Bundle Public Board of Directors 14 January 2026

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- 3.0 - DRAFT Public BoD Minutes Nov v1.0 - 18.11.25

4 Action List and Matters Arising
- 4.0 - Public BoD Action List Nov 25 v1.0 - 19.11.25

5 Governor Log of Assurance Questions and Responses (For Information)
- 5.0 - Governor Log of Assurance Questions v1.0 - 09.01.25
- 5.1 - NED Assurance 2025 - 10.12.25

6 Parent Story
- 6.0 - Parent Story cover sheet to Board of Directors December

7 CEO, Managing Director, and Chair's Report
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9 Management Executive Committee Upward Report and Terms of Reference for Ratification
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10 Integrated Performance Report
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11 MIS Combined Maternity and Neonates Quarterly Report Q2
- 11.0 - Mat-Neo Q2 2025-26 quality report
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12 Safeguarding Strategy for Approval
- 12.0 - Safeguarding Strategy BoD
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13 Six Monthly Nurse and Allied Health Staffing Report
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14 Learning from Deaths Report Q1
- 14.0 - Learning From Deaths Q1 Cover Sheet
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15 Quality Assurance Committee Upward Report and Terms of Reference for Ratification
- 15.0 - QAC Upward Dec 25
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16 Freedom to Speak Up Q1 and Q2 Report
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17 People Committee Upward Report and Terms of Reference for Ratification
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18 Non-Clinical Governance Committee Upward Report and Terms of Reference for Ratification
    18.0 - NCGC Upward Report Jan 26 v1.1
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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 14 JANURY 2026, 09:30 – 12:00 VENUE: ROOM T0.24, BATH SPA UNIVERSITY SION HILL CAMPUS, SION HILL, BATH, BA1 5SF

Item	Item	Presenter	Enc.	For
OPENING BUSINESS				
1.	Chair's Welcome, Introductions, Apologies and Declarations of Interest: Kheelna Bavalia	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 5 November 2025		Enc.	A
4.	Action Log		Enc.	A/D
5.	Governor Log of Assurance Questions and Responses (For Information)		Enc.	I
6.	Parent Story	Toni Lynch, Chief Nursing Officer	Pres.	I/D
7.	CEO and Managing Director's Report	Cara Charles-Barks, Chief Executive / John Palmer, Managing Director	Enc.	I
7.1.	Chair's Report	Liam Coleman, Interim Chair	Enc.	I
Governance				
8.	Board Assurance Framework Summary Report	Roxy Milbourne, Interim Head of Corporate Governance	Enc.	I/D
9.	Management Executive Committee Upward Report and Terms of Reference for Ratification	John Palmer, Managing Director	Enc.	I/D
10.	Integrated Performance Report	Toni Lynch, Chief Nursing Officer	Enc.	I/D
The People We Care For				
11.	MIS Combined Maternity and Neonates Quarterly Report Q2	Jane Farey, Obstetric Lead / Zita Martinez, Director of Midwifery	Enc.	I/D
12.	Safeguarding Strategy for Approval	Jo Baker, Associate Director for Vulnerable People	Enc.	A
13.	Six Monthly Nurse and Allied Health Staffing Report	Toni Lynch, Chief Nursing Officer	Enc.	I/D
14.	Learning from Deaths Report Q1	Sarah Richards, Deputy Chief Medical Officer	Enc.	I/D
15.	Quality Assurance Committee Upward Report and Terms of Reference for Ratification	Simon Harrod, Non-Executive Director	Enc.	I/D/A

The People We Work With				
16.	Freedom to Speak Up Q1 and Q2 Report	Para Perera, RUH Freedom to Speak Up Guardian / Elizabeth Swift, SFT Freedom to Speak Up Guardian	Enc.	I/D
17.	People Committee Upward Report and Terms of Reference for Ratification	Paul Fairhurst Non-Executive Director	Enc.	I/D/A
The People in Our Community				
18.	Non-Clinical Governance Committee Upward Report and Terms of Reference for Ratification	Sumita Hutchison, Vice-Chair	Enc.	I/D/A
19.	Charities Committee Upward Report	Sumita Hutchison, Vice-Chair	Enc.	I/D
20.	Audit and Risk Committee Upward Report and Terms of Reference for Ratification	Joy Luxford, Non-Executive Director	Enc.	I/D/A
21.	Finance and Performance Committee Upward Report	Antony Durbacz, Non-Executive Director	Enc.	I/D
CLOSING BUSINESS				
22.	Any Other Business	Liam Coleman, Interim Chair	Verbal	-
Date of Next Meeting: Wednesday 4 March 2026, 09:30 – 12:00 Venue: Room G.07, Bath Spa University Locksbrook Campus, Locksbrook Road, Bath, BA1 3EL				

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

Present:

Members

Liam Coleman, Interim Chair *(Chair)*
Sumita Hutchison, Interim Vice-Chair
Simon Harrod, Non-Executive Director
Joy Luxford, Non-Executive Director
Hannah Morley, Non-Executive Director *(until 15:20)*
Antony Durbacz, 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, Interim Group Transformation and Innovation Officer
John Palmer, Managing Director
Jocelyn Foster, Chief Strategic Officer
Toni Lynch, Chief Nursing Officer
Bernie Bluhm, Acting Chief Operating Officer
Kheelna Bavalia, Interim Chief Medical Officer

In attendance

Roxy Milbourne, Interim Head of Corporate Governance
Sharon Manhi, Head of Patient Experience *(item 7)*
David French, Head of Audiology *(item 7)*
Zita Martinez, Director of Midwifery *(items 13 & 14)*
Jane Farey, Obstetric Lead *(items 13 & 14)*
Member of the public
Abby Strange, Corporate Governance Manager *(minute taker)*

Apologies

Paul Fairhurst, Non-Executive Director

BD/25/10/01 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 of Directors confirmed that they had no additional interests to declare.

BD/25/10/02 Written questions from the public

The Interim Chair summarised a number of questions that had been submitted by a member of the public via email on 25th June and a further question that had been submitted by the same member of the public on 29th October. The Board had responded to some of the questions at their public meeting in July, but they had not been able to answer all of the questions at the time. They were now in a position to provide a full and comprehensive response to the remaining questions and the Interim Chair relayed the response to those in attendance. He confirmed that the full list of questions and responses would be made available on the Trust website.

BD/25/11/03 Minutes of the Board of Directors meeting held in public on 3 September 2025

The minutes of the meeting held on 3rd September 2025 were approved as a true and accurate record.

BD/25/11/04 Action List and Matters Arising

The actions presented for closure were approved. The following action was discussed in more detail:

PB622 – The Board emphasised the importance of producing a BSW Hospitals Group anti-racism statement for both service users and staff. The Managing Director reflected on the responsibilities of the Trust as an employer and advised that a listening event had recently taken place with more due to be scheduled. It was confirmed that this action could be closed.

BD/25/11/05 Governor Log of Assurance Questions and Responses

The Governor Log was presented for information.

BD/25/11/06 Item Discussed at Private Board

The Interim Chair provided a summary of the Board's discussions in private. He explained that there was a continued focus on the Trust's ongoing operational and financial challenges including the increased demand in Urgent and Emergency Care (UEC), Non-Criteria to Reside (NCTR), and comorbidity challenges in caring for patients.

BD/25/11/07 Patient Story

The Chief Nursing Officer welcomed the Head of Patient Experience and the Head of Audiology to the meeting and introduced the patient story which centred around the reduced waiting time for hearing aid fittings. The Head of Audiology explained that there had been a focused effort to reduce the waiting time from referral to diagnosis and this had subsequently increased the waiting time for hearing aid fittings to approximately 14 months. The team had since introduced an option for suitable patients to have their hearing aids posted to them and had temporarily reduced some hearing aid fitting appointments from 45 to 30 minutes. The service was now fully recruited and the waiting time had reduced to approximately 10 months. This was estimated to further reduce to 6 weeks by spring 2026.

The Board commended the patient story as an example of how the Trust could work differently to better meet the needs of patients. They reflected on the amount of work that was being done to validate waiting lists across other specialities and the need to develop transformational solutions that would deliver sustainable reductions. The patient story would be shared across the specialties and the Interim Chief Transformation and Innovation Officer would work with the Head of Audiology to develop a case to support other specialities to think about opportunities for self-service and digitalisation.

Action: Interim Chief Transformation and Innovation Officer

Hannah Morley asked whether staff were energised for further change. The Head of Audiology indicated that the team was the key enabler to this work. Changes had been implemented collaboratively and staff were energised for the next set of changes because they would have the time and capacity to trial new ideas.

The Board of Directors noted the patient story and the Chief Nursing Officer thanked the Head of Audiology and Head of Patient Experience for attending the meeting.

BD/25/11/08 CEO, Managing Director, and Chair's Report

The Chief Executive summarised her section of the report and highlighted that the critical risks for the Trust and the Group were the financial position and operational pressures. The Trust was in NHS Oversight Framework 4 for finance but the actions that it had been taking were beginning to have an impact. The system had been asked to go further by reducing the agreed £10m deficit to a breakeven position but this was not without risk. The Trust's work to improve performance had been phenomenal but there was ongoing pressure in the UEC domain due to increased attendances and the introduction of the Wait 45 (W45) initiative. The team were working hard to resolve the overcrowding and it was important to acknowledge the difficult circumstances that the Emergency Department (ED) Team were working under. The Trust was currently rated 112th out of 132 Trusts in the national league tables due to its operational and financial performance challenges and the position was expected to change in the next 6-12 months.

The Group Leadership Team was beginning to come together with the appointment of the Group Chief People and Chief Finance Officers and the Group Strategic Clinical Transformation Director. A Group Chief Strategic Officer was also due to be recruited imminently. The development of the Group strategy continued and this would create a high-level long term vision aligned with the NHS 10 Year Health Plan, acting as a call to action and a clear narrative for staff, partners, and communities.

The Managing Director reiterated that it was a challenging time for the Trust and thanked the Executive Team for their ongoing efforts. There were definite signs of improvement in Referral to Treatment (RTT), diagnostics, and cancer and a call to action had been initiated to help the organisation to focus on the priority areas. There had been a number of important visits and the Trust was due to have an oversight discussion with the Chief Executive of NHS England (NHSE) on 13th November to review the improvement that was required in the second half of the year. A Turnaround Team was also being brought in to provide forensic support in achieving the Trust's agreed £17m year-end deficit.

The organisation had recently had a Care Quality Commission (CQC) inspection of ED and the Urgent Treatment Centre (UTC) and a challenging report was anticipated. It was essential that the organisation maintained safety and quality in the context of resolving the operational and financial challenges and the report would support the Trust in delivering improvements. Quality initiatives such as the Excellent Care at Every Level Accreditation Programme were ongoing and The Discharge Lounge and Critical Care Unit had recently achieved bronze and gold accreditation respectively.

The Chair reported that the 2025 Governor Elections had now concluded. He thanked the outgoing Governors on behalf of the Board and welcomed the newly elected and returning Governors. He also highlighted that the Trust's 2025 Annual General Meeting had taken place on 25th September and a recording was available on the website.

The Board of Directors noted the report.

BD/25/11/09 Annual Report and Accounts

The Interim Head of Corporate Governance reported that the Annual Report and Accounts had been laid before parliament on 16th September and were presented in

public at the Annual General Meeting on 25th September. She advised that they were available to view on the Trust website.

The Board of Directors noted the update.

BD/25/11/10 Management Executive Committee Upward Report

The Managing Director presented the report and highlighted the development of the ED Overnight Business Case. He advised that formal approval had now been received from the BSW Integrated Care System Triple Lock Investment Panel and the Trust had gone out to advert. This was likely to feature in the report that the CQC would issue following their unannounced visit to ED and UTC. The Committee had discussed several key risks including the increase in sickness absence. This risk was well described and work was ongoing to identify suitable interventions. A number of decisions and approvals had also been made by the Committee as detailed within the report.

The Board of Directors noted the report.

BD/25/11/11 Integrated Performance Report

Operational Performance

The Acting Chief Operating Officer reported that ambulance handovers had improved to below 40 minutes in October following the implementation of the W45 initiative. This had increased overcrowding in ED and changes were being made to the configuration of the department to address this. Discussions were also ongoing with the ambulance service and other community partners to engage their support of flow through the hospital. 4 hour performance had improved now that type 3 data had been mapped but performance was still significantly below where it needed to be.

RTT continued to improve but this could be impacted by winter pressures. NCTR remained a challenge and work was ongoing with community partners to develop plans to address this and to deliver additional capacity during the winter months. Cancer performance was expected to improve in November but there were some challenges in diagnostics and work was ongoing to increase activity at both the Trust and Sulis.

Simon Harrod sought clarity on what had driven the improvement in RTT. The Acting Chief Operating Officer advised that the improvement was driven by a combination of validation, waiting list scrutiny and insourcing to target specific waiting lists. These measures would continue until the waiting lists had stabilised and work was ongoing alongside this to understand the capacity and demand profiles of each specialty.

Sumita Hutchison asked whether the NCTR target was realistic and whether the Trust was tracking Same Day Emergency Care (SDEC) readmissions. The Acting Chief Operating Officer advised that the Trust could do more internally but NCTR primarily relied on community partners who were experiencing their own challenges. This had been escalated and the Regional Director had agreed to take this forward. Discussions were also ongoing to determine whether capacity could be opened up to minimise the impact of winter pressures. In terms of SDEC, readmissions rates were not being raised as a clinical concern.

Sumita Hutchison sought assurance around the culture of utilising Sulis. The Acting Chief Operating Officer confirmed that work was ongoing to ensure that Sulis was seen as an

extension of the Trust and the number of patients being transferred across was increasing. There were challenges in terms of administration and pathway processes but these were being resolved at pace to support the Trust's operational recovery.

Quality
The Chief Nursing Officer reported that 5 pressure ulcers were recorded in August and the organisation continued to run an improvement programme. There had been 4 falls resulting in moderate harm and a Patient Safety Incident Investigation (PSII) had been launched to identify whether there was any new learning. Clostridioides Difficile Infections had slowed in 25/26 but work continued to identify causal links. Focused work was also ongoing around E. coli with urinary being a consistent theme.

The combined shift fill rates for registered nurses was 84% and 92% for days and nights respectively. The rates for healthcare support workers was slightly lower for days at 82% due to vacancies and a bespoke programme was being developed to address this. Staffing levels had continued to reduce but the Trust remained within the expected parameters. Operational pressures across maternity and neonatal services continued, particularly in relation to staffing, acuity, and demand, and mitigation measures were in place. No neonatal deaths or stillbirths had been reported in this period but there had since been some variance which would be detailed in the next report.

The Board sought assurance around safe staffing and indicators that would demonstrate the impact of reduced staffing on flow. The Chief Nursing Officer advised that there were concerns about the level of sickness in registered nurses and midwifes across the organisation and the Trust needed to be cautious. An Equality and Quality Impact Assessment was in place around the reduction in staffing as were twice daily safe staffing meetings, but fill rates had started to become slightly lower than they should be. Controls were being rebalanced and a bespoke programme was being developed around the concept of moral injury and psychological safety to ensure that staff felt safe and supported. In terms of indicators around the impact on flow, this was multifactorial and the majority of the evidence was qualitative rather than quantitative.

Hannah Morley asked when the PSIIs around falls and pressure ulcers were likely to be completed. The Chief Nursing Officer advised that the work was almost complete. The teams were currently testing interventions and triangulating data to form part of the report.

Workforce
The Chief People Officer reported that the Trust was in a strong position in terms of turnover and vacancy but was 120 Whole Time Equivalents over plan for September. The workforce control process had been reviewed and strengthened in response to this and staff would only be recruited for quality and performance purposes. Sickness absence had increased and a broader discussion would take place around the application of the sickness absence policy alongside department specific work. It would take time to resolve this and the work could be delayed by winter pressures.

Finance
The Chief Finance Officer reported that the RUH Group was £12.8m adverse to plan at the end of September but the run rate had improved since the first part of the year with a £0.5m better than planned recovery trajectory. The productivity improvement was around 2.8% which was below target but the Trust was delivering more for its cost base following

the 6% growth in cost weighted activity. The organisation was behind on its capital plan but some of the schemes could be stepped back up if the financial environment changed.

The Board sought assurance on the cash position and deficit support funding. The Chief Finance Officer confirmed that the cash balance was around £19m. A recovery trajectory needed to be developed around the capital plan and work needed to take place to determine how the cash position would be managed across the Group. Deficit support funding continued to be discussed with the region.

The Board of Directors noted the report.

BD/25/11/12 Seasonal Plan

The Acting Chief Operating Officer provided an overview of the winter plan which had been developed to provide operational resilience between 27th October and the end of March 2026. She outlined the key risks and mitigation strategies and indicated that demand had already exceeded the level of expected activity. This would continue to be monitored and work was ongoing to identify additional external and internal capacity. Learning had been identified around how the Trust managed internal escalation and there was a need to reshape the OPEL status, interventions, and escalation of responsibilities to senior leaders during incidents.

Simon Harrod shared his concern around the process for managing the transfer of suitable patients to Sulis. The Acting Chief Operating Officer advised that the Sulis and Elective Recovery System Lead and been brought into the operational management of the Trust to lead on orthopaedics and what could be accommodated at Sulis. She would also be tasked with determining how patients who could not be transferred to Sulis could receive treatment before the end of March 2026

The Board of Directors noted the report.

BD/25/11/13 MIS Combined Maternity and Neonates Quarterly Report Q1

The Chief Nursing Officer welcomed the Director of Midwifery and the Obstetric Lead to the meeting who summarised the report. They explained that 1 stillbirth and 1 neonatal death had been reported in Q1 and the Mothers and Babies: Reducing Risks through Audits and Confidential Enquiries 2024 report indicated that the Trust had an average stillbirth rate and lower than average neonatal mortality and extended perinatal rate. The highest scoring maternity and neonates risk in Q1 related to maternity triage non-compliance with medical timescales and work was ongoing to shortlist obstetric consultants. A risk had also been identified around ultrasound capacity and progress on this would continue to be reported to the Board.

The Trust continued to be compliant with the Maternity Incentive Scheme and the service continued to meet 90% compliance for Saving Babies Lives Care Bundle v3.2. Term admissions into the Neonatal Unit had decreased since Q4 with the Transitional Care Pathway remaining open 100% of the time in Q1. There had been 1 baby in the reporting period identified as a potential avoidable term admission and a rapid review was being undertaken. It was proposed that progress reporting on the Ockenden 15 Immediate and Essential Actions was closed down as the Trust had not been required to submit evidence of compliance since December 2022. The outstanding sub-actions had been incorporated into the improvement plan and there were no high risk concerns.

The Interim Chair sought assurance that the Ockenden sub-actions would receive the same level scrutiny and visibility through the improvement plan. The Director of Midwifery confirmed that the sub-actions would be clearly detailed within the improvement plan.

The Board of Directors noted and approved the report including the proposal to close reporting against the Ockenden Immediate and Essential Actions.

BD/25/11/14 Midwifery and Bi-Annual Staffing Report

The Director of Midwifery provided an overview of maternity, neonatal nursing, and medical staffing at the Trust between January and June 2025. She highlighted that maternity services were fully funded to the establishment level recommended by the April 2023 BirthRate+ assessment with a positive recruitment pipeline. Staffing in the neonatal unit had improved and the Trust was on trajectory to be compliant with Qualified in Specialty recommendations in Q2 in line with the agreed action plan. The medical workforce was stable and remained compliant with British Association of Perinatal Medicine standards. Key risks included under-provision of Allied Health Professionals and pharmacy support and low neonatal outreach staffing levels.

The Managing Director asked whether the Trust was seeking both informal and formal insights coming out of the National Maternity Review. The Director of Midwifery explained that information had been limited to date and learning would be shared as soon as it had been identified. She added that she had good connections and was working with the system to gather intelligence where possible.

The Board of Directors approved the report and noted the current staffing position. They were supportive of the ongoing strategic workforce planning required to maintain safe, high quality maternity and neonatal care.

BD/25/11/15 Annual Mortality Review

The Interim Chief Medical Officer provided an overview of the report which evidenced the organisation's compliance with the requirement to conduct and learn from reviews of the care provided to patients who had died. The Trust had recorded 1349 deaths during 24/25 and no patient had been assessed as having very poor care overall. Mortality rates were within the expected range but there had been an uptick in Summary Hospital-level Mortality Indicator data due to coding gaps which were now being addressed. This would carry over into 25/26 and the Mortality Surveillance Group was monitoring this. The backlog of Structured Judgement Reviews (SJRs) was decreasing but further work needed to be done to move this forward at pace. The limited capacity of governance and clinical leads was a consistent theme and would be investigated as part of this work.

Antony Durbacz sought assurance around the recovery of the coding backlog. The Interim Chief Medical Officer confirmed that resource had been put in place to recover the coding backlog but suggested that the plan would benefit from additional scrutiny and support. The Interim Chief Transformation and Innovation Officer added that the Trust was due to embark on a 12 week deployment of Artificial Intelligence enabled coding. This would need to be thoroughly tested and was being resourced by the national team with a view to wider deployment.

Sumita Hutchison asked whether there was evidence that patients were dying in hospital that should be dying elsewhere. The Interim Chief Medical Officer advised that national

data indicated that the Trust was not doing as well as it could and suggested that this was investigated through the Quality Assurance Committee.

The Interim Chair sought clarity on how many SJRs the Trust should be expecting to undertake each year. The Interim Chief Medical Officer agreed to look into this and advised that the selection criteria had been revised to ensure that the Trust was focusing in the right areas and was not duplicating SJRs with other processes.

Action: Interim Chief Medical Officer

The Board of Directors approved the report.

BD/25/11/16 Medical Revalidation Annual Statement

The Interim Chief Medical Officer provided an overview of the Trust's compliance against the statutory professional standards and confirmed that oversight of appraisal validation and responding to concerns processes was monitored by the Responsible Officer Advisory Committee. She highlighted that the gap in appraisal numbers related to in year movement of doctors and confirmed that processes would be refined to better capture this going forward. A benchmarking exercise had indicated that resource for appraisal was low and this would be addressed alongside a review of the appraisal policy and the expansion of the existing appraisal network.

The Board discussed the need to align appraisal policies, processes and tools across the Group to balance resource and capacity. They acknowledged that this was complex in that different systems were currently in use.

Sumita Hutchison asked whether any safety or performance risks had arisen from missed appraisals. The Interim Chief Medical Officer advised that while appraisals were a good tool for improving quality and professional standards, there were other tools that were better equipped to surface issues.

The Board agreed that the organisation was compliant with the Medical Profession Responsible Officers Regulations 2010 and approved annex A for signature.

BD/25/11/17 Quality Assurance Committee Upward Report

Simon Harrod highlighted the pressures in UEC and the concerns that had been raised around overnight staffing. He informed the Board of ongoing monitoring of quality standards following the reduction in nursing bank shifts and evidence that this had impacted the ability to book bank workers. Issues had been identified around clinical audit resource and work was ongoing to reduce the number of audits. Assurance had been received around patients that had been lost to follow up with 6000 out of 7000 patients validated and no clinical harm identified. A review of the risk register had been commissioned and positive feedback had been received around the implementation of BadgerNet in maternity.

The Board of Directors noted the report.

BD/25/11/18 People Committee Upward Report

The Board of Directors noted the report, including the Equality, Diversity and Inclusion Annual Report which had been approved at their meeting in private on 16th October and published on the website ahead of the 30th October deadline.

BD/25/11/19 Non-Clinical Governance Committee Upward Report

Sumita Hutchison reported that there were risks around the timely delivery of the SALIX Decarbonisation Programme and Electronic Patient Record Programme. Cleaning standards continued to be a concern with inconsistent performance and a reliance on bank hours and the Data Security and Protection Toolkit audit had resulted in partial assurance with remedial actions in progress. The Committee had discussed digital infrastructure and legacy systems and noted that while the situation remained fragile, mitigations were in place. The BSW Hospitals Group Climate Change Adaptation Plan had been identified as a robust piece of work but it was noted that delivery capacity was extremely limited.

The Board discussed the issues around the cleaning resource and debated whether further recruitment was needed due to the impact on quality. They reflected on the importance of understanding the unintended consequences of workforce controls and the need to determine where facilities should sit within the corporate services redesign. Once this had been established, the workforce model would be reviewed.

The Board discussed their concerns around cyber security and how the Trust would respond to the ongoing disruption of services following a cyber-attack. The Interim Chief Transformation and Innovation Officer emphasised the need for vigilance and advised that the Trust followed national NHSE Policy. He explained that the organisation's business continuity plans accounted for service disruption and agreed to share the detail of this with the Non-Clinical Governance Committee.

Action: Interim Chief Transformation and Innovation Officer

The Board of Directors noted the report.

BD/25/11/20 Charities Committee Upward Report

Sumita Hutchison provided an overview of the report and alerted the Board to a risk around the green heart garden which the Trust had committed to deliver alongside the Dyson Cancer Centre. Capital pressures meant that the project was now at risk and the Committee had sought further detail on this.

The Board of Directors noted the report.

BD/25/11/21 Audit and Risk Committee Upward Report

Joy Luxford provided an overview of the report and highlighted that the Trust needed to do more around the internal audit recommendations to obtain a suitable opinion at year end. The Committee had agreed a new approach to support this but would need to maintain close oversight of key internal audit actions arising throughout the year. The Local Counter Fraud Service deep dive report on RUHX had identified 14 recommendations which had all been accepted and the National Cost Collection Report had provided assurance around increasing data quality. The results had been referred to the Finance and Performance Committee to note the Group benchmarking.

The Board of Directors noted the report.

BD/25/11/22 Finance and Performance Committee Upward Report

Joy Luxford provided an overview of the key discussion points from the meeting in September and thanked colleagues for their hard work in recovering the financial and

operational performance positions. She advised that work was ongoing to plan for subsequent years and this would be shared with the Board in due course.

Antony Durbacz provided an overview of the key discussion points from the meeting in October and commented that the recovery plans were well documented but more transparency was needed around the financials. He highlighted the uncertainty around capital planning and the need to ensure that a reasonable plan was built for 26/27.

The Board of Directors noted the report.

BD/25/11/23 Any Other Business

The Board noted that it was the Chief Strategic Officer's last public Board of Directors meeting and thanked her for her significant contribution during her time at the Trust.

The Meeting closed at 16:15

Royal United Hospitals Bath
NHS Foundation Trust

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.	**BD/25/11/07**	**Nov 2025**	**Mar 2026**	This is likely to form part of the broader clinical transformation work to provide a use case for digital enablement. **Open**	**Chief Transformation and Innovation Officer (Interim)**
PB624	**Annual Mortality Review** Interim Chief Medical Officer to look into how many SJRs the Trust should be expecting to undertake each year.	**BD/25/11/15**	**Nov 2025**	**Jan 2026**	This has been picked up by the Mortality Surveillance Group and will be reported to the Quality Assurance Committee following review at the Clinical Effectiveness Committee. **To close**	**Interim Chief Medical Officer**
PB625	**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.	**BD/25/11/19**	**Nov 2025**	**Mar 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. **Open**	**Chief Transformation and Innovation Officer (Interim)**

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**5**
Date of Meeting:	**14 January 2026**		

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

1. Executive Summary of the Report

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

One new question, NOV25, was raised since the last report was presented in November 2025. This relates to staff concerns about ongoing corporate redesign work and the need for communication, transparency and engagement.

The question was sent to Sumita Hutchison, Vice-Chair, and Paul Fairhurst, Senior Independent Director who subsequently met with the Staff Governors to hear the feedback that they had received from staff in more detail. This was then escalated to the Senior Responsible Officer for the Corporate Services Redesign and Board of Directors as a whole. A Corporate Services Review briefing with Jude Gray, Chief People Officer, took place with all staff on 9th December 2025. Non-Executive Directors have also scheduled a regular meeting with Staff Governors to hear staff concerns. The question was closed at the Council of Governors meeting on 15th December 2025.

2. Recommendations (Note, Approve, Discuss)

The report is presented for information.

3. Legal / Regulatory Implications

The Council of Governors has a duty to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors.

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

There are no risks on the risk register.

5. Resources Implications (Financial / staffing)

There are no resource or financial implications.

6. Equality and Diversity

All Governors, no matter their background, can raise questions of NEDs at any time.

7. References to previous reports

November 2025

8.	Freedom of Information
Public	

9.	Sustainability
Governors have asked questions on various topics including sustainability. The log of assurance questions is held online.	

10.	Digital
Governors have asked questions on various topics including digital. The log of assurance questions is held online.	

Appendix 1: Governor Log of Assurance Questions

Date:	**12th November 2025**
Source Channel	**Email from Staff Governor**
Date Sent & Responder	Sent to Sumita Hutchison, Vice-Chair, Paul Fairhurst, Senior Independent Director, and Hannah Morley, Non-Executive Director via email on 12th November 2025.
Question and ID	**NOV25** Could you provide assurance that staff concerns about the corporate redesign are being actively addressed and that measures are in place to improve communication, transparency, and engagement.
Process / Action	Sent to Sumita Hutchison, Vice-Chair and Paul Fairhurst, Senior Independent Director via email on 12th November 2025.
Answer	The question was sent to Sumita Hutchison, Vice-Chair, and Paul Fairhurst, Senior Independent Director who subsequently met with the Staff Governors to hear the feedback that they had received from staff in more detail. This was then escalated to the Senior Responsible Officer for the Corporate Services Redesign and Board of Directors as a whole. A Corporate Services Review briefing with Jude Gray took place with all staff on 9th December. Non-Executive Directors have scheduled a regular meeting with Staff Governors to hear staff concerns.
Closed?	Closed at the Council of Governors meeting on 15th December 2025.

Report to:	**Public Board of Directors**	**Agenda item:**	**6**
Date of Meeting:	**14 January 2026**		

Title of Report:	**Parent story**
Status:	**For discussion**
Board Sponsor:	**Toni Lynch, Chief Nursing Officer**
Author:	**Heidi Green, Consultant Nurse, Neonatal Intensive Care Unit** **Zita Martinez, Director of Midwifery**
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.

Parent experience and improvement through learning

Albie was born at RUH following a caesarean section in April 2022 and very sadly died as he and his parents travelled home from hospital.

Albie's case was subject to a coronial inquest. Results from post-mortem indicate that Albie died due to a severe lung infection which had developed prior to delivery (congenital pneumonia). During his time in hospital, it was noted that there were concerns regarding his condition during his hospital stay and although Albie appeared well and had been seen by a consultant prior to discharge, additional actions could have been taken that may have identified the congenital pneumonia and prevented his death.

Learning and actions

1. Routine pulse oximetry for all newborns (≥34 weeks), integrated into the newborn physical examination pathway- The BAPM Framework for Routine Pulse Oximetry Testing recommends, routine pulse oximetry for all asymptomatic babies ≥34 weeks in all UK birth settings for early detection of hypoxaemic conditions such as congenital heart disease, respiratory illness, and infection. The framework aims to: Identify babies with low oxygen saturations early, enable timely investigation and treatment, avoid unnecessary

mother–baby separation, provide parents with clear information. ensure robust audit and governance mechanisms

2. Full sets of newborn observations, including saturations, for any baby presenting with feeding concerns, jaundice concerns, parental worry, or other soft signs.
3. Use of NEWTT2 for structured escalation - supporting consistent recognition and escalation of early deterioration.
4. A strengthened focus on professional curiosity and responsiveness to parental concern.
5. Reinforced culture of early escalation and clear multidisciplinary communication.
6. LMNS Safety Group presentation for potential wider learning.

Since implementation of these actions, the RUH have identified 2 cases of congenital pneumonia in infants that showed no clinical signs.

The Great Western Hospitals NHS Foundation Trust and Salisbury NHS Foundation Trust have also implemented pulse oximetry monitoring.

Delays described by Albie's mother, Rebecca regarding the coronial process
This parent story has been shared with the Coroner's Office.

Feedback to Albie's parents
Albie's parents have requested that we share Albie's story, and it is important we share our learning across the South West region as it is directly transferable to other maternity and neonatal services. Albie's story has been shared at BSW Hospitals Group Joint Committee prior to the RUH Board of Directors.

RUH continues to work with Albie's family, and the maternity and neonatal team are being supported, through what has been a very traumatic case for all involved.

The Bereavement Midwife is in contact with Albie's parents, and has agreed with them that following this presentation, BSW Hospitals Group, Chief Executive will write to them.

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

3.	Legal / Regulatory Implications
The Health and Care Act 2022	

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)

Nil

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

7.	References to previous reports
BSW Hospitals Joint Committee – December 2025	

8.	Freedom of Information
Public.	

Report to:	**Public Board of Directors**	**Agenda item:**	**7**
Date of Meeting:	**14 January 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 Roxy Milbourne, Interim Head of Corporate Governance**		
Appendices	**None**		

1. Executive Summary of the Report

The purpose of the Chief Executive's Report is to provide a summary of key concerns and highlight these to the Board of Directors. Updates included in this report are:

Chief Executive's Report

- Risks including financial position and performance pressures

Group

- Joint Committee update
- Leadership Team
- Group Governance
- Group priorities
- EPR Deployment Options Appraisal
- Clinical Transformation Programme
- Corporate Services Progreamme
- Council of Governors Workshop
- Board to Board development

National update

- Resident Doctors Industrial Action
- NHS Oversight Framework

Managing Director's Report

- Local (RUH)
  - Operational
  - Finance
  - Turnaround update
  - Medium term financial plan
  - Quality
  - Call to action
  - 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 Hospitals Group has made tangible progress in stabilising its financial position following a period of significant challenge in the early part of 2025/26. While the first quarter saw the components of the Group with significant adverse variances to plan, interventions implemented post Month 4 have begun to deliver tangible improvements. However, at Month 8 this progressed has slowed and the recovery plan trajectory has not been met, leading to a number of corrective actions being implemented. This ensured the confidence of Regulators was maintained and secured the release of Deficit Support Funding, totalling £15.6m, for the year to date.

At an organisational level the largest in month variance from the recovery plan was at Great Western Hospitals (£0.7m), with the Royal United Hospitals (£0.6m) and Salisbury Hospital (£0.3m) also off plan. In total for the year to date the Group is off plan by £43.3m, which is £1.6m adverse to the recovery plan position, the key drivers remain Urgent Care pressures, Non-Criteria to Reside numbers, Drug costs and inflationary impacts. As can be seen from the graph below, in future months there is a step up in the recovery trajectories at all Care Organisations so it is essential progress gets back on target, despite the pressures faced.

Urgent & Emergency Care (UEC) Update

UEC remains challenged across all three acutes in terms of demand and system flow. Internal actions are underway and will continue over the next few months.

There continues to be significant improvements in the average time for ambulance handovers at all three acute Trusts following the implementation of W45, and each of our hospitals are focusing on increasing P0 discharges and ensuring decisions regarding care are taken in a timely way to improve flow through our EDs.

The number of patients waiting to leave acute Trust beds remains a challenge – with continuing high numbers of No Criteria to Reside (NCTR) across all three. In December 2025, a system wide Mega MADE event was undertaken to support

increased community daily discharges and P0 discharges, with on-site support from all partners to ensure timely discharge on the more complex pathways. This has contributed to an increase in the number of future planned discharges and there is a dashboard being created to monitor the effects of the MADE impact.

As expected, winter flu has brought operational challenges. However, due to planning of cohort wards and testing, the impact has been less than in previous years despite the earlier presentation of flu across the system than predicted.

Demand into EDs continues to be a challenge and there is ongoing work with community providers to develop understanding of this change and what we can collectively action to mitigate the risks that are associated with this increase.

Elective

Whilst a number of risks exist in elective performance, it is worth celebrating the enormous hard work and perseverance by teams across BSW to reduce the number of patients waiting over 65 weeks. A year ago over 3.5% of our patients were waiting over a year for treatment – this now stands at 1.2%. At the end of December 2025, we had 18 patients waiting over 65 weeks (14 GWH, 4 SFT, 0 RUH).

Some of the key risks currently being managed in elective care are:

- Rising demand in referrals leading to challenges sustaining our access standards. This is being mitigated by the development of a clear demand management programme with the ICB.
- Loss of capacity due to winter pressures and industrial action. Clear winter plans have been developed across the group aiming to maximise elective activity during this period however this remains a significant risk.
- Planning for 2026/27 not providing sufficient capacity to meet our access goals. Given the challenged financial environment and high growth, the group needs to ensure adequate capacity and productivity is delivered in the year ahead to continue our positive progress in meeting our national targets around elective access. Each Trust is actively developing these plans to ensure we maximise the care we deliver within limited funds.

National Update

Resident Doctors Industrial Action

Resident Doctors took industrial action from 7.00 am on Wednesday 17th to 6.59 am on Monday, 22nd December 2025. Thanks to the staff across our hospitals who worked hard to keep services running and minimise the impact of Industrial Action on our patients as much as possible.

NHS Oversight Framework – NHS Trust Performance League Tables

In November 2024, the Secretary of State announced that NHS England would assess NHS Trusts against a range of performance criteria and publish the results.
NHS England published the 2025/26 quarter two segmentation results and performance dashboard, an outline of performance within BSW Hospitals Group is outlined below:

Great Western Hospitals NHS Foundation Trust was ranked 82 out of 134 Trust's in the country, the previous quarter's ranking was 76.

Royal United Hospitals Bath NHS Foundation Trust was ranked 105 out of 134 Trust's in the country, the previous quarter's ranking was 112

Salisbury NHS Foundation Trust was ranked 70 out of 134 Trust's in the country, the previous quarter's ranking was 57.

The segmentation rating for each Trust remained the same since the last quarter, with both GWH and SFT rating 3 and the RUH 4.

Further information on the league tables can be found via https://www.england.nhs.uk/nhs-oversight-framework/segmentation-and-league-tables/

Group Development

Joint Committee

Our latest BSW Hospitals Group Joint Committee meeting was held on 17th December 2025 with focus being on discussion of Group Priorities and Prioritisation Approach, Financial Sustainability & Recovery, Care Organisation Risks, the EPR Programme, as well as our Clinical Transformation and Corporate Services Programmes. A report from the December Group Joint Committee has been included with January Trust Board papers.

Leadership Team

December saw changes to both the composition of the Group Executive and to the responsibilities associated with respective Executive Director portfolios considered at the Remunerations Committees in Common. The creation of a Chief Risk Officer role was approved, as were changes to the portfolio of responsibilities relating to the existing Chief Strategy Officer; Chief Transformation and Innovation Officer; and Strategic Clinical Transformation Director roles. The proposed changes are intended to ensure that respective Executive Director portfolios will effectively support the delivery of the Group's strategic aims, operational objectives, and regulatory requirements, and that the 'balance' of responsibilities across all Executive Director roles is appropriate.

The recruitment of the Group Chair continues with interviews scheduled during January.

Group Governance and Assurance Arrangements and Transition Roadmap

To support safe and effective mobilisation of our new Operating Model by April 2026, the Governance Working Group has continued developing the Group's detailed operating blueprint and governance and assurance framework. The Governance Working Group will work closely with the newly established Non-Executive Director Reference Group which met on 5th January 2026.

Group Priorities and Prioritisation Approach.

In November five areas of prioritised focus for the Group were agreed as follows:

1. Recovery (Performance & Finance)

2. EPR re-planning and implementation
3. Clinical transformation and clinical services framework design
4. Completion of the Corporate Services Review for services identified as mission critical
5. 2026/27 planning including Group Mobilisation

Interaction between these component parts (particularly recovery and EPR implementation) remains significant. To enable alignment and understanding of constraints a Group 'Engine Room' is to be established to sit alongside the CEO led Performance, Risk and Recovery Committee, the purpose of this forum is to facilitate agile and dynamic management of resources available in the delivery of the Group's programmes of work.

EPR Deployment Options Appraisal

A team of Executives from across the Group is nearing completion of an EPR Deployment programme options appraisal. Joint Committee review and decision is scheduled in January 2026.

Clinical Transformation Programme.

In November and December our BSW Hospitals Transforming Models of Care Programme mobilised, led by the Chief Transformation & Innovation Officer and a Clinical Transformation Steering Group. Three workstreams are planned:

- Designing single managed services
- Designing a model care organisation
- Supporting the medium-term financial planning

Through the Clinical Transformation Programme, clinical services will be supported to work together and explore potential service models. Clinical Transformation Groups (CTGs) will support clinical service transformation, with an ambition to mobilise six CTGs in 2026 – happy to put in public domain

Corporate Services Programme

Our Corporate Services Programme is making progress and the design stage for each of the services is underway with governance arrangements well established.

Group Board-to-Board Development Days.

The 2026/27 Group Board and a series of Board development days are being scheduled with the next Board-to-Board development day planned to take place in February 2026.

Councils of Governors Workshop

In early December 2025, the three Councils of Governors met to discuss the emerging Group Operating Model, our developing Group Narrative and Vision, and our Clinical Transformation Programme; the next session will be held in early February 2026.

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 110/123 in November, and we have seen a step increase in our Cancer 28 day faster diagnosis from 52.9% in September 2025 to 75.3% in December 2025 (+22.4%). 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 has improved, with type 1 performance improving from 56.63% in October to 57.70% in November, and all types performance improving from 65.3% in October to 66.90% in November. The average ambulance handover time has improved further to 31.6 minutes against a target of 33 minutes. RUH has commenced with a UEC reset plan which will focus on refreshing internal professional standards, improving board/ward rounds, redesign of escalation processes and streaming within ED Majors and UTC.

Our winter plans have been finalised, which include using 12 beds in Philip Yeoman Ward and working with HCRG to open 20 beds on Ward 4 at St Martins Hospital. These will be for patients who no longer meet criteria to reside and are awaiting their discharge. As of early January, 15 beds are open on Ward 4 and Philip Yeoman has been in use since 29th December.

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.

There was an increase in overall RTT performance in November of 2.3% to 63.0%. 18-week performance remains on track with our recovery trajectory, with the percentage of patients waiting less than 18 weeks for their outpatient appointment increasing to 66.4%.

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.

As we look forward to Q4, 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 October against all three of the standards but remained under the national target. The most notable improvements were in Breast and Skin.
However, 62 day performance will deteriorate from November 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. 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 November, 71.05% of patients received their diagnostic within the 6-weeks against the 71.60% target. 102 additional diagnostic tests were delivered in month, compared to October.

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 headline is £1.8m deficit in the month, and £15.9m Year to date. The do nothing run rate therefore remains at £24m deficit.

This position is £0.7m adverse to the recovery trajectory in month, and now £0.3m adverse to recovery trajectory year to date.

The drivers of variance to trajectory in month are:

- £0.3m Industrial Action costs
- £0.3m BSW High Cost Drugs not mitigated
- £0.1m other variances

Once again the position had income ahead of plan at RUH and Sulis.
There is a growing risk of commissioner affordability and non payment, although could be mitigated by additional RTT sprint funds in Q4.

This is offset by Pay and Non pay expenditure has broadly flat-lined and is not reducing at required rate.

Disappointingly in reaching this position a number of backdated costs, stock adjustment and income recording issues, totalling £1m arose in month; and therefore £1m of balance sheet efficiency, including opportunities identified Finance and Hunter team work programme have had to be transacted this month.

Divisional Position against total trajectory

Variance to Forecast by Division - Nov 25	In Month				Year to Date			
	RUH				RUH			
	Forecast	Actual	Variance	Variance	Forecast	Actual	Variance	Variance
	£'m	£'m	£'m	%	£'m	£'m	£'m	£'m
Commissioning Income	41.108	41.606	0.498		327.303	328.384	1.081	
Surgery	(11.139)	(11.484)	(0.345)	-3.1%	(90.484)	(91.012)	(0.528)	-0.6%
Medicine	(14.193)	(14.838)	(0.645)	-4.5%	(112.086)	(113.374)	(1.288)	-1.1%
FASS	(8.715)	(9.101)	(0.386)	-4.4%	(68.934)	(69.679)	(0.745)	-1.1%
E&F	(2.845)	(2.666)	0.179	6.3%	(22.196)	(21.715)	0.481	2.2%
Corporate	(4.012)	(3.798)	0.213	5.3%	(32.647)	(32.666)	(0.019)	-0.1%
HIWE	0.000	0.000	0.000		0.000	(0.000)	(0.000)	
R&D	(0.000)	(0.000)	(0.000)		(0.000)	(0.000)	(0.000)	
0	**0.205**	**(0.282)**	**(0.487)**		**0.956**	**(0.062)**	**(1.018)**	
Sulis	**0.268**	**0.058**	**(0.210)**		**0.507**	**0.262**	**(0.245)**	
Reserves, Capital Charges and Profiling	**(1.573)**	**(1.546)**	**0.028**		**(17.063)**	**(16.110)**	**0.952**	
Adjusted Financial Performance - Group	**(1.100)**	**(1.770)**	**(0.669)**		**(15.600)**	**(15.910)**	**(0.310)**	

Key Drivers		
November Industrial Action	(0.250)	(0.250)
BSW High Cost Drugs & Devices growth against run rate	(0.400)	(0.900)
Sulis Recovery	(0.210)	(0.245)
Other	0.191	1.085
	(0.669)	**(0.310)**

3. Turnaround update – Programme summary

At M8 RUH forecast outturn (FOT) on a straight line basis was £23.9m with a commitment to find additional savings of circa £7.1m to bring this figure to £17m. Whilst an outline of additional initiatives has been developed to achieve the added savings, there is significant risk in this. The Trust, acknowledging its contribution to the ICS position, will likely be required to identify and deliver additional savings of around £1.7m although this is yet to be finalised.

In total, the Trust is seeking to deliver an additional £8.7m of savings over and above M8 FOT of £24m. Hunter Healthcare have been commissioned to help the Trust maximise its potential to deliver this.

The Divisions have updated their forecasts to reflect scheme development discussed at run rate meetings and FIRMs, which will strengthen the position but will require ongoing further review.

Initial Observations/Insights
The second FIRMs were held this week and Divisions presented revised position statements reflecting M8, adjusted for RR opportunities and savings identified through the turnaround process. Key risks identified at FIPB and Executive decisions requested being addressed:

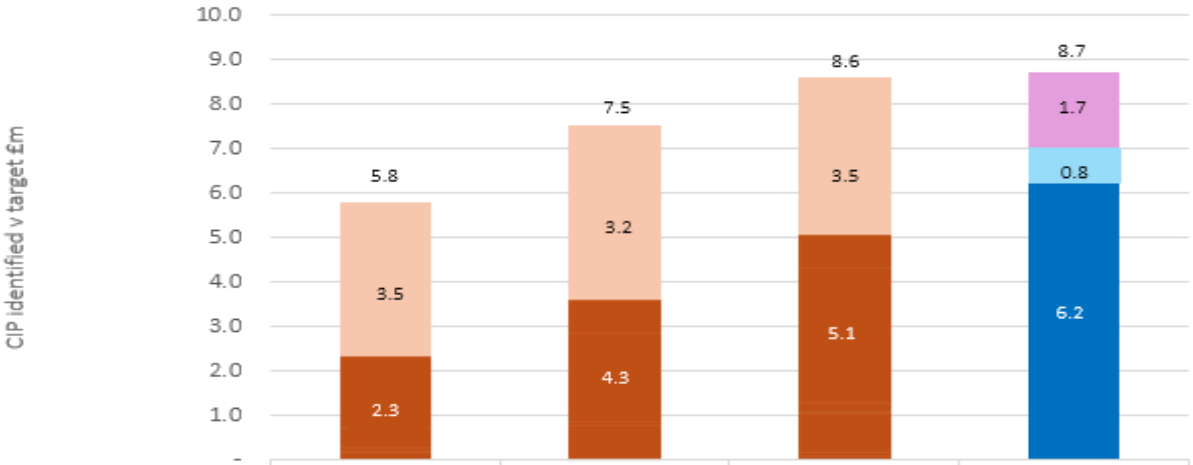
- Sickness policy revision to reduce sickness rates which have arisen in recent months; and
- High-cost drugs funding shortfall discussion with Commissioners raised with group CFO.

Opportunities identified have been estimated at £8.6m which have been risk assessed to £5.1m, including £1m which has been crystallised in M8.

The following observations are made:

- Risk assessed opportunity value represents 72% (£5.1m/£7.1m) of RUH only stretched savings target and 57% (£5.1m/£8.7m) of total stretched savings target of £8.7m (inc. system stretch).
- We are supporting Trust Divisions tasked with developing PIDs at pace for approval which will underpin an increase in risk assessed value as initiatives are further developed and firmed up.
- Savings opportunities portfolio shows progression with £1.1m increase over week 4.

A further pipeline of programme opportunities has been developed to work through as well.

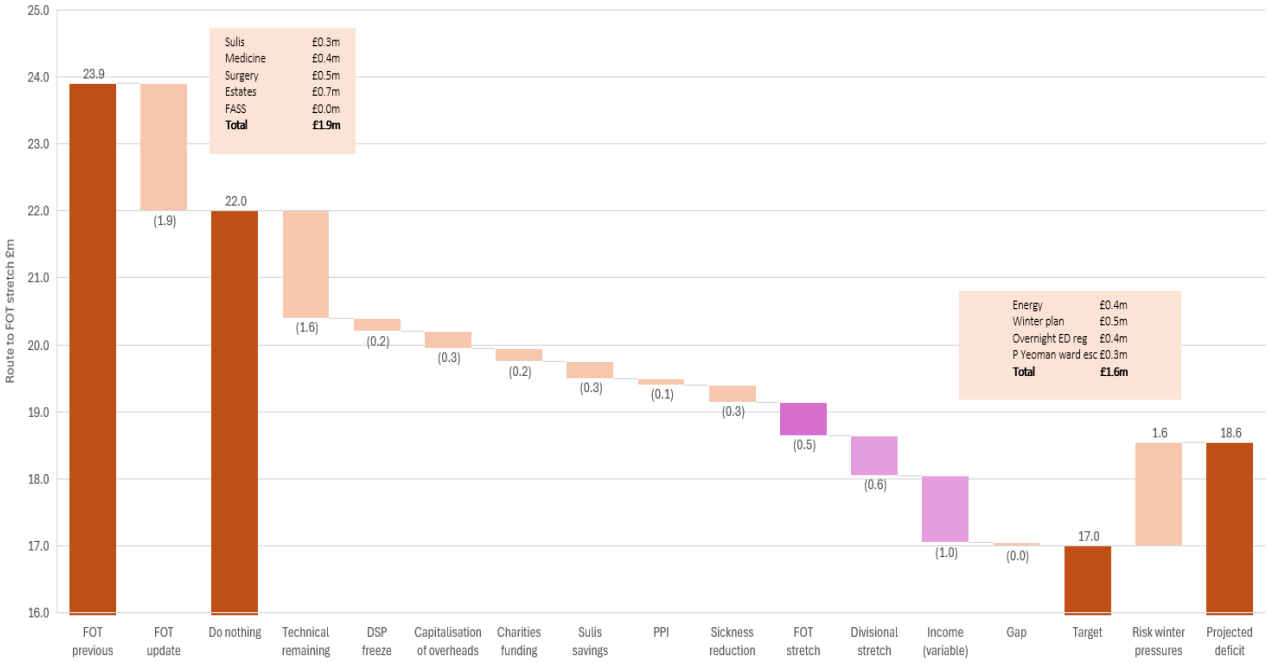


	W3	W4	W5	Target
Stretch	3.5	3.9	3.5	
Target group				1.7
Target RUH M8 uplift				0.8
Target RUH baseline				6.2
Sulis		0.8	0.8	
Technical	1.5	2.0	3.0	
Corporate	0.0	0.1	0.2	
HR	0.0	0.0	0.0	
E&F	0.5	0.7	0.9	
Surgery	0.1	0.0	0.1	
Medicine	0.1	0.0	0.1	
FASS	0.2	0.0	0.0	
Total	5.8	7.5	8.6	8.7

Week 5 increase by £1.1m to £8.6m. Increase in risk assessed by 0.8m to £5m.

Indicative opportunities – Route to Control total £17m Deficit

We have indicated a route from the SL FOT of £23.9m to the control total stretch of £17m deficit as below, subject to evolution and validation, recognising winter pressure risk.



4. Medium Term Financial Plan

The Trust submitted a first draft 3year Medium Term Plan to NHSE on 16th December. This key performance expectations and financial parameters are set out in tables below.

The headlines are:

1. Compliance with RTT performance targets, but non-compliance with UEC performance targets.

2. Underlying financial surplus of £15.1m, but challenging front-loaded delivery and a 26/27 deficit of £1.6m after delivery of stretching £36.1m (6%) savings plan.

Further work is underway to translate this into detailed operational delivery plans and a final submission is due with NHS England by 12 February.

Current position versus NHSE expectation(5.12.2025)

	Metric	Latest RUH position (Oct '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	65.3%	78%	82% by Mar '27	75.3%	83%	76.1%	85%	TBC
	12-hour ED performance	9.1%	4.9%	3.9%	7.0%	Year on year reduction	6.9%	Year on year reduction	TBC
	Ambulance handover	37 mins	33 mins	Reduce toward 15 mins	31 mins	Further improvement	31 mins	15 mins	TBC
Elective & Diagnostic	18w RTT Performance	60.7%	67.7%	74.7% for RUH *(65% or 7% improvement, whichever is higher.)*	74.7%	To bridge the ask between74.7% and 92% constitutional standard	78.9%	92%	TBC
	DM01	70.5%	83.9%	86.9% for RUH *(3% improvement)*	12.5%	To bridge the ask between 86.9% and 99%	9.0%	99%	TBC
Cancer	28d FDS	53.7% (Sep '25)	80.2%	80%	76.1%	80%	76.1%	80%	TBC
	31d	91% (Sep '25)	93.7%	94%	94.7%	96%	96.1%	96%	TBC
	62d RTT	58.3% (Sep '25)	75.3%	80%	70.0%	82.5%	70.0%	85%	TBC
Workforce	30% Reduction in agency use	13.6 WTE	5.0 WTE	*30% improvement relative to M6*	5 WTE	Improvement	4 WTE	Zero agency spend	TBC
	10% reduction in bank spend	268.8 WTE	261 WTE	*10% reduction relative to M6*	-11 WTE	Improvement	-6 WTE	30% reduction relative to 25/26	-6 WTE
	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)*	2%		2%	"Sustained improvement"	2%
	Savings Plan		15.0m (29.7m)		36.1m		10.0m		8.6m
	Balanced or surplus financial position	-£14.1m	-£17m	Balance or surplus	-1.6m		0.0m	Balance or surplus	10.9m

RUH 3 year financial plan

	2026/27 £m	2027/28 £m	2028/29 £m	Recurrent Cumulative £m
25/26 forecast outturn (£17m plus stretch)	-14.3			
Remove transitional funding	-19.2			
Remove deficit support funding	0.0			
Adjust for non-recurring items - Technical items	-4.8			
Adjust for non-recurring items and balances to FYE	-6.3			
Further NR improvements to deliver in year stretch	-2.7			
25/26 Underlying position	-47.3			
Adjust for full impact of block rebasing	37.9			
Revised 25/25 ULP restated for block rebasing	-9.4	15.1	16.6	-9.4
Net tariff deflator (including inflation on ULP)	-12.7	-12.4	-12.6	-37.6
Cost pressures(incl CNST)	-5.3	-3.0	-3.0	-11.3
Net margin on growth	6.4	6.8	8.8	22.0
CIP	36.1	10.0	8.6	54.7
Transformation and innovation headroom	0.0	0.0	0.0	0.0
Net margin on release of ERF top-slice	0.0	1.5	0.0	
EPR set up	-1.0	0.0	0.0	
Phasing adjustment for block rebasing	-28.1	-18.0	-7.4	
Transitional funding	12.3	0.0	0.0	
Deficit support funding	0.0	0.0	0.0	0.0
In Year Financial Position	-1.6	0.0	10.9	
Underlying Financial Psition	15.1	16.6	18.3	18.3
Estimated inherent productivity	4.1%	1.6%	3.2%	

- 3yr MTFP is stretching but deliverable
- However, financial challenge is heavily front-loaded and in advance of critical enablers such as left Shift, EPR and Capital investment
- Assumes pay and price inflation is fully funded in line wit national model
- 6% CIP target in 26/27, driving £15.1m underlying surplus
- Plans not yet developed. £55m saving is beyond £34m Productivity opportunities identified by NHSE benchmarking and will require service transformational and redesign
- Finance Plan not triangulated to Workforce plan for 1st draft
- In year position deflated due to phasing of block contract rebasing
- Surplus of £10.9m in 28/29 leading to scope for investment in transformation and innovation
- RUH position is favourable to BSW Hospitals group partners.
- BSW Hospitals group deficit of £45.1m in Yr1
- ICB breakeven

5. Quality

Unannounced inspection of Urgent and Emergency Care by the Care Quality Commission

The Care Quality Commission (CQC) undertook an unannounced inspection of Urgent and Emergency Care in October 2025.

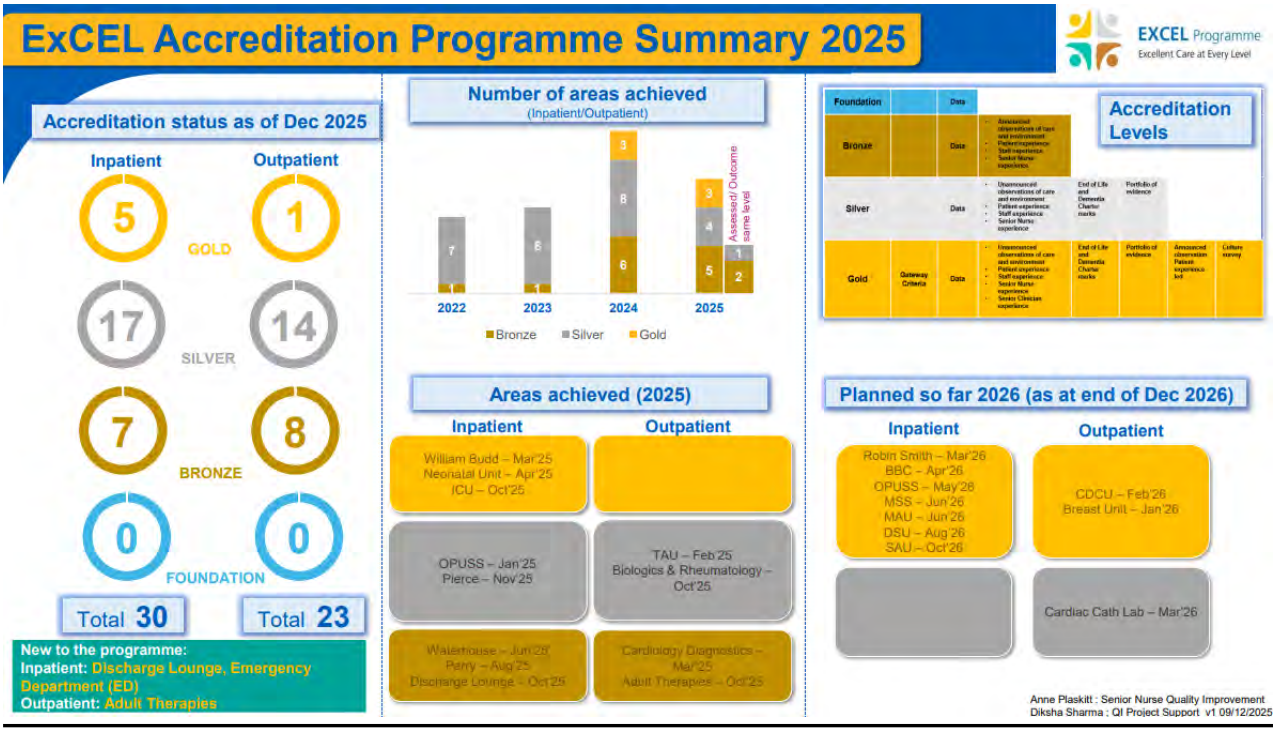
Following immediate feedback the Trust has made improvements to three key areas:

- Medical staffing in the Emergency Department at night between midnight and 8am.
- Environmental safety concerns for high-risk vulnerable mental health patients attending the service.
- Fire safety risks including blocked fire exits and access to Paediatric Resus.

The Trust awaits the draft report from the CQC, once published, it will be presented to the Board of Directors.

Accreditation

Excellent Care at Every Level
The Excellent Care at Every Level Accreditation Programme is the most significant quality improvement programme across the Trust. Since the last public Board of Directors, Pierce ward and the Biologics and Rheumatology Unit achieved Silver Accreditation. The infographic tracks the improvement journey for all clinical areas.



6. Use of Trust Seal

The Trust seal was last used on 9th January 2026 for:

1. The Deed of Surrender at Trowbridge Community Hospital between NHS Property Services Limited and the Royal United Hospitals Bath NHS Foundation Trust.

2. The lease relating to land at Bath Fertility Clinic, Roman Way, Bath Business Park, Peasedown St John, Bath, BA2 8SG between Repromed Limited and the Royal United Hospitals Bath NHS Foundation Trust.

7. Membership

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

By becoming a Member, our staff, patients and local community are given the opportunity to influence how the hospital is run and the services that it provides. Membership is completely free and offers three different levels of involvement. Through the Council of Governors, Members are given a greater say in the development of the hospital and can have a direct influence in the development of services.

Simply sign up here: https://secure.membra.co.uk/RoyalBathApplicationForm/

8. Consultant Appointments

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

Ms Aiste McCormick was appointed as Consultant Gynaecological Oncologist. Ms Aiste McCormick will join us in March 2026 and is currently Locum Consultant at Gateshead Health NHS Foundation Trust.

Dr Nicole Corin was appointed as Consultant in Paediatric Orthopaedic and joined the Trust in December 2025.

Dr Rebecca Crowley was appointed as Consultant in Obstetrics. Dr Rebecca Crowley will join us in March 2026 and is currently Locum Consultant Obstetrician at University Hospitals Bristol and Weston NHS Foundation Trust.

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

Birth registration services available at the RUH

In November the RUH launched a Birth registration service for babies on the Neonatal Intensive Care Unit at the RUH. Parents of babies who are receiving care on the neonatal unit are now able to register their baby's birth at the hospital. This means they don't need to travel off site and leave their babies to visit a register office.

The new service is provided by Bath & North East Somerset Council's Registrations team. By bringing this service into the hospital, we're helping families stay together during what can be an incredibly emotional and stressful time. It's a small change that makes a big difference to parents' peace of mind.

Local GP shares pancreatic cancer experience to urge early detection

During Pancreatic Cancer Awareness Month in November, a Devizes GP shared his personal experience to encourage others to know and act on the signs of pancreatic cancer,

Around 10,000 people are diagnosed with pancreatic cancer in the UK every year, and early detection is vital for the best prognosis possible.

Charles Cowen was diagnosed and treated at the RUH but did not experience the typical signs of pancreatic cancer. Charles encouraged anyone and everyone to get checked for symptoms they are concerned about.

RUH Bath maternity team praised in latest national CQC survey

In December, the maternity team at the RUH was once again recognised for delivering supportive and respectful care, following the publication of the Care Quality Commission's (CQC) 2025 Maternity Survey.

Feedback from women and birthing people who gave birth at the RUH earlier in 2025 showed the Trust performing better or much better than most hospitals in England across 28 of the key questions. Respondents highlighted feeling listened to, respected and supported throughout their maternity journey.

The annual survey, carried out by the Care Quality Commission (CQC), asked women and birthing people who have used the maternity service about their experience of maternity care, from antenatal care and labour and birth through to postnatal care.

Babies born at the RUH to have the opportunity to receive genetic testing, as part of world-leading research study

In December the RUH highlighted the Generation Study, a groundbreaking initiative led by Genomics England in partnership with the NHS, launching at the RUH in 2026. The study, which is one of the world's largest research studies of its kind, explores how whole genome sequencing could be used to screen newborns for over 200 rare but treatable conditions that usually appear in the first few years of life.

By identifying these conditions at the earliest stage possible, instead of waiting until symptoms might appear, we can offer more timely treatment and the right support for families, helping children to live healthier lives.

RUH's Musician in Residence spreads festive cheer at Christmas

Musician in Residence at the RUH, Frankie Simpkins, shared the joy and connection that music brings to the hospital's patients and staff during December.

Frankie has been the RUH's Musician in Residence for 12 years through the Soundbite Music Programme and with support from Friends of the RUH. As a result, she is really attuned to the difference music makes to patients and staff all the way through the year.

A clip of Frankie playing to a patient on the RUH's Older People's Unit caught the attention of the online community and clearly demonstrated the physical and mental health benefits of providing music in hospitals.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**7**
Date of Meeting:	**14 January 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 December 2025. 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 December 2025. Activities relating to formal Committees of the Board are reported through upward reports.

Council of Governors Update:
The Council of Governors met on the 15th December 2025 and approved the appointment of Kate Cozens, Public Governor for Mendip, as Lead Governor. During January, Governors will elect a Deputy Lead Governor to work alongside Kate.

The Council welcomed proposals to reduce the number of working groups and improve communication, aiming to minimise the demand on Governors' time. It was agreed that the Lead Governor and Interim Head of Corporate Governance will form a Task and Finish Group in January 2026, with a proposal to be brought to the Council in March 2026.

Non-Executive Directors Update:
The Board is asked to note that Hannah Morley, Non-Executive Director, has formally tendered her resignation from the Board, with her final day of service to be at the conclusion of the January Board meeting. Hannah Morley has made a significant contribution to the Trust during her tenure, bringing clinical expertise and valuable insight to the Board and its committees. The Board extends its sincere thanks and appreciation for Hannah's dedication and service to the Royal United Hospitals Bath NHS Foundation Trust.

Chair attendance at key meetings during December 2025
- Regular meetings with Non-Executive Directors
- RUH Extraordinary Board meeting – Business Planning
- Council of Governors informal governor welcome and introduction
- BSW Hospitals Group Joint Committee
- BSW Hospitals Group Remuneration Committee in Common
- Staff Governor & NED monthly feedback meeting

Report to:	**Public Board of Directors**	**Agenda item:**	**8**
Date of Meeting:	**14 January 2026**		
Title of Report:	**Board Assurance Framework Summary Report**		
Status:	**Assurance**		
Board Sponsor:	**Liam Coleman, Chair** **John Palmer, Managing Director**		
Author:	**Roxy Milbourne, Interim Head of Corporate Governance** **All Executive Directors**		
Appendices	**None**		

1. Executive Summary of the Report

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

What is a Board Assurance Framework (BAF):

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

Due to the nature of risks on a BAF they will change slowly. This is because they usually need significant actions to develop additional controls and/or mitigations for complex issues. They may also be highly dependent on factors that are outside of the direct control and/or influence of the Trust/Executive Lead. The current BAF has 12 risks.

Format of the paper

The BAF paper has two parts to it:

- Part 1: Board Assurance Framework – Scorecard.
- Part 2: Board Assurance Framework - Summary of changes.

Part I: Board Assurance Framework – Scorecard

The scorecard shows:

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

Part 2: Board Assurance Framework - Summary of changes

The summary of changes shows:

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

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

3.	Legal / Regulatory Implications
It is best practise the have a Board Assurance Framework in place that provides assurance against the principal risks to the achievement of our Trust Strategy.	

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)
The Board Assurance Framework sets out the principal risks to the achievement of the Trust Strategy. As such, it forms a key part of the wider risk management framework for the Trust.	

5.	Resources Implications (Financial / staffing)
The Board Assurance Framework sets risks related to resources. It also requires significant time and input to ensure that it reflects the position across multiple areas and functions.	

6.	Equality and Diversity
The content of the BAF sets key risks that may impact equality and diversity.	

7.	References to previous reports/Next steps
Board sub-committees routinely receive updates on risks that fall within their areas of responsibility.	

8.	Freedom of Information
Available in public board papers.	

9.	Sustainability
The content of the BAF sets out key risks that may be associated with or impact sustainability. There is one risk in particular that has sustainability context.	

10.	Digital
The content of the BAF sets out key risks that may be associated with or impact digital.	

Royal United Hospitals Bath NHS Foundation Trust

Board Assurance Framework 2025/2026

Board: JANUARY 2026

Part I: Board Assurance Framework – Scorecard

BAF	DESCRIPTION OF THE RISK	OBJECTIVE	SCORE LAST BOARD	SCORE CURRENT BOARD	DIRECTION	EXEC LEAD	COMMITTEE
1.1	There is a risk that not meeting internally and externally set standards of quality and safety may result in harm to patients and/or experience below expected.	The people we care for	20	**20**	STATIC	Chief Nursing Officer	Quality
1.2	Increasing demand for both emergency and planned care is exceeding our capacity to treat patients promptly, leading to longer wait times for procedures. This could negatively impact patient outcomes and satisfaction.	The people we care for	16	**16**	STATIC	Chief Operating Officer	Quality

BAF	DESCRIPTION OF THE RISK	OBJECTIVE	SCORE LAST BOARD	SCORE CURRENT BOARD	DIRECTION	EXEC LEAD	COMMITTEE
2.1	Without fostering a culture of inclusion and actively addressing possible managerial discrimination, we may hinder staff recruitment and retention, expose the Trust to financial and reputational damage, and undermine our ability to deliver the best possible patient care.	The people we work with	16	**16**	STATIC	Chief People Officer	People
2.2	Without strong management and leadership development, including succession planning, we risk limiting our ability to transform and innovate, cultivate a positive culture and sustain improvements. This could negatively impact patient care, staff satisfaction, and workforce stability.	The people we work with	16	**16**	STATIC	Chief People Officer	People

BAF	DESCRIPTION OF THE RISK	OBJECTIVE	SCORE LAST BOARD	SCORE CURRENT BOARD	DIRECTION	EXEC LEAD	COMMITTEE
3.1	Without delivering the financial plan and ensuring financial accountability across the organisation the Trust may not achieve financial recovery and sustainability, affecting our control to provide safe, appropriate and effective care to our patients.	The people in our community	16	**20**	INCREASE	Chief Finance Officer	Finance
3.2	If Sulis Hospital does not deliver its financial target it may have a direct financial impact to RUH financial position.	The people in our community	12	**12**	STATIC	Chief Finance Officer	Subsidiary
3.3	Without reducing unwanted variation and addressing inequity of care, people may not receive appropriate levels of care.	The people in our community	16	**16**	STATIC	Chief Medical Officer	Quality
3.4	Our aging estate with increasing backlog maintenance needs could lead to service disruptions, compromised patient safety, failure to meet regulatory requirements in addition to degrading the experience for patients and staff.	The people in our community	16	**16**	STATIC	Chief Nursing Officer	Non-Clinical Governance
3.5	Climate change and its accelerating consequences may threaten the health of patients, staff, and the wider community. Failure to achieve net zero goals and adapt to climate-related risks (e.g., overheating, flooding) may jeopardise the Trust's sustainability, its ability to provide care, and its commitment to future generations.	The people in our community	15	**15**	STATIC	Chief Nursing Officer	Non-Clinical Governance
3.6	Insufficient digital capabilities may hinder the Trust's potential to enhance patient and staff experiences, optimise efficiency, and improve overall effectiveness and care delivery.	The people in our community	16	**16**	STATIC	Chief Transformation & Innovation Officer	Non-Clinical Governance
3.7	Cyber-security breaches, caused by deliberate malicious acts or inadvertent actions by staff, could result in an inability to use digital platforms, resulting in loss of services and data across the Trust, and in turn causing risk to patients.	The people in our community	16	**16**	STATIC	Chief Transformation and Innovation	Non-Clinical Governance
3.8	Delayed or suboptimal deployment of the joint Electronic Patient Record would result in clinical, strategic, and financial benefits not being realised and impact the delivery of the Trust future operating model.	The people in our community	-	**16**	NEW RISK	Chief Transformation and Innovation	Non-Clinical Governance

Part II: Board Assurance Framework - Summary of changes

People we care for:

	Risk description	Update since the last Board
1.1	There is a risk that not meeting internally and externally set standards of quality and safety may result in harm to patients and/or experience below expected.	• This risk was discussed at the Quality Assurance Committee on 8 December 2025. • The risk statement has been broadened to explicitly reference both internal and external standards, and to include the risk of "experience below expected" as well as harm. • The risk ratings remain unchanged, but the list of linked operational risks has been expanded to reflect a broader scope. These changes demonstrate ongoing refinement of the Trust's approach to quality and safety risk management. • Full review of the risk, controls and assurance has been completed by the committee.
1.2	Increasing demand for both emergency and planned care is exceeding our capacity to treat patients promptly, leading to longer wait times for procedures. This could negatively impact patient outcomes and satisfaction.	• This risk was discussed at the Finance and Performance Committee (FPC) on 25 November 2025. All updates were accepted, with no material changes to the risk itself. • Full review of the risk, controls and assurance has been completed by the committee. • The Committee, in agreement with the Chief Operating Officer, recommended splitting the risk into two distinct areas: elective and non-elective. This work will be undertaken, with a further update to be presented to the Board in 2026.

People we work with:

	Risk description	Update since the last Board
2.1	Without fostering a culture of inclusion and actively addressing possible managerial discrimination, we may hinder staff recruitment and retention, expose the Trust to financial and reputational damage, and undermine our ability to deliver the best possible patient care.	• The People Committee reviewed this risk at its meeting in November 2025, the Board further discussed the risks in December 2025 and it was agreed that a review of the "People We Work With" risks would be undertaken by the People Committee in February 2026. It is anticipated that these risks will be further refined as part of that process.
2.2	Without strong management and leadership development, including succession planning, we risk limiting our ability to transform and innovate, cultivate a positive culture and sustain improvements. This could negatively impact patient care, staff satisfaction, and workforce stability.	• The People Committee reviewed this risk at its meeting in November 2025, the Board further discussed the risks in December 2025 and it was agreed that a review of the "People We Work With" risks would be undertaken by the People Committee in February 2026. It is anticipated that these risks will be further refined as part of that process.

People in our community:

	Risk description	Update since the last Board
3.1	Without delivering the financial plan and ensuring financial accountability across the organisation the Trust may not achieve financial recovery and sustainability, affecting our control to provide safe, appropriate and effective care to our patients.	• This risk was discussed at the Finance and Performance Committee (FPC) on 25 November 2025. • There was no material change to the risk statement: The core risk remains focused on the Trust's ability to deliver the financial plan and maintain financial accountability to achieve financial recovery and sustainability, with direct implications for safe, effective patient care. • The Committee reviewed the causes of the risk, management of the risk and any sources of assurance and gaps. They agreed to increase the risk score from 16 to 20. • This adjustment reflects a more realistic appraisal of the likelihood and impact of financial pressures facing the Trust, as well as a shift in risk appetite in light of ongoing challenges. The revised scores better capture the complexity and uncertainty in delivering financial recovery and sustainability and will support more robust oversight and mitigation going forward. • Full review of the risk, controls and assurance has been completed by the committee.

	Risk description	Update since the last Board
3.2	If Sulis Hospital does not deliver its financial target it may have a direct financial impact to RUH financial position.	• With a new Chief Finance Officer now in post, this risk will be reviewed and discussed at the Subsidiary Oversight Committee in January 2026.
3.3	Without reducing unwanted variation and addressing inequity of care, people may not receive appropriate levels of care.	• This risk was discussed at the Quality Assurance Committee on 8 December 2025. • This risk is being reviewed with the Chief Medical Officer and work will continue via the Committee.
3.4	Our aging estate with increasing backlog maintenance needs could lead to service disruptions, compromised patient safety, failure to meet regulatory requirements in addition to degrading the experience for patients and staff.	• This risk was discussed at the Non-Clinical Governance Committee (NCGC) on 10 December 2025. • The risk wording has been expanded to provide greater context, now explicitly referencing the impact on patient and staff experience as well as regulatory requirements. • No change to the risk score which remains at 16 (Impact 4 × Likelihood 4). • Full review of the risk, controls and assurance has been completed by the committee.
3.5	Climate change and its accelerating consequences may threaten the health of patients, staff, and the wider community. Failure to achieve net zero goals and adapt to climate-related risks (e.g., overheating, flooding) may jeopardise the Trust's sustainability, its ability to provide care, and its commitment to future generations.	• This risk was discussed at the Non-Clinical Governance Committee (NCGC) on 10 December 2025. • The risk wording has been expanded to include the broader impact on patients, staff, and the community, and the risk of failing to adapt to climate-related risks. • No change to the risk score which remains at 15 (Impact 3 × Likelihood 5). • Full review of the risk, controls and assurance has been completed by the committee. • Mitigating actions were made clearer, with timelines for governance review and the development of a new 5-year Sustainability Strategy.
3.6	Insufficient digital capabilities may hinder the Trust's potential to enhance patient and staff experiences, optimise efficiency, and improve overall effectiveness and care delivery	• This risk was discussed at the Non-Clinical Governance Committee (NCGC) on 10 December 2025. • The risk wording and score has remained the same. • Controls, assurance, and mitigating actions are now more detailed, including the move to a single Group digital service over time. • Full review of the risk, controls and assurance has been completed by the committee.
3.7	Cyber-security breaches, caused by deliberate malicious acts or inadvertent actions by staff, could result in an inability to use digital platforms, resulting in loss of services and data across the Trust, and in turn causing risk to patients	• This risk was discussed at the Non-Clinical Governance Committee (NCGC) on 10 December 2025. • The risk wording and score has remained the same. • The narrative was expanded, with more detail on the causes of risk and progress on mitigating actions. Controls and assurance mechanisms are more comprehensive, with updates on progress and external reviews. • Full review of the risk, controls and assurance has been completed by the committee.
3.8	Delayed or suboptimal deployment of the joint Electronic Patient Record would result in clinical, strategic, and financial benefits not being realised and impact the delivery of the Trust future operating model.	• This is a new risk added to the Board Assurance Framework following Board agreement at its meeting on 3 December 2025. The Board noted that the risk should be included but acknowledged that its wording, scoring, and mitigating actions may need to be adjusted in the coming weeks, subject to the outcome of key decisions regarding the EPR programme.

Royal United Hospitals Bath
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Report to:	**Public Board of Directors**	**Agenda item:**	**9**
Date of Meeting:	**14 January 2025**		
Title of Report:	**Management Executive Committee Upward Report**		
Status	**For information**		
Author	**Abby Strange, Corporate Governance Manager**		

Key discussion points and matters to be escalated from the meetings on 26th November and 17th December 2025

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

November 2025

- **Business Planning for 2026/27:** The Committee had a robust discussion around the draft business plan. They noted key updates around national guidance, funding allocations, and changes to the 2026/27 planning timeline. They considered the initial scoring of the Board Assurance Checklist, progress so far, risks, and next steps, including the Board sign off timeline.

- **Unannounced Care Quality Commission (CQC) visit to the Emergency Department (ED) and Urgent Treatment Centre (UTC):** The Trust remains under inspection, awaiting the CQC report. The Committee received an overview of the action plans that had been developed to date.

- **Integrated Performance Report including Tiering Update:** The Committee acknowledged the need to maintain the agreed trajectories through the winter period. They noted the continued operational risk due to growth in demand, the Wait 45 initiative, and staff sickness levels. Mortality and nurse staffing remained in special cause variation. The financial recovery was ahead of trajectory due to income generation and cost reduction remained a priority.

December 2025

- **Business Planning for 2026/27:** The draft plan was submitted to NHS England on 17th December 2025. Further work is required around Urgent and Emergency Care (UEC), Referral to Treatment (RTT), elective recovery, cancer targets, and workforce alignment.

- **Recovery and Tiering:** As of 18th November 2025, there had been improvements in ambulance handovers, 12 hour, RTT, diagnostics, and cancer 28 day performance, but 4 hour performance remained behind plan. Cancer 62 day performance had deteriorated, and a recovery plan is in place to return to trajectory by February 2026.

- **Financial Position:** The Trust's financial recovery has slowed, with a projected year-end deficit of £24m against a target of £17m. Enhanced controls and

priority actions have been identified in conjunction with the Turnaround Team and work continues to build on this at pace.

- **Winter Pressures:** Despite additional capacity being in place, urgent care flow remains fragile. Industrial action and non-elective demand have compounded risks.

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

November 2025

- **Trust Mid-Year Review:** The Committee received an update following the Trust's Mid-Year Review with NHS England and the Integrated Care Board (ICB) who confirmed that the Trust is expected to achieve statutory and financial targets for the year.

December 2025

- **Trust Millennium Electronic Patient Record (EPR) Upgrade:** A timeline and resource plan are being developed to upgrade Millennium following delays around the BSW EPR Programme. Mitigation requires close monitoring, and a plan is in development.

- **Clinical Administration Letter Backlog:** The Committee discussed the patient safety risks posed by the backlog of clinic letters. They approved an option to invest in software to reduce administration time and to reallocate resource for 6 months to focus on typing. Early adoption of Ambient Voice Technology in six specialties shows significant reduction in letter processing time, supporting future rollout.

- **UTC Capital Funding Opportunity:** The Committee received an update on capital funding opportunities to support a redesign of ED and UTC and identified a preferred option to develop.

ASSURE: Inform the Board where positive assurance has been achieved

November 2025

- **Internal Audit – Actions Update:** The Committee will receive a quarterly update going forward to ensure that the Senior Leadership Team has adequate oversight of the programme of internal audit, upcoming audits, and outstanding actions.

December 2025

- **Human Tissue Authority (HTA) Compliance:** All corrective and preventative actions identified during an unannounced inspection of the Trust's mortuary by the HTA in February 2025 have been completed. The HTA has confirmed that regulatory action has been lifted.

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

November 2025

- **Risk Register Summary Report:** A new risk relating to the BSW EPR implementation will be added to the risk register.

- **Clinical Administration:** The Committee discussed the emergence of multifactorial risks around clinical administration. An overarching risk is in development.

December 2025

- **Business Planning for 2026/27:** The Committee discussed several risks in relation to the business plan including Cost Improvement Programme deliverability and financial sustainability, workforce sickness, overcrowding in ED, and non-elective demand growth.

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

November 2025

- **The Older Persons Unit Short Stay:** The team were praised by the Getting It Right First Time (GIRFT) Team for multidisciplinary excellence.

- **Wiltshire Health and Care:** The dissolution of Wiltshire Health and Care has been successfully concluded on behalf of BSW Hospitals Group.

December 2025

- **Clinical Value Review:** The first comprehensive review of elective pathways has been completed, identifying efficiency and productivity opportunities. This work will underpin multi-year transformation and financial improvement.

APPROVALS: Decisions and Approvals made by the Committee

November 2025

- **Policies:** The Committee approved the following documents:
  - Safe Staffing Standard Operation Procedure (SOP)
  - Managing Patient Property Policy
  - e-Rostering Policy
  - Use of Generative AI Policy

- **Management Executive Committee Terms of Reference (ToR):** The Committee agreed key updates and made several additional amendments. The ToR are attached at appendix 1 for endorsement by the Board of Directors.

- **Risk Register Summary Report:** Three new or upgraded risks and one downgraded risk were approved.

December 2025

- **Clinical Administration Letter Backlog:** The Committee approved an option to invest in software and to reallocate some resource for 6 months.

- **Data Protection by Design and Default Policy:** The Committee approved the policy which had been amended to reflect the updated NHS Data Security Protection Toolkit.

- **Philip Yeoman Conversion:** The Committee approved the temporary conversion of Philip Yeoman Ward from elective to general medical to support with winter pressures.

- **Oasis Boardroom:** The Committee supported the return of the Oasis space to a boardroom subject to a review of IT and furniture requirements.

- **Risk Register Summary Report:** Three new or upgraded risks were approved.

Royal United Hospitals Bath
NHS Foundation Trust

Management Executive Committee (MEC)
Terms of Reference

1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the **Management Executive Committee** (the Committee). The Committee is the executive and operational decision-making committee of the Trust. It has the powers specifically delegated in these Terms of Reference.

The **Management Executive Committee** is accountable to the Board of Directors through the Managing Director for the operational management of the Trust and delivery of objectives agreed by the Board.

2. Terms of Reference

a. Purpose

The Committee is the decision-making committee of the Trust, its purpose being to make management decisions on issues within the remit of the executive directors and to support individual executive directors to deliver their delegated responsibilities by providing a forum for briefing, exchange of information and resolution of issues.

It will ensure timely clinical and operational decision making and risk mitigation processes in delivering the Trust's objectives through the operating plans and strategy.

The Committee will promote and embed the Trust's You Matter Strategy, with Improving Together as a key enabler.

The Management Executive Committee is accountable to the Board of Directors through the Managing Director for the coordination and operational management of the system of internal control and for the delivery of the objectives set by the Board of Directors.

It is the formal mechanism for supporting the Managing Director in effectively discharging their responsibilities as Accounting Officer. The Managing Director holds Trust level responsibility for the daily management of the Trust.

The Management Executive Committee will set appropriate frameworks, policies and procedures to support delivery of the organisational objectives. The Management Executive Committee will continually monitor and review all aspects of the operational performance of the Trust, including in relation to the quality of its services, workforce, finance, clinical and corporate governance and the management of risk, and it will put in place corrective measures where necessary.

The Management Executive Committee will champion the Improving Together methodology as the principal tool for embedding quality and service improvement across the Trust and will work in ways that reflect and embody the Trust's values.

The Management Executive Committee, in conjunction with the Strategic Executive Forum, will ensure that there is alignment between Strategic planning and Operational delivery with the ultimate aim of delivering the Trust's You Matter Strategy.

b. Objectives

The Management Executive Committee will be in two parts:

Part 1 – Engine Room

(i) Oversee the Trust's performance against breakthrough objectives
(ii) Oversee the Trust's Project Wall, ensuring that large-scale Corporate projects are delivered according to plan and enabling delivery of the breakthrough objectives

Part 2 – Management Executive Committee

The Management Executive Committee has delegated powers from the Board of Directors, via the Managing Director, to oversee the day-to-day management of all systems and functions across the whole organisation's activities (both clinical and non-clinical), which also supports the achievement of the organisation's objectives.

In particular the Management Executive Committee will:

Monitor Performance

(i) monitor the Trust's performance against key targets, quality and safety measures, business plans, actions arising from recommendations by CQC and other external bodies;

(ii) monitor performance against agreed operational priorities and other activities;

(iii) oversee actions arising from the integrated performance report and performance manage the delivery of those action plans;

(iv) oversee the delivery of QIPP within the Trust;

Approve Business Cases for new investments

(v) approve business cases for the filling of additional clinical posts over and above existing complements, taking account of the delegated resource responsibilities and the Trust's corporate objectives ; (replacement of consultant posts with a like

for like consultant on the same or fewer PA's, undertaking predominantly the same caseload will be approved via the Executive Performance Review Meetings);

(vi) approve business cases and service developments which require investment of £75,000 or above; (business cases of less than £75,000 will be approved by the Executive Performance Review Meetings);

(vii) scrutinise the capital programme ahead of Board of Directors' approval;

Monitor Risks

(viii) monitor the effectiveness of the management of significant risks as per the Strategic Framework for Risk Management, namely the Committee is responsible for;

- the final approval of all risks added to the Risk Register with a score of ≥ 12, to assess whether the scoring and proposed action plans are appropriate;
- the monthly review of all current risks on the Risk Register with a current score of ≥ 12, monitoring progress against the action plan agreed to mitigate the risk, or identifying actions necessary to achieve completion of the action plan;
- the monthly notification of all Risk Register entries that remain unapproved after two months;

(ix) oversee the structures, processes and responsibilities for identifying and managing key risks facing the organisation, prior to discussion at the Board of Directors;

(x) scrutinise all risk-related disclosure statements, in particular the Annual Governance Statement, prior to approval by the Board of Directors;

Assess Policies and Procedures

(xi) assess the operational effectiveness of policies and procedures and provide final approval for updates to Trust policies and procedures;

(xii) scrutinise and comment on key performance and governance reports prior to submission to the Board of Directors to ensure their accuracy and quality;

Support our People

(xiii) ensure effective coordination and collaboration across the Trust's clinical and corporate divisions;

(xiv) ensure that the Trust meets both the letter and spirit of its obligations around equality, diversity and inclusion, and that these are central to its work;

General Duties

The Management Executive Committee will ensure that governance and assurance systems operate effectively and thereby underpin clinical care.

The Management Executive Committee will put in place and maintain effective systems to ensure safe, effective and timely care for all patients.

3. Membership

The Committee will meet monthly, with no less than ten meetings per year.
The Management Executive Committee will be in two parts, with different membership for each part, comprised as follows:

Part 1 – Engine Room (Week 4)

- Managing Director (Chair)
- Chief Medical Officer
- Chief Operating Officer
- Chief Nursing Officer
- Hospital Director, Sulis
- Head of Corporate Governance
- Clinical Responsible Officers (CROs) of Delivery Groups
- Senior Responsible Officers (SROs) of Delivery Groups
- Divisional Representation *
    - Deputy Chief Operating Officers
    - Divisional Directors
    - Divisional Directors of Operations
    - Divisional Directors of Nursing
    - Director of Midwifery
    - Director of Operational Finance
    - Deputy Chief People Officer
    - Deputy Director of Estates and Facilities
    - Director of Pharmacy
    - Chief Digital Information Officer
- Engine Room Facilitators

Part 2 – Management Executive Committee

- Managing Director (Chair)
- Chief Medical Officer
- Chief Operating Officer
- Chief Nursing Officer
- Hospital Director, Sulis

- Head of Corporate Governance
- Divisional Representation *
    - Deputy Chief Operating Officers
    - Divisional Directors
    - Divisional Directors of Operations
    - Divisional Directors of Nursing
    - Director of Midwifery
    - Director of Operational Finance
    - Deputy Chief People Officer
    - Deputy Director of Estates and Facilities
    - Director of Pharmacy
    - Chief Digital Information Officer

* To ensure the best use of Divisional Leadership time, a minimum of one (1) representative from each Division can attend, providing there is representation from each function within the triumvirate e.g. one Divisional Director, one (1) Divisional Director of Operations and one Divisional Director for Nursing / Midwifery as a minimum.

The Head of Communications will be invited to attend meetings as an observer.

Whilst the Group Executives are not substantive members of the Committee, they may attend any/all meetings as they decide.

3.1 Quorum

Monthly: A quorum is one third of the members which must include at least two (2) Executive Directors and at least one (1) representative from each Division & at least one (1) representative from each Triumvirate role (see above).

In the absence of the Managing Director, another nominated Executive Director will Chair.

3.2 Attendance by Members

If an Executive Director member is unable to attend a meeting, they can nominate a deputy (if an appropriate deputy is available) to attend the meeting in their place.

This will not be necessary in the case of Divisional members, provided that at least one member from that Division is in attendance.

3.3 Attendance by Officers

The Executive Management Committee may call upon any employee to attend the Committee.

4. Frequency

The Management Executive Committee will normally meet monthly on the last Wednesday of each month. Other senior managers within the organisation may be called on to attend part of the meeting to present papers as the subject matter expert.

Papers for each meeting will be circulated no later than the Friday of the week before the next meeting.

5. Accountability and Reporting Arrangements

The Management Executive Committee will be accountable to the Board of Directors through the Managing Director. The Board of Directors will be informed of the Executive Management Committee's work through a no less-than-quarterly upward report to the Board of Directors.

The sub-committees and groups of the Management Executive Committee will provide regular reports of their activities to the Management Executive Committee using the Committee and Group Upward Reporting template. The Management Executive Committee will receive a report on current risks, as specified in the Strategic Framework for Risk Management, at each meeting.

There will be clear lines of communication between Management Executive Committee and Strategy Executive Forum to ensure information, discussion and decisions are shared between the two meetings.

6. Authority

The Management Executive Committee is authorised by the Board of Directors, through the Managing Director, to pursue/investigate any activity within its terms of Reference.

The Management Executive Committee has been established to oversee, coordinate, review and assess the effectiveness of operational activities within the Trust.

The Management Executive Committee is authorised to create sub-groups or working groups, as are necessary to fulfil its responsibilities within its terms of reference. However, the Management Executive Committee may not delegate executive powers and remains accountable for the work of any such group.

Any sub-groups or working groups will report directly and to an agreed schedule to the Management Executive Committee who will oversee their work.

7. Monitoring Effectiveness

The Management Executive Committee will undertake an annual review of its performance against its work plan and the Trust's Annual Plan in order to evaluate the achievement of its duties. This review will be received by the Board of Directors.

8. Other Matters

The Head of Corporate Governance is responsible for arranging the provision of administrative support to the Management Executive Committee including:

a. Agreement of the agenda with the Chair and attendees;
b. Collation of the papers;
c. Taking the minutes and keeping a record of the matters arising and issues to be carried forward; and
d. Advising the Management Executive Committee on pertinent issues around governance and procedure.

9. Review

These terms of reference will be reviewed at least annually as part of the monitoring effectiveness process.

Approved by the Board of Directors on 14 January 2026

Report to:	**Public Board of Directors**	**Agenda item:**	**10**
Date of Meeting:	**14 January 2026**		
Title of Report:	**Integrated Performance Report**		
Status:	**For Noting**		
Board Sponsor:	**Bernie Bluhm, Acting Chief Operating Officer** **Toni Lynch, Chief Nursing Officer** **Jude Gray, Chief People Officer** **Simon Wade, Chief Finance Officer**		
Author:	**Operational Team** **Rob Elliot, Lead for Quality Assurance** **Matt Foxon, Site HR Director** **Jon Lund, Director of Operational Finance**		
Appendices	**Appendix 1: Integrated Performance Report slide deck** **Appendix 2: Trust Scorecard**		

1. Executive Summary of the Report

The report provides an overview of the Trusts Performance for the period up to and covering November 2025, aligned to our True North Pillars and breakthrough objectives agreed for the year.

The slide pack includes an overarching Executive summary with each section providing a more detailed summary on key indicators and measures monitored via the Integrated Performance Report.

This programme drives improvement on the three nationally reported measures: price cap compliance, framework provision and our total spend on agency as a percentage of our total pay bill.

Operational Performance

The average ambulance handover delay for November 2025 was 31.6 minutes, a decrease from 36.8 minutes on average in October 2025. Through November 2025 the total hours lost was 820. This is a 274-hour decrease compared to last month's lost hours of 1,094. 58.2% of handovers were completed within 30 minutes.

RUH 4-hour performance in November was 57.70% on the RUH footprint (unmapped), an increase of 1.07% from October's performance (56.63%). Non-admitted performance was 70.9%, which was an increase against the performance for October (68.69%) and admitted performance remained static at 28.37% (October 28.69%).

The numbers of patients going through our MSDEC (686) decreased in November compared to October (761) and FSDEC numbers also reduced slightly (30). This was mainly driven by use of MSDEC trolleys overnight causing decreased flow each day following. This was due to heightened activity coming through the front door. Our performance for MSDEC at 36.8% for November 2025 (October 39.2%) remains just below the national target of 40% of patients going through an SDEC pathway.

In November 2025, 71.05% of patients received their diagnostic within the 6-weeks against the 71.60% target. Performance improved 0.55% from previous month. In

month, 102 additional diagnostic tests were delivered when compared to October 2025.

In October (Cancer is reported one month in arrears) performance improved against all three standards but remained under national target. 28 Days improved by 11.4% to 64.9% with most specialties seeing an improvement, the most significant being in Breast increasing by 18.5%. 31 Days improved by 2% to 93.6%, above trajectory but under national target. 62 Days improved by 5.9% to 64.0% with the notable increases in Breast and Skin (11.8% and 9.7% improvements respectively). Performance will deteriorate from November to January due to recovery of the Skin MOPS backlog with more breach patients being treated.

In November, RTT saw an increase in overall performance of 2.3% to 63.0%. The percentage of patients waiting less than 18 weeks for their first outpatient appointment was 66.4% (+2.5% from October). Total over 52-week waiters decreased from 644 to 545 (-15%). For patients over 65 weeks, the Trust saw a decrease from 44 to 33 patients.

Quality

Pressure Ulcers

For November 2025, the RUH reported 0.6 pressure ulcers per 1,000 bed days (10 pressure ulcers). The RUH reported three category 3 pressure ulcers, three category 3 medical device related pressure ulcers on one man in ITU and four category 2 pressure ulcers.

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

Falls

In November 2025 there were 4 reported falls that resulted in moderate harm to patients, these occurred in 4 different clinical areas. There were 5.3 falls per 1000 bed days in November, this is down from 6.68 in October 2025. Any new actions or areas of learning from these incidents were agreed and included in the falls work plan to ensure improvement work is planned and completed. As a result of several falls across the 3 divisions a trust wide PSII (Patient safety incident investigation) has been commissioned and is aimed to be completed in 3-6 months. The PSII is ongoing.

Infection Prevention and Control

There were 14 cases of Clostridioides Difficile infection (CDI) (9 HOHA and 5 COHA) reported during November 2025. There have been 54 cases against a threshold of 75 reported to date for 2025/26. With the increase in cases, we have seen 3 Periods of Increased Incidence, with a review and ribotyping in progress. The October 2025 rate per 100,000 bed days for the Trust is 43.09, against the SW rate of 31.41.

There have been 9 cases of *E. coli* infection (2 HOHA and 3 COHA) during November 2025 There has been 69 cases reported against a threshold of 77. With a predominant cause being urinary, there are future initiatives in progress to start in the New Year. The October rate per 100,000 per days is 36.93 against the SW rate of

48.57.

MSSA rates have stabilised this month and to support the IVAD group there are further plans to start ward-based training and engagement sessions in the New Year to support learning gaps.

Patient Support and Complaints
In November the Trust received 37 new formal complaints, this compares to 30 received in October. The complaint rate per 1000 contacts is 0.59 and the number of reopened complaints increased over November (5). These were spread across the divisions. 78% (target 90%) of complaint responses were closed within the agreed timeframe.

Safe Staffing
Registered Nurse day shift fill rate was 84% (target 90%)
Healthcare Support Worker (HCSW) day shift fill rate was 87% (target 90%)
RN and HCSW day fill rates are below 90% performance target since June 2025. The current night shift fill rate for RN and HCSW remains above 90%.

The top contributor for HCSW day fill rate is HCSW vacancy, this has been impacted by the national change in visa and sponsorship rules. The top contributors for low RN fill rates is vacancy within Paediatrics, William Budd and Emergency Department (ED). New nursing staff are due to commence in December in all areas. Recruitment continues for remaining RN vacancies with additional recruitment events planned in January 2026.

Perinatal Update
The October and November Perinatal report highlights areas of focus for the service:

- The neonatal service has experienced a period of high service acuity following a reduction in cot capacity within North Bristol Trust (NBT) level 3 tertiary provider in October 2025. This has been compounded by an increased vacancy rate within the neonatal nursing workforce due to an increased parental leave rate. A risk assessment has been conducted outlining risk management actions inclusive of escalation procedures and operational staffing contingencies
- Monthly workforce metrics continue to be monitored as part of the Perinatal Quality Surveillance Oversight Model (PQSOM). Metrics below target measures have been identified for further review /'Deep Dive' to understand drivers and practice influencing factors to improve understanding and underpin improvement work where necessary. The areas identified are:
    - Sickness rates
    - Roster 'Shift Fill' and the impact of current Flexible working agreements
    - Mary Ward staffing vs acuity
- During November the National Maternity Outcomes Signal and System (MOSS) Tool went live. The monthly summary of service position pertaining to perinatal mortality will form part of the monthly safety metrics within the PQSOM. The Integrated Care Board (ICB)'s Local Maternity and Neonatal System (LMNS) are in the process of developing SOPs to

support the required governance reporting structures should the service receive a system 'alert'
- The service has maintained mandatory training standards to 90% compliance with 90% achievement within each applicable staff group across Practical Obstetric Multi-Professional Training (PROMPT), Saving Babies Lives (SBL) inclusive of fetal monitoring training and Newborn Basic Life Support (NBLS) as per Maternity Incentive Scheme year 7 requirements.
- The service was made aware of the 'prevention of future deaths report' published in the public domain during November 2025 for the deaths of Jennifer and Agnes Cahill within another provider. The Community Midwifery Matron supported by the Obstetric Lead Consultant for Birth Choices have conducted a benchmarking exercise of the current RUH community and home-birth service provision against the identified learning within Jennifer and Agnes' care. Monitoring of progress any identified actions report into specialty governance for senior leadership oversight.

The service is pleased to highlight that:
- Following the operational transformation of the flu vaccination programme in 2024 the current administrations of the flu vaccine to pregnant women in 25/26 currently exceeds the total number of administrations for the whole of the 24/25.
- Women's and children's research has secured inclusion as a pilot site for the 'Generation' Research study.

Workforce

Summary of key workforce metrics

- Actual Total WTE in November 2025 was 5807 an increase on the October position. The RUH is currently 222wte over plan, the majority of which is due to a growth in substantive whole time equivalent (wte).
- The vacancy rate has further reduced to – 0.85% in November. This figure masks vacancies in key areas Emergency Medicine and Pathology
- Bank usage has further increased in November, exceeding the planned bank usage as outlined in the workforce plan. This is due to increasing sickness levels and the impact of the doctor's strike.
- Agency spend as a proportion of the total pay bill remains below target and within the expected range at 0.69, a small increased from last month's 0.68% and is well within the control parameters and below the 2.5% target.
- The overall in month sickness rate for November was 6.31%, highest levels since July 2022.
- In-month turnover in November 2025 was relatively low at 0.41%, which in turn has further cut the 12-month rate to 7%.
- Overall appraisal compliance has fallen by over half a percentage point to 78.46% and moves further away from the 90% target. All Divisions have not improved on their respective positions reported last month and no Division is achieving target with only R&D, Medicine and Surgery above 80%.
- Mandatory Training compliance continues to meet target at 88.8% in November, though has fallen fractionally for the third successive month.

The priorities within our People agenda will continue the work around financial

recovery, management of sickness absence and improving appraisal compliance.

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

Non-attendance due to sickness
A Trust wide task and finish group commences in January 2026, to understand the root causes and subsequent actions to that can be taken to support staff well-being in response to increasing sickness (and increasing sickness from ASD).

The Welbeing and Supporting Attendance Policy is being currently being reviewed with a view to being amended.

Training continues for the Wellbeing and Supporting Attendance Policy and the People Hub are working through the top 100 long term absences ensuring long term sickness cases are appropriately managed. A regular review meeting is in place to work through long term sickness cases to ensure the correct level of support is in place.

Appraisal Compliance and Quality
The appraisal rate remains approximately 12.5% below our compliance target of 90%.

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

Agency and Bank Usage
Agency wte has reduced slightly in November 2025 to 10.7 but remains above planned levels but remains one of the lowest levels of agency usage nationally.

Bank usage increased in November 2025, with reasons of sickness and the doctors' strike. Sickness Reduction and staff wellbeing is going be a focus over the next 3 months and then next 3 years. This will have an impact on staff wellbeing and in turn our usage of wte.

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

Finance
The RUH Group is £15.910m adverse to plan at the end of November, of which £15.896m arising in RUH Trust and £0.014m adverse 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 £11.9m variance arising from under delivery of the £29.7m savings programme and acceleration of delivery plan and scoping of further areas to close the unidentified gap must be top priorities for the organisation. £12.1m remains unidentified at his time and there are delivery risks within planned schemes. £3.4m arises from UEC savings where demand growth and higher than planned NCTR are the key contributors.

Operational budget pressures have maintained in November with cumulative pressures arise from increased spend on high cost drugs and devices (£1.1m), Pay Award (£0.3m) Resident Doctors budget pressures (£1.2m), and Resident Doctor Strike (£0.5m). This is partly offset by increased cost controls and non-recurrent benefits (£2.3m).Sulis is adverse to plan by £0.014m. Performance against NHS and private patients is offsetting the under performance on CDC activity based income. Further adverse variances arise from deterioration in the exit run rate from 24/25 (£4m)

For August 2025 the Trust had an implied productivity improvement of 2.6% against the breakthrough objective of 6.7%. Cost weighted activity grew by 4.7% compared to inflation adjusted cost growth of 2.1%. Given that some of the activity growth is in non-elective activity we do not see a direct financial benefit from this productivity.

The Trust is significantly adverse to plan, and is in discussions with ICB and NHSE to deliver a forecast outturn of £17m and if possible further contribute to £7.4m additional savings alongside BSW Hospitals Group partners.

The support this the Trust has commissioned additional Turnaround Support from Hunter Healthcare who began work on 17 November.

2.	Recommendations (Note, Approve, Discuss)
The Board 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, Quality, Workforce, and Financial assurance risks as set out in the paper.	

6.	Equality and Diversity
NA	

7.	References to previous reports
Standing agenda item.	

8.	Freedom of Information
Public	

9.	Sustainability
None identified.	

10.	Digital
None identified.	

NHS
Royal United Hospitals Bath
NHS Foundation Trust

Integrated Performance Report

December 2025
(November Data)

The RUH, where you matter

Trust Priorities 2025/26

Royal United Hospitals Bath NHS Foundation Trust

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

Vision Metrics (7-10 Years)

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

Breakthrough Objectives 2025/26 (12-18 months)

Valuing Patient & Staff time
Achieving ambulance offload times

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

Productivity
Maximising value, eliminating waste

Corporate Projects 2025/26

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

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

Strategic Initiatives (3-5 Years)

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

What is an Integrated Performance Report (IPR)

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

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

NHS
Royal United Hospitals Bath
NHS Foundation Trust

Executive Summary

December 2025
(November 2025 Data)

The RUH, where you matter

Trust Executive Summary: Operational Performance Dashboard

Domain	Measure	Month	Latest Performance	Previous Performance	Month-End Target	Year-End Target	Assurance	Variation	Variation Detail
Urgent Care	12 Hour Trolley Waits	Nov-25	155	112		0			Special Cause Concerning - Above Upper Control Limit
Urgent Care	12 Hour Trolley Waits (% Type 1 Atts)	Nov-25	8.7%	9.1%	8.6%	0.0%			Common Cause Variation
Urgent Care	4 Hour ED Performance	Nov-25	57.7%	55.8%	66.6%	72.0%			Common Cause Variation
Urgent Care	Average Ambulance Handover Time (mins)	Nov-25	32	37	33	33			Special Cause Improving - Below Lower Control Limit
Urgent Care	ED Patients Assessed in under 15 mins	Nov-25	68.9%	64.6%					Special Cause Improving - Above Upper Control Limit
Urgent Care	No Criteria to Reside (% Occupied Beds)	Nov-25	19.3%	18.6%		10.0%			Common Cause Variation
Urgent Care	Non Elective Length of Stay	Nov-25	8.5	8.1		8.4			Special Cause Improving - Run Below Mean
Elective Activity	RTT Incomplete Pathways over 52 weeks	Nov-25	1.4%	1.7%	1.7%	1.0%			Special Cause Improving - Two Out of Three Low
Elective Activity	RTT Incomplete Pathways over 65 weeks	Nov-25	33	83		0			Common Cause Variation
Elective Activity	RTT Performance	Nov-25	63.0%	60.7%	62.1%	67.7%			Common Cause Variation
Elective Activity	RTT Wait to First Outpatient Appointment (% <18 weeks)	Nov-25	66.4%	63.9%	70.0%	72.0%			Common Cause Variation
Diagnostics	CT Productivity (CT Activity DM01 Volume At or Above Plan)	Nov-25	147	-11		0			Special Cause Concerning - Run Below Mean
Diagnostics	DM01 Performance (% <6 weeks)	Nov-25	71.0%	70.5%	90.5%	95.0%			Common Cause Variation
Diagnostics	MRI Productivity (MRI Activity DM01 Volume At or Above Plan)	Nov-25	-105	-84		0			Special Cause Concerning - Run Below Mean
Cancer	Cancer 28 Day Diagnosis	Oct-25	64.6%	52.8%	78.9%	80.0%			Common Cause Variation
Cancer	Cancer 31 Day Treatment	Oct-25	91.9%	88.1%	92.4%	90.0%			Common Cause Variation
Cancer	Cancer 62 Day Standard	Oct-25	63.5%	58.3%	74.0%	75.0%			Common Cause Variation

The RUH, where you matter

* November data

Overview – Executive Themes and Actions to Raise at Board

Call to Action

UEC – 4 hour	RUH 4-hour performance in November was 57.70% on the RUH footprint (unmapped), an increase of 1.07% from October. Ambulance handovers were 1 minute better than target (31.6 v 33mins) for November, although behind trajectory in December. 12 Hour Performance has improved from 9% to 8.7% for November and 8.0% in December. NCTR performance 92.5 patients, increased of 4.2 from October but reduced to 77.8 patients in December, 29.8 above the 48 targeted trajectory.
Financial Recovery - £17m Deficit	The RUH is £15.910m adverse to plan at the end of November, of which £15.896m is at RUH and £0.014m adverse in Sulis. The key driver is £11.9m variance from under delivery of the £29.7m savings programme. £12.1m remains unidentified at his time and there are delivery risks within planned schemes. The turnaround team continues to provide to support on run rate reductions to support the year end position as well as the identification of future savings opportunities.
Referral to Treatment times – 65 weeks	In November RTT performance was 63%, an increase of 2.3% from October The percentage of patients waiting less than 18 weeks for their first outpatient appointment was 66.4% (+2.5%) and total over 52-week waiters decreased from 644 to 545 (-15%) For patients over 65 weeks, the Trust saw a decrease from 83 to 33 patients and we have achieved the target of Zero over 65 week waits by end of December 2025. The number of 52 week waits has reduced to 493 at end of December, the lowest level in 2 years.
Cancer – 28 day Faster Diagnosis	Cancer 28 day faster diagnosis improved from 52.9% in September 2025 to 70.7% (Nov), which is a +17.8% improvement Challenges remain for 31 and 62 day targets where performance has been negatively impacted from the improvements in the diagnostic phase of the cancer pathway. Focused work is underway to recovery performance against trajectory.
Diagnostics – DM01 Backlog	In November 2025, 71.05% of patients received their diagnostic within the 6-weeks against the 71.60% target. Significant recovery required to return to trajectory but there are clear actions to get to 16.1% over 6 weeks by end of year. Risks remain in two areas - demand being higher than we have modelled – particular risks in ultrasound demand exceeding capacity and capacity mobilisation being delayed.
Patient Safety & Staff Wellbeing	SHMI is above the upper control line. There are concerns with data validity due to a significant number of uncoded episodes and spells which contribute to the mortality data. The Trust Mortality Group has been re-established to urgently strengthen and triangulate our mortality data. Day nursing fill rates for Registered Nurse and Healthcare Support Workers has improved slightly in November but remain below target. This is due to vacancies in key areas e.g. ED and increased sickness absence overall. Urgent workstreams continue to address the underlining caused and mitigate potential patient safety and quality risks. The overall in month sickness rate for November was 6.31%, highest levels since July 2022 when the rate was elevated by COVID. In January 2026, the Trust will undertake a sickness task-and-finish project to identify root causes of rising rates, review the Managing Wellbeing at Work policy, implement Perkbox as an organisation-wide platform to enhance EAP, wellbeing, and resilience, and establish a Culture Response Team

Balanced Scorecard – SWOT Analysis

Successes

- Zero over 65 week waiters as at 31st December 2025
- Cancer 28 day faster diagnosis improved from 52.9% in September 2025 (+17.8%)
- RUH ranking on 4 hour standard has improved from 123 to 103 / 124 (November data)
- 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).
- Business case approved to open St Martins Ward 4 (20 beds) from the 29th December 2025 to the 31st March 2026 to support NCTR community responsibility reduction

Opportunities

- Digital opportunities in Outpatients for Quarter 4 – AI test of change, automation of referral process & electronic check-in
- Quarter 4 Elective Sprint Funding to reduce elective waiting times
- Further strengthening of financial controls
- Turnaround Team commenced 17th November 2025
- UEC reset programme
- Implementation of Internal Professional Standards

Priorities

- Maintenance of patient safety
- Delivery of the financial and operational recovery plan ‘Call to Action’
- Business planning for next 3 year cycle
- 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 move through Winter period.
- Introduction of a new Employee Assistance Programme (Perkbox).
- Development of Ambient and other digital applications
- Corporate Services Redesign
- Improve coding compliance

Risk/Threats

- Very challenging financial recovery plan to year end
- Cash projections and risk to capacity plan
- Significant increases in UEC demand far outstripping planned levels
- Maintenance of patient safety in light of financial & performance pressures
- 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
- Inability to balance delivery across financial and operational plan

Executive Summary

Performance

The average ambulance handover delay for November 2025 was 31.6 minutes, a decrease from 36.8 minutes on average in October 2025. Through November 2025 the total hours lost was 820. This is a 274-hour decrease compared to last month's lost hours of 1,094. 58.2% of handovers were completed within 30 minutes.

RUH 4-hour performance in November was 57.70% on the RUH footprint (unmapped), an increase of 1.07% from October's performance (56.63%). Non-admitted performance was 70.9%, which was an increase against the performance for October (68.69%) and admitted performance remained static at 28.37% (October 28.69%).

The numbers of patients going through our MSDEC (686) decreased in November compared to October (761) and FSDEC numbers also reduced slightly (30). This was mainly driven by use of MSDEC trolleys overnight causing decreased flow each day following. This was due to heightened activity coming through the front door. Our performance for MSDEC at 36.8% for November 2025 (October 39.2%) remains just below the national target of 40% of patients going through an SDEC pathway.

In November 2025, 71.05% of patients received their diagnostic within the 6-weeks against the 71.60% target. Performance improved 0.55% from previous month. In month, 102 additional diagnostic tests were delivered when compared to October 2025.

In October (Cancer is reported one month in arrears) performance improved against all three standards but remained under national target. 28 Days improved by 11.4% to 64.9% with most specialties seeing an improvement, the most significant being in Breast increasing by 18.5%. 31 Days improved by 2% to 93.6%, above trajectory but under national target. 62 Days improved by 5.9% to 64.0% with the notable increases in Breast and Skin (11.8% and 9.7% improvements respectively). Performance will deteriorate from November to January due to recovery of the Skin MOPS backlog with more breach patients being treated.

In November, RTT saw an increase in overall performance of 2.3% to 63.0%. The percentage of patients waiting less than 18 weeks for their first outpatient appointment was 66.4% (+2.5% from October). Total over 52-week waiters decreased from 644 to 545 (-15%). For patients over 65 weeks, the Trust saw a decrease from 44 to 33 patients.

Executive Summary

Quality

Pressure Ulcers
For November 2025, the RUH reported 0.6 pressure ulcers per 1,000 bed days (10 pressure ulcers). The RUH reported three category 3 pressure ulcers, three category 3 medical device related pressure ulcers on one man in ITU and four category 2 pressure ulcers.

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

Falls
In November 2025 there were 4 reported falls that resulted in moderate harm to patients, these occurred in 4 different clinical areas. There were 5.3 falls per 1000 bed days in November, this is down from 6.68 in October 2025. Any new actions or areas of learning from these incidents were agreed and included in the falls work plan to ensure improvement work is planned and completed. As a result of several falls across the 3 divisions a trust wide PSII (Patient safety incident investigation) has been commissioned and is aimed to be completed in 3-6 months. The PSII is ongoing.

Infection Prevention and Control
There were 14 cases of Clostridioides Difficile infection (CDI) (9 HOHA and 5 COHA) reported during November 2025. There have been 54 cases against a threshold of 75 reported to date for 2025/26. With the increase in cases, we have seen 3 Periods of Increased Incidence, with a review and ribotyping in progress. The October 2025 rate per 100,000 bed days for the Trust is 43.09, against the SW rate of 31.41.

There have been 9 cases of *E. coli* infection (2 HOHA and 3 COHA) during November 2025 There has been 69 cases reported against a threshold of 77. With a predominant cause being urinary, there are future initiatives in progress to start in the New Year. The October rate per 100,000 per days is 36.93 against the SW rate of 48.57.

MSSA rates have stabilised this month and to support the IVAD group there are further plans to start ward-based training and engagement sessions in the New Year to support learning gaps.

Patient Support and Complaints
In November the Trust received 37 new formal complaints, this compares to 30 received in October. The complaint rate per 1000 contacts is 0.59 and the number of reopened complaints increased over November (5). These were spread across the divisions. 78% (target 90%) of complaint responses were closed within the agreed timeframe.

Executive Summary

Quality cont…

Safe Staffing
Registered Nurse day shift fill rate was 84% (target 90%)
Healthcare Support Worker (HCSW) day shift fill rate was 87% (target 90%)
RN and HCSW day fill rates are below 90% performance target since June 2025. The current night shift fill rate for RN and HCSW remains above 90%.

The top contributor for HCSW day fill rate is HCSW vacancy, this has been impacted by the national change in visa and sponsorship rules. The top contributors for low RN fill rates is vacancy within Paediatrics, William Budd and Emergency Department (ED). New nursing staff are due to commence in December in all areas. Recruitment continues for remaining RN vacancies with additional recruitment events planned in January 2026.

Perinatal Update
The October and November Perinatal report highlights areas of focus for the service:

- The neonatal service has experienced a period of high service acuity following a reduction in cot capacity within North Bristol Trust (NBT) level 3 tertiary provider in October 2025. This has been compounded by an increased vacancy rate within the neonatal nursing workforce due to an increased parental leave rate. A risk assessment has been conducted outlining risk management actions inclusive of escalation procedures and operational staffing contingencies
- Monthly workforce metrics continue to be monitored as part of the Perinatal Quality Surveillance Oversight Model (PQSOM). Metrics below target measures have been identified for further review /'Deep Dive' to understand drivers and practice influencing factors to improve understanding and underpin improvement work where necessary. The areas identified are:
    - Sickness rates
    - Roster 'Shift Fill' and the impact of current Flexible working agreements
    - Mary Ward staffing vs acuity
- During November the National Maternity Outcomes Signal and System (MOSS) Tool went live. The monthly summary of service position pertaining to perinatal mortality will form part of the monthly safety metrics within the PQSOM. The Integrated Care Board (ICB)'s Local Maternity and Neonatal System (LMNS) are in the process of developing SOPs to support the required governance reporting structures should the service receive a system 'alert'
- The service has maintained mandatory training standards to 90% compliance with 90% achievement within each applicable staff group across Practical Obstetric Multi-Professional Training (PROMPT), Saving Babies Lives (SBL) inclusive of fetal monitoring training and Newborn Basic Life Support (NBLS) as per Maternity Incentive Scheme year 7 requirements.
- The service was made aware of the 'prevention of future deaths report' published in the public domain during November 2025 for the deaths of Jennifer and Agnes Cahill within another provider. The Community Midwifery Matron supported by the Obstetric Lead Consultant for Birth Choices have conducted a benchmarking exercise of the current RUH community and home-birth service provision against the identified learning within Jennifer and Agnes' care. Monitoring of progress any identified actions report into specialty governance for senior leadership oversight.

Executive Summary

Quality cont…

The service is pleased to highlight that:
Following the operational transformation of the flu vaccination programme in 2024 the current administrations of the flu vaccine to pregnant women in 25/26 currently exceeds the total number of administrations for the whole of the 24/25.
Women's and children's research has secured inclusion as a pilot site for the 'Generation' Research study.

Executive Summary

Workforce

Summary of key workforce metrics

- Actual Total WTE in November 2025 was 5807 an increase on the October position. The RUH is currently 222wte over plan, the majority of which is due to a growth in substantive whole time equivalent (wte).
- The vacancy rate has further reduced to – 0.85% in November. This figure masks vacancies in key areas Emergency Medicine and Pathology
- Bank usage has further increased in November, exceeding the planned bank usage as outlined in the workforce plan. This is due to increasing sickness levels and the impact of the doctor's strike.
- Agency spend as a proportion of the total pay bill remains below target and within the expected range at 0.69, a small increased from last month's 0.68% and is well within the control parameters and below the 2.5% target.
- The overall in month sickness rate for November was 6.31%, highest levels since July 2022.
- In-month turnover in November 2025 was relatively low at 0.41%, which in turn has further cut the 12-month rate to 7%.
- Overall appraisal compliance has fallen by over half a percentage point to 78.46% and moves further away from the 90% target. All Divisions have not improved on their respective positions reported last month and no Division is achieving target with only R&D, Medicine and Surgery above 80%.
- Mandatory Training compliance continues to meet target at 88.8% in November, though has fallen fractionally for the third successive month.

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

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

Non-attendance due to sickness

A Trust wide task and finish group commences in January 2026, to understand the root causes and subsequent actions to that can be taken to support staff well-being in response to increasing sickness (and increasing sickness from ASD).

The Welbeing and Supporting Attendance Policy is being currently being reviewed with a view to being amended.

Executive Summary

Workforce cont…

Training continues for the Wellbeing and Supporting Attendance Policy and the People Hub are working through the top 100 long term absences ensuring long term sickness cases are appropriately managed. A regular review meeting is in place to work through long term sickness cases to ensure the correct level of support is in place.

Appraisal Compliance and Quality:

The appraisal rate remains approximately 12.5% below our compliance target of 90%.

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

Agency and Bank Usage

Agency wte has reduced slightly in November 2025 to 10.7 but remains above planned levels but remains one of the lowest levels of agency usage nationally.

Bank usage increased in November 2025, with reasons of sickness and the doctors' strike. Sickness Reduction and staff wellbeing is going be a focus over the next 3 months and then next 3 years. This will have an impact on staff wellbeing and in turn our usage of wte.

Recruitment

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

Executive Summary

Finance

The RUH Group is £15.910m adverse to plan at the end of November, of which £15.896m arising in RUH Trust and £0.014m adverse 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 £11.9m variance arising from under delivery of the £29.7m savings programme and acceleration of delivery plan and scoping of further areas to close the unidentified gap must be top priorities for the organisation. £12.1m remains unidentified at his time and there are delivery risks within planned schemes. £3.4m arises from UEC savings where demand growth and higher than planned NCTR are the key contributors.

Operational budget pressures have maintained in November with cumulative pressures arise from increased spend on high cost drugs and devices (£1.1m), Pay Award (£0.3m) Resident Doctors budget pressures (£1.2m), and Resident Doctor Strike (£0.5m). This is partly offset by increased cost controls and non-recurrent benefits (£2.3m).Sulis is adverse to plan by £0.014m. Performance against NHS and private patients is offsetting the under performance on CDC activity based income. Further adverse variances arise from deterioration in the exit run rate from 24/25 (£4m)

For August 2025 the Trust had an implied productivity improvement of 2.6% against the breakthrough objective of 6.7%. Cost weighted activity grew by 4.7% compared to inflation adjusted cost growth of 2.1%. Given that some of the activity growth is in non-elective activity we do not see a direct financial benefit from this productivity.

The Trust is significantly adverse to plan, and is in discussions with ICB and NHSE to deliver a forecast outturn of £17m and if possible further contribute to £7.4m additional savings alongside BSW Hospitals Group partners.

The support this the Trust has commissioned additional Turnaround Support from Hunter Healthcare who began work on 17 November.

Trust Executive Summary: Key Metrics

Business Plan Delivery November 2025

Activity Plan

	YTD Plan	YTD Actual	Variance	Change per Day Actual
OP News	134,929	139,876	4,947	+29
OP Follow Ups	204,943	211,180	6,237	+37
Daycases	26,054	24,879	-1,175	-7
EL Inpatients	3,187	2,724	-463	-3
ED Attendances	69,571	70,557	986	+4
NEL Admissions	41,424	43,442	2,018	+8
Diagnostic tests	115,423	113,152	-2,271	-13

Planning Assumptions

	Plan	YTD Actual
GP Referral Growth*	0.0%	1.8%
ED Atts Growth	2.6%	4.1%
NEL Admit Growth (excludes maternity)	3.4%	10.5%
NCTR	52	93
NEL Length of Stay (for 14 days)	7.1	6.7

* 1 month reporting lag

Performance

		Year End Target	Current Month Plan	Actual
RTT	<18 1st app	71.7%	70.0%	66.4%
	<18 weeks	67.7%	66.0%	63.0%
	>52 weeks	1.0%	1.2%	1.4%
Cancer	62 days*	75.0%	74.0%	63.5%
	31 days*	96.0%	92.4%	91.9%
	28 days*	80.0%	78.9%	64.7%
ED	4hr type 1	72.0%	66.6%	57.7%
	4hr All Types	78.0%	73.3%	66.9%
	12 hours	reduction	8.6%	8.7%
DM01	> 6 weeks	5.0%	9.5%	29.0%

* 1 month reporting lag

Finance

	YTD Plan	YTD Actual	Variance
Cash Releasing Savings	£19,799	£7,861	-£11,938
Financial Position	£0	-£16,026	-£16,026
Productivity	+6.5%	+2.6%	-3.9%

Figs to Aug 25

Workforce

	YTD Planned	YTD Actual	Variance
Pay Savings (£000s)	£10,774	£3,338	-£8,164
WTE Reduction	5585.3	5802.2	216.9
Sickness - 12 Month	4.70%	5.07%	0.37%

Part 1 | People We Care For

Providing safe and effective care

Right care, right time, right place

Improve the experience of those who use our services

Royal United Hospitals Bath
NHS Foundation Trust

Operational Report

December 2025
(November 2025 Data)

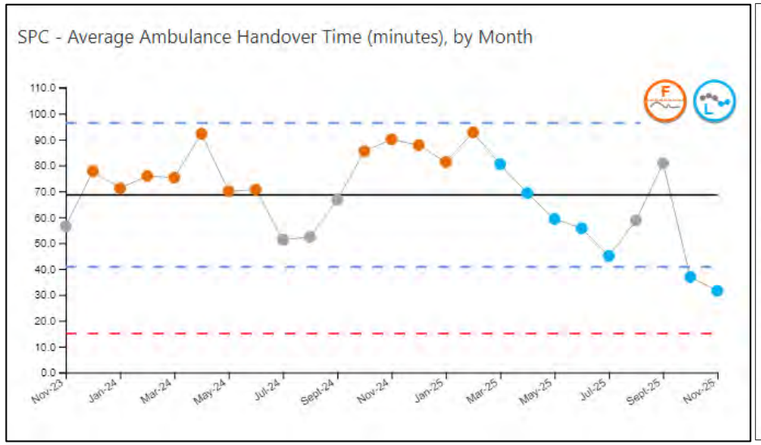
The RUH, where you matter

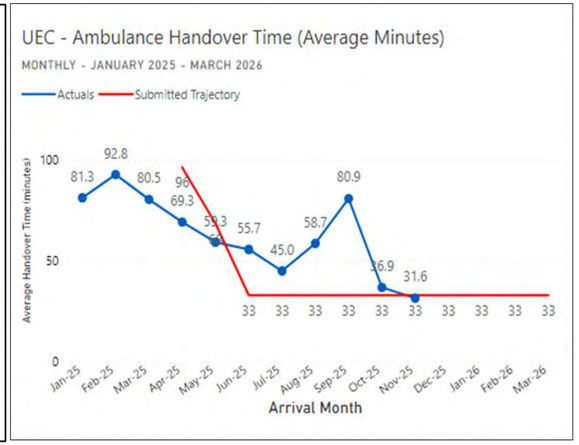
Ambulance Handover Times

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. In November, the Trust met the target.* *Average ambulance handover = 33mins (30th June 2025)*





This measure demonstrates a special cause variation, as it is improving, but is currently failing the target of 15 minutes.

The average ambulance handover delay for November 2025 was 31.6 minutes, a decrease from 36.8 minutes on average in October 2025. Through November 2025 the total hours lost was 820. This is a 274-hour decrease compared to last month's lost hours of 1,094. 58.2% of handovers were completed within 30 minutes.

November 2025 performance is 1 minute ahead of trajectory; December so far is currently showing a worsened position, at 9 minutes behind trajectory (04/12/2025).

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.	JR	TBC – Jan26/Feb26
Plan and agree case for change supporting an EMAC model within current ED Obs footprint.	MP	Jan26
Recruit 10.24 WTE registrars following business case approval.	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**

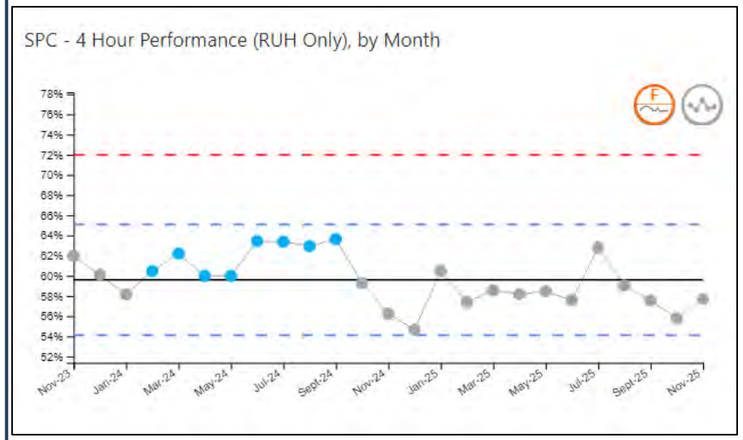
Risks and Mitigation

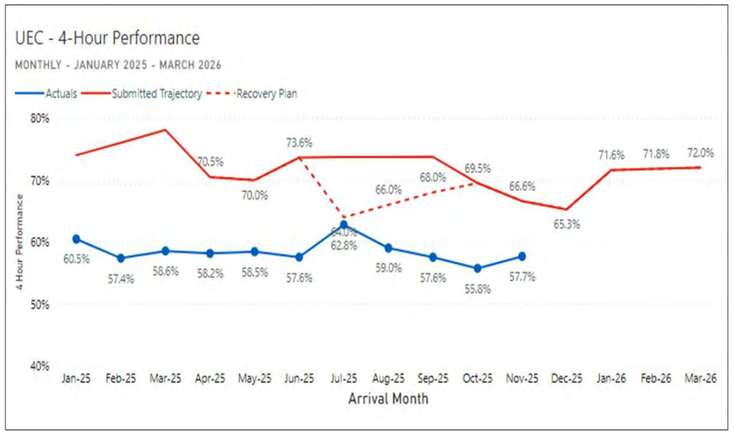
- Risk of >45min handover duration.
  - Site/ED extended handover process in place.
- Risk of patient deterioration in an ambulance not offloaded.
  - RUH ED review of deteriorating pts, QI project in progress.

4 Hour Performance

Royal United Hospitals Bath NHS Foundation Trust

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





This measure demonstrates a common cause variation, as it is not improving, and is currently failing the target of 72%

	Admit	Non-admit	Total	Target
ED	19.48%	35.84%	**27.74%**	**42%**
CED	61.13%	86.78%	**82.14%**	**95%**
UTC	69.12%	88.89%	**87.47%**	**95%**
Total	**28.37%**	**70.9%**	**57.70%**	**72%**

*78% target incl. MIU

Understanding Performance

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

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

Countermeasures	Owner	Due Date
Implement the National Acuity Model to support triage and streaming.	JR	TBC, Jan26/Feb26
Plan and agree case for change supporting an EMAC model within current ED Obs footprint.	MP	Jan26
Recruit 10.24 WTE registrars following business case approval.	MP/BI	Mar27
Support implementation and monitoring of IPS 2025 via UEC Improvement Programme.	Leadership team	Mar26

Risks and Mitigation

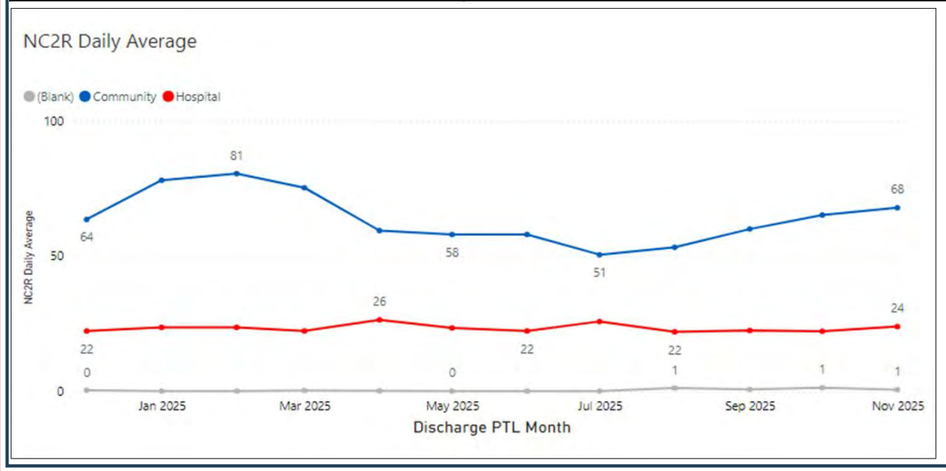
- Risk of increase mortality due to extended wait times in ED/UC.
- Risk of staff burnout and disengagement due to overcrowding.
  - UEC improvement programme to reduce overcrowding.

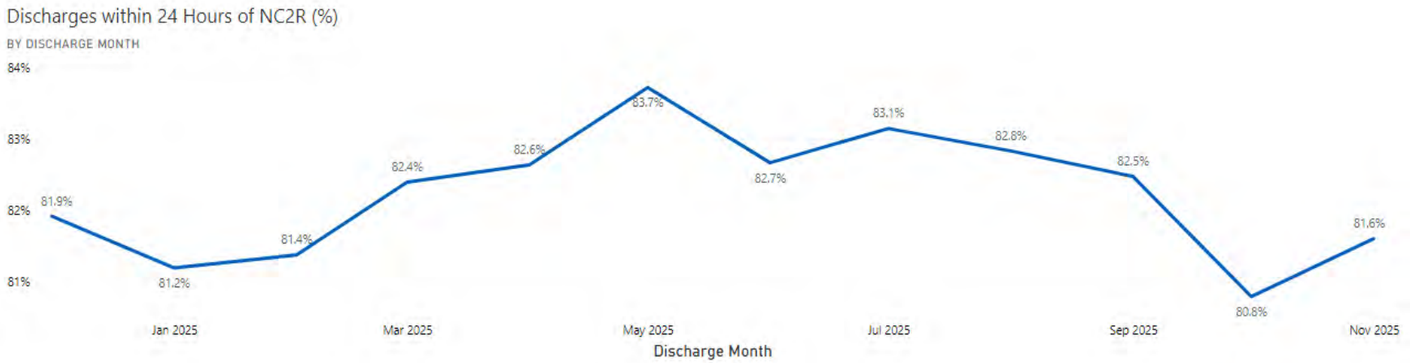
Non-Criteria to Reside

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 November 2025, the average number of NCTR patients per day was 92.5, an increase of 4.2 patients compared to October 2025. Discharges within 24 hours of NCTR (all pathways) increased in November to 81.6%; Pathways 1-2, 29.3% of patients were discharged within 24 hours, 31.8% within 48 hours and 79.4% 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 November, the daily average for community responsibility patients remained unchanged at 68 patients.*





Understanding Performance

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

Improved performance:
Hospital responsibility NCTR has increased by 2 patients to a daily average of 24 patients, compared to the April 2025 baseline. In addition, for November, 94.9% of the hospital responsibility patients were discharged within 24-hour hours of non-criteria, 94.9% within 48 hours (no change) and 99.0% within 7 days.

Countermeasures	Owner	Due Date
Follow up desktop exercise led by the RUH with system partners date to be arranged for early January 2026, aims to follow up on the actions to deliver the following, noting that in December w/c 15th December the RUH is participating in a Mega MADE event to drive up referrals and discharge which will also identify areas of improvement that will link to this group, 1) To collaboratively identify opportunities to improve flow through and from the RUH for patients who will discharge under a P1, 2, 3 pathway. 2) To inform strategic demand and capacity decisions. 3) To identify countermeasures to support sufficient flow for our patients and their families.	Sarah Hudson	January 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). Improvement noted, further work planned throughout December.	Sarah Hudson	December 25
Roll out of the NHS Federated Data Platform Optimised Patient Tracking and Intelligent Choices Application (OPTICA) which has been implemented at the RUH, to all locality partners to establish an accurate and reliable data system to identify and track patients without criteria to reside. Providing a single source of the NCTR position. Project resource identified who will start January 2026 to support implementation.	Sarah Hudson	February 2026

Risks and Mitigation

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

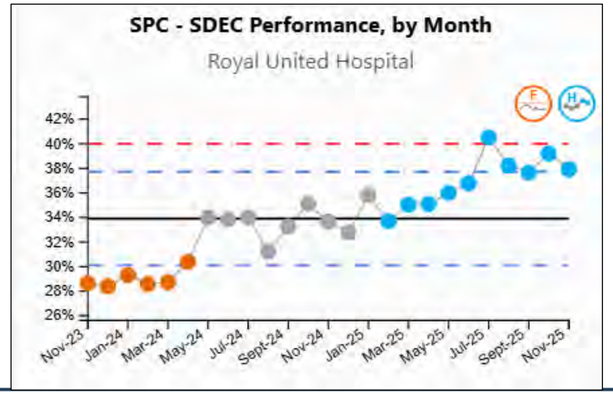
SDEC

Royal United Hospitals Bath NHS Foundation Trust

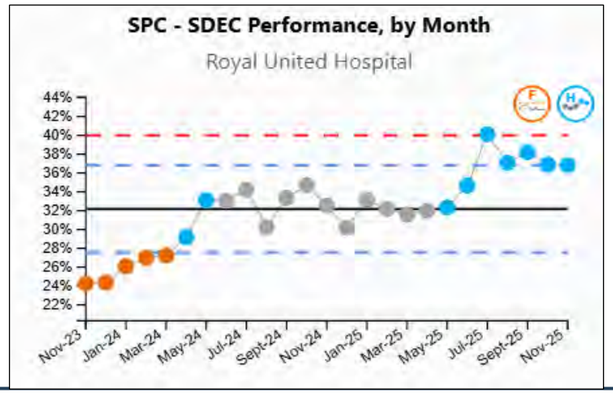
UEC Delivery Group Driver Metric

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

Trust Wide SDEC Performance November 2025: **37.9%** against a target of 40%



Medicine Division SDEC Performance November 2025: **36.8%** against a target of 40%



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

Service / Monthly Activity	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25
Medical SDEC (previously Amb Care/DAA)	581	777	642	720	761	686
Frailty SDEC (OPRAA and OPAU)	24	30	30	39	37	30

Understanding Performance

- November Medical Division SDEC performance has held at 36.8%, but MSDEC activity is a little reduced at 686. The slight reduction in performance and activity is likely related to staffing, but also trolley spaces being used for non-SDEC patients (especially overnight). There were days in November where Medical SDEC had more patients than they had space to see, due to lack of flow from the trolleys onto MAU or specialty wards.

Ongoing Improvement blockers:

- Reduced Medical SDEC capacity due to Consultant vacancies – this situation has worsened due to staff sickness

Countermeasures	Owner	Due Date
Acute Medicine consultant posts to go back out to advert, and locum secured from November 25	CY	24/12/25
Change in MSS SBAR approved by Execs – due to start 3/11/25 – to release Acute Medical Consultants to focus on SDEC and MAU.	FM	On pause due to securing locum for MSS
Continued Integrated Front Door (IFD) working including Joint Winter Planning	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 planned for January 2026	CY	30/1/26

Risks and Mitigation

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

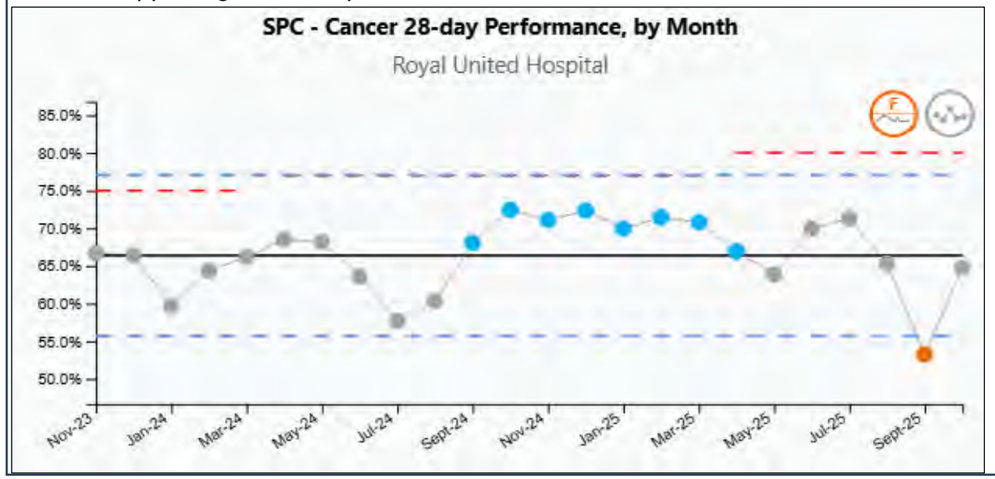
<u>Flow from SDECs to specialty beds</u>
High risk of impact
Site aware
SOPs to be followed
B6 Coordinator training

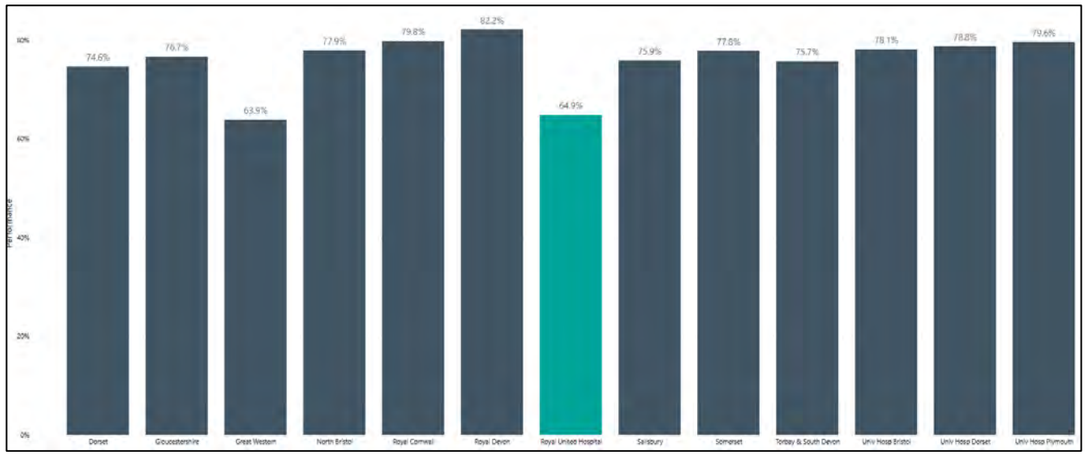
28 Day Cancer Performance

Royal United Hospitals Bath NHS Foundation Trust

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

SPC & supporting data if required





Understanding Performance

Performance increased in October to 64.9% with improvement in most specialties – further improvement across Nov / Dec

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

In month challenges:
- Breast improvement to 82% through reduced one-stop wait.
- Colorectal recovery to 47%. All OPAs consistently at 7 days. Colonoscopy now 17 days but increasing over Christmas.
- Reported CT/CTC 16 days. CTC utilisation pilot delayed.
- Gynae on trajectory at 72% – PMB now 4 days.
- Skin recovery above trajectory at 46% due to earlier recovery. First OPA increase over Christmas days. Telederm expansion in Q4.
- Urology LATP reduced to 8 days but reported MRI 18 days.

Countermeasures	Owner	Due Date
Breast locum consultant extensions	HW	December 2025
Breast one-stop WLIs	HW	January 2026
Ringfenced colonoscopy capacity	TS	December 2025
Endoscopy and Gastro consultant recruitment	TS	Dec 25 / Apr 26
Dermatology additional clinics to lower OPA wait <28 days	GJ	January 2026
MRI scan and report sessions	NA	January 2026
LATP sessions to manage demand following MRI	KR	January 2026
LATP nursing bid 3.88 WTE through business planning	KR/EJ	April 2026
STT pathway – awaiting group IT approval for Cinapsis	KR/EJ	January 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

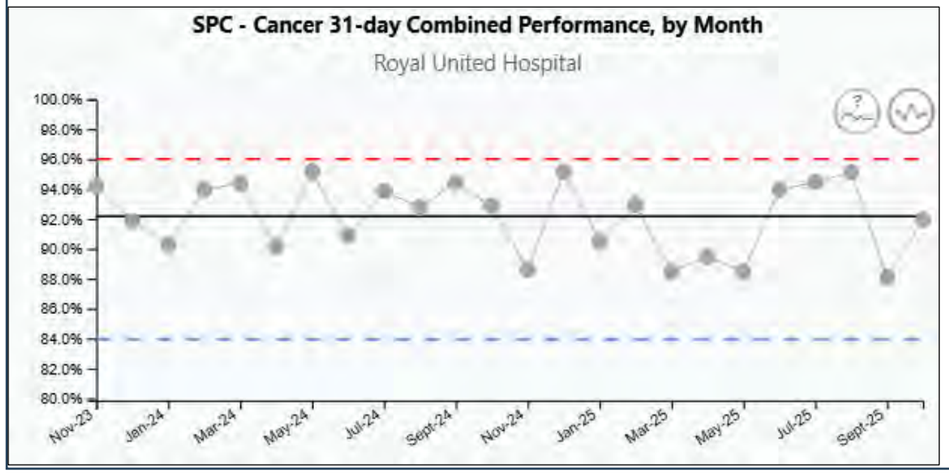
Mitigation:
- SWAG/NHSE funding for WLIs, locums, in / outsourcing
- Telederm
- Pathway change (Gynaecology / Prostate / Colorectal)

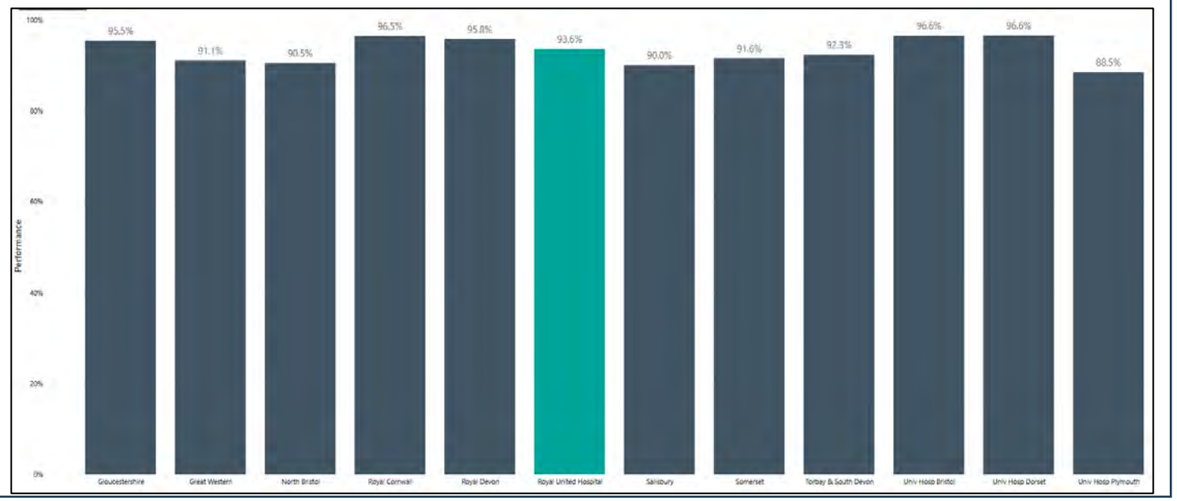
31 Day Cancer Performance

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 increased to 93.6%, above trajectory (92.5%). Deterioration expected Nov – Jan due to Skin MOPS recovery

Top contributors:
Breast, Skin, Urology

In month challenges:
- Breast delays to surgery. Increased subsequent surgery and radiotherapy breaches.
- Dermatology MOPs increased to 48 days. Insourcing commenced in November with backlog cleared by end of January. Impact on Trust performance.
- Urology breaches primarily due to increased robotic prostatectomy WLIs to treat long waiting patients for subsequent treatment. Waiting time now at 4 weeks.

Countermeasures

Countermeasures	Owner	Due Date
Breast recording of patient choice delays	RJS	December 2025
Theatre WLIs	HW	January 2026
Additional substantive consultant	HW	April 2026
Skin MOPS insourcing	GJ	December 2025
Dermatology workforce skill-mix review	GJ/SS	January 2026
Urology – identify third HIFU practitioner for training	KR/EJ	January 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

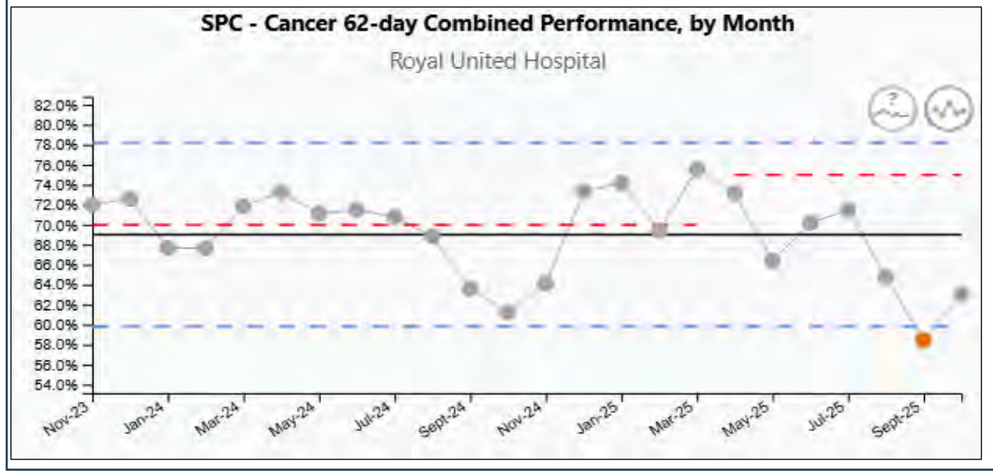
Mitigation:
- WLI, in/outsourcing and locums
- Long term workforce planning
- Telederm

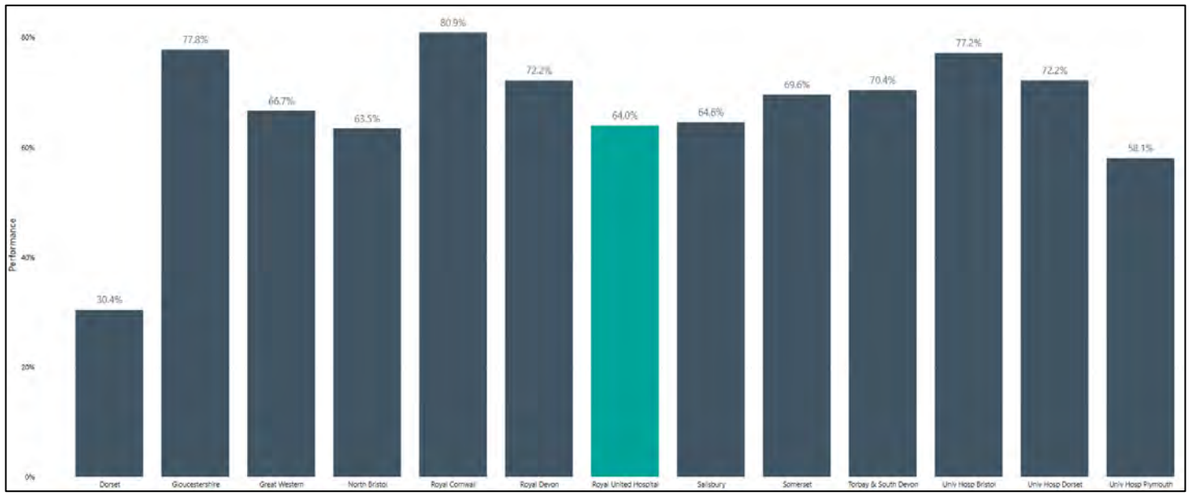
62 Day Cancer Performance

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 5.9% improvement to 64.0%

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

In month challenges:
- Breast patients impacted by one-stop waits.
- Colorectal recovery to 47%. Diagnostic pathway and additional investigations. 62 day backlog reducing.
- Skin OPA increasing due to Christmas. MOPS backlog clearance will reduce performance Dec-Jan, improve Feb. Impact on Trust performance.
- Upper GI impacted by longer OGD waits – above 3 weeks.
- Urology top contributor remains LATP but waits now 8 days to see performance improvement from December.

Countermeasures	Owner	Due Date
Breast substantive consultant surgeon request	HW	December 2025
Breast one-stop WLIs	HW	January 2026
Ringfenced colonoscopy capacity	TS	December 2025
Endoscopy and Gastro consultant recruitment	TS	Dec 25 / Apr 26
Ringfenced OGD capacity	TS	February 2026
MOPS insourcing	GJ	December 2025
Dermatology long term staffing plan / skill-mix review	GJ	December 2025
LATP nursing bid 3.88 WTE through business planning	KR/EJ	April 2026
MRI WLIs	NA	January 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

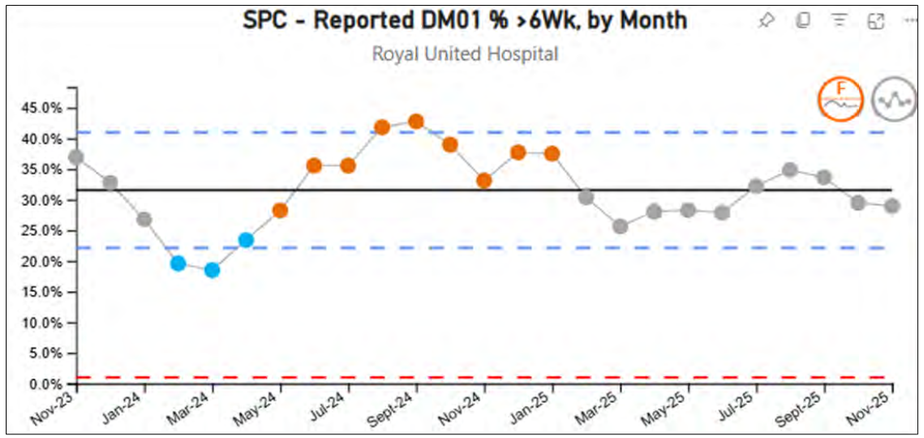
Mitigation:
- WLI, in/outsourcing, locums
- Workforce planning
- Pathway change (Breast / Gynaecology / Prostate / Colorectal)

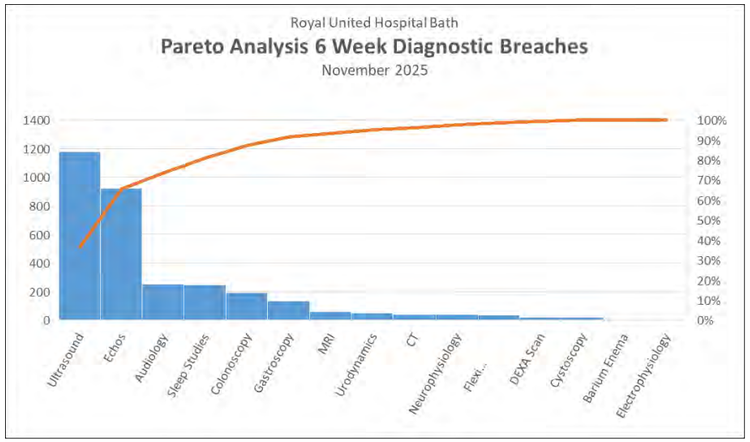
Diagnostic waits

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 November 2025, 71.05% of patients received their diagnostic within the 6-weeks against the 71.60% target.*
- *Performance improved 0.55% from previous month. In month, 102 additional diagnostic tests were delivered when compared to October 2025.*
- *DM01 trajectory reviewed to account for additional demand (RTT schemes) and mitigation (additional capacity) - end of year target 83.9% compliance.*
- *The **top contributors** to 6-week breaches were USS, Echo and Audiology.*
- *Key drivers of underperformance were:*
  - *Echo and Endoscopy behind on activity delivery.*
  - *Increased demand for routine diagnostics, following RTT recover insourcing schemes.*
  - *Increased demand for urgent and cancer referrals.*
  - *Delay in transferring Sleep Studies to Sulis CDC*

Countermeasures	Owner	Due Date
Continuation of WLIs for USS, MRI and Echo.	NA/CF	In place
USS insourcing at weekends *Additional USS activity at Sulis CDC in-week (insourcing) 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

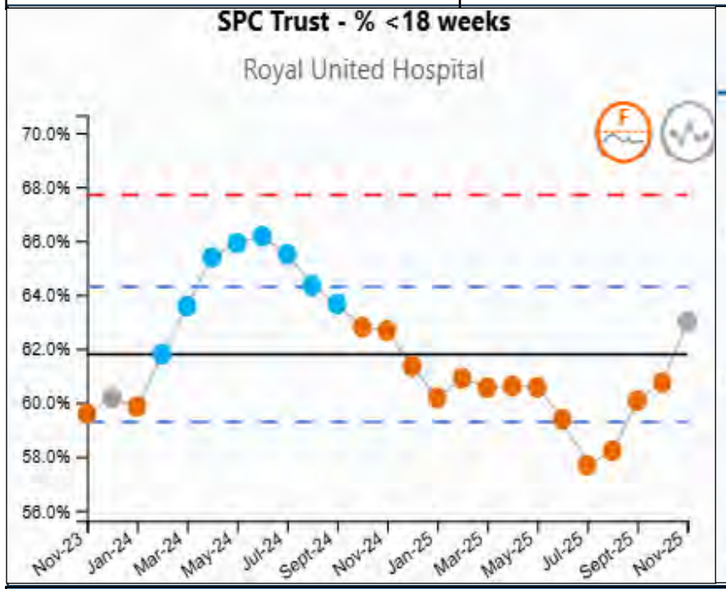
Risks and Mitigation

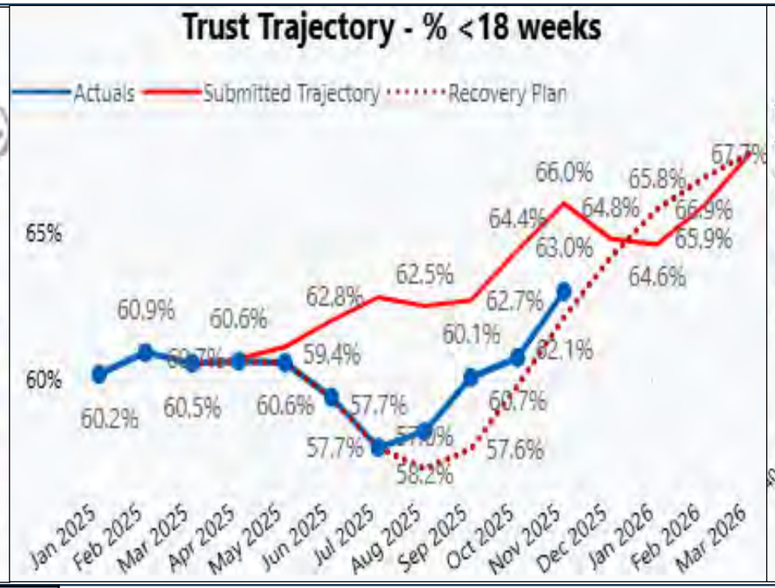
- **Risks:**
  - Sickness
  - Increased demand from RTT insourcing initiatives
  - USS staffing
  - Additional strikes
  - Delay to additional capacity schemes (USS, Echo, Endo)
- **Mitigations:**
  - Additional capacity at Sulis (USS, CT, MRI and Echo)
  - Insourcing scheme for Echo (RUH)

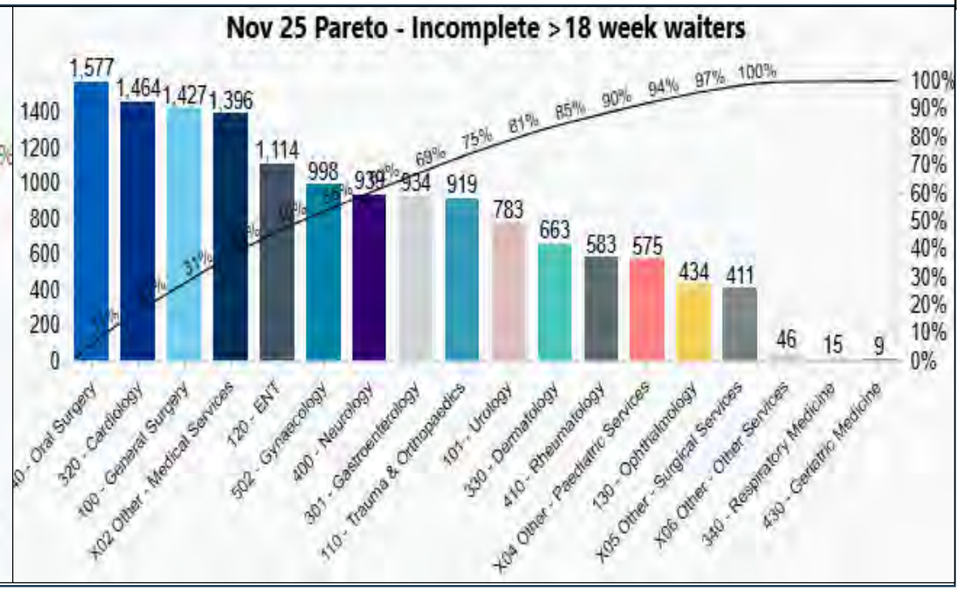
Referral To Treatment (RTT) 18 weeks

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 November was 63% vs a target of 67.7%, Trajectory 66%, Recovery Plan 62.1% for November. This is 2.3% Improvement on the previous month
- The top Contributors to over 18 week breaches were in the following 5 specialties.
  - Oral Surgery 1577
  - Cardiology 1464
  - General Surgery 1427
  - ENT 1114
  - Gynaecology 998

Countermeasures	Owner	Due Date
Gastro – insourcing to support wait to first appointment	Division	Nov 25
Oral Surgery – additional WLI clinics including LAs	Division	Ongoing
12 week Challenge started Aug 25 – completed November 25	Bluhm	Nov 25
Trust taking part in 3rd NHSE validation sprint – Nov to and December – admin validation with clinical support as appropriate	Dando	Dec 25

Risks and Mitigation

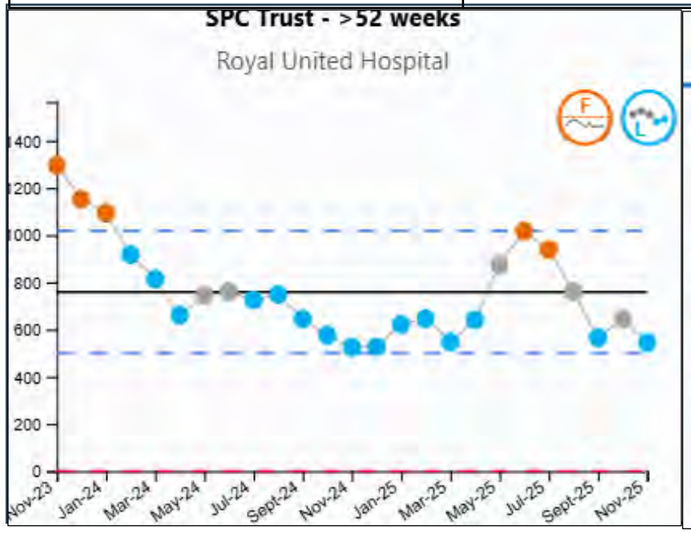
Risks:
- Radiology capacity for routine patients v. cancer pts
- Specialist radiology capacity for Guided injections (T&O but spines in particular)
- Physical space for gastro, ENT and general surgery

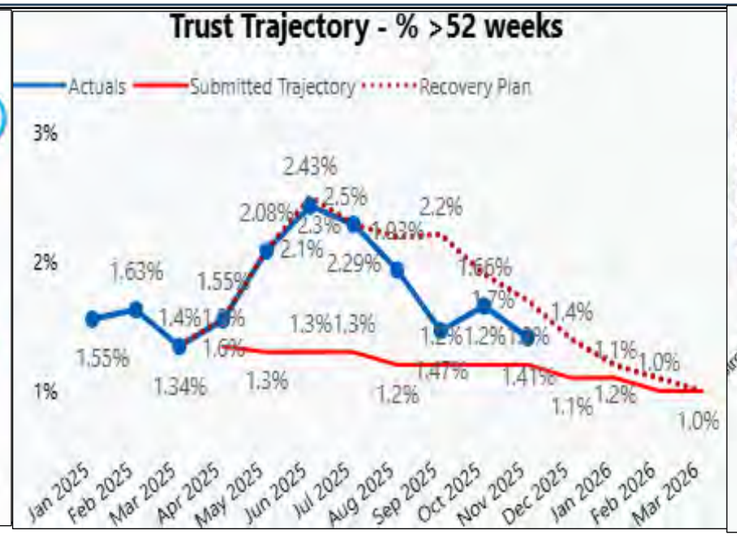
Mitigation:
- Sulis support for guided injections

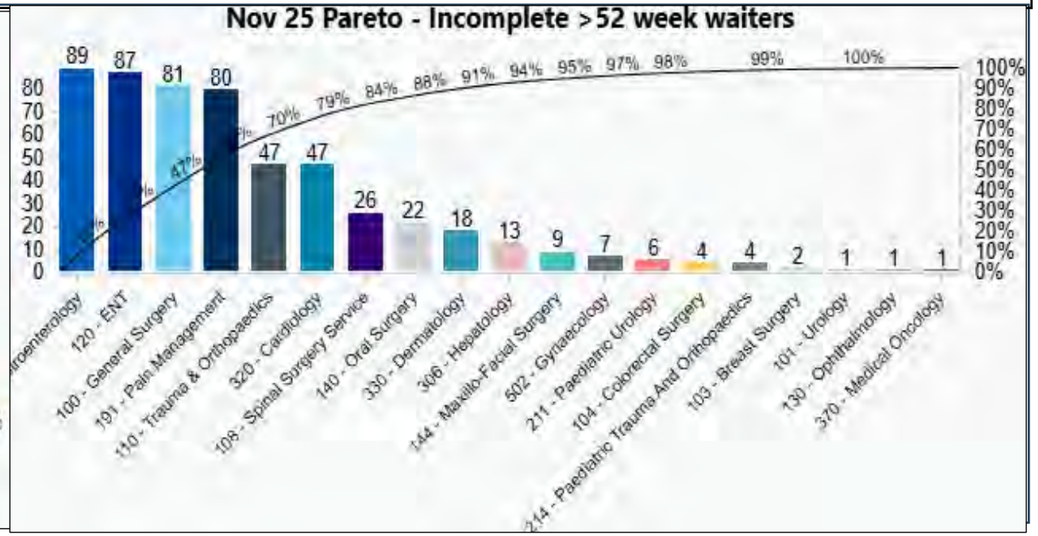
Referral To Treatment (RTT) over 52 weeks

Royal United Hospitals Bath NHS Foundation Trust

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







Understanding Performance

- The number of >52-week patients decreased from 644 to 545 (-15%).
- 1.4% of total RTT patients have waited >52 weeks vs target of <1%, Trajectory of 1.2%, Recovery Plan 1.7% for November
- The top contributors to >52-week breaches Pain, Gastroenterology, ENT and General Surgery:
  - Pain decreased in November from 128 to 80 patients waiting >52 weeks (-38%)
  - Gastroenterology decreased in November from 104 to 89 patients waiting >52weeks (-14%)
  - ENT increased in November from 81 to 87 patients waiting >52weeks (+7%)
  - General Surgery increased in November from 78 to 81 patients waiting >52weeks (+4%)

Countermeasures	Owner	Due Date
Spines – review of pathways following GIRFT visit, fluoroscopic injections being provided by Sulis where appropriate	Prosser	Dec 25
Gastro – insourcing to see longest waiting patients	Shaw	Nov 25
Pain – weekly PTL meetings with NHSE, support from Sulis with suitable procedures	Maxfield	Dec 25
Insourcing completed in ENT – focus on wait to first appt for Paediatric patients	Gillett	Dec 25

Risks and Mitigation

Risks:
- Routine radiology capacity including reporting
- Complexity of some gastro patients requiring multiple diagnostics
- ENT outpatient capacity for Paediatrics (age limitations)

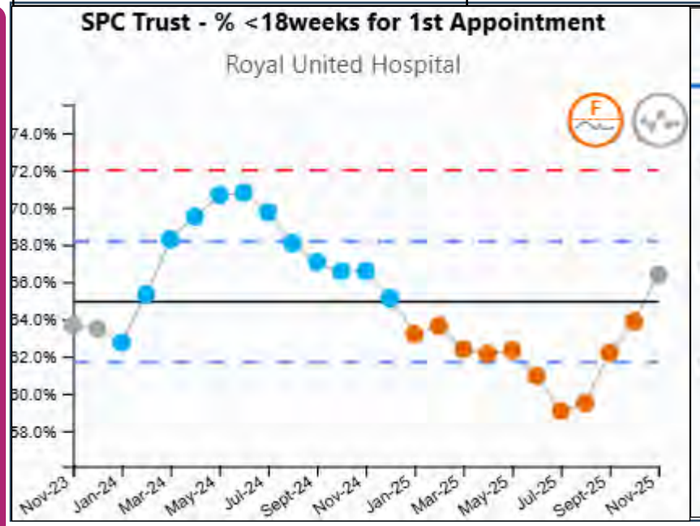
Mitigations:
- Scoping support for Pain from additional provider to take whole pathways

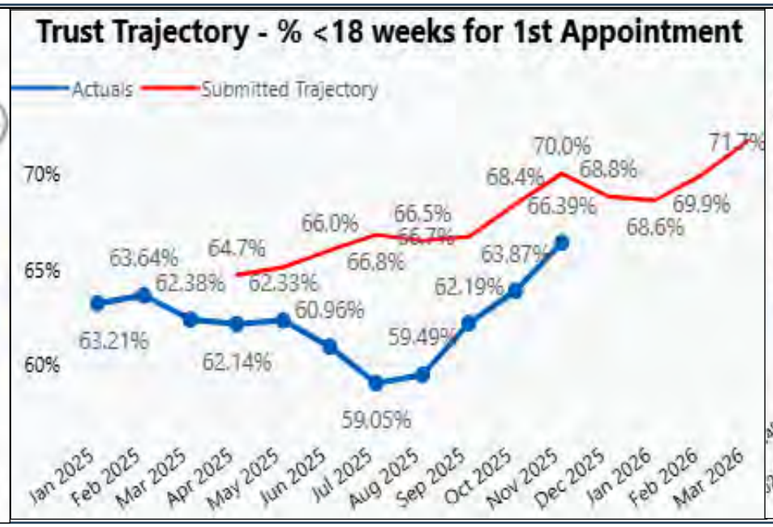
Referral To Treatment (RTT) Wait to 1st Outpatient Appointment

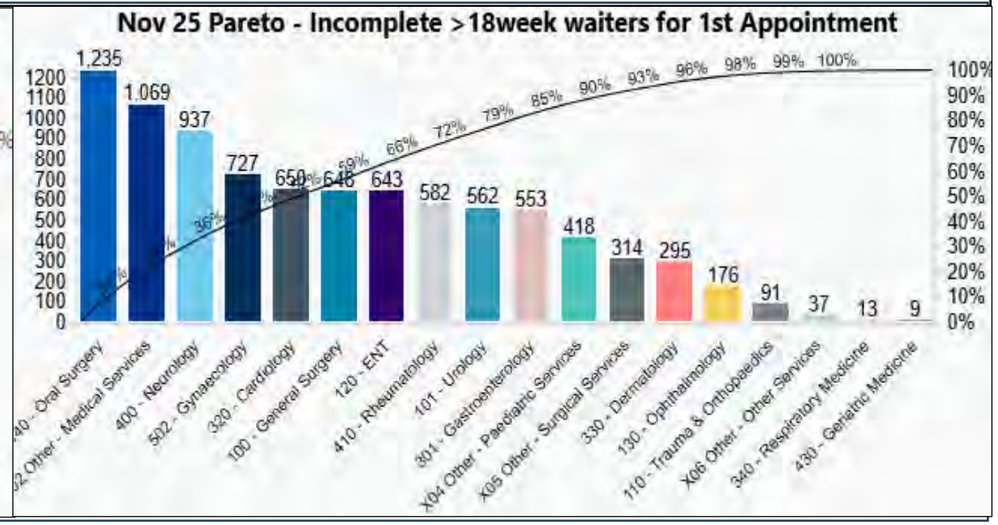
Royal United Hospitals Bath NHS Foundation Trust

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

- 66.4% of patients were waiting <18 weeks for a 1st outpatient appointment vs a target of 72%, trajectory of 70% for November. This is +2.5% on the previous month
- The top contributors of over 18-week breaches for 1st appointments were
  - Oral Surgery 1235
  - Neurology 937
  - Gynaecology 727
  - Pain 674
  - Cardiology 650

Countermeasures	Owner	Due Date
WLI in Cardiology – delivering 1,000 new appts per year – currently agreed 8 weeks in advance through VCARP	Frape	Ongoing
Pain – intensive support from NHSE including demand and capacity plan. Potential outsourcing to take whole pathways – independent sector provider	Stopp	Jan 26
Oral Surgery – WLI clinics	Gillett	Ongoing
WLIs for general Gynae 1st appt – insourcing from 2nd week of January 26 – Saturdays only (in tandem)	Jarvis	Jan 26

Risks and Mitigation

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

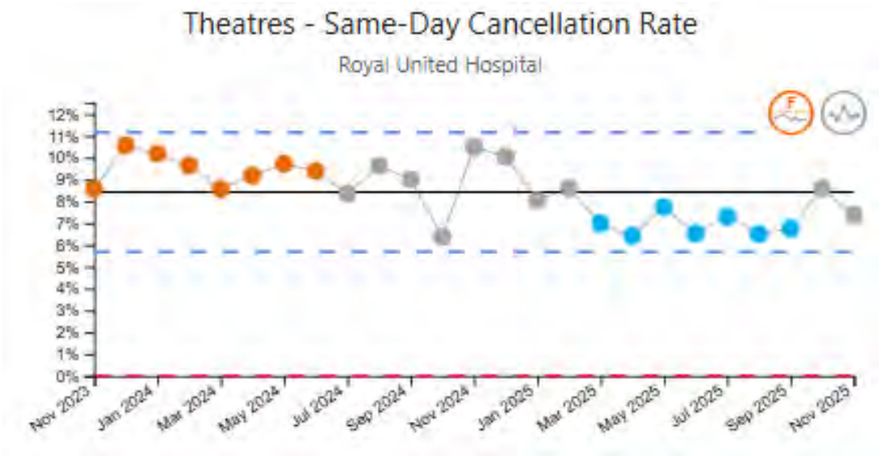
Mitigations:
- SBAR for additional specialty Dr in Oral Surgery
- Scoping insourcing for Gynae if no suitable locum available

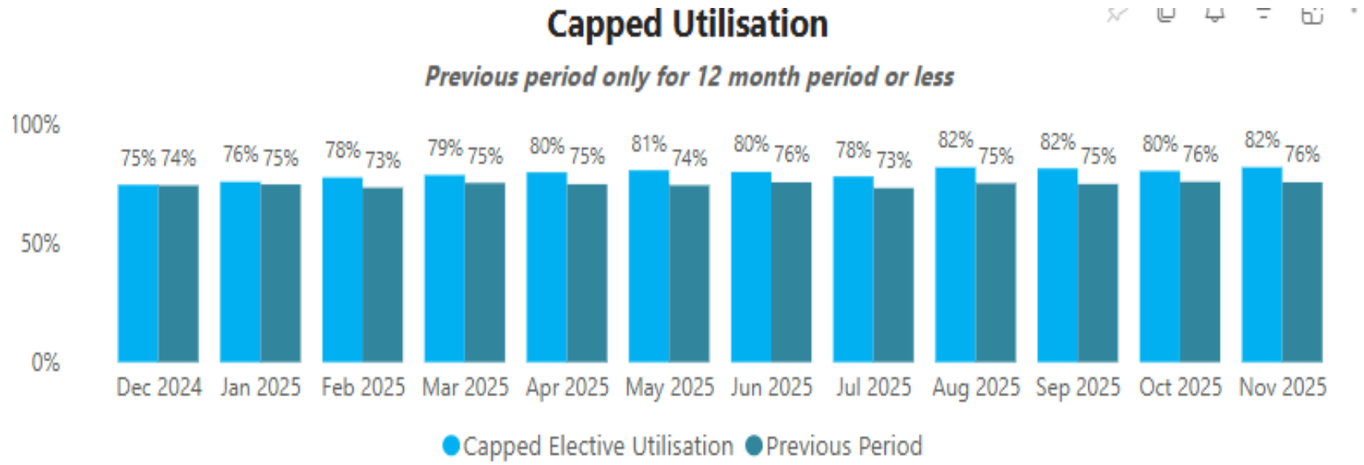
Theatre Utilisation

Royal United Hospitals Bath NHS Foundation Trust

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 up significantly I at 84.4% in Nov on Model Hospital
- Cancelations in month decreased this would have had an impact on utilisation.
- Recruitment within the elective booking team and return after long term sickness is helping push booking out closer to 4 weeks

Countermeasures	Owner	Due Date
Refresh 6-4-2 scheduling standards for theatres and all specialties with a focus on ensuring booking P3/P4 patients out to 4 weeks. Now embedding as Business as Usual	Adam Dougherty	Complete
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:
Elective Booking team staff vacancies / recruitment are a concern

Mitigation:
Progress has been made with recruitment and new people in post, this is continuing

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%		Nov-25	23.6%	X	F		Common Cause Variation
People we care for	% No criteria to reside Adult G&A occupied beds		10.0%		Nov-25	19.3%	X	F		Common Cause Variation
People we care for	% of patients waiting >12hrs in ED		0.0%		Nov-25	8.7%	X	F		Common Cause Variation
People we care for	A&E Arrivals - Ambulance (av per day)				Nov-25	90			H	Special Cause Concerning - Above Upper Control Limit
People we care for	Adult % G&A bed occupancy		92.0%		Nov-25	97.0%	X	F		Common Cause Variation
People we care for	Mean time in ED - >75y				Nov-25	511			H	Special Cause Concerning - Two Out of Three High
People we care for	Non Elective Length of Stay		8.4		Nov-25	8.5	X	?	L	Special Cause Improving - Run Below Mean
People we care for	Number of 65 week waiters incomplete pathways			0	Nov-25	33	X			Common Cause Variation

Alerting Watch Metric Commentary

Royal United Hospitals Bath NHS Foundation Trust

Understanding Performance and Countermeasures

Provisional alerting watch metrics (flagged in September)

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

Understanding Performance and countermeasures

- Initiatives to improve discharges by midday are being led by the Clinical Divisions, Clinical Site Team and Discharge Liaison Team and supported through the daily performance and flow meeting to improve on the November position of 24.3% of discharges before midday and continued focus on P0 no criteria patients with wards, therapy and discharge liaison team that are hospital responsibility daily to improve upon 94.9% of discharges within 24 hours of NCTR.

- The average ambulance handover delay for November 2025 was 31.6 minutes, a decrease from 36.8 minutes on average in October 2025. Through November 2025 the total hours lost was 820. This is a 274-hour decrease compared to last month's lost hours of 1,094. 58.2% of handovers were completed within 30 minutes.

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

- RUH 4-hour performance in November was 57.70% on the RUH footprint (unmapped), an increase of 1.07% from October's performance (56.63%). Non-admitted performance was 70.9%, which was an increase against the performance for October (68.69%) and admitted performance remained static at 28.37% (October 28.69%).

- Over >65 week waiters continue to be driven by capacity constraints in specific pathways/sub-specialties e.g. Gastroenterology and Spines. Additional capacity is being provided by insourcing and mutual aid. Likely to report 3 breaches for 21st December in Gastro and Spines. To note Pain have no 65 week breaches for 21st December.

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				Nov-25	79.7%				Common Cause Variation
People we care for	% with Discharge Summaries Completed within 24 Hours				Nov-25	84.9%				Common Cause Variation
People we care for	A&E Arrivals - Walk ins (av per day)				Nov-25	206				Common Cause Variation
People we care for	Mean time in ED - Admitted (mins)				Nov-25	498				Common Cause Variation
People we care for	Mean time in ED - Mental health				Nov-25	320				Common Cause Variation
People we care for	Mean time in ED - Not Admitted (mins)				Nov-25	225				Common Cause Variation
People we care for	Number of 52 Week Waiters Incomplete Pathways				Nov-25	545				Special Cause Improving - Two Out of Three Low
People we care for	RUH hospital at home team occupancy	Average occupancy	62.0		Nov-25	66.2	✓			Special Cause Improving - Above Upper Control Limit
People we care for	Weekend discharge %				Nov-25	22.0%				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

Quality Report

December 2025
(October / November 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%		Nov-25	78.4%	✗	?		Common Cause Variation
People we care for	% of ED admissions <60mins from CRtP		80.0%	80.0%	Nov-25	77.6%	✗	?	H	Special Cause Improving - Two Out of Three High
People we care for	Medication Incidents per 1000 bed days		7.0		Nov-25	7.7	✗	?		Common Cause Variation
People we care for	Number of complaints received		30		Nov-25	37	✗	?		Common Cause Variation
People we care for	Number of reopened complaints each month		3		Nov-25	5	✗	?		Common Cause Variation
People we care for	Readmissions - Total		10.5%		Oct-25	10.1%	✓	P	H	Special Cause Concerning - Above Upper Control Limit
People we care for	SHMI				Jul-25	108.0%			H	Special Cause Concerning - Above Upper Control Limit
People we care for	Total monthly fill rate, day hours, HCA		90.0%		Nov-25	88.7%	✗	F	H	Special Cause Improving - Above Upper Control Limit
People we care for	Total monthly fill rate, day hours, RN		90.0%		Nov-25	82.4%	✗	?	L	Special Cause Concerning - Two Out of Three Low
People we care for	Total monthly fill rate, night hours, RN		90.0%		Nov-25	91.7%	✓	?	L	Special Cause Concerning - Run Below Mean
People in our community	% Difference in 28 Day Diagnosis Performance between IMD 1-2 vs IMD 9-10		0.0%		Oct-25	-1.0%	✗	?		Common Cause Variation
People in our community	% Difference in DNA rates between IMD1-2 and IMD 9-10		0.0%		Nov-25	4.3%	✗	F		Common Cause Variation

Watch Metrics - Quality - Non-Alerting

Strategic Goal	Measure	Measure Description	Local Year-End Target	National Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
People we care for	% of ED patients assessed <15mins				Nov-25	68.9%			H	Special Cause Improving - Above Upper Control Limit
People we care for	Clostridium Difficile Rate	Hospital or Community Onset, Healthcare Associated, per 100,000 beddays			Oct-25	43.09				Common Cause Variation
People we care for	Concerns are acknowledged within 2 working days		90.0%		Nov-25	97.0%	✓	P		Common Cause Variation
People we care for	E.coli bacteraemia Rate	Hospital or Community Onset, Healthcare Associated, per 100,000 beddays			Oct-25	36.93				Common Cause Variation
People we care for	Early Identification of Deteriorating Patient	NEWS 5+ Screening Completed in 30 - Trust (%)			Nov-25	27.2%				Common Cause Variation
People we care for	Flu - Healthcare Onset (+3 days)				Nov-25	10				Common Cause Variation
People we care for	Klebsiella spp Rate	Hospital or Community Onset, Healthcare Associated, per 100,000 beddays			Oct-25	30.78				Common Cause Variation
People we care for	Mixed Sex Accommodation Breaches				Nov-25	158			L	Special Cause Improving - Run Below Mean
People we care for	MRSA Bacteraemias Rate	Hospital or Community Onset, Healthcare Associated, per 100,000 beddays			Oct-25	0.00			L	Special Cause Improving - Below Lower Control Limit
People we care for	MSSA Rate	Hospital or Community Onset, Healthcare Associated, per 100,000 beddays			Oct-25	30.78				Common Cause Variation
People we care for	Never events		0		Nov-25	0	✓	F	L	Special Cause Improving - Below Lower Control Limit
People we care for	Number of Hospital Acquired Pressure Ulcers Category 2		5		Nov-25	4	✓	?		Common Cause Variation
People we care for	Number of Hospital Acquired Pressure Ulcers Category 3		4		Nov-25	3	✓	P		Common Cause Variation
People we care for	Number of Hospital Acquired Pressure Ulcers Category 4				Nov-25	0			L	Special Cause Improving - Below Lower Control Limit
People we care for	Pseudomonas aeruginosa Rate	Hospital or Community Onset, Healthcare Associated, per 100,000 beddays			Oct-25	6.16				Common Cause Variation
People we care for	Scanning Compliance for patients being given medication				Nov-25	60.9%			H	Special Cause Improving - Above Upper Control Limit
People we care for	Serious incidents with overdue actions		5		Nov-25	5	✓	?		Common Cause Variation
People we care for	Total monthly fill rate, night hours, HCA		90.0%		Nov-25	103.9%	✓	?	H	Special Cause Improving - Above Upper Control Limit
People in our community	Delivery of Financial Control Total	Variance from Revised Plan		0	Nov-25	-16026	✓			
People in our community	Reduction in Agency Expenditure	Agency as % of Total Pay			Nov-25	0.7%			L	Special Cause Improving - Below Lower Control Limit

Trust Scorecard - Quality Board Metrics (November 2025 Data)

Section Of Scorecard	Strategic Goal	Measure	Measure Description	Local Year-End Target	National Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
National KPI	People we care for	% treated and admitted or discharged within four hours (To ensure 78% of patients can be treated within 4 hours of arrival at ED)		72.0%	95.0%	Nov-25	57.7%	✗	F		Common Cause Variation
National KPI	People we care for	28 day referral to informed of diagnosis of all cancers		80.0%	80.0%	Oct-25	64.6%	✗	F		Common Cause Variation
National KPI	People we care for	Average Handover Time for All Arrivals (mins)	Average ambulance handover time (mins)	33		Nov-25	32	✓	F	L	Special Cause Improving - Below Lower Control Limit
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%	Oct-25	91.9%	✓	?		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%	Oct-25	63.5%	✗	?		Common Cause Variation
National KPI	People we care for	Diagnostic tests maximum wait of 6 weeks		95.0%	95.0%	Nov-25	71.0%	✗	F		Common Cause Variation
National KPI	People we care for	RTT - Incomplete Pathways over 52 weeks		1.0%		Nov-25	1.4%	✗	F	L	Special Cause Improving - Two Out of Three Low
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%	Nov-25	66.4%	✗	F		Common Cause Variation
Vision	People we care for	% Key national standards met in the month		100.0%		Nov-25	22.2%	✗			
Vision	People we care for	% of positive responses to friends and family test	Improve the experience of those who use our service			Nov-25	97.3%			H	Special Cause Improving - Above Upper Control Limit

Alerting watch metric commentary: Safe Staffing

Royal United Hospitals Bath NHS Foundation Trust

Understanding Performance

Registered Nurse day shift fill rate was 84% (target 90%).
Healthcare Support Worker (HCSW) day shift fill rate was 87% (target 90%).

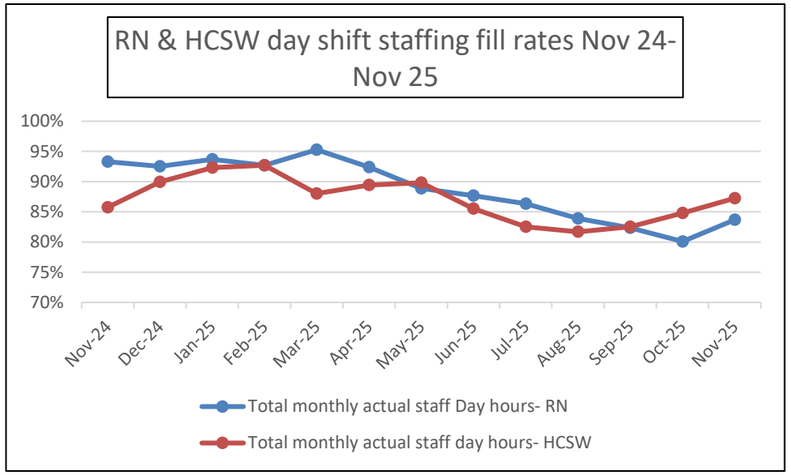
RN and HCSW day fill rates are below 90% performance target since June 2025. The current night shift fill rate for RN and HCSW remains above 90%.

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

The top contributors for low RN fill rates is vacancy within Paediatrics, William Budd and Emergency Department (ED). New nursing staff are due to commence in December in all areas. Recruitment continues for remaining RN vacancies with additional recruitment events planned in January 2026.

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

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



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

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

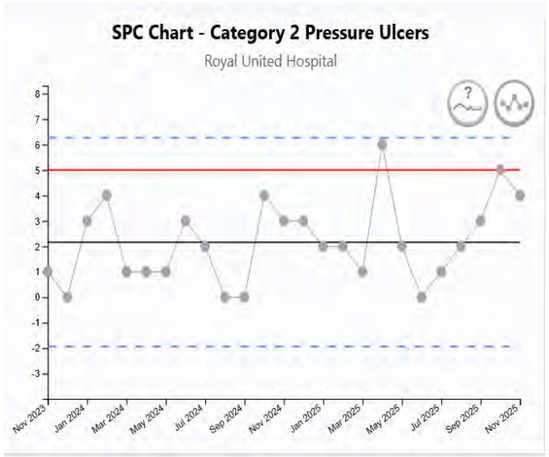
Countermeasures	Owner	Due Date
Active recruitment to all HCSW vacancies Trust wide.	Divisional Directors of Nursing / Associate Chief Nurse Workforce	January 2026
Redeployment of staff reflected on health roster to improve accurate fill rates.	Divisional Directors of Nursing	ongoing
HCSW retention event aligned to national HCSW day, review opportunities for HCSW forum. These have taken place during November/December with an evaluation due in January 2026.	Divisional Director of Nursing (FaSS)	January 2026
Recruitment to band 5 RN vacancies within Paediatrics and ED. ED specific recruitment event planned 16.1.26. Attendance at University recruitment events 26.1.26 and 11.2.26	Matron for Paediatrics and ED	January 2026

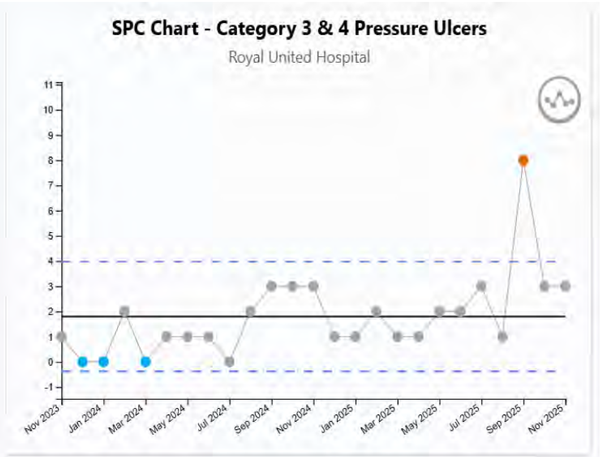
Pressure Ulcers

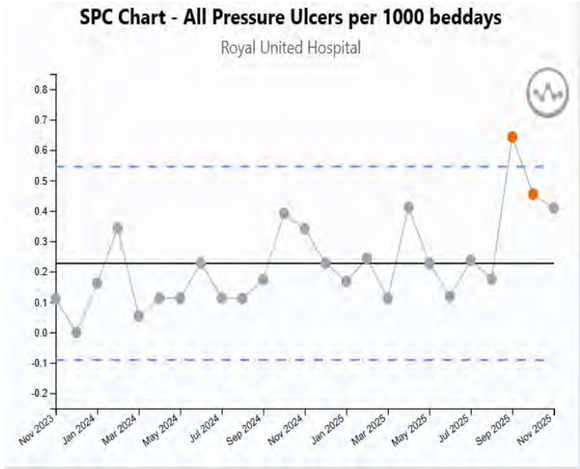
Royal United Hospitals Bath NHS Foundation Trust

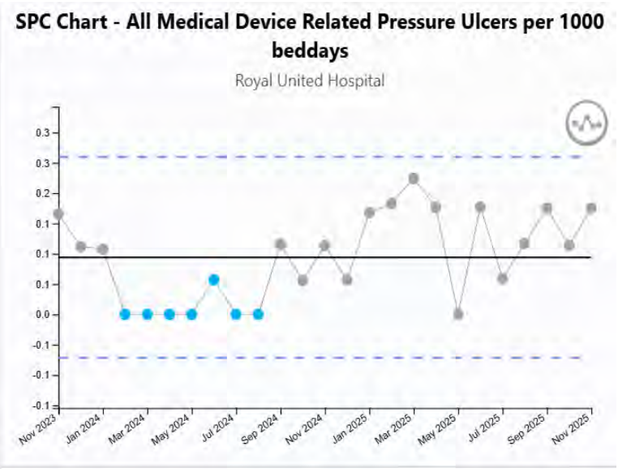
We are driving this metric because..	Pressure ulcers are estimated to cost the NHS £1.4m per day. Maintaining a low incidence of pressure ulcers is a Trust priority. The national acquired prevalence benchmark is 9.6% (2021) and the RUH prevalence was 1.3% in May 2025.

Improving the experience of those who use our service









Understanding Performance

For November 2025, the RUH reported 0.6 pressure ulcers per 1,000 bed days (10 pressure ulcers). The RUH reported three category 3 pressure ulcers, three category 3 medical device related pressure ulcers and four category 2 pressure ulcers.

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

Countermeasures	Owner	Due Date
Band 6 nursing staff to undertake daily skin care rounds in clinical areas where pressure ulcer performance has deteriorated.	Specialty Matrons	Ongoing
Divisions to start monitoring compliance with skin assessment and risk assessment (Braden) and report monthly to the Tissue Viability Improvement Group.	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	Jan-26

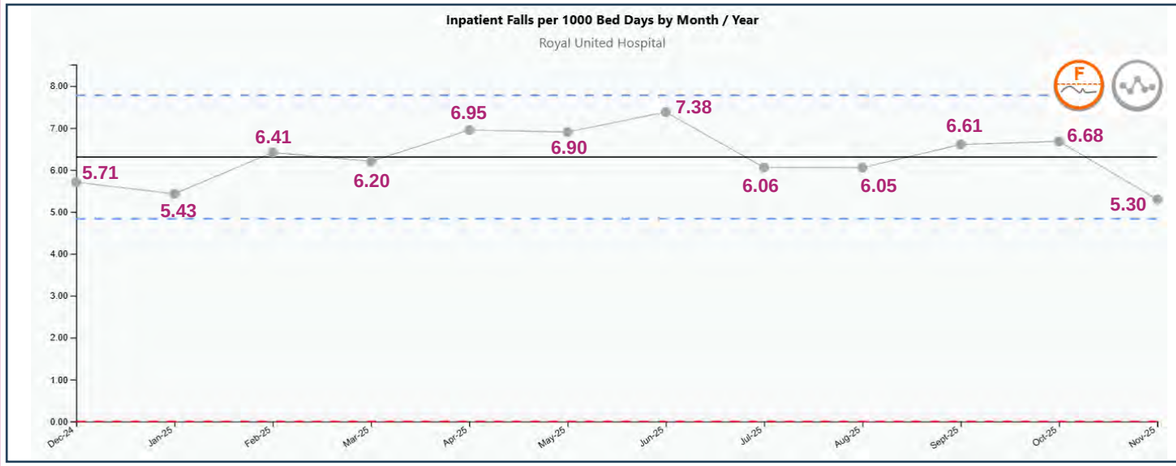
Risks and Mitigation

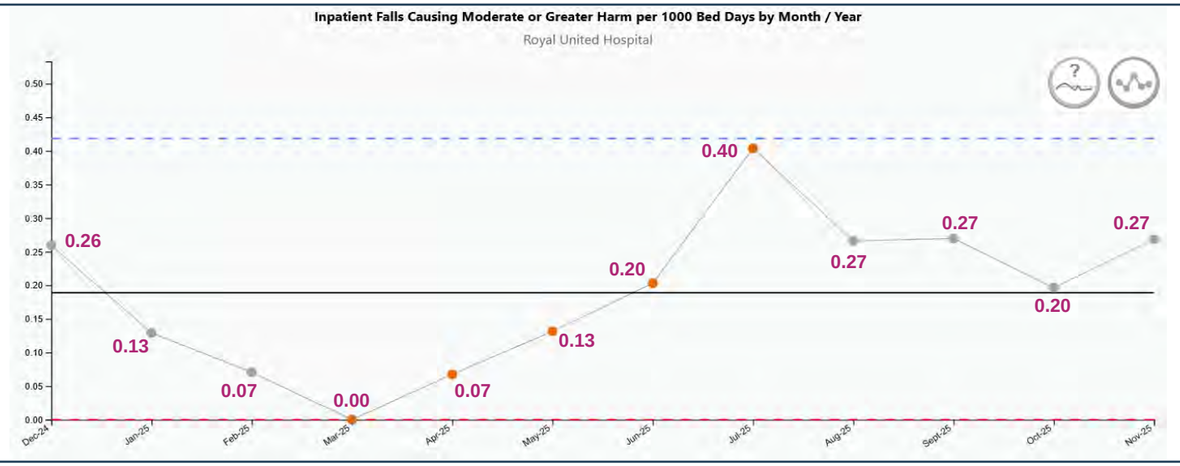
There is a risk that the lack of timely skin bundle assessments will impact on the ability to reduce avoidable pressure ulcers.

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

Falls

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





Understanding Performance

Data shows that during November 98.73% of inpatients did not fall in our care which has remained consistent. There were 4 reported inpatient falls that resulted in moderate harm to patients.

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. Compliance end of November 33% (previously 41% in May) - project extended due to decreasing compliance.	Ward Manager	Feb-26
Increase the number of patients sitting out for lunch to 80% by Dec 2025 on an elderly care ward to prevent deconditioning. On average 73% of patients were sat out in October.	Ward Manager/ QI lead for falls	Dec-25
Trust-wide falls PSII commissioned May 2025 (as a result of several falls across the 3 divisions) - final draft completed for circulation December 2025.	Associate Director of Patient Safety and Quality	Dec-25

Risks and Mitigation

1. Lying and standing blood pressure compliance had been reducing, there has been an increase in the past 2 months - there is suspicion of a correlation between reduced compliance and reduced staffing numbers. Monthly league table now being circulated with senior sisters, matrons and CPF's.

2. Flu season has begun and has led to ward/bay closures. This may limit the ability to complete social/ group activities.

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	84%	89%	91%	117%
C30 SAU	89%	100%	96%	97%
Cardiology	82%	83%	98%	98%
CCU	97%	82%	100%	97%
Charlotte	70%	93%	99%	101%
Cheselden	75%	85%	82%	127%
Children	86%	49%	87%	63%
Combe	80%	99%	82%	141%
ED	87%	94%	89%	90%
Forrester Brn	83%	100%	67%	106%
Haygarth	84%	105%	91%	127%
Helena	69%	97%	100%	100%

Ward/ Department	Fill rate day RN %	Fill rate day HCSW %	Fill rate night RN %	Fill rate night HCSW %
MAU	80%	87%	98%	103%
MSS	89%	97%	97%	100%
OPAU	82%	83%	99%	90%
OPUSS	73%	101%	96%	99%
Parry	81%	93%	93%	105%
Philip Yeoman C32	100%	51%	101%	17%
Pierce Ward	85%	95%	99%	102%
Pulteney	97%	98%	119%	96%
Respiratory	83%	97%	91%	121%
Robin Smith	95%	91%	100%	99%
Waterhouse	76%	90%	80%	142%
William Budd	78%	101%	91%	102%

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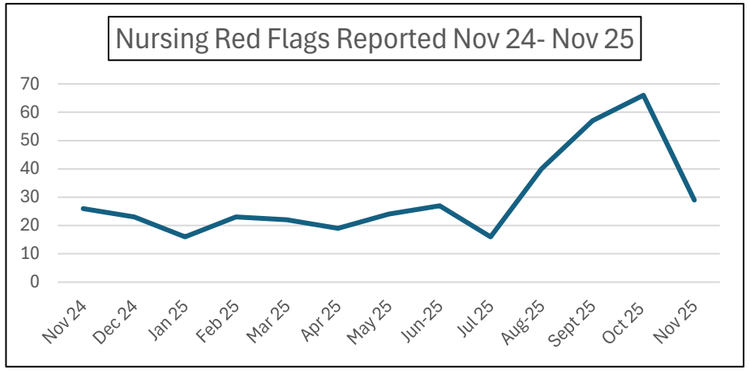


Day Shift Average Fill Rate		Night Shift Average Fill Rate	
RN	HCSW	RN	HCSW
84%	87%	93%	100%

Understanding Performance

The combined day shift fill rates for RNs across the 24 inpatient wards was 84% and 93% respectively for nights. The combined day shift fill for HCSWs was 93% and 100% for the night shift.
The table above shows the monthly fill rate for the inpatient wards and Emergency Department.

20 wards fell below 90% fill rate for RN staffing on day shifts. Cheselden and Helena wards fell below 90% due to temporary ward relocation and a reduced bed base resulting in a reduced nurse staffing requirement. William Budd, Paediatrics and Emergency Department fell below the 90% primarily due to current vacancy which is actively being recruited into Pulteney ward was > 101% on RN nights due to increased patient acuity.

The decreased HCSW fill rate < 90% in all areas other than Philip Yeoman ward (PY) is primarily due to HCSW vacancy. The fill rate continues to improve as HCSW commence in post. PY fill rate is <90% due to varying elective occupancy levels and planned staffing levels.
The increase HCSW fill rate >101% particularly on night shifts reflects the deployment of additional staff in response to increased dependency and enhanced care patients.

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

Countermeasures	Owner	Due Date
To recruit to remaining HCSW vacancies by March 2026. HCSW from October recruitment campaign due to start Dec 25/Jan 26. HCSW listening events planned Nov/Dec 25	Senior Sister/ Charge Nurse & Matrons	Mar-26
Focus on red flag resolution on SafeCare. Education of raising and reviewing of Red Flags during safer staffing meetings.	Matron/Deputy Divisional Directors of Nursing	Jan-26
To recruit into Paediatric ward RN vacancies (interviews planned December 2025 (4x WTE)	Paediatric Matron & Senior Sister/ Charge Nurse	Jan-26
To recruit into Emergency Department band 5/6/7 registered nurse vacancies. Recruitment awareness day 16.1.26	Emergency Department Matron	Feb-26

Risks and Mitigations

There is a risk that the current HCSW vacancies will remain vacant and decreased fill rate <90% will continue. To mitigate this risk there is a Trust wide recruitment campaign with successful candidates starting 15th Dec 2025 and 12th Jan 2026.

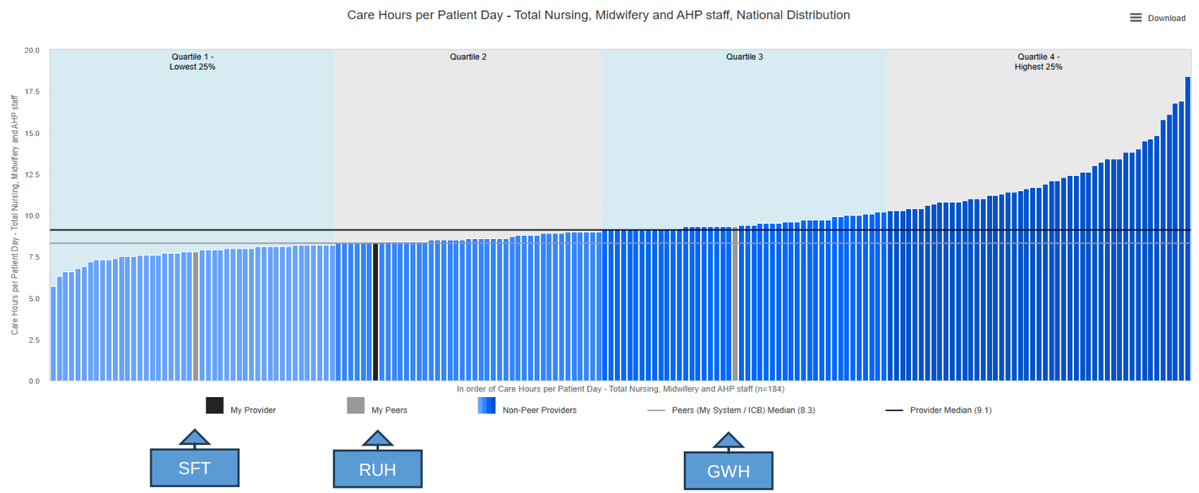
There are twice daily safer staffing meetings to review safe staffing and potential risks or red flags with mitigation put in place as appropriate. This will include redeployment of staff.

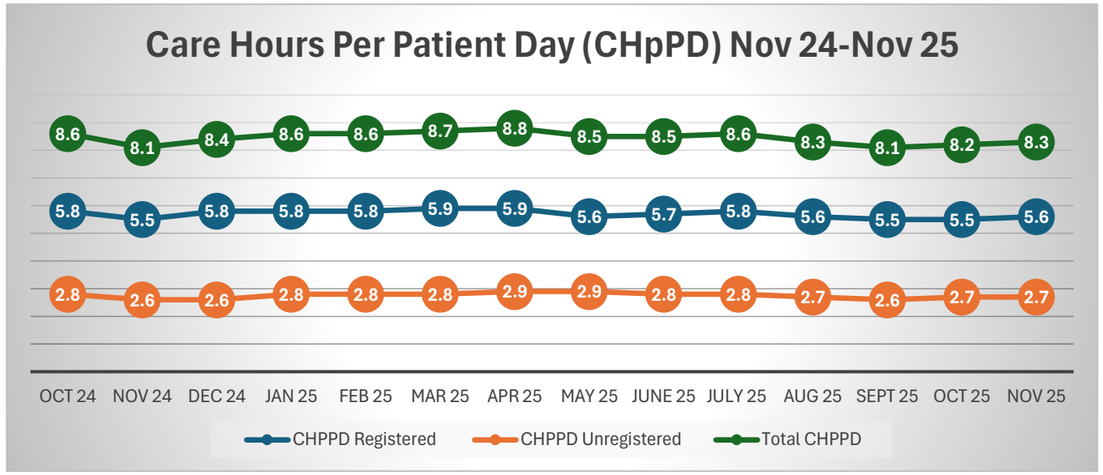
There were 29 red flags reported by wards in November, a decrease from 66 reported in October. The breakdown of the 29 red flags was predominantly (96%) due to a shortfall of 25% RN time due to short notice sickness and vacancy. All these were reviewed and appropriate mitigation put in place including staff redeployment as required.

Care Hours (Nursing Inpatient Areas)

Royal United Hospitals Bath NHS Foundation Trust

We are driving this metric because..	Care hours per patient day (CHPPD) measures the total hours worked by Registrants (Nurses and Nurse Associates) and Healthcare Support Workers divided by the average number of patients at midnight. CHPPD data provides information on how the Nursing workforce is deployed and how productively.





Understanding Performance

The average monthly CHPPD is 8.3. CHPPD continues to remain stable for both registered and unregistered staff over the past quarter. Since April 2025 we have seen an overall decrease in the total CHPPD which would align the decrease in overall RN and HCSW fill rates.

When reviewed on Model Hospital (latest data available September 2025) we remain 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	Jan-26
Active recruitment to HCSW and Registrant vacancies	Divisional Directors of Nursing / Matrons	Ongoing

Risks and Mitigations

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

Mitigations:
- Twice daily safe staffing meetings, reviewing both unfilled shifts alongside acuity and dependency of all wards.
- HCSW recruitment campaign. Focus on start dates aligned to Dec 25/ 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
- Listening events for HCSW underway

Infection Prevention and Control

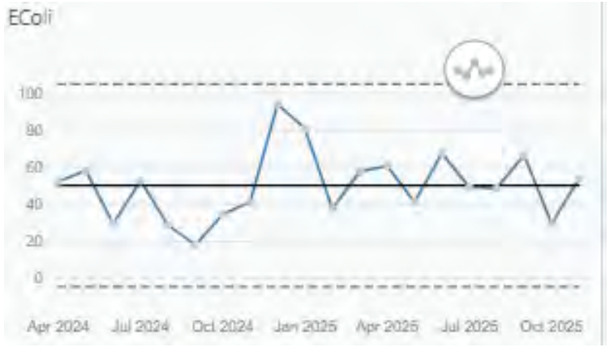
Royal United Hospitals Bath NHS Foundation Trust

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 14 cases of Clostridioides Difficile infection (CDI) (9 HOHA and 5 COHA) reported during November 2025. There have been 54 cases against a threshold of 75 reported to date for 2025/26. There has been 3 incidences of a period of increased incidence, that are under review and ribotyping has been requested. The October 2025 rate per 100,000 bed days for the Trust is 43.09, against the SW rate of 31.41. Our population continues to be predominately White British in 83% of cases and 75% of cases over 70 years.

There were 9 cases of *E. coli* infection (2 HOHA and 3 COHA) reported during November 2025. There have been 69 cases reported for 2025/26 against a threshold of 77. Predominant cause remains urinary, with 2 cases having a catheter. The October rate per 100,000 per days is 36.93 against the SW rate of 48.57.

MSSA cases have increased again for the Trust in October 2025, although this has stabilised in November with 2 cases. The effectiveness of practice vs protocol will be monitored over the next 3 months and reviewed in February 2026. Further ward-based training and engagement sessions will be followed up in the New Year 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 pre and post meals within a bay on an older person's unit by 30% within 3 months. Planned wipes trial to support patient hygiene. Trial in place on Helena and OPUSS.	Infection Prevention and Control	Nov-25 In Progress
Gloves off campaign: To ensure clinical gloves are worn appropriately. **Aim:** To reduce the inappropriate use of gloves by 30% within 3 months. Team are working with areas across the Trust to support the ongoing role out of the programme.	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

Risks and Mitigation

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

There is a risk *E coli* numbers continue to rise due to a urinary sourced infections in over 65% of cases
Mitigations: embedding of the hydration project will support *E. coli* infection reduction through good hydration and QI looking at driving the quality of care. Plan to trial innovative products in the New Year which have seen positive outcomes for previous patients.

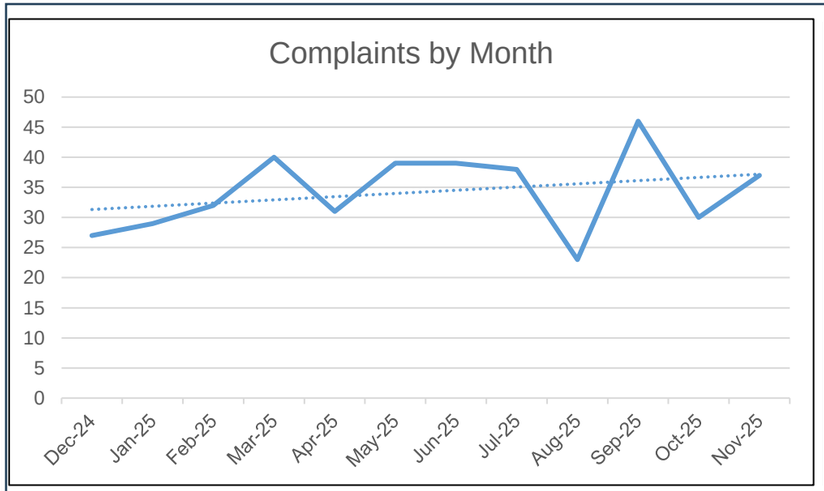
MSSA Bacteraemia's are increasing and are contributing to high rates – **Mitigations** continue route cause analysis to investigate outcomes to promote best practice and learning. Further deep dive and follow up of cases in relation to CVC. Breakout group to now commence for IPC and practice

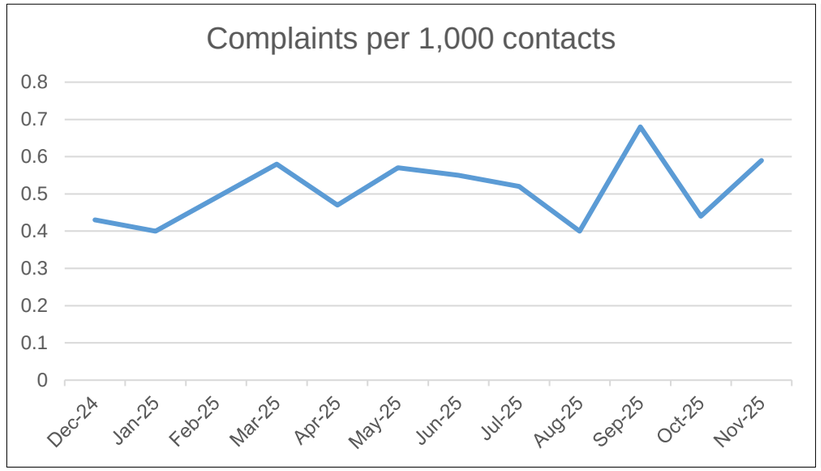
Patient Support & Complaints (PSCT)

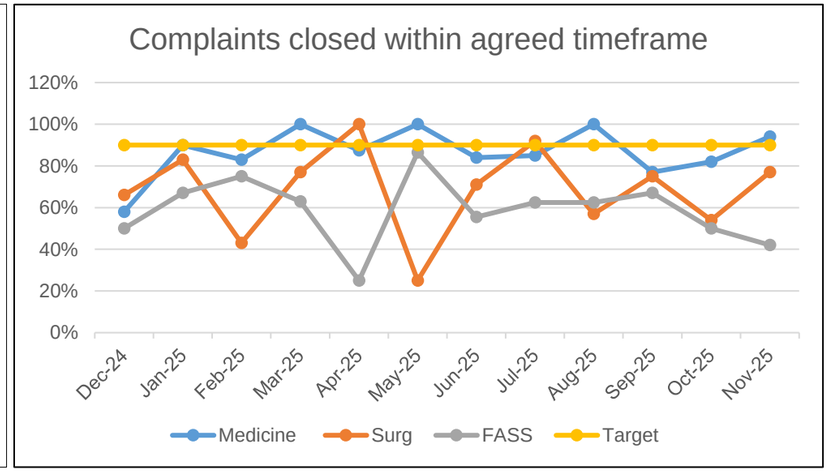
Royal United Hospitals Bath NHS Foundation Trust

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 November 2025, the Trust received 37 new complaints, this was an increase from October (30).
The Emergency Department received the highest number of complaints (n=6) followed by Maternity (n=4).
The majority of complaints were about clinical care (n=26) consistent with previous months.
The Medicine Division received the highest number of new complaints (n=16).
The complaint rate per 1000 patients in November was 0.59 which has increased from 0.44 in October.
97% of all concerns were acknowledged within 2 working days.
The response times for formal complaints continues to fall below the target of 90%. In November 78% of complaints were closed within the agreed timeframe.
Complaint closure rates varied by Division over November, FASS decreased to 42%, the Surgical Division increased to 77% and the Medicine Division increased to 94% 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 January 2026.	Patient Experience Team	Jan-26
Complaints and concerns policy has been updated following a review by the Patient Safety Nurses. The policy has been approved by the Patient Experience Committee and published on the website.	Deputy Head of Patient Experience & Engagement	Nov-25
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

There are ongoing concerns about the responsiveness of staff to patient/family concerns requiring resolution.

As a result, a metric for percentage of concerns responded to within 14 working days (early resolution) has been introduced, with a Trust target of 70%. If a concern has not been responded to in 10 working days PSCT will escalate the concern within the divisional governance structures.

The new 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.

Royal United Hospitals Bath
NHS Foundation Trust

Royal United Hospitals Bath
Perinatal Quality Surveillance Tool (PQST)

November 2025

October 2025 data

The RUH, where you matter

Safe – Maternity Workforce

	Target	Threshold G	Threshold A	Threshold R	Aug 25	Sept 25	Oct 25	Comment
Midwife to birth ratio	1:24	<1:24		≥1:26	1.27	1.30	1:30	Trained staff only included in acuity data
Midwife to birth ratio (including bank)	1:24	<1:24		≥1:26	1.26	1:28	1:28	Care hours required, trained and support staff included in acuity data.
Percentage of 'staff meets Acuity' BBC	100%	>90%		<70%	82	59	61	Babies born Aug, Sep, Oct =332, 380, 379 25/26 Average so far 354 per month
Percentage of 'staff meets Acuity' Mary Ward (inpatient care)	100%	>90%		<70%	60	29	31	
Confidence factor in BirthRate+ recording BBC	60%	>60%		<50%	80	75	78	Percentage of episodes for which data recorded
Confidence factor in BirthRate+ recording Mary Ward	60%	>60%		<50%	88	87	81	Percentage of episodes for which data recorded
Percentage maternity sickness rolling 12 months	<4%	<4%		>5%	3.20	3.20	4.24	One month behind
Percentage Maternity turnover rolling 12 months	≤5%	≤5%		≥7%	2.33	2.33	1.84	
1:1 care not provided in labour	0	0		>1	0	0	0	
Labour ward coordinator not supernumerary episodes	0	0		≥1	1	0	0	
Number of NICE red flags on Birth Rate +	NICE 2015				7	8	6	A 'red flag' event is a warning indicator that something may be wrong with midwifery staffing BBC (2) - 8/10/25 - 1 x delay in care, 1 x delay from admission for IOL to beginning Mary (4) 10/10/25 and 13/10/25 - 3 x delay in administering

Countermeasure /Action (completed last month)	Owner

Countermeasure /Action (planned this month)	Owner
Deep dive into sickness by cost centre as reporting rolling 12 months for maternity services but some areas have greater impact on bank, birth to midwife ratio and redeployment needs	Matrons

Pipeline actuals in month

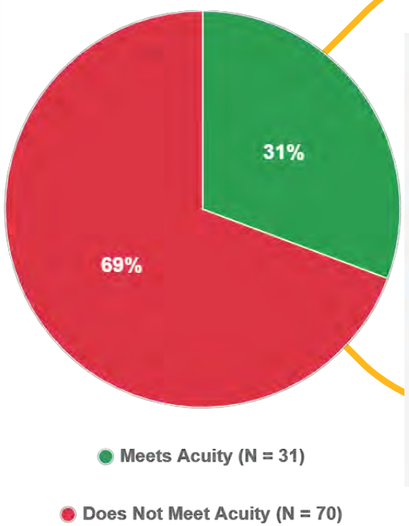
Substantive MW vacancy	Secondment	Mat leave	Fixed term in post	Budget V actual
+ 8.55	3.44	9.54	1.64	-2.79

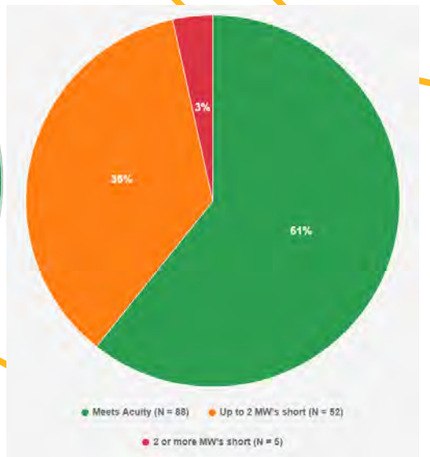
Substantive MSW vacancy	Secondment	Matern leave	Fixed term in post	Budget V actual
-3.82	2.4	1.25	0	-7.47

Summary of management actions relating to staffing V acuity

BBC Action (top 5)	Times occurred	Percentage
Redeploy MW internally	47	48
Operational support MW included in BBC staffing no.	26	27
Escalate to Manager on call/Matron	11	11
Redeploy MW community	5	5
CSF MW included in BBC staffing no.	4	4

Mary ward BBC





Safe – Neonatal Workforce

	Target	Threshold G	Threshold A	Threshold R	July 25	Aug 25	Sept 25	Oct 25	Comment
Neonatal nurse vacancy					4.19	4.41	6.05	7.32	Continue uplift to band 4 to support SNA training .
Neonatal parenting leave							2.2	3.16	
Percentage neonatal sickness rolling 12 months	100%	<4%		>5%	3.29	3.63	3.69	3.66	1 month lag
Percentage neonatal turnover rolling 12 months	<5%	<5%		<7%	4.96	3.05	0.88	0.84	
Percentage neonatal nursing shifts filled to BAPM standard	100%	>90 %		<80 %	98.36	90.16	83.05	73.3	High acuity, vacancy, maternity leave LTS
Percentage medical shifts filled to BAPM minimal standard	100%	>90		<80	93.65	95.16	98.33	95.2	• Note minimal standards.
Percentage neonatal QIS trained	70%	<70 %		<60 %	65%	70.8	70.8%	70.8%	
Percentage of TC shifts with staff dedicated to TC care	100%	>90 %		<80 %	100	100	97%	78%	Maternity supported TC when no TC nurse on **10** occasions
Percentage of shifts with SN team leader	100%	>90 %		< 80 %			25.42	18%	National Av L2: 70.3 (Badger)

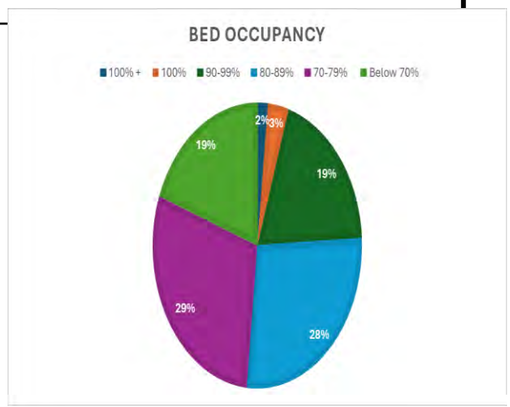
Is the standard of care being delivered?

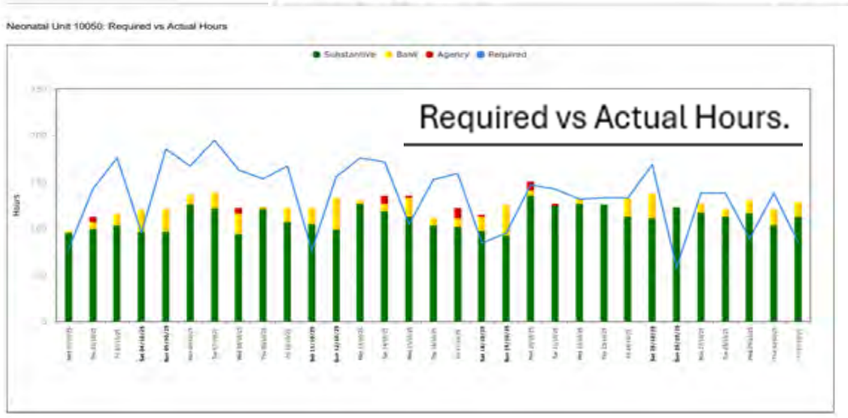
- **Sickness now above Trust Target 6.56% (89.9 FTE days lost) in October.**
- **Decrease in BAPM nursing shift fill, due to High acuity, maternity leave, LTS and leavers.**
- **TC staffed 78% with dedicated TC nurse. 26% of shifts between 5-8 babies cared for on TCP. 13% of these shifts were not supported by correct nurse :baby ratio**
- **Additional nurse shifts to make all shifts BAPM compliant 10.7 (Source Badger)**

Countermeasure /Action (completed)	Owner
X 2 Band 6 appointed. Start date October B5 3 WTE appointed. Start date October/November. B5 x 1 FTC 12 months start October	KF
Risk assessment completed and added to risk register regarding actions to close the gap of anticipated acuity pressures secondary to neighboring level 3 NICU cot closures	KF
Countermeasure /Action (planned)	**Owner**
Long line agency approved 1 WTE band 5 conditional offer from last round of interviews 1 WTE B5 shortlisting	KF

October, 80% of shifts between 70-103% bed occupancy. Work force established calculated on average of 70%

Bank/Agency/Opel/redeployment	
Filled Bank shifts	58
Unfilled Bank shifts	56
Filled Agency Shifts	6
Unfilled agency shifts	5
Redeployed shifts paeds	6
% of B7/B6 specialist roles pulled clinical from their role	40%
% Opel Black	15%
% Opel Red	29%
% Opel Amber	26%
% Opel Green	30%





Safe – Acuity

	Target	Threshold			July 25	Aug 25	Sept 25	Oct 25	Comment
		G	A	R					
Obstetric consultant presence on BBC	60 hours	>60 hours		<60 hours	98	98	98	98	No change
Obstetric consultant non-attendance to clinical situation	100%	100%		<100 %	100	100	100	100	No incidents
Obstetric percentage daily MDT ward round	100%	100%		<100 %					Reviewed by LWC daily, MS forms completed if no ward round completed with immediate escalation
Birth within BAPM L2 place of birth standards	100%	100%		<100 %	100	100	100	100	100% births in the right unit
Number of days in LNU outside of BAPM guidance	0%	<0		>2*	0	0	4	0	No days in LNU outside of BAPM guidance
Anaesthetic rota compliance	70%	≥70%		<70%	100	100	100	100	

Countermeasure /Action (completed)	Owner

Countermeasure /Action (planned)	Owner

Is the standard of care being delivered?

- Obstetric percentage daily MDT ward round reporting by exception

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

New Cases for October 25

Patient Safety Events

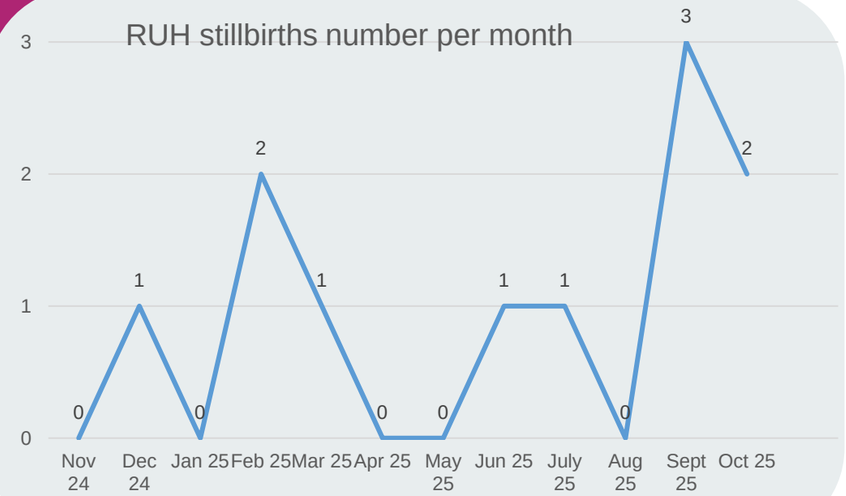
Case Ref	Date	Category	Patient Safety Event	Outcome/Learning/Actions	MNSI Ref	PSII
145188	02/10/25	Moderate	Neonatal death 30+4	Awaiting Perinatal Mortality Review. Known congenital abnormality.		
145338	07/10/25	Moderate	Mec aspiration	Referred to Maternity and Newborn Safety Investigation. Awaiting outcome. Normal MRI.		
145533	09/10/25	Moderate	Intrauterine fetal death 22+5	Awaiting Perinatal Mortality Review.		
145637	15/10/25	Moderate	Uterine inversion & 5L major obstetric haemorrhage	MultiProfessional Safety Review held 27/10/25. Awaiting further review by anaesthetic lead.		
145713	19/10/25	Moderate	Intrauterine fetal death 37+3	Awaiting Perinatal Mortality Review.		
145754	20/10/25	Moderate	Intrauterine fetal death 24+0	Awaiting Perinatal Mortality Review. Known congenital abnormality.		
145901	25/10/25	Moderate	Laceration to infant head	Awaiting After Action Review		

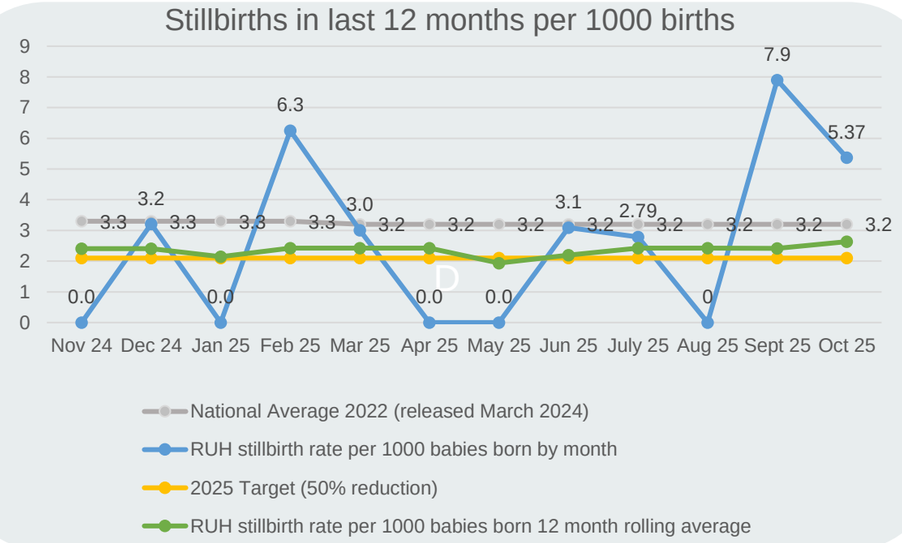
Ongoing Maternity and Neonatal Reviews

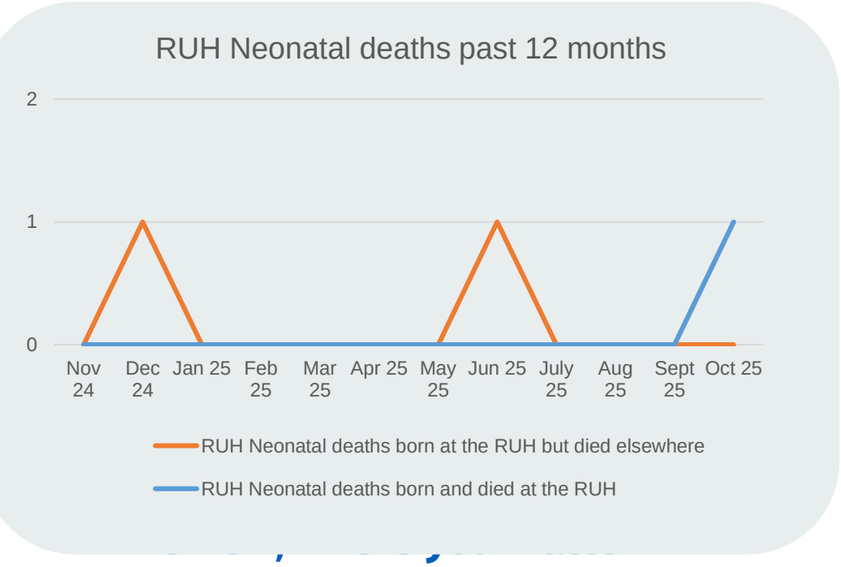
Case Ref	Date	Category	Incident	Outcome/Learning/Actions/ Update of progress	MNSI Ref	PSII Ref
141630	08/06/2025	Moderate	Therapeutic hypothermia	Ongoing Maternity & Neonatal Safety Investigation	MI-042892	
141606	07/06/2025	Moderate	Therapeutic hypothermia	Ongoing Maternity & Neonatal Safety Investigation	MI-042893	
144946	23/09/25	Moderate	IUD	Awaiting outcome of Maternity & Neonatal Safety Investigation referral	MI-047238	
144945	23/09/25	Moderate	Indirect maternal death	Awaiting Intergrated Care Board Local Maternity & Neonatal Systems facilitated review		

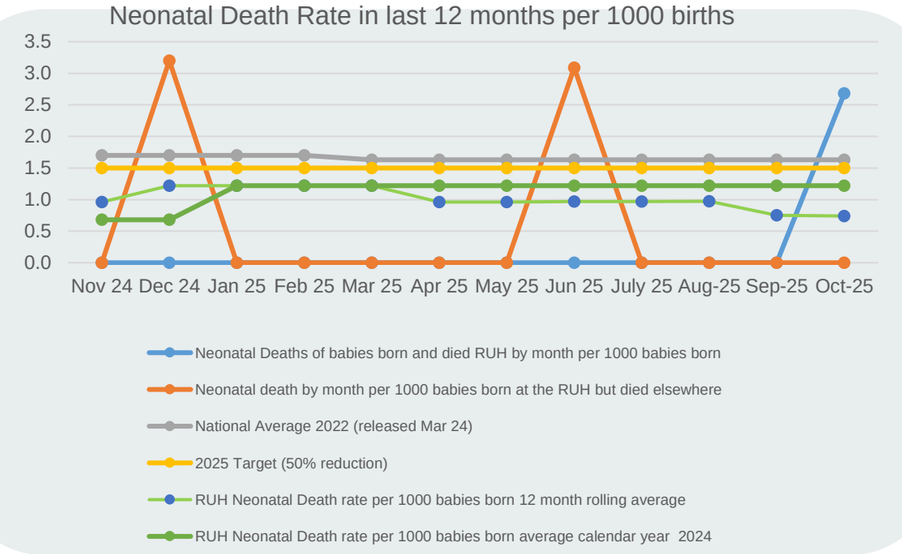
Number of IVH	Nil	**Number of PVL**	Nil
Maternity Safety Support Programme	N/A	**Coroner's regulation 28**	N/A

Safe- Perinatal Mortality Review Tool (PMRT)









Background information

All perinatal deaths have been reported using the Perinatal Mortality Review Tool (PMRT) tool. PMRT reporting is mandated by MIS Safety Action 1 of the NHSR Maternity Incentive Scheme year 6. A quarterly update paper is shared with the board.

Perinatal deaths are defined from 22 weeks and include neonatal deaths, but stillbirths are defined from 24 weeks. The rate of stillbirth and perinatal death may therefore be different.

Stillbirth and neonatal death rate is presented as ‘rate per 1000 births’ for national benchmarking, therefore the numbers per month are presented on separate graphs.

During March 25 we received the MBRRACE-UK report of 2023 deaths at the RUH. This identified new national averages for both stillbirth and neonatal deaths therefore the charts on this slide have been adjusted to reflect the new national averages for accurate benchmarking.

Monthly update

2 antenatal stillbirths (1 with known congenital abnormalities), & 1 additional late fetal loss.

1 neonatal death (with known congenital abnormalities).

Identified learning

Awaiting PMRT

Improvement actions & timescales

Learning from October PMRT embedded into new systems and processes.

PMRT grading of care - Key

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

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

No PMRT grading of care C or D in October

Case Ref	Date	Category	Incident	Outcome/Learning/Actions	MNSI Reference	PSI Reference
144762	16/09/25	Moderate	IUD 34/40	PMRT grading B & B		
144945	23/09/25	Moderate	IUD 33+4	PMRT grading B & B		
145824	07/10/25	Moderate	NND 36+3 (UHBW Lead)	PMRT grading A (AN care only)		

Risk Register

ID	Description	Risk rating
3182	Risk of increased neonatal cot occupancy	16
3101	Maternity triage non-compliance with medical review timescale a per RCOG guidance	15
2950	There is a risk that neonatal patients may be cared for outside of British Association of perinatal medicine (BAPM)	12
2785	As a result of the current level of clinical pharmacist provision to the Neonatal Unit (NNU), the British Association of Perinatal Medicine (BAPM) Service Quality Standards are not being met.	12
3013	USS capacity	12
2717	Sharing of father's information	10
3147	Health inequalities impact women and birthing people cared for by the RUH	10
3105	There is a risk that a deteriorating patient may not be recognised due to the lack of integration between MEWS and BadgerNet	9
3112	Neonatal CPAP respiratory support devices	9
3059	The unavailability of critical maternity equipment, such as birthing beds and neonatal resuscitaires	9
3171	Neonatal Allied Health Professional Workforce Risk Non-Compliance BAPM	8
3185	Inadequate Maternity and Neonatal Voices Partnership Infrastructure	8
2649	Delay in IOL	8
2949	There is a risk that use of GP surgeries for maternity community services will incur costs resulting in cost pressure for the organisation	8
3146	Inconsistent Dietetic cover to support management of diabetic pathway in pregnancy	6
2784	Adult basic life support compliance requires 90% of each staff group	6
2948	There is a risk that due to a gap between demand and capacity to process the increasing volume of Maternity Subject Access requests	6
3094	Fragmented Safeguarding Documentation across maternity, neonatal and safeguarding	6
3093	There is a risk that the neonatal service will remain a paper-based service as a result of not being incorporated with the maternity EPR programme which will impact on sharing of information and integration with maternity services.	6
2679	There is a risk to inaccurate digital Blood Pressure recordings and subsequent care planning due to the service not currently having enough digital BP machines	5
3143	Inconsistent patient record integration into Badgernet EPR	6

Countermeasure /Actions (completed this month)	Risk

Countermeasure /Action (planned this month)	Risk
Considerations for temporary staffing uplift based on commissioned cots. Explore long line bank, agency block bookings and potential bank uplift options.	3182
Develop and implement escalation SOP for neonatal bed pressures imperative we obtain agreement for earlier approval of agency of 48 hours prior, and protection for education workforce (<1.0wte).	3182
Coordinate with network partners for timely uplifts, repatriations and transfers Increase flexibility in maternity and neonatal scheduling and discharge planning i.e. TC service workforce.	3182

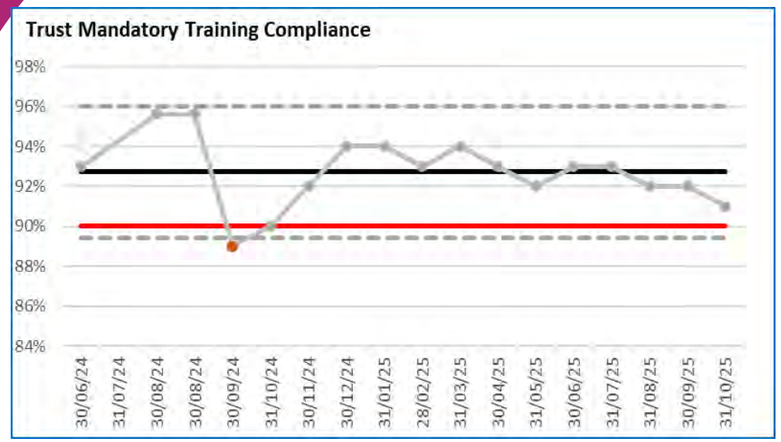
New risks

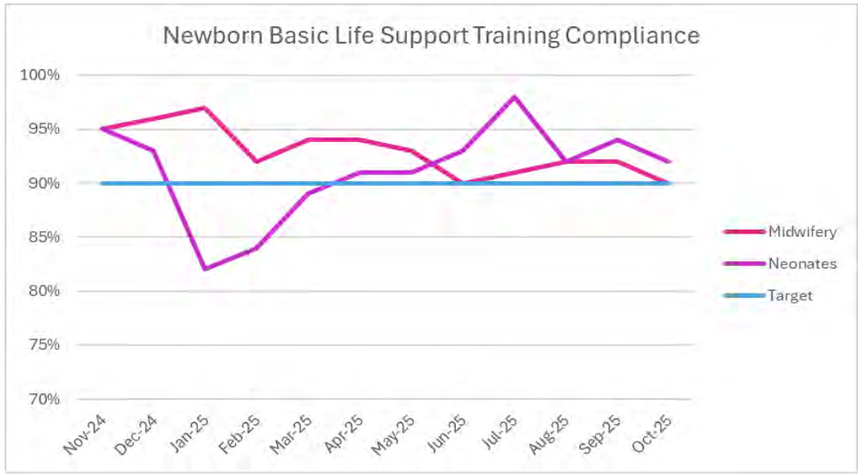
approved in October 2025

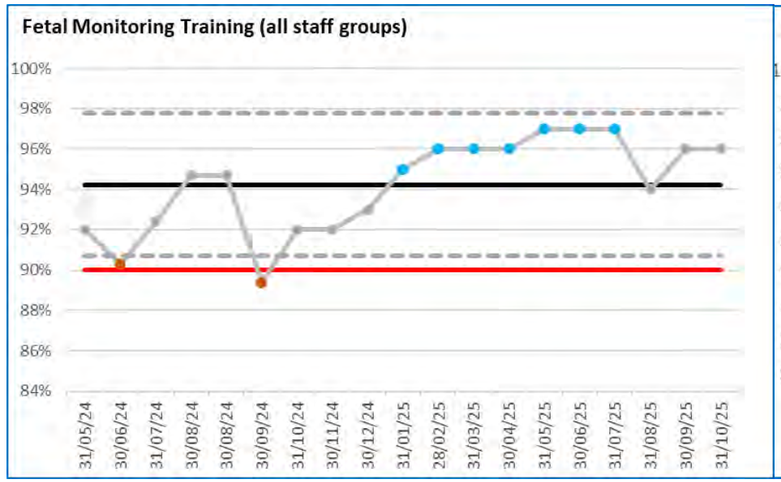
- 3182 (16)
- 3185 (8)

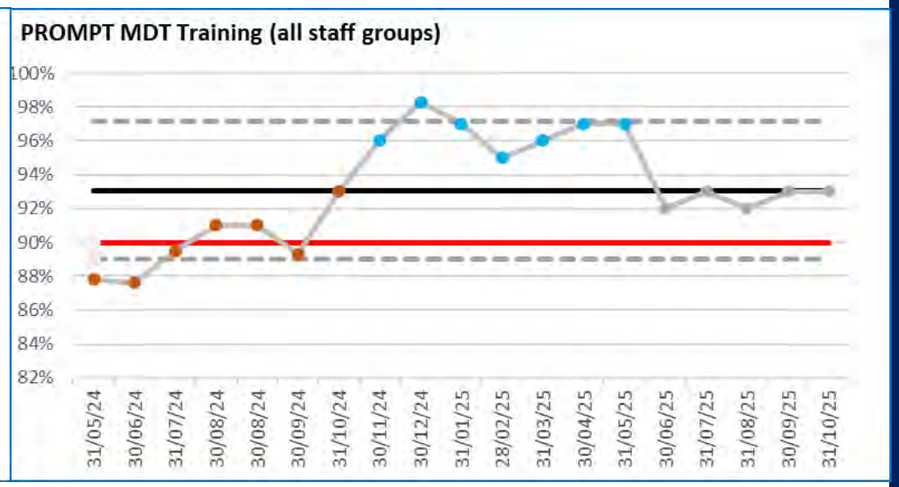
1 risk closed (2562 - EPR for maternity services related to the decision for maternity to withdraw)

Well-led – Training









Training
Compliance data being sent to all MDT leads monthly to ensure good information sharing between all staff groups.

Countermeasures/action:
- Bespoke refresher skills sessions available for community staff : Skills drills and newborn life support with dates booked for the next year. This is supported by the resuscitation team and advanced neonatal nurse practitioners (ANNPs)
- Additional skills sessions available to newly qualified staff and senior students facilitated by the Retention and Education team.
- ABLS managed in specialty moving forwards as part of the PROMPT programme. 95% and will pass MIS deadline
- Fetal monitoring 95.7%
- PROMPT 95%
- Trust mandatory training (MAT/NEO) 91%
- NBLS 95%

Risks:
- The use of our own compliance tracker as opposed to using ESR data – ESR still reflects theatre teams which impacts on our compliance. Linking in with ESR and Theatres to find a resolution to this for transparency and information sharing
- Rotation of obstetric & anaesthetic doctors' impact on compliance within this staff group for both fetal monitoring and PROMPT – see countermeasures
- Consultant compliance for SBL – aware importance of attendance
- SHO risk for PROMPT but lower threshold mitigation
- Clinical activity and acuity impacting staff availability
- Risk of not meeting MSW MPDD compliance in November but session will be recorded and disseminated to any MSW's who do not attend to ensure compliance with SBL and MIS by end of November. If all attend in November, compliance at 100%.

Neonatal Training Compliance- October 2025

Nursing NLS Compliance
(* does not include 4 new starters in supernumerary period or Mat leave)

QIS *	Reasons for QIS non-compliance
94.7% * compliant	2 – failed theory component Retake on 12 Nov

73.4%* of Registered workforce (RN+NA) NLS qualified by end Sept

Medical NLS Compliance
(* does not include F2 and those not attending births unaccompanied)

ANNP	Reasons for NLS non-compliance
100%	N/A

Consultant	Reasons for NLS non-compliance
100%	N/A

RN / NA NBLS Compliance
(* does not include 2 new starters in supernumerary period or Mat-leave)

RN+NA *	Reasons for non-compliance
95.5%	2 non-compliant – non-attendance at SD pulled off SD to work clinically

Nursery Nurse NBLS Compliance

NN	Reasons for non-compliance
100% compliant	**Nil**

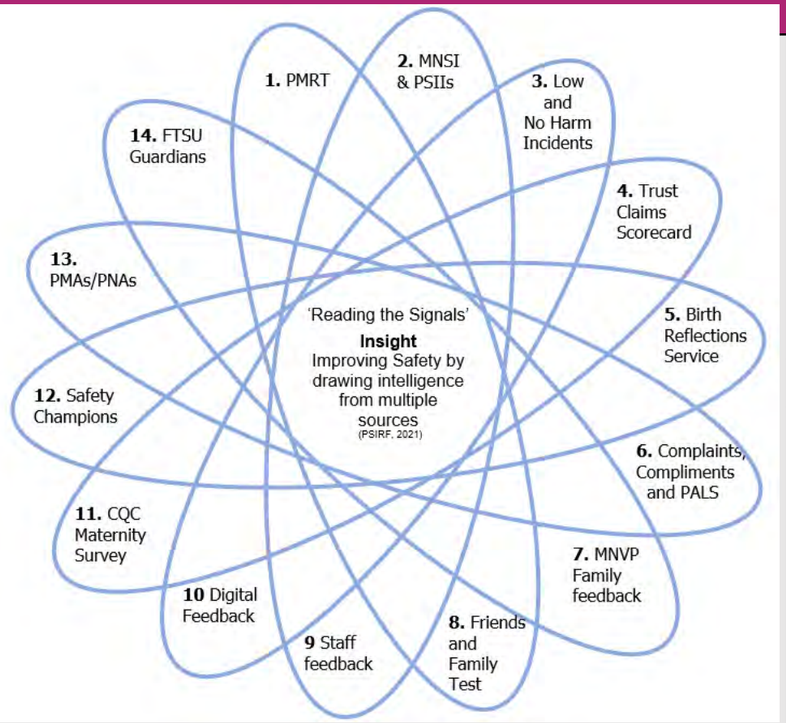
Rotational medical trainees	Reasons for NBLS/NLS non-compliance
63 % (85%)	22% of non-compliance started after July 2025 thus actions to address within 6 months. Data caption clarity issues – awaiting confirmation.

Mandatory Nursing Professional Update Study Day

	Mar	May	June	Oct
RN / NA/ NN	19	13	9	9
Total	32.7 %	55%	70.6 %	83.6%

10.9% non-attenders due to service need and maternity

Family Feedback 'Insights' Triangulation Group



Bi-Monthly meeting
Insights and Quality Improvement – Next meeting 1st December 2025

Safety Champions Staff Feedback

Maternity:

- Community staff redeployment to Acute
- Reflections on equity, especially regarding on-call and night duties in acute settings for community-based staff - We are initiating a comprehensive evaluation of the community and home birth service, including the out-of-hours provision.
- Refurbishment of the Mary Ward staff rest room has now been completed. The space looks significantly improved and offers a more comfortable and welcoming environment for our team.

Neonates :

- The Neonatal Unit has been in a sustained period of high escalation due to a combination of significant pressures: Workforce challenges: High vacancy rates, staff sickness, and reliance on temporary staffing (bank and agency) have impacted service delivery. Clinical acuity, Service displacement.

Maternity and Neonatal Voices Partnership (MNVP)

Key points raised

46 conversations. Postnatal group in Bath, Chippenham, Military Event Corsham, 1:1s

- Communication whilst inpatient / language used
- Communication regarding care transfer
- Clinicians not introducing themselves by name and role, explaining what they are going to do during appointment
- Lack of awareness regarding MNVP padlet
- Positive feedback regarding Badger App
- Neonatal – positive staff when baby 'moves up' a room
- Partners inclusion in birth experience
- Positive feedback on BBC birth environment
- Positive praise regarding care and listening by student midwives
- Partner feedback -Midwife looked at birth preferences and incorporated so much into their unplanned caesarean, it made such a difference

Next Steps:

- Recent MNVP feedback to be shared at insights and Quality improvement – triangulated themes and inform next steps

September 25 Themes

- Caring supportive staff
- Time keeping of antenatal appointments
- Posters in family facing areas
- Improved visibility of feedback opportunities –NNU
- Trust wide improvement for capturing positive feedback and compliments

Compliments & Complaints September

Formal Compliments	**2**		**PALS Contacts**	**12**
			Formal Complaints	**2**

4 x PCST contac to various members of staff working in different areas

Friends & Family Survey

Key Achievements:

- 5 pieces of positive feedback
- 0 pieces of feedback with learning opportunities

Identified Areas of Improvements:

- Discussion – reduction in feedback ?relation to changes in QR code for FFTs

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:**

- Band 8 or above sponsor for each MIS element
- Continued compliance with PMRT
- DOC/MNSI/ENS referrals remain 100%
- Continued non requirement for use of Locum obstetricians

Next Steps for Progressions:

- Bi monthly Quad leadership meets at safety champions
- Bi-monthly culture slide to continue in safety champions PQST
- Training compliance across all staff groups fluctuates per month however overall compliance remains strong- continued challenge of small numbers resulting in large impact on overall compliance.

RISKS

- Element 6 - MSDS non -compliance due to technical failure following implementation of Badgernet

Perinatal Culture & Leadership

- Mary Ward environmental improvements progressing; staff rest area completed, wayfinding replaced, lighting replaced (now dimmable), wall mural to commence December 25
- Strengthening of leadership programme in maternity – postnatal ward leadership team expansion to remain permanent (Band 7 advert out substantively following quality impact assessment)
- Focus on MSW workforce following Culture Conversation feedback and additional intelligence – engagement sessions underway to explore improvements and ensure team have opportunity to raise concerns/suggestions
- Implementation of 'Greatix' platform within neonates – next steps to roll out for maternity teams
- Further culture coaches to undergo training January 26 – including 'Train the Trainer' session for existing team

RUH Neonatal Pneumothorax: Thematic Analysis. An update

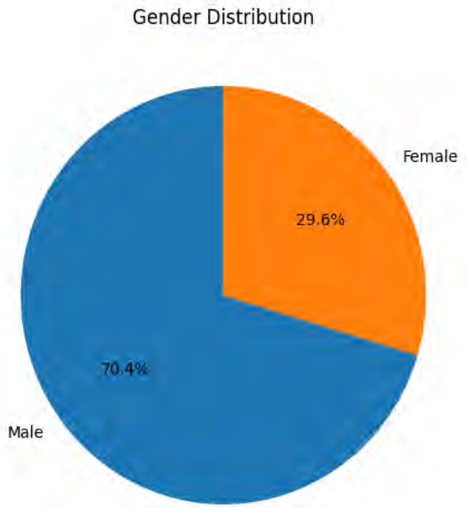
Background

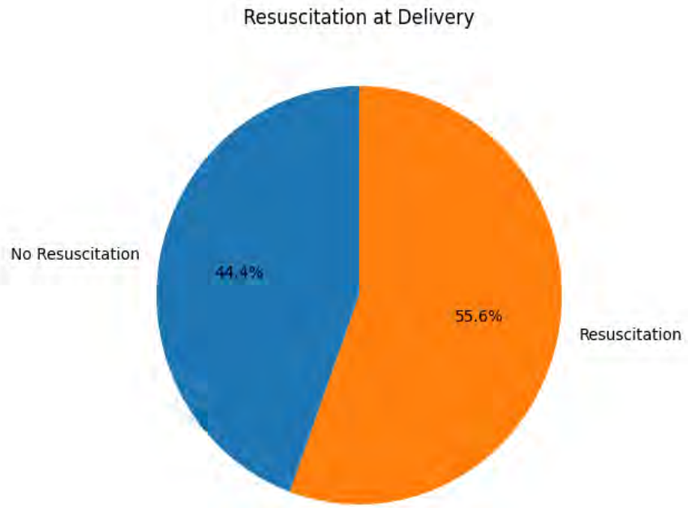
Pneumothorax in neonates is air leak in the pleural space causing lung collapse. Often linked to prematurity, mechanical ventilation, or underlying lung pathology. Can be life-threatening if it progresses to tension pneumothorax.

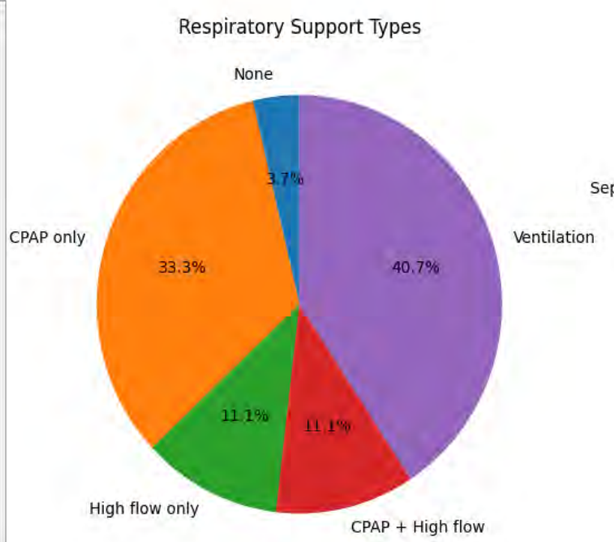
During Quarter 3 in 2024/25 it was noted that we had a cluster of 9 neonates with pneumothorax within our unit population. We wanted assurance that there were not any associated factors may have that influenced this. The data was collected from medical records and Badgernet for all treated neonates over 2 years and 6 months period.

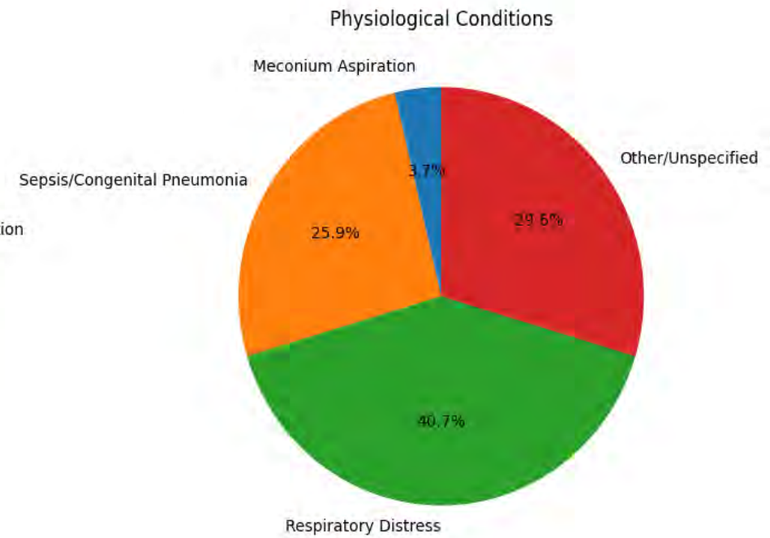
Between January 2023 and June 2025, 27 neonates were treated for a pneumothorax. There were 10255 live births in the RUH during this period. This provides an incidence of 0.26% of live births. Recent UK-based studies present overall incidence of neonatal pneumothorax is approximately 2 per 1,000 live births (0.22%) and 19 per 1,000 Neonatal Intensive Care Unit admissions (1.9%).

- **Incidence**
- **RUH data (Jan 2023–Jun 2025): 27 cases out of 10,255 live births. Local incidence: 0.26**
- **Findings: No cause for concerns identified.**
- **Gender: 70% male, 30% female**
- **Mode of Delivery: 70% caesarean section**
- **Respiratory Support: 70% received PEEP**
- **Prematurity: 22% born <37 weeks**
- **Low Birth Weight: 7%**
- **Surfactant Use: 83% of preterm neonates received it timely, 1 case it could have been administered * hours earlier**
- **No pneumothorax occurred during mechanical ventilation.**









Next steps

Action	Expected Completion Date	Completion Date
Alert staff to importance of completing Datix on all babies who develop pneumothorax. Datix Trigger list recirculated	06/10/2025	04/09/2025
Explore wider data set: identify if caesarean rate is greater than national average	10/10/2025	20/10/2025
Statify data set wider, inclusive of mode of ventilation before and after identification of pneumthorax, type of resuscitation and EDI characteristics.	07/12/2025	In progress
Share report for increase in staff awareness in Neonatal Operations meeting	20/10/2025	20/10/2025
Implement Neonatal Pneumothorax as Theme of the Week within neonatal setting for scheduled learning	24/11/2025	In progress
Share learning with Safety Champions	16/10/2025 and 21/11/25	In progress
Share thematic analysis with SW NODN	05/12/2025	In progress
Share learning with LMNS	18/11/2025	In progress
Develop Simulation Scenario and further educational resources to maintain clinical skills	01/12/2025	In progress

NEONATAL PNEUMOTHORAX: THEMATIC ANALYSIS

- **Summary**
- 96.3 % neonates had good outcomes.
- One neonatal death (not directly due to pneumothorax). No iatrogenic causes identified.
- Care aligned with national standards.
- RUHs pneumothorax rate is 0.4% above national average.
- No concerns or learning needs identified.
- Male gender and caesarean birth remain key risk factors.
- Opportunity to further stratify data
- **Identified learning**
- Learning had taken place in 2023 with delayed surfactant administration that may have contributed to development of Pneumothorax.
- No areas of learning identified in subsequent cases.
- Sharing this report with obstetric and neonatal clinical teams
- Good clinical care evidenced.

Royal United Hospitals Bath
NHS Foundation Trust

Perinatal Quality Support Oversight Model

December 2025

November 2025 data

The RUH, where you matter

Safe – Maternity Workforce

	Target	Threshold G	Threshold A	Threshold R	Sept 25	Oct 25	Nov 25	Comment
Midwife to birth ratio	1:24	<1:24		≥1:26	1.30	1:30	1.26	Trained staff only included in acuity data
Midwife to birth ratio (including bank)	1:24	<1:24		≥1:26	1:28	1:28	1.25	Care hours required, trained and support staff included in acuity data.
Percentage of 'staff meets Acuity' BBC	100%	>90%		<70%	59	61	74	
Percentage of 'staff meets Acuity' Mary Ward (inpatient care)	100%	>90%		<70%	29	31	47	
Confidence factor in BirthRate+ recording BBC	60%	>60%		<50%	75	78	85	Percentage of episodes for which data recorded
Confidence factor in BirthRate+ recording Mary Ward	60%	>60%		<50%	87	81	90	Percentage of episodes for which data recorded
Percentage maternity sickness rolling 12 months	<4%	<4%		>5%	3.20	4.24	3.45	One month behind
Percentage Maternity turnover rolling 12 months	≤5%	≤5%		≥7%	2.33	1.84	3.67	
1:1 care not provided in labour	0	0		>1	0	0	0	
Labour ward coordinator not supernumerary episodes	0	0		≥1	0	0	0	
Number of NICE red flags on Birth Rate +	NICE 2015				8	6	2	A 'red flag' event is a warning indicator that something may be wrong with midwifery staffing 1)Delay between admission for induction and beginning of process 2) Missed or delayed care

Countermeasure /Action (completed last month)	Owner

Countermeasure /Action (planned this month)	Owner
Deep dive into sickness hours in different cost centres in month	Gemma Day
Flexible working review to support roster planning/shift fill	Kerry Perkins/Jo Coggins
Review impact of 'percentage meets acuity' challenges for Mary ward	Kerry Perkins

Pipeline actuals in month

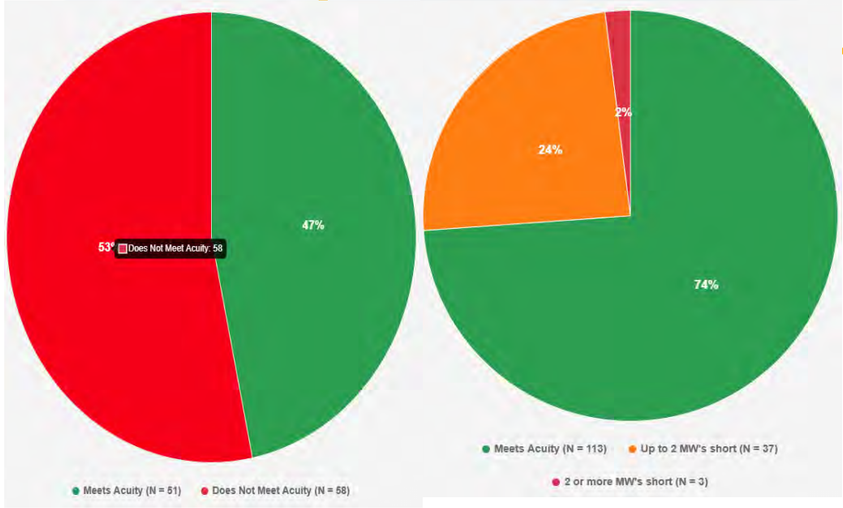
Substantive MW vacancy	Secondment	Mat leave	Fixed term in post	Budget V actual
7.4	3.44	8.74	1.64	-3.14

Substantive MSW vacancy	Secondment	Matern leave	Fixed term in post	Budget V actual
-0.73	2.4	1.25	0	-4.38

Summary of management actions relating to staffing V acuity

BBC Action (top 5)	Times occurred	Percentage
Redeploy MW internally	2	67%
CSF MW included in BBC staffing numbers	1	33%

Mary ward BBC



Safe – Neonatal Workforce

	Target	Threshold G	Threshold A	Threshold R	Sept 25	Oct 25	Nov 25	Comment
Neonatal nurse vacancy					6.05	7.32	3.14	Continue uplift to band 4 to support SNA training . 4.25 WTE new starters still SN
Neonatal parenting leave WTE/%		>3			2.2 4.75	3.16 6.28%	3.16 7.03%	
Percentage neonatal sickness rolling 12 months	100%	<4%		>5%	3.69	3.66	3.72	
Percentage neonatal turnover rolling 12 months	<5%	<5%		<7%	0.88	0.84	0.00	
Percentage neonatal nursing shifts filled to BAPM standard	100%	>90%		<80 %	83.05	73.3	75	High acuity, vacancy, maternity leave LTS
Percentage medical shifts filled to BAPM minimal standard	100%	>90		<80	98.33	95.2	90	• Note minimal standards. • 1x ANNP sickness for > 6 weeks
Percentage neonatal QIS trained	70%	<70 %		<60 %	70.8%	70.8%	70.8%	
Percentage of TC shifts with staff dedicated to TC care	100%	>90%		<80 %	97%	78%	80%	Maternity supported TC when no TC nurse on 2 occasions
Percentage of shifts with SN team leader	100%	>90 %		< 80 %	25.42	18%	44.64	National Av L2: 67.94 (Badger)

Is the standard of care being delivered?

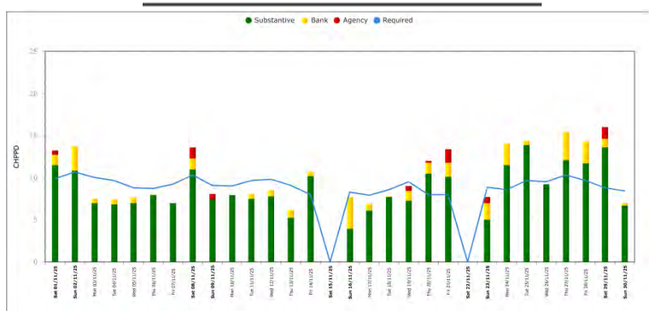
- **Sickness 4.87% for the month. 68.1 FTE days lost**
- **BAPM nursing shift fill remains poor, due to High acuity, maternity leave, LTS and leavers.**
- **TC staffed 78% with dedicated TC nurse. 23% of shifts between 5-8 babies cared for on TCP. 18% of these shifts were not supported by correct nurse :baby ratio**
- **Additional nurse shifts to make all shifts BAPM compliant 8.8 (Source Badger)**
- **% of shifts covered by Bank staff 8.42 % (source Badger) 3.2 WTE bank 0.6 WTE agency**
- **1 LIS (Limitation in Service) form submitted for November**
- **5 Bristol babies and 2 from Swindon, admitted to NNU 27% of total admissions. An additional 6 babies still being cared for from October admissions.**

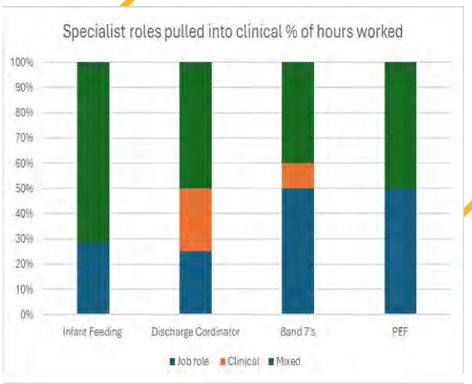
Countermeasure /Action (completed)	Owner
B6&5 recruits in place, completing supernumerary time.	KF

Countermeasure /Action (planned)	Owner
Long line agency approved 1.6 wte B5 awaiting recruitment process completion PEF and clinical 6 awaiting interview	KF

Bank/Agency/Opel/Redeployment	
Filled Bank shifts	53
Unfilled bank shifts	29
Filled agency Shifts	9
Unfilled agency shifts	22
% Opel Black	3%
% Opel Red	13%
% Opel Amber	36%
% Opel Green	48%

Required vs Actual Hours.





November 95% of shifts between 70-100% cot occupancy

Safe – Acuity

	Target	Threshold			Sept 25	Oct 25	Nov 25	Comment
		G	A	R				
Obstetric consultant presence on BBC	60 hours	>60 hours		<60 hours	98	98	98	No change
Obstetric consultant non-attendance to clinical situation	100%	100%		<100 %	100	100	100	No incidents
Obstetric percentage daily MDT ward round	100%	100%		<100 %				Reviewed by LWC daily, MS forms completed if no ward round completed with immediate escalation.
Birth within BAPM L2 place of birth standards	100%	100%		<100 %	100	100	100	100% births in the right unit
Number of days in LNU outside of BAPM guidance	0%	<0		>2*	4	0	8	No days in LNU outside of BAPM guidance. Twins <28 weeks remained due to lack of NICU capacity within network.
Anaesthetic rota compliance	70%	≥70%		<70 %	100	100	100	

Countermeasure /Action (completed)	Owner

Countermeasure /Action (planned)	Owner

Is the standard of care being delivered?

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

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

Patient Safety Events

≥ Moderate Harm Events in November

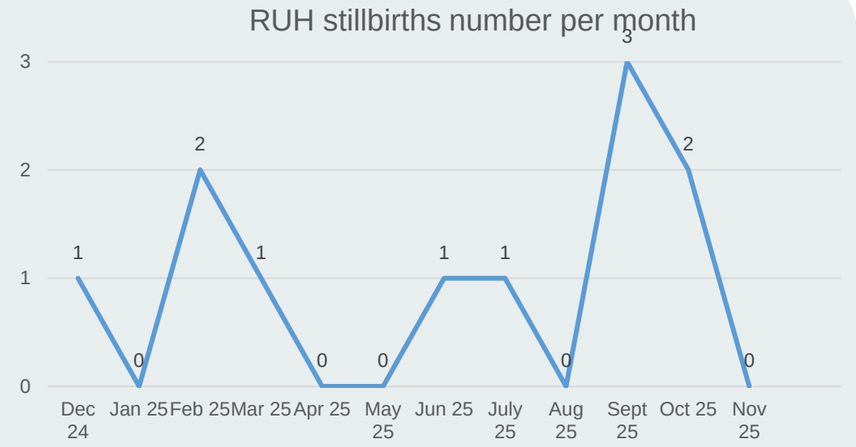
Case Ref	Date	Category	Patient Safety Event	Outcome/Learning/Actions	MNSI Ref	PSII
146425	06/11/25	Moderate	Maternal admission to Intensive Therapy Unit (ITU)	Initial Multi Professional Safety Review (MPSR) held on 14/11/25. Further review required with key stakeholders from urgent care		
146963	20/11/25	Severe	Readmission to Neonatal Intensive Care Unit (NICU) with abnormal magnetic resonance imaging (MRI)	Multi Professional Safety Review held on 04/12/25. Awaiting results of clinical investigations.	MI-049980	

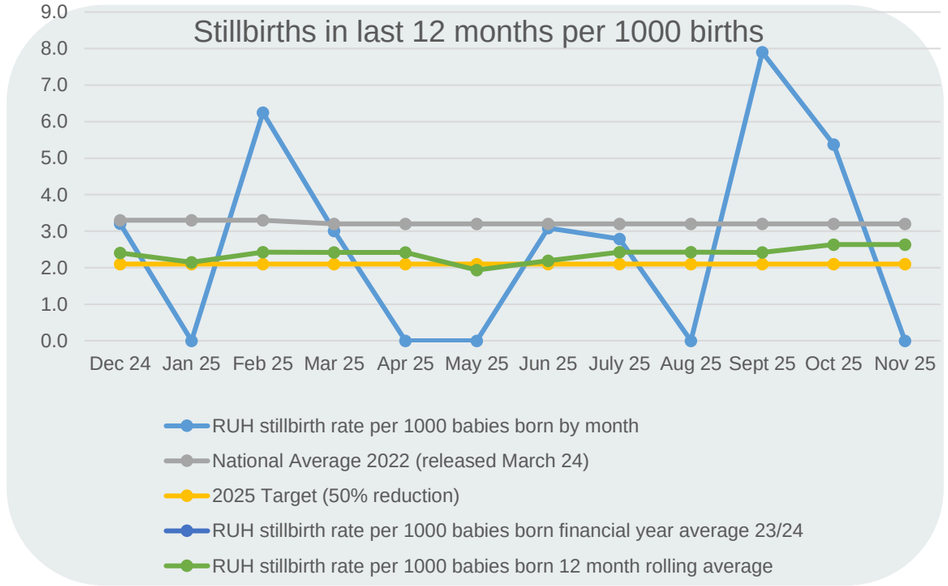
Ongoing Patient Safety Learning Responses

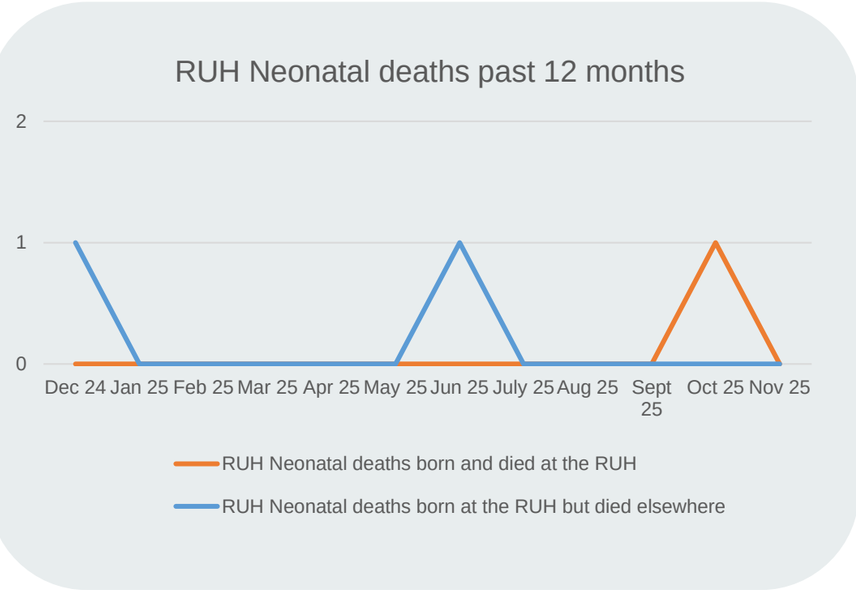
Case Ref	Date	Category	Incident	Outcome/Learning/Actions/ Update of progress	MNSI Ref	PSII Ref
144946	23/09/25	Moderate	Intrauterine death	Awaiting outcome of Maternity & Neonatal Safety Investigation referral	MI-047238	
144945	23/09/25	Moderate	Indirect maternal death	Integrated Care Board Local Maternity & Neonatal Systems facilitated review held on 05/12/25- to reconvene in Jan 2026 further information requested of non-maternity care providers		
144851	23/09/25	Never Event	Retained foreign object	Systems Engineering In Patient Safety (SEIPS) /ACCIMAP taken place on 11/12/25		

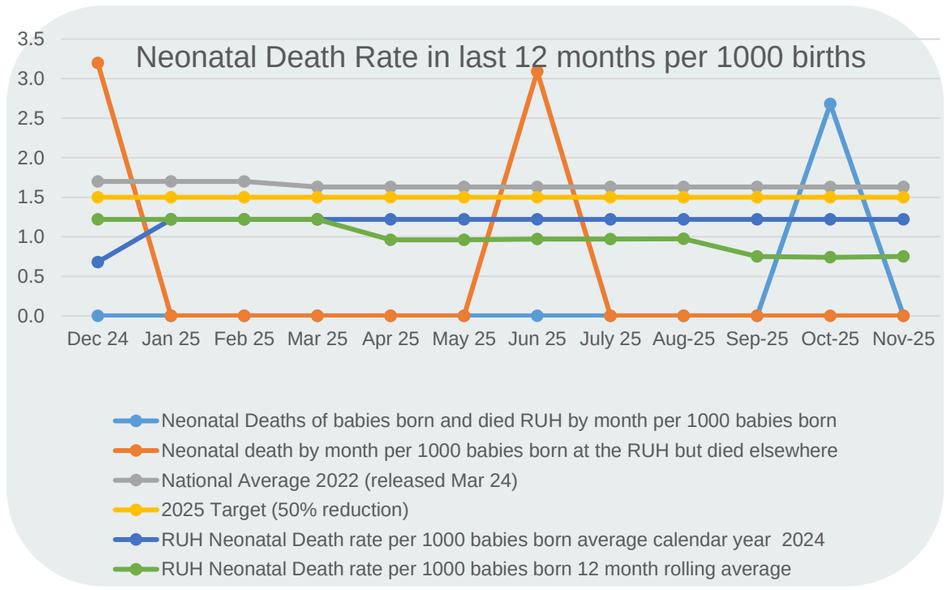
Number of IVH	Nil	**Number of PVL**	Nil
Maternity Safety Support Programme	N/A	**Coroner's regulation 28**	N/A

Safe- Perinatal Mortality Review Tool (PMRT)









Background information

All perinatal deaths have been reported using the Perinatal Mortality Review Tool (PMRT) tool. PMRT reporting is mandated by MIS Safety Action 1 of the NHSR Maternity Incentive Scheme year 6. A quarterly update paper is shared with the board.

Perinatal deaths are defined from 22 weeks and include neonatal deaths, but stillbirths are defined from 24 weeks. The rate of stillbirth and perinatal death may therefore be different.

Stillbirth and neonatal death rate is presented as ‘rate per 1000 births’ for national benchmarking, therefore the numbers per month are presented on separate graphs.

During March 25 we received the MBRRACE-UK report of 2023 deaths at the RUH. This identified new national averages for both stillbirth and neonatal deaths therefore the charts on this slide have been adjusted to reflect the new national averages for accurate benchmarking.

Monthly update

0 stillbirths or NND in November 2025

Identified learning

Review of process of internal reporting for NND <22weeks as impact on rolling annual neonatal mortality rates. This would not be reflected in MBRACE external statistics

Improvement actions & timescales

Please see subsequent PMRT slide

PMRT grading of care - Key

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

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

One PMRT grading of care C or D in November

Case Ref	Date	Category	Incident	Outcome/Learning/Actions	MNSI Reference	PSI
145188	02/10/25	Unavoidable Death	NND 30+2	Care graded B, B, B		
145713	19/10/25	Moderate	IUD 37+3	Antenatal care ungraded pending post mortem. Care graded as D following the birth of the baby. Learning identified in relation to Anti-D • Improving communication between the blood transfusion laboratory and community maternity teams • Introducing new processes for allocating daily worklists to improve workload visibility • Providing enhanced support for junior staff when managing complex workloads across multiple sites • Strengthening education for staff about the importance of timely Anti-D administration and sensitising events.		
No Ref.	May 2025	Unavoidable death	IUD 25+3	Care booked at RUH then transferred to University Hospitals Bristol and Western NHS Foundation Trust (UHBW). Feedback provided to family. Care to be graded by UHBW.		

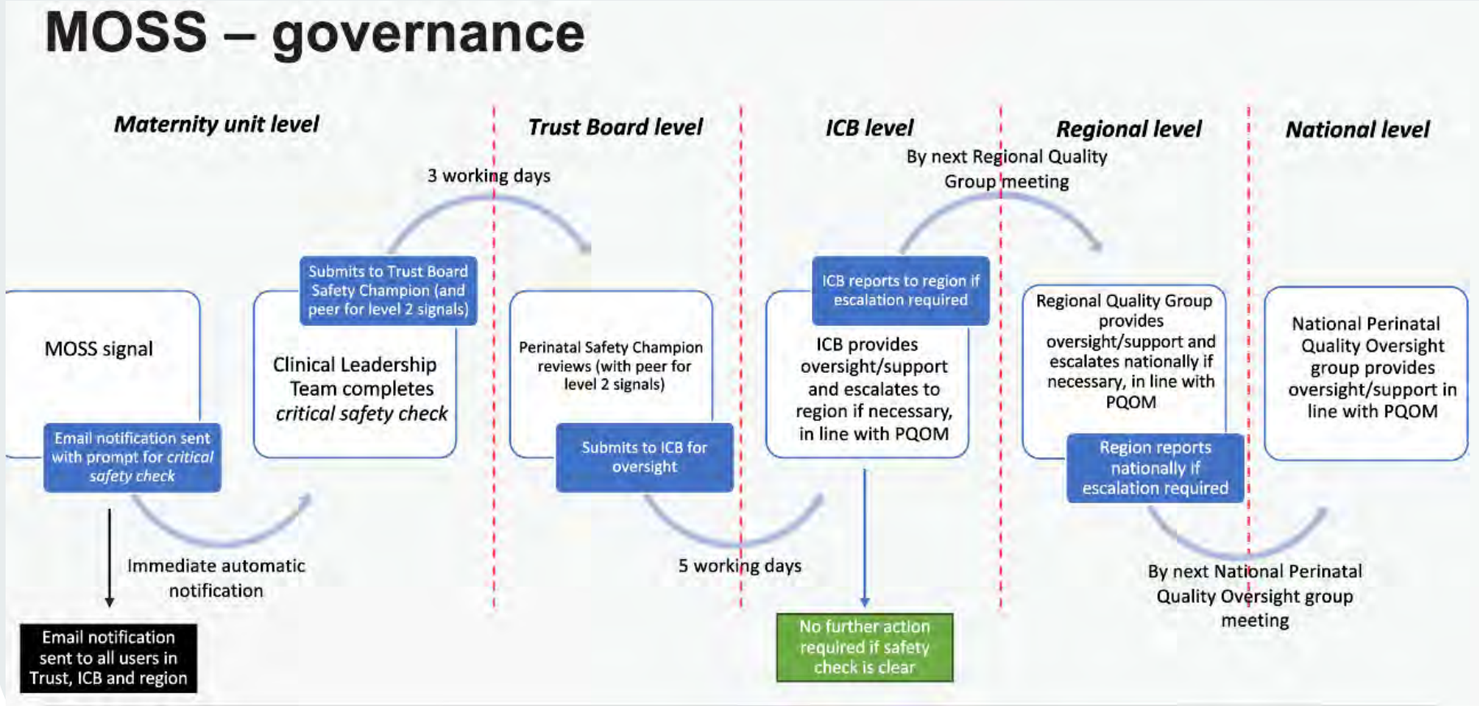
Maternity Outcomes Signal System- MOSS

The charts used in MOSS are based on analysis of three outcome measures agreed by experts including clinicians, statisticians and service users as part of a stakeholder group convened by NHS England.

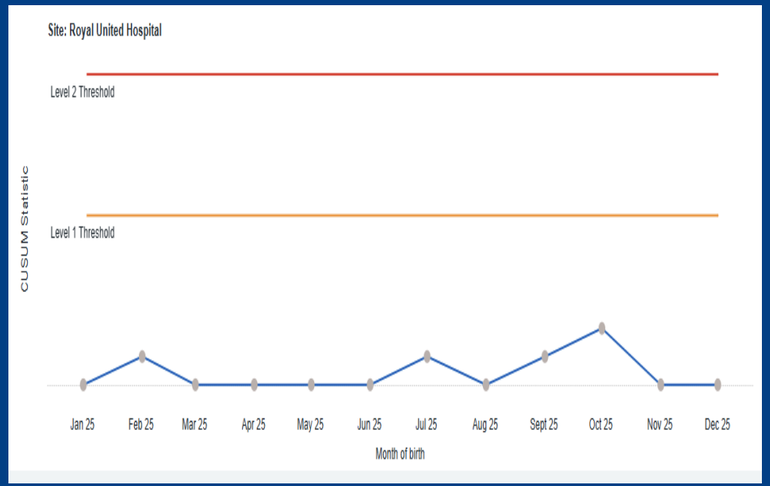
These include term stillbirth and term neonatal death up to 28 days (with a third measure being added in future: Term Grade 2 or 3 Hypoxic Ischaemic Encephalopathy (HIE)). These were chosen as they have a high potential of causation from care and service delivery issues (e.g. avoidable harm, sub-optimal care), they have a low index of causation from known clinical conditions, and they are defined and recorded in a consistent and standardised way in clinical information systems.

In MOSS, the chart used to provide maternity outcomes signals is the cumulative sum chart (CUSUM), however, another chart is included to provide further context. Further information on the methodologies used to produce each chart is available below.

MOSS – governance



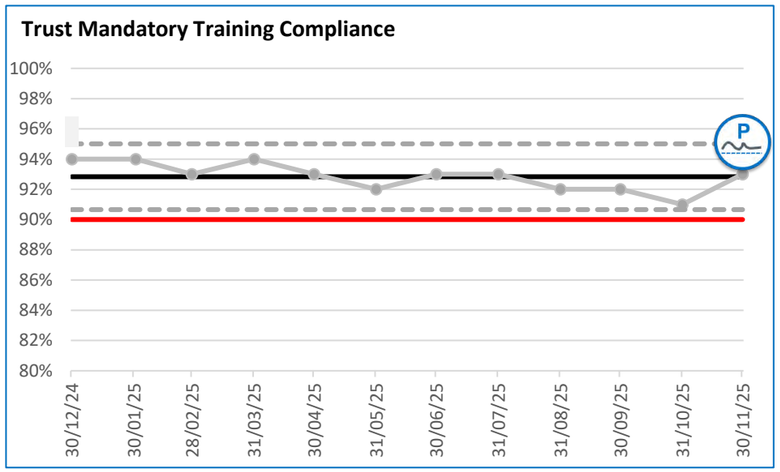
RUH Data November 2025

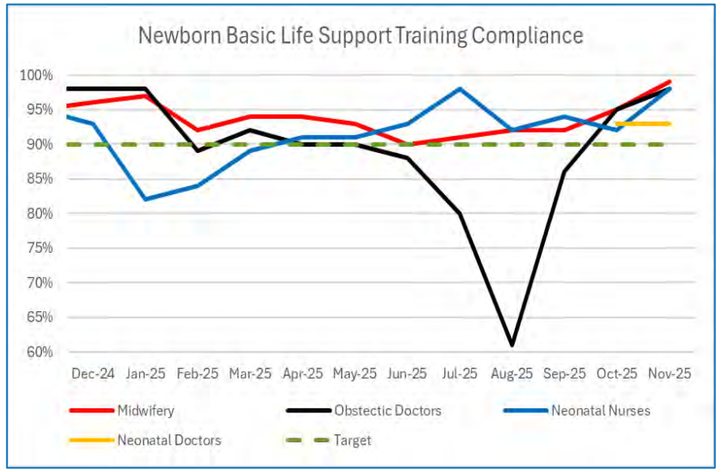


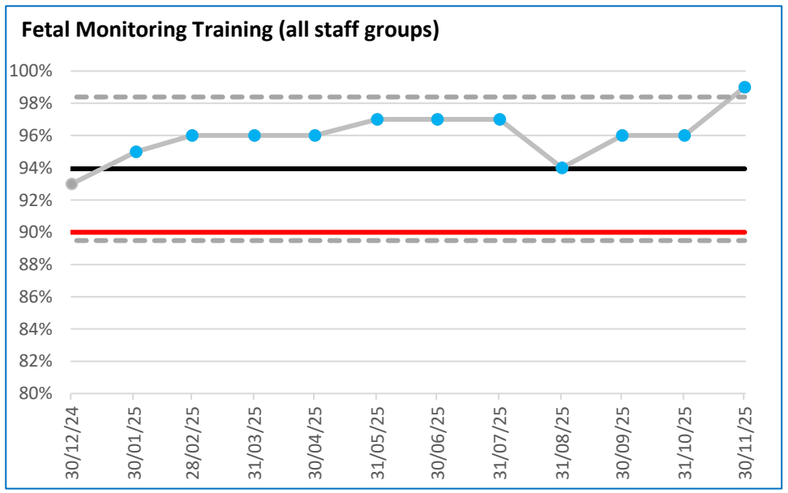
Signal summary table

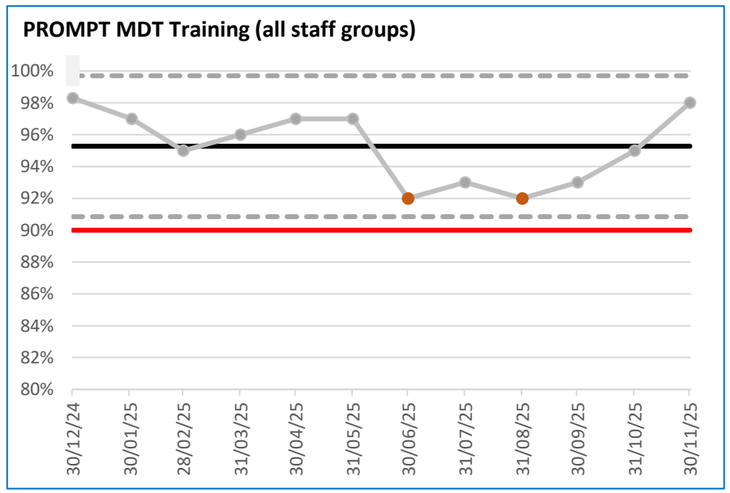
Signals over last 6 months		Signals over last 12 months	
Level 1	Level 2	Level 1	Level 2
0	0	0	0

Well-led – Training









Training
Compliance data being sent to all MDT leads monthly to ensure good information sharing between all staff groups.

Countermeasures/action:

- Bespoke refresher skills sessions available for community staff : Skills drills and newborn life support with dates booked for the next year. This is supported by the resuscitation team and advanced neonatal nurse practitioners (ANNPs).
- Additional skills sessions available to newly qualified staff and senior students facilitated by the Retention and Education team.
- Community Birth Team and joint paramedic training day
- ABLS managed in specialty moving forwards as part of the PROMPT programme. 98.4%
- Fetal monitoring 99.7%
- PROMPT 98.4%
- Trust mandatory training (MAT/NEO) 95%
- NBLS as per graph. All above 92%
- MIS training compliance met.

Risks:

- The use of our own compliance tracker as opposed to using ESR data – ESR still reflects theatre teams which impacts on our compliance. Linking in with ESR and Theatres to find a resolution to this for transparency and information sharing.
- Rotation of obstetric & anaesthetic doctors' impact on compliance within this staff group for both fetal monitoring and PROMPT – see countermeasures
- MDT mix on study days Dec - March
- SHO risk for PROMPT but lower threshold mitigation
- Clinical activity and acuity impacting staff availability.

Compliance to National Guidance – MIS year 7

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

Maternity Incentive Scheme (CNST) Year 7

- **Key Achievements:**

- Band 8 or above sponsor for each MIS element
- Continued compliance with PMRT
- DOC/MNSI/ENS referrals remain 100%
- Continued non requirement for use of Locum obstetricians
- Check and challenge meeting with SC and DOM complete

Next Steps for Progressions:

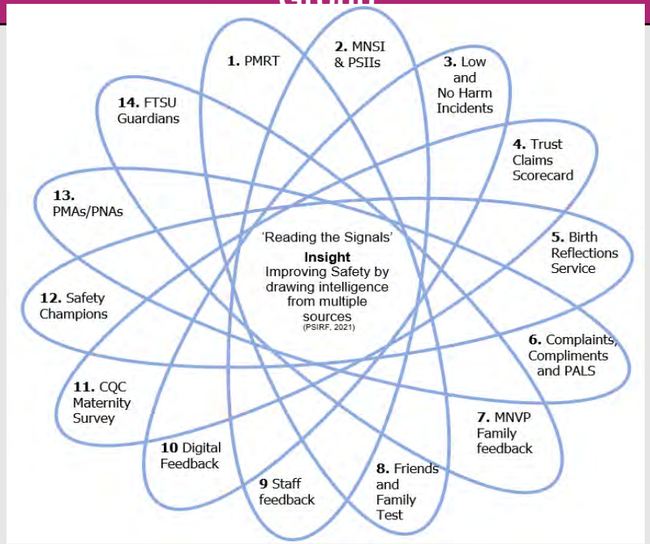
- Bi monthly Quad leadership meets at safety champions
- Bi-monthly culture slide to continue in safety champions PQST
- Training compliance across all staff groups fluctuates per month however overall compliance remains strong- continued challenge of small numbers resulting in large impact on overall compliance.

RISKS

- Element 6 - MSDS non -compliance due to technical failure following implementation of Badgernet – risk assessment underway

Responsive – Service insights

Family Feedback 'Insights' Triangulation Group



Workforce Change:

Perinatal Insights & Improvements Midwife – Jo Coggins to recommence bi-monthly meetings from January 2026 – invites to follow

Safety Champions Staff Feedback

Maternity:

- Community staff redeployment to Acute
- Reflections on equity, especially regarding on-call and night duties in acute settings for community-based staff - We are initiating a comprehensive evaluation of the community and home birth service, including the out-of-hours provision.
- Refurbishment of the Mary Ward staff rest room has now been completed. The space looks significantly improved and offers a more comfortable and welcoming environment for our team.

Neonates :

- The Neonatal Unit has been in a sustained period of high escalation due to a combination of significant pressures: Workforce challenges: High vacancy rates, staff sickness, and reliance on temporary staffing (bank and agency) have impacted service delivery. Clinical acuity, Service displacement.

Maternity and Neonatal Voices Partnership (MNVP)

Key points raised

- Partners inclusion in birth experience
- Positive feedback on BBC birth environment
- Positive praise regarding care and listening by student midwives
- Partner feedback -Midwife looked at birth preferences and incorporated so much into their unplanned caesarean, it made such a difference

Next Steps:

- Recent MNVP feedback to be shared at insights and Quality improvement – triangulated themes and inform next steps – January 26

November 25 Themes

- Families not 'Feeling heard'
- Cleanliness and meal availability on ward poor
- Poor communication around personalised care plans for women with PIH
- Postnatal care and Infant Feeding/Supplementation
- Delayed analgesia and sub-standard medicines management processes

Compliments & Complaints November 25

Formal Compliments	**0**	**PALS Contacts**	**15**
		Formal Complaints	**7**

Friends & Family Survey

Key Achievements:

- 6 pieces of positive feedback (Top 3 themes: Care & Treatment, Staff attitude, Communication & Information giving)
- 1 piece of feedback with learning opportunities (Key themes: Discharge process, staff behaviour & communication)

Identified Areas of Improvements:

FFTs

ExperienceFeedbackAspectName	Positive	Negative	Total
Care and Treatment	6		6
Communication and information	4	1	5
Discharge Process and Follow-Up	1	1	2
Environment and Cleanliness	2		2
Involvement in Decisions	3		3
Nutrition and Hydration	1		1
Overall Experience	3		3
Privacy and Dignity	3		3
Staff Attitude and Behaviour	5	1	6
Total	**6**	**1**	**7**

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

December 2025
(November Data)

The RUH, where you matter

Breakthrough and Vision Metrics Summary

Royal United Hospitals Bath
NHS Foundation Trust

Strategic Goal	Measure Group	Measure	Measure Category	Latest Survey	Latest Performance	Trend
People we work with	Employee Experience	% Satisfied with extent organisation values their work (National)	Breakthrough	2024	42.7%	
People we work with	Employee Experience	% Agreeing organisation values work (Pulse)	Context	25-26 Q2	46.1%	
People we work with	Employee Experience	% Agreeing that immediate manager values work (National)	Context	2024	74.7%	
People we work with	Employee Experience	% Agreeing that immediate manager values work (Pulse)	Context	25-26 Q2	71.7%	
People we work with	Employee Experience	% Agreeing that feel valued by team (National)	Context	2024	72.1%	
People we work with	Employee Experience	% Recommend Trust as place to work (National)	Vision	2024	63.5%	
People we work with	Employee Experience	% Recommend Trust as place to work (Pulse)	Watch	25-26 Q2	52.4%	
People we work with	Employee Experience	% Agreeing that organisation acts fairly regarding career progression (National)	Vision	2024	56.1%	
People we work with	Employee Experience	% Experienced discrimination from public (National)	Vision	2024	10.5%	
People we work with	Employee Experience	% Experienced discrimination from managers/colleagues (National)	Vision	2024	8.2%	

Metrics where the Latest Survey shown is a year are derived from the National Staff Survey and are updated annually.. after formal publication by the National Team.
Those where the Latest Survey references a specific quarter are derived from the Pulse survey and are updated 3 times a year.. in Quarters 1. 2 and 4. No Quarter 3 survey is run to avoid a clash with the National Survey.
Pulse survey questions pertaining to feeling valued first asked in 25026 Q2.

Metric Summary I

Royal United Hospitals Bath
NHS Foundation Trust

Strategic Goal	Measure Group	Measure	Measure Category	Latest Month	Latest Performance	Trend	Target	Target Met	Months Since Last Met	Target Feasibility Assurance	Variation	Variation Detail
People we work with	Workforce Plan	Total WTE	Watch	Nov-25	5807.3		<=5585.3	✗	Not in FY			SPC not appropriate
People we work with	Workforce Plan	Substantive WTE	Context	Nov-25	5503.3		<=5322.7	✗	6			SPC not appropriate
People we work with	Workforce Plan	Bank WTE	Context	Nov-25	293.3		<=257.6	✗	Not in FY	F	L	Special Cause Improving - Two out of Three Low
People we work with	Workforce Plan	Agency WTE	Context	Nov-25	10.7		<=5.0	✗	6	F		Common Cause
People we work with	Vacancy	Vacancy Rate	Key Standard	Nov-25	-0.85%		<=4.00%	✓	0			SPC not appropriate
People in our community	Pay	Pay Bill % on Agency	Watch	Nov-25	0.69%		<=2.50%	✓	0	P		Common Cause
People we work with	Turnover & Leavers	In Month Turnover	Key Standard	Nov-25	0.41%		<=0.92%	✓	0	P	L	Special Cause Improving - Two out of Three Low
People we work with	Turnover & Leavers	12 Month Turnover	Key Standard	Nov-25	7.00%		<=11.0%	✓	0	P	L	Special Cause Improving - Run Below Mean
People we work with	Turnover & Leavers	Leavers Inside 1st Year	Context	Nov-25	2.60		N/A					

Metric Summary II

Royal United Hospitals Bath
NHS Foundation Trust

Strategic Goal	Measure Group	Measure	Measure Category	Latest Month	Latest Performance	Trend	Target	Target Met	Months Since Last Met	Target Feasibility Assurance	Variation	Variation Detail
People we work with	Sickness Absence	In Month Sickness	Key Standard	Oct-25	6.31%		<=4.70%	✗	5	F	H	Special Cause Concerning - Two out of Three High
People we work with	Sickness Absence	Short Term Sickness	Context	Oct-25	3.18%		N/A					
People we work with	Sickness Absence	Long Term Sickness	Context	Oct-25	3.13%		N/A					
People we work with	Sickness Absence	12 Month Sickness	Key Standard	Oct-25	5.07%		<=4.70%	✗	11	F	H	Special Cause Concerning - Run Above Mean
People we work with	Sickness Absence	In Month ASD Sickness	Driver	Oct-25	1.71%		TBC			F	H	Special Cause Concerning - Above Upper Control Limit
People we work with	Appraisal	Appraisal Compliance	Key Standard	Nov-25	78.46%		>=90.0%	✗	Pre-2021	F	L	Special Cause Improving - Two out of Three Low
People we work with	Appraisal	AfC Appraisal Compliance	Context	Nov-25	79.22%		>=90.0%	✗	Pre-2021	F	L	Special Cause Improving - Two out of Three Low
People we work with	Appraisal	M&D Appraisal Compliance	Context	Nov-25	70.40%		>=90.0%	✗	Pre-2021	F	L	Special Cause Concerning - Run Below Mean
People we work with	Training	Mandatory Training Compliance (Core)	Key Standard	Nov-25	88.80%		>=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

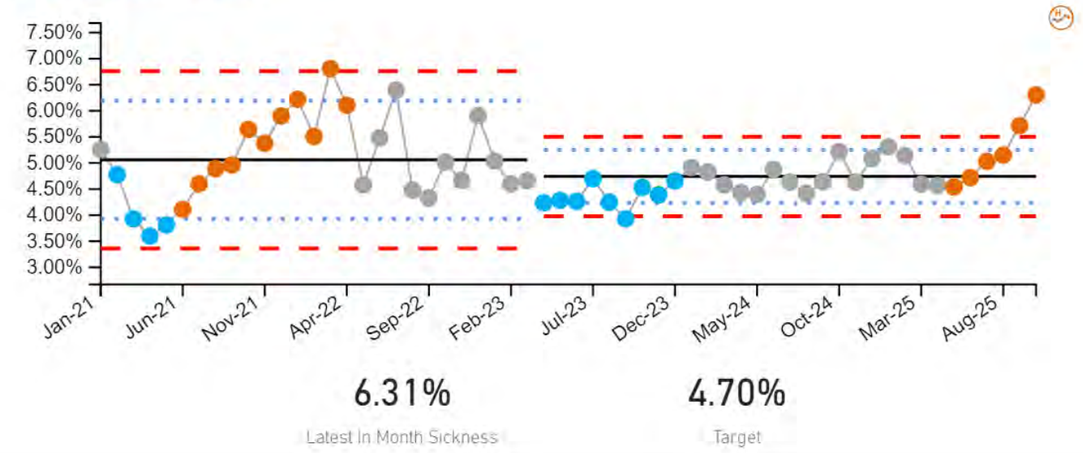
Royal United Hospitals Bath NHS Foundation Trust

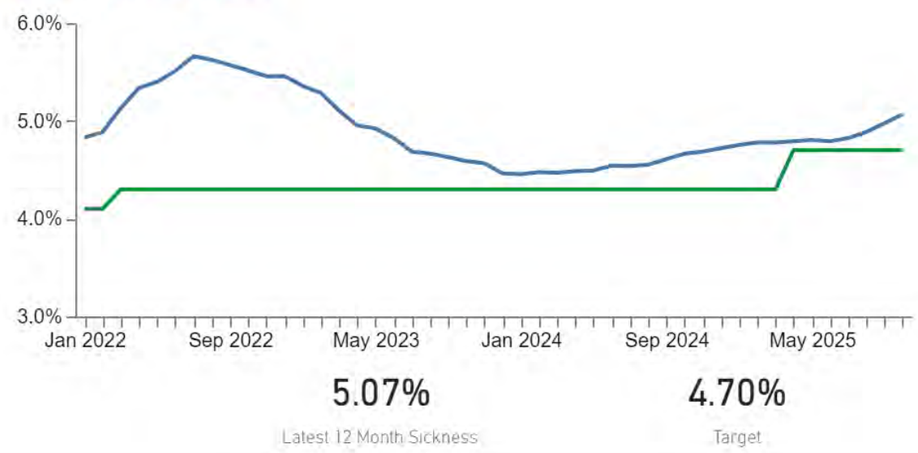
DRIVING

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.





Understanding Performance
• October's in-month sickness rate of 6.31% is the highest since July 2022, when the rate was elevated by increased COVID cases. The 12-month rate exceeds 5% for the first time since March 2023. In simple terms, the current level of sickness is not too dissimilar from the tail end of the pandemic, highlighting just how elevated it is. • From an already elevated position, the Anxiety, Stress and Depression rate rose by c. 0.3 percentage points (over 20%) on last month. • Absence due to Cold, Cough and Flu significantly rose, with 1749.1 WTE days lost. For comparison, that is c. 300 WTE days up on the same month in 2023 and 2024 and is on par with December 2024/January 2025 when it last peaked. • Estates and Facilities (8.67%) and Medicine (7.30%) have the highest in-month rates and have been trending up for several months.

Countermeasures	Owner	Due Date
Surgery: overall sickness reduced in month, further deep dive work to be undertaken and action plans following this to be developed.	Divisional Tri	February 26
Medicine: Targeted additional HR support in areas of high absence, including ED as part of CQC action plan. Delivery of staff survey action plan and ongoing organsiational development support within the Emergency Department.	People Partner	February 26
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
FaSS: Audit of LTS cases to ensure support and management plans in place / estimated rtw date. Culture work to improve working conditions / reduce stress and anxiety.	People Partner	April 26
Trust-wide: 1. Sickness task and finish January 2026 – identify root causes for increasing rates. 2. Managing wellbeing at work policy review 3. Perk box implementation: Organisation-wide improved EAP, wellbeing and colleagues resilience platform 4. Culture Response team established to support ED and most impacted (by sickness) areas	DCPO	February 26

Anxiety, Stress and Depression Sickness

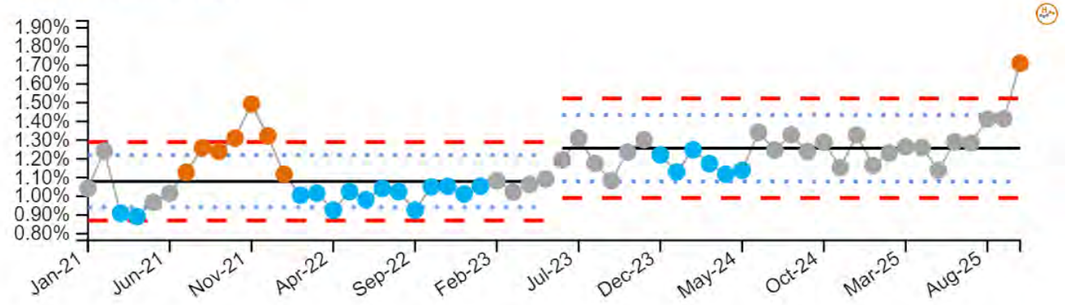
Royal United Hospitals Bath NHS Foundation Trust

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.

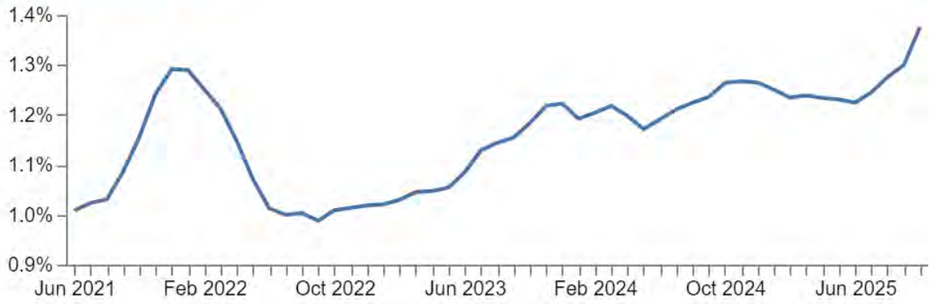
Trust In Month Rate



1.71%

Latest In Month Rate

Trust 6 Month Trend



1.38%

Latest 6 Month Rate

Understanding Performance
• For several days in October, more than 280 people were off due to Anxiety, Stress and Depression. In previous months, levels have not reached 260 on any given day. • Emergency Medicine has an in-month rate of 4.73% and is a key contributor in Medicine having a divisional rate of 2.13%, though several other directorates also exceed 2%. • Estates and Facilities (1.90%) and Corporate (1.68%) also have seen notable increases on September's position, though apart from a few pockets the issue currently seems to be more duration than frequency.

Countermeasures	Owner	Due Date
Surgery: this remains a diver for the division. Hot spot areas in pain and surgery management. Plans to design and implement cultural improvement plans with support from Culture team.	Divisional Tri	February 2026
Emergency Department: Targeted HR support provided around ongoing absence cases. 14th January feedback and next steps session following programme of leadership development sessions.	People Partner and OD team	January 2026
FaSS: Mediation / team facilitation commissioned in two areas to support positive working relationships and improve culture.	People Partner and Div Tri	January 2026
Trustwide: launch of Perk box, to support colleagues to access broader 24/7 well-being support. Culture Response Team established to boost support and wellbeing in most impacted areas.	AD for Culture	January 2026

Risks and Mitigation

Appraisal

Royal United Hospitals Bath NHS Foundation Trust

DRIVING

Key Standard

We are driving this metric because

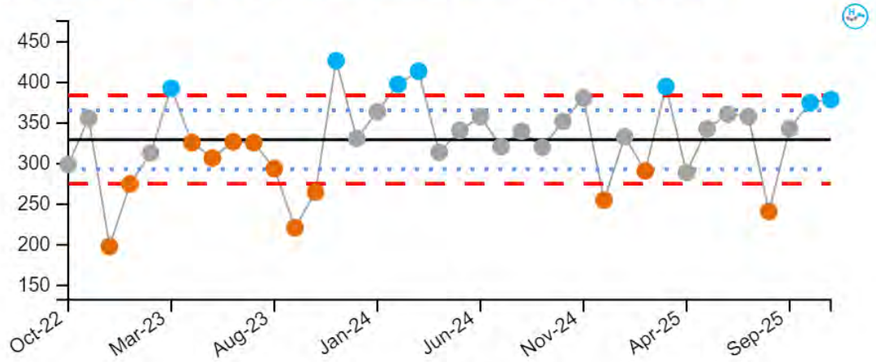
Timely, high-quality appraisals improve performance, engagement and productivity, reducing sickness and burnout. All colleagues should have access to a meaningful programme of interaction with their managers, including an annual appraisal. The organisation has set a 90% compliance target for the annual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

Trust Appraisal Compliance

78.5%
Latest Appraisal Compliance

90.0%
Target

Appraisals Completed in Month When Month First Reported



379
Appraisals Completed in Month

Understanding Performance
• Overall compliance has fallen by over half a percentage point to 78.46% and moves further away from the 90% target. • All main Divisions have failed to improve on their respective positions reported last month and no Division is achieving target with only R&D, Medicine and Surgery above 80%. • 14 Directorates across the organisation are achieving 90%, but 19 Directorates are below 70% highlighting the wide variation. • Corporate Division continues to have the worst compliance of main Divisions at 64.92%. Since April compliance has been within a 4% range, showing an unwanted stability. • Estates and Facilities' compliance has fallen by almost 2.5 percentage points from last month to 78.66%, which in part is likely a reflection of a lot of people going out of date from a push 12 months ago. Though not alone in having experienced a notable drop since the start of the Financial Year, the 10 percentage points lost is the greatest loss.

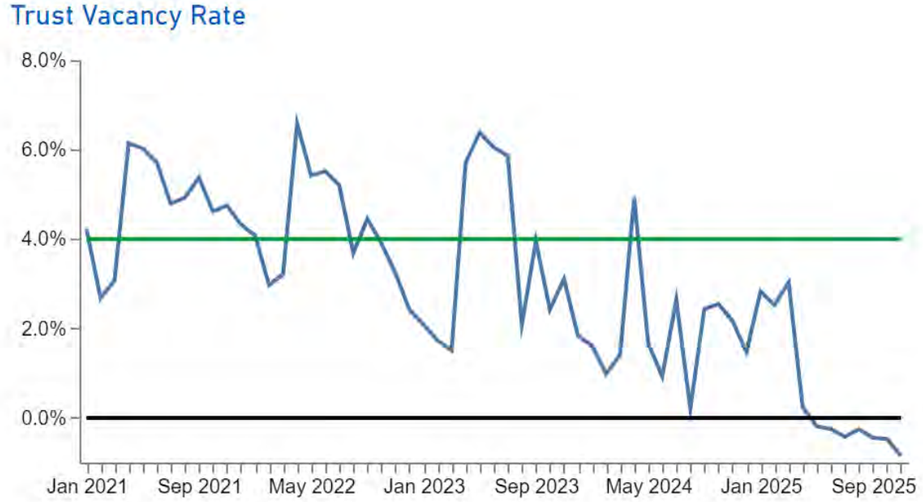
Countermeasures	Owner	Due Date
Surgery: department improvement plans submitted in October to be monitored in performance review meetings	Divisional tri	Jan 26
Medicine: Driver measures set and continue to be monitored at specialty level through PRM process. Additional appraisal capacity created in ED to support Medical Appraisal	People Partner	Ongoing
Estates and Facilities: A3's being carried out on departments which are failing to hit 90% compliance.	E&F Board/ People Partner	Ongoing
FaSS: Successfully completed and shared positive evaluation of group appraisal model which showed potential for improving team working and clarity of roles and sense of feeling valued. To roll out to other teams.	People Partner	April 2026

Risks and Mitigation
Risk of low compliance with appraisal is that some colleagues may not receive the support, recognition or performance review they need, and may miss opportunities to set / refresh objectives. Mitigations are that regular lone management activity is transacting some of this activity, albeit not in as coordinated a way. KPMG Audit is being used to improve performance. The quality and consistency of appraisals remain an important driver for improvement.

Vacancy

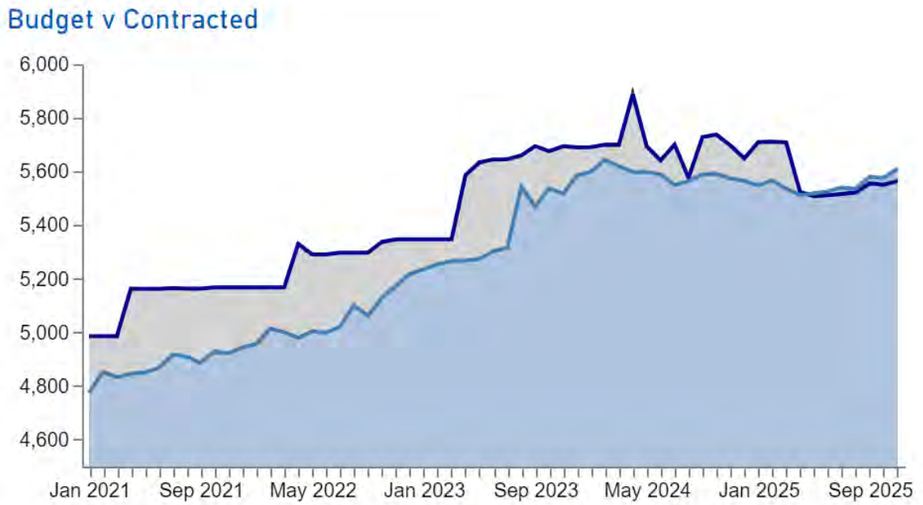
Royal United Hospitals Bath NHS Foundation Trust

Key Standard



-0.85%
Latest Vacancy Rate

4.00%
Target



5564.3
Latest Budget

5611.7
Latest Contracted

-47.4
Latest Vacancy

Understanding Performance
Unit 4 indicates that the Trust is over-established by 0.85% or 47.4 WTE. However, this overview masks the vacancies which exist in some areas such as: • At a directorate level, most directorates report fewer than 10 WTE vacancies. Exceptions are Emergency Medicine and Pathology (both 12.7 WTE). • Band 3 Clinical Support Workers (88.5 WTE) and Band 5 Nurses (64.1 WTE) have the highest vacancies when split by account code.

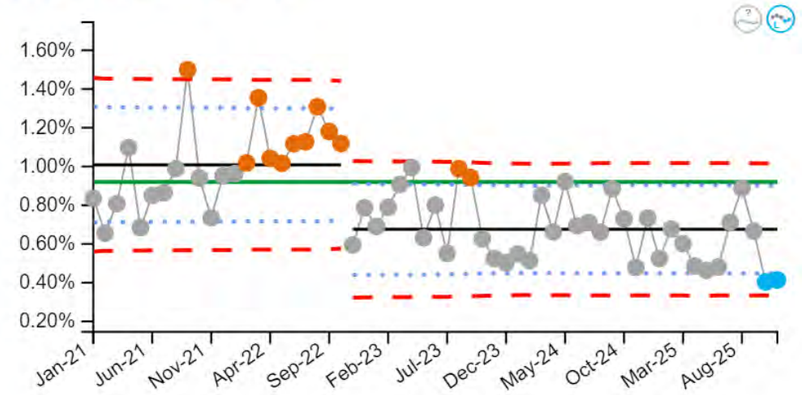
Countermeasures	Owner	Due Date
International Recruitment cohorts eligible for ILR will be supported to help the retention of this diverse workforce. Provision includes legal workshops to assist with application process and hardship funds	AD for Talent & Capacity	Open
ED Recruitment is being prioritised within the recruitment pipeline to support the staffing establishment and reduce reliance on temporary staffing	Head of Talent	Jan 26
Health Care Support Worker campaign closed in September recruiting 37WTE across all areas of the hospital. Start dates ranging from 15th December to 26th January 2026 to align with HCSW induction training.	Head of Talent	Feb 26

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

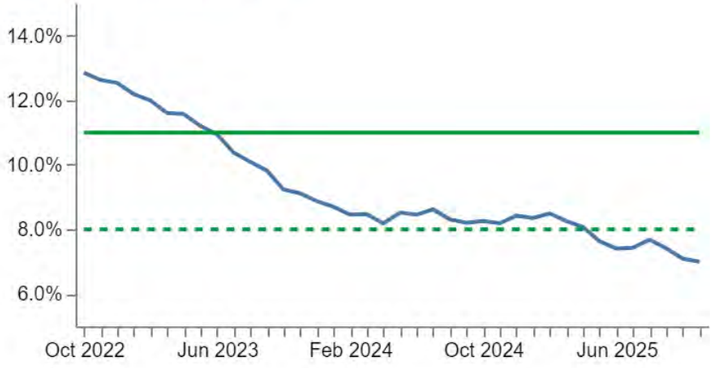
Trust In Month Turnover



0.41%
Latest In Month Turnover

0.92%
Target

Trust 12 Month Turnover



7.00%
Latest 12 Month Turnover

11.00%
Target

Division	In Month	12 Month
Capital Summary [Division]	2.75%	12.53%
Charity Summary [Division]	8.19%	29.18%
Corporate Division	0.70%	8.98%
Estates and Facilities Division	0.86%	6.71%
Family and Specialist Service Division	0.21%	8.33%
Medical Division	0.30%	6.08%
Research & Development [Division]	1.97%	9.80%
Surgical Division	0.48%	6.55%

Main Staff Group	In Month	12 Month
Add Prof Scientific and Technic	1.41%	14.29%
Additional Clinical Services	0.10%	9.65%
Administrative and Clerical	0.93%	9.15%
Allied Health Professionals	0.67%	9.41%
Estates and Ancillary	0.60%	6.75%
Healthcare Scientists	1.21%	10.73%
Medical and Dental	0.22%	1.99%
Nursing and Midwifery Registered	0.19%	4.20%

Understanding Performance

- In month turnover in November was broadly on par with that in October at 0.41%. It undercuts the rate in November 2024, resulting in 12-month turnover falling further to 7.00%.
- Main Divisions all have a turnover below 9%, with Estates and Facilities, Medicine and Surgery all below 7%. The healthiness of these low rates may be questioned and a barrier to achieving organisational objectives.
- Only the Add Prof Scientific and Technic and Healthcare Scientist staff groups have turnover above 10% over 12 months. However, a higher percentage is more easily achieved given their comparatively smaller size and the leavers WTE is respectively only 19.6 and 17.9.

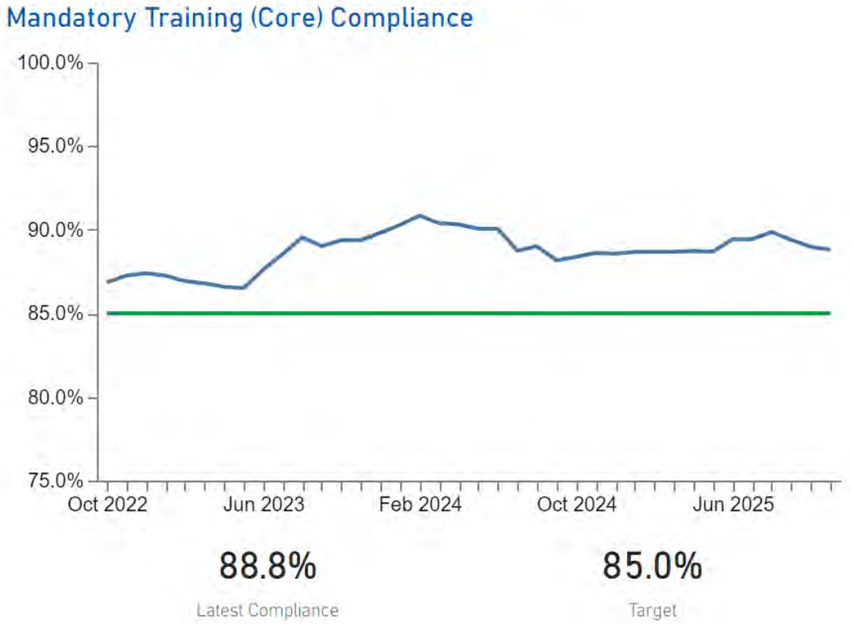
Countermeasures	Owner	Due Date
No counter measures in place due to 12- month turnover below target.		
Surgery: monitoring hot spots for turnover; Pain, Pathology and Surgery Management.	Divisional Tri	March 2026 – on going, on trac.

Risks and Mitigation

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

Mandatory Training

Key Standard



Understanding Performance
• Overall compliance has fallen negligibly to 88.8%. This is the third successive month where compliance has fallen; however, at this point it does not trigger a cause for concern and the 85% target is comfortably exceeded. • At Divisional level, only Capital Summary is not achieving target. Only 6 subject completions across the Division would achieve target; however, this would not guarantee all its Directorates would individually meet target. • Emergency Medicine is one of 6 directorates below the tolerance level. Its compliance has been drifting down over the past few months, likely reflecting its challenged position as a service, and now requires over 250 completions to achieve target. • Chief Executive is the other main Directorate where over 20 completions would be required to achieve target. • There is no significant change in terms of which subjects are below their targeted rate.

Countermeasures	Owner	Due Date
Surgery: even though training target met. Areas for improvement remain the same; resus, safeguarding and moving and handling. Importance to complete this training discussed at management board and planning to send those out of date to managers.	Divisional tri	December 2025
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/ DPP	Ongoing
Subjects proposed to move from annual to two yearly following review by MLOG – to be reviewed by Improvement and Insight committee (will impact on compliance levels).	Head of Corp Education	Re-commence Jan 2026
Resus as People Directorate Driver. A 3 being completed	Head of Resus	February 2026

Risks and Mitigation
Risk ID2791 Resus staffing, vacancies and sickness. Team have been delivering to a compliance of 50%. **Mitigations:** - 2.0 wte recruited and started in July 2025 - Resus risk established as PRM Driver Measure - Group level scoping ongoing to mitigate short term risks and seek sustainable long-term solution.

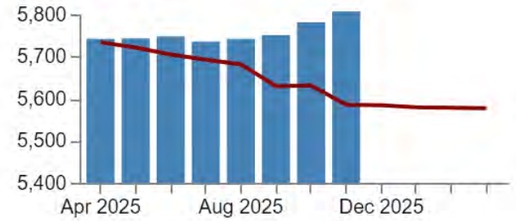
Performance vs Workforce Plan

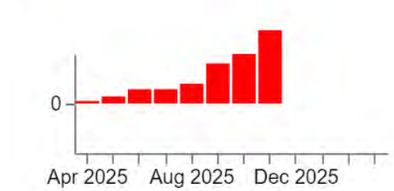
Royal United Hospitals Bath NHS Foundation Trust

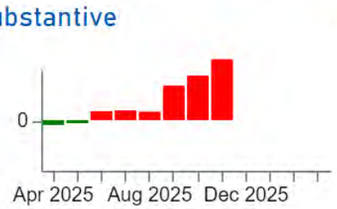
Driver

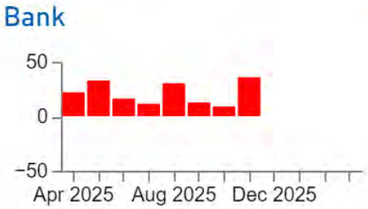
We are driving this metric because

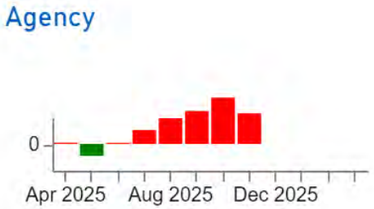
Achieving the Workforce Plan will be a key factor in achieving the financial savings required. Affording regular attention to progress against the plan will enable more timely intervention should deviation become apparent.











Plan

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

Actual

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Total	5,741.71	5,742.75	5,747.91	5,735.38	5,741.74	5,750.87	5,781.06	5,807.26				
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				
Bank	326.67	329.39	304.82	297.91	303.90	277.22	272.48	293.28				
Agency	6.23	3.76	6.20	8.60	10.80	11.15	13.68	10.71				

Understanding Performance
• Actuals (5,807.3) are +222 WTE vs plan (5,585.3), with the gap steadily widening month on month since April 25. • A combination of a planned reduction and actual growth has resulted in Substantive WTE now exceeding plan by 180.6 WTE. • Bank use remain above plan (+35.7 WTE). After reductions in September and October, usage increased in November, which is likely a reflection of increased sickness and the doctor's strike. • Agency use reduced slightly in November to 10.7 WTE but remain over 2 times the planned level.

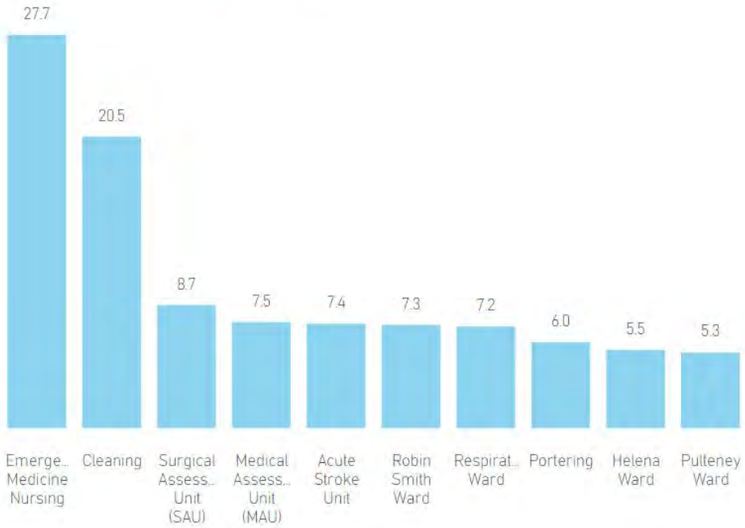
Countermeasures	Owner	Due Date
VCARP process has changed and become Executive led, this should lead to a reduction in bank usage. All controls remain in place	Exec Team	Ongoing
Turnaround Team are supporting cost controls across the organisation.	Exec Team	March 31st 2026
A revised end of year wte number has been devised based on the recurrent position the organisation feels it will begin 2026/2027.	Organisation Wide	March 31st 2026
Defined detailed plans are being worked through to reduce pay costs within 26/27	Organisation Wide	March 31st 2026
Sickness Reduction is going to have an even larger focus on it over the next 3 months and then next 3 years. This will have an impact on staff well being and in turn our usage of wte.	Organisation Wide	March 31st 2026 and March 31st 2029

Bank & Agency Use

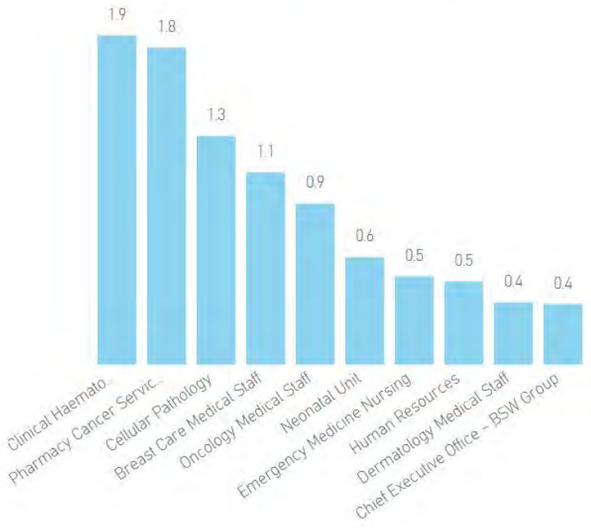
Royal United Hospitals Bath NHS Foundation Trust

Key Standard

Top Departments for Bank Use In Month



Top Departments for Agency Use In Month



PWR Staff Group Breakdown

PWR Staff Group	Bank WTE	Agency WTE
Medical and Dental	18.4	5.7
Registered/ Qualified Scientific, Therapeutic and Technical staff	11.0	1.8
Registered Nursing, Midwifery and Health Visiting Staff	99.8	1.1
NHS Infrastructure support	52.4	0.8
Support to Clinical Staff	111.5	

Understanding Performance

- Bank use remains above plan (+35.7 WTE) which is likely a reflection of increased sickness and the doctor's strike.
- Agency use reduced slightly in November to 10.7 WTE but remain over the planned level.
- Emergency Medicine continues to be the top user of bank (27.7 WTE). The slightly reduced level of use first seen in September has been sustained.
- Cleaning is the second highest user of bank (20.5 WTE). Although marginally up on last month the demand is relatively stable and consistent across the calendar year.
- Trust Agency use is predominantly within the Medical and Dental staff group (5.7 WTE). Although this represents a reduction on previous months and the lowest figure since June.

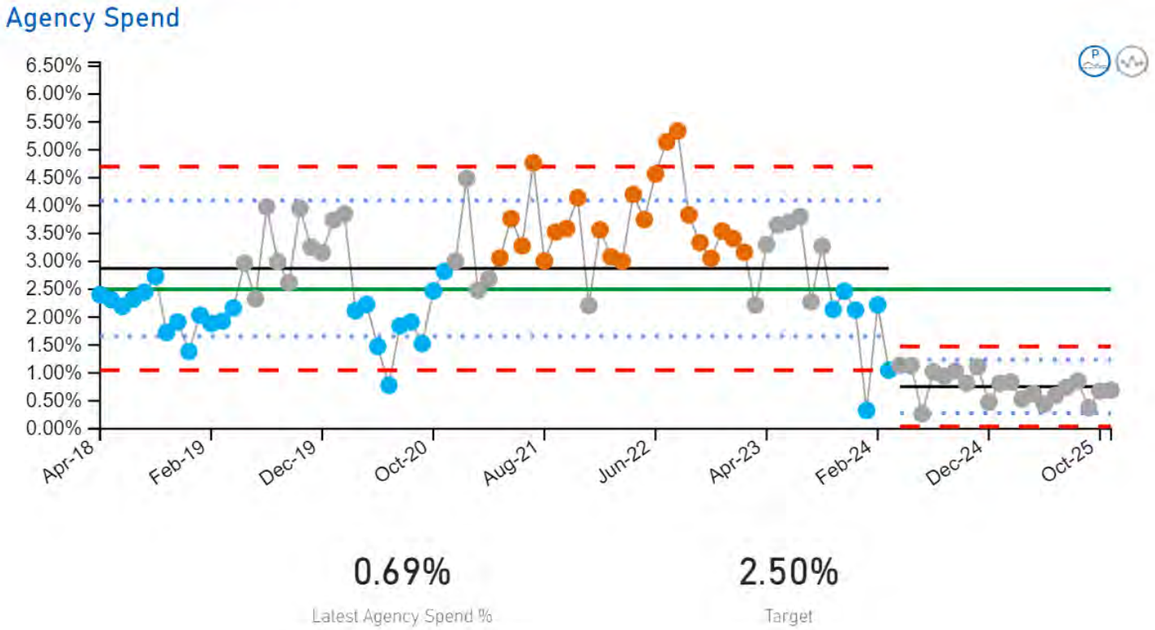
Countermeasures	Owner	Due Date
VCARP process has changed and become Executive led, this should lead to a reduction in bank usage. All controls remain in place.	*Exec Team*	*Open*
E&F- Cleaning posts being recruited into with around 15 new starters coming in Nov/Dec. This will reduce bank spend in cleaning. Focus on reducing sickness which will contribute to reduced need for bank cover.	Cleaning Team	Ongoing
FaSS: Ongoing efforts to recruit to essential clinical roles which have been hard to fill will reduce agency spend. Bespoke support from Talent Acquisition team.	People Partner	Ongoing

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
• Agency spend as a proportion of the total pay bill remains below target and within the expected range at 0.69%. • Agency use remains primarily driven by the need to cover hard to fill Medical and Dental Consultant roles especially in Oncology Medical and Cellular Pathology • Breast Care Medical staffing recorded an in-month spend exceeding £30k and continues to show consistent, moderate levels of agency use over recent months.

Countermeasures	Owner	Due Date
Temporary Staffing Team continues to source best value provision for hard to fill Medical and Dental roles whilst working with suppliers to ratchet down rates to reach compliance with South West Agency rate card	Temporary Staffing Team	Open
ED recruitment campaigns in place and trajectory set to reduce use of bank based on recruitment pipeline. The Recruitment team prioritising onboarding new joiners to support service delivery	Head of Talent	Open
Temporary Staffing Team secured longline agency booking for NICU via a framework at price cap to support service delivery. Exit strategy will align to cost reduction at end of December when mutual aid to NBT concludes	Temporary Staffing Manager	Jan 2026
Workforce planning and controls continue to drive a reduction in temporary staffing spend.	Exec Team	Open

Risks and Mitigation
Risk: Locum Oncology Medical Consultants are the top contributor for agency spend. **Mitigation**: Recruited 3 Oncology Consultants with start dates ranging from October 2025 to February 2026 supporting our exit strategy. Further work on capacity and demand via business planning

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

December 2025
(November Data)

The RUH, where you matter

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

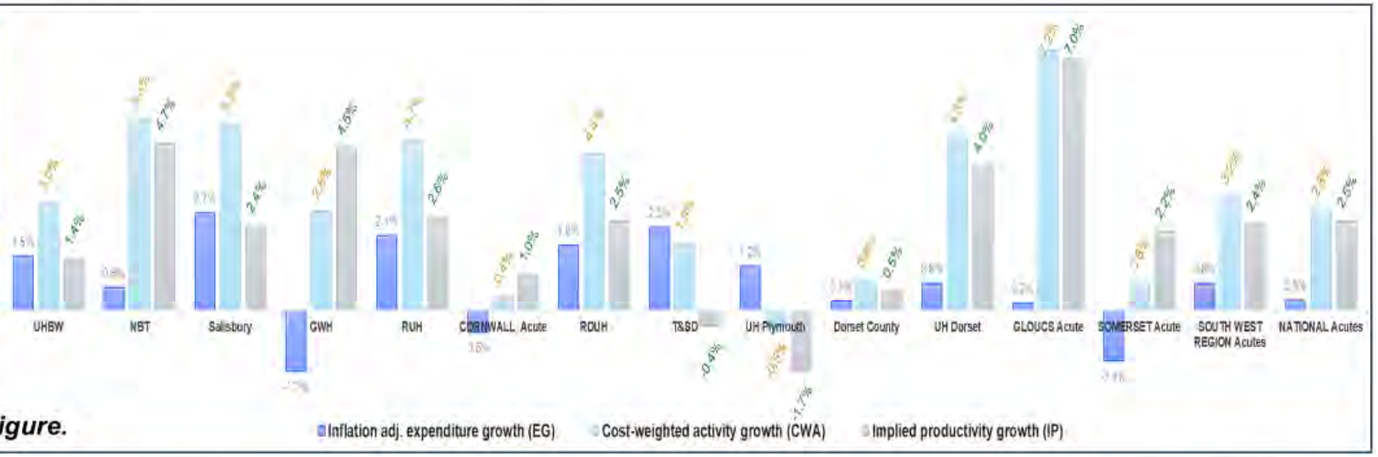
Royal United Hospitals Bath NHS Foundation Trust

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	

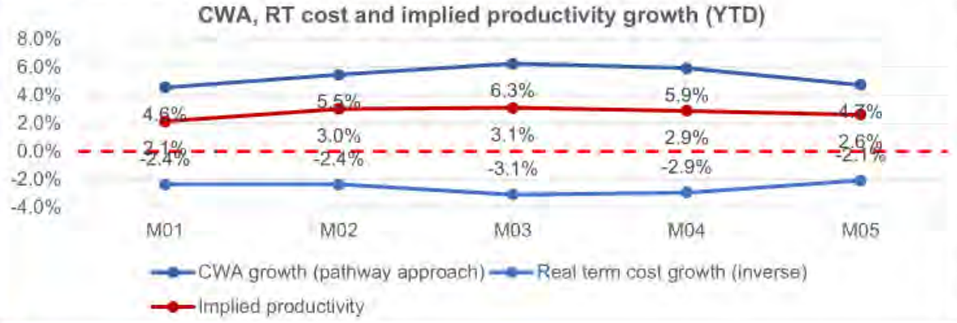
M5 2025/26	24/25 Comparison, unadjusted			Movement from M4, unadjusted		
	Inflation adj. expenditure growth	Cost weighted activity growth	Implied productivity growth	Inflation adj. expenditure growth	Cost weighted activity growth	Implied productivity growth
RUH	2.1%	4.7%	**2.6%**	-0.9%	-1.2%	**-0.3%**
BSW	0.9%	4.2%	**3.2%**	-0.6%	-0.7%	**-0.1%**
NHSE Acute Median	0.3%	2.8%	**2.5%**	-0.2%	0.1%	**0.4%**

Data are published by NHS England several months behind, M5 is the latest available figure.



Understanding Performance

Data for August 25 show an implied productivity growth of 2.6% compared to M5 24/25, this ranks as the fifth largest productivity increase in the South-West Region (of 13 providers). This is driven by cost weighted activity growth of 4.7% with an inflation adjusted expenditure growth of 2.1%. Compared to M4 25/26 implied productivity reduced by 0.3%. Cost weighted activity reduced by 1.2% and expenditure reduced by 0.9%.



Countermeasures	Owner	Due Date	Update
Delivery of Productivity improvements and cash releasing savings target set out in Operational Plan for 25/26	Savings programme SRO	Ongoing	
Develop metric to be based on real-time data 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	

Risks and Mitigation

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

Income & Expenditure Year to Date (NHSE Performance)

Royal United Hospitals Bath NHS Foundation Trust

I&E to October 2025	YTD											
	RUH			Sulis			Inter-Group			Total Group Position		
	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Actual £'m	Variance £'m
Commissioning Income	328.244	328.384	0.140	19.738	20.272	0.534	0.000	0.000	0.000	347.981	348.655	0.674
Clinical Education Income	13.928	13.108	(0.820)	0.000	0.000	0.000	0.000	0.000	0.000	13.928	13.108	(0.820)
Other Income	35.109	36.899	1.790	16.031	15.428	(0.603)	(2.662)	(2.650)	0.012	48.477	49.677	1.199
Pay	(236.733)	(244.870)	(8.137)	(16.529)	(17.256)	(0.727)	0.000	0.000	0.000	(253.263)	(262.127)	(8.864)
Non Pay	(110.765)	(122.029)	(11.264)	(16.423)	(15.533)	0.890	0.591	1.021	0.430	(126.597)	(136.541)	(9.944)
EBITDA	**29.782**	**11.491**	**(18.291)**	**2.816**	**2.911**	**0.094**	**(2.071)**	**(1.629)**	**0.442**	**30.527**	**12.772**	**(17.755)**
Depreciation & Amortisation	(15.671)	(15.486)	0.185	(2.185)	(2.232)	(0.047)	1.454	1.182	(0.272)	(16.403)	(16.536)	(0.133)
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	(6.248)	(5.947)	0.301	(0.355)	(0.416)	(0.062)	0.256	0.215	(0.041)	(6.347)	(6.148)	0.198
Surplus/(Deficit)	**(5.758)**	**(23.425)**	**(17.667)**	**0.276**	**0.262**	**(0.014)**	**(0.362)**	**(0.232)**	**0.130**	**(5.844)**	**(23.395)**	**(17.551)**
Donated/Grant Income	(5.844)	(7.485)	(1.641)	0.000	0.000	0.000	0.000	0.000	0.000	(5.844)	(7.485)	(1.641)
Adjusted Financial Performance	**0.086**	**(15.940)**	**(16.026)**	**0.276**	**0.262**	**(0.014)**	**(0.362)**	**(0.232)**	**0.130**	**0.000**	**(15.910)**	**(15.910)**

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 £15.9m. This is resulting from delays to delivery against the savings programme (£11.9m), deterioration in the exit run rate (£4.0), and operational pressures arising from increased spend on high cost drugs and devices (£1.1m), Resident Doctors budget pressures (£1.2m), pressures from pay awards (£0.3m) and July and November Strike Costs (£0.5m). This has been offset in part through non-recurrent technical adjustments (£1.1m) and increased controls (£2m).

Sulis is adverse to plan by £0.02m. CDC continues to make a loss with activity 94% of budget but total income was 118% of budget.

Countermeasures	Owner	Due Date
On-going: Acceleration of our saving plans that have been scoped for UEC, theatres, outpatients and corporate restructuring; converting plans into deliverables, opportunities into plans; as well as scoping of the un-identified savings requirement at Trust and BSW Hospitals Group level	Delivery Group SROs; Trust Management Executive, BSW Hospitals Group Joint Committee and BSW ICS Recovery Board	On-going
On-going: Maximising profit margin at Sulis CDC and Sulis Orthopaedic Centre, including the transfer of activity that flows to Sulis to maximise the use of capacity. **New target set at £1.5m surplus.**	System Delivery Director for Planned Care and Sulis Director	On-going
Minimising cost pressures arising from Winter Pressures and impact of Tiering Recovery Plans for Elective and Urgent Care	Chief Operating Officer	On-going
Delivery of activity based income and productivity margin on RTT Investment	Divisional Tris	On-going
Reducing bank spend across all staff groups, by 91wte compared to current usage	Divisional Tris & Corporate Departments	On-going

Recovery Summary

The headline is £1.8m deficit in the month, and £15.9m Year to date.

The do nothing run rate therefore remains at £24m deficit.

This position is £0.7m adverse to the recovery trajectory in month, and now £0.3m adverse to recovery trajectory year to date

The drivers of variance to trajectory in month are:

- £0.3m Industrial Action costs
- £0.3m BSW High Cost Drugs not mitigated
- £0.1m other variances

Once again the position had income ahead of plan at RUH and Sulis.

There is a growing risk of commissioner affordability and non payment, although could be mitigated by additional RTT sprint funds in Q4

This is offset by Pay and Non pay expenditure has broadly flat-lined and s not reducing at required rate.

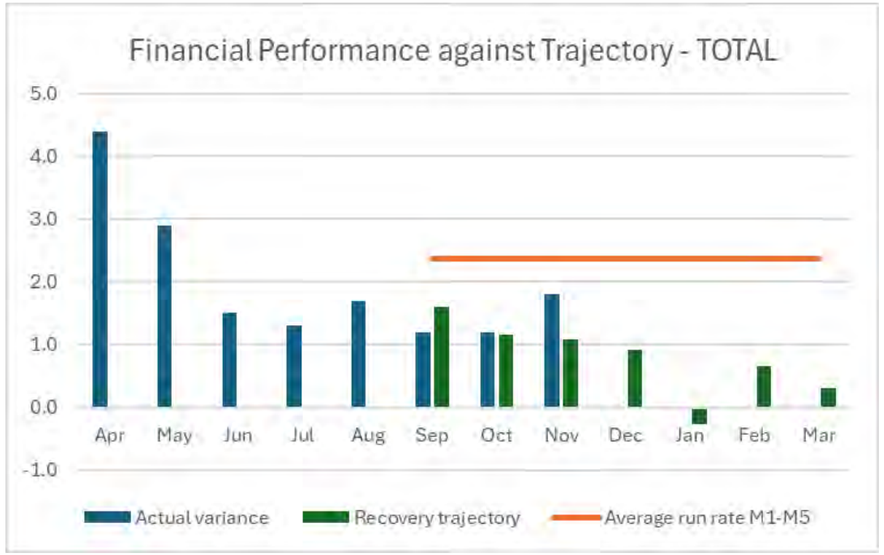
Disappointingly in reaching this position a number of backdated costs, stock adjustment and income recording issues, totalling £1m arose in month; and therefore £1m of balance sheet efficiency, including opportunities identified Finance and Hunter team work programme have had to be transacted this month.

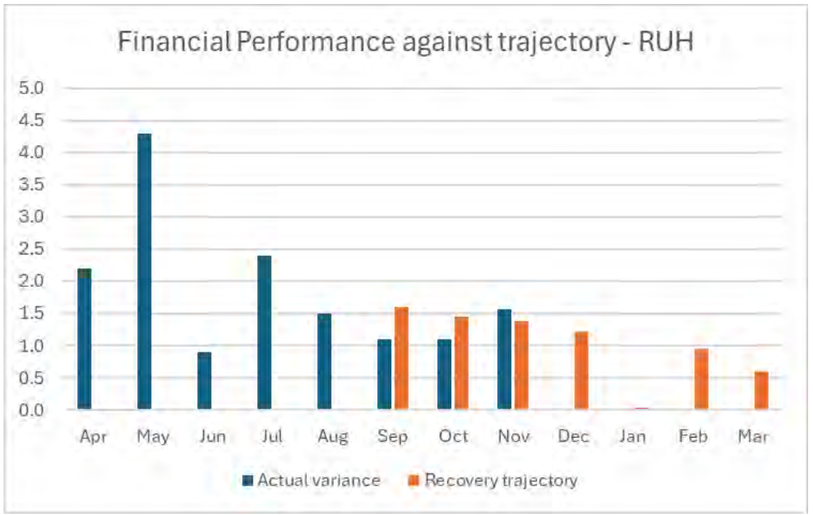
Divisional Position against Control Total Trajectory

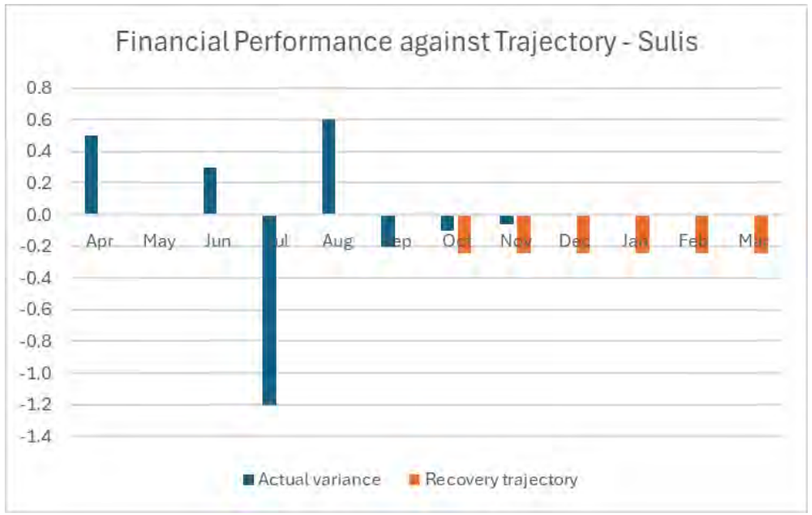
Variance to Forecast by Division - Nov 25	In Month RUH				Year to Date RUH			
	Forecast	Actual	Variance	Variance	Forecast	Actual	Variance	Variance
	£'m	£'m	£'m	%	£'m	£'m	£'m	£'m
Commissioning Income	41.108	41.606	0.498		327.303	328.384	1.081	
Surgery	(11.139)	(11.484)	(0.345)	-3.1%	(90.484)	(91.012)	(0.528)	-0.6%
Medicine	(14.193)	(14.838)	(0.645)	-4.5%	(112.086)	(113.374)	(1.288)	-1.1%
FASS	(8.715)	(9.101)	(0.386)	-4.4%	(68.934)	(69.679)	(0.745)	-1.1%
E&F	(2.845)	(2.666)	0.179	6.3%	(22.196)	(21.715)	0.481	2.2%
Corporate	(4.012)	(3.798)	0.213	5.3%	(32.647)	(32.666)	(0.019)	-0.1%
HIWE	0.000	0.000	0.000		0.000	(0.000)	(0.000)	
R&D	(0.000)	(0.000)	(0.000)		(0.000)	(0.000)	(0.000)	
0	**0.205**	**(0.282)**	**(0.487)**		**0.956**	**(0.062)**	**(1.018)**	
Sulis	**0.268**	**0.058**	**(0.210)**		**0.507**	**0.262**	**(0.245)**	
Reserves, Capital Charges and Profiling	**(1.573)**	**(1.546)**	**0.028**		**(17.063)**	**(16.110)**	**0.952**	
Adjusted Financial Performance - Group	**(1.100)**	**(1.770)**	**(0.669)**		**(15.600)**	**(15.910)**	**(0.310)**	

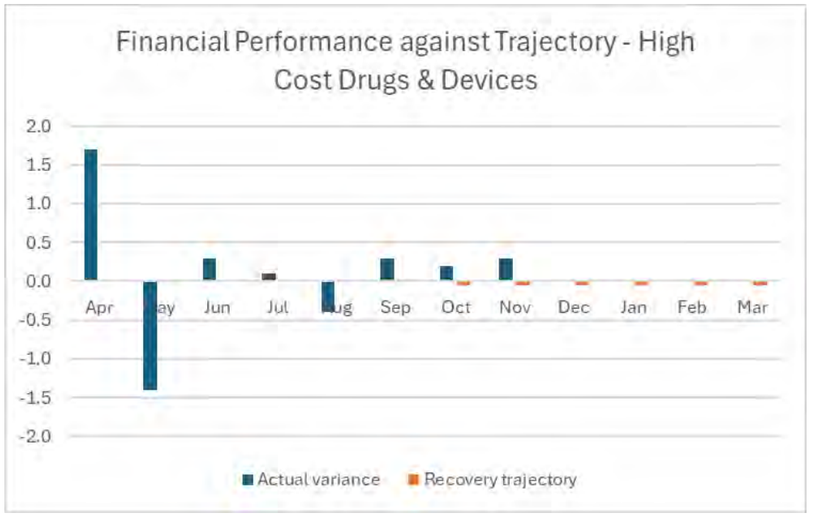
Key Drivers		
November Industrial Action	(0.250)	(0.250)
BSW High Cost Drugs & Devices growth against run rate	(0.400)	(0.900)
Sulis Recovery	(0.210)	(0.245)
Other	0.191	1.085
	(0.669)	**(0.310)**

Graphs against Control Total Trajectory





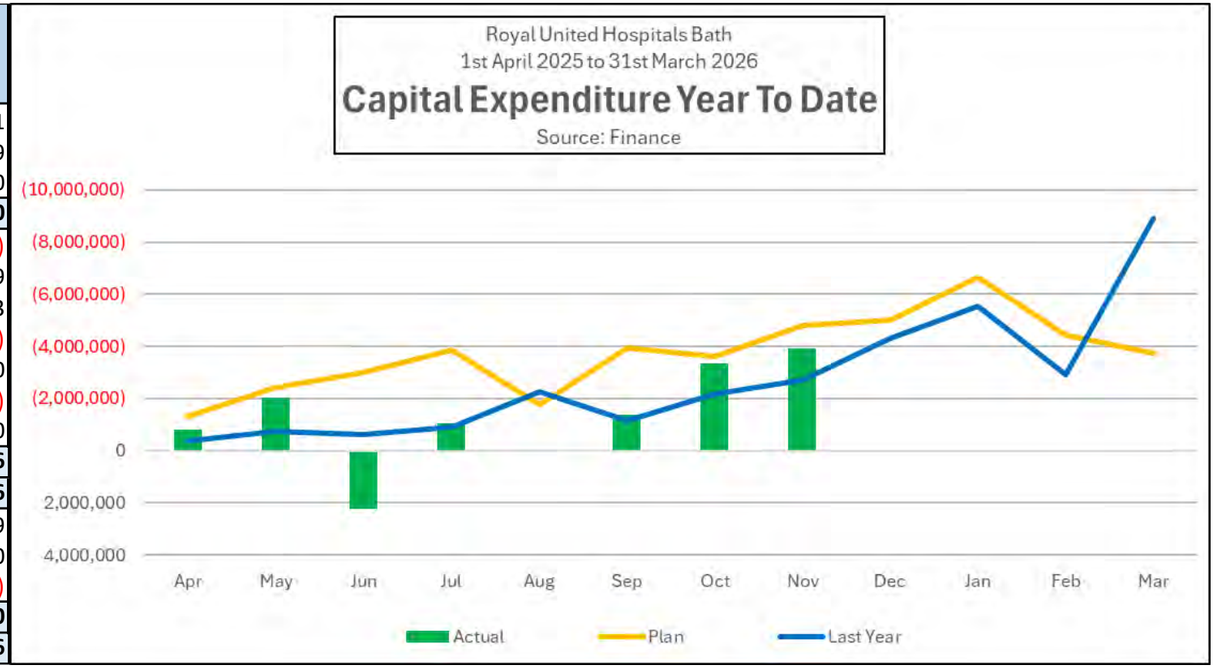




Capital – Operational, Grant & Donated

Royal United Hospitals Bath NHS Foundation Trust

Position as at 30th November 2025	Annual Plan £'m	Forecast Outturn £'m	YTD Plan £'m	YTD Actuals £'m	YTD Variance £'m
Decarbonisation	(3.135)	(3.135)	(1.546)	(0.095)	1.451
BSW EPR	(2.865)	(1.599)	(0.599)	0.000	0.599
Sulis Lease	(0.953)	(0.953)	0.000	0.000	0.000
Strategic Schemes Total	**(6.953)**	**(5.687)**	**(2.145)**	**(0.095)**	**2.050**
IT	(1.750)	(1.650)	(0.992)	(1.139)	(0.147)
Medical Equipment (MEC)	(1.910)	(1.548)	(0.521)	(0.182)	0.339
Estates, CRG & Projects	(1.700)	(2.259)	(1.272)	(0.969)	0.303
Sulis	(0.250)	(0.395)	(0.136)	(0.272)	(0.136)
Right of Use Leases	(0.300)	(0.760)	(0.150)	0.000	0.150
Minor	0.543	0.491	0.592	0.519	(0.073)
Lease Provision release (Modular Theatre)	(0.547)	(0.547)	0.000	0.000	0.000
Other Schemes Total	**(5.914)**	**(6.668)**	**(2.479)**	**(2.043)**	**0.436**
TOTAL : Operational Capital	**(12.867)**	**(12.355)**	**(4.624)**	**(2.138)**	**2.486**
Decarbonisation (Salix)	(10.820)	(10.820)	(8.947)	(6.678)	2.269
PET-CT	(2.000)	0.000	(0.200)	0.000	0.200
Minor donated schemes	(0.300)	(0.300)	(0.200)	(0.290)	(0.090)
TOTAL : Donated & Grant Funded	**(13.120)**	**(11.120)**	**(9.347)**	**(6.967)**	**2.380**
OVERALL TOTAL	**(25.987)**	**(23.475)**	**(13.971)**	**(9.105)**	**4.866**



Understanding Performance

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

Committed capital has been reviewed with capital leads, a paper presented at the June TME, which agreed to hold back £1.745 million of uncommitted spend, the largest of this is the CT replacement. Capital leads and finance are reviewing if any spend can now be brought forward.

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 for in-year is £1.3 million underspend against allocation in year, underspends will impact CDEL available to the Trust in 2026/27.

Countermeasures	Owner	Due Date
Not Actioned: EPR project 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	June 25
Completed: Due to the adverse revenue position capital expenditure not contractually committed or is mandated has been held.	CPMG	Complete
Not Actioned: EPR project team are undertaking a review of the programme with several options being considered. The operational & financial implications of the outcome of review will need to be mitigated	EPR Board	Nov 2025

Risks and Mitigation

Multi-Year EPR forecast outturn at end of project is a £1.0 million overspend against approved FBC. This could increase further pending the review of the programme and option chosen.

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.

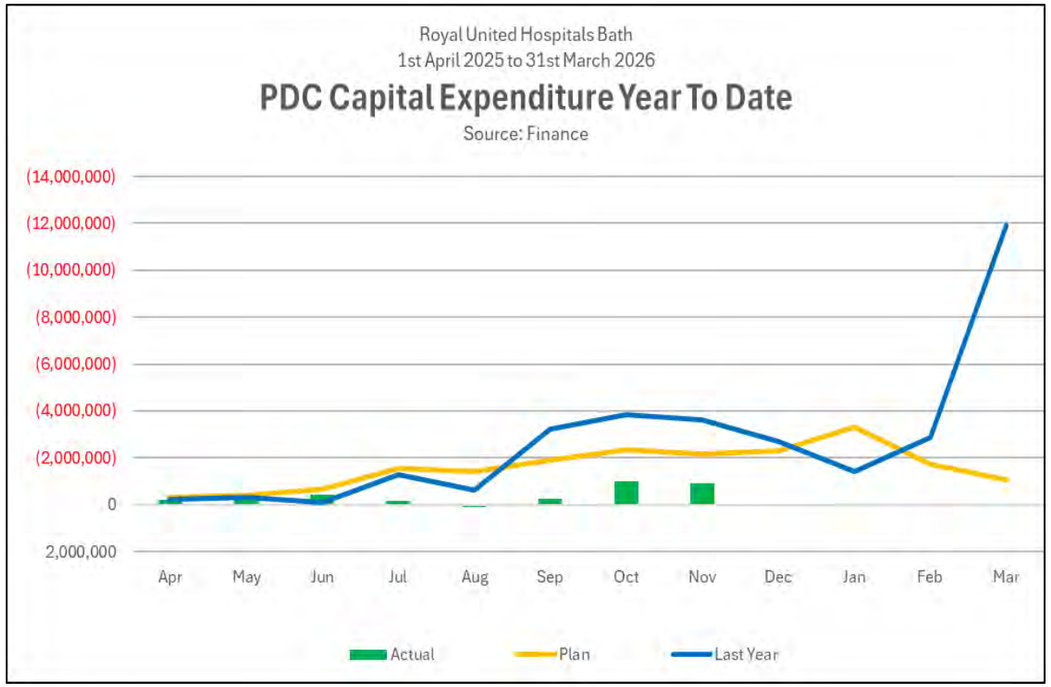
Salix grant funding agreement states it is to utilised by 31st March. Due to delay in programme notified by the contractor, the project team have obtained agreement from Salix to defer the commission funding to next year. Any slippage in the tight programme risks further costs slippage for which funding 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 30th November2025		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)	(2.301)	0.654	Approved, MOUs signed
Other Schemes : Solar Energy, RAAC Removal & Pathology		(0.566)	(0.566)	(0.350)	(0.092)	0.258	Approved, MOUs signed
Total Other		**(3.521)**	**(3.521)**	**(3.305)**	**(2.393)**	**0.912**	
Estates:	Fire Safety Programme	(1.890)	(1.890)	(1.062)	(0.077)	0.986	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)	0.000	(0.012)	(0.012)	
	Chiller Replacement (Pathology)	(0.720)	(0.720)	(0.325)	(0.004)	0.321	
	Maternity Estates Safety Schemes	(0.718)	(0.718)	(0.372)	(0.014)	0.358	
	Other Estates Safety schemes	(1.936)	(1.936)	(0.541)	(0.159)	0.381	
Total Estates Safety		**(6.164)**	**(6.164)**	**(2.300)**	**(0.267)**	**2.033**	
Diagnostics:	MRI replacement	(1.448)	(2.323)	(0.300)	(0.008)	0.292	We have had approval for the UEC schemes, MRI software & Sulis MRI replacement schemes. The Elective schemes have been withdrawn due to revenue implications. Approval is still pending for the CDC expansion & Trowbridge 4th site, these schemes are still under review with the Regional team and have not yet been submitted to the national team for approval
	MRI Acceleration software	(0.143)	(0.143)	(0.143)	0.000	0.143	
	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)	(0.500)	(0.450)	(0.037)	0.413	
	CDC 4th Site Trowbridge Design works to RIBA stage 4	(0.024)	(0.263)	(0.024)	(0.015)	0.009	
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	(0.400)	0.000	0.400	
UEC:	Admisson & Transfer Lounge	(1.700)	(1.700)	(0.400)	(0.103)	0.297	
	Medical Short Stay expansion	(0.850)	(0.850)	(0.400)	(0.042)	0.358	
	Integrated front Door / SDEC (Seed Funding)	(0.300)	0.000	(0.180)	0.000	0.180	
	Neurology Ward reconfiguration and relocation	(3.100)	(3.100)	(1.450)	(0.175)	1.275	
	IPC Programme	(1.350)	(1.350)	(0.800)	(0.024)	0.776	
	SDEC digital enabling	(0.400)	0.000	(0.400)	0.000	0.400	
Total Constitutional Standards		**(12.034)**	**(10.348)**	**(5.317)**	**(0.414)**	**4.903**	
TOTAL : PDC Funded		**(21.719)**	**(20.033)**	**(10.922)**	**(3.074)**	**7.848**	



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 As at October 2025	M8 FY 2025-26 30/11/2025 £'m	FY 2024-25 31/03/2025 £'m	Variance £'m	% Variance
Non current assets				
Intangible assets	6.732	7.096	(0.364)	(5.130)%
Property, Plant & Equipment	320.787	330.248	(9.461)	(2.865)%
Right of use assets - leased assets for lessee	46.976	49.730	(2.754)	(5.538)%
Investments in associates and joint ventures	3.941	3.941	0.000	0.000%
Trade and other receivables	7.704	5.184	2.520	48.611%
Total non current assets	**386.140**	**396.199**	**(10.059)**	**(2.539)%**
Current Assets				
Inventories	6.532	6.782	(0.250)	(3.686)%
Trade and other receivables	34.798	30.746	4.052	13.179%
Cash and cash equivalents	25.365	36.648	(11.283)	(30.787)%
Total current assets	**66.695**	**74.176**	**(7.481)**	**(10.085)%**
Current Liabilities				
Trade and other payables	(51.139)	(61.625)	10.486	(17.016)%
Other liabilities	(17.897)	(8.634)	(9.263)	107.285%
Provisions	(0.297)	(0.932)	0.635	(68.133)%
Borrowings	(2.230)	(2.530)	0.300	(11.858)%
Total current liabilities	**(71.563)**	**(73.721)**	**2.158**	**(2.927)%**
Total assets less current liabilities	**381.272**	**396.654**	**(15.382)**	**(3.878)%**
Non current liabilities				
Provisions	(9.895)	(1.315)	(8.580)	652.471%
Borrowings	(53.176)	(54.896)	1.720	(3.133)%
Total assets employed	**318.201**	**340.443**	**(22.242)**	**(6.533)%**
Financed by:				
Public Dividend Capital	286.889	285.705	1.184	0.414%
Income and Expenditure Reserve	(9.768)	13.658	(23.426)	(171.519)%
Revaluation reserve	41.080	41.080	0.000	0.000%
Total equity	**318.201**	**340.443**	**(22.242)**	**(6.533)%**

Understanding Performance

Non-current assets – Top contributor is property, plant and equipment with a net variance of £9.461m. The variance is made of capital spend, depreciation charged year to date, impairment and lease restoration provisions.

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

The key contributor to the increase in receivables is income accruals in non-NHS debtors.

Current liabilities – Top contributor is trade and other payables with a net movement of £10.49m. Key variance is the payment of capital creditors £5.19m and non-capital creditors £8.05m.
Other liabilities show a net year-to-date movement of £9.2m, transitional funding was received in advance and been deferred, along with quarterly invoices raised earlier than scheduled.

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

Total equity – The decline in reserves 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.

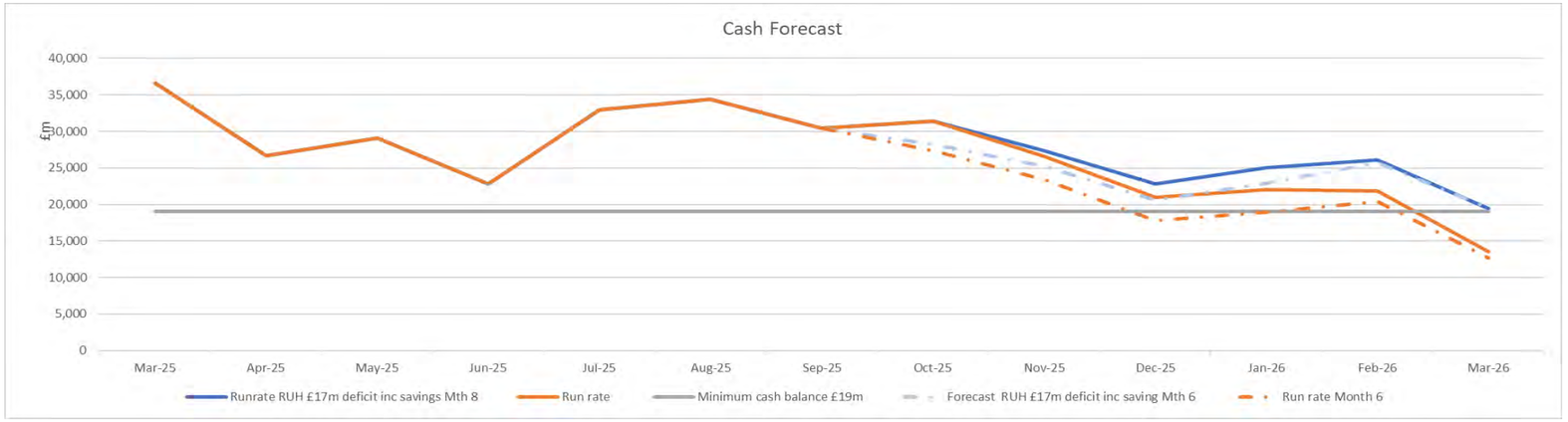
Risks relating to receivables, payables, BPPC and cash have been set out in their respective slides.

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 and Recovery Director	Monthly monitoring
Payables – This will continue to be monitored, however, there are close links to non pay saving plans.	Head of Financial Services	Monthly Monitoring
Equity – Monthly position will be monitored by the finance team; however, equity will be impacted by the level of the saving plan that is achieved.	Operational Finance Director & Manager Director	Monthly Monitoring

Cash

Royal United Hospitals Bath NHS Foundation Trust

Statements of Cash Flows	Actual £'m
EBITDA deficit	(1.991)
Income recognised in respect of capital donations (cash and non-cash)	(6.967)
Impairments	13.482
Working capital movement	(6.035)
Provisions	(0.635)
Net cash generated from operating activities	**(2.146)**
Capital Expenditure	(8.476)
Cash receipts from asset sales	0.024
Donated cash for capital assets	2.530
Interest received	1.204
Net cash used in investing activities	**(4.718)**
Public dividend capital received	1.184
Capital element of finance lease rental payments	(0.874)
Interest on loans	(0.057)
Interest element of finance lease	(1.192)
PDC dividend (paid)/refunded	(3.479)
Net cash used in financing activities	**(4.417)**
Decrease in cash and cash equivalents	**(11.282)**
Opening cash balance	36.648
Closing cash balance	**25.366**
Adjusted for petty cash	(0.004)
Adjusted closing cash balance	**25.362**



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.

Understanding Performance

From the graph above, the actual cash balance was £6.52m lower than the planned cash balance submitted for 2025/26.

Key drivers:

1. System revenue support of £1.44m was not received as anticipated.
2. Capital PDC inflow was £3.08m below forecast.
3. Other operating income was £1.25m less than expected.
4. The anticipated capital payment of £2.42m did not occur.
5. BACs payments were £1.33m higher than forecast.
6. Planned savings of £2.72m 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.

Royal United Hospitals Bath
NHS Foundation Trust

Trust Scorecard - December 2025

(November 2025 Data)

The RUH, where you matter

Interpreting summary icons

These icons provide a summary view of the important messages from SPC charts.

	Variation / performance Icons		
Icon	**Technical description**	**What does this mean?**	**What should we do?**
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
H L	Special cause variation of a CONCERNING nature.	**Something's going on!** Something, a one-off or a continued trend or shift of numbers in the wrong direction	**Investigate** to find out what is happening / has happened. Is it a one off event that you can explain? Or do you need to change something?
H L	Special cause variation of an IMPROVING nature.	**Something good is happening!** Something, a one-off or a continued trend or shift of numbers in the right direction. Well done!	Find out what is happening / has happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Assurance icons		
Icon	**Technical description**	**What does this mean?**	**What should we do?**
?	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
F	This process is not capable and will consistently FAIL to meet the target.	If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
P	This process is capable and will consistently PASS the target if nothing changes.	If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Vision Metrics

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	% Key national standards met in the month		100.0%		Nov-25	22.2%	X			
People we care for	% of positive responses to friends and family test	Improve the experience of those who use our service			Nov-25	97.3%				Special Cause Improving - Above Upper Control Limit
People we work with	% Recommend RUH as a place to work	From the quarterly Pulse survey	70.0%		Jul-25	52.4%	X			
People we work with	% staff reporting they have personally experienced discrimination at work from manager, team leader or other colleagues	From the quarterly Pulse survey			Jul-24	16.7%				
People we work with	% staff say the organisation acts fairly with regard to career progression/promotion	From the quarterly Pulse survey			Jul-24	50.1%				
People in our community	% difference in RTT performance between IMD 1-2 and IMD 9-10		0.0%		Nov-25	-2.0%	X			Special Cause Improving - Run Above Mean
People in our community	Delivery of Breakeven Position YTD	Variance from Plan YTD	£0.00m	£0.00m	Nov-25	-£16.01m	X			

National KPIs

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	% 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%	Nov-25	57.7%	✗	F		Common Cause Variation
People we care for	28 day referral to informed of diagnosis of all cancers		80.0%	80.0%	Oct-25	64.6%	✗	F		Common Cause Variation
People we care for	Average Handover Time for All Arrivals (mins)	Average ambulance handover time (mins)	33		Nov-25	32	✓	F	L	Special Cause Improving - Below Lower Control Limit
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%	Oct-25	91.9%	✓	?		Common Cause Variation
People we care for	Combined 62 day cancer targets for GP referral, screening and consultant upgrade		75.0%	75.0%	Oct-25	63.5%	✗	?		Common Cause Variation
People we care for	Diagnostic tests maximum wait of 6 weeks		95.0%	95.0%	Nov-25	71.0%	✗	F		Common Cause Variation
People we care for	RTT - Incomplete Pathways in 18 weeks		63.1%	95.0%	Nov-25	63.0%	✗	?		Common Cause Variation
People we care for	RTT - Incomplete Pathways over 52 weeks		1.0%		Nov-25	1.4%	✗	F	L	Special Cause Improving - Two Out of Three Low
People we care for	RTT – wait to 1st OP appointment	% patients waiting <18 weeks for their first OP appt	72.0%	72.0%	Nov-25	66.4%	✗	F		Common Cause Variation

Breakthrough Objectives

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	100% Ambulances waiting <30 mins	Average ambulance handover time (mins)	33		Nov-25	32	✓	F	L	Special Cause Improving - Below Lower Control Limit
People in our community	YTD % change in productivity compared to 24/25	Increase in cost weighted activity minus increase in inflation adjusted expenditure			Jun-25	2.8%				

Note: one Breakthrough Objective is currently not reported above.

- % staff say the organisation values their work - *Workforce team have advised that this question has not been asked on the quarterly pulse survey in the last year, so there is no regular data that can be included on this report.*

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%		Nov-25	23.6%	X	F		Common Cause Variation
People we care for	% No criteria to reside Adult G&A occupied beds		10.0%		Nov-25	19.3%	X	F		Common Cause Variation
People we care for	% of patients waiting >12hrs in ED		0.0%		Nov-25	8.7%	X	F		Common Cause Variation
People we care for	A&E Arrivals - Ambulance (av per day)				Nov-25	90			H	Special Cause Concerning - Above Upper Control Limit
People we care for	Adult % G&A bed occupancy		92.0%		Nov-25	97.0%	X	F		Common Cause Variation
People we care for	Mean time in ED - >75y				Nov-25	511			H	Special Cause Concerning - Two Out of Three High
People we care for	Non Elective Length of Stay		8.4		Nov-25	8.5	X	?	L	Special Cause Improving - Run Below Mean
People we care for	Number of 65 week waiters incomplete pathways			0	Nov-25	33	X			Common Cause Variation

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				Nov-25	79.7%				Common Cause Variation
People we care for	% with Discharge Summaries Completed within 24 Hours				Nov-25	84.9%				Common Cause Variation
People we care for	A&E Arrivals - Walk ins (av per day)				Nov-25	206				Common Cause Variation
People we care for	Mean time in ED - Admitted (mins)				Nov-25	498				Common Cause Variation
People we care for	Mean time in ED - Mental health				Nov-25	320				Common Cause Variation
People we care for	Mean time in ED - Not Admitted (mins)				Nov-25	225				Common Cause Variation
People we care for	Number of 52 Week Waiters Incomplete Pathways				Nov-25	545				Special Cause Improving - Two Out of Three Low
People we care for	RUH hospital at home team occupancy	Average occupancy	62.0		Nov-25	66.2	✓			Special Cause Improving - Above Upper Control Limit
People we care for	Weekend discharge %				Nov-25	22.0%				Common Cause Variation

Watch Metrics - Quality - Alerting

Strategic Goal	Measure	Measure Description	Local Year-End Target	National Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
People we care for	% complaints responded to within agreed timescales with the complainant		90.0%		Nov-25	78.4%	✗	?		Common Cause Variation
People we care for	% of ED admissions <60mins from CRtP		80.0%	80.0%	Nov-25	77.6%	✗	?	H	Special Cause Improving - Two Out of Three High
People we care for	Medication Incidents per 1000 bed days		7.0		Nov-25	7.7	✗	?		Common Cause Variation
People we care for	Number of complaints received		30		Nov-25	37	✗	?		Common Cause Variation
People we care for	Number of reopened complaints each month		3		Nov-25	5	✗	?		Common Cause Variation
People we care for	Readmissions - Total		10.5%		Oct-25	10.1%	✓	P	H	Special Cause Concerning - Above Upper Control Limit
People we care for	SHMI				Jul-25	108.0%			H	Special Cause Concerning - Above Upper Control Limit
People we care for	Total monthly fill rate, day hours, HCA		90.0%		Nov-25	88.7%	✗	F	H	Special Cause Improving - Above Upper Control Limit
People we care for	Total monthly fill rate, day hours, RN		90.0%		Nov-25	82.4%	✗	?	L	Special Cause Concerning - Two Out of Three Low
People we care for	Total monthly fill rate, night hours, RN		90.0%		Nov-25	91.7%	✓	?	L	Special Cause Concerning - Run Below Mean
People in our community	% Difference in 28 Day Diagnosis Performance between IMD 1-2 vs IMD 9-10		0.0%		Oct-25	-1.0%	✗	?		Common Cause Variation
People in our community	% Difference in DNA rates between IMD1-2 and IMD 9-10		0.0%		Nov-25	4.3%	✗	F		Common Cause Variation

Watch Metrics - Quality - Non-Alerting

Strategic Goal	Measure	Measure Description	Local Year-End Target	National Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
People we care for	% of ED patients assessed <15mins				Nov-25	68.9%			H	Special Cause Improving - Above Upper Control Limit
People we care for	Clostridium Difficile Rate	Hospital or Community Onset, Healthcare Associated, per 100,000 beddays			Oct-25	43.09				Common Cause Variation
People we care for	Concerns are acknowledged within 2 working days		90.0%		Nov-25	97.0%	✓	P		Common Cause Variation
People we care for	E.coli bacteraemia Rate	Hospital or Community Onset, Healthcare Associated, per 100,000 beddays			Oct-25	36.93				Common Cause Variation
People we care for	Early Identification of Deteriorating Patient	NEWS 5+ Screening Completed in 30 - Trust (%)			Nov-25	27.2%				Common Cause Variation
People we care for	Flu - Healthcare Onset (+3 days)				Nov-25	10				Common Cause Variation
People we care for	Klebsiella spp Rate	Hospital or Community Onset, Healthcare Associated, per 100,000 beddays			Oct-25	30.78				Common Cause Variation
People we care for	Mixed Sex Accommodation Breaches				Nov-25	158			L	Special Cause Improving - Run Below Mean
People we care for	MRSA Bacteraemias Rate	Hospital or Community Onset, Healthcare Associated, per 100,000 beddays			Oct-25	0.00			L	Special Cause Improving - Below Lower Control Limit
People we care for	MSSA Rate	Hospital or Community Onset, Healthcare Associated, per 100,000 beddays			Oct-25	30.78				Common Cause Variation
People we care for	Never events		0		Nov-25	0	✓	F	L	Special Cause Improving - Below Lower Control Limit
People we care for	Number of Hospital Acquired Pressure Ulcers Category 2		5		Nov-25	4	✓	?		Common Cause Variation
People we care for	Number of Hospital Acquired Pressure Ulcers Category 3		4		Nov-25	3	✓	P		Common Cause Variation
People we care for	Number of Hospital Acquired Pressure Ulcers Category 4				Nov-25	0			L	Special Cause Improving - Below Lower Control Limit
People we care for	Pseudomonas aeruginosa Rate	Hospital or Community Onset, Healthcare Associated, per 100,000 beddays			Oct-25	6.16				Common Cause Variation
People we care for	Scanning Compliance for patients being given medication				Nov-25	60.9%			H	Special Cause Improving - Above Upper Control Limit
People we care for	Serious incidents with overdue actions		5		Nov-25	5	✓	?		Common Cause Variation
People we care for	Total monthly fill rate, night hours, HCA		90.0%		Nov-25	103.9%	✓	?	H	Special Cause Improving - Above Upper Control Limit
People in our community	Delivery of Financial Control Total	Variance from Revised Plan		0	Nov-25	-16026	✓			
People in our community	Reduction in Agency Expenditure	Agency as % of Total Pay			Nov-25	0.7%			L	Special Cause Improving - Below Lower Control Limit

Watch Metrics - Workforce - 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 work with	% Staff with annual appraisal		90.0%		Nov-25	78.5%	✗			Common Cause Variation
People we work with	Information Governance Training Compliance		85.0%		Nov-25	85.3%	✓			Special Cause Concerning - Two Out of Three Low
People we work with	Sickness Rate		3.5%		Oct-25	5.1%	✗			Special Cause Concerning - Above Upper Control Limit

Watch Metrics - Workforce - 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 work with	Mandatory Training Compliance		85.0%		Nov-25	88.8%	✓	P		Common Cause Variation
People we work with	Turnover - Rolling 12 months		11.0%		Nov-25	7.0%	✓	P	L	Special Cause Improving - Below Lower Control Limit
People we work with	Vacancy Rate		4.0%		Nov-25	-0.5%	✓	?	L	Special Cause Improving - Below Lower Control Limit

Watch Metrics - Finance - Alerting

Strategic Goal	Measure	Measure Description	Local Year-End Target	National Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
People in our community	30 days payment performance for all non-NHS invoices	Percentage of bills paid within target			Nov-25	86.0%				Special Cause Concerning - Below Lower Control Limit
People in our community	30 days payment performance for NHS invoices	Percentage of bills paid within target			Nov-25	62.0%				Special Cause Concerning - Below Lower Control Limit
People in our community	Delivery of capital programme		5.0%		Nov-25	65.0%	X			Common Cause Variation

Watch Metrics - Finance - 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 in our community	Delivery of planned cash balance		5.0%		Nov-25	-22.0%	✓			Special Cause Improving - Below Lower Control Limit
People in our community	Forecast Outturn variance against plan				Nov-25	-£17600k				
People in our community	Total variance against plan Year to date				Nov-25	-£16127k				
People in our community	YTD Variance against plan for income				Nov-25	£1110k				
People in our community	YTD Variance against plan for Non Pay				Nov-25	-£11365k				
People in our community	YTD Variance against plan for Pay				Nov-25	-£8137k				

Notes on Data

Variation and Assurance Icons
Where a metric has fewer than 12 monthly data points available, the SPC methodology is not appropriate so both the Variation and Assurance icons are not shown.
Furthermore, where no local target has been supplied it is not possible to show an Assurance icon.

Missing Metrics
Some metrics that were proposed for 2025/26 are not shown in this report because data is not available or has not yet been provided:

- Breakthrough Objective - % staff say the organisation values their work - *Workforce team have advised that this question has not been asked on the quarterly pulse survey in the last year, so there is no regular data that can be included on this report.*
- Vision Metric - 100% of reported patient safety incidents are triaged and a range of learning responses (including PSII) are completed demonstrating quality improvement recommendations - *The metric will be included from next month's scorecard.*
- Vision Metric - Carbon emission reduction (% carbon footprint reduction of electricity & gas) - *The metric will be included from next month's scorecard.*
- Watch Metrics - Achievement of 95% of invoices supported by a Purchase Order - *This will be included from next month's scorecard.*

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	Public Board of Directors	Agenda item No:	11
Date of Meeting:	14 January 2026		

Title of Report:	Maternity and Neonatal Safety Report Quarter 2 2025/26
Board Sponsor:	Antonia Lynch, Chief Nursing Officer
Author(s):	Zita Martinez, Director of Midwifery Kerry Perkins, Patient Safety Lead Midwife
Appendices	Appendix 1: NHSE MNVP statutory obligation Appendix 2: Q2 TC/ATAIN report

1. Executive Summary of the Report

This report highlights the status and safety measures in place for maternity and neonatal services, with a focus on monitoring and addressing safety concerns.

Stillbirths and neonatal deaths in Quarter (Q2) have been reported to the MBRRACE-UK, and a Perinatal Mortality Review Tool (PMRT) used where applicable, excluding medical terminations.

Maternity and Neonatal Safety Investigations (MNSI) team received one referral in Q2.

Maternity Incentive Scheme (MIS) continues to be monitored through perinatal governance. Saving Babies' Lives Care Bundle (Version 3.2, Element 6) compliance was 84% in Q2. A temporary reduction was anticipated due to the implementation of the electronic patient record system (BadgerNet), which changed audit methodology from a 25-case sample to a review of the entire maternity cohort. Regular improvement meetings are held with the Local Maternity and Neonatal System Lead Midwife to monitor progress and drive compliance.

Using data insights from the Maternity and Neonatal Voices partnership (MNVP) and Safety Intelligence data using the Patient Safety Incident Response Framework (PSIRF), thematic reviews identified bladder care, neonatal readmissions, and obstetric haemorrhage as areas for improvement. The neonatal pneumothorax Quality Improvement (QI) project is currently being reviewed through governance, and the venous thrombosis embolism (VTE) Quality Improvement project continues reporting through perinatal governance.

Maternity & Neonatal Voices Partnership (MNVP), hosted by the Integrated Care Board, provide insights into family experience through a variety of ways including governance, PMRT and Insights and Quality Improvement. They are a quorate member of several committees enabling co-production of services. It has been identified that the NHSE MNVP statutory obligation regarding the employment status of MNVP is not being met. MNVP are employed as volunteers, however ICBs should consider more permanent employment terms (Appendix 1). A risk assessment is currently being undertaken to add to this to the risk register. The Trust and ICB are also producing an action plan to mitigate the risk and have prioritised actions proportionate to available MNVP resource.

In summary, the service is actively monitoring and improving safety measures, with a focus on reducing mortality rates and improving outcomes and experience for families.

2. Recommendations (Note, Approve, Discuss)

Discuss.

3. Legal / Regulatory Implications

It is a legal requirement to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

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

In Q2 two new risk assessments were presented and approved for the risk register:

Risk No	Domain of Risk	The Risk	
3171	Patient Safety & Quality	Neonatal Allied Health Professional Workforce Risk Non-Compliance BAPM	8
3147	Patient Safety & Quality	Health inequalities impact women and birthing people cared for by the RUH	10

Table 1: New risk, Q2 2025/26

Current open risks scoring >12 in Maternity and Neonates Q2 2025/6 scoring:

Risk No	Domain of Risk	The Risk	
3101	Patient Safety & Quality	Maternity triage non-compliance with medical review timescales as per RCOG guidance	15
3013	Patient Safety & Quality	There is a risk that maternity services are unable to deliver timely USS pathways because of USS capacity, demand, and workforce issues, which is likely to impact on patient care such as avoidable maternal and neonatal harm	12
2950	Patient Safety & Quality	There is a risk neonatal patients will be cared for outside of BAPM guidelines by nursing staff who are not qualified in specialty (QIS)	12
2785	Patient Safety & Quality	As a result of the level of clinical pharmacist provision to the NNU, BAPM service quality standards are not being met	12

Table 2: Ongoing risks scoring >12 Q2 2025/26

All risks are managed as per the Trust Risk Management Policy

5. Resources Implications (Financial / staffing)

Compliance with the Maternity Incentive Scheme has financial and safety implications for the Trust. There is a financial commitment required by the Trust to achieve full compliancy.

6.	Equality and Diversity
Equality and Diversity legislation is an integral component to registration.	

7.	References to previous reports
Previous monthly Perinatal Quality Surveillance reporting Q1 Maternity and Neonatal Safety Reports Q2 report - Quality Assurance Committee, December 2025.	

8.	Publication
Public.	

REPORT OVERVIEW

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document '*Implementing a revised perinatal quality surveillance model*' (December 2020). The purpose of the report is to inform the Local Maternity and Neonatal System (LMNS) Board and the Board of Directors of present or emerging safety concerns within Maternity and Neonatal services. The information within the report reflects actions and progress in line with the three-year delivery plan (3YDP) for Maternity and Neonatal Services of 2023. It also outlines the current position of compliance with the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) including Saving Babies Lives Care Bundle V3.2 (SBL).

1.0 PERINATAL MORTALITY AND MORBIDITY

The following graphs demonstrate RUH performance against the national ambition to reduce stillbirths in the UK by 50%, and the local ambition for continual progression in reducing perinatal mortality. From March 2025 the national averages have been adjusted to reflect the publication of the MBRRACE-UK report of 2023 perinatal mortality revised National averages. Although there was an increase in stillbirth rate per 1000 in September, the service continues to be below the national average and monitors for learning and any themes.

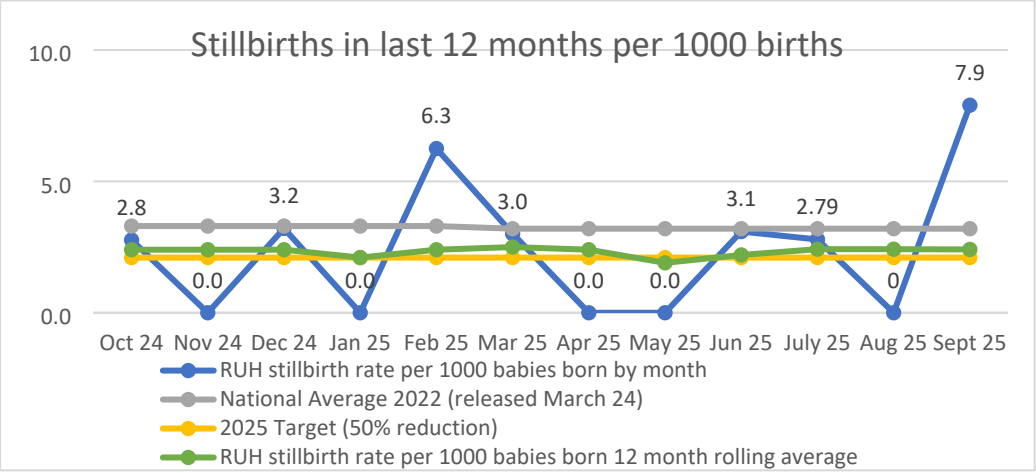


Figure 1: RUH NHS Trust stillbirth rate per 1000 births over last 12 months

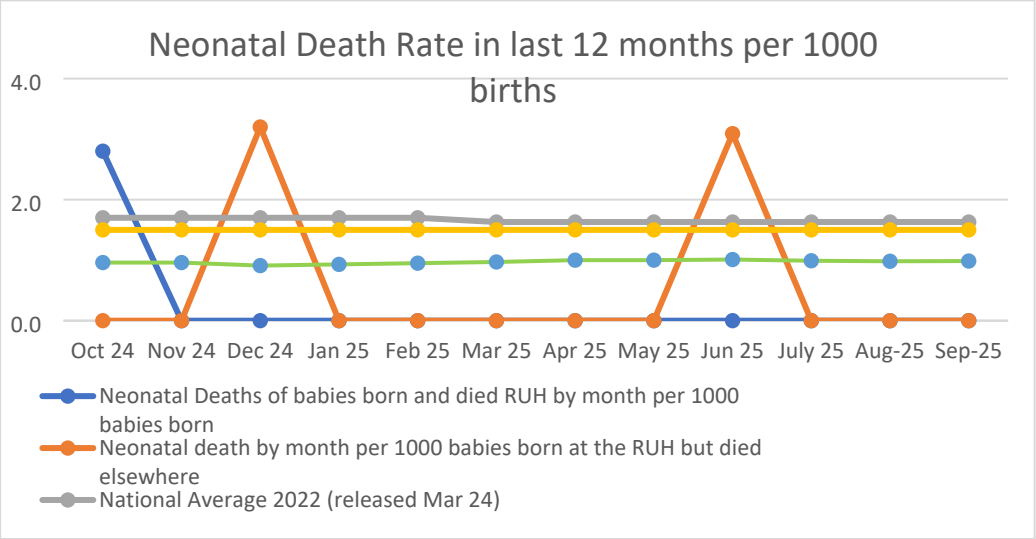


Figure 2: RUH NHS Trust Neonatal Death rate per 1000 births over last 12 months

MBRRACE-UK collects data on perinatal deaths, defined as stillbirths from 22 weeks' gestation and neonatal deaths up to 28 days of age, excluding terminations. Due to differing definitions (stillbirths recorded from 24 weeks, perinatal deaths from 22 weeks), reported rates may vary.

Trusts are provided with initial MBRRACE-UK perinatal mortality rate per 1000 births; results are subsequently stabilised and adjusted to reflect if the RUH statistics were representative of the national socioeconomic demographics. Therefore, MBRRACE crude, and stabilised and adjusted rates for the RUH will be different. MBRRACE-UK collates the data for those babies who were born at the RUH and subsequently died elsewhere. This report has separated these values to ensure alignment of internal mortality data figures ahead of reported and adjusted MBRRACE-UK figures, see figures 1 and 2.

One antenatal stillbirth at 30 weeks of pregnancy was reported in Q2. There was one neonatal death born at the RUH but died at United Hospital Bristol & Weston NHS Foundation Trust (UHBW).

2.0 PERINATAL MORTALITY REVIEW TOOL (PMRT)

2025/26 (excluding terminations for abnormalities)	Q2 25/26	Annual total 25/26 (fiscal)	Annual total 2025 (calendar year)
Stillbirths (>37 weeks)	2	3	2
Stillbirths(>24weeks-36+6weeks)	2	4	3
Late miscarriage (22+weeks-23+6weeks)	0	0	0
Neonatal death at the RUH	0	0	
Neonatal death elsewhere following birth at the RUH	0	0	0
Total	**4**	**7**	**5**

Table 3: Perinatal Mortality summary by number of cases, Quarter 2 2025/26

PMRT reporting is a requirement of Safety Action 1 of the NHS-R Maternity Incentive

Scheme. All perinatal mortality cases are subject to an Multi – professional safety review within 1 week to identify any immediate safety concerns or learning using the Patient Safety Incident Response Framework (PSIRF). All perinatal mortality cases are then reviewed using the PMRT process during monthly MDT meetings. Family feedback is sought and provides a focus for discussions alongside clinical review. If the PMRT process identifies further concerns or learning opportunities, this is escalated to the patient safety team to drive service improvements.

Family concerns/questions are discussed at the monthly PMRT meeting, and all families are offered support through a single point of contact during the review process. Families may choose to receive a draft report pending further investigation results such as postmortem which can take considerable time to receive due to a national shortage of Paediatric Pathologists. This continues to significantly impact the timeliness of postmortem examinations following neonatal deaths and stillbirths. This delay not only affects the completion of the Perinatal Mortality Review tool (PMRT) process but also has a profound emotional impact on bereaved families, who often face extended periods of uncertainty while awaiting answers about their baby's death. The inability to provide timely postmortems results can impact families' ability to process grief, delay closure, and in some cases, affect future pregnancy planning. It also limits the maternity service's capacity to deliver prompt learning and implement improvements in care. Efforts to mitigate these delays locally are ongoing: however, the issue remain a national workforce challenge requiring strategic attention to ensure families receive compassionate, timely, and informative care during the most difficult of circumstances. A risk assessment is currently being agreed through governance processes.

Standards for quarterly and annual PMRT compliance for MIS can be found in table 4.

A. PMRT PROCESS MEASURES

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	Q2 25/26	Annual 24/25	Standard
Notification of all perinatal deaths eligible to notified to MBRRACE-UK to take place within seven working days.	**100%**	**100%**	**95%**
Surveillance of all perinatal death's information must be completed within one month of the death. Deaths where the surveillance form needs to be assigned to another Trust for additional information are excluded from the latter.	**100%**	**100%**	**95%**
A PMRT review must be commenced within two months following the death of a baby.	**100%**	**100%**	**50%**
Percentage of PMRT review meetings which have met quoracy as outlined within the PMRT recommended	**100%**	**100%**	**100%**

composition.			
A draft PMRT report must be completed within four months of a baby's death.	**100%**	**75%**	**50%**
A PMRT must be completed within six months of the death of a baby's death.	**100%**	**75%**	**50%**
All parents will have been told that a review of their baby's death is taking place and asked for their contribution of questions and/or concerns.	**100%**	**100%**	**95%**
Quarterly reports will have been submitted to the Trust Board from 6 May 2022 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.	**100%**	**100%**	**100%**

Table 4: PMRT Process Measures Quarter 1 25/26

Q2 2025/26 PMRT BIRTH DATA

Birth Data	
Cases for PMRT review	4
Antenatal stillbirth	3
Intrapartum stillbirth	1
Late fetal losses	0
Early neonatal death	0
Late neonatal death	0

Table 5: PMRT birth data Q2 25/26

The quarterly birth data may differ from number of provisional grading depending on the availability of records/family feedback being received.

B. Q2 2025/26 PMRT REVIEWS PROVISIONAL GRADING

Case	Grading of care at provisional MDT review (pending further clinical investigation results)	
Antenatal Stillbirth 39+4	Care of mother and baby up to point of baby was confirmed as having died	A
	Care of mother following the confirmation of death of baby	B
Antenatal stillbirth 34+0	Care of mother and baby up to point of baby was confirmed as having died	B

	Care of mother following the confirmation of death of baby	B
Antenatal stillbirth 33+4	Care of mother and baby up to point of baby was confirmed as having died	B
	Care of mother following the confirmation of death of baby	B

Table 6: Q2 2025/26 provisional grading of care pending further clinical investigation results

PMRT	Grading of care key
Grade A	No issues with care identified that would have impacted on the outcome
Grade B	Care issues which would have made no difference to the outcome
Grade C	Care issues which may have made a difference to the outcome
Grade D	Care issues which were likely to have made a difference to the outcome

Table 7: PMRT grading of care key

C. Q2 2025/26 PMRT INITIAL REVIEW LEARNING OPPORTUNITIES

No themes or commonalities have been identified from initial PMRT reviews in Q2.

D. Q2 2025/26 LEARNING FROM COMPLETED PMRT REVIEWS

Two PMRT reports were completed in Q2. Actions and learning opportunities were identified as follows.

Issue/area for improvement	Review Response/Action plan	Action target date
1. Referral pathway for private scan service	Review usual referral process and update process and/or guideline if required	Oct 25
2. Management of pregnancy for women who have previous uterine or significant surgery	Update guidelines to reflect standard practice for monitoring of cervical length at anomaly scan	Dec 25

Table 8: Q2 2025/26 PMRT completed reviews improvement plan

E. 2025/26 OUTSTANDING REVIEWS AWAITING FINAL GRADING (excluding Q2)

Case	Provisional grading of care pending further clinical investigation results	
Late Neonatal Death	Care of mother and baby up to point of birth of baby	B
	Care of the baby from birth up to death of baby	C

Table 9: 2024/25 ongoing reviews pending further clinical results

Ethnicity and index of multiple depravation will be reported for all PMRT cases from Q3.

F. CHILD DEATH OVERVIEW PANEL (CDOP)

There were no RUH neonatal deaths reported to CDOP in Q2. One baby was born at the RUH but died elsewhere, the RUH will contribute to the external Trust CDOP process, and the care provided by the RUH has received PMRT review.

2.1 SAVING BABIES LIVES CARE BUNDLE 3.2

The Saving Babies Lives Care Bundle v3.2 (SBL) provides evidence-based best practice to achieve the national ambition to halve the rate of perinatal mortality by 2025 by driving innovation and quality improvement in key areas in maternity care. As part of the three-year delivery plan, providers are responsible for fully implementing all interventions of the care bundle. All PMRT reviews are triangulated against SBL and improvements identified. Table 10 provides triangulation of care concerns against each element of SBL.

July	August	September
Number of perinatal mortality cases where smoking in pregnancy was a relevant issue (Element 1)		
0	0	0
Number of perinatal mortality cases where fetal growth: risk assessment, surveillance or management was an issue (Element 2)		
0	0	0
Number of perinatal mortality cases where raising awareness of reduced fetal movements (RFM) was an issue (Element 3)		
0	0	1
Number of perinatal mortality cases where effective fetal monitoring during labour was an issue (Element 4)		
0	0	0
Number of perinatal mortality cases annually where the prevention, prediction, preparation, or perinatal optimisation of preterm birth was relevant issue (Element 5)		
0	0	0
Number of perinatal mortality cases annually where the management of diabetes was an issue (Element 6)		
0	0	0

Table 10: Q2 2025/26 PMRT care concerns triangulated against SBL elements.

During Q2, there was one reported stillbirth where reduced fetal movements were a contributing factor (SBL Element 3). A thorough review found no care concerns about the management pathway of RFM that would have altered the outcome. There were no stillbirths, neonatal deaths, or cases of suspected hypoxic-ischemic encephalopathy (HIE) associated with intrapartum care during this period

There is strong evidence linking undiagnosed fetal growth restriction (FGR) to stillbirth making antenatal detection vital in reducing the risk of stillbirth with timely birth of the baby. In Q2, one baby who was predicted to be growth restricted was born outside of the optimal gestation. Although the baby was born outside of the optimal time, previous scans showed normal growth until 37+6 weeks gestation, whereby induction of labour was appropriately commenced the following day.

The service has reviewed those babies born FGR that were not identified antenatally. There were eleven babies born unexpectedly FGR. Eight identified no care concerns that would have identified FGR, one scan should have been performed following community referral and two scan reviews identified slight overmeasurement of estimate fetal growth. Individual learning and discussion at consultant meetings have addressed the learning. There was no impact on the outcome for these babies.

3.0 MATERNITY AND NEONATAL SAFETY INVESTIGATIONS (FORMERLY THE HEALTHCARE SAFETY INVESTIGATION BRANCH) AND MATERNITY PATIENT SAFETY INCIDENT INVESTIGATIONS

Maternity and Neonatal Safety Investigations (MNSI) undertake maternity investigations in accordance with the Department of Health and Social Care criteria (Maternity Case Directions 2018), taken from Each Baby Counts and MBRRACE-UK. In accordance with these defined criteria, eligible babies include all term babies (at least 37 completed weeks of gestation) born following labour who have one of the following outcomes:

- Maternal Deaths
- Intrapartum stillbirth
- Early neonatal death
- Severe brain injury diagnosed in the first seven days of life.

There were no completed reports in Q2. Table 11 shows two ongoing MNSI reviews from Q1. One referral was made and accepted in Q2, see table 12. Initial findings from multi-professional safety reviews (MPSR) identified learning around appropriate and timely referral and parental antenatal education.

No cases in Q2 25/26 have met the criterion for Early Notification Scheme referral to NHS-Resolution.

Reference	Event Summary	Investigation Status	External Notifications	Duty Of Candour	Key Learning Identified
MI-042892	Neonatal transfer to tertiary unit for therapeutic cooling. MRI post cooling	Investigation progressing at family's request	None	Yes	Information sharing with parent on safe sleeping and feeding advice immediately post birth

	was normal.				
MI-042893	Neonatal transfer to tertiary unit for therapeutic cooling. MRI post-cooling was normal.	Investigation progressing at family &Trust's request	None	Yes	Risk assessment process at booking and during labour. Compliance with intrapartum intermittent auscultation (IA) Enhance escalation pathways

Table 11. Ongoing MNSI Referrals 25/26

Reference	Event Summary	Investigation Status	External Notifications	Duty Of Candour	Key Learning Identified
MI-047238	Intrapartum intrauterine death	Accepted	None	Yes	

Table 12. New MNSI Referrals Q2 25/26

3.1 CORONER REGULATION 28

The Trust attended an inquest into a neonatal death in 2022, attributed to congenital pneumonia. Safety recommendations from the local review had already been implemented and audited to ensure meaningful, sustained improvements in practice. In collaboration with the family, the maternity service developed a training video (presented to the Board of Directors as a 'Parent story' earlier in this meeting), which is now incorporated into annual mandatory training. As a result, a Regulation 28 report was not issue.

3.2 MATERNITY PATIENT SAFETY INCIDENT INVESTIGATIONS (PSII)

There were no Patient Safety Incident Investigations (PSII) that reached completion in Q2 and no new PSIIs declared. One PSII has been shared with the family for their comments.

Reference	Event Summary	External Notifications	Duty Of Candour	Key Learning Identified
Datix 133329	Late Neonatal Death at Day 8 of life.	MBRRACE PMRT CDOP Coroners	Initiated 15/10/2024	• Review of neonatal triage in maternity • Standardise safety netting • Review out of date guidelines

Table 13. Maternity and Neonatal Patient Safety Incident Investigations Q2 25/26

3.3 TRUST CLAIMS SCORECARD – OBSTETRICS

The Trust's latest scorecard (Q1) correlates open, and closed claims managed by the

Trust legal team during 2024. Obstetric-related claims currently represent around 17% of the total number of claims within the Trust, yet account for approximately 80% of the overall financial value. This reflects the high-cost nature of these obstetric cases rather than a high frequency of incidents.

For context, the NHS Resolution (NHSR) Annual Report and Accounts 2024/25 indicates that obstetrics accounts for 11% of clinical claims by volume and 53% by value nationally. While the Trust's figures are above the national averages, this is consistent with the complexity and severity often associated with obstetric claims.

The service is actively implementing measures to reduce both the likelihood and impact of obstetric claims, including:

- **Enhanced Clinical Governance:** Strengthening incident review processes by continuing to embed Patient Safety Incident Response Framework (PSIRF) and learning from national and local themes.
- **Training and Simulation:** Expanding multidisciplinary training in obstetric emergencies to improve team response and patient safety including multidisciplinary training with outside agencies such as paramedics in homebirth situations.
- **Early Resolution and Engagement:** Working closely with NHS Resolution to promote early engagement and resolution strategies, reducing litigation costs.
- **Data-Driven Insights:** Using claims data to identify trends and inform targeted quality improvement initiatives.

These actions aim to improve patient outcomes, reduce risk exposure, and align the Trust more closely with national benchmarks over time.

Figure 3 shows the ten high volume high case value cases for the Trust are obstetric claims between 2017 and 2020, totalling £122,998,950 awarded to patients and families. Seven of these claims relate to Cerebral Palsy/hypoxic brain injury, this being the highest litigation claim nationally, two to Erbs Palsy and one to Meningitis.

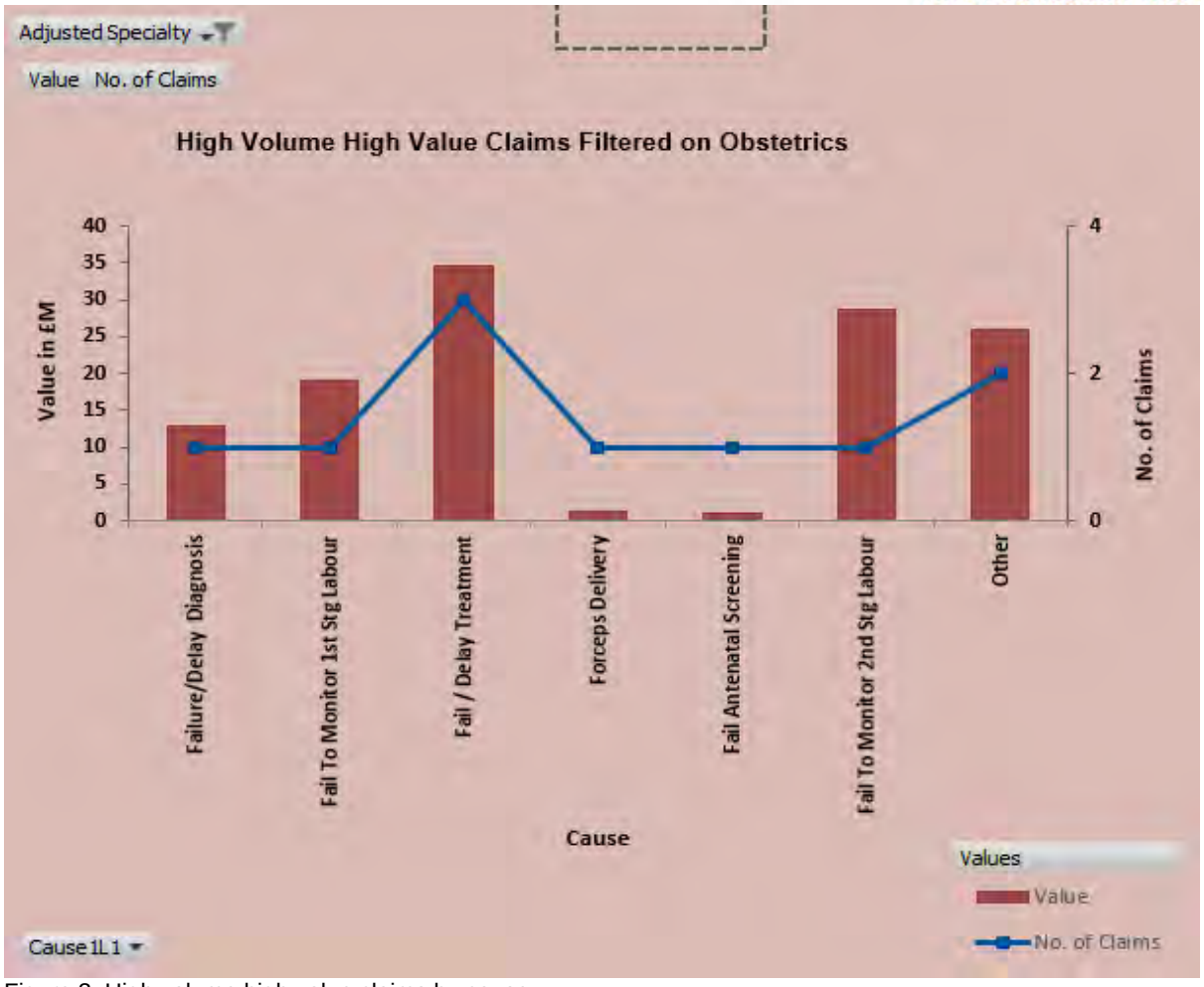


Figure 3. High volume high value claims by cause

3.4 LEARNING AND IMPROVEMENT FROM PMRT, FAMILY FEEDBACK, MNSI & CLAIMS

Triangulation of feedback and insights identified the following themes:

- Improved postnatal experience for women and families - this is addressed through the Perinatal Culture and Leadership Programme (PCLP)
- Bladder care
- Informed consent to aid decision making
- Effective intermittent auscultation fetal monitoring
- Guideline management
- Medicine management

Bladder care, informed consent to aid decision making and effective intermittent auscultation fetal monitoring are priorities that were set in 2024/25 following the Insights report with ongoing Q2 projects that are monitored through governance.

A quality improvement project is ongoing in response to continued errors in risk assessing and prescribing of Low Molecular Weight Heparin with updates presented

through governance. The perinatal medicine safety committee reports into the trust medicine safety group.

A thematic review of incidents of major obstetric haemorrhage >1500mls is underway and will be reported through speciality governance.

Guidelines are monitored monthly through governance. Baseline Assessment tools (BAT) help identify current practices against recommended NICE standards with a current review of all BATs against guidelines underway. A multidisciplinary review of all guidelines and standard operating procedures (SOP) has been undertaken to aid staff and ensure alignment with national guidelines and SBLv3.2.

Following feedback from staff, the perinatal service now provides feedback via a monthly newsletter with a specialist services providing updates. Microsoft Teams RUH Maternity Team, case review QR code posters to full reports and quality and safety whiteboards displayed in clinical areas with a 'Safety Hot Spot' of the month. Safety Hotspots are identified from co-incidental learning through service insights such as themes of low and no harm incidents, audit and, or family feedback. Furthermore, local insights for learning are fed into the mandatory training programme as per the Core Competency Framework version 2 (CcFv2).

4.0 THREE YEAR MATERNITY AND NEONATAL SERVICES (3YDP)

The Trust continues to work toward compliance with the 3YDP. The Perinatal Pelvic Health Service is well embedded, and recruitment and retention continue to be in a positive position.

Key workforce improvements have led to a reduction in sickness absence rates in both maternity and neonatal services and 100% retention of newly qualified midwives since 2023. A strong focus has been maintained on building a positive culture of safety, enhancing co-production with service users, and improving staff and family engagement.

The neonatal service continues to work towards achieving external accreditations such as UNICEF Baby Friendly Initiatives (BFI) and Bliss Baby Charter Gold.

The Perinatal Service remains committed to delivering safe, personalised, compassionate, and equitable maternity and neonatal services, with ongoing governance oversight to monitor progress, ensure continuous improvement, and respond to national expectations.

5.0 TRAINING COMPLIANCE FOR ALL STAFF GROUPS IN MATERNITY RELATED TO THE CORE COMPETENCY FRAMEWORK

The report provides evidence of training compliance, including a response to year 7 of MIS, Safety Action 8. The Core Competency Framework version 2.2 sets out clear expectations for all Trusts, aiming to address known variation in training and competency assessment for maternity staffing across England. It ensures that training to address significant areas of harm are included as minimum core requirements and

standardised for every maternity and neonatal service. Compliance with attendance and demonstrated competence for fetal monitoring, neonatal resuscitation, and multi-disciplinary training (MDT) Emergency Skills Training (PROMPT) across all staffing groups can be found in Figure 4.

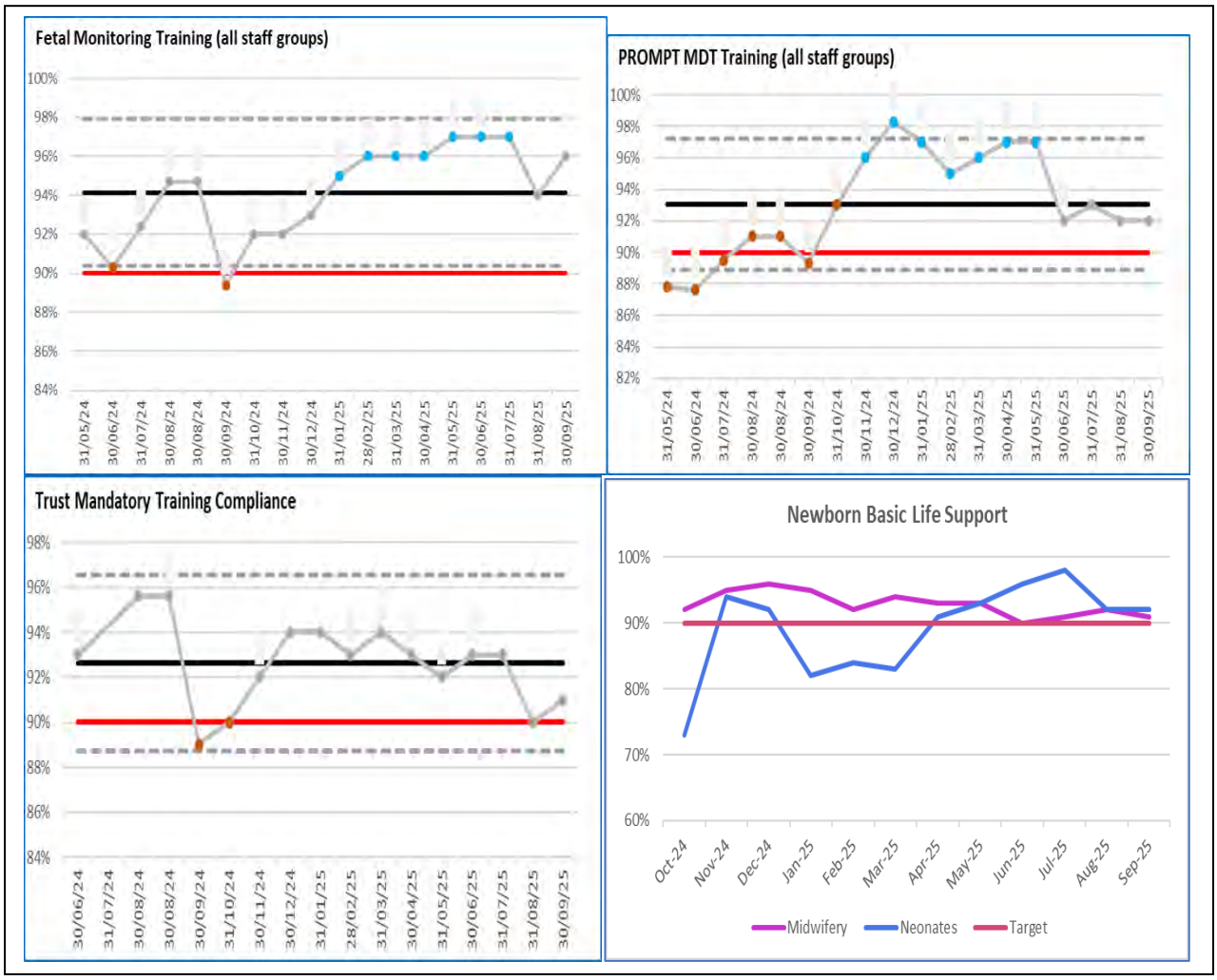


Figure 4. Maternity Training Statistical Process Charts for PROMPT, Fetal Monitoring, Mandatory Training compliance and Adult Basic Life Support compliance

Specific training standards for all staffing identified within the Saving Babies Lives Version 3.2 are externally assessed by the Integrated Care Board (ICB) Local Maternity and Neonatal System (LMNS) for both content and compliance.

6.0 BOARD LEVEL SAFETY CHAMPIONS

The Maternity and Neonatal Safety Champions are active in their role to listen to the staff voice in maternity services. All staff are invited to attend monthly 'listening event' meetings and interact with Safety Champions during walkabouts with the Chief Nursing Officer, the Non-Executive Director for Maternity and Neonatal services, and the Obstetric, Neonatal and Maternity Safety champions.

Themes raised to the Safety Champions during Q2 were:

- Well managed critical incident resulting in temporary closure
- Positive culture during launch of maternity Badgernet
- Positive feedback from families, students, and staff

Current work to address the concerns raised:

- Neonatal Badgernet
- No vacancy for students qualifying in January 2026

Identified themes, commonalities and actions from this feedback is monitored via the Maternity and Neonatal Safety Champions meetings and is triangulated with further service insights in the Maternity and Neonatal 'Insights' report to drive our continuous improvement work.

7.0 NHS RESOLUTION MATERNITY INCENTIVE SCHEME UPDATE Q2 2025/26

The Clinical Negligence Scheme for Trusts (CNST) released the Maternity (and perinatal) Incentive Scheme Year 7 on 2 April 2025. Updates on progress and monitoring towards achievement of the 10 Safety Actions outlined, is completed and shared within Maternity and Neonatal Speciality Governance meeting and Board Level Safety Champions monthly.

Each of the 10 Safety Actions has a senior perinatal leader sponsor with oversight of the compliance requirements and regular meetings with the patient safety lead to identify and act on any concerns. Compliance in Q2 remains the same however progress on individual elements within each Safety Action is being made.

	Maternity Incentive Scheme Y6 - Safety Action Detail	Current position	Anticipated submission position March 26
1	Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths that occurred from 1 December 2024 to 30 November 2025 to the required standard?		
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?		
3	Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?		
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?		
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?		

6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?		
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users		
8	Can you evidence the following three elements of local training plans and 'in-house,' one day multi professional training?		
9	Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal safety and quality issues?		
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB)(known as Maternity and Newborn Safety Investigations Special Health authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?		

Table 14: Q2 2025/26 MIS year 7 compliance

It has been identified that the NHSE MNVP statutory obligation regarding the employment status of MNVP is not being met (by the ICB). MNVP are employed as volunteers however ICBs should consider more permanent employment terms (Appendix 1). A risk assessment is currently being undertaken to add to the risk register. The Trust and ICB are also producing an action plan to mitigate the risk and have prioritised actions proportionate to available MNVP resource.

7.1 SAFETY ACTION 6 - SAVING BABIES LIVES CARE BUNDLE V3.2

Saving Babies Lives Care Bundle Version 3.2 implementation is subject to ongoing continuous improvement work. The Service is compliant using the SBL NHSE Implementation Tool and at least quarterly improvement discussions with the ICB have been held. Compliance in Q2 was 84%. There was an anticipated reduction in compliance due to the implementation of Badgernet with compliance expected to improve in Q3. Although there has been a reduction in compliance for elements 4 and 6, significant progress has been made in other elements with an anticipated further improvement in Q2.

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Partially implemented	80%	Partially implemented	80%
Element 2	Fetal growth restriction	Partially implemented	85%	Partially implemented	85%
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%
Element 4	Fetal monitoring in labour	Partially implemented	80%	Partially implemented	80%
Element 5	Preterm birth	Partially implemented	73%	Partially implemented	85%
Element 6	Diabetes	Fully implemented	100%	Partially implemented	83%
All Elements	TOTAL	Partially implemented	81%	Partially implemented	84%

Table 15. RUH Maternity position for implementation of Saving Babies Lives Care Bundle v3.2

Areas of risk which may delay further progress have been identified including ultrasound demand and capacity which is on the risk register with a joint action plan with radiology monitored through governance.

The Trust is required to provide an obstetric lead consultant and neonatal lead consultant to optimise the provision of Element 5. Whilst there are named leads and job plans, job descriptions do not include the roles and responsibilities for leadership and oversight of the implementation of Element 5. The Trust Board is advised to note that the RUH have appointed Peri prem leads and are therefore compliant with this intervention.

8.0 SAFE MATERNITY AND NEONATAL STAFFING

8.1 MIDWIFERY STAFFING

In September 2025, the midwifery establishment reported no substantive vacancies, though 3.76 WTE were on secondment and 8.67 WTE on parental leave. Recognising the ongoing impact of parental leave on workforce availability, RUH has agreed to fund an additional 8.0 substantive WTE to support safe staffing. A fixed-term vacancy of 1.3 WTE remains in place.

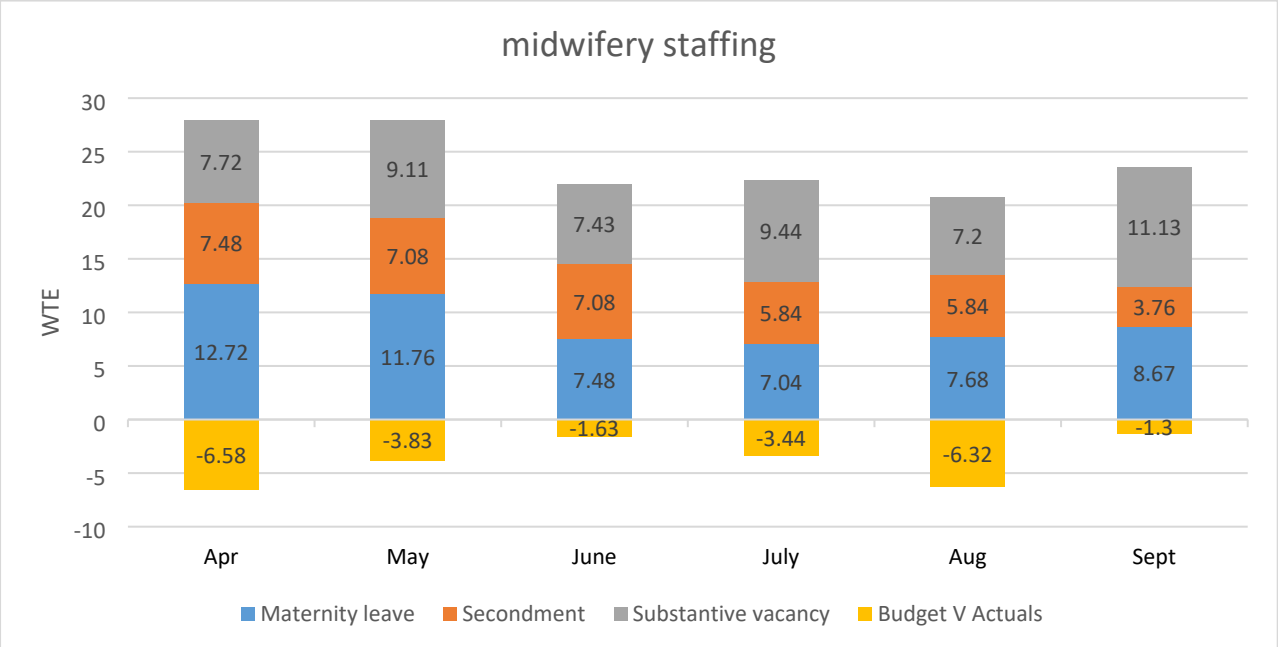


Figure 5. Midwifery Workforce staffing vacancy and forecast (not including long-term sickness)

Table 16 outlines some of the key process and outcome measures during Q2 for the provision of safe midwifery staffing levels.

Measure	Aim	July	August	September
Midwife to birth ratio	1:24	1:27	1:27	1:28
Midwife to birth ratio including bank	1:24	1:25	1:26	1:26
Episodes of inability to maintain	0	0	1	0

Supernumerary labour ward coordinator (LWC) status				
1:1 care not provided	0	0	0	0
Confidence factor in Birth-rate+ recording	60%	80%	80%	75%

Table 16: Midwifery staffing safety measures

The midwife to birth ratio advised in the Birthrate+ report 2021 has not been achieved in Q2 due to high activity and acuity. Management actions including redeployment of staff to maintain safety are mobilised and are monitored through governance.

There was one episode recorded of non-supernumerary status of the LWC. On investigation this was for a five-minute period and the LWC remained available to staff, there were no safety concerns.

8.2 MEDICAL STAFFING

The service is compliant with Bath Birthing Centre (BBC) consultant presence and twice daily MDT ward rounds and has moved to exception reporting. This is monitored daily and if no ward round is completed due to activity and acuity an MS Teams forms is completed which initiates immediate escalation. Improvement work continues exploring enhancing consultant review and oversight for postnatal readmissions. As part of the Maternity Incentive Scheme (MIS) Safety Action 4, the maternity service will undertake a comprehensive staff survey focused on compensatory rest. This initiative aims to assess current practices and staff experiences, with the intention of identifying areas for improvement in rest and fatigue management. The findings will support the development of targeted actions to enhance staff wellbeing and patient safety. Compliance with anaesthetic staffing remains within the acceptable range.

Measure	Aim	July	August	September
Consultant presence on BBC (hours/week)	≥90 hours	98	98	98
Consultant non-attendance (in line with RCOG guidance)	0	0	0	0
Twice daily MDT ward round	90%	94%	94%	95%
Anaesthetic staffing	>70%	100%	100%	100%

Table 17: Obstetric staffing safety measures

8.3 NEONATAL NURSING STAFFING

In Q2, the overall nursing vacancy has increased to 5.14 WTE. There is no longer over-establishment of Band 4 roles as the nursing apprentice has qualified and recruited into B5 vacancy. One WTE band 6 has commenced the trainee Advanced Neonatal Nurse Practitioner (ANNP) role which has increased B6 vacancy. Recruitment efforts remain ongoing to fill the remaining vacant posts. Q2 has also seen an increase in parenting leave.

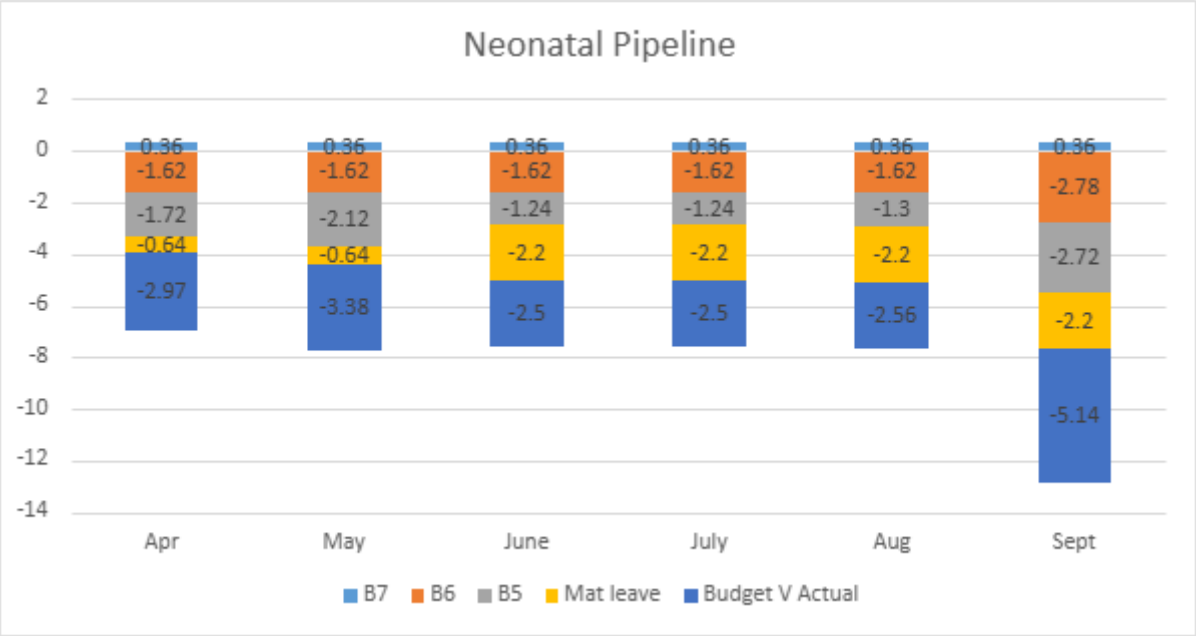


Figure 6. Neonatal nurse workforce staffing vacancy and forecast

MIS Safety Action 4 outlines the requirement to demonstrate compliance with meeting British Association of Perinatal Medicine (BAPM) neonatal nursing standards. Nurses holding the qualified in speciality (QIS) qualification in neonatal nursing remains above 70% in August and September 2025/26.

Measure	Aim	July	August	Sept
Percentage of nursing establishment who hold Qualified in Speciality (QIS) qualification.	>70%	65%	70%	70%
Percentage of Transitional care (TC) shifts with staff dedicated to TC care only	>90%	100%	100%	97%
Neonatal Nursing Vacancy rate (WTES)		2.50	2.56	5.14

Table 18. Neonatal nursing staff

QIS is a Continued Professional Development in addition to Bachelor of Science Paediatric Nursing. Funding has been obtained in 2025 from the Southwest Operational Delivery Network (SWODN) which has mitigated the risk and allowed for compliance currently at 70% in line with BAPM standards however there is no identified ongoing funding stream for QIS training, resulting in a risk to current training pipeline. The risk remains on the Maternity and Neonatal Risk Register, Risk 2950 (Section 10.0). The risk will remain until permanent funding is identified.

8.4 NEONATAL MEDICAL STAFFING

The service has maintained compliance with the BAPM standards for neonatal medical workforce across Q2 of 25/26 in line with safety standard 4 of MIS.

Measure	Aim	July	August	September
Tier 1 separate rota compliance 24/7	100%	93.65%	95.16%	98.33%

'At least one resident Tier 1 (ANNP or junior doctor ST1-3) practitioner dedicated the providing emergency care for the neonatal service 24/7'				
Tier 2 Separate rota compliance 12h per day 'Resident Tier 2 (ANNP or junior doctor ST4-8) practitioner dedicated solely to the neonatal service 12 hours a day during the busiest times of the day'	100%	100%	100%	100%
Tier 2 compliance: significant geographical separation between neonatal and paediatric units 'The Tier 2 (ANNP or junior doctor ST4-8) practitioner should be immediately available at all times to the neonatal unit and the labour ward. If the site of the paediatric unit makes this immediate response impossible separate Tier 2 rotas are required'	100%	100%	100%	100%
Tier 3 daytime compliance All consultants on-call for the unit have regular weekday commitments to the neonatal service only (ideally with a 'consultant of the week' system) and all consultants do a minimum of four 'consultant of the week' service weeks per year	100%	100%	100%	100%
Tier 3 compliance No on-call rota should be more onerous than one in six		compliant		

Table19. Neonatal medical workforce compliance

Gaps in the clinical rotas continue to be prioritised, which impacts the ability of ANNPs to fulfil all four pillars of advance practice.

9.0 INSIGHTS FROM SERVICE USERS AND MATERNITY AND NEONATAL VOICES PARTNERSHIP

9.1 COMPLAINTS, COMPLIMENTS, PATIENT ADVICE AND LIAISON SERVICE (PALS)

	July	August	Sept
Number of Patient Advice and Liaison Service (PALS) contacts/concerns	18	15	20
Number of formal complaints	3	1	0

Table 20. Complaints and compliments Q2 25/26

Compliments to the service were received across all areas of Maternity and Neonatal care. A continued theme amongst compliments to the service is the kindness and compassion care showed to birthing people and their families.

During Q2, four formal complaints were received, all complaints, PALS contacts and informal feedback are assessed for commonalities, trends, or themes within the monthly Maternity and Neonatal Insights and Quality Improvement group.

Improvement of immediate postnatal care for inpatients continues to be an area of focus. The addition of 2 wte Band 7 midwives on Mary ward has enabled Band 7 leadership on each day shift. The 'operational flow' role alongside this has ensured prioritisation of planned discharges against new admissions and better oversight of bed status and the need for escalation when required. Therefore, the process of discharge for patients and families is more streamlined and ward staff have more time to spend with women and birthing people requiring ongoing inpatient care. Collation of feedback regarding the quality impact of these changes continue as part of the wider Perinatal Culture and Leadership (PCLP) project and early analysis indicates a high degree of satisfaction amongst the MDT ward team with consensus that the change should become permanent.

9.2 SERVICE 'INSIGHTS' SAFETY PRIORITIES

All service feedback 'insights' received 'in month' are reviewed for thematic assessment of trends or commonalities seeking identification of areas for improvement. Any identified 'in month' themes or trends requiring action are shared via the Perinatal Quality Surveillance Tool (PQST) shared with Board Level Safety Champions and the Trust Insights and Improvement Committee.

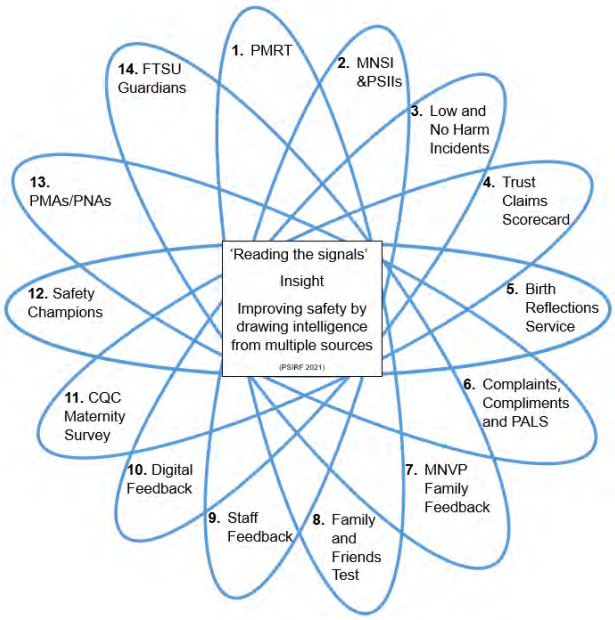


Figure 7. Sources of service 'Insight' analysed monthly via the Maternity and Neonatal Triangulation of feedback group.

The 2023/24 Insights report provided comprehensive themes and actions for improvement drawing from triangulated feedback with the recommendations below

aligning with national priorities and the 3YDP. After careful consideration, the Insights report will move to 2 yearly to allow for implementing and embedding the priorities identified in 2023/24 allowing for resources to be directed toward sustainable chang. Regular updates will continue to be provided through governance.

1) Fetal Monitoring – Intermittent Auscultation

A review and update of relevant clinical guidelines was completed in Q2 to ensure alignment with current best practice. In addition, the service is actively participating in the national quality improvement initiative *Listen2Baby*, with the Fetal Monitoring Lead Midwife contributing to this work. Alongside this, the Fetal Monitoring Lead Midwife is undertaking the RUH QSIR (Quality, Service Improvement and Redesign) course and is leading a local quality improvement project focused on enhancing the delivery of intermittent auscultation. Progress will be monitored through Specialty and Divisional Governance structures, as well as the Perinatal Review Meeting (PRM), with regular updates provided.

2) Information provision to ensure Informed Consent

The quality improvement project to improve information for families in the antenatal period and an information leaflet is in draft aimed at improving informed consent conversations about potential birth recommendations. It has been co-produced with the maternity and neonatal voices partnership (MNVP). Virtual tours are now available to service users and include links to additional resources to promote informed decision making about place of birth and birth choices.

3) Improving patient experience in the immediate postnatal care provision

The RUH joined the Perinatal Culture and Leadership Programme (PCLP) in Autumn 2023 and with support from the quadrumvirate and perinatal culture coaches produced an improvement plan following culture conversations with a wide range of staff who work in the inpatient areas. 6 themes were identified and actions derived from further conversations which are monitored through governance.

Improvement work into insight's triangulation to evaluate feedback from patient safety, families and staff linking with the Trust values is currently underway.

10.0 RISK REGISTER

There were two new risks added in Q2, all risks and emerging risks are monitored through Maternity and Neonatal Specialty Governance

Risk No	Domain of Risk	The Risk	
3171	Patient Safety & Quality	Neonatal Allied Health Professional Workforce Risk Non-Compliance BAPM	8
3147	Patient Safety & Quality	Health inequalities impact women and birthing people cared for by the RUH	10

Table 21. New risk for the Maternity and Neonatal risk register Q2 2025/26

During Q2 no risks were closed. Risk is monitored by the patient safety lead midwife and all risks rating >12 is reported monthly via Speciality and Divisional governance with Trust Management Executive, oversight to ensure appropriate actions are taken in accordance with the Trust risk framework.

Risk No	Domain of Risk	The Risk	
3103	Patient Safety & Quality	There is a risk women categorized as amber of green do not receive a medical review in line with RCOG Triage guidance (2023)	15
3013	Patient Safety & Quality	There is a risk that USS service, provided jointly by maternity and radiology, does not have enough capacity	12
2950	Patient Safety & Quality	There is a risk that due to the current compliance of percentage of staff QIS trained in the LNU below BAPM standards, the quality of care being delivered to the babies at risk of being compromised	12
2785	Patient Safety & Quality	There is a risk that the current pharmacist cover for the Neonatal Unit does not meet clinical needs or BAPM standards	12

Table 22. Maternity and Neonatal Risk Register rating >12

Moderate and low risks are monitored as per Trust Risk Management policy.

11.0 AVOIDING ADMISSION INTO THE NEONATAL UNIT (ATAIN) & TRANSITIONAL CARE

During Q2, the Transitional Care (TC) pathway maintained 99% operational availability, with staffing consistently meeting the identified TC model requirements on average 95% of the time. There were no missed opportunities to provide TC care, and no admissions to the Neonatal Unit (NNU) occurred due to capacity or staffing constraints that would have otherwise met TC admission criteria.

Importantly, no babies were admitted to or remained on the NNU solely due to the need for nasogastric tube feeding—an intervention that could have been supported within the TC pathway if appropriate provisions were in place.

However, on average, 26% of shifts involved caring for more than the recommended four babies within the TC pathway. This resulted in a baby-to-nurse ratio exceeding the British Association of Perinatal Medicine (BAPM) standard of 1:4. Despite this, there were no reported harm incidents.

The service remains committed to enhancing joint care delivery with the maternity team. A key focus is upskilling Maternity Support Workers (MSWs) to support TC families. Progress on this initiative has been delayed due to MSW vacancies and high turnover. To address this, engagement events are planned in collaboration with Human Resources to explore strategies for improving MSW recruitment and retention. This work is aligned with the Perinatal Care Leadership Programme (PCLP)

workstream.

The two top leading causes for admission to TC remain the same as in Q4, the third leading cause has changed from requiring feeding support (11%):

- Requirement for intravenous antibiotics 24%
- Requirement for 'Kaiser' observations for a risk of sepsis 24%
- Babies below 2nd centile 13%

In Q2, 2 babies were admitted to the Neonatal Unit from TCP when the TC nurse identified the deteriorating patient, both required respiratory support. There has been 100% compliance with the use of NEWTT2 observations charts. 2 babies were cared for in the NNU flat with their parents whilst remaining on the TC pathway due to high acuity on Mary ward to alleviate bed pressures.

The ATAIN working group identified five possible avoidable admission into the NNU, an increase from Q1. This remains below the national target of 6%. No commonalities were identified however fetal monitoring, escalation, and interpretation of CTGs was highlighted as a potential compounding factor, as in previous quarter. Where learning has been highlighted, information is cascaded to the teams via safety briefs, Newsletter, Quality Boards and is shared at the maternity Neonatal Governance Meeting. Fetal monitoring training is also tailored based on local intelligence.

Q2 saw three babies admitted to the NNU from other areas within the RUH such as ED or Children's ward. The admissions were appropriate and agreed via consultant-to-consultant decision.

12.0 PERINATAL CULTURE AND LEADERSHIP PROGRAMME

The Perinatal Culture and Leadership Programme (PCLP) aim to support perinatal Quadrumvirate (Quad) teams to create and craft positive safety cultures within perinatal services. The programme design was in direct response to nationally derived intelligence regarding the intrinsic relationship between a positive workplace culture and continuous quality improvement. The RUH service now has four trained culture coaches and training of further coaches is scheduled. Two rounds of culture conversations/staff engagement sessions have occurred and from these PCLP Improvement Plan has been derived to track progress of actions around emergent themes. For efficiency and completeness this has been merged with the Staff Survey action plan as numerous commonalities were identified.

Significant progress around staffing structures on the inpatient ward, strengthened leadership and estates/environment work have been achieved with positive feedback from staff, families, and Safety Champion. Further engagement sessions are to follow to capture feedback from wider teams and to formulate new and ongoing priorities. Reporting from this project is via Maternity and Neonatal Safety Group on a quarterly basis.

13.0 EQUITY AND EQUALITY

The RUH Maternity Equity and Equality Group relaunched in November 2024 to align with the BSW Equity and Equality plan and evolving national guidance including the Department of Health's Core20plus5 Framework and the Three-Year Delivery Plan priorities. Core membership includes clinical leads across all departments and the MNVP. The groups improvement plan continues to focus on four strategic priorities:

- Improving data quality and responsiveness
- Enhancing language and communication
- Expanding access to physical and digital care
- Promoting staff equity

The improvement plan is being actively monitored through governance structures and focuses on tangible outcomes and impact. Improvement projects in Q2 included:

- Commencement of antenatal and postnatal care case loading for women racialised as Black or brown, in line with progress towards Core20plus5 framework maternity goal.
- Development of a Maternity specific Learning Disabilities passport and 'Your choices' whiteboards in all birthing areas for enhancing and communicating personalised care preferences.
- Co-production of a language access to care passport with the MNVP, aimed at removing barriers to accessing urgent maternity care for families with English as an additional language.
- Digital poverty scheme promotion for Maternity service users alongside the launch of Badgernet EPR
- Launch of Virtual tours to support informed decision making about choice of place of birth and enhance informed decision making.

Continued collaboration across teams and with service users remains central to achieving meaningful equity in maternity and neonatal care. Launch of the passports and enhancing efforts to understand the experiences of lesser heard voices will be prioritised in Q3.

14.0 MATERNITY TRIAGE

The National review of maternity services in 2022 by the Care Quality Commission (CQC) identified significant variation for maternity triage with no national targets or standards. The Royal College of Obstetricians and Gynaecologist (RCOG) published the Good Practice paper on Maternity Triage in 2023 which recommended operational structure and pathways to support safe care of pregnant and newly postnatal women and people outside of scheduled appointments.

In response, the RUH commenced a journey to implement the Birmingham Symptom specific Obstetric Triage System (BSOTS), a Trust wide quality improvement project requiring investment in estates and staffing culminating in the opening of the maternity

triage unit in May 2024.

The service continues to review call waiting times and abandonment, phone call quality, and risk assessment, in person activity and BSOTS compliance including feedback from staff and families which is monitored via governance.

15.0 RECOMMENDATIONS

The Board of Directors is asked to discuss and approve the content of the report.

16.0 APPENDICES

Appendix 1 MNVP

Appendix 2 Transitional Care Pathway and ATAIN Audit Q2 2025/26

APPENDIX 1

NHSE MNVP statutory obligation

Problem

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

Action required

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

NHS England

Escalation (see technical guidance)

The RUH, where you matter

Clinical Audit Report

Transitional Care Pathway and ATAIN Audit Q2 2025/2026

Speciality: RUH Local Neonatal Unit

Division: Family & Specialist Services Division

Project team				
Kirstie Flood	Title/grade:	Lead Nurse	Data period:	Q2 July 2025-September 2025
Sarah Goodwin	Title/grade:	Neonatal Governance Lead	Report completion:	January 2026

Transitional Care Pathway and ATAIN Audit Q2 2025

Contents

Executive Summary

This report presents the findings of the Q2 2025/26 audit of the Transitional Care Pathway (TCP) and the Avoiding Term Admissions into Neonatal Units (ATAIN) programme at the Royal United Hospitals Bath NHS Foundation Trust. The audit covers the period from July to September 2025 and reflects our ongoing commitment to reducing avoidable term admissions, minimising mother–baby separation and improving neonatal outcomes.

Key Achievements

In Q2, the Transitional Care Pathway (TCP) demonstrated impressive performance across key metrics, with 100% compliance in NEWTT2 documentation and escalation protocols, reflecting robust clinical governance and effective staff training. The TCP remained operational for 99% of the quarter, with 95% of shifts meeting the established staffing model. Utilisation of the pathway continued to improve, with 44% of babies receiving all their care on TCP and an additional 20% receiving partial care, an upward trend from previous quarters. Parental feedback was unanimously positive, highlighting the compassionate, supportive care provided by the TCP team and reinforcing the value of the service in promoting family-centred care.

Key Challenges and Strategic Priorities

During Q2, the Transitional Care Pathway faced some challenges, with 14% of shifts exceeding the recommended 1:4 nurse-to-baby ratio due to high acuity within the Neonatal Unit, which impacted the ability to consistently support the pathway. Additionally, five avoidable term admissions were identified, an increase from two in Q1, highlighting ongoing areas for improvement, particularly in fetal monitoring and CTG interpretation.

In response, several actions are being progressed, including the planned conversion of Room G into a 4-bedded parent and baby residential bay to enhance rooming capacity, stabilising maternity staffing and introducing a training package to support flexible working across the perinatal pathway. This will help ensure safe, consistent care and improve resilience for women/birthing people , babies, and families to enable expansion of the TCP cot capacity to eight, aligning with GIRFT recommendations.

Quality improvement initiatives are also underway, such as the continuous positive airway pressure (CPAP) on Skin Early Intervention (COSEI) pilot, a thematic review of pneumothorax cases, and enhanced validation of ATAIN data to support service development and ensure equitable care delivery.

This report provides assurance of the Trust's continued progress in delivering safe, effective, and family-centred neonatal care. The findings and actions outlined support compliance with the Maternity Incentive Scheme (Year 7, Safety Action 3) and contribute to the broader objectives of the LMNS and ICB.

Background

The ATAIN (Avoiding Term Admissions into Neonatal Units) programme is a national patient safety initiative aimed at reducing unnecessary admissions of term babies to neonatal units. Its primary focus is to prevent avoidable separation of mothers and babies, recognising the

critical importance of early bonding for both physiological stability and long-term health outcomes.

Evidence shows that early separation can negatively impact maternal mental health, breastfeeding success, and infant development. Therefore, minimising separation, except when medically necessary.

At RUH, ongoing monitoring of neonatal admissions and modifiable factors supports continuous service evaluation and improvement. This audit contributes to the Trust's compliance with the Maternity Incentive Scheme (Year 7, Safety Action 3) and reflects the work of the ATAIN working group in driving quality and safety in maternity and neonatal care.

Objectives

- To assess compliance with the pathways of care into transitional care which have been jointly approved by maternity and neonatal teams focusing on minimising the separation of mothers and babies (Guidance Neo-100). Neonatal teams are involved in decision making and planning care for all babies in transitional care.
- To ensure the pathway of care into transitional care is fully implemented, it will be monitored and audited on a quarterly basis. Audit findings will be shared with the neonatal safety champion, the Local Maternity and Neonatal System (LMNS), and the Integrated Care Board (ICB) quality surveillance meeting.
- To evaluate the number of admissions into the Neonatal Unit that would have met TCP admission criteria but were admitted to the neonatal unit due to capacity or staffing issues.
- To evaluate the number of babies that were admitted to or remained on LNU because of their need for nasogastric tube feeding but could have been cared for on a TCP if nasogastric feeding was supported there, 34+0 - 36+6.
- To provide a data record of existing transitional care activity, (regardless of place - which could be a Transitional Care, postnatal ward, virtual outreach pathway etc.) The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery, nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered.
- To analyse staff/parent data captured via a questionnaire around satisfaction, quality, and safety of care.
- Outline the key findings and improvements identified by the ATAIN working group activity on a quarterly basis for sharing within Maternity and Neonatal Governance structures and the Board Level Safety Champion.
- To provide evidence and assurance of progression with the action plan for sharing with the neonatal maternity safety champion, and Board Level Champion, LMNS and ICB quality surveillance meeting each quarter.
- To provide an audit trail of evidence that reviews of all term babies transferred or admitted to the LNU, irrespective of their length of stay.

The ATAIN working group is responsible for completing a thematic review of the primary reasons for all admissions, with a focus on the leading cause/ reason(s) for admission through a deep dive to determine relevant areas of improvement to be addressed. This is in line with the working group terms of reference.

Key Findings

Standard	Compliance July 2025	Compliance August 2025	Compliance September 2025	This Quarters total (Q2)	Year total to date 2025/2026
Audit findings shared with neonatal safety champion	**Complete**	**Complete**	**Complete**	**N/A**	**N/A**
The % of babies who received **all** their care on the TCP pathway	**40%**	**45%**	**48%**	**82 babies 44% average of all admissions**	**192 babies 49% average of all admissions**
The % of babies who received care on the TCP for **part** of their admission	**16%**	**20%**	**23%**	**37 babies 20% average of all admissions**	**65 babies 17% average of all admissions**
The number of admissions to the neonatal unit that met TC criteria but unable to receive care on TC ward due to mat/neo capacity or staffing issues	**2**	**0**	**0**	**2**	**0**
% of shifts TCP nurse provided as per TCP staffing model	**95%**	**98%**	**92%**	**Average 95%**	**Average 98%**
% of shifts TCP nurse: baby ratio was above 1:4 as per recommendation**.**	**10%**	**15%**	**18%**	**Average 14%**	**Average 15%**
% of days >4 babies cared for on TCP	**17%**	**27%**	**33%**	**Average 26%**	**Average 36%**
TCP open	**100%**	**100%**	**98%**	**Average 99%**	**Average 99.5%**
Number of babies transferred to neonatal unit from TCP for higher level of care	**1**	**1**	**0**	**2**	**7**
The percentage of term transfers or admissions	**100%**	**100%**	**100%**	**100%**	**100%**

reviewed by the ATAIN working party irrespective of their length of stay.					
The number of avoidable term admissions 37+0 weeks gestation and above admitted to the neonatal unit	**2**	**1**	**2**	**5**	**7**
The number of term babies transferred or admitted to the neonatal unit from other areas – for example Emergency Department, Children's ward.	**0**	**0**	**3**	**3**	**4**

Clinical Audit Report

Project title
Transitional Care and ATAIN Audit Q2 2025 July - September 2025

Division
Family & Specialist Services Division

Specialty
Local Neonatal Unit

Disciplines involved
Neonatal Nurse Consultant, Neonatal Senior Sister
Obstetric Consultant, Patient Safety Midwives
ATAIN working group

Project leads
Kirstie Flood Lead Nurse
Sarah Goodwin Neonatal Governance Lead

Standards
Maternity Incentive Scheme – Year 7. Safety Action 3.

Sample

- All admissions to LNU and TCP from 01/07/2025-30/09/2025 to determine if the correct location of care was achieved.

- All babies born at 37+0 weeks gestation and above from 01/07/2025-30/09/2025 who were admitted to the LNU.

Data source

Badger Net, LNU and TCP admission book and individual medical notes.

Audit type

Retrospective and live data collection.

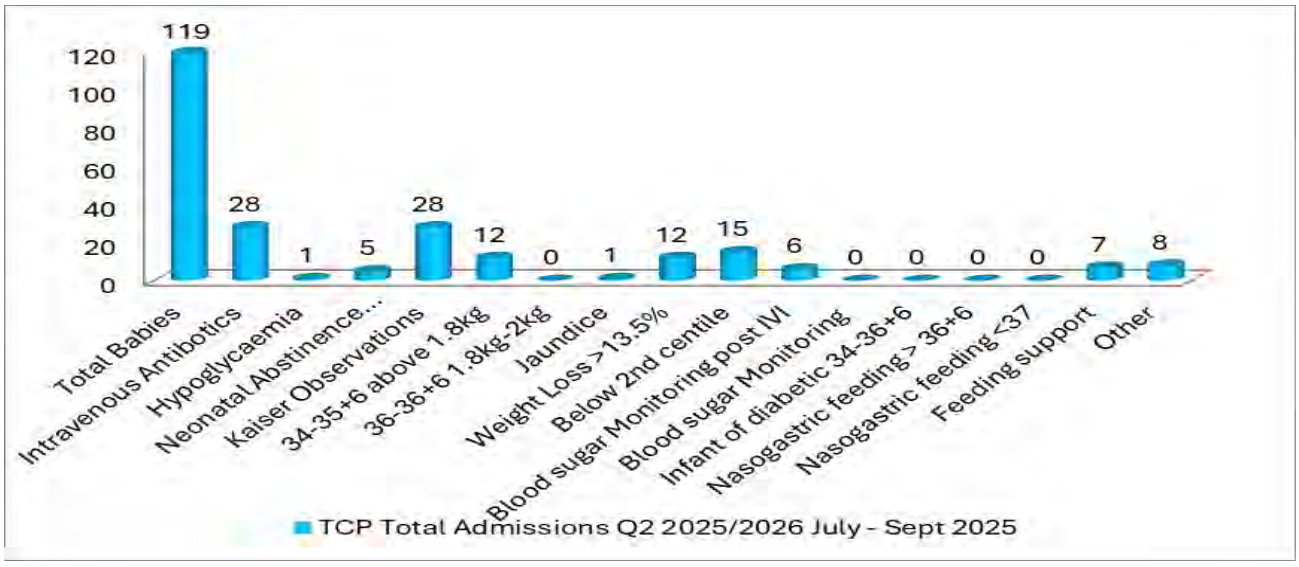
Transitional Care Audit Findings Q2.

Staffing Overview:

In Q2, the Transitional Care Pathway (TCP) was operational 99% of the time, with 95% of shifts meeting the staffing model. However, 14% of shifts exceeded the recommended 1:4 nurse-to-baby ratio due to high neonatal unit acuity, limiting flexibility to support TCP. On average, 26% of shifts involved caring for more than four babies on TCP. No missed opportunities for TCP care were identified, and no babies remained on the Neonatal Unit solely due to nasogastric feeding needs. The staff feedback questionnaire remains open to support ongoing service evaluation and improvement.

Admission Summary

The leading causes of admission to the Transitional Care Pathway (TCP) in Q2 remained consistent: 24% required intravenous antibiotics, 24% required 'Kaiser' observations for suspected sepsis, and 13% were babies below the 2nd centile. Four babies were transferred from TCP to the neonatal unit—two for escalation of care due to respiratory needs, identified promptly through effective use of NEWTT2 charts (100% compliance), and two due to capacity pressures on Mary Ward, though they remained on the TCP pathway with parents accommodated in the neonatal unit. The Perinatal Culture & Leadership programme continues to support positive collaboration between maternity and neonatal teams, with ongoing efforts to expand TCP cot provision, which will require further workforce investment.



Title: RUH TC and ATAIN Audit Q2 2025 July 2025-September 2025	Authors: Kirstie Flood Lead Nurse Neonatal Unit Sarah Goodwin Neonatal Governance Lead
Date: January 2026	Version: 1

Figure 1: Values of admissions to the RUH Transitional Care Pathway (TCP) by causation Q2 2025-2026

Parental TCP feedback and Impact on Service Improvement

Parental feedback remains a vital driver of quality improvement within the Transitional Care Pathway (TCP). Families are invited to share their experiences via a QR code-linked survey, with responses collated by the Trust-wide Patient Experience Team. In Q2, five families responded, all highlighting the exceptional care and support provided by the TCP team. A consistent theme of compassion, empathy, and practical support around infant feeding. Additional written feedback received through Patient Experience Matters echoed this sentiment. These insights are shared with service leads and used to inform ongoing improvements, reinforcing the importance of family-centred care and supporting initiatives to enhance the environment and experience on the TCP.

ATAIN Audit Findings Q2

In Q2, five avoidable term admissions to the Local Neonatal Unit (LNU) were identified through ATAIN MDT reviews, an increase from two in Q1. The cases involved a range of contributing factors, including misclassification of labour stage and CTG interpretation, missed sepsis screening, and decisions relating to elective caesarean timing. While no single theme was consistent across all cases, fetal monitoring, escalation, and CTG interpretation remain recurring areas for improvement. These cases have informed targeted learning, including the development of a 45-minute multidisciplinary teaching session focused on human factors, escalation, intrauterine resuscitation, and fetal physiology. This training aligns with national recommendations (e.g. Ockenden and East Kent reports) and supports updates to local fetal monitoring guidelines and escalation SOPs. Learning is shared widely through governance forums, safety boards, and training resources to drive continuous improvement in maternity and neonatal care.

Admissions to the neonatal unit from other areas in the hospital

In Q2, three term babies were admitted to the Neonatal Unit from other areas within RUH, including the Emergency Department and Children's Ward. All admissions were reviewed and appropriate, with consultant-to-consultant decisions made in line with Guideline NEO-129, which ensures that the right babies are seen at the right time by the right professionals. This pathway has had a positive impact on patient safety and experience by streamlining care, reducing unnecessary transfers, and protecting vulnerable neonates from potential exposure to community-acquired infections.

Term Admissions to the Neonatal Unit – Q2 Analysis

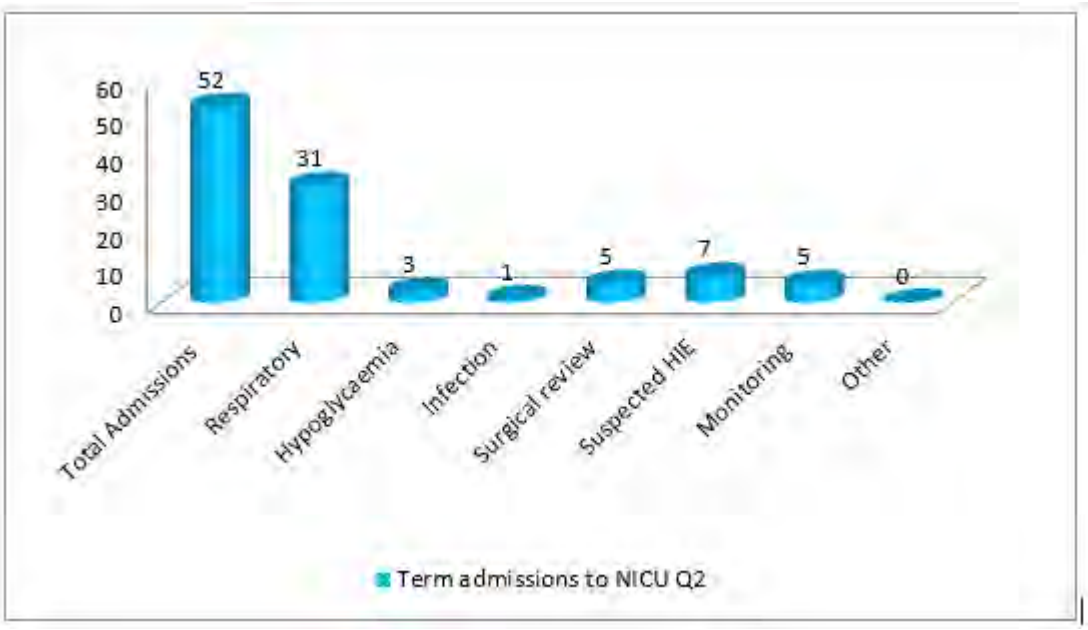


Figure 2: values of Term admissions to the Neonatal Unit RUH by causation Q2 2025-2026

The leading cause of term admissions to the Local Neonatal Unit (LNU) in Q2 was respiratory symptoms, consistent with national trends. Multidisciplinary review found no concerns or common issues in respiratory management, and all admissions were deemed clinically appropriate.

Since the introduction of routine pulse oximetry screening in January 2025, 13 babies have been admitted following failed screens, requiring monitoring, respiratory support, and/or medical care. While this has contributed to an increase in ATAIN rates, it reflects the success of early detection and timely intervention. These outcomes have been positively received and were presented at both the LMNS and BAPM Annual Conference as evidence of the screening programme's impact on improving neonatal safety and care quality.

Quality Improvement Projects

Progression with the implementation of the "CPAP on skin early intervention" (COSEI) Project to reduce the parent-infant separation of term babies with transient tachypnoea of the newborn. At present 3 babies have benefited from this intervention, with 2 still needing ongoing respiratory support after the 90 minutes treatment, thus admission to the Neonatal Unit. This care pathway is dependent on the adequate ANNP and nurse staff availability as 1:1 care on the birthing suite is warranted. Simulation training continues to increase experience of staff.

Completion of a QI project, a thematic review of the last 2.5 years of all babies that have had a pneumothorax diagnosed whilst being cared for on the LNU. Following review of these babies and their antenatal, intrapartum, and subsequent postnatal care, any themes will be recognised and potential areas for improvement will be actioned where relevant. Upon implementing any appropriate changes, measurable improvements will be audited.

Ongoing Improvement Workstreams

Work continues to review the inclusion of 37+ week readmissions in ATAIN data, with benchmarking against the Southwest Neonatal Network to ensure consistency and equity. New guidelines for the care of community infants under three months requiring paediatric intensive care have been published and are being audited for compliance, alongside NEO-129.

A Collaborative Transitional Care Special Interest Group (TC SIG) has been established to drive service improvement and cultural alignment between maternity and neonatal teams. In response to parental feedback, an action plan is being developed to improve the environment on Mary Ward.

Quarterly audits of newborn observation records using the NEWTT2 tool continue to provide assurance, with Q2 showing full compliance. Learning from ATAIN MDT reviews is triangulated with other feedback sources and shared across the Mat Neo team to inform ongoing quality improvement.

Standard 10 sets of records with baby observations	**Q4 2024-2025**	**Q1 2025-2026**	**Q2 2025-2026**
The NEWTT2 chart should be fully completed With core observation	100%	90%	100%
Correct time interval in between observations	100%	100%	100%
The total NEWTT 2 score should be calculated and correct	100%	90%	100%
Escalation is compliant with the NEWTT2 escalation pathway	100%	60%	100%
If score above 0 has the response been documented in the baby notes	100%	80%	100%
Is the chart labelled	n/a	n/a	n/a

Table 1. Audit results of NEWTT2 compliance Q2 2025-2026

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**12**
Date of Meeting:	**14 January 2026**		

Title of Report:	**Maternity, Children and Adult Safeguarding Strategy**
Status:	**For review and approval for publication**
Board Sponsor:	**Antonia Lynch, Chief Nursing Officer**
Author:	**Paula Lockyer, Named Midwife for Safeguarding, Mike Menzies, Named Nurse for Safeguarding Children, Rachel Burns, Named Professional Adult Safeguarding**
Appendices	**Appendix 1: Safeguarding Strategy 'Think Family'** **Appendix 2: Deliverables for Safeguarding Strategy– Sunray Diagram – 3-year plans for Maternity, Children and Young People, and Adult Safeguarding**

1. Executive Summary of the Report

This is the first strategy dedicated to Maternity, Children and Adult safeguarding, which is aligned to the Trust Vulnerable People Strategy. It sets out our commitment to ensure that every person accessing services at the Royal United Hospitals Foundation Trust (RUH) receives the highest standard of care. It is essential that we prioritise the needs of those who are most vulnerable, to protect them from harm, ensuring that their safety, dignity, and well-being are at the forefront of our minds. This document outlines how the Safeguarding team will support the ambitions of the Vulnerable People Strategy.

To help us achieve our vision, the strategy has three ambitions:

- The hospital as a safe community. *Everyone Matters.*
- A skilled trained and competent workforce. *Working Together.*
- Embedding safeguarding learning into practice. *Making a Difference.*

To achieve the three ambitions, there are four goals:

- To achieve >90% level 2 And 3 safeguarding children and adults training compliance. *Working Together*
- To embed safeguarding supervision across the Trust. *Making a Difference*
- To ensure learning from local and national and Trust quality assurance activity are embedded into practice. *Making a Difference.*
- Embed a "Think Family" approach to safeguard our most vulnerable families. *Everyone Matters.*

To effectively achieve our ambitions, we will focus on the key groups of safeguarding,

Maternity, Children and Young People, and Adults. Each group with have their own 3-year workplan to deliver the ambitions set out in the Vulnerable People Strategy and the Safeguarding Strategy.

We will develop and embed a quality assurance cycle, analysing quantitative and qualitative data which will help us know the impact of the care and support we deliver, and to inform shaping of our service.

We have ensured that our Trust Safeguarding Vision aligns closely with the BaNES Community Safety and Safeguarding Partnership (BCSSP), and Wiltshire Safeguarding Vulnerable People's Partnership (SVPP) strategic vision/plan to:

'Work in partnership to develop a person-centred culture across organisations where the child, adult and communities are at the heart of the work we do ensuring people are safe in their homes, educational settings and communities'.

We are committed to working collaboratively with women, birthing people, children, young people, adults, their families and carers and support networks, alongside our partners in the wider community, to continuously uphold these values and improve our services. One of the key deliverables is understanding how the people we care for, families and carers (including unborn babies) will either see and feel the impact of the strategy and what difference we are making to their safeguarding experiences in the Trust.

2.	**Recommendations (Note, Approve, Discuss)**

The Board of Directors is requested to review and approve the Strategy for publication.

3.	**Legal / Regulatory Implications**

The Children Act 1989/2004 is the foundational law for child protection and welfare in England, establishing the principle that a child's welfare is paramount and outlining the legal framework for childcare. The Act imposes a legal duty on hospitals to safeguard and promote the welfare of children, requiring staff to undergo training and act on concerns of harm, abuse, or neglect.

Working Together to Safeguard Children 2023 is statutory guidance published by the UK Department for Education (DfE) that outlines how organisations and professionals in England must collaborate to protect and promote the welfare of children. This involves a multi-agency, multi-disciplinary approach, with clear communication and shared responsibility among all staff and partner agencies. It replaces the 2018 edition and introduces significant updates, including a focus on a 'Think family, work family' approach and new structures for lead safeguarding partners.

The Care Act 2014 is a legal framework for safeguarding adults at risk of abuse or neglect. It includes within hospitals and other settings. The Trust is required to act, promote wellbeing, and work with partner agencies, and apply the six key principles:

empowerment, prevention, proportionality, protection, partnership, and accountability.

The Mental Capacity Act 2005 is a UK law (for England and Wales) that provides a legal framework for making decisions for people aged 16 and over who lack the capacity to make those decisions themselves. It operates under five principles, including the presumption of capacity, the provision of support to help people make their own decisions, and the requirement that any decision made for someone lacking capacity must be in their best interests and the least restrictive option. The Act also enables individuals to plan for their future by making Lasting Powers of Attorney or Advance Decisions to refuse treatment.

Health and Care Act 2022 provide frameworks for protecting children and vulnerable adults from abuse, neglect, and exploitation.

A legal requirement is to make sure services are accessible to all people with protected characteristics under the Equality Act 2010.

The Safeguarding Strategy is underpinned by the legal requirements and aims to improve the care standards for unborn babies and all people of all ages, and to safeguard and protect from harm.

4.	**Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)**
There are no known risks arising or identified.	

5.	**Resources Implications (Financial / staffing)**
There are no costs to the safeguarding team or trust associated with the Strategy or three-year plans	

6.	**Equality and Diversity**
Legislation in relation to equality, diversity and human rights should be applied when implementing procedures and processes in respect of vulnerable people. ‘Respecting diversity, promoting equality and ensuring human rights will help to ensure that everyone using health and social care services receives safe and good quality care.’ (Care Quality Commission). Equality, diversity and inclusion perspectives are included in the Safeguarding Strategy. We are committed to embedding the core values of equality and diversity in all safeguarding work and interventions.	

7.	**References to previous reports/Next steps**
The Safeguarding “Think Family Strategy and associated sunray diagram three-year plans were discussed at the Vulnerable People Committee meeting on 7th August 2025.	

8.	Freedom of Information
Public.	

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

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

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Royal United Hospitals Safeguarding Strategy

'Think Family'

Foreword

The Safeguarding Maternity, Children and Young People, and Adult Strategy sets out our commitment to ensure that every person accessing services at the Royal United Hospitals Foundation Trust (RUH) receives the highest standard of care. It is essential that we prioritise the needs of those who are most vulnerable, to protect them from harm, ensuring that their safety, dignity, and well-being are at the forefront of our minds.

Informed by a human rights perspective, we recognise that everyone has the right to live free from abuse and neglect.

The RUH has a Vulnerable People Strategy, with a vision that 'all Vulnerable People will receive the right care and support, in the right place and at the right time'. This document outlines how the Safeguarding team will support the ambitions of the Vulnerable People Strategy.

Authors: RUH Maternity, Children's and Adult Safeguarding Team August 2025

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Our Vision	**An embedded 'Think Family' approach with a strong safeguarding culture where safeguarding is everyone's responsibility ensuring that the people we care for feel safe.**
Trust Values	**Everyone Matters** · **Working Together** · **Making a difference**
Our Ambitions	**The hospital as a safe community, with systems and processes that adopt an open culture** **A skilled, trained and competent workforce who can recognise and respond to abuse and neglect** **Embedding safeguarding learning into practice to ensure the best possible outcomes for our patients**
Our Goals	To achieve > 90% level 2 and 3 safeguarding adults and children training compliance in the appropriate staff groups. To embed safeguarding supervision across the Trust. To ensure learning from local and national and Trust quality assurance activity are embedded into practice. Embed a 'Think Family' approach to safeguard our most vulnerable families.
How we will achieve our goals?	Adult, children and young people, and maternity 3-year delivery plan. Encourage staff to attend and participate in safeguarding training and supervision. Obtain and act on feedback from the people we care for, the people in our community and people we work with, our RUH community. To ensure we are meeting their needs.

Royal United Hospitals Bath
NHS Foundation Trust

Introduction

Our Safeguarding Strategy sets out our commitment to ensuring that every child, young person, family and adult accessing care at the Royal United Hospitals Bath NHS Foundation Trust (RUH) receives the highest standard of care and the right level of support at the right time. When we get this right, we can make a difference for unborn babies, children, young people, adults, their families and the communities they live in. It is essential that we prioritise the needs of those who are most vulnerable, to protect them from harm, ensuring that their safety, dignity and well-being are at the forefront of our minds.

Our strategy is built on the principles of the RUH Trust's core values and underpinned by the Vulnerable People's Strategy vision and ambitions. We are committed to working collaboratively to support unborn babies, children, young people, adults and their families, alongside their support networks and with our partners in the wider community, to continuously uphold these values and improve our services. The RUH Trust will work tirelessly to support the safeguarding needs of the people we care for, the people we work with (including carers, staff and visitors) and the communities we live in.

We will work with our partners in BaNES, Swindon and Wiltshire Integrated Care Board, BaNES Community Safety and Safeguarding Partnership (BCSSP), Wiltshire Safeguarding Vulnerable Peoples Partnership (SVPP) and Somerset Safeguarding Partnership to provide robust leadership in line with: Working Together to Safeguard Children (2023), the Children Act (1989) the National Safeguarding Accountability and Assurance Framework (2024) and the Care Act (2014).

Why have we made this strategy and who have we made it for?

We want to make sure that all unborn babies, Children, Young People, Adults and their families with safeguarding needs and vulnerabilities, receive the appropriate level of support whilst they are under our care. Delivering personalised care to improve outcomes continues to be our focus.

We aim to ensure that when an unborn baby, child, young person or adult is identified as suffering or likely to suffer significant harm, there is a prompt, appropriate and effective response to ensure the protection and support of the individual and their immediate family. We will work across Maternity, Children and Adult safeguarding, to understand and identify the level of support required, from a collaborative 'Think Family' approach.

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The Safeguarding Strategy has identified 3 ambitions to align with those set out in the Vulnerable People Strategy:

- The hospital as a safe community, with systems and processes that adopt an open culture and 'Think Family' approach.
- A skilled, trained and competent workforce.
- Embedding learning into practice to provide the highest standard of care and the best possible outcomes.

To achieve our ambitions, we have 4 goals:

- To achieve > 90% Level 2 and 3 safeguarding adults and children training compliance in the appropriate staff groups. Change to align.
- To embed safeguarding supervision across the Trust.
- To ensure our internal and external learning is embedded into practice and assess how outcomes are impacted to ensure we are making a difference.
- Embed a 'Think Family' approach to safeguard our most vulnerable families. We will foster a professionally curious workforce, who will be confident in capturing the child, young person and adult's voice to be able to demonstrate a day in the life for them and their family.

To effectively achieve our ambitions, we will focus on the key groups of safeguarding, Maternity, Children and Young People, and Adults. Each group with have their own 3-year workplan to deliver the ambitions set out in the Vulnerable People Strategy and the Safeguarding Strategy and are described below.

We will develop and embed a quality assurance cycle, analysing quantitative and qualitative data which will help us know the impact of the care and support we deliver, and to inform shaping of our service.

We have ensured that our Trust Safeguarding Vision aligns closely with the BaNES Community Safety and Safeguarding Partnership (BCSSP), and Wiltshire Safeguarding Vulnerable People's Partnership (SVPP) strategic vision/plan to:

'Work in partnership to develop a person-centred culture across organisations where the child, adult and communities are at the heart of the work we do ensuring people are safe in their homes, educational settings and communities'.

We are committed to working collaboratively with women, birthing people, children, young people, adults, their families and carers and support networks, alongside our partners in the wider community, to continuously uphold these values and improve our services.

Royal United Hospitals Bath
NHS Foundation Trust

Maternity

How will we achieve our ambitions in maternity?

We will:

Ensure there is ongoing regular provision of safeguarding children training for all maternity and neonatal staff in line with the standards set out in the Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019).

Ensure that there are safeguarding supervisors trained across maternity to provide bespoke, 1-1 and group safeguarding supervision to all maternity staff when required.

Ensure that learning from any local Rapid Reviews or Child Safeguarding Practice Reviews is translated into an action plan for the Trust and embedded into practice through training, supervision and audit. Through this process we will be able to understand what difference this has made to outcomes for families.

Ensure that the RUH maternity service applies a 'Think Family' approach to all risk assessments, with an equal focus on assessing and supporting fathers/partners as there is on the mothers/birthing persons. This will include the embedding into practice of any new initiatives that support a robust holistic assessment of the family circumstances.

How will women/birthing people with complex social factors and their partners/ family see and feel the impact of our ambitions?

When women/birthing people and their partners tell us they:

- Feel welcome and safe in the care of the RUH Maternity Service.
- Feel included and involved in decisions about their care and valued for who they are.
- Have been given individualised care that is tailored to their specific needs.
- Feel empowered to make positive changes in their lives that will help them to be safe and responsive carers to their babies.
- Have been encouraged and supported to actively manage their health and wellbeing.

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Children and Young People

How will we achieve our ambitions in the Children's facing workforce?

We will ensure there is ongoing provision of safeguarding children training for relevant clinical staff in line with the standards set out in the Safeguarding Children and Young People : Roles and Competencies for Healthcare Staff (2019).

We will ensure that there are safeguarding supervisors trained across the children and adult facing workforce to provide ad hoc, 1-1 and group safeguarding supervision to all staff when required. We will also continue to explore opportunities for joint 'Think Family' supervision with the Adult safeguarding team.

We will ensure that learning from any local Rapid Reviews or Child Safeguarding Practice Reviews is translated into an action plan for the Trust and embedded into practice through training, supervision and audit. Through this process will be able to understand what difference this has made to outcomes for families.

How will children and young people their families and carers know that we are making a difference to their safeguarding experiences in the Trust?

- Their views will be heard and acted on.
- They will see and experience that we understand the quality and impact of the care and support we deliver. Vulnerable children, young people and their families/carers, will feel listened to and know that we have heard their experiences alongside feedback from staff and partner organisations.
- Children, young people and their families will feel included and involved in decisions about their care and feel valued for who they are.

Adults at risk

We aim to be a trusted, safe organisation where all adults at risk of harm, abuse or neglect are safeguarded by staff who feel empowered, valued and supported.

Making Safeguarding Personal (MSP)

The Trust is committed to embedding the 6 safeguarding key principles defined in The Care Act (2014), ensuring that person-led safeguarding is delivered, enhancing the involvement, choice and control of the individual with care and support needs, as well as improving quality of life, and safety.

The Care Act (2014)

6 safeguarding principles:

- **Empowerment**
- **Protection**
- **Proportionality**
- **Prevention**
- **Partnership**
- **Accountability**

How will we achieve our ambition in safeguarding adults at risk?

- We will ensure that when we work with adults at risk of harm their human rights are upheld.
- We will ensure a safe and competent workforce who are able to safeguard adults at risk of harm, aligned with the Adult Safeguarding: Roles and Competencies for Healthcare Staff (2024)
- We will foster a culture of openness and honesty when safeguarding concerns have arisen and take time to explain those concerns clearly.
- We will be accountable to our patients, staff and community partners and ensure '*Safeguarding is Everybody's business'.*

How will adults at risk, families and patients know and feel the impact of this strategy?

- When abuse is identified, those affected are involved and empowered to engage and make their own decisions with valid consent.
- A trained and knowledgeable workforce, who place the person at the centre through their understanding of their roles and responsibilities and skills to respond to safeguarding adult concerns, do 'with' people and not do 'to' people.
- An open culture where patients and staff feel able to raise concerns and confidence that their voice will be heard.

In delivering the Safeguarding Maternity, Children and Young People and Adult safeguarding strategy we will aim to live out our Trust vision and values which are aligned to the Vulnerable People Strategy.

References:

Working Together to Safeguard Children, UK: Home Office 2023

The Children Act 1989

Safeguarding Accountability and Assurance Framework , NHS England, 2024

The Care Act 2014

Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Fourth edition : January 2019

Adult Safeguarding : Roles and Competencies for Healthcare Staff London RCPCH, Second edition : July 2024

Review date August 2028

Royal United Hospitals Bath
NHS Foundation Trust

The hospital as a safe community

Foundation Year

- Implementation of the new BadgerNet electronic record system for maternity, ensuring the safeguarding sections are used effectively.
- Embed the use of the Graded Care Profile 2 Antenatal (GCP2A) neglect toolkit within the Wiltshire Lotus team.
- Seek feedback from the women/birthing people with complex factors and their experience of Lotus team care In order to further develop the service.
- Seek feedback from the women who are given HOPE Boxes due to separation from their babies through the family court, to assess the impact
- Work alongside the trust IDSVA to ensure that families affected by domestic abuse receive support and staff are trained in routine enquiry and effective response to disclosure.
- Develop strategies to ensure that a 'Think Family' approach is embedded across the maternity service.
- Produce resources to support people with learning disabilities and autistic people using maternity services.

Year 2

- Join the BadgerNet safeguarding platform meetings, to further develop the safeguarding sections of the EPR.
- Use regular feedback from the Lotus team caseload to inform and develop future practice, alongside the continued use of audit.
- Liaise with the safeguarding midwives across the BSW area regarding the use of the GCP2A toolkit and train wider workforce across the region, including representatives from Children's Social Care.

Year 3

- Maternity safeguarding service tailored to individual needs with a Think Family approach
- A clear shared vision with safeguarding partners for how to improve outcomes for babies and their families across all levels of need and types of harm.

The RUH

Maternity Safeguarding Strategy

"An embedded 'Think Family' approach with a strong safeguarding culture where safeguarding is everyone's responsibility ensuring that the people we care for feel safe."

- Confident and competent maternity workforce that know how to respond to safeguarding concerns in an individualised, appropriate and timely way.
- Midwives working in collaboration with families to empower them to make positive changes.
- An embedded culture of learning that uses evidence-based practice and professional expertise to inform and guide decisions to keep babies and their families safe.

- Roll out trauma awareness training across the wider Lotus and maternity teams.
- Start recording and monitoring attendance at group safeguarding supervision sessions.
- Produce a guideline for staff when working with families where one or both parents are a registered sex offender.

- Widen the SIRS project to the whole Lotus team and plan for further roll out to gain relevant safeguarding information on all fathers.
- Audit the use of the cannabis screening tool within the audit of women with complex social factors in order to assess how well embedded this is in practice.
- Use qualitative data from dashboard to inform priorities for identified learning into practice.

- Elevation of the Specialist Support Midwives to band 7 in line with the maternity safeguarding model in other trusts.
- Work with the maternity recruitment and retention team to ensure that maternity and neonatal level 3 safeguarding children training compliance is maintained above 90%.
- Continue to ensure that safeguarding supervision is available to all midwives on a 1-1, group and ad hoc basis.
- Implement trauma awareness training for the safeguarding team.
- Work with staff around registered sex offenders and balancing risk/not being judgemental and working to individualised safety plans.

- Commence the Sharing Information Regarding Safeguarding (SIRS) pilot in Bath. This will involve midwives caring for the more complex families contacting the fathers GP to ask for any relevant safeguarding information to be shared.
- Embed the use of the new cannabis screening tool with expectant parents.
- Continue to share learning from audit, reviews, feedback from parents and partner organisations. Cross-referencing with safeguarding data will allow us to assess the influence on outcome measures.
- Integrate with Trust AMaT processes to demonstrate learning from audits and reviews.
- Conduct thematic audits informed by local and national safeguarding data/emerging themes.

A skilled trained and competent workforce

Embedding learning into practice

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The hospital as a safe community

Foundation Year

- Support the BSW shared EPR planning to ensure processes and systems continue to protect those we care for.
- Use regular feedback from the Childrens workforce and families/children/YP to inform and develop future practice, alongside the continued use of audit.
- Work alongside the trust IDSVA to ensure that families affected by domestic abuse receive support and staff are trained in routine enquiry and effective response to disclosure.
- Develop strategies to ensure that a “Think Family” approach is embedded across the children’s facing service.

Year 2

- Support the BSW shared EPR planning/implementation to ensure processes and systems continue to protect those we care for and ensure the smooth transition to the new shared EPR processes.
- Use regular feedback from the Childrens workforce and families/children/ young people to inform and develop future practice, alongside the continued use of audit.

Year 3

- Children’s safeguarding service tailored to individual needs with a Think Family approach.
- A clear shared vision where all staff will respond to children, young people and family’s needs to ensure they feel safe and responded to across all levels of need and types of harm.

The RUH

Children and Young People Strategy

“An embedded ‘Think Family’ approach with a strong safeguarding culture where safeguarding is everyone’s responsibility ensuring that the people we care for feel safe.”

- Confident and competent workforce that know how to respond to safeguarding concerns in an individualised, appropriate and timely way.
- To demonstrate the impact of the strategy on improving safeguarding outcomes across the system.

- An embedded culture of learning that uses evidence-based practice and professional expertise to inform and guide decisions to keep children, young people and families safe.

- Roll out trauma awareness training across the wider workforce.
- To continue focusing on the Think family agenda across the Trust.
- Continue to be a listening organisation, demonstrating the positive impact of learning across the children’s facing workforce.
- Ongoing support for the transitional safeguarding agenda.

- Embed learning from audits, including analysis of impact and outcomes.
- Use qualitative data from dashboard to inform priorities for identified learning into practice.
- Develop resources to support learning from Child Safeguarding Practice Reviews.
- Measure the impact of any learning from reviews.
- Use of data, audit and review outcomes to identify targeted learning opportunities in the Trust.

- Implement trauma awareness training for the safeguarding team.
- Continue to seek views of children, young people and families/carers to further inform the strategy.
- Work with partner agencies to inform the transitional safeguarding agenda from children to adult care.
- Continue to support children and young people with risks outside the home/contextual safeguarding agenda.
- To analyse the impact of learning from audit, reviews, feedback from children/Young people, families/carers and partner organisations. Cross-referencing with safeguarding data will allow us to assess the influence on outcome measures.
- Triangulating with Divisional Governance systems to share key safeguarding messages across the Trust.

- Continue to share learning from audit, feedback from parents and partner organisations. Cross-referencing with safeguarding data will allow us to assess the influence on outcome measures.
- Share learning from National and Local Child Safeguarding Practice Reviews.
- Integrate with Trust AMaT processes to demonstrate learning from audits and reviews.
- Develop a joined up safeguarding dashboard with BSW ICB partners to ensure robust collection of quantitative data.

A skilled, trained and competent workforce

Embedding learning into practice

NHS
Royal United Hospitals Bath
NHS Foundation Trust

Care Act 2014 Safeguarding Principles

Empowerment | **Prevention** | **Proportionality** | **Protection** | **Partnership** | **Accountability**

The hospital as a safe community

Foundation Year

- Assuring that safeguarding practice is person-centred and outcome focused.
- Seeking assurance that safeguarding practice is continually improving.
- Embed person centred approaches to adult safeguarding.
- People at risk of abuse and neglect are asked for their desired outcomes from the safeguarding process and these directly inform what happens.
- Embedding the Empowerment principle – Personalisation and the presumption of person-led decisions and informed consent.

Year 2

- Strengthen opportunities for adults with lived experience to provide feedback.
- To embed an open, honest, transparent culture with strong communication and partnership working to ensure effective adult safeguarding.
- **Person Centred Engagement:** Ensure that people are supported and empowered to make decisions and achieve the best outcomes.
- Record and monitor attendance at group safeguarding supervision sessions. Develop a tool to measure impact.
- Use patient feedback to inform training to enable best practice, encourage professional challenge and evidence what is working well whilst highlighting areas requiring further development and/or strengthening.
- Roll out trauma awareness training across adult facing staff.
- Established group of safeguarding link staff across the Trust.

Year 3

- A culture where all staff respond to safeguarding concerns and adults at risk are listened to. Relatives, friends, their representatives and people in local communities are responded to and valued by staff.
- Confident and competent staff that use trauma informed practise to address safeguarding concerns in an individualised, appropriate and timely way.
- Patient involvement and the principles of Making Safeguarding Personal (MSP) are embedded in safeguarding activities.

The RUH

Adult Safeguarding Strategy

An embedded 'Think Family' approach with a strong safeguarding culture where safeguarding is everyone's responsibility ensuring that the people we care for feel safe."

Impact:

- An embedded culture of learning that uses evidenced based practice and professional expertise to inform and guide decisions and interventions aimed at protecting adults at risk.
- SARs and DARDs are used to promote effective learning and improvement actions to prevent future harm to adults at risk.

- **Training**
  To promote greater understanding of 'when do you raise a safeguarding concern' and 'making safeguarding personal'.
- Promoting awareness of adult safeguarding and how concerns can be raised. Creation of Safeguarding and Domestic Abuse link staff.
- Work across Trust Divisions to ensure that Level 3 Safeguarding adult training reaches compliance and is maintained above 90%.
- Scope and roll out a programme of adult safeguarding supervision to adult facing staff on a 1-1, group and ad hoc basis.
- Implement trauma awareness training for the safeguarding team.
- **Patient experience**
  To gather the safeguarding experience of patients, families and carers through feedback opportunities to strengthen learning for staff.

A skilled trained and competent workforce

- **Safeguarding Adult Reviews (SARs) and Domestic Abuse Related Death Reviews (DARDs)– Learning.**
- Develop appropriate materials to support the dissemination of learning.
- Measuring the impact of our safeguarding response.
- Use qualitative data to understand the lived experience of those supported by the safeguarding process.
- Using data and audit outcomes to identify targeted areas for promotion through learning.
- Develop Audit processes which identifies both qualitative and quantitative data, to monitor the reporting of safeguarding concerns, Making Safeguarding Personal (MSP) and Equality, Diversity and Inclusion (EDI).
- Seek to evidence the outcomes and impact of work done, to promote a holistic and person-centred approach, ensuring the voice of the person is heard throughout their life regardless of their age.
- Share thematic learning and actions and embed into practice and service development.

Embedding learning into practice

Report to:	**Public Board of Directors**	**Agenda item:**	**13**
Date of Meeting:	**14 January 2026**		

Title of Report:	**Annual Nursing Workforce and Establishment Review**
Status:	**For discussion and approval**
Board Sponsor:	**Antonia Lynch, Chief Nursing Officer**
Authors:	**Simon Andrews, Associate Chief Nurse for Workforce and Education** **Natasha Browne, Professional Lead for Workforce Growth (AHP, Nursing and Midwifery)**
Appendices	**Appendix 1: Safe Staffing Dashboard** **Appendix 2: National Quality Board Recommendations self-assessment** **Appendix 3: Developing Workforce Safeguard Recommendations self-assessment**

1. Executive Summary of the Report

Background:

This report provides an in-depth analysis of the Nursing staffing levels with a lens on patient safety, staff experience and development to sustain our workforce. The assessment evaluates Nursing staffing compliance underpinned by the principles described in Developing Workforce Safeguards (NHSI 2018) and measures against National Quality Board (NQB) standards and National Institute for Health and Care Excellence (NICE) guidance. This report runs concurrently with its counterparts in Midwifery and Allied Health Professionals (AHPs).

There is clear national evidence of a direct correlation between staffing levels and patient outcomes, including the incidence of adverse events and inpatient mortality. The review aimed to assess current staffing establishments across various inpatient areas, including the Intensive Care Unit (ICU) and the Emergency Department, to assure the Trust Board that departmental establishments meet service demand with high quality care and achieve safe staffing standards.

A comprehensive staffing review was conducted using multiple methodologies, including:

- The Shelford Safer Nursing Care Tool
- Care Hours Per Patient Day (CHPPD)
- Workforce data including vacancy, turnover, sickness, and appraisals
- Patient quality and outcome data
- Patient and staff experience metrics

Key headlines include:

- The establishment review has identified the need for no further investment during this review period in nursing establishments for inpatient wards, Paediatrics and the Emergency department.
- Nursing vacancy and turnover remains low within inpatient wards which contributes to safe staffing.
- The Emergency Department continues to have significant nursing vacancy; however, this is supported with a recruitment trajectory to recruit into vacancies by Spring 2026.
- Inpatient fill rate for Registered Nurses and Healthcare Support Workers has remained consistent for the period of this report.

- There has been a reduction in the reliance on high-cost agency in specialist areas due to successful recruitment.
- Substantive recruitment to the Enhanced Care Team has contributed to a significant reduction in agency spend as well as improved personalised care and support.
- The increasing complexity of patient care, particularly for people experiencing a mental health crisis and people living with dementia who require additional staffing and specialised training.
- Feedback from staff surveys highlights a decline in all but one area in the healthcare support workers staff survey results and 'people promise markers' with a significant decline in staff engagement areas, feeling recognised and rewarded and flexible working. For nursing a decline in results was noted across most areas particularly in being safe, health and wellbeing and morale in the workplace.
- The hospital has successfully facilitated a substantial number of students and learners in clinical practice, contributing positively to workforce development and reinforcing the importance of adequate supervisory support to sustain high learner volumes and associated revenue generation. The report also notes a planned reduction in apprenticeship placements as part of measures to achieve financial sustainability.

The Report Recommends:

- A change in the paediatric skill mix to meet the needs of the children and young people we care for with increased mental health needs.
- A focus on Healthcare Support Worker succession planning and identifying high risk areas for maternity leave and vacancy and utilising diverse pathways such as HCSW2RN, return to practice and military placements to support these areas to ensure safe staffing.
- Professional Nurse Advocates: Develop a group wide strategy and provide Board oversight on the data capture in this area through quarterly reports. To support with morale, staff engagement and supporting a voice that counts. Utilising the role effectively in national reports has evidenced an improvement in sickness and turnover rates resulting in financial savings (Deutsch, et al, 2023).
- Enhancing workforce diversity: Strengthen initiatives aimed at improving workforce diversity and reducing discrimination, ensuring that staff from all backgrounds feel supported and valued.
- Review of outpatient safer staffing as part of the bi-annual establishment review process aligned to the outpatient transformation programme.
- National Agenda for Change Nursing Profiles: Align current nursing roles to updated national profiles. Reviewing clinical skills, job descriptions and establishment skill mix impact of the new profiles. This work is being conducted across the BSW Group model to standardise.

The cycle of biannual reviews continues to assess staffing levels support safe care; the next round of reviews has commenced and will be presented to the Board of Directors in 2026.

2.	**Recommendations (Note, Approve, Discuss)**

The Board is asked to **discuss** and **approve** the recommendations detailed in the report, outlining the current context and statement of need.

3. Legal / Regulatory Implications

The National Quality Board (NQB) guidance (2013) requires trusts to undertake a full nursing and midwifery safe staffing review annually, and at least every six months to review nursing, midwifery and care staffing capacity and report this to a public Board meeting.

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

This report outlines identified gaps in workforce establishment which present risks identified on the risk register as below:

Risk ID	Directorate & Specialty	Description of the Risk	Current Risk Rating
2764	Trust Wide	Risks to patient safety and staff wellbeing as a result of the Nursing, AHP and Midwifery workforce cost reduction programme	16
2075	Medicine-Emergency Medicine	Risk that patient safety will be affected by inadequate staffing within ED and the Urgent Treatment Centre	16
3068	FaSS-Gynaecology	Gynaecology nursing workforce shortall	12
3118	FaSS- Oncology	Oncology outpatients nursing workforce shortfall	12
3020	Surgery-Urology	Nursing workforce sustainability for provision of local anaesthetic transperineal prostate biopsy in urology outpatients	8

5. Resources Implications (Financial / staffing)

This proposal outlines no further increase to budgeted Nursing establishment.

6. Equality and Diversity

Compliant with the Equality and Diversity Policy.

7. References to previous reports

- Mid-year review of Nurse staffing levels – July 2025
- Paediatric Inpatient Skill Mix Change – Quality Assurance Committee April 2025
- Annual Establishment Review – January 2025
- Mid-year review of Nurse staffing levels – January 2024
- Mid-year review of Nurse staffing levels – Quality Governance Committee 2023

8. Freedom of Information

Not Applicable

Introduction

The purpose of this paper is to provide the Board of Directors with an assessment of Nursing staffing levels and escalate workforce challenges at Royal United Hospitals, Bath. It measures the Trusts compliance with the Developing Workforce Safeguards (NHSI 2018) standards, which builds on National Quality Board (NQB) standards and National Institute of Health and Care Excellence Guidance (NICE, 2014).

This paper focuses specifically on a review of nursing workforce levels for inpatient areas including the Intensive Care Unit (ICU) and the Emergency Department (ED) undertaken from June 2024 to June 2025 the graphs and data contained in the paper cover the period from June 2024 to June 2025 to enable the observation of trends.

The workforce requirements for safe Maternity services and the Neonatal Unit (NNU) have been reviewed separately, and the paper was reported to the Board of Directors in November 2025.

Background

Evidence has shown there is a direct correlation between the registered nurse-to-patient ratio and the incidence of adverse events (Murphy et al 2021) which includes an increased risk of inpatient mortality (Musy et al 2021). Furthermore, economic modelling demonstrated that increasing the number of registered Nurses (RNs) delivered better outcomes with a net decrease in cost due to reduced length of hospital stays (Griffiths et al, 2018). A later study found for every additional hour of RN care available during the first 5 days of a patient's hospital stay, the risk of death was reduced by 3% (Griffiths 2019).

Reducing mortality is not the only benefit of increasing nurse staffing; studies have also shown a direct correlation between nurse staffing levels and patient outcomes. Shang et al (2019) found the risk of health care acquired infections increased by 15% when patients were exposed to low staffing levels. The research concluded that while healthcare support workers have an important part to play in maintaining the safety of patients, they cannot act as substitute for registered nurses.

The primary aim for the establishment review was to assess the hospital current establishments against the principles of Safe Staffing across inpatient wards and the Emergency Department, and to determine if investment was required to deliver Safe Staffing. The National Quality Board (NQB, 2016) guidance, 'Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, sustainable and productive staffing'. which provides a set of expectations (Appendix 1) for nursing and midwifery care staff, and an expectation that the RUH measures and improve patient outcomes, people productivity and financial sustainability all together.

Ward staffing review methodology

A full review is undertaken annually, with a 'light touch' review at six months which was last presented at RUH Trust Board in July 2025. The RUH has a systematic, evidence-based, and

triangulated approach which aims to provide safe, competent,
and fit for purpose staffing levels to deliver efficient, effective, and high-quality care.

The twice-yearly reviews are led by the Associate Chief Nurse for Workforce and Education, supported by the Divisional Finance Manager for Medicine, Divisional Human Resources Business Partner and took place throughout December 2024 – February 2025 the comprehensive data set is comprised of:

- Shelford Safer Nursing Care Tool Acuity/Dependency staffing multiplier (A nationally validated tool reviewed in 2013 - previously AUKUH acuity tool)
- Care Hours Per Patient Day (CHPPD)
- Workforce data including vacancy, turnover, sickness, appraisals, and ethnicity.
- Professional judgement
- Peer group validation
- Benchmarking and review of national guidance including Model Health System data
- Review of e-Rostering Key performance Indicators
- Patient quality and outcome data including falls, pressures ulcers & other harms
- Patient experience including Friends and Family Test, Patient Advice and Liaison Service (PALS) and Complaints
- Staff experience including staff survey results and Freedom to Speak Up information.

Each ward was represented by their Ward Senior Sister / Charge Nurse, Matron, and the relevant Divisional Director of Nursing. Clinical Leads, Speciality Managers and Human Resource (HR) Business Partners were also invited to attend. The outputs of the establishment reviews are discussed later in this report.

National guidance and research underpinning the Annual Nursing and AHP workforce review:

The National Quality Board (2017)

The expectations are fulfilled partly by this review, and the detailed action plan (Appendix 3) has been updated with progress towards compliance with the 37 recommendations that make up the three over-arching expectations. The latest full review of the action plan (October 2025) shows the RUH is compliant with 30 of the 37 recommendations.

This report aligns with the NQBs shared commitment by highlighting how workforce strategies, particularly in recruitment, induction, support, and education can contribute to improving the experience of care across clinical pathways.

Developing Workforce Safeguards (NHSE, 2018)

Effective workforce planning is central to delivering safe, high-quality care. The *Developing Workforce Safeguards* (DWS) guidance (NHSE, 2018) sets out a clear framework for establishing safe staffing levels through triangulated decision-making, combining evidence-based tools,

professional judgement, and patient outcomes. It reinforces the importance of robust governance and board-level oversight in ensuring staffing meets the needs of patients and services.

The latest DWS self-assessment in July 2025 (Appendix 3) shows compliance with all 14 of the Developing Workforce Safeguards recommendations.

Building on this, the *National Quality Board Improving Experience of Care Framework* (2022) refreshes the understanding of quality by positioning experience of care as a core pillar alongside safety and effectiveness. It emphasises the need for inclusive leadership, co-production with patients and carers, and consistency across systems in how experience is embedded into care delivery.

Together, these frameworks highlight that workforce establishment is not just about numbers; it's about ensuring the right skill mix, compassionate care, and a culture that values what matters to people. This report reflects these principles on a local level by exploring how workforce strategies particularly recruitment, induction, support, and education contribute to safe staffing and improved experience of care across our services.

Learner Experience, Support and Professional Pipelines

National policy increasingly recognises learner experience as central to workforce sustainability. The *Developing Workforce Safeguards* (NHSE, 2018) and *NQB Experience of Care Framework* (2022) both emphasise triangulating data combining feedback, professional judgement, and workforce metrics to drive quality and safety.

This approach is reinforced by the Graduate Guarantee, which ensures employment opportunities for newly qualified nurses and midwives, and the Safe Learning Environment Charter (SLEC), which defines what good looks like in clinical learning environments, supporting supernumerary time, supervisor continuity and recognising the value in compassionate and kind support of learners. Together, these frameworks support a shift from transactional metrics to person-centred planning.

The Professional Workforce Team are applying this thinking across Nursing by integrating learner feedback, re-evaluating KPIs, and aligning apprenticeship and education pathways with workforce establishment needs, ensuring learners are valued, supported, and strategically embedded in the future workforce. This approach is supported by the most recent National Education and Training Survey (NETS, 2024) which indicated that 87% of respondents felt more inclined to remain in the NHS when qualified when they'd had a positive learning experience.

Apprenticeship Programmes such as the Student Nurse Associate and Registered Nurse Degree Apprenticeship are supported in the 10 Year Plan (NHSE, 2025) which has an ambition of nursing apprenticeships to increase to 22% by 2031 (an increase of the national picture at 7%). The data outlined below demonstrates a decline locally of apprenticeship routes due to vacancy and financial pressures following financial options appraisal with non-recurrent funding.

Equality, Diversity and Inclusion

The main reports and guidance informing Equality, Diversity, and Inclusion (EDI) includes the Marmot Review (2010), which highlights the scale and persistence of discrimination and racism affecting patient outcomes, The Workforce Race Equality Standard (WRES) established in 2014 consistently reports disparities in the experiences of Black, Asian and Minority Ethnic (BAME) staff compared to white staff, and as an acute provider the RUH is expected to show progress against a number of indicators. The local picture in the communities surrounding the RUH, suggest a global majority population of around 8% the total population of Bath (Census, 2021). In London (for example) the global majority population according to the same census suggests a global majority population at 60%. This highlights the stark ethnic diversity gap and underscores the importance of targeted EDI strategies to ensure inclusion, representation and diversity of thought is promoted.

The NHS Long Term Workforce Plan (2023) embeds EDI as a strategic priority, recognising that inclusive workplaces improve staff experience, retention, and patient outcomes. The accompanying EDI Improvement Plan outlines targeted actions to address inequalities related to gender, sexuality, disability, ethnicity, and other protected characteristics.

The other principles underpinning this report are recommendations from the following resources:

- National Institute for Clinical Excellence (NICE)
- Safer Nursing Care Tool for inpatient wards and the Emergency Department
- The Royal College of Emergency Medicine (for the Emergency Department)
- Safer Nursing Care Tool for the Paediatric RSV inpatient wards
- British Thoracic Society (for respiratory services)
- Guidelines for the provision of Intensive Care Services
- Association for Perioperative Practice, Staffing for Patients in the Perioperative Setting (for Theatres and recovery)
- British Cardiovascular Society (for the Acute Cardiac Unit)
- Get It Right First Time (for the Acute Stroke Unit).

Considerations over the last 6 months since the previous twice-yearly safer staffing review

Ward refurbishment programme

The ward refurbishment programme has required Charlotte, Cheselden and Helena wards to relocate in turn to B12 ward (old Intensive Care Unit) since April 2025 to allow essential maintenance and fire safety work to be undertaken as planned. This has resulted in a different ward layout and occupancy levels. Nurse staffing has been reviewed for the period of reduced occupancy with continued adherence to the NICE recommended registered nurse to patio ratio of 1:7.

B36 Intensive Care Unit

In March 2025, the B36 Intensive Care Unit (ICU) reopened as a modernised, single-footprint unit with capacity for up to 16 patients. Consolidating services into one ICU has enabled a more efficient staffing model, reducing the overall establishment by eliminating duplication of roles previously

required to safely staff two separate units, while continuing to meet national Guidelines for Provision of Intensive Care Services (GPICS) standards.

Reduced dependency on high-cost temporary staffing (Agency)

Due to the successful recruitment and retention across the Nursing workforce, high-cost temporary staffing has significantly reduced and remained consistently low for the period of this report. To uphold safety in the difficult to recruit and retain areas such as Urgent and Emergency Care, agency staff may still be used, although there is robust oversight by the Chief Nursing Officer (CNO) and Divisional Directors of Nursing (DDON).

Nursing workforce overview

Registered Nursing

Figure 1 demonstrates the vacancy rates for bands 5 – 7 registered nurses, this information however, should be interpreted with some caution across both Nursing and Healthcare Support Worker data. Workforce vacancy figures are currently calculated as the difference between budgeted and contracted WTE. The data is finance information and there is limited triangulation between workforce (Electronic Staff Register) and finance data.

The Trust has seen a rise in registered nurse vacancies in February 2025. The Trust has vacancies in its Children's inpatient team, Respiratory ward and Emergency Department (ED). Active recruitment has seen an overall reduction in vacancies with new staff scheduled to commence in post between September and November 2025 for Children's and Respiratory ward. The Emergency Department had 31WTE registered nurse vacancies in June 2025, successful recruitment has seen this reduce to 12WTE in November 2025. There is an active ED recruitment campaign in place.

Turnover rates for registered nursing remain extremely low and this continues to be monitored monthly to support the employment of newly qualified nurses as part of the NHSE graduate guarantee programme. Sickness rates for the same group of staff remained stable, hovering between 5-6.5%, however this is more than is accounted for in the headroom and therefore has a financial cost to the Trust. Appraisal rates initially showed an upward trend but since August 2024 has slowly declined to around 83%.

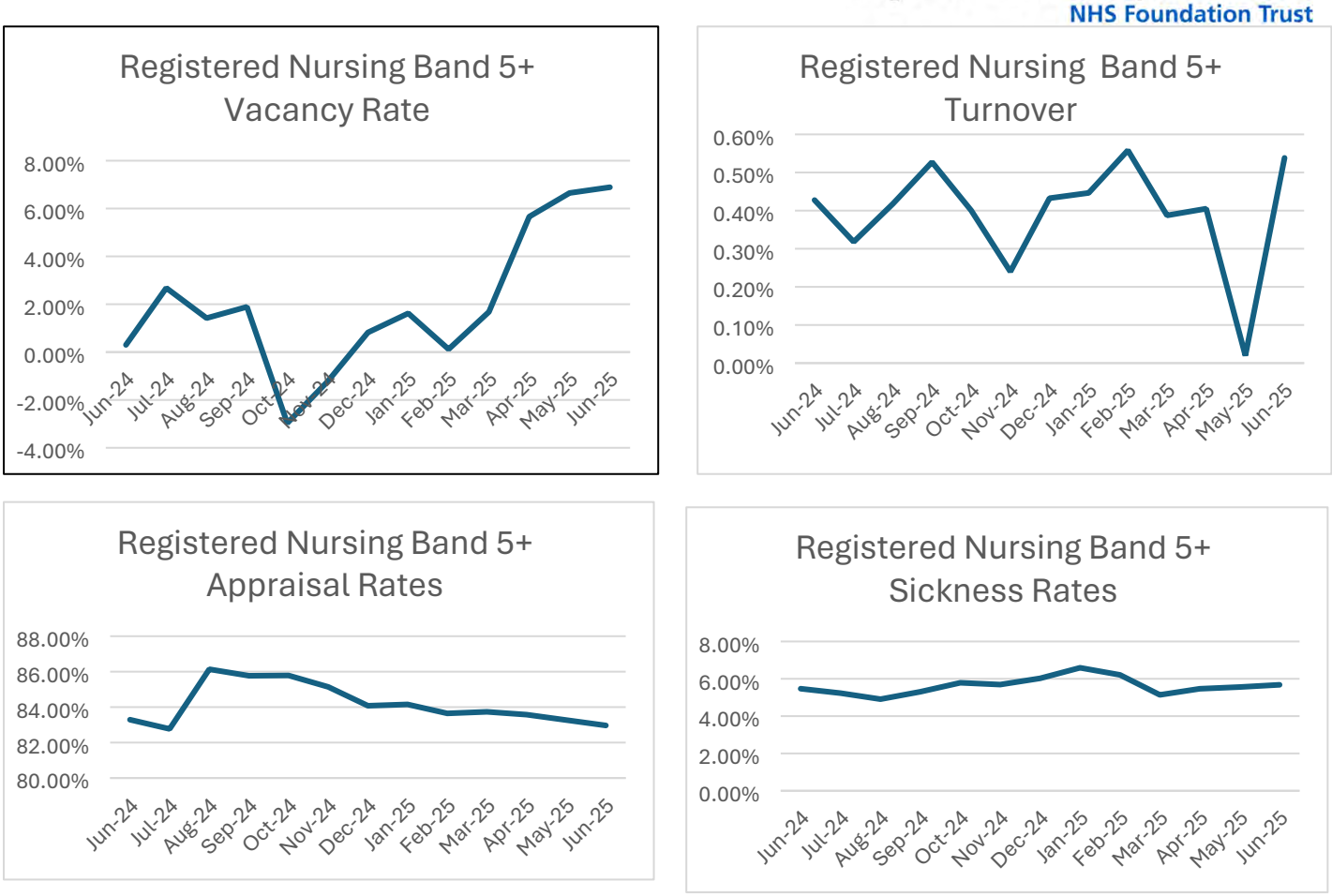


Figure 1: Registered Nurse workforce dashboard June 2024 – June 2025

Health Care Support Workers (HCSWs)

Data cleansing is ongoing to ensure accurate separation of HCSWs from other professional roles, including nursing associates and porters. As a result, Figure 2 currently reflects multiple professions. Throughout much of the reporting period, vacancy levels have remained stable at approximately 14%. However, from April 2025 onwards, an increase in vacancies has been observed, while turnover rates have consistently remained below 1.5%.

Manual analysis of staffing establishments identified 48WTE HCSW vacancies across wards and departments in June 2025. In response, the Trust launched targeted HCSW recruitment campaigns, the most recent in October 2025, successfully appointing 39WTE HCSWs. The Trust remains committed to achieving zero HCSW vacancies and actively participates in the NHS England HCSW Community of Practice to support this goal.

Turnover rates have fluctuated slightly, peaking at 1.3% in March 2025, but continue to remain significantly low overall. Appraisal compliance for Bands 2–4 initially showed steady improvement, reaching approximately 85% in September 2024. Since February 2025, compliance has gradually

declined from 84% to 81%. Sickness rates for Bands 2–4 have improved over the reporting period, reducing from around 8% to 6%.

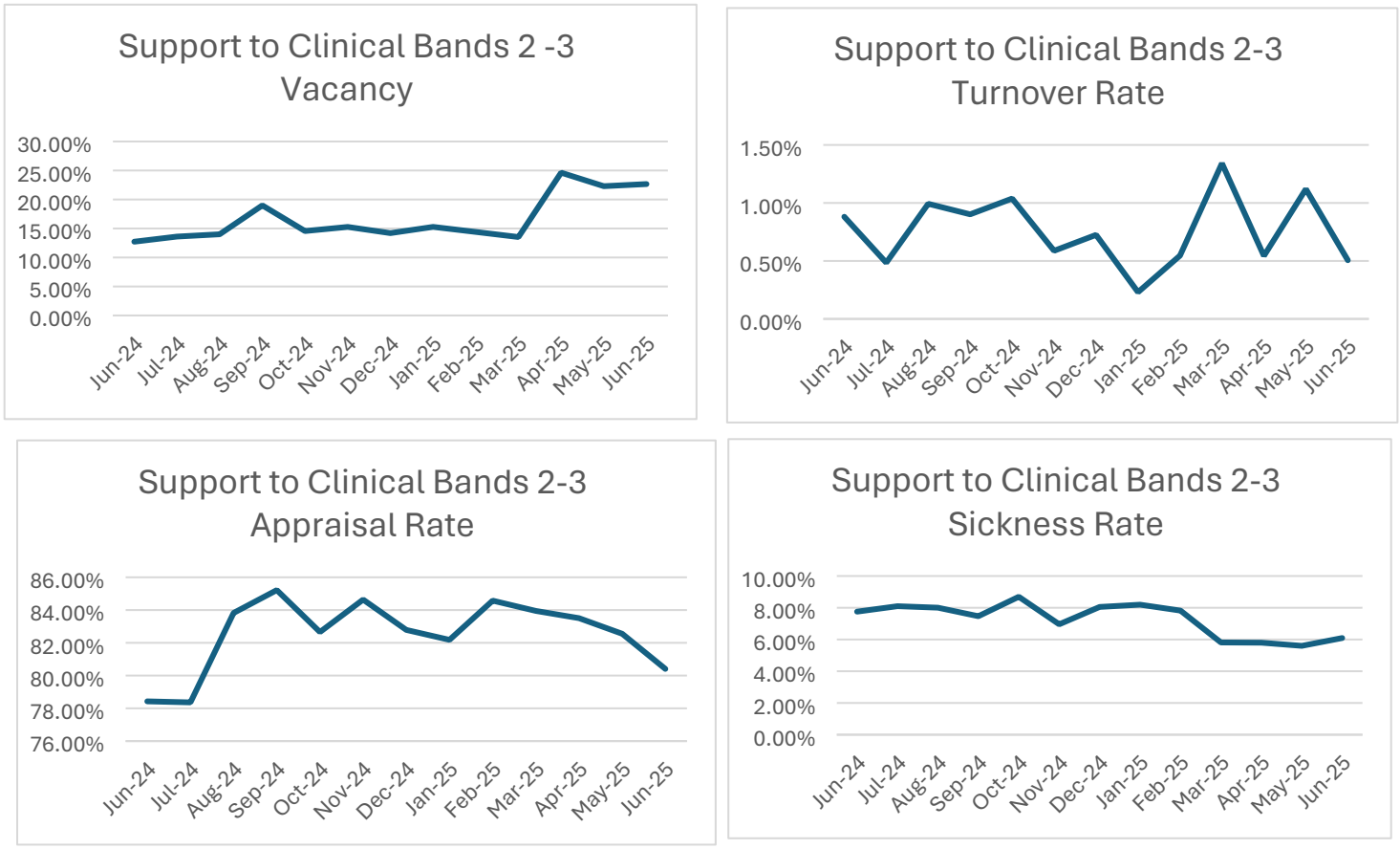


Figure 2: Support to Clinical Bands 2-3 workforce dashboard

Temporary staffing-

Nursing teams have continued to prioritise efficient resource utilisation, balancing clinical risk, maintaining safe staffing levels, and ensuring financial sustainability. Notably, non-mental health registered nurse agency usage has significantly reduced during the reporting period, as illustrated in chart 2. From January to June 2025, registered nurse agency usage was maintained at zero detailed in Chart 1.

Efforts to reduce reliance on nursing bank staff have also remained a key focus, as shown in Graphs 1 and 2. While some fluctuation in bank usage has occurred during the reporting period, demand has been influenced by several factors, including high sickness rates (both short and long term),

parental leave, study leave, apprenticeship placements exceeding funded establishment, and additional activity such as waiting list initiatives linked to elective recovery.

As of M4 2025/26, the bank usage is within the funded establishment and the nursing, midwifery and AHP budgets are underspent by £1,229,000 therefore demonstrating that staff are assessing staffing levels against patient acuity to ensure the resources are used effectively and efficiently.

Graph 1: Registered Nursing bank usage (WTE) July 2024-June 2025

Graph 2: Healthcare Support Worker bank usage (WTE) June 2024-July 2025

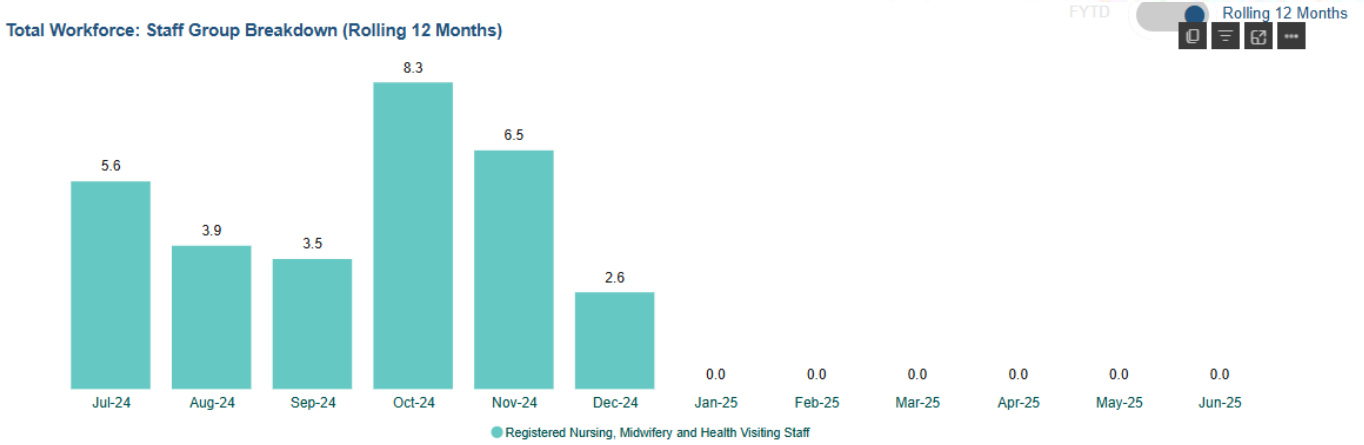


Chart 1: Registered Nurse agency usage (WTE) July 2024- June 2025

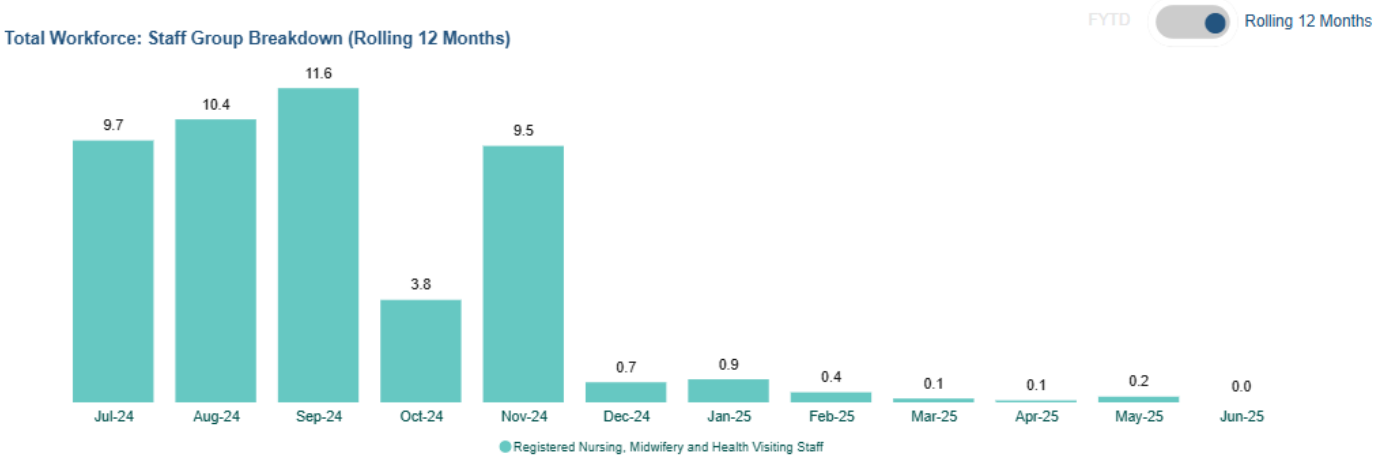


Chart 2: RMN agency usage (WTE) July 2024- June 2025

Students and Learners in Clinical Practice

Between June 2024 and June 2025, the Royal United Hospitals (RUH) Bath provided substantial support to a diverse cohort of students and learners undertaking clinical placements. In response to national workforce planning insights, the emphasis on internationally educated nurses (IENs) was reduced following a successful recruitment drive in previous years that significantly lowered vacancy rates.

During this transitional period, the Professional Workforce team strategically shifted focus toward enhancing the sustainability of the local workforce pipeline. This included diversifying the learner population and strengthening engagement with locally educated individuals, ensuring a more resilient and long-term approach to workforce development.

To proactively address anticipated vacancies and seasonal winter pressures, the Professional Workforce Team have started to explore workforce solutions with shorter lead times and greater cost-effectiveness to support critical services where demand is highest. This includes evaluating opportunities such as:

- Utilising waiting lists for the Healthcare Support Worker to Registered Nurse (HCSW2RN) pathway
- Expanding access to military placements
- Promoting and supporting Return to Practice roles

This approach reflects a commitment to flexible and responsive workforce planning, ensuring the RUH can adapt to evolving service needs while maintaining high standards of care.

Pathway	2024 – 2025 figures
Internationally Educated Nurses	0
RN outside of UK: HCSW2RN	0
Pre-Registration Learners	262
Care Certificate and New to Care Course	90
Student Nurse Associate	5
Registered Nurse Degree Associate	3
T Level Learners	12

Table 1: Number of learners in practice June 24-June 25

Staff Experience

136 Freedom to Speak up (FTSU) escalations were captured from June 2024 to June 2025. 39 of these were from Nursing and Midwifery. The main themes were (in order of prevalence): staff safety and wellbeing (28), inappropriate attitudes and behaviours (23), bullying and harassment (13), and patient safety and quality (11). Chart 3 demonstrates the split between Divisions.

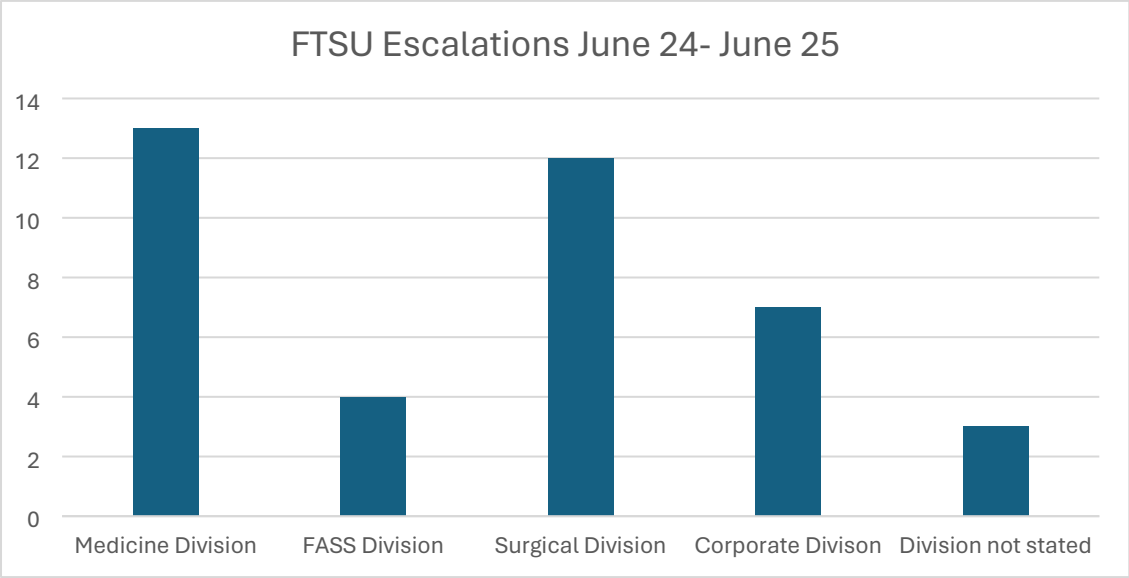


Chart 3: Number of FTSU per division June 2024-June2025

NHS Staff Survey

Between 2023 and 2024, feedback from the NMC-registered workforce at RUH shows a mixed picture of progress and areas requiring attention. The response rate remained steady at 56%, with over 1,100 colleagues sharing their views. Overall, the organisation continues to perform strongly in areas such as compassion and inclusivity, which maintained a high score of 7.4, and teamwork, which improved to 7.0. Staff engagement also held firm at 7.0, reflecting a consistent sense of involvement and commitment across the workforce. Notably, the score for learning culture rose to 6.1, suggesting that efforts to promote professional development are beginning to have a positive impact.

However, the findings detailed in figure 3 highlight several areas where further focus is needed. Recognition and reward remain a concern, with a score of 5.9 that falls below the Trust average and shows no improvement from the previous year. Similarly, morale continues to lag at 5.9, indicating persistent challenges in staff satisfaction and wellbeing. Safety and health improved only marginally to 5.7, and flexible working saw a slight decline to 6.2, both of which underscore the need for stronger initiatives to support work-life balance and overall wellbeing. While staff feel they have a voice, the score of 6.8 suggests there is still room to strengthen involvement in decision-making processes.

In 2016, the Trust agreed to pay nurses and midwives a 30-minute paid break for those working >12-hour shifts. In 2024, the Board agreed to remove a 30-minute paid break to generate a cost saving of 2.5m. The break was removed from all rosters in September 2024, just prior to the release of the staff survey. This has had a significant impact on the morale and is reflected in the score and free text comments from the staff survey (Figure 3 and 4).

In summary, the RUH has maintained strong performance in inclusivity, engagement, and teamwork, and has made progress in fostering a learning culture. However, recognition, morale, wellbeing, and flexibility remain priority areas for improvement. Addressing these issues will be essential to sustaining a motivated and resilient workforce in the year ahead.

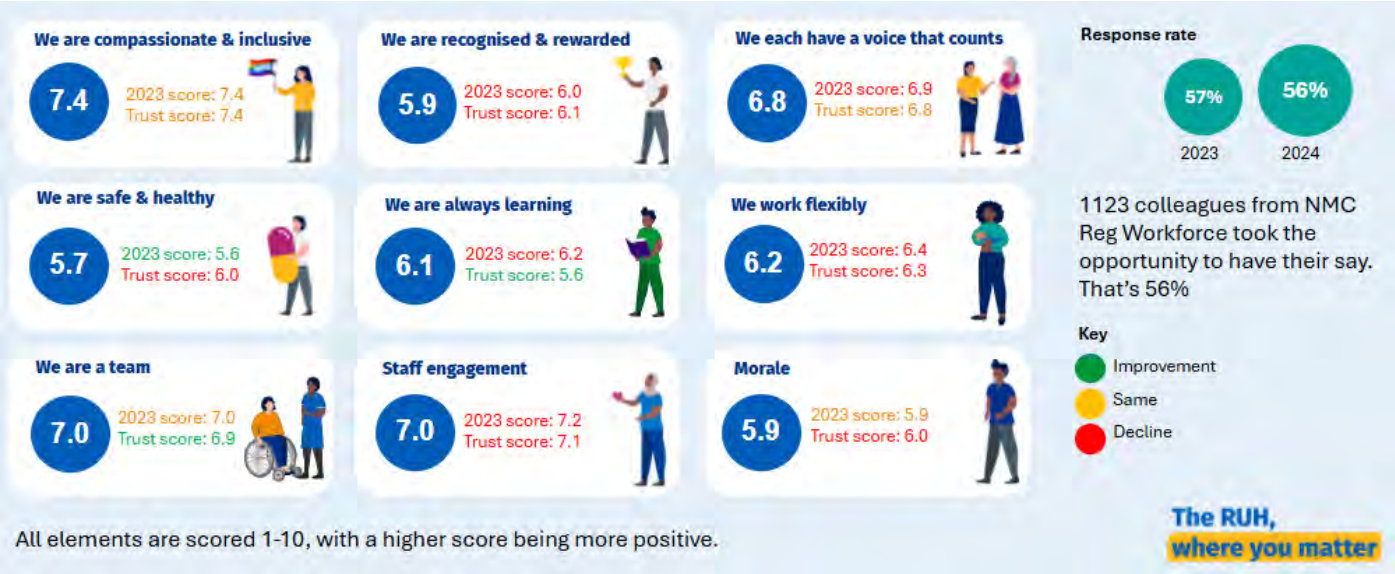


Figure 3: RUH Registered Nursing and Midwifery NHS annual Staff Survey Results 2024

For the additional clinical workforce, which includes porters and other essential support staff, the 2024 survey results provide valuable insight into engagement and wellbeing. The response rate was 47%, slightly down from 48% in 2023, with 513 colleagues sharing their views. Overall, the scores reflect a workforce that values compassion and inclusivity, which remained strong at 7.2, and teamwork, which held steady at 6.7. Staff engagement also maintained a positive level at 6.7, suggesting that these colleagues continue to feel connected to their roles and the wider organisation.

However, the findings as shown in figure 4 highlight several areas that require focused attention. Recognition and reward scored just 5.5, below the Trust average and unchanged from the previous year, indicating that staff in these roles may feel undervalued. Similarly, morale remains low at 5.8, and the sense of safety and wellbeing sits at 5.9, both of which point to ongoing challenges in creating a supportive environment. Flexible working scored 5.9, showing little improvement and suggesting that work-life balance remains a concern for this group. Learning opportunities were rated at 5.3, significantly below the Trust average, highlighting a need to strengthen access to development and progression for these staff members. While the score for having a voice in decision-making is 6.5, this remains below the Trust benchmark, indicating further work is needed to ensure these colleagues feel heard and involved.

In summary, while compassion, inclusivity, and engagement remain positive aspects of the experience for additional clinical staff, there are clear priorities for improvement in recognition, morale, wellbeing, flexibility, and learning opportunities. Addressing these areas will be key to ensuring that this vital part of the workforce feels valued, supported, and equipped to thrive in their role.

Figure 4: Additional Clinical Staff Survey Results 2024

Student Experience

The National Education Training Survey (NETS) was conducted from October 2024 to December 2024 with results being released at the end of the fiscal year of 24/25. This survey is the largest of its kind with 14.74% learner nurses nationally responding to the survey and is open to any learner who has had a clinical placement in the last 12 months.

Locally, the response rate for the nurses was 29% which was an increase of 14% on previous years. However, it is important to note that some areas of nursing education arms such as apprentices we're vastly underrepresented with 0 responses locally. T Level learners are not currently included in the survey respondents.

KPI	National	Nursing National	RUH Nursing
Bullying & Undermining	83.16%	83.90%	89.64%
Discrimination	86.81%	86.14%	83.56%
Facilities	65.94%	67.73%	76%
Induction	81.71%	80.79%	83.78%
Overall experience	76.21%	76.83%	80.48%
Quality of care	72.35%	73.18%	73.02%
Raising concerns	83.95%	85.55%	85.59%

Sexual safety	91.24&	89.75%	86%
Supervision	71.71%	71.86%	73.31%
Teaching and learning	68.34%	70%	73.31%
Teamwork	75.43%	75.90%	83.11%
Wellbeing	81.13%	82.90%	79.73%
Workload	63.38%	62.12%	63.51%

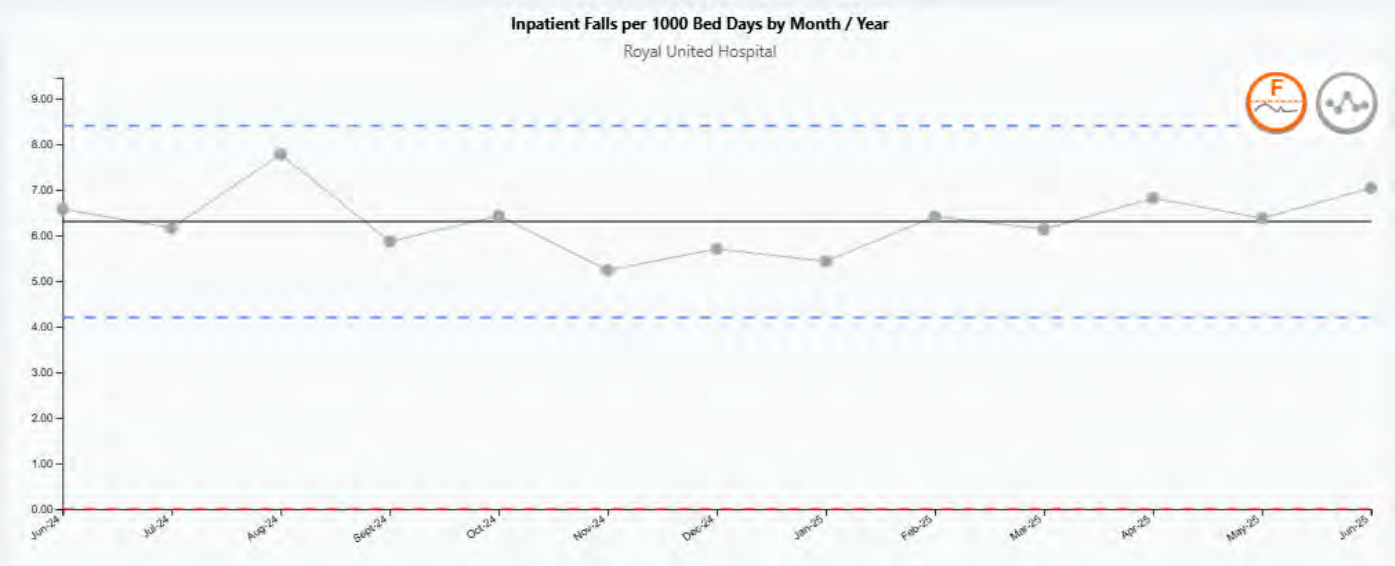
Table 2: RUH NETS Survey 2024 Benchmarking

Key Quality indicators for safer staffing

Falls

The falls rate has remained within the expected variance throughout the reporting period. Analysis indicates that 98% of inpatients do not experience a fall while receiving care in our organisation, consistent with last year's performance. The highest incidence of falls continues to occur within medical inpatient areas, particularly older persons' wards, where patient frailty and multiple comorbidities significantly increase fall risk.

It is recognised that Healthcare Support Worker (HCSW) vacancies persist within inpatient areas. As HCSWs provide the majority of 1:1 enhanced support for patients at high risk of falls, these vacancies present an ongoing challenge in mitigating fall risk.



Graph 3: RUH's Number of falls per 1,000 bed days June 2024 – June 2025

Pressure Ulcers

Between June 2024 and June 2025, the RUH recorded 80 hospital-acquired pressure ulcers (categories 2–4), including those associated with medical devices. The wards with the highest incidence were Respiratory (13 cases), ITU (10 cases), Haygarth (8 cases), and Combe, MAU, Parry, and Pulteney (six cases each).

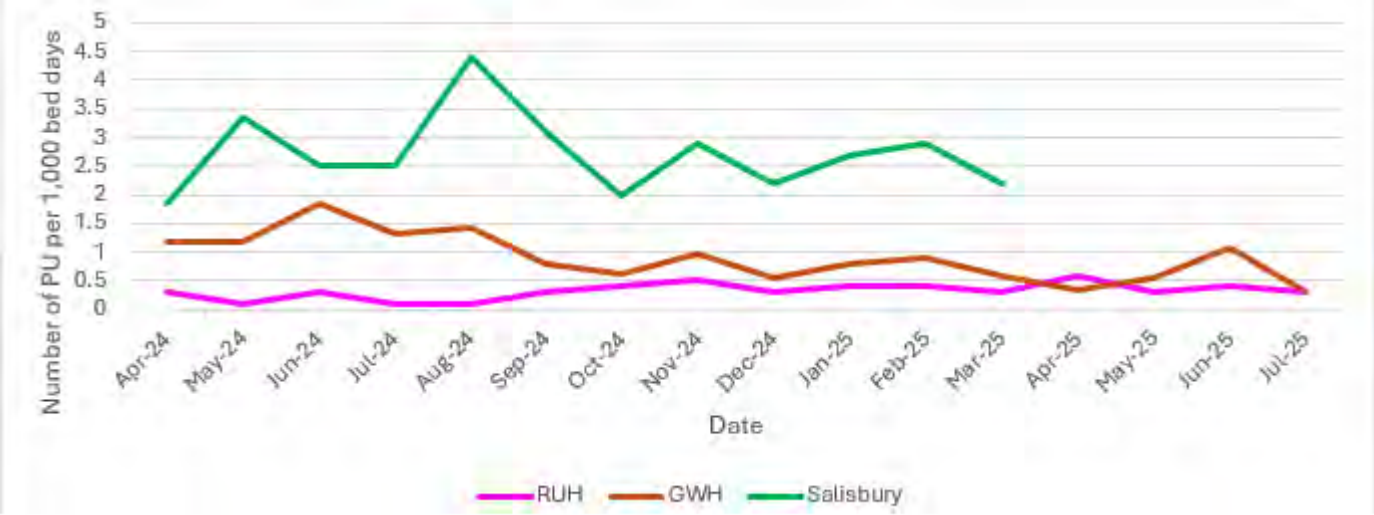
In response, targeted improvement plans have been implemented. The Respiratory ward presented its action plan to the Tissue Viability Improvement Group, introducing daily skin rounds led by the nurse in charge to identify early signs of pressure damage, with particular attention to protection under oxygen therapy devices. ITU also shared its improvement strategy, and while a device-related ulcer was reported in July, overall trends indicate progress in reducing occurrence. Haygarth remains under close monitoring following six category 3 ulcers, with the medical division actively engaged in oversight.

Despite these challenges, there were notable successes to celebrate. Fifteen wards remained pressure-ulcer-free throughout the year, earning certificates to display proudly. Among these, Helena, Coronary Care Unit, and Mary ward have achieved 11 consecutive years without a pressure ulcer, while Cheselden and the Emergency Department Observation Ward have maintained 10 years. Theatres and PACU reached nine years, and other areas such as Acute Stroke Unit, NICU, and Medical Short Stay also demonstrated sustained improvement.

Benchmarking data further reinforces RUHs strong performance compared to regional peers. Across 1,000 bed days. RUH maintained a stable trend well below two, reflecting the effectiveness of prevention strategies and continuous monitoring.

In summary, while targeted action remains essential in high-incidence areas, the overall picture demonstrates progress and sustained excellence in many wards.

Pressure Ulcer per 1000 bed days April 2024-July 2025 (BSW)

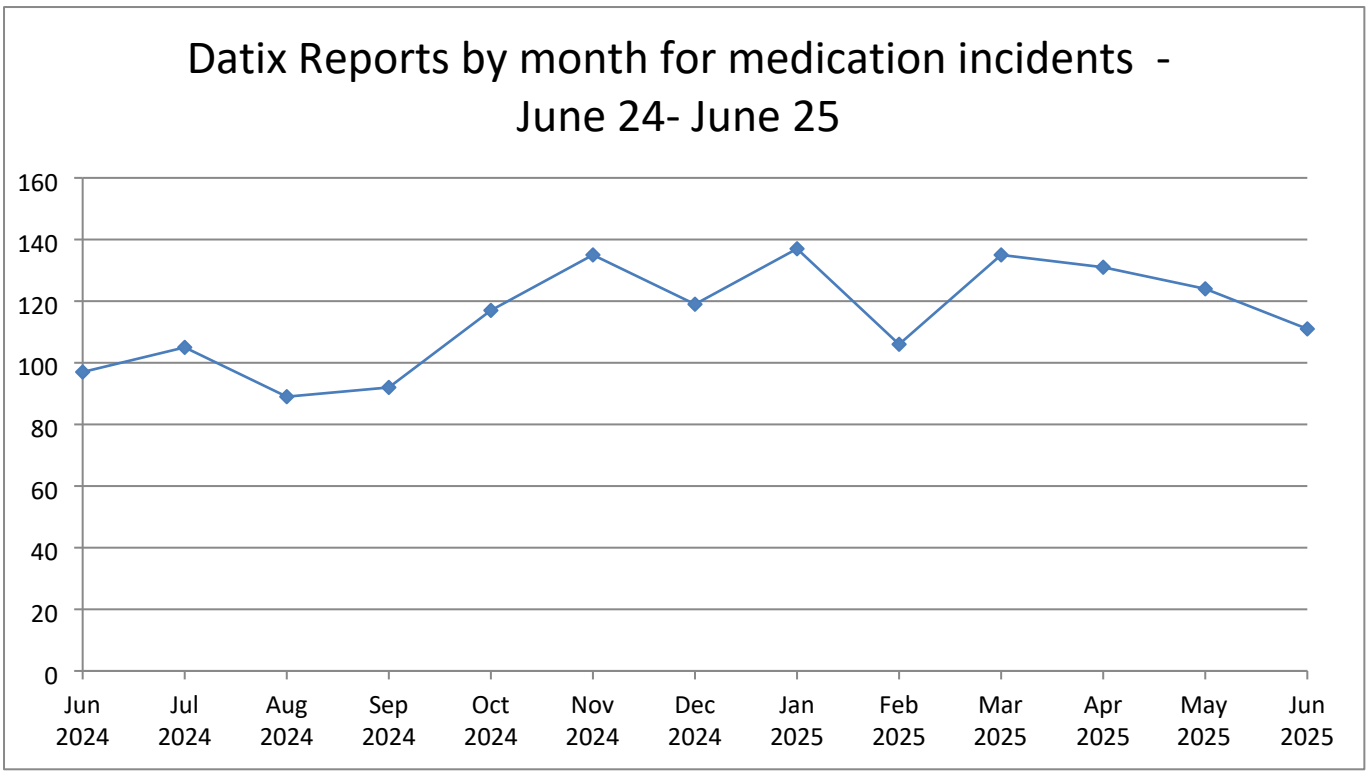


Graph 4: RUH pressure ulcers benchmarking against BSW acute providers April 24-Jul 25

Medication Incidents

Graph 5 illustrates the number of Datix reports related to medication incidents over the 12-month period from June 2024 to June 2025. Monthly figures ranged between approximately 89 and 137 reports, indicating some fluctuation throughout the year.

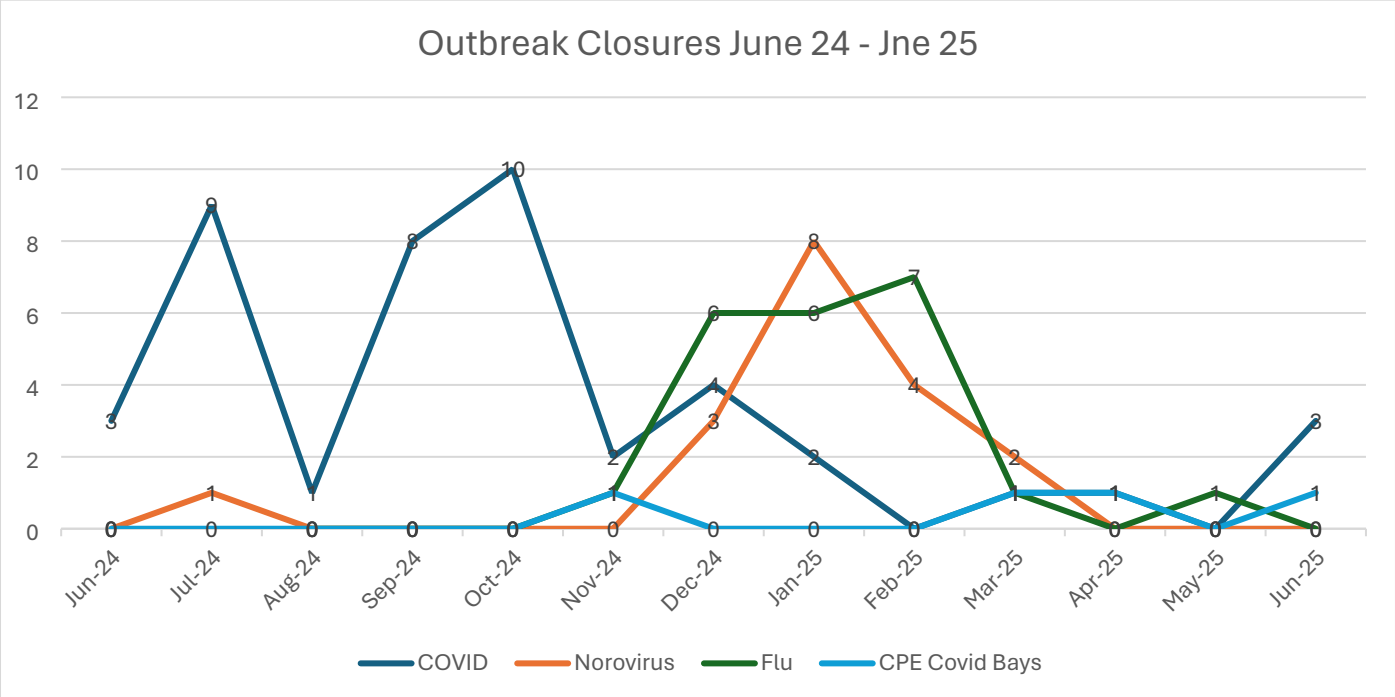
From April 2025 onwards, a gradual downward trend is observed. Overall, the data reflects a relatively consistent pattern of medication-related incidents, with minor seasonal variation.



Graph 5: RUHs medication incidents (trust wide) June 2024 – June 2025

Infection prevention and control

In 2024/25, flu transmission presented atypical patterns, with patients testing positive more than five days post-exposure and experiencing prolonged symptoms, which delayed bay reopening and required adaptive infection control measures supported by senior divisional and site leadership. COVID-19 related pressures remained consistent with previous years despite lower case numbers, with 205 lost bed days and 183 bay closures - comparable to 2023/24 figures - highlighting ongoing operational impact. Seasonal spikes in COVID-19 cases were observed in September and October across both years. Norovirus outbreaks led to 51 bay closures due to confirmed cases and an additional 80 due to exposure, with peak activity in June/July and January/February, resulting in 216 lost bed days. The review of infection outbreaks did not identify any workforce concerns. Effective isolation and cohorting practices remain essential to prevent further transmission and safeguard patient safety.

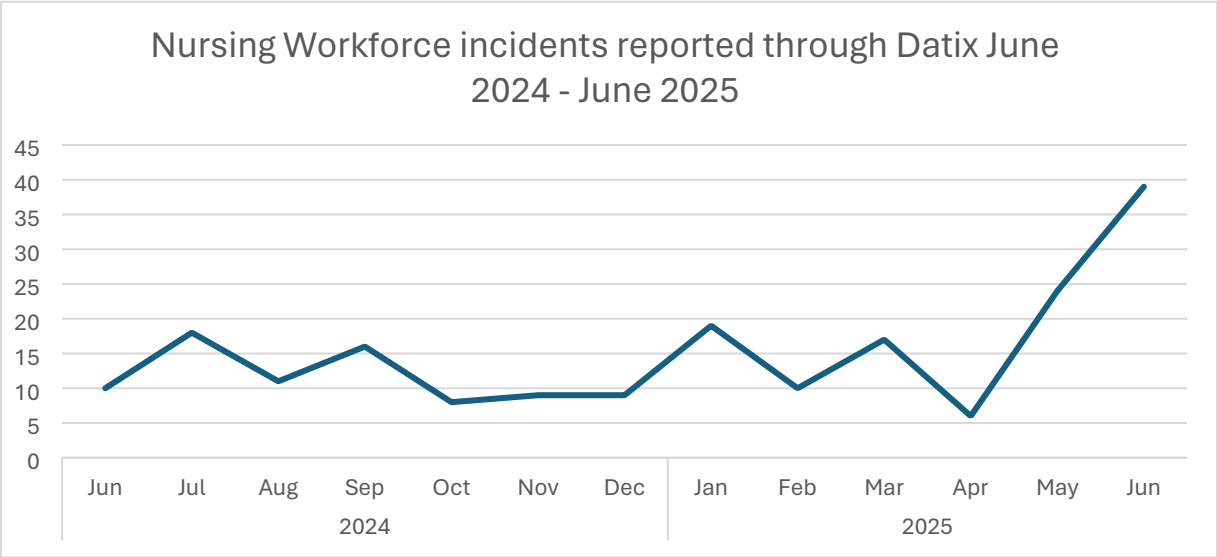


Graph 6: RUHs infection outbreaks June 2024 – June 2025

Reported workforce incidents

Graph 7 represents Datix incidents related to the Nursing Workforce from June 2024 to June 2025. There is a clear upward trend in reported incidents relating to nursing workforce from April 2025 onwards which correlates with increased vacancy in both RN and HCSW roles.

The most prevalent incident themes relating to nursing workforce is the lack of suitably trained staff, low levels of staff due to sickness/leave followed by low levels of staff due to unexpected staff transfers.



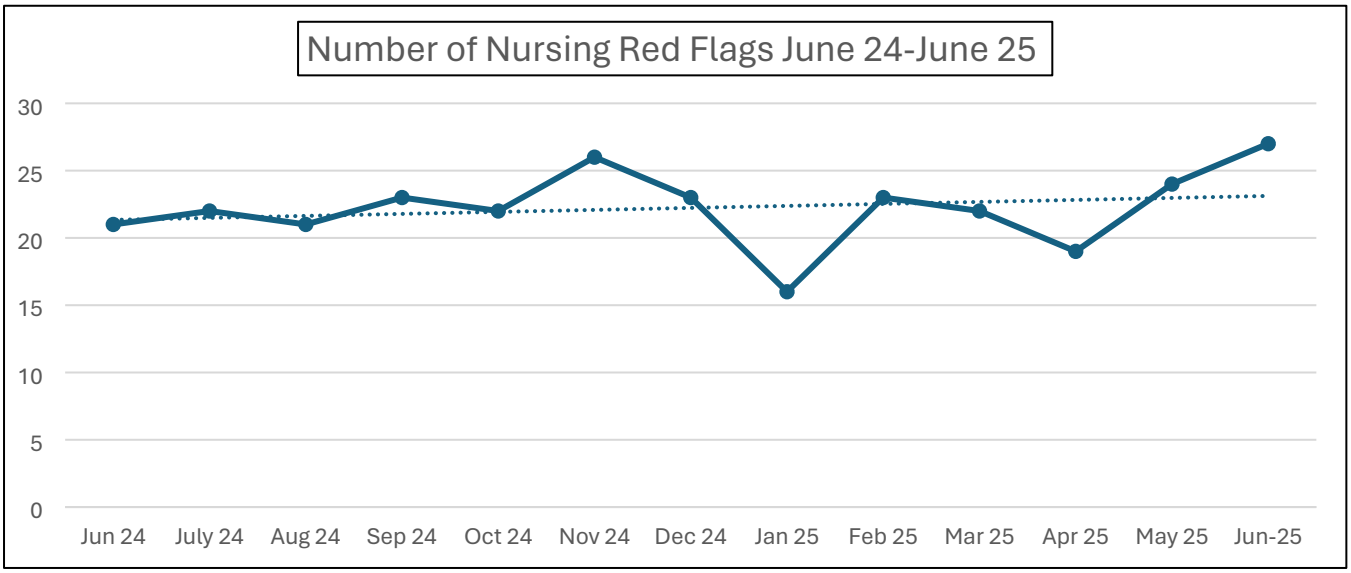
Graph 7: RUHs workforce incidents reported through Datix, June 2024 – June 2025

Roster Red Flags

The nurse in charge can raise a red flag within the staffing roster when, in their professional judgement, nursing levels are insufficient to meet patient care needs. This triggers an alert to the Matron and requires immediate action to resolve the issue.

While nursing teams are encouraged to raise red flags, anecdotal feedback suggests that high workload pressures, particularly in areas such as the Emergency Department, may contribute to under-reporting. To address this, twice-daily Senior Nurse-led safer staffing meetings review all red flags alongside professional judgement and implement appropriate mitigation measures.

Over the past 12 months, education and promotion of the red flag system within SafeCare have been undertaken, supporting improved accuracy in reporting. Graph 8 shows an upward trend in red flags from June 2024 through June 2025, peaking at 27 in June. The main reason for shortfall of registered Nurses by 25%, followed by omission of comfort rounds. Live professional judgement remains critical in assessing whether staffing levels meet patient acuity and demand.



Graph 8: RUHs number of nursing roster red flags June 2024 – June 2025

Nursing Fill-rates

Table 3 shows the percentage of actual staff hours delivered compared to planned hours (fill rate) for Registered Nurses (RNs) and Healthcare Support Workers (HCSWs), split by day and night shifts from June 2024- June 2025. RN fill rates during the day shifts fluctuated between 88% and 95%. HCSW fill rates ranged from 84% to 93%.

In contrast, night shifts show comparatively higher fill rates RN, generally between 95% and 100%. HCSW coverage at night was consistently above 90%. The increase HCSW fill rate >100% particularly on night shifts reflect the deployment of additional staff in response to increased dependency and enhanced care patients.

From June 2025 fill rates have started to reduce slightly but remain above 85%. This is due to increased nursing vacancies and staff being redeployed to mitigate risk. Nurse fill rates are monitored monthly through the Nursing, Midwifery and AHP Workforce Group and form part of the Trust wide quality report submitted to Board monthly.

Total average	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Total monthly actual staff Day hours- RN	89%	90%	90%	89%	91%	93%	93%	94%	93%	95%	92%	89%	88%
Total monthly actual staff day hours- HCSW	86%	86%	85%	84%	90%	86%	90%	92%	93%	88%	89%	90%	86%
Total monthly actual staff night hours- RN	98%	98%	95%	95%	97%	97%	97%	100%	100%	99%	97%	96%	89%
Total monthly actual staff night hours - HCSW	90%	91%	91%	102%	96%	97%	90%	104%	103%	102%	99%	101%	97%

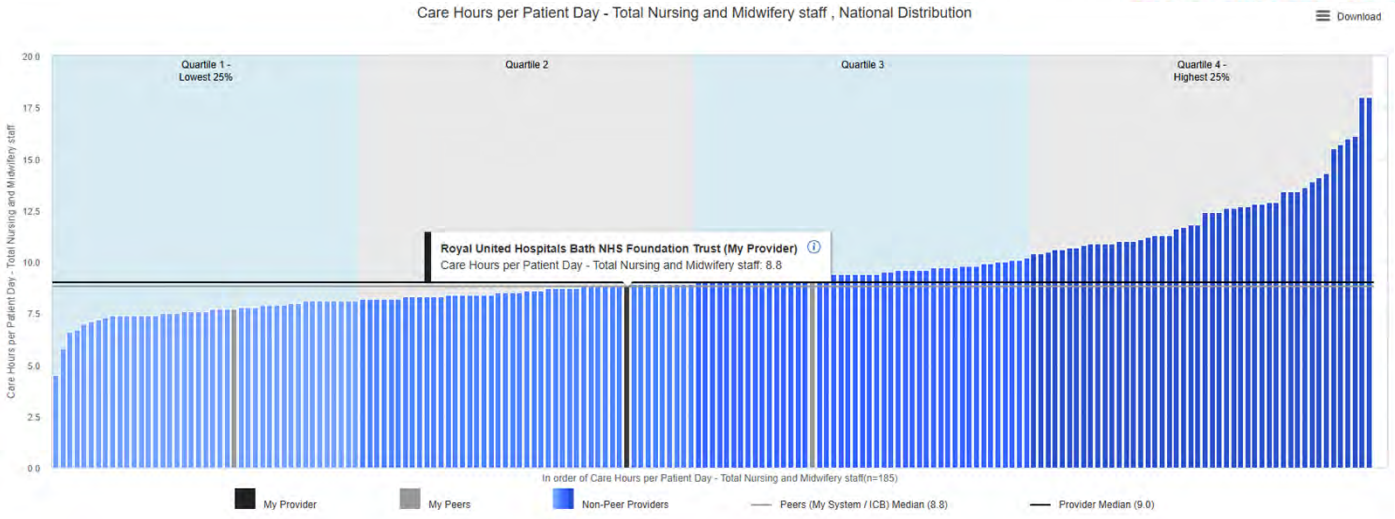
Table 3: RUHs Nursing and HCSW fill rates for day and night shifts, June 2024 – June 2025.

Ward Establishment Assessments

Benchmarking using the Model Hospital - Health System

The RUH care hours per patient per day (CHPPD), recommended in the Carter Review (2015), are provided in the Model Hospital dashboard as a standardised model for Trusts to benchmark. Each month, the hours worked during day and night shifts by registered nurses, midwives, and HCSWs are totalled. The number of patients occupying beds at midnight is recorded daily, summed for the month, and divided by the number of days in the month to calculate a daily average. The total hours worked are then divided by the daily average number of patients to produce the CHPPD rate.

The Nursing and Midwifery workforce care hours per patient per day are in line with the peer median of 8.8.



Graph 9: RUHs benchmarking of CHPPD for nursing and midwifery – June 2025

Twice-Yearly Ward Establishment Review

Conclusion of establishment assessments

A robust ward staffing establishments review and SNCT was conducted using mixed methodologies and aligned with recommendations from the National Quality Board, NICE guidance, and RCN Nursing Workforce Standards. Overall, staffing establishments remain appropriate and within guidelines except for the Children's ward.

Some areas with high acuity and dependency continue to exceed available HCSW ratios for 1:1 care. However, recommendations for uplifts or skill mix changes were not made due to the implementation and full recruitment of the Enhanced Care Team, which is expected to positively impact enhanced care delivery and nurse staffing requirements.

The Children's ward establishment was recommended for a skill mix redesign in response to changing patient needs. The Lancet Child and Adolescent Health Journal (2025) highlight a national trend of increasing admissions of children and young people (CYP) to acute hospital wards due to mental health concerns. On average, the Children's ward cares for four CYP with mental health needs at any one time, requiring a different skill set.

The revised establishment introduces Mental Health Support Workers (MHSWs), who possess the skills necessary to care for this patient group. One Band 5 Registered Nurse post was replaced with an MHSW, maintaining the same total number of staff per shift but with a skill mix better suited to patient needs. Importantly, this change did not require additional financial investment.

The Children's ward skill mix redesign was approved by the Quality Assurance Committee in April 2025.

Safe staffing principles

The principles underpinning Safe Staffing as described by NHSI (2018) is that reviews must be evidence based using tools and data, triangulated with outcomes and professional judgement.

Registered Nurse to patient ratios

Registered Nurses to patient ratio was first described by the National Institute for Clinical Excellence (2014) and recommended a minimum of 1:7 RN to patient ratio for inpatient wards. A ratio of 1:7 is now the absolute minimum due to the acuity and dependency of patients has increased in the 7 years since its publication. The RUHs rising acuity of patients, more therapeutic activity taking place overnight and the impact of more geographically spread clinical areas has increased the pressure on the staffing resource both day and night. Therefore, a ratio of 1:7 is now deemed appropriate to ensure staffing levels are within safe limits. The review has calculated the establishments to meet a 1:7 ratio throughout the 24-hour period (Appendix 1).

Registered Nurse to unregistered Nursing staff ratios

The Royal College of Nursing (2006) recommended establishment composition is 65% registered nurse and 35% unregistered care staff for general inpatient wards. For this review 65/35% has been applied where appropriate and is described in Appendix 2. Work undertaken as part of this review includes closer alignment to achieve the 65/35% split or that described as best practice guidance as per specialty.

Seven wards currently operate above a 70:30 registered-to-unregistered staff ratio, reflecting the increased complexity and intensity of patient needs within these specialties: Emergency Department, Paediatrics, Oncology, Coronary Care, ICU, Medical Assessment Unit, and Surgical Assessment Unit. These areas require a higher proportion of registered staff to deliver safe and effective care.

Four wards maintain an agreed 60:40 ratio (Cheselden, Forrester Brown, Pierce, and Philip Yeoman). This skill mix reflects ward layout and the higher dependency of patients, necessitating additional Healthcare Support Worker (HCSW) support. Importantly, this adjustment does not impact the Registered Nurse-to-patient ratio, which remains at no more than 1:7 in these areas.

Focus will continue on reviewing overall registered-to-unregistered ratios to ensure any reductions are aligned with planned models of care and supported by appropriate quality impact assessments and evaluations.

Registered Nurse to Nurse Associate ratio

The support of Nurse Associate (NA) roles continues to be part of a model of care forming part of the registered nurse ratio. As per Health Education England in response to the Shape of Caring Review (2015) the role helps build the capacity of the nursing workforce and the delivery of high-quality care. The role differs from Registered Nurses in several ways, namely registered with the NMC underpinned by the standards of proficiency for Nursing Associates the role can provide, monitor, and reassess care but cannot perform primary assessments and prescribe care. Nursing

Associates can undertake relevant procedures having been assessed as competent, for example the administration of medication. The Nursing Associate must be the fourth (or above) registrant on duty (consensus across BSW).

Ward Leadership roles

All wards have a supervisory senior sister/charge nurse role assigned, which is one of the key recommendations from the Francis report (2013) and is considered vital to maintain high quality care, address care concerns in a timely manner and support/supervise staff.

The ward coordinator role is excluded from providing direct patient care and is in place across all ward areas for a long day shift seven days a week.

The clinical leadership Band 6 sister/charge nurse role to have fully established and funded 24/7 clinical leaders in all inpatient wards and departments was realised in January 2025. Following a period of embedding of the role in all areas the next steps are to ensure this clinical leadership role is matched with a development programme which is due to commence in January 2026.

Professional Judgement

Professional judgement is applied to the twice-yearly establishment reviews which includes; the ward purpose, ward geography and layout, patient acuity and dependency, any specialist care requirements which impact on the time taken to provide care i.e., Infection, Prevention and Control (IPC), any staffing standards required for specialist wards i.e., Acute Coronary Unit, Acute Stroke Unit, or any significant workforce learning acuity or significant events that warrant added seniority and specific skills.

Headroom

Headroom is the percentage financial uplift applied when calculating inpatient establishments from Band 3 HCSW shifts to the band 6 co-ordinator (as it excludes the supervisory sister/charge nurse post) this is to ensure there are sufficient staff. The Shelford Group recommends 22%, however the headroom at the RUH is 20%, this is on the low side, and 20% has been applied to all Nursing establishment reviews other than the Emergency Department (ED) Intensive Care Unit and the Paediatric inpatient ward. The ED review includes a headroom of 27% as recommended by the Royal College of Emergency Medicine and similarly the paediatric ward including the paediatric assessment unit includes a headroom of 25% as per the Royal College of Nursing. The Intensive Care Unit as part of the single unit restructure saw an increase in headroom from 20% to 24% as recommended within the Guidelines for Provision of Intensive Care Services (GPICS). This enables staff to undertake the considerable levels of training and clinical supervision to ensure they possess the right knowledge and skills to deliver safe care.

Nursing Workforce Risks on the Risk register

The RUH currently has five approved nursing-related risks recorded across three divisions. Of these, two are rated as high risk (score 16, red):

- Risk 2764: The potential impact of the Nursing, AHP, and Midwifery workforce cost reduction programme on staff wellbeing.
- Risk 2075: Nurse vacancies within the Emergency Department (ED) and Urgent Treatment Centre (UTC).

Both high-rated risks have action plans in place, focusing on staff wellbeing initiatives and recruitment trajectories, with mitigation measures scheduled for completion by March 2026.

The remaining three risks are medium-rated and each has an associated recruitment action plan to address workforce gaps.

Risk ID	Directorate & Specialty	Description of the Risk	Current Risk Rating
2764	Trust Wide	Risks to patient safety and staff wellbeing as a result of the Nursing, AHP and Midwifery workforce cost reduction programme	16
2075	Medicine-Emergency Medicine	Risk that patient safety will be affected by inadequate staffing within ED and the Urgent Treatment Centre	16
3068	FaSS-Gynaecology	Gynaecology nursing workforce shortall	12
3118	FaSS- Oncology	Oncology outpatients nursing workforce shortfall	12
3020	Surgery-Urology	Nursing workforce sustainability for provision of local anaesthetic transperineal prostate biopsy in urology outpatients	8

Table 4: Risk register entries for nursing workforce risks

Equality, Diversity and Inclusion

Research highlights the persistence of discrimination and racism affecting patient outcomes (Marmot, 2005). Racism towards NHS staff harms individuals and compromises patient care quality. Addressing racism and fostering an inclusive work environment is essential for staff well-being and optimal patient outcomes. The Workforce Race Equality Standard (WRES) consistently reports disparities in the experiences of Black, Asian and Minority Ethnic (BME) staff compared to white staff, particularly in career progression and discrimination.

In the 2024 NHS staff survey, over double the percentage of global majority staff had experienced discrimination from staff in the last 12 months (16.1%) compared to their white peers (6.1%). To create an inclusive environment, RUH has implemented actions such as RUH Inclusion Weeks, a second cohort of Routes to Success (positive action programme), Inclusion Champion Training, a reasonable adjustments review, launched a Neurodivergence Support Group, trained 12 staff as Cultural Ambassadors, encouraged speaking up via Report + Support, launched an EDI newsletter, conducted site accessibility reviews, and joined the Sunflower lanyard scheme.

This data below shows that Band 5 has the highest representation of Global Majority staff, with 65.3% in Nursing and Midwifery Registered roles. In contrast, higher bands such as Band 8 and 9 have significantly lower representation, indicating a need for improved career progression opportunities for Global Majority staff.

Global Majority Representation as a % of total Global Majority AfC staff as of September 2025.		
Band	Organisation Overall	Nursing and Midwifery Registered
Band 2	25.6%	
Band 3	27.3%	
Band 4	9.5%	
Band 5	53.9%	65.3%
Band 6	20.8%	26.6%
Band 7	11.5%	9.9%
Band 8a	6.4%	4.5%
Band 8b	9.0%	0%
Band 8c	9.3%	0%
Band 8d	0%	0%
Band 9	20%	0%

Table 5: RUH global majority representation as a percentage of Agenda for Change(AfC) staff

Increased junior workforce and learning acuity

Establishments must account for the time clinical staff require for mandatory training, professional development, revalidation, teaching, mentorship, and supervisory roles, including supporting students and apprenticeships, in line with the national workforce target of 30% (NHSE). Currently, inpatient areas have a 20% headroom allowance, with study leave funded at 1.5% unavailability. However, the increasing number of learners and the emphasis on staff well-being have placed significant pressure on supervisory capacity, particularly in non-ward-based areas where headroom for nursing staff is 0%. The existing headroom is insufficient, and work is underway to develop a departmental training needs analysis.

Ward leaders have highlighted supervision challenges associated with the growing range of learners, especially within a junior workforce. The NMC national guidance (2022), implemented in 2023, introduced preceptorship requirements for all newly registered staff, adding further demand on supervisory resources. Robust retention and recruitment strategies aim to 'grow our own' nurses, supporting a diverse learner population, including T-level and undergraduate students, student nursing associates, nurse degree apprentices, return-to-practice candidates, and newly qualified staff.

Education teams have played a pivotal role in training overseas nurses to full registration, while Clinical Practice Facilitators continue to support the wider nursing workforce through clinical skills development, staff support, and restorative clinical supervision aligned with their Professional Nursing Advocate roles.

Professional Nurse Advocates

Currently, our organisation has 24 Professional Nurse Advocates (PNAs), most of whom work in educational support roles. This creates a local ratio of approximately 1 PNA per 60–170 nurses, depending on the area. While PNAs provide vital support for staff wellbeing, education, and professional development, there is no formal reporting structure or data collection process to measure their impact on workforce retention or staff support at present.

However, national evidence strongly suggests that a robust PNA strategy can positively influence retention, resilience, and overall workforce sustainability. Developing a structured approach to capture and evaluate PNA contributions locally. The increase in PNAs is a key workstream in 25/26 for our workforce growth and retention team, this will be reported in the next mid- year review report.

Priorities for 2024/2025

Zero Vacancies Ambition: Continue working towards zero vacancies across the nursing workforce with a healthy talent pool waiting to join the Trust. Expand the 'grow our own' pipeline of Nursing staff by increasing T-level placements, pre-registration placements, Military placements, cadets, and apprenticeships, whilst balancing the learning acuity in the clinical areas. Focused recruitment and 'grow your own models' for hard to recruit areas.

Equity and Discrimination: Increase equity and reduce discrimination for staff from a global majority. This includes continuing the development of staff through leadership training and tackling racism directly. The continuation of the Routes to Success programme funded via the NHSE continuous practice development funds will enable an additional 22 nursing, midwifery and AHP staff to benefit from this programme in 25/26.

Board Reporting: The implementation of The Professional Workforce Team Performance Review Meeting to gather better oversight to Board around the challenges and celebrations in workforce growth and retention.

National Agenda for Change Nursing Profiles: Align current nursing roles to updated national profiles. Reviewing clinical skills, job descriptions and establishment skill mix impact of new updated national nursing profiles. To review this as BSW group model to improve equity and standardisation.

Establishment Review Process: Continue to develop the establishment review process and expand into the outpatient departments alongside the outpatient transformation workstreams. Use these reviews to inform safer staffing and provide Board assurance.

Cross-System Working: Work with system colleagues to identify and undertake workforce focussed cross-system working opportunities.

Good Rostering Practice: Embed good rostering practice across both Nursing and AHP, demonstrated through Roster Key Performance Indicators and a reduction in the reliance on temporary workforce.

Recommendations to the Board

- Discuss the report at Trust Board as an ongoing requirement of the National Quality Board and developing workforce safeguards guidance around safe staffing assurance.

- Note the findings of this annual ward establishments review and the Trust's position in relation to adherence to the monitored metrics on nurse staffing levels.

- Recognise the ongoing improvements in RUH compliance with the guidance from the National Quality Board on safe, sustainable, and productive staffing.

- Continue the ongoing advancements in RUH compliance with the NICE guidelines on safe staffing for nursing in inpatient wards.

- Acknowledge the ongoing multiple risks and challenges, including the enhanced care needs of patients, high learning acuity of staff, high sickness rates, and vacancies impacting service provision.

- Support the continued Trust-wide commitment and momentum on actions to fill vacancies and further reduce reliance on high-cost agency and bank staff, against the backdrop of rising acuity, emergencies and elective recovery.

Conclusion

This report on nursing safe staffing provides assurance to the Board that there are no current safety concerns or themes related to nursing staffing during the period January 2025 – June 2025.

The recent establishment review identified no requirement for additional investment at this time, other than the approved skill mix changes within the Children's ward. However, the nursing workforce continues to require focused attention to enhance staff experience, recruit into specialist areas, and retain and develop a skilled workforce to meet the evolving needs of patients and the wider community.

In line with the Developing Workforce Safeguards Recommendations (2018), the Chief Nursing Officer and Chief Medical Officer confirm, following the bi-annual safe staffing review, that nurse staffing levels are safe, effective, and sustainable**.**

The nursing workforce requires continued focus on recruitment into outstanding vacancies within the Emergency Department, alongside targeted work on retention strategies. These priorities will be monitored closely, together with the Trust's overall reliance on temporary staffing.

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Appendix 1: Safe Staffing Dashboard

					Budgeted Establishment							Planned CHPPD is calculated based on the type and number of shifts set up in the Template and number of the beds in the ward				Actual Demand CHPPD is calculated based on the Type and numbers of the patients in the ward	Actual CHPPD is calculated based on the nursing hours ward staff worked and the number of the patients the ward had at midnight
												Planned on Template (Long day factor applied)				Actual Demand average in December 2024 (in Safe Care)	Actual average (Calculated on actual hours provided and average patient numbers at midnight)
Division	Unit Name	Shift	Bedbase	Total with escalations	Budgeted Total Nursing (WTE)	Budgeted RNs (WTE)	Budgeted Unregistered Nursing (WTE)	Skill Mix (RN:URN)	RN: Patient Ratio	RN:Patient Ratio National/Collegiate Guidance (R/G Rated)	URN:Patient Ratio	Planned Registered (CHPPD)	Planned Unregistered (CHPPD)	Total Planned CHPPD	Safe Care	Total Actual Demand CHPPD	Total Actual CHPPD
FaSS	Paediatric Inpatients 24340	Day	33	32	69.67	62.49	7.18	84:16	1:3	1:3 /1:9 (1:2 HDU)	1:33	8.2	1.5	9.7	8.6	10	12.8
		Night	33								1:33						
	William Budd Ward 10420	Day	22	22	45.8	39.5	10.5	77:23		1:7 (1:5 Chemo)	1:11	6.9	2.1	9.0	10.6	7.5	12.1
		Night	22	21					1:4		1:11						
Medicine	Emergency Medicine 11850	Long Day	71		197.43	150.64	46.89	75:25	Variable	1:8(min) (1:4(Max))	variable					Variable	
		Night	71														
	Acute Stroke Unit 24143	Day	30	30	50.12	43.79	11.34	69:31	1:4	1:10.1 Acute 2:09:1	1:8	5.7	1.5	7.7	8.0	7.7	8.2
		Night	30								1:10						
	Cardiology Ward 24041	Day	36	36	51.67	33.64	18.03	64:36		1:7	1:9	4.0	2.2	6.2	5.8	6.2	6.3
		Night	36						1:6		1:12						
	Chesselden Ward 10485	Day	16	22	33.58	17.34	16.24	50:42	1:7	1:7	1:7	3.8	2.7	6.5	7.3	7.5	6.4
		Night									1:11						
	Combe Ward 10210	Day	26	26	38.73	25.07	13.66	64:36	1:7	1:7	1:9	4.1	2.5	6.4	6.1	7.2	7.7
		Night	26								1:13						
	Coronary Care Unit 24042	Day	8	8	24.87	18.13	5.94	74:26	1:3	1:3	1:8	8.9	3.3	12.2	12.2	10.7	12.1
		Night	6								1:8						
	Haygarth Ward 10670	Day	24	26	36.75	23.87	12.88	65:35	1:6	1:7	1:8	4.0	2.4	6.4	6.4	6.8	7.5
		Night	24								1:12						
	Hinton Ward 10270	Day	19	19	32.54	23.13	9.41	82:18	1:6	1:7	1:9	4.4	2.7	7.1	7.3	7.6	9.5
		Night	18								1:9						
	Medical Assessment Unit 10650	Day	38	38	69.28	49.67	19.61	71:29	1:5	1:6 1:2 Level 2	1:10	5.0	2.3	7.5	8.9	7	8.5
	24 beds/ 14 Trolleys	Night	36								1:13						
	Medical Short Stay 10365	Day	19	22	25.97	17.34	7.73	69:32	1:6	1:7	1:18	3.8	1.9	5.8	5.7	6.3	6.2
		Night	18								1:9						
	Older Persons Assessment Unit 10370	Early	27	27	49.68	31.91	17.14	64:36	1:5	1:7	1:9	6.2	2.6	8.8	8.1	8.8	9.6
		Late	27														
		Night	27								1:9						
	Older Persons Ger Short Stay 10230	Day	27	27	40.53	25.07	15.46	65:35	1:7	1:7	1:9	4.2	2.6	6.8	6.3	7.4	8
		Night	27								1:9						
	Parry Ward 10430	Day	28	28	37.85	24.97	12.88	66:35	1:7	1:7	1:9	3.6	2.6	6.2	5.7	6.7	6.7
		Night	28								1:14						
	Respiratory Ward 10360	Day	33	33	64.5	43.1	21.4	66:34	1:4	1:2 NIV 1:4 Ward	1:8	5.6	2.8	8.4	7.9	7.9	11
		Night	33								1:8						
	Waterhouse Ward 10220	Day	24	24	38.63	24.97	13.66	64:36	1:6	1:7	1:8	4.6	2.5	6.9	6.6	7.2	9.1
		Night	24								1:12						
Surgery	Charlotte Ward 11550	Day	22	22	29.23	19.03	10.2	64:36	1:7	1:7	1:11	3.6	2.1	5.7	5.7	6	8.3
		Night	22								1:11						
	Day Surgery Unit 24061 - Trolleys	Day	38	38	26.19	15.72	10.47	60:40	1:5		1:13	NA	NA	NA	NA	NA	NA
	Forrester Brown Ward 10950	Day	24	24	40	24.97	15.03	54:46	1:6	1:7	1:6	4.1	3.4	7.6	7.4	7.2	9.7
		Night	24								1:8						
	Intensive Care Unit 12400	Day	13	13	103.87	86.86	16.81	83:7	1:1	1:1 Level3 1:2 Level2	1:13					Various- DPCS	
		Night	13								1:13						
	Philip Yeoman Ward 10940	Day	12	12	19.22	11.28	7.93	58:42	1:6	1:7	1:6	3.8	2.8	6.7	4.8	8.5	10.8
		Night	12								1:12						
	Pierce Ward 11020	Day	28	28	48.15	26.76	21.39	58:42	1:6	1:7	1:7	4.1	3.4	7.4	7.2	7.3	10.6
		Night	28								1:7						
	Pulteney Ward 10661	Day	30	30	46.16	30.12	16.04	62:38	1:6	1:7	1:8	4.2	2.6	6.9	6.8	7	9.4
		Night	30								1:10						
	Robin Smith Ward 10690	Day	28	28	40.22	24.97	15.25	62:38	1:7	1:7	1:7	3.7	2.4	6.1	6.0	7	12.2
		Night	28								1:14						
	Surgical Assessment Unit 10865	Early	27	28	38.65	27.55	11.1	71:29	1:5	1:6	1:14	4.6	1.8	6.3	6.2	6.3	13.8
	16 beds 11 trolleys	Late	27						1:5								
		Night	27						1:7		1:14						

Appendix 2: National Quality Board recommendations, self-assessment

Supporting NHS Providers to deliver the right staff with the right skills, in the right place at the right time - safe sustainable and productive staffing – Nursing and Midwifery

37 recommendations: 19 are compliant and complete, 18 require further action which will be monitored monthly through the Nursing, Allied Health Professional and Midwifery Workforce Committee.

Expectation	Descriptor	No.	Recommendation	Current measures in place	RUH Assessment	Identified actions required	Timescale	Lead
		1.1 Evidence-based workforce planning						
	Boards should ensure there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients at all times, across all care settings in NHS provider organisations. Boards should ensure there is an annual strategic staffing review, with evidence that this is developed using a triangulated approach (i.e. the use of evidence-based tools, professional judgement, and comparison with peers), which takes							

	account of all healthcare professional groups and is in line with financial plans. This should be followed with a comprehensive staffing report to the board after six months to ensure workforce plans are still appropriate. There should also be a review following any service change or where quality or workforce concerns are identified. Safe staffing is a fundamental part of good quality care, and CQC will therefore always include a focus on staffing in the inspection frameworks for NHS provider organisations. Commissioners should actively seek to assure themselves that providers have sufficient care staffing capacity and capability, and to monitor outcomes and quality standards, using information that providers supply under the NHS Standard	

	Expectation 1: Right staff Contract							
1: Right staff	Boards should ensure there is sufficient and sustainable staffing capacity and capability to provide safe and effective care to patients at all times, across all care settings in NHS provider organisations. Boards should ensure there is an annual strategic staffing review, with evidence that this is developed using a triangulated approach (i.e. the use of evidence-based tools, professional judgement and comparison with peers), which takes account of all healthcare professional groups and is in line with financial plans. This should be followed	1.1.1	The organisation uses evidence-based guidance such as that produced by NICE, Royal Colleges and other national bodies to inform workforce planning, within the wider triangulated approach in this NQB resource	Triangulated approach to staffing establishments well embedded. Shelford SNCT used. Embedded 'safecare' as part of eRostering. Emergency Department workforce RCEM/RCN standards implemented. Royal college/ national guidance utilised to support workforce planning.	**Complete**		NA	
		1.1.2	The organisation uses workforce tools in accordance with their guidance and does not permit local modifications, to maintain the reliability and validity of the tool and allow benchmarking with peers.	All tools used as recommended.	**Complete**	Monitor the impact on the inclusion of 'enhanced care' scoring.	NA	
		1.1.3	Workforce plans contain sufficient provision for planned and unplanned leave, e.g. sickness, parental leave, annual leave, training, and supervision requirements.	20% included in all direct care in-patient areas. Compliance monitored as part of Healthroster reporting suite.	**Action Required**	Review headroom for inpatient and non-ward-based areas.	09/26	SA
		1.2 Professional judgement						
		1.2.1	Clinical and managerial professional judgement and scrutiny are a crucial element of workforce planning and are used to interpret the results from evidence-based tools, taking account of the local context and patient needs. This element of a triangulated approach is key to bringing together the outcomes from evidence-based tools alongside	6 monthly staffing reviews include face to face meetings with Corporate Nursing Team/Divisional Directors of Nursing/Matron/Senior Sister/Charge Nurses as well as workforce systems and finance. Professional judgement key part of the reviews	**Complete**		NA	

	with a comprehensive staffing report to the board after six months to ensure workforce plans are still appropriate. There should also be a review following any service change or where quality or workforce concerns are identified. Safe staffing is a fundamental part of good quality care, and CQC will therefore always include a focus on staffing in the inspection frameworks for NHS provider organisations. Commissioners should actively seek to assure themselves that providers have sufficient care staffing capacity and capability, and to monitor outcomes and quality		comparisons with peers in a meaningful way.					
		1.2.2	Professional judgement and knowledge are used to inform the skill mix of staff. They are also used at all levels to inform real-time decisions about staffing taken to reflect changes in case mix, acuity/dependency, and activity	As above. Professional judgement also used as part of the twice daily staffing review meetings. Introduction of Safer Staffing SOP	**Complete**	.	NA	
		1.3 Compare staffing with peers						
		1.3.1	The organisation compares local staffing with staffing provided by peers, where appropriate peer groups exist, taking account of any underlying differences.	Previous benchmarking included through establishment reviews and targeted at specific services under development. BSW nursing investment and agreed safer staffing principles	**Action Required**	Build on the current benchmarking capabilities included in the Model Hospital. Work with eRoster team to introduce reporting that includes benchmarking data across BSW.	03/26	SA
		1.3.2	The organisation reviews comparative data on actual staffing alongside data that provides context for differences in staffing requirements, such as case mix (e.g. length of stay, occupancy rates, caseload), patient movement (admissions, discharges, and transfers), ward design, and patient acuity and dependency.	All considered as part of the systematic staffing reviews	**Complete**		NA	
		1.3.3	The organisation has an agreed local quality dashboard that triangulates comparative data on staffing and skill mix with other efficiency and quality metrics: e.g. for acute inpatients, the model hospital dashboard will include CHPPD.	Integrated performance report includes all staffing and quality metrics.	**Complete**		NA	

	standards, using information that providers supply under the NHS Standard Expectation 1: Right staff Contract							
		2.1 Mandatory training, development, and education						
2: Right Skills	Boards should ensure clinical leaders and managers are appropriately developed and supported to deliver high quality, efficient services, and there is a staffing resource that	2.1.1	Frontline clinical leaders and managers are empowered and have the necessary skills to make judgements about staffing and assess their impact, using the triangulated approach outlined in this document.	Senior Sister/Charge Nurse leadership education programme including workforce training.	**Action Required**	Roll-out Band 6 sister/charge Nurse training to maintain competence, skills and knowledge through education sessions and staffing/ establishment review meetings. Introduction of Band 6 Leadership and development programme to include workforce education.	03/26	SA/ NB
		2.1.2	Staffing establishments take account of the need to allow clinical staff the time to undertake mandatory training and continuous professional development, meet revalidation requirements, and fulfil teaching, mentorship, and supervision roles, including the support of preregistration and undergraduate students.	20% headroom allowance and provision of supervisory Senior Sister/Charge Nurse. Funded allocation for study leave is 1.5%l Introduction of revised Clinical Practice Facilitator (CPF) model for all areas to support in areas training and supervision. Nursing and AHP learner dashboard to monitor learner numbers.	**Action Required**	Further scope the learners in all areas and across all programmes, and the time required to supervise. Review the number of assessors within departments to match demand. Review headroom for inpatient and non-ward-based areas Monitor impact of new CPF structure. Introduction of departmental training needs analysis	09/26	SA

	reflects a multiprofessional team approach. Decisions about staffing should be based on delivering safe, sustainable, and productive services. Clinical leaders should use the competencies of the existing workforce to the full, further developing and introducing new roles as appropriate to their skills and expertise, where there is an identified need or skills gap.							
		2.1.3	Those with line management responsibilities ensure that staff are managed effectively, with clear objectives, constructive appraisals, and support to revalidate and maintain professional registration.	All expectations clearly included in JD and annual objectives for line managers	**Complete**	Monitored as part of ongoing HR key performance metrics	NA	
		2.1.4	The organisation analyses training needs and uses this analysis to help identify, build, and maximise the skills of staff. This forms part of the organisation's training and development strategy, which also aligns with Health Education England's quality framework.	Mandatory and essential training analysis in place per role.	**Action Required**	Review of current department training needs analysis baseline Implementation of training needs analysis for departments and align to CPD arrangements.	03/26	JP
		2.1.5	The organisation develops its staff's skills, underpinned by knowledge and understanding of public health and prevention, and supports behavioural change work with patients, including selfcare, wellbeing and an ethos of patients as partners in their care.	Comprehensive training programmes in place to equip staff with required Skills. Introduction of clinical skills team and divisional CPF teams	**Complete**		NA	
		2.1.6	The workforce has the right competencies to support new models of care. Staff receive appropriate education and training to enable them to work more effectively in different care settings and in different ways. The organisation makes realistic assessments of	Comprehensive training programmes in place to equip staff with required Skills Review of mandatory and essential trainings subjects with subject matter experts as part of national review .	**Complete**		NA	

			the time commitment required to undertake the necessary education and training to support changes in models of care.					
		2.1.7	The organisation recognises that delivery of high-quality care depends upon strong and clear clinical leadership and well-led and motivated staff. The organisation allocates significant time for team leaders, professional leads, and lead sisters/charge nurses/ward managers to discharge their supervisory responsibilities and have sufficient time to coordinate activity in the care environment, manage and support staff, and ensure standards are maintained.	100% Supervisory ward leader time established in all inpatient direct care areas. Continue to review % of time achieved as supervisory.	**Complete**		NA	
		2.2 Working as a multiprofessional team						
		2.2.1	The organisation demonstrates a commitment to investing in new roles and skill mix that will enable nursing and midwifery staff to spend more time using their specialist training to focus on clinical duties and decisions about patient care.	Range of new roles developed to meet service needs have been implemented within divisional workforce and patient pathways. Successful nurse associate and registered nurse apprenticeship pathways and roles. Introduction of enhanced care team.	**Action Required**	Establishment reviews to evaluate nurse associate workforce and align this to skill mix and patient pathways consistently. OPD establishment review process to review new roles.	03/26	SA

		2.2.2	The organisation recognises the unique contribution of nurses, midwives and all care professionals in the wider workforce. Professional judgement is used to ensure that the team has the skills and knowledge required to provide high-quality care to patients. This stronger multiprofessional approach avoids placing demands solely on any one profession and supports Improvements in quality and productivity, as shown in the literature	Multiprofessional approach to all aspects of workforce development and training delivered within an integrated Training, Development and Workforce department AHP workforce lead appointed. Retention, development and growth roles recruited. MDT approach to establishment review process.	**Complete**		NA	
		2.2.3	The organisation works collaboratively with others in the local health and care system. It supports the development of future care models by developing an adaptable and flexible workforce (including AHPs and others), which is responsive to changing demand and able to work across care settings, care teams and care boundaries.	Strong record of working with other providers both in provider and HEI/FE sector. Continue with current approach and strengthen partnership working with local colleges to maximise T-levels and apprenticeships.	**Complete**		NA	
		2.3 Recruitment and retention						

		2.3.1	Leadership that closely resembles the communities it serves. The research outlined in the NHS provider roadmap42 demonstrates the scale and persistence of discrimination at a time when the evidence demonstrates the links between staff satisfaction and patient outcomes.	RUH plan to address equality and diversity within trust linked to WRES data Supporting equity – DALS and Routes to success programme. RCN Ambassador programme	**Action Required**	Embedding of RCN ambassador programme Band 6 leadership programme.	05/26	JP/ NB
		2.3.2	The organisation has effective strategies to recruit, retain and develop their staff, as well as managing and planning for predicted loss of staff to avoid over-reliance on temporary staff.	Retention and recruitment of Paediatrics and Theatres established maintains the Focus. Continue to monitor monthly.	**Complete**		NA	
		2.3.3	In planning the future workforce, the organisation is mindful of the differing generational needs of the workforce. Clinical leaders ensure workforce plans address how to support staff from a range of generations, through developing flexible approaches to recruitment, retention, and career development	Generational work starting to be incorporated into projects for retention and recruitment and specifically, around preceptorship. Adverts focusing on generational cohort.	**Complete**		NA	
		3.1 Productive working and eliminating waste						
3: Right Place		3.1.1	The organisation uses ‘lean’ working principles, such as the as a way of eliminating waste.	Transformation work is underpinned by the ‘improving together methodology.’	**Complete**		NA	

and Time				The techniques applied as appropriate including reviews of care hours, SNCT, Quality metrics, and model hospital productivity data.				
	Boards should ensure staff are deployed in ways that ensure patients receive the right care, first time, in the right setting. This will include effective management and rostering of staff with clear escalation policies, from local service delivery to reporting at board if concerns arise. Directors of nursing, Directors of operations, Directors of finance and Directors of workforce should take a collective	3.1.2	The organisation designs pathways to optimise patient flow and improve outcomes and efficiency e.g. by reducing queuing.	Incorporated in service Redesign. SDECS, fit-to-sit area, DAA, the discharge lounge, and H@H.	**Complete**		NA	
		3.1.3	Systems are in place for managing and deploying staff across a range of care settings, ensuring flexible working to meet patient needs and making best use of available resources.	Staff are employed to be fully flexible (skills and competence allowing). Continued review as part of daily staffing meetings to maximise flexibility of staff	**Complete**		NA	
		3.1.4	The organisation focuses on improving productivity, providing the appropriate care to patients, safely, effectively and with compassion, using the most appropriate staff.	Staff are employed to be fully flexible (skills and competence allowing). The workforce and quality meetings review productivity. The enhanced care team addressed the areas for further skills.	**Complete**		NA	
		3.1.5	The organisation supports staff to use their time to care in a meaningful way, providing direct or relevant care or care support. Reducing time wasted is a key priority.	Included as part of methodology of reviews of staffing. Direct care time monitored. Other roles	**Complete**		NA	

	leadership role in ensuring clinical workforce planning forecasts reflect the organisation's service vision and plan, while supporting the development of a flexible workforce able to respond effectively to future patient care needs and expectations.			utilised to maximise direct Care. Assurance through SafeCare.				
		3.1.6	Systems for managing staff use responsive risk management processes, from frontline services through to board level, which clearly demonstrate how staffing risks are identified and managed.	Clear escalation processes in place and risk register, daily staffing meeting. PSIRF roll-out will inform the new way to review and learn from any staffing issues. Monthly divisional dashboard support governance to the board.	**Complete**		NA	
		3.2 Efficient deployment and flexibility						
		3.2.1	Organisational processes ensure that local clinical leaders have a clear role in determining flexible approaches to staffing with a line of professional oversight, that staffing decisions are supported and understood by the wider organisation, and that they are implemented with fairness and equity for staff.	Involvement of clinical leaders at all levels in setting establishment levels and rostering workforce. This is systematically reviewed through 6 monthly staffing reviews reported to board	**Complete**		NA	
		3.2.2	Clinical capacity and skill mix are aligned to the needs of patients as they progress on individual pathways and to patterns of demand, thus making the best use of staffing resource and facilitating effective patient flow.	Clinical speciality, acuity, dependency and pathways included as part of the systematic review of staffing Levels. Where the skill falls out of an area- the Enhanced care team has been created.	**Complete**		NA	

		3.2.3	Throughout the day, clinical and managerial leaders compare the actual staff available with planned and required staffing levels, and take appropriate action to ensure staff are available to meet patients' needs.	Twice daily reviews of staffing levels planned and actual undertaken at care group, Division and trust wide level through daily staffing meetings linked to site.	**Complete**		NA	
		3.2.4	Escalation policies and contingency plans are in place for when staffing capacity and capability fall short of what is needed for safe, effective, and compassionate care, and staff are aware of the steps to take where capacity problems cannot be resolved.	Escalation policies in place into site for unresolved staffing issues. Temporary staffing escalation in place and resource shared Trust-wide when required Safer Staffing SOP	**Complete**		NA	SA
		3.2.5	Meaningful application of effective e-rostering policies is evident, and the organisation uses available best practice from NHS Employers and the Carter Review Rostering Good Practice Guidance (2016).	Use of eRoster systematically reviewed and managed through the management team structure. Divisional monthly roster reviews. KPIs reviewed at the monthly workforce committee. Roster policy is being published by HR.	**Complete**		NA	
		3.3 Efficient employment, minimising agency use						
		3.3.1	The annual strategic staffing assessment gives boards a clear medium-term view of the likely temporary staffing requirements. It	Currently undertake 6 monthly staffing reviews that take account of all the	**Complete**		NA	

			also ensures discussions take place with service leaders and temporary workforce suppliers to give best value for money in deploying this option. This includes an assessment to maximise flexibility of the existing workforce and use of bank staff (rather than agency), as reflected by NHS Improvement guidance.	recommendations. Staffing reviews closely aligned to the Retention & Recruitment and temporary staffing strategies and clear actions in place to maximise bank use and reduce agency A programme of work NAMIP provide assurance of 10 active drivers to create efficiencies for bank and agency usage.				
		3.3.2	The organisation is actively working to reduce significantly and, in time, eradicate the use of agency staff in line with NHS Improvement's nursing agency rules, supplementary guidance and timescales.	Reduced agency usage in line with NHSI guidance. Continued reduction in agency usage. Safer staffing SOP and executive only authorisation process			NA	
		3.3.3	The organisation's workforce plan is based on the local Sustainability and Transformation Plan (STP), the place-based, multi-year plan built around the needs of the local population.	The Nursing workforce teams is very much engaged in the business cycle and local process provided. The sustainability focus is on addressing appropriate headroom and standardised Job plans.	**Complete**		NA	
		3.3.4	The organisation works closely with commissioners and with Health Education England, and submits the workforce plans, using the defined process, to inform	RUH is fully engaged in development of	**Complete**		NA	

			supply and demand modelling.	Workforce planning aspects and matching the establishments to commissioned work.				
		3.3.5	The organisation supports Health Education England by ensuring that high quality clinical placements are available within the organisation and across patient pathways, and actively seeks and acts on feedback from trainees/students, involving them wherever possible in developing safe, sustainable, and productive services.	Strong systems in place to identifying placement capacity and monitor student allocation and quality across all staff groups. The NETS survey is monitored with an action plan is in place.	**Complete**		NA	

Recommendation	Evidence	Compliance	Action plan
1. Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance	-Monthly Nursing & Midwifery Safe Staffing/ workforce meeting and reports set out as per expectations of the NQB (2016). -Safer Nursing Care Tool data collection April & Oct -Bi-annual establishment review Dec-Feb & Aug-Sep -CHPPD reported monthly in comparison with peers to the integrated performance review	Compliant	NA
2. Trusts must ensure the three components are used in their safe staffing processes: – evidence-based tools (where they exist) – professional judgement – outcomes	Evident within the Bi-annual establishment review presentation reports	Compliant	NA
3. We will base our assessment on the annual governance statement, in which trusts will be required to confirm their staffing governance processes are safe and sustainable	Confirmation included in annual governance statement that our staffing governance processes are safe and sustainable	Compliant	NA
4. We will review the annual governance statement through our usual regulatory arrangements and performance management processes, which complement quality outcomes, operational and finance performance measures	-Confirmation included in annual governance statement that our staffing governance processes are safe and sustainable. -All outcomes are triangulated in the bi-annual safe staffing report.	Compliant	NA
5. As part of this yearly assessment we will also seek assurance through the SOF, in which a provider's performance is monitored against five themes	-Quality dashboards developed for nursing (e-rostering performance metrics, fill-rates, and finance within the monthly Nursing workforce group reports and included in the integrated performance review. -Electronic rostering and KPIs reported monthly, and areas of improvement acknowledged	Compliant	NA
6. As part of the safe staffing review, the director of nursing and medical director must confirm in a statement to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable	-The Chief Nurse Officer signs-off the annual establishment review meetings -The CNO is positioned as responsible director for monthly Nursing & Midwifery safer staffing metrics -The CNO plays an active leadership role for Safe Staffing evolvement and aspirations -The CNO chairs the monthly Nursing workforce group -Statement CMO/CNO as part of the bi-annual board report	Compliant	NA
7. Trusts must have an effective workforce plan that is updated annually and signed off by the chief executive and executive leaders. The board	-Evident in the bi-annual Nursing Safe Staffing Report.	Compliant	NA

should discuss the workforce plan in a public meeting			
8. They must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their board every month	-Quality dashboards developed for nursing vacancies, fill rates, CHPPD, rostering red flags, performance metrics, monthly clinical dashboard e.g. falls are presented monthly at the Integrated performance report to board. -Electronic rostering reported and areas of improvement acknowledged	Compliant	NA
9. An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the board by ward or service area twice a year, in accordance with NQB guidance and NHS Improvement resources. This must also be linked to professional judgement and outcomes	-Evident in the Bi-annual safe staffing nursing report -Bi-annual establishment review cycle -SNCT assessment April and October	Compliant	NA
10. There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool	- Evident and continuously reviewed by the Associate Chief Nurse for Workforce & Education. -Any changes are presented at the Nursing Workforce Group chaired by the CNO – and reflected in the bi-annual reports as well as a supporting EQIA. The budgets and establishments are set annually. -The Associate Chief Nurse for Workforce and Education is responsible for the training of the Safer Nursing Care Tool (SNCT) and ensuring staff are aware that adaptions to the tool are not condoned	Compliant	NA
11. As stated in CQC's well-led framework guidance (2018)6 and NQB's guidance7 any service changes, including skill-mix changes, must have a full quality impact assessment (QIA) review	EQIA evident (most recent is the Paediatric inpatient establishment) reviewed at the Monthly Nursing workforce group and applied to the bi-annual Nursing safe staffing reports as an appendix.	Compliant	NA
12. Any redesign or introduction of new roles (including but not limited to physician associate, nursing associates and advanced clinical practitioners – ACPs) would be considered a service change and must have a full QIA	EQIA assessment is embedded within the business case and annual business planning processes. For specifically, a change within the Nurse Associates a EQIA will be completed by the Associate Chief Nurse of Workforce and Education as per the Nursing processes	Compliant	NA
13. Given day-to-day operational challenges, we expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety,	-Dynamic risk assessments undertaken at twice daily Trust wide daily operational oversight and leadership for staffing led by allocated Senior Nurse (Divisional Director of Nursing or Deputy)	Compliant	NA

quality, finance, performance and staff experience must be clearly described in these risk assessments			
14. Should risks associated with staffing continue or increase and mitigations prove insufficient, trusts must escalate the issue (and where appropriate, implement business continuity plans) to the board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example, wards, beds and teams, realignment, or a return to the original skill mix.	-Twice-daily operational oversight of safe-staffing and site management. Senior Nurse leadership chairs the meetings. -Business continuity plans in place to support. Escalation process and professional judgement guidance included in the safe staffing standard operating procedure for nursing and midwifery.	Compliant	NA

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**14**
Date of Meeting:	**14 January 2026**		

Title of Report:	**Learning from Deaths (Q1)**
Status:	**For Information and Discussion**
Board Sponsor:	**Kheelna Bhavalia, Interim Chief Medical Officer**
Author:	**Heather Boyes, Head of Healthcare Legal Services**
Appendices	**None**

1. Executive Summary of the Report

Of the SJRs completed during Q1, 21 (81%), assessed the overall care to be either Good (a score of 4) or Very Good (a score of 5). This is an increase from 80% in Q4 but a decrease from 88% in Q3.

0% of SJRs completed in the last quarter rated overall care as very poor or poor. Issues relating to lack of senior review and documentation were identified as the causes of reduced quality of care in patients who died.

There has been a significant decrease in the number of SJRs being completed but those patients who have been reviewed, have been completed in a more timely manner.

17 inquests were opened and 49 were concluded during Q1, one following an in-person hearing.

The Trust did not receive any Regulation 28 Reports.

The Trust has a high percentage of invalid diagnosis codes, specifically with *primary diagnosis as a sign or symptom* (R codes) entering Q1 we are in the lowest quartile in the country. RUH is the second lowest performing trust in the Southwest for having uncoded episodes.

2. Recommendations (Note, Approve, Discuss)

To note.

3. Legal / Regulatory Implications

The Care Quality Commission (CQC) report *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England* found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements/learning were being missed.

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

-

5.	Resources Implications (Financial / staffing)
Some specialties are struggling due to reduced consultant numbers. Even those that are fully staffed, struggle to complete the reviews in a timely manner.	

6.	Equality and Diversity
N/A	

7.	References to previous reports/Next steps
Q4 2024/25	

8.	Freedom of Information
Public	

9.	Sustainability
N/A	

10.	Digital
N/A	

Royal United Hospitals Bath
NHS Foundation Trust

Learning from Deaths

April to June 2025 (Q1)

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

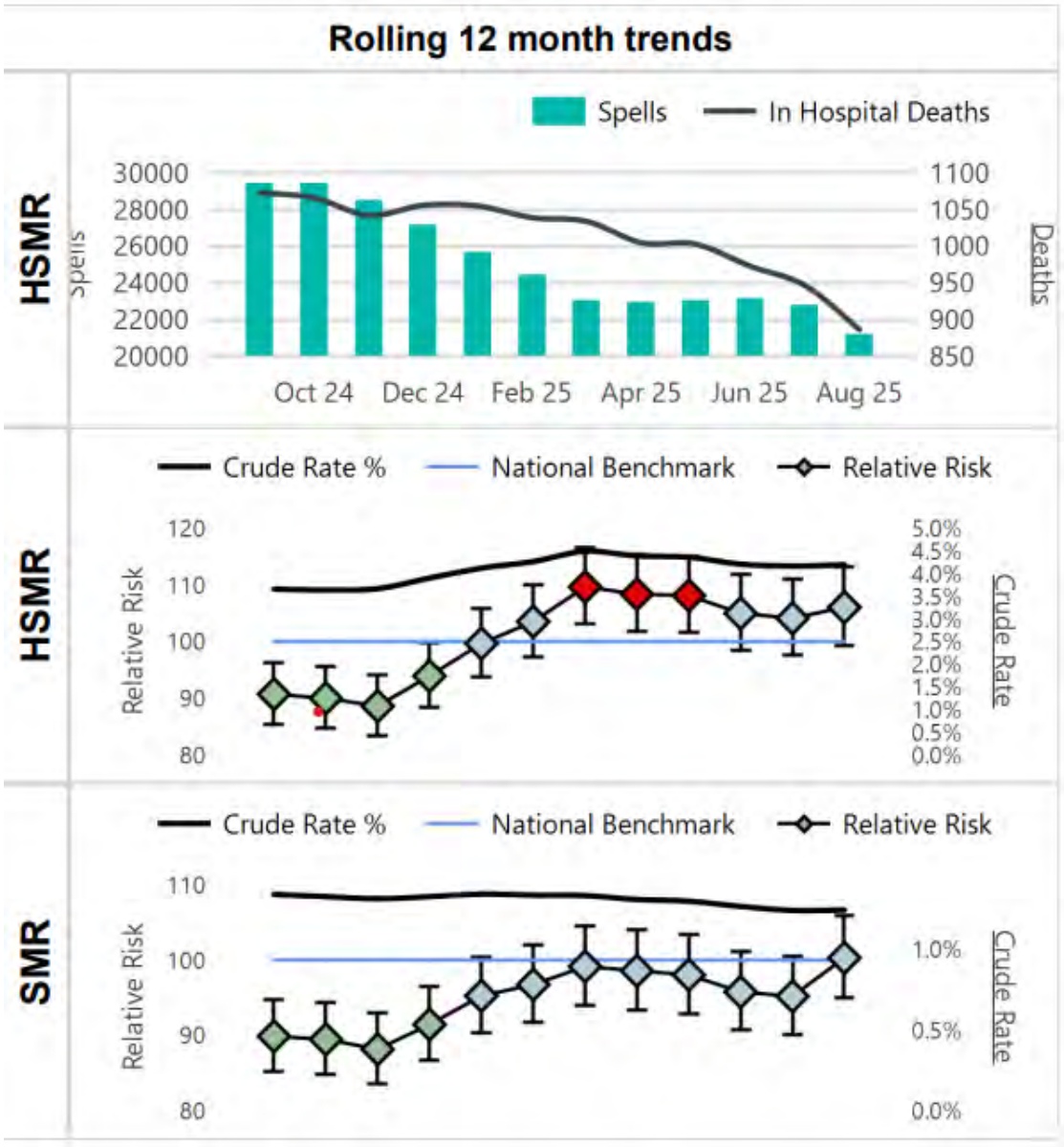
1.0 Summary Data

1.1 The number of in-patient deaths in Q1 was 318.

1.2 Due to incomplete coding the Telstra team have advised that the HSMR and SHMI should be interpreted with significant caution. Our HSMR was above the national benchmark for Q1. Whilst the contract with Telstra has ceased they are able to retrospectively review our HSMR and SHMI as the coding backlog has recently improved.

1.3 Our Standardised Mortality Ratio (SMR) data for Q1 continues to sit within the expected range, and is showing a downward trend, below the national benchmark.

1.4 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 Q1 we are in the lowest quartile in the country. RUH is the second lowest performing trust in the Southwest for having uncoded episodes.


Rolling 12 month trends
HSMR
Spells
In Hospital Deaths
30000
28000
26000
24000
22000
20000
1100
1050
1000
950
900
850
Deaths
Oct 24
Dec 24
Feb 25
Apr 25
Jun 25
Aug 25
HSMR
Crude Rate %
National Benchmark
Relative Risk
120
110
100
90
80
Relative Risk
5.0%
4.5%
4.0%
3.5%
3.0%
2.5%
2.0%
1.5%
1.0%
0.5%
0.0%
Crude Rate
SMR
Crude Rate %
National Benchmark
Relative Risk
110
100
90
80
Relative Risk
1.0%
0.5%
0.0%
Crude Rate

1.5 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.

1.6 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)
- Legal Services
- Medical Examiner
- Coroners, Reg 28s

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.

2.3 Regarding Structured Judgement Reviews (SJRs), in Q1 13% (n=40) of patients who died during Q1 were selected for SJR, plus an additional 5 patients whose death had occurred during an earlier quarter.

2.4 Figure 2 demonstrates the selection criteria for those patients who died during Q1. The selection criteria used most frequently was that the patient was a surgical patient (all surgical patients have an SJR), followed by Medic/Nursing Concern.

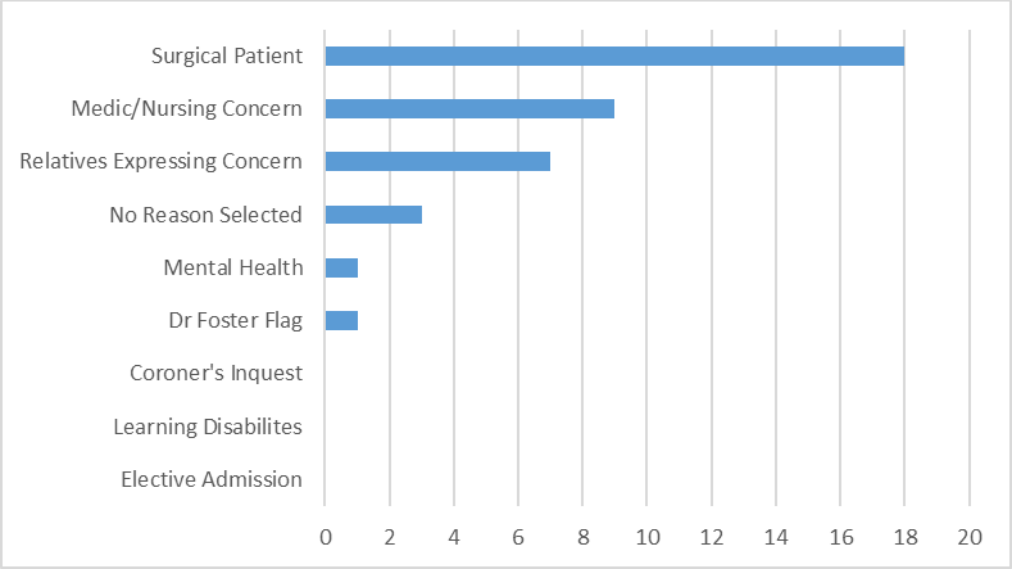


Figure 2: Number of deaths selected for SJR by selection criteria

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 58%. It is positive that changes to the selection criteria has resulted in a reduction in the number of deaths being selected for an SJR. It is also positive that those SJRs that were completed during the quarter were completed in a more timely manner than has been seen previously. The concern

is the reduction in the number of SJRs being completed. The backlog will continue to grow if the number being completed is exceeded by the number being selected.

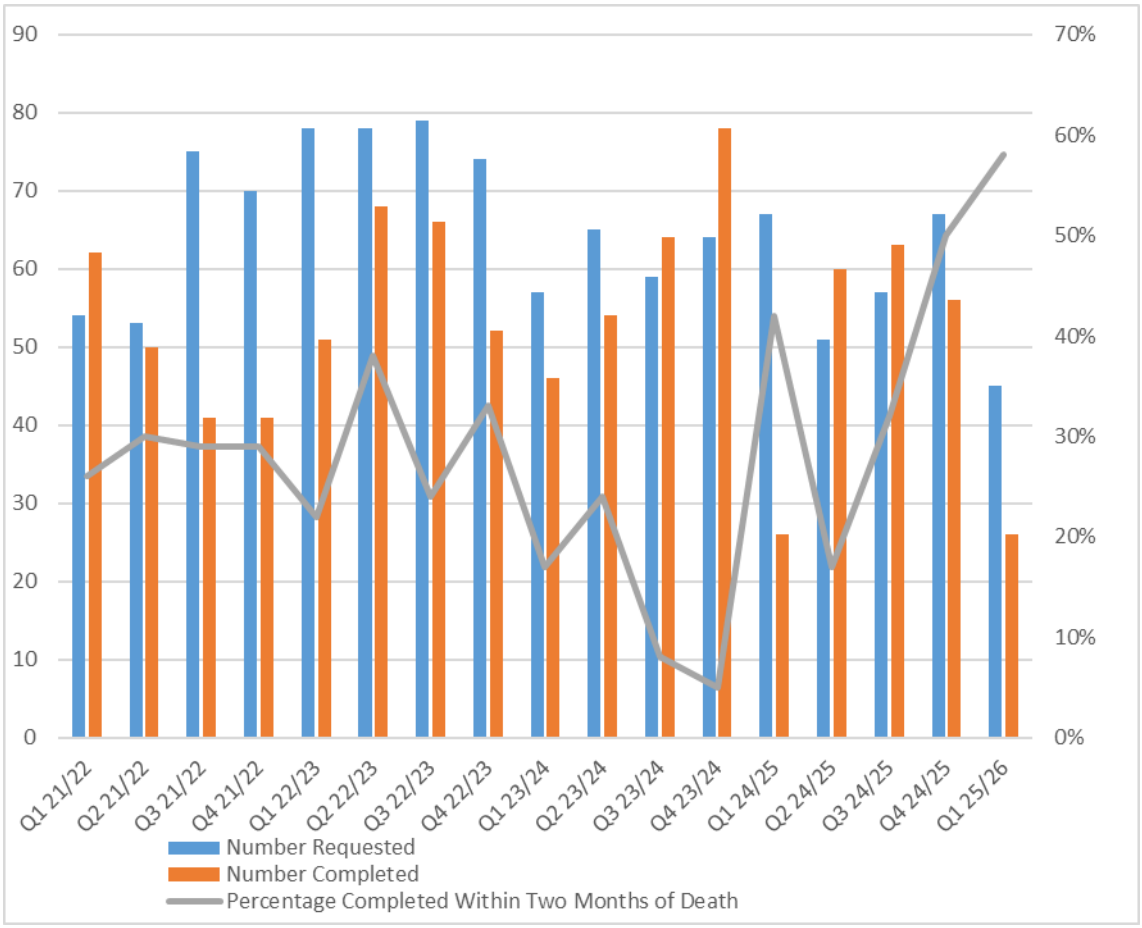


Figure 3: Number of completed SJRs v Number Requested and % completed within two months of the death

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

3.0 Learning from Mortality Reviews

3.1 Of the SJRs completed during Q1, 21 (81%), assessed the overall care to be either Good (a score of 4) or Very Good (a score of 5). This is an increase from 80% in Q4 but a decrease from 88% in Q3.

3.2 No patients were assessed as having received very poor care, or poor care overall.

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

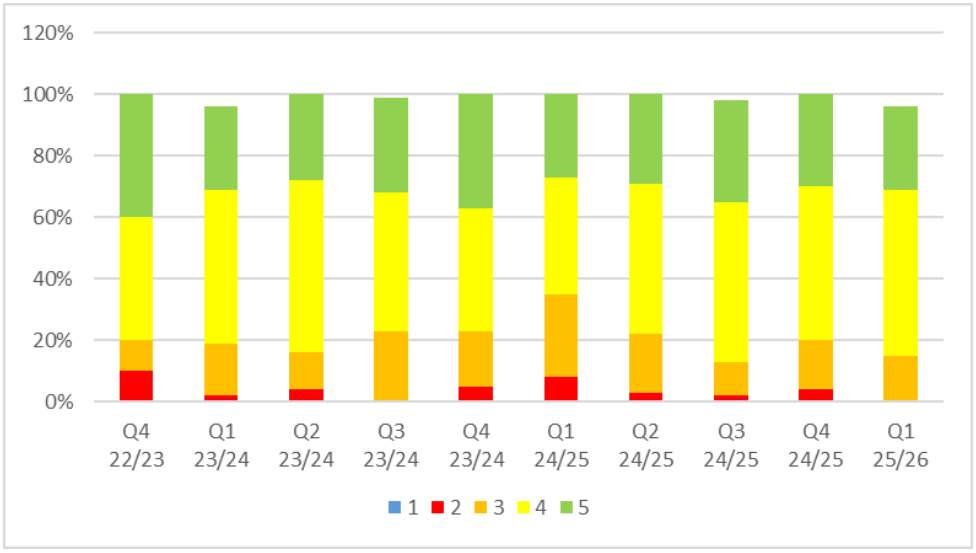


Figure 4: Score Allocated to Overall Care by Quarter

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. It is important to recognise that in 73% of cases, either no additional learning was identified, or it was recognised that the care delivered was of a good or excellent standard.

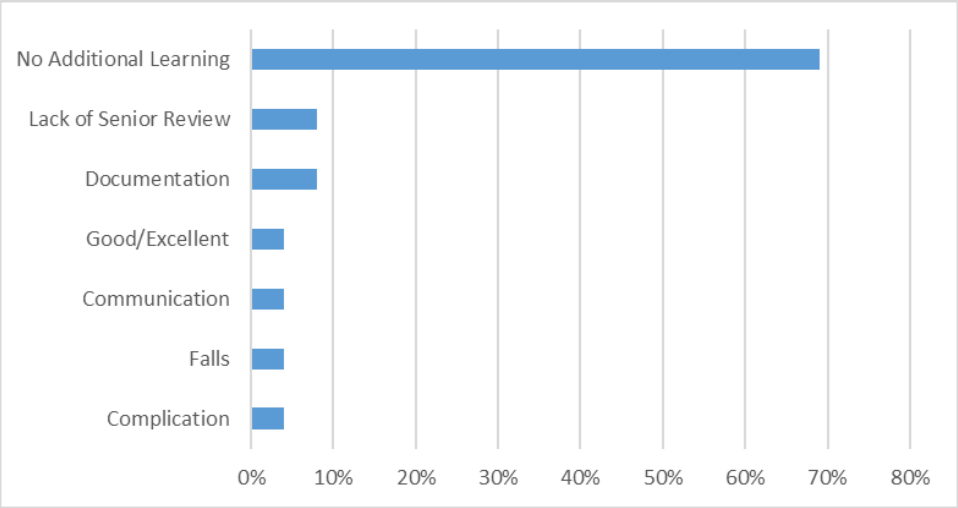


Figure 5: SJR themes

3.7 The reduced number of completed SJRs makes identifying themes more challenging. Two SJRs referenced that patients who are not progressing as expected, should receive a senior review. In both instances, it was concluded that the outcome was unlikely to have been unchanged.

3.8 Two SJRs reference lack of documentation; in the first, the reviewer comments that the reasoning for continuing a drug that appeared to be making the patient drowsy (potentially contributing to a fall) could not be found within the records. In the second, the rationale for not escalating a patient with mental health concerns and no next of kin to ITU was not documented. In both cases, it was documented that the care was otherwise excellent.

4.0 Inquests

4.1 17 inquests were opened and 49 (the Trust chased an update in relation to several older matters) were concluded during Q1. The Trust was required to attend one in-person hearing which related to the death of a patient following the implementation of an incorrect insulin regime. The Coroner did not make a Regulation 28 Report, stating he was impressed with the improvements the Trust had already implemented.

4.2 No 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, die 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 Clinical Effectiveness Committee is standing up a mortality group again, to lead our mortality review work and steer this work and share timely insights and learning for discussion at clinical effectiveness group. The first meeting is scheduled for December 2025.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**15**
Date of Meeting:	**14 January 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 8 December 2025

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

Back-office functions such a coding and the response to complaints (66% within mutually agreed timeframe against target of 90%) are delayed due to gaps in the teams and shortage of time in clinicians job plans.

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

Backlog in Structured Judgement Reviews (SJRs) not clearing as expected. Coding for Summary Hospital-level Mortality Indicator (SHMI) is catching up. A new Mortality Surveillance Group has been set up to give assurance that hospital mortality rates are not an outlier (Dec 25).

Relaunch of Urgent and Emergency Care (UEC) programme, delivering professional standards with red lines. There is concern over naming and the time it will take to change behaviours.

Nursing short term sickness is well above headroom. Increasing number of red flags due to short notice sickness. Twice daily staffing meetings are in place to mitigate shortages.

Maternity and neonatal voices partnership – discussions are ongoing with the Integrated Care Board (ICB) to fund current post (part of the national 3-year delivery plan for maternity).

The Neonatal Unit continues to be very busy with the closure of cots in Bristol and a general increase in demand across the South West.

The paediatric audiology review to benchmark against British Academy of Audiology (BAA) quality standards is delayed by 6 months due to clinical and admin shortages.

ASSURE: Inform the Board where positive assurance has been achieved

There were a very low number of reopened complaints.

Following the Care Quality Commission (CQC) surgical review in 2024, 19 of the 21 actions identified have been completed.

RISK: Advise the Board which risks were discussed and if any new risks were identified
The Board Assurance Framework (BAF) updated quality risks were discussed. Risk 1.1 was approved. Further work is required around risk 3.3 (reducing unwanted variation in care and inequity). There is concern that the risk register has long standing risks with risk ratings that do not change, even with multiple mitigations. There is a tendency to describe the problem rather than the risk.
CELEBRATING OUTSTANDING: Share any practice innovation or action that the committee considers to be outstanding
Staff Flu vaccinations are some of the highest in the South West. A Trust wide regular safety bulletin has been introduced.
APPROVALS: Decisions and Approvals made by the Committee
The Committee reviewed and agreed an updated Terms of Reference to which minor amendments had been made. The updated Terms of Reference is appended for onward approval by the Board.

Appendix 1

Royal United Hospitals Bath
NHS Foundation Trust

Quality Assurance Committee

Terms of Reference

1. Purpose

The Quality Assurance Committee is established to be a sub-Committee of the Board of Directors and is the Board assurance committee for all quality related matters.

2. Duties

The Committee shall ensure that the Board of Directors is adequately assured in relation to patient safety, clinical quality, clinical effectiveness and patient experience and safeguarding which will include, but is not limited to:

- Trust-Level operational risks, BAF risks and related Statutory Duty/Compliance are appropriately managed.
- That the patient safety priorities improvement work is progressing together with the implementation of the Patient Safety Incident Response Framework.
- Compliance with national reviews, public inquiries, and coronial outcomes.
- Quality and safety risks related to the digital programme are visible and managed appropriately.
- Clinical outcomes and effectiveness including review and response to national clinical audits, national registries etc.
- Mortality rates surveillance, learning from deaths and LeDeR reviews.
- Regulatory compliance i.e. Care Quality Commission.
- Equality and Quality Impact Assessments (EQIAs) assessments are utilised as per the policy.
- Provision of safe, high-quality delivery of maternity care and any associated risks.
- That systems and processes are sufficiently safeguarding vulnerable people.
- Quality and safety risks related to the people plan are visible and managed appropriately.
- Assurance that the organisational culture aligns and supports safe and high-quality patient care and strongly supports learning.

This shall ensure that the Committee maintains oversight of:

- Management systems and structures to ensure that sufficient analysis of incidents, complaints, claims, clinical audits, service reviews etc. is undertaken to reflect, learn and make recommendations for required changes to improve quality of care provided to patients.
- Concerns raised by the Insight and Improvement Committee, in regard to issues of patient safety and quality which require Board level attention and resolution.

- The quality work programme and the support required for quality improvement by the Quality & Patient Safety work streams, Clinical Audit, Learning and Development and digital services.
- The Committee shall assure itself that regulatory requirements are complied with, with proven and demonstrable assurance, and immediate and effective action is taken where this is identified as deficient.
- The Committee shall monitor and assure itself that it can with confidence, and evidence, assure the Board, patients, public, and other stakeholders that the Trust is complying with its regulatory requirements and can evidence this.
- The Committee shall seek to embed the culture of compliance and continuous improvement within the organisation.
- The Committee shall ensure compliance with the CQC registration requirements and standards and shall oversee the detailed work plan arising from inspections, alerts or other highlighted concerns raised by the CQC.
- The Committee shall also monitor key areas of compliance, such as NHS Resolution General Risk Management Schemes and Clinical Negligence Scheme for Trusts and other key areas of quality compliance as they arise.
- The Committee shall ensure the Trust has robust risk management systems and processes in place for regulatory compliance, quality, patient safety, statutory duty/compliance and reputational (quality-related) risks. In particular, the Committee will:

    - act as the forum for these risks to be discussed, and assure itself that where concerns are raised, action is taken, and that action plans are completed.

    - act in accordance with Board approved risk appetite and risk tolerance levels when reviewing risks.

3. Membership

The Committee shall be appointed by the Board to ensure representation by Non-Executive and Executive Directors.

The membership of the Committee shall consist of:

- Non-Executive Director (Chair)
- Two other Non-Executive Directors
- Chief Nursing Officer (Lead Executive)
- Chief Medical Officer
- Chief Operating Officer

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

In the absence of an Executive Director, their deputy will be invited to represent them and will count towards quoracy.

Each member will have one vote with the Chair having the casting vote, if required. Should a vote be required a decision will be determined by a simple majority.

The following members are required to attend meetings of the Quality Assurance Committee:

- Deputy Chief Nursing Officer (with a responsibility for Quality Governance)
- Deputy Chief Medical Officer (with a responsibility for Quality Governance)
- Head of Corporate Governance

Where the Committee deems it necessary, other colleagues may be invited to attend for specific matters as and when appropriate.

4. Quorum

- Business will only be conducted if the meeting is quorate.

- The Committee will be quorate with three members, including at least two Non-Executive Directors (of which one may be the Chair), either the Chief Nursing Officer or the Chief Medical Officer (or their formally nominated deputy).

- Members should attend 75% of the scheduled meetings.

5. Accountability and Reporting Arrangements

The Committee will be accountable to the Board of Directors.

The Chair of the Committee will ensure that the Board is fully sighted on areas of compliance and non-compliance and will report on the activities of the Committee to the next Public Board meeting.

The Chair of the Committee will make recommendations to the Board on any area within the Committee's remit where disclosure, action or improvement are needed.

The Chair of the Committee will liaise with the Chairs of other Board Committees where necessary to ensure that cross-committee issues receive adequate oversight (by, for example, arranging to attend other Committee meetings).

The Committee will consider matters referred to it by those other Committees. The Committee will develop and maintain a meeting schedule which will outline the key reports it will consider during the year.

6. Sub-Committees

The Committee may establish, where relevant, sub-committees to provide further in-depth analysis about specific aspects of the Committee's work programme.

All sub-committees are to have terms of reference that are developed and approved by the Committee.

All sub-committee will provide an upward report to the Committee in line with the agreed work plan and an annual report to include a review of the effectiveness of the sub-committees.

The Committee shall maintain oversight of the business of the following committees through the receipt of regular upward reports:

- Medicines Committee
- Insight and Improvement Committee
- Patient Experience Committee
- Infection Prevention and Control Committee
- Vulnerable Persons Assurance Committee
- Clinical Effectiveness Committee

7. Frequency

The Committee will meet on a bi-monthly basis.

The Committee will meet a minimum of six times a year.

Additional meetings may be arranged when required to support the effective functioning of the Committee.

8. Authority

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary.

9. Monitoring Effectiveness

The Committee will undertake an annual review of its performance against its Terms of Reference and work plan in order to evaluate the achievement of its duties. This review will be presented to the Board in the form of the Committee's annual report.

10. Other Matters

The servicing, administrative and appropriate support to the Chair and Committee will be the responsibility of the Head of Corporate Governance. The Head of Corporate Governance will be responsible for providing administrative and governance support to the Committee, including:

- Agreement of the agenda with the Chair / Chief Nursing Officer

- Collation of the papers which will be disseminated five working days in advance of the meeting.
- Arranging for the minutes and actions list which will be disseminated five working days after the meeting has taken place.
- Accessing advice to the Committee as required.

11. Review

These terms of reference will be reviewed annually as part of the monitoring effectiveness process.

12. Approval

Approved by Quality Assurance Committee: 8th December 2025

Ratified by the Board of Directors on: 14th January 2026

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**16**
Date of Meeting:	**14 January 2026**		

Title of Report:	**Freedom to Speak Up Q2 2025-26 Report**
Status:	**For information and assurance**
Board Sponsor:	**Kheelna Bavalia, Interim Chief Medical Officer**
Author:	**Elizabeth Swift, Interim Freedom to Speak Up Guardian for RUH (substantive FTSUG at Salisbury NHSFT)**
Appendices	**None**

1. Executive Summary of the Report

This report provides details of activity for Q1 & Q2 2025/26 in relation to concerns raised and the opportunities for learning and service change – key components include:

- The SFT FTSUG is supporting RUH during an extended period of sick leave. A temporary workplan has been agreed to outline the prioritised activities to be continued or paused by the FTSUG across the organisation and RUH, ensuring that statutory responsibilities and key strategic work are maintained while enabling a manageable workload during this interim period which will end January 2026. Consequently, the FTSU service is a 'light touch' approach for this period.
- In addition, in response to changes in the RUH executive team, FTSU moved to sit under the CMO office in Q2.
- RUH FTSU Q1 data is not included in this report. The SFT FTSUG was unable to access Q1 data this during this interim arrangement period. This will be reconciled for the end of year report.
- RUH FTSU Q2 is not in line with national trajectory on two aspects. Firstly, the number of concerns raised at RUH is lower and most likely due to the change in service. However, of note, early indicators suggest this has increased back up in Q3. Secondly, of the concerns that are reported, we had a higher proportion of anonymous reporting (25% of total) compared to nationally reported (12%). Not all systems allow for anonymous reporting in the way we do, which will be a factor, but this may also speak to visibility and understanding of the FTSU process and psychological safety.
- The top themes are Element of Inappropriate Attitudes or Behaviours and Staff Safety (includes stress and wellbeing) – work with Business Partners and advisors and OD to influence culture change and leadership development.

2. Recommendations (Note, Approve, Discuss)

The Board is asked to note the contents of the report which is provided for information, discussion and assurance as part of a quarterly update.

3. Legal / Regulatory Implications

NHS England has confirmed that Freedom to Speak Up, and the role of Guardians, will be incorporated into the NHS Standard Contract for 2026/27, providing assurance

of ongoing commitment to the national support and guidance of Guardians. NHS England will assume responsibility for leading this work from 2026/27 onwards. team to provide insight and experience of FTSU. Updates will be shared in due course for further analysis and action.

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)
This will be reviewed in the new year.	

5.	Resources Implications (Financial / staffing)
Our RUH FTSUG returns from maternity leave this month and in the new year will be an opportunity to reflect on any variation from national trajectory and renew our approach.	

6.	Equality and Diversity
We note that 42% of concerns raised by colleagues in Q2 were from a BAME background. I do not have the information of whether this expected, comparable or a trend shift, and will need to be explored as part of a reset.	

7.	References to previous reports/Next steps
As above, in terms of next steps, our RUH FTSUG returns from maternity leave this month and in the new year will meet with CMO and be an opportunity to reflect on any variation from national trajectory and renew our approach	

8.	Freedom of Information
Nil of note	

9.	Sustainability
Nil of note	

10.	Digital
Nil of note	

1 Purpose

1.1 The purpose of this paper is to provide the Organisational Development and People Management Board with an opportunity to discuss areas that need a more focused and deliberate approach, seek assurance that progress is being made within the Trust in relation to the National Freedom to Speak Up Guardian agenda, and alerting the Board to concerns raised about quality and safety.

2 Background

2.1 The National Guardian's Office is an independent, non-statutory body with the remit to lead cultural change in the NHS so that speaking up becomes business as usual. The office is not a regulator but is sponsored by the Care Quality Commission (CQC) and NHS England.

All organisations which regulate or provide NHS healthcare should implement the principles and actions set out in the report Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS – http://freedomtospeakup.org.uk

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3 Update from the National Guardian's Office (NGO)

3.1 NHS England and the Department of Health and Social Care have confirmed that the role of Freedom to Speak Up Guardian will remain part of NHS Standard Contract for 2026/27, providing crucial certainty about the future of the guardian role.

This announcement addresses concerns raised following news of the National Guardian's Office closure in March 2026. The commitment demonstrates ongoing support for guardians' vital work in ensuring workers' voices are heard. NHS England will take over responsibility for national support and guidance of guardians from 2026/27 onwards, as functions transfer from the National Guardian's Office. Until then, the National Guardian's Office remains the primary point of contact and support for all guardians.

The confirmation reinforces the essential role guardians play in developing safer, fairer, and more transparent healthcare systems throughout England.

The government's new 10 Year Health Plan for England "Fit for the Future" promises to build on the National Guardian's work. The "Fit for the Future" policy paper suggests the government is keen to ensure that concerns raised by staff will be acted on more quickly:

"Many of the NHS's worst scandals happened – or lasted longer- because staff were ignored, or did not feel able to speak up. We will act more quickly on staff concerns. The National Guardian for Freedom to Speak Up in the NHS trains and supports a network of 1,300 FTSU Guardians across England, offering guidance to encourage employees to share concerns about patient safety. Now that these guardians have been established, we will do more to integrate their role".

"As part of its wider inspection responsibilities, a core function of CQC will be to assess whether every provider (and in time, Integrated Care Boards) has effective FTSU functions, and the right skills and training in place".

Speak Up Week at RUH

Alongside business as usual we are focusing on Following Up to our colleagues by:

- Having targeted bulletins from CEO, MD and CMO during October speak up week, mirrored through BSW Hospitals Group.
- New portable banner designed and procured for FTSU that aligns across the BSW group with local contact details.

3.3 Regional Update:

FTSU Guardian continues to attend regional meetings, including mentoring and supporting new FTSU Guardians. SFT supporting BSW colleagues during period of sickness absence/maternity leave at RUH and mentoring the recently appointed FTSUG at GWH.

3.4 Local Update:

- Connecting with Chief People Officer to give oversight of concerns raised.
- FTSUG made connections with People Hub, Divisional Management Nursing Teams and other senior leaders.
- FTSU data submitted to the National Guardian's Office.

4 Summary of Concerns for Q2 (July – September 2025)

Profession	Cases Q1 2025-26	Cases Q2 2025-26	Cases Q3 2025-26	Cases Q4 2025-26
Medical & Dental	Data unavailable	0		

Nurses & Midwifery Registered	"	3		
Additional clinical services (HCA/MCA,chaplains)	"	1		
Additional professional scientific and technical (Psyc. Pharmacy)	"	2		
Ambulance (patient transport services)	"	0		
Healthcare scientists	"	0		
Allied Healthcare Professionals	"	0		
Administration/Clerical – inc.Board members	"	3		
Estates and Ancillary	"	2		
Students	"	0		
Not known	"	1		
Other (volunteers etc)	"	0		
Total		**12**		

The cases are recorded against the following themes which have been set by the National Guardian's Office. Please note that some cases will contain more than one theme.

	Themes	**Cases Q1 2025-26**	**Cases Q2 2025-26**	**Cases Q3 2025-26**	**Cases Q4 2025-26**
1	Element of Patient Safety and Quality*		5		
2	Worker safety* (work related stress, inadequate PPE, lone working etc)		7		
3	Element of other inappropriate behaviours*		6		
4	Bullying/Harassment*		4		
5	System/Process		5		
6	Disadvantageous and/or demeaning treatment*(detriment)		1		
7	Other		0		
8	Number of cases raised anonymously*		3		
9	Line management competency concerns				

Cases that have an element of patient safety or quality have been escalated immediately to appropriate senior leaders for appropriate action.

*Data submitted quarterly to the National Guardian's Office.

Cases raised broken down into Divisions:

Division	**Cases Q1**	**Cases Q2**	**Cases Q3**	**Cases Q4**

Medicine	Data unavailable	2		
Surgery	"	2		
FASS	"	4		
Corporate	"	4		
Resident Doctor	"	0		
Not disclosed	"	0		

The number of concerns raised at RUH are lower than the national trajectory, which would average at approximately 36 concerns per quarter, most likely due to the limited FTSU Service available. Inappropriate behaviours and staff safety are concerns that are raised most frequently. The FTSUG meets regularly with the People Advisors and HR Business Partners to share relevant information and update on progress on concerns that require action or are currently in a process.

42% of concerns raised by colleagues in Q2 were from a BAME background.

Total amount of concerns raised in Q2 having an element of poor line managers competency or behaviours or both is 6. There were also 6 concerns raised that could have been resolved through Human Resources/Employee Relations/Payroll or Counter fraud. In some cases, they had tried but had no response.

4.1 **Action for Q3**

- Continue to action concerns raised and further develop cross-organisational relationships.
- FTSUG to give comprehensive handover to substantive Guardian on her return and offer any support needed.

5 Recommendations

5.1 The Board is asked to note the critical importance of maintaining a healthy Freedom to Speak Up culture across the organisation, as evidenced by recent case examples.

In support of this, the next steps will include implementing the recommendations from the Dash Review. Additionally, it will be essential to closely monitor the engagement of BAME colleagues with the FTSU service, to ensure that high levels of access are not indicative of a deterioration in confidence or barriers to accessibility to other forms of support for this staff group.

The contents of the report are provided for information, discussion, and assurance.

Elizabeth Swift
Lead Freedom to Speak Up Guardian
Salisbury NHS Foundation Trust
Interim Freedom to Speak Up Guardian for Royal United Hospitals Bath

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**17**
Date of Meeting:	**14 January 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 held 19 November 2025

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

No items to report.

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

Change Management (ongoing monitoring): a key focus area for the Committee is to seek assurance that a robust change management methodology is in place to bring staff with us through complex change; and that staff related issues are a key element of the five Transformation Programmes.

- Vacancy freeze affecting available transformation resource and development session attendance.
- Approach lacks adequate prioritisation. Embedding the new capability is not happening as quickly as hoped.
- Delivery groups are being prioritised; a process of standard work is being established; Group colleagues have co-produced a toolkit ('Surviving and thriving through change'); case studies demonstrating the benefits of change management methodology will be developed (but that is 6-9 months away).
- Committee reassured as to the benefits of the methodology but not assured on adoption and prioritisation.

Breakthrough objective – staff feeling valued (2025/26) (ongoing monitoring):

- Feedback suggests staff feel recognised by their managers but undervalued by the Trust (which has other priorities - saving money, national rankings etc).
- Discussed link between sickness absence and our wellbeing offer.
    - Launched Perkbox, a new staff wellbeing and benefits platform. Provides a more comprehensive Employee Assistance Programme (including free counselling with GP out of hours services, in-house counselling, crisis support, salary sacrifice and self-help resources for staff) - significant expansion of the offer. Launch aligns RUH offer with GWH and SFT.
    - Other proposed changes to wellbeing offer discussed. Focussed on need for clear and effective staff communications.
    - Health and wellbeing proposed as 2026/27 breakthrough objective.
- Appraisal rates:
    - A small improvement has been made but there has been no step change.
    - KPMG engaged to assess approach to staff appraisal/impact on wellbeing. Report to be presented to January Committee.
    - Appraisal policy to be changed to state clearly that appraisal is a professional responsibility for medics. Expectation set for zero missed appraisals next year for medical workforce.
    - Business case being developed proposing increase in medical appraiser pay.

Sickness absence (ongoing monitoring):

- Absence rates elevated for this time of year. Over half long term.
- Main reasons ASD, MSK and Gastro.
- Rates high in E&F, Surgery and Medicine.
- People Partners supporting divisions.

Training (ongoing monitoring)

- Compliance levels reduced – training stood down due to operational pressures.
- Compliance levels expected to increase given some mandatory training will move from annual to every 2 years (in line with national ambition).

ASSURE: Inform the board where positive assurance has been achieved

Medical workforce (ongoing monitoring):

- Job planning:
  - electronic system in place for two years; job planning framework built (including consistency panels and job planning timelines); supported by regular and consistent internal messaging; has become part of the culture within divisions; teams understand how plans support recruitment business cases by evidencing understanding of demand capacity.
  - erostering: will help ensure we meet demand in the best way possible - Management Executive Committee has approved HealthRota business case.
  - 96% of job plans signed (second highest in region). Aim to build further to align with capacity planning and move from NHSE attainment level 1 to level 4.
  - Job planning update to be added to People Programme dashboard.
- Resident Doctor 10 point plan:
  - update noted (will be presented quarterly).
  - Annual report to be presented alongside Guardian of Safe Working Hours report.
  - Chief Registrar to be invited to attend future Committee on behalf of the Resident Doctor Forum, to share insights on the impact of the 10 Point Plan.
  - Report on pay bill elements to be presented to January Committee.

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

Board Assurance Framework (BAF):

- Revised BAF presented, all risks reviewed, revisions proposed.
- Noted that risks did not cover the opportunity and risk associated with workforce planning, staffing levels and pay costs – principal to achieving the Trust's strategy and subject to Committee oversight (as detailed in Terms of Reference).
- Revised risks presented to Private Board in December.
- Interim Head of Corporate Governance, Chief, and Deputy Chief People Officers to undertake a further review in January.

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

- Medical job planning: significant progress made, increasing from 45% of signed job plans to 96% in six months; positive shift in culture.

APPROVALS: Decisions and Approvals made by the Committee
Terms of Reference The Committee reviewed and agreed an updated Terms of Reference to which minor amendments had been made. The updated Terms of Reference is appended for onward approval by the Board.

Appendix 1

Royal United Hospitals Bath
NHS Foundation Trust

People Committee
Terms of Reference

1) Introduction

The RUH Board have agreed to establish a Sub-Committee of the Board known as the People Committee.

The purpose is to obtain assurance for the Board that all issues relating to the RUH workforce are being addressed and that workforce risks are being mitigated and/or managed.

The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

2) Objectives

To provide assurance to the Board on the overall delivery of the Trust's People Plan and to ensure alignment between RUH's People Plan and the You Matter Strategy. The Committee will receive assurance to the Board regarding delivery of the RUH People Plan. The Committee will oversee delivery against People Plan strategic themes (Capacity, Capability, Culture) and foundations (Restorative Just & Learning Culture/Civility & Kindness, User Friendly People Processes).

The Committee shall ensure the Trust has robust risk management systems and processes in place for workforce risks, statutory duty/compliance and reputational (workforce related) risks. In particular, the Committee will:

- Act as the forum for these risks to be discussed, and assure itself that where concerns are raised, action is taken, and that action plans are completed.
- Act in accordance with Board approved risk appetite and risk tolerance levels when reviewing risks.

3) Membership

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

- A Non-Executive Director (Chair)
- Two other Non-Executive Director's
- Chief People Officer

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

In the absence of an Executive Director, their deputy will be invited to represent them.

Meetings of the Committee shall also be attended by:

- Deputy Chief People Officer

- At least one of the Chief Nursing Officer or the Chief Medical Officer, or their deputies will attend every scheduled meeting of the Committee.
- Chief Operating Officer
- Head of Corporate Governance
- The Associate Directors for People will attend as required.
- Divisional Directors of Operations (on a rotational basis)
- Other managers / RUH colleagues will attend when invited (with agreement of the Chair).

4) Quorum and attendance

4.1 Business will only be conducted if the meeting is quorate. The People Committee will be quorate with three members present, at least two of whom must be NEDs.

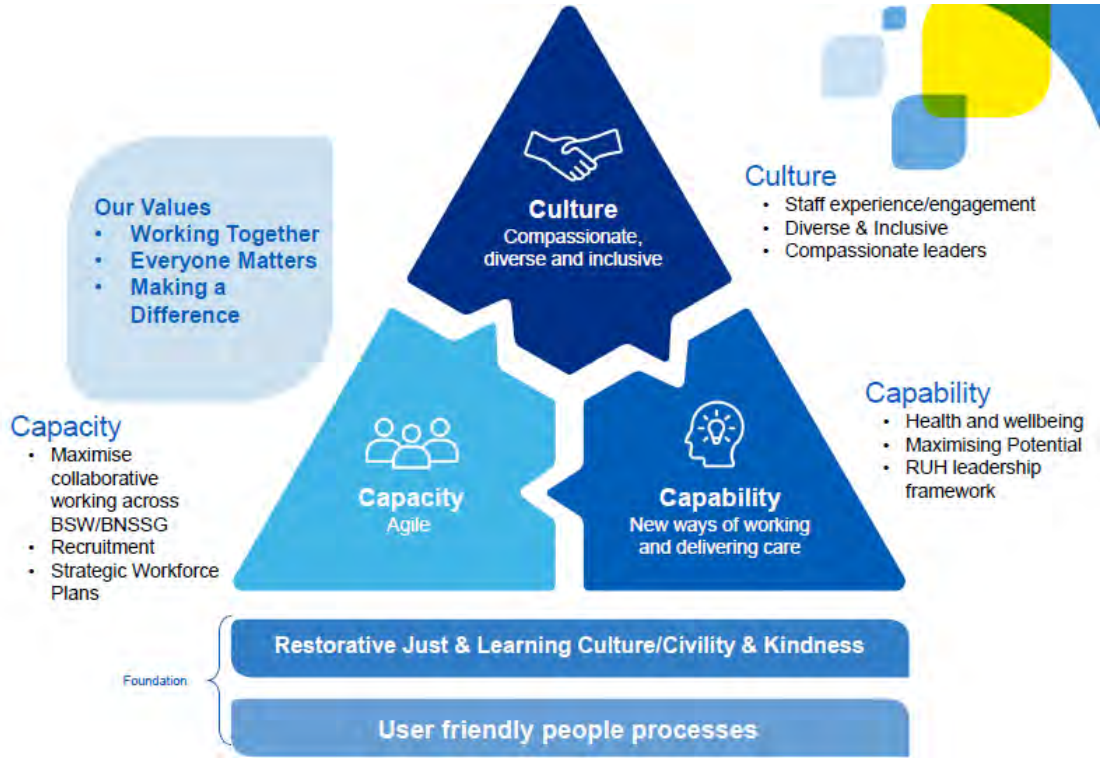
4.2 Members will be required to attend a minimum of four meetings per year and will be required to send a Deputy if they cannot attend.

5) Roles and responsibilities

The Committee will:

5.1 Advise the Board on the People agenda, considering relevant best practice and alignment with strategic objectives and values.

5.2 Monitor, and receive assurance on, the key areas of the People Plan which will include but are not limited to:



5.3 Agree a schedule of 'deep dive' reports and associated projects as required.

5.4 Define refine and monitor an agreed set of people-related Key Performance Indicators and oversee the People Plan Dashboard.

5.5 To undertake high level, exception-based monitoring of the delivery of the People Plan to ensure that the RUH is operating in accordance with its objectives and where it is not, assure itself that appropriate action is being taken by the Executive Team.

5.6 Seek assurance on 'read-across' and linkage between the RUH People Plan and the RUH Transformation Programme, particularly on issues related to the workforce.

5.7 To assess the factors, across BSW, that contribute to the risk of failure to deliver the People Plan and monitor the effectiveness of action plans to address these.

5.8 Seek assurance that staff voice and feedback mechanisms (surveys, forums) are embedded in People Plan delivery.

5.9 Equality, Diversity, and Inclusion: Monitor and seek assurance on EDI objectives and progress as part of People Plan oversight.

5.10 Workforce transformation and system integration: Strengthen oversight of workforce transformation initiatives and collaborative working across the Group.

6) Reporting

6.1 The Chair of the People Committee will ensure that the Board is fully sighted on areas of compliance and non-compliance and will report on the activities of the Committee to the next Public Board meeting.

6.2 The Chair of the People Committee will make recommendations to the Board on any area within the Committee's remit where disclosure, action or improvement are needed.

6.3 The Chair of the People Committee will liaise with the Chairs of other Board Committees where necessary to ensure that cross-committee issues receive adequate oversight (by, for example, arranging to attend other Committee meetings).

7) Frequency

The Committee will meet at least six times a year. Additional meetings may be arranged as required.

8) Other Matters

8.1 The Corporate Governance team will be responsible for providing administrative and governance support to the Committee, including:

- Agreement of the agenda with the Chair / Vice-Chair / Chief People Officer

- 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.
- Accessing advice to the Committee as required.

8.2 The Committee will undertake an annual review of its performance against its Terms of Reference and work plan to evaluate the achievement of its objectives. The outcome of this review will be reported to the Board.

8.3 These Terms of Reference will be reviewed at least every year as part of the process of monitoring the Committee's effectiveness.

Terms of Reference approved by the People Committee on: 19 November 2025

Ratified by the Board of Directors on: 14 January 2026

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**18**
Date of Meeting:	**14 January 2026**		
Title of Report:	**Non-Clinical Governance Committee Upward Report**		
Status	**For discussion**		
Author	**Sumita Hutchison, Interim Vice Chair**		

Key discussion points and matters to be escalated from the meeting on 15 September 2025

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

Annual Security Report

- The Annual security report showed a rising trend in violence/aggression impacting staff safety with acknowledged reporting limitations; the committee highlighted the need for a deeper workforce-focused review via the People Committee.

Fire Safety and Backlog Maintenance Risk

- The Committee discussed continued deterioration in estates condition, with fire safety-critical risks concentrated across buildings and clinical environments.
- While individual risks are actively managed through Datix, Authorising Engineer oversight and committee scrutiny, the overall risk trajectory was worsening, driven by prolonged capital underinvestment and ageing infrastructure.
- Members expressed concern that controls are increasingly compensatory rather than preventative, raising the risk of business interruption or safety incidents.
- The meeting recognised the risk clearly but did not reach consensus on whether escalation beyond current controls is sufficient without additional capital or reprioritisation. Board attention is required on whether current capital prioritisation and risk appetite remain appropriate.

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

- Emergency Preparedness Resilience and Response (EPRR) / digital business continuity rehearsal maturity: Committee expectation that tabletop and operational exercises should be strengthened and made routine (quarterly suggested), with a group-wide exercise planned.
- Cleaning standards risk Performance has dipped in recent months; sickness/turnover and estate factors continue to drive variability. Monitoring via national cleaning standards audit outputs and "watch" metrics (vacancies, bank fill, etc.), with expectation of sustained compliance by spring/new financial year.
- Emergency Department (ED) Care Quality Commission (CQC) estates action plan: Immediate safety/compliance actions completed (including 24/7 ED

security and increased cleaning), with ongoing monitoring and a larger future decision on refurbishment/modular/rebuild options.

- Green Plan deliverability: The Committee supports the direction but highlighted delivery risk (limited team capacity; reliance on champions; lack of protected time) and asked for clearer operationalisation and explicit response to latest internal audit findings.

ASSURE: Inform the Board where positive assurance has been achieved

- The Committee received a digital services update from the Interim Chief Digital Information Officer. It was confirmed that work was underway to replace Winscribe with T-Pro digital dictation, incorporating ambient voice technology to address outpatient typing backlogs. There was committee expectation that this will reduce the current risk position.

- Data Security and Protection Toolkit (DSPT) trajectory: Greater confidence expressed in achieving compliance this year, reflecting earlier start and stronger evidence/testing approach, though resource intensity remains.

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

The committee discuss the proposed changes and updates to the following BAF risks in detail:

3.4	Our aging estate with increasing backlog maintenance needs could lead to service disruptions, compromised patient safety, failure to meet regulatory requirements in addition to degrading the experience for patients and staff.
3.5	Climate change and its accelerating consequences may threaten the health of patients, staff, and the wider community. Failure to achieve net zero goals and adapt to climate-related risks (e.g., overheating, flooding) may jeopardise the Trust's sustainability, its ability to provide care, and its commitment to future generations.
3.6	Insufficient digital capabilities may hinder the Trust's potential to enhance patient and staff experiences, optimise efficiency, and improve overall effectiveness and care delivery.
3.7	Cyber-security breaches, caused by deliberate malicious acts or inadvertent actions by staff, could result in an inability to use digital platforms, resulting in loss of services and data across the Trust, and in turn causing risk to patients.
3.8	Delayed or suboptimal deployment of the joint Electronic Patient Record would result in clinical, strategic, and financial benefits not being realised and impact the delivery of the Trust future operating model.

- BAF 3.8: Electronic Patient Record (EPR) – score 16: had been added/aligned across the three Trusts within the Group. It was framed as core to delivering clinical/digital benefits and requires explicit risk acceptance linked to EPR option choice.

- BAF 3.4 / Datix 2110 (backlog maintenance / fire / business continuity) – score 16 and potentially worsening: Committee heard that risk is longstanding and slow-moving, with concern it may trend upwards given backlog/fire context.

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

- Food & drink safety and quality assurance: Strong external assurance signals (e.g., high audit outcomes and 5-star inspection referenced) and progress on sustainability/local procurement, with potential to be positioned more visibly as an exemplar.

APPROVALS: Decisions and Approvals made by the Committee

- The Committee reviewed and agreed an updated Terms of Reference to which minor amendments had been made to provide clarity on deep dives and site visits and to reflect key changes to the membership and quorum. The updated Terms of Reference is appended for onward approval by the Board.
- Green Plan endorsement was discussed with clear caveats on deliverability and audit response required.

Appendix 1

Royal United Hospitals Bath
NHS Foundation Trust

Non-Clinical Governance Committee
Terms of Reference

1. Constitution

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

2. Terms of Reference

2.1 Purpose

To provide assurance to the Board that the Trust has a robust framework in place for the management of risks arising from or associated with estates and facilities, environment and equipment, environmental sustainability, health and safety, digital development, cyber-security, information governance, business continuity and other non-clinical areas as may be identified.

The Committee will provide assurance to the Board around the processes for the delivery of non-clinical services and systems and maintain oversight of the effectiveness and value of those services.

To provide assurance to the Board that robust controls are in place to ensure compliance with external and internal regulatory guidance for the delivery of non-clinical services and systems.

2.2 Objectives

The primary objectives of the Committee are to provide assurance to the Board that the key critical non-clinical systems and processes are effective and robust, and to provide effective scrutiny in these areas under delegated responsibility from the Board. The Committee will ensure a sustained focus on reputational management and how any potential risks could impact the Trust, in addition to maintaining oversight of business continuity across the Trust.

The Committee will oversee and monitor performance in the following non-clinical systems and processes:

- Digital including the Electronic Patient Record.
- Cyber Security.
- Information Governance.
- Health & Safety.
- Estates and Facilities.
- Environmental Sustainability.

The Committee shall ensure the Trust has robust risk management systems and processes in place for Estates and Facilities, Digital, Information Governance, Health & Safety and Environmental risks, statutory duty/compliance and reputational (non-clinical related) risks. In particular, the Committee will:

- Act as the forum for these risks to be discussed, and assure itself that where concerns are raised, action is taken, and that action plans are completed.
- Act in accordance with Board approved risk appetite and risk tolerance levels when reviewing risks.

In addition, the Committee will:

- Review the controls and assurances against relevant risks on the Board Assurance Framework, in order to assure the Board that priority risks to the organisation are being managed and to facilitate the completion of the Annual Governance Statement at year end.
- If required, undertake deep-dives or site visits into the key critical non-clinical areas to provide greater understanding and assurance.
- Consider external and internal assurance reports and monitor action plans, in relation to non-clinical risk, resulting from improvement reviews/notices from the Health and Safety Executive and other external assessors.
- On occasion seek assurance from a Lead Director from another Committee.
- Receive the Emergency Preparedness, Resilience, and Response (EPRR) Annual Report, including the overall assurance rating, to ensure that the Trust is compliant with the NHS EPRR Framework.

3. Membership

Membership of the Committee will comprise of:

- Non-Executive Director (Chair)
- 2 other Non-Executive Directors
- Chief Nursing Officer in capacity as Interim Director of Estates and Facilities (Lead Executive)
- Chief Transformation and Innovation Officer

In the absence of an Executive Director, their deputy will be invited to represent them and will count toward quoracy.

The following staff are required to attend meetings of the Non-Clinical Governance Committee:

- Chief Digital Information Officer
- Head of Information Governance
- Deputy Director of Estates and Facilities
- Head of Corporate Governance

Where the Committee deems it necessary, other colleagues may be invited to attend for specific matters as and when appropriate.

4. Quorum and Attendance

Business will only be conducted if the meeting is quorate. The Committee will be quorate with three members present, including at least two Non-Executive Directors and one Executive Director.

Members will be required to attend a minimum of 4 meetings per year.

5. Frequency

The Committee will meet a minimum of four times a year. Additional meetings may be arranged as required.

6. Accountability and Reporting Arrangements

The Committee will be accountable to the Board. The Chair of the Committee will complete an upward report to the Board of Directors on the activity of the Committee at its last meeting. The report shall draw to the attention of the Board issues that require disclosure to the full Board or require executive action.

The Committee shall refer to the other Board Assurance Committees (the Audit and Risk, People, Finance and Performance and the Quality Assurance Committees) matters considered by the Committee to be relevant to their work. The Committee will consider matters referred to it by those other Assurance Committees.

The Committee will develop a work plan which will describe the key reports it will consider during the year. This work plan will be agreed by the Committee.

7. Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Board will retain responsibility for all aspects of internal control, supported by the work of the Committee, satisfying itself that appropriate processes are in place are in place to provide the required assurance.

The Committee has decision making powers with regard to the ratification of non-clinical policies and approval of non-clinical procedural documents. It is established to provide recommendations to the Board on risk management, governance and patient, staff and public safety issues.

The Committee is authorised to create sub-groups or working groups, as are necessary to fulfil its responsibilities within its terms of reference. The Committee may not delegate executive powers (unless expressly authorised by the Board) and remains accountable for the work of any such group.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary.

8. Monitoring Effectiveness

The Committee will undertake an annual review of its performance against its Terms of Reference and work plan in order to evaluate the achievement of its duties.

9. Other Matters

The Committee shall be supported administratively by the Head of Corporate Governance, whose duties in this respect will include:

- Agreement of the agenda with the Chair and Executive Leads.
- 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.
- Advising the Committee on pertinent areas.

10. Review

These terms of reference will be reviewed annually as part of the monitoring effectiveness process.

Terms of Reference approved by the Non-Clinical Governance Committee on 10th December 2025

Ratified by the Board of Directors: 14th January 2026

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**19**
Date of Meeting:	**14 January 2026**		
Title of Report:	**Charities Committee Upward Report**		
Status	**For information**		
Author	**Sumita Hutchison, Interim Vice-Chair and Chair of Charities Committee**		

Key discussion points and matters to be escalated from the meeting on 4 December 2025

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

Pressure on charitable financial position and liquidity:

- The Committee reviewed a deteriorating in-year financial position, with income below plan due to phasing of development and legacy income, however there is a strong forecast for Q4.
- There has been high unplanned expenditure arising from the Cancer Centre car park demolition.
- There is a deficit in the RUHX General Fund.

Risk of funds being held without clear spending plans:

- The Committee identified a recurring risk of restricted and unrestricted funds being held for extended periods without delivery plans (including within both RUHX and Friends of the RUH). This presents governance, reputational, and opportunity-cost risks and requires active management and escalation. Funds have been raised but are often not being spent in a timely way which has reputational and outcome impacts.

Green Heart delivery risk and dependency on future funding:

- The Green Heart is the donor-promised and legally required landscaped green space for the Dyson Cancer Centre; the main risk is non-delivery due to Trust financial pressures, and mitigation includes phased delivery, £500k Trust allocation, £40k (approved in committee meeting) for updated designs and joint pursuit of additional funding.

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

- The Committee approved the launch of a lottery which will be administered by Woods Valldata Affinity Lottery Team which will generate additional funds for the charity.

ASSURE: Inform the Board where positive assurance has been achieved

Governance and controls:

- The Committee received assurance that:

- The RUHX team is now fully staffed and embedding systems and processes.
- Financial controls, fraud self-assessment, and investment governance arrangements are in place and operating effectively.
- The risk register is actively reviewed, with new risks added (including group governance) and mitigations identified.

Grant approvals:

- Grant awards and the £40k Green Heart design funding were scrutinised and approved in line with delegated authority, with a request for enhanced reporting on issues arising at approvals meetings going forward.

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

- 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

- Friends of the RUH impact - Volunteer numbers have increased significantly year-on-year (from 198 to 238), the wellbeing garden has been completed, and further grant funding (£150k) will become available to the Trust in 2026.
- Community engagement - Walk of Life 2026 marks its 20th year, with an ambitious £100k+ income target and strong participation expectations, reflecting sustained community support.
- Donor acquisition and major donor pipeline is outperforming the plan.
- As part of the Charities increased focus on sustainability, RUHX have been awarded £40,000 from West of England Combined Authority (WECA) for solar feasibility.

APPROVALS: Decisions and Approvals made by the Committee

- Grant awards and the £40k Green Heart design funding were scrutinised and approved in line with delegated authority.

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**20**
Date of Meeting:	**14 January 2026**		
Title of Report:	**Alert, Advise and Assure Report – Audit & Risk Committee**		
Status:	**For information**		
Author:	**Joy Luxford, Non-Executive Director and Chair of Audit and Risk Committee**		

Key Discussion Points and Matters to be escalated from the meeting held on 8th December 2025

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

- KPMG, the Internal Auditor flagged that 14 actions (previously agreed by management) were overdue and needed management action in a timely manner to address the identified risks. This, combined with key internal reports with limited assurance (e.g. Discharge and Data Security & Protection Toolkit graded as 'Partial Assurance with improvement required'), means that the board should prepare itself for a repeat of the 'Partial Assurance with improvements required' opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control at the end of the financial year. This will have an impact on the External Auditors value for money statement. The Audit Committee and Management Executive Committee are maintaining close oversight of key Internal Audit Actions arising throughout the year but the pace of change that was required has not been delivered so far.

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

- As mentioned above, overdue actions alongside 'requires improvement' Internal Audit reports limit the assurance in specific areas that can be provided on the Trust's control environment.

ASSURE: Inform the board where positive assurance has been achieved

- Internal Audits - (1) The Discharge report was given an assurance rating of Partial Assurance with improvement required, (amber / red). This highlighted risks around data completion, validation, errors and usability of forms. (2) The Staff Wellbeing (appraisals) report was given an assurance rating of Significant Assurance with minor improvements identified, (green/amber). This highlighted opportunities around monitoring achievements and improving the quality of appraisal conversations. In both cases, Management accepted the recommendations and have agreed to implement improvements to mitigate or minimise the risks identified.
- Internal Audit - Advisory Review into Artificial Intelligence benchmarked RUH against 21 other Trusts and highlighted areas for further development.

- External Audit - The Committee noted finalisation of the Charity and Sulis annual financial accounts FY24/25 and discussed lessons learnt and overruns for both the Trust (£22k) and Sulis (£8k).
- The Local Counter Fraud Service deep dive report on Recruitment was received and it was noted that 7 recommendations were made in relation to design and operating effectiveness of controls. All recommendations were accepted by management with action plans put in place to address the risks identified.
- Grip and Control Review was received and areas of strength and development were noted.

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

Two emerging risks were discussed in relation to

(1) needing to better define and seek approval for the accounting treatment for the group structure/care organisation associated costs to ensure that intra-group accounting practices are not overly complicated, time-consuming and/or duplicative.

(2) Emerging themes resulting from the Freedom to Speak Up Report. The Committee was notified of upward trends in relation to inappropriate attitudes and behaviours and concerns around staff safety. Further work needs to be done to validate this given we have had a long period of absence (due to sickness) of our Freedom to Speak Up Champion.

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

- None noted this meeting.

APPROVALS: Decisions and Approvals made by the Committee

- The Committee approved that the Chair and Senior Finance Team could review the FY26/27 External audit plan offline ahead of the next Audit Committee meeting to ensure any adjustments could be actioned quickly. A report back and final approval will come to the next meeting.
- The Committee reviewed and agreed an updated Terms of Reference to which minor amendments had been made to further align with best practice and the HFMA Handbook. The updated Terms of Reference is appended for onward approval by the Board.
- The Committee noted reports relating to an external risk review, 2 internal audits (Discharge and Staff Wellbeing), 1 advisory review (Artificial Intelligence) 1 Local Counter Fraud Service deep-dive (Recruitment), System for Raising Concerns, Debtors and Creditors, Salary Overpayments and Underpayments, Grip and Control, and Code of Governance.
- The Committed noted the finalisation and submission to Companies House of the Sulis Accounts for FY24/25.

- The Committee agreed to meet separately to review effectiveness.

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

Appendix 1

Royal United Hospitals Bath
NHS Foundation Trust

Audit and Risk Committee Terms of Reference

1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Audit and Risk Committee. The Committee is a non-executive Committee of the Board and has no executive powers other than those specifically delegated in these Terms of Reference.

2. Membership and Attendance

The committee shall be appointed by the Board from amongst its independent, Non-Executive Directors and shall consist of not less than three members at least one of whom will have financial background. A quorum shall be two of the three independent members. One of the members will be appointed chair of the committee by the Board. The Chair of the organisation itself shall not be a member of the committee.

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

Others in attendance	Chief Financial Officer Director of Operational Finance Head of Corporate Governance External Audit Internal Audit Local Counter Fraud Specialists Head of Financial Services

In addition, one of either the Chief Nursing Officer or the Chief Medical Officer or one of their deputy or associate directors will attend each meeting of the Committee to provide a clinical perspective to the discussions.

Each member will have one vote with the Chair having the casting vote, if required. Should a vote be required a decision will be determined by a simple majority.

a. Attendance by Members

The Chair of the Committee will be expected to attend 100% of the meetings. Other Committee members will be required to attend a minimum of 75% of all meetings and be allowed to send a Deputy to one meeting per annum.

b. Attendance by Officers

The Chief Financial Officer and appropriate Internal and External Audit, and Local Counter Fraud representatives shall normally attend meetings.

The Chief Executive and other Executive Directors may be required to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of

that Director. The Chief Nursing Officer and the Chief Medical Officer will be required to attend on an alternate basis.

3. Purpose and Objectives

(a) Governance, internal control and risk management

The Committee shall oversee and scrutinise the establishment and maintenance of an effective system of internal control and probity across the whole of the organisation's activities that supports the achievement of the organisation's objectives.

In particular, the Committee will:

- Review the adequacy and accuracy of all risk and control related disclosure statements (in particular, the Annual Governance Statement and Value for Money assessment), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board;
- Review, and where necessary approve the Annual Report and Accounts and assess the extent to which these comply with relevant legislation and guidance;
- Oversee the Trust's risk management arrangements, including the risk management strategy, the Board's risk appetite and the effectiveness and coordination of the various risk registers;
- Assess the effectiveness and responsiveness of the Board Assurance Framework process, including the consistency of risk scoring, the completion of actions to fill gaps in control and assurance, and the extent to which the BAF is aligned with the Trust's objectives and the wider risk management system as above;
- Review the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- Review the policies and procedures for all work related to fraud and corruption as set out in the Secretary of State Directions and as required by the NHS Counter Fraud Authority.
- Review the organisation's reporting on compliance with the NHS Provider Licence, NHS code of governance and the fit and proper persons test.
- The Committee shall ensure an annual review of the register of interests and confirm compliance with NHS England guidance on managing conflicts of interest. Satisfying itself that the organisation's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest.

In carrying out this work the Committee will place significant reliance on the work of Internal Audit, External Audit and other assurance functions, but will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of governance, probity and internal control, together with indicators of their effectiveness.

(b) Internal Audit
The Committee shall ensure that there is an effective internal audit function in place, which complies with the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit and Risk Committee, Accounting Officer and the Board. This will be achieved by:

- provision of a value for money Internal Audit service;
- review and approval by the Committee of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework and from engagement with the other Board Committees; and
- consideration of the findings emerging from internal audit work (and management's response), ensuring that all accepted recommendations are actioned within agreed timescales, and facilitating co-ordination between the Internal and External Auditors to optimise resources and ensure shared learning;
- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation; and
- periodic review of the efficiency and effectiveness of internal audit.

(c) External Audit
The Committee shall review the work and findings of the External Auditor appointed by the Council of Governors and consider the implications and management's responses to their work. This will be achieved by:

- consideration of the appointment and performance of the External Auditor;
- discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy;
- discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust, and associated impact on the audit fee;
- review all External Audit reports, including agreement of the annual audit letter before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses, and
- consideration of any lessons or learning emerging post-audit to ensure greater efficiency and effectiveness in future years (to also include learning from the External Auditor's work with other clients and the wider sector).

(d) Local Counter Fraud Specialist
The Committee shall ensure compliance with the requirements of Section 24 of the NHS Standard Contract that the Trust has put in place appropriate arrangements to address counter fraud and security management issues, including that there is an effective counter fraud function established by management that meets the NHS Requirements of the Government Functional Standard 013: Counter Fraud and provides independent assurance to the Committee, Chief Executive and Board. This will be achieved by:

- Consideration on the appointment of a Counter Fraud Service, the fee and Terms and Conditions of engagement;
- Oversee the effective operation of Counter Fraud and to ensure that the Counter Fraud Service is appropriately resourced and has appropriate standing within the Trust; and
- Review the Counter Fraud Policies, Strategies/Plans and to consider major findings of Counter Fraud Reports, management's response and subsequent action.

(e) Other Assurance Functions

The Audit and Risk Committee shall review the findings or ensure that they are reviewed by a relevant body, of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.

These will include externally commissioned reviews by relevant Department of Health and Social Care Arm's Length Bodies or Regulators/Inspectors relating to the governance and operations of the Trust. In such cases, the Committee will seek assurance from those directly involved in the review that the relevant learning has been taken on board and shared, and that plans to address any recommendations are on track.

The Committee will seek and receive assurance around the Trust's approach to ensuring data quality, in relation, in particular to the internal and external reporting of financial and operational performance.

The Committee will also seek and receive assurance that the Trust has adequate information governance arrangements, such that it effectively safeguards patient and other sensitive information in its possession in line with relevant legislation and guidance from the Information Commissioner's Office.

The Committee may rely upon the work of other committees within the organisation, which can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Non-Clinical Governance Committee, the Quality Assurance Committee and the Finance and Performance Committee. These committees may also ask the Audit and Risk Committee to consider, as part of its work plan, issues that are brought to their attention that fall more appropriately within this Committee's remit.

The Committee shall also ensure that the requirements set out in the Trust's Standing Financial Instructions and Standing Orders are addressed, which also include:

- Monitoring compliance with Standing Orders and Standing Financial Instructions;
- Reviewing schedules of losses, compensations and settlements with staff, and making recommendations to the Board; and
- Reviewing schedules of debtors/creditors balances over 6 months old and over a de-minimis limit as defined by the Audit and Risk Committee and related explanations/action plans.
- Reviewing the register of interests, gifts and hospitality to ensure that personal interests do not conflict with those of the Trust and that positions are not abused for personal gain or to benefit family and friends.

(f) Management
The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, probity and internal control. They may also request specific reports from individual functions within the organisation as they may be appropriate to the overall arrangements.

(g) Financial Reporting
The Audit and Risk Committee shall review the Annual Financial statements before submission to the Board, focusing particularly on:

- the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
- Changes in, and compliance with, accounting policies and practices
- Un-adjusted mis-statements in the financial statements
- Major judgemental areas
- Significant adjustments resulting from the audit

(h) System for raising concerns
The committee shall review the effectiveness of the arrangements in place for allowing staff (and contractors) to raise (in confidence) concerns about possible improprieties in any area of the organisation (financial, clinical, safety or workforce matters) and ensure that any such concerns are investigated proportionately and independently, and in line with the relevant policies.

4. Accountability and Reporting Arrangements

The Committee will be accountable to the Board of Directors. A report of the meeting will be submitted and presented at the next available Board meeting by the Chair who will draw to the attention of the Board issues that require disclosure to the full Board or require Executive action. The Committee shall have the authority to escalate any significant issues or concerns to the Board outside the normal reporting cycle where urgent attention is required.

The Committee shall refer to the other Board Assurance Committees (the Non Clinical Governance Committee, the Quality Assurance Committee, the People Committee and the Finance and Performance Committee) matters considered by the Committee to be relevant to their work. The Committee will consider matters referred to it by those three Assurance Committees.

The Committee shall conduct an annual self-assessment of its effectiveness using the HFMA Audit Committee Effectiveness Checklist.

The committee will report to the board at least annually on its work in support of the annual governance statement, specifically commenting on the:

- fitness for purpose of the assurance framework
- completeness and ‘embeddedness’ of risk management in the organisation
- effectiveness of governance arrangements

- appropriateness of the evidence that shows that the organisation is fulfilling regulatory requirements relating to its existence as a functioning business.

This annual report should also describe how the committee has fulfilled its terms of reference and give details of any significant issues that the committee considered in relation to the financial statements and how they were addressed. An annual committee effectiveness evaluation will be undertaken and reported to the committee and the board.

5. Frequency

The Committee will meet no less than four times a year.

Additional meetings may be arranged when required to support the effective functioning of the Trust. Internal and External Audit may request a meeting if required.

6. Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary.

7. Secretariat and administration

The Committee shall be supported administratively by the members of the Corporate Governance and Finance teams whose duties in this respect will include:

- Agreement of the agenda with the Chair / Chief Financial Officer
- 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.
- Accessing advice to the Committee as required.
- Chief Financial Officer, Head of Financial Services and Head of Corporate Governance to advise the Committee on pertinent areas.

8. Review

The Committee shall undertake an annual review of its Terms of Reference, taking into account any changes in statutory, regulatory, or recognised best practice guidance.

Terms of Reference reviewed and approved by the Audit and Risk Committee: 8th December 2025

Terms of Reference to be ratified by the Board: 14th January 2026

Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors**	**Agenda item:**	**21**
Date of Meeting:	**3 December 2025**		
Title of Report:	**Alert, Advise and Assure Report – Finance and Performance Committee**		
Status:	**For information**		
Author:	**Antony Durbacz, Non-Executive Director**		

Key Discussion Points and Matters to be escalated from the meeting held on 25 November 2025

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

- RUH has committed to a challenging financial objective for the year at a deficit of £17m deficit. With significant improvements in underlying performance in the second half of the year to deliver this objective. In the month RUH was £0.2m better than trajectory due to higher income, offset by lower than anticipated diagnostic recovery at Sulis and lower recovery of high-cost drugs. These now offer a risk against the anticipated trajectory benefits. The net risk position against the £17m is now estimated at £1.5m this is significantly improved on the prior month as it considers the impact of the newly appointed turnaround team. At this stage this offers a level of reassurance.

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

- The external scrutiny of the operational performance remains intense with focus being applied at numerous levels within the NHS. Although intense it's also clear that some of the support has been positive and constructive including support to increase overnight staffing levels in UEC
- As is to be expected, the operational recovery profiles are well documented and understood. During the month overall performance against the trajectories have been broadly positive against these trajectories. Of note is the significant reduction in ambulance handover times There is now a clear definition of what needs to happen both externally and internally to achieve the objectives. Demand remains a prime factor.

ASSURE: Inform the board where positive assurance has been achieved

- The team presented the preliminary findings on radiology, which indicates that in the short term we have capacity in CT and MRI but have a shortfall in Ultrasound. Although we have capacity improvements in cost effectiveness remain. In ultrasound the solution is to increase the sonographer workforce. DM01 performance is challenged by performance in Sleep, Echo and audiology

RISK: Advise the board which risks where discussed and if any new risks were identified.
• Preparation for the business plan are underway, with some national guidance now being received. Timelines are challenging and the requirement is more onerous than previously, with an extended 3-year reach and profiling within those years. In addition, there is the complication of: resource stretch, even more challenging performance objectives, the evolving Group structure and uncertainty on the outturn of the 2026 financial picture. • The BAF was reviewed and the committee agreed with its content • The committee noted the high risk items identified in the trust risk register relevant to FPC
CELEBRATING OUTSTANDING: Share any practice, innovation or action that the committee considers to be outstanding
• The team has been under extreme scrutiny, but they continue to be positive and professional in the way they address the challenges • The committee noted the results of the National Cost collection submission which continues to show RUH overall cost are below the national average
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 RUH. It was satisfied that the appropriate supply chain procedures had been applied. It did not review the underlying business case

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