Bundle Public Board of Directors 4 March 2026

0 Agenda
- 0.0 - Draft Public BoD Agenda Mar 26 v1.5 - 03.03.26

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Apologies
Andrew Hollowood

2 Written Questions from the Public

3 Minutes of the Board of Directors meeting held in public on 14 January 2026
- 3.0 - DRAFT Public BoD Minutes Jan v1.0 - 09.02.26

4 Action List and Matters Arising
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- 6.0 - RUH MD CEO Public BoD Report FebMar 26

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- 10.0 - QAC upward report Feb v2

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12 Finance and Performance Committee Upward Report
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16 Mortality Update
- 16.0 - Mortality Update - BOARD March 2026
- 16.1 - Quarterly Learning From Deaths Report Q2 25 26 Final
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17 Maternity Incentive Scheme / Clinical Negligence Scheme for Trusts Sign Off (for noting in public)
- 17.0 - MIS board report Year 7 (2)
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18 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 4 MARCH 2026, 09:30 – 12:00 VENUE: ROOM G.07, BATH SPA UNIVERSITY LOCKSBROOK CAMPUS, LOCKSBROOK ROAD, BATH, BA1 3EL

Item	Item	Presenter	Enc.	For
1.	Chair's Welcome, Introductions, Apologies and Declarations of Interest: Andrew Hollowood	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 14 January 2026		Enc.	A
4.	Action Log		Enc.	A/D
5.	Patient Story	Toni Lynch, Chief Nursing Officer	Pres.	I/D
6.	CEO and Managing Director's Report	Cara Charles-Barks, Chief Executive / John Palmer, Managing Director	Enc.	I
7.	Chair's Report	Liam Coleman, Interim Chair	Enc.	I
8.	Item withdrawn			
9.	Management Executive Committee Upward Report	John Palmer, Managing Director	Enc.	I/D
10.	Quality Assurance Committee Upward Report	Simon Harrod, Non-Executive Director	Enc.	I/D
11.	People Committee Upward Report	Paul Fairhurst Non-Executive Director	Enc.	I/D
12.	Finance and Performance Committee Upward Report	Antony Durbacz, Non-Executive Director	Enc.	I/D
13.	Charities Committee Upward Report	Sumita Hutchison, Non-Executive Director	Enc.	I/D
14.	Subsidiary Oversight Committee Terms of Reference for Approval	Antony Durbacz, Non-Executive Director	Enc.	A
15.	Integrated Performance Report	Kheelna Bavalia, Interim Chief Medical Officer	Enc.	I/D
16.	Mortality Update	Kheelna Bavalia, Interim Chief Medical Officer	Enc.	I/D
17.	Maternity Incentive Scheme / Clinical Negligence Scheme for Trusts Sign Off (for noting in public)	Toni Lynch, Chief Nursing Officer	Enc.	I
CLOSING BUSINESS				
18.	Any Other Business	Liam Coleman, Interim Chair	Verbal	-
19.	Resolution to exclude the press and public that representatives of the press and other members of the	Liam Coleman, Interim Chair	Verbal	

	public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest. Business to be discussed in private session includes: • Detailed financial reports; • Commercially in confidence reports			

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 14 JANUARY 2026, 09:30 – 12:00
VENUE: ROOM T0.24, BATH SPA UNIVERSITY, SION HILL, BATH, BA1 5SF

Present:

Members

Liam Coleman, Chair *(Chair)*
Sumita Hutchison, Interim Vice-Chair
Simon Harrod, Non-Executive Director
Joy Luxford, Non-Executive Director
Hannah Morley, Non-Executive Director
Antony Durbacz, Non-Executive Director
Paul Fairhurst, Non-Executive Director
Cara Charles-Barks, Chief Executive
Jude Gray, Group Chief People Officer
Simon Wade, Group Chief Finance Officer
Andrew Hollowood, Clinical Strategic Transformation Director
Jonathan Hinchliffe, Group Transformation and Innovation Officer (Interim)
John Palmer, Managing Director
Toni Lynch, Chief Nursing Officer
Sarah Richards, Deputy Chief Medical Officer *(deputising for the Chief Medical Officer)*

In attendance

Roxy Milbourne, Interim Head of Corporate Governance
Jodie da Rosa, Head of Midwifery *(item 6 & 11)*
Zita Martinez, Director of Midwifery *(items 6 & 11)*
Jo Baker, Associate Director for Vulnerable People *(item 12)*
Abby Strange, Corporate Governance Manager *(minute taker)*
Governor Observers
Members of the public

Apologies

Kheelna Bavalia, Interim Chief Medical Officer
Bernie Bluhm, Chief Operating Officer

BD/26/01/01 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. The Board noted that the Chief Operating Officer was not in attendance due to the ongoing critical incident at the Trust. They confirmed that they had no additional interests to declare.

BD/26/01/02 Written questions from the public

The Interim Chair confirmed that no written questions had been received from the public.

BD/26/01/03 Minutes of the Board of Directors meeting held in public on 5th November 2025

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

BD/26/01/04 Action List and Matters Arising
The actions presented for closure were approved.

Sumita Hutchison referenced a question that she had asked around patients who were dying in hospital and should be dying elsewhere. She asked that this was recorded as an action to investigate through the Quality Assurance Committee (QAC).

Action: Corporate Governance Manager

BD/26/01/05 Governor Log of Assurance Questions and Responses
The Governor Log was presented for information.

BD/26/01/06 Parent Story
The Chief Nursing Officer welcomed the Director of Midwifery and the Head of Midwifery and Neonates to the meeting and introduced the Parent Story which centred around the death of a child, Albie. Albie was born at the RUH in April 2022 and very sadly passed away as he and his parents travelled home from the hospital. The case was subject to a coronial inquest and results from the post-mortem indicated that Albie died from congenital pneumonia. There were concerns regarding Albie's condition during his hospital stay and although he appeared well and had been seen by a consultant prior to discharge, additional actions may have prevented his death. The organisation continued to work closely with Albie's parents to improve services and integrate their voice, and they had requested that his story and the learning from it was shared. It had already been shared at the BSW Hospitals Group Joint Committee and with the Coroner's Office.

The Director of Midwifery and Head of Midwifery and Neonates provided an overview of the learning and actions that had been taken since Albie's death. This included integration of routine pulse oximetry for all newborns, full sets of newborn observations for any baby presenting with soft signs, use of NEWTT2 for structured escalation, strengthened focus on professional curiosity and responsiveness to parental concern, and reinforced culture of early escalation and clear multidisciplinary communication.

The Chief Nursing Officer highlighted two questions that had arisen at the Joint Committee around the implementation of learning across the Group and what feedback Albie's parents were seeking. She explained that learning had been implemented across the Group and two non-symptomatic babies had since been identified as having congenital pneumonia. In terms of feedback, Albie's parents had requested a letter from the Chief Executive, who had agreed to write to them following the presentation.

The Managing Director asked what they key consideration was for maternity services during the current planning cycle. The Director of Midwifery reported that the key focus was workforce. This was being reviewed through Birthrate Plus to ensure that the right staffing models were in place, particularly on Mary Ward. The Chief Nursing Officer added that local intelligence highlighted increasing acuity in maternity and it was likely that an uplift in staffing would be recommended.

The Chief Executive reflected on the increasing acuity in maternity and the wider context for future healthcare provision. She sought clarity on the role of the organisation in prevention, communication, and the medicalisation of giving birth over the next ten years and beyond. The Director of Midwifery advised that modelling needed to be undertaken

around the acute service. She explained that different skillsets were needed to address the increasing elective activity, theatre capacity, inductions, and maintaining flow.

The Interim Chair asked whether the organisation was the main point of contact for Albie's parents during the coronial service delay and whether it had the infrastructure to support parents in navigating this difficult time. The Head of Midwifery and Neonates reported that Albie's family had been supported by the Maternity and Neonatal Independent Senior Advocate NHS pilot and the local bereavement team. This had provided the organisation with invaluable feedback and had improved mortality reviews by ensuring that they were family centred. The Chief Nursing Officer added that Albie's mother, Rebecca, was in the process of becoming a volunteer with the bereavement service and acknowledged the significant difference that she would make.

The Board of Directors noted the report and the learning that had been implemented. They extended their thanks, gratitude, and respect to Albie's parents for their willingness to engage with the organisation and requested that this was recorded in the Chief Executive's letter.

Action: Chief Executive

BD/26/01/07 CEO, Managing Director, and Chair's Report

The Chief Executive provided an overview of the critical risks, with particular emphasis on the financial position and Urgent and Emergency Care (UEC) pressures. She reported that expenditure was being driven by UEC demand and work was ongoing with system partners to address this. Demand had increased significantly over the preceding six weeks, and resetting UEC demand across the system was a key priority for 2026. There had been significant progress in elective recovery, with no patients waiting over 65 weeks at the end of December, and work continued to ensure sustainable recovery. The Group Leadership Team had been strengthened by the appointment of Simon Wade as Chief Finance Officer and Jude Gray as Chief People Officer. The Nomination and Remuneration Committees in Common had also approved the creation of a Chief Risk Officer role and agreed changes to executive portfolios to better support delivery of the Group's strategic aims, operational objectives, and regulatory requirements.

The Managing Director reported that data demonstrated early progress in key areas through the call to action, and while the Trust's national ranking had improved to 105 out of 134. He reiterated the significant achievement of eliminating all 65 week waits and confirmed that the Trust was on trajectory to deliver zero patients waiting over 52 weeks by the end of the financial year. Cancer performance remained challenging; however, a step change had been achieved in the 28 day faster diagnosis standard, with focused work ongoing to address the 62 day backlog. In relation to UEC pressures, discussions continued with the Integrated Care Board (ICB) regarding escalation levels and Non-Criteria to Reside (NCTR).

The Chief Finance Officer reported a 9% growth in monthly income alongside significant productivity gains. The turnaround team had implemented key workstreams with progress overseen through a bi-weekly Financial Intervention Programme Board. While delivery remained challenging, the Trust was in a more positive position in relation to achieving its £17m target deficit.

The Board of Directors reflected on the sustained pressure on the workforce, particularly in relation to sickness absence. The Chief People Officer outlined ongoing revisions to

the Sickness Policy to rebalance the approach between wellbeing and operational discipline. A Task and Finish Group was being established to strengthen grip and understanding of sickness absence, supported by enhanced wellbeing offers, and targeted interventions in areas with the greatest impact on patient care, team resilience, and finances. The Board noted the importance of cultural change, clearer accountability at divisional level, and embedding financial ownership across the organisation. They recognised that the turnaround team was introducing discipline and exploring technical opportunities to decompress the situation without asking the workforce to do more.

The Board acknowledged that many of the benefits from cultural, structural, and technical changes delivered via the turnaround team would be realised over the medium to longer term, with more limited impact on the current year position. They noted that work was ongoing to quantify the financial impact of NCTR and to strengthen the evidence base for system discussions and future planning. They also discussed the sustainability of recent performance improvements. The Chief Executive and Managing Director acknowledged the challenge in balancing recovery with sustainable improvement and confirmed that the focus was on incremental, embedded change, supported by strengthened leadership, Group working, longer-term service redesign, and capital investment priorities.

The Board of Directors noted the report.

BD/26/01/7.1 Chair's Report

The Interim Chair summarised his report and highlighted that the Council of Governors had met on 15th December 2025 to approve the appointment of Kate Cozens, Public Governor for Mendip, as Lead Governor.

The Board of Directors noted the report.

BD/26/01/08 Board Assurance Framework (BAF) Summary Report

The Interim Head of Corporate Governance presented the report and provided an overview of the BAF scorecard which indicated where risk scores had increased, decreased, or remained static since the last report to the Board. She summarised the changes that had been made, highlighting that work was ongoing to split risk 1.2 into two risks focusing on elective and non-elective. Further work was also required around the people risks and the Board would receive the updated risks in March. No material changes had been made to risk 3.1 but the score had increased from 16 to 20 to represent a more realistic likelihood given the financial pressures facing the Trust. Risk 3.8 was a new risk relating to the Joint Electronic Patient Record (EPR) and had been adopted across all three Trusts in December.

The Board of Directors noted the report.

BD/26/01/09 Management Executive Committee (MEC) Upward Report and Terms of Reference for Ratification

The Managing Director summarised the report and presented the updated MEC Terms of Reference for ratification, noting that a minor amendment was required to clarify that the Chief Executive was the Trust's Accountable Officer. He highlighted that constructive discussions were ongoing with the region regarding potential capital investment for the development of a modular unit to relocate the Urgent Treatment Centre. There were also longer term aspirations to rebuild the Emergency Department (ED). This would require capital flexibility, and had been escalated to the region.

The Board of Directors discussed the capital opportunities in ED and whether they aligned with the ten year plan and ambitions to move care into community settings. They agreed that this was not a conflict, acknowledging that while greater integration and investment was needed in the community, the acute infrastructure needed to be right-sized to safely manage demand. The Trust was managing similar patient volumes to peer organisations with a comparatively smaller bed base and ED footprint, and immediate operational pressures required action alongside longer-term transformation. Future models needed to balance integrated, preventative care with sufficient acute capacity.

The Board of Directors noted the report and ratified the updated MEC Terms of Reference subject to the discussed amendment.

BD/26/01/10 Integrated Performance Report (IPR)

The Chief Nursing Officer presented the report. She did not provide an update on finance as this has been covered within item seven.

Operational Performance

UEC performance continued to be significantly impacted by the volume and acuity of patients and corridor care had been introduced as a mitigating measure. Safety mitigations were in place but patient acuity was a challenge and work was ongoing with system partners to improve flow and develop alternative capacity to better meet demand. The Trust was strengthening its review of quality and safety metrics at the front door to better mitigate potential patient harm.

Workforce

Vacancy and turnover rates remained low; however, there were persistent vacancies in key areas, particularly ED. The Trust was actively backfilling through temporary staffing and had implemented an aggressive recruitment plan. Agency usage had increased alongside a modest rise in bank usage. Sickness absence had increased to 6.31% and an improvement group was in place to address this and support staff wellbeing. Appraisal completion had fallen to 78% and recovery would be prioritised once sickness had reduced. Mandatory training remained on target but continued to be closely monitored.

Quality

Mortality indicators remained off track and there were concerns around the ability to triangulate data due to the backlog in clinical coding and Structured Judgement Reviews (SJRs). Safe staffing levels had dipped below expected thresholds on inpatient wards, largely due to sickness absence. C. diff infection rates remained within trajectory, but there had been a concerning increase in November. Rates had risen nationally, with high prevalence in the South West and the Trust was taking a precautionary approach. Reviews had not identified cross-infection or specific causal factors.

The Board queried the apparent correlation between the implementation of the revised sickness policy and a significant increase in sickness absence. They expressed concern and sought clarity on when the policy review would be concluded. The Managing Director reiterated that the issue had been recognised, and a task and finish approach was being taken to analyse the data in detail. The Chief People Officer anticipated that the policy would be signed off via MEC at the end of February.

The Board discussed patient harm and experience associated with corridor care and the known challenges in capturing and evidencing harm in non-clinical environments. The Chief Nursing Officer advised that the Trust had introduced nationally aligned patient information leaflets explaining the reasons for corridor care and offering an apology. Staff were also speaking directly with patients and families, and offering apologies.

The Chief Executive reflected that from April, the Group would begin meet as a Board in Common, with similar issues being considered across the organisations. She suggested that a joint presentation would be valuable to evaluate the impact of the financial challenge on quality and safety. This would be an opportunity to have a robust discussion and around corridor care, sickness absence, and other related risks across the Group. The Chief Nursing Officer confirmed that preparatory work was already underway and she would discuss the suggestion with her Group colleagues.

Action: Chief Nursing Officer

The Board noted the report and collectively emphasised that corridor care was not dignified or aligned with the Trust's values. They apologised to patients and the public for the necessity of this measure.

BD/26/01/11 MIS Combined Maternity and Neonates Quarterly Report Q2

The Interim Chair welcomed the Director of Midwifery and Head of Midwifery and Neonates to the meeting who summarised the report. They highlighted a challenge in the obstetric workforce against the Royal College of Obstetricians and Gynaecologist recommendations. There had been no patient safety incidents related to this but it was likely to impact patient experience and next steps were being devised. The ICB hosted Maternity and Neonatal Voices Partnership was not compliant with national guidance and the Trust had formally escalated this at Trust, ICB, and regional levels. Learning was due to be reviewed from a recent case in Manchester where a woman and her baby had died at home and assurance was provided that the Trust was in a strong position in terms of its home birthing service.

The Chief Executive asked whether initial opportunities had been identified around maternity and working at scale across the Group. The Director of Midwifery confirmed that there was strong communication across the Group, with different strengths having been identified in each service and significant opportunities for improvement, particularly around community services, elective activity, and communication.

Sumita Hutchison sought clarity on what the Trust was doing to improve support for those from global majority backgrounds. The Director of Midwifery confirmed that the Trust had launched a continuity team and had mobilised an equality and equity workstream. This was data driven and while the trends did not indicate that it was an area of concern, the continuity team had been developed to improve dialogue and information gathering.

The Board of Directors noted the report and recognised the improvements that had been made in maternity through the leadership of the Chief Nursing Officer and Director of Midwifery. The Interim Chair thanked the Director of Midwifery and Head of Midwifery and Neonates for attending the meeting.

BD/26/01/12 Safeguarding Strategy for Approval

The Interim Chair welcomed the Associate Director for Vulnerable People to the meeting who provided an overview of the Maternity, Children, and Adult Safeguarding Strategy.

She outlined the ambitions and goals and confirmed that the strategy was aligned to the Vulnerable People Strategy. Safeguarding was complex and the organisation had a commitment to ensure that everyone accessing services received the highest standard of care. The delivery plans created a clear model of work over the next few years with an emphasis on person centre care and a 'think family' approach. The strategy had been approved by the Vulnerable People Committee and QAC.

Paul Fairhurst acknowledged the complexities within safeguarding and suggested that the terminology was clarified to keep the scope of the strategy within the remit of safeguarding duties. The Associate Director for Vulnerable People agreed to review the terminology to ensure that clear boundaries were in place.

Action: Associate Director for Vulnerable People

The Board discussed the need for the Trust to progress this work at a local level while the Group matured. They acknowledged that the delivery plans would be periodically reviewed and decisions would be made in service of both local and Group ambitions. The Chief Executive advised that greater alignment would be delivered over the next year, utilising Improving Together to set strategic intentions and local breakthrough objectives.

The Board of Directors approved the Safeguarding Strategy and the Interim Chair thanked the Associate Director for Vulnerable People for attending the meeting.

BD/26/01/13 Six Monthly Nurse and Allied Health Staffing Report

The Chief Nursing Officer summarised the report which provided an in-depth analysis of the Trust's nursing staffing levels. The report concluded that no further investment was needed for inpatient wards, paediatrics, and ED during the review period. Nursing vacancy and turnover remained low within inpatient wards but there were significant vacancies in ED and a recruitment trajectory was in place. The inpatient fill rate remained consistent for the reporting period but had started to decrease more recently and feedback from staff surveys highlighted a decline in most areas for both Healthcare Support Workers (HCSWs) and nurses.

The Board noted that there was no published evidence base or NHS England (NHSE) identified exemplar organisations to enable benchmarking of the outpatient nursing establishment. They discussed the need to review the multiprofessional workforce and suggested that a similar report should be produced around the medical workforce. The Deputy Chief Medical Officer agreed to produce a standard report going forward.

Action: Deputy Chief Medical Officer

The Chief Executive recommended introducing a retention role in ED to provide pastoral support. The Chief Nursing Officer confirmed that the Trust's retention midwife was working with the ED team and establishments were being reviewed with a view to creating a post within the existing cost base.

The Board discussed the timing of the report and whether more up to date data could be provided going forward. The Chief Nursing Officer explained that the delay in presenting the data related to the significant volume of work that was required. She advised that other sources of contemporaneous data were available through reports such as the IPR.

The Board of Directors noted the report and approved the recommendations as set out within the report.

BD/26/01/14 Learning from Deaths Report Q1

The Deputy Chief Medical Officer provided an overview of the report and highlighted that the RUH was the second lowest performing Trust in the South West for uncoded episodes. Data needed to be interpreted with a significant degree of caution and a Mortality Surveillance Group (MSG) had been stood up to monitor this. There was a significant backlog of SJRs and common themes were included within the report. Of the SJRs that had been completed in Q1, 81% assessed the overall care to be either good or very good and 0% rated overall care as poor or very poor. Mortality was a key metric and it was essential that the Trust introduced appropriate controls to provide better assurance going forward.

The Board had a robust discussion around the backlogs in coding and SJRs and recognised the need for more positive assurance. They noted that MSG would be reviewing variation in resourcing SJRs across the divisions and implementing clear guidance. They emphasised the need to ensure that the coding investment was targeted around recovering the backlog and agreed that the IPR would be used to track regularisation of the dataset going forward. They also requested that QAC challenge and check the recovery trajectory.

Action: Interim Chief Medical Officer
Action: Quality Assurance Committee

The Chief Transformation and Innovation Officer reported that there was an underinvestment in coding across the Group and explained that the RUH was due to commence a twelve week trial Artificial Intelligence enabled coding solution with NHSE. This would eventually be rolled out across the Group and was part of the digital convergence that was needed. The Clinical Strategic Transformation Director shared his concern that coding had been misidentified as the issue around mortality and advised that a Group learning and benchmarking exercise would be done.

The Board of Directors noted the report.

BD/26/01/15 QAC Upward Report and Terms of Reference for Ratification

Simon Harrod summarised the report and presented the updated Committee Terms of Reference for ratification. He highlighted that support services such as coding and complaints were delayed due to gaps in the teams and a shortage of time in job plans.

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

BD/26/01/16 Freedom to Speak Up (FTSU) Q1 and Q2 Report

The Interim Chair welcomed the Salisbury Foundation Trust (SFT) and RUH FTSU Guardians to the meeting who presented the report. They advised that there had been a gap in the service at the Trust due to an extended period of sick leave and the SFT FTSU Guardian had provided the RUH with support to ensure that it remained compliant. They summarised the activity for Q2 of 25/26, detailing the key themes and opportunities for learning and service change. Q1 data was not available and would be reconciled in the end of year report.

The Board discussed the report and their concern that 42% of cases related to staff from a global majority background. They suggested that this was triangulated with other

reports such as the Workforce Race Equality Standard. The RUH FTSU Guardian confirmed that she would triangulate FTSU data with other Equality, Diversity and Inclusion reports.

Action: RUH FTSU Guardian

The Board acknowledged the vulnerability of the FTSU services across the Group. The Chief Executive confirmed that work was ongoing to review FTSU capability and a proposal had been developed to ensure best use of resource.

The Board of Directors noted the report and the Interim Chair thanked the SFT and RUH FTSU Guardians for attending the meeting.

BD/26/01/17 People Committee Upward Report and Terms of Reference for Ratification

Paul Fairhurst summarised the report and presented the Committee's updated Terms of Reference for ratification. The Committee continued to focus on the embedding of change management methodology and capabilities and had not felt assured in terms of adoption and prioritisation. In contrast, a positive report had been received around job planning, with 96% of job plans signed, ranking the Trust second highest in the region.

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

BD/26/01/18 Non-Clinical Governance Committee Upward Report and Terms of Reference for Ratification

Sumita Hutchison provided an overview of the report and presented the Committee's updated Terms of Reference for ratification. Violence and aggression impacting staff safety had been identified as a rising trend and it was suggested that an in depth review was undertaken by the People Committee. There had also been a discussion around fire safety and backlog maintenance, noting that controls were increasingly compensatory and the overall risk trajectory was worsening. Board attention was required to determine whether capital prioritisation and the risk appetite remained appropriate.

The Board had a robust discussion around fire safety and backlog maintenance. They recognised the need to ensure that the risk was being managed as well as mitigated and reflected on the impact of the EPR on the capital plan. They acknowledged that options were being reviewed to prioritise compliance requirements and emphasised the need to ensure that capital allocated to fire safety and backlog maintenance was fully spent. The Chief Finance Officer agreed to provide the Board and Joint Committee with an update on work to review and prioritise capital to deliver on compliance requirements.

Action: Chief Finance Officer

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

BD/26/01/19 Charities Committee Upward Report

Sumita Hutchison summarised the report and advised that while there was a strong forecast for Q4, the in-year charitable financial position was deteriorating due to the phasing of development and legacy income. Risks had also been identified around restricted and unrestricted funds being held for extended periods without delivery plans and non-delivery of the Green Heart landscaped garden for the Dyson Cancer Centre.

The Committee noted the report.

BD/26/01/20 Audit and Risk Committee Upward Report and Terms of Reference for Ratification

Joy Luxford provided an overview of the report and presented the Committee's updated Terms of Reference for ratification. She highlighted that the 24/25 annual financial accounts had been finalised for both the charity and Sulis. The Internal Auditor had flagged that the Trust should prepare for a modified opinion due to the number of actions that were overdue, lack of timely management action, and key internal audit reports with limited assurance. This would impact the External Auditor's value for money statement. New systems had been implemented to ensure closer oversight of key internal audit actions arising throughout the year, but change had not yet been delivered at pace.

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

BD/26/01/21 Finance and Performance Committee Upward Report

Antony Durbacz summarised the report and highlighted that the Committee remained concerned about the Trust's ability to deliver the year-end target deficit and continued to monitor the situation closely. Despite the Trust's financial challenge, the results of the National Cost Collection submission continued to demonstrate that the organisation's overall costs were below the national average.

The Board of Directors noted the report.

BD/26/01/22 Any Other Business

The Chair acknowledged that this was Hannah Morley's last meeting. He thanked her on behalf of the Board for her significant contribution during her time as Non-Executive Director.

The Meeting closed at 12:45

Agenda Item: 4

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

Action No	Details	Agenda Item No	First Raised	Action by	Progress Update & Status	Lead
PB623	**Patient Story** Chief Transformation and Innovation Officer (Interim) to work with the Head of Audiology to develop a case to support other specialties to think about opportunities for self-service and digitalisation. ***January 2026*** This is likely to form part of the broader clinical transformation work to provide a use case for digital enablement.	**BD/25/11/07**	**Nov 2025**	**Mar 2026**	This will be picked up through the Clinical Services Transformation Programme. **To close**	**Chief Transformation and Innovation Officer (Interim)**
PB624	**Annual Mortality Review** Quality Assurance Committee to investigate whether there was evidence that patients were dying in hospital who should be dying elsewhere.	**BD/25/11/15**	**Nov 2025**	**Jan 2026**	A joint piece of work between the re-established Mortality Surveillance Group and End of Life Care Surveillance Group will incorporate this as part of their work to review our palliative care provision. We will align with the ongoing work of the Royal College of Physicians, following their position statement in 2025.There are 2 specific risks (2973, 3241) related to palliative care capacity to note that are under review by	**Quality Assurance Committee**

Action No	Details	Agenda Item No	First Raised	Action by	Progress Update & Status	Lead
					the group. This will go to Clinical Effectiveness Committee in Q2. It is recommended that this action is closed for Board and picked up as action for QAC. **To close**	
PB626	**Non-Clinical Governance Committee Upward Report** Chief Transformation and Innovation Officer (Interim) to share how the business continuity plans accounted for digital service disruption with the Non-Clinical Governance Committee. ***January 2026*** An initial discussion took place with the Chief Operating Officer, Deputy Chief Operating Officer, and EPRR Lead on 24th December 2025. Further work continues.	**BD/25/11/19**	**Nov 2025**	**Mar 2026**	EPRR are conducting Business Continuity Plan (BCP) review with support from Digital Services for those plans affected by cyber security and / or digital disruption. The RUH Chief Operating Officer and Group Chief Transformation and Innovation Officer (Interim) have agreed to conduct joint tabletop exercises in the new financial year, with EPRR updating BCPs and disaster recovery plans. **To close**	**Chief Transformation and Innovation Officer (Interim)**
PB627	**Action List and Matters Arising** Corporate Governance Manager to record an action from the meeting in November 2025 for the Quality Assurance Committee to investigate whether here was evidence that patients were dying in hospital who should be dying elsewhere.	**BD/26/01/04**	**Jan 2026**	**Mar 2026**	Complete. The minutes from the Public Board of Directors meeting in November 2025 have been updated and the action is recorded on the action log under PB624. **To close**	**Corporate Governance Manager**

Action No	Details	Agenda Item No	First Raised	Action by	Progress Update & Status	Lead
PB628	**Parent Story** Chief Executive to record the Board of Directors' thanks, gratitude, and respect to Albie's parents for their willingness to engage with the organisation in her letter to them.	**BD/26/01/06**	**Jan 2026**	**Mar 2026**	Complete. The Chief Executive wrote to Albie's parents on 29th January 2026. **To close**	**Chief Executive**
PB629	**Integrated Performance Report** Chief Nursing Officer to discuss the Chief Executive's suggestion to evaluate the impact of the financial challenge on quality and safety across the Group with her Group counterparts.	**BD/26/01/10**	**Jan 2026**	**Mar 2026**	Clarity sought from the Chief Executive. Verbal update to be provided at the meeting. **Open**	**Chief Nursing Officer**
PB630	**Safeguarding Strategy for Approval** Associate Director for Vulnerable People to review the terminology used in the strategy to ensure that it remained within the scope of safeguarding duties.	**BD/26/01/12**	**Jan 2026**	**Mar 2026**	The terminology has been reviewed and is within the scope of maternity safeguarding. **To close**	**Associate Director for Vulnerable People**
PB631	**Six Monthly Nurse and Allied Health Staffing Report** Deputy Chief Medical Officer to produce a standard medical workforce report.	**BD/26/01/13**	**Jan 2026**	**Mar 2026**	This report requires all doctors to be e-rostered. The e-rostering programme starts this month with a phased roll out. In Q4 26/27 the aim will be to replicate the nursing report which goes to Board. This will be an annual report which will incorporate job planning. **To close**	**Deputy Chief Medical Officer**

Action No	Details	Agenda Item No	First Raised	Action by	Progress Update & Status	Lead
PB632	**Learning from Deaths Report Q1** Interim Chief Medical Officer to ensure that the IPR is used to track regularisation of the mortality dataset going forward.	**BD/26/01/14**	**Jan 2026**	**Mar 2026**	Summary Hospital-level Mortality Indicator (SHMI) data is reported in the IPR. **To close**	**Interim Chief Medical Officer**
PB633	**Learning from Deaths Report Q1** Quality Assurance Committee to challenge and check the recovery trajectory of the mortality dataset.	**BD/26/01/14**	**Jan 2026**	**Mar 2026**	Mortality Update on agenda at item 16. **To close**	**Quality Assurance Committee**
PB634	**Freedom to Speak Up Q1 and Q2 Report** RUH FTSU Guardian to triangulate FTSU data with other Equality, Diversity, and Inclusion Reports.	**BD/26/01/16**	**Jan 2026**	**Mar 2026**	Discussions have taken place with the People Team, and a meeting is due to be set up to bring the FTSU and Culture Teams together to support thematic triangulation. Some information is currently embargoed, and further discussions are due to take place to take place around access to and use of data. FTSU data-keeping processes have also been strengthened to ensure that information relating to all protected characteristics is captured where possible. This will enable the identification of any themes associated with specific protected characteristics. **To close**	**RUH FTSU Guardian**

Action No	Details	Agenda Item No	First Raised	Action by	Progress Update & Status	Lead
PB635	**Non-Clinical Governance Committee Upward Report** Chief Finance Officer to provide the Board and Joint Committee with an update on ongoing work to review and prioritise capital to deliver on compliance requirements.	**BD/26/01/18**	**Jan 2026**	**Mar 2026**	Group wide Strategic Capital Group dates have been established. As part of this process Capital schemes will be prioritised at Group level to address highest areas of concerns within available cash. Work will be reported into Joint Committee for sign off. **To close**	**Chief Finance Officer**

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**5**
Date of Meeting:	**4 March 2026**		

Title of Report:	**Patient story**
Status:	**For discussion**
Board Sponsor:	**Toni Lynch, Chief Nursing Officer**
Author:	**Sharon Manhi, Head of Patient Experience** **Allison Ponsford, Haematology Ambulatory Care Advanced Clinical Practitioner**
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.

Aaron's Haematology Ambulatory Care experience

Aaron was diagnosed with Acute Myeloid Leukaemia (AML) on 3 June 2024. He started his first round of chemotherapy on 18 June and stayed on William Budd ward until 23 July 2024. As Aaron was clinically stable, he was discharged home under the care of the Haematology Ambulatory Care Service (HACS) instead of remaining as an inpatient for his post chemotherapy bone marrow recovery.

Traditionally patients like Aaron are treated with four cycles of intensive chemotherapy with each cycle requiring an admission to William Budd ward for an average of 28 days. This allows for chemotherapy administration and monitoring until blood count recovery.

Aaron was admitted as an inpatient for the second cycle of chemotherapy and was an inpatient for 9 days. As the HACS management had worked well for Aaron previously, he had a facilitated early discharge with HACS management once again. During his post cycle two recovery, he had a 48-hour emergency admission to the Medical Assessment Unit (MAU) with a neutropaenic fever.

Once his bone marrow had recovered Aaron was readmitted to the inpatient ward for his third cycle of chemotherapy and stayed for 5 days. Post cycle three, he had a further safely managed admission with a neutropenic fever involving an 11 day stay.

His fourth and final cycle of chemotherapy was given over a 6-day inpatient stay and Aaron was discharged with HACS management.

Both of Aaron's emergency admissions took place outside HACS operational hours.

Aaron remained under HACS management until 3 April 2025. His post treatment surveillance is managed with three monthly bone marrow aspirates and Consultant reviews in outpatient clinic appointments.

Aaron's inpatient stays were much reduced in length of stay for cycles 2-4 chemotherapy and he was able to spend increased time at home with his young family. Aaron was one of the earlier AML patients managed by HACS and at that time the service was in the initial stages of development and providing Aaron's chemotherapy ambulatory was not an option.

The service aligns with the 2026 National Cancer Plan for England, in particular a commitment to the reduction of waiting times for treatment and providing treatment closer to home. The National Cancer Plan (2026) also stipulates that every cancer patient should receive personalised care, receiving a tailored plan covering treatment, psychological support, and rehabilitation and this is a key component of the HACS service.

The service demonstrates an ability to unlock capacity, improve clinical safety, reduce waiting times for treatment, reduce length of stay and enhance patient and family experience.

Background and context

Haematology Ambulatory Care enables some treatments previously requiring inpatient hospital stay, including high dose chemotherapy and stem cell transplant to be safely delivered in a day unit setting. It started in the UK 20 years ago in large tertiary cancer centres but is a newly emerging model of specialist service provision in local hospital settings and is being delivered very differently across our regional cancer network.

The HACS service has been developed to meet the growing demand for cancer services. This reflects the increasing number of cancer patients, advances in anti-cancer treatments and therapies including transplant options. HACS patients are virtual inpatient level, requiring a higher level of daily clinical management than can be facilitated in the Medlock Day Unit.

The service started in November 2023 and to date, the team has supported 107 patients.

Due to the intense nature of the management of patients under HACS, it has been possible to provide admission avoidance, direct admission and earlier management of escalating clinical situations which eases the pressure on front door services.

Data from the first 6 months of 2025 (January to June) shows that 626 bed days were saved. A bed on William Budd ward costs £1,683 per night whereas a HACS outpatient attendance costs £235. Aside from staff costs the bed day savings are £1,053,558 reducing to £906,448 with the cost of the outpatient attendance.

Every patient under the care of the HACS team is asked to complete a feedback form on their experience of the service.

'It is so much better to be able to go home, especially to sleep at home. It means that I can carry on my normal life to a great extent.'

'It has been a very good experience. I have felt supported. The staff have explained everything to me. They are very kind and caring and experts in their field.'

'Thanks to you amazing ambulatory team my wife is now stable and back on track to her old self with treatment ongoing.'

Next Steps

1. Aaron's experience will be shared with staff across the Trust to raise awareness and understanding of the service and care for patients under HACS management.

2. Development and build of virtual ward platform for clinical safety, Trust wide visibility, governance, financial autonomy and accountability.
3. Introduction of Computerised Ambulatory Delivery Devices (CADD) which will allow chemotherapy drugs to be given at home through a pump which can be worn by the patient as a backpack.
4. The HACS team are planning the first autologous stem cell transplant in May 2026 with the treatment provided in an ambulatory care setting. When ambulatory transplant goes "live" the Advanced Practitioners will review the patient at the weekend post stem cell infusion.
5. Transition to a seven-day service which will require enhanced clinical and administrative capacity to ensure safe, effective and co-ordinated care.
6. The patient pathway for in hours presentations are now triaged either by the Acute Oncology Service or the Haematology team. These teams will coordinate the most appropriate location for review, which may include bringing patients into an outpatient clinic or to the Emergency Department or the Medical Same Day Emergency Care Service.

7. The Trust ambition is to develop a combined Haematology and Oncology Same Day Emergency Care Service model, and a plan is being actively developed, to enable direct access to the service and clinicians, thereby bypassing the Emergency Department. In the interim, the service as commenced a clinician led advice line. This enables more advanced clinical

advice to be provided and supports better liaison with the haematology and oncology consultant teams. This provides clinical support for 24/7.

8. In relation to neutropenic diet, the available evidence, research and Consultant opinion provides mixed views on the necessity, however, there is consensus that sterile water is used a drinking water. In light of Aaron's reflections, the Matron is developing a neutropenic 'alert card' that can be given to patients. This would allow them to present key information to clinical teams elsewhere in the hospital if required. The Matron is also working actively with the Medical Assessment Unit and Same Day Emergency Care teams to ensure they have the right knowledge. This work will be overseen by the Trust wide Nutrition Group.
9. During Aaron's admission timeframe the cleaning outcomes were inconsistent as evidenced by audit scores. Since this time the audit schedule has changed to ensure clinical areas can be differentiated and where cleanliness does not meet the expected standard, immediate, remedial action can be taken.

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

3.	Legal / Regulatory Implications
Under the Health and Social Care Act 2008 and the Health and Social Care Act 2012, NHS Trusts have a legal duty to secure continuous improvement in safety, clinical effectiveness and patient experience. The Care Quality Commission (CQC) regulates NHS Trusts against the fundamental standards including person centred care. The NHS Constitution for England sets out patient rights, including to be involved in decisions and to be treated with dignity and respect.	

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

5.	Resources Implications (Financial / staffing)
None	

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

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

8.	Freedom of Information
Public.	

Report to:	**Public Board of Directors**	**Agenda item:**	**6**
Date of Meeting:	**4 March 2026**		
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 Katie McClean, Executive Assistant**		
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 Governance and Assurance Arrangements and Transition Roadmap
- Group Priorities and Prioritisation Approach
- EPR Deployment Options Appraisal
- Clinical Transformation Programme
- Corporate Services Progreamme
- Board to Board development
- Councils of Governors Workshop

National update

- Resident Doctors Industrial Action
- National Cancer Plan for England

Managing Director's Report

- Local (RUH)
  - Operational
  - Finance
  - Turnaround update
  - Medium term financial plan
  - Quality
  - Business plan for next year
  - Use of Trust Seal
  - 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 & Recovery

The financial position for month 10 showed a deficit of £6.8m, with a year-to-date adverse variance of £35.2m. At an individual Care Organisation level, performance has remained challenged across all sites due to the financial impact of continued operational pressures and the difficulties of delivering efficiencies in these circumstances. The year-to-date deficit positions for Care Organisation are Royal United Hospitals Bath (£18.3m), Great Western Hospitals (£8.5m) and Salisbury (£8.4m). These are in line with the revised recovery plan submitted February 2026 which assumes a year end deficit of £42m.

All Care Organisations have a number of measures in place to mitigate the deficit position, which includes additional controls, closure of escalation capacity, and increased delivery of Elective income..

Urgent & Emergency Care (UEC) Update

UEC remains challenged across all three care organisations, this is due to a number of factors including demand, acuity of patients, and flow through our hospitals. The number of patients waiting to leave acute trust beds remains a challenge – with sustained high numbers of NCTR across all three organisations.

Additional surge beds in community hospitals and additional pathway capacity has been put in place, in response to the demand but the position remains challenging. UEC improvement plans are in place and focus on improving internal processes, discharges, and ensuring decisions regarding care are taken in a timely way.

A further challenge across all three acutes is an increase in the number of cases of winter flu and norovirus in January and February.

Ongoing key risks – Delivery of four-hour performance and 12-hour delays in Emergency Departments continues to be challenging. The non elective demand into acute trusts remains at a higher level than planned. NCTR continues above plan and the acute focus is on ensuring daily discharges are aligned to meet the demand and internal flow through the beds. There are several internal and system actions underway to mitigate these key risks and the focus continues to be on quality and safety across the trusts.

All three organisations will have an increased and refreshed focus regarding the reduction of care of people within corridors. We recognise that this is not the experience we would want anyone to have and will be working hard to resolve this.

Elective

A number of risks to delivery are currently being managed across BSW Hospitals Group on elective care. These include ongoing operation pressures on UEC as outlined above, a focus to maintain activity as appropriate, in line with national guidance, as a result of the national shortage of Heraeus cement. In addition: –

- **Sprint delivery.** A national RTT sprint has been launched for Q4 across BSW. The sprint requires a focus on additional new appointments in Q4 and an improvement to delivery of 18 weeks at year end.
- **Advice and Refer**. A requirement of the national NHSE planning guidance is to adopt Advice and Refer for all elective referrals to Trusts. This aims to reduce the need for new appointments by providing more advice electronically. Work is underway to design and implement the shift from a referral support services to Advice and Refer across the Group and a series of shared tools have been developed to support modelling and implementation across the three care organisations.

National Update

Resident Doctors Industrial Action

The British Medical Association (BMA) have announced that Resident Doctors in England have voted to continue industrial action for another six months (until August 2026) in their February 2026 ballot, with 93% voting yes on a 53% turnout. This follows a rejection of the Government's offer and previous strikes, the last of which was in December 2025.

National Cancer Plan for England

A new National Cancer Plan was published in early February 2026 which sets out a long term approach to improving cancer outcomes, experience and equity over the next decade so that by 2035, 3 in 4 people diagnosed with cancer will be cancer-free, or living well with cancer, after 5 years – as well as improve quality of life for people living with the disease.

Further information on the National Cancer Plan can be found https://www.gov.uk/government/collections/national-cancer-plan-for-england

Group Development

Joint Committee

Our latest BSW Hospitals Group Joint Committee meeting was held on 18th February 2026 with a focus on Financial Sustainability & Recovery, Risks in Care Organisations and across Group, Integrated Performance Report Development, our Group Non-Executive Director Model, the Roadmap for transition to Group Board, Group Assurance Manual and Terms of Reference for the Group Board, and Risk & Assurance Committee. A report from the February Group Joint Committee has been included with March Trust Board papers.

Leadership Team

Since the last report, we have seen the appointment of Mark Ellis as our Chief Risk Officer. The Remuneration Committees in Common also approved appointment of Judy Dyos, Chief Nursing Officer at SFT, as interim part time Chief Strategy Officer. With these appointments, the Executive leadership team is fully established albeit with two interim positions still in place.

The recruitment of an interim Group Chair continues with interviews scheduled for early March.

Group Governance and Assurance Arrangements and Transition Roadmap
The governance development work to support safe mobilisation to our new Operating Model is continuing led by our Governance Working Group. Supporting this work, the Non-Executive Governance Reference Group met on 2nd February, to consider the Governance Roadmap and transition timeline.

Group Priorities and Prioritisation Approach.
Our five areas of prioritised focus for the Group and Care Organisations remain as follows:

1. Recovery (Performance & Finance)
2. EPR implementation
3. Clinical transformation
4. Corporate Services Review
5. 2026/27 planning including Group Mobilisation

The Group Leadership team meets weekly to monitor progress in these priority areas.

EPR Deployment Options Appraisal
The EPR programme, has been working on delivery planning. Final costs and draft delivery plan will be presented to the BSW Group Executive, Care Organisations, and BSW Hospitals Group Joint Committee in March 2026, with a final delivery plan to be confirmed in April.

Clinical Transformation Programme
Clinical Transformation Groups (CTGs) will be established to support clinical service transformation with an ambition to mobilise at least six CTGs in 2026. A steering group comprising clinical, operational and transformation leads from the three Care Organisations has been established and will work to ensure the programme is resourced to enable successful delivery.

Corporate Services Programme
Our Corporate Services Programme, is making progress with the design stage for services underway and governance arrangements well established. The Steering Group and Design Authority meet regularly, and designs have been approved for seven corporate services with consultation planning well underway. The financial impact of the programme is being tracked for each service, with clear targets set for 2026-27 and 2027-28.

Group Board-to-Board Development Days.
The 2026/27 Group Board dates are being scheduled. A Board-to-Board development day is planned to take place in early May 2026 and will focus on Group Strategy and preparations for transition to our new Group Operating Model.

Councils of Governors Workshop
On 3rd February the three Councils of Governors had a development session.. There was briefing and discussion on the Group Chair appointment process, the Group Operating Blueprint, including Non-Executive Director Model development, and the role of Governors in a Group model.

MANAGING DIRECTOR'S REPORT

At the beginning of September, the Trust moved into Tier 1 for four performance targets, Urgent and Emergency Care (UEC), Referral to treatment (RTT), Cancer and Diagnostics and Segment 4 against the new NHS Oversight Framework (originally ranking 112 / 134). As a result, we set out six priority areas to focus our improvement as part of a Trust wide 'Call to action' - UEC, financial recovery, 65 week waits for RTT, Cancer 28-day faster diagnosis, diagnostics backlog waits and patient safety. The Oversight Framework for Q2 2025/26 was published on 11th December 2025 and the Trust remains in Segment 4 but has improved its ranking to 105 / 134.

Key improvements include zero 65 week waiters as of 31st December 2025, an improved ranking on the 4-hour standard (for all types performance) with the RUH improving from 113/123 in October to 103/123 at the end of January 2026, and we have seen a step increase in our Cancer 28 day faster diagnosis from 52.9% in September 2025 to 67.7% in January 2026. Further details on all operational performance and financial recovery are provided below.

We continue to report progress via a weekly assurance meetings cycle with the regional team for all performance areas with internal assurance being provided via the Finance and Performance Committee reporting to the Board of Directors.

1. Operational

Urgent and Emergency Care

4- hour Performance decreased by 3.5% to 53.2%. Average ambulance handover time increased from 30.7 minutes to 73 minutes in January. 12 Hour Performance has deteriorated from 7.7% to 13.9%. Deterioration in performance KPIs is driven by signifciant additional urgent care demand with 7 consecutive days of ambulance arrivals > 100, in addition to a peak of 56 beds closed due to Flu. Average NCTR numbers was 97.6 patients, (53.6 patients above plan).

RUH has commenced with a UEC reset plan which embedding our refreshed internal professional standards; improving board/ward rounds; redesign of escalation processes and streaming within ED Majors and UTC.

Our winter plans, which include using 12 beds in Philip Yeoman Ward and working with HCRG to open 20 beds on Ward 4 at St Martins Hospital for NCTR patients, were successfully operationalised.

Referral to Treatment

We have a high level of confidence in our RTT recovery plans. Lessons learned from the Elective 12 week challenge are continuing to support our recovery and the programme approach has been shared with the national team.

We are continuing to keep our focus on good PTL management with a strengthened governance and executive oversight of our processes.

Evidence that we are focussing on the right things is visible in our performance numbers again this month.

We are proud to be able to say that we reported zero 65 week breaches at the end of December and this is a testament to the work that our operational, clinical and administrative colleagues have put into this recovery programme. This standard has been sustained throughout January.

Over 52-week waits continued to reduce from 465 to 436 from Dec to Jan; this is 1.07% of our total RTT waiting list and we remain on track to achieve the national target briging this below 1%.

We will continue to rely on insourcing activity for a small number of our specialities and as part of our planning for 26/27 we will be exploring all opportunities to remove our reliance on insourcing through improved productivity and efficiency and by right sizing our capacity to meet our demand.

Cancer
Performance improved in December against all three of the standards but remained behind our recovery trajectory. The most notable improvements were in Breast and Skin.

62 day performance will remain significantly below trajectory up to January due to recovery of the Skin Minor Ops (MOPS) backlog with more breach patients being treated. An executive decision was made to work through all of the backlog using all additional capacity and modelling has identified that we will achieve this by the end of January. We would then expect us to achieve our planned end of March position and we remain on track to clear the MOPS backlog. We are in contact with our regional and national cancer colleagues and our Chief Operating Officer is providing an enhanced level of scrutiny and leadership to the cancer PTL meetings.

Diagnostics
In January, 76.1% of patients received their diagnostic within the 6-weeks is 0.4% below trajectory but represents 4.5% improvement from December.

We recognise that there is further opportunity to work with the Sulis CDC and we will be increasing our focus on maximising CDC capacity to further support our diagnostic recovery.

2. Finance

The RUH Group is £18.3m adverse to plan at the end of January, of which £18.5m arising in RUH Trust and £0.15m favourable 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 has secured funding and regional approval to commission a Turnaround team who started in the Trust on 17 November. 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 £14.5m 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. Within this there is £3.6m unidentified Group savings, £2.9m UEC savings due to NCTR and activity growth levels, £0.7m Corporate Redesign slippage and £1.9m Outpatient transformation slippage. Workforce plan reductions have been offset by staff sickness levels rising to 6.1% and c20% above last Winter; as well as operational pressures in clinical administration, notably typing backlogs.

Operational budget pressures have maintained in January with cumulative pressures arising from increased spend on high-cost drugs and devices (£1.6m), Pay Award (£0.3m) Resident Doctors budget pressures (£2.1m). Industrial Action was funded in Month 10, covering all IA to date. The remaining cost pressures are partly offset by increased cost controls and non-recurrent benefits (£4.3m). Sulis is favourable to plan by £0.15m. Non-Pay costs have underspent against plan including backdated charges to the RUH. Further adverse variances arise from deterioration in the exit run rate from 24/25 (£5m)

Cash balances for the Trust are £20.2m, this includes cash received in advance. Cashflow forecasts have been undertaken which show cash balances reducing to £15.2m by April on a do-nothing scenario and c£19.5m in line with Recovery trajectory. £19.5m is judged to be the minimum working cash limit to enable contractual obligations to be met in time; and therefore; enhanced cash monitoring and controls are being developed, in advance of potential requests for NHSE revenue cash support loans.

For October 2025 the Trust had a year-on-year implied productivity improvement of 1.8% against the breakthrough objective of 6.7%. Cost weighted activity grew by 4.1% compared to inflation adjusted cost growth of 2.3%. Given that much of the activity growth is in non-elective activity we do not see a direct financial benefit from this productivity.

At the end of Month 10 the Trust has a deficit YTD of £18.3m. In month the deficit was £1.6m.
This position was in line with the latest Recovery Plan and represents a continued stabilisation of financial run rate, and during a time a significant operational pressure.

The straight-line trajectory would be £22.4m, which is considerable improvement of the £32m straight-line projection from earlier in the financial year.
The Trust has developed a Recovery Plan to achieve a £20.5m deficit, whilst continuing to strive for further improvement.
This Recovery Pla has been approved by BSW Hospitals Group Joint Ctte and agreed with NHSE.

3. Turnaround update

The Trust secured funding from ICB and commissioned a Turnaround Team (Hunter Healthcare) to support delivery of the financial position. The team joined the Trust on 17 November and are now in Week 14.
The programme has supported the Trust:

- To improve the run rate and develop the Recovery Plan to £20.5m deficit
- Improve and embed financial improvement governance, at Trust and Divisional level, to increase capacity and improve delivery and financial stewardship
- Generate new opportunities and subject specialist expertise to accelerate financial improvement

4. Medium Term Financial Plan

The Trust has developed a Medium Term Plan, in collaboration across BSW Hospitals Group. This was approved by the Board and submitted to NHSE on 12 February, the plan was compliant with national priority metrics, including Cancer and Planned Care, except for Urgent & Emergency Car which will take longer to recover to national standards. Noting also the financial plan is heavily front loaded with £5m of savings required, of which £36m is in Yr1 and has delivery risks still to be fully mitigated in year 1. A paper is on the Public board agenda

5. Quality

Infection, Prevention and Control

The Trust has experienced significant outbreaks of norovirus and flu over the last month, impacting up to 150 inpatient beds. The Infection, Prevention and Control team have led the management and response to the increased infections, working closely with clinical, cleaning and site management teams to ensure patients are isolated and recovered in the most effective way. The Chief Nursing Officer welcomed NHS England Southwest Infection, Prevention and Control (IPC) team recently, who reviewed the IPC systems and processes, feedback is awaited. At times of increased infections, the Trust requires more isolation capacity than is available and therefore patients are cohorted with like infections. The Estates plan includes redesigning the Urgent and Emergency Care footprint inclusive of providing isolation spaces, increasing side rooms, however, in an aging estate, the number required will not be realised without capital significant investment.

Care Quality Commission

The Care Quality Commission (CQC) undertook an unannounced inspection of the Urgent and Emergency Care Unit in October 2025. An internal action plan was developed in response to initial feedback, as previously reported, and work continues to improve the experience of patients, carers, and staff. The Trust awaits the draft report from the CQC.

6. Business plan for next year

On 12 March 2026 the Trust submitted to NHS England its Integrated Medium Term Plan, setting out our objectives for the next three years, covering performance activity, workforce, finance, transformation and quality, to meet the needs of our local population and national goals.

The plan was developed in collaboration with our BSW Hospitals Group partners, Great Western Hospitals NHS Foundation Trust and Salisbury Foundation Trust, and with the BaNES, Swindon and Wiltshire Integrated Care Board.

Headlines from the plan are:

- Compliance with RTT, cancer and diagnostic performance targets planned, and improvement in urgent and emergency care access targets, although not to national standard.
- Milestones outlined for the transformation over the next three years in clinical services, corporate services, digital (shared EPR) and the RUH estate
- Total workforce numbers planned to remain static in 2026/27, reflecting reduced staff numbers in some areas, related to efficiency and corporate redesign, offset by increased substantive staff in clinical specialities to reduce outsourcing costs and improve service sustainability.
- Stretching financial plan, requiring a £55.0m recurrent Cost Improvement Programme over the next 3 years, and forecasting a breakeven position in all years.

	Metric	Latest RUH position (Dec'25)	RUH plan Mar '26	26/27 NHSE Instruction	26/27 RUH Plan	27/28 NHSE Instruction	27/28 RUH Plan	28/29 NHSE Instruction	28/29 RUH Plan
UEC	4-hour ED performance RUH and MIU Footprint	65.7%	78%	82% by Mar '27	75.3%	83%	80.2%	85%	82.0%
	12-hour ED performance	7.7%	4.9%	3.9%	6.3%	Year on year reduction	5.3%	Year on year reduction	5.0%
	Ambulance handover	31 mins	33 mins	Reduce toward 15 mins	30 mins	Further improvement	29 mins	15 mins	28 mins
Elective & Diagnostic	18w RTT Performance	60.7%	67.7%	*74.7% for RUH (65% or 7% improvement, whichever is higher)*	74.7%	Bridge between 74.7% and 92% Target	83.4%	92%	92.0%
	52 Week Waiters	644	331 (1%)	*Improvement on 1%*	198 (0.8%)		62 (0.4%)		0
	DM01	28.3%	16.1%	*3% improvement at ICB level 13.1% for RUH*	12.5%	To bridge between 13.1% and 1%	9.0%	99%	1.0%
Cancer	28d FDS	53.7% (Sep '25)	80.2%	80% annual ave	80.0%	80% annual ave	80.5%	80% annual ave	80.7%
	31d	91% (Sep '25)	93.7%	94%	94.2%	96%	96.0%	96% annual ave	96.1%
	62d RTT	58.3% (Sep '25)	75.3%	80%	80.5%	82.5%	82.7%	85%	85.1%
Workforce	30% Reduction in agency use	13.6 WTE	5.0 WTE	*30% improvement relative to M6*	-5wte	Improvement	-2wte	Zero agency spend	0
	10% reduction in bank spend	268.8 WTE	261 WTE	*10% reduction relative to M6*	-10%	Improvement	-10%	30% reduction relative to 25/26	-10%
	Sickness rate (rolling 12 month average)	4.97% (Sep '25)	5.3%	Improvement	4.8%	Improvement	4.6%	4.1%	4.4%
Finance	2% productivity improvement	2.4%	6.7%	*% for RUH (2% improvement)*	5.0%		2.7%	"Sustained improvement"	1.5%
	Savings Plan	Version 11	15.0m (29.7m)	36.1m	36.1m	10.0m	10.3m	8.6m	8.7m
	Balanced or surplus financial position	-£14.1m	-£17m	Balance or surplus	0.0m	Balance or surplus	0.0m	Balance or surplus	0.0m

The plan notes a number of enablers required to deliver the plan, including significant demand management to bring UEC attendances back within funded levels and required capital investment in UEC and inpatient wards.

Risks to delivery of the plan:

- Sustained growth in urgent care demand continues to exert pressure on UEC performance, flow and capacity, impacting on quality, safety of care and financial sustainability.

- Unprecedented level of savings required, in excess of the productivity opportunity identified through national benchmarking
- Capacity to deliver change, given the scale of transformation required

Next steps

The Trust is awaiting feedback from NHS England on the plan. In the meantime, work is ongoing to:

- Continue to develop and mature the 2026/27 Cost Improvement Plan to deliver the planned £36.1m savings
- Model the impact of new Advice and Refer pathways for GPs to access specialist advice, supporting the management of patients in their own home
- Support the wider health system's work to reduce the growth in demand of patients seeking urgent and emergency care
- Begin to cascade objectives to teams across the Trust, using our Improving Together operating model to develop scorecards at Trust, Divisional, Specialty and team levels that deliver the 2026/27 plan
- Develop a public version of the final plan, to share with patients, partners and communities.

7. Use of Trust Seal

The Trust Seal has not been used since the last meeting.

8. 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/

9. Consultant Appointments

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

Dr Semini Greening was appointed as Consultant Medical Oncologist, Dr Semini Greening will join us in June and is currently Specialty Trainee at Oxford University Hospitals NHS Trust.

Dr Henry Atkinson was appointed as Consultant in Radiology with a specialist interest in Head & Neck Radiology, Dr Henry Atkinson will join us in September and is currently speciality Trainee at Mersey and West Lancashire Teaching Hospitals NHS Trust.

Dr Mohamed Ebidalla was appointed as Consultant Ophthalmologist, Dr Mohamed Ebidalla is currently working at the Trust as a Locum Consultant but it is anticipated that he will start the substantive post in April.

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

Call for women to attend 'lifesaving' cervical screening appointments
During Cervical Cancer prevention week in January, an RUH patient shared her experience of cervical cancer screening and cancer treatment to encourage others to make sure they take up the offer of a 'lifesaving' cervical screening test. Carly Brown was just 32 when she was diagnosed, she had put off testing, feeling she was too young to get this type of cancer. After getting symptoms checked out, she was diagnosed with cervical cancer and treated. Carly hopes her experience will show women the importance of going to those appointments and not ignoring symptoms as early detection can save your life.

RUH supports world's largest-ever Parkinson's disease research study
Researchers at the RUH began recruiting to the world's largest-ever clinical trial of treatments to slow or stop the progression of Parkinson's disease in January.
The Edmond J Safra Accelerating Clinical Trials for Parkinson's Disease (EJS ACT-PD) trial is helping to accelerate the search for effective treatments for Parkinson's with an innovative trial design which tests multiple treatments in parallel. Parkinson's disease is one of the world's fastest growing neurological conditions, with 166,000 people affected in the UK today. Parkinson's gets progressively worse and although there are treatments that can help with symptoms, these become less effective over time, meaning there is an urgent need to find treatments that can slow or stop the disease progression. Initially, the trial will be testing two drugs known to be safe and effective at treating other conditions: a blood pressure medication and a drug used to treat an enlarged prostate.

Brothers have same robotic cancer surgery just weeks apart
In January, two brothers who underwent successful surgery for prostate cancer within just weeks of each other at the RUH called on men with a family history of the cancer to get themselves checked. David and Robert Taylor both had successful robotic radical prostatectomies, carried out by the surgical urology team using the RUH's Da Vinci surgical robot.
Robert went to his GP for a general check up, was offered a Prostate Specific Antigen test to check for prostate conditions and not long after was referred to the RUH and diagnosed with prostate cancer and successfully treated. As a result his brother also decided to get tested and was diagnosed and treated.

Click café launched to support digital confidence
The RUH teamed up with Age UK in January for the first in a series of 'Click Cafés' at the RUH. The free drop in sessions are designed to offer 1-1 support to help those aged 55+ get connected and feel confident online, including tech troubleshooting, using the NHS App and keeping in touch with loved ones.

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Report to:	**Public Board of Directors**	**Agenda item:**	**7**
Date of Meeting:	**4 March 2026**		

Title of Report:	**Chair's Board Report**
Status:	**To note**
Board Sponsor:	**Liam Coleman, Chair**
Author:	**Roxy Milbourne, Interim Head of Corporate Governance**
Appendices	**None**

1.	**Executive Summary of the Report**
This is a regular report for information and accountability, summarising Chair and Non-Executive Director (NED) activities and key events relating to the governor activities for the period post January 2026. Activities relating to formal Committees of the Board are reported through upward reports.	

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

3.	**Legal / Regulatory Implications**
This paper maintains compliance with governance standards.	

4.	**Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)**
Risks are minimal, the paper demonstrates transparency and accountability, supporting public confidence.	

5.	**Resources Implications (Financial / staffing)**
No significant financial or staffing implications are anticipated.	

6.	**Equality and Diversity**
There is no adverse impact on equality, diversity, or inclusion.	

7.	**References to previous reports/Next steps**
This is a regular report.	

8.	**Freedom of Information**
This report is Public, no confidential information is included.	

9.	**Sustainability**
No direct impact on the Trust's environmental sustainability or net zero carbon commitment.	

10.	**Digital**
No direct implications for the Trust's Digital Strategy.	

Chair's Board Report
This is a regular report for information and accountability, summarising Chair and Non-Executive Director (NED) activities and key events relating to the governor activities for the period since the last public Board meeting. Activities relating to formal Committees of the Board are reported through upward reports.

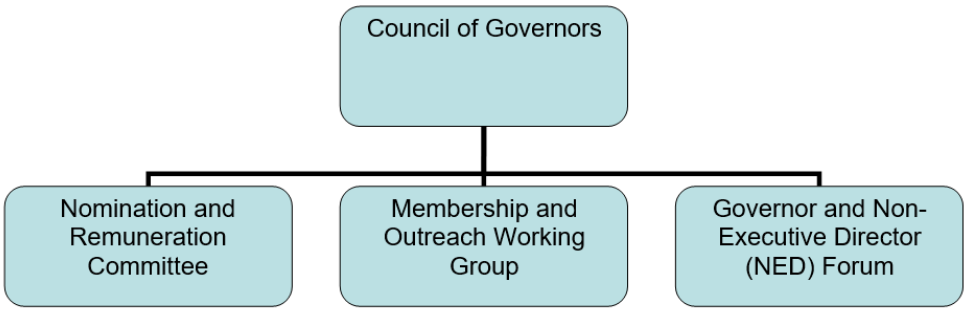
Council of Governors Update - 3rd February 2026
The Council of Governors met extraordinarily on 3rd February 2026 to consider urgent proposals relating to the Interim Group Chair arrangements across BSW Hospitals Group. They noted that the Joint Council of Governors Nomination and Remuneration Committee had reviewed the Group Chair recruitment process and advised that, due to only one candidate remaining, the substantive recruitment should be paused.

The Council subsequently approved the appointment of an Interim Group Chair for an 18-month term, to ensure stability across the developing BSW Hospitals Group. They also approved amendments to the Group Chair job description to reflect suitability for an interim appointment.

The appointment process will now proceed via the Joint Council of Governors Nomination and Remuneration Committee on behalf of all three Councils. Interviews are due to take place on 9th March 2026. Each Council will convene an extraordinary meeting to approve the appointment after this date.

Council of Governors Update - 24th February 2026
The Council of Governors met on 24th February 2026 and approved the appointment of Craig Jones, Staff Governor, as Deputy Lead Governor. Craig will be working alongside Kate Cozens who was appointed as Lead Governor in December 2025.

The Council received a proposed new working group structure. This was developed by a Governor Task and Finish Group which was established as agreed at the Council of Governors meeting in December 2025. The Council was supportive of the proposal and approved the new structure which is centred around enabling Governors to fulfil their statutory duties. The structure is detailed as follows:



Non-Executive Directors Update:
The Chair and Non-Executive Directors attended the BSW Hospitals Group Workshop on 12 February, contributing to discussions on group development and future collaborative governance arrangements.

Chair attendance at key meetings during January and February 2026

- Regular meetings with Non-Executive Directors
- Subsidiary Oversight Committee
- BSW Hospitals Group Remuneration Committee in Common
- BSW Hospitals Group Joint Committee (January and February)
- Bath Spa University Inaugural Chancellor's Dinner
- Quarterly meeting with Wera Hobhouse MP
- BSW Recovery Assurance Meetings – monthly
- BSW Chairs' Meeting
- BSW Hospitals Group Workshop
- RUH Nomination & Remuneration Committee
- RUH Paid Breaks Grievance Appeal Hearing
- Staff Governor & NED monthly feedback meetings
- Weekly 121 meetings with Chief Executive
- Weekly 121 meetings with Vice Chair

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Report to:	**Public Board of Directors**	**Agenda item:**	**9**
Date of Meeting:	**4 March 2026**		
Title of Report:	**Management Executive Committee Upward Report**		
Status	**For information and discussion**		
Author	**Abby Strange, Corporate Governance Manager**		

Key discussion points and matters to be escalated from the meeting

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

January 2026

- **Business Planning:** The Committee received the second cut of the business plan and the proposed priorities for 26/27. They noted that the plan remained non-compliant in Urgent and Emergency Care (UEC) and that further assurance was needed around finance and workforce. Final sign off would take place at an Extraordinary Board of Directors meeting on 10th February 2026.

- **Financial Sustainability:** The RUH Group year-end deficit forecast was between £18m - £25m. The Committee noted that demand pressures continued to threaten delivery of the planned outturn and received an overview of the turnaround initiatives. It was recognised that every effort was being made to deliver further corrective action.

- **Operational Pressures:** January had been a challenging month for the organisation, particularly in terms of UEC demand. The Trust had done well to absorb the high increased in demand with elective cancellations remaining low, but pressures were prolonged.

February 2026

- **Risk Management Capacity and Oversight:** The Committee discussed concerns around delays in approving risks and the increasing organisational risk profile. Additional temporary resource is being explored to improve risk governance, alongside a newly formed task and finish group.

- **Financial Position:** The organisation remains targeted to deliver a £17m deficit with a current projection is approximately £19m. Cost Improvement Programme (CIP) delivery in 26/27 remains a significant risk and NHS England (NHSE) have emphasised the need for strengthened processes and weekly reporting.

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

January 2026

- **Mortality Data:** The Committee discussed concerns around the validity of mortality data. They acknowledged the impact of the backlogs in coding and

Structured Judgement Reviews (SJRs) on the organisations ability to assure itself and noted that work was ongoing to recover the position.

- **External Review of Risk:** The Committee received an independent peer review into the maturity and effectiveness of the Trust's risk management arrangements. This highlighted the need for more consistent processes and clearer alignment across the system. The Trust has begun to strengthen its internal structures and is ensuring alignment with the emerging BSW Hospitals Group arrangements.

- **Internal Audit:** Management Executive Committee members were encouraged to complete Internal Audit actions relating to this year's internal audits. Internal Auditors were concerned about the time it was taking to complete agreed actions. The Committee continues to monitor progress against outstanding actions.

February 2026

- **Safety Metrics:** The Committee noted emerging concerns around some safety metrics including pressure ulcers, falls, and nursing staffing levels. There had been an increase in serious harm events and further triangulation would be undertaken to better understand this.

- **Sickness Absence:** Sickness remains above 6% for the third consecutive month. A task and finish group has been established to develop both immediate and longer term interventions. This would be supported by the amended Wellbeing and Supporting Attendance Policy which the Committee approved.

- **Mortality Data:** The Committee received an update on progress around coding and SJR backlogs and noted that the backlog of SJRs is due to be cleared by the end of the financial year.

ASSURE: Inform the Board where positive assurance has been achieved

January 2026

- **Internal Professional Standards (IPS):** The Committee received an overview of the Trust-wide IPS programme that had been launched, supported by Getting It Right First Time (GIRFT) and digital feedback tools. They noted that a policy would be developed to underpin this.

February 2026

- **Performance Improvements:** Referral to Treatment (RTT) improvements continue with the Trust on track to deliver 0 52 week waits by year-end. February showed recovery from January's exceptionally high UEC demand and some UEC and elective indicators placed the Trust within the top 50 nationally. Elective activity had been protected despite the high demand and significant daily discharge rates had contributed to maintaining safe flow.

- **Medical Appraisal Process Reform:** The Committee received an overview of the updated Medical Appraisal model which aims to improve consistency, quality assurance, and accountability in medical appraisals. A plan is being devised to manage the transition, and the updated policy is due to be presented to the Joint Local Negotiating Committee for approval.

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

January 2026

- **Estates Backlog and Fire Safety Risk Review:** The Committee received an update on the Trust's fire safety related risk exposure and agreed to increase the rating of the estates backlog maintenance risk and fire safety related risks.

- **Risk Management Report:** The Committee received an overview of the organisational risk register and approved three new or upgraded risks and one downgraded risk.

February 2026

- **Risk Management Report:** The Committee received an overview of the organisational risk register and approved two new risks and four downgraded risks.

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

January 2026

- **Operational Pressures:** January had been a challenging month for the organisation, and the Trust had done well to absorb the high increase in demand.

February 2026

- **Elective Recovery:** The Committee celebrated the RUH Group's achievement in sustaining elective activity during winter pressures.

- **Joint Group Policy Development:** The Committee welcomed the development of policies through the BSW Hospitals Group to improve consistency across the three organisations.

APPROVALS: Decisions and Approvals made by the Committee

January 2026

- **Chair's Action:** The Committee noted that the following approvals had been made via Chair's Action due to the timescales involved.
    - **Modern Equivalent Asset (MEA) Acceleration:** Approval to proceed with the immediate commissioning of the MEA valuation to enable completion within the 2025/26 financial year.

    - **RTT Super Clinics:** Approval to deliver RTT sprint super clinics for new outpatient appointments. This will be funded by NHSE RTT sprint funding

- **Clinical Administration:** The Committee approved a proposal to use a combination of agency and overtime to eliminate typing and un-cached backlogs.

- **Business Planning Investment Requests:** The Committee approved the RTT investment case shortlist. They also supported the shortlisting of several areas for growth funding.

- **West of England Pathology Network:** The Committee approved an annual Trust investment in a shared funding model across member Trusts, subject to discussion with the Peninsula Pathology Network.

- **Mandatory Learning Policy:** The Committee ratified the policy which had been updated to reflect key changes that are taking place nationally as part of statutory and mandatory learning reform.

- **BSW Hospitals Group Immigration and Visa Approach:** The Committee approved a Group approach to immigration and visas.

February 2026

- **Chair's Action:** The Committee noted that a decision had been made via Chair's Action to temporarily suspend the da Vinci second surgical robot programme for 8 weeks. The theatre would be used for non-robotic procedures during this time.

- **Medical Appraisal Process:** The Committee approved an increase in appraisal renumeration to align with Trusts across the South West region.

- **Automated Dispensing Cabinets:** The Committee approved in principle the business case for the Trust wide rollout of Automated Dispensing Cabinets. This will enable significant improvements in medicines safety and auditability.

- **Policies:** The Committee approved the following policies:
    - Wellbeing and Supporting Attendance Policy
    - Temporary Staffing Policy
    - Group Redeployment Policy, subject to a minor terminology amendment.

- **Haematology and Oncology:** The Committee approved the preferred growth business case option in principle but requested further detail.

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Report to:	**Public Board of Directors**	**Agenda item:**	**10**
Date of Meeting:	**4 March 2026**		
Title of Report:	**Alert, advise and assure report - Quality Assurance Committee**		
Status	**For Information**		
Author	**Simon Harrod, Non-Executive Director**		

Key discussion points and matters to be escalated from the meeting on 9 February 2026

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

As previously described in upward reports from QAC, and like many NHS providers, the Trust continues to experience pressures linked to workforce shortages and operational demand.

These pressures have contributed to delays in administrative tasks such as clinical letter production and mortality coding.

Completing clinical audit work - an essential component of providing safe, effective care - has also been affected by limited dedicated time in clinical job plans and the identification of audit leads. Several mandatory audits are rated red or amber.

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

Independent Review of Risk
An external review of the Trust's risk management approach has highlighted the need for more consistent processes and clearer alignment across the system. In response, the Trust has begun strengthening its internal structures and is ensuring alignment with the emerging Bath & North East Somerset, Swindon and Wiltshire (BSW) Group-wide arrangements. This work will support more robust identification and oversight of risks across care pathways.

ASSURE: Inform the Board where positive assurance has been achieved

Mortality Coding
Bank resource is now in place. Coding will start to be accurate and will allow the Summary Hospital-level Mortality Indicator (SHMI) data to be interpreted as an accurate data point.

Structured Judgement Review (SJR) Backlog
Extra resource has been added to remove the backlog of SJRs. The backlog of 71 (12 months) will be completed by February, and the 5-year backlog of 134 will be completed by March 26.

Patient Safety and Clinical Harm Review Work
In keeping with national expectations, the Trust is developing a structured programme to identify whether long waiting times in some elective pathways may have led to

patient harm. This oversight work forms part of the Trust's commitment to transparency and proactive risk reduction and aligns with national safety improvement methodology.

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

There are four new risks scoring above 16:

- Insufficient medical palliative care provision
- Unable to upgrade out of date Datix software
- Potential clinical harm to pts in outpatient pathways
- Delays in typing and sending clinical letters

Routine quality improvement activity was reduced secondary to operational pressures and staffing issues.

Areas have not reviewed compliance with National Institute for Health and Care Excellence (NICE) guidance for several years. There is particular concern in oncology.

These risks are being managed through established governance routes and will feed into system-wide improvement programmes where relevant.

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

The Trust has recently completed all required actions from the Human Tissue Authority. This reflects strong regulatory compliance and positive progress in areas under external scrutiny.

APPROVALS: Decisions and Approvals made by the Committee

There are no approvals to report.

Royal United Hospitals Bath
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Report to:	**Public Board of Directors**	**Agenda item:**	**11**
Date of Meeting:	**4 March 2026**		
Title of Report:	**Alert, Advise and Assure Report – People Committee**		
Status:	**For discussion**		
Author:	**Paul Fairhurst, Chair of the People Committee**		

Key Discussion Points and Matters to be escalated from the meeting on 6 February 2026

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

No items to report.

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

Staff Survey

- Results embargoed until March. The Committee will conduct a detailed review at their March meeting. Report to be presented to March Management Executive Committee (MEC) and April Board.
- Group Task and Finish Group will ensure alignment of timelines, processes and responses.

Sickness absence (ongoing monitoring):

- In month sickness levels remain unusually high.12-month sickness continues to trend upward. The RUH is now an outlier regionally and nationally (though other Trusts are starting to see upward spikes).
- Anxiety, stress, and depression are the leading causes of both short- and long-term sickness. Turnover is low in some areas where sickness is high (potential link but unconfirmed without staff feedback). Thursdays and Fridays have the highest sickness levels, especially on inpatient wards. Staff survey data shows concerns around career progression, team behaviours, safety culture and incident reporting.
- Mitigations:
    - Process / policy: weekly long term sickness reviews, strengthened return to work processes; review of attendance management policy and short term sickness mechanism.
    - Resource: extra HR support in hotspot areas; advert out for 3 x HR professionals to support managers.
    - Division-specific actions: Musculoskeletal deep-dives (Surgery), wellbeing meetings (Estates & Facilities (E&F)), Emergency Department recruitment / retention plan (Medicine).
    - Trust-wide actions: Perkbox being promoted for 24/7 wellbeing support; weekly task & finish group to understand root causes and develop action plans. Data to be analysed by demographics / protected characteristics – suggested to also triangulate by specific service / clinical area / professional group and to analyse financial impact by professional group.
    - Actions to be shared with MEC in February and People Committee in March.

Appraisals (ongoing monitoring):

- Overall compliance has improved marginally to 80.32% but remains below the 90% target. There has been a large increase in Cleaning (89.87%) but Corporate remains

low. Medicine, Surgery, FASS improved but remain below January / December 2024 levels.

- KPMG appraisal audit reported “significant assurance with minor improvement opportunities”. Agreed improvement actions include monitoring compliance; enhancing wellbeing conversations, strengthening development planning, targeted manager training, and capturing objective setting for new starters within Learn Together.
- Other mitigations: monthly performance review meeting monitoring; targeted divisional actions (Medicine, Surgery, E&F); A3 improvement work.

Vacancies and turnover (ongoing monitoring)

- The Trust is over established by 0.87% (48.7 Whole Time Equivalents), but this masks localised vacancies (Emergency Medicine, Pharmacy, Oncology, General Surgery).
- Slight increase in in-month turnover, 12-month turnover is increasingly low / unhealthy.
- KPMG audit reports that the RUH is in line with NHS safety standards. There are 7 actions for improvement predominately around artificial intelligence use in recruitment.

Allied Health Professional (AHP) Strategic workforce report and recommendations (development)

- Previously the RUH has lacked a structure / focus for AHPs and the AHP Lead is a new role. A 2025 AHP Strategic workforce report provided an overview of the AHP workforce and established a baseline understanding of current workforce challenges.
- The AHP Strategy is in development stage. The second of 5 strategic priorities will address AHP People Planning. Recommendations will address 3 areas aligned to the NHS long term workforce plan: Train, Retain, Reform. As the strategy progresses risks will emerge, including around AHP workforce planning: we anticipate the strategy and plans will reveal a shortfall of AHPs.
- The Strategy will be presented to the People Committee. This work will be transferrable across Group.

Multiprofessional Educational Quality Review (development)

- Annual quality review by NHS England (NHSE) for placement providers. The purpose is to enable good communication between senior leaders at the RUH as a local education provider and those in NHSE South West. Held to discuss the learning environment for all Undergraduate and Postgraduate learners. Consists of NHSE’s Provider Self-Assessment.
- Successes shared include growing multidisciplinary faculty Simulation Based Education; progress in strengthening education governance, safety awareness, and professional development; strengthened culture of collaboration resulting in improved learner support, educational quality, and equitable workforce development.
- Risks requiring oversight include burnout impacting learners and supervisors; educational space limitations / ageing facilities; rota gaps, particularly in Ear Nose and Throat; rising supervision demand in Ophthalmology; lack of Healthcare Scientist professional lead.
- Governance of these risks via Risk Register to be reported back to the Committee.

ASSURE: Inform the board where positive assurance has been achieved

Medical workforce (ongoing monitoring):

- Job planning:
  - The 2026-27 job planning round is open.
  - Consistency panels are in place for February and March (comprising staff-side and management representatives. The purpose is to ensure that job roles are evaluated consistently across different departments and that job plans follow national guidance).
  - The 2026-27 planning round emphasises team job plans and "neighbourhood" teams (focusing on shifting care from hospitals to community-based settings) – the national integrated neighbourhood team plan is due in February.
  - The Committee was reassured by confidence that a 95%+ completion rate is achievable.
- Resident Doctor 10 point plan:
  - Progress has been made regarding policies, procedures and framework.
  - Tangible changes that will be felt by Resident Doctors (e.g. training, study leave reimbursement, rest facilities and breaks, exception reporting, locker access, breast feeding spaces, hot food out of hours etc.) are work in progress: expect to see positive impact in next survey.

Immigration and Visa update

- RUH, GWH and SFT Care Organisation Leadership Teams (COLTs) approved implementation of the following changes:
  - Extension of visa duration: The maximum length of the initial visa will increase from three years to five years (to strengthen retention, reduce administrative burden, provide greater security and continuity for international colleagues).
  - Introduction of a 13- week average pay calculation for colleagues whose salaries fall marginally below the minimum salary threshold. Provides a fairer and more accurate reflection of earnings and supports continued eligibility for sponsorship where appropriate.
- The Committee discussed risk of conflict with Home Office guidance (resulting in enforcement action/ sponsor licence suspension). Advised the risk is mitigated by full transparency with the Home Office on earnings calculations. GWH has had several visa renewals approved on this basis (as have other Trusts).

Library Services – NHSE Quality Review

- NHSE conducts a rigorous Quality & Improvement Assessment every 3 years, involving meetings with key stakeholders (including the Chief People Officer) based upon submissions by the Academy Library against 16 Essential Indicators set by NHSE.
- For this period, all 9 essential indicators at Established Level are in place; 6 out of 7 essential indicators at the Good Level are in place.
- NHSE celebrated numerous areas of good practice including: the Academy Library is business critical in enabling evidence informed decision helping to inform clinical & non-clinical practice, saving staff time & money and improving patient care; excellent joint working recognised across BSW; embedded leadership & collaboration; innovative learner support for all staff & students.
- NHSE identified several areas for further work including improving staffing ratios; monitoring the impact of additional administrative tasks to support Learning &

Development; Trust / group wide implementation of LibKey Nomad browser extension to all PCs (easier access to paid-for research content); Group wide implementation of nationally purchased clinical decision support tool British Medical Journal (BMJ) Best Practice into the new group Electronic Patient Record (EPR).
RISK: Advise the board which risks where discussed and if any new risks were identified.
The relevant risks are detailed throughout the report.
CELEBRATING OUTSTANDING: Share any practice, innovation or action that the committee considers to be outstanding
Library Services – NHSE Quality Review
APPROVALS: Decisions and Approvals made by the Committee
There are no approvals to report.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**12**
Date of Meeting:	**24 February 2026**		
Title of Report:	**Alert, Advise and Assure Report – Finance and Performance Committee**		
Status:	**For information**		
Author:	**Antony Durbacz, Non-Executive Director**		

Key Discussion Points and Matters to be escalated from the meeting held on 24 February 2026

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

- Cashflow forecasts indicate that there may be a risk of going below the minimum required to maintain effective performance in the first quarter of 2026/27, there are several uncertainties in the position, and this is being actively managed.
- The available Capital Departmental Expenditure Limit (CDEL) for the Group is constrained with some pooling of resources needed. The allocation will need to be carefully managed on a risk basis.

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

- As we approach the year end, there is improved visibility on the full year outturn, with relatively high certainty around the outcome at £20.5m. This still has several actions to achieve the forecast especially given operational pressure. Some of the Identified opportunities that would have contributed to the committed £17m will now crystallise in 26/27.
- The business plan is now moving through the external review process and so may be subject to change following these reviews.
- The Committee will continue to focus/review on the plans to deliver the Cost Improvement Programme (CIP) for 26/27.

ASSURE: Inform the board where positive assurance has been achieved

- Except for the 4 hour standard there is increasing confidence in achieving the committed trajectories for the constitutional operational standards by year end. This success may result in revised tiering status for these standards.

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

- The Board Assurance Framework (BAF) now segments the operational risk into elective and non-elective activity giving improved visibility for risk management.
- The reporting of operational risks needs to be better aligned to the new Group standard.

CELEBRATING OUTSTANDING: Share any practice, innovation or action that the committee considers to be outstanding
• Given the unprecedented demand at the front door, the performance should be celebrated even if it fell short of constitutional standards. There is evidence to support the underlying performance despite the demand surge.
APPROVALS: Decisions and Approvals made by the Committee
• The Committee recommends to the Board approval of the investment in the provision of a turnkey solution for a CT scanner at the RUH. It was satisfied that the appropriate supply chain procedures had been applied and that the accompanying business plan yielded a benefit to the RUH. • The Committee recommends to the Board approval of the award to Vanguard as principal contractor on the Urgent Treatment Centre (UTC) modular award, which has been made under the provision of the NHS Shared Business Services (SBS) framework. Work will continue on the development of the full business case under the funding assumptions outlined by the regional team.

The Board is asked to NOTE the content of the report.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board or Directors**	**Agenda item:**	**13**
Date of Meeting:	**4 March 2026**		
Title of Report:	**Charities Committee Upward Report**		
Status	**For discussion**		
Author	**Sumita Hutchison, Charities Committee Chair**		

Key discussion points and matters to be escalated from the meeting

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

- **Green Heart Risk:** The Green Heart project remains a high risk on the risk register. The Committee has not yet received full assurance that progress by the Trust has been made, which could lead to fundraising by the charity. The Trust has committed to a contribution of up to £500k, however there remains a risk as the capital funding could be spent on other programmes such as the electronic patient record. Capital funding requirements are likely to be required to fulfil donor wishes and planning obligations. The Board is asked to note this continuing exposure and press for a definitive Trust capital commitment or agreement to re-scope and with a clear plan from the Trust so the charity can start to fundraise.

- **Financial Pressure:** The RUHX General Fund remains in deficit (£318k overdrawn as at 31 January 2026), resulting in a pause on new General Fund grant applications. Total income is £515k below budget year to date, primarily due to legacy and donation income not converting to cash as planned. The Board is asked to note the ongoing risk to charitable grant-making capacity. However, financial projections for the charity are positive.

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

- **Strategic Spending:** The Committee discussed the need for the Trust to become more strategic in how raised funds are deployed by the divisions. There is a shared recognition that spending decisions can be reactive and ad hoc. Greater alignment with Trust strategy, particularly the new RUHX five-year fundraising strategy, would increase impact and donor confidence. Support is needed from colleagues at the Trust to:
  1. Spend the money in a timely way.
  2. Maximise benefit by being strategic rather than reactive about spending.

- **Operating Budget 2026/27:** The 2026/27 operating budget was approved in principle, subject to further work on ensuring the levy and fundraising income model is right-sized to sustain the charity's operational infrastructure. The Committee agreed that the charity must generate sufficient income to fund its

own operations and not erode charitable reserves. A review of the levy structure (currently 25%) is ongoing with Finance, with options to be reported back by May 2026.

- **Investment Review:** A Task and Finish Group on investments will be established to review the current portfolio held with Barclays (£4.2m total: £1.4m cash at 1.35%, falling to 1.15% from February 2026, and £2.76m discretionary). The group will consider whether the current provider, asset allocation, and risk profile remain appropriate post-Cancer Centre completion, and whether a broader market review of investment managers is warranted.

ASSURE: Inform the Board where positive assurance has been achieved

- **Friends of the RUH:** The Committee received an update from the Friends of the RUH and noted ongoing positive engagement.

- **Volunteering Programme:** Significant growth in volunteering was reported by Friends of the RUH: 257 volunteers contributed 24,791 hours across 26 distinct roles in 2025, up from 207 volunteers and 22,294 hours the previous year. The Committee celebrated this outstanding contribution. It also recognised the strategic opportunity to better connect RUHX's volunteer programme with volunteering roles across the wider Trust, aligning with health inequalities objectives, supporting pathways back to work, and addressing drivers of ill health in the community.

- **Financial Position:** The Committee noted the financial position as at 31 January 2026. The total fund balance stands at £6,625k. Investment performance showed an unrealised gain of £211k and a 12-month return of 3.96%. The Cancer Centre car park and demolition works are progressing with £937k of committed expenditure remaining, forecast for completion in 2026/27.

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

- The key risks are identified in the alert section of the report.

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

- **Volunteering Growth:** The expansion of the Friends of the RUH volunteer programme, with 257 people giving nearly 25,000 hours in 26 roles, is outstanding. The Committee particularly recognised the potential to connect this with Trust-wide volunteering and social prescribing, helping people to get

back to work and addressing health inequalities across the Bath and North East Somerset community.

- **Walk of Life 2025:** The 20th anniversary event raised over £90,500 plus £2,500 in corporate sponsorship with 350 participants, a standout community fundraising achievement.

APPROVALS: Decisions and Approvals made by the Committee

The Committee approved:

- The RUHX 2026/27 Operating Budget, subject to further work on levy and right-sizing the income model.
- The establishment of a Task and Finish Group on investment portfolio review.

The Board is asked to:

- Note the continuing Green Heart capital risk and seek Trust commitment on funding.
- Note the General Fund deficit position and endorse management's in-year grip approach.
- Support the move towards a more strategic approach to charitable expenditure.
- Note the volunteering programme achievements and support linkage with Trust-wide volunteering and health inequalities strategy.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Subsidiary Oversight Committee	Agenda item:	14
Date of Meeting:	19 January 2026		

Title of Report:	Subsidiary Oversight Committee Terms of Reference Review
Status:	For Approval
Board Sponsor:	Antony Durbacz, Non-Executive Director, Chair of SOC
Author:	Roxy Milbourne, Interim Head of Corporate Governance

1. Executive Summary of the Report

The Subsidiary Oversight Committee Terms of Reference (ToR) (approved November 2024) have been reviewed. Minor changes have been made, and a summary of these changes can be seen below, these changes have been highlighted in yellow within the ToR:

Membership and Quorum:

- Removal of Chief Strategic Officer as a member as this role has moved to Group.

- Addition of the Director of Operational Finance as an attendee.

The amended ToR was approved by the Subsidiary Oversight Committee at their meeting on 19th January 2026 and are submitted to the Board of Directors for ratification.

2. Recommendations (Note, Approve, Discuss)

The Board of Directors is asked to ratify the amended Subsidiary Oversight Committee Terms of Reference.

3. Legal / Regulatory Implications

The Subsidiary Oversight Committee Terms of Reference require that legal and regulatory implications are adhered to.

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

Not applicable

5. Resources Implications (Financial / staffing)

Not applicable

6. Equality and Diversity

Not applicable

7. References to previous reports

The Committee Terms of Reference replace the previous version approved in November 2025.

8.	Freedom of Information
Public	

9.	Sustainability
Not applicable	

10.	Digital
Not applicable	

Subsidiary Oversight Committee
Terms of Reference

1. Constitution of the Committee

The Board of Directors hereby resolves to establish a Committee of the Board of Directors to be known as the Subsidiary Oversight Committee (the Committee). The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

2. Purpose and objectives

The Committee is established to provide the Board of Directors with assurance on the appropriate management of the Trust's wholly owned subsidiary companies and where the Trust has a shareholding or interest in a company (known as related company/entity). In particular, the Committee is established to:

- Ensure that where the Trust has an interest, or shareholding, the Trust has appropriate oversight and governance
- Set out the relevant governance and oversight arrangements in respect of the Sulis Hospital Bath.

The Committee is a standing committee of the Board of Directors (the Board) but will only carry out its functions where the Trust has any wholly owned subsidiary entities in existence.

The Committee is authorised to:

- Perform any of the activities within its terms of reference;
- Obtain outside professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary; and
- Consider and make recommendations to the Board of Directors on any and all items of which they should be aware to fulfil their responsibility

3. Roles and Responsibilities

The duties of the Committee are as follows:

- Ensuring the Trust has a clear strategy for the use and development of subsidiary companies. In relation to Sulis Hospital Bath, the Committee should ensure that the company supports the Trust's strategic priorities
- Seek assurance that the Board of Sulis Hospital Bath is taking steps to develop and maintain a culture of openness, fairness, equality and learning to support the delivery of high-quality services
- Seek assurance and where necessary, providing support to Sulis Hospital Bath in obtaining and maintaining correct and up to date registration with the Care Quality Commission, as well as appropriate licensing with NHS England
- Seeking assurance that the Board of Sulis Hospital Bath is fulfilling its reporting

and filing obligations to Companies House within agreed or mandated timescales.

- Agreeing with Sulis Hospital Bath clear financial and operational targets and objectives, and receiving regular updates as to performance against these.
- Maintaining a clear view of the subsidiary level risk profile and exposure (safety, quality, operational, reputational and financial) across the group profile.
- Ensuring the Trust has a clear governance framework and structure for oversight of Sulis Hospital Bath. This framework will confirm the Sulis Board's obligations to:
    - Attend the Committee to present the annual accounts for the previous year and the annual plan for the forthcoming year.
    - Provide an annual report on the company's activities to the Committee to include the extent to which key performance indicators have been met.
    - Report on relevant regulatory frameworks, including risks and mitigation plans where standards may have been compromised.
    - To confirm that there is a clear and transparent process for appointing the senior leadership team of Sulis Hospital Bath.
- Ensure the mobilisation of new subsidiary companies/entities is delivered effectively and aligned to the business case.

4. Membership

The Committee shall be appointed by the Board of Directors and shall consist of:

- A Non-Executive Director (Chair)
- Another Non-Executive Director (with a clinical background)
- Chief Financial Officer
- Chief Nursing Officer

In the absence of the Chair of the Committee, another Non-Executive Director will perform this role.

Each executive member must nominate a deputy to attend in their place when they are unable to. These nominated deputies will have voting rights and be counted towards the quorum. Additionally, in the event that neither the Chief Nursing Officer nor their deputy is able to attend a meeting, they may submit a report setting out the extent to which they are assured as to the quality of care provided at Sulis Hospital.

5. Quorum and attendance

Business will only be conducted if the meeting is quorate. The Committee will be quorate with two voting members of the Board of Directors present (at least one Executive Director and one Non-Executive Director).

Meetings of the Committee shall also be attended by:

- Managing or Hospital Director of the company/entity
- Chief Operating Officer

- ~~Chief Strategic Officer~~
- Chief Medical Officer (or deputy)
- Director of Operational Finance
- Head of Corporate Governance
- Specialist expertise as required

The Chair of the subsidiary company/entity will be invited to attend a majority of the meetings of this Committee.

Any member of the Board of Directors can attend.

6. Reporting

Minutes of Committee meetings will be recorded; and will normally be confirmed as accurate at the next meeting of the Committee.

The Chair of the Committee shall draw to the attention of the Board of Directors any issues that require disclosure to the full Board. The Committee shall also raise any significant concerns in relation to the business undertaken directly with the Board in a timely manner.

The Committee will report annually to the Board of Directors on the performance of its duties as reflected within its Terms of Reference.

Any items of specific concern or which require the Board of Directors approval will be subject to a separate report.

7. Frequency

The Committee will consider and agree on the frequency and timing of meetings needed to allow it to discharge all of its responsibilities.

Meetings will be held no less than four times per year, with additional meetings where necessary.

In normal circumstances, a minimum notice period of two weeks must be given for any other meetings of the Committee. Emergency meetings can be arranged, at shorter notice, if this is approved and evidenced as such, by the majority of the members of the Committee.

8. Secretariat and administration

The Head of Corporate Governance is a member of the committee and has corporate responsibility for:

- Liaising with the chair on all aspects of the work of the committee, including providing advice.
- Ensuring the committee acts in accordance with standing orders and scheme of reservation and delegation.

- Collation of the papers which will be disseminated five working days in advance of the meeting.
- Arranging for minutes and actions which will be disseminated five working days after the meeting.

These Terms of Reference will be subject to an annual review. The Committee shall conduct an annual self-assessment on the performance of its duties as reflected within its Terms of Reference and report any conclusions and recommendations for change to the Board.

As part of this assessment, the Committee shall consider whether or not it receives adequate and appropriate support in fulfilment of its role and whether or not its current workload is manageable.

Terms of Reference approved by the Committee on: **19th January 2026**

Ratified by the Board of Directors on: **4th March 2026**

Report to:	**Public Board of Directors**	**Agenda item:**	**15**
Date of Meeting:	**4 March 2026**		
Title of Report:	**Integrated Performance Report**		
Status:	**For Noting**		
Board Sponsors:	**Bernie Bluhm, Chief Operating Officer Toni Lynch, Chief Nursing Officer Jude Gray, Chief People Officer Simon Wade, Chief Finance Officer**		
Authors:	**Sufi Husain, Deputy COO / Sarah Hudson, Dep COO UEC / Operational Team Rob Elliot, Lead for Quality Assurance / Quality Team Matt Foxon, Site HR Director / Workforce Team Jon Lund, Director of Operational Finance / Tom Williams, Head of Financial Management / Financial Team**		
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 January 2026, 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 January 2026 was 67.4 minutes, a significant increase from 30.7 minutes on average in December 2025. Through January 2026 the total hours lost was 2,538. This is a 1,680-hour increase compared to last month's lost hours of 858. 35.4% of handovers were completed within 30 minutes.

RUH 4-hour performance in January was 54.20% on the RUH footprint (unmapped), a decrease of 2.47% from December's performance (56.67%). Non-admitted performance was 67.05%, which was a decrease against the performance for December (68.80%). January's admitted performance worsened to 27.62% (December 30.79%).

The numbers of patients going through our Medical Same Day Emergency Care (MSDEC) (799) increased in January compared to December (739) however Frailty Same Day Emergency Care (FSDEC) numbers reduced slightly (22). This was due to

increased acuity and increased length of stay within our Older Person's Unit (OPU) wards. Our performance for MSDEC at 38.5% for January 2026 (December 2025, 35.5%) remains just below the national target of 40% of patients going through an SDEC pathway.

In January, Referral to Treatment (RTT) performance saw an increase in overall performance of 0.5% to 63.1%. The percentage of patients waiting less than 18 weeks for their first outpatient appointment was 66.2% (+0.4% from December). Total over 52-week waiters decreased from 465 to 402 (-13%). The Trust continued to maintain having zero patients waiting over 65 weeks.

In January 2026, 76.1% of patients received their diagnostic procedure within the 6-weeks against the 76.5% target. Performance improved 4.44% from December 2025.

In December (Cancer is reported one month in arrears) performance improved against all three national standards. 28-Day Faster Diagnosis Standard (FDS) improved by 2.1% to 72.7% with Breast, Skin and Urology all recording notable improvements. 31-Days improved by 4.9% to 94.8% with Breast performance increasing by 7.5%, although Skin deteriorated due to planned treatment of patients >62 days. 62-day performance improved by 11.5% to 65.9% with Breast, Colorectal and Urology recovering. Performance against the FDS standard will deteriorate in January due to Skin first appointment waiting times in the first half of the month but with recovery expected in February.

Safety

Pressure Ulcers:

In January the Trust reported 1.0 pressure ulcers per 1,000 bed days (18 Pressure ulcers on 15 patients. The report consisted of two category 3 pressure ulcers, five category 2 medical device related pressure ulcers and eleven category 2 pressure ulcers. This is a significant increase of category 2 pressure ulcers. Locations on the body were sacrum, heels, bridge of nose and ear. The patient themes were non concordance with care, multiple comorbidities, poor blood supply and approaching end of life.

Falls

In January there were 4 reported falls that resulted in moderate or above harm to patients, 1 is being reviewed and may be reclassified as a collapse. There were 9.08 falls per 1000 bed days in December, this is an increase from 5.30 in November 2025. This has reduced in January; we will continue to monitor this increase to determine whether it represents a sustained trend. If the variation persists, the Falls Prevention and Improvement Group will review the data and agree targeted improvement actions.

Infection Prevention and Control

Due to the increased prevalence of influenza within the community, there has been a noticeable rise in patients testing positive for influenza more than 72 hours after admission, representing special cause variation in January. This trend is likely

influenced by recognised in-hospital exposures, contact with visitors, or delayed symptom onset from community-acquired infection prior to admission. It is important to note that the timing of influenza exposure and subsequent positive test results can vary and is not always scientifically predictable or reliably attributable to a single source.

Patient Support and Complaints
In January the Trust received 39 new formal complaints, this compares to 26 received in December. The complaint rate per 1000 patient contacts is 0.58. Across the Divisions 82.8% (target 90%) of complaint responses were closed within the agreed timeframe. However, closure rates varied by Division; FASS increased to 90%, the Surgical Division increased to 67% and the Medicine Division remained at 100% for the month.

Safe Staffing
The combined shift fill rates for days for RNs across the 24 inpatient wards/departments was 85% and 94% respectively for nights. The combined shift fill for HCSWs was 96% for the day and 104% for the night shift.

Perinatal Update
The Bath Somerset and Wiltshire (BSW) Group Local Maternity and Neonatal System (LMNS) have approved a new template for standardisation of the Perinatal Quality Support and Oversight Model (PQSOM) formerly known as PQST. This month is the first presentation of data on the new template.

Monthly workforce metrics continue to be monitored as part of the PQSOM. Metrics falling below target measures have been identified. January 2026 data highlights increased operational pressures across both maternity and neonatal services, driven by increased birth activity, and increased ‘in month’ sickness rates. Subsequently the Midwife-to-birth ratios exceeded the 2023 Birth Rate + target of 1:24, with ‘staff meets acuity’ indicators falling below target thresholds on both BBC and Mary Ward. This has prompted further review of roster planning, flexible working agreements and sickness trends. A particular focus and ‘deep dive’ has been identified and commenced within the Maternity Support Workers (MSW) workforce where sustained disproportionate high sickness, turnover and vacancy is seen.

Neonatal services cot occupancy was at 80–104% on 48% of shifts. Despite high occupancy the service saw improved supernumerary nurse-in-charge cover and full BAPM, compliant nursing shifts following risk mitigation actions put in place in response to risk register entry 3185. During January the percentage of Qualified in Specialty (QIS), trained workforce decreased to 66.6% following an influx of new starters, no QIS members have left the service. An action plan is in development to recover the position, with projected recovery in March 26 following completion and final assessment of 2 members of staff. Progress will be reported into specialty governance alongside a service risk assessment.

One event of Moderate harm was reported in the month of January pertaining to a post-partum haemorrhage of 4L. A review has been undertaken and no patient safety incident identified, and the event was deemed to be unavoidable. Duty of Candour was commenced by the repairing obstetric consultants. Perinatal Pelvic Health Service follow up has been arranged and families will be informed of the review of care outcome.

One event of Severe harm has been reported into trust from GWH regarding a query obstructed bowel following an elective caesarean birth at the RUH in June 2025. Inquiries are ongoing between RUH and GWH to establish chronology of events, harm and the incident in question, as ICE records indicate no obstruction or injury and a care plan of conservative management.

3 PSIRF learning responses are ongoing during the month of January.

There were three stillbirths reported in the month of January. No neonatal deaths were reported. No MOSS alerts were received.

A case cohort review is in progress being led by the Bereavement lead midwife supported by the Quality and Patient Safety Team to identify any commonalities or areas of focus for system improvement to support our ambitions for continual reduction in perinatal mortality.

Patient feedback remained largely positive, citing personalised care and supportive staff interactions, with no formal complaints raised, recurring improvement opportunities within contacts pertain to communication, postnatal information quality and ward environment. The service's 'Go-Live' with digitalisation of Cardiotocography (CTG) is in progress and due to 'Go-Live' in February 2026.

Workforce

Sickness absence remained high in January, with in-month sickness at 6.26% and the 12-month rate rising to 5.29%, the highest since February 2023. Anxiety, Stress and Depression (ASD) continued to be the leading cause of absence. Cold and flu also contributed significantly, accounting for 1.21% absence and 2,110 WTE days lost following a mid-month peak. These levels continue to reduce staff availability across services.

To manage this, HR support has been deployed to hotspot areas with strengthened reviews of both long- and short-term sickness. E&F is focusing on long-term cases and implementing the new sickness policy, while Surgery and FASS are prioritising high-impact clinical areas. The Trust is also increasing visibility of Perkbox wellbeing support. The updated Attendance and Wellbeing Policy has been approved and will launch on 9 March 2026 with enhanced manager support.

ASD-related sickness remains a concern at 1.42%, the sixth consecutive month above 1.4%. Targeted HR support is in place in high-ASD areas, alongside Trust-wide promotion of counselling and wellbeing services.

Appraisal compliance declined to 79.41%, down 0.9 percentage points, with all divisions falling and Corporate lowest at 63.28%. Divisions are responding through PRMs, A3 reviews and targeted reporting to drive improvement.

Mandatory training compliance remains above target at 88.62% but continues to trend downward. Several areas—including Resuscitation, Adult and Child Safeguarding, and Level 2 Manual Handling—are below target. Divisions are increasing e-learning access, improving resus training, and targeting priority subjects such as Paediatric Resuscitation and Moving & Handling.

The Trust remains slightly over-established by 47.4 WTE (–0.85%), influenced by 355.5 WTE of unidentified pay savings. The largest gaps remain Band 3 HCSWs (73.9 WTE) and Band 5 nurses (53.3 WTE). Divisions are progressing recruitment activity, with Medicine aiming for full HCSW establishment by April 2026. A redesigned visa offer has been introduced to support retention and staff nearing Indefinite Leave to Remain.

Turnover remains stable in-month at 0.59%, while the 12-month rate has risen to 7.02%. Corporate turnover is highest at 9.48%.
The Trust remains 189.5 WTE above the workforce plan. The substantive gap has reduced to 146 WTE, but bank usage fell marginally and agency use remains high at 18.6 WTE, above target for six consecutive months. Workforce controls, bank-to-substantive conversion and redesign work continue.

Bank usage is highest in Emergency Medicine nursing (24.5 WTE) and Cleaning (19 WTE), both at their lowest levels in a year. Agency use continues to be dominated by Medical and Dental staffing, exceeding the full agency plan for January. Agency spend reached 0.99% of the pay bill, with consultants—particularly in Oncology, Cellular Pathology, Haematology and Breast Care—accounting for over two-thirds of spend. Nurse agency use has reduced slightly. Divisions are reviewing unfunded cleaning requests, prioritising ED recruitment, and onboarding additional cleaners from April–May.

Finance

The RUH Group is £18.3m adverse to plan at the end of January, of which £18.5m arising in RUH Trust and £0.15m favourable 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 has secured funding and regional approval to commission a Turnaround team who started in the Trust on 17 November. 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 £14.5m 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. Within this there is £3.6m unidentified Group savings, £2.9m UEC savings due to NCTR and activity growth levels, £0.7m Corporate Redesign slippage and £1.9m Outpatient transformation slippage. Workforce plan reductions have been offset by staff sickness levels rising to 6.1% and c20% above last Winter; as well as operational pressures in clinical administration, notably typing backlogs.

Operational budget pressures have maintained in January with cumulative pressures arising from increased spend on high-cost drugs and devices (£1.6m), Pay Award (£0.3m) Resident Doctors budget pressures (£2.1m). Industrial Action was funded in Month 10, covering all IA to date. The remaining cost pressures are partly offset by increased cost controls and non-recurrent benefits (£4.3m). Sulis is favourable to plan by £0.15m. Non-Pay costs have underspent against plan including backdated charges to the RUH. Further adverse variances arise from deterioration in the exit run rate from 24/25 (£5m)

Cash balances for the Trust are £20.2m, this includes cash received in advance. Cashflow forecasts have been undertaken which show cash balances reducing to £15.2m by April on a do-nothing scenario and c£19.5m in line with Recovery trajectory. £19.5m is judged to be the minimum working cash limit to enable contractual obligations to be met in time; and therefore; enhanced cash monitoring and controls are being developed, in advance of potential requests for NHSE revenue cash support loans.

For October 2025 the Trust had a year-on-year implied productivity improvement of 1.8% against the breakthrough objective of 6.7%. Cost weighted activity grew by 4.1% compared to inflation adjusted cost growth of 2.3%. Given that much 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 continues to be assessed at £47.3m and is aligned with 25/26 Recovery Actions and Forecast Outturn; although £2.1m of unmitigated risks dependent on final exit run rate. This has been the baseline for 26/27 planning. The Trust operates within BSW Integrated Care System which has reported a £16.1m adverse variance to plan year to date, of which BSW Hospitals Group is £35.2m adverse to plan partially offset by ICB favourable variance to plan of £19.1m. The worsening in month is broadly aligned to the anticipated Month 10 position.

The Trust continues to work hard to deliver recovery actions, supported by the Turnaround team, to deliver the £17m Forecast Outturn. However, at the end of month the most likely position is £20.5m and this has been submitted to NHSE as the most likely forecast outturn.

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

3.	Legal / Regulatory Implications
Trust Single Oversight Framework.	

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

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

6.	Equality and Diversity
NA	

7.	References to previous reports
Standing agenda item	

8.	Freedom of Information
Private	

9.	Sustainability
None identified.	

10.	Digital
None identified.	

NHS
Royal United Hospitals Bath
NHS Foundation Trust

Integrated Performance Report

February 2026
(January 2026 Data)

The RUH, where you matter

Trust Priorities 2025/26

NHS
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.

NHS
Royal United Hospitals Bath
NHS Foundation Trust

Executive Summary

February 2026
(January 2026 Data)

The RUH, where you matter

Trust Executive Summary: Operational Performance Dashboard

Executive Summary

* January

Domain	Measure	Month	Latest Performance	Previous Performance	Month-End Target	Year-End Target	Assurance	Variation	Variation Detail
Urgent Care	12 Hour Trolley Waits	Jan-26	328	137		0	F	H	Special Cause Concerning - Above Upper Control Limit
Urgent Care	12 Hour Trolley Waits (% Type 1 Atts)	Jan-26	13.4%	7.7%	8.8%	0.0%	F	H	Special Cause Concerning - Above Upper Control Limit
Urgent Care	4 Hour ED Performance	Jan-26	54.2%	56.7%	71.6%	72.0%	F	L	Special Cause Concerning - Run Below Mean
Urgent Care	Average Ambulance Handover Time (mins)	Jan-26	67	31	33	33	F		Common Cause Variation
Urgent Care	ED Patients Assessed in under 15 mins	Jan-26	69.9%	64.7%				H	Special Cause Improving - Above Upper Control Limit
Urgent Care	No Criteria to Reside (% Occupied Beds)	Jan-26	20.4%	17.0%		10.0%	F		Common Cause Variation
Urgent Care	Non Elective Length of Stay	Jan-26	8.2	9.1		8.4	?		Common Cause Variation
Elective Activity	RTT Incomplete Pathways over 52 weeks	Jan-26	1.0%	1.2%	1.2%	1.0%	F	L	Special Cause Improving - Below Lower Control Limit
Elective Activity	RTT Incomplete Pathways over 65 weeks	Jan-26	0	0		0	?	L	Special Cause Improving - Two Out of Three Low
Elective Activity	RTT Performance	Jan-26	63.1%	62.6%	64.6%	67.7%	F		Common Cause Variation
Elective Activity	RTT Wait to First Outpatient Appointment (% <18 weeks)	Jan-26	66.2%	65.8%	68.6%	72.0%	F		Common Cause Variation
Diagnostics	CT Productivity (CT Activity DM01 Volume At or Above Plan)	Jan-26	-85	-219		0	?	L	Special Cause Concerning - Run Below Mean
Diagnostics	DM01 Performance (% <6 weeks)	Jan-26	76.1%	71.6%	93.1%	95.0%	F	H	Special Cause Improving - Increasing Run
Diagnostics	MRI Productivity (MRI Activity DM01 Volume At or Above Plan)	Jan-26	-132	-150		0	?	L	Special Cause Concerning - Two Out of Three Low
Cancer	Cancer 28 Day Diagnosis	Dec-25	73.1%	69.9%	80.7%	80.0%	F		Common Cause Variation
Cancer	Cancer 31 Day Treatment	Dec-25	93.2%	88.5%	92.0%	90.0%	?		Common Cause Variation
Cancer	Cancer 62 Day Standard	Dec-25	63.8%	55.7%	75.3%	75.0%	?		Common Cause Variation

Overview – Executive Themes and Actions to Raise at Board

Call to Action

UEC – 4 hour	RUH 4-hour performance in January was 54.20% on the RUH site, a decrease of 2.47% from December performance (56.67%). Non-admitted performance was 67.05%, which was a decrease against the performance for December (68.80%) with Decembers admitted performance also decreasing to 27.62% (December 30.79%). Activity in MSDEC increased in January to 799 patients, the highest recorded value (December 739). Medical Division SDEC performance was 38.5% for January 2026 which is just below the national target of 40% of patients going through an SDEC pathway.
Financial Recovery - £17m Deficit	The RUH is £18.3m adverse to plan at the end of January, of which £18.5m is at RUH and £0.15m favourable in Sulis. The Trust continues to work hard to deliver recovery actions, supported by the Turnaround team, to deliver the £17m Forecast Outturn. However, at the end this month the most likely position is £20.5m and this has been submitted to NHSE as the most likely forecast outturn. The turnaround team continues to provide support on run rate reductions to support the year end position as well as future years savings opportunities.
Referral to Treatment times – 65 weeks	RTT performance was 63.1% at end of January 2026 which is a continued improvement from previous months however was 1.5% behind our RTT plan (64.6%). The percentage of patients waiting less than 18 weeks for their first outpatient appointment was 65.8% (+0.4% from December). Total over 52-week waiters continued to decrease to 402 (-13% reduction on previous month). The Trust continued to maintain having zero patients waiting over 65 weeks.
Cancer – 28-day Faster Diagnosis	Cancer is reported one month in arrears. December performance improved against all three national standards. 28 Day FDS improved by 2.1% to 72.7% with Breast Skin and Urology all recording notable improvements. 31 Days improved by 4.9% to 94.8% with Breast performance increasing by 7.5%, although Skin deteriorated due to planned treatment of patients >62 days. 62 day performance improved by 11.5% to 65.9% with Breast, Colorectal and Urology recovering. Performance against the FDS standard will deteriorate in January due to Skin first appointment waiting times in the first half of the month but with recovery expected in February.
Diagnostics – DM01 Backlog	In January 2026, 76.1% of patients received their diagnostic procedure within the 6-weeks against the 76.5% target. Performance improved 4.44% from December 2025.
Patient Safety & Staff Wellbeing	The number of pressure ulcers has breached the upper control limit and falls resulting in harm per 1000 bed days has increased has increased. Staffing red flags have increased, and nursing fill rates continue to fall below target across several clinical areas. Analysis of key metrics is underway to better understand potential causal factors. The Trust Mortality Group is now meeting fortnightly to strengthen mortality surveillance and improve the triangulation of mortality data. Mixed Sex Accommodation breaches show a slight improvement, and a focused piece of work is progressing across BSW to validate data. Current breaches occur within assessment areas rather than inpatient wards. December in-month sickness was **6.26%**, with **Anxiety, Stress & Depression (ASD)** the leading cause; **colds/flu** alone accounted for **1.21%** and peaked mid-month. The **12-month rate** rose to **5.29%**, the highest since Feb-23. In January, **ASD sickness** was **1.42% -** down from October's peak but ~15% above the mid-2023–August norm (1.23%) - equating to ~330 extra WTE days lost. Actions: targeted HR support and sickness reviews in hotspot areas (Medicine, Surgery/FASS; ED R&R plan in place); E&F embedding policy and enabling adjusted-duty returns; trust wide promotion of Perkbox counselling/wellbeing resources; Surgery designated ASD driver.

Balanced Scorecard – SWOT Analysis

Successes

- Sustained zero over 65 week waiters since end of December 2025
- Continuing reduction in number of patients waiting over 52 weeks
- December performance on 28 Day FDS improved by 2.1% to 72.7%
- Oversight Framework for Q2 2025/26 published on 11th December 2025 -Trust remains in Segment 4 but has improved its ranking to 105 / 134 (previously 112).
- Capital investment to relocate Urgent Treatment Centre by Q4 2026/27
- Extended Emergency Medicine Ambulatory Care (EEMAC) opened at the end of January 2026 – concept proved, the focus now is on increasing throughput to positively impact 4-hour performance.
- Revised Forecast Outturn £20.5m approved by Joint Ctte and accepted by NHSE
- M10 £1,569m deficit delivery in line with revised Forecast Outturn £1,500m
- Command and Control Actions – expenditure controls and elective sprint income and Turnaround Recovery Plans embedding and delivering

Opportunities

- Digital opportunities in Outpatients - AI test of change, automation of referral process & electronic check-in
- Quarter 4 Elective Sprint Funding for Outpatients, Cancer and independent sector to reduce elective waiting times
- Further strengthening of financial controls
- UEC reset programme
- NHSE UEC 4-hour sprint March 2026
- Implementation of Internal Professional Standards
- Capital investment to support our 3 year MTFP
- Commercial opportunities including sale and Leaseback of Assets
- I&E deficit causing working capital cashflow pressures
- Stretching 26/27 financial plan with £55m of 3yr savings, heavily front-loaded to £36m in 26/27 – not yet fully identified or all mature to embed fully in operating budgets
- Indicative national capital allocations of £108m over 4yr for Estates Safety, UTC, Integrated Fronto Door and CDC – subject to full business cases
- Unmitigated risks against £84m 4yr Operational CDEL budget
- No clarity over national digital funding in Medium Term Plan

Priorities

- Maintenance of patient safety
- Delivery of the financial and operational recovery plan ‘Call to Action’
- Business planning for next 3-year cycle – move to implementation plan
- Fully embed revised EQIA process into decision making
- Escalation of areas where we are off plan to ICB where commissioning assumptions have not materialise
- Staff health and well-being as we come out of the winter period and plan for 2026/27.
- Trustwide promotion of Perkbox counselling/wellbeing resources
- Development of Ambient and other digital applications
- Corporate Services Redesign
- Improve coding compliance
- Delivering and transacting identified Recovery Actions in Q4 including Elective Sprint funding.
- Identifying and delivering further £3.5m of recovery including technical solutions by year end
- Ongoing Command and Control and Recovery Actions to year end
- 26/27 Savings delivery plans and maturity assessment; with delivery structure and governance to assure delivery
- Cashflow and I&E forecasting for Q1 26/27
- Capital programme full business case development and risk mitigation

Risk/Threats

- Consistently reduced nursing fill rates, long waits in Front Door areas adversly impacting patient outcomes: pressure ulcers and falls
- Maintenance of patient safety in light of financial & performance pressures
- Significant increases in UEC demand far outstripping planned levels
- Prolonged period of winter pressure will exacerbate flow challenges
- Financial controls fatigue
- Continuation of Resident Doctor Industrial Action
- Staff morale and burn out due to constant pressures of workload
- Navigation of the Tiering process and increased regulation
- CQC Unannounced Inspection to UEC and the risk to deterioration in Trust rating
- Ongoing operational pressures, notably UEC demand, critical incidents and escalation leading to premium escalation costs and delays in savings
- Contract Income challenges and disputes
- Year end audit and assurance of Recovery Actions

Executive Summary

Performance

The average ambulance handover delay for January 2026 was 67.4 minutes, a significant increase from 30.7 minutes on average in December 2025. Through January 2026 the total hours lost was 2,538. This is a 1,680-hour increase compared to last month's lost hours of 858. 35.4% of handovers were completed within 30 minutes.

RUH 4-hour performance in January was 54.20% on the RUH footprint (unmapped), a decrease of 2.47% from December's performance (56.67%). Non-admitted performance was 67.05%, which was a decrease against the performance for December (68.80%). January's admitted performance worsened to 27.62% (December 30.79%).

The numbers of patients going through our Medical Same Day Emergency Care (MSDEC) (799) increased in January compared to December (739) however Frailty Same Day Emergency Care (FSDEC) numbers reduced slightly (22). This was due to increased acuity and increased length of stay within our Older People's Unit (OPU) wards. Our performance for MSDEC at 38.5% for January 2026 (December 2025, 35.5%) remains just below the national target of 40% of patients going through an SDEC pathway.

In January, Referral to Treatment (RTT) performance saw an increase in overall performance of 0.5% to 63.1%. The percentage of patients waiting less than 18 weeks for their first outpatient appointment was 66.2% (+0.4% from December). Total over 52-week waiters decreased from 465 to 402 (-13%). The Trust continued to maintain zero patients waiting over 65-weeks.

In January 2026, 76.1% of patients received their diagnostic procedure within the 6-weeks against the 76.5% target. Performance improved 4.44% from December 2025.

In December (Cancer is reported one month in arrears) performance improved against all three national standards. 28 Day Faster Diagnosis Standard (FDS) improved by 2.1% to 72.7% with Breast, Skin and Urology all recording notable improvements. 31-Days improved by 4.9% to 94.8% with Breast performance increasing by 7.5%, although Skin deteriorated due to planned treatment of patients >62 days. 62-day performance improved by 11.5% to 65.9% with Breast, Colorectal and Urology recovering. Performance against the FDS standard will deteriorate in January due to Skin first appointment waiting times in the first half of the month but with recovery expected in February.

Executive Summary

Quality

Pressure Ulcers:
In January the Trust reported 1.0 pressure ulcers per 1,000 bed days (18 Pressure ulcers on 15 patients. The report consisted of two category 3 pressure ulcers, five category 2 medical device related pressure ulcers and eleven category 2 pressure ulcers. This is a significant increase of category 2 pressure ulcers. Locations on the body were sacrum, heels, bridge of nose and ear. The patient themes were non concordance with care, multiple comorbidities, poor blood supply and approaching end of life.

The system themes were a very busy ED where two patients developed pressure ulcers on trolleys where they were in the department for a prolonged period due to bed pressures, poor staff understanding of skin deterioration and actions to take to prevent pressure ulcer development.

Falls
In January there were 4 reported falls that resulted in moderate or above harm to patients, 1 is being reviewed and may be reclassified as a collapse. There were 9.08 falls per 1000 bed days in December, this is up from 5.30 in November 2025. This has reduced in January; we will continue to monitor this increase to determine whether it represents a sustained trend. If the variation persists, the Falls Prevention and Improvement Group will review the data and agree targeted improvement actions. As a result of several falls across the 3 divisions a trust wide PSII (Patient safety incident investigation) has been commissioned and is awaiting final sign off.

Infection Prevention and Control
Due to the increased prevalence of influenza within the community, there has been a noticeable rise in patients testing positive for influenza more than 72 hours after admission, representing special cause variation in January. This trend is likely influenced by recognised in-hospital exposures, contact with visitors, or delayed symptom onset from community-acquired infection prior to admission. It is important to note that the timing of influenza exposure and subsequent positive test results can vary and is not always scientifically predictable or reliably attributable to a single source.

Patient Support and Complaints
In January the Trust received 39 new formal complaints, this compares to 26 received in December. The complaint rate per 1000 patient contacts is 0.58. Across the Divisions 82.8% (target 90%) of complaint responses were closed within the agreed timeframe. However, closure rates varied by Division; FASS increased to 90%, the Surgical Division increased to 67% and the Medicine Division remained at 100% for the month.

Safe Staffing
The combined shift fill rates for days for RNs across the 24 inpatient wards/departments was 85% and 94% respectively for nights. The combined shift fill for HCSWs was 96% for the day and 104% for the night shift.

Executive Summary

Quality cont...

Perinatal Update
The Bath Somerset and Wiltshire (BSW) Group Local Maternity and Neonatal System (LMNS) have approved a new template for standardisation of the Perinatal Quality Support and Oversight Model (PQSOM) formerly known as PQST. This month is the first presentation of data on the new template.

Monthly workforce metrics continue to be monitored as part of the PQSOM. Metrics falling below target measures have been identified. January 2026 data highlights increased operational pressures across both maternity and neonatal services, driven by increased birth activity, and increased 'in month' sickness rates. Subsequently the Midwife-to-birth ratios exceeded the 2023 Birth Rate + target of 1:24, with 'staff meets acuity' indicators falling below target thresholds on both BBC and Mary Ward. This has prompted further review of roster planning, flexible working agreements and sickness trends. A particular focus and 'deep dive' has been identified and commenced within the Maternity Support Workers (MSW) workforce where sustained disproportionate high sickness, turnover and vacancy is seen.

Neonatal services cot occupancy was at 80–104% on 48% of shifts. Despite high occupancy the service saw improved supernumerary nurse-in-charge cover and full BAPM-compliant nursing shifts following risk mitigation actions put in place in response to risk register entry 3185. During January the percentage of Qualified in Specialty (QIS) - trained workforce decreased to 66.6% following an influx of new starters, no QIS members have left the service. An action plan is in development to recover the position, with projected recovery in March 26 following completion and final assessment of 2 members of staff. Progress will be reported into specialty governance alongside a service risk assessment.

One event of Moderate harm was reported in the month of January pertaining to a post-partum haemorrhage of 4L. A review has been undertaken and no patient safety incident identified, and the event was deemed to be unavoidable. Duty of Candour was commenced by the repairing obstetric consultants. Perinatal Pelvic Health Service follow up has been arranged and families will be informed of the review of care outcome.

One event of Severe harm has been reported into trust from GWH regarding a query obstructed bowel following an elective caesarean birth at the RUH in June 2025. Inquiries are ongoing between RUH and GWH to establish chronology or events, harm and the incident in question, as ICE records indicate no obstruction or injury and a care plan of conservative management.

3 PSIRF learning responses are ongoing during the month of January

There were three stillbirths reported in the month of January. No neonatal deaths were reported. No MOSS alerts were received.

A case cohort review is in progress being led by the Bereavement lead midwife supported by the Quality and Patient Safety Team to identify any commonalities or areas of focus for system improvement to support our ambitions for continual reduction in perinatal mortality.

Patient feedback remained largely positive, citing personalised care and supportive staff interactions, with no formal complaints raised, recurring improvement opportunities within contacts pertain to communication, postnatal information quality and ward environment. The service's 'Go-Live' with digitalisation of Cardiotocography (CTG) is in progress and due to 'Go-Live' in February 2026.

Executive Summary

Workforce

Sickness absence remained high in January, with in-month sickness at 6.26% and the 12-month rate rising to 5.29%, the highest since February 2023. Anxiety, Stress and Depression (ASD) continued to be the leading cause of absence. Cold and flu also contributed significantly, accounting for 1.21% absence and 2,110 WTE days lost following a mid-month peak. These levels continue to reduce staff availability across services.

To manage this, HR support has been deployed to hotspot areas with strengthened reviews of both long- and short-term sickness. E&F is focusing on long-term cases and implementing the new sickness policy, while Surgery and FASS are prioritising high-impact clinical areas. The Trust is also increasing visibility of Perkbox wellbeing support. The updated Attendance and Wellbeing Policy has been approved and will launch on 9 March 2026 with enhanced manager support.

ASD-related sickness remains a concern at 1.42%, the sixth consecutive month above 1.4%. Targeted HR support is in place in high-ASD areas, alongside Trust-wide promotion of counselling and wellbeing services.

Appraisal compliance declined to 79.41%, down 0.9 percentage points, with all divisions falling and Corporate lowest at 63.28%. Divisions are responding through PRMs, A3 reviews and targeted reporting to drive improvement.

Mandatory training compliance remains above target at 88.62% but continues to trend downward. Several areas—including Resuscitation, Adult and Child Safeguarding, and Level 2 Manual Handling—are below target. Divisions are increasing e-learning access, improving resus training, and targeting priority subjects such as Paediatric Resuscitation and Moving & Handling.

The Trust remains slightly over-established by 47.4 WTE (–0.85%), influenced by 355.5 WTE of unidentified pay savings. The largest gaps remain Band 3 CSWs (73.9 WTE) and Band 5 nurses (53.3 WTE). Divisions are progressing recruitment activity, with Medicine aiming for full HCSW establishment by April 2026. A redesigned visa offer has been introduced to support retention and staff nearing Indefinite Leave to Remain.

Turnover remains stable in-month at 0.59%, while the 12-month rate has risen to 7.02%. Corporate turnover is highest at 9.48%.
The Trust remains 189.5 WTE above the workforce plan. The substantive gap has reduced to 146 WTE, but bank usage fell only marginally and agency use remains high at 18.6 WTE, above target for six consecutive months. Workforce controls, bank-to-substantive conversion and redesign work continue.

Bank usage is highest in Emergency Medicine nursing (24.5 WTE) and Cleaning (19 WTE), both at their lowest levels in a year. Agency use continues to be dominated by Medical and Dental staffing, exceeding the full agency plan for January. Agency spend reached 0.99% of the pay bill, with consultants—particularly in Oncology, Cellular Pathology, Haematology and Breast Care—accounting for over two-thirds of spend. Nurse agency use has reduced slightly. Divisions are reviewing unfunded cleaning requests, prioritising ED recruitment, and onboarding additional cleaners from April–May.

Executive Summary

FInance

The RUH Group is £18.3m adverse to plan at the end of January, of which £18.5m arising in RUH Trust and £0.15m favourable 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 has secured funding and regional approval to commission a Turnaround team who started in the Trust on 17 November. 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 £14.5m 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. Within this there is £3.6m unidentified Group savings, £2.9m UEC savings due to NCTR and activity growth levels, £0.7m Corporate Redesign slippage and £1.9m Outpatient transformation slippage. Workforce plan reductions have been offset by staff sickness levels rising to 6.1% and c20% above last Winter; as well as operational pressures in clinical administration, notably typing backlogs.

Operational budget pressures have maintained in January with cumulative pressures arising from increased spend on high-cost drugs and devices (£1.6m), Pay Award (£0.3m) Resident Doctors budget pressures (£2.1m). Industrial Action was funded in Month 10, covering all IA to date. The remaining cost pressures are partly offset by increased cost controls and non-recurrent benefits (£4.3m). Sulis is favourable to plan by £0.15m. Non-Pay costs have underspent against plan including backdated charges to the RUH. Further adverse variances arise from deterioration in the exit run rate from 24/25 (£5m)

Cash balances for the Trust are £20.2m, this includes cash received in advance. Cashflow forecasts have been undertaken which show cash balances reducing to £15.2m by April on a do-nothing scenario and c£19.5m in line with Recovery trajectory. £19.5m is judged to be the minimum working cash limit to enable contractual obligations to be met in time; and therefore; enhanced cash monitoring and controls are being developed, in advance of potential requests for NHSE revenue cash support loans.

For October 2025 the Trust had a year-on-year implied productivity improvement of 1.8% against the breakthrough objective of 6.7%. Cost weighted activity grew by 4.1% compared to inflation adjusted cost growth of 2.3%. Given that much 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 continues to be assessed at £47.3m and is aligned with 25/26 Recovery Actions and Forecast Outturn; although £2.1m of unmitigated risks dependent on final exit run rate. This has been the baseline for 26/27 planning.

The Trust operates within BSW Integrated Care System which has reported a £16.1m adverse variance to plan year to date, of which BSW Hospitals Group is £35.2m adverse to plan partially offset by ICB favourable variance to plan of £19.1m. The worsening in month is broadly aligned to the anticipated Month 10 position.

The Trust continues to work hard to deliver recovery actions, supported by the Turnaround team, to deliver the £17m Forecast Outturn. However, at the end of month the most likely position is £20.5m and this has been submitted to NHSE as the most likely forecast outturn.

The RUH, where you matter

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

Key Cost Drivers

Royal United Hospitals Bath NHS Foundation Trust

Business Plan Delivery January 2026

Activity Plan

	YTD Plan	YTD Actual	Variance	Change per Day Actual
OP News	167,546	172,656	5,110	+24
OP Follow Ups	255,863	264,403	8,540	+40
Daycases	32,925	31,386	-1,539	-7
EL Inpatients	3,987	3,286	-701	-3
ED Attendances	86,296	88,450	2,154	+7
NEL Admissions	51,897	55,322	3,425	+11
Diagnostic tests	144,231	141,988	-2,243	-11

Planning Assumptions

	Plan	YTD Actual
GP Referral Growth*	0.0%	3.1%
ED Atts Growth	2.6%	5.1%
NEL Admit Growth (excludes maternity)	3.4%	11.7%
NCTR	44	100
NEL Length of Stay (for 1+ days)	6.2	6.7

* 1 month reporting lag

Performance

		Year End Target	Current Month Plan	
RTT	<18 1st app	71.7%	68.6%	66.2%
	<18 weeks	67.7%	64.6%	63.1%
	>52 weeks	1.0%	1.1%	1.0%
Cancer	62 days*	75.0%	75.3%	63.7%
	31 days*	96.0%	92.0%	93.0%
	28 days*	80.0%	80.7%	73.2%
ED	4hr type 1	72.0%	71.6%	54.2%
	4hr All Types	78.0%	77.3%	64.3%
	12 hours	reduction	8.8%	13.4%
DM01	> 6 weeks	5.0%	6.9%	23.9%

* 1 month reporting lag

Finance

	YTD Plan	YTD Actual	Variance
Cash Releasing Savings	£24,508	£10,267	-£14,241
Financial Position	£0	-£18,331	-£18,331
Productivity	+6.7%	+1.8%	-4.9%

Figs to Oct 25

Workforce

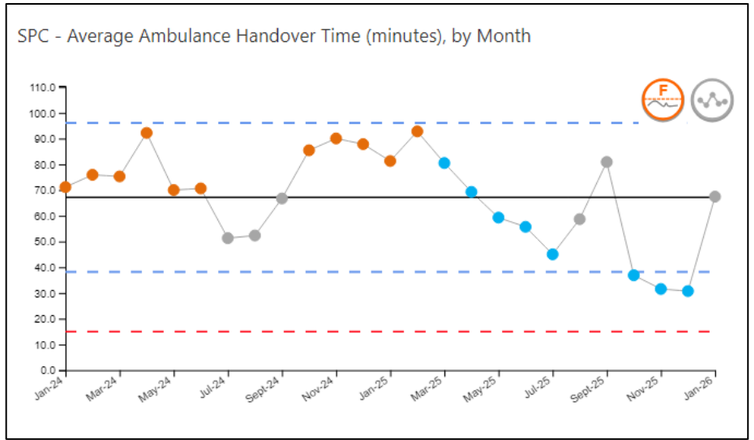
	YTD Planned	YTD Actual	Variance
Pay Savings (£000s)	£12,144	£3,878	-£8,266
WTE Reduction	5584	5777	193.0
Sickness - 12 Month	4.84%	6.14%	1.30%

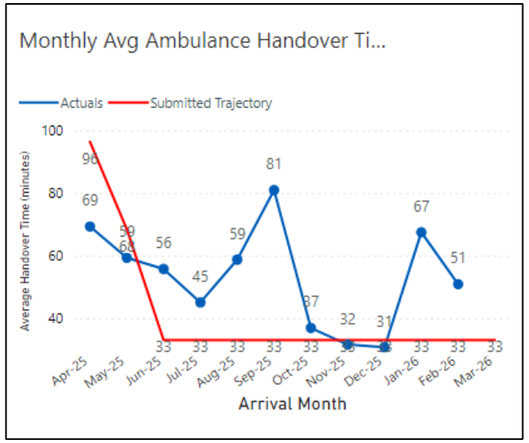
Ambulance Handover Times

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)*





This measure demonstrates a single incident of common cause variation following a series of three positive special cause variation. Broadly, performance is improving but is currently failing the target of 15 minutes.

The average ambulance handover delay for January 2026 was 67.4 minutes, a significant increase from 30.7 minutes on average in December 2025. Through January 2026 the total hours lost was 2,538. This is a 1,680-hour increase compared to last month's lost hours of 858. 35.4% of handovers were completed within 30 minutes.

January 2026 performance is 34 minutes behind trajectory; February 2026 so far is showing a slightly improved position, at 18 minutes behind trajectory (06/01/2025).

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
- Increased instances of corridor care due to W45.

Countermeasures	Owner	Due Date
Implement the National Acuity Model to support triage and streaming. **IN PROGRESS – training, soft-launching Feb26.**	JR	TBC – Jan26/Feb26
Plan and agree case for change supporting an EEMAC model within current ED Obs footprint. **COMPLETE – continually improving.**	MP	Jan26
Recruit 10.24 WTE registrars following business case approval. **IN PROGRESS – adverts in pipeline.**	MP/BI	Mar27
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**

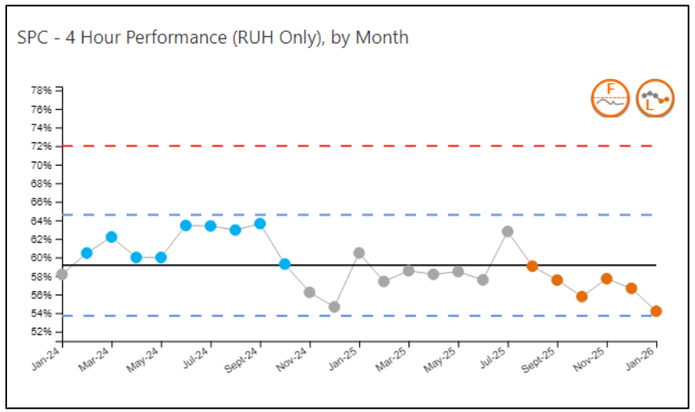
Risks and Mitigation

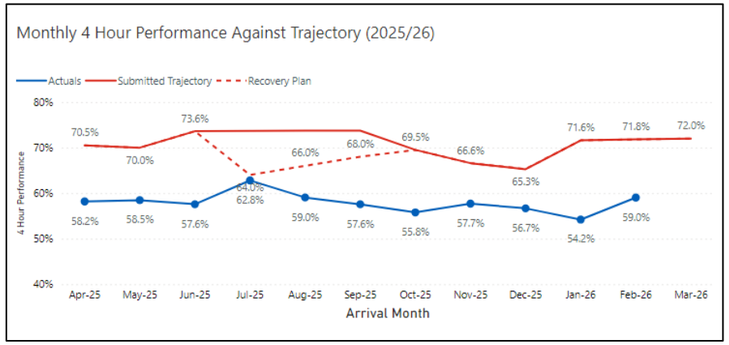
- Risk of >45min handover duration.
  - Site/ED extended handover process in place.
- Risk of patient deterioration in an ambulance not offloaded.
  - RUH ED review of deteriorating pts, QI project in progress.

4 Hour Performance

Royal United Hospitals Bath NHS Foundation Trust

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





This measure demonstrates a negative special cause variation as it is worsening and is currently failing the target of 72%

	Admit	Non-admit	Total	Target
ED	16.24%	28.86%	**22.50%**	**42%**
CED	76.07%	93.36%	**90.03%**	**95%**
UTC	64.63%	88.28%	**85.67%**	**95%**
Total	**27.62%**	**67.05%**	**54.20%**	**72%**

*78% target incl. MIU

Understanding Performance

Blockers to achievement:

- ED exit block due to lack of flow into downstream wards
- ED used as default when assessment areas are full
- Delays in speciality response times
- Increase in ambulance conveyance numbers
- Increase in frailty attendance and admission
- Sustained NCTR >18%
- Winter IPC impact

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
Implement the National Acuity Model to support triage and streaming. **IN PROGRESS – training, soft-launching Feb26.**	JR	TBC, Jan26/Feb26
Overnight streaming – current state analysis.	JR	TBC
Plan and agree case for change supporting an EEMAC model within current ED Obs footprint. **COMPLETE – continually improving.**	MP	Jan26
Recruit 10.24 WTE registrars following business case approval. **IN PROGRESS – adverts in pipeline.**	MP/BI	Mar27
Support implementation and monitoring of IPS 2025 via UEC Improvement Programme.	Leadership team	Mar26

Risks and Mitigation

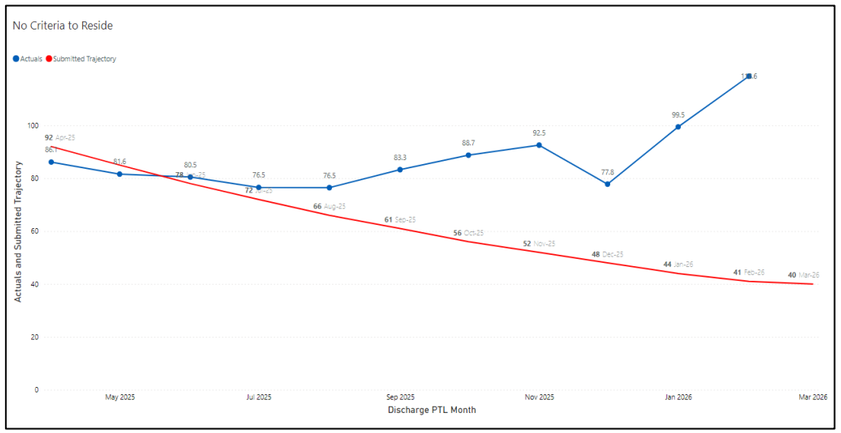
- Risk of increase mortality due to extended wait times in ED/UC.
- Risk of staff burnout and disengagement due to overcrowding.
    - UEC improvement programme to reduce overcrowding.

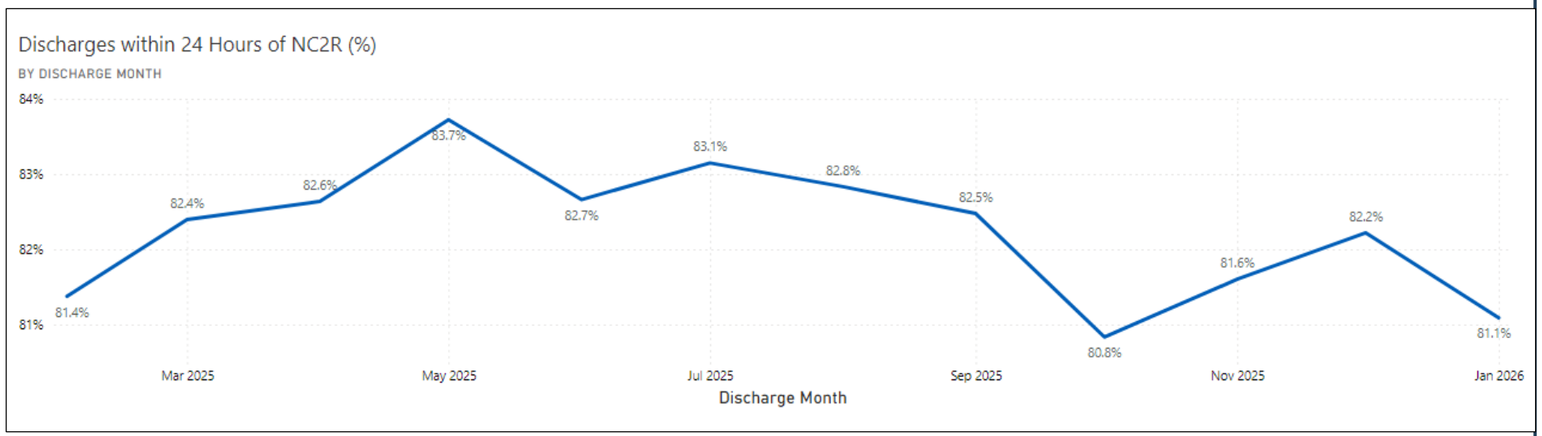
Non-Criteria to Reside

Royal United Hospitals Bath NHS Foundation Trust

UEC Delivery Group Driver Metric

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 January 2026, the average number of NCTR patients per day was 99.5 an increase of 22.3 patients compared to* December *2025, reflecting the anticipated post-Christmas increase in frail patients. Discharges within 24 hours of NCTR (all pathways) decreased in January to 81.1%; Pathways 1-2, 32.4% of patients were discharged within 24 hours, 47.2% within 48 hours and 82.8% within 7 days. A total of 40 patients per day (community and hospital responsibility) are to be delivered in line with the BSW trajectory; in January, the daily average for community responsibility patients increased significantly to 71 patients from 57.*





Understanding Performance

Blockers to achievement:
Community capacity for pathway 1 and 2 patients, more specifically in the Wiltshire locality. The RUH referral demand exceeds available capacity. St Martins Ward 4 opened at the end of December 2025 for Wiltshire and BANES P1 and P2 patients awaiting a date for discharge or have a planned future discharge date, the aim for Q4 to provide additional capacity and support RUH occupancy reduction. In month there has also been an increase in Somerset P1-P3 patients, to a daily average of 19 patients compared to 14. Somerset ICB have responded and increased the daily discharge number.

Improved performance:
Hospital responsibility NCTR has increased to a daily average of 28 patients daily, and in January, despite this increase, 93.3% of the hospital responsibility patients were discharged within 24-hour hours of non-criteria, 96.8% within 48 hours and 99.6% within 7 days. Overall improvement in NCTR LoS; P0 ↓0.2 days, P1 ↓1.3 days, P2 ↓2.7 days and P3 ↓2.1 days,

Countermeasures	Owner	Due Date
Discharge Partnership Group (RUH UEC programme), has formed, first meeting January 2026. Await workplan details to reduce time from RUH referral to pathway acceptance and improve discharge within 48 hours, plus and the system actions taken as part of the BSW Mega MADE event in December to improve clinical pathways that affect discharge planning for example eating disorders, acute brain injury, delirium.	Sarah Hudson	February 2026
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). Process in place, including embedding long length of stay reviews on a Tuesday (+ 21 days) resulting in a reduction on the daily average and maintaining >94% NCTR hospital discharging within 24 hours. Impact of actions under review in February 2026.	Sarah Hudson	Implemented January 2026
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. Project resource identified who started January 2026 to support implementation. Aim to implement April 2026 when HCRG change care transfers hub processes.	Sarah Hudson	April 2026

Risks and Mitigation

Non-delivery of the BSW community responsibility NCTR reduction trajectory to deliver the equivalent of 40 patient per day (or 9% 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.

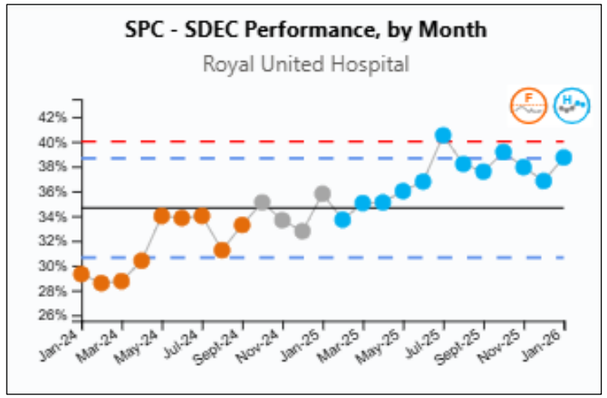
SDEC

Royal United Hospitals Bath NHS Foundation Trust

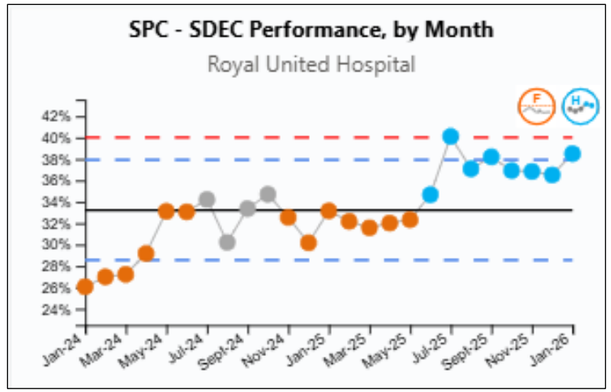
UEC Delivery Group Driver Metric

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 January 2026: **38.7%** against a target of 40%



Medicine Division SDEC Performance January 2026: **38.5%** against a target of 40%



Medical Division are responsible for two SDEC services:
Please see Frailty SDEC slide for more information.

Service / Monthly Activity	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26
Medical SDEC (previously Amb Care/DAA)	642	720	761	686	739	799
Frailty SDEC (OPRAA and OPAU)	30	39	37	30	24	22

Understanding Performance

- January Medical Division SDEC performance has increased to 38.5%. MSDEC activity was 799 patients which is the highest recorded value in the dataset and represents approx. 36 patients per day.

Ongoing Improvement blockers:

- Reduced Medical SDEC capacity due to Consultant vacancies
- Nursing capacity and sickness have reduced ability to improve further during January.
- High use of SDEC trolleys overnight in January (25/31 nights in January had more than 5 patients in trolleys overnight) which reduces SDEC effectiveness in the morning. Average LOS on a trolley increased in December to 27.9 hours and was 15.2 hours in January. Both measures are demonstrating high demand and challenges in achieving patient flow from the assessment areas.

Countermeasures	Owner	Due Date
Acute Medicine consultant posts to go back out to advert in Feb, and locum secured from November 25-March 26	CY	24/2/26
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	On pause due to securing locum for MSS
Continued Integrated Front Door (IFD) working, GIRFT support and actions related to RAT/streaming	BI, CY, RK	Ongoing
BSW SDEC Oversight and Working Group - to ensure a consistent BSW delivery against the national requirements	CY and RK	Ongoing
Six-month Review of MSDEC	CY	28/2/26

Risks and Mitigation

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

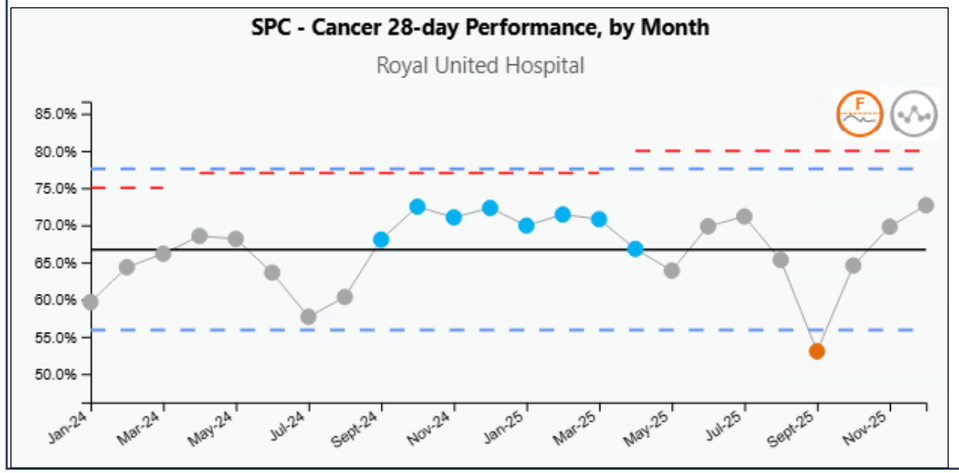
<u>Flow from SDECs to specialty beds</u>
High risk of impact
Site aware
SOPs to be followed

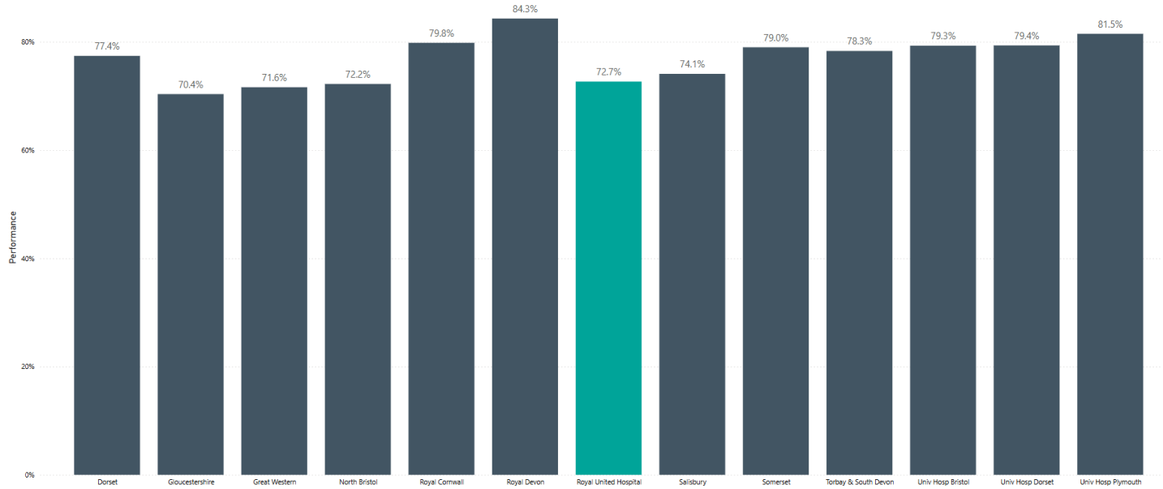
28 Day Cancer Performance

Royal United Hospitals Bath NHS Foundation Trust

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

SPC & supporting data if required





Understanding Performance

Performance improved further in December, reaching 72.7% (provisional) but remains below trajectory

Top contributors:
Colorectal, Gynae, Skin, Urology

In month challenges:
- Breast improvement to 88.8% - one-stop wait <14 days.
- Colorectal remains challenged at 44.7%. OPAs consistently at 7 days. Colonoscopy at 19 days. Reported CTC 15 days. CTC utilisation pilot commenced in January.
- Gynae reduction of 6.8% to 70.0%. Breaches due to gynae-onc OPA, histology, and typing.
- Skin achieved 81.6%. Long January OPA waits (high demand/Christmas leave) to impact performance.
- Urology LATP now 9 days. MRI scan/report waits reducing.

Countermeasures	Owner	Due Date
Breast locum consultant extension / recruitment	HW	April 2026
GWH endoscopy mutual aid	TS	January 2026
Endoscopy and Gastro consultant recruitment	TS	Jan / Apr 26
CTC patient contact pilot – commenced	EN	March 2026
Gynaecology Wid-Easy pilot	AJ/LA	March 2026
Dermatology additional insourcing for OPA	GJ	March2026
Skill-mixing / recruitment of non-medical staff	GJ	July 2026
LATP nursing bid 3.88 WTE through business planning	KR/EJ	April 2026
LATP WLIs	KR/EJ	February 2026

Risks and Mitigation

Risks:
- Demand increase
- Financial position
- Recruitment, recruitment, depending on WLIs, locums, in / outsourcing
- Pressures from RTT, DM01
- IT capacity – group model

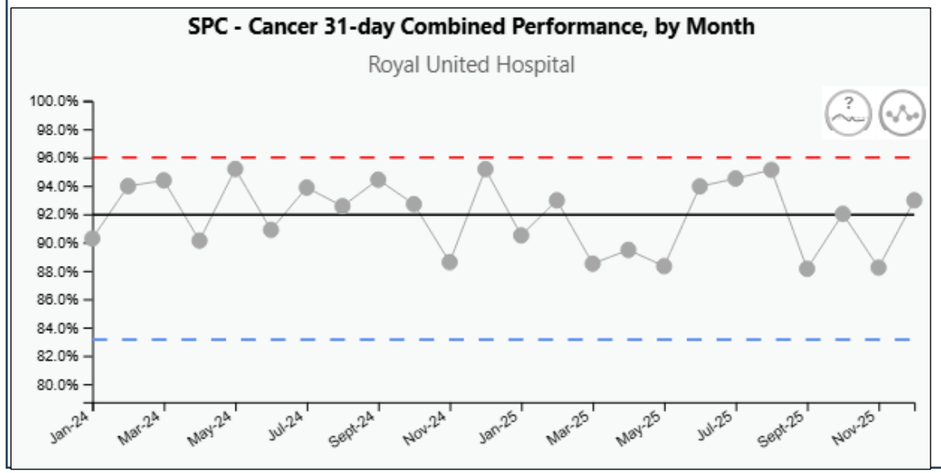
Mitigation:
- SWAG/NHSE funding for WLIs, locums, in / outsourcing
- Telederm
- Pathway change (Gynaecology / Prostate / Colorectal)

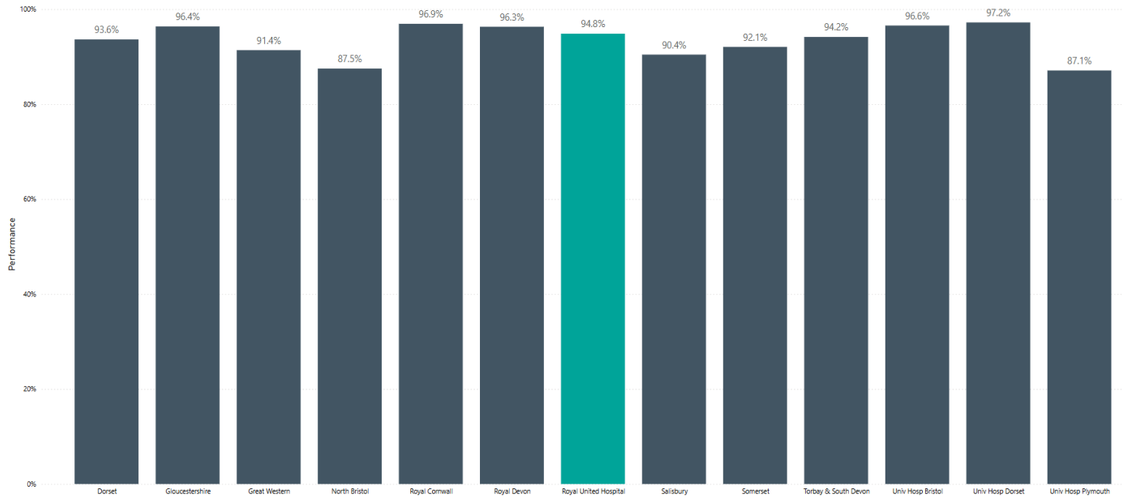
31 Day Cancer Performance

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

Performance improved to 94.8% following Breast recovery

Top contributors:
Skin

In month challenges:
- Breast achieved the standard but two patients were delayed for subsequent surgery.
- Long waiting Skin patients awaiting MOPS planned for treatment in December and January through insourcing. Significant impact expected on Trust performance in both months before recovery from February.

Countermeasures	Owner	Due Date
Theatre WLIs	HW	March 2026
Additional substantive consultant	HW	April 2026
Skin MOPS insourcing	GJ	Dec 25 – Feb 26
Dermatology workforce skill-mix	GJ	July 2026
Urology locum consultant recruitment	KR/EJ	April 2026

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

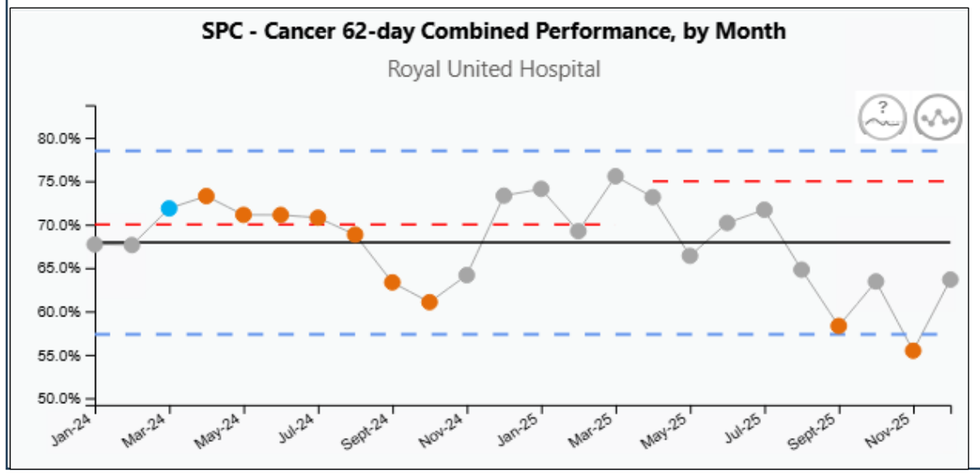
Mitigation:
- WLI, in/outsourcing and locums
- Long term workforce planning
- Telederm

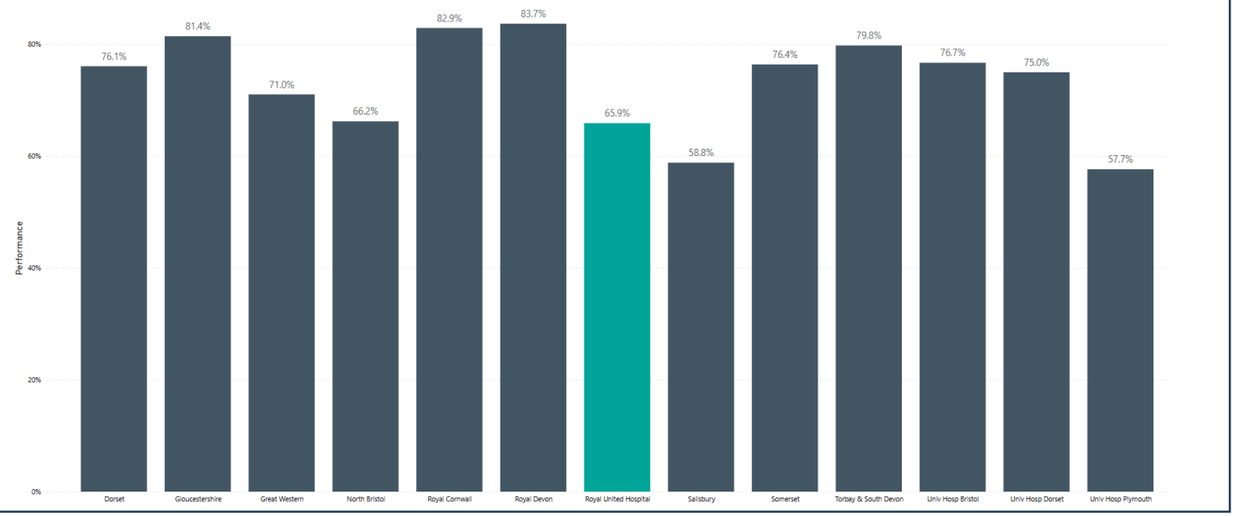
62 Day Cancer Performance

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 improvement of 11.5% to 65.9%

Top contributors:
Breast, Colorectal, Lung, Skin, Urology

In month challenges:

- Breast improved by 6.9% but breaches high. Surgical waiting times and sustained high screening demand.
- Colorectal improved to 58.5%. Endoscopy, additional investigations and OPA post-diagnosis.
- Multiple individual delays impacting Lung patients' pathways; waits for PET, EBUS, CT biopsy, Oncology OPA and diagnostics at other Trusts.
- Skin OPA/MOPS causing breaches. Recovery from February.
- Prostate MRI scan/report and LATP now improved. Late HIFU referrals from other Trusts causing lengthy breaches.

Countermeasures	Owner	Due Date
Breast locum consultant extension / recruitment	HW	April 2026
Breast theatre WLIs	HW	March 2026
Ringfenced endoscopy capacity	TS	Jan / Feb 2026
Endoscopy and Gastro consultant recruitment	TS	Jan / Apr 26
Detailed breach review	TS/NL	February 2026
MOPS insourcing	GJ	Dec 25 - Feb 26
Dermatology workforce skill-mix	GJ	July 2026
LATP nursing bid 3.88 WTE through business planning	KR/EJ	April 2026
Urology locum consultant recruitment	KR	April 2026

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:

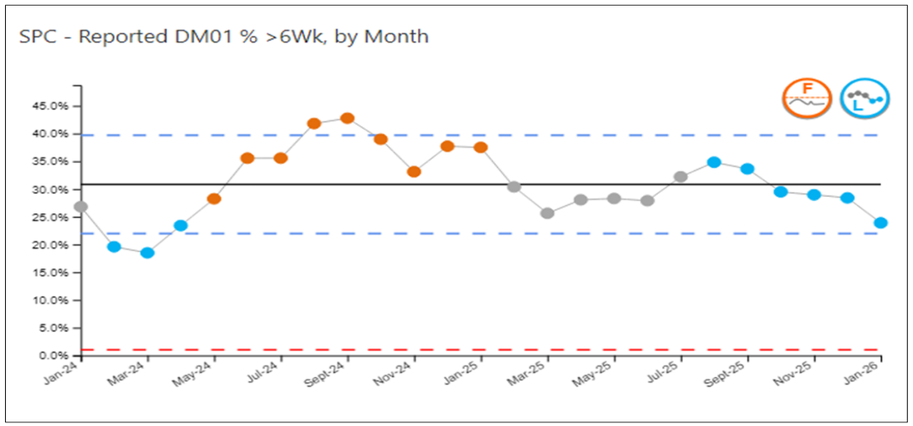
- WLI, in/outsourcing, locums
- Workforce planning
- Pathway change (Breast / Gynaecology / Prostate / Colorectal)

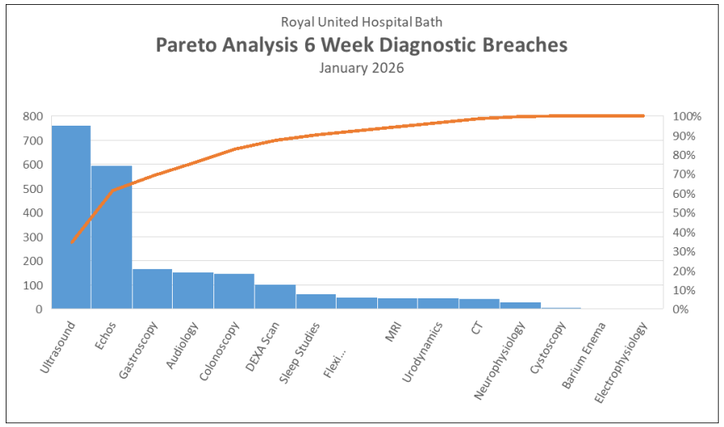
Diagnostic waits

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 January 2026, 76.1% of patients received their diagnostic within the 6-weeks against the 76.5% target.*
- *Performance improved 4.44% from December 25.*
- *DM01 trajectory reviewed to account for additional demand (RTT schemes) and mitigation (additional capacity) - end of year target 83.9% compliance.*
- *USS, MRI and Cystoscopy performing above plan.*
- *The **top contributors** to 6-week breaches were USS, Echo and Endoscopy.*
- *Key drivers of underperformance were:*
  - *Echo and Endoscopy behind on activity delivery.*
  - *Increased demand for diagnostic tests.*
  - *Challenges with data availability and validation*

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) in place since August 2025* *- additional 7 days/week mobilisation form January 2026 (extra room, doubles capacity)*	PN/NA SH/NA	In place From August 2025
Transfer of Sleep Studies activity to Sulis CDC (still waiting to recruit physiologists)	Sulis CDC	Q4 25/26
Weekly review of each modality – performance, demand and activity against trajectory. (~3% performance gain)	NA/JS	In place

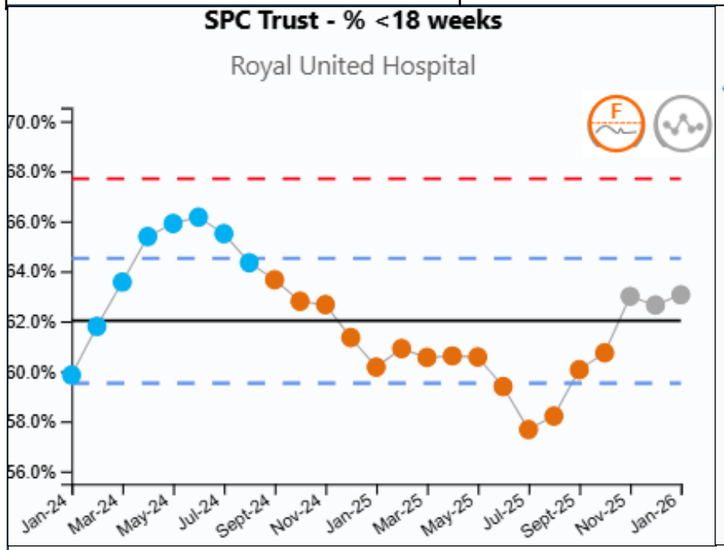
Risks and Mitigation

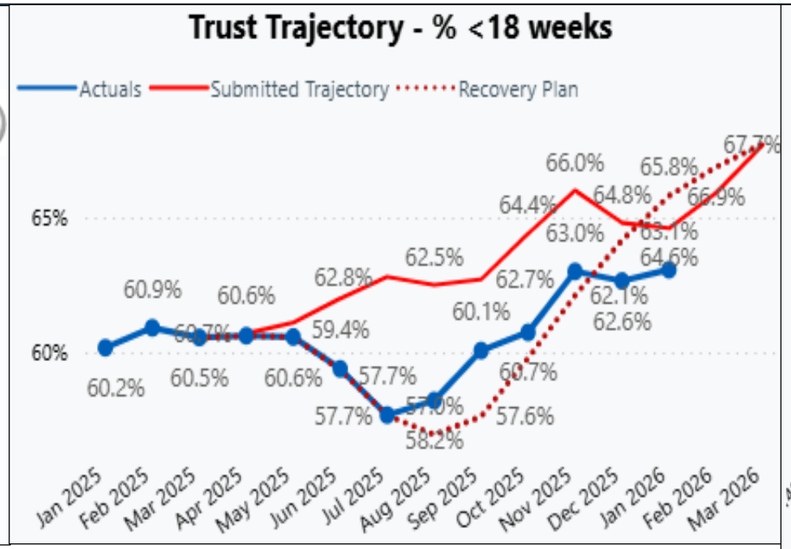
- **Risks:**
  - Sickness
  - Increased demand
  - USS staffing
  - Additional strikes
  - Delay to additional capacity schemes (USS, Echo, Endo)
- **Mitigations:**
  - Additional capacity at Sulis (USS, CT, MRI and Echo)
  - Insourcing scheme for Echo (RUH)

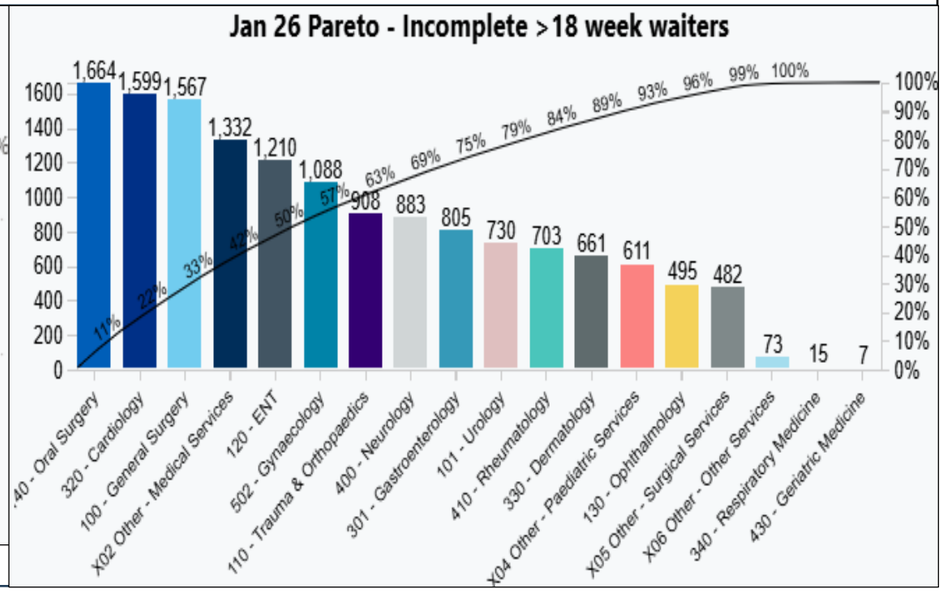
Referral To Treatment (RTT) 18 weeks

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 January was 63.1% vs trajectory of 64.6%. This is 0.4% increase on the previous month but 1.5% behind trajectory.
- The top Contributors to over 18 week breaches were in the following 5 specialties
  - Oral Surgery 1664
  - Cardiology 1599
  - General Surgery 1567
  - ENT 1210

Countermeasures	Owner	Due Date
General Surgery – suitable cohort of hernias and lap choles to Sulis for treatment	Division	Mar 26
Oral Surgery – outsourcing to Oral Surgery Ltd	Division	Mar 26
Cardiology – super clinics commenced Jan 26	Division	Mar 26
Trust taking part in 4th NHSE validation sprint – Nov to and December – admin validation with clinical support as appropriate	Dando	March 26

Risks and Mitigation

Risks:

- Radiology capacity for routine patients v. cancer pts
- Specialist radiology capacity
- Physical space for gastro, ENT and general surgery

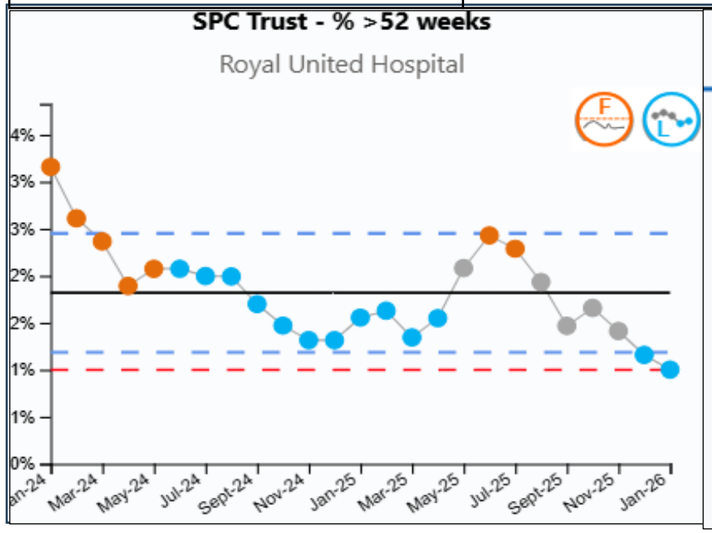
Mitigation:

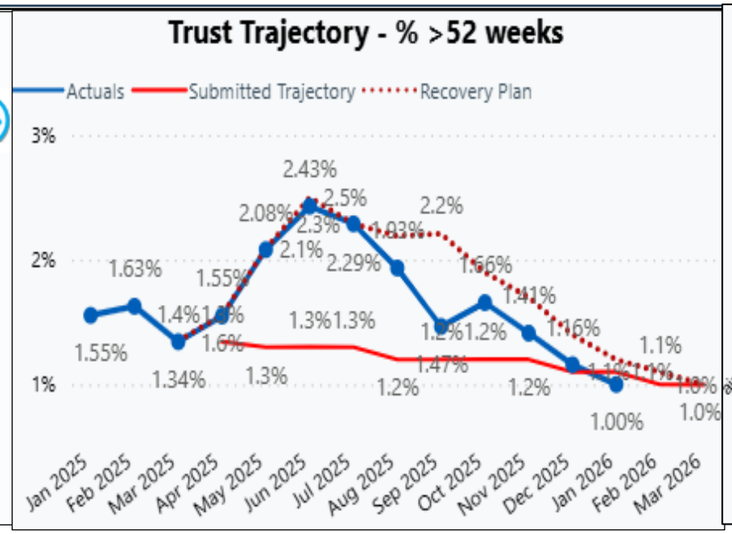
- ENT patients transferred to Sulis for 1st OPA where triaged as suitable

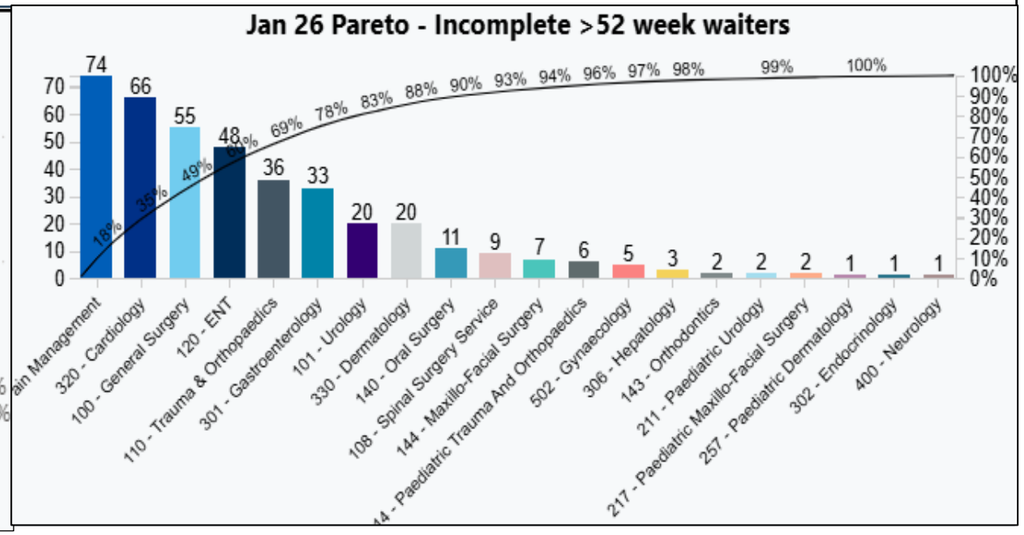
Referral To Treatment (RTT) over 52 weeks

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 465 to 402 (-13%).
• 1% of total RTT patients have waited >52 weeks vs target of <1%, Trajectory of 1.1%, Recovery Plan 1.2% for January
• The top contributors to >52-week breaches: Pain, Cardiology, General Surgery and ENT:
  • Pain increased in January from 69 to 74 (+7%)
  • Cardiology decreased in January from 69 to 66 (-4%)
  • General Surgery decreased in January from 72 to 55 (-24%)
  • ENT decreased in January from 61 to 48 (-21%)

Countermeasures	Owner	Due Date
Cardiology – super clinics provided for longest waiting patients	Frape	Mar 26
Gastro – additional management support including weekly recovery meetings	Shaw	Mar 26
Pain – weekly PTL meetings with NHSE, support from Sulis with suitable procedures. Insourcing to commence Feb 26 to support wait to 1st OPA	Maxfield/Price	Mar 26
Additional WLI theatre lists for longest waiting patients	Gillett	Feb 26

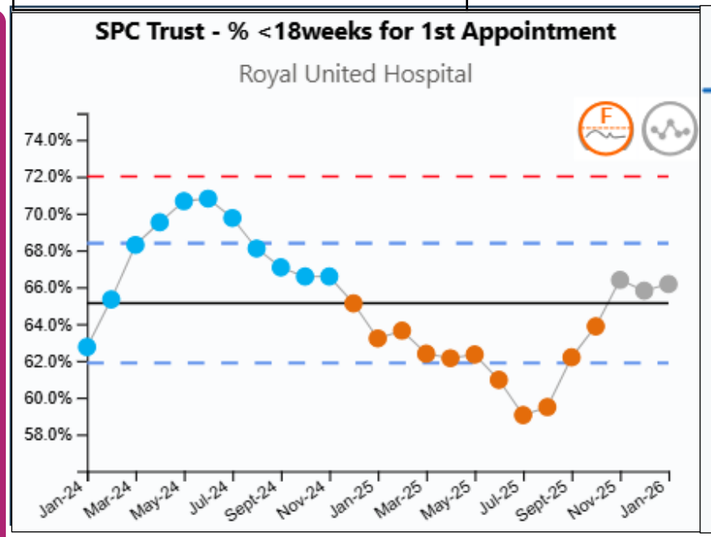
Risks and Mitigation
Risks: • Routine radiology capacity including reporting • Complexity of some gastro patients requiring multiple diagnostics • ENT outpatient capacity for Paediatrics (age limitations) **Mitigations:** • Support from Sulis for suitable pain procedures

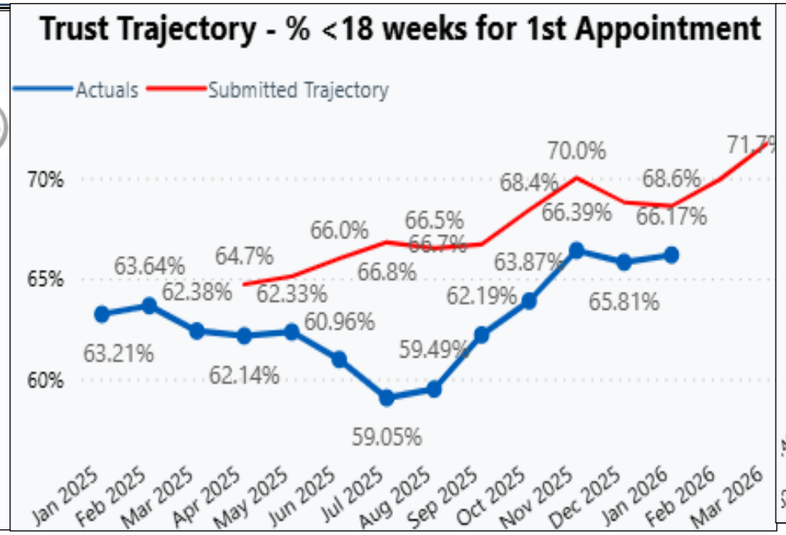
Referral To Treatment (RTT) Wait to 1st Outpatient Appointment

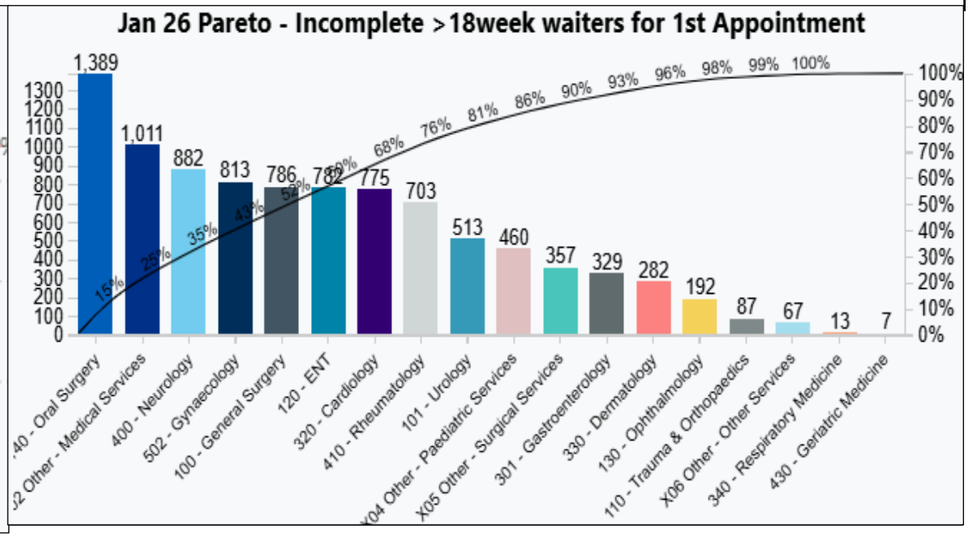
Royal United Hospitals Bath NHS Foundation Trust

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

Outpatient Delivery Group Driver Metric







Understanding Performance

- 66.2% of patients were waiting <18 weeks for a 1st outpatient appointment vs a target of 72%, trajectory of 68.6% for January. This is +0.4% on the previous month
- The top contributors of over 18-week breaches for 1st appointments were
  - Oral Surgery 1389
  - Neurology 882
  - Gynaecology 813
  - General Surgery 786
  - Pain 729

Countermeasures	Owner	Due Date
Super clinics in Cardiology for Quarter 4	Frape	Mar 26
Pain – intensive support from NHSE including demand and capacity plan. Insourcing to commence Feb 26	Stopp	Mar 26
Oral Surgery – outsourcing agreed to commence mid Feb 26	Gillett	Mar 26
Gynaecology – insourcing commenced mid Jan 26 with WLI Saturday clinics	Jarvis	Mar 26

Risks and Mitigation

Risks:
- Multiple diagnostics in Cardiology pathway
- Conversion to procedures for Pain patients
- Radiology capacity

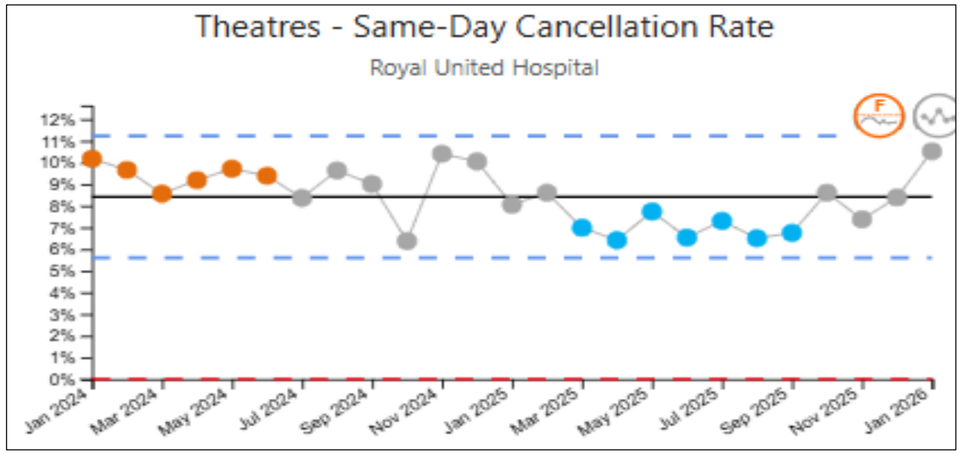
Mitigations:
- SBAR for additional specialty Dr in Oral Surgery

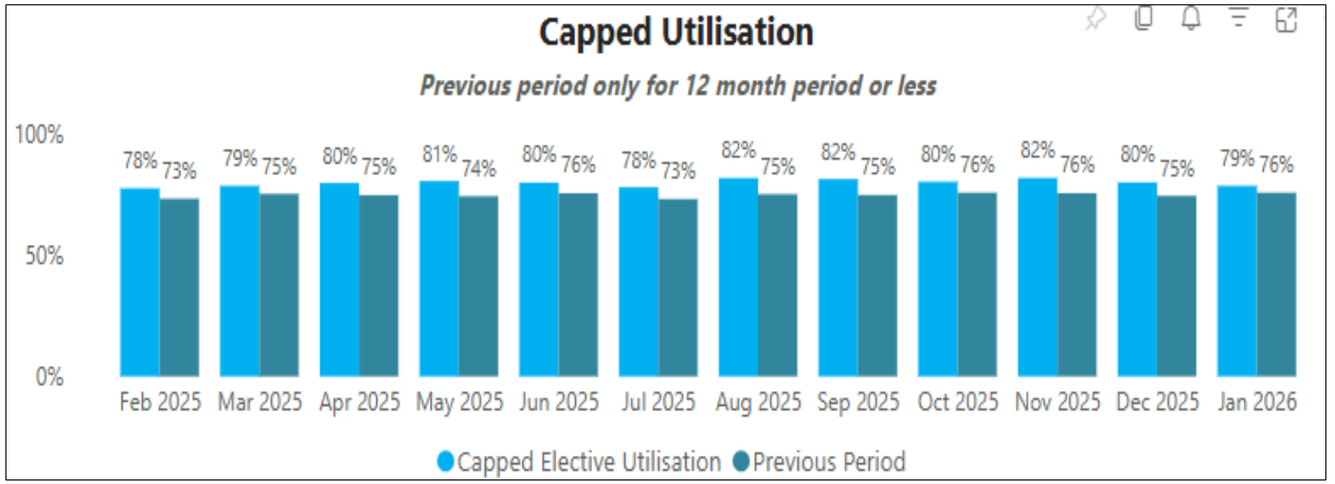
Theatre Utilisation

Royal United Hospitals Bath NHS Foundation Trust

We are driving this metric because.. Performance Target: capped utilisation 85 %	*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.*

Theatres Delivery Group Driver Metric





Understanding Performance
• Capped utilisation was at 82.1% on Model Hospital for December- Overall utilisation has remained at or close to 80% despite the very challenging operational pressures in month • Cancelations in Jan show and increase in month – reflects the operational challenges facing the trust and availability of hospital beds and trolleys on DSU • Recruitment within the elective booking team is continuing

Countermeasures	Owner	Due Date
Areas of focus are within Ophthalmology and Gynaecology – review of practice and HVLC process adoption- additional cases up to GIRFT levels now regular practice	Duncan Leadbeater, Karen Rye	March 26
Recruitment into Inpatient booking team Keeping focus on current vacancies to try and get to full establishment	Adam Dougherty, Lynne Presley	Mar 26

Risks and Mitigation
Risk: Trust site situation has seen real pressure on DSU and elective beds **Mitigation:** Much focus and support on the Emergency pathways to help mitgate the site pressures and reduce risk to elective/DSU capacity

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%		Jan-26	22.2%	X	F		Common Cause Variation
People we care for	% No criteria to reside Adult G&A occupied beds		10.0%		Jan-26	20.4%	X	F		Common Cause Variation
People we care for	% of patients waiting >12hrs in ED		0.0%		Jan-26	13.4%	X	F	H	Special Cause Concerning - Above Upper Control Limit
People we care for	% with Discharge Summaries Completed within 24 Hours				Jan-26	84.2%			L	Special Cause Concerning - Two Out of Three Low
People we care for	A&E Arrivals - Ambulance (av per day)				Jan-26	93			H	Special Cause Concerning - Above Upper Control Limit
People we care for	Adult % G&A bed occupancy		92.0%		Jan-26	98.3%	X	F		Common Cause Variation
People we care for	Mean time in ED - >75y				Jan-26	600			H	Special Cause Concerning - Above Upper Control Limit
People we care for	Mean time in ED - Admitted (mins)				Jan-26	596			H	Special Cause Concerning - Above Upper Control Limit
People we care for	Mean time in ED - Mental health				Jan-26	682			H	Special Cause Concerning - Above Upper Control Limit
People we care for	Mean time in ED - Not Admitted (mins)				Jan-26	251			H	Special Cause Concerning - 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 September)

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

Understanding Performance and countermeasures

- The number of patients in the Emergency Department awaiting admission over 12 hours from decision, increased significantly in January (328 compared to 137 patients in December) due to an increase in ambulance arrivals, increase in admission rate (35%), increase in beds affected and empty due to IPC restrictions, and an overall increase in community responsibility NCTR all contributing to an increase in admission demand and a reduction is bed availability. Despite most weekdays in January achieving c100 discharges per day.

- The median time in ED was 232 minutes for all pathways in January; 192 minutes for non-admitted and 471 minutes for admitted.

- Adult general and acute bed occupancy in January was 98.35% (93.85% in December). Occupancy does not reflect the use of additional escalation capacity (winter 2025/26 accessing up to 69 escalation/ED Corridor/pre-emptive moves to inpatient wards/planned winter escalation and space accessed due to business continuity/critical incident. Average monthly occupancy in January 2026 for RUH Hospital at Home was 115% (62 beds = 100% capacity). Hospital at Home have started some surgical pathways too, including pancreatitis and diverticulitis which are working well.

- Initiatives to improve discharges by midday are being led by the Clinical Divisions (including the work on Internal Professional Standards), Clinical Site Team, Discharge Liaison Team and supported through the daily performance and flow meeting to improve discharge rate (22.3% January 2026) and sustained use of the discharge lounge (c40 patients transferring weekdays with a peak of 45 patients in January). Continued focus on P0 no criteria patients with wards, therapy and discharge liaison teams, that are hospital responsibility, to sustain and improve upon discharges within 24 hours of NCTR (January 93.3%).

- % Discharge summaries completed within 24 hours in January 2026 was 84% (82.7% in December 2025).

- The average ambulance handover delay for January 2026 was 67.4 minutes, a significant increase from 30.7 minutes on average in December 2025. Through January 2026 the total hours lost was 2,538. This is a 1,680-hour increase compared to last month's lost hours of 858. 35.4% of handovers were completed within 30 minutes.

- RUH 4-hour performance in January was 54.20% on the RUH footprint (unmapped), a decrease of 2.47% from December's performance (56.67%). Non-admitted performance was 67.05%, which was a decrease against the performance for December (68.80%). January's admitted performance worsened to 27.62% (December 30.79%).

- The Trust reported zero 65-week waiters on 31st January 2026. Close monitoring continues to ensure this trend continues throughout Q4.

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	% No criteria to reside pathway 0 discharges				Jan-26	79.8%				Common Cause Variation
People we care for	A&E Arrivals - Walk ins (av per day)				Jan-26	197				Common Cause Variation
People we care for	Non Elective Length of Stay		8.4		Jan-26	8.2	✓	?		Common Cause Variation
People we care for	Number of 52 Week Waiters Incomplete Pathways				Jan-26	402			L	Special Cause Improving - Below Lower Control Limit
People we care for	Number of 65 week waiters incomplete pathways			0	Jan-26	0	✓		L	Special Cause Improving - Two Out of Three Low
People we care for	RUH hospital at home team occupancy	Average occupancy	62.0		Jan-26	71.4	✓	F	H	Special Cause Improving - Above Upper Control Limit
People we care for	Weekend discharge %				Jan-26	20.9%				Common Cause Variation

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

Safety Report

February 2026
(January 2026 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%		Jan-26	82.9%	✗	?		Common Cause Variation
People we care for	% of ED admissions <60mins from CRtP		80.0%	80.0%	Jan-26	53.8%	✗	?		Common Cause Variation
People we care for	Early Identification of Deteriorating Patient	NEWS 5+ Screening Completed in 30 - Trust (%)			Jan-26	25.7%			L	Special Cause Concerning - Run Below Mean
People we care for	Flu - Healthcare Onset (+3 days)				Jan-26	48			H	Special Cause Concerning - Above Upper Control Limit
People we care for	Number of complaints received		30		Jan-26	39	✗	?		Common Cause Variation
People we care for	Number of Hospital Acquired Pressure Ulcers Category 2		5		Jan-26	11	✗	?	H	Special Cause Concerning - Above Upper Control Limit
People we care for	Number of reopened complaints each month		3		Jan-26	6	✗	?		Common Cause Variation
People we care for	Readmissions - Total		10.5%		Dec-25	9.8%	✓	P	H	Special Cause Concerning - Above Upper Control Limit
People we care for	Scanning Compliance for patients being given medication				Jan-26	58.2%			L	Special Cause Concerning - Decreasing Run
People we care for	Serious incidents with overdue actions		5		Jan-26	10	✗	?		Common Cause Variation
People we care for	Total monthly fill rate, day hours, RN		90.0%		Jan-26	83.5%	✗	?	L	Special Cause Concerning - Run Below Mean
People in our community	% Difference in DNA rates between IMD1-2 and IMD 9-10		0.0%		Jan-26	5.0%	✗	F	H	Special Cause Concerning - Run Above Mean

Watch Metrics - Quality - Non-Alerting (Page 1 of 2)

Strategic Goal	Measure	Measure Description	Local Year-End Target	National Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
People we care for	% of ED patients assessed <15mins				Jan-26	69.9%			H	Special Cause Improving - Above Upper Control Limit
People we care for	Concerns are acknowledged within 2 working days		90.0%		Jan-26	99.0%	✓	P		Common Cause Variation
People we care for	Medication Incidents per 1000 bed days		7.0		Jan-26	6.8	✓	?		Common Cause Variation
People we care for	Mixed Sex Accommodation Breaches				Jan-26	160			L	Special Cause Improving - Run Below Mean
People we care for	Never events		0		Jan-26	0	✓	?		Common Cause Variation
People we care for	SHMI				Sep-25	103.4%			L	Special Cause Improving - Decreasing Run
People we care for	Total monthly fill rate, day hours, HCA		90.0%		Jan-26	91.4%	✓	F	H	Special Cause Improving - Above Upper Control Limit
People we care for	Total monthly fill rate, night hours, HCA		90.0%		Jan-26	107.8%	✓	P	H	Special Cause Improving - Above Upper Control Limit
People we care for	Total monthly fill rate, night hours, RN		90.0%		Jan-26	93.5%	✓	?		Common Cause Variation
People in our community	% Difference in 28 Day Diagnosis Performance between IMD 1-2 vs IMD 9-10		0.0%		Dec-25	3.3%	✓	?		Common Cause Variation
People in our community	Delivery of Financial Control Total	Variance from Revised Plan		0	Jan-26	-18632	✓		L	Special Cause Improving - Below Lower Control Limit
People in our community	Reduction in Agency Expenditure	Agency as % of Total Pay			Jan-26	0.7%			L	Special Cause Improving - Run Below Mean

Watch Metrics - Quality - Non-Alerting (Page 2 of 2)

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	Clostridium Difficile Rate	Hospital or Community Onset, Healthcare Associated, per 100,000 beddays			Dec-25	30				Common Cause Variation
People we care for	E.coli bacteraemia Rate	Hospital or Community Onset, Healthcare Associated, per 100,000 beddays			Dec-25	73				Common Cause Variation
People we care for	Klebsiella spp Rate	Hospital or Community Onset, Healthcare Associated, per 100,000 beddays			Dec-25	6				Common Cause Variation
People we care for	MRSA Bacteraemias Rate	Hospital or Community Onset, Healthcare Associated, per 100,000 beddays			Dec-25	0				Special Cause Improving - Below Lower Control Limit
People we care for	MSSA Rate	Hospital or Community Onset, Healthcare Associated, per 100,000 beddays			Dec-25	0				Common Cause Variation
People we care for	Number of Hospital Acquired Pressure Ulcers Category 3		4		Jan-26	2	✓			Common Cause Variation
People we care for	Number of Hospital Acquired Pressure Ulcers Category 4				Jan-26	0				Special Cause Improving - Below Lower Control Limit
People we care for	Pseudomonas aeruginosa Rate	Hospital or Community Onset, Healthcare Associated, per 100,000 beddays			Dec-25	6				Common Cause Variation

Trust Scorecard - Quality Board Metrics (January 2026 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%	Jan-26	54.2%	X	F	L	Special Cause Concerning - Run Below Mean
National KPI	People we care for	28 day referral to informed of diagnosis of all cancers		80.0%	80.0%	Dec-25	73.1%	X	F		Common Cause Variation
National KPI	People we care for	Average Handover Time for All Arrivals (mins)	Average ambulance handover time (mins)	33		Jan-26	67	X	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%	Dec-25	93.2%	✓	?		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%	Dec-25	63.8%	X	?		Common Cause Variation
National KPI	People we care for	Diagnostic tests maximum wait of 6 weeks		95.0%	95.0%	Jan-26	76.1%	X	F	H	Special Cause Improving - Increasing Run
National KPI	People we care for	RTT - Incomplete Pathways over 52 weeks		1.0%		Jan-26	1.0%	X	F	L	Special Cause Improving - Below Lower Control Limit
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%	Jan-26	66.2%	X	F		Common Cause Variation
Vision	People we care for	% Key national standards met in the month		100.0%		Jan-26	11.1%	X			
Vision	People we care for	% of positive responses to friends and family test	Improve the experience of those who use our service			Jan-26	97.9%			H	Special Cause Improving - Above Upper Control Limit

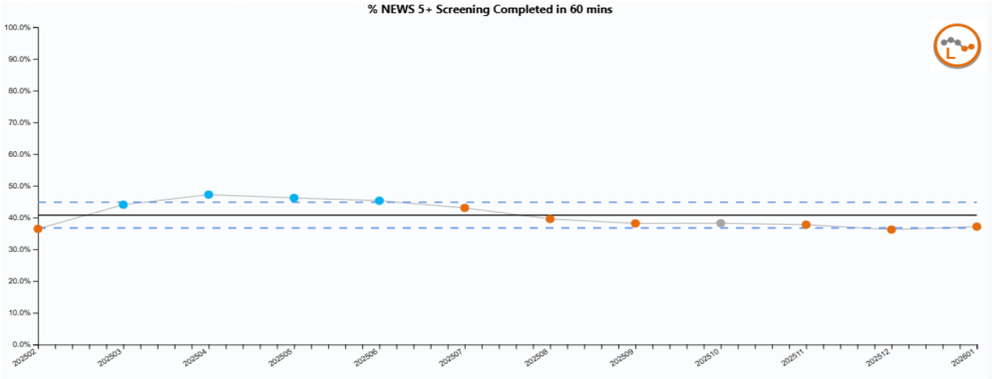
Alerting Watch Metric Commentary: Deteriorating patient: NEWS 5+ completed in 60 – Trust)

Royal United Hospitals Bath NHS Foundation Trust

Understanding Performance

Is the metric improving? What's the top contributor for under-over achievement? Why is it happening?

- Metric has been changed (Nov '25) to measure compliance of screening patients with NEWS 5+ within **60 minutes** as opposed to 30 minutes to bring the RUH in line with national standards. Performance has shown a gradual decline over the past 12 months. After a brief period of improvement early in 2025, the metric has trended downward and remains consistently below the mean, showing no sustained improvement in timely screening.



Countermeasures	Owner	Due Date
Change from screening compliance for NEWS 5+ within 30 minutes to 60 minutes to bring us in line with national standards; performance will be monitored through the Deteriorating Patient Improvement Group. Trust scorecard to be updated to reflect change to 60 minute standard.	Digital lead	Mar-26
Monthly ward scorecard review with 4 lowest responding wards to NEWS 5+ compliance are met with review of specific challenges in responding to e-alerts and tailor specific training to staff to improve vigilance and response to patient deterioration.	Sepsis lead	Feb-26
Monthly review of all trust e-learning sepsis compliance, 4 lowest scoring wards identified and targeted support offered to ensure staff adhere to trust mandatory training.	Sepsis lead	Feb-26
All ward staff identifying as having a poor understanding of patient deterioration and the actions required are allocated 1:1 support with the sepsis team, to increase their knowledge and empower them to escalate and initiate the trust sepsis care plan.	Sepsis lead	Feb-26
All additional teaching sessions run by wards include the sepsis team to provide a structured and comprehensive teaching of actions required when patient deterioration is identified, including responding to the e-alert, escalating the patient, and starting the sepsis care plan.	Sepsis lead	Feb-26

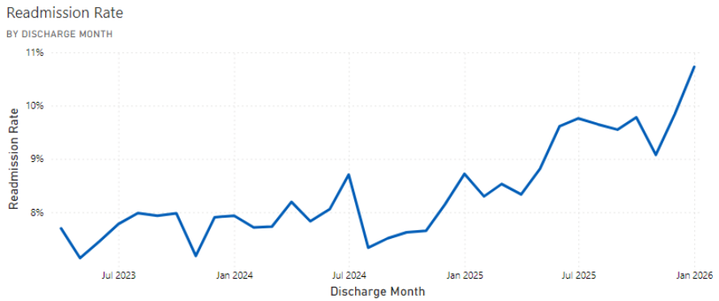
Alerting Watch Metric Commentary: Flow indicators (re-admissions and % ED admissions < 60 minutes from CRtP)

Royal United Hospitals Bath NHS Foundation Trust

Understanding Performance — Sarah Hudson, Interim Deputy Chief Operating Officer Urgent Care

Readmission Rate

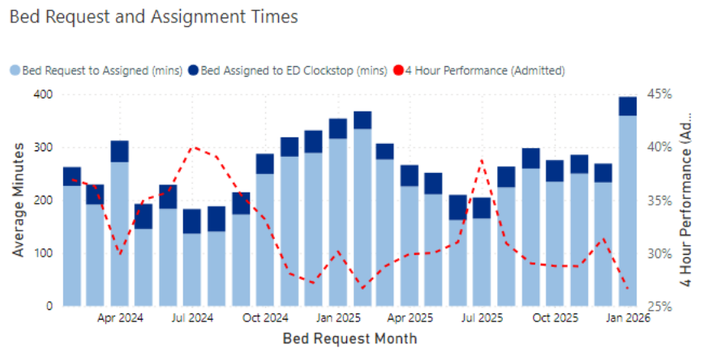
The readmission rate within 30 days of discharge, has been increasing since April 2025; April 2025 8.3% and December 9.84%. Please note that the January position is subject to change, as is dependent upon the clinical coding backlog, therefore the data period is to the end of December 2025. The increase since April 2025 is driven by an increase for patients who had a zero-day length of stay being re-admitted; more specifically, and based on the specialty level data, those patients who have gone through a same day emergency care pathway or short stay pathway in an assessment area. The increase correlates to the opening of the expanded Medical SDEC area in May 2025 and an overall increase in attendances through Medical, Frailty, Surgical and Trauma and Orthopedic SDECs this financial year. An increase in readmission is expected when increasing SDEC capacity.



Date range	SDEC attendance number
April 2024 – December 2024	14,783
April 2025 – December 2025	18,634

% ED Admissions <60 minutes from Clinically ready to proceed (CRtP)

The RUH does not currently use the metric clinically ready to proceed, this is an action within the UEC programme as part of the Emergency Care Dataset implementation, as use decision to admit. The trust has not been compliant with the standard of admission within 60 minutes of a decision to admit, however in 2025/26 there have been improvement compared to the same period the year before.



Month and Year	April 2024	April 2025	December 2024	December 2025
Average Transfer Time (minutes)	272	226	289	234

Optimum bed placement is an ongoing focus on the work of the clinical site team, which includes pre-emptive ward moves, proactive use of escalation, increasing discharges through the discharge lounge and the aim to left shift the discharge profile to increase discharges before midday (noting that the RUH is in the upper quartile positively for adult and general length of stay over 2 days). The UEC work programmes that supports improvement for this standard include; delivery of the NHS England FOCUSED framework, internal professional standards and the RUH Discharge Partnership Group.

Countermeasures	Owner	Due Date
Readmission rates: The Clinical Divisions review readmission rates as part of the divisional and specialty governance processes. No immediate actions planned, will be managed through the clinical divisions at a specialty level.	Divisional Governance Leads	Not applicable
% ED Admissions <60 minutes from Clinically ready to proceed (CRtP): Actions and monitoring are through the RUH UEC programme.	RUH UEC programme	Not applicable

Alerting Watch Metric Commentary: Scanning compliance for patients being given medication

Royal United Hospitals Bath NHS Foundation Trust

Understanding Performance

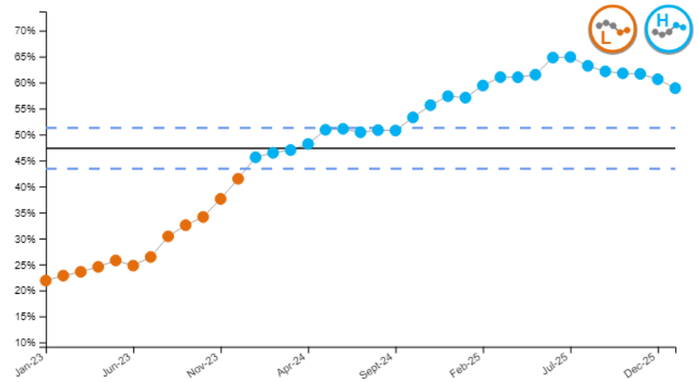
The performance for scanning compliance for patients given medication shows a trend of decreasing compliance.

There has been a reduction in patient scan compliance from a high of 65% in July 2025 to 59% in January 2026.

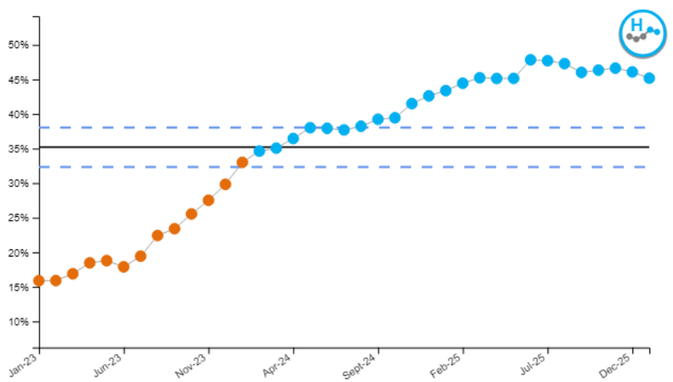
There has been a reduction in medication scan compliance from a high of 48% in June 2025 to 45% in January 2026.

Mid-month data from February 2026 for both metrics currently shows a reversal of this trend.

SPC - Patient Scans Compliance, by Month



SPC - Medication Scans Compliance, by Month



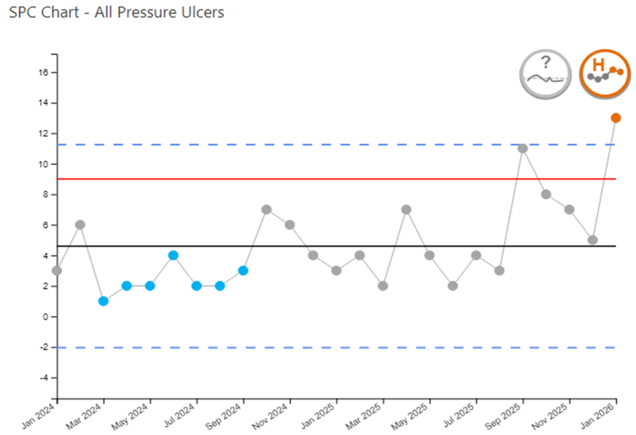
Countermeasures	Owner	Due Date
Define and agree target for patient scan compliance and incorporate into ward accreditation.	Scanning lead	Apr-26
Collate RUH insights from data collected as part of Barcode Medication Administration on Patient Safety study.	Scanning lead	Mar-26
Use insights from Barcode Medication Administration on Patient Safety study to define next steps for Barcode Medicine Administration A3.	Scanning lead	Apr-26

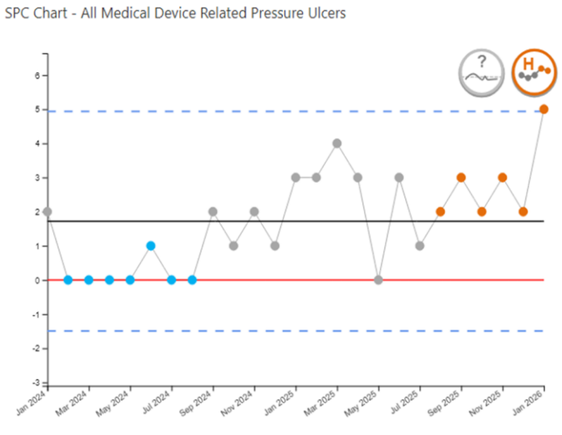
Pressure Ulcers

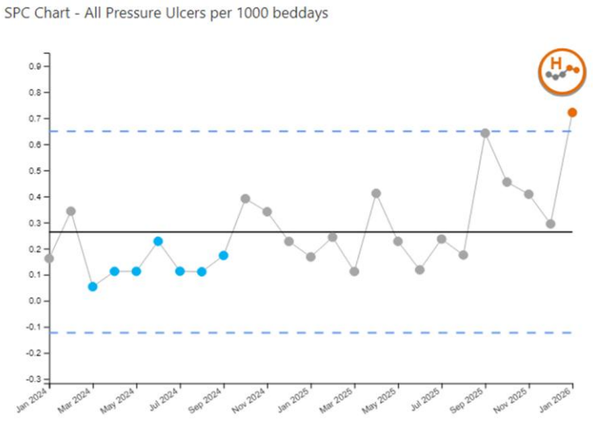
Royal United Hospitals Bath NHS Foundation Trust

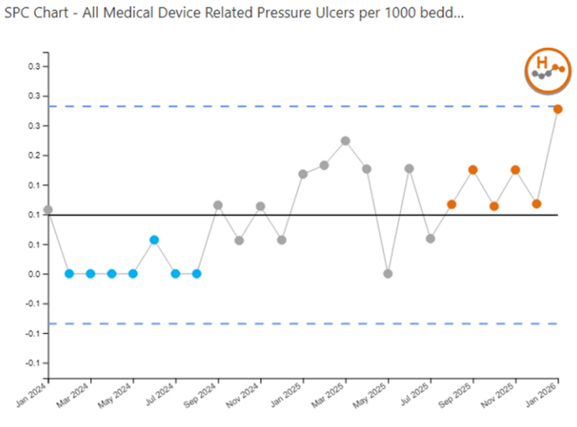
We are driving this metric because..	Pressure ulcers are estimated to cost the NHS £1.4m per day. Maintaining a low incidence of pressure ulcers is a Trust priority. The national acquired prevalence benchmark is 9.6% (2021) and the RUH prevalence was 1.3% in May 2025.

Improving the experience of those who use our service









Understanding Performance

For January 2026, the RUH reported 1.0 pressure ulcers per 1,000 bed days (18 pressure ulcers). The RUH reported two category 3 pressure ulcers, five category 2 medical device related pressure ulcers and eleven category 2 pressure ulcers.

Locations were on the heel, sacrum, bridge of nose and ear. The patient themes were non concordance, multiple co-morbidities, poor blood supply & end of life.
The system themes were understanding skin deterioration, two patients in ED had prolonged stays on a trolley. The Divisions are working closely with the wards on action plans for improvement.

Countermeasures	Owner	Due Date
ED to escalate those vulnerable patients to bed management at an early stage to expediate a ward bed as soon as possible.	ED 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
The Divisions are monitoring safer staffing levels against harm events and escalating where necessary.	Matrons	Ongoing
Improve patient compliance with pressure ulcer prevention.	Tissue Viability Improvement Group	Mar-26

Risks and Mitigation

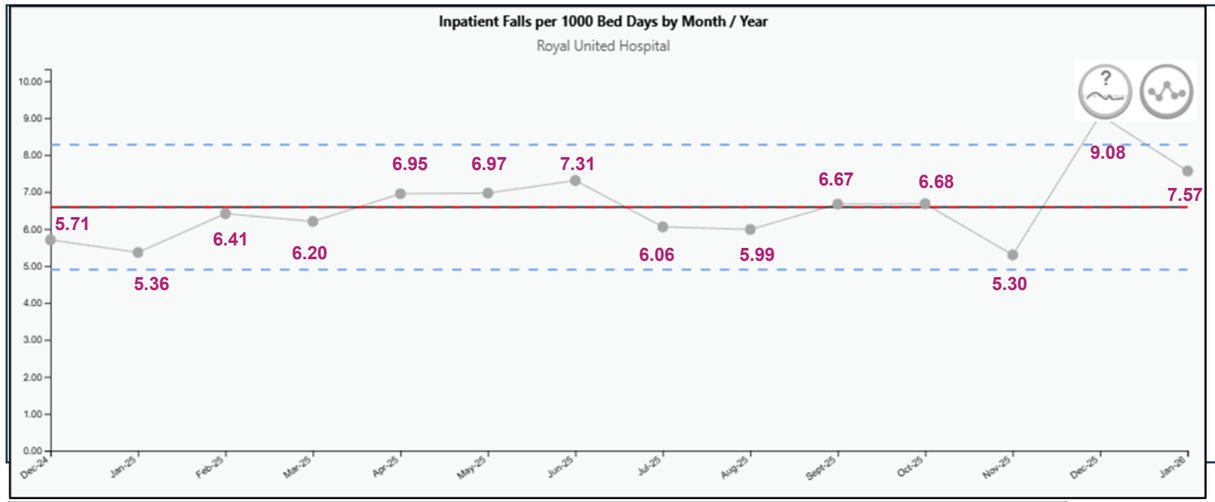
There is a risk that the lack of timely skin bundle assessments will impact on the ability to reduce avoidable pressure ulcers.

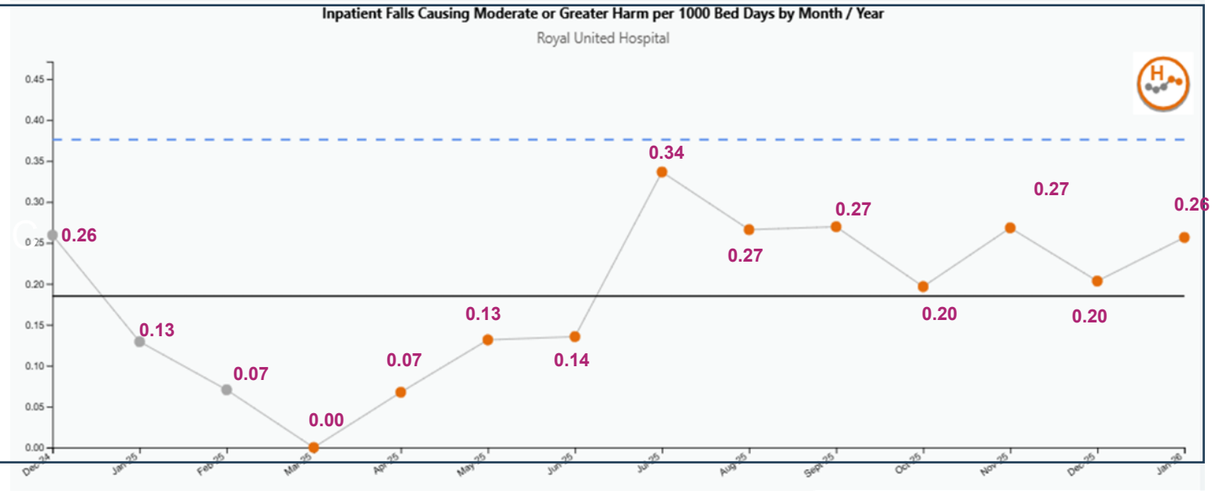
The mitigation is that the Tissue Viability Improvement Group monitors compliance with the Matron who will work with the clinical area to implement improvements.

Falls

Providing Safe and Effective Care

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





Understanding Performance

Data shows that during January 98.26% of inpatients did not fall in our care. There were 4 reported inpatient falls that resulted in moderate (or above) harm to patients, 1 is currently being reviewed and may be reclassified to a collapse. Falls per 1,000 bed days in January were within the expected range, following an increase In December.

Falls are multifactorial, meaning they are caused by a combination of factors and all inpatients over 65 should have a multifactorial risk assessment. These factors include frailty, comorbidities and deconditioning which causes a decrease in muscle strength 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 trust wide to 50% – Compliance end of December trust wide was 33% (previously 41% in May) - project extended due to decreased compliance.	Ward Manager	Feb-26
Analysis of themes given the increase in falls with harm	Associate Director of Patient Safety and Quality	Feb-26

Risks and Mitigation

1. Lying and standing blood pressure compliance had been reducing; there is suspicion of a correlation between reduced compliance and increased clinical demand. A monthly league table is being circulated with senior sisters, matrons and CPF's.
2. Operationally the trust has had an increase in acuity and number of admissions- this could be contributing towards an increased number of falls due to several factors affecting patient care e.g. time to prevent deconditioning.

Safe Staffing (Nursing Inpatient Areas)

Royal United Hospitals Bath NHS Foundation Trust

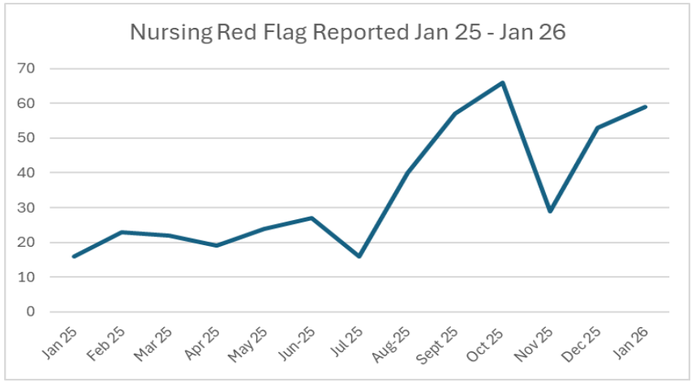
We are driving this metric because..	Nurse staffing fill rates is a measure of wards being sufficiently and safely staffed.
Performance Target:	For staffing fill rates to remain >90%

Breakthrough Objective

Ward/Department	Fill rate day RN %	Fill rate day HCSW %	Fill rate night RN %	Fill rate night HCSW %
Acute Stroke	82%	96%	88%	117%
SAU	92%	91%	117%	99%
Cardiology	82%	90%	95%	100%
CCU	96%	71%	99%	74%
Charlotte	76%	98%	98%	137%
Cheselden	76%	81%	85%	121%
Children	88%	68%	88%	91%
Combe	77%	97%	81%	148%
ED	95%	92%	89%	100%
Forrester Brn	81%	99%	86%	104%
Haygarth	78%	98%	86%	136%
Helena	95%	144%	100%	152%
MAU	83%	83%	107%	99%

Ward/Department	Fill rate day RN %	Fill rate day HCSW %	Fill rate night RN %	Fill rate night HCSW %
MSS	86%	153%	142%	99%
OPAU	84%	80%	100%	101%
OPUSS	79%	98%	87%	100%
Parry	77%	89%	95%	102%
Philip Yeoman	100%	131%	101%	113%
Pierce Ward	85%	95%	99%	99%
Pulteney	94%	92%	101%	97%
Respiratory	82%	87%	87%	92%
Robin Smith	91%	89%	99%	100%
Waterhouse	70%	94%	83%	155%
William Budd	80%	93%	99%	98%

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



Day Shift Average Fill Rate		Night Shift Average Fill Rate	
RN	HCSW	RN	HCSW
85%	94%	96%	104%

Understanding Performance

The combined day shift fill rates for RNs across the 24 inpatient wards was 85% and 96% respectively for nights. The combined day shift fill for HCSW was 96% and 104% for the night shift. The table above shows the monthly fill rate for the inpatient wards and emergency department.

17 wards fell below 90% fill rate for RN staffing on day shifts and 10 wards on a night shift. Cheselden and Helena wards fell below 90% due to temporary ward relocation and a reduced bed base resulting in a reduced nurse staffing requirement. Paediatrics and Emergency Department fell below the 90% primarily due to current vacancy which is actively being recruited. MAU, MSS and SAU have seen a fill rate >101% due tp escalation capacity and additional beds being opened requiring staff above the planned establishment.

The decreased HCSW fill rate < 90% is primarily due to vacancy. The fill rate continues to improve as HCSW commence in post. Philip Yeoman ward fill rate is >101% due to repurposing of the ward to support winter capacity which has required an increased HCSW skill mix.
The increase HCSW fill rate >101% particularly on night shifts reflects the deployment of additional staff in response to increased dependency and enhanced therapeutic observations of care.

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 April 2026.	Senior Sister/ Charge Nurse & Matrons	Apr-26
Focus on Red flag resolution on SafeCare. Safe Staffing SOP launched with nursing teams 22.1.26.	Matron/Deputy Divisional Directors of Nursing	Feb-26
To recruit into Paediatric ward RN vacancies	Paediatric Matron & Senior Sister/ Charge Nurse	Apr-26
To recruit into Emergency Department band 5/6/7 registered nurse vacancies. Recruitment event 16.1.26. Staff due to commence March/ April 2026	Emergency Department Matron	Apr-26

Risks and Mitigations

There is a risk that the current RN/HCSW vacancies will remain vacant and decreased fill rate <90% will continue. To mitigate this Jan 26 HCSW induction and successful RN recruitment in ED and Paediatrics with staff due to start from April 26.

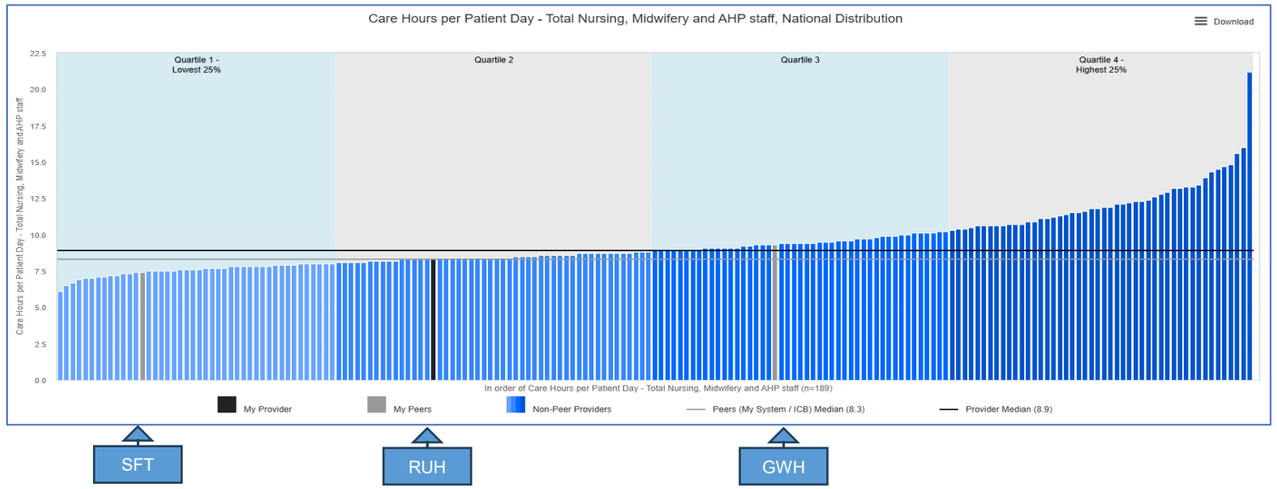
There are twice daily safer staffing meetings to review safe staffing and potential risks or red flags with mitigation put in place as appropriate. This will include redeployment of staff. The redeployment of nursing staff to mitigate vacant shifts will have an impact on fill rates.

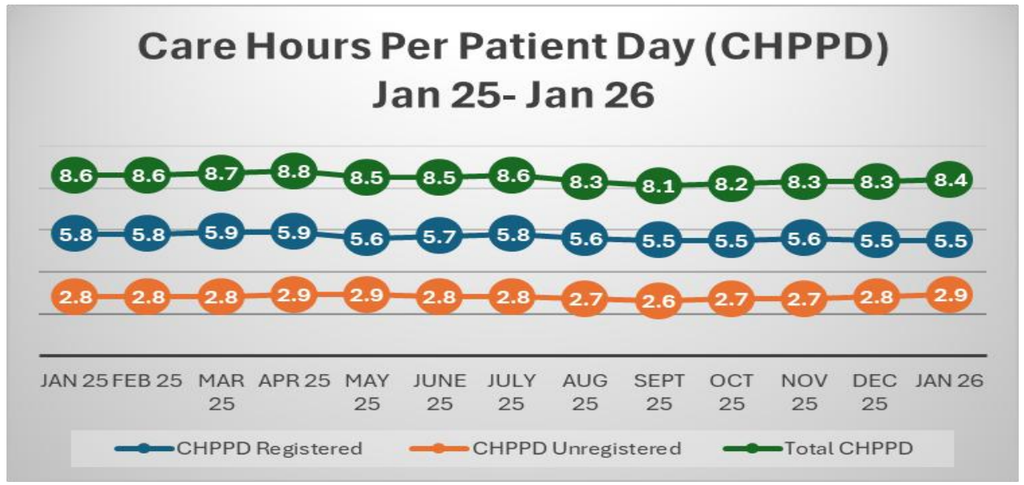
There were 59 red flags reported by wards in January, an increase from 53 reported in December. The breakdown of the 59 red flags was predominantly (74%) due to a shortfall of 25% RN time due to short notice sickness and vacancy. All these were reviewed by the matron and divisional senior nurse teams 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

In January CHPPD is 8.4. CHPPD continues to remain stable for both registered and unregistered staff over quarter 3. Since April 2025 we have seen an overall decrease in the total CHPPD which align with the decrease in overall RN and HCSW fill rates. January 2026 data shows a slight increase in HCSW CHPPD which would correspond with the focused HCSW recruitment which took place in October.

When reviewed on Model Hospital (latest data available November 2025) the Trust remains in quartile 2 and continue to benchmark in line with the peer median 8.3.

Countermeasures	Owner	Due Date
Review results of Safer Nursing Care Tool outcome data from October 2025 collection.	Associate Chief Nurse Workforce & Education	Mar-26
Active recruitment to HCSW and Registrant vacancies.	Divisional Directors of Nursing / Matrons	Ongoing

Risks and Mitigations

The risks identified from SafeCare in January show an increase in levels of short-term absence alongside existing vacancy which is reviewed at the twice daily safer staffing meetings chaired by a senior nurse.

Mitigations:
- Twice daily safe staffing meetings, reviewing both unfilled shifts alongside acuity and dependency of all wards.
- HCSW recruitment campaign. Focus on start dates aligned to Jan 26 HCSW specific inductions.
- Focused joint led (Nurse & HR) sickness reduction programme.
- Prospective and retrospective roster reviews
- Safe staffing levels are highlighted within the clinical site meetings.

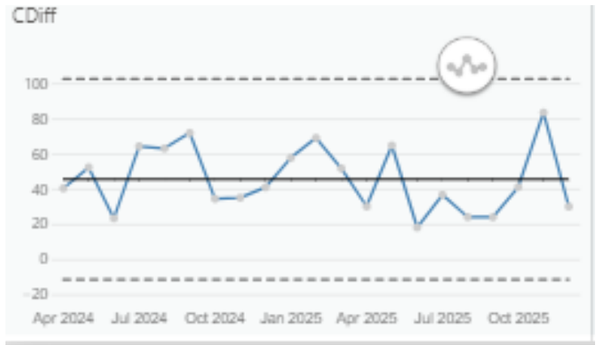
Infection Prevention and Control

Royal United Hospitals Bath NHS Foundation Trust

Providing Safe and Effective Care

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

CDI Healthcare Associated 100,000 bed days



E. coli Healthcare Associated 100,000 bed days

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

Understanding performance

There were 5 cases of Clostridioides Difficile infection (CDI) (2 HOHA and 3 COHA) reported during December 2025. There have been 59 cases against a threshold of 75 reported to date for 2025/26. The 3 periods of increased incidence across the Trust, had shown no cross contamination when the ribotyping was returned and through investigation these had been classed as unavoidable. The 2025/26 rate per 100,000 bed days for the Trust is 45.08 for Dec 25, against the SW rate of 33.52 (for Nov '25) Our population is predominantly > 70 years old in 80% of cases.

There were 12 cases of *E. coli* infection (10 HOHA and 2 COHA) reported during December 2025. There have been 81 cases reported for 2025/26 against a threshold of 77. Predominant cause remains urinary in 40 of the cases across 25/26, with 13 cases having a catheter. The November 2025 rate per 100,000 per days is 51.28 against the SW rate of 42.05 (for Nov 25).

MSSA have stabilised over the last 2 months and there were zero cases for December 2025. The effectiveness of practice vs protocol will be monitored over the next 3 months and reviewed again in February 2026. Further ward-based training and engagement sessions will be followed up in the through January and February '26 to support practice vs protocol.

Countermeasures	Owner	Due Date
To reduce ingestion of environmental bacteria and virus' during a hospital stay, we will enhance hand hygiene opportunities. **Aim:** To increase patient hand hygiene compliance before and after meals within a bay on an older person's unit by 30% within 3 months. Trials to expand across the ward from one bay on OPUSS and Helena, with a further product trialling on William Budd and ED for comparison	Infection Prevention and Control	Review latest data at the end of March 2026 In Progress
Gloves off campaign: To ensure clinical gloves are worn appropriately. **Aim:** To reduce the inappropriate use of gloves. Team are working with areas across the Trust to support the ongoing role out of the programme including the Proud to Prevent Programme to increase staff knowledge.	Infection Prevention and Control	Ongoing QI 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. Currently on trial in MAU.	Infection Prevention and Control	Ongoing development 2025/26

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. This will include the introduction of the updated infection cleaning requirements going live as of 26th January 2026

There is a risk *E. coli* numbers continue to rise due to a urinary sourced infections in over 50% of cases
Mitigations: embedding of the hydration project will support *E. coli* infection reduction through good hydration and QI looking also driving the quality of patient personal care. Different initiatives are being progressed by procurement that will improve patient experience e.g. Uroshield

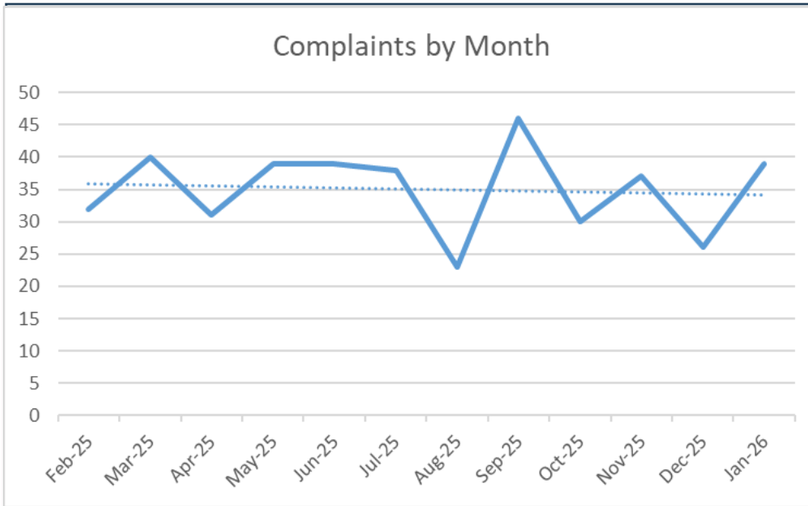
MSSA Bacteraemia's are increasing and are contributing to high rates – **Mitigations** continue route cause analysis to investigate outcomes to promote best practice and learning. A trolley dash is planned for the 28th January to focus on care and maintenance of Intra venous cannulas to promote knowledge, research and rationale.

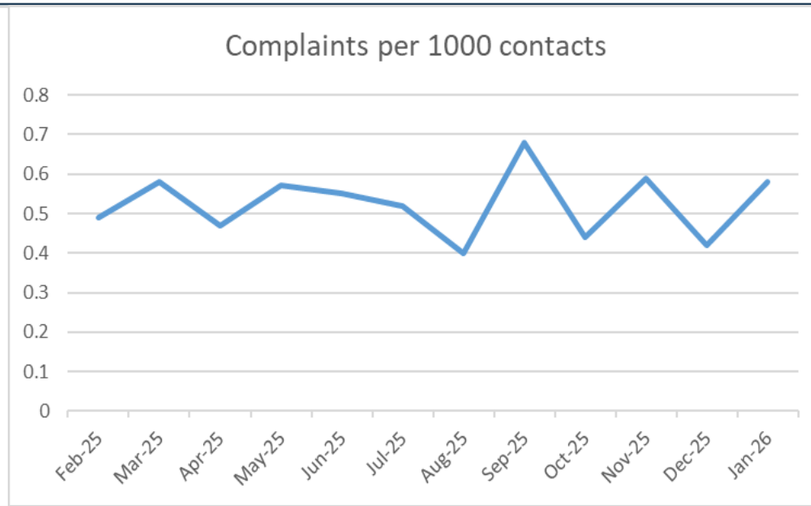
Patient Support & Complaints (PSCT)

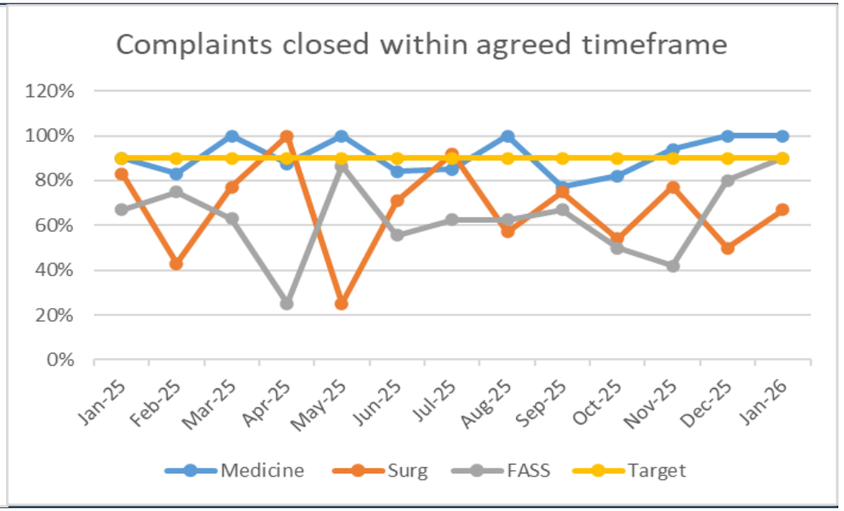
Royal United Hospitals Bath NHS Foundation Trust

We are driving this metric because..	The Trust values feedback and recognises that complaints and compliments provide a valuable insight into how we can improve our services for patients and families. The NHS Complaint Standards supports organisations to provide a quicker, simpler and more streamlined complaints handling service. The standards have a strong focus on early resolution. *90% of complaints responded to within agreed timeframe.*

Improving the experience of those who use our service







Understanding Performance

In January 2026, the Trust received 39 new complaints, this was an increase from December (n=26) – graph 1.
The Emergency Department (n=7) and Orthopaedics (n=7) received the highest number of complaints.
The majority of complaints were about clinical care (n=22) consistent with previous months.
The Medicine Division received the highest number of new complaints (n=21), Surgery (n=13), FASS (n=3), Corporate (n=1) and Digital (n=1).
The complaint rate per 1000 patients in January was 0.58 which has increased from 0.42 in December – graph 2.
99% of all concerns were acknowledged within 2 working days.
The response times for formal complaints continues to fall below the target of 90% with 82.9% of the complaints closed in January responded to within the agreed timeframe – graph 3.
Complaint closure rates varied by Division over January, FASS increased to 90%, the Surgical Division increased to 67% and the Medicine Division remained at 100% for the month.

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 February 2026.	Patient Experience Team	Feb-26
Complaints and concerns policy has been updated following a review by the Patient Safety Nurses. Compliance with the agreed processes is being monitored and any actions for improvement will be discussed between the Patient Experience Team and Patient Safety Lead Nurses.	Patient Experience Team / Patient Safety Lead Nurses	Feb-26
Continue to monitor compliance with agreed complaint response times in the Divisions. Corporate complaints team attend weekly meetings to discuss progress updates and highlight outstanding/overdue complaints and concerns where responses have not been received.	PSCT/Patient Safety Lead Nurses	Ongoing

Risks and Mitigation

The revised governance structures within the three clinical 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.

A focus on setting realistic timeframes for responding to some complaints which are more complex.

Royal United Hospitals Bath
NHS Foundation Trust

Perinatal Quality and Support Oversight Model (PQSOM)

February 2026

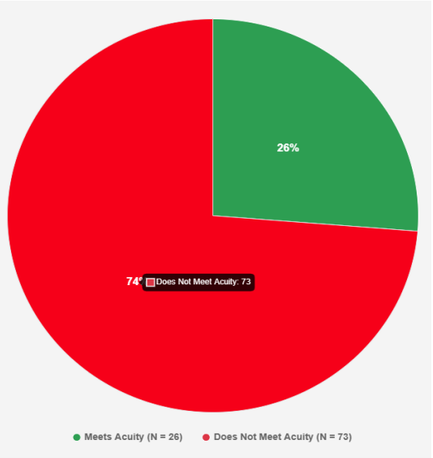
January 2026 data

The RUH, where you matter

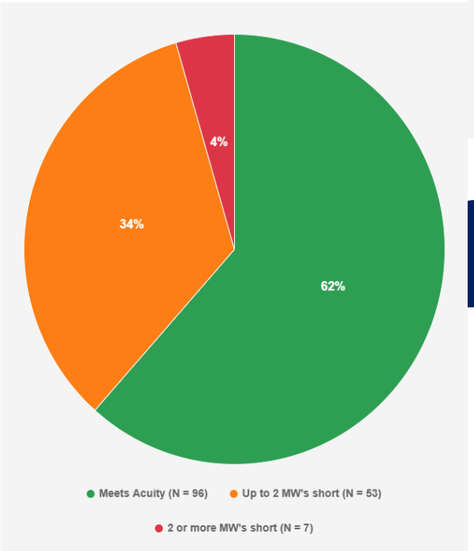
Maternity Midwifery Workforce

	Target	Threshold		Nov 25	Dec 25	Jan 26	Comment
		G	R				
Midwife to birth ratio	1:24	<1:24	≥1:26	1:26	1:29	1:31	Trained staff only included in acuity data
Midwife to birth ratio (including bank)	1:24	<1:24	≥1:26	1:25	1:27	1:29	Trained staff only included in acuity data
Episodes where 1:1 care provided in labour not achieved	0	0	>1	0	0	0	
Episodes where Labour ward coordinator not maintained supernumerary status	0	0	≥1	0	0	1	Documented in error during period of escalation. LWC was overseeing AN CTG for 20 mins and redeployment actions taken to resolve. Did not prevent clinical oversight of labour ward therefore not impacting SN status
Number of NICE red flags on BirthRate+	NICE 2015	-	-	2	3	16	Separate intrapartum and inpatient red flags plus narrative
Percentage of 'staff meets Acuity' **(BBC)**	100%	>90%	<70%	74	70	62	
Percentage of 'staff meets Acuity' **(Mary Ward - inpatient care)**	100%	>90%	<70%	47	50	28	Includes MSW and Registered Midwives. MSW vacancy increased and in month MSW sickness
Confidence factor in BirthRate+ recording **(BBC)**	60%	>60%	<50%	85	80	84	Percentage of episodes for which data recorded
Confidence factor in BirthRate+ recording **(Mary Ward - inpatient care)**	60%	>60%	<50%	90	83	80	Percentage of episodes for which data recorded
Percentage midwifery in month turnover				0.00%	0.00%	-	1 month lag
Percentage MSW in month turnover				0.00%	4.04%	-	1 month lag
Midwives in month sickness percentage				4.06%	5.87%	-	1 month lag
Maternity Support Workers in month sickness percentage				14.09%	20.96%	-	1 month lag

Postnatal/antenatal ward



Intrapartum



In month Opel Status

Maternity NHS Survey 25/26	Proportion of midwives responding 'agree' or 'strongly agree' to whether they would recommend their trust as a place to work or receive treatment (reported annually)	**GMC 25/26**	Proportion of specialty trainees in obstetrics and gynaecology rating the quality of clinical supervision out of hours as 'excellent' or 'good' (reported annually)	**National Education and Training Survey 25/26**	

Maternity Midwifery Workforce Countermeasures

Overview Analysis:

- Increased Birth to midwife ratio (1:29) – See potential causes
- One episode of SN status not maintained - Error in recording
- Percentage staff meets acuity BBC - 62% reflective of above
- Percentage staff meets acuity Mary = 28% - see ongoing actions- review underway

- N.B. Actively recruiting to fixed term vacancy and substantive vacancy

Potential Cause:

- Increased MW: Birth ratio and staff meet acuity reductions =
  - High MSW and Midwifery in month sickness rates (identified from bank request data)
  - MSW Vacancy
  - Increased birth rate = 20 more births in Jan 26 than Dec 25

Substantive MW vacancy	Secondment	Mat leave	Fixed term in post	Budget V actual
5.91	3.65	10.34	2.14	-5.94

Substantive MSW vacancy	Secondment	Mat leave	Fixed term in post	Budget V actual
-1.16	1	1.25	0.92	-3.41

BBC management action (top 5)	Times occurred	Percentage
Redeploy MW internally	52	41%
Operational support MW included in BBC staffing numbers	24	19%
Escalate to Manager on call/Matron	14	11%
CSF MW included in BBC staffing number	11	9%
Redeploy MW community	11	9%

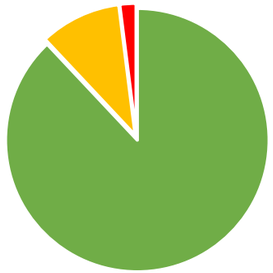
Countermeasure / Action	Owner	Status	Due	Outcome/Update
Deep dive into sickness hours in different cost centres in month	Matron		Feb 26	Strengthened reporting/certification process Support for line managers with new Trust policy MSW culture and engagement work ongoing Seasonal sickness increase noted
Flexible working review to support roster planning/shift fill	Matron		April 26	Agreement review underway. Expired agreement review deadline 6th March 26
Recruiting to midwifery vacancy	Matron		ASAP	Vacancy will increase in March due to 3 WTE leavers and 2WTE Mat leave returner reductions = 5WTE. ITR request submitted.
Review impact of percentage meets acuity challenges for Mary ward	Matron		March 26	

Identified Risk	Mitigating Action
No current Midwifery workforce risks on risk register.	

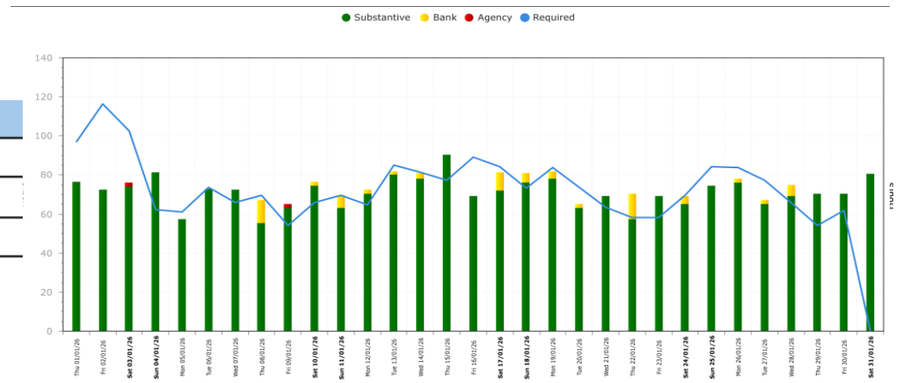
Neonatal Workforce

	Target	Threshold		Nov 25	Dec 25	Jan 26	Comment
		G	R				
Limitation in service / exemption report episodes				1/1	1/0	0	Exemption report 1 birth outside of L2 standards – 26 week birth
Nurse in charge supernumerary (%)		100%		44.64	56.14	75.81	
Percentage neonatal nursing shifts filled to BAPM standard	100%	>90%	<80%	90	90	100	Lower acuity and recruitment has improved our picture
Percentage neonatal QIS trained	>70%	<70%	<60%	70.8%	70.8%	66.6	New starters have diluted %
Percentage medical shifts filled to BAPM minimal standard (2018)	100%	>90%	<80	90	90	87	See staffing paper -32% of shifts in January utilised Bank/Locum for safe staffing.
Percentage neonatal turnover in month	<5%	<5%	<7%		0%	0%	
Percentage of neonatal nursing in month vacancy				3.14	2.43	2.14	
Percentage neonatal in month sickness				4.87%	3.03%	5.58%	

Safer Care compliance



Bank/Agency usage	
Filled Bank shifts	27
Unfilled Bank shifts	18
Filled Agency Shifts	2
Unfilled Agency Shifts	0



Opel 1 Opel 2 Opel3 Opel4

Annual Workforce Surveys					
NHS staff Survey 25/26	Proportion of nurses responding 'agree' or 'strongly agree' to whether they would recommend their trust as a place to work or receive treatment (reported annually)	**GMC 25/26**	Proportion of specialty trainees in obstetrics and gynaecology rating the quality of clinical supervision out of hours as 'excellent' or 'good' (reported annually)	**Natonal Education and Training Survey 25/26**	

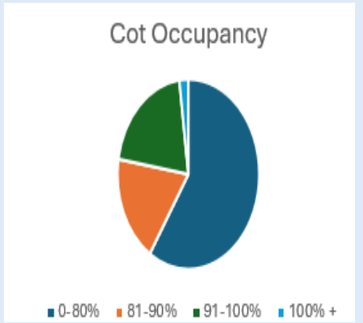
Neonatal Workforce Countermeasures

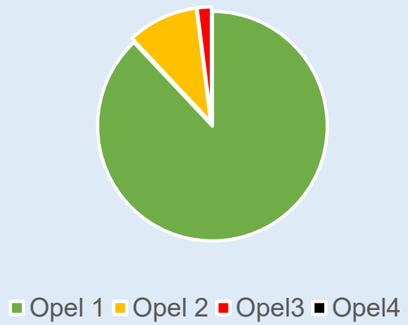
Overview Analysis:

- Sickness 5.58 % for the month. 84.7 FTE days lost (increase from Dec)
- TC staffed 100% with dedicated TC nurse. 44% of shifts between 5-10 babies cared for on TCP. 21% of these shifts were not supported by correct nurse :baby ratio
- Additional nurse shifts to make all shifts BAPM compliant 0 (Source Badger)
- % of shifts covered by Bank staff 3.85 % (source Badger) 6.22 WTE bank 0.6 WTE agency
- Parenting Leave 4.14 WTE 8.42%
- 0 limitation in service (LIS) declarations in January 26
- 0% specialist roles pulled clinically in escalation
- 6 babies from NBT and 2 St Michaels

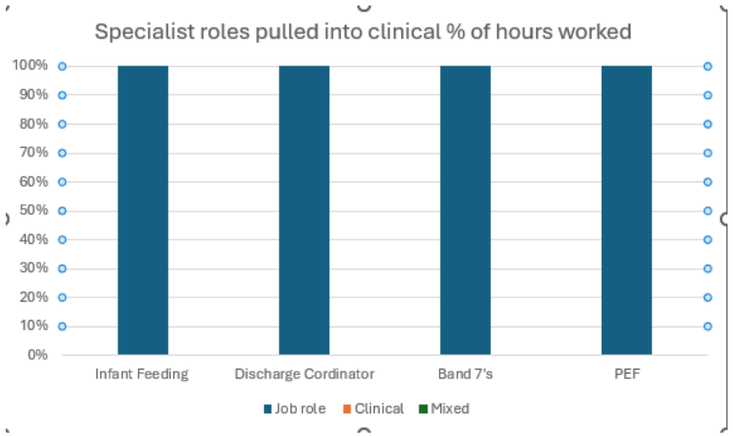
Potential Cause:

- January 48% of shifts between 80-104% cot occupancy





Countermeasure / Action	Owner	Status	Due Date
B6 appointed	KF		April 2026
PEF and clinical band 6 out for internal FT contract	KF		March 2026
RUH ODN workforce review in progress	KF/KP		March 2026



Identified Risk	Mitigating Action
Risk 3182 Neonatal Cot occupancy	See Risk register action plan

Medical & Anesthetics Workforce

	Target	Threshold		Nov25	Dec 25	Jan 26	Comment
		G	R				
Obstetric consultant presence on labour ward	60 hrs	>60 hrs	<60 hrs	98	98	98	
Compliance to RCOG 'Must attend' obstetric consultant roles and responsibilities guidance	100%	100%	<100%	100	100	100	
Obstetric MDT ward round twice daily percentage	100%	100&	<100%	100	100	100	Reviewed by LWC daily, MS forms completed if no ward round completed with immediate escalation.
Shifts filled by locum obstetric cover	0	-	-	0	0	0	
Anaesthetic rota compliance	70%	≥70%	<70%	100	100	100	
Percentage medical shifts filled to BAPM minimum standards	100%	>90%	<80%				
Shifts filled by locum/bank neonatal cover	0	-	-	15	15		No locum cover required – all filled with Bank ANNP

Annual Workforce Surveys					
NHS staff Survey 25/26	Proportion of n responding 'agree' or 'strongly agree' to whether they would recommend their trust as a place to work or receive treatment (reported annually)	**GMC 25/26**	Proportion of specialty trainees in obstetrics and gynaecology rating the quality of clinical supervision out of hours as 'excellent' or 'good' (reported annually)	**RCOG compensatory rest cultural survey response percentage**	

Incidents & Investigations

New Patient Safety Events Graded Moderate or Above

Case Ref (Datix)	Incident Date	Category	Incident	Investigation update – Outcome/Learning/Actions	MNSI Ref	PSI Ref
148052	6/6/25 reported 02/01/26	Severe	Day 17 ? Bowel obstruction post caesarean birth	Incident reported into trust by GWH. No access to re-admission documentation or identification of incident. All ICE records of medical imagery reviewed no evidence of bowel obstruction or injury. No evidence of surgical management. Communication with GWH ongoing to establish chronology and incident. Harm to remain until assurance of no severe harm received. Duty Of Candour Lead : to be confirmed following confirmation of harm Family Engagement Lead : To be confirmed following confirmation of harm		
148231	07/01/26	Unexpected death	Intrauterine perinatal death at 23 weeks of pregnancy	No immediate care concerns following MDT review. Awaiting Perinatal Mortality Review (PMRT). Duty Of Candour lead : Obstetric consultant JF Family Engagement Lead: Bereavement Midwife BW		
148265	09/01/26	Unexpected death	Intrauterine stillbirth at 24 weeks of pregnancy	No immediate care concerns following MDT review. Awaiting MDT review and Perinatal Mortality Review (PMRT). Duty Of Candour lead : Obstetric consultant JF Family Engagement Lead: Bereavement Midwife BW		
148371	10/01/26	Unexpected death	Intrauterine stillbirth at 30 weeks of pregnancy	No immediate care concerns following MDT review. Awaiting Perinatal Mortality Review (PMRT). Duty Of Candour lead : Obstetric consultant JF Family Engagement Lead: Bereavement Midwife BW		
148702	21/01/26	Moderate	4 L Post-partum Hemorrhage	Awaiting MDT review and confirmation of level of harm. Duty Of Candour lead : To be confirmed Family Engagement Lead: TG		

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

Incidents & Investigations

Ongoing Patient Safety Events Graded Moderate or Above

Case Ref (Datix)	Incident Date	Category	Event	Investigation update – Immediate Learning/Actions		MNSI Ref	PSI Ref
146963	20/11/25	Severe	Readmission to NICU with abnormal MRI	Family consent gained for MNSI – in progress Local Review ongoing : Process improvements identified regarding monitoring and management of hypoglycaemia in midwifery postnatal care provision therefore PSIRF learning response of an MDT review in progress.	Leads for MDT review : Advanced Neonatal Nurse Practitioner and Postnatal Ward Midwifery Sister Duty Of Candour Lead : Neonatal Consultant TS Family engagement Lead: Quality Improvement and Patient Safety Lead JC	MI-049980	
146425	06/11/25	Moderate	Maternal ITU admission	Patient Safety Incident Response –MDT/ After Action Review in progress between Maternity and the Emergency Department. Duty Of Candour Lead : Obstetric Consultant S Hayward Family Engagement Lead T Gay	Key Lines of Enquiry agreed with the family • Were there any earlier opportunities to have identified infection within the postnatal period prior to escalation to critical care • Are we assured by the current processes of communication between Emergency Department and Obstetrics to support collaborative care planning inclusive of medication management. • Are we assured by the process'/identification of deterioration within Same Day Emergency Care Centre		
143919		Moderate	Unidentified Fetal growth restriction with abnormal MRI	Patient safety Incident Response- MDT panel with external subject Matter Expert (SME) review Duty Of Candour Lead – Obstetric Consultant Nisha V Family Engagement Lead T Gay	Key Lines Of Enquiry agreed with the family • To review the plan of care for fetal growth monitoring specific to this pregnancy. • To review the timing of birth • To review the current standard process and procedures for monitoring of fetal growth within multiple pregnancies under RUH care • To review the current systems in place to ensure accurate and robust processes of fetal growth monitoring, and documentation to support obstetric decision making.		
144946	23/09/25	Unexpected Death	Intrauterine death	Ongoing Maternity & Neonatal Safety Investigation referral Duty Of Candour Lead: Obstetric Consultant V Medland Family Engagement Lead : Bereavement Midwife B Walsh	Immediate learning identified regarding Thiopurine use and Obstetric Cholestasis. • MHRA alert identified • Yellow card event raised • UK Teratology Information Services monograph – out of date no reference to the MHRA – service informed – Monograph to be updated • RUH Medicines Safety Officer (MSO) informed of event and collaborative approach to learning and improvement ongoing to ensure cross divisional learning and improvement • Ongoing exploration of data capture to safeguard women currently pregnant who may be taking thiopurines	MI-047238	
147338	08/12/25	Severe Harm	Transfer for active therapeutic cooling. Abnormal MRI	Family consent for Maternity and Newborn Safety Investigation gained – Review in progress Duty Of Candour lead : Obstetric consultant L Atherton Family Engagement Lead: T Gay	Multi Professional Safety Review held on12/12/25. No Trust care concerns identified	MI-050463	
144945	23/09/25	Moderate	Indirect maternal death	Integrated Care Board Local Maternity & Neonatal Systems facilitated review held on 05/12/25. Awaiting further MDT reconvene into be organised by ICB Family engagement offered by Perinatal patient safety team and Bereavement midwife			

Emerging Learning from Local Learning Responses

Situational Overview:

- 3 MDT panels held in January with learning responses ongoing – see ongoing review slides – reports to come to March Governance
- 1 after action review (AAR) planned in February 26

Analysis & Enablers of Success 'What went well' :

- Engagement from the MDT
- Openness and honesty from staff regarding current process concerns within USS pathways.

Learning and Reflections:

- Review of MEWS and Maternity Sepsis tool alignment
- MEWS charts within the ED
- Documentation and timing of neonatal of observations
- Governance of Glucoboost/Glucogel on Mary Ward
- Transcription errors within digital systems within USS pathways

Sharing of Learning & Next Steps:

- Review of Sepsis tool due to be aligned to MEWS parameters
- MEWS training video and posters.
- NEWTT 2 audit to commenced on AMaT
- Risk 3202- Audit of system information accuracy to inform consideration of risk increase

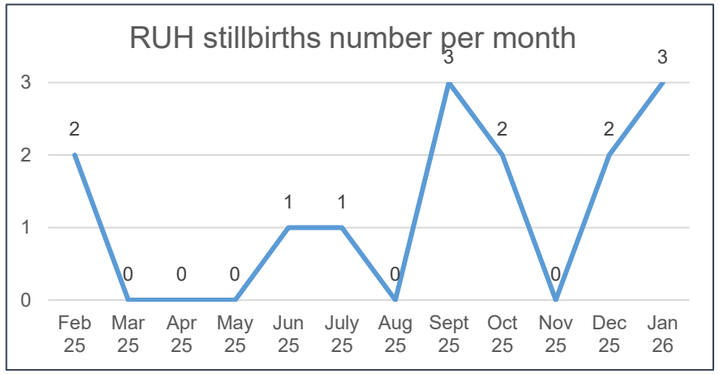
3202	There is a risk maternity ultrasound imaging and clinical data may not be reliably shared across Soliton, BadgerNet, and Millennium systems, potentially compromising safe maternity care.	16	6	6

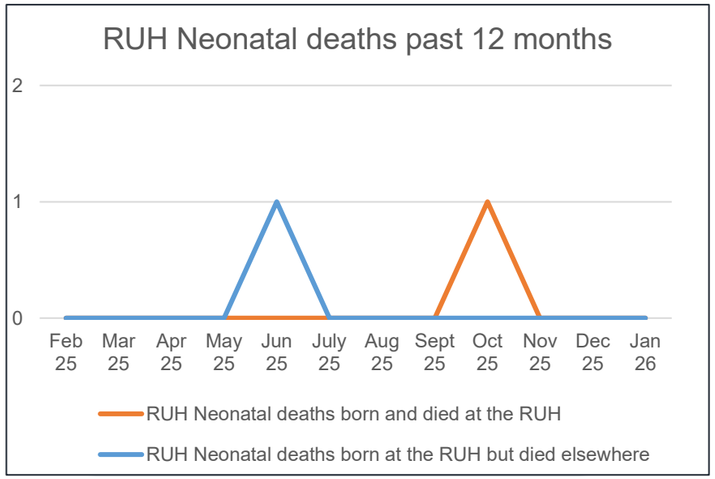
Incidents & Investigations

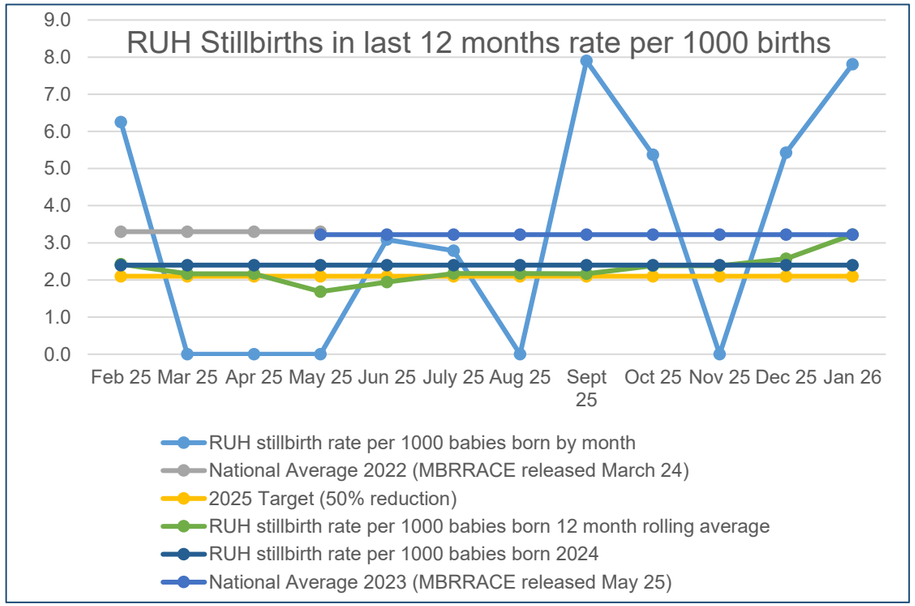
Closed Patient Safety Events Graded Moderate or Above

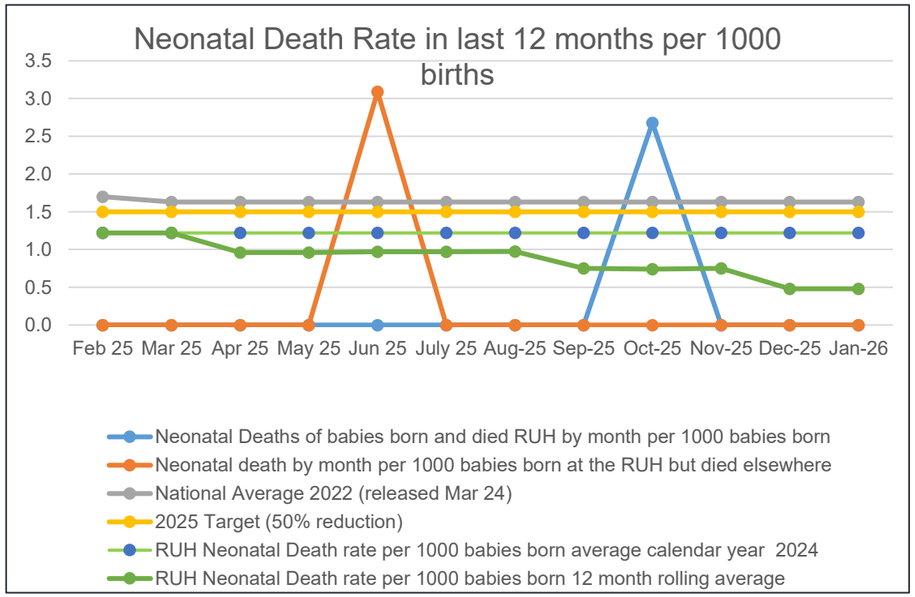
Case Ref (Datix)/MNSI/PSII	Incident Date	Category	Event	Quality and Safety Recommendations	Action plan	Montioring Group
147317	02/12/25	Moderate	Perineal 4th degree	Multi Professional Safety Review held on 07/01/26. No care concerns identified.	-	-
147834	25/12/25	Moderate	Perineal 4th degree	Multi Professional Safety Review held on 07/01/26. No care concerns identified.	-	-

Perinatal Mortality Review Tool (PMRT)

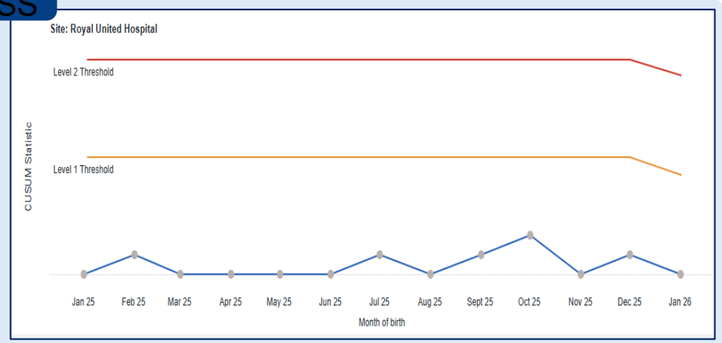








MOSS



Monthly update

3 stillbirths and 0 NND in January 26– please see incident slide

Annual calendar year RUH SB rate for 2025 is:
2.8 per 1000 births.
An increase from 2.4 per 1000 births during 2024, although remains lower than the latest MBRRACE reported national average of 3.2 per 1000 for births in 2023 (MBRRACE, 2025)

Annual calendar year RUH Neonatal death rate for 2025 is: 0.48 per 1000 births. This is a reduction of 50% from the 2024 rate. The latest MBRRACE national average from births in 2023 was 1.62 per 1000 births

Identified learning

Increased annual stillbirth rate noted for 2024 and 2025 vs 2022 and 2023.
No clear commonalities identified within initial reviews
Action: for Bereavement midwife BW to conduct a case cohort review of all stillbirths in 2024 and 2025 inclusive of Equality and Equity review to identify any areas of care provision which require review.

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 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:**

- **Confirmation that continued progression with SBL to 93%**
- Check and challenge meeting with SC and DOM complete

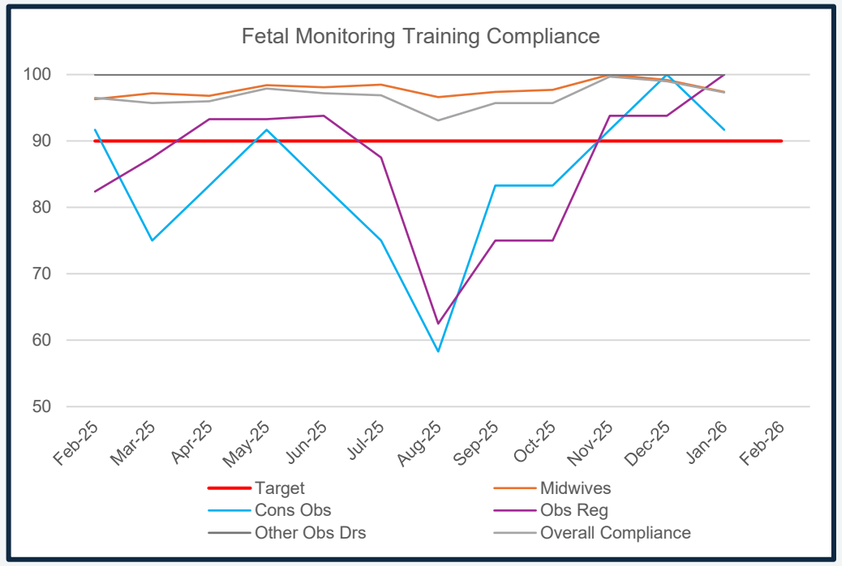
Next Steps for Progressions:

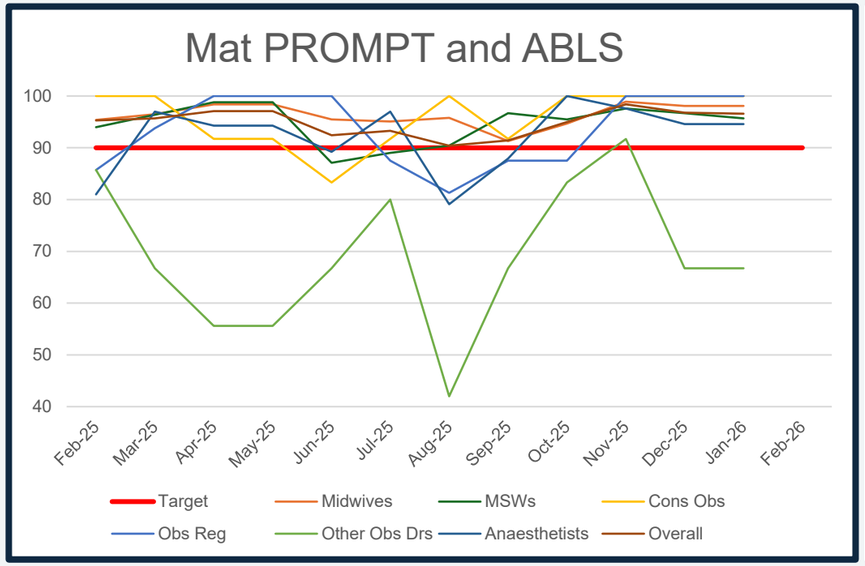
- Accountable officer sign off meeting 23-01-2025
- Board report to proceed through governance process

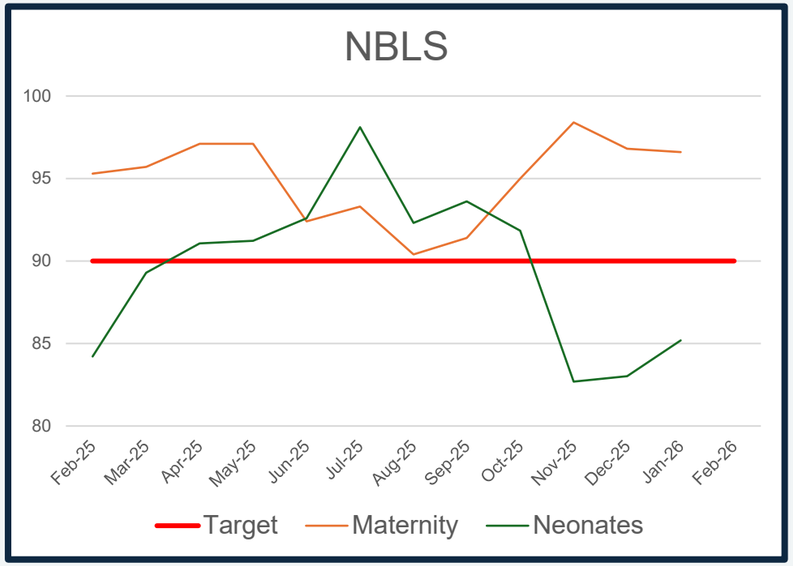
RISKS

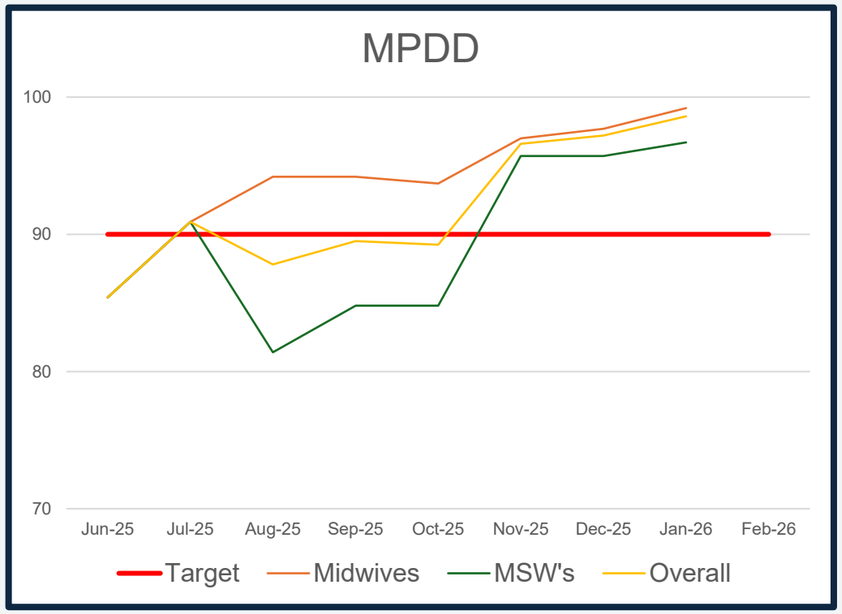
- Nil

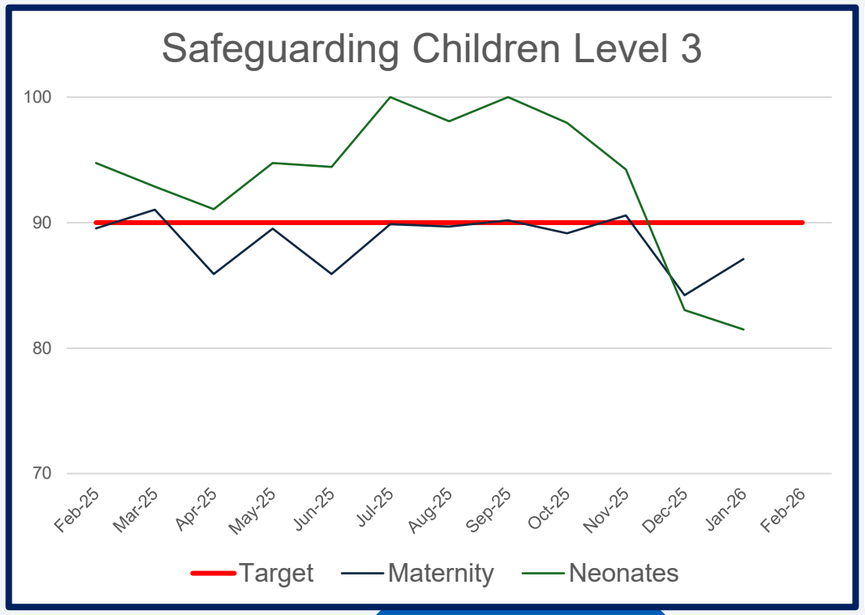
Training

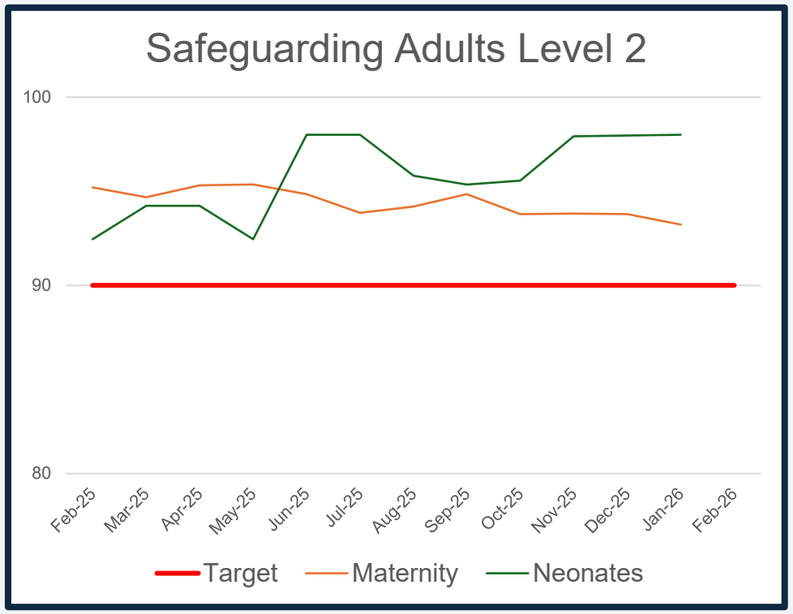

Fetal Monitoring Training Compliance
100
90
80
70
60
50
Feb-25
Mar-25
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Target
Midwives
Cons Obs
Obs Reg
Other Obs Drs
Overall Compliance


Mat PROMPT and ABLS
100
90
80
70
60
50
40
Feb-25
Mar-25
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Target
Midwives
MSWs
Cons Obs
Obs Reg
Other Obs Drs
Anaesthetists
Overall


NBLS
100
95
90
85
80
Feb-25
Mar-25
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Target
Maternity
Neonates


MPDD
100
90
80
70
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Target
Midwives
MSW's
Overall


Safeguarding Children Level 3
100
90
80
70
Feb-25
Mar-25
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Target
Maternity
Neonates


Safeguarding Adults Level 2
100
90
80
Feb-25
Mar-25
Apr-25
May-25
Jun-25
Jul-25
Aug-25
Sep-25
Oct-25
Nov-25
Dec-25
Jan-26
Feb-26
Target
Maternity
Neonates

Training Countermeasures

Overview Analysis:

- Other Obstetric compliance for PROMPT and ABLS not at target
- Compliance still under 90% for Safeguarding L3 and Manual Handling
- Training picture positive overall
- New TNA in process – to present proposal at March Governance

Potential Cause:

- New Doctor rotations in Jan 26 – staff booked on so will be trained within set time
- Extra Manual Handling trainers only just completed training

Countermeasure / Action	Owner	Status	Due Date
Build MH into study day	JM/CR	In progress	May 2026

Identified Risk	Mitigating Action
Manual Handling compliance	Being built into study day from June 2026
New NBLS algorithms	Community plan being built for new home birth algorithm
Funding for laptops/iPads - unspent budget	

Perinatal Insights: *'Listening to every story to improve every*

Compliments & Complaints

Total Contacts	**Compliments**	8
17	**Complaints**	0

Friends & Family

Contacts: 3
Very Good: 2
Good: 1

- Excellent care & treatment
- Staff Attitudes
- Cleanliness

Maternity & Neonatal Voices Partnership

N = 72

☺	😐
• Great communication from doctors/midwives/students around procedures • Doctors taking time to listen to anxieties and to address them • In person BF support in community • Midwife in recovery to support with BF after traumatic birth • Neonatal staff warm & welcoming • 'Small things' enacted by staff made a huge difference; turning lights down, knocking before entering, 'reading the room' • Midwives confident to support BF a small baby without suggesting formula	• Written info around post LSCS recovery- not just video • Midwives staring at laptops (now use digitised recording) • Parents of second and subsequent babies believed to 'know the system' - less explanations offered • Staff used 'hands on' approach to BF • Insufficient info around local support groups • Midwives not always 'reading the room' - lack of personalised care • More info needed around Labour notes on Badger App

Safety Champions

- Staff reported to be 'kind, caring & welcoming'
- Food enjoyable and hot
- Out of area mother staying on NNU felt cared for and reported staff had made the transfer much 'calmer'
- NNU family really impressed with meal vouchers for partners and free parking

Insights Walk & Talks

(10 conversations)

- Noisy ward environment
- Samples left on windowsills and bathrooms
- I had to tell staff when I last took tablets as it had not been recorded
- 'My partner felt very welcomed'
- The *xxx* took the time to sit with me and made me some toast as I had not eaten

Themes & Escalations

- Personalised care; continuity of team or individual – highly valued (AN)
- Meet the midwife/ Hello Baby – highly valued – Can we expand
- Ward environment: Consider periods of lower lighting and encourage staff to minimise noise and facilitate privacy & dignity e.g. knock and wait
- Medicines – delayed analgesia, ePMA compliance (QI project underway)
- Build on the family's 'welcome' ; explanations, introductions, ask about Badger App – offer refreshments, facilitate comfort e.g. fans

Neonatal feedback

Source SW Neonatal network. 5 Responses. 5 Positive comments include:

- ***.Please tell us about anything that we did well, that had a positive impact on your experience.*** In the 3 days my baby had neonatal care the girls we seen where amazing answered and guided through questions I asked. Maddie in particular we seen often and gave us so much comfort in everything that was happening Maddie is truly brilliant.
- 1 negative comment: **Please tell us about anything that helped or made**

Part 2 | People We Work With

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

NHS
Royal United Hospitals Bath
NHS Foundation Trust

Workforce Report

February 2026
(January 2026 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 that immediate manager values work (National)	Context	2024	74.7%	
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 Q4	52.0%	
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	Jan-26	5767.8		<=5579.3	✗	Not in FY			SPC not appropriate
People we work with	Workforce Plan	Substantive WTE	Context	Jan-26	5468.7		<=5322.7	✗	8			SPC not appropriate
People we work with	Workforce Plan	Bank WTE	Context	Jan-26	280.4		<=251.6	✗	Not in FY	F		Common Cause
People we work with	Workforce Plan	Agency WTE	Context	Jan-26	18.6		<=5.0	✗	8	F	H	Special Cause Concerning - Run Above Mean
People we work with	Vacancy	Vacancy Rate	Key Standard	Jan-26	-0.85%		<=4.00%	✓	0			SPC not appropriate
People in our community	Pay	Pay Bill % on Agency	Watch	Jan-26	0.99%		<=2.50%	✓	0	P		Common Cause
People we work with	Turnover & Leavers	In Month Turnover	Key Standard	Jan-26	0.59%		<=0.92%	✓	0	P		Common Cause
People we work with	Turnover & Leavers	12 Month Turnover	Key Standard	Jan-26	7.02%		<=11.0%	✓	0	P		Common Cause
People we work with	Turnover & Leavers	Leavers Inside 1st Year	Context	Jan-26	6.60		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	Dec-25	6.26%		<=4.98%	✗	7	F	H	Special Cause Concerning - Two out of Three High
People we work with	Sickness Absence	Short Term Sickness	Context	Dec-25	2.97%		N/A					
People we work with	Sickness Absence	Long Term Sickness	Context	Dec-25	3.29%		N/A					
People we work with	Sickness Absence	12 Month Sickness	Key Standard	Dec-25	5.29%		<=4.70%	✗	13	F	H	Special Cause Concerning - Run Above Mean
People we work with	Sickness Absence	In Month ASD Sickness	Driver	Dec-25	1.42%		TBC			F	H	Special Cause Concerning - Run Above Mean
People we work with	Appraisal	Appraisal Compliance	Key Standard	Jan-26	79.41%		>=90.0%	✗	Pre-2021	F		Common Cause
People we work with	Appraisal	AfC Appraisal Compliance	Context	Jan-26	80.14%		>=90.0%	✗	Pre-2021	F		Common Cause
People we work with	Appraisal	M&D Appraisal Compliance	Context	Jan-26	71.62%		>=90.0%	✗	Pre-2021	F	L	Special Cause Concerning - Run Below Mean
People we work with	Training	Mandatory Training Compliance (Core)	Key Standard	Jan-26	88.62%		>=85.0%	✓	0	P		Common Cause

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

Sickness

Royal United Hospitals Bath NHS Foundation Trust

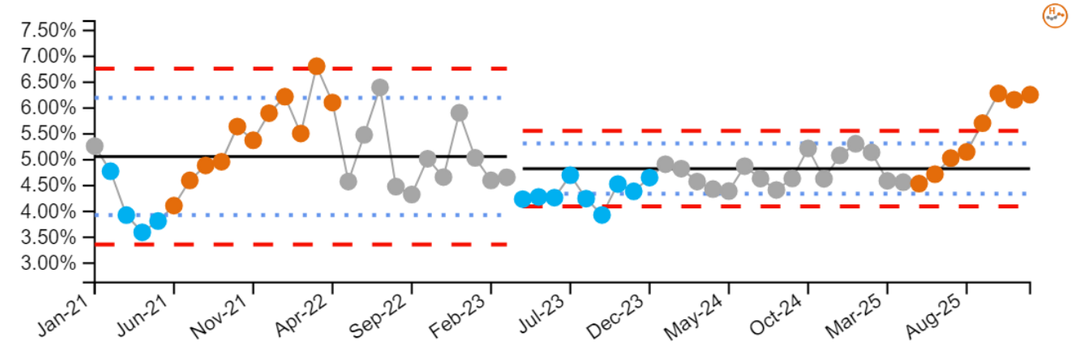
DRIVING

Key Standard

We are driving this metric because

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

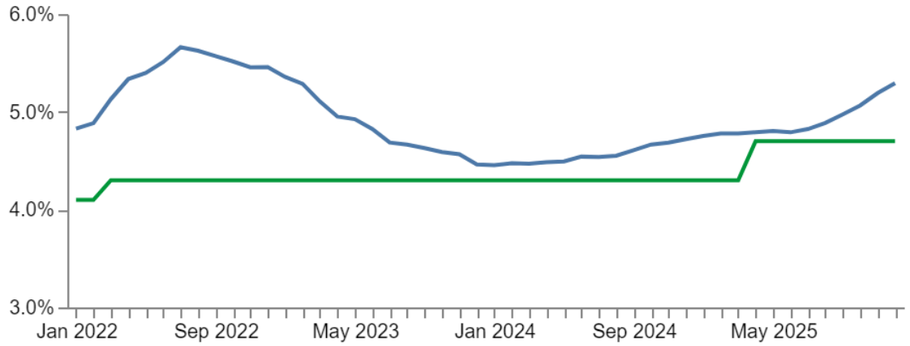
Trust In Month Trend



6.26% Latest In Month Sickness

4.98% Target

Trust 12 Month Trend



5.29% Latest 12 Month Sickness

4.70% Target

Understanding Performance

- In-month sickness rate remained elevated in December at 6.26%.
- 12-month sickness has increased half a percentage point in 6 months, now standing at 5.29%. This rate is the highest since February 2023, where the figures were still impacted by the Omicron Covid outbreak.
- Anxiety, Stress and Depression remains the top reason for sickness absence
- The absence rate for Cold and Flu alone was 1.21% - the equivalent of 2110.1 WTE days being lost – with the number absent peaking in the middle third of the month.

Countermeasures	Owner	Due Date
Medicine: Additional HR resource allocated to hot spot sickness areas. Reviews of long term and short term sickness cases via people hub. ED R&R plan in place to provide support to colleagues.	People Partner	Ongoing
Estates and Facilities: Driver in Estates and Facilities. Facilities holding directorate PRMs to support with sickness and embedding of new sickness policy. Focus on LTS and supporting staff back to work with adjusted duties.	People Partner	April 26
Surgery and FASS – focusing on Medical sickness reviews in hot spot areas.	People Parter	April 26
Trustwide: Increase engagement with EAP (Perkbox) through intensive communication plan	Culture Team	April 26

Risks and Mitigation

Risk: Levels of sickness absence remain high at a time of operational challenge, and in the context of central resources to support wellbeing being limited.
Mitigation: Introduction and fuller engagement with wellbeing resources and services via Perkbox (communications campaign to increase messaging throughout Q4), and more skilled human resources coming online with Group Staff Wellbeing Service (2026/27 Q1)

Anxiety, Stress and Depression Sickness

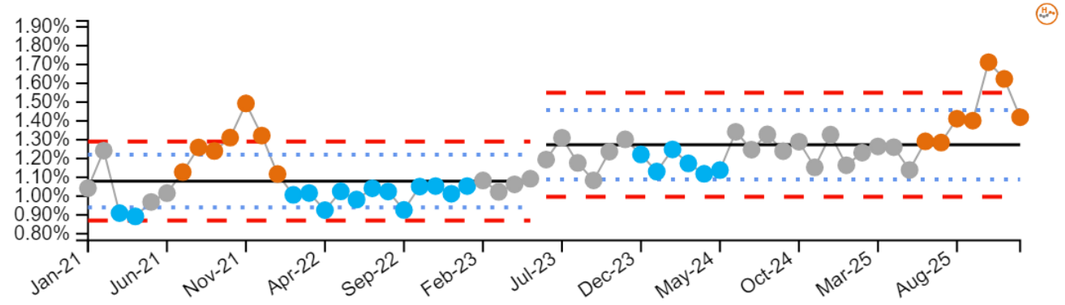
Royal United Hospitals Bath NHS Foundation Trust

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.

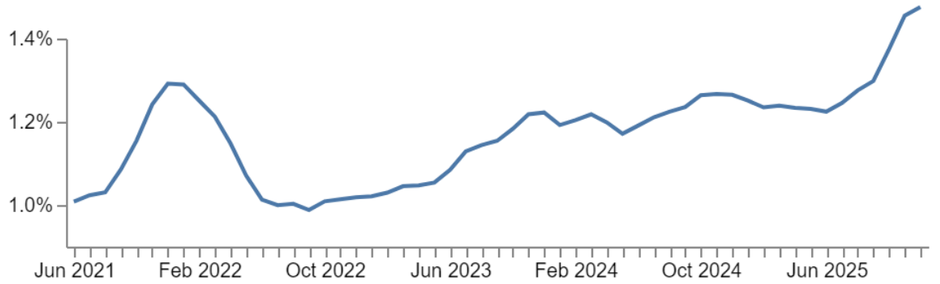
Trust In Month Rate



1.42%

Latest In Month Rate

Trust 6 Month Trend



1.48%

Latest 6 Month Rate

Understanding Performance

- Although down from its peak in October, January's anxiety, stress and depression sickness rate (1.42%) continues a run of months dating back to August where the rate exceeds 1.4%.
- For context, the average rate from mid-2023 to August was 1.23%. Compared to that norm, January's figure is still 15% up. That equates to c.330 more WTE days being lost - roughly equivalent to 10 extra people being absent for every day of the month.
- Prior to mid-2023, the norm was 1.08%. Against this benchmark, January's rate is just under a third higher. In other words, if we were performing in line with two and a half to three years ago the WTE days lost may have equated to around 60 people being absent for every day of the month. The actual WTE days lost is equivalent to 79 people being absent for every day of the month.

Countermeasures	Owner	Due Date
Surgery: driver for the division. HR liaising with top contributing areas to ensure sickness is being supported.	Divisional Tri	March 2026
Trust: Perkbox with access to 24/7 couselling support available launched.	Culture team	February 2026
Please see divisional countermeasures provided under 'sickness' above.		

Risks and Mitigation

Please see risk and mitigation under 'sickness' above.

Appraisal

Royal United Hospitals Bath NHS Foundation Trust

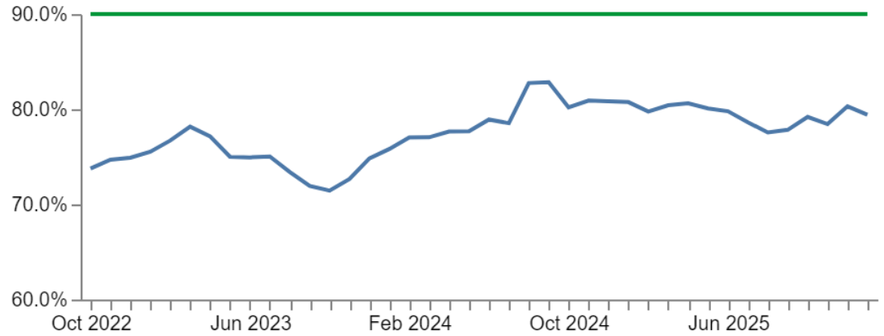
DRIVING

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.

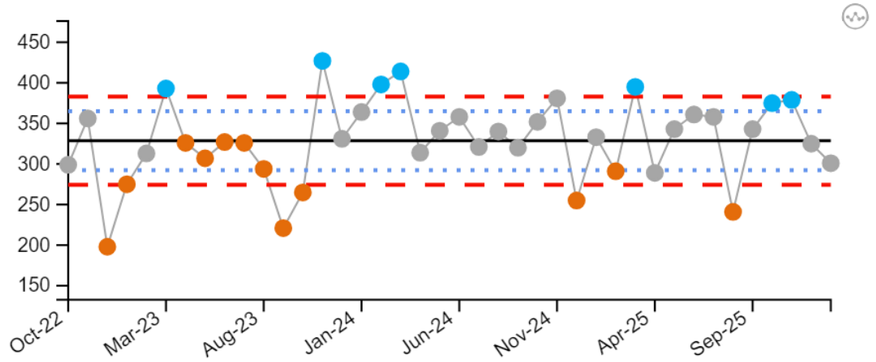
Trust Appraisal Compliance



79.4%
Latest Appraisal Compliance

90.0%
Target

Appraisals Completed in Month When Month First Reported



301
Appraisals Completed in Month

Understanding Performance
• Appraisal compliance has fallen 0.9 percentage points to 79.41%, drifting further away from target. • All main Divisions have lower compliance rates compared to December, with Surgery and R&D both over two percentage points down. • Corporate Division (63.28%) continues to have the poorest compliance of the main Divisions, with only six of its 16 directorates having at least two thirds of its staff compliant

Countermeasures	Owner	Due Date
Medicine: Driver measures set through Specialty PRM's resulting in increases in compliance in hot spot areas of Gastro, ED and Cardiology.	People Partner	Feb 26
Estates and Facilities: A3's being carried out on departments which are failing to hit 90% compliance. January Divisional rate at 88.64%	E&F Board	Ongoing
Surgery: Significant incidents have had an impact on appraisal rates. Driver measures set through Specialty PRM's, with HR supporting to produce reports on who is out of date.	Divisional Tri	March 2026
FASS: 1 directorate over 90%. Driver measures set through Specialty PRM's, with HR supporting to produce reports on who is out of date.	Divisional Tri	March 2026

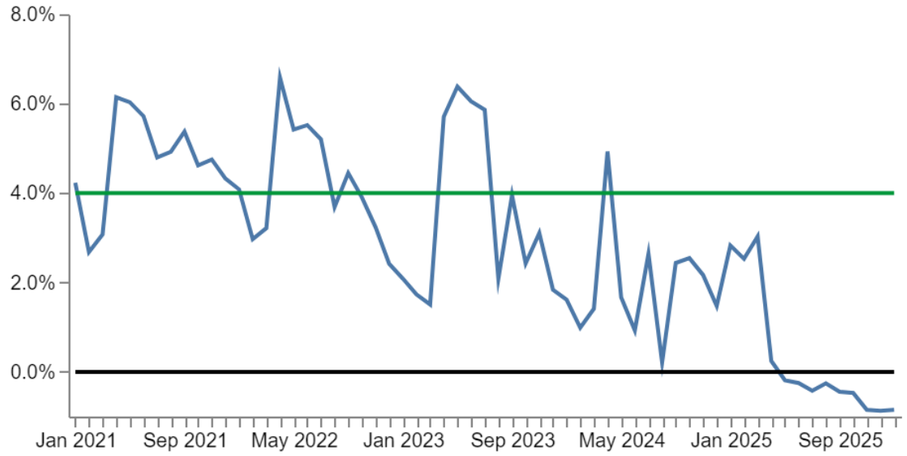
Risks and Mitigation

Vacancy

Royal United Hospitals Bath NHS Foundation Trust

Key Standard

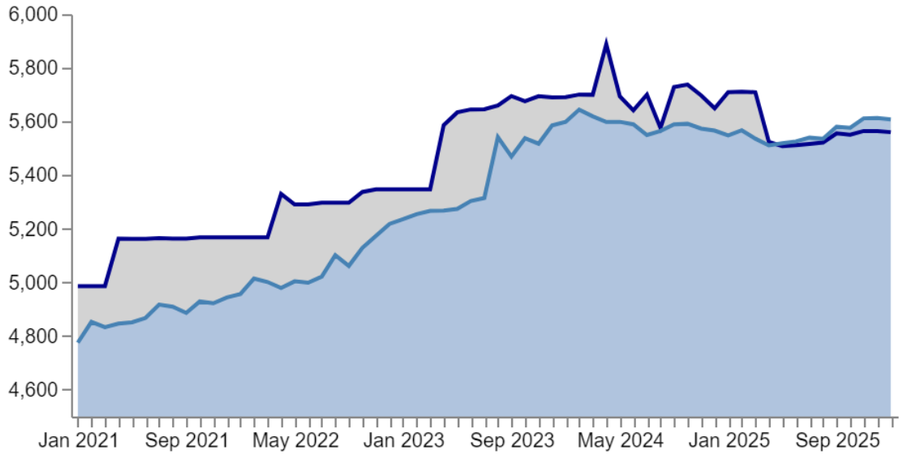
Trust Vacancy Rate



-0.85% Latest Vacancy Rate

4.00% Target

Budget v Contracted



5559.9 Latest Budget

5607.2 Latest Contracted

-47.4 Latest Vacancy

Understanding Performance

- The overall Trust vacancy position remains relatively static, with a vacancy of -47.4 WTE (-0.85%). The small reductions to budget and contracted WTE evident effectively cancelled each other out.
- Unidentified Pay Savings continue to be significant, taking 355.5 WTE from the budget.
- The three clinical divisions remain all over-established (FASS: -1.53%; Medicine: -0.86%; Surgery: -2.17%) reflecting their respective unidentified pay savings. Corporate (2.11%), Estates and Facilities (4.40%) and R&D (3.87%) all report vacancies, though practically these may not be actively recruited to.
- Clinical Support Workers B3 remain the account code with the greatest vacancy (73.9 WTE), though the gap is closing month on month with growth in contracted WTE.
- Band 5 Registered Nurses have the next highest vacancy (53.3 WTE). Whilst this is down on last month, this is due to a lower budget rather than growth in contracted WTE.

Countermeasures	Owner	Due Date
Medicine: ED recruitment trajectory has seen improvement in vacancy rate. HCSW fully established by April and Registered Nursing vacancy rate falling to under 10 WTE by April with further recruitment ongoing. Recruitment Team prioritising ED recruitment	People Partner	April 26
Surgery and FASS: Requests for recruitment being monitored through internal processes.	Divisional Tri	April 26
Clinical Support Workers – Recruitment working with Divisions to devise quarterly recruitment assessment days for HCSW for experienced and New to care – next scheduled for March 2026.	Recruitment	April 26
Immigration and Visa with effect from February we will offer 5 year visa on joining to take employee to the point of being eligible for ILR. Additionally, for those renewing or switching route we're operating a 13 week average pay period to give our people the best possible chance of remaining.		

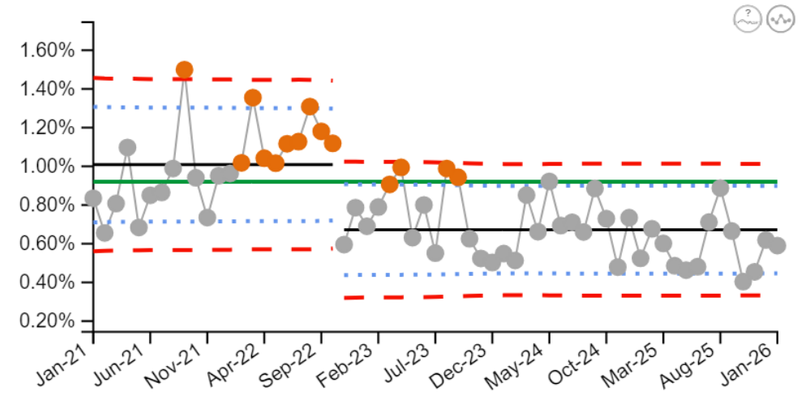
Risks and Mitigation

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

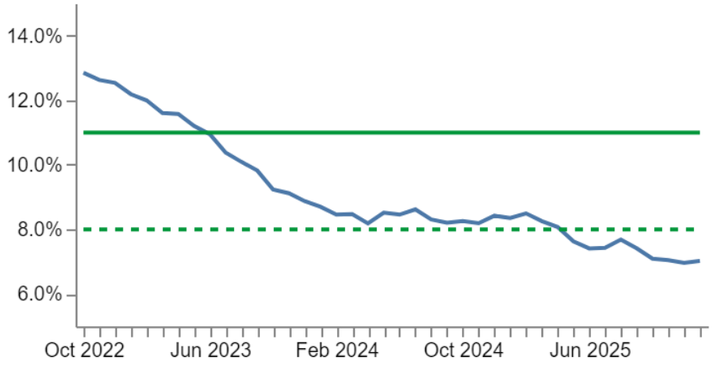
Trust In Month Turnover



0.59% Latest In Month Turnover

0.92% Target

Trust 12 Month Turnover



7.02% 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	1.39%	9.48%
Estates and Facilities Division	0.67%	7.28%
Family and Specialist Service Division	0.43%	8.41%
Medical Division	0.41%	6.04%
Research & Development [Division]	1.97%	9.80%
Surgical Division	0.65%	6.36%

Main Staff Group	In Month	12 Month
Add Prof Scientific and Technic	1.60%	14.22%
Additional Clinical Services	0.86%	10.08%
Administrative and Clerical	1.03%	9.60%
Allied Health Professionals	0.54%	7.69%
Estates and Ancillary	0.58%	6.95%
Healthcare Scientists	0.61%	10.69%
Medical and Dental	0.48%	2.82%
Nursing and Midwifery Registered	0.27%	3.91%

Understanding Performance

- In-month turnover held steady in January at 0.59%, remaining below target and within expected limits.
- 12-month turnover has marginally increased to 7.02% but continues to be at a level that may be considered unhealthy.
- Corporate had the highest in-month turnover at 1.39% and has the highest 12-month turnover rate of Divisions at 9.48%. It is likely that turnover in this area will increase notably in coming months as staff transfer to Group partners as part of the restructure.

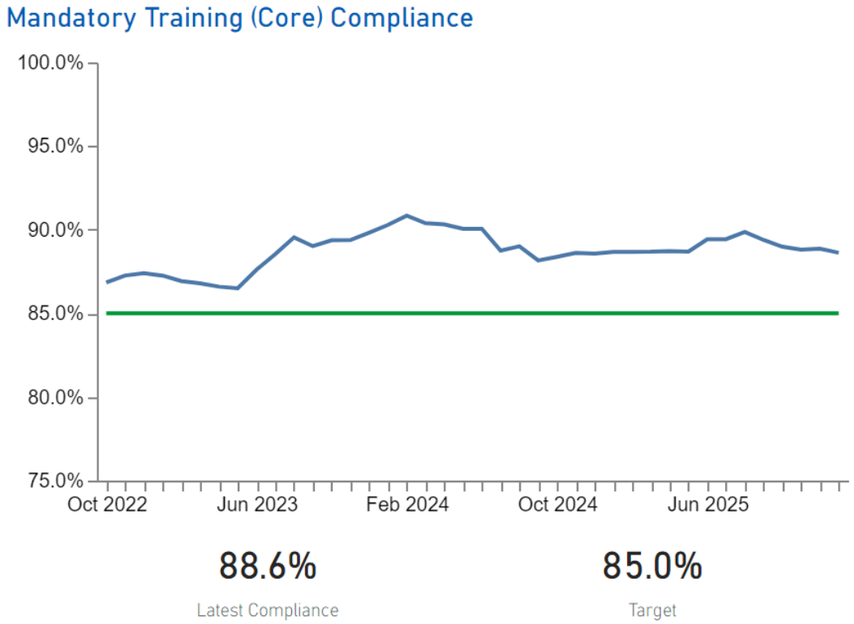
Countermeasures	Owner	Due Date
All divisions: Monitoring leaving reasons and exit interviews.	People Partner	Ongoing

Risks and Mitigation

Turnover remains lower than what might be considered as 'healthy' levels. This may reflect wider uncertainty in the healthcare jobs market.

Mandatory Training

Key Standard



Understanding Performance
• Mandatory Training compliance remains above target but at 88.62% continues to be on a downward trend from its peak in August. • All main Divisions continue to exceed the 85% target. • The three resuscitation subjects, both Level 3 Safeguarding subjects, Level 2 Safeguarding Children and Level 2 Manual Handling remain the core mandatory subjects where their respective targets are not being met.

Countermeasures	Owner	Due Date
Medicine: Provided independent ability to undertake e-learning and taught aspects of resus training within the Emergency Department to ease operational pressure from completion	People Partner	Feb 26
E&F: Oliver McGowan Training level 2 rates remain low due to courses being full day and offsite for Porters. Staff have now been booked onto courses to increase compliance.	AD for Facilities/ Logistics manager	On going
Surgery: remains over trust target. Lowest training level is Resus Peads. Focusing on improving this over the next month.	Divisional Tri	March 26
FASS: training remains over target. Asking division to focus on Moving and Handling level 2.	Divisional Tri	

Risks and Mitigation

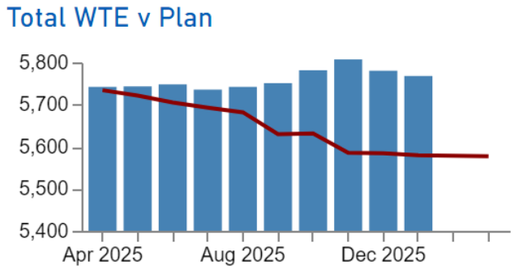
Performance vs Workforce Plan

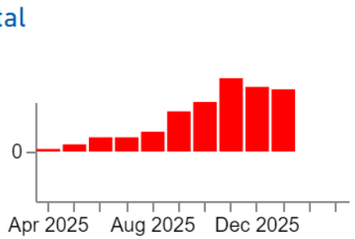
Royal United Hospitals Bath NHS Foundation Trust

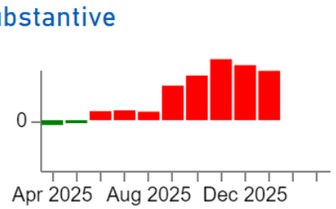
Driver

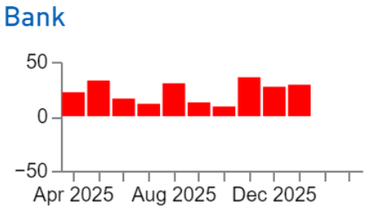
We are driving this metric because

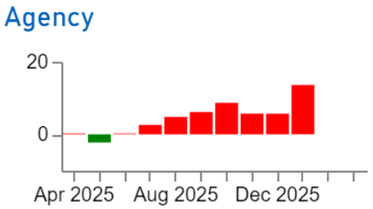
Achieving the Workforce Plan will be a key factor in achieving the financial savings required. Affording regular attention to progress against the plan will enable more timely intervention should deviation become apparent.











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	5,750.87	5,781.06	5,807.26	5,780.19	5,767.78		
Substantive	5,408.81	5,409.60	5,436.89	5,428.87	5,427.04	5,462.50	5,494.90	5,503.27	5,485.95	5,468.74		
Bank	326.67	329.39	304.82	297.91	303.90	277.22	272.48	293.28	283.55	280.44		
Agency	6.23	3.76	6.20	8.60	10.80	11.15	13.68	10.71	10.69	18.60		

Understanding Performance

- Though slightly improved on last month, the Trust continues to exceed the total outlined in the Workforce plan at the start of the Financial Year by 189.5 WTE.
- Actual substantive numbers are down for second successive month, which against a now static planned figure closes the gap in this domain to 146.0 WTE.
- The reduction in actual bank usage from last month was only 3.1 WTE against a planned 5 WTE reduction. The in-month gap been plan and actual has therefore slightly widened to 28.9 WTE.
- Agency use is 3.72 times higher than planned at 18.6 WTE. This is also the sixth successive month where agency use has exceeded 10 WTE – or double the targeted 5 WTE – demonstrating how ambitious that target is.

Countermeasures	Owner	Due Date
Tight workforce and establishment control through existing controls	Trustwide	31/03/2026
Reduction in Bank wte due to previous employment of substantive staff	Trustwide	31/03/2026
Workforce redesign – Ensuring we have the rught workforce in the right place at the right time	Trustwide	31/03/2026
Regular triangulation of workforce, finance and operational / Ongoing monitoring of recruitment versus turnover	Trustwide	31/03/2026

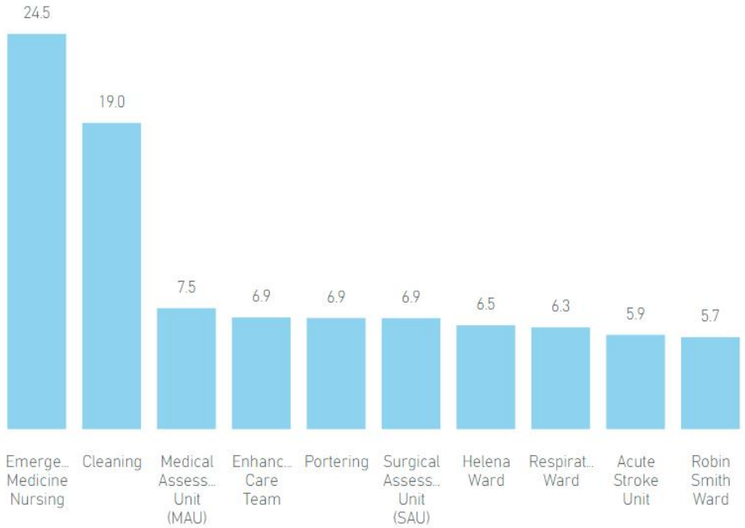
Risks and Mitigation

Bank & Agency Use

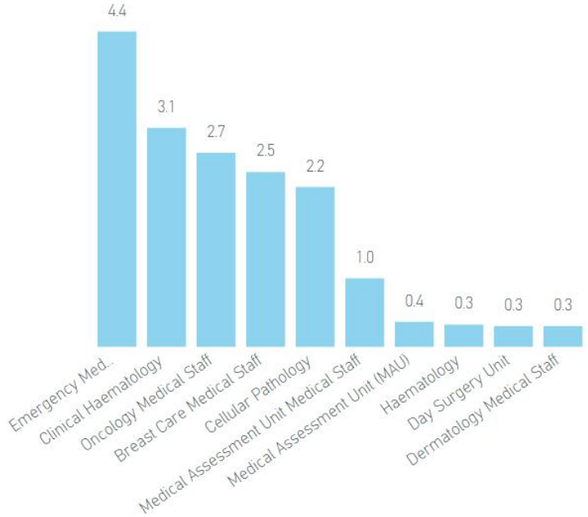
Royal United Hospitals Bath NHS Foundation Trust

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	24.2	10.8
Registered Nursing, Midwifery and Health Visiting Staff	90.1	5.8
Registered/ Qualified Scientific, Therapeutic and Technical staff	9.6	1.3
Support to Clinical Staff	104.8	
NHS Infrastructure support	51.4	-0.4

Understanding Performance

Bank usage was 280.4 against a target of 251.6WTE due to escalation areas and critical incident

Emergency Medicine Nursing remains the top user of bank. Though the 24.5 WTE used in January is the lowest in a year, this should be viewed alongside the increase in agency use which means temporary staffing use overall is comparable with previous months.

• Cleaning remains the second top user of bank and has also reported its lowest use for at least a year at 19.0 WTE.

• Most agency use remains associated with Medical and Dental staff, with the total for this staff group alone exceeding the planned level.

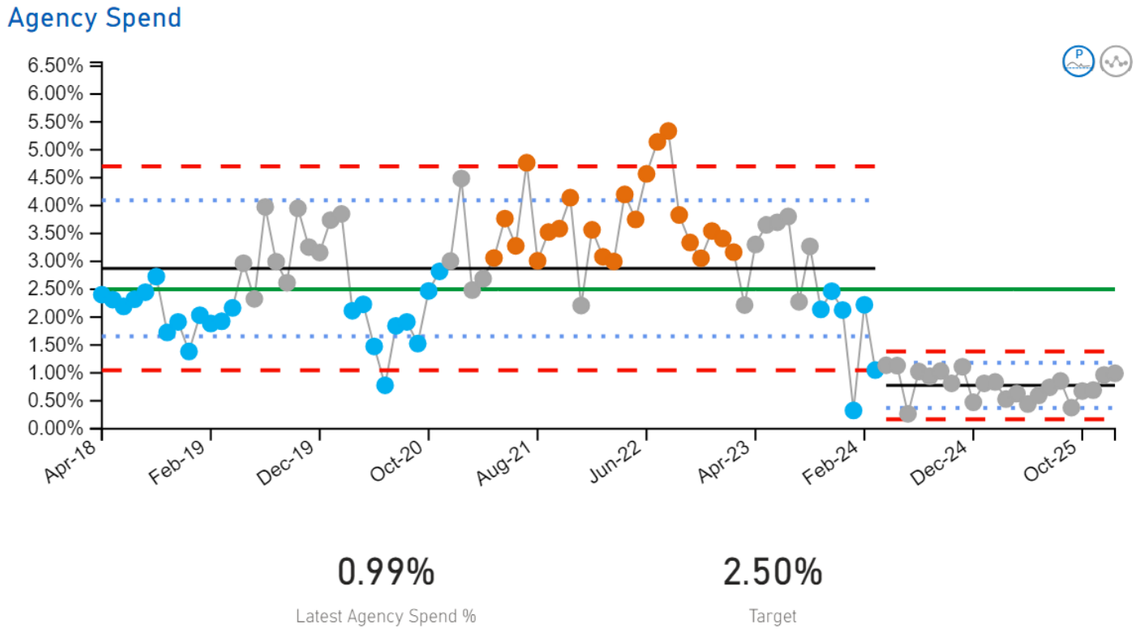
Countermeasures	Owner	Due Date
E&F- Review of unfunded cleanings being requested which is contributing to additional bank spend.	AD for Facilities	Ongoing
ED clearances are being prioritised – 4 Nurses started 16/2 and currently clearing 14 Nurses with start dates in March/April.	Recruitment /Divisional	April 2026
Cleaning-recruitment campaign currently appointed 8 cleaners with provisional start dates of April/May	Recruitment /Divisional	April 2026

Risks and Mitigation

There is a risk that winter pressures and increased sickness absence will increase bank spend within quarter 4 2025/26.

Agency Spend as % of Total Pay Bill

Key Standard



Understanding Performance
•As a proportion of the total pay bill, January's agency spend was the highest in the Financial Year to date at 0.99%. Nonetheless this figure remains below target of 2.5% . • The top contributor for agency spend was on consultants, with Oncology Medical Staff, Cellular Pathology, Clinical Haematology and Breast Care Medical Staff accounting for over 80% of the consultant total. • Nurse agency spend was £4k down on December, but still comparatively high for the Financial Year to date. Emergency Medicine, Day Surgery and MAU were top contributors. • There was a notable increase in Non-Clinical agency spend (+£32k), which is primarily associated with the Theatre Scrub Staff cost centre.

Countermeasures	Owner	Due Date
ED: longline agency provision sourced to demonstrate best value and maintain safe staffing levels to cover the period of recruitment	Staffing solution	May 2026
Consultant Recruitment is being prioritised with Talent Specialist overseeing recruitment campaigns. 15 consultants at offer stage with start dates from March to September 2026. 10 consultant vacancies in pipeline (3 advertising/2 shortlisting/5 interview stages) 4 consultants started in 2025 to cover the stated areas.	Recruitment/M&D Team	May 2026
ED clearances are being prioritised – 4 Nurses started 16/2 and currently clearing 14 Nurses with start dates in March/April.	Recruitment/M&D Team	May 2026

Risks and Mitigation

Part 3 | People In Our Community

Deliver a sustainable financial position

Equity of access to
RUH for all

Carbon emission reduction

Royal United Hospitals Bath
NHS Foundation Trust

Finance Report

February 2026
(January 2025 Data - M10)

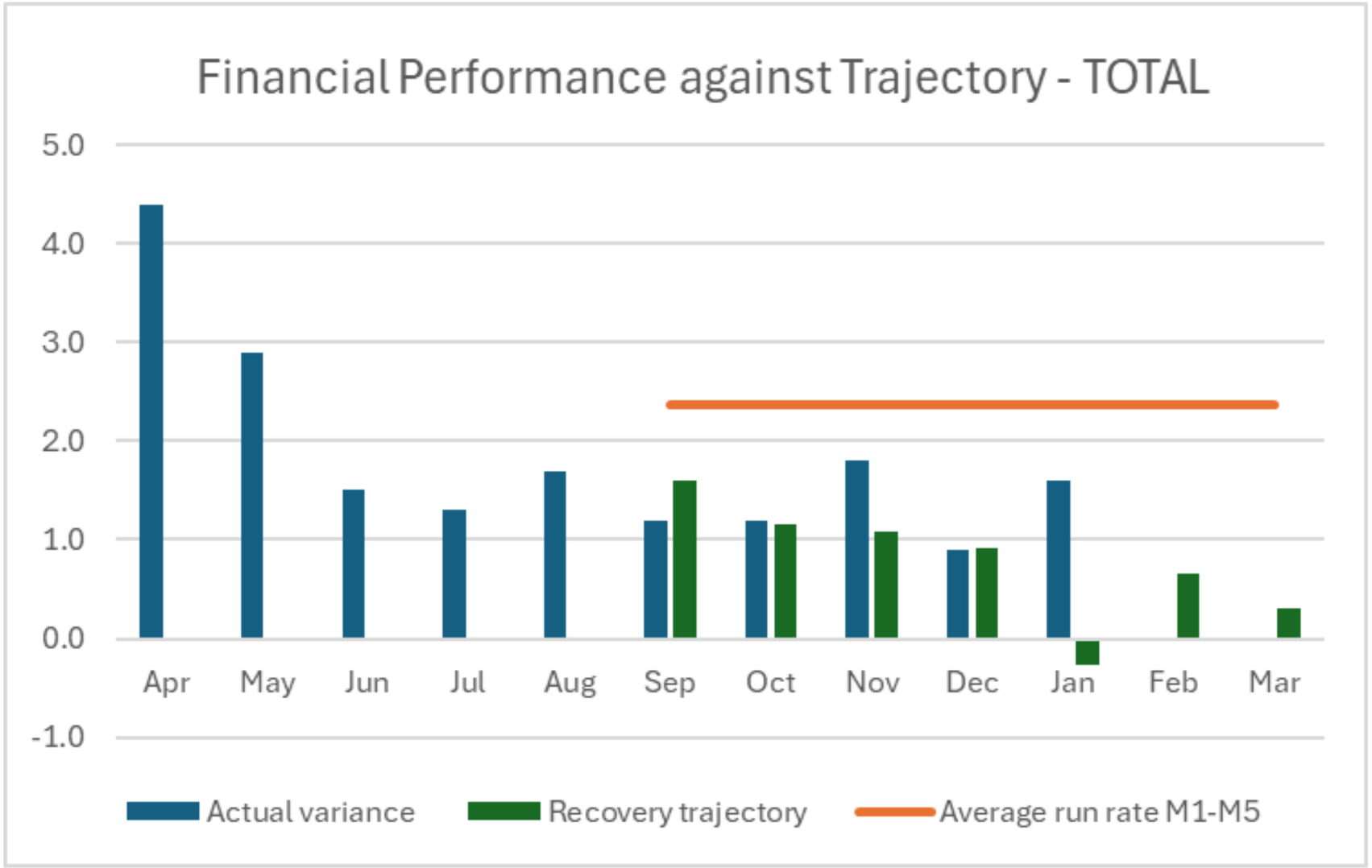
The RUH, where you matter

Progress against Month 6 Recovery Plan

At the end of Month 6 the Trust developed a path to £17m FOT deficit, as well as agreeing to seek to contribute to close BSW Hospitals Group gap to breakeven of £7.4m.

The graph plots the monthly (surplus) / deficit; and the progress against the Recovery Trajectory set out at Month 6, the yellow bar represents the average monthly run rate M1 and 5 and can clearly see the improvement in the run rate since the beginning of the year.

The performance deviates against the control total trajectory in Month 10, as a number of identified risks have crystalised in the position and the most likely case is now £20.5m FOT



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

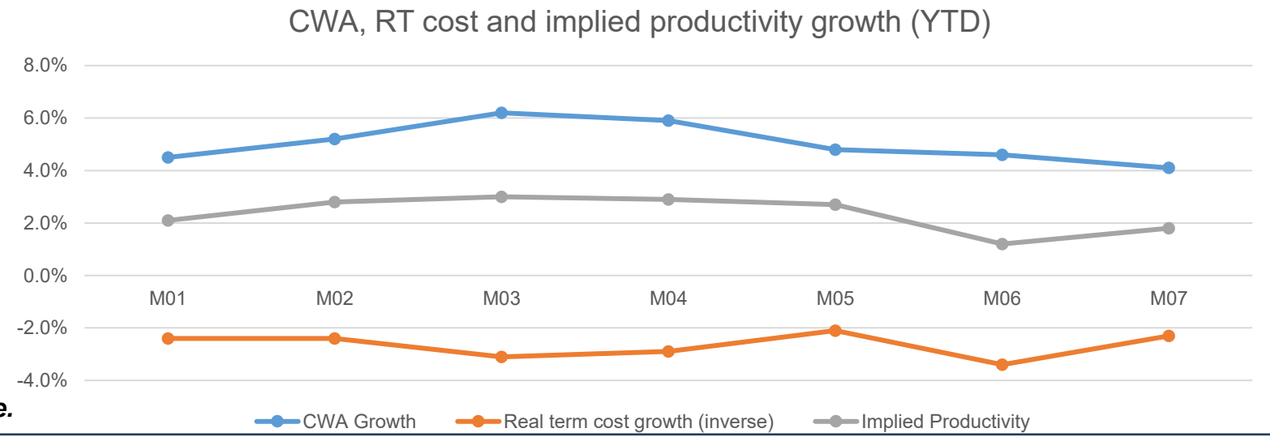
Royal United Hospitals Bath NHS Foundation Trust

Breakthrough Objective

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

	24/25 Comparison, unadjusted			Movement from M6, unadjusted		
M7 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	4.1%	2.3%	**1.8%**	-0.5%	-1.1%	**0.6%**
NHSE Median	3.3%	-0.2%	**3.5%**	-0.3%	-0.2%	**-0.1%**

Data are published by NHS England several months behind, M7 is the latest available figure.



Understanding Performance	Countermeasures	Owner	Due Date	Update	Risks and Mitigation
RUH productivity growth for YTD measured against previous year is 1.8% NHS England total productivity is 3.5% and South-West 3.8%, however it should be noted that these figures are now for all providers not just acute and specialist trusts. The **NHSE productivity growth for acute and specialist trusts is 2.8%.** RUH ranked 139th of 205 Trusts. Compared to the previous month RUH productivity increased by 0.6%, with inflation adjusted expenditure growth decreasing by 0.5% and cost weighted activity growth decreasing by 1.1% RUH **cost weighted activity growth was 4.1% and real terms resource use growth was 2.3%** (NHSE 3.3% and -0.2%, and SW 4.2% and 0.4% respectively) In the group **GWH had productivity growth of 4.8%** (cost weighted activity growth was 2.3% and real terms resource use growth was -2.4%), **SFT had productivity growth of 2.6%** (cost weighted activity growth was 5.1% and real terms resource use growth was 2.5%)	Delivery of Productivity improvements and cash releasing savings target set out in Operational Plan for 25/26	Savings programme SRO	Ongoing		• Ensure understanding of the metric and calculations • If Productivity improvements are not sufficiently cash releasing this could lead to achievement of the metric but failure to delivery financial performance targets
	Develop metric to be based on real-time data Develop metric to be calculated at Division level	Head of Financial Projects	Ongoing	The costing team have 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.	
	Establish single KPI for each Specialty to focus on during 25/26	Divisional/ Specialty 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.

Update to latest Recovery Plan

The RUH Group underlying deficit continues to be assessed at £47.3m, and is aligned with 25/26 Recovery Actions and Forecast Outturn; although £2.1m of unmitigated risks related to Sulis CDC and High Cost Drugs demand growth dependent on final exit run rate. £47.3m has been the baseline for 26/27 planning.

Income & Expenditure Year to Date (NHSE Performance)

Royal United Hospitals Bath NHS Foundation Trust

I&E to January 2026	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	411.247	412.487	1.240	24.388	25.390	1.002	0.000	0.000	0.000	435.637	437.877	2.242
Clinical Education Income	17.238	15.899	(1.339)	0.000	0.000	0.000	0.000	0.000	0.000	17.238	15.899	(1.339)
Other Income	43.645	45.827	2.181	20.477	19.366	(1.111)	(3.328)	(3.384)	(0.056)	60.794	61.809	1.015
Pay	(295.745)	(307.015)	(11.270)	(20.708)	(21.669)	(0.961)	0.000	0.000	0.000	(316.454)	(328.684)	(12.231)
Non Pay	(139.311)	(152.395)	(13.084)	(20.551)	(19.194)	1.358	0.786	1.339	0.553	(159.077)	(170.251)	(11.174)
EBITDA	**37.074**	**14.803**	**(22.271)**	**3.606**	**3.893**	**0.288**	**(2.542)**	**(2.045)**	**0.497**	**38.139**	**16.650**	**(21.489)**
Depreciation & Amortisation	(19.589)	(19.098)	0.491	(2.721)	(2.781)	(0.061)	1.817	1.482	(0.335)	(20.493)	(20.397)	0.095
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	(7.810)	(7.558)	0.252	(0.435)	(0.513)	(0.077)	0.320	0.265	(0.055)	(7.926)	(7.806)	0.120
Surplus/(Deficit)	**(3.946)**	**(25.335)**	**(21.389)**	**0.450**	**0.599**	**0.149**	**(0.405)**	**(0.299)**	**0.106**	**(3.900)**	**(25.035)**	**(21.135)**
Donated/Grant Income	(3.900)	(6.704)	(2.804)	0.000	0.000	0.000	0.000	0.000	0.000	(3.900)	(6.704)	(2.804)
Adjusted Financial Performance	**(0.046)**	**(18.632)**	**(18.585)**	**0.450**	**0.599**	**0.149**	**(0.405)**	**(0.299)**	**0.106**	**(0.000)**	**(18.331)**	**(18.331)**

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 £18.6m. This is resulting from delays to delivery against the savings programme (£14.5m), deterioration in the exit run rate (£5m), and operational pressures arising from increased spend on high cost drugs and devices (£1.7m), Resident Doctors budget pressures (£1.7m), pressures from pay awards (£0.3m). Industrial Action was funded in Month 9 as well as funding of variable activity (£0.9m). Further benefits trough non-recurrent technical adjustments (£2.8m) and increased controls (£1.4m).

Sulis shows a benefit against plan of £0.1m. CDC performance has recovered and the beneficial position is through reduced non-pay costs, with some historic costs attributed to the RUH.

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

Budget – by Division

Royal United Hospitals Bath
NHS Foundation Trust

Budget by Division		In Month				Year to Date			
		RUH				RUH			
	Yearly Budget £'m	Budget £'m	Actual £'m	Variance £'m	Variance %	Budget £'m	Actual £'m	Variance £'m	Variance £'m
Commissioning Income	474.900	40.224	39.408	(0.817)		394.346	395.586	1.240	
Clinical Education Income	20.549	1.655	1.183	(0.472)		17.238	15.899	(1.339)	
Deficit Support Funding	19.198	1.248	1.181	(0.067)		16.901	16.901	0.000	
Surgery	(135.655)	(11.296)	(11.023)	0.273	2.4%	(112.816)	(113.732)	(0.916)	-0.8%
Medicine	(164.801)	(13.985)	(14.379)	(0.394)	-2.8%	(137.051)	(142.381)	(5.330)	-3.9%
FASS	(102.764)	(8.866)	(9.188)	(0.322)	-3.6%	(85.511)	(87.695)	(2.183)	-2.6%
E&F	(33.411)	(2.885)	(2.600)	0.285	9.9%	(27.855)	(27.075)	0.779	2.8%
Corporate	(66.307)	(5.463)	(5.642)	(0.179)	-3.3%	(55.365)	(56.718)	(1.353)	-2.4%
HIWE	0.000	0.000	(0.000)	(0.000)		0.000	0.000	0.000	
R&D	0.000	0.000	0.016	0.016		0.000	0.016	0.016	
Unallocated Savings	5.402	0.450	0.000	(0.450)		4.501	0.000	(4.501)	
Reserves	10.114	1.106	1.051	(0.055)		8.306	3.337	(4.969)	
Finance Charges	(27.291)	(2.274)	(2.096)	0.178		(22.742)	(22.771)	(0.029)	
Adjusted Financial Performance - RUH	**(0.065)**	**(0.086)**	**(2.090)**	**(2.003)**		**(0.046)**	**(18.632)**	**(18.585)**	
Sulis	0.000	0.108	0.558	0.449		0.450	0.599	0.149	
Inter Group	(0.450)	(0.022)	(0.036)	(0.013)		(0.405)	(0.299)	0.106	
Adjusted Financial Performance - Group	**(0.515)**	**(0.001)**	**(1.568)**	**(1.567)**		**(0.002)**	**(18.331)**	**(18.329)**	
Impairment	*(13.621)*	*0.000*	*0.000*	*0.000*		*(13.621)*	*(13.482)*	*0.139*	
Donated/Grant Income	*11.666*	*0.972*	*0.156*	*(0.816)*		*9.721*	*6.779*	*(2.943)*	
Unadjusted Financial Performance	***(2.471)***	***0.971***	***(1.412)***	***(2.383)***		***(3.902)***	***(25.035)***	***(21.133)***	

Understanding Performance

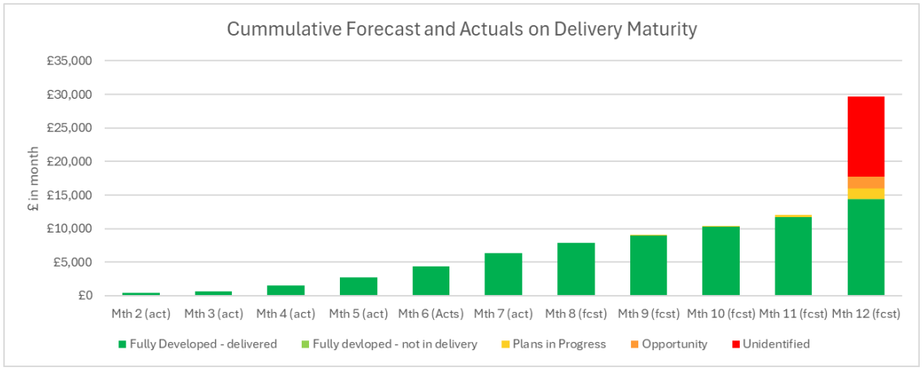
This table shows the spend against current budgets. Note that annual savings target **have** now been devolved to Divisional budgets. The YTD negative variances highlight the lack of delivery of savings.

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.

Countermeasures	Owner	Due Date

Savings Delivery Against Plan

Royal United Hospitals Bath NHS Foundation Trust



	In Month		YTD			Programme Status						
	Month 10 Acts	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	28	(306)	430	3,333	(2,903)	495	0	12	**507**	0	3,493	4,000
Outpatients Delivery Group	63	(187)	632	2,500	(1,869)	898	0	9	**907**	1,593	500	3,000
Elective Delivery Group	71	(87)	830	1,583	(753)	1,146	0	0	**1,146**	254	0	1,400
Corporate Services	175	(33)	1,343	2,083	(740)	1,863	0	2	**1,865**	0	635	2,500
Central Delivery Group	558	(71)	5,109	6,288	(1,179)	7,646	84	521	**8,251**	0	0	8,251
Estates & Facilities	145	13	1,516	1,317	199	1,763	0	0	**1,763**	0	0	1,763
Unidentified		(356)	0	3,561	(3,561)	0	0	0	**0**	0	2,885	2,885
SULIS	46	4	408	417	(9)	500	0	1,000	**1,500**	0	0	1,500
Total excluding Group	**1,086**	**(1,022)**	**10,267**	**21,082**	**(10,816)**	**14,312**	**84**	**1,544**	**15,940**	**1,847**	**7,512**	**25,300**
Group	0	(367)	0	3,667	(3,667)	0	0	0	0	0	4,400	4,400
Total including Group	**1,086**	**(1,389)**	**10,267**	**24,749**	**(14,482)**	**14,312**	**84**	**1,544**	**15,940**	**1,847**	**11,912**	**29,700**

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

Understanding Performance

£10.3m savings have been delivered year to date, £1.1m up on last month but the monthly reporting shows delivery not to be increasing. The Trust now has a £14.5m shortfall against plan year to date, a major contributor to the Trust overall adverse variance to plan.

Programme delivery is now working with Hunter Healthcare to accelerate savings delivery however to achieve forecast year end position identified opportunity areas need to be worked up to deliverable plans. However, £14m remains unidentified.

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, Recovery Director and Hunter Healthcare	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
FIRM and PRM working with Hunter Healthcare to identify and deliver further areas of savings opportunities.	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	86,296	88,450	2,154	21,697,129	21,879,346	182,217
DC	38,591	41,835,488	40,091	44,363,159	32,925	31,386	-1,539	36,406,134	36,893,300	487,166
EL	3,669	20,125,247	4,889	27,520,855	3,987	3,286	-701	22,457,443	18,253,334	-4,204,108
HCD	189,019	54,025,019	0	59,871,909	0	180,828	180,828	49,657,679	50,167,334	509,655
NE	59,967	192,340,342	62,038	200,334,168	51,897	55,322	3,425	168,246,614	165,887,918	-2,358,696
OP	780,366	115,506,647	758,359	114,941,069	630,157	668,563	38,406	95,324,492	99,724,866	4,400,374
OT	3,374,847	17,449,521	2,978,127	17,901,214	2,483,626	2,837,325	353,699	14,944,178	15,013,833	69,655

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 January, SOC continues to perform under plan by £1.6m, this is due to delays in getting access to the second theatre and the absence of planned Saturday lists which was included in the plan – in-month performance accounts for £180k of this under-delivery and improvement from the last quarter.

Over performance for non-elective income in General Surgery and T&O continued reflecting the ongoing operational pressures.

The high-cost drugs and devices performance was under plan by £249k in-month to a YTD of £509k over, a significant decrease in performance against plan from M9.

Countermeasures	Owner	Due Date
Work with Pharmacy and Commissioners to mitigate HCDD growth risk, either through additional funding or change in practice	Income Team	Ongoing
Continue to work up robust planning for HCDD for 2026/27 to calculate the ongoing risk going into next year, in light of tariff changes under consultation to move a number of key drugs into the main activity tariff.	Income/ Pharmacy	Ongoing
Finalise final activity plan for 26/27 following agreement for 2026/27 RTT investments and growth plans with Divisions	Income Team	31st March

Risks and Mitigation

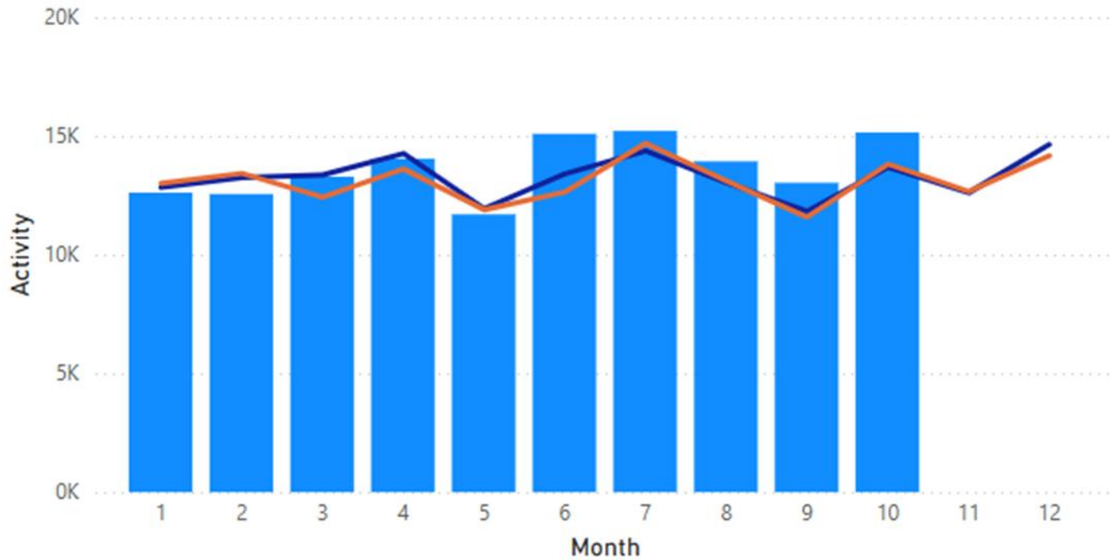
- Stranded fixed costs where variable income is not reimbursed due to Activity Management Plan process
- Iterative review of forecast against developing plans and improved planned activity delivery resulting from RTT investments.
- NHS Spec Com challenging the coding of cardiac home monitoring put at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

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

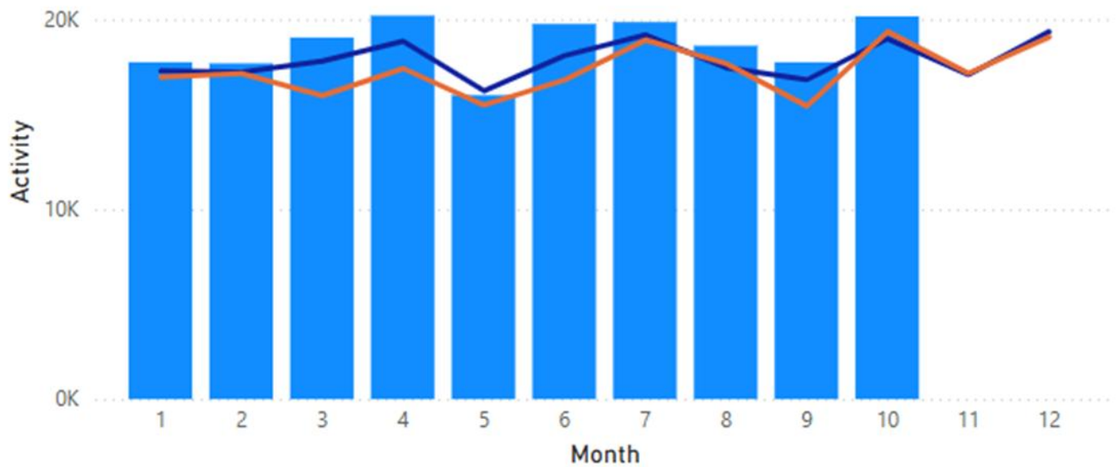
25-26 Actual Activity YTD
25-26 Plan Activity
24-25 Actual Activity

Royal United Hospitals Bath
NHS Foundation Trust

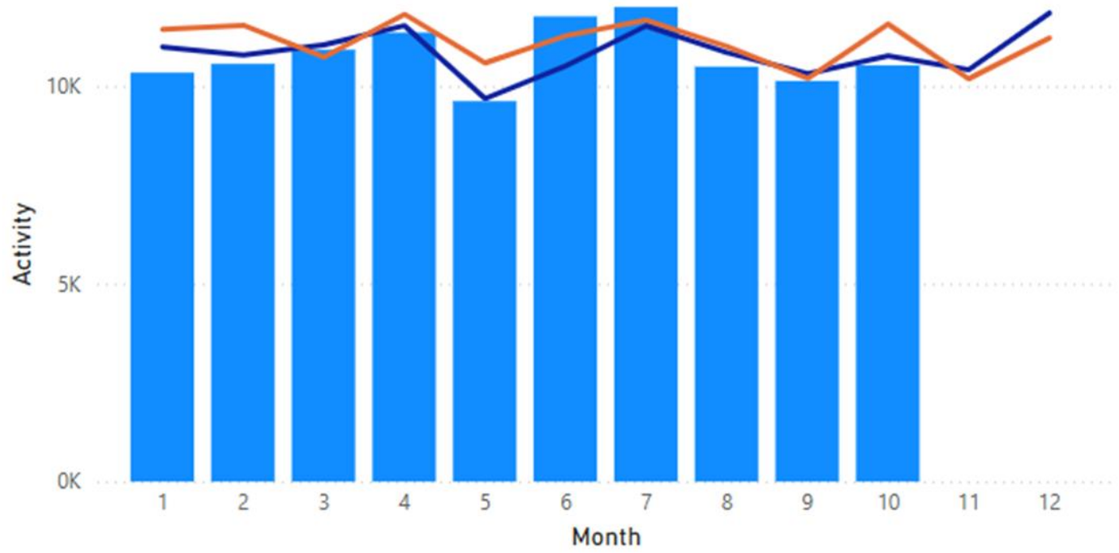
New Outpatient



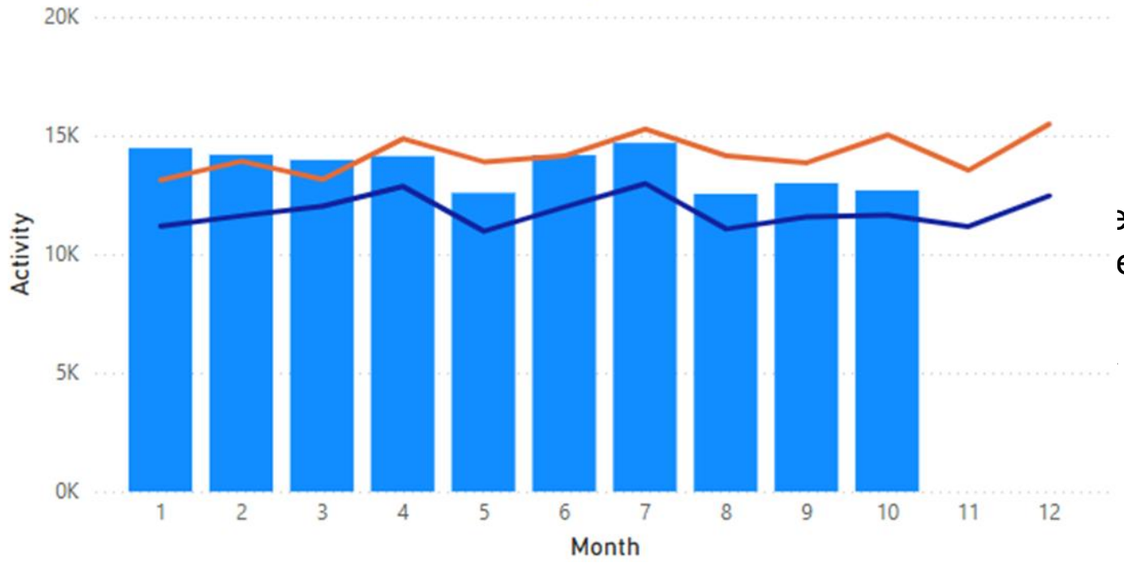
Outpatient Fup



Outpatient Procedures



Other outpatient



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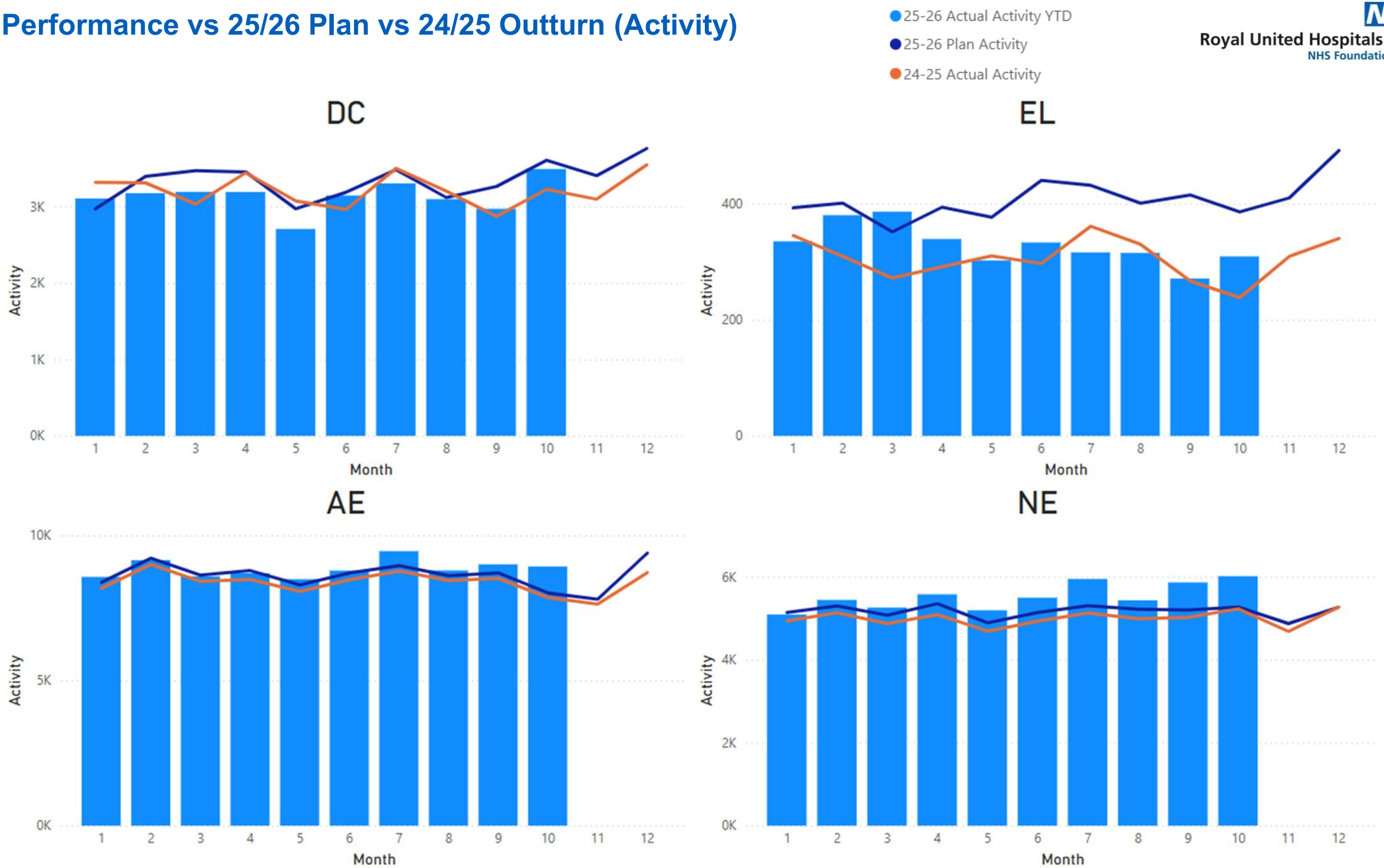
YTD Performance vs 25/26 Plan vs 24/25 Outturn (Activity)

Royal United Hospitals Bath
NHS Foundation Trust

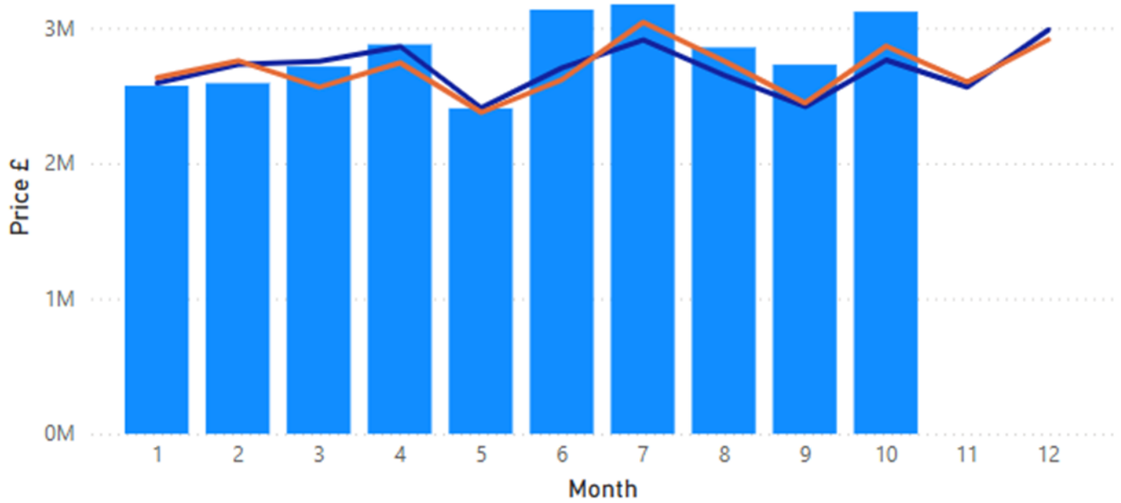


YTD Performance vs 25/26 Plan vs 24/25 Outturn (Price)

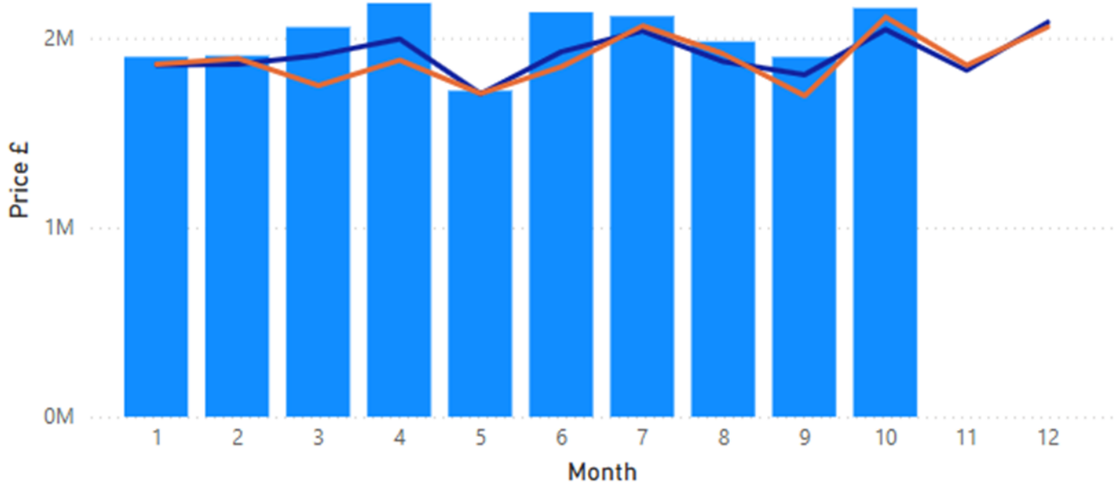
25-26 Actual Price YTD
25-26 Plan Price
24-25 Actual Price

Royal United Hospitals Bath
NHS Foundation Trust

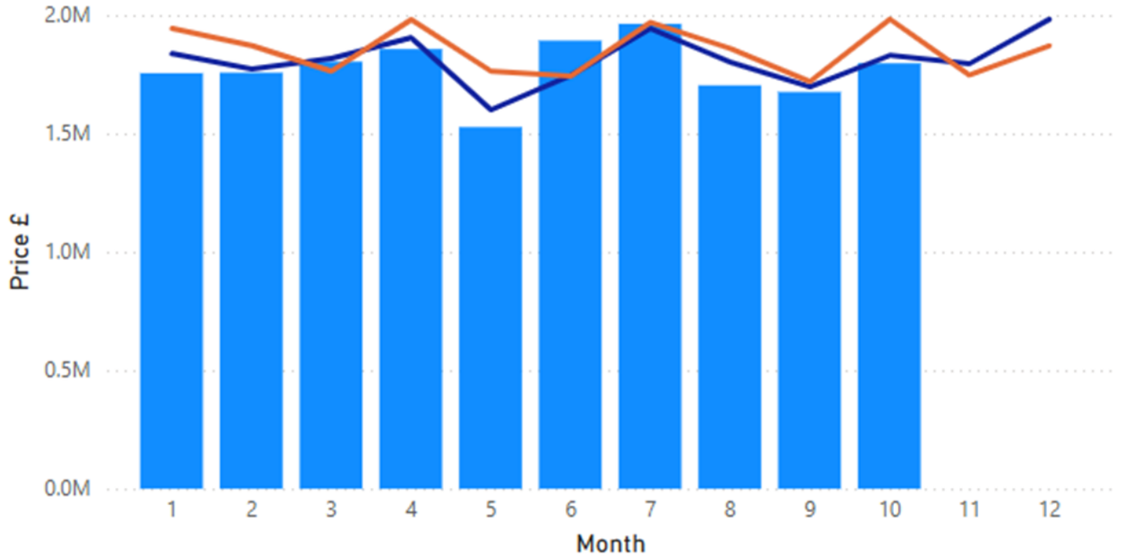
New Outpatient



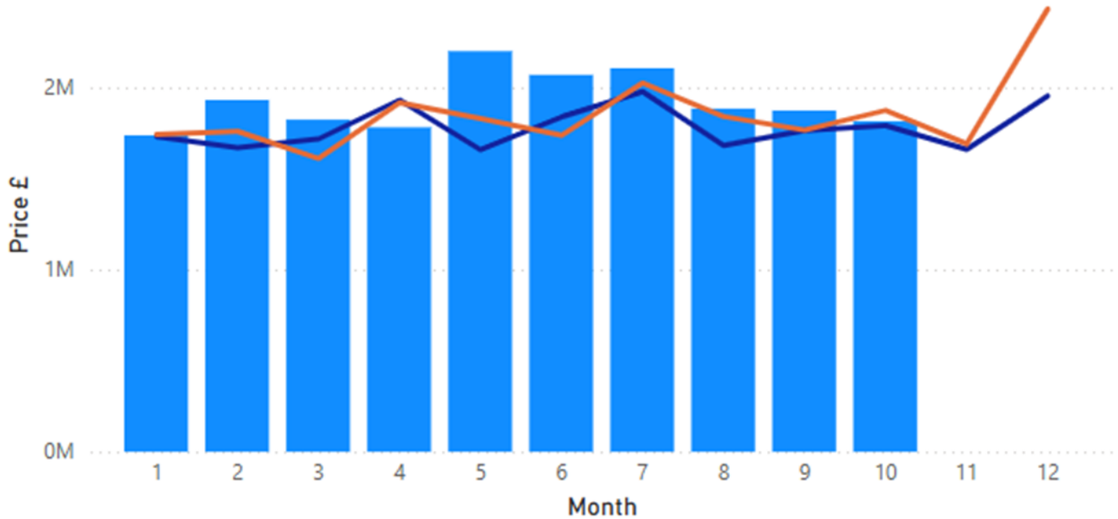
Outpatient Fup



Outpatient Procedures

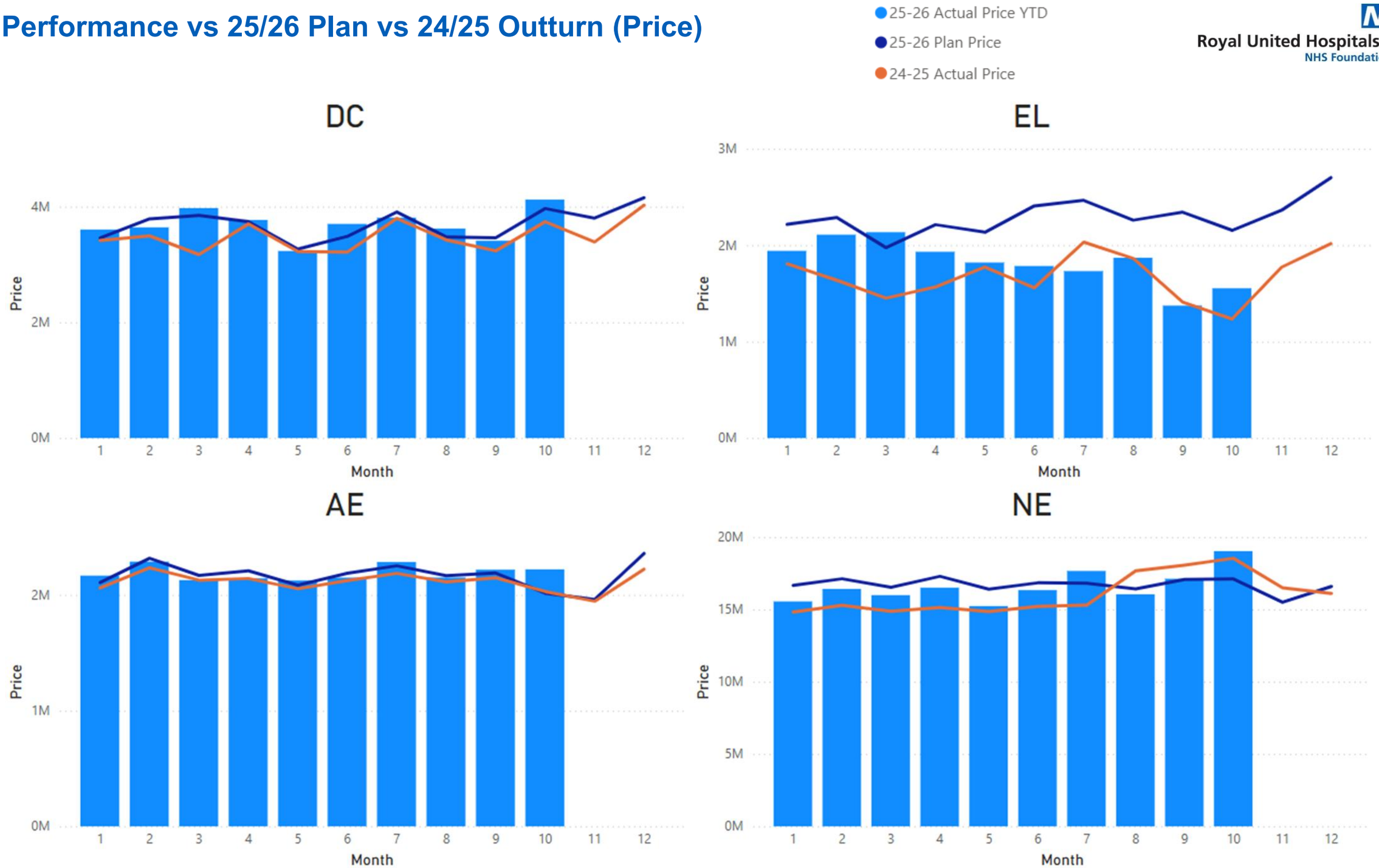


Other outpatient



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	(5.456)	(5.388)	0.068	(54.412)	(54.633)	(0.221)
Junior Medical	(3.526)	(3.737)	(0.211)	(35.320)	(37.382)	(2.063)
Registered Nursing and Midwifery	(8.101)	(8.960)	(0.859)	(92.020)	(89.552)	2.468
Registered ST&T	(4.705)	(3.518)	1.187	(35.986)	(34.537)	1.450
Other Clinical Support	(4.839)	(4.958)	(0.119)	(48.757)	(49.619)	(0.862)
NHS Infrastructure Support	(3.839)	(3.947)	(0.108)	(38.475)	(39.845)	(1.370)
Other	(0.126)	(0.108)	0.019	(1.264)	(1.446)	(0.183)
Unallocated Savings	0.933	0.000	(0.933)	9.033	0.000	(9.033)
Reserves	0.127	0.000	(0.127)	1.457	0.000	(1.457)
Surplus/(Deficit)	**(29.532)**	**(30.617)**	**(1.084)**	**(295.745)**	**(307.015)**	**(11.270)**
Pay Vacancy Factor Included Above	1.026	0.000	(1.026)	10.256	0.000	(10.256)

Pay by Spend Type	In Month RUH			Year to Date RUH		
	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Actual £'m	Variance £'m
Substantive	(30.237)	(28.759)	1.478	(302.784)	(287.835)	14.949
Pay Vacancy Factor	1.026	0.000	(1.026)	10.256	0.000	(10.256)
Net Budget	**(29.211)**	**(28.759)**	**0.452**	**(292.528)**	**(287.835)**	**4.693**
Bank	(0.086)	(1.322)	(1.235)	(0.856)	(14.407)	(13.551)
Agency	(0.024)	(0.311)	(0.286)	(0.242)	(2.215)	(1.973)
WLI	(0.099)	(0.104)	(0.005)	(1.002)	(1.314)	(0.312)
Other	(0.112)	(0.122)	(0.010)	(1.117)	(1.244)	(0.127)
Surplus/(Deficit)	**(29.532)**	**(30.617)**	**(1.084)**	**(295.745)**	**(307.015)**	**(11.270)**

Understanding Performance

Pay budgets are overspent by £11.3m. The Pay vacancy factor (£10.3m) has been delivered but further recurrent Pay savings (£9.0m) 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 which has risen to £0.7m, which has been funded by increased income.

In Month pay costs have reduced, both against previous month (£0.9m) and against a Month 1-9 run rate (£0.1m). There have been escalation costs of around £0.3m in month offset by reduced enhancement and increased grip and control.

Agency costs are currently less than 1% of the total pay costs, well below the 3% expectation. Bank costs are currently 4.7% of the total pay costs.

Countermeasures	Owner	Due Date

Risks and Mitigation

Budget – Pay by Division & Type

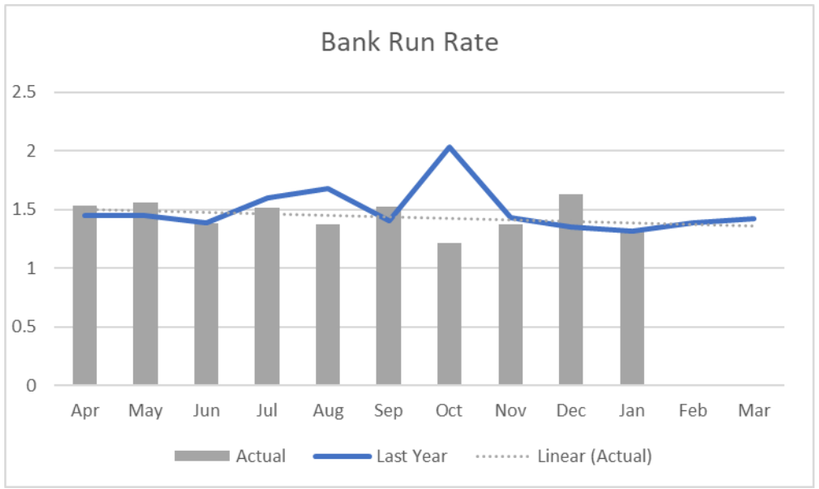
Royal United Hospitals Bath NHS Foundation Trust

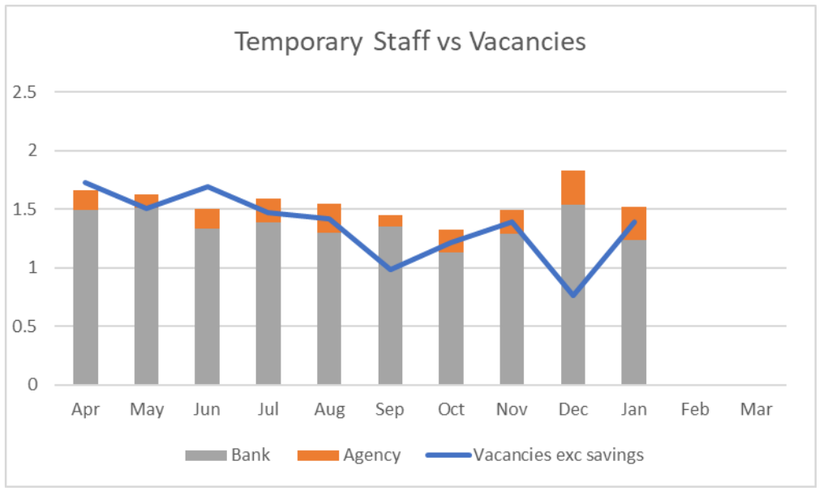
Pay by Division	In Month RUH Budget £'m	In Month RUH Actual £'m	In Month RUH Variance £'m	Year to Date RUH Budget £'m	Year to Date RUH Actual £'m	Year to Date RUH Variance £'m
Surgery	(8.097)	(8.215)	(0.119)	(80.506)	(81.668)	(1.162)
Medicine	(10.536)	(11.091)	(0.555)	(105.466)	(110.729)	(5.263)
FASS	(5.616)	(5.801)	(0.185)	(56.192)	(57.486)	(1.294)
E&F	(1.721)	(1.782)	(0.061)	(17.691)	(17.845)	(0.154)
Corporate	(3.156)	(3.184)	(0.029)	(31.529)	(33.449)	(1.920)
HIWE	(0.291)	(0.335)	(0.045)	(2.906)	(3.101)	(0.195)
R&D	(0.284)	(0.285)	(0.001)	(2.843)	(2.889)	(0.047)
Reserves	0.154	0.077	(0.077)	1.258	0.152	(1.106)
Unallocated Savings	0.013	0.000	(0.013)	0.129	0.000	(0.129)
Surplus/(Deficit)	**(29.532)**	**(30.617)**	**(1.084)**	**(295.745)**	**(307.015)**	**(11.270)**
Pay Vacancy Factor Included Above	1.026	0.000	(1.026)	10.256	0.000	(10.256)

Variance by Functional Area	In Month Medical Staff	Ward	ED	Maternity	Other	Savings	Total
Substantive	0.337	0.585	0.129	0.047	0.295	(0.946)	0.447
Bank	(0.251)	(0.492)	(0.132)	(0.065)	(0.295)	0.000	(1.235)
Agency	(0.210)	(0.031)	(0.014)	0.000	(0.032)	0.000	(0.286)
Other	0.000	0.000	0.000	0.000	(0.010)	0.000	(0.010)
Surplus/(Deficit)	**(0.124)**	**0.062**	**(0.018)**	**(0.018)**	**(0.042)**	**(0.946)**	**(1.084)**

Variance by Functional Area	Year to Date Medical Staff	Ward	ED	Maternity	Other	Savings	Total
Substantive	1.731	6.174	1.837	0.840	2.955	(9.156)	4.381
Bank	(2.393)	(5.007)	(1.911)	(0.842)	(3.398)	0.000	(13.551)
Agency	(1.837)	(0.086)	(0.075)	0.000	0.025	0.000	(1.973)
Other	0.000	0.000	0.000	0.000	(0.127)	0.000	(0.127)
Surplus/(Deficit)	**(2.499)**	**1.082**	**(0.149)**	**(0.003)**	**(0.544)**	**(9.156)**	**(11.270)**

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)	(325.0)	8.4
Junior Medical	(450.8)	(486.5)	(35.7)
Registered Nursing and Midwifery	(1,808.1)	(1,793.4)	14.7
Registered ST&T	(684.5)	(672.6)	11.9
Other Clinical Support	(1,616.7)	(1,609.0)	7.8
NHS Infrastructure Support	(886.0)	(874.8)	11.2
Other	(1.4)	(3.9)	(2.5)
Unallocated Savings	139.0	0.0	(139.0)
Reserves	18.0	0.0	(18.0)
Surplus/(Deficit)	**(5,624.0)**	**(5,765.2)**	**(141.2)**
Pay Vacancy Factor Included Above	216.5	0.0	(216.5)

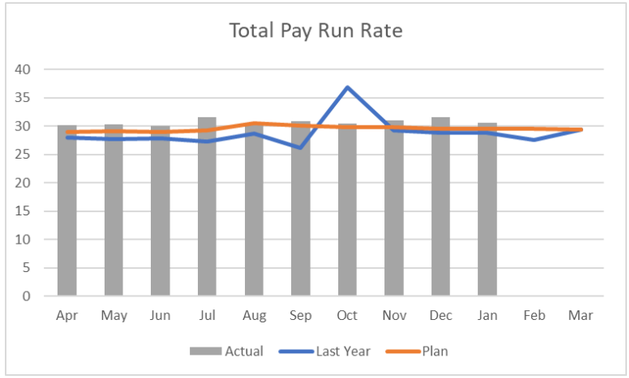
WTE by Spend Type	In Month RUH		
	Budget WTE	Actual WTE	Variance WTE
Substantive	(5,826.1)	(5,474.9)	351.2
Pay Vacancy Factor	216.5	0.0	(216.5)
Net Budget	**(5,609.6)**	**(5,474.9)**	**134.7**
Bank	(16.3)	(271.7)	(255.4)
Agency	0.0	(18.6)	(18.6)
WLI	1.9	0.0	(1.9)
Other	0.0	0.0	0.0
Surplus/(Deficit)	**(5,624.0)**	**(5,765.2)**	**(141.3)**

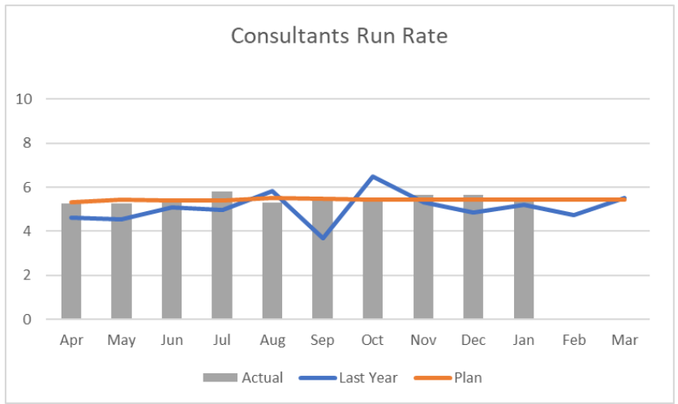
WTE by Division	In Month RUH		
	Budget WTE	Actual WTE	Variance WTE
Surgery	(1,412.0)	(1,455.4)	(43.4)
Medicine	(1,984.8)	(2,066.8)	(82.1)
FASS	(1,035.1)	(1,046.5)	(11.4)
E&F	(537.4)	(531.9)	5.5
Corporate	(565.5)	(556.4)	9.0
HIWE	(47.8)	(47.8)	0.0
R&D	(62.3)	(57.0)	5.3
Reserves	17.4	(3.4)	(20.8)
Unallocated Savings	3.5	0.0	(3.5)
Surplus/(Deficit)	**(5,624.0)**	**(5,765.2)**	**(141.2)**
Pay Vacancy Factor Included Above	216.5	0.0	(216.5)

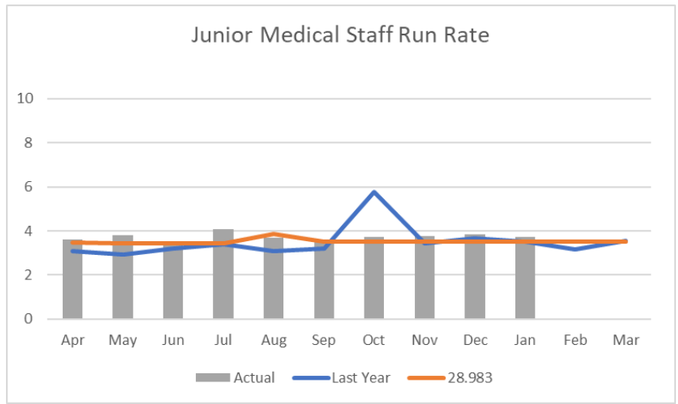
WTE Variance by Functional Area	In Month						
	Medical Staff	Ward	ED	Maternity	Other	Savings	Total
Substantive	-4.73	128.87	26.17	9.08	112.39	-139.00	132.78
Bank	-15.73	-120.01	-29.50	-13.74	-76.45	0.00	(255.43)
Agency	-10.75	-1.38	-4.42	0.00	-2.05	0.00	(18.60)
Other	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Surplus/(Deficit)	**-31.21**	**7.48**	**-7.75**	**-4.66**	**33.89**	**-139.00**	**(141.25)**

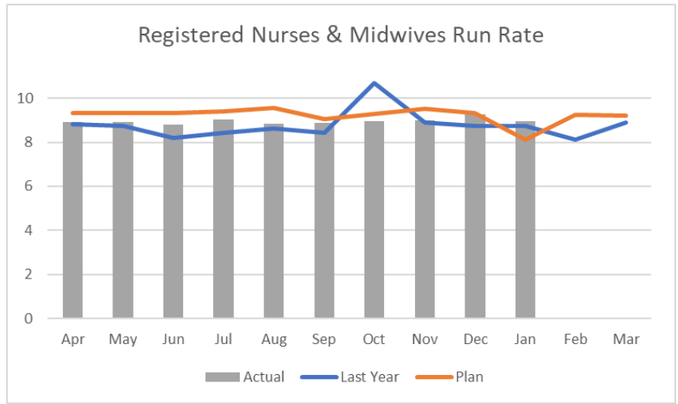
Pay Run Rate Graphs

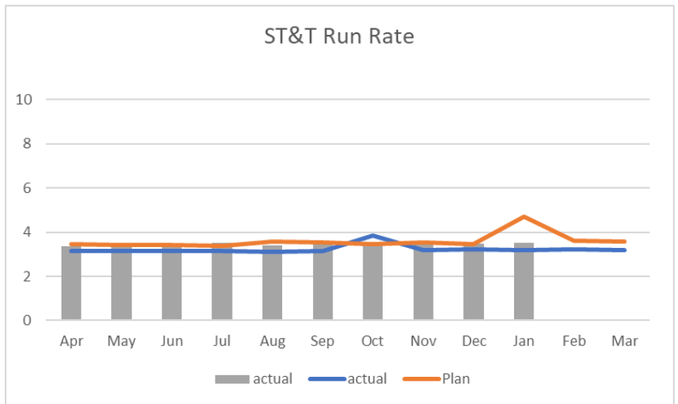
Royal United Hospitals Bath
NHS Foundation Trust

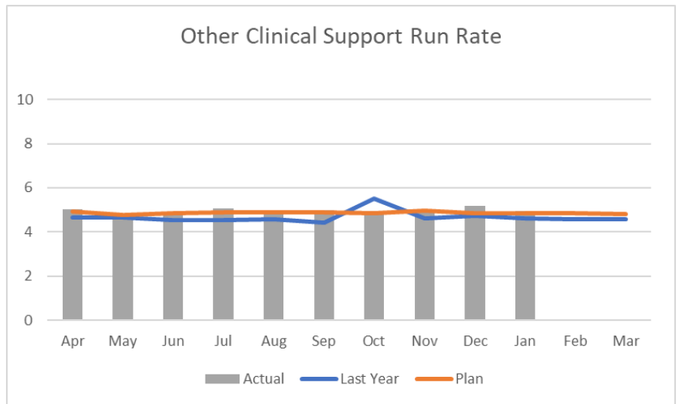


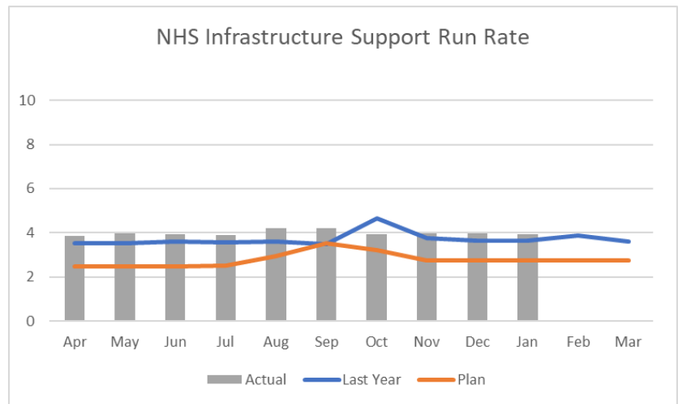












Budget – Non-Pay

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	(4.897)	(5.065)	(0.169)	(45.320)	(47.874)	(2.554)
In Tariff Drugs	(0.859)	(0.795)	0.064	(7.668)	(8.005)	(0.337)
Clinical Supplies and Services	(3.664)	(4.001)	(0.336)	(39.044)	(41.736)	(2.692)
Other Non Pay	(5.726)	(5.393)	0.333	(57.438)	(54.780)	2.658
Unallocated Savings	0.564	0.000	(0.564)	8.196	0.000	(8.196)
Reserves	0.346	0.000	(0.346)	1.964	0.000	(1.964)
Surplus/(Deficit)	**(14.236)**	**(15.254)**	**(1.018)**	**(139.311)**	**(152.395)**	**(13.084)**

Budget by Division	In Month RUH			Year to Date RUH		
	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Actual £'m	Variance £'m
Surgery	(3.135)	(2.923)	0.213	(30.839)	(31.940)	(1.101)
Medicine	(2.045)	(2.029)	0.016	(19.677)	(20.899)	(1.222)
FASS	(0.755)	(0.818)	(0.064)	(7.111)	(7.610)	(0.499)
E&F	(1.678)	(1.358)	0.320	(15.314)	(14.546)	0.768
Corporate	(2.672)	(2.857)	(0.184)	(28.316)	(28.590)	(0.274)
HIWE	(0.103)	(0.054)	0.049	(1.028)	(0.965)	0.064
R&D	(0.054)	(0.075)	(0.020)	(0.541)	(0.300)	0.241
Capital Charges	0.010	(0.023)	(0.034)	0.103	(0.319)	(0.422)
High Cost Drugs and Devices	(5.064)	(5.065)	(0.001)	(46.863)	(47.874)	(1.011)
Unallocated Savings	0.491	0.000	(0.491)	4.906	0.000	(4.906)
Reserves	0.769	(0.053)	(0.822)	5.368	0.647	(4.721)
Surplus/(Deficit)	**(14.236)**	**(15.254)**	**(1.018)**	**(139.311)**	**(152.395)**	**(13.084)**

Understanding Performance

Non-pay spend is £13.1m overspent against budget. £8.1m of this relates to undelivered savings and £1.6m as the exit run rate.

There is a net underfunding of £1.6m due as ICB-funded high-cost drugs are at the Trust's risk

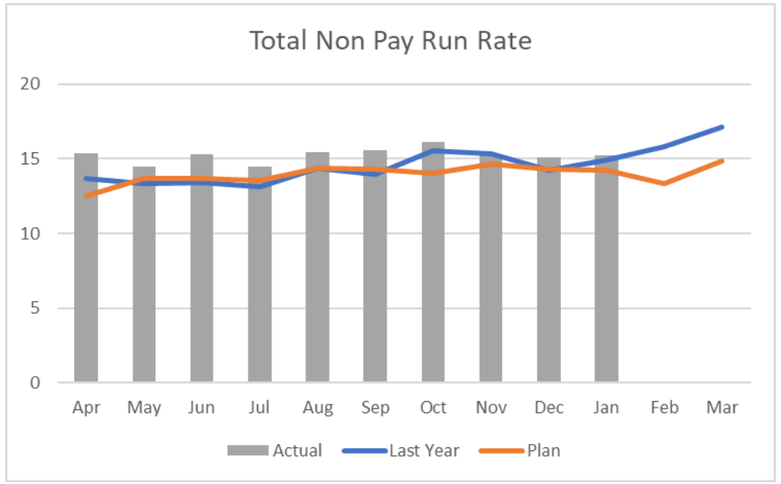
Estates and Facilities are currently underspent due to reduced utilities costs, although that is expected to reduce during the winter months.

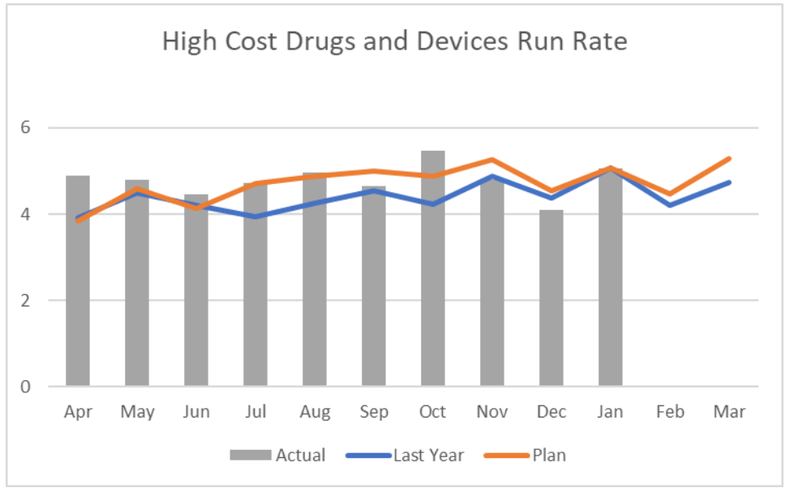
Countermeasures	Owner	Due Date

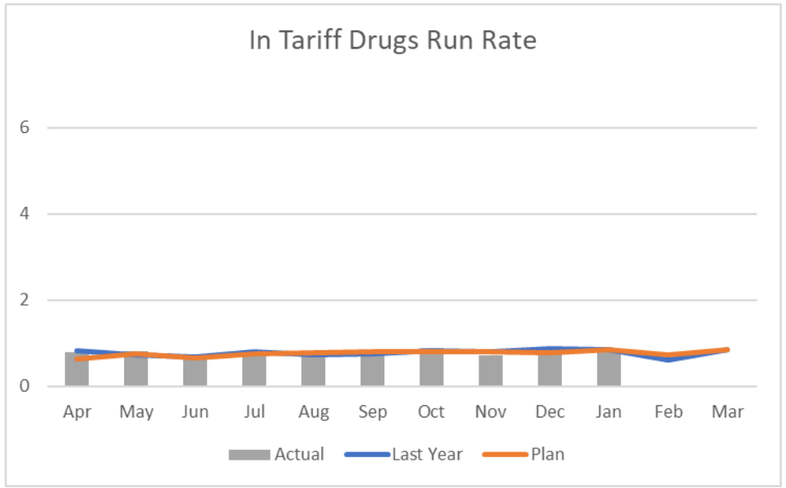
Risks and Mitigation

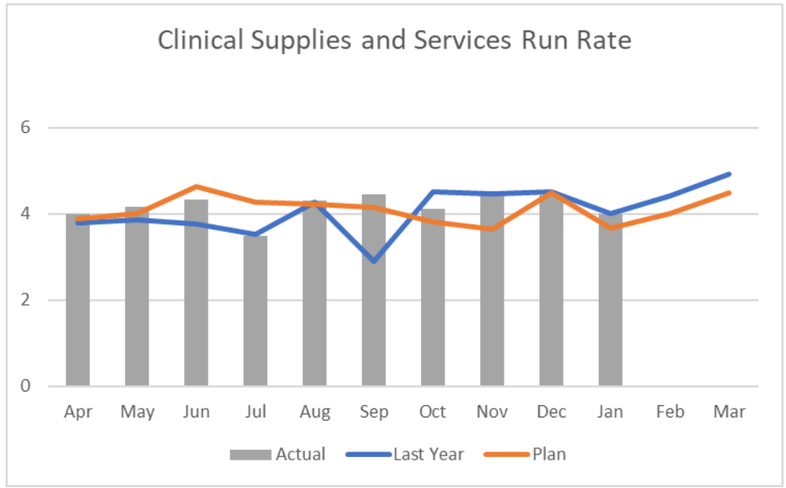
Non Pay – Run Rate Graphs

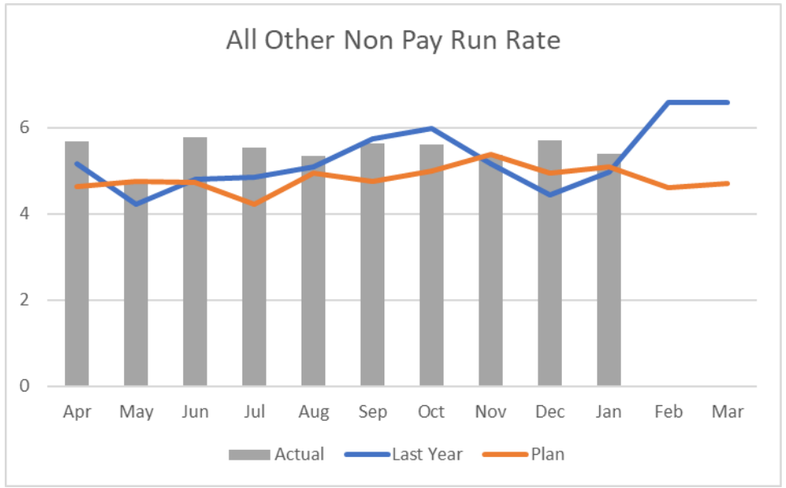
Royal United Hospitals Bath
NHS Foundation Trust











System Financial Position

Royal United Hospitals Bath NHS Foundation Trust

January 2026 (M10) Financial Position

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

Financial position vs plan

	GWH				RUH				SFT				BSW Group				ICB				System			
	Plan	Actual	Variance	RAG	Plan	Actual	Variance	RAG	Plan	Actual	Variance	RAG	Plan	Actual	Variance	RAG	Plan	Actual	Variance	RAG	Plan	Actual	Variance	RAG
Month 10 YTD (£m)*	0.0	(8.5)	(8.5)		0.0	(18.3)	(18.3)		0.0	(8.4)	(8.4)		0.0	(35.2)	(35.2)		0.0	19.1	19.1		0.0	(16.1)	(16.1)	

Financial position vs Revised trajectories (Most Likely)

	GWH				RUH				SFT				BSW Group				ICB				System			
	Plan	Actual	Variance	RAG	Plan	Actual	Variance	RAG	Plan	Actual	Variance	RAG	Plan	Actual	Variance	RAG	Plan	Actual	Variance	RAG	Plan	Actual	Variance	RAG
Month 10 YTD (£m)*	(8.4)	(8.5)	(0.1)		(18.3)	(18.3)	0.0		(8.4)	(8.4)	0.0		(35.1)	(35.2)	(0.1)		19.1	19.1	0.0		(16.0)	(16.1)	(0.1)	

Month 10 Adjusted YTD financial trajectory vs Actual:

- The system is reporting a £16.1m adverse variance against plan. This position includes Deficit supporting funding of £19.5m to Month 10 (FY £23.4m).
- When compared to the Revised financial trajectory, the system was broadly in line with the anticipated Month 10 position.
- The ICB position has been updated to reflect 10/12ths of the agreed FY FOT, £22.9m.

*Note: All values are presented on a rounded basis (+/- £0.1m).
**Revised trajectory values represent trajectory values, adjusted for the receipt of Deficit support funding, to an overall system breakeven position.

Key Drivers

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

	GWH	RUH	SFT	Group	ICB	System
	£'m	£'m	£'m	£'m	£'m	£'m
M10 YTD Variance	**(8.5)**	**(18.3)**	**(8.4)**	**(35.2)**	**19.1**	**(16.1)**
Driven by:						
Efficiency schemes	(9.2)	(14.2)	(7.6)	(31.0)	10.0	(21.0)
Pay / Workforce	(7.0)	(2.9)	(1.0)	(10.9)		(10.9)
Drugs		(0.3)	(1.0)	(1.3)		(1.3)
Other items	7.7	(0.9)	1.2	8.0	9.1	17.1

Main drivers of the M10 YTD variance:

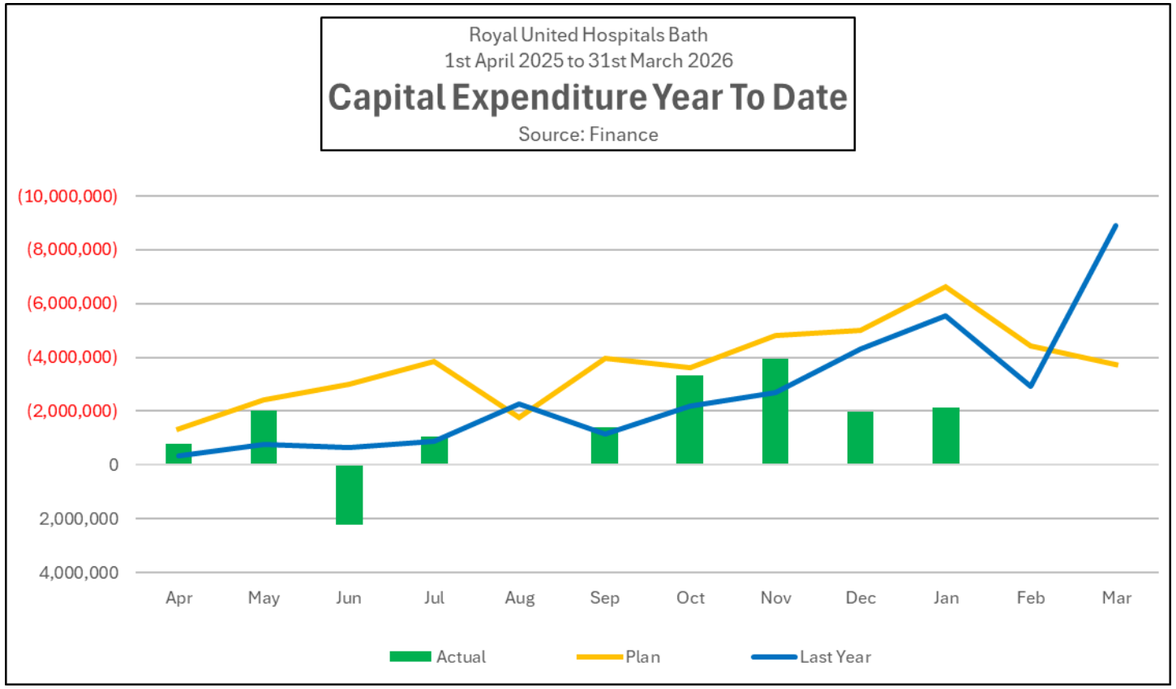
- Group CIP under-delivery & unidentified/non delivery £31m (In-month £2.3m).
- Pay/Workforce drivers £10.9m (In-month £1.3m).
- Other items includes Income generation, Subsidiary and PY Outturn impacts.
- ICB includes mitigations previously reported via FIC/Board.

*Note: All values are presented on a rounded basis (+/- £0.1m).
**Revised trajectory values represent trajectory values, adjusted for the receipt of Deficit support funding, to an overall system breakeven position.

Capital – Operational, Grant & Donated

Royal United Hospitals Bath NHS Foundation Trust

Position as at 31st January 2026	Annual Plan £'m	Forecast Outturn £'m	YTD Plan £'m	YTD Actuals £'m	YTD Variance £'m
Decarbonisation	(3.135)	(3.135)	(2.342)	(2.608)	(0.266)
BSW EPR	(2.865)	(2.329)	(1.996)	0.000	1.996
Sulis Lease	(0.953)	(0.989)	(0.953)	(0.989)	(0.036)
Strategic Schemes Total	**(6.953)**	**(6.453)**	**(5.291)**	**(3.597)**	**1.694**
IT	(1.750)	(1.650)	(1.372)	(1.422)	(0.050)
Medical Equipment (MEC)	(1.910)	(1.691)	(1.854)	(0.379)	1.475
Estates, CRG & Projects	(1.700)	(2.092)	(1.488)	(1.236)	0.252
Sulis	(0.250)	(0.558)	(0.194)	(0.390)	(0.196)
Right of Use Leases	(0.300)	(0.590)	(0.225)	(0.413)	(0.188)
Minor	0.543	0.699	0.650	0.771	0.121
Disposals - NBV write off	0.000	0.691	0.000	0.691	0.691
Lease Provision release (Modular Theatre)	(0.547)	(0.547)	0.000	0.000	0.000
Other Schemes Total	**(5.914)**	**(5.738)**	**(4.483)**	**(2.378)**	**2.105**
TOTAL : Operational Capital	**(12.867)**	**(12.191)**	**(9.774)**	**(5.975)**	**3.799**
Decarbonisation (Salix)	(10.820)	(9.554)	(9.523)	(7.603)	1.920
Decarbonisation (NEEF)	0.000	(0.051)	0.000	0.000	0.000
PET-CT	(2.000)	0.000	(0.400)	0.000	0.400
Minor donated schemes	(0.300)	(0.315)	(0.250)	(0.313)	(0.063)
TOTAL : Donated & Grant Funded	**(13.120)**	**(9.920)**	**(10.173)**	**(7.916)**	**2.257**
OVERALL TOTAL	**(25.987)**	**(22.111)**	**(19.947)**	**(13.891)**	**6.056**



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. However, the CT replacement can now be covered this year.

An updated cashflow has been received from contractor for the Decarbonisation scheme, this shows spend starting in July and running into next financial year.

EPR latest forecast was to spend all in year however this was received too late to reflect in this paper.

Countermeasures	Owner	Due Date
Completed: EPR project 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 Project	Complete
Completed: Due to the adverse revenue position capital expenditure not contractually committed or is mandated has been held.	CPMG	Complete
Completed: EPR project team are undertaking a review of the programme with several options being considered. The options are to be presented to the Joint Board for agreement	EPR Board	Complete
Action : The operational & financial implications of the outcome of the EPR decision will need to be mitigated. The risks of the reduction in funding to be outlined in a paper to MEC / Trust Board	CPMG	Feb 25

Risks and Mitigation

Multi-Year EPR forecast outturn based on the revised option approved by Board is a £9 million overspend against the original approved FBC. This will significantly reduce capital funding for other areas and increase risks through lack of investment.

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.

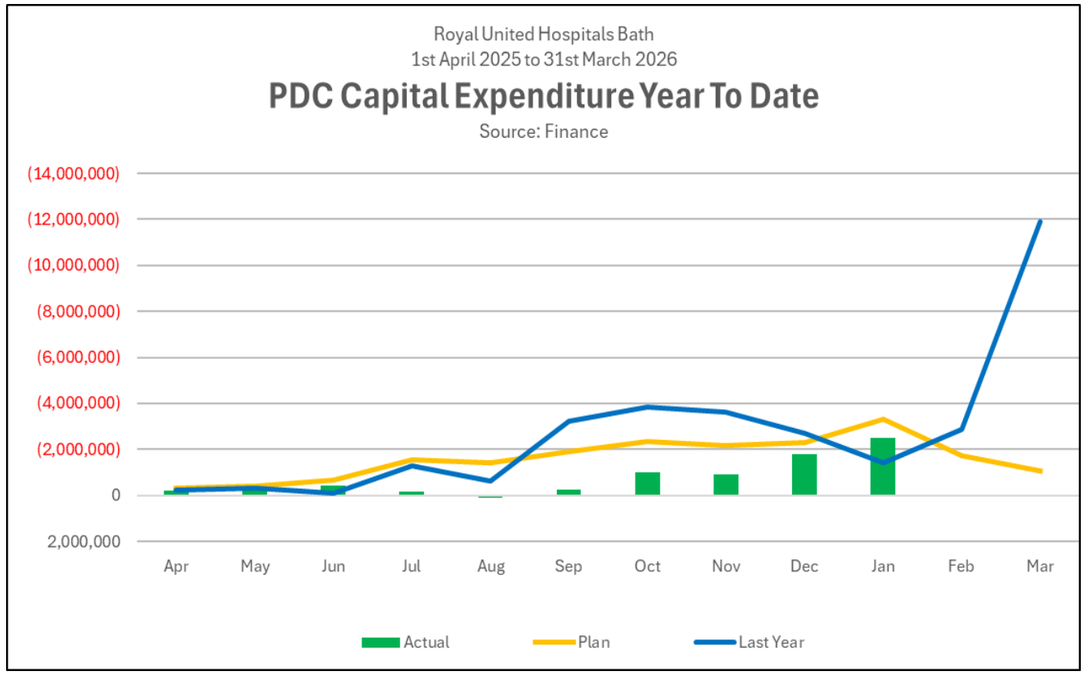
Salix grant funding agreement states it is to utilised by 31st March. Due to delay in programme notified by the contractor, the project team have obtained agreement from Salix to defer the commission funding to next year. Any slippage in the tight programme risks further costs slippage for which funding has not been agreed.

The revenue position and the impact on cash availability remain a risk to the capital programme.

Capital – PDC Funded

Royal United Hospitals Bath NHS Foundation Trust

PDC Funded Capital Position as at 31st January 2026		Annual Plan £'m	Forecast Outturn £'m	YTD Plan £'m	YTD Actuals £'m	YTD Variance £'m	Approval status
BSW EPR		(2.955)	(2.955)	(2.955)	(2.673)	0.282	Approved, MOUs signed
Other Schemes : Solar, RAAC Removal, EV, Cardiology & Pathology Equip		(0.810)	(0.810)	(0.643)	(0.208)	0.435	Approved, MOUs signed
Total Other		**(3.765)**	**(3.765)**	**(3.598)**	**(2.881)**	**0.717**	
Estates:	Fire Safety Programme	(1.890)	(1.890)	(1.524)	(0.446)	1.078	Estates strategy funding £5m approved & MOU signed. A further £1.1m funding has been approved in November
	Sterile Services Autoclave/Steriliser Replacement	(0.900)	(0.900)	(0.300)	(0.019)	0.281	
	Chiller Replacement (Pathology)	(0.720)	(0.720)	(0.523)	(0.004)	0.519	
	Maternity Estates Safety Schemes	(0.718)	(0.718)	(0.577)	(0.014)	0.563	
	Other Estates Safety schemes	(1.936)	(1.936)	(1.286)	(0.233)	1.053	
Total Estates Safety		**(6.164)**	**(6.164)**	**(4.210)**	**(0.716)**	**3.494**	
Diagnostics:	MRI replacement	(1.448)	(2.323)	(1.529)	(0.403)	1.126	We have had approval for the UEC schemes, MRI software & Sulis MRI replacement schemes. The Elective schemes apart from Automationhave been withdrawn due to revenue implications. Approval is still pending for the CDC expansion & Trowbridge 4th site, these schemes are still under review
	MRI Acceleration software	(0.143)	(0.143)	(0.143)	(0.162)	(0.020)	
	ECHO Equipment for Phyiological Scieinces	(0.120)	(0.120)	(0.120)	0.000	0.120	
	CDC Expansion- Design works to RIBA stage 4	(0.750)	(0.067)	(0.600)	(0.035)	0.565	
	CDC 4th Site Trowbridge Design works to RIBA stage 4	(0.024)	(0.024)	(0.024)	(0.011)	0.013	
Elective:	Gastroenterology / General Surgery Out Patient clinic rooms	(0.250)	0.000	(0.250)	(0.009)	0.241	
	Gynae Theatre Clinical Pathway Redesign	(1.600)	0.000	(1.000)	0.000	1.000	
	Elective Admin automation PDC	(0.800)	(0.800)	0.000	0.000	0.000	
UEC:	Admisson & Transfer Lounge	(1.700)	(1.700)	(1.000)	(1.049)	(0.049)	
	Medical Short Stay expansion	(0.850)	(0.850)	(0.850)	(0.360)	0.490	
	Integrated front Door / SDEC (Seed Funding)	(0.300)	0.000	(0.240)	0.000	0.240	
	Neurology Ward reconfiguration and relocation	(3.100)	(3.100)	(2.450)	(1.243)	1.207	
	IPC Programme	(1.350)	(1.350)	(1.350)	(0.479)	0.871	
	SDEC digital enabling	(0.400)	0.000	(0.400)	0.000	0.400	
Total Constitutional Standards		**(12.834)**	**(10.476)**	**(9.956)**	**(3.752)**	**6.204**	
TOTAL : PDC Funded		**(22.763)**	**(20.405)**	**(17.764)**	**(7.349)**	**10.415**	



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 also behind plan due to the late approval of schemes by the national team.	**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
Two of the Return to Constitutional Standards Schemes are not yet approved. The other Return to Constitutional Standards cases were approved much later than expected. There is a risk to deliverability due to approval delayed. Where capital funding is used for seed funding to develop business case, should the project not proceed there is risk to the revenue position. 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	M10 FY 2025-26 31/01/2026 £'m	FY 2024-25 31/03/2025 £'m	Variance £'m	% Variance
Non current assets				
Intangible assets	6.422	7.096	(0.674)	(9.498)%
Property, Plant & Equipment	326.222	330.248	(4.026)	(1.219)%
Right of use assets - leased assets for lessee	47.857	49.730	(1.873)	(3.766)%
Investments in associates and joint ventures	3.941	3.941	0.000	0.000%
Trade and other receivables	7.613	5.184	2.429	46.856%
Total non current assets	**392.055**	**396.199**	**(4.144)**	**(1.046)%**
Current Assets				
Inventories	6.731	6.782	(0.051)	(0.752)%
Trade and other receivables	33.641	30.746	2.895	9.416%
Cash and cash equivalents	20.171	36.648	(16.477)	(44.960)%
Total current assets	**60.543**	**74.176**	**(13.633)**	**(18.379)%**
Current Liabilities				
Trade and other payables	(52.617)	(61.625)	9.008	(14.617)%
Other liabilities	(9.696)	(8.634)	(1.062)	12.300%
Provisions	(0.369)	(0.932)	0.563	(60.408)%
Borrowings	(2.125)	(2.530)	0.405	(16.008)%
Total current liabilities	**(64.807)**	**(73.721)**	**8.914**	**(12.092)%**
Total assets less current liabilities	**387.791**	**396.654**	**(8.863)**	**(2.234)%**
Non current liabilities				
Provisions	(9.908)	(1.315)	(8.593)	653.460%
Borrowings	(54.151)	(54.896)	0.745	(1.357)%
Total assets employed	**323.732**	**340.443**	**(16.711)**	**(4.909)%**
Financed by:				
Public Dividend Capital	294.329	285.705	8.624	3.018%
Income and Expenditure Reserve	(11.677)	13.658	(25.335)	(185.496)%
Revaluation reserve	41.080	41.080	0.000	0.000%
Total equity	**323.732**	**340.443**	**(16.711)**	**(4.909)%**

Understanding Performance

Non-current assets
Capital assets: £6.573m variance is driven by movements in capital spending, depreciation charges, impairments, and lease restoration provisions.

Current assets
Cash: Explained in cash slide.
Receivables: Increase driven by income accruals & prepaid expenses within non-NHS debtors. Additionally, there has been a slight deterioration in collection year-to-date.

Current liabilities
Trade & Other Payables: £9.008m variance driven by settlement of capital creditors (£5.360m) and non-capital creditors (£12.429m).
Other liabilities: £1.062m movement reflects transitional funding received in advance, and early quarterly invoicing. In addition, R&D deferred income reports a £3.6m debit, driven by expenditure incurred ahead of income recognition.

Non-current liabilities
Increase of £8.58m in provisions for restoration costs relating to Sulis Hospital.

Total equity
The decline in reserves is 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.

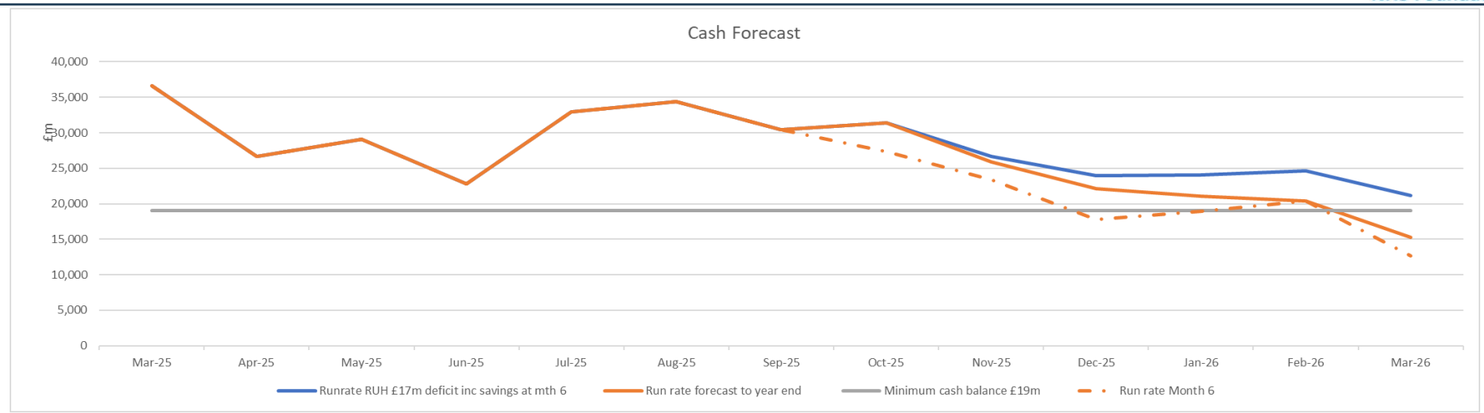
Risks relating to receivables, payables, BPPC and cash have been set out in their respective slides.

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	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.	Operational Finance Director & Trust Management Executive	Monthly Monitoring

Cash

Royal United Hospitals Bath NHS Foundation Trust

Statements of Cash Flows	Actual £'m
EBITDA deficit	1.059
Income recognised in respect of capital donations (cash and non-cash)	(7.916)
Impairments	13.482
Working capital movement	(9.952)
Provisions	(0.550)
Net cash used in operating activities	**(3.876)**
Capital Expenditure	(26.574)
CDC lease set up	3.241
Cash receipts from asset sales	0.015
Donated cash for capital assets	7.603
Interest received	1.434
Net cash used in investing activities	**(14.282)**
Public dividend capital received	8.624
Capital element of finance lease rental payments	(1.543)
Interest on loans	(0.113)
Interest element of finance lease	(1.495)
PDC dividend (paid)/refunded	(3.479)
Net cash generated from financing activities	**1.682**
Decrease in cash and cash equivalents	**(16.477)**
Opening cash balance	36.648
Closing cash balance	**20.171**
Adjusted for petty cash	0.005
Adjusted closing cash balance	**20.176**



The solid blue line represent the forecast of £17m deficit (£19.5m deficit RUH and £1.5m surplus) at month 8, the dotted blue line represents the same forecast at month 6.
The orange line represents the run rate forecast at month 8, the dotted orange line represents the same forecast at month 6. 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 at £19m is the minimum cash balance required for the Trust.
Late authorisation of a central capital scheme means some 2025/26 capital creditor payments will slip into 2026/27; finance are working with project leads to re-map the revised cash flows. Costs will still be accrued in 2025/26, but the cash outflow moves into 2026/27, inflating the year-end cash balance—although this cash is already committed.

Understanding Performance

In Month 10, the net cash flow was £1.032m deficit, resulting in the actual cash balance of £20.176m, which is £3.595m below the forecast balance.

Key drivers:

1. Variable income received was £3.625 below forecast
2. System revenue support of £1.44m was not received as anticipated.
3. Capital PDC inflow was £2.521m below forecast.
4. Other operating income was £1.836m more than expected.
5. Capital payment was £1.321m below forecast.
6. Planned savings of £2.882m 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 Purchase Order Compliance

Royal United Hospitals Bath NHS Foundation Trust

	Invoice Totals 202510					
ision	Off Purchase Order £'m	On Purchase Order £'m	Total £'m	% on PO	% on PO M9	%
Capital Summary	0.037	0.919	0.956	96.126	99.125	- 2.999
Total capital PO compliance	**0.037**	**0.919**	**0.956**	**96.126**	**99.125**	**- 2.999**
Corporate Division	0.250	1.252	1.502	83.343	78.940	4.403
Estates And Facilities Division	0.110	0.486	0.596	81.620	85.518	- 3.898
Family And Specialist Service Division	0.078	0.392	0.470	83.378	79.563	3.815
Health Innovation West of England	-	0.063	0.063	100.000	97.144	2.856
Medical Division	0.253	1.394	1.647	84.663	82.382	2.281
Research & Development	0.001	0.004	0.005	88.196	60.985	27.210
Surgical Division	0.035	2.137	2.172	98.397	96.384	2.013
Total revenue PO compliance	**0.726**	**5.729**	**6.455**	**88.755**	**86.566**	**2.189**
Total compliance in January	**0.763**	**6.647**	**7.410**	**89.706**	**89.619**	**0.087**

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

The table above outlines purchase order (PO) compliance across the Trust for Month 9; it excludes suppliers exempt from using a PO.

Key drivers of non-compliance by divisions are as follows:

- Capital: Not considered material, as only 1 invoice was outside the purchase order process, primarily relating to legal costs on lease of land.
- Corporate division: Site management, telecommunications and quality improvement centre expenses were processed without POs.
- Estates and facilities: laundry services, transport services and waste management services invoices were processed without POs.
- Family and Specialist Service Division: Maternity screening, oncology medical staff, and pharmacy invoices were processed without POs.
- Medical Division: Radiology medical staff, adult therapies outpatients, radiology and ultrasound invoices were processed without POs.
- Surgical Division: Orthopaedic prosthesis loan kits and consumables invoices were processed without POs.

Countermeasures	Owner	Due Date
The Group Chief Finance Officer has requested that PO compliance is 95% compliance by the end of Qtr1 25/26.	Divisional Finance Managers and Procurement	Ongoing
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

Risks and Mitigation

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

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

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

Sulis

Royal United Hospitals Bath NHS Foundation Trust

Month Performance against Budget P10

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)	1,884	1,985	101	427	489	62				2,311	2,474	162
Other Patient Care Income	1,562	1,489	(73)							1,562	1,489	(73)
Other Operating Income	35	30	(5)		48	48	854	844	(10)	889	922	34
Income Total	3,481	3,505	23	427	537	110	854	844	(10)	4,763	4,886	123
Pay	(1,584)	(1,624)	(40)	(234)	(293)	(60)	(359)	(291)	68	(2,177)	(2,208)	(32)
Non Pay	(1,483)	(975)	508	(193)	(266)	(73)	(494)	(552)	(58)	(2,170)	(1,793)	377
Depreciation	(232)	(238)	(6)	(36)	(41)	(5)				(267)	(278)	(11)
Expenditure Total	(3,299)	(2,836)	463	(462)	(600)	(138)	(854)	(844)	10	(4,614)	(4,280)	334
Operating Surplus/(Deficit)	183	668	486	(34)	(63)	(28)	(0)	0	0	148	606	458
Other Finance Charges	(34)	(36)	(1)	(6)	(12)	(7)				(40)	(48)	(8)
Other Gains/Losses												
Finance Charges	(34)	(36)	(1)	(6)	(12)	(7)				(40)	(48)	(8)
Surplus/(Deficit)	148	633	485	(40)	(75)	(35)	(0)	0	0	108	558	449

Balance Sheet
Cash Balance £2.3m
Average of prior year £1.615m

Understanding Performance

NHS Income: Sulis income was 5% / £653k favourable vs budget.
CDC activity ahead of Budget by 26%/ £110k of budget.
Private patient Income: £73k adverse vs budget, however ahead of last year by £112k

Pay: £32k adverse vs budget, agency costs and overtime very closely managed.

Non-Pay: £377k favourable vs Budget, with savings within Gas, loan kit and movement to balance sheet for prior months fixed assets.

Countermeasures	Owner	Due Date
CDC strategic planning with RUH	Simon M	On-going
Work closely with Somerset to fully understand the impact of exceeding IAPs	Sam Harrison	On-going
Optimise the surgeon mix and availability to ensure a steady predictable flow of high margin work in Sulis	Sam Harrison	On-going

Risks and Mitigation

Risks
- Somerset's IAP will be exceeded and income my be withheld
- CDC activity levels and costs continuing to make a loss.

Mitigation:
Per table to left

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**16**
Date of Meeting:	**4 March 2026**		

Title of Report:	**Mortality Update**
Status:	**For information**
Board Sponsor:	**Kheelna Bavalia, Interim Chief Medical Officer**
Author:	**Emma-Kate Reed, Deputy Chief Medical Officer**
Appendices	**Appendix 1: Q2 Learning from Deaths Report** **Appendix 2: Q3 Learning from Deaths Report**

1. Executive Summary of the Report

The Learning form Deaths National guidance was published in 2017. Learning from deaths is an integral part of our trust governance and quality improvement work. From April 2017 trusts are required to collect and publish on a quarterly basis specified information on deaths. This followed the CQC December 2026 review Learning, Candour and accountability. A review of the way NHS Trusts review and investigate the deaths of patients in England.

The RUH monitors Summary Hospital Mortality Indicator (SHMI). This allows us to identify areas where further review is required through our learning from deaths process. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die based on average England figures, given the characteristics of the patient treated there.

The SHMI regularly reviewed and reported to board quarterly alongside information from the Medical Examiners (ME) referrals. The ME team requests Divisions to work with specialty teams and when requested for them to complete a Structure Judgement review (SJR).

Acute Care Trusts including RUH use the Royal College of Physicians Structured Judgement review case methodology. It is essential that the Mortality Review process occurs in a timely manner. Delays reduce the opportunity for learning from deaths and the risk that timely improvement does not occur resulting in ongoing risks to patient safety and quality.

A focused piece of work has been undertaken to improve our processes, oversight, and governance, to support the trusts recording, reporting, and understanding of mortality and learning from deaths. There are three main areas to highlight.

1. Coding:

The SHMI data for RUH cannot currently be accurately interpreted as there has been a significant gap in the coding episodes that have been completed. As a result of the incomplete coding the SHMI cannot be meaningfully interpreted.

The coding resource requirement has been identified and addressed. Recruitment into the vacancy gaps has now occurred, and addition bank hours approved to clear

the built-up backlog by end May 2026. This will support the future accurate interpretation of SHMI.

Whilst there is a backlog, and the SHMI continues to be interpreted with caution, it is essential that there are robust methods to triangulate the mortality data to ensure that there are no mortality concerns that have not been identified through SHMI.

2. Structure Judgement Reviews:

The completion of SJR is a process that supports mortality data triangulation. There remains a significant delay in completion of SJRs, resulting in a continuing back log that has grown over a few years. As of February 1st, 2026, there were 68 SJRs that had not been completed since 1st April 2025 (23 Medicine, 44 Surgery, 1 FASS). There are an additional 149 outstanding dating back to 1st April 2021(78 medicine, 67 surgery, 4 FASS).

As part of our prioritised mortality focus during Q4, the CMO requested a SJR sprint-type approach to complete all overdue SJRs. This is being done in two parts:

a) All overdue since 1st April 2025 to be completed by 28th February 2026.
b) All overdue since 1st April 2021 to be addressed by 31st March 2026

The work is being led by divisional teams, and the table below shows the weekly progress through February. This is to ensure all the SJRs from this period are completed, and we have confidence this will be met.

Table to show outstanding SJR 2025/6

	03/02/2026	10/02/2026	17/02/2026	24/2026	End of Month
Medicine	25	16	12	9	
Surgery	45	45	22	5	
FASS	1	1	1	1	

In addition, the SJR policy has been reviewed to bring in line with national recommendations, and this will give us slightly more focused inclusion criteria.

Following the completion of the outstanding SJR's from April 2025 to date, a rapid review of the learning identified, and the agreement of the new SJR policy; the remaining list of 149 outstanding SJRs since 2021 will be addressed in March 2026.

A retrospective application of the new SJR policy will be made and any that do not meet the criteria will be subject to general discussion through specialty governance meetings rather than a full SJR. Those cases that have been through another process such as the coronial process, or complaints process, will also not be subjected to an SJR on the bases there has already been an alternative robust review.

It is noted that during this period the trust moved to paperless inpatients, and this will be a factor in the approach. A balanced approach triangulated against the learning yielded from delayed SJR's will be taken.

3. Oversight and Governance

The Mortality Surveillance Group (MSG) has been re-established, as a multi-professional group meeting is chaired fortnightly by the Deputy CMO. This group is overseeing the SJR recovery work and will set a sustainable approach going forward. One of the key MSG functions is to ensure triangulation of our mortality data. This triangulation includes information from:

- SJRs
- Incident reporting/patient safety
- Clinical audits (where there are mortality indicators)
- Complaints, PALS
- National reports (where there are mortality indictors, eg NELA)
- Medical Examiner
- LeDer
- Coroners, Reg 28s
- Litigation

This work has begun, and from the triangulation to date, the group have confirmed no areas of concern.

The Divisional Governance teams continue to review their data and share any learning as well as report to the Mortality Surveillance Committee, which will upward report to Clinical Effectiveness Committee.

4. Data Dashboard

SHMI is part of the Integrated IPR and is reviewed at Joint Committee.

Work has commenced with GWH and SFT to have a consistent Power BI dashboard on mortality. This will incorporate the national framework recommended trust dashboard, and by working as a Group will allow us to triangulate and share learning.

To conclude, Q2 and Q3 Learning from Death reports are attached as appendices.

This update is provided to assure the Board that RUH:

- is not an outlier for SHMI data
- recognises the need for enhanced triangulation given coding gaps and is addressing through various data points
- has addressed issues related to coding
- is addressing the SJR backlog with Q4 sprint approach
- is strengthening our governance and oversight around mortality to maintain scrutiny

2.	Recommendations (Note, Approve, Discuss)
Board is requested to note the update and approve the revised approach taken for Mortality review **Board is requested to approve Q2 and Q3 reports.**	

3.	Legal / Regulatory Implications
The Learning from Deaths process is required to be a priority for all NHS organisations to ensure learning can be identified and improvements can be made. In addition, there needs to be increased engagement with families and carers to recognise their insights as a vital source of learning. This is detailed in the National Guidance on Learning from Deaths published March 2017. Nationally mandated Medical Examiner Service since September 2020.	

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

5.	Resources Implications (Financial / staffing)
Recruit to Trust Mortality Lead Vacancy 1.0-1.5 PA Coding staff recruited to support coding backlog Review of SJR process, currently variation between Divisional teams for funding and allocation of SJRs for completion. Review planned Q4 of variation between divisions and cross-reference to RUH job planning policy.	

6.	Equality and Diversity
None identified.	

7.	References to previous reports/Next steps
Nil	

8.	Freedom of Information
Learning for Death report -Public	

9.	Sustainability
None identified.	

10.	Digital
BSW Power BI mortality dashboard (Meetings to be re-started led by GWH, all 3 trusts involved dates tbc)	

Royal United Hospitals Bath
NHS Foundation Trust

Learning from Deaths

July to September 2025 (Q2)

The RUH Q2 Learning form Deaths, report allows us to review our mortality data and any mortality trends. The quarterly (Q2) Learning from Deaths report also gives us an opportunity to review our trust processes and maintain a robust approach to support Learning from Deaths in our hospital. This gives us an opportunity to reflect and learn, and to maintain high quality and safe patient care for all.

The national guidance on Learning from Deaths recommends an annual report. This Q2 report covers the period of July, August, September 2025.

1.0 Summary Data Q2

1.1 The number of in-patient deaths in Q2 was 298.

1.2 The number of in-patient deaths that had a Medical Examiner screening in Q2 was 298. All patient deaths that occurred at RUH were screened by the Medical Examiner team.

1.3 There were 30 SJRs requested (10% of adult deaths) following Medical Examiner screening with subsequent allocation to clinical teams.

1.4 From the 30 reviews requested to be reviewed via Structured Judgement review (SJR) 18 were within the mandatory groups. (Medical/Nursing concern 7, relatives expressing concern 7, Learning Disability 4). The additional 11 reviews were surgical patients, (1 patient SJR no category listed).

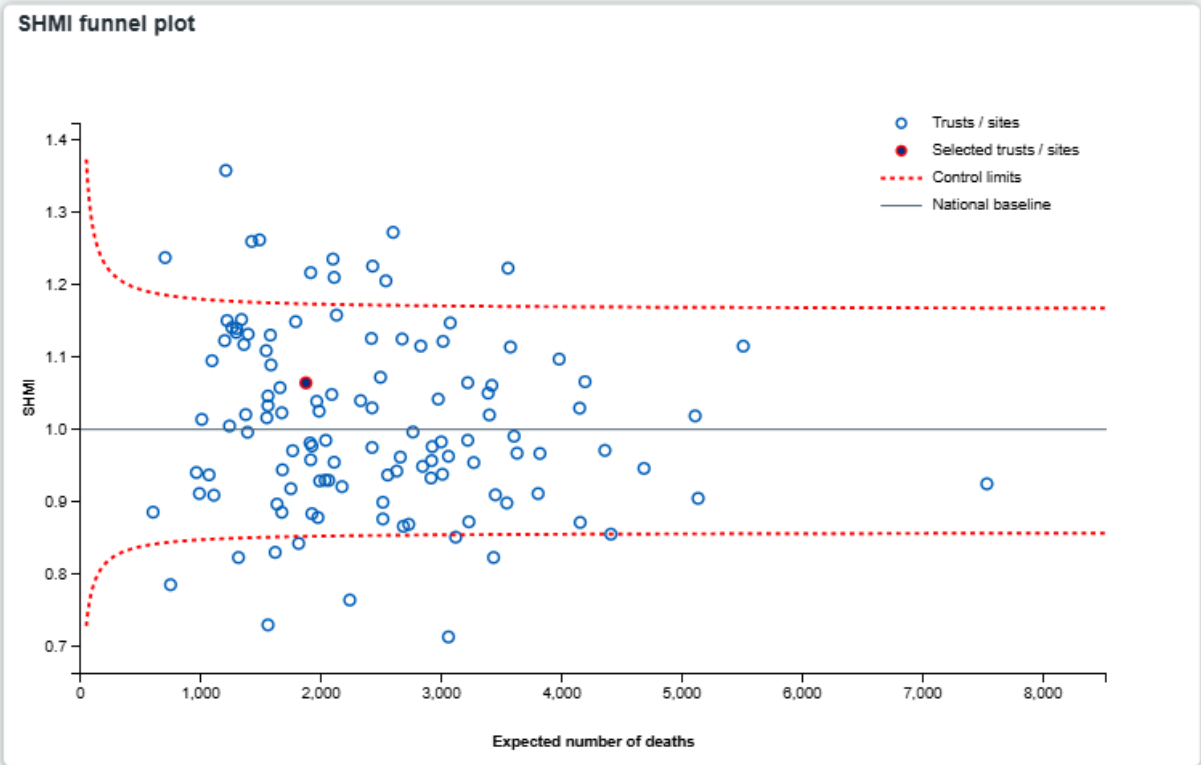
1.5 The RUH, along with GWH and SFT, have no longer continued the Telstra contract (as of September 2025), and will use SHMI as our mortality indicator rather than HSMR in line with many other trusts and with NHS England. Due to a period of incomplete coding at the RUH, HSMR and SHMI data needs to interpreted with caution. The incomplete coding resulted in a 5-month lag which has impacted the interpretation of the RUH mortality data.

1.6 For the year 2025/2026 there has been approval for additional coding resource to ensure the backlog of coding is completed. A complete coding data set will mean that the SHMI can be accurately interpreted and reviewed. This is essential to ensure that clinical data can be interpreted to provide robust governance and assurance around

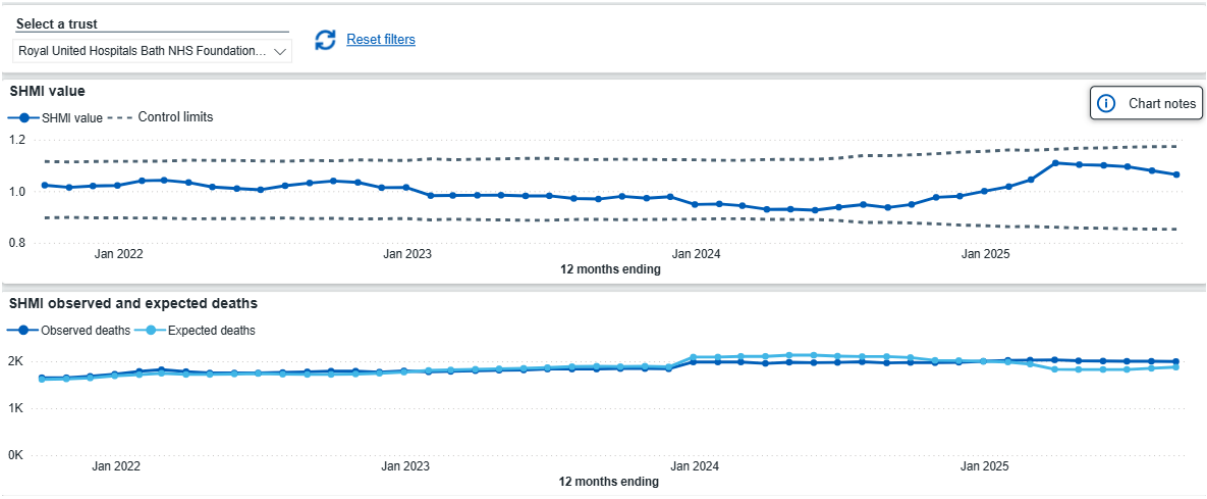
mortality rates in our hospital. Complete clinical coding will also allow specialty teams to identify any mortality signals that require a focused review to ensure areas for learning and focus and well as identifying examples of good practice.

1.7 Our Standardised Mortality Ratio (SMR) data for Q2 continues to sit within the expected range, and is showing a downward trend, below the national benchmark.

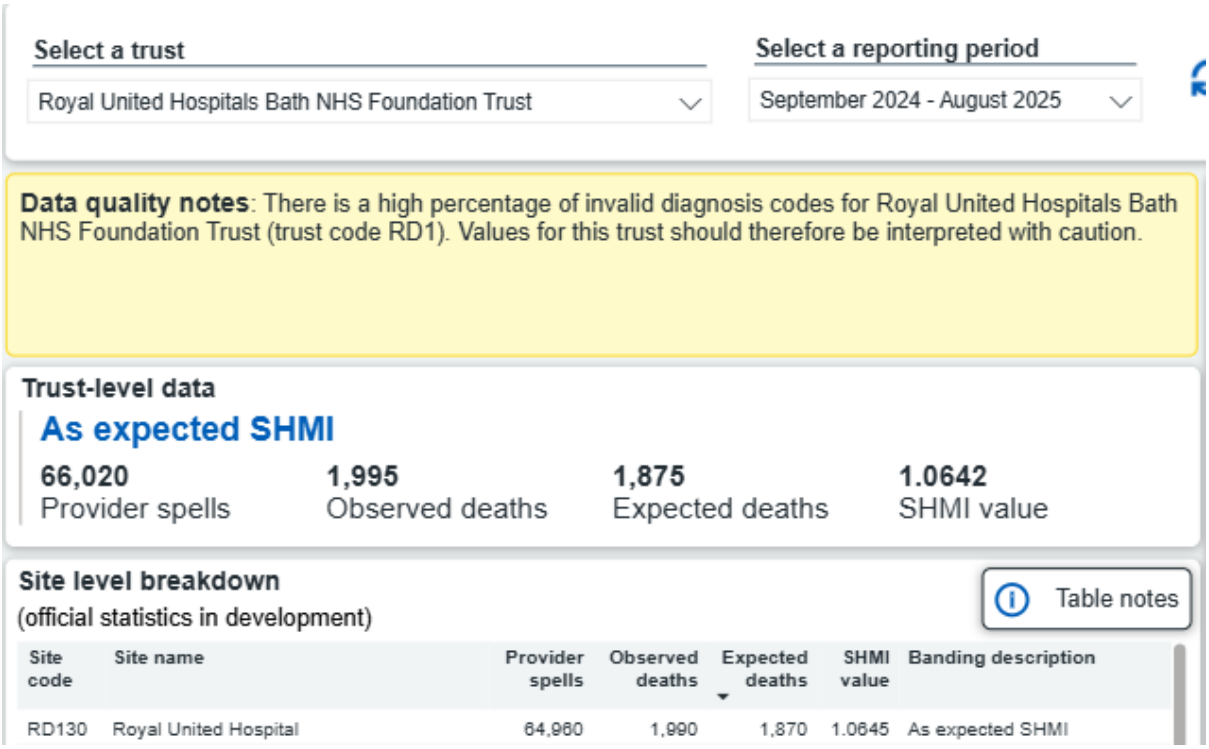
1.8 Further investigation points to coding issues as we continue to have a high percentage of invalid diagnosis codes, specifically with *primary diagnosis as a sign or symptom* (R codes); entering Q2 we are in the lowest quartile in the country. RUH is the second lowest performing trust in the Southwest for having uncoded episodes.



These graphs show the trend over time.



We remain within expected with the Data Quality note as this includes a period in time where we have a high number of uncoded records.



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

1.10 The Mortality Surveillance Group (MSG) has been re-established, and a multi-professional group meeting is chaired fortnightly by the Deputy CMO. This group had not been operational since March 2025 and was re-established in December 2025. The group meets initially fortnightly to ensure a focused approach to RUH mortality surveillance. Whilst there is a clear rationale for the change in data trend, the MSG can be vigilant to ensure the SHMI data is not masking other changes or concerns that warrant further exploration in order to maintain our quality and safety standards. One of the key MSG purposes is to ensure triangulation of our mortality data. This triangulation includes: -

- SJRs
- Incident reporting/patient safety
- Clinical audits (where there are mortality indicators)
- Complaints, PALS
- National reports (where there are mortality indictors, eg NELA)
- Litigation
- Medical Examiner
- Coroners, Reg 28s

1.11 There have been no areas of concern for mortality from the national audits based on the data we presented for Q2 to the Clinical Effectiveness Committee.

1.12 From Q4 the Learning from Death report will include data to confirm the number of cases that have been reviewed through the alternative response pathways. This will include those cases that have been managed through PALS, legal services, patient safety response and safeguarding.

1.13 There is newly embedded robust governance framework. The MSG reports to RUH Clinical Effectiveness Committee which reports to the Quality Assurance Committee.

2.0 Mortality Review Process

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

2.2 The performance of the Medical Examiners is considered in greater detail in the quarterly Medical Examiner Office Reports. The Medical Examiners screen all deaths and a standard proforma is used to ensure consistency in the cases that are selected for SJR. The Medical Examiner Office Report details the performance of the screening process. The Medical Examiner Office report is escalated to the National ME team. With the re-established MSG the report is also shared with this group. This supports the triangulation of mortality data and identifies any learning that can then be shared with divisional teams.

2.3 Regarding Structured Judgement Reviews (SJRs), in Q2 10% (n=30) of patients who died during Q2 were selected for SJR, plus an additional 2 patients whose death had occurred during an earlier quarter.

2.4 Figure 2 demonstrates the selection criteria for those patients who died during Q2. The selection criteria include: -

- When families or carers or staff have raised concern about care provided.
- When a person has a learning disability (this patient group are known to experience poorer health outcomes)
- When a person has a severe mental illness (this patient group are known to experience poorer health outcomes)
- When the ME has identified potential learning outcomes
- When a person is having an elective operation or procedure
- When there are patterns in mortality data or alerts from our regulators that suggest needing a more detailed review.
- When the patient is a surgical patient (RUH criteria)

The most frequently used criteria is when the patient was a surgical patient (all surgical patients have an SJR), followed by Medical /Nursing Concern. This is consistent with what was seen in Q1. There has been a small increase in the number of SJRs requested because the patient has a Learning Disability. Safeguarding have been informed to allow triangulation with the LeDeR process. The SJR policy is due to be reviewed by the MSG to ensure that the categories are in line with the national

recommendations. For example, completing an SJR on all surgical patients is specific to RUH rather than being a national recommendation.

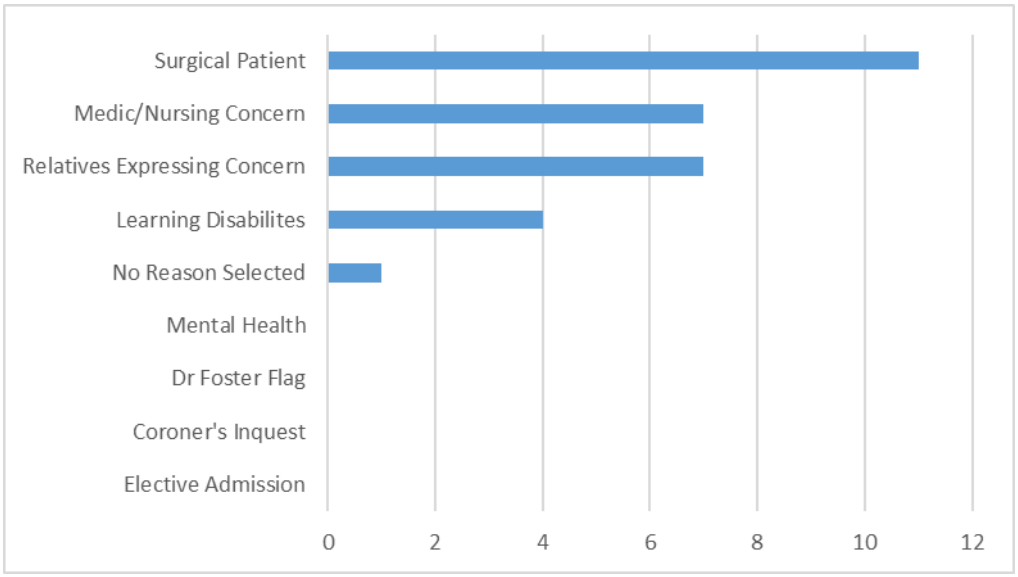


Figure 2: Number of deaths selected for SJR by selection criteria

2.5 Figure 3 illustrates the number of SJRs requested per quarter, compared to the number completed and the percentage of SJRs that were completed within two months of the patient's death. The Trust target is to complete 95% of SJRs within 2 months of the death; our latest achievement is 67%. This is an improvement from 20% for Q2 results from the previous 12 months.

2.6 It had been previously approved through the Clinical Effectiveness committee that those cases that were being reviewed via a coronial or inquest process did not need to have a second review process in the format of a SJR as there is an already identified review process, unless other criteria requiring SJR had been met, which would then require a SJR to be completed. This has resulted in a reduction in the number of deaths being selected for an SJR. It is positive that those SJRs that were completed during Q2 were completed in a timelier manner than has been seen previously. It is noted that there has been significant reduction in the number of SJRs being completed. The concern is that the backlog will continue to grow if the number being completed is exceeded by the number being selected.

2.7 The MSG has requested that there is a sprint approach to complete the backlog SJR for 2025-26. This included those outstanding SJRs from Q2. The divisions have been requested to prioritise the Q2 SJRs as part of this workstream with a request for all outstanding Q2 SJRs to be completed by the end February 2026.

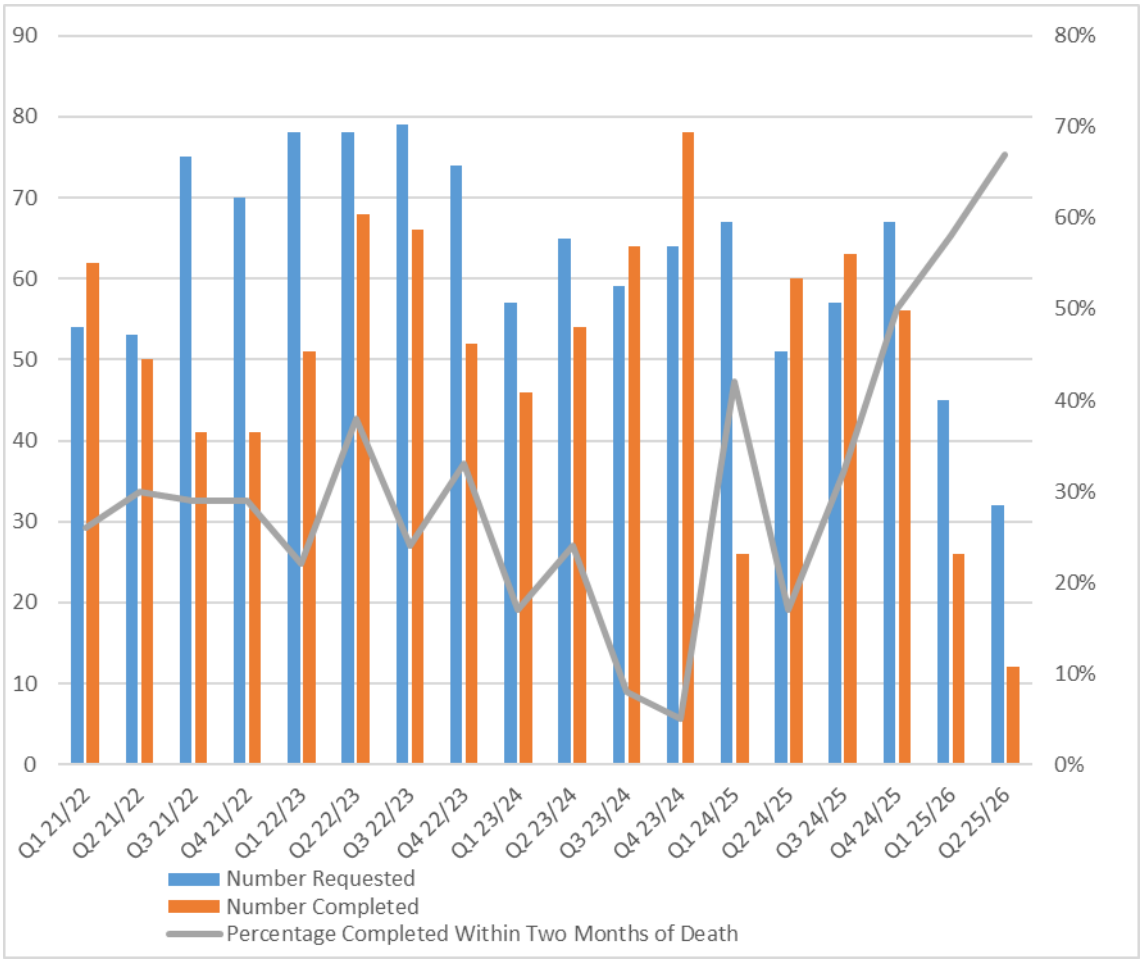


Figure 3: Number of completed SJRs v Number Requested and % completed within two months of the death

2.8 There are 71 outstanding SJRs for patients who have died since 1st January 2025. Of these, 25 are awaiting completion by Medicine; 45 are awaiting completion by Surgery, 1 awaiting completion by FASS (16 of those relate to patients who died under the care of General Surgery). 7 of these are still within the 2 month time frame for completion.

2.9 Following completion of review of the backlog of SJR's, it has been agreed historic cases that have already been the subject of a detailed review, via another process such as a formal complaint, incident investigation or inquest, will be removed from the case list, on the basis that the opportunity for additional learning is limited. Following scrutiny of the completed SJRs for 2025-26 including Q2, there will be a review of the cases and themes that will be reviewed by the mortality surveillance group.

2.10 There are 134 outstanding SJRs for the 4 years leading to 31/3/2025. This includes 66 in medicine, 64 in surgery and 4 in FASS. There is being monitored by the newly established MSG.

3.0 Learning from Mortality Reviews

3.1 Of the SJRs completed during Q2, 8 (67%) assessed the overall care to be either Good (a score of 4) or Very Good (a score of 5). This is a decrease from 81% in Q1, and 80% in Q4.

3.2 No patients were assessed as having received very poor care, but four (33%) were assessed as having received poor care overall.

3.3 The figure below shows the rating of overall care by quarter has remained largely consistent until this quarter. However, the picture is potentially distorted by the small data set. For example, two patients received poor care in Q4 but because a large number of SJRs were completed, this only amounted to 4% of those reviewed. However, to provide assurance, this data should be triangulated with incidents and complaints.

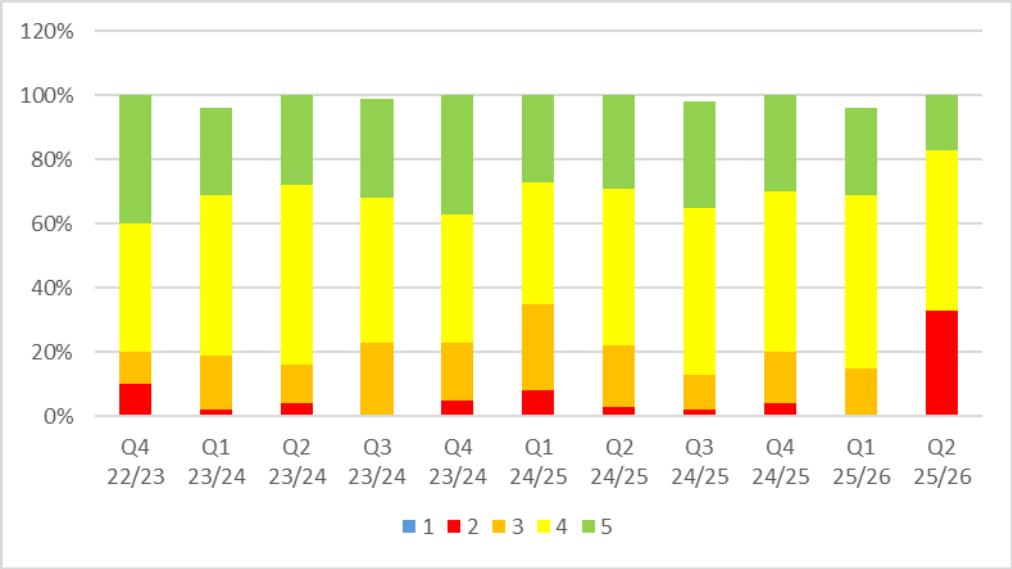


Figure 4: Score Allocated to Overall Care by Quarter

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

element of care that appears to be substandard, even if it did not ultimately affect the outcome.

3.6 The below shows the most commonly occurring themes arising from completed SJRs. In 59% of cases, either no additional learning was identified, or it was recognised that the care delivered was of a good or excellent standard.

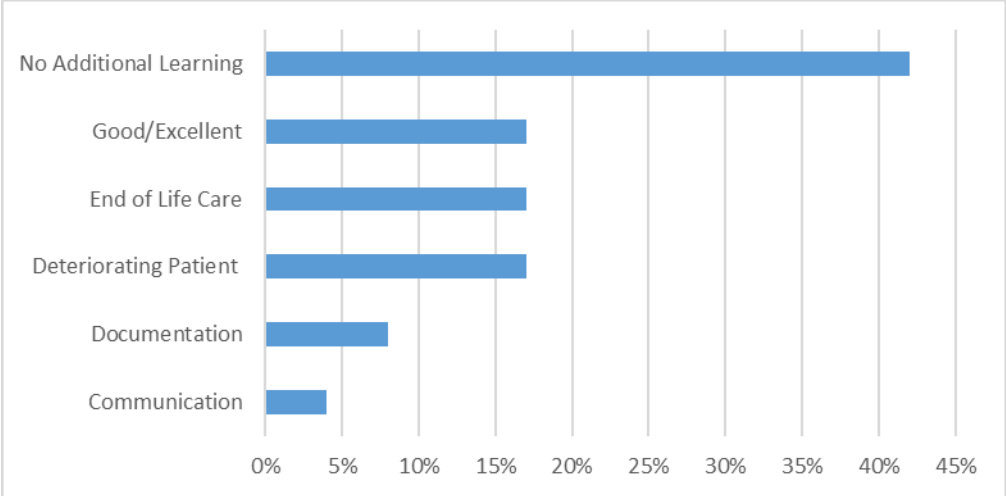


Figure 5: SJR themes

3.7 The reduced number of completed SJRs makes identifying themes more challenging. Two SJRs referenced that patients whose deterioration appears not to have been recognised or responded to promptly. In one instance, it is concluded that the outcome is unlikely to have been impacted by the delay, but in the second, it is stated that lack of continuity of care amongst senior clinicians resulted in ward-round plans not being followed and the patient's downward trajectory not being identified. Both these SJRs have been shared with the divisional teams.

3.8 Two SJRs reference poor experience at the end of life. One states there should have been advanced planning in relation to whether the patient wished to be brought to hospital and in relation to adequate pain relief. In the second instance, a patient with capacity undertook self-discharge because she wished to die at home. Whilst planning with the Palliative Care Team had been initiated, arrangements to leave hospital had not yet been put in place. The patient undertook self-discharge as she felt she could not wait any longer – she sadly died in the hospital car park. Both SJRs have been shared with divisional teams and shared with the End-of-Life Steering group to ensure that any additional learning can be identified and shared with specialty and divisional teams to prevent recurrence.

3.9 There is not an even distribution of SJRs that take place across the 3 bed holding divisions. As part of the SJR process review it will include a review of the trust wide process to ensure that there are representative samples across the 3 bed-holding divisions to maximise multi-professional learning to support the continuing delivery of high-quality care to all patients.

3.10 The planned review of the RUH SJR process will include the clarification of the onward process in those cases where the Medical Examiner referral identifies a patient safety concern. To ensure the integration of the SJR and PSIRF process (Patient safety incident reporting framework). PSIRF is designed to support patient safety reviews. It is proposed that the SJR policy will be reviewed during Q4. Any change recommendations related to the SJR process will be reviewed by the MSG with approval sought at CEC.

4.0 Inquests

4.1 17 inquests were opened and 12 were concluded during Q2. The Trust was required to attend one in-person hearing which related to the death of a one-day-old baby. HM Coroner was very critical of the lack of oxygen saturations undertaken and the decision to discharge the baby home. However, a Regulation 28 Report was not made due to the improvements that had already been implemented. This case was reviewed by the FASS division, and the improvements were implemented prior to the inquest.

4.2 No other Regulation 28 Reports were received during the quarter.

5.0 Next Steps

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

5.2 In conjunction with GWH & SFT, we have ceased our contract with Telstra to provide our data reports from September 2025. However, due to the longstanding contract with RUH Telstra have provided basic reports until December 2025.

5.3 We are continuing to work with GWH& SFT to build a single Power BI dashboard to share more timely data and insights into mortality data. GWH have already commenced this work for us to collectively build on.

5.4 The MSG currently meets 2 weekly lead the mortality review work and steer this work allowing the sharing of timely insights and learning for discussion and escalation through the governance framework to the clinical effectiveness group. The SJR process review will be completed during the year 2025-6. This will include the appointment of a trust-wide mortality lead. It is important that the themes identified are shared with divisional teams to ensure there is learning shared with teams to improve the experience for patients in our care and their families. It will also be an opportunity to share and recognise good practice.

5.5 During the year 2025-26 there will also be a review of the Morbidity & Mortality review process and upward reporting mechanism to MSG to ensure trust wide learning.

Learning from Deaths
October to December 2025 (Q3)

The RUH Q3 Learning form Deaths, report allows us to review our mortality data and any mortality trends. The quarterly (Q3) Learning from Deaths report also gives us an opportunity to review our trust processes and maintain a robust approach to support Learning from Deaths in our hospital. This gives us an opportunity to reflect and learn, and to maintain high quality and safe patient care for all.

The national guidance on Learning from Deaths recommends an annual report. This Q3 report covers the period of October, November, December 2025.

1.0 Summary Data

1.1 The number of in-patient deaths in Q3 was 342.

1.2 The number of in-patient deaths that had a Medical Examiner screening in Q3 was 342. All patient deaths that occurred at RUH were screened by the medical examiner team.

1.3 There were 30 SJRs requested (10% of adult deaths) following Medical Examiner screening with subsequent allocation to clinical teams.

1.4 From the 30 reviews requested to be reviewed via Structured Judgement review (SJR) 15 were within the mandatory groups. (Medical/Nursing concern 7, relatives expressing concern 2, Learning Disability 5, Mental Health 1). The additional 15 reviews were 14 surgical patients, (1 patient SJR no category listed).

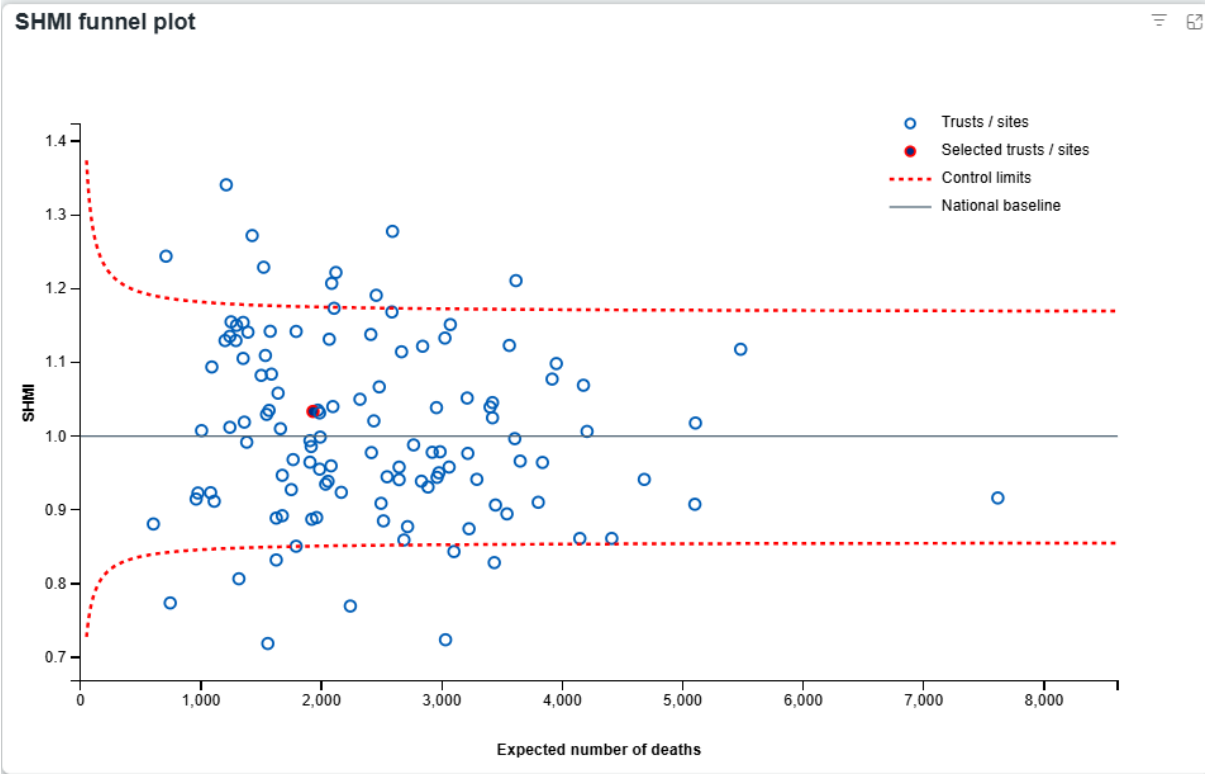
1.5 The RUH, along with GWH and SFT, have not continued the previously commissioned Telstra contract (September 2025), and will use SHMI as our mortality indicator rather than HSMR in line with many other trusts and with NHS England. Due to a period of incomplete coding at the RUH, both HSMR and SHMI data needs to interpreted with caution. The incomplete coding resulted in a 5-month lag which has impacted the interpretation of the RUH mortality data.

1.6 For the year 2025/2026 there has been approval for additional coding resource to ensure the backlog of coding is completed. A complete coding data set will mean that the SHMI can be accurately interpreted and reviewed. This is essential to ensure that clinical data can be interpreted to provide robust governance and assurance around

mortality rates in our hospital. Complete clinical coding will also allow specialty teams to identify any mortality signals that require a focused review to ensure areas for learning and focus and well as identifying examples of good practice.

1.7 Our Standardised Mortality Ratio (SMR) data for Q3 continues to sit within the expected range, and is showing a downwards trend, and remains below the national benchmark.

1.8 Further investigation points to coding issues as we have a high percentage of invalid diagnosis codes, specifically with *primary diagnosis as a sign or symptom* (R codes) entering Q3 we are in the lowest quartile in the country. RUH remains the second lowest performing trust in the Southwest for having uncoded episodes.



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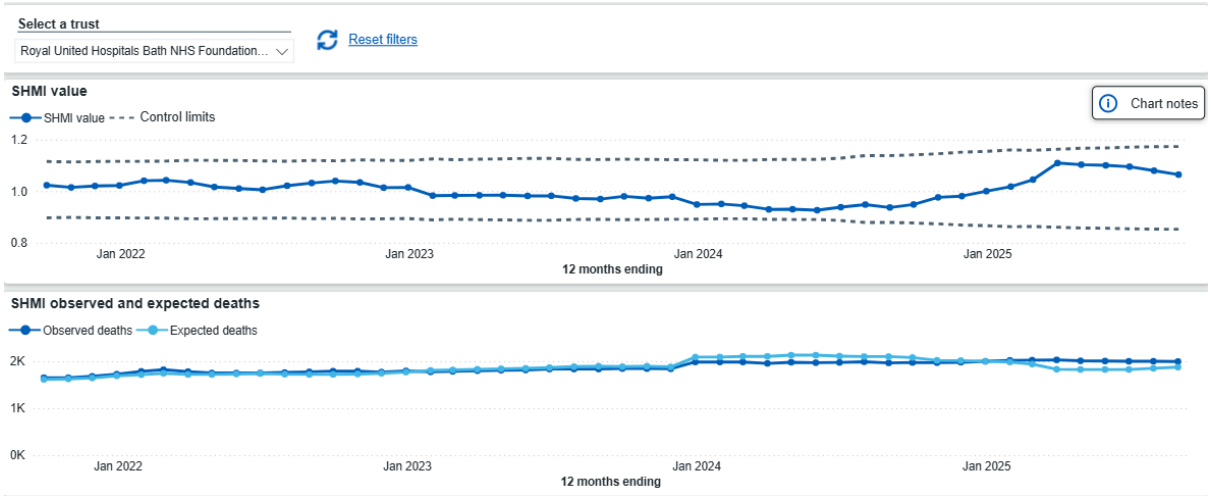

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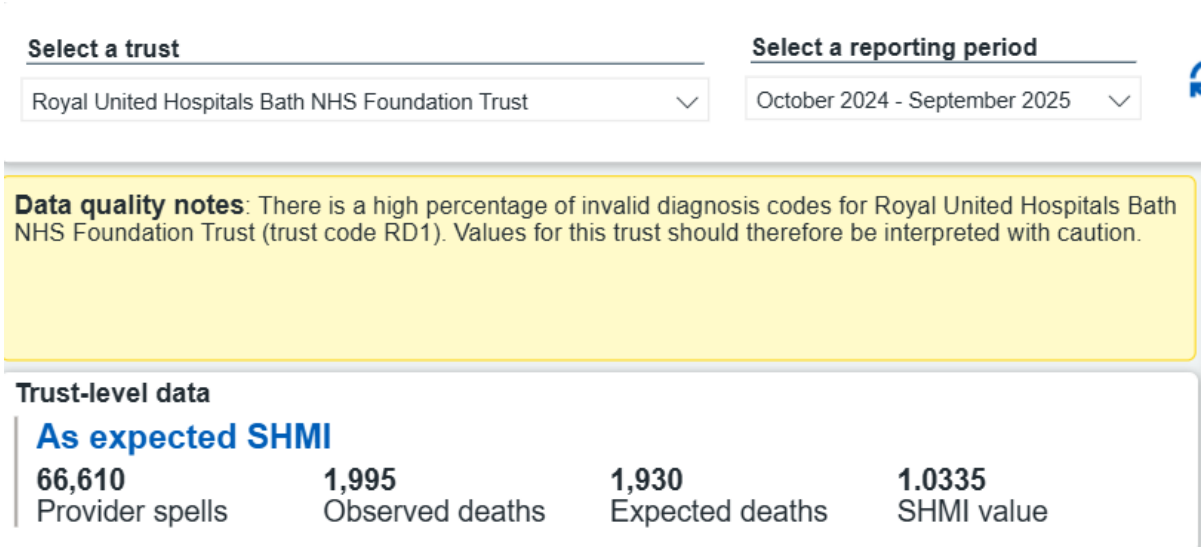


1.9 This change in trend correlates with periods where coding was unable to be undertaken due to workforce gaps in our coding team, with recruitment delayed by held vacancies and limitations on use of temporary staffing in order to meet our financial recovery plan.

1.10 Whilst there is a clear rationale for the change of data trend, we need to be vigilant and confident that this data is not masking other changes or concerns that warrant further exploration in order to maintain our quality and safety standards. A mortality group has been re-established with a planned meeting for December 2025. The

purpose of the Mortality group is to ensure triangulation of our mortality data. This triangulation will include: -

- SJRs
- Incident reporting/patient safety
- Clinical audits (where there are mortality indicators)
- Complaints, Pals
- National reports (where there are mortality indictors, eg NELA)
- Litigation
- Medical Examiner
- Coroners, Reg 28s

1.11 There have been no areas of concern for mortality from the national audits based on the data we presented for Q3 to the Clinical Effectiveness Committee. There were two claims received in Q2 that related to the death of a patient. One in relation to a DVT leading to a PE (index incident 2023) and one relating to a delayed diagnosis of cancer (index incident 2021).

1.12 From Q4 the Learning from Death report will include data to confirm the number of cases that have been reviewed through the alternative response pathways. This will include those cases that have been managed through PALS, legal services, patient safety response and safeguarding.

1.13 There is newly embedded robust governance framework. The MSG reports to RUH Clinical Effectiveness Committee which reports to the Quality Assurance Committee.

2.0 Mortality Review Process

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

2.2 The performance of the Medical Examiners is considered in greater detail in the quarterly Medical Examiner Office Reports. The Medical Examiners screen all deaths, and a standard proforma is used to ensure consistency in the cases that are selected for SJR. The Medical Examiner Office Report details the performance of the screening process. The Medical Examiner Office report is escalated to the National ME team. With the re-established MSG the report is also shared with this group. This supports

the triangulation of mortality data and identifies any learning that can then be shared with divisional teams.

2.3 Regarding Structured Judgement Reviews (SJRs), in Q3 10% (n=30) of patients who died during Q3 were selected for SJR.

2.4 Figure 2 demonstrates the selection criteria for those patients who died during Q3. The selection criteria include: -

- When families or carers or staff have raised concern about care provided.
- When a person has a learning disability (this patient group are known to experience poorer health outcomes)
- When a person has a severe mental illness (this patient group are known to experience poorer health outcomes)
- When the ME has identified potential learning outcomes
- When a person is having an elective operation or procedure
- When there are patterns in mortality data or alerts from our regulators that suggest needing a more detailed review.
- When the patient is a surgical patient (RUH criteria)

The most frequently used criteria are when the patient was a surgical patient (all surgical patients have an SJR), followed by Medical /Nursing Concern. This is consistent with what was seen in Q1 and Q2. There has been an increase in the number of SJRs requested because the patient has a Learning Disability. Safeguarding have been informed to allow triangulation with the LeDeR process. The SJR policy is due to be reviewed by the MSG to ensure that the categories are in line with the national recommendations. For example, completing an SJR on all surgical patients is specific to RUH rather than being a national recommendation.

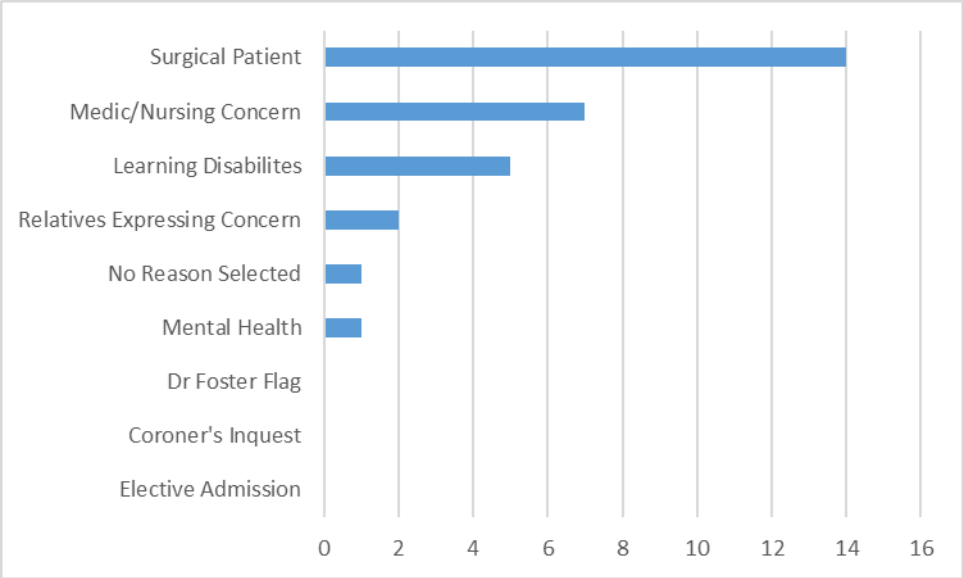


Figure 2: Number of deaths selected for SJR by selection criteria

2.5 Figure 3 illustrates the number of SJRs requested per quarter, compared to the number completed and the percentage of SJRs that were completed within two months of the patient's death. Since this data was produced there has been a further improvement in the number of SJRs completed. The Trust target is to complete 95% of SJRs within 2 months of the death; our latest achievement is 29%. This is a decrease from 32% in Q3 24/25. There has been a targeted focus on reducing the SJR backlog and the three divisions have worked hard to achieve this significant improvement.

2.6 It had been previously approved through the Clinical Effectiveness committee that those cases that were being reviewed via a coronial or inquest process did not need to have a second review process in the format of a SJR as there is an already identified review process, unless other criteria requiring SJR had been met, which would then require a SJR to be completed. This has resulted in a reduction in the number of deaths being selected for an SJR. It is positive that those SJRs that were completed during Q2 were completed in a timelier manner than has been seen previously. It is noted that there has been significant reduction in the number of SJRs being completed. The concern is that the backlog will continue to grow if the number being completed is exceeded by the number being selected.

2.7 The MSG has requested that there is a sprint approach to complete the backlog SJR for 2025-26. This included those outstanding SJRs from Q2. The divisions have been requested to prioritise the Q2 SJRs as part of this workstream with a request for all outstanding Q2 SJRs to be completed by the end February 2026.

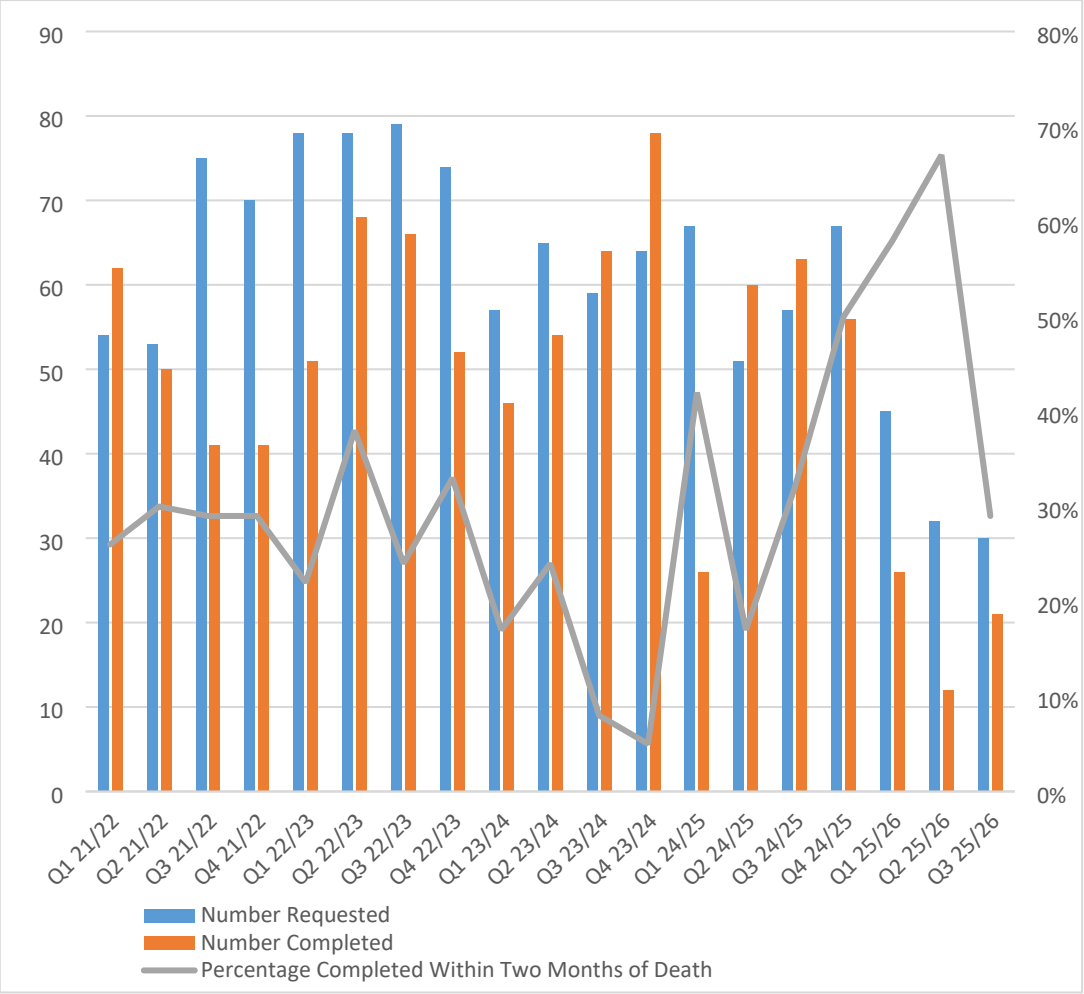


Figure 3: Number of completed SJRs v Number Requested and % completed within two months of the death

2.8 There are 15 outstanding SJRs for patients who have died between 1st January 2025 and 31st December 2025. Of these, 9 are awaiting completion by Medicine; 5 are awaiting completion by Surgery; 1 is awaiting completion by FASS. The divisions have been asked to clear this backlog by the end of February 2026.

2.9 Following completion of review of the backlog of SJR's, it has been agreed historic cases that have already been the subject of a detailed review, via another process such as a formal complaint, incident investigation or inquest, will be removed from the case list, on the basis that the opportunity for additional learning is limited. Following scrutiny of the completed SJRs for 2025-26 including Q3, there will be a review of the cases and themes that will be reviewed by the mortality surveillance group.

2.10 There are 134 outstanding SJRs for the 4 years leading to 31/3/2025. This includes 66 in medicine, 64 in surgery and 4 in FASS. There is being monitored by the newly established MSG.

3.0 Learning from Mortality Reviews

3.1 Of the SJRs completed during Q3, 19 (90%) assessed the overall care to be either Good (a score of 4) or Very Good (a score of 5). This is an increase from 68% in Q2 and 81% in Q1.

3.2 No patients were assessed as having received very poor care, but 1 (5%) was assessed as having received poor care overall.

3.3 The figure below shows the rating of overall care by quarter. Following an apparent dip in the quality of care provided in Q2, Q3 has seen a significant improvement. However, the picture is potentially distorted by the small data set. To provide assurance, this data should be triangulated with incidents and complaints.

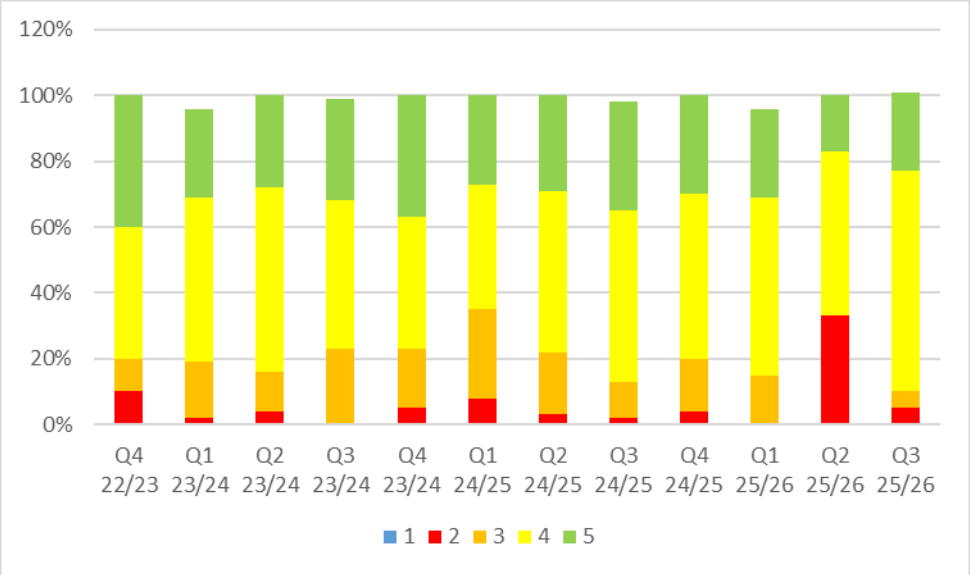


Figure 4: Score Allocated to Overall Care by Quarter

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

3.6 The below shows the most commonly occurring themes arising from completed SJRs. In 53% of cases, either no additional learning was identified, or it was recognised that the care delivered was of a good or excellent standard.

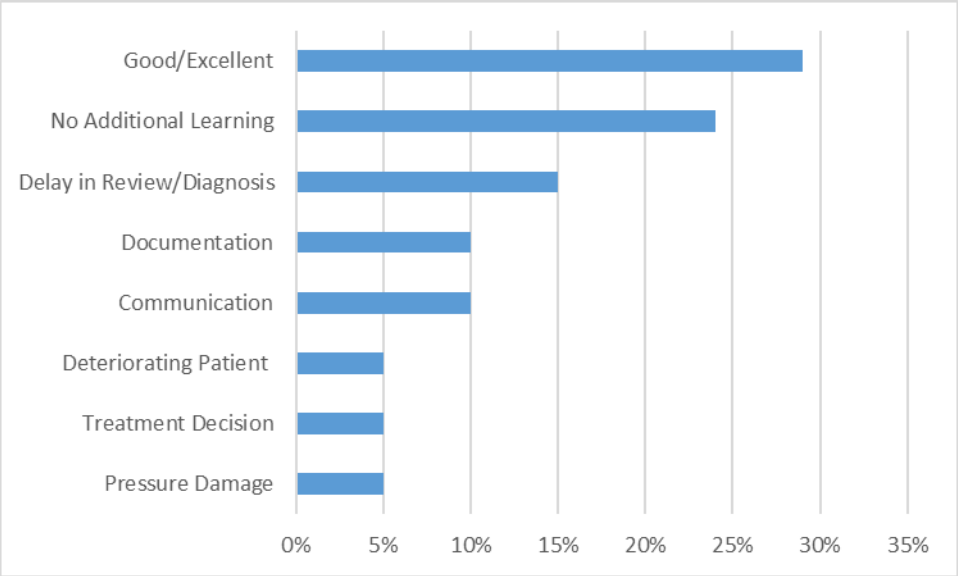


Figure 5: SJR themes

3.7 The reduced number of completed SJRs makes identifying themes more challenging. Three SJRs commented upon delays in reviews or diagnoses. The first related to a delay in doctor review once the patient was noted to be deteriorating. The delay is not thought to have contributed to the patient's death. One SJR refers to a delay in identifying a fracture, potentially contributing to the patient developing pneumonia, delirium and an AKI. The third related to a delay in recognising the patient had developed an AKI. The patient was noted to already be very frail.

3.8 The SJR for the patient who was assessed as receiving poor care overall notes that the patient's deterioration was not detected quickly enough. Initially he was able to communicate but lost that ability after admission. The SJR highlights the importance of reading earlier entries in the medical records to allow such changes in presentation to be swiftly identified. It is unclear whether the patient's death could have been avoided however.

3.9 There is not an even distribution of SJRs that take place across the 3 bed holding divisions. As part of the SJR process review it will include a review of the trust wide process to ensure that there are representative samples across the 3 bed-holding divisions to maximise multi-professional learning to support the continuing delivery of high-quality care to all patients.

3.10 The planned review of the RUH SJR process will include the clarification of the onward process in those cases where the Medical Examiner referral identifies a patient safety concern. To ensure the integration of the SJR and PSIRF process (Patient safety incident reporting framework). PSIRF is designed to support patient safety reviews. It is proposed that the SJR policy will be reviewed during Q4. Any change recommendations related to the SJR process will be reviewed by the MSG with approval sought at CEC.

4.0 Inquests

4.1 16 inquests were opened and 11 were concluded during Q3. The Trust was required to attend two in-person hearings. The first related to a gentleman whose family had concerns that the Trust had missed signs that their relative was deteriorating because of sepsis. The coroner was satisfied the gentleman had died because of Natural Causes but was concerned that the patient had been "lost" between medical and surgical specialities. A Regulation 28 Report was not made.
The second hearing related to a gentleman who attended ED on two occasions, with abdominal pain. On the second occasion, he was diagnosed with a Small Mesenteric Artery thrombus. The family were concerned that an earlier opportunity to treat had been missed. The coroner was satisfied that the patient's presentation was unusual and did not make any criticisms of the care. It was also found that earlier treatment would have been unlikely to change the outcome. A Regulation 28 Report was not made.

4.2 No other Regulation 28 Reports were received during the quarter.

5.0 Next Steps

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

5.2 In conjunction with GWH & SFT, we have ceased our contract with Telstra to provide our data reports from September 2025. However, due to the longstanding contract with RUH Telstra have offered to provide basic reports until December 2025.

5.3 We are continuing to work with GWH& SFT to build a single Power BI dashboard to share more timely data and insights into mortality data. GWH have already commenced this work for us to collectively build on.

5.4 The MSG currently meets fortnightly to lead the mortality review work and steer this work allowing the sharing of timely insights and learning for discussion and escalation through the governance framework to the clinical effectiveness group. The SJR process review will be completed during the year 2025-6. This will include the appointment of a trust-wide mortality lead. It is important that the themes identified are shared with divisional teams to ensure there is learning shared with teams to improve the experience for patients in our care and their families. It will also be an opportunity to share and recognise good practice.

5.5 During the year 2025-26 there will also be a review of the Morbidity & Mortality review process and upward reporting mechanism to MSG to ensure trust wide learning.

5.6 During Q4 both the SJR and Learning form Deaths Policy will be reviewed. The Learning form Deaths Policy will be reviewed in line with the PSIRF approach to patient safety which has been introduced at RUH since the writing of the previous policy 2022-2025.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**18**
Date of Meeting:	**4 March 2026**		

Title of Report:	**Maternity Incentive Scheme Declaration Year 7**
Status:	**For noting**
Board Sponsor:	**Antonia Lynch, Chief Nursing Officer and Board Safety Champion**
Author:	**Zita Martinez, Director of Midwifery and Neonates** **Jane Farey, Obstetric Clinical Director**
Appendices	**Appendix 1: Maternity (and perinatal) Incentive Scheme Year 7** **Appendix 2: MIS Year 7 Board Notification Form**

1. Executive Summary of the Report

The Maternity and Neonatal Service within the Family and Specialist Services (FASS) Division has completed its self-assessment against all ten Safety Actions and their associated sub-requirements for the Maternity Incentive Scheme (MIS) Year 7 (Appendix 1). A full compliance position has been confirmed for each Safety Action, supported by documented evidence that has been reviewed internally.

In previous years, internal audit of Safety Actions was undertaken by KPMG. For Year 7, no internal KPMG audit was commissioned. To maintain robust assurance, the Division implemented an enhanced internal 'check and challenge' process. This process was led by Board-Level Safety Champions and the Managing Director, with active involvement from the perinatal senior leadership team. It involved a detailed review of evidence for six of the ten Safety Actions to ensure accuracy, completeness, and alignment with national MIS guidance and technical standards.

Alongside this internal assurance, four Safety Actions will be subject to external validation by national bodies. These include verification by Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) and the Perinatal Mortality Review Tool (PMRT) for perinatal mortality reviews, NHS England for data submissions to the Maternity Services Data Set, and NHS Resolution and Maternity and Newborn Safety Investigations (MNSI) for qualifying incident reporting.

The Care Quality Commission (CQC) will also cross-reference evidence where inspections occurred during the reporting period, however the Trust did not have an inspection during this reporting period.

The Trust Board received this report at their meeting in private on 4 February 2026 and gave permission to the Chief Executive Officer (CEO), Cara Charles-Barks, to sign the Board declaration form prior to submission to NHS Resolution, which was submitted to NHSR in advance of 3 March 2026.

2. Recommendations (Note, Approve, Discuss)

The Trust Board is asked to note confirmation that the Royal United Hospitals Bath NHS Foundation Trust (RUH) has appointed PERIPrem leads who are now in post. Each lead has a supporting job description, which outlines their roles and responsibilities to provide leadership and oversight of the implementation of Element 5 of the Saving Babies' Lives Care Bundle. The Trust Board is asked to note the current infrastructure supporting the Maternity and Neonatal Voices Partnership (MNVP), commissioned by the Local Maternity and Neonatal System (LMNS) and the Integrated Care Board (ICB), is not compliant with national guidance. The Trust has formally escalated these concerns through the Perinatal Quality Oversight Model at Trust, ICB, and regional levels. An agreed action plan is now in place with the ICB to address the identified gaps.

3.	**Legal / Regulatory Implications**
N/A	

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

5.	**Resources Implications (Financial / staffing)**
N/A no financial implication within this paper.	

6.	**Equality and Diversity**
Equality, Diversity and Inclusion assessment not required as no significant changes to services or policy.	

7.	**References to previous reports/Next steps**

MIS Year 7 evidence Accountable Officer 'check and challenge' meeting held on 23rd January 2026 with, Gill May (ICB Accountable Officer), Antonia Lynch (Chief Nursing Officer & Board Level Maternity & Neonatal Safety Champion), Simon Harrod (Non-Executive Director & Board Level Maternity and Neonatal Safety Champion). Led by Zita Martinez (Director of Midwifery and Neonates) and Jane Farey (Obstetric Clinical Lead).

The Trust Board received this report at their meeting in private on 4 February 2026 and gave permission to the Chief Executive Officer (CEO), Cara Charles-Barks, to sign the Board declaration form prior to submission to NHS Resolution. The CEO signed to confirm that:

1) The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document included in this document.
2) There are no reports covering either year 2024/25 or 2025/26 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration from the same time-period (e.g. CQC inspection report, Healthcare Safety Investigation Branch (HSIB)/MNSI investigation

reports etc.). All such reports should be brought to the MIS team's attention before 3 March 2026.

3) Any reports covering an earlier time-period may prompt a review of a previous MIS submission. If, following a review of a previous MIS submission, it is found that the Trust was non-compliant then the Trust will immediately return to NHS Resolution, that year's MIS funds that were awarded, irrespective of it being a prior financial year.

In addition, the CEO ensured that the Accountable Officer (AO) for Bath and North East Somerset, Salisbury and Wiltshire Integrated Care Board (ICB) was appraised of the MIS Safety Actions' evidence and declaration form. The CEO and AO both signed the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution.

The Board declaration was sent to NHS Resolution via **nhsr.mis@nhs.net** by the deadline of 12 noon on 3 March 2026.

8.	**Freedom of Information**
Public.	

9.	**Sustainability**
N/A.	

10.	**Digital**
N/A.	

1. Purpose

1.1 The purpose of this paper is to demonstrate to the Trust Board that the Service has achieved all 10 Safety Actions for the Maternity Incentive Scheme (MIS) Year 7.

1.2 The purpose of this paper is to ensure the Trust Board are satisfied that the evidence provided demonstrates achievement of the ten maternity Safety Actions and sub-requirements as set out in MIS Year 7 (Appendix 1) and evidenced within the MIS self-declaration form (Appendix 2).

1.3 This paper accompanies the declaration form (Appendix 2) and should be used to detail the Services' position and progress with MIS Year 7.

1.4 To confirm there are no reports covering either year 2024/25 or 2025/26 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration from the same time-period (e.g. CQC inspection report, Healthcare Safety Investigation Branch (HSIB)/MNSI investigation reports etc.).

2. Background

2.1 The Maternity Incentive Scheme is part of the Clinical Negligence Scheme for Trusts (CNST) that is now in Year 7. The scheme incentivises ten maternity Safety Actions, Trusts that can demonstrate they have achieved all ten of the Safety Actions will recover the element of their contribution to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

2.2 Trusts that do not meet the ten out of ten Safety Actions will not recover their contribution to the CNST maternity incentive fund but may be eligible for a small discretionary payment from the scheme to help make progress against actions they have not achieved.

2.3 The scheme uses a self-assessment declaration form that must be signed off by the Trusts Chief Executive Officer to confirm the Trust Board are satisfied with the evidence provided to demonstrate achievement of meeting each Safety Action.

2.4 The Trust has conducted internal processes led by Board Level Safety Champions to review and validate the evidence supporting compliance with MIS Year 7.

2.5 In previous years, internal audit of Safety Actions was undertaken by KPMG. For Year 7, no internal KPMG audit was commissioned. To maintain robust assurance, the Division implemented an enhanced internal 'check and challenge' process. This process was led by Board-Level Safety Champions and the Managing Director, with active involvement from the perinatal senior leadership team. It involved a detailed review of evidence for all of the ten Safety Actions to ensure accuracy, completeness, and alignment with national MIS guidance and technical standards.

2.6 In addition, assurance for Safety Actions 1, 2, 6, and 10 will be strengthened through external validation processes, ensuring independent confirmation of compliance alongside the internal 'check and challenge' review.

2.7 The Trust is also responsible for ensuring the Accountable Officer for the ICB is appraised of the MIS Safety Action evidence.

2.8 The relevant reporting period for MIS year 7 is 1 December 2024 to 30 November 2025. The Board declaration form must be sent to NHSR before 12 noon on 3 March 2026. The Board declaration was submitted to NHSR following Private Board of Directors approval on 4 February, 2026.

3. Declaration of Compliance

3.1 The Maternity and Neonatal Service within the Family and Specialist Services (FASS) Division is declaring compliance with each of the ten Safety Actions and their sub requirements. This position is supported following an in-depth internal 'check and challenge" review.

SA no.	Safety Action Title	Compliance self certified	Validation Process
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Compliant	External by MBRRACE
2	Are you submitting data to the Maternity Services Data Set to the required standard?	Compliant	External by NHS Digital
3	Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies?	Compliant	Internal
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Compliant	Internal
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Compliant	Internal
6	Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Compliant	External by LMNS ICB
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users.	Compliant	Internal
8	Can you evidence the following 3 elements of local training plans and in house one day multi professional training?	Compliant	Internal
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?	Compliant	Internal

10	Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme.	Compliant	External by NHS Resolution

Tabe 1: Overview of compliance status and method of validation

4.0 Safety Action Updates

4.1 Safety Action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review and report perinatal deaths to the required standard?

4.1.1 The Service is compliant and there is sufficient data to evidence the position against the required timeframes and standards. This is demonstrated within the Quarterly PMRT reports. The Quarterly PMRT reports are shared with the Safety Champions, Trust Board (via the Quarterly Quality Reports) and the LMNS.

4.1.2 NHS Resolution will use data from MBRRACE-UK, to cross reference against the Trusts' self-certification. MBRRACE-UK will take the data extract for verification on 3 February 2026.

4.2 Safety Action 2: Are you submitting data to the Maternity Services Data set to the required standard?

4.2.1 The service has received formal confirmation from NHS Digital that the data quality standards reflected on the scorecard are fully compliant.

4.3 Safety Action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

4.3.1 The Service is compliant; there is sufficient supporting evidence to demonstrate there are pathways of care into transitional care (TC) in place which aligns with the British Association of Perinatal Medicine (BAPM) Transitional Care Framework for Practice.

4.3.2 The Service has undertaken at least one quality improvement (QI) initiative to decrease admissions and/or length of infant/mother separation. The progress on the QI initiative has been shared with the Safety Champions and LMNS.

4.4 Safety Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

4.4.1 The service is fully compliant across all staff groups, including obstetric medical, anaesthetic medical, neonatal medical, and neonatal nursing. There is robust evidence available to confirm and support this position of compliance.

4.5 Safety Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

4.5.1 The Service is compliant with Safety Action 5, the funded establishment is in line with the most recent Birthrate+ recommended funded establishment, and one to one care and supernumerary status compliance has remained at 100% for the MIS relevant reporting period.

4.6 Safety Action 6: Can you demonstrate you are on track to compliance with all elements of the Saving Babies Lives Care Bundle Version Three (SBLCB V3)?

4.6.1 The Service is compliant using the Saving Babies Lives NHSE Implementation Tool and at least quarterly required improvement discussions with the ICB have been held.

4.6.2 On 24 December 2025, the Service received confirmation from the LMNS/ICB that compliance with Safety Action 6 has been achieved. While full implementation of SBLCB v3 remains in progress, current compliance stands at 93%, with key areas of improvement focused on strengthening PERIPrem pathways. Planned work includes revisiting PERIPrem QI pathways as a multidisciplinary team, enhancing shared learning and Quality Improvement activity, and progressing the sustainability plan for the maternity ultrasound pathway, specifically the uterine artery doppler component. These actions form part of the ongoing programme to ensure full, sustainable compliance with SBLCB v3.

4.6.3 The Trust Board confirms to the LMNS/ICB that the Royal United Hospitals Bath NHS Foundation Trust (RUH) has appointed PERIPrem leads in post, and each lead has a supporting job description outlining their roles and responsibilities to ensure leadership and oversight of the implementation of Element 5. Furthermore, the Service shared a copy of the job description at the Accountable Officer 'check and challenge' meeting on 23 January 2026, providing assurance that the requirement for leadership and oversight has been met.

4.6.4 Table 2 outlines SBLCB V3 element progress and the % of interventions fully implemented.

Intervention Elements	Description	Element Progress	% of Interventions Fully Implemented
Element 1	Smoking in Pregnancy	Fully Implemented	100%
Element 2	Fetal Growth Restriction	Partially Implemented	95%
Element 3	Reduced Fetal Movement	Fully Implemented	100%
Element 4	Fetal Monitoring in Labour	Partially Implemented	80%
Element 5	Preterm Birth	Partially Implemented	88%
Element 6	Diabetes	Fully Implemented	100%
All Elements	**TOTAL**	**Partially Implemented**	**93%**

Table 2: SBLCB V3 Implementation progress

4.7 Safety Action 7: Listen to women, parents, and families using maternity and neonatal services and coproduce with service users.

4.7.1 The Service is compliant with Safety Action 7. The Maternity and Neonatal Voices Partnership (MNVP) for Bath and North East Somerset, Swindon and Wiltshire (BSW) have co-produced the RUH CQC Maternity Survey action plan and progress with actions have been shared with Safety Champions and the LMNS.

4.7.2 The current infrastructure for the Maternity and Neonatal Voices Partnership (MNVP), as commissioned by the LMNS/ICB, does not meet the requirements set out in national guidance. In response, the Trust has formally escalated this issue through the Perinatal Quality Oversight Model at Trust, ICB, and regional levels. An action plan is in place with the ICB to address these gaps.

4.8 Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

4.8.1 The Service is compliant with Safety Action 8 and can confirm all staff working in maternity services have attended annual training.

4.8.2 Training compliance for all requirements (PROMPT, Fetal Wellbeing and Neonatal Life Support) is above 90% overall and for each staff group. A 90% minimum compliance is required for MIS.

4.9 Safety Action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

4.9.1 The Service is compliant with Safety Action 9. The Perinatal Quality Surveillance Model (PQSM) is fully embedded, and governance processes ensure intelligence flows from ward to Board. Trust-level intelligence is routinely escalated to the LMNS/ICB and regional quality groups to enable early action and support for areas of concern, in line with PQSM requirements.

4.9.2 The Service has drafted an updated Perinatal Quality Surveillance and Oversight Model (PQSOM) in preparation for national implementation. This draft has been shared with the LMNS for review and alignment, demonstrating proactive engagement and readiness for future compliance requirements.

4.9.3 Maternity and Neonatal Board Level Safety Champions (BSCs) actively support the perinatal leadership team (quadrumvirate) to understand, communicate, and champion learning, challenges, and best practice. There is documented evidence of regular

engagement sessions with staff and service users, ensuring that feedback informs improvement work.

4.9.4 The Service and BSCs monitor progress and actions relating to local improvement projects, including those arising from the Perinatal Culture and Leadership Programme. These projects utilise the Patient Safety Incident Response Framework (PSIRF) methodology and are reviewed at least quarterly at Board or delegated sub-committee level.

4.9.5 Evidence of collaboration with LMNS and ICB leads is in place, demonstrating shared learning and triangulation of safety intelligence. This includes escalation of concerns, review of thematic learning, and alignment with regional oversight processes.

4.10 Safety Action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme.

4.10.1 The Service is compliant with Safety Action 10, all qualifying cases have been reported to HSIB/MNSI. There were 2 qualifying Early Notification (EN) cases to NHS Resolution's EN Scheme within the relevant time period.

4.10.2 For all qualifying cases statutory duty of candour letters have been sent to families covering the required information. Trust Board have oversight of HSIB/MNSI and EN incidents and sight of compliance with the statutory duty of candour as part of the PQSM.

5.0 Summary

5.1 The Service is proposing that a position of compliance is declared against each of the 10 Safety Actions for the Maternity Incentive Scheme Year 7.

5.2 The proposed position of compliance follows an internal in-depth review of the evidence and external validation processes as outlined in MIS Year 7.

6.0 Recommendations and Next Steps

6.1 The Trust Board received this report at their meeting in private on 4 February 2026 and gave permission to the Chief Executive Officer (CEO), Cara Charles-Barks, to sign the Board declaration form prior to submission to NHS Resolution. The CEO signed to confirm that:

1) The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity Safety Actions meets the required safety actions'

sub-requirements as set out in the safety actions and technical guidance document included in this document.

2) There are no reports covering either year 2024/25 or 2025/26 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration from the same time-period (e.g. CQC inspection report, Healthcare Safety Investigation Branch (HSIB)/MNSI investigation reports etc.). All such reports should be brought to the MIS team's attention before 3 March 2026.

3) Any reports covering an earlier time-period may prompt a review of a previous MIS submission. If, following a review of a previous MIS submission, it is found that the Trust was non-compliant then the Trust will immediately return to NHS Resolution that year's MIS funds that were awarded, irrespective of it being a prior financial year.

6.2 In addition, the CEO ensured that the Accountable Officer (AO) for Bath and North East Somerset, Salisbury and Wiltshire Integrated Care Board (ICB) was appraised of the MIS Safety Actions' evidence and declaration form. The CEO and AO both signed the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution.

The Board declaration was sent to NHS Resolution via **nhsr.mis@nhs.net** by the deadline of 12 noon on 3 March 2026.

NHS Resolution

Maternity (Perinatal) Incentive Scheme

Year Seven v1.0

Conditions of the scheme

Ten maternity safety actions

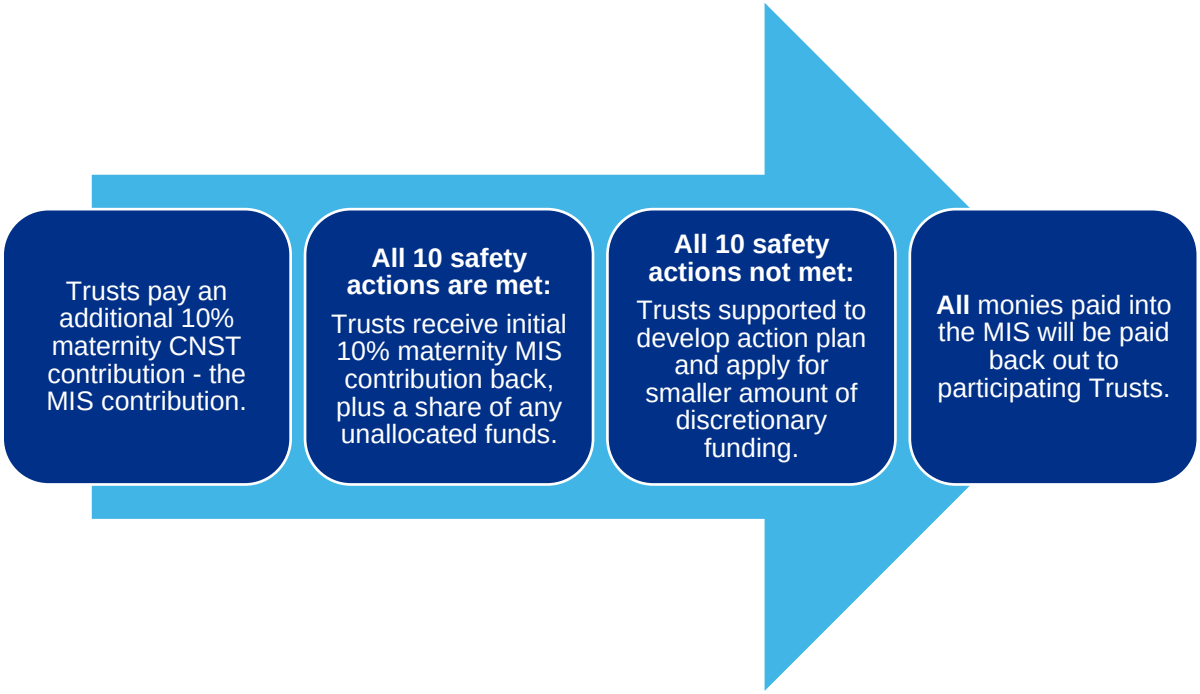
Additional guidance

Contents

Introduction

Now in its seventh year of operation, NHS Resolution's Maternity (Perinatal) Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025.

The MIS applies to all acute Trusts that deliver maternity services and are members of the Clinical Negligence Scheme for Trusts (CNST). As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST MIS fund:



The original ten safety actions were developed in 2017 and have been updated annually by a Collaborative Advisory Group (CAG) including NHS Resolution, NHS England, Royal College of Obstetricians and Gynaecologists (RCOG), Royal College of Midwives (RCM), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), Royal College of Anaesthetists (RCoA), the Neonatal Clinical Reference Group (CRG), the Care Quality Commission (CQC), the Maternity and Newborn Safety Investigation Programme (MNSI) and service user representatives.

Trusts that can demonstrate they have achieved all ten of the safety actions in full will recover their trust's element of the contribution relating to the CNST MIS fund and this will be returned to the source of the initial CNST payment. They will also receive a share of any unallocated funds.

Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST MIS fund but may be eligible for a smaller discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a lower level than the 10% contribution to the MIS fund and is

subject to a cap decided annually by NHS Resolution. The balance of unallocated funds will be shared with the trusts who have achieved all ten safety actions.

MIS year seven: conditions

- To be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution via nhsr.mis@nhs.net by **12 noon** on **3 March 2026** and must comply with the following conditions:
- Trusts must achieve all ten maternity safety actions.
- The declaration form is submitted to the Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the Director of Midwifery/Head of Midwifery and Clinical Director for maternity services.
- The Trust Board must then give their permission to the Chief Executive Officer (CEO) to sign the Board declaration form prior to submission to NHS Resolution. The Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.
- The Trust's CEO must sign to confirm that:

☑ The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document included in this document.

☑ There are no reports covering either year 2024/25 or 2025/26 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration from the same time-period (e.g. CQC inspection report, Healthcare Safety Investigation Branch (HSIB)/ MNSI investigation reports etc.). All such reports should be brought to the MIS team's attention before 3 March 2026.

☑ Any reports covering an earlier time-period may prompt a review of a previous MIS submission. *If, following a review of a previous MIS submission, it is found that the Trust was non-compliant then the Trust will immediately return to NHS Resolution that year's MIS funds that were awarded, irrespective of it being a prior financial year.*

- In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICS) is apprised of the MIS safety actions' evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution.

The Regional Chief Midwives will provide support and oversight to Trusts when receiving Trusts' updates from Local Maternity and Neonatal System (LMNS) and regional meetings, focusing on themes highlighted when Trusts have incorrectly declared MIS compliance in previous years of MIS.

NHS Resolution will continue to investigate any concerns raised about a Trust's performance either during or after the confirmation of the MIS results. See 'Reverification'.

NHS Resolution will publish the outcomes of the MIS verification process, Trust by Trust, for each year of the scheme (updated on the NHS Resolution Website).

External verification

Trust MIS submissions will be subject to a range of external verification points at the end of the submission period. These include cross checking with:

MBRRACE-UK data (safety action 1 standards a, b and c).

NHS England regarding submission to the Maternity Services Data Set (safety action 2, all criteria).

MNSI will cross-check the **National Neonatal Research Database (NNRD)** and **NHS Resolution** will cross-check the **NHS Resolution database** for qualifying MNSI and EN incidents reportable (safety action 10) and externally verify that standards A and B have been met in the relevant reporting period. In addition, for standards B and C(i) there is a requirement to complete the field on **NHS Resolution's Claims Reporting Wizard (CMS)**, whether families have been advised of NHS Resolution's involvement. Completion of this will also be monitored and externally validated.

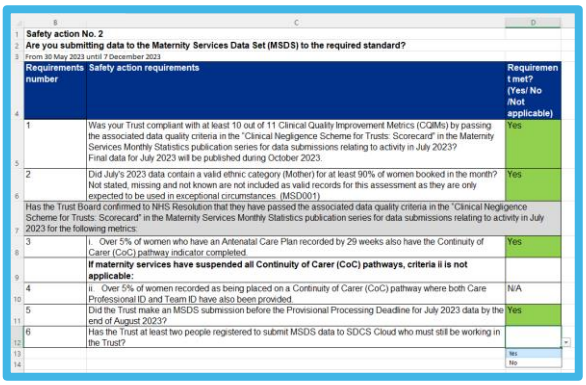
Trust submissions will also be sense checked with the **CQC**, and for any CQC visits undertaken within the time period, the CQC will cross-reference to the MIS via the key lines of enquiry.

Trusts found to be non-compliant following this external verification process cannot report full compliance with the MIS for that year.

Evidence for submission

- The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided internally in the Trust to support the Trust Board decision only. This will not be reviewed by NHS Resolution unless requested. See 'Reverification'.
- On the Board Declaration form Trusts must declare YES/NO or N/A (where appropriate) against each of the elements within each safety action sub-requirements.

- Only for specific safety action requirements, Trusts will be able to declare N/A (not applicable) against some of the sub requirements.
- The Trust must also declare on the Board declaration form whether there are any external reports which may contradict their MIS submission and that the MIS evidence has been discussed with commissioners.



Safety action No. 2

Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Was your Trust compliant with at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) by passing the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023? Final data for July 2023 will be published during October 2023.	Yes
2	Did July's 2023 data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	Yes
	Has the Trust Board confirmed to NHS Resolution that they have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics:	
3	i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks also have the Continuity of Carer (CoC) pathway indicator completed.	Yes
	If maternity services have suspended all Continuity of Carer (CoC) pathways, criteria ii is not applicable:	
4	ii. Over 5% of women recorded as being placed on a Continuity of Carer (CoC) pathway where both Care Professional ID and Team ID have also been provided.	N/A
5	Did the Trust make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023?	Yes
6	Has the Trust at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust?	

Yes
No

- In the event that an MIS submission is found to be knowingly false or misleading, NHS Resolution will escalate the matter to the appropriate regulatory and investigative authorities.
- Trusts will need to report compliance with MIS by **12 noon on 3 March 2026** using the Board declaration form, which will be published on the NHS Resolution website in the forthcoming months.
- The Trust declaration form must be signed by the Trust's CEO, on behalf of the Trust Board and by AO of Clinical Commissioning Group/Integrated Care System.
- The Board declaration form will be made available on the MIS webpage during the MIS reporting period.

'What Good Looks Like'

Trusts are reminded to retain all evidence used to support their compliance position. In the event that NHS Resolution are required to review supporting evidence at a later date (as described below) it must be made available as it was presented to support Board assurance at the time of submission.

Timescales and appeals

- Any queries relating to the ten safety actions must be sent in writing by e-mail to NHS Resolution via nhsr.mis@nhs.net prior to 3 March 2026.
- The Board declaration form must be sent to NHS Resolution via nhsr.mis@nhs.net between 17 February 2026 and 3 March 2026 at 12 noon. An electronic acknowledgement of Trust submissions will be provided within 48 hours from 3 March 2026.
- Submissions and any comments/corrections received after 12 noon on 3 March 2026 will not be considered.

- The Appeals Advisory Committee (AAC) will consider any valid appeal received from participating Trusts within the designated appeals window timeframe.
- There are two possible grounds for appeal:
    - Alleged failure by NHS Resolution to comply with the published 'conditions of scheme' and/or guidance documentation.
    - Technical errors outside the Trust's control and/or caused by NHS Resolution's systems which a Trust alleges has adversely affected its CNST rebate.
- The NHS Resolution MIS clinical team will review all appeals to determine if these fall into either of the two specified grounds for appeal. If the appeal does not relate to the specified grounds, it will be rejected, and NHS Resolution will correspond with the Trust directly with no recourse to the AAC.
- Any appeals relating to a financial decision made, for example a discretionary payment made against a submitted action plan, will not be considered.
- Appeals must be made in writing to NHS Resolution on the agreed template within two weeks of the final notification of results. Information on how to do this will also be communicated to all Trusts when the confirmed MIS results are sent out.

Trusts who have not met all ten safety actions

Trusts that have not achieved all ten safety actions may be eligible for a smaller amount of funding to support progress. To apply for funding, such Trusts must submit a completed action plan together with their completed Board declaration form by 12 noon on 3 March 2026 to NHS Resolution nhsr.mis@nhs.net.

Action plans submitted must be:

- Submitted on the action plan template in the Board declaration form.
- Signed and dated by the Trust CEO.
- Specific to the action(s) not achieved by the Trust.
- SMART (specific, measurable, achievable, realistic and timely) and must enable the financial calculation of the funding requested.
- Detailed regarding banding and Whole Time Equivalent (WTE). Any new roles to be introduced as part of an action plan must include this information.
- Sustainable - Funding is for one year only, so Trusts must demonstrate how future funding will be secured.
- Only submitted for safety actions that have not been achieved.

NHS England Chief Nursing Officer wrote to all NHS Trusts on 8th April 2021 confirming that commissioners must ensure that any funding awarded to implement the agreed action plan for improvement is ringfenced for the maternity service to support the delivery of the action plan.

Reverification

Reverification is initiated if a concern is raised that a Trust Board may have incorrectly declared compliance with one or more of the ten safety actions' sub-requirements within the MIS. This may be identified through whistleblowing or following a CQC report that may call into question the original declaration. This concern may relate to any completed year of the MIS.

In the first instance, Trusts are asked to complete their own internal review of the evidence that was used to support their compliance for the relevant year at the time of submission. This must be the same evidence that was used to inform the Trust Board at the point of declaration. Trusts will be given the opportunity to downgrade their position at this point.

If following their own internal review, the Trust remains confident that their compliance declaration was correct, the Trust will be asked to provide all of their supporting evidence to NHS Resolution. A full review of the relevant evidence will then be undertaken by two members of the MIS clinical team.

Following this review, any Trusts found to have mis-declared compliance will be notified and will be required to repay the funds originally awarded to them for that MIS year. They will be asked to develop an action plan to introduce safety improvements and work towards full compliance, and they will be advised to bid for discretionary funding to support this action plan. Any discretionary funds agreed must be spent on the improvements in the agreed plan. Any amount of discretionary funding agreed will be deducted from the total MIS rebate amount repayable to NHS Resolution.

If a mis-declaration has been identified (as above), reverification of the previous MIS year will automatically be initiated. When a further mis-declaration is identified, this process will then be repeated for the previous year. This process will be limited to impact the current MIS year, and the two preceding historical MIS years only. For each year where a mis-declaration is identified, the Trust must return to NHS Resolution the full MIS funds originally rewarded for those years, irrespective that they are previous financial years.

Any funds retrieved from non-compliant Trusts will be redistributed to all Trusts that achieved compliance for the applicable MIS year. This redistribution must take place within the same financial year that NHS Resolution receives the funds.

Need Help?

If you have any queries or concerns regarding any aspect of the MIS, please contact the MIS clinical team on nhsr.mis@nhs.net. There is a FutureNHS MIS workspace where queries can be submitted, and additional information and resources will be provided.

To ensure you receive all correspondence relating to the MIS, please add your name to the MIS contacts list.

Safety action 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?

Required Standard
a) **Notify all death:** All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days. (See technical notes 1 to 5). b) **Seek parents' views of care**: For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 1 December 2024 onwards. (See technical notes 6 to 8) c) **Review the death and complete the review:** For deaths of babies who were born and died in your Trust from 1st December 2024 onwards multi-disciplinary reviews using the PMRT should be carried out; 95% of reviews should be started within two months of the death, and a minimum of 75% of multi-disciplinary reviews should be completed and published within six months. For a minimum of 50% of the deaths reviewed an external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT**.** (See technical notes 9 to 18) d) **Report to the Trust Executive:** Quarterly reports of reviews of all deaths should be discussed with the Trust Maternity and Board Level Safety Champions and submitted to the Trust Executive Board on an ongoing basis from 1 December 2024. (See technical notes 19 to 20)
Minimum Evidence Requirement for Trust Board
Notifications must be made, and surveillance forms completed using the MBRRACE-UK reporting website (see technical notes 2 & 4 regarding the introduction of the NHS Submit a Perinatal Event Notification (SPEN) system in 2025). The PMRT must be used to review the care and reports about individual deaths should be generated via the PMRT. A report should be received by the Trust Executive Board each quarter that includes details of the deaths reviewed, any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.
Verification process
Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form by **12 noon** on **3 March 2026**.

NHS Resolution will use data from MBRRACE-UK/PMRT, to cross-reference against Trust self-certifications. MBRRACE-UK/PMRT will take the data extract for verification on 3 February 2026. Note that it is essential that the technical notes are consulted to ensure that each standard is fully understood and met, for example, what 'starting a review' means and how this is assessed in the verification process.
Relevant Time period
From 1 December 2024 to 30 November 2025

Link to technical guidance

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Required Standard
This relates to improving the quality and completeness of the submission to the Maternity Services Data Set (MSDS). 1. July 2025 data contains valid birthweight information for at least 80% of babies born in the month. This requires the recorded weight to be accompanied by a valid unit entry. (Relevant data tables include MSD401; MSD405). 2. July 2025 data contains valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing, and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (Relevant data tables include MSD001; MSD101).
Minimum Evidence Requirement for Trust Board
The Clinical Negligence Scheme for Trusts: Scorecard in the Maternity Services Monthly Statistics publication series can be used to evidence meeting all criteria.
Verification process
All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form by **12 noon** on **3 March 2026**. NHS England will cross-reference self-certification of all criteria against data and provide this information to NHS Resolution.
Relevant Time period
From 2 April 2025 to 30 November 2025

Link to technical guidance

Safety action 3: Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies?

Required Standard
a) Pathways of care into transitional care (TC) are in place which includes babies between 34+0 and 35+6 in alignment with the BAPM Transitional Care Framework for Practice **Or** Be able to evidence progress towards a transitional care pathway from 34+0 in alignment with the British Association of Perinatal Medicine (BAPM) Transitional Care Framework for Practice and submit this to your Trust and the neonatal Operational Delivery Network (ODN) on behalf of the LMNS Boards. b) Drawing on insights from themes identified from any term or late preterm admissions to the neonatal unit, undertake or continue at least one quality improvement initiative to decrease admissions and/or length of infant/mother separation. Progress on initiatives must be shared with the Safety Champions and LMNS.
Minimum Evidence Requirement for Trust Board
Evidence for standard a) to include: **For units with TC pathways** • Local policy/pathway of TC admission criteria based on BAPM framework for Transitional Care and meeting a minimum of at least one element of HRG XA04. **For units working towards TC pathways** • An action plan signed off by Trust and the neonatal ODN on behalf of the LMNS Board for a move towards the TC pathway based on BAPM framework for babies from 34+0 with clear timescales for implementation and progress from MIS Year 6.
Evidence for standard b) to include: 1. By 2 September 2025, register the QI project with local Trust quality/service improvement team. 2. By the end of the reporting period, present an update to the LMNS and Safety Champions regarding development and any progress. OR For units continuing a QI project from the previous year, demonstrate progress at 6 months and end of MIS reporting year with updates to LMNS and Safety Champions.
Verification process
Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by **12 noon** on **3 March 2026**.
Relevant Time period
From 2 April 2025 to 30 November 2025

Link to technical guidance

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Required Standard
a) Obstetric medical workforce
1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas: a. currently work in their unit on the tier 2 or 3 rota or b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) or c. hold a certificate of eligibility (CEL) to undertake short-term locums. Please see technical guidance for further details 2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance to the Trust Board, Trust Board level Safety Champions and LMNS Board. rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf 3) Trusts/organisations should be working towards implementation of the RCOG guidance on compensatory rest where Consultants and Senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. **While this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance.** rcog-guidance-on-compensatory-rest.pdf 4) Trusts should ensure they are compliant with Consultant attendance in person to the clinical situations listed in the RCOG workforce document for a minimum of 80% of applicable situations: 'Roles and Responsibilities of the Consultant providing acute care in obstetrics and gynaecology' into their service roles-responsibilities-consultant-report.pdf
b) Anaesthetic medical workforce
A Duty Anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising Anaesthetic Consultant at all times. Where the Duty Anaesthetist has other

responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)

c) Neonatal medical workforce

The neonatal unit meets the relevant BAPM national standards of medical staffing.

or

the standards are not met but there is an action plan with progress against any previously developed action plans and monitored via a risk register.

Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).

d) Neonatal nursing workforce

The neonatal unit meets the BAPM neonatal nursing standards.

or

the standards are not met but there is an action plan with progress against any previously developed action plans and monitored via a risk register.

Any action plans should be shared with the LMNS and Neonatal ODN.

Minimum Evidence Requirement for Trust Board

Obstetric medical workforce

1) Trusts/organisations should demonstrate their compliance through an audit via Medical Human Resources.

   Information on the CEL for short term locums is available here: www.rcog.org.uk/cel

   This page contains all the information about the CEL including a link to the guidance document:
   Guidance on the engagement of short-term locums in maternity care (rcog.org.uk)

   A publicly available list of those doctors who hold a certificate of eligibility of available at https://cel.rcog.org.uk

2) Trusts should ensure they are compliant with the engagement of long-term locums using the monitoring effectiveness tool contained within the RCOG guidance document (P8).

3) Trusts/organisations should be working towards developing standard operating procedures, to assure Boards 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. Evidence of compliance could also be demonstrated by obtaining feedback from Consultants and senior SAS Doctors about their ability to take appropriate compensatory rest in such situations.
NB. All 3 of the documents referenced are all hosted on the RCOG Safe Staffing Hub Safe staffing | RCOG

4) Trusts' positions with the requirement should be shared with the Trust Board, the Board-level Safety Champions as well as LMNS.

Anaesthetic medical workforce

The rota should be used to evidence compliance with ACSA standard 1.7.2.1. This can be a representative month of the rota.

Neonatal medical workforce

The Trust is required to formally record in Trust Board minutes whether it meets the relevant BAPM recommendations of the neonatal medical workforce.

If the requirements are not met, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies. The agreed action plan should be monitored via a risk register.

A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN).

Neonatal nursing workforce

The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020).

For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies. The agreed action plan should be monitored via a risk register.

A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal ODN.

Verification process
Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by **12 noon** on **3 March 2026**.
Relevant Time period
From 2 April 2025 to 30 November 2025

Link to technical guidance

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Required Standard
a) A systematic, evidence-based process to calculate midwifery staffing establishment has been completed within the last three years. If this process has not been completed within three years due to measures outside the Trust's control, evidence of communication with the BirthRate+ organisation (or equivalent) should demonstrate this. b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above. c) The Midwifery Coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator **at the start of every shift**) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift. d) All women in active labour receive one-to-one midwifery care. e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Trust Board every six months (in line with NICE midwifery staffing guidance), during the MIS year seven reporting period.
Minimum Evidence Requirement for Trust Board
The midwifery staffing report submitted will comprise evidence to support a, b, c and d progress or achievement. It should include: • A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated. • In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. • Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.

- The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners.

- Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing.

    - The Midwife to birth ratio.

    - The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.

- Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty at the start of every shift and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.

Verification process

Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by **12 noon** on **3 March 2026**.

Relevant Time period

From 2 April 2025 to 30 November 2025

Link to technical guidance

Safety action 6: Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

Required Standard
Provide assurance to the Trust Board and ICB that you are on track to achieve compliance with all six elements of the current version of SBLCB v3 through quarterly quality improvement discussions with the ICB.
Minimum Evidence Requirement for Trust Board
Trusts should be able to demonstrate that at least two (and up to three) quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust. These discussions should include the following: • Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. • Progress against locally agreed improvement aims. • Evidence of sustained improvement where high levels of reliability have already been achieved. • Regular review of local themes and trends with regard to potential harms in each of the six elements. • Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate. *The Three-Year Delivery Plan for Maternity and Neonatal Services* set out that providers should fully implement Saving Babies Lives Version Three by March 2024. However, where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory. To support compliance, a national Implementation Tool is available for trusts to use if they wish on the Maternity Transformation Programme's Future NHS platform. If used, the tool can support providers to baseline current practice against SBLCBv3, agree a local improvement trajectory with their ICB, and track progress locally in accordance with that trajectory. Where Trusts are not using the Implementation Tool as evidence of compliance, they should provide a signed declaration from the Executive Medical Director declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB.
Verification process

Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by **12 noon** on **3 March 2026**.
Relevant Time period
From 2 April 2025 to 30 November 2025

Link to technical guidance

Safety action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

Required Standard

1. Trusts should work with their LMNS/ICB to ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (published November 2023) including supporting:

   a) Infrastructure
   b) Strategic influence and decision-making.
   c) Engagement and listening to families.

2. Trusts should ensure an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including joint analysis of free text data, and progress monitored regularly by Safety Champions and LMNS Board.

Minimum Evidence Requirement for Trust Board

1.

a) Evidence of MNVP infrastructure being in place from your LMNS/ICB including all of the following:

- Job descriptions for MNVP team
- Contracts for service or grant agreements
- Budget with allocated funds for IT, comms, engagement, training and administrative support
- Local service user volunteer expenses policy including out of pocket expenses and childcare costs

If the above evidence of an MNVP, commissioned and functioning as per national guidance, is unobtainable, there should be evidence that this has been escalated via the Perinatal Quality Surveillance Model (PQSM) at trust, ICB and regional level.

If evidence for a) cannot be provided, then the escalation route must be followed as stated above.

Evidence requirements for b) and c) are only required if evidence has been provided for a)

b) Terms of Reference and evidence of attendance including minutes/action logs that show the MNVP Lead as a quorate member of trust governance, quality, and

safety meetings at speciality/divisional/directorate level including all of the following:

- Safety Champion meetings
- Maternity quality and safety meetings
- Neonatal quality and safety meetings
- PMRT review meeting
- Patient safety meeting
- Guideline committees

c) Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.

2) Evidence of an action plan coproduced following joint review of the annual CQC Maternity Survey free text data which CQC have confirmed is available to all trusts free of charge.

Verification process

Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by **12 noon** on **3 March 2026**.

Relevant Time period

From 2 April 2025 to 30 November 2025

Link to technical guidance

Safety action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi-professional training?

Required Standard
90% of attendance in each relevant staff group at: 1. Fetal monitoring training 2. Multi-professional maternity emergencies training 3. Neonatal resuscitation training See technical guidance for full details of relevant staff groups. ALL staff working in maternity should attend annual training. A 90% minimum compliance is required for every staff group by the end of the MIS year 7 period (30 November 2025). For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. A commitment and action plan approved by Trust Board must be formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust. It is important for units to continue to implement all six core modules of the Core Competency Framework, but this will not be measured in Safety Action 8.
Minimum Evidence Requirement for Trust Board
*See technical guidance for details of training requirements and evidence.
Verification process
Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by **12 noon** on **3 March 2026**.
Relevant Time period
From 1 December 2024 to 30 November 2025

Link to technical guidance

Safety action 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?

Required Standard

a) All Trust requirements of the Perinatal Quality Surveillance Model (PQSM) must be fully embedded with evidence of Trusts working towards the revised Perinatal Quality Oversight Model (PQOM) when published in 2025.

b) The expectation is that discussions regarding safety intelligence take place at the Trust Board (or at an appropriate sub-committee with delegated responsibility), as they are responsible and accountable for effective patient safety incident management and shared learning in their organisation. These discussions must include ongoing monitoring of services and trends, with evidence of reporting/escalation to the LMNS/ODN/ICB/ Local & Regional Learning System meetings.

c) All Trusts must have Maternity and Neonatal Board Safety Champions (BSC) who are actively supporting the perinatal leadership team in their work to better understand and craft local cultures.

Minimum Evidence Requirement for Trust Board

Evidence for point a) and b)

- Evidence that a non-executive director (NED) has been appointed and is working with the BSC to develop collaborative relationships between staff, the frontline Maternity, Neonatal and Obstetric Safety Champions, the Perinatal Leadership Team and the Trust Board to understand, communicate and champion learning, challenges, and best practice.

- Evidence that a review of maternity and neonatal quality and safety is undertaken by the Trust Board (or an appropriate Trust committee with delegated responsibility) using a minimum data set as outlined in the PQSM at least quarterly. This should be presented by a member of the **Perinatal leadership team** to provide supporting context. In line with the PQSM, this must include a review of thematic learning informed by PSIRF, training compliance, minimum staffing in maternity and neonatal units, and service user voice and staff feedback and review of the culture survey or equivalent.

- Evidence of collaboration with the LMNS/ODN/ICB lead(s), showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM.

- Evidence of ongoing engagement sessions with staff as previous years of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2025.

- Evidence that in addition to the regular Trust Board/sub-committee review of maternity and neonatal quality as described above, the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting. Scorecard data is triangulated with other quality and safety metrics to inform targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. These quarterly discussions must be held at least twice in the MIS reporting period at a Board or directorate level quality meeting.

Evidence for point c):

Evidence that the Board Safety Champions are supporting their perinatal leadership team to better understand and craft local cultures, including identifying and escalating safety and quality concerns and offering relevant support where required. This will include:

- Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal Leadership Team and the MNVP lead (where their infrastructure is in, as per safety action 7 place) at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.
- Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.

Verification process
All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form by **12 noon** on **3 March 2026**.
Relevant Time period
From 2 April 2025 to 30 November 2025

Link to technical guidance

Safety action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025

Required Standard
(A) Reporting of all qualifying cases to MNSI from 1 December 2024 to 30 November 2025. (B) Reporting of all qualifying EN cases to NHS Resolution's EN Scheme from 1 December 2024 until 30 November 2025. (C) For all qualifying cases which have occurred during the period 1 December 2024 to 30 November 2025, the Trust Board are assured that: i. the family have received information on the role of MNSI and NHS Resolution's EN scheme in a format that is accessible to them[1]; and ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour. 1 https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/accessibleinfo/
Minimum Evidence Requirement for Trust Board
Trust Board sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution. **Trust Board** sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme. This needs to include reporting where families required a format to make the information accessible to them and should include any occasions where this has not been possible, with a SMART plan to address any challenges for the future. **Trust Board** sight of evidence of compliance with the statutory duty of candour.
Verification process
All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form by **12 noon** on **3 March 2026**. There is also an external verification process. MNSI will cross-check the National Neonatal Research Database (NNRD) and NHS Resolution will cross-check the NHS Resolution database for qualifying MNSI and EN incidents reportable from 1 December 2024 until 30 November 2025 and will externally verify that standards A and B have been met in the relevant reporting period.

In addition, for standard B and C(i) there is a requirement to complete the field on NHS Resolution's Claims Reporting Wizard (CMS), whether families have been advised of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.
Relevant Time period
From 1 December 2024 to 30 November 2025

Link to technical guidance

Technical Guidance

Technical Guidance for Safety Action 1	
Further guidance and information is available on the PMRT website: Maternity Incentive Scheme FAQs. This includes information about how you can use the downloadable reports from the PMRT case management system to track your notifications, reviews and your progress throughout the year meeting Safety Action 1 standard: www.npeu.ox.ac.uk/pmrt/faqsmis These FAQs are also available on the MBRRACE-UK/PMRT reporting website www.mbrrace.ox.ac.uk	
SA 1(a) – Notify all eligible deaths	
1.Which perinatal deaths must be notified to MBRRACE-UK?	Details of which perinatal deaths must be notified to MBRRACE-UK are available at: www.npeu.ox.ac.uk/mbrrace-uk/perinatal-programme
2.Where are perinatal deaths notified?	Notifications of deaths must be made, and surveillance forms completed, using the MBRRACE-UK reporting website. It is planned that the Submit a Perinatal Event Notification (SPEN) system will be released by NHS England in 2025. Once this is released notifications of deaths must be made through SPEN and this information will be passed to MBRRACE-UK. It will still then be necessary for reporters to log into the MBRRACE-UK/PMRT system to provide the surveillance information, update the notification if required and to use the PMRT.
3.Should we notify babies who die at home?	Notification and surveillance information must be provided for babies who died after a home birth where care was provided by your Trust and those babies who die at home having been discharged from your Trust.
4.What is the time limit for notifying a perinatal death?	All perinatal deaths eligible to be reported to MBRRACE-UK, via SPEN when available, must be notified to MBRRACE-UK within seven working days.
5.What are the statutory obligations to notify neonatal deaths?	The Child Death Review Statutory and Operational Guidance (England) sets out the obligations of notification of neonatal deaths to local Child Death Overview Panels. Neonatal deaths must be notified to Child Death Overview Panels (CDOPs) within two working days of the death (where working days are regarded as Monday to Friday).

	This guidance is available at: https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england MBRRACE-UK is now the mechanism for reporting neonatal deaths to the relevant CDOP and the National Child Mortality Database (NCMD). The notification of a neonatal death to MBRRACE-UK will automatically be notified to the local CDOP and the NCMD.
SA 1(b) – Seek parents' view of care	
6.We have informed parents that a local review will take place and they have been asked if they have any feedback or questions about their care. However, this information is recorded in another data system and not the clinical records. What should we do?	In order that parents' feedback, perspectives, and any questions they have can be considered during the review, this information needs to be incorporated as part of the review and entered into the PMRT. So, if this information is held in another data system it needs to be brought to the review meeting, incorporated into the PMRT and considered as part of the review discussion. The importance of parents' feedback and perspectives is highlighted by their inclusion as the first set of questions in the PMRT. Materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials
7.We have contacted the bereaved parents and they don't wish to have any involvement in the review process. What should we do?	Following the death of their baby, before they leave the hospital, all parents must be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of a neonatal death parents should also be told that a review will be undertaken by the local CDOP. Verbal information should be supplemented by written information. The process of parent engagement should be guided by the parents. Not all parents will wish to provide their perspective of the care they received or raise any questions and/or concerns, but all parents should be given the opportunity to do so. Some parents may also change their mind about being involved and, without being intrusive, they should be given more than one opportunity to provide their feedback and raise any questions and/or concerns they may subsequently have about their care. Materials to support parent engagement in the local review process are available on the PMRT website at:

	https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials
8.Parents have not responded to our messages and therefore we are unable to discuss their feedback at the review. What should we do?	Following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of a neonatal death parents should also be told that a review will be undertaken by the local CDOP. Verbal information should be supplemented by written information. If, for any reason, this does not happen and parents cannot be reached after three phone/email attempts, send parents a letter informing them of the review process and inviting them to be in touch with a key contact, if they wish. In addition, if a cause for concern for the mother's wellbeing was raised during her pregnancy consider contacting her GP/primary carer to reach her. If parents do not wish to input into the review process, ask how they would like findings of the perinatal mortality review report communicated to them. Consider whether parental feedback could be impacted by communication barriers, such as reading level or their first language not being English. For some parents, it may be necessary to give them the opportunity to provide feedback via a number of different methods. Materials to support parent engagement in the local review process, including an outline of the role of key contact, are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials PMRT parent materials have been translated into Welsh and the eleven most common languages spoken other than English. See the notes accompanying the flowchart as well as template letters and ensure engagement with parents is recorded within the parent engagement section of the PMRT.
SA 1(c) – Review the death and complete the review	
9.Which perinatal deaths must be reviewed to meet safety action one standards?	The following deaths should be reviewed to meet safety action one standards: i. Late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation)

	ii. Stillbirths (from 24+0 weeks' gestation) iii. Neonatal death from 22 weeks' gestation (or 500g if gestation unknown) up to 28 days after birth While it is possible to use the PMRT to review post neonatal deaths (from 29 days after birth) this is NOT a requirement to meet the safety action one standard.
10.What is meant by "starting" a review using the PMRT?	Starting a review in the PMRT requires the death to be notified to MBRRACE-UK for surveillance purposes, and the PMRT to be used to complete the first review session (which might be the first session of several) for that death. As an absolute minimum all the 'factual' questions in the PMRT must be completed for the review to be regarded as started; it is not sufficient to just open and close the PMRT tool, this does not meet the criterion of having started a review. The factual questions are highlighted within the PMRT with the symbol: FQ If the PMRT is completed for the booking and antenatal management questions this will ensure that all the relevant factual questions have been answered.
11.What does "multi-disciplinary reviews" mean?	To be multi-disciplinary the team conducting the review should include at least one and preferably two of each of the professionals involved in the care of pregnant women and their babies. Ideally the team should also include an external member (see below). Bereavement care staff (Midwives and Nurses) should form part of the review team to provide their expertise in reviewing the bereavement and follow-up care, and advocate for the parents. Unless they have been specifically employed to do so, it should not be the responsibility of bereavement care staff to run the reviews, chair the panels nor provide administrative support. A list of the members needed to conduct a multi-disciplinary review is available here: https://www.npeu.ox.ac.uk/pmrt/implementation-support See www.npeu.ox.ac.uk/pmrt/faqsmis for more details about multi-disciplinary review.
12.Who can be an "external panel member"?	External panel member(s) should be relevant senior clinicians who are currently practicing clinically and work in a hospital external to the trust undertaking the review and external to any trust involved in the care at any stage.

	Their role is to be present at the review panel and actively participate in the review to provide a 'fresh pair of eyes', independent and robust view of the care provided. This may involve challenging the care that was provided. They should be from a relevant specialities (you may require more than one dependent on the details of the case) and should be senior enough to provide challenge where appropriate and should actively participate in the discussions about the care. If more than one Trust is involved in the review, because more than one Trust was involved in the care, none of these staff members are 'external' panel members because they do not provide an independent view of the care. They should not be listed as 'external' members in the participant list. Although the MNVP member (see SA7) may not be employed directly by the Trust they should not be regarded as, nor documented as, an 'external' member. They are present to represent the wider parent voice. To ensure that external members of the review panel are identified as such the 'participant' feature in the PMRT system has been modified so that this is clear. See www.npeu.ox.ac.uk/pmrt/faqsmis for more details of how to identify external participants.
13.What should we do if our post-mortem service has a long turn-around time or a Coronial post-mortem is likely to take a long time?	For deaths where a post-mortem (PM) has been requested (hospital or coronial) and is likely to take more than six months for the results to be available, the PMRT team at MBRRACE-UK advise that you should start the review of the death, complete and publish the report using the information you have available. When the PM results come back you should contact the PMRT team at MBRRACE-UK who will re-open the review so that the information from the PM can be included. Should the PM findings change the original review findings then a further review session should be carried out taking into account this new information. If you wait until the PM is available before starting a review you risk missing earlier learning opportunities, especially if the turn-around time is considerably longer than six months. Where the post-mortem turn-around time is quicker, then the information from the post-mortem can be included in the original review. Families should be kept informed throughout.

14.What is review assignment?	Where care has been provided in more than one Trust, ideally the review should involve all Trusts in a joint meeting. However, this is not always possible. A feature available in the PMRT is the ability to assign reviews to another Trust for review of elements of the care if some of the care for the women and/or her baby was provided in another Trust. For example, if the baby died in your Trust but antenatal care was provided in another Trust you can assign the review to the other Trust so that they can review the care that they provided. Following their review, the other Trust reassigns the review back to your Trust. You can then review the subsequent care your Trust provided. This avoids multiple, and potentially conflicting, reports being produced, the outcomes of which can be confusing for parents. Instead, a single report is produced, covering the care provided by all Trusts, which can then be summarised as a whole for parents.
15.How does 'assigning a review' impact on safety action 1, especially on starting a review?	If you need to assign a review to another Trust this may affect the ability to meet some of the deadlines for starting, completing and publishing that review. This will be accounted for in the PMRT verification process.
16.What should we do if we do not have any eligible perinatal deaths to review within the relevant time period?	If you do not have any babies that have died between 1 December 2024 and 30 November 2025 you should partner-up with a Trust with which you have a referral relationship to participate in case reviews. This will ensure that you benefit from the learning that arises from conducting reviews.
17.What deaths should we review outside the relevant time period for the Year 7 MIS?	Trusts should review all eligible deaths using the PMRT as a routine ongoing process, irrespective of the timeframe and verification process. Notification, provision of surveillance information and reviewing should continue beyond the deadline for completing the year 7 MIS requirements.
18.What happens when an MNSI (formerly HSIB) investigation takes place?	It is recognised that for a small number of deaths (term intrapartum stillbirths and early neonatal deaths of babies born at term) investigations will be carried out by MNSI (formerly HSIB). Your local review using the PMRT should be started (to identify any early and immediate learning which needs to be actioned) but not completed until the MNSI report is complete. You should consider inviting the MNSI reviewers to attend these reviews to act as external members of the review team, thereby enabling the

	learning from the MNSI review to be incorporated into the PMRT review. Depending upon the timing of the MNSI report completion achieving the standards for these babies may therefore be impacted by timeframes beyond the Trust's control. For an individual death you can indicate in the MBRRACE-UK/PMRT case management screen that an MNSI investigation is taking place, and this will be accounted for in the external verification process
SA 1(d) – Report to the Trust Executive Board	
19.Can the PMRT help by providing a quarterly report that can be presented to the Trust Executive Board?	Authorised PMRT users can generate reports for their Trust, summarising the results from completed reviews over a period of time defined by the user. These are available under the 'Your Data' tab in the section entitled 'Perinatal Mortality Reviews Summary Report and Data extracts'. These reports can be used as the basis for quarterly Trust Board reports and should be discussed with Trust Maternity Safety Champions.
20.Is the quarterly review of the Trust Executive Board report based on a financial or calendar year?	This can be either a financial or calendar year. Reports for the Trust Executive Board summarising the results from completed reviews over a period time can be generated within the PMRT, by authorised PMRT users, for a user-defined period of time. These are available under the 'Your Data' tab and the report is entitled 'Perinatal Mortality Reviews Summary Report and Data extracts'. Note that these reports will only show summaries, issues and action plans for reviews that have been completed and published, therefore the time period selected may need to relate to an earlier period than the current quarter and may lag behind the current quarter by up to six months.
Guidance – technical issues and updates	
What should we do if we experience technical issues using PMRT?	All Trusts are reminded to contact their IT department regarding any technical issue in the first instance. If this cannot be resolved, then the issue should be escalated to MBRRACE-UK. This can be done through the 'contact us' facility within the MBRRACE-UK/PMRT system or by emailing us at: mbrrace.support@npeu.ox.ac.uk

If there are any updates on the PMRT for the MIS**, where will they be published?**	Any updates on the PMRT or the MBRRACE-UK notification and surveillance in relation to the MIS safety action 1, will be communicated via NHS Resolution email and will also be included in the MBRRACE-UK/PMRT 'message of the day'.

Link to Safety Action 1

Technical Guidance for Safety Action 2	
For criteria 1 how is the measure constructed?	***Numerator***: Number of MSD401 records in the reporting period with a birth date in the reporting period, with a corresponding MSD405 record in the reporting period where a valid birthweight is recorded. ***Denominator***: Number of MSD401 records in the reporting period with a birth date in the reporting period.
What counts as valid birthweight recording in the MSD405CareActivityBaby table?	A valid birthweight record requires all three of the following: 1. An appropriate birthweight SNOMED code in the MSD405.ObsCode field (see metadata* for list of codes). 2. The numerical birthweight is recorded in the MSD405.ObsValue field. 3. The relevant unit ('G', 'KG', or 'Kilograms') is recorded in the MSD405.UCUMUnit field. The full metadata for this criteria can be found on the Metadata page in the Clinical Negligence Scheme for Trusts Scorecard
Where can I find out further technical information on the above metrics?	Technical information, including relevant MSDSv2 fields and data thresholds required to pass the above metrics can be accessed on NHS Digital's website In the "Meta Data" file (see 'construction' tabs) available within the Maternity Services Monthly Statistics publication series: https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics
Where can I find out more about MSDSv2?	https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set
Where should I send any queries?	**On MSDS data** For queries regarding your MSDS data submission, or on how your data is reported in the monthly publication series or on the Maternity Services DashBoard please contact maternity.dq@nhs.net. **For any other queries**, please email nhsr.mis@nhs.net

Link to Safety Action 2

Technical Guidance for Safety Action 3	
What is the definition of transitional care?	Transitional care is not a place but a service (see BAPM guidance) and can be delivered either in a separate transitional care area, within the neonatal unit and/or in the postnatal ward setting. Principles include the need for a multidisciplinary approach between maternity and neonatal teams; an appropriately skilled and trained workforce, data collection with regards to activity, appropriate admissions as per HRGXA04 criteria and a link to community services.
How can we evidence progress towards a transitional care service?	A current action plan with specified timescales and progress against these should be reviewed by the Trust and the neonatal ODN on behalf of the LMNS Boards before the 30 November 2025.
How do we identify our themes of unplanned term admissions?	All term admissions will be reported through DATIX/LFPSE (as per local implementation of PSIRF) and themes identified through this intelligence. ATAIN proforma reviews are no longer mandated.
Late preterm infants are now included- why?	Some units with an established transitional care service may choose to review reasons late preterm infants (34-36+6) are admitted to the neonatal unit (rather than to a transitional care unit). The focus of QI projects should be to reduce infant/mother separation. Routine review of admissions of late preterm infants is not required for this safety action.
Who should be involved in the quality improvement initiatives?	The team should include members of maternity and neonatal multidisciplinary team including liaising with service user representative (MNVP) and support sourced from Trust quality improvement and service improvement teams if required.
How do we register our quality improvement initiative?	This will vary depending on local Trust policy. In the absence of any Trust policy, evidence of registering the quality improvement initiative, could be documented in the Safety Champion minutes.

What is considered as evidence of an update on the quality improvement initiative?	Evidence should include: 1) a presentation to the LMNS which includes an aim statement, measures, change actions and outcomes. 2) Discussion with Safety Champions and noted in the minutes at least once before the end of the reporting period.
Can we continue the QI project commenced in year 6?	Yes, If the QI project undertaken in year 6 is felt to be progressing this safety action, it can continue to be used as a QI project for year 7. However, this should be discussed and agreed with the LMNS and Safety Champion In this case evidence should include 1. Presentation to the LMNS of progress at 6 months and at the end of the reporting period 2. Discussion with Safety Champions and noted in the minutes at least once before the end of the reporting period.
Where can we find additional guidance regarding this safety action?	https://www.bapm.org/resources/24-neonatal-transitional-care-a-framework-for-practice-2017 https://www.e-lfh.org.uk/programmes/avoiding-term-admissions-into-neonatal-units/ Implementing-the-Recommendations-of-the-Neonatal-Critical-Care-Transformation-Review-FINAL.pdf (england.nhs.uk) Framework: Early Postnatal Care of the Moderate-Late Preterm Infant | British Association of Perinatal Medicine (bapm.org) B1915-three-year-delivery-plan-for-maternity-and-neonatal-services-march-2023.pdf (england.nhs.uk) The Handbook of Quality and Service Improvement Tools: the_handbook_of_quality_and_service_improvement_tools_2010-2.pdf (england.nhs.uk)

Link to Safety Action 3

Technical Guidance for Safety Action 4	
a) Obstetric medical workforce guidance	
How can the Trust monitor adherence with the standard relating to short term locums?	Trusts should establish whether any short-term (2 weeks or less) tier 2/3 locums have been undertaken between February and August 2025. Medical Human Resources (HR) or equivalent should confirm that all such locums met the required criteria.
What should a department do if there is non-compliance i.e. locums employed who do not meet the required criteria?	Trusts should review their approval processes and produce an action plan to ensure future compliance.
Can we self-certify compliance with this element of safety action 4 if locums are employed who do not meet the required criteria?	No. An action plan must be developed to prevent this happening in the future, but Trusts would still need to declare non-compliance with this action.
Where can I find the documents relating to short-term locums?	All related documents are available on the RCOG safe staffing page. Safe staffing | RCOG
How can the Trust monitor adherence with the standard relating to long-term locums?	Trusts should use the monitoring/effectiveness tool contained within the guidance (p8) to audit their compliance for each new long-term locum who starts at the Trust over a 6-month period after February 2025 to 30 November 2025.
What should a department do if there is a lack of compliance demonstrated in the audit tool regarding the support and supervision of long-term locums?	Trusts should review their audits and identify where improvements to their process needs to be made. They should produce a plan to address any shortfalls in compliance and assure the Board this is in place and being addressed.
Can we self-certify compliance with this element of safety action 4 if long-term locums are employed	No.

who are not fully supported/supervised?	
Where can I find the documents relating to long-term locums?	All related documents are available on the RCOG safe staffing page. Safe staffing | RCOG
How can the Trust monitor adherence with the standard relating to Standard operating procedures for Consultants and SAS Doctors taking compensatory rest after non-resident on call?	Trusts should have documentary evidence of standard operating procedures and their implementation. Evidence of implementation/compliance could be demonstrated by obtaining feedback from Consultants and SAS doctors about their ability to take appropriate compensatory rest in such situations.
What should a department do if there is a lack of compliance, either no Standard operating procedure or failure to implement such that senior medical staff are unable to access compensatory rest?	Trusts should have a standard operating procedure document regarding compensatory rest. Trusts should identify any lapses in compliance and where improvements to their process needs to be made. They should produce a plan to address any shortfalls in compliance and have this as evidence that they are working towards compliance.
Can we declare compliance with this element of safety action 4 if we do not have a standard operating procedure or it is not fully implemented?	Yes. However, while this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance.
Where can I find the documents relating to compensatory rest for Consultants and SAS Doctors?	All related documents are available on the RCOG safe staffing page. Safe staffing | RCOG
How can the Trust monitor adherence with the standard relating to Consultant attendance out of hours?	Departments can audit Consultant attendance for clinical scenarios or situations mandating their presence in the guidance. Trusts should audit any 3-month period from February 2025 to 30 November 2025 and must be compliant for at least 80% of applicable situations. Departments may also wish to monitor adherence via incident reporting systems.

	Feedback from departmental or other surveys may also be employed for triangulation of compliance.
What should a department do if there is non-compliance with attending mandatory scenarios/situations?	Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.
Can we self-certify compliance with this element of safety action 4 if Consultants have not attended all clinical situations on the mandated list?	Yes, as long as compliance can be demonstrated for 80% of applicable clinical situations as detailed in the RCOG roles and responsibilities of the Consultant providing acute care in obstetrics and gynaecology RCOG workforce document.
Where can I find the roles and responsibilities of the Consultant providing acute care in obstetrics and gynaecology RCOG workforce document?	https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/
For queries regarding this safety action please contact: nhsr.mis@nhs.net (MIS Team) or workforce@rcog.org.uk (RCOG).	
b) Anaesthetic medical workforce guidance	
Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1	A duty anaesthetist is immediately available for the obstetric unit 24 hours a day. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patient in order to be able to attend immediately to obstetric patients.
c) Neonatal medical workforce guidance	
Do you meet the BAPM national standards of medical staffing depending on unit designation?	If not, Trust Board should agree an action plan and outline progress against any previously agreed action plans. There should also be an indication as to whether the standards are not met is due to insufficient funded posts or no trainee or/suitable applicant for the post (rota gap) alongside a record of the rota tier affected by the gaps.

	This action plan should be submitted to the LMNS and ODN.
BAPM BAPM_Service_Quality_Standards_FINAL.pdf (amazonaws.com)	
NICU **Neonatal Intensive Care Unit**	All staffing roles should be limited to neonatal care at all levels, i.e. no cross cover with general paediatrics. Trusts that have more than one NNU providing IC or HD care should have separate cover at all levels of medical staffing appropriate for each level of unit. **Tier 1** Rotas should be European Working Time Directive (EWTD) compliant and have a minimum of 8 WTE staff Units with more than 7000 deliveries should have more than one Tier 1 medical support **Tier 2** EWTD compliant rota with a minimum of 8 WTE staff NICUs undertaking more than 2500 IC days per annum should augment their Tier 2 medical cover (more than one staff member per shift) **Tier 3** Minimum of 7 WTE Consultants on the on-call rota with 24/7 availability of a Consultant Neonatologist NICUs undertaking more than 2500 IC days per annum should provide two Consultant led teams during normal working hours. Neonatal Consultant staff should be available on site in all NICUs for at least 12 hours a day,

	generally expected to include two ward rounds/handovers For units undertaking more than 4000 IC days per annum, consideration should be given to 24-hour Consultant presence All NICU Consultants appointed from 2010 should have CCT or equivalent in Neonatal Medicine.
LNU **Local Neonatal Unit**	Where LNUs have a very busy paediatric/neonatal service and/or have neonatal and paediatric services that are a significant distance apart, the above staffing levels should be enhanced. The threshold should be judged and monitored on clinical governance grounds such as the ability consistently to attend paediatric or neonatal emergencies immediately when summoned. Units with more than 7000 deliveries should have more than one Tier 1 medical support. **Tier 1** Rotas should be EWTD compliant and have a minimum of 8 WTE staff who do not cover general paediatrics in addition. **Tier 2** Shared rota with paediatrics as determined by a Trust or Health Board's annual NNU activity, comprising a minimum of 8 WTE staff. **Tier 3** Consultants should have a CCT in paediatrics or CESR in paediatrics or an equivalent overseas neonatal or paediatric qualification and substantial exposure to tertiary neonatal practice at least the equivalent of neonatal SPIN. At least one LNU Tier 3 Consultant should have either a CCT in neonatal medicine or neonatal SPIN module (if this was available during training). All Consultants covering the service must demonstrate expertise in neonatal care (based

	on training, experience, CPD and on-going appraisal).
SCU **Special Care Unit**	**Tier 1** Rotas should be EWTD compliant and have a minimum of 8 WTE staff who may additionally cover paediatrics if this does not reduce safety and quality of care delivery. There should be a resident Tier 1 practitioner dedicated to the neonatal service during weekday day-time hours and an immediately available resident Tier 1 practitioner 24/7. **Tier 2** Shared rota with paediatrics comprising a minimum of 8 WTE staff. Tiers 1 and/or 2 may be able to be covered by appropriately skilled nursing staff **Tier 3** A minimum of 7 WTE Consultants on the on-call rota with a minimum of 1 Consultant with a designated lead interest in neonatology. Tier 3 Consultants should have a Certificate of CCT in paediatrics or Certificate of Eligibility for Specialist Registration (CESR) in paediatrics or an equivalent overseas neonatal or paediatric qualification. They must demonstrate knowledge, skills and CPD appropriate for the level of neonatal care through annual appraisal. Minimum of 1 Consultant with a designated lead interest in neonatology, who should have completed a special interest (SPIN) module in Neonatology*. (if this was available during training)
Our Trust do not meet the relevant neonatal medical standards and in view of this an	There also needs to be evidence of progress against any previously agreed action plans. This will enable Trusts to declare compliance with this sub-requirement.

action plan, ratified by the Board has been developed. Can we declare compliance with this sub-requirement?	
When should the review take place?	The review should take place at least once during the MIS year 7 reporting period.
Which risk register should this be on?	This should be locally decided depending on individual provider arrangements to ensure regular progress and monitoring.
Please access the followings for further information on Standards	BAPM_Service_Quality_Standards_FINAL.pdf (amazonaws.com)
d) Neonatal nursing workforce guidance	
Where can we find more information about the requirements for neonatal nursing workforce?	Neonatal Nurse staffing standards are set out in the BAPM Service and Quality Standards (2022) service-and-quality-standards-for-provision-of-neonatal-care-in-the-uk The Neonatal Nursing Workforce Calculator (2020) should be used to calculate cot side care and guidance for this tool is available here: Guidance-for-Neonatal-Nursing-Workforce-Tool.pdf Access to the tool and more information will be available through your Neonatal ODN Education and Workforce Lead Nurse.
Our Trust does not meet the relevant nursing standards and in view of this an action plan, ratified by the Board has been developed. Can we declare compliance with this sub-requirement?	There also needs to be evidence of progress against any previously agreed action plans. This will enable Trusts to declare compliance with this sub-requirement.

Link to Safety Action 4

Technical Guidance for Safety Action 5	
What midwifery red flag events could be included in six monthly staffing report (examples only)? **We recommend that Trusts continue to monitor the red flags as per previous year and include those in the six-monthly report to the Trust Board, however this is currently not within the minimal evidential requirements but more a recommendation based on good practice.**	• Redeployment of staff to other services/sites/wards based on acuity. • Delayed or cancelled time critical activity. • Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing). • Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication). • Delay of more than 30 minutes in providing pain relief. • Delay of 30 minutes or more between presentation and triage. • Full clinical examination not carried out when presenting in labour. • Delay of two hours or more between admission for induction and beginning of process. • Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output). • Any occasion when one Midwife is not able to provide continuous one-to-one care and support to a woman during established labour. Other midwifery red flags may be agreed locally. Please see the following NICE guidance for further details and definitions: safe-midwifery-staffing-for-maternity-settings-pdf-51040125637
Can the labour ward coordinator be considered to be supernumerary if for example they had to relieve staff for breaks on a shift?	A supernumerary coordinator must be allocated for every shift and must start each shift with protected supernumerary status. It is accepted that there may be short periods when the coordinator is temporarily unavailable due to rapidly changing acuity on the labour ward to ensure safety for women, families and staff in the department. The co-ordinator should exercise professional judgement and escalate, if covering for breaks creates a safety risk to other women on labour ward. As long as there is clear evidence that the local escalation policy has been initiated in these circumstances, and this

	is not a recurrent daily event, Trusts may declare compliance with this standard. If the co-ordinator is regularly required to cover for breaks (more than 2-3 times a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in their action plan mentioned in the section above.
What if we do not have 100% supernumerary status for the labour ward coordinator?	An action plan should be produced detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved.
What if we do not have 100% compliance for 1:1 care in active labour?	An action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. Completion of the action plan will enable the Trust to declare compliance with this sub-requirement.
What if we have been unable to complete a BirthRate+ review within three years due to measure outside the Trust's control?	If this process was commenced but has not been completed within three years due to measures outside the Trust's control, evidence of communication with the BirthRate+ organisation (or equivalent) should demonstrate this.
What should we do if we disagree with the findings of a BirthRate+ review for our circumstances?	BirthRate+ encourages the use of professional judgement in the final determination of maternity safe staffing levels in line with the safe staffing guideline. Professional judgment on safe staffing numbers / levels is the responsibility of the Director of Midwifery / Head of Midwifery, and any deviation from the findings of the BirthRate+ (or equivalent) should be highlighted and clearly documented in the midwifery staffing oversight report that is shared with Board.

Link to Safety Action 5

Technical Guidance for Safety Action 6	
Where can we find guidance regarding this safety action?	Saving Babies' Lives Care Bundle v3: saving-babies-lives-version-three/ An implementation tool is available for trusts to use if they wish at future.nhs.uk/SavingBabiesLives and includes a technical glossary for all metrics and measures. For any further queries regarding the bundle or tool, please email england.maternitytransformation@nhs.net Any queries related to MSDS issues for this safety action can be sent to NHS Digital mailbox maternity.dq@nhs.net. Some data items are (or will later become available) on the National Maternity Dashboard (Element 1); from NNAP Online (Element 5); and from NPID (Element 6). For any other queries relating to MIS compliance, please email nhsr.mis@nhs.net
Is there a requirement on Trusts to evidence SBLCB process and outcome measures through their data submissions to Maternity Services Data Set?	Trusts should be capturing SBLCB data as far as possible in their Maternity Information Systems/Electronic Patient Records and submitted to the MSDS. Where MSDS does not capture all process and outcome indicators given in the care bundle, this is indicated in the Implementation Tool.
What percentage performance is required to be compliant for a given intervention?	Where element process and outcome measures are listed in the evidence requirement of the SBLCB V3 a performance threshold is recommended. However, LMNS/ICBs are able to agree local performance thresholds with a provider in view of local circumstances, and the agreed local improvement trajectory.
How do we provide evidence for the interventions that have been implemented?	Trusts will need to verify with their LMNS/ICB that they have an implemented service locally.
Will the eLfH modules be updated in line with SBLCBv3?	The SBL e-learning for health modules have all been updated to reflect the changes in version 3. A new module for element 6 has also now been developed and published on the e-learning for health site.

Link to Safety Action 6

Technical Guidance for Safety Action 7	
What is the Maternity and Neonatal Voices Partnership?	An MNVP listens to the experiences of women, birthing people and families, and brings together service users, staff and other stakeholders to plan, review and improve maternity and neonatal care. MNVPs ensure that service user voice is at the heart of decision-making in maternity and neonatal services by being embedded within the leadership of provider Trusts and feeding into the local maternity and neonatal system (LMNS). MNVPs ensure service user voice influences improvements in the safety, quality and experience of maternity and neonatal care.
How do we know our MNVP is in line with guidance?	NHS England have published supporting materials including a case study and FAQ for working in line with the guidance here.
We are unsure about the funding for Maternity and Neonatal Voices Partnerships	It is the responsibility of ICBs to: Commission and fund MNVPs, to cover each Trust within their footprint, reflecting the diversity of the local population in line with the ambition above.
What does evidence of MNVP engagement look like?	Engagement can include lots of different methods as detailed in the MNVP Guidance under the section *Engagement and listening to families*. Evidence for this includes: • 15 Steps for Maternity and Neonatal report • MNVP Annual Report • Engagement reports • Expenses paid to service users • List of organisations engaged • Online surveys and feedback mechanisms • Analysis of surveys by demographics of respondents
Why have we removed the need to show evidence of engagement and strategic influence if MNVP infrastructure is not in place?	To enable meaningful, trauma-informed engagement with women and families and to act on what is heard, it is essential that MNVP infrastructure i.e. an adequately funded, employed, trained and supported MNVP team, is in place first. This change reflects feedback from MNVPs who are not adequately resourced to carry out their expected functions in line with the MNVP Guidance.
Why is escalation required where an MNVP is not commissioned and functioning in line with guidance and	Where an MNVP is not adequately funded by the ICB to carry out its functions, there is a risk that Trusts are not adequately listening and acting on safety concerns raised by women and families. Therefore, the Trust must escalate via PQSM to resolve.

what should this look like?	ICBs are expected to develop an action plan with the Trust in response to the escalation and monitor progress through agreed governance processes and via a risk register. Trusts should put mitigating actions in place to listen and coproduce with women and families proportionate to MNVP resourcing available until the MNVP is commissioned in line with guidance. MNVPs are required to be commissioned and function in line with the MNVP Guidance by the end of the Three-Year Delivery Plan (March 26) therefore this will be an expectation for all organisations after this time.

Link to Safety Action 7

Technical Guidance for Safety Action 8	
How will the 90% attendance compliance be calculated?	The training requires 90% attendance of relevant staff groups by the end of the 12-month MIS period at: 1. Fetal monitoring training 2. Multi-professional maternity Emergencies training 3. Neonatal resuscitation Training
Which maternity staff should be included for Fetal monitoring and surveillance (in the antenatal and intrapartum period)?	Staff who have an intrapartum obstetric responsibility (including antenatal and triage) must attend the fetal surveillance training. Maternity staff attendees must be 90% compliant for each of the following groups to meet the minimum standards: • Obstetric Consultants and SAS Doctors. • All other Obstetric Doctors contributing to the obstetric rota (without the continuous presence of an additional resident tier Obstetric Doctor). • Midwives (including Midwifery Managers and Matrons, Community Midwives; Birth Centre Midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity Theatre Midwives who also work outside of theatres. Staff who do not need to attend include: • Anaesthetic staff • Maternity Critical Care staff (including Operating Department Practitioners, Anaesthetic Nurse Practitioners, Recovery and High Dependency Unit Nurses providing care on the maternity unit) • MSWs • GP and Foundation Level Trainees
Which maternity staff should be included for Maternity emergencies and multi-professional training?	Maternity staff attendees must include 90% of each of the following groups to meet the minimum standards: • Obstetric Consultants and SAS Doctors. • All other Obstetric Doctors including Obstetric Trainees (ST1-7), Sub Speciality Trainees, Locally Employed Doctors (LED), Foundation Year Doctors and GP Trainees contributing to the obstetric rota. • Midwives (including Midwifery Managers and Matrons), Community Midwives; Birth Centre Midwives (working in co-located and standalone birth centres) and bank/agency Midwives. • Maternity Support Workers and Health Care Assistants (to be included in the maternity skill drills as a minimum). • Obstetric Anaesthetic Consultants and autonomously practising Obstetric Anaesthetic Doctors.

	• All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) who contribute to the obstetric rota. This updated requirement is supported by the RCoA and OAA. • Maternity theatre staff are a vital part of the multidisciplinary team and are encouraged to attend the maternity emergencies and multiprofessional training, however they will not be required to attend to meet MIS year 7 compliance assessment. • Neonatal staff are a vital part of the multidisciplinary team and are encouraged to attend the maternity emergencies and multiprofessional training, however there will be no formal threshold for attendance required to meet MIS year 7 compliance. At least one emergency scenario/drill should be conducted in a clinical area during the whole MIS reporting period, ensuring attendance from the relevant wider professional team, including theatre staff and neonatal staff. The clinical area can be any area where clinical activity takes place e.g. Delivery Suite, Clinic, A&E, theatre, a ward. This should not be a simulation suite.
Training attendance for agency staff	It is the responsibility of the employing agency to provide training for staff, so these staff will not be included in your MIS declaration. However, it is the responsibility of the Trust to ensure that all agency staff have met minimum training requirements before working in the Trust.
Long-term sickness and maternity leave	Any staff absent from work due to long-term sickness (>28 days) or on maternity / parental leave (28 days) will be unable to work clinically or attend training while absent, so these staff will not be included in your MIS declaration while they are absent from work, and for one month after their return. These staff should be prioritised to attend any outstanding training as soon as possible on their return.
Training attendance for rotational medical staff	It is the gold standard that all staff attend training in the unit that they are currently working in, so that they can benefit from local learning and training alongside their multi-disciplinary colleagues, however it is appreciated that this may be especially challenging for rotational staff. In the following circumstances, evidence from rotating resident doctors having completed their training in another maternity unit will be accepted: • Staff must be on rotation.

	• The training must have taken place in any previous Trust on their rotation during the MIS training reporting 12-month period. • Rotational posts must be shorter than 12 months. This evidence may be a training certificate or correspondence from the previous maternity unit. For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. A commitment and action plan must be approved by Trust Board and formally recorded in Trust Board minutes to ensure every staff member has attended all required training within a maximum 6-month period from their start-date with the Trust (but ideally much sooner).
Does the multidisciplinary obstetric emergency training have to be conducted in the clinical area?	Ideally at least one emergency scenario should be conducted in any clinical area as part of each emergency training day. You should aim to ensure that all staff attending emergency training participate in an emergency scenario that is held in a clinical area, but this will not be measured in year 7 of MIS.
Which staff should be included for neonatal resuscitation training?	The staff listed below are required to attend neonatal resuscitation training within MIS year 7: • Neonatal Consultants/SAS Doctors or Paediatric Consultants/SAS Doctors covering neonatal units. • Neonatal resident Doctors (who attend any births) • Neonatal Nurses (Band 5 and above) • Advanced Neonatal Nurse Practitioner (ANNP) • Midwives (including Midwifery Managers and Matrons), Community Midwives, Birth Centre Midwives (working in co-located and standalone birth centres) and bank/agency Midwives. The staff groups below are not required to attend in-house neonatal resuscitation training within this MIS year: • Staff who have already attended a neonatal resuscitation training course consistent with BAPM basic capability Neonatal Airway Capability or above (including external courses such as NLS) during MIS year 7 • NLS instructors that have taught on a course during MIS year 7

	• All Obstetric and Anaesthetic Doctors (Consultants, SAS, LE Doctors and Anaesthetic Trainees) contributing to the obstetric rota. • Maternity Critical Care staff (including Operating Department Practitioners, Anaesthetic Nurse Practitioners, Recovery and High Dependency Unit Nurses providing care on the maternity unit). • Local policy should determine whether Maternity Support Workers are included in basic neonatal resuscitation dependant on their role within the service. • If Nursery Nurses work within the service, this should also be recognised in your local training needs analysis.
Which members of the team can teach basic neonatal resuscitation?	Registered RC-trained NLS instructors should deliver the in-house neonatal resuscitation training annual updates.
What do we do if we do not have enough instructors who are trained as an NLS instructor?	Your Neonatal Consultants and Advanced Neonatal Practitioners (ANNP) will be qualified to deliver the training. You can also liaise with your LMNS to explore sharing of resources. It is recognised that for smaller hospitals, such as those with Special care units, there may be difficulty in resourcing qualified trainers. These units must provide evidence to their Trust Board that they are seeking mitigation across their LMNS and an action plan to work towards qualified NLS instructor status. As a minimum, training should be delivered by someone who holds a valid NLS certificate. Please see the RCUK website for the latest guidance regarding NLS GIC training
Who should attend additional neonatal resuscitation training (such as NLS)?	*A minimum of 90% of paediatric/neonatal staff **who attend neonatal resuscitations unsupervised** should have been trained and assessed in line with the guidance below.* *In line with* The British Association of Perinatal Medicine Neonatal Airway Safety Standard Framework for Practice *(April 2024)* *All neonatal staff undertaking responsibilities as an **unsupervised** first attender / primary resuscitator attending any birth must have reached a minimum of 'basic capability' as described in the BAPM Neonatal Airway Capability Framework.* *No specific training course is mandated. However, the Resuscitation Council UK Neonatal Life Support (NLS) provider certification includes all skills required*

	for Basic capability and most skills required for Standard capability. Staff that attend births **with supervision at all times** will not need to complete this assessment process for the purpose of MIS compliance.
The Core Competencies TNA suggests periods of time for each element of training, e.g. 9 hours for fetal monitoring. Is this a mandated amount of time?	We envisage that the fetal monitoring and obstetric emergencies training will require 1 whole day each. The hours for each element of training can be flexed by the individual Trust in response to their own local learning needs.

Link to Safety Action 8

Technical Guidance for Safety Action 9	
Where can I find additional resources?	NHS England, Perinatal Quality Surveillance Model PSIRF (Patient Safety Incident Response Framework) Maternity and Neonatal Safety Champions Toolkit September 2020 (england.nhs.uk) NHS England » Maternity and Neonatal Safety Improvement Programme The Safety Culture - Maternity & Neonatal Board Safety Champions - FutureNHS Collaboration Platform workspace is a dedicated place for Non-Executive Director and Executive Director maternity and neonatal Board Safety Champions to access the culture and leadership programme, view wider resources and engage with a community of practice to support them in their roles. The Perinatal Culture and Leadership Programme - Maternity Local Transformation Hub - Maternity (future.nhs.uk) is a dedicated space for NHS England's Perinatal Culture and Leadership Programmes, with resources for senior leaders and their teams to support local safety culture work.
Perinatal Leadership Team	
Who is the Perinatal Leadership team and are they different to the Quad?	For the purposes of this safety action, the definition of the Perinatal Leadership Team as described in this document, (also known as the 'Quad') consists of neonatal, obstetric, midwifery and operational leads as a minimum. We recognise there may be additional maternity and neonatal leaders as designated by the Trust, for example a Neonatal Nurse Lead, Anaesthetic Lead or service user / MNVP who may form part of the Perinatal Leadership Team.
Perinatal Quality Surveillance / Oversight Model	
What is the expectation around the Perinatal Quality Surveillance Model?	The Perinatal Quality Surveillance Model (PQSM) must be reviewed and the local governance for sharing intelligence checked, and when needed, updated. • Describe the local governance processes in place to demonstrate how intelligence is shared from the ward to Board. • Formalise how Trust-level intelligence will be shared and escalated with the LMNS/ICB/ODN quality group and from there with regional quality groups which will

	include the Regional Chief Midwife and Lead Obstetrician. • Review the involvement of service user voice leadership in perinatal quality oversight processes and ensure alignment with PQSM A revised version of the PQSM model, to be known as the Perinatal Quality Oversight Model (PQOM) is due to be published in 25/26. Trusts are expected to work to fully embed the PQSM model and evidence work towards implementation of the revised PQOM.
Reporting to Trust Board	
Why has the frequency of the requirement to report to Board changed to quarterly?	To facilitate meaningful discussion, review of data and action, Trusts will now be required to report to their Board at least quarterly. This change reflects feedback received during the development this safety action. Trust board meeting schedules vary and a requirement to report at every meeting may not allow for meaningful discussion and action. Where Trusts are currently reporting to their board more frequently, there is no requirement to reduce the frequency to quarterly. Trusts are encouraged to determine locally if there is a need to report to the Board more frequently.
What do we need to include in the report presented to Board each quarter?	The report should be locally produced as set out in PQSM appx 1. It should include themes identified in line with PSIRF, and actions being taken to support; SUV feedback; staff feedback from frontline Champions' engagement sessions; minimum staffing in maternity and neonatal services and training compliance. Themes and progress with culture improvement plans following local cultural surveys or equivalent should also be included. This may include the SCORE culture survey, any subsequent local culture surveys or qualitative insight, the NHS staff survey, NHS pulse survey, focus groups or suitable alternative. The report can also include additional measures as agreed by the Trust.
What constitutes a Trust Board, can sub committees be categorised as a Board?	In year 6 the standard was updated to reflect that an appropriate Trust Board sub-committee, chaired by a Trust Board member, can be delegated to undertake the monthly review of perinatal safety intelligence reporting. If a sub-committee of the Board undertakes this work, an exception report or highlight report must still be provided to the Board

	including the minimum data set as outlined in the PQSM, and there should be evidence of discussion in the Board minutes.
Culture Surveys	
What is the expectation for Trusts to undertake culture surveys?	Every maternity and neonatal service across England will have participated in the Perinatal Culture and Leadership Programme between 2022-2025. As part of this programme every service completed work to meaningfully understand the culture of their services. This diagnostic was either a SCORE culture survey or an alternative as agreed with the national NHSE team. Diagnostic insights and plans for improvement were to be shared with the Trust Board to enable an understanding and garner support for the work to promote optimal safety cultures, based on the diagnostic findings. The expectation is that all maternity and neonatal services continue paying attention to local cultures and work with their Patient Safety Collaboratives to do this, including considering appropriate interventions to support culture change. The improvement plan should evolve over time in response to updated data and insight and is not something that will ever be 'completed' as culture is ever evolving.
What if our maternity and neonatal services did not undertake the SCORE culture survey as part of the national programme?	The national offer to undertake a SCORE culture survey was a flexible, opt out offer. If your maternity and neonatal services demonstrated that they were already completing work to meaningfully understand local culture, and therefore opted out of the SCORE survey, the expectation is that the Board receives updates on this alternative work. It is important culture improvement work does not stop after formal participation in the national Perinatal Culture and Leadership Programme. The expectation is Trusts work with their Patient Safety Collaboratives to use other data sources, such as the NHS Staff Survey, Pulse Survey's, or suitable local alternatives to continue evolving local culture improvement plans.
Perinatal Culture and Leadership Programme	
Who is expected to have undertaken the Perinatal Culture and Leadership programme?	Senior perinatal leadership teams from all Trusts that have a maternity and neonatal service in England have undertaken the PCLP. This will be representation from the midwifery, obstetric, neonatal, and operational professional groups, usually consisting of the DoM/HoM, Clinical Lead / CD for obstetrics, Clinical Lead for neonates and the Operational Manager.

Safety Champions	
What is the rationale for the Board level Safety Champion safety action?	It is important to ensure all staff are aware of who their frontline and Board Safety Champions are if concerns are to be actively shared. Sharing of insights and good practice between providers, their LMNS, ODN, ICS and regional quality groups should be optimised. The development of a local pathway which describes these relationships, how sharing of information will take place and names of the relevant leaders, will support this standard to realise its aims. The guidance in the link below will support the development of this pathway. Maternity-and-Neonatal-Safety-Champions-Toolkit--2020.pdf
Do both the NED and Executive BSC and all members of the Perinatal Leadership team have to be present at each meeting?	Ideally the meeting would have both Board Safety Champions (BSC) and at least two members of the Perinatal Leadership Team present. If this is not always possible, it would be appropriate for either the Executive or NED BSC and at least one member of the Perinatal Leadership Team to be present, However, the expectation is that each professional group is represented throughout the year, and that the nominated member attending brings all four voices to the conversation. The MNVP play a vital role in developing maternity and neonatal services. Where the infrastructure is in place, MNVP leads should be embedded within the providers leadership team. As stated in SA7 they should be a quorate member of this meeting, sending a deputy member of their team when required. As per SA7, If evidence of an appropriately funded MNVP is not in place and there are meetings when the MNVP is not consistently represented, this should be escalated to Trust board, ICB quality board and regional perinatal team. If quoracy for the meeting is not achieved, Trust's will need to show evidence of how their board safety champions are hearing the voice of families and using this to inform decision making.
What are the expectations of the NED and Exec Board Safety Champion in relation to their support for the Perinatal Culture and Leadership	As detailed in previous year's MIS guidance, regular engagement between Board Safety Champions and senior perinatal leadership teams provides an opportunity to share safety intelligence, examples of best practice, identified areas of challenge and need for support. The meetings should be conducted in an appreciative way, with the perinatal teams being open and transparent and the Board Safety Champions being curious and supportive.

Programme (PCLP), culture surveys and ongoing support for the Perinatal Leadership teams?	
What should be discussed at the bi-monthly meetings between the Board Safety Champion(s) and the Perinatal Leadership teams?	As a minimum the bi-monthly meetings should include the following content: - Ongoing Learning from the Perinatal Culture and Leadership Development Programme and how they are using this locally. - How they plan to continue being curious about their local culture. This may be in the form of pulse surveys, or team check ins. - Progress with interventions relating to culture improvement work, and any further support required from the Board. - Feedback on the support being provided by the Patient Safety Collaboratives - Discussion of any themes from patient feedback, MNVP and complaints. - Escalation and oversight of any concerns or issues raised by staff and resulting actions - Oversight of compliance and progress with CNST, CQC action plans, Ockenden, Kirkup etc
Do the non-executive and executive maternity and neonatal Board Safety Champion have to register to the dedicated FutureNHS workspace to access the resources available this year?	We encourage all NED and Exec Board Safety Champions to register on the Future NHS Safety Culture - Maternity & Neonatal Board Safety Champions - FutureNHS Collaboration Platform workspace. New content and resources are added throughout the year, and we would encourage all BSC's to continue to access the page to benefit from these. You can also reach out to other Board Safety Champions and develop your own community of peer support. However, this will not be a formal requirement in year 7 of the MIS.
We have not continued to undertake feedback	Parts a) and b) of the required standard builds on the previous year requirements of the MIS in building visibility and creating the conditions for staff to meet and establish a relationship with their Board level Safety Champions to raise

sessions with the Board Safety Champion, what should we do?	concerns relating to safety and identify any support required from the Board. Evidence of quarterly staff engagement sessions will need to be provided covering this reporting period, it is expected that there will be at least quarterly sessions organised and widely advertised to staff. This may include the sessions being visible in wards and notice boards. Staff should be supported to engage with these sessions as freely as possible and a record of feedback and actions made available to all staff after the session Part b) requires that progress with actioning named concerns from staff feedback sessions are visible. This builds on requirements made in year three and four of the MIS and the expectation is that this should have been continued.
We are a Trust with more than one site. Do we need to complete the same frequency of engagement sessions in each site as a Trust on one site?	Yes. The expectation is that the same number of engagement sessions are completed at each individual site on a quarterly basis.
What are the expectations of the Board safety Champions in relation to quality improvement work undertaken by the Maternity and Neonatal Quality Improvement Programme?	The Board safety Champions will be expected to continue their support for continuous quality improvement by working with the designated improvement leads to participate and mobilise improvement via the MatNeo Patient Safety Collaboratives. Trusts will be required to undertake improvement including data collection and testing work aligned to the national priorities.
Scorecards	
Where can I find more information re my Trust's scorecard?	More information regarding your Trust's scorecard can be found here.
Why do we need to review the scorecard	The scorecard is a quality improvement tool that provides insight into claims in support of clinical governance and quality assurance in your organisation. It provides details of

quarterly alongside current complaint and incident data?	all CNST claims, combined with data from the EN scheme and can provide a full picture of maternity related claims in your organisation. The scorecard provides 10 years of claims experience allowing the impact of clinical effectiveness and safety interventions to be assessed over time. It should be reviewed alongside other data sets to provide a fuller picture of safety. It highlights themes occurring in claims which can be addressed through staff education and training. The scorecard provides a number of speciality filtered views allowing quick access to the relevant data for your division/speciality. Where data sharing agreements exist, members may share scorecard data to support learning across partnerships, networks and regions. The safety and learning team at NHS Resolution can support you in accessing and using your scorecard, nhsr.safety@nhs.net . A short video on using your scorecard can be found here Videos (resolution.nhs.uk) (Extranet login required). The GIRFT/NHS Resolution Learning from Litigation Claims can be found here Best-practice-in-claims-learning-FINAL.pdf (gettingitrightfirsttime.co.uk) and includes advice on engaging with NHS Resolution Safety and Learning resources, including the scorecard.
Examples have been requested for the scorecards.	The key to making this exercise meaningful is the triangulation of the data. Categorisation of the historical claims on the scorecard and any action taken, then presenting these alongside current incidents and complaints. This allows identification of potential themes or trends, identification of the impact of any learning, and allows you to act quickly if any historical themes re-emerged. NHS Resolution have developed an example template to share, and this can be accessed via the FutureNHS platform Maternity Incentive Team workspace, or the MIS Team can send a copy out on request. NHS Resolution staff are always happy to talk through this process if it is helpful.

Link to Safety Action 9

Technical Guidance for Safety Action 10	
Where can I find information on MNSI?	Information about MNSI and maternity investigations can be found on the MNSI website https://mnsi.org.uk
Where can I find information on the Early Notification scheme?	Information about the EN scheme can be found on the NHS Resolution website: • EN main page • Trusts page • Families page
What are qualifying incidents that need to be reported to MNSI?	Qualifying incidents are term deliveries (≥37+0 completed weeks of gestation), following labour, that resulted in severe brain injury diagnosed in the first seven days of life. These are any babies that fall into the following categories: (i) when the baby was therapeutically cooled (active cooling only), or (ii) has been diagnosed with moderate to severe encephalopathy, consisting of altered state of consciousness (lethargy, stupor or coma) and at least one of the following: (aa) hypotonia; (bb) abnormal reflexes including oculomotor or pupillary abnormalities; (cc) absent or weak suck; (dd) clinical seizures Trusts are required to report their qualifying cases to MNSI via the electronic portal. Once MNSI have received the above cases they will triage them and advise which investigations they will be progressing for babies who have clinical or MRI evidence of severe brain injury. * This definition was updated from 1 October 2023. Please see our website for further information, this does not change the cases referred to MNSI.
What is the definition of labour used by MNSI and EN?	The definition of labour used by MNSI and EN includes: • Any labour diagnosed by a health professional, including the latent phase (start) of labour at less than 4cm cervical dilatation. • When the mother called the maternity unit to report any concerns of being in labour, for example (but not limited to)

	abdominal pains, contractions, or suspected ruptured membranes (waters breaking). • Induction of labour (when labour is started artificially). • When the baby was thought to be alive following suspected or confirmed pre-labour rupture of membranes.
Current reporting requirements to MNSI and NHS Resolution	Trusts are required to report their qualifying cases to MNSI via their reporting portal. In addition, Trusts are required to notify to NHS Resolution, via the Claims Reporting Wizard of qualifying EN cases once MNSI have confirmed they are progressing an investigation due to clinical or MRI evidence of severe brain injury. The Trust must input the MNSI reference number to confirm the investigation is being undertaken by MNSI (otherwise it is rejected). Trusts must also use the EN report form: EN-Report-Form.pdf. Please select Sangita Bodalia, Head of Early Notification (legal) at NHS Resolution on the Claims Reporting Wizard. Once the MNSI final report has been shared by the Trust, the EN team will triage the case based on the MRI findings and then confirm to the Trust which cases will proceed to a liability investigation. We strongly advise making a note of the Claims Management System (CMS) reference number received once the matter is reported, as this will be confirmation that the case has been successfully reported to NHS Resolution.
Reporting when Submit Perinatal Event Notification (SPEN) is introduced	When the new single reporting system also known as Submit Perinatal Event Notification (SPEN) is implemented (expected sometime in 2025) then Trusts will be required to report eligible cases for MNSI and NHS Resolution via the Submit Perinatal Event Notification (SPEN). Further information will be shared once there is an implementation date for SPEN.
What qualifying EN cases need to be reported to NHS Resolution?	• Trusts are required to report cases to NHS Resolution where MNSI are progressing an investigation i.e. those where there is clinical or MRI evidence of severe brain injury and have a confirmed reference number. • Where a family have declined a MNSI investigation, but have requested an EN investigation, the case should also be reported to NHS Resolution and advised of this reason for reporting. There is more information here: ENS Reporting Guide - December 2023 (for Member Trusts) - NHS Resolution

Cases that do not require to be reported to NHS Resolution	• Cases where families have requested a MNSI investigation where the baby has a normal MRI. • Cases where Trusts have requested a MNSI investigation where the baby has a normal MRI. • Cases that MNSI are not investigating.
What if we are unsure whether a case qualifies for referral to MNSI or NHS Resolution?	If a baby has a clinical or MRI evidence of severe brain injury and the case is being investigated by MNSI because of this, then the case should also be reported to NHS Resolution via the Claims Reporting Wizard along with the MNSI reference number (document the MNSI reference in the "any other comments box").
Who should we contact if we have any queries?	Please contact a member of the Early Notification team to discuss further (nhr.enteam@nhs.net) or MNSI maternity team maternityadmins@mnsi.org.uk.
Candour	Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 provides that a health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided. Regulation 20 In accordance with the statutory duty of candour, in all relevant cases, families should be 'advised of what enquiries in relation to the incident the health body believes are appropriate' – 20(3)(a) and details of any enquiries to be undertaken (20)(4)(b). This includes details of enquiries undertaken by MNSI and NHS Resolution. Assistance can be found on NHS Resolution's website, including the guidance 'Saying Sorry' as well as an animation on 'Duty of Candour' Trust Boards should be aware that if a breach of the statutory duty of candour in relation to a qualifying case comes to light which calls the validity of certification into question this may result in a review of the Trust submission and in addition trigger escalation to the CQC.
Will we be penalised for late reporting?	Trusts are strongly encouraged to report all qualifying cases to MNSI as soon as they occur and to NHS Resolution as soon as MNSI have confirmed that they are taking forward an investigation. NHS Resolution recommend that you report within

	14 days, as this enables NHS Resolution to initiate processes in relation to family engagement. Trusts will meet the required standard if they can evidence to the Trust Board that they have reported all qualifying cases to MNSI and where applicable, to NHS Resolution and this is confirmed with data held by NNRD and MNSI and NHS Resolution. Where qualifying cases are not reported within two years from the date of the incident, these cases will no longer be eligible for investigation under the Early Notification scheme. Please inform NHS Resolution EN team if this occurs.
What do you mean by accessible format?	A holistic view of the family needs should be considered. Accessibility can include (but is not limited to) language, easy read, digital versus printed versions
What happens if we are not able to provide accessible information to the family?	We encourage you to explore options to support the provision of accessible information, and onward escalation where needed. MNSI have initial referral cards and family information available in multiple languages. If the language requested is not available MNSI will translate into the language required. These can be provided on request from your maternity investigator by the Trust. The Board report should outline any occurrences where accessible information could not be provided, reasons and a SMART action plan to address any challenges for the future.
If we are unable to provide information in an accessible way, will we fail the safety action?	You will be able to pass the safety action as long as a SMART action plan has been developed to support addressing any challenges for the future.
Are there any resources from MNSI and NHSR that we can use?	NHS Resolution have produced an animation for families which can be accessed here: Early Notification Scheme animation on Vimeo There is also a page on the NHS Resolution website: Support for families or carers - NHS Resolution MNSI have a family page on their website: For families

Link to Safety Action 10

MIS Year 7 FAQ	
What do you mean by Trust Board?	Unless explicitly stated, Trust Board can be interpreted as 'the Trust Board or appropriate sub-committee with delegated authority' as long as these sub-committees provide Trust Board with output following their review and discussion.
Why aren't we reporting everything directly to Trust Boards?	Trust Boards have a broad scope of responsibility, covering all aspects of the Trust's governance, strategy, and finances. They provide strategic direction and oversight, while sub-committees such as the Quality Governance Committee takes a more hands-on role in monitoring quality and safety performance reviewing and scrutinising operational detail. It is vital that the most pertinent information that is conveyed to Trust Boards is clearly recognised and not lost in the operational detail of reporting. A sub-committee's in-depth examination of data, reports, and practices provides the Board with a clear understanding of the Trust's performance on quality and safety, including any immediate priorities or exceptions.
How can I evidence an appropriate sub-committee?	A Board Assurance Framework should highlight the decision-making processes within a Trust and detail those committees with delegated authority from the Board. Individual Terms of Reference from sub-committees should also contain this information. Minutes of sub-committee meetings should demonstrate that the required discussion around MIS standards have taken place, including any output which will be conveyed to the Trust Board. This must be recognised within Trust Board minutes.
What is a Quality Governance Committee, and how does it differ from a Trust Board?	A Quality Governance Committee (QGC) is a committee of the Trust Board responsible for overseeing the Trust's quality and safety governance arrangements. It provides assurance to the Trust Board that the Trust has robust systems in place to identify, assess, and mitigate risks to patient safety. The QGC also reviews the Trust's quality improvement initiatives and provides recommendations to the Trust Board. The information presented to a QGC will be more detailed and specific than the information presented to the Trust Board. They should receive regular updates on the Trust's performance in key quality and safety areas, as well as specific data on individual incidents and concerns. The QGC should also have the opportunity to discuss the Trust's quality improvement plans and provide feedback and recommendations.

	A QGC is appropriate to review evidence around safety actions, provide additional scrutiny **and then report to the Trust Board, delivering a summary and highlighting any exceptions or particular areas of concern.** **It is important to ensure that this process facilitates Trust Board oversight, rather than replaces it.**
Where can I find more information about Board Reporting via Quality Governance Committees?	Effective Board Assurance Committees Quality Governance in the NHS
Does 'Board' refer to the Trust Board or would the Maternity Services Clinical Board suffice for the Board notification form?	Trust Boards must self-certify the Trust's final MIS declaration following consideration of the evidence provided. It is recommended that all executive members e.g. finance directors are included in these discussions. If subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of governance which we will escalate to the appropriate arm's length body/NHS system leader. We escalate these concerns to the CQC for their consideration if any further action is required, and to the NHS England regional director, the Deputy Chief Midwifery Officer, Regional Chief Midwife and Department of Health and Social Care (DHSC) for information. In addition, we now publish information on the NHS Resolution website regarding the verification process, the name of the Trusts involved in the MIS re-verification process as well as information on the outcome of the verification (including the number of safety actions not passed).
Do we need to discuss this with our commissioners?	Yes, the CEO of the Trust will ensure that the AO for their ICB is apprised of the MIS safety action evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the evidence to be submitted to NHS Resolution. The declaration form must be signed by both CEO and the AO of Clinical Commissioning Group/Integrated Care System before submission.

What documents do we need to send to you?	The Board declaration form will need to be sent to NHS Resolution. Ensure the Board declaration form has been approved by the Trust Board, signed by the Trust CEO and AO (ICB). Where relevant, an action plan is completed for each action the Trust has not met. **Please send only the Board notification form to NHS Resolution. Do not send your evidence or any narrative related to your submission to NHS Resolution unless requested to do so for the purpose of reverification.** Any other documents you are collating should be used to inform your discussions with the Trust Board. These documents and any other evidence used to assure the Board of your position must be retained. In the event that NHS Resolution are required to review supporting evidence at a later date it must be made available as it was presented to support Board assurance at the time of submission.
Where can I find the Trust reporting template which needs to be signed off by the Board?	The Board declaration Excel form will be published on the NHS Resolution website in 2025 and all Trusts will be notified. It is mandatory that Trusts use the Board declaration Excel form when declaring compliance to NHS Resolution. If the Board declaration form is not returned to NHS Resolution by 12 noon on 3 March 2026, NHS Resolution will treat that as a nil response.
Will you accept late submissions?	We will not accept late submissions. The Board declaration form and any action plan will need to be submitted to us no later than **12 noon on 3 March 2026**. If not returned to NHS Resolution by 12 noon on 3 March 2026, NHS Resolution will treat that as a nil response.
Our Trust has queries, who should we contact?	Any queries prior to the 3 March 2026 must be sent in writing by e-mail to NHS Resolution via nhsr.mis@nhs.net
Please can you confirm who outcome letters will be sent to?	The MIS outcome letters will be sent to Trust's nominated MIS leads.
What if Trust contact details have changed?	It's the responsibility of the Trusts to inform NHS Resolution of the most updated MIS link contacts via the link on the NHS Resolution website.

What if my Trust has multiple sites providing maternity services?	Multi-site providers will need to demonstrate the evidential requirements for each individual site. The Board declaration should reflect overall actions met for the whole Trust.
Will there be a process for appeals this year?	Yes, there will be an appeals process. Trusts will be allowed 14 days to appeal the decision following the communication of results. The AAC will consider any valid appeal received from participating Trusts within the designated appeals window timeframe. There are two possible grounds for appeal: • Alleged failure by NHS Resolution to comply with the published 'conditions of scheme' and/or guidance documentation. • Technical errors outside the Trusts' control and/or caused by NHS Resolution's systems which a Trust alleges has adversely affected its CNST rebate. NHS Resolution clinical advisors will review all appeals to ensure validity, to determine if these fall into either of the two specified Grounds for Appeal. If the appeal does not relate to the specified grounds, it will be rejected, and NHS Resolution will correspond with the Trust directly with no recourse to the AAC. Any appeals relating to a financial decision made, for example a discretionary payment made against a submitted action plan, will not be considered. Further detail on the appeals window dates will be communicated when final results are confirmed and sent to Trusts.
How does the financial element of the scheme work?	NHS Resolution introduced the MIS to support the delivery of safer maternity care through the introduction of an incentive element to contributions to the CNST. NHS trusts that provide maternity services are charged an amount in addition to their CNST maternity contribution for the MIS. Where a trust has successfully demonstrated achievement against the ten safety actions, it will recover its element of MIS contribution that went into the maternity incentive fund, plus a share of any unallocated funds. **This rebate will be returned to the original funding source**. Trusts unable to demonstrate achievement of the ten actions may be able to apply for a lesser sum from the fund to help them achieve any unmet actions.

	Where a reverification of a prior year takes place, if the trust is found to have mis-declared compliance it must immediately repay to NHS Resolution the funds originally awarded for that MIS year. This is irrespective of the reverification being conducted in a different financial year. Any funds retrieved from non-compliant trusts will be redistributed to all trusts that achieved compliance for the applicable MIS year. This redistribution will take place within in the same financial year that NHS Resolution receives the returned funds. As NHS Resolution is not deemed a supplier in this arrangement and the arrangement does not meet the definition of a contract, the monies received from the scheme are considered out of scope of IFRS 15. Instead, they are treated as per IAS 1, in that the receipts of funds are offset against the cost of the scheme. Since the scheme relaunched for 2022/23 compliance with the ten safety actions was assessed in 2024/25. The contributions to the MIS were collected and distributed against achievement of the actions in the 2024/25 financial year.
If we haven't spent our MIS funds, can we carry them over to the next financial year.	You will need to adhere to the relevant statutory accounting standards for NHS bodies that this may fall under. NHS Resolution has no influence over this, and if you need any further guidance on the accounting treatment then we recommend speaking to your regional finance contact at NHS England.
Merging Trusts	Trusts that will be merging during the year seven reporting period (April 2025 – January 2026) must inform NHS Resolution of this via nhsr.mis@nhs.net so that arrangements can be discussed. In addition, Trust's Directors of Finance or a member of the finance team must make contact with the NHS Resolution finance team by email at nhsr.contributions@nhs.net as soon as possible to discuss the implications of the changes in the way maternity services are to be provided. This could have an impact on the contributions payable for your Trust in 2025/26 and the reporting of claims and management of claims going forward.

Maternity Incentive Scheme - Year 7 Board declaration form

Trust name	**Royal United Hospitals Bath NHS Foundation Trust**
Trust code	**T318**

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	Yes		-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Clinical workforce planning	Yes		-	
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	Yes		-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	Yes		-	
Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**10**	-		
Total sum requested			-	

Sign-off process confrming that:

* The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

* The content of this form has been discussed with the commissioner(s) of the trust's maternity services
* There are no reports covering either **this year (2025/26) or the previous financial year (2024/25)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports must be brought to the MIS team's attention.
* If declaring non-compliance, the Board and ICS agree that any discretionary funding will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
* We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of Board governance which will be escalated to the appropriate arm's length body/NHS System leader.

Electronic signature of Trust Chief Executive Officer (CEO):	
For and on behalf of the Board of	Royal United Hospitals Bath NHS Foundation Trust
Name:	Cara Charles-Barks
Position:	Chief Exective officer, Royal United NHS Foundation Trust
Date:	17/02/2026

Electronic signature of Integrated Care Board Accountable Officer:	
In respect of the Trust:	Royal United Hospitals Bath NHS Foundation Trust
Name:	Gill May
Position:	Chief Nursing Officer for BSW Integrated Care Board
Date:	25/02/2026