral	0.000	0.000	1.500	1.500	1.500	1.845	1.845	1.845	0.000	0.345	(1.845)	(1.845)
RUH	Savings	Savings maturity	4.000	12.200	20.000	8.000	0.000	0.000	0.000	0.000	4.000	(20.000)	4.000	4.000
RUH	Savings	Discretionary spend freeze	0.000	0.000	0.000	0.000	1.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
RUH	Budget management	Operational budget management	0.000	0.000	0.000	0.000	2.800	1.000	2.800	0.000	0.000	0.000	0.000	(2.800)
RUH	Budget management	Delivery of Constitutional standards business case benefits	0.000	0.000	0.000	0.000	2.800	0.500	0.500	0.500	0.500	0.500	0.000	0.000
RUH	Technical or Funding	Ongoing balance sheet reviews	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.491	0.000	0.491	(0.491)	0.000
RUH	Technical or Funding	Cash management	0.000	0.000	0.000	0.000	1.000	0.500	0.500	0.500	0.000	0.500	(0.500)	(0.500)
RUH	Technical or Funding	Annual leave management	0.000	0.000	0.000	0.000	2.500	2.500	2.500	2.500	2.500	2.500	0.000	0.000
		Gross Mitigation	33.000	41.600	34.725	21.425	20.780	12.821	14.621	12.079	12.643	(22.646)	0.564	(1.978)
		% of Comparable Operating Expenditure	*5.5%*	*7.0%*	*5.8%*	*3.6%*	*3.5%*	*2.1%*	*2.5%*	*2.0%*	*2.1%*			
		Net unmitigated Risk before ICS Deficit Support	(16.100)	(13.900)	(8.400)	(25.600)	(22.442)	(25.084)	(21.700)	(24.952)	(20.404)	(16.552)	4.548	1.296

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	474.504	40.144	40.141	(0.003)		234.852	233.932	(0.921)	
Clinical Education Income	19.898	1.662	1.443	(0.219)		9.926	9.251	(0.675)	
Deficit Support Funding	19.198	2.394	2.394	0.000		10.832	10.832	0.000	
Surgery	(135.479)	(11.495)	(11.515)	(0.020)	-0.2%	(67.326)	(68.267)	(0.941)	-1.4%
Medicine	(164.626)	(14.488)	(14.474)	0.014	0.1%	(81.171)	(84.007)	(2.836)	-3.5%
FASS	(102.706)	(9.054)	(8.841)	0.213	2.4%	(50.416)	(51.645)	(1.229)	-2.4%
E&F	(33.367)	(2.760)	(2.767)	(0.007)	-0.2%	(16.756)	(16.647)	0.109	0.7%
Corporate	(65.391)	(5.451)	(5.869)	(0.418)	-7.7%	(32.705)	(33.866)	(1.161)	-3.5%
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	5.020	0.677	0.000	(0.677)		2.510	0.000	(2.510)	
Reserves	10.191	0.665	0.328	(0.337)		4.101	1.324	(2.776)	
Finance Charges	(27.291)	(2.274)	(2.226)	0.049		(13.645)	(13.702)	(0.057)	
Adjusted Financial Performance - RUH	**(0.050)**	**0.020**	**(1.384)**	**(1.405)**		**0.201**	**(12.796)**	**(12.997)**	
Sulis	0.500	0.001	0.195	0.194		0.119	0.011	(0.108)	
Inter Group	(0.450)	(0.021)	(0.030)	(0.009)		(0.319)	(0.171)	0.148	
Adjusted Financial Performance - Group	**0.000**	**0.000**	**(1.219)**	**(1.219)**		**0.000**	**(12.956)**	**(12.956)**	
Impairment	*(13.621)*	*0.000*	*0.000*	*0.000*		*(13.621)*	*(13.482)*	*0.139*	
Donated/Grant Income	*11.666*	*0.972*	*0.630*	*(0.342)*		*5.833*	*1.356*	*(4.477)*	
Unadjusted Financial Performance	***(1.955)***	***0.972***	***(0.589)***	***(1.561)***		***(7.788)***	***(25.083)***	***(17.295)***	

Forecast outturn have been produced for Month 6 and will be updated to provide a Division level control total.

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 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 Utility spend down against plan by £0.6m.

Countermeasures	Owner	Due Date
Completed: Update budgets to include the agreed plans to deliver RTT performance improvements	Financial Management Team	30 September

Key Cost Drivers

Royal United Hospitals Bath NHS Foundation Trust

Business Plan Delivery September 2025

Activity Plan

	YTD Plan	YTD Actual	Variance	Change per Day Actual
OP News	99,834	101,593	1,759	+21
OP Follow Ups	152,478	154,798	2,320	+28
Daycases	19,452	18,469	-983	-12
EL Inpatients	2,355	2,086	-269	-3
ED Attendances	52,001	52,308	307	+4
NEL Admissions	30,899	32,073	1,174	+14
Diagnostic tests	85,939	83,058	-2,881	-34

Planning Assumptions

	Plan	YTD Actual
GP Referral Growth	0.0%	1.7%
ED Atts Growth	2.6%	3.3%
NEL Admit Growth (excludes maternity)	3.4%	9.5%
NCTR	61	83
NEL Length of Stay (for 1+ days)	6.2	6.8

Performance

		Year End Target	Current Month Plan	Actual
RTT	<18 1st app	71.7%	66.7%	62.2%
	<18 weeks	67.7%	62.7%	60.1%
	>52 weeks	1.0%	1.2%	1.5%
Cancer	62 days*	75.0%	70.6%	64.8%
	31 days*	96.0%	89.5%	96.1%
	28 days*	80.0%	74.5%	65.9%
ED	4hr type 1	72.0%	73.7%	57.6%
	4hr All Types	78.0%	79.4%	67.6%
	12 hours	reduction	4.6%	9.0%
DM01	> 6 weeks	5.0%	11.9%	33.6%

* 1 month reporting lag

Finance

	YTD Plan	YTD Actual	Variance
Cash Releasing Savings	£17,301	£6,812	-£10,489
Financial Position	£0	-£12,956	-£12,956
Productivity	+6.7%	+2.8%	-3.9%

Figs to June 25

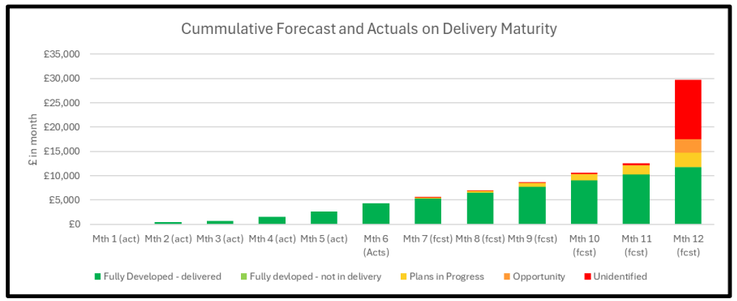
Workforce

	YTD Planned	YTD Actual	Variance
Pay Savings (£000s)	£6,027	£4,011	-£2,016
WTE Reduction	5629	5748	119.0
Sickness (1 mth lag)		5.11%	

Performance Measures

Savings Delivery Against Plan

Royal United Hospitals Bath
NHS Foundation Trust



	In Month			YTD			Programme Status						
	Month 6 Acts	Plan Mth^	Month Variance to Plan	Acts YTD	Plan YTD	YTD Variance to Plan	Fully Developed - in delivery	Fully Developed - not in delivery	plans in progress	In Forecast Outturn	opportunity	unidentified	Grand Total
Delivery Group													
UEC Delivery Group	38	333	(296)	257	2,000	(1,743)	453	0	129	**583**	0	3,417	4,000
Outpatients Delivery Group	312	250	62	353	1,500	(1,147)	740	0	560	**1,299**	1,201	500	3,000
Elective Delivery Group	254	158	95	470	950	(480)	993	0	0	**993**	507	0	1,500
Corporate Services	149	208	(59)	625	1,250	(625)	1,640	17	80	**1,738**	0	763	2,500
Central Delivery Group	823	629	195	2,205	3,773	(1,568)	3,528	170	4,370	**8,068**	66	0	8,134
Estates &Facilities	74	132	(58)	225	790	(565)	488	0	3	**490**	1,090	0	1,580
Unidentified		356	(356)	0	2,137	(2,137)	0	0	0	**0**	0	3,084	3,084
SULIS	28	42	(13)	224	250	(26)	500	0	1,000	**1,500**	0	0	1,500
Total excluding Group	**1,679**	**2,108**	**(429)**	**4,359**	**12,649**	**(8,291)**	**8,341**	**187**	**6,142**	**14,670**	**2,864**	**7,764**	**25,298**
Group	0	367	(367)	0	2,200	(2,200)	0	0	0	0	0	4,400	4,400
Total including Group	**1,679**	**2,475**	**(796)**	**4,359**	**14,849**	**(10,491)**	**8,341**	**187**	**6,142**	**14,670**	**2,864**	**12,164**	**29,698**

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

£4.4m savings have been delivered year to date, £1.7m up on last month. The increase is the reduction in temporary staffing and net contribution benefits from Outpatient and Elective activity.. The Trust now has a £10.5m shortfall against plan year to date, a major contributor to the Trust overall adverse variance to plan.

Programme delivery is now accelerating to improve savings delivery however to achieve forecast year end position identified opportunity areas need to be worked up to deliverable 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.	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
Divisions and Delivery Groups working together to ensure delivery of the plans and opportunities identified as well as working to identify plans for 26_27.	Delivery Group SRO and DOOs.	Next few months.

Risks and Mitigation

Risk on delivery of remaining unidentified due to operational pressures and the transformational nature required to deliver in short term.

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 few next months.

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	25,393,066	103,480	26,017,711	52,001	52,308	307	13,074,605	13,007,613	-66,992
DC	38,591	41,835,488	40,091	44,363,159	19,452	18,469	-983	21,590,039	21,857,534	267,495
EL	3,669	20,125,247	4,889	27,520,855	2,355	2,086	-269	13,235,914	11,677,780	-1,558,134
HCD	189,019	54,025,019	0	59,871,909	0	104,865	104,865	28,520,307	29,979,810	1,459,503
NE	59,967	192,340,342	62,038	200,334,168	30,899	32,073	1,174	100,834,683	99,834,106	-1,000,577
OP	780,366	115,506,647	758,359	114,941,069	376,076	383,542	7,466	56,803,241	55,927,470	-875,771
OT	3,374,847	17,449,521	2,978,127	17,901,214	1,483,081	1,688,004	204,923	8,911,734	9,287,881	376,147

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 September, SOC remains under plan by £0.7m, this is due to delays in getting access to the second theatre.

RTT investments had a significant impact in month driving the increase in outpatient and day case activity. This is mainly the result of insourcing in ENT and Gastro along with ongoing WLI where posts are being recruited.

The high-cost drugs and devices performance is £1.4m over plan, of which £1m is eligible for pass-through funding and £0.4m represents a cost pressure due to the fixed contract envelope.

Countermeasures	Owner	Due Date
Review the impact of the investments and the impact on operational performance outlining the recurrent need for business planning.	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
Ensure there is robust planning where possible for HCDD for 2026/27 to calculate the ongoing risk going into next year.	Income/ Pharmacy	30 November

Risks and Mitigation

- Stranded fixed costs where variable income is not reimbursed due to Activity Management Plan process
- Iterative review of forecast against developing plans and improved planned activity delivery resulting from RTT investments.
- NHS Spec Com challenging the coding of cardiac home monitoring put at risk the income in the plan and forecast for this activity.

YTD ERF Income Performance (Key Commissioners)

Royal United Hospitals Bath NHS Foundation Trust

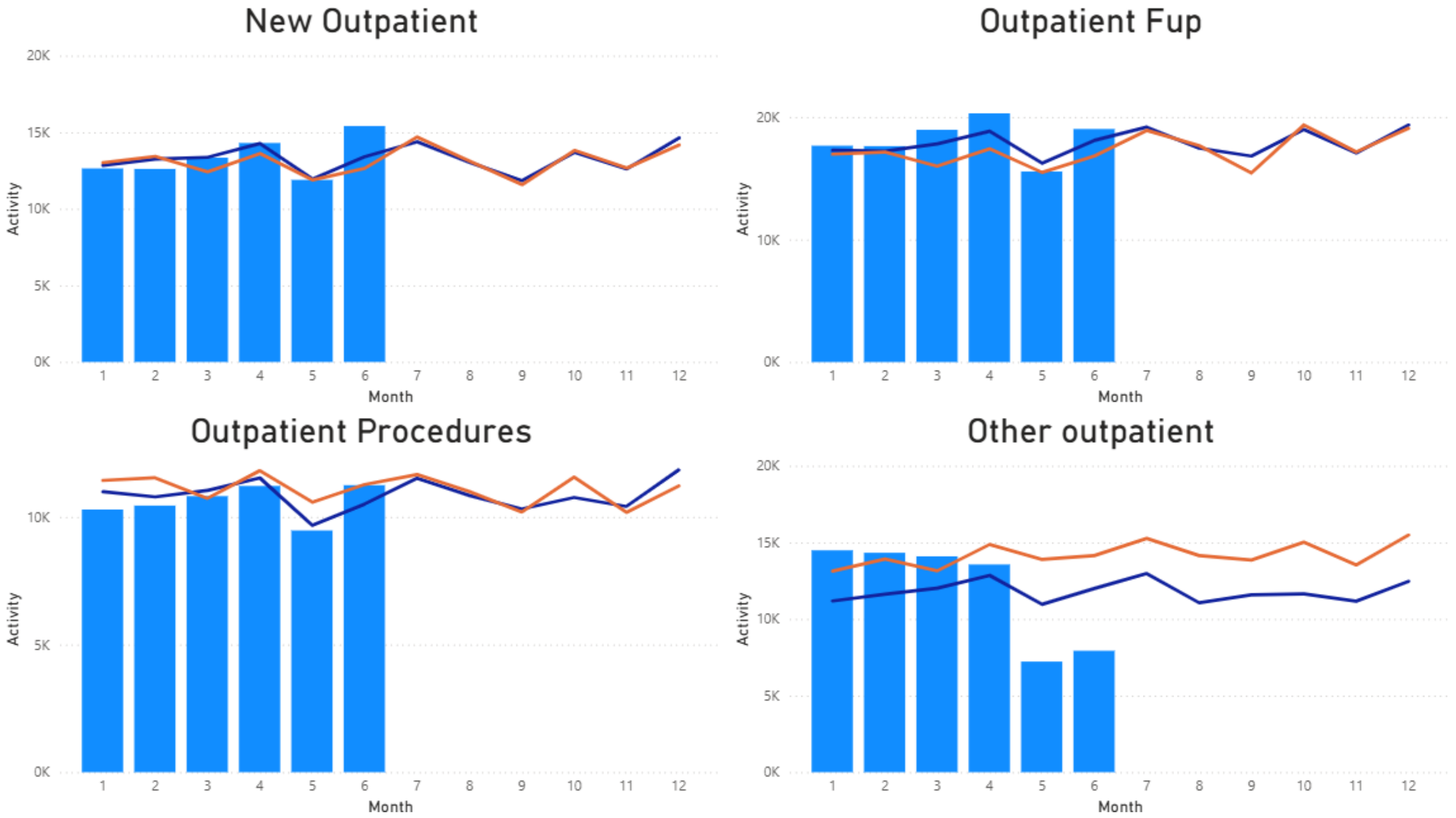
Commissioner	SOC*	Strikes*	RTT & Other	Total
BNSSG	(53,301)	(727)	349,111	295,083
BSW	(539,674)	(13,506)	(647,960)	(1,201,140)
Gloucs.	0	(66)	21,025	20,959
Somerset	(73,289)	(1,996)	625,586	550,301
Spec Com	0	(141)	261,013	260,872
YTD Variance	(666,264)	(16,436)	608,774	(73,926)

Investments for RTT for insourcing came into effect in month resulting in a significant increase in activity recovering much of the under delivery against plan reported in August.

***Commissioner apportioned based on overall plan for the relevant activity**

ERF Income includes Daycase, Elective and New Outpatients

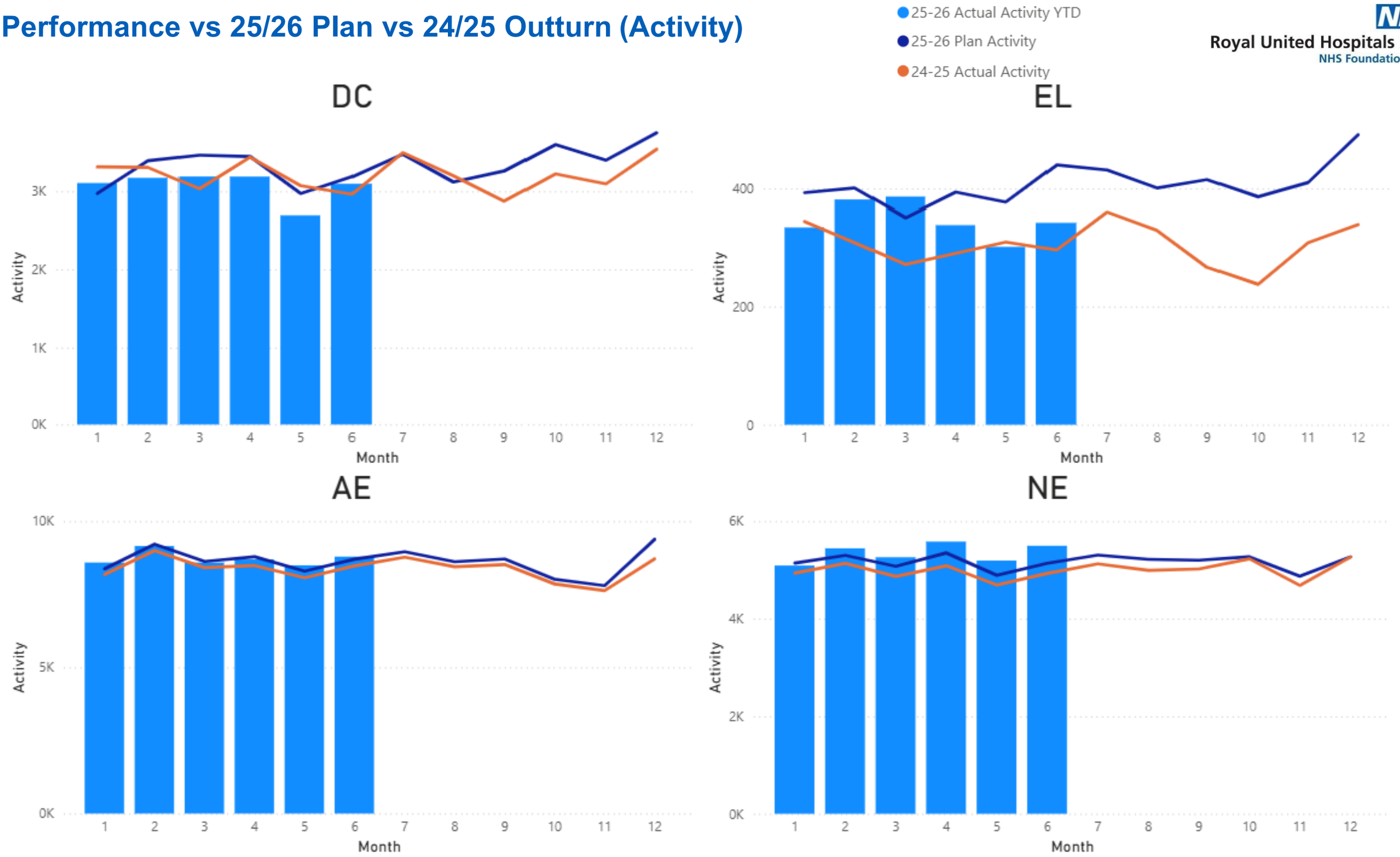
YTD Performance vs 25/26 Plan vs 24/25 Outturn (Activity)



Maternity ante-natal activity is missing for M5 & M6 due to go live of the new system disrupting data flows, this will catch up once the data flow is reinstated in the next few weeks.

YTD Performance vs 25/26 Plan vs 24/25 Outturn (Activity)

Royal United Hospitals Bath
NHS Foundation Trust

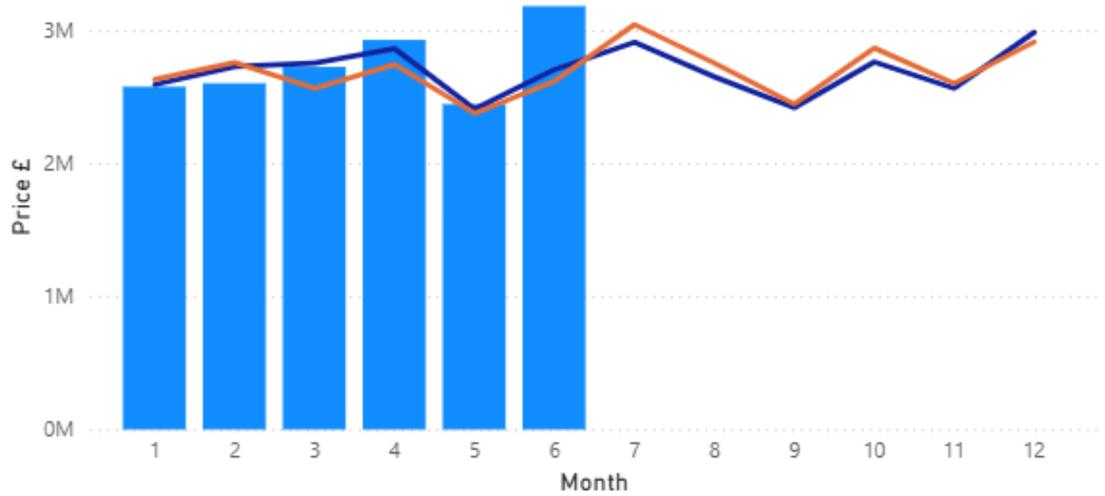


YTD Performance vs 25/26 Plan vs 24/25 Outturn (Price)

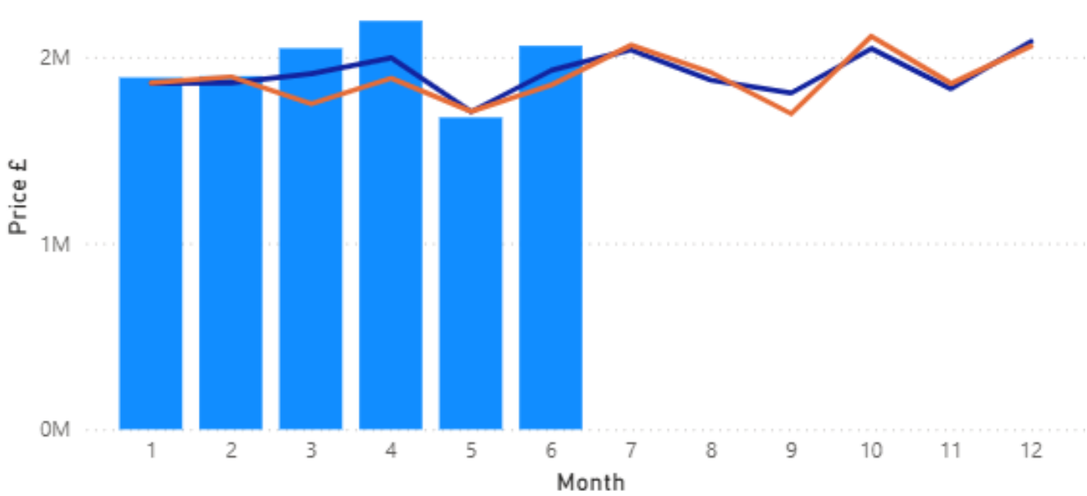
25-26 Actual Price YTD
25-26 Plan Price
24-25 Actual Price

Royal United Hospitals Bath
NHS Foundation Trust

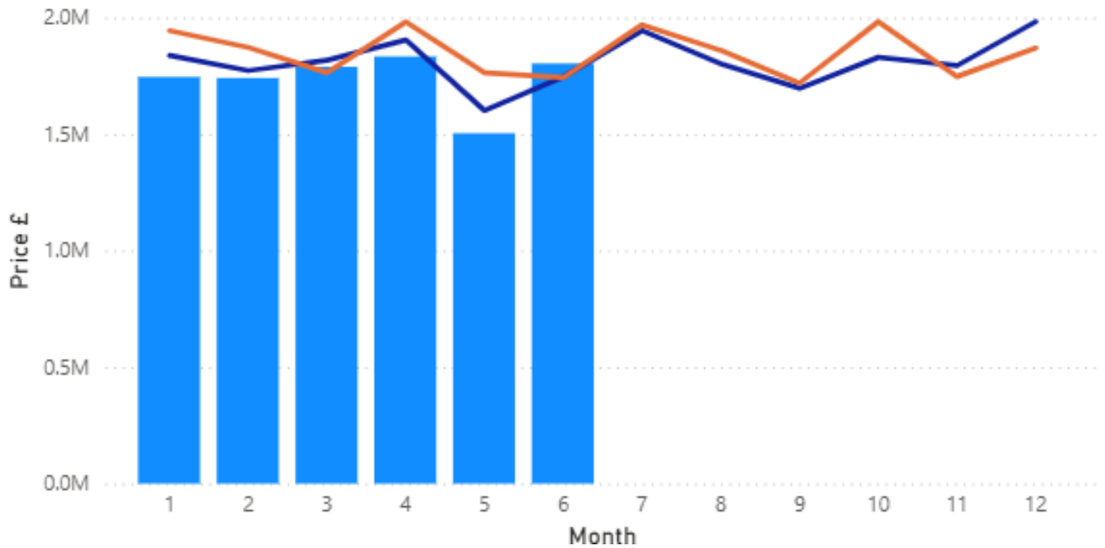
New Outpatient



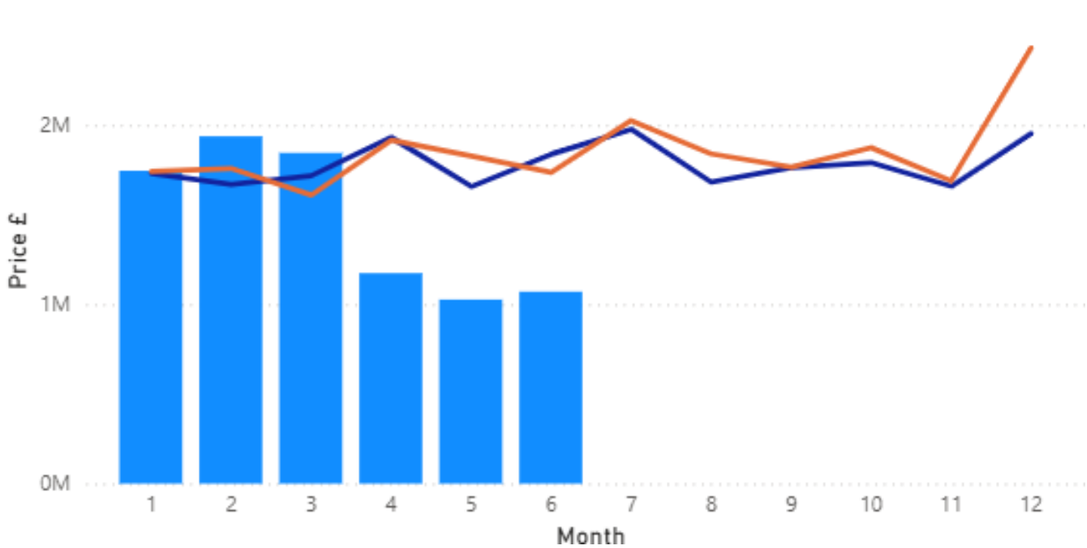
Outpatient Fup



Outpatient Procedures

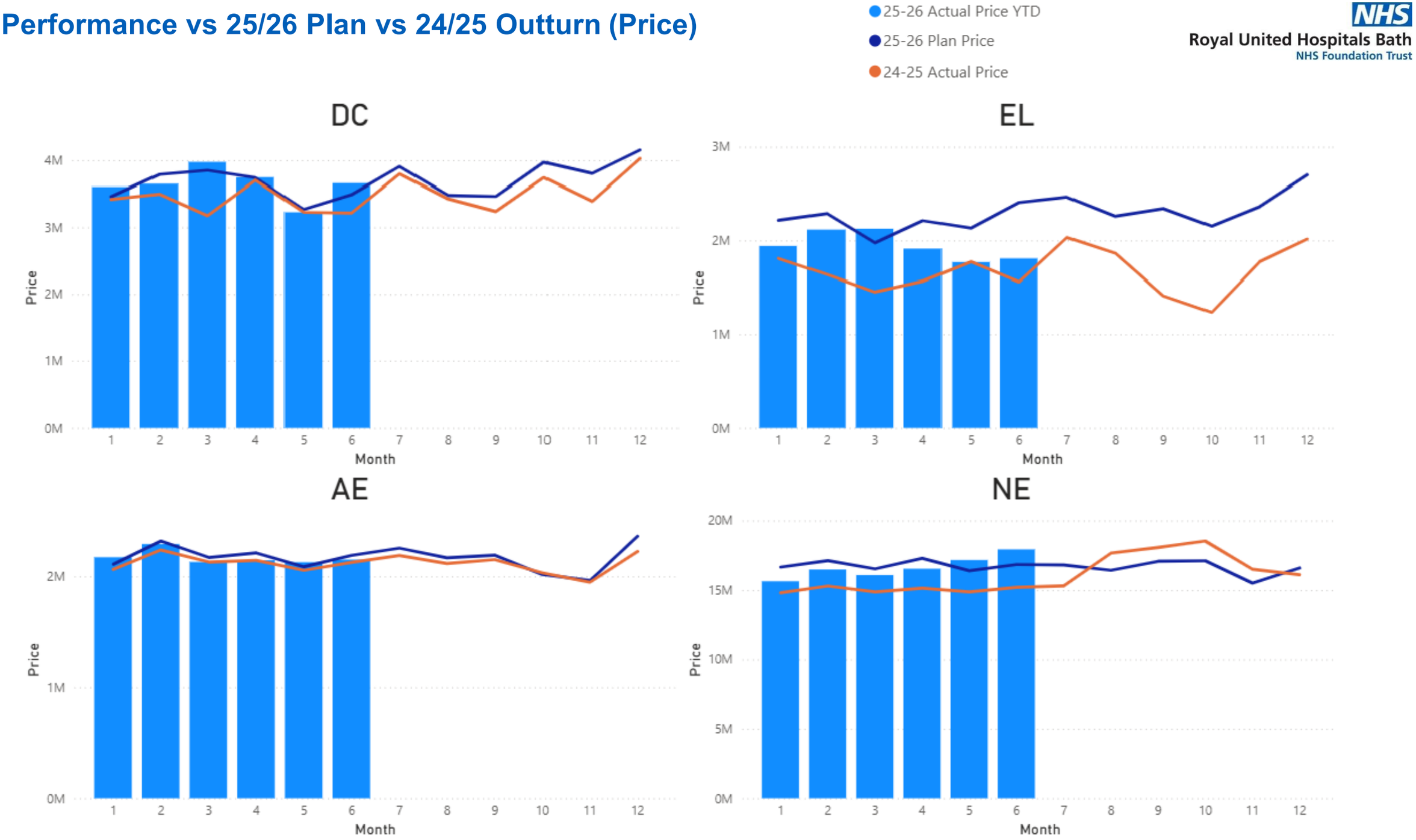


Other outpatient



Maternity ante-natal activity is missing for M5 & M6 due to go live of the new system disrupting data flows, this will catch up once the data flow is reinstated in the next few weeks.

YTD Performance vs 25/26 Plan vs 24/25 Outturn (Price)



Royal United Hospitals Bath
NHS Foundation Trust

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	(5.489)	(5.519)	(0.030)	(32.609)	(32.547)	0.063
Junior Medical	(3.526)	(3.581)	(0.055)	(21.215)	(22.297)	(1.082)
Registered Nursing and Midwifery	(9.034)	(8.877)	0.157	(55.838)	(53.372)	2.465
Registered ST&T	(3.531)	(3.494)	0.037	(20.809)	(20.587)	0.222
Other Clinical Support	(4.897)	(4.983)	(0.086)	(29.293)	(29.700)	(0.407)
NHS Infrastructure Support	(3.919)	(4.191)	(0.272)	(23.261)	(24.020)	(0.759)
Other	(0.126)	(0.176)	(0.050)	(0.758)	(0.916)	(0.158)
Unallocated Savings	0.209	0.000	(0.209)	5.745	0.000	(5.745)
Reserves	0.227	0.000	(0.227)	1.074	0.000	(1.074)
Surplus/(Deficit)	**(30.086)**	**(30.821)**	**(0.735)**	**(176.964)**	**(183.439)**	**(6.475)**
Pay Vacancy Factor Included Above	1.026	0.000	(1.026)	6.154	0.000	(6.154)

Pay by Spend Type	In Month RUH			Year to Date RUH		
	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Actual £'m	Variance £'m
Substantive	(30.511)	(28.793)	1.717	(181.183)	(171.779)	9.404
Pay Vacancy Factor	1.026	0.000	(1.026)	6.154	0.000	(6.154)
Net Budget	**(29.485)**	**(28.793)**	**0.692**	**(175.029)**	**(171.779)**	**3.250**
Bank	(0.174)	(1.524)	(1.350)	(0.513)	(8.870)	(8.357)
Agency	(0.024)	(0.123)	(0.099)	(0.145)	(1.152)	(1.007)
WLI	(0.291)	(0.218)	0.073	(0.606)	(0.885)	(0.279)
Other	(0.112)	(0.162)	(0.050)	(0.670)	(0.753)	(0.082)
Surplus/(Deficit)	**(30.086)**	**(30.821)**	**(0.735)**	**(176.964)**	**(183.439)**	**(6.475)**

Understanding Performance

Pay budgets are overspent by £6.5m. The Pay vacancy factor (£6.1m) has been delivered but further Pay savings (£5.7m) have not yet been achieved. The Pay awards have generated a net £0.3m pressure, with £1.3m of pay costs being offset by £1m of income. Pay costs also include 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% expectation. Bank costs are currently 4.8% of the total pay costs.

Countermeasures	Owner	Due Date

Risks and Mitigation

Budget – Pay by Division & Type

Royal United Hospitals Bath
NHS Foundation Trust

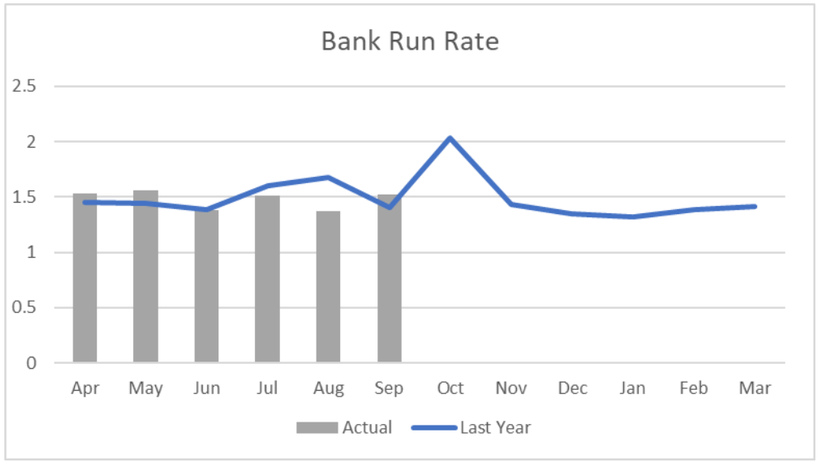
Pay by Division	In Month			Year to Date		
	RUH			RUH		
	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Actual £'m	Variance £'m
Surgery	(8.406)	(8.124)	0.282	(48.146)	(48.905)	(0.760)
Medicine	(10.934)	(11.088)	(0.154)	(63.192)	(65.911)	(2.719)
FASS	(5.717)	(5.805)	(0.088)	(33.640)	(34.293)	(0.653)
E&F	(1.727)	(1.826)	(0.099)	(10.358)	(10.756)	(0.397)
Corporate	(3.149)	(3.541)	(0.392)	(18.919)	(20.383)	(1.464)
HIWE	(0.291)	(0.291)	(0.001)	(1.743)	(1.797)	(0.054)
R&D	(0.284)	(0.243)	0.041	(1.706)	(1.716)	(0.010)
Reserves	0.441	0.097	(0.344)	0.854	0.321	(0.533)
Unallocated Savings	(0.019)	0.000	0.019	(0.114)	0.000	0.114
Surplus/(Deficit)	**(30.086)**	**(30.821)**	**(0.735)**	**(176.964)**	**(183.439)**	**(6.475)**
Pay Vacancy Factor Included Above	1.026	0.000	(1.026)	6.154	0.000	(6.154)

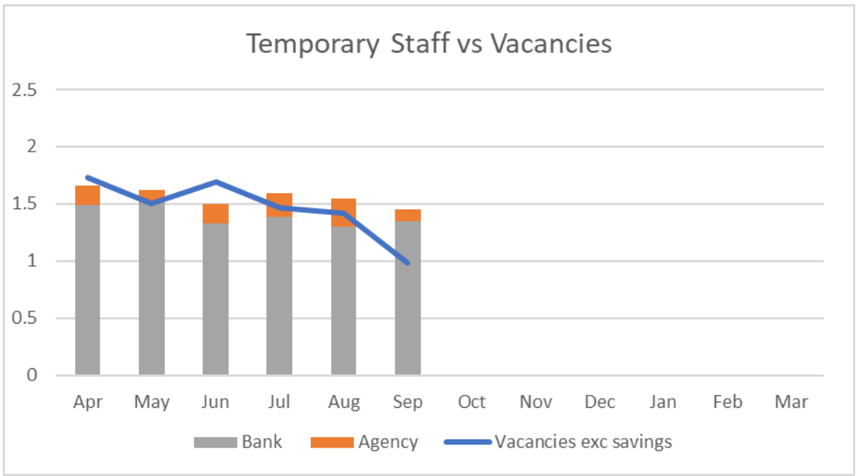
Variance by Functional Area	In Month						
	Medical Staff	Ward	ED	Maternity	Other	Savings	Total
Substantive	0.283	0.641	0.171	0.081	(0.190)	(0.222)	0.764
Bank	(0.186)	(0.525)	(0.197)	(0.110)	(0.332)	0.000	(1.350)
Agency	(0.213)	(0.001)	0.000	0.000	0.116	0.000	(0.099)
Other	0.000	0.000	0.000	0.000	(0.050)	0.000	(0.050)
Surplus/(Deficit)	**(0.116)**	**0.115**	**(0.027)**	**(0.029)**	**(0.456)**	**(0.222)**	**(0.735)**

Variance by Functional Area	Year to Date						
	Medical Staff	Ward	ED	Maternity	Other	Savings	Total
Substantive	1.236	3.674	1.291	0.548	2.041	(5.819)	2.971
Bank	(1.403)	(2.965)	(1.276)	(0.546)	(2.167)	0.000	(8.357)
Agency	(1.027)	(0.025)	0.000	0.000	0.045	0.000	(1.007)
Other	0.000	0.000	0.000	0.000	(0.082)	0.000	(0.082)
Surplus/(Deficit)	**(1.195)**	**0.684**	**0.015**	**0.002**	**(0.163)**	**(5.819)**	**(6.475)**

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

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	(333.4)	(324.6)	8.9
Junior Medical	(450.8)	(487.4)	(36.5)
Registered Nursing and Midwifery	(1,829.9)	(1,807.4)	22.5
Registered ST&T	(656.5)	(666.4)	(9.8)
Other Clinical Support	(1,628.0)	(1,606.4)	21.6
NHS Infrastructure Support	(902.2)	(892.8)	9.4
Other	(1.4)	(3.2)	(1.8)
Unallocated Savings	152.6	0.0	(152.6)
Reserves	28.6	0.0	(28.6)
Surplus/(Deficit)	**(5,621.1)**	**(5,788.0)**	**(166.9)**
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	(5,821.8)	(5,464.2)	357.7
Pay Vacancy Factor	216.5	0.0	(216.5)
Net Budget	**(5,605.3)**	**(5,464.2)**	**141.1**
Bank	(17.7)	(312.7)	(295.0)
Agency	0.0	(11.2)	(11.2)
WLI	1.9	0.0	(1.9)
Other	0.0	0.0	0.0
Surplus/(Deficit)	**(5,621.1)**	**(5,788.0)**	**(166.9)**

WTE by Division	In Month		
	RUH		
	Budget WTE	Actual WTE	Variance WTE
Surgery	(1,411.0)	(1,454.6)	(43.6)
Medicine	(1,982.6)	(2,070.8)	(88.1)
FASS	(1,041.4)	(1,046.9)	(5.6)
E&F	(531.6)	(546.4)	(14.7)
Corporate	(565.2)	(566.1)	(0.9)
HIWE	(47.8)	(43.4)	4.5
R&D	(62.3)	(56.5)	5.8
Reserves	28.0	(3.4)	(31.4)
Unallocated Savings	(7.1)	0.0	7.1
Surplus/(Deficit)	**(5,621.1)**	**(5,788.0)**	**(166.9)**
Pay Vacancy Factor Included Above	216.5	0.0	(216.5)

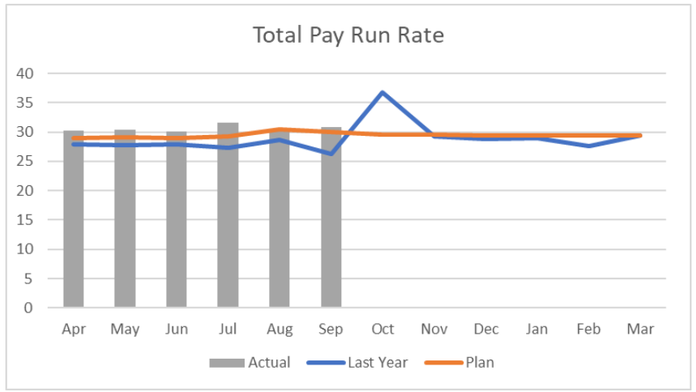
WTE Variance by Functional Area	In Month						
	Medical Staff	Ward	ED	Maternity	Other	Savings	Total
Substantive	-12.64	125.30	32.82	11.85	134.46	-152.58	139.21
Bank	-9.89	-126.38	-39.59	-21.83	-97.29	0.00	(294.98)
Agency	-8.32	0.00	0.00	0.00	-2.83	0.00	(11.15)
Other	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Surplus/(Deficit)	**-30.85**	**-1.08**	**-6.77**	**-9.98**	**34.34**	**-152.58**	**(166.92)**

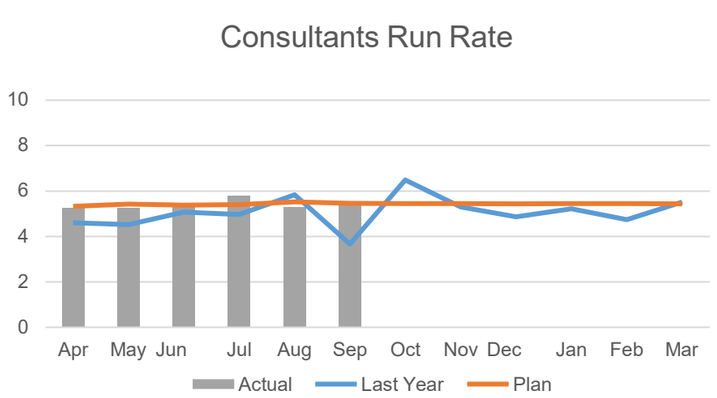
NB. We have applied a WTE target to Pay Savings from Month 3 to more closely align pay variances and WTE variances

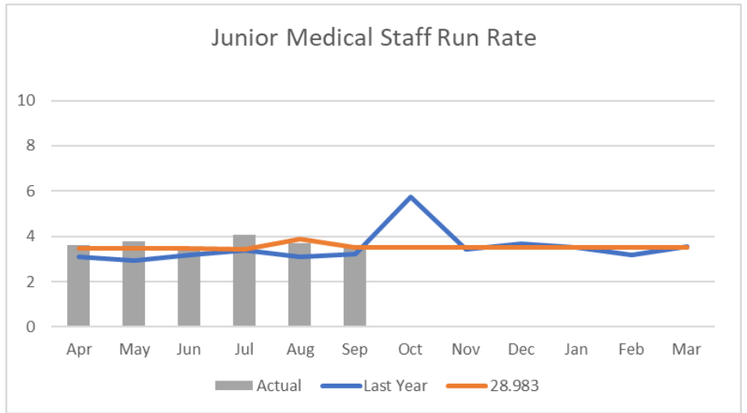
Actual WTE reporting will be marginally different between Workforce reporting and Finance reporting due to technical differences in the datasets for PWR and PFR in respect of Bank Hours worked per week, and small variations in classification of substantive staff. Finance and Workforce teams undertake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

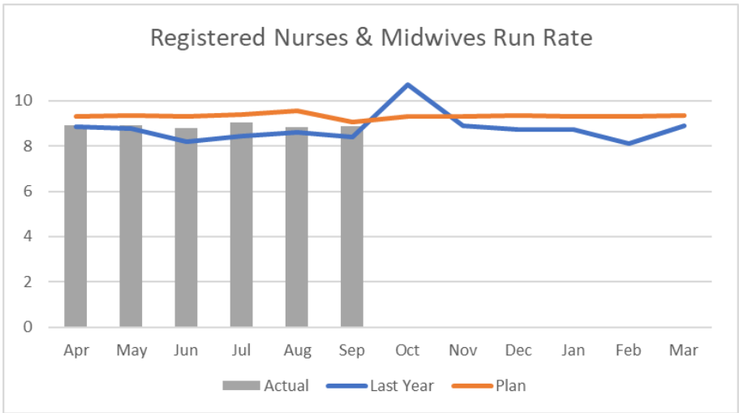
Pay Run Rate Graphs

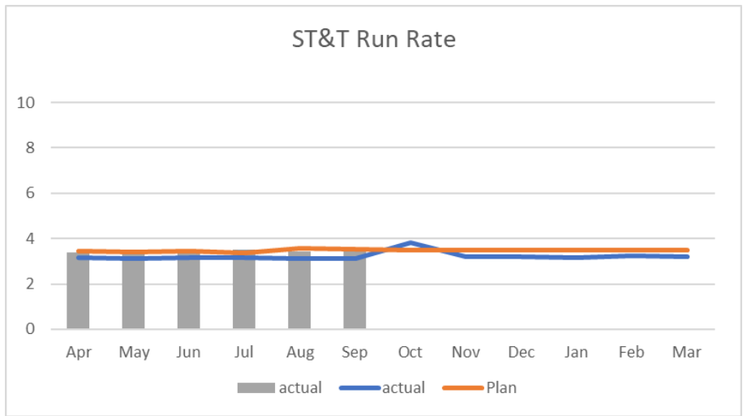
Royal United Hospitals Bath
NHS Foundation Trust

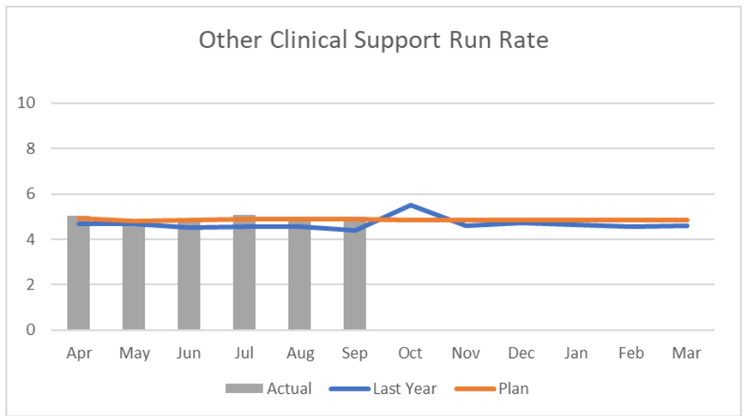


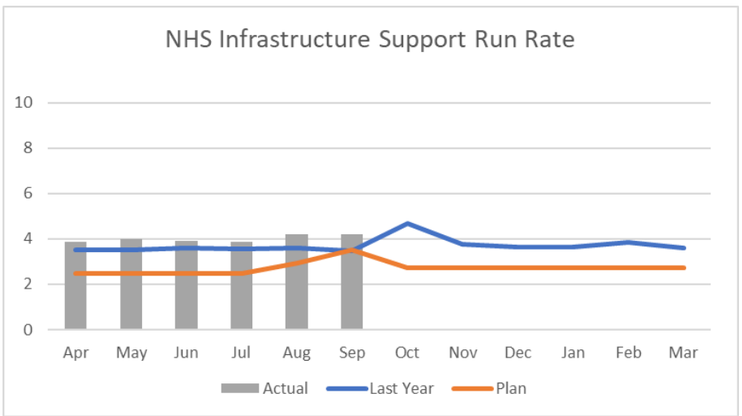












Budget – Non-Pay

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	(4.835)	(4.650)	0.185	(26.234)	(28.460)	(2.226)
In Tariff Drugs	(0.811)	(0.836)	(0.025)	(4.409)	(4.722)	(0.313)
Clinical Supplies and Services	(3.782)	(4.453)	(0.671)	(23.771)	(24.747)	(0.975)
Other Non Pay	(5.305)	(5.636)	(0.331)	(34.271)	(32.696)	1.575
Unallocated Savings	0.781	0.000	(0.781)	5.753	0.000	(5.753)
Reserves	(0.318)	0.000	0.318	0.868	0.000	(0.868)
Surplus/(Deficit)	**(14.269)**	**(15.574)**	**(1.305)**	**(82.064)**	**(90.625)**	**(8.560)**

Budget by Division	In Month RUH			Year to Date RUH		
	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Actual £'m	Variance £'m
Surgery	(2.710)	(3.175)	(0.465)	(18.288)	(19.066)	(0.778)
Medicine	(2.237)	(2.374)	(0.137)	(11.376)	(12.114)	(0.738)
FASS	(0.759)	(0.717)	0.041	(3.997)	(4.381)	(0.384)
E&F	(1.549)	(1.492)	0.057	(9.531)	(9.080)	0.451
Corporate	(2.667)	(2.991)	(0.324)	(15.975)	(16.864)	(0.890)
HIWE	(0.103)	(0.081)	0.022	(0.617)	(0.423)	0.194
R&D	(0.054)	(0.052)	0.002	(0.324)	(0.185)	0.139
Capital Charges	0.010	0.011	0.000	0.062	(0.022)	(0.084)
High Cost Drugs and Devices	(4.990)	(4.650)	0.340	(27.129)	(28.460)	(1.331)
Unallocated Savings	0.749	0.000	(0.749)	2.944	0.000	(2.944)
Reserves	0.041	(0.052)	(0.093)	2.166	(0.030)	(2.196)
Surplus/(Deficit)	**(14.269)**	**(15.574)**	**(1.305)**	**(82.064)**	**(90.625)**	**(8.560)**

Understanding Performance

Non-pay spend is £8.6m overspent against budget. £5.7m of this relates to undelivered savings and £0.9m as the exit run rate.

High-cost drugs and devices are overspent by £2.2m, £1.7m of which is funded 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

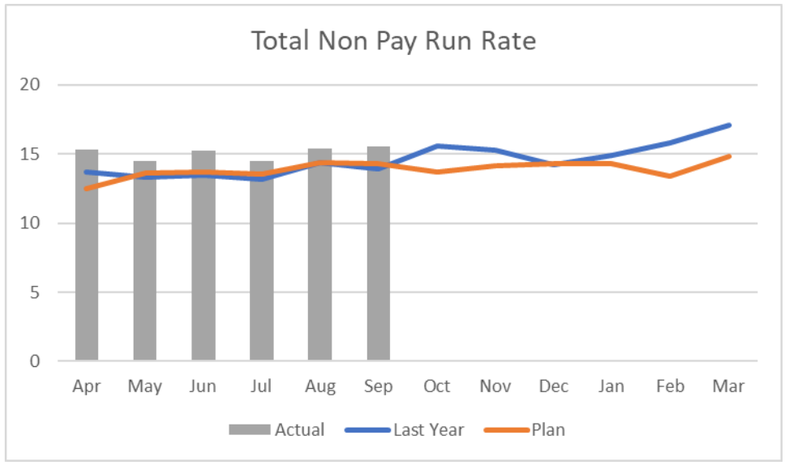
Estates and Facilities are currently underspent due to reduced utilities costs.

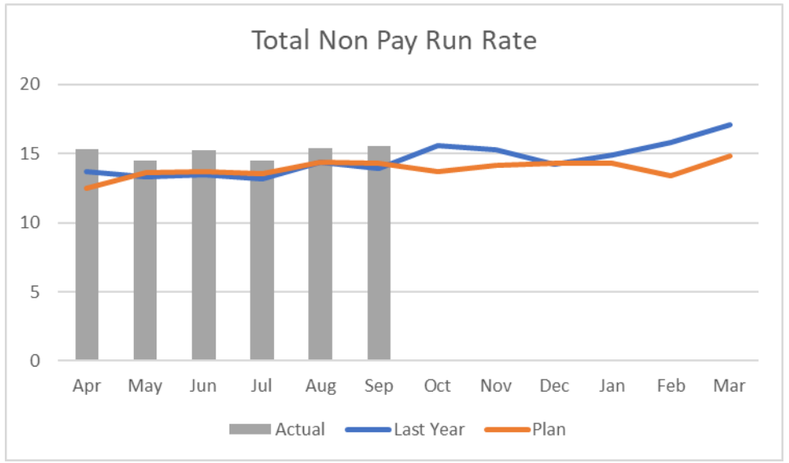
Countermeasures	Owner	Due Date

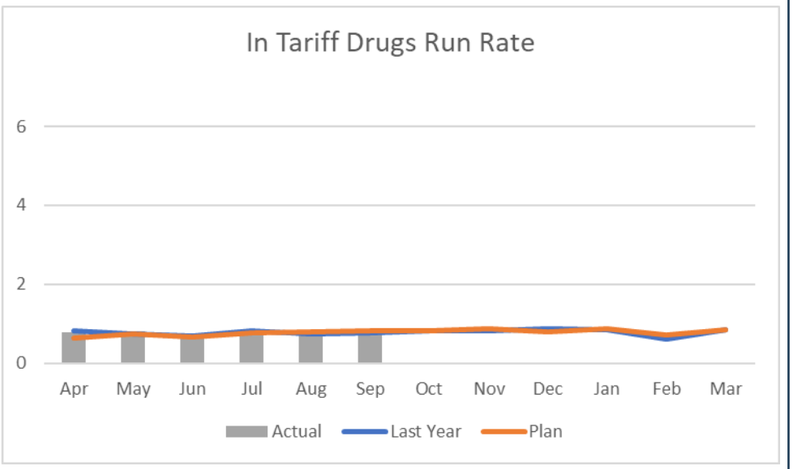
Risks and Mitigation

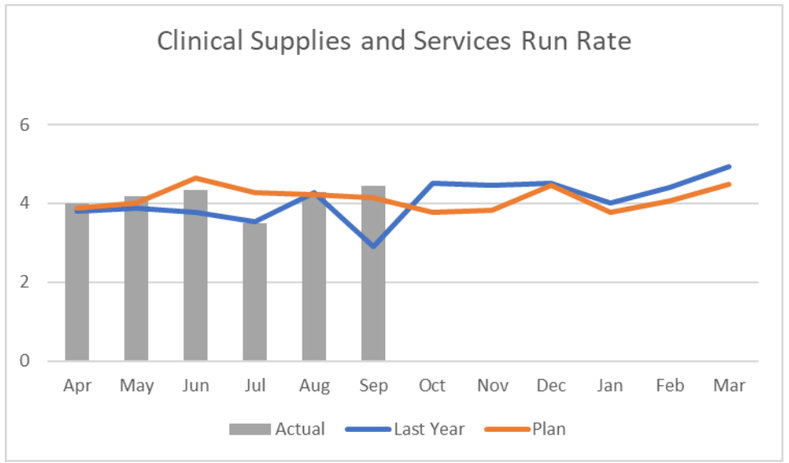
Non Pay – Run Rate Graphs

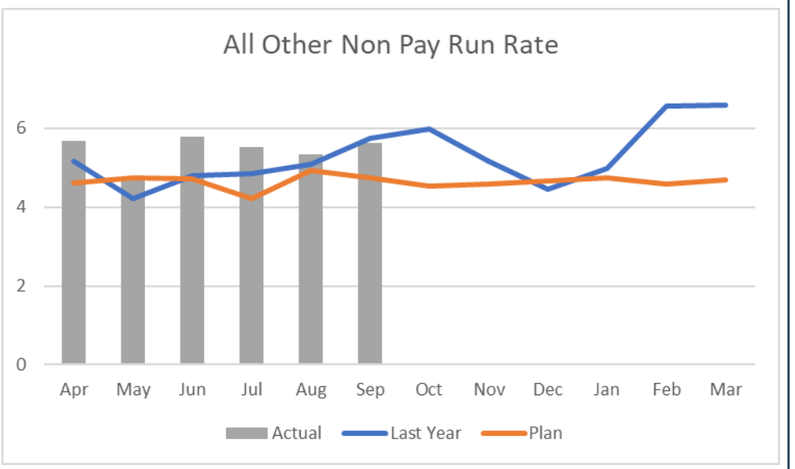
Royal United Hospitals Bath
NHS Foundation Trust







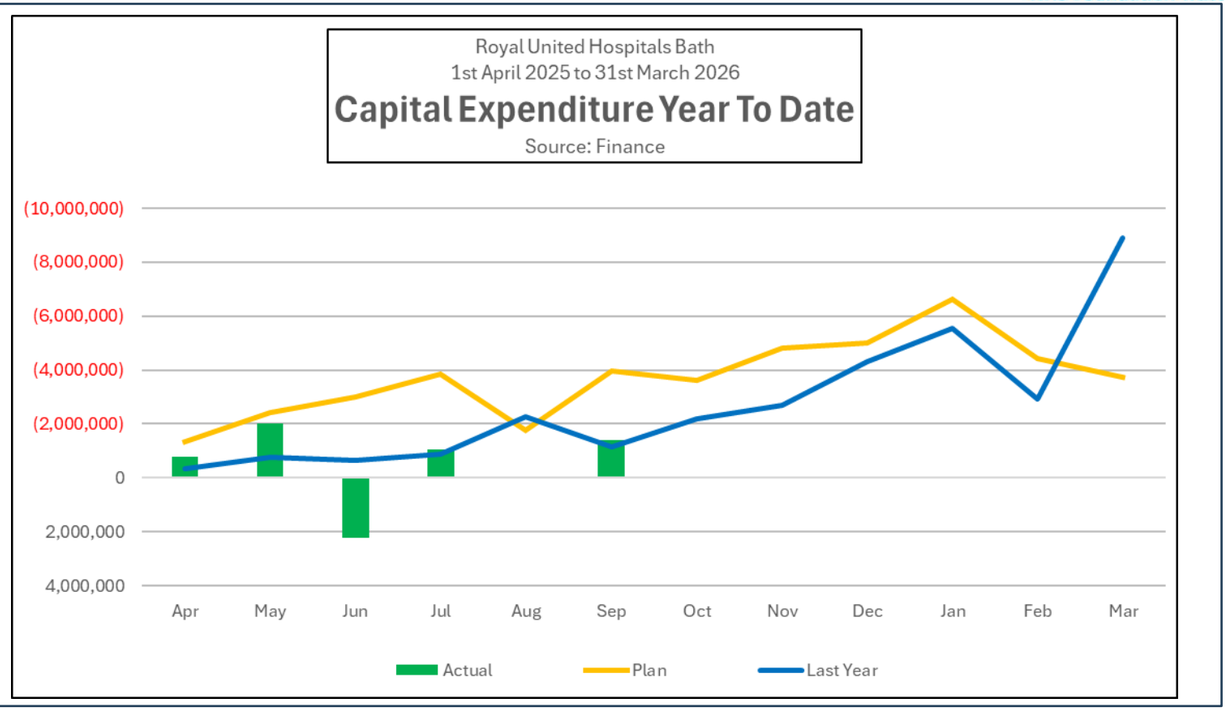




Capital – Operational, Grant & Donated

Royal United Hospitals Bath
NHS Foundation Trust

Position as at 30th September 2025	Annual Plan £'m	Forecast Outturn £'m	YTD Plan £'m	YTD Actuals £'m	YTD Variance £'m
Decarbonisation	(3.135)	(3.135)	(0.750)	(0.074)	0.676
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	**(6.953)**	**(6.953)**	**(0.750)**	**(0.074)**	**0.676**
IT	(1.750)	(1.650)	(0.612)	(0.813)	(0.201)
Medical Equipment (MEC)	(1.910)	(0.680)	(0.413)	0.026	0.439
Estates, CRG & Projects	(1.700)	(1.392)	(1.056)	(0.602)	0.454
Sulis	(0.250)	(0.143)	(0.078)	(0.010)	0.068
Right of Use Leases	(0.300)	(0.760)	(0.150)	0.000	0.150
Minor	0.543	0.543	0.616	0.511	(0.105)
Lease Provision release (Modular Theatre)	(0.547)	(0.547)	(0.547)	(0.547)	0.000
Other Schemes Total	**(5.914)**	**(4.629)**	**(2.240)**	**(1.434)**	**0.806**
TOTAL : Operational Capital	**(12.867)**	**(11.582)**	**(2.990)**	**(1.508)**	**1.482**
Decarbonisation (Salix)	(10.820)	(10.820)	(7.489)	(1.794)	5.695
PET-CT	(2.000)	0.000	0.000	0.000	0.000
Minor donated schemes	(0.300)	(0.300)	(0.150)	(0.290)	(0.140)
TOTAL : Donated & Grant Funded	**(13.120)**	**(11.120)**	**(7.639)**	**(2.083)**	**5.556**
OVERALL TOTAL	**(25.987)**	**(22.702)**	**(10.629)**	**(3.591)**	**7.038**



Understanding Performance

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

Committed capital has been reviewed with capital leads, a paper presented at the June TME, which 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. Presented as negative costs in June due to reversal of accrual based on previous cashflow.

EPR latest forecast for in-year is £0.6 million underspend against allocation in year, underspends will impact CDEL available to the Trust in 2026/27.

Countermeasures	Owner	Due Date
Not Actioned: EPR project accountant and Manager to 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
Completed: In response to the adverse revenue position capital expenditure that has not been contractually committed or is mandated has been held.	CPMG	Complete
Not Actioned: EPR project team are undertaking a review of the programme with several options being considered. The operational & financial implications of the outcome of review will need to be mitigated	EPR Board	Nov 2025

Risks and Mitigation

Multi-Year EPR forecast outturn at end of project is a £0.9 million overspend against approved FBC. This could increase further and is being reviewed by the EPR project accountant.

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.

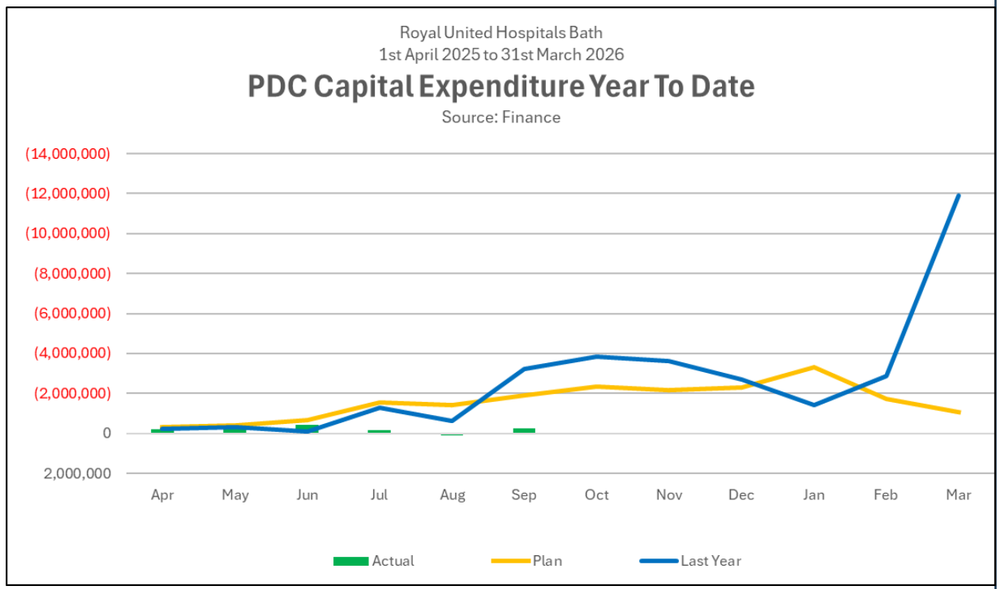
Salix grant funding agreement states it is to utilised by 31st March. Due to delay in programme notified by the contractor, the project team are in discussions with Salix to defer the commission funding to next year. If this is not agreed this will be a pressure to next year's trust funding, which is 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 30th September 2025		Annual Plan £'m	Forecast Outturn £'m	YTD Plan £'m	YTD Actuals £'m	YTD Variance £'m	Approval status
BSW EPR		(2.955)	(2.955)	(2.878)	(1.086)	1.792	FBC approved,
Other Schemes : Solar Energy, RAAC Removal & Pathology		(0.560)	(0.560)	(0.150)	(0.001)	0.149	Approve
Total Other		**(3.515)**	**(3.515)**	**(3.028)**	**(1.087)**	**1.941**	
Estates:	Fire Safety Programme	(1.890)	(1.890)	(0.647)	(0.000)	0.6	
	Sterile Services Autoclave/Steriliser Replacement	(0.900)	(0.900)	0.000	(0.012)		
	Chiller Replacement (Pathology)	(0.720)	(0.720)	(0.198)	0		
	Maternity AHU Replacement	(0.630)	(0.630)	(0.226			
	Other Estates Safety schemes	(0.916)	(0.916)	(			
Total Estates Safety		**(5.056)**	**(5.**				
Diagnostics:	MRI replacement	(1.448)					
	MRI Acceleration software	(0					
	ECHO Equipment for Phyiological Scieinces						
	CDC Expansion- Design works to RIBA stage 4						
	CDC 4th Site Trowbridge Design works to RIBA sta						
Elective:	Gastroenterology / General Surgery Out Pat						
	Gynae Theatre Clinical Pathway Rede						
UEC:	Admisson & Transfer Lounge						
	Medical Short Stay expan						
	Integrated front Do						
	Neurology W						
	IPC Pro						
	S						
Total Con							
TO							



Understanding Performance	Countermeasures	Owner	Due Date
EPR scheme is behind plan for the PDC funded element, the current forecast from EPR Board is for full allocation to be spent in year. The Return to Constitutional Standards schemes are yet to be approved, which is why there is no committed spend YTD.	**Completed:** 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. .

Trust - Statement of Financial Position

Royal United Hospitals Bath NHS Foundation Trust

Statement of financial position As at September 2025	M6 FY2025-26 30/09/2025 £m	FY2024-25 31/03/2025 £m	Variance £m	%Variance
Non current assets				
Intangible assets	6.286	7.096	(0.810)	(11.415)%
Property, Plant & Equipment	320.302	330.248	(9.946)	(3.012)%
Right of use assets - leased assets for lessee	47.498	49.730	(2.232)	(4.488)%
Investments in associates and joint ventures	3.941	3.941	0.000	0.000%
Trade and other receivables	4.891	5.184	(0.293)	(5.652)%
Total non current assets	**382.918**	**396.199**	**(13.281)**	**(3.352)%**
Current Assets				
Inventories	6.795	6.782	0.013	0.192%
Trade and other receivables	27.775	30.746	(2.971)	(9.663)%
Cash and cash equivalents	30.461	36.648	(6.187)	(16.882)%
Total current assets	**65.031**	**74.176**	**(9.145)**	**(12.329)%**
Current Liabilities				
Trade and other payables	(42.724)	(61.625)	18.901	(30.671)%
Other liabilities	(23.705)	(8.634)	(15.071)	174.554%
Provisions	(0.427)	(0.932)	0.505	(54.185)%
Borrowings	(2.238)	(2.530)	0.292	(11.542)%
Total current liabilities	**(69.094)**	**(73.721)**	**4.627**	**(6.276)%**
Total assets less current liabilities	**378.855**	**396.654**	**(17.799)**	**(4.487)%**
Non current liabilities				
Provisions	(9.895)	(1.315)	(8.580)	652.471%
Borrowings	(53.440)	(54.896)	1.456	(2.652)%
Total assets employed	**315.520**	**340.443**	**(24.923)**	**(7.321)%**
Financed by:				
Public Dividend Capital	285.705	285.705	0.000	0.000%
Income and Expenditure Reserve	(11.265)	13.658	(24.923)	(182.479)%
Revaluation reserve	41.080	41.080	0.000	0.000%
Total equity	**315.520**	**340.443**	**(24.923)**	**(7.321)%**

Understanding Performance

Non-current assets – Top contributor is property, plant and equipment with a net variance of £10.04m. The variance is made of depreciation charged year to date, capital spend, impairment and lease restoration provisions.

Current assets – Cash variance is set out within the cash slide.

The key contributor to the decrease in receivables is release of accruals due to payment and a slight increase in collections.

Current liabilities – Top contributor is other liabilities with a net movement of £15.1m year to date, this relates to transitional funding received in advance which has been deferred.
Key movement in the decrease in trade and other payables is payment of capital creditors £7.12m and non-capital creditors £11.689m.

Non-current liabilities – Significant increase of £8.58m in provisions relates to a provision for restoration costs relating to Sulis Orthopaedic Centre.

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.

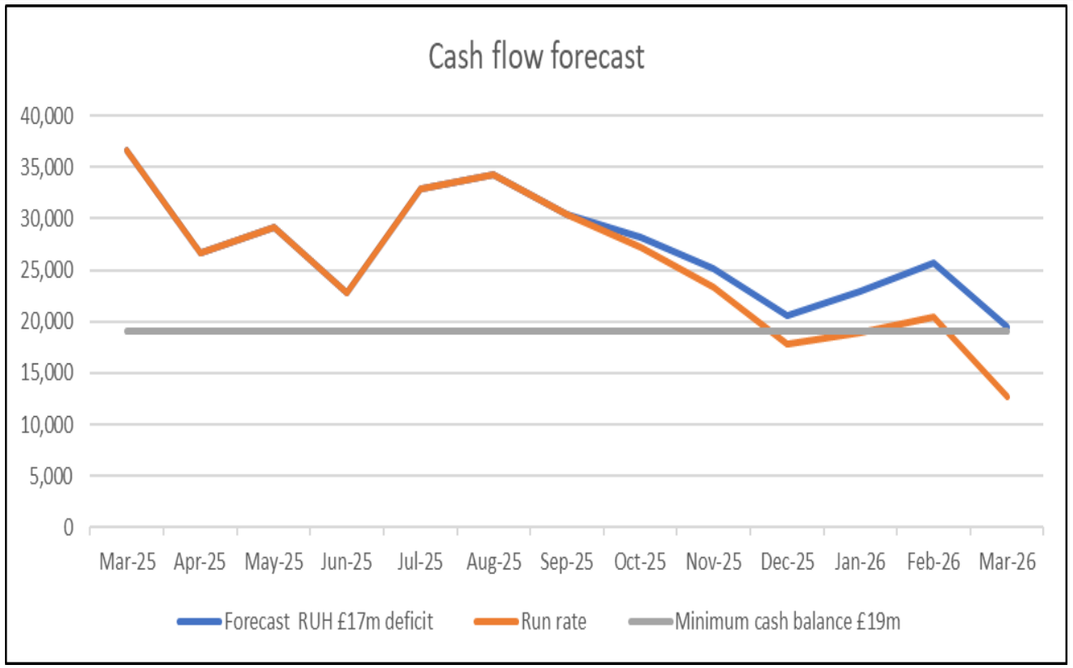
Risks relating to receivables, payables, BPPC and cash have been set out in their respective slides.

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 & John Palmer	Monthly Monitoring

Cash

Royal United Hospitals Bath NHS Foundation Trust

Statements of Cash Flows	Actual £'m
EBITDA deficit	(8
Income recognised in respect of capital donations (cash and non-cash)	
Impairments	
Working capital movement	
Provisions	
Net cash used in operating activities	
Capital Expenditure	
Cash receipts from asset sales	
Donated cash for capital assets	
Interest received	
Net cash used in investing activities	
Capital element of finance lease rental p	
Interest on loans	
Interest element of finance lease	
PDC dividend (paid)/refunded	
Net cash used in financing	
Decrease in cash and ca	
Opening cash balan	
Closing cash	
Adjuste	
A	



The blue line represent the forecast of £17m deficit (£19.5m deficit RUH and £1.5m surplus) Sulis.

The orange line represents the run rate forecast, this is made up of actual cash flow to date and assumes these savings year to date continue at the same rate.

The grey line is the minimum cash balance required for the Trust.

Understanding Performance

From the graph above, actual cash balances were £4.4m lower than the forecast balance.

Key drivers:

1. Fixed income inflows were £3.224m higher than forecast.
2. Capital PDC inflow of £4.206m was not received as forecast.
3. Receipts from HMRC totalled £2.010m, compared to the forecast of £0.459m.
4. Pay costs were £2.312m higher than forecast.
5. BACs payment exceeded forecast by £3.803m.
6. Slippage in capital spend of £4.207m
7. Planned savings of £3.121m were not achieved as expected.

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	**1.226**	0.293	0.665	0.086	0.182	0.000	£0.882m invoices are approved and awaiting payment. The outstandin with the debt recovery policy.
NHS England	**0.707**	0.177	0.507	0.000	0.002	0.022	Oldest invoice is under review by Financia requested. The remaining balance
Great Western Hospitals NHS F/T	**0.528**	0.119	0.189	0.038	0.095	0.086	£0.120m relates to Sim balances are b
NHS Bath and North East Somerset Swindon and Wiltshire Integrated Care Board	**0.492**	0.448	0.044	0.000	0.000		
HCRG Care Services Ltd	**0.349**	0.028	0.320	0.000			
Sundry Customers - Overseas Patient	**0.290**						
RUH Charitable Fund							
Gloucestershire Hospitals NHS F/T							
Alliance Medical Limited							
BANES Council							
Tota							

Understanding Performance	Countermeasures	Owner	Due Date	Risks and Mitigation
The total amount of invoiced receivables as at 30 September 2025 is £6.6m. From the table above, of the total receivable balance of £4.4m, £1.5m is not yet due for collection, while the remaining balances are being chased for payment in line with the Trust bad debt recovery policy, with some amounts already 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	
L Rowlands (Retail) Ltd	**(1.100)**	0.000	(1.106)	0.006	0.000	0.000	Approved for payment.
Oracle Corporation UK LTD	**(0.972)**	(0.046)	(0.172)	(0.175)	(0.195)	(0.385)	Invoices were held due to No PO No Pay policy.
NHS Supply Chain (Consumables)	**(0.677)**	(0.677)	0.000	0.000	0.000	0.000	Invoices paid in October.
Veolia Energy &Utility Services UK LTD	**(0.603)**	(0.603)	0.000	0.000	0.000	0.000	Not due for payment.
Beckman Coulter UK Ltd	**(0.465)**	(0.465)	0.000	0.000	0.000	0.000	Invoices paid in October.
Great Western Hospitals NHS Foundation Trust	**(0.389)**	(0.029)	(0.110)	(0.073)	(0.030)	(0.148)	£0.107 invoices were paid in October, £0.030 approved for payment and the remaining invoices are awaiting approval.
Moduleco Healthcare LTD	**(0.388)**	0.000	0.000	0.000	(0.388)	0.000	Credit note of £0.024 was approved and the invoice of £0.412 is pending BH approval following completion of works.
NHS Supply Chain (Maintenance)	**(0.369)**	(0.170)	0.000	(0.199)	0.000	0.000	£0.207 invoices were paid in October and £0.162 approved for payment.
Intuitive Surgical Ltd	**(0.303)**	(0.303)	0.000	0.000	0.000	0.000	Invoices of £0.158 was paid in October and the remaining invoices are awaiting approval.
North Bristol NHS Trust	**(0.301)**	(0.003)	(0.099)	(0.055)	(0.053)	(0.092)	Invoices of £0.158 approved for payment and the remaining invoices are awaiting approval.
Total	**(5.568)**	**(2.295)**	**(1.487)**	**(0.496)**	**(0.665)**	**(0.625)**	

Understanding Performance	Countermeasures	Owner	Due Date	Risks and Mitigation
The total amount of invoiced creditors at 30 September 2025 was £11.2m. From the table above, of the total £5.6m balance, £2.295m is not yet due for payment, while the remaining balances are being chased for approval with budget holders.	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

	Sep-25		Aug-25		% Variance	
	Volume ('m)	£'m	Volume ('m)	£'m	Volume ('m)	£'m
Non NHS						
Total bills paid in the year	37.019	198.02	30.327	164.713	22%	20%
Total bills paid within target	35.237	169.532	28.909	138.538	22%	22%
Percentage of bills paid within target	**95%**	**86%**	**95%**	**84%**	**0%**	**2%**
NHS						
Total bills paid in the year	0.72	9.29	0.5	7.304	45%	27%
Total bills paid within target	0.57	5.393	0.37	3.855	55%	40%
Percentage of bills paid within target	**79%**	**58%**	**74%**	**53%**	**7%**	**10%**
Total						
Total bills paid in the year	37.743	207.31	30.827	172.017	22%	21%
Total bills paid within target	35.81	174.925	29.279	142.393	22%	23%
Percentage of bills paid within target	**95%**	**84%**	**95%**	**83%**	**0%**	**1%**

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 values. There is a slight improvement of 1% in values as at September 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

The percentage is based on invoices paid in month and excludes the exceptions as set out in the No PO No Pay policy.

Understanding Performance	Countermeasures	Owner	Due Date	Risks and Mitigation
The table above outlines purchase order (PO) compliance across the Trust for Month 6; it excludes suppliers exempt from using a PO. Key drivers of non-compliance by divisions are as follows : - Capital summary: BSW EPR recharges, autoclave replacement design and SEOC invoices were processed without POs. - Corporate division; Procurement recharges and licence renewal in finance, EPR services, medical records, and patient experience team invoices were processed without POs. - Estates and facilities: Waste management service, transport service, and non-patient portering invoices were processed without POs. - Family and Specialist Services: Gynaecology outpatients, oncology medical staff, clinical haematology, maternity contracts, and pharmacy week coverage invoices were processed without POs. - Medical Division; Radiology and dermatology medical staff, adult therapies patients, and ultrasound invoices were processed without POs. - Surgical Division; Cellular pathology, robotic assisted surgery, orthopaedic prosthesis loan kits invoices were processed without POs.	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	Ongoing	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	Ongoing	

Sulis – In Month

Royal United Hospitals Bath
NHS Foundation Trust

Month Performance against Budget P06

Statement of Comprehensive Income	SULIS Budget	SULIS Actual	SULIS Variance	CDC Budget	CDC Actual	CDC Variance	SOC Budget	SOC Actual	SOC Variance	TOTAL Budget	TOTAL Actual	TOTAL Variance
Commissioner Income (NHSE/CCG)	1,972	2,137	165	496	396	(100)				2,468	2,533	65
Other Patient Care Income	1,172	1,434	261							1,172	1,434	261
Other Operating Income	34	36	2				841	787	(54)	875	822	(53)
Income Total	3,178	3,606	428	496	396	(100)	841	787	(54)	4,515	4,789	274
Pay	(1,488)	(1,694)	(206)	(229)	(202)	26	(372)	(303)	69	(2,089)	(2,199)	(110)
Non Pay	(1,451)	(1,470)	(20)	(188)	(129)	58	(469)	(484)	(15)	(2,107)	(2,084)	24
Depreciation	(239)	(234)	5	(35)	(34)	2				(274)	(268)	7
Expenditure Total	(3,178)	(3,398)	(220)	(452)	(366)	86	(841)	(787)	54	(4,471)	(4,551)	(80)
Operating Surplus/(Deficit)	0	208	208	44	30	(14)	0	0	0	44	238	194
Other Finance Charges	(37)	(37)	0	(6)	(6)	0				(43)	(43)	0
Other Gains/Losses												
Finance Charges	(37)	(37)	0	(6)	(6)	0				(43)	(43)	0
Surplus/(Deficit)	(37)	171	208	38	24	(14)	0	0	0	1	195	194

Balance Sheet
Cash Balance £1.21m
Average of prior year £1.615m
Cash currently forecast to run out in November

Understanding Performance

NHS Income: Sulis income was 108% of budget. All modalities apart from General Surgery exceeded budget. CDC activity was 80% of Budget. The shortfall was in Radiology, Cardiology and Sleep Studies.
Other patient Care Income: 122% of budget with the overachievement in Trauma & Orthopaedics and Cosmetics.
Pay: Payroll plus Agency costs were in line with budget. Provider fees were £106k above, driven by the higher activity than budgeted.
Non Pay: Total non pay costs were £24k lower than budget. Positive variances were in electricity (£56k), external services (£58k) and insurance (28k). These were offset by negative variances in rent (£104k) and £46k in small equipment purchases.

Countermeasures	Owner	Due Date
Getting bookings in earlier – 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 & Endoscopy	Sam Harrison	Now in place
Optimise the surgeon mix and availability to ensure a steady predictable flow of high margin work in Sulis	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

Sulis – Year to Date

Royal United Hospitals Bath NHS Foundation Trust

YTD Performance against budget **YTD P06**

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)	11,719	11,951	232	3,057	2,635	(421)				14,776	14,587	(189)
Other Patient Care Income	7,023	7,372	349							7,023	7,372	349
Other Operating Income	199	185	(14)				4,407	3,666	(741)	4,606	3,851	(755)
Income Total	18,941	19,509	568	3,057	2,635	(421)	4,407	3,666	(741)	26,405	25,810	(595)
Pay	(8,819)	(9,378)	(558)	(1,340)	(1,628)	(288)	(2,049)	(1,636)	413	(12,209)	(12,642)	(433)
Non Pay	(8,175)	(7,488)	687	(1,633)	(1,756)	(123)	(2,358)	(2,030)	328	(12,167)	(11,274)	893
Depreciation	(1,430)	(1,409)	21	(210)	(204)	7		0	0	(1,640)	(1,613)	28
Expenditure Total	(18,425)	(18,275)	150	(3,184)	(3,588)	(404)	(4,407)	(3,666)	741	(26,015)	(25,528)	487
Operating Surplus/(Deficit)	516	1,234	717	(127)	(952)	(825)	(0)	0	0	389	281	(108)
Other Finance Charges	(232)	(232)	0	(39)	(39)	(0)				(271)	(270)	0
Other Gains/Losses		(0)	(0)								(0)	(0)
Finance Charges	(232)	(232)	0	(39)	(39)	(0)				(271)	(270)	0
Surplus/(Deficit)	285	1,002	717	(166)	(991)	(825)	(0)	0	0	119	11	(108)

Understanding Performance

Countermeasures	Owner	Due Date

Risks and Mitigation

Appendix

Business Rules

SPC Guidance

Business Rules - Driver metrics

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

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

Business Rules – Watch metrics

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

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

Business Rules – Standard/Mandatory Metrics

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

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

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

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Public Board of Directors	Agenda item:	12.0
Date of Meeting:	5 November 2025		

Title of Report:	RUH Winter plan for urgent and emergency care 2025/26
Status:	For discussion
Board Sponsor:	Bernie Bluhm, Chief Operating Officer
Author:	Sarah Hudson, Director of Site Operations
Appendices	1. RUH Winter plan for urgent and emergency care 2025/26 2. RUH Quality impact assessment BSW template winter assurance

1. Executive Summary of the Report

The aim of this report is to provide an overview of the Royal United Hospitals Bath NHS Foundation Trust (RUH) winter plan which has been developed to deliver operational resilience for the winter period 2025/26, specially from week commencing the 27th of October 2025 to the end of March 2026. The plan has been produced based on.

- Learning from 2024/25
- Capacity and demand modelling
- System planning assumptions
- RUH estates and capital plan

The purpose of this report is to provide assurance that planning in conjunction with modelling of activity and evaluation of winter schemes, will sustain the key acute trust performance targets and trajectories whilst supporting wide system resilience, specifically; 4-hour urgent and emergency care access, infection prevention and control, referral to treatment and cancer waiting times. In addition to supporting staff resilience.

Provide assurance that all actions are in place to reduce overcrowding within the Emergency Department and improve flow within the RUH and across the wider system. There are several national key safety themes which remain a high focus and as such have been considered when developing this plan:

- Timely ambulance handover
- Time to first clinical assessment
- Timely access to specialist opinion in line with the internal professional standards
- Clear internal and external escalation response
- Management of deteriorating patients
- Plans to ensure robust staffing across all staff groups

The plan will be subject to further refinement ahead of the winter period reflecting Trust developments and wider system actions over the coming months which will complement a BSW system wide response during the winter period.

2.	Recommendations (Note, Approve, Discuss)

The report is for approval; specifically, to seek agreement on the following.

- The proposal to utilise Philip Yeoman ward (12 beds) for non-elective trauma and orthopaedic activity, which includes elective displacement to Sulis Hospital and associated impact and noting that the proposal is for a two-month period (December to the end of January 2026).
- On call manager role and responsibilities including a proposed change to weekday and weekend duty managers until night shift medical handover.
- Forecasted bed base and occupancy and associated risk with BSW system partner delivery.

3.	Legal / Regulatory Implications

No legal or regulatory implications identified.

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

Risks relating to 4-hour performance and ambulance handover time.

Risks associated with the BSW system partner elements of the winter plan including NCTR reduction in line with agreed plans and schemes to deliver additional capacity including specialist services such as respiratory hubs.

5.	Resources Implications (Financial / staffing)

Presented in the paper as options for consideration, and or alternatives to planned expenditure which will be developed and implemented through the weekly winter working group once agreed.

6.	Equality and Diversity

The aim of the RUH winter plan is to improve access and to provide assurance that all actions are in place to reduce overcrowding within the Emergency Department and improve flow within the RUH and across the wider system to the benefit of all patients and staff.

7.	References to previous reports/Next steps

Strategic Executive Forum 14/08/2025
Management Executive Committee 27/08/2025 and 24/09/2025

8.	Freedom of Information

Public

9.	Sustainability

Nil to note.

10.	Digital

Nil to note.

Winter Plan for Urgent and Emergency Care 2025/26

1. Executive Summary

The aim of this report is to provide an overview of the Royal United Hospitals Bath NHS Foundation Trust (RUH) winter plan which has been developed to deliver operational resilience for the winter period 2025/26, specially from week commencing the 27th of October 2025 to the end of March 2026. The plan has been produced based on.

- Learning from 2024/25
- Capacity and demand modelling
- System planning assumptions
- RUH estates and capital plan

1.1 Overview and purpose of the plan

The purpose of this report is to provide assurance that planning in conjunction with modelling of activity and evaluation of winter schemes, will sustain the key acute trust performance targets and trajectories whilst supporting wide system resilience, specifically; 4-hour urgent and emergency care access, infection prevention and control, referral to treatment and cancer waiting times. In addition to supporting staff resilience.

Provide assurance that all actions are in place to reduce overcrowding within the Emergency Department and improve flow within the RUH and across the wider system. There are several national key safety themes which remain a high focus and as such have been considered when developing this plan:

- Timely ambulance handover
- Time to first clinical assessment
- Timely access to specialist opinion in line with the internal professional standards
- Clear internal and external escalation response
- Management of deteriorating patients

- Plans to ensure robust staffing across all staff groups

The plan will be subject to further refinement ahead of the winter period reflecting Trust developments and wider system actions over the coming months which will complement a BSW system wide response during the winter period.

1.2 Summary of key risks and mitigation strategies

A weekly meeting has been established for the winter period with the key RUH stakeholders to oversee the development and implementation of the schemes and actions identified in this paper to be chaired by the Director of Site Operations, reporting to the Chief Operating Officer, and supported by the Clinical Division Directors, to ensure that the programme is clinically led. High level risks identified include.

- Emergency Department overcrowding affecting patient and staff experience and quality
- Rapid ambulance handover within 45 minutes to improve category two response times
- Urgent treatment centre practitioner and Emergency Department senior decision makers overnight staff levels and the consistently of matching staff to demand
- Sustaining Hospital at Home occupancy at 62 patients
- Non criteria to reside improvement to number of occupied beds days in line with BSW trajectory (9% bed base occupancy) as limited number of non-elective escalation beds available
- Impact of planned estates work on the non-elective bed base
- Earlier discharge and occupancy of the discharge lounge
- Trauma and orthopaedic elective delivery during winter
- Resident doctor industrial action
- Understanding primary care demand and impact on secondary care to be able to respond – use of predictive analytics
- Delivery of system winter schemes including adult acute respiratory illness and pathway one capacity

1.3 Strategic goals for winter resilience and mitigation strategies

The winter plan should mitigate or minimise the impact of winter on our constitutional standards (including ambulance handovers within 45 minutes), patient and staff safety and experience. The RUH will be a proactive and supportive partner within the BSW group and systems (Somerset and BNSSG) to ensure the collaborative approach to manage witter is optimised.

To ensure operational resilience and patient safety throughout the winter period, the hospital is focused on delivering a coordinated strategy that mitigates seasonal pressures and optimises urgent and emergency care (UEC) pathways. Key strategic goals include maintaining patient flow, reducing avoidable admissions, and maximising discharge efficiency. The UEC programme underpins this approach through the redesign of the Urgent Treatment Centre (UTC) to improve front-door streaming and reduce ED congestion, expansion of Same Day Emergency Care (SDEC) to manage more than 40% of the medical take, and capacity management to review ward configuration aligned with bed modelling and reduction in non-elective length of stay. A core component of the mitigation strategy is the “Home is Best” initiative, which aims to deliver 9% of the bed base through no criteria to reside (NCTR) pathways, supported by integrated discharge planning and community-based care. These measures collectively support the hospital’s ambition to maintain safe staffing, reduce escalation, and ensure timely access to care during peak demand.

---

2. Objectives

- Ensure patient safety and continuity of care during periods of high demand.
- Minimise delays in urgent and emergency care.
- Improve system-wide coordination and flow.
- Reduce unnecessary hospital admissions and length of stay.

---

3. Governance and Leadership

3.1 Winter planning team members

Stakeholders from RUH Clinical Divisions, Business Intelligence, Infection Prevention and Control, Capital Projects, and facilities have been consulted in the production of this plan (table 1).

Name	Role
Bernie Bluhm	Chief Operating Officer
Jason Lugg	Deputy Chief Nursing Officer
Olivia Ratcliffe	Deputy Chief Nursing Officer
Fenella Maggs	Clinical Director Medicine
Jo Lloyd-Rees	Divisional Director of Nursing Medicine
Calum MacGregor	Divisional Director of Operations Medicine
Sufi Hussain	Deputy Chief Operating Officer
Jonny Price	Clinical Director Surgery
Mel Broad	Divisional Director of Nursing Surgery
Meggan Jarvis	Divisional Director of Operations FASS
Kevin Jenner	Divisional Director of Nursing FASS
Ian Kerslake	Clinical Director FASS
Erin Houlihan	Matron for Housekeeping
Mandy Rumble	Clinical Lead Capital Projects
Lisa Hocking	Deputy Director Infection, Prevention & Control & Associate Chief Nurse
Jamie Caulfield	Deputy Director of Estates and Facilities
Gary Cross	Head of Security
Shaun Lomax	Deputy Head of BIU
Charlie Gale	Head of BIU
Annika Atkins	Programme Lead: Future Analytics
Sarah Hudson	Director of Site Operations
Nuno Aguiar	Specialty Manager Radiology & Diagnostics
Helen Back	Associate Director for People – Capability and Planning
Kevin Worlock	Head of Cleaning Services

Table 1: RUH Winter weekly group membership

3.2 Meeting frequency

A weekly meeting has been established for the winter period with the key RUH stakeholders to oversee the development and implementation of the schemes and actions identified in this paper to be chaired by the Director of Site Operations, reporting to the Chief Operating Officer, and supported by the Clinical Division Directors, to ensure that the programme is clinically led. To provide a cross-Divisional forum in which to review such proposals prior to presentation to the Chief Operating

Officer and appropriate forums for example Executive Team or the Management Executive Committee.

3.3 Escalation framework

To ensure operational resilience and patient safety, the RUH has embedded a robust escalation framework that enables timely, coordinated responses to system pressures and management during incidents (critical and business continuity). The framework is designed to support the delivery of urgent and emergency care and maintain flow across the hospital and wider system.

The Trust conducts four site meetings daily, during which demand, capacity, and flow are assessed using a defined set of criteria. Each criterion is scored, and the cumulative score determines the hospital's Operational Pressures Escalation Level (OPEL). The status is also submitted to SHREWD Resilience, a system-wide platform that provides a real-time operational view of local urgent care systems. SHREWD enables users to quickly identify pressure points, understand causative factors, and initiate appropriate actions, supporting the effectiveness of the BSW System Coordination Centre.

The Trust's escalation status is updated four times daily and is visible on both Millennium and the Trust website, ensuring transparency and accessibility. A site report is also distributed internally and externally via email at each update point, facilitating system-wide situational awareness and coordinated response.

In preparation for winter 2025/26, the Trust Escalation Policy was reviewed and updated in May 2025, introducing operational changes to enhance responsiveness. Notably, the NHS England FOCUSSED model has been incorporated to guide structured decision-making for bed management.

Additional arrangements for winter include:

- Confirmation of escalation spaces in line with NHS England guidance.
- Defined escalation structure and authority levels: Clear governance for triggering actions during demand surges, ensuring timely activation of surge capacity and workforce deployment.

This escalation framework is aligned with the Trust's broader winter resilience strategy and should be read in conjunction with the following supporting documents:

- OPEL Escalation Triggers and Escalation Policy
- Confirmed/suspected Influenza Policy
- Incident Response Plan (EPRR)
- Business Continuity Plans – Trust-wide and Departmental

Together, these arrangements ensure that RUH remains responsive, resilient, and capable of delivering safe, effective care throughout the winter period.

4. Demand Forecasting and Capacity Planning

A comprehensive and data-driven approach is essential to ensure resilience across services during the winter period. This section outlines key planning domains that underpin operational readiness. It begins with data analysis, using historical activity trends, flu and COVID-19 modelling, and weather forecasts to anticipate demand surges. Based on these projections, the plan details bed capacity planning, including acute, critical care, and step-down facilities, to support safe patient flow. A robust surge planning framework defines escalation triggers and thresholds to guide timely responses during periods of increased pressure. Finally, elective activity planning outlines strategies for prioritisation and potential deferrals to maintain clinical safety and optimise resource allocation.

4.1 Data analysis

Winter 2024/25 provided insights into managing heightened demands and seasonal challenges. With increased patient admissions due to flu and respiratory illnesses, the RUH faced significant pressures on staff, resources, and infrastructure. The experience highlighted the importance of proactive planning, optimising patient flow, and reinforcing infection prevention measures. It also recognised the need for more robust staffing strategies and cross-department collaboration during peak periods. Three critical incidents were declared over winter. The root cause being a sustained increase in clinical acuity affecting ICU and specialty bed occupancy, which was not forecasted.These learnings have been invaluable in refining the approach for 2025/26, ensuring the RUH are better prepared to handle future winter surges while striving to deliver high-quality patient care.

4.11 ED attendances

Daily ED attendance numbers were highly variable last winter (2024/2025), averaging 276.6 per day with 90% of days between 238 and 313. Despite there being signals of the factors that influence attendance numbers, e.g. day of the week, time of year and bank holidays, and our use of modelling that incorporates these into a forecast, there is still high degree of uncertainty.

It is known that Monday had the highest average attendances but there is still high variability, between 254 and 331. This high variability exists within each day of the week, from Friday with the lowest amount to Wednesday and Sunday with the highest, demonstrating that day of the week is a small factor in the overall variability seen.

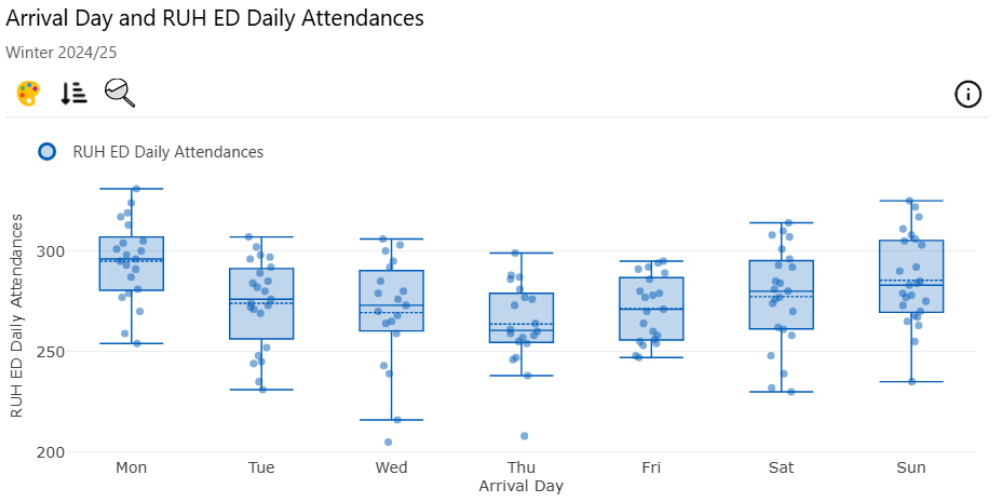


Chart 1: RUH Daily attendances by day of the week

The Prophet model forecast generated by BSW BI Team (red-line in chart 2 below) shows attendances declining throughout October 2025 before rising slightly in mid-November to mid-December 2025 and declining the week before Christmas until mid-January. This is followed by a rise until mid-March. This follows a similar trend to last winter but with a higher dip in January. There is uncertainty in the forecast, with an average range of 94 attendances between the lower & upper forecast (not shown on chart).

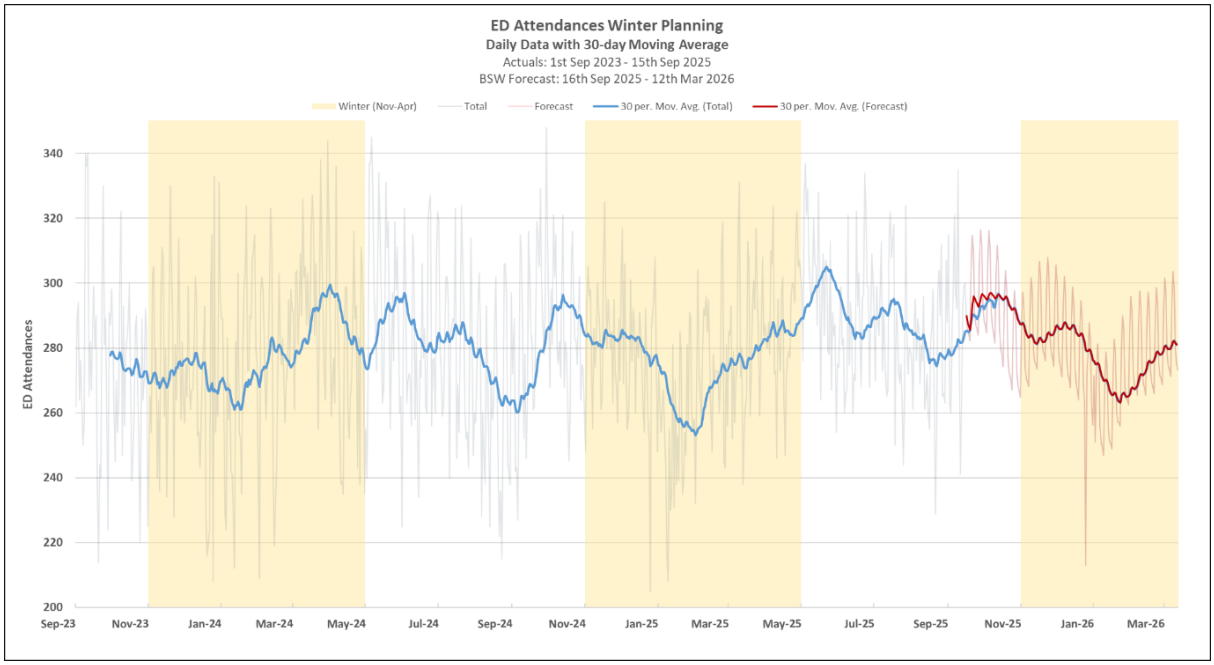


Chart 2: RUH ED attendances daily average

Whilst ED attendances are forecasted to repeat the January dip, the acuity of these patients has been shown to increase during this time (see January-2024 and January-2025 in chart 3 below):

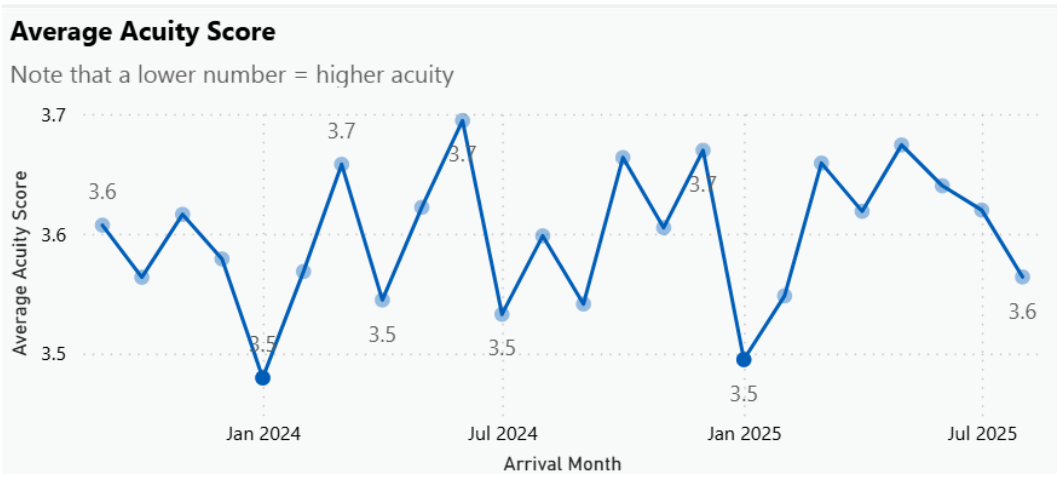


Chart 3: RUH ED average acuity score January 2024 – January 2025

The following four charts show the activity split by admitted/non-admitted and adults/paediatrics. The forecasted element is derived from the total forecast proportioned monthly into each category (based on the last winter) and not forecasted specifically by the model.

4.12 Non-admitted ED patients – adults

Patients who are not admitted following an ED attendance is much more seasonal than admitted (for adults) and is expected to follow a similar trend to last winter. The majority of patients who attend ED via the UTC are not admitted. This position reinforces that planning, especially for Q4 must be focused to ensure that UTC is staffed to manage the demand and operate to a standard where >90% of patients are seen and discharged within 4 hours of arrival.

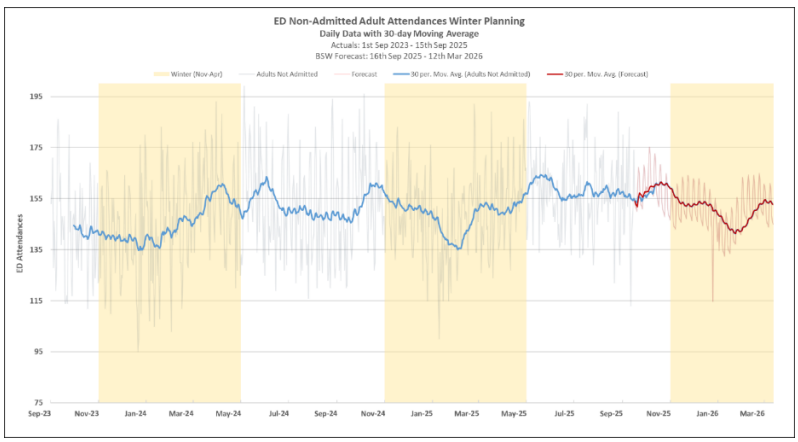


Chart 4: ED non admitted attendances – adult

4.13 Non-admitted ED patients – children

Children who are not admitted following an ED attendance is highly seasonal. Typically, there is a fast increase in October to November followed by drop in summer months which is forecasted for this winter. An increase in medical staffing during these periods is required, especially in the evening and at weekends, when the demand profile is higher.

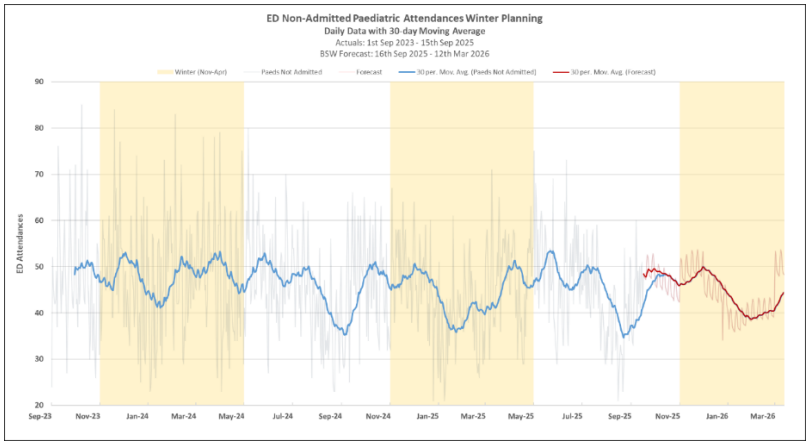


Chart 5: ED non admitted attendances - children

4.14 Admitted demand – adult

The percentage of patients admitted to the RUH is expected to remain consistent during the winter period. Discharge planning therefore needs to be in line with the forecasted demand and recognising the predicted periods of bed shortfall as per the bed modelling, which will be supported by actions being taken as part of the Urgent and Emergency Care improvement programme.

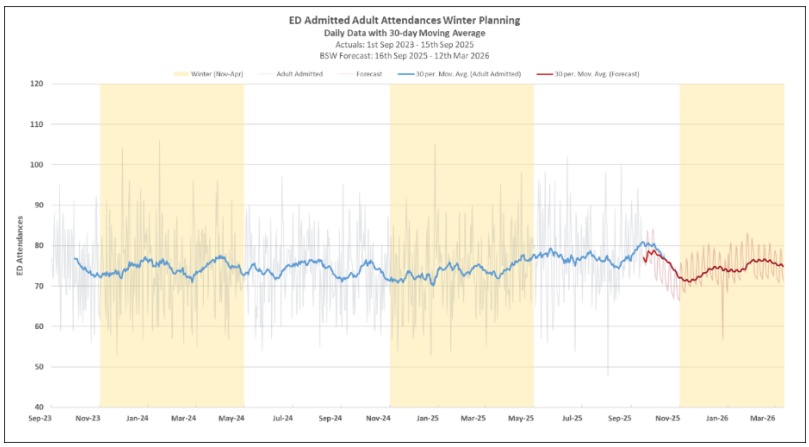


Chart 6: ED admitted attendances – adult

4.14 Admitted demand – children

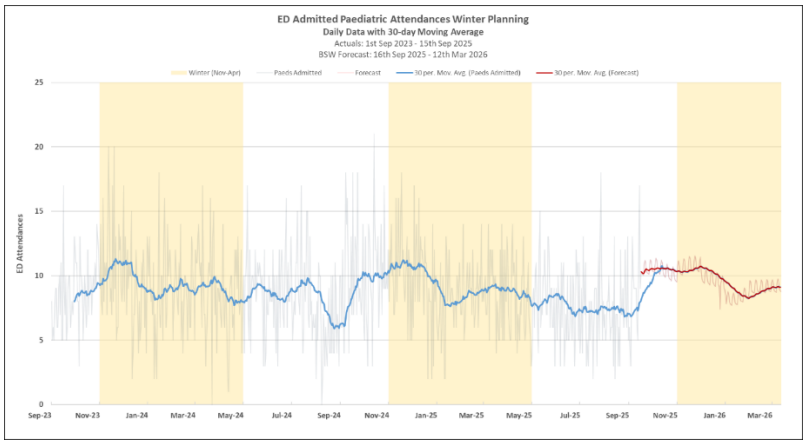


Chart 7: ED admitted attendances - children

4.2 Bed capacity planning

4.21 Bed Base

In planning for winter, the RUH has a total of **512** core General Adult beds, **5** funded escalation beds. Currently there is no vacant ward space on the RUH Combe Park site to convert into additional winter capacity to address surge.

Included in the core bed total are **forty protected elective** beds in the RUH and therefore the total number of **non-elective** beds available for winter 2025/26 are **472**.

Clinical Division	Core Beds	Escalation	Total
FASS	22	0	22
Medicine	331	4	335
Surgery	159	1	160
Total beds	**512**	5	517
Total elective capacity	**40**	**0**	**40**
Total non-elective capacity	**472**	**5**	**477**

Table 2: General Adult (G&A) core and escalation beds by clinical division

Further to the adult general and acute bed, there are also **twenty-four** core children's beds and a further **5** escalation beds: a total of **29** beds available for children (excluding neonatal care). The forecasted bed model currently demonstrates that there is sufficient bed capacity for children.

There is current capacity for **62** patients in the RUH hospital at home service. In line with bed modelling rules, the hospital at home capacity has been reflected as a factor which manages non-elective bed day demand and is therefore included in this calculation and not as additional bed capacity. The non-criteria to reside position, based upon year-to-date actuals, is not forecasted to improve in this model. If, the BSW improvement programmes deliver, the model will be reviewed.

Overall, there is no net increase in the bed capacity planned for winter 2025/26, and the escalation capacity also remains unchanged, although reduced compared to winter 2024/25.

In April 2025, the forecasted occupancy submitted to NHS England as part of planning, forecasted a bed surplus during the winter period (table 3).

		Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Plan	Total beds Required Adult & Paeds	551	542	538	541	499	503	475	476	494	500	467	487
Plan	Total Beds Available Adult & Paeds	551	551	551	551	542	542	542	541	541	541	541	541
Plan	Bed Surplus / Shortfall Adult & Paeds	0	9	13	10	43	39	67	65	47	41	74	54
Plan	**Total Bed Occupancy Adult & Paeds**	**100.0%**	**98.4%**	**97.6%**	**98.2%**	**92.1%**	**92.8%**	**87.6%**	**88.0%**	**91.3%**	**92.4%**	**86.3%**	**90.0%**
Actual	**Actual Sitrep Occupancy**	**95.2%**	**94.5%**	**94.0%**	**92.2%**	**93.7%**							

		Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Plan	Total Adult beds Required - CAPPED	522	513	509	512	470	474	446	447	465	471	438	458
Plan	Total Beds Available	522	522	522	522	513	513	513	512	512	512	512	512
Plan	Bed Surplus / Shortfall	0	9	13	10	43	39	67	65	47	41	74	54
Plan	**Total Adult Bed Occupancy**	**100.0%**	**98.3%**	**97.5%**	**98.1%**	**91.6%**	**92.4%**	**86.9%**	**87.3%**	**90.8%**	**92.0%**	**85.5%**	**89.5%**
Actual	**Actual Adult Occupancy**	**96.2%**	**95.6%**	**95.2%**	**93.8%**	**95.6%**							

		Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Plan	Total Paeds beds Required	29	29	29	29	29	29	29	29	29	29	29	29
Plan	Total Beds Available	29	29	29	29	29	29	29	29	29	29	29	29
Plan	Bed Surplus / Shortfall	0	0	0	0	0	0	0	0	0	0	0	0
Plan	**Total Paed Bed Occupancy**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Actual	**Actual Paeds Occupancy**	**73.2%**	**69.6%**	**67.8%**	**57.2%**	**52.9%**							

Table 3: Adult and paediatric occupancy combined

The delivery of the bed surplus is predicated on the delivery in NCTR occupancy is delivered (table 4) and length of stay improvements.

		Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Plan	NC2Roccupied beds in plan	86	90	91	86	90	86	94	97	86	102	105	105
Plan	**NC2Roccupied beds trajectory**	**92**	**85**	**78**	**72**	**66**	**61**	**56**	**52**	**48**	**44**	**41**	**40**
Plan	Change to NC2Roccupied beds	6	-5	-13	-14	-24	-25	-38	-45	-38	-58	-64	-65
Plan	NC2R%occupied beds trajectory	17.6%	16.6%	15.3%	14.1%	14.0%	12.9%	12.6%	11.6%	10.3%	9.3%	9.4%	8.7%
Actual	**Actual NCTR**	**86**	**82**	**81**	**77**	**77**							

Table 4: NCTR improvement assumed in occupancy

The bed surplus in the plan is only possible if BSW deliver the agreed NCTR trajectory in line with 2025/26 planning. Currently this is not being achieved, and this constitutes a high risk to patient flow during winter. If the NCTR benefit is removed, the adult average occupancy is 97.9% for the year, which is in line with the actuals in the sitrep, this includes some months being capped at 100% and as per the planning there were some months with an expected bed shortfall. Table 5 details the capped occupancy without any NCTR improvements (which in effect means running at 25/26 levels).

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Annual
Total Adult beds Required - CAPPED	522	518	522	522	494	499	484	492	503	521	502	521	508.0
Total Beds Available	522	522	522	522	522	513	513	512	521	521	521	521	519.0
Bed Surplus / Shortfall	0	4	0	0	28	14	29	20	18	0	19	0	11
Total Adult Bed Occupancy	100%	99%	100%	100%	95%	97%	94%	96%	97%	100%	96%	100%	97.9%

Table 5: Capped occupancy with no NCTR improvement forecast

4.22 Same Day Emergency Care (SDEC)

SDEC access is key to support ED attendance and admission avoidance. The trust SDEC rate for the winter period of October 2024 to the end of March 2025 was 34.4% across all the services, which is in line with the current trend. It has been assumed that the SDEC rate will continue for Q3 and Q4 in line with planning for 2025/26 and the non-elective bed modelling. The RUH Urgent and Emergency Care programme has been supporting an increase (August 2025 38.3%), the risk will be the use of Medical and Surgical SDEC capacity overnight as mitigation for escalation capacity, which would compromise flow through the SDEC services.

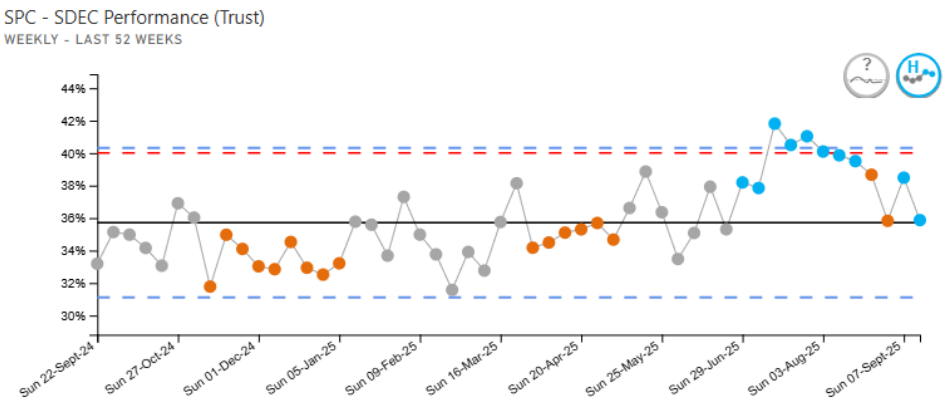


Chart 8: Trust same day emergency care % of patients seen via these pathways

4.23 Factors affecting flow through the hospital

There are several factors which affect patient flow which require close monitoring as business as usual, although through the winter period will be more challenged requiring additional corrective actions taken to improve the position. Areas include patients without criteria to reside, discharge lounge occupancy, infection rates, demand for radiology diagnostics and the planned capital estate programme.

Patients without criteria to reside. During August 2025, the Trust had an average of 71.5 patients waiting who had no criteria to reside. This remains above the system refreshed target of 40 patients or 9% of the bed base. The forecast for winter 2025/26 has assumed that BSW delivers against its improvement programme.

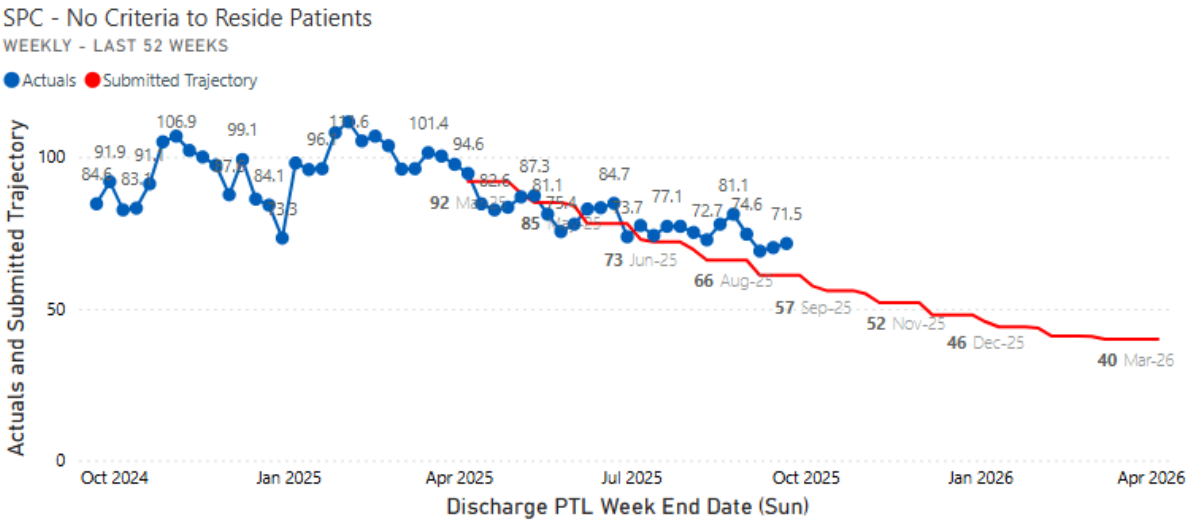


Chart 9: Daily average number of patients not meeting criteria to reside actual and forecast

Discharge Lounge Occupancy. To support early flow out of the ED and to support proactive actions to prevent ED overcrowding if 35 to 40 patients per day were discharged from the lounge it would support consistent flow out of the ED for admitted patients, equivalent to 35% of discharges per day. If capital funding is approved in January 2026 the Discharge Lounge will be relocated with the opportunity to increase the throughput per day due to the flexibility of the space with side rooms, beds and chairs and the ability to use the space as a transfer lounge overnight.

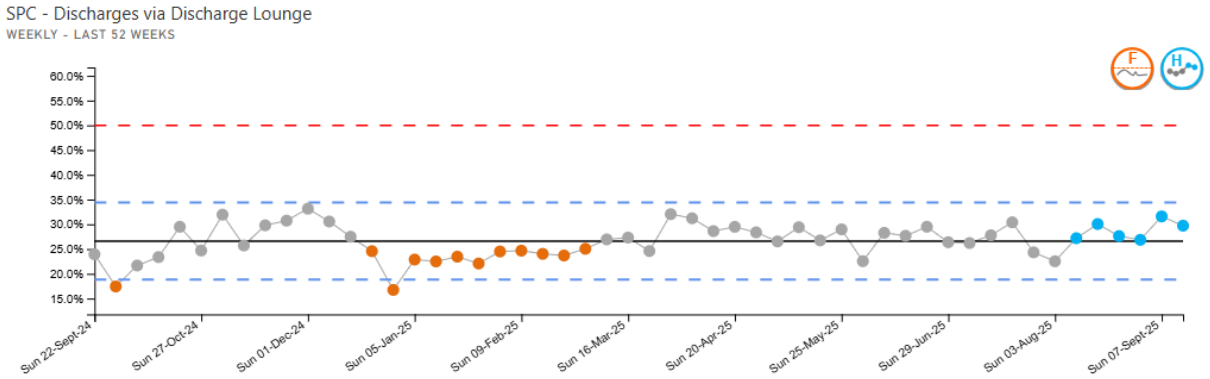


Chart 10: Discharges via the discharge lounge22/09/2024 to 07/09/2025

Increase in radiology inpatient and ED diagnostics demand. Activity levels are in line with capacity plans for this year for CT and MRI. However, increased demand is currently impacting on waiting times and current capacity is insufficient to offset the increased referral volume in year. In 2025-2025, the demand for radiology diagnostics has increased circa 10% year on year. The top contributor for this increase was CT, compared to previous year (chart x). There is CT scanner and an MRI scanner ringfenced for IP/ED work which run 24/7. These scanners deliver on average, 2487 CT scans and 365 MRI scans per month – these activity figures benchmark against the top tier nationally in terms of utilisation and productivity. Capacity has been stable, with activity levels remaining consistent. Despite this, demand continues to impact on waiting times, with increasing number of referrals as well as more complex tests. Further work is required to understand and minimise the impact of diagnostic delays on the patient's time in the Emergency Department and length of stay if admitted.

Additional arrangements to be agreed for winter 2025/26, are focussed on CT, which is the key driver for performance at present.

- Increase ringfenced IP/ED capacity within existing scanning capacity:
- Ringfence 4 hours of CT scanning in one of the OP scanners.
- The associated reduction in OP capacity to support the additional 4 hours of IP scanning every day (Mon-Fri) is mitigated against the increased CT provision at the CDC

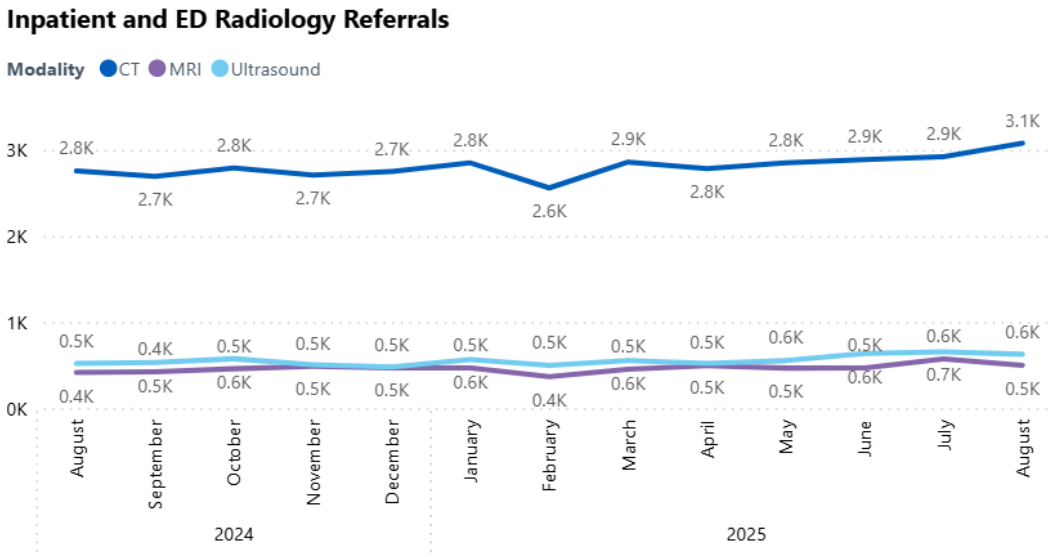


Chart 11: Demand for CT, MRI and ultrasound as an inpatient or attending the emergency department

Infection. In winter, the infections which are of the highest concern in terms of the volume of patients are Clostridioides difficile (C. diff), Covid-19 and Influenza A and influenza B. NHS England will write to the Trust by the end of October 2025 to state when the official start of the influenza season is due to start and end. Modelling, based upon Australian surveillance, has not yet been shared, however anticipating that severe respiratory illness rates will start to increase from early November 2025, peak December and sustain until early February. Actions are therefore required to manage the expected increase in demand for children presenting to ED with RSV and for all patients requiring admission access to rapid testing, and if diagnosed, support timely isolation.

In analysing the impact of IPC on RUH length of stay, there is statistically little correlation between length of stay and occupancy with IPC affected beds (0.1 for LOS and 0.3 for occupancy) - which is very weak positive correlation. However, daily outbreak meetings will support the effective and safe use of beds which are closed in affected areas and the management of patients who are recovered to ensure that side rooms and cohort areas are used effectively. Further work is required on early identification and sampling in Front Door areas and isolation to minimise impact.

4.3 Surge Planning

4.31 The following outlines the schemes currently in development to support patient flow and increase capacity during the winter period to support surge planning. These initiatives are designed to enhance operational resilience and ensure safe, effective

care delivery across the acute hospital setting. In sections 11.12 and 11.13 are detailed costings for each scheme, table 6 below summaries the current forecasted expenditure based on current timelines and skill mix.

Scheme Type	Financial Value (£)
Flow	£340,000
Capacity	£181,000
Total	**£521,000**

Table 6: Financial value of the winter schemes

The staffing trajectories linked to the winter schemes have been considered, to include the impact on bank usage. The net impact has been calculated, based upon the proposed schemes across Months 8 to 12 is 18.6 WTE per month, with an increase to 19 WTE in month 9 only (December 2025).

The following flow initiatives are designed to enhance patient movement through the hospital system, reduce delays, and improve discharge efficiency.

- Deployment of additional Band 3 discharge coordinators on weekends and bank holidays (08:00–16:00).
- Establishment of an Outliers Team (2 MNPs and two Resident Doctors) to manage patients in escalation areas and outlier wards, including weekend coverage.
- Redistribution of therapists (e.g. chest physiotherapy, orthopaedic therapy) to inpatient wards, including weekend coverage. Coordination with the Head AHP.
- Addition of pharmacists to support early to take away (TTA) medication preparation and supply and medicine reconciliation.
- Establish mechanism to work with HCRG and the care homes with the highest ED conveyance and referral to SDEC rates.
- Inpatient specialties to assume responsibility for all CapMan-attributed patients regardless of location, reducing acute medicine burden and sharing inpatient risk. Using the Trusts Capacity Management System (CapMan) to provide each specialty medical team with a list of all patients requiring admission, who are not in the correct location and or are in an assessment or short stay ward to improve ownership, discharge planning and length of stay reduction.
- Institute an additional Upper GI Consultant Round on Mondays and Thursday to reduce time for senior clinical review of patients by this subspecialty and thus reducing length of stay.

- Roster discharge coordinators to work on weekends to improve weekend discharges.
- Conversion of elective theatre lists to Trauma and ESAC to reduce surgical non-elective length of stay.

The following schemes aim to increase physical and workforce capacity to meet anticipated winter demand.

- Utilisation of Philip Yeoman ward (12 beds) for non-elective trauma and orthopaedic activity, which includes elective displacement to Sulis Hospital and associated impact.
- Overnight staffing for Surgical and Medical SDEC with one Band 5 registered nurse per area, seven days a week.
- If HCRG cannot bridge P1 care packages, establish a bridging service using available virtual ward capacity for Wiltshire residents (defined postcode area).
- Pending NHS England funding for Medical Short Stay Unit expansion.
- Relocation of the discharge lounge in January 2026, following capital work, to C16 with two registered nurses on night shift. Interim alternative location closer to core wards under review.
- Locum GIM consultant to cover MSS specialty ward (approved and budgeted under acute medicine).
- Optimisation of Angio list utilisation over winter.
- Respiratory support for front door services by Acute Medicine and Respiratory teams.
- Expansion of IMPACT service beyond BANES for COPD patients during winter.
- Improvement of point-of-care testing strategy and pathology testing capacity and response times.
- Proposed change to weekday and weekend duty managers until night shift medical handover and on call expectations and role of Directors and Managers.
- Infection Prevention and Control capacity to enhance out-of-hours resilience.
- Maintain pace of internal and system actions to close winter bed gap: RUH Hospital at Home occupancy at 95%, NCTR to 9% of bed base, SDEC ≥40% of take, Philip Yeoman surge plan (Jan–Mar 2025), ICU surge above 16 patient occupancy.

4.32 Phillip Yeoman change of use (elective to non-elective)

- Current use of the ward is for clean elective orthopaedic joint surgery.

- Propose that elective Joint surgery will cease on the RUH site during the following period 01/12/25 - 28/02/26.
- The theatre capacity will be repurposed for Trauma and day case surgery which will have the benefit of reducing demand for overnight inpatient beds and reduce length of stay for inpatients awaiting surgery.
- PY beds will be used flexibly for medicine and surgery non-elective demand clinically led to agree on the allocation of the released beds.
- Mitigation for the loss of elective operating on the RUH site will include
    - Increasing utilisation and throughput in
    - Altering case mix towards greater day surgery during this period
    - Prioritising completion of urgent/complex (RUH only) cases prior to this period

4.33 Upper GI Consultant Round

- There is limited consultant workforce with an Upper GI sub-specialism leading to less-than-optimal access to sub-specialty review for this inpatient cohort.
- Additional b consultant Ward rounds will be instituted on Monday and Thursday mornings.
- More frequent sub-specialty review by senior clinician will support reduction of length of stay

4.34 Intensive Care Unit capacity

ICU currently offer 16 beds. There is the opportunity to increase the ICU admission numbers when in surge, using PACU to support immediate flow, to a maximum of 3 additional patients.

In hours, if ICU capacity is exceeded >16 and providing there are no patients awaiting ward beds, ICU can seek mutual aid through the South-West Critical Care Network – this should be only used as an extreme measure in surge and when all other options have been explored. ICU will report our CRITCON status through both DoS and to site daily to give an understanding of the strain the unit is under.

4.35 Paediatric capacity

Access to Acute Respiratory Infection (ARI) hubs will be provided across BSW over winter in line with NHS England guidance.

The inclusion criteria are adults and children with acute respiratory symptoms, most likely due to infection (e.g. bacterial or viral infections including COVID-19, respiratory syncytial virus (RSV), influenza), who have been identified through an initial remote/triage consultation as requiring face-to-face assessment but not hospitalisation. In 2025/26, 111 will be able to refer directly, enhancing 2024/25 model of GP referral.

A further two hundred slots are provided in 2025/26, totalling 1800 slots over four months. The hubs open from 1st November 2025 to 28th February 2026 as per the RSV surge planning based on the Australia tracking model. BSW have targeted more capacity in Wiltshire based on learning from coverage in 2024/25. There is also surge capacity built in including the week after Christmas for additional slots which will flex dependent on need.
Following changes during 2025, surgically expected patients should present directly to paediatric assessment unit (PAU) and no longer through Children's Emergency Department (CED). A SOP is in development for Surgery medical team to add these expected patients onto Aramis for oversight of patient flow.

4.36 System requirements to be delivered to support the RUH winter position

- Children's community Acute Respiratory Illness (ARI) capacity which is also accessible to RUH UTC.
- Adult community Acute Respiratory Illness (ARI) capacity.
- Delivery of community non-criteria to reside occupancy in line with BSW plan.
- Expectation of high occupancy (>90%) of community virtual wards.
- Consistent community partner in-reach to RUH Emergency Department and Assessment Areas to step down with community support.
- Mental Health response to transfer ≤24 hours (AWP and Oxford Health).
- Vaccination programme in care homes to reduce ED attendance and admissions and the requirement to vaccinate on admission, if unvaccinated.
- Hospice capacity to support the CHC fast track pathway. CHC Fast Track, for rapidly deteriorating patients reaching the end of their lives is managed by the care Transfer Hub, who work closely with the ICB CHC team. Referrals are scrutinised in the care transfer hub to ensure the correct pathway has been recommended and presented. Through the daily NCTR calls the team can

check updates on brokerage sourcing. This enables the Trust to monitor and escalate any delays.
- Care coordination and Health Heros delivery of ED attendance reduction.
- Delivery of community-based point of care testing to prevent ED attendance.
- Proactive avoidance of ED attendance from Care Homes (collaboration with care homes, community partners, SWASFT and the RUH Teams OPU and Hospital at Home).

4.37 Partner working including the voluntary sector

The RUH will continue to work with partners including the voluntary sector.

- The RUH Wellbeing Hub, which included Bath Mind, is currently reviewing how the services can increase presence in front door areas during winter in collaboration with the RUH Care Transfer Hub team.
- Drug and Alcohol Liaison
- Homeless Teams
- Complex case management
- High impact user group

4.4 Elective activity planning

- Elective inpatient joint work on the RUH site will cease from 01/12/25 to 31/01/26 to enable the change of use of Phillip Yeoman Ward to support trauma and medicine Surge
- Loss of Elective Orthopaedic activity on RUH site and impact on RTT will be mitigated by:
    - Prioritisation and expediting urgent and long waiting “RUH only” patients for admission prior to PY conversion
    - Transfer of foot and hand lists to Sulis to create additional capacity for RUH only orthopaedics prior to winter closure
    - Increase productivity/throughput on SOC theatre lists
    - Develop enhanced care to expand pool of patients suitable for SOC (Surgical and Anaesthetically)
- Case mix will be scheduled to prioritise daycase only for P3/P4 cases between 18/12/25 - 14/01/26 to maximise utilisation of operating capacity by minimising risk of cancellations due to bed availability.

The actions that are in place to manage elective activity include:

- Trauma Assessment Unit for patients with complex injuries and conditions that need specialist orthopaedic input and treatment. The on-call team can accept referrals to the unit from GP practices, minor injuries units and the Emergency Department for assessment and investigation if deemed appropriate for the unit. Local anaesthetic hand surgeries are performed in the treatment room in the unit. The service is open 07:00 to 20:00, seven days a week, other than Christmas Day and Boxing Day. Work Is required to reduce the heavy demand on TAU and the orthopaedic clinical time responding to referrals for advice and attendances via the community MIUs. Minimising this demand would release time to support an improved response times to ED.
- ENT assessment room in the Surgical Assessment Unit to remove, in hours, patients presenting to the ED. Action is required to determine if patients with quinsy can be treated in the assessment room.
- Support the step down of Intensive Care Unit (ICU) patients within 4-6 hours to a maximum of 24 hours of request.
- Ensure Surgical SDEC capacity is available for 07:30 start,

5. Emergency Department (ED) Readiness

The SWASFT forecast is for an overall increase in incident volumes of 5% compared to last year. At a Trust level, key dates have been identified for the highest incident volumes - New Year's Day is forecast to be the busiest day with 3,686 incidents followed by Boxing Day with 3,450 incidents.

- **Workforce Planning**: Rota coverage is reviewed regularly for all disciplines, flexible staffing models, regular forward-view of locum planning against staffing numbers, continued work to utilise full budget (vacancy of 11.26%) and increase establishment to meet capacity.
- **Triage Improvements**: Rapid triage and streaming protocols will be in place through both the UTC and ED as a business-as-usual improvement.
- **Ambulance Handover Protocols**: Continue to work against W45 standard. Rapid offload and assessment, utilisation of ambulatory pathways and streaming from ED as BAU.
- **Flow Improvements**: As per section Same-day emergency care (SDEC), discharge lounge utilisation.

6. Admission Avoidance and Early Discharge

- **SDEC and Hospital-at-Home** services expansion.
- **Frailty Pathways**: Front-door frailty assessment and community support.
- **Discharge Planning**: Daily board rounds, Estimated Discharge Date setting, and Discharge-to-Assess model.
- **Community and Social Care Coordination**: Integration with local authority and third-sector providers.

7. Infection Prevention and Control (IPC)

In winter, the infections which are of the highest concern in terms of the volume of patients are Clostridioides difficile (C. diff), Covid-19 and Influenza A and influenza B. NHS England will write to the Trust by the end of October 2025 to state when the official start of the influenza season is due to start and end, this will include intelligence based upon Australian surveillance. Actions will be determined to manage any expected increase in demand, access to rapid testing, and if diagnosed, support timely isolation.

In analysing the impact of IPC on RUH length of stay, there is statistically little correlation between length of stay and occupancy with IPC affected beds (0.1 for LOS and 0.3 for occupancy) - which is very weak positive correlation. However, daily outbreak meetings will support the effective and safe use of beds which are closed in affected areas and the management of patients who are recovered to ensure that side rooms and cohort areas are used effectively. Further work is required on early identification and sampling in Front Door areas and isolation to minimise impact.

Rapid COVID-19 and influenza testing will be provided by the laboratory in hours seven days a week.

Additional point of care testing for COVID-19 and influenza will be available for out of lab hours testing for patients who are symptomatic and require hospital admission. This service will be dependent on emergency department staff being trained and deemed competent to run the tests in a designated space, approved by the laboratory. This will facilitate the appropriate isolation based on a local test, which will require Laboratory confirmation in hours.

The in and out of hours process will be outlined in the 2025/26 winter swabbing guidance.

The IPC team will provide weekend plans each Friday for any effected areas. The IPC team will provide outbreak support as per the existing escalation protocol for weekend working in extreme outbreak circumstances.

7.1 Vaccination strategy

The NHS England winter planning guidance states that a vital part of preventing illness and improving system resilience, it will be important to maximise the winter vaccination campaign. As well as eligible population groups, it is imperative that employers make every effort to maximise uptake in patient-facing staff – for their own health and wellbeing, for the resilience of services, and crucially for the safety of the patients they are caring for.

The RUH Occupational Health Team are commencing a staff flu vaccination service from the start of October 2025. All RUH staff will receive an email from Vaccination Track inviting them to book an appointment, in addition peer vaccinators are available to visit areas.

The national COVID-19 vaccination programme remains the prevention of severe illness (hospitalisations and deaths) arising from COVID-19. As currently available COVID-19 vaccines provide limited protection against mild and asymptomatic disease, the focus of the programme is on offering vaccination to those most likely to directly benefit from vaccination, particularly those with underlying health conditions that increase their risk of hospitalisation following infection. For autumn 2025, running from the 1st of October 2025, the joint committee on vaccination and immunisation (JCV)I advises that a COVID-19 vaccine should be offered to:

- adults aged 75 years and over
- residents in a care home for older adults
- persons aged 6 months or over who are immunosuppressed

JVCI does not advise an offer of COVID-19 vaccination within the autumn 2025 national COVID-19 vaccination programme for frontline health and social care workers, staff working in care homes for older adults, unpaid carers, and household contacts of people with immunosuppression.

Outstanding action: *Supporting the vaccination programme for the immunisation of patients discharging to care homes. System support required to understand the primary care and care home response.*

7.2 Testing protocols

The Trust is compliant with the national standards for prevention and control of infections and related guidance outlining the requirements for providers to assess the risk of, prevent, detect, and control the spread of infections, including those that are health care associated. Compliance against the code is reviewed regularly through the Infection Prevention and Control Committee and daily meetings in the event of an outbreak.

7.3 Outbreak management plans

It is a requirement of the Health and Social Care Act 2008 (DH 2015) that an evidence-based isolation policy exists incorporating local risk assessment findings and measures that includes indications and procedures for the infection control management of isolated patients. Patients must be promptly assessed for infection risk. Patients who may present a particular cross-infection risk should be isolated on arrival and appropriate clinical samples and screening undertaken as per trust protocols to establish the causative pathogen. The following policies are relevant to winter planning and infection prevention and control at the RUH.

- Confirmed/suspected Influenza Policy
- Clostridioides difficile trust policy
- Management of diarrhoea and vomiting
- Isolation policy
- Outbreak control

Throughout the year the organisation isolates patients due to infection risk in line with trust guidance. In winter, the infections which are considered to be of the highest concern in terms of the volume of patients are Clostridioides difficile (C. diff), Covid-19 and Influenza A and influenza B. NHS England will write to the Trust by the end of October 2025 to state when the official start of the influenza season is due to start and end. Patients presenting with these infections require isolation, preferably in a side

room. However, cohorting patients with the same infection, who have been diagnosed on the same day is also possible and will be coordinated by the IPC team supported by the clinical site team. Furthermore, patients who have been exposed to an infection whilst admitted and will require isolation as a contact.

The side room capacity across the RUH Combe Park site is 101 side rooms: fifty-one medical, 35 surgical, 5 William Budd and 10 paediatrics. There are also 8 side rooms on Mary ward. There are also bays across the Trust which have access to a bathroom within the bay and doors on the bay area which supports isolation.

The priority will be to always keep patients safe. Infection control will be engaged with winter planning to ensure patients are placed into the most appropriate beds to minimise the spread of any infection.

The actions that are in place:

- Review of infection issues at all site meetings, all direct admit areas to be contacted every morning by the IPC team as needed, with all other wards monitored and visited as per ward request or as Laboratory results indicate.

- In an outbreak, decision making regarding cleaning brought forward in the day so that decisions are known for the 1pm site meeting. There will be an outbreak meeting every day at 09:30 if there are any areas closed.

- In the event of an outbreak occurring at the weekend / Bank Holiday, the on-call Medical Microbiologist would be contacted for advice who is available 24hrs of the weekend/bank holiday and can be contacted via Switchboard.

- Prior to each weekend the IPC team will provide site with a weekend plan to work within if there are outbreaks of infections ongoing; this plan will be based upon risks to and occupancy needs, to support safety and patient flow.

- Infection control on-call arrangements at weekends/Bank Holidays during an outbreak from 1st of October 2025 until 31st of March 2026. The Infection Control Team will provide an on-call service in extreme circumstances for multiple ward closures (more than three) due to outbreaks of uncontrolled infection, and where the on-call microbiologist is unable to manage the situation alone.

- Reporting of all closed areas and empty beds within closed areas within daily sitreps and included within the Trusts three times daily site reports.

Additional arrangements to be agreed for winter 2025/26.

- Review of the side room within the Trusts Capacity Management System (CapMan) to ensure that there is appropriate use of side rooms in line with the trust policy.
- Requests for cleans managed within the Trusts CapMan system has been updated to better specify the type of clean and the timing to optimise patient flow.
- In-hours review of patients presenting to ED/MAU/SAU who potentially require a side room - led by the matrons/senior sisters especially during periods of high demand.
- Point of care testing out of hours in ED Covid and Flu and MAU Covid to support operational decision-making regarding isolation – review assessment area activity in hours (in addition to out of hours) and confirm the resilience of the supply of kit.
- Rapid COVID, Flu and RSV testing by the RUH laboratory during winter (in hours only).
- Respiratory panel guidance and review prior to sending away – takes 72 hours from receipt of specimen in Bristol, during which the patient requires isolation.
- Cohort ward mobilisation – revised standard operating procedure (SOP) for cohort wards. Currently the process is to isolate patients in a side room in the specialty ward required for their ongoing care. Respiratory ward is used to cohort patients seventy-four and under years old to isolate Covid-19 infections, and Waterhouse ward for patients over 75 years old. Parry ward is the designated ward to cohort influenza.
- Fit testing compliance and training availability.
- Education and training of the Clinical Site Team - update on IPC
- Confirm that the current Haematology and Oncology ward staff testing for symptomatic staff continues and clarify the SOP for side room use now the ward is in a new location.
- The IPC service has spent the last year developing a localised tool to support our staff select the right personal protective equipment (PPE) for the right infection (as one set of PPE is not suitable for every infection). Staff in general do not know what to PPE to select outside of the standard infections they see, and it is inconsistent if they got it right especially if it is a high consequence disease they are facing. Phone app has been developed which requires deployment.

8. Workforce Resilience

The NHS England guidance for winter planning highlights the need to support staff during a period of the year with higher demand for services which can affect staff resilience. In line with the Trust vision of 'The RUH, where you matter' the following is accessible to RUH staff during winter.

8.1 Staff wellbeing

The RUH provides services for staff which are available all year round and, supported by the communications team, throughout winter staff will be encouraged and signposted to access the following services according to the individuals need.

- Physical health: Occupational Health, physiotherapy staff service, smoking cessation, and exercise classes.
- Mental health: Employee assistance programme, Staff wellbeing outreach, Mental health first aid, stress and burnout workshops and trauma risk management (TRiM).
- Financial wellbeing handbook and access to discounts.
- Working Life: Freedom to speak up, Unions, Staff networks, spiritual care centre, People Hub support, reasonable adjustments, accommodation, childcare, shops and facilitations, mediation, nurse & midwifery advocates, kindness, and civility training are available to access by staff. Furthermore, the trust also now has a violence prevention and reduction policy, a three-step approach that helps to keep staff safe, by clearly outlining unacceptable behaviour and giving staff the tools to act when we see it.
- As part of the Trust vision 'The RUH, where you matter' and as a thank you for the extraordinary efforts made each day, the Trust offers every substantive employee in the Trust a 'What Matters to You Day'. This additional day away from work to allow staff to take the time to do something that matters to them around their birthday.

8.2 Sickness absence contingency

Workforce has been a key improvement workstream in the financial year 2025/26. The focus has been on ensuring that there are sufficient staff to provide safe care and delivery the required activity in line with business planning trajectories and financial spend. Staffing has been considered for each professional group and issues have

been highlighted with corresponding actions and designated lead for winter 2025/26. Furthermore, the on-call senior managers rota is required to be completed for December and January to ensure that there is full coverage, the director on call rota is complete. As the winter plan develops, any additional requirements will be quantified.

Additional arrangements to be agreed for winter 2025/26.

- Ensure that there are sufficient staff to provide safe care and delivery the required activity in line with business planning trajectories and financial spend.
- Rota review to ensure minimal variation throughout the December and January bank holiday period and school holidays.
- On call Directors and Managers rota to be completed for October 2025 to the end of March 2026 to ensure there is appropriate skill mix and cover.

8.3 Staff communications

The RUH will continue to update staff, as per business as usual, through regular briefings, OPEL status and escalation alerts.

9. Communications and Public Messaging

The RUH communications team will collaborate with Group colleagues on an aligned plan and shared assets where appropriate. There are also regular meetings already in train with NHSE national and regional communications colleagues and a tool kit will be developed to support the following high-level objectives:

Proactive approach

- Use of case studies
- Collaborating as a system
- Patient-focussed
- Vaccination awareness
- Promoting leadership and clinician voice
- Maintaining public and staff confidence in NHS operational planning

KPIs as follows:

- Positive public perception
- Vaccination uptake
- Correct uptake of services
- Incident communications effectiveness
- Stakeholder and staff management

9.1 Internal communications

Proactive communication with staff about our winter plan and tangible outputs.
Real time ND reactive communication with staff with SnapComs and tickertape to all computers on the RUH system as part of the trust EPRR processes. Tactics include but not limited to a weekly programme of staff briefs, executive led information videos and live question and answer sessions.

9.2 External communications

The RUH communication plan will work in collaboration with system partners to support the following.

- Raising awareness of the services provided by local community pharmacists to help direct people to the right place for their needs and to help reduce pressure on GP and emergency health care services.
- Focusing on keeping people well by signposting them to the right service for their needs.
- Encouraging those eligible for a free flu and Covid-19 vaccination.
- Signposting people to online healthcare advice such as the healthier together website for parents of under-fives and young people, getting support to quit smoking and signing up to your energy supplier's priority services register and staying warm.
- Winter messaging over Christmas and New Year bank holidays and at predictable time of high demand.
- Promoting BSW winter schemes and how to access.

9.3 Stakeholder coordination

The RUH will continue to work proactively with all external stakeholders, proactively link with the BSW systema coordination centre, attend all BSW Touchpoint calls and be in daily contact with other providers in BNSSG and Somerset in line with our patient flow.

10. Monitoring, Review, and Continuous Improvement

- **Key Performance Indicators (KPIs)**: 4-hour standard, ambulance handovers, SDEC activity and non-criteria to reside. A weekly meeting has been established for the winter period with the key RUH stakeholders to oversee the development and implementation of the schemes and actions identified in this

paper to be chaired by the Director of Site Operations and supported by the Clinical Division Directors, to ensure that the programme is clinically led.

- **Daily Operational Reporting**: The Trust conducts four site meetings daily, during which demand, capacity, and flow are assessed using a defined set of criteria. Each criterion is scored, and the cumulative score determines the hospital's Operational Pressures Escalation Level (OPEL). The status is also submitted to SHREWD Resilience, a system-wide platform that provides a real-time operational view of local urgent care systems. SHREWD enables users to quickly identify pressure points, understand causative factors, and initiate appropriate actions, supporting the effectiveness of the BSW System Coordination Centre. The Trust's escalation status is updated four times daily and is visible on both Millennium and the Trust website, ensuring transparency and accessibility. A site report is also distributed internally and externally via email at each update point, facilitating system-wide situational awareness and coordinated response.

  In preparation for winter 2025/26, the Trust Escalation Policy was reviewed and updated in May 2025, introducing operational changes to enhance responsiveness. Notably, the NHS England FOCUSSED model has been incorporated to guide structured decision-making for bed management.

- **Post-Winter Review**: Learning from winter 2024/25 was captured in the three post critical incident reviews (standard Trust EPRR practice) and a trust wide survey of staff which has been used in this panning and presented to the Trust Strategic Executive Forum and Trust Management Executive Committee. Further to the planning for winter 2025/26 it is proposed to establish a winter planning forum chaired by the Director of Site Operations supported by the Clinical Division Directors to review learning from previous winters and effectively plan to optimise clinical capacity, bed utilisation and patient flow for future winters. To provide a cross-Divisional forum in which to review such proposals prior to presentation to the Chief Operating Officer and appropriate forums for example Executive Team or the Trust Management Executive Committee. The following schedule is recommended.

  - Undertake trust wide survey as per 2024/25 process.

- Establish a winter planning forum to meet monthly from May 2026, moving to weekly in July 2025 with stakeholders who have contributed to 2025/26 winter planning.
- May 2026 review of 2025/26 winter schemes & actions, successes, and learning.
- Winter plan 2026/27 first draft June 2026 submitted to the Chief Operating Officer for review and further discussion with the Executive Team.
- August 2026 winter plan scheme, and actions reviewed and prioritised
- September 2026 winter plan presented to Trust Management Executive Committee – in priority order
- Agreement to implement in priority order as external funding agreed
- Implementation October 2026

---

11. Appendices

11.1 Escalation levels and actions matrix

Available on the RUH intranet accessible to all staff; OPEL framework, OPEL action cards and the trust escalation policy which incorporates the full hospital protocol.

11.2 Contact list for winter resilience team

Organisation	Executive Lead	Operational Lead	Discharge and Flow Lead	Clinical Lead
RUH	Bernie Bluhm	Sarah Hudson	Emma Crockett	Fenella Maggs

11.3 Vaccination schedule

The RUH flu vaccination schedule is in line with the national programme; processes in place as per 2024/25.

11.4 Surge capacity site maps and bed plans

As described in section four.

11.5 Outbreak response protocols

Available on the RUH intranet accessible to all staff; policies and guidance, outbreak management including a decision tree to aid recognition of potential outbreaks, information for patients and visitors, control measures and symptomatic staff.

11.6 Cleaning

The cleaning team plays a pivotal role in supporting the site team's response to isolate patients when an infection is diagnosed and in the coordination of the cleaning of areas which have been closed due to infection; ensuring that the clinical space is returned to service in line with IPC direction and timelines. The cleaning team will continue to work closely with the Infection Prevention and Control Team and the Clinical Site Team to respond to demand and the proactive planning and coordination of the opening of clinical areas that have been closed to admission due to infection restrictions. The team will also ensure that the communication with the clinical areas is clear regarding the type of clean required to prevent any delays in the clinical areas reopening. As the winter plan develops, and further information regarding the demand for cleans any additional requirements will be quantified; for example, how many cleans by type were required in Q4 2024/25 and do we have the capacity for Q4 2025/26 to respond.

11.7 Security

The security team will continue to collaborate with the clinical site team to implement proactive measures to maintain a safe a calm environment with additional patrols conducted in areas which are deemed to be at a higher risk. As the winter plan develops, any additional requirements will be quantified.
Security team will also support with traffic management (ambulances) in busy periods and supporting staff safety- escorting them to their cars (onsite) after shifts.

11.8 Portering

Portering plays a key role in patient transfers and minimising delays ensuring that patients are moved safely and effectively, especially during high demand periods. Portering supervisors and the clinical site team will continue to collaborate closely to

streamline communication and respond to transfer requests and be part of any response to the reopening of any beds closed due to infection or estates work. As the winter plan develops, any additional requirements will be quantified.

11.9 Severe weather procedures

The Trust is required to plan for and respond to a wide range of incidents such as extreme weather, an infectious disease outbreak or a major road traffic collision nearby. When an incident occurs, the organisation must deliver an effective incident response whilst maintaining critical services. Within the health community this programme of work is referred to as Emergency Preparedness, Resilience and Response (EPRR).

The Trust's arrangements for severe weather are in place to provide guidance when normal business activities have been affected by severe weather which causes difficulties for staff, patients, and visitors in attending the hospital or its periphery clinics. These arrangements adhere to the Trust's Incident Response Framework and can be used either as a whole or in part to respond to the specific impacts of a given period of inclement weather; these include snow, ice, storms causing roads to become blocked and flooding in the local area as part of the RUH hot and cold weather plan. The response also includes staff accommodation.

Arrangements include Severe Weather action cards, Business Continuity Plans and Staffing & Transport Coordination Centre Standard Operating Procedures. The Trust has 4x4 inpatient transport provided by its' current inpatient transport provider, FAST Ambulance. The Trust also has arrangements in place to secure 4x4 transport for staff through FAST Ambulance. The aim of these arrangements is to maintain safe staffing levels, protect critical Trust functions, safely manage an increase of trauma patients presenting through the Emergency Department, and to rebalance emergency and elective activity as required. If these arrangements are activated Command, Control and Communication will follow the established process as set out within the Trust Incident Response Plan and link with the Bath and Northeast Somerset, Swindon and Wiltshire (BSW) local health resilience partnership (LHRP) for planning and response as required.

11.10 Mortuary

The mortuary has a permanent capacity of 80 fridges, supplemented by two additional units to support business-as-usual (BAU) demand. This brings the total capacity to:

- 104 spaces with bariatric contingency (1 bariatric space)
- 110 spaces without bariatric contingency

A review of mortuary occupancy over the past three years has identified a recurring 14-day period, from 24th December to 7th January, during which the mortuary is increasingly busy, and capacity is challenged. The highest recorded occupancy during this period was 104 patients in 2022. To address the seasonal surge in demand while minimising disruption to mortuary operations and the wider Trust, an options appraisal was undertaken. Considering resource constraints (including time, cost, and health and safety considerations), the decision has been made to assemble a temporary 12-person storage unit in the Chapel.

The solution will provide an additional 12 spaces, ensuring sufficient capacity during peak periods. However, it will mean that viewings cannot take place in the mortuary while the temporary unit is in use. The unit, supplied by Nutwell Logistics, will be pre-paid and deployed flexibly, installed only when demand necessitates it. The approach allows the Trust to respond effectively to increases and decreases in occupancy whilst keeping the impact on bereavement services to a minimum.

Finally, the mortuary has a service level agreement with Flax Bourton, however we expect that Flax Bourton will not be able to accommodate any increases in demand from the RUH over this period due to their own winter capacity constraints.

11.10 Pharmacy

Pharmacy cover for peak days and weekends – As the winter plan develops, any additional requirements will be quantified.

11.11 Clinical Site Management

Additional arrangements to be agreed for winter 2025/26.

- Using the Trusts Capacity Management System (CapMan) to provide each specialty medical team with a list of all patients requiring admission, who are not in the correct location and or are in an assessment or short stay ward to improve ownership, discharge planning and length of stay reduction.

- Infection isolation and side room usage within the Trusts Capacity Management System (CapMan) to ensure that there is appropriate use of side rooms in line with the trust policy.
- Isolation of patients within 4 hours of an infection diagnosis – all areas of the hospital including the front door.
- Requests for special cleans managed within the Trusts CapMan system requires review – to better specify the type of clean and the timing to optimise patient flow.
- Hospital at Night service currently manages c55 patients per night which supports the prioritisation of work for the Resident Doctors and the management of the deteriorating of patient. Aim to sustain and develop the range of services including the consideration if bed managers overnight support cannulation and phlebotomy, which will also support early blood and discharge.
- Maximise the occupancy of the discharge lounge (> 40 patients per day), supported by the UEC Improvement Programme and the CapMan development to ensure that all eligible patients are discharged via this service.
- Improve bed downtime and allocation in line with national standards.
- Command centre function and outward reporting to support proactive patient flow.
- Discharge coordinators cover at the weekend to support discharge and Monday flow.

- 11.12 Surge planning – Flow (detail linked to section 4.3)

ID	Description	Cost (£)	Action	Delivery Date	RAG
1	Deployment of two additional Band 2 discharge coordinators on weekends and bank holidays (08:00–16:00). November to end of March 2026 (21 weeks)	£14,000	Currently one discharge coordinator covers Sunday for the hospital. Ideally it would be beneficial to have 2 additional discharge coordinators on a Saturday and 2 on a Sunday/Bank holiday. Costs based on bank rates.	01.11.25	
2	Establishment of an Outliers Team (2 MNPs and two Resident Doctors) to manage patients in escalation areas and outlier wards, including weekend coverage.	£122,000	If approved, requirement to advertise these posts and communicate this to the teams. Costs based on recruitment.	01.11.25	
3	Redistribution of therapists (e.g. chest physiotherapy, orthopaedic therapy) to inpatient wards, including weekend coverage. Coordination with the Head AHP.	£113,000	Note there is a current 15% turnover in Therapies and actively recruiting. ICU acuity & capacity: 1.0 WTE B6 Physiotherapist (KPI: 1–3-day LoS reduction post ICU and offset cross cover from rest of teams) (current UEC working group in home is best) PY: 1.0 WTE B6 PT or OT and 2x B3 (KPI mitigate NCTR therapy delays increasing unsustainably) Skill mix on PY currently not right match for OPU caseload – PY staff would see T&O outliers. ED, MAU & MSS: 3.0 WTE B6 to cover additional frailty caseload and current shortfall in referral responsiveness performance (KPI 30 mins in ED and 90 mins in MAU. Current performance 40-70	01.12.25	

ID	Description	Cost (£)	Action	Delivery Date	RAG
			in ED and 270+ in MAU) (business case submitted 2024/25) Assuming that the current arrangements for weekend provision continue (50 shifts c £9k funded by vacancy). Costs based on recruitment.		
4	Addition of pharmacists to support early to take away (TTA) medication preparation and supply and medicine reconciliation.	£41,000	1x additional B7 Pharmacist to decision make and prescribe, based in MAU but can flex to support. 1x additional B5 Technician to support dispensary on weekends to enable faster TTAs in line with additional weekend discharge support. Costs based on bank rates.	01.11.25	
5	Establish mechanism to work with HCRG and the care homes with the highest ED conveyance and referral to SDEC rates.	£0	Promotion of the OPU advice and guidance line as business as usual. Requires collaboration of RUH OPU and Hospital at Home teams with care homes, frailty lead, SWASFT and community partners.	01.12.25	
6	Inpatient specialties to assume responsibility for all CapMan-attributed patients regardless of location, reducing acute medicine burden and sharing inpatient risk. Using the Trusts Capacity Management System (CapMan) to provide each specialty medical team with a list of all patients requiring	£0	CapMan processes will be ready to roll our week beginning 13.10.25. Change in Medical team practice 01.11.25.	01.11.25	

ID	Description	Cost (£)	Action	Delivery Date	RAG
	admission, who are not in the correct location and or are in an assessment or short stay ward to improve ownership, discharge planning and length of stay reduction.				
7	Institute an additional Upper GI Consultant Round on Mondays and Thursday to reduce time for senior clinical review of patients by this subspecialty and thus reducing length of stay.	£10,000	1. Options: 2. Additional sessions by existing consultants (risk that these will not be picked up) 3. Take existing consultants out of elective capacity (risk to OP or Endo performance – both RTT/DM01) 4. Locum consultant (not yet costed) Costs based on additional PAs.	01.12.25	
8	Conversion of elective theatre lists to Trauma and ESAC to reduce surgical non-elective length of stay.	£40,000	Options for mitigation (do combination of all three): 1. Sulis – hernias only. Cost unknown currently (tariff – keep lap chole at RUH due to tariff benefits). Specialty Manager discussing with clinical lead on 1.10.25. 2. Weekend WLIs at RUH (swap surgeons around to meet case mix requirement). Theatre 1 is the biggest capacity risk. Costs based on 1 list per week over 16 weeks and additional PAs being picked up and additional theatre staff. Risks – consultants do not take up lists or burn-out. *N.B. Need to understand interdependence on daycase*	01.12.25	

ID	Description	Cost (£)	Action	Delivery Date	RAG
			unit staffing on Saturdays due to potential consultation for nursing staff. 3. Reduce elective theatre schedule for 2 weeks over Christmas/New Year period (22.12.25-3.1.26 inclusive) recognising bank holidays, increased annual leave and patient reluctance during this time) and flip lists to emergency cases.		
Total		**£340,000**			

- 11.13 Surge planning – Capacity (detail linked to section 4.3)

ID	Description	Cost (£)	Action	Delivery Date	RAG
1	Utilisation of Philip Yeoman ward (12 beds) for non-elective trauma and orthopaedic activity, which includes elective displacement to Sulis Hospital and associated impact.	£0	• Modelling for 3-month closure option to determine number of operations required. • Initial analysis for 2 –months (initial ask) to avoid 52-week breaches for 2-month closure suggests best case of 10 additional procedures required over baseline, likely case of 19 cases, and worst case of 36 cases for 2-month closure. Specific cases in this cohort would need to be booked to avoid cases. Does not include impact to 52-week breaches for February onwards. • 3-month modelling being completed and impact on % <18 weeks. • List of 36 patients being reviewed for Sulis suitability and patients to be contacted to check availability. • Potential mitigations and impact of each, with associated confidence/risk of delivery and interdependencies being collated. • Assumes current budget in place for PY and Resident Doctor cover. • Linked also to action 15 for Frailty cover.	Analysis to be completed by 1.10.25	
2	Overnight staffing for Surgical and Medical SDEC with one Band 5 registered nurse per area, seven days a week.	£82,000	To manage x5 Medical and x8 Surgical patients overnight. Costs based on bank rates.	01.11.25	
3	If HCRG cannot bridge P1 care packages, establish a bridging service using available virtual ward capacity for Wiltshire residents (defined postcode area).	£0	No action required if community partners deliver the NCTR reduction.	TBC	

ID	Description	Cost (£)	Action	Delivery Date	RAG
4	Pending NHS England funding for Medical Short Stay Unit expansion	£0	Dependent upon NHSE capital funding approval. Action to explore the use of the extra capacity for medical patients depending upon the clinical need i.e. may choose to use it for something other than MSS expansion.	TBC	
5	Relocation of the discharge lounge in January 2026, following capital work, to C16 with two registered nurses on night shift. Interim alternative location closer to core wards under review.	£43,000	Dependent upon NHSE capital funding approval. If approved by the start of October 2025, works can commence to open mid-January 2026. Costs based on bank rates for 11 weeks.	12.01.26	
6	Locum GIM consultant to cover MSS / outliers specialty ward (approved and budgeted under acute medicine). Aim to Maintain pace of internal and system actions to close winter bed gap: ≥40% SDEC activity	£0	Medicine Division have offered a one-month trial to a Locum GIM consultant (awaiting to hear back). Continue to recruit full time staff (2.6 WTE vacancy at present). Costs assumed to be covered with vacancy.	20.11.25	
7	Optimisation of Angio list utilisation over winter.	£7,500	Clinical Lead in Cardiology to agree how to best use the capacity in the Cath lab to decrease the waits for angio flow. Costs based on additional PAs.	01.12.25	
8	Respiratory support for front door services by Acute Medicine and Respiratory teams.	£7,500	Under discussion as part of the whole system respiratory plan. Costs based on additional PAs.	01.12.25	
9	Expansion of IMPACT service beyond BANES for COPD patients during winter.	£0	Currently in discussion with the Division and Specialty Team.	TBC	
10	Improvement of point-of-care testing strategy and pathology testing capacity and response times.	£0	Currently in discussion with the Division and Specialty Team.	TBC	
11	Proposed change to weekday and weekend duty managers	£0	Model to be agreed with the Chief Operating Officer.	TBC	

ID	Description	Cost (£)	Action	Delivery Date	RAG
	until night shift medical handover and on call expectations and role of Directors and Managers.				
12	Infection Prevention and Control capacity to enhance out-of-hours resilience.	£4,000	½ day cover on a Sat and or Sunday in extreme outbreak situations only. Band 7 or 8a. Costs based on bank rates.	20.10.25 – 29.03.26	
13	Maintain pace of internal and system actions to close winter bed gap: RUH Hospital at Home occupancy at 95%	£0	Currently in discussion with the Division and Specialty Team.	TBC	
14	Maintain pace of internal and system actions to close winter bed gap: NCTR to 9% of bed base	£0	BSW ICB action	TBC	
15	Increase in Frailty 5 PAs to cover Frailty within MAU and ward areas to support flow and reduce length of stay (OPU led)	£37,000	In response to predicted frailty demand. Costs based on additional PAs.	01.11.25	
16	OPU weekends	£0	Currently in place to support weekend flow as atrial – aim to continue throughout the winter period. Costs assumed to be within funded establishment.	25.10.25	
17	Theatre Recovery/ICU staffing to meet surge demands	£0	Currently in discussion with the Division and Specialty Team. Costs assumed to be within funded establishment.	TBC	
18	Acute Oncology Service (AOS) set presence in SDEC 10:00- 14:00 Trial	£0	Trial set hours in MSDEC for AOS to support with flow. This will need to be balanced against impact to seeing outliers. Costs assumed to be within funded establishment.	03.11.25	
Total		**£181,000**			

11.14 Surge planning impact on WTE.

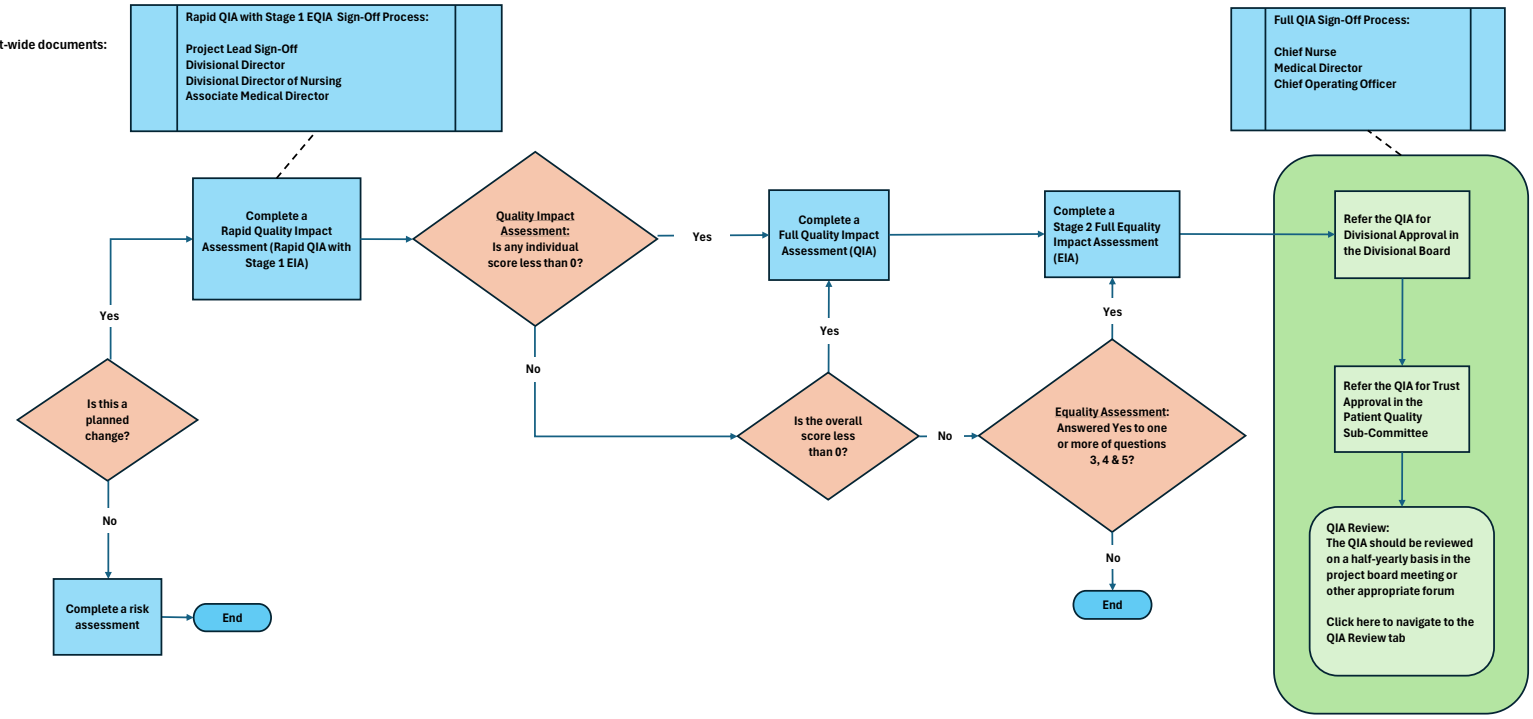
The staffing trajectories linked to the winter schemes have been considered, to include the impact on bank usage. The net impact has been calculated, based upon the proposed schemes across Months 8 to 12 to be 18.6 WTE per month, with an increase to 19 WTE in month 9 only (December 2025).

Version	Date	Place in document	Changes	Comments

Impact Assessment Process

This process has been created in line with Trust-wide documents:

- **Quality Governance Framework**
- **Equality, Diversity & Inclusion Policy**



Rapid Quality Impact Assessment (QIA)

Does the project or change impact two or more organisations?	**No**	If **Yes**, please complete a **Full QIA**

1. Rapid Assessment	
Date of Assessment:	19 September 2025
Division:	Corporate
Specialty:	COO Office
Project or Workstream Name:	Working Winter Plan 2025/26
Executive Sponsor/Clinical Lead [for Corp]**:**	Bernie Bluhm
Operational/Project Lead [for Corp]**:**	Sarah Hudson
Project Support:	Sarah Hudson

6. Sign-Off			
	Name	**Signature**	**Date**
6.1. Project Lead Sign-Off:	Sarah Hudson	Sarah Hudson	22/09/2025
6.2. Divisional Director:	Bernie Bluhm	Bernie Bluhm	23/09/2025
6.3. Divisional Director of Nursing:	Toni Lynch	Toni Lynch	24/09/2025
6.4. Associate Medical Director:	Kheelna Bavilia	Kheelna Bavilia	25/09/2025

IMPORTANT: E-signatures accepted if supported by e-trail

2. Monitoring	
Review Frequency:	**Weekly**
Name of meeting or Programme Board where this QIA will be monitored:	Weekly Winter Group
Next Review Due By:	01 November 2025

3. Project/Change Details
Overall Description of the Project/Change
The QIA/EQIA has been developed to inform the development of the RUH winter plan 2025/26. The winter plan should mitigate or minimise the impact of winter on our constitutional standards (including ambulance handovers within 45 minutes), patient and staff safety and experience. The objectives are to ensure patient safety and continuity of care during periods of high demand, minimise delays in urgent and emergency care, improve system-wide coordination and flow and reduce unnecessary hospital admissions and length of stay. The context for the winter seasonal plan and associated impacts from doing nothing include: 1. Winter pressures due to influenza, COVID-19, RSV and Norovirus result in greater risk of infection and bed closures. 2. Anticipated increases in demand, increased acuity of hospital admissions and delayed discharges due to social care pressures increase hospital bed occupancy and delay the flow of patients through the hospital. 3. Risk to use of temporary escalation usage including corridor care, longer waits in ED and staff burnout as a result of unmitigated winter pressures.

4. Quality Impact Assessment - Impact of Do Nothing	**Impact and Severity**	**High-Level Likelihood**	**Overall Score**
Duty of Quality & Responsiveness - How the change or project affects partner organisation, safeguarding. High-level impact towards health inequalities and supporting people to stay well**, considering the nine protected characteristics**	-3 High negative impact	4 - Likely	**-12**
Patient Experience - High-level impact upon our patients and population	-3 High negative impact	5 - Almost Certain	**-15**
Patient Safety - High-level impact to the safety of patients and likelihood of improvements to quality and safety?	-3 High negative impact	5 - Almost Certain	**-15**
Clinical Effectiveness - Impact to reduce variations in care and to ensure best practice is delivered in a cost-effective way	-3 High negative impact	4 - Likely	**-12**
Overall Score - If rapid assessment returns an **overall score** of **<0 or any individual score is lower than 0** a **full QIA is required**			**-54**

Stage 1 Equality Impact Assessment

At this stage, the following questions need to be considered:

5. Equality Impact Assessment	**Answers**
1. What is the name of the policy, strategy or project?	Working Winter Plan 2025/26
2. Briefly describe the aim of the policy, strategy, project. What needs or duty is it designed to meet?	The QIA/EQIA has been developed to inform the development of the RUH winter plan 2025/26. The winter plan should mitigate or minimise the impact of winter on our constitutional standards (including ambulance handovers within 45 minutes), patient and staff safety and experience. The objectives are to ensure patient safety and continuity of care during periods of high demand, minimise delays in urgent and emergency care, improve system-wide coordination and flow and reduce unnecessary hospital admissions and length of stay. The context for the winter seasonal plan and associated impacts from doing nothing include: 1. Winter pressures due to influenza, COVID-19, RSV and Norovirus result in greater risk of infection and bed closures. 2. Anticipated increases in demand, increased acuity of hospital admissions and delayed discharges due to social care pressures increase hospital bed occupancy and delay the flow of patients through the hospital. 3. Risk to use of temporary escalation usage including corridor care, longer waits in ED and staff burnout as a result of unmitigated winter pressures.
3. Is there any evidence or reason to believe that the policy, strategy or project could have an adverse or negative impact on any of the nine protected characteristics? Refer to image below	**No**
4. Is there evidence or other reason to believe that anyone with one or more of the nine protected characteristics (see image below) have different needs and experiences that this policy is likely to assist i.e. there might be a relative adverse effect on other groups?	**No**
5. Has prior consultation taken place with organisations or groups of persons with one or more of the nine protected characteristics of which has indicated a pre-existing problem which this policy, strategy, service redesign or project is likely to address?	**No**
On completion of Stage 1: **A Full Equality Impact Assessment** will be **required if** you have answered **YES** to **one or more of questions 3, 4 and 5 above**	

Equality Impact Assessment

Are we Treating Everyone Equally?

Define the document. What is the document about? What outcomes are expected?

Consider if your document/proposal affects any persons (Patients, Employees, Carers, Visitors, Volunteers and Members) with protected characteristics? Back up your considerations by local or national data, service information, audits, complaints and compliments, Friends & Family Test results, Staff Survey, etc.

If an adverse impact is identified what can be done to change this? Are there any barriers? Focus on outcomes and improvements. Plan and create actions that will mitigate against any identified inequalities.

If the document upon assessment is identified as having a positive impact, how can this be shared to maximise the benefits universally?

Trust Equality and Diversity Objectives

Better health outcomes for all	Improved patient access and experience	Empowered engaged and included staff	Inclusive leadership at all levels

Our Vision

Great Western Hospitals NHS Foundation Trust wants its services and opportunities to be as accessible as possible, to as many people as possible, at the first attempt.

Full Quality Impact Assessment (QIA)

1. Initial Assessment	
Date of Initial Assessment:	19 September 2025
Division:	Corporate
Specialty:	COO Office
Project or Workstream Name:	Winter Plan 2025/26
Executive Sponsor:	Bernie Bluhm
Operational Lead:	Rob Presland
Project value (if applicable)**:**	£0.8m

2. Monitoring	
Review Frequency:	Weekly
Name of meeting or Programme Board where this QIA will be monitored:	Weekly Winter Group
Next Review Due By:	01 November 2025

6. Sign-Off	Name	Signature	Date
6.1. Divisional Sign-Off:	Rob Presland	Rob Presland	02/09/2025
6.2. Chief Nurse & Medical Director to complete: (If no concerns, please sign & date below)			
Provide details of any significant concerns regarding implementation:	Some schemes have anticipated slippage due to the likelihood of recruitment delays e.g. additional therapy resource.		
Chief Nurse Sign-Off:	Bernie Bluhm	Bernie Bluhm	22/09/2025
Medical Director Sign-Off:	Toni Lynch	Toni Lynch	23/09/2025
Chief Operating Officer Sign-Off:	Kheelna Bavilia	Kheelna Bavilia	24/09/2025

IMPORTANT: E-signatures accepted if supported by e-trail

Note: The Chief Nurse & Medical Director will decide if COO sign-off required

3. Project/Change Details
Overall Description of the Project/Change
The QIA/EQIA has been developed to inform the development of the RUH winter plan 2025/26 to ensure patient safety, clinical effectiveness and patient experience are maintained or improved during periods of increased seasonal demand.

4. Impact Assessment

Indicators		Impact Details (include mitigation/control - do these measures address the risk? Describe the impact of the Improvement	Select the Impact	Risk Score For NEGATIVE Impacts		
				Impact	Likelihood	Overall Score
Patient or Staff Safety	How will this planned change potentially impact the safety of patients, staff or any other person? Consider: • The impact on quality e.g. incidents, IP&C, medicines safety etc • Will there be an improvement in safety and quality? • How this planned change may impact safe staffing levels • The impact on the Trust's regulation, for example, CQC	**Risks:** There are a number actions within the winter plan that are focused on improving quality and safety. If we are unable to deliver projects that have a direct impact on demand and reduced discharge ready delays prior to going into Winter, we will be faced with extended lengths of stay for patients, longer waits within the Emergency Department, potential increases in ambulance handover delay and impact to elective recovery due to increased use of outlier capacity. Vaccination programmes are also in place for staff and patients returning to care homes. Without the uptake of vaccinations there is a potential for more staff sickness and increased reliance on management of patients waiting to return to care homes. **Mitigations:** Winter plan actions focus on prevention, vaccination, provision of additional capacity, additional infection prevention and control measures and leadership capacity and capability. Mitigations compliment existing workstreams within the UEC transformation programme focused on reducing non elective length of stay.	**NEGATIVE**	**3 - Serious**	**5 - Almost Certain**	**15**
Clinical Effectiveness	Have clinicians been involved in developing the planned change? Is there evidence to support the change? What will be the impact on the implementation of evidence based practice? For example, case studies, best practice, alignment to NICE guidelines/professional body/clinical standards) Consider: • The impact on helping people to stay well, supporting shared decision making & self management • The impact on clinical workforce capability care and skills • The impact on reducing variations in care • How to ensure best practice care is delivered in the most cost effective way	**Risks:** Clinicians are leading on many of the changes that are likely to support improvement. There is other work being led by division and corporate management teams. A data driven approach has been used in transformational work but other areas of work are based on the result of previous learning from winter. Delivering the actions within the UEC transformation programme and winter plan will support staff and aims to maximise time to care for patients and support patients with their families and relatives to get to the place they call home as soon as possible. **Mitigations:** Specific action areas on clinical effectiveness and staff effectiveness are included within the plan. These include extended hours for complex discharge support for Wards, additional capacity to support discharge planning (e.g. therapy / pharmacy screening) and dedicated porters and transfer teams to support release of time to care on wards. The RUH Weekly Winter Group will also monitor implementation against anticipated benefits to inform learning for future years.	**NEGATIVE**	**3 - Serious**	**4 - Likely**	**12**
Patient Experience	What impact is the planned change likely to have on self-reported experience of patients and service users? Consider: • If there is a need for patient & public consultation as per Section 242(1B) of the NHS Act 2006, as amended in Health Act 2007 • Healthcare environment, privacy, dignity and respect of patients, families and carers • Patient choice; waiting times; access to services or care • Equality and diversity • Response to national/local surveys/complaints/PALS/incidents	**Risks:** Delivery of the winter plan will enable proactive management and prevention of patients being inappropriately cared for in areas of temporary escalation including the same day emergency care areas. The aim of the winter plan will be to provide care for patients in the right place, first time. This will also impact on staff and patients relatives. **Mitigations:** UEC improvement programme to support redirection of patients to the right place first time, including SDECs, and assessment areas. Prevention of delayed offloading through expansion of current services such as SDEC and planned escalation areas and the conversion of elective to non-elective capacity at peak times of surge to provide capacity. Policies and standard operating procedures also exist to support patients and their families and carers including in situations where patients may be in a temporary escalationn area. This outlines roles and responsibilities for quality and safety reviews and facillitating duty of candour conversations about patient admission status, the reason for the temporary placement, and the plan for transfer to a designated bed space.	**NEGATIVE**	**3 - Serious**	**5 - Almost Certain**	**15**
Duty of Quality	What is the impact of this planned change on the organisation's duty to safeguard children, young people and adults? Consider: • The potential impact on partner organisations and shared risk • If the service relies on other services to deliver care	**Risks:** There is a risk that seasonal pressures can increase pressure on system partners to facillitate discharge for patients with complex needs including potential safeguarding and mental health, leading to delays and higher bed occupancy, and potentially risk of premature discharge and risk of readmission. **Mitigations:** Development of the winter plan with system partners including community healthcare, local authorities and mental health trusts to mitigate risks to uneccessary admission and delayed discharge. The plan includes targeted areas of focus with partners to increase out of hospital capacity utilisation, such as NHS at Home / virtual ward occupancy.	**NEGATIVE**	**3 - Serious**	**4 - Likely**	**12**
Staff	How will this planned change impact staff retention or the ability to attract staff? Consider: • The potential impact on staff morale • How this change may affect respect shown between colleagues	**Risks:** There is a risk of staff sickness due to covid / flu, reduction in staff resilience due to winter pressures and additional unplanned absence associated with industrial action. **Mitigations:** The seasonal plan includes an enhanced programme of staff wellbeing and support initiatives, vaccination and use of temporary staffing pools to mitigate dilution of staffing ratios on ward areas.	**NEGATIVE**	**3 - Serious**	**4 - Likely**	**12**
Equality, Inclusion & Health Inequalities	How will the planned change offer opportunities to promote equality & inclusion?	Please complete the Stage 1 Equality Impact Assessment in the "**Rapid QIA with Stage 1 EIA**" tab to demonstrate you have analysed how the service or policy meets any particular needs of equalities groups or helps promote equality in some way, or it could have a negative or adverse impact for any of the equalities groups				

5. Key Quality Indicator (KQI) Monitoring	
Important notes	**Describe the quality indicators and monitoring arrangements**
Add the Key Quality Indicators (KQIs) in the next box that you will actively monitor after the change has taken place to ensure the mitigations you had planned, and are deploying, are working. Outline core clinical quality indicators, performance metrics and patient outcome measures in place to review impact on quality improvements and expected impact on these measures	KQIs: Various measures in place but will include: Non-elective length of stay and associated patient flow metrics Staff vaccination coverage Bed occupancy (open / closed / closed and empty) Infection, prevention and control monitoring (nosocomial infection rates). Datix incidents relating to use of temporary escalation spaces Staff survey / staff sickness absence Mortality rates / Quality metrics Pressure Ulcers, fall etc

Stage 2 Full Equality Impact Assessment

A full Equality Impact Assessment (or 'Equality Analysis') will be required if the initial (stage 1) assessment has identified the potential for negative impact, on the basis of disability, pregnancy /maternity, race, sex, disability, age, sexual orientation or religion

1	**Identify the aims of the policy or service and how it is implemented**	
	Key questions	**Answers / Notes**
1.1	What is the name of the policy, strategy or project?	
1.2	Briefly describe purpose of the service/policy including • How the service/policy is delivered and by whom? • If responsibility for its implementation is shared with other departments or organisations • Intended outcomes	
1.3	Provide brief details of the scope of the policy or service being reviewed, for example: • Is it a new service/policy or review of an existing one? • Is it a national requirement? • How much room for review is there?	
1.4	Do the aims of this policy link to or conflict with any other policies of the Trust?	
2	**Consideration of available data, research and information**	
	Monitoring data and other information should be used to help you analyse whether you are delivering a fair and equal service. Please consider the availability of the following as potential sources: • Demographic data and other statistics, including census findings • Recent research findings (local and national) • Results from consultation or engagement you have undertaken • Service user monitoring data (including ethnicity, gender, disability, religion/belief, sexual orientation and age) • Information from relevant groups or agencies, for example trade unions and voluntary/community organisations • Analysis of records of enquiries about your service, or complaints or compliments about them • Recommendations of external inspections or audit reports	
	Key questions	**Data, research and information that you can refer to**
2.1	What is the equalities profile of the team delivering the service/policy?	
2.2	What equalities training have staff received?	
2.3	What is the equalities profile of service users?	
2.4	What other data do you have in terms of service users or staff? (e.g results of customer satisfaction surveys, consultation findings). Are there any gaps?	
2.5	What engagement or consultation has been undertaken as part of this EIA and with whom? What were the results?	
2.6	If you are planning to undertake any consultation in the future regarding this service or policy, how will you include equalities considerations within this?	
3	**Assessment of impact: 'Equality analysis'**	
	Based upon any data you have considered, or the results of consultation or research, use the spaces below to demonstrate you have analysed how the service or policy: • Meets any particular needs of equalities groups or helps promote equality in some way. • Could have a negative or adverse impact for any of the equalities groups	

	Protected Characteristics	**Examples of what the service has done to promote equality**	**Examples of actual or potential negative or adverse impact and what steps have been or could be taken to address this**
3.1	**Gender** – identify the impact/potential impact of the policy on women and men.		
3.2	**Pregnancy and maternity**		
3.3	**Gender Reassignment/ Transgender** – identify the impact/potential impact of the policy on transgender people (Note an individual's assigned sex and gender does not align, meaning the person may be transgender)		
3.4	**Disability** - identify the impact/potential impact of the policy on disabled people (ensure consideration both physical and mental impairments)		
3.5	**Age** – identify the impact/potential impact of the policy on different age groups		
3.6	**Race** – identify the impact/potential impact on different black and minority ethnic groups		
3.7	**Sexual orientation** - identify the impact/potential impact of the policy on lesbians, gay, bisexual & heterosexual people		
3.8	**Marriage and civil partnership** – does the policy/strategy treat married and civil partnered people equally?		
3.9	**Religion/belief** – identify the impact/potential impact of the policy on people of different religious/faith groups and also upon those with no religion		
3.10	**Sex** - does the policy/strategy treat people of all sexes equally? Sex is defined as either of the two main categories (male and female) into which humans and most other living things are divided on the basis of their reproductive functions		
3.11	**Socio-economically disadvantaged** – identify the impact on people who are disadvantaged due to factors like family background, educational attainment, neighbourhood, employment status can influence life chances		
3.12	**Rural communities** – identify the impact / potential impact on people living in rural communities		

QIA Review

R1. Impact Re-Assessment			
Date of review			
Name of meeting or Board where the QIA has been reviewed			
Were risks identified in the initial assessment?	Select	If **Yes**, complete section R2.1. If **No**: go to R2.2.	

R2. Mitigations & Key Quality Indicator (KQI) Monitoring
R2.1. Risks identified in the initial assessment
Reference the KQIs from the initial quality impact assessment and describe the impact the project/change has had on them

Once R2.1. completed, go to R2.2.

R2.2. Further risks or unintended adverse consequences identified since the initial assessment			
Have you identified further risks or unintended adverse consequences?	Select	If **Yes**, complete this section If **No**: go to R3.	
List these identified risks or adverse consequences and the measures you will implement to mitigate and manage them			

Once R2.2. completed:
go to R3.1. for Full QIA review sign off
or R3.2. for Rapid QIA review sign off

R2.2. Further risks or unintended adverse consequences identified since the initial assessment

Notes:

1. Once review completed, **update** the Next Review Due By box in the Full or Rapid QIA tab
2. **Flag** specific elements of work that you foresee may need quality/equality assessments in the next quarter

R3.1. Sign-Off			
R3.1.1 Divisional	Name	Signature	Date
Divisional Sign-Off:			
R3.1.2. Chief Nurse & Medical Director to complete:			
Provide details of any significant concerns regarding the review:			
If no concerns, please sign & date below:			
	Name	Signature	Date
Chief Nurse Sign-Off:			
Medical Director Sign-Off:			
Chief Operating Officer Sign-Off:			

IMPORTANT: E-signatures accepted if supported by e-trail

R3.2 Sign-Off for Rapid QIA Review			
	Name	Signature	Date
3.2.1. Project Lead Sign-Off:			
3.2.2. Divisional Director:			
3.2.3 Divisional Director of Nursing:			
3.2.4. Associate Medical Director:			

IMPORTANT: E-signatures accepted if supported by e-trail

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Board of Directors	Agenda item:	13.0
Date of Meeting:	5 November 2025		

Title of Report:	Maternity and Neonatal Safety Report Quarter 1 2025/26
Board Sponsor:	Antonia Lynch, Chief Nursing Officer
Author(s):	Zita Martinez, Director of Midwifery Kerry Perkins, Patient Safety Lead Midwife
Appendices	Appendix 1: MBRRACE 2024 report (2023 data) Appendix 2: Transitional Care Pathway and ATAIN Audit Q1 2025/26 Appendix 3: 3 Year Delivery Plan/Ockenden Close Down Report

1. Executive Summary of the Report

This report highlights the current status and safety measures in place for maternity and neonatal services, with a focus on monitoring and addressing safety concerns.

Stillbirths and neonatal deaths in Q1 have been reported to MBRRACE-UK, and a Perinatal Mortality Review Tool (PMRT) will be used where applicable, excluding medical terminations.

MBRRACE-UK report (March 2024, (2023 data)) indicated the Royal United Hospitals (RUH) had an average stillbirth rate and a lower-than-average neonatal mortality and extended perinatal rate compared to similar trusts (Appendix 1).

Maternity and Neonatal Safety Investigations (MNSI) team received two referrals in Q1, both accepted for investigation at the family's request.

Maternity Incentive Scheme (MIS) compliance reporting began in Q1, with ongoing monitoring of Safety Actions. The service continued meeting 90% compliance for Saving Babies Lives Care Bundle Version 3.2 and will continue working on improvement.

Term Admissions into the Neonatal Unit (ATAIN) have decreased since Q4, with the Transitional Care Pathway remaining open 100% of the time in Q1 (Appendix 2).

The service is conducting thematic reviews on issues such as bladder care, neonatal readmissions, medication management, neonatal pneumothorax, and obstetric haemorrhage, using data insights from the Maternity and Neonatal Voices Partnership (MNVP) and Safety Intelligence data using the Patient Safety Incident Response Framework (PSIRF).

In summary, the service is actively monitoring and improving safety measures, with a focus on reducing mortality rates and improving outcomes and experience for families.

2. Recommendations (Note, Approve, Discuss)

The Board is asked to discuss and approve the report.

3.	Legal / Regulatory Implications

It is a legal requirement to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

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

In Q1 five new risk assessments were presented and approved for the risk register:

Risk No	Domain of Risk	The Risk	
3101	Patient Safety & Quality	Maternity triage non-compliance with medical review timescales as per RCOG guidance	15
3112	Patient Safety & Quality	Neonatal CPAP respiratory support devices	9
3143	Patient Safety & Quality	MEWS chart remaining paper based following implementation of Badgernet	9
3093	Digital	Neonatal Electronic Patient Record (EPR)	6
3094	Patient Safety & Quality	Fragmented Safeguarding documentation across perinatal services and safeguarding team	6

Table 1: New risk, Q1 2025/26

Current open risks scoring >12 in Maternity and Neonates Q1 2025/6 scoring:

Risk No	Domain of Risk	The Risk	
3101	Patient Safety & Quality	Maternity triage non-compliance with medical review timescales as per RCOG guidance	15
3013	Patient Safety & Quality	There is a risk that maternity services are unable to deliver timely USS pathways because of USS capacity, demand, and workforce issues, which is likely to impact on patient care such as avoidable maternal and neonatal harm	12
2950	Patient Safety & Quality	There is a risk neonatal patients will be cared for outside of British Association of Perinatal Medicine (BAPM) guidelines by nursing staff who are not qualified in specialty (QIS)	12
2785	Patient Safety & Quality	As a result of the level of clinical pharmacist provision to the NNU, BAPM service quality standards are not being met	12
2717	Patient Safety & Quality	There is a risk that information sharing of father's information is not facilitated resulting in a safeguarding incident with potential harm to unborn/newborn babies	12

Table 2: Ongoing risks scoring >12 Q1 2025/26

All risks are managed as per the Trust Risk Management Policy.

5.	Resources Implications (Financial / staffing)
Compliance with the Maternity Incentive Scheme for Trusts has financial and safety implications for the Trust. There is a financial commitment required by the Trust to achieve full compliancy.	

6.	Equality and Diversity
Equality and Diversity legislation is an integral component to registration.	

7.	References to previous reports
Previous monthly Perinatal Quality Surveillance reporting Q1 report 2025/26 – Maternity and Neonatal Safety Champions, October 2025 Q1 report 2025/25 – Quality Assurance Committee, October 2025	

8.	Publication
Public.	

Report Overview

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document '*Implementing a revised perinatal quality surveillance model'* (December 2020). The purpose of the report is to inform the Local Maternity and Neonatal System (LMNS) Board and the Board of Directors of present or emerging safety concerns within Maternity and Neonatal services. The information within the report reflects actions and progress in line with the three-year delivery plan (3YDP) for Maternity and Neonatal Services of 2023.

The Trust is no longer required to submit evidence of compliance with the 15 Immediate and Essential Actions from the Ockenden 2022 report. Following significant progress with 80 of the 93 sub actions being complete, the perinatal service has formally closed reporting on the Ockenden actions. Outstanding actions have been incorporated into the service priorities for 2025/26 and aligned to the 3YDP (Appendix 3). This report also outlines the current position of compliance with the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) including Saving Babies Lives Care Bundle V3.2 (SBL).

1.0 PERINATAL MORTALITY AND MORBIDITY

The following graphs demonstrate RUH performance against the national ambition to reduce stillbirths in the UK by 50%, and the local ambition for continual progression in reducing perinatal mortality. From March 2025 the national averages have been adjusted to reflect the publication of the MBRRACE-UK report of 2023 perinatal mortality revised National averages.

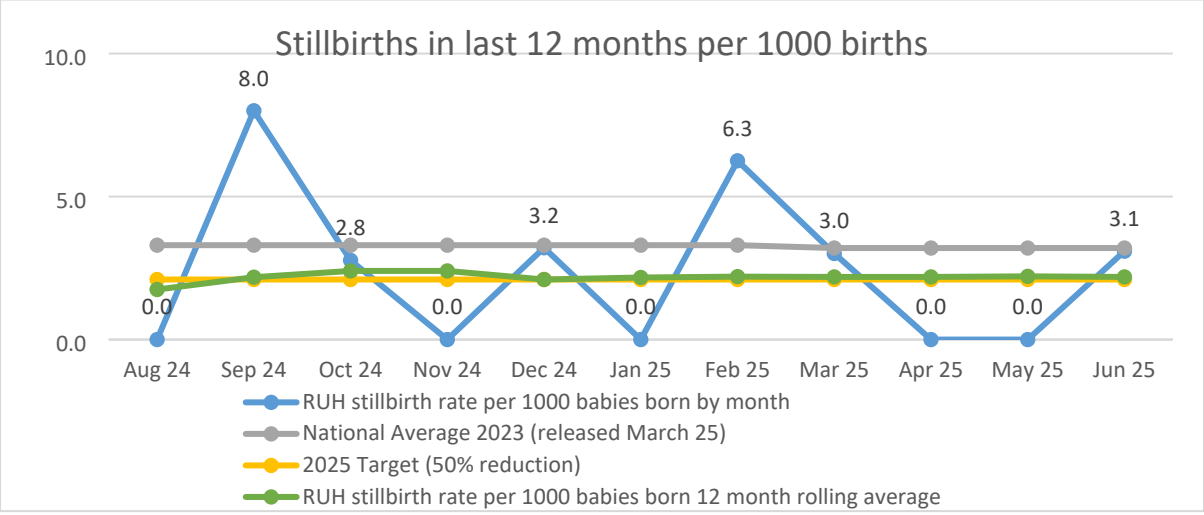


Figure 1: RUH NHS Trust stillbirth rate per 1000 births over last 12 months

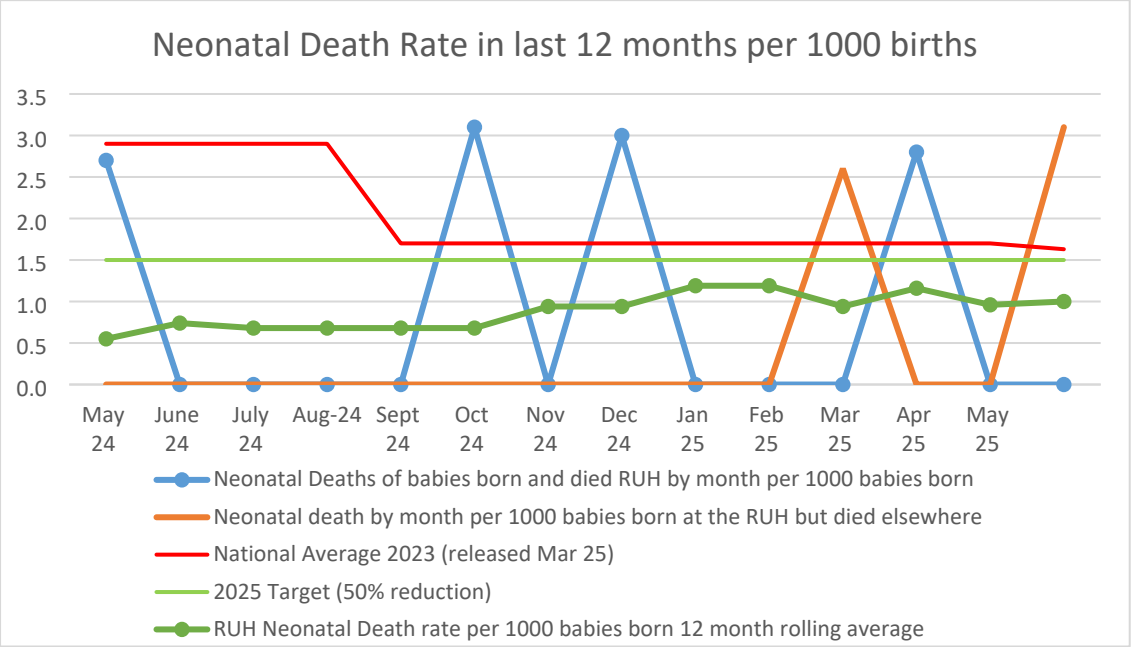


Figure 2: RUH NHS Trust Neonatal Death rate per 1000 births over last 12 months

MBRRACE-UK collects data on perinatal deaths, defined as stillbirths from 22 weeks' gestation and neonatal deaths up to 28 days of age, excluding terminations. At RUH, the Electronic Patient Record (EPR) captures stillbirths from 24 weeks and neonatal deaths. Cases outside this, such as pre-viability neonatal deaths (<22 weeks) and births between 22–24 weeks are manually identified and added to the MBRRACE-UK dataset. Due to differing definitions (stillbirths recorded from 24 weeks, perinatal deaths from 22 weeks), reported rates may vary.

Trusts are provided with initial MBRRACE-UK perinatal mortality rate per 1000 births; results are subsequently stabilised and adjusted to reflect if the RUH statistics were representative of the national socioeconomic demographics. Therefore, MBRRACE crude, and stabilised and adjusted rates for the RUH will be different. MBRRACE-UK collates the data for those babies who were born at the RUH and subsequently died elsewhere. This report has separated these values to ensure alignment of internal mortality data figures ahead of reported and adjusted MBRRACE-UK figures, see figures 1 and 2.

One antenatal stillbirth at 30 weeks of pregnancy was reported in Q1. There was one neonatal death born at the RUH but died at United Hospital Bristol and Weston NHS Foundation Trust (UHBW).

2025/26 (excluding terminations for abnormalities)	Q1 25/26	Annual total 25/26 (fiscal)	Annual total 2025 (calendar year)
Stillbirths (>37 weeks)	0	0	1
Stillbirths(>24weeks-36+6weeks)	1	1	2

Late miscarriage (22+weeks-23+6weeks)	0	0	0
Neonatal death at the RUH	0	0	1
Neonatal death elsewhere following birth at the RUH	1	1	1
Total	**2**	**2**	**5**

Table 3: Perinatal Mortality summary by number of cases, Quarter 1 2025/26

2.0 PERINATAL MORTALITY REVIEW TOOL (PMRT)

PMRT reporting is a requirement of Safety Action 1 of the NHS-R Maternity Incentive Scheme. All perinatal mortality cases are subject to a multi-disciplinary team (MDT) team review within 1 week to identify any immediate safety concerns or learning using the Patient Safety Incident Response Framework (PSIRF). All perinatal mortality cases are then reviewed using the PMRT process during monthly MDT meetings. If the PMRT process identifies further concerns or learning opportunities, this is escalated to the patient safety team to drive service improvements.

Family concerns/questions are discussed at the monthly PMRT meeting, and all families are offered support through a single point of contact during the review process. Families may choose to receive a draft report pending further investigation results such as postmortem which can take considerable time to receive due to a national shortage of Paediatric Pathologists. The service is currently undertaking a risk assessment to include this on the Trust risk register under the Patient Experience domain.

Standards for quarterly and annual PMRT compliance for MIS can be found in table 4.

A. PMRT PROCESS MEASURES

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	Q1 25/26	Annual 24/25	Standard
Notification of all perinatal deaths eligible to notified to MBRRACE-UK to take place within seven working days.	**100%**	**100%**	**95%**
Surveillance of all perinatal death information must be completed within one month of the death. Deaths where the surveillance form needs to be assigned to another Trust for additional information are excluded from the latter.	**100%**	**100%**	**95%**
A PMRT review must be commenced within two months following the death of a baby.	**100%**	**100%**	**50%**

Percentage of PMRT review meetings which have met quoracy as outlined within the PMRT recommended composition.	**100%**	**100%**	**100%**
A draft PMRT report must be completed within four months of a baby's death.	**N/A**	**75%**	**50%**
A PMRT must be completed within six months of the death of a baby's death.	**N/A**	**75%**	**50%**
All parents will have been told that a review of their baby's death is taking place and asked for their contribution of questions and/or concerns.	**100%**	**100%**	**95%**
Quarterly reports will have been submitted to the Trust Board from 6 May 2022 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.	**100%**	**100%**	**100%**

Table 4: PMRT Process Measures Quarter 1 25/26

B. Q1 2025/26 PMRT BIRTH DATA

Birth Data	
Cases for PMRT review	3
Antenatal Stillbirth	2
Intrapartum stillbirth	0
Late fetal losses	0
Early neonatal death	1
Late neonatal death	0

Table 5: PMRT birth data Q1 25/26

The quarterly birth data may differ from number of provisional grading depending on the availability of records/family feedback being received.

C. Q1 2025/26 PMRT REVIEWS PROVISIONAL GRADING

Case	Grading of care at provisional MDT review (pending further clinical investigation results)	
Antenatal Stillbirth	Care of mother and baby up to point of baby was confirmed as having died	A
	Care of mother following the confirmation of death of baby	B

Table 6: Q1 2025/26 provisional grading of care pending further clinical investigation results

PMRT	Grading of care key
Grade A	No issues with care identified that would have impacted on the outcome
Grade B	Care issues which would have made no difference to the outcome
Grade C	Care issues which may have made a difference to the outcome
Grade D	Care issues which were likely to have made a difference to the outcome

Table 7: PMRT grading of care key

D. Q1 2025/26 PMRT INITIAL REVIEW LEARNING OPPORTUNITIES

No themes or commonalities have been identified from initial PMRT reviews in Q1.

E. Q1 2025/26 LEARNING FROM COMPLETED PMRT REVIEWS

One PMRT report was completed in Q1. Actions and learning opportunities were identified as follows.

Issue/area for improvement	Review Response/Action plan	Action target date
1. Counselling with neonatal and obstetric team as part of antenatal clinic care	Communication between professional groups when joint counselling is required to ensure appropriate information is provided in line with SBL	July 25

Table 8: Q1 2025/26 PMRT completed reviews improvement plan

F. 2025/26 OUTSTANDING REVIEWS AWAITING FINAL GRADING (excluding Q1)

Case	Provisional grading of care pending further clinical investigation results	
Late Neonatal Death	Care of mother and baby up to point of birth of baby	B
	Care of the baby from birth up to death of baby	C
	Care of mother following the death of baby	Another provider to grade
Antenatal	Care of mother and baby up to point of birth of baby	A

Stillbirth	Care of mother following the death of baby	A

Table 9: 2024/25 ongoing reviews pending further clinical results

2.1 SAVING BABIES LIVES CARE BUNDLE 3.2

The Saving Babies Lives Care Bundle v3 (SBL) provides evidence-based best practice to achieve the national ambition to halve the rate of perinatal mortality by 2025 by driving innovation and quality improvement in key areas in maternity care. In Q1 version 3.2 was released with revision and updates in several elements. As part of the three-year delivery plan, providers are responsible for fully implementing all interventions of the care bundle. All PMRT reviews are triangulated against SBL and improvements identified. Table 10 provides triangulation of care concerns against each element of SBL.

April	**May**	**June**
Number of perinatal mortality cases where smoking in pregnancy was a relevant issue (Element 1)		
0	0	0
Number of perinatal mortality cases where fetal growth: risk assessment, surveillance or management was an issue (Element 2)		
0	0	0
Number of perinatal mortality cases where raising awareness of reduced fetal movements was an issue (Element 3)		
0	0	1
Number of perinatal mortality cases where effective fetal monitoring during labour was an issue (Element 4)		
0	0	0
Number of perinatal mortality cases annually where the prevention, prediction, preparation, or perinatal optimisation of preterm birth was relevant issue (Element 5)		
0	0	0
Number of perinatal mortality cases annually where the management of diabetes was an issue (Element 6)		
0	0	0

Table 10: Q1 2025/26 PMRT care concerns triangulated against SBL elements

During Q1, there was one reported stillbirth where reduced fetal movements (RFM) were a contributing factor (SBL Element 3). A thorough review found no care concerns about the management pathways of RFM that would have altered the outcome. There were no stillbirths, neonatal deaths, or cases of suspected hypoxic-ischemic encephalopathy (HIE) associated with intrapartum care during this period

There is strong evidence linking undiagnosed fetal growth restriction (FGR) to stillbirth making antenatal detection vital in reducing the risk of stillbirth with timely birth of the baby. All babies in Q1 who were predicted to be growth restricted were born at the optimal gestation. There was one baby born with FGR after the optimal time of birth that was not predicted to be growth restricted. Learning was identified in relation to scan images with no impact on the outcome.

3.0 MATERNITY AND NEONATAL SAFETY INVESTIGATIONS (FORMERLY THE HEALTHCARE SAFETY INVESTIGATION BRANCH) AND MATERNITY PATIENT SAFETY INCIDENT INVESTIGATIONS

Maternity and Neonatal Safety Investigations (MNSI) undertake maternity investigations in accordance with the Department of Health and Social Care criteria (Maternity Case Directions 2018), taken from Each Baby Counts and MBRRACE-UK. In accordance with these defined criteria, eligible babies include all term babies (at least 37 completed weeks of gestation) born following labour who have one of the following outcomes:

- Maternal Deaths
- Intrapartum stillbirth
- Early neonatal death
- Severe brain injury diagnosed in the first seven days of life

Table 11 summarises the completed MNSI review from Q3 referral. Two referrals were made and accepted in Q1 (table 12).

Two cases in Q1 25/26 have met the criterion for Early Notification Scheme referral to NHS-Resolution. One has been accepted, the second is pending confirmation of acceptance at the time of reporting.

Reference	Event Summary	Investigation Status	External Notifications	Duty Of Candour	Key Learning Identified
MI-038594	Neonatal transfer to tertiary unit for therapeutic cooling. MRI post cooling was normal	Investigation progressing at family request	None	Initiated 04/10/2024	Update Trust guidance on reduced fetal movements to align with national standards. Align guidance on presence of fresh blood in labour with national guidance Consideration of holistic assessment. Management of fluid in labour

					Strengthen escalation oversight to obstetric team.

Table 11. Completed MNSI investigations Q1 25/26

The completed MNSI report received in Q1 2025/26 issued two safety recommendations. These focused on aligning Trust guidance with national standards for the identification of antepartum haemorrhage during labour and ensuring timely obstetric review, in addition to updating the Trust's guidance and checklist for reduced fetal movements to reflect national recommendations. Safety recommendations are issued when evidence indicates that changes are required to improve care safety. Notably, both recommendations had already been identified during local multidisciplinary team (MDT) review and have been actioned accordingly.

Reference	Event Summary	Investigation Status	External Notifications	Duty Of Candour	Key Learning Identified
MI-042892	Neonatal transfer to tertiary unit for therapeutic cooling. MRI post cooling was normal	Investigation progressing at family's request	None	Yes	Information sharing with parent on safe sleeping and feeding advice immediately post birth
MI-042893	Neonatal transfer to tertiary unit for therapeutic cooling. MRI post-cooling was normal.	Investigation progressing at Trust's request	None	Yes	Risk assessment process at booking and during labour. Compliance with intrapartum intermittent auscultation (IA) Enhance escalation pathways

Table 12. New MNSI Referrals Q1 25/26

3.1 CORONER REGULATION 28

Not applicable for this reporting period.

3.2 MATERNITY PATIENT SAFETY INCIDENT INVESTIGATIONS (PSII)

There were no Patient Safety Incident Investigations (PSII) that reached completion in Q1 and no new PSIIs declared. One PSII is currently in draft with immediate learning from rapid review identified.

Reference	Event Summary	External Notifications	Duty Of Candour	Key Learning Identified
Datix 133329	Late Neonatal Death at Day 8 of life.	MBRRACE PMRT Child Death Oversight Panel (CDOP) Coroners	Initiated 15/10/2024	Review of neonatal triage in maternity Standardise safety netting Review out of date guidelines

Table 13. Maternity and Neonatal Patient Safety Incident Investigations Q1 25/26

3.3 TRUST CLAIMS SCORECARD – OBSTETRICS

The Trust's latest scorecard correlates open and closed claims managed by the Trust legal team during 2024. The legal claims span a time frame from 2014-2024. Obstetric accounts for approximately 12% of claims made to the Trust but represents 62% of the value of Trust claims at approximately £3.7m. The eight, high volume, high case value cases for the Trust are all obstetric.

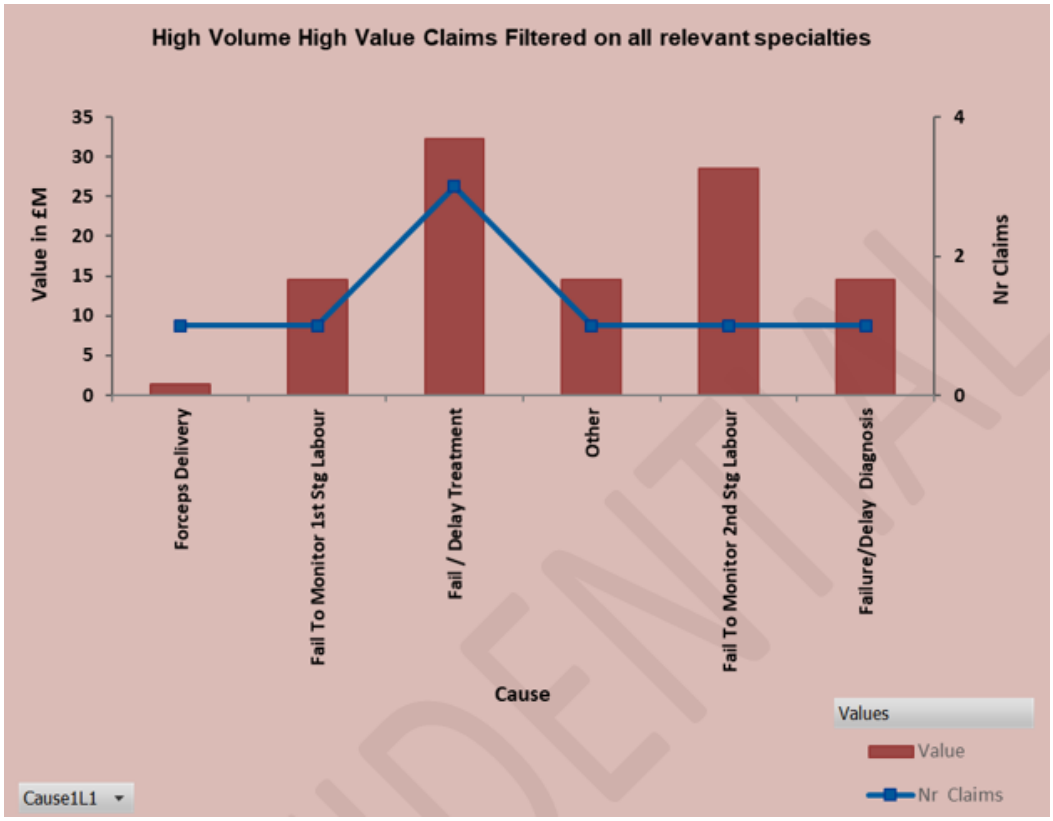


Figure 3. High volume high value claims by cause

Six of these claims relate to Cerebral Palsy/hypoxic brain injury, Erbs Palsy (n=1) and Meningitis (n=1). Further triangulation of information is underway to identify themes and learning from claims and will be reported in the Q2 report.

Obstetrics are an outlier when compared to the national and regional averages but receive the same number of claims as other Trusts of a similar type and size. Updated benchmarking in this regard is due imminently.

3.4 LEARNING AND IMPROVEMENT FROM PMRT, FAMILY FEEDBACK, MNSI & CLAIMS

Triangulation of feedback and insights identified the following themes:

- Improved postnatal experience for women and families - this is addressed through the Perinatal Culture and Leadership Programme (PCLP)
- Bladder care
- Informed consent to aid decision making
- Effective intermittent auscultation fetal monitoring
- Guideline management
- Medicine management

Bladder care, informed consent to aid decision making and effective intermittent auscultation fetal monitoring are priorities that were set in 2024/25 following the

Insights report with ongoing QI projects that are monitored through governance. To enable implementing and embedding of the Divisional priorities the Insights report will be undertaken every 2 years, rather than annually. This approach aims to direct resources towards sustainable change with a focused effort on delivering measurable improvements to deliver high-impact, evidence-informed, improvements in safety, experience and outcomes across maternity and neonatal services.

A thematic review is currently underway in response to continued errors in risk assessing and prescribing of Low Molecular Weight Heparin which will be presented through governance with an improvement plan. The perinatal service has also implemented a multidisciplinary Medicine Safety Committee which will report through governance.

The service has recognised an increase in major obstetric haemorrhage >2000mls in March, April and May 2025. All cases have been individually reviewed by the patient safety team with local learning identified and disseminated in some cases. Due to the consistent increase above the national average, a thematic review is being undertaken to determine if there is any wider learning and will be reported through speciality governance.

Guidelines are monitored monthly through governance. Baseline Assessment tools help identify current practices against recommended NICE standards and there are plans to further enhance guidelines by performing a service wide review of all guidelines to aid staff and ensure alignment with national guidelines and SBLv3.2.

Learning and Improvement drivers from service insights are fed back to staff in a variety of formats including: the maternity newsletter, staff e-mails, staff safety briefings, patient safety ‘Safety Catch’ newsletter, Microsoft Teams RUH Maternity Team, case review QR code posters to full reports and quality and safety whiteboards displayed in clinical areas with a ‘Safety Hot Spot’ of the month. Safety Hotspots are identified from co-incidental learning through service insights such as themes of low and no harm incidents, audit and, or family feedback. The service is reviewing how staff want to receive information and feedback to ensure learning is optimised and staff are not flooded with information. Furthermore, local insights for learning are fed into the mandatory training programme as per the Core Competency Framework version 2 (CcFv2).

4.0 THREE YEAR MATERNITY AND NEONATAL SERVICES (3YDP)

The Trust has made substantial progress in delivering of the 3YDP, with 36 of the 44 recommendations achieved. Achievements include the establishment of a Perinatal Pelvic Health Service, improved midwifery recruitment and retention through enhanced onboarding and professional development, embedding of Family Integrated Care in neonatal services, and significant digital advancements, including the rollout of NEWTT2 and a new Maternity Electronic Patient Record, BadgerNet.

Key workforce improvements have led to a reduction in sickness absence rates and 100% retention of newly qualified midwives since 2023. A strong focus has been maintained on building a positive culture of safety, enhancing co-production with service users, and improving staff and family engagement.

Looking ahead, priorities for the final year of the 3YDP include further strengthening compassionate care, advancing equity initiatives, sustaining workforce development, embedding digital systems, and achieving external accreditations such as UNICEF Baby Friendly Initiative (BFI) and Bliss Baby Charter Gold.

Trusts are no longer required to submit evidence of compliance with the 15 Immediate and Essential Actions form the Ockenden 2022 report. Significant progress in completing and embedding 80 of the 93 sub-actions has been made into business-as-usual practice. Outstanding actions have been aligned with the themes of the 3YPD: listening to women and families, supporting the workforce, developing a safety culture and strengthening standards and structures.

The Perinatal Service remains committed to delivering safe, personalised, and equitable maternity and neonatal services, with ongoing governance oversight to monitor progress, ensure continuous improvement, and respond to national expectations.

5.0 TRAINING COMPLIANCE FOR ALL STAFF GROUPS IN MATERNITY RELATED TO THE CORE COMPETENCY FRAMEWORK

The report provides an update on the local training, including a response to year 7 of MIS, Safety Action 8. The Core Competency Framework, version 2.2 sets out clear expectations for all Trusts, aiming to address known variation in training and competency assessment for maternity staffing across England. It ensures that training to address significant areas of harm are included as minimum core requirements and standardised for every maternity and neonatal service. Compliance with attendance and demonstrated competence for fetal monitoring, neonatal resuscitation, and multi-disciplinary training (MDT), Emergency Skills Training (PROMPT) across all staffing groups can be found in Figure 4.

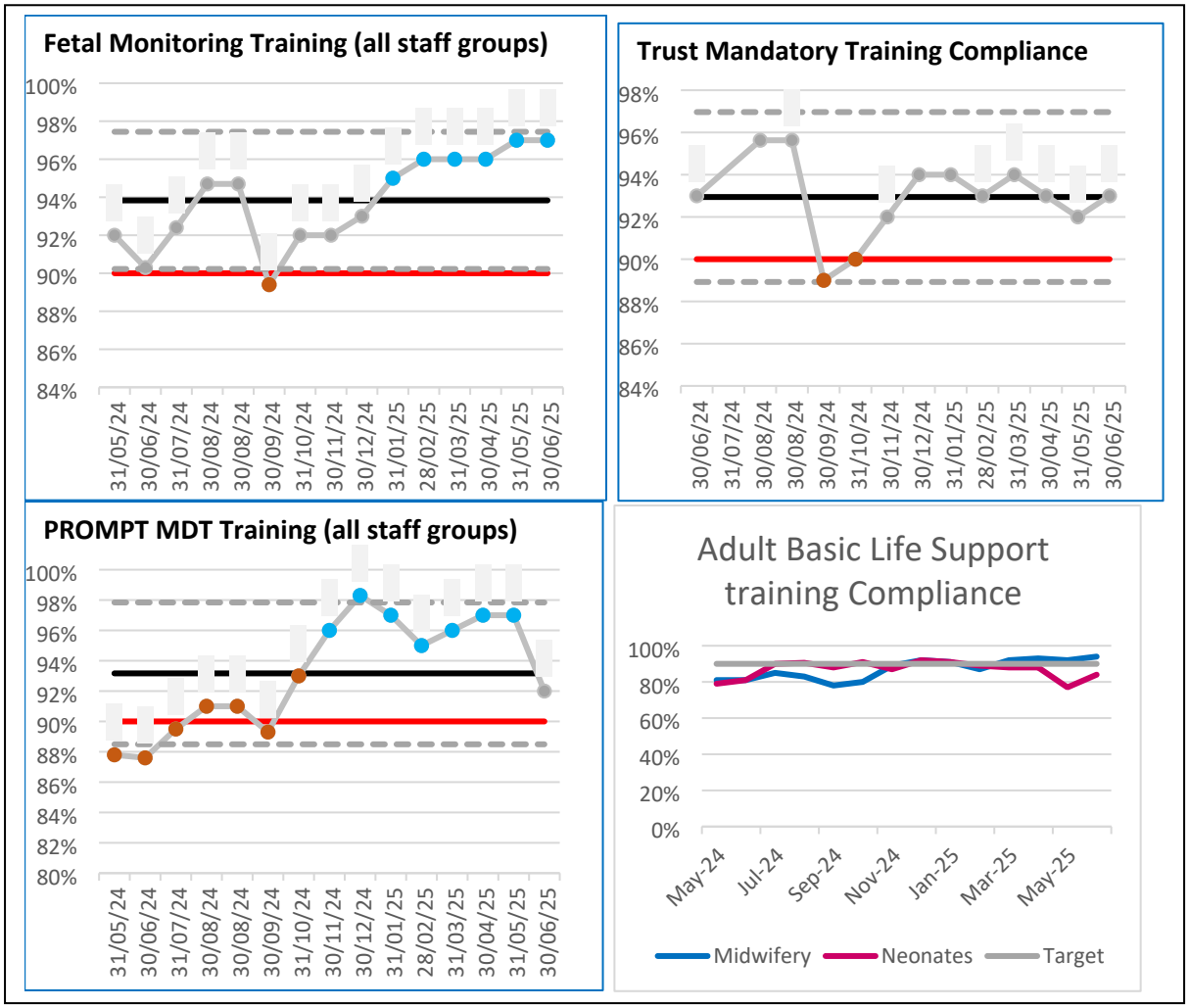


Figure 4. Maternity Training Statistical Process Charts for PROMPT, Fetal Monitoring, Mandatory Training compliance and Adult Basic Life Support compliance, as of 31/06/2025

Specific training standards for all staff identified within the Saving Babies Lives version 3.2 are externally assessed by the Integrated Care Board (ICB) Local Maternity and Neonatal System (LMNS) for content and compliance.

During Q1 the service achieved compliance for PROMPT at 92% and Fetal Wellbeing at 97% (target 90%) detailed as per figure 4, which are compliant for MIS. Adult Basic Life Support training for neonatal staff dropped below the Trust target due to an extended period of high activity and acuity necessitating prioritising clinical shift cover over training. An increase to achieve the Trust target is expected in Q2 and will be monitored monthly via governance meetings.

6.0 BOARD LEVEL SAFETY CHAMPIONS

The Maternity and Neonatal Safety Champions are active in their role to listen to the staff voice in maternity services. All staff are invited to attend monthly 'listening event' meetings and interact with Safety Champions during walkabouts with the Chief

Nursing Officer, the Non-Executive Director for Maternity and Neonatal services, and the Obstetric, Neonatal and Maternity Safety Champions.

Themes raised to the Safety Champions during Q1 were:

- High neonatal unit acuity well managed by the team
- Positive feedback from families, students and staff
- Positive feedback following increase in leadership on Mary ward

Current work to address the concerns raised:

- Advanced Neonatal Nurse Practitioner (ANNP) vacancy and impact of shift changes to support rota vacancy – mitigated by recruiting to trainee ANNP post
- Increase in number of reclining chairs for parents/families

Identified themes, commonalities and actions from this feedback is monitored via the Maternity and Neonatal Safety Champions meetings and is triangulated with further service insights in the Maternity and Neonatal 'Insights' report to drive our continuous improvement work.

7.0 NHS RESOLUTION MATERNITY INCENTIVE SCHEME UPDATE Q1 2025/26

The Clinical Negligence Scheme for Trusts (CNST) released the Maternity (and perinatal) Incentive Scheme Year 7 on 2 April 2025. Updates on progress and monitoring towards achievement of the 10 Safety Actions is completed and shared within Maternity and Neonatal Speciality Governance meeting and Board Level Safety Champions on a monthly basis.

Each of the 10 Safety Actions has a senior perinatal lead sponsor with oversight of the compliance requirements and regular meetings with the patient safety lead to identify and act on any concerns. Compliance in Q1 is as follows:

	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?		

Table 14: Q1 2025/26 Mis year 7 compliance

7.1 SAFETY ACTION 6 - SAVING BABIES LIVES CARE BUNDLE V3.2

Saving Babies Lives Care Bundle Version 3.2 implementation is subject to ongoing continuous improvement work. The Service is compliant using the SBL NHSE Implementation Tool and at least quarterly improvement discussions with the ICB have been held. The service-maintained compliance at 90% in Q1 after validation from the LMNS. Although there has been a reduction in compliance for elements 4 and 6, significant progress has been made in other elements with an anticipated further improvement in Q2.

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	90%	Fully implemented	100%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	80%	Partially implemented	90%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Fully implemented	100%	Partially implemented	60%	CNST Met
Element 5	Preterm birth	Partially implemented	81%	Partially implemented	93%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Partially implemented	83%	CNST Met
All Elements	TOTAL	Partially implemented	86%	Partially implemented	90%	CNST Met

Table 15. RUH Maternity position for implementation of Saving Babies Lives Care Bundle v3.2

Areas of risk which may delay further progress have been identified including ultrasound demand and capacity which is on the risk register with a joint action plan with radiology monitored through governance. The implementation of a new electronic

patient record system (EPR) may also see a reduction in compliance, actions to mitigate this are in place including regular review of electronic data to identify further training requirements.

8.0 SAFE MATERNITY AND NEONATAL STAFFING

8.1 MIDWIFERY STAFFING

As of June 2025, the midwifery establishment has no substantive vacancies, however there are 7.08wte on secondment, and 12.72wte on Maternity leave. Due to the consistent rates of maternity leave cover required within the service, the RUH has agreed an additional 8.0 substantive WTE into budget to minimise impact on clinically available workforce vacancy and maintenance of safe staffing. This means there is a fixed term vacancy of 1.63wte which is being held to allow for recruitment to existing midwifery students.

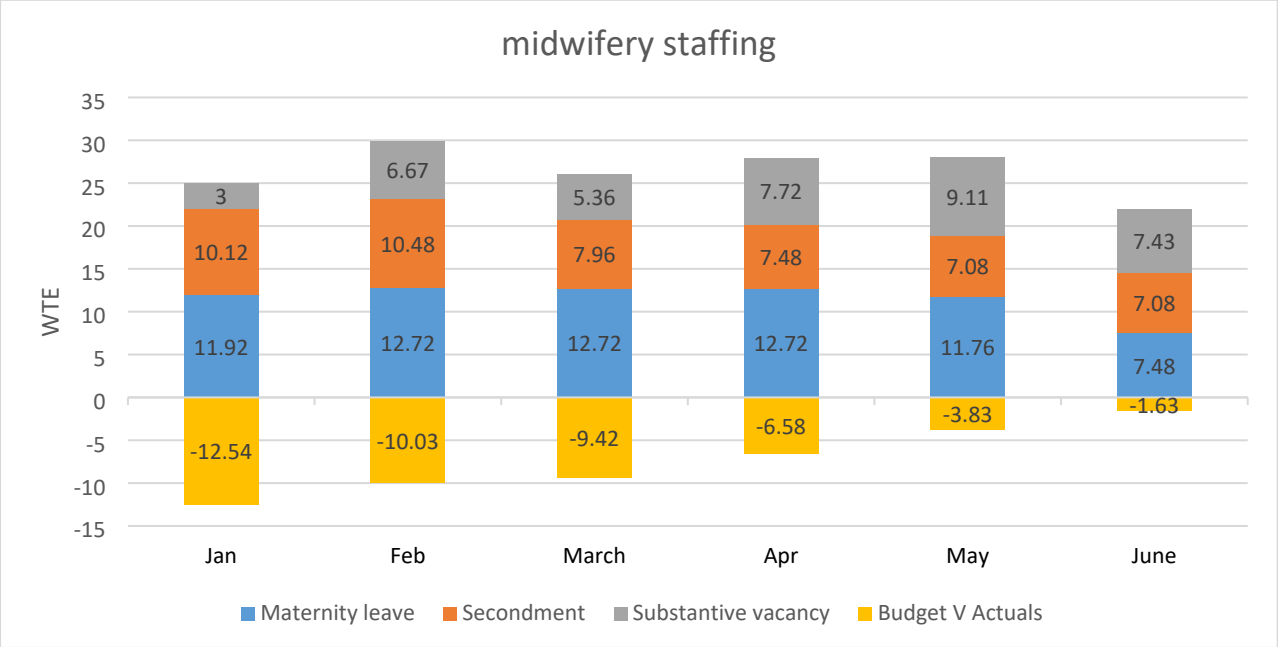


Figure 5. Midwifery Workforce staffing vacancy and forecast (not including long-term sickness)

Table 16 Outlines some of the key process and outcome measures during Q1 for the provision of safe midwifery staffing levels.

Measure	Aim	April	May	June
Midwife to birth ratio	1:24	1:27	1:30	1:26
Midwife to birth ratio including bank	1:24	1:24	1:25	1:24
Episodes of inability to maintain Supernumerary labour ward coordinator (LWC) status	0	0	0	1
1:1 care not provided	0	0	0	1
Confidence factor in Birth-rate+ recording	60%	82	86	87

Table 16: Midwifery staffing safety measures

The midwife to birth ratio advised in the Birthrate+ report 2021 has been achieved in April and June. In May, this was not achieved due an increase in births of 33 in month compared to April and June.

There was one episode recorded of non-supernumerary status of the Labour Ward Coordinator (LWC). On investigation this was due to the LWC being the named midwife along with a maternity support worker for a woman who had been de-escalated from high dependency care who was awaiting transfer to the postnatal ward. The LWC remained available to staff, there were no safety concerns, and the episode was resolved within 15 minutes.

8.2 MEDICAL STAFFING

The service is compliant with BBC consultant presence and twice daily MDT ward rounds and has moved to exception reporting. This is monitored daily and if no ward round is completed due to activity and acuity an MS Teams forms is completed which initiates immediate escalation. Improvement work continues exploring enhancing consultant review and oversight for postnatal readmissions. Compliance with anaesthetic staffing remains within the acceptable range.

Measure	Aim	April	May	June
Consultant presence on BBC (hours/week)	≥90 hours	98	98	98
Consultant non-attendance (in line with RCOG guidance)	0	0	0	0
Twice daily MDT ward round	90%	94%	97%	97%
Anaesthetic staffing	>70%	100%	100%	100%

Table 17: Obstetric staffing safety measures

8.3 NEONATAL NURSING STAFFING

In Q1the overall nursing vacancy has improved, reducing from 4.84 WTE to 2.09 WTE. The over-establishment of two Band 4 roles to support Student Nurse Associates and one Nursing Apprentice has been offset against the vacancy. Recruitment efforts remain ongoing to fill the remaining vacant posts. An honorary contract has also been issued for a neonatal nurse from Yeovil to support service delivery.

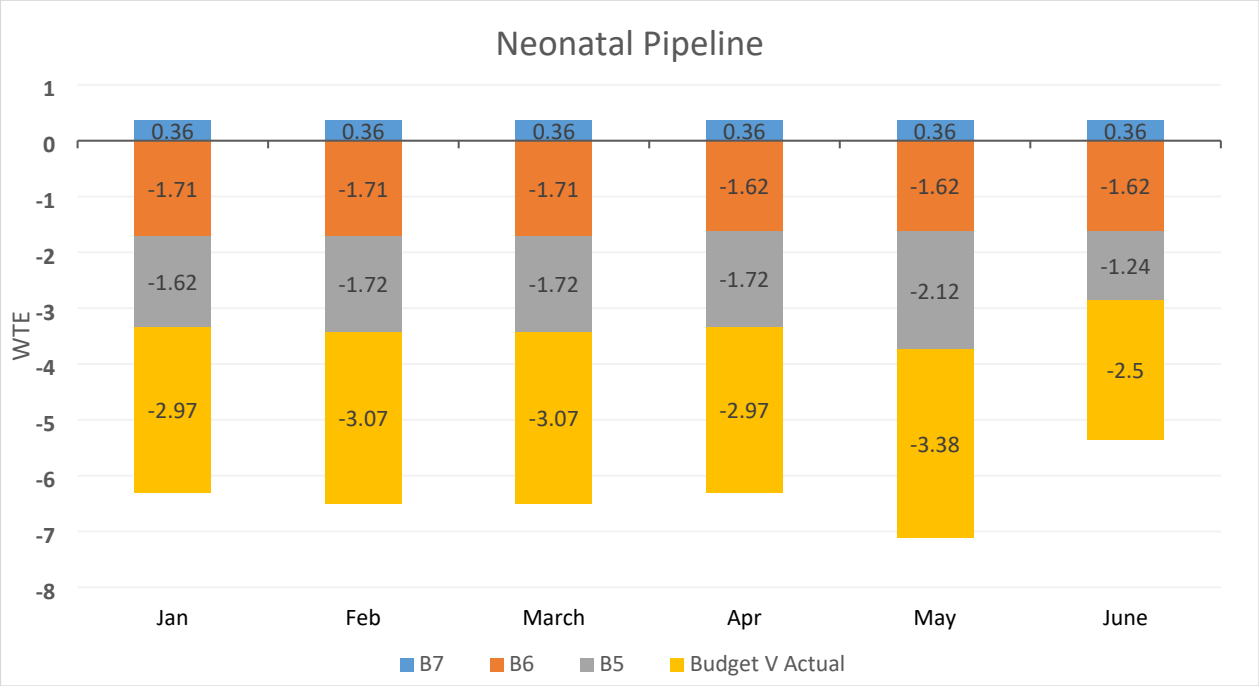


Figure 6. Neonatal nurse workforce staffing vacancy and forecast (not including long-term sickness)

MIS Safety Action 4 outlines the requirement to demonstrate compliance with meeting British Association of Perinatal Medicine (BAPM) neonatal nursing standards. May saw an increase in compliance for nurses holding the Qualified in Speciality (QIS) qualification in neonatal nursing with and anticipated compliance at 70% in Q2 2025/26.

Measure	Aim	April	May	June
Percentage of nursing establishment who hold Qualified in Speciality (QIS) qualification.	>70%	60%	65%	65%
Percentage of Transitional Care (TC) shifts with staff dedicated to TC care only	>90%	100%	100%	100%
Neonatal Nursing Vacancy rate (WTE)		1.36	2.11	2.09

Table 18. Neonatal nursing staff

QIS is Continued Professional Development in addition to the Bachelor of Science Paediatric Nursing. There is no identified ongoing funding stream for QIS training, however funding has been secured for a subsequent cohort, there is a risk to recurrent funding and pipelines. The risk remains on the Maternity and Neonatal Risk Register, Risk 2950 (Section 10.0).

Actions towards mitigation of the risk, and reduction in the likelihood of quality of care being impacted will be monitored via Maternity and Neonatal Specialty Governance and Maternity and Performance Review Meetings for financial planning.

8.4 NEONATAL MEDICAL STAFFING

The service has maintained compliance with the BAPM standards for neonatal medical workforce across Q1 of 25/26 in line with Safety Action 4 of MIS.

Measure	Aim	April	May	June
Tier 1 separate rota compliance 24/7 'At least one resident Tier 1 (ANNP or junior doctor ST1-3) practitioner dedicated the providing emergency care for the neonatal service 24/7'	100%	100%	100%	100%
Tier 2 Separate rota compliance 12h per day 'Resident Tier 2 (ANNP or junior doctor ST4-8) practitioner dedicated solely to the neonatal service 12 hours a day during the busiest times of the day'	100%	100%	100%	100%
Tier 2 compliance: significant geographical separation between neonatal and paediatric units 'The Tier 2 (ANNP or junior doctor ST4-8) practitioner should be immediately available at all times to the neonatal unit and the labour ward. If the site of the paediatric unit makes this immediate response impossible separate Tier 2 rotas are required'	100%	100%	100%	100%
Tier 3 daytime compliance All consultants on-call for the unit have regular weekday commitments to the neonatal service only (ideally with a 'consultant of the week' system) and all consultants do a minimum of four 'consultant of the week' service weeks per year	100%	100%	100%	100%
Tier 3 compliance No on-call rota should be more onerous than one in six		compliant		

Table 19. Neonatal medical workforce compliance

There was successful recruitment to the ANNP training post which will commence in September 2025. Rota gaps continue to be prioritised with the negative impact on the ability for ANNPs to fulfil all four pillars of advance practice.

9.0 INSIGHTS FROM SERVICE USERS AND MATERNITY AND NEONATAL VOICES PARTNERSHIP

9.1 COMPLAINTS, COMPLIMENTS, PATIENT ADVICE AND LIAISON SERVICE

(PALS)

	April	May	June
Number of formal compliments	1	3	2
Number of Patient Advice and Liaison Service (PALS) contacts/concerns	3	22	14
Number of formal complaints	2	3	1

Table 20. Complaints and compliments Q1 25/26

Compliments to the service were received across all areas of Maternity and Neonatal care. A continued theme amongst compliments to the service is the kindness and compassion care showed to birthing people and their families.

During Q1, six formal complaints were received, all complaints, PALS contacts and informal feedback are assessed for commonalities, trends, or themes within the monthly Maternity and Neonatal 'Insights' Family feedback Triangulation group.

The service identified improving patient experience in the immediate postnatal care period as a safety priority for 2024/2025 and is a focus for the Perinatal Leadership and Culture Programme (PCLP). Senior leadership was increased on Mary ward along with an operational support midwife to support flow through the maternity service, including supporting staff breaks. These changes have received positive feedback from staff. Progress on the PCLP Quality Improvement project is monitored quarterly through speciality governance.

9.2 SERVICE 'INSIGHTS' SAFETY PRIORITIES

All service feedback 'insights' received 'in month' are reviewed for thematic assessment of trends or commonalities seeking identification of areas for improvement. Any identified 'in month' themes or trends requiring action are shared via the Perinatal Quality Surveillance Tool (PQST) shared with Board Level Safety Champions and Trust Insights and Improvement Committee, chaired by the Chief Nursing Officer.

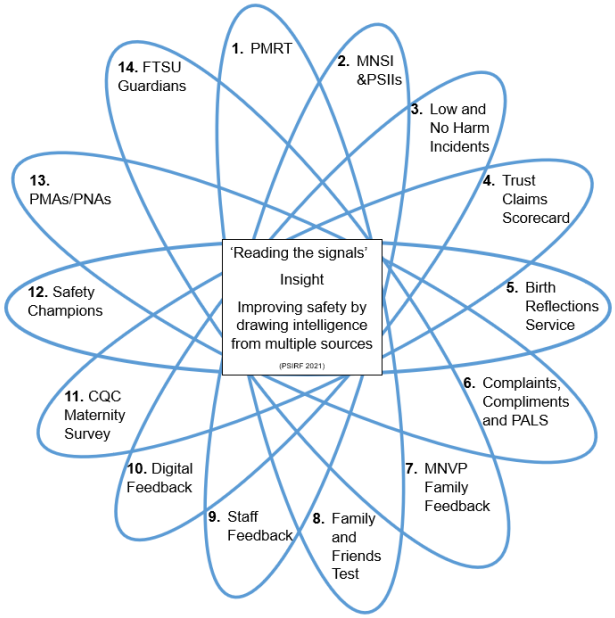


Figure 7. Sources of service 'Insight' analysed monthly via the Maternity and Neonatal Triangulation of feedback group.

The 2023/24 Insights report provided comprehensive themes and actions for improvement drawing from triangulated feedback with the recommendations below aligning with national priorities and the 3YDP. After careful consideration the Insights report will move to 2 yearly to allow for implementing and embedding the priorities identified in 2023/24 allowing for resources to be directed toward sustainable change. Regular updates will continue to be provided through governance.

1) Fetal Monitoring – Intermittent Auscultation

A national quality improvement project has commenced called Listen2Baby. The fetal monitoring lead midwife has undertaken the RUH Quality, Service Improvement and Redesign (QSIR) course and is leading a quality improvement project looking at how to improve the way intermittent auscultation is delivered. This will be monitored through Speciality and Divisional Governance and Performance Review Meetings (PRM) with progress updates.

2) Information provision to ensure Informed Consent

A quality improvement project is being undertaken to improve information for families in the antenatal period. Focus groups and a social media survey have been undertaken and key positive themes and areas for improvement identified. An information leaflet is being co-produced with the Maternity and Neonatal Voices Partnership (MNVP) aimed at promoting conversations and providing information on areas for improvement. Virtual tours have been available for some years and are being updated to include interactive platforms and QR codes links to videos and additional resources are underway.

3) Improving patient experience in the immediate postnatal care provision

The RUH joined the Perinatal Culture and Leadership Programme (PCLP) in Autumn 2023 and with support from the quadrumvirate and perinatal culture coaches produced an improvement plan following culture conversations with a wide range of staff who work in the inpatient areas. Six themes were identified and actions derived from further conversations which are monitored through governance.

Improvement work into insight's triangulation to evaluate feedback from patient safety, families and staff linking with the Trust values is currently underway.

10.0 RISK REGISTER

There were five new risks added in Q1, all risks and emerging risks are monitored through Maternity and Neonatal Specialty Governance

Risk No	Domain of Risk	The Risk	
3101	Patient Safety & Quality	Maternity triage non-compliance with medical review timescales as per RCOG guidance	15
3112	Patient Safety & Quality	Neonatal CPAP respiratory support devices	9
3143	Patient Safety & Quality	MEWS chart remaining paper based following implementation of Badgernet	9
3093	Digital	Neonatal Electronic Patient Record (EPR)	6
3094	Patient Safety & Quality	Fragmented Safeguarding documentation across perinatal services and safeguarding team	6

Table 21. New risk for the Maternity and Neonatal risk register Q1 2025/26

During Q1 no risks were closed. Risk is monitored by the Patient Safety Lead Midwife and all risks rating >12 is reported monthly, via Speciality and Divisional Governance with Management Executive Committee, oversight to ensure appropriate actions are taken in accordance with the Trust risk framework.

Risk No	Description	Scoring
3103	There is a risk women categorized as amber of green do not receive a medical review in line with RCOG Triage guidance (2023)	15
3013	There is a risk that USS service, provided jointly by maternity and radiology, does not have enough capacity	12
2950	There is a risk that due to the current compliance of percentage of staff QIS trained in the LNU below BAPM standards, the quality of care being delivered to the babies at risk of being compromised	12
2785	There is a risk that the current pharmacist cover for the Neonatal Unit does not meet clinical needs or BAPM standards.	12
2717	Shared Father/Partner information within the multi-agencies	12

Table 22. Maternity and Neonatal Risk Register rating >12 June 2025

Moderate and low risks are monitored as per Trust Risk Management policy.

11.0 AVOIDING ADMISSION INTO THE NEONATAL UNIT (ATAIN) & TRANSITIONAL CARE

During Q1, the Transitional Care (TC) pathway maintained 100% operational availability, with staffing consistently meeting the identified TC model requirements on average 100% of the time. There were no missed opportunities to provide TC care, and no admissions to the Neonatal Unit (NNU) occurred due to capacity or staffing constraints that would have otherwise met TC admission criteria.

Importantly, no babies were admitted to or remained on the NNU solely due to the need for nasogastric tube feeding—an intervention that could have been supported within the TC pathway if appropriate provisions were in place.

On average, 16% of shifts involved caring for more than the recommended four babies within the TC pathway. This resulted in a baby-to-nurse ratio exceeding the British Association of Perinatal Medicine (BAPM) standard of 1:4. Despite this, there were no reported harm incidents.

The service remains committed to enhancing joint care delivery with the maternity team. A key focus is upskilling Maternity Support Workers (MSWs) to support TC families. Progress on this initiative has been delayed due to MSW vacancies and high turnover. To address this, engagement events are planned in collaboration with Human Resources to explore strategies for improving MSW recruitment and retention. This work is aligned with the Perinatal Care Leadership Programme (PCLP) workstream.

The two leading causes for admission to TC remain the same as in Q4, the third leading cause has changed from requiring feeding support (11%):

- Requirement for intravenous antibiotics 25%
- Requirement for ‘Kaiser’ observations for a risk of sepsis 24%
- Requirement for feeding support 12%

The ATAIN working group identified one possible avoidable admission into the NNU in Q1. The review ascertained that expediting birth may have resulted in the baby not requiring admission to the Neonatal Unit and local learning actions were set in response.

Q1 saw one baby admitted to the NNU from other areas within the RUH such as the Emergency Department or the Children’s ward. The admission was appropriate and was agreed via consultant-to-consultant decision.

12.0 PERINATAL CULTURE AND LEADERSHIP PROGRAMME

The Perinatal Culture and Leadership Programme (PCLP), funded by NHSE, aims to support perinatal Quadrumvirate (Quad) teams to create and craft positive safety cultures within perinatal services. The programme design was in direct response to nationally derived intelligence regarding the intrinsic relationship between a positive workplace culture and continuous quality improvement. It aligned with the response to the Immediate and Essential Actions in the Independent Review of Maternity Services at Shrewsbury and Telford Hospitals and informs the Three-Year Delivery Plan for Maternity and Neonatal Services with the overarching aim is to support all perinatal teams in England to create and craft the conditions for a positive culture of openness, safety, and continuous improvement.

Following the training of four Culture Coaches and a series of multidisciplinary culture conversations, feedback and insights were triangulated to identify priority areas. Based on this analysis, the inpatient ward, encompassing antenatal, postnatal, and transitional car was selected as the primary focus for the culture improvement programme.

An extensive action plan was subsequently developed, informed by the key themes and issues that emerged during the engagement process.

Significant progress pertaining to staffing structures on the inpatient ward, strengthened leadership and estates/environment work have been achieved with positive feedback from both staff and families. Follow up culture conversation were undertaken and thematic analysis undertaken with updates quarterly through governance. Next steps include an update on the improvement plan to ensure aligning with continuous feedback, escalation of concern following a pause to Capital Projects (Mary ward staff room) and training further cultured coaches. Note: as of October 2025 – the ward staff room refurbishment has been completed.

13.0 EQUITY AND EQUALITY

Since the release of Better Births by NHSEI in 2021, which prioritised safer, more personalised, and equitable care, national guidance has continued to evolve—most notably with the Department of Health's Core20PLUS5 Safer Maternity Care framework. In response, BSW developed its Equity & Equality Strategy 2021–2024, followed by the Health Inequalities Quality Account Priority (2023/24) and the Three-Year Delivery Plan (2023–2026).

At RUH, benchmarking against Core20PLUS5 led to the relaunch of the Equity and Quality Group in November 2024. Four strategic priorities were identified:

- Improving data quality and responsiveness
- Enhancing language and communication
- Expanding access to physical and digital care
- Promoting staff equity

The group has set out clear aims to:

- Align RUH initiatives with the LMNS Equity and Equality Plan
- Strengthen equity and equality improvements for staff
- Increase engagement and ownership from clinical leads across all departments
- Embed MNVP involvement and co-production in all workstreams
- Ensure regular review and governance oversight of actions.

While measurable progress is expected over the longer term, the foundations for sustainable change are now firmly in place. An extensive improvement plan is being actively monitored through governance structures, and future updates will focus on tangible outcomes and impact. Continued collaboration across teams and with service users remains central to achieving meaningful equity in maternity and neonatal care.

14.0 MATERNITY TRIAGE

The National review of maternity services in 2022 by the Care Quality Commission (CQC) identified significant variation for maternity triage with no national targets or standards. The Royal College of Obstetricians and Gynaecologist (RCOG) published the Good Practice paper on Maternity Triage in 2023 which recommended operational structure and pathways to support safe care of pregnant and newly postnatal women and people outside of scheduled appointments.

In response, the RUH commenced a journey to implement the Birmingham Symptom specific Obstetric Triage System (BSOTS), a Trust wide quality improvement project requiring investment in estates and staffing culminating in the opening of the maternity triage unit in May 2024.

The service has commenced a review of the service to include call waiting times and abandonment, phone call quality and risk assessment and in person activity and BSOTS compliance including feedback from staff and families. Following audit, it was identified that women categorised as ‘amber’ and ‘green’ did not receive a medical review in line with RCOG guidelines (2023). This is due to a lack of dedicated medical cover ‘in hours’ which impacts on the quality of care received. A risk was added to the risk register (table 21) in Q1 scoring 15 and will be monitored via governance.

15.0 RECOMMENDATIONS

The Board of Directors is asked to discuss and approve the content of the report.

16.0 APPENDICES

Appendix 1 MBRRACE 2024 report (2023 data)

Appendix 2 Transitional Care Pathway and ATAIN Audit Q1 2025/26

Appendix 3 3 Year Delivery Plan/Ockenden Close Down Report

Royal United Hospitals Bath NHS Foundation Trust

MBRRACE-UK perinatal mortality report: 2023 births

This report concerns stillbirths and neonatal deaths among the 4,195 babies born within your Trust in 2023. It includes details of the stillbirths and neonatal deaths for births that occurred in your Trust in 2023, as well as background information on all births.

- Birth numbers are obtained from routine data sources and may not match locally recorded numbers.
- Births before 24 completed weeks gestational age and all terminations of pregnancy are EXCLUDED.
- Neonatal deaths are reported by place of birth, irrespective of where the death occurred, as denominator data on the place of care is not available for all births.

Key messages

All deaths

1. Your stabilised & adjusted stillbirth rate is **2.95 per 1,000 total births**. This is around the average for similar Trusts & Health Boards.
2. Your stabilised & adjusted neonatal mortality rate is **0.88 per 1,000 live births**. This is lower than the average for similar Trusts & Health Boards.
3. Your stabilised & adjusted extended perinatal mortality rate is **3.83 per 1,000 total births**. This is lower than the average for similar Trusts & Health Boards.

Excluding deaths due to congenital anomalies

1. Your stabilised & adjusted stillbirth rate excluding deaths due to congenital anomalies is **2.63 per 1,000 total births**. This is lower than the average for similar Trusts & Health Boards.
2. Your stabilised & adjusted neonatal mortality rate excluding deaths due to congenital anomalies is **0.73 per 1,000 live births**. This is lower than the average for similar Trusts & Health Boards.
3. Your stabilised & adjusted extended perinatal mortality rate excluding deaths due to congenital anomalies is **3.35 per 1,000 total births**. This is lower than the average for similar Trusts & Health Boards.

Full details of your perinatal mortality rates can be found on page 2.

Recommended actions

The stabilised & adjusted mortality rates for your Trust were similar to, or lower than, those seen across similar Trusts and Health Boards. However, if the aspiration of your Trust is to seek rates comparable with the best performing countries, for example those in Scandinavia, ensure that a review using the Perinatal Mortality Review Tool (PMRT) has been carried out for all the deaths in this report to assess care, identify and implement service improvements to prevent future similar deaths.

Definitions

Late fetal loss:	A baby born between 22 and 23 completed weeks gestational age showing no signs of life, irrespective of when the death occurred.
Stillbirth:	A baby born at or after 24 completed weeks gestational age showing no signs of life, irrespective of when the death occurred.
Neonatal death:	A live born baby who died up to 28 completed days after birth.
Extended perinatal death:	A stillbirth or neonatal death.

1. Your perinatal mortality rates

The mortality rates are reported for babies born within your Trust at 24 completed weeks gestational age or later, excluding terminations of pregnancy. The **crude mortality rate** is the number of deaths for every 1,000 births (or 1,000 live births for neonatal mortality) and is a snapshot of mortality for your organisation for births in 2023. However, this can be misleading as a measure of the underlying (or long-term) mortality rate due to chance variation and differences between Trusts and Health Boards in the proportion of high risk pregnancies. The **stabilised & adjusted mortality rate** provides a more reliable estimate of the underlying mortality rate, accounting for mother's age, socio-economic deprivation, baby's sex and ethnicity, multiplicity, and (for neonatal deaths only) gestational age at birth. While it is not possible to adjust for all potential risk factors, these measures do provide an important insight into the perinatal mortality for births within your Trust in 2023.

To account for the wide variation in case-mix, all Trusts and Health Boards have been classified hierarchically into five comparator groups: (i) Level 3 Neonatal Intensive Care Unit (NICU) and surgical provision; (ii) Level 3 NICU; (iii) 4,000 or more births per annum at 22 weeks or later; (iv) 2,000-3,999 births per annum at 22 weeks or later; (v) under 2,000 births per annum at 22 weeks or later**.**

Your Trust has been included in the comparator group with 4,000 or more births per annum.

Perinatal mortality (all deaths)

Type of death	Number	Crude rate	Stabilised & adjusted rate (95% C.I.)		Comparison to the average for similar Trusts & Health Boards
Stillbirth	**6**	**1.43**	**2.95**	**(2.34 to 3.58)**	**Up to 5% higher or up to 5% lower**
Neonatal	**1**	**0.24**	**0.88**	**(0.52 to 1.42)**	**More than 5% and up to 15% lower**
Extended perinatal	**7**	**1.67**	**3.83**	**(3.17 to 4.79)**	**More than 5% and up to 15% lower**

Perinatal mortality (excluding deaths due to congenital anomalies)

Type of death	Number	Crude rate	Stabilised & adjusted rate (95% C.I.)		Comparison to the average for similar Trusts & Health Boards
Stillbirth	**6**	**1.43**	**2.63**	**(1.79 to 3.64)**	**More than 5% and up to 15% lower**
Neonatal	**1**	**0.24**	**0.73**	**(0.46 to 1.16)**	**More than 5% and up to 15% lower**
Extended perinatal	**7**	**1.67**	**3.35**	**(2.54 to 4.53)**	**More than 5% and up to 15% lower**

Comparisons with similar Trusts and Health Boards

Your estimated stabilised & adjusted mortality rate for each type of death has been compared with the average mortality rate for Trusts and Health Boards in the same comparator group and is shown below as a coloured circle:

- more than 15% lower than the average for the group
- more than 5% and up to 15% lower than the average for the group
- up to 5% higher or up to 5% lower than the average for the group
- more than 5% higher than the average for the group

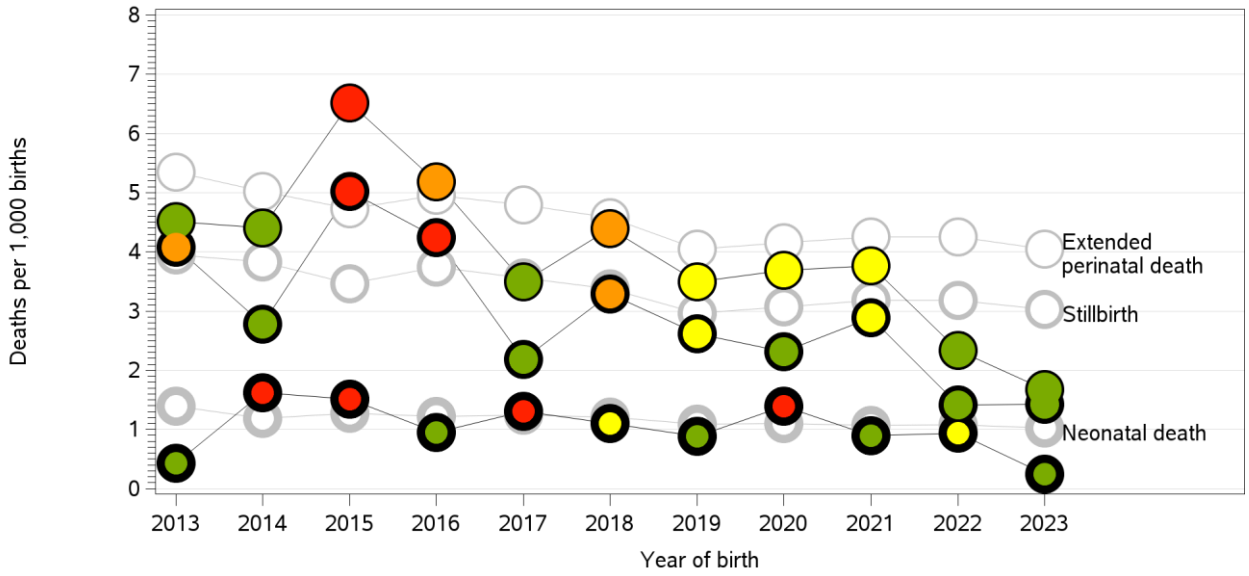
Trusts and Health Boards whose mortality rates are marked ● or ● should carry out an initial investigation of their data quality and possible contributing local factors that might explain the high rate. Irrespective of where they fall in the spectrum of national performance all Trusts and Health Boards should use the national PMRT to review all their stillbirths and neonatal deaths.

2. Mortality rates over time

Crude mortality by year of birth (all deaths)

Crude mortality rates for each type of death compared to the average mortality rate for Trusts and Health Boards in the same comparator group (shown in grey) by year of birth.

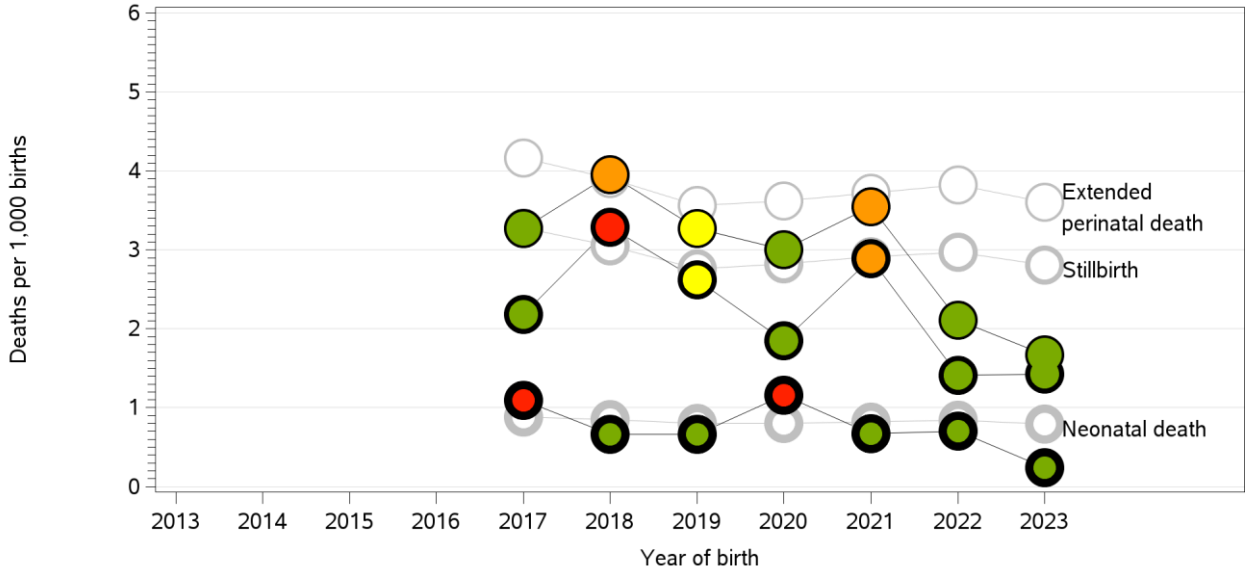
Due to updates to the data, these results might differ slightly from those in previous reports.



Crude mortality by year of birth (excluding deaths due to congenital anomalies)

Crude mortality rates for each type of death, excluding deaths due to congenital anomalies, compared to the average mortality rate for Trusts and Health Boards in the same comparator group (shown in grey) by year of birth. Rates are reported from 2017 onwards.

Due to updates to the data, these results might differ slightly from those in previous reports.

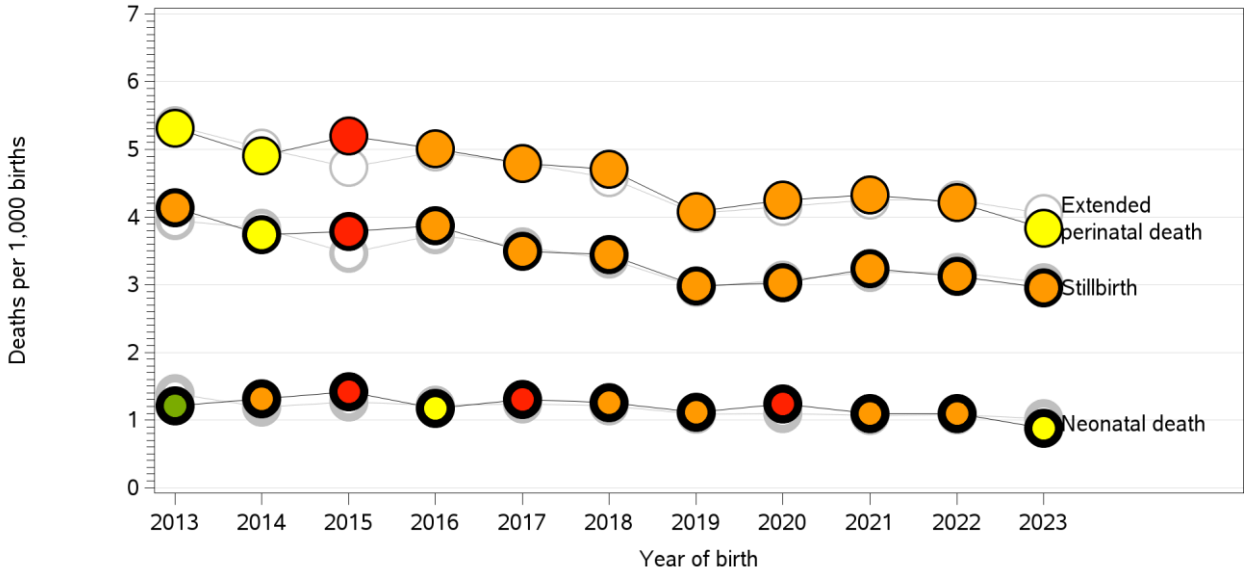


Mortality rates over time *continued*

Stabilised & adjusted mortality by year of birth (all deaths)

Stabilised & adjusted mortality rates for each type of death compared to the average mortality rate for Trusts and Health Boards in the same comparator group (shown in grey) by year of birth.

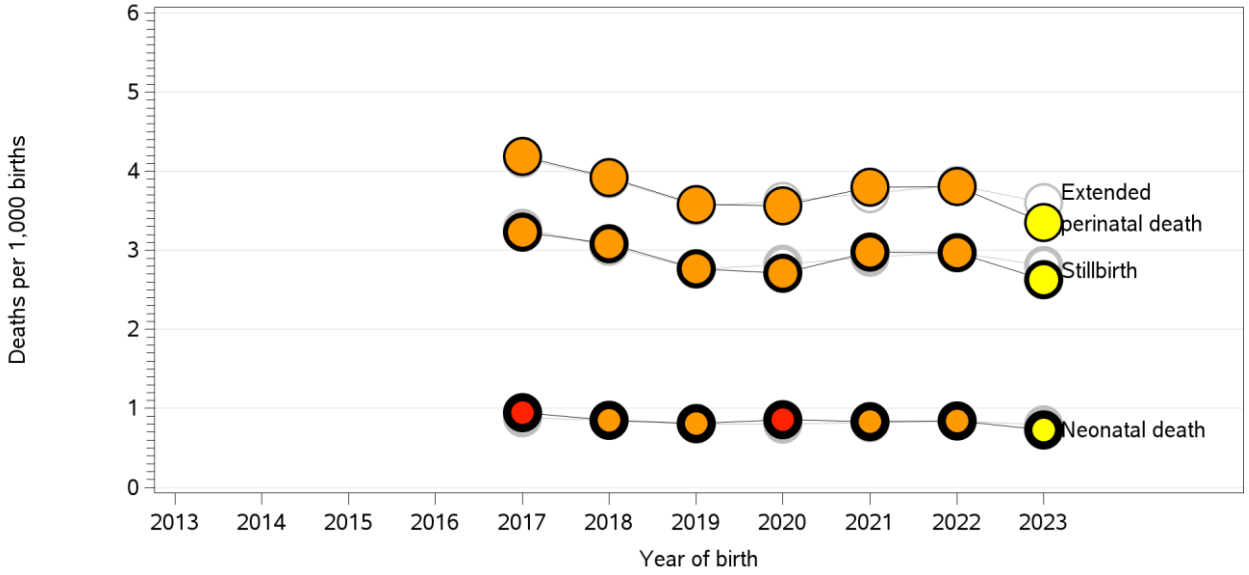
Due to updates to the data and improvements to the statistical methodology used, these results might differ slightly from those in previous reports.



Stabilised & adjusted mortality by year of birth (excluding deaths due to congenital anomalies)

Stabilised & adjusted mortality rates for each type of death, excluding deaths due to congenital anomalies, compared to the average mortality rate for Trusts and Health Boards in the same comparator group (shown in grey) by year of birth. Rates are reported from 2017 onwards.

Due to updates to the data and improvements to the statistical methodology used, these results might differ slightly from those in previous reports.



3. Your perinatal deaths

Deaths of babies born within your Trust

The crude mortality rates reported here are for babies born within your Trust, excluding births before 24 weeks gestational age and all terminations of pregnancy, together with the equivalent UK-wide rates.

These rates are subject to random variation, especially when the number of deaths is small. Stabilised & adjusted mortality rates are presented on page 2 which provide more reliable estimates of the underlying (long-term) mortality rates for your Trust.

Rates per 1,000 births		Stillbirths						Neonatal Deaths				Extended perinatal deaths	
		Antepartum		Intrapartum		Unknown		Early		Late			
Your Trust	*Rate (N)*	1.4	(6)	0.0	(0)	0.0	(0)	0.0	(0)	0.2	(1)	1.7	(7)
UK-wide	*Rate*	2.8		0.3		0.1		1.0		0.6		4.8	

The rates of extended perinatal death for your Trust, by gestational age at delivery, are shown below. Equivalent UK-wide rates are also shown for comparison.

Rates per 1,000 births		Extended perinatal deaths by gestational age									
		$24^{+0} – 27^{+6}$		$28^{+0} – 31^{+6}$		$32^{+0} – 36^{+6}$		$37^{+0} – 41^{+6}$		≥ 42^{+0}	
Your Trust	*Rate (N)*	300.0	(3)	0.0	(0)	8.4	(2)	0.5	(2)	0.0	(0)
UK-wide	*Rate*	323.3		98.4		17.4		1.6		2.1	

Place of neonatal death by gestational age

In the table below, information is shown that differentiates between the neonatal deaths of live born babies who were born and subsequently died within your Trust and those who were born within your Trust but died elsewhere. The percentage and number of babies in each group is shown by gestational age at birth.

Place of Death		Gestational group									
		$24^{+0} – 27^{+6}$		$28^{+0} – 31^{+6}$		$32^{+0} – 36^{+6}$		$37^{+0} – 41^{+6}$		≥ 42^{+0}	
Within your Trust	*% (N)*	0%	(0)		(0)		(0)		(0)		(0)
Outside your Trust	*% (N)*	100%	(1)		(0)		(0)		(0)		(0)

Post-mortem

The percentage of stillbirths and neonatal deaths for which parents were offered a post-mortem examination is given below, differentiating between those who were born and subsequently died within your Trust and those who were born within your Trust but died elsewhere.

For births within your Trust, a post-mortem was offered for 83% of stillbirths and 100% of neonatal deaths, compared with 97% and 91% UK-wide.

Place of Death		Post-mortem offered (as % of deaths)			
		Stillbirths		Neonatal Deaths	
Within your Trust	*% (n/N)*	83%	(5/6)		(0/0)
Outside your Trust	*% (n/N)*	Not applicable		100%	(1/1)
UK-wide	*%*	97%		91%	

The percentage of post-mortems offered or for which consent was obtained and where the cause of death was reported to MBRRACE-UK as Unknown is shown below. You should ensure that the cause of death on the MBRRACE-UK data reporting system is updated once the post-mortem results are known.

Cause of death		Post-mortem			
		Offered		Consent obtained	
Unknown	*% (N)*	100%	(2/2)	50%	(1/2)

Your perinatal deaths *continued*

Cause of death

The tables below describe the cause of death reported to MBRRACE-UK for stillbirths which occurred in your Trust and for neonatal deaths of babies who were born in your Trust. They are listed by the primary categories of the 'Cause Of Death & Associated Conditions' (CODAC) system of death classification.

Congenital anomaly is reported as the cause of death for all deaths where a congenital anomaly is coded as either the primary cause of death or an associated condition.

In order to ensure accurate, consistent reporting using the CODAC system of death classification, Trust and Health Board Perinatal Review groups should focus on the quality of cause of death coding.

			Infection		Neonatal		Intrapartum		Congenital anomaly		Fetal	
Stillbirths	Your Trust	*% (N)*	0.0%	(0)	0.0%	(0)	0.0%	(0)	0.0%	(0)	0.0%	(0)
	UK-wide	%	2.8%		1.2%		1.3%		8.4%		5.0%	
Neonatal Deaths	Your Trust	*% (N)*	0.0%	(0)	100%	(1)	0.0%	(0)	0.0%	(0)	0.0%	(0)
	UK-wide	%	8.2%		40.1%		1.2%		35.0%		3.5%	

			Cord		Placental		Maternal		Unknown		Missing	
Stillbirths	Your Trust	*% (N)*	0.0%	(0)	66.7%	(4)	0.0%	(0)	33.3%	(2)	0.0%	(0)
	UK-wide	%	5.6%		35.3%		3.4%		34.3%		2.9%	
Neonatal Deaths	Your Trust	*% (N)*	0.0%	(0)	0.0%	(0)	0.0%	(0)	0.0%	(0)	0.0%	(0)
	UK-wide	%	0.0%		2.1%		0.8%		7.3%		1.9%	

Babies born at 22 to 23 weeks gestational age

It is vital for MBRRACE-UK to be able to present perinatal mortality rates from 22 weeks gestational age onwards, as recommended by the World Health Organization, in order that UK rates can be compared internationally. As there is no statutory registration of late fetal losses at 22 and 23 weeks gestational age, it is essential that your Trust ensures that there is a rigorous system for reporting these deaths to MBRRACE-UK.

The number of late fetal losses at 22 and 23 weeks gestational age reported by your Trust for babies born in 2023 was 2. Please continue to review this information in order to ensure that all late fetal losses are reported to MBRRACE-UK.

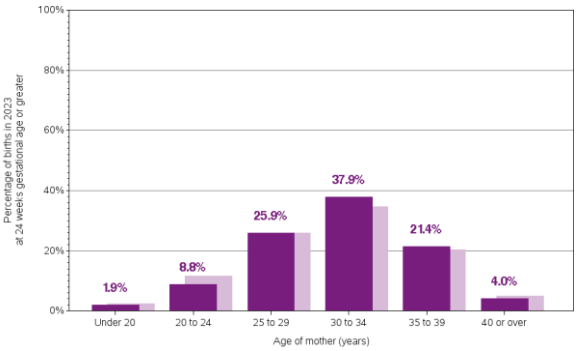
		Deaths of babies born at 22 to 23 weeks gestational age	
		Late fetal losses	Neonatal deaths
Your Trust	*N*	2	1

4. Your births

Age of mother

The proportion of mothers under 25 years of age was lower than that of the UK as a whole: 10.8% versus 14.0%.

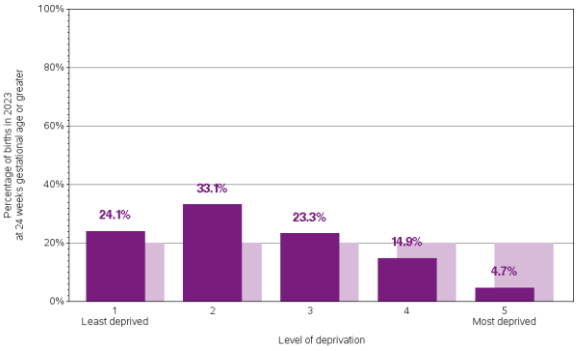
Across the UK the mothers were: 2.4% under 20; 11.6% 20 to 24; 25.9% 25 to 29; 34.7% 30 to 34; 20.4% 35 to 39; 5.0% 40 and over.



Socio-economic deprivation

This graph shows the distribution of births by level of deprivation, based on the postcode of the mother's residence and using the Children in Low-Income Families Local Measure.

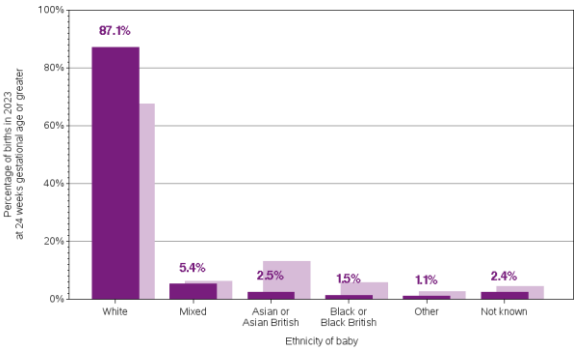
The mothers giving birth in your Trust were considerably less likely to live in areas of high deprivation than those giving birth across the UK as a whole.



Ethnicity of baby

The proportion of babies of non-White ethnicity was considerably lower than that of the UK as a whole: 10.4% versus 28.0%.

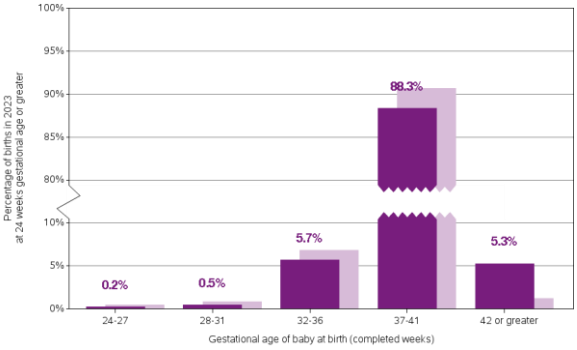
Across the UK the babies were of the following ethnicities: 67.5% White; 6.2% Mixed; 13.2% Asian or Asian British; 5.8% Black or Black British; 2.8% other; 4.4% not known.



Gestational age

In your Trust, 10 babies (0.2%) were born at 24 to 27 weeks gestational age, lower than the 0.4% seen in the UK as a whole. There was also a lower percentage of babies born at 28 to 31 weeks compared with the national average: 0.5% versus 0.8%.

In addition, 221 babies (5.3%) were born post-term (42 weeks or greater), a higher percentage than the UK average of 1.2%.

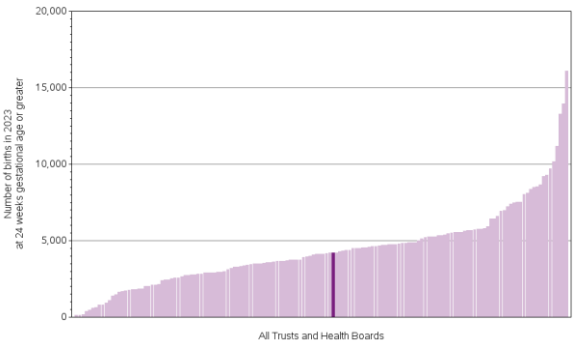


Your births *continued*

Number of births

There were 4,195 births in your Trust at 24 weeks gestational age or later, excluding terminations of pregnancy.

The purple line in the graph opposite shows that the number of births in your Trust puts you in the middle third of all Trusts and Health Boards in the UK.



Percentage of births taking place in your Trust by commissioning organisation

The table below provides the percentage and number of births in your Trust at 24 weeks gestational age or later from each of the commissioning organisations for which over 1% of their births at 24 weeks gestational age or later occurred within your Trust. These organisations are Sub-Integrated Care Boards (Sub-ICBs) in England, Health Boards in Scotland and Wales and Local Commissioning Groups (LCGs) in Northern Ireland.

In total, the births from these organisations accounted for 99.3% of your births at 24 weeks gestational age or later in 2023.

Commissioning organisation	% Births (N)	Commissioning organisation	% Births (N)
1. NHS Bath and North East Somerset, Swindon and Wiltshire ICB - 92G	38.7% (3236)	2. NHS Somerset ICB - 11X	13.1% (619)
3. NHS Bristol, North Somerset and South Gloucestershire ICB - 15C	3.3% (310)		

5. Data reporting

Completeness of key data items for DEATHS AT YOUR TRUST

It is vital that complete, accurate data is reported to MBRRACE-UK. For births in 2023, we received over 99% of information on key data items for the deaths which occurred within your Trust.

The tables below provide details of completeness for key items in the data collection form. While the rest of this report concerns babies born within your Trust, these tables show the overall completeness of data for **deaths at your Trust no matter where they were born**. The percentage of data reported is given for each item, together with a coloured diamond denoting the level of completeness:

- ♦ less than 70.0% complete
- ♦ 70.0% to 84.9% complete
- ♦ 85.0% to 96.9% complete
- ♦ 97.0% to 99.9% complete
- ♦ 100% complete

These data items have been assessed as they are all readily available and essential to the accurate reporting of extended perinatal mortality for your Trust. For those items scoring red, orange or yellow it is essential that completeness is improved. Achieving this may well require collaboration with receiving and referring units.

Mother's details	Completeness	
Name	100.0%	♦
UK-wide	100.0%	
Postcode of residence	100.0%	♦
UK-wide	100.0%	
Ethnicity	83.3%	♦
UK-wide	97.0%	
Age	100.0%	♦
UK-wide	100.0%	

Birth	Completeness	
Type of onset of labour	100.0%	♦
UK-wide	98.8%	
Actual place of birth	100.0%	♦
UK-wide	99.5%	
Date and time of birth	100.0%	♦
UK-wide	99.4%	
Final mode of birth	100.0%	♦
UK-wide	99.4%	

Booking and antenatal care [note 1]	Completeness	
Smoking	100.0%	♦
UK-wide	97.6%	
Body mass index	100.0%	♦
UK-wide	100.0%	
Intended type of care at booking	100.0%	♦
UK-wide	95.5%	
Estimated date of delivery	100.0%	♦
UK-wide	100.0%	

Baby's outcome	Completeness	
Date death confirmed [note 2]	100.0%	♦
UK-wide	100.0%	
Whether alive at onset of care [note 2]	100.0%	♦
UK-wide	95.4%	
Whether admitted to NNU [note 3]	-	
UK-wide	99.6%	
Main cause of death	100.0%	♦
UK-wide	97.4%	

Baby's characteristics	Completeness	
Birth weight	100.0%	♦
UK-wide	98.9%	
Gestational age at birth	100.0%	♦
UK-wide	99.2%	

Note 1: Excluding mothers reported as never booked.
Note 2: This data item is collected for stillbirths only.
Note 3: This data item is collected for neonatal deaths only.

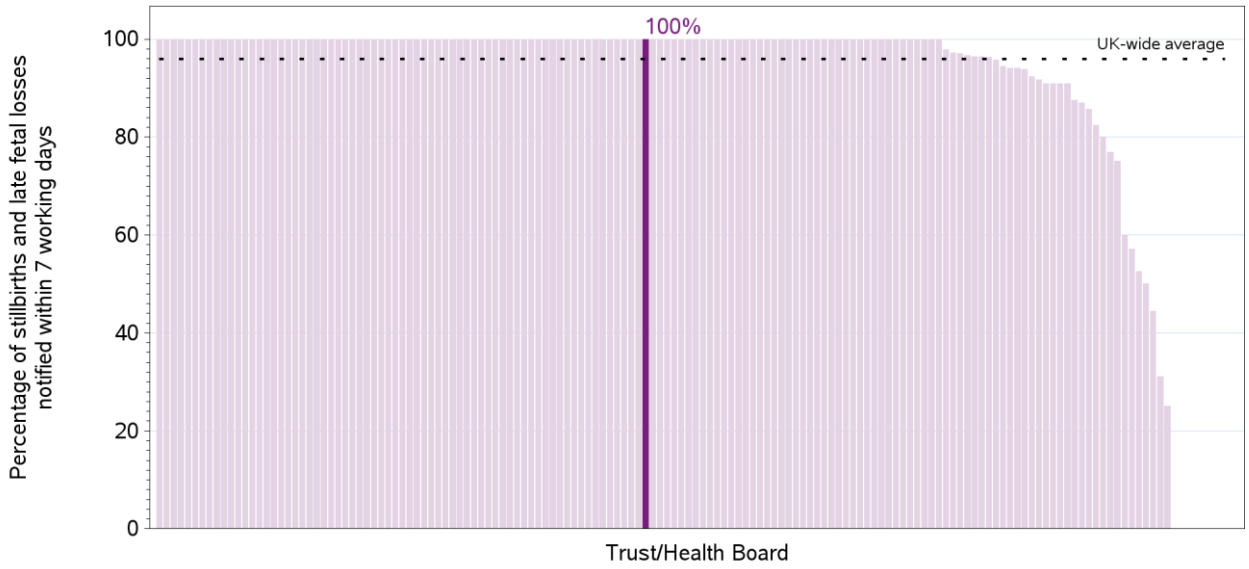
Percentage of deaths notified by your Trust within 7 working days

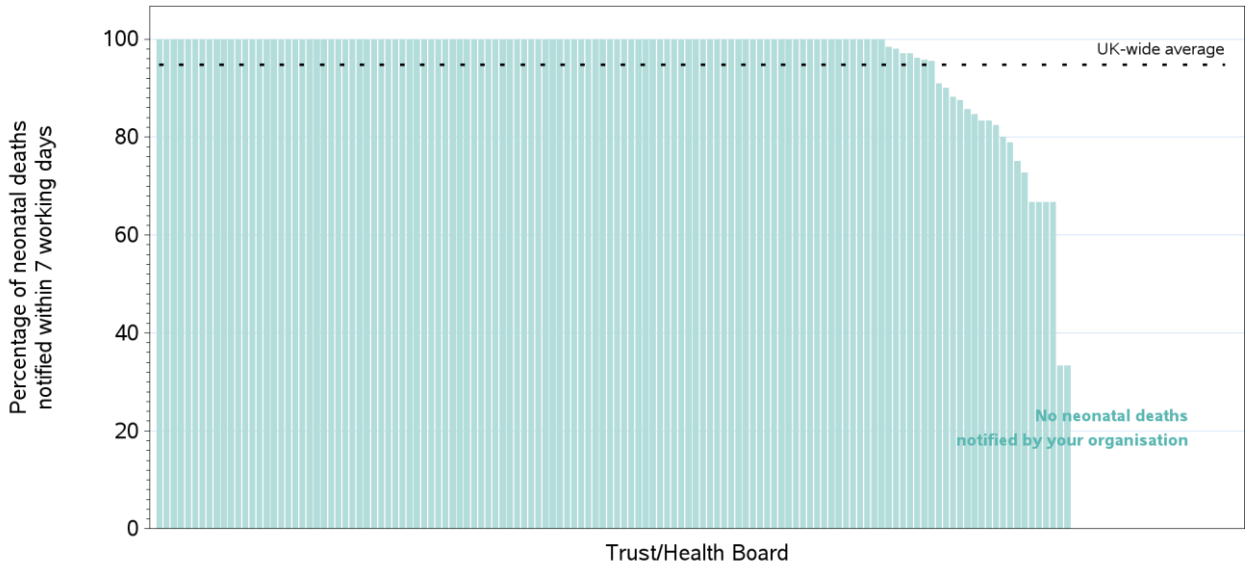
The MBRRACE-UK timeliness benchmarks for the notification of deaths and completion of surveillance data are:

1) All deaths should be **notified** to MBRRACE-UK within 7 working days of the death occurring. The full surveillance data does not have to be complete at this point.

2) Trusts and Health Boards should aim to **complete** surveillance data entry for each death within 90 days of the death occurring. The final cause of death can be updated at a later date, if necessary.

The graphs below show the percentage of stillbirths & late fetal losses and neonatal deaths notified by your Trust within the 7 working days benchmark period.





About this report

MBRRACE-UK

This report presents one element of the work of MBRRACE-UK, a collaboration led from the National Perinatal Epidemiology Unit at the University of Oxford, with members from the University of Leicester (who lead the perinatal aspects of the work), University of Birmingham, Chelsea and Westminster Hospital NHS Foundation Trust, The Newcastle upon Tyne Hospitals NHS Foundation Trust, National Maternity Voices and Sands.

MBRRACE-UK is commissioned by the Healthcare Quality Improvement Partnership on behalf of NHS England, the Welsh Government and, with some individual projects, other devolved administrations and Crown Dependencies.

Data sources

Deaths were reported to MBRRACE-UK by the Trust or Health Board where the death occurred. The information about births was obtained from routine sources – the Office for National Statistics, Personal Demographics Service, National Records of Scotland, Public Health Scotland, Northern Ireland Maternal and Child Health, States of Guernsey Health and Social Services Department, and States of Jersey Health Intelligence Unit. Home births are reported where the birth was registered via a Trust or Health Board. Births and deaths are attributed according to the configuration of Trusts and Health Boards on 1 September 2024.

Deaths from all causes except termination of pregnancy are reported, including those resulting from congenital anomalies. The information in this report may not match other locally or nationally reported rates, as births before 24 weeks gestational age have been excluded from most tables due to differences in reporting by Trusts and Health Boards. Further details on the methods we have used are included in the Technical Manual.

Deaths included in this report

The MBRRACE-UK real-time data monitoring tool (RTDM) can be used to identify the deaths included in this report by selecting "Born within your trust/HB" as the trust/health board of birth. The RTDM uses live surveillance data on perinatal deaths where the baby was born at, or died at your Health Board, and is available to anyone registered to use the MBRRACE-UK reporting system.

Data viewer

The MBRRACE-UK Data Viewer can be used to view data on a map and compare perinatal mortality rates for the organisations responsible for the commissioning and provision of care.

MBRRACE-UK, Department of Population Health Sciences, University of Leicester, George Davies Centre, Leicester, LE1 7RH.

Tel: +44 (0)116 252 5425 **Email:** mbrracele@npeu.ox.ac.uk **Web:** http://www.npeu.ox.ac.uk/mbrrace-uk

© 2025 TIMMS, Department of Population Health Sciences, University of Leicester

Clinical Audit Report

Appendix 2: Transitional Care Pathway and ATAIN Audit
Q1 2025/2026

Speciality: RUH Local Neonatal Unit

Division: Family & Specialist Services Division

Project team				
Kirstie Flood	Title/grade:	Lead Nurse	Data period:	Q1 April 2025 - June 2025
Sarah Goodwin	Title/grade:	Neonatal Governance Lead Nurse	Report completion:	July 2025

Royal United Hospitals Bath
NHS Foundation Trust

Transitional Care Pathway and ATAIN Audit Q1 2025

Contents

Executive summary
Background
Objectives
Key findings

Clinical audit report
Project title
Division
Specialty
Disciplines involved
Project leads
Standards
Sample
Data source
Audit type
Audit findings

Transitional Care and ATAIN Action Plan

Appendix 1: Detailed analysis of babies requiring TCP

Appendix 2: Detailed analysis of term babies admitted to the Neonatal Unit

Appendix 3: PCLP February Board report update

Background

ATAIN is an acronym for **A**voiding **T**erm **A**dmissions **I**nto **N**eonatal Units. It is a national programme of work initiated under patient safety to identify harm leading to term admissions. The current focus is on reducing harm and avoiding an unnecessary separation of mother and baby.

Mothers and babies have a physiological and emotional need to be together, hours and days following birth – this is important for physiological stability of baby and initiation of maternal infant interaction. There is overwhelming evidence that separation of mother and baby so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding and long-term morbidity for mother and child. This makes preventing separation, except for compelling medical reason, an essential practice in maternity services and an ethical responsibility for healthcare professionals.

Neonatal Transitional Care (NTC) is special "*care in additional to normal infant care, provided in a postnatal clinical environment by the mother or an alternative resident carer, supported by appropriately trained healthcare professionals"* (BAPM 2017), avoiding the need for maternal/infant separation that admission to a neonatal unit may cause.

As part of the RUH Maternity and Neonatal services, the continued monitoring of admission data and modifiable factors which may have impacted upon the resulting admission allows the continuous evaluation of current systematic care provision and seeks to identify key areas of improvement.

This audit report is demonstrative of the upward reporting from the ATAIN working group's Terms of Reference (TOR), supporting the continued improvement of our services and supplementary evidence of the Maternity Incentive Scheme - year Severn, Safety Action 3*.

**Safety Action 3: To demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the avoiding term admissions (ATAIN) into Neonatal units (LNU) programme.*

Objectives

- To assess compliance with the pathways of care into transitional care which have been jointly approved by maternity and neonatal teams focusing on minimising the separation of mothers and babies. Please see Guidance Neo-100. Neonatal teams are involved in decision making and planning care for all babies in transitional care.
- To monitor that the pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, Local Maternity and Neonatal System (LMNS), commissioner and Integrated Care Board (ICB) quality surveillance meeting each quarter.
- To evaluate the number of admissions into the neonatal unit that would have met TC admission criteria but were admitted to the neonatal unit due to capacity or staffing issues.
- To provide a data record of existing transitional care activity (regardless of location - which could be a Transitional Care (TC), birthing suite, postnatal ward, virtual outreach pathway etc.).
- To analyse staff/parent data captured via a questionnaire around both satisfaction and quality and safety of care.
- Outline the key findings and improvements identified by the ATAIN working group's activity on a quarterly basis for sharing within Maternity and Neonatal Governance structures and the Board Level Safety Champion.
- To provide evidence and assurance of progression with the action plan for sharing with the neonatal maternity safety champion, and Board Level Champion, LMNS and ICB quality surveillance meeting each quarter.
- To provide an audit trail of evidence that reviews of all term babies transferred or admitted to the LNU, irrespective of their length of stay.

The ATAIN working group is responsible for completing a thematic review of the primary reasons for all admissions, with a focus on the leading cause/ reason(s) for admission through a deep dive to determine relevant areas of improvement to be addressed. This is in line with the working group's Terms of Reference (TOR).

Key findings

Standard	Compliance April 2025	Compliance May 2025	Compliance June 2025	This Quarter total (Q1)	Year total to date 2025/2026
Audit findings shared with neonatal safety champion	**Complete**	**Complete**	**Complete**	**N/A**	**N/A**
The % of babies who received **all** their care on the TCP pathway – require higher level care (would otherwise require NNU admission)	**49%**	**53%**	**56%**	**110 babies 53% average of all admissions**	**110 babies 53% average of all admissions**
The % of babies who received care on the TCP for **part** of their admission	**12%**	**18%**	**10%**	**28 babies 13%**	**28 babies 13%**
The number of admissions to the neonatal unit that would have met current TC admission criteria but were admitted to the neonatal unit due to capacity or staffing issues	**0**	**0**	**0**	**0**	**0**
% of shifts TCP nurse provided as per TCP staffing model	**100%**	**100%**	**100%**	**100%**	**100%**
% of shifts TCP nurse: baby ratio was above 1:4 as per recommendation.	**18%**	**18%**	**13%**	**16% av.**	**16% av.**
% of days >4 babies cared for on TCP	**48%**	**42%**	**50%**	**47% av.**	**47% av.**
TCP open	**100%**	**100%**	**100%**	**100%**	**100%**
Number of babies transferred to neonatal unit from TCP for step up in care	**1**	**3**	**1**	**5**	**5**

The number of avoidable term admissions 37+0 weeks gestation and above admitted to the neonatal unit	**0**	**1**	**0**	**1**	
The number of term babies transferred or admitted to the neonatal unit from other areas – for example Emergency Department, Children's ward.	**1**	**0**	**0**	**1**	

Table 1: Key findings from the Transitional Care audit

Clinical Audit Report

Project title

Transitional Care and ATAIN Audit Q1 2025/2026 April - June 2025

Division

Family & Specialist Services Division

Specialty

Local Neonatal Unit

Disciplines involved

Neonatal Nurse Consultant, Neonatal Governance Lead Nurse, Senior Sister

Obstetric Consultant, Patient Safety Midwives

ATAIN working group

Project leads

Kirstie Flood, Lead Nurse

Sarah Goodwin, Neonatal Governance Lead Nurse

Standards

Maternity Incentive Scheme - year Seven. Safety Action 3.

Sample

- All admissions to LNU and TCP to determine if the correct location of care was achieved.
- All babies born at 37+0 weeks gestation and above from who were admitted to the LNU.

Data source

Badger Net, LNU and TCP admission book and individual medical notes.

Audit type

Retrospective and live data collection.

1.0 Transitional Care Audit Findings Q1.

1.1 Staffing

- During Q1 the transitional care pathway remained open for 100% of the time, with staffing meeting the identified transitional care pathway model 100% of the time.
- There were, on average 16% of shifts had more than 4 babies being cared for on the TCP where there was no additional staffing provided from within the neonatal team and thus the baby nurse ratio was above the BAPM recommendations of 1:4. No harm resulted however this can have an impact of staff fatigue and morale. Datix were completed on all occasions when staffing fell outside BAPM standards, no datix related to clinical care provision were submitted.
- On no occasion were there identified missed opportunities to have provided TC care or identified admissions to the neonatal unit that would have met current TC admission criteria but were admitted to the neonatal unit due to capacity or staffing issues.
- TC staffing feedback survey is out for circulation to identify themes and triangulate feedback between staff and families. There has been a low completion rate, therefore the rationale for staff completion has been communication and this will be monitored. This staff survey is distributed quarterly.

1.2 Admissions

The leading causes of admission to the TCP (figure 1), remains consistent. The 3rd leading cause continues to vary.

- Requirement for intravenous antibiotics 25%
- Requirement for 'Kaiser' observations for a risk of sepsis 24%
- Below 2nd Centile 12%

Last year, 2 new locally agreed criteria were introduced; babies below 2nd centile and 34-35+6/40 above 1.8kg. Combined, these have risen to 20% of the total admissions to the TCP with Q1. The additional criteria aims to provide early additional parental support for preventative care for associated risks of hypogylcaemia and poor feeding often associated with lower gestations and intrauterine growth restriction (IUGR) and ensure early identification and initiation of vitamins and milk fortifier are implemmented.

During Q1 an average of 66% of total admissions for Neonatal Unit spent all of part of their admission on the Transitional Care Pathway.

More accurate data collection methods are now being used to monitor maximum number of babies cared for on the TCP per day, at any one given time, rather than only at the beginning of a shift. This is due to the transient nature of admissions and discharges throughtout the day and is a more accurate reflection of capacity and demand. On average, 47% of days saw greater than 4 babies being cared for on the TCP. 16% of these were not supported by an extra staff member which exceeds the BAPM staffing recommendation.

In Q1, 5 babies relocated from the TCP to the Neonatal Unit with a deterioration in condition requiring a higher level of care. This demonstrates a good level of observation and care in recognising a deteriorating patient from the TC nurse. Five babies displayed worsening signs of respiratory distress and 1 baby had hypoglycaemia and required a high concentration of Intravenous glucose.

The Perinatal, Culture & Leadership programme (PCLP) includes TC with a focus on improving communication and collaborative working between maternity and TC staff groups. The QI project is monitored quarterly through governance. The capacity and demand analysis of the Transitional Care Pathway provision (cots and workforce) is an ongoing piece of work, led the Neonatal Matron and Senior Sister.

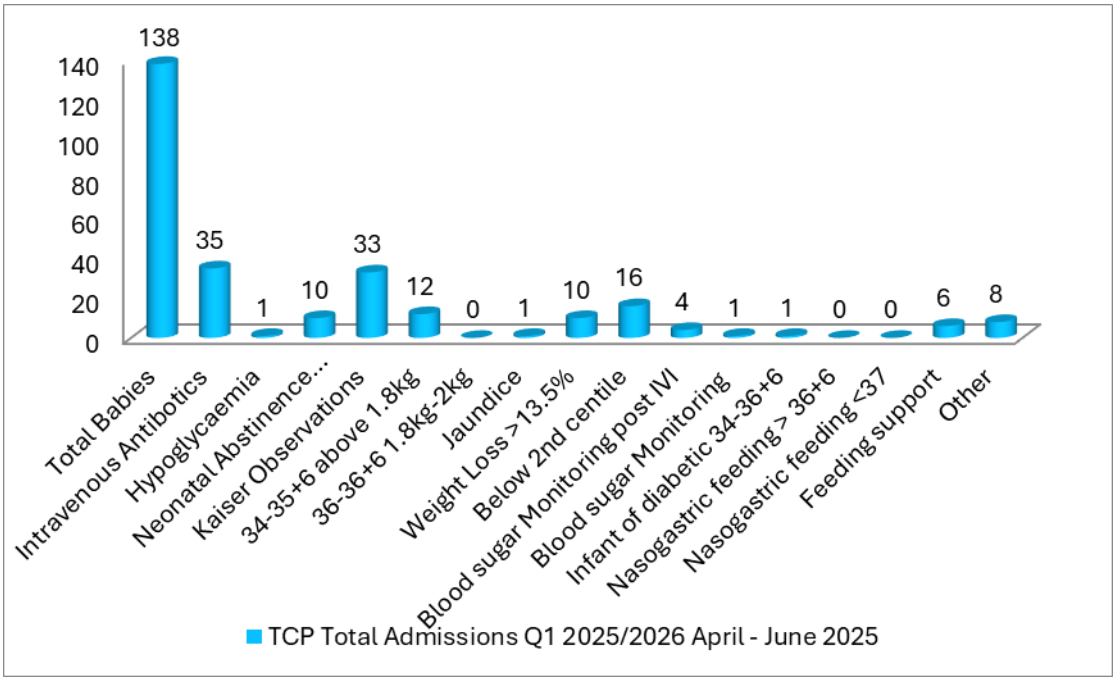


Figure 1: values of admissions to the RUH Transitional Care Pathway (TCP) by causation Q1 25/26

2.0 Parental Transitional Care Pathway feedback

The Transitional Care Pathway (TCP) seeks parental feedback via an optional patient/parent survey sent to all families who received TC care via a QR code which is collated by the Trust-wide patient experience team. The results are provided to service providers for analysis to identify improvements.

During Q1, 3 responses were received to the TCP patient experience survey.

- There was commonality regarding positive feedback relating to the level of care and generous time and support provided by the TC team. Also, good communication was mentioned by all.
- 1 mother discussed how she felt the Mary ward was an extremely hot environment, where there were not enough electrical sockets and a broken bedside lamp. She felt the lack of electric sockets meant one had to choose between having bed plugged in or breast pump. The environment on Mary ward is a theme from previous reports. This has also been identified by the Board Level Maternity and Neonatal Safety Champions.

2.1 Staff TCP feedback

- In Q1, no completed staff survey responses were submitted. The Service plans to engage further with staff who work on the TC and encourage colleagues to participate in the survey. The survey will be released on a quarterly basis to avoid survey fatigue.

3.0 ATAIN Audit Findings Q1

- The ATAIN working group meets fortnightly to undertake a Multi-Disciplinary Team (MDT) review of all admissions and transfers into the Neonatal Unit assessing if alterations in care may have provided opportunities to have avoided the admission into the Local Neonatal Unit (LNU), therefore providing insight into areas of potential service and quality improvements.

- Q1 identified 1 possible avoidable admission to the LNU, this is a reduction from the 2 avoidable admissions noted in quarter 4.

The MDT ascertained in this case that had the birth been expedited it may have resulted in the infant not requiring admission.

All learning from ATAIN is shared quarterly within Maternity and Neonatal Safety Governance (MNSG) and via the Quality and Safety Boards (information boards in the clinical areas). The Maternity Fetal Monitoring Lead utilises the cardiotocography (CTG) discussed from ATAIN cases to share examples locally and across the Local Maternity and Neonatal System to identify learning opportunities and any arising themes. These cases are also added to a portfolio of CTGs that are used as part of MDT discussions on the Fetal Monitoring Training.

As a result of ATAIN reviews, the Service has developed a 45-minute teaching session that is dedicated to Human Factors and escalation. The cases will be used as part of the training to aid teaching and to provide rationale relating to the importance of escalating concerns. The training also includes intrauterine resuscitation, fetal physiology, with specific focus on the 2nd stage of labour and how hypoxia can rapidly evolve. The current fetal monitoring guideline supports this. The escalation in labour Standard Operating Procedure is in the process of being updated. The training includes midwives, registrars and obstetricians.

4.0 Admissions to the Neonatal Unit from other clinical areas in the hospital.

- In line with standard 3, Neonatal Unit transfers or admissions of all term babies transferred or admitted to the Neonatal Unit from other areas within the RUH, regardless of their length of stay, are reviewed. This includes transfers from Emergency Department (ED) and the Children's ward. In Q1, 2025 there was 1 baby admitted from home via ED, a decrease by 3 from the previous quarter. Admissions are assessed against current admission guidance seeking to ascertain if the LNU was the appropriate care setting. The review looks for common themes within the source and reason for admission.

- This admission was for a baby that was having possible seizure activity and required cerebral function monitoring (CFM). The decision that the LNU was an appropriate location of care was made by Consultant to Consultant and the need for CFM resulted in the LNU admission as per guideline discussed below.

- There are two guidelines associated with infants readmitted from the community that impacts neonatal care: Neo - 129 Location of Care of Community Infants < 10 days of Age and Guideline of Care for Community Infants less than 3 months admitted to Paediatrics needing Intensive Care, the latter has not been uploaded to the RUH Clinical Guideline directory as yet, but this being actioned.

- These guidelines detail current pathways of care for all babies that are readmitted from home to the RUH. This is to improve the efficiency of the service and protect the vulnerable and immunosuppressed babies being cared for in the LNU from a potential risk of introducing community acquired infections into the LNU via re-admissions. It is also imperative to recognise the potential impact on patient experience, with families often appreciating the holistic aspects of the current referral pathways back into care via maternity and neonatal services. This guideline is currently awaiting upload by the Trust central policy department.

- Where cases have highlighted learning, information is cascaded to the teams via "Theme of the week", with relevant educational resources, on vignette Safety Catches, shift Safety Briefs, local newsletters, Quality Board displays and is shared at the Maternity Neonatal Safety and Governance meeting.

4.1 Detailed analysis of Term admissions by causation to LNU Q1 2025/26

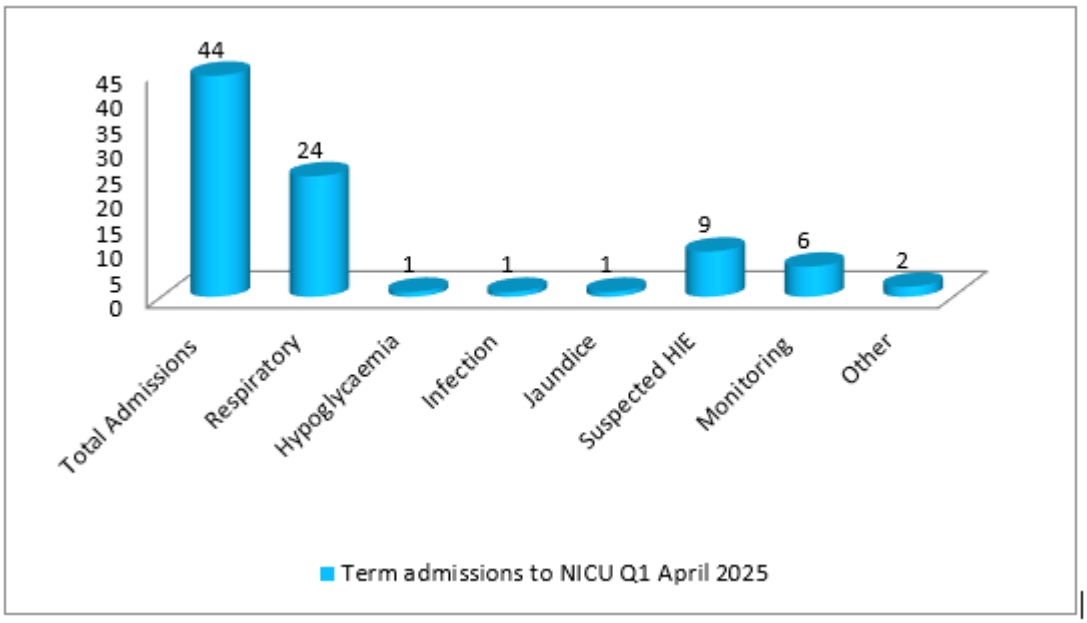


Figure 1: Reason for term admissions to the Neonatal Unit

When reviewing the leading causes for admission to the LNU during Q1, respiratory symptoms remain the leading cause of term admissions, this is in line with national data.
No commonalities or cause for concerns in respiratory management was identified within the MDT review of care, all admissions were deemed as appropriate based on the clinical presentation of the babies.

5.0 Quality Improvement Projects

- Progression with the implementation of the “CPAP on skin early intervention” (COSEI) Project to reduce the parent-infant separation of term babies with transient tachypnoea of the newborn. At present, 3 babies have benefited from this intervention, with 2 still needing ongoing respiratory support after the 90 minutes treatment, thus admission to the Neonatal Unit. This care pathway is dependent on the adequate ANNP and nurse staff availability as 1:1 care on the birthing suite is warranted. Simulation training continues to increase experience of staff.

- Commencement of a QI project – a thematic review of the last 2.5 years of all babies that have had a pneumothorax diagnosed whilst being cared for on the LNU. Following review of these babies and their antenatal, intrapartum and subsequent postnatal care, any themes will be recognised and potential areas for improvement will be actioned where relevant. Upon implementing any appropriate changes, measurable improvements will be audited.

6.0 Ongoing work streams

- Exploration of data capture concerning 37+ week gestation babies being readmitted into neonatal services and included within the neonatal ATAIN rates. The services continue to benchmark against other neonatal units within the Southwest Neonatal Network.

- Publication of Guideline of Care of Community infants less than 3 months of age admitted to Paediatric needing Intensive Care across both paediatric and neonatal clinical directories.

- Audit compliance with recent publication of the Guidelines – "Care of Community Infants less than 3 months admitted to Paediatrics needing Intensive Care" and Neo – 129 Location of Care of Community Infants less than 10 days of age.

- A Collaborative TC Special Interest Group (SIG) between the Neonatal team and Maternity has been formed. Improvement to the TCP service and culture are being explored associated with an action plan to address the parental feedback related to the environment on Mary Ward.

- Provide quarterly assurance, by audit of 10 sets of notes handheld and/or digital. This tool is designed to support recognition and escalation of the deteriorating Newborn. NEWTT2 outlines a standardised escalation response including who is responsible, time scale of review target, and support information for further escalation. Q1, non-compliance was identified in 50% of notes. An improvement plan is being developed by the Clinical Education Team to revise teaching pertaining to NEWTT2 observations, following a new set of staff working on TCP.

Appendix

Neo – 129 Location of care of community infants less than 10 days of age https://webserver.ruh-bath.nhs.uk/clinical_directory/clinical_guidelines/documents/neonatology/NEO-129_Location_of_care_for_community_infants_less_than_10_days.pdf?t=54098.94

Action	Details	Progress	Lead	Due	RAG status	Completion date
1.Ensure the appropriate process is followed in line with NEWTT2 observations within the TCP						
Provide quarterly assurance by audit of 10 sets of notes. This tool is designed to support recognition and escalation of the deteriorating Newborn	NEWTT2 outlines a standardised escalation response including: who is responsible, time scale of review target, and support information for further escalation.	Quarter 3 2023/24 demonstrated compliance by 80% Staff training and awareness increased of correct escalation pathway. Quarter 4 was 100% compliant	Neonatal transitional care lead	30 June 2024		June 2024
2. Collaborative Working Group to implement change, improve, and progress TCP service.						
Conversion of clinical room G into a 4 bedded Parent and baby residential bay, to reduce the length of time babies are cared for on the neonatal unit by being able to room in mothers to establish feeding sooner	To provide additional space for parents to stay alongside their baby, and to offer TCP for 34/40 week babies where postnatal ward may not be correct environment	Project due to start in June to install rails to partition off each bed space Convert the Visitor toilet into a shower room complete.	Neonatal transitional care lead and Maternity Matron	Feb 2025		Feb 2025
TCP working group to be established to work together to implement change and improve and progress TCP service	This group will have members of staff across all grades from the neonatal unit with a senior maternity representative	Specialist Interest working group now established and upward reporting structure	Neonatal Transitional Care Lead and Senior Midwife	Sept 2024		Sept 2024

Analyse parental negative feedback related to Mary ward environment	Review and develop an action plan to address themes of negative feedback where feasible.	Staff and parental feedback surveys active and ongoing. Formulate action plan to address any theme where able.	Neonatal Transitional Care Lead and Maternity and Neonatal Matron	Sept 2025		Dec 2025
3.To ensure verification of ATAIN Data to ensure accuracy and equity of provision across the Network						
To examine the Southwest Operational Network Dashboard ATAIN Data	Have a greater understanding and awareness of Data with particular focus on readmission of 37+/40 babies from home or other areas within the RUH and that impact on ATAIN Data	To arrange a meeting with the Network Data Manager and Analyst	Consultant ANNP and Neonatal Governance Lead Nurse	June 2025		May 2025
4. Ensure robust TC workforce to flex to increased acuity, facilitating Service Specification compliance with nurse: patient ratio						
To achieve approval to staff according to unit commissioning and BAPM standards	To staff according to BAPM standards	Review staffing needs and allocating bank early	Neonatal TC Lead	Sept 2025		
Develop escalation plan for time of high acuity on TC and low neonatal staffing levels	To develop additional neonatal tube feeding training for MSW and/or midwifery selected workforce for times of escalation	Training resource available.	Maternity and Neonatal Matron	Jan 2026		
5. Perform a thematic review of all babies that have been admitted to the LNU and been diagnosed with a Pneumothorax within the last 2 years. (MIS 2025 project)						
To review all babies that have been diagnosed with a pneumothorax whilst being on the neonatal unit	To establish any commonalities of care which may have	Review of all notes and compile a report	Neonatal Governance Lead Nurse	September 2025		

	contributed. Ascertain any potential learning.					

Appendix 3

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Board of Directors**	**Agenda item:**	**13.3**
Date of Meeting:	**5 November 2025**		

Title of Report:	**Ockenden Close Down and Three Year Delivery Plan Progress Report**
Status:	**For Information**
Board Sponsor:	**Toni Lynch, Chief Nursing Officer**
Author:	**Jodie da Rosa, Head of Midwifery**
Appendices	**None**

1. Executive Summary of the Report

This report proposes the close of progress reporting of the Ockenden 15 Immediate and Essential Actions (IEAs) and provide a position statement of the implementation progress of the Three-Year Delivery Plan (3YDP). Since December 2022, the Trust is no longer required to submit evidence of compliance with the 15 IEAs to the South West Region.

Following significant progress, the Perinatal Services request to formally close Ockenden reporting in March 2025, with 80 of the 93 sub-actions fully implemented and embedded into business-as-usual practice. The progress for each of the 93 sub actions has been monitored via Specialty Governance and Maternity and Neonatal Safety Champions via the Internal Performance Review (IPR) report. Outstanding actions have been incorporated into the service priorities for 2025/26 and aligned to the 3YDP themes: listening to women and families, supporting the workforce, developing a safety culture, and strengthening standards and structures.

The Trust has already made substantial progress in delivering the 3YDP, with 36 of the 44 recommendations achieved. Achievements include the establishment of a Perinatal Pelvic Health Service, improved midwifery recruitment and retention through enhanced onboarding and professional development, embedding of Family Integrated Care in neonatal services, and significant digital advancements, including the rollout of NEWTT2 and a new Maternity Electronic Patient Record, BadgerNet.

Key workforce improvements have led to a reduction in sickness absence rates and 100% retention of newly qualified midwives since 2023. A strong focus has been maintained on building a positive culture of safety, enhancing co-production with service users, and improving staff and family engagement.

Looking ahead, priorities for the final year of the 3YDP include further strengthening compassionate care, advancing equity initiatives, sustaining workforce development, embedding digital systems, and achieving external accreditations such as UNICEF Baby Friendly Initiative (BFI and Bliss Baby Charter Gold.

The Perinatal Service remains committed to delivering safe, personalised, and equitable maternity and neonatal services, with ongoing governance oversight to monitor progress, ensure continuous improvement, and respond to national

expectations. The Service will now provide quarterly 3YDP progress updates to Board and Safety Champions as part of routine reporting within the Quarterly Quality Reports.

2.	Recommendations (Note, Approve, Discuss)
The Board is asked to approve the closure of reporting against the Ockenden Immediate and Essential Actions.	

3.	Legal / Regulatory Implications
Nil	

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)
Nil – through the proposed closure of reporting as outstanding actions will migrate to the Board quarterly reporting.	

5.	Resources Implications (Financial / staffing)
Nil	

6.	Equality and Diversity
Nil.	

7.	References to previous reports/Next steps
2024/5 – Quarterly reporting to Board of Directors	

8.	Freedom of Information
Public.	

9.	Sustainability
Nil.	

10.	Digital
Requirement of a Neonatal Digital System – reporting is migrated to the Maternity and Neonatal Quarterly reporting to Board of Directors.	

1. Purpose

1.1 The purpose of this report is to update Board of Directors on the following criteria:

- A summary of the achievements to date with the progress of the Ockenden 15 Immediate and Essential Actions (IEAs)
- Inform of any outstanding Ockenden actions, the governance for monitoring progress with each of these actions and the timeline for completion.
- A position statement on the Trust responsibilities outlined in the 3YDP for maternity and neonatal services.

2. Background

2.1 The Ockenden II Report was published following an inquest at Shrewsbury and Telford NHS Trust by the Independent Review of Maternity Services. The report identified 15 IEAs consisting of 93 sub actions.

2.2 Since December 2022, the Trust is no longer required to submit evidence of compliance with the 15 IEAs to the South West Region. The progress for each of the 93 sub actions has been monitored via Specialty Governance and Maternity and Neonatal safety champions via the Internal Performance Review (IPR) report.

2.3 In June 2023 NHS, England published the 3YDP for Maternity and Neonatal Services which runs from March 2023 to March 2026. The plan encompasses four themes and supporting objectives with the overall aim to make maternity and neonatal care safer, more personalised and more equitable. The plan outlines what the NHS needs to have in place and sets responsibilities for NHS England, Integrated Care Board and NHS Trusts.

3YDP Themes	3YDP Objectives
Listening to women and families with compassion	**Care that is personalised** **Improve equity for mothers and babies** **Work with service users to improve care**
Supporting our workforce	**Grow our workforce** **Value and retain our workforce** **Invest in skills**
Developing and sustaining a culture of safety	**Develop a positive safety culture** **Learning and improving** **Support and oversight**
Meeting and improving standards and structures	**Standards to ensure best practice** **Data to inform learning** **Making better use of technology**

Table 1: 3YPD Themes and Objectives

2.4 The 3YDP encompasses several national quality and safety standards and recommendations such as Ockenden II, Saving Babies Lives Care Bundlev3 and the Maternity Incentive Scheme.

2.5 Following the publication of the 3YDP the Service generated the RUH Single Improvement Plan (SIP). The aim of the single improvement plan was to continue to monitor progress with the Ockenden 15 IEAs which were categorised based on the 4 themes from the 3YDP and also incorporate recommendations from the Trust NHSE maternity review in 2022.

3.0 Final Ockenden Position

3.1 Significant progress has been made to date with implementation of the 15 IEAs and associated 93 sub actions (table 2). In February 2025 the decision was made by Maternity and Neonatal Governance to formally close Ockenden reporting and transition to facilitate a focus on the Three-Year Delivery Plan for Maternity and Neonatal services.

	Red	Amber	Green	Blue	Grey (Not Applicable)	Total
March 2025	0	3	6	80	4	93

RAG Key: Red = not compliant, not commenced. Amber = commenced, not progressing. Green = commenced and on track. Blue = compliant, business as usual. Grey = no action for RUH
Table 2 – progress on IEAs

3.2 The perinatal service has introduced a range of systems and process to embed the Ockenden sub actions and as a result 80 actions are compliant with evidence available and considered business as usual.

3.3 Areas of focus, (Amber actions) not yet progressing from Ockenden will be incorporated into service priorities for 2025/2026 and aligned to the themes from the 3YDP. These include:

Outstanding Amber Actions	3YDP Theme
Review the locally calculated uplift for minimum safe staffing levels	**Supporting our workforce**
Develop and maintain a conflict of clinical opinion policy – linked to Marta's law and deteriorating patient	**Developing and sustaining a culture of safety, learning and support**
Postnatal readmissions must be seen by a consultant within 14 hours of readmission	**Supporting our workforce and Developing and sustaining a culture of safety, learning and support**

Table 3: Outstanding Ockenden Amber Actions

4.0 Three Year Delivery Plan Year One and Two Progress

4.1 The 3YDP for maternity and neonatal services is now in the third year of implementation as of March 2025. The Trust has a responsibility to deliver the forty-four recommendations defined within the 3YDP over a three-year period.

4.2 The Perinatal service has made good progress towards implementing the framework with a total of thirty six of the forty-four recommendations implemented.

4.3 To monitor progress against the implementation of the 3YDP a Red, Amber Green rating is used. The green rating accounts for recommendations that have been completed or take place on a continual basis through an existing forum. The Amber rating accounts for recommendations that have an existing proposal in place ready to commence. The red rating accounts for recommendations where a proposal is yet to be defined.

4.4 The perinatal service current position as of March 2025 is as follows:

3YDP	Red	Amber	Green	Total
March 2025	2	6	36	44

Table 4: Current RAG position 3YDP

4.5 The service will ensure proposals for red actions are prioritised throughout this next financial Year 2025/2026 and where applicable conduct a risk assessment and consideration for the Trust Risk Register. The red actions where a proposal is yet to be defined are as follows:

Red Action 3YDP	Theme
Provide administrative support to free up pressured clinical time	Growing, retaining and supporting our workforce
Procure a neonatal EPR system	Standards and structures the underpin safer, more personalised, and more equitable care

Table 5: Red Actions 3YDP

4.5.1 Theme 1 Listening to Women and families' key achievements

In partnership with Bath and North East Somerset, Swindon and Wiltshire (BSW) ICB, RUH perinatal service implemented a Perinatal Pelvic Health Service (PPHS) in 2023 which is now fully embedded, with self-referral available during pregnancy and up to 12 months postpartum. In February 2024, 500 self-referrals were recorded.

The Chief People Officer has been appointed as the Trust's Baby Friendly Guardian to support progress towards UNICEF Gold Accreditation.

The Neonatal Unit received the Trust's *Working Together* award for implementing the Family Integrated Care (FiCare) model, promoting partnership between families and healthcare professionals to improve outcomes.

4.5.2 Theme 2 Growing, retaining and supporting our workforce key achievements

Following the Trust's 2021 Birthrate Plus® (BR+) assessment, a successful business case was developed and approved, resulting in full funding and recruitment to the BR+ recommended staffing levels.

A thorough review of the recruitment and onboarding process was undertaken, leading to the introduction of a well-planned induction and orientation programme, incorporating adequate supernumerary time across all clinical areas. A robust midwifery preceptorship programme was also developed and implemented, achieving a 100% retention rate for newly qualified midwives (NQMs) and contributing to a significant reduction in midwifery sickness absence rates, from 7.89% in 2022 to 3.9% as of January 2025. This success has attracted national attention and has been showcased at multiple forums and conferences.

Further investment has been made into continuous professional development (CPD) opportunities for all staff members, including the development of apprenticeship pathways for maternity support workers, ensuring a sustainable and skilled workforce for the future.

In addition, a flexible rostering system has been implemented, designed in collaboration with staff to promote wellbeing and support a positive work-life balance, ensuring that rosters are fit for purpose and responsive to the needs of the workforce.

4.5.3 Theme 3 Developing and sustaining a culture of safety, learning and support key achievements

Key achievements include embedding the Maternity and Neonatal Voices Partnership (MNVP) into governance structures, with strong co-production reflected in patient materials. The perinatal service has made significant progress through the final wave of the National Perinatal Culture and Leadership Programme (PCLP), focusing on the inpatient ward—introducing enhanced Senior Leadership Team (SLT) presence and a new operational midwife role to support flow.

Quality improvement is driven by PSIRF methodology, rapid reviews, learning from MNSI, and local insights. Inclusive leadership is supported through multi-model staff feedback, culture conversations, and a flat hierarchy approach. Structured pathways and increased senior leadership visibility empower staff to speak up, with proactive hotspot identification. Safety Champions are also now well embedded, with additional visibility and support from the Executive Director and new Non-Executive Director through walkabouts and open Q&A sessions.

4.5.4 Theme 4: Standards and structures that underpin safer, more personalised and more equitable care key achievements

The Perinatal service celebrated the successful rollout of NEWTT 2, a newborn early warning track and triggers tool to improve the detection and care of unwell babies, enabling timely escalation of care. The tool was previously used only within the Transitional Care Pathway but is now implemented across all relevant areas.

Expansion of the Neonatal Outreach workforce has enabled the introduction of a home tube feeding service, contributing to reduced hospital length of stay and enhancing the overall family experience, with plans to extend further to include home phototherapy to treat neonatal jaundice.

Within Maternity, significant progress has been made in digital developments; the foundational work for BadgerNet implementation is now in place. Over the past year, the service has also successfully launched a digital Single Point of Access (SPA) for pregnancy booking, improved social media engagement, and transitioned to digital patient leaflets to enhance accessibility and communication, including being available in different languages.

5.0 Three Year Delivery Plan Year Three Next Steps

5.1 Theme 1 Listening to Women and families

The service will continue to prioritise embedding compassionate care by strengthening staff training and support to ensure all interactions with women and families are consistently sensitive and family centred. Improving feedback mechanisms is a key focus, with plans to enhance systems for collecting, analysing, and acting on feedback to drive service improvements.

Throughout Year 3, the service will focus on achieving Baby Friendly Initiative (BFI) Silver re-accreditation and working towards BFI Gold and Bliss Baby Charter Gold accreditations.

Staff training will be delivered with a focus on communication and emotional support skills. Regular feedback forums will be established, alongside transparent reporting of actions taken in response to feedback received. Progress will be monitored through user satisfaction metrics, and initiatives will be adjusted as needed to sustain improvements.
The service will focus on advancing equity and equality projects to reduce disparities in perinatal outcomes through the newly established Perinatal Equity and Equality Group. To drive improvement four key priorities have been identified.

1) Improving data quality and response
2) Language and communication
3) Access to both physical and digital care
4) Staff Equity

Actions against each priority have been set and are monitored through quarterly Governance updates.

5.2 Theme 2 Growing, retaining and supporting our workforce

Next year, the priorities for Perinatal services at RUH will focus on growing, retaining, and reforming the workforce to strengthen service delivery and improve outcomes. Recruitment into all vacant roles will remain a key objective to ensure sufficient capacity and safe staffing levels across services.

In line with outstanding Ockenden actions, there will be a review of the locally calculated uplift for minimum safe staffing levels to ensure these align with national standards and best practice, embedding this into wider workforce planning and establishment reviews.

The service will build on the success of the midwifery retention work by focusing on Maternity Support Worker retention, exploring enhanced development opportunities and wellbeing initiatives.

A focus on reforming roles and succession planning will support the development of a more sustainable and responsive workforce, with new models of working aligned to service needs. In response to the red-rated Ockenden action, work will begin to scope and develop proposals for administrative support models designed to release pressured clinical time. This will include assessing current administrative gaps and exploring how targeted support roles could reduce clinical burden, improve workflow efficiency, and support safe care delivery.

Equity will continue to be central, ensuring the workforce better reflects the communities it serves. Strengthening leadership, including reverse mentorship opportunities for staff racialised as Black or Brown, will help embed inclusive and compassionate leadership.
Improving staff experience will remain a key priority to support morale, engagement, and the overall quality of care. This will include delivery of actions from the Perinatal Culture and Leadership Programme (PCLP), contributing to a positive and safe working environment for all staff.

5.3 Theme 3 Developing and sustaining a culture of safety, learning and support

Efforts will continue to embed co-production at all levels, with a particular emphasis on enhancing neonatal engagement and securing funding for the BSW neonatal element of the Maternity and Neonatal Voices Partnership (MNVP), to strengthen the family voice. Improvements will also be made to the mechanisms for gathering and acting on parent feedback to ensure lived experience informs service improvement.

The Perinatal Culture and Leadership Programme (PCLP) action plan will address critical areas, including Transitional Care (TC) provision, workforce models, and patient flow, with a sustained focus on bolstering family support and embedding a positive safety culture.

Embedding the Patient Safety Incident Response Framework (PSIRF) will remain a key priority. This will include strengthening processes for rapid reviews, staff support through Professional Midwifery Advocates (PMAs) and Professional Nurse Advocates (PNAs), family involvement, and advancing the implementation of Martha's Law within maternity working groups to ensure prompt and effective escalation of concerns regarding deteriorating patients.

In response to an outstanding, red-rated actions from the Ockenden review, RUH will develop and implement and embed a Conflict of Clinical Opinion Policy. This policy will provide a clear framework for managing and escalating differing clinical views, especially in the context of deteriorating patients, ensuring timely decision-making and prioritisation of safety. Aligned with Martha's Law, this initiative will reinforce a culture of transparency and professional accountability, supporting staff to raise concerns. Alongside, an obstetric workforce review will be conducted which will underpin the Trusts ability to deliver timely consultant input, ensuring all postnatal readmissions are reviewed by a consultant within 14 hours. This will support improved clinical oversight, patient safety and timely escalation of care.

Culture conversations, led by trained culture coaches, will focus on targeted areas such as Ultrasound Services and TC within the PCLP framework, with biannual discussions integrated to strengthen safety intelligence and promote staff engagement. In response to national CQC maternity inspections, thematic areas including health equity, triage, leadership, and safety culture will be addressed through targeted improvement work, supported by mock assessments and national self-assessment tools to monitor and evidence progress.

5.4 Theme 4: Standards and structures that underpin safer, more personalised and more equitable care

The Perinatal service is focusing on several key initiatives to ensure care is safer, more personalised and equitable. The Maternity Badgernet system is being implemented to enhance digital integration, and the procurement of a new Neonatal EPR system is underway to streamline patient record management. Data quality transition to Badgernet is a priority to ensure accurate and accessible information.

The newly launched Perinatal Equity and Equality Group is driving a more focused approach, with clinical leads engaged in championing quality improvement projects based on local data to reduce disparities in care.

Efforts continue towards achieving Bliss Baby Charter Gold status, with Family Integrated Care (FiCare) foundations being built for better care of premature and sick babies. A review of Transitional Care services will ensure capacity meets demand for infants requiring enhanced neonatal care.

Triage processes remain a focus, with a workforce model review exploring medical and advanced practice roles to improve efficiency. Additionally, a review of Obstetric Ultrasound

services will assess capacity, workforce models, and leadership improvements to enhance team culture and operational effectiveness.

6.0 Conclusion

The Perinatal Service has made substantial progress in delivering against the Ockenden 15 Immediate and Essential Actions (IEAs) and embedding the improvements into routine maternity and neonatal care. With 80 of the 93 sub-actions fully compliant and transitioned into business-as-usual practice, the Service has formally closed Ockenden reporting and aligned outstanding actions to the wider Three-Year Delivery Plan (3YDP).

Significant achievements have been realised across all four 3YDP themes, including the successful implementation of key initiatives such as the Perinatal Pelvic Health Service, full recruitment to Birthrate Plus® staffing levels, and the embedding of Family Integrated Care (FiCare) in neonatal services. The Trust has also demonstrated strong leadership in workforce retention, professional development, digital innovation, and co-production with service users.

As of March 2025, 36 of the 44 3YDP recommendations have been completed, with clear action in place to address outstanding areas. The focus for the final year of the 3YDP will be on further embedding a culture of safety, enhancing equity and accessibility, strengthening workforce sustainability, and improving the standards and structures that underpin safe, personalised care.

The Service remains committed to continuous improvement, delivering against national expectations, and ensuring maternity and neonatal services are safe, personalised, equitable, and responsive to the needs of the women, families, and communities it serves. The Service will now provide quarterly 3YDP progress updates to Board and Safety Champions as part of routine reporting within the Quarterly Quality Reports.

Report to:	**Board of Directors**	**Agenda item:**	**14.0**
Date of Meeting:	**5 November 2025**		

Title of Report:	**Bi-annual Midwifery, Neonatal Nursing and Medical Staffing Report**
Status:	**For approval**
Board Sponsor:	**Antonia Lynch, Chief Nursing Officer**
Author:	**Zita Martinez, Director of Midwifery** **Kerry Perkins, Patient Safety Lead Midwife** **Jodie da Rosa, Head of Midwifery and Neonates**
Appendices	**None**

1. Executive Summary of the Report

This report provides data for the period of January to June 2025 inclusive.

This bi-annual report provides an overview of maternity, neonatal nursing, and medical staffing at the Royal United Hospitals Bath NHS Foundation Trust for the period January to June 2025. It outlines compliance with national standards, workforce metrics, and key developments across the perinatal workforce.

Maternity Services
Maternity services are fully funded to the establishment level recommended by BirthRate+, in alignment with the Ockenden 2022 safe staffing guidance. The funded establishment stands at 191.83 WTE. In April 2025, while a vacancy factor was applied to most nursing budgets across the Trust, Maternity and Neonatal services were exempt. This exemption was approved by the Trust Board, ensuring the preservation of safe staffing levels and the continued delivery of high-quality perinatal care.

The service remains in a strong position, with a reduced vacancy rate (1.63 WTE including maternity leave), 13.56 WTE new starters, and improved workforce metrics including a rolling turnover rate of 1.04% and sickness rate of 3.39%. Compliance with Birthrate Plus® (BR+) standards is maintained, including 1:1 care in labour and supernumerary labour ward coordinator status. Shift fill rates remain high, and escalation procedures are effectively mitigating staffing pressures.

Neonatal Services
The Local Neonatal Unit (LNU) has seen improvements in staffing, with Band 5 and 6 vacancies reduced to 2.5 WTE and a decrease in turnover and sickness rates. Compliance with BAPM standards is being actively monitored, with 93.3% of shifts meeting recommended staffing levels and 93.85% Qualified in Speciality (QIS) trained coverage. However, QIS compliance remains below the 70% target (currently 65%), with an action plan in place to achieve compliance by Q2 2025.

Medical Staffing
The neonatal medical workforce remains compliant with British Association of Perinatal Medicine (BAPM) standards across all tiers. Consultant presence and anaesthetic cover are consistently maintained, with no reported gaps in clinical cover during the reporting period.

Workforce Challenges
Key risks include under-provision of Allied Health Professionals (AHPs) and pharmacy support, both of which fall short of BAPM recommendations. These gaps have been added to the Trust Risk Register. The service is also operating below recommended levels for Neonatal Outreach staffing, currently at 1.8 WTE against a recommended 6.6 WTE. Despite this, the outreach team has successfully implemented a Home Tube Feeding pathway, demonstrating positive outcomes and cost savings.

Recommendations
The Board is asked to note the current staffing position and support the ongoing strategic workforce planning required to maintain safe, high-quality maternity and neonatal care.

Requirements for Maternity Incentive Scheme (MIS) Year 7 reporting:

- For the Board to formally record in Trust Board minutes the compliance with BAPM recommendations of the neonatal medical workforce.
- For the Board to agree on the action plan and evidence of progress against previous action to address non-compliance with QIS BAPM Nurse staffing standards.
- For the Board to evidence midwifery staffing budget reflects establishment as calculated in the April 2023 BirthRate+ assessment.

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

3.	Legal / Regulatory Implications
It is a legal requirement to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). Trust to support Birthrate Plus® report 2023 and meet BAPM Neonatal staffing standards. Maternity Incentive Scheme Year 7 standards.	

4.	Risk related to staffing (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc.)	
3101	Maternity triage non-compliance with medical review timescales as per RCOG guidance	15
2950	There is a risk that neonatal patients may be cared for outside of BAPM guidelines for nursing staff who are not qualified in speciality (QIS)	12
2785	There is a risk the current pharmacy provision for the NNU does not meet clinical needs or BAPM standards	12
2591	There is a risk that the current funded provision of Allied Health Professionals in the Neonatal Unit will not continue following cease of fixed term funding from neonatal Operational Delivery Network	8

Table 1: Risk related to staffing

5.	Resources Implications (Financial / staffing)
Nil at this juncture.	

6.	Equality and Diversity
Equality and Diversity legislation is an integral component to registration.	

7.	References to previous reports/Next steps
Maternity Incentive Scheme combined Maternity and Neonatal Safety Quality report Q4, 24/2025 and Q1 2025/26 Birthrate Plus® (BR+) report data from 2022, presented to Trust Board 2023 Perinatal Quality Surveillance Tools (PQST) presented monthly.	

8.	Freedom of Information
Public.	

BI-ANNUAL MIDWIFERY AND NEONATAL STAFFING REPORT

1.0 Background

1.1 It is a requirement that NHS providers continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board (NQB, 2016) requirements.

1.2 Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that Trusts develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings.

1.3 The Department of Health (DH 2009) recommended an adequate and appropriate workforce with the leadership, skill mix and competencies to provide excellent care at the point of delivery; organised into managed clinical networks, with hospitals providing neonatal care working together to ensure that babies and their families receive care in the most appropriate setting.

2.0 Executive Summary

2.1 This report provides a summary of the measures in place to ensure safe midwifery and neonatal nurse staffing; including clinical and specialist roles, headroom requirement, fill rates, escalation, recruitment and retention, midwife to birth ratio, Birth Rate Plus® Live Acuity Tool compliance with supernumerary labour ward coordinator status, one to one care in labour, and red flag incidents.

2.2 It provides evidence of compliance that Obstetric medical workforce is monitored to ensure locum doctors meet MIS criteria, and consultants comply with the attendance requirement set out in the Royal College of Obstetricians (RCOG) workforce document 'Roles and responsibilities on the consultant providing acute care in obstetrics and gynaecology'.

2.3 Evidence that a duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should always have clear lines of communication to the supervising anaesthetic consultant is provided. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients to be able to attend immediately to obstetric patients in line with Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1

2.4 It also provides a summary of measures taken to demonstrate working towards compliance with safe staffing for the Local Neonatal Unit (LNU) to include an annual nursing workforce review, including a mid-year review and collaborative working with the Operational Delivery Networks (ODN) to ensure recruitment and retention, skill mix and flexible working. A summary of compliance for neonatal medical workforce meets BAPM national standards, or actions to mitigate if not compliance are in place and are shared with the Local Maternity & Neonatal System (LMNS) and ODN.

3.0 BirthRate Plus® Workforce Planning for Midwifery staffing

3.1The service is fully funded to the establishment recommended by BirthRate+, this is in line with midwifery safe staffing recommendations from Ockenden 2022. The BirthRate+ funded establishment is 191.83 Whole Time Equivalent (WTE).

3.2 In April 2025, a vacancy factor was applied to most nursing budgets across the Trust. However, Maternity and Neonatal services were exempt from this adjustment. This exemption was endorsed by the Trust Board to ensure that safe staffing levels within maternity and neonatal care are maintained, protecting the quality and safety of perinatal services.

3.3 BirthRate+ is the only recognised national tool for calculating midwifery staffing levels. It is recommended that a BirthRate+ assessment is undertaken every three years to ensure planned staffing establishment is in line with changing activity and acuity. The next BirthRate+ assessment is due to be completed 2026.

3.4 In addition to clinical midwifery posts, consideration needs to be given to recommendations from national reports such as Ockenden, Maternity Incentive Scheme (MIS) and the 3-year Maternity and Neonatal Delivery Plan. This will need to be considered within Bath, North East Somerset, Wiltshire and Sailsbury (BSW) Integrated Care System workforce planning. The service continues to explore service needs and long-term funding to make care safer, personalised and equitable.

4.0 Recruitment and retention

4.1 The service is fully staffed to funded establishment. Vacancy has continued to be held for midwifery students resulting in an ongoing bank requirement with an anticipated reduction in Q3. Maternity leave and secondments remained stable until June where both saw a significant reduction as per table 2.

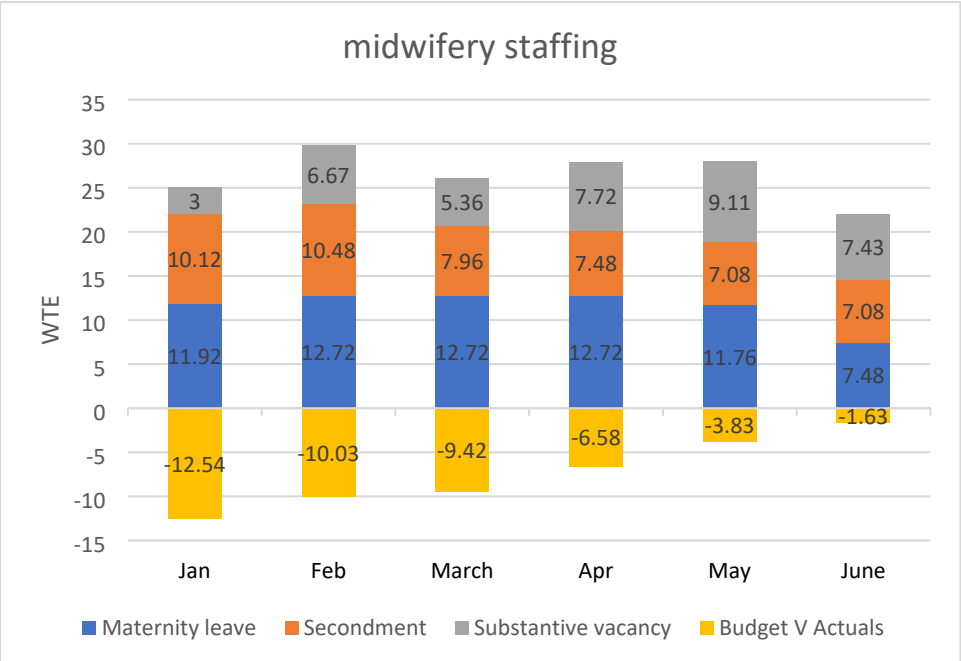


Table 2: Midwifery pipeline

4.2 The service has no band 5, 6 or 7 leavers in the reporting period.

4.3 Rolling turnover rate saw a decrease from 3.86% in December 2024 to 1.04% in June 2025.

5.0 Sickness rates

5.1 Midwifery sickness rates have remained relatively stable over the reporting period other than in January, the 12-month rolling sickness rate remains below the Trust target is 3.39%. The top contributor for episodes and days lost is anxiety/stress/depression/other psychiatric at 332 days over 23 episodes (based on 11.5 hours shifts). Supporting attendance is managed in line with guidelines with a focus on health and wellbeing.

Month	sickness %
Jan 25	5.63%
Feb 25	4.23%
March 25	4.54%
April 25	3.64%
May 25	3.96%
June 25	4.00%

Table 3: In month sickness % for midwives

Reason	Sickness days	Episodes
Anxiety/stress/depression/other psychiatric	332	23
Cold, cough, flu – influenza	123	48
Back problems	101	51

Table 4: top three reasons for sickness (over reporting period)

6.0 Planned vs Actual

6.1 Table 5 highlights the position for midwifery shift fill rates including bank. Shift fill rates improved monthly compared to the last reporting period, other than June where the shift fill remained the same.

Month	Day qualified %	Night qualified %
Jan 25	93%	93%
Feb 25	96%	94%
March 25	94%	93%
April 25	93%	93%
May 25	95%	92%
June 25	93%	92%

Table 5: Shift fill rates

6.2 Mitigation and Escalation

Mitigations and escalation processes are implemented to manage any shortfalls in planned versus actual midwifery staffing. Staffing and Operational Pressures Escalation Level Midwifery Framework (OPELMF) status is reviewed daily by the senior operational leadership team and mitigated where redeployment is considered based on acuity to ensure safe staffing is maintained. When midwifery staffing does not meet acuity, the following measures are taken to maximise staffing into critical functions to maintain safe care for the women and their babies in line with the Maternity Escalation Policy:

- Request midwifery staff undertaking specialist roles to work clinically
- Elective work assessed to identify risk and utilise available staffing
- Managers at Band 7 level and above work clinically
- Relocate staffing to ensure one to one care in labour and the labour ward coordinator remains supernumerary
- Activate the on-call midwives from the community to support Bath Birth Centre (BBC)
- Request additional support from the on-call midwifery manager
- Consult closely with maternity services at other sites to manage and move capacity as required (mutual aid)

As a result of improved shift fill and initiating the escalation policy, the need to utilise on call staff remains extremely low and will therefore not be reported going forward. This will continue to be monitored and reported on if an increase arises.

6.3 Midwife to birth ratio

The midwife to birth ratio is calculated monthly using BR+ methodology. The BR+ Midwife to birth ratio 1:24 target was introduced in July 2023 to align with the outcome RUH BR+ Report 2023. There were months when the midwife to birth ratio was above the target due to increased activity and acuity and holding vacancy. Mitigations explained in 6.2 were enacted during times of escalation to preserve safety.

Midwife to birth ratio	Target	Jan 25	Feb 25	March 25	April 25	May 25	June 25
Substantive only	1.24	1.28	1.26	1.36	1.27	1.30	1.26

Including bank	1.24	1.27	1.24	1.24	1.24	1.25	1.24

Table 6: midwife to birth ratio

6.4 Supernumerary status

As part of Maternity Incentive Scheme Safety Action 5 Trusts are required to demonstrate supernumerary status of the midwifery coordinator in charge of labour ward. This is to oversee safety on the labour ward and oversight of all birth activity within the service. An internal performance review is conducted monthly to monitor compliance and reported via speciality governance. Table 7 outlines the compliance for the past 6 months.

Month	Days per month	Shifts per month	Compliance
January 25	31	62	100%
February 25	28	56	100%
March 25	31	62	100%
April 25	30	60	100%
May 25	31	62	100%
June 25	30	60	99.4%

Table 7: Supernumerary status of labour ward coordinator

There was one episode reported in June where the Labour Ward Coordinator (LWC) is reported as not being supernumerary. On further investigation the LWC was the named caregiver along with a maternity support worker for 2 women who had been deescalated from high dependency care and were awaiting transfer to the postnatal ward. This was for a period of 15 minutes and at no time was the coordinator unavailable or safety compromised.

6.5 1:1 care in labour

Women in established labour are required to have 1:1 care and support from an assigned midwife to ensure the safe, high-quality provision of care. As part of Maternity Incentive Scheme Safety Action 5, Trusts are required to demonstrate the provision of 1:1 care in active labour. An internal performance review is conducted monthly to monitor compliance and reported via speciality governance. Table 8 outlines the compliance for the past 6 months.

	Jan 25	Feb 25	March 25	April 25	May 25	June 25
1:1 care in established labour	100%	100%	100%	100%	100%	100%

Table 8: 1:1 care in labour – source BR+ live acuity tool

6.6 Inpatient ward acuity

The inpatient ward-based acuity tool data is entered prospectively for the upcoming 6 hours based on care hours required. Midwives and support staff are included in the acuity calculation.

Compliance data has evidenced that staffing has consistently not met the acuity, with a data entry compliance consistently around 86% (confidence factor >60%). The service has met with Birthrate+ and reset the ward staffing baseline to reflect changes made form the perinatal

culture and leaderships programme action plan. This includes a trial of increasing leadership on the inpatient ward and a new role to support flow and staff break culture.

Escalation to the ward manager and LWC ensures that ward safety is maintained in periods of high acuity and actions detailed in section 6.2 are initiated.

6.7 Specialist Midwives

BR+ recommends 18.37wte specialist midwives including management and non-clinical element of specialist roles.

There are currently 18.17wte specialist midwives including those in management positions available to be deployed to mitigate in times of escalation. A number of these roles are externally funded but form part of requirements of Ockenden, MIS and the 3-year Maternity and Neonatal Delivery Plan. Discussions continue within BSW to explore service needs and long-term funding to make care safer, personalised and equitable.

7.0 NICE Red Flag Events (NG14, published 27/02/2015)

7.1 A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. Actions to reduce red flag events includes operational management actions such as initiation of the Operational Pressures Escalation Level Midwifery Framework (OPELMF). NICE Red Flag events are all recorded on BR+ acuity tool, the reliability of this data is also analysed on the tool via the confidence factor which should be maintained above 75%.

7.2 There are 9 national red flags agreed by NICE. Other midwifery red flags may be agreed locally. The service has reset Birthrate+ to align with national red flags.

8.0 Clinical Workforce - Obstetric and Anaesthetic staffing

8.1 The Trust has not employed any locum obstetric staff doing the reporting period. All Locum shifts are covered by Obstetricians who work in the unit in accordance with the safety requirement of Maternity Incentive Scheme (MIS) Year 7.

8.2 Throughout the next 6 months the Service will work towards developing standard operating procedures, to assure the Trust Board that Consultants/senior SAS Doctors working as non-resident on-call out of hours are not undertaking clinical duties following busy night on-calls disrupting sleep, without adequate rest. This is to ensure patient safety as fatigue and tiredness following a busy night on-call can affect performance and decision-making. Feedback will be sought from Consultants and senior SAS Doctors about their ability to take appropriate compensatory rest in such situations. This is a minimum requirement of the MIS Year 7.

8.2 Table 9 provides evidence of consultant obstetric presence in line with RCOG guidelines

	Jan 25	Feb 25	March 25	April 25	May 25	June 25
Hours Consultant present	98	98	98	98	98	98

Table 9: Consultant presence in hours

8.3 Table 10 shows consultant attendance when clinically indicated. There were no episodes when the on-call consultant did not attend.

	Jan 25	Feb 25	March 25	April 25	May 25	June 25
Consultant non-attendance when clinically indicated	0	0	0	0	0	0

Table 10: Consultant presence in hours

8.4 Table 11 provides evidence of dedicated obstetric rostered junior anaesthetic staff and a consultant allowing for clear escalation to a dedicated consultant if required. The rota demonstrates compliance with the Anaesthetic Clinical services Accreditation (ACSA) Standard 1.7.2.2.1 This is a minimum requirement of the MIS Year 7.

	Jan 25	Feb 25	March 25	April 25	May 25	June 25
Junior Dr rostered	100%	100%	100%	100%	100%	100%
Consultant Rostered	100%	100%	100%	100%	100%	100%

Table 11: Consultant presence in hours

9.0 Neonatal Nurse Staffing

9.1 The Neonatal Nursing Workforce Tool (2020) has been adapted from the Clinical Reference Group (CRG) Workforce Calculator (Dinning) Tool (2013) and provides a consistent method for calculation of nursing establishment requirements; this tool should be used for direct patient care in the LNU only. NHSE (2016) recommends an uplift of 25%, headroom is currently built into budget at 23%.

9.2 As recommended by NHSE, Transitional Care and Community Outreach should be delineated from the inpatient neonatal budget. Based on service cot occupancy and activity calculations in 2023/24, safe staffing levels were maintained from the inpatient establishment and budget. There is ongoing consideration of suitable service delivery models and continued capacity and demand data collection pertaining to current provision and staffing.

9.3 As of June 2025, the overall nursing vacancy has improved, reducing from 4.84 WTE to 2.09 WTE. The over-establishment of two Band 4 roles to support student nurse associates and one nursing apprentice has been offset against the vacancy. Recruitment efforts remain ongoing to fill the remaining vacant posts. n honorary contract has also been issued for a neonatal nurse from Yeovil to support service delivery.

9.4 Nurse rolling turnover rate remains stable and below the Trust rolling KPI of 11% at 5.04%.

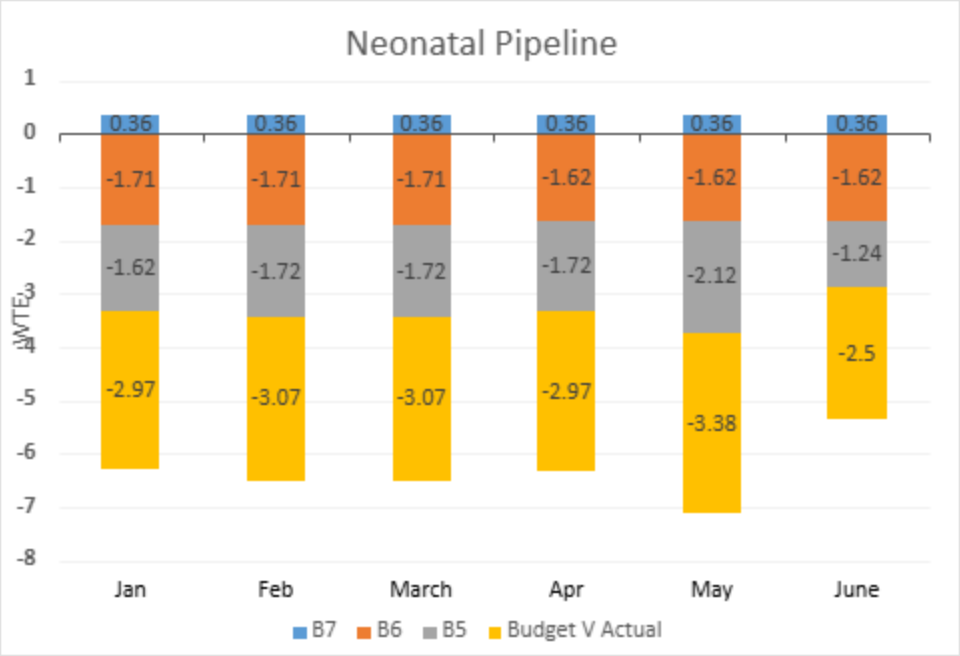


Table 12: Nurse vacancy pipeline

10.0 Sickness

10.1 There have been variations with monthly sickness absence rates however the rolling sickness rate remains below the Trust target of 4% at 3.21%. The top episode for sickness days lost remains cold, cough, flu – influenza at 23 episodes resulting in 62 lost days (based on 11.5-hour shifts). The largest number of sickness days lost at 68 is due to Anxiety/stress/depression/other psychiatric illness over 8 episodes. Supporting attendance is a priority for line manager as per trust guidelines with a focus on staff health and wellbeing.

Month	Sickness %
January 25	7.91%
February 25	5.25%
March 25	1.55%
April 25	2.73%
May 25	2.32%
June 25	5.02%

Table 13: In month sickness % for registered nurses

Reason	Sickness days	Episodes
Anxiety/stress/depression/other psychiatric	68	8
Cold, Cough, Flu - Influenza	62	23
Injury, fracture	15	2

Table 14: top three reasons for sickness (over reporting period)

11.0 Transitional Care

11.1 In line with BAPM (2017) guidance, all Local Neonatal Units (LNUs) are expected to provide a Transitional Care (TC) service. The current TC provision is staffed from the LNU

patient-facing budget, with 100% of shifts covered by a neonatal nurse or nursing associate. The Trust currently operates a 4-bed TC service, with the aim of maintaining a 1:4 nurse-to-patient ratio in accordance with BAPM standards.

11.2 The recent GIRFT (Getting It Right First Time) report recommends expanding the TC service to at least 8 beds, based on the Trust's birth rate. The neonatal service frequently provides care for more than four babies within the TC pathway. In Q1, 47% of shifts involved caring for more than four babies, with 16% of these not meeting the recommended staffing ratios. However, all eligible babies received appropriate transitional care during this period. Where higher acuity required two nurses, 100% of those shifts were fully staffed.

11.3 A review of current staffing is underway to assess the feasibility of expanding TC cot provision. The service is also exploring a perinatal workforce model to support TC delivery on the postnatal ward, including the potential to upskill maternity support workers and establish a dedicated TC team. Quarterly reports are maintained and escalated to the Trust Board, and ongoing data collection continues to inform future service planning.

12.0 Neonatal Community Outreach Workforce

12.1 The Neonatal Community Outreach service currently operates with 1.8 WTE nurses, delivering a six-day service in line with GIRFT (2022) recommendations. However, this remains significantly below the staffing levels outlined in the BAPM Neonatal Outreach Framework, which recommends 1 WTE nurse per 800 births, plus an additional lead outreach nurse. Based on an average birth rate of 4,500, the recommended establishment would be 6.6 WTE to support a comprehensive seven-day service.

12.2 The service has successfully expanded its scope to include Home Tube Feeding (HTF), which has demonstrated measurable benefits including increased breastfeeding rates, reduced hospital length of stay, and improved parental experience. Over a six-month period, five babies were supported through HTF, with an average of three days at home before nasogastric tube removal and an estimated five inpatient days saved per baby. At an average cost of £505 per Special Care cot day, this equates to a cost saving of approximately £13,130. Feedback from families has been positive, with early discharge and home-based care reported as safe and well-supported.

12.3 The service will explore options for further expansion of the outreach service, in line with BAPM standards, to enable the introduction of additional pathways such as home antibiotics and home phototherapy, offering further clinical and financial benefits.

13.0 Qualified in Speciality (QIS)

13.1 The British Association of Perinatal Medicine (BAPM) recommends all ITU and HDU patients should be cared for by a nurse who is qualified in specialty (QIS) trained. QIS is a post registration education pathway, combined with clinical competency which allows registered nurses working in neonatal units to become equipped with the specific knowledge and skills to practice safely and effectively in neonatal critical care. It is best practice for special care babies to also be cared for by a QIS trained nurse although national standards can still be met if they are supervised by a QIS nurse. The supervisory nurse in charge and

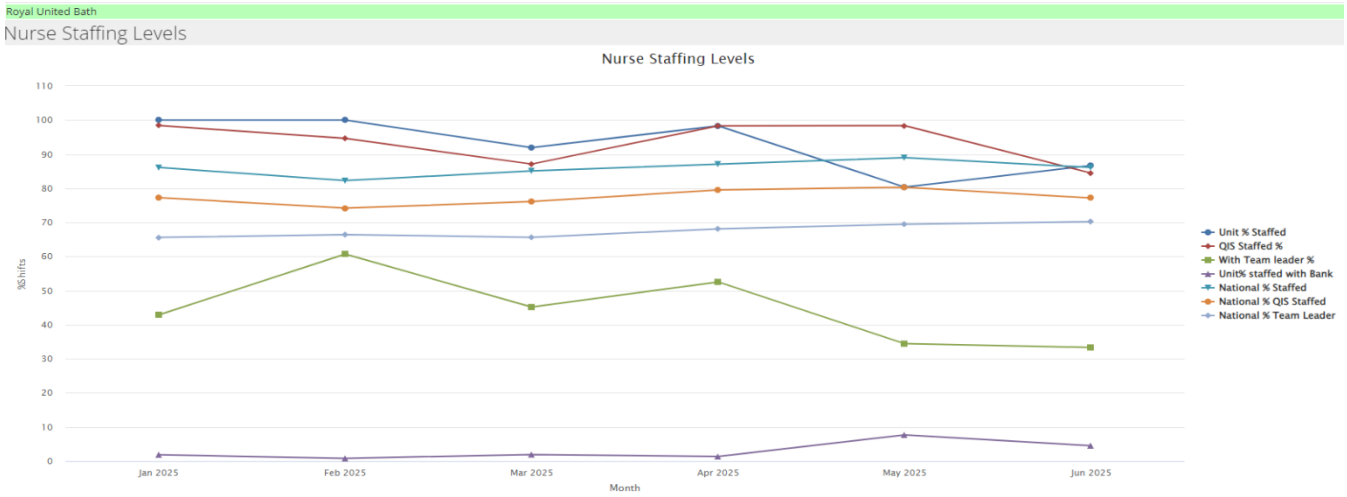
nurse overseeing TC must also be QIS trained. The national standard for neonatal LNU establishment in QIS training is 70% of the nursing patient facing workforce.

13.2 There are national, regional and local challenges in achieving the 70% QIS compliance rate. In Q1 the SWODN provided all services with guidance on who to include in QIS calculations which resulted in the RUH compliance to fall to 60%. Currently RUH QIS is 65% of the qualified workforce. The service does not currently meet compliance to BAPM Nurse staffing standards. Graph 1 represents QIS trained neonatal nurse staffing provision over the review period. During the reporting period 93.3% of shifts were staffed to BAPM recommendations, with 93.85% of shifts QIS to toolkit. QIS compliance is monitored via the Maternity and Neonatal Specialty Governance and remains on the Trust Risk Register (2950) with the service implementing an action plan to achieve the national BAPM recommendation of 70%. It is anticipated that RUH will be complaint at 70% by Q2 2025. Following a successful pilot of QIS training in the Southwest, the course will be continuing with new cohorts from September. CPD funding has been secured for 2025 for one staff nurse in 2025 and 2 in 2026. Table 15 outlines completed actions to date and ongoing actions required to meet compliance to BAPM Nurse staffing levels.

Action Plan towards Risk Mitigation:		**Target Completion date**
1.	Shifts allocations/rostering overseen by senior sister to ensure stability in the number of QIS members of staff on each shift to meet service need.	Ongoing
2.	Shift swap requests/allocations made in response to short-term sickness to preserve QIS staff on each shift	Ongoing
3.	Monthly monitoring of percentage of neonatal shifts staffed to BAPM standards shared at board level as part of monthly internal performance review Perinatal Quality Surveillance Tool to provide assurance of effectiveness of actions 1 and 2.	Complete
4.	Four nurses are enrolled on QIS course in Birmingham for 2024/2025 funded via Trust-Wide CPD funding.	Complete
5.	Successful pilot of SWODN QiS course. 1 nurse due to complete in September 2025. Further 3 funded places with 1 to commence in September 25 and 2 places in January 26.	Ongoing September 2026
6.	Identification of Risk on Maternity and Neonatal Risk Register to ensure progression of actions towards mitigation	Complete
7.	All new starters to the Neonatal Unit to complete the Southwest Neonatal Foundation programme	Complete
8.	Additional skills and simulation training for existing staff	Ongoing.

Table 15: Neonatal Nursing Workforce Action Plan

13.3 During periods of high acuity staff are redeployed and rosters changed to ensure adequate QIS trained nurses are available for baby's needing intensive or high dependency care. There is mitigation in place as all nurses complete the Southwest Neonatal Foundation programme and local induction programme, and all are supported with gaining experience in intensive and high dependency care.



Graph 1 QIS shift fill rates

14.0 Neonatal Medical Staffing

14.1 BAPM Optimal arrangements for Local Neonatal Units and Special Care Baby Units in the UK including guidance on their staffing; a Framework for Practice (2018) provides guidance on optimal activity levels and additional guidance on medical staffing for LNUs. Medical staffing comprises roles traditionally undertaken by medical practitioners now also undertaken by appropriately trained and experienced Advanced Neonatal Nurse Practitioners (ANNPs). ANNPs provide a high standard of practical skills, assessment and care planning, experience, continuity of care and empathy for families providing a solid foundation for neonatal services which strengthens medical trainee experience and service progression.

14.2 The following standards are set by BAPM (2018)

- At least one resident Tier 1 (ANNP or junior doctor ST1-3) practitioner dedicated the providing emergency care for the neonatal service 24/7.
- Resident Tier 2 (ANNP or junior doctor ST4-8) practitioner dedicated solely to the neonatal service 12 hours a day during the busiest times of the day.
- The Tier 2 (ANNP or junior doctor ST4-8) practitioner should be immediately available at all times to the neonatal unit and the labour ward. If the site of the paediatric unit makes this immediate response impossible separate Tier 2 rotas are required.
- Tier 3 compliance requires all consultants on-call for the unit to have regular weekday commitments to the neonatal service only (ideally with a 'consultant of the week' system) and all consultants do a minimum of four 'consultant of the week' service weeks per year.
- No on-call rota should be more onerous than one in six.

BAPM Standard	RUH
Tier 1 separate rota compliance 24/7	Compliant
Tier 2 separate rota compliance 12h per day	Compliant

Tier 2 compliance: significant geographical separation between neonatal and paediatric units	N/A
Tier 3 daytime compliance	Compliant
Tier 3 compliance on-call rota	Compliant

Table 16: Medical workforce

Consultant additional Roles; Funded PA's	RUH
Clinical Lead	1 neonates/paediatric
Governance	0.5
Perinatal Mortality Review (PMRT)	0
Educational +/- college tutor	0.75 neonates/paediatric
NNU lead Doctor	0.5

Table 17: Consultant additional roles

14.3 The neonatal service has had an ANNP vacancy since September 2024 numerous attempts to recruit to the ANNP post at tier 1 and tier 2 level were unsuccessful. This vacancy has since been advertised as a trainee ANNP post which has been recruited to
and the successful candidate will commence a full-time course from September 2025 with expected rota working in role from September 2026. The impact on safe medical staffing has been mitigated with the use of the bank, and the removal of rostered non-clinical time for ANNP's.

14.4 Table 18 provides evidence of the percentage of shifts that were staffed as per BAPM minimal medical staffing requirements during the period of January 2025 to June 2025.

	Jan 2025	Feb 2025	March 2025	April 2025	May 2025	June 2025
Tier 1 and tier 2 level staffing as per BAPM	98%	98%	98%	99%	97%	98%
Consultant Cover	100%	100%	100%	100%	100%	100%

Table 18: Medical staffing compliance with BAPM standards

15.0 Allied Health Professionals (AHP) and Pharmacy Provision

15.1 In addition to nursing staff, neonatal services require key contributions from an essential group of AHPs to enhance service provision and optimise short and long-term

neurodevelopment and mental health of infants and their families; this is advocated in the Neonatal Critical Care Review 2019.

15.2 Each AHP specialty has developed staffing recommendations and competencies which provide a model for embedded service provision as part of the wider neonatal team (BAPM 2022). The National standards for acute AHP provision are based on unit cot allocation and presented in table 19, in addition each AHP should have 0.15 WTE allocated for neurodevelopmental follow up clinic. The RUH provides neurodevelopmental clinics with physiotherapy and occupational therapy input and refer to other AHP as required.

National standards for SCBUs, LNUs and Medical NICUs					
	OT	Physio	Dietitian	S&LT*	Clinical Psychologist
IT cot	0.05	0.05	0.1	0.05	0.055
HD cot	0.05	0.05	0.05	0.05	0.055
SC cot	0.05	0.05	0.033	0.05	0.055
TC cot	0.02	0.05	0.033	0.02	0.055
1/2 day clinic	0.15	0.15	0.15	0.15	

Table 19: National standards for AHP WTE provision (BAPM 2022)

15.3 The service recognises a significant gap in AHP provision to recommended BAPM standards and is reflected in the Risk Register entry 2591. The risk is monitored via Maternity and Neonatal Safety Governance. The provision of Ockenden funds has supported recruitment of AHPs within the LNU however this does not fully meet the BAPM recommendations, the current provision and deficit are identified in Table 20 and now inclusive of recommended follow up provision. Focussed work for AHPs is on inpatient babies with support provided by a named Consultant and ANNP, the lack of adequate provision prevents AHP being involved in all infant's care and as such only see infants of greatest risk of developmental delay such as less than 32 weeks' gestation as routine. To mitigate this, MDT specialist interest groups have also been implemented such as a Family Integrated Care (FiCare) and Nutrition to share best practice interventions. This position is reflective of all neonatal units within the southwest region.

15.4 The current deficit does not account for the awaited AHP and pharmacy workforce BAPM recommendations for Neonatal Outreach Services which are currently under development. The BAPM Outreach Framework states that Psychological Professional at band 8a should provide 1 wte for community care with a Band 5 psychological assistant, this is in addition to the inpatient wte specified below*.

AHP	Current provision (WTE)	Deficit against BAPM (WTE)
Physio	0.2	1.15
OT	0.35	0.93
SALT	0.2	1.08

Dietician	0.2	1.09
Psychologist	0.3	0.86
Pharmacist	0.08	1.24 *(3.24)

Table 20: AHP wte comparison

15.5 Pharmacy provision did not form part of the Ockendon review and funding provisions. The Neonatal and Paediatric Pharmacists Group (NPPG) has Pharmacy Staffing Standards for Neonatal Services that support the BAPM standards. BAPM standards state the pharmacist must have sufficient time allocated to fulfil their specialist role, with a minimum of 0.12 whole time equivalent (WTE) pharmacist for a 5-day service (and 0.168 WTE for a 7-day service) for each funded Intensive Care cot, for every two funded High Dependency cots and for every four funded Special Care cots.

15.6 Incident reporting has highlighted recurring themes related to medication safety within the neonatal service, primarily linked to limited pharmacy provision. Issues identified include expired medications, unavailability of drugs at the point of repatriation—resulting in the need for invasive administration—and delays in drug delivery. Additionally, the current pharmacy capacity has constrained the ability to prioritise staff training and the development of drug monographs and clinical guidelines.

In light of national maternity and neonatal safety inquiries, including the forthcoming Thirlwell Inquiry, this has been identified as a priority area for improvement. The associated risks to patient safety and service quality have been formally recognised and added to the Trust Risk Register (number 2785).

16.0 Specialist roles

16.1 BAPM Service specification states additional provision should be implemented for staff delivering quality, management and other non-direct patient-facing roles which are additional to the direct patient care ratios. Every provider of neonatal care should ensure that non-direct patient-facing roles include provision for a designated lead nurse, clinical nurse educator, supernumerary shift co-ordinator, discharge planning / outreach co-ordinator, bereavement lead, patient safety and governance nursing lead and infant feeding lead are in addition to other roles outlined in the Toolkit for High Quality Neonatal Services (2009).

16.2 The service currently maintains four dedicated specialist roles: 0.4 WTE Neonatal Education and Quality Lead, 0.4 WTE Safety Governance Lead, and 0.5 WTE Family Integrated Care Lead. Remaining specialist functions, as recommended by BAPM, are assigned to individuals from the clinical nursing establishment. These roles are subject to redeployment during periods of staffing escalation, which may impact the continuity of specialist-led initiatives

17.0 Recommendations

- Review headroom requirements in line with BR+ and BSW training expectations.
- Develop a workforce strategy for externally funded posts.
- Continue monitoring transitional care demand and pharmacy provision.

- Progress a business case for Neonatal Outreach expansion in line with BAPM guidance.

18.0 Conclusion

Maternity services are a high-risk specialism; the impact of poor care can be life changing for women and their families. Investment in safe maternity staffing not only safeguards the provision of high-quality care and best outcomes but also mitigates the reputational and litigious risk for the organisation.

Neonatal services offer the best start in life to babies who have care needs which will have a lifelong impact if not provided in line with National standards. Having a baby in neonatal care has a significant impact to parental mental health which is long standing if they do not receive the care and support as per national requirements.

The Trust Board is asked to discuss the report and note the position of staffing in maternity and neonatal services.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Board of Directors**	**Agenda item:**	**15.0**
Date of Meeting:	**Wednesday 5th November 2025**		

Title of Report:	**Annual Mortality Review 2024-25**
Status:	**For Information**
Board Sponsor:	**Kheelna Bavalia, Chief Medical Officer**
Author:	**Heather Boyes, Head of Healthcare Legal Services**
Appendices	**None**

1. Executive Summary of the Report

Executive Summary

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

This report focusses on patients who died in hospital between 1st April 2024 and 31st March 2025.

- The Trust recorded 1349 deaths of patients in hospital.
- 209 Structured Judgement Review's (SJR) have been completed.
- No patient who died during 2024/25 assessed as having received very poor care overall. The percentage receiving good or excellent care has remained the same.

Inquests:

- 21 inquests were concluded – this is lower than expected and likely reflects the high workload of the local Coroner's Court. No Regulation 28 Reports were received.

PSIRF

- The Trust formally transitioned to the new Patient Safety Incident Response Framework (PSIRF) in April 2024. The Trust continues to embed PSIRF and instigated PSIIs where deaths are thought more likely than not due to problems in care and 6 investigations were carried out.

In hospital mortality was examined for inpatient admissions to Royal United Hospitals Bath NHS Foundation Trust for the 12-month period from May 2024 to April 2025 that met the relevant criteria.

Mortality rates are standardised and reported as Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-Level Mortality Indicator (SHMI). The Clinical Outcomes Group received a monthly report from Telstra Health UK (formerly Dr Foster) which provides an updated rolling monthly update on a number of mortality indicators and has been reported throughout the year through the quarterly Learning from Death reports.

The Telstra Health UK report published in August 2025 covers the period November 2023 to October 2024, but not beyond as the data for November 2024 to March 2025 has been impacted by coding gaps.

- The Telstra report shows HSMR slightly lower than statistically expected in the latest report, and within expected range for weekend deaths.

- SMR is lower than statistically expected
- The SHMI data was reported as 110.28 for the period from May 2024-April 2025. This was above the expected range, with an uptick seen initially starting in Q3 and rising further in Q4 2024/25. These changes correlate and mirror the rise in invalid coding during this period.

We are aware of, and are addressing, the issues around coding.

2.	Recommendations (Note, Approve, Discuss)
This 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)
Due to incomplete coding data there is a risk the Trust's SHMI data is not a full reflection of the Trust's crude mortality. Risks 2786, 2862 and 2787.	

5.	Resources Implications (Financial / staffing)
No specific resource implication identified.	

6.	Equality and Diversity
The report highlights gaps in the collation of data in relation to ethnicity, religion and learning disability. It is unclear if each function has undertaken an equality analysis.	

7.	References to previous reports
Annual Mortality Review 2023-24	

8.	Freedom of Information
Public	

1.0 Introduction

The Care Quality Commission (CQC) 2016 report *'Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England'* found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements/learning were being missed. *The National Guidance for Learning from Death* was published in March 2017 following a number of high-profile cases of suboptimal clinical governance. Trusts are now mandated to implement a system of 'mortality governance'. A mortality review database has been implemented to enable the collection of data relating to patients that have died in the Trust.

1.1 Mortality review process

All deaths are screened against specific criteria by the Medical Examiner at the time of certification of the death. If a death meets any of these criteria, then a structured judgement review is requested.

Structured Judgement Review

The Trust has adopted the recommendation from The Royal College of Physicians to embed the Structured Judgement Review (SJR) as a means of standardising the way in which a review of patient care is conducted. All surgical and medical deaths meeting certain criteria are reviewed utilising this approach which is a type of case note review that provides both quantitative and qualitative information on care that goes well or not so well. The SJR results in a score on a scale of 1 (very poor) to 5 (very good). The score is allocated to each phase of care and a rating of overall care. The outcomes of the SJR are reviewed within the specialty and divisional governance process where they are triangulated with other patient safety data to identify any themes and to inform local improvement.

1.2 Governance Arrangements

The Trust has oversight and assurance of the learning from deaths process through the following governance forums:

Mortality and Morbidity (M&M) Meetings

Within the Divisions specialities undertake Mortality and Morbidity review meetings regularly throughout the year and review cases identified through the SJR process. A number hold cross specialty M&M meetings with learning feeding into the clinical Divisions and beyond where appropriate.

Mortality Surveillance Group

The Mortality Surveillance group ensures that all hospital associated deaths and those who have died within 30 days of discharge, are proactively monitored, reviewed, reported and where necessary, investigated. The Mortality Surveillance Group is chaired by the Deputy Chief Medical Officer and reports to the Trust Quality and Safety Group. The Group receives and reviews the following:

- Structured Judgement Reviews

  The mortality review group receive and discuss a quarterly Learning from Deaths dashboard which includes key performance indicators related to the completion of SJRs as well as a summary of the SJR outcomes.

- The LeDeR Annual Report

  The Mortality Review Committee receives a summary of the Learning Disability Annual Report (LeDeR) programme activity. The NHS Long Term Plan made a commitment to continue LeDeR and to improve the health and wellbeing of people with a learning disability. NHS England and NHS Improvement published *'Learning from lives and deaths – People with a learning disability and autistic people (LeDeR) policy 2021'* which sets out the review process and local delivery expectations. In the future the BSW LeDeR Steering

group will be sharing learning from each local LeDeR Review undertaken with an RUH focus.
The RUH Learning Disability and Autism Lead shares learning from each local LeDeR Review undertaken and scrutinised by the BSW LeDeR Governance and Assurance Group with the RUH Mortality Surveillance Group.

- Inquest report information
  An inquest will be opened by a coroner when the cause of death is unknown, when the person may have died a violent or unnatural death, or when the death has occurred in police or state custody.

The Mortality Surveillance Committee has been replaced by the Mortality Committee which reports to the Clinical Effectiveness Committee, chaired by the Deputy CMO.

Clinical Outcomes Group

The Clinical Outcomes Group reports to the Trust Quality and Safety Group, is chaired by the Chief Medical Officer. The group receives and reviews a monthly report produced by Telstra Health UK (formerly Dr Foster) which includes:

- Hospital Standardised Mortality Ratio (HSMR) review
  This is a type of adjusted mortality rate used to monitor in hospital mortality rates across NHS Trusts. It is based on a subset (basket) of 56 diagnosis groups that account for approximately 80% of in-hospital deaths nationally. This is expressed as a ratio and placed into one of three bandings:
    - Statistically significantly higher than expected
    - Within the expected range
    - Statistically significantly lower than expected
- Standardised Mortality Ratio (SMR) for all diagnoses review
  This is a type of adjusted mortality rate used to monitor in hospital mortality rates across NHS Trusts. It is based on all diagnosis groups
- Summary Hospital-Level Mortality Indicator (SHMI) review
  This is a type of hospital mortality rate which includes deaths up to 30 days post discharge and all diagnosis groups excluding still births.

The data is benchmarked against national and regional peers and this alongside local intelligence is utilised to identify any trends and anomalies in the Trust's performance including reviewing unexpected deaths.

The Clinical Outcomes Group has been replaced by the Clinical Effectiveness Committee, chaired by the Deputy CMO. The Group reports into Quality Assurance Committee, chaired by the Chief Nurse and Chief Medical Officer.

Patient Safety Event Oversight Group

Since the 1st April 2024, the Patient Safety Event Oversight Group, chaired by the Associate Director for Patient Safety and Quality. The Group reports into the Insight and Improvement Committee, chaired by the Chief Nurse. , is chaired by the Chief Nurse. The Group is responsible for reviewing and approving all patient safety reports, including those arising from the death of a patient. The PSIRF describes the approach to managing patient safety incidents

Local Child Death Review (CDR) Meeting

The child death process varies quite considerably depending on whether the death is expected or unexpected and where the death occurs. The process for unexpected deaths is led through a Joint Agency Response (JAR) process which includes specially trained on call Health responders (often health visitors) who attend the scene and hospital alongside specially trained police officers. These replace the on-call out of hours community paediatrician. All unexpected deaths in children should be brought to hospital for initial investigations, safeguarding considerations and discussion with the coroner as well as family support. Subsequently the JAR process is led by the community

paediatricians who chair reviews for children who die unexpectedly in the community or who are brought in deceased to the RUH.

Meetings are within the first week and then when final post-mortem results are available and all the key professionals involved in the child's care should be invited to the meeting. The meeting will:

- Review circumstances of death and outcome of investigation
- Decide how cause of death will be shared and by whom with parents
- Plan support for the family
- Review professional responses to the child's death
- Collate information for the Child Death Overview Panel (CDOP)
- Consider if abuse or neglect was a factor in child's death and record decision.
- Form C case report of the meeting will be sent to the Coroner.

Regional CDOPs meetings are held monthly and intermittently publish reports on regional death statistics, trends and learning outcomes. There is currently a significant backlog in post mortems due to the regional lack of pathologists.

RUH paediatricians chair the review for children who die in the RUH or are expected deaths in the community whose care was co-ordinated by RUH paediatricians. Trust guidelines for child death and lab processing of samples/chain of evidence have been updated.

2.0 Demographic overview of patient deaths during 2024/25

During 2024/25, 1349 of the Royal United Hospitals Bath NHS Foundation Trust's patients died in hospital. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 361 in the first quarter;
- 310 in the second quarter;
- 331 in the third quarter;
- 347 in the fourth quarter

The demographics of the patients who died were as follows:

Table 1 Mortality Review Database

Nineteen patients with learning disabilities died - eight were female and 11 were male. This is considered further below under LeDeR.

Table 2 below shows the age of the patients who died at the RUH, divided by gender. Of note, the Mortality Database, the source of this data, only permits the recording of "male" or "female".

Consideration should be given to increasing the number of options available within this category to greater reflect the society the Trust serves.

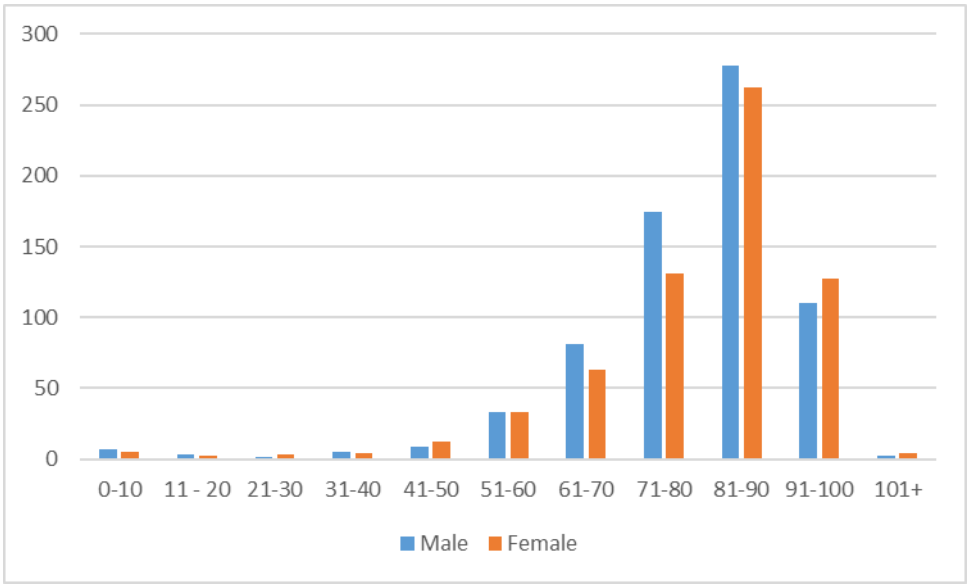


Table 2 Mortality Review Database

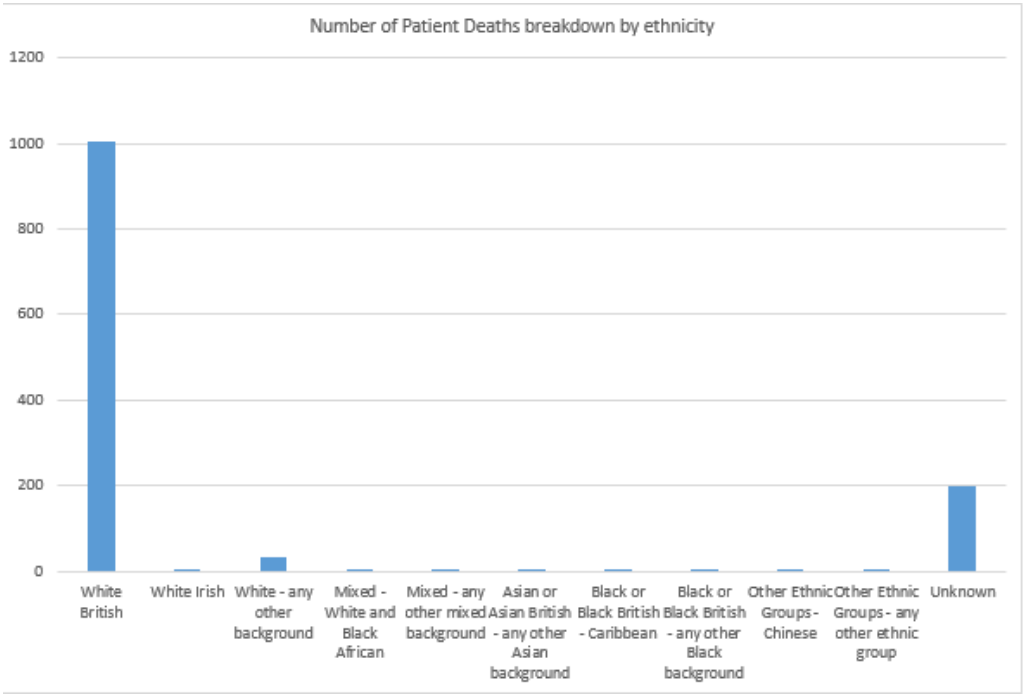


Table 3 Millennium

Deprivation and Mortality

Bath and North East Somerset, Swindon and Wiltshire has a combined population of around 940,000 people (BSW Together Report, 2025). Life expectancy across the three areas varies from 73 years to 91 years according to sex and geographical location (BSW Inequalities Strategy 2021-2024).

The Indices of Deprivation 2015 provide a set of relative measures of deprivation for small areas across England, based on seven domains of deprivation. The domains were combined using the following weights to produce the overall Index of Multiple Deprivation (IMD):

- Income Deprivation (22.5%)
- Employment Deprivation (22.5%)
- Education, Skills and Training Deprivation (13.5%)
- Health Deprivation and Disability (13.5%)
- Crime (9.3%)
- Barriers to Housing and Services (9.3%)
- Living Environment Deprivation (9.3%)

The Indices of Deprivation measure deprivation on a relative rather than an absolute scale, so a neighbourhood ranked 100th is more deprived then a neighbourhood ranked 200th, but this does not mean it is twice as deprived. Deciles are calculated by ranking the 32,844 small areas in England from most deprived to least deprived and dividing them into 10 equal groups. Decile 1 represents the most deprived area and Decile 10 represents the least deprived area.

3.0 Mortality review outcomes 2024/25

3.1 Structured Judgement Reviews

Of the 1349 patient deaths between 01/04/2024 and 31/03/2025, 220 were screened into the SJR process. Table 4 demonstrates the criteria that resulted in an SJR being requested, the two largest categories were Coroner's Inquest and surgical patients (all deaths of surgical patients are selected for an SJR).

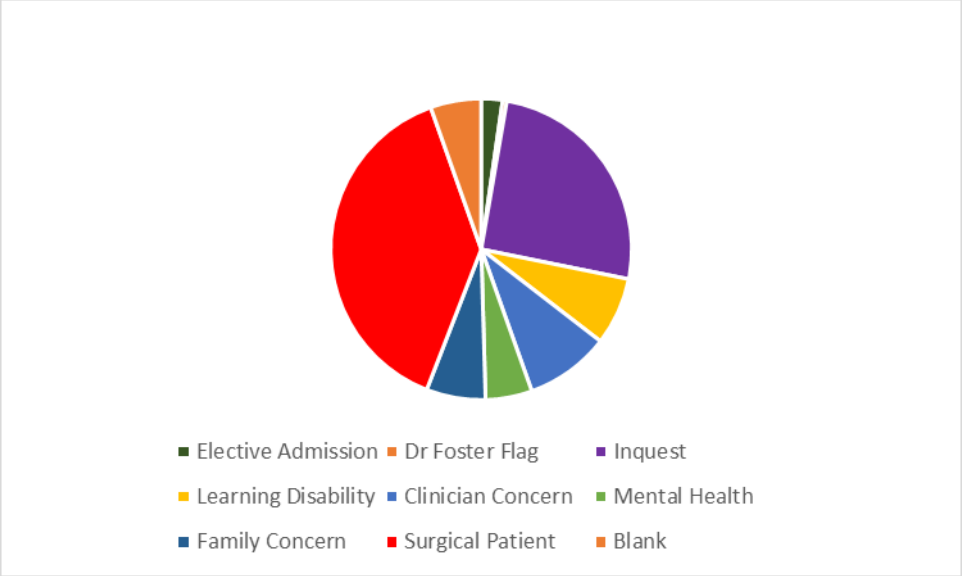


Table 4: SJR selection criteria

The table below sets out the ratings of care for each phase of an inpatient admission and overall care. Of the 209 SJRs completed during the financial year, 79% (166) assessed the overall care to be either Good (a score of 4) or Very Good (a score of 5).

No SJR identified overall care as being Very Poor (a score of 1) but one example of ongoing and end of life care being very poor was recorded. 3% (7) of SJRs assessed overall care as poor. In 13% (6) of SJRs the quality of the record keeping was assessed as below expected quality.

Rating Type	Average	Number of	Number Of 1s	Number Of 2s	Number Of 3s	Number Of 4s	Number Of 5s
Initial Admission	4.16	207	0	6	29	97	75
Ongoing Care	4.11	170	1	8	26	71	64
Care During	4.19	58	0	0	5	37	16
Return To Theatre	4.00	5	0	0	0	5	0
Perioperative Care	4.05	40	0	1	5	25	9
End Of Life	4.26	163	1	1	18	77	66
Overall	4.08	207	0	7	34	101	65
Patient Record	4.00	206	1	5	50	86	64

Table 5 Phase of Care Ratings

A Datix record is produced when an SJR identifies either a phase of care or overall care as very poor or poor or when care is thought to have contributed to a patient's death.

Table 6 shows the themes arising from completed SJRs. In 59% of SJRs (123) no additional learning was identified and in 13% (27) the learning identified was that the care provided had been Good or Excellent.

The fact that nearly 60% of SJRs do not identify additional learning does raise the question as to whether we are identifying the right cases to scrutinise. Therefore the screening criteria have been amended; it is no longer necessary to conduct an SJR simply because the death is being considered by the Coroner and it is not necessary to conduct an SJR for every patient who was on a DoLS at the time they died.

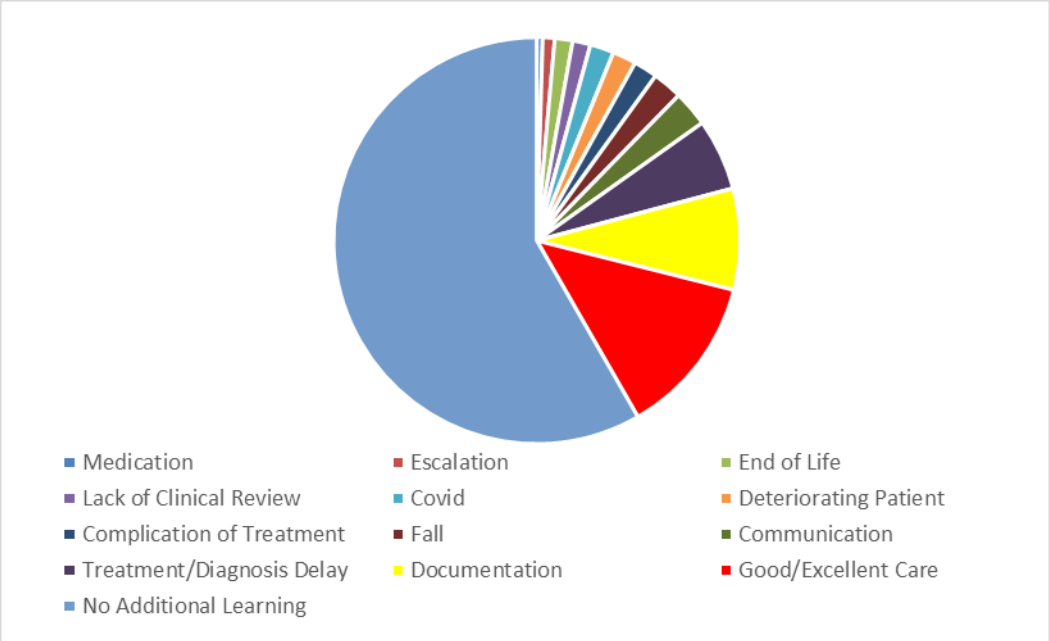


Table 6: SJR themes

Quality of documentation (with some issues arising as a result of the transfer to electronic records), delays in diagnosis and treatment (a general feeling that each step needed to be taken a little more quickly), communication (particularly with families towards the end of a patient's life) and inpatient falls were the themes identified.

3.2 Inquests

5 inquest hearings took place during the financial year. This is a decrease on the previous year A far greater proportion of matters have been dealt with by way of an "All Read" inquest – an inquest when only written evidence is considered. 21 matters were concluded overall; this is a significant decrease when compared to previous years and is likely a result of the high workload of the local Coroner's Court.

The Trust has not received any Regulation 28 Reports.

3.3 The Learning Disabilities Mortality Review

LeDeR was established in 2017 and is funded by NHS England. It is a service improvement programme to improve care for people with a learning disability and autistic people. LeDeR aims to reduce health inequalities for people with a learning disability and autistic people and to prevent early deaths. All deaths of patients (people) with a learning disability and autistic people within the Trust are reported to LeDeR. A structure judgement review (SJR) is completed in relation to each death of a person.

The BSW LDAN Steering Group is co-ordinated by Bath and North-East Somerset, Swindon and Wiltshire Integrated Care Board (ICB) and is being held virtually through Microsoft Teams. The Trust lead for Learning Disabilities and Autism sits on this panel. The BSW LDAN Steering Group has produced a 3-year strategy with priorities for each year that are linked with the BSW Learning Disabilities and Autism Programme Board based on thematic learning from LeDeR reports.

Deaths reported to LeDeR between 1st April 2024- 31st March 2025:

Patient	Month of Death	Gender	Age	Speciality at death	Cause of death
A	April	M	64	Gastroenterology	Awaiting Coroner
B	May	M	81	Gastroenterology	Pneumonia
C	July	F	59	Endocrinology	Acute Bronchopneumonia
D	August	M	35	Respiratory Medicine	Bronchopneumonia Duchenne muscular dystrophy
E	August	M	18	ITU	Multiple organ failure Aspiration pneumonia Kyphoscoliosis
F	August	F	82	Geriatrics	Pneumonia COPD
G	September	F	61	Gastroenterology	Hepatorenal failure Urosepsis
H	September	F	59	ITU	Multi-organ failure, Heart failure Myocardial infarction
I	October	M	25	ITU	Community-acquired pneumonia COVID-19
J	October	F	70	Respiratory Medicine	Aspiration pneumonia Oropharyngeal dysphagia
K	November	M	61	MAU	Metastatic caecal carinoma, Chronic kidney disease
L	January	F	22	ITU	Aspiration pneumonia Congenital scoliosis Cerebral palsy

M	January	M	35	Respiratory Medicine	Acute Bronchopneumonia Spastic Paraplegia Cerebral Palsy
N	February	M	66	Acute Medicine	Sepsis of unknown origin
O	February	M	68	Geriatrics	Inanition Learning disability
P	February	M	35	Respiratory Medicine	Type two respiratory failure Pneumonia
Q	February	F	65	Respiratory Medicine	Bronchopneumonia
R	March	F	58	Haematology	Acute Myeloid Leukaemia

Table 7: Cases referred to LeDeR

3.4 Clinical Outcomes Group and Mortality Indicators

The Clinical Outcomes Group received a monthly report from Telstra Health UK (formerly Dr Foster) which provides an updated rolling monthly update on a number of mortality indicators. The report published in August 2025 covers the period November 2023 to October 2024. We have utilised this time period as the data for November 2024 to March 2025 has been impacted by coding delays. The data reported the following:

Metric	Result
HSMR+ (Basket of 41 Diagnoses)	90.3, statistically lower-than-expected
Emergency Weekday/Weekend HSMR+	Weekday – 90.4, lower-than-expected Weekend – 92.6, within the expected range
SMR+ (All Diagnoses)	89.6, statistically lower-than-expected

Table 8: Telstra Data

The Hospital Standardised Mortality Ratio (HSMR) is the ratio of 'observed deaths/expected deaths' having standardised the figures by taking into account risk factors such as age, diagnoses and the presence of other diseases (the hospital's case mix) for a basket of 41 diagnosis groups that account for around 85% of deaths in a hospital such as the RUH. It measures only those deaths that occur in hospital and uses Hospital Episode Statistics (HES) as its data source. The HSMR is reviewed each month by the Clinical Outcomes Group who take responsibility for reviewing and driving actions surrounding all alerts outside of the expected range.

3.5 PSIRF

The Trust formally transitioned to the new Patient Safety Incident Response Framework (PSIRF) in April 2024. PSIRF embeds patient safety incident response within a wider system of continuous improvement and prompts a systematic cultural shift towards system-wide patient safety management. Patient safety event responses are conducted for the sole purpose of learning to identify opportunities to improve systems and reduce risk. Engaging with those affected by a patient safety event improves our understanding of what happened, and therefore the opportunity to prevent a similar incident in the future.

The Trust continues to embed PSIRF and instigated PSIIs where deaths are thought more likely than not due to problems in care and 6 investigations were carried out. Findings are then used to identify actions that will lead to improvements in the safety of the care patients receive and a PSII does not determine preventability.

3.6 Babies, Children and Mothers

The situation with babies, children and mothers is complex. Unexpected paediatric deaths are often confirmed in the community and brought to the RUH for further investigation. The paediatric intensive care unit (PICU) is in Bristol Children's Hospital. Critically ill children admitted to the RUH will be stabilised and transferred to the PICU and sadly some do die there. Likewise the RUH Local Neonatal Unit (LNU) is a level 2 Neonatal unit working as part of an operational delivery network across the South West with the sickest and most preterm infants born at the RUH transferred to regional tertiary level 3 neonatal intensive care units (NICU), most commonly this is St Michaels or Southmead in Bristol. Extremely premature babies (<27/40) at risk of delivery will often be transferred to level 3 NICUs in utero for optimised care, this includes those at the edge of viability. To ensure alignment to nationally reported neonatal mortality data from Mother's and Babies Reducing Risk through Audit and Confidential Enquiries (MBRRACE) the numbers listed in this report are identified by place of birth rather than place of death.

To add complication, there are also children who live within BANES/RUH's area or are receiving care under the paediatric team that die suddenly in other geographic areas – these are not included if the RUH has not been involved in their final illness.

Although deaths in this group are much rarer it is important to be cognoscente of the nuances, impact of deaths in this area as relatively small numbers in these categories have highlighted serious Trust deficiencies in other areas of the country.

During April 2024 – March 2025 the Trust recorded deaths in patients under the age of 18:

Stillbirths (>37 weeks)	3
Stillbirths (>24 weeks – 36+6 weeks)	5
Late miscarriage (22+0 weeks – 23+6 weeks)	2
Neonatal deaths	3
Neonatal death elsewhere following birth at the RUH	1
Paediatric death	7
Maternal deaths	0

Table 10: paediatric, neonatal, intrauterine and maternal death 2024/25

3.6a Paediatric Deaths:

There were 7 unexpected deaths and 4 expected deaths between 1st April 2024 and March 31st 2025. The expected deaths included an extremely premature baby born at the RUH at 22+0 and showed signs of life for 1 minute. A premature neonatal patient with complications of lung hypoplasia. A 5 year old with a progressive brain tumour and a 2 year old with a progressive neuro-metabolic condition. Both older children died at home being supported by the RUH team in conjunction with children's palliative care service.

Of the unexpected deaths: 5 children died at home or in a public place and 4 of these were brought to the RUH for the child death process. There were 2 Suicide by hanging (13y and 17y), a sudden cardiac event in a 17 year old that has led to the immediate family having cardiac/genetic screening. An 8 year old died from a Road Traffic Collision. A 16 year old with a complex medical background and under the ongoing care of the RUH team had a sudden unexpected death at home and was brought to the Bristol children's hospital where the Child death investigations were undertaken.

2 of the 7 unexpected deaths were neonatal patients. A term baby from elective section born in unexpectedly critically poor condition died after 1 hour of resuscitative efforts. A 9 day old presenting with diarrhoea and multi organ failure and dying in PICU in Bristol. These are currently referred to the Coroner and awaiting inquest as the deaths are unexplained.

All of the non neonatal unexpected deaths were investigated through the Joint Agency response which has continued to work effectively and were also referred to the Coroner as per process. This process has worked well this last year and is continually checked with the JAR quarterly review meetings.
The neonatal deaths have all gone through the perinatal mortality review tool (PMRT) which feeds directly into CDOPs. The neonatal deaths are also reviewed in a regional South West Neonatal Network Mortality Review meetings on a quarterly basis. The RUH neonatal death rate is similar to others in the South West which as an area has one of the lowest neonatal mortality rates in England.

There is a Coronial inquiry currently hearing evidence (Sep 2025) from an unexpected neonatal death in 2022.

We have been working alongside the Medical Examiners (ME) to comply with legal change that all deaths are discussed with the ME. Currently any deaths involving children in the trust which are not reported to the coroner are and have been discussed with the Medical examiner. The ME will also contact the family within 5 days of the death to ensure no concerns.

CDOP feedback: The RUH paediatric team was commended for the care of a complex neurometabolic patient from the CDOP review especially for working closely with the family to achieve their wishes and best interests of the child in a complex and challenging case. The southwest 23-34 CDOP Mortality report was released in August 2024 and includes crude death rates per area.

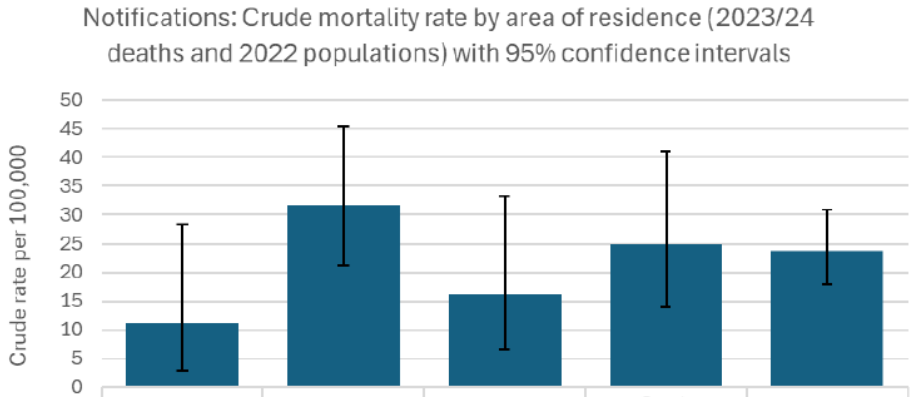


Table 11: Crude Mortality Rate by Area

2024-2025 report will be released later this year.

3.6b Maternal Deaths:

In maternity, during the period of 24/25 there have been no direct, or indirect, maternal deaths within the Trust. We have are not aware of any deaths where the mother received maternity care within RUH Services, and subsequently died in another Trust within one year of birth as per MBRRACE maternal death definition.

3.6c Stillbirths and neonatal deaths PMRT process:

All stillbirths and neonatal deaths, during 2024-2025 have been reported have to MBRRACE (Mothers and Babies Reducing Risk through Audit and Confidential Enquiries-UK) and have been assessed for eligibility for Perinatal Mortality Review Tool (PMRT) review, and where appropriate reporting into the CDOP panel. Medical termination of pregnancies (MTOPs) are excluded from reporting.

The RUH rolling 12-month average stillbirth rate is 2.2 per 1000 births remaining below the reported national average of 3.3 per 1000 births. The neonatal mortality 12-month rolling average is 0.98 per 1000 births, remaining below the reported national average of 1.7 per 1000 births.

The 2023 MBRRACE-UK perinatal mortality report, published on 8th May 2025, presents data on stillbirths and neonatal deaths among 4,195 babies born at the Royal United Hospitals Bath NHS Foundation Trust (RUH), excluding births before 24 weeks and terminations. The report uses stabilised and adjusted rates to enable fair comparison with similar Trusts (4,000+ births/year), accounting for key demographic and clinical factors. RUH's stillbirth rate was 2.63 per 1,000 total births (average), neonatal mortality was 0.73 per 1,000 live births (lower than average), and extended perinatal mortality was 3.35 per 1,000 total births (lower than average), excluding congenital abnormalities. Findings have been shared with governance teams and safety champions, and MBRRACE recommends continuation of using using the Perinatal Mortality Review Tool (PMRT) to assess care and implementation of the full Saving Babies Lives Care Bundle especially if aiming for outcomes comparable to leading countries like those in Scandinavia

The Perinatal Mortality Review Tool (PMRT) is a nationally mandated process for the systematic review of stillbirths and neonatal deaths. Completion of PMRT reporting is a core requirement of Safety Action 1 within the NHS Resolution Maternity Incentive Scheme.
The review is conducted via an online platform, drawing on data from maternity records and parental feedback to ensure a comprehensive and compassionate evaluation of care provided during pregnancy, birth, and the postnatal period. Once the data is submitted, a multidisciplinary panel, quorate as per MBRRACE-UK standards, convenes to assess and grade the quality of care. This panel typically includes consultants, maternity safety champions, bereavement care professionals, and an external clinician.

During the review, the panel aims to:

- Grade the care provided,
- Determine the cause of death where possible,
- Identify key learning points,
- Address any specific questions raised by the family.

Following the review, PMRT generates a detailed report, grading of care, and responses to the family's questions. PMRT grading of care is a four-level system (A-D) used within the Perinatal Mortality Review Tool (PMRT) to assess the quality of care given to a mother and baby surrounding a stillbirth or neonatal death.This report is shared with the parents, unless they choose not to receive it.

Stillbirths (>37 weeks)	3
Stillbirths (>24 weeks – 36+6 weeks)	5
Late miscarriage (22+0 weeks – 23+6 weeks)	2
Neonatal deaths	3
Neonatal death elsewhere following birth at the RUH	1
Paediatric death	7

Maternal deaths	0

Table 12: Table of PMRT referrals 2024/25

PMRT	Grading of care key
Grade A	No issues with care identified that would have impacted on the outcome
Grade B	Care issues which would have made no difference to the outcome
Grade C	Care issues which may have made a difference to the outcome
Grade D	Care issues which were likely to have made a difference to the outcome

Table 13: PMRT grading of care

Within the reporting period 13 cases had a PMRT completed and published. The care was graded as:

Stillbirth		
	Care until diagnosis	Care following diagnosis of stillbirth
Grade A	6	7
Grade B	3	1
Grade C	1	2
Grade D	0	0

Neonatal death			
	Care until birth	Care from birth until death	Care following death
Grade A	1	3	2
Grade B	2	0	0
Grade C	0	0	1
Grade D	0	0	0

Table 14: PMRT Gradings

Saving Babies' Lives Care Bundle

The Saving Babies Lives Care Bundle V3 (SBL) provides evidence-based best practice to achieve the national ambition to halve the rate of perinatal mortality by 2025 by driving innovation and quality improvement in key areas in maternity care. As part of the three-year delivery plan, providers are responsible for fully implementing all interventions for all 6 elements of SBL. SBLCB V3 implementation is subject to ongoing continuous improvement work. The Service is compliant using the SBL NHSE Implementation Tool and at least quarterly improvement discussions with the ICB have been held. The service received confirmation from the LMNS ICB on 12 December 2024, that compliance with Safety Action 6 has been met. Whilst full implementation of SBLCB V3 is not in place yet, compliance is still achieved as the ICB have confirmed it is assured that all 'best endeavours', and sufficient progress, have been made towards full implementation. Further review of the audit schedule is underway with an aim to meet stretch targets.

Intervention Elements	Description	Element Progress	% of Interventions Fully Implemented
Element 1	Smoking in Pregnancy	Partially Implemented	90%
Element 2	Fetal Growth Restriction	Partially Implemented	80%
Element 3	Reduced Fetal Movement	Fully Implemented	100%
Element 4	Fetal Monitoring in Labour	Fully Implemented	100%
Element 5	Preterm Birth	Partially Implemented	93%
Element 6	Diabetes	Fully Implemented	100%
All Elements	TOTAL	Partially Implemented	90%

Table 15. RUH Maternity position for implementation of Saving Babies Lives Care Bundle v3.

From Quarter 4 all PMRT reviews were triangulated against SBL and improvements identified and will become part of routine reporting for 2025/2026. Table XX provides triangulation of care concerns against each element of SBL.

January	February	March
Number of perinatal mortality cases where smoking in pregnancy was a relevant issue (Element 1)		
0	0	0
Number of perinatal mortality cases where fetal growth: risk assessment, surveillance or management was an issue (Element 2)		
0	0	0
Number of perinatal mortality cases where raising awareness of reduced fetal movements was an issue (Element 3)		
0	1	1
Number of perinatal mortality cases where effective fetal monitoring during labour was an issue (Element 4)		
0	0	0
Number of perinatal mortality cases annually where the prevention, prediction, preparation, or perinatal optimisation of preterm birth was relevant issue (Element 5)		
0	0	0
Number of perinatal mortality cases annually where the management of diabetes was an issue (Element 6)		
0	0	0

Table 16: Q4 2024/25 PMRT care concerns triangulated against SBL elements

Although both women reported reduced fetal movements (RFM) during their care pathways in Q4, PMRT reviews found no concerns in the care provided that would have altered the outcomes. While RFM was noted in both cases, it was not considered a contributing factor to the stillbirths.

Post-mortem delays

There is a national shortage of paediatric pathologists, which continues to significantly impact the timeliness of postmortem examinations following neonatal deaths and stillbirths. This delay not only affects the completion of the Perinatal Mortality Review Tool (PMRT) process but also has a profound emotional impact on bereaved families, who often face extended periods of uncertainty while awaiting answers about their baby's death.

The inability to provide timely postmortem results can impact families' ability to process their grief, delay closure, and in some cases, affect future pregnancy planning. It also limits the maternity service's capacity to deliver prompt learning and implement improvements in care.
Efforts to mitigate these delays locally are ongoing; however, the issue remains a national workforce challenge requiring strategic attention to ensure families receive compassionate, timely, and informative care during the most difficult of circumstances.

Local Child Death Review / Joint Agency Response (JAR)
Paediatric deaths at the RUH or with care at the RUH are reviewed in our departmental internal morbidity and mortality meetings whilst awaiting the formal feedback from the CDOPs committee.
1 patient who died at the RUH has an outstanding child death review meeting being organised for later this year.

Of note there is a significant issue with paediatric post-mortems due to the lack of trained pathology staff in the south of England. Initial post-mortems take a minimum of 6-8 weeks but specialist samples such as bone, brain or heart can take between 12 and 24 months for results. This can make it extremely challenging for the PMRT review process and for families whilst awaiting the final cause of deaths especially in unexpected cases. This is not expected to improve in the near future.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Board of Directors**	**Agenda item:**	**16.0**
Date of Meeting:	**Wednesday 5th November 2025**		

Title of Report:	**Responsible Officer Professional Standards Annual Report**
Status:	**For Information/Discussion**
Board Sponsor:	**Kheelna Bavalia, Interim Chief Medical Officer**
Author:	**Stewart Redman**
Appendices	**Annex A FQAI**

1. Executive Summary of the Report

This Responsible Officer annual report provides an overview of our compliance against statutory professional standards requirements. Oversight of the appraisal, revalidation, and responding to concerns processes is monitored through our monthly Responsible Officer Advisory Committee (ROAC). It is through this Committee, which has lay representation, revalidation decisions are made, and where any concerns, need for support, intervention, or failure to engage are identified and escalated.

2024/2025 has continued to be a consolidation year following a change in appraisal expectation during the Covid 19 pandemic and immediate recovery years. We have gradually increased compliance rates back to pre-pandemic levels. We have embedded use of our appraisal electronic platform (Premier IT, PReP) and returned appraisal and revalidation back to business as usual.

Our issues of concern around professional competency and/or conduct remain low, and where possible are managed through informal processes in line with General Medical Council (GMC) and MHPS (Maintaining High Professional Standards) guidance. Issues tend to be related to behavioural and conduct rather than clinical competency. We work closely with our HR People Team to align with all workforce approaches.

The attached appendix is the templated report that we are required to submit to NHSE.

Our 2024/25 Medical Appraisal Completion data shows:

Total number of completed appraisals - 375
Total number of appraisals approved missed - 7
Total number of unapproved missed – 63*
*In addition; 55 joined within year and not uploaded previous appraisal on PReP by 31 March 2025, 16 registered on PReP and left in year prior to completing their Appraisal, 2 retired but remained connected

Our 2024/25 Medical Revalidation

Total number of revalidation recommendations submitted to the GMC - 120
Total number of late recommendations - 19
Total number of positive recommendations - 89
Total number of deferrals made – 31

Our unapproved missed appraisals remain high, and this has been our key focus of this year. Our current reliance on self-arrangement between doctors and appraisers has made it challenging for the team to oversee in year. This is being reviewed with view to deploying a change in approach from 2026. We are aware this will be received with missed response and have trained additional appraisers to help manage the change.

We continue work on quality of appraisal and recognise improvements in our appraisal policy and working practice can support this. We also recognise we will need to review remuneration, as we are a low outlier and this will be a contributing factor.

We have also seen an upwards drift in the number of deferrals made to the GMC, and the main reason for this was the doctor having not completed their 360 Feedback process. The system for the formal 360 process is digitally supported, and well established, and going forward we will need to reset a proactive approach through our appraiser network.

We have areas where we can continue to develop and demonstrate continuous learning. Our focus for 25/26 has been:

- Increasing our appraiser pool, with focus on recruiting for SAS doctors, to meet an ambition that our appraiser cohort reflect our whole medical workforce community.
- Follow up of missed appraisals, drawing in regulatory levers and processes to support when required
- Bringing forward review of revalidation evidence to allow earlier intervention
- Improving the presentation of information at ROAC for robust decision making.
- Review of appraisal policy, with view to update and implement from April 2026
- Improve our process for responding to queries to the RO's office.
- Extending our current appraisal IT Platform contract whilst we work through possible opportunity to align across BSW Group.

This work will continue into 2026/27 when we aim to eliminate all unapproved missed appraisals and improve our data collection so we can monitor in year trends and better assess variation and equality impact.

We also hope to work more closely with GWH and SFT to further align processes and

identify opportunity for joint work.

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

3.	Legal / Regulatory Implications
This report refers to compliance with regulatory function of the Responsible Officer. The trust is required to support the delivery of this.	

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)
What are the risks arising or identified in the report. Risks need to be added to the risk register in advance of submitting the report and the risk number stated.	

5.	Resources Implications (Financial / staffing)
It is noted that we benchmark as a low outlier across the region for appraiser numeration and this has been raised through our joint local medical committee. This will need to be reviewed in order to maintain our appraisal function. A business case will be written and presented to the trust Management Executive Committee, to consider alongside an updated appraisal policy to support the improvements we need to make, for anticipated role out in 2026.	

6.	Equality and Diversity
We currently do not collate our data to have good enough insights into any adverse equality and diversity impacts, and we will work to address this going forward. Our crude numbers do show we have a low proportion of non-consultant in our appraiser workforce and we have recently undertaken a targeted recruitment drive to address. We will undertake an equality impact assessment on the revised appraiser policy. This is particularly important in the context of 2021 GMC Fair to Refer report showing doctors with a primary medical qualification from abroad are subject to unfavourable variation with regards to be referred, investigated and sanctioned for professional standards issues.	

7.	References to previous reports/Next steps
N/A	

8.	Freedom of Information
Public	

9.	Sustainability

N/A

10.	Digital
The IT issues raised are around procurement of our appraisal platform, which is a statutory requirement for us to have. We currently do not align across BSW Hospitals group which is a direction of travel.	

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2024 – 31 March 2025

1A – General

The board/executive management team of:

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Yes
Action from last year:	Andrew Hollowood has become Interim Managing Director of the RUH and Kheelna Bavalia is the Interim Chief Medical Officer. Sarah Richards remains Deputy Chief Medical officer and Deputy RO
Comments:	Kheelna Bavalia to continue as Interim Chief Medical Officer and RO and Sarah Richards as deputy RO

Action for next year:	None

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes
Action from last year:	The IT system is up for re-procurement.
Comments:	The Responsible Officer is supported by the Responsible Officer Advisory Committee comprising of: Kheelna Bavalia, Interim Chief Medical Officer & Responsible Officer Sarah Richards, Deputy Responsible Officer Stewart Redman, Associated Medical Director for Appraisal and Revalidation Joanna Hole Lay Member Lucy Tainton & Debra Scoplin, Appraisal & Revalidation Admin Support Alison Stead Medical Staffing Manager The Trust continues to use Prep IT system which facilitates on-line appraisals and data collection and facilitates twice yearly appraiser training. The procurement of a new system has been delayed with the aim of aligning and jointly re-procuring a system across BSW Group
Action for next year:	Work closer across BSW Hospitals group for best practice and consistency, including IT system procurement.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	
Action from last year:	None
Comments:	The Trust records all information relating to medical practitioner revalidation in a web enabled medical revalidation system. A system is in

	place to ensure that the records are checked monthly in order to maintain accurate records. The Trust uses the interface from the Electronic Staff Record to check all the medical practitioners are registered appropriately with their designated body
Action for next year:	None

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Yes
Action from last year:	None
Comments:	Our 'Medical Appraisal Policy' was reviewed January 2023 and is due for further review, on a three yearly basis.
Action for next year	Review underway for implementation April 2026

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	Not a formal peer review
Action from last year:	Engage in regional review and continue to seek opportunities to benchmark.
Comments:	We have held discussions with the Salisbury appraisal team and have adapted some of their documentation around locally employed doctors for use at the RUH. We are planning to jointly procure a new IT appraisal system with them. We have had a meeting with the Swindon appraisal team to discussed shared induction of appraisers. We obtain a level of external benchmarking from regional Revalidation and Appraisal meetings and discussing aspects of the professional standard with our peers. We also get some bench marking from the external appraisal trainers who have run our twice-yearly updates.

Action for next year:	Engage in regional review and continue to seek opportunities to benchmark.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Yes
Action from last year:	None
Comments:	Our trust induction is for all doctors joining, including short-term placements. Where doctors continue their prescribed connection elsewhere, we do not arrange appraisal or revalidation but provide information to them as needed to support their continuing professional development. We use MPIT system to share information between Responsible Officers. For those who require a prescribed connection, we follow the same onboarding process as consultants in terms of aligning to our Responsible Officer, use MPIT form for information request, review appraisal history and offer current appraisal in our system with a 360. For those in training programmes and taking a gap, we offer support in line with that for resident doctors and were we can, we offer flexibility of use between our appraisal IT system and training platform. All other grades of staff have an annual appraisal, the outputs of which can feed into the appraisal system in the organisation they have their prescribed connection with. We have connected our Prep IT system to the GMC to support cross referencing and maintain integrity of our doctors lists. We have also had a renewed focus in induction of new doctors on making sure they have the correct connection to the GMC.
Action for next year	None

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Yes
Action from last year:	Continue to work on the quality of appraisal outputs
Comments:	This has been a focus at appraiser training. All of the trust based appraisals are happening on the Prep system and the quality of the outputs has increased with repeat rounds of audit using the ASPAT scoring tool, feedback and discussions at appraiser training.
Action for next year:	This will continue to be a focus for 2026/2027, with the aim to reduce variation and continue improvement in quality of output where required

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Yes
Action from last year:	Continue to work on the process to ensure all doctors are actively engaging with appraisal each year.
Comments:	We have adopted the prescribed appraisal year from 1st April to 31st March and individually follow up all doctors (involving their clinical lead or divisional lead) to ensure they either have a missed approved appraisal (long term leave) or have an appraisal completed in year. This active process from the appraisal team has seen a year on year drop in the number of missed appraisals.
Action for next year:	To eliminate unapproved missed appraisals

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Yes

Action from last year:	None
Comments:	The Trust has the following policy 'Medical Appraisal Policy' ratified in January 2023
Action for next year:	Review policy in Q3/Q4 2025/2026 for implementation April 2027

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	Yes
Action from last year:	Keep an eye on appraiser capacity and demand.
Comments:	We were able to grow our appraiser numbers in 2024, following a change in renumeration structure, which is now sliding scale. We have recently had a recruitment round; in anticipation some may step down We will need to revisit our renumeration as we are a low outlier, and plan to tie that in with a revised appraisal policy and implementation approach. .
Action for next year:	Monitor and manage capacity of appraisers

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Yes

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Action from last year:	Continue working to ensure appraisers are up to date with appraiser CPD
Comments:	We use ASPAT as a quality assurance tool for appraisal output. Appraiser feedback is collated through the appraisal platform. Individual feedback is given, and through training sessions we have seen consistent improvement in ASPAT scores. We have discussed engagement with appraiser training at the ROAC. We request appraisers have 2.5 days of CPD every 5 years. We have now contacted those who haven't attended training in the last 2 years to engage or risk having to step down as an appraiser. We are moving to in-house delivery of appraiser training in line with many other trusts.
Action for next year:	Deliver in-house appraiser training and address low attendance. Quality assurance through ASPAT and Feedback Oversight will be through ROAC

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Yes
Action from last year:	Continue this approach.
Comments:	The ASPAT scores, qualitative feedback, appraiser CPD and any other metrics are regularly reviewed by the appraisal team and then presented to the ROAC. Once a year this report goes to the Board.
Action for next year:	Continue this approach.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	None
Comments:	Revalidation recommendations are reviewed and made at ROAG. We aim to review 3 months in advance, to allow time to address outstanding issues. On few occasions, late recommendations have been submitted, usually when trying to support a doctor presenting the required information close to the revalidation date.
Action for next year:	Eliminate any late GMC recommendations, by bringing the interventions earlier in the timeline

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	None
Comments:	Our main reason for deferral is incomplete patient and colleague feedback. This remains a legacy issue following Covid, like in many other organisations. Doctors are informed by email if a deferral or non-engagement is made. To support improvement, we have switched to using Edgecombe 360 tool, and request feedback to be collated between 3rd and 4th year appraisal cycles. Moving to allocation should increase our visibility of this and help us to manage it through appraisers
Action for next year:	Trend referral recommendations and reasons and review quarterly at ROAC

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Yes
Action from last year:	None
Comments:	Each department has medical and nursing clinical governance leads. These regularly meet and oversee clinical governance issues within their department. They also employ a variety of reporting mechanisms and departmental meetings to monitor performance and ensure learning. The departmental leads attend Divisional Clinical Governance and report. The Divisional Clinical Governance Leads meet with the Senior Nurse and Medical Director at the Operational Governance Meeting.
Action for next year:	None

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Yes
Action from last year:	None
Comments:	Issues raised regarding doctors' competency are dealt with as appropriate either informally or by using the Department of Health's document "Maintaining Professional Standard in the Modern NHS". The Trust has a Managing Conduct Policy which mirrors Maintaining High Professional Standards and is the mechanism by which all issues of conduct are dealt with. In addition the Trust has a Managing Capability Concerns of Medical and Dental Staff Policy.
Action for next year:	Improve consistency in logging conduct and performance issues for data trends and themes, to be reviewed by ROAC quarterly

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Yes
Action from last year:	None
Comments:	Information is provided from Premier IT outputs
Action for next year:	None

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Yes
Action from last year:	None
Comments:	Yes, there is a policy and procedure in place - Managing Capability Concerns of Medical and Dental Staff Policy. We also have our Freedom to Speak Up: Raising Concerns Policy
Action for next year:	None

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Yes

Action from last year:	None
Comments:	Our numbers of concerns are generally low, and managed on case-by case basis, in line with Maintaining Professional Standards (MHPS) framework. We include PPA and HR support as required, as well as NED engagement. No concerns have been raised. We could improve our analysis, and interim reporting, and will work on this for next year. We have recently amended our ROAC agenda and format to support this
Action for next year:	Improve our quality assurance process and analysis of responding to concerns. Will engage with BSW Group trusts for benchmarking and peer review

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Yes
Action from last year:	None
Comments:	In line with Maintaining Professional Standards, where an issue is raised formally, other employing organisations are informed of the nature of the concerns we are investigating.
Action for next year:	None

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	Yes

Action from last year:	None
Comments:	Our policies and procedures are designed to ensure equity and fairness in line with Maintaining Professional Standards and an Equality Impact Assessment is completed whenever policies are written or updated.
Action for next year:	None

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Yes
Action from last year:	None
Comments:	The Trust respond to any NHS Employer/Trust Solicitor updates such as changes in legislation incorporating into Trust policy as necessary. These changes are reported and negotiated as appropriate via JLNC
Action for next year:	None

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	Continue to monitor
Comments:	The Trust respond to any NHS Employer/Trust Solicitor updates such as changes in legislation incorporating into Trust policy as necessary. These changes are reported and negotiated as appropriate via JLNC. We would also link in as necessary with our GMC Liaison Officer.

Action for next year:	Continue to monitor

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Yes
Action from last year:	None
Comments:	Pre-employment checks for all staff including locums are in line with NHS Employers Guidance. Framework agencies are used initially if agency doctors are required, this ensures all appropriate pre-employment checks are in place. CV's are checked by the appropriate consultant to ensure the agency doctor has the appropriate qualifications etc. If non-framework agencies are used, Staffing Solutions Department ensures all appropriate pre-employment checks are carried out
Action for next year:	None

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Yes
Action from last year:	None

Comments:	The Trust is supporting Joy at Work which encourages a safe, positive working environment to support colleagues in their clinical practice.
Action for next year:	Continue

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes
Action from last year:	None
Comments:	In line with Trust policy and values we promote our Equality Diversity and Inclusion Strategy.
Action for next year:	Continue to monitor alongside all staff groups to Board.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Yes
Action from last year:	None
Comments:	We actively encourage reflective learning as part of our appraisal process. Colleagues are able to report inappropriate behaviours through our Freedom to Speak Up Guardian and our Report and Support System.

Action for next year:	Continue to monitor

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Yes
Action from last year:	None
Comments:	Medical Appraisal incorporates 360 feedback which includes patient and colleague feedback during revalidation.
Action for next year:	Continue this process

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Y/N	Yes/No
Action from last year:	None
Comments:	We apply a consistent approach regardless of country of primary qualification.
Action for next year:	Review our data trends to explore if any variation and themes

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not

restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Yes
Action from last year:	None
Comments:	The RO and Associate MD for Appraisal attend regional meeting organised by the region RO team. The appraisal team have engaged is some benchmarking and shared learning within our ICB (Swindon and Salisbury). Benchmarking information is also gained from the experienced external trainers at the local appraiser training twice a year.
Action for next year:	Continue to engage with other organisations/teams

Section 2 – metrics

Year covered by this report and statement: 1 April 2024 – 31 March 2025 .

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review (this figure was live time DR's connected on GMC July25 not as of 31/03/25)	518 (at 31.3.2025)
Total number of appraisals completed	375
Total number of appraisals approved missed	7
*Total number of unapproved missed (see comments below for break down)	*63 (see comments below)
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	89
Total number of late recommendations	19
Total number of positive recommendations	89
Total number of deferrals made	31
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	31
Total number of trained case investigators	7
Total number of trained case managers	3
Total number of concerns received by the Responsible Officer[2]	3
Total number of concerns processes completed	3
Longest duration of concerns process of those open on 31 March (working days)	n/k
Median duration of concerns processes closed (working days)[3]	n/k

[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

Total number of doctors excluded/suspended during the period	2
Total number of doctors referred to GMC	2
Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	n/a
Total number of new doctors joining the organisation	n/a
Total number of new employment checks completed before commencement of employment	n/k
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld[4]	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
*In addition; 55 joined within year and not uploaded previous appraisal on PReP by 31 March 2025, 16 registered on PReP and left in year prior to completing their Appraisal, 2 retired but remained connected Monitor and manage appraiser capacity and demand. Continue to work on the process to ensure all doctors are actively engaging with appraisal each year. Continue working to ensure appraisers are up to date with appraiser CPD
Actions still outstanding
The IT system is up for re-procurement.
Current issues

[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

We continue to have some unapproved missed appraisals. We have been working hard to bring this down.

We are updating our appraisal policy and processes to mitigate the risk of unapproved missed appraisal and improve more timely oversight and management. The move to allocation will help be part of this.

The IT system needs re-procuring.

Manage the transit from externally facilitated Appraiser training to in-house training.

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):

Update 'Medical Appraisal Policy' for implementation April 2026

Bring data trends and themes, to be reviewed by ROAC quarterly

Work closer across BSW Hospitals group for best practice and consistency, including IT system procurement.

Engage in regional review and continue to seek opportunities to benchmark.

To eliminate unapproved missed appraisals

Monitor and manage capacity of appraisers to meet demand

Deliver in-house appraiser training and address low attendance.

Quality assurance through ASPAT and Feedback, for improvements in quality of outputs

Eliminate any late GMC recommendations

Trend referral recommendations and reasons and review quarterly at ROAC

Improve consistency in logging conduct and performance responding to concerns. Will engage with BSW Group trusts for benchmarking and peer review

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

We have an engaged appraisal group but see variation in quality.

Time pressure remains a challenge, and we will have to review our renumeration approach. We are an outlier across the region, and this is impacting the quality of appraisal.

This will improve with a re-set of our expectations, and clarity between 'recommendations' and 'requirements'. This will be for both appraisers and appraisees, and we will bring this in with an updated appraisal policy.

Our responding to concerns numbers remain low, and where issues do arise, they tend to be behavioural, or conduct related rather than performance and clinical capability. We will formalise our reporting of activity and capturing of themes.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	

Name:	
Role:	
Signed:	
Date:	

Name of the person completing this form:	
Email address:	

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**17.0**
Date of Meeting:	**5 November 2025**		
Title of Report:	**Alert, advise and assure report -Quality Assurance Committee**		
Status	**For Information**		
Author	**Simon Harrod, Non Executive Director**		

Key discussion points and matters to be escalated from the meeting on 13 October 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
Pressure on the Emergency Department (ED) continues with increased incidence of corridor care since the adoption of the 45 minute ambulance drop off. There are also concerns over cover at night; waiting on a business case for increased medical staffing.
ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance
With a reduction in nursing Bank shifts, relating to financial controls, there is ongoing monitoring of quality standards with increasing concern that the quality of care is suffering. The risk score has been increased in the Board Assurance Framework (BAF). There has been an increase in sickness absence amongst the nursing cohort reflecting pressure on the workforce. Progress in clinical audits including some national audits continues to be slow, mainly due to limited resource and difficulty in recruiting leads. It was acknowledged this was an issue across may Trusts and work was ongoing to reduce the number of audits the Trust was engaged in.
ASSURE: Inform the Board where positive assurance has been achieved
Following a report to the Board in April, patients lost in virtual files have been identified and validation commenced. So far out of 7000 pts identified, 6000 have been validated with no clinical harm found. Most were administrative duplicates. Further work is being done to access clinical harm on long waiters in various specialities. The Chief Nursing Officer has commissioned a review of the risk register reflecting the number of old risks with infrequent updates.
RISK: Advise the Board which risks were discussed and if any new risks were identified
A reduction in booking of bank shifts has conversely made it harder to book nurses as bank workers are opting to do shifts at Bristol rather than risk bank shifts not being available or cancelled at Bath.

CELEBRATING OUTSTANDING: Share any practice innovation or action that the committee considers to be outstanding
The annual mortality rate remains within an expected range. BadgerNet has had a successful implementation in maternity. The Trust was no longer required to submit evidence in compliance with the 15 immediate and essential actions from the Ockenden 2022 Report.
APPROVALS: Decisions and Approvals made by the Committee
The Committee approved the Medical Revalidation Annual Report approved subject to the provision of further clarity on some of the numbers.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**18.0**
Date of Meeting:	**05 November 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 06 October 2025 meeting

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

None

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

10 Point Plan for Resident Doctors (development): NHSE Plan (published in August) aims to improve the working lives of resident doctors. Establishes measures to address issues such as payroll errors, lack of rest facilities, ensuring work schedules are issued at least eight weeks in advance, preventing unnecessary repetition of mandatory training when doctors move between trusts. Trusts required to develop action plans within 12 weeks.

- Deputy CMO appointed as the responsible senior leader/ Chief Registrar as the peer representative. They are to report to the Board.
- Committee assured that plans and internal governance reporting structures are being developed. Update to be presented to the November Committee (then quarterly reports).

Guardian of Safe Working Hours Annual Report 2024-25 (ongoing monitoring): 2016 Junior Doctors Contract introduced a system allowing doctors to submit exception reports when actual hours of work vary from their rota, they fail to get adequate rest breaks, or they are unable to attend agreed educational activities due to service commitments. Additional hours may lead to compensatory time off in lieu or payment. Divisions may be "fined" if safe working limits are breached.

- Despite significant challenges RUH continues to comply with the 2016 contract.
- In year progress includes increased number of exception reports (reflecting EPR and better engagement with the system); payment system for accepted reports working well; regular meetings between HR/ Guardian to ensure real time handling of rotas/ other HR issues; redesign of ENT rota; improved attendance at Doctor's forum.
- Six exception reports flagged with safety concerns. All downgraded following review.
- Committee noted the substantial Locum spend (£2.4m) to cover rota gaps.
- Discussions ongoing re spending of the accrued fines (c£50k). Reforms expected imminently to reduce restrictions on how fines can be spent.
- Future challenges: changing facilities, showers and lockers requiring improvement; lack of Phlebotomy support on wards
- Mar-Sept 2025 exception report analysis shows increasing number of exception reports (largely for overtime) especially in Gastro, Geriatrics and General Medicine.
- Future reports to be presented to Committee alongside 10 Point Plan reports.

Sexual Safety (ongoing monitoring): CQC definition "being and feeling psychologically and physically safe, including being free of and safe from behaviour of a sexual nature that is unwanted or that makes another person feel uncomfortable, afraid or unsafe".

- RUH Policy launched May 2025.

- Action plan developed, based on Charter. Broadly compliant but further work needed to further promote and embed the Policy/ Charter, encourage speaking up and make support more specialised.
- Training being promoted (NHSE programme and internally developed).
- People Function will work with Trade Unions across Group as this develops.
- Internal governance routes are being agreed.
- Committee assured, whilst noting some areas requiring further attention.

Staff Wellbeing – Stress and Burnout (ongoing monitoring): Committee updated on project to test risk assessment and wellbeing support.

- Colleagues identify with stress and burnout definition and compassion fatigue; open to sharing; want to be listened to.
- Some staff perceive a mismatch between RUH wanting staff to feel valued and the inability to access wellbeing support when needed. Feedback also underscores the importance of getting the basics right.
- Colleagues want this work to continue.
- Project has demonstrated positive impact of organisational wellbeing services. Outcomes and insights being fed into design of Group wellbeing service.

Equality, Diversity and Inclusion (EDI) (ongoing monitoring):

- EDI Annual Report approved.
- WRES and WDES components to be published on the Trust's website by 31st October (deadline met, following approval at 16 October extraordinary Board).
- Full report attached as appendices to this report for information.

UK visa and settlement rules - April 2025 changes (ongoing monitoring):

- Band 3 pay falls short of visa salary threshold by £53 (set intentionally, seemingly).
- Of 955 colleagues on visas and 638 requiring sponsorship, 51 cannot be sponsored.
- Discussed attempts by other trusts to work around the threshold.
- Discussed impact on staffing levels and pay costs to backfill vacancies.
- Working across Group to standardise knowledge.
- Committee assured preparations are progressing and employee support is in place (including clinics, hardship funds).

Breakthrough objective – staff feeling valued (ongoing monitoring): Feedback suggests staff feel recognised by their managers but undervalued by the Trust (which is perceived to have other priorities - saving money, national rankings etc).

- Divisions assessing top contributors to staff not feeling valued
- KPMG auditing RUH appraisal process. Report due in November.
- Free of charge employee benefits and engagement platform (Vivup) being adopted (already in use at GWH/ SFT)
- People and Communications teams reviewing organisational comms and language around praise, celebration and encouragement

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.

- Transformation programmes are allocated across Exec portfolios, embedding leadership sponsorship approach. Three stage change management training in place.
- Many Outpatients projects stuck at “Desire” project point. Staff report lack of bandwidth to support transformational change whilst contending with tiering. DDO Medicine reports some specialities/ divisions feeling overloaded.
- Capability/ capacity risk to be captured in the BAF/ Risk Register.
- Changed approach to assurance: rather than review updates at programme level (too broad) or project level (too granular), the Committee will conduct assurance- based conversations, drawing out themes arising/ key blockages, with exception reporting.

ASSURE: Inform the board where positive assurance has been achieved

10 Point Plan for Resident Doctors: plans and internal governance being developed.
Guardian of Safe Working Hours: compliance with the 2016 contract.
Sexual Safety Policy and Plan: broadly compliant, some areas requiring attention.
UK visa and settlement rules: preparations progressing, employee support in place.
Mutually Agreed Resignation Scheme (MARS): closure report presented.

RISK: Advise the board which risks where discussed and if any new risks were identified.

- No movement in BAF workforce risks: review requested.
- Medical workforce: some risks not captured in the Register or BAF: to be reviewed.
- Discussion focussed on risks in ED (filling vacancies) and Haematology & Oncology (capacity and vacancies).

CELEBRATING OUTSTANDING: Share any practice, innovation or action that the committee considers to be outstanding

None

APPROVALS: Decisions and Approvals made by the Committee

EDI Annual Report

Royal United Hospitals Bath
NHS Foundation Trust

Equity and Inclusion Annual Report 2025

The RUH, where you matter

Contents

Our frameworks……3

Our equality goals……5

Our Networks……7

Achievements this year……9

Monitoring our progress……12

- Workforce Equity Standards 12
- Pay Gaps 14
- NHS High Impact Actions 16

Looking to the year ahead……17

EDI Action Plan: 2024-26……20

The Equality Act 2010 and Public Sector Equality Duty (PSED)

The Equality Act 2010 outlines the nine personal characteristics that are protected by law. It highlights behaviour that is unlawful and sets out our role as a public sector organisation. The aim of the act is to help Britain become a fairer society, improve public services, and help business perform well.

Section 149 (1) of the Equality Act (2010) imposes a duty on 'public authorities' and other bodies when exercising public functions to have due regard for the need to:

- Eliminate discrimination, harassment, victimisation, and any other conduct that is prohibited by or under the Act.
- Advance equality of opportunity between persons who share a relevant Protected Characteristic and persons who do not share it.
- Foster good relations between persons who share a relevant Protected Characteristic and persons who do not share it.

Public Sector Equality Duty (PSED) compliance

In addition to these duties as a public sector body we are required to:

- Publish information annually to show our compliance with the Equality Duty
- Set and publish equality objectives, at least every four years
- Publish information to show that we have consciously thought about the three aims of the Equality Duty (listed above) as part of the process of decision making.

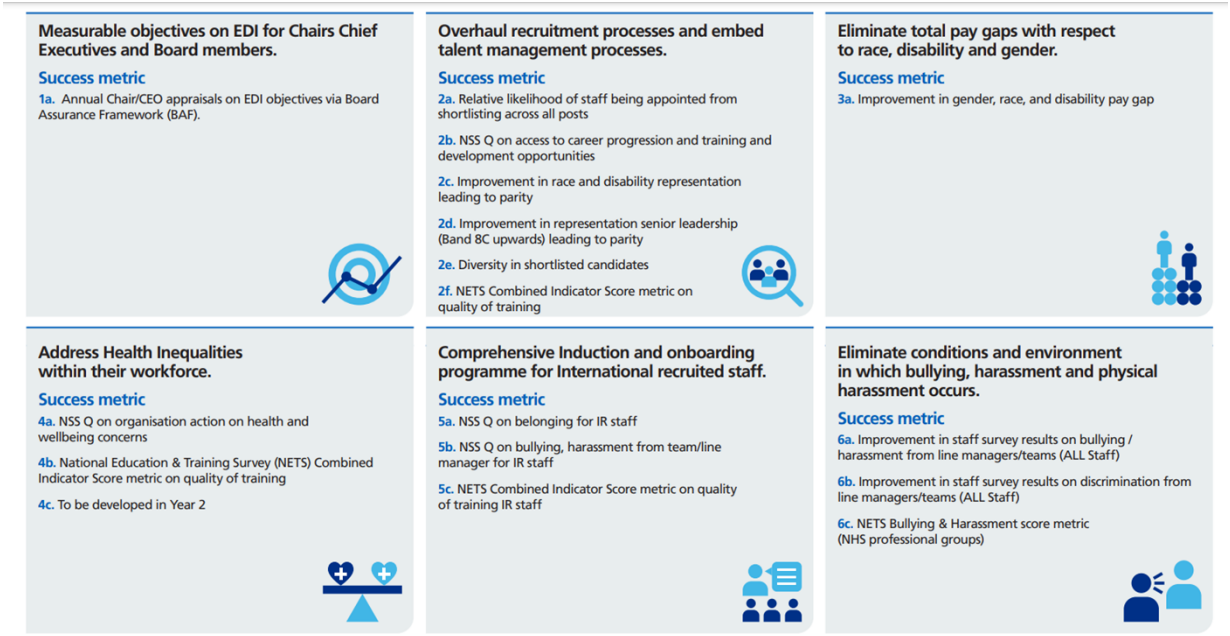
Our frameworks

NHS Equality, Diversity and Inclusion Improvement Plan

In June 2023 NHS England released 6 High Impact Actions to improve inclusion in the NHS, that sit alongside the wider NHS People Plan. The plan states:

> Ensuring our staff work in an environment where they feel they belong, can safely raise concerns, ask questions and admit mistakes is essential for staff morale – which, in turn, leads to improved patient care and outcomes (West, 2021).
>
> This can only be done by treating people equitably and without discrimination.
>
> An inclusive culture improves retention, supporting us to grow our workforce, deliver the improvements to services set out in our Long Term Plan, and reduce the costs of filling staffing gaps

There are six high impact actions for NHS Trusts and Integrated Care Boards to implement to address the prejudice and discrimination – direct and indirect – that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce. These actions have been included in our Equality Diversity and Inclusion Action Plan and progress updated in this report.



Our equality goals

In line with our frameworks and in collaboration with our staff across the RUH, we are focussing on three main goals:

To create safe, inclusive, diverse teams and working environments in which people feel they belong, are valued, and can thrive.

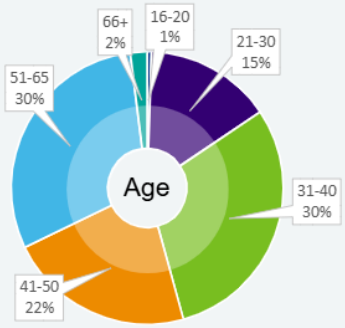
To promote and design-in diversity at all levels, advocating the benefits of this both internally and to our wider community.

To reduce occurrences of discrimination, prejudice, abuse, and harassment based on difference across all organisational teams, structures, and systems.

The people we work with

The staff survey not only helps us learn what really matters to you, it also helps us learn more about the people we work with. **So of the 3,406 colleagues who completed the staff survey what did we learn?**

We work with people from every age group, spanning multiple generations from 16 – 66+.



24%

of us live and work with a long term health condition or disability

6 religions are most commonly observed at the RUH

Buddhism Christianity Hindusim Islam Judaism Sikhism

We represent lots of different cultures and histories

British: 2430
Other Asian backgrounds: 285
Indian: 206
Other white backgrounds: 202
African: 77
Irish: 30
Chinese: 25
Mixed and multiple ethnic groups: 24
Other ethnicities: 22
Caribbean: 16
Pakistani: 11
Arab: 8
Bangladeshi: 3
Gypsy or Irish traveller: 2

74% of us identify as female

1 in 20 are part of the LGBTQ+ Community

The people we work with

The staff survey not only helps us learn what really matters to you, it also helps us learn more about the people we work with. **So of the 3,647 colleagues who completed the staff survey what did we learn?**

Over **1,000 of us work from home** (sometime, often or all the time)

1 in 5 of us work **part time** (up to 29 hours)

2 in 5 of us have responsibility for **caring for children.**

Almost **30%** of us **looks after others** with a **long term condition outside of work**

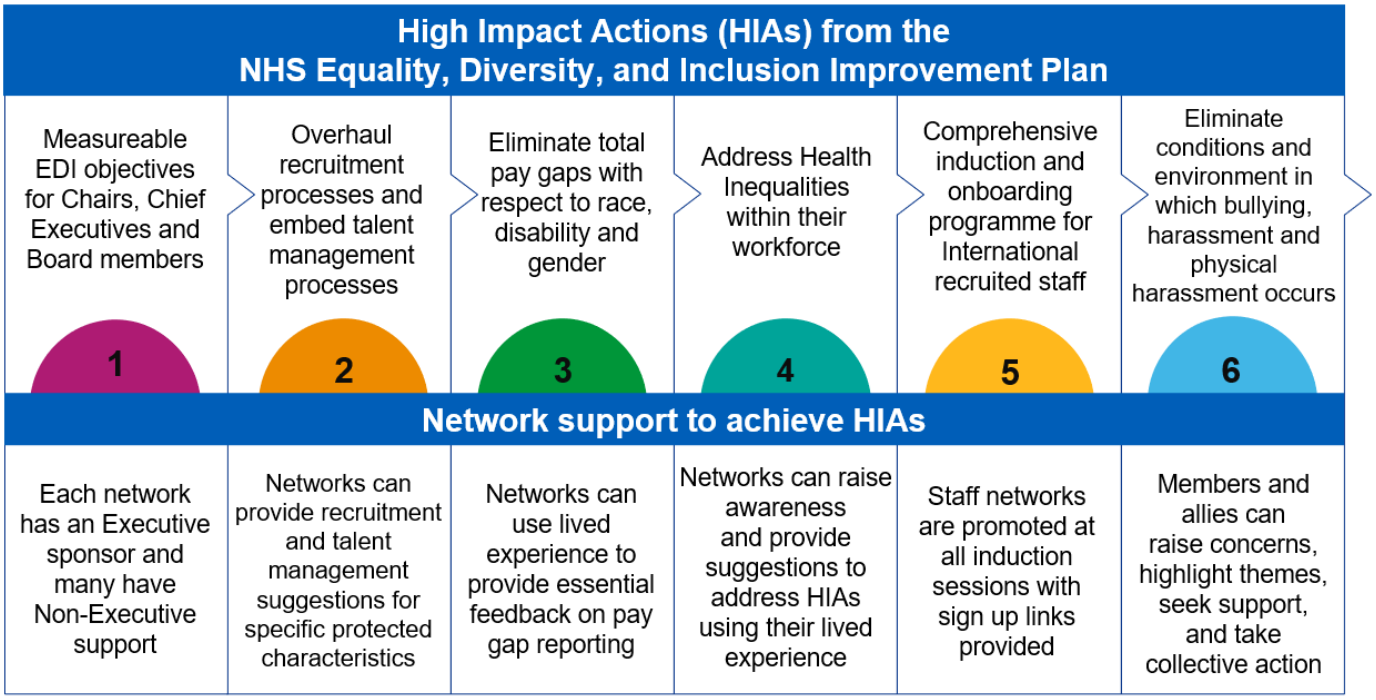
The RUH, where you matter

35% of us have worked at the RUH for **more than 10 years**, including over 800 colleagues who have worked for the RUH for 15 years+

Our Networks

We have six staff networks at the RUH. They are employee-led, active spaces designed to help lead change. They create the opportunities for colleagues to share experiences, inform improvement programmes and support the development of a safe and inclusive culture.

Our networks continue to support the organisation in delivering against the High Impact Actions of the NHS England EDI Improvement Plan.



RUH Staff Networks: 2024/25

- **Armed Forces Network** (a Resource Network for veterans, members of the armed forces and their families)
- **Enable Network** (a highly active space supporting disabled and neurodiverse colleagues, and those with long-term health conditions)
- **LGBTQ+ Network** (supporting staff who are part of the Lesbian, Gay, Bisexual, Transgender and Queer+ Community).
- **Women's and Men's Networks** (seeking to create meaningful engagement spaces for women and men to discuss issues related to their experiences at work)

- **Race, Ethnicity and Cultural Heritage (REACH) Network** (Working to engage, empower and improve working experiences for colleagues from the full spectrum of diverse backgrounds, cultures, beliefs and religions)

We also have three specialist support groups focusing on neurodiversity, menstrual health and menopause.

You can read more about our Networks and follow their progress on our website.

Achievements this year

Over the last 12 months, alongside a range of objectives, we have been working on strengthening and building on our progress in 2023/24. Having implemented a range of EDI programmes, our focus this year has been on consolidating and embedding this work, so that it can make a deep, meaningful and lasting positive impact for colleagues and teams.

Through our initiatives and collaborations we have:

- Re-designed our approach to staff networks to respond to the need to engage meaningfully amid increasing operational pressures and a changing social context.

- Continued to take positive action: the second cohort of our extremely popular programme *Routes to Success* got underway with 21 colleagues from the Global Majority and their sponsors.

- Continued to embed and promote our anti-racism programme at local and regional events, including the South West HR Directors Forum, local business shows and BSW Hospitals Group Boards.

- Continued to grow and strengthen our Inclusion Champions network, aiming to grow to one in every RUH team by 2027.

- Introduced intersectional inclusion weeks, bringing together staff networks with colleagues from across the Trust (and neighbouring organisations) with events, development activities and opportunities to engage with what really matters to colleagues.

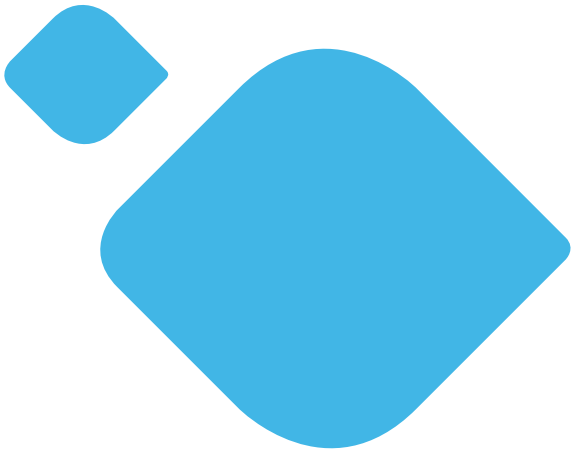
- Launched our Working with Cancer Policy, which is starting to provide improved experiences for colleagues with cancer. This forms a platform to further our support around other long-term health conditions.

- Launched and started to embed our Violence Prevention and Reduction Programme, which helps to create safe and inclusive working environments for our staff.

- Reworked our reasonable adjustments process (and policy) to remove barriers and delays for individuals and their managers.

- Internally commissioned a targeted accessibility audit, to help us understand where we need to improve our estate to support staff accessibility.

- Designed and launched our EDI Newsletter, which has attracted diverse contributions from across the organisation.



Achievements this year

Embedding the RUH's Anti-racism statement and toolkits to support allyship, conversations about race and team inclusion.

We launched our brand-new EDI newsletter in Spring. Each issue tells stories from across the Trust about EDI projects teams have rolled out, team celebrations and community events.

Re-launching the RUH's Inclusion Champions, bringing colleagues from across the organisation to share best practice, listen to concerns and actively role model allyship.

The second cohort of our highly esteemed positive action programme ("Routes to Success") supporting Global Majority colleagues to develop their clinical careers at the RUH

Monitoring our progress

Workforce Equality Standards – Race

Every year we comply with the Workforce Race Equality Standard (WRES) submission to NHS England. This measures our performance against 9 indicators, some of which relate to workforce statistics, and others which are derived from the annual NHS staff survey results.

Overview

Our 2024 WRES report tells us that we need to continue to step-up our efforts to support Global Majority colleagues, whose experience remains less positive than white colleagues.

The percentage of Global Majority staff believing the Trust provides equal career progression continues to fluctuate each year (currently at 52%) but remains above the acute Trust benchmarking average.

Global Majority colleagues continue to report that they experience more bullying, harassment and abuse from members of the public and from colleagues than white colleagues.

There is a continuing trend downwards in Global Majority colleagues experiencing discrimination from managers, and harassment, abuse and bullying from staff. This may be an early indication that our educational and strategic interventions are having a positive impact. However, we remain above the median in both measures (managers and staff).

Areas of Focus

- Further embedding, promotion and education around our Violence Prevention and Reduction (VPR) Programme, especially in relation to intersectional nuances, and greater team-based ownership.
- More targeted focus on development and setting up for success during a time of very low staff turnover (therefore reduced internal progression opportunities)
- More focus on closing the experiential gap between white and Global Majority colleagues.

This year there are unique opportunities to align EDI workstreams with those of others in BSW Hospitals Group. This will help us to understand regional variations in experience, and to design group-level interventions impacting local services.

Monitoring our progress

Workforce Equality Standards – Disability

Following the same approach as the WRES review, every year we also comply with the Workforce Disability Equality Standard (WDES). For WDES we are measured against 10 indicators relating to workforce statistics, as well as workforce experience taken from the annual NHS staff survey results.

Overview

We continue to see a steadily improving picture in the results related to colleagues with disability and long-term conditions (LTCs), although there are some areas in need of more focused attention.

Percentage of colleagues with long-term conditions experiencing harassment, bullying or abuse from managers and from colleagues continues to fall, and remains below the benchmarking group average.

Having experienced harassment, bullying or abuse at work, more colleagues with a long-term condition reported it than colleagues without, and this is 12% higher than it was in 2020. This may suggest that our efforts to improve psychological safety with better reporting mechanisms is having a positive impact. Reporting has also improved for colleagues without a disability or long-term condition.

More colleagues with a disability or long-term condition report feeling pressure to come to work when not well than those without, but this continues to fall, and is now about 4 percentage points better than the acute hospital benchmarking average.

Areas of focus

Progress around these metrics is largely positive, but slow. Work is needed to embed the interventions we have implemented so they become increasingly alive and meaningful in colleagues' day-to-day experiences.

This includes:

- Developing targeted and evidence-based approaches to career progression and development for colleagues with disabilities and long-term conditions
- Demonstrating through organisational story-telling how barriers are being actively removed in response to increased reporting of incidents
- Designing significantly greater intelligence into our colleague wellbeing and recognition offer, building on the launch of our flexible working and managing attendance policies.
- Communicating more robustly our reviewed processes for staff getting quick, 'friction-free' access to workplace adjustments.

Monitoring our progress

Pay Gaps – Gender

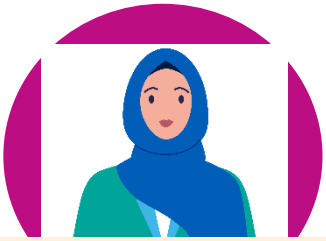
As an organisation employing more than 250 staff, the RUH is required to publish information on its gender pay audit (Equality Act 2010). The data presented here form a snapshot as of 31 March 2025.

Key points:

- For AfC staff, both the median pay gap (£2.31) and the mean pay gap (87p) are in favour of females and have widened in the past year. The distribution of males and females across staff groups and AFC Bands continues to be a key factor in this.
- For Medical & Dental staff, both the median and mean gaps have widened in favour of males in monetary terms. However, as the increase in the gap is not as great as the increase in the male mean, the mean percentage gap has slightly reduced. Time in grade and Clinical Excellence Awards remain key factors.

Male Median Pay (all staff): £19.49

Agenda for Change Staff: £16.93
Medical and Dental Staff: £52.10



Female Median Pay (all staff): £20.10

Agenda for Change Staff: £19.24
Medical and Dental Staff: £36.27

Median Pay Gap (all staff): -3.12%
Agenda for Change staff: -13.62% Medical and Dental Staff: 30.38%

Male Mean Pay (all staff): £25.39

Agenda for Change Staff: £19.07
Medical and Dental Staff: £49.70

Female Mean Pay (all staff): £21.72

Agenda for Change Staff: £19.94
Medical and Dental Staff: £41.86

Mean Pay Gap (all staff): 14.45%
Agenda for Change staff: -4.55% Medical and Dental Staff: 15.78%

Monitoring our progress

Pay Gaps – Ethnicity

In line with the NHS High Impact Actions and our Public Sector Equality Duty under the Equality Act 2010, we also review our ethnicity pay gap on an annual basis. The data presented here form a snapshot as of 31 March 2025.

Key points:

- Our overall median pay gap between Global Majority and white staff has reduced to 44p in favour of Global Majority colleagues, whereas the overall mean pay gap is £1.49 in favour of White staff.
- The difference between these is due to the distribution of staff across the Agenda for Change banding, with Global Majority staff mostly represented within our middle quartiles and more white staff represented at the lower and upper quartiles.
- We have an ethnicity pay gap within our medical and dental workforce, which has widened slightly (to £10.20 median and £4.74 mean). Analysis is being undertaken to establish recruitment, retention and progression strategies to level this up, whilst also recognising that progress here has been slower in 2024/25 due to reduced recruitment activity.
- Work will begin over 2025/26 and into 2026/27 to understand the factors influencing medical and dental ethnicity pay gaps across the BSW Hospitals Group.

Global Majority Median Pay (all staff): £20.26

Agenda for Change Staff: £19.80
Medical and Dental Staff: £35.99

White Median Pay (all staff): £19.82

Agenda for Change Staff: £18.66
Medical and Dental Staff: £46.19

Median Pay Gap (all staff): -2.30%
Agenda for Change staff: -6.13% Medical and Dental Staff: 22.07%

Global Majority Mean Pay (all staff): £21.61

Agenda for Change Staff: £19.57
Medical and Dental Staff: £42.03

White Mean Pay (all staff): £23.10

Agenda for Change Staff: £19.83
Medical and Dental Staff: £46.77

Mean Pay Gap (all staff): 6.43%
Agenda for Change staff: 1.29% Medical and Dental Staff: 10.14%

Monitoring our progress

NHS High Impact Actions for the NHS EDI Improvement Plan.

1

Measurable EDI objectives for Chairs, Chief Executives and Board members

All Executive's now have measurable EDI objectives embedded within their appraisals and reflect on their impact as part of the appraisal process. EDI effectiveness is also embedded into the Board Self Assessment Tool.

2

Overhaul recruitment processes and embed talent management processes

We have trained a team of Independent Inclusion Advisors (RCN Cultural Ambassadors) to help review and co-create new approaches to recruitment to remove bias from processes. A Group talent management plan, aiming to design-out barriers to inclusive progression will form part of the 2026/27 People Plan

3

Eliminate total pay gaps with respect to race, disability and gender

We have started to address pay gaps by increasing our focus on inclusive recruitment, positive action, and a range of reviewed policies and procedures aiming to design-out blockers to progression. More nuanced data analysis is still required to understand more clearly the experiences of colleagues with protected characteristics.

4

Address health inequalities within the workforce

We continue to monitor the support provided to staff through our annual Equality Delivery System review and have developed actions to support staff with specific health conditions. Reviewed Employee Assistance Programme (EAP) now more responsive to demographic factors in health and wellbeing provision.

5

Comprehensive induction and onboarding programme for International recruited staff

Our support package for internationally recruited colleagues has been extremely successful and lead to high retention rates. With this recruitment avenue no longer active, our focus is on supporting internationally recruited colleagues to thrive and progress their careers with us.

6

Eliminate conditions and environment in which bullying, harassment and physical harassment occurs

Reducing discrimination and improving the reporting of incidents remains key to the RUH People Plan. We have increased reporting safety by adopting Report+Support, working more closely with Freedom to Speak Up and developing our People Hub to provide equitable support and guidance towards resolution.

Looking to the year ahead

Our action plan for the next 12-18 months focusses on continuing the positive progress made so far. These actions align with our three core EDI goals:

Create safe, inclusive, diverse teams and working environments in which people feel they belong, are valued, and can thrive.

We will continue to build our network of Inclusion Champions, aiming to have one in every ward and team across the RUH. This helps to ensure allyship is more than just words, with colleagues taking an active role in leading change in their teams to create truly inclusive environments. We will develop our approach to EDI engagement and network membership by creating an intersectional programme of activity.

Having focussed on reducing discrimination for the last two years, our 2025/26 programme of activity will embed the work undertaken to improve experiences for those with disability or long-term health conditions, and colleagues from the Global Majority.

Design-in inclusive practices at all levels, advocating the benefits of this both internally and to our wider community.

We will be using our local people data to understand more accurately what and where the true blockers to inclusion are, and establishing targeted interventions to remove them.

Working with the other care organisations in BSW Hospitals Group, we will be establishing a design centre of excellence for inclusive practice. Drawing strongly on data analysis, coproduction, current research and best practice guidance, we will develop new processes for attraction, recruitment, retention and progression, which are sensitive to the widest possible range of needs and preferences.

Reduce occurrences of discrimination, prejudice, abuse, and harassment based on difference across the organisation.

We have seen improvements in this area, but we need to stay focused on building psychologically safe forums for sharing experiences, understanding the cause of negative experience and taking impactful action to address concerns.

Proactively, this will involve increased delivery of our newly-launch leadership and change management programmes (which are oriented around ethical, compassionate and inclusive practice), building the strength and confidence of our inclusion champions, and engaging our staff networks with our inclusion data to coproduce meaningful actions that make a genuine difference.

Everyone Matters

Diversity is a fact. It is about each of us and the variety of unique experiences, qualities, and characteristics we all possess.

Working Together

Inclusion is an act, and together we strive for Equity. We work to promote fairness in our procedures and processes, remove barriers and create a culture that embraces, respects and values difference.

Making a Difference

Belonging is the outcome, where every person feels part of the team.

Royal United Hospitals Bath
NHS Foundation Trust

Equality, Diversity, and Inclusion Action plan 2025/26

EDI Action Plan: 2024/25-2026

The below table provides a progress update to our 2024/25 EDI action plan, which will continue into 2026. In 2026/27 there will be a BSW Hospitals Group People Plan, which will enable one strategic programme of inclusion practice for all three care organisations. This will improve impact through better alignment, whilst retaining a local focus based on local data.

EDI Action Plan 2024/25		
Executive Lead: Chief People Officer (BSW Hospitals Group) **Programme SRO: Associate Director for People – Culture Change (RUH)**		
Action	**Progress and/or new activity 2025/26**	**Project Coordination Lead**
1.Contintue to recruit and embed Inclusion Champions across the RUH. Working to develop role models of active allyship through training, meetings, and annual development sessions for Inclusion Champions.	Network of inclusion champions continues to grow (150% since 2024), with a steady stream of new sign-ups. Aim is to have one in each RUH team by the end of 2026/27. Focus for 2025/26 is to ensure continued engagement with staff networks, EDI team and internal inclusion agenda.	Equality, Diversity and Inclusion (EDI) Facilitator
2: Continue to develop the role of the Executive sponsors for Staff Networks and engagement sessions for senior leaders.	Networks continue to have executive and non-executive sponsors. Network members have increased by around 35% over the last twelve months. 2025/26 focus is on improving capacity and release for network chairs, and greater alignment with strategic inclusion programmes (including our new intersectional / topical inclusion weeks)	EDI Facilitator
3: Lead an organisation wide engagement strategy to increase the number of staff engaging with staff networks by 20% in 2025.	We have seen a 35% increase in network membership and 150% increase in the number of inclusion champions.	EDI Facilitator

	Ongoing work is to coproduce a BSW Hospitals Group approach to the networks, and to ensure activity is aimed at making tangible change, as well as providing representation.	
4. Develop a team of 20 Independent Advisors across the Trust to lead a 'people processes' programme of review. Review to start with recruitment process from start to end. Employee Relations processes to be the second phase after 6-8 months. Recruitment to begin July 2024 and training to begin October 2024.	We have trained and supported our first cohort (currently preparing for the second). Advisors will support recruitment panels for those with protected characteristics applying for Band 7 and above roles. The work with Employee Relations has been paused due to capacity, but is planned to commence once the BSW Group People Function develops its central hub.	Head of EDI / Head of Resourcing
5. Continue to deliver the positive action programme *Routes to Success*. Cohort 2 to begin in September 2024 with an ongoing sustainability plan for the programme developed by November 2024. This includes embedding the programme as business as usual for the Nursing Workforce offering.	Programme continues to run with growing energy and success. Twenty-one more colleagues have undertaken the programme, all with sponsors. 2026: Measure impact, increase development offer for sponsors and scale-up to provide the opportunity to Global Majority colleagues across BSW Hospitals Group.	Head of EDI
6. Work in collaboration with talent colleagues and REACH Network to promote and support informal and formal mentoring offers.	Deferred to 2026/27	Head of EDI / Head of Leadership and Change Management
7a. Launch new reporting system summer 2024 'Report and Support' and work in collaboration with Divisional People Partners and the People Hub to promote the platform. 7b. Work with Divisional People Partners and Culture Team to deliver tailored and specific messaging around the use of Report and Support and Dignity at Work policies based on outcomes from NHS Staff Survey results.	System launched and being used, enabling rapid intervention to support those having adverse experiences. Also enables thematic data analysis to improve the quality of the people service offered to colleagues. 2026: Review efficacy and return-on-investment in relation to Staff Survey results and our demographic data. People Hub and Divisional People Partners respond to concerns raised, (as through other reporting systems), and use data to influence policy / process development.	Head of People Hub / Head of EDI / EDI Facilitator

8. Work in collaboration with the People Hub to develop best practice skills and approaches to handling cases of bullying, harassment and abuse reported through the new system.	Collaborative working has been increasing since initial sessions around the use of Report+Support. Action complete with work ongoing.	Head of EDI / Head of People Hub / DPPs
9. Deliver a communication plan to improve the representation of Disabled and neurodiverse staff and those with a long-term health conditions in day-to-day communications and campaigns.	Initial work has commenced, and is now part of a larger communication style, tone and accessibility review. 2025/26: Forms part of strategic design work for the new communications function that will serve BSW Hospitals Group.	Head of EDI / Communications Officer
10. Develop a resource hub with information on allyship for disabled and neurodiverse staff, as well as easy access information on services and support available for those who need it.	We have established a Neurodiversity Support Group (an off-shoot of our Enable Network), which is working to collate a resource hub in collaboration with specialists and experts by experience from across the organisation and beyond (e.g. internal Learning Disabilities service and Employment Inclusion).	EDI Facilitator / Neurodiversity Support Group Chair
11. Increase links with local community groups to improve sign posting and connectivity for all staff networks, as well as wider system support to develop opportunities for external and joint education and awareness events.	Individual networks have been establishing links with local organisations and partnerships, as well as larger national bodies (such as RCN). Our seasonal inclusion agenda draws on external and local expertise (e.g. from local mental health organisations).	Head of Equality, Diversity, and Inclusion / Equality, Diversity, and Inclusion Facilitator SRO: Associate Director for People & Culture Change
12. Lead a project to review the accessibility and inclusivity of the RUH site and how we compare against Disability Confident Frameworks.	A site accessibility audit has commenced using internal, specialist expertise in collaboration with our Enable Network. Results will be used to inform future decisions about the development and maintenance of our estate to remove barriers to inclusion. Results expected: January 2026	Head of Equality, Diversity, and Inclusion SRO: Associate Director for People & Culture Change

13. Support a programme of work to understand and address gender and ethnicity pay gap challenges within Medical and Dental workforce. Delivering all national actions as outlined in the NHS EDI Action Plan.	Analysis of pay differentials within Medical and Dental has been undertaken, and we are now using this to inform how we resource those professional groups. Progress in this area is likely to remain steady since turnover in those roles is slow.	Medical Workforce Partner with support from Head of EDI SRO: Deputy Chief Medical Officer with support from Associate Director for People & Culture Change
14. Develop a plan of action in line with NHS England's national approach to the LGBTQ+ Rainbow badge scheme. To include reviewing the next accreditation cycle and any outstanding actions to help develop equity in experience for staff and patients.	Our LGBTQ+ Network have been taking the lead with distributing the Rainbow badges and sign-posting colleagues to further educational resources, as well as encouraging colleagues to pledge their allyship and allegiance. Full plan of action is in progress, pending National guidance on the continuation of the scheme.	Head of Equality, Diversity, and Inclusion. SRO: Associate Director for People & Culture Change
15. Work in collaboration with Deputy Chief Nurse, strategic improvement teams and Trust governance teams to develop a standardised approach to Equality Impact Assessments and their application across trust wide decision-making processes. To include creation of guidance for staff and development of key staff members to support skill growth in all areas.	Work in progress: Standard EQIA templates and processes have been created and are in the process of being refined and piloted.	Head of Equality, Diversity, and Inclusion. SRO: Deputy Chief Nursing Officer

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**19**
Date of Meeting:	**5 November 2025**		
Title of Report:	**Non-Clinical Governance Committee Upward Report**		
Status	**For discussion**		
Author	**Sumita Hutchison, Interim Vice Chair**		

Key discussion points and matters to be escalated from the meeting on 15 September 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

- SALIX Decarbonisation Programme (Capital Risk)
  - The £24m SALIX decarbonisation scheme (with £13m to be spent by 31 March 2026) is at significant risk due to the financial instability of a key subcontractor responsible for manufacturing heat-pump infrastructure.
  - If delivery milestones are not met, grant funding may be forfeited, and the Trust would have to self-fund remaining works.
  - Mitigations: contractor engagement to recover manufactured components, exploring alternate suppliers, and ongoing dialogue with funders for flexibility.
  - Escalate to Board for oversight and inclusion in financial risk reporting. A detailed Situation, Background, Assessment and Recommendation (SBAR) report and financial exposure estimate will follow.

- Electronic Patient Record (EPR) Programme Viability and Re-phasing
  - The EPR Group Programme faces capacity, resourcing and timing pressures.
  - Clinical, digital, and operational capacity are stretched; recruitment delays mean several posts remain vacant.
  - The SRO warned that, under current conditions, the programme cannot be delivered to its original timeline or scope.
  - Recommendations for the Board to consider:
    - Commission a full options appraisal to assess implications of elongating timelines, re-phasing go-lives, or adjusting scope (including the late addition of Sulis).

        - Determine the strategic prioritisation of the programme against recovery and financial pressures.

- Cleaning Standards
    - Despite recruitment of 37 new cleaners, performance remains inconsistent and below target.
    - High turnover, sickness and continued reliance on high amount of bank hours per week are causing variance across wards.
    - Environmental clutter and ageing estate further limit cleaning outcomes.
    - No reduction in risk score is proposed; in fact, risk could worsen under agency/bank controls.
    - Board awareness required: potential impact on infection prevention and staff morale.

- Information Governance & Cyber Security
    - The KPMG Data Security and Protection Toolkit (DSPT) audit resulted in partial assurance, highlighting documentation gaps and capacity constraints within the Information Governance (IG) and Cyber Teams.
    - Remedial actions are underway, led by the Associate Director of Information Assurance and Data Protection Officer.
    - The Board is asked to note that there is resource fragility and single-point-of-failure risk in IG.
    - A follow-up report will return to Audit & Risk Committee and the Non-Clinical Governance Committee (December) for progress assurance.

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

- Digital Infrastructure and Legacy Systems
    - Continued reliance on out-of-support systems (e.g., Winscribe dictation, Windows 2008 servers) poses resilience and clinical risks (e.g. backlog of letters, delayed coding).

- Mitigation: procurement of TPro dictation platform underway; migration from legacy servers starting imminently.

- Assurance improving but remains fragile pending implementation.

- Clinical Coding Backlog
  - Persistent backlog of uncoded data impacting data quality, mortality statistics, and potentially patient-safety analytics.

  - While elective coding (and associated income) is prioritised, non-elective coding delays risk masking patient-safety trends.

  - Options under discussion to contract external coding support or expand AI-assisted solutions.

- Workforce Dependence in Cleaning and Estates
  - Heavy reliance on bank/agency cleaning hours continues.

  - Variability in ward standards linked to workforce instability and environmental clutter.

  - Requires continued monitoring by Estates & Facilities Board and Infection Prevention and Control Committee.

- Climate Adaptation and Sustainability Capacity
  - The BSW Hospitals Group Climate Change Adaptation Plan is a robust piece of work, but delivery capacity is extremely limited.

  - The Sustainability Team lacks resource to progress medium-term actions; there is a growing gap between strategic ambition and deliverability due to financial pressures.

  - The Committee agreed to flag this to Board as a strategic risk to net-zero and adaptation commitments.

ASSURE: Inform the Board where positive assurance has been achieved

- Facilities Network / Cyber Security
  - Advanced Threat Protection (Microsoft Defender) now rolled out to almost all devices, reducing cyber risk scores from 12→6.

- Capital Programme Delivery
    - In-year capital investment on track, with robust project governance through Estates & Facilities Board and Capital Committee.
    - Fire Safety Programme nearing completion with strong clinical cooperation.
- Recruitment Drive in Cleaning
- 37 cleaners appointed and 10 further posts advertised, indicating positive momentum despite turnover challenges.

RISK: Advise the Board which risks were discussed and if any new risks were identified

- The risks that were discussed by the Committee are highlighted throughout the report.

CELEBRATING OUTSTANDING: Share any practice innovation or action that the committee considers to be outstanding

- Climate Change Adaptation Paper
    - Excellent cross-trust collaboration producing a comprehensive, evidence-based plan.
    - Recognised by committee for quality and clarity.
    - Constructive suggestions to strengthen it with anchor partnerships and nature-based solutions.
- Digital Team Progress
    - Significant advances in Advanced Threat Protection deployment, and pragmatic management of ageing infrastructure risks.
- Capital and Estates Management
- Completion of major fire safety works in Princess Anne Wing noted as an example of effective working.

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:**	**20**
Date of Meeting:	**5 November 2025**		
Title of Report:	**Charities Committee Upward Report**		
Status	**For discussion**		
Author	**Sumita Hutchison, Interim Vice Chair**		

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

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

- Income shortfall & pressure on General Fund/Reserves. Year to date (YTD) income to August 2025 is materially below budget mainly due to weaker-than-planned donations and legacy receipts; legacy accruals not yet converting to cash. YTD expenditure is significantly above plan (c.£2.1m vs c.£1.3m), largely driven by Cancer Centre car park demolition.

  The Board is asked to note the risk to the General Fund if income slips and endorse close in-year control and contingency triggers if half 2 (H2) income lags.

- Investment policy suitability in current market. £4.1m held with Barclays: £1.4m in cash (rate notified to fall from 1.45% to 1.40% in November) and £2.7m discretionary (bonds/equities). While YTD return is improved (3.57% vs 2.03% in the prior year), the Committee queried whether the risk/return and cash-versus-discretionary split remain optimal given the near-term cash calls (Cancer Centre works) and rates available elsewhere.

  The Board is asked to support a time-boxed review of the Investment Policy and provider performance, balancing liquidity needs with risk-appropriate returns.

- Green Heart risk. The Committee wishes this risk (as previously referenced) to be explicitly flagged to the Board. Capital funding requirements to fulfil both donor wishes and planning obligations.

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

- Restricted research funds not fully mobilised Trust-wide. Current research activity is healthy but skewed to areas with historical restricted funds (e.g., rheumatology). Capacity and process frictions mean some designated/restricted pots are under-utilised.

  Action in train: Engagement with fund leads (e.g., liver/leukaemia) to unlock spend; website/process updates so staff can clearly apply for research funding;

explore creating a designated, non-restricted “Small Grants – Research” pot (target c.£50k) to enable Trust-wide calls.

ASSURE: Inform the Board where positive assurance has been achieved

- Annual Report & Accounts. Committee approved the Annual Report and Financial Statements for recommendation to Trustees, subject to minor tidy-ups. Narrative increasingly evidences improving trajectory and impact.

- Reserves Policy. Policy approach unchanged; calculation refreshed. Correction noted in paper; required reserve level confirmed at £530k (increase reflects staff retention and therefore higher potential redundancy provision). The Committee noted and accepted the amendment.

- Investment performance (year-to-date). Despite the cash rate step-down notice, overall investment performance is up on prior year; unrealised gains reported (£177k YTD).

RISK: Advise the Board which risks were discussed and if any new risks were identified

- The risks that the Committee discussed are highlighted throughout the report.

CELEBRATING OUTSTANDING: Share any practice innovation or action that the committee considers to be outstanding

- Research impact and breadth. Strong, patient-benefitting portfolio enabled by charitable funds.

- Reporting quality and delivery. The Finance Team’s work to progress the accounts through audit and present clear variance drivers was commended. The growing, positive narrative for RUHX’s impact and trajectory was recognised by the Committee.

APPROVALS: Decisions and Approvals made by the Committee

The Committee approved:

- The Charities Annual Report and Accounts and recommended them for approval and signing to the Trustees.
- A number of grant applications.
- The External Fundraisers Policy.
- A higher reserve level of £530k.

The following decisions and endorsements are requested from the Board:

- Endorse an Investment Policy review and time-boxed working-group activity.
- Note the General Fund/Reserves exposure and endorse management’s proposed in-year grip/trigger approach.

- Note the Reserves Policy update (new figure £530k) and the approved Annual Report & Accounts for Trustee signing (subject to minor edits).
- Note the research actions and support creation of a designated, non-restricted small-grants pot (seed-funding route to come back with options).

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**21**
Date of Meeting:	**5 November 2025**		
Title of Report:	**Alert, Advise and Assure Report – Audit & Risk Committee**		
Status:	**For information**		
Author:	**Joy Luxford, Non-Executive Director**		

Key Discussion Points and Matters to be escalated from the meeting held on 30 September 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

- None noted at this meeting.

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

- KPMG, the Internal Auditor flagged that 18 actions (previously agreed by management) were overdue and needed management action in a timely manner to address the identified risks. The Audit Committee agreed a new approach to support the progression of recommendations but inaction will lead to a repeat of the 'Partial Assurance with improvements required' opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control at the end of the year. There is a need to maintain close oversight of key Internal Audit Actions arising throughout the year and to implement lessons learnt from the FY24/25 audit processes.
- Deloitte, the External Auditor noted an over-run in the Trust's audit fieldwork during the FY24/25 audit which will lead to additional costs. The Audit Committee requested that Deloitte present the figures and rationale at the next meeting and that lessons learnt should be incorporated formally into the Audit Plan for FY25/26 to enable the Audit Committee to oversee implementation.

ASSURE: Inform the board where positive assurance has been achieved

- The Internal Audit report on Cyber Assessment Framework (CAF) aligned Data Security & Protection Toolkit was given an assurance rating of Partial Assurance with improvement required', (amber / red). This highlighted risks around data security and protection, resourcing of IT including single points of failure, and the cultural change needed to implement improvement programmes at the required pace. Management accepted the recommendations and have agreed to implement improvements to mitigate or minimise the risks identified.
- The Local Counter Fraud Service deep dive report on RUHX was received and it was noted that 14 recommendations were made in relation to design and operating effectiveness of controls. All recommendations were accepted by management with action plans put in place to address the risks identified.

• The Committee noted progress in relation to finalisation of the annual accounts FY24/25 including the Charity Accounts. • The Committee noted the submission of the National Cost Collection (NCC) report and received assurance around increasing data quality, reduced number of errors and referred the results to the Financial and Performance Committee to note the group benchmarking on cost control.
RISK: Advise the board which risks were discussed and if any new risks were identified
Risks were discussed in relation to • data security and protection (As per internal audit report noted in ASSURE section) and • The significant increase in uncoded activity (c. £65m transactions) in FY24/25 within the NCC report, due to resourcing constraints, which represents a significant proportion of non-elective activity and raises risks in spotting trends in health or mortality outcomes and ensuring completeness of income collection.
CELEBRATING OUTSTANDING: Share any practice, innovation or action that the committee considers to be outstanding
• None noted this meeting.
APPROVALS: Decisions and Approvals made by the Committee
• The Committee approved that the Chair and Senior Finance Team could review the change to the journal posting process (as required as part of the financial system upgrade which will happen between meetings) and report back impact, risk mitigation and any new controls at the next meeting. • The Committee noted reports relating to 1 internal audit, 1 Local Counter Fraud Service deep-dive, debtors and creditors, overpayments, waivers or breaches of standing orders, losses and special payments.

The Board is asked to NOTE the content of the report.

Royal United Hospitals Bath
NHS Foundation Trust

RZ2.Report to:	**Public Board of Directors**	**Agenda item:**	**22**
Date of Meeting:	**5 November 2025**		
Title of Report:	**Alert, Advise and Assure Report – Finance & Performance Committee**		
Status:	**For information**		
Author:	**Joy Luxford, Non-Executive Director**		

Key Discussion Points and Matters to be escalated from the meeting held on 23 September 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

- Financial - The RUH Group is £11.7m adverse to the plan at the end of August which has triggered regulatory intervention. The key reason YTD is £9.7m variance arising from under delivery of the £29.7m savings programme. Acceleration of delivery of the recovery plan and scoping of further areas to close the unidentified gap must be top priorities for the organisation. A key focus in the revised recovery plan is lower utilisation of bank staff, not consuming escalation beds and financial recovery at Sulis which requires more efficient use of the additional surgical capacity and the Community Diagnostic Centre (CDC). The board needs to keep under careful consideration its risk appetite in these areas.
- Operational/Performance - As a consequence of our performance against our constitutional standards in Referral to Treatment (RTT), Diagnostics, Cancer and Urgent and Emergency Care (UEC) we remain in tier 1, which has resulted in higher levels of scrutiny and the need to show improving trajectories against our submitted annual plan. The 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.
- Given high demand growth and higher than planned Non-Criteria to Reside (NCTR) and the remaining £10.8m unidentified saving targets there is significant risk in delivering the existing recovery plan to achieve a £19m deficit (forecast position). RUH has been further challenged to improve its forecast financial performance by an additional £2m before year-end (£17m deficit at year-end). The additional stretch target is considered work in process and at this stage key elements could be at risk.

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

- Progress has been made on the plans to support the 2025/26 financial recovery plan. They have now been incorporated into the relevant divisional budgets. There remains gaps in terms of achieving the overall ambition and work continues to address this. A pragmatic view has been sought on the realisation of the schemes, with substitution where appropriate. Pace of execution, and partner organisation contractual support, continues to be key

drivers for success. The RUH Managing Director will escalate concerns around delivery by partners to NHS England (NHSE) in tiering meetings to seek efficient and safe patient pathways, mitigate discharge delay, and impact to NCTR.

- 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 going forward.
- With the publishing of the NHS 10 year plan, providers are required to produce a medium term plan for the next 5 years to be completed by the end of December. The BSW system is being supported by an external financial consultant to ensure alignment across the group. The Committee discussed the need to incorporate lessons learnt from this year's plan into forward planning.
- The Board should note delays in approval of Capital funding from the Region and NHSE which increases the risk to delivery of our capital programme, potential loss of capital funds, and difficulty in completion of projects this financial year due to time constraints. This issue will be escalated to NHSE by the MD in tiering meetings to mitigate delays and seek to improve capital project success.

ASSURE: Inform the board where positive assurance has been achieved

- The committee received reassuring descriptions of the improvement work and programme activities against constitutional standards in Referral to Treatment (RTT), Diagnostics, Cancer and Urgent and Emergency Care (UEC) and financial recovery plans.

RISK: Advise the board which risks were discussed and if any new risks were identified

- The committee discussed the wording and scoring of the corporate risk (3165) around delivery of the annual financial plan and recommended an increase to the likelihood of the risk from 4 to 5, resulting in a new risk score total = 20 (highly likely - 5, major impact - 4) with controls and actions needing immediate implementation to mitigate the associated risk.

CELEBRATING OUTSTANDING: Share any practice, innovation or action that the committee considers to be outstanding

- The efforts of the whole team in identification and delivery of the recovery plan should be recognised. It should be noted that the operational performance shows an improving trend against the constitutional standards. Although they still fall short of the target requirements there is evidence that trajectories are moving towards the submitted annual plan.

APPROVALS: Decisions and Approvals made by the Committee

- The committee recommends to the RUH Board that it awards via Chair's Action a construction works contract to KP Wilton Ltd for the delivery of the Admission and Transfer Lounge for a contract period of 8 months. This capital project is expected to deliver a step-change in Urgent and Emergency Care (UEC) performance, patient flow, and care quality through targeted estate enhancements. The funding and the business case are yet to be confirmed by NHSE for this project, but they are expected in the next 2 months. At this stage in the financial year, a preferred supplier for the work is required to give the Trust the best opportunity to deliver the project should funding become available. Given the tight timeframes expected, the committee recommends that this is enacted under Chair's Action to expedite progression to contract commitment, subject to business case and funding approval, CPMG approval and Head of Financial Services approval. Approval of this recommendation report does not commit the Trust to spending this contract value with the supplier at this stage. The contract value is £1,410,220 incl. VAT and a competitive process was undertaken to determine the preferred supplier.

The Board is asked to NOTE the content of the report.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Board of directors**	**Agenda item:**	**22.1**
Date of Meeting:	**29/10/25**		
Title of Report:	**Alert, Advise and Assure Report FPC Committee**		
Status:	**For information**		
Author:	**Antony Durbacz**		

Key Discussion Points and Matters to be escalated from the meeting held on 29/10/25

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

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

- RUH has committed to a challenging financial objective for the year at a deficit of £17m deficit. With significant improvements in underlying performance in the second half of the year to deliver this objective. The trust highlights an unmitigated risk against this objective of £6.5m. Within the risks the severity of winter is included but is inevitably difficult to quantify. Through enquiry there is evidence of logically designed and documented pathways to achieving this objective. Indeed, in the month the trajectory was achieved. Progress against these objectives will be closely monitored against these trajectories. There was evidence that there was correlation between most of the investments required to improve operational performance but the new requirements arising from ED will require additional resource beyond that assumed in the plan.
- The external scrutiny of the operational performance remains intense with focus being applied at numerous levels within the NHS. Although intense its also clear that some of the support has been positive and constructive
- As is to be expected, the operational recovery profiles are well documented and understood. During the month overall performance against the trajectories have been mixed. There is now a clear definition of what needs to happen both externally and internally to achieve the objectives. Demand remains a prime factor.

ASSURE: Inform the board where positive assurance has been achieved

-

RISK: Advise the board which risks where discussed and if any new risks were identified.

- As RUH transitions into the group structure greater clarity needs to be established on investment approval processes. This is also complicated by the existing spending restrictions
- Preparation for the business plan are underway, with some national guidance now being received. Timelines are challenging and the requirement is more

onerous than previously, with an extended 3 year reach and profiling within those years. In addition, there is the complication of : resource stretch, even more challenging performance objectives, the evolving Group structure and uncertainty on the outturn of the 2026 financial picture. • At a local level there is uncertainty on the progress of the EPR programme and its potential impact in year.
CELEBRATING OUTSTANDING: Share any practice, innovation or action that the committee considers to be outstanding
• The team has been under extreme scrutiny but they continue to be positive and professional in the way they address the challenges
APPROVALS: Decisions and Approvals made by the Committee
• The committee recommends to the board approval of the investment in the provision of a new MRI scanner at Sulis. It was satisfied that the appropriate supply chain procedures had been applied. It did not review the underlying business case • The committee recommends to the board approval of the investment in the refurbishment of the B12 neurology building. It was satisfied that the appropriate supply chain procedures had been applied. It did not review the underlying business case

The Board is asked to NOTE the content of the report.