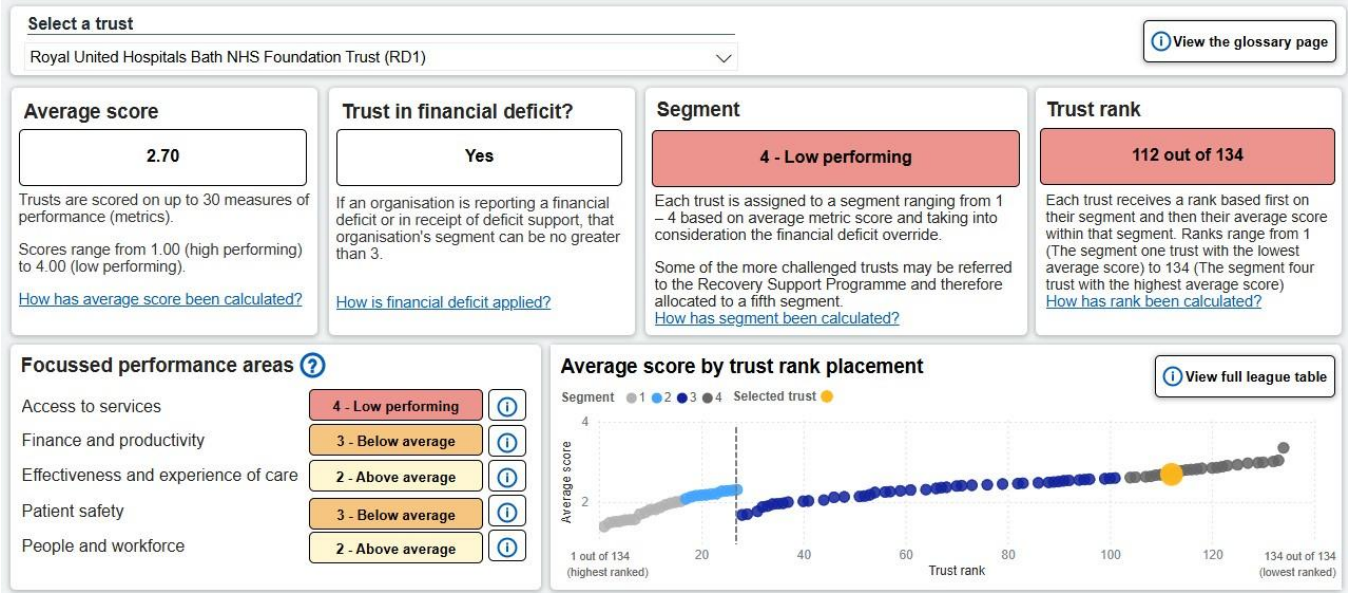
Royal United Hospitals Bath
NHS Foundation Trust

Royal United Hospitals Bath NHS Foundation Trust Annual General Meeting
Thursday 25th September 2025
Questions to the Board of Directors

Finance

Question	Response
Why when in the AGM the accounts are discussed by the executive the position is described as healthy and break even and yet the staff are then asked to submit ideas for any savings we can find, there is a freeze on purchasing everything from Sellotape to staff and the message to staff is one of financial doom and gloom.	The financial challenges facing the NHS are growing over time, as temporary funding provided during Covid pandemic is withdrawn and the Government has doubled its productivity improvement expected of NHS from 1% to 2%. For financial year 23/24 the trust was able to deliver a balanced financial position. For 24/25, as will be discussed at his year's AGM the Trust had a financial deficit of £4.2m, after successfully delivering £32.3m of savings. For financial year 25/26 the position has deteriorated as a further challenge to delivery £29.7m has been taken on and year to date £11.7m adverse to plan. This £11.7m deficit is material enough to trigger additional regulatory oversight and leading to reductions in cash balances and deferral of capital expenditure. Manging the communication of this and striking a fair balance between recognising the success of financial improvement and delivery, whilst also being honest and stretching about the need to make further savings is discussed frequently by Board of Directors and Executive Team and Management Executive Committee. The Trust is making financial improvement but still has further to go to reach a sustainable financial position.

National Oversight Framework (NOF)

Question	Response
My question is in the latest list of Hospitals why is the RUH so far down the list? What is the criteria for this list?	Focussed performance areas for the NOF are: access to services, finance and productivity, effectiveness and experience of care, patient safety and people and workforce. Based on their performance in these services along with other considerations, such as overall level of financial deficit, each trust has been placed into one of four core segments. Segment 1 represents the organisations with the narrowest range of challenges while segment 4 contains those with the broadest. Trusts in the lower performing segments are likely to receive additional support to help them improve but support can be provided to any organisation, where it is needed. 

	There are areas we know we need to do better for our patients, and the results are very disappointing for us. Our collective job over the coming weeks and months is to improve this position with as much pace as we can, whilst ensuring that the improvements we make are sustained. I want to reassure you that there are plans already underway that are supporting our recovery and whilst we have a lot to do, there are a few green shoots: • We have introduced recovery plans for our diagnostic waits, and we are working closely with Sulis Hospital, which hosts our Community Diagnostic Centre. We're particularly focussing on reducing waits for ultrasound, echocardiograms, and sleep and have plans in place to increase capacity in these areas to help reduce waiting times for patients. • In the last couple of months, there have also been some improvements in our cancer performance against the 28 days to diagnosis target; and during September we are bringing in some additional clinic capacity to support our RTT improvement.
Why was the hospital ranked so low in the recent national tables? Bath and its surrounds do not present with complex	It's important to separate two things: what the rankings are measuring, and what the awards we've won are recognising. **First, the rankings.**

demographics as is the case with so many large metropolitan areas. It is notable and delightful that the hospital has won awards for teamwork and compassion and care, but the logic for most organisations doing well in these areas is that this competence should have a knock-on effect on service and outcomes. It's curious then that this follow through is not there. Therefore, I would like to understand how a hospital can win applause for its organisational climate and culture and such a poor ranking for overall healthcare.	The national league tables are driven mainly by operational performance—things like how quickly patients are seen in the Emergency Department, how long they wait for surgery, cancer treatment times, and access to scans. These are very visible measures and they're under pressure everywhere, not just in Bath. **Second, the awards.** Our recent recognition for teamwork and compassion reflects the culture and behaviours of our staff. That's about kindness, support, and professionalism. It shows that people here are working with the right values, which is a vital foundation. But having a good culture doesn't automatically or immediately fix the flow problems that drive national rankings. **Why Bath isn't "simple."** On paper, we don't have the same levels of deprivation or complexity as inner-city hospitals. But our local challenges are different: • We serve an older population with more long-term conditions and frailty. • Discharges are complicated by rural geography and limited community/social-care capacity. • We have historic bottlenecks in diagnostics and theatres which slow elective recovery. • And like all trusts, we are still catching up from COVID disruption and the impact of industrial action. **What we're doing about it.** There is a clear programme in place to improve flow and reduce backlogs:

	• Expanding same-day emergency and frailty care so patients don't need to be admitted unnecessarily. • Improving discharge processes and working closely with community partners to free up beds. • Running more theatre and diagnostic sessions, including evenings and weekends. • Stabilising our workforce—reducing reliance on agency staff and protecting high-value clinical sessions. • Using daily dashboards and closer operational grip to monitor progress and unblock delays quickly. **How we'll show progress.** You should expect to see improvements first in diagnostics and theatre productivity, then in waiting-list and cancer pathway performance, and finally in emergency flow as discharge reliability improves. We will report these metrics openly so the Board can hold us to account. **In summary:** The reason we can win awards for culture yet still rank poorly overall is that those two things are measuring different aspects of the hospital. The good news is that our culture is a strength—it means we have the right people and teamwork to deliver change. Now we need to translate that into shorter waits and better access, and we have a clear plan to do so.

Bed Capacity and Constraints

Question	Response
What are the primary factors in contributing to high-capacity constraints on beds being full, and/or bottlenecks in the hospital, and what are the plans to address these?	a) In August 2025, the trust bed occupancy for adults was 95.6%. 16.2% of the beds occupied in the hospital were by patients who no longer meet the criteria to reside and require system partner support to discharge. In line with the 2025/26 national planning guidance, there should be no more than 9% of beds occupied for patients who no longer meet criteria to reside, and in addition, patients should be discharged typically within 24 hours (may vary with more complex pathways). b) The hospital has made positive progress on managing patients who are hospital responsibility to discharge. In August 85% of patients who no longer met criteria and were hospital responsibility were discharged in 24 hours. RUH is also nationally in the top decile for patients with a length of stay of + 2 days and top quartile for 0–1-day length of stay. c) Early discharge is a constraint, with 20.6% of patients discharged before midday in August (RUH year-end target of 45%). Actions to support improvement in performance include sustained use of the discharge lounge with routinely 40 patients discharging via the Lounge on a weekday. There is a capital plan pending approval with NHS England to relocate the Discharge Lounge into the main hospital site, with side rooms and additional capacity, to increase the number of patients transferring home and freeing up core bed capacity. d) There is an Urgent and Emergency Care improvement workstream that is focused on home is best, the aim to improve internal hospital flow and reducing delays.

	e) The ward therapy teams have been focused on changing pathways to discharge aiming to get patients home and avoiding the need for a community bed. Good progress has been made. f) Overall, in 2025/26 the bed base has been reduced, with the closure of a ward to support the expansion of a Hospital at Home service and the closure of escalation capacity in line with national guidance to improve outcomes and the experience of our patients. g) There is a constant demand for single rooms to safely manage and isolate people with infections. We are caring for a high number of patients with infections such clostridioides difficile (c.diff), norovirus, COVID-19 and flu. These infections not only require isolation, they can increase length of stay and delay discharge planning to community settings. This has a direct impact on patient flow. h) We are cognisant we exceeded our NHS England thresholds for C.diff and e.coli during 2024/25. It is recognised that nationally the C.diff rates increased by 35%, the cause of this is not well understood currently. Most cases were not preventable; however typing has demonstrated there was one case of cross infection. We know many of the E.coli infections were linked to Urinary Tract Infections (UTI) and improvement work has commenced to address the primary causes of UTI prevention in our patient population along with our community health protection partners. Currently for 2025/26, we are not breaching the performance thresholds.
Has the hospital got a long-term vision for building more wards/departments to	a) The bed capacity modelling has shown that for the population served and demand, there is a net deficit. A business case has been developed to increase capacity.

accommodate the population increasing, and the timeframe for this?	b) Focus in 2025/26 has been on the development of care in the patient's home with the expansion of the Hospital at Home services managed by the RUH (current capacity of 62 patients). In addition, the Clinical Divisions have been further developing the same day emergency care services, aiming to sustain 40% of patients going through these services to avoid emergency department attendance and for patients to have the right care in the right place first time with the right specialist. c) The RUH is working with system partners in line with the NHS ten-year plan to deliver care closer to home and to reduce the number of patients who no longer need to be in an acute RUH bed.
Does the hospital have a strategy to increase beds whilst ensuring there are enough staff members to operate these wards safely?	If capacity is increased (as answered in the question above) the staffing levels would be defined, as they are currently, in line with the safer staffing standards. The RUH has a low vacancy rate.
How does operating at maximum capacity affect the ability to discharge patients safely, and what is the hospital doing to address issues like 'boarding' patients in ED for extended periods?	a) The trust has processes in place to proactively manage the clinical priority of patients with the trust Site Management Team working in collaboration with the Emergency Department and Assessment areas to support the patients who require admission from ED. During periods of high demand there are processes in place, following agreed escalation processes and action cards to maintain patient and staff safety. b) RUH does not place any patients outside of a bed space on any wards, with the exception of escalation spaces in line with national standards.

	c) There are Urgent and Emergency Care improvement workstreams focused on; Urgent Treatment Centre capacity, Emergency Department Ambulatory Care, Same day emergency care expansion and ward processes (part of the home is best workstream). Business as usual action to utilise the Discharge Lounge and maximise RUH Hospital at home capacity.
How does operating at near to maximum capacity financially impact the hospital, especially with regards to increased costs for temporary staff, overtime, and higher use of supplies. Are the staff equally supported for these high stress events and how?	a) The Trust has assessed that approx. £4m of cost premium is incurred as a result of operating at maximum capacity, particularly within emergency care pathways and impacting ED and inpatient wards. The Trust is working internally and with system partners to improve urgent care pathways. You rightly highlight additional temporary staffing costs. There is an overall loss of productivity which can conversely add to costs such as extending length of stay through increased risk of infection, delays to access tests and procedures and slower discharge processes. b) The RUH provides services for staff which are available all year round and, supported by the communications team, throughout winter staff will be encouraged and signposted to access the following services according to the individuals need. • Physical health: Occupational Health, physiotherapy staff service, smoking cessation, and exercise classes. • Mental health: Employee assistance programme, Staff wellbeing outreach, Mental health first aid, stress and burnout workshops and trauma risk management (TRiM). • Financial wellbeing handbook and access to discounts.

	• Working Life: Freedom to speak up, Unions, Staff networks, spiritual care centre, People Hub support, reasonable adjustments, accommodation, childcare, shops and facilitations, mediation, nurse & midwifery advocates, kindness, and civility training are available to access by staff. Furthermore, the trust also now has a violence prevention and reduction policy, a three-step approach that helps to keep staff safe, by clearly outlining unacceptable behaviour and giving staff the tools to act when we see it. • As part of the Trust vision 'The RUH, where you matter' and as a thank you for the extraordinary efforts made each day, the Trust offers every substantive employee in the Trust a 'What Matters to You Day'. This additional day away from work to allow staff to take the time to do something that matters to them around their birthday. • Mental health first aiders. • Listening events. • Regular 1:1s and proactive managing attendance. • Peer support. • Senior team visibility. • Regular trust staff communication.