Bundle Public Board of Directors 1 April 2026

0 Agenda
- 0.0 - Draft Public BoD Agenda Apr 26 v1.4 - 26.03.26

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Judy Dyos
Simon Harrod
Jonathan Hinchliffe
Joy Luxford

2 Written Questions from the Public

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- 3.0 - DRAFT Public BoD Minutes March v1.0 - 23.03.26

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10 Finance and Performance Committee Upward Report
- 10.0 - Finance Upward Reporting 240326 v2.0 - 30.03.26

11 Audit and Risk Committee Upward Report
- 11.0 - Upward Report Audit & Risk Ctte 190326

12 Non-Clinical Governance Committee Upward Report
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14 Staff Survey Results
- 14.0 - RUH_cover sheet - staff survey 2025
- 14.1 - 2025 Staff Survey - RUH High-Level Overview (004)jg

15 Delegation of Sign Off - Annual Report and Accounts and Quality Account
- 15.0 - Delegation of Approval – Annual Report & Accounts and the Quality Account - 23.03.26

16 NHSE Licence Self-Certification - CoS7
- 16.0 - NHSE Licence Self-Certification - CoS7 - 2026-27 - 26.03.26
- 16.1 - Self-certification_template_CoS 7 V1 - 26.03.26

17 Annual Health and Safety Compliance Report
- 17.0 - Annual Health and Safety Report 2024-25

18 Any Other Business

MEETING IN PUBLIC OF THE BOARD OF DIRECTORS OF THE ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST
WEDNESDAY 1 APRIL 2026, 09:30 – 12:00
VENUE: ROOM T0.24, UNIVERSITY OF BATH SION HILL CAMPUS, SION HILL, BATH, BA1 5SF

Item	Item	Presenter	Enc.	For
1.	Chair's Welcome, Introductions, Apologies and Declarations of Interest: Judy Dyos, Simon Harrod, Jonathan Hinchliffe, Joy Luxford	Liam Coleman, Chair	Verbal	-
2.	Written questions from the public		Verbal	I/D
3.	Minutes of the Board of Directors meeting held in public on 4 March 2026		Enc.	A
4.	Action Log		Enc.	A/D
5.	CEO and Managing Director's Report	Cara Charles-Barks, Chief Executive / John Palmer, Managing Director	Enc.	I
6.	Chair's Report	Liam Coleman, Chair	Enc.	I
7.	Board Assurance Framework Summary Report	Roxy Milbourne, Interim Head of Corporate Governance	Enc.	I/D
8.	Management Executive Committee Upward Report	John Palmer, Managing Director	Enc.	I/D
9.	People Committee Upward Report	Paul Fairhurst Non-Executive Director	Verbal	I/D
10.	Finance and Performance Committee Upward Report	Antony Durbacz, Non-Executive Director	Enc.	I/D
11.	Audit and Risk Committee Upward Report	Sumita Hutchison, Non-Executive Director	Enc.	I/D
12.	Non-Clinical Governance Committee Upward Report • Emergency Preparedness, Resilience and Response Annual Assurance	Sumita Hutchison, Non-Executive Director	Enc.	I/D
13.	Integrated Performance Report	Bernie Bluhm, Chief Operating Officer	Enc.	I/D
14.	Staff Survey Results	Jude Gray, Chief People Officer	Enc.	I/D
15.	Delegation of Sign Off - Annual Report and Accounts and Quality Account	Roxy Milbourne, Interim Head Corporate Governance	Enc.	A
16.	NHSE Licence Self-Certification – CoS7	Roxy Milbourne, Interim Head Corporate Governance	Enc.	A
17.	Annual Health and Safety Compliance Report	Toni Lynch,	Enc.	I/D

		Chief Nursing Officer / Jamie Caulfield, Deputy Director of Estates and Facilities		
CLOSING BUSINESS				
18.	Any Other Business	Liam Coleman, Chair	Verbal	-
19.	Resolution to exclude the press and public that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest. Business to be discussed in private session includes: • Detailed financial reports; • Commercially in confidence reports	Liam Coleman, Chair	Verbal	
Date of Next Meeting: Wednesday 3 June 2026, 09:30 – 12:00 **Venue: Room T0.24, Bath Spa University Sion Hill Campus, Sion Hill, Bath, BA1 5SF**				

Key:

A – Approval	Enc – Paper enclosed with the meeting pack
D – Discussion	Pres– Presentation to be delivered at the meeting
I – Information	Verbal – Verbal update to be given by the presenter at the meeting

Royal United Hospitals Bath
NHS Foundation Trust

ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST
MINUTES OF THE MEETING OF THE PUBLIC BOARD OF DIRECTORS
WEDNESDAY 4 MARCH 2026, 09:30 – 12:00
VENUE: ROOM G.07, BATH SPA UNIVERSITY LOCKSBROOK CAMPUS, LOCKSBROOK ROAD, BATH, BA1 3EL

Present:
Members
Liam Coleman, Chair *(Chair)*
Sumita Hutchison, Interim Vice-Chair
Simon Harrod, Non-Executive Director
Joy Luxford, Non-Executive Director
Antony Durbacz, Non-Executive Director
Paul Fairhurst, Non-Executive Director
Cara Charles-Barks, Chief Executive
Jude Gray, Group Chief People Officer
Simon Wade, Group Chief Finance Officer
Jonathan Hinchliffe, Group Chief Digital and Information Officer (Interim)
Andrew Hollowood, Clinical Strategic Transformation Director
Mark Ellis, Group Chief Risk Officer
John Palmer, Managing Director
Toni Lynch, Chief Nursing Officer
Kheelna Bavalia, Interim Chief Medical Officer
Bernie Bluhm, Chief Operating Officer

In attendance
Roxy Milbourne, Interim Head of Corporate Governance
Amanda King, Chief Registrar *(observer)*
Sharon Manhi, Head of Patient Experience *(item 5)*
Alison Ponsford, Haematology Ambulatory Care Advanced Clinical Practitioner *(item 5)*
Ros Helps, Macmillan Nurse Specialist *(item 5)*
Abby Strange, Corporate Governance Manager *(minute taker)*
Governor Observer
Members of the public

Apologies
Judy Dyos, Group Chief Strategic Officer

BD/26/03/01 Chair's Welcome, Introductions, Apologies and Declarations of Interest:
The Chair welcomed everyone to the meeting and confirmed that apologies had been received from those listed above. The Board confirmed that they had no additional interests to declare.

BD/26/03/02 Written questions from the public
The Chair confirmed that no written questions had been received from the public.

BD/26/03/03 Minutes of the Board of Directors meeting held in public on 14th January 2026
The minutes of the meeting held on 14th January 2026 were approved as a true and accurate record subject to the following amendment:

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Sumita Hutchison noted that an action had not been recorded around the disproportionate impact of experiences of those from a global majority background in relation to the Maternity Incentive Scheme Q2 Report. She agreed to send the action and its update to the Corporate Governance Manager to included in the minutes.

Action: Sumita Hutchison, Non-Executive Director

BD/26/03/04 Action List and Matters Arising

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

PB629 – The Chief Executive advised that work would be undertaken around the triangulation and visibility of risk as a single Integrated Performance Report (IPR) was developed across the Group. The Chief Risk Officer explained that a data led and risk based approach would be taken to this and there would be a focus on the output measures relating to the NHS Oversight Framework (NOF). In terms of the impact of the financial challenge on quality and safety, development work was ongoing to improve data and ensure that financial and quality metrics were triangulated to inform decision making. The Board agreed to close the action, noting that the Joint Committee would review the scope of the Group IPR as it evolved.

The Board had a discussion around enhancing the IPR to provide a forward view alongside the historical data. They reflected that the IPR would always generate some retrospective discussion and that improvement trajectories helped to provide a forward view. They acknowledged that data would evolve over time to develop the forward view and that at a higher level, the primary focus would be returning to NOF2.

BD/26/03/05 Patient Story

The Chair welcomed the Head of Patient Experience, Haematology Ambulatory Care Advanced Clinical Practitioner, Macmillan Nurse Specialist, and Divisional Director of Nursing FASS to the meeting who presented the patient story together with the Chief Nursing Officer. The story centred around Aaron, who described his cancer journey, highlighting both positive aspects of his care and challenges experienced when entering the hospital through the Emergency Department (ED). His reflections provided an important insight into the patient impact of pathway design, particularly the feeling of safety and continuity.

The Haematology Ambulatory Advanced Clinical Practitioner reported that the service was still in its early stages but was demonstrating significant benefits for patients by enabling care closer to home and reduced hospital stays. She described ongoing projects, including the introduction of ambulatory chemotherapy and plans to commence ambulatory cell transplantation, with the first patient targeted for May. While admissions back into the Trust had been managed safely, some occurred outside of ambulatory working hours, and the team was working to better anticipate deteriorating patients to avoid ED attendance.

The Board recognised the constraints within ED and the need for direct access pathways to the William Budd Unit. The Divisional Director of Nursing FASS outlined current cover arrangements and explained that bed availability could necessitate the use of alternative assessment areas. Work was underway to explore expansion to a seven-day service for Haematology and Oncology and to develop a Same Day Emergency Care (SDEC) model within the Cancer Centre to divert appropriate patients away from ED. The Macmillan

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Nurse Specialist emphasised the role of community support and the potential to deliver more treatment at home. She described the highly personalised nature of the service and its ambition to expand while maintaining safe staffing levels and resilience. A virtual ward of 15 beds was being developed to mirror the functionality of the William Budd Unit.

The Board considered wider strategic implications. Members discussed alignment with the 10-year plan for less hospital-centric models and the need for consistent pathway design across clinical services to ensure patients understood how and when to access hospital-based care. The complexity of multiple SDEC models operating across different specialties and the need for joined-up digital and workforce solutions was highlighted. The Board also discussed rising cancer demand, increased emergency cancer presentations, and the need to understand underlying causes through better data analysis. The Dyson Cancer Centre was recognised as a key asset, in raising standards of cancer care and supporting growth over coming years. Consideration was given to how learning from this case study could be applied across other services and the wider Group.

The Board reflected on the recently published national cancer plan and how it could support the ambitions around cancer treatment. They discussed the potential for neighbourhood-based models and community Systemic Anti-Cancer Therapy Centres, highlighting the need for coherent workforce and estates planning. The Macmillan Nurse Specialist emphasised the importance of community-based care, wrap-around support, and adequate Cancer Nurse Specialist provision to ensure continuity for patients living longer with complex needs.

The Board of Directors noted the patient story and extended their thanks to Aaron and his family. The Chair thanked the Head of Patient Experience, Haematology Ambulatory Care Advanced Clinical Practitioner, Macmillan Nurse Specialist, and Divisional Director of Nursing FASS for attending the meeting.

BD/26/03/06 CEO and Managing Directors' Report

The Chief Executive recognised the significant operational pressures experienced across the Group at the start of the year, including high levels of flu and sustained emergency demand. These pressures had contributed to the Trust's year-to-date deficit of £20.5m, and the Trust continued to work closely with the turnaround team. Urgent and Emergency Care (UEC) remained an area of significant challenge, despite improvements in ED performance, and there were concerns regarding the level of corridor care across the Group. A regional recovery plan on corridor care was being prepared and would form a key measure of ongoing oversight. Elective recovery performance was highlighted as a major achievement, with notable reductions in waiting lists and strong progress in cancer and diagnostic pathways. Industrial action continued to be disruptive, and national resolution was required. Priority areas across the Group remained: performance and financial recovery, Electronic Patient Record implementation, clinical transformation, the corporate services review, and Group mobilisation. A joint Board development session was due to take place in May to ensure alignment across the Care Organisations and clarity on risks.

The Managing Director described an exceptionally positive recent period in performance with improved standing against national targets and the removal of 1,500 patients from waiting lists in six weeks through sprint funding. He emphasised the ongoing impact of infection-related bed closures and the requirement for infrastructure change to achieve

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long-term stability. Capital plans, including the Urgent Treatment Centre (UTC) modular build, were recognised as essential to increasing assessment capacity and mitigating infection control pressures. In terms of business planning, discussions were ongoing with system, regional and national partners. The ambitions for year 1 of the plan would be challenging, and efforts continued to secure funding, including elective recovery funding and Cancer Alliance support.

Non-Executive Directors (NEDs) raised concerns regarding delivery of Non-Criteria to Reside (NCTR) targets and asked what additional interventions were required. The Chief Operating Officer described work that was underway, including repurposing the ED observation unit as an emergency care facility, embedding clinical operational standards across specialties with the support of Getting It Right First Time, expanding frailty support at the front door, and strengthening partnerships and sensible conveyancing with the ambulance service. Longer-term benefits were also expected from the future UTC modular build. The key risk continued to be community demand management but the Trust needed to continue to focus on the elements that it could control. The Board discussed flow, bed base alignment and the extent to which infrastructure limitations were driving length of stay. Debate reflected the need for both improved clinical ownership of pathways and broader strategic solutions relating to the estate and workforce configuration.

The Board considered equality, diversity and inclusion, in the context of increasing geopolitical tension and findings from recent staff engagement. The importance of allyship and anti-racist approaches was highlighted, alongside mandatory training and stronger leadership visibility. The Chief People Officer advised that while there was not yet a fully formulated plan, belonging, development and wellbeing had emerged as key themes. The Board agreed that work would be progressed via the People Committee.

Action: People Committee

The Board discussed sickness absence as a critical factor underpinning the Trust's recovery plans. While sickness levels were not exceeding last year's peak, there was a continuation of local spikes with ED and acute medicine identified as areas of concern. The Managing Director confirmed that work was underway through a task-and-finish group, alongside rollout of Perkbox, an updated Supporting Attendance Policy, long-term sickness programmes, pattern analysis for short-term absence, and increased capacity within the People Team. The Board requested that the People Committee receive a full report at a future meeting.

Action: Chief People Officer

The Board of Directors noted the report.

BD/26/03/07 Chair's Report

The Chair provided a summary of Chair, NED and Governor activities for the period post January 2026. He highlighted that the Council of Governors had met extraordinarily on 3rd February 2026 to consider urgent proposals relating to the Interim Group Chair arrangements across the Group and had subsequently approved the appointment of an Interim Group Chair for an 18-month term. The appointment process was proceeding via the Joint Council of Governors Nomination and Remuneration Committee, with interviews due to take place on 9th March 2026.

The Board of Directors noted the report.

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BD/26/03/08 Item withdrawn

BD/26/03/09 Management Executive Committee (MEC) Upward Report
The Managing Director presented the report and provided assurance that the issues being raised by NEDs were being activity addressed and monitored at Executive level. He highlighted continued pressures associated with mortality resourcing and ongoing work to recover the position. He also advised that an external review of risk had identified the need for a more robust methodological and infrastructure framework and work had commenced to strengthen internal structures while ensuring alignment with emerging Group arrangements. The Committee continued to closely monitor outstanding internal audit actions, safety metrics, mortality data, and sickness absence indicators.

The Board of Directors noted the report.

BD/26/03/10 Quality Assurance Committee Upward Report
Simon Harrod presented the report and highlighted the Committee's continued concerns regarding insufficient administrative and governance resourcing, particularly in relation to letter production and coding, and the allocation of time within medical job plans. He explained that although progress had initially appeared limited, mortality data was now being correctly coded and the backlog of Structured Judgement Reviews (SJRs) was being addressed. The Committee had also noted the identification of four new risks relating to inadequate palliative care capacity, patient harm associated with long outpatient waits, delays in typing and issuing clinical letters, and departmental compliance with National Institute for Health and Care Excellence guidance.

The Board had a discussion around the risk that the Trust did not have sufficient clinical governance resource and capability. The Chief Risk Officer advised that further alignment across Group governance, risk and clinical leadership structures would strengthen assurance as the work matured.

The Board of Directors noted the report.

BD/26/03/11 People Committee Upward Report
Paul Fairhurst presented the report and advised that the issues raised had been comprehensively discussed during item 6.

The Board of Directors noted the report.

BD/26/03/12 Finance and Performance Committee Upward Report
Antony Durbacz presented the report, highlighting the emerging year-end forecast £20.5m deficit position, which was regarded as reasonable in the current context. He advised that the cash position could come under pressure depending on how the deficit evolved, and that mitigation planning was essential. The Committee continued to scrutinise the status of the Cost Improvement Programme (CIP) for the coming year, noting that significant work remained and delays to delivery would create a substantial financial risk. January had been particularly challenging in terms of operational pressures and UEC performance and the Committee recognised that the situation would have been considerably worse without the intervention of the Chief Operating Officer and her team.

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The Board considered the Group-wide work on the cashflow risk, including the establishment a Cash Committee across the three Care Organisations to ensure transparent monitoring, coordinated planning and, where required, movement of cash between organisations. Engagement with the Integrated Care Board and regional teams regarding potential support was also noted, with an initial position expected to be presented at the next Joint Committee meeting. The governance requirements relating to potential cash support loans were discussed and it was noted that in the event of the Trust requiring external cash support, Board approval would be mandatory. There would be implications of breaching minimum cash levels in terms of the Trust's NOF rating and external audit opinion.

The Board of Directors noted the report.

BD/26/03/13 Charities Committee Upward Report

Sumita Hutchison presented the report and highlighted the continued risks associated with the Green Heart project. She explained that while donors and external stakeholders had an expectation that development work would proceed, the Trust had not yet taken the required steps to progress the scheme, and there was a small but material risk around the potential loss of a £500k allocation should it remain unutilised. The Committee also identified wider issues regarding charitable funds management in that expenditure was not always timely or strategically aligned. A more proactive and coordinated approach was needed to ensure charitable funds delivered maximum value for the organisation. The significant contribution of the Friends of the RUH had been acknowledged, and there had been exploration of opportunities to consider volunteer engagement more strategically, aligning the Friends' work with the Trust's wider volunteering activity to develop a more dynamic and integrated service.

The Board discussed the risks associated with the Green Heart project. The Executive Team was asked to provide an update on the plan for progressing the scheme.

Action: Executive Team

The Board of Directors noted the report.

BD/26/03/14 Subsidiary Oversight Committee (SOC) Terms of Reference for Approval

Antony Durbacz presented the updated SOC Terms of Reference for ratification, highlighting minor changes that had been made to the membership and quorum. He advised that this was approved by the Committee on 19th January 2026.

The Board of Directors ratified the amended SOC Terms of Reference.

BD/26/03/15 Integrated Performance Report (IPR)

The Interim Chief Medical Officer presented the report, providing an overview of each domain:

Operational Performance

There were significant challenges in UEC, deterioration in 4-hour performance, increased handover delays, and rising demand through ED and assessment areas. Medical SDEC activity had increased, but overall hospital flow remained constrained. Elective performance had improved, with reductions in 52-week waits, sustained zero 65-week waits, and improved 18-week and diagnostic performance. There had been substantial

operational effort in high-volume cancer pathways to improve performance against 31 and 62-day standards and early unvalidated February data suggested better-than-expected performance for the Faster Diagnosis Standard.

Quality
There had been a rise in category 2 pressure ulcers and an increase in falls over recent months and this was being closely monitored. Infection prevention and control had been challenged through January, particularly in terms of the impact of flu and norovirus on patient flow. In terms of complaints data, long waits and corridor care were key drivers of poor experience and it was essential to improve communication and reduce waiting times.

Workforce
Workforce pressures were ongoing, with sickness absence remaining high, particularly relating to anxiety, stress, and depression, and concentrated in the most pressured clinical areas. A task-and-finish group was examining these issues in detail, with attention to psychological safety and staff wellbeing. There was strong correlation between low staffing fill rates and patient safety outcomes with operational and environmental factors exacerbating harm, including frailty levels, norovirus, ED congestion and corridor care.

Finance
The Trust ended January £18.3m adverse to plan. Efforts continued to deliver a year-end deficit of £17m, though the more likely forecast position was £20.5m. The organisation remained in NOF4 and the turnaround team continued to work to strengthen financial discipline to ensure a successful Q1 of 26/27.

The Board had a discussion around the alignment and presentation of risk across the IPR, strengths, weaknesses, opportunities, and threats analysis, the Board Assurance Framework and the risk register, noting the need for a consolidated, single view of risk. Members also reflected on the need to strengthen the visibility of quality measures, particularly the triangulation of staffing fill rates, patient outcomes and safety signals, and emphasised the importance of developing a balanced IPR, ensuring parity between finance, performance, workforce, and quality reporting.

The Board considered the strength of grip and oversight around patient safety and were assured by the Chief Nursing Officer that nurse staffing levels, rosters, fill rates and associated patient safety risks were monitored through a comprehensive, multilayered control framework, including twice-daily safe-staffing meetings, out-of-hours escalation, active redeployment, enhanced matron oversight and a digital audit programme providing real-time compliance data. She emphasised the need to fully understand the situation so that a comprehensive improvement plan could be developed and confirmed that this would be reported up to the Board via the Quality Assurance Committee.

The Board of Directors noted the report.

BD/26/03/16 Mortality Update
The Interim Chief Medical Officer summarised the report and advised that Summary Hospital-level Mortality Indicator (SHMI) data remained within expected limits, with a temporary uptick in Q4 of 24/25 attributed to incomplete coding during that period. The Trust was dependent on accurate coding and it was essential to triangulate multiple data sources during periods of data quality concern. Recent data indicated that SHMI had

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stabilised and was beginning to reduce. Significant progress had also been made in reducing the backlog of SJRs and all outstanding reviews from April 2025 onwards had now been completed. In terms of the more historic backlog, clear selection criteria was needed as this had been broader than national standards, resulting in a higher number of cases for review. The newly established Mortality Surveillance Group (MSG) had realigned criteria to national expectations and would retrospectively assess older reviews to ensure proportionality and sustainability. Thematic analysis of SJR findings for the current year was also planned to identify priority areas for improvement. Oversight and governance was being reviewed and strengthened through MSG, with opportunities already identified to systematise triangulation of mortality-related data, including information from the Medical Examiner's Office, Regulation 28 reports and coroner findings. Work was underway to strengthen the reporting cycle and the Trust was also collaborating to develop a Group mortality dashboard to improve timeliness and visibility of key indicators.

Board members discussed the timing at which the SHMI dataset would fully reflect the improvements in coding and the sustainability of the new processes, including whether job planning across the divisions would prevent future backlogs. The Interim Chief Medical Officer acknowledged that this would take time to filter through, with more complete datasets expected from Q3 of 25/26 onwards. She added that divisional variation was being reviewed and new selection criteria would inform appropriate resourcing and clear job-planned responsibilities.

The Board discussed the extent to which historic data would remain affected by previous coding delays and reflected on coding variation across the Group, noting a 20% difference between organisation, and the importance of consistent, high-quality data to support Group-level decision making. The Interim Chief Medical Officer clarified that SHMI would not retrospectively adjust historic data points, and the focus was on restoring accuracy going forward. While retrospective use of data to inform commissioning and service priorities remained valid, reliability for historic performance analysis would potentially be limited.

The Board of Directors noted the report and thanked the Interim Chief Medical Officer for her leadership in resolving the coding and SJR backlogs.

BD/26/03/17 Maternity Incentive Scheme (MIS) / Clinical Negligence Scheme for Trusts Sign Off

The Chief Nursing Officer reported that the Trust had achieved full compliance with the MIS Year Seven and confirmed that the Board of Directors had given permission to the Chief Executive to sign the Board declaration form prior to submission to NHS Resolution at their meeting in private on 4th February 2026.

The Board of Directors noted the report.

BD/26/03/18 Any Other Business

No other business was discussed.

BD/26/03/19 Resolution to exclude the press and public

The Chair proposed that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of

the business to be transacted, publicity of which would be prejudicial to the public interest.

The Board of Directors approved the resolution.

The Meeting closed at 12:00

Agenda Item: 4

ACTION LIST - BOARD OF DIRECTORS MEETING IN PUBLIC
WEDNESDAY, 4 MARCH 2026

Action No	Details	Agenda Item No	First Raised	Action by	Progress Update & Status	Lead
PB636	**MIS Combined Maternity and Neonates Q2 Report** Sumita Hutchison to discuss what the Trust was doing in response to national data on poorer outcomes for patients from a global majority with the Director of Midwifery to explore whether reports to Board can contain some specific data on this.	**BD/26/01/11**	**January 2026**	**April 2026**	Maternity services continue to prioritise equity and equality through a well-established workstream focused on reducing disparities for women from Black, Asian and Mixed ethnic groups. The team is reviewing the national Maternity and Neonatal Equalities Dashboard and has launched continuity of care for these groups in line with national priorities. Progress is routinely monitored through governance processes and system-wide work via the BSW LMNS group. The latest MBRRACE-UK data has been reviewed, with an annual mortality review underway, and a dedicated equity section has been included in Board reporting to strengthen visibility and accountability. **To close**	**Sumita Hutchison**

Action No	Details	Agenda Item No	First Raised	Action by	Progress Update & Status	Lead
PB637	**Minutes of the Board of Directors meeting held in public on 14th January 2026** Sumita Hutchison to send an action around relating to the Maternity Incentive Scheme Q2 Report and its update to the Corporate Governance Manager to include in the January minutes.	**BD/26/03/03**	**March 2026**	**April 2026**	Complete. The minutes of the meeting on 14th January 2026 have been updated, and the action has been included on the action list, numbered PB636. **To close**	**Sumita Hutchison**
PB638	**CEO and Managing Directors' Report** People Committee to progress work equality, diversity and inclusion in the context of increasing geopolitical tension and findings from recent staff engagement.	**BD/25/03/06**	**March 2026**	**April 2026**	We will build this into the 2026/27 Forward Plan for the papers going to People & Culture Committees as part of development of the BSW Hospitals Group People Plan. **To close**	**People Committee**
PB639	**CEO and Managing Directors' Report** Chief People Officer to provide the People Committee with a full report on the recovery of sickness absence at a future meeting.	**BD/25/03/06**	**March 2026**	**April 2026**	A report was submitted to the People Committee for their meeting on 30th March 2026. **To close**	**Chief People Officer**
PB640	**Charities Committee Upward Report** Executive Team to provide an update on the plan for progressing the Green Heart project.	**BD/25/03/13**	**March 2026**	**April 2026**	Verbal update to be provided at the meeting. **Open**	**Executive Team**

Report to:	Public Board of Directors	Agenda item:	5
Date of Meeting:	1 April 2026		
Title of Report:	Chief Executive & Managing Director's Report		
Status:	For Information		
Board Sponsor:	Cara Charles-Barks, Chief Executive Officer & John Palmer, Managing Director		
Author:	Helen Perkins, Senior Executive Assistant to Chief Executive and Katie McClean, Executive Assistant		
Appendices	None		

1.	Executive Summary of the Report

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

Chief Executive's Report

- Risks
  - Financial Position and Recovery
  - Urgent and Emergency Care (UEC) Update
  - Elective

National Update

- NHS Staff Survey
- 2026/27 NHS Pay Award
- National Oversight Framework

Group

- Joint Committee
- Leadership Team
- Group Governance and Assurance Arrangements and Transition Roadmap
- Group Priorities and Prioritisation Approach
- EPR Deployment Options Appraisal
- Clinical Transformation Programme
- Corporate Services Programme
- Group Board to Board Development Days
- Councils of Governors Workshop

Managing Director's Report

- Local (RUH)
  - Operational
  - Finance
  - Medium term financial plan
  - Quality
  - Business planning
  - Use of Trust Seal
  - Consultant Appointments

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

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

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

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)
Strategic and environmental risks are considered by the Board on a regular basis and key items are reported through this report.	

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

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

7.	References to previous reports/Next steps
The Chief Executive and Managing Director submit a report to every Board of Directors meeting.	

8.	Freedom of Information
Public	

9.	Sustainability
Further opportunities to improve sustainability should be pursued to contribute towards the Finance Improvement Programme.	

10.	Digital
Further opportunities to improve digital sustainability and solutions should be pursued to contribute towards the future developments across all Trusts.	

Group Chief Executive and Managing Director Report

GROUP CHIEF EXECUTIVE'S REPORT

Risks

Financial Position & Recovery
The financial recovery plan across the Group requires delivery of a £42m year-end deficit across the 3 Care Organisations. At month 11 there was a cumulative deficit of £42.9m, which was in line with the recovery trajectory. Month 11 again saw a series of operational challenges resulting in additional bed capacity requirements and led to restrictions on capacity for additional elective work, though the impact of these was anticipated and mitigated. At Care Organisation level the year to date deficit positions are Great Western Hospitals (£12.3m), Royal United Hospitals Bath (£19.5m) and Salisbury Hospital (£11.2m).

Moving into the final month of the year it is anticipated the impact of improved elective performance, reduced escalation costs and technical measures will be sufficient to ensure the Group achieves the revised financial trajectory of £42m deficit.

Following a resubmission process during early March, the 2026/27 Operating and Financial plan was submitted on March 18th.

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 are some slight improvements across some indicators due to reduced IPC challenges as we emerge out of the winter period.

There has been a decline in the average time for ambulance handovers at all three acute Trusts due to the impacts of winter; high demand, and IPC issues. 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. BSW Hospitals Group has submitted a plan to reduce and eliminate corridor care and the actions will form part of each acute UEC improvement plan.

The number of patients waiting to leave acute Trust beds remains a challenge – with continuing high numbers of No Criteria to Reside across all three care organisations. The internal improvement plans and support from GIRFT is focusing attention on the introduction of Clinical Operational Standards which focus on internal improvements that will support improved internal flow.

A system wide winter debrief is being planned for April where lessons learnt, and improvements will be captured and fed back to all system partners.

Elective
Some of the risks currently being managed across the group on elective care include

- Year-end delivery. As the year concludes, performance is being closely monitored across the Group particularly for 18 weeks RTT due to sprint funding and activity. All Care Organisations are working to maximise performance through validation, sprint clinics, and existing RTT improvement work.
- The Referral Support Service, which manages referrals across BSW, is closing partially from April and then fully by June as part of ICB restructures. This may cause a demand spike to Trusts as fewer referrals are triaged away from hospitals, plans are being developed to mitigate impact.

National Update

NHS Staff Survey
The NHS Staff Survey results were published on 12th March 2025 utilising data gathered from across the three Care Organisations last autumn at what was a challenging time for each Trust and the wider NHS.

Across BSW Hospitals Group, over 9,000 staff took the time to complete the survey, 56.8% of our workforce, which is above the national average. The survey is a valuable way of helping us understand colleagues' experiences and where we should focus our efforts both to build on what we are getting right, and where we need to make improvements.

One of the concerns staff have raised through the survey is their own career development, and this is one of the many things we are looking to address as we continue to build our Group, improved career opportunities, and opportunities to share learning will be benefits of our closer collaboration

Staff wellbeing scores remained in line with the national average and supporting the wellbeing of our people is fundamental to delivering excellent patient care, and it will continue to remain a priority for our Group.

Over the coming months we will review the results in more detail with teams across the Care Organisations and work together to identify practical actions that will make a real difference to our staff.

2026/27 NHS Pay Award
The Government recently announced that NHS staff are to receive a 3.3% pay award in 2026/27, which BSW Hospitals Group will be applying for all colleagues on Agenda for Change terms and conditions from 1st April 2026.

National Oversight Framework
Under the NHS Oversight Framework, on 18th March 2026 NHS England published the 2025/26 quarter three segmentation results and league tables figures, an outline of performance within BSW Hospitals Group is outlined below:

Great Western Hospitals NHS Foundation Trust was ranked 85 out of 134 Trust's in the country, the previous quarter's ranking was 82 (3 places lower than in quarter two).

Royal United Hospitals Bath NHS Foundation Trust was ranked 102 out of 134 Trust's in the country, the previous quarter's ranking was 105 (3 places higher than in quarter two).

Salisbury NHS Foundation Trust was ranked 67 out of 134 Trust's in the country, the previous quarter's ranking was 70 (3 places higher than in quarter 2).

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

There is a huge amount of work going on across the three Care Organisations to maintain and improve our position with great progress already being made around our operational performance.

Group Development

Joint Committee

Our latest BSW Hospitals Group Joint Committee meeting was held on 20th March 2026 with focus being on discussion of our Strategic Planning Framework, Financial Sustainability & Recovery, Integrated Performance Report Development, the Roadmap for transition to Group Board, the Corporate Services programme, Temporary Staffing Model, Performance Management Framework, the Group Risk Management Policy, and our Organisational Development Programme. A report from the March Group Joint Committee has been included with April Trust Board papers.

Leadership Team

Following interviews held on 9th March, we have appointed our interim Group Chair. The three Councils of Governors met between 11th and 16th March to approve the appointment of Paul von der Heyde and this has been confirmed by NHSE. Paul joins us on 1st April 2026.

Since Joint Committee review and approval of the Non-Executive model on 18th February, the three Care Organisation Councils of Governors (CoGs) have met, and each has endorsed the recommended NED model. Terms of Reference for a Joint Nominations & Remuneration Committee to oversee the process have been approved by CoGs. The Nominations & Remuneration Committee will meet in March to consider the NED role description and recruitment process, which is expected to run through April 2026.

The Group executive leadership team is almost fully established albeit with two interim positions still in place. The external recruitment for the Chief Digital & Information Officer has been launched, with interviews scheduled for 28th April. In Care Organisations, interviews for the substantive RUH CMO post were held in early March, and the recruitment to the RUH Chief Nursing Officer role has begun following the announcement by our colleague Toni Lynch of her planned retirement in June 2026.

Group Governance and Assurance Arrangements and Transition Roadmap

The governance development work supporting support safe mobilisation of our new Operating Model, is continuing led by our Governance Working Group. Supporting

this work, the Non-Executive Governance Reference Group meets monthly. On 2nd March, the NED team considered the Governance Roadmap and detailed transition timeline. The team also discussed the draft Partnership Collaboration Agreement, which will be finalised in coming weeks.

On 16th March, the pilot Risk and Assurance Committee (RAC) held its inaugural meeting to shape how group-level risk and assurance will operate ahead of go-live planned in July. The committee reviewed and discussed draft Terms of Reference, the approach to developing the initial group Board Assurance Framework (BAF), and the developing group risk register and Risk Management Policy.

Group Priorities and Prioritisation Approach.

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

1. Recovery (Performance & Finance)
2. EPR implementation
3. Clinical transformation through the acute services review and clinical services framework design
4. Completion of the Corporate Services Review
5. 2026/27 planning including Group Mobilisation

The Group Leadership team meets weekly to ensure progress is maintained in these priority areas.

EPR Deployment Options Appraisal

Following our decision in January to reset the programme timeline, the EPR programme has been working with suppliers on delivery planning. Final costs and draft delivery plan will be presented to the BSW Group Executive, Care Organisations, and BSW Hospitals Group Joint Committee in April 2026, with a final delivery plan to be confirmed in April/May.

Clinical Transformation Programme.

The Clinical Transformation Programme has begun. Clinical Transformation Groups (CTGs) are being established, initially in dermatology, diabetes and paediatric orthopaedics. The CTGs will explore potential service models, using a set of design principles founded on serving our population, supporting our teams and reduction of unwarranted variation. Clinical leads in identified services are being briefed by the CMOs about the programme. A steering group meets monthly and will work to ensure the programme is resourced to enable successful delivery.

Corporate Services Programme

Our Corporate Services Programme is making progress with the design stage for services nearing completion. The Steering Group and Design Authority meet regularly, and designs have been approved for seven services with consultation planning well underway. SLAs are being developed for each of the shared corporate services. The financial impact of the programme is being tracked for each service, with clear targets set for 26-27 & 27-28. Detailed phasing of benefits is being planned by service leads.

Group Board-to-Board Development Days.

The 2026/27 Group Board dates including a series of Board development days are being scheduled. From July, Group Boards will be held on the first Thursday of the month.

The next Board-to-Board development day is planned to take place in Trowbridge on 7th May and will focus on preparations for transition to our new Group Operating Model, our strategic planning framework and major milestones in our draft strategic plan.

Councils of Governors Workshop

The next Councils of Governors development session will be held on 30th April 2026; the agenda for the day will be co-designed to address local and group priorities.

MANAGING DIRECTOR'S REPORT

In September 2025, 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 Q3 2025/26 was published in March 2026 and the Trust remains in Segment 4 but has improved its ranking to 102 / 134.

Key improvements include RUH maintaining zero 65 week waiters as of 1st March 2026, an improved ranking on the 4-hour standard (for all types performance) with the RUH improving from 113/123 in October to 100/123 in March 2026. and we achieved the national target to reduce the number of patients waiting to less than 1% of our total waiting list ahead of trajectory. 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 by 1.8% to 56.0%. The average ambulance handover delay for February 2026 was 71.2 minutes, a slight increase from 67.4 minutes in January 2025. Average NCTR numbers was 97.6 patients, (53.6 patients above plan). Our performance for MSDEC at 41.9% for February 2026 is the highest percentage that we have seen and means we have met the national target of 40% of patients going through an SDEC pathway in February.

RUH continues to embed our refreshed internal professional standards; improving board/ward rounds; redesign of escalation processes and streaming within ED Majors and UTC.

Referral to Treatment

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

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

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

We are proud to be able to say that we reported zero 65 week breaches at the end of February and furthermore we reduced the number of patients waiting over 52-weeks to 0.8% of our waiting list and this achieved the national target of bringing this below

1%. RTT performance continues to improve with expectation to achieve the national target by 31st March. This is a testament to the work that our operational, clinical and administrative colleagues have put into this recovery programme.

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
We achieved the national target for 31 days however January performance on the 28-day and-62 day standards was 65.2% and 57.1% respectively which was below traectory.

This continued underperformance was anticipated as it was agreed that the Trust would prioritise treating long waiting patients which would result in temporary deterioration in performance. Cancer performance is reported 1 month in arrears but our unvalidated position for February indicates that the Trust will achieve the 28 day and 31 day standard in both February and March. This would be the first time that the Trust will have aheived the 28 day target.

62 day performance is not expected to meet target at year end. This is due to a high number of breaches in urology, skin and colorectal. Skin and colorectal are showing significant improvement in waiting times with improvement in urology expected to take longer.

Diagnostics
In February 2026, 84% of patients received their diagnostic within 6-weeks ahead of our 80.8% trajectory. Performance improved by 7.95% from January 26 we remain on track to acheive our year target of 84.1%.

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.

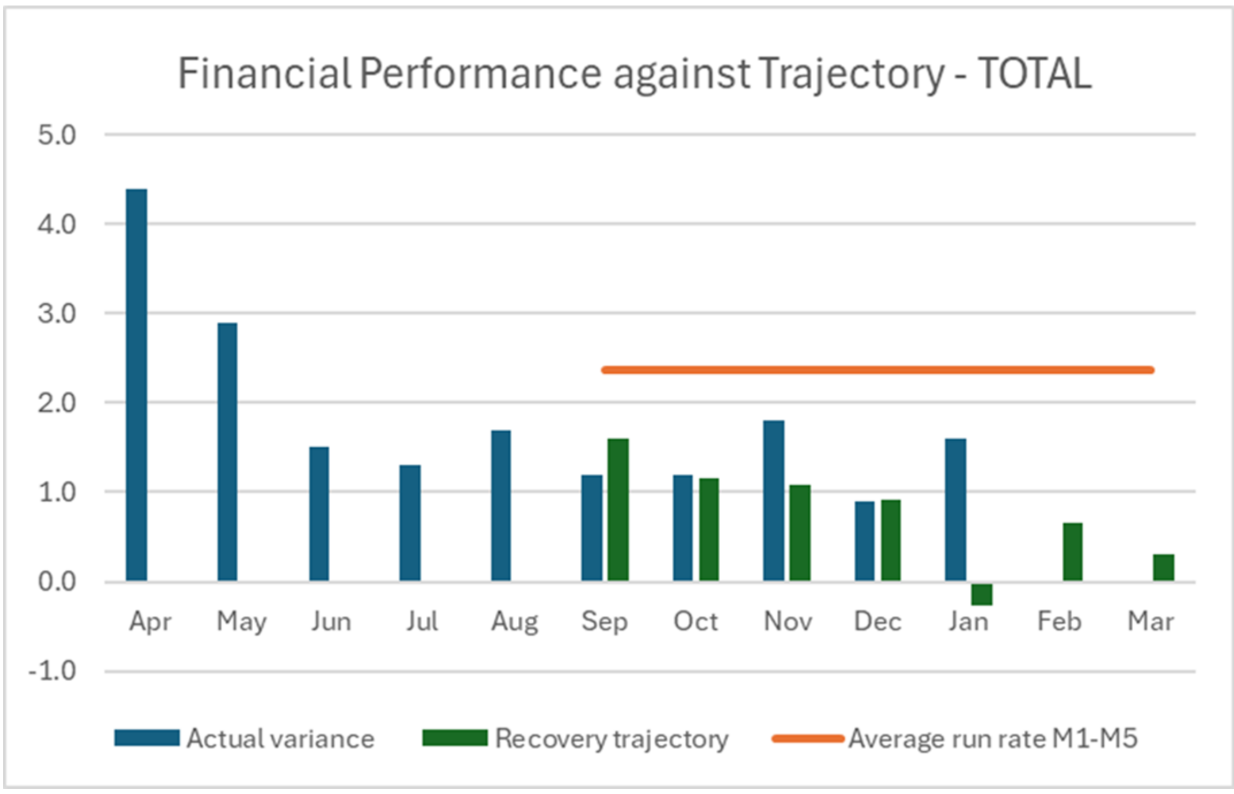
2. Finance

Our financial position remains unsustainable, but has stabilised and improved over the last 6 months

- At the end of Month 10 the Trust has a deficit YTD of £18.3m. In month the deficit was £1.6m.
- The straight-line trajectory would be £22.4m, which is considerable improvement of the £32m straight-line projection from earlier in the financial year.
- The Trust has developed a Recovery Plan to achieve a £20.5m deficit (System £19m), whilst continuing to strive for further improvement. The Trust was striving for £17m but operational pressures have reduced the opportunity, and some opportunities have now been deferred to 26/27 financial plan.

- The Trust secured funding from ICB and commissioned a Turnaround Team (Hunter Healthcare) to support delivery of the financial position.
- The team joined the trust on 17 November and are now in Wk14.
- The programme has supported the Trust:
- to improve the run rate and develop the Recovery Plan to £20.5m deficit
- improve and embed financial improvement governance, at Trust and Divisional level, to increase capacity and improve delivery and financial stewardship
- generated new opportunities and subject specialist expertise to accelerate financial improvement

Forecast £20.5m (System £19m): Position agreed with NHSE and on track for delivery. The goal is to limit year end deficit to £17m and contribute towards System breakeven



3. Quality

Pressure Ulcers

The Trust has seen a general increase in the number of reported pressure ulcers over the past year. While several contributory factors are likely, work is ongoing to establish the underlying causes and to understand any correlation between nursing safe staffing fill rates and the rise in pressure ulcers. A thematic patient safety incident investigation is now in its final stages, which will help determine whether current improvement initiatives are appropriately targeted. To provide strengthened oversight and accelerate improvement a Tissue Viability Improvement Group has been established. Clinical areas where clusters have been identified are already receiving focused support and enhanced monitoring by the Divisional Directors of Nursing. All

improvement workstreams will report monthly to the Insight and Improvement Committee.

Mixed Sex Accommodation Breaches

The Trust has achieved a substantial reduction in reported mixed sex accommodation breaches over the past 12 months. Between February 2025 and February 2026, reported breaches decreased by 58%. It is important to note that no breaches occurred within the inpatient bed base; incidents were predominantly associated with assessment areas. This improvement is largely attributable to strengthened data validation processes, which have enhanced the accuracy and reliability of reporting. Work is continuing across the Hospital Group, in collaboration with the ICB, to identify and progress further opportunities for improvement.

Care Quality Commission

We continue to await the draft report from the Care Quality Commission (CQC) following the unannounced inspection of the Urgent and Emergency Care Unit in October 2025.

4. Business planning update

Since the last Board on 4th March 2026, there have been further discussions regarding the final business plan for 2026-2029. As a result, two changes have been made since the plan was submitted in February 2026. These are an improvement to our 4 hour trajectory for March 2029 to achieve the national target of 85% and an additional £1.5m of savings offset by a reduction in transitional funding. These changes reflect both feedback from the regional team and local changes across the BSW Group to collectively improve our financial position.

The final plan was submitted on 18th March 2026 and we are awaiting confirmation on approval of our 3-year plan from NHS England.

Our plan delivers against national targets across the three years for Referral to treatment, Diagnostics, Cancer Standards and Workforce Metrics. It provides an improvement in 4-hour performance of 10% in year 1, 5% in year 2 and 3 achieving the national target in March 2029. Our corresponding financial plan aims to move the organisation to a break-even position across the planning period but does require a higher savings plan in year 1 compared to latter years.

Whilst this is a balanced plan delivering performance improvements and financial sustainability, the plan remains extremely challenging with some very significant financial and operational risks. It is reliant on further Elective (ERF) and Cancer funding and capital funding to redesign our emergency front door and refurbish ward environments. It will also require support from system and community partners to reduce emergency demand and improve timeliness of discharge. We will continue to focus on derisking the plan as we move to the implementation and delivery phase.

The focus for the next quarter is to develop and mature our Year 1 Cost Improvement Plan, work closely with partners to realise demand management and delayed discharge (NC2R) plans and develop full business cases in support of our Urgent

Treatment Centre modular and Integrated Front door for Emergency Care, Surgical Same Day Emergency Care expansion and inpatient ward refurbishment.

Below is a summary of what our plan delivers over the next three years.

3-Year Medium Term Financial Plan - Plan on a page

	Metric	Latest RUH position (Dec'25)	RUH plan Mar '26	26/27 NHSE Instruction	26/27 RUH Plan	27/28 NHSE Instruction	27/28 RUH Plan	28/29 NHSE Instruction	28/29 RUH Plan
UEC	4-hour ED performance RUH and MIU Footprint	65.7%	78%	82% by Mar '27	75.3%	83%	80.2%	85%	85.0%
	12-hour ED performance	7.7%	4.9%	3.9%	6.3%	Year on year reduction	5.3%	Year on year reduction	5.0%
	Ambulance handover	31 mins	33 mins	Reduce toward 15 mins	30 mins	Further improvement	29 mins	15 mins	28 mins
Elective & Diagnostic	18w RTT Performance	60.7%	67.7%	74.7% for RUH *(65% or 7% Improvement, whichever is higher)*	74.7%	Bridge between 74.7% and 92% Target	83.4%	92%	92.0%
	52 Week Waiters	644	331 (1%)	*Improvement on 1%*	198 (0.8%)		62 (0.4%)		0
	DM01	28.3%	16.1%	*3% improvement at ICB level 13.1% for RUH*	12.5%	To bridge between 13.1% and 1%	9.0%	99%	1.0%
Cancer	28d FDS	53.7% (Sep '25)	80.2%	80% annual ave	80.0%	80% annual ave	80.5%	80% annual ave	80.7%
	31d	91% (Sep '25)	93.7%	94%	94.2%	96%	96.0%	96% annual ave	96.1%
	62d RTT	58.3% (Sep '25)	75.3%	80%	80.5%	82.5%	82.7%	85%	85.1%
Workforce	30% Reduction in agency use	13.6 WTE	5.0 WTE	*30% improvement relative to M6*	-5wte	Improvement	-2wte	Zero agency spend	0
	10% reduction in bank spend	268.8 WTE	261 WTE	*10% reduction relative to M6*	-10%	Improvement	-10%	30% reduction relati ve to 25/26	-10%
	Sickness rate (rolling 12 month average)	4.97% (Sep '25)	5.3%	Improvement	4.8%	Improvement	4.6%	4.1%	4.4%
Finance	2% productivity improvement	2.4%	6.7%	% for RUH *(2% improvement)*	5.0%		2.7%	"Sustained improvement"	1.5%
	Savings Plan	Version 14	15.0m (29.7m)	37.6m (£56.6m over 3 yrs)	37.6m	10.0m	10.3m	8.6m	8.7m
	Balanced or surplus financial position	-£14.1m	-£17m	Balance or surplus	0.0m	Balance or surplus	0.0m	Balance or surplus	0.0m

5. Use of Trust Seal

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

6. Membership

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

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

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

7. Consultant Appointments

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

Ms Emma Stewart-Parker was appointed as Consultant in Emergency General Surgery, Ms Emma Stewart-Parker will join us in May and is currently working as Consultant in General Surgery at Guys and St Thomas NHS Foundation Trust.

Mrs Ileana Geogloman was appointed as Consultant in Emergency General Surgery, Mrs Ileana Geogloman will join us in May and is currently working as Consultant in General Surgery at the Queen Elizabeth Hospital, King Lynn NHS Foundation Trust.

Miss Lydia Longstaff was appointed as Consultant in Emergency General Surgery, Miss Lydia Longstaff will join us in March and is currently working as Locum Consultant in General Surgery at the Royal United Hospital, Bath.

Dr Josiah Orlando Carter was appointed as Consultant in Gastroenterology, Dr Josiah Orlando Carter will join us in April and is currently working as Specialty Doctor in Gastroenterology at the Royal United Hospital, Bath.

Dr Ben Masterman was appointed as Consultant in Gastroenterology, Dr Ben Masterman will join us in June and is currently working as Speciality Trainee in Gastroenterology at the Royal United Hospital, Bath.

Dr Laura Backhouse was appointed as Consultant in Gastroenterology, Dr Laura Backhouse will join us in April and is currently working as Speciality Trainee in Gastroenterology at the Royal United Hospital, Bath.

Dr Mohsin Gondal was appointed as Consultant in Cardiology, Dr Mohsin Gondal will join us in April and is currently working as Post-CCT PCI fellow at University Hospital Birmingham.

Dr John Graby was appointed as Consultant in Cardiology, Dr John Graby will join us in September and is currently working as Cardiology Registrar at University Hospitals Bristol & Weston NHS Foundation Trust.

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

Women urged to check for symptoms of ovarian cancer

During Ovarian Cancer Awareness Month in March, an RUH patient shared her experience of having ovarian cancer and called on others to be aware of the signs and symptoms of the disease.

Each year 7,400 women are diagnosed with ovarian cancer in the UK.

Christine Grant, 68, from Trowbridge, urged women to get themselves checked as soon as something doesn’t feel right, as finding a problem early means it’s more treatable. She praised the ‘excellent care and support’ she had received at the RUH during her treatment.

Clinical Nurse Specialist Day

National Clinical Nurse Specialist Day took place in March, we marked the day by shining a spotlight on the incredible work of our Cancer Nurse Specialists.

We spoke to Emily, one of our Clinical Nurse Specialists and a Gynaecological Cancer Nurse Specialist, about what her role involves and why she finds it so rewarding. We

shared the story and photos on our social media channels, where it received a really positive response and lots of engagement.

School leaver careers fair

March also saw the Trust hold its popular school leavers careers fair, aimed at young people interested in learning about out the range of career opportunities available at the RUH and in the NHS. Colleagues from across the hospital came to talk about their specialist fields, including maternity, therapies, biomedical science, nursing, cardiology, radiotherapy, and research.

Events like this help the Trust to continue to build on its links with the people in our community while showcasing the incredible variety of career options available at the RUH.

Celebrating the work of Bath Sound

We worked with Bath Sound – formerly Bath Hospital Radio – to highlight their incredible work for the people we care and the local community.

Formed in 1964, the award-winning Bath Sound - the longest-running radio station in Bath - is a volunteer-run, charitable radio station that was formed to serve the RUH

Now broadcasting via the internet, its audience tunes in from as far afield as Australia - but the station's core purpose remains bringing information, comfort and great music to those being cared for and working in the local hospital.

We filmed a video for our social media channels with two of Bath Sound's volunteers who talked about the station and how it had changed since it was formed more than 60 years ago.

Report to:	Public Board of Directors	Agenda item:	6
Date of Meeting:	1 April 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 since the last Board meeting in March 2026. Activities relating to formal Committees of the Board are reported through upward reports.	

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

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

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

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

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

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

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

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

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

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

Chair and Lead Governor Meeting – 16th March
The Chair met with the Interim Head of Corporate Governance, the Lead Governor, the Deputy Lead Governor and Vice Chair on 16th March to discuss current Trust and Group matters and to support ongoing engagement between the Board and the Council of Governors.

The meeting included Trust and Group-level updates. Governors shared feedback from recent external engagement, including an NHS Providers webinar, and discussed priorities for Governor agenda setting ahead of the next Council of Governors Away Day in April. The discussion also provided an opportunity for Governors to raise questions and reflect on current risks and developments affecting the Trust and the wider Group.

Overall, the meeting supported constructive dialogue, effective information sharing and continued alignment between the Board and the Council of Governors during a period of organisational transition.

Extraordinary Council of Governors Meeting – 16th March 2026
On 16 March 2026, an Extraordinary Council of Governors Meeting was held to consider the proposed Group Non-Executive Director (NED) model and new Chair appointment. Governors received an update on the development of consistent Group-wide arrangements for NED appointments, remuneration, and oversight, supporting the establishment of the BSW Hospitals Group governance framework.

At the same meeting, the Council of Governors approved the appointment of Paul von der Heyde as Interim Group Chair, ahead of his formal commencement in April 2026.

Chair attendance at key meetings during March 2026
- Regular meetings with Non-Executive Directors
- BSW Hospitals Group Joint Committee (March)
- BSW Chairs’ Meeting
- Weekly 1:1 meetings with Chief Executive
- Weekly 1:1 meetings with Vice Chair

Report to:	Public Board of Directors	Agenda item:	7
Date of Meeting:	1 April 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 13 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 considerable 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

April 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	Finance and Performance
NEW 1.2	Increasing demand for urgent & emergency care is exceeding the trusts capacity to assess, treat & admit patients in a timely manner, leading to sustained emergency department overcrowding Corridor Care and failure to meet national performance targets.	The people we care for	-	**16**	NEW	Chief Operating Officer	Finance and Performance
NEW 1.3	Planned care demand exceeds available clinical, and diagnostic capacity, resulting in increasing waiting times for outpatients' appointments and procedures, with a growing risk of harm, patient dissatisfaction, and breach of national RTT standards.	The people we care for	-	**16**	NEW	Chief Operating Officer	Finance and Performance

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	20	**20**	STATIC	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	**16**	STATIC	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 has been updated and is due to be reviewed at the Quality Assurance Committee in April 2026.
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 Finance & Performance agreed that this risk (covering both emergency and planned care pressures) had become too broad to govern effectively and no longer reflected the distinct operational drivers, assurance pathways, and external performance requirements now impacting each area. • At the Board meeting in March, the Board agreed to close this risk and split into two distinct areas: elective and non-elective. The new risks approved by the Board are documented below.
NEW 1.2	Increasing demand for urgent & emergency care is exceeding the trusts capacity to assess, treat & admit patients in a timely manner, leading to sustained emergency department overcrowding Corridor Care and failure to meet national performance targets.	• This risk relates to sustained levels of urgent and emergency care demand that continue to place pressure on the Trust's ability to assess, treat and admit patients within national standards. • The risk reflects ongoing challenges associated with increasing ambulance arrivals, changes in patient acuity and frailty, continued non-criteria-to-reside pressures, and the operational implications of revised handover arrangements. • The risk includes strengthened articulation of causes alongside refined controls and sources of assurance. These include oversight through the Urgent and Emergency Care Steering Group, BIU-enabled performance and flow meetings, and enhanced reporting arrangements to support effective monitoring and escalation. • The current risk score is 16.
NEW 1.3	Planned care demand exceeds available clinical, and diagnostic capacity, resulting in increasing waiting times for outpatients' appointments and procedures, with a growing risk of harm, patient dissatisfaction, and breach of national RTT standards.	• This risk relates to ongoing pressures across elective, outpatient and diagnostic services, arising from capacity constraints, backlog management, and variation in pathways. It reflects the need to continue strengthening processes that support effective triage, booking and administration, alongside consistent delivery of outpatient care. • The Finance and Performance Committee has reviewed the risk and confirmed that it includes appropriate elective-specific controls and sources of assurance. These include strengthened Patient Tracking List (PTL) governance arrangements, targeted Referral to Treatment (RTT) training, speciality-level deep-dive reviews, and improvement actions aligned to GIRFT and Model Hospital programmes. • The current risk score is 16.

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.	• In the November 2025 Board Assurance Framework, Risk 2.1 focused on culture, inclusion, and staff experience, including their influence on workforce retention and organisational culture. While there was broad agreement that the risk description could be updated, it was agreed that this should be revisited once the Group operating blueprint and revised risk management framework are fully established. • In the interim, the actions, sources of assurance and areas for development have been refreshed and strengthened, as detailed in the appendix, to ensure continued oversight and alignment with emerging Group-wide approaches.
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 February 2026 update provides a more detailed articulation of the People risk, including greater clarity around leadership capacity, management capability, and organisational approaches to identifying and developing talent. • Controls have been updated to reflect current leadership development programmes, apprenticeship pathways, compassionate leadership initiatives, and alignment with the future Group People Plan. • The update also identifies areas for further development, including the continued strengthening of talent management and succession planning arrangements, enhanced use of digital tools to support team-level culture and engagement, and clearer progression pathways to support staff following development activity.

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.	• The risk was reviewed at the Finance and Performance Committee meeting in February 2026. The overall risk position remained unchanged from that previously escalated to the Board in December, with the risk score and underlying drivers continuing to be considered valid. • Updates made at the February review focused on improving the clarity and articulation of the risk, including a clearer presentation of causes, controls, and sources of assurance. There was no material change to the substance or scoring of the risk.
	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.	• The Operational Director of Finance reviewed the risk. Minor presentational updates have been identified; however, no material changes have been made to the substance or scoring of the risk. The updates will be considered further by the Subsidiary Oversight Committee at its April meeting.
3.3	Without reducing unwanted variation and addressing inequity of care, people may not receive appropriate levels of care.	• This risk has been significantly strengthened and updated; it is due to be reviewed at the Quality Assurance Committee in April 2026.
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 reviewed by the Non-Clinical Governance Committee on 16 March 2026. • The risk remains unchanged in substance, with no amendments to the wording and no material change to the overall risk position. The current risk score remains 16 (Impact 4 × Likelihood 4). • The Committee discussed the context of increasing backlog maintenance requirements, estate condition challenges across a number of domains and emerging fire-related risks. As a result, it was noted that the Board will be asked to consider whether an increase in the risk score would better reflect the Trust's current estate-related risk exposure. No change to the risk score has been made at this stage.
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 risk was reviewed by the Non-Clinical Governance Committee on 16 March 2026. • The risk remains unchanged in substance from the previous review, with the risk score and underlying drivers continuing to be considered valid. • Updates made through this review focused on improving the clarity and emphasis of the risk, including clearer articulation of causes, controls, and sources of assurance, rather than reflecting any material change to the content or scoring of the risk.
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	• These risks were reviewed by the Non-Clinical Governance Committee on 16th March. • Each risk remains unchanged in substance from the previous review, with the risk scores and underlying drivers continuing to be considered valid. • Updates made through this review focused primarily on improving the clarity and presentation of the risks, including clearer articulation of causes, controls, and sources of assurance, rather than reflecting any material change to the content or scoring of the risks. • Work is also ongoing to ensure appropriate alignment between these Board Assurance Framework risks and the wider Risk Register.
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.	

Report to:	Public Board of Directors	Agenda item:	8
Date of Meeting:	4 March 2026		
Title of Report:	Management Executive Committee Upward Report		
Status	For information and discussion		
Author	Abby Strange, Corporate Governance Manager		

Key discussion points and matters to be escalated from the meeting on 25 March 2026
ALERT: Alert to matters that require the Board's attention or action, e.g. non-compliance, safety, or a threat to the Trust's strategy
• **Fire Safety Audit:** The Committee received an action plan that had been developed in response to a recent Fire Safety Audit. It was noted that mitigation will be delivered on a phased, risk-based basis, reflecting current capital constraints, and that the position is appropriately captured on the Trust's risk register. • **Cash Flow:** The Committee discussed short-term cash flow modelling and the range of mitigations available, including ongoing engagement with system partners and NHS England as required. • **Staff Survey:** The Committee reviewed the 2025 Staff Survey results, which highlighted opportunities to further improve workload, wellbeing, access to development and career progression, and to address variation in experience for Global Majority colleagues. The importance of a visible, organisation-wide response with clear ownership was emphasised.
ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance
• **Safety Metrics:** The Committee emphasised the need to maintain safety standards amid operational and financial pressures and continues to monitor a small number of safety metrics through established governance routes. • **Clinical Value Review:** The Committee noted that governance and decision-making frameworks were being strengthened alongside ongoing work to support strategic commissioning discussions. • **Business Planning and Budget:** The Committee discussed the scale of the financial challenge for 2026/27, including the significant savings requirement, and noted that the capital programme will require close monitoring in the context of cash flow constraints.
ASSURE: Inform the Board where positive assurance has been achieved
• **Organisational Performance and Delivery:** The Committee noted that a strong end-of-year position is forecast, with positive feedback received at the

most recent provider oversight meeting. The Committee also reflected on improvement across Referral to Treatment (RTT), cancer, and diagnostics performance.

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

- **Risk Register Management:** The Committee noted an increase in the overall number of risks recorded on the risk register, including a number of higher-scoring risks. The Committee recognised the importance of continued focus on mitigation delivery and assurance and noted that this will be supported through the newly established Risk Management Improvement Group.

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

- **Frailty Same Day Emergency Care (SDEC) Model:** The Committee recognised the proposal as an innovative multi-disciplinary model intended to support earlier assessment and, where appropriate, facilitate same-day discharge.

APPROVALS: Decisions and Approvals made by the Committee

- **Risk Register:** The Committee approved updates to the Risk Register, including new, upgraded, and downgraded risks.
- **Digital Cell Pathology Extension:** The Committee approved a one-year contract extension.
- **Radiology Business Case:** The Committee approved the proposal to increase substantive capacity by utilising existing expenditure, supporting delivery of forecast activity levels and planning targets for diagnostics.
- **Divisional Restructuring:** The Committee approved the proposal recommending a targeted rebalancing of RUH clinical divisions.
- **Oncology and Haematology Investment:** The Committee approved year one of the growth investment case.
- **Frailty SDEC Business Case:** The Committee approved the business case in principle, subject to clarification of the funding route.
- **Policies:** The Committee ratified the following policies:
    - Annual Leave Policy
    - Armed Forces and Leave Policy
    - Pay for New and Existing Parents Policy

Report to:	Public Board of Directors	Agenda item:	10
Date of Meeting:	1 April 2026		
Title of Report:	Alert, Advise and Assure Report Finance and Performance Committee – 24 March 2026		
Status:	For information and assurance		
Author:	Antony Durbacz, Chair of Finance and Performance Committee		

Key Discussion Points and Matters to be escalated from the meeting held on 24 March 2026
ALERT: Alert to matters that require the board's attention or action, e.g. non-compliance, safety or a threat to the Trust's strategy
• Cashflow forecasts indicate a potential risk of breaching internal cash management thresholds during Quarter 1 of 2026/27. This position is subject to a number of uncertainties and is being actively managed through established financial controls, system-level engagement and ongoing monitoring by the Committee.
ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance
• As we approach the year end, there is improved visibility on the full year financial outturn, there is high certainty around the forecast deficit outcome. • The Committee will continue to closely scrutinise the plans to deliver the 2026/27 Cost Improvement Programme, with a particular focus on deliverability and sustainability. • Performance against cancer waiting time trajectories remains positive for the 28-day and 31-day standards. The 62-day standard continues to lag and remains under active review.
ASSURE: Inform the board where positive assurance has been achieved
• The Committee provides assurance that significant progress has been made in aligning operational risks with the Trust's corporate risk framework, strengthening the link between operational performance, financial oversight and Board-level assurance.
RISK: Advise the board which risks where discussed and if any new risks were identified
• No new risks were identified by the Committee. Relevant financial and operational risks discussed are already captured within the Corporate Risk Register and continue to be monitored through established governance arrangements.

CELEBRATING OUTSTANDING: Share any practice, innovation or action that the committee considers to be outstanding
• Notable improvements in Referral to Treatment (RTT) performance have been achieved, supported by targeted sprint funding. • Significant improvement in Community Diagnostic Centre (CDC) performance has contributed positively to delivery of the DMO1 trajectory and the 28-day cancer standard.

APPROVALS: Decisions and Approvals made by the Committee
• The Committee recommends that the Board approve the award of a 24-month non-committed call-off contract for the provision of multi-disciplinary consultancy services to support Estates and Capital Projects, in line with procurement regulations and the Scheme of Delegation. • The Committee also recommends Board approval of the Trust's budget 2026/27.

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

Report to:	Public Board of Directors	Agenda item:	11
Date of Meeting:	1 April 2026		
Title of Report:	Alert, Advise and Assure Report – Audit & Risk Committee		
Status:	For information		
Author:	Joy Luxford, Chair of Audit and Risk Committee		

Key Discussion Points and Matters to be escalated from the meeting held on 19th March 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

- **Risk Management -** The Committee received an external review of risk management which highlighted a lack of structural alignment, capability and inconsistent processes at RUH Bath. This formalises a recurring theme that there is an immediate need for investment, experienced personnel and resources to address these findings. The Committee would encourage the board to prioritise this area.

- KPMG, the Internal Auditor flagged that 23 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. Patient Safety Incident Response Framework, Discharge and Data Security & Protection Toolkit graded as 'Partial Assurance with improvement required'), means that the board should prepare itself for a repeat of a limited assurance 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. KPMG have kindly offered to do a revalidation exercise of overdue items ahead of the next audit committee meeting to ensure an up to date view is maintained.

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

- As mentioned above, poor risk management processes, and overdue actions alongside 'requires improvement' Internal Audit reports limit the assurance in specific areas that can be provided on the Trust's internal control environment.

ASSURE: Inform the board where positive assurance has been achieved

Internal Audits

- Patient Safety Incident Response Framework report was given an assurance rating of Partial Assurance with improvement required, (amber / red). This

highlighted risks around inconsistent sharing of learning, un-timely investigations and the need for more oversight and training.

- (2) The Management of IT Applications was given an assurance rating of Partial Assurance with improvement required, (amber / red). This highlighted risks around weaknesses in performance monitoring and limitations in roll-out of Multi-Factor Authentication.
- (3) The Board Assurance Framework (BAF) report was given an assurance rating of Significant Assurance with minor improvements identified, (green/amber). This highlighted opportunities around consistency and linking to the corporate risk register.
- (4) The Capital Programme Report was given an assurance rating of Significant Assurance with minor improvements identified, (green/amber). This highlighted opportunities around consistently applying prioritisation across departments.

Other Governance Items

- A Grip and Control report was received and areas of strength and development were noted. An improving position has been maintained which is credit to the finance team and continued focus on the 'Call to Action'.
- Full compliance was noted through the NHS Code of Governance and Provider Licence requirements Self-Assessment.
- The Committee noted the results of its effectiveness self-assessment review based on the HFMA Checklist.

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

- **Resource constraints** - A recurring risk was discussed throughout the meeting in relation to insufficient resource and investment into vital process and control areas due to financial constraints; including risk management, patient safety, and IT that will limit RUH's ability to deliver its strategy, consistent levels of safety and compliance with constitutional and best practice standards. Of particular note was the lack of personnel in key areas and the needed investment to manage risk processes, particularly as we move into a BSW group.

- **External Audit risk -** As part of external audit planning, Deloitte raised a new significant area of focus surrounding the property valuation given the change in approach and level of judgement and estimation needed. Additional audit work will be needed to satisfy the auditors on the reasonableness of the assumptions used. An additional £30k audit fee has been estimated for the extra scope in audit work.

CELEBRATING OUTSTANDING: Share any practice, innovation or action that the committee considers to be outstanding
• The Internal Audit and Local Counter Fraud Plans for 26/27 have been co-designed to provide assurance across the group incorporating group, joint and site specific audits. • The Finance and External Audit Team were congratulated for the progress made against the External Audit timeline - which puts us in a far better position than prior years. • The Finance team were commended for their work on improving grip and control, particularly in relation to 'no PO no pay' where considerable focus and improvement has been made during the year bringing compliance up to 90%.

APPROVALS: Decisions and Approvals made by the Committee
Internal Audit and Local Counter Fraud Service (LCFS) • The Committee approved an Interim Internal Audit Plan for 26/27 highlighting some areas for further consideration (quality, medical devices). KPMG will review and report back at the next Audit Committee. • The Committee approved the Local Counter Fraud Audit Plan for 26/27. • The Committee noted reports as described above. • The Committee approved a 12 month extension for KPMG to deliver Internal Audit and LCFS under the original contract terms. **External Audit** • The Committee approved the External Audit Plan for 25/26. • The Committee agreed to • (1) adopt the proposed accounting policies for preparation of the 2025/26 accounts, • (2) the arrangements for the signing of the audited accounts and related documents in June 2026 • (3) note and approve the process for finalising the accounting estimates and material judgements, recognising that more review would be needed of the Property Valuation given its significance this year. • (4) accept the going concern assessment and statement for inclusion in the disclosure for the Annual Report and Accounts 25/26. **Other Governance Items** • The Committee noted reports on BAF, Debtors and Creditors, waivers, Salary Overpayments and Underpayments, Grip and Control, Declaration of Interests and Gifts, and Code of Governance.

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

Report to:	Public Board of Directors	Agenda item:	12
Date of Meeting:	1 April 2026		
Title of Report:	Non-Clinical Governance Committee Upward Report		
Status	For information and assurance		
Author	Sumita Hutchison, Non-Executive Director		
Appendices:	Appendix 1: EPRR Core Standard Assurance Summary 2025		

Key discussion points and matters to be escalated from the meeting of 16 March 2026

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

Critical Infrastructure and Fire Safety

- The Committee considered an update on critical infrastructure risks, including fire safety and statutory compliance across the Trust estate. The Committee was unanimous that the scale, complexity and strategic significance of these risks sit beyond the remit of the Non-Clinical Governance Committee and require full Board oversight.
- The Committee agreed that a dedicated paper should be brought to the Board to support a focused discussion on assurance, patient and staff safety, and the wider strategic and capital implications. A Board paper is being prepared by the Executive team for consideration.

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

Green Plan and Climate Adaptation Plan

- The Committee reviewed the Green Plan and Climate Adaptation Plan and agreed that they cannot be formally approved at Committee level at this stage.
- The Committee advises that a Board-level steer is required to determine the Trust's ambition, priorities and pace for delivery, taking account of current resourcing constraints. This will enable the plans to be either formally approved or appropriately reframed.

Emergency Preparedness, Resilience and Response (EPRR)

- The Committee received the annual EPRR assurance update and was assured that the Trust continues to meet national EPRR core standards. The Committee noted the positive assurance position and the ongoing programme of work to maintain and strengthen preparedness, resilience and response arrangements.
- The Committee received assurance that the Trust continues to meet national EPRR core standards. The NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board EPRR assurance outcome letter, confirming a Fully Compliant rating for the second consecutive year, is included as an appendix for Board assurance.

ASSURE: Inform the Board where positive assurance has been achieved
Information Governance and Data Security • The Committee provides assurance that the Trust's information governance and data protection arrangements continue to improve, supported by positive internal audit findings and strengthened group-wide assurance arrangements. The overall trajectory remains positive, with further assurance to be provided through the Audit Committee. **Health and Safety Governance** • The Committee noted the annual Health and Safety Report and upward reporting from the Health and Safety Committee and is assured that key risks are being identified, escalated and managed through the Trust's governance framework.
RISK: Advise the Board which risks were discussed and if any new risks were identified
• The Committee reviewed updates to relevant Board Assurance Framework risks, including those relating to the estate and climate change. No new risks were identified that are not already captured within the Trust's risk registers. • The Committee approved an increase to BAF 3.4 (Ageing estate / backlog maintenance) from a risk score of 16 to 20 and recommended escalation of this risk to the Board, with detailed discussion to take place in Private Session.
CELEBRATING OUTSTANDING: Share any practice innovation or action that the committee considers to be outstanding
Catering and Food Safety — Roadmap to Soil Association Gold Accreditation • The Committee recognised the continued progress made by catering colleagues towards achieving Soil Association Gold accreditation, reflecting sustained commitment to food quality, safety, sustainability and patient experience within a complex acute hospital environment.
APPROVALS: Decisions and Approvals made by the Committee
• Annual Health and Safety Report (March 2025) - noted • Health and Safety Committee Upward Report - noted • EPRR Annual Assurance Update - noted • Green Plan and Climate Adaptation Plan - not approved; escalation to Board recommended • Critical infrastructure and fire safety risks - escalation to Board recommended

The Board is asked to NOTE the report.

28 November 2025

Via Email

Dear Bernie,

Royal United Hospital NHS Foundation Trust - EPRR Core Standard Assurance Summary 2025

Many thanks for preparing the self-assessment, supporting evidence and your EPRR team engagement at the EPRR assurance review meeting held on 6th October. This letter summarises the outcomes from the meeting, capturing agreed actions and points from our discussions.

The Core Standards have been reviewed and in addition to the Core standards self-assessment, you provided a comprehensive report detailing the achieved EPRR portfolio in the last year and at the assurance review meeting Angela provided a detailed update reflecting on the year and the look forward.

Compliance level

Organisation	2021	2022	2023	2024	2025
RUH	Substantial	Partial	Substantial	Full	Full

RUH have assessed themselves fully compliant with a detailed narrative to support their submission.

Headlines

There have been personnel changes within the Executive Management team at COO and Deputy COO levels and planned sickness for the Head of EPRR, which left the EPRR portfolio managing at reduced capacity, and this has also impacted delays in plan sign off during this period.

Despite the operational challenges the EPRR team have undertaken a tremendous amount of work to maintain compliance and noting these are minimal core standards and are the foundation of further work, the team stating this is the base and further continual development is needed.

A substantial number of regular in-house training has been undertaken including incident response and business continuity for all band 6's and above. Currently the team are working through divisional specific business continuity training. Regular

loggist training is undertaken with an established pool of eighteen trained loggists and this training has been opened to on-call managers and the site team. PRPS training is undertaken with two full sessions per month for up to sixteen staff from ED and Site, this training compliance data is reported to the Trust Board. The team are looking for further 'train the trainer' opportunities with SWAST.

The EPRR team have continued to maintain their personal development and show a strong appetite for learning with training in the following areas: Emergo Senior Facilitator Training, Risk Management in Civil Protection, Health Diploma in EPRR and Structured debrief refresher training.

The team also demonstrated good engagement and collaborative working throughout the assurance process and a collaborative approach with the LHRP and LHRP sub-groups such as the risk working group, RUH established the BSW Hospital Group for EPRR providing a forum for collaboration in relation to training and exercising and are scheduled to support colleagues at Salisbury Hospital with an Emergo exercise later in the month.

Work is underway to review and revitalise the EPRR governance, with the introduction of new templates for reporting and redesign of strategic reporting structures to strengthen oversight, provide clarity on aims, objectives and expectations. There has been creation of a lessons learnt database which includes internal, local and national learning, sense checking do we comply, what further actions can be taken and are there risks for considering or mitigate. The RUH EPRR and corporate risk registers have been worked through to align with the work of the BSW LHRP RWG and an incident record excel database has been set up recording all electronic and paper records from incident response.

Looking forward to 2025/2026 there are plans to

- Participate in the National Tier 1 Exercise Pegasus.
- Undertake an RUH Emergo exercise (Feb 2026)
- Continuation of the regular EPRR training schedule
- Develop of the Learn Together Platform to include Principles of Health Command
- Increase visibility of the EPRR team, to enhance resilience
- Enhanced exercise programme to include no notice drills as supported by the Executive team

The outcomes of this assurance review will be included in the annual EPRR System assurance summary letter which is submitted to NHS England South West. The ICB will be required to present a system summary of the assurance process to the LHRP. NHS England will produce and submit a regional report to the NHS England National Team by end of December 2025.

Finally, thank you to you and the EPRR team for your hard work over the last year, especially with changes of AEO, planned sickness within the EPRR team while maintaining the management of other concurrent issues and incidents.

Yours sincerely

Rachael Backler
Chief Delivery Officer
NHS Bath and North East Somerset, Swindon, and Wiltshire Integrated Care Board

Report to:	Public Board of Directors	Agenda item:	13
Date of Meeting:	1 April 2026		
Title of Report:	Integrated Performance Report		
Status:	For Noting		
Board Sponsors:	Bernie Bluhm, Chief Operating Officer Toni Lynch, Chief Nursing Officer Jude Gray, Chief People Officer Simon Wade, Chief Finance Officer		
Authors:	Sufi Husain, Deputy COO / Sarah Hudson, Dep COO UEC / Operational Team Rob Elliot, Lead for Quality Assurance / Quality Team Matt Foxon, Site HR Director / Associate Directors for People and Workforce Team Jon Lund, Director of Operational Finance / Tom Williams, Head of Financial Management / Financial Team		
Appendices	Appendix 1: Integrated Performance Report slide deck		

1.	Executive Summary of the Report

The report provides an overview of the Trusts Performance for the period up to and covering February 2026, aligned to our True North Pillars and breakthrough objectives agreed for the year.

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

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

Operational Performance

The average ambulance handover delay for February 2026 was 71.2 minutes, a slight increase from 67.4 minutes on average in January 2025. Through February 2026 the total hours lost was 2,427. This is a 111-hour decrease compared to last month's lost hours of 2,538. 34.5% of handovers were completed within 30 minutes.

RUH 4-hour performance in February was 56.02% on the RUH footprint (unmapped), an increase of 1.82% from January’s performance (54.20%). Non-admitted performance was 66.97%, which was a slight decrease against the performance for January’s (67.05%).

The numbers of patients going through our Medical Same Day Emergency Care (MSDEC) (679) decreased in February compared to January (799) however Frailty Same Day Emergency Care (FSDEC) numbers remained static (23). Our performance for MSDEC at 41.9% for February 2026 is the highest percentage that we have seen and means we have met the national target of 40% of patients going through an SDEC pathway in February.

In February, Referral to Treatment (RTT) performance saw an increase in overall performance of 3.2% to 66.2% vs trajectory of 65.9%. The percentage of patients waiting less than 18 weeks for their first outpatient appointment was 69.7% (+ 3.5% from January). Total over 52-week waiters decreased from 402 to 326 (-19%). The Trust continued to maintain having zero patients waiting over 65-weeks.

In February 2026, 84.05% of patients received their diagnostic within the 6-weeks against the 80.8% target. Performance improved 7.95% from January 2026.
DM01 trajectory reviewed to account for additional demand (RTT schemes) and mitigation (additional capacity) - end of year target 84.1% compliance.

In January (Cancer is reported one month in arrears) cancer performance deteriorated against all three national standards. 28-Day Faster Diagnosis Standard (FDS) reduced by 7.2% to 65.5% with the biggest drivers in Skin, Upper GI and Urology. 31-Days deteriorated slightly just below national target, by 1.2% to 93.6% with Skin accountable for the majority of breaches. 62-day performance was impacted by lower performance in Colorectal, Lung and Urology, reducing by 8.5% to 57.4%. Recovery against the FDS standard is expected in February 31-days will maintain performance close to national standard, however 62-days will continue to be very challenged with performance considerably below trajectory and national standard.

Quality

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

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

Pressure Ulcers

In February 2026, the RUH reported a rate of 1.0 pressure ulcers per 1,000 bed days equating to nine cases. These included three category 3 pressure ulcers, one category 2 medical-device–related pressure ulcer and four category 2 pressure ulcers. One case has progressed in depth and has therefore been reclassified as a category 4.

To provide strengthened oversight and accelerate improvement a Tissue Viability Improvement Group has been established. This group is conducting detailed reviews of recent cases and is leading the development of an urgent targeted action plan. Two clinical areas where clusters have been identified are already receiving focused support and enhanced monitoring. All improvement workstreams will report monthly to the Insight and Improvement Committee to ensure visibility of progress and timely escalation where required

Falls
Data shows that during February 98.43% of inpatients did not fall in our care. Trust wide 89.18% of adult inpatients had a falls risk assessment completed within 6 hours of admission (Mar 25- Feb 26). In February there were 2 reported falls that resulted in moderate or above harm to patients, 1 occurred in the community and 1 as an inpatient. There were 6.97 falls per 1000 bed days in February, this is down from 9.01 in December 2025.

Infection Prevention and Control
During February we continued to be impacted by the end of the influenza outbreaks. Whilst the number of influenza cases had decreased from 167 to 94 during February, the Trust was also experiencing an increased number of patients developing and presenting with Norovirus, impacting the number of closed beds being reported externally.

During February there was one Healthcare Associated MRSAB reported, (3 cases against a zero tolerance). Five cases of C.difficile infection, (71 cases against a threshold of 75) and 14 E.coli bacteraemia's (98 cases against a threshold of 77). Vapour cleaning is now being trialled for specific infections post discharge from single rooms, as part of bigger revision of how post discharge cleans are requested and completed.

Patient Support and Complaints
In February, the Trust received 34 new formal complaints, a decrease from 39 in January. This equates to a complaint rate of 0.54 per 1,000 patient contacts, compared with 0.58 in January. Performance against the agreed response timeframe was 87.9%, below the Trust target of 90%. More than 60% of complaints received in February related to clinical care and concerns.

The majority of concerns raised continue to relate to outpatient services, with recurring themes including waiting times for new and follow-up appointments, delays in receiving test results and clinic letters and difficulties in communication with departments. Thematic coding is underway to gain a deeper understanding of the underlying issues and to inform and drive further improvement work across outpatient pathways.

Safe Staffing
The combined shift fill rates for days for RNs across the 24 inpatient wards/departments was 82% and 95% respectively for nights. The combined shift fill for HCSWs was 93% for the day and 105% for the night shift.

Perinatal Update
Digital safety remains an area requiring focused attention, with a significant risk identified relating to the quality and availability of maternity data. Work is underway to

strengthen data reliability, improve system functionality and ensure appropriate mitigation is in place.

A review is also underway into the digital risks affecting how information is shared between obstetric ultrasound systems. Several previously identified risks are now being combined into a single, updated risk entry, with escalation planned for April 2026. Current limitations in information flow are affecting the reliability of fetal growth surveillance, so immediate safeguards have been put in place while longer-term digital improvements are developed to strengthen safety and assurance.

Workforce metrics during February identified that the Midwife-to-birth ratios remained above target (2023 BR+ target) and Mary Ward continues to report low compliance within "staff meet acuity" percentages. This is reflective of rising dependency, safeguarding demand and increased perinatal mental health complexity. A matron-led deep dive into Mary Ward (2023 vs 2026) is analysing workload drivers to ensure the BR+ reassessment which is currently in progress accurately captures current service acuity.

Neonatal nursing continues to operate with fragility due to high parental leave, long-term sickness and dependency on bank and agency cover; BAPM compliance fluctuated in February. The service is undertaking a benchmarking exercise against the BAPM 2025 standards, which indicates that our activity levels align with those of a 'high-activity' Local Neonatal Unit. This work has highlighted a potential medical workforce gap, and further evidence gathering is underway to fully understand the position.

User feedback from MNVP, Friends and Family, Walk & Talk reviews and Safety Champion visits identifies themes of waiting times, communication clarity, feeding support during transitional periods, staff workload, and the desire for a calmer ward environment. While many families report positive staff attitudes and compassionate care, inconsistent information-sharing and environmental pressures remain present within feedback.

Two new moderate-harm events (major obstetric haemorrhage and a 34-week intrauterine death) were reported in February, with no immediate care concerns identified. Ongoing learning responses shows a commonality of documentation quality within BadgerNet and cross-system record transfers. One low-harm event After Action Review (AAR) was commenced in February pertaining to community frenulotomy services with immediate learning implemented and follow up operational meeting planned in March to explore long term service improvements if required.

February saw one stillbirth and no neonatal deaths, with RUH's 2025 rates remaining below national averages. Whilst local stillbirth rates for 2024–25 also remain below national levels they are slightly higher than in 2022–23. As part of our routine commitment to learning and quality improvement, a full cohort review with equity

analysis has been initiated to better understand the pattern, reflecting professional curiosity rather than concern.

Training compliance is positive across maternity and neonates but remains below target in Safeguarding Level 3 and some basic life-support modules (ABLS/PBLS), primarily due to roster pressures, rotation timing and course cancellations. Additional study days and changes to mandatory update content are planned to improve compliance by mid-2026.

Deteriorating Patient
Performance has fallen below the lower control limit, primarily driven by reduced compliance with sepsis screening and delays in escalation. The multidisciplinary Deteriorating Patient Improvement Group (DPIG) is providing targeted support to affected clinical areas and is reviewing the digital prompts and escalation pathways to strengthen early recognition and response.

In February 2026, 86 hospital-acquired Acute Kidney Injuries (AKIs) were reported. Reducing avoidable AKIs remains a key priority for DPIG, with ward-based quality improvement initiatives underway focusing on hydration optimisation, medication review processes, and timely clinical escalation.

Workforce
The Trust continues to face significant workforce pressures, with overall sickness remaining high at 6.00% and the rolling annual rate rising to 5.35%. This is equivalent to more than 12,000 additional WTE days lost and is driven heavily by Anxiety, Stress & Depression (ASD) and Cold/Flu, which together account for 44% of all absence. Estates & Facilities, Medicine and Surgery remain the most affected areas. Divisions are progressing a range of actions, including manager follow-ups, deep-dive analysis and Trust-wide sickness reduction work.

ASD sickness remains at unprecedented levels, with a January rate of 1.44% contributing 500 additional WTE days lost and an estimated £60k cost pressure. Tailored support is being provided in Surgery, alongside A3 root-cause analysis work in Estates & Facilities.

Appraisal compliance has recovered to 80.61% but remains well below the 90% target. Actions are ongoing through PRMs and A3 processes to address gaps and improve consistency.

The Trust is now approximately 20 WTE over-established. Corporate and Estates & Facilities hold the highest vacancy gaps, with Band 3 CSWs and Band 5 Nurses remaining key vacancy hotspots. Divisional vacancy control processes continue to manage recruitment and mitigate risks.

Turnover remains low at 0.58% in-month and 7.00% annually, which may be limiting workforce movement. Mandatory training remains strong at 89.17%, though some directorates continue to require focused local monitoring.
Delivery against the Workforce Plan remains challenging, with the Trust around 220 WTE above plan and agency staffing significantly above expectations (23.16 WTE versus 5 WTE planned). Actions are focused on reducing sickness, strengthening recruitment and approval controls, and wider workforce transformation and skill-mix initiatives.

Emergency Medicine continues to be the highest user of both bank (23 WTE) and agency (5.9 WTE) staff. February agency spend is reported at 1.5× the January level, driven partly by a coding query and high consultant agency usage. Recruitment pipelines in ED and ongoing cleaning recruitment are expected to relieve some of this pressure, while Group project-related agency spend will cease in March.
Overall, high sickness—particularly ASD—ongoing deviations from the Workforce Plan, and elevated reliance on agency staffing continue to present material risks to operational delivery and financial stability. These areas will require sustained Trust-wide focus as the organisation progresses into the 26/27 planning cycle.

Finance

The RUH Group is £19.4m adverse to plan at the end of January, of which £19.7m arising in RUH Trust and £0.3m favourable in Sulis. This is significantly adverse to plan and has triggered regulatory intervention, immediate enhanced expenditure controls & a Call to Action across the organisation. The trust has secured funding and regional approval to commission a Turnaround team who started in the Trust on 17 November. The Trust is subject to Finance Override in National Oversight Framework (NOF) and taken together with UEC and Elective performance delivery places the Trust in Level 4.

The key driver is £16.1m variance arising from under delivery of the £29.7m savings programme and acceleration of delivery plan and scoping of further areas to close the unidentified gap must be top priorities for the organisation. Within this there is £4.0m unidentified Group savings, £3.2m UEC savings due to NCTR (67 above plan) and activity growth levels (ED attendances 3.8% above plan), £0.7m Corporate Redesign slippage and £1.9m Outpatient transformation slippage. Workforce plan reductions have been offset by staff sickness levels rising to 6.0% and c20% above last Winter; as well as operational pressures in clinical administration, notably typing backlogs.

Operational budget pressures have maintained in February with cumulative pressures arising from increased demand for high-cost drugs and devices (£2.1m), underfunding of Pay Award (£0.3m) Resident Doctors budget pressures (£1.7m). Industrial Action was funded in Month 10, covering all IA to date. The remaining cost pressures are partly offset by increased cost controls and non-recurrent benefits (£6.8m). Sulis is favourable to plan by £0.3m driven by profit margin in core business. A further adverse variance arises from deterioration in the exit run rate from 24/25 (£5.5m)

In February commissioning income was c£1.2m adverse to forecasted levels, driven by annual leave in school holidays, uncached outpatient appointment and impact of emergency demand pressures & IPC on elective capacity. Recovery during March is the key operational priority to deliver the forecast outturn control total, supported by daily command and control actions from Operations teams.

The Trust operates within BSW Integrated Care System which has reported a £20.1m adverse variance to plan year to date, of which BSW Hospitals Group is £41.3m adverse to plan partially offset by ICB favourable variance to plan of £21.2m. The worsening in month is broadly aligned to the anticipated Month 11 position.

The Trust has agreed a Forecast Outturn control total with NHSE of £20.5m, continues to work hard to deliver recovery actions, supported by the Turnaround team, to deliver this.

Trust cash balances for the Trust are £20.1m. Cashflow forecasts have been undertaken which show cash balances reducing to £16.1m by April on a do-nothing scenario. £19.5m is judged to be the minimum working cash limit to enable contractual obligations to be met in time; and therefore, enhanced cash monitoring and controls are being developed, in advance of potential requests for NHSE revenue cash support.

For October 2025 NHSE published data showing the Trust had a year-on-year implied productivity improvement of 1.8% against internal the breakthrough objective of 6.7%. Cost weighted activity grew by 4.1% compared to inflation adjusted cost growth of 2.3%. Given that much of the activity growth is in non-elective activity we do not see a direct financial benefit from this productivity. The cost base used to calculate growth in year has also impacted from recharging between Sulis and the RUH for SOC and cost growth for Sulis CDC, therefore the 'real' productivity is forecast to be higher than this.

The RUH Group underlying deficit continues to be assessed at £47.3m and is aligned with 25/26 Recovery Actions and Forecast Outturn. This has been the baseline for 26/27 and Medium Term Planning.

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

3.	Legal / Regulatory Implications
Trust Single Oversight Framework.	

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

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

6.	Equality and Diversity
NA	

7.	References to previous reports
Standing agenda item	

8.	Freedom of Information
Public	

9.	Sustainability
None identified.	

10.	Digital
None identified.	

Integrated Performance Report

March 2026

(February 2026 Data)

The RUH, where you matter

Trust Priorities 2025/26

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.

Executive Summary

March 2026
(February 2026 Data)

The RUH, where you matter

Trust Executive Summary: Operational Performance Dashboard

Executive Summary

Domain	Measure	Month	Latest Performance	Previous Performance	Month-End Target	Year-End Target	Assurance	Variation	Variation Detail
Urgent Care	12 Hour Trolley Waits	Feb-26	219	328		0			Special Cause Concerning - Above Upper Control Limit
Urgent Care	12 Hour Trolley Waits (% Type 1 Atts)	Feb-26	12.7%	13.4%	6.7%	0.0%			Special Cause Concerning - Above Upper Control Limit
Urgent Care	4 Hour ED Performance	Feb-26	56.0%	54.2%	71.8%	72.0%			Special Cause Concerning - Run Below Mean
Urgent Care	Average Ambulance Handover Time (mins)	Feb-26	71	67	33	33			Common Cause Variation
Urgent Care	ED Patients Assessed in under 15 mins	Feb-26	67.1%	69.9%					Special Cause Improving - Two Out of Three High
Urgent Care	No Criteria to Reside (% Occupied Beds)	Feb-26	22.9%	20.4%		10.0%			Special Cause Concerning - Above Upper Control Limit
Urgent Care	Non Elective Length of Stay	Feb-26	9.1	8.2		8.4			Common Cause Variation
Elective Activity	RTT Incomplete Pathways over 52 weeks	Feb-26	0.8%	1.0%	1.1%	1.0%			Special Cause Improving - Below Lower Control Limit
Elective Activity	RTT Incomplete Pathways over 65 weeks	Feb-26	0	0		0			Special Cause Improving - Below Lower Control Limit
Elective Activity	RTT Performance	Feb-26	66.2%	63.1%	65.9%	67.7%			Special Cause Improving - Above Upper Control Limit
Elective Activity	RTT Wait to First Outpatient Appointment (% <18 weeks)	Feb-26	69.7%	66.2%	69.9%	72.0%			Special Cause Improving - Above Upper Control Limit
Diagnostics	CT Productivity (CT Activity DM01 Volume At or Above Plan)	Feb-26	-41	-72		0			Special Cause Concerning - Run Below Mean
Diagnostics	DM01 Performance (% <6 weeks)	Feb-26	84.0%	76.1%	94.1%	95.0%			Special Cause Improving - Increasing Run
Diagnostics	MRI Productivity (MRI Activity DM01 Volume At or Above Plan)	Feb-26	-83	-104		0			Special Cause Concerning - Two Out of Three Low
Cancer	Cancer 28 Day Diagnosis	Jan-26	65.6%	73.2%	77.2%	80.0%			Common Cause Variation
Cancer	Cancer 31 Day Treatment	Jan-26	93.4%	95.0%	90.2%	90.0%			Common Cause Variation
Cancer	Cancer 62 Day Standard	Jan-26	57.2%	64.6%	72.2%	75.0%			Special Cause Concerning - Two Out of Three Low

Overview – Executive Themes and Actions to Raise at Board

Call to Action

Theme	Detail
UEC – 4 hour	RUH 4-hour performance in February was 56.02% on the RUH site, an increase of 1.82% from January performance (54.2%). Non-admitted performance was 66.97% which was an increase against the performance for January (67.05%) with Januarys admitted performance also increasing to 31.56% (January 27.62%). Activity in MSDEC decreased in January to 679 patients, the impact of IPC bed closures and high admission demand requiring medical SDEC to remain open overnight however represents 41.3% of the medical take through an SDEC pathway, above the national target of 40%.
Financial Recovery - £17m Deficit	The RUH Group is £19.4m adverse to plan at the end of January, of which £19.7m arising in RUH Trust and £0.3m favourable in Sulis. The Trust has agreed a Forecast Outturn control total with NHSE of £20.5m, continues to work hard to deliver recovery actions, supported by the Turnaround team, to deliver this. Trust cash balances for the Trust are £20.1m. Cashflow forecasts have been undertaken which show cash balances reducing to £16.1m by April on a do nothing scenario. £19.5m is judged to be the minimum working cash limit to enable contractual obligations to be met in time; and therefore enhanced cash monitoring and controls are being developed, in advance of potential requests for NHSE revenue cash support.
Referral to Treatment times – 65 weeks	In February, RTT performance saw an increase in overall performance of 3.2% to 66.2% vs trajectory of 65.9%. The percentage of patients waiting less than 18 weeks for their first outpatient appointment was 69.7% (+ 3.5% from January). Total over 52-week waiters decreased from 402 to 326 (-19%). The target for over 52 week waiters was achieved with 0.8% of patients on the waiting list being over 52 weeks vs the Trust target of 1%. The Trust continued to maintain having zero patients waiting over 65 weeks.
Cancer – 28-day Faster Diagnosis	In January (Cancer is reported one month in arrears) performance deteriorated against all three national standards. 28 Day FDS reduced by 7.2% to 65.5% with the biggest drivers in Skin, Upper GI and Urology. 31 Days deteriorated slightly just below national target, by 1.2% to 93.6% with Skin accountable for the majority of breaches. 62 day performance was impacted by lower performance in Colorectal, Lung and Urology, reducing by 8.5% to 57.4%. Recovery against the FDS standard is expected in February, 31 days will maintain performance close to national standard, however 62 days will continue to be very challenged with performance below trajectory and national standard.
Diagnostics – DM01 Backlog	In February 2026, 84.05% of patients received their diagnostic within the 6-weeks against the 80.8% target. Performance improved 7.95% from January 2026. DM01 trajectory reviewed to account for additional demand (RTT schemes) and mitigation (additional capacity) - end of year target 84.1% compliance.
Patient Safety & Staff Wellbeing	As reported last month, the Trust has seen an increase in hospital-acquired pressure ulcers over the past 12 months. Work is ongoing to understand the underlying causes, and a thematic Patient Safety Incident Investigation (PSII) is now in its final stages, which will help identify key learning and improvement opportunities. In addition a focused Tissue Viability Task and Finish Group has been established to drive targeted actions and support sustained improvement. Significant progress has been achieved in addressing the backlog of Structured Judgement Reviews (SJRs) with all cases dating back to April 2025 now completed as part of the ongoing work to strengthen mortality oversight. The Trust continues to face significant workforce pressures, with overall sickness remaining high at 6.00% and the rolling annual rate rising to 5.35%. Sickness is driven heavily by Anxiety, Stress & Depression (ASD) and Cold/Flu, which together account for 44% of all absence. Estates & Facilities, Medicine and Surgery remain the most affected areas. Divisions are progressing a range of actions, including manager follow-ups, deep-dive analysis and Trust-wide sickness reduction work.

Balanced Scorecard – SWOT Analysis

Successes

- Sustained zero over 65-week waiters since end of December 2025
- The target to reduce over 52-week waiters below 1% was achieved in February (0.8%)
- RTT performance continued to improve and was 66.2% which is a +3.2% improvement on the previous period
- Capital investment to relocate the Urgent Treatment Centre by Q3 2026/27 and support for development of the Integrated Front Door business case.
- Extended Emergency Medicine Ambulatory Care (EEMAC) opened at the end of January 2026 – concept proved, the focus remains on increasing throughput to positively impact 4-hour performance and corridor care.
- Elective Sprint funding initiatives mobilised to improve RTT and activity

Opportunities

- Digital opportunities in Outpatients - AI test of change, automation of referral process & electronic check-in
- Extension of Elective Sprint Funding for Outpatients, Cancer and independent sector to continue improvements into next financial year
- Further embedding of financial improvement in business as usual learning lessons from Turnaround
- UEC reset programme
- NHSE UEC 4-hour sprint March 2026 – three schemes underway
- Frailly hub development
- Implementation of Internal Professional Standards
- Capital investment to support our 3 year MTFP
- Commercial opportunities including sale and leaseback of Assets

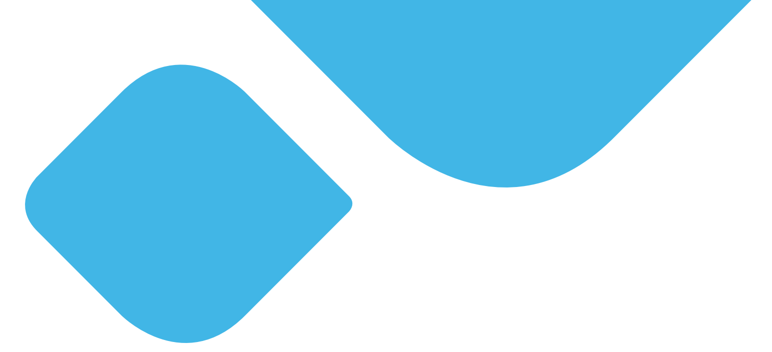
Priorities

- Maintenance of patient safety
- Delivery of the financial and operational recovery plan 'Call to Action'
- Business planning for next 3-year cycle – move to implementation plan
- Business case development for Major Capital Schemes
- 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 plan for 2026/27.
- Trustwide promotion of Perkbox counselling/wellbeing resources
- Development of Ambient and other digital applications
- Corporate Services Redesign
- Improve coding compliance
- Implementation of Shared EPR – preparation phase
- Implementation of Advice and Refer
- Continued Command and Control financial improvement measures, notably maintaining elective income and controls for medical staffing expenditure and communications to whole organisation
- Finalising Month 12 financial recovery actions

Risk/Threats

- Consistently reduced nursing fill rates, long waits in Front Door areas adversely impacting patient outcomes: pressure ulcers and falls
- Maintenance of patient safety in light of financial & performance pressures
- Significant increases in UEC demand far outstripping planned levels
- Financial controls fatigue and loss of capacity following Turnaround
- Closure of RSS service may shift significant administrative and clinical workload to the RUH
- 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
- Extending impact of peak operational pressures leading to increased costs
- Significant financial savings ask for 2026/27 to deliver a breakeven position Cash projections and risk
- Capital funding shortfalls leading to operational risks and revenue cost pressures

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

Operational Performance

March 2026
(February 2026 Data)

The RUH, where you matter

Executive Summary

<u>Performance</u>

The average ambulance handover delay for February 2026 was 71.2 minutes, a slight increase from 67.4 minutes on average in January 2025. Through February 2026 the total hours lost was 2,427. This is a 111-hour decrease compared to last month's lost hours of 2,538. 34.5% of handovers were completed within 30 minutes.

RUH 4-hour performance in February was 56.02% on the RUH footprint (unmapped), an increase of 1.82% from January's performance (54.20%). Non-admitted performance was 66.97%, which was a slight decrease against the performance for January's (67.05%).

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Key Cost Drivers

Business Plan Delivery February 2026

Activity Plan

	YTD Plan	YTD Actual	Variance	Change per Day Actual
OP News	183,606	189,486	5,880	+25
OP Follow Ups	280,418	290,461	10,043	+43
Daycases	36,329	34,699	-1,630	-7
EL Inpatients	4,397	3,532	-865	-4
ED Attendances	94,095	96,734	2,639	+8
NEL Admissions	56,769	60,719	3,950	+12
Diagnostic tests	157,961	157,341	-620	-3

Planning Assumptions

	Plan	YTD Actual
GP Referral Growth*	0.0%	2.5%
ED Atts Growth	2.6%	5.4%
NEL Admit Growth (excludes maternity)	3.4%	12.1%
NCTR	41	108
NEL Length of Stay (for 1+ days)	5.8	6.8

* 1 month reporting lag

Performance

		Year End Target	Current Month Plan	
RTT	<18 1st app	71.7%	69.9%	69.7%
	<18 weeks	67.7%	65.9%	66.2%
	>52 weeks	1.0%	1.0%	0.8%
Cancer	62 days*	75.0%	72.2%	57.1%
	31 days*	96.0%	90.2%	93.2%
	28 days*	80.0%	77.2%	65.2%
ED	4hr type 1	72.0%	71.8%	56.0%
	4hr All Types	78.0%	77.7%	64.7%
	12 hours	reduction	6.7%	12.7%
DM01	> 6 weeks	5.0%	5.9%	16.0%

* 1 month reporting lag

Finance

	YTD Plan	YTD Actual	Variance
Cash Releasing Savings	£27,223	£11,076	-£16,147
Financial Position	£0	-£19,411	-£19,411
Productivity	+6.7%	+1.8%	-4.9%

Figs to Oct 25

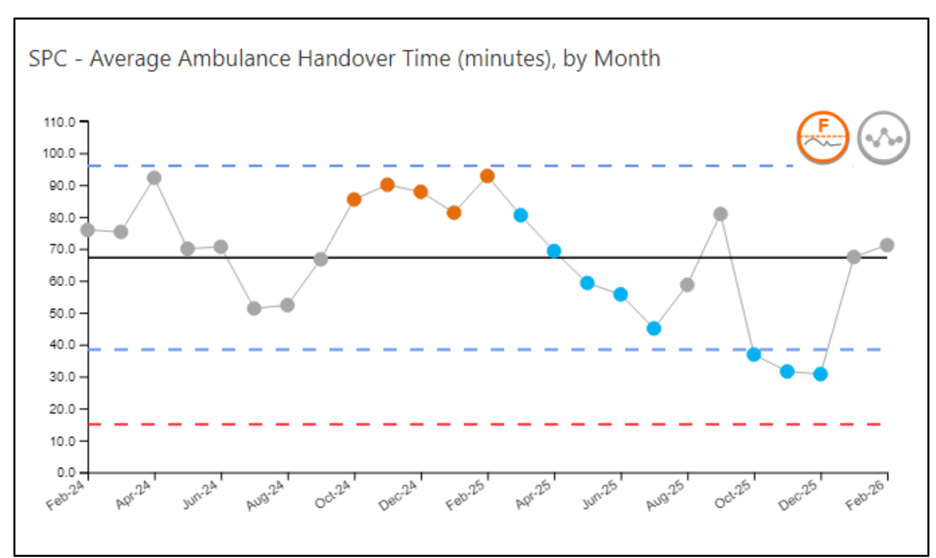
Workforce

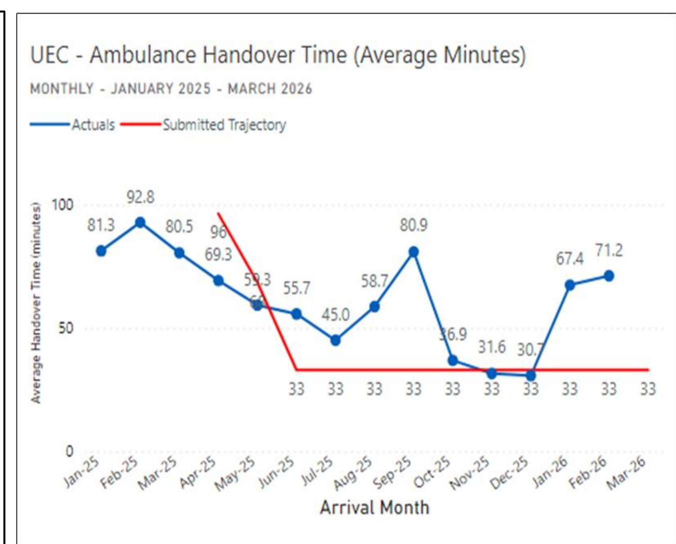
	YTD Planned	YTD Actual	Variance
Pay Savings (£000s)	£14,815	£4,491	-£10,324
WTE Reduction	5578.27	5793.2	214.9
Sickness - 12 Month	4.90%	6.00%	1.10%

Ambulance Handover Times

We are driving this metric because.. Performance Target:	*The Trust is not meeting the national standard of offloading ambulances into our Emergency Department within 15 minutes. The average offload time in Q1 2025 was 80 minutes. Ambulance offload delays reduce emergency response capacity, delay critical care, and strain hospital resources, putting patient safety and community health at risk.* *Average ambulance handover = 33mins (30th June 2025)*

Breakthrough Objective





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

The average ambulance handover delay for February 2026 was 71.2 minutes, a slight increase from 67.4 minutes on average in January 2025. Through February 2026 the total hours lost was 2,427. This is a 111-hour decrease compared to last month's lost hours of 2,538. 34.5% of handovers were completed within 30 minutes.

February 2026 performance is 38.2 minutes behind trajectory; March 2026 so far is showing a worsened position, at 58 minutes behind trajectory (03/03/2026).

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.

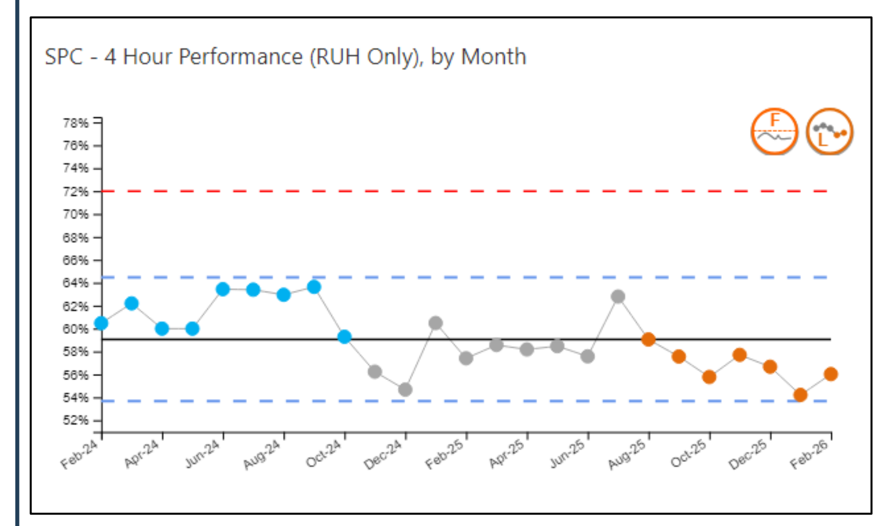
Countermeasures	Owner	Due Date
Implement the National Acuity Model to support triage and streaming. **Launched – ongoing optimisation, 15 trained.**	JR	Apr26
Plan and agree case for change supporting an EEMAC model within current ED Obs footprint. **Launched – ongoing optimisation, ave. 19pts/day.**	MP	**Ongoing.**
Support implementation and monitoring of IPS 2025 via UEC Improvement Programme.	Leadership team	Mar26
Recruit 10.24 WTE registrars following business case approval. **IN PROGRESS – 10 WTE advertised.**	MP/BI	Mar27

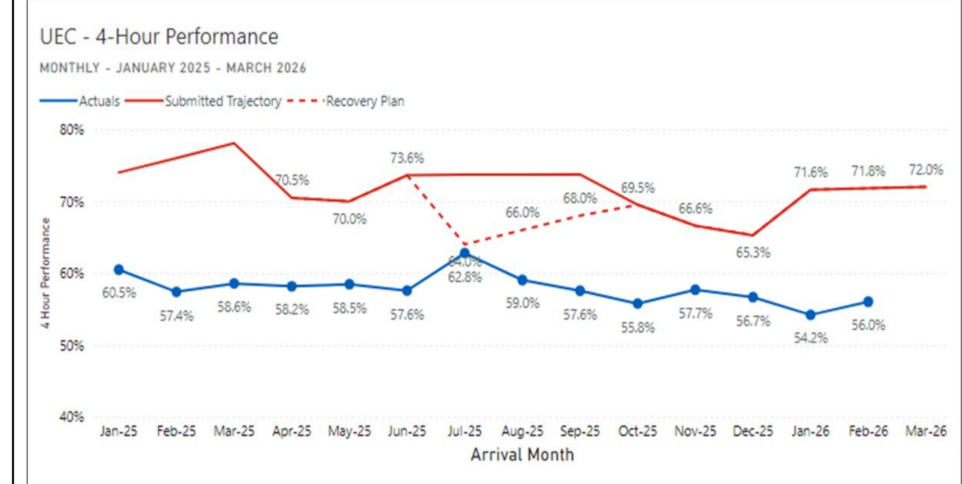
Risks and Mitigation

- 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

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





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

	Admit	Non-admit	Total	Target
ED	20.80%	29.19%	**24.98%**	**42%**
CED	71.38%	86.94%	**84.16%**	**95%**
UTC	76.49%	88.07%	**87.00%**	**95%**
Total	**31.56%**	**66.97%**	**56.02%**	**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

Countermeasures	Owner	Due Date
Implement the National Acuity Model to support triage and streaming. **Launched – ongoing optimisation, 15 trained.**	JR	Apr26
Overnight streaming observation and re-education. JR undertaking night shifts supporting proper process.	JR	Apr26
Plan and agree case for change supporting an EMAC model within current ED Obs footprint. **COMPLETE – continually improving ave. 19pts/day.**	MP	**Ongoing.**
Recruit 10.24 WTE registrars following business case approval. **IN PROGRESS – 10 WTE advertised.**	MP/BI	Mar27
Support implementation and monitoring of IPS 2025 via UEC Improvement Programme.	Leadership team	Mar26

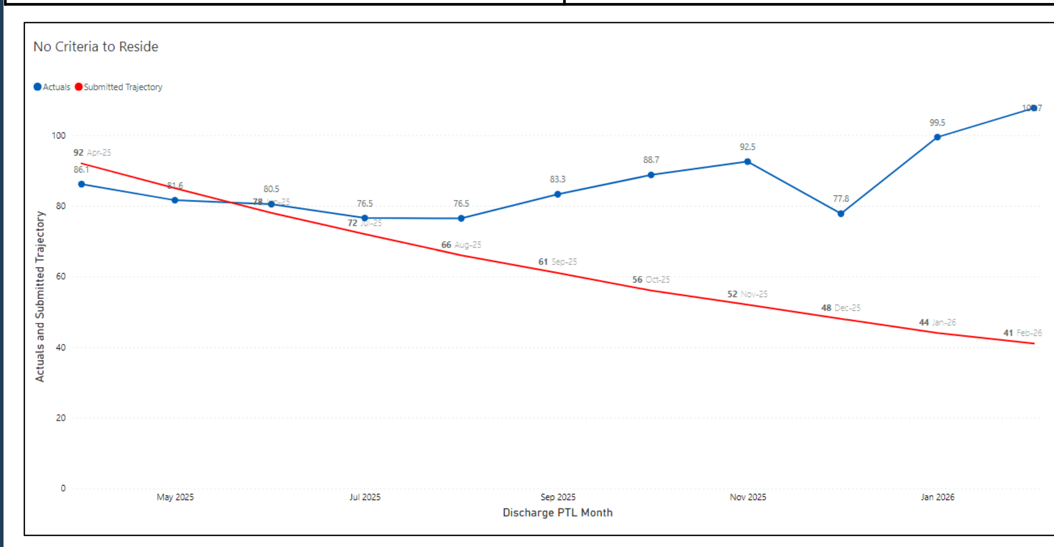
Risks and Mitigation

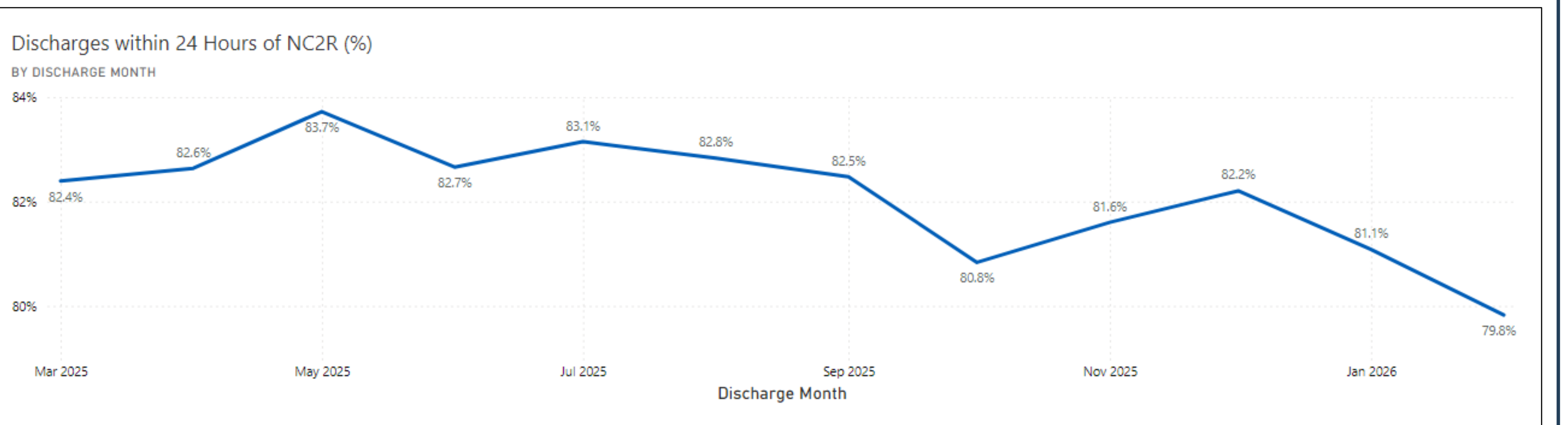
- Risk of increase mortality due to extended wait times in ED/UC.
- Risk of staff burnout and disengagement due to overcrowding.
  - UEC improvement programme to reduce overcrowding.

Non-Criteria to Reside

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 February 2026, the average number of NCTR patients per day was 108 an increase of 8.5 patients compared to January 2026, reflecting the winter increase in frail patient admissions and the impact of infection control on discharge. Discharge timelines for community pathways 1-2, deteriorated in February to 29.2% of patients discharging within 48 hours 45.2%. The performance target is that a total of 40 patients per day (community and hospital responsibility) are to be delivered in line with the BSW trajectory; in February, the daily average for community responsibility patients increased to 78 patients from 71 in January.*

UEC Delivery Group Driver Metric





Understanding Performance

Blockers to achievement:
Community capacity for pathway 1 and 2 patients, in both the Wiltshire and BANES locality; the RUH referral demand exceeds available capacity. St Martins Ward 4 opened at the end of December 2025 for Wiltshire and BANES P1 and P2 patients awaiting a date for discharge or with a planned future discharge date, the aim in Q4 25/26 to provide additional capacity and support RUH occupancy reduction. The capacity is therefore due to close 31st March 2026, and without additional community capacity there is a risk to April community responsibility NCTR occupancy increasing.

Improved performance:
Hospital responsibility NCTR has increased by one patient to a daily average of 29 patients, and in February, despite this increase, 93.7% of the hospital responsibility patients were discharged within 24-hour hours of non-criteria, 97.3% within 48 hours and 99.0% within 7 days.

Countermeasures	Owner	Due Date
Clinical Operational Standards/IPS and the Clinical and Operational Standards, more specially the long length of stay review process (> 21 days) to ensure next steps re completed to impact on the reduction in NCTR hospital and Community	SH	Launch 30/03/26
Providing a single source of the NCTR position. Roll out of the NHS Federated Data Platform Optimised Patient Tracking and Intelligent Choices Application (OPTICA) which has been implemented at the RUH, to all locality partners to establish an accurate and reliable data system to identify and track patients without criteria to reside. Providing a single source of the NCTR position. Project resource identified who started January 2026 to support implementation. Aim to implement April 2026 when HCRG change care transfers hub processes.	SH	28 April 2026
NCTR patient discharge planning and the opportunities to increase the number of discharges before midday and or early transfer to the discharge lounge to support early flow out of ED and Assessment Units.	SH	28 April 2026

Risks and Mitigation

Non-delivery of the BSW community responsibility NCTR reduction trajectory to deliver the equivalent of 40 patient per day (or 9% of the non-elective bed base). The impact of which will be the non-closure of escalation and core bed capacity.

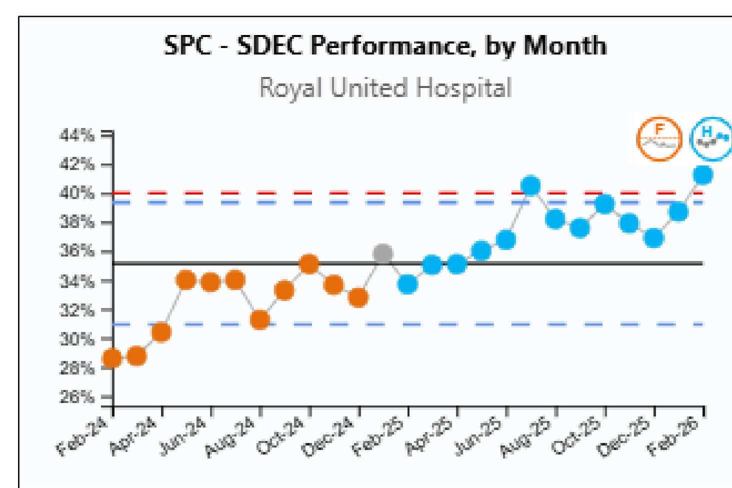
SDEC

Royal United Hospitals Bath NHS Foundation Trust

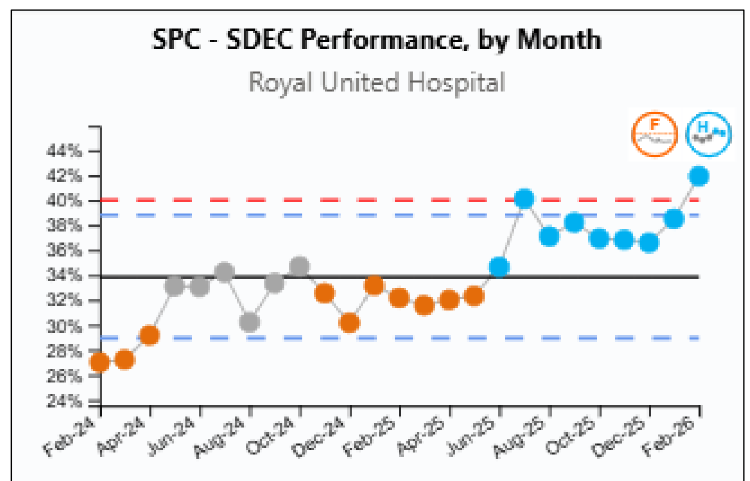
We are driving this metric because..	*SDEC models are a credible alternative to admission which are known to improve exit block and flow from ED. They support UEC recovery by reducing long waits in ED which are associated with worse patient outcomes and increased mortality. They can support in reducing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

UEC Delivery Group Driver Metric

Trust Wide SDEC Performance February 2026: **41.3%** against a target of 40%



Medicine Division SDEC Performance February 2026: **41.9%** against a target of 40%



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

Service / Monthly Activity	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26
Medical SDEC (previously Amb Care/DAA)	720	761	686	739	799	679
Frailty SDEC (OPRAA and OPAU)	39	37	30	24	22	23

Understanding Performance

- The overall Trust SDEC performance has exceeded the 40% target in February at a value of 41.3%, supported by a SDEC performance in Medical Division of 41.9%. This is the highest SDEC performance ever achieved.

Ongoing Improvement blockers:

- Reduced Medical SDEC capacity due to Consultant vacancies
- High use of SDEC trolleys overnight continued in February (23 nights had >5 patients in trolleys overnight) which reduces SDEC effectiveness in the morning. There were several occasions where all thirteen trolleys were used overnight. Average LOS on a trolley has come down slightly in February but remains high at 13.6 hours. Both measures are demonstrating high demand and challenges in achieving patient flow from the assessment areas.

Countermeasures

Countermeasures	Owner	Due Date
Acute Medicine consultant post and other Resident Doctor posts are out to advert.	CY	24/5/26
Change in MSS SBAR approved by Execs – due to start 3/11/25 – to release Acute Medical Consultants to focus on SDEC and MAU.	FM	On pause due to securing locum for MSS (extension to September approved)
Continued Integrated Front Door (IFD) working, GIRFT support and actions related to RAT/streaming	BI, CY, RK	Ongoing
BSW SDEC Oversight and Working Group - to ensure a consistent BSW delivery against the national requirements	CY and RK	Being reviewed (? To be BSW or Group led)
Six-month Review of MSDEC	CY	28/3/26 (delay due to CI)

Risks and Mitigation

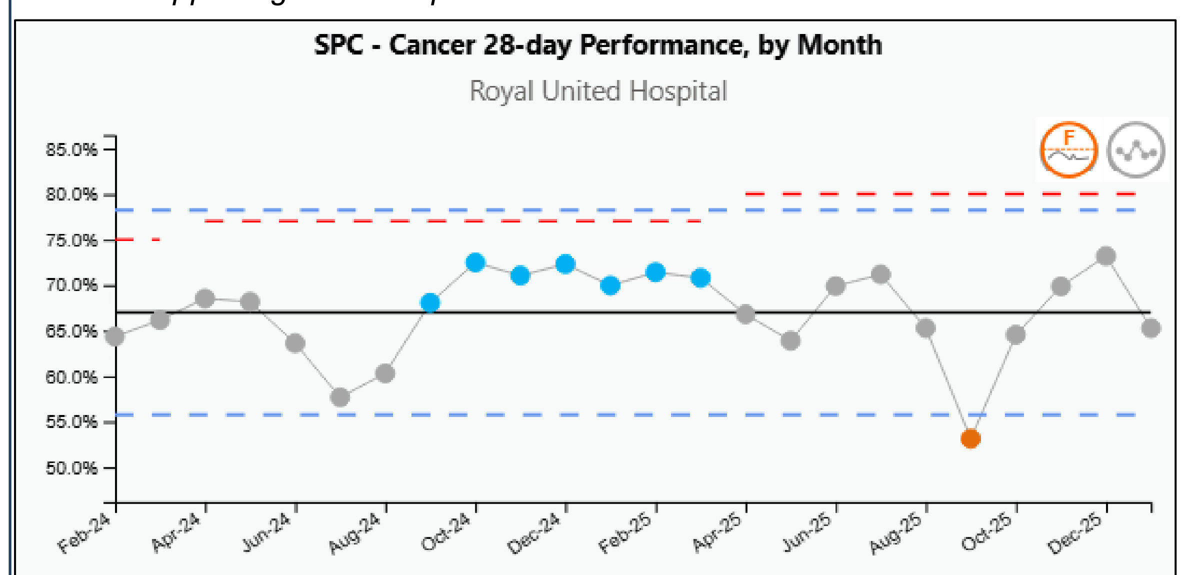
Consultant recruitment (acute med)
High risk of impact
Using consultant funding differently: 0.4 ST3+ recruited, 0.53 ST3+ being recruited, 1.0 Chief Reg requested
Opportunity for shared recruitment/job plans (Cardiology, ITU)

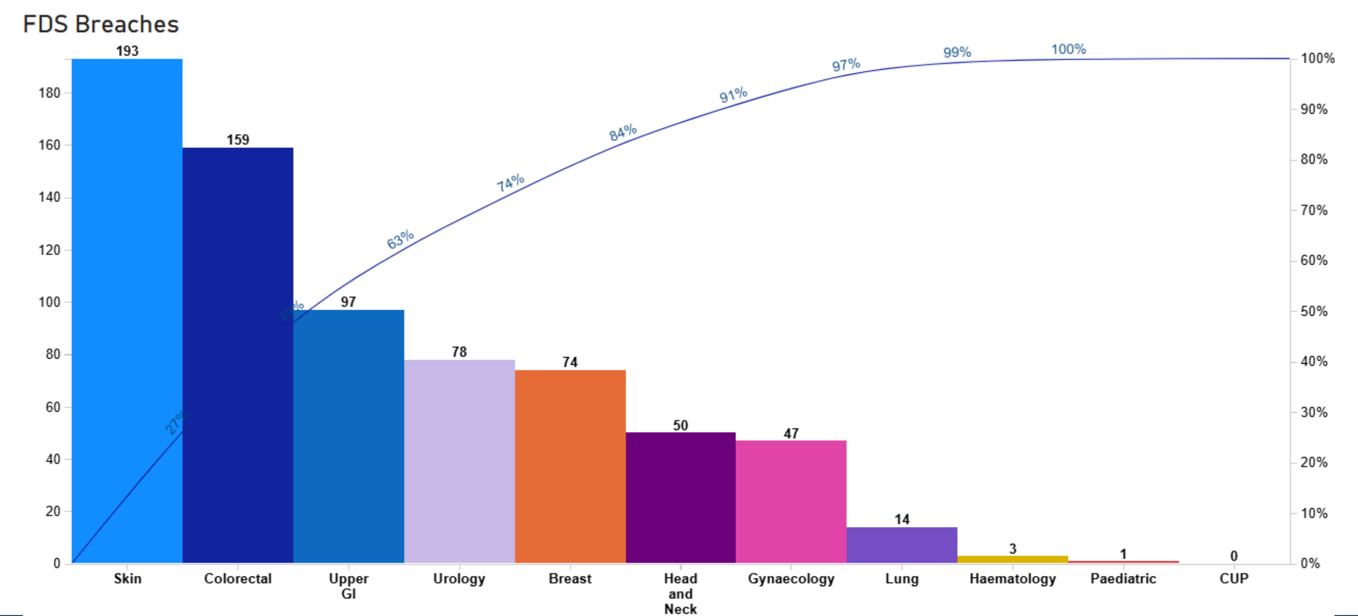
Flow from SDECs to specialty beds
High risk of impact
Site aware
SOPs to be followed

28 Day Cancer Performance

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

SPC & supporting data if required





Understanding Performance
Performance deteriorated in January to 65.5%, remaining below trajectory **Top contributors:** Colorectal, Skin, Upper GI, Urology **In month challenges:** • Breast above target at to 87.1%. Further improvement from February with one-stop wait at 12 days. • Colorectal at 46.3%. Endoscopy reduced to 12 days. CTC utilisation pilot helping to reduce CTC waits to 10 days. • Skin deterioration to 59.5% following OPA waits increase due to high demand/Christmas leave – recovered in Feb. • Upper GI impacted by endoscopy waits at Sulis over Christmas. • MRI scan/report at 15 days and LATP increase to 21 days following additional MRI reporting.

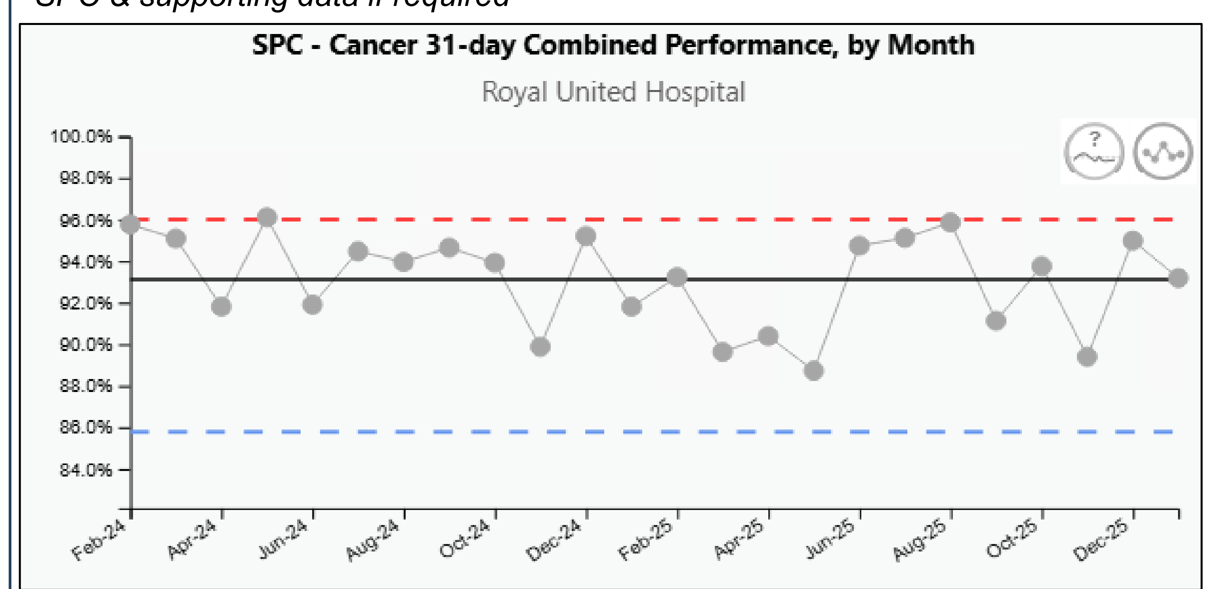
Countermeasures	Owner	Due Date
Breast locum consultant extension / recruitment	HW	April 2026
GWH endoscopy mutual aid continuing	TS	March 2026
Gastro consultant recruitment	TS	April - June 26
CTC patient contact pilot – funding to extend to May	EN	May 2026
Dermatology additional insourcing for OPA	GJ	April 2026
Skill-mixing / recruitment of non-medical staff	GJ	October 2026
Increased endoscopy insourcing	TS	March 2026
LATP nursing bid 3.88 WTE through business planning	KR/EJ	April 2026
Locum consultant recruitment	KR	August 2026

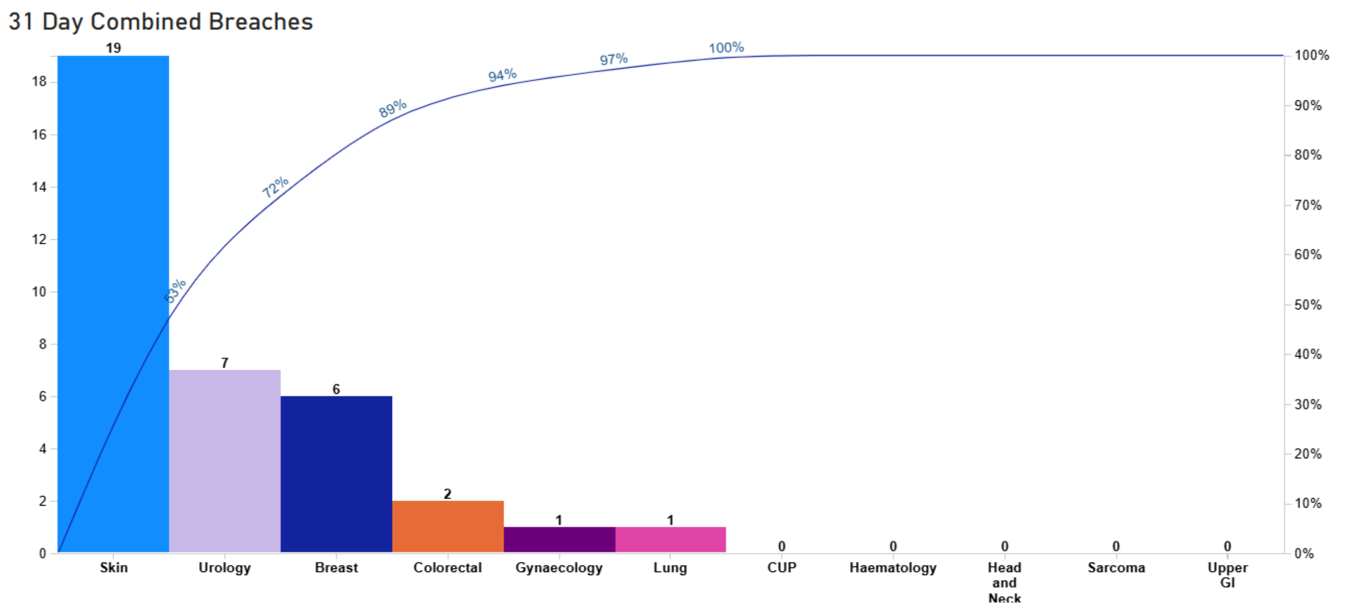
Risks and Mitigation
Risks: • Demand increase • Financial position • Recruitment, recruitment, depending on WLIs, locums, in / outsourcing • Pressures from RTT, DM01 • IT capacity – group model **Mitigation:** • SWAG/NHSE funding for WLIs, locums, in / outsourcing • Telederm • Pathway change (Gynaecology / Prostate / Colorectal)

31 Day Cancer Performance

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

SPC & supporting data if required





Understanding Performance

Performance slight reduction to 93.6% following Breast surgical breaches

Top contributors:
Breast, Skin

In month challenges:
- Breast fractionally below national standard as waiting times for some surgical patients just above 31 days.
- Short notice ending of locum contract – new locum being sourced to replace.
- Additional MOPS capacity to treat long waiting Skin patients across December-March.
- MOPS capacity planned into 26/27.

Countermeasures	Owner	Due Date
Theatre WLIs Additional substantive consultant business case New locum consultant appointment	HW HW HW	March 2026 April 2026 April 2026
Skin MOPS insourcing Dermatology workforce skill-mix	GJ GJ	March 2026 October 2026
Urology locum consultant recruitment	KR/EJ	August 2026

Risks and Mitigation

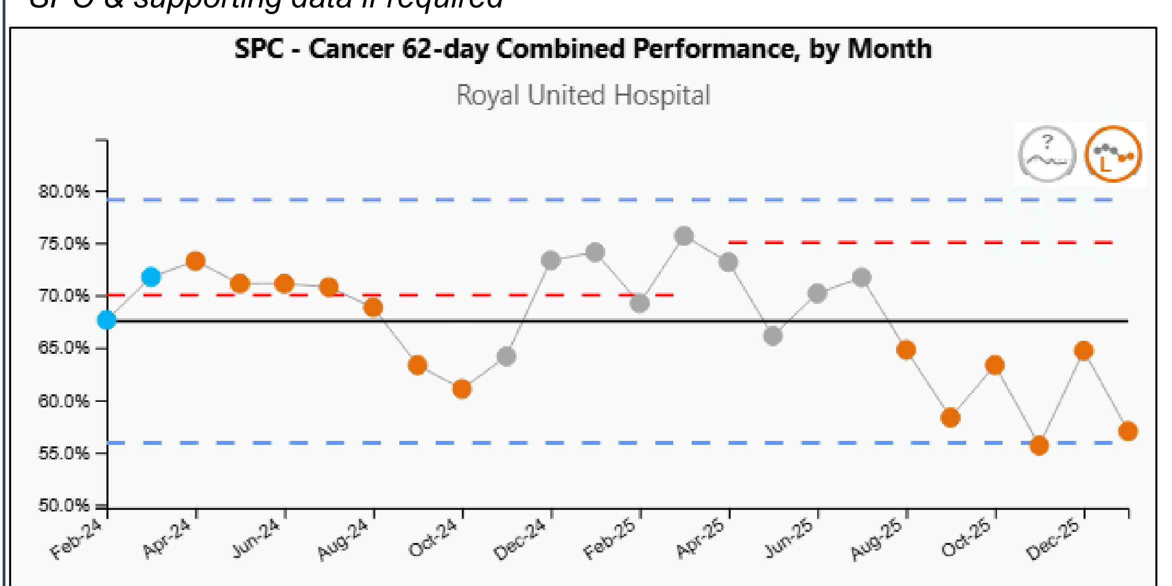
Risks:
- Demand increase
- Sickness
- In/outsourcing, locum, WLI dependency
- Increases in referral for procedures from locums
- Pressures from RTT
- Chemo/RT demand increase

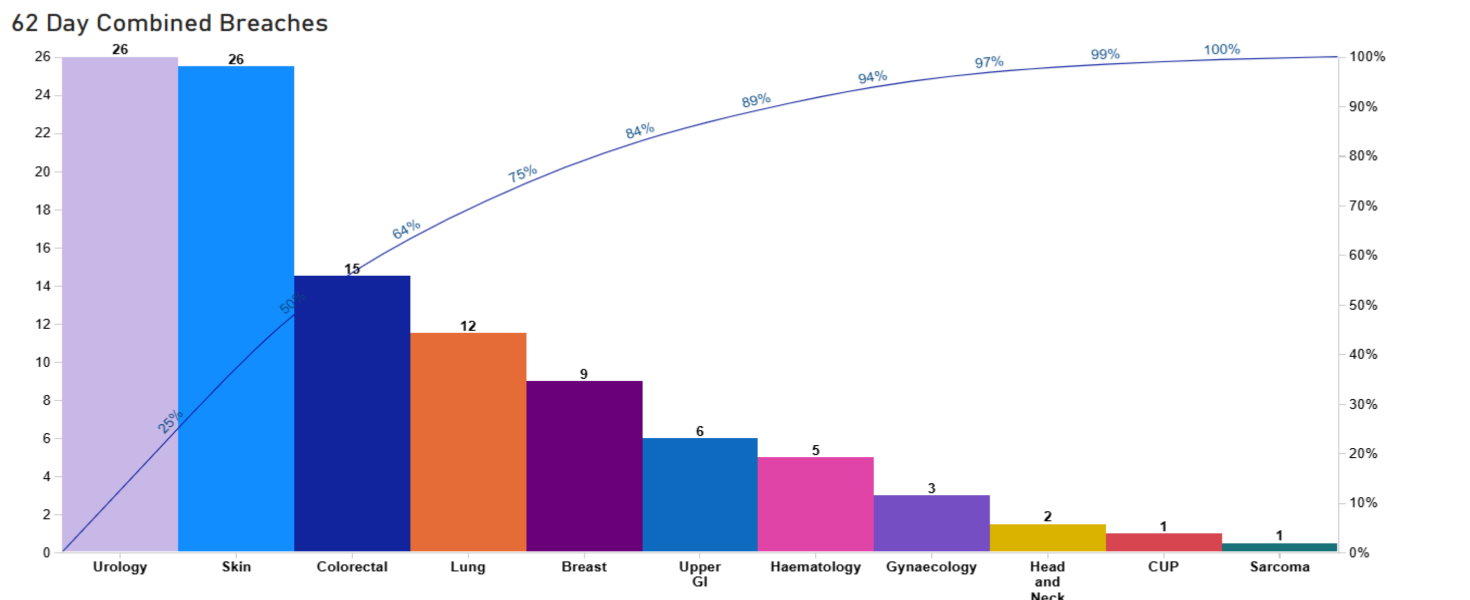
Mitigation:
- WLI, in/outsourcing and locums
- Long term workforce planning
- Telederm

62 Day Cancer Performance

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

SPC & supporting data if required





Understanding Performance

Performance reduced to 57.4%

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

- Breast improved, now achieving standard. Reduced one-stop waiting support better performance but increased demand impacting surgical waiting times.
- Colorectal reduced to 40.8%. Main delays in diagnostic pathway – long endoscopy waits now improved with insourcing, ringfenced capacity, GWH mutual aid.
- Diagnostic pathway delays impacting Lung patients –oncology treatment WLIs to reduce end of pathway waits.
- Skin OPA/MOPS impacting performance – OPAs now reduced to <14 days and MOPS <25 days.
- Prostate MRI scan/report and LATP most consistent cause for breaches.

Countermeasures	Owner	Due Date
Breast locum consultant extension / recruitment	HW	April 2026
Breast theatre WLIs	HW	March 2026
Gastro consultant recruitment	TS	April - June 2026
Endoscopy increased insourcing	TS	March 2026
Chemo and Radiotherapy WLIs	AF	March 2026
MOPS insourcing	GJ	March 2026
Dermatology workforce skill-mix	GJ	October 2026
LATP nursing bid 3.88 WTE through business planning	KR/EJ	April 2026
Urology locum consultant recruitment	KR	April 2026

Risks and Mitigation

Risks:

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

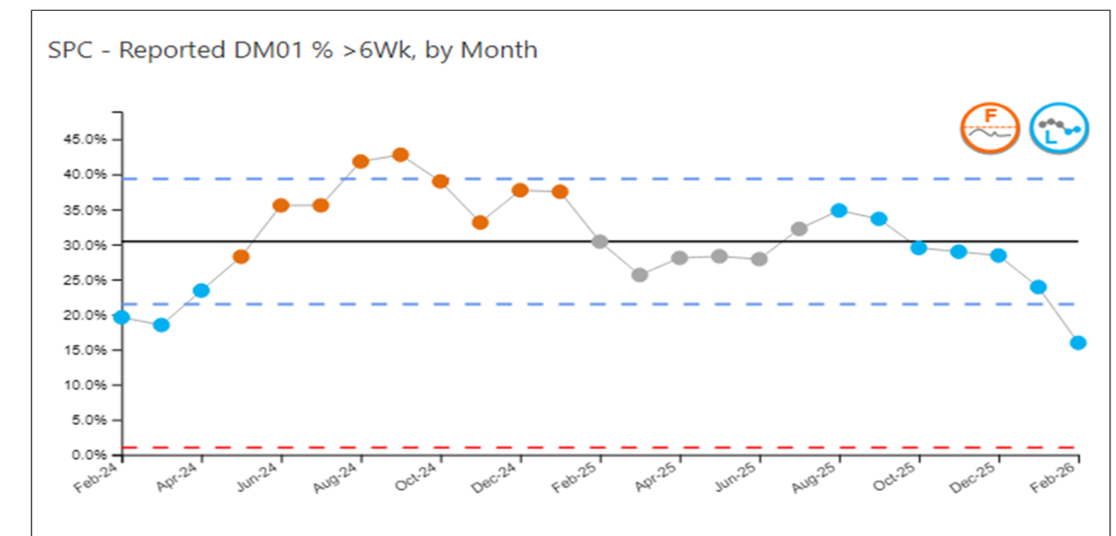
Mitigation:

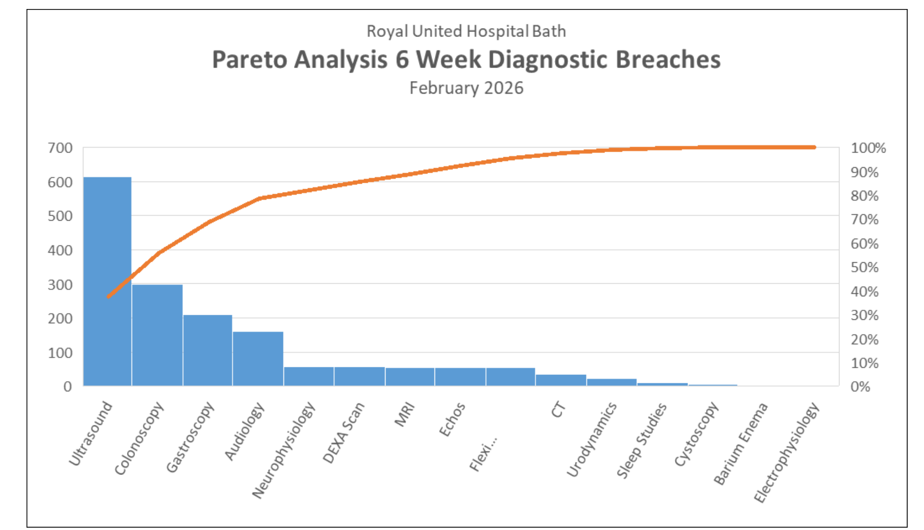
- WLI, in/outsourcing, locums
- Workforce planning
- Pathway change (Breast / Gynaecology / Prostate / Colorectal)

Diagnostic waits

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 February 2026, 84.05% of patients received their diagnostic within the 6-weeks against the 80.8% target.
- Performance improved 7.95% from January 26.
- DM01 trajectory reviewed to account for additional demand (RTT schemes) and mitigation (additional capacity) - end of year target 84.1% compliance.
- USS, MRI, Echo, Audiology and Cystoscopy performing above plan.
- The **top contributors** to 6-week breaches were USS, Audiology and Endoscopy.
- Key drivers of underperformance were:
  - Endoscopy behind on activity delivery.
  - Increased demand for diagnostic tests.

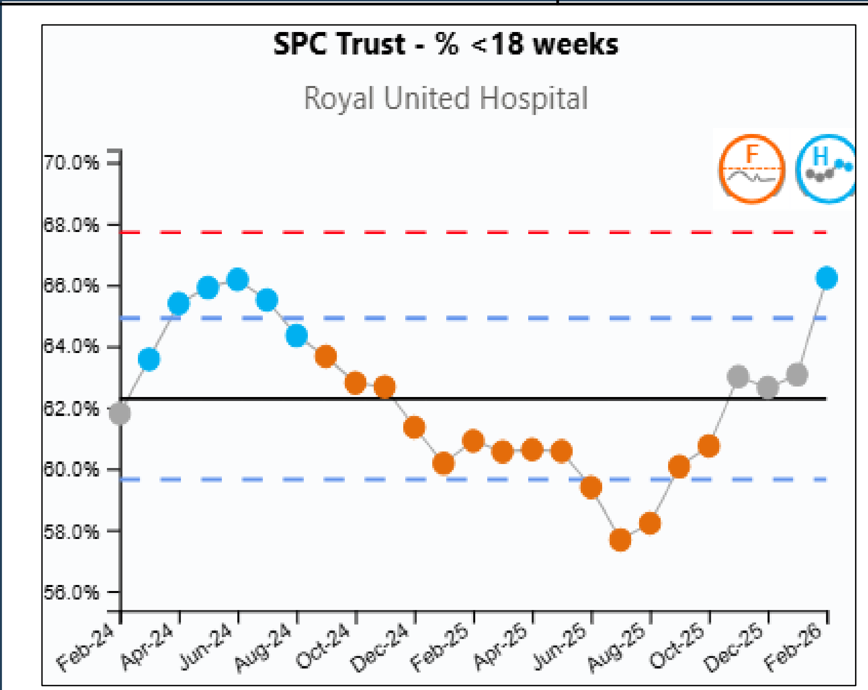
Countermeasures	Owner	Due Date
Continuation of WLIs for USS, MRI and Echo.	NA/CF	In place
USS insourcing at weekends Additional USS activity at Sulis CDC in-week (insourcing) in place since August 2025 - additional 7 days/week mobilisation form January 2026 (extra room, doubles capacity)	PN/NA SH/NA	In place From August 2025
Transfer of Sleep Studies activity to Sulis CDC (still waiting to recruit physiologists)	Sulis CDC	Q4 25/26
Weekly review of each modality – performance, demand and activity against trajectory. (~3% performance gain)	NA/JS	In place

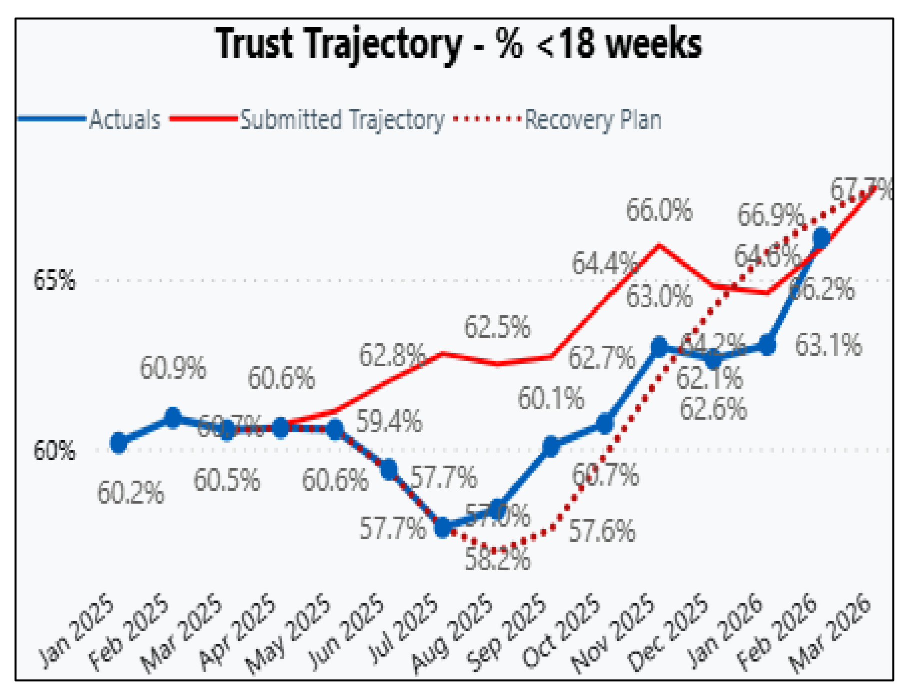
Risks and Mitigation

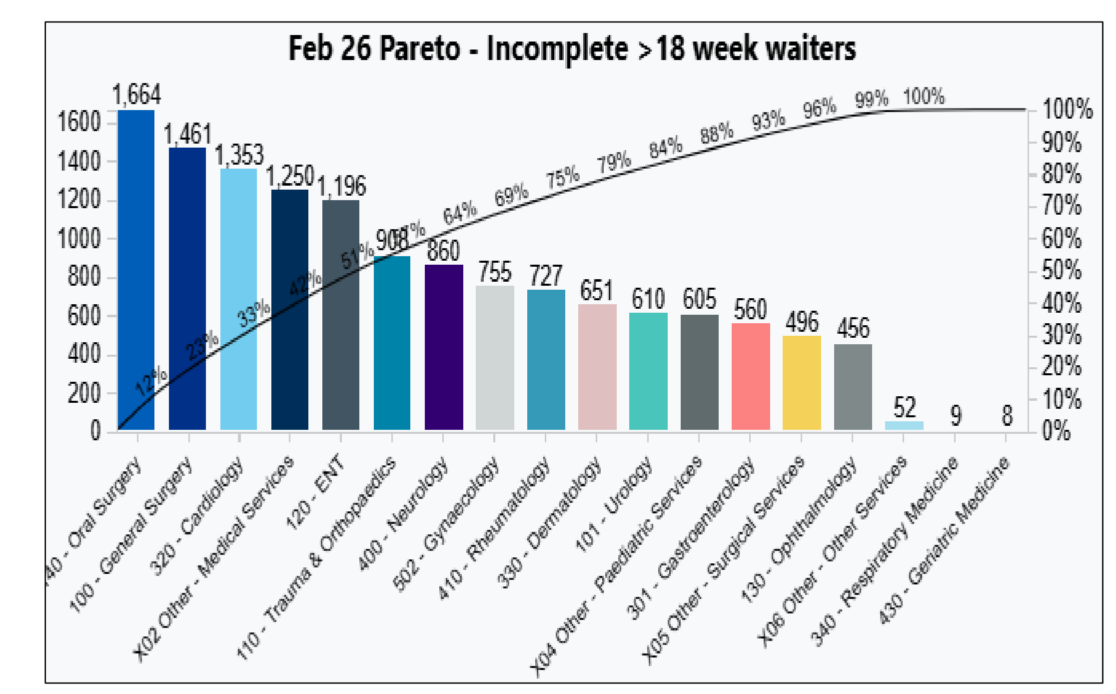
- **Risks:**
  - Sickness
  - Increased demand
  - USS staffing
  - Additional strikes
  - Delay to additional capacity schemes (USS, Echo, Endo)
- **Mitigations:**
  - Additional capacity at Sulis (USS, CT, MRI and Echo)
  - Insourcing scheme for Echo (RUH)

Referral To Treatment (RTT) 18 weeks

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 February was 66.2% vs trajectory of 65.9%. This is 3.2% increase on the previous month
- The top Contributors to over 18 week breaches were in the following 4 specialties
  - Oral Surgery 1664
  - General Surgery 1461
  - Cardiology 1365
  - ENT 1196

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

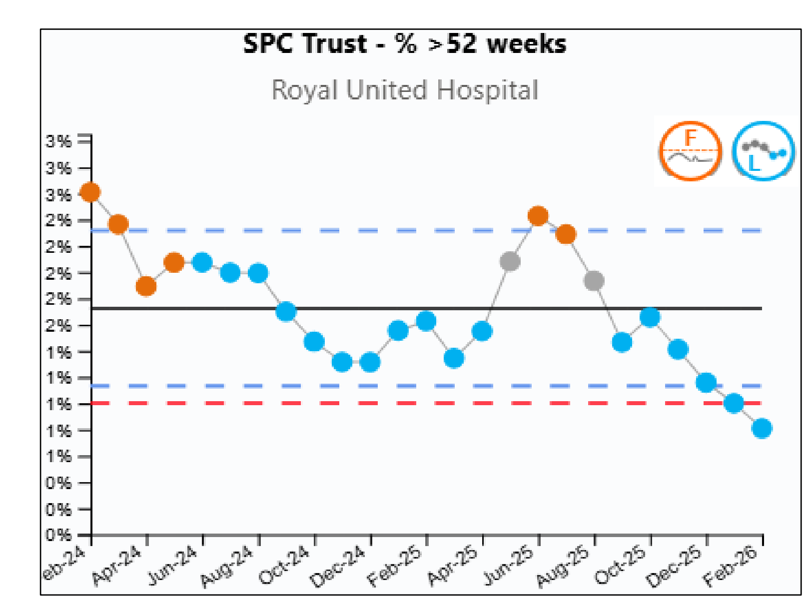
Risks and Mitigation

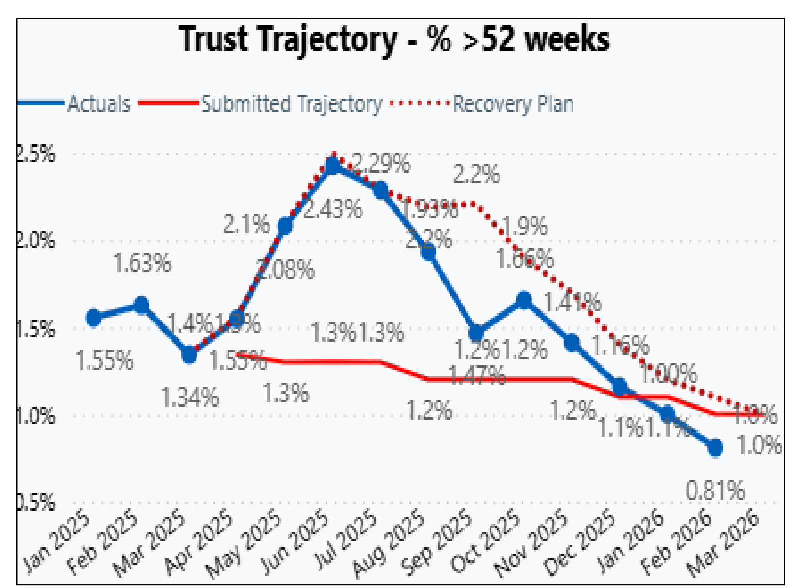
Risks:
- Radiology capacity for routine patients v. cancer pts
- Specialist radiology capacity
- Physical space for gastro, ENT and general surgery

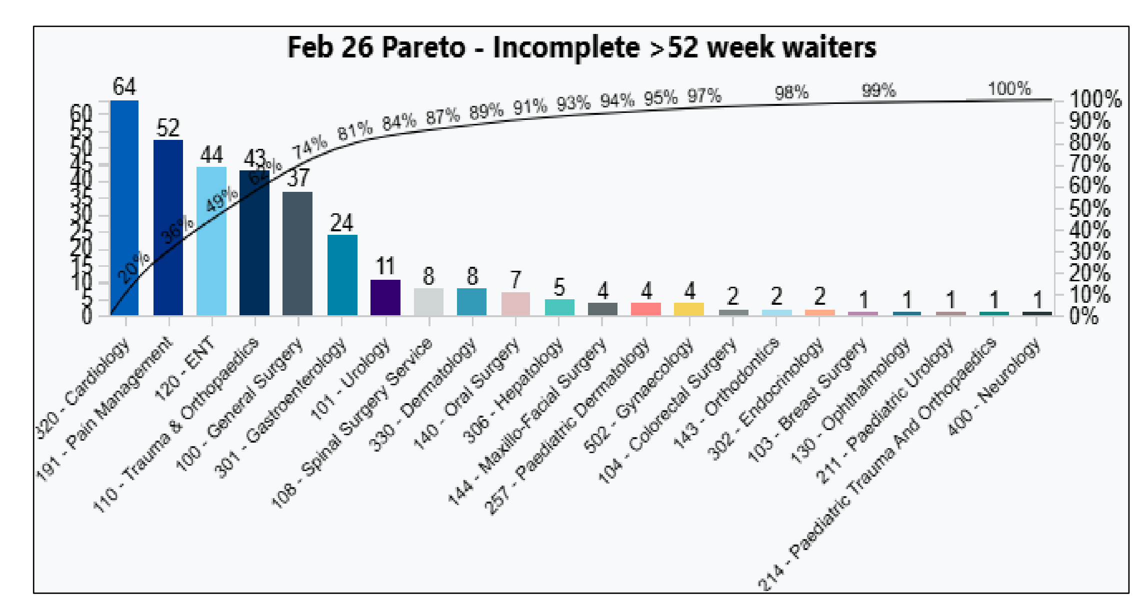
Mitigation:
- ENT patients transferred to Sulis for 1st OPA where triaged as suitable

Referral To Treatment (RTT) over 52 weeks

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 402 to 326 (-19%).
- 0.8% of total RTT patients have waited >52 weeks vs target of <1%, Trajectory of 1%, Recovery Plan 1.1% for February
- The top contributors to >52-week breaches: Cardiology, Pain, ENT and T&O:
    - Cardiology decreased from 66 to 64 (-3%)
    - Pain decreased from 74 to 52 (+30%)
    - ENT decreased from 48 to 44 (-8%)
    - T&O increased from 45 to 51 (+13%)

Countermeasures	Owner	Due Date
Cardiology – super clinics provided for longest waiting patients	CF	Mar 26
Gastro – additional management support including weekly recovery meetings	TS	Mar 26
Pain – weekly PTL meetings with NHSE, support from Sulis with suitable procedures. Insourcing to commence Feb 26 to support wait to 1st OPA	KM/ST	Mar 26
Additional WLI theatre lists for longest waiting patients in ENT	NG	Mar 26

Risks and Mitigation

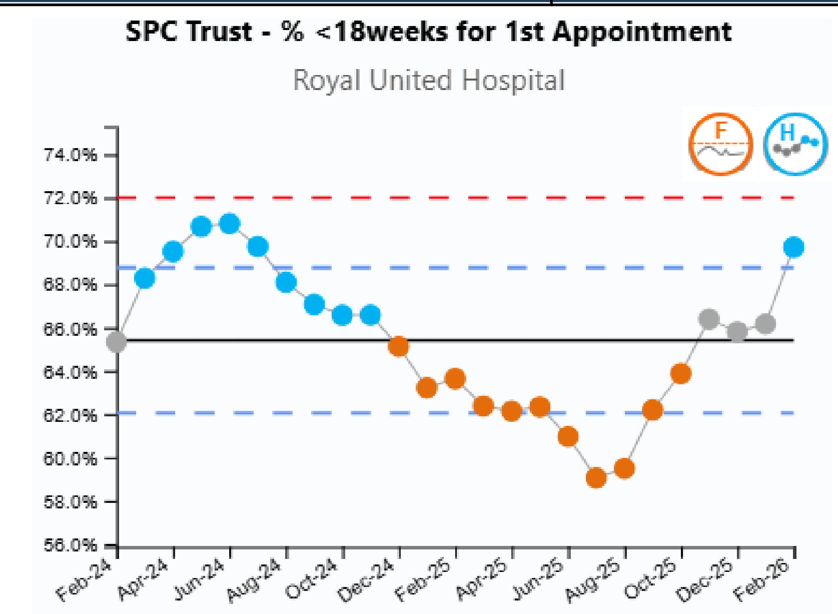
Risks:
- Routine radiology capacity including reporting
- Complexity of some gastro patients requiring multiple diagnostics
- ENT outpatient capacity for Paediatrics (age limitations)

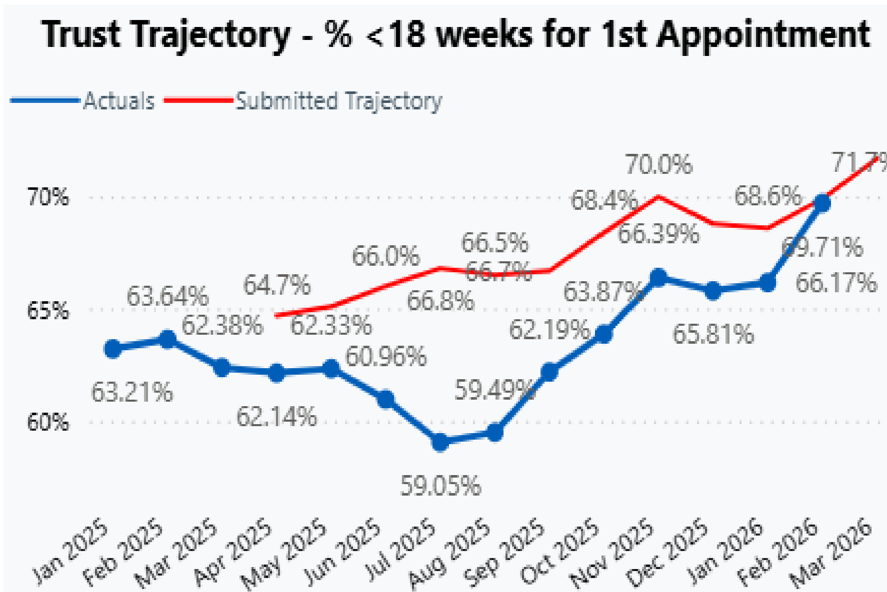
Mitigations:
- Support from Sulis for suitable pain procedures

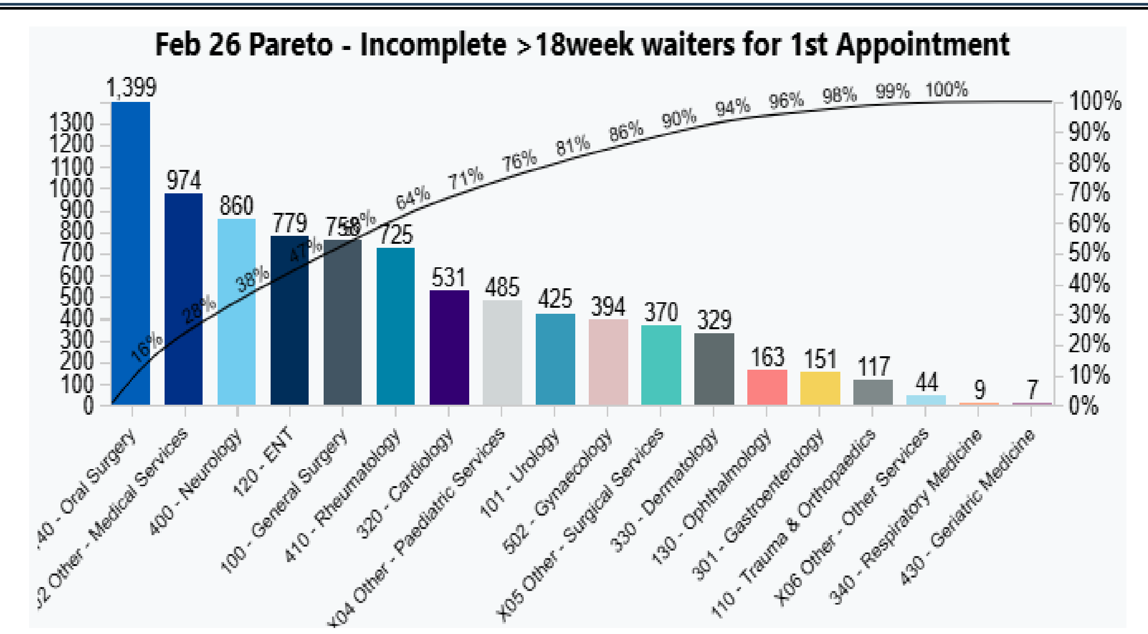
Referral To Treatment (RTT) Wait to 1st Outpatient Appointment

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

- 69.7% of patients were waiting <18 weeks for a 1st outpatient appointment vs a target of 72%, trajectory of 69.9% for February. This is +3.5% on the previous month
- The top contributors of over 18-week breaches for 1st appointments were
  - Oral Surgery 1399
  - Neurology 860
  - ENT 779
  - General Surgery 758
  - Pain 723

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

Risks and Mitigation

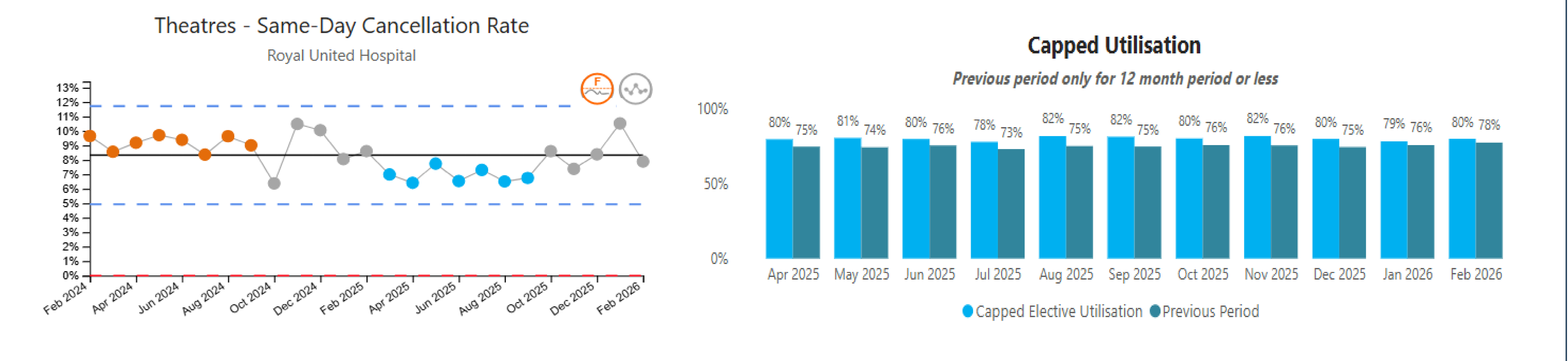
Risks:
- Multiple diagnostics in Cardiology pathway
- Conversion to procedures for Pain patients
- Radiology capacity

Mitigations:
- SBAR for additional specialty Dr in Oral Surgery

Theatre Utilisation

We are driving this metric because.. Performance Target: capped utilisation 85 %	*Theatre utilisation is a key metric to drive a reduction in waiting lists and reduce costs and year to date utilisation is steadily improving but remains below the 85% target, this remains an opportunity to optimise capacity, reduce delays, and enhance efficiency.*

Theatres Delivery Group Driver Metric



Understanding Performance

- Capped utilisation was at 79.5% on Model Hospital for January - this reflects the continued challenging operational pressures in month and was affected by increased cancelations – it is better than the same period previous year
- Cancelations in February have improved and are back to within target
- Recruitment within the elective booking team has continued

Countermeasures

Countermeasures	Owner	Due Date
Areas of focus are within Ophthalmology and Gynaecology – review of practice and HVLC process adoption- additional cases up to GIRFT levels now regular practice A further process review for ophthalmology is being adopted as an improvement to support these HVLC lists	DL, KR	March 26
Recruitment into Inpatient booking team Keeping focus on current vacancies to try and get to full establishment	AD, LP	March 26

Risks and Mitigation

Risk: Trust site situation is improving and PY reopening will allow Orthopaedic joint replacement to restart

Mitigation:
Continued close work with wards and SSU to support flow through theatres

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%		Feb-26	22.3%	X	F		Common Cause Variation
People we care for	% No criteria to reside Adult G&A occupied beds		10.0%		Feb-26	22.9%	X	F	H	Special Cause Concerning - Above Upper Control Limit
People we care for	% of patients waiting >12hrs in ED		0.0%		Feb-26	12.7%	X	F	H	Special Cause Concerning - Above Upper Control Limit
People we care for	% with Discharge Summaries Completed within 24 Hours				Feb-26	83.8%			L	Special Cause Concerning - Two Out of Three Low
People we care for	A&E Arrivals - Ambulance (av per day)				Feb-26	89			H	Special Cause Concerning - Above Upper Control Limit
People we care for	Adult % G&A bed occupancy		92.0%		Feb-26	97.9%	X	F		Common Cause Variation
People we care for	Mean time in ED - >75y				Feb-26	599			H	Special Cause Concerning - Above Upper Control Limit
People we care for	Mean time in ED - Admitted (mins)				Feb-26	587			H	Special Cause Concerning - Above Upper Control Limit
People we care for	Mean time in ED - Mental health				Feb-26	717			H	Special Cause Concerning - Above Upper Control Limit
People we care for	Mean time in ED - Not Admitted (mins)				Feb-26	258			H	Special Cause Concerning - Above Upper Control Limit
People we care for	Non Elective Length of Stay		8.4		Feb-26	9.1	X	?		Common Cause Variation

Alerting Watch Metric Commentary

Understanding Performance and Countermeasures

Provisional alerting watch metrics (flagged in September)

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

Understanding Performance and countermeasures

- The number of patients in the Emergency Department awaiting admission over 12 hours from decision, increased significantly in January to 328 and has reduced in February to 219 patients due to an increase in ambulance arrivals, increase in admission rate (35%), increase in the number of beds affected and empty due to IPC restrictions, and an overall increase in community responsibility NCTR all contributing to an increase in admission demand and a reduction is bed availability. Despite most weekdays in January achieving c90+ discharges per day.

- The median time in ED was 226 minutes for all pathways in February (232 in January); 193 minutes for non-admitted and 435 minutes for admitted.

- Adult general and acute bed occupancy in February was 97.9% (98.35% in January). Occupancy does not reflect the use of additional escalation capacity (winter 2025/26 accessing up to 69 escalation/ED Corridor/pre-emptive moves to inpatient wards/planned winter escalation and space accessed due to business continuity/critical incident.

- Initiatives to improve discharges by midday are being led by the Clinical Divisions (including the work on board and ward rounds), Clinical Site Team, Discharge Liaison Team and supported through the daily performance and flow meeting to improve discharge rate (23% February 2026) and sustained use of the discharge lounge (c40 patients transferring weekdays with a peak of 43 patients in February). Continued focus on P0 no criteria patients with wards, therapy and discharge liaison teams, that are hospital responsibility, to sustain and improve upon discharges within 24 hours of NCTR (February 93.7%).

- % Discharge summaries completed within 24 hours in February 2026 was 84.1% (84% in January 2026).

- Average monthly occupancy in January 2026 for RUH Hospital at Home was 118% (62 beds = 100% capacity). In February there were 192 admissions and an average of 6.9 admissions per day. Hospital at Home have started some surgical pathways too, including pancreatitis and diverticulitis which are working well.

- The Trust reported zero 65-week waiters at the end of February. Close monitoring continues to ensure this trend continues throughout Q4.

Non-Alerting Watch Metrics

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				Feb-26	78.3%				Common Cause Variation
People we care for	A&E Arrivals - Walk ins (av per day)				Feb-26	207				Common Cause Variation
People we care for	Number of 52 Week Waiters Incomplete Pathways				Feb-26	326				Special Cause Improving - Below Lower Control Limit
People we care for	Number of 65 week waiters incomplete pathways			0	Feb-26	0	✓			Special Cause Improving - Below Lower Control Limit
People we care for	RUH hospital at home team occupancy	Average occupancy	62.0		Feb-26	73.2	✓			Special Cause Improving - Above Upper Control Limit
People we care for	Weekend discharge %				Feb-26	19.7%				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

Quality Report

March 2026 (February 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%		Feb-26	87.9%	✗			Common Cause Variation
People we care for	% of ED admissions <60mins from CRtP		80.0%	80.0%	Feb-26	58.0%	✗			Common Cause Variation
People we care for	Early Identification of Deteriorating Patient	NEWS 5+ Screening Completed in 30 - Trust (%)			Feb-26	24.0%				Special Cause Concerning - Two Out of Three Low
People we care for	Flu - Healthcare Onset (+3 days)				Feb-26	46				Special Cause Concerning - Above Upper Control Limit
People we care for	Medication Incidents per 1000 bed days		7.0		Feb-26	8.4	✗			Common Cause Variation
People we care for	Never events		0		Feb-26	1	✗			Common Cause Variation
People we care for	Number of complaints received		30		Feb-26	34	✗			Common Cause Variation
People we care for	Number of Hospital Acquired Pressure Ulcers Category 2		5		Feb-26	5	✓			Special Cause Concerning - Run Above Mean
People we care for	Readmissions - Total		10.5%		Jan-26	10.1%	✓			Special Cause Concerning - Above Upper Control Limit
People we care for	Serious incidents with overdue actions		5		Feb-26	7	✗			Common Cause Variation
People we care for	SHMI				Oct-25	105.6%				Special Cause Concerning - Above Upper Control Limit
People we care for	Total monthly fill rate, day hours, RN		90.0%		Feb-26	81.7%	✗			Special Cause Concerning - Below Lower Control Limit
People in our community	% Difference in 28 Day Diagnosis Performance between IMD 1-2 vs IMD 9-10		0.0%		Jan-26	-2.4%	✗			Common Cause Variation
People in our community	% Difference in DNA rates between IMD1-2 and IMD 9-10		0.0%		Feb-26	4.1%	✗			Common Cause Variation

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

Strategic Goal	Measure	Measure Description	Local Year-End Target	National Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
People we care for	% of ED patients assessed < 15mins				Feb-26	67.1%				Special Cause Improving - Two Out of Three High
People we care for	Concerns are acknowledged within 2 working days		90.0%		Feb-26	98.0%	✓			Common Cause Variation
People we care for	Mixed Sex Accommodation Breaches				Feb-26	143				Special Cause Improving - Run Below Mean
People we care for	Number of reopened complaints each month		3		Feb-26	1	✓			Common Cause Variation
People we care for	Scanning Compliance for patients being given medication				Feb-26	63.0%				Special Cause Improving - Above Upper Control Limit
People we care for	Total monthly fill rate, day hours, HCA		90.0%		Feb-26	91.3%	✓			Special Cause Improving - Above Upper Control Limit
People we care for	Total monthly fill rate, night hours, HCA		90.0%		Feb-26	106.2%	✓			Special Cause Improving - Above Upper Control Limit
People we care for	Total monthly fill rate, night hours, RN		90.0%		Feb-26	93.5%	✓			Common Cause Variation
People in our community	Reduction in Agency Expenditure	Agency as % of Total Pay			Feb-26	15.0%				

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

Strategic Goal	Measure	Measure Description	Local Year-End Target	National Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
People we care for	Clostridium Difficile Rate	Hospital or Community Onset, Healthcare Associated, per 100,000 beddays			Jan-26	43				Common Cause Variation
People we care for	E.coli bacteraemia Rate	Hospital or Community Onset, Healthcare Associated, per 100,000 beddays			Jan-26	18				Common Cause Variation
People we care for	Klebsiella spp Rate	Hospital or Community Onset, Healthcare Associated, per 100,000 beddays			Jan-26	24				Common Cause Variation
People we care for	MRSA Bacteraemias Rate	Hospital or Community Onset, Healthcare Associated, per 100,000 beddays			Jan-26	0				Special Cause Improving - Below Lower Control Limit
People we care for	MSSA Rate	Hospital or Community Onset, Healthcare Associated, per 100,000 beddays			Jan-26	24				Common Cause Variation
People we care for	Number of Hospital Acquired Pressure Ulcers Category 3		4		Feb-26	3	✓			Common Cause Variation
People we care for	Number of Hospital Acquired Pressure Ulcers Category 4				Feb-26	0				Special Cause Improving - Below Lower Control Limit
People we care for	Pseudomonas aeruginosa Rate	Hospital or Community Onset, Healthcare Associated, per 100,000 beddays			Jan-26	6				Common Cause Variation

Trust Scorecard - Quality Board Metrics (February 2026 Data)

Section Of Scorecard	Strategic Goal	Measure	Measure Description	Local Year-End Target	National Target	Month	Latest Performance	Target Met Last Month	Assurance	Variation	Variation Detail
National KPI	People we care for	% treated and admitted or discharged within four hours (To ensure 78% of patients can be treated within 4 hours of arrival at ED)		72.0%	95.0%	Feb-26	56.0%	X			Special Cause Concerning - Run Below Mean
National KPI	People we care for	28 day referral to informed of diagnosis of all cancers		80.0%	80.0%	Jan-26	65.6%	X			Common Cause Variation
National KPI	People we care for	Average Handover Time for All Arrivals (mins)	Average ambulance handover time (mins)	33		Feb-26	71	X			Common Cause Variation
National KPI	People we care for	Combined 31 day cancer targets for first treatment, subsequent surgery, subsequent drug, subsequent radiotherapy and subsequent other treatments; excludes subsequent active monitoring and subsequent palliative care		90.0%	90.0%	Jan-26	93.2%	✓			Common Cause Variation
National KPI	People we care for	Combined 62 day cancer targets for GP referral, screening and consultant upgrade		75.0%	75.0%	Jan-26	56.8%	X			Special Cause Concerning - Two Out of Three Low
National KPI	People we care for	Diagnostic tests maximum wait of 6 weeks		95.0%	95.0%	Feb-26	84.0%	X			Special Cause Improving - Increasing Run
National KPI	People we care for	RTT - Incomplete Pathways over 52 weeks		1.0%		Feb-26	0.8%	✓			Special Cause Improving - Below Lower Control Limit
National KPI	People we care for	RTT – wait to 1st OP appointment	% patients waiting <18 weeks for their first OP appt	72.0%	72.0%	Feb-26	69.7%	X			Special Cause Improving - Above Upper Control Limit
Vision	People we care for	% Key national standards met in the month		100.0%		Feb-26	33.3%	X			
Vision	People we care for	% of positive responses to friends and family test	Improve the experience of those who use our service			Feb-26	97.0%				Special Cause Improving - Above Upper Control Limit

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

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

Readmission Rate

The readmission rate within 30 days of discharge, has been increasing since April 2025; April 2025 8.3% and February 2026 9.59%. Please note that the February position is subject to change, as is dependent upon the clinical coding backlog. The increase since April 2025 is driven by an increase for patients who had a zero-day length of stay being re-admitted; more specifically, and based on the specialty level data, those patients who have gone through a same day emergency care (SDEC) pathway or short stay pathway in an assessment area. The increase correlates to the opening of the expanded Medical SDEC area in May 2025 and an overall increase in attendances through all SDECs this financial year. An increase in readmission is expected when increasing SDEC activity. The February 2026 position is noted to have increased, linked to the Trust SDEC performance exceeding the 40% national target (41.3%), supported by a SDEC performance in Medical Division of 41.9%, the highest SDEC performance ever achieved.

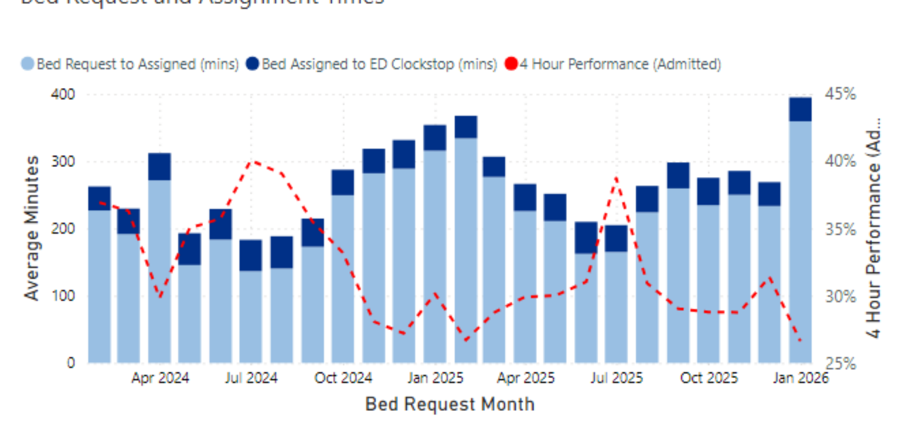
Date range	SDEC attendance number
April 2024 – February 2025	18,211
April 2025 – February 2026	23,210

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

The RUH does not currently use the metric clinically ready to proceed, as use decision to admit. The trust has not been compliant with the standard of admission within 60 minutes of a decision to admit. Optimum bed placement is an ongoing focus on the work of the clinical site team, which includes pre-emptive ward moves, proactive use of escalation, increasing discharges through the discharge lounge and the aim to left shift the discharge profile to increase discharges before midday (noting that the RUH is in the upper quartile positively for adult and general length of stay over 2 days). Time to admission is affected by an increase in ambulance arrivals, increase in admission rate (currently 35%), increase in the number of beds affected and empty due to IPC restrictions, and an overall increase in community responsibility NCTR all contributing to an increase in admission demand and a reduction is bed availability. The UEC work programmes that supports improvement for this standard include; delivery of the NHS England FOCUSED framework, internal professional standards and the clinical operational standards.

Month and Year	April 2024	April 2025	February 2025	February 2026
Average Transfer Time (minutes)	288	250	354	395

Readmission Rate
BY DISCHARGE MONTH



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

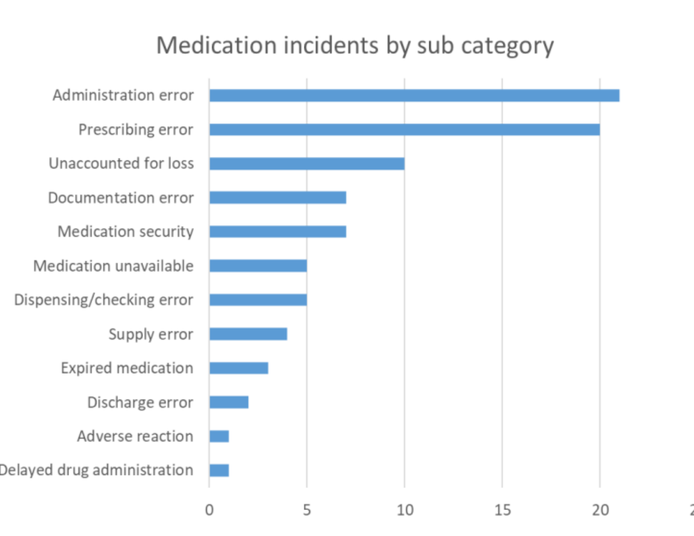
Alerting Watch Metric Commentary: Medication Incidents per 1000 bed day

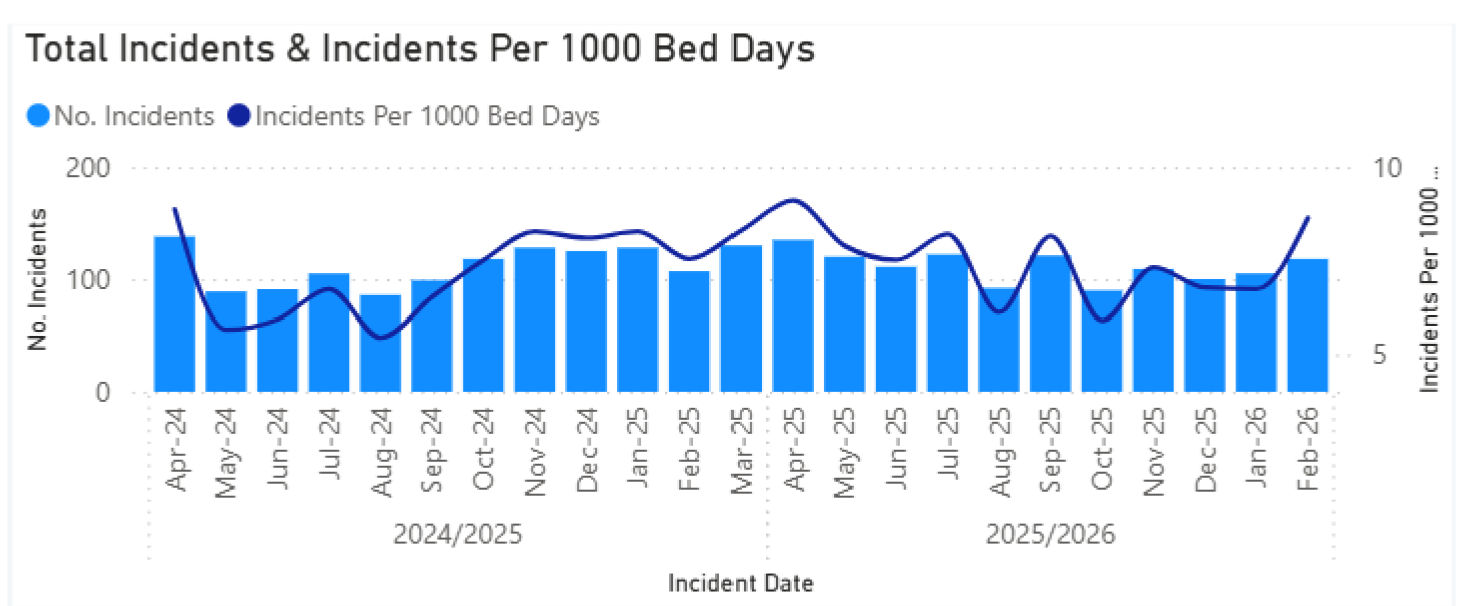
Understanding Performance

Total incidents per 1000 bed days increased in February to 8.64%, local year-end target is 7%.

Themes and trends
Themes and trends were similar to previous months. The majority of incidents were low or no harm, with one incident reported as moderate harm and no severe harm incidents.

Administration and prescribing incidents were the most common incident types reported. High throughput areas including ED and pharmacy reported the highest number of Incidents. In February the Trust remained in escalation at many points which may have had an impact on incident numbers in these areas. The Medicines Safety Group will continue to review this metric as well as themes and trends to monitor and identify areas of improvement.





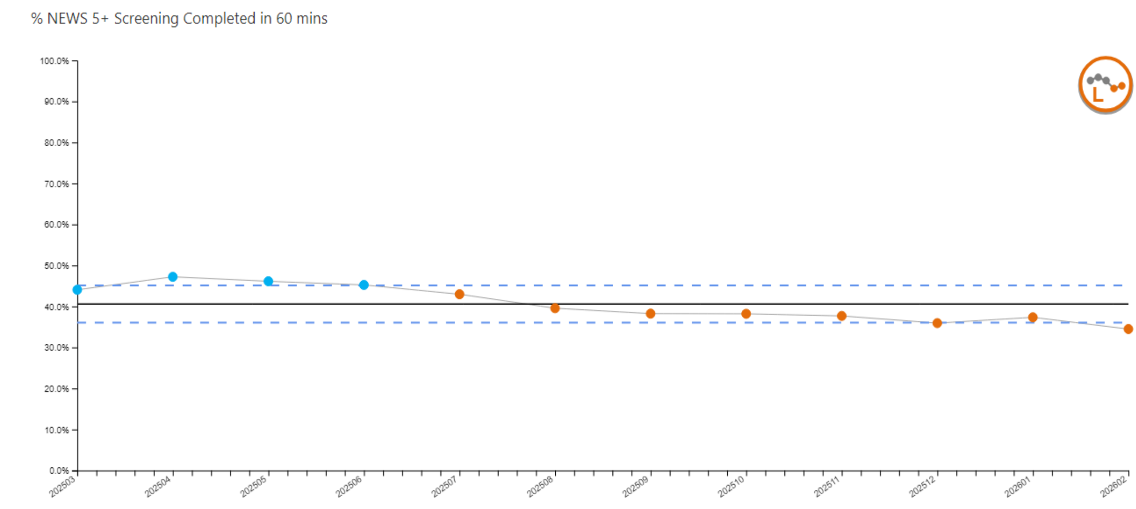
Countermeasures	Owner	Due Date
Incident themes and trends monitored via Medicines Safety Group. Medication safety workplan in place to monitor high risk themes and drive improvement work.	Claire McKenzie	NA

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

Understanding Performance

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

- NB: timing has changed from NEWS 5+ within 30 minutes to NEWS 5+ within **60** minutes. This is to bring the RUH in line with national standards, having been an outlier reporting on NEWS 5+ within 30 minutes. This was carried out in January 2026 and reflected in the February and this month's report to IIC. After a brief period of improvement early in 2025, the metric has trended downward and remains consistently below the mean, indicating no sustained improvement in timely screening. This is based on the EPR alert compliance and is not a true reflection of clinical bedside care.
- This metric originates from an historic CQUIN and is no longer fully aligned with current Trust, Regional or National priorities. Work is underway through the Deteriorating Patient Improvement Group to review and refresh the metric set, and it is anticipated that this measure will be revised as part of updating the reporting framework. For example, a structured audit of NEWS escalation processes is currently being developed and will be piloted through a PDSA cycle with planned implementation in May 2026.

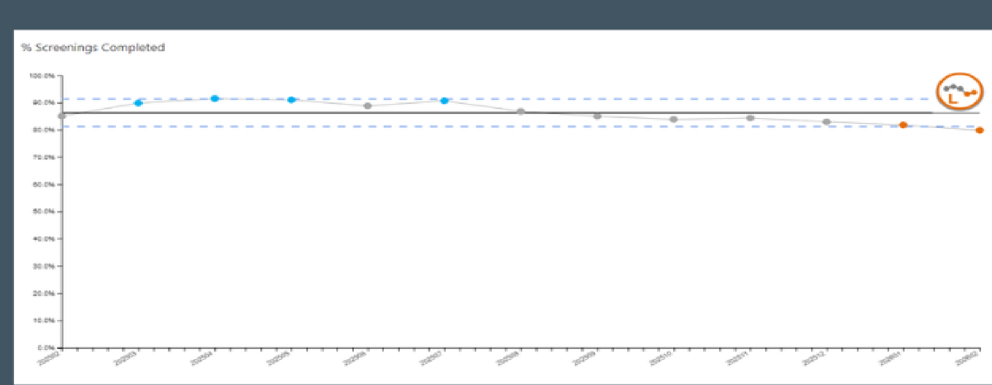


Countermeasures	Owner	Due Date
All ward staff identifying as having a poor understanding of patient deterioration and the actions required are allocated 1:1 support with the sepsis team, to increase their knowledge and empower them to escalate and initiate the trust sepsis care plan.	Sally Marden	April 2026
Focused teaching by SKIP team on 4 lowest performing wards (Waterhouse, Cardiac, Haygarth and MAU).	Sally Marden	April 2026
E-Learning compliance on lowest performing wards reviewed and issues addressed.	Sally Marden	April 2026
All additional teaching sessions run by wards include the sepsis team to provide a structured and comprehensive teaching of actions required when patient deterioration is identified, including responding to the e-alert , escalating the patient , and initiating the sepsis care plan.	Sally Marden	April 2026

Deteriorating Patient Trust - February 2026

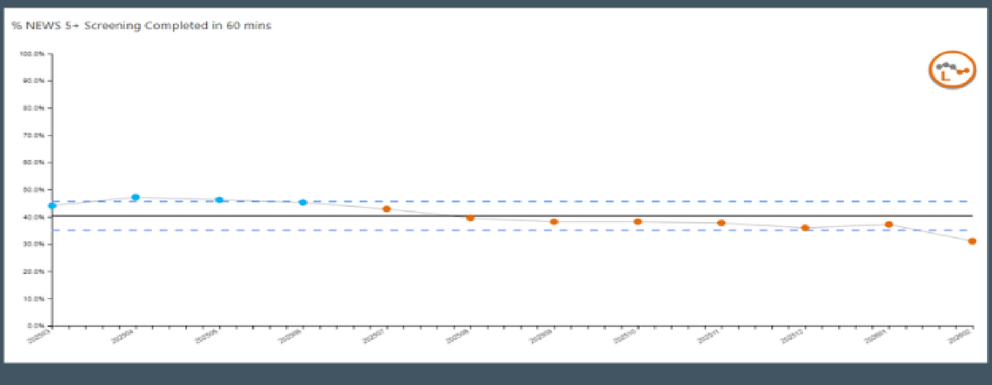
Sepsis Screening Compliance if NEWS increases ≥2

Last Month Performance	Ongoing Mean	Sepsis Screening
80%	87%	No. Alerts 1775
		No. Screened 1417



NEWS 5+ Screening Compliance in 60 minutes

Last Month Performance	Ongoing Mean	Sepsis Screening
31%	30%	No. Alerts 567
		No. Screened 176



Acute Kidney Injury

Number of Hospital Acquired AKIs

Grade 1	Grade 2	Grade 3
73	8	5

Fluid Balance

Compliance with fluid balance chart

82%

Training Compliance

Compliance with Level 2 AKI training

92.5%

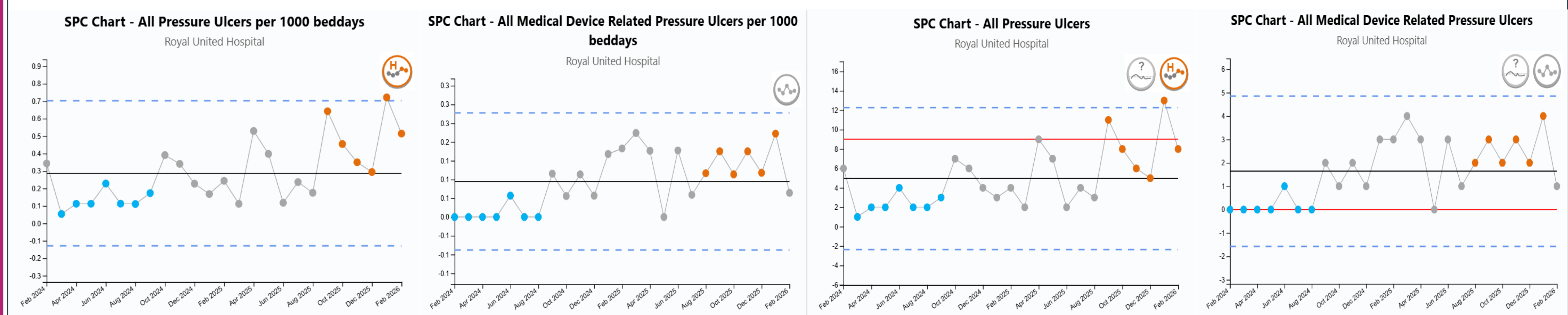
Compliance with Level 2 Sepsis training

86.6%

Pressure Ulcers

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 February 2026, the RUH reported 1.0 pressure ulcers per 1,000 bed days (9 pressure ulcers). The RUH reported three category 3 pressure ulcers, one category 2 medical device related pressure ulcer and four category 2 pressure ulcers. Due to the evolving depth one lady has been validated as category 4.

Locations were on the heel, sacrum, labia, ankle and spine. The patient themes were non concordance, multiple co morbidities, poor blood supply and end of life care.

The system themes were poor understanding of skin deterioration, prolonged stay in ED and lack of heel off loading. The Divisions are working closely with the wards on action plans for improvement.

Countermeasures	Owner	Due Date
ED to escalate those vulnerable patients to bed management at an early stage to expediate a ward bed as soon as possible.	ED Matrons	Ongoing
Divisions to start monitoring compliance with skin assessment and risk assessment (Braden) and report monthly to the Tissue Viability Improvement Group from May 2025.	Specialty Matrons	Ongoing
The Divisions are monitoring safer staffing levels against harm events and escalating where necessary	Matrons	Ongoing
Improve patient compliance with pressure ulcer prevention – delayed due to TVN work pressures	Tissue Viability Improvement Group	April 2026

Risks and Mitigation

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

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

Falls

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

Providing Safe and Effective Care

Understanding Performance

Data shows that during February 98.43% of inpatients did not fall in our care. Trust wide 89.18% of adult inpatients had a falls risk assessment completed within 6 hours of admission (Mar 25- Feb 26). There were 2 reported falls that resulted in moderate (or above) harm to patients, 1 in the community and 1 as an inpatient. Falls per 1,000 bed days in February were within the expected range, following an increase In December.

Falls are multifactorial, meaning they are caused by a combination of factors and all inpatients over 65 should have a multifactorial risk assessment. These factors include frailty, comorbidities and deconditioning which causes a decrease in muscle strength because of inactivity.

NICE guidance advises all inpatients at risk of falls should have lying and standing blood pressure (BP) recorded as part of the multifactorial risk assessment. This is used to diagnose a health condition called Orthostatic hypotension that increases the risk of falls. Analysis reveals that one of the top contributing factors is patients not receiving the assessment.

Countermeasures	Owner	Due Date
Increase compliance in lying and standing blood pressure trust wide to 50% – Compliance in February was 36%, up from 34% in January - project extended. Specific projects currently in place in several wards.	Ward Manager	May-26
Trust-wide falls PSII commissioned May 2025 (as a result of several falls across the 3 divisions)- The report is awaiting final sign off through PSEOG.	Associate Director of Patient Safety and Quality	Mar-26

Risks and Mitigation

1. Lying and standing blood pressure compliance had been reducing, but the past 3 months has shown a steady increase. A monthly league table is being circulated with senior sisters, matrons and CPF's. Focused work is being completed in several wards.
2. Operationally the trust has had an increase in acuity and number of admissions- this could be contributing towards an increased number of falls due to several factors affecting patient care e.g. time to prevent deconditioning.

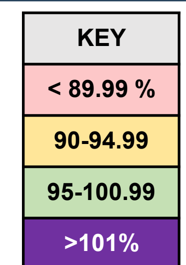
Safe Staffing (Nursing Inpatient Areas)

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%	102%	92%	129%
SAU	92%	110%	114%	101%
Cardiology	88%	87%	97%	101%
CCU	94%	85%	100%	81%
Charlotte	73%	96%	100%	107%
Cheselden	70%	86%	75%	137%
Children	86%	81%	106%	105%
Combe	78%	98%	86%	138%
ED	94%	98%	95%	98%
Forrester Brn	83%	96%	98%	101%
Haygarth	78%	112%	93%	123%
Helena	77%	109%	98%	99%
MAU	83%	87%	106%	104%

Ward/Department	Fill rate day RN %	Fill rate day HCSW %	Fill rate night RN %	Fill rate night HCSW %
MSS	80%	116%	107%	100%
OPAU	86%	84%	95%	107%
OPUSS	76%	94%	90%	102%
Parry	82%	93%	96%	104%
Philip Yeoman	100%	118%	105%	123%
Pierce Ward	85%	90%	99%	98%
Pulteney	85%	90%	99%	98%
Respiratory	79%	75%	89%	84%
Robin Smith	88%	92%	98%	98%
Waterhouse	66%	98%	80%	148%
William Budd	78%	93%	98%	100%



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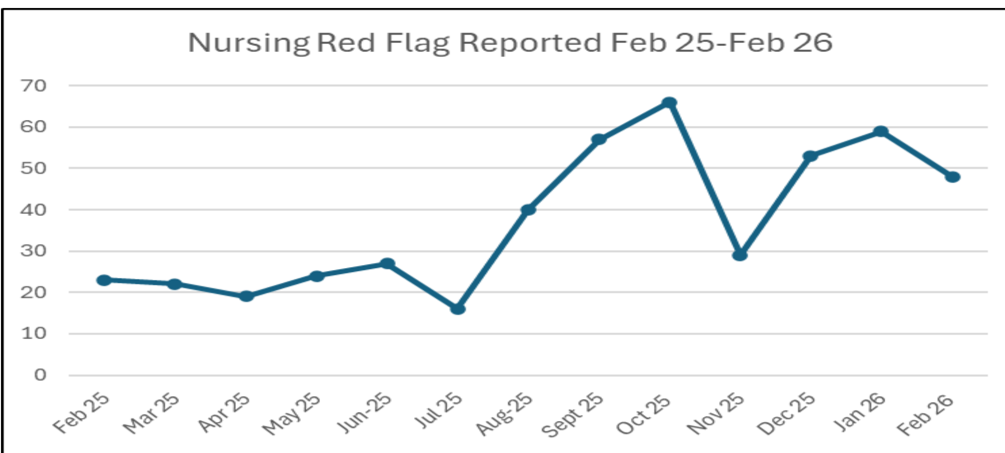


Day Shift Average Fill Rate		Night Shift Average Fill Rate	
RN	HCSW	RN	HCSW
82%	93%	95%	105%

Understanding Performance

The combined day shift fill rates for RNs across the 24 inpatient wards was 82% and 95% respectively for nights. The combined day shift fill for HCSW was 93% and 105% for the night shift. The table above shows the monthly fill rate for the inpatient wards and emergency department. The emergency department has continued to see improved fill rates in line with successful recruitment.

20 wards fell below 90% fill rate for RN staffing on day shifts and 4 wards on a night shift. Cheselden and Helena wards fell below 90% due to temporary ward relocation and a reduced bed base resulting in a reduced nurse staffing requirement whilst ensuring safe staffing was maintained. Paediatrics fell below the 90% primarily due to current vacancy which is actively being recruited. MAU, MSS and SAU have seen a fill rate >101% due to escalation capacity and additional beds being opened requiring staff above the planned establishment.
The decreased HCSW fill rate < 90% is primarily due to vacancy. The fill rate continues to improve as HCSW commence in post. Philip Yeoman ward fill rate is >101% due to repurposing of the ward to support winter capacity which has required an increased HCSW skill mix.
The increase HCSW fill rate >101% particularly on night shifts reflects the deployment of additional staff in response to increased capacity, dependency and enhanced therapeutic observations of care.

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

Countermeasures	Owner	Due Date
To recruit to remaining HCSW vacancies by May 2026.	Senior Sister/ Charge Nurse & Matrons	May 26
Effective, live safecare updates to reflect correct nursing hours worked and improve the accuracy of the day shift fill rate.	Senior Sister/Matron	May 26
To recruit into Paediatric ward RN vacancies	Paediatric Matron & Senior Sister/ Charge Nurse	Apr-26
To recruit into Emergency Department band 5/6/7 registered nurse vacancies. Recruitment event 16.1.26. Staff due to commence March/ April 2026	Emergency Department Matron	Apr-26

Risks and Mitigations

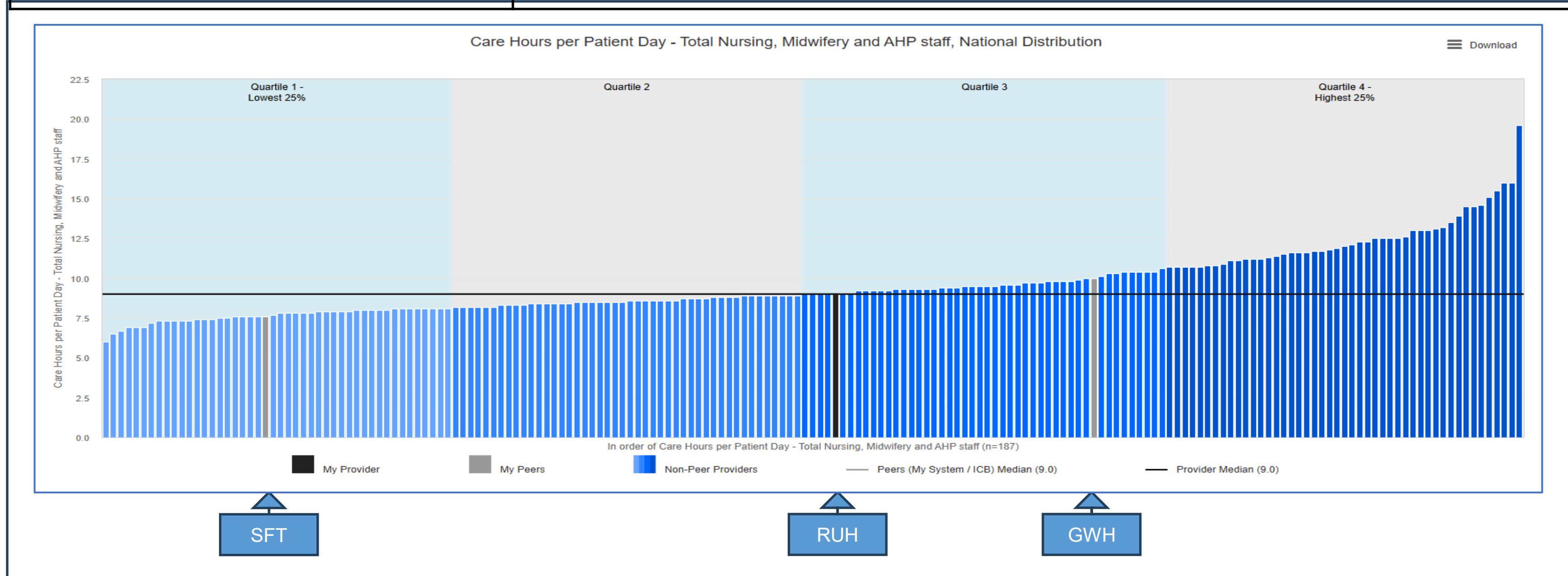
There is a risk that the current RN/HCSW vacancies will remain vacant and decreased fill rate <90% will continue. To mitigate this March 26 HCSW induction and successful RN recruitment in ED and Paediatrics with staff due to start from April 26.

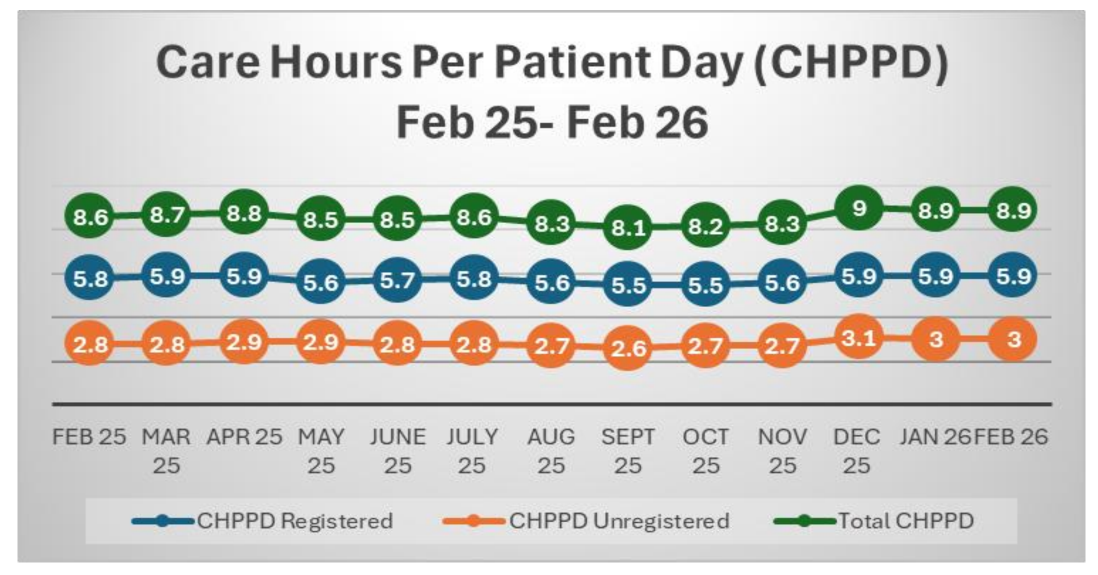
There are twice daily safer staffing meetings to review safe staffing and potential risks or red flags with mitigation put in place as appropriate. This will include redeployment of staff. The redeployment of nursing staff to mitigate vacant shifts will have an impact on fill rates.

There were 48 red flags reported by wards in February, a decrease from 59 reported in January. The breakdown of the 48 red flags was predominantly (77%) due to a shortfall of 25% RN time due to short notice sickness and vacancy. All these were reviewed by the matron and divisional senior nurse teams and mitigation put in place including staff redeployment as required.

Care Hours (Nursing Inpatient Areas)

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





Understanding Performance

In February CHPPD is 8.9 Since December 2025 we have seen an overall increase in the total CHPPD which align with the focused HCSW and RN recruitment.

When reviewed on Model Hospital (latest data available December 2025) we have moved from quartile 2 to quartile 3 and continue to benchmark in line with the peer median 9.0.

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

Risks and Mitigations

The risks identified from SafeCare in February show an increase in levels of short-term absence alongside existing vacancy and the operational need for additional escalation capacity which is reviewed at the twice daily safer staffing meetings chaired by a senior nurse.

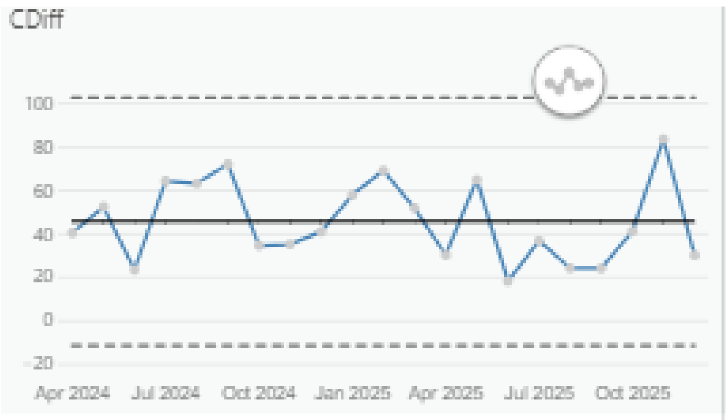
Mitigations:
•Twice daily safe staffing meetings, reviewing both unfilled shifts alongside acuity and dependency of all wards.
• Department specific HCSW and RN recruitment
•Focused joint led (Nurse & HR) sickness reduction programme
•Prospective and retrospective roster reviews
•Safe staffing levels are highlighted within the clinical site meetings

Infection Prevention and Control

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 was one healthcare associated meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia reported during February. There have been 3 cases against a zero threshold for 2025/26.

There were 5 cases of *Clostridioides Difficile* infection (CDI) (3 HOHA and 2 COHA) reported during February 2026. There have been 71 cases against a threshold of 75 reported to date for 2025/26. The 2025/26 rate per 100,000 bed days for the Trust is 40.79 for January, against the SW rate of 32.47 (for Jan '26)

There were 14 cases of *E. coli* infection (5 HOCA, 9 COHA) reported during February 2026. There have been 98 cases reported for 2025/26 against a threshold of 77. The January 2026 rate per 100,000 per days is 52.54 against the SW rate of 40.86 (for Jan 26).

There was zero MSSA during February 2026. Ward-based training and engagement sessions were continued during February '26 to support practice vs protocol.

The number of Influenza cases decreased from 167 to 94 during February, However the medical wards were also impacted by Norovirus at the same time. This had a significant impact on the number of beds closed across the site during the whole of February, particularly impacting the medical division.

Countermeasures	Owner	Due Date
To reduce ingestion of environmental bacteria and virus' during a hospital stay, we will enhance hand hygiene opportunities. **Aim:** To increase patient hand hygiene compliance before and after meals within a bay on an older person's unit by 30% within 3 months. Trials to expand across the ward from one bay on OPUSS and Helena, with a further product trialling on William Budd and ED for comparison	Infection Prevention and Control	Review latest data at the end of March 2026 In Progress
Gloves off campaign: To ensure clinical gloves are worn appropriately. **Aim:** To reduce the inappropriate use of gloves by 30% within 3 months. Team are working with areas across the Trust to support a Trust wide adoption. The Hand Hygiene audit has now been amalgamated to include the gloves off audit, and ward stock is being reduced.	Infection Prevention and Control	Ongoing rollout during 2026
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. Currently on trial in MAU, ICU and Respiratory is about to test.	Infection Prevention and Control	Ongoing development 2025/26

Risks and Mitigation

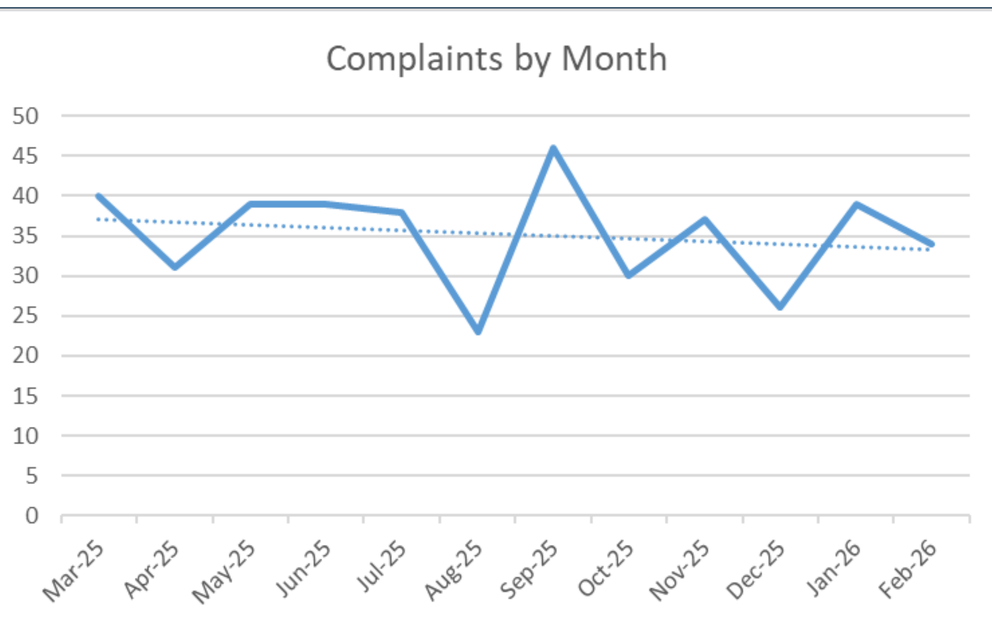
There is a risk that the CDI threshold will be exceeded due to the increasing number of infections being detected.
Mitigations: Maintaining surveillance, hand hygiene, stool chart compliance and environmental cleaning. This will include the introduction of vapour cleaning as outlined in the updated infection cleaning requirements. This went live on the 2nd March 2026.

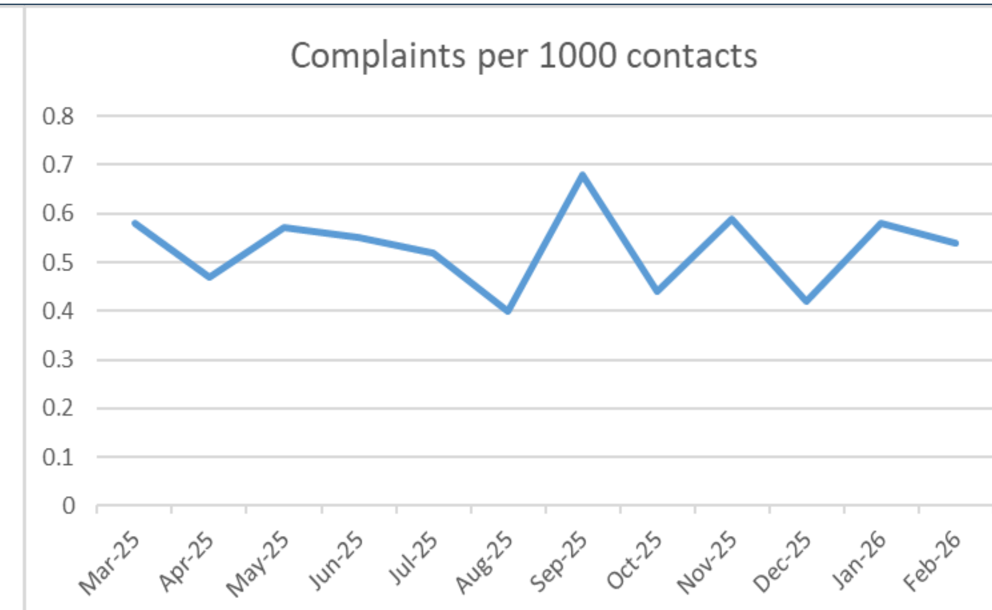
There is a risk *E. coli* numbers continue to rise due to a urinary sourced infections in over 50% of cases **Mitigations**: The Trust is implementing a coordinated programme of quality improvement initiatives to support a sustained reduction in *E. coli* infections. IPC & the QI team are jointly leading the delivery of six core quality standards, designed to provide a holistic and system-wide impact on patient outcomes. An overview of these standards is set out in the driver diagram on the following slide.
A key operational challenge remains the ability to bring all relevant workstreams together at pace, as clinical and operational teams are required to prioritise frontline service delivery. Work continues to ensure alignment, minimise duplication, and maintain momentum across all improvement activities.

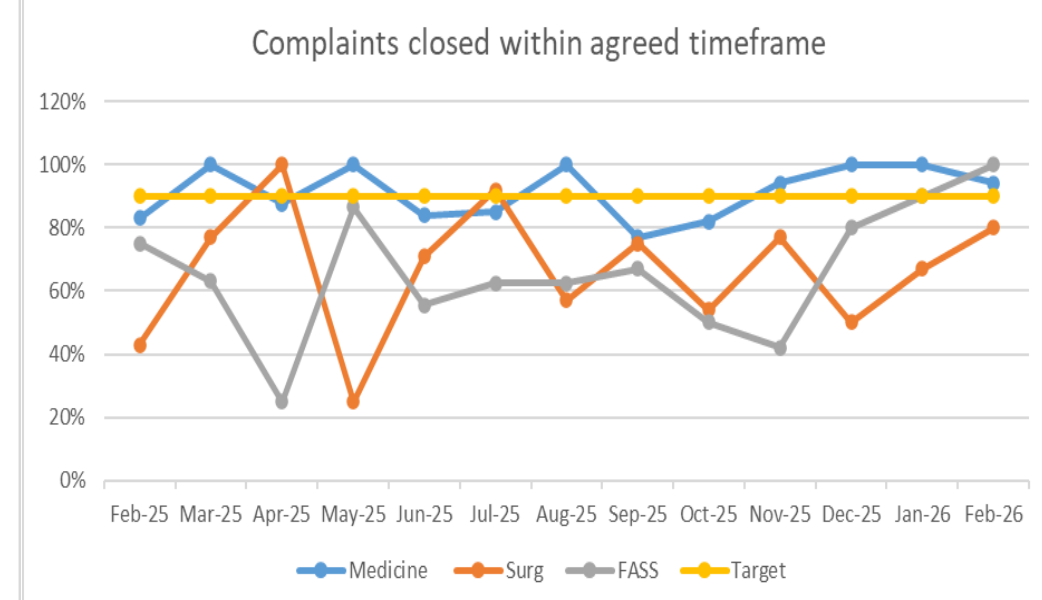
Patient Support & Complaints (PSCT)

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 February 2026, the Trust received 34 new complaints, this was a decrease from January (graph 1). The majority of complaints were about clinical care (n=21) consistent with previous months.

The Medicine Division received the highest number of new complaints (n=18), Surgery (n=8), F&SS (n=7) and Estates and Facilities (n=1).

The complaint rate per 1000 patients in February was 0.54 which has decreased from 0.58 in January (graph 2). 98% of all concerns were acknowledged within 2 working days.The response times for formal complaints continues to fall below the target of 90% with 87.9% of the complaints closed in February responded to within the agreed timeframe (graph 3). Complaint closure rates varied by Division over February, F&SS increased to 100%, the Surgical Division increased to 80% and the Medicine Division decreased at 94% for the month.

Countermeasures	Owner	Due date
The Patient Experience Team will undergo thematic coding and analysis of a sample of complaints that were themed, on receipt in Q4 and Q1, as 'clinical care'. The results will be presented to the Insights and Improvement Committee in July-26.	Patient Experience Team	July-26
Monthly meetings, starting in March 2026, involving the corporate Patient Experience Team, divisional patient safety nurses and other divisional representatives, will focus on complaints and concerns; the process, oversight and improvement of responses.	Patient Experience Team/ Patient Safety Lead Nurses	ongoing
F&SS are starting to log compliments they receive in the Division onto DATIX. They are starting a pilot from 1st April with the intention of rolling the initiative out across the Division. This will provide a more accurate understanding of the positive patient experience in the Division.	F&SS	ongoing

Risks and Mitigation

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

The new governance structures within the 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.

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

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

Maternity & Neonatal Perinatal Quality Support and Oversight Model (PQSOM)

March 2026

February 2026 data

The RUH, where you matter

Executive Summary & Items for Escalation

Key Signals:

New Significant digital data quality risk (16) and evolving escalation of current USS digital interoperability safety risks (Risks 3267, 3281, 3202). USS risk re-evaluation and combination in progress with anticipated escalation of risk in April 26. Immediate safeguards and long-term digital solution planning required to control and mitigate risks.

BR+ reassessment and Mary Ward deep dive progressing to ensure workforce planning reflects rising acuity, complexity and activity patterns

Neonatal nursing workforce establishment review findings received from the SW ODN, with early indications of potential non-compliance with Specialist Commissioning requirements and a recovery plan is in development.

Assurance Level:

Rating	Assurance Level
Substantial	
Good	
Partial	
Limited	

Strategic Alignment:

Outstanding care

Valued teams

Better together

Sustainable future

Recommendations & Escalations:

To discuss and note: A cross-perinatal workforce review is underway across maternity, neonatal nursing and neonatal medical teams following BR+, the Mary Ward deep dive, the SW ODN review and BAPM 2025 medical benchmarking. Early modelling shows targeted investment may be required across several staff groups, and the service will consolidate this into one coordinated MatNeo workforce options appraisal and business case to support a unified, system-aligned proposal.

Items for escalation: Emerging workforce capacity pressures and digital functionality gaps across perinatal services signal a need for aligned Trust-level support to strengthen long-term service resilience.

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

Compliments & Complaints

Total Contacts	**Compliments**	23
31	**Complaints**	2/7

Friends & Family

Contacts: 4
Very Good: 2
Good: 2

- Excellent care & treatment
- Staff Attitudes
- Clinical care given

Maternity & Neonatal Voices Partnership

N = 77

- Recognition of parent exhaustion when imparting importing info
- More support with feeding when baby transitioning from NNU to ward
- More explanation of staff 'role'
- AN Education – needs provision in different formats, explains context around risk, offers opportunity to view birth environment
- PN support better with CoC and clear information around who to contact once at home – practical 'baby care' would be useful addition to feeding support
- Ward environment should feel calm and processes well-explained
- MNVP resources inconsistently shared by staff

- Better feeding support needed in early PN period with CoC and better quality of conversations around options
- Relationships with staff – continuity is important as is a calm, approachable manner. Without this parents can feel isolated or dismissed
- **BadgerNet**: 'useful' but tendency for staff to rely on signposting rather than explaining things.
- Felt to be hard to view upcoming information/appts
- Log-in challenges
- Too clinical – would like clear explanations in plain language

Safety Champions

- Visited Triage and NNU during high acuity
- Noted staff were busy but appeared calm and professional
- Absence of ward clerk in NNU delaying entry/exit to unit – taking staff away from clinical care
- Staff in triage apologising to families for delay in medical review – feeling that an ACP may be a compromise to mitigate
- NNU felt extremely busy with 3 new admissions within an hour - short term agency cover arranged to help

Insights Walk & Talks

Feedback Themes and Quotes

Delays in Care
"Post LSCS – asked for analgesia and midwife went to get it but seemed to t ke a long time... By the time it was received, pain level was considerable."

Communication & Information
"I didn't know how to get food or where the bathroom was until a student showed me."

Emotional Impact
"Felt unimportant, not informed, stressed, anxious about baby's wrlbeing... All of these things overshadowed the good aspects of care.

Environment & Facilities
"Did find urine in bedpan in bathroom on more than one occasion."

Staffing & Workload
"Midwife was lovely, Apologised I had to wait for doctor. Clearly busy – need more.

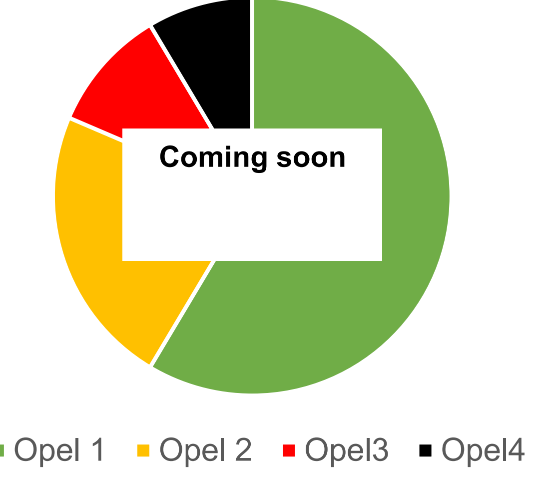
- Excellent care and experiences noted in Triage, Hummingbird Team and Ultrasound/ANC

Source: SW neonatal Network feedback questionnaire.

Maternity Workforce

	Target	Threshold		Dec 25	Jan 26	Feb 26	Comment
		G	R				
Midwife to birth ratio	1:24	<1:24	≥1:26	1:29	1:31	1:26	Trained staff only included in acuity data
Midwife to birth ratio (including bank)	1:24	<1:24	≥1:26	1:27	1:29	1:25	
Episodes where 1:1 care provided in labour not achieved	0	0	>1	0	0	0	
Episodes where Labour ward coordinator not maintained supernumerary status	0	0	≥1	0	1	0	
Number of NICE red flags on BirthRate+	NICE 2015	-	-	3	16	12	7 intrapartum. All sickness related. Appropriate escalation and actions. 7 delay in IOL 5 inpatient. All related to intrapartum red flags requiring redeployment resulting in delays in IOL
Percentage of 'staff meets Acuity' **(BBC)**	100%	>90%	<70%	70	62	69	
Percentage of 'staff meets Acuity' **(Mary Ward - inpatient care)**	100%	>90%	<70%	50	28	46	
Confidence factor in Birthrate+ recording **(BBC)**	60%	>60%	<50%	80	84	86	Percentage of episodes for which data recorded
Confidence factor in Birthrate+ recording **(Mary Ward - inpatient care)**	60%	>60%	<50%	83	80	92	Percentage of episodes for which data recorded
Percentage midwifery in month turnover	0.8%	<0.8%	>0.8%	0.00	0.00	0.21	0.4 in month leavers FTE
Percentage MSW in month turnover	0.8%	<0.8%	>0.8%	3.33	3.15	1.35	0.6 in month leavers FTE
Midwives in month sickness percentage	<5%	<5%	>5%	4.99	4.34		1 month lag
Maternity Support Workers in month sickness percentage	<5%	<5%	>5%	12.55	9.51		1 month lag

In month Opel Status



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

Maternity Midwifery Workforce Countermeasures

Overview Analysis:

- Birthrate+ confidence BBC 88%, Mary Ward 92% — high completeness, need to better understand drivers for Mary workforce not meeting acuity and links to independent BR+ Review Report
- Deep dive underway comparing Mary Ward activity 2023 vs 2026, including: readmissions data and dependency profiles safeguarding cases (notably increased in volume and complexity) complaints, compliments and user experience themes infant feeding acuity and BFI-aligned workload and social/medical complexity patterns

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

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

Countermeasure / Action	Owner	Status	Due	Outcome/Update
Deep dive into sickness hours in different cost centres in month	Gemma Day		Feb 26	Strengthened reporting/certification process Support for line managers with new Trust policy MSW culture and engagement work ongoing Seasonal sickness increase noted
Flexible working review to support roster planning/shift fill	Kerry Perkins Jo Coggins		April 26	Line managers meeting with staff
Recruiting to midwifery vacancy	Di Butler/SLT		Ongoing	5WTE. Interviews early March
Review impact of percentage meets acuity challenges for Mary ward	Kerry Perkins		April 26	Gathering local intelligence data and intel to present to SLT

Potential Cause:

MW vacancy – active recruitment in progress.
Held vacancy for 2.77 WTE MSc learners

BBC management action (top 5) Data from Feb 2026	Times occurred	Percentage
Redeploy MW internally	46	35%
Operational support MW included in BBC staffing numbers	27	21%
Escalate to Manager on call/Matron	13	10%
Redeploy MW community	13	10%
Clinical Skills Facilitator MW included in BBC staffing number	11	8%

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

Strengthening Safe Staffing: Key findings from the 2026 BR+ Independent Report and Implications for RUH

March 2026

Jodie da Rosa Head of Midwifery and Neonates

Key Findings from the 2026 Birthrate Plus

1. BR+ Remains a Valid and Strategic Workforce Planning Tool

- The 2026 independent review confirmed that BR+ continues to be the nationally recognised methodology for maternity workforce planning.
- It provides assurance that Trusts' workforce assessments are aligned with national standards and strategic planning expectations

2. Methodology Requires Updating to Reflect Modern Maternity Pressures

- The review identified that refinements are required to reflect increasing clinical acuity, social complexity, mental health need, administrative burden, and evolving care pathways.
- Updated expectations should be integrated into current assessments rather than waiting for the next BR+ cycle.

Implications for RUH

BSW HOSPITALS GROUP

Integrating Updated BR+ Expectations

- RUH is midway through its Birthrate Plus® reassessment, allowing the Trust to apply updated expectations immediately.

Responding to Rising Acuity and Complexity

- RUH is experiencing patterns consistent with the national review, including higher clinical acuity, social complexity, safeguarding demands, and mental health pressures.

Strengthening Workforce Planning Assurance

- The review confirms that BR+ remains a sound and reliable methodology, supporting RUH in making evidence-based safe-staffing decisions.

Importance of Professional Judgement

- BR+ must be used alongside senior midwifery professional judgement and local insight, particularly as RUH's population needs shift.

Opportunity for Service Improvement

- Integrating the updated BR+ expectations now supports proactive workforce planning, enabling RUH to adapt to new care pathways and avoid workforce misalignment.

Mary Ward: Deep Dive Underway Strengthening BR+ Narrative

- Increase in acuity
- Increase in safeguarding and PNMH
- Analysing staff feedback/complaints to support supervisory band 7
- Review pathway for redeployment in escalation
- Review NIPE provision to ensure cost effective method of delivering
- Reviewing TC to ensure NNU staffed to commissioned cot capacity

Next Steps: Deep Dive + Strategic Workforce Planning

April 2026

Mary Ward Deep Dive

May 2026

RUH BR+ Assessment Report

May-July 2026

Business and Financial Planning

May- November 2026

Action planning &Trust Board Agreement MIS Year 8

Workforce Investment and Recruitment

Safer, more personalised, and equitable care

Neonatal Workforce

	Target	Threshold		Nov 25	Dec 25	Jan 26	Feb 26	Comment
		G	R					
Limitation in service / exemption report episodes				1/1	1/0	0	1/0	1 Limitation in service
Nurse in charge supernumerary (%)		100%		44.64	56.14	75.81	59.26	Ongoing high parenting leave and long term sickness
Percentage neonatal nursing shifts filled to BAPM standard (%)	100%	>90%	<80%	76	71	100	90.74	
Percentage neonatal QIS trained (%)	>70%	<70%	<60%	70.8%	70.8	53.3	66	Incorrect data input for Jan. QiS compliance expected to be 70.7% in March 26
Percentage neonatal turnover in month (%)	<5%	<5%	<7%		0	0	1.85	1 leaver 0.9 FTE Relocation
Percentage of neonatal nursing in month vacancy (%)				3.14	2.43	2.14	2.31	Awaiting B5 and B6 planned to start throughout March and April 26
Percentage neonatal in month sickness (%)	<5%	<5%	>5%	4.87	3.03	5.58	4.42	

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

Neonatal Workforce Countermeasures

Overview Analysis:

- Sickness reduced to 4.42% (67.9 FTE days lost), indicating a positive month-on-month improvement, though operational pressure remains.TC staffed at 96%, with pockets of vulnerability: 14% of shifts caring for 5–8 babies, and 16% of these not meeting required nurse-to-baby ratios, necessitating 3.3 additional shifts to achieve full BAPM compliance.
- Temporary workforce reliance remained moderate with 4.8% of nursing shifts filled by bank/agency and 8.42% (4.14 WTE) unavailable due to parenting leave, impacting rota resilience.
- Escalation pressures continued, with one Limitation in Service (LIS) declaration, partial redeployment of specialist roles to clinical cover, and three external neonatal admissions contributing to activity levels.

Substantive Neonatal Nursing Vacancy	Secondment	Parenting Leave	Fixed term in post	Budget V actual
2.55		4.16	1.77	

Countermeasure / Action	Owner	Status	Due	Outcome/Update
South-West ODN Neonatal Nursing Establishment Review	Supervisory Sister, Perinatal Matron, Head of Midwifery and Neonates, Business Manager		April 26	Results shared in Feb 26. Options appraisal currently being drafted. ODN shared potential for non compliance with Spec Com contract which will require a recovery plan. Plan being drafted to share at April 26 MatNeo governance
Transitional Care Workforce and Clinical Pathway Review	Supervisory Sister, Perinatal Matron, Head of Midwifery and Neonates, Neonatal Nurse Consultant		May 2026	Initial workforce workshop completed. Options appraisal to be drafted and shared at April26 Governance

Potential Cause:

- High parental leave and long-term sickness driving workforce gaps
- Temporary cot closures in Bristol throughout Jan- May 26 may impact acuity of patient

Mitigations and management actions to support safe staffing Data from Feb 2026	Number of occasions
Redeploy specialist neonatal nurses	6
Redeploy paediatric nurses	1
Shift out to Bank (filled/unfilled)	30/14
Shift out to Agency (filled/unfilled)	3/4

Identified Risk	Mitigating Action
Risk 3182 Increased Neonatal Cot Capacity and workforce impact	Linked to Countermeasure/Action slide

Medical & Anesthetics Workforce

	Target	Threshold G	Threshold R	Nov25	Dec 25	Jan 26	Feb 26	Comment
Obstetric consultant presence on labour ward	60 hrs	>60 hrs	<60 hrs	98	98	98	96	
Compliance to RCOG 'Must attend' obstetric consultant roles and responsibilities guidance	100%	100%	<100%	100	100	100	100	
Obstetric MDT ward round twice daily percentage	100%	100%	<100%	100	100	100	100	Reviewed by LWC daily, MS forms completed if no ward round completed with immediate escalation.
Shifts filled by locum obstetric cover	0	-	-	0	0	0	0	
Anaesthetic rota compliance	70%	≥70%	<70%	100	100	100	100	
Percentage medical shifts filled to BAPM minimum standards (2018)	100%	>90%	<90%	90	90	87	90	
Percentage medical shifts filled to BAPM minimum standards (2025)	100%	>90%	<80%	16.6	16	8	12.5* 58**	*Results presented as day and night duty compliance. **Results represent overall shift fill for each tier requirement combined.
Shifts filled by locum/bank neonatal cover	0	-	-	15	15	0	20	11 Bank ANNP 9 medical locum Percentage of ANNP Bank – 7.85% Percentage of Medical Locum – 6.4%

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

Neonatal Medical Workforce Countermeasures

Overview Analysis:

- Neonatal medical staffing continues to rely on temporary workforce solutions, with 11 ANNP bank shifts and 9 medical locum shifts required in February to maintain safe clinical cover. ANNP bank shifts account for 7.85% of total clinical cover, while medical locum usage contributes 6.4%, highlighting ongoing dependence on non-substantive staffing to ensure service resilience
- Benchmarking exercise for BAPM 2025 Medical compliance completed. Identifies gap in Teir 1 rota. The BAPM 2025 minimum standards are considered aspirational, and the service will adopt a phased approach towards achieving full compliance, recognising the scale of workforce transformation required. An options appraisal is currently being drafted and options costed. Risk currently being drafted to reflect the new RUH position.

Potential Cause:

Identified Risk	Mitigating Action
Risk 3182 Neonatal Cot Capacity and nursing workforce impact	Linked to Countermeasure/Action slide
Medical Workforce Risk in progress	

Countermeasure / Action	Owner	Status	Due	Outcome/Update
Options appraisal to be drafted following benchmarking exercise	Neonatal Nurse Consultant, Clinical Lead, Head of Midwifery and Neonates		Update due April 2026	Bi-weekly meetings to explore options and associated costs.
Agree BSW reporting alignment for BAPM 2025 standards	Neonatal Nurse Consultant		April 2026	
Finalise risk assessment	Neonatal Nurse Consultant, Head of Midwifery and Neonates		April 2026	Final position to be shared at MNSG April 2026

Incidents & Investigations

New Patient Safety Events Graded Moderate or Above (Feb 26)

Case Ref (Datix)	Incident Date	Category	Incident	Investigation update – Outcome/Learning/Actions	MNSI Ref	PSII Ref
149426	10/02/2026	Moderate	High vaginal wall tear with major obstetric hemorrhage (2.8L) and Intensive Therapies Unit admission	Initial review commenced 19.02.26 - no immediate care concerns Learning: Discussion of emerging concern regarding breath of documentation following transition to Badger.net EPR.	NA	NA
149967	24/02/2025	Moderate	Intrauterine death at 34 weeks of pregnancy	No immediate care concerns following initial review. Perinatal Mortality Review Tool (PMRT) process commenced Duty Of Candour Lead : J Ficquet Bereavement Lead consultant Family Engagement Lead: B Walsh Bereavement Midwife	NA	NA

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

Incidents & Investigations

Ongoing Patient Safety Events Graded Moderate or Above

Datix	Incident Date	Category	Event	Investigation update – Immediate Learning/Actions		MNSI Ref	PSI Ref
148702	21/01/26	Moderate	4 L Post-partum Hemorrhage	13.02.26 – initial multi-professional review , event deemed unavoidable. No patient safety Incident identified	Incidental learning identified pertaining to documentation within badger.net.		
148052	6/6/25 reported 02/01/26	Severe	Day 17 ? Bowel obstruction post caesarean birth	Incident reported into trust by GWH. No access to re-admission documentation or identification of incident. DOC Lead – not yet allocated until incident and level of harm verified	All available records of medical imagery reviewed no evidence of bowel obstruction or injury. No evidence of surgical management. Communication with GWH ongoing to establish chronology and incident. Harm to remain until assurance of no severe harm received – anticipated downgrade and closure March 26.		
147338	08/12/25	Severe Harm	Transfer for active therapeutic cooling. Abnormal MRI	Family consent for Maternity and Newborn Safety Investigation gained – Review in progress DOC Lead : Obstetric Consultant Family Engagement Lead: Patient Safety review lead	Multi Professional Safety Review held on12/12/25. No Trust care concerns identified Staff interviews to be conducted week commencing the 9th March	MI-050463	
146963	20/11/25	Severe	Readmission to NICU with abnormal MRI	Family consent gained for MNSI – in progress DOC Lead: Neonatal Consultant Family Engagement Lead : Quality and Patient Safety Lead	Local PSIRF learning response ongoing : Key Lines Of Enquiry:	MI-049980	
146425	06/11/25	Moderate	Maternal ITU admission with group A strep sepsis	Patient Safety Incident Response –MDT/ After Action Review in progress between Maternity and the Emergency Department. DOC Lead: Obstetric Consultant Family Engagement Lead: Patient Safety Lead Midwife	Key Lines of Enquiry agreed with the family: • Were there any earlier opportunities to have identified infection within the postnatal period prior to escalation to critical care • Are we assured by the current processes of communication between Emergency Department and Obstetrics to support collaborative care planning inclusive of medication management. • Are we assured by the process'/identification of deterioration within Same Day Emergency Care Centre		
144946	23/09/25	Unexpected death	Intrauterine death 37+3	On-going Maternity & Neonatal Safety Investigation referral DOC Lead: Bereavement Lead Obstetrician Family Engagement Lead : Bereavement Midwife	Draft report received, factual accuracy response returned. Anticipated final report March 26	MI-047238	
145104	23/09/25	Moderate	Indirect maternal death	Integrated Care Board Local Maternity & Neonatal Systems facilitated review engagement offered by Perinatal patient safety team and Bereavement midwife	Initial panel held on 05/12/25. Further MDT co-ordinated by ICB planned in March 26.		
143919	22/08/25	Moderate	Unidentified fetal growth restriction with abnormal MRI	Patient safety Incident Response- MDT panel with external subject Matter Expert (SME) review			

Incidents & Investigations

No Closed Patient Safety Events Graded Moderate or Above

Case Ref (Datix)/MNSI/PSII	Incident Date	Category	Event	Quality and Safety Recommendations	Action plan	Montioring Group
					-	-

Data correct as of 31st July 2025. The data in the preceding month may have changed due to timing of previous months reporting

Emerging Learning from Local Learning Responses

Situational Overview:

- 6 week old baby under the Supporting infant Feeding and Nurture (SiFAN) team attended frenulotomy service appointment in community birth centre. Following frenulotomy the baby became unresponsive and floppy. Emergency care and resuscitation was provided by midwifery team , paramedic crew attended and baby transferred to the RUH Emergency department where a vaso-vagal episode was diagnosed and the baby returned home the same day.

Analysis & Enablers of Success 'What went well' :

- Good engagement with AAR
- Quick paramedic response and attendance
- Positive team working
- Immediate debrief hosted by midwifery sister

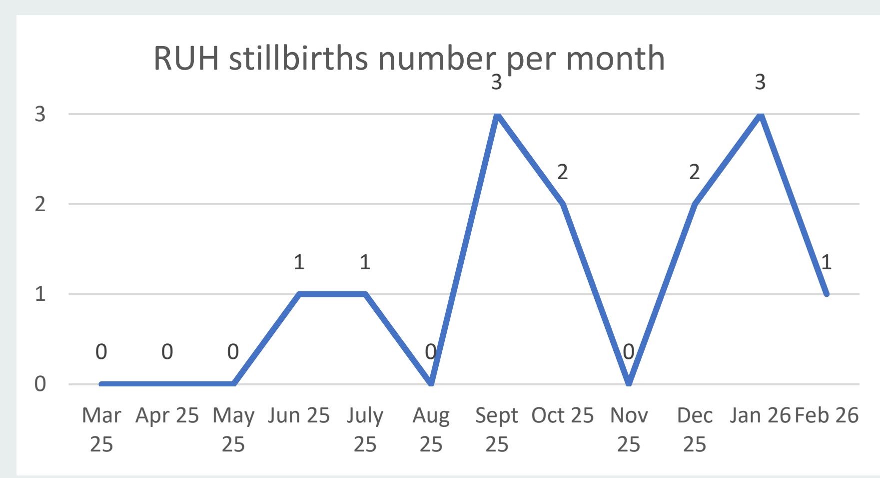
Learning and Reflections:

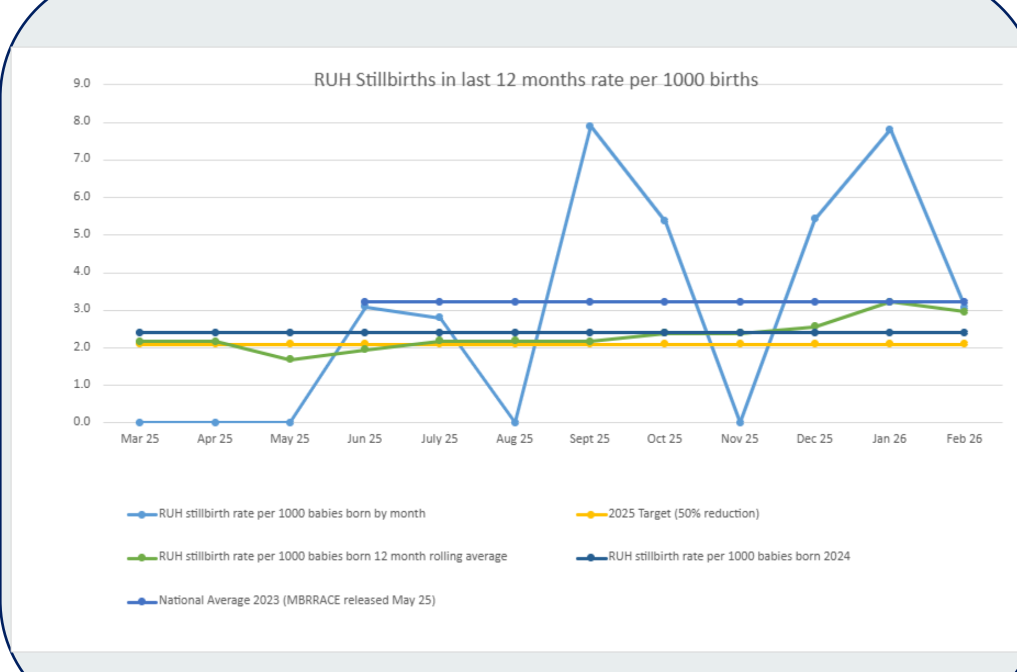
- Resuscitation was not seamless due to unexpected nature of event and environmental factors
- Staff performed newborn life support as this was most familiar to their profession – however the baby was 6 weeks of age and therefore would have warranted paediatric life support – no harm was caused as a result.

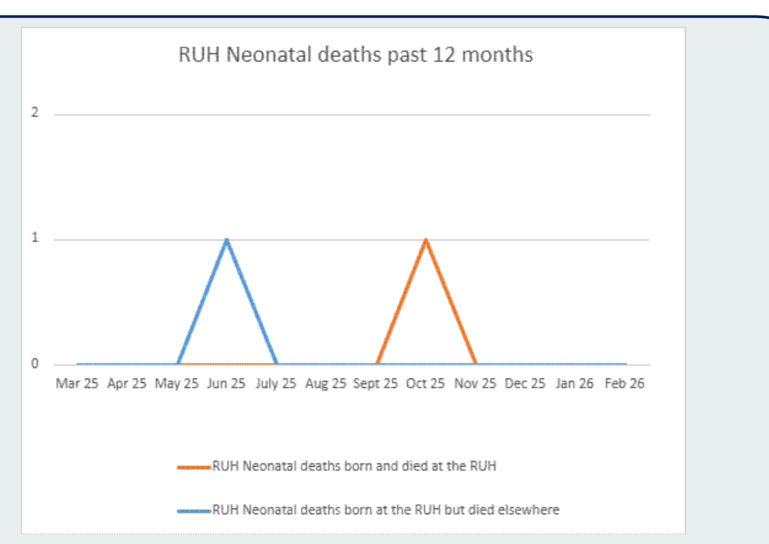
Sharing of Learning & Next Steps:

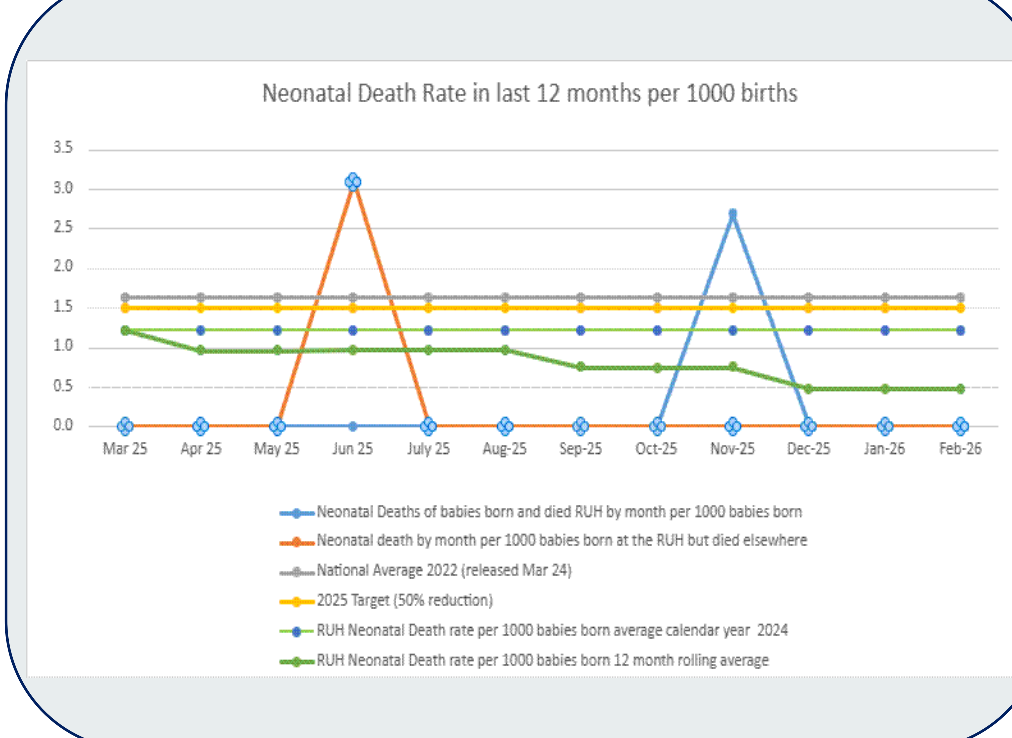
- To set up a resuscitation station at the start of all frenulotomy clinics to support staff in seamless resuscitation should the event of its use be required
- To ensure all SiFAN frenulotomy practitioners are peadiatric life support trained
- To conduct a further review with Service leaders to discuss the event, staff findings from the AAR to identify any operational/systematic changes required in response.

Perinatal Mortality Review Tool (PMRT)









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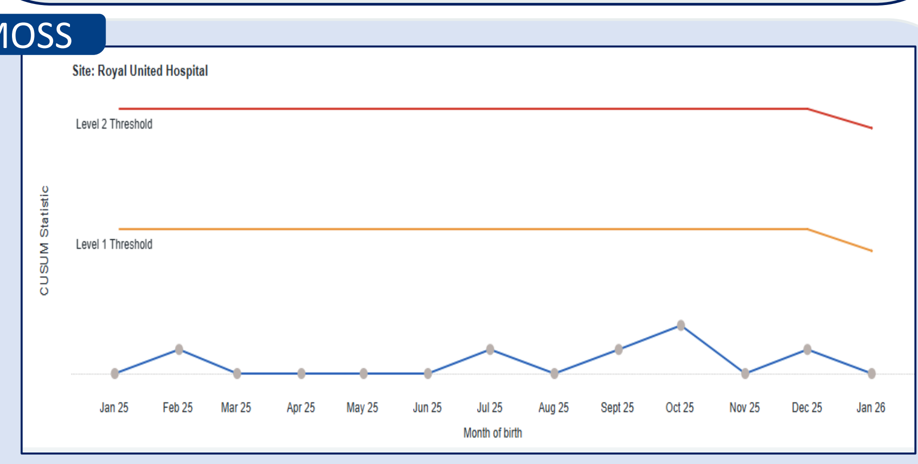


Background information

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

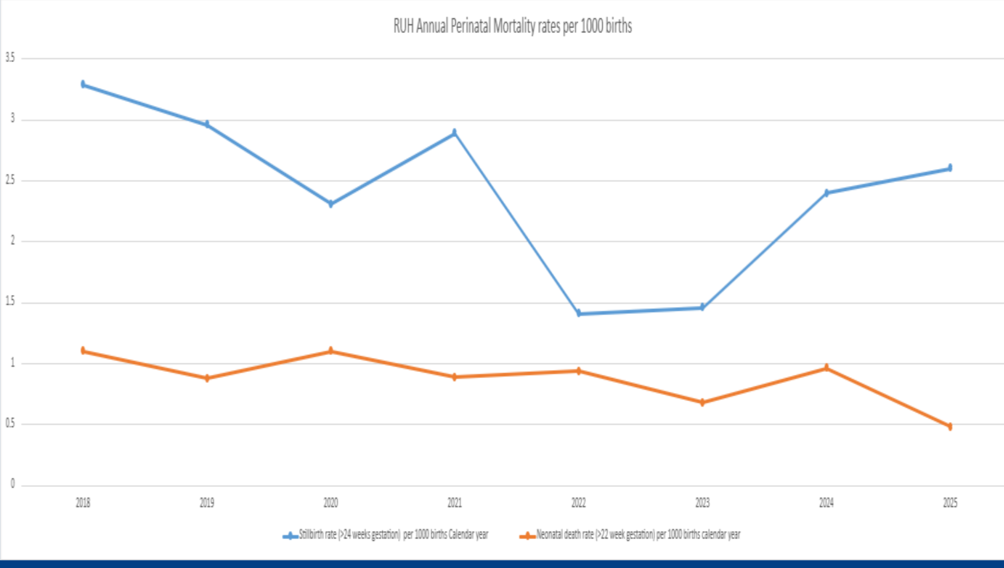
1 stillbirth and 0 NND in February 26– see incident slide

Annual calendar year RUH SB rate for 2025 is:

2.8 per 1000 births.

An increase from 2.4 per 1000 birthszduring 2024, although remains lower than the latest MBRRACE reported national average of 3.2 per 1000 for births in 2023 (MBRRACE, 2025)

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



Identified learning

Increased annual stillbirth rate noted for 2024 and 2025 vs 2022 and 2023.

No clear commonalities identified within initial reviews

Action: for Bereavement midwife B Walsh to conduct a case cohort review of all stillbirths in 2024 and 2025 inclusive of Equality and Equity review to identify any areas of care provision which require review.

PMRT Grading of Care

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

PMRT ID	Date of incident	PMRT Review Date	Incident	Grading of Care	Outcome/Learning/Actions	MNSI Reference	PSI Reference
Datix 147614	16/12/25	06/02/26	Intrauterine stillbirth at 38+4 weeks of pregnancy	Care graded A (before the baby died) and D (after the death of the baby confirmed).	Action: Feedback family concerns to chaplaincy team.	NA	NA
145533	09/10/25	27/02/26	Intrauterine perinatal death at 22+5 weeks of pregnancy	Care graded A (before the baby died) and B (after the death of the baby confirmed).	Learning: Parents were not given form to collect their feedback of care Action: PMRT information leaflet to be incorporated into DOC letter	NA	NA
144762	16/09/25	27/02/26	Intrauterine stillbirth at 34 weeks of pregnancy	Care graded B (before the baby died) and B (after the death of the baby confirmed).	Learning: RUH uses intergrowth charts to plot estimated fetal weights from USS. Other Trusts utilise alternative systems and therefore the Estimated Fetal Weight (EFW) from other Trusts is not always plotted on the RUH EFW charts on Badgernet. Action: RUH screening team to plot all EFW where USS has been performed at another Trust Learning: Blood test not taken from mother Action: Addition of stillbirth blood bundle (checklist) to patients EPR.	NA	NA
148231	07/01/26	27/02/26	Intrauterine perinatal death at 23+2 weeks of pregnancy	Care graded A (before the baby died) and B (after the death of the baby confirmed).	Learning: Blood test not taken from mother Action: Addition of stillbirth blood bundle (checklist) to patients EPR.	NA	NA
148371	10/01/26	27/02/26	Intrauterine stillbirth at 30+2 weeks of pregnancy	Care before death of baby pending further information Care graded B (after the death of the baby confirmed).	Learning: Blood test not taken from mother Action: Addition of stillbirth blood bundle (checklist) to patients EPR.	NA	NA

New Risk Assessments March 2026

Poor-quality maternity data limiting effective surveillance of maternity services

The risk?

Domain	Consequence (1-5) or N/A	x	Likelihood (1-5) or N/A	=	Risk score (1-25) or N/A
Patient Safety & Quality	3	x	2	=	6
Health and Safety		x		=	
Patient Experience		x		=	
Workforce		x		=	
Statutory, Legal or Reputational		x		=	
Estates and Facilities		x		=	
Finance including claims		x		=	
Service Delivery/ Performance		x		=	
Environmental					
Digital	4		4		16
Information Governance					
RISK SCORE (take the highest risk score)				=	16

Current Mitigations

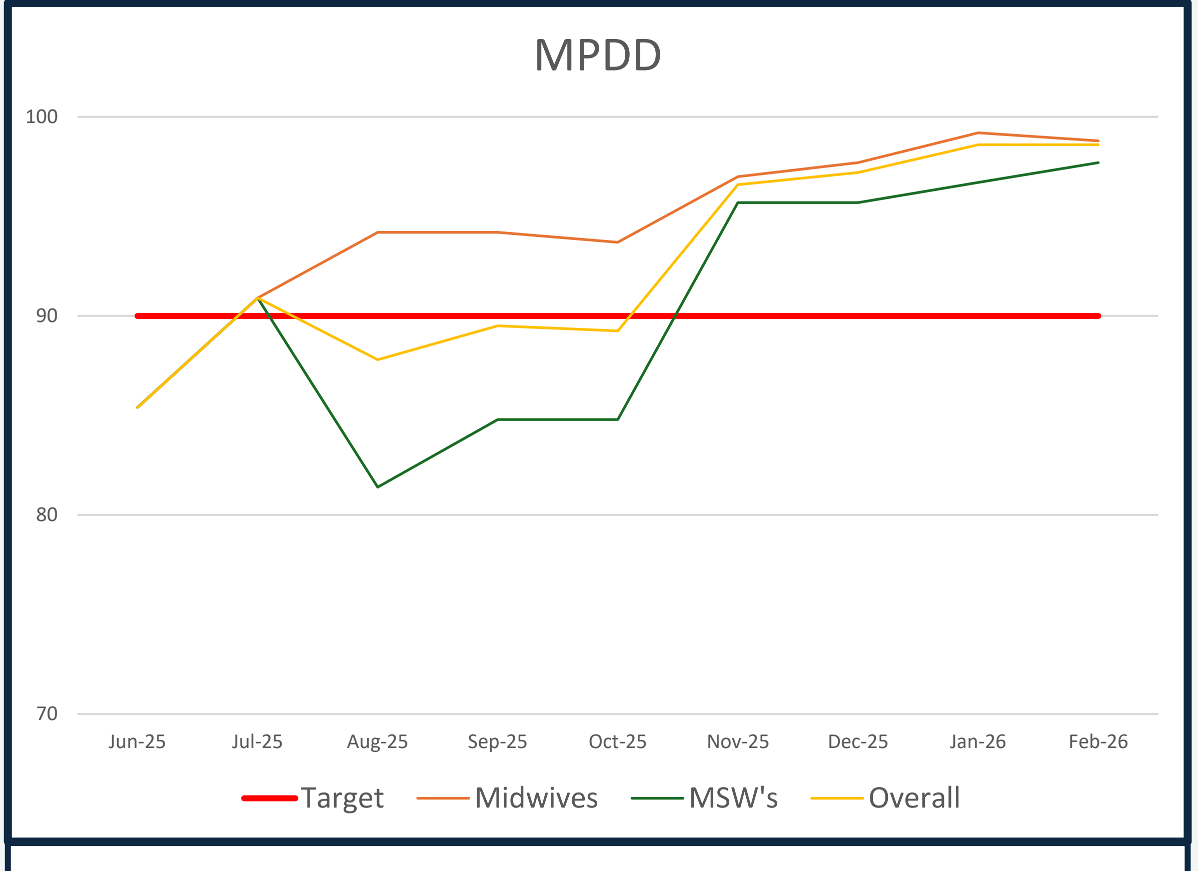
1. Clinical coding and data quality checks in place, including routine validation by the maternity data team and review of MSDS submissions
   - Monthly governance reporting to maternity governance, Safety Champions, and LMNS structures to allow 'read across' of other sources of service insight to spot trends or themes.
   - Use of incident reporting, clinical audit, and weekly MDT review forums to identify safety concerns and triangulate themes.
   - Maternity Dashboard (interim version) providing partial visibility of key clinical indicators
   - Review and benchmarking against national publications
2. Investigation into the metrics within MSDS which failed data quality – eg smoking at time of delivery with remedial action planning

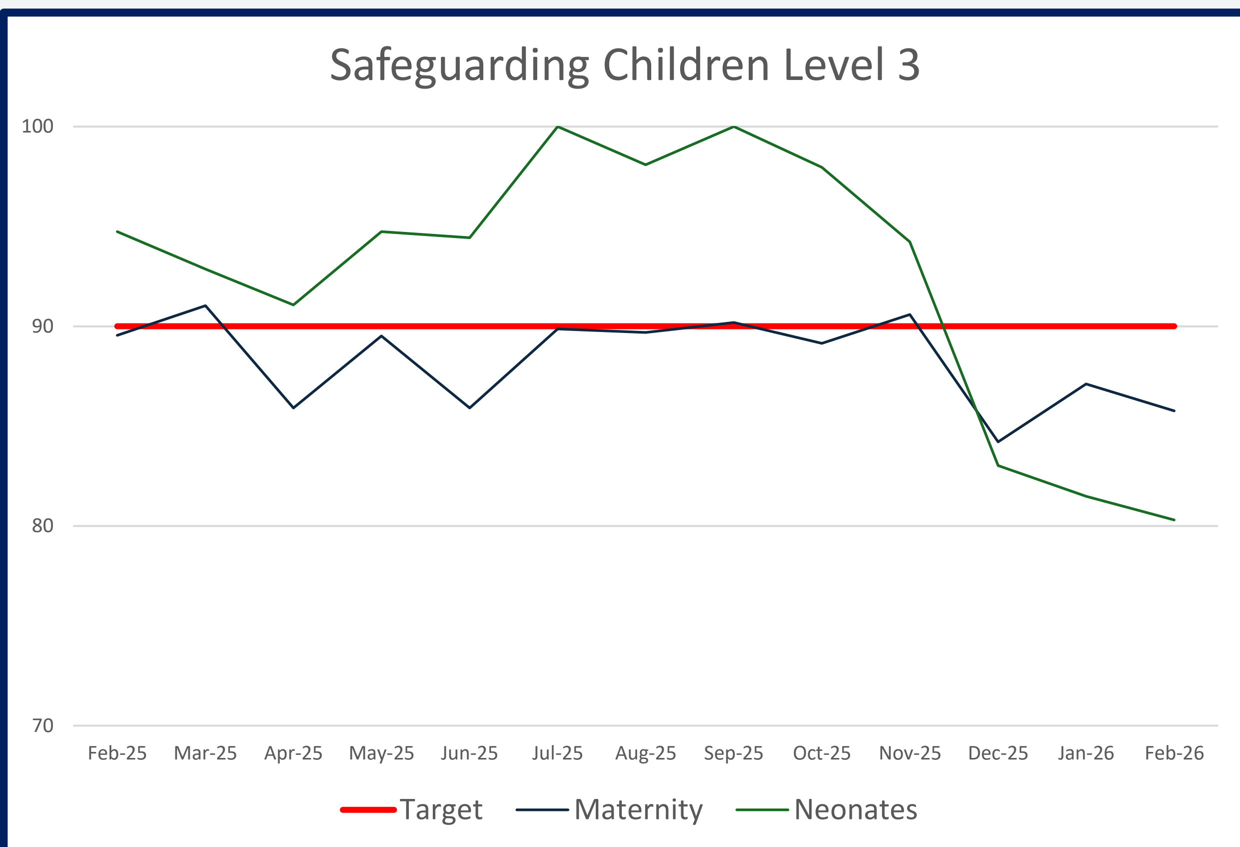
What should be in place?

1. Maternity dashboards aligned to previous dashboard and national reporting
2. Accurate digital information submissions to national platforms
3. Adequate human resource within the BIU team dedicated to Perinatal services to 'build' the reports lost in digital transformation to badger.net

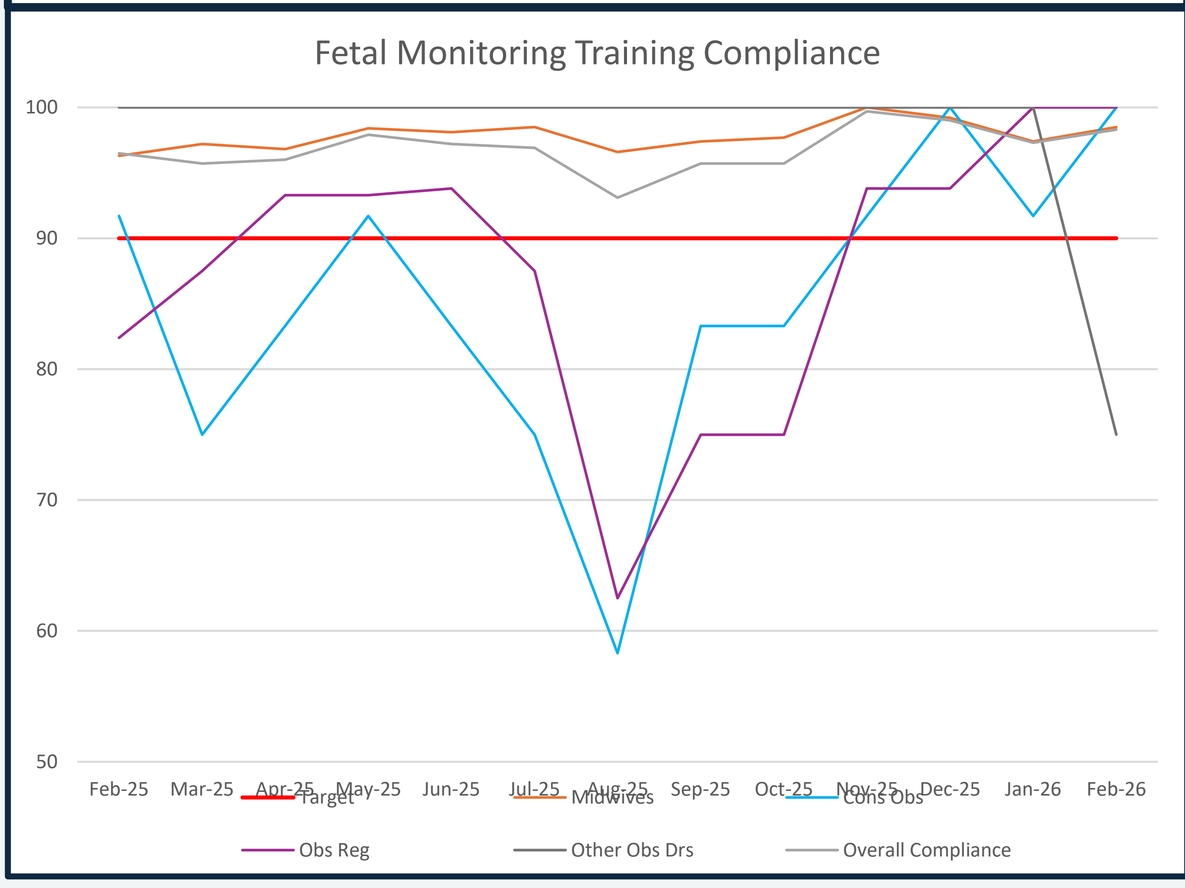
Actions to close the gaps?

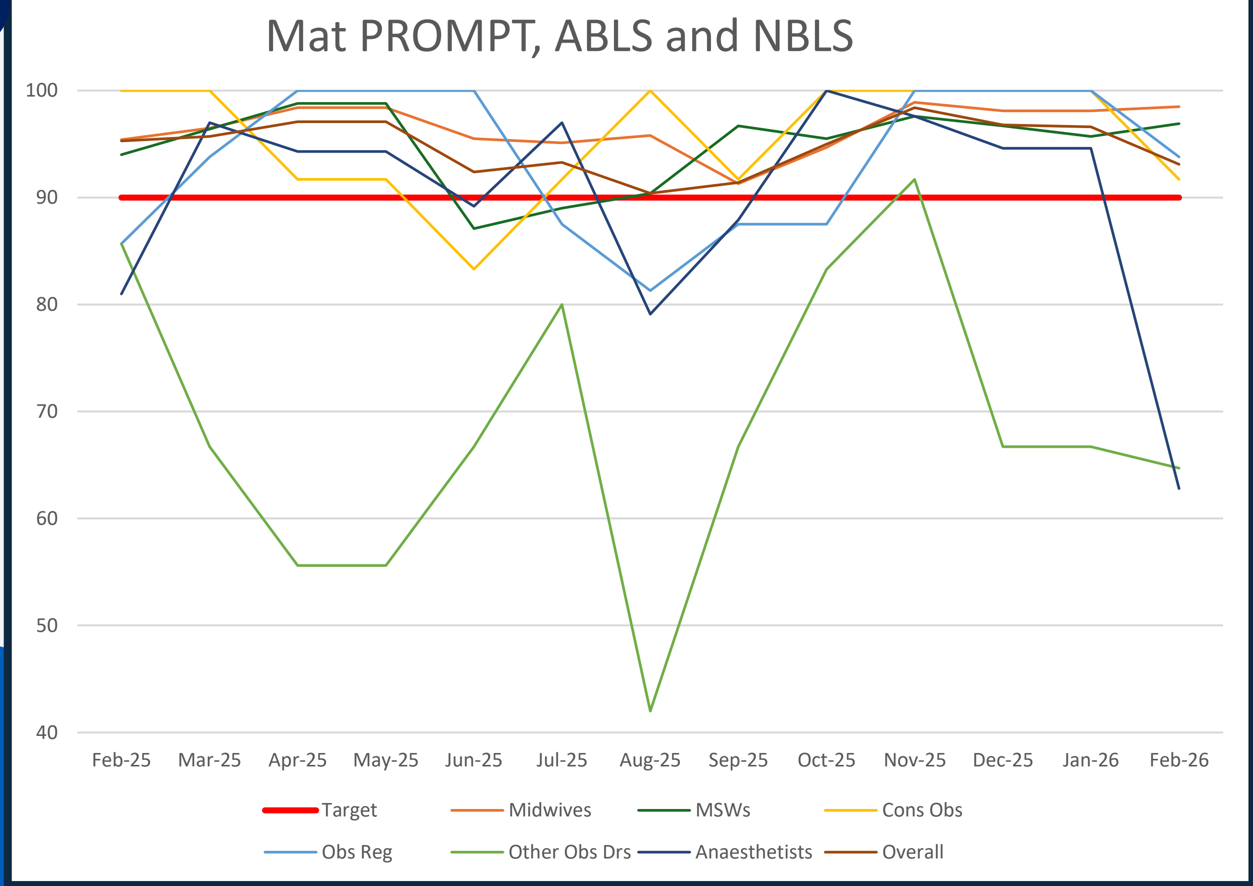
1. Benchmarking of current dashboard indicators against previous available metrics signposting availability of information in other platforms if possible
2. Prioritisation of metric 'build's for BIU analyst based upon the action above
3. Development of an enhanced maternity dashboard, supporting early warning detection and the ability to "read the signals" through triangulation of incidents, complaints, outcomes, and workforce indicators.
4. Inclusion of E+E metrics in all clinical audits for early detection while dashboard not in place

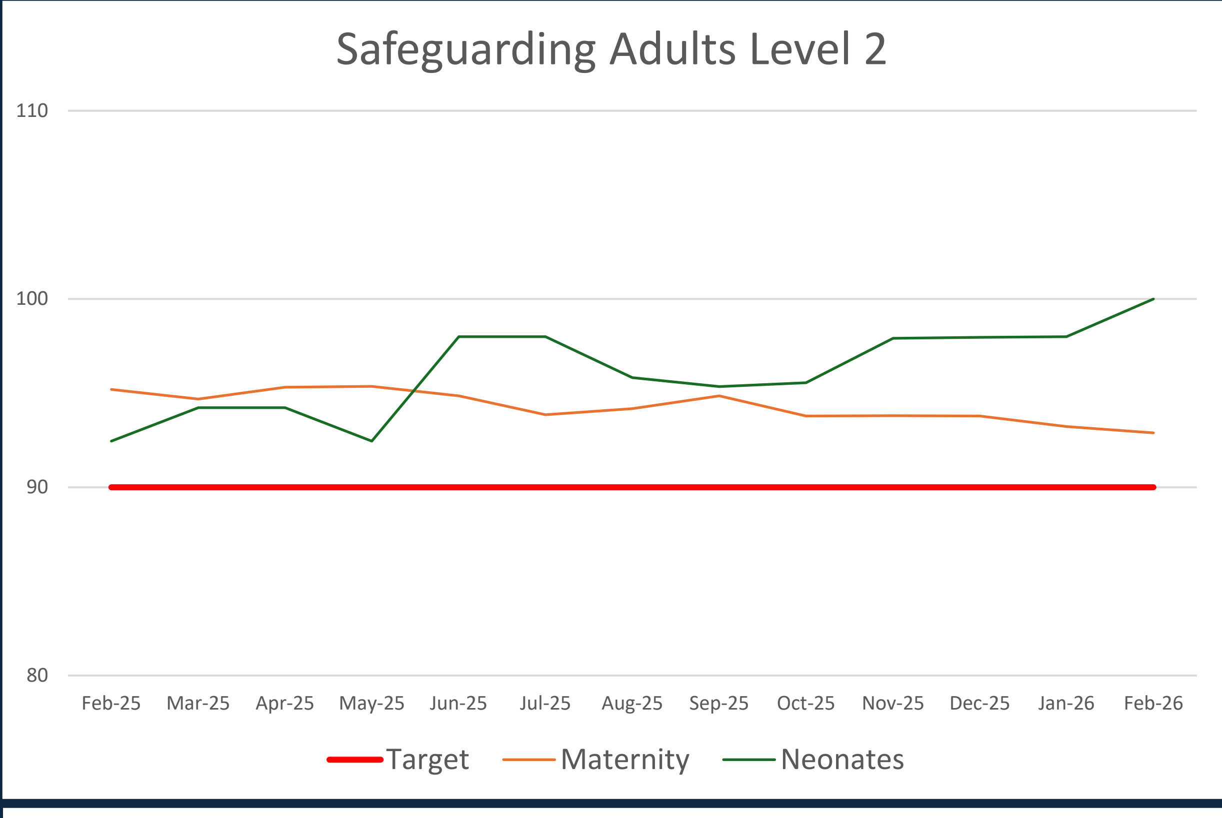


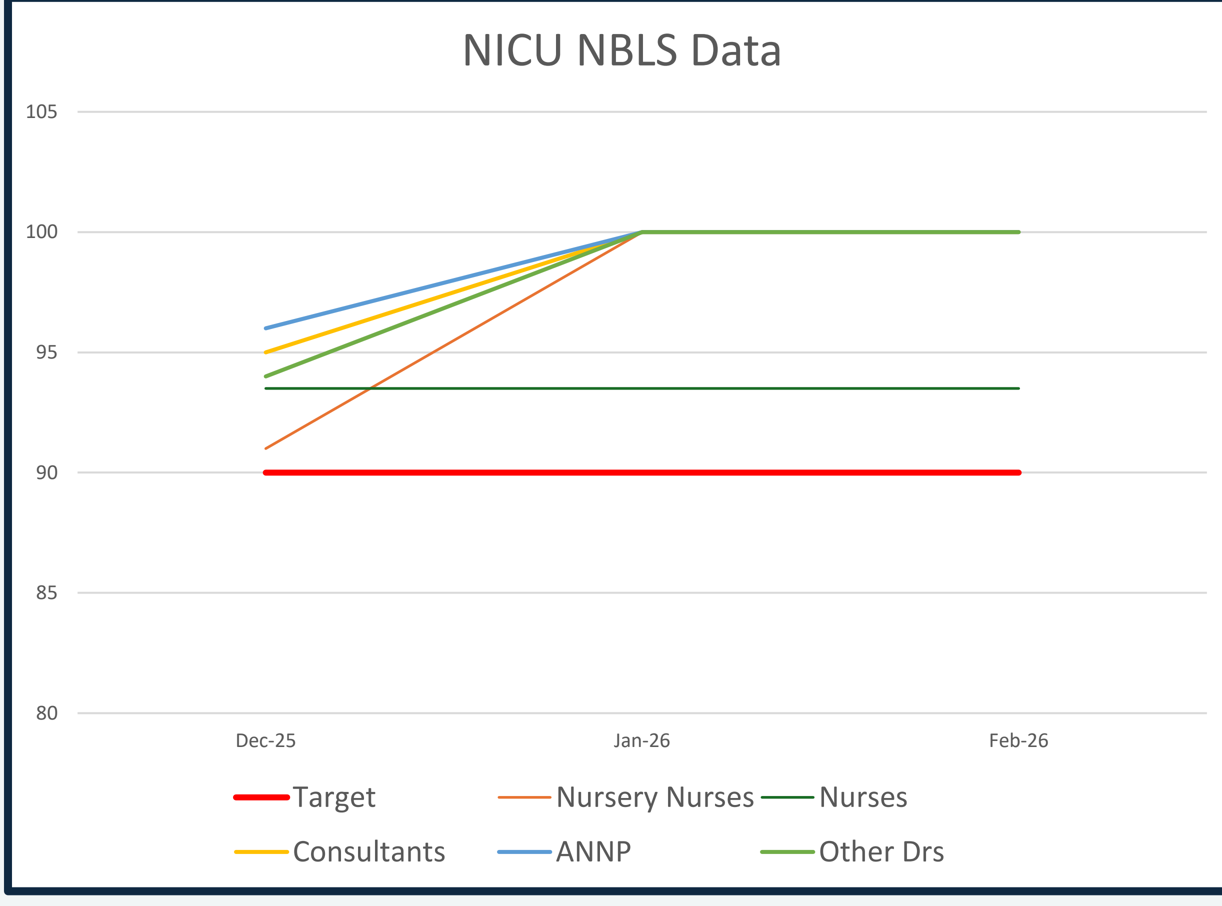


Training









Training

Neonatal ABLS =
Nursing Staff – 87%
Medical Staff – 84%

Neonatal PBLS =
Nursing Staff – 85%
Medical Staff – 68%

Training Countermeasures - Maternity

Overview Analysis and Potential Causes:

- Other Obs Drs compliance for PROMPT and ABLS not at target due to Dr rotations in Jan/Feb. All booked on so compliance projection good
- Compliance still under 90% for Safeguarding L3. Projected to drop to 77% with recent cancellation. In discussions for plans for extra study days
- Manual Handling still under 90% but slowly increasing
- Training picture positive overall
- New TNA in process – to present proposal at April Governance

Countermeasure / Action	Owner	Status	Due Date
Build MH into mandated study day	JM/CR	In progress	May 2026
Extra L3 Safeguarding Days	JM/PL	In Progress	May 2026

Identified Risk	Mitigating Action
Manual Handling compliance	Being built into study day from June 2026
New NBLS algorithms	Community plan being built for new home birth algorithm
Funding for laptops/iPads - unspent budget	Sat with Finance Currently
L3 Children's Safeguarding Compliance	Extra study days planned. Options being explored for alternative options for delivering Level 3 training for perinatal services consideration of BSW resource.

Training Countermeasures - Neonates

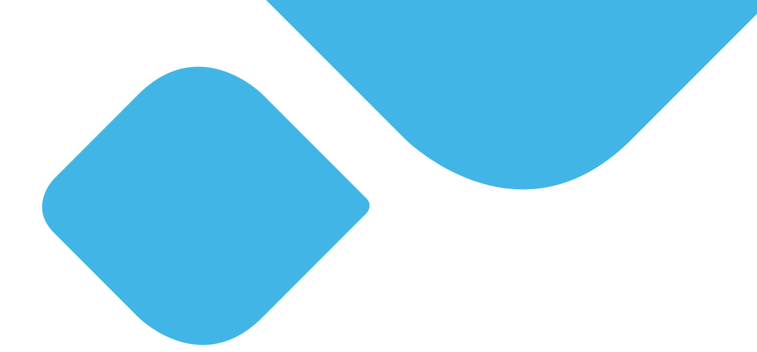
Overview Analysis and Potential Causes:

- ABLS + PBLS compliance below 90%. Difficulty with accessing training during working day due to acuity. Compliance will continue to be variable until next year as now being added to professional update SD
- Safeguarding Level 3 compliance below 90%. Many new starters and staff expiring at same time and most recent monthly study day cancelled. More booked on course, so should improve in next months
- Other mandatory training compliance good

Countermeasure / Action	Owner	Status	Due Date
Build ABLS + PBLS into mandatory update day	TS	In progress	March 2026
6 booked onto SGL3 course and early booking encouraged	TS	In progress	July 2026

Identified Risk	Mitigating Action
ABLS + PBLS compliance	Built into professional update day from March 2026
Children's L3 Safeguarding compliance	Options being explored for alternative options for delivering Level 3 training for perinatal services consideration of BSW resource.

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

Workforce Report

March 2026
(February 2026 Data)

The RUH, where you matter

Breakthrough and Vision Metrics Summary

Strategic Goal	Measure Group	Measure	Measure Category	Latest Survey	Latest Performance	Trend
People we work with	Employee Experience	% Satisfied with extent organisation values their work (National)	Breakthrough	2024	42.7%	
People we work with	Employee Experience	% Agreeing that immediate manager values work (National)	Context	2024	74.7%	
People we work with	Employee Experience	% Agreeing that feel valued by team (National)	Context	2024	72.1%	
People we work with	Employee Experience	% Recommend Trust as place to work (National)	Vision	2024	63.5%	
People we work with	Employee Experience	% Recommend Trust as place to work (Pulse)	Watch	25-26 Q4	52.0%	
People we work with	Employee Experience	% Agreeing that organisation acts fairly regarding career progression (National)	Vision	2024	56.1%	
People we work with	Employee Experience	% Experienced discrimination from public (National)	Vision	2024	10.5%	
People we work with	Employee Experience	% Experienced discrimination from managers/colleagues (National)	Vision	2024	8.2%	

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

Metric Summary I

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	Feb-26	5796.7		<=5578.3		Not in FY			SPC not appropriate
People we work with	Workforce Plan	Substantive WTE	Context	Feb-26	5484.7		<=5322.7		9			SPC not appropriate
People we work with	Workforce Plan	Bank WTE	Context	Feb-26	288.9		<=250.6		Not in FY			Special Cause Improving - Run Below Mean
People we work with	Workforce Plan	Agency WTE	Context	Feb-26	23.2		<=5.0		9			Special Cause Concerning - Run Above Mean
People we work with	Vacancy	Vacancy Rate	Key Standard	Feb-26	-1.21%		<=4.00%		0			SPC not appropriate
People in our community	Pay	Pay Bill % on Agency	Watch	Feb-26	1.48%		<=2.50%		0			Special Cause Concerning - Trending up
People we work with	Turnover & Leavers	In Month Turnover	Key Standard	Feb-26	0.58%		<=0.92%		0			Special Cause Improving - Run Below Mean
People we work with	Turnover & Leavers	12 Month Turnover	Key Standard	Feb-26	7.00%		<=11.0%		0			Special Cause Improving - Run Below Mean
People we work with	Turnover & Leavers	Leavers Inside 1st Year	Context	Feb-26	5.15		N/A					

Metric Summary II

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	Jan-26	6.00%		<=5.22%		8	F	H	Special Cause Concerning - Two out of Three High
People we work with	Sickness Absence	Short Term Sickness	Context	Jan-26	3.18%		N/A					
People we work with	Sickness Absence	Long Term Sickness	Context	Jan-26	2.82%		N/A					
People we work with	Sickness Absence	12 Month Sickness	Key Standard	Jan-26	5.35%		<=4.70%		14	F	H	Special Cause Concerning - Run Above Mean
People we work with	Sickness Absence	In Month ASD Sickness	Driver	Jan-26	1.45%		TBC			F	H	Special Cause Concerning - Run Above Mean
People we work with	Appraisal	Appraisal Compliance	Key Standard	Feb-26	80.61%		>=90.0%		Pre-2021	F		Common Cause
People we work with	Appraisal	AfC Appraisal Compliance	Context	Feb-26	81.02%		>=90.0%		Pre-2021	F		Common Cause
People we work with	Appraisal	M&D Appraisal Compliance	Context	Feb-26	76.29%		>=90.0%		Pre-2021	F		Common Cause
People we work with	Training	Mandatory Training Compliance (Core)	Key Standard	Feb-26	89.17%		>=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.

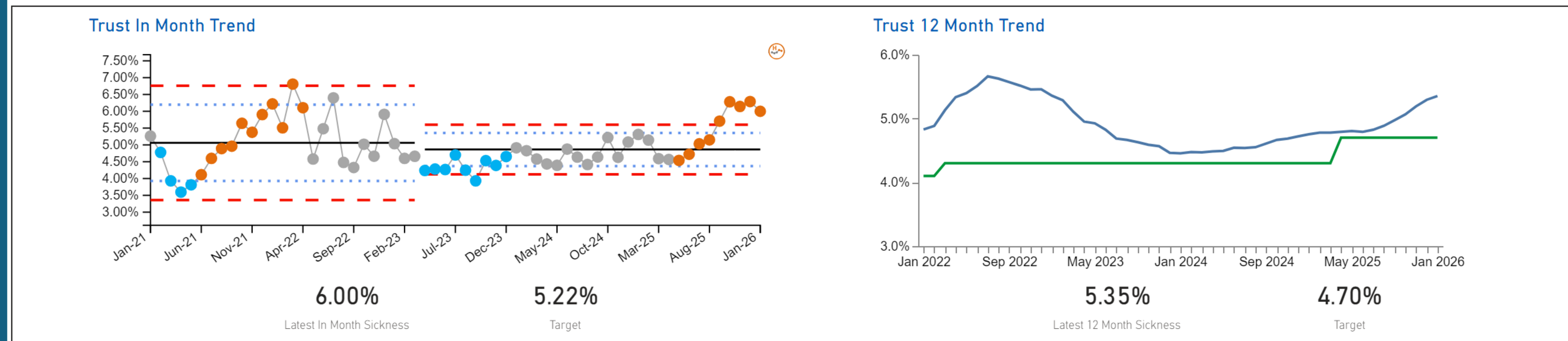
Sickness

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

January's in-month sickness rate was 6.00% which equates to over 10,000 WTE days having been lost. Although this rate is down on the previous three months, it remains elevated compared to previous January figures (2025 – 5.31%; 2024 – 4.91%; 2023 – 5.05%).

Sickness absence continues to rise. The rolling 12-month rate is now 5.35%, which is 0.6 percentage points higher than a year ago.

In January, 43.6% of all sickness was due to Anxiety, Stress & Depression or Cold & Flu. This is slightly higher than December's 42.4%, showing how much these two causes continue to drive the overall sickness rate

Estates and Facilities has the highest in-month (8.76%) and 12-month (7.24%) rates, but in WTE days lost (and thus likely cost) terms Medicine and Surgery have the highest figures.

Countermeasures	Owner	Due Date
Medicine: Analysis and actions related to higher than expected sickness during February half term. All managers contacted to discuss absence patterns with relevant members of staff .	DPP	March 2026
Surgery: working with clinical leads to support medical sickness. Successful work undertaken in Anaesthetics will be rolled out to other departments.	DPP	April 2026
FASS: deep dive into medical sickness taking place in hot spot areas.	DPP	April 2026
A Trust-wide Sickness Task & Finish Group has been established, complemented by a new HR-led Sickness Absence Reduction Group. Both groups are implementing a coordinated programme of actions aimed at reducing sickness absence across the organisation.	HR	April 2026

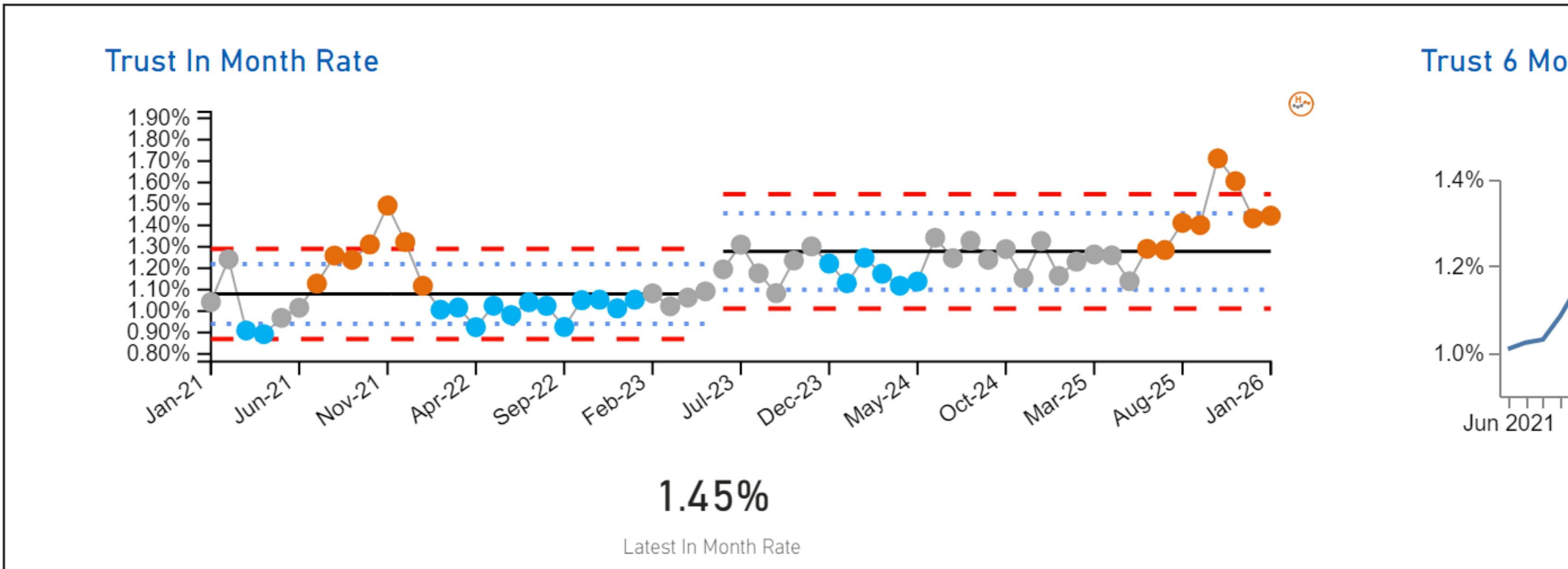
Risks and Mitigation

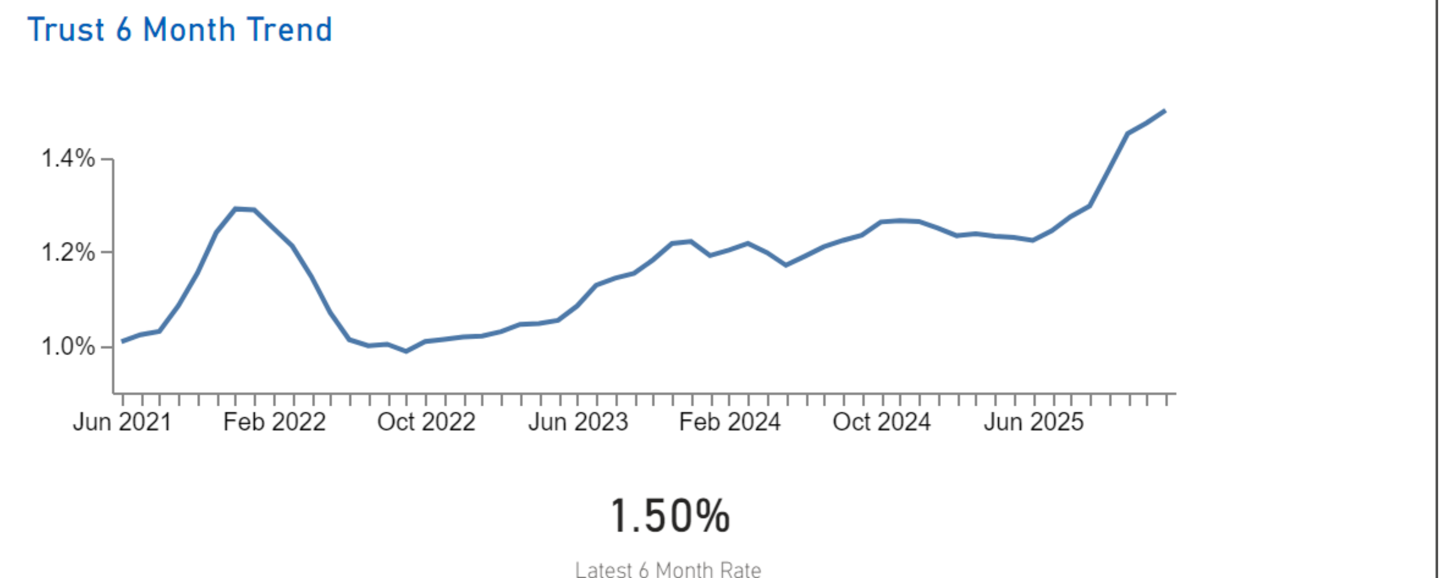
- Concerns raised around the Maintaining Attendance policy and its ease of use.
- This has been mitigated by running manager focus groups to provide feedback – the policy was relaunched in March 26 with manager training

Anxiety, Stress and Depression Sickness

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.





Understanding Performance

Between January 2021 and July 2025, an in-month anxiety, stress and depression sickness rate above 1.4% was recorded just once. In contrast, each of the last six months reported have been 1.4% or higher with January 2026 at 1.44%.

Compared to January 2025, an additional 500 WTE days were lost in January 2026 for this reason alone.

Though the ESR methodology is crude and lacks nuance, the estimated cost it calculates suggests an indicative increased cost on last January of c.£60k.

Emergency Medicine, Oncology and Older People's Unit are directorates that all have in month rates over 2% and over 150 WTE days lost.

Countermeasures	Owner	Due Date
Surgery: Has remained a driver all year. Working with hot spot areas to tailor support packages.	Tri	April 2026
E&F- A3 being started in Cleaning to understand root cause and focus on Anxiety/Stress and Depression.	DPP/ Coach House	May 2026
Perkbox promotion, providing staff with 24/7 confidential EAP counselling and specialist support.	AD for Culture	May 2026

Risks and Mitigation

Levels of ASD sickness absence remain high at a time of operational challenge, and in the context of central resources to support wellbeing being limited.

Introduction and fuller engagement with wellbeing resources and services via Perkbox (communications campaign to increase messaging throughout Q4)

Appraisal

Royal United Hospitals Bath NHS Foundation Trust

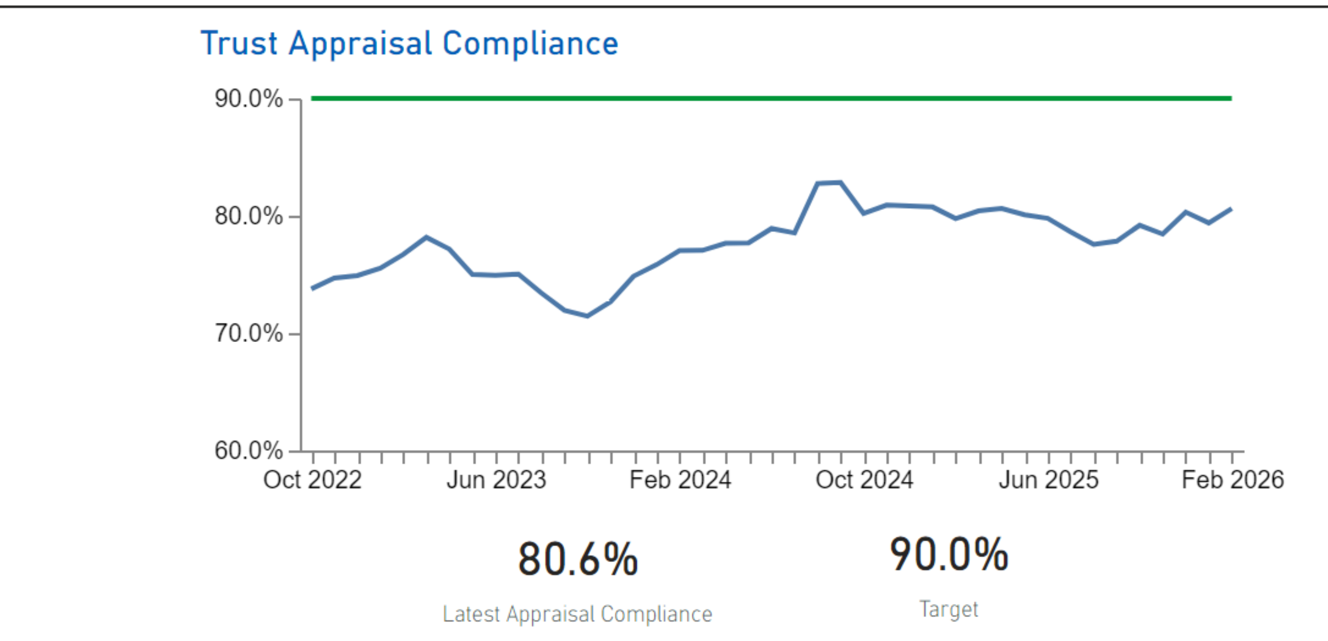
DRIVING

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.

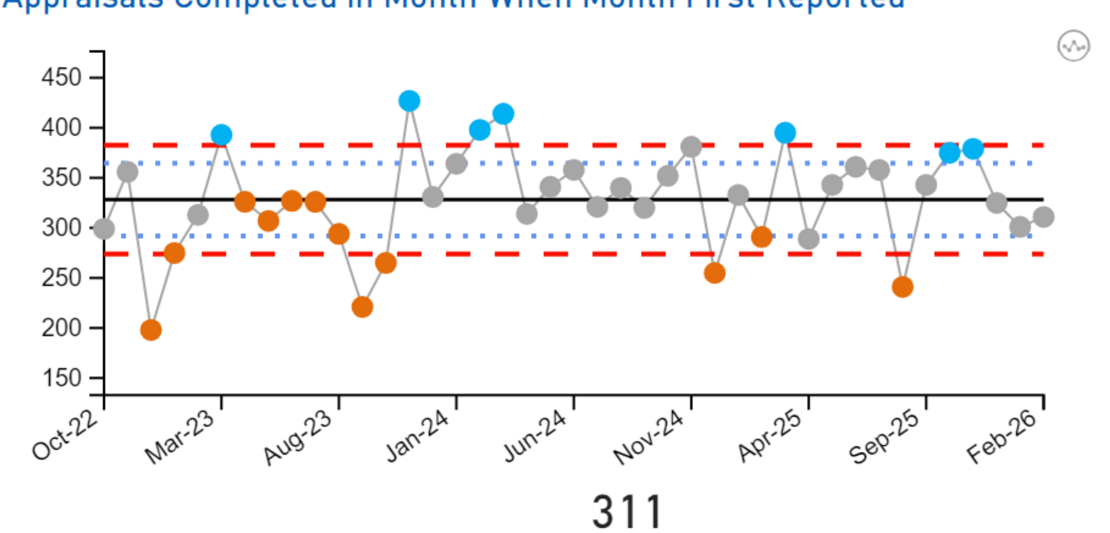
Trust Appraisal Compliance



80.6%
Latest Appraisal Compliance

90.0%
Target

Appraisals Completed in Month When Month First Reported



311
Appraisals Completed in Month

Understanding Performance

Appraisal compliance has risen to **80.61%**, but this largely represents a return to early-2025 levels rather than a genuine improvement. The Trust appears to have a ceiling of around **81%**, leaving it consistently **~500 appraisals short** of the **90% target**.

Reaching 90% overall would require some Divisions to exceed this level, yet the highest performers—**R&D (87.69%)** and **Estates & Facilities (87.60%)**—remain below target, with Estates & Facilities already slipping after their December push.

Medicine has improved to **83.89%** but is still more than six percentage points off target.

The **Corporate Division** continues to have the lowest compliance at **62.93%**, declining since October, likely reflecting reduced engagement during the ongoing restructure.

Countermeasures	Owner	Due Date
Medicine: Focus on and discussions with Cardiology through specialty PRM process resulted in increase in compliance 80.2% (5% increase on previous month).	DPP	March 26
Surgery: has seen an increase in month. Continued focus in speciality PRMs and this will be a driver again for 26/27.	DPP	April 26
Estates and Facilities: Estates has hit 90% however Facilities, particularly Facilities manager team are falling below. Action is complete within next month and continue A3 process.	E&F Board	Ongoing

Risks and Mitigation

Potential risks around appraisals not being completed are:

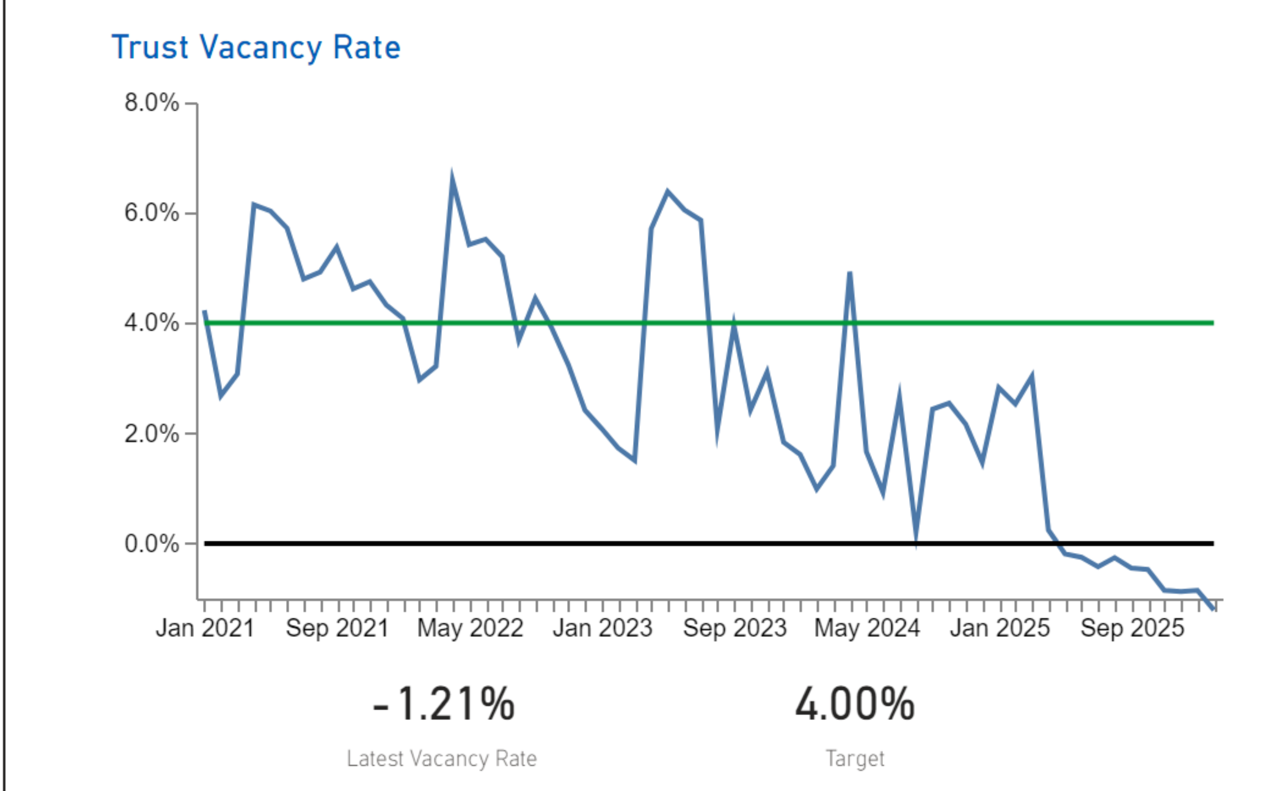
- Reduced Staff engagement and morale
- Lack of clear objectives and personal development

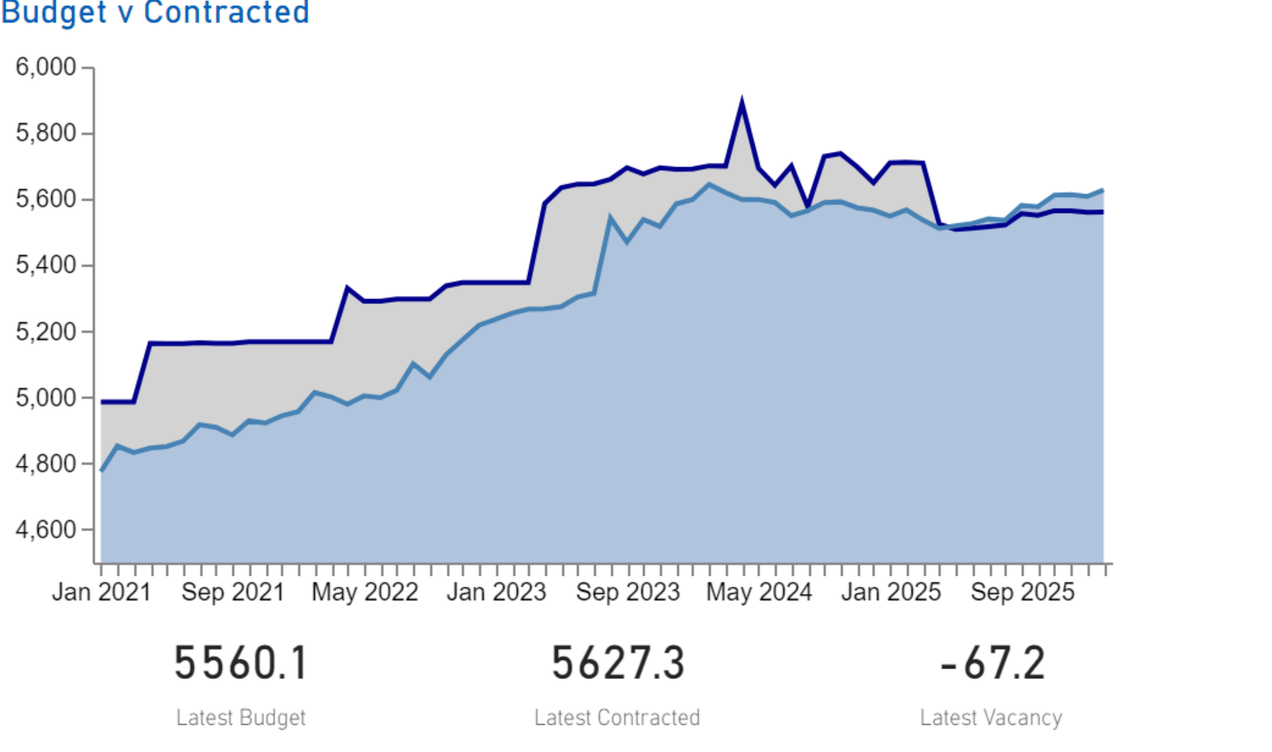
To mitigate this:

- There needs to be protected time for both appraiser and appraisee to complete appraisal.
- The appraisal needs to add value and be beneficial
- Senior Leadership Teams to communicate the importance of appraisals

Vacancy

Key Standard





Understanding Performance
With Contracted WTE growth outpacing Budget WTE growth at the overall Trust level in February, the aggregated position has shifted to being further over-established by c.20 WTE.

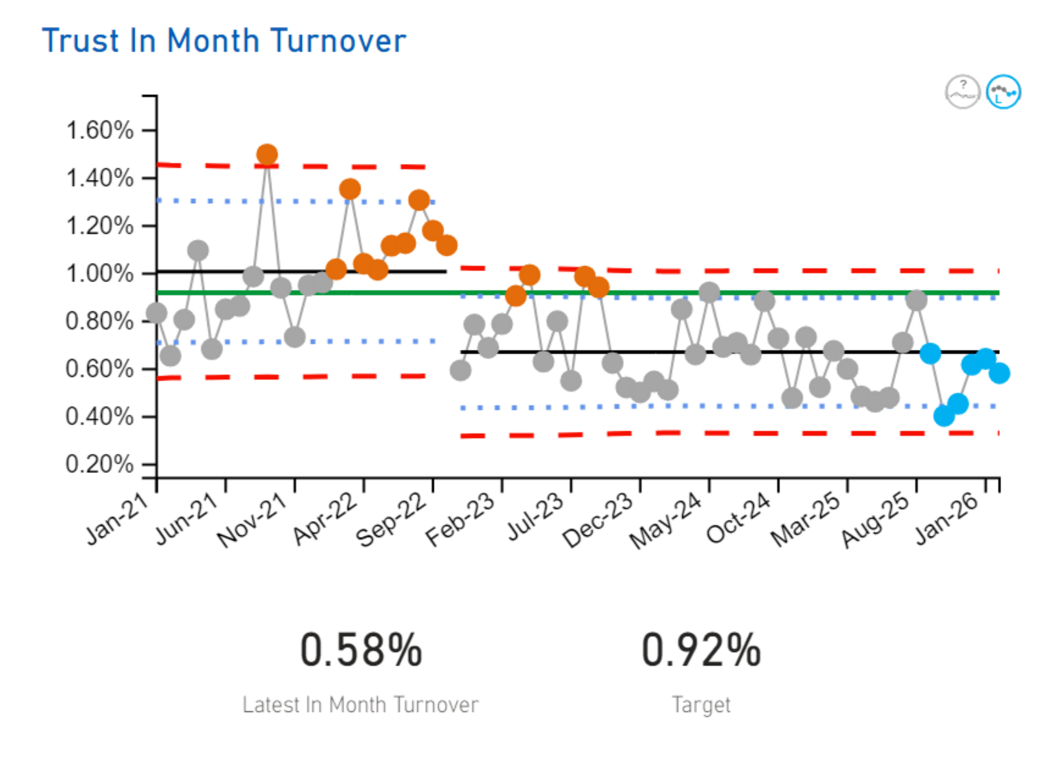
Countermeasures	Owner	Due Date
Divisions: Monitoring recruitment requests through the vacancy control processes.	*Divisional Tri*	*April 26*

Risks and Mitigation
Risk: Government wide 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

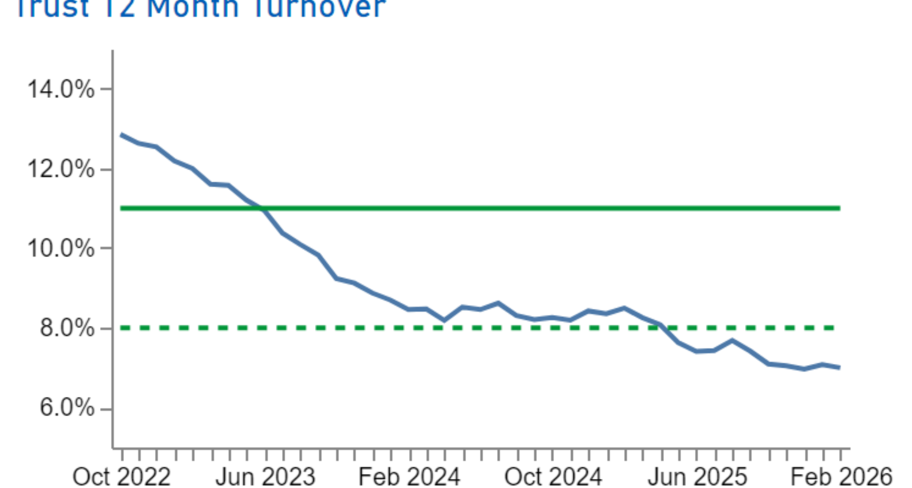
Trust In Month Turnover



0.58% 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	0.51%	9.19%
Estates and Facilities Division	0.33%	6.89%
Family and Specialist Service Division	1.14%	8.44%
Medical Division	0.27%	5.68%
Research & Development [Division]	1.48%	8.97%
Surgical Division	0.77%	6.96%

Main Staff Group	In Month	12 Month
Add Prof Scientific and Technic	1.23%	12.37%
Additional Clinical Services	0.98%	10.44%
Administrative and Clerical	0.91%	9.82%
Allied Health Professionals	0.26%	6.24%
Estates and Ancillary	0.40%	7.20%
Healthcare Scientists	1.23%	11.35%
Medical and Dental	0.12%	2.80%
Nursing and Midwifery Registered	0.28%	3.70%

Understanding Performance

In-month turnover remains below target and inside the expected parameters at 0.58%.
At 7.00%,12-month turnover continues the run of stable points since October with all have fallen inside a 0.15 percentage point range. However, this rate may be considered unhealthily low.
FASS (1.14%) is the only division to have an in-month rate above 1%. Whilst several of its directorates have rates above 1% for February, of these only Pharmacy repeatedly has higher rates.
Corporate (9.19%) has the highest 12-month rate of divisions, though this rate and the pattern of turnover does not present cause for concern.
By staff group, the highest rates are for Add Prof Scientific and Technic staff and Healthcare scientists. With leavers WTE only 17.0 and 18.7 respectively over 12 months, their small denominators are key to this. In terms of leavers WTE, Administrative and Clerical (103.1) and Additional Clinical Services (95.0) are the top contributors.

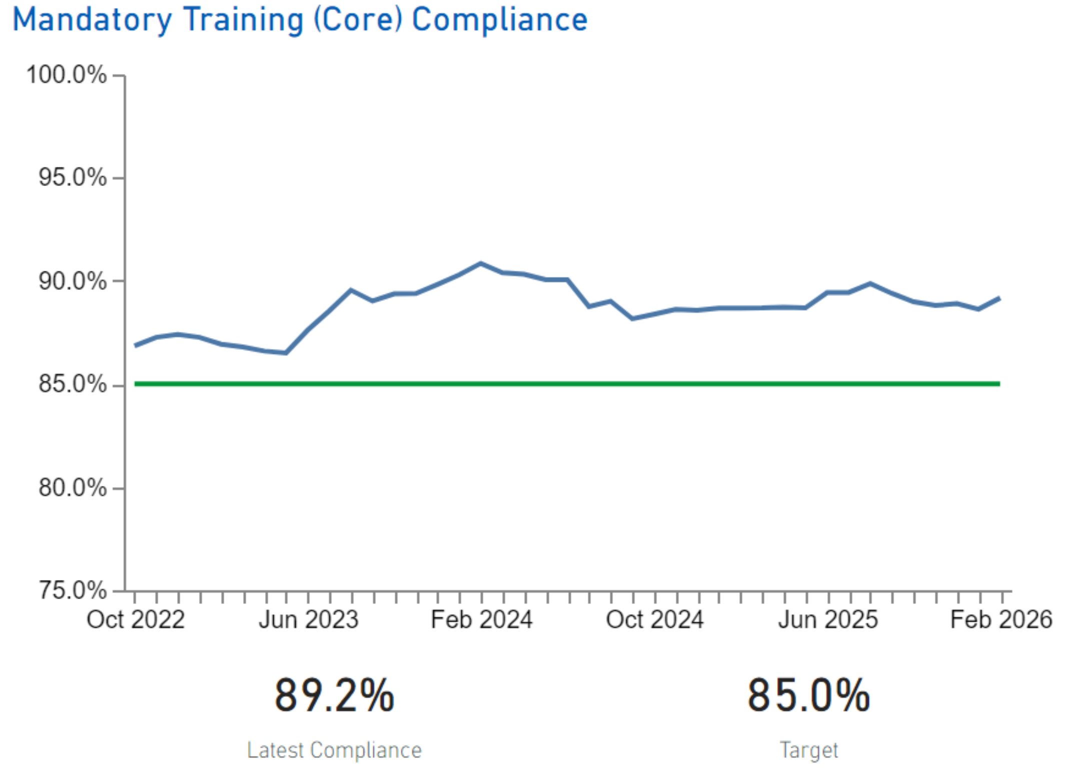
Countermeasures	Owner	Due Date
Surgery: turnover remains below trust target. Still monitoring leavers through divisional board and PRMs.	Divisional Tri	

Risks and Mitigation

Turnover remains very low and may be considered unheathily low – leading to other workforce metrics deteriorating.

Mandatory Training

Key Standard



Understanding Performance
Overall compliance has slightly improved to 89.17%, reversing some of the drop-off over winter. Except for Capital Summary (where only a small number of additional completions would be required to achieve target), all divisions are bettering 85% overall. There are a number of directorates whose performance is below the targeted 85% and in some cases below the 80% tolerance. Of the subjects reported as not meeting their targets last month, Resuscitation Newborn Basic Life Support has now bettered its target with compliance at 90.32%. In contrast, Safeguarding Adults Level 3 has fallen below its tolerance level to 83.22%.

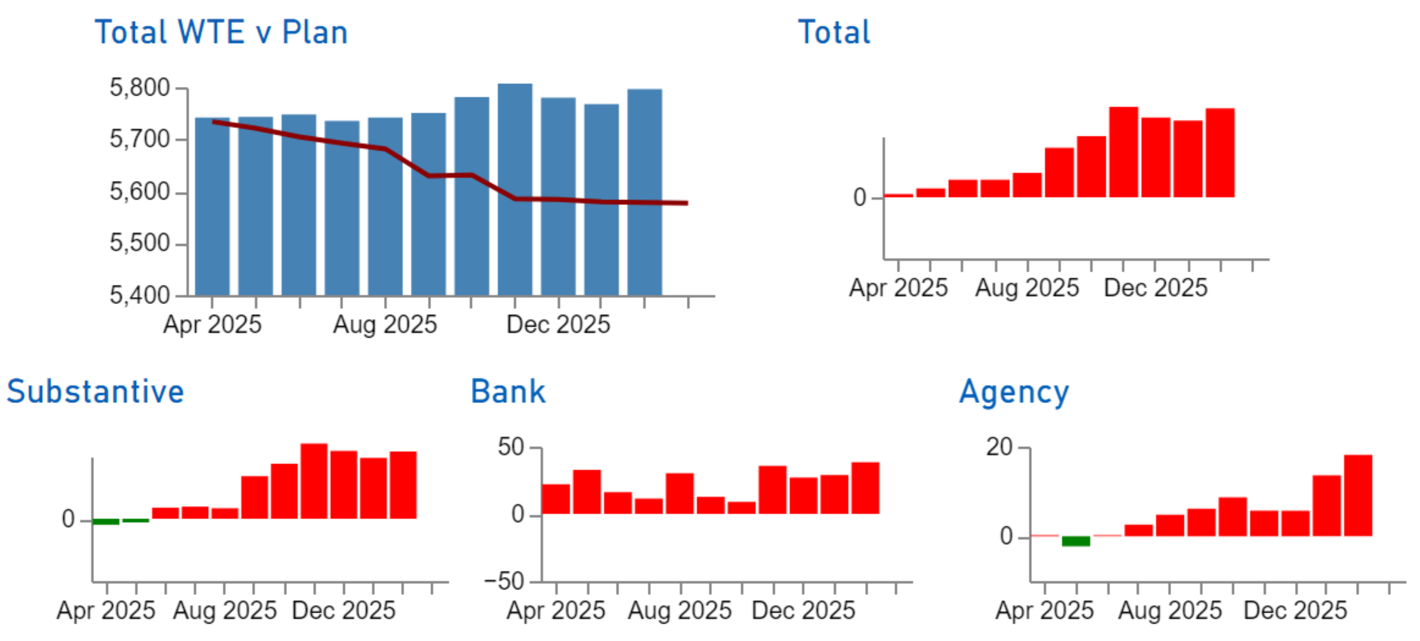
Countermeasures	Owner	Due Date
Medicine: Emergency department practical resus training decoupled from e-learning to allow additional flexibility in completion.	Deputy People Partner	March 26
Mandatory Learning Oversight Group (MLOG) proposals: Adult and Paediatric Basic Life Support, IG and fire safety proposed to move from 1 yearly to 2 yearly compliance – awaiting IIC approval.	Head of Corporate Education	April 26
Surgery: Resus Peads remains a hot spot area. List of those out of date has been sent to divisional tri to monitor.	Divisional Tri	April 26
FASS: Nearly at 90% complaint. Focusing on Moving and Handling level 2.	Divisional Tri	April 26

Risks and Mitigation
Site specific MLOG paused awaiting group governance for Group approach to MLOG

Performance vs Workforce Plan

Driver

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



Plan

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

Actual

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Total	5,741.71	5,742.75	5,747.91	5,735.38	5,741.74	5,750.87	5,781.06	5,807.26	5,780.19	5,767.78	5,796.69	
Substantive	5,408.81	5,409.60	5,436.89	5,428.87	5,427.04	5,462.50	5,494.90	5,503.27	5,485.95	5,468.74	5,484.66	
Bank	326.67	329.39	304.82	297.91	303.90	277.22	272.48	293.28	283.55	280.44	288.87	
Agency	6.23	3.76	6.20	8.60	10.80	11.15	13.68	10.71	10.69	18.60	23.16	

Understanding Performance

Following increases to substantive, bank and agency, the gap between actuals and planned figures has widen to almost 220 WTE.

After a dip in January, February's actual substantive figure has returned to level reported in December.

Actual bank WTE has slightly increased to 288.9 WTE but remains within the expected range of performance based on the past few months.

The planned agency figure for February (5 WTE) has again been significantly exceeded (+18.16) and is the tenth time in the financial year to date where the plan has not been realised.

Countermeasures	Owner	Due Date
Sickness Reduction Initiative with the aim to improve health and wellbeing of our staff but also to support substantive levels reduce bank and agency usage in the organisation.	Senior Leadership Team - HR	May 2026
Continuation of Recruitment and Workforce Controls – including vacancy reviews and approval processes before recruitment.	Executive Team	May 2026
Workforce Transformation - Skill Mix Reviews, Recruiting to what is needed not what has always been there, Right Skill – Right Place – Right Time.	Head of Workforce Planning	May 2026

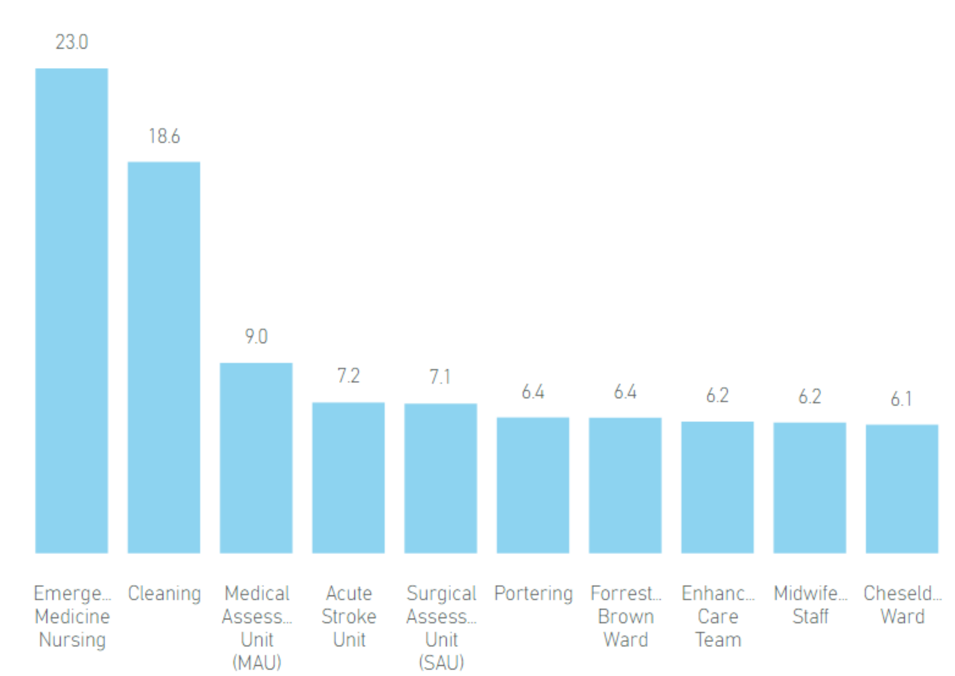
Risks and Mitigation

The RUH FOT for March 26 that has been submitted as part of the 26/27 workforce plan will be higher than initially predicted – meaning we will need to potentially reduce further in 26/27 than initially planned if we don't control our numbers now.

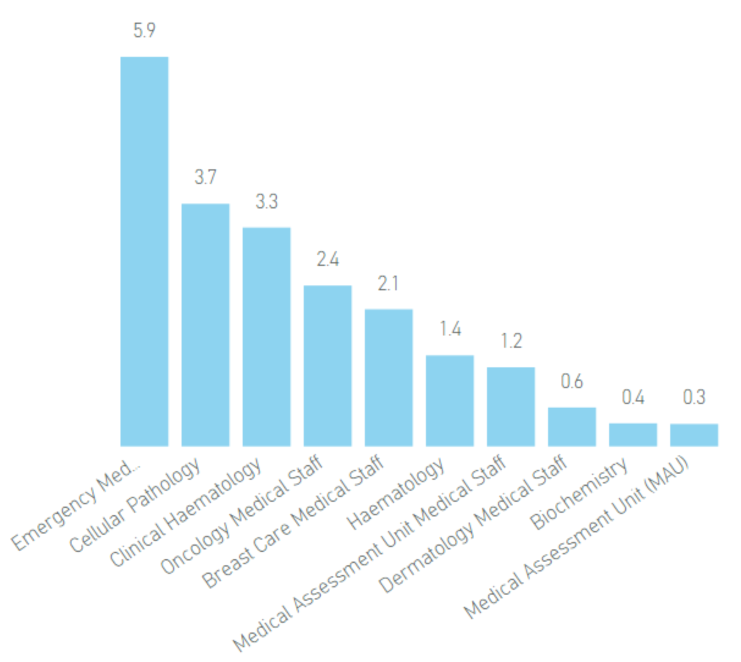
Bank & Agency Use

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	20.7	11.0
Registered Nursing, Midwifery and Health Visiting Staff	97.3	7.1
Registered/ Qualified Scientific, Therapeutic and Technical staff	9.7	4.0
Support to Clinical Staff	109.1	
NHS Infrastructure support	51.9	-0.4

Understanding Performance

Emergency Medicine remains the top user of bank (23.0 WTE). Whilst this continues a downward trend in this metric, this is offset by a swing to agency use with the directorate now the leading user of agency (5.9 WTE).

The combined figures suggests that demand has been broadly consistent since September. What has changed is how that demand is met.

Cleaning is the second highest user of bank. At 18.6 WTE, the level of use was the directorate's lowest in the year.

Medical and Dental agency use alone continues to exceed the overall planned use, with the key contributing directorates being those with long-standing challenges.

Countermeasures	Owner	Due Date
Demands in ED remain high with additional staff being requested to cover corridor care. Along with the continued long lines for agency band 5 nurses supporting vacancies in the area. The agency use will reduce in March as a pipeline of new starters join the team. 15 nurses started in Feb/March with 9 internal and 6 external. 4 nurses due to start in next 2 months. Current pipeline – 1 x staff nurse and 2 x ED A advertised – closing 19/22 March	Staffing Solutions	May 2026
Cleaning recruitment campaign – 5 started early March – 2 due to start on 23/03. No further activity in pipeline.	Staffing Solutions/REC	April 2026
Additional Medical agency required to support services until the end of the financial year.	Staffing Solutions	April 2026

Risks and Mitigation

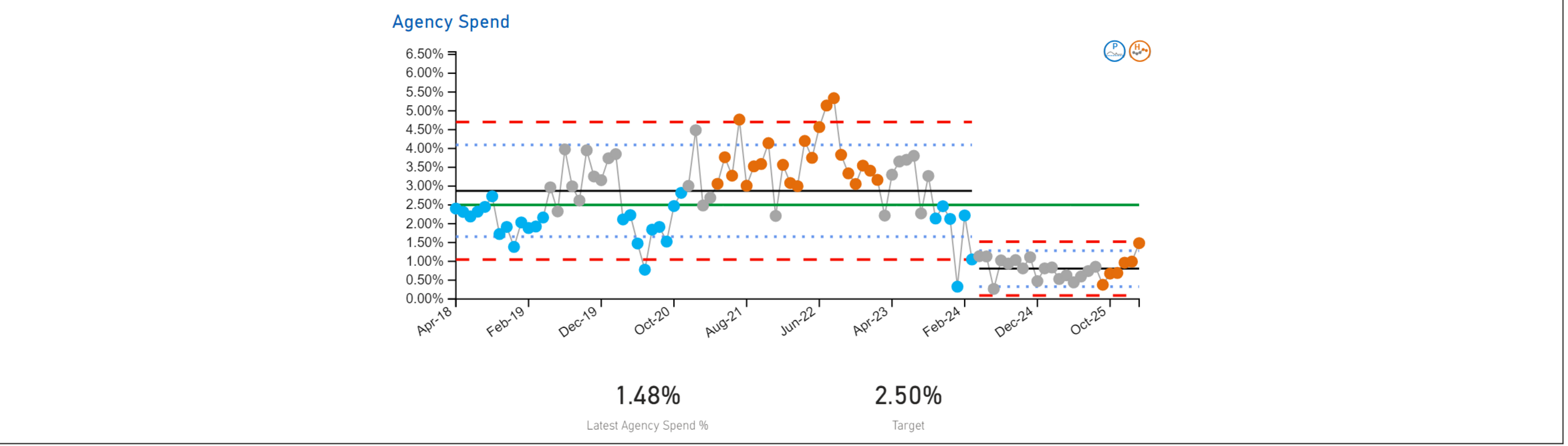
High sickness levels may increase reliance on bank and agency staffing, leading to higher costs and reduced continuity.
Targeted health and wellbeing initiatives are underway to improve staff wellbeing and reduce sickness absence, helping to minimise the need for temporary staffing.
Medical Agency short term support to reduce waiting lists until the end of March.

Month

Feb-26

Agency Spend as % of Total Pay Bill

Key Standard



Understanding Performance

As it stands, Unit 4 data shows February's agency spend being 1.5 times that of January. Despite this, agency spend as a proportion of the total pay bill remains comfortably below its 2.5% target.

Consultant spend continues to be the biggest contributor. The in-month spend of £245k is the highest in the financial year to date, with Oncology Medical Staff and Cellular Pathology accounting for over half of this.

Countermeasures	Owner	Due Date
ED Nursing agency long lines continue until March 2026, 5 wte bookings through Framework so all within NHSI Price cap.	Staffing Solutions	April 2026
Increase on agency expenditure under Group covering internal projects across group. This expenditure under agency will cease in March 2026.	Executive Team/VCA RP Process	April 2026
Medical Agency demand has increased during February, this will continue in March, as FASS have required short term additional Medical support which will remain in place until March 2026.	Staffing Solutions	May 2026

Risks and Mitigation

Risks
Over-reliance on agency staff in the NHS increases costs, weakens continuity of care, strains permanent teams, and creates operational instability.

Mitigation
Recruitment plans to reduce reliance in agency spend in key areas such as ED.

Part 3 | People In Our Community

Deliver a sustainable financial position

Equity of access to
RUH for all

Carbon emission reduction

Financial Performance

March 2026

(February 2026 Data)

The RUH, where you matter

Revised Forecast Outturn – M9 – Revised to £20.5m most likely (1)

After Month 9 the Trust has developed a revised Forecast Outturn and Recovery Plan, and commissioned Hunter Healthcare Turnaround team to support and established a Financial Improvement Programme Board to oversee delivery. The tables below provide a reconciliation from previous Recovery Plan forecast to revised forecast; and a bridge of recovery actions to deliver £20.5m compared to M9 run rate; together with sensitivity analysis. The position was shared and agreed with NHSE Regional Team, CEO and CFO, and shared with Joint Ctte and BSW Recovery Board.

At Month 11 the Trust reported an in month deficit of £1.6m which was broadly in line with this revised trajectory

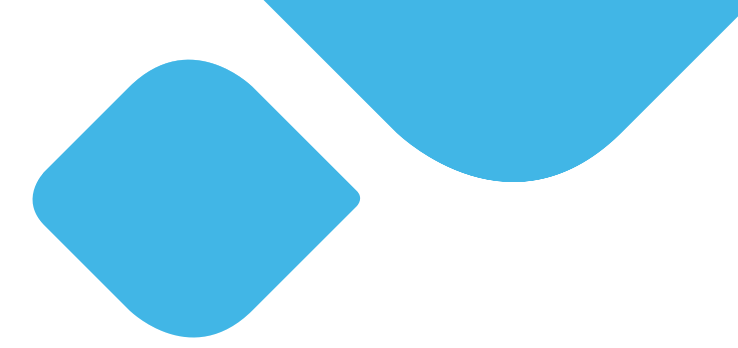
There remain risks to year end FOT,

1. arising from the RAG risk assessment of FOT assumptions in Month 12 – managed via FIPB
2. Recovery of adverse activity income from M!1
3. Audit assurance and timing of management estimates, such as MEA valuation – managed via Finance team
4. Contract Income year end settlements – managed by Finance team

The worst case FOT is estimated £24.3m, and this has been shared with NHSE via regional assurance meetings and PFR

Run Rate Forecast Outturn	(16.8)	(1.9)	(1.9)	(1.9)	(22.4)	
Recovery Actions						
Action (Please add rows as required)		M10 £m	M11 £m	M12 £m	Total £m	Risk Level
Technical balance sheet movements - reduced deferred income and red		2.1			2.1	M
Charity revenue contribution			0.2		0.2	M
Capital to Revenue Transfers			0.2		0.2	M
Modern Equivalent Asset revaluation				0.8	0.8	H
Discretionary Spend			0.1	0.1	0.2	M
Command and Control - Pay		0.1	0.2	0.2	0.5	H
Sickness		0.1	0.1	0.1	0.2	M
Sulis Cost improvement		0.1	0.1	0.1	0.3	M
Sulis Private Patient			0.1	0.1	0.1	M
Pharmacy stretch		0.1	0.1	0.1	0.4	M
Exec Budget reviews			0.1	0.1	0.3	M
Internal Critical Incident Costs		(0.3)			(0.3)	L
Winter Energy run rate		(0.2)	(0.2)		(0.4)	L
Winter Plan		(0.2)	(0.2)	(0.2)	(0.5)	L
Total Forecast - Wk 9 Turnaround update	(16.8)	(0.0)	(1.1)	(0.5)	(18.4)	
Contract income risks		(1.4)	(0.1)	(0.1)	(1.7)	M
PDC charge				(0.4)	(0.4)	M
Further stretch					0.0	H
Sub Total Recovery Actions		(1.5)	(1.2)	(1.0)	(20.5)	
Total Forecast - Likely Case 26 Jan	(16.8)	(1.5)	(1.2)	(1.0)	(20.5)	
Further stretch					0.0	
Resident Drs VAT reclaim				0.5	0.5	H
RTT Sprint income margin			0.1	0.1	0.2	H
Sale and leaseback of staff accomodation				2.0	2.0	H
Further - tbc				0.8	0.8	H
Total Forecast - Best Case	(16.8)	(1.5)	(1.1)	2.4	(17.0)	

M11 update



	Target	Actuals	Movement
Run Rate	- 1,900	- 1,900	-
Charity Revenue Contribution	200	200	-
Capital to Revenue	200	200	-
Discretionary Spend	100	100	-
Command and Control - Pay	200	200	-
Sickness	100	7	- 93
Sulis Cost improvement	100	107	7
Sulis Private Patients	100	-	- 100
Pharmacy stretch	100	- 110	- 210
Exec Budget Reviews	100	81	- 19
Contract income risks	- 100	- 100	-
Winter Energy run rate	- 200	- 200	-
Winter Plan	- 200	- 200	-
			-
			-
Identified for Month 11	- 1,200	- 1,615	- 415
Activity Performance		- 1,194	- 1,194
Sprint Performance Margin		150	150
Technical Adjustments (previous month)		267	267
Profiling		1,309	1,309
			-
Actual for Month 11	- 1,200	- 1,083	117

This table describes the Month 11 actual position compared to the Recovery Plan aligned to the £20.5m deficit.

In February commissioning income was c£1.2m adverse to forecasted levels, driven by annual leave in school holidays, uncached outpatient appointment and impact of emergency demand pressures & IPC on elective capacity.

Recovery during March is the key operational priority to deliver the forecast outturn control total, supported by daily command and control actions from Operations teams.

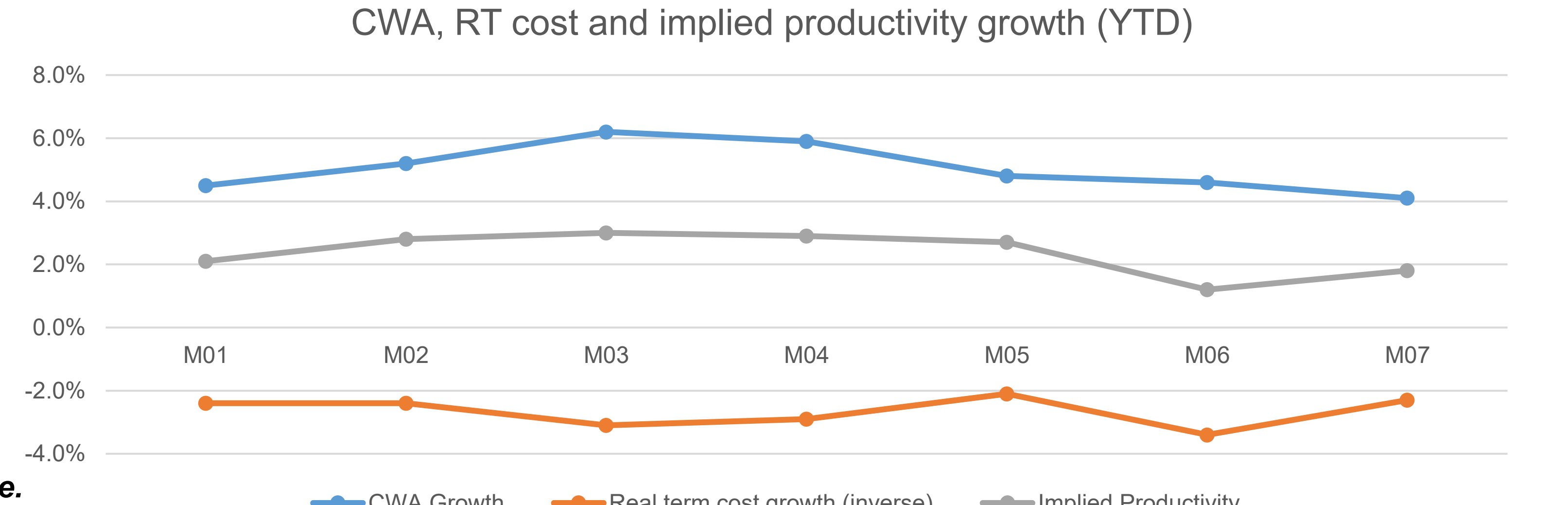
Year to date % change in productivity compared to 24/25

Breakthrough Objective

We are driving this metric because... Performance Target: Improve Implied Productivity by 6.7% compared to 24/25	*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.*

M7 2025/26	24/25 Comparison, unadjusted			Movement from M6, unadjusted		
	Inflation adj. expenditure growth	Cost weighted activity growth	Implied productivity growth	Inflation adj. expenditure growth	Cost weighted activity growth	Implied productivity growth
RUH	4.1%	2.3%	**1.8%**	-0.5%	-1.1%	**0.6%**
NHSE Median	3.3%	-0.2%	**3.5%**	-0.3%	-0.2%	**-0.1%**

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



Understanding Performance	Countermeasures	Owner	Due Date	Update	Risks and Mitigation
RUH productivity growth for YTD measured against previous year is 1.8% NHS England total productivity is 3.5% and South-West 3.8%, however it should be noted that these figures are now for all providers not just acute and specialist trusts. The **NHSE productivity growth for acute and specialist trusts is 2.8%.** RUH ranked 139th of 205 Trusts. For October 2025 NHSE published data showing the Trust had a year-on-year implied productivity improvement of 1.8% against internal the breakthrough objective of 6.7%. Cost weighted activity grew by 4.1% compared to inflation adjusted cost growth of 2.3%. Given that much of the activity growth is in non-elective activity we do not see a direct financial benefit from this productivity. The cost base used to calculate growth in year has also impacted from recharging between Sulis and the RUH for SOC and cost growth for Sulis CDC, therefore the 'real' productivity is forecast to be higher than this.	Delivery of Productivity improvements and cash releasing savings target set out in Operational Plan for 25/26	Savings programme SRO	Ongoing		• Ensure understanding of the metric and calculations • If Productivity improvements are not sufficiently cash releasing this could lead to achievement of the metric but failure to delivery financial performance targets
	Develop metric to be based on real-time data Develop metric to be calculated at Division level	Head of Financial Projects	Ongoing	The costing team have developed a productivity calculation one month in arrears for the whole trust and by division. This is currently being tested to ensure reliability and understanding prior to being used for reporting.	
	Establish single KPI for each Specialty to focus on during 25/26	Divisional/ Specialty Tris	Ongoing		

Underlying Financial Position (BAF Reference)

I&E to January 2026	Annual Budget	Forecast
	Total Group	Total Group
	Budget £'m	Forecast £'m
Income	565.156	565.156
Pay	(353.922)	(365.978)
Non Pay	(166.740)	(175.133)
Finance Charges	(46.500)	(46.500)
EBITDA	**(2.005)**	**(22.455)**
Donated/Grant Income	(1.955)	(1.955)
Adjusted Financial Performance	**(0.500)**	**(20.500)**
Transitional Funding	(19.200)	(19.200)
Technical Adjustments	(4.800)	(4.800)
Non-Recurrent Benefits		(2.725)
Underlying Financial Performance	**(24.065)**	**(47.225)**

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

- The 2025/26 Financial Plan includes elements of non-recurrent funding, such as the £19.2m transitional funding and the £4.8m technical adjustments
- To deliver a sustainable level of cash, allowing for capital investments, the medium term plan is should aim for a £6.0m surplus level
- A 1% vacancy factor is a reasonable level to aim for on a recurrent basis to allow for reasonable turnover and recruitment delays. Changing this from the current ~4% would equate to £9.3m further savings requirement
- This position is stated before the impact of 26/27 & Medium Term funding settlement that would be expected to delivery a further 2% efficiency each year, £12.7m

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

Update to latest Recovery Plan

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

Income & Expenditure Year to Date (NHSE Performance)

I&E to February 2026	YTD											
	RUH			Sulis			Inter-Group			Total Group Position		
	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Actual £'m	Variance £'m
Commissioning Income	452.103	456.408	4.306	26.520	27.958	1.437	0.000	0.000	0.000	478.623	484.366	5.743
Clinical Education Income	18.893	17.593	(1.301)	0.000	0.000	0.000	0.000	0.000	0.000	18.893	17.593	(1.301)
Other Income	47.901	49.580	1.679	22.607	21.538	(1.069)	(3.661)	(3.755)	(0.094)	66.847	67.363	0.517
Pay	(325.281)	(337.963)	(12.682)	(22.681)	(24.044)	(1.363)	0.000	0.000	0.000	(347.961)	(362.007)	(14.046)
Non Pay	(152.842)	(169.339)	(16.497)	(22.507)	(21.098)	1.409	0.883	1.497	0.615	(174.467)	(188.940)	(14.473)
EBITDA	**40.774**	**16.280**	**(24.495)**	**3.939**	**4.353**	**0.414**	**(2.778)**	**(2.258)**	**0.521**	**41.935**	**18.375**	**(23.559)**
Depreciation & Amortisation	(21.548)	(21.007)	0.541	(2.987)	(3.061)	(0.074)	1.999	1.634	(0.365)	(22.536)	(22.434)	0.102
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	(8.591)	(8.368)	0.224	(0.475)	(0.560)	(0.085)	0.352	0.289	(0.063)	(8.714)	(8.639)	0.075
Surplus/(Deficit)	**(2.986)**	**(26.578)**	**(23.592)**	**0.477**	**0.733**	**0.256**	**(0.427)**	**(0.335)**	**0.092**	**(2.936)**	**(26.180)**	**(23.244)**
Donated/Grant Income	(2.928)	(6.768)	(3.840)	0.000	0.000	0.000	0.000	0.000	0.000	(2.928)	(6.768)	(3.840)
Adjusted Financial Performance	**(0.058)**	**(19.810)**	**(19.752)**	**0.477**	**0.733**	**0.256**	**(0.427)**	**(0.335)**	**0.092**	**(0.008)**	**(19.412)**	**(19.404)**

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 £19.4m. This is resulting from delays to delivery against the savings programme (£16.1m), deterioration in the exit run rate (£5.5m), and operational pressures arising from increased spend on high cost drugs and devices (£2.1m), Resident Doctors budget pressures (£1.7m), pressures from pay awards (£0.3m). Industrial Action was funded in Month 9 as well as funding of variable activity (£0.9m). Further benefits trough non-recurrent technical adjustments (£4.8m) and increased controls (£2.0m).

Sulis shows a benefit against plan of £0.3m. Clinical income is up across NHS, Private Patient with the CDC position improving in the last few months. .

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

Budget – by Division

Budget by Division	Yearly Budget £'m	In Month RUH Budget £'m	In Month RUH Actual £'m	In Month RUH Variance £'m	In Month RUH Variance %	Year to Date RUH Budget £'m	Year to Date RUH Actual £'m	Year to Date RUH Variance £'m	Year to Date RUH Variance £'m
Commissioning Income	475.043	39.456	42.050	2.593		433.803	437.636	3.833	
Clinical Education Income	20.549	1.655	1.693	0.038		18.893	17.593	(1.301)	
Deficit Support Funding	19.198	1.399	1.872	0.473		18.300	18.773	0.473	
Surgery	(135.787)	(11.319)	(11.441)	(0.123)	-1.1%	(124.134)	(125.173)	(1.039)	-0.8%
Medicine	(164.811)	(13.627)	(14.285)	(0.658)	-4.8%	(150.678)	(156.666)	(5.988)	-4.0%
FASS	(102.764)	(8.365)	(8.704)	(0.339)	-4.0%	(93.876)	(96.398)	(2.522)	-2.7%
E&F	(33.411)	(2.733)	(2.817)	(0.084)	-3.1%	(30.588)	(29.892)	0.696	2.3%
Corporate	(66.307)	(5.461)	(5.362)	0.098	1.8%	(60.826)	(62.080)	(1.254)	-2.1%
HIWE	0.000	0.000	(0.000)	(0.000)		0.000	(0.000)	(0.000)	
R&D	0.000	0.000	(0.016)	(0.016)		0.000	0.000	0.000	
Unallocated Savings	5.402	0.450	0.000	(0.450)		4.952	0.000	(4.952)	
Reserves	10.114	0.806	(1.599)	(2.405)		9.112	1.738	(7.374)	
Finance Charges	(27.291)	(2.274)	(2.569)	(0.295)		(25.016)	(25.340)	(0.323)	
Adjusted Financial Performance - RUH	**(0.065)**	**(0.012)**	**(1.178)**	**(1.166)**		**(0.058)**	**(19.810)**	**(19.752)**	
Sulis	0.000	0.000	0.000	0.000		0.477	0.733	0.256	
Inter Group	(0.450)	0.000	0.000	0.000		(0.427)	(0.335)	0.092	
Adjusted Financial Performance - Group	**(0.515)**	**(0.012)**	**(1.178)**	**(1.166)**		**(0.008)**	**(19.412)**	**(19.404)**	
Impairment	*(13.621)*	*0.000*	*0.000*	*0.000*		*(13.621)*	*(13.482)*	*0.139*	
Donated/Grant Income	*11.666*	*0.972*	*(0.064)*	*(1.036)*		*10.693*	*6.714*	*(3.979)*	
Unadjusted Financial Performance	***(2.471)***	***0.960***	***(1.243)***	***(2.202)***		***(2.936)***	***(26.180)***	***(23.244)***	

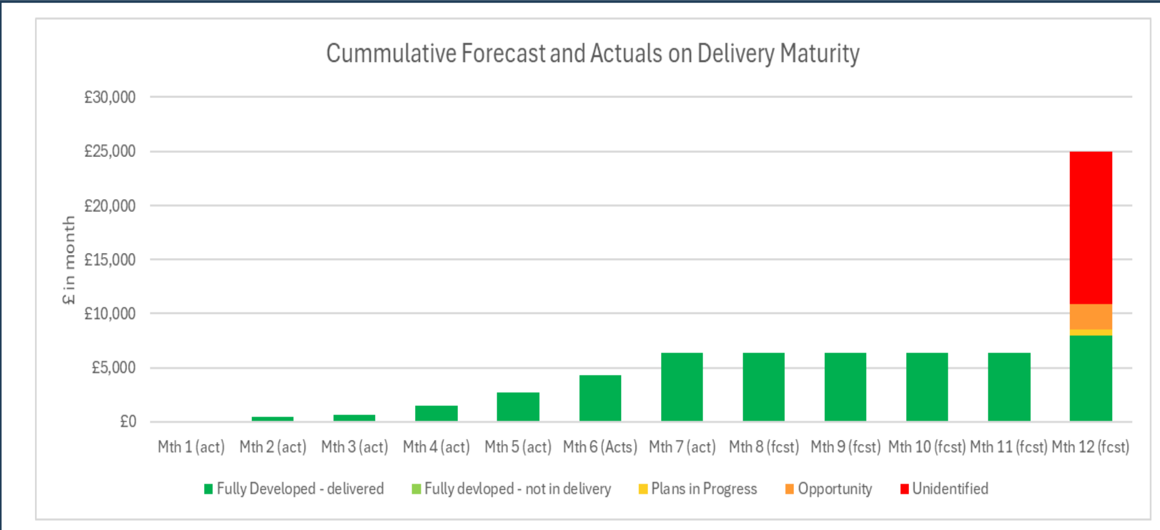
Understanding Performance

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

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

Countermeasures	Owner	Due Date

Savings Delivery Against Plan



	In Month			YTD			Programme Status						
	Month 11 Acts	Plan Mth ^	Month Variance to Plan	Acts YTD	Plan YTD	YTD Variance to Plan	Fully Developed - in delivery	Fully Developed - not in delivery	plans in progress	In Forecast Outturn	opportunity	unidentified	Grand Total
Delivery Group													
UEC Delivery Group	38	333	(296)	467	3,667	(3,199)	500	0	0	**500**	0	3,500	4,000
Outpatients Delivery Group	213	250	(37)	845	2,750	(1,906)	1,048	0	9	**1,057**	1,443	500	3,000
Elective Delivery Group	71	158	(87)	901	1,742	(840)	1,146	0	0	**1,146**	254	0	1,400
Corporate Services	215	208	7	1,559	2,292	(733)	1,723	0	2	**1,725**	0	775	2,500
Central Delivery Group	(141)	629	(770)	4,967	6,917	(1,949)	5,669	0	519	**6,188**	0	1,139	7,327
Estates & Facilities	145	132	13	1,660	1,448	212	1,793	0	0	**1,793**	0	0	1,793
Unidentified	0	356	(356)	0	3,917	(3,917)	0	0	0	**0**	0	3,778	3,778
SULIS	268	42	226	676	458	218	668	0	832	**1,500**	0	0	1,500
Total excluding Group	**809**	**2,108**	**(1,299)**	**11,076**	**23,191**	**(12,115)**	**12,547**	**0**	**1,362**	**13,909**	**1,697**	**9,691**	**25,297**
Group	0	367	(367)	0	4,033	(4,033)	0	0	0	0	0	4,400	4,400
Total including Group	**809**	**2,475**	**(1,666)**	**11,076**	**27,224**	**(16,148)**	**12,547**	**0**	**1,362**	**13,909**	**1,697**	**14,091**	**29,697**

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

Understanding Performance

£11.1m savings have been delivered year to date, £0.9m up on last month but the monthly reporting shows delivery not to be increasing. The Trust now has a £16.1m shortfall against plan year to date, a major contributor to the Trust overall adverse variance to plan.

Programme delivery is now working with Hunter Healthcare to accelerate savings delivery however to achieve forecast year end position identified opportunity areas need to be worked up to deliverable plans. However, £15.8m remains unidentified.

Countermeasures	Owner	Due Date
Acceleration of our saving plans that have been scoped for UEC, theatres, outpatients and corporate restructuring, re-forecasting weekly and consistent reporting to fortnightly Engine room to build momentum.	Delivery Group SROs, Finance team, Recovery Director and Hunter Healthcare	On Going
Delivery Groups to collaborate with BSW ICS Delivery Groups to ensure out of hospital delivery plans are clear and are supporting Savings delivery e.g. reduction in NCTR & attendance avoidance plans	Delivery Group SROs	On Going
FIRM and PRM working with Hunter Healthcare to identify and deliver further areas of savings opportunities.	Trust Management Executive and Budget Holders	Monitoring Impact
Divisions and Delivery Groups working together to ensure delivery of the plans and opportunities identified as well as working to identify plans for 26_27.	Delivery Group SRO and DOOs.	Next few months.

Risks and Mitigation

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

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

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

Commissioning Income & Activity (by POD)

POD Grp Code	24-25 Actual Activity	24-25 Actual Price	25-26 Plan Activity	25-26 Plan Price	25-26 Plan Activity YTD	25-26 Actual Activity YTD	25-26 Variance Activity YTD	25-26 Plan Price YTD	25-26 Actual Price YTD	25-26 Variance Price YTD
AE	100,553	25,393,066	103,480	26,017,711	94,095	96,734	2,639	23,658,183	23,913,771	255,588
DC	38,591	41,835,488	40,091	44,363,159	36,329	34,699	-1,630	40,208,700	40,556,383	347,682
EL	3,669	20,125,247	4,889	27,520,855	4,397	3,532	-865	24,820,242	19,480,564	-5,339,677
HCD	189,019	54,025,019	0	59,871,909	0	198,212	198,212	54,342,470	54,860,437	517,968
NE	59,967	192,340,342	62,038	200,334,168	56,769	60,719	3,950	183,746,325	181,974,242	-1,772,083
OP	780,366	115,506,647	758,359	114,941,069	690,260	731,116	40,856	104,479,113	109,378,717	4,899,604
OT	3,374,847	17,449,521	2,978,127	17,901,214	2,719,050	3,146,038	426,989	16,351,381	16,503,041	151,660

Excluding Critical Care, Excess Bed Days

Understanding Performance

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

As at the end of February, SOC remains under plan by £1.8m, £312k in-month.

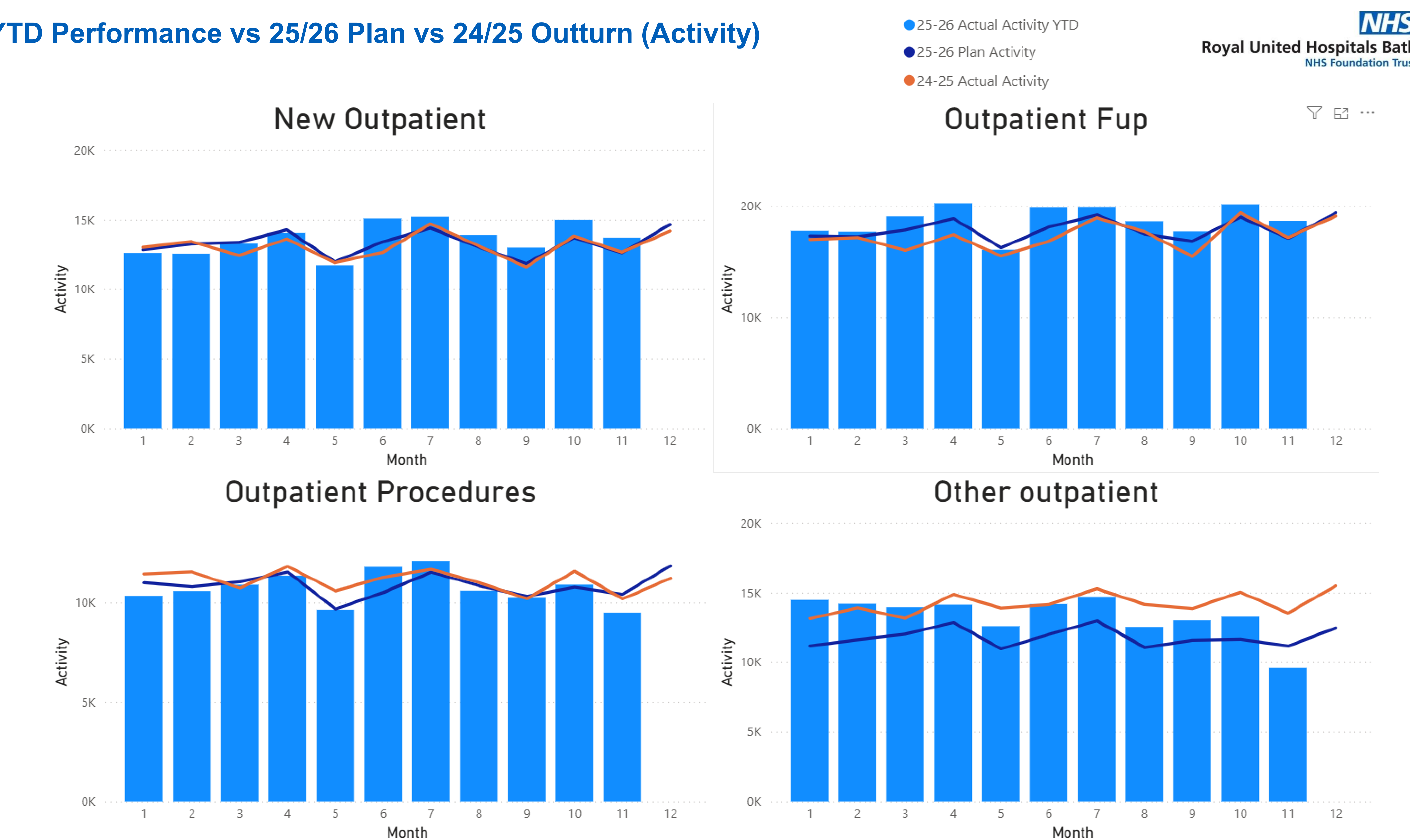
OP activity was down on January despite a full month of sprint activity underway even after accounting for a shorter working month, the most significant areas of reduction were in Ophthalmology and Therapies. Audiology activity fell for providing devices where the additional work clearing the hearing aid backlog has been completed.

The high-cost drugs and devices performance was very slightly over plan, so YTD over performance increased by only £14k to £518k.

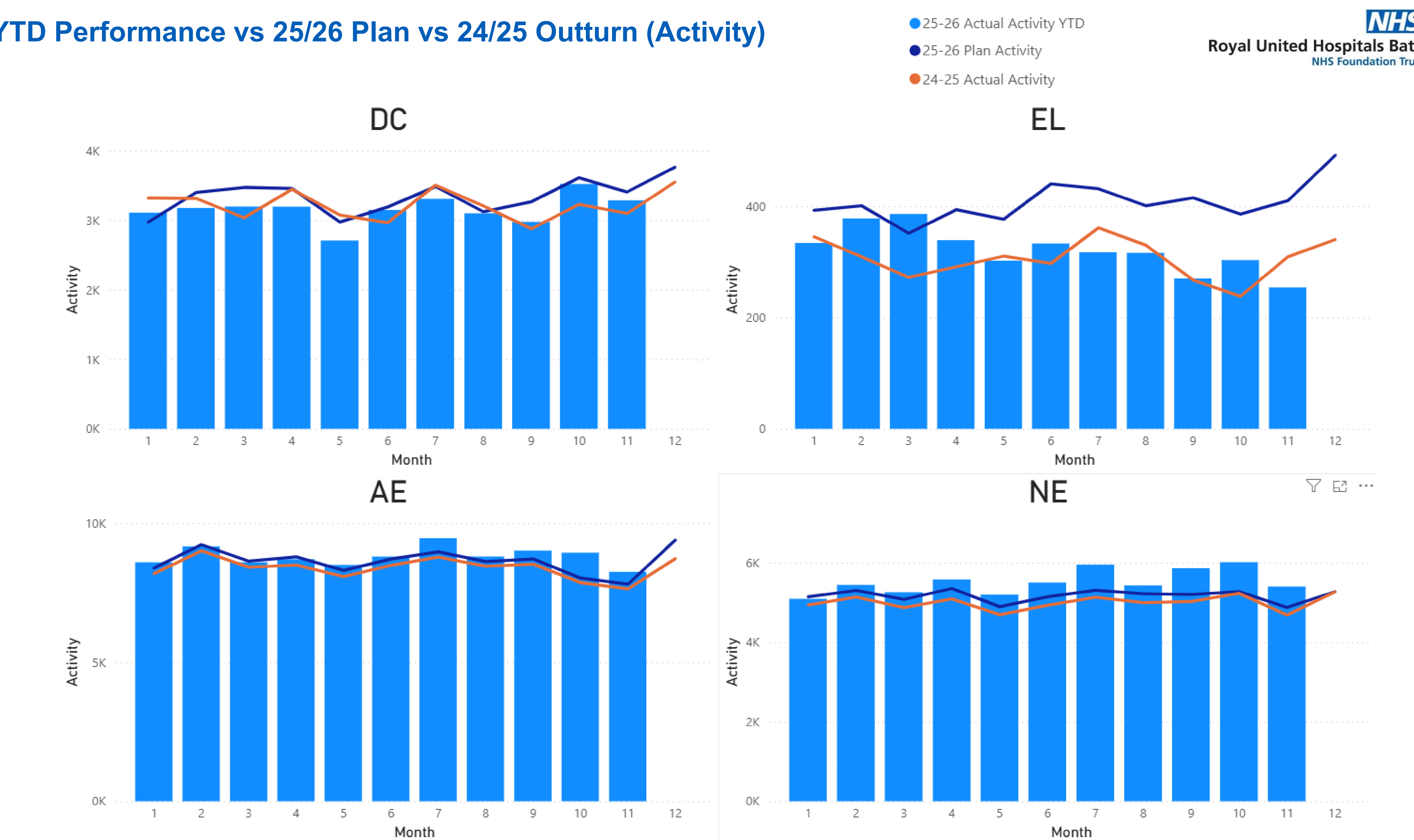
Countermeasures	Owner	Due Date
Work with Pharmacy and Commissioners to mitigate HCDD growth risk, either through additional funding or change in practice	Income Team	Ongoing
Continue to work up robust planning for HCDD for 2026/27 to calculate the ongoing risk going into next year, in light of tariff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

Risks and Mitigation

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

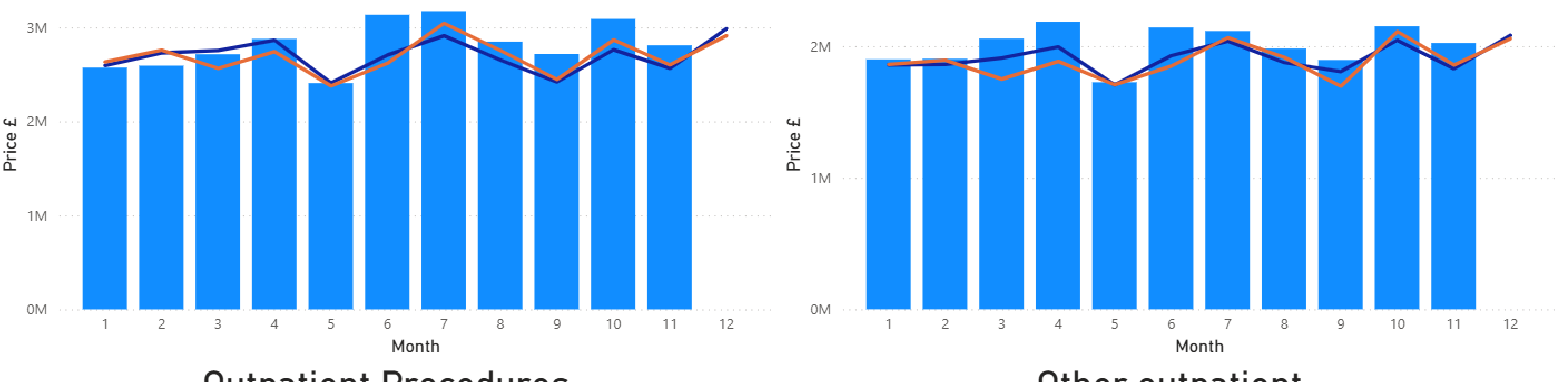


YTD Performance vs 25/26 Plan vs 24/25 Outturn (Activity)
25-26 Actual Activity YTD
25-26 Plan Activity
24-25 Actual Activity
NHS
Royal United Hospitals Bath
NHS Foundation Trust
New Outpatient
20K
15K
10K
5K
0K
Activity
1 2 3 4 5 6 7 8 9 10 11 12
Month
Outpatient Fup
20K
10K
0K
Activity
1 2 3 4 5 6 7 8 9 10 11 12
Month
Outpatient Procedures
10K
5K
0K
Activity
1 2 3 4 5 6 7 8 9 10 11 12
Month
Other outpatient
20K
15K
10K
5K
0K
Activity
1 2 3 4 5 6 7 8 9 10 11 12
Month


YTD Performance vs 25/26 Plan vs 24/25 Outturn (Activity)
25-26 Actual Activity YTD
25-26 Plan Activity
24-25 Actual Activity
NHS
Royal United Hospitals Bath
NHS Foundation Trust
DC
4K
3K
2K
1K
0K
Activity
Month
EL
400
200
0
AE
10K
5K
0K
NE
6K
4K
2K
0K
1
2
3
4
5
6
7
8
9
10
11
12

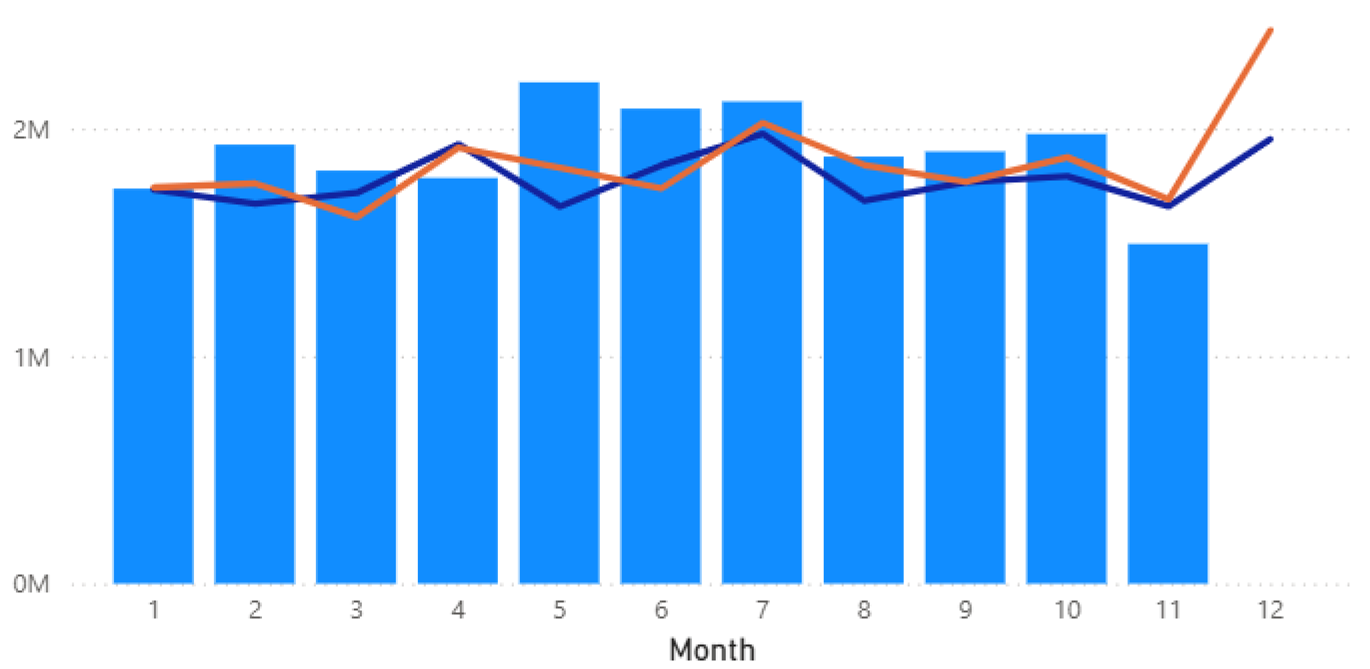
YTD Performance vs 25/26 Plan vs 24/25 Outturn (Price)

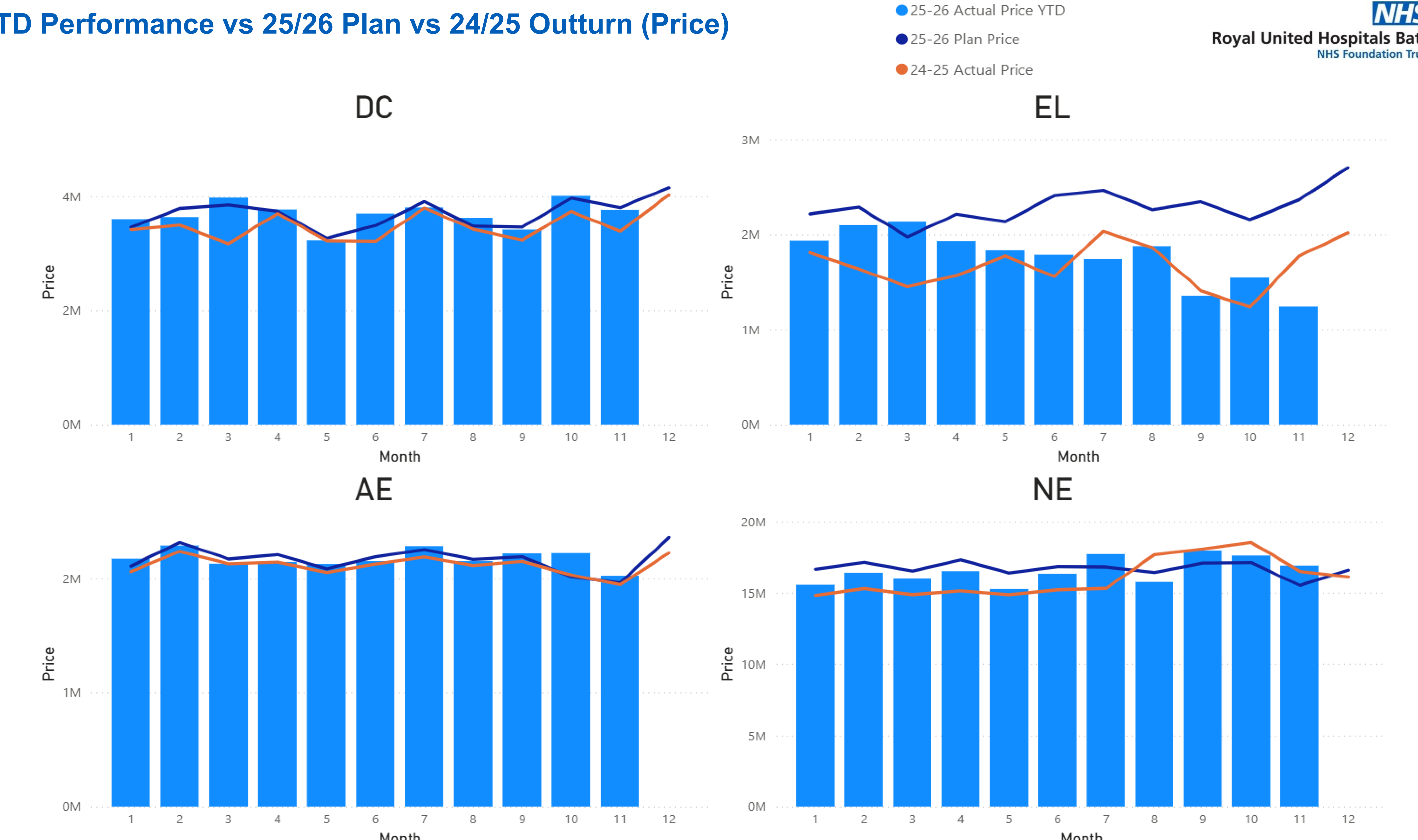
25-26 Actual Price YTD
25-26 Plan Price
24-25 Actual Price



2.0M
1.5M
1.0M
0.5M
0.0M
Price £
1 2 3 4 5 6 7 8 9 10 11 12
Month

Other outpatient





YTD Performance vs 25/26 Plan vs 24/25 Outturn (Price)
25-26 Actual Price YTD
25-26 Plan Price
24-25 Actual Price
NHS
Royal United Hospitals Bath
NHS Foundation Trust
DC
4M
2M
0M
Price
1
2
3
4
5
6
7
8
9
10
11
12
Month
EL
3M
2M
1M
0M
Price
Month
AE
2M
1M
0M
Price
Month
NE
20M
15M
10M
5M
0M
Price
Month

Budget – Pay

Pay by Staffing Type	In Month			Year to Date		
	RUH			RUH		
	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Actual £'m	Variance £'m
Senior Medical	(5.456)	(5.538)	(0.081)	(59.869)	(60.170)	(0.302)
Junior Medical	(3.526)	(3.608)	(0.082)	(38.845)	(40.990)	(2.145)
Registered Nursing and Midwifery	(9.200)	(9.092)	0.108	(101.220)	(98.644)	2.576
Registered ST&T	(3.607)	(3.524)	0.082	(39.593)	(38.061)	1.532
Other Clinical Support	(4.839)	(4.979)	(0.140)	(53.596)	(54.599)	(1.002)
NHS Infrastructure Support	(3.836)	(4.066)	(0.230)	(42.311)	(43.911)	(1.600)
Other	(0.126)	(0.140)	(0.014)	(1.390)	(1.587)	(0.197)
Unallocated Savings	0.930	0.000	(0.930)	9.963	0.000	(9.963)
Reserves	0.124	0.000	(0.124)	1.581	0.000	(1.581)
Surplus/(Deficit)	**(29.535)**	**(30.948)**	**(1.413)**	**(325.281)**	**(337.963)**	**(12.682)**
Pay Vacancy Factor Included Above	1.026	0.000	(1.026)	11.282	0.000	(11.282)

Pay by Spend Type	In Month			Year to Date		
	RUH			RUH		
	Budget £'m	Actual £'m	Variance £'m	Budget £'m	Actual £'m	Variance £'m
Substantive	(30.239)	(28.852)	1.387	(333.023)	(316.687)	16.337
Pay Vacancy Factor	1.026	0.000	(1.026)	11.282	0.000	(11.282)
Net Budget	**(29.214)**	**(28.852)**	**0.362**	**(321.742)**	**(316.687)**	**5.055**
Bank	(0.086)	(1.362)	(1.275)	(0.942)	(15.768)	(14.826)
Agency	(0.024)	(0.467)	(0.443)	(0.266)	(2.682)	(2.416)
WLI	(0.099)	(0.146)	(0.047)	(1.101)	(1.460)	(0.359)
Other	(0.112)	(0.121)	(0.010)	(1.229)	(1.366)	(0.137)
Surplus/(Deficit)	**(29.535)**	**(30.948)**	**(1.413)**	**(325.281)**	**(337.963)**	**(12.682)**

Understanding Performance

Pay budgets are overspent by £12.7m. The Pay vacancy factor (£11.3m) has been delivered but further recurrent Pay savings (£10.0m) have not yet been achieved. The Pay awards have generated a net £0.3m pressure, with £1.3m of pay costs being offset by £1m of income. Pay costs also include the estimated impact of industrial which has risen to £0.7m, which has been funded by increased income.

In Month pay costs have increased, both against previous month (£0.3m) and against a Month 1-10 run rate (£0.2m). There have been escalation costs of around £0.3m and costs of sprint (£0.3m) partly in month offset by increased grip and control.

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

Countermeasures	Owner	Due Date

Risks and Mitigation

Budget – Pay by Division & Type

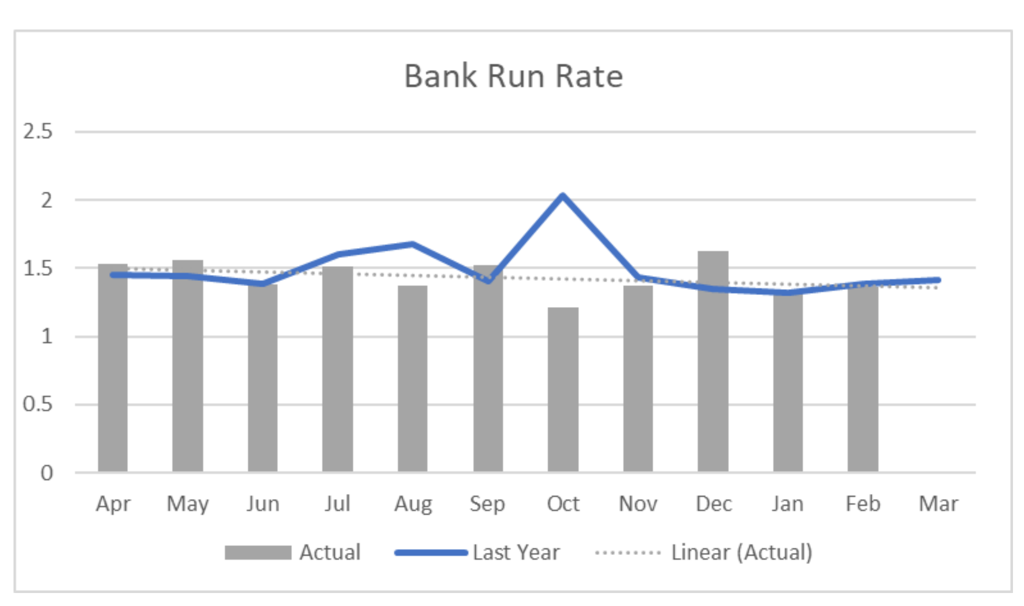
Royal United Hospitals Bath
NHS Foundation Trust

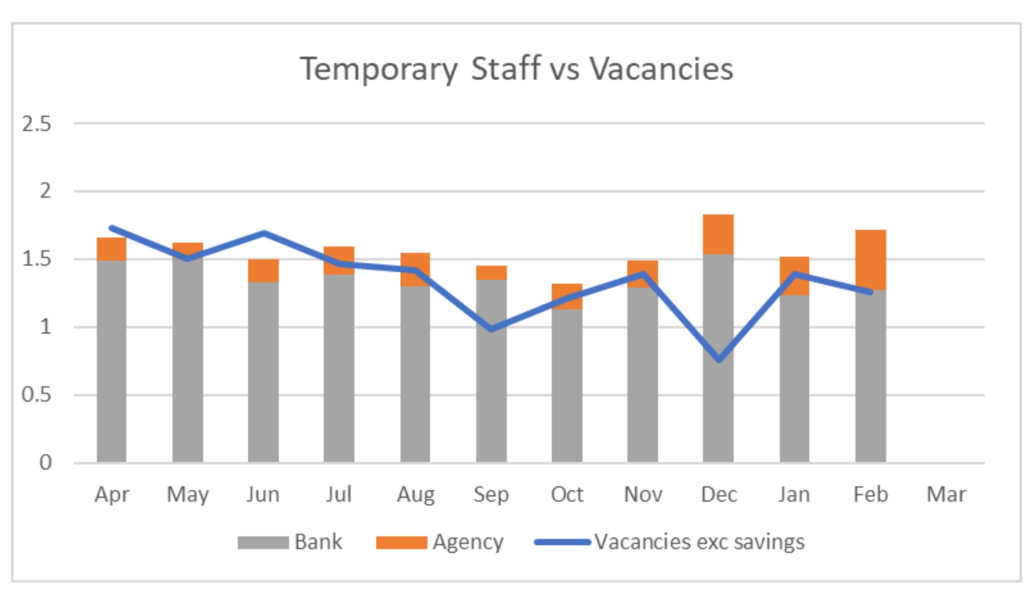
Pay by Division	In Month RUH Budget £'m	In Month RUH Actual £'m	In Month RUH Variance £'m	Year to Date RUH Budget £'m	Year to Date RUH Actual £'m	Year to Date RUH Variance £'m
Surgery	(8.104)	(8.198)	(0.094)	(88.609)	(89.866)	(1.257)
Medicine	(10.528)	(11.210)	(0.682)	(115.994)	(121.939)	(5.945)
FASS	(5.616)	(5.843)	(0.227)	(61.807)	(63.329)	(1.521)
E&F	(1.721)	(1.763)	(0.042)	(19.412)	(19.609)	(0.196)
Corporate	(3.156)	(3.414)	(0.258)	(34.685)	(36.863)	(2.178)
HIWE	(0.291)	(0.349)	(0.059)	(3.196)	(3.450)	(0.254)
R&D	(0.284)	(0.313)	(0.029)	(3.127)	(3.203)	(0.076)
Reserves	0.152	0.143	(0.009)	1.409	0.294	(1.115)
Unallocated Savings	0.013	0.000	(0.013)	0.142	0.000	(0.142)
Surplus/(Deficit)	**(29.535)**	**(30.948)**	**(1.413)**	**(325.281)**	**(337.963)**	**(12.682)**
Pay Vacancy Factor Included Above	1.026	0.000	(1.026)	11.282	0.000	(11.282)

Variance by Functional Area (In Month)	Medical Staff	Ward	ED	Maternity	Other	Savings	Total
Substantive	0.339	0.600	0.113	0.086	0.120	(0.943)	0.315
Bank	(0.264)	(0.522)	(0.131)	(0.077)	(0.282)	0.000	(1.275)
Agency	(0.251)	(0.017)	(0.025)	0.000	(0.149)	0.000	(0.443)
Other	0.000	0.000	0.000	0.000	(0.010)	0.000	(0.010)
Surplus/(Deficit)	**(0.177)**	**0.061**	**(0.043)**	**0.009**	**(0.320)**	**(0.943)**	**(1.413)**

Variance by Functional Area (Year to Date)	Medical Staff	Ward	ED	Maternity	Other	Savings	Total
Substantive	2.070	6.774	1.950	0.925	3.076	(10.099)	4.696
Bank	(2.657)	(5.529)	(2.042)	(0.919)	(3.680)	0.000	(14.826)
Agency	(2.088)	(0.103)	(0.101)	0.000	(0.124)	0.000	(2.416)
Other	0.000	0.000	0.000	0.000	(0.137)	0.000	(0.137)
Surplus/(Deficit)	**(2.676)**	**1.143**	**(0.192)**	**0.006**	**(0.864)**	**(10.099)**	**(12.682)**

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





Budget – Pay – WTE

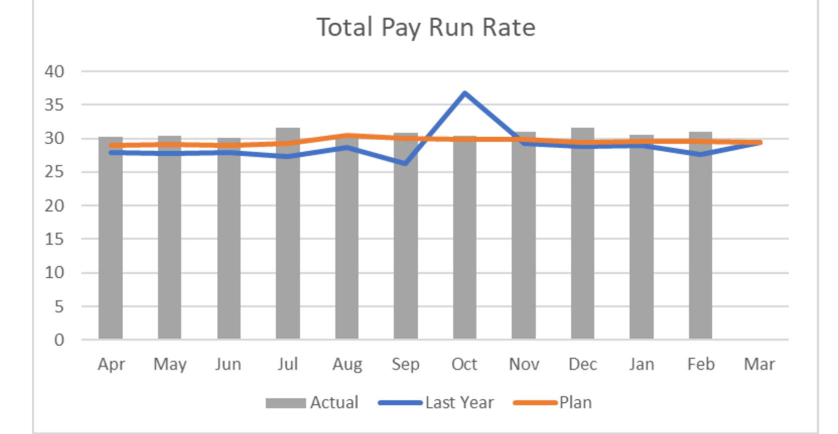
WTE by Staffing Type	In Month RUH Budget WTE	In Month RUH Actual WTE	In Month RUH Variance WTE
Senior Medical	(333.4)	(331.7)	1.8
Junior Medical	(450.6)	(501.5)	(50.9)
Registered Nursing and Midwifery	(1,808.1)	(1,802.7)	5.4
Registered ST&T	(684.5)	(675.0)	9.6
Other Clinical Support	(1,617.1)	(1,608.1)	9.0
NHS Infrastructure Support	(885.0)	(866.0)	19.0
Other	(1.4)	(3.9)	(2.5)
Unallocated Savings	138.0	0.0	(138.0)
Reserves	18.0	0.0	(18.0)
Surplus/(Deficit)	**(5,624.2)**	**(5,788.9)**	**(164.7)**
Pay Vacancy Factor Included Above	216.5	0.0	(216.5)

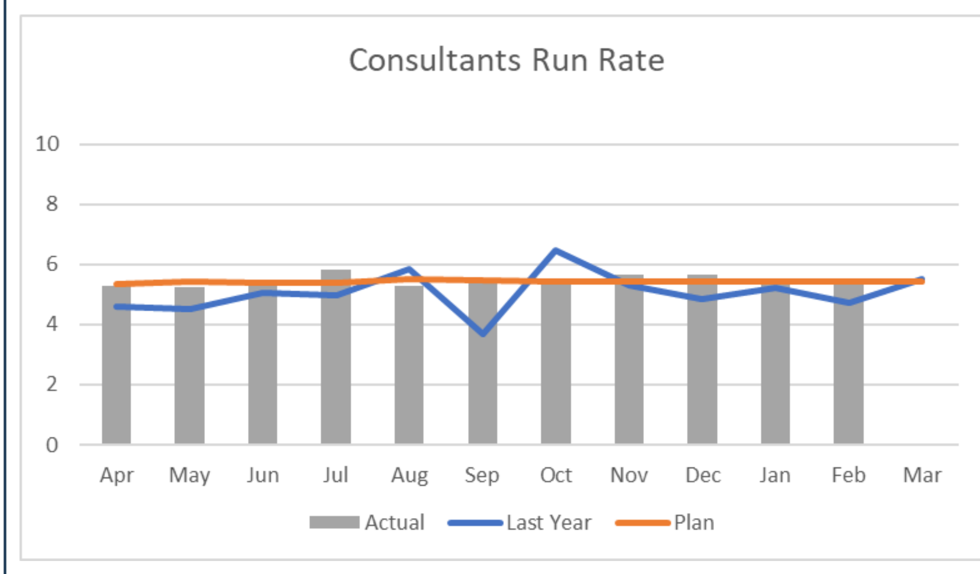
WTE by Spend Type	In Month RUH Budget WTE	In Month RUH Actual WTE	In Month RUH Variance WTE
Substantive	(5,826.3)	(5,488.5)	337.8
Pay Vacancy Factor	216.5	0.0	(216.5)
Net Budget	**(5,609.8)**	**(5,488.5)**	**121.3**
Bank	(16.3)	(277.3)	(261.0)
Agency	0.0	(23.2)	(23.2)
WLI	1.9	0.0	(1.9)
Other	0.0	0.0	0.0
Surplus/(Deficit)	**(5,624.2)**	**(5,788.9)**	**(164.7)**

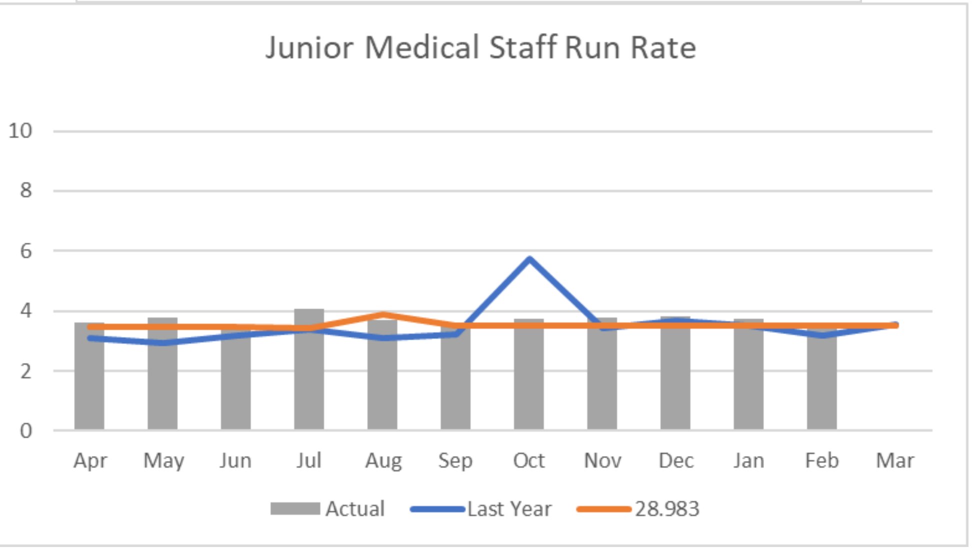
WTE by Division	In Month RUH Budget WTE	In Month RUH Actual WTE	In Month RUH Variance WTE
Surgery	(1,413.3)	(1,464.0)	(50.7)
Medicine	(1,983.8)	(2,083.1)	(99.3)
FASS	(1,035.1)	(1,048.1)	(13.0)
E&F	(537.4)	(528.3)	9.1
Corporate	(565.5)	(554.5)	11.0
HIWE	(47.8)	(48.7)	(0.8)
R&D	(62.3)	(58.8)	3.6
Reserves	17.4	(3.5)	(20.9)
Unallocated Savings	3.5	0.0	(3.5)
Surplus/(Deficit)	**(5,624.2)**	**(5,788.9)**	**(164.7)**
Pay Vacancy Factor Included Above	216.5	0.0	(216.5)

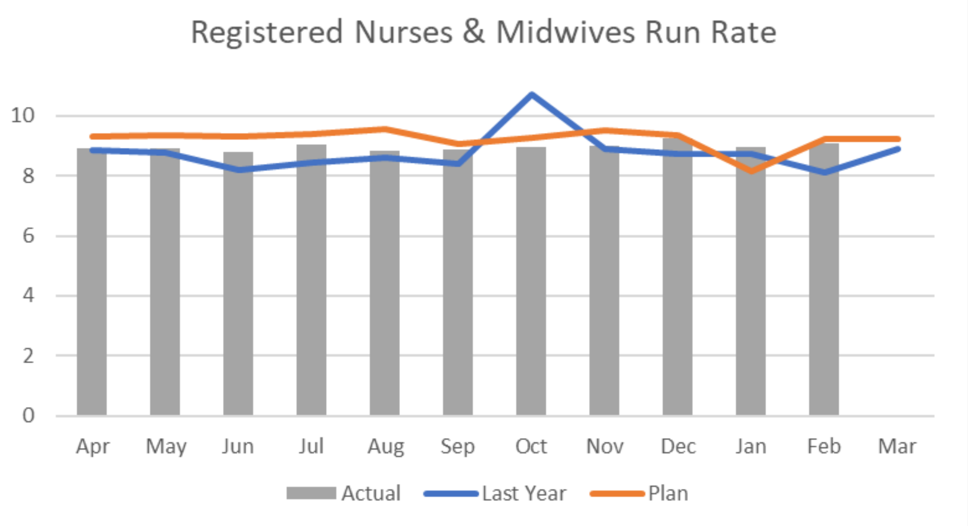
WTE Variance by Functional Area	In Month Medical Staff	Ward	ED	Maternity	Other	Savings	Total
Substantive	-25.61	128.30	25.33	11.04	118.35	-138.00	119.41
Bank	-16.43	-127.51	-25.94	-15.99	-75.08	0.00	(260.95)
Agency	-11.04	-1.21	-5.91	0.00	-5.00	0.00	(23.16)
Other	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Surplus/(Deficit)	**-53.08**	**-0.42**	**-6.52**	**-4.95**	**38.27**	**-138.00**	**(164.70)**

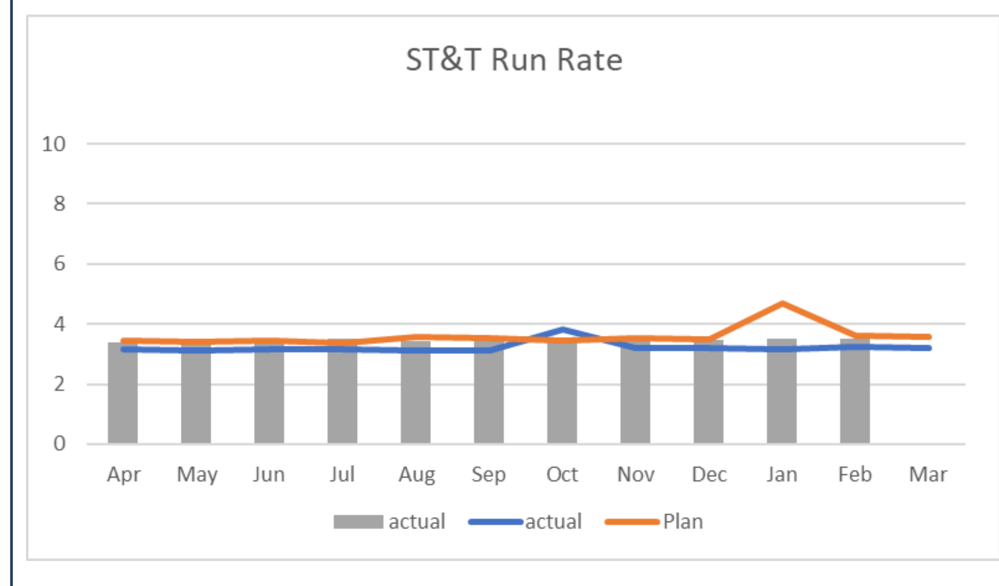
Pay Run Rate Graphs

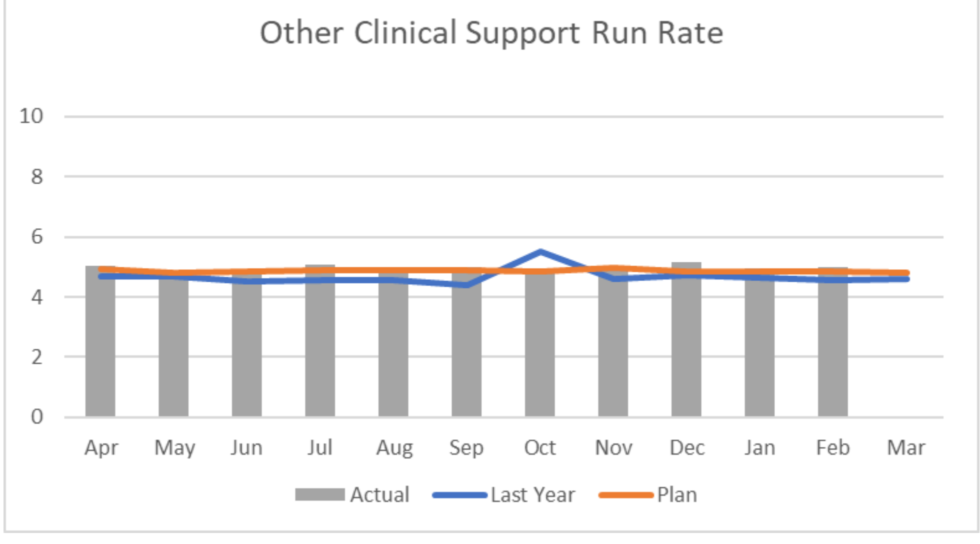


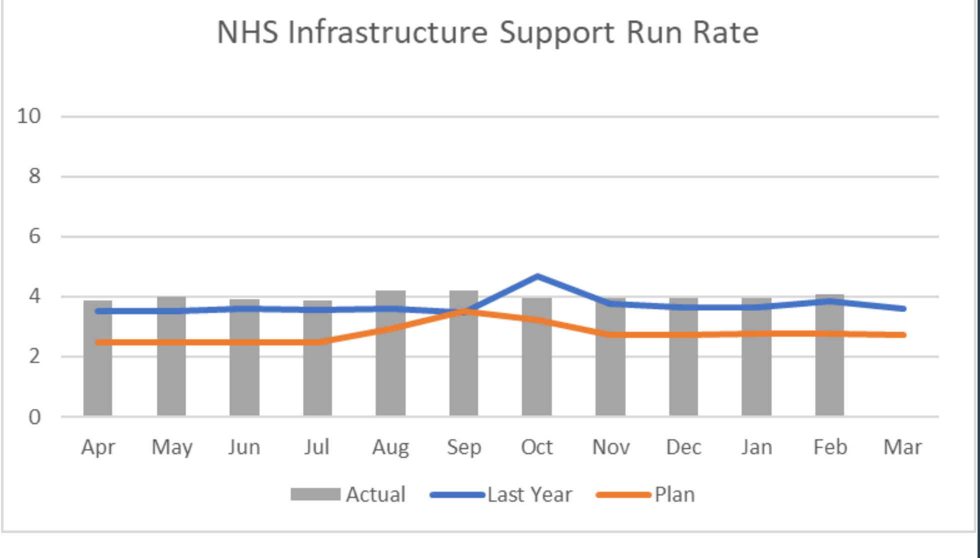












Budget – Non-Pay

Non-Pay by Type	In Month RUH Budget £'m	In Month RUH Actual £'m	In Month RUH Variance £'m	Year to Date RUH Budget £'m	Year to Date RUH Actual £'m	Year to Date RUH Variance £'m
High Cost Drugs and Devices	(4.096)	(4.566)	(0.470)	(49.416)	(52.440)	(3.024)
In Tariff Drugs	(0.721)	(0.715)	0.005	(8.389)	(8.721)	(0.332)
Clinical Supplies and Services	(3.713)	(4.897)	(1.184)	(42.757)	(46.633)	(3.876)
Other Non Pay	(5.728)	(6.765)	(1.038)	(63.166)	(61.545)	1.620
Unallocated Savings	0.662	0.000	(0.662)	8.858	0.000	(8.858)
Reserves	0.064	0.000	(0.064)	2.028	0.000	(2.028)
Surplus/(Deficit)	**(13.531)**	**(16.944)**	**(3.412)**	**(152.842)**	**(169.339)**	**(16.497)**

Budget by Division	In Month RUH Budget £'m	In Month RUH Actual £'m	In Month RUH Variance £'m	Year to Date RUH Budget £'m	Year to Date RUH Actual £'m	Year to Date RUH Variance £'m
Surgery	(3.185)	(3.341)	(0.156)	(34.024)	(35.280)	(1.257)
Medicine	(2.010)	(2.176)	(0.167)	(21.687)	(23.076)	(1.389)
FASS	(0.723)	(0.755)	(0.032)	(7.834)	(8.365)	(0.531)
E&F	(1.526)	(1.587)	(0.061)	(16.840)	(16.133)	0.707
Corporate	(2.670)	(3.368)	(0.698)	(30.986)	(31.958)	(0.972)
HIWE	(0.103)	(0.078)	0.025	(1.131)	(1.043)	0.089
R&D	(0.054)	(0.031)	0.023	(0.595)	(0.331)	0.264
Capital Charges	0.010	(0.296)	(0.307)	0.114	(0.615)	(0.728)
High Cost Drugs and Devices	(4.248)	(4.566)	(0.318)	(51.111)	(52.440)	(1.328)
Unallocated Savings	0.491	0.000	(0.491)	5.397	0.000	(5.397)
Reserves	0.487	(0.746)	(1.233)	5.855	(0.099)	(5.954)
Surplus/(Deficit)	**(13.531)**	**(16.944)**	**(3.412)**	**(152.842)**	**(169.339)**	**(16.497)**

Understanding Performance

Non-pay spend is £16.5m overspent against budget. £8.9m of this relates to undelivered savings and £2.0m as the exit run rate.

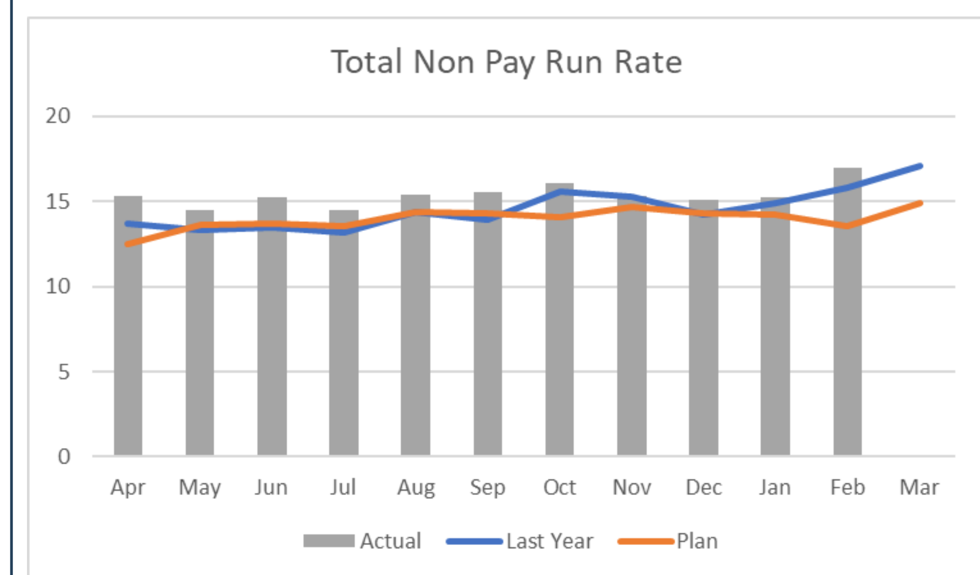
There is a net underfunding of £2.1m as ICB-funded high-cost drugs are at the Trust's risk

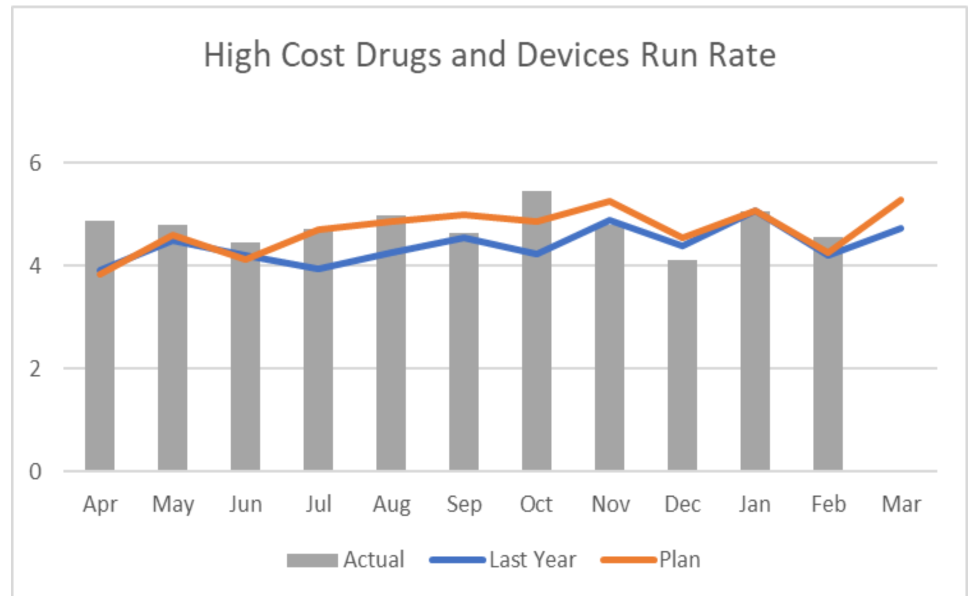
Estates and Facilities are currently underspent due to reduced utilities costs, although that is expected to reduce during the winter months.

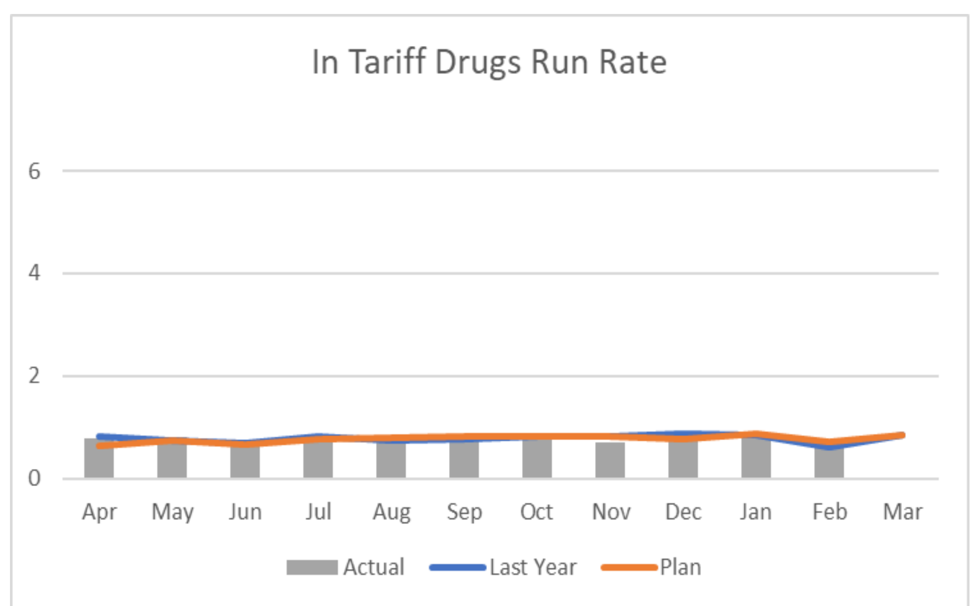
Countermeasures	Owner	Due Date

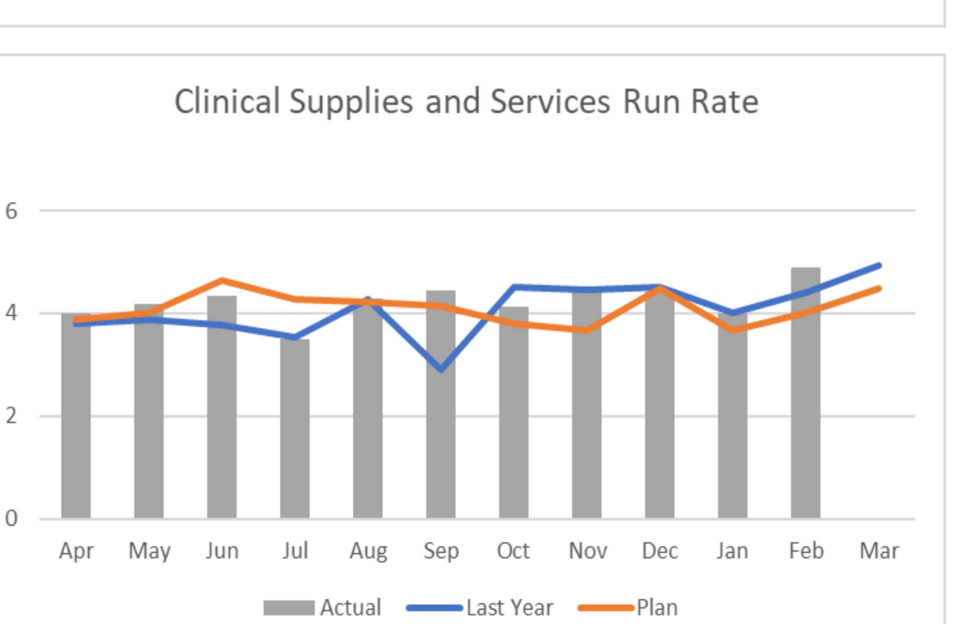
Risks and Mitigation

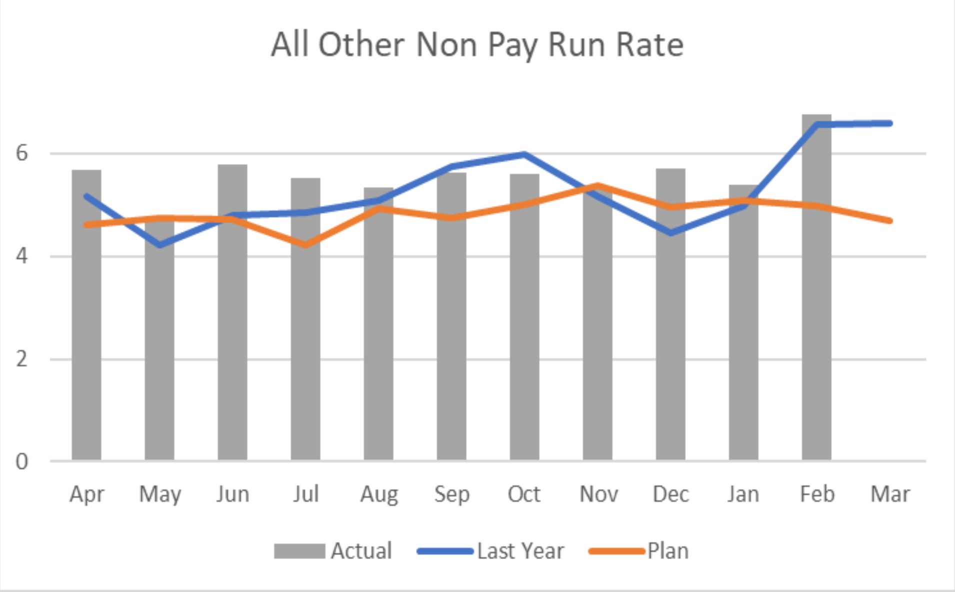
Non Pay – Run Rate Graphs











February 2026 (M11) Financial Position

Financial position vs plan

	GWH				RUH				SFT				BSW Group				ICB				System			
	Plan	Actual	Variance	RAG	Plan	Actual	Variance	RAG	Plan	Actual	Variance	RAG	Plan	Actual	Variance	RAG	Plan	Actual	Variance	RAG	Plan	Actual	Variance	RAG
Month 11 YTD (£m)*	0.0	(10.7)	(10.7)		0.0	(19.4)	(19.4)		0.0	(11.2)	(11.2)		0.0	(41.3)	(41.3)		0.0	21.2	21.2		0.0	(20.1)	(20.1)	

Financial position vs Revised trajectories (Most Likely)

	GWH				RUH				SFT				BSW Group				ICB				System			
	Plan	Actual	Variance	RAG	Plan	Actual	Variance	RAG	Plan	Actual	Variance	RAG	Plan	Actual	Variance	RAG	Plan	Actual	Variance	RAG	Plan	Actual	Variance	RAG
Month 11 YTD (£m)*	(10.5)	(10.7)	(0.2)		(19.5)	(19.4)	0.1		(11.2)	(11.2)	0.0		(41.2)	(41.3)	(0.1)		21.0	21.2	0.2		(20.2)	(20.1)	0.1	

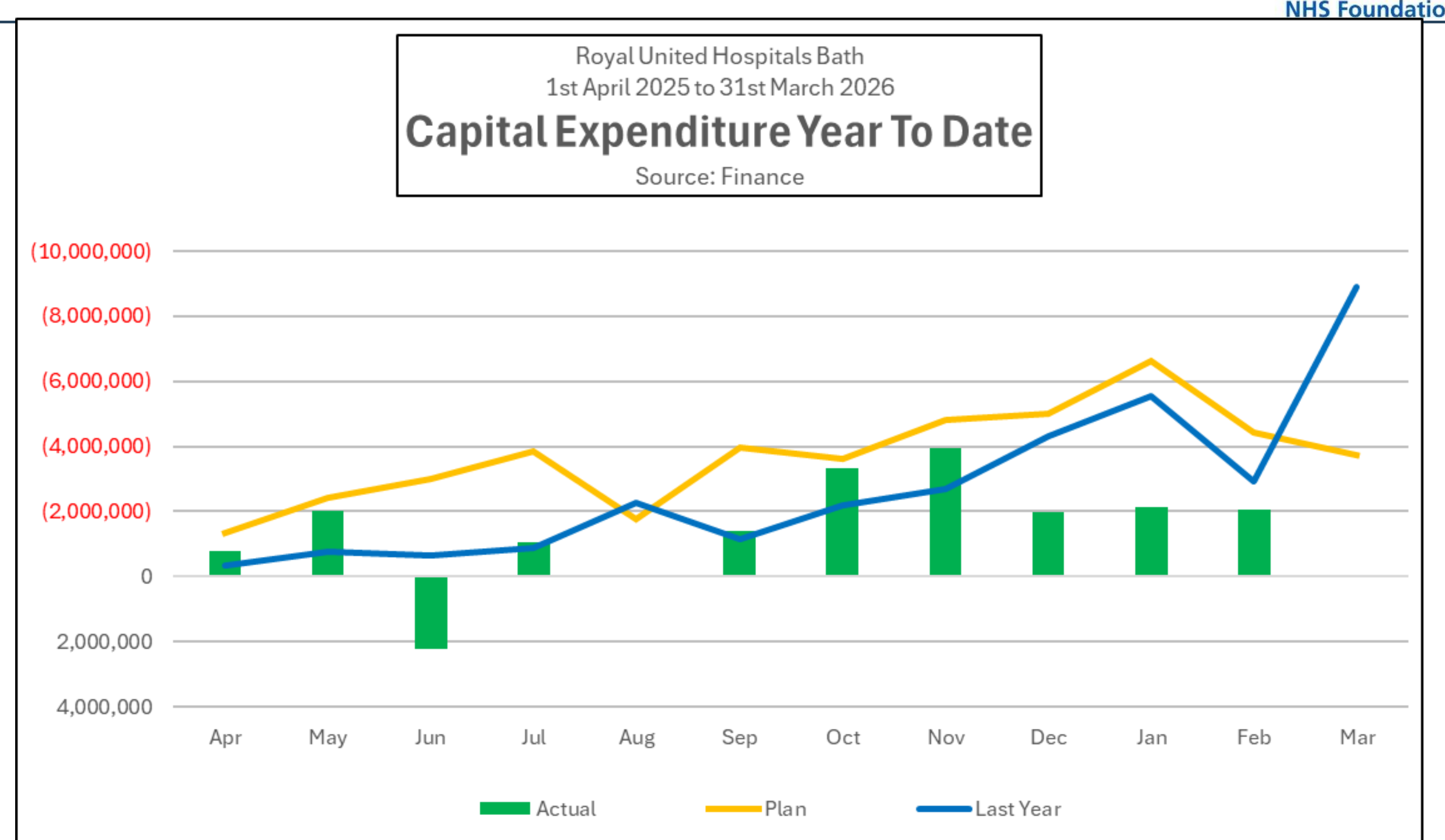
Month 11 Adjusted YTD financial trajectory vs Actual:

- The system is reporting a £20.1m adverse variance against plan. This position includes Deficit supporting funding of £17.6m to Month 11 (equating to 9/12ths of FY planned £23.4m).
- When compared to the Revised financial trajectory, the system was slightly ahead of the anticipated Month 11 position.
- The ICB position has been updated to reflect 11/12ths of the agreed FY FOT, £22.9m.

*Note: All values are presented on a rounded basis (+/- £0.1m).
**Revised trajectory values have been adjusted for the receipt of Deficit support funding and reflects the latest view of provider trajectories as indicated within Draft M11 Provider Financial returns.

Capital – Operational, Grant & Donated

Position as at 28th February 2026	Annual Plan £'m	Forecast Outturn £'m	YTD Plan £'m	YTD Actuals £'m	YTD Variance £'m
Decarbonisation	(3.135)	(3.135)	(2.740)	(3.192)	(0.452)
BSW EPR	(2.865)	(2.443)	(2.521)	(0.198)	2.323
Sulis Lease	(0.953)	(0.989)	(0.953)	(0.989)	(0.036)
Strategic Schemes Total	**(6.953)**	**(6.567)**	**(6.214)**	**(4.379)**	**1.835**
IT	(1.750)	(1.650)	(1.562)	(1.423)	0.139
Medical Equipment (MEC)	(1.910)	(1.707)	(1.883)	(1.186)	0.697
Estates, CRG & Projects	(1.700)	(2.117)	(1.596)	(1.514)	0.082
Sulis	(0.250)	(0.558)	(0.223)	(0.507)	(0.284)
Right of Use Leases	(0.300)	(0.506)	(0.225)	(0.431)	(0.206)
Minor	0.543	0.762	0.543	0.777	0.234
Disposals - NBV write off	0.000	0.697	0.000	0.697	0.697
Lease Provision release (Modular Theatre)	(0.547)	(0.547)	0.000	0.000	0.000
Other Schemes Total	**(5.914)**	**(5.626)**	**(4.946)**	**(3.588)**	**1.358**
TOTAL : Operational Capital	**(12.867)**	**(12.193)**	**(11.160)**	**(7.967)**	**3.193**
Decarbonisation (Salix)	(10.820)	(9.554)	(10.820)	(7.602)	3.218
Decarbonisation (NEEF)	0.000	(0.051)	0.000	0.000	0.000
PET-CT	(2.000)	0.000	(0.500)	0.000	0.500
Minor donated schemes	(0.300)	(0.383)	(0.275)	(0.383)	(0.108)
TOTAL : Donated & Grant Funded	**(13.120)**	**(9.988)**	**(11.595)**	**(7.985)**	**3.610**
OVERALL TOTAL	**(25.987)**	**(22.181)**	**(22.755)**	**(15.952)**	**6.803**



Understanding Performance

Operational capital is behind plan due to late allocation confirmation but is still expected to be fully spent, with no significant risks identified.

Committed capital was reviewed at June TME, where £1.745m of uncommitted spend was held back, though the CT replacement can now proceed this year.

Decarbonisation scheme cashflow now shows spend starting in July and running into next year, and mitigations are in place to maximise in-year spend.

The EPR forecast has shifted to a £364k underspend; despite mitigations, there remains a risk of under-utilising the CDEL allocation.

Countermeasures	Owner	Due Date
Completed: EPR project to provided an update paper on EPR cost pressure to Trust Board. A decision on committing future CDEL funding or reduction in scheme needs to be taken or additional PDC funding obtained.	EPR Project	Compl ete
Completed: Due to the adverse revenue position capital expenditure not contractually committed or is mandated has been held.	CPMG	Compl ete
Completed: EPR project team are undertaking a review of the programme with several options being considered. The options are to be presented to the Joint Board for agreement	EPR Board	Compl ete
Completed: The operational & financial implications of the outcome of the EPR decision will need to be mitigated. The risks of the reduction in funding to be outlined in a paper to MEC / Trust Board	CPMG	Compl ete

Risks and Mitigation

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

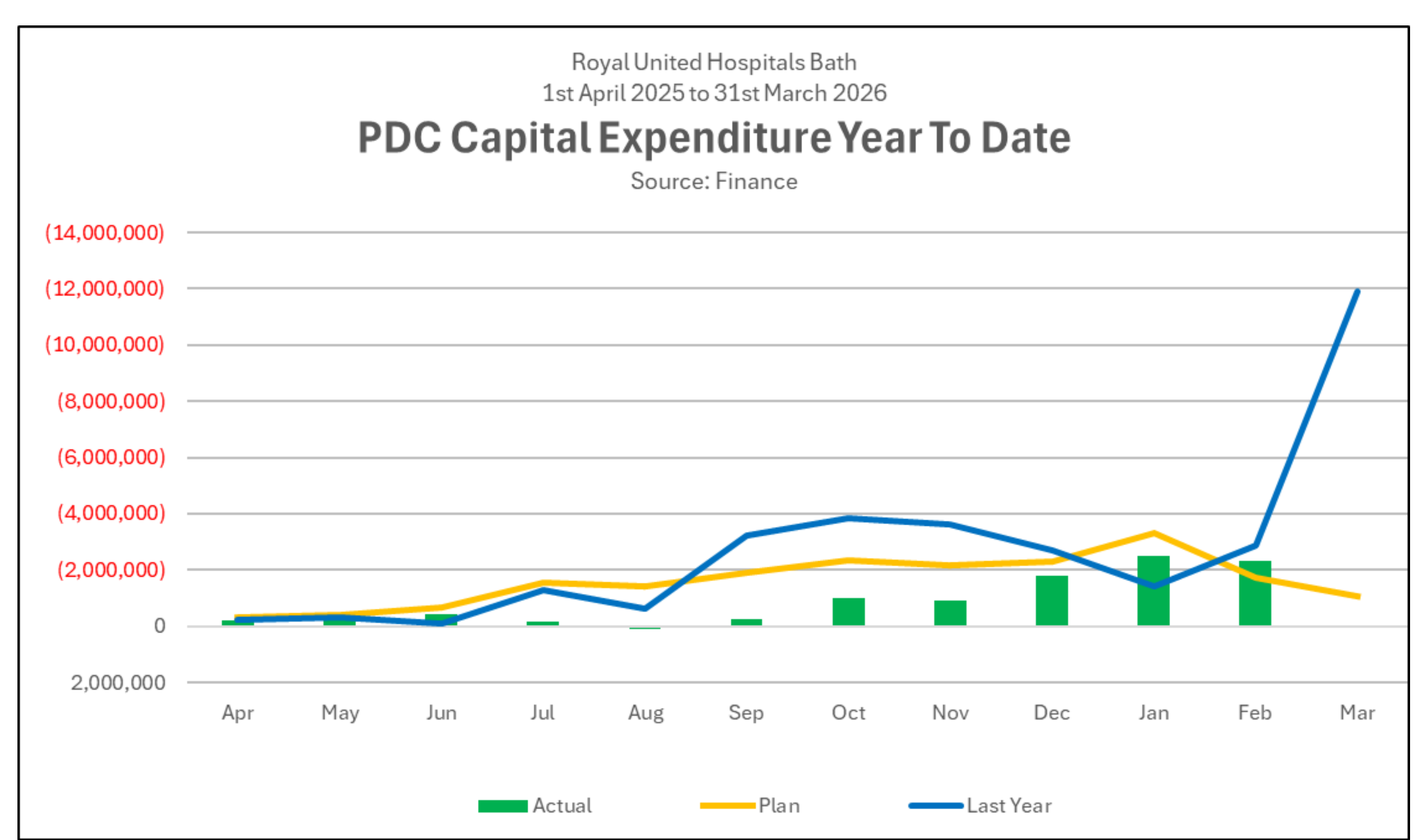
The EPR programme team are forecasting an underspend of £364k, however this requires £2.3m spend to be achieved in March. There are weekly meetings in place.

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

PDC Funded Capital Position as at 28th February 2026		Annual Plan £'m	Forecast Outturn £'m	YTD Plan £'m	YTD Actuals £'m	YTD Variance £'m	Approval status
BSW EPR		(2.955)	(2.955)	(2.955)	(2.955)	0.000	Approved, MOUs signed
Other Schemes : Solar, RAAC, EV, Cardiology, Maternity & Pathology Equip		(0.877)	(0.859)	(0.703)	(0.207)	0.496	Approved, MOUs signed
Total Other		**(3.832)**	**(3.814)**	**(3.658)**	**(3.162)**	**0.496**	
Estates:	Fire Safety Programme	(1.890)	(1.890)	(1.755)	(0.741)	1.014	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)	(0.600)	(0.036)	0.564	
	Chiller Replacement (Pathology)	(0.720)	(0.720)	(0.650)	(0.005)	0.645	
	Maternity Estates Safety Schemes	(0.718)	(0.718)	(0.680)	(0.016)	0.665	
	Other Estates Safety schemes	(1.936)	(1.936)	(1.658)	(0.592)	1.066	
Total Estates Safety		**(6.164)**	**(6.164)**	**(5.344)**	**(1.389)**	**3.955**	
Diagnostics:	MRI replacement	(2.323)	(2.323)	(1.435)	(0.729)	0.705	We have had approval for the UEC schemes, MRI software & Sulis MRI replacement schemes. The Elective schemes apart from Automation have been withdrawn due to revenue implications.
	MRI Acceleration software	(0.143)	(0.143)	(0.143)	(0.162)	(0.020)	
	ECHO Equipment for Phyiological Scieinces	(0.120)	(0.120)	(0.120)	(0.120)	0.000	
	CDC Expansion- Design works to RIBA stage 4	(0.067)	(0.067)	(0.675)	(0.042)	0.633	
	CDC 4th Site Trowbridge Design works to RIBA stage 4	(0.263)	(0.263)	(0.024)	(0.037)	(0.013)	
	Radiology & Cardiology IT Integtation	(0.182)	0.000	0.000	0.000	0.000	
Elective:	Gastroenterology / General Surgery Out Patient clinic rooms	0.000	0.000	(0.250)	0.000	0.250	
	Gynae Theatre Clinical Pathway Redesign	0.000	0.000	(1.300)	0.000	1.300	
	Elective Admin automation PDC	(0.800)	(0.800)	0.000	0.000	0.000	
UEC:	Admisson & Transfer Lounge	(1.700)	(1.700)	(1.300)	(1.439)	(0.139)	
	Medical Short Stay expansion	(0.850)	(0.850)	(0.850)	(0.489)	0.361	
	Integrated front Door / SDEC (Seed Funding)	0.000	0.000	(0.270)	0.000	0.270	
	Neurology Ward reconfiguration and relocation	(3.100)	(3.100)	(2.950)	(1.885)	1.065	
	IPC Programme	(1.350)	(1.350)	(1.350)	(0.354)	0.996	
	SDEC digital enabling	0.000	0.000	(0.400)	0.000	0.400	
Total Constitutional Standards		**(10.898)**	**(10.716)**	**(11.066)**	**(5.138)**	**5.928**	
TOTAL : PDC Funded		**(20.894)**	**(20.694)**	**(20.068)**	**(9.690)**	**10.378**	



Understanding Performance
The Return to Constitutional Standards schemes are behind plan due to the late approval of schemes by the national team. All schemes are expected to be spent in full in line with forecast. No significant risks have been identified by capital leads.

Countermeasures	Owner	Due Date
Completed: In response to the adverse revenue position capital expenditure that has not been contractually committed or is mandated has been held. This will include PDC financed schemes where there is an ongoing revenue consequence that has not been agreed by CPMG or Board.	CPMG	Immediate

Risks and Mitigation
The Return to Constitutional Standards 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

Statement of financial position	M11 FY 2025-26 28/02/2026 £'m	FY 2024-25 31/03/2025 £'m	Variance £'m	% Variance
Non current assets				
Intangible assets	6.380	7.096	(0.716)	(10.090)%
Property, Plant & Equipment	328.884	330.248	(1.364)	(0.413)%
Right of use assets - leased assets for lessee	47.614	49.730	(2.116)	(4.255)%
Investments in associates and joint ventures	3.941	3.941	0.000	0.000%
Trade and other receivables	7.537	5.184	2.353	45.390%
Total non current assets	**394.356**	**396.199**	**(1.843)**	**(0.465)%**
Current Assets				
Inventories	6.574	6.782	(0.208)	(3.067)%
Trade and other receivables	37.077	30.746	6.331	20.591%
Cash and cash equivalents	20.136	36.648	(16.512)	(45.056)%
Total current assets	**63.787**	**74.176**	**(10.389)**	**(14.006)%**
Current Liabilities				
Trade and other payables	(53.760)	(61.625)	7.865	(12.763)%
Other liabilities	(10.994)	(8.634)	(2.360)	27.334%
Provisions	(0.388)	(0.932)	0.544	(58.369)%
Borrowings	(1.831)	(2.530)	0.699	(27.628)%
Total current liabilities	**(66.973)**	**(73.721)**	**6.748**	**(9.153)%**
Total assets less current liabilities	**391.170**	**396.654**	**(5.484)**	**(1.383)%**
Non current liabilities				
Provisions	(9.908)	(1.315)	(8.593)	653.460%
Borrowings	(54.294)	(54.896)	0.602	(1.097)%
Total assets employed	**326.968**	**340.443**	**(13.475)**	**(3.958)%**
Financed by:				
Public Dividend Capital	298.809	285.705	13.104	4.587%
Income and Expenditure Reserve	(12.921)	13.658	(26.579)	(194.604)%
Revaluation reserve	41.080	41.080	0.000	0.000%
Total equity	**326.968**	**340.443**	**(13.475)**	**(3.958)%**

Understanding Performance

Non-current assets
Capital assets: £4.196m decrease is driven by movements in capital spending, depreciation charges, impairments, and lease restoration provisions.

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

Current liabilities
Trade & Other Payables: £7.865m variance reflects the settlement of capital creditors (£2.260m) and non-capital creditors (£18.086m),
Other liabilities: £2.360m movement reflects transitional funding received in advance, and early quarterly invoicing. In addition, R&D deferred income reports a £1.560m debit, driven by expenditure incurred ahead of income recognition.

Non-current liabilities
Increase of £8.59m in provisions for restoration costs relating to Sulis Hospital.

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

Risks and Mitigation

Risks include:

Slippage in capital spend. Mitigated through monthly CPMG meetings and monthly reporting to ICB and NHSE.

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

Countermeasures	Owner	Due Date
Capital – Monitored through CPMG and monthly reporting to ICB and NHSE.	Head of Financial services	Monthly monitoring
Cash – the saving plan has a direct impact on the level of cash the Trust will have available. Cash releasing savings will need to be realised to maintain the cash balance.	Trust Management Executive	Monthly monitoring
Payables – This will continue to be monitored, however, there are close links to non pay saving plans.	Head of Financial Services	Monthly Monitoring
Equity – Monthly position will be monitored by the finance team; however, equity will be impacted by the level of the saving plan that is achieved.	Operational Finance Director & Trust Management Executive	Monthly Monitoring

Cash

Statements of Cash Flows	Actual £'m
EBITDA deficit	2.797
Income recognised in respect of capital donations (cash and non-cash)	(7.965)
Impairments	13.482
Working capital movement	(10.004)
Provisions	(0.531)
Net cash used in operating activities	**(2.221)**
Capital Expenditure	(29.725)
CDC lease set up	3.241
Cash receipts from asset sales	0.009
Donated cash for capital assets	4.492
Interest received	1.530
Net cash used in investing activities	**(20.452)**
Public dividend capital received	13.104
Movement in loans from the DHSC	(0.312)
Capital element of finance lease rental payments	(1.543)
Interest on loans	(0.113)
Interest element of finance lease	(1.495)
PDC dividend (paid)/refunded	(3.479)
Net cash generated from financing activities	**6.162**
Decrease in cash and cash equivalents	**(16.512)**
Opening cash balance	36.648
Closing cash balance	**20.136**
Adjusted for petty cash	0.005
Adjusted closing cash balance	**20.141**

Understanding Performance

As at February 2026, the cash balance was £20.1m, which is £3m below the forecast position.

Key drivers:

1. Commissioning income was £4.m below forecast.
2. Other operating income was £1.1m below forecast.
3. Education and training income exceeded forecast by £1.8m.
4. Suppliers' payment were £2.5m below forecast..
5. Capital payments was £5.2m below forecast due to slippage.

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
Ongoing review of cash forecasts to reflect updated run-rates and payment patterns.	Delivery Group SROs	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.

Trust Top Ten Debtors

Top ten debtors	Total £'m	Not due £'m	1 - 30 days £'m	31-60 days £'m	61-90 days £'m	>91 days £'m	Comments
HCRG Care Services Ltd	**1.655**	0.413	0.446	0.002	0.341	0.452	£0.9m in dispute and this is being resolved with Financial Management. The balance is being chased in line with the debt recovery policy.
NHS England South West (South West South) - Q85	**0.746**	0.000	0.732	0.014	0.000	0.000	£0.7m is being chased in line with the debt recovery policy.
University Hospital Bristol and Weston NHS Foundation Trust (RA7)	**0.602**	0.245	0.208	0.017	0.037	0.095	A statement of account was issued to the debtor to address queries regarding the overdue balance.
NHS Banes, Swindon, & Wiltshire ICB	**0.599**	0.435	0.025	0.066	0.000	0.073	£0.043m is currently with Financial Management pending a charge query raised. £0.090m invoice would be re-raised as one consolidated invoice in response to the query from BSW ICB.
Coloplast Ltd	**0.233**	0.000	0.082	0.000	0.151	0.000	The contract is currently in dispute and is being resolved with Financial Management.
Gloucester Hospital NHS F/T (RTE)	**0.218**	0.000	0.049	0.020	0.031	0.118	Ongoing issues with Locums Nest shift payments. Financial Management and Gloucester are currently in discussions to address the issues. Senior management and the purchasing team are now involved to help resolve them.
Sundry Customers - Overseas Patient	**0.199**	0.000	0.014	0.024	0.000	0.161	All debt prior to 1 April 2025 debt has been fully provided for within the bad debt provision. Where appropriate, outstanding balances have been referred to the Trust's debt recovery agency or placed on instalment plan.
Alliance Medical Limited	**0.144**	0.069	0.075	0.000	0.000	0.000	£0.075m is being chased in line with the debt recovery policy.
North Bristol NHS Trust (RVJ)	**0.144**	0.000	0.075	0.007	0.062	0.000	Debt is being chased in line with the debt recovery policy, and Financial Management have been involved for a swift response.
Dorthy House Foundation	**0.142**	0.003	0.047	0.000	0.000	0.092	Debt is being reviewed within Senior Management to resolve.
Total	**4.683**	**1.165**	**1.753**	**0.151**	**0.623**	**0.991**	
Sulis debtors	**2.011**	1.130	0.347	0.288	0.033	0.212	Statement of account was shared with Sulis. Ongoing discussions regarding the SOC recharges and MDT. The outstanding balances relate to business-as-usual recharges, which are being chased in line with the debt recovery policy. Discussions are also being held at senior levels within both organisation to support timely resolution.
BSW Group Debtors (SFT and GWH)	**0.555**	0.192	0.071	0.032	0.012	0.248	**GWH** - £0.120m invoice relates to Trust Senior Management recharges, with Operational Finance Director. **SFT** - £0.078m relates to SOC invoices which SFT are currently reviewing in linw with the contract. £0.057m relates to procurement recharge which is being reviewed pending when the supporting documentation is provided. Outstanding balances are being chased in line with debt recovery policy.
Total value of all invoiced debtors on balance sheet	**8.610**	**3.076**	**2.360**	**0.593**	**1.192**	**1.389**	This represents total value of invoiced debtors outstanding as at February 2026.

Understanding Performance

The total balance of the top 10 debtors is £4.683m out of which £1.165m is not yet due for collection. The overdue balances are being chased for payment in line with the Trust bad debt recovery policy, with some balances provided for as bad debt.

As at 28 February 2026, the debtor balance owed to the Trust within the BSW Group is £0.555m and Sulis is £2.011m. Sulis makes up 23% of invoiced debtors for the period

Overall, the total value of invoiced debtors held on the balance sheet is £8.610m.

Countermeasures	Owner	Due Date
Active management via Accounts Receivable Team and support from Senior Finance Team.	Head of Financial Services	Continuous

Risks and Mitigation

Collectability of receivables which will have an impact on the financial performance of the Trust if they are required to be written off.

Late collection of receivables will affect the cash position of the Trust.

Risks are being mitigated through the application of the Trust debt policy.

Trust Top Ten Creditors

NHS
Royal United Hospitals Bath
NHS Foundation Trust

Top Ten Creditors	Total £'m	Not due £'m	1 - 30 days £'m	31-60 days £'m	61-90 days £'m	>91 days £'m	Comments
Veolia Energy & Utility Services UK Ltd	**(1.566)**	(0.774)	(0.792)	0.000	0.000	0.000	£0.792m with finance for approval. £0.774m with the requisitioner to receipt the order.
L Rowlands (Retail) Ltd	**(1.239)**	0.000	(1.239)	0.000	0.000	0.000	£1.239m awaiting approval at the divisional review stage.
Siemens Healthcare Ltd	**(0.927)**	(0.927)	0.000	0.000	0.000	0.000	£0.128m approved and ready for payment. £0.799m with the requisitioner to receipt the order.
NHS Supply Chain (Consumables)	**(0.681)**	(0.336)	(0.345)	0.000	0.000	0.000	£0.681m approved and ready for payment.
Softcat Plc	**(0.619)**	(0.128)	(0.491)	0.000	0.000	0.000	£0.049m approved and ready for payment. £0.569m with the requisitioner to receipt the order.
Beckman Coulter	**(0.469)**	(0.469)	0.000	0.000	0.000	0.000	£0.469m approved and ready for payment.
ID Medical Group Ltd	**(0.464)**	(0.250)	(0.214)	0.000	0.000	0.000	£0.050m approved and ready for payment. £0.414m with the budget holder for approval.
Total Energies Gas & Power Ltd	**(0.427)**	(0.427)	0.000	0.000	0.000	0.000	£0.033m approved and ready for payment. £0.394m at the divisional review stage of approval.
NHS Supply Chain (Maintenance)	**(0.369)**	(0.277)	(0.092)	0.000	0.000	0.000	£0.238m approved and ready for payment. £0.131m with the requisitioner to receipt the order.
Accenture (UK) Ltd	**(0.334)**	(0.334)	0.000	0.000	0.000	0.000	£0.334m with the requisitioner to receipt the order.
Total	(7.094)	(3.922)	(3.172)	**0.000**	**0.000**	**0.000**	
Sulis Creditors	**(0.325)**	(0.325)	0.000	0.000	0.000	0.000	£0.199m approved and ready for payment. £0.126m with the budget holder for approval.
Intragroup Creditors (GWH and SFT)	**(0.302)**	(0.244)	(0.038)	(0.020)	0.000	0.000	**GWH** - £0.038m - with the budget holder for authorisation. **SFT** - £0.244m - with the budget holder for authorisation, £0.020m - budget holder has requested more information before approval.
Total value of all invoiced creditors on balance sheet	**(14.610)**	(9.664)	(4.138)	(0.335)	(0.224)	(0.250)	This represents total value of invoiced creditors outstanding as at February 2026.

Understanding Performance

The total balance of the top 10 creditors is £7.094m out of which £3.922m is not yet due for payment. The remaining balances are being chased for approval with the budget holders.

As at 28 February 2026, the creditor balance owed by the Trust within the BSW Group is £0.302m and Sulis is £0.325m.

Overall, the total value of invoiced creditors held on the balance sheet is £14.610m

Countermeasures	Owner	Due Date
Active management by Accounts Payable team.	Head of Financial Services	Continuous

Risks and Mitigation

The payment of amounts due will have an impact on the cash position and will have to be closely monitored in relation to the available cash balance.

Better Payment Practice Code

	Feb-26		Jan-26		% Variance	
	Volume ('m)	£'m	Volume ('m)	£'m	Volume ('m)	£'m
Non NHS						
Total bills paid in the year	66.837	353.384	59.719	319.922	12%	10%
Total bills paid within target	62.978	307.766	57.033	278.087	10%	11%
Percentage of bills paid within target	**94%**	**87%**	**96%**	**87%**	**-2%**	**0%**
NHS						
Total bills paid in the year	1.356	17.509	1.221	16.059	11%	9%
Total bills paid within target	1.077	11.013	0.974	10.007	11%	10%
Percentage of bills paid within target	**79%**	**63%**	**80%**	**62%**	**-1%**	**1%**
Total						
Total bills paid in the year	68.193	370.893	60.94	335.981	12%	10%
Total bills paid within target	64.055	318.779	58.007	288.094	10%	11%
Percentage of bills paid within target	**94%**	**86%**	**95%**	**86%**	**-1%**	**0%**

Understanding performance

Compliance with the Better Payment Practice Code (BPPC) fell below the statutory threshold of 95% for February. Overall performance was 94% by volume and 86% by value.

NHS invoice value performance remains the main driver of non-compliance.

Countermeasures	Owner	Due Date
Active management by Accounts Payable team with support from procurement.	Head of Financial services & Procurement	Continuous
Adherence to Better Payment Practise Code including adherence to No PO No Pay policy will support more accurate cash forecasting.	All budget holders & Procurement Team	31 March

Risks and Mitigation

The payment of amounts due will have an impact on the cash position and will have to be closely monitored in relation to the available cash balance.

Trust Purchase Order Compliance

Division	Invoice Totals 202511					
	Off Purchase Order £'m	On Purchase Order £'m	Total £'m	% on PO M11	% on PO	%
Capital Summary	0.014	1.786	1.800	99.228	96.126	3.103
Total capital PO compliance	**0.014**	**1.786**	**1.800**	**99.228**	**96.126**	**3.103**
Corporate Division	0.104	1.343	1.447	92.815	83.343	9.473
Estates And Facilities Division	0.061	0.549	0.610	90.071	81.620	8.450
Family And Specialist Service Division	0.061	0.335	0.396	84.549	83.378	1.171
Health Innovation West of England	0.001	0.073	0.073	99.123	100.000	- 0.877
Medical Division	0.581	1.672	2.252	74.220	84.663	- 10.443
Research & Development	0.005	0.027	0.033	84.188	88.196	- 4.007
Surgical Division	0.059	1.574	1.633	96.372	98.397	- 2.025
Total revenue PO compliance	**0.871**	**5.573**	**6.445**	**86.478**	**88.755**	**- 2.277**
Total compliance in February	**0.885**	**7.359**	**8.244**	**89.261**	**89.706**	**- 0.445**

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

Understanding Performance

The table above outlines purchase order (PO) compliance across the Trust for Month 11; it excludes suppliers exempt from using a PO.

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

- Capital: Non-compliance is minimal (1%) and not considered material.
- Corporate division: Telecommunications, patient experience team and informatics management invoices were processed without POs.
- Estates and facilities: Non-compliance primarily relates to laundry services, transport services, waste management services, and sterile services invoices processed without POs.
- Family and Specialist Service Division: Invoices for maternity screening, gynaecology outpatients, and oncology medical staff were processed without POs.
- Medical Division: Invoices for radiology, dermatology, and cardiology medical staff, emergency medicine consumables and adult therapies outpatient were processed without POs.
- Surgical Division: Non-compliance largely relates to invoices for lease costs at the Frome Medical Centre, orthopaedic prosthesis loan kits, and blood products that were processed without POs.

Countermeasures	Owner	Due Date
The Group Chief Finance Officer has requested that PO compliance is 95% compliance by the end of Qtr1 25/26.	Divisional Finance Managers and Procurement	Ongoing
PO compliance is monitored through the non pay group. Invoices over £2,500 without a PO are being held and will only be released for payment through the non pay group.	Divisional Finance Managers, Financial Services and Procurement Teams	Ongoing

Risks and Mitigation

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

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

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

Sulis

YTD Performance against budget YTD P11

Statement of Comprehensive Income	SULIS			CDC			SOC			TOTAL		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance
Commissioner Income (NHSE/CCG	21,255	22,644	1,389	5,265	4,607	(658)				26,520	27,251	731
Other Patient Care Income	13,577	13,904	327							13,577	13,904	327
Other Operating Income	375	374	(1)		706	706	8,655	7,261	(1,394)	9,030	8,342	(688)
Income Total	35,207	36,922	1,715	5,265	5,314	48	8,655	7,261	(1,394)	49,127	49,497	369
Pay	(16,317)	(17,590)	(1,272)	(2,479)	(3,122)	(643)	(3,884)	(3,333)	552	(22,681)	(24,044)	(1,363)
Non Pay	(15,163)	(13,935)	1,228	(2,573)	(3,234)	(661)	(4,771)	(3,929)	842	(22,507)	(21,098)	1,409
Depreciation	(2,599)	(2,612)	(13)	(388)	(448)	(60)				(2,987)	(3,061)	(74)
Expenditure Total	(34,080)	(34,137)	(57)	(5,440)	(6,805)	(1,365)	(8,655)	(7,261)	1,394	(48,175)	(48,203)	(28)
Operating Surplus/(Deficit)	1,127	2,785	1,658	(175)	(1,491)	(1,316)	(0)	(0)	(0)	952	1,294	342
Other Finance Charges	(407)	(417)	(10)	(68)	(143)	(75)				(475)	(560)	(85)
Other Gains/Losses		(0)	(0)								(0)	(0)
Finance Charges	(407)	(417)	(10)	(68)	(143)	(75)				(475)	(560)	(85)
Surplus/(Deficit)	720	2,368	1,648	(242)	(1,634)	(1,392)	(0)	(0)	(0)	477	734	257

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

Understanding Performance

NHS Income: Sulis income YTD/£1.7m favourable vs budget.
CDC activity ahead of Budget by £48k, -£658k behind in activity but ahead £706k due to other income.
Private patient Income: £327k favourable vs budget.
Pay: £1.4m adverse vs budget
Non Pay: £1.4m favourable vs Budget, with savings continuing.
Overall to deliver £734k, £257k favourable vs Budget.

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

Risks and Mitigation

Risks
- CDC activity levels and costs continuing to make a loss.

Mitigation:
Per table to left

Appendix

Business Rules

SPC Guidance

Business Rules - Driver metrics

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

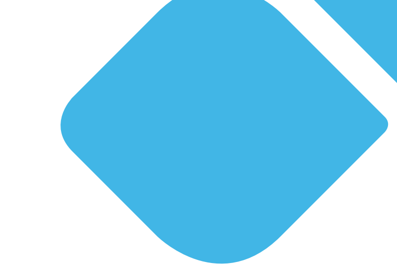
Business rules updated on 23/04/25 to reflect the move to SPC charts in PowerBI

Business Rules – Watch metrics

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

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

Business Rules – Standard/Mandatory Metrics



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

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

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

Report to:	Public Board of Directors	Agenda item:	14
Date of Meeting:	1 April 2026		

Title of Report:	RUH Staff Survey Results 2025
Status:	Discussion
Board Sponsor:	Jude Gray, Chief People Officer
Author:	Ben Padfield, Associate Director for People – Culture Change & Matt Foxon, Site HR Director
Appendices	Appendix 1: RUH Results Summary

1. Executive Summary of the Report

The 2025 RUH Staff Survey shows a mixed picture of stability, ongoing pressure, and areas needing focused improvement. Response rates fell slightly, reflecting a broader decline across NHS trusts. Key strengths include continued civility and kindness, strong team relationships, a high sense of purpose, and positive perceptions of patient care. Most staff feel valued by colleagues, supported by managers, and confident in reporting negative experiences, with improvements in violence and harassment reporting.

Challenges centre on career development, workload, and wellbeing. Opportunities for training and progression have declined, largely due to financial constraints and difficulty releasing staff. Workload pressures remain significant, with low perceived staffing levels and high levels of stress, burnout and emotional exhaustion. Despite low turnover, many staff still consider leaving. Disparities persist for Global Majority staff and colleagues with disabilities, who report higher discrimination.

Some improvements include fewer unpaid hours and greater ability to make suggestions for improvement. The report concludes with priorities for 2026/27: strengthening appraisals and one-to-ones, improving organisational communication, addressing wellbeing systematically, reinforcing a learning culture, and protecting strengths like team cohesion and compassionate management.

2. Recommendations (Note, Approve, Discuss)

Discuss.

3. Legal / Regulatory Implications

CQC – Staff survey is an important cultural measure impacting quality, safety and compliance.

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

BAF risks 2.1 and 2.2

5. Resources Implications (Financial / staffing)

N/A

6.	Equality and Diversity
WRES/WDES initial data is included in the report.	

7.	References to previous reports/Next steps
This report builds on briefer reports discussed at earlier meetings. Next steps for People Programme Planning are including as high-level priorities in the report.	

8.	Freedom of Information
Public.	

9.	Sustainability
N/A	

10.	Digital
AI tools used to collate themes.	

Staff Survey Results: High level themes

2025 Staff Survey

Response rates

For the 2025 Staff Survey, we joined up our approach across BSW Hospitals Group to offer a standard and consistent way for **16,588** of our colleagues to share their views of working both at BSW Hospitals Group and in the NHS.

We heard back from **9,425** of our people resulting in an overall response rate of 57% for the Group. Whilst a decline compared to 2024 of 5%, this result is **above the average** for our staff survey providers (49% for IQVIA), who also saw a year-on-year decline in response (52% last year).

Trust	2024	2025	% to LY
Great Western Hospitals NHS Foundation Trust	70.9%	**66.0%**	-4.9%
Royal United Hospitals Bath NHS Foundation Trust	54.3%	**52.1%**	-2.1%
Salisbury NHS Foundation Trust	59.1%	**52.4%**	-6.6%
BSW Hospitals Group Total	61.5%	**56.8%**	-4.7%

BSW Hospitals Group overview

Shared themes across the Group

- Common reduction in the pillar metric Recommend as a place to work
- Common positive indicators regarding staff opinions being sought, making suggestions and improvements in the workplace
- Although above/in line with sector average, staff reporting organisation taking positive action on their wellbeing is a common theme of decline

Career Development Opportunities

- Opportunities for Career Development: most declined question in all three care organisations. Team members are saying they feel strain to obtain CPD opportunities. This may be due to misunderstanding of what CPD actually is.

  May be reflective of the operating environment in 2025 incorporating group restructure, organisation pressure limiting time to release staff for development activities, admin recruitment freeze, and controls on discretionary spend.

Managerial Support

- Encouragement and Feedback: positive theme of engaging staff opinions, suggestions and improvements into matters affecting their work.
- Health and Well-being: Colleagues are not seeing this as a priority and there is an opportunity to put this at the heart of change. Presenteeism.

Organisational Commitment

- Patient Care Priority: common decline in staff reporting patient being top priority and friends and family test (happy with standard of care). May be reflective of focus cost savings and workforce transformation programmes.
- Acting on Concerns: improvement of staff reporting incidents of violence and a common theme that all organisations may benefit from improving a feedback loop to demonstrate how concerns are managed.

Results sharing timeline

Key dates for communication of the 2025 Staff Survey results	
28th November	The 2025 Staff Survey closes
15th December	Initial top-level data becomes available for GWH, RUH, and SFT
16th December	Draft submission of initial results
March	Trust Management packs distributed
March	Divisional results shared with Care Organisations
May	Results shared at Care Organisation People & Culture Committees
June	Results shared at Trust Boards
October	Launch of the 2026 Staff Survey

Top level results for RUH

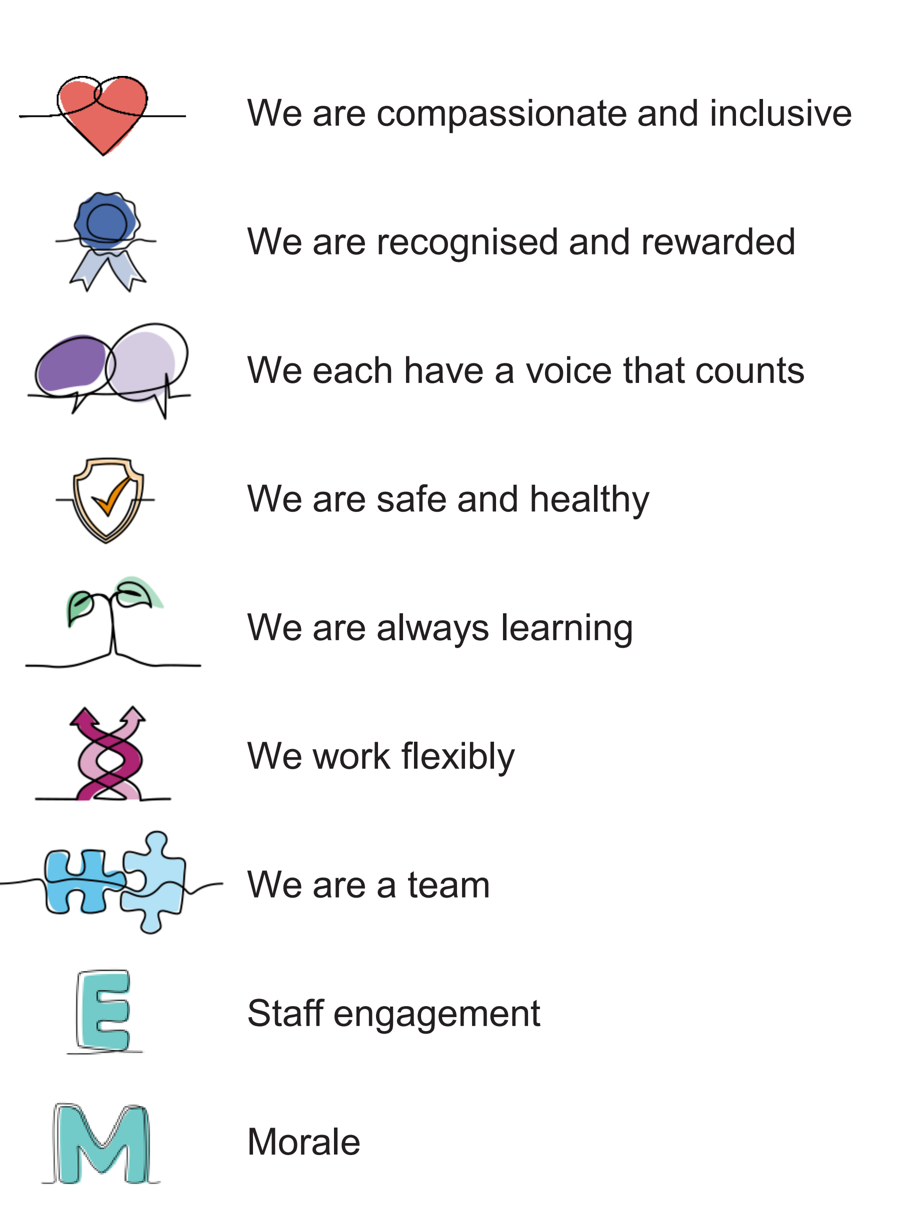
From our People Promise themes we have seen 2 minor improvements, around 'working flexibly' in a 'safe and healthy' way. Four scores remain static, and 3 have declined from 2024: these include 'having a voice', 'always learning' and 'staff engagement'.

Compassion and inclusion remains the highest of our outcomes, potentially a positive result of our well-established 'safe and inclusive working environment' and 'Kindness and Civility' programmes.

The 2025 results show decreases across our Vision/Pillar metrics, with a 3.4% decline in the organisation being recommended as a place to work. This is likely to be a reflection of the operational and financial pressures with which the organisation is currently grappling, alongside a wider social narrative around NHS productivity and expenditure.

Question	Metric type	2024 Result	**2025 Result**	% to LY	Comparator
I would recommend my organisation as a place to work….	Pillar	63.6%	**60.2%**	-3.4	*56.3%*
Organisation acts fairly towards career progression	Pillar	Not available	**50.9%**	-	*53.3%*
Not experienced discrimination from Manager/team leader or other colleagues	Pillar	91.7%	**91.6%**	-0.1	*91.2%*
Satisfied with extent organisation values my work	Breakthrough	42.9%	**41.6**	-1.3	*41.9%*

Comparator score is the average response for Picker



	2024	**2025**	*Comparator*
We are compassionate and inclusive	7.4	**7.4**	*7.3*
We are recognised and rewarded	6.0	**6.0**	*5.9*
We each have a voice that counts	6.7	**6.6**	*6.6*
We are safe and healthy	6.0	**6.1**	*6.1*
We are always learning	5.6	**5.5**	*5.6*
We work flexibly	6.2	**6.3**	*6.2*
We are a team	6.8	**6.8**	*6.7*
Staff engagement	6.9	**6.8**	*6.7*
Morale	5.9	**5.9**	*5.8*

Successes and challenges for RUH

Most improved:

Reporting and reduction in negative experiences: In 2025/26 we worked to further embed our Violence Prevention and Reduction Policy, and to increase reporting using Report+Support.

Most Declined:

There is an emergent theme around availability and support for developing in role/skills and broader career development. This is almost certainly related to the temporary challenges in releasing colleagues from duties and obtaining funding for bespoke programmes of development.

Positive outliers:

We are above the Picker average on various measures, related to colleagues being polite and civil to each other, being able to make impactful suggestions, making Reasonable Adjustments and feeling confident that the organisation provides good patient care.

Negative outliers:

We are currently falling below the Picker average in terms of learning from incidents and taking action following reporting. Colleagues continue to struggle to meet conflicting demands (resulting in unpaid overwork), which again is likely to be related to the current sustainability context.

Most Improved Scores	Org 2025	Org 2024
Last experience of physical violence reported	73.7%	69.4%
Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	46.8%	42.6%
Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	76.7%	73.7%
In last 3 months, have not come to work when not feeling well enough to perform duties	47.2%	44.4%
Achieve a good balance between work and home life	55.5%	52.9%

Most Declined Scores	Org 2025	Org 2024
Care of patients/service users is organisation's top priority	69.5%	75.1%
There are opportunities for me to develop my career in this organisation	49.2%	54.7%
Able to access the right learning and development opportunities when I need to	55.4%	60.3%
Organisation ensure errors/near misses/incidents do not repeat	61.6%	66.4%
Have opportunities to improve my knowledge and skills	65.8%	70.5%

Top 5 scores vs Organisation Ave	Org	Picker
If friend/relative needed treatment would be happy with standard of care provided by organisation	66.1%	60%
Disability: organisation made reasonable adjustment(s) to enable me to carry out work	78.2%	73.1%
Colleagues are understanding and kind to one another	73.4%	68.5%
Able to make suggestions to improve the work of my team/dept	74.6%	69.9%
Colleagues are polite and treat each other with respect	74.1%	69.6%

Bottom 5 scores vs Organisation Ave	Org	Picker
Feedback given on changes made following errors/near misses/incidents	53%	59.3%
Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	46.8%	52.3%
Organisation ensure errors/near misses/incidents do not repeat	61.6%	65.7%
Able to meet conflicting demands on my time at work	43%	46.5%
Last experience of harassment/bullying/abuse reported	50.4%	53.7%

WRES and WDES for RUH

24% of respondents have a disability

This is an increase from 23.6% in 2024

21.4% of respondents are Global Majority

This is a decrease from 21.5% in 2024

Question	Trust	White staff	BME staff	Without a long-term condition	With a long-term condition
q16a: Not experienced discrimination from patients/service users, their relatives or other members of the public	91%	96%	73%	90%	91%
q16b: Not experienced discrimination from manager/team leader or other colleagues	92%	94%	82%	93%	88%

We have seen a very slight decline in response rates for colleagues from the Global Majority, which is likely related to our overall response rate reduction.

Despite an overall response rate reduction, we have seen a slight increase in responses from colleagues with a disability and/or a long-term health condition. This may be linked to the 2024/25 Breakthrough Objective focus on programmes such as Working with Cancer, reasonable adjustments and improving accessibility.

The ENABLE network remains our most engaged and active staff network.

For Reference 2025: Q31b: Organisation made reasonable adjustments to enable me to carry out my work (78.2%, up 0.8% from 2024 and 5.1% higher than the Picker average)

Brief Themes – Areas for Acknowledgement

- ✓ Strong colleague relationships: Staff report high levels of kindness, respect, and appreciation among colleagues (73–83%).
- ✓ Supportive line management: Managers listen, encourage, value staff, and show interest in wellbeing (63–75%).
- ✓ High sense of purpose: 88% feel their role makes a difference to patients;
- ✓ 70% say patient care is the organisation's top priority.
- ✓ Safety and inclusion: Very high scores for not experiencing violence, harassment, or discrimination from managers or colleagues (≈90%+).
- ✓ Disability support: 78% say reasonable adjustments are provided—significantly above peer organisations.
- ✓ Improving areas: Increases in reporting violence, reduced unpaid hours, improved work–life balance, and better reporting of harassment/abuse.

Brief Themes – Areas for Improvement

- Career development concerns: Significant falls in opportunities for development, L&D access, and career progression fairness (49–55%, down from previous years).
- Workload and staffing pressures: Low scores for realistic time pressures (23%), adequate staffing (29%), and ability to meet conflicting demands (43%).
- Limited impact of appraisals: Although most staff receive them (85%), few find them useful (24–34%).
- Weak organisational responsiveness: Staff lack confidence that concerns or incidents are addressed (47–53%), and feedback after incidents is low.
- Retention challenges: Only 43% don't think about leaving; only 53% unlikely to look for another job.
- Pay dissatisfaction: Only 31% satisfied with pay.
- Persistent wellbeing issues: Emotional exhaustion (24%), burnout (30%), and stress-related unwellness remain notable.

Themes to inform 2026-29 People Plan

1. **Career & Appraisal Quality** – Restore confidence in development and make appraisals meaningful. (Career opportunities 49%; appraisal usefulness 24–34%).
2. **Workload & Staffing Experience** – Reduce avoidable pressure and improve perceived adequacy of staffing/time (realistic time pressures 23%; enough staff 29%; conflicting demands 43%).
3. **Responsive, Learning Culture** – Close the loop on concerns and incidents (feedback after incidents 53%; confidence concerns are addressed 47–52%).
4. **Wellbeing & Burnout** – Target hot spots and reduce emotional exhaustion/burnout indicators (24%/30%).
5. **Retention & Advocacy** – Improve intent to stay and recommendation as a place to work (60% recommend; 43% don't think about leaving).
6. **Protect Strengths** – Sustain high team cohesion, compassionate line management and disability adjustments (73–83% team; 63–75% manager support; 78% reasonable adjustments).

RUH Staff Survey 2025 reveals a picture of the organisation that is consistent with other sources of data (including workforce metrics, narrative feedback and experiential evidence from a range of engagement activity).

Staff experience continues to reflect the primary challenges with which the organisation is dealing, including perceived lack of resource to support staffing, some forms of learning and other progressional priorities. Turnover is low, but sickness and dissatisfaction are elevated. A struggle to maintain wellness and satisfaction is persistent.

- Short-term: Improvement actions are already underway to tackle staff health and wellbeing, appraisal quality and compliance and to enable more development and workforce motility.
- Medium-term: 2025 Staff Survey will form the core data source for the BSW Group People Plan (RUH bespoke programmes).

Report to:	Public Board of Directors	Agenda item:	15
Date of Meeting:	1 April 2026		
Title of Report:	Delegation of Approval – Annual Report & Accounts and the Quality Account		
Status:	For approval		
Board Sponsor:	Cara Charles-Barks, Chief Executive		
Author:	Roxy Milbourne, Interim Head of Corporate Governance		
Appendices	None		

1. Executive Summary of the Report

All NHS provider Trusts are required annually to produce and publish both:

- the Annual Report and Accounts, and
- the Quality Account.

Statutory submission deadlines require these documents to be completed and approved within strict timescales. The usual practice at the Trust has been for the Board of Directors to delegate final approval of these documents to the relevant Board Committees due to the timing of external audit, partner review processes, and the nationally mandated publication deadlines. This approach is consistent with previous years, as reflected in last year's Annual Report update paper (June 2025) and the Quality Account Board paper (May 2025).

For 2025/26, changes to the Board calendar - including the Board-to-Board session on 6 May, which replaces the May public Board - mean that Board approval timings fall later than national deadlines. In order to ensure compliance with statutory obligations, Board approval of delegations is required at the April meeting.

This report therefore asks the Board to **delegate authority** for the approval, finalisation and sign-off of:

1. **The Annual Report and Accounts** – to the **Audit & Risk Committee**; and

2. **The Quality Account** – to the **Quality Assurance Committee**.

Once approved by the relevant committees, the documents will be published and submitted in accordance with statutory requirements.

2. Recommendations

The Board is asked to:

1. **Delegate authority to the Audit & Risk Committee** to approve the *Annual Report and Accounts 2025/26* on behalf of the Board, following completion of external audit work.
2. **Delegate authority to the Quality Assurance Committee** to approve the *Quality Account 2025/26* for publication on the Trust's website by 30 June 2026.
3. **Note** that the Annual report is private until the final document is laid before Parliament. It will be made publicly available on the Trust website by 30

September 2026.
4. **Note** that by publishing our Quality Account on our website by 30th June 2026, and forwarding the link to NHS England, the Trust fulfils its statutory obligation to submit to the report to the Secretary of State.

3.	Legal / Regulatory Implications

- Annual Report and Accounts must comply with NHS England's Annual Reporting Manual.
- Quality Accounts must be produced and published under the National Health Service (Quality Accounts) Regulations 2010.
- Failure to meet statutory deadlines may constitute a breach of regulatory requirements.

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

Risks relate to non-compliance with statutory deadlines and publication requirements. Delegation mitigates timing risks created by the revised 2026 Board schedule and external audit timelines.

5.	Resources Implications (Financial / staffing)

None identified. Work is led by the Corporate Governance, Finance and Quality Governance teams.

6.	Equality and Diversity

No adverse impact identified.

7.	References to previous reports/Next steps

- Annual Report update 2025 – presented to Board in June 2025 – delegation to Audit and Risk Committee.
- Quality Accounts update – presented to Board in May 2025 – delegation to Quality Assurance Committee

8.	Freedom of Information

The Annual report is private until the final document is laid before Parliament. It will be made publicly available by 30 September 2026.

By publishing our Quality Account on our website by 30th June 2026, and forwarding the link to NHS England, the Trust fulfils its statutory obligation to submit to the report to the Secretary of State.

9.	Sustainability

It is now a requirement that sustainability is included within the annual report.

10.	Digital

Digital is incorporated into the annual report.

Delegation of Approval – Annual Report & Accounts and the Quality Account

Annual Report & Accounts

NHS England's Annual Reporting Manual (ARM) sets out the requirement for all NHS providers to produce an annual report and accounts and submit these ahead of Parliamentary laying. In previous years, due to the timing of external audit review, the Board of Directors has delegated approval of the Annual report and Accounts to the Audit & Risk Committee.

This year is no different; the final audit opinion and completion steps are scheduled for 15 June. As this date falls after the scheduled Board meeting on 3 June, the Board would not be in a position to approve the final Annual Report and Accounts within the timescales. Delegating approval to the Audit & Risk Committee therefore ensures the Trust remains compliant with NHS England requirements and avoids unnecessary delay to submission.

Milestone	Leads	Timeline
Audit Committee sign off	Audit Committee	22 June 26
Submission to NHSE	Finance Team	By Noon - 30 June 26
Lay before Parliament	Corporate Governance	July 2026
Full and final annual report and accounts and auditor annual report submission to NHSE	Finance Team	30 Sep 25

Quality Account

Under the National Health Service (Quality Accounts) Regulations 2010, providers must publish an annual Quality Account by 30 June. The Quality Account is developed in collaboration with stakeholders and must be reviewed externally by partner organisations.

This year's external partner consultation and deadlines run beyond the June Board meeting and remain aligned to the Quality Assurance Committee's meeting schedule.

Proposed Approach for 2025/26

The Board is asked to endorse the continuation of the established and efficient governance arrangement whereby final approval of statutory documents is delegated to the relevant Board Committees.

This enables:

- Timely compliance with NHS England deadlines.
- Completion of external audit and consultation processes.
- Detailed committee-level scrutiny prior to publication.
- Assurance that documents meet regulatory expectations before submitting to the Secretary of State and NHS England.

Recommendations

The Board of Directors is asked to:

1. **Delegate authority to the Audit & Risk Committee** to approve the Annual Report and Accounts 2025/26 on behalf of the Board, following completion of external audit work.
2. **Delegate authority to the Quality Assurance Committee** to approve the Quality Account 2025/26 for publication on the Trust's website by 30 June 2026.
3. **Note** that the Annual report is private until the final document is laid before Parliament. It will be made publicly available on the Trust website by 30 September 2026.
4. **Note** that by publishing our Quality Account on our website by 30th June 2026, and forwarding the link to NHS England, the Trust fulfils its statutory obligation to submit to the report to the Secretary of State.

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Report to:	Public Board of Directors	Agenda item:	16
Date of Meeting:	1 April 2026		

Title of Report:	NHSE Licence Self-Certification – CoS7 (2026/27)
Status:	Approval
Board Sponsor:	Cara Charles-Barks, Chief Executive
Author:	Roxy Milbourne, Interim Head of Corporate Governance
Appendices	Appendix 1: Self certification Condition CoS7- Commissioner Requested Services (CRS) Requirements

1. Executive Summary of the Report

The Trust operates under an NHS Provider Licence and is required to self-certify on an annual basis whether or not it is compliant with the conditions of the NHS Provider Licence.

With the introduction of a refreshed provider licence in 2023 the self-certification for G6 (3) and FT4 has ceased to remove duplication with the annual report. However, the Trust is still required to self-assess against CoS7 (Commissioner Requested Services).

CoS7(3) requires NHS Foundation Trusts providing Commissioner Requested Services (CRS) to certify that they have a reasonable expectation that the required resources will be available to deliver designated services.

NHS England provides a standard template for this purpose (Appendix 1). Once approved, the template will be completed and signed by the Chair and Chief Executive and published in the Key Publications section of the Trust website.

This report invites the Board to approve the Trust's CoS7 self-certification for 2026/27. In completing the NHS England template, the Board is asked to note the following factors (as reflected in the 'factors to draw attention to' section of the template):

- The 2025/26 annual accounts are prepared on a going concern basis.
- Income and expenditure budgets have been set on robust and agreed principles and divisions should be able to provide high quality healthcare within the resources available, provided the efficiency plans are achieved.
- The year to date and the annual financial position are detailed in the Monthly Integrated Performance Report and regular Finance update reports presented to the Board of Directors and relevant Board sub-committees and Executive Led Groups.
- The Trust is working to achieve the best possible financial position for 2026/27 in agreement with the ICB and NHSE however the emergent nature of the financial settlement for 2026/27 including system wide dependencies and the

impact of a restricted ERF cap for example mean that the operational plan will be a challenge to meet full delivery across all domains (financial, operational performance, quality and workforce).

- The financial plan for 2026/27 is challenging with an efficiency and productivity target of £37.6m (6.7% of turnover) which is not without significant risk, and an overall planned breakeven position. Improvement plans are in place, however, the pace and scale required must be considered in the context of operational pressures, capacity and support required from system partners.

2.	Recommendations (Note, Approve, Discuss)
The Board is requested to approve the Trust's CoS7 self-certification for publication on the Trust website and to authorise the Chair and Chief Executive to sign the NHS England template (Appendix 1) on the Trust's behalf. In doing so, the Board confirms declaration B within Condition CoS7 as 'Confirmed', based on the evidence and narrative set out within the template.	

3.	Legal / Regulatory Implications
Failure to comply with licence conditions (or failure to mitigate against / repair breaches) may result in the Trust breaching its regulatory and statutory obligations.	

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc.)
Failure to meet the conditions of the NHS Provider Licence can lead to NHS England imposing compliance and restoration requirements or, in some circumstances, monetary penalties. This could ultimately lead to regulatory intervention. The most likely impact is reputational, including potential adverse impact on patients' and stakeholders' confidence in the Trust as a provider of NHS services.	

5.	Resources Implications (Financial / staffing)
Not Applicable	

6.	Equality and Diversity
Not Applicable	

7.	References to previous reports
This is an annual process and forms part of the Board's annual work-plan.	

8.	Freedom of Information
Public.	

Worksheet CoS7

Financial Year to which self-certification relates | **2026_27**

Declarations required by Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

	Statement	Response
3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	
	OR	
3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	Confirmed
	OR	
3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.	

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

• The 2025/26 annual accounts are prepared on a going concern basis.

• Income and expenditure budgets have been set on robust and agreed principles and divisions should be able to provide high quality healthcare within the resources available, provided the efficiency plans are achieved.

• The year to date and the annual financial position are detailed in the Monthly Integrated Performance Report and regular Finance update reports presented to the Board of Directors and relevant Board sub-committees and Executive Led Groups.

• The Trust is working to achieve the best possible financial position for 2026/27 in agreement with the ICB and NHSE however the emergent nature of the financial settlement for 2026/27 including system wide dependencies and the impact of a restricted ERF cap for example mean that the operational plan will be a challenge to meet full delivery across all domains (financial, operational performance, quality and workforce).

• The financial plan for 2026/27 is challenging with an efficiency and productivity target of £37.6m (6.7% of turnover) which is not without significant risk, and an overall planned breakeven position. Improvement plans are in place, however, the pace and scale required must be considered in the context of operational pressures, capacity and support required from system partners.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Cara Charles-Barks	**Name**	Paul von der Heyde
Capacity	Chief Executive	**Capacity**	Chair
Date		**Date**	

Report to:	Public Board of Directors	Agenda item:	17
Date of Meeting:	1 April 2026		

Title of Report:	Health and Safety Annual Report 2024/2025
Status:	For Information
Board Sponsor:	Toni Lynch, Chief Nursing Officer and Interim Director of Estates & Facilities
Author(s):	Corrina Sheridan, Health and Safety Manager Jamie Caulfield, Deputy Director Estates & Facilities
Appendices	Appendix 1: Annual Health and Safety Report 2024/2025

1. Executive Summary of the Report

This annual report has been prepared to inform the Board of Directors of the health and safety management activities from 1 April 2024 to 31 March 2025. These activities are based on the Trust's management responsibilities and governance defined herein. These align with the Health and Safety Executive (HSE) key health and safety issues in healthcare provision. The Trust approach and framework are intended to give visibility and assurance that the Trust has measures in place to limit the impact of health and safety issues on patients, employees, and members of the public.

The Health and Safety Committee and its subcommittees are in place and well attended. They review the risk areas and actions, develop mitigation plans, and monitor progress.

The health and safety audits are in the final year of the 3-year rolling program; the health and safety (H&S) team has audited 54 of the 96 known departments within these 12 months. The audits have identified a need to embed the risk assessment process, which will require capacity and an assessment of knowledge and skills in undertaking the assessments.

During the reporting period, 642 reported incidents were recorded compared to 438 in the previous year. This signifies an improving ‘reporting culture’ within the organisation.

The number of Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) reportable incidents increased from 18 in 2023/24 to 29 in 2024/25.

All health and safety training subjects demonstrate increased compliance among Trust staff who complete them.

2. Recommendations (Note, Approve, Discuss)

There are no recommendations arising from this report. The Board is asked to note the contents of the report, including the key themes, emerging risks and areas where assurance remains constrained, which will continue to be overseen through existing governance arrangements.

3.	Legal / Regulatory Implications

Primary legislation
- Health and Safety at Work etc. Act 1974
- Health and Social Care Act 2008

Key regulations
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Management of Health and Safety at Work Regulations 1999
- Workplace (Health, Safety and Welfare) Regulations 1992
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013

Topic-specific statutory requirements
- Manual Handling Operations Regulations 1992
- Control of Substances Hazardous to Health Regulations 2002 (COSHH)
- Electricity at Work Regulations 1989
- Control of Asbestos Regulations 2012
- Ionising Radiations Regulations 2017 and Ionising Radiation (Medical Exposure) Regulations 2017

Best practice and technical guidance
- Relevant Health Technical Memoranda (HTMs), Approved Codes of Practice and national best-practice guidance applicable to healthcare environments.

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

The Health and Safety Committee oversees a range of health and safety risks recorded on the Trust risk register (Datix), including risks associated with estate condition, environmental safety, workforce capability and statutory compliance. While controls and mitigating actions are in place, some risks remain constrained by factors such as estate backlog and resource capacity and therefore continue to require active management and oversight through established governance arrangements.

5.	Resources Implications (Financial/staffing)

As outlined in Datix risk 2159, there is no dedicated budget to staff the Fit-Testing service. Interim arrangements have been put in place using the Health and Safety team budget, including limited Bank staff support and the purchase of masks and filters, to maintain service provision.

The Health and Safety Committee receives upward assurance from a number of specialist disciplines, highlighting an ageing estate and known backlog maintenance challenges, where reliance on interim and compensatory controls is necessary to manage safety risks in the context of constrained planned investment. These factors require continued active management through established estates, fire safety and health and safety governance arrangements.

6.	Equality and Diversity

There are no identified adverse equality or diversity implications arising directly from this

report. The health and safety risks described apply across the organisation and are managed through established governance arrangements to support the safety of all patients, staff and visitors.

7.	References to previous reports/Next steps

Annual Health & Safety Report 2023/24 - NCGC
Health & Safety Committee Upward Report Q1 2023/24 - NCGC
Health & Safety Committee Upward Report Q2 2023/24 - NCGC
Health & Safety Committee Upward Report Q3 2023/24 - NCGC

8.	Freedom of Information

Public

9.	Sustainability

While this report does not introduce specific sustainability actions, the health and safety risks described are closely linked to the condition and performance of the estate. Increased reliance on interim controls and unplanned works can undermine energy efficiency and sustainability outcomes when compared to planned, strategic investment.

10.	Digital

There are no new digital implications arising from this report. Health and safety assurance relies on established digital systems supporting incident reporting, training records, estates monitoring and access control. Some of these systems are legacy or capacity-constrained and are managed through existing digital, estates and risk governance arrangements.

Annual Health and Safety Report 2024-25

Reference Number:	Agenda item 17
Author & Title:	Corrina Sheridan, Health and Safety Manager
Sponsor:	Toni Lynch, Chief Nursing Officer and Interim Director of Estates & Facilities
Action required:	For Information

Annual Health and Safety Report 2024-25

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DRAFT

1. Executive Summary

This annual report has been prepared to inform the Board of Directors of the health and safety management activities from 1 April 2024 to 31 March 2025. The activities are based upon the Trust management responsibilities and governance defined herein. These align with the Health and Safety Executive (HSE) key health and safety issues in healthcare provision. The Trust approach and framework are intended to give visibility and assurance that the Trust has measures in place to limit the impact of health and safety issues on patients, employees, and members of the public.

The Health and Safety Committee and its subcommittees are in place and well-attended. They review the risk areas and actions, develop mitigation plans, and monitor progress.

The health and safety audit process was completed during 2024/25, the second year of a 3-year rolling program; the Health and Safety (H&S) team has audited 54 of the 96 known departments within these 12 months. The audits have identified a need to embed the risk assessment process, which will require capacity and an assessment of knowledge and skills to undertake the assessments.

During the reporting period, 642 reported incidents were recorded compared to 438 in the previous year. The number of Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) reportable incidents increased from 18 in 2023/24 to 29 in 2024/25.

Health and safety training modules have met the required targets, except for level 2 moving and handling; work is underway to provide additional Induction sessions to improve compliance. These figures do not include Bank or Agency staff.

2. Introduction and Background

2.1 Introduction

The Health and Safety Manager has compiled this annual report in the same format and style as previous annual reports. The data and content have been prepared with input from the Interim Head of Estates, the Health and Safety Manager, and the Health and Safety team.

This annual report covers the period from 1 April 2024 to 31 March 2025. It aims to provide essential information regarding the Trust's health and safety arrangements to protect its employees, patients, contractors, and members of the public.

The Trust's health and safety management system framework is based on the 1997 Health and Safety Executive publication, Successful Health and Safety Management (HSG 65), which follows the plan-do-check-act approach.

The Trust also creates, monitors, and develops an annual Health & Safety Action Plan. This plan is the main operational driver for the Trust, enabling continuous improvement in its safety management system through regular review of performance against key objectives. The key objectives are determined and progressed annually, and a regular focus is provided on the Trust's H&S improvement priorities for the year.

During 2024-25, the key themes for the H&S Action Plan were:

- Developing robust health & safety leadership is essential for creating a progressive health & safety culture within the organisation.
- Implementing a proactive health & safety audit programme across the Trust.
- Continuing to formalise the moving & handling training programme within the wards & departments across the Trust
- Enabling processes to help ensure safe control of hazardous substances (COSHH) across the Trust.
- Horizon scan for new regulations/legislation and guidance affecting Health and Safety law and arrangements.
- To provide a fit-for-purpose fit-testing service.

Progress regarding these principal Health & Safety Action Plan objectives is outlined within Section 4.

The Health and Safety Executive (HSE) identified key health and safety issues in healthcare provision. The Trust has measures in place to limit these impacts on patients, employees, and members of the public.

2.2 Management Responsibilities

Responsibility for health & safety in the Trust rests with the Board of Directors, specifically with the Executive Lead responsible for Health and Safety.

Trust responsibilities are managed through the Health & Safety Committee (HSC) and the Trust Health and Safety Policy.

Staff at all levels throughout the Trust have devolved health and safety responsibilities, and the Trust has a risk management framework to measure and manage them.

3. Governance and Assurance from Subgroups

3.1 Governance Structure

The Executive Lead responsible for Health and Safety chairs the organisation's Health and Safety Committee (HSC), which includes representatives from staff and management across various departments. The Committee meets quarterly.

The HSC reports upward to the Non-Clinical Governance Committee (NCGC), which reviews the minutes of the quarterly meetings.

Two key subgroups (Safer Staff Group and Safer Environment Group) collect and review quarterly reports from all specialist subgroup meetings. As shown in Figure 1, the HSC subgroups are assigned operational assurance for specific areas or aspects. A relevant expert chairs each subgroup, which is represented by Staff and Trust leaders, and meets quarterly.

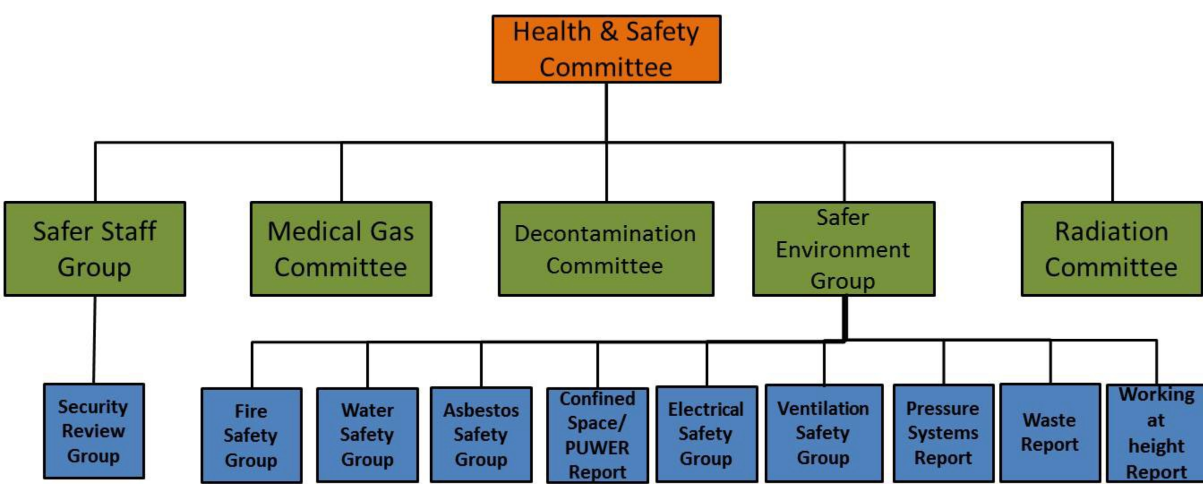


Figure 1: The Trust Health and Safety structure

The Health and Safety team comprises a Health and Safety Manager (Band 7), a Health and Safety Advisor (Band 5 part-time, two days a week), a Manual Handling Lead (Band 5) and two Health and Safety Support officers (Band 4).

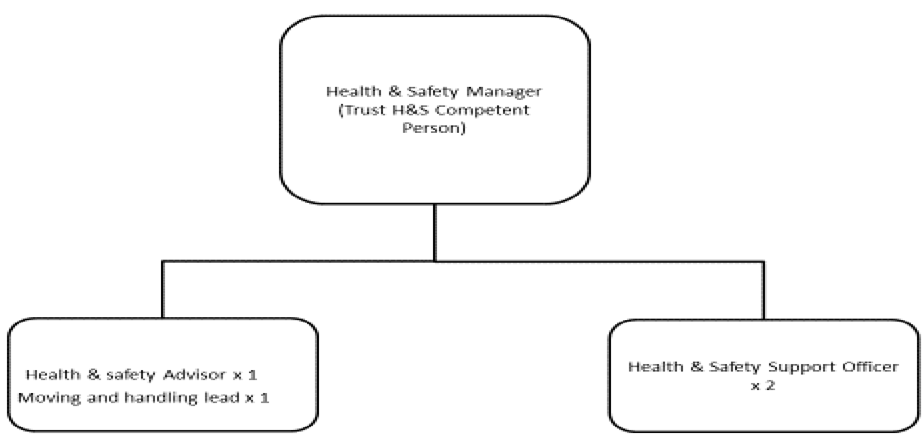


Figure 2: The Health and Safety team structure

3.2 Safer Staff Group

Chaired by: Health and Safety Manager

Item	Status	Comments
Policy		Under review-out of date.
Terms of Reference		Within date. Undergone significant review.
Attendance		Well represented.

The Safer Staff Group (SSG) meets quarterly and reports to the Health and Safety Committee. The statistics presented in the SSG report are taken from the Datix reporting system.

The information in the quarterly report enables SSG to agree on or recommend actions necessary to meet current and future legal, regulatory, and internal standards for staff Health & Safety, project-manage those actions, and monitor performance in this area. The SSG identifies key risks to the Trust and reports these to the Health and Safety Committee as part of the Trust's Risk Assurance Framework. The report contains details of the total number of accidents/incidents reported to the Health and Safety Team during the relevant quarter and the incidents that were reported to the Health

and Safety Executive (HSE) in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013.

3.3 Medical Gas Committee

Chaired by: Head of Estates and Deputy Head of Estates

Item	Status	Comments
Policy		Within date.
Terms of Reference		Within date.
Attendance		Well represented (75-100%) with temporary variation during the year due to personnel changes. However, attendance from IPC was limited.

Key Updates

The medical gas committee has met quarterly.

- **Designated Nursing Officer Training (DNOs):** Considerable progress has been made with identifying and training DNOs. A working group has undertaken a training needs analysis, developed a training plan, and identified individuals requiring training, including the 'training burden' on the organisation. Changes have been made to the mandatory training requirement, which will take twelve months to embed. The recently appointed Fire Safety Trainer will deliver face-to-face 'top-up' training for DNOs during local fire safety training sessions.

- **Cylinder and Stock Management**: The Deputy Head of Facilities provided an assurance report. There are no concerns to note, although it is recognised that the report's contents will change with the proposed Terms of Reference.

Key Risks

Insufficient Designated Nursing Officers (DNO) training for the nursing team (Datix 1898 – Score rating 8)

- **Description:** Insufficient nursing staff trained in medical gases to function as the designated nursing officer and sign permits. As a result, there is a risk that untrained staff sign permits to interrupt the provision of piped medical gases to patients or that staff are unaware of how to respond in an emergency.

- **Control Measures:** Authorised Persons (Medical Gas) provide additional support to nurses in charge upon issuance of permits to work, explaining their responsibilities and ensuring that no patients are adversely affected by potential disruptions to the supply of medical gases.

- **Progress Notes:** Estates Officers have begun delivering enhanced face-to-face training in ward areas. This was trialled in the 'augmented care areas' and is now being rolled out across the site. Progress and effectiveness are monitored through the Medical Gas Committee.

3.4 Decontamination Committee

Chaired by: Head of Estates and Deputy Head of Estates

Item	Status	Comments
Policy		Within date.
Terms of Reference		Within date.
Attendance		Infrequent representation from Microbiology, IPC, FASS, Surgery, Theatres, Urology, Medicine, Endoscopy, Clinical Engineering or Pathology. Good representation from Decontamination

Key Updates

The Decontamination Committee has made the following progress during the past twelve months:

- **Accreditation and Standards:** The Sterile Services Department retained ISO 13485:2016 accreditation for quality management. An unannounced audit by BSI passed with only one minor non-conformance related to standard operating procedure (SOP) training recording. The audit was successfully passed, with only one minor non-conformance being identified. This non-conformance relates to the recording of staff members' SOP training. A corrective action plan has been submitted, and actions are being progressed.

- **Quality:** Product non-conformance averaged below 0.20% for the year, while service-level agreements (SLAs) permit up to 1% non-conformance. Note that some non-conformances are due to damaged instrumentation. Environmental monitoring has taken place as required. The differential pressure regime to maintain cleanliness has been satisfactory. Temperatures within the inspection,

assembly, and packing (IAP) clean room have been within best-practice limits. Inspection, assembly and packing of microbiological contact plates have been within permissible limits.

- **Local Decontamination Audits:** These have taken place as planned. However, there are some gaps in assurance regarding the actions taken in response to non-conformances, and strengthening this assurance is a priority for the Committee during the following year.

Key Risks

Obsolete porous load autoclaves (Risk 2329 – Score 12)

- **Description:** The autoclaves and clean steam generators serving the sterile services department are beyond the end of life, and consequently, there is a business continuity risk that they will eventually fail beyond repair. One of the six autoclaves has failed beyond economical repair. The department needs at least 3 autoclaves to maintain current production levels. A business continuity incident would likely result in the cancellation of theatre waiting lists, impacting patient care or the costly reprovision of sterile services from the private sector.

- **Control Measures:** Planned Maintenance has been increased where possible to prolong asset life. Critical spares are retained from decommissioned units, but this is unsustainable.

- **Progress Notes:** A business case presenting options for their replacement has been developed and was presented to the Clinical Refurbishment Group (CRG), a Capital Prioritisation and Management Group (CPMG) subgroup. This is currently being tendered and expected to be completed within the next 6 months.

3.5 Safer Environment Group

Chaired by: Head of Estates or Deputy Head of Estates

Item	Status	Comments
Policy		N/A
Terms of Reference		Currently under review
Attendance		Well represented. However, variable attendance from Cleaning, Microbiology, SEO (Elec) and IPC.

The Safer Environment Group (SEG) oversees several safety groups and disciplines and reports to the Health & Safety Committee.

The scope of the SEG has increased during the previous 12 months to strengthen its governance over safety domains that previously had no explicit routes to the Board. This includes RAAC, Radon, Pest Control, PLACE, and Waste. The Terms of Reference are under review to reflect these changes and will be submitted to the Health & Safety Committee for approval in November 2024.

Key Updates

- **Backlog Maintenance:** There continue to be challenges with backlog maintenance across the Combe Park estate. The value of backlog maintenance is anticipated to have increased further from last year's value of £66M. As a result, the number of safety incidents reported via Datix due to the environment is increasing.

- **Radon Testing & Management:** Comprehensive radon testing is now part of a rolling programme across the site.

- **Capital Projects (safety-related):** Significant refurbishment and installation works completed. Enhanced fire safety measures, utility improvements, accessibility upgrades, and security enhancements were implemented. Emergency lighting system upgrades were carried out.

Key Risks

ID2110 - Business interruption due to backlog maintenance or critical infrastructure risks. Score 16.

- There is an escalating risk of service disruption due to growing backlog maintenance (>£66m) and critical infrastructure issues (£23m). Contributing factors include inadequate ventilation, fire safety deficiencies, and faulty systems. The backlog is increasing by £5m annually, outpacing the £1m average investment, potentially impacting patient care and the environment for extended periods.

ID1882 - Damaged Fire Doors. Score 15.

- There is a risk that numerous fire doors across our site, identified as requiring repair, upgrading, or replacement, may not effectively contain fire or smoke due to their current condition. Our fire safety officer is currently reviewing conditions across the site to support prioritisation and scheduling of works as funds are available.

ID1886 - Fire compartmentation deficiencies. Score 15.

- There is a risk that breaches in fire compartmentation across the site could prevent the fire from being contained and, therefore, reduce the effectiveness of progressive horizontal evacuation. Progress has been made to ensure that fire training now identifies the requirement to move two compartment lines from any risk; a “Permit to breach” has been implemented as part of the wider investment for 2025-26.

ID1881 - Emergency Lighting. Score 12.

- There is a risk that, due to non-compliant emergency lighting in certain outpatient and non-clinical areas, insufficient lighting levels may impede the safe evacuation of people or the execution of department business continuity plans during an emergency. The focus for 24/25 is to update the programme of emergency lighting replacements and install lighting in the remaining inpatient areas identified in the programme; however, there has been a delay and this is expected to continue through 25/26.

ID2684 - Fire Risk Assessments (FRA). Score 12.

- FRA Surveys have been completed across the site, with final surveys currently underway in accommodation blocks. The assessor highlighted several generic risks that could compromise patient safety during a fire or evacuation. The focus for 25/26 is to ensure that all responsible persons are issued improvement plans.

ID2723 - Risk to Health from Radon Gas. Score 12.

- Elevated cancer risk due to Radon gas exposure, particularly for staff working in areas with Radon levels above the action threshold for extended periods. Controls: Trust policy for Radon management, co-authored by Estates and the Radiation Protection Advisor/Subject Matter Expert Monitoring in high-risk areas

(Residences, Children Ward, Neonatal Unit) and areas with noted high Radon levels; Yearly monitoring and fan maintenance in Medical Equipment Management/Medical Equipment Library area to keep levels below action threshold; Radon control barriers included in new building foundations; Expanded monitoring to wider areas of the Trust as advised by external contractor.

ID1881 - Departments have insufficient emergency lighting. Score 12.

- A phased action plan has been developed to address this work. Phase 4, involving another 28 departments, has commenced.

ID1205 - The Trust cannot demonstrate sufficient compliance with the Control of Asbestos Regulations (CAR) 2012. Score 6.

- This Datix is historic (2015), and significant improvement has been made in the last three years. The Trust now has yearly asbestos audits, a suite of revised SOPs, and a revised Asbestos Management Plan (AMP). The Asbestos Management Plan and corresponding SOPs have been reviewed, reissued, and staff trained. As a result, the score was reduced to 6, and we are now awaiting a further audit by the Authorising Engineer.

ID1891 - Periodic Testing and Inspection is out of date—score 12.

- A five-year action plan has been developed, and the Trust is in the third year of its implementation. However, it is currently stalling, hence the risk rating has increased from 9.

ID2493 - Obsolete Nurse Call Haygarth and Forrester Brown Wards. Score 12.

- The ageing Haygarth and Forrester Brown nurse call systems are now obsolete and no longer supported by the manufacturer. If the main control panel fails, the ward will have no call bell system until a new one is purchased and installed. A project is underway to upgrade nurse call systems. To date, Cheselden Ward has been completed, and further areas are underway. However, these areas have not yet been completed, and the delays have increased the risk.

3.6 Radiation Protection Committee (RPC)

The RPC reviews the management of radiation safety within the Trust, including compliance with the Ionising Radiations Regulations 2017 (IRR17) and aspects of the

Environmental Permitting Regulations 2016 (EPR16) related to radioactive materials. The RPC reports to the Trust Health and Safety Committee. It also reviews compliance with the patient-focused Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER17). These aspects of the RPC's work are reported to the Trust Quality and Safety Group and are not included in this report.

The RPC met in April and November 2024.

Regulatory Compliance and Inspections

The Trust contacted the Environment Agency (EA) in December regarding an anticipated permit breach related to the amount of Selenium-75 held on site. Following supply issues with SeHCAT capsules from GE, the orders placed were increased to avoid short-notice cancellations of patient scans. During December, due to patients not attending appointments, the number of capsules on-site was higher than expected, and the deadline for cancelling the order for the next delivery was missed. The EA was contacted in advance of the delivery and granted the RUH permission to exceed the Se75 limit on a temporary basis. It was noted that no other permit limits (waste accumulation or disposal) would be exceeded. Following the incident, procedures for monitoring and ordering SeHCAT capsules have been revised to avoid any recurrence.

There were no regulatory inspections during 2024-25.

Significant Changes to Practices

Nuclear Medicine and DEXA moved to Department B58 in the Dyson Cancer Centre in May 2024. All risk assessments and Local Rules have been reviewed to reflect changes in practice resulting from the move. During a changeover period, a split service was run with some scanning continuing in C16 to maximise capacity. This concluded successfully with no significant incidents reported. The old "Clinical Imaging and Measurement" and "Medical Physics and Bioengineering" Departments were monitored for radioactive contamination, and the results confirmed that no radioactive sources remain, there is no radioactive contamination, and there are no radioactive signs or trefoils.

Management of Radiation Protection

The RPC's business included:

- Review and ratification of appointments of qualified experts (Radiation Protection Advisers (RPA), Radioactive Waste Adviser (RWA), Laser Protection Adviser (LPA), Radiation Protection Supervisors (RPS) and Laser Protection Supervisors (LPS).

- Monitor the compliance audit schedule and review radiation risk assessments, local rules, and contingency plan rehearsals. Some of these are overdue for review, with an agreed plan to tackle the backlog.

- Receiving reports on compliance with legislation and good practice from managers and RPSs. There are no significant issues to escalate.

- Review of the management of radiation protection, including staff dosimetry and the results of investigations of doses above investigation thresholds, communication between employers where individuals have more than one employment, arrangements for classified workers, environmental radiation monitoring, and review of incidents involving radiation exposure.

Exceptions and Challenges

Training is an identified area of regulatory non-compliance

- HSE/EA expectation is that any training requirements identified in the radiation risk assessment are met and that they are evidenced.

- Basic radiation awareness training is now included as part of all staff's mandatory health and safety training on Learn Together.

- The recording of other delivered radiation protection training has been set up on Learn Together, for staff working in radiation areas, so that training compliance can be monitored more effectively.

- Work continues to create and deliver learning packages for approximately 40 individual staff groups who work directly with radiation or in radiation-controlled areas and who require training specific to their roles. The long-term goal is to set these up on Learn Together as on-demand courses.

Appointment of Radiation Protection Supervisors

- RPSs were not appointed for the use of mini-C-arms in TAU and Theatres, in breach of IRR. At the end of 2024/25, this issue was being escalated, as the use of these X-ray imaging systems could not continue without an appropriately trained RPS.

Radiation Protection expert staffing

- The RPC reported concerns that timely progress against regulatory compliance issues is challenging due to staffing vacancies in Medical Physics and, especially, very limited numbers of RPA- and MPE-certified staff. There are concerns that this situation would worsen if medical physics services were extended to Salisbury or other ICS locations without an adequate increase in medical physics staffing.

4. Progress against the Health and Safety Action Plan

4.1 Leadership

The annual health and safety plan set out key actions that focus the Trust's attention on encouraging strong leadership through active management and collective ownership, and on creating healthier, safer workplaces by targeting risk priorities and implementing effective measurement and monitoring systems.

The Health and Safety team supports departments upon request by conducting risk assessments. Generic risk assessment templates are available on the intranet health and safety page for Departments to amend and use. The Health and Safety team is also responsible for providing the Face Fit testing service to the Trust without any funding, health and safety audit, and it also provides face-to-face moving and handling training across the Trust; this includes Induction, training the trainer for the Department trainers and as required the team investigates incidents, advises on health and safety issues and endeavours where possible to promote a good health and safety culture. Other functions are described within the report.

Key themes from the annual health and safety action plan:

- Developing robust health and safety leadership is essential in driving and improving the Trust's safety culture.

Health & Safety training for the Trust Executive and Non-Executive Board members

was initially delivered in February 2024, and the designated Trust Executive responsible for leading on health and safety changed at the start of 2024/25, from the Director of Estates to the Director of Nursing.

A Health & Safety for Managers Training course was developed and delivered by the H&S Department and continued to be provided during 2024/25 each month via Microsoft Teams. It is recorded on the Trust's "Learn Together" education and learning platform. During 2024/25, 19 additional Managers were trained via this medium. This essential training continues to be provided monthly as a 'one-hour' session on Microsoft Teams, and managers are regularly encouraged to attend to continue improvements in H&S leadership.

- Health and safety audits are a fundamental requirement of any safety management system. It is essential that audits be undertaken to continually improve the Trust's safety culture. This enables understanding and proactive planning for improvements when safety concerns are identified.

The Health & Safety Audit program completed its second year of a 3-year cycle during 2024-25, and the details of this significant achievement are highlighted in the audit section [4.2].

- Ensure that moving and handling training is delivered to all staff in line with organisational requirements.

The Trust Moving and Handling Leads deliver moving and handling training to the Departmental trainers. The Departmental trainers provide ongoing handling training, monitoring, and mentoring for staff at the ward level, which achieved significant improvements during 2024-25.

Four courses for new trainers were provided, and 16 new Departmental manual handling trainers were trained. Ten refresher sessions for Department Trainers have been completed, and 44 trainers have been refreshed.

- Safe control of substances hazardous to health and routine checking of safe systems of work are key requirements of a robust safety management system.

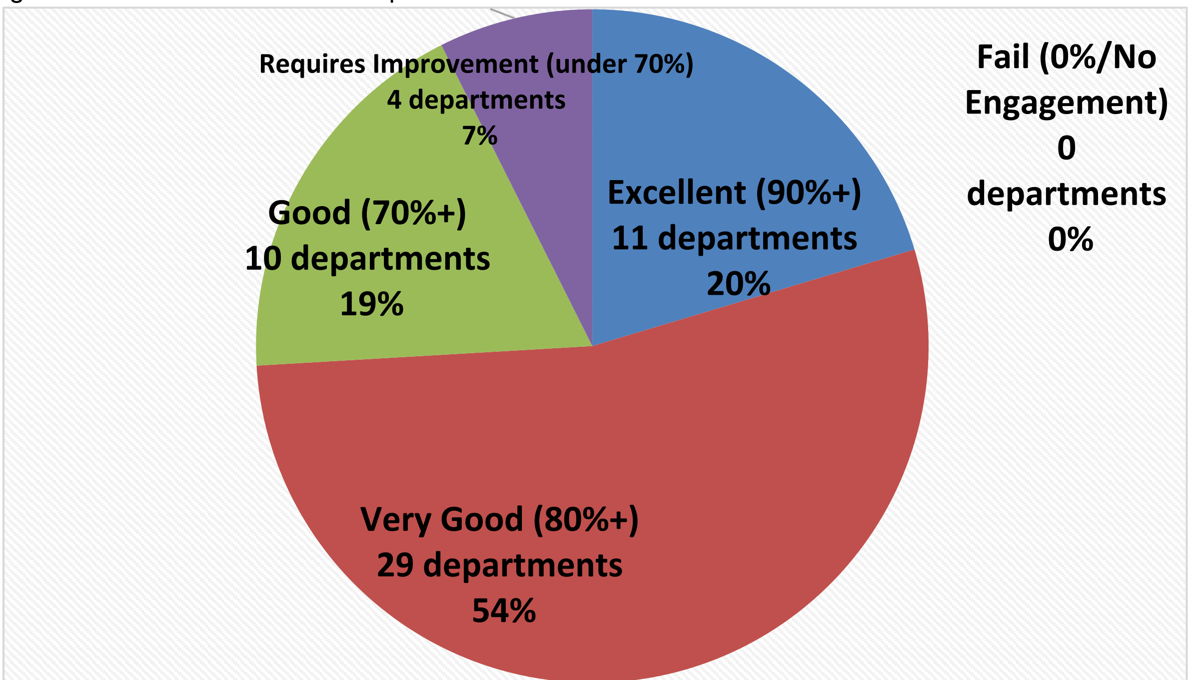
4.2 Audit

Under the Trust Health and Safety policy, section 6.1, and in line with HSE best practices, formal safety auditing is part of our management control system. This

process identifies whether the Trust meets its legal responsibilities under the Health and Safety at Work, etc. Act 1974 and ensures effective action is being taken to safeguard our staff and patients.

The Health and Safety team conducted a comprehensive audit of all RUH departments, planned over three years. By the end of 2024 - 2025 (Year Two), the team audited **54 of the remaining 96 known departments**. The audit timetable for 2025 - 2026 (Year Three) is communicated to all divisions during the quarterly Safer Staff Group meetings.

Figure 3: Results from the 54 completed audits



Audit Score	Number of Departments	Percentage
90+	11	20%
80+	29	54%
70+	10	19%
Below 70	4	7%
Not Complete	0	0%
Total	54	100

Figure 4 illustrates the scores for 54 respondents across 15 areas reviewed in the audit. Figure 4 consolidates information from all verified audits conducted throughout Quarters 1 to 4 of 2024 - 2025 (Year Two).

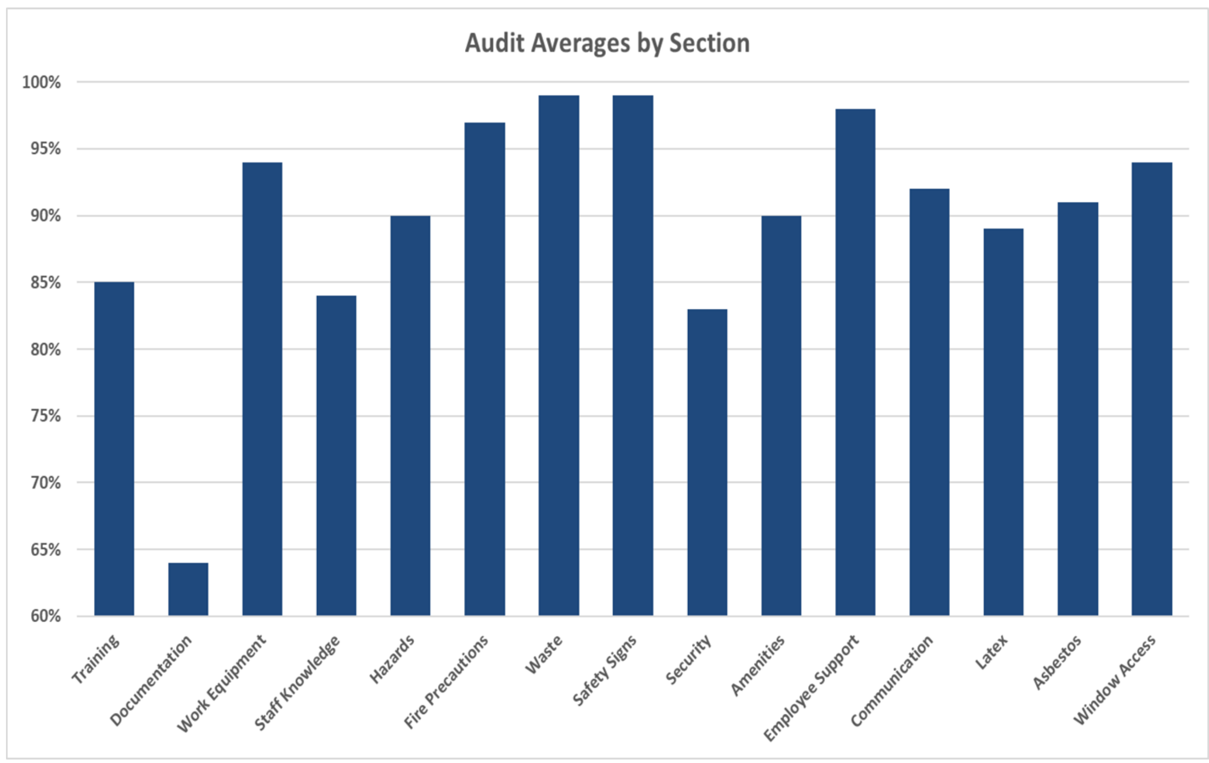


Figure 4: Verified audits undertaken throughout Q1, Q2, Q3 and Q4 of 2024-2025 (Year Two)

Areas of Focus

Documentation (63%)

Documentation is crucial for protecting the Trust in litigation. It ensures compliance with legal obligations and demonstrates a proactive approach to managing health and safety risks.

Risk assessments are essential documentation items that help protect our staff and patients and ensure compliance with the law. They focus on significant workplace risks—the ones with the potential to cause actual harm.

The Health & Safety team initiated online training sessions focused on risk assessments, health and safety for managers, and understanding COSHH (Control of Substances Hazardous to Health) to enhance documentation practices. Participation has been encouraging, with 38 staff completing risk assessment training and 13 managers completing health and safety training.

Departments are asked to author their own risk assessments. Staff with knowledge and understanding of the work involved are best positioned to identify hazards and risks and ensure accurate and relevant documentation.

The Health and Safety Committee will continue to oversee the documentation audit results, which measure documentation practices. The Committee will highlight ongoing documentation compliance in reports to the Non-Clinical Governance Committee.

The Health and Safety team will support departments needing help with documentation.

Staff Knowledge (84%)

Under the Management of Health and Safety at Work Regulations 1999, employers must make suitable and sufficient risk assessments and consult with employees. Staff should be aware of safety documentation and emergency procedures to mitigate risks effectively.

The audit aims to ensure that all employees are familiar with the contents and locations of safety documents. Departments are encouraged to involve staff in creating and reviewing safety documentation to foster a deeper understanding. The health and safety team reinforces this through various training courses, including risk assessment, manual handling, and COSHH.

The Health and Safety Committee will monitor and report on audit results, and review and promote participation in various training programs.

Training (85%)

Training is vital in preventing incidents and ensuring legal compliance. Under the Health and Safety (Training for Employment) Regulations 1990, appropriate training must be provided, with refresher sessions for high-risk, complex, or infrequent tasks.
Mandatory training in both essential and core subjects showed improvement over the reporting year, with core subjects above target (88.68% as of March 2025) and essential subjects also over target (89.50% as of March 2024).

The Health and Safety Committee and its subcommittees will closely monitor and report on training compliance levels and follow up with departments that are not meeting targets.

In cases of ongoing non-compliance, divisional or departmental representatives are responsible for addressing the issue during divisional or departmental meetings to increase awareness and compliance levels. The People Directorate also monitors mandatory training and reports through the People Committee.

4.3 Horizon Scanning

The Health and Safety Manager and Advisor are members of the IOSH Southwest Health Care group. This group allows the sharing of best practices and the identification of changes in health and safety legislation. The Health and Safety Manager continues to develop and maintain working relationships with health and safety team members at SFT and GWH to share best-practice examples.

4.4 Manual Handling

Ergonomics and Working Environment, Including DSE

The Trust is required to undertake risk assessments for ergonomics and the working environment, which are achieved through the Trust template assessment for display screen equipment (DSE). Individual employees are responsible for preparing DSE assessments, and line managers are responsible for ensuring these are produced and for implementing mitigations that may arise from them. DSE assessments need to be undertaken by staff and reviewed/updated whenever any ergonomics or working environment changes occur (e.g., staff member moves, new desks, or equipment). The Health and Safety team has supported 77 DSE assessments this year, a slight reduction of 2 from last year. Many of these assessments have been for existing staff with new issues requiring support in setting up workstations to ensure the best setup within the workplace.

Moving and Handling Training

The Health and Safety team has a competent Moving and Handling Lead to deliver training on moving and handling across the Trust. This includes Induction training for all new starters who will be assisting patients, falls kit training, and department trainers via Train-the-Trainer courses. To mitigate the single point of failure of having only one competent person to provide the moving and handling training, a second team member undertook an external manual handling train-the-trainer course in July 2024.

4.5 Face Fit Testing (FFT)

The Health and Safety team continues to run the Fit testing service with no extra resources, which has impacted the health and safety service provision. Extra hours provided by our bank staff member have now ceased. The only hours available are 6 per week, provided by one member of the Health and Safety team. There is no cover for sickness or annual leave, so in these instances, appointments are cancelled.

*FFP3 face masks protect from viruses, bacteria, and solid or liquid toxic aerosols. These masks are commonly used by those working in the healthcare industry as personal protective equipment (PPE)

4.6 Control of Substances Hazardous to Health (COSHH)

Information about managing COSHH is available on the Trust Intranet. The Health and Safety team provides COSHH awareness sessions on Teams, which are booked via the Learn Together platform. The team also supports departments, upon request, by conducting risk assessments, including COSHH assessments.

Safe control of substances hazardous to health and routine checking of safe systems of work are key requirements of a robust safety management system. The Health & Safety Audits completed during 2024-25 include a section of questions regarding the 'Control of Substances Hazardous to Health' [COSHH] and ensured that essential feedback on any improvement requirements identified was provided to the appropriate Departmental management.

The 'Control of Substances Hazardous to Health [COSHH] Training course was developed and delivered by the H&S Department and continued to be provided during 2024/25 every month via Microsoft Teams and is recorded on the Trust's' Learn Together' education and learning platform.

During 2024/25, 25 additional Managers and staff were trained via this medium. This essential training continues to be provided monthly as a 'one-hour' session on Microsoft Teams, and managers are regularly encouraged to attend or to encourage other delegates from their teams who are responsible for good COSHH management within their wards and departments to attend.

5. Progress against other Key Objectives

5.1 Incidents

Table 1 demonstrates the breakdown of reported incidents from 2019-20 to 2024-25,

using the risk categories and data drawn from Datix.

Category	2020-21	2021-22	2022-23	2023-24	2024-25	Trend
Environment/H&S non-clinical	57	85	52	55	96	↑
Fire	72	70	59	40	79	↑
Ill Health	260	118	76	93	156	↑
Personal Accident/accidental injury	315	258	249	294	311	↑
Vehicle	2	0	1	1	0	↓
Total	**706**	**531**	**437**	**483**	**642**	↑

Table 1: Breakdown of incidents

The table documents the total number of Health & Safety incidents reported. The top three categories within personal accidents/accidental injury are as follows:

Collision/contact with an object [95]. Only three of these incidents were reported as 'moderate harm', and two of which were reported as RIDDOR accidents. The remainder were low- or no-harm reports.

Contact with sharps/needlestick [151]. - No trend was noted; departments affected are spread across the Trust. 119 of these incidents were reported as 'minor harm', and only 1 as 'moderate harm'. None were reported as a RIDDOR level incident.

Reported issues include no harm and incorrect disposal of sharps within the reported incidents.

Slip, trip or fall. [66] - There continues to be a trend of wet floors throughout this year, as reported incidents related to slips, trips, and falls continue to occur. Of those reported, 12 were classified as 'moderate harm', of which 10 were reported as RIDDOR incidents. The remainder were reported as low or no-harm incidents. The cleaning department management has been notified of this trend, as it affects them and compliance with cleaning protocols, whilst the remainder are due to wet weather, which brings water and leaves into corridors through footfall and general staff care and attention.

5.2 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) Incidents

There were twenty-nine [29] RIDDORS reported from 1 April 2024 to 31 March 2025, as highlighted in Table 2.

	Estates & Facilities	Family & Specialist Services	Medical Division	Surgical Division	Totals
Another kind of accident	1	1	1	0	**3**
Fell from a height	0	1	0	0	**1**
Lifting and handling injuries	3	0	4	1	**8**
Physical assault	0	1	2	2	**5**
Slip, trip, fall, same level	3	1	3	3	**10**
Struck against	1	0	0	0	**1**
Struck by an object	0	0	0	1	**1**
Totals	**8**	**4**	**10**	**7**	**29**

Table 2: Incidents by RIDDOR Accident Types and Divisions in which they occurred

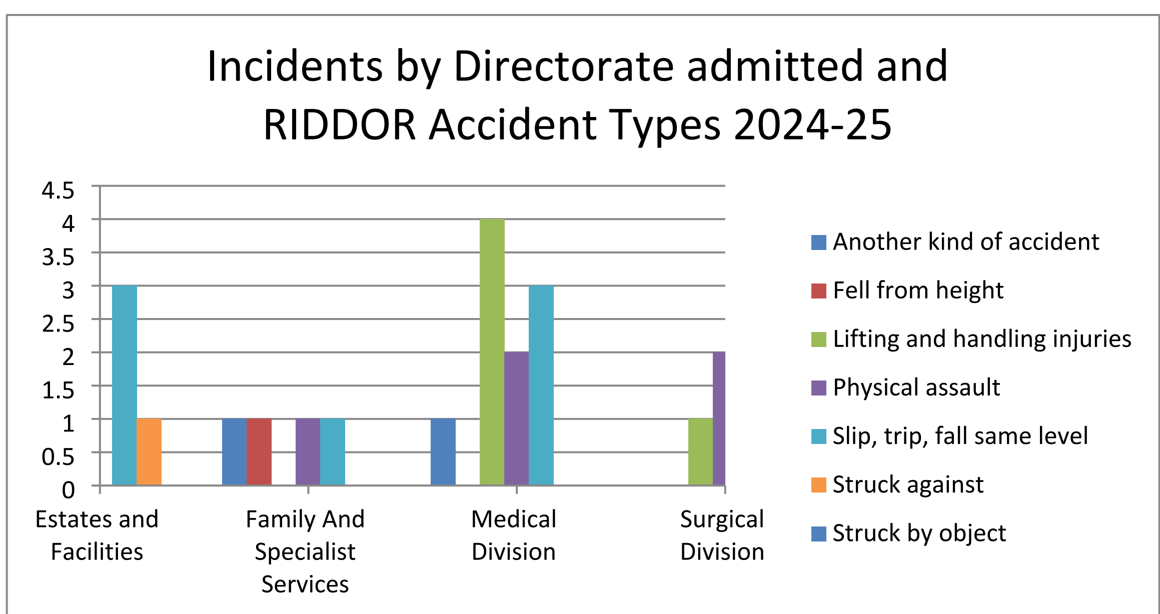


Table 3: RIDDOR incidents by accident type and location

There have been 642 incidents reported via the Datix system during 2024/25 compared to 438 in the previous year. RIDDOR reportable incidents have increased

from 18 to 29. The health and safety team oversees all reported incidents and determines which should be reported under RIDDOR.

Table 4 identifies the types of reported RIDDOR incidents over the last three years.

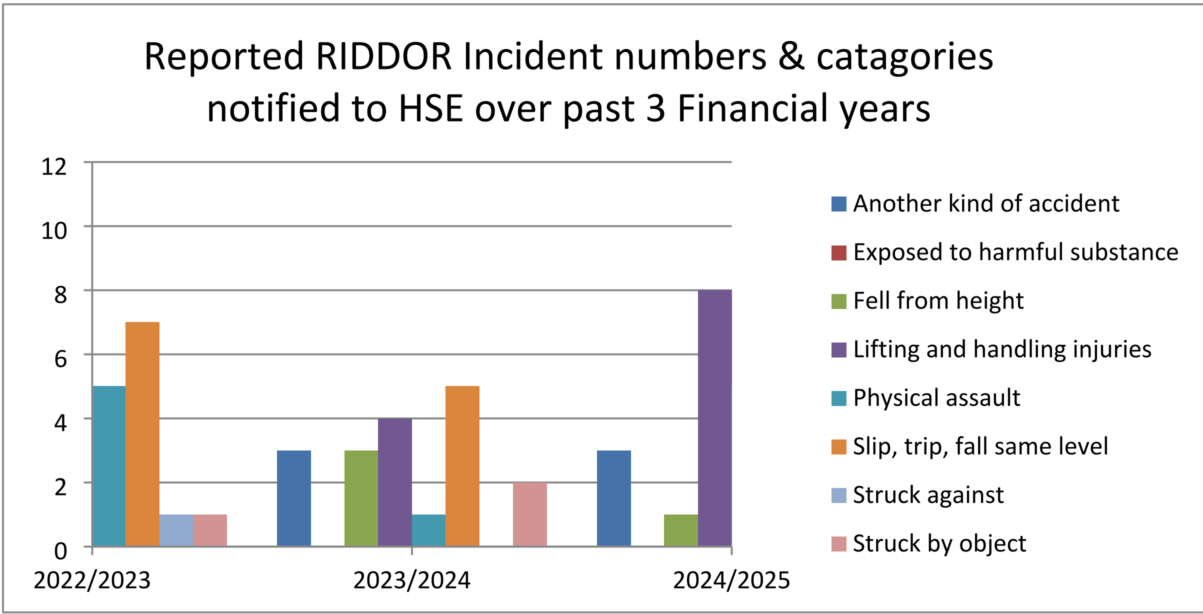
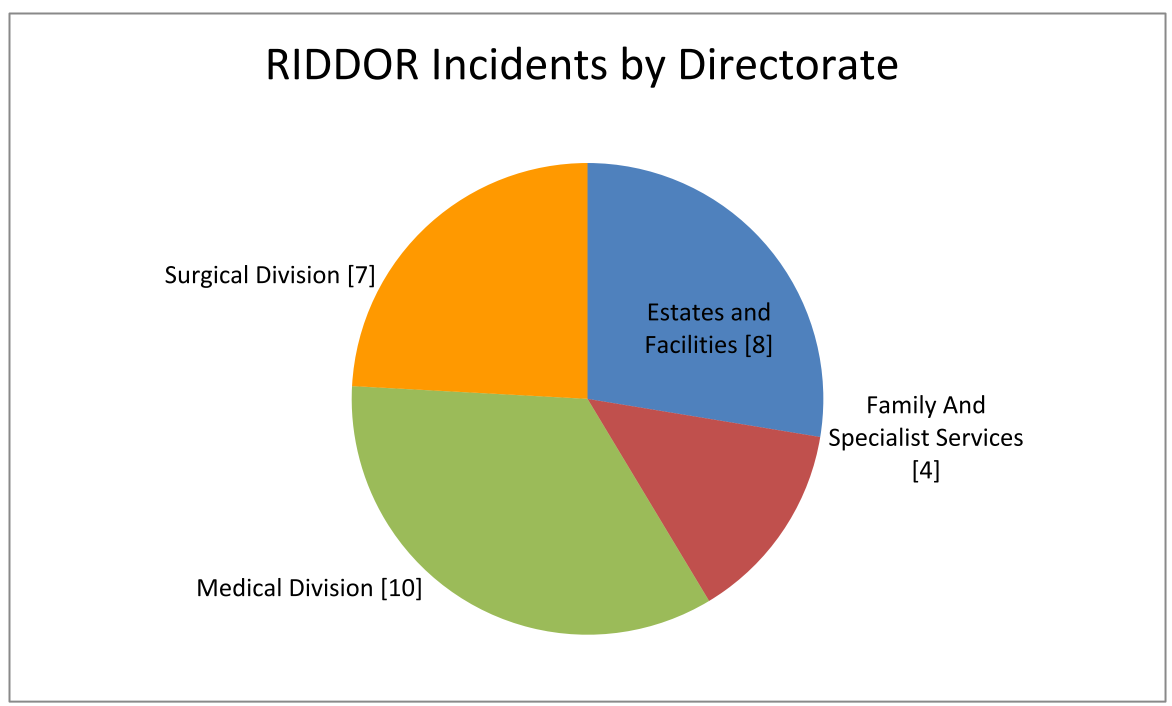


Table 4: Three-year overview of reported RIDDOR incidents



5.3 Health and Safety Mandatory Training

Health and safety training relates to the areas shown in Table 5. The training compliance figures and annual trajectory for the reporting year are shown.

Subject	2020-21	2021-22	2022-23	2023-24	2024-25	Trend	Target
Conflict Resolution Training	**89.1%**	87.4%	88.1%	96.7%	95.2	↓	85%
H & S	**87.8%**	84.7%	83.1%	92.6%	94.1	↑	85%
Moving and Handling (Level 1)-Loads	**88.8%**	85.6%	84.5%	92.7 %	92.4	↓	85%
Moving and Handling (Level 2)-Patients	**76.4**	71.1%	76.2 %	83.6%	82.3	↓↑	85%

Table 5: Health and Safety Mandatory Training Compliance

Health and safety training modules have met the required targets, except for level 2 moving and handling; work is underway to provide more Induction sessions for level 2 moving and handling to improve compliance. These figures do not include Bank or Agency staff.

Safety training

All line managers must manage health and safety as part of their responsibilities, and all staff must work safely and follow health and safety arrangements. The Health and Safety team has provided H&S training for managers, risk assessment training, and COSHH training via the Microsoft Teams one-hour session for each subject, which can be booked via the Learn Together platform.

5.4 Culture

The Trust acknowledges that establishing and growing a strong health and safety culture is a fundamental cornerstone of ensuring our safety management systems remain safe, efficient, and effective for all stakeholders and is an integral part of the Trust's health and safety Transformation planning and the reinvigoration and continued growth of its safety culture. The annual health and safety plan is also derived from the understanding that all Trust staff need to help in continual H&S improvement,

whether that is a simple promotion and reinforcement of positive action, such as consistently reporting something unsafe that you have observed or following a safe system of work to keep yourself and your colleagues safe at work.

All the health and safety annual action plan objectives and targets have been reviewed and approved by the Health and Safety Committee and selected as this year's health and safety improvement actions based on identified safety concerns at a national or local level, or as potential areas of improvement.

The results of the health and safety audit demonstrate that improvements are required.

5.5 Fire Safety

2025 builds on the advances made in the previous year. The Fire Safety Strategic Action Plan continues to serve as the basis for the Fire Team's work and progress. During the previous twelve months, the Fire Safety Committee has made considerable progress in the following areas:

- **Fire Safety Policy 803.** This has been ratified, and its next review is due on 12 June 2026. Minor amendments regarding the updated responsible Director will be completed.

- **Fire Safety Protocols**. These are being reviewed and, where necessary, rewritten to support the management arrangements and actions regarding fire safety. The progress of these is part of the Project and the driver's fortnightly review. There has been progress in implementing new Standard Operating Procedures, and others are currently being developed.

- **Recruitment.** The fire safety trainer is now in a more defined role and plays a key role in improving training compliance. In addition, in March 2025, the Fire Safety Manager joined the team to fulfil the role of full-time fire safety manager, replacing the additional shared role previously held by the Associate Director of Estates and the Senior Estates Officer (Buildings).

- **Fire Risk Assessments**. Fire Risk Assessments (Datix 2684, score 12) – 95% of FRA reviews complete; remaining accommodation blocks and wards will be finished once Fire Improvement works are concluded. Community sites are now incorporated into the programme.

- **Planned Maintenance**. A new Fire Extinguisher maintenance contract is in place, and works are progressing. Maintenance of other fire assets is on program, and additional quotes are being sourced for the Damper maintenance contract.

- **Training compliance** – Trust-wide compliance at 87.9% (above internal target of 85%, below HTM target of 90%). Bank staff compliance is improving but remains low at 76.8%. Monthly targeted sessions established.

Key Fire Infrastructure Risks

The Trust Board has been made aware of several critical risks related to the Trust's fire safety infrastructure. These risks, previously identified, require ongoing attention and significant investment to ensure the safety of patients, staff and visitors. Key points include:

- **Fire Safety Improvement Works (J4 Projects) – PAW (Princess Anne Wing)**
  - Charlotte works complete
  - Central Phase 1 area complete
  - Chesleden nearing completion – target end of October 2025
  - Mary Ward – dates tbc

- **Central Block programme tbc (likely November 2025 onwards)**
  - Cath Labs Lift conversion to Evacuation Lift and compartmentation works

- **Fire Compartmentation Survey –** the audits of fire compartmentation, including dampers and fire doors, carried out so far need to be supported by a full compartmentation survey of building structures and substrates. To ensure that when a survey is carried out, it is appropriate to the required compartmentation and sub-compartmentation, and to the required level of fire-resistance, to be compliant and to provide the optimum time for evacuation, these surveys need to be in accordance with a current building fire strategy. We are currently awaiting a quote (expected October/November 2025) for the provision of retrospective fire strategies for our buildings that lack a suitable fire strategy. This quote is from a fire engineering provider, OFR (formerly Olsson Fire & Risk UK Ltd). The delay in receiving the quotes is due to the increased demand for Fire Engineers following the Grenfell Tragedy.

- **Evacuation procedures** – Programme of site-wide evacuation policy and localised plans being developed. Exercises in Helena, MSS, SAU and Cath Labs have identified key improvements.

- **Fire Alarm and Detection Cause and Effects** - Inspections began in 2025 for the whole site and will be monitored by the Fire Task and Finish Group. A review of the issues is underway, and a project is in place to address the identified issues through a risk-based action plan.

While actions are being taken to improve fire detection, alarms, and emergency lighting in priority areas, it is important to emphasise that some risks will persist due to budget limitations. Ongoing vigilance, staff training, and regular risk assessments will be crucial to maintaining safety standards in areas awaiting future improvements.

5.6 Risk Management and Mitigation

The Health and Safety Committee oversees various risks captured on the risk register (Datix) and managed by the most appropriate subgroups. Each identified risk is assigned a named lead and an associated action plan with specific timeframes.

The Committee ensures that all risks are systematically reviewed and appropriate mitigation strategies are implemented. This includes regularly monitoring and updating the risk register to reflect any changes in the risk landscape. The Committee also ensures that all staff are adequately trained and informed about the risks and mitigation measures.

Furthermore, the Committee collaborates with other departments and external agencies to ensure a comprehensive risk management approach. This includes sharing best practices, conducting joint risk assessments, and participating in external audits and inspections.

6 Conclusion/Summary

In conclusion, the Health & Safety Annual Report 2024/2025 provides a comprehensive overview of the Trust's health and safety management activities over the past year. The report highlights significant achievements, including the successful implementation of health and safety audits, increased training compliance, and effective incident-reporting mechanisms. Despite challenges such as resource constraints and the need for improved risk assessments, the Trust has demonstrated

a commitment to maintaining a safe environment for patients, employees, and the public.

The Health and Safety Committee and its subcommittees have played a crucial role in identifying and mitigating risks, ensuring that all necessary measures are in place to address potential hazards. The progress made in key areas, such as training Designated Nursing Officers in medical gas and managing obsolete and aged equipment and estate, underscores the Trust's dedication to continuous improvement. The Trust aims to build on these achievements by addressing documentation gaps, enhancing training compliance, and fostering a robust health and safety culture. The ongoing efforts to monitor and update the risk register, collaborate with external agencies, and implement best practices will be instrumental in achieving these goals.